

# Update in Addiction Medicine: The Important Role of Primary Care in Longitudinal Assessment and Treatment

Joint Mental Health Summit  
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# DISCLOSURES

- I have no personal fiduciary conflicts of interest
- I work full time for the University of Utah and Department of Veterans Affairs
- The views expressed in this presentation are solely my own and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government or any other university or organization

# OVERALL GOAL

Identify the critical roles that primary care providers have in the longitudinal assessment and treatment of patients with addictions

# OUTLINE

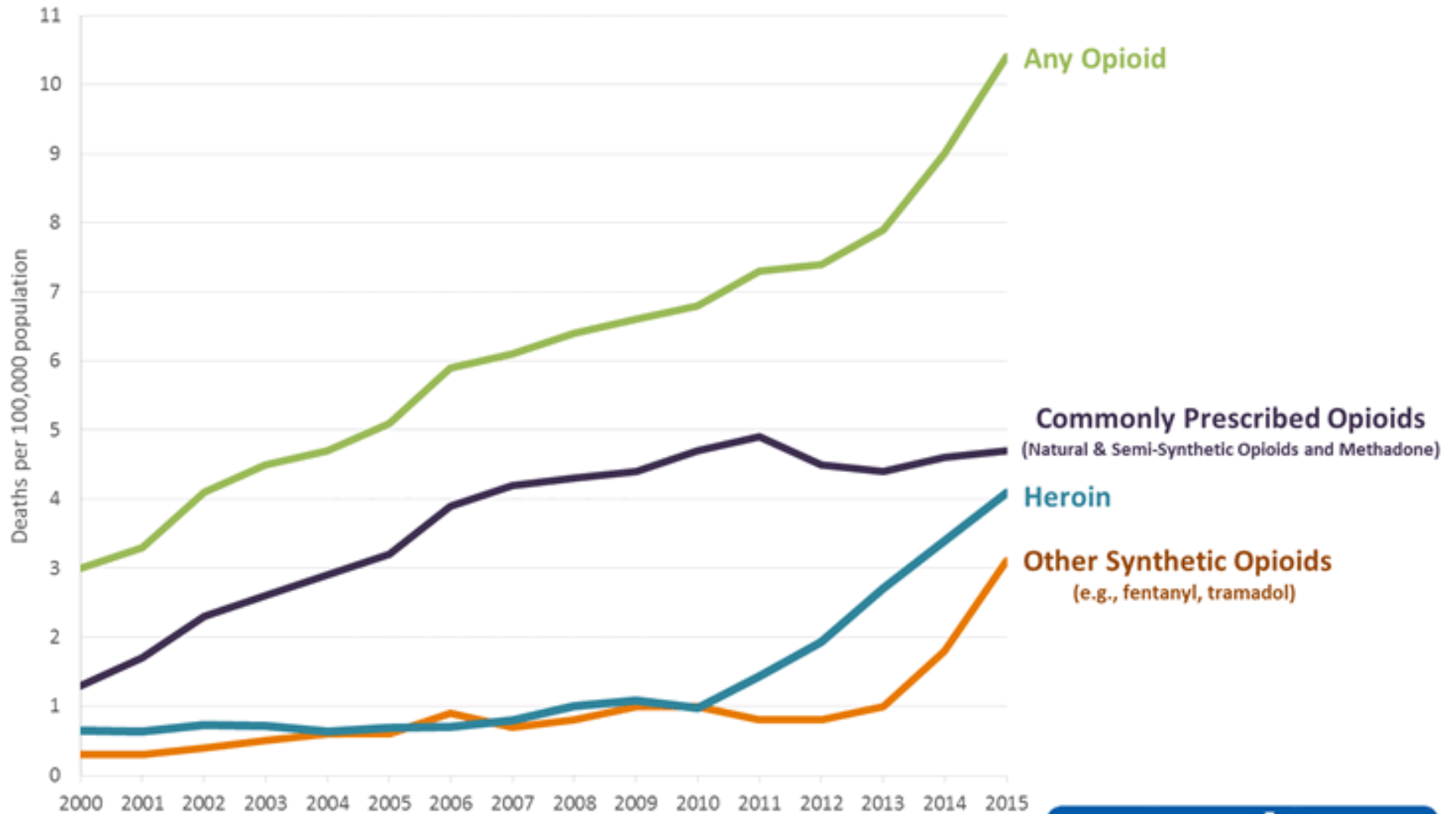
1. Why should primary care be concerned
2. Vexing issue: pain and addiction – current thoughts and policy implications
3. Success at access to medication treatment using buprenorphine for opioid use disorder
4. Is primary care the answer?
5. Pithy thoughts to help drive the policy debate...

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# OVERDOSE DEATHS IN THE US

## Overdose Deaths Involving Opioids, United States, 2000-2015



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA; US Department of Health and Human Services, CDC; 2016. <https://wonder.cdc.gov/>.

[www.cdc.gov](http://www.cdc.gov)  
Your Source for Credible Health Information

# YOUTH: SOME STAGGERING NUMBERS

- ~ 70% of high school students tried alcohol
- ~ 50% will have taken an illegal drug
- ~ 40% will have smoked a cigarette
  
- ~ 14%-20% will have used a prescription drug for a nonmedical purpose in prior year
  - 72% of those with non-medical use obtained them from home (6% from friends)

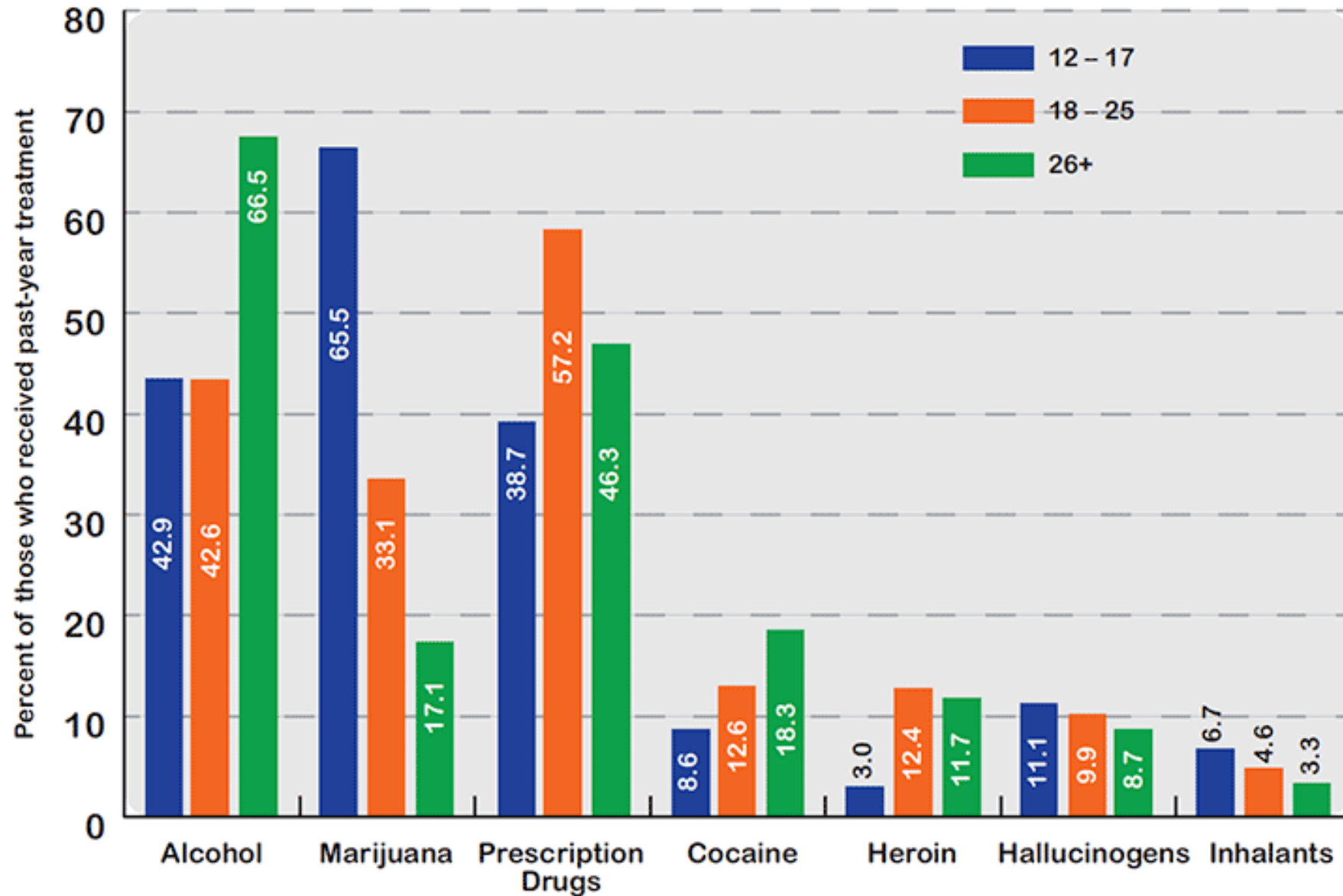
Johnston LD, et.al. Monitoring the Future National results on Adolescent drug use: Overview of Key findings, 2013

NIH/NIDA, Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide, 2014

Ontario Student Drug Use and Health Survey, 2011

Brands B et.al. Nonmedical use of opioid analgesics among Ontario students. Canadian Family Physician. Vol 56. 256-62. March 2010

# ADDICTION TREATMENT BY AGE



SAMHSA, Center for Behavioral Statistics and Quality, NSDUH, 2013

NIH/NIDA, Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide, 2014



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# THE ADDICTION-PAIN PROBLEM

- Telling the difference between a pain patient and a patient with drug use is not easy
  - What (really) is the pain?
  - Are there behavioral or mental health components
  - The patient may be new to a provider
  - The patient may be familiar to your peers – misconceptions and perceptions
- The provider may not be comfortable
  - in identifying and managing pain syndromes
  - in identifying and managing addictions

# THE PAIN-ADDICTION PRIMARY CARE CONUNDRUMS

- PCPs are confronted with **patient challenges**:
  - Prescription opioid misuse, opioid use disorders, and opioid related morbidity and death are increasing
  - Increased attention to pain and addressing pain
  - Increased mental health co-morbidity
- PCPs are confronted with **assessment and treatment challenges**:
  - Lack of education on opioid (and pain) assessment, treatment, referral
  - No uniform screening procedures (no evidence either)
  - Relative lack of access to pain/addiction referral resources
  - Patient preferences
  - Role out of collaborative care models (**VEXING!**)

# PRIMARY CARE ENVIRONMENT



*"Sometimes I think the collaborative process would work better without you."*

# THE PAIN CHALLENGE IN THE VA

- In Veterans, chronic pain is common
  - >50% of older Veterans experience chronic pain
    - 60% of Veterans from Middle East conflicts
    - Up to 75% of female Veterans have chronic pain
  - More than 2 Mil Veterans with  $\geq$  one pain diagnosis in VA (2012, 1/3 on opioids)
  - National Health Interview Survey (NHIS) (2016)
    - 66% of Veterans vs. 56% of non-veterans with pain in prior 3 months
- In Veterans, chronic pain is often severe
  - 9.1% of Veterans vs 6.3% of non-veterans with severe pain
  - 7.8% of younger veterans vs 3.2% of non-veterans with severe pain, with an Odds Ratio of 3.1 after controlling for other risk factors.

# PRESCRIPTION OPIOID USE & OPIOID USE DISORDER

- Prescription opioid therapy for pain in (Q1 FY 2017):
  - 281,020 Veterans on long-term opioid therapy
  - 33,149 Veterans on high dose opioids (>100 MED)
- Prevalence of addiction to opioids in VHA
  - Opioid Use Disorder in 11 of each 1,000 Veterans receiving care from VA (FY 2015)
  - Unclear how many patients on long term opioid treatment formally transition to opioid use disorder

# PRIMARY CARE - IMPLICATIONS OF THE CDC GUIDELINE

Centers for Disease Control and Prevention

# MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 65

March 15, 2016

## CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



# WHAT HAPPENED?

## .... PILL CONTROL

- Quality Metrics on dose
  - Dose >120 (NCQA)
- Payer restrictions
- Prescription Drug Monitoring
  - No warrant needed
- Pharmacy Red Flags
- DEA and law enforcement
- Medical Board Rules
- Employer Rules
- FDA plans “new hoops” for doctors



# URGENT ANNOUNCEMENT

FEBRUARY 21, 2018

Beginning immediately our intractable pain and palliative care clinic cannot authorize any opioids to be paid by Medicare. This includes any health plan to which you have turned over your Medicare benefits.

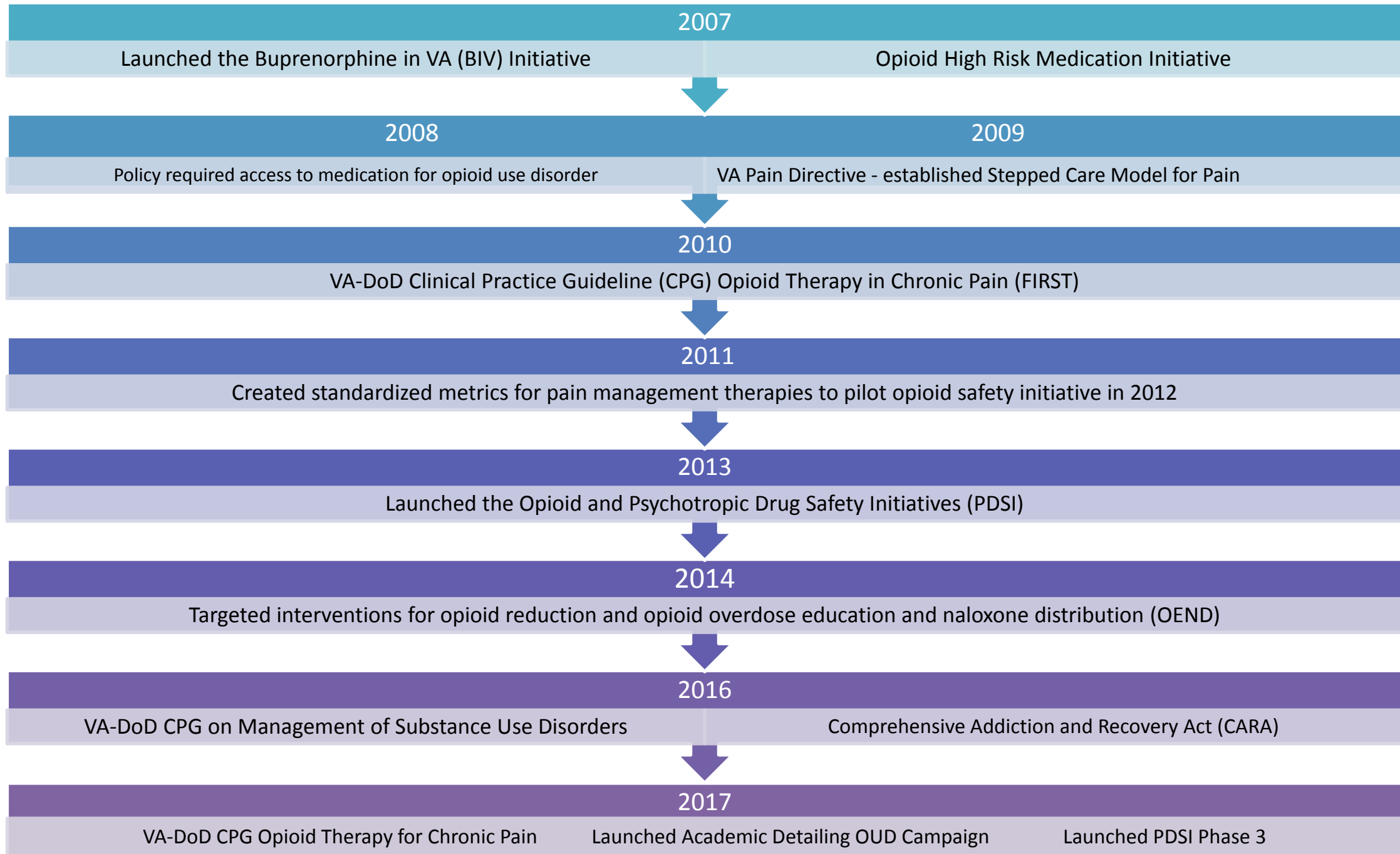
The Federal Medicare Program has just placed all internists, like myself, on a "Quota Opioid System". We can only prescribe a limited amount each year that will be paid by Medicare. My quota has already been exceeded. [REDACTED]

Beginning at your next clinic visit you will have to self-pay for opioids as a note will be put on your prescription to this effect. Medicare will continue to pay for your non-opioid medications.

We highly recommend you contact your health plan for a pain specialist who can prescribe opioids to you as we believe we will have to soon discharge any patient who has Medicare.

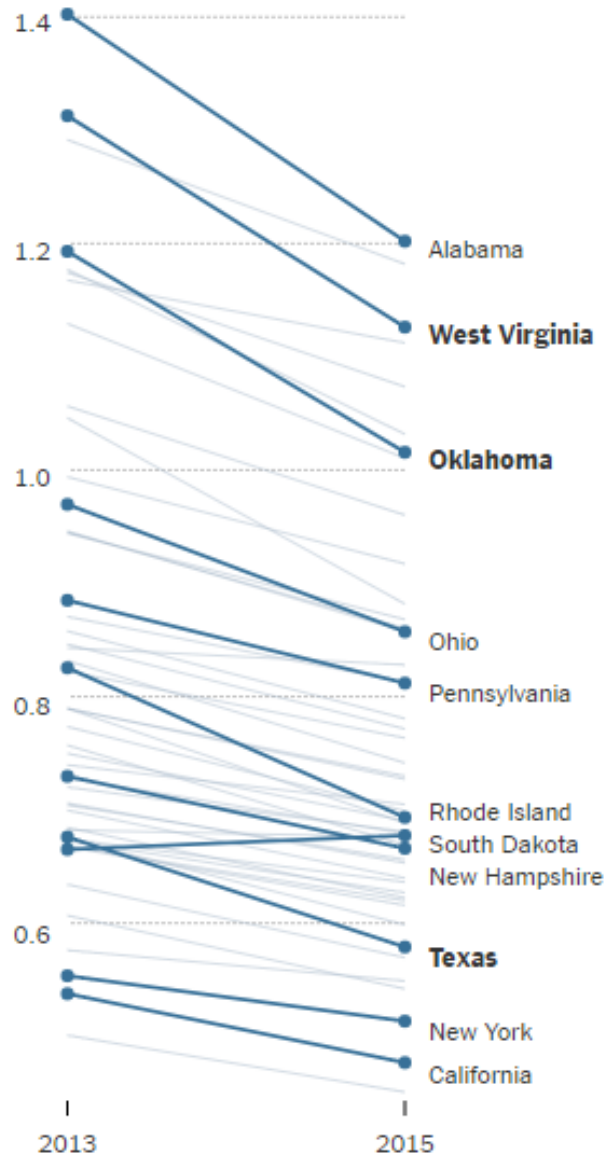
I highly disagree with this policy, but it is now a Federal government policy.

# VA INITIATIVES .....





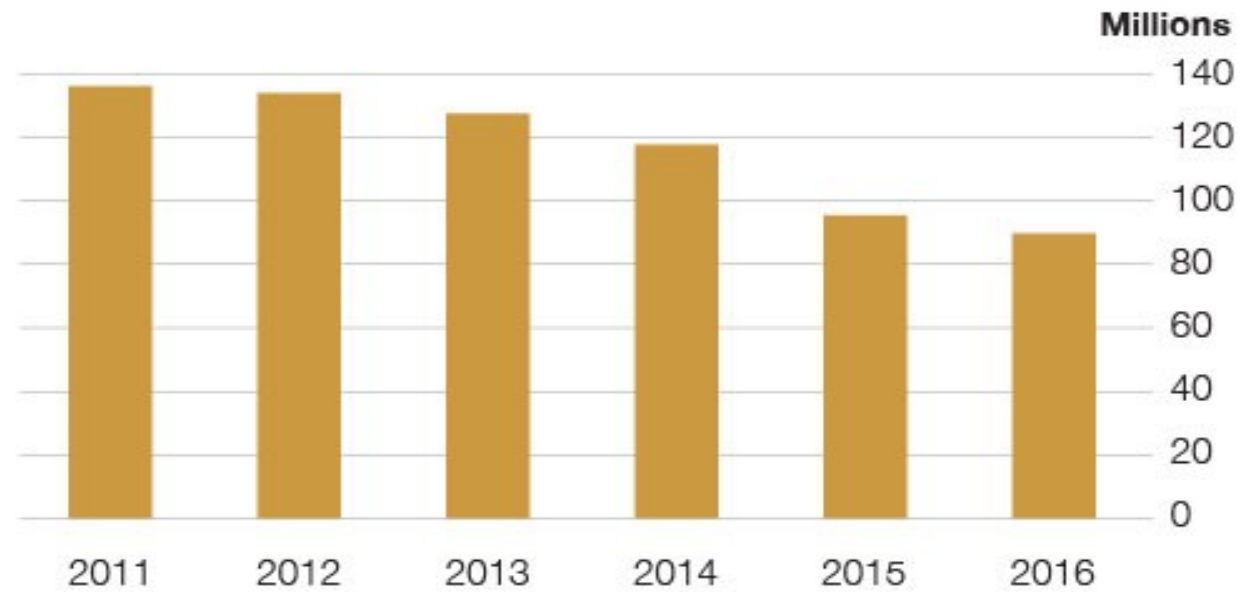
## Decline in Opioid Prescriptions Prescriptions per capita



Note: The data measures dispensed prescriptions from more than 85 percent of all retail pharmacies in the country.

Source: IMS Health

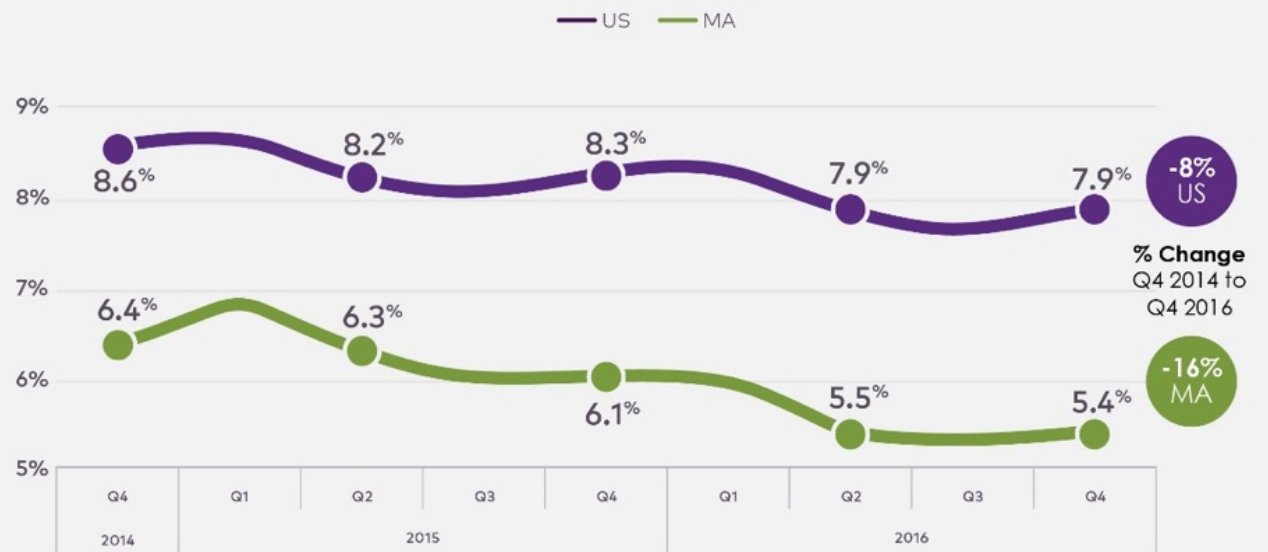
## Hydrocodone Prescriptions Falling



Source: QuintilesIMS Institute

www.energyandresourcesdigest.com

## % of patients receiving opioid Rx



SAMPLE: Approximately 250,000 patients seeing over 500 providers in Massachusetts each quarter; over 3 million patients seeing over 7,000 providers each quarter in the rest of the United States. Limited to providers on athenahealth network since 2014.

SOURCE: athenaResearch

COMMENTARY

## Turning the tide or riptide? The changing opioid epidemic

Stefan G. Kertesz, MD, MSc

Birmingham VA Medical Center, University of Alabama at Birmingham School of Medicine, Birmingham, Alabama, USA

### ABSTRACT

The US opioid epidemic has changed profoundly in the last 3 years, in ways that require substantial recalibration of the US policy response. This report summarizes the changing nature of overdose deaths in Jefferson County (home to Birmingham, Alabama) using data updated through June 30, 2016. Heroin and fentanyl have come to dominate an escalating epidemic of lethal opioid overdose, whereas opioids commonly obtained by prescription play a minor role, accounting for no more than 15% of reported deaths in 2015. Such local data, along with similar reports from other localities, augment the insights available from the Centers for Disease Control and Prevention's current overdose summary, which lacks data from 2015–2016 and lacks information regarding fentanyl in particular. The observed changes in the opioid epidemic are particularly remarkable because they have emerged despite sustained reductions in opioid prescribing and sustained reductions in prescription opioid misuse. Among US adults, past-year prescription opioid misuse is at its lowest level since 2002. Among 12th graders it is at its lowest level in 20 years. A credible epidemiologic account of the opioid epidemic is as follows: although opioid prescribing by physicians appears to have unleashed the epidemic prior to 2012, physician prescribing no longer plays a major role in sustaining it. The accelerating pace of the opioid epidemic in 2015–2016 requires a serious reconsideration of governmental policy initiatives that continue to focus on reductions in opioid prescribing. The dominant priority should be the assurance of subsidized access to evidence-based medication-assisted treatment for opioid use disorder. Such treatment is lacking across much of the United States at this time. Further aggressive focus on prescription reduction is likely to obtain diminishing returns while creating significant risks for patients.

### KEYWORDS

Opioids; opioid use disorder; overdose; pain; prescriptions; primary care; treatment access





## Will strict limits on opioid prescription duration prevent addiction? Advocating for evidence-based policymaking

Mallika L. Mundkur, MD, MPH<sup>a</sup>, Adam J. Gordon, MD, MPH<sup>b,c</sup>, and Stefan G. Kertesz, MD, MSc<sup>d,e</sup>

<sup>a</sup>Program on Regulation, Therapeutics, and Law (PORTAL), Division of Pharmacoepidemiology and Pharmacoeconomics, Department of Medicine, Brigham and Women's Hospital, Boston, Massachusetts, USA; <sup>b</sup>Departments of Medicine, University of Utah School of Medicine, Salt Lake City, Utah, USA; <sup>c</sup>Departments of Psychiatry, University of Utah School of Medicine, Salt Lake City, Utah, USA; <sup>d</sup>Birmingham VA Medical Center, Birmingham, Alabama, USA; <sup>e</sup>Department of Medicine, University of Alabama at Birmingham School of Medicine, Birmingham, Alabama, USA

# OUTLINE

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# Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic

Nora D. Volkow, M.D., Thomas R. Frieden, M.D., M.P.H., Pamela S. Hyde, J.D., and Stephen S. Cha, M.D.

The rate of death from overdoses of prescription opioids in the United States more than quadrupled between 1999 and 2010 (see graph), far exceeding the combined death toll from cocaine and heroin overdoses.<sup>1</sup> In 2010 alone, prescription opioids were involved in 16,651 overdose deaths, whereas heroin was implicated in 3036. Some 82% of the deaths due to prescription

N ENGL J MED 370;22 NEJM.ORG MAY 29, 2014

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The New England Journal of Medicine

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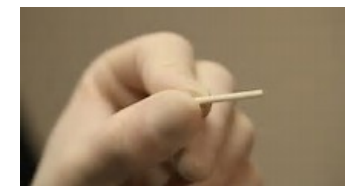
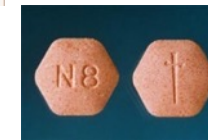


### Characteristics of Medications for Opioid-Addiction Treatment.

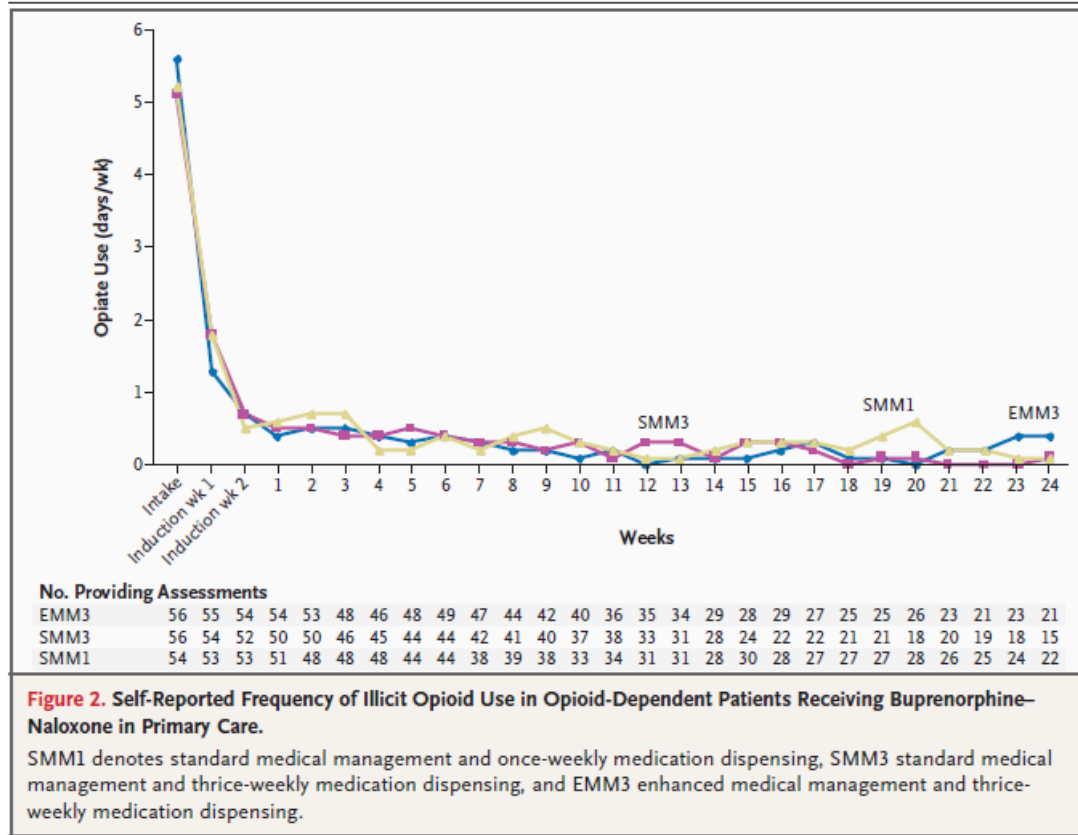
Characteristic	Metadone	Buprenorphine	Naltrexone
Brand names	Dolophine, Methadose	Subutex, Suboxone, Zubsolv	Depade, ReVia, Vivitrol
Class	Agonist (fully activates opioid receptors)	Partial agonist (activates opioid receptors but produces a diminished response even with full occupancy)	Antagonist (blocks the opioid receptors and interferes with the rewarding and analgesic effects of opioids)
Use and effects	Taken once per day orally to reduce opioid cravings and withdrawal symptoms	Taken orally or sublingually (usually once a day) to relieve opioid cravings and withdrawal symptoms	Taken orally or by injection to diminish the reinforcing effects of opioids (potentially extinguishing the association between conditioned stimuli and opioid use)
Advantages	High strength and efficacy as long as oral dosing (which slows brain uptake and reduces euphoria) is adhered to; excellent option for patients who have no response to other medications	Eligible to be prescribed by certified physicians, which eliminates the need to visit specialized treatment clinics and thus widens availability	Not addictive or sedating and does not result in physical dependence; a recently approved depot injection formulation, Vivitrol, eliminates need for daily dosing
Disadvantages	Mostly available through approved outpatient treatment programs, which patients must visit daily	Subutex has measurable abuse liability; Suboxone diminishes this risk by including naloxone, an antagonist that induces withdrawal if the drug is injected	Poor patient compliance (but Vivitrol should improve compliance); initiation requires attaining prolonged (e.g., 7-day) abstinence, during which withdrawal, relapse, and early dropout may occur

# BUPRENORPHINE PRODUCTS

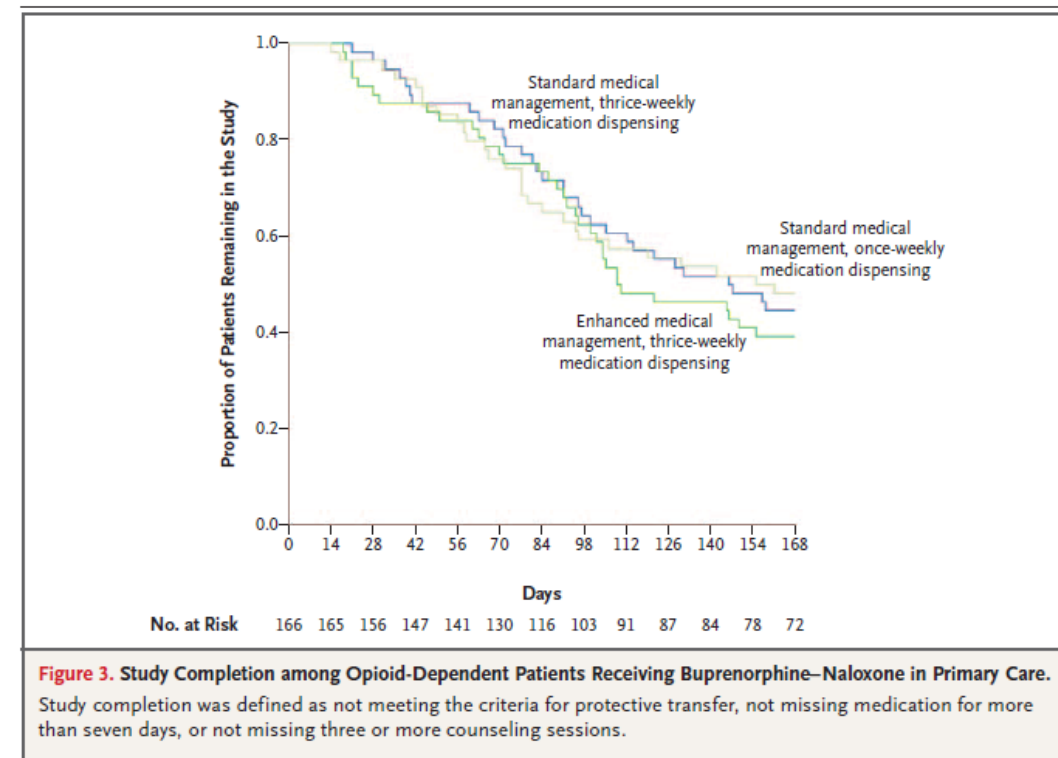
- Buprenorphine IV (1981)
  - Indication: **Pain**
- Buprenorphine (2002)
  - Indication: **Opioid use disorder**
- Buprenorphine/Naloxone (2002)
  - Indication: **Opioid use disorder**
  - SL/Buccal Tablets and Film available
- Buprenorphine Patches (2010)
  - Indication: **Pain**
- Buprenorphine Implants (2016)
  - Indication: **Opioid use disorder**
- Buprenorphine Depot Injections (2018)
  - Indication: **Opioid use disorder**



# BUPRENORPHINE WORKS



Almost all formative studies regarding buprenorphine were in *primary care*



# OFFICE-BASED SETTINGS FOR ADDICTION

- Addiction treatment for can be provided in office-based settings similar to treatments for
  - Like other medical and mental health disorders
- Barriers to initiate or provide addiction care occur when providers in office-based settings attempt to make these environments “feel” like formal substance abuse treatment program environments
  - These environments are different!
  - Its hard to replicate an addiction treatment environment
  - “Keep it simple” and “grow from experience”

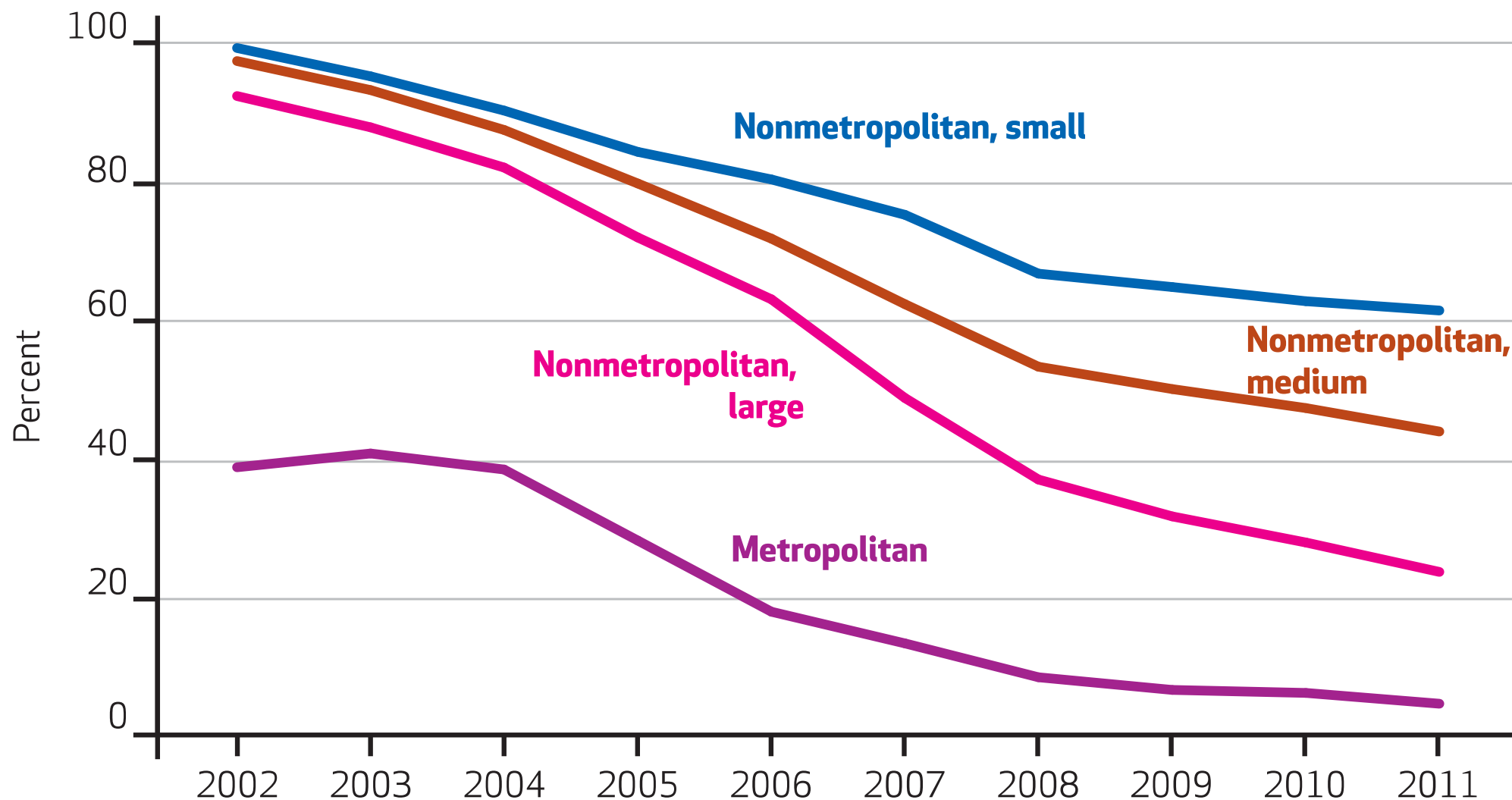
Gordon AJ, et. al. Models for implementing buprenorphine treatment in the VHA. Fed Pract. 2009.

Gordon AJ, et. al. . Facilitators and barriers in implementing buprenorphine in the Veterans Health Administration. Psychol Addict Behav.2011

Oliva EM et. al. Barriers to use of pharmacotherapy for addiction disorders and how to overcome them. Curr Psychiatry Rep. 2011.

### EXHIBIT 3

## Percentage Of US Population Living In Treatment Shortage Counties, By Rural-Urban Categories, 2002-11

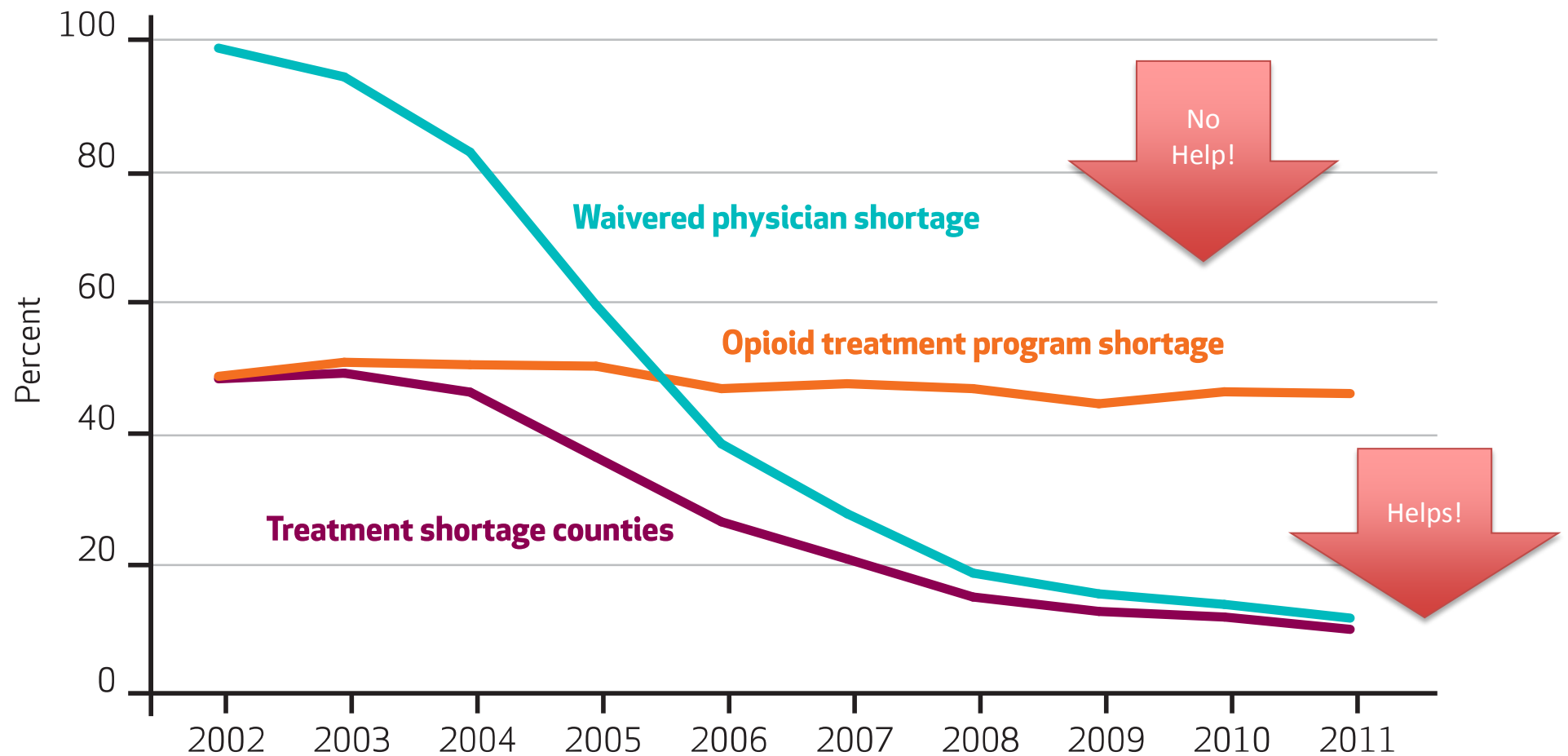


Dick AW, et.al. Growth In Buprenorphine Waivers For Physicians Increased Potential Access To Opioid Agonist Treatment, 2002-11. Health Affairs. 2015

# MORE BUPRENORPHINE IMPROVES ACCESS

## EXHIBIT 2

Percentage Of US Population Living In Counties With A Shortage Of Opioid Treatment Programs, A Shortage Of Waivered Physicians, And Treatment Shortage Counties, 2002-11



Dick AW, et.al. Growth In Buprenorphine Waivers For Physicians Increased Potential Access To Opioid Agonist Treatment, 2002-11. Health Affairs. 2015

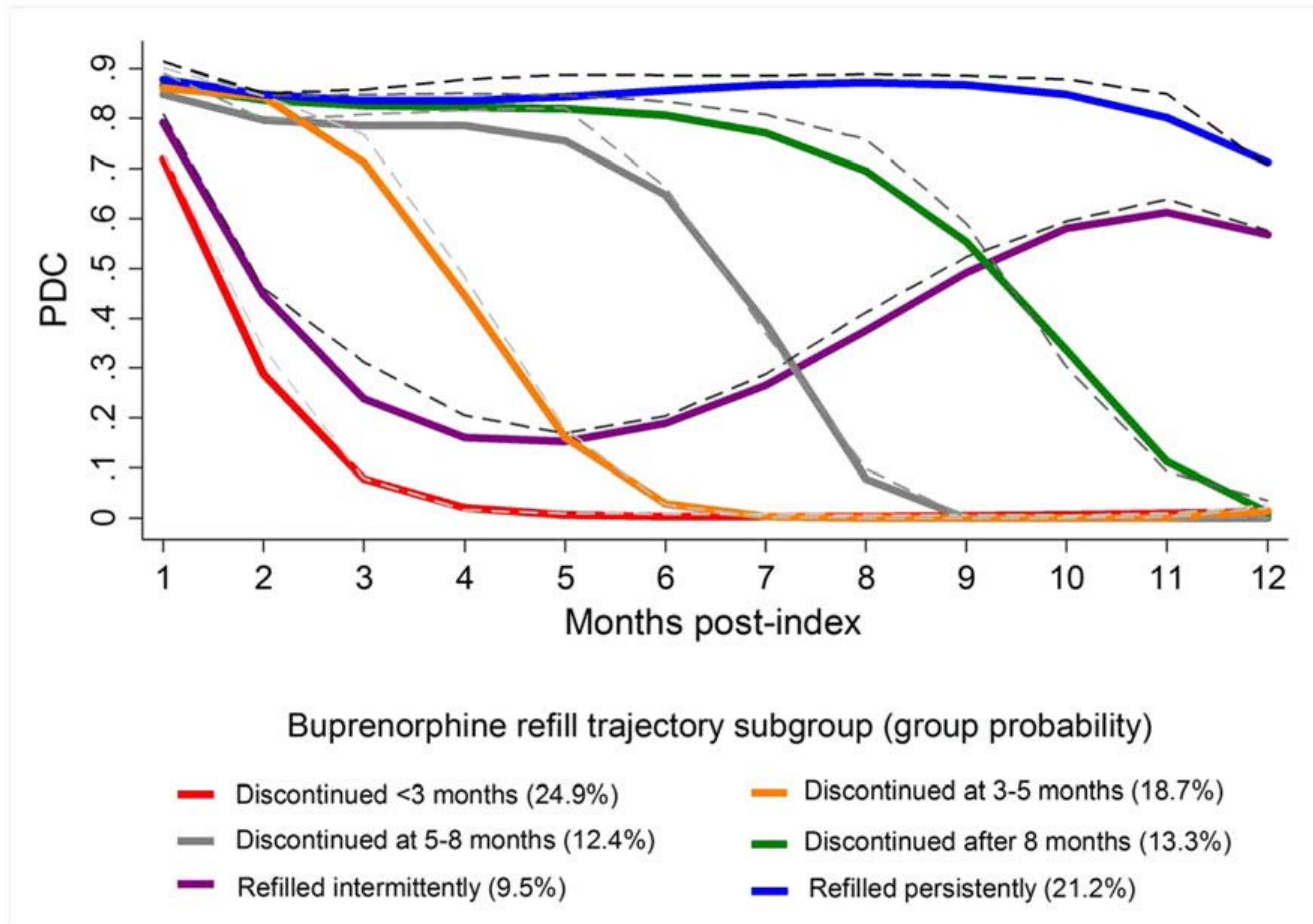
- Among 3,234 buprenorphine prescribers, 245,016 patients who received a new buprenorphine prescription:
  - Prescribers' median monthly patient census was **13 patients**
  - the median episode duration was **53 days**

**Table. Buprenorphine-Prescribing Physicians' Monthly Patient Censuses**

	Monthly Patient Census, Median (IQR)	Incident Rate Ratio (95% CI)	P Value
All prescribers (n = 3234)	13 (5-36)	NA	NA
<b>State</b>			
California	7 (4-17)	0.69 (0.58-0.83)	<.001
Florida	11 (4-30)	1.10 (0.91-1.33)	.32
Massachusetts	22 (8-59)	1.87 (1.55-2.65)	<.001
Michigan	11 (4-26)	1 [Reference]	
New York	11 (4-27)	1.04 (0.87-1.25)	.66
Pennsylvania	18 (6-46)	1.51 (1.25-1.82)	<.001
Texas	10 (4-29)	1.05 (0.85-1.29)	.67
<b>Year Buprenorphine Treatment Episode Began</b>			
2010	9 (4-22)	1 [Reference]	
2011	10 (4-27)	1.23 (1.20-1.26)	<.001
2012	12 (4-33)	1.41 (1.37-1.45)	<.001
2013	14 (5-37)	1.48 (1.43-1.53)	<.001

Stein BD, et al. Physician Capacity to Treat Opioid Use Disorder With Buprenorphine-Assisted Treatment. JAMA. 2016.

# PA MEDICAID OUTCOMES



Lo-Ciganic W et. al. Association between Trajectories of Buprenorphine Treatment and Emergency Department and In-patient Utilization Addiction. 2016.



# PA MEDICAID OUTCOMES

- Six trajectories were identified:
  - 24.9% discontinued buprenorphine <3 months
  - 18.7% discontinued between 3 and 5 months
  - 12.4% discontinued between 5 and 8 months
  - 13.3% discontinued >8 months
  - 9.5% refilled intermittently
  - 21.2% refilled persistently for 12 months
- **Persistent refill trajectories** associated with:
  - **18% lower risk of all-cause hospitalizations**
    - HR =0.82, (CI) = 0.70-0.95
  - **14% lower risk of ED visits**
    - HR=0.85, 95% CI= 0.78-0.95

# VA: EARLY ADOPTER OF BUPRENORPHINE

## Implementation of buprenorphine in the Veterans Health Administration: Results of the first 3 years

Adam J. Gordon<sup>a,□</sup>, Jodie A. Trafton<sup>b,1</sup>, Andrew J. Saxon<sup>c,2</sup>, Allen L. Gifford<sup>d,3</sup>, Francine Goodman<sup>e,4</sup>, Vincent S. Calabrese<sup>e,5</sup>, Laura McNicholas<sup>f,6</sup>, Joseph Liberto<sup>g,7</sup>,  
for the Buprenorphine Work Group of the Substance Use Disorders Quality Enhancement Research Initiative (SUD QUERI)<sup>8</sup>

- Take home points: from 2003-2005
  - Opioid Dependence increased 7.3% (to 26,859)
  - Veterans prescribed BUP increased from 53 to 739
  - 16 of 21 regional VA networks had prescribed any buprenorphine
  - Two VA regional networks accounted for 31% of buprenorphine prescriptions



# BUPRENORPHINE IN THE VA (BIV)

## Listserve Engagement

VHA National  
Buprenorphine  
VHA National Opioids  
VHA National Addictions  
BIV

## Voluntary Prescriber List

Creation and maintenance  
of a 100+ member list  
used for the transfer of  
patients within VA

## Answers to Common Inquires

Buprenorphine and  
Telehealth,  
Model Informed Consent,  
policies and procedures

## Guidances

Resource Guide,  
Protocol/SOP guides,  
guidance collections  
for common situations



## Sharepoint

These resources are  
broadcast to listserve and  
are available on the BIV  
Sharepoint site, hosted by  
OMHS

## In-Service Webinar Trainings

Conducted monthly  
40-50 average attendance  
25 produced since 2007

## Scholarship Reputation

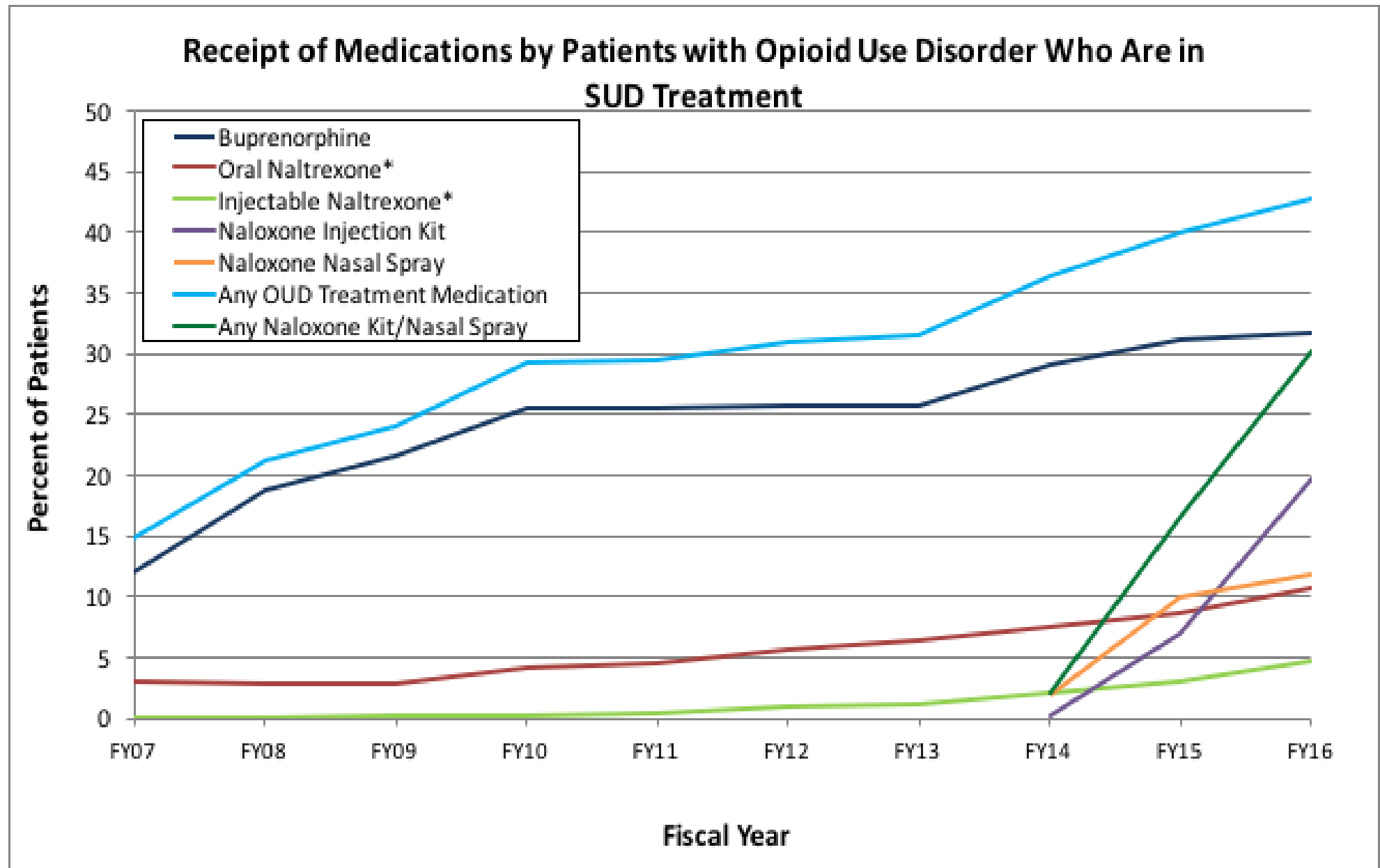
Peer-reviewed published  
articles on buprenorphine  
usage, implementation,  
access, opioid-use disorder  
assessment

## Monthly eNewsletter

“A Tool For  
Buprenorphine Care”  
79 issues produced since  
2007

**approximately 100 email contacts per month**

# IN THE VETERANS ADMINISTRATION...



# VA MEDICATION TREATMENT FOR OUD

- **34% of patients diagnosed with OUD receive medications**
- ~20,000 Veterans on medication treatment for opioid use disorder
- Big push to do in Primary Care

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# RECOGNITION OF PROBLEM

- In primary care clinic:
  - 58% have any addiction history
  - 50% have had a mental health diagnosis
  - 26% have chronic pain
- The most vexing patients (pain and addiction) are in primary care
- Addiction treatment services are (generally) swamped and provide one modality of treatment
- Patients may prefer primary care environments for addiction

# IF OPIOID USE DISORDER IS A CHRONIC DISORDER...

....why are we  
treating it like an  
episodic  
disease?



# ADDICTION DISORDERS ARE TREATABLE LIKE ANY OTHER CHRONIC ILLNESS

- **Type 1 Diabetes**
  - 30% to 50% relapse each year requiring additional medical care
  - Significant societal consequences
- **Hypertension and Asthma**
  - 50% to 70% relapse each year requiring additional medical care
  - Significant societal consequences
- **Alcohol and Other Drug Diseases**
  - 40% to 60% relapse each year
  - Significant societal consequences
  - Few patients receive treatment!

**Why the difficulty in engagement and treatment of addiction? Why is it so vexing for health care providers to treat addiction?**

# DO WHAT ABOUT ADDICTIVE DISORDERS?

They are treated by “normal” health care providers

*Public Health Reviews, Vol. 35, No 2*

## **Can Substance Use Disorders be Managed Using the Chronic Care Model? Review and Recommendations from a NIDA Consensus Group**

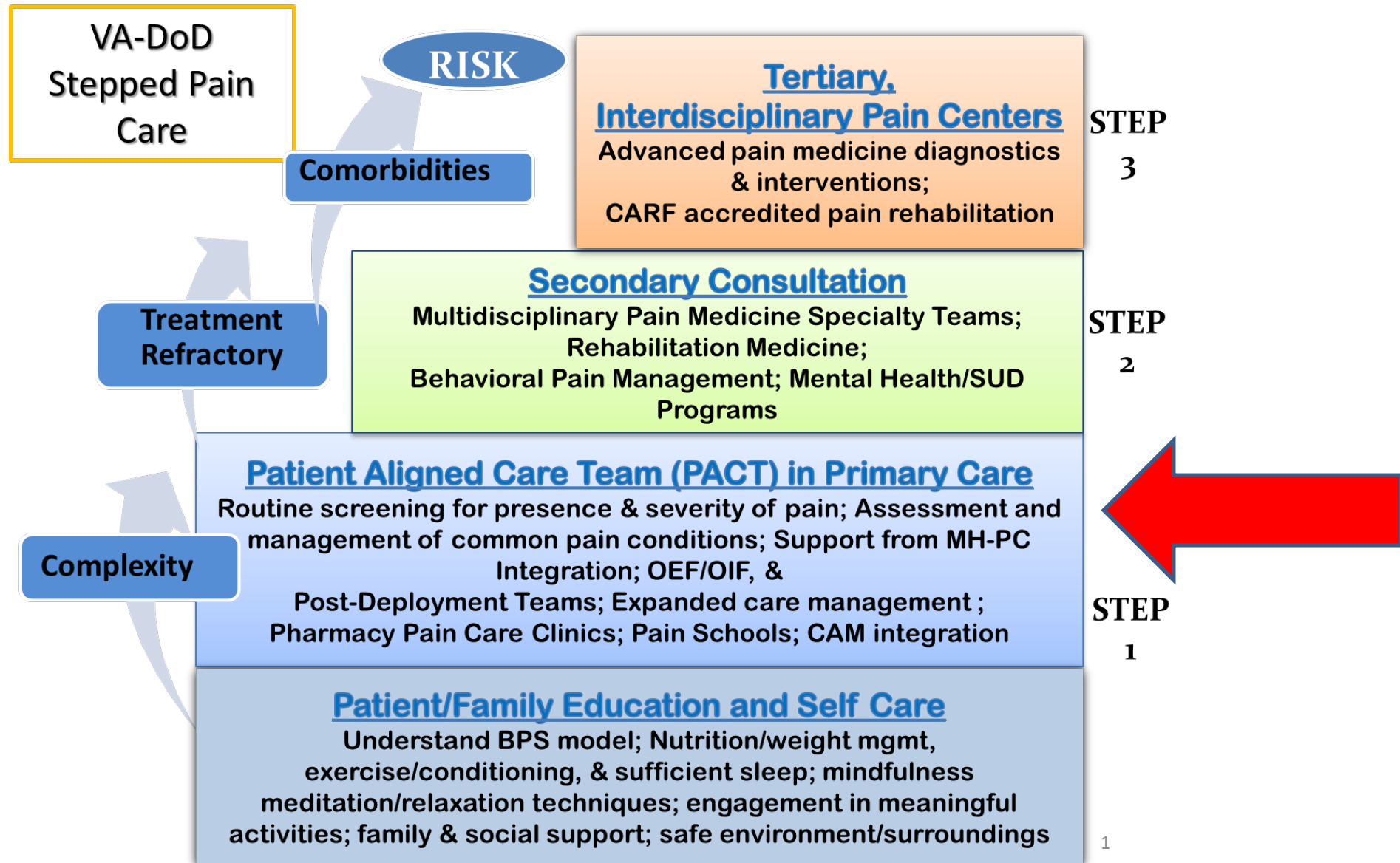
A. Thomas McLellan, PhD,<sup>1</sup>  
Joanna L. Starrels, MD, MS,<sup>2</sup>  
Betty Tai, PhD,<sup>3</sup>  
Adam J. Gordon, MD, MPH,<sup>4</sup>  
Richard Brown, MD, MPH,<sup>5</sup>  
Udi Ghitza, PhD,<sup>3</sup>  
Marc Gourevitch, MD,<sup>6</sup>  
Jack Stein, PhD,<sup>3</sup>  
Marla Oros, RN, MS,<sup>7</sup>  
Terry Horton, MD,<sup>8</sup>  
Robert Lindblad, MD,<sup>9</sup>  
Jennifer McNeely, MD, MS<sup>6</sup>

McLellan, et.al. Public Health Reviews, 2014

# PRIMARY CARE APPROACH

- Major push has been to **screen for hazardous alcohol use** in primary care
- Emerging literature regarding how to screen for drug/prescription drug problems
- **Push for collaborative and integrative health care models**
- Push to consider pharmacotherapy for all patients identified as having addictions
- **SBIRT**
  - **S**creening
    - assessment
  - **B**rief **I**nterventions
    - or “treatment”
  - **R**eferral to **T**reatment processes

# VA-DOD STEPPED CARE MODEL FOR PAIN



# VA STEPPED CARE FOR OPIOID USE DISORDER



# MOVE FROM EDUCATION TO INTEGRATION

- Integration and Coordination of Care is important
  - Addiction occurs in a variety of settings
  - Pain and addiction competency should be universal
  - Integration of pain and addiction services into Primary Care is important
    - BUT CHALLENGING !!!
- No easy answers to patient complexity
- Addiction impacts health and healthcare engagement
- Big gaps in the evidence-base on pain and addiction and how to address concurrent problems
- Patient centered care is important

# ADDRESSING THE PROBLEM IN PRIMARY CARE

- Change the culture
  - Team care and at least interdisciplinary approaches
  - Addiction is important and must be addressed
- Empower all providers to address addiction
  - Active training and retraining of wrap around services
  - Co-location services (PC-MHI, co-location models)
- Physician targets
  - Primary care addiction expertise (ABAM/ASAM)
  - Encourage buprenorphine waivered clinicians (58%!!!)

# ADDRESSING THE PROBLEM IN PRIMARY CARE

- Address “vulnerability” in specialized clinics
- Provide easy linkages to addiction and mental health care
- Don’t build a new system of care, do what you do but do it for patients with addiction
  - Don’t necessarily need more salaried employees or policies or procedures!





# Patient-aligned Care Team Engagement to Connect Veterans Experiencing Homelessness With Appropriate Health Care

*Adi V. Gundlapalli, MD, PhD, MS,\*†‡§ Andrew Redd, PhD,\*† Daniel Bolton, PhD,\*† Megan E. Vanneman, PhD, MPH,\*†§ Marjorie E. Carter, MSPH,\*† Erin Johnson, BA,‡|| Matthew H. Samore, MD,\*† Jamison D. Fargo, PhD, MS,\*‡¶|| and Thomas P. O'Toole, MD‡||#*

**Background:** Veterans experiencing homelessness frequently use emergency and urgent care (ED).

**Objective:** To examine the effect of a Patient-aligned Care Team (PACT) model tailored to the unique needs of Veterans experiencing homelessness (H-PACT) on frequency and type of ED visits in Veterans Health Administration (VHA) medical facilities.

**Research Design:** During a 12-month period, ED visits for 3981 homeless Veterans enrolled in (1) H-PACT at 20 VHA medical centers (enrolled) were compared with those of (2) 24,363 homeless Veterans not enrolled in H-PACT at the same sites (nonenrolled), and (3) 23,542 homeless Veterans at 12 non-H-PACT sites (usual care) using a difference-in-differences approach.

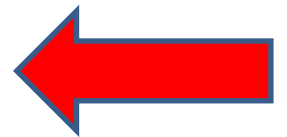
**Measure(s):** The primary outcome was ED and other health care utilization and the secondary outcome was emergent (not preventable/avoidable) ED visits.

**Results:** H-PACT enrollees were predominantly white males with a higher baseline Charlson comorbidity index. In comparing H-PACT enrollees with usual care, there was a significant decrease in ED usage among the highest ED utilizers (difference-in-differences,  $-4.43$ ;  $P < 0.001$ ). The decrease in ED visits were significant though less intense for H-PACT enrollees versus nonenrolled ( $-0.29$ ,  $P < 0.001$ ). H-PACT enrollees demonstrated a significant increase in the proportion of ED care visits that were not preventable/avoidable in the 6 months after enrollment, but had stable rates of primary care, mental health, social work, and substance abuse visits over the 12 months.

**Conclusions:** Primary care treatment engagement can reduce ED visits and increase appropriate use of ED services in VHA for Veterans experiencing homelessness, especially in the highest ED utilizers.

**Key Words:** homelessness, Veterans, emergency care

(*Med Care* 2017;55: S104–S110)



## Patient Predictors and Utilization of Health Services Within a Medical Home for Homeless Persons

### ABSTRACT

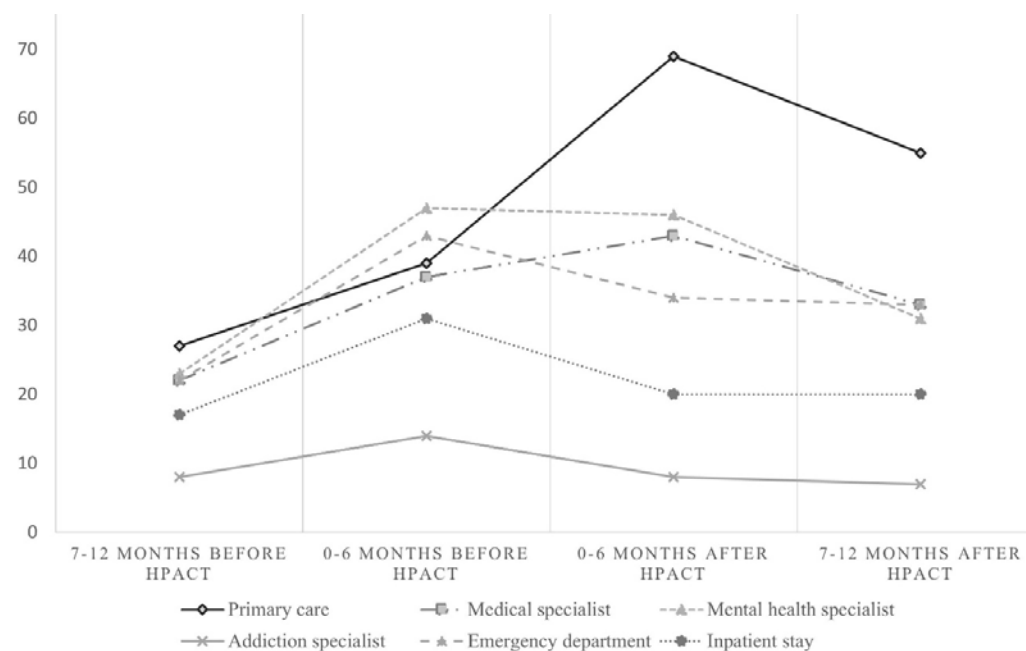
**Background:** The Veterans Health Administration (VHA) established a patient-centered medical home model of care for Veterans experiencing homelessness called Homeless Patient Aligned Care Teams (HPACTs) to improve engagement with primary care and reduce utilization of hospital-based services. To evaluate the impact of HPACT, we compare the number and type of health care visits in the twelve months before and after enrollment in one HPACT, and explore patient characteristics associated with increases and decreases in visits.

**Methods:** We conducted a chart review of VHA medical records for all patients enrolled in an HPACT in Pittsburgh, PA between May 2012 and December 2013 (n=179). Multivariable mixed effect logistic regressions estimated differences in having any visit in the 0-6 months and 7-12 months before and after HPACT enrollment, and multinomial logistic regressions predicted increases or decreases versus no change in number of visits over 12 months.

**Results:** Compared to 0-6 months prior to HPACT, patients were more likely to visit primary care in the 0-6 months (OR=4.91, CI=2.94-8.20) and 7-12 months (OR=2.30, CI=1.42-3.72) following HPACT. Patients were less likely to visit the ED or to be hospitalized in the 0-6 months (OR=0.57, CI=0.34-0.94; and OR=0.55, CI=0.25-0.76) and 7-12 months following HPACT (OR=0.43, CI=0.33-0.91; and OR=0.45, CI=0.26-0.80). Patients were less likely to visit mental health (OR=0.35, CI=0.20-0.60) and addiction specialists (OR=0.39, CI=0.18-0.84) in the 7-12 months following HPACT. Overall, 59% of patients had increases in primary care visits following HPACT. Female patients and those with self-housing were less likely to have increases versus no change in primary care visits (RRR=0.15, CI=0.03-0.74; and RRR=0.35, CI=0.14-0.90).

**Conclusions:** An integrated HPACT model was successful in engaging homeless Veterans in primary care for one year, potentially contributing to reductions in ED use. More tailored approaches may be needed for vulnerable populations experiencing homelessness, including homeless women.

**Keywords:** Health care utilization, Patient-centered medical home, Homeless, Veterans





# VULNERABLE VETERAN – INNOVATIVE PATIENT ALIGNED CARE TEAM:

## THE VIP INITIATIVE

*AN IDEAS2 – VISN 19 SERVICE AND  
RESEARCH COLLABORATIVE*

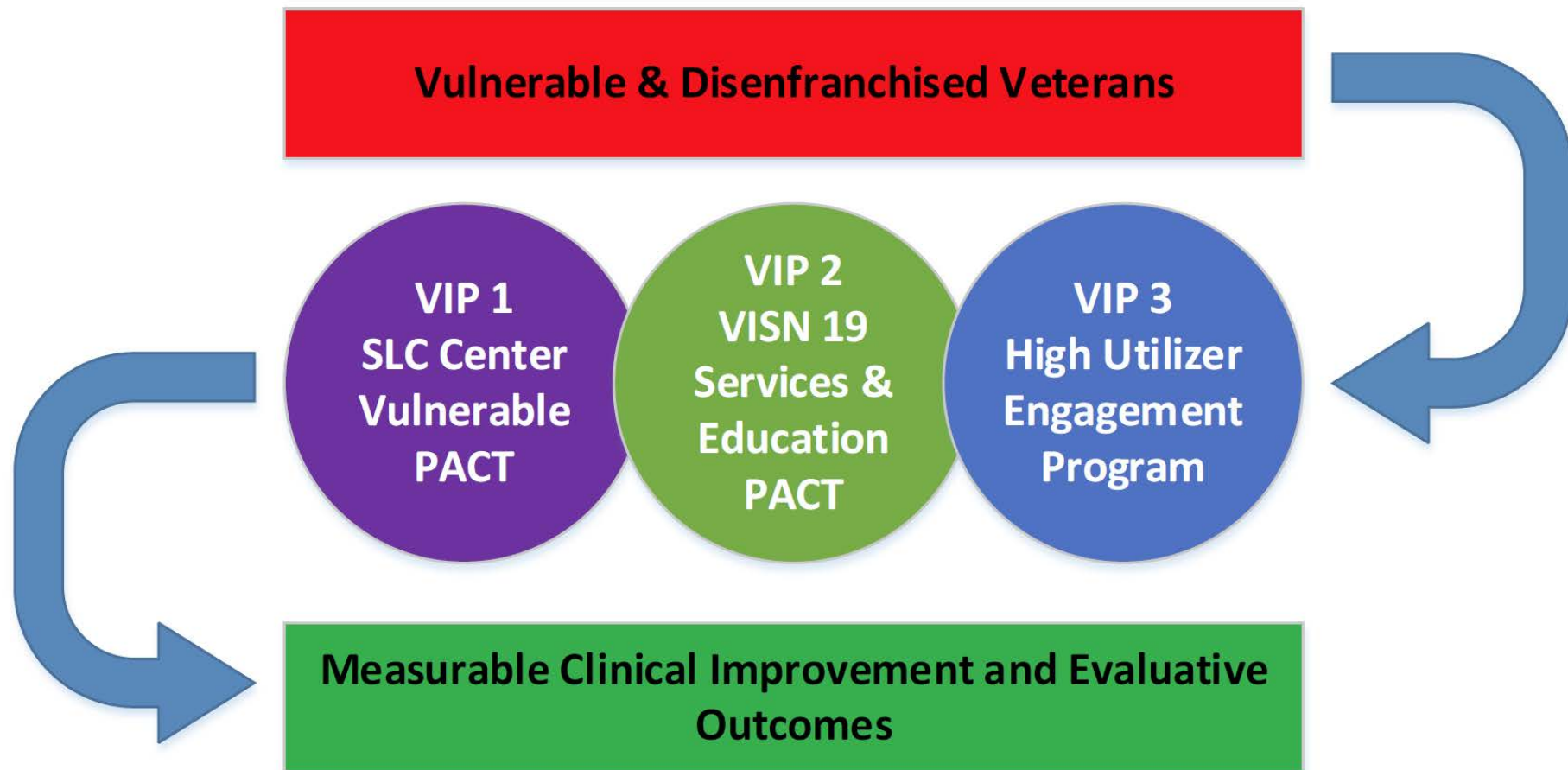




# VIP SERVES THE FOLLOWING VETERANS

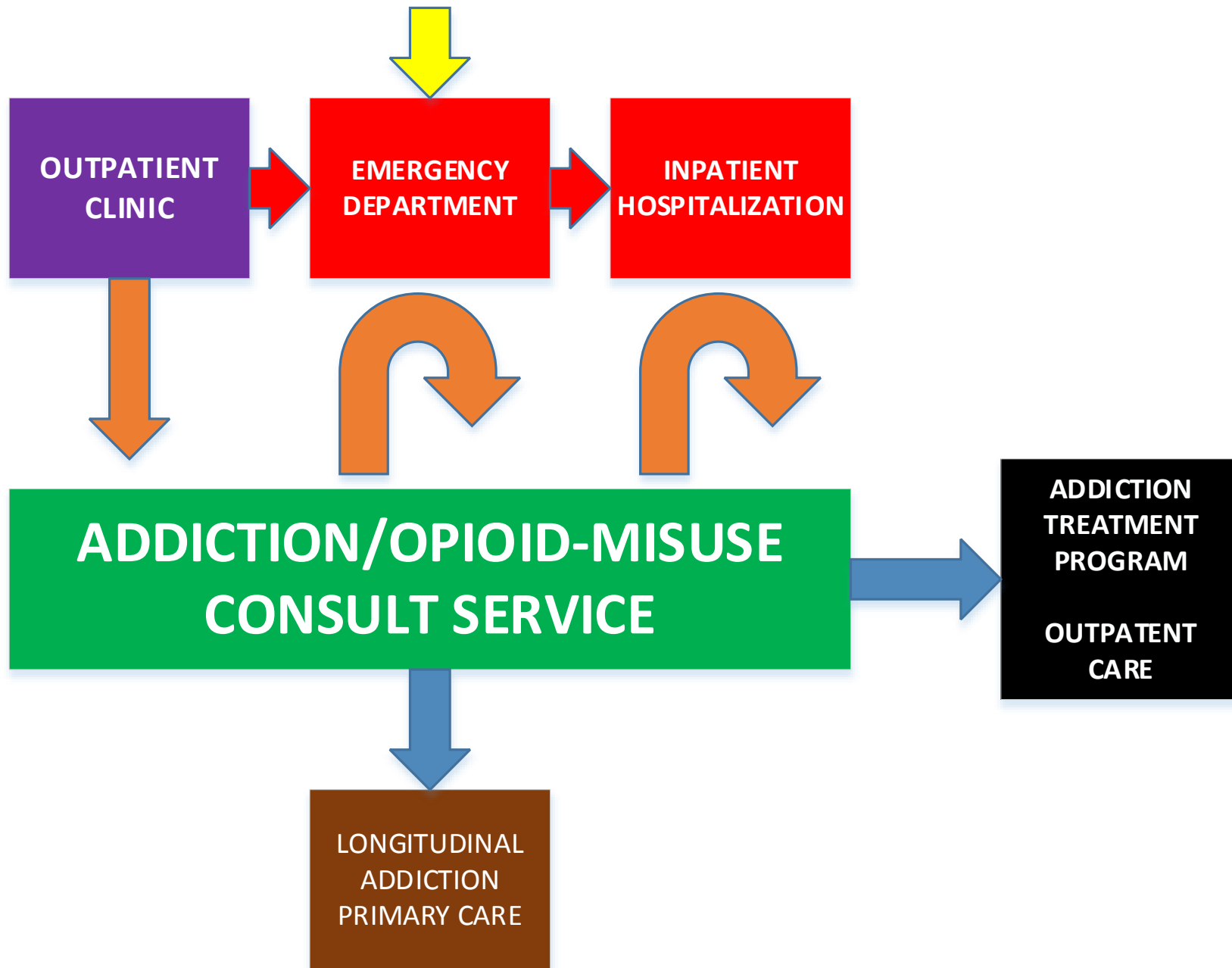
1. unhealthy alcohol use and/or addiction disorders
2. co-occurring addiction and pain disorders
3. social determinants (e.g., homeless or at-risk for homelessness)
4. high “utilizers” of health care services
5. Those with high risk for opioid medication influenced morbidity and in need of risk assessment and risk mitigation
6. those who may need high intense, high frequency primary care engagement
7. those who fall off the pain or opioid use disorder stepped care models

# VIP INPUTS AND OUTPUTS



# THE IDEA...

Health Care and Environment



# OUTLINE

1. Why should primary care be concerned
2. The story in the VA
3. Vexing issue: pain and addiction – current thoughts and policy implications
4. Success at access to medication treatment using buprenorphine for opioid use disorder
5. Is primary care the answer?
- 6. Pithy thoughts to help drive the policy debate...**



# PITHY COMMENTS

- **Access to addiction care is complex and nuanced...**
  - It may not be easy to mandate in large health systems
- **Facilitating access is difficult and involves patient, provider, and system factors...**
- **Once access is obtained, can that care be longitudinal?**
  - Addiction treatment services are generally episodic...
  - Chronic disease requires chronic treatment...

# PITHY COMMENTS

- **We may be beyond access; will quality follow?**
  - Defining quality is difficult and varies
  - Research can contradict policy implementation
    - (e.g., Medication Treatment with additional counseling)
- **Addiction care in the US is highly regulated politicized**
  - Addiction health care providers are not treated like endocrinologists
  - Patients with addiction are not treated like patients with diabetes

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# EXTRA SLIDES



**HEALTH**  
UNIVERSITY OF UTAH

# DSM 5 DEFINITION: OPIOID USE DISORDER

- Failure to fulfill role obligations at work, school, or home
- Recurrent use in hazardous situations
- ~~Legal problems related to opioid use~~ **(GONE)**
- Continued use despite substance-related social or interpersonal problems
- Tolerance
- Withdrawal/physical dependence
- Loss of control over amount of substances consumed
- Preoccupation with controlling substance use
- Preoccupation with substance use activities
- Impairment of social, occupational, or recreational activities
- Use is continued despite persistent problems related to substance use
- **Craving or a strong desire to use a substance (NEW)**

Criteria:

2-3 (mild)

4-5 (moderate)

6 or more (severe)

# WHAT ABOUT DOSE?

## PREDICTION MODEL FOR 2 YEAR RISK OF OPIOID OVERDOSE AMONG PATIENTS ON OPIOIDS

Characteristic	Unadjusted HR	Adjusted HR
Age +1 yr	0.93 (0.88-0.98)	<b>0.93 (0.89-0.98)</b>
Mental Health Dx	4.2 (2.9-6.1)	<b>3.4 (2.3-5.0)</b>
Psychotropic Rx	2.8 (1.9-4.3)	
Substance abuse/dependence	6.0 (4.0-9.0)	<b>3.5 (2.3-5.4)</b>
Tobacco	2.3 (1.6-3.3)	<b>1.5 (1.0-2.3)</b>
Hx opioid Rx in prior year	1.4 (1.0-2.0)	
Long-acting opioid	2.5 (1.3-4.9)	<b>2.0 (1.0-3.9)</b>
Daily opioid +10 MME	1.01 (0.99-1.03)	
Hepatitis C	2.8 (1.0-7.6)	

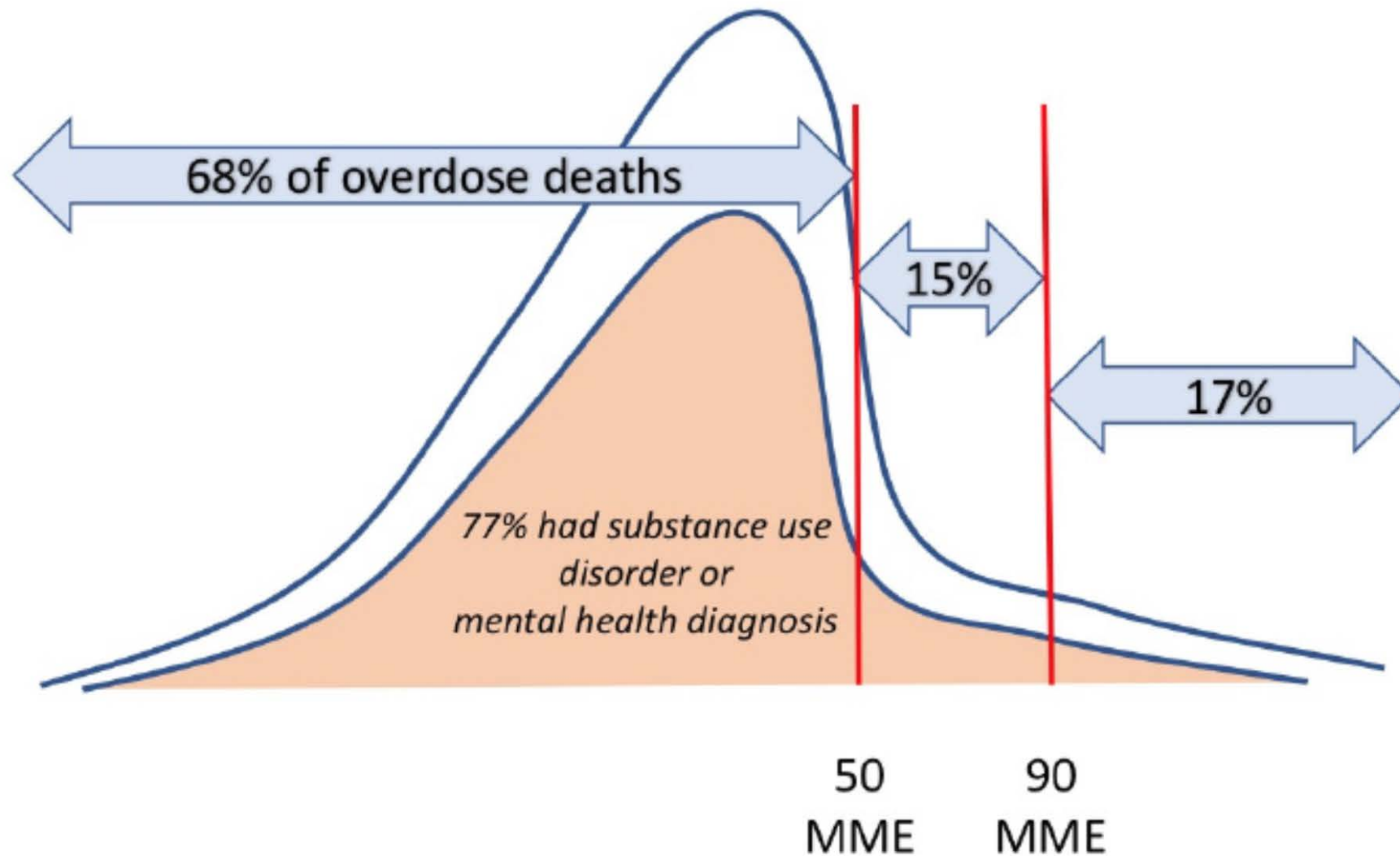
Not an independent predictor!

# STRONG DIAGNOSTIC AND HEALTH CARE EVENT RISK FACTORS FOR OVERDOSE OR SUICIDE- RELATED EVENTS

Risk factor	Odds Ratio	Model Parameter
• Prior overdose or suicide-related event	23.1	2.62
• Detoxification treatment	18.5	.06
• Inpatient mental health treatment	16.6	1.0
• Sedative use disorder diagnosis	11.2	.23
• Stimulant use disorder diagnosis	8.1	.73
• Opioid use disorder diagnosis	8.0	.31
• Mixed substance use disorder	8.0	.33
• Cannabis use disorder	5.9	.27
• Bipolar disorder	5.8	.82
• Alcohol use disorder	5.3	.36
• Other mental health disorder	5.7	.73
• Major Depression	4.8	.61
• Emergency Department visit	3.4	.72
• Fall or accident	2.9	.44
• PTSD	2.6	.34
• Tobacco use disorder	2.2	.18
• AIDS	2.2	.20
• Liver Disease	2.2	.15
• Other neurological disorder	2.1	.18
• Electrolyte disorders	2.0	.19

**Where  
is  
dose?**

# Distribution of Overdose Deaths (n=842) According to Prescribed Dose, Among Veterans Prescribed Opioids in Fiscal Year 2013 (n=1,395,056)





## Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review FREE

- Voluntary + well-run programs
- Dose reduction can be achieved for some patients
- Some may feel better
- “Very low quality evidence”
- May not apply to involuntary
- No prospective study of mandatory, involuntary opioid discontinuation
- Insufficient evidence on adverse events such as “overdose, switch to illicit opioids, onset of suicidality”

# PROPOSED: CMS PROPOSAL FOR 2019

- 5 or 7 day limit for “opioid naïve” patients:  
no exception

"We are proposing important new actions to reduce seniors' risk of being addicted to or overdoing it on opioids while still having access to important treatment options," said Demetrios Kouzoukas, CMS deputy administrator and director of the Center for Medicare, on a phone call with reporters. "We believe these actions will reduce the oversupply of opioids in our communities."

*Med Page Today, February 1, 2018*

- Deny payment at point of sale if  
cumulative MED >90
  - Allow prior authorization
  - Exceptions: hospice, metastatic cancer

# DO THE CDC GUIDELINES MANDATE TAPERS?

CDC Rec #7 (2016)

**REGULARLY REASSESS**

*“If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids”*

Evidence Type 4 (Lowest evidence)