Treatment of OUD in Primary Care: Collaborative Care Approach

Charles Brackett, MD, MPH

5/17/19

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The Opioid Crisis

A family mourns the death of their son, Brian Malmsbury, who overdosed on heroin in the basement of their home.
From left to right: Brian's half sister, Brittany Neff; Brian's stepfather, Damian Neff; and Brian's mother, Patty Neff.

72,000 OD deaths in 2017

200/day

National Vital Statistics System
Mortality File

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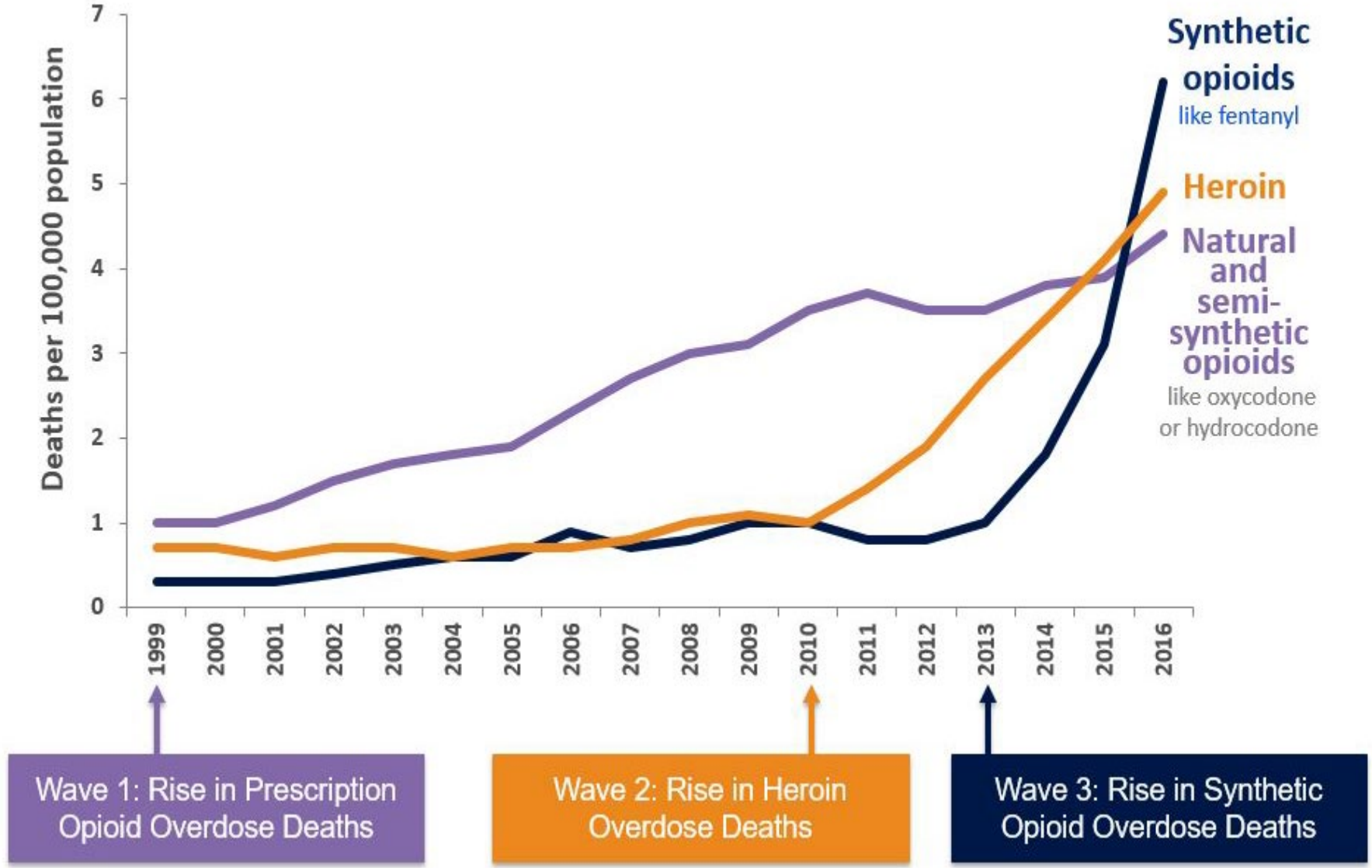
3 Waves of the Rise in Opioid Overdose Deaths



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Treatment (MAT) Works!

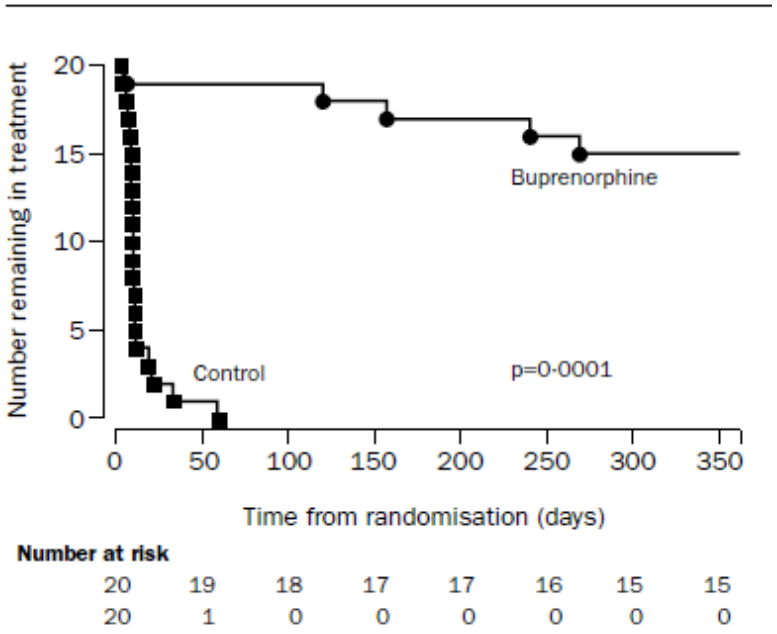

Figure 2: **Kaplan-Meier curve of cumulative retention in treatment**

- OAT reduces all cause mortality 70%
- Reduces illicit opioid use
- Reduces other drug use
- Reduces criminal activity
- Improves psycho-social function
- Improves mental health
- Reduces HIV and Hep C
- Reduces ED visits and admissions
- Reduces overall medical costs

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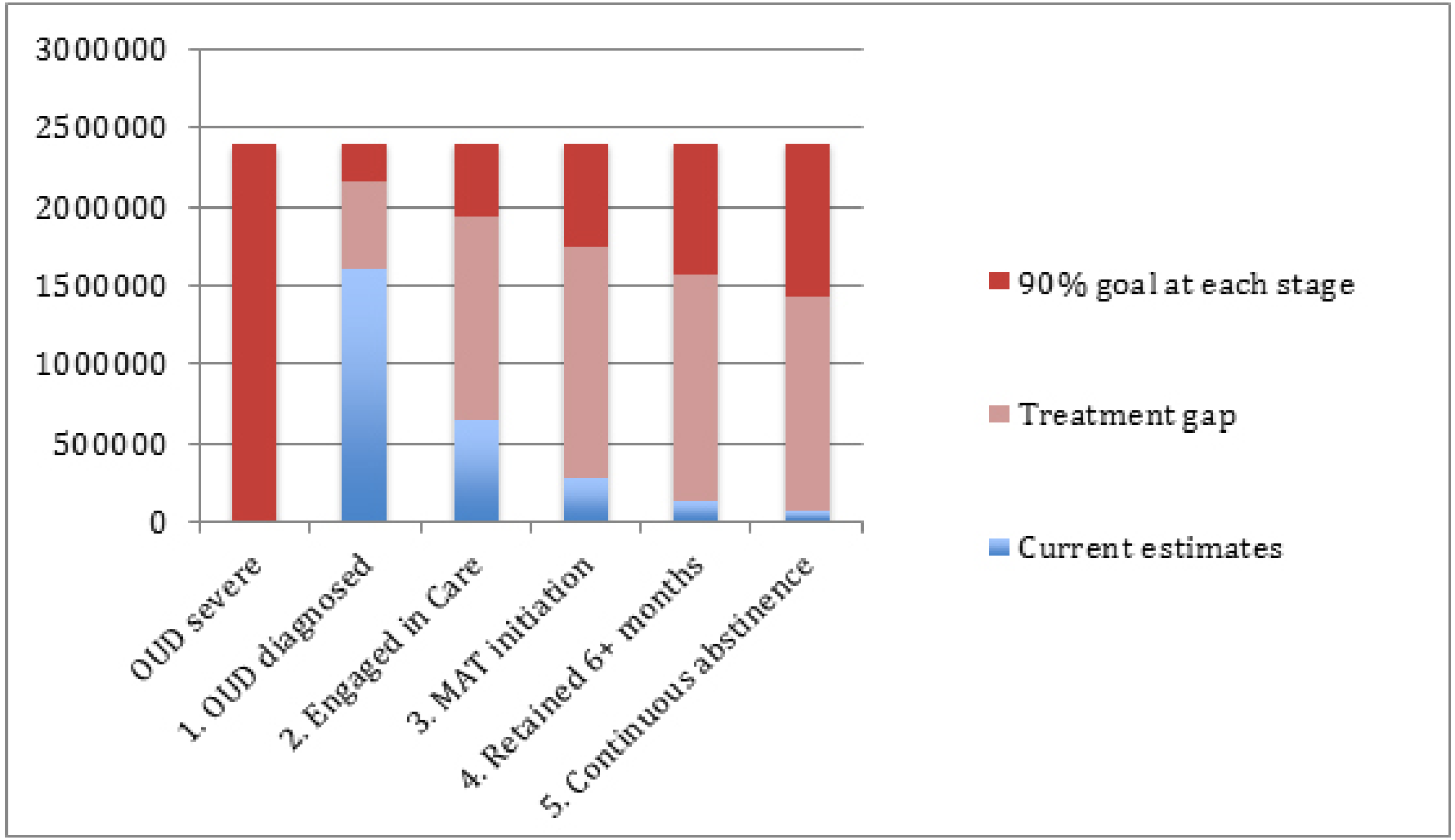
Treatment Gap

Cascade of Care for Opioid Use Disorder

-Williams AR et al Health Affairs 2017



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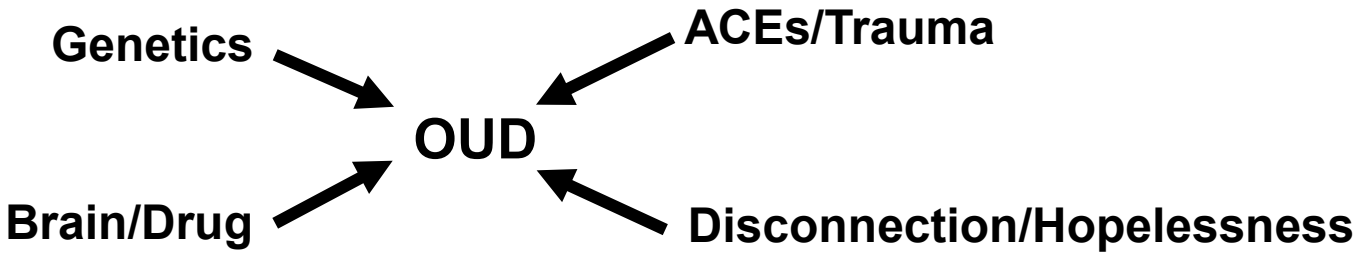
Barriers to Treatment

- Inadequate recognition
- Inadequate access:
  - Shortage of Addiction Specialists
  - Financial and logistical barriers
  - Leads to missed opportunities
- Challenges navigating complex healthcare systems
- Addiction care is often fragmented from other medical and mental health care
- Stigma/misunderstanding

Reducing Stigma by Understanding Addiction

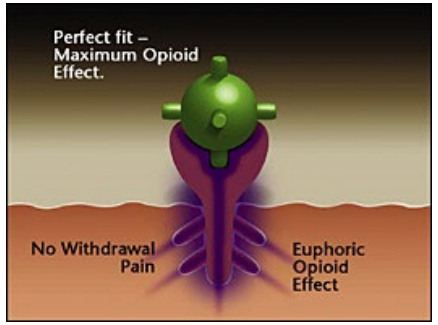


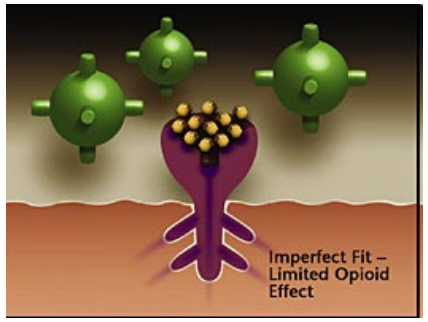
- Getting high→seeking escape from suffering, feel "normal"
- Willful misbehavior/moral failing→chronic disease
- Criminals to be punished/shamed→Persons in need of help+care
- OAT as "replacing one addiction with another"→highly effective evidence-based standard of care

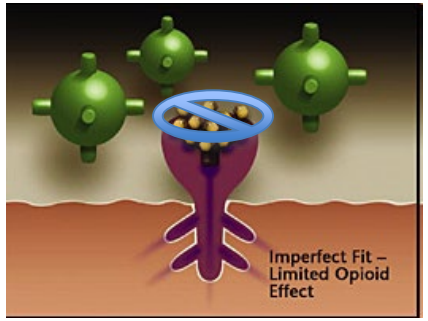
Treatment Gap by Mainstreaming OUD Treatment into General Medical Care

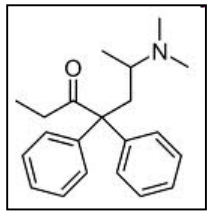
- Inadequate recognition→Screen for OUD
- Inadequate access:
  - Shortage of Addiction Specialists→ Treatment by Generalist Clinicians
  - Financial and logistical barriers→ primary care visits, close to home
  - Leads to missed opportunities→ capture reachable moments
- Challenges navigating complex healthcare systems→ make it simple
- Addiction care is often fragmented from other medical and mental health care→ integrate care
- Stigma/misunderstanding→ ”treat like any other patient”

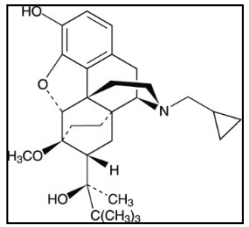
Medication Assisted Therapy

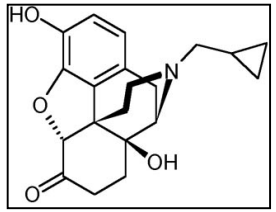












Full MU Agonist:

Methadone

Partial MU Agonist:

Buprenorphine

Full MU Antagonist:

Naltrexone

- Naltrexone has the highest receptor BINDING AFFINITY, then buprenorphine, then methadone

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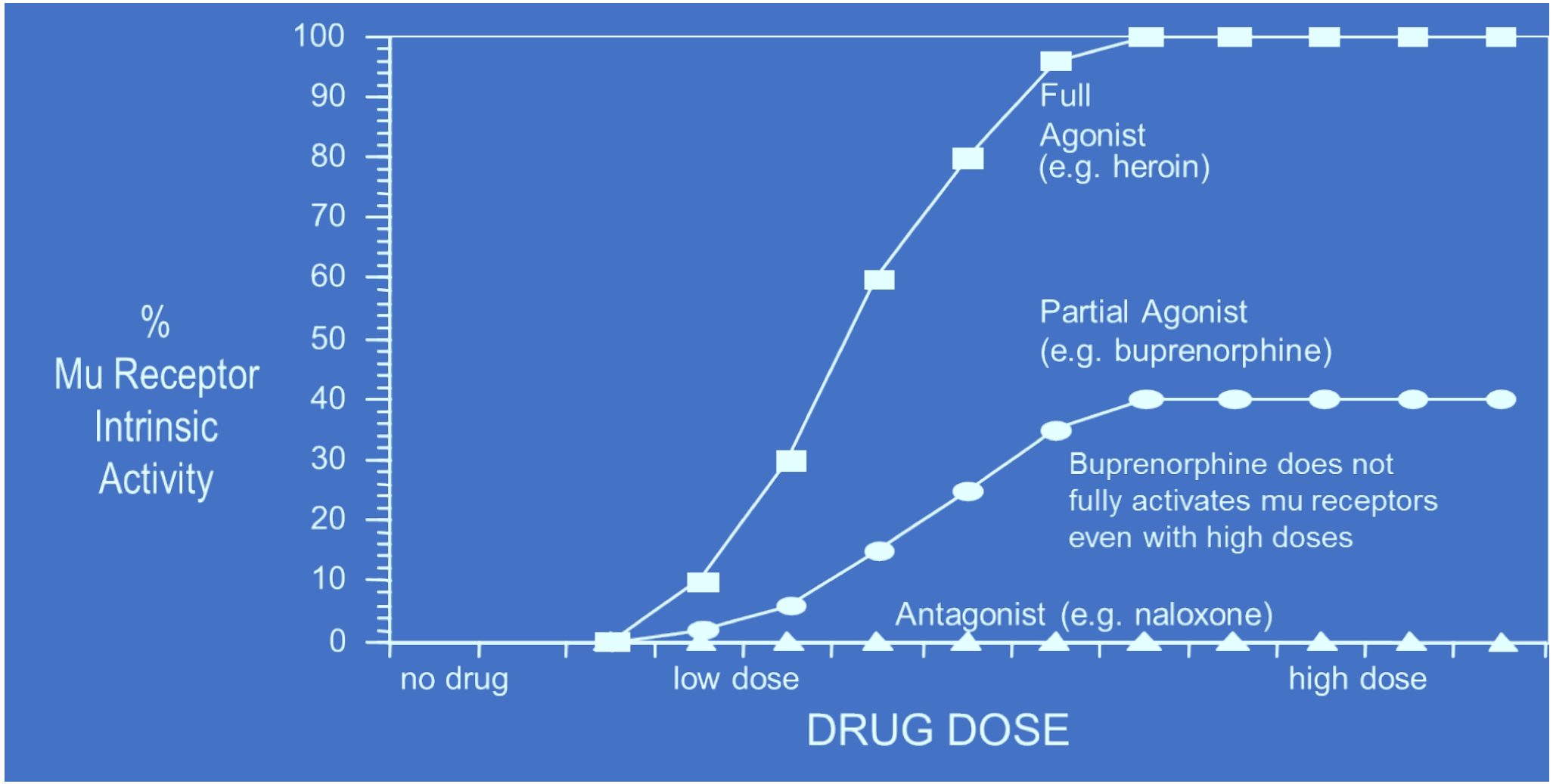
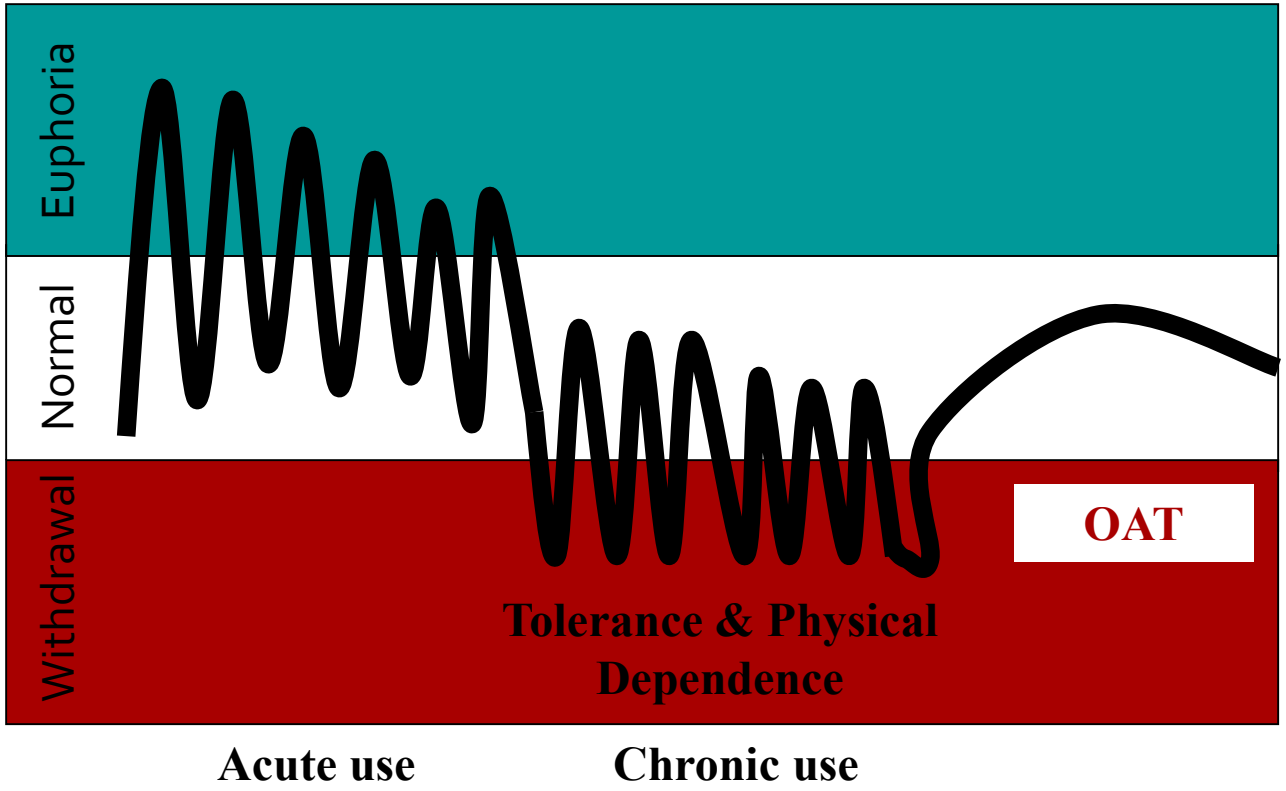
Intrinsic Activity: Full Agonist (Methadone), Partial Agonist (Buprenorphine), and Antagonist (Naloxone)



Opioid Agonist Therapy (OAT)

Methadone & Buprenorphine



Methadone Maintenance

- "gold standard"
- Reduces use, sociopathy, seroconversion…
- Can't be prescribed for opiate dependence in clinic- need OTP
- Can be dispensed inpt, 3 day rule
- Drawbacks:
  - Weight gain, brain fog, hypogonadism
  - Daily→frequent visits, transportation/availability
  - for-profit clinics, risk by association
  - Stigma

Buprenorphine

- Partial agonist with high binding affinity
- Slow kinetics
- Less reinforcing
- Reduces withdrawal symptoms
- Reduces craving
- Blocks other opiates
- buprenorphine+naloxone (4:1)
  - Generic sublingual pills
  - Suboxone films
  - Bunavail, Zubsolv, Probuphine (6mo implant), Sublocade

Prescribing buprenorphine

- Need a special DEA #
  - DATA 2000: MDs prescribe after 8 hour course
  - CARA 2016: PAs and NPs prescribe after 24 hour course (as of 2/27/17)
  - 30 first year, can then apply to go up to 100
- Schedule III- available in pharmacies
- Can prescribe in outpatient setting- PC, psych
  - Greater access/availability, less stigma
- OK to use in hospital for intercurrent illness and dispense 3d without DEA#

Naltrexone

- Opiate receptor antagonist- Patients must be fully detoxed. Helps craving 2 ways
- Oral: No better than placebo, due to poor adherence
- Can work for patients who are
  - highly motivated or legally mandated to be abstinent
  - in closely supervised settings
  - milder OUD
  - In occupations not permitting OAT: driving, medical…
  - Probation: 70% less opiate use, 50% less reincarceration
  - Medical personnel
- Injectable monthly form: Vivitrol
  - Limited data, low quality studies (Russia, jail)
  - No head to head trials with OAT, until….

JAMA Psychiatry | Original Investigation

Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence
A Randomized Clinical Noninferiority Trial

Lars Tanum, MD, DMSci; Kristin Klemmetsby Solli, MSc; Zill-e-Huma Latif, MD; Jūratė Šaltytė Benth, PhD; Arild Opheim, MSc; Kamni Sharma-Haase, MD; Peter Krajci, MD, PhD; Nikolaj Kunøe, MSc, PhD

JAMA Psychiatry. doi:10.1001/jamapsychiatry.2017.3206
Published online October 18, 2017.

Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial

Joshua D Lee, Edward V Nunes Jr, Patricia Novo, Ken Bachrach, Genie L Bailey, Snehal Bhatt, Sarah Farkas, Marc Fishman, Phoebe Gauthier, Candace C Hodgkins, Jacquie King, Robert Lindblad, David Liu, Abigail G Matthews, Jeanine May, K Michelle Peavy, Stephen Ross, Dagmar Salazar, Paul Schkolnik, Dikla Shmueli-Blumberg, Don Stablein, Geetha Subramaniam, John Rotrosen

www.thelancet.com **Published online November 14, 2017** |

Primary Care and the Opioid-Overdose Crisis — Buprenorphine Myths and Realities

Sarah E. Wakeman, M.D., and Michael L. Barnett, M.D.

Myths and Realities of Opioid Use Disorder Treatment.

Myth	Reality	Possible Policy Response
Buprenorphine treatment is more dangerous than other chronic disease management.	Buprenorphine treatment is simpler than many other routine treatments in primary care, such as titrating insulin or starting anticoagulation. But physicians receive little training in it.	Amend federal buprenorphine-treatment eligibility requirements to include training completed during medical school and require training during medical school or residency. Add competency questions to U.S. Medical Licensing Examination and other licensing exams.
Use of buprenorphine is simply a "replacement" addiction.	Addiction is defined as compulsively using a drug despite harm. Taking a prescribed medication to manage a chronic illness does not meet that definition.	Public health campaign to reduce stigma associated with addiction treatment, similar to past campaigns (e.g., HIV) that provided education and challenged common myths.
Detoxification for opioid use disorder is effective.	There are no data showing that detoxification programs are effective at treating opioid use disorder. In fact, these interventions may increase the likelihood of overdose death by eliminating tolerance.	Advocacy from professional physician organizations to educate federal and state agencies and policymakers about evidence-based treatment and the lack of evidence for short-term "detoxification" treatment.
Prescribing buprenorphine is time consuming and burdensome.	Treating patients with buprenorphine can be uniquely rewarding. In-office inductions and intensive behavioral therapy are not required for effective treatment.	Develop and disseminate protocols for primary care settings that emphasize out-of-office induction and treatment.
Reducing opioid prescribing alone will reduce overdose deaths.	Despite decreasing opioid prescribing, overdose mortality has increased. Patients with opioid use disorder may shift to the illicit drug market, where the risk of overdose is higher.	Develop a national system of virtual consultation for physicians to reach addiction and pain specialists who can support treatment of patients with suspected opioid use disorder.

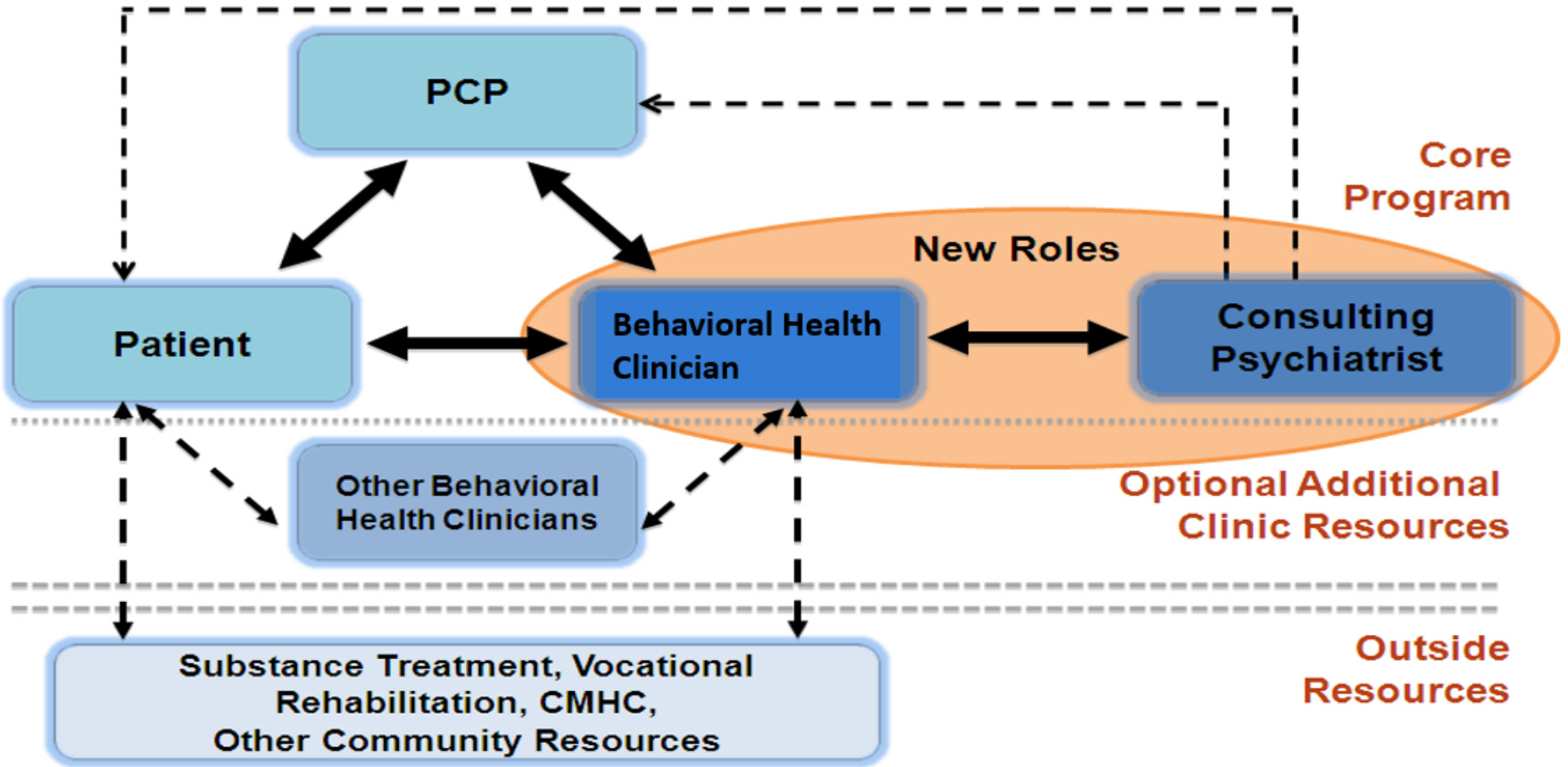
- 4 RCTs comparing primary care based vs specialty care based showed better outcomes with primary care based treatment
  - Treatment retention 86% vs. 67%
  - Opioid abstinence: 67% vs. 35%
  - Patient satisfaction: 77% vs 38%

Primary Care-Based Models for the Treatment of Opioid Use Disorder

-Korhuis et al, Annals 2017

- 12 models of care examined; conclusions:
- Psychosocial services are critical; better if on-site; more extensive counseling may not lead to better outcomes than brief counseling
- Key to success is having a nonphysician "glue person" in the integration/coordination role
- Tiered care, coordinated with specialty addiction treatment services
- Education and outreach important to reduce stigma, increase uptake and # of waivered MDs
- The ideal model of care depends on local factors: expertise available, population, proximity to addiction center of excellence, reimbursement policies, geographic factors…

Model- Collaborative/Integrated Care



People Collaborate **Systems Integrate**

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JAMA Internal Medicine | Original Investigation

Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care

The SUMMIT Randomized Clinical Trial

Katherine E. Watkins, MD, MSHS; Allison J. Ober, PhD; Karen Lamp, MD; Mimi Lind, LCSW; Claude Setodji, PhD; Karen Chan Osilla, PhD; Sarah B. Hunter, PhD; Colleen M. McCullough, MPA; Kirsten Becker, MS; Praise O. Iyiewuare, MPH; Allison Diamant, MD; Keith Heinzerling, MD; Harold Alan Pincus, MD

FCONCLUSIONS AND RELEVANCE Among adults with OAUD in primary care, the SUMMIT collaborative care intervention resulted in significantly more access to treatment and abstinence from alcohol and drugs at 6 months, than usual care.

JAMA Intern Med. doi:10.1001/jamainternmed.2017.3947
Published online August 28, 2017.

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D-H MAT Model

- Collaborative Care—Massachusetts Model
  - Care shared between Rx-r and BHC
- VT hub and spoke model
  - relationship with addiction treatment program
- MA role: UDT/PDMP/BAM/pending prescriptions
- MAT visit type
- eDH tools, note templates, guideline

Determining who is appropriate for PC-Bup

- Moderate-severe OUD
- Acknowledgment and motivation
- Severity of addiction
  - Amount, route
  - Other substances
- Psychiatric co-morbidities
- Psycho-social
  - Drug free housing
  - Job/school
  - Supportive relationships

TREATMENT NEEDS QUESTIONNAIRE

Patient Name/ID: _____Date: . Staff Name/ID: ____

Ask patient each question, circle answer for each	Yes	No
Have you ever used a drug intravenously?	2	0
If you have ever been on medication-assisted treatment (e.g. methadone, buprenorphine) before, were you successful? (If never in treatment before, leave answer blank)	0	2
Do you have a chronic pain issue that needs treatment?	2	0
Do you have any significant medical problems (e.g. hepatitis, HIV, diabetes)?	1	0
Do you ever use cocaine, even occasionally?	2	0
Do you ever use benzodiazepines, even occasionally?	2	0
Do you have a problem with alcohol, have you ever been told that you have a problem with alcohol or have you ever gotten a DWI/DUI?	2	0
Do you have any psychiatric problems (e.g. major depression, bipolar, severe anxiety, PTSD, schizophrenia, personality subtype of antisocial, borderline, or sociopathy)?	1	0
Are you currently going to any counseling, AA or NA?	0	1
Are you motivated for treatment?	0	1
Do you have a partner that uses drugs or alcohol?	1	0
Do you have 2 or more close friends or family members who do not use alcohol or drugs?	0	1
Is your housing stable?	0	1
Do you have access to reliable transportation?	0	1
Do you have a reliable phone number?	0	1
Did you receive a high school diploma or equivalent (e.g. did you complete > 12 years of education)?	0	1
Are you employed?	0	1
Do you have any legal issues (e.g. charges pending, probation/parole, etc)?	1	0
Are you currently on probation?	1	0
Have you ever been charged (not necessarily convicted) with drug dealing?	1	0

Totals _____ + _____

Total possible points is 26
Scores 0-5 excellent candidate for office based treatment
Scores 6-10 good candidate for office based treatment with tightly structured program and on site counseling
Scores 11-15 candidate for office based treatment by board certified addiction physician in a tightly structured program or HUB induction with follow up by office based provider or continued HUB status
Scores above 16 candidate for HUB (Opioid Treatment Program-OTP) only

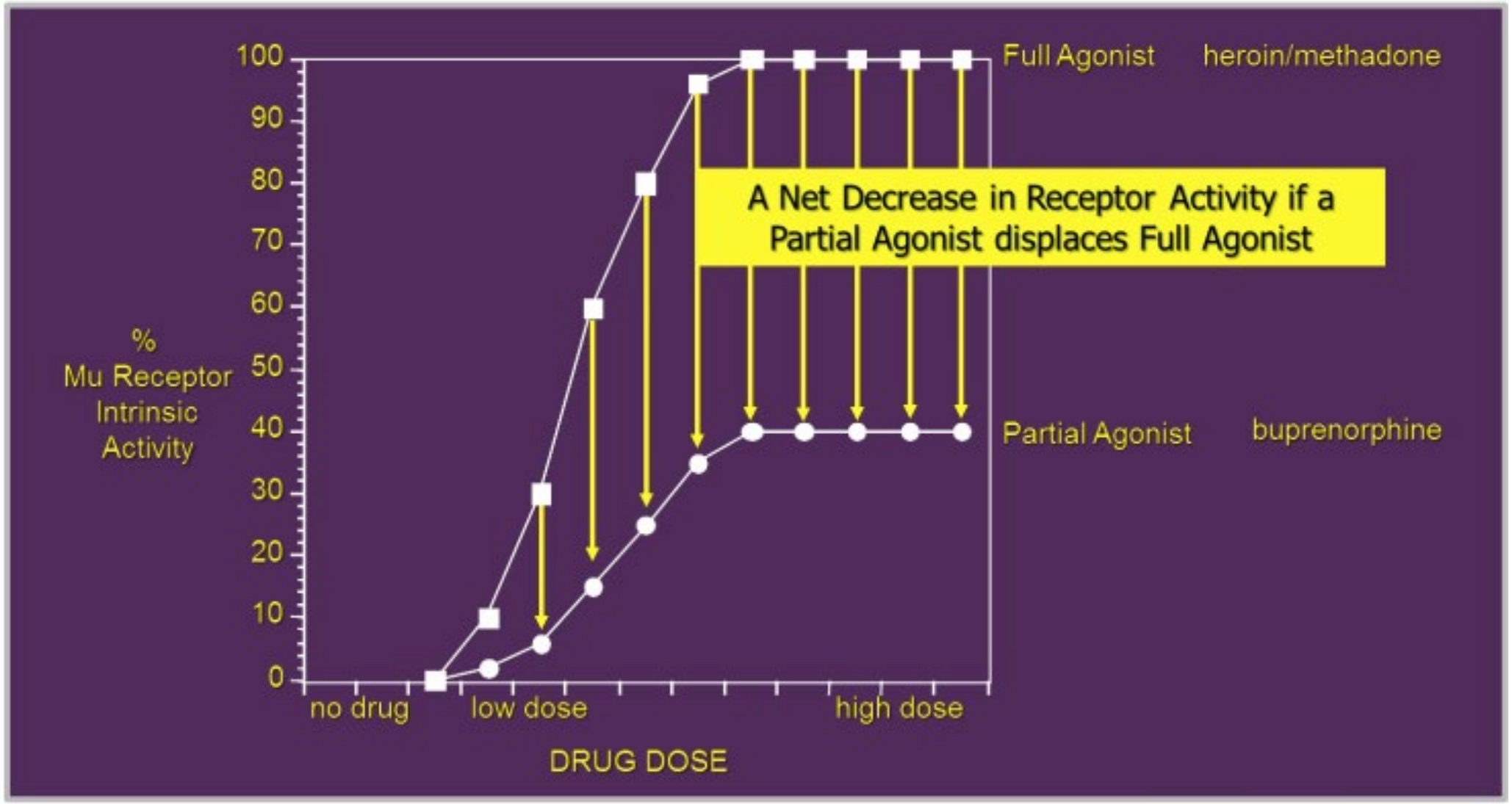
Intake: in-person, team approach

- MA: UDT, Pregnancy test, PDMP, BAM
- BHC:
  - add detail to intake, complete template
    - Addiction history, other illicits, sedatives/etoh
    - Psych co-morbidities
    - Psycho-social circumstances, motivation
  - Education about addiction, treatment options
  - Review rules/expectations: treatment agreement
  - Choose and document single appointed pharmacy
  - Discuss counseling options, negotiate a plan, ROI

Intake…

- Prescriber:
  - Review BHC note, elaborate on issues
  - Review medical co-morbidities, medications
  - Physical exam and lab testing
  - Review consent/Tx agreement- sign
  - Assessment and Plan
    - Induction plan
    - Consider naloxone
    - Follow-up (MAT appointment) with BHC, Prescriber

Induction: Precipitated Withdrawal



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Induction: where?

- Not needed if on Bup (street or other program)
- Home induction (pt instructions)
- In-office induction
- IOP induction

If you get called...

- Try another dose of buprenorphine
- For recalcitrant symptoms:
  - Acetaminophen/ibuprofen for aches/pains
  - Loperamide for diarrhea/cramps
  - Diphenhydramine or trazodone for insomnia
  - Clonidine 0.1 q 2 hours for severe anxiety/jitters
  - Promethazine 25mg po q 6 for nausea

Follow-up: Stabilization and Maintenance

- Target dose 12-16 mg/day
- Weekly follow-up until “stable”
- MA: UDT, PDMP, BAM
- BHC/prescriber:
  - Assessment of progress and risk of diversion
  - Assess craving, discuss relapse triggers
  - Assess psychiatric symptoms
  - Check in on outside counseling/mutual help
  - Encouragement/Motivational interviewing
  - Promote healthy lifestyle, coping skills (MM)
- Random pill/film counts and UDTs

Consent/Treatment Agreement
in eDH consent library: “all locations”

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Primary Care

Name:

DOB:

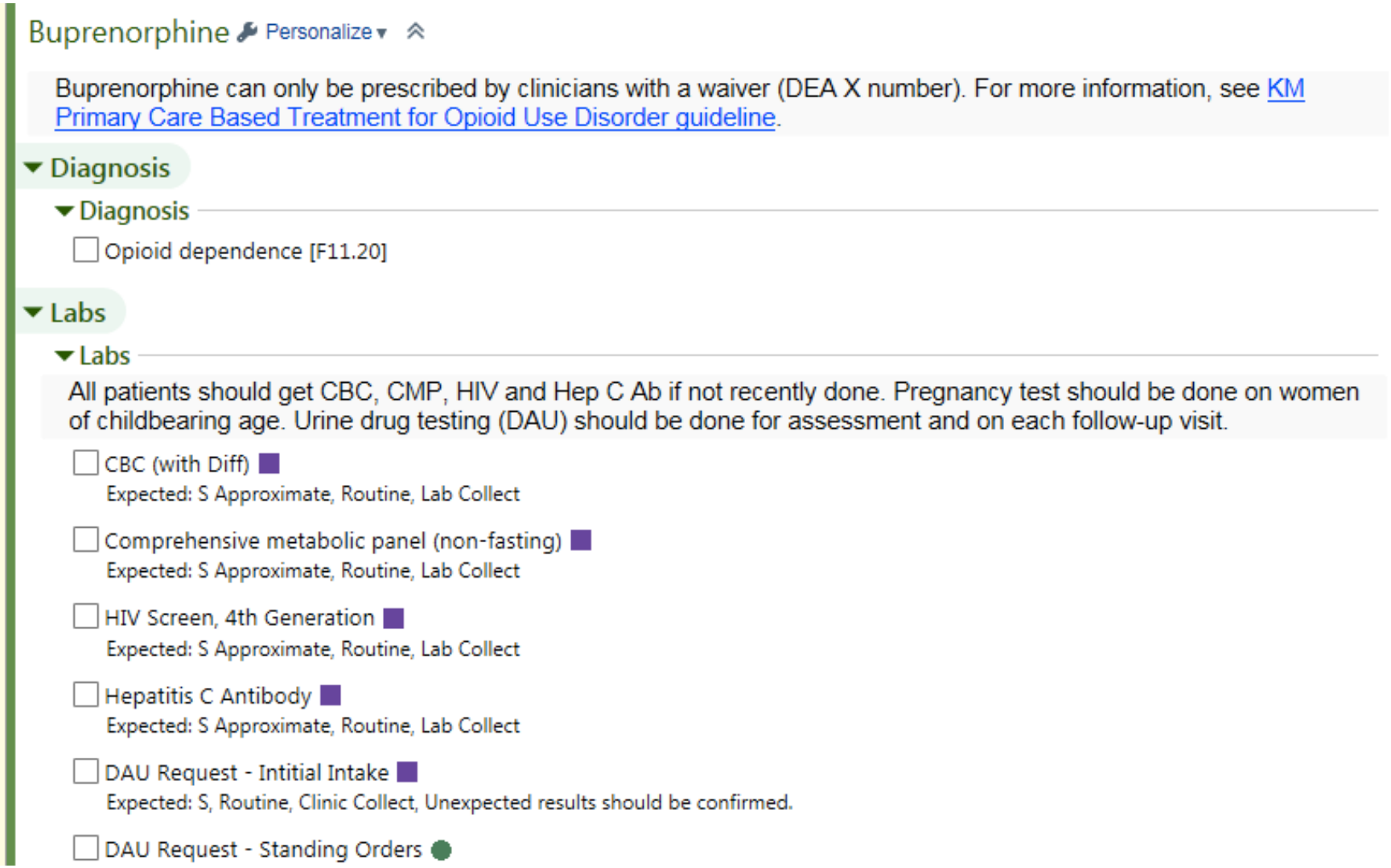
MRN:

BUPRENORPHINE INFORMED CONSENT AND TREATMENT AGREEMENT

Buprenorphine is an FDA approved medication for treatment of opioid use disorder (addiction) that is both a stimulator (agonist) and partial blocker of the opioid receptor. The opioid agonist effect reduces withdrawal symptoms and craving, while the blocking effect, at higher doses, prevents or lessens the effect (high) of using another opioid drug. There are other medical treatments for opiate addiction, including methadone and naltrexone. All medications should be used in together with psycho-social treatments, such as counseling, mutual help groups, and self-management apps, websites and books.

Buprenorphine can result in physical dependence similar to other opioids. Withdrawal symptoms are generally less intense than with heroin or methadone, and can be minimized by tapering gradually over several weeks to months. Buprenorphine can cause drowsiness- so you should arrange not to drive until you are accustomed to its effects. Combining buprenorphine with other substances, especially those which can cause sedation such as benzodiazepines (Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) or alcohol, can be dangerous. A number of deaths have

Buprenorphine Smartset



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Progress Note

Available Smartphrases used to document buprenorphine visit

When documenting use one of the following smartphrases in the appropriate documentation section.

Intake notes by BHC and prescriber
.BUPINTAKEBHC
.BUPINTAKERX

Patient instructions for home induction
.BUPHOMEINDUCTIONPTINSTRUCTIONS

Note fragments to use within an existing follow up template
.BUPFUHISTORY
.BUPFUPLAN

Full follow up note
.BUPFUNOTE

Medications

Buprenorphine/naloxone comes in several forms: suboxone films or generic pills are preferred by most insurance plans. See here for a directory of preferred product and prior authorization requirements by insurance. Target dose is 8-16 mg once/day

- Induction Dose of Suboxone — Click for more
- Stabilization Dose of Suboxone — Click for more
- Maintenance Dose of Suboxone — Click for more

Patient Education

Patient Education

- [ ] Alcohol and Drug Problems (ENGLISH)
- [ ] Substance Use Self-Management Resources and Mutual Support Groups
- [ ] Buprenorphine Home Induction Instructions

Referrals

Referrals

Clinicians cannot directly refer to DH substance abuse services. Give the patient treatment resources websites and phone numbers by clicking in the Patient Education section, and ask them to call for an evaluation. A list of treatment options is here.

- [ ] Referral to Behavior Health Clinician (Primary Care Only) - Where Available
  Internal Referral, Routine, Specialty Service Requested
- [ ] eConsult to Psychiatry (Primary Care Use Only)
  Internal Referral, Psychiatry

Follow-Up

Follow Up

Use "SC" (special clinic) or "SCE" (special clinic extended) visit types to trigger the pre-visit work flows.

- [ ] In 3 Days
- [ ] Follow up with BHC (1 week) and Me (2 weeks)
- [ ] 1 Week BHC
- [ ] 1 Week with me

Self-Management Resources and Mutual Support Groups

Comprehensive list of resources: http://med.dartmouth-hitchcock.org/sumhi/patient-education-support.html

- Alcoholics Anonymous: www.aa.org
- Narcotics Anonymous: http://na.org/
- Self-Management Addiction Recovery Program: www.smartrecovery.org
- www.addictionsandrecovery.org
- Digital device Applications (Apps)
    - recoveryBox- for a range of addictions
    - Hazelden Field Guide to Life
    - Sober Grid
    - 12 Steps AA Companion

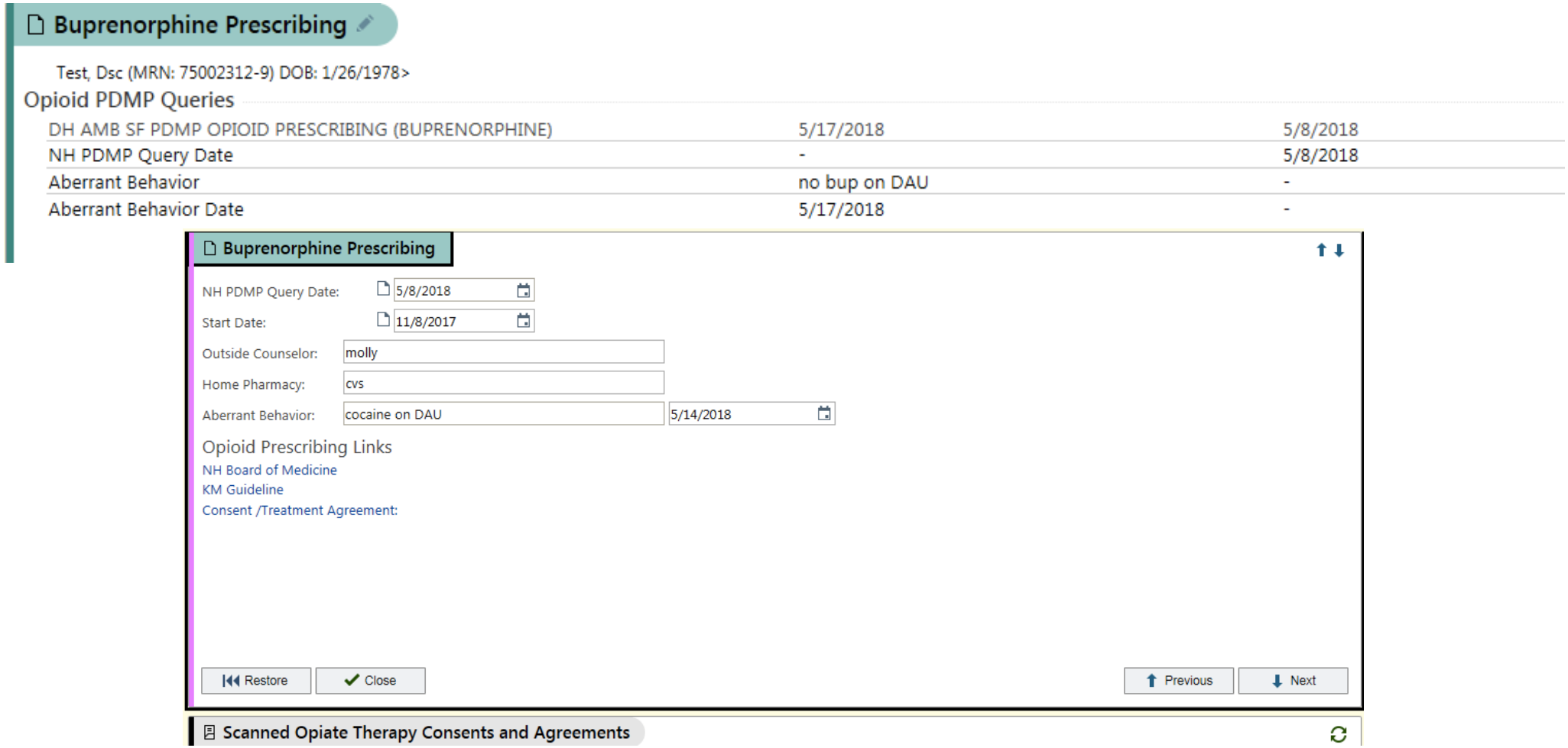
Treatment Options

Comprehensive list of resources: http://med.dartmouth-hitchcock.org/sumhi/treatment-recovery.html

- http://www.dartmouth-hitchcock.org/alcohol_drug.html DH guide to options in NH and VT, arranged by treatment intensity
- http://nhtreatment.org/ Recent comprehensive guide to options in NH
- https://findtreatment.samhsa.gov/ National directory
- www.addictionrecoveryguide.org National directory, also with other information and resources for the patient and their family
- www.uvmentalhealth.org Upper Valley resources for all behavioral health issues
- www.uvalltogether.org , includes a "Consumer's Guide to Substance Use Treatment" Upper Valley resources, including pdf booklet (print copies available to stock in clinic
- Substance related crises 1-844-711-4357 (HELP)
- 211 http://www.vermont211.org/ http://www.211nh.org/

Decisions in Recovery: Treatment for Opioid Use Disorder. A patient handbook discussing MAT options
http://store.samhsa.gov/shin/content/SMA16-4993/SMA16-4993.pdf

Navigator



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Primary Care Based Treatment of Opioid Use Disorder

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Treating pain in pts on bup

- Precipitating relapse by stopping bup
- Tolerance
- Blocking effect of buprenorphine (>95% receptors occupied w/ 16mg/d)

- Emerging consensus to keep buprenorphine going
- Non opioid pain relief preferred: NSAIDs, SNRI, GP, blocks, ketamine
- Raise and split the dose of buprenorphine
- Adding opioids to buprenorphine can add analgesia without euphoria
  - Po oxycodone
  - Fentanyl and hydromorphone (dilaudid) have highest binding capacity

Urine Toxicology Collection

- Supervised, not observed – trauma informed approach
- No personal belongings in bathroom aside from cell phone, wallet
- Trash receptacle kept outside of the bathroom, no flushing toilet until sample is handed to attendant
- Consider adding coloring agent to toilet water
- Do not send suspicious samples for testing
- If concerned: communicate with the patient, obtain repeat sample.
  - Consider checking specific gravity (1.002-1.03) or creatinine (>20mg/dL)
- Oral swabs: more tamper resistant, but generally less reliable compared to urine toxicology.

Screening and Confirmatory Tests

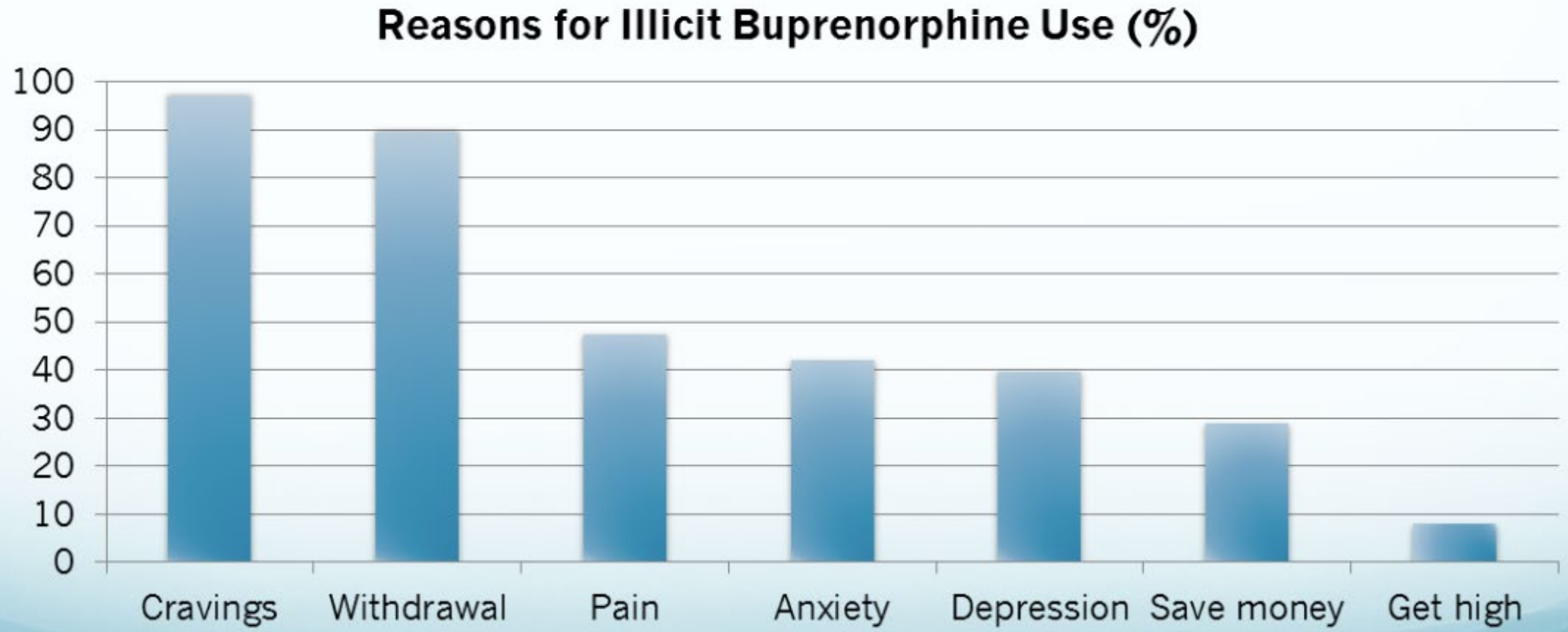
A common clinical approach:

- Test for a panel of commonly-used substances using screening tests
- Then to perform confirmatory tests only for positive results whose accuracy is important for treatment planning
- Confirmatory testing is not necessary in every case

Screening Tests	Confirmatory Tests
▪ Relatively rapid, inexpensive methods, usually based on immunoassay.	▪ Use more expensive, time-consuming methods that combine chromatography and spectrometry.
▪ Can be performed in a lab, or using kits for onsite point-of-care testing (POCT).	▪ Likely performed in a certified lab – so may take longer to return to Provider
▪ Results are considered presumptive until confirmed by a more definitive test.	▪ More precise and more specific than screening tests, and thus their results are considered definitive.

DuPont et al., 2013
Moeller et al., 2017
SAMHSA, 2012

Diversion and Misuse of Buprenorphine



Adapted from: Schuman-Olivier Z, Albanese M, Nelson SE, et al. Self-treatment: illicit buprenorphine use by opioid-dependent treatment seekers. J Subst Abuse Treat. 2010 Jul;39(1):41-50. doi:

Misuse Potential of Buprenorphine

- Abuse potential less than full opioid agonists.
- Euphoria in non-opioid dependent individuals.
- Abuse among opioid-dependent individuals is relatively low.
- Most illicit use is to prevent or treat withdrawal and cravings.

Yokel MA et al. Curr Drug Abuse Rev (2011)
Alho H., et al. Alcohol Dependence (2007)

Signs a Patient May Be Struggling

- Missed appointments
- Requests early refills of buprenorphine or other meds with misuse potential
- Decreased social functioning
- Arriving impaired or inappropriate behavior
- Inappropriate toxicology results
- Tampered urine screens
- Unable to void, or demanding to void immediately
- Calls or reports that the patient is “selling” medication
- Emergency room visits, hospitalizations

Responding to Patient Struggles

- Address behavior with patient
  - Discuss with patient ASAP.
  - Verbalize your concerns.
  - Be supportive.
- Establish new intensified treatment plan:
  - Patient-specific and achievable in your setting.
  - Signed agreements.
  - Involve patient in the process.

Revision of Treatment Plan May Include:

- More frequent visits
- Buprenorphine dose adjustment
- Shortened prescriptions
- Loss of refills
- Team engagement with counselor
- Increased counseling: Relapse prevention groups, individual therapy, IOP.
- Clinical team meeting with patient
- Psychiatric evaluation
- Residential treatment
- Involvement of social services
- Increased provider collaboration
- Family/support involvement

Transferring to Higher Level of Care

Communication is key: provider to program

- Warm hand-off whenever possible
- Confirm last prescription – consider bridge script
- Support through the transfer process
- Discuss if patient may return for re-evaluation at future date

Annals of Internal Medicine

SPECIAL ARTICLE

The Next Stage of Buprenorphine Care for Opioid Use Disorder

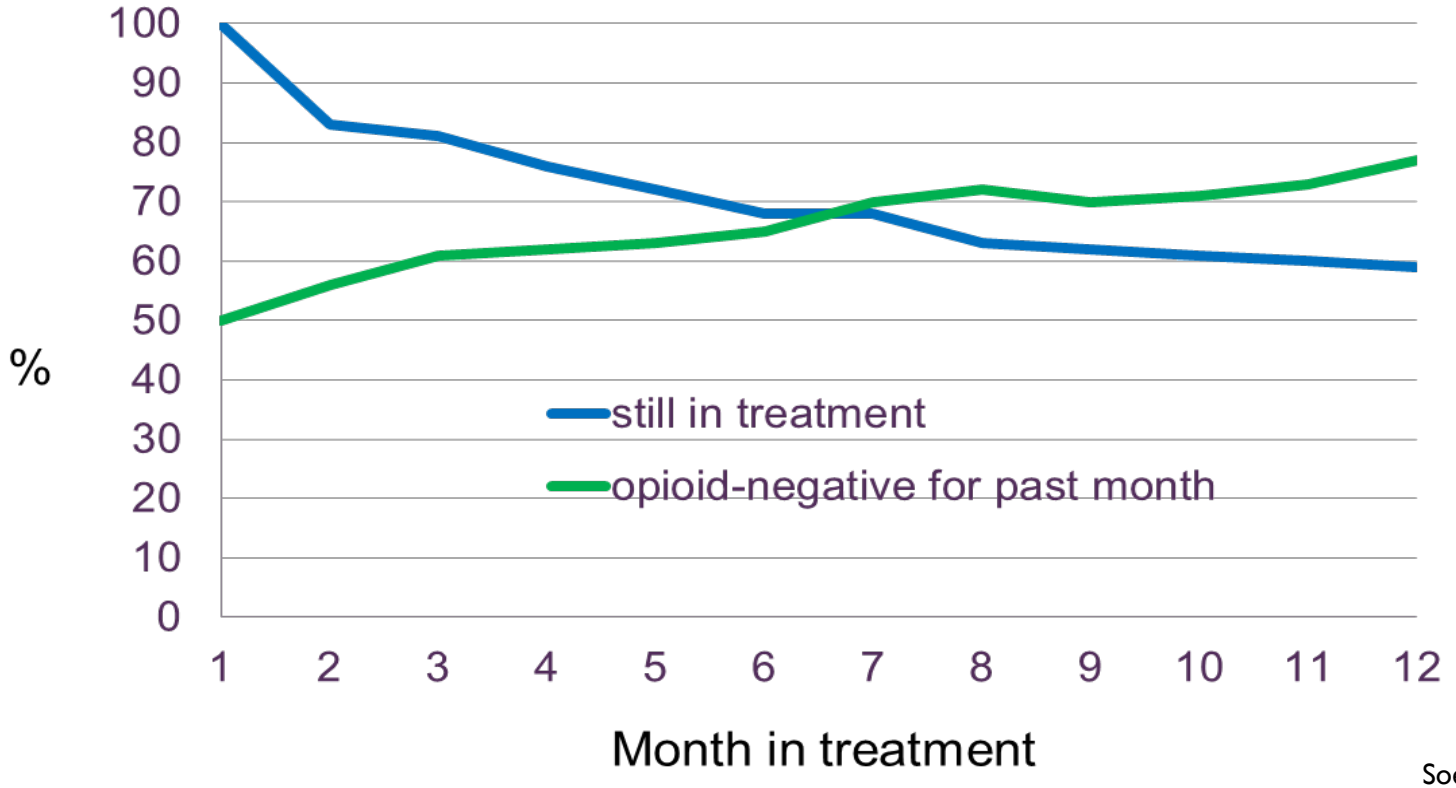
Stephen A. Martin, MD, EdM; Lisa M. Chiodo, PhD; Jordon D. Bosse, MS, RN; and Amanda Wilson, MD

Table. Buprenorphine Care: Previous Approaches Compared With New Findings and Recommendations

Previous Approach	New Findings and Recommendations
A medical setting is needed for induction.	Home induction is also safe and effective (6).
Benzodiazepine and buprenorphine coprescription is toxic.	Buprenorphine should not be withheld from patients taking benzodiazepines (5).
Relapse indicates that the patient is unfit for buprenorphine-based treatment.	Relapse indicates the need for additional support and resources rather than cessation of buprenorphine treatment (43).
Counseling or participation in a 12-step program is mandatory.	Behavioral treatments and support are provided as desired by the patient (6).
Drug testing is a tool to discharge patients from buprenorphine treatment or compel more intensive settings.	Drug testing is a tool to better support recovery and address relapse (56).
Use of other substances is a sign of treatment failure and grounds for dismissal from buprenorphine treatment.	Buprenorphine treatment does not directly affect other substance use, and such use should be addressed in this context (43).
Buprenorphine is a short-term treatment, prescribed with tapered dosages or for weeks to months.	Buprenorphine is prescribed as long as it continues to benefit the patient (6).

Buprenorphine Outcomes & Retention

Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids.



Soeffing et al., 2009

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Referral to Tx: Resource website

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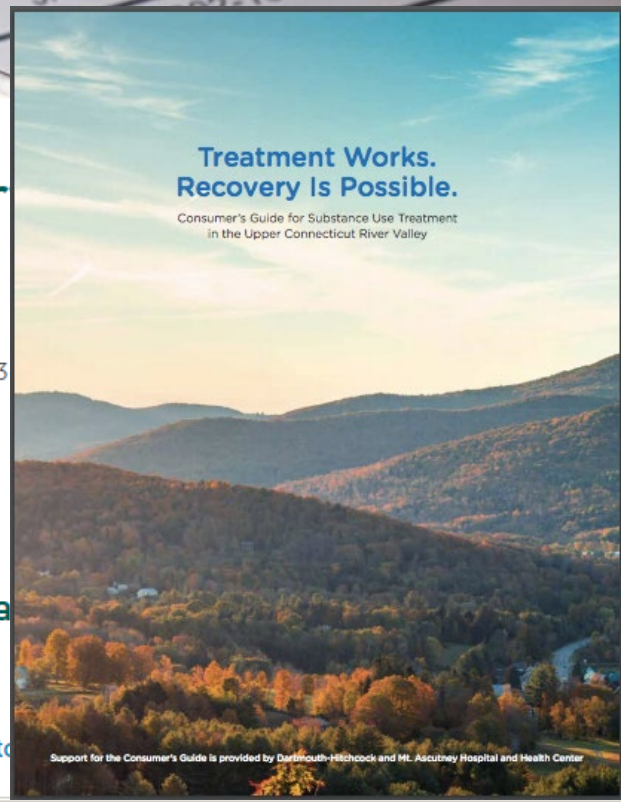
Crisis Lines

- Substance related crises: 1-844-711-4357 (HELP)
- New Hampshire suicide and mental health crisis line: 1-603
- National Suicide Prevention Lifeline: 1-800-273-8255
- Teen crisis intervention: 1-800-639-6095
- 2-1-1 New Hampshire
  Listing of hotlines and other resources multiple topics

Directories and Guidance in Seeking Trea

- 2-1-1 New Hampshire
- Vermont 2-1-1
- New Hampshire Online Alcohol and Drug Treatment locato
- New Hampshire Care Paths: Substance Use Concerns



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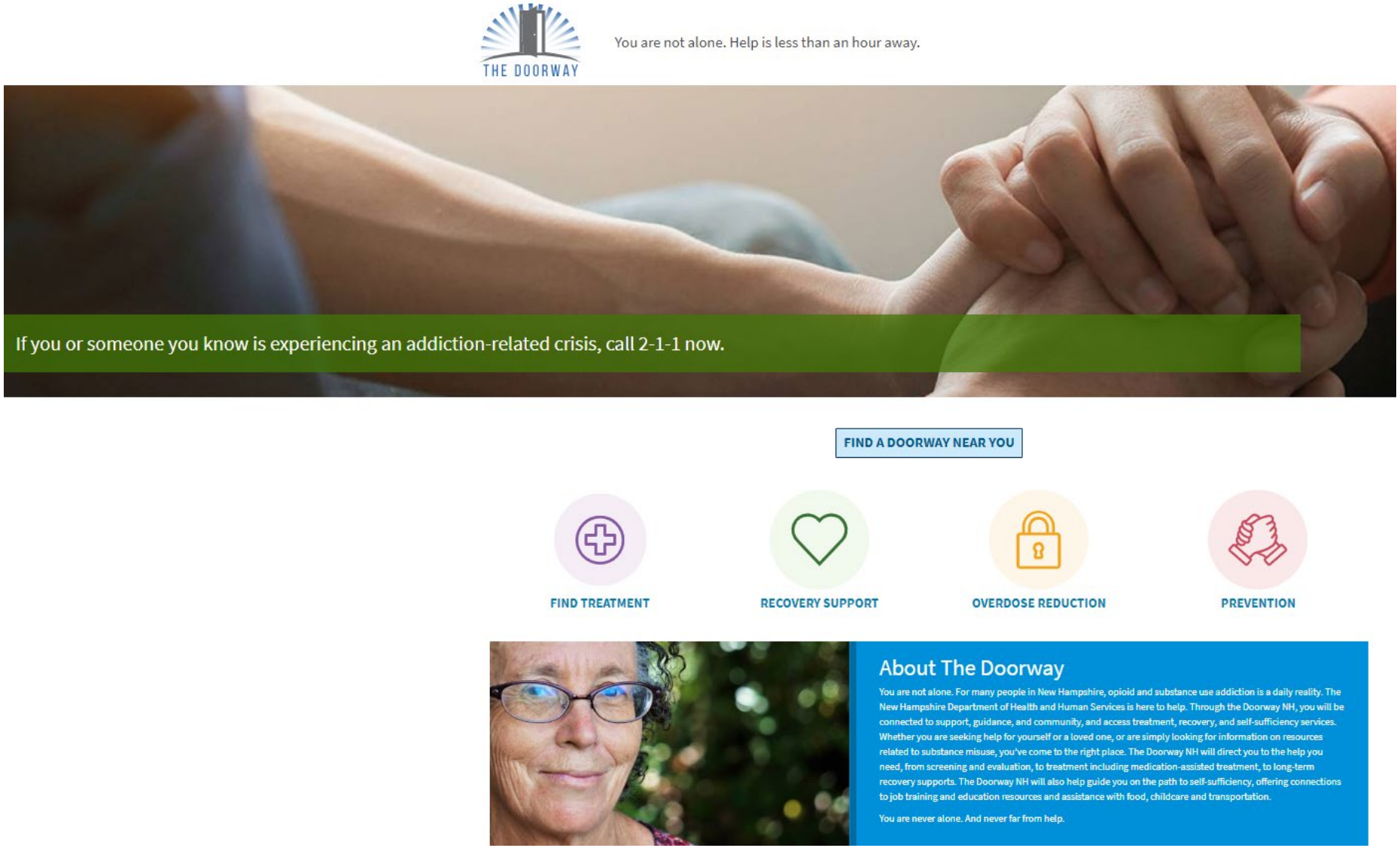
Doorway/Hubs



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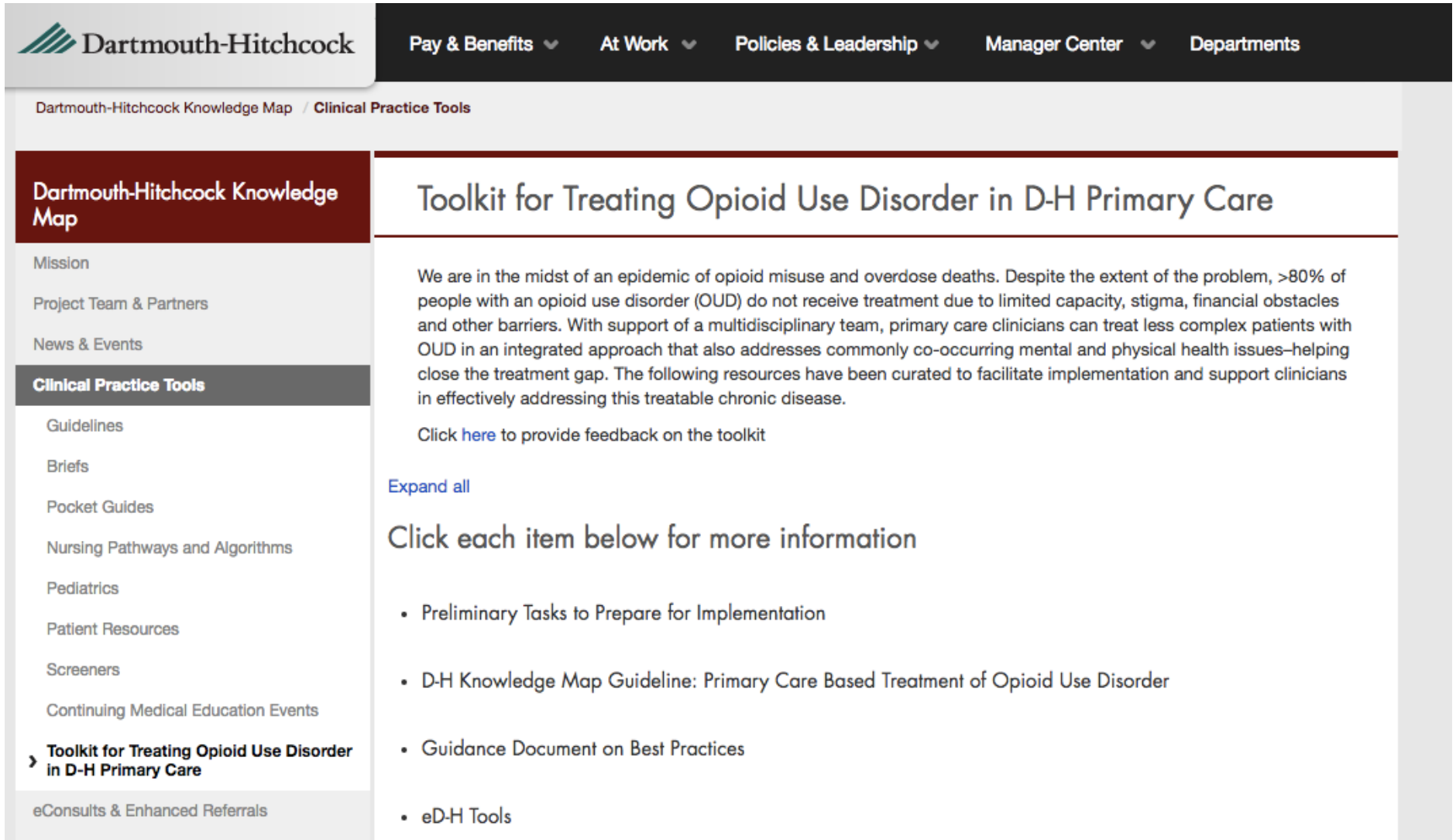
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Patient Resources
Screeners
Continuing Medical Education Events
Toolkit for Treating Opioid Use Disorder in D-H Primary Care
eConsults & Enhanced Referrals
Toolkit for Treating Opioid Use Disorder in D-H Primary Care
We are in the midst of an epidemic of opioid misuse and overdose deaths. Despite the extent of the problem, >80% of people with an opioid use disorder (OUD) do not receive treatment due to limited capacity, stigma, financial obstacles and other barriers. With support of a multidisciplinary team, primary care clinicians can treat less complex patients with OUD in an integrated approach that also addresses commonly co-occurring mental and physical health issues–helping close the treatment gap. The following resources have been curated to facilitate implementation and support clinicians in effectively addressing this treatable chronic disease.
Click here to provide feedback on the toolkit
Expand all
Click each item below for more information
Preliminary Tasks to Prepare for Implementation
D-H Knowledge Map Guideline: Primary Care Based Treatment of Opioid Use Disorder
Guidance Document on Best Practices
eD-H Tools