Medication for Opioid Use Disorder (MOUD) in Primary Care: Implementing the OBAT Model

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DISCLOSURES -

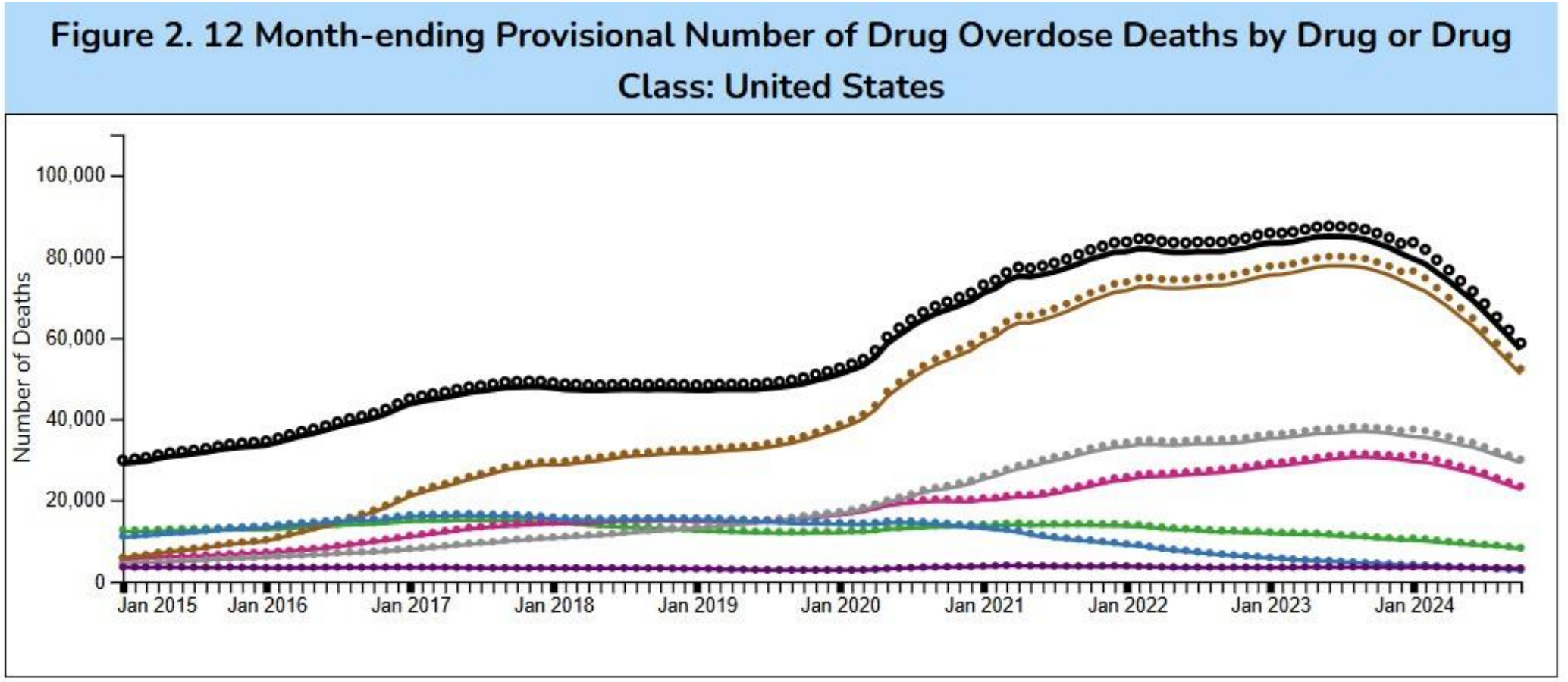
- Elizabeth Haberkorn, DNP, FNP-BC- Speaker
  - I have no relevant financial relationships

OBJECTIVES

1. Define the OBAT model and describe its role in primary care settings.
2. Compare and contrast the efficacy and safety profiles of buprenorphine and naltrexone for treating OUD.
3. Identify key steps in initiating MOUD and integrating it into a primary care workflow.

DRUG EPIDEMIC

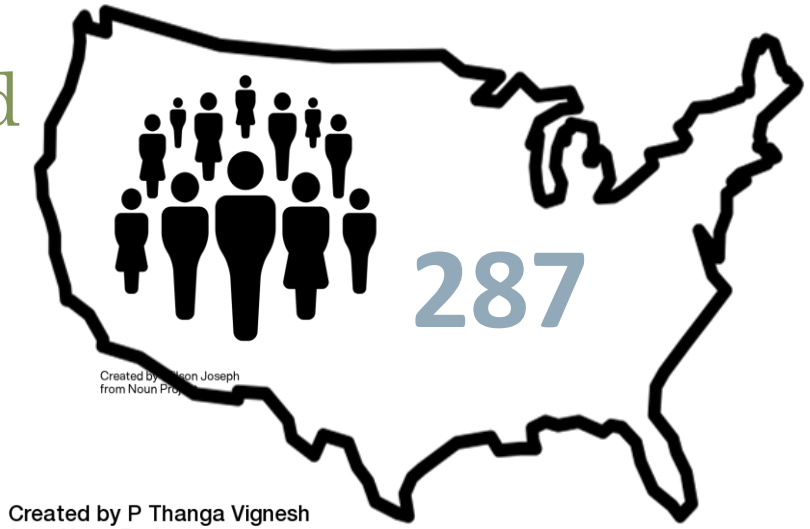
WE STILL HAVE AN OPIOID/DRUG EPIDEMIC



NCHS, National Vital Statistics System.

BACKGROUND

- From 2022 to 2023,
  - death rates increased for cocaine and psychostimulants
  - deaths decreased for synthetic opioids
  - HOWEVER….not for everyone
  - Healthcare costs

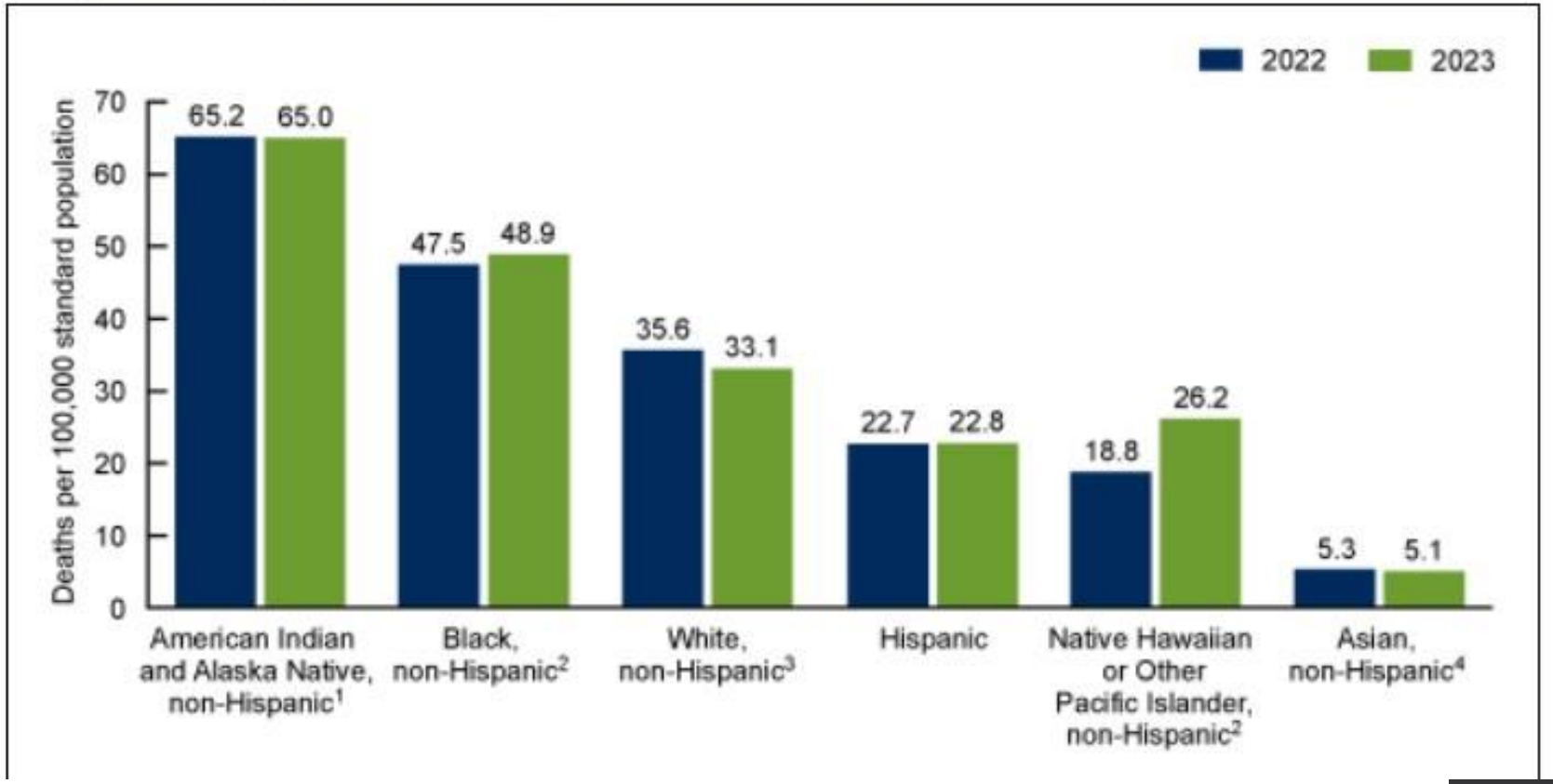


people die everyday from a drug overdose in the United States[1]

RACIAL/ETHNIC DISPARITIES IN DEATHS

- Whites - lower rate
- Highest for American Indian and Alaska Native

Figure 3. Age-adjusted drug overdose death rate, by race and Hispanic origin: United States, 2022 and 2023



Garnett et al., 2024.

What can primary care providers do?

<20%

People with OUD receive MOUD.

We can increase this.

We can provide MOUD with an engaging, low barrier, harm reduction approach!

Wu et al, 2016

OBAT Model

- Office-Based Addiction Treatment (OBAT) is a team-based, evidence-based model that expands MOUD access in primary care
- Leverages RN Care Managers to lead daily addiction care and support prescribers
- Reduces provider burden and improves care coordination
- Integrated into routine workflows — no separate clinic or specialty required
- Nationally recognized and replicated across 40+ sites

https://www.addictiontraining.org/about-us/bmc-obat/

Evidence for OBAT

- Higher Retention Rates - OBAT programs at Boston Medical Center show 72% 12-month retention in MOUD treatment.[1]
- Efficient Use of Clinician Time - RN Care Managers handle coordination and follow-up, allowing providers to focus on diagnosis and complex care.[2]
- Replicated Nationwide - Implemented in 40+ community health centers and academic settings via BMC's national TA program.[3]
- Cost-Effective, Chronic Care Model - PROUD Trial confirms OBAT delivers improved outcomes at comparable cost to usual care.

1. LaBelle CT, Han SC, Bergeron A, Samet JH. (2016). *Journal of Substance Abuse Treatment.*
2. Alford DP, LaBelle CT, Richardson JM, et al. (2011). *Journal of General Internal Medicine.*
3. Boston Medical Center OBAT Clinical Guidelines (2021). https://www.bmcobat.org
4. Korthuis PT, et al. (2022). *Annals of Internal Medicine.*

Roles

Role	Key Responsibilities
Provider (MD/DO/NP/PA)	Diagnose OUD, prescribe MOUD, oversee treatment plan, adjust meds as needed
RN Care Manager	Conduct intake, coordinate care, track adherence, provide ongoing education/support
Community Health Worker / Peer Support	Address social determinants, connect to housing, benefits, recovery support
Behavioral Health (as available)	Offer optional therapy; collaborate on co-occurring conditions

Why OBAT Matters – Addressing Health Gaps

- Nurses manage addiction like other chronic diseases — education, coordination, and monitoring
- People with OUD have a 15–20 year shorter life expectancy than the general population *(Degenhardt et al., 2020)*
- Most do not receive routine preventive care, including cancer screenings, vaccines, or chronic disease management *(Wakeman & Barnett, 2018)*

Why OBAT Matters – Extending Reach

- OBAT reconnects patients with the healthcare system, improving long-term health outcomes *(Korthuis et al., 2022)*
- Proven effective in rural clinics, shelters, jails, syringe programs, and EDs *(Hood et al., 2020)*
- Embedding MOUD in primary care reduces overdose risk and addresses health disparities

HARM REDUCTION

Harm reduction is an evidence-based, nonjudgmental approach that seeks to reduce the health and social harms associated with substance use without requiring abstinence

- Improve quality of life
- Reducing overdose risk
- Increasing access to care

Individual-Level:

- "Set of practical strategies and ideas aimed at reducing negative consequences associated with drug use."

Societal-Level:

- "Harm reduction is a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."

(Harm Reduction Coalition, 2024, SAMSHA, 2023)

Perceived Barriers

for PCPs to Treating Addiction and OUD

Stigma

Apprehension

Resource Constraints

Time Constraints

Limited Knowledge about Addiction and OUD

Concerns about Safety and Liability

Case Study: A Call for Help

- 42-year-old woman, Ellen, a tax preparer
- Prescribed opioids after a car accident in her 20s
- Took Norco for years, gradually increased to 3–4 Norco 10 mg daily
- Lost her PCP; couldn’t find another provider to continue pain management
- Began purchasing pills illicitly, eventually progressed to **inhaling** to increase effectiveness
- Recently **overdosed on fentanyl-laced pills** and was hospitalized
- Now calling the clinic, asking if you’re accepting new patients

Assessment of OUD

- A **substance use history** includes the type, route, and frequency
- Key assessment tools include:
  - **COWS** (Clinical Opiate Withdrawal Scale) to assess withdrawal severity
  - **DSM-5** criteria to determine the presence and severity of OUD
- Review of **PDMP** and urine drug screening can aid clinical decision-making.
- Assess for co-occurring conditions such as depression, anxiety, PTSD, and chronic pain.
- Labs?

(Wesson & Ling, 2003), (American Psychiatric Association, 2013, p. 123), (SAMHSA, 2012)

Barrier: Stigma

- **Internal stigma**: Provider discomfort, bias, or misconceptions about addiction
- **External stigma**: Patient experiences of judgment, dismissal, or being labeled

Solution: Normalize and Train

- Treat MOUD as **routine medical care** — like managing diabetes or hypertension
- Provide **staff-wide training** on non-stigmatizing, person-first language
- Use **scripts or signage** to model respectful communication (e.g., “person with OUD” vs. “addict”)
- Engage patients in a **nonjudgmental, harm-reduction approach**

Diagnosis and Severity of OUD

- **DSM-5 criteria** defines OUD based on 11 behavioral and physiological symptoms occurring within a 12-month period.
- Severity levels:
  - **Mild**: 2–3 criteria
  - **Moderate**: 4–5 criteria
  - **Severe**: 6 or more criteria
- Example: Ellen meets 7 criteria.

(American Psychiatric Association, 2013, p. 123)

4 C's of Addiction Diagnosis

(Jovey, 2012)

DSM-5 Diagnostic Criteria	
Craving	Craving, or a strong desire to use opioids.
	Opioids taken in larger amounts or over a longer time than intended.
Loss of Control	Persistent desire or unsuccessful efforts to cut down or control opioid use.
	Spending a great deal of time obtaining, using, or recovering from opioids.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by its effects.
Compulsive Use	Giving up or reducing important social, occupational, or recreational activities due to use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
Use Despite Consequences	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms
	Score (2-3: Mild, 4-5:Moderate, 6+ Severe)

(American Psychiatric Association, 2013, p. 123)

Ellen's 1st visit

- Provider reviews **RN intake summary**: substance use history, DSM-5 criteria, COWS score, and lab orders
- Physical exam and Establishes **formal diagnosis** of OUD
- Discusses **treatment options**, including MOUD (e.g., buprenorphine, naltrexone)
- Engages patient in **shared decision-making, established goals**
- Orders finalized labs if needed (CBC, CMP, TSH, Lipids, Hep C, HIV, pregnancy test, etc.)

COWS: Clinical Opiate Withdrawal Scale

- Resting pulse
- Sweating
- Restlessness
- Pupil Size
- Bone/ joint pain
- Runny nose or tearing
- GI upset
- Tremor
- Yawning
- Anxiety/ irritability
- Gooseflesh skin

Score: mild, moderate, moderately severe, severe






Sign or Symptom	Score
Resting pulse rate *Measured while patient resting for 1 min*	0 = pulse rate 80 or below 1 = pulse rate 81-100 2 = pulse rate 101-120 4 = pulse rate greater than 120
Sweating *Not accounted for by activity or room temperature*	0 = no report of chills or flushing 1 = subjective report of chills or flushing 2 = flushed or observable moistness on face 3 = beads of sweat on brow or face 4 = sweat streaming off face
Restlessness *Observation during assessment*	0 = able to sit still 1 = reports difficulty sitting still, but is able to do so 3 = frequent shifting or extraneous movements of legs/arms 5 = Unable to sit still for more than a few seconds
Pupil size	0 = pupils pinned or normal size for room light 1 = pupils possibly larger than normal for room light 2 = pupils moderately dilated 5 - pupils so dilated that only the rim of the iris is visible
Bone or Joint pain *not attributed to chronic or acute injury*	0 = not present 1 = mild diffuse discomfort 2 = patient reports severe diffuse aching of joints/ muscles 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort
Runny nose or tearing *not accounted for by cold symptoms or allergies*	0 = not present 1 = nasal stuffiness or unusually moist eyes 2 = nose running or tearing 4 = nose constantly running or tears streaming down cheeks
GI Upset *over last ½ hour*	0 = no GI symptoms 1 = stomach cramps 2 = nausea or loose stool 3 = vomiting or diarrhea 5 = Multiple episodes of diarrhea or vomiting
Tremor *observation of outstretched hands*	0 = No tremor 1 = tremor can be felt, but not observed 2 = slight tremor observable 4 = gross tremor or muscle twitching
Yawning *observation during assessment*	0 = no yawning 1 = yawning once or twice during assessment 2 = yawning three or more times during assessment 4 = yawning several times/minute
Anxiety or Irritability	0 = none 1 = patient reports increasing irritability or anxiousness 2 = patient obviously irritable anxious 4 = patient so irritable or anxious that participation in the assessment is difficult
Gooseflesh skin	0 = skin is smooth 3 = piloerection of skin can be felt or hairs standing up on arms 5 = prominent piloerection

Score: 5-12 mild; 13-24 = moderate; 25-36 = moderately severe; >36 = severe (Wesson & Ling, 2003)

Barrier: Time Constraints

- First MOUD visits can be **long and complex**
- PCPs may feel they lack time to assess, educate, and initiate treatment

OBAT Solution:

- **RN Care Manager** handles in-depth intake, education, and COWS assessment
- Provider focuses on **diagnosis and shared decision-making**
- **CHW and RN** provide continued support between visits
- Team-based care model = **efficient, sustainable, patient-centered**

FDA Approved MOUD

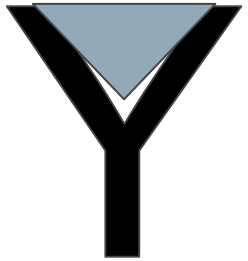
1. **Buprenorphine**: Combined with naloxone (generic, Suboxone® and Zubsolv®), or **extended-release injectable** (Sublocade® and Brixadi®)
2. **Naltrexone**: Oral or extended-release injectable (Vivitrol®)
3. **Methadone**: Dispensed only through federally regulated opioid treatment programs (OTPs)

MOUD is safe, evidence-based, and effective in primary care settings.

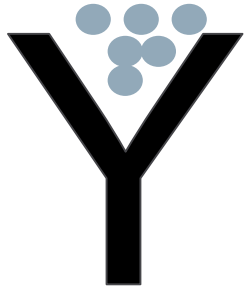
All *reduce use* and *overdose risk*, but differ in mechanism, delivery, and accessibility.

(SAMHSA, 2018, Wakeman et al. (2020))

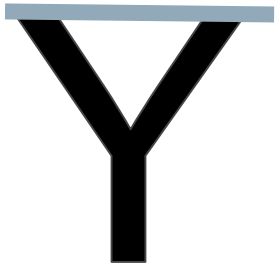
Methadone fully activates the mu receptor

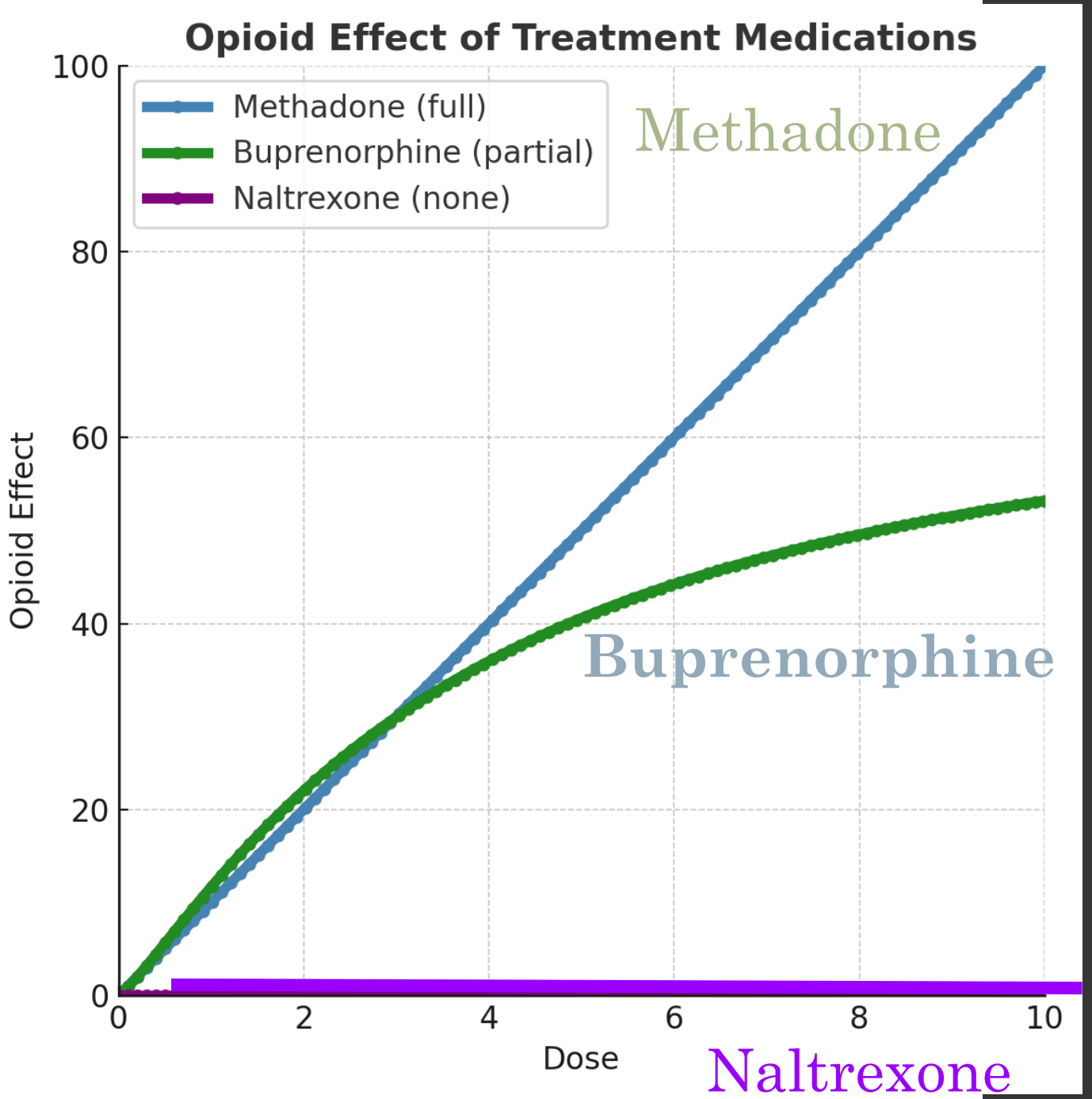


Buprenorphine partially activates the mu receptor, lower overdose risk



Naltrexone completely blocks the mu receptor, preventing any opioid effects





(Sordo et al., 2017), (Lee et al., 2018), (NIDA, 2021)

Myth or Fact

Treating opioid use disorder with buprenorphine or methadone is often misunderstood as simply substituting one drug or addiction for another.

FACT: Bup/Methadone do cause physiologic dependence but this is DIFFERENT that addiction as it is not accompanied by the 4 C's of addiction (Cravings, loss of Control, Compulsive use, use despite negative Consequences)

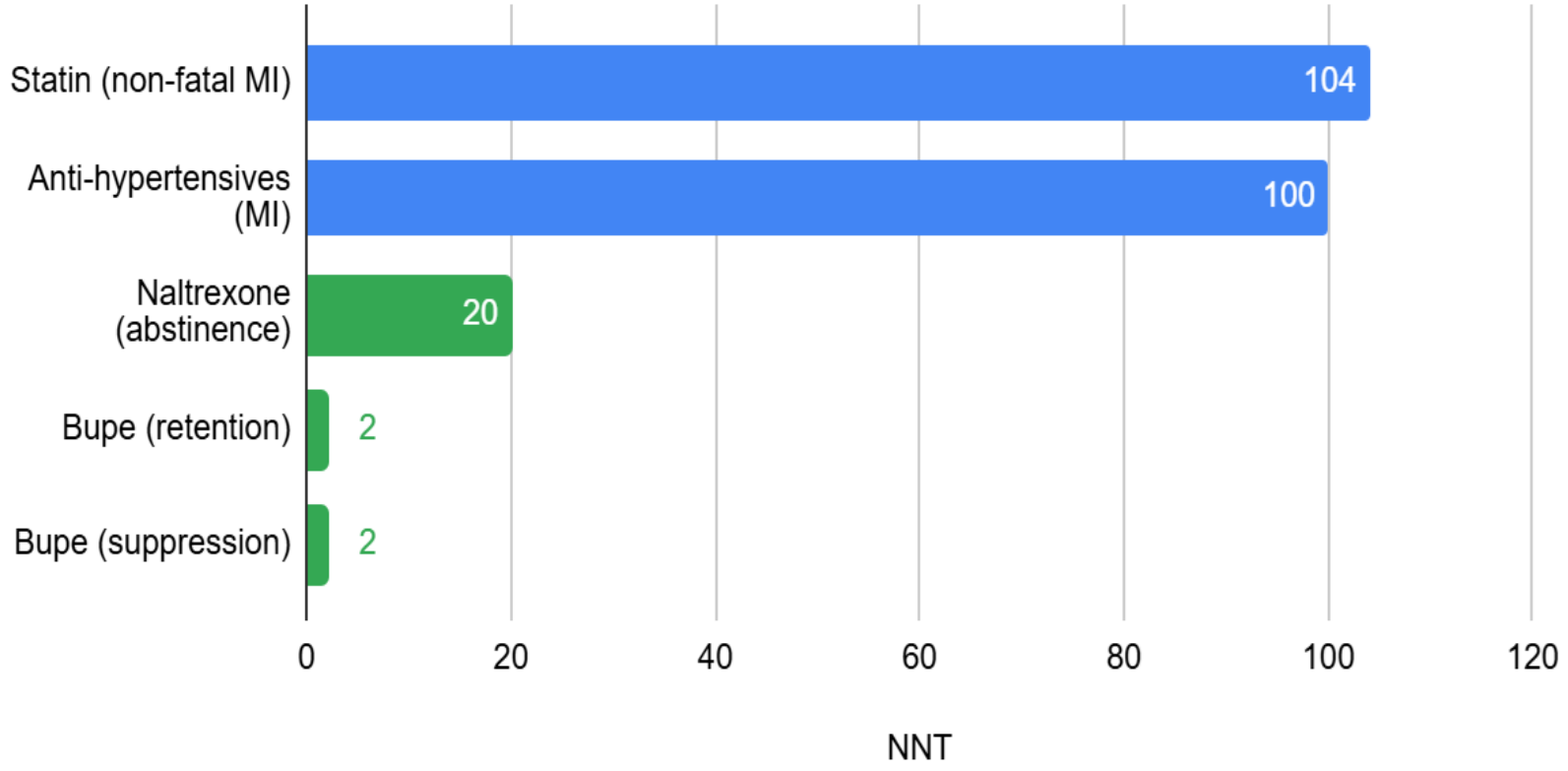
	Methadone	Buprenorphine	Naltrexone
Initiation	Anytime Daily Visits	Moderate Withdrawal	Opioid Free 7-10 days
Administration	Liquid	Films, tablets, Injectables	Pill/Injectable Monthly
Delivery	Licensed Opioid Treatment Programs	Rx	Rx
Reduces Withdrawal and Cravings	Yes	Yes	Not as much
Pregnancy	Yes	Yes	No
Helps with Pain	Yes	Yes	No

	Methadone	Buprenorphine	Naltrexone
Considerations	• Access • Transportations • Willing to take daily medications • May be more suitable for pts with high opioid tolerance	• Safer profile than methadone in polypharmacy • Multiple administration options • Prescribe with refills	• Desires to be opioid free • Strong social support
Caution	• Polypharmacy • Q-Tc Interval • CYP450 enzyme interactions • Potential stigma of OTP	• Increased risk for OD with benzo • May not be effective with people with high opioid tolerance • Precipitated withdrawal fear	• High return to use • High Overdose Risk if D/C

(McCance-Katz et al., 2010)

EVIDENCE FOR MOUD

- Buprenorphine is one of our most effective medications in primary care



Adapted from Wakeman et al., 2020; thennt.com; Hood et al., 2019;
Raleigh, 2017; Mattick et al., 2014;

↓ >50% overdose mortality!

Wu et al., 2016; Hood et al., 2019; Jonas et al., 2014; Raleigh, 2017; Mattick et al., 2014; thennt.com; Wakeman et al., 2020

Myth or Fact

MOUD is appropriate for short-term but not long-term treatment

X

Myth: Strong evidence for lowering overdose mortality, retention in treatment.

- Most people who stop buprenorphine return to opioid use

Buprenorphine Induction Approaches

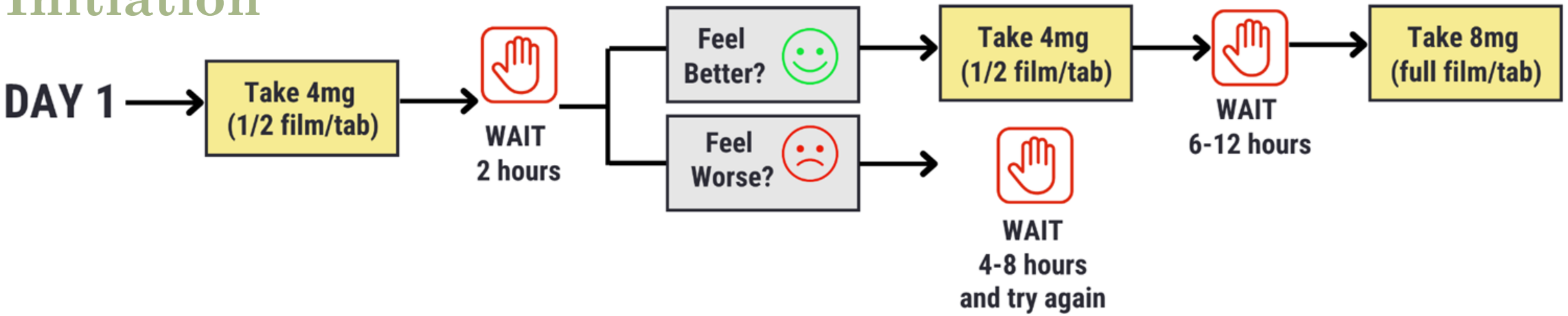
- **Standard Home Induction**
  - Patient waits for moderate withdrawal (COWS ≥ 8–12)
  - Takes initial 2–4 mg dose, then titrates over 24–48 hrs
- **Low-Dose (Micro) Induction**
  - Starts with very small doses while continuing full agonists
  - Slowly builds buprenorphine without triggering withdrawal
- **High-Dose (Macrodose) Induction**
  - Single 16–32 mg dose on Day 1 once in withdrawal
  - Faster stabilization, useful for severe OUD or limited follow-up

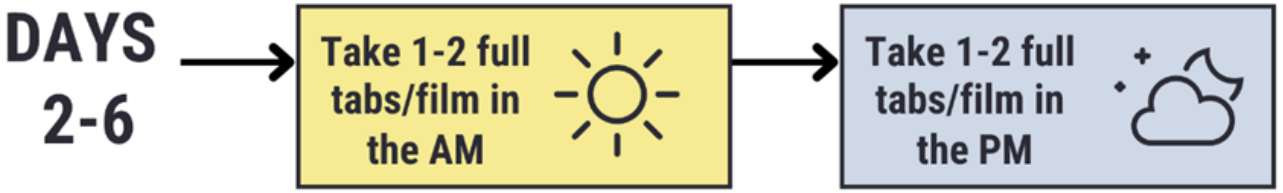
(Herring et al., 2021, SAMSHA, 2012, Cohen et al., 2022

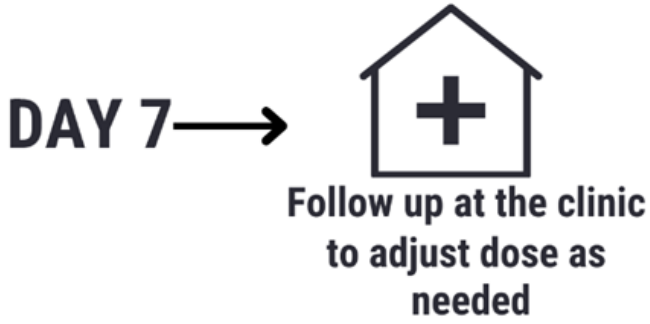
Buprenorphine/Naloxone Formulations

Generic SL tablets	Suboxone® SL films	Zubsolv® SL tablets	Sublocade® injection	Brixadi® weekly injection	Brixadi® monthly injection
2 mg bup / 0.5 mg naloxone	2 mg bup / 0.5 mg naloxone	1.4 mg bup / 0.36 mg naloxone	100 mg	8 mg	64 mg
	4 mg bup / 1 mg naloxone	2.9 mg bup / 0.71 mg naloxone	300 mg	16 mg	96 mg
8 mg bup / 2 mg naloxone	8 mg bup / 2 mg naloxone	5.7 mg bup / 1.4 mg naloxone		24 mg	128 mg
	12 mg bup / 3 mg naloxone	8.6 mg bup / 2.1 mg naloxone		32 mg	
		11.4 mg bup / 2.9 mg naloxone			

Standard Bupe Initiation







General Tips

- Stop your opioid for 24-72 hours
- When you are in moderate opioid withdrawal, begin your buprenorphine as indicated.
  - If you begin too early, you can get very sick ("precipitated withdrawal")
- Don't drink, eat, or smoke/vape/chew tobacco 15 mins before and after your buprenorphine does
- Let your buprenorphine dissolve completely in your mouth, do not chew or swallow
- Call your MOUD Nurse with any questions or concerns
  - **123-456-7890**

Buprenorphine Low-Dose Initiation

Day	Buprenorphine Dose	Continue full Agonist?	Notes
Day 1	0.5 mg once	✅ Yes	Begin while still taking opioids
Day 2	0.5 mg BID	✅ Yes	Monitor for precipitated withdrawal
Day 3	1 mg BID	✅ Yes	May split full agonist dose
Day 4	2 mg BID	✅ Yes	
Day 5	4 mg AM / 2 mg PM	✅ Optional	May taper off full agonist
Day 6	12–16 mg total	❌ No	Transition complete

Opioid Withdrawal Medication Management

Name	Mechanism of Action	Indication
Lofexidine	Alpha 2 Adrenergic Agonist	General opioid withdrawal
Clonidine	Alpha 2 Adrenergic Agonist	Anxiety & opioid withdrawal
Loperamide	Anti-Diarrheal	Diarrhea
Ondansetron	Antiemetic	N/V
Trazodone	Sedative, antidepressant	Insomnia
Hydroxyzine	Antihistamine/anxiolytic	Anxiety
Ibuprofen	NSAID	Muscle Aches
Cyclobenzaprine	Muscle Relaxant	Muscle cramps

Barrier - Apprehension & Limited Knowledge

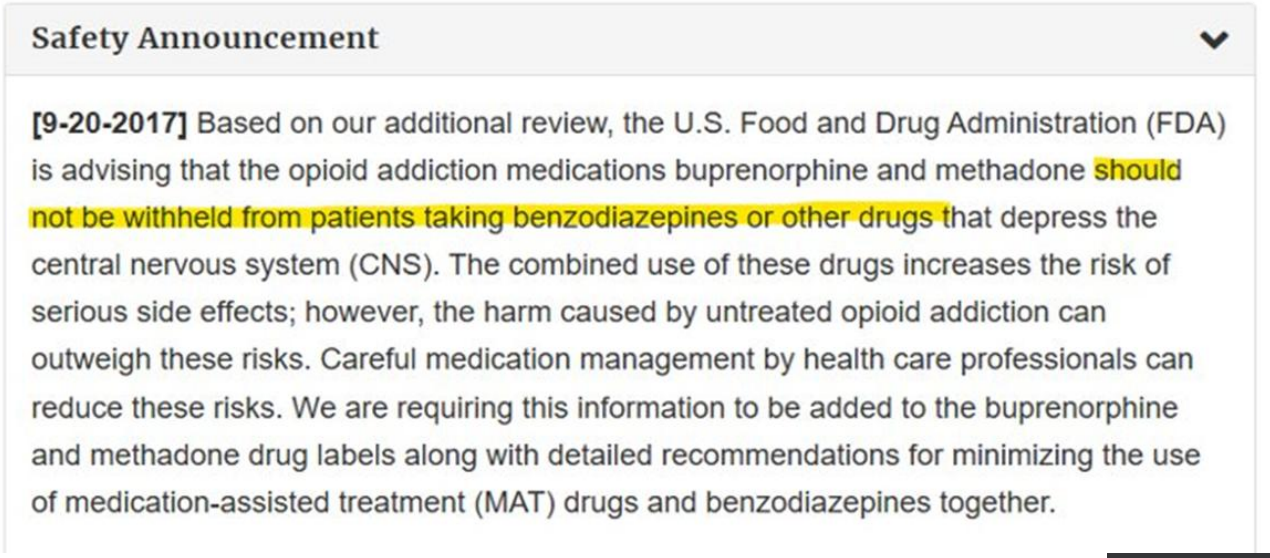
- Fear of “doing it wrong” or managing complex cases
- Lack of formal training in addiction medicine
- Start small — even **one patient** makes a difference
- OBAT model supports with **RN-led education and follow-up**
- Clinical resources, protocols, and consultation lines available

Ellen – 2-Week Follow-Up

- Successfully initiated buprenorphine with RN CM support
- Maintained daily 16 mg dose; denies cravings or opioid use
- **UDS positive for amphetamines** – not prescribed
- Provider re-evaluates stability; uses motivational interviewing to explore stimulant use
- Referral to counseling recommended for ongoing support
- OBAT team continues wraparound support and monitoring

Myth or Fact

MOUD should still be provided for OUD even if a person uses other substances at the same time



Safety Announcement

[9-20-2017] Based on our additional review, the U.S. Food and Drug Administration (FDA) is advising that the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS). The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks. Careful medication management by health care professionals can reduce these risks. We are requiring this information to be added to the buprenorphine and methadone drug labels along with detailed recommendations for minimizing the use of medication-assisted treatment (MAT) drugs and benzodiazepines together.

FDA Drug Safety Communication, 2021

FACT: MOUD save lives

- No relevant medical interaction between MOUD and stimulants (meth/cocaine), cannabis, and psychedelics
- Risk of OD is higher when combined with sedatives (alcohol, benzos), but not a reason to stop
- REMEMBER HARM REDUCTION

Barrier – Safety and liability concerns

- Worry about precipitated withdrawal, misuse, or overdose
- Fear of legal risk or DEA scrutiny when initiating MOUD
- Buprenorphine is safe and supported for primary care use
- SUPPORT Act (2018) removed waiver requirements (SAMHSA, 2023)
- Denying MOUD may pose greater liability risk (Wakeman & Barnett, 2018)
- OBAT model adds team-based oversight and documentation

SAMHSA, 2023; Wakeman & Barnett, 2018; HHS, 2022)

Ellen – 3 month follow-up

- Ellen continues monthly RN CM visits for MOUD follow-up
- At 3-month provider visit, she completes an annual physical
- Stable on 16 mg buprenorphine daily
- Expresses frustration with daily dosing and carrying medication
- Ellen also expresses interest in starting therapy

Myth or Fact

MOUD must be accompanied by behavioral health/counseling

X

Myth: MOUD alone is lifesaving treatment. There is no requirement for behavioral counseling

- Usually once the person is on MOUD, they are more open to considering behavioral counseling

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Center For Drug Evaluation and Research
U.S. Food and Drug Administration
Silver Spring, Maryland

May 9, 2023

Substance Abuse and Mental Health Services Administration
Rockville, Maryland

Dear Colleague:

As overdose deaths involving opioids, particularly illicitly manufactured fentanyl, continue to remain extremely high across the country[1], we are pleased that the opportunity to treat people with safe and effective medications for opioid use disorder (OUD), such as buprenorphine, has increased with the passage of Section 1262 of the Consolidated Appropriations Act, 2023. This section of the Act removes the requirement that a health care practitioner apply for a separate waiver to dispense certain controlled medications, including buprenorphine. Medication treatment saves lives, and we encourage colleagues in the field to screen for OUD and to initiate or refer for treatment as indicated.

An often-cited barrier to prescribing buprenorphine for the treatment of OUD is the perception that patients must engage in counseling and other services in order to start or continue receiving the medication.[2,3,4] This letter serves to clarify the importance of counseling and other services as part of a comprehensive treatment plan, but to also reiterate that the provision of medication should not be made contingent upon participation in such services.[5,6]

https://www.samhsa.gov/sites/default/files/dear-colleague-letter-fda-samhsa.pdf

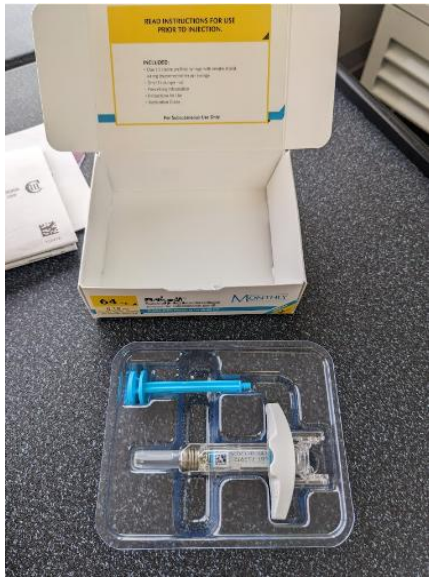
Barrier – Limited Resources

- Small practices may feel they lack staff, time, or infrastructure
- OBAT model allows for scalable, team-based care
- RN Care Managers expand capacity without needing more providers
- CHWs connect patients to community resources and support
- Telehealth counseling, online support groups, and remote education increase access
- MOUD in primary care is achievable even in resource-limited settings

(Korthuis et al., 2022)

Long-Acting Injectable Buprenorphine

- Consider for:
  - Patients with adherence concerns
  - Individuals who prefer less frequent dosing
  - Transitions from inpatient, ED, or carceral settings
- Workflow considerations:
  - Requires PA (sometimes)
  - Administered by trained staff (e.g., RN)
  - Cold chain storage may be needed
  - Monthly dose tracking



Personal Photo Haberkorn, E (2024)

Reduce

- Strip/pill burden
- Diversion risk
- Stigma (no visible/ daily medication)

(Heil et al., 2023)

Ellen – Sustained Recovery in Primary Care

- Receives monthly Brixadi® injections at RN Care Manager visits
- Connected to a therapist with flexible telehealth access
- Actively participating in a recovery community
- Now engaged in primary care with a focus on prevention
- OBAT supports long-term stability, health, and connection

Key Takeaways: Integrating MOUD with OBAT

- Addiction isn’t linear — but primary care is the right place
- You’re not alone: RN Care Managers and CHWs make it sustainable
- OBAT is not specialty care — it’s better primary care
- Start with one patient — structure + support make it possible

Resources

- Me! Elizabeth Haberkorn – ehaberkorn@mednetone.net or emhaberk@med.umich.edu
- https://michigan-open.org/ - OPEN offers a variety of programs to engage providers and community members, including training programs, take back events, naloxone distribution, and more.
  - SUD/MOUD Patient-Specific Management
  - Clinic Technical Assistance
- https://www.addictiontraining.org/about-us/bmc-obat/
  - OBAT Clinical Guidelines
  - OBAT Clinical Tools and Forms
- https://ancbonline.org/
  - Consider hiring or training an RN to be an addiction certified RN
- https://amersa.org/
  - Improve health and wellbeing through multidisciplinary leadership in substance use education, research, clinical care and policy
- https://www.michigan.gov/opioids

References

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