

Primary Care Provider Role in SUD Screening, Prevention, and Treatment

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Honoraria:

- Panelist for Providers Clinical Support System-Exchange webinar series

Learning Objectives

- Understand why substance use is relevant to primary care
- Know that screening for substance use is recommended by the USPSTF
- Learn that there are team-based approaches to addressing substance use in primary care

Survey

My clinic uses a screening tool to assess substance use for adults?

A. Always

B. Sometimes

C. Never

D. I don't know

Why are we here?

Top risk factors for early disability or death

All ages

1 High systolic blood pressure
2 Smoking
3 High fasting plasma glucose
4 Low birthweight
5 High body-mass index
6 Short gestation
7 Ambient particulate matter
8 High LDL cholesterol
9 Alcohol use
10 Household air pollution

Age 25-49

1 Alcohol use
2 High systolic blood pressure
3 High body-mass index
4 Smoking
5 Unsafe sex
6 High fasting plasma glucose
7 High LDL cholesterol
8 Drug use
9 Ambient particulate matter
10 Kidney dysfunction

(Murray) Lancet 2020

1-Year Prevalence of Drug Use

National Survey on Drug Use and Health – 2020

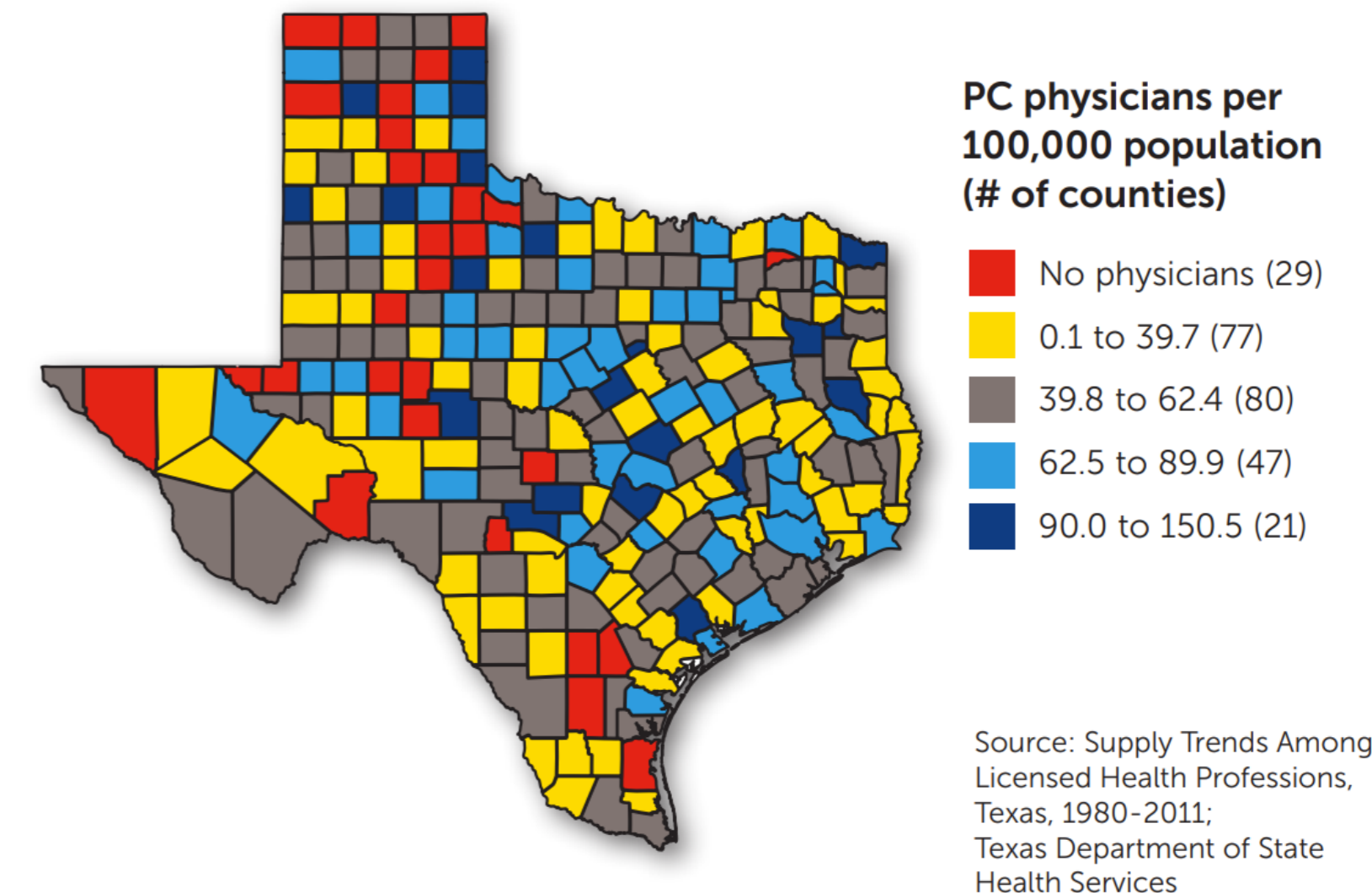
Alcohol Use	~ 176 million
Alcohol Dependence	1:20
Cocaine Use	~ 4.8 million
Cocaine Dependence	1:9
Heroin Use	~ 0.94 million
Heroin Dependence	<1:2
Marijuana	~ 48 million
Marijuana Dependence	1:14
Prescription Opioids	~75 million
Rx Opioid Dependence	1:58
Methamphetamine	~ 2.2 million
Methamphetamine Dependence	1:2

NSDUH 2020

Lots of people access primary care

- 82% of Americans visited a doctor or health professional last year
 - Half of visits (500 million) to a primary care provider
 - Primary care visits are for
 - 1/3 prevention
 - 1/3 new problem
 - 1/3 chronic problem
- Texas has 22,000 primary care physicians
 - 212 primary care providers/100,000
 - 47th in access to primary care in the US

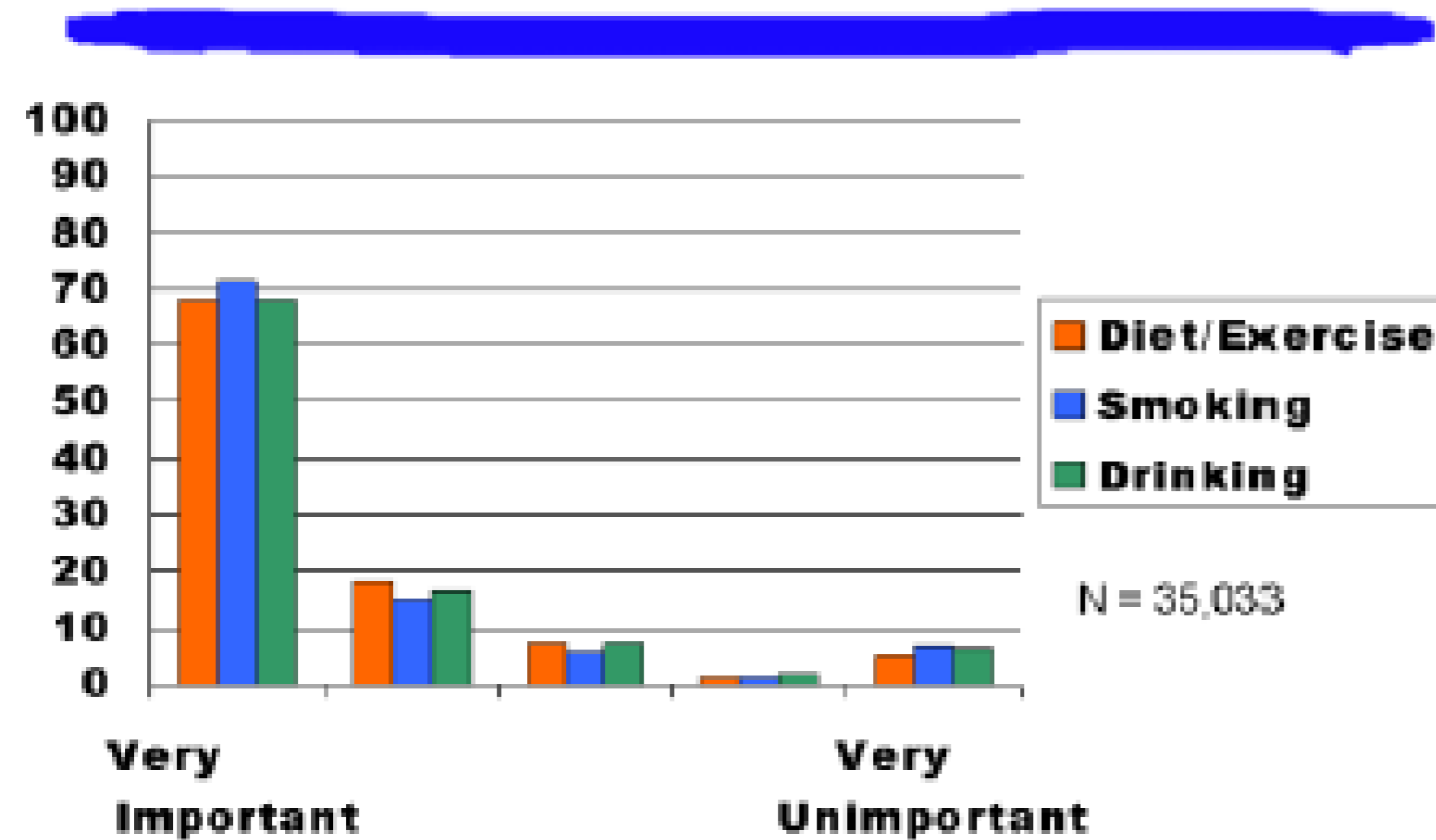
Primary care physicians per 100,000 population, 2011



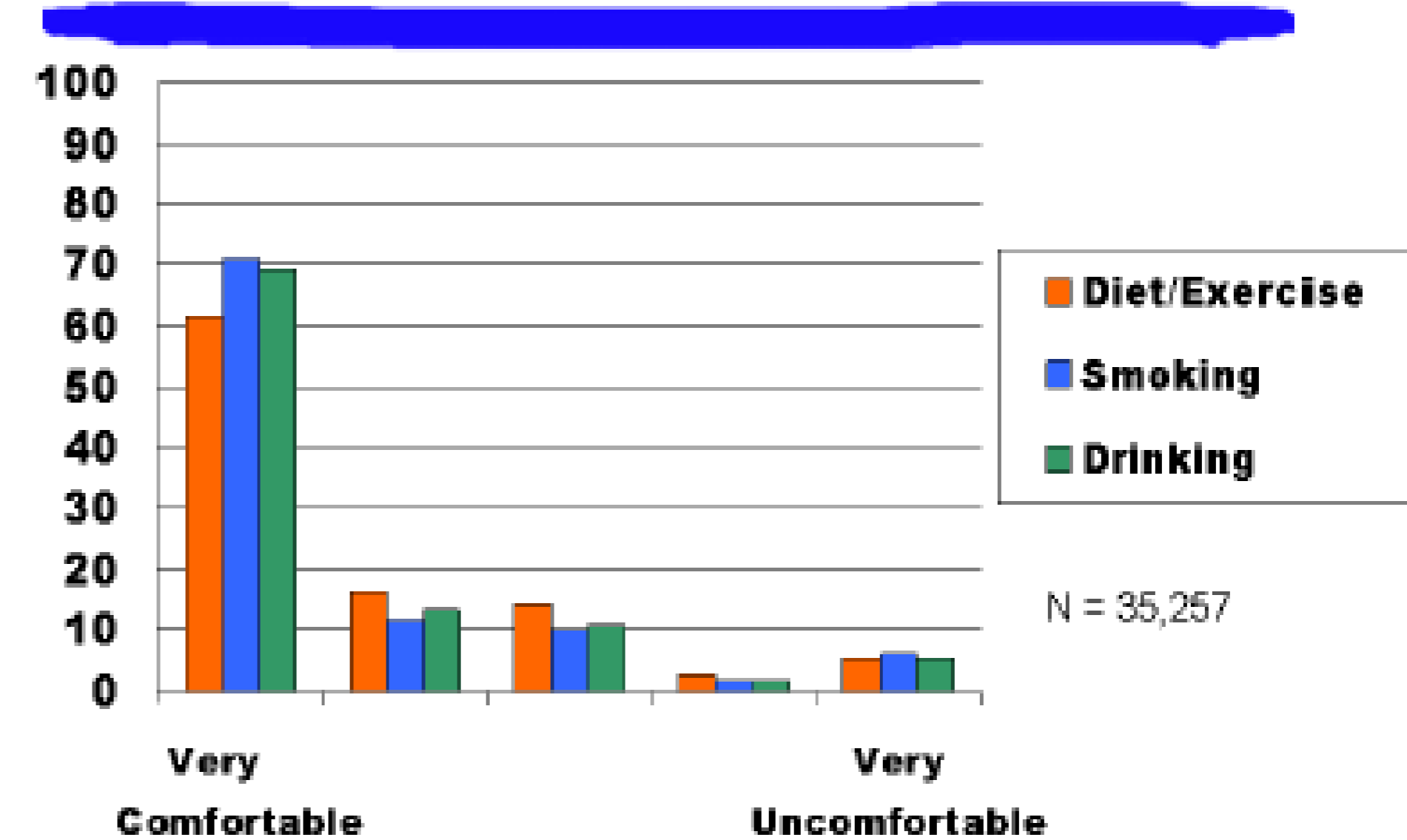
U.S. National Plan and Provider Enumeration System, September 2022; <https://www.cdc.gov/nchs/fastats/physician-visits.htm>; US Census Health Status and Medical Services Utilization: 2013, 2018

Patients don't mind

Patient Sense of Importance



Patient Comfort—Cutting Back



RWJ Cutting Back Study 2004

*Jennifer
McNeely,
MD MS*

Feasibility of Implementing Alcohol and Drug Screening in Primary Care

Screening for Unhealthy Drug Use

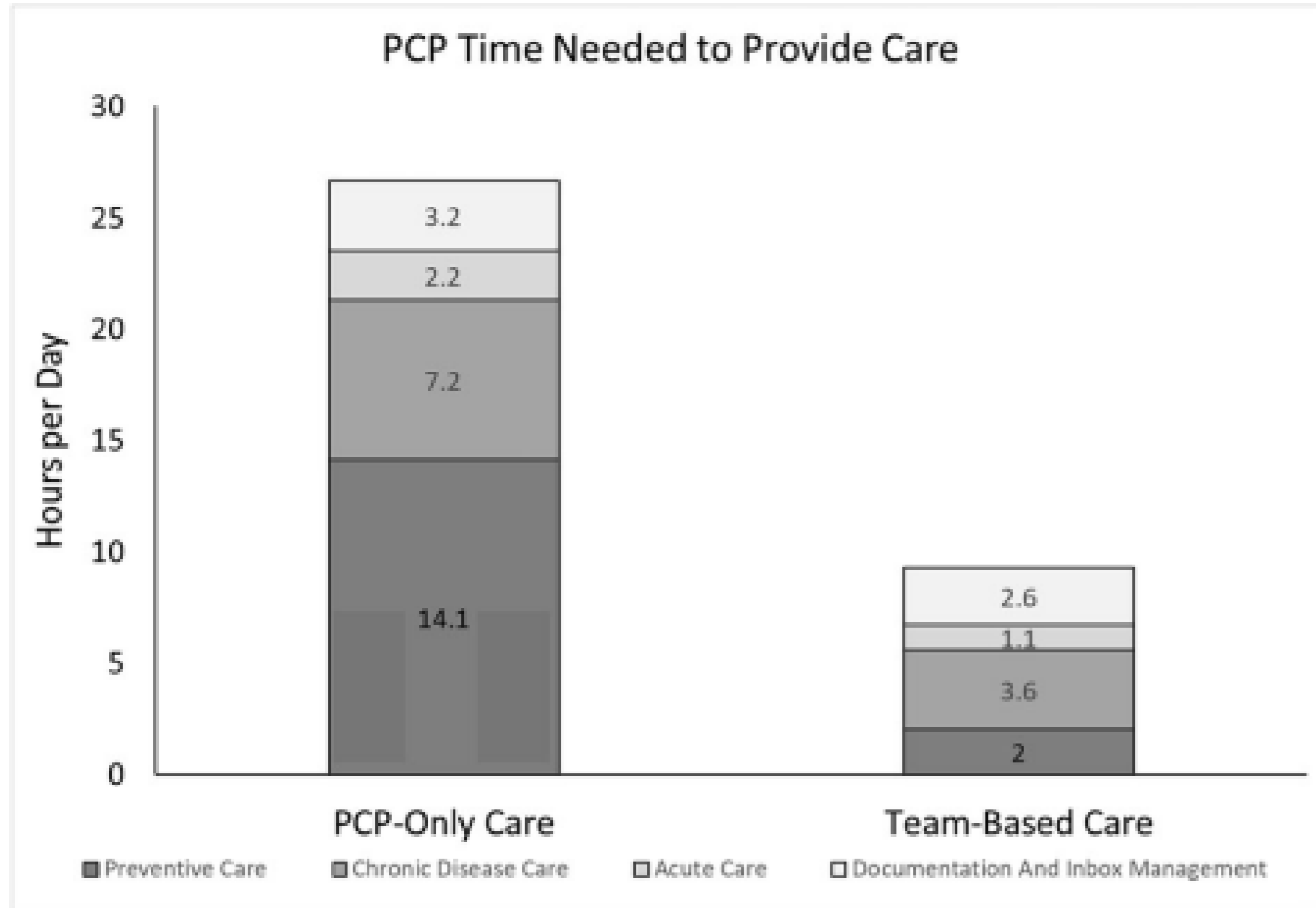
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

- Adults 18 or older
- Seen in settings where services for diagnosis, treatment, and care can be provided or referred
- No recommendation on frequency



There isn't enough time



Porter et al, JGIM 2022

Table 1 Estimated Time Needed to Provide Guideline-Based Preventive and Chronic Disease Care for an Average US 2500 Adult Patient Panel

		Team-based care*		Strength of evidence for time estimates ^b
		PCP time (h/day)	Non-PCP time (h/day)	
Preventive care services	Weight loss to prevent obesity-related morbidity and mortality in adults: counseling	4.11	3.77	Strong
	Healthy diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: behavioral counseling interventions	2.36	2.16	Moderate
	Unhealthy alcohol use in adults: counseling	1.77	1.48	Strong
	Abnormal blood glucose and type 2 diabetes mellitus: counseling	1.39	1.27	Moderate
	Tobacco smoking cessation in adults: counseling	0.89	0.74	Strong
	Sexually transmitted infections: behavioral counseling	0.74	0.62	Strong
	Unhealthy drug use: counseling	0.47	0.39	Strong
	Depression in adults: screening	0.31	0.31	Moderate
	Intimate partner violence, elder abuse, and abuse of vulnerable adults: counseling	0.18	0.17	Strong
	Statin use for the primary prevention of cardiovascular disease in adults: counseling	0.18	0.00	Strong
	Weight loss to prevent obesity-related morbidity and mortality in adults: screening	0.17	0.17	Strong
	Unhealthy alcohol use in adults: screening	0.17	0.17	Strong
	Tobacco smoking cessation in adults: screening	0.17	0.17	Strong
	Unhealthy drug use: screening	0.17	0.17	Strong
	Cervical cancer: screening	0.15	0.09	Moderate
	Hypertension in adults: screening	0.12	0.12	Weak
	Lung cancer: screening	0.10	0.00	Moderate
	Statin use for the primary prevention of cardiovascular disease in adults: screening	0.09	0.00	Strong
	Depression in adults: referral	0.09	0.09	Moderate
	Influenza vaccine	0.09	0.09	Weak
	Falls prevention in community-dwelling older adults: screening	0.07	0.00	Moderate
	Intimate partner violence, elder abuse, and abuse of vulnerable adults: screening	0.05	0.05	Strong
	Skin cancer prevention: behavioral counseling	0.05	0.00	Moderate
	Latent tuberculosis infection: screening	0.03	0.03	Moderate
	Colorectal cancer: screening	0.03	0.00	Strong
	Abnormal blood glucose and type 2 diabetes mellitus: screening	0.03	0.03	Moderate
	Breast cancer: screening	0.02	0.00	Moderate
	Screening for chlamydia	0.01	0.01	Moderate
	Screening for gonorrhea	0.01	0.01	Moderate
	Hepatitis B virus infection in adults: screening	0.01	0.01	Moderate
Prevention of human immunodeficiency virus infection: preexposure prophylaxis	0.01	0.00	Moderate	
Tetanus, diphtheria, pertussis vaccine	0.01	0.01	Weak	
Osteoporosis to prevent fractures: screening	0.01	0.00	Moderate	
Screening for syphilis infection in nonpregnant adults	0.01	0.01	Moderate	
Aspirin use to prevent cardiovascular disease and colorectal cancer: counseling	<0.01	0.00	Strong	
Human papillomavirus vaccine	<0.01	<0.01	Weak	
Aspirin use to prevent cardiovascular disease and colorectal cancer: screening	<0.01	0.00	Strong	
Hepatitis C virus infection in adults: screening	<0.01	<0.01	Moderate	
Immunodeficiency Virus infection: screening	<0.01	<0.01	Moderate	
Folic acid for the prevention of neural tube defects: preventive medication	<0.01	0.00	Moderate	
Abdominal aortic aneurysm: screening	<0.01	0.00	Strong	
Pneumococcal conjugate vaccine	<0.01	<0.01	Weak	
Pneumococcal polysaccharide vaccine	<0.01	<0.01	Weak	
Zoster recombinant vaccine	<0.01	<0.01	Weak	

Rankings of Preventive Service

1. Childhood immunization
2. Smoking prevention/cessation
3. Aspirin
4. Alcohol screening & intervention
5. Cervical cancer screening
6. Colorectal cancer screening
7. Chlamydia and gonorrhea screening
8. Cholesterol screening
9. Hypertension screening & treatment
10. AAA screening

Maciosek et al. 2017; Solberg et al. 2008



<https://twitter.com/astros/status/1568281636948566016>

Survey

My clinic provides collaborative care?

A. For all patients

B. Only for certain diagnoses

C. No

D. I'm not sure what collaborative care is

*Katharine
Bradley,
MD MPH*

**Lessons Learned and Unanswered Questions from
Trials of Collaborative Care for Alcohol and
Substance Use Disorders**

Physicians can't do it alone

- Collaborative care models
 - Systematic assessment
 - Non-physician care manager
 - Guideline based care
 - Available specialist for recommendations
- Depression and poorly controlled diabetes/cardiovascular disease
 - Improved measures of both
 - Improved quality of life
 - Improved treatment satisfaction

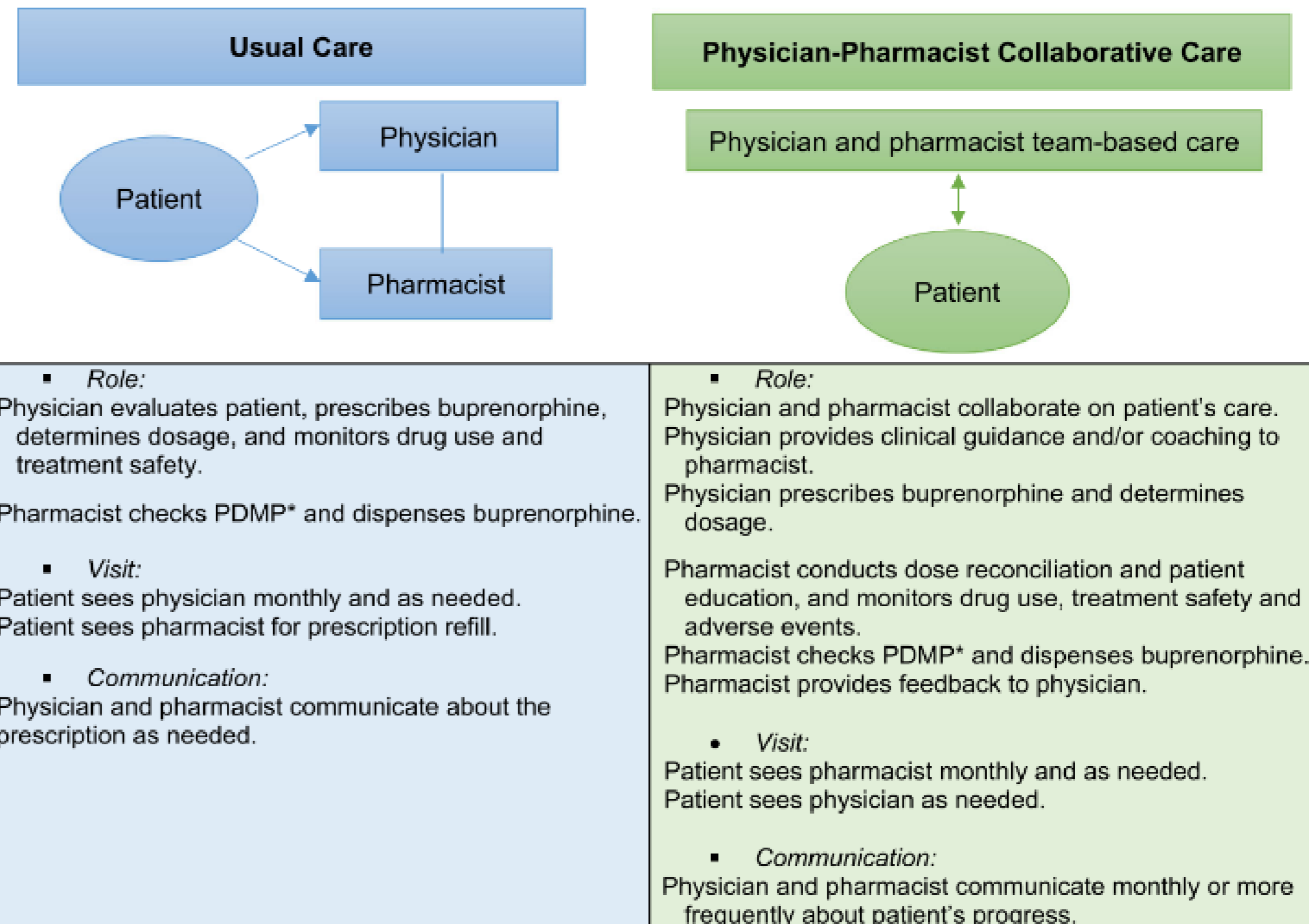
Katon et al. NEJM 2010

*Lisa
Marsch
PhD*

Pharmacist-integrated Collaborative Care in OUD Treatment

Pharmacies can do more than dispense medications

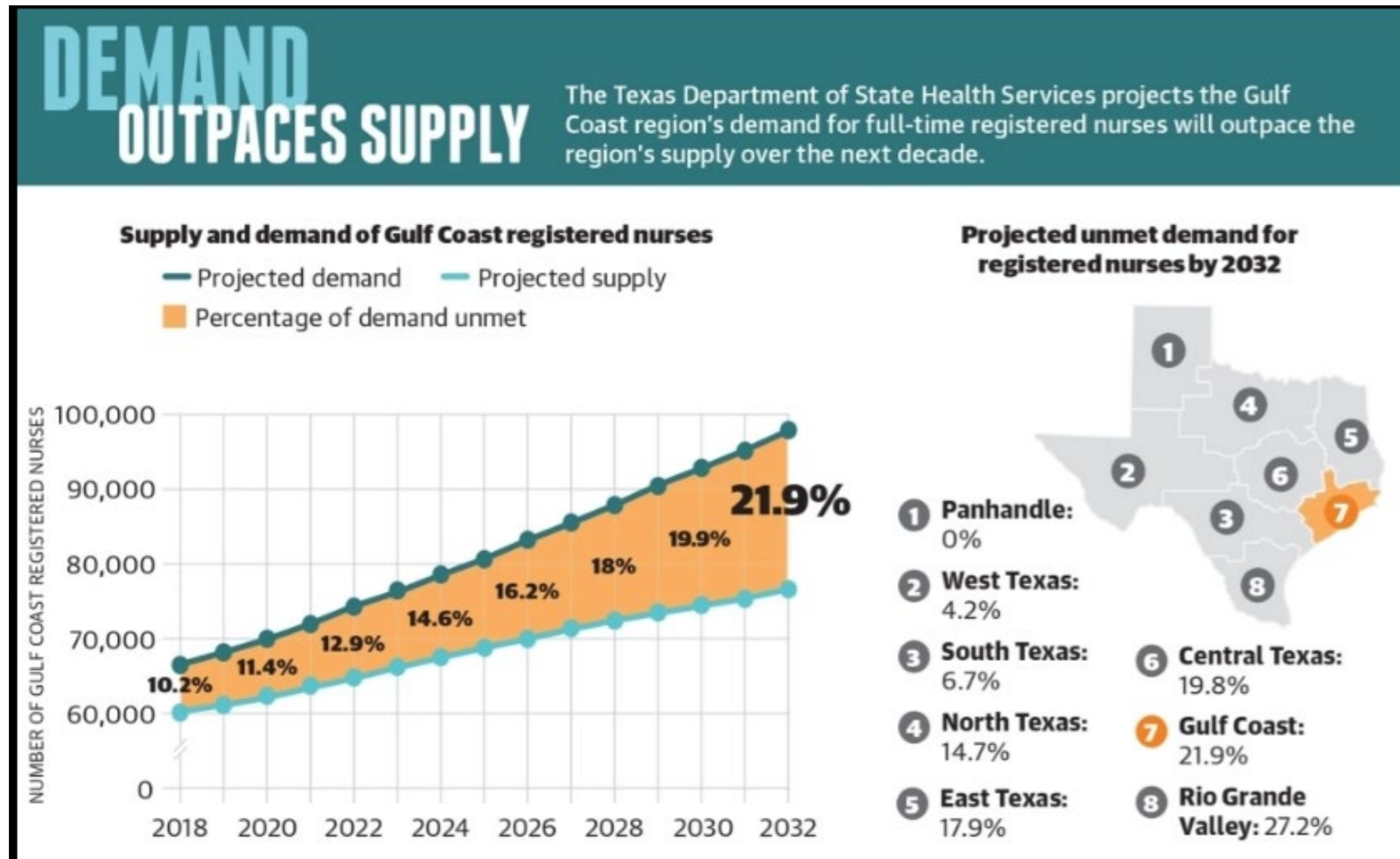
- Pharmacists are highly trusted
- 89% of Americans live within 5 miles of a pharmacy
- Pharmacists already manage controlled substances
- Pharmacists counsel about medications
- Pharmacists can screen for OUD



*PDMP: Prescription Drug Monitoring Program

Cochran et al. 2021; Wu et al. 2021

It is hard to have collaborative care when no one has bandwidth



Ronald Winters/Community Impact Newspaper June 28, 2021; CBS News January 30, 2023

Can we automate or technologically assist SUD screening and intervention in primary care?

Bart et al. *Addict Sci Clin Pract* (2020) 15:4
<https://doi.org/10.1186/s13722-020-0180-2>

Addiction Science &
Clinical Practice

Rossom et al. *Addict Sci Clin Pract* (2021) 16:37
<https://doi.org/10.1186/s13722-021-00245-7>

Addiction Science &
Clinical Practice

MEETING REPORT

Open Access

Developing a clinical decision support for opioid use disorders: a NIDA center for the clinical trials network working group report

Gavin B. Bart^{1*}, Andrew Saxon^{2,3}, David A. Fiellin⁴, Jennifer McNeely⁵, John P. Muench⁶, Christopher W. Shanahan⁷, Kristen Huntley⁸ and Robert E. Gore-Langton⁹



RESEARCH

Open Access

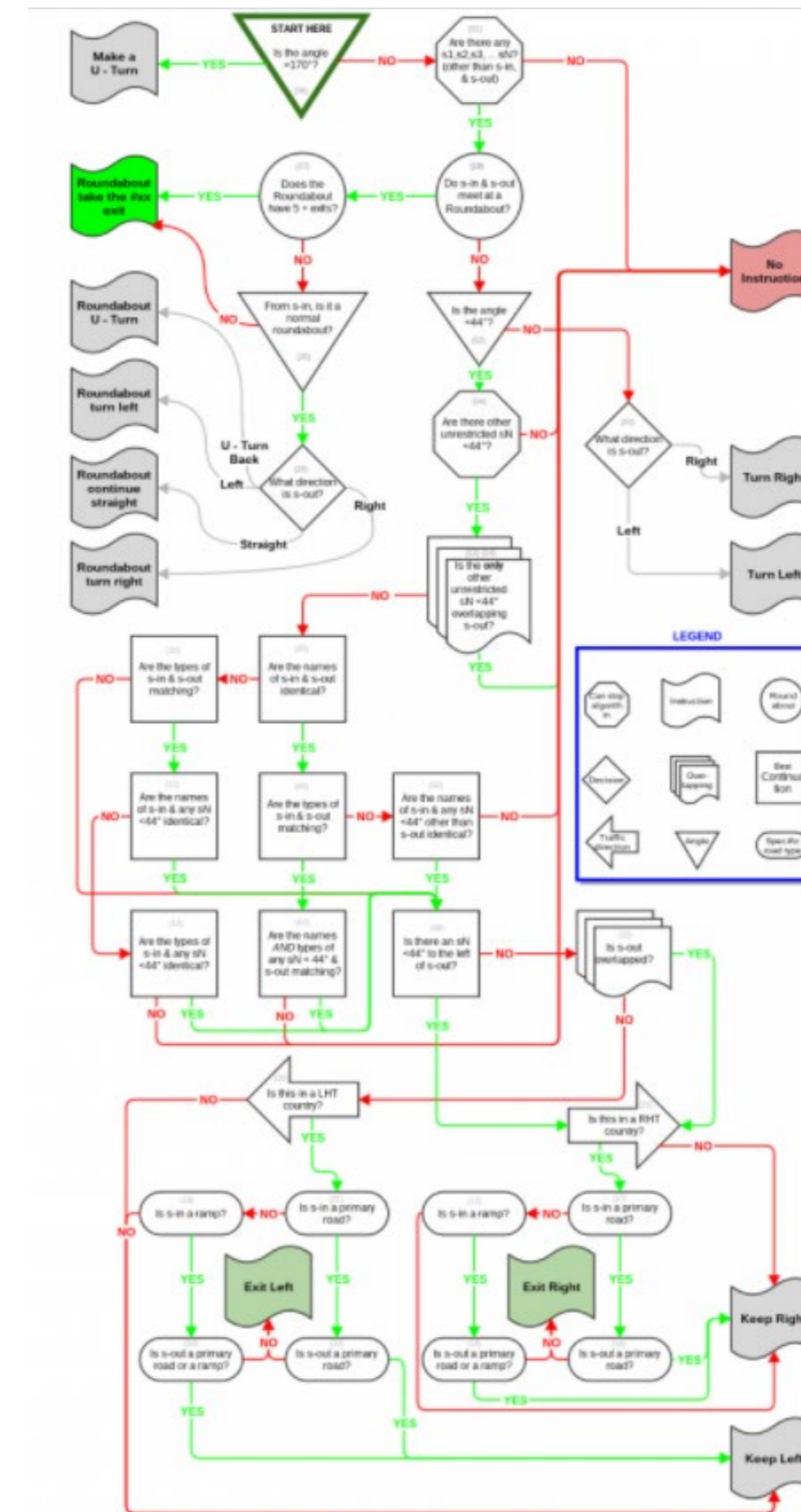
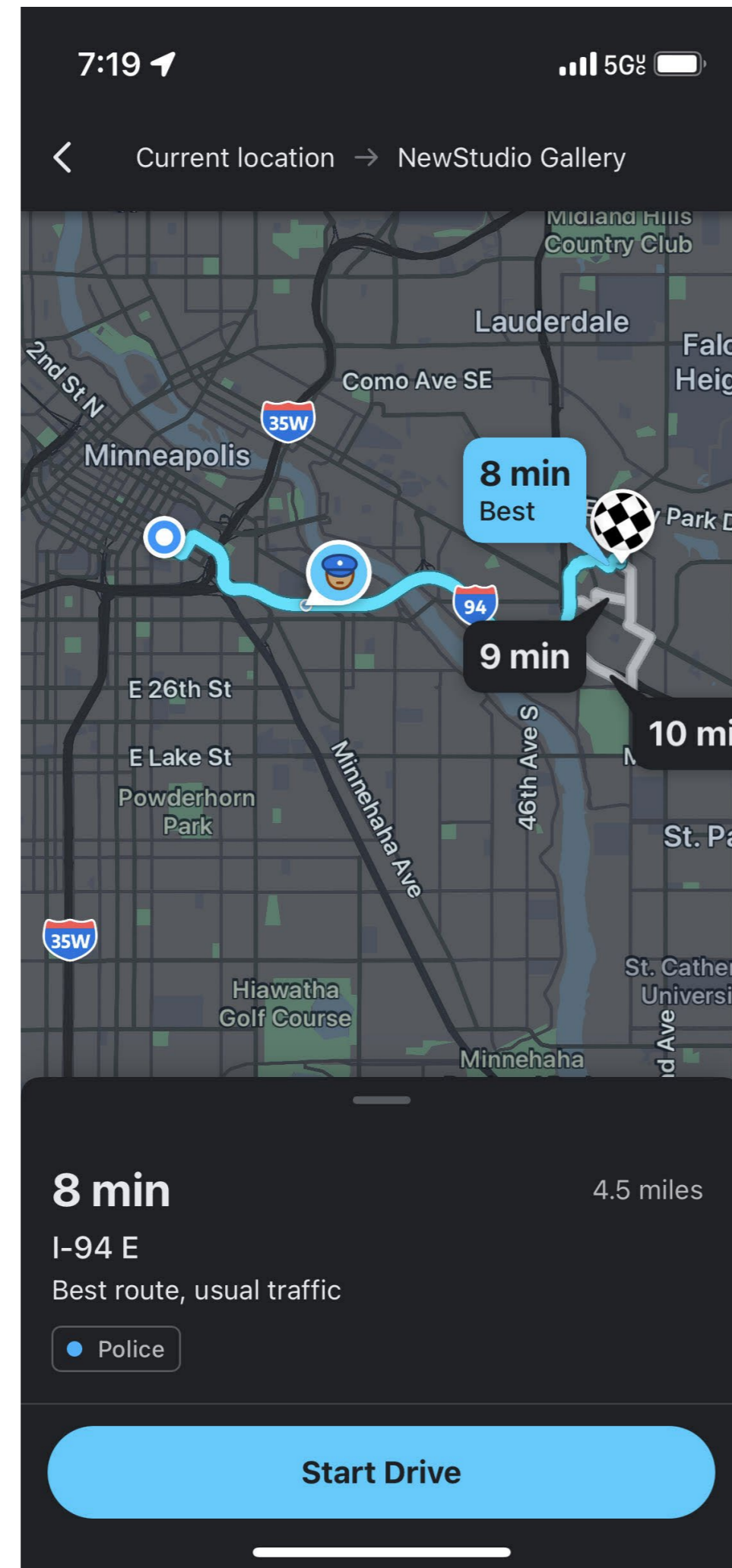
A pilot study of the functionality and clinician acceptance of a clinical decision support tool to improve primary care of opioid use disorder

Rebecca C. Rossom^{1,2*}, JoAnn M. Sperl-Hillen¹, Patrick J. O'Connor¹, A. Lauren Crain¹, Laurel Nightingale¹, Anne Pylkas^{3,4}, Kristen V. Huntley⁵ and Gavin Bart^{2,6}



Bart et al. 2020; Rossom et al. 2021

Automating complex decisions in real-time



Pilot Interface

PRIORITYWIZARD
for HealthPartners

Alerts

- **Make sure the patient has a rescue kit. If they do not, order it here.** | [View PCMP for this patient](#)

Screening

▶ **TAPS Opioid & Heroin Survey (opio score: 2, heroin score: 2, on 4/25/2018)**
Your patient has screened positive for opioid use disorder (OUD). Please complete the ODM survey to determine if he or she has OUD.

▶ **ODM Survey (ODM score: 7 on 4/25/2018)**
Your patient meets criteria for opioid use disorder.

Is patient interested in and ready for treatment?
 yes no

Treatment: Suboxone initiation

Relevant diagnosis:
None

Relevant labs:

None

Relevant current medications:
None

Clinical Opiate Withdrawal Scale:
 Score: none
 Date/time: Not administered within the last 12 hours

Educational Materials for Patients
[Suboxone Handout](#)

Important treatment considerations

- Refer patients with chronic pain to the pain clinic for pain management in parallel with their opioid use disorder treatment.

Do you want to perform an in-clinic induction or an at-home induction?
 In-clinic At-home

Recommendations

- It is critical that patient is in withdrawal before prescribing suboxone. Please administer the COWS questionnaire. Patient should score 5 or greater to begin suboxone.
- Order LFTs
- Order Suboxone 2mg if patient is has a low tolerance for opioids
- Order Suboxone 4mg if patient is has a high tolerance for opioids
- Print at-home induction instructions (2mg starting dose)
- Print at-home induction instructions (4mg starting dose)
- Consider order for Clonidine for breakthrough withdrawal symptoms for patients without hypotension
- Consider order for Zulfen for breakthrough withdrawal symptoms
- Refer patient for additional chemical dependency resources
- Patient should return to clinic in one week.

Treatment selection

Answers below have been completed based on electronic health record data, but please change the answers if they are incorrect or outdated.

Is the patient pregnant?
 yes no

Does the patient have severe liver disease?
 yes no

Does the patient have severe respiratory disease?
 yes no

Does the patient have any alcohol use disorder? (To screen your patient for alcohol use disorder, use the TAPSQ)
 yes no

Does the patient use benzodiazepines?
 yes no

Does the patient have chronic pain?
 yes no

Is the patient at risk for suicide?
 yes no

Educational Materials for Patients

- [Treatment Option Overview](#)
- [Suboxone Handout](#)
- [Methadone Handout](#)
- [Naltrexone Handout](#)

Suboxone in primary care

GO

- Suboxone has the best evidence for successfully treating OUD in primary care (on par with IM naltrexone, which is only available in specialty care, and methadone, which is only available in community methadone clinics), but is only available to wavered prescribers. [Click here for guidance on prescribing](#)

Suboxone in specialty care

GO

- If your patient opts for suboxone but you are not wavered to prescribe it and do not have a wavered provider in your clinic to refer your patient to, or if your patient has a relative contraindication to suboxone such as alcohol use disorder, you can refer your patient to specialty addiction care to receive suboxone here

Oral Naltrexone

Warning

- Oral naltrexone can be prescribed by any prescriber, but it does not tend to be as effective as suboxone (which requires a DEA waiver), IM naltrexone (which is only available in specialty care), or methadone (which is only available in community methadone clinics). [Click here for guidance on prescribing](#)

IM Naltrexone

GO

- If your patient opts for naltrexone but has relative contraindications, such as severe liver disease, or if your patient would like to use IM naltrexone, you can refer your patient to specialty addiction care here

Methadone

GO

- Methadone is available in multiple clinics through the methadone program. [Print information on available methadone clinics here](#)



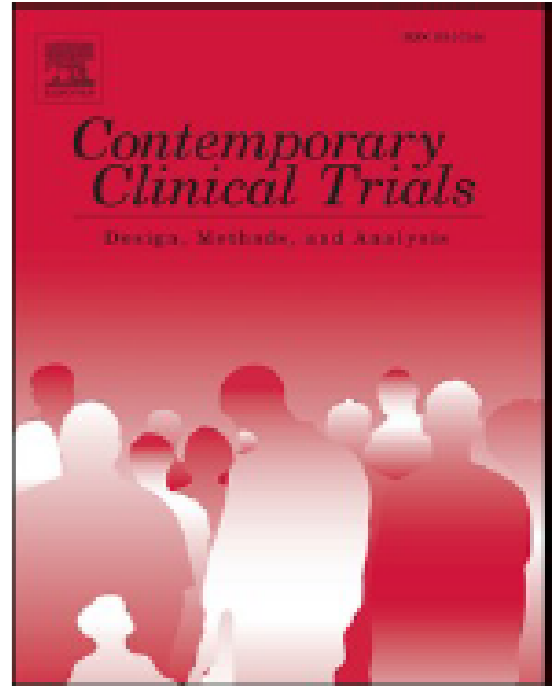


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Contemporary Clinical Trials

journal homepage: www.elsevier.com/locate/conclintrial



Design of a pragmatic clinical trial to improve screening and treatment for opioid use disorder in primary care

Rebecca C. Rossom^{a,*}, A. Lauren Crain^a, Patrick J. O'Connor^a, Eric Wright^b, Irina V. Haller^c, Stephanie A. Hooker^a, JoAnn M. Sperl-Hillen^a, Anthony Olson^c, Katrina Romagnoli^b, Leif Solberg^a, Steven P. Dehmer^a, Jacob Haapala^a, Caitlin Borgert-Spaniol^a, Lorraine Tusing^b, Jule Muegge^a, Clayton Allen^c, Heidi Ekstrom^a, Kristen Huntley^d, Jennifer McCormack^e, Gavin Bart^f



Rossom et al. 2023

Survey

Primary care is the right place for SUD screening, prevention, and treatment

- A. Strongly agree
- B. Agree
- C. Somewhat agree
- D. Somewhat disagree
- E. Disagree
- F. Strongly disagree

Thank You

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