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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

SCREENING FOR OUD

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UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

SPEAKER DISCLOSURES

✓ Any conflicts of interest?

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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OBJECTIVES

1. Name two OUD screeners
2. Discuss barriers to OUD screening
3. Describe implementation strategies for OUD screening

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CHAMP

Collaborating to Heal Addiction and Mental Health in Primary Care

Funding: This work was supported by the National Institute of Mental Health (NIH/NIMH; grant U014289744). The statements presented in this work are solely the responsibility of the author(s) and do not necessarily represent the views of the National Institutes of Health.

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The authors do not have any personal, professional, or financial conflicts of interest to disclose for this work. The authors did not work with or were otherwise influenced by any external sponsors for this work. Dr. Saxon has received travel support from Alkermes, Inc., consulting fees from Indivior, Inc., and royalties from UpToDate, Inc. Anna Ratzliff, MD, PhD receives royalties from Wiley for her book on integrated care.

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HELPING TO END ADDICTION LONG-TERM (HEAL)

NIH's HEAL Initiative is an aggressive, trans-agency effort to speed scientific solutions to stem the national opioid public health crisis.

https://heal.nih.gov/

The initiative is funding hundreds of projects nationwide. Researchers are taking a variety of approaches to tackle the opioid epidemic through:

- Understanding, managing, and treating pain
- Improving treatment for opioid misuse and addiction

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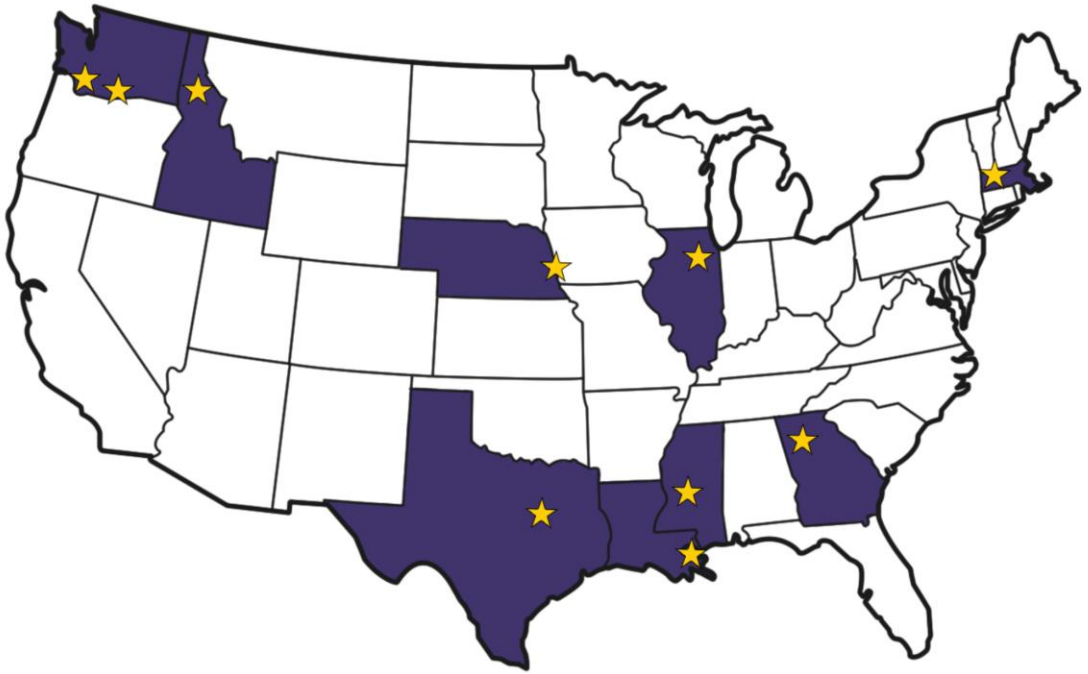
STUDY SETTING

Study Aims:

- Evaluate the effectiveness of routine screening for OUD in primary care
- Evaluate the effectiveness of CoCM for co-occurring opioid use and mental health disorders
- Evaluate approaches to sustaining CoCM for co-occurring disorders

7 states and over 24 clinics



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DOES SYSTEMATIC SCREENING FOR OUD HELP US IDENTIFY MORE PEOPLE WITH OUD?

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WHY OUD SCREENING?

Unhealthy Drug Use: Screening

June 09, 2020

Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Read the Full Recommendation Statement | Download (PDF)

Recommendation Summary

Population	Recommendation	Grade
Adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B
Adolescents	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents. See the "Practice Considerations" section for suggestions for practice regarding the I statement.	I

USPSTF recommends screening by asking questions about unhealthy drug use in adults 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

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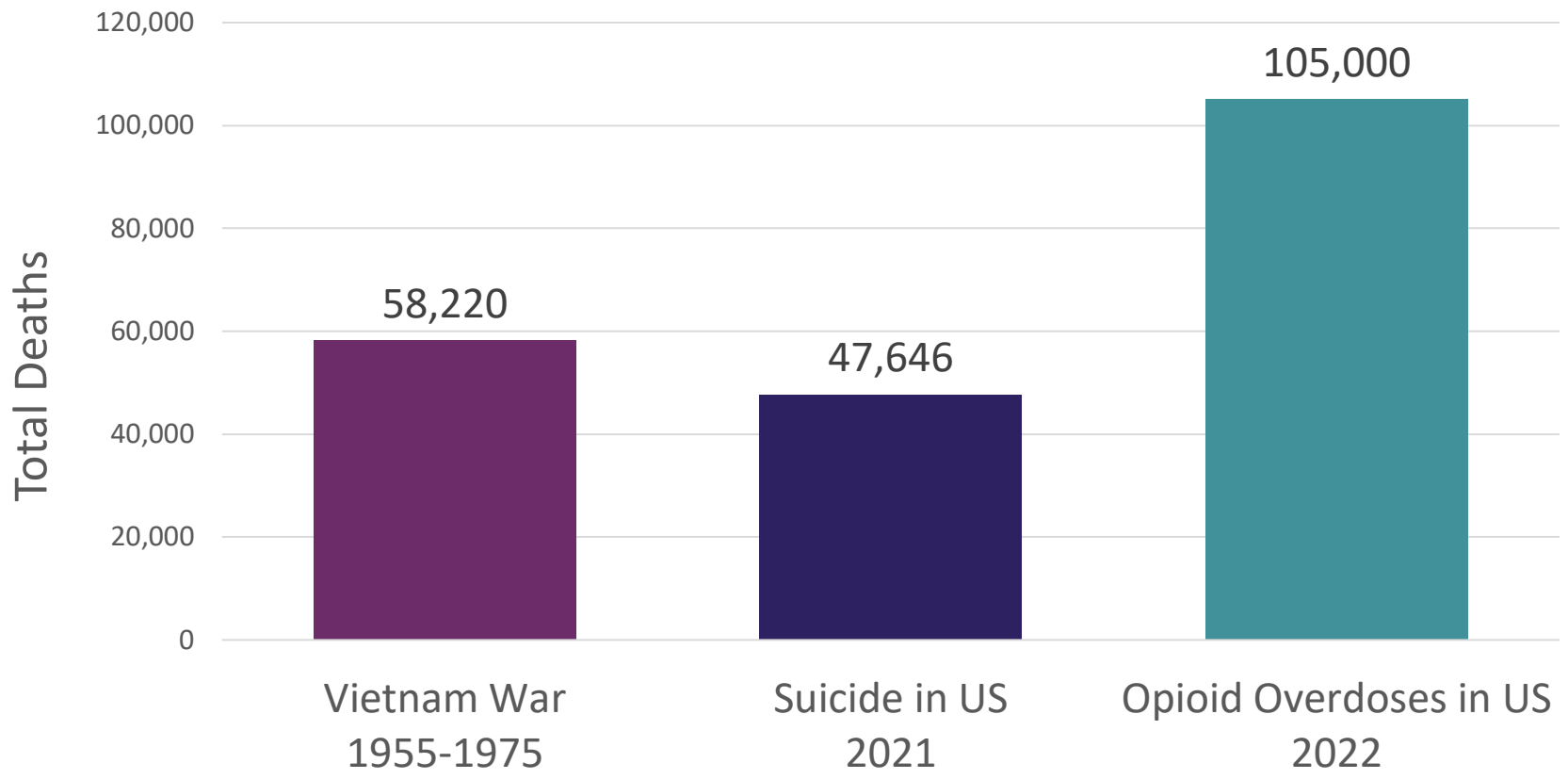
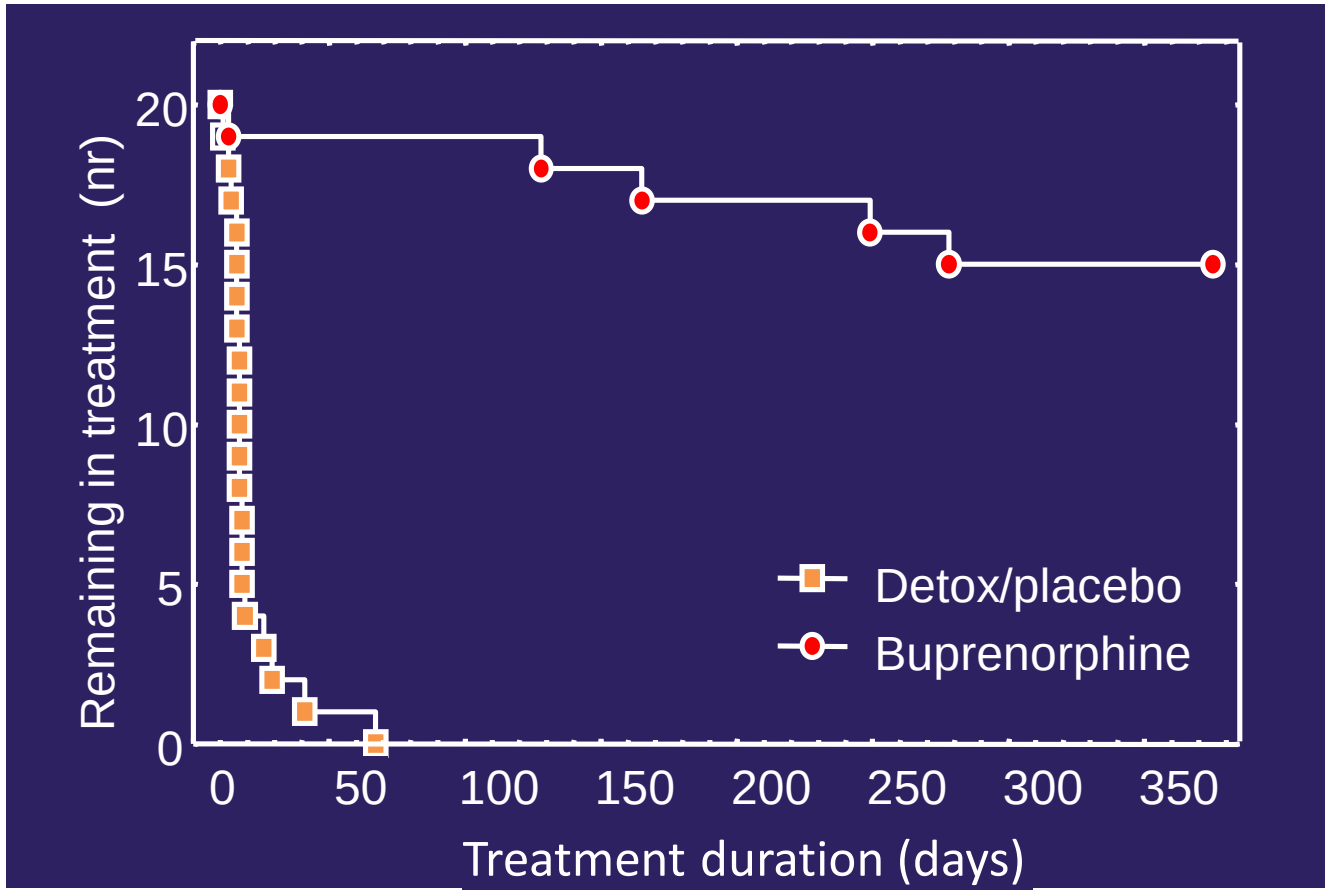
TO SAVE LIVES!



WE HAVE TREATMENT THAT WORKS!



1 yr Mortality

Detox (Placebo) 4/20 (20%)

vs

mOUD (Buprenorphine) 0/20 (0%)

Kakko J et al. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomized, placebo-controlled trial. Lancet 361(9358):662-8, 2003.

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DOES SYSTEMATIC SCREENING FOR OUD HELP US IDENTIFY MORE PEOPLE WITH OUD?

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QUALATATIVE/FORMATIVE EVALUATION OF SCREENING

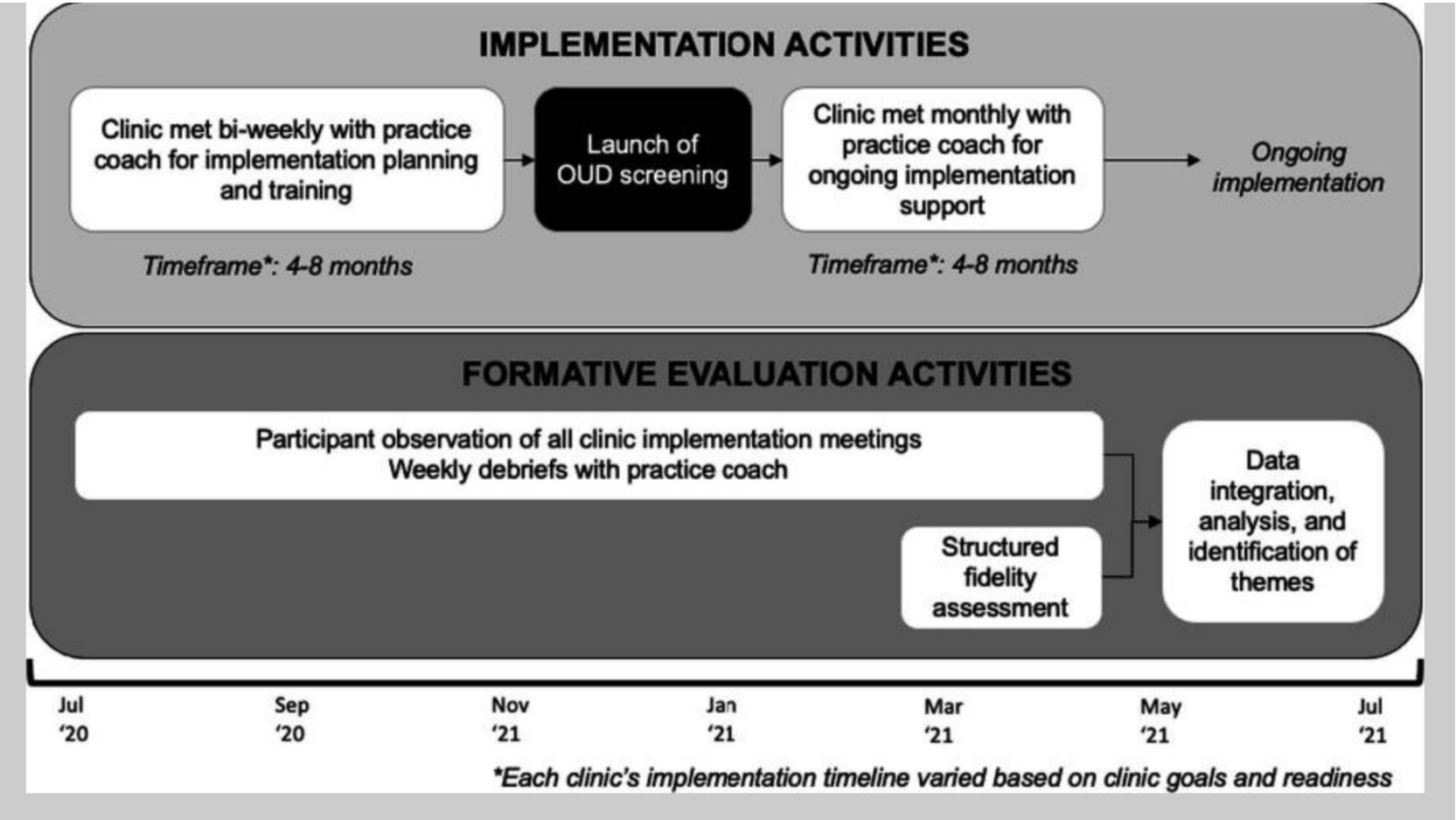

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Table 1. Clinic Characteristics and Screening Practices	
Number of clinics represented	10
Number of health systems represented	9
Geographic setting of clinics*	
Urban	2
Suburban	6
Rural	2
Clinic setting characteristics	
FQHC	2
Trainee site (residents, interns)	3
Academic medical center affiliated	2
Existing SUD screening in place?	
Yes	3
No	7
Screening frequency	
Universal – every visit	2
Universal – annually	8
Screening visit formats	
In person visits only	8
Both in person & telehealth	2
Primary approach to OUD screening capture	
Patient completes on paper	8
Patient completes electronically (e.g., patient portal or third-party app)	2
Patients completes via verbal administration with clinic staff	0
***Based on clinic self-description**	

Integrating Routine Screening for Opioid Use Disorder into Primary Care Settings: Experiences from a National Cohort of Clinics

Elizabeth J. Austin, MPH[1], Elsa S. Briggs, MS[1], Lori Ferro, MHA[2], Paul Barry, LICSW[3], Ashley Heald, MA[3], Geoffrey M. Curran, PhD[5,6], Andrew J. Saxon, MD[2,4], John Fortney, PhD[2,3,7], Anna D. Ratzliff, MD, PhD[2,3], and Emily C. Williams, PhD, MPH[1,7]

[1]Department of Health Systems and Population Health, School of Public Health, University of Washington, Box 351621, Seattle, WA, USA; [2]Department of Psychiatry and Behavioral Sciences, School of Medicine, University of Washington, Seattle, WA, USA; [3]Advancing Integrated Mental Health Solutions (AIMS) Center, University of Washington, Seattle, WA, USA; [4]Center of Excellence in Substance Addiction Treatment and Education, VA Puget Sound, Seattle, WA, USA; [5]Departments of Pharmacy Practice and Psychiatry, University of Arkansas for Medical Sciences, Little Rock, AR, USA; [6]Central Arkansas Veterans Health Care System, Little Rock, AR, USA; [7]Center of Innovation for Veteran-Centered and Value-Driven Care, Health Services Research & Development, VA Puget Sound, Seattle, WA, USA.

BACKGROUND: The U.S. Preventive Services Task Force recommends routine population-based screening for drug use, yet screening for opioid use disorder (OUD) in primary care occurs rarely, and little is known about barriers primary care teams face.

OBJECTIVE: As part of a multisite randomized trial to provide OUD and behavioral health treatment using the Collaborative Care Model, we supported 10 primary care clinics in implementing routine OUD screening and conducted formative evaluation to characterize early implementation experiences.

DESIGN: Qualitative formative evaluation.

APPROACH: Formative evaluation included taking detailed observation notes at implementation meetings with individual clinics and debriefings with external facilitators. Observation notes were analyzed weekly using a Rapid Assessment Process guided by the Consolidated Framework for Implementation Research, with iterative feedback from the study team. After clinics launched OUD screening, we conducted structured fidelity assessments via group interviews with each site to evaluate clinic experiences with routine OUD screening. Data from observation and structured fidelity assessments were combined into a matrix to compare across clinics and identify cross-cutting barriers and promising implementation strategies.

KEY RESULTS: While all clinics had the goal of implementing population-based OUD screening, barriers were experienced across intervention, individual, and clinic setting domains, with compounding effects for telehealth visits. Seven themes emerged characterizing barriers, including (1) challenges identifying who to screen, (2) complexity of the screening tool, (3) staff discomfort and/or hesitancies, (4) workflow barriers that decreased screening follow-up, (5) staffing shortages and turnover, (6) discouragement from low screening yield, and (7) stigma. Promising implementation strategies included utilizing a more universal screening approach, health information technology (HIT), audit and feedback, and repeated staff trainings.

CONCLUSIONS: Integrating population-based OUD screening in primary care is challenging but may be made feasible via implementation strategies and tailored practice facilitation that standardize workflows via HIT, decrease stigma, and increase staff confidence regarding OUD.

KEY WORDS: opioid use disorder; screening; primary care.

J Gen Intern Med
DOI: 10.1007/s11606-022-07675-2

BACKGROUND

With rising incidence of, associated mortality resulting from, and effective treatment for opioid use disorder (OUD), urgency exists to identify and link patients with OUD to evidence-based treatment.[1] In 2020, there were over 93,000 overdose-related deaths in the USA and a continued steady rise in new OUD diagnoses.[2] Effective medications to treat OUD (MOUD) reduce opioid-related mortality and improve quality of life.[1,3] Yet access to MOUD has been limited by prior federal policies requiring provider licensing (for buprenorphine) and/or supervised disbursement of medication (for methadone). As a result, only 21% of patients with diagnosed OUD nationally receive MOUD, with lower treatment access

BARRIERS TO OUD SCREENING

- (1) challenges identifying who to screen
- (2) complexity of the screening tool
- (3) staff discomfort and/or hesitancies
- (4) workflow barriers that decreased screening follow-up
- (5) staffing shortages and turnover
- (6) discouragement from low screening yield
- (7) stigma

Table 2 Summary of Barriers and Promising Strategies for OUD Screening Implementation in Primary Care Settings

CFIR domain	Barriers experienced	Promising strategies
Intervention characteristics	• Identifying who, when, and how often to screen for OUD was complicated • The NIDA-Modified ASSIST (NMA) felt overly complex and challenging to administer	• Utilize a more universal OUD screening approach (e.g., every patient, every visit) to reduce workflow complexity • U enh • Id a
Individual characteristics	• Staff expressed discomfort, hesitancy, and uncertainty with OUD screening administration and follow-up	all roles to reduce discomfort and hesitancy around OUD discussions with patients • Providing forums for staff to voice concerns about OUD screening and provision of OUD care • Provide clinical staff with access to OUD experts and/or mentors to a
Inner setting	• Clinics struggled to optimize workflow and ensure screening provided opportunity for follow-up of positive screens • The low yield from OUD screening felt discouraging • Screening felt burdensome to already-busy clinics	• In effe • C pro
Outer setting	• Stigma may deter patients from seeking OUD care in primary care settings	• C rela reducing wait times, offering alternative treatment approaches) • Advertise the availability of primary care-based OUD care to the broader community • Identify and reduce stigma within clinic policies and practices

"I mean, I kind of know what it's for, but **I don't know how to explain it in full detail**, like if a patient asks about it."

"MAs are just doing a push back… the MAs feel that they're overworked, you're just adding one more thing to their plate for them to do, what does a positive screen mean, what's in it for them, what does it mean for them?"

"Maybe some of our screening could actually come out differently **if people knew as part of our advertisement that we offer buprenorphine**."

PROMISING IMPLEMENTATION STRATEGIES

- (1) Utilize a more universal screening approach
- (2) Use Health information technology (HIT) if possible
- (3) Implement audit and feedback
- (4) Repeat staff trainings

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Intervention characteristics	• Identifying who, when, and how often to screen for OUD was complicated • The NIDA-Modified ASSIST (NMA) felt overly complex and challenging to administer	• Utilize a more universal OUD screening approach (e.g., every patient, every visit) to reduce workflow complexity • Use health information technology (e.g., automated reminders) to enhance screening workflow consistency • Identify OUD screening tools that are brief and simple to administer
Individual characteristics	• Staff expressed discomfort, hesitancy, and uncertainty with OUD screening administration and follow-up	• Providing trainings, scripts, and 1:1 coaching for clinical staff of all roles to reduce discomfort and hesitancy around OUD discussions with patients • Providing forums for staff to voice concerns about OUD screening and provision of OUD care • Provide clinical staff with access to OUD experts and/or mentors to address knowledge gaps and provider self-efficacy
Inner setting	• Clinics struggled to optimize workflow and ensure screening provided opportunity for follow-up of positive screens • The low yield from OUD screening felt discouraging • Screening felt burdensome to already-busy clinics	• Incorporate audit and feedback strategies to increase workflow effectiveness • Clarify clinic goals for OUD screening and the importance of providing life-saving OUD care • Leverage clinical champions (e.g., a waivered primary care provider) to increase staff buy-in for OUD screening
Outer setting	• Stigma may deter patients from seeking OUD care in primary care settings	• Understand external (e.g., local, community) resources for OUD–related care; tailor care to be responsive to patient demand (e.g., reducing wait times, offering alternative treatment approaches) • Advertise the availability of primary care-based OUD care to the broader community • Identify and reduce stigma within clinic policies and practices

NIDA-MODIFIED ASSIST: SCORING

NIDA-Modified ASSIST– CHAMP – Self Report Format

Thank you for taking this brief screen about opioid use. The following questions ask you about your experience using these substances. Some of these substances may be prescribed by a doctor; however, if you have taken such medications for reasons other than as prescribed or taken them more frequently or at higher doses than prescribed, please answer the questions accordingly. Use a (✓) to indicate your answer.

Use of Prescription Opioids Other Than as Prescribed, Q1-6

***Prescription opioids** include fentanyl, oxycodone [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.*

In the past 3 months…	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
1. How often have you used prescription opioids? **IF ANSWER IS 'NEVER' SKIP TO QUESTION 7.**	0	2	3	4	6
2. How often have you had a strong desire or urge to use prescription opioids?	0	3	4	5	6
3. How often has your use of prescription opioids led to health, social, legal or financial problems?	0	4	5	6	7
4. How often have you failed to do what was normally expected of you because of your use of prescription opioids?	0	5	6	7	8

In your lifetime…	No, Never	Yes, but not in the past 3 months	Yes, in the past 3 months
5. Has a friend or a relative or anyone else ever expressed concern about your use of prescription opioids?	0	3	6
6. Have you ever tried and failed to control, cut down or stop using prescription opioids?	0	3	6

Street Opioid Use, Q7-12

***Street opioids** include fentanyl, heroin, opium, kratom etc.*

In the past 3 months…	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
7. How often have you used street opioids? **IF ANSWER IS 'NEVER', END OF SCREEN.**	0	2	3	4	6
8. How often have you had a strong desire or urge to use street opioids?	0	3	4	5	6
9. How often has your use of street opioids led to health, social, legal or financial problems?	0	4	5	6	7
10. How often have you failed to do what was normally expected of you because of your use of street opioids?	0	5	6	7	8

In your lifetime…	No, Never	Yes, but not in the past 3 months	Yes, in the past 3 months
11. Has a friend or a relative or anyone else ever expressed concern about your use of street opioids?	0	3	6
12. Have you ever tried and failed to control, cut down or stop using street opioids?	0	3	6

Level of risk associated with different Substance Involvement Score ranges for illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

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CHAMP SHORT OPIOID SCREEN (SOS)

In response to the opioid epidemic, we routinely ask two questions about opioid use and offer expanded treatment opportunities in our clinic.

The answers to these questions will give us important information that we will use to take care of you in the best way possible.

1) In the past three months, have you used opioid medications prescribed for you at higher dosages or more often than prescribed? (*Includes: oxycodone [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, tramadol, fentanyl etc.)*

Please Circle YES NO

2) In the past three months, have you used any opioids not prescribed for you? (*Includes: oxycontin, fentanyl, heroin, kratom etc*.)?

Please Circle YES NO

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The Power of OUD Screening

DIVISION OF POPULATION HEALTH IN COLLABORATION WITH
THE AIMS CENTER

April 2021

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AT THE END OF NMA TRAINING, CLINICAL TEAMS SHOULD BE ABLE TO:

- Describe why NIDA Modified ASSIST (NMA) screening is important for care delivery
- Discuss how stigma may impact NMA screening
- Name one strategy to introduce the NMA to a patient

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FEEDBACK: PLEASE TYPE INTO THE CHAT!

Why is it important to screen for opioid use disorder(OUD)?

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JUST LIKE ANY OTHER HEALTH SCREENING!

- Might seem uncomfortable or seem like it a sensitive topic
- Information about opioid use is important for a patient's health!

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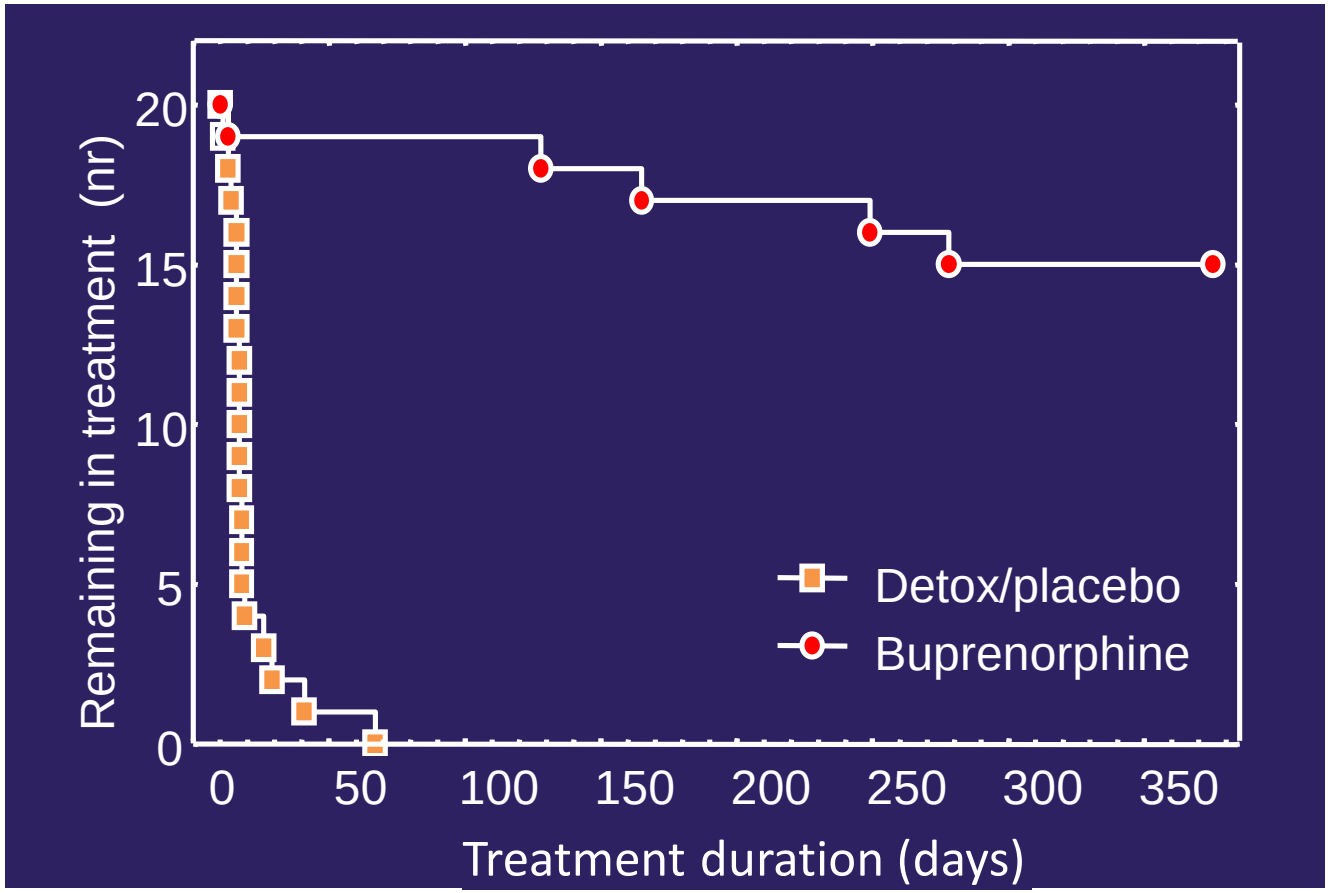
OUD IS A DISEASE IS NOT A CHOICE

- Opioid Prescribing in the USA 2018[1]
  - Still double the rate of 1999
  - 5% of world's population, 80% of opioid prescriptions
- 53% of people who use heroin and 10-20% prescribed opioid pain meds develop OUD[2]
- Important factors
  - Biology
  - Environment
  - Exposure

1 Doctors And Dentists Still Flooding U.S. With Opioid Prescriptions NPR 07/17/20

2 OUD epidemiology, pharmacology, clinical manifestations, course, screening, assessment and Diagnosis Eric Strain and Andrew Saxon, Up to date, 12/2019

WE HAVE TREATMENT THAT WORKS!



1 yr Mortality

Detox
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4/20 (20%)

vs

mOUD
(Buprenorphine)

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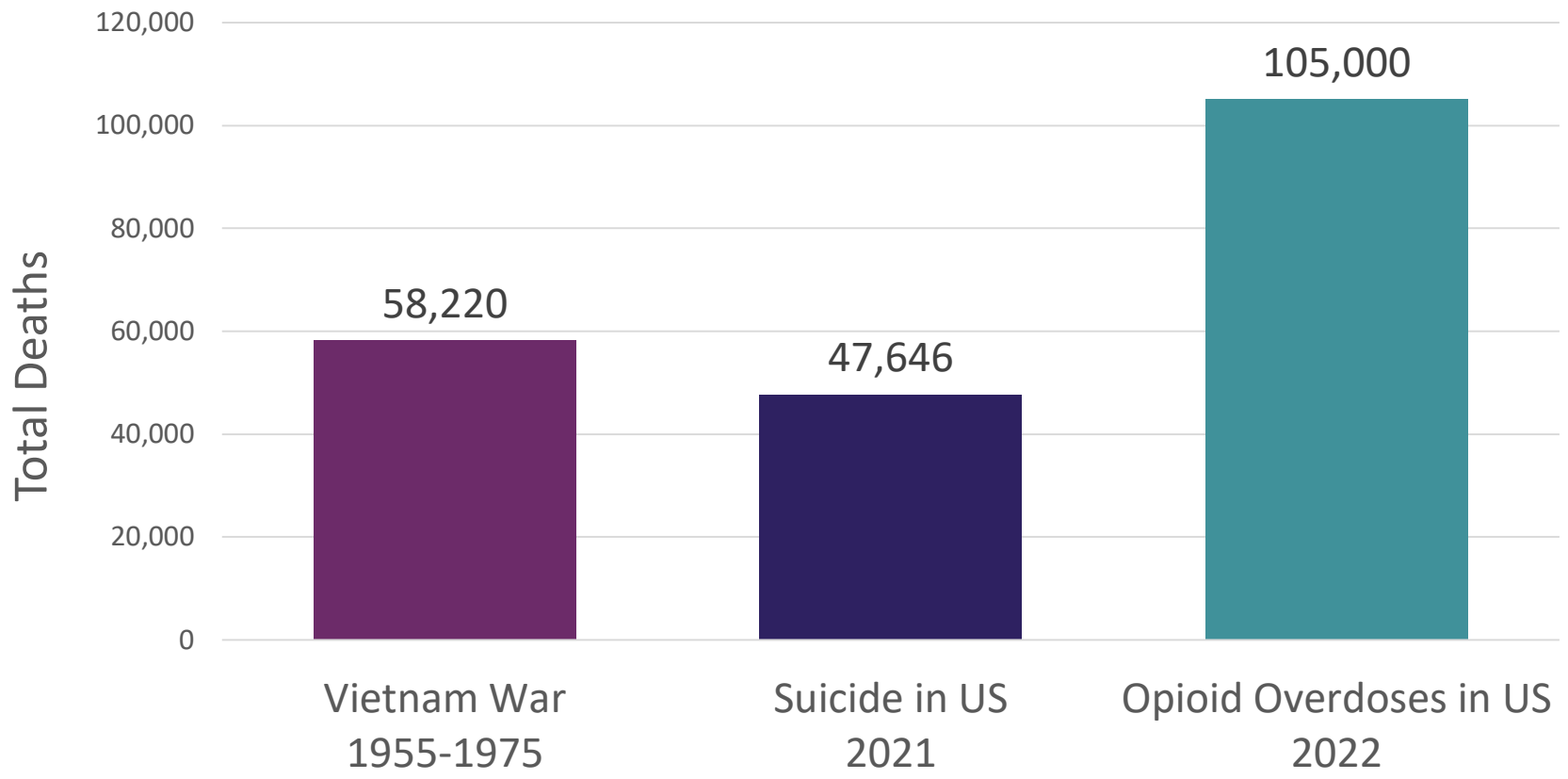
TO SAVE LIVES!



"Our disease
jeopardizes our jobs and
our relationships with the people we love.
It's a terrible disease…
It's kind of counterintuitive that people who
need the help the most are the ones that
people least want to help…"

- *Patrick J. Kennedy*

Founder The Kennedy Forum and Former Congressman

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OUD SCREENING: NIDA-MODIFIED ASSIST

NIDA-Modified ASSIST– CHAMP – Self Report Format

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In your lifetime...	No, Never	Yes, but not in the past 3 months	Yes, in the past 3 months
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Patient completes **NMA Self Report** paper form:

- You can directly hand a copy of the NMA to the patient to complete on their own. We developed the NMA to be used in this way. Many studies have shown that patients can successfully fill out these kinds of forms by themselves and do not need your assistance.
- If the patient completes the NMA on paper, immediately enter the score into the EHR.
- You may be asked to be responsible for alerting the provider if follow up is indicated by the patient's score.

Rooming staff complete **NMA Interview Format** form with the patient:

- Some rooming staff administer the NMA verbally as part of the rooming process, entering the score directly in the EHR.
- If you are administering the PHQ 9 in this way, **it is very important that you ask the questions exactly as written on the form, including the suggested names of the relevant substances. We also ask that you read the full introduction.**
- **Be sure that you do not make the patient feel rushed in any way so as to ensure accurate responses.**
- **Do NOT enter "0" in the EHR if the patient did not complete the NMA**
- Make a note in the chart if the patient was unwilling or unable to compete the NMA.
- You may be asked to be responsible for alerting the provider if follow up is indicated by the patient's score.

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NIDA-MODIFIED ASSIST: SCORING

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FEEDBACK: PLEASE TYPE INTO THE CHAT!

How do patients respond to being screened with NMA?

What concerns do you think patients may have about being asked the questions on the NMA screener?

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YOU HAVE AN IMPORTANT ROLE IN NORMALIZING SCREENING

- Use person first language
- Use standardized tools – like the NMA
- Use standardized scripts to introduce screening
- Share the benefits of screening with patients
- Review results with patients so their time feels valued

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CONSIDER STIGMA, UNCONSCIOUS BIAS AND LANGUAGE

- Sometimes just the words we use have a bigger impact than we think
- A commonplace term to us might evoke prejudice and bias in others
- Words have powerful positive and negative associations that evoke feeling and action

Substance use, recovery and linguistics: The impact of word choice on explicit and implicit bias. Ashford et al, Drug And Alc Dep, 189, June 2018

PROPOSED PERSON-FIRST TERMINOLOGY TO REDUCE STIGMATIZATION

Avoid	Preferred
Abuse	Use (or specify low-risk or unhealthy use; the latter includes at-risk/hazardous use, harmful use, substance use disorder, and addiction)
Addict, user, abuser	Person with (the disease of) addiction, a substance use disorder, or gambling disorder
Dirty vs clean urine	Positive or negative, detected or not detected
Misuse, problem	More accurate terms include at-risk or risky use, hazardous use, unhealthy use to describe the spectrum from risky/at-risk/hazardous use through disorder
Relapse	Use, return to use, recurrence (of symptoms) or disorder vs remission specifiers (early or sustained) as defined by DSM-5
Substitution, replacement, medication assisted treatment	Opioid agonist treatment, medication treatment, psychosocially assisted pharmacologic treatment, treatment

Recommended Use of Terminology in Addiction Medicine, *J Addict Med*, 2021

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INTRODUCING THE NMA

- *Example script:*
  - *We have a new screening tool that we're now using routinely with our patients. It's connected to expanded treatment opportunities we are offering here at the clinic in response to the opioid epidemic.* *This screening will give your provider important information that they can use to guide your healthcare decisions and help us take care of you in the best way possible.*
- *Introduction from the NMA:*
  - *Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with opioid use. Some of the substances we'll talk about are prescribed by a doctor, but I will only record use of those substances if you have taken them for reasons or in doses other than as prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.*

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PRACTICE!

- Pairs in a break-out room
- First person picks one introduction and practices delivering this introduction to your partner
- Then, second person practices delivering this introduction
- We will come back together to discuss!

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DEBRIEF

- What went well?
- Anything you would do differently?

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DISCUSSION

What makes it easier to complete screening?

What makes it challenging to complete screening?

What has helped make screening work for other screeners, like PHQ-9?

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RESOURCES: NMA TOOLKIT

- Additional information on NMA
- FAQs
- Example workflows
- PCP scripts and codes for patients with a positive OUD screen
- PCP scripts for presenting Narcan to patients

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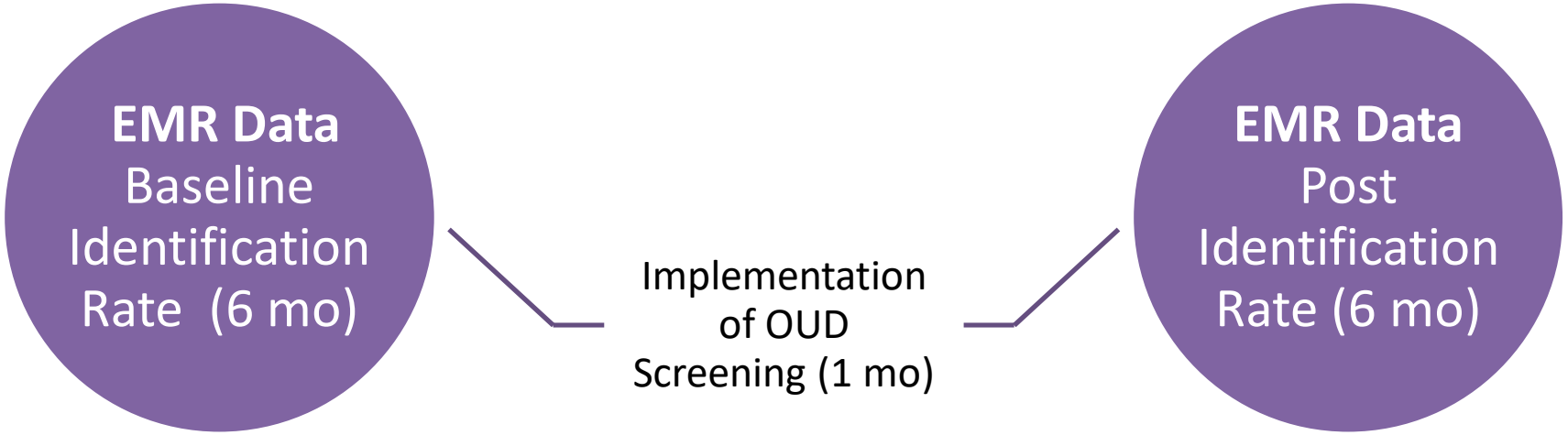
QUANTITATIVE STUDY DESIGN:

Does screening for OUD increase identification*?*

- 20 primary care clinics from
- Practice facilitation included training, coaching and technical support during biweekly virtual meetings during the preparation phase and monthly virtual meetings once screening was initiated. An OUD screening toolkit
- **Pre-Post Identification of Patients with OUD using ICD-10 Code**



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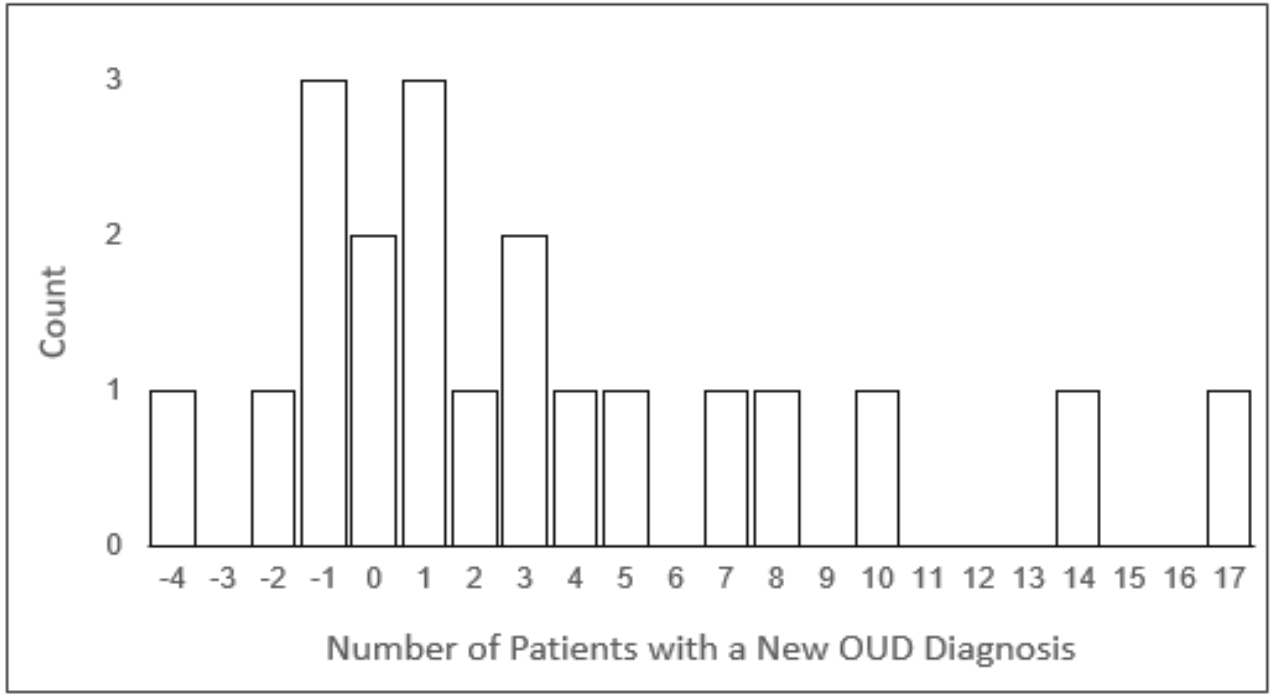
SCREENING RESULTS

- Overall, 65% (n=13) of the clinics reported a pre-post increase in patients with a new OUD diagnosis, 25% (n=5) reported a decrease, and 10% (n=2) reported no change.
- The median percentage of patients with a new OUD was not statistically significant

Figure 1. Histogram of pre-post changes in the number of patients with a new OUD diagnosis



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CONCLUSIONS

This study found that universal screening for OUD in a range of primary care clinics did not increase identification of OUD among patients with undiagnosed OUD.

- **Considerations:**
  - Patients may not have had a follow-up diagnostic assessment (difficult to engage and lack of appointment availability
  - Low yield was disheartening to clinicians and may have impacted evaluation of positive screens
  - Potential for lack of disclosure by patients including due to stigma
- **Limitations:**
  - Clinics self selected to study and may not generalize
  - OUD screening was conducted in multiple ways
  - Potential for variability in OUD screening implementation
  - May have needed a longer window of observation
  - Clinicians may not have correctly recorded diagnoses
  - Pandemic

Practice Implications:

- May consider more targeted screening
- May invest in outreach efforts to attract new patients seeking care for OUD
- May focus on engagement efforts to keep patients in treatment

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Thank you!
QUESTIONS AND DISCUSSION

Acknowledgements:
CHAMP Team and Trial Clinics
AIMS Center

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