



Patient predictors of substance use disorder treatment initiation in primary care

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ABSTRACT

Introduction: Primary care clinics are opportune settings in which to deliver substance use disorder (SUD) treatment, but little is known about which patients initiate treatment in these settings.

Methods: Using secondary data from a RCT that aimed to integrate SUD treatment into a federally qualified health center (FQHC) using an organizational readiness and collaborative care (CC) intervention, we examined patient-level predictors of initiation of evidence-based practices for opioid and/or alcohol use disorders (OAUDs): a brief behavioral treatment (BT) based on motivational interviewing and cognitive behavioral therapy and medication-assisted treatment (MAT) (extended-release injectable naltrexone (XR-NTX) for patients with an alcohol use disorder or opioid use disorder and buprenorphine/naloxone (BUP/NX) for patients with an opioid use disorder). Using the Andersen model of health care access, we tested bivariate and multivariate logistic regression models to assess associations between patient factors and initiation of BT and MAT.

Results: Twenty-three percent of all participants ($N = 392$) received BT and 13% received MAT. In the multivariate model examining factors associated with initiation of BT, being of “other” or “multiple” races compared with being White ($OR = 0.45$, $CI = 0.22$, 0.92), being homeless ($OR = 0.45$, $CI = 0.21$, 0.97) and having been arrested within 90 days of baseline ($OR = 0.21$, $CI = 0.63$, 0.69) were associated with significantly lower odds of initiating BT. Greater self-stigma ($OR = 1.60$, $CI = 1.06$, 2.42), receiving MAT ($OR = 5.52$, $CI = 2.34$, 12.98), and having received the CC study intervention ($OR = 12.95$, $CI = 5.91$, 28.37) were associated with higher odds of initiating BT. In the multivariate model examining patient factors associated with initiating MAT, older age ($OR = 1.07$, $CI = 1.03$, 1.11), female gender ($OR = 3.05$, $CI = 1.25$, 7.46), having a diagnosis of heroin abuse or dependence (with or without alcohol abuse or dependence compared with have a diagnosis of alcohol dependence only ($OR = 3.03$, $CI = 1.17$, 7.86), and having received at least one session of BT ($OR = 6.42$, $CI = 2.59$, 15.94), were associated with higher odds of initiating MAT.

Conclusions: Individuals who initiate BT for OAUDs in a FQHC are less likely to be homeless and more likely to have greater self-stigma. Those who receive MAT are more likely to be of older age, female, and to have a diagnosis of heroin abuse or dependence, with or without concomitant alcohol abuse or dependence, rather than alcohol abuse or dependence alone. Receiving collaborative care (e.g., a warm handoff, and follow-up by a care coordinator) may be critical to initiating BT. Receiving at least one session of BT is associated with higher odds of receiving MAT, and receiving MAT is associated with higher odds of receiving BT. The Andersen model of health care access provides some insight into who initiates BT and MAT for OAUD treatment in FQHC-based primary care; further research is needed to explore system-level factors that may also influence treatment initiation.

Abbreviations: ASSIST, Alcohol, Smoking and Substance Involvement Screening Test; AUD, Alcohol use disorder; BT, Brief treatment; BUP/NX, Buprenorphine/naloxone; CC, Collaborative care; CI, Confidence interval; CIDI, Comprehensive International Diagnostic Interview; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth edition; EBP, Evidence-based practice; FDA, Food and Drug Administration; FQHC, Federally Qualified Health Center; GED, General Equivalency Diploma; MAT, Medication-assisted treatment; NIDA, National Institute on Drug Abuse; OAUD, Opioid and alcohol use disorder; OR, Odds ratio; OUD, Opioid use disorder; RCT, Randomized controlled trial; SASS, Substance Abuse Stigma Scale; SD, Standard deviation; SF-12, Short-Form 12 Health Survey; SUD, Substance use disorder; XR-NTX, Extended-release injectable naltrexone

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1. Introduction

There is a large, unmet need for substance use disorder (SUD) treatment in the United States and, because specialty care settings cannot accommodate this need, there is a nationwide call for primary care practices, including federally qualified health centers (FQHCs) which provide primary care to medically underserved populations, to integrate SUD services (National Prevention Council, 2011; Office of National Drug Control Policy (ONDCP), 2010; U.S. Department of Health and Human Services (HHS) Office of the Surgeon General, 2016). In 2015, 20.4 million adults in the U.S. (representing 8.4% of all adults) needed treatment for an illicit drug or alcohol use problem; of these, 18.1 million did not receive it (Park-Lee, Lipari, Hedden, Copello, & Kroutil, 2015). Among those who perceived they needed treatment and did not receive it (863,000), 39% tried to get treatment but did not succeed (Park-Lee et al., 2015). Untreated opioid and/or alcohol use disorders (OAUds) are of particular concern because of high rates of morbidity, and mortality (Coben et al., 2010; Hines, Barrett, Jiang, & Steiner, 2014; Owens, Barrett, Weiss, Washington, & Kronick, 2014; Ronan & Herzig, 2016), as well as increasing consequences, including overdose deaths, from the non-medical use of prescription opioids and transition to heroin (Mendelson, Flower, Pletcher, & Galloway, 2008).

Historically, SUD treatment in the U.S. has been provided in specialty care settings, but barriers such as long waiting lists, lack of child care, and lack of availability hinder treatment utilization in these settings (Appel, Ellison, Jansky, & Oldak, 2004; Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Grant, 1997). Further, many people who need treatment are not aware that they need it or do not know how or where to seek it (Park-Lee et al., 2015; Substance Abuse and Mental Health Services Administration, 2013). There is growing evidence that integrated medical and SUD care compared with non-integrated care improves outcomes for people with SUDs and that it is cost-effective (Savic, Best, Manning, & Lubman, 2017).

Primary care is thought to be well-suited to provide SUD treatment because the prevalence of alcohol use disorders and use of illicit drugs is higher among primary care patients than it is in the general population due to comorbidity of SUDs with other illnesses that bring people into medical care (Cherpitel & Ye, 2012; Pilowsky & Wu, 2012), and most individuals visit a primary care provider at least once a year (Blackwell, Lucas, & Clarke, 2014). Further, several evidence-based treatments for SUDs—medications for OAUds in particular but also brief therapy interventions—are available and appropriate for delivery in primary care settings (Balhara, 2014; Doolittle & Becker, 2011; Drainoni et al., 2014; Mauger, Fraser, & Gill, 2014; Myles & Raybould, 2000; Schackman, Leff, Polsky, Moore, & Fiellin, 2012; Tofighi et al., 2014). And, because SUDs are increasingly understood as chronic and similar to medical conditions that require long-term, continuous care, SUDs are thought to be well-suited for treatment in primary care (McLellan, Lewis, O'Brien, & Kleber, 2000; Tai & Volkow, 2013). Community health centers such as FQHCs are of particular importance because expanded health insurance coverage under the Patient Protection and Affordable Care Act substantially increased the number of individuals seeking medical care in these settings (Angier et al., 2015; Wallace, Young, Rodriguez, Bonilla, & Pourat, 2016), they are the largest source of primary health care for underserved individuals, and 1 in 12 people in the U.S. receives primary care in these settings (Rosenbaum et al., 2017). Increased identification and treatment of SUDs in FQHCs and other community health centers could address unmet need among a substantial number of individuals who never receive treatment (Substance Abuse and Mental Health Services Administration, 2011).

As integration of SUD treatment with primary care expands, additional study is needed to ensure that services meet patient needs (Buck, 2011; LoSasso & Byck, 2010; Substance Abuse and Mental Health Services Administration, 2017). Because primary care patients initially may not be seeking treatment for their SUD from their primary care provider when they present for an appointment, understanding which

factors may facilitate or hinder treatment initiation after a positive screen for an SUD can inform efforts to increase treatment initiation. In a prior study from which data for the present study were drawn, we studied the effects of a dual intervention strategy—organizational readiness and collaborative care (CC)—on integrating OAUD treatment into a FQHC. Although that study resulted in 61% of providers prescribing MAT, only 23.5% of all participants received BT and only 13% received MAT (Watkins et al., 2017) suggesting the need to understand which patients are most (and least) likely to receive services in primary care and, ultimately, to improve treatment access and initiation.

With regard to access to health care in general, Andersen (1995) suggests that health care settings must have the capacity to provide appropriate treatment, and that three domains of patient factors predict health care access: predisposing characteristics, i.e., those that cannot easily be changed to facilitate access to care; enabling or inhibiting resources, which are factors that are mutable and facilitate or hinder access; and need or severity factors, which are factors related to the current illness, in this case the SUD (Andersen, 1995). Addressing these factors can facilitate targeted interventions that increase access to care and treatment initiation. Although several studies have examined patient-level predictors of treatment initiation in SUD specialty care settings, we are only aware of one study that has examined SUD treatment initiation in a primary care setting, finding that entry into a primary care-based buprenorphine treatment program was associated with identification of other chronic medical conditions (Rowe, Jacapraro, & Rastegar, 2012).

The present study examines patient-level factors associated with treatment initiation in two of the largest clinics of a FQHC that recently implemented a motivational-interviewing and cognitive behavioral therapy - based brief treatment (BT) and medication-assisted treatment (MAT) for patients identified with an OAUD during routine screening (Watkins et al., 2017; Ober et al., 2015). We included variables from prior literature predictive of treatment entry in specialty care across the Andersen categories of treatment access, such as race/ethnicity (Kirchner, Booth, Owen, Lancaster, & Smith, 2000; Saum, Hiller, Leigey, Inciardi, & Surratt, 2007; Schwartz, Kelly, O'Grady, Mitchell, & Brown, 2011; Weisner, Matzger, Tam, & Schmidt, 2002); age (Weisner et al., 2002), gender (Green, Polen, Dickinson, Lynch, & Bennett, 2002), education (Weisner et al., 2002) (predisposing characteristics); being stably housed and not homeless (Corsi, Kwiatkowski, & Booth, 2007), being legally employed (Saum et al., 2007; Schwartz et al., 2011), having health insurance (Saum et al., 2007), stigma (Barry, McGinty, Pescosolido, & Goldman, 2014; Crapanzano, Vath, & Fisher, 2014; Florez et al., 2015; Kulesza et al., 2016; Matthews, Dwyer, & Snoek, 2017) (enabling/inhibiting resources); and history of treatment for a SUD (Schwartz et al., 2011; Siegal, Falck, Wang, & Carlson, 2002), legal and social problems (Carlson et al., 2010; Siegal et al., 2002; Weisner et al., 2002), having more problems associated with drugs than with alcohol (Corsi et al., 2007), SUD severity (measured by frequency, consequences and symptoms of dependence) (Weisner et al., 2002), and perceived need, readiness or desire for treatment (Corsi et al., 2007; Schwartz et al., 2011; Siegal et al., 2002) (need/severity factors).

Our primary research questions were: "What predisposing, enabling/inhibiting resources, and need/severity factors predict initiation of BT for an OAUD in primary care," and, "what predisposing, enabling/inhibiting resources, and need/severity factors predict initiation of MAT for an OAUD in primary care?"

This study is a secondary analysis of data from a randomized controlled trial (RCT) that tested the effectiveness of a dual intervention strategy (organizational readiness and collaborative care (CC)) for implementing BT and MAT to treat OAUds in primary care (Watkins et al., 2017; Ober et al., 2017; Ober et al., 2015). The study focused on OAUds because these disorders are common among primary care patients and because there are effective, FDA-approved medications approved for use across medical settings (Balhara, 2014; Doolittle & Becker, 2011; Drainoni et al., 2014; Mauger et al., 2014; Myles & Raybould, 2000;

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