

Fighting opioid addiction in primary care—new study shows it's possible

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For many of the 2 million Americans addicted to opioids, getting good treatment and getting off prescription painkillers or heroin may seem like a far-off dream.

But a new study suggests the answer could lie much closer to home, in the primary care clinics where they go for basic medical care.

Evidence compiled by a University of Michigan team suggests that primary care physicians and their existing teams of nurses, medical assistants, social workers and pharmacists can indeed provide effective addiction care using anti-opioid medication.

The researchers hope their findings will encourage more general practitioners to start offering medication-assisted therapy or MAT. They've published the new systematic review of the peer-reviewed evidence in *PLoS One* as a way of showing which elements worked for primary care physicians and clinics who did try providing MAT.

A drug to get off drugs

MAT combines a medication called buprenorphine with counseling. It has a track record of success for easing the withdrawal from opioid dependence - but it requires frequent check-in visits, drug monitoring tests and prescription refills for months or even years on end.

In addition, the federal government requires that physicians take an eight-hour course to before they can prescribe buprenorphine. All of this contributes to a current environment where few primary care physicians provide buprenorphine as addiction treatment.

Use of MAT has increased in recent years, driven by the opioid crisis and MAT coverage through Medicaid expansion in many states. The federal government has increased the number of MAT patients that one physician can treat at any given time. Nurse practitioners and physician assistants can also get permission to prescribe MAT in states where they have prescribing privileges.

But the number of people who need addiction care still far outpaces the number who can provide MAT using buprenorphine or its more-intensive and more-restricted cousin methadone.

"There is a major need to do this," says Pooja Lagisetty, M.D., M.Sc., the study's lead author and a University of Michigan primary care doctor who provides MAT to her own patients at the VA Ann Arbor Healthcare System. "It's hard to convince primary care physicians to do this work when they're already busy and they don't have additional addiction-related training or experience. But if we can learn from others and find a way to offer physicians logistical support, then maybe it's possible."

Studying the studies

Lagisetty and her colleagues looked globally for common elements in successful primary care MAT models. They compiled data from 41 studies conducted in several U.S. states, as well as Great Britain, Australia, Canada, Ireland, France and Italy.

In general, they find that patients had the highest chance of successful opioid addiction treatment when their [primary care physician](#) worked with a team of non-physicians to deliver MAT.

The successful models featured coordinated care, in which physicians handled the patient encounters where their skills were required or most needed, and other team members helped patients between doctor appointments. Nurse case managers, who handled duties including regular phone calls to track patients' symptoms and cravings, were a common element. A few care models were based solely on a physician handling all MAT duties.

"Multidisciplinary teams featured in the bulk of the studies we evaluated, though every one took a different approach and many ended

up with similar results," says Lagisetty, a clinical lecturer in the Division of General Internal Medicine at Michigan Medicine, U-M's academic medical center, and a member of U-M's Institute for Healthcare Policy and Innovation.

A large majority of the sites included in the studies did not have a specific addiction focused counselor. "This suggests primary care clinics have a bit of 'wiggle room' to use the resources and staff already available at their respective clinics to manage all the components of MAT," Lagisetty notes.

Best of the best

The researchers zeroed in on 7 studies that showed the best success - with 60 percent or more of patients staying on their MAT regimen for three months or more, and a good score on the standard scale the U-M researchers developed.

Lagisetty notes that many of the clinics in these best studies did not have an addiction psychologist or other addiction counselor as part of their teams. Many, but not all, required patients to sign contracts pledging they would avoid opioids.

The new analysis also shows that primary clinics do not need to give the first dose of buprenorphine to patients while they're physically in the clinic.

These "inductions", which occur hours after the patient has stopped using opioids and is beginning to feel the symptoms of withdrawal, can occur at home as long as the patient has someone to call about any cravings or symptoms they may feel after starting to take the medication.

She hopes the new systematic review of the evidence for primary care

MAT will spur more clinics to consider offering the option. She also points to a recent Annals of Internal Medicine scoping review that evaluated the different models for MAT laid out by local and state government agencies.

Primary care teams already provide intensive treatment for other conditions and medication regimens, Lagisetty observes. These range from anticoagulation medicine for people with high risk of blood clots, to managing heart failure patients and people on insulin for diabetes.

Such patients also often require checks between physician appointments while they are being stabilized. Non-[physician](#) team members help with dose monitoring and frequent check-ins by phone or in person with the patient. "We can build upon these existing resources to similarly treat patients with MAT," she says.

In fact, Lagisetty and two of her co-authors on the new paper, Amy Bohnert, Ph.D., and Michele Heisler, M.D., M.S., published a paper last year setting forth the anticoagulation clinic model as a model for MAT. She notes that anticoagulation medications don't come with the kind of federal regulations that buprenorphine has.

"We already have studies showing that MAT in primary care can produce similar results to providing it in specialty care settings, and patients might be more willing to seek help in a primary care setting because of the lack of stigma and the ability to address their other health concerns," she concludes. "Doing MAT in primary care makes sense.

"I don't think that many [primary care](#) physicians went into medicine with a desire to focus on treating addiction," she concedes. "However, opioid addiction is increasingly becoming common in our practices and our patients are struggling to find help. Primary care doctors don't need to all be treating 100 patients. It can just be five. We should just have the

medication in our tool box and be able to screen and potentially treat [patients](#) in our own setting."

More information: Pooja Lagisetty et al, Primary care models for treating opioid use disorders: What actually works? A systematic review, *PLOS ONE* (2017). [DOI: 10.1371/journal.pone.0186315](https://doi.org/10.1371/journal.pone.0186315)

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