Addressing the Opioid Crisis in Vermont: Lessons Learned from Primary Care Physicians

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Background

Opioid Misuse in Vermont:

- The number of Vermonters seeking treatment for opioid abuse is increasing, particularly in Chittenden County.
- Emergency department visits and deaths related to opioid misuse continue to increase, both locally and nationally.

Opioid Addiction Treatment:

- The Drug Addiction Treatment Act (2000) was passed to allow physicians to prescribe buprenorphine-naloxone for opioid addiction, termed Office-Based Opioid Therapy (OBOT).
- OBOT has been shown to be a highly effective treatment for opioid addiction.
- The Hub and Spoke model was implemented in Vermont to connect specialty treatment centers with outpatient OBOT providers.

Project Goal: To identify barriers to providing OBOT that primary care physicians (PCPs) face in Chittenden County, Vermont.

Methods

- Performed structured interviews with 25 PCPs in Chittenden County regarding experiences and attitudes towards OBOT.
- Particular emphasis was placed on barriers to expanding OBOT capacity.
- Results were analyzed using the Grounded Theory approach.

Results

Barriers to Providing OBOT

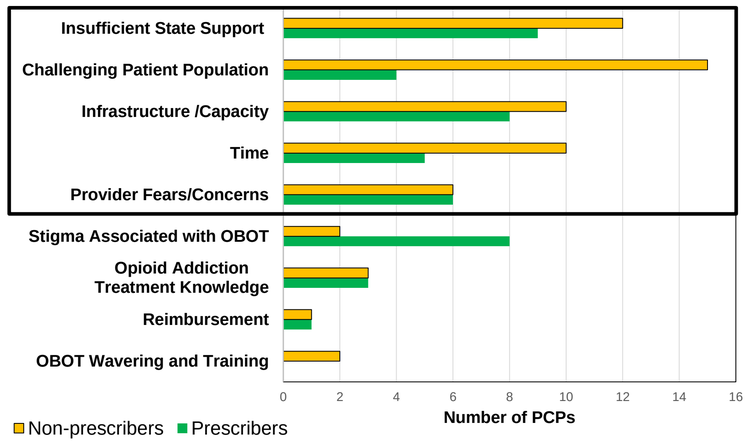


Figure 1: Top barriers of providing OBOT for Non-OBOT (**n=14**, gold) and OBOT (**n=11**, green) PCPs

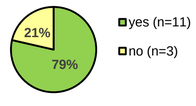
Table 1. Characteristics of PCPs

Characteristic	Median/Percent
Years in Practice	16.5 yrs Range: 1-38 yrs
Private practice	28%
Providing OBOT services	44%
OBOT panel size	30 Range:1-112

Top 5 Barriers to Providing OBOT:

1. Insufficient state logistical support
2. Challenging patient population
3. Infrastructure/Capacity of the practice
4. Available time
5. Provider fears/concerns

Figure 2: The percentage of Non-OBOT providers who would provide OBOT if identified barriers were removed



Ways To Improve the Hub and Spoke Model

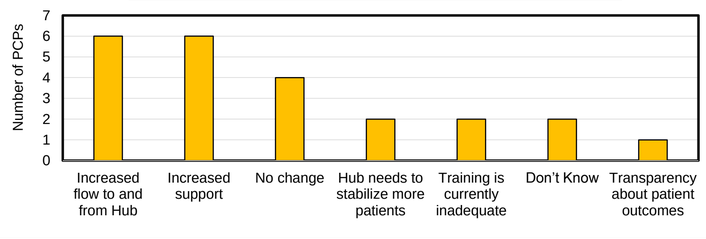


Figure 3: Combined OBOT and Non-OBOT providers describe ways to improve The Hub and Spoke Model in VT

Important Lessons Learned From Experienced OBOT PCPs:

- Providing OBOT is clinically satisfying
- Experienced OBOT physicians are happy to mentor new OBOT providers
- More physician education is needed

Potential Impact of Barrier Removal:

- Approximate current waiting list in Chittenden County = 200
- Mean patient panel size of OBOT providers = 40
- The number of providers which said yes to providing OBOT if barriers were removed =11.

Residual Waiting = 200- (11X40) = -220

- Removal of barrier will have a significant impact on the current OBOT waiting list

Discussion

- There were discrepancies in barriers noted between the Non-OBOT and OBOT providers.
  - Non-OBOT providers were more likely to report that OBOT patients were challenging than were OBOT providers.
  - OBOT providers were more likely to acknowledge the stigma associated with OBOT.
- Both groups desired increased state support for OBOT.
- A large proportion of Non-OBOT providers are willing to begin seeing OBOT patients if the identified barriers are addressed.

Recommendations

1. **Increase state support/resources for OBOT**
   - Hub and Spoke
   - Case management and counseling
2. **Peer mentorship for newly waivered OBOT providers by experienced OBOT providers**
   - Remedy perception vs. reality
   - Address fears and concerns
   - Ensure success
3. **Best practices guidelines**
   - Physician education
   - Organization/coordination of office, staff, and physicians within a practice