Lessons from the front lines: Treating pain and opioid use disorder in primary care – Considerations for subspecialty collaboration

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Learning Objectives

1. Identify factors impacting the treatment of opioid use disorder (OUD) with medication-assisted treatment (MAT) in primary care.

2. Outline models for the integration of OUD treatment in primary care, and describe a current model at MUSC integrating OUD treatment in primary care.

3. Explore future opportunities in for OUD treatment in primary care
Introduction

National Drug Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2017

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018
National Drug Overdose Deaths
Number Among All Ages, 1999-2017

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Introduction
Introduction

Age Adjusted Overdose Death Rate: USA 2017

NOTES: Deaths are classified using the International Classification of Diseases, 10th Revision. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X65, and Y10–Y14. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf#3.
Introduction

• OUD increases odds of overdose by 12

• There are large gaps in the treatment of OUD and the availability of providers

• Primary care providers prescribe the majority of opioid in the US

• Primary care is a major gateway into the US health system

• As the primary care infrastructure is in place, expansion of OUD in primary care is feasible
Case Presentation

63 y/o F presented to MUSC University Internal Medicine clinic for establishment of care with a complaint of uncontrolled pain.

- Worsening lower back pain with increased frequency of visits to Columbia area ED for evaluation and treatment of pain

- Patient asks for transition from oxycodone to hydromorphone

- Accompanied by husband who reports increasing sedation from medications and inability to complete iADL’s

- Had been tried on methadone in the past for chronic pain but stopped due to nausea
Case Presentation (continued)

Past Medical History:
- Seronegative inflammatory arthritis
- Bipolar disorder (follows with psychiatrist) with 2 prior suicide attempts by overdose
- Heart failure with preserved ejection fraction

Social History:
- Lives with current husband
- History of abuse in prior relationships
- Everyday smoker
- No illicit drug or EtOH use

Medications:
- Oxycodone 10mg TID,
- Venlafaxine XR 150mg Daily
- Lamictal 200mg Daily
- Benztropine 0.5mg Daily
- Clonazepam 1mg TID prn anxiety
- Sulfasalazine 1gm BID
- Hydroxychloroquine 200mg BID
- Torsemide 20mg Daily
Case Presentation (clinical course)

Assessment / Plan

• Patient diagnosed with **opioid use disorder (OUD)**

• Collateral information obtained from psychiatrist and discussed case with local mentor

• Patient returned **within 1 week** for buprenorphine counseling and **successfully completed outpatient buprenorphine induction**
What Factors Contributed To This Outcome?

Primary Care Provider MAT Training
› Attitudes toward MAT in primary care
› X-waiver training

Primary Care Delivery Models
› Office Based Opioid Treatment
› Hub and Spoke
› ECHO

Identifying Patients
› Screening For Opioid Use Disorder
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Attitudes Toward MAT in Primary Care

Sarah Oros, MD
Lillian Christon, PhD
Kelly Barth, DO
Carole Berini, MS
Bennie Padgett
Vanessa Diaz, MD, MSCR
Theory of Planned Behavior

Intentions precede behavior

Qualitative and quantitative questions can be formulated to capture attitudes, subjective norms and perceived behavior control

Translate to intentions in order to affect interventions
Methods

Participants were elicited through email
  › $40 gift card for participation

7 focus groups conducted, limited to 10 participants each
  › 15 minute survey eliciting subjective norms, perceived behavioral control, and attitudes through Likert-scale questions
  › 45 minutes in semi-structured TPB guided questions

Themes were identified throughout the transcribed focus groups
Main Themes Identified

General Attitudes toward Buprenorphine and Naltrexone

› Attitudes supportive of MAT in Primary Care
  › Alleviate craving, patient motivation, treats a disease, capitalize within established patient-provider relationship, within PCP scope of practice
› Expressed challenges toward MAT use in Primary Care
  › Stigma, diversion of intended use, “replacing one drug for another”, time limitation in PCP visits

Subjective Norms toward MAT

› Groups that would approve or disprove MAT
  › Community, patients, colleagues, institution, society

Perceived Behavioral Control

› Identifying barriers and enablers to utilization of MAT
  › Education, system, dedicated protocols, financial, legal
Quantitative Results

General attitudes did not differ significantly among the different focus groups for Buprenorphine (5.6/7) or Naltrexone (5.8/7).

For subjective norms (3.4/7) and perceived behavioral control (3.9/7), participants’ perspectives were more neutral, indicating less perceived pressure and self-efficacy in actually prescribing.

Differences between Faculty (IM, FM) and Residents regarding Buprenorphine

- Faculty reported lower subjective norms (2.43 vs 3.18, \( p < 0.04 \))
- Faculty reported higher controllability (4.89 vs 3.15, \( p < 0.01 \))

Residents reported higher intention to prescribe Naltrexone (4.8 vs 3.6, \( p < 0.02 \))
Conclusion from focus groups

Primary care providers identified benefits to prescribing MAT

Several identified barriers limit its use

- Education is a commonly identified need
- Residents and PAs identified need for supervising physician support
- Faculty identified need for practice and colleague support

Future Directions

- Integrate buprenorphine waiver training into residency education
- Provide protected time for faculty to get waived
- Will need an integrated system of care and protocols to introduce MAT into primary care practices
Waiver Resources

PCSS waiver training materials and training grants available

At MUSC Dr. Barth and colleagues have conducted 11 waiver training sessions and trained 346 health professionals in SC
- Additional funding for protected time through SC Department of Alcohol and Other Drug Abuse Services (DAODAS; via 21st Century Cures Funding)
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Identifying Patients
 › Screening For Opioid Use Disorder
Office-Based Opioid Treatment in Primary Care

Practice-based Model
• Any provider with waiver training can offer OBOT
• Advantage
  • Offer treatment immediately to patients already established with a PC clinic
  • “One-Stop Shop”
    • Coordinate treatment of HIV, HCV or prenatal care
• Disadvantage
  • Variable Support Staff and Systems
  • Relationship with addiction specialist for complex patients
• 38% retention at 2 years


Hub and Spoke

Systems Based Model
• Ex. Vermont

https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke
Project Extension for Community Healthcare Outcomes (ECHO)

Since initiation of the teleECHO clinic focused on SUDs in 2005 New Mexico has:

• One of the highest number of X-waivered physicians per capita.
• Experienced rapid growth of waived physicians practicing in traditionally underserved areas


https://echo.unm.edu/about-echo/model/
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<td>Carolyn Bogdon, FNP</td>
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Current MUSC Primary Care MAT Delivery Model

- Office-Based Opioid Treatment
  - “Local Champion”
  - Addiction Medicine Support
  - SC MAT Access Support

- Future
  - Chronic Care Model
  - Partnership with ED for Fast Track
  - Inpatient Induction

http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
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Guidelines: Screening For Dysfunctional Opioid Use

Chronic Opioid Use

• Evaluate benefit and harms of opioid therapy q3months – CDC

• Evaluate risk and benefit of opioid therapy q3mons – VA / DOD

• Patients using opioid therapy > 6 weeks need evaluation for opioid misuse – CMS/MIPS
Health Resource and Services Administration (HRSA) Primary Care Training and Enhancement Grant

Dr. Bill Moran – Division Chief General Internal Medicine
Dr. Bill Basco – Director of General Pediatrics
Dr. Vanessa Diaz – Department of Family Medicine

Supplemental Funding from HRSA PCTE grant
• Improve student and resident education on identification of OUD
• Improve faculty training on identification of OUD
• Improve Treatment of OUD by expansion of MAT
University Internal Medicine - Screening for Opioid Use Disorder Quality Improvement Project

**Aim:** Identify primary care patients with opioid use disorder and start MAT.

**Population:** UIM Patients receiving chronic opioid therapy (≥ 6 opioid prescriptions from UIM in the past year) ~ 274 patients identified
- Patients enrolled in Sickle Cell Medical Home were excluded

**Change Idea:** Standardize OUD evaluation in patients on chronic opioid therapy

**Intervention:**
1. Screen all patients on chronic opioid therapy for OUD using Current Opioid Misuse Measure (COMM)
2. Internal referral for OUD evaluation in patients who screen (+) = score ≥ 9
COMM survey

Sensitivity: 77%
Specificity: 66%
Positive Predictive Value: 66%
Negative Predictive Value: 95%
Completion Time ~ 10 min
Balancing Measures

• Loss of confidentiality
  • Do not screen patients until roomed (i.e., Not at registration)

• Patient Survey fatigue
  • Only screen once per year
  • Incorporate survey into visit

• Staff / Provider fatigue
  • Post scripting through clinic on how to respond to patient questions
  • Documentation aid
FYI Flag: Medication Agreement

Link to medication agreement pdf

Last UDS
University Internal Medicine clinic wants to treat chronic pain in the **safest way possible**.

Starting January 2019, every patient who receives pain medication through University Internal Medicine clinic will receive a **confidential survey** about their pain and their medication use.

This will allow us to provide the **safest care**.

If you have any questions or concerns, please feel free to ask any of your healthcare team members.
OUD Screening Workflow
(next slide)
RN / LPN / CMA

- Pt roomed
- FYI Flag Present
  - Yes: COMM completed
  - No: Stop here
- Yes
- COMM delivered

MD / APP

- Referral for OUD evaluation
  - Yes: COMM > 9
  - No: COMM reviewed & documented
- No
FYI Flag: Medication Agreement

Link to medication agreement pdf

Document COMM score
The Common Opioid Misuse Measure (COMM) was completed on: ***
Score: ***

Instructions
A score of > 9 indicated that a patient is at risk for opioid use disorder. This patient warrants further evaluation for opioid use disorder and possible benefit from treatment with Medication-Assisted Treatment (MAT) with suboxone (buprenorphine / naloxone):

1) Please send an Epic Message to Dr. Samuel O. Schumann III noting COMM score and requesting evaluation for opioid use disorder

2) Please order BMP, LFT's, hepatitis C Ab, urinary beta-hcg (female only), and UDS and forward the results to Dr. Schumann (or assign as co-signer)

3) Please delete these instructions and do not include in the final note
Example of Scripting for resident / faculty reviewing COMM

Positive COMM (≥ 9)

› Thank you for completing the survey on your pain and how you are taking opioid pain medications. The results of this survey show that:
  › The current opioid medications you are taking, and
  › The way you are taking your medications ....may be unsafe

› This places you at risk for opioid medication complications, such as overdose.
› We would like for you to meet with another doctor in our office / practice about your pain and the medications used to treat you pain.
› At this appointment, the physician will either continue your current opioid pain medication, and / or discuss additional options for pain treatment.
› I will place a referral to get this appointment schedule and a nurse from our clinic will call you to help you schedule this appointment.
› I will continue to address all of your primary care / internal medicine, pain and prescription needs.
› What questions do you have?
Additional Preparation

- Prior to start all 274 patients were chart reviewed
  - Any patient without an FYI Flag had it added
  - Hospice and those no longer receiving opioids were excluded
  - Patients receiving chronic opioids through other clinics (ex. Rheumatology and Pain Management) were included
- Bi-monthly Education for Residents / Students
- Monthly Detailing for Faculty

- Dr. Katie Anderson, MD
  - UIM Junior Faculty
  - X-waivered during residency at U Penn
Results

- Start Date: Jan 7\textsuperscript{th}, 2019
  - 47 patients (17\%) were screened and had "dot phrase" documentation
    - 13 (28\%) patients had COMM ≥ 9 and referred for further evaluation
      - 10 patients evaluated to date (most completed 2 appointments)
        - 0 patients diagnosed with OUD
        - 0 patients agreed to attend pain rehab
        - 3 have completed chronic pain psychologist assessment
        - 2 patients completely weaned off opioids
      - 2 additional patients were found to have heroin abuse and fast tracked to buprenorphine therapy in UIM
  - 0 patients diagnosed with OUD
  - 0 patients agreed to attend pain rehab
  - 3 have completed chronic pain psychologist assessment
  - 2 patients completely weaned off opioids
  - 2 additional patients were found to have heroin abuse and fast tracked to buprenorphine therapy in UIM
Process Limitations

• Low Delivery of COMM by staff
  • Staff Turn Over

• Detailing of clinical providers
  • Some residents rotate q2weeks
  • Technology: Dot Phrase and Comments Section

• Dot Phrase Report
  • Initial trouble capturing information
  • Report 2\textsuperscript{nd} Edition – Dot Phrase must be used AND use in the comment section or not captured

• Low Faculty Uptake

• Scheduling Challenges
Future Directions

3rd Edition of Report
- Amanda Williamson
  - Identify Deficient
    - Medication agreement
  - COMM screen
  - Next Appointment
    - Huddle report

Staff / Provider Education with feedback
(report)
Case Follow up

- Adherent with buprenorphine therapy for **18 months to date**
- **Completing all iADLs and returned to driving**
- Navigated 2 orthopedic surgeries and successfully transitioned back to buprenorphine
- She is **now caretaker of husband** who suffered an unexpected health decline

MAT in Primary Care

- Education of Trainees and Faculty is needed
- Offering MAT in primary care does not have to change patient demographics
- Office-Based Opioid Treatment is a reasonable model
  - An office “Champion” may help streamline treatment
  - Practice support and System support is needed
- Identifying and reaching patients with OUD is a limitation
Questions?
Sample Quotes

General Supportive Attitudes:

› “Right, like our patients that go into DKA in the hospital, we don’t say ‘no more insulin,’ right?”
   – Family Medicine Resident

› “Well I have seen the advantages that it brings in that some people who are not functional, losing jobs, can actually go back to work and live a normal life.”
   – Internal Medicine Resident

General Challenges:

› “I think the other disadvantage I see is that we don’t want to simply treat opioid use disorder [...] because we don’t want to be known for maybe a Center for Opioid use disorder and we want to still be focusing on other comorbidities.”
   – Internal Medicine Faculty

› “… pills without skills is a fool’s errand. The medicines are fine, they’ll help, but if you don’t have a context for treating, you’re wasting your time [...] it’s a problem at the clinic level, but at these larger political, economical levels it’s really a problem.”
   – Family Medicine Faculty
Sample Quotes

Subjective Norms

› “Maybe the folks in the waiting room wouldn’t want to be surrounded by drug addicts.”
  – Family Medicine Faculty

› “I think with PAs too, our dependence on supervising physicians, somewhat has a huge influence over, [...] whether that becomes part of our scope of practice.”
  – PA Faculty

Perceived Behavioral Control

› “Training and tools for me on misuse, so that I could identify patients. Feeling like I could send him to a support system of care, so if I were prescribing and they also had counseling wrapped in that would be big and just better training about monitoring use of the medications.”
  – Internal Medicine Faculty

› “... seeing it and doing it in real life is a lot better than reading it [...] because that's not real life cause it takes nuance, you know, it’s an art and a science, so I think going there, being there, give us more of the art.”
  – Internal Medicine Residents