Provider Perceptions of Medication for Opioid Use Disorder (MOUD) in Allegheny County, Pennsylvania

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ALLEGHENY COUNTY HEALTH DEPARTMENT

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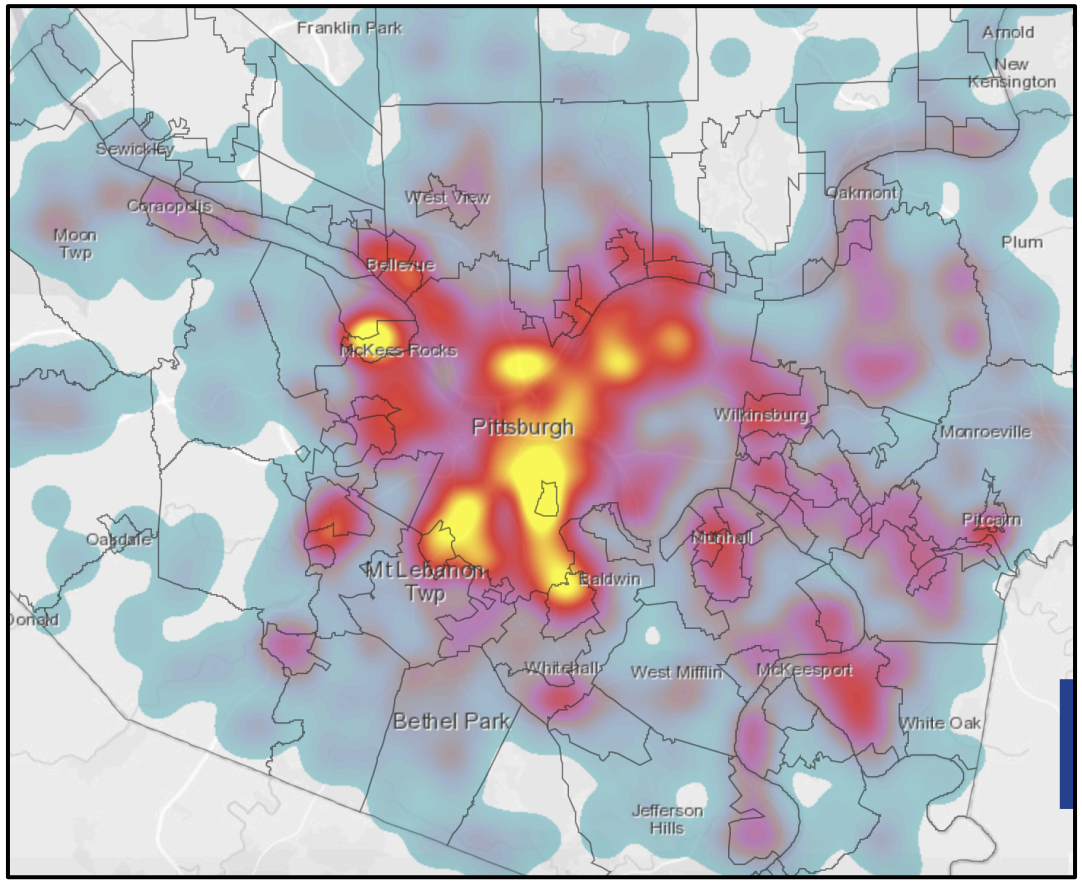
Background

- MOUD: Shown to be safe, cost- effective, and lower the risk of opioid overdose
- Access to and use of MOUD, as well as expansion of MOUD prescribers, has been limited
- Perceived barriers from prior qualitative work
  - Access
  - Knowledge
  - Stigma

Allegheny County, Pennsylvania

Allegheny County, Pennsylvania



A cumulative heat map of overdose deaths from 2008 to 2017 in Allegheny County.

- Opioid-related overdose rates higher than in other parts of the state and the U.S.
- Our study focused on 8 communities with highest need

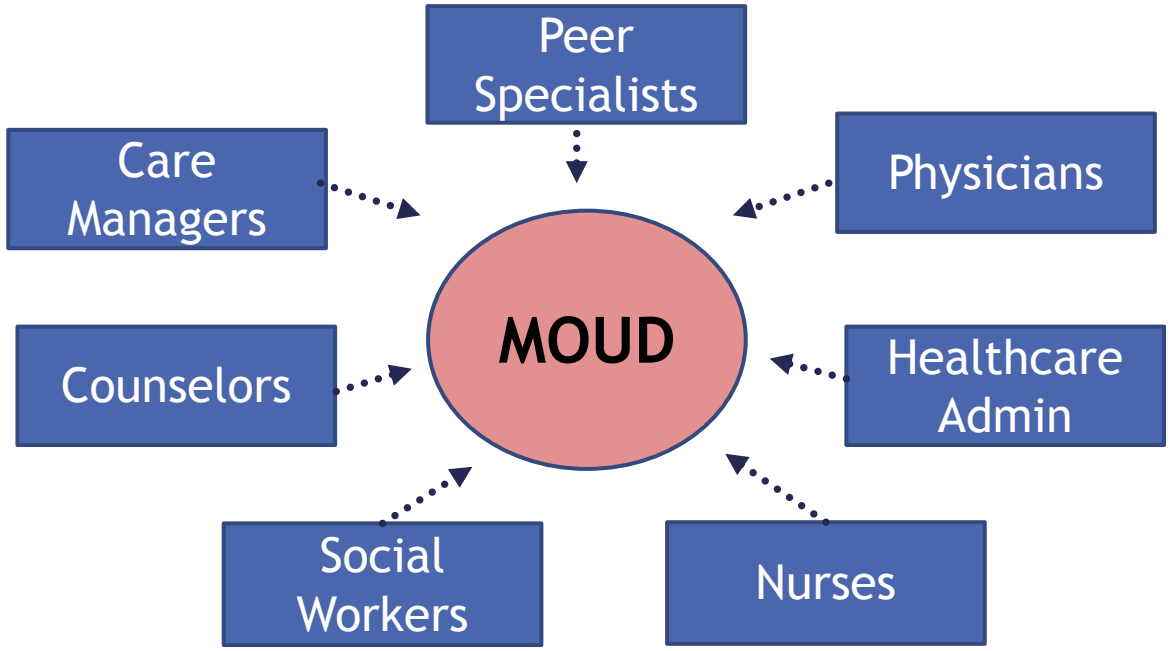
Study Aims

To qualitatively explore attitudes, opinions, and beliefs regarding MOUD of healthcare and social service providers in Allegheny County, Pennsylvania.

Study Design

- Part of a larger rapid-cycle assessment ethnographic study
- Data Collection
  - Interviews with community stakeholders
  - Observations of community meetings and events addressing opioid use

What has been tried in your community to deal with opioid use and overdose, and what do you think is needed?



Sample

- Snowball sampling method
- Interviews between 7/03/2018 and 5/03/2019
- Subset of one-on-one and group interviews
  - 45 healthcare and social service participants
  - Transcripts that contained discussions of MOUD

Data Coding

- Coding rulebook from initial study
  - “MOUD”: applied to any mention of pharmacologic treatment of opioid use disorder broadly or naming of specific medications
- Open coding approach
  - Two research team members separately coded the first 3 transcripts, compared codes, and then altered, merged, and added codes
  - Repeated until saturation – no new codes related to content topics or categories were created
  - Final MOUD coding rulebook

Thematic Analysis

Uncover patterns and categories

Relationships and interactions identified to generate themes

Themes longitudinally reviewed and refined by the study team

Participant Demographics

Characteristic	Sample, N
N	45
Age, years (median)	43
Female	31
Provider Groups	
Physician	9
Nurse	6
Administrator	10
Peer Support Specialist	3
Care Manager/Social Worker	6
Counselor	3
Other*	8

*This category includes housing supervisors and paramedics. It also includes office staff members who were included in a group interview with non-specified clinical roles.

"They need to be on [MOUD] **as long as they need to be on** [it]. If you push people off of methadone, or buprenorphine, they die. **You do not push these patients off.** You don't."

Physician

"I don't think **substituting one drug for another** is a [mumble]. I think it's a good way to help somebody get through a process until they realize '**wait a minute, this isn't the right thing, it's more negative than positive for me.**'"

Housing Case Manager

Theme 1: Purpose and Duration of MOUD

“I don't think that patients ever look at [buprenorphine] as a crutch. And I think when it works for them really well, they look at it like a gift. It's like **‘Oh my gosh, I got my life back.’”**

Physician

“**Sometimes this medication becomes a curse**...you have to take that Sub every morning…go to the doctors every month…you just want to live your life without these things every day…like [diabetics] have to take their insulin [every day].”

Peer Support Specialist

Theme 1: Purpose and Duration of MOUD

"How many licensed facilities do [different areas] have, how many all cash Subutex facilities do they have, and what are the overdoses in that ZIP code? **If your treatment is different, in one area verses another treatment, then your outcomes are going to be different**…But we tend to not talk about the treatment side, and it being related to the epidemic."

Physician

- Lack of a centralized, trustworthy, and freely accessible source
- Internet info challenging to navigate and unreliable

Theme 2: Lack of Uniformity and Quality Control of MOUD

"I try to teach the clinicians…you are diagnosed with hypertension, what is the response? You get medication, and you get treatment, you know? …But if you have an opioid use disorder, you cannot just give them a medication. I mean there are like all these, you know hoops you have to go through…**this treatment is so highly stigmatized**. You know we are looking at two chronic conditions…but it is how we treat them [differently]"

Healthcare Administrator

"Then [abstinence-based support groups] tell people that come in there that are on maintenance medication, **'You are not really in recovery, you are not really clean because you are taking this medicine.'** Um, like that is kind of [messed] up because you are telling this person this, and **this may be the only thing that is working for them at this time**."

Peer Support Specialist

Theme 3: Barriers to Entry and Navigation of MOUD -- Stigma

"You need to have…**really knowledgeable case managers** that have worked in this area before. Because **you may not get that person on the phone again.** You may not get them in front of you again. So having really knowledgeable staff, really knowledgeable about what resources are out there for them, **being able to do things rapidly, intervene rapidly, because their window of wanting helping might close too.**"

Healthcare Administrator

"If someone has a **heart attack at 4:00 pm on Friday afternoon, we send them to the cath lab and everybody comes in** and does a cardiac catherization but if someone says at 4:00 pm on a Friday afternoon, I finally want to stop using, you know **we are just like well, come back Monday.** You know? We have the whole weekend we gotta get through now."

Physician

Theme 3: Barriers to Entry and Navigation of MOUD -- Referral System and Time to Treatment

Conclusions & Limitations

- Dissonance among providers may contribute to differences among clinical practices
- Lack of uniformity, coupled with barriers to care, may limit patients
- Understanding providers' beliefs and current structural barriers will better inform the design of referral systems and delivery of clinical practice

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Discussion

- Best clinical practices for patients with OUD
- SAMHSA Treatment Improvement Protocol (TIP) 63 release in 2018

Table. Buprenorphine Care: Previous Approaches Compared With New Findings and Recommendations

Previous Approach	New Findings and Recommendations
A medical setting is needed for induction.	Home induction is also safe and effective (6).
Benzodiazepine and buprenorphine coprescription is toxic.	Buprenorphine should not be withheld from patients taking benzodiazepines (5).
Relapse indicates that the patient is unfit for buprenorphine-based treatment.	Relapse indicates the need for additional support and resources rather than cessation of buprenorphine treatment (43).
Counseling or participation in a 12-step program is mandatory.	Behavioral treatments and support are provided as desired by the patient (6).
Drug testing is a tool to discharge patients from buprenorphine treatment or compel more intensive settings.	Drug testing is a tool to better support recovery and address relapse (56).
Use of other substances is a sign of treatment failure and grounds for dismissal from buprenorphine treatment.	Buprenorphine treatment does not directly affect other substance use, and such use should be addressed in this context (43).
Buprenorphine is a short-term treatment, prescribed with tapered dosages or for weeks to months.	Buprenorphine is prescribed as long as it continues to benefit the patient (6).

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