Mass General Brigham

Addressing Opioid Use in Primary Care

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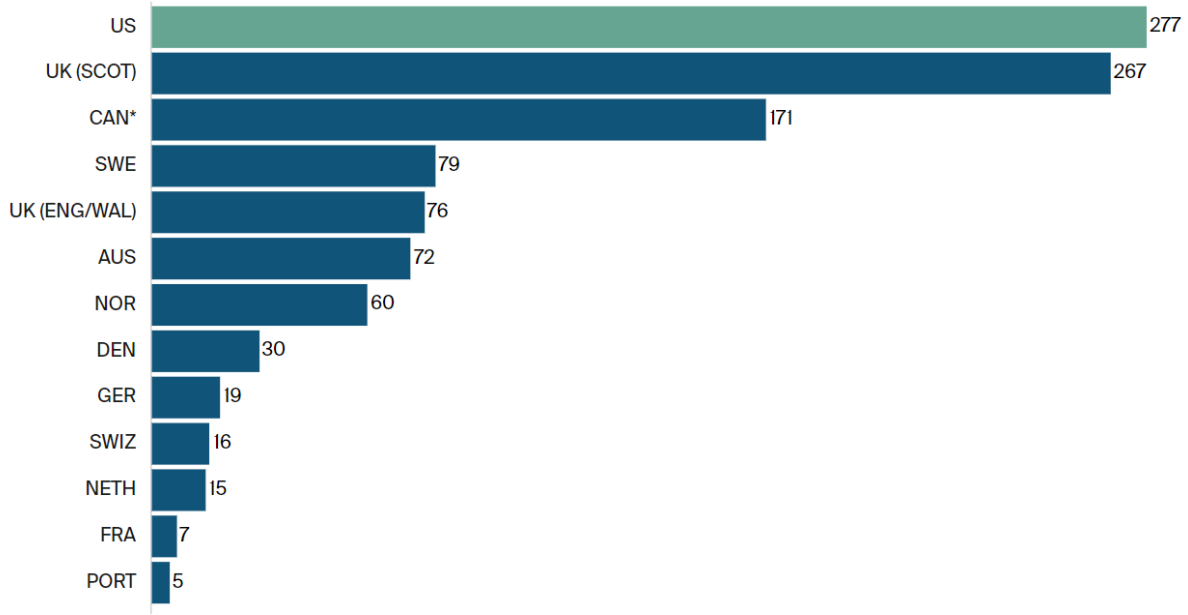
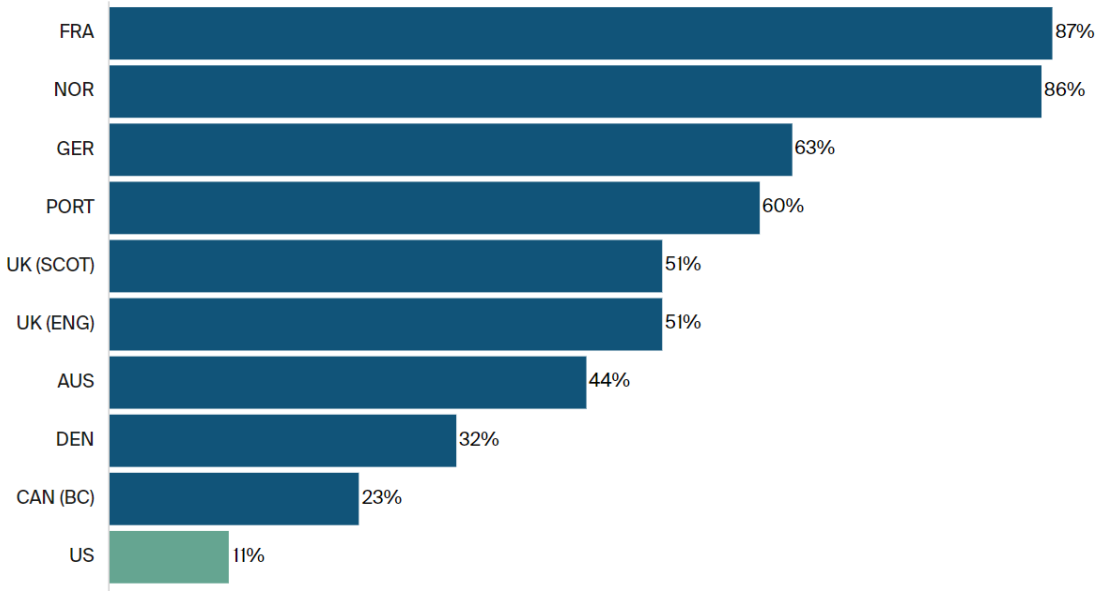
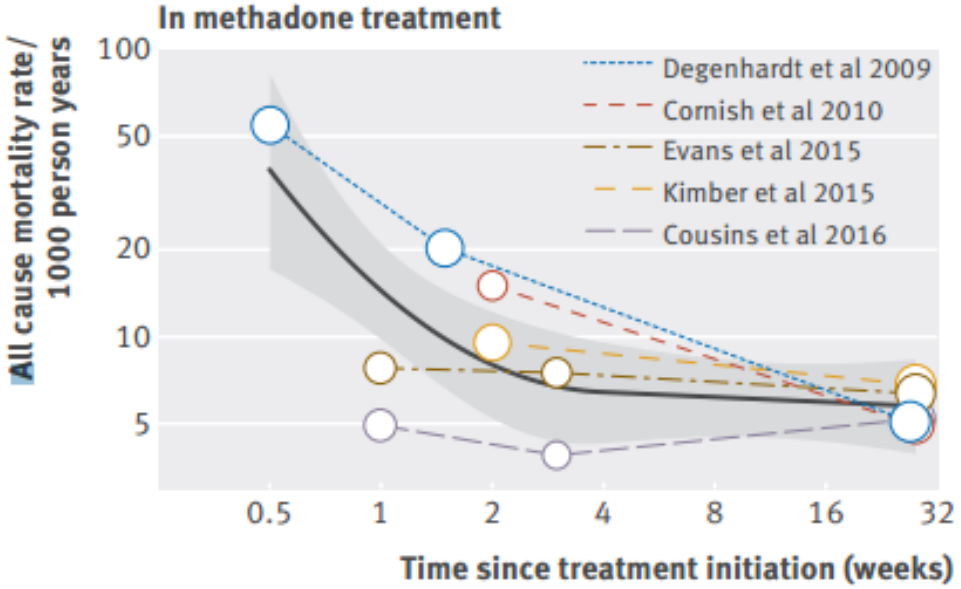
US leads the globe in overdose deaths, yet treatment gaps persist

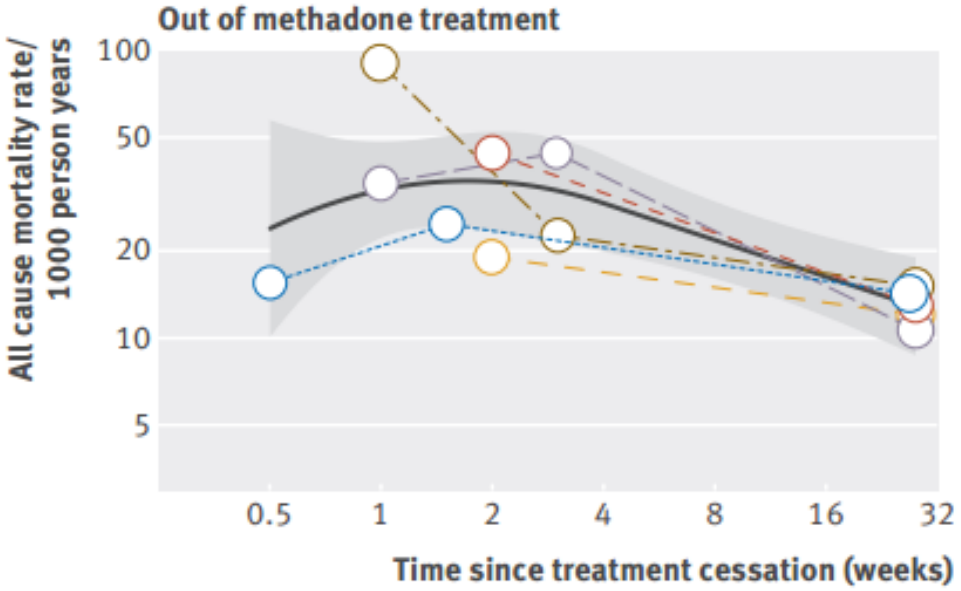
Overdose or drug-related death rate per 1 million population (unadjusted), 2020 or latest year available



Percentage of people with high-risk opioid use or opioid use disorder (OUD) who received opioid-substitution treatment







Methadone and buprenorphine reduce mortality

All cause **mortality rates (per 1000 person years):**

- In methadone treatment: 11.3
- Out of methadone treatment: 36.1

- In buprenorphine treatment: 4.3
- Out of buprenorphine treatment: 9.5

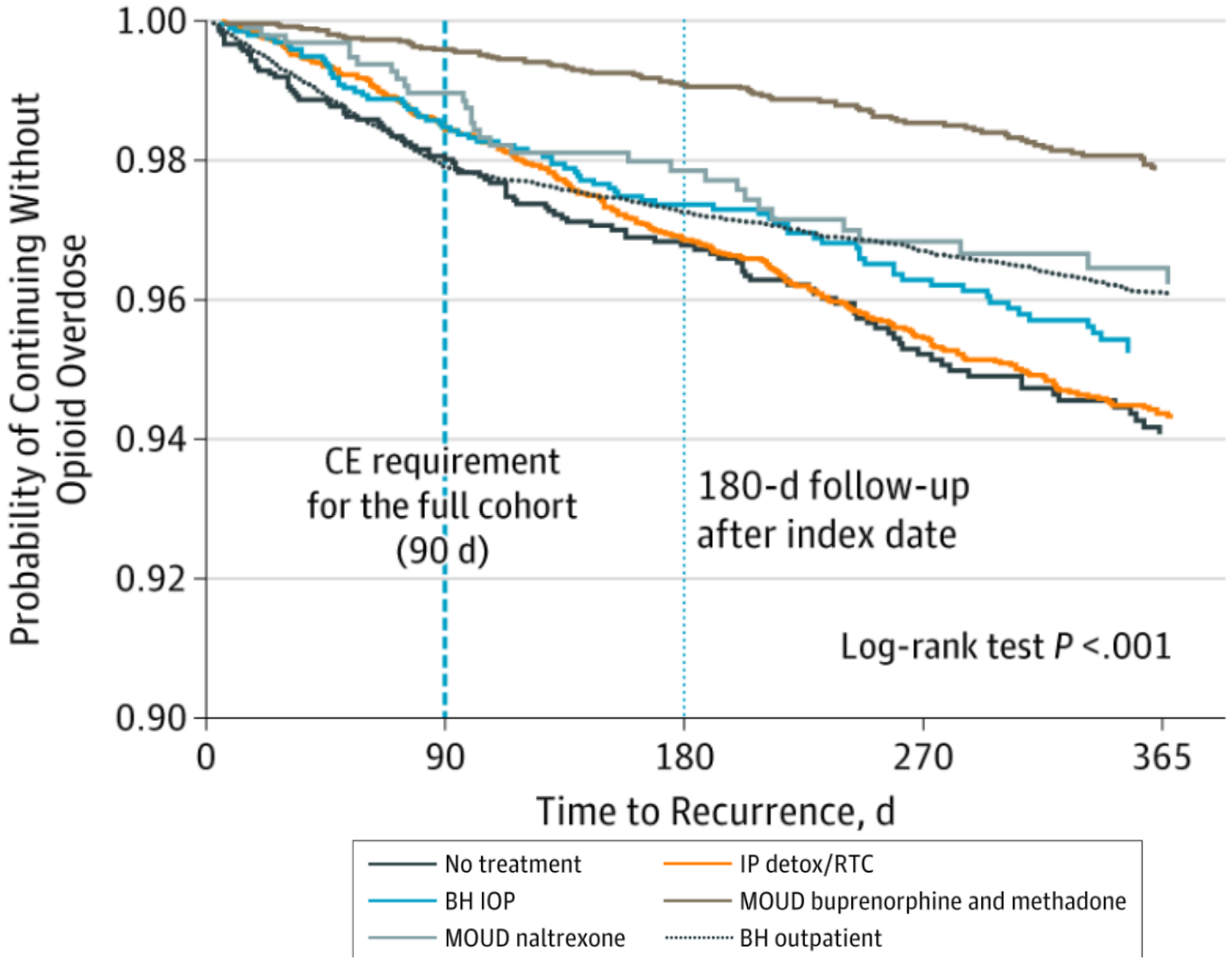
Overdose **mortality rates:**

- In methadone treatment: 2.6
- Out of methadone treatment: 12.7

- In buprenorphine treatment: 1.4
- Out of buprenorphine treatment: 4.6

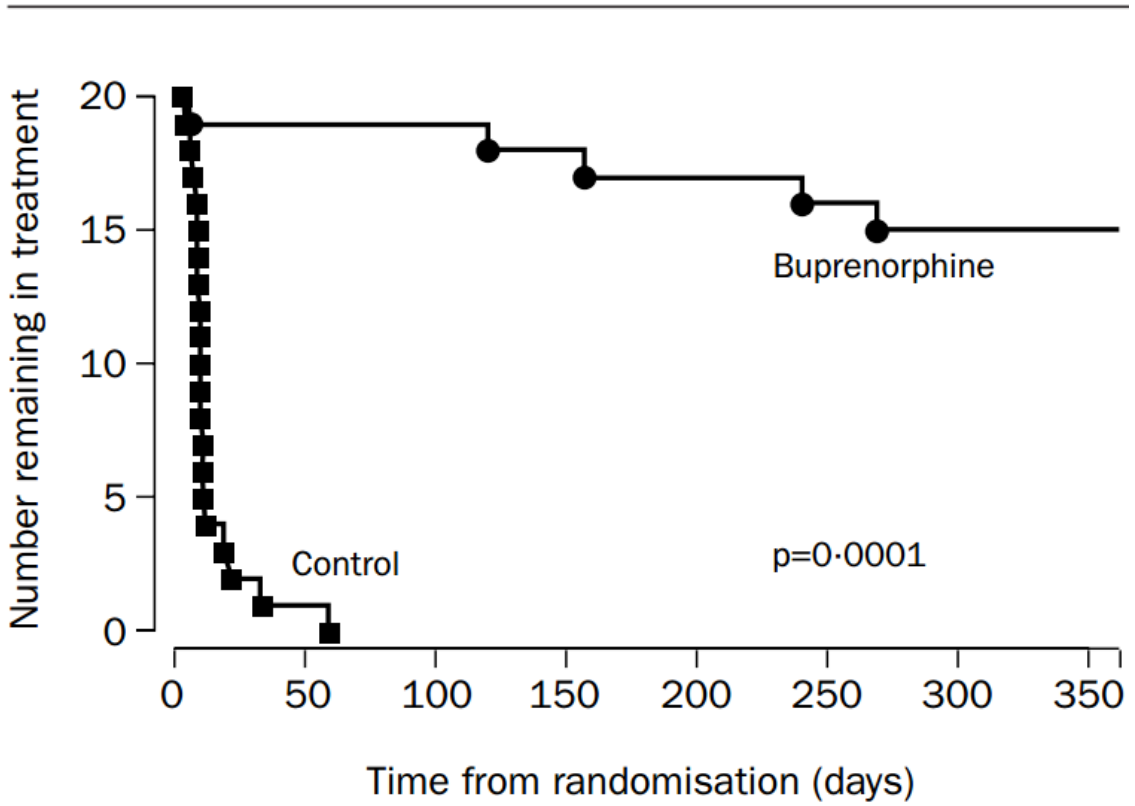
Sordo L, Barrio G, Bravo MJ, et al. *BMJ*. 2017;357:j1550. Published 2017 Apr 26.

Methadone & buprenorphine associated w/ reduced OD



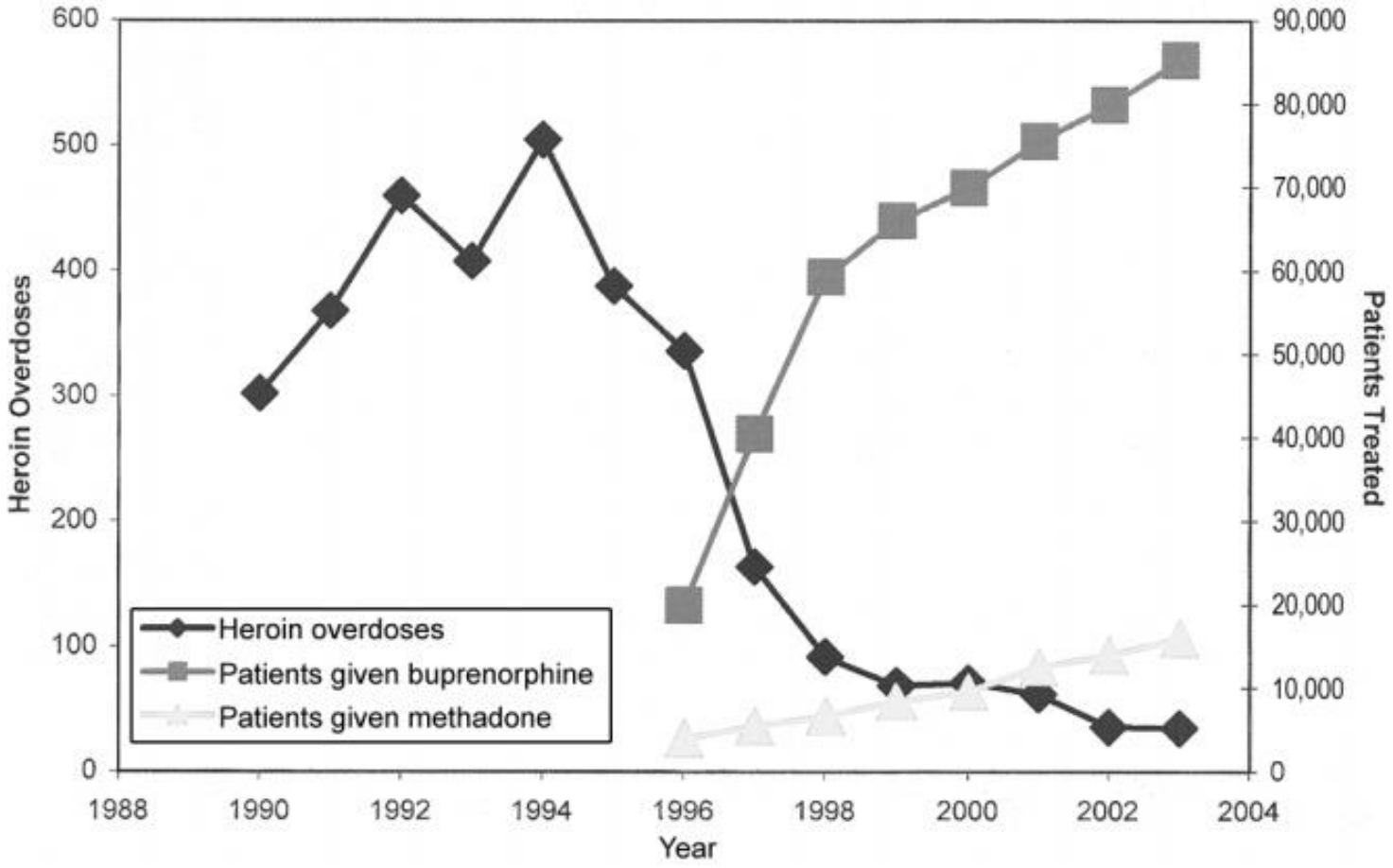
Wakeman SE, Larochelle MR, Ameli O, et al. *JAMA Netw Open.* 2020;3(2):e1920622.

Buprenorphine treatment outcomes superior to withdrawal management plus psychosocial treatment



Kakko et al. The Lancet, Volume 361, Issue 9358, 2003, 662 - 668

Expansion of access to opioid agonist therapy saves lives



- France expanded access to buprenorphine
- No required physician training, no patient limits, no toxicology or counseling requirements
- ~90,000 pts treated w/ buprenorphine, 10,000 w/ methadone
- 5-fold reduction in heroin overdose deaths, 6-fold reduction in active IDU, HIV prevalence among PWID decreased from 40% to 20%

Carrieri MP, Amass L, Lucas GM, Vlahov D, Wodak A, Woody GE. *Clin Infect Dis*. 2006;43 Suppl 4:S197–S215. doi:10.1086/508184

Most treated patients achieve remission over time

Table 2.

Change in clinical characteristics from study entry to follow-up 18, 30, and 42 months later.

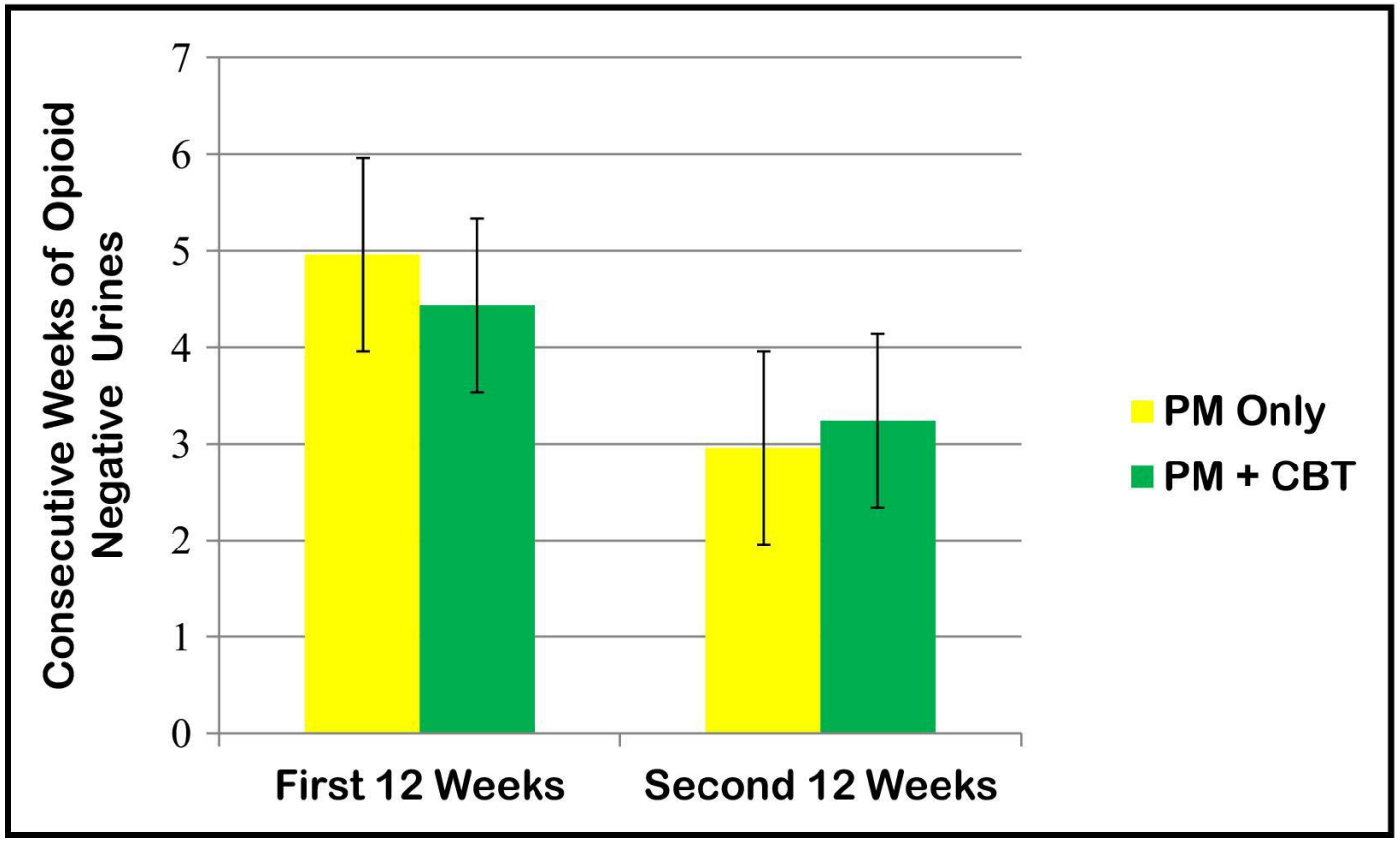
Participant characteristics	Month 0[1] (*n* = 338)	Month 18 (*n* = 252)	Month 30 (*n* = 312)	Month 42 (*n* = 306)
Substance use, past month				
Current opioid dependence[2], %**	100	16.3[a]	11.5	7.8[b]
Abstinent from illicit opioids[3], %***	0	51.2[a]	63.5[b]	61.4[b]
Opioid agonist treatment, %	0	31.8	38.1	36.9

Using healthcare touchpoints as reachable moments

- Initiating methadone in hospital:
  - 82% present for follow-up addiction care
- Initiating buprenorphine in hospital vs withdrawal management alone:
  - Buprenorphine: 72.2% enter treatment after discharge
  - Withdrawal management : 11.9% enter treatment after discharge
- Initiating buprenorphine in ED vs referral to treatment
  - 78% vs 37% engaged in buprenorphine treatment at 30 days
  - Fewer days of opioid use w/ buprenorphine tx

J Gen Intern Med. Aug 2010; 25(8): 803–808; JAMA Intern Med 2014 Aug;174(8):1369-76.); D'Onofrio et al. JAMA 2015 Apr 28;313(16):1636-44

Treatment effective in primary care



No difference in opioid use, study completion, or cocaine use between the 2 groups

Fiellin DA et al. Am J Med 126:1 2013

NASEM consensus report

Conclusion 6:
Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of U.S. Food and Drug Administration–approved medication for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.

Treatment with FDA-approved medications is clearly effective in a broader range of care settings (e.g., office-based care settings, acute care, and criminal justice settings) than is currently the norm. There is no scientific evidence that justifies withholding medications from OUD patients in any setting or denying social services (e.g., housing, income supports) to individuals on medication for OUD. Therefore, to withhold treatment or deny services under these circumstances is unethical.

Identify patients through screening or acute presentation

Make a diagnosis

Initiate treatment without delay

Retain patients in treatment

Making a Diagnosis of OUD:

Problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period (mild =2-3; moderate = 4–5; severe = 6+)

1. Opioids taken in larger amounts or over a longer period of time than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time spent in activities to obtain, use, or recover from opioids.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems.
7. Important social, occupational, or recreational activities are given up or reduced.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance.
10. Tolerance*
11. Withdrawal*

* Tolerance and withdrawal insufficient to make diagnosis if due to prescribed medication

Initiating effective treatment

Medication

Psychosocial interventions

Recovery supports

Harm reduction

Similar to Management of Diabetes or HIV

- Goal to prevent acute and chronic complications
- Patient-centered and directed treatment plans and goals
- Treatment includes:
  - Medication
  - Behavioral support
  - Lifestyle changes
  - Regular monitoring

Goal of medication for OUD: buprenorphine& methadone

- Relieve withdrawal symptoms
- Block effects of other opioids
- Reduce cravings
- Prevent overdose

Understanding Buprenorphine

- Partial opioid agonist, ceiling effect for respiratory depression
- Higher retention in treatment and abstinence rates seen w/ doses >16 mg
- At higher doses, likely as effective as methadone
- Effective & safe in pregnancy and breastfeeding
- **High affinity** for opioid receptor → can displace full agonist opioids resulting in "precipitated withdrawal"
- To initiate, wait until person is in mild to moderate withdrawal
  - COWS score 8+
  - ~12 hours since last use of a short-acting opioid
  - 72 hours for chronic methadone use
  - Or low dose initiation

Starting Buprenorphine

Confirm	• Confirm diagnosis of opioid use disorder
Explore	• Explore patient's goals, treatment history, periods of remission, experiences with medication, desire to try buprenorphine
Utilize	• Utilize encounter as opportunity to engage around other health screening (HIV screening, Hepatitis screening, vaccination for HAV, HBV)
Incorporate	• Incorporate harm reduction: naloxone, drug checking, safer use practices, discussion of PrEP if sharing injection equipment
Start	• Start/prescribe buprenorphine and arrange follow-up

Traditional buprenorphine initiation dosing

Prescribe buprenorphine 4mg films/tablets: Advise patient to take one dose, wait 30-60 min and if still symptomatic take another 4 mg

Take 4-8 mg Q6H PRN ongoing cravings or withdrawal

Most patients feel better with total daily dose of 16 mg-24mg. However, may require 24 mg+ (particularly if using fentanyl)

Day 2-7: Take total dose needed on day 1 as a daily or BID dose

Low dose or high dose initiation strategies emerging

Ongoing management of patients

Check in visits, frequently at first, space out as stabilize

Like any chronic care management:

- evaluate symptoms (cravings, withdrawal, use)
- benefits or challenges with medication
- need for additional support
- focus on patient identified goals

Patients don't fail treatment, but treatment can fail patients

If person not doing well, modify treatment

- Increase dose
- Increase supports
- If persistent challenges, explore changing meds
- Incorporate harm reduction

Take home points

Increased access to opioid use disorder treatment in primary care is needed to address overdose crisis

Opioid use disorder is a treatable, good prognosis condition and treating it is feasible and fulfilling

Like other chronic conditions, it can be diagnosed, treated, and managed in general medical settings

Thank you!

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