Addressing Substance Use Disorder in Primary Care

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Your health deserves a partner.

Disclosures

- I currently have no relationships of any kind with any company whose products or services in any way relate to the practice of medicine, medical education or research.

Objectives

- Describe approaches to integrating treatment for substance misuse in primary care.
- Identify steps to adopting treatment to address substance misuse in primary care.

Why primary care?

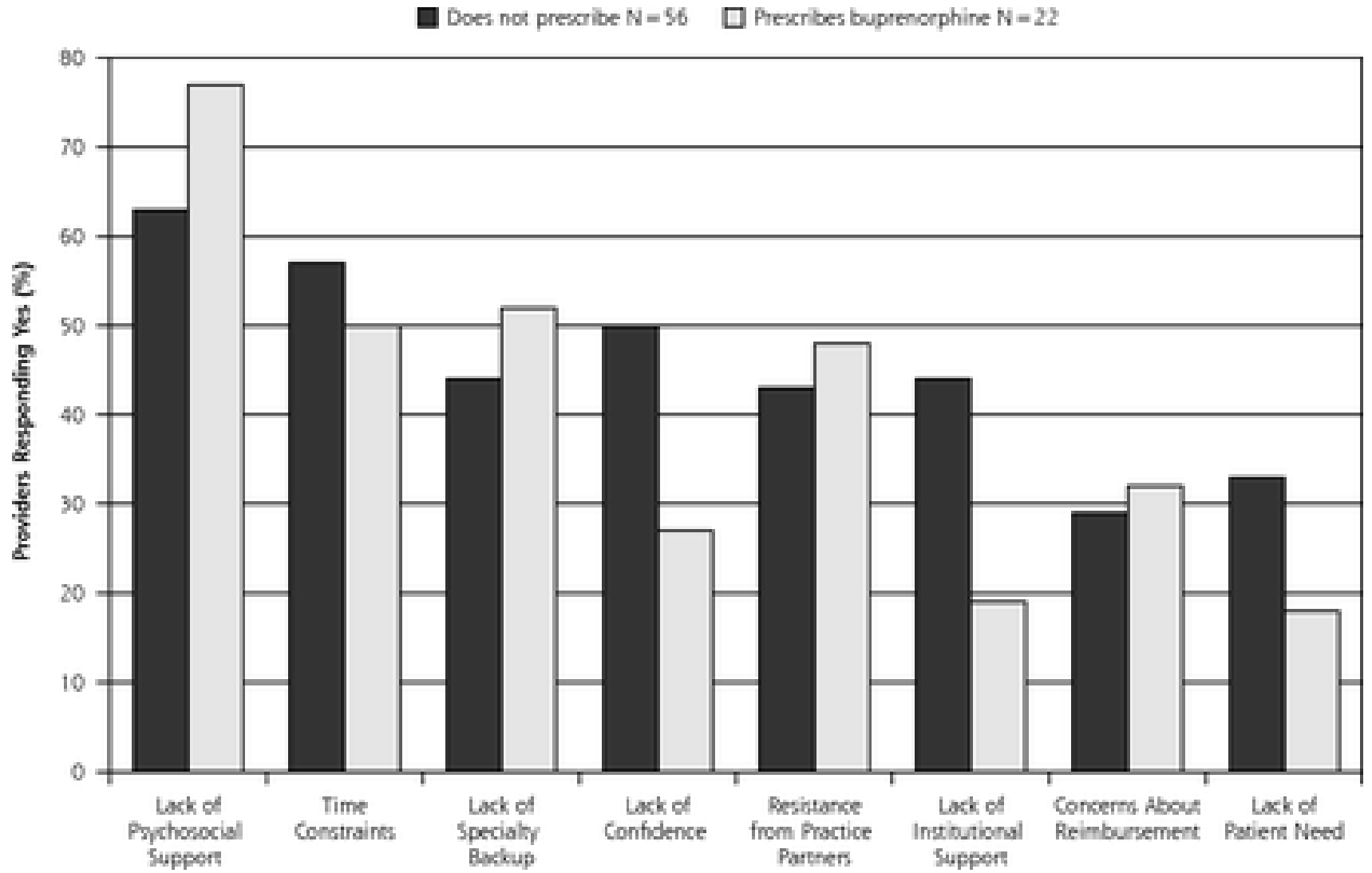
- 1 in 2 office visits nationally are done by primary care
- Issues with capacity of inpatient & residential facilities
- 80% return to use after detox services

- Care delivery requires clinicians and team who are:
  - Patient-centered
  - Trauma-informed
  - Community-minded
  - Relationship-oriented

Bridge to Recovery

What are the concerns about embarking on this path?

Barriers to prescribing buprenorphine



Hutchinson BA, et al. Ann Fam Med 2014;12(2):128-33

“EACH CHRONIC DISEASE CRISIS IS DUMPED ON THE SHOULDERS OF PHYSICIANS, WHO ARE CONSTRAINED BY A SYSTEM THAT DOES NOT ADDRESS THE ROOT CAUSES: IT IS LIKE REPEATEDLY MOPPING UP A WET FLOOR WHILE THE ROOF CONTINUES TO LEAK.”

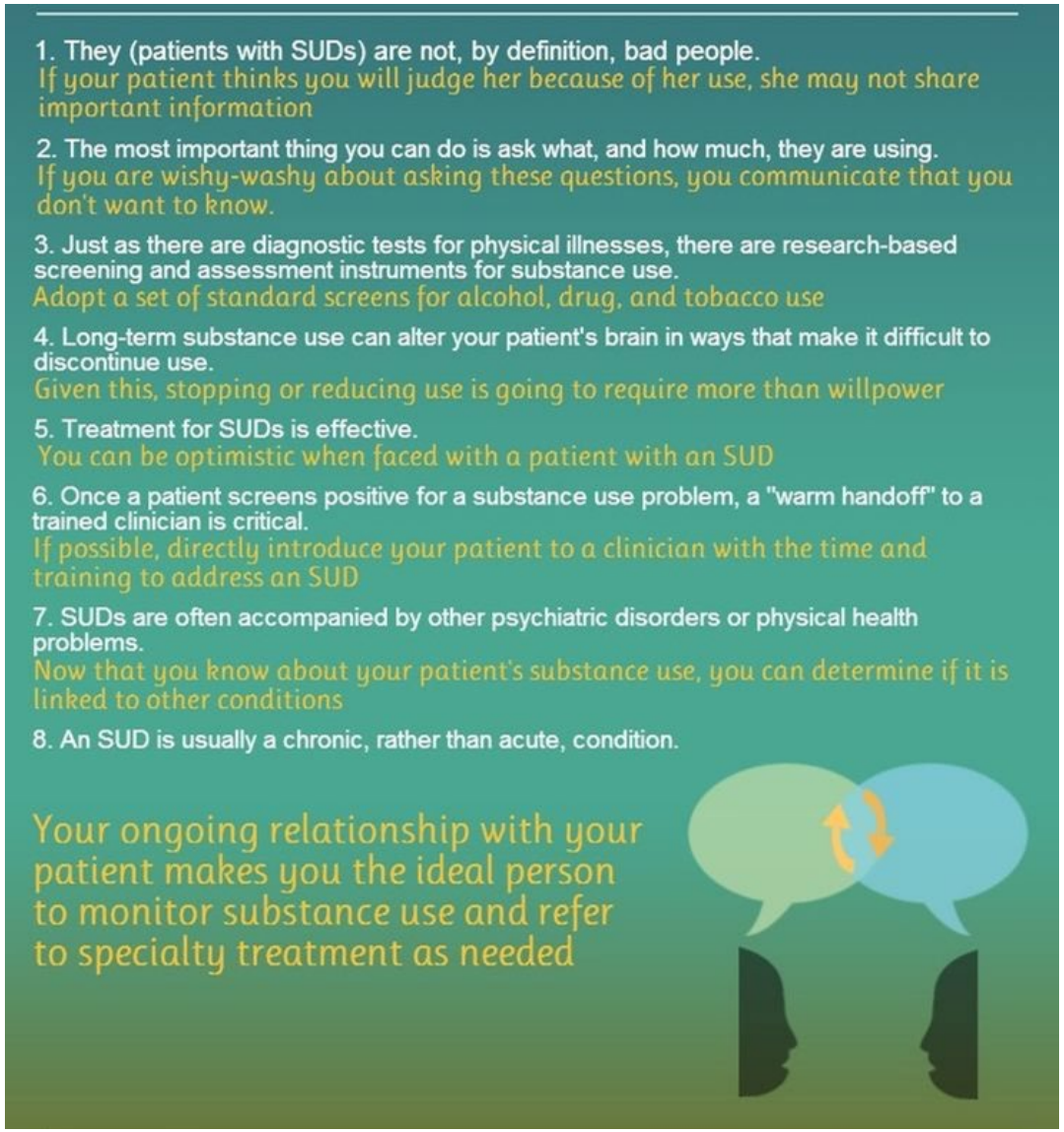
JONAS ET AL. N ENGL J MED CATALYST 2019
HTTPS://CATALYST.NEJM.ORG/CAUSE-CRISES-WHOLE-HEALTH-WHOLE-PERSON/

Setting yourself up for success

- Culture
- Who do you want to treat?
- Initiation of treatment
- Refills?
- Use of Urine Drug Screens
- Use of Treatment Agreements
- Coverage while away
- Support & Referral

Who do you want to treat?

- Bridging primary and specialty care
- Patient factors
  - Diagnoses
  - Medication options
- Fiscal factors
  - types of insurance that will be accepted
  - whether or not to apply to patient assistance programs
  - fees, payment plans, and policies.
- Identify the individual at the clinic who will address prior authorization for insurance if needed.



Recommendation Summary

Population	Recommendation	Grade
Adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B
Adolescents	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents. See the "Practice Considerations" section for suggestions for practice regarding the I statement.	I

Recommendation Summary

Population	Recommendation	Grade
Adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B
Adolescents aged 12 to 17 years	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years. See the Clinical Considerations section for suggestions for practice regarding the I statement.	I

Arguments for Screening

- Magnitude of the Problem
- Avoiding medication interactions

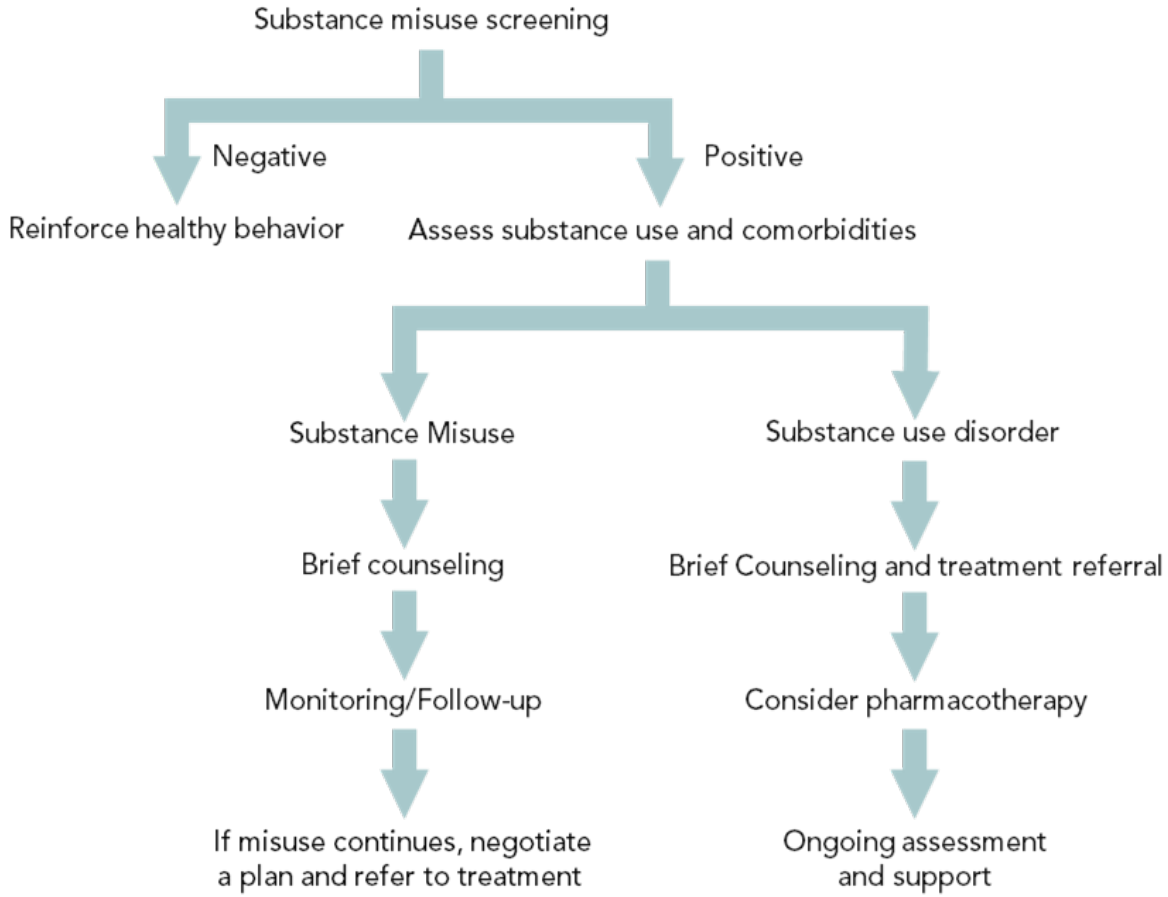
  Lindsey WT, et al. Am J Drug Alcohol Abuse. 2012 Jul; 38(4):334-43.

- Alter prescribing habits

  Arnsten JH,, et al. J Gen Intern Med. 2002 May; 17(5):377-81.

- Improve overall quality of care

  Shapiro B, et al. Am Fam Physician. 2013;88(2):113-21



Brief screening instruments

SINGLE ITEM SCREENER

SMITH PC, ET AL. ARCH INTERN MED. 2010;170(13):1155–1160.

- How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons? (A positive screen is 1 or more days.)

TWO ITEM SCREENER FOR VA

TIET QQ, ET AL. JAMA INTERNAL MEDICINE.2015;175(8):1371–1377.

- How many days in the past 12 months have you used drugs other than alcohol? (A positive screen is 7 or more days)
- How many days in the past 12 months have you used drugs more than you meant to? (A positive screen is 2 or more days)

Initiation of Treatment (buprenorphine)

In office/Onsite initiations

- Process for getting medicines on-site
- Often requires multiple visits for initiation
- Patient may need to present in withdrawal

Off-Site initiations

- No need to get medications on-site
- Initiation does not require multiple initial visits
- Patient need not present sick

Off-Site Initiations – DO THEM

Buprenorphine - Beginning Treatment

Day One: Before taking a buprenorphine tablet you want to feel lousy from your withdrawal symptoms. Very lousy. It should be at least 12 hours since you used heroin or pain pills (oxycontin, vicodin, etc.) and at least 24 hours since you used methadone.

Wait it out as long as you can. The worse you feel when you begin the medication, the better it will make you feel and the more satisfied you will be with the whole experience.

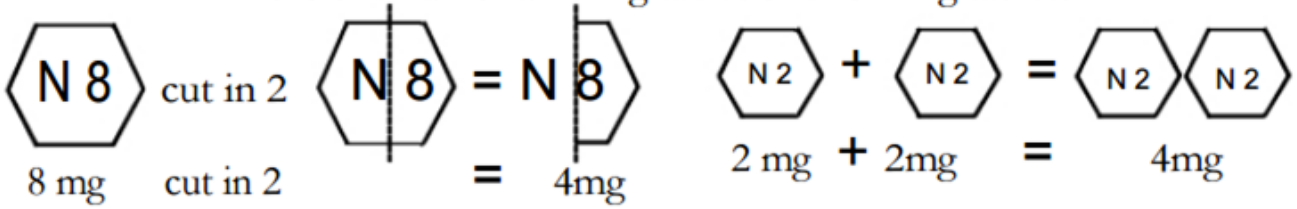
You should have a least 3 of the following feelings:

- joint and bone aches
- bad chills or sweating
- anxious or irritable
- goose pimples
- twitching, tremors or shaking

- very restless, can't sit still
- heavy yawning
- enlarged pupils
- runny nose, tears in eyes
- stomach cramps, nausea, vomiting, or diarrhea

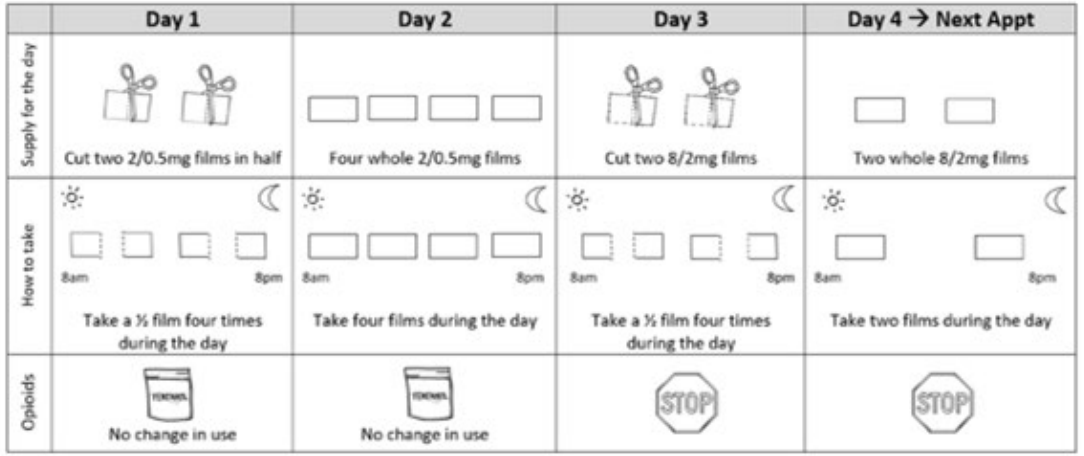
First Dose: 4 mg of Buprenorphine (Bup) under the tongue.

This is one half of an 8 mg tablet or two 2 mg tablets:



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628995/bin/11606_2008_866_MOESM1_ESM.pdf

Low Dose initiations



Appointment scheduling and refills

- No standardized or evidence-based approach
- Use of telemedicine
- Weekly visits x 4 weeks
  - May consider co-pays a barrier to this
- If doing well, biweekly for 1-2 visits
- Monthly for 6 months to year
- May consider after 6-12 months to change frequency to q 2-3 months with refills

Initial Visit

- Must be patient-centered
  - Nonjudgmental
  - Respectful
  - Empathetic

Rollnick S, et al. Motivational Interviewing in Health Care: Helping Patients Change Behavior. New York, NY: Guilford Press; 2008:6–7.

Recovery oriented care

Recovery comes in many pathways

Focus on addressing problems of greatest concern to patient

Support patients making their own informed decisions about treatment

Help patients further grow recovery capital by offering or connecting them to additional services

SAMHSA's Guiding Principles of Recovery

- **Recovery emerges from hope.**
- **Recovery is person driven.**
- **Recovery occurs via many pathways.**
- **Recovery is holistic.**
- **Recovery is supported by peers and allies.**
- **Recovery is supported through relationships and social networks.**
- **Recovery is culturally based and influenced.**
- **Recovery is supported by addressing trauma.**
- **Recovery involves individual, family, and community strengths and responsibilities.**
- **Recovery is based on respect.**

Words Have Power. People First.

Using affirmative language to inspire hope and advance family recovery.

Stigmatizing Language	Current Language
Addict	Person with a substance use disorder
Addicted infant	Infant with Neonatal Abstinence Syndrome (NAS)
Addicted to [alcohol/drug]. . .	Has a [alcohol/drug] use disorder
Alcoholic	Person with an alcohol use disorder
Clean	Abstinent
Clean screen	Substance-free
Crack Babies	Substance-exposed infant or Substance–affected infant
Lapse / Relapse / Slip	Resumed/experienced a recurrence
Medication-Assisted Treatment (MAT)	Medications for Addiction Treatment (MAT)
Opioid replacement	Medications for Addiction Treatment (MAT)
Opioid Replacement Therapy (ORT)	Medications for addiction treatment (MAT)
Pregnant Opiate Addict	Pregnant person with opioid use disorder
Reformed addict or alcoholic	Person in recovery
Substance Abuse	Substance use disorder
Substance abuse/abuser	Person with a substance use disorder
Substance Misuse	Substance use / non-medical use

Initial Visit/Assessment

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period of time than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance.
10. *Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of an opioid.
11. *Withdrawal.

*This criterion is not met for individuals taking opioids solely under appropriate medical supervision.

Severity:

∀ Mild: Two or three symptoms	∀ Moderate: Four or five symptoms	∀ Severe: Six or more symptoms

Initial Visit/Assessment

Cardiovascular	Injection drug use: endocarditis, septic thrombophlebitis
Cancer	Injection drug use: hepatocellular carcinoma related to hepatitis C
Endocrine/ Metabolic	Opioids: osteopenia, hypogonadism, erectile dysfunction, decreased sperm motility, menstrual irregularity including amenorrhea, infertility
Hepatic	Injection drug use: hepatitis B, hepatitis C, hepatitis D, infectious and toxic hepatitis
Hematologic	Injection drug use: hematologic consequences of liver disease from hepatitis C, hepatitis C-related cryoglobulinemia and purpura
Infectious	Opioids: aspiration pneumonia, sexually transmitted infections Injection drug use: endocarditis, cellulitis, necrotizing fasciitis, pneumonia, septic thrombophlebitis, mycotic aneurysm, septic arthritis (unusual joints, such as sternoclavicular), osteomyelitis (including vertebral), epidural and brain abscess, abscesses and soft tissue infections, mediastinitis, malaria, tetanus, hepatitis B, hepatitis C, hepatitis D, HIV, botulism
Neurologic	Opioids: seizure (overdose and hypoxia), compression neuropathy, sleep disturbances
Nutritional	Opioids: protein malnutrition
Other Gastro-intestinal	Opioids: constipation, ileus, intestinal pseudo-obstruction, sphincter of Odi spasm, nausea
Pulmonary	Opioids: respiratory depression/failure, bronchospasm, exacerbation of sleep apnea, noncardiogenic pulmonary edema, bullae Injection drug use: pulmonary hypertension, talc granulomatosis, septic pulmonary embolism, pneumothorax, emphysema, needle embolization
Renal	Opioids: rhabdomyolysis, acute renal failure, factitious hematuria Injection drug use: focal glomerular sclerosis (HIV, heroin), glomerulonephritis from hepatitis or endocarditis, chronic renal failure, amyloidosis, nephrotic syndrome (hepatitis C)

Behavioral Health Assessment

- Depressive disorders, anxiety disorders, bipolar disorder, PTSD, dependent, and anti-social personality disorders common in individuals with SUD

Compton WM III, et al.. Am J Addict. 2000;9(2):113–125.

Compton WM, et al. Arch Gen Psychiatry. 2007;64(5):566–576.

Reynolds M, et al. Drug Alcohol Depend. 2005;77(3):251–258.)

- Intimate Partner Violence (IPV)
  - Increased risks of victim and perpetrators
  - Exceeds 50% in some settings

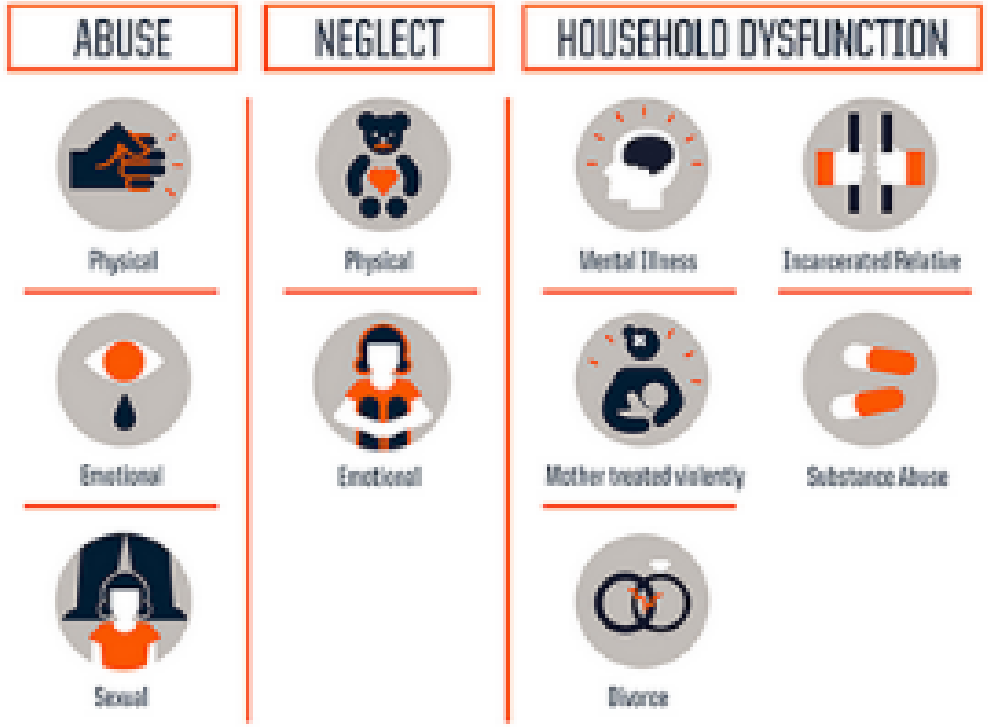
Stuart GL, et al. Subst Use Misuse. 2009;44(9–10):1298–1317.)

WHAT ARE THEY?

ACEs are ADVERSE CHILDHOOD EXPERIENCES

HOW PREVALENT ARE ACEs?

The three types of ACEs include



WHAT IMPACT DO ACEs HAVE?

Substance History

Components of Comprehesive Substance Use History

- DOC (drug of choice)
- Age of onset
- Method of Use
- Use at height
- Last Use, how much and when
- Frequency of use
- Longest period of recovery
- Review of other substances
- Positive effects
- Negative consequences

- Treatment History
  - Locations
  - Time in Treatment
  - Reason for Relapse
- Family History
  - ACE Score
    - Increased rates prescription drug misuse
    - Lifetime risk illicit drug use
    - Ever having a drug problem

Anda RF, et al. BMC Public Health 2008;4(8):198.

Dube SR, et al. Pediatrics. 2003;111(3):564-72.

Social History

Social factors that affect prognosis, influence engagement/retention in treatment, and guide treatment planning include:

- Transportation and childcare needs.
- Adequacy and stability of housing.
- Criminal justice involvement.
- Employment status and quality of work environment.
- Details about drug use from people the patient lives or spends time with
  - obtain with patient's consent
- The patient's sexual orientation, identity, and history, including assessing risk factors for HIV and sexually transmitted infections.
- Safety of the home environment
  - NB: substance use substantially increases the risk of intimate partner violence; screen all women presenting for treatment for domestic violence).

Clinical Testing

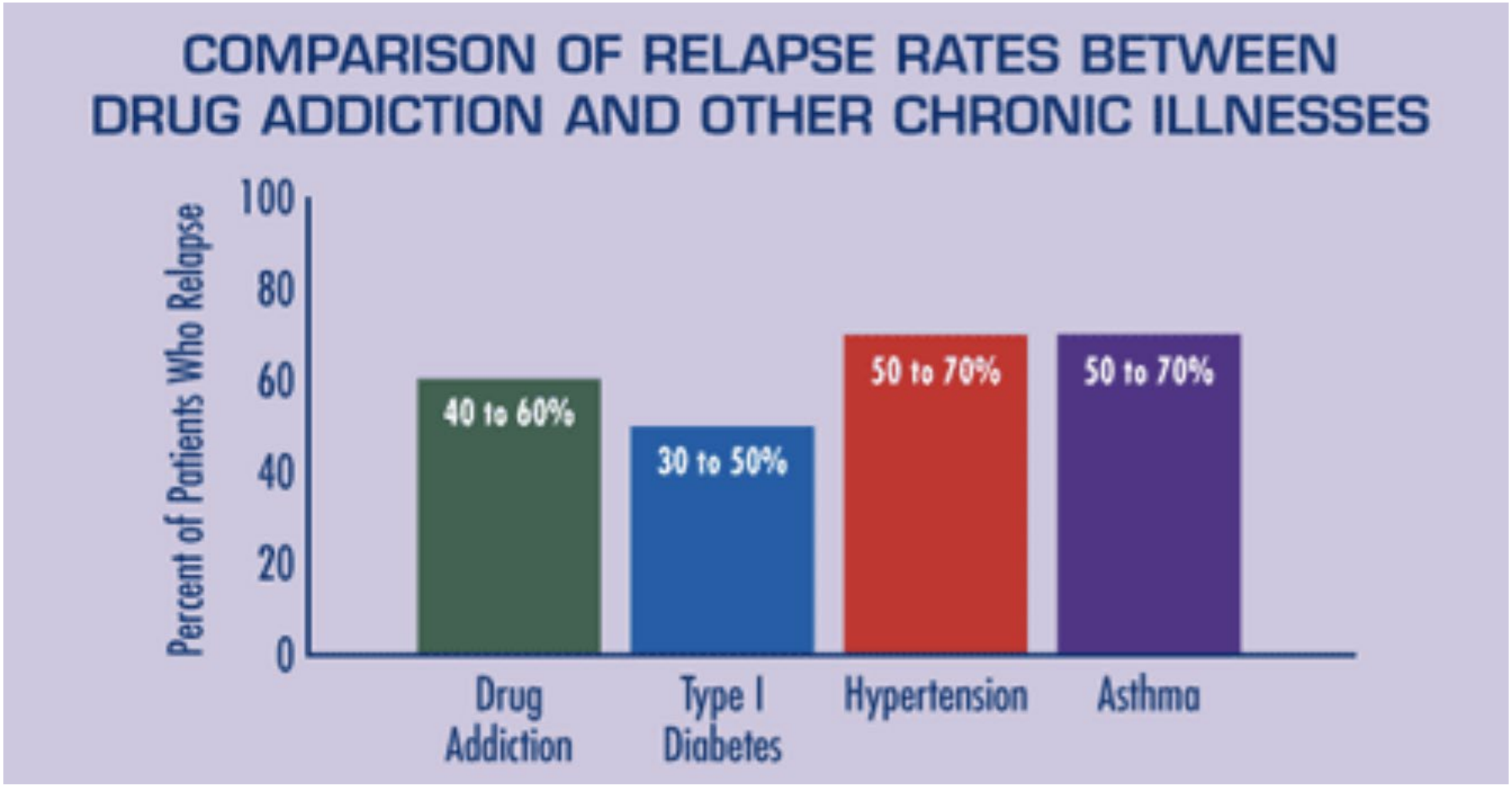
- Urine Drug Screen
  - Positive tests not diagnostic of OUD
  - Interpret negative results carefully
  - False positive and False Negatives are possible

- Other testing
  - Pregnancy test
  - Liver function tests
  - Hep B and C serology
  - HIV serology
- Considerations
  - PrEP
  - DoxyPEP

Maintenance Visit

- Assess recovery process
  - Both what the patient says and way they say it
- Return to use?
  - UDS - assistive tool
  - Free time utilization
- Cravings?
- Side effects?
- Aftercare?
- Stressors?
  - Triggers for relapse
  - Sleep
  - Social structures

Return to use…



JAMA 2000;284:1689-95.

Treatment Agreements

- Can be helpful in the following ways
  - Establish treatment goals and clear consent of process
  - Helps establish structure for individual
  - Helps disclose progression of care over time
- Agreements are not meant to be contractual obligations
  - Not meant to be hung over patient's head for recurrence
  - Not meant to be used to threaten patients

Lack of supports

- Remember, you are starting from primary care
  - You build something out of nothing every day
- CFR 42, Part 2 & Primary Care Clinics
  - OBOT vs OTP
  - Higher level of confidentiality does not apply to program when is a “general medical care facility”
  - Have patients sign release allowing for disclosure
  - SAMHSA - http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs
- Behavior Health & Aftercare
- Social Support & Services

Behavioral Health & Aftercare

- SAMHSA
  - Do not delay initiation of pharmacologic treatment for OUD simply because behavioral health is not immediately available
- Integrated Behavioral Health Models
- Community Resources

Counseling for treatment

- Goals
  - Improve problem-solving skills
  - Find incentives for recovery
  - Build a set of techniques to resist drug use
  - Replace drug use with constructive, rewarding activities

Substance Abuse and Mental Health Services Administration. (2013). *Enhancing motivation for change in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series 35. HHS Publication No. (SMA) 13-4212. Rockville, MD: Substance Abuse and Mental Health Services Administration.

McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. *Psychiatric Clinics of North America, 33*(3), 511–525.

Moore, B. A., Fiellin, D. A., Cutter, C. J., Buiono, F. D., Barry, D. C., Fiellin, L. E., … Schottenfeld, R. S. (2016). Cognitive behavioral therapy improves treatment outcomes for prescription opioid users in primary care buprenorphine treatment. *Journal of Substance Abuse Treatment, 71,* 54–57.

Questions?

We look forward to continuing this conversation