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Provider Perspectives on Implementation of CDC Guidelines for Opioid Maintenance Therapy

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Problem Identification

The opioid epidemic is a severe and complex public health crisis in the U.S. that has affected approximately 1.6 million individuals with opioid use disorder (OUD) as reported in 2019. However the actual prevalence of OUD might be higher as many patients using opioids lack a formal diagnosis.7

Despite increased awareness of the OUD epidemic through scholarly work, outreach programs, and policies, it remains a complex issue requiring a comprehensive approach to address prevention and treatment, which healthcare providers are often tasked to navigate.4

Challenges of prescribing opioids could be further complicated by feared legal consequences of over-prescribing, as well as government oversight via the Prescription Drug Monitoring Program. However, the American Academy of Family Physicians emphasizes the distinctive capability of primary care providers to provide patient-centered care, especially in rural settings with limited access to specialized addiction treatment.7

In utilizing their longstanding relationships with patients, primary care providers can employ office-based treatments to lower opioid-related mortality and enhance patient outcomes. This can be particularly useful in the setting of opioid maintenance therapy.7

This project seeks to further explore the challenges providers at Newtown Primary Care face in prescribing maintenance opioids in the setting of chronic pain management and determine how to optimize accessibility to the clinical guidelines.

- Connecticut State Department of Public Health participates in the State Unintentional Drug Overdose Reporting System (SUDORS).6

- According to the SUDORS, between 2015 and 2023, there have been 10,562 deaths in Connecticut due to unintentional and undetermined drug overdose deaths.6

- Of the total deaths in Connecticut, 1,671 deaths were in Fairfield County, which includes the city of Newtown. 73% of the deaths were males with an average age of 44.1 years old.5

- Fentanyl or Fentanyl analogues comprised 71% of the drug types that contributed to the total number of deaths in Fairfield County.6
Unique Cost Considerations

In 2017, the combined economic cost of opioid use disorder and fatal opioid overdose in the United States amounted to $1,021 billion, with $471 billion attributed to opioid use disorder and $550 billion to fatal opioid overdose.

In 2017, three New England states—Connecticut, Maine, and Massachusetts—experienced elevated per capita combined costs associated with the opioid overdose epidemic.

### TABLE 2

Cost components of opioid use disorder and fatal opioid overdose, by jurisdiction — 38 states and the District of Columbia, 2017

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Estimated case count of opioid use disorder</th>
<th>Case count of fatal opioid overdose</th>
<th>Combined cost of opioid use disorder and fatal opioid overdose, $ (millions)</th>
<th>Per capita cost of opioid use disorder, $</th>
<th>Per capita cost of fatal opioid overdose, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>28,000</td>
<td>955</td>
<td>6,194.1</td>
<td>17,222.6</td>
<td>1,726</td>
</tr>
</tbody>
</table>

### TABLE 1

Case counts and costs of opioid use disorder and fatal opioid overdose and per capita cost, by jurisdiction — 38 states and the District of Columbia, 2017

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Estimated case counts of opioid use disorder</th>
<th>Substance use treatment</th>
<th>Criminal justice</th>
<th>Lost productivity</th>
<th>Reduced quality of life</th>
<th>Health care cost</th>
<th>Lost productivity cost</th>
<th>Value of statistical life lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>28,000</td>
<td>411.8</td>
<td>46.5</td>
<td>194.9</td>
<td>411.8</td>
<td>5,129.2</td>
<td>5.2</td>
<td>1,378.2</td>
</tr>
</tbody>
</table>
"I don't prescribe maintenance opioids for many people. I usually only prescribe them if they've been on them previously. For example, if a few people have taken Tramadol for a long time, I'll continue them on it."

"I think the biggest barrier is the routine follow-up and getting people to return to care, and sometimes still dealing with uncontrolled pain."

-Anonymous Physician

"The challenge is once [the patients are] on the opioid, it's hard to taper down or get them off, even if you do reassess them and evaluate the risks. I think that's why many providers are hesitant to get involved."

-Nya Rossi, Physician Assistant

"A lot of times I refuse [to prescribe maintenance opioids] because I see very limited use for long-term opioid use; and if a patient is needing long-term opioids...and in need of that level of care, then they most likely require a specialist who can provide more comprehensive management."

-Anonymous Physician

"I tried to help a patient who was actively in withdrawal, and it was very scary and she was okay, but it was acute and I didn't feel I had a good handle on how to make sure she was safe and how to advance treatment properly."

"I had another patient that was lost to follow up and he ended up running out of his Suboxone and was buying it from the street or using other medications to medicate, and that was a problem. I talked to him about it after he came back to the clinic, and we were able to work it out. He was okay with doing a urine drug screen once every month for 3 months in a row."

-Dr. Eurica Chang, MD

"With opioids unfortunately, patients might start delving into different types of it. For example, one patient was on buprenorphine, and then he stopped the buprenorphine and took his friend's painkillers for a few days and ended up in withdrawal. You could see someone who is sober one week and some of them are trying to do the right thing, and then they have these moments of relapse leading them to try other things."

"For psychiatric concerns, I follow-up with patients about their medications and how they're feeling; but I have had patients that were over-taking their medication, some of them being controlled substances, and I had to notify the doctor and they would then follow-up with the patient."

-Melinda Soto, Licensed Clinical Social Worker
A 7-question anonymous survey was distributed to 5 healthcare providers (3 physicians and 2 physician assistants) of Newtown Primary Care.

The aim of the survey was to assess primary care providers’ current views on the implementation and ease of accessibility of the current CDC guidelines on opioid maintenance therapy for chronic pain.

A poster draft with a summary of the CDC guidelines as well as instructions and conversion factors for calculating morphine milligram equivalents was also provided with the survey.

Follow-up and review of the poster draft was conducted in the form of open-ended questions to gain perspective on future interventions as well as feedback regarding the poster.

The final poster would contain a concise and educational summary of guidelines/recommendations for opioid maintenance therapy that providers could hang in their workspaces for convenient reference.

As the providers in this clinic mainly prefer to manage patients who are in the maintenance phase of treatment, the poster does not reflect guidelines for initiation or stabilization treatment phases (poster shown on next slide).
The initial survey assessing provider views on the accessibility and ease of implementation of the CDC guidelines gathered an 80% response rate and prompted an informal discussion on the challenges of prescribing opioids in the primary care setting.

75% of respondents stated that they understand the CDC guidelines on maintenance opioid therapy moderately well and have been moderately successful in implementing the guidelines into their daily practice.

Many agreed that a significant barrier includes encouraging patients to attend their follow-up appointments, even in the case of patients on maintenance therapy. 100% of the providers who responded to the survey also indicated that their knowledge of prescribing maintenance opioids was acquired during residency.

Responses regarding how providers would like to receive and/or access information on the current guidelines also varied greatly among the providers of the clinic.

With concurrent distribution of the poster of summarized guidelines, multiple providers expressed that it was useful in offering concise and relevant information most pertinent to their preference in working with patients in the maintenance phase of treatment.
Evaluation of Effectiveness and Limitations

Evaluation of the effectiveness of this intervention could include interviewing the providers in 6 and 12 months regarding whether they have referenced the poster of summarized guidelines and how useful it was for implementation into their practice.

Limitations include a small sample size of primary care providers (physicians and physician assistants) from a single family medicine clinic. Limited time at this site prevented thorough determination of efficacy of the intervention over the long term.

A further limitation is that various providers had different preferences for the format in which they would like to receive/access information on the guidelines.
Recommendations for Future Interventions

Provide multiple platforms to providers to best meet their preferences for accessing the CDC guidelines as well as enhancing skills for evaluating risk and prescribing opioid maintenance therapy:

- Optional training sessions/rotations during and/or after residency with Pain Medicine or Palliative Care to offer more hands-on, real-time exposure to working with patients during induction, stabilization, and maintenance phases of treatment.

- Emails with bullet-point clinical updates, either monthly or as the guidelines change.

- Online modules and fliers/posters that can be posted in outpatient clinics.

- Dot phrase in the EMR for assessment of the patient, evaluation of risk, as well as follow up recommendations.

The physicians at Newtown Primary Care also discussed how they learned about the CDC guidelines and how to implement opioid therapy during residency. Another intervention could include offering courses about the three phases of opioid therapy during the pre-clinical years of medical school.
References


