Linking Opioid Treatment in Primary Care

Roxanne Lewin M.D.
One of the fundamental barriers to providing effective treatment is the fact that addiction is not integrated into medical practice. And a lot of medical people like and want it that way; they do not want to deal with addiction; they do not like to deal with the people and they do not feel effective addressing the problem.\\footnote{148}

--Keith Humphreys, PhD
Professor
Stanford Medical School
The Facts

- Fewer than 10 percent of individuals with an alcohol use disorder and only about 20 percent of individuals with an opioid use disorder receive specialty treatment.

- Many individuals with a substance use disorder do not perceive a need for treatment.

- Evidence supports the use of medication-assisted treatment (MAT) for both alcohol and opioid use disorders.
FDA Approved Medications

MEDICATIONS USED TO TREAT DRUG ADDICTION

- Tobacco Addiction
  - Nicotine replacement therapies (available as a patch, inhaler, or gum)
  - Bupropion
  - Varenicline

- Opioid Addiction
  - Methadone
  - Buprenorphine
  - Naltrexone

- Alcohol and Drug Addiction
  - Naltrexone
  - Disulfiram
  - Acamprosate
Management of Substance Use Disorder as a Chronic Disease

- Population identification
- Evidence based practice guidelines
- Collaborative practice models to include clinician and ancillary support services
- Patient self-management education
Identification and Treatment of Substance Use Disorders: The Role of Primary Care Providers

- Evidence supports implementation of coordinated and integrated care models that support the role of primary care in substance use treatment services.

- Available data suggests that receiving medication-assisted treatment in primary care may also serve as an entry point to address other health care needs.

- As the health care system’s front line, primary care providers are well positioned to identify and engage individuals who require—or are at risk of requiring—treatment.

- Primary care providers, including nurse practitioners and physician assistants, collectively write a significant percentage—about half—of all opioid prescriptions in the United States.
Interviews conducted with 78 providers who received the waiver as part of a pilot project in Washington found that fewer than 30 percent of the providers actually prescribed the medication. Nearly 80 percent of those who did not prescribe cited a lack of psychosocial supports as a barrier, and half reported a lack of confidence in their ability to manage opioid addiction.

Access to specialty behavioral health professionals is important for individuals receiving medication-assisted treatment from their primary care providers.
Linking Opioid Treatment in Primary Care

- Hospitals
- Health Centers
- School-Based Health Centers
- Home Health Agency
- Durable Medical Equipment
- Long-term Skilled Nursing & Rehabilitation

[Map showing locations of facilities]
Bassett’s Initiatives

Comprehensive Opioid Epidemic Strategy

- Naloxone for OD reversal
- MAT in Primary Care
- Medication return/safe disposal
- Pain care/Continuum of care
- Safe Prescribing

Risk screening-goal of maintaining opioid naïve
Naloxone

Naloxone should be offered to anyone who feels they are at risk for witnessing a drug overdose and prescribed to every patient at risk for an opioid overdose.

**Naloxone Order Panel (Smart-Set)** to assist in prescribing, documenting, patient education, and billing.

**Naloxone Prescribing Best Practice Advisory (BPA)** to notify you if your patient meets existing risk criteria for opioid overdose per Bassett & CDC Guidelines.

**Opioid Risk Tool (ORT)** to facilitate risk stratification for future opioid aberrant behaviors.
The Role of Electronic Medical Records in Safe Prescribing
Current Initiatives

- Safe prescribing (PMP use, Naloxone prescribing, employing CDC guideline)
- Medication take back program/safe disposal
- Pain committee
- Inpatient pain management service
- Robust effort to get primary care providers waived to prescribe suboxone
- MAT for Opioid Addiction in Primary Care
- MAT for Opioid Addiction in pregnant women – OB Department
- Opioid Community Task Force
- Improvement of community relationships
Two-Pronged Approach: MAT in Primary Care

- Increasing the number of primary care providers who are trained to prescribe buprenorphine can significantly increase access to medication-assisted treatment.

- Access to specialty care within primary care clinics—Addiction and Psychiatry.
The hub: Opioid Withdrawal Program
The spokes: buprenorphine-waivered primary care providers.
Program Description

- Objective: To develop withdrawal management services for substance use disorders (SUD) (ambulatory detoxification) within community-based addiction treatment programs that provide medical supervision and allow simultaneous or rapid transfer of stabilized patients into the associated SUD services, and to provide/link with care management services that will assist the stabilizing patient to address the life disruption related to the prior substance use.

- Program start date: October 2016

- Two locations – 40 minutes apart
Core Components:

- Establishing referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.
- Addressing licensure/certification status of withdrawal management services based upon service category, i.e., ambulatory detoxification or ancillary withdrawal service.
- Identification/recruitment of a medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/Naltrexone as well as familiarity with other withdrawal management agents.
- Identification of community providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.
- Development of community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training approved by the OASAS medical director, if provided in an OASAS setting.
- Development of care management services within the SUD treatment program. For patients who qualify for Health Home services, development of a referral/shared care relationship with appropriate Health Homes. Care management will be expected to continue for the period the patient is in the treatment program. Care management may be enhanced by peer supports.
- Agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.
Process

Establish with Bassett Primary Care
- History and physical exam
- Baseline lab work
- Referrals
- Care Planning

Referral to Addiction Medicine
- Nurse Intake and needs assessment
- Detailed history of addiction and treatment
- Psycho-social Assessment
- Care Planning
Integrated Addiction Care:

Initial Assessment and Referral by PCP

Initial Addiction Assessment

Supervised Induction with Buprenorphine

Acute Treatment Phase

Maintenance Phase – Managed by PCP
Integration model: Co-located & Collaborative
Offered appointments

94 Initial evaluations

12 Patients lost to follow-up after initial evaluation

68 patients entered treatment

29 Patients transferred to Primary Care Providers for Maintenance Treatment

14 AUD

30 Patients in treatment with the Addiction program
Treatment drop-out

9 patients
- 2 cited pain needs not met; continued to use illicit opioids
- 2 relocated
- 2 arrested; 1 entered court mandated long-term treatment facility
- 3 left program after starting to work
68 patients treated OUD
- 40 males and 28 females
- 14 patients with legal issues – family court; parole; probation
- 8 women in family court

- **Other substance use**
- 64 continues to smoke marijuana
- 14 presented with illicit buprenorphine use only
- 26 patients used illicit drugs during the course of tx: cocaine, benzodiazepine, illicit opioids < 2 times.
Role of Urine Drug Screens

Used as a therapeutic tool.
Test results are used to generate therapeutic discussion with the patient at every visit.
- ARUP pain management drug panel across the network
  - Turnaround time 1-3 days
  - Creatinine concentration is also provided.
  - Qualitative Liquid Chromatography/Time of Flight Mass Spectrometry/Enzyme Immunoassay/Quantitative Spectrophotometry
Recommended UDS Panel:

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<td>Benzodiazepine-like:</td>
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<td>- buprenorphine, codeine, fentanyl,</td>
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Sample Urine Drug Screen Report

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Diversion of buprenorphine

- Two U.S. surveys of people with opioid use disorders found that a majority of those who used illicit buprenorphine reported that they used it for therapeutic purposes (i.e., to reduce withdrawal symptoms, reduce heroin use, etc.)

- Ninety-seven percent reported using to prevent cravings, 90 percent to prevent withdrawal, and 29 percent to save money.

- Illicit use of buprenorphine decreased as individuals had access to treatment.

- The minority proportion of people who use buprenorphine illicitly to get high (ranging from 8 to 25 percent) has been shown to decrease over time, which could suggest that people abandon this goal after they experience the drug’s blunted rewarding effects.

- Patients in treatment for opioid use disorder rarely endorse buprenorphine as the primary drug of abuse.

- While there is some risk associated with misuse of buprenorphine, the risk of harms, such as fatal overdose, are significantly lower than those of full agonist opioids.
Patients diagnosed with Opioid Addiction

- Opioid Addiction only
  - n=41
- Opioid Addiction and Chronic Pain
  - n=27
Pain and anxiety

- Not in treatment for anxiety: 58%
- Pain and anxiety: 42%
Linking Opioid Treatment in Primary Care

#transferred at weeks in treatment

![Graph showing the number of transfers at different weeks in treatment. The x-axis represents weeks (2 to 40), and the y-axis represents the number of transfers (0 to 7). The graph indicates a peak around 12 weeks.]
Maintenance Phase

Primary management is by PCP
Recommended follow-up is every 4 wks
MD/NP visits supplemented by RN support
PCPs are encouraged to reach out to the addiction medicine team when needed.
No wait time – patients get seen within a week if there is a concern
Hepatitis C and SUD

People with substance use disorders (SUDs), account for 68% to 80% of infected individuals in developed countries, a direct result of the opioid epidemic.

Following a decade of fairly steady decline of this population, there have been recent sharp increases in HCV.

People who inject drugs account for approximately 75 percent of all new HCV infections.

The need for HCV screening and linkage to care is essential.
Opportunities for change:

- Patient opportunities
- Program opportunities
- Network opportunities
- Changes made so far