

# Interdisciplinary Management of Opioid Use Disorder in Rural Primary Care Settings

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BRIAN GARVEY, MD, MPH

REBECCA CANTONE, MD

OREGON HEALTH & SCIENCE UNIVERSITY

SCAPPOOSE RURAL HEALTH CENTER



# Disclosures

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We have no personal disclosures.

# Objectives

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- Summarize the problem
- Basics of MAT
- Discuss our program



# Survey

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Who feels like opioid dependence affects their rural community?

How many of you have faced challenges in your clinic or practice setting due to opioid dependence?

Anyone in the audience witnessed an overdose or administered naloxone?

How many prescribe buprenorphine?

- Why or why not?

# The problem

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# Substance use disorder and opioid abuse

## Oregon Data

- In 2013, almost 1 in 4 Oregonians received a prescription for opioid medications
- Oregon ranked 2nd among all states in non-medical use of pain relievers (i.e. prescription pain medication).
- More drug poisoning deaths involved prescription opioids than any other type of drug, including methamphetamines, heroin, cocaine, and alcohol

Source:

<https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/prescription-drug-overdose-state-plan.pdf>

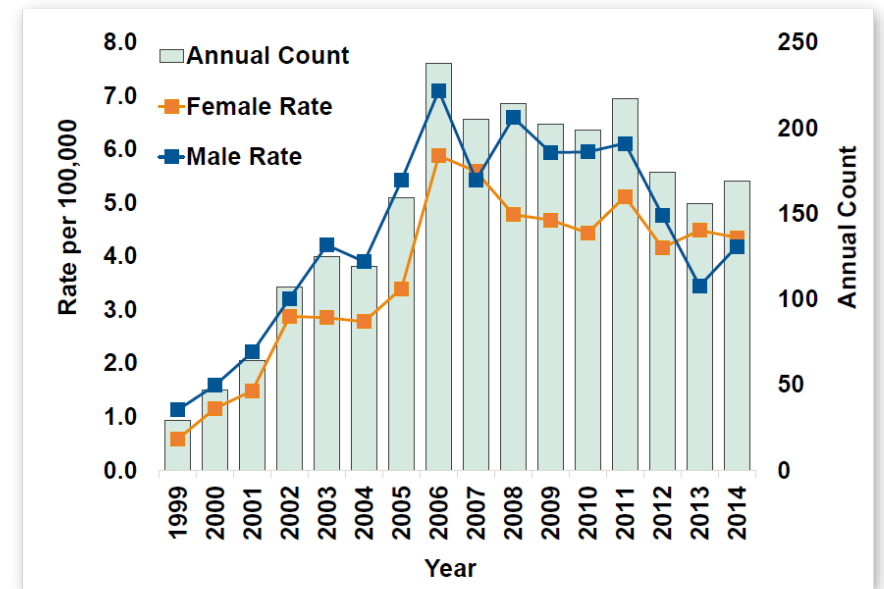
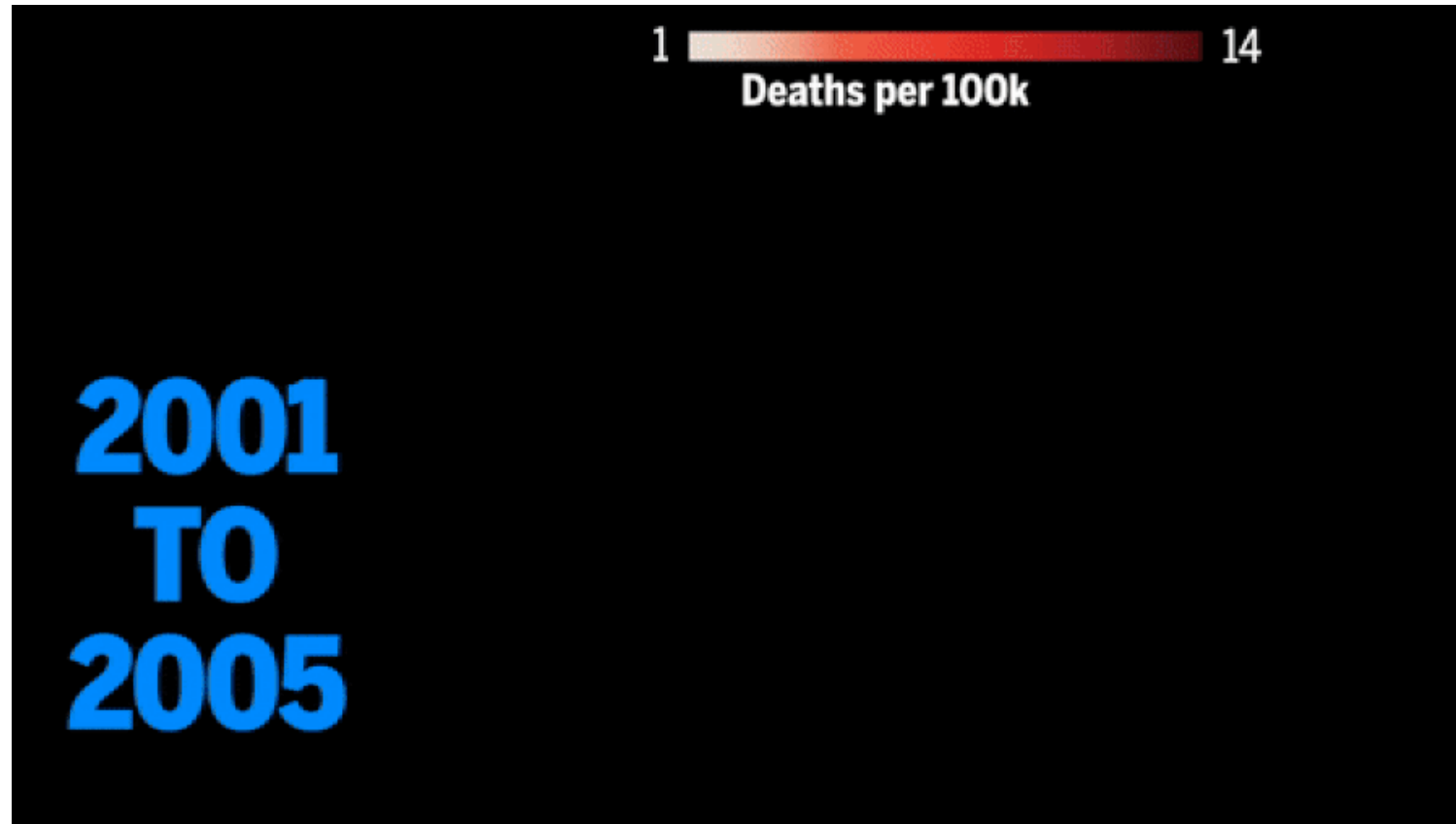


Figure 1. Unintentional and undetermined prescription opioid poisoning deaths and death rates, Oregon, 1999-2014.

# Evolution of opioid overdose deaths in OR

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Source: [https://www.oregonlive.com/trending/2017/07/oregon\\_opioid\\_overdose\\_deaths.html](https://www.oregonlive.com/trending/2017/07/oregon_opioid_overdose_deaths.html)

# The Register-Guard

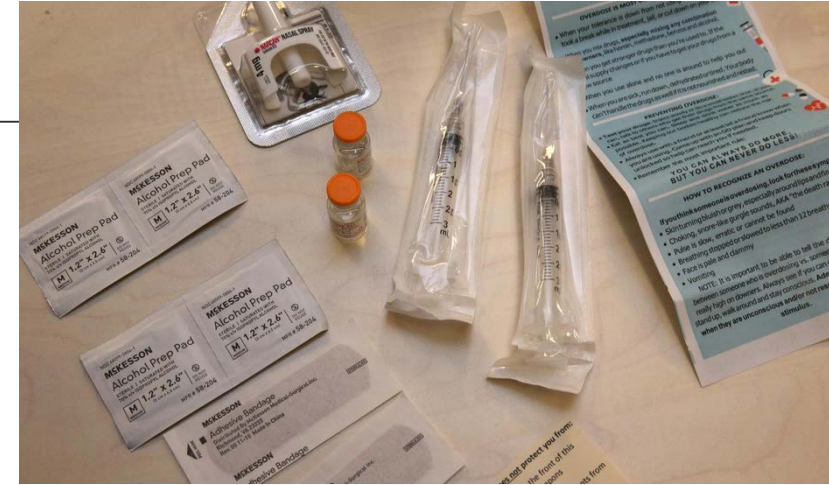
## Eugene-Springfield heroin overdoses spike climbs to 23

By Chelsea Deffenbacher

Posted Sep 25, 2018 at 6:01 PM

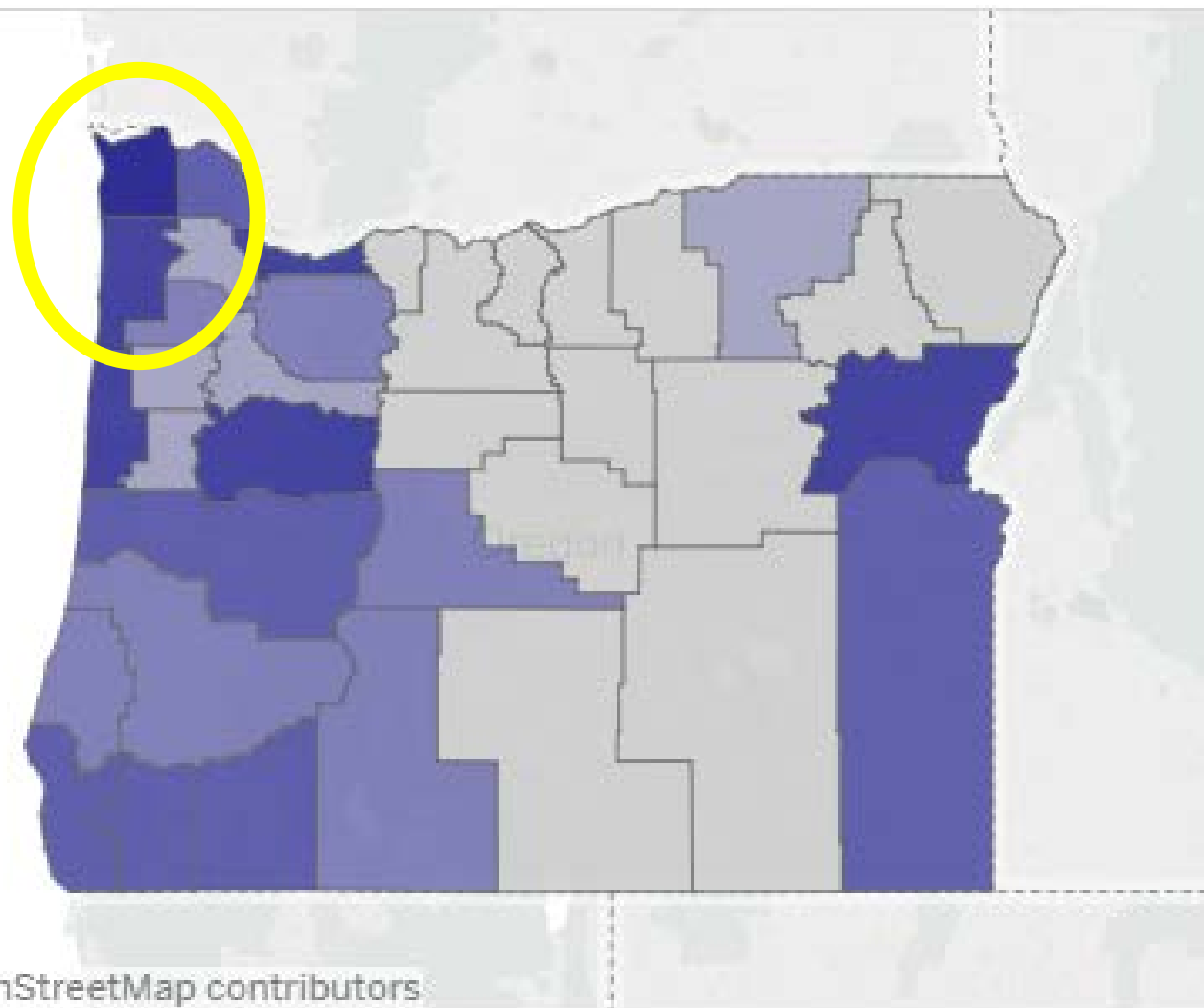
Updated Sep 27, 2018 at 2:31 PM

There were 23 drug overdoses in the Eugene-Springfield area between Friday and Monday afternoon, the latest numbers available in the overdose surge sweeping Lane County.





## Oregon Drug Overdose Deaths



### Overdose Death Drug Type

Any Opioid

### Years for Map

2010-2014

### Death Rate per 100,000 Population

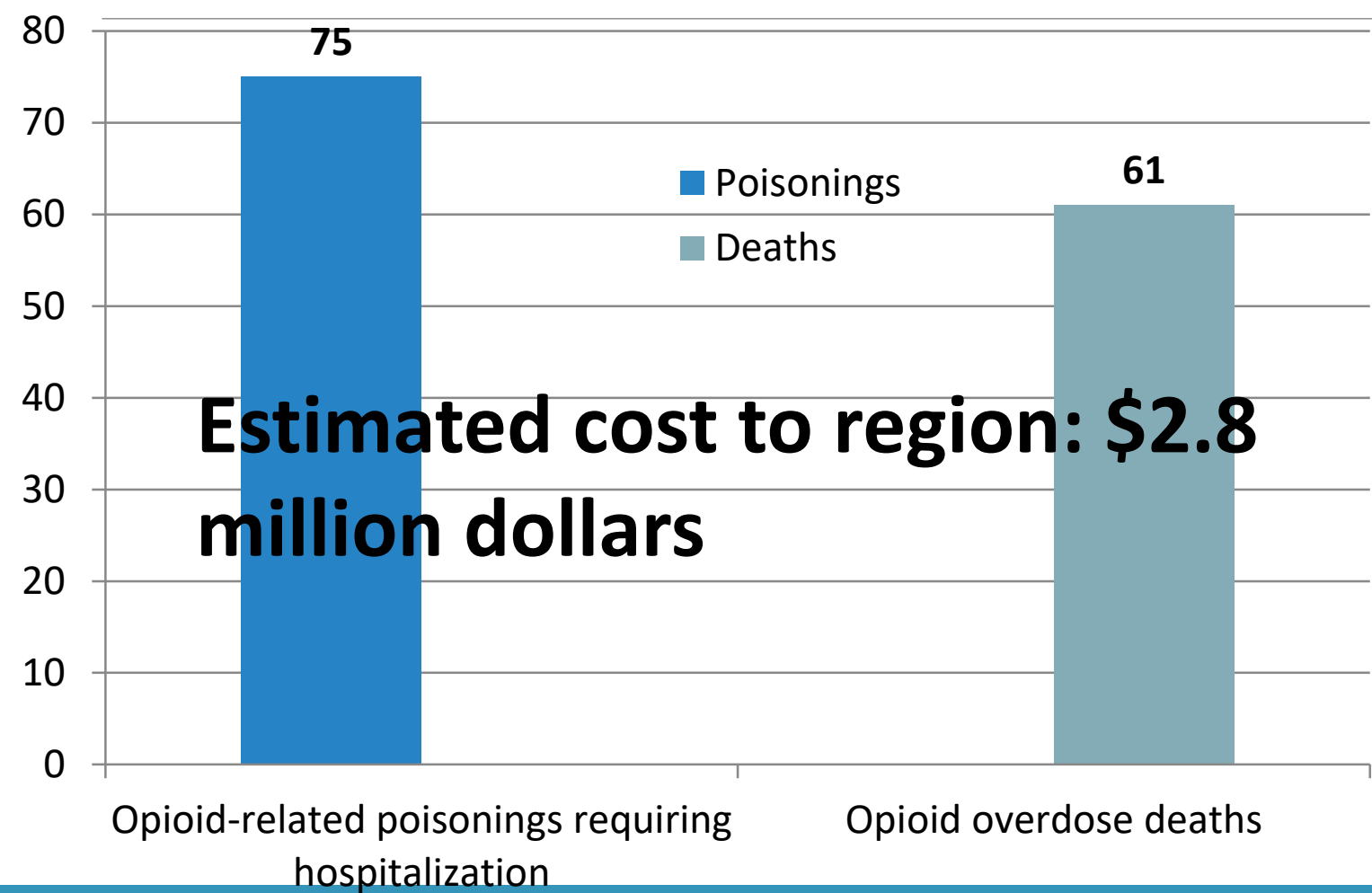
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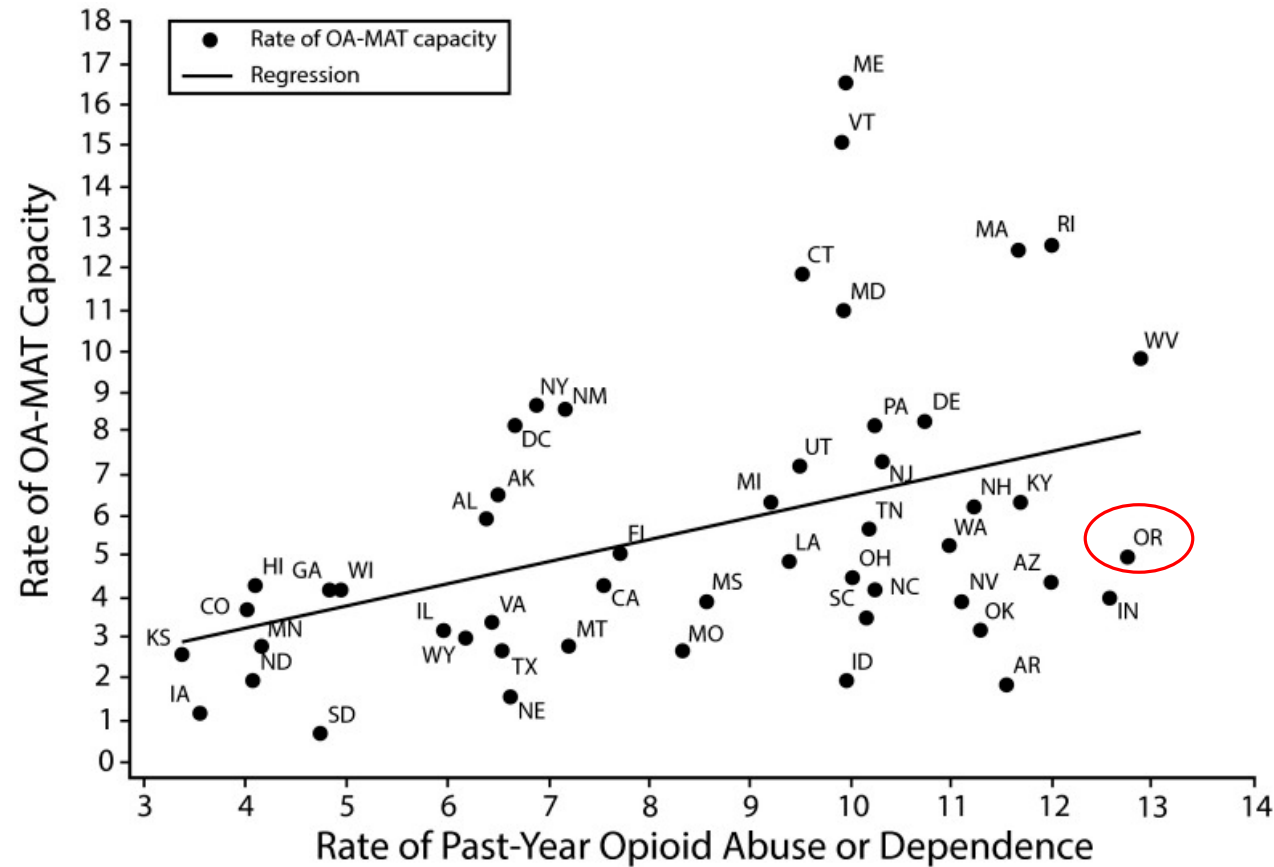
- OpenStreetMap contributors



# Literature Review: 2010-2014 Columbia, Tillamook and Clatsop Counties



# Comparison of state rates of past-year OUD and MAT capacity



Source: Am J Public Health. 2015 August; 105(8): e55–e63.

# Basics of opioid use disorder and buprenorphine

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# What is Opioid Use Disorder (OUD)?

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## DSM 5 Criteria:

- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining the opioid
- Craving or a strong desire to use opioids
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
- Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
- \*Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

**2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe**

# MAT

## 3 primary components

- Medication
- Counseling/Behavioral Health Interventions
- Support from Family and Friends

## 3 primary medication options

- Methadone
- Buprenorphine
- Naltrexone



Source: <http://www.addictionoc.com/addressingopioid-addiction-medication-assisted-treatment-mat-fears/>

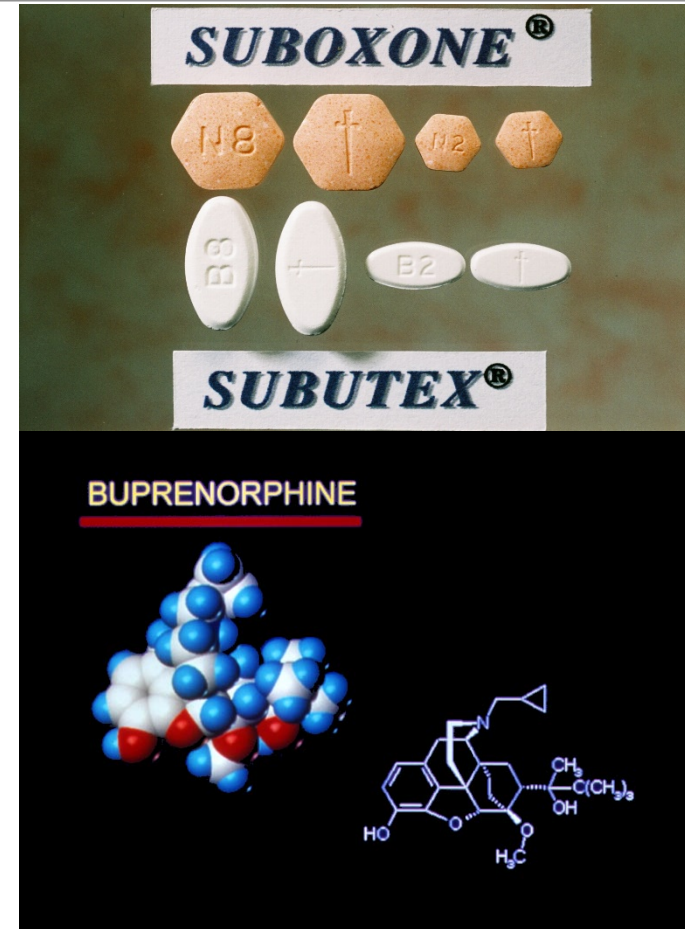
# Buprenorphine: How does it work?

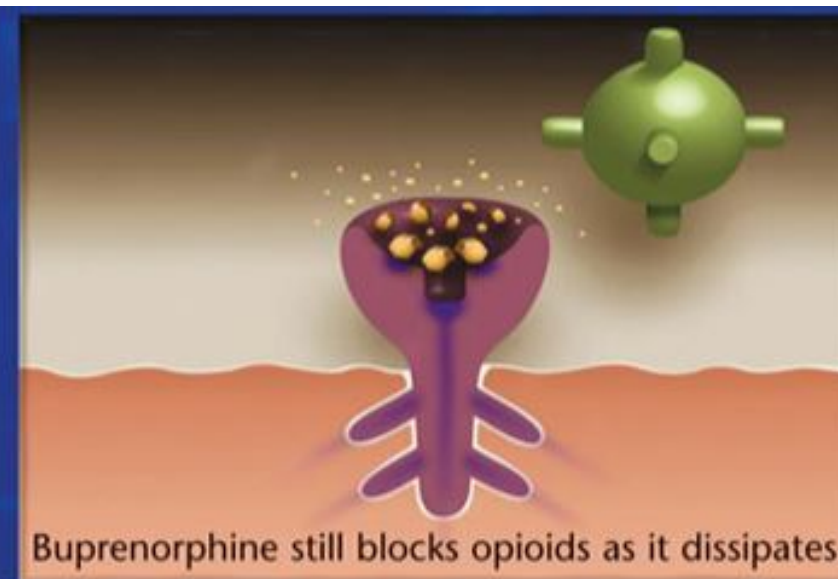
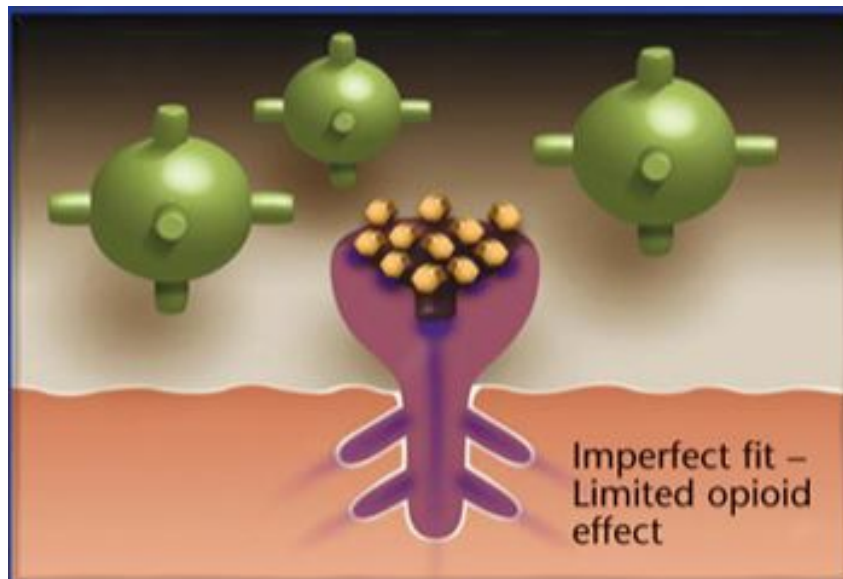
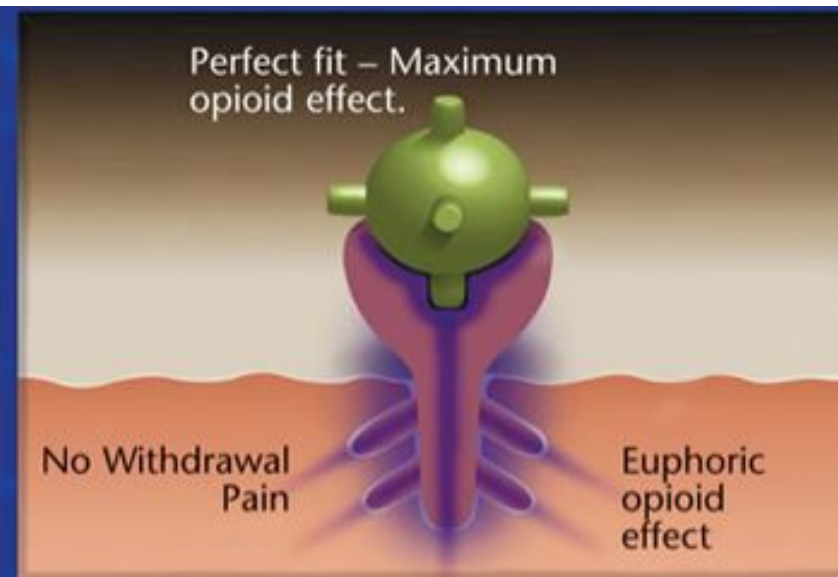
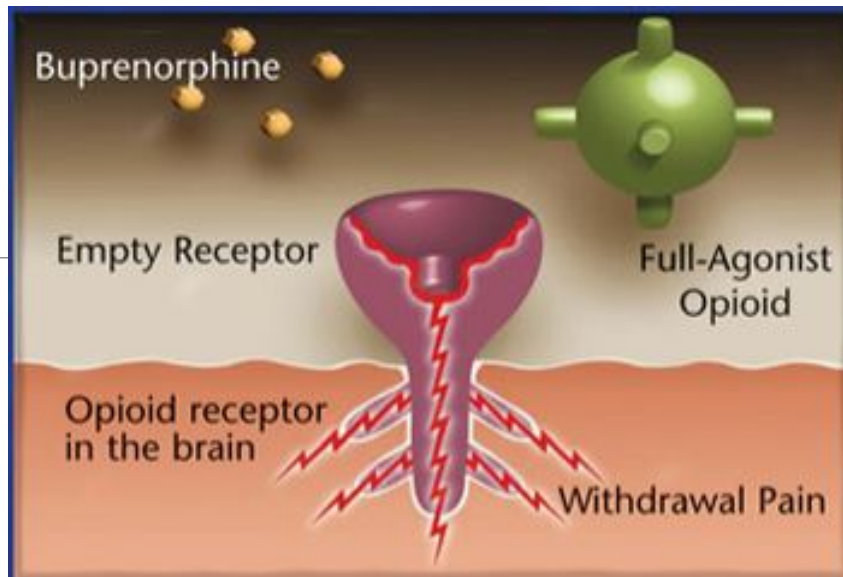
Buprenorphine has unique pharmacological properties that help:

- Lower the potential for misuse
- Diminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings
- Increase safety in cases of overdose

Buprenorphine is not a substitute for methadone, it is one more choice on the treatment menu

Both should be used in a comprehensive treatment setting

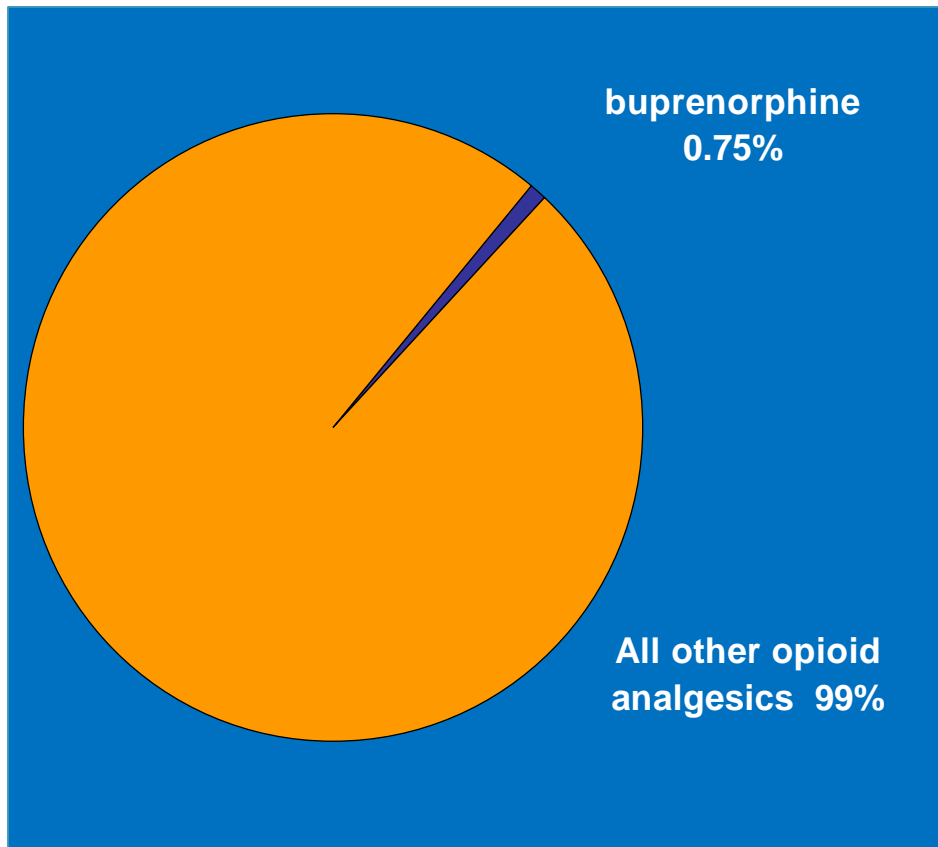






# Opioid Analgesics in Drug-related ED Visits 2006

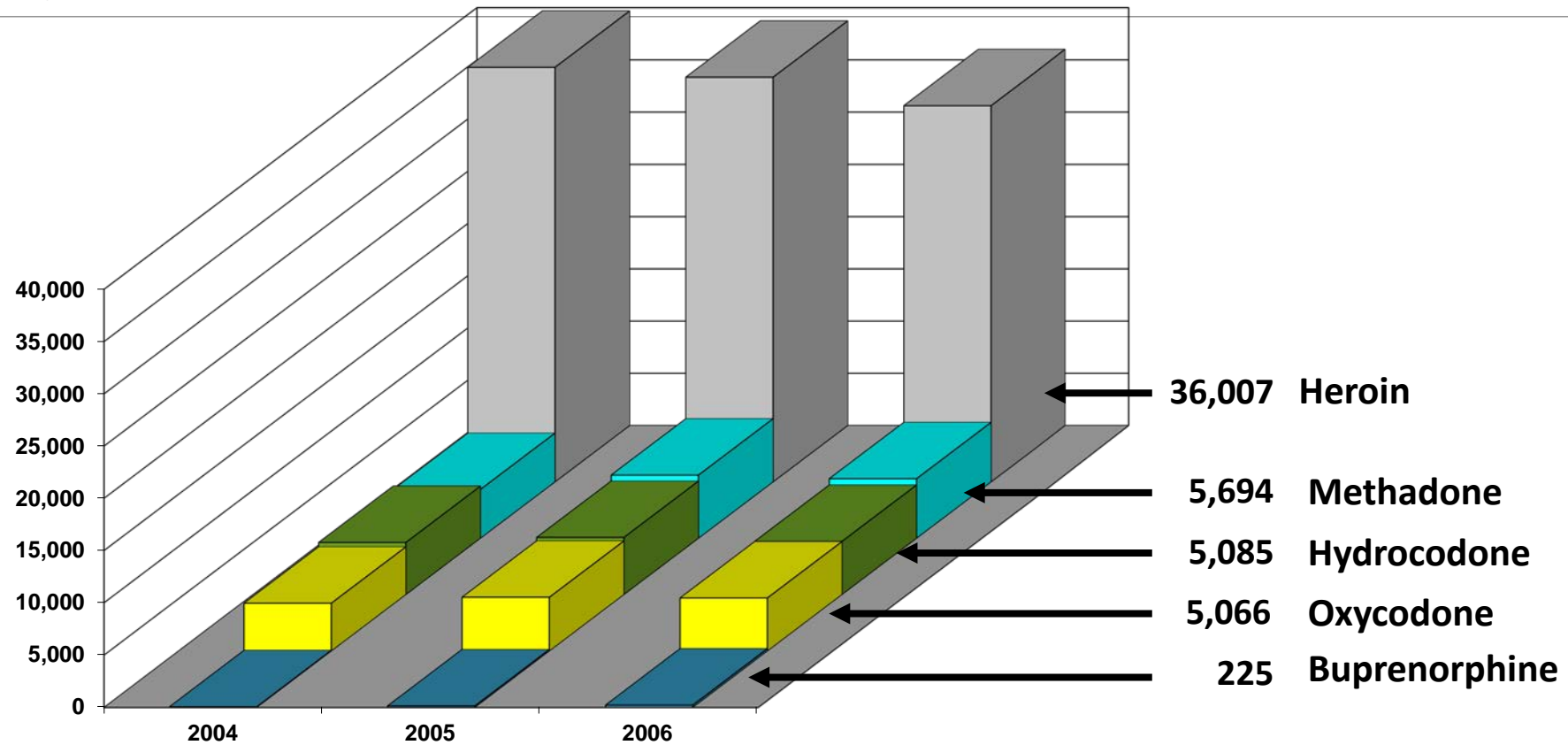
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Of the 47,538 opioid analgesics reported in drug-related ED visits, 358 were buprenorphine (all case types)

Source: DAWN Live!, Unweighted reports from 292 to 304 EDs. Accessed 10/2/2007.

# Opiate Reports in Emergency Department Visits Related to Drug Misuse/Abuse



Source: U.S. SAMHSA; DAWN Live! Oct 2, 2007

# Interdisciplinary Management of OUD

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# MAT

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Source: <http://www.addictionoc.com/addressingopioid-addiction-medication-assisted-treatment-mat-fears/>



# Initiation of program

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- Prior to 2016
  - “Traditional Model”
  - 1-2 MAT Providers, slowly expanding
  - *Ad hoc* behavioral health involvement
  - Provider-driven
  - Census approximately 40 patients with small increases
  - Significant unmet need

Collective feeling among our group: “...*we can do better.*”

# How we started

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Strategic intake process– examine for honesty and looking for level of desired support

Include behavioral health specialists interested in addiction at intake and throughout

Go out to the community to change the reputation of opioid use and buprenorphine to a more positive one

- Discuss risk reduction, bust myths of these folks looking “high”
- Emphasize that medication is not replacing counseling

# What did we do?

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Drew the line of acceptance of patients to those WANTING and WILLING, regardless of relapse risk or support system

Hired a care management RN and changed the clinic model

- Less physician/PA/NP time to counsel patients
- More rewarding = more prescribers quickly!

Probably lost a little money, then regained from grants and increased productivity (RVU system)

Utilized a model from the University of Massachusetts to risk stratify patients to increase support as needed



# Key Players

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## Patient

## MAT Nurse

- Principal communicator and educator for the MAT patient.
- Regular assessment, keen observer to changes in patient status and compliance

## MAT Provider (MD, DO, PA or NP)

- Supervise care provided by the team, provide clinical advice and backup for the team, and to reinforce the MAT Program Requirements at visits.
- Available for management questions and arrange coverage when not reachable.

## MAT Behavioral Health Consultant (BHC)

- Completes psychosocial assessment of behavioral health need and creates plan to address needs
- Facilitates referral to mental health or substance abuse services in the community

## MAT Medical Director (MD or DO)

- Medical and administrative oversight of the program, registry, and adherence is state and federal requirement
- MAT Medical Director is available to MAT Providers and team for clinical consultation and decision making.



# Unique elements of our program

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Increase BH “touches”

Panel management outside of physician visit

- Require PCP (not necessarily at our clinic)
- Co-management of chronic conditions
- HCV Treatment, HIV treatment available

Physicians focus on dose, side effects, and overall progress, but acknowledge not the best to manage psychological strategies for managing addiction

We encourage anyone thinking about prescribing to have some sort of mental health support

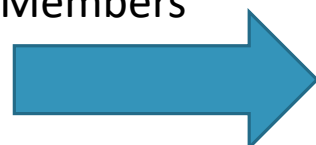
Level of Support



Compliance Measures



Additional Team Members



|  | 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.<br><br>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.<br>Routine advancement from Tier 2 | Routine advancement from Tier 3.<br><br>Doing well in recovery. | Eligible for advancement from Tier 3.<br><br>Doing well in recovery. |
| <b>Rx Total Duration</b>                   | 1 week                       | 2 weeks   | 4 weeks   | 12 weeks  | 24 weeks   |
| <b>RF Duration</b>                         | 0                            | 2 weeks   | 1-4 weeks   | 4 week  | 4 week   |
| <b>Scheduled UDS<sup>1</sup></b>           | Weekly                       | Every 2 weeks   | Every 4 weeks   | Every 12 weeks  | Every 12 weeks   |
| <b>Random Call-In<sup>1</sup></b>          | Every 2 weeks                | Every 4 weeks   | Every 8 weeks   | Every 12 weeks  | Every 12 weeks   |
| <b>MAT prescriber Visits</b>               | Every 2 weeks                | Every 4 weeks   | Every 8 weeks   | Every 12 weeks  | Every 24 weeks   |
| <b>Nurse Visits</b>                        | Weekly, alternating with PCP | Every 2 weeks, alternating with PCP   | Every 4 weeks, alternating with PCP   | Every 6 weeks in between PCP visits                             | Every 12 weeks in between PCP visits                                 |
| <b>Behavioral Health Touch<sup>2</sup></b> | Twice Weekly                 | Every 2 weeks   | Q 3 months  | Q 6 months  | Q 6 months   |
| <b>Behavioral Health Plan Review</b>       | Monthly                      | Monthly   | Q 3 months  | Q 6 months  | Q 6 months   |
| <b>Minimum Time to Next Tier</b>           | 2 weeks                      | 4 weeks   | 8 weeks   | 16 weeks  | 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.

<sup>1</sup> These are maximum intervals; the PCP may ask the MAT team for more frequent UDSs or random call-ins at their discretion

<sup>2</sup> A "Behavioral Health Touch" is defined as two way communication between the Behavior Health Consultant or Behavioral Health Resource Specialist and the patient.

# MAT Process Overview

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## Step 1: Diagnosis

- Patient diagnosed with opioid dependence and deemed appropriate for MAT

## Step 2a: RN Intake

- The MAT nurse conducts an intake visit(s) with the patient to review program requirements.
- Sign consent
- Intake labs are ordered under the PCP's name and cc'd to MAT provider

## Step 2b: BHC Intake

- BHC conducts psychosocial assessment and creates a plan to address and monitor need
- If indicated, referral to mental health services in the community

**Patient**



Diagnosed with opioid dependence and referred by PCP

**RN Intake**



**BHC Intake**



**Induction**



Can occur under supervision in office or at home

**Stabilization & Maintenance**



Tier System

**Graduation or Discontinuation**

# MAT Process Overview

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## Step 3: MD visit and plans for induction

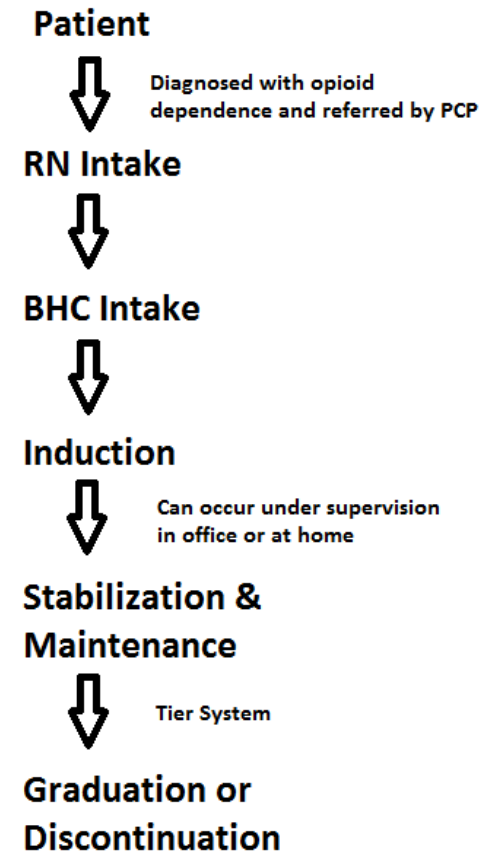
- Induction generally at home or under nurse supervision

## Step 4: Maintenance

- Follows tier system, blend of BHC, RN and MD visits

## Step 5: Graduation/discontinuation

- A patient may be involuntarily discontinued from the MAT program at any time:
  - ...at the discretion of the MAT team for failure to meet program requirements
  - ...if MAT is no longer felt to be effective or appropriate for the patient
  - ...or if the patient may also voluntarily discharge themselves when they feel ready to maintain sobriety without medication.





# Participation Requirements

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Abstinence from illicit drugs, marijuana, prescription opioids, and alcohol. BZD's generally not recommended.

## Refills:

- In person during nurse or provider visits, should be scheduled prior to running out by calling the MAT nurse
- Early refills will generally not be granted

## Random call-in policy

- Must have a reliable way to be contacted and means to get to the clinic during any business day
- Bring buprenorphine prescription bottle or film packages for medication count

## Engagement with non-pharmaceutical elements

- Engage in substance abuse and/or mental health services
- Medication alone rarely addresses all aspects of treatment
- Literature supports that patients do better with adjunctive treatment focused on behavioral change.

# Induction on Buprenorphine

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- Clinic induction – dosing in the clinic while monitoring Clinical Opiate Withdrawal Scale
- Home Induction – given rx to take at home
- Must stop all opioids to prevent precipitated withdrawal
- Increasingly more patients in withdrawal or already tried buprenorphine prior to visit
- All need phone or clinic follow up in 1-2 days

# Maintenance

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Start with support and 1-2 visits per week, gradually decrease to maintenance phase

Expect periods with need for more intensive support (i.e., not “no maintenance”).

- Ongoing abuse of opioids despite an adequate medication dose.
- Ongoing use of cocaine, alcohol, barbiturates, amphetamine, benzodiazepines or other illicit drugs.
- “Problem” use of prescription benzodiazepines characterized by impairment, sedation, overdose, adverse medical events or unsafe behaviors.
- Failure to adhere to call back policy for random pill counts or UDSs.
- Failure to keep appointments with BHC or other team members.
- Inconsistent buprenorphine in urine testing

# Discontinuation

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## Reasons to consider discontinuation:

- Continued use of illicit drugs, Rx opioids, or problematic use of prescription benzodiazepines for more than three months.
- Three or more missed appointments or inability to contact patient.
- Three or more failures to adhere to the call back policy and keep appointments for UDS or pill counts.
- Refusal to seek or comply with mental health care when recommended to do so by the MAT team.
- If the MAT provider feels that MAT is ineffective or inappropriate for the patient.
- Patient alteration of a prescription or a UDS.

## Grounds for immediate discontinuation:

- Repeated (two) negative urine tests for buprenorphine. An exception may be if the patient was not expected to have any remaining buprenorphine when the UDS was submitted.
- Patient found through other means (such as law enforcement) to be diverting medication.
- Patient or anyone acting on their behalf being verbally or physically abusive or threatening to any staff member or patient at FM clinic.





# Next steps

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1. Assess capacity/needs and interest
  - BHC
  - RN
  - Waivered MD, DO, NP, PA
2. Agree upon specific clinical algorithms/determination of workflows
3. Clinic Training
  - Trauma-informed care
  - Substance abuse disorder
  - Etc.
4. On-going support
  - Collaboration with regional partners

# Questions?

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Brian Garvey, MD, MPH: [garveyb@ohsu.edu](mailto:garveyb@ohsu.edu)

Rebecca Cantone, MD: [cantone@ohsu.edu](mailto:cantone@ohsu.edu)

OHSU Scappoose Clinic: 503-418-4222