Development of a Primary Care Curriculum for Buprenorphine Therapy in Opioid Use Disorder

Fanny Xu, MD; Michelle Lim, DO; Linda Russell, LMFT; Elizabeth Iten, MD

INTRODUCTION

The opioid crisis was declared a public health emergency in 2017 and has been exacerbated by the COVID-19 pandemic. Provisional CDC data from Jan 2020-Jan 2021 shows 60,866 deaths from opioid overdose, a 27% increase in deaths from 2017. Expanding access to treatment for opioid use disorder (OUD) continues to be a key priority emphasized by the CDC. Integrating buprenorphine therapy in primary care has long been identified as a promising strategy to improve access.

OBJECTIVE

Develop a curriculum to train residents in buprenorphine therapy for OUD, in a primary care clinic within the John Muir Health system.

METHODS

To integrate buprenorphine training into our residency clinic, we addressed multiple areas across our healthcare organization:

RESIDENT PROVIDERS	Incorporate "X" waiver training into curriculum. Foster resident advocacy in health system.
FACULTY	Incorporate "X" waiver training into faculty administrative time. Identify community resources for expert consultation.
CLINICAL PROTOCOLS	Develop buprenorphine protocols with guidance from experts in the community, that includes regular in-person and telehealth visits, home induction, CURES and urine toxicology monitoring, and after-hours management.
PSYCHOSOCIAL SUPPORT	Collaborate with our integrative behavioral health team and identify community resources for OUD support.
PRACTICE MANAGEMENT	Create schedule templates, order supplies, and train support staff.
PHARMACY SUPPORT	Identify a 24-hour pharmacy partner that stocks and is familiar with buprenorphine.
IT SUPPORT	Make changes to electronic health system to support new clinical protocols, ie. ordering point of care drug screen. Confirmed 42 CFR Part 2 restrictions do not apply to buprenorphine therapy in integrated primary care setting.
BILLING ISSUES	Identify OUD billing issues specific to insurance plans common in our patient population, including coverage for visits, buprenorphine, and naloxone.
INTER-DEPARTMENTAL COLLABORATION	In conjunction with the Behavioral Health department and Emergency department, hire a Substance Use Navigator for care coordination needs related to substance use across the John Muir Health system.

RESULTS

Figure 1. Provider training for buprenorphine

For 24 residents, we organized a training with 4 hours of in-person instruction and 4 hours of online content. For incoming residents, we incorporated 8 hours of online training into the existing "Vulnerable Population Health" core rotation. For faculty members, the 8 hours of online training was incorporated into their administrative time. We also invited guest speakers with expert experience in OUD to didactic sessions, and used the California Substance Use phone line for additional provider support.

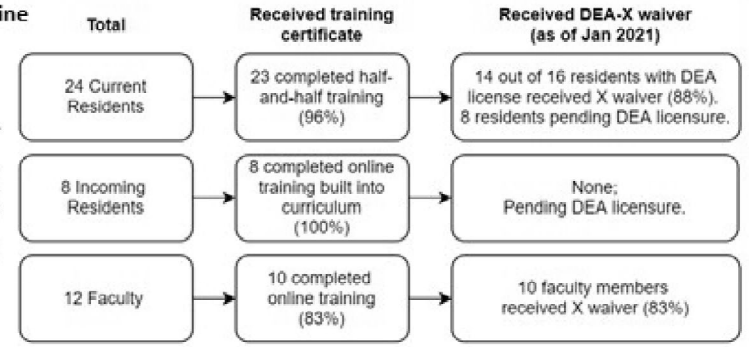

Figure 2. Buprenorphine induction schedule in residency clinic

Outpatient rotations have reserved timeslots, which are released for other visits if no induction is scheduled.

	MON	TUES	WED	THURS	FRI	WEEKEND
Patient contact	Intake (1 hr)	Induction f/u (30 min)	Induction f/u (30 min)	Psychosocial check-in (30 min)	Induction f/u (30 min)	On-call resident
Type	Office visit	Video visit	Video visit	Phone call	Video visit	Phone call prn

Figure 3. Management of patients on buprenorphine

Patient needs	Treatment overview
Scheduled to start induction	See induction schedule for first week above. Baseline CMP, Utox, urine hCG. CURES check. HIV/Hep B/Hep C if hx intravenous drug abuse.
Recently started induction in ED	Start patient on home Induction protocol in ED, schedule for next available induction followup visit in clinic. Coordinated by Substance Use Navigator.
Started induction in past month	After induction schedule for first week, weekly visits and check-in phone calls for psychosocial needs. Random Utox within the first month.
Stable on a dose and was induced more than 1 month ago	Depending on patient stability and risk factors, may change to monthly visits. Check-in phone calls for psychosocial needs depending on access to other behavioral health support. Random Utox every 2 months, CURES check every 4 months. LFTs 3 months after induction, then annually.
Desires to wean off buprenorphine	Slow taper as tolerated, increase frequency of visits and check-in phone calls for psychosocial needs.

DISCUSSION

To prepare residents to treat OUD with buprenorphine, we (1) provided opportunities for X-waiver licensure, and (2) integrated buprenorphine therapy into our residency clinic. Major barriers included administrative hurdles in a health system that is unfamiliar with OUD treatment in primary care, and provider hesitancy due to inexperience. The COVID-19 pandemic caused setbacks, including a hiring freeze that delayed onboarding a Substance Use Navigator for care coordination. However, it also presented a new opportunity by popularizing telehealth visits, which is helpful for home inductions. In addition to X-waiver training and developing clinical protocols, primary care programs planning to start buprenorphine therapy should give consideration to administrative issues (ie. practice management, IT, billing), addressing provider hesitancy, and fostering collaborations (ie. emergency department, behavioral health).