Evolution of Opioid Use Disorder in Primary Care

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LEARNING OBJECTIVES

1. Understand current models for OUD treatment in primary care, and how a tiering model can be used as communication tool for a clinic and providers

2. Understand how a multi-disciplinary primary care team can support people affected by substance use

3. Discuss strategies to support clinics and clinicians in treating SUD/OUD care in the post- X-waiver era

HUB AND SPOKE MODEL

Vermont Hub and Spoke Model[7]

Hubs

- High intensity MAT
- Methadone buprenorphine naltrexone
- Regional locations
- All staff specialize in addiction treatment

Patients

Information

Consultation

Training

Spokes

- Maintenance MAT
- Buprenorphine naltrexone
- Community locations
- Lead Provider + nurse and LADC/MA counselor

Adapted from https://blueprintforhealth.vermont.gov

BROOKLYN, J. R., & SIGMON, S. C. (2017). VERMONT HUB-AND-SPOKE MODEL OF CARE FOR OPIOID USE DISORDER: DEVELOPMENT, IMPLEMENTATION, AND IMPACT. JOURNAL OF ADDICTION MEDICINE, 11(4), 286–292. HTTPS://DOI.ORG/10.1097/ADM.0000000000000310.

BRIDGE MODEL

Screen For OUD

- Short-term prescription for buprenorphine.
- Refers to outpatient bridge clinic.

Link

- Bridge prescription provided.
- Peer recovery support intiated.
- SUD counseling

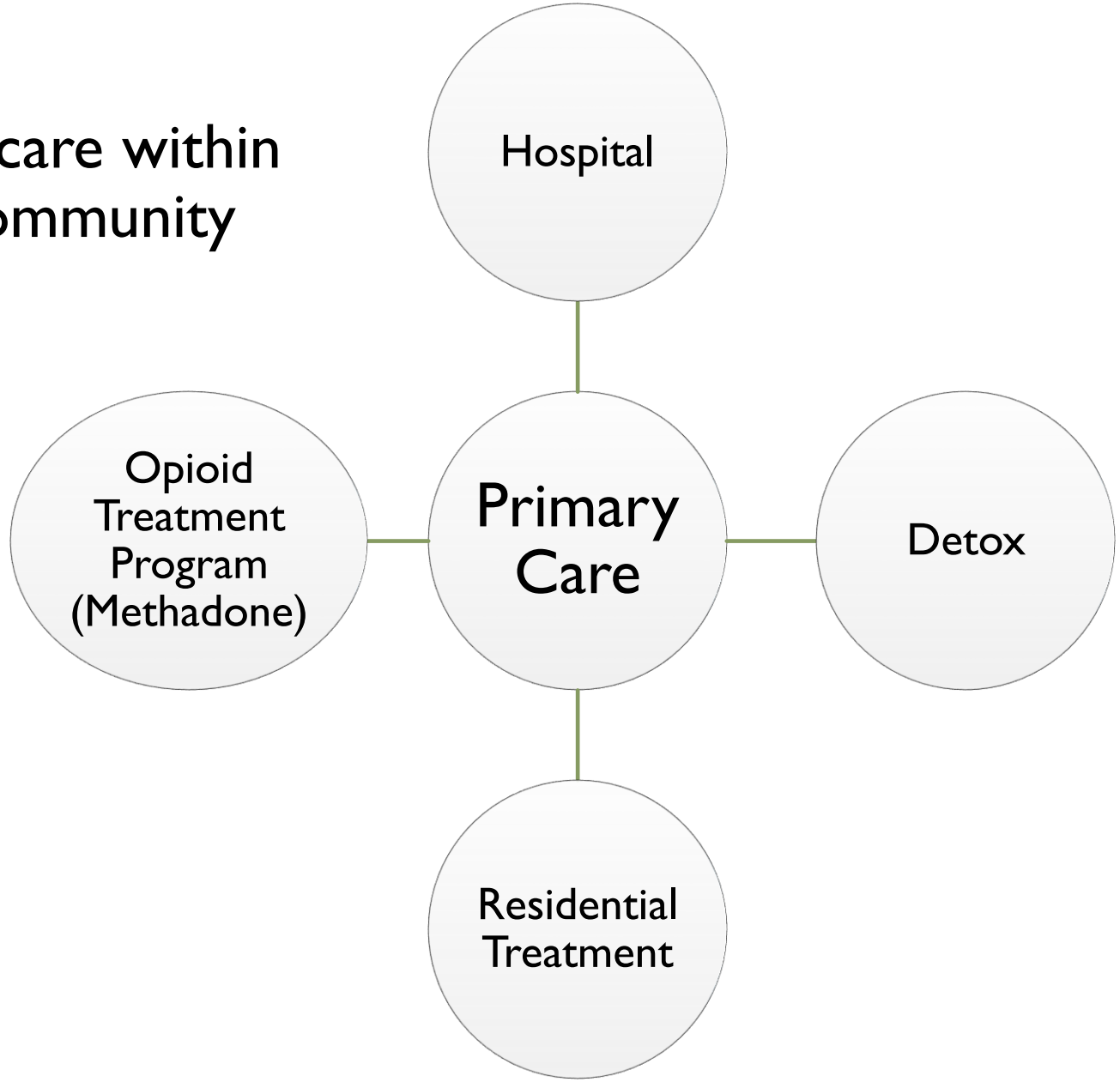
Educate

- Overdose prevention.
- Naloxone training/ education.

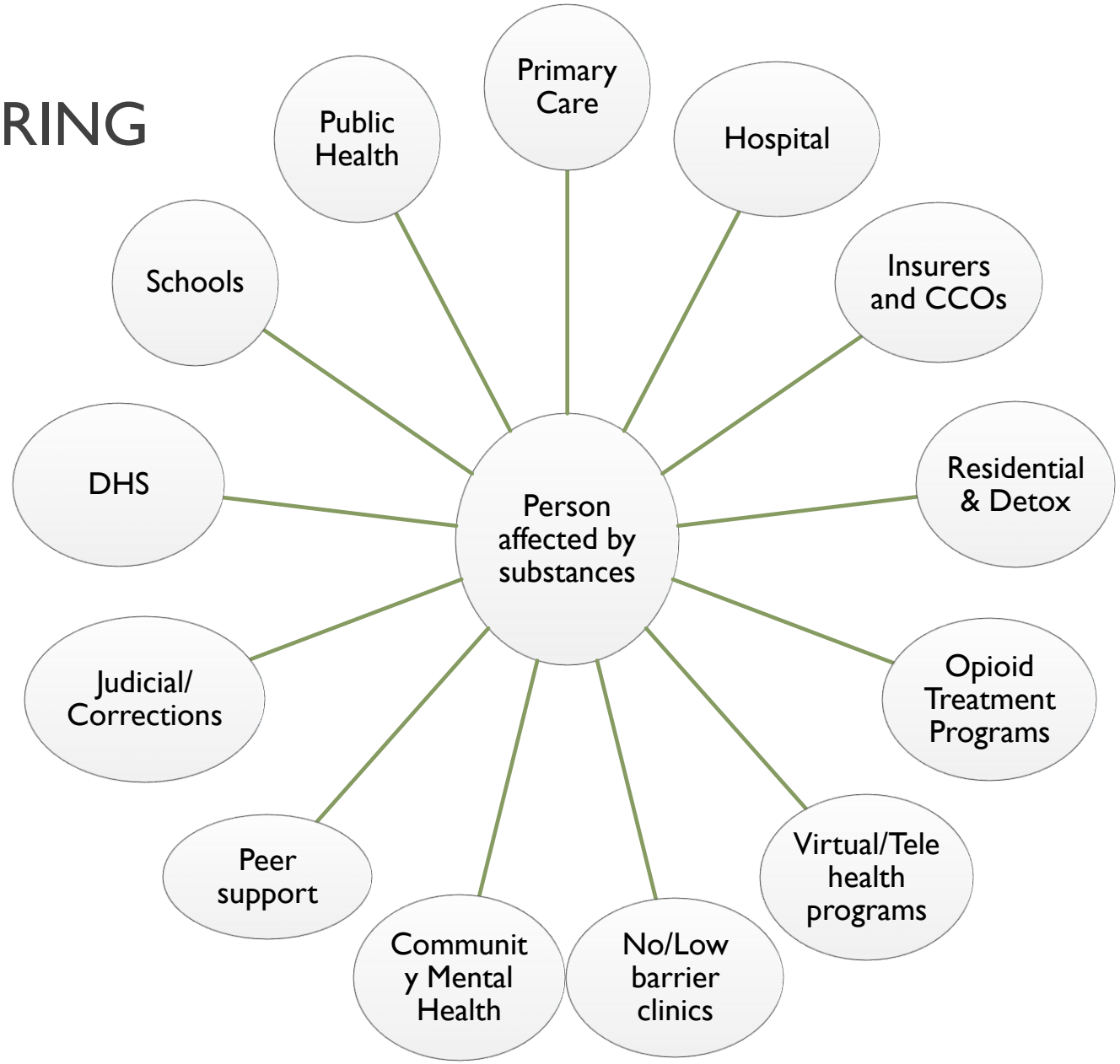
Bridge clinics provide a range of comprehensive services to individuals, including:

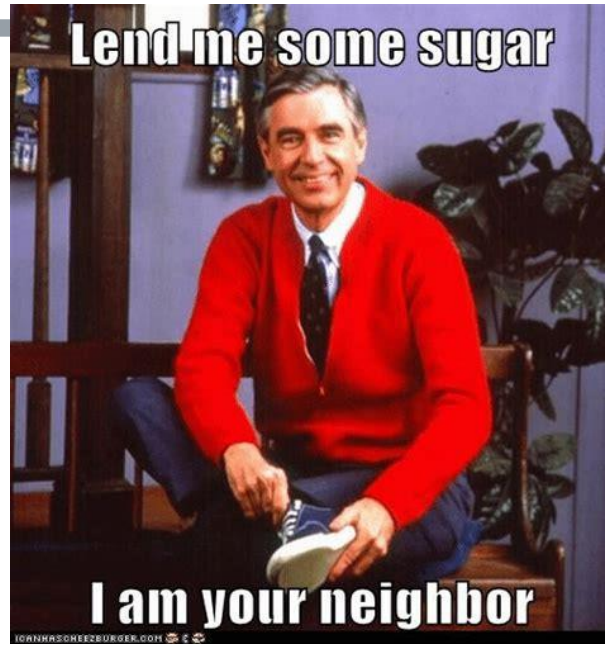
- MOUD
- Medication management
- Counseling
- Nurse care navigation
- Recovery support services
- Overdose prevention and naloxone training

Historical SUD care within the medical community



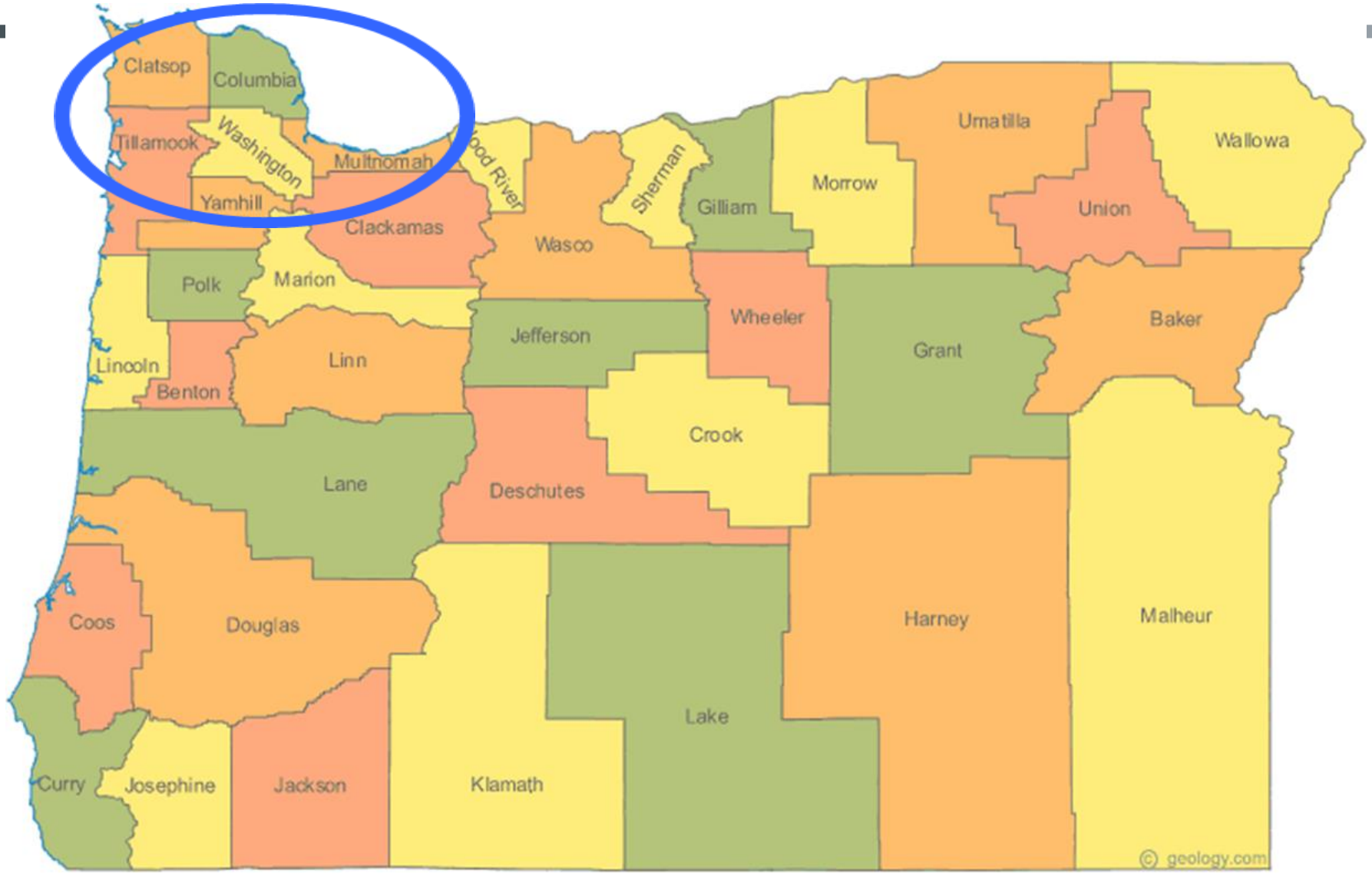
DYNAMIC RESOURCE SHARING





OHSU Academic Medical Center

OHSU Scappoose Family Medicine Rural Health Center



OHSU Scappoose Service Areas

OHSU SCAPPOOSE FAMILY MEDICINE

- Federally-certified Rural Health Clinic
- Primary Care Medical Home
- FM Residency training site
- Graduate Student training site
- Embedded Substance Use Disorder/MOUD program

SUD CORE TEAM

Matt Chan, MD

SUD Program Director

David Casey, LCSW, CADCIII

Behavioral Health Consultant

Savanna Cate, CHW

Community Health Worker

Scappoose SUD RN**

MISSION STATEMENT

- The mission of the OHSU Family Medicine Scappoose Clinic is to provide a comprehensive, whole-body health approach to help people move away from addiction and toward a meaningful and fulfilling life.

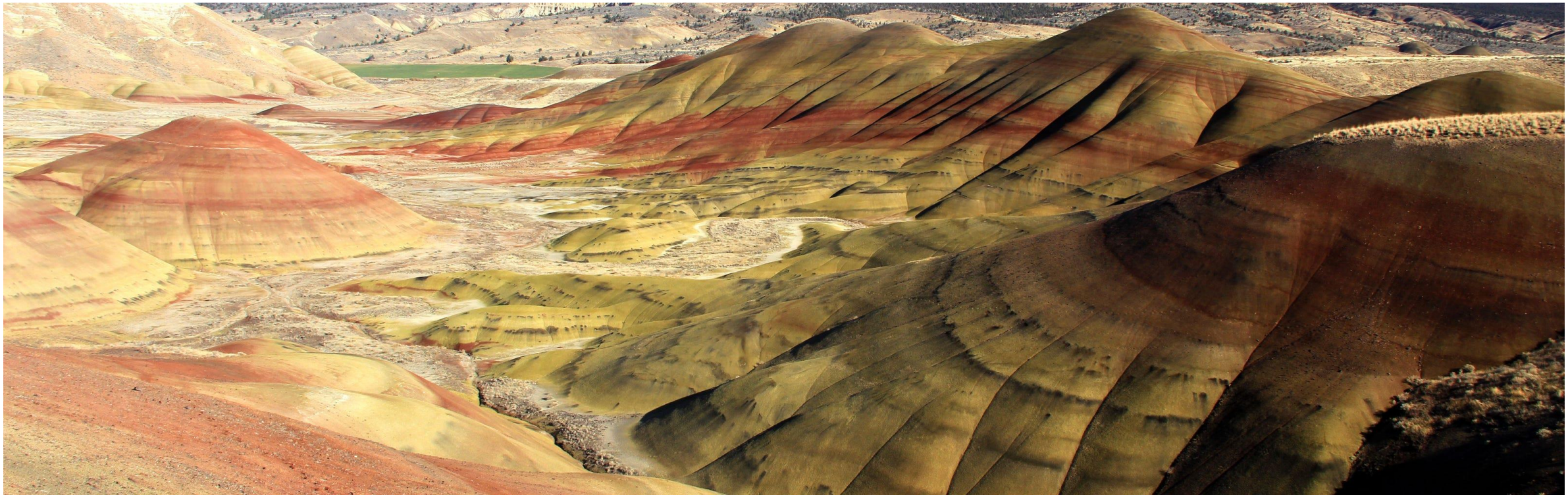
- Our goal is to meet our patients with compassion, humanity, forgiveness, and humility, to provide them with the relational care that all people deserve.

OUR SUD/MOUD PROGRAM MODEL

- Integrated into Primary Care
  - Behavioral-Health Focused
  - Full spectrum Primary Care (Adults, Peds, Prenatal)
  - Dedicated SUD/MOUD Weekly ½ Day Clinic
  - Patient visits based on Tiering System (adapted from Univ of Mass Model)

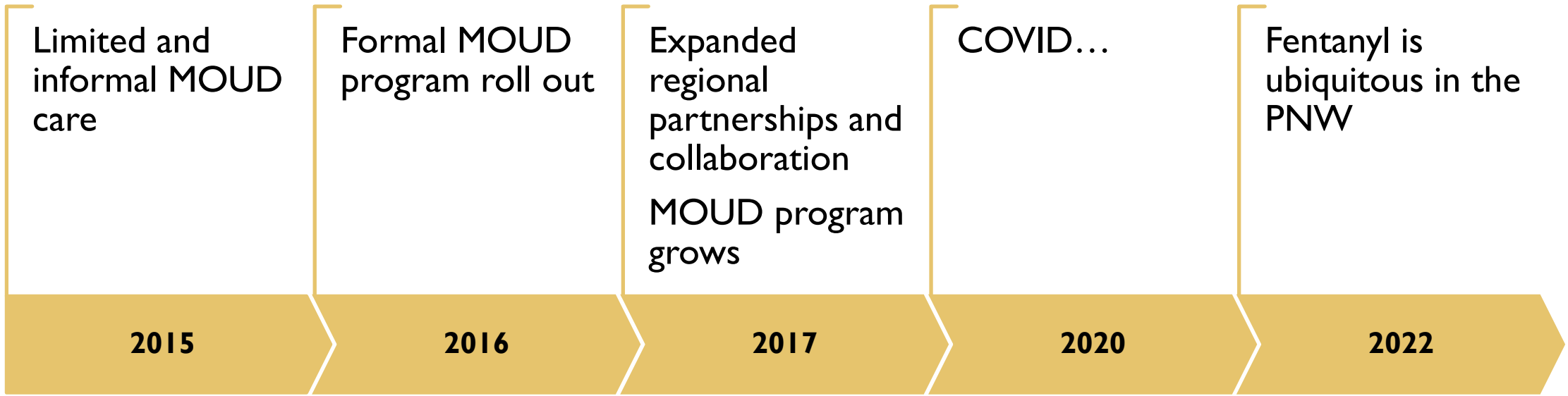
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Indications	Induction, relapse	Recent Instability, Short term harm reduction (on-going opiate use failing stepped care), other drugs of abuse, psychiatric instability, pain complications. Routine advancement from Tier 1	Chronic, "stable" Instability, Long term harm reduction (on-going opiate use failing stepped care), other drugs of abuse, psychiatric instability, pain complications. Routine advancement from Tier 2	Routine advancement from Tier 3. Doing well in recovery.	Doing well in recovery
Rx Total Duration	1 week	2 weeks	4 weeks	8 weeks (4 weeks with 1 RF)	12 weeks (4 weeks with 2 RF)
RF Duration	0	2 weeks	1-4 weeks	4 weeks	4 weeks
Scheduled UDS[1]	Weekly	Every 2 weeks	Every 4 weeks	Every 8 weeks	Every 12 weeks
MAT Prescriber Visits	Every 2 weeks	Every 4 weeks	Every 8 weeks	Every 8 weeks	Every 12 weeks
Nurse Visits	Weekly, alternating with MAT provider	Every 2 weeks, alternating with MAT provider	Every 4 weeks, alternating with MAT provider	Every 8 weeks alternating with MAT provider	Every 12 weeks alternating with MAT provider
Behavioral Health Touch	Twice Weekly	Every 2 weeks	Every 12 weeks	Every 24 weeks	Every 24 weeks
Behavioral Health Plan Review	Every 4 weeks	Every 4 weeks	Every 12 weeks	Every 24 weeks	Every 24 weeks
Minimum Time to Next Tier	2 weeks	4 weeks	8 weeks	Dependent on circumstance	N/A

Adapted from "Family Health Center of Worcester Office-Based Opioid Treatment (OBOT) of Opioid and Opiate Dependence Clinical Quality Management Plan." Authored by Philip Bolduc, MD, OBOT Program Director at Family Health Center of Worcester, University of Massachusetts Medical School, Department of Family Medicine and Community Health, Worcester, MA.



THE CHANGING LANDSCAPE

TIMELINE


Limited and informal MOUD care
2015
Formal MOUD program roll out
2016
Expanded regional partnerships and collaboration
MOUD program grows
2017
COVID…
2020
Fentanyl is ubiquitous in the PNW
2022

Heroin-dominant (Pre-COVID)

- Standard buprenorphine initiation protocols were simpler
- Stabilization of opioid symptoms typically within the first 48 hours
- Patients were quickly able to engage in BH therapy work
- Robust psychotherapy group attendance
- Patients scheduled follow up appointments before leaving the clinic
- Advancing through Tier system was more streamlined

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Fentanyl-dominant (Post-COVID)

- Transition to buprenorphine more complex
- Stabilization taking weeks or months (if at all)
- Need for more frequent visits limited by PCP access
- Visit attendance much more variable
- BH work much more crisis focused during initiation and early engagement
- Psychotherapy group engagement minimal at best

ADAPTATIONS

Behavioral Health

- Hybrid virtual/phone & F2F appts
- Expansion of BH team supported through CPCCO
- Back-to-Back visits with Prescribers to reduce no-shows
- Spreading out intake process

Medical

- Hybrid virtual/phone & F2F appts
- Maximizing bridge prescriptions
- Disseminating rapidly evolving buprenorphine prescribing practices
- Increasing access to Sublocade and Vivitrol
- Ensuring naloxone each initial visit

Social Determinants

- SDH screening
- Reducing tele-communications barriers
- Reducing transportation barriers
- Resource outreach and sharing with other organizations
- Harm Reduction Kits

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INCORPORATING TELEHEALTH INTO PRIMARY CARE

Considerations

- Reducing time to first visit (e.g. as low-barrier as possible)
- Integrating tele-health as an extension of primary care
- Undetermined Federal telehealth exemptions
- Relationship building between patient and clinic team member
- Limited tele-communications infrastructure in rural environment

ADJUSTING PATIENT AND PROVIDER EXPECTATIONS WITH TELE-HEALTH AND PRIMARY CARE

Intake

- Patient referred to OHSU Scappoose Clinic
- Schedule virtual/phone/office visit with provider ASAP
- Schedule back-to-back visit with BHC

Initial

- Provider performs initial assessment for prescribing needs
- Universal naloxone prescribing, need for harm reduction kits
- Assess for SDH screening, referral to CHW

Follow up

- Determined by Tier system
- Prioritizing flexibility, and ideally synced with BHC to complete intake

SUPPORTING CLINICAL ENVIRONMENT AND CLINICIANS

Removal of DATA Waiver (X-Waiver) Requirement

Section 1262 o removes the federal require ribe medications, li is provision, and effective i).

All practitioner may now prescribe bupr ble state law and SAMHSA e mentation of a separate provi hat becomes effective in Ju idance.

275 Annual Re

275 Annual Re

Last Updated: 01/25/2023

Stop Opioids, Start Buprenorphine (Traditional)

Traditional

3-day Low Dose Crossover

7-day Low Dose Crossover

Macro-starts

Quick Start (Narcan, then Bup)

Low-High Starts

Post-overdose reversal

Traditional

3-day Low Dose Crossover

7-day Low Dose Crossover

Macro-starts

Quick Start (Narcan, then Bup)

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Post-overdose reversal

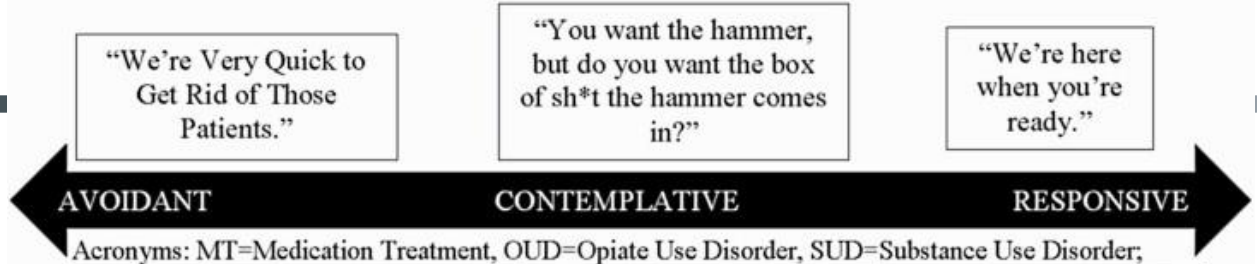
Sublocade

Brixadi**

Vivitrol

How do we educate patients?

How do we educate ourselves?



Acronyms: MT=Medication Treatment, OUD=Opiate Use Disorder, SUD=Substance Use Disorder;

Attributes	Avoidant (C1, C3, C12)	Contemplative (C5, C6, C8, C10, C11)	Responsive (C2, C4, C7, C9
BH conceptualized includes SUD	-BH is not seen as inclusive of persons with SUD -Absence of plans to expand clinic capacity for patients with SUD treatment needs	-Varying buy-in about legitimacy of including SUD treatment into BH -Plans to expand clinic capacity to include SUD treatment in BH services	-Widespread buy-in about legitimacy of SUD treatment into BH and medical care -Ongoing improvements and refinement to care processes for SUD/BH care needs
Organizational comfort BH/SUD integration	-Comfort with behavioral health assessment/treatments of mental health issues -Resistance towards patients with SUD treatment needs	-Comfort with behavioral health assessment/treatments of mental health issues -Mixture of discomfort/fear about needs to expand care options for patient with SUD -Acknowledgement of need to build capacity for SUD services	-Commitment to provide SUD as a key component of behavioral health that also includes mental health services -Compassionate clinical stance to SUD treatment needs
Behavioral Health Workforce	Absence or minimal on-site behavioral health care providers with restricted scope	Co-located behavioral health providers with some restrictions on scope	-Co-located behavioral health integrated with SUD training -Care coordination strategies for patients with SUD
Capacity for MT	No waiver prescribers for OUD MT treatment	-No waivered prescribers for OUD MT **or** -Waivered prescribers who are not currently prescribing	-Waivered prescriber(s) for OUD MT **or** -Coordinated referral pathway to SUD services and OUD MT

BH=Behavioral Health; OUD=Opiate Use Disorder; MT=medication treatment; SUD= Substance Use Disorder

O'MALLEY DM, ABRAHAM CM, LEE HS, RUBINSTEIN EB, HOWARD J, HUDSON SV, KIEBER-EMMONS AM, CRABTREE BF. SUBSTANCE USE DISORDER APPROACHES IN US PRIMARY CARE CLINICS WITH NATIONAL REPUTATIONS AS WORKFORCE INNOVATORS. FAM PRACT. 2022 MAR 24;39(2):282-291. DOI: 10.1093/FAMPRA/CMAB095. PMID: 34423366; PMCID: PMC8956130.

FEARING THE UNKNOWN


The More You Know

CONCENTRATE THE TRAINING

Dedicate ½ day or full day to SUD or OUD care

Creating specialty day clinic to allow for bolus of training experience

Allows more dedicated access if needed

LEVERAGING PATIENT RISK STRATIFICATION

Using Tier stratification to identify lower risk, stabler patients to transition onto less-experienced provider panels

Gradually integrate more complex patients, or initiations as comfort increases

GUIDANCE AND CONTINUING EDUCATION

OHSU Echo Series

OHSU IMPACT Consult Line

UCSF Warmline

SUPPORTING EACH OTHER

BH Support

- Connections to broader systems and initiatives
- Clinical autonomy to deliver the care that will be the most meaningful to individual patients vs focus on financial aspects
- Collegial respect from medical counterparts for unique clinical expertise – seen as equal contributor to care
- Robust BH team for clinical consultation and collaborative care

CHW Support

- Figuring out how to work with patients with ambivalence
- Patients interested in detox and then lost to follow up
- Supervisor support and understanding of the heart of community health work

	Maximally disruptive OUD care (current state)	Potential practice and policy alternatives
Enrolling	- Long wait times - Restricted intake hours - Long visits, often before dosing with methadone (and hence patients experience withdrawal); buprenorphine commonly not offered on first visit	- Same day treatment access; expanded OTP hours - Same-day treatment entry with service delivery structured to avoid withdrawal - Buprenorphine prescription at first visit
Attendance	- Methadone typically requires daily in-person dosing at an OTP for at least the first 90 days of treatment	- Telehealth, ambulatory clinic, and pharmacy-based methadone - OTPs adopt flexible rules (including durations) for take-home doses
Medication	- Limited patient choice for medication formulation (e.g., tablets, films, long-acting injectable) - Restrictions on medication dose and duration (e.g., not allowing more than 6 months of treatment, not increasing buprenorphine above 16 mg total daily dose, methadone titration schedules unresponsive to fentanyl era needs)	- Patient preference drives medication formulation - Shared clinical decision-making drives dose and treatment duration - Update methadone consensus guidelines to account for changes in drug supply, including synthetic opioids/ fentanyl
Treatment requirement	- Medication treatment contingent on patient willingness to participate in Individual and group counseling	- Counseling offered but not required
Urine drug testing (UDT)	- Treatment mandates or stresses abstinence from other substances, imposes requirements for frequent UDT with penalties for aberrant tests	- Stop mandating routine UDT - Embrace medication-first strategies where medication not contingent on substance use
Fragmentation	- OUD care separated from general medical care; separated from community-based services, including harm reduction services	- Integrate methadone and buprenorphine in all general medical settings including hospitals, EDs, ambulatory, and specialty addictions care and settings tailored to specific populations (e.g., pregnant persons, culturally specific) - Integrate MOUD in non-traditional settings (e.g., syringe service programs, housing programs)
Limited rural access	Long drive-times to attend in-person OUD visits	- Expand access to mobile methadone and buprenorphine - Expanded telehealth access

Englander, H., Gregg, J. & Levander, X.A. Envisioning Minimally Disruptive Opioid Use Disorder Care. *J GEN INTERN MED* **38**, 799–803 (2023). https://doi.org/10.1007/s11606-022-07939-x

Re-envisioned Patient-centered Recovery Support

	Support 1	Support 2	Support 3	Support 4	Support 5
Indications	Initiation onto MOUD, or new patient to practice Managing acute medical/psychiatric issues Frequent return to use or ongoing polysubstance use	Stabilizing patient Recent instability Managing acute medical/psychiatric issues Occasional return to use or ongoing polysubstance use	Stabilized **Sublocade or Vivitrol patients Patients might be using other substances, however are stable in their OUD care	Stabilized Doing well in recovery	Long term stabilized Doing well in recovery
Rx Total Duration	~1-2 weeks	~2 weeks	4 weeks	8 weeks	12 weeks
Visit interval (B2B with BH and prescriber)	Every 1 week	Every 2 weeks	Every 4 weeks	Every 8 weeks (BH PRN)	Every 12 weeks (BH PRN)
Visit types	In-person or Telehealth	In-person or Telehealth	In-person or Telehealth	In-person or Telehealth	In-person or Telehealth

CLINIC CULTURE ADAPTATIONS

- Trauma-informed training for support staff
  - Understanding patient behaviors as manifestations of substance use
- Forgiveness to the patient, and asking forgiveness from patients for the trauma inflicted by the institution of medicine
- Moving away from "gatekeeper" status
  - Dismantling ingrained attitudes towards controlled medications in our learners
- Transforming the "transactional visit" to a partnership approach
- To UDT (urine drug test) or not to UDT…?

AREAS FOR GROWTH

- Optimizing SUD core team
- Streamlining communication between community partners
- Expanding collaboration with corrections (emulate Clackamas and Clatsop)
- Contingency management program (meth, OUD?)
- Measure 110 funding?
- Methadone in primary care??

TAKE AWAYS

- Tiered system for stratifying patients can create structure and shared language for a team
- Co-existence between tele-health and in-person care
- Consider concentrated training, "go slow" technique to help assimilate SUD care for newer providers, or incorporating longitudinal training and support lines
- Move towards minimally disruptive care = patient-centered care

THANK YOU!

- Columbia Pacific CCO Crew
- OHSU Scappoose Clinic
- Columbia County Partner Organizations

QUESTIONS?

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