



# Treatment of Addiction in Primary Care

**Christina Lasich MD**

**Grace Katie Bell RN, MSN, RN-BC, CARN, PHN**

**Alinea Stevens MD MPH**

**Gina Anderson MSN, NP-C**

Heroin Kills  
One  
Every  
Nine Minutes





# **Resilience in changing environment**

**Evidence Based Approaches**

# Why Primary Care?

Only 1 out of 10 people with opioid use disorder get treatment





# Primary Care MAT Programs: Ten Elements of Success

California Healthcare Foundation (CHCF)

# 10 Elements of Success

**1) A Champion**

**2) Staffing for  
Administrative Activities**

**3) Team-based Approach**

**4) Connection to  
Behavioral Health**

**5) Mentoring Support for physicians**

**Two Waived Docs per Practice**

**7) Assessing patient readiness**

**8) An Induction Approach that fits**

**9) Pharmacist Willing to Partner**

**10) Sustainable Financing**

# Champion

- 1. Passionate advocate for best practices care**
- 2. Essential to transforming of the clinic culture**
- 3. Emerges naturally in the clinic**
- 4. Support from clinic administration**



# Champion educates and supports clinic staff

## 1. Identifying the barrier of stigma within the clinic

Belief, Language, Attitude

## 2. Reach into all departments, cultivate allies

Front desk staff, Medical Assistants, Billing and coding

## 3. Community allies and alliances

Participate in opioid coalitions and SUD collaborations





# Integrating Addiction Medicine into Primary Care Practice Requires Staff !

**Or Does it?**



# COMPLIANCE

**Are you ready to report to DEA?**

**Are you within your waiver limit?**

**Are your medical records organized?**




It takes a  
**Village**

To save one  
**Life**



# Team @ Work

Case Managers   
**Nursing, Counselors,  
Medical Assistants**  
**All can get INVOLVED**

  
**Administration**  
**IT Support**  
**Run the Business**



  
**Providers**  
**Waivered or NOT**  
**All Specialty Areas**

  
**Office Assistants**  
**Answer the Phone**  
**Wrangle the Schedule**

# Team-based approach for MAT programs

The flow of patient care from screening to intake to induction to stabilization involves a team based approach.

1. Wrap-around services within the clinic or refer to community resources.
2. Early stabilization requires close monitoring, dose management and supportive care.



# MAT Program Manager

1. Develops patient pathways, program policies & procedures & structure.
2. Supports team processes and maintains communication with Medical Director and clinic administrators.
3. Program Manager usually holds another role on the MAT team such as RN, SUD counselor or BH therapist.



# DEA waived prescriber (MD, NP, PA)

- 1. Leads patient care**
- 2. Conducts weekly case reviews**
- 3. Makes referrals for all medical and behavioral needs.**
- 4. Works closely with RN Case Manager for safe inductions, dosing and stabilization.**



# RN Case Manager

- 1. Screens and assesses for MAT admission**
- 2. Works with prescriber for induction planning and care**
- 3. Stabilization, assessment of buprenorphine dosing**
- 4. Management of side effects.**
- 5. Treatment planning including BH and SUD counseling needs**





# SUD Counselor (CAADC I-II; LAADC)

- 1. Partners with patient with treatment goals**
- 2. Treatment planning, program adherence, ongoing interventions and follow-up.**
- 3. Works with community treatment resources access Outpatient, Intensive Outpatient and Residential levels of care.**
- 4. Utilizes ASAM whole-person criteria for appropriate level of care.**



# Behavioral Health Therapists (LCSW, LMFT, PhD, PsyD)

- 1. Collaborates with MAT team for all therapeutic needs.**
- 2. Participates in case reviews.**
- 3. Refers to psychiatry if needed.**
- 4. Facilitates and develops curriculums for Refill/Stabilization groups.**



# Medical Assistants

## 1. Supports inductions and weekly groups

- a. Collecting of urine drugs screens
- b. Vitals
- c. Manages patient flow at group visits

## 2. Can also function as patient navigators



# Stop Filling the Hole, Heal the Hole

**Jerry Moe, National  
Director of the  
Children's Program at  
the Betty Ford Center**



# Behavioral Health Specialists Can...



# PROJECT MATCH

Journal of Mental Health; 1998

**Matching Patients with EtOH Use Disorder to treatment  
(N=1726)**

**Cognitive Behavioral Therapy  
12-Step Facilitated  
Motivational Enhancement Treatment**

**All Patients Showed Improvement**

# Two Waivered Providers



## For Physicians

Get DATA 2000 8 Hour Waiver Qualifying  
Buprenorphine Training.

**Up to 9 *AMA PRA Category 1 Credit*<sup>™</sup>**

\$199 user fee

## For Nurse Practitioners and Physicians Assistants

Part 1 (8 hrs) of a 24 hour credit activity for  
NPs/PAs.

\$199 user fee for all 24 hours

# Mentorship for Physicians





# Assessing Patient Readiness

**Everyone is motivated  
when they are going  
through withdrawals**



# Motivating Factors

**Legal - court, probation, jail**

**Children - Child Protective Services**

**Family/Friends**

**Mortality - Overdose, Infectious  
Diseases, Witness Death of Friends**

**Financial - “I can’t afford it anymore”**

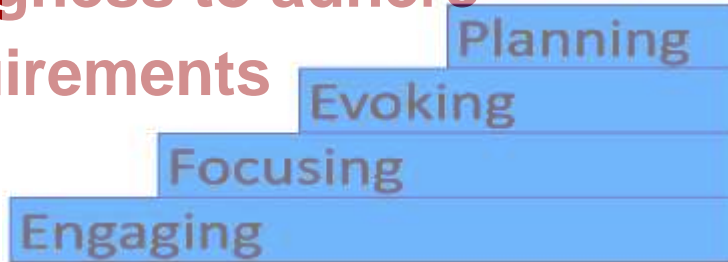


# Motivational Question

**Determine stage of change**

**Assess risk level - high level of risk less likely to change**

**Assess willingness to adhere to program requirements**



# Tools

Readiness To Change Questionnaire (Treatment Version)  
(RCQ-TV)

Readiness Ruler

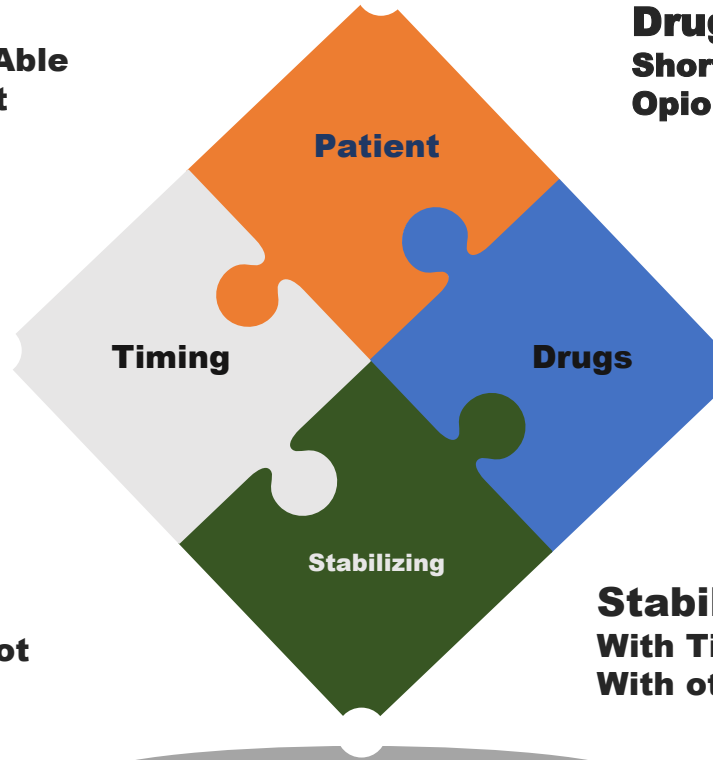


The animation  
automatically begins.

**The Induction Puzzle,  
Starting Buprenorphine  
Without Causing  
Precipitated  
Withdrawals**

**Patient**  
Motivated and Able  
Pregnant or Not

**Drugs**  
Short or Long Acting  
Opioids



**Timing**  
Opioid-Free or Not  
@Home or Not

**Stabilizing**  
With Time  
With other Drugs

**References:**

Journal of Substance Abuse Treatment; "Comparison of Buprenorphine Induction Strategies"; 2011; June; 40(4): 349-356  
The New England Journal of Medicine; "Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure"; 2010; 363:2320-31

# Pharmacist Partnership

Deborha E Boatwright BSP Pharm, JD. Buprenorphine and Addiction: Challenges for the Pharmacist. *Journal of American Pharmaceutical Association*. [Volume 42, Issue 3](#), May–June 2002, Pages 432-438.

<https://doi.org/10.1331/108658002763316860>



# Sustainable Financing

**How do we pay for all of the program costs?**

- **Non billable staff (case manager, program director, counselor, medical assistants, etc.)**
- **Therapy same day as provider refill visit**
- **Space**



# Sustainable Financing (cont.)

**Identify the cost**

**Explore community partnerships**

**Talk to your payors**



# El Dorado Community Health Center Project



## Collaboration with California Health and Wellness

- Identified patient by insurance
- ~ 57% Medi Cal (large portion California Health and Wellness)
- Reviewed services by complexity
- Selected performance metrics
- Ongoing study by quarter as patient numbers increase and patients

## Results of Study



**Overall average costs decreased**

**Inpatient and pharmacy have the greatest costs reduction**

**ER and specialists costs also decreased**

**Hospital OP costs, other medical, and primary care costs increased**

**Primary care costs increase is a desirable effect**

# Opportunities

## Work with payor to offset costs of program

- Provide a case manager
- Contract for behavioral health
- Identify case rate instead of cap rate for primary care



# **SUMMARY of 10 Elements of Success**

**1) A Champion**

**2) Staffing for  
Administrative Activities**

**3) Team-based Approach**

**4) Connection to  
Behavioral Health**

**5) Mentoring Support for physicians**

**Two Waived Docs per Practice**

**7) Assessing patient readiness**

**8) An Induction Approach that fits**

**9) Pharmacist Willing to Partner**

**10) Sustainable Financing**



# Case Presentations

# Opioid Use in Pregnancy



22 yo F G5P2012 presents at 9 weeks to your office. She had started taking pills for chronic pain after an MVA 3 yrs ago and currently taking 180 norcos/month but sometimes more from a friend.

Past tx: She has tried methadone on the street, tried tapering without success.

Social: She lives with her partner who does not use but they are in the process of becoming homeless because he just lost his job. They don't have insurance.

This is an unintended but desired pregnancy and she would like to hear options for treatment.

# What are the options for treatment?

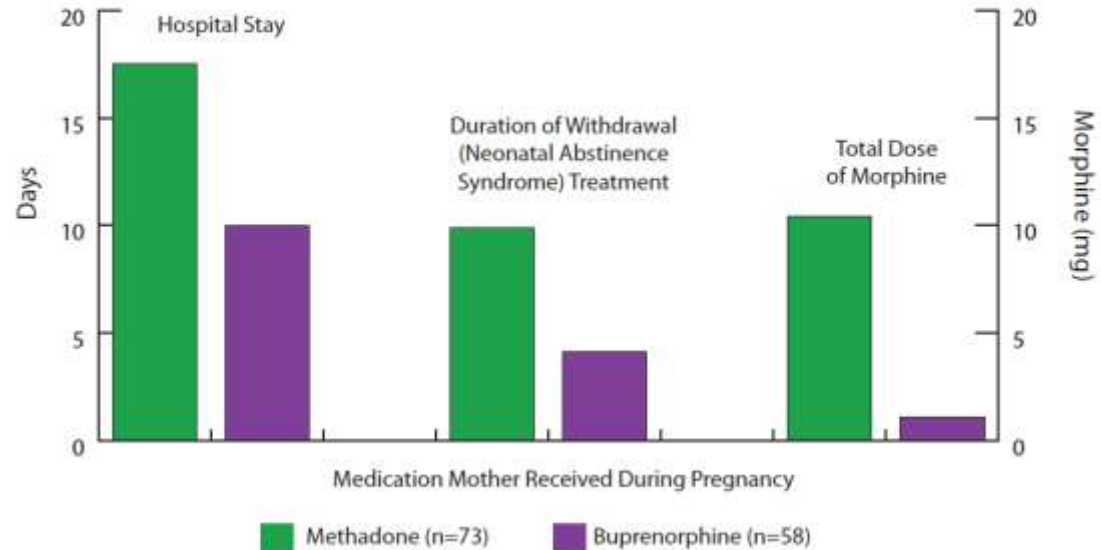
Methadone

Buprenorphine

Taper

[Hendrée E. Jones](#), Ph.D., [Gabriele Fischer](#), M.D., [Sarah H. Heil](#), Ph.D., [Karol Kaltenbach](#), Ph.D., [Peter R. Martin](#), M.D., [Mara G. Coyle](#), M.D., [Peter Selby](#), M.B.B.S., [Susan M. Stine](#), M.D., Ph.D., [Kevin E. O'Grady](#), Ph.D., and [Amelia M. Arria](#), Ph.D. Maternal Opioid Treatment: Human Experimental Research (MOTHER)-Approach, Issues, Lessons Learned. *Addiction*. 2012 Nov;107(01):28-35. doi: [10.1111/j.1360-0443.2012.04036.x](https://doi.org/10.1111/j.1360-0443.2012.04036.x)

Mothers' Buprenorphine Treatment During Pregnancy Benefits Infants





# Considerations During Pregnancy

## 1) Social Support

- a) Engaging community programs (home health RN, family, WIC, housing resources)

## 2) Access to Treatment

- a) Policy implications
- b) System in place for pregnancy and access to MAT

## 4) Neonatal Abstinence Score (transitions of care)



# Neonatal Abstinence Scores

Withdrawal symptoms occur 48–72 hours after birth

1. Tremors, hyperactive reflexes, seizures
2. Excessive or high-pitched crying, irritability, yawning, stuffy nose, sneezing, sleep disturb
3. Poor feeding, loose stools, dehydration, poor weight gain
4. Increased sweating, temperature instability



After birth, baby suffers from withdrawal



# Effects of Opioids on newborn

## In utero effects:

1. Poor fetal growth
2. Prolonged hospitalization (including NICU admission)
3. Poor postnatal growth, dehydration, and seizures

Data on long-term developmental outcomes



# Concurrent EtoH + Opioid Use

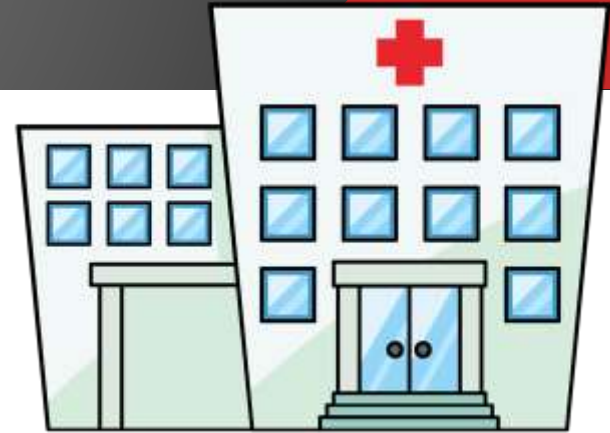


32 yo unemployed, divorced male presents with alcohol use disorder severe- reports drinking 8 - 12 drinks daily for past five years. Began drinking age 14. History of meth use but no use in past 5 years. Pt reports IV heroin use of ½ -1 gram daily for past 2 years. Currently living with mother. His mother says he can continue to stay with her if he stops drinking and using drugs. Patient reports a 10-day residential social detox 18 months ago but resumed alcohol and heroin within 24 hours of discharge. He had declined residential treatment following that detox phase. Patient expresses a strong desire to stop drinking and using. Expresses fear of withdrawal from both substances. Adverse Childhood Experiences (ACEs) score is 6/10.

# Challenges and Considerations

Safe withdrawal management:

- Home withdrawal management not recommended.
- Hospital withdrawal management rarely available.



Setting - most often a bed in “social detox” with non-medical staff monitoring vitals and assisting patient with self-administration of medication per MD’s protocols.

Risks: withdrawal seizures, delirium tremens from EtOH w/d. *Severe opioid withdrawal symptoms can cause a patient to leave treatment and resume use.*

# Strategies and Pitfalls



Use polysubstance withdrawal protocols for safe alcohol withdrawal and comfort through the first days of opioid withdrawal.

Consider initiating low dose buprenorphine on day 2 or 3 of alcohol withdrawal.

Close collaboration with staff of social detox. Follow-up care with prescriber and RN case manager on day 4 or 5 of withdrawal phase.

Patients with AUD and OUD do best with at least 30 days in residential treatment with continued buprenorphine.

## Case of Opioids + BNZ



53 year old woman with lumbar pain following lumbar discectomy with laminectomy presents to you because of worsening pain and to establish care. She is currently taking hydrocodone/APAP 10/325 tablet every 4 hours (6/day) and has been taking it for over 5 years. Two years ago she began taking alprazolam 0.5mg three times per day for anxiety as prescribed by previous primary provider. She is also using zolpidem 10mg at bedtime. Her CURES report shows that hydrocodone is frequently filled a week early. Her urine drug test is consistent except for positive test result for oxazepam. When questioned, she admits to using a friends diazepam when she ran short of her medications. Her pain has been a 9/10 lately and she is feeling depressed.

# Step-wise Solution

Pain and Chemical Dependency  
Roller-Coaster



**1**

## STAGE 1

**Motivate the patient for CHANGE**



**2**

## STAGE 2

**Promote Chemical STABILITY**



**3**

## STAGE 3

**Introduce OTHER SOLUTIONS for pain:**



**4**

## STAGE 4

**Step through the doorway of HEALTH:**



**5**

## STAGE 5

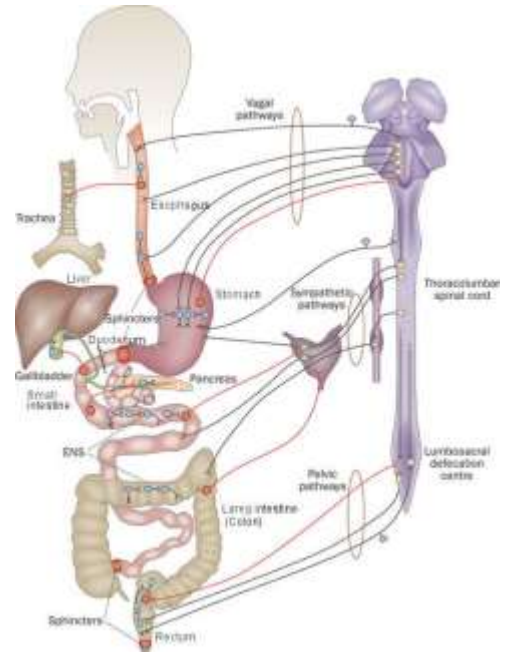
**Begin a slow TAPER:**



# Neutralize the Nervous System

**The Neutralizing Medications: “calm the nerves”**

- **Beyond Gabapentin is Zonisamide, Topiramate, Tiagabine and Pregabalin**
- **TCA= Tricyclic Analgesics (amitriptyline, imipramine, desipramine)**
- **Baclofen, a muscle relaxant and NMDA antagonist**



# Step-wise Solution

Pain and Chemical Dependency  
Roller-Coaster



**1**

## STAGE 1

**Motivate the patient for CHANGE**



**2**

## STAGE 2

**Promote Chemical STABILITY**



**3**

## STAGE 3

**Introduce OTHER SOLUTIONS for pain:**



**4**

## STAGE 4

**Step through the doorway of HEALTH:**



**5**

## STAGE 5

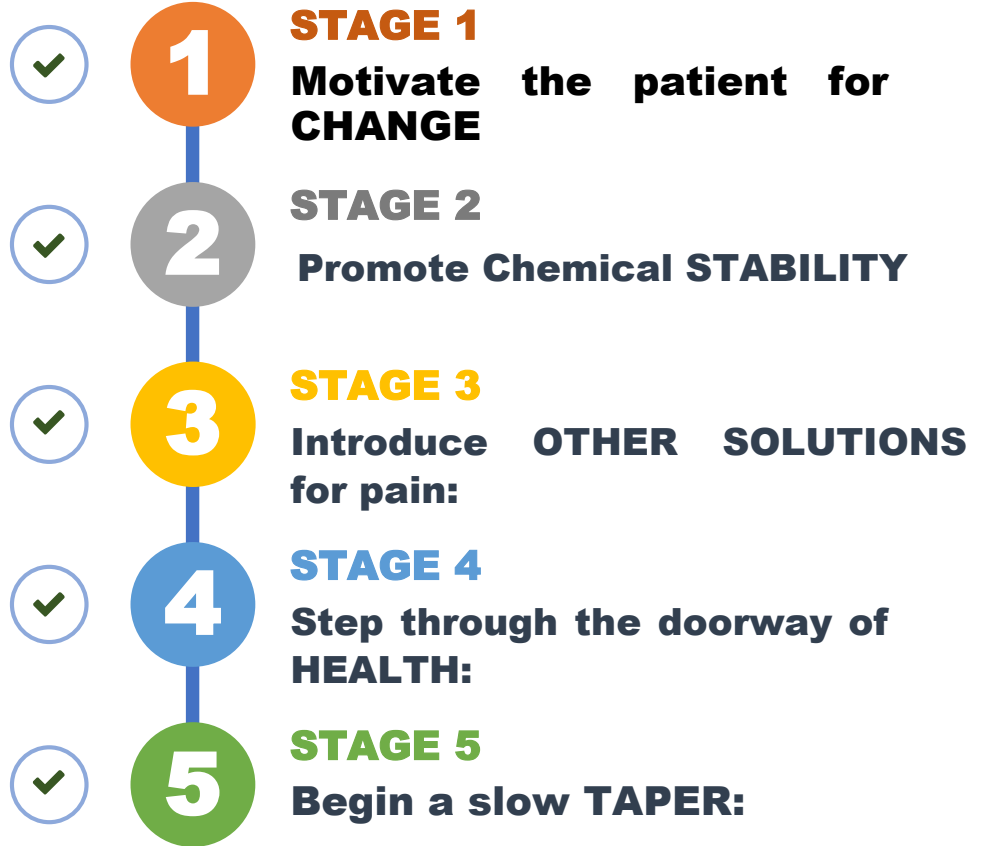
**Begin a slow TAPER:**

# Anti-inflammatory Diet



# Step-wise Solution

Pain and Chemical Dependency  
Roller-Coaster



# Case of Opioids + Stimulants

**32 yo female pt with hx of IV heroin use x 4 yrs along with methamphetamines. She is homeless and has a history of diagnosed bipolar and admits to using heroin and meth to keep her mood stable. She uses heroin and meth with her boyfriend. Pt has a history of multiple overdoses**



# Harm Reduction vs Relapse Prevention or Both?

## Barriers to relapse prevention

- **Homeless**
- **Transportation**
- **Lack of support**
- **Partner uses**
- **Multiple substances**



# Opioid Free, still on Meth



**Pt was inducted with buprenorphine and was accepted to a residential treatment facility funded by the County coordinated by the Homeless Outreach Program. On the day of admission, the pt did not want to leave her boyfriend and declined. She continued the MAT program and continues to test negative for opioids, but positive for methamphetamines. She continues to decline behavioral health therapy, but agreed to taking lamotrigine, and risperidone.**

**Do we continue prescribing buprenorphine when she doesn't follow the requirements of the program?**

# The Matrix Model

**Group Psychotherapy**

Individual Counseling

Family Therapy

**Contingency Management**

Crystal Methamphetamine Anonymous

**Treatment of Co-occurring Disorders**





# Contingency Model

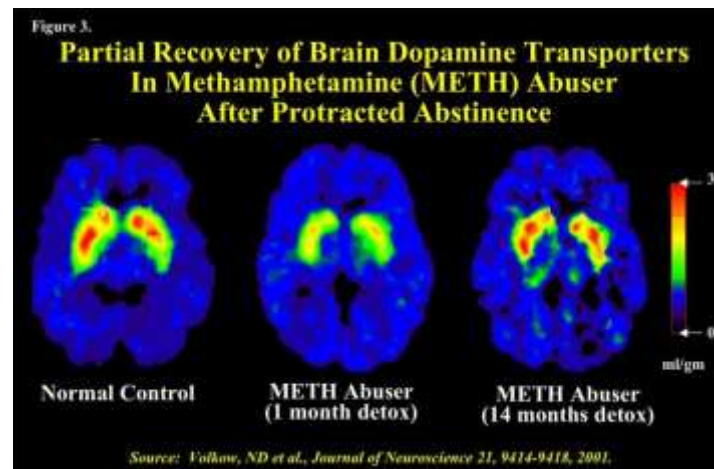
Highly effective in increasing treatment retention and promoting abstinence

## Positive reinforcement

- Congratulate on successes
  - Showing up to appointments
  - Highlight urine drug screen free of opioids

Tangible rewards to reinforce positive behaviors

Voucher-based or prize incentives



# Why Primary Care or MAT

**We see many of these patients in primary care already**

**Many have barriers to care (e.g., transportation)**

**Treat the whole person - one stop shop**

**High percentage of co-occurring mental health illness**

**Diagnosis and treatment of comorbid diseases such as HIV, Hep C, and STDs**



# Which of the following is a removable barrier to integrating SUD treatment into primary care?

- a. **Induction process**
- b. **Staffing shortage**
- c. **Money**
- d. **Team motivation**
- e. **All of the above**



**According to Project Match, which behavioral treatment is appropriate for use in a wide range of people with EtOH use disorder?**

- a. Cognitive Behavioral Therapy (CBT)**
- b. 12 Step Facilitated Treatment (TSF)**
- c. Motivation Enhancement Treatment (MET)**
- d. All of the above**



# Which of the following is an inferior option for treatment of Opioid Use disorder during pregnancy

- A) Buprenorphine**
- B) Methadone**
- C) Naltrexone/ Abstinence**
- D) None of the above**
- E) All of the Above**

# True or False?

**Group Sessions for Patient slow down the practice, reduce volume, and provide little revenue generation.**



# References

Matching Patients with Alcohol Disorders to Treatments: Clinical Implications from Project Match; Journal of Mental Health, 1998

Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure; Jones, H. et al; The New England Journal of Medicine; 2010; 363: 2320-31

A comparison of buprenorphine induction strategies: patient-centered home-based inductions versus standard-of-care office-based inductions; Cunningham, C. et al; Journal of Substance Abuse Treatment; 2011; 40(4): 349-356

Transdermal Buprenorphine, Opioid Rotation to Sublingual Buprenorphine and Avoidance of precipitated Withdrawals: A review of literature and Demonstration of Three Chronic Pain Patients treated with Butrans; Howard, K. et al; Journal of Therapeutics; 2015; Vol 22 Issue 3 pg199-205

Hudak ML, Tan RC, Committee on Drugs, et al. Pediatrics. 2012;129:e540-60

[Hendrée E. Jones](#), Ph.D., [Gabriele Fischer](#), M.D., [Sarah H. Heil](#), Ph.D., [Karol Kaltenbach](#), Ph.D., [Peter R. Martin](#), M.D., [Mara G. Coyle](#), M.D., [Peter Selby](#), M.B.B.S., [Susan M. Stine](#), M.D., Ph.D., [Kevin E. O’Grady](#), Ph.D., and [Amelia M. Arria](#), Ph.D. Maternal Opioid Treatment: Human Experimental Research (MOTHER)-Approach, Issues, Lessons Learned. Addiction. 2012 Nov;107(01):28-35. doi: [10.1111/j.1360-0443.2012.04036.x](https://doi.org/10.1111/j.1360-0443.2012.04036.x)

Deborha E Boatwright BSP Pharm, JD. Buprenorphine and Addiction: Challenges for the Pharmacist. Journal of American Pharmaceutical Association. [Volume 42, Issue 3](#), May–June 2002, Pages 432-438. <https://doi.org/10.1331/108658002763316860>