INNOVATIONS IN PRIMARY CARE

Providing Office-Based Treatment of Opioid Use Disorder

Courtenay Gilmore Wilson, PharmD; E. Blake Fagan, MD

Ann Fam Med 2017;15:481. https://doi.org/10.1370/afm.2139.

THE INNOVATION

Office-Based Opioid Treatment (OBOT) with buprenorphine has been available since 2000; however, many barriers to OBOT within primary care exist, and only 3.6% of family medicine physicians are waivered to prescribe buprenorphine.[1] We have successfully integrated OBOT into our primary care practice, expanding access to treatment for opioid use disorder.

WHO & WHERE

A team comprising a physician, a clinical pharmacist, a nurse practitioner, and a behavioral medicine specialist developed OBOT for the Mountain Area Heath Education Center, which is a large family medicine residency serving over 23,000 patients in rural western North Carolina.

HOW

Nationally, 80% of patients with opioid use disorder do not have access to treatment.[2] One of these patients was ours. A young mother, whose 2 children we had delivered, asked us for help that we could not provide. Not long after, she died of an overdose. This was our impetus to begin OBOT in 3 phases: foundation, pilot, and expansion.

Foundation

As a large organization, engaging stakeholders, including the C-suite, risk management, and medical and clinical directors, was a crucial first step. Common concerns we addressed included the time required to provide OBOT, the challenging patient population addressed by this service, and potential legal implications. Educating leadership on the local impact of this epidemic, sharing anecdotes of current patients, and outlining a team-based approach to OBOT were especially powerful tools in this conversation. Over the course of a year, we gained approval to begin OBOT.

Pilot

In July 2015, we formed our team from existing resources: a physician champion, who led the team; a clinical pharmacist, who wrote the policies and procedures, patient agreements, and treatment protocols (Supplemental Appendix); a nurse practitioner, who screened eligible patients; and a Licensed Clinical Social Worker, who provided counseling to our patients. No additional funding was needed for this pilot. We used existing resources, such as the Providers' Clinical Support System for Medication Assisted Treatment (http://pcssmat.org), and a local psychiatrist to provide clinical support. Initially, we only treated established patients in the maintenance phase of their treatment. By starting with these clinically stable patients, our team was able to gain the hands-on experience that is vital in OBOT. During the first year, 5 faculty physicians prescribed buprenorphine for 14 patients.

Expansion

In July 2016, we expanded our OBOT service. We trained an additional 11 faculty physicians and incorporated annual buprenorphine training for third year residents into the residency curriculum. We opened our service to new patients and started inductions. In September 2016, we formed group medical OBOT visits, and in March 2017 we hired a Licensed Clinical Social Worker who is also a Licensed Clinical Addiction Specialist to coordinate our program, augment behavioral medicine services, and grow our program to a target of 100 patients. Funding for this position was justified by the increase in medical visits for OBOT demonstrated during the pilot phase. In May 2017, the nurse practitioner began prescribing buprenorphine. We currently treat over 50 patients with opioid use disorder in western North Carolina.

LEARNING

Providing OBOT in primary care requires coordination, time, and communication across members of the health care team. Having a core interdisciplinary team is essential. Starting slowly will allow the team to adapt to unexpected barriers and to increase their own comfort level with OBOT. Once the OBOT service is established, then the team can focus on growth.

Conflicts of interest: authors report none.

Corresponding author
Courtenay Gilmore Wilson, PharmD, BCPS, BCACP, CDE, CPP
UNC Eshelman School of Pharmacy
123 Hendersonville Rd, Asheville, NC 28803
Courtenay.wilson@mahec.net

Key words: buprenorphine; opioid use disorder; primary health care; interdisciplinary team

Author affiliations, references, and a supplemental appendix are available at http://www.AnnFamMed.org/content/15/5/481/suppl/DC1/.