A Model to Provide Medication-Assisted Treatment for Opioid Use Disorder in a Rural Residency Clinic

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Introduction

- Wisconsin experienced 16.9 opioid-related deaths/100,000 persons in 2017, higher than the national average[1]
- Medication-assisted treatment (MAT) with buprenorphine/naloxone is effective for opioid use disorder (OUD)[2,3,4]
- 60% of rural counties lack a physician able to prescribe buprenorphine[5]
- Barriers that limit widespread use of MAT in rural clinics include time constraints, lack of behavioral health resources, and specialty care support[5]
- The UW Belleville Family Medicine clinic provides MAT, partners with a county-level AODA program and has access to a state-wide tele-medicine program

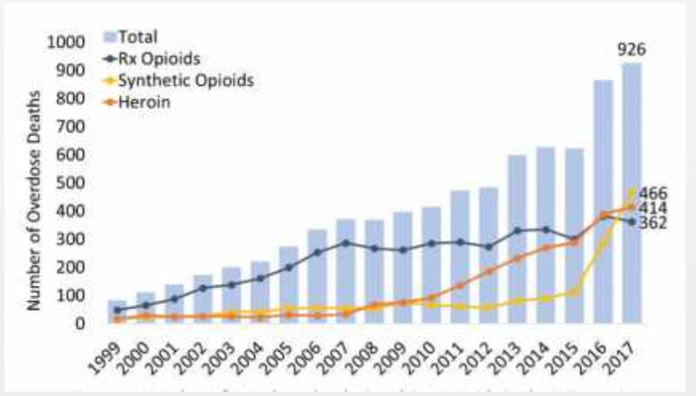


Figure 1. Number of overdose deaths involving opioids in Wisconsin, by opioid category. Drug categories presented are not mutually exclusive, and deaths might have involved more than one substance. Source: CDC WONDER

Objective

- Assess initial quality outcomes in a new rural MAT program designed to address three barriers limiting widespread uptake of MAT: time constraints, lack of behavioral resources, and lack of specialty care support

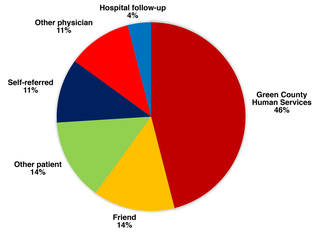
Methods

- For non-pregnant adults with moderate-to-severe OUD, MAT was provided with behavioral therapy as needed, which included referral to county-level AODA services
- MAT providers had access to continuous addiction medicine phone consultation and a state wide tele-medicine program (Project ECHO)
- If buprenorphine induction was recommended, this was done with at-home induction, if not contraindicated, using RN telecommunication and administration of the subjective opioid withdrawal scale (SOWS)
- Primary outcomes
  - MAT retention at 3 months
  - MAT retention at 6 months
  - Monthly relapse rates (urine drug screen or patient report) within each of the first 6 months of treatment
- Secondary outcomes
  - Access to care (days between first contact and first appointment)
  - Involvement in any form of behavioral health

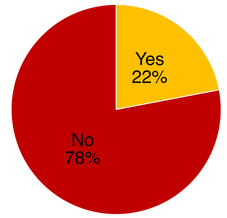
Patient Characteristics

- From July 2018 to May 2019, 32 patients (34±9.9 years; 28% female) met criteria for moderate-to-severe opioid use disorder and were treated using MAT

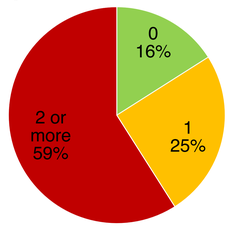
Referral Source



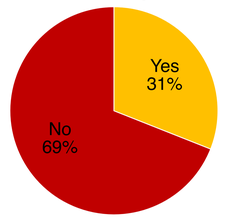
Concurrent Chronic Pain Diagnosis



Psychiatric Co-morbidities



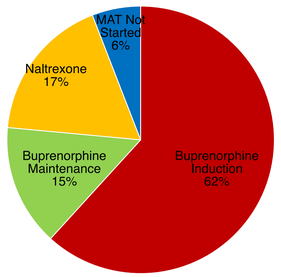
Co-morbid Hepatitis C



Intake Visit

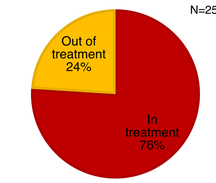
- As of May 2019, 5 of 9 residents and 6 of 6 faculty had buprenorphine waiver
- Standard note template to discuss:
  - Opioid use history, longest period of abstinence, barriers to stop use
  - Substance use contacts, legal issues, motivators to quit, support system
  - Other substance use, treatment history
  - Psychiatric history
- DSM V Criteria for diagnosis of moderate-to-severe opioid use disorder
- Discussion of MAT options – buprenorphine, naltrexone, methadone
- Rx for naloxone
- Referral to Green County AODA or therapy if indicated
- Labs – CMP, Hep B, Hep C, HIV, INR, UDS
- If buprenorphine – in-clinic induction vs home induction

Intake Visit Treatment Plan

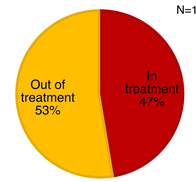


Primary Outcomes

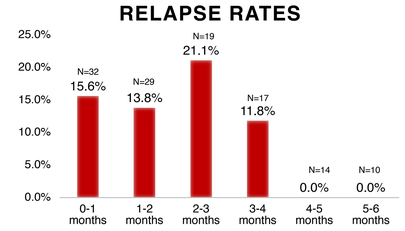
3 MONTH RETENTION RATE



6 MONTH RETENTION RATE

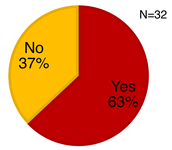


RELAPSE RATES



Secondary Outcomes

ENGAGEMENT IN BEHAVIORAL HEALTH



ACCESS TO CARE

- Mean = 10 days ± 11.5 days
- Median = 7 days

Conclusions

- Initial data suggest this model is able to address the barriers to providing MAT in a rural setting
- Further longitudinal data will help evaluate quality MAT metrics

References

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Funding

UW-Madison Department of Family Medicine and Community Health

Conflicts of Interest

None

UW Health

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN-MADISON