

# Primary Care Buprenorphine Programs: Ten Elements of Success



Addiction to opioids (including prescription painkillers and heroin) can be successfully treated through medication-assisted treatment (MAT), which is treatment that combines medication — specifically, buprenorphine and methadone — with behavioral health services. Incorporating MAT into primary care practices has increased access to care for patients who need it, saving lives and increasing recovery rates. (Because methadone cannot be prescribed for addiction outside of a licensed opioid treatment program, while buprenorphine is available to primary care physicians, this paper focuses exclusively on buprenorphine.)

Even as the nation grapples with solutions to the opioid addiction epidemic, buprenorphine remains underused. Only half of the physicians who are authorized to prescribe buprenorphine do so, due to worries about the stigma attached to this patient population, inadequate staff support, and paperwork requirements.<sup>1</sup> At the same time, practices around the country have overcome these barriers through a variety of approaches.

This fact sheet is an excerpt from the report *Recovery Within Reach: Medication-Assisted Treatment of Opioid Addiction Comes to Primary Care* available at [www.chcf.org](http://www.chcf.org).

## Ten Elements of Success

Experienced clinicians and experts in the field identified 10 elements common to successful primary care buprenorphine programs:

- 1. A champion.** Any clinical practice that wants to incorporate buprenorphine into its treatment program must have champions at the administrative and clinical levels. Because all staff — especially those at the front desk — must support the decision to treat patients with substance use disorders, it is critical that executive leadership send a consistent message to the entire organization as well as provide training and support to staff.
- 2. Staffing for administrative activities.** The US Drug Enforcement Agency conducts random site visits to physician offices that have buprenorphine waivers, to ensure that these offices can produce medical records showing dates and amounts of medications prescribed for each patient, and can document that they have not exceeded their maximum number of actively treated patients. These reports can be pulled from the electronic health record.<sup>2</sup> Some clinics keep separate logs, maintained by a medical assistant or other staff member, to ensure that physicians stay within the limit.
- 3. Team-based approach.** One of the benefits of the office-based opioid treatment model is the ability of a clinical care team to develop trusting relationships with patients. Team models enable the clinic, using a variety of practitioners, to provide patients with the wraparound support services they need. Patients new to treatment, or patients with complex needs, often require extensive monitoring to determine appropriate dosing and to ensure that the patient stabilizes. Clinics can designate a nurse care manager, nurse practitioner, physician assistant, social worker, health educator, or other staff member to be the main point of contact and manage the program details, while the physician is responsible for the addiction diagnosis, prescription management, and periodic follow-up visits. Team-based approaches can thus provide a high level of patient support while not overburdening physicians.
- 4. Connection to behavioral health services.** All buprenorphine protocols and guidelines recommend that patients receive behavioral health services as part of their treatment. Counseling, support groups, and 12-step programs are important components of a comprehensive approach to treating substance use disorder. Many interviewees noted that since some 12-step programs consider MAT to be substance use and discourage it, it is essential to identify programs that support patients in taking buprenorphine. Patients who refuse counseling or who do not have access to such services should not be disqualified from buprenorphine treatment.
- 5. Mentoring support for physicians.** Mentoring programs that support providers and improve their confidence in treating opioid use disorders allow clinicians to learn from their peers about treatment approaches, particularly for complex patients. By providing access to expert guidance, these mentoring services promote the use of

evidence-based practices, and can improve the scope and strengthen the infrastructure of a primary care practice.

6. **Two waived doctors per practice.** Having at least two physicians with waivers to prescribe buprenorphine is becoming a recognized best practice for primary care practices using MAT. Because patients on buprenorphine need frequent visits and follow-up, it can be challenging for a single physician to meet the needs of those patients in a timely fashion. Having at least one additional physician who can prescribe, even without taking on a large caseload, can provide needed backup and mitigate one obstacle often cited by physicians, as well as provide on-site peer support.
7. **Assessing patient readiness.** Before beginning treatment with buprenorphine, patients should be assessed for their opioid use disorder, the presence of other drugs, and the stage of withdrawal. The assessment should also include the level of support they have from family and friends and their overall readiness for treatment.
8. **An induction approach that fits.** Most protocols recommend observing patients during the induction process to ensure that the patient properly takes the medication, to monitor effects, and to establish appropriate dosage levels. In some cases, pharmacies have established separate waiting rooms to conduct the observed dosing.

Increasingly, however, physicians have found that patients do not need to be observed and that home induction can be safe and effective, an approach that is supported by the literature and ASAM practice guidelines.<sup>3,4</sup> The ASAM Guideline Committee recommends that the prescribing physicians or patients should be experienced with buprenorphine to do home-based induction.

9. **Pharmacists willing to partner.** Many primary care settings do not maintain an on-site pharmacy, although some do keep a small supply of buprenorphine. Primary care practices generally refer their patients to community pharmacies. Nevertheless, developing a strong relationship with at least one pharmacy is essential, given the importance of being able to fill prescriptions in a timely manner.

For example, insurance issues can delay a pharmacy providing medication. Pharmacists do not always realize they need to send the claim to state Medi-Cal and not to the managed care plan. Pharmacists can also partner with the primary care practice by monitoring patients for obvious signs of substance use, such as the smell of alcohol on a patient's breath, or signs of potential diversion, such as filling multiple opioid medications. Some pharmacies have even set up a separate window to provide privacy during observed dosing.

10. **Sustainable financing.** Many programs are grant funded. Sustainable financing for buprenorphine is an ongoing concern. Although buprenorphine itself is covered by Medi-Cal, funding for the administrative support, as well as for collaborative care teams, is often harder to come by.

Some early adopters have developed solutions. One clinic runs group sessions for patients with opioid addiction. During the group session, patients are individually pulled out for a physician visit, during which they receive their next prescription for buprenorphine. Although group sessions are not covered, the clinic can bill for the medical face-to-face encounters.

A similar strategy to ensure reimbursement for team care involves having a nurse or behavioral health provider manage the patient's care, with a physician seeing the patient at the end of the visit to review the treatment plan and write prescriptions.

Another financing approach that several states have pursued is the Health Homes Medicaid state plan option under Section 2703 of the ACA. Under this program, states can receive a 90:10 federal Medicaid match for certain services provided to specified populations. States can establish health home models tailored to individuals with opioid use disorders as a way to develop comprehensive programs that include case management and counseling.<sup>5</sup>

## Endnotes

1. Eliza Hutchinson et al., "Barriers to Primary Care Physicians Prescribing Buprenorphine," *Annals of Family Medicine* 12, no. 2 (March/April 2014), [www.annfammed.org](http://www.annfammed.org).
2. Personal conversation with DEA officer during random site visit at Dr. Kelly Pfeifer's practice, February 2016.
3. Eleanor Patterson, poster presentation, presented April 11, 2014, American Society of Addiction Medicine (ASAM) 45th Annual Medical-Scientific Conference, reported in Medscape, [www.medscape.com](http://www.medscape.com).
4. *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, American Society of Addiction Medicine (May 27, 2015), [www.asam.org](http://www.asam.org) (PDF).
5. Kathy Moses and Julie Klebonis, "Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States," Centers for Medicare & Medicaid Services, January 2015, [www.medicare.gov](http://www.medicare.gov) (PDF).