Northwest (HHS Region 10)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

The Northwest & Pacific Southwest ATTCs and the CTN Western States Node present:

Opioid Clinical Decision Support in Primary Care: CTN-0095

Thank you for joining us!
The webinar will begin shortly.

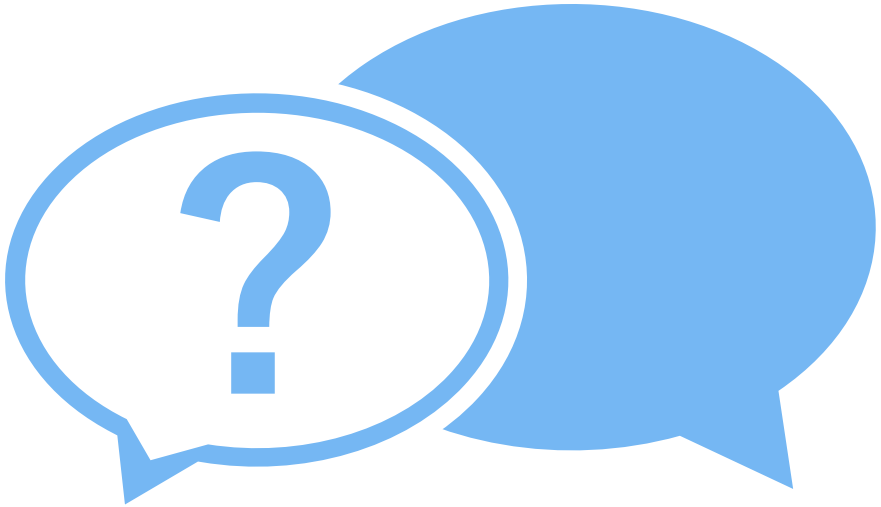
- **You are muted with camera off.** Attendees are automatically muted with their cameras off for the webinar. Please type questions in the chat box!

- **Slides and a recording** of this presentation will be made available on our website at: http://attcnetwork.org/northwest later this week.

SAMHSA
Substance Abuse and Mental Health Services Administration

Q&A

Questions? Please type them in the chat box!



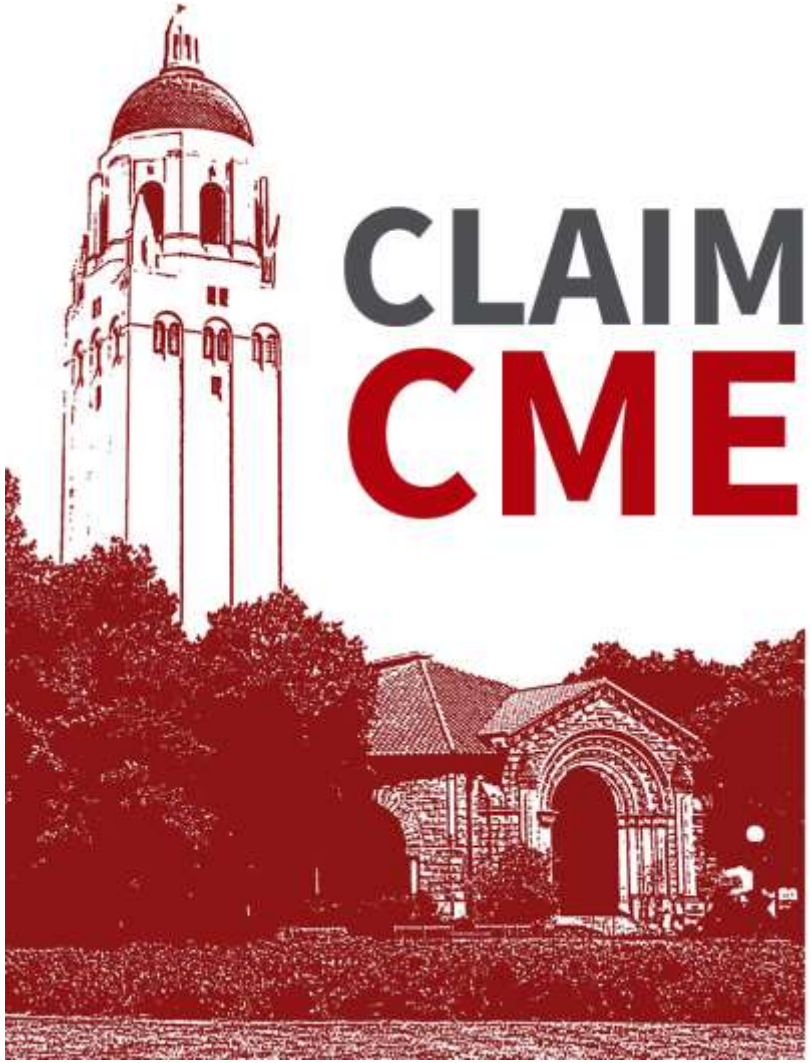
ATTC Survey, Slides, Recording

Look for our survey in your inbox!

We greatly appreciate your feedback!

Every survey we receive helps us improve and continue offering our programs.

A link to the slides and recording will also be provided in this email.



Questions? Email:
stanfordcme@stanford.edu

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Opioid Clinical Decision Support in Primary Care: CTN-0095

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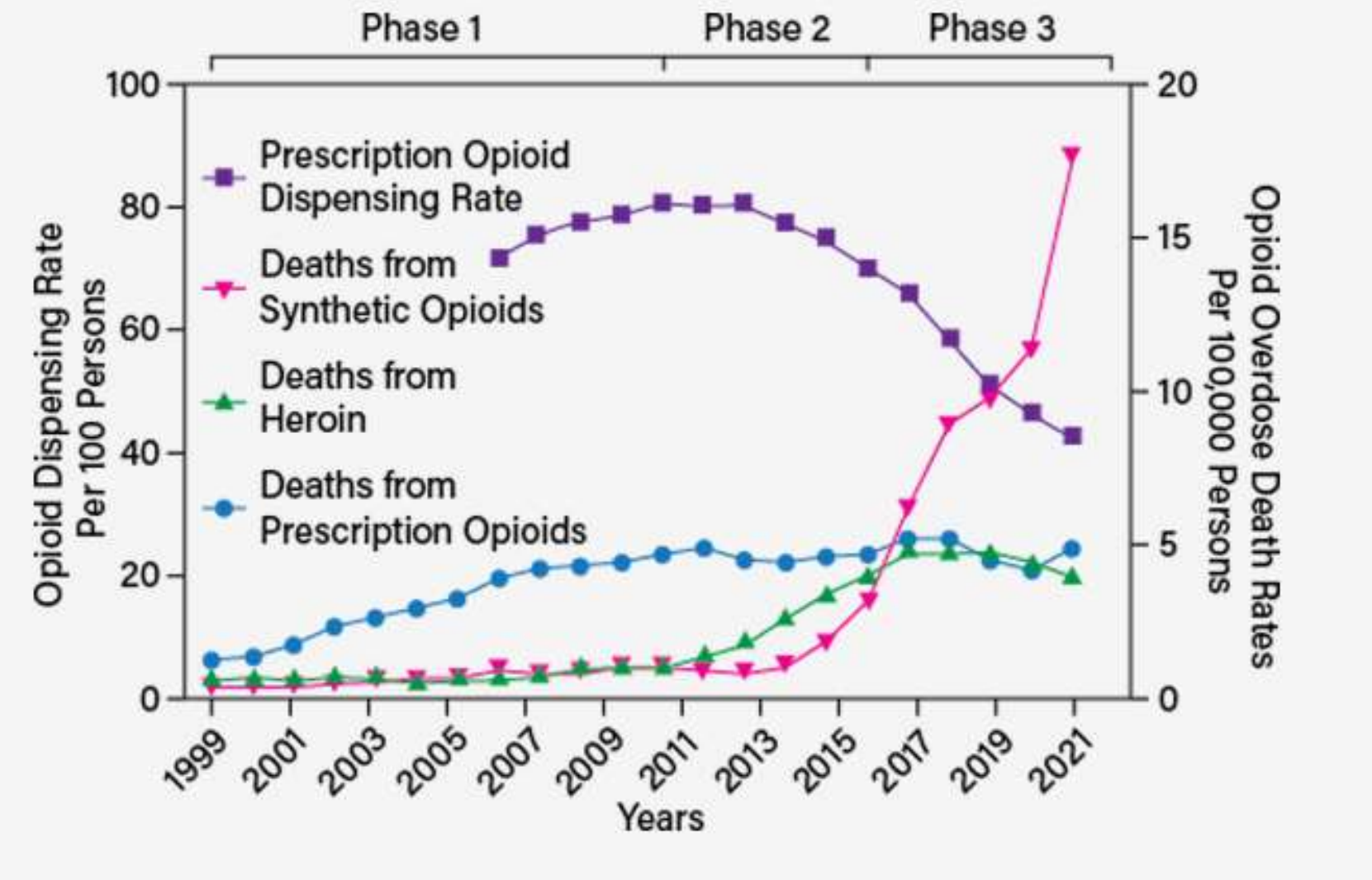
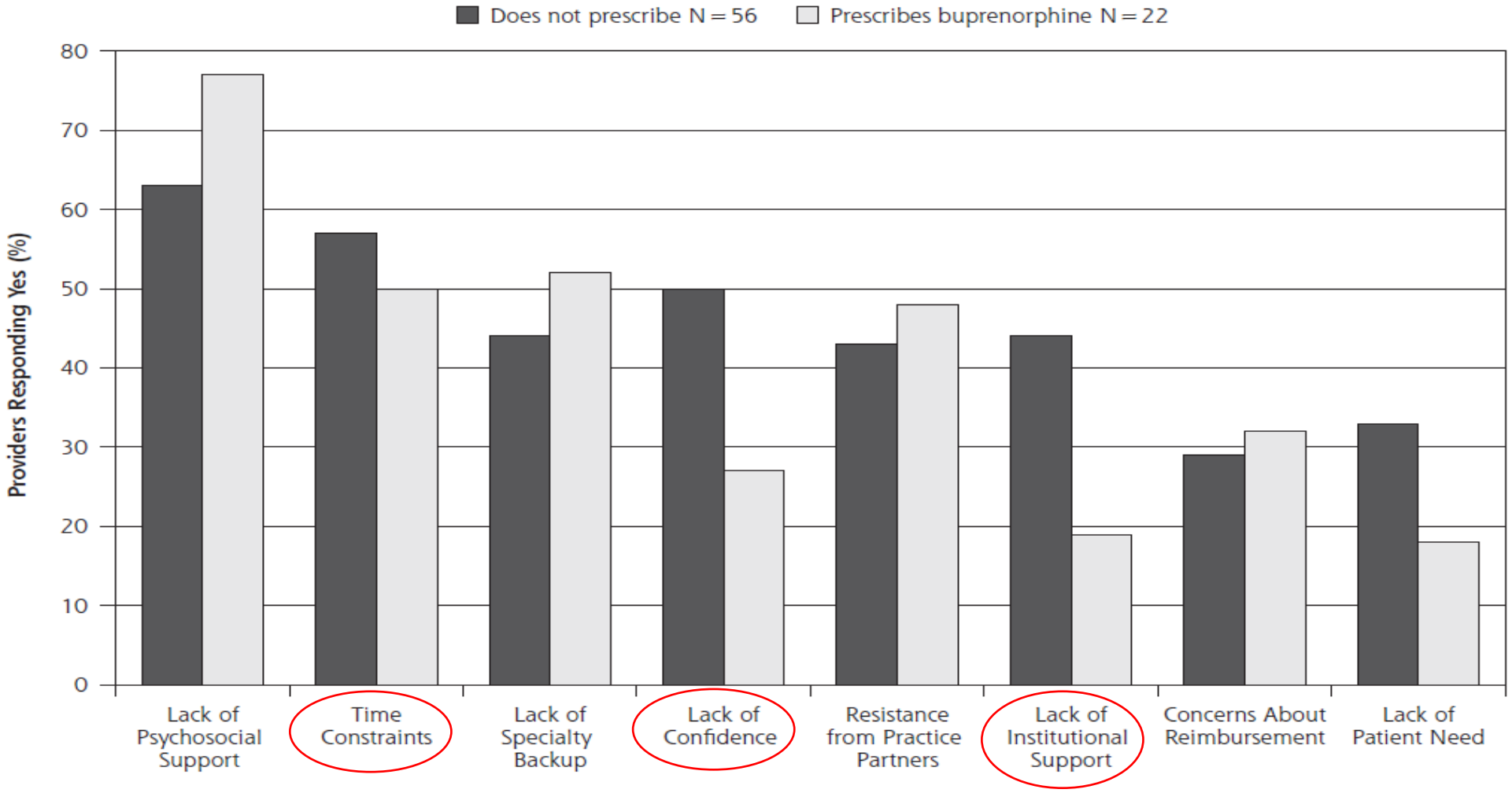
Background


Phase 1
Phase 2
Phase 3
Prescription Opioid Dispensing Rate
Deaths from Synthetic Opioids
Deaths from Heroin
Deaths from Prescription Opioids
Opioid Dispensing Rate Per 100 Persons
Opioid Overdose Death Rates Per 100,000 Persons
Years
0
20
40
60
80
100
0
5
10
15
20
1999
2001
2003
2005
2007
2009
2011
2013
2015
2017
2019
2021

Barriers to prescribing

- Many are structural
- Some may respond to clinical decision support tools



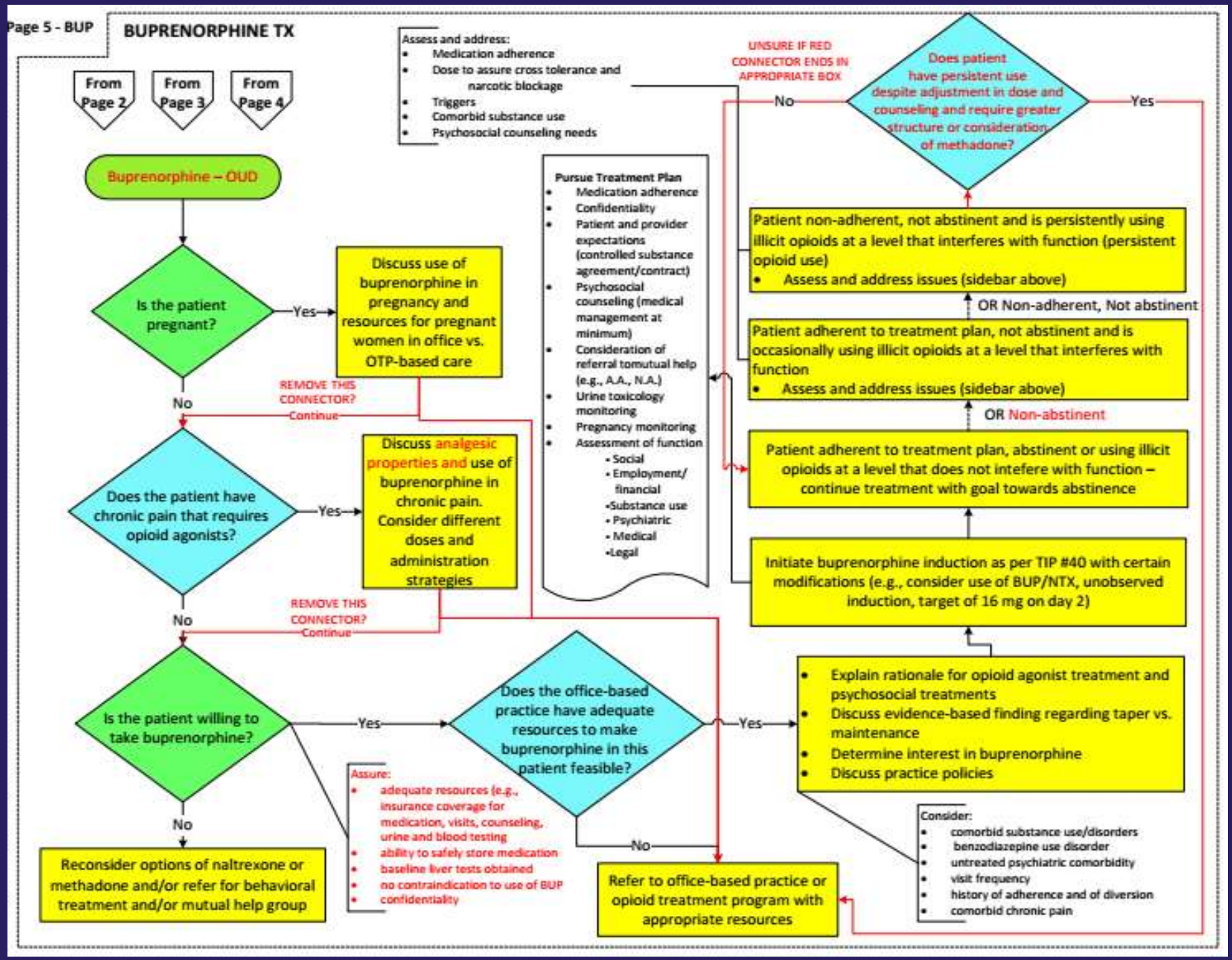
Is there an e-solution?

Translating guidelines into apps may help, but

- **PCCs need to toggle between app and EHR**
- **The app doesn't "know" the patient**
- **Decision tree not automated**

Why not integrate guidelines into EHR?

- **Data collection and assimilation can be automated**
- **Can be personalized for known risks, previous/current treatments, relative contraindications**



- NIDA expert panel produced a white paper specifying the needed content for clinical decision support
- Could we translate this into real-time CDS?

CV Wizard PCC View

CV Wizard | Print Patient Only & Close | Print Provider Only & Close | Print All & Close (double sided printer) | Print All & Close (single sided printer)

Provider | Patient | Feedback | Statin Risk Assessment Tool

Patient Name	Age	Lifetime Cardiovascular(CV) Risk**	10 Year CV Risk**
CVW,TESTONE	64	Calculated for ages 20-59	33.1%

Relevant problems: Diabetes

Lipids

CV Risk Reduction: 8 %*

Priority: 2

Goal: Consider statin initiation.

Labs:

LDL (mg/dl)	130	8/17/18
HDL (mg/dl)	35	2/17/18
TRIG (mg/dl)	220	2/17/18
TC (mg/dl)	250	2/17/18

Treatment Considerations:

- Statin initiation or intensification is recommended due to diabetes and CV risk. Many experts recommend high intensity statin doses for CV risk > 7.5%.

Other Considerations:

- Baseline ALT measurement is recommended by many experts prior to statin therapy initiation.

Blood Pressure

CV Risk Reduction: 0 %*

Goal: BP < 140/90

Labs:

BP (mm Hg)	110/80	8/23/18
Last BP (mm Hg)	150/80	8/17/18

Glucose/A1C

CV Risk Reduction: 5 %*

Priority: 3

Goal: A1C <= 7.9

Labs:

A1c (%)	8.8	8/17/18

Medications:

- Metformin HCl Tab 500 MG

Treatment Considerations:

- If appropriate, consider increasing metformin as tolerated (to 1000 mg bid).
- Consider starting a sulfonylurea (e.g. glimepiride).
- Consider starting a DPP4 inhibitor (e.g. linagliptin 5 mg qd).

Other Considerations:

- Annual kidney function tests(GFR) are recommended for metformin use.
- Consider monthly visits and/or interim phone calls until A1c goal achieved.
- Urinary albumin excretion test (e.g. UMACR) may be due.
- Consider using diabetes educator, dietitian, or MTM pharmacist support.

BMI : 26.3

CV Risk Reduction: < 1 %* (based on 3 unit drop in BMI)

Priority: 4

Treatment Considerations:

- Discuss advantages of reducing weight by 10-20 lbs. Potential actions are listed on patient interface.

Tobacco Use : YES

CV Risk Reduction: 9 %*

Priority: 1

Treatment Considerations:

- Tobacco use is identified. Assess readiness and consider varenicline (Chantix), bupropion (Zyban), or nicotine patch, gum, lozenge, or inhaler. Type "hp connect" in Epic orders for smoking cessation counseling referral. Additional options listed on patient interface.

Aspirin or Blood Thinner Use : YES

CV Risk Reduction: 0 %*

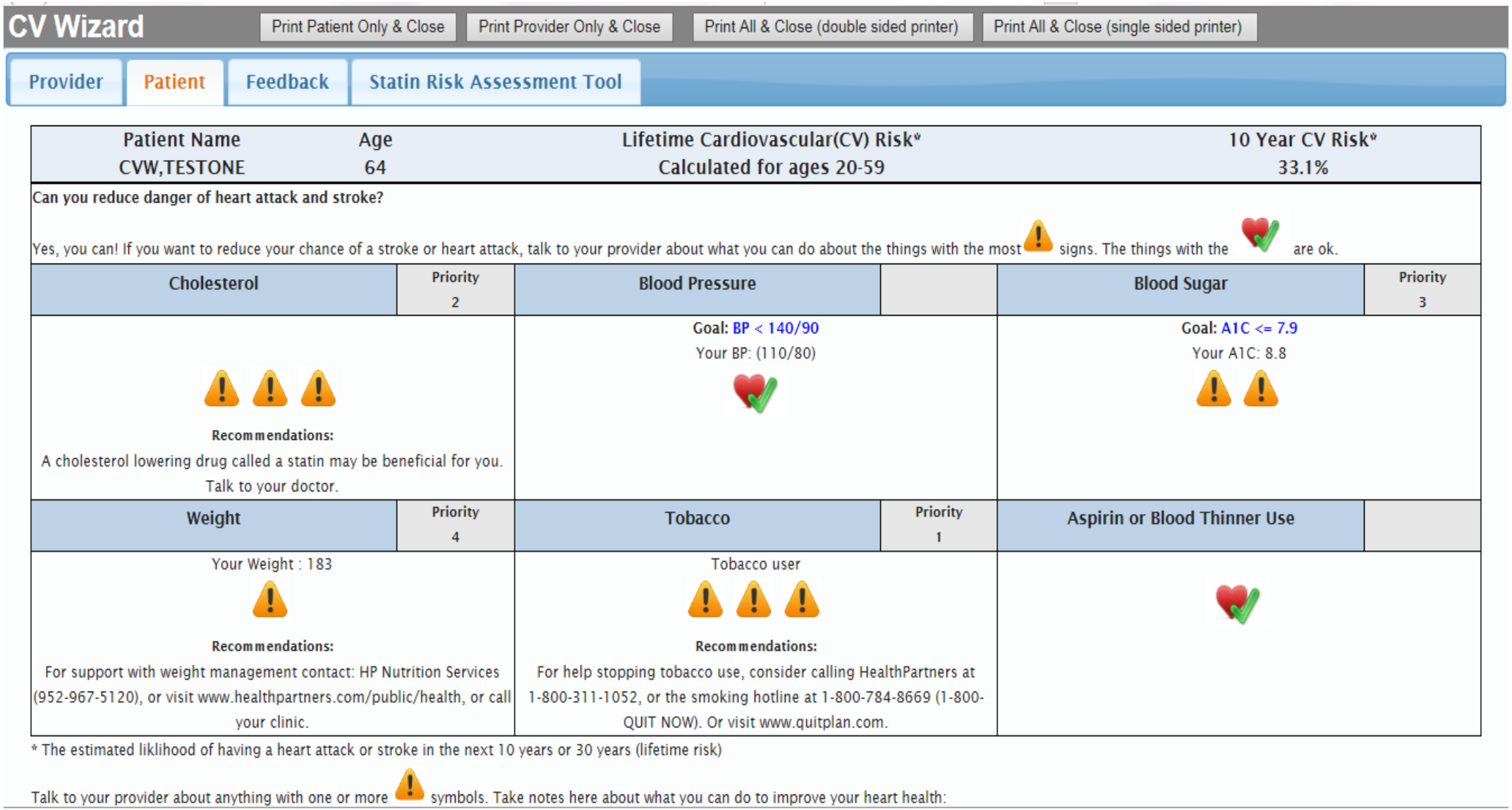
Medications:

- Aspirin Tab 81 MG

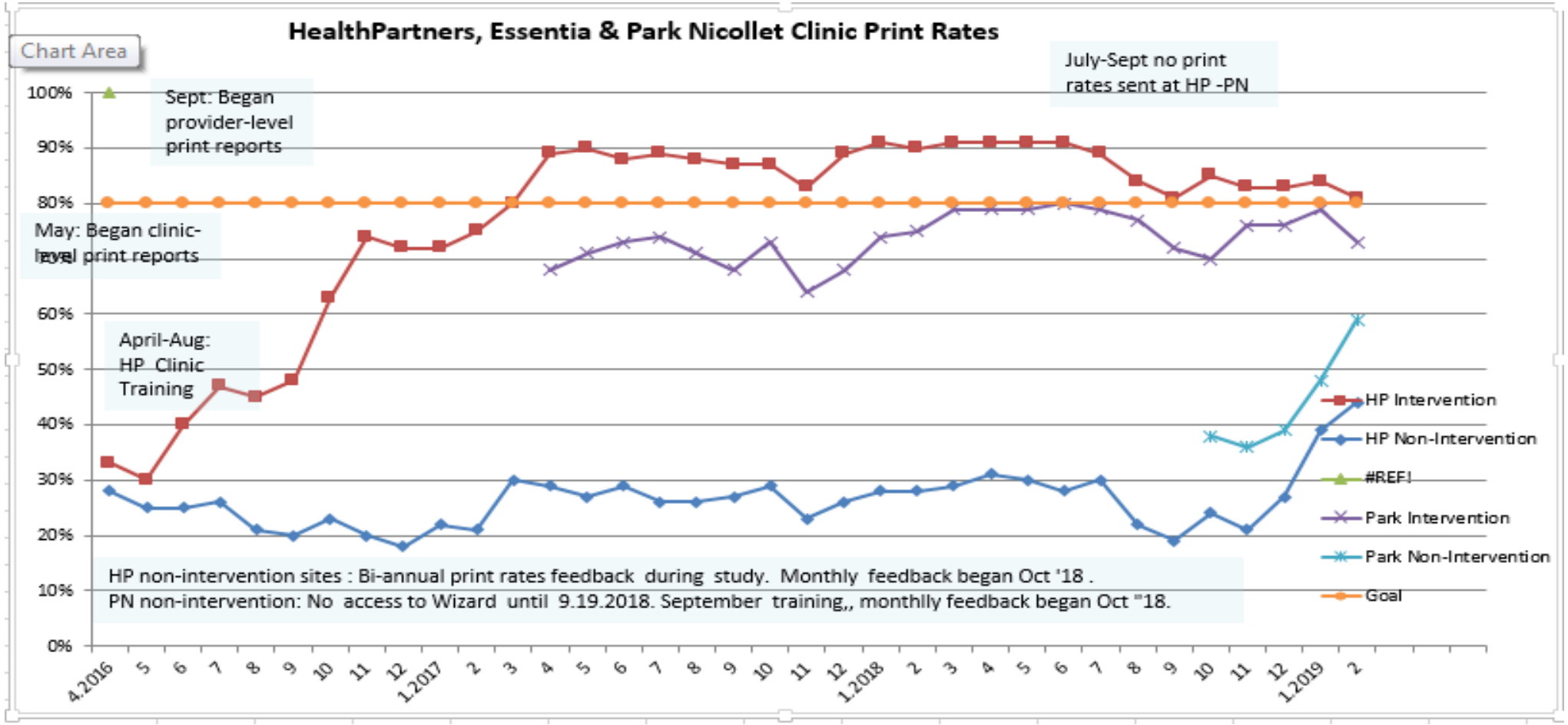
Treatment Considerations:

- Clinical indication for ASA: Yes
- Low dose aspirin is recommended for primary prevention of cardiovascular disease and colorectal cancer if patient places a higher value on these benefits than the potential harm from bleeding and is willing to undergo long-term therapy.

CV Wizard Patient View



High print rates, improves CV health



- CV Wizard provides CDS for both patients and PCCs, targeting higher -risk patients
- Used since 2006, part of usual care at HealthPartners
- CV Wizard improves BP and A1C and decreases 10-year CV risk.
- Print rate around target of 80% has been sustained

Pilot Study

- One year breaking the white paper into components and restructuring them into 60+ decision support algorithms
- 6-month feasibility/usability pilot of 55 PCCs June-Dec 2018
  - 8 Waivered MDs → intervention group
  - 24 non-waivered MDs → randomized to intervention or control
  - 23 non-waivered NPs/PAs → randomized to intervention or control
- Successfully implemented and tested the CDS; PCCs gave useful feedback to improve the tool, including:
  - Modular
  - “Easy” buttons
  - Notebuilder

Multi-Site Cluster-Randomized Trial

	**Setting: 92 primary care clinics at 3 sites** HealthPartners (MN, WI), Geisinger (PA), Essentia (outstate MN)
	**Patient Inclusion Criteria** Aged 18-75; high risk for OUD or opioid overdose (Epic), OUD dx, on MOUD, or recent overdose
	**Primary Outcome Measures** • **OUD diagnosis** within 30 days of index visit for patients at high risk of OUD • **Naloxone prescription** within 30 days of index for patients with/at high risk for OUD • **MOUD orders or referral** to OUD treatment within 30 days of index for patients with/at high risk for OUD • **Total days covered by an MOUD rx** in 90 days after index visit for patients with/at high risk for OUD

Multi-Site Cluster-Randomized Trial

Secondary Outcomes:

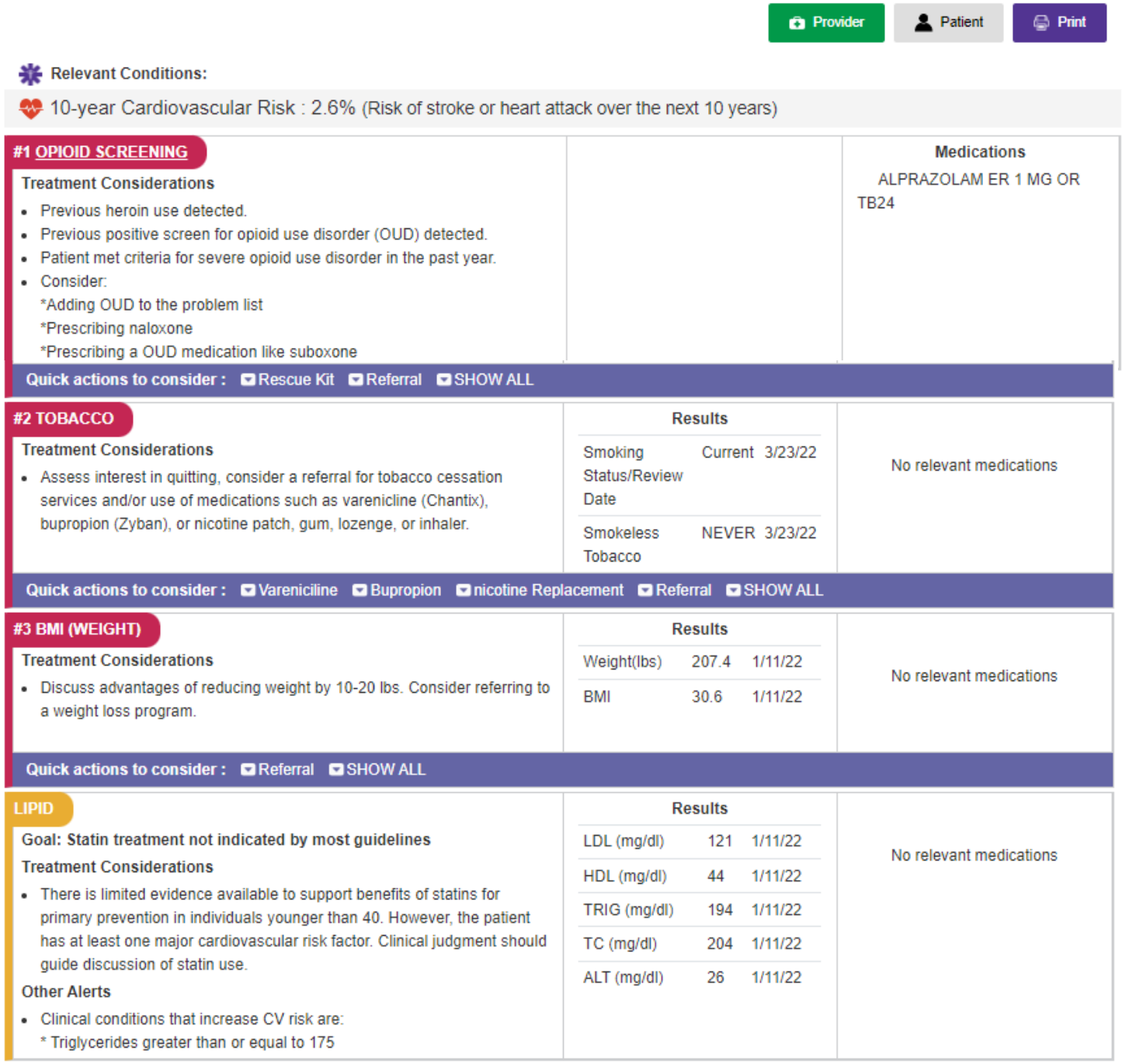
- **OUD dx, naloxone rx, MOUD orders or referral** within 90 days
- **ED visits** during observation period
- **Hospitalizations** during observation period
- **Total costs of care** during observation period
- **All-cause mortality** during observation period
- Fatal and non-fatal **opioid overdoses** during observation period
- **Rates of tool use** in intervention clinics
- PCC **confidence** in treating OUD at baseline and 9 months
- Intervention PCC ratings of **satisfaction and acceptability** of the tool at 9 months

Mixed Methods Aim

- Use quantitative & qualitative methods to identify, describe and quantify barriers & facilitators to implementation to adapt it to maximize its use & effectiveness

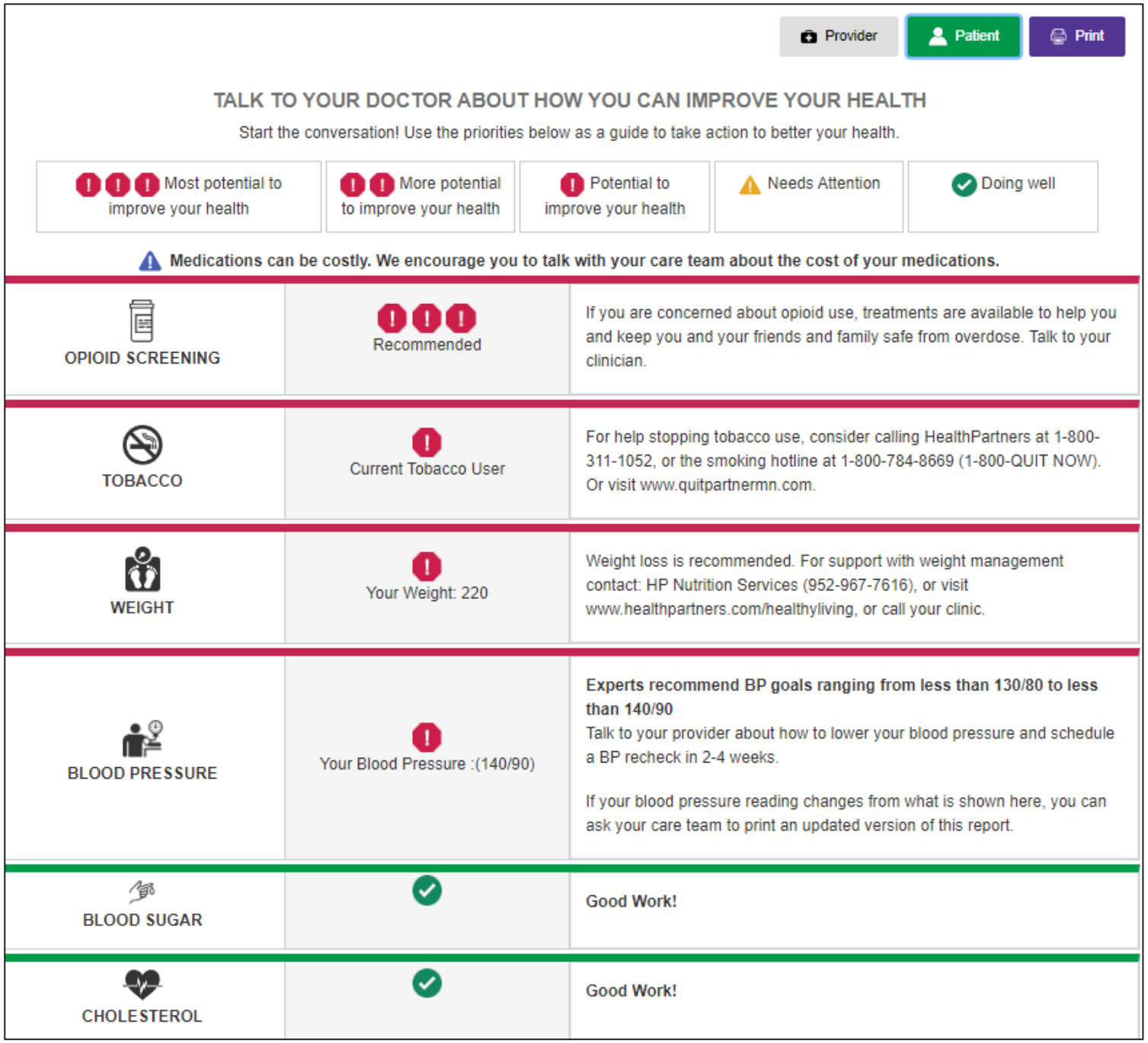
Clinician Handout

- Includes lab values, treatment considerations, and safety alerts
- Can be given to patients with high literacy and numeracy



Patient Handout

- Designed for lower literacy and numeracy
- Uses symbols to relay risk and what would be of most benefit to health if actions taken



Provider | Patient | Print

TALK TO YOUR DOCTOR ABOUT HOW YOU CAN IMPROVE YOUR HEALTH

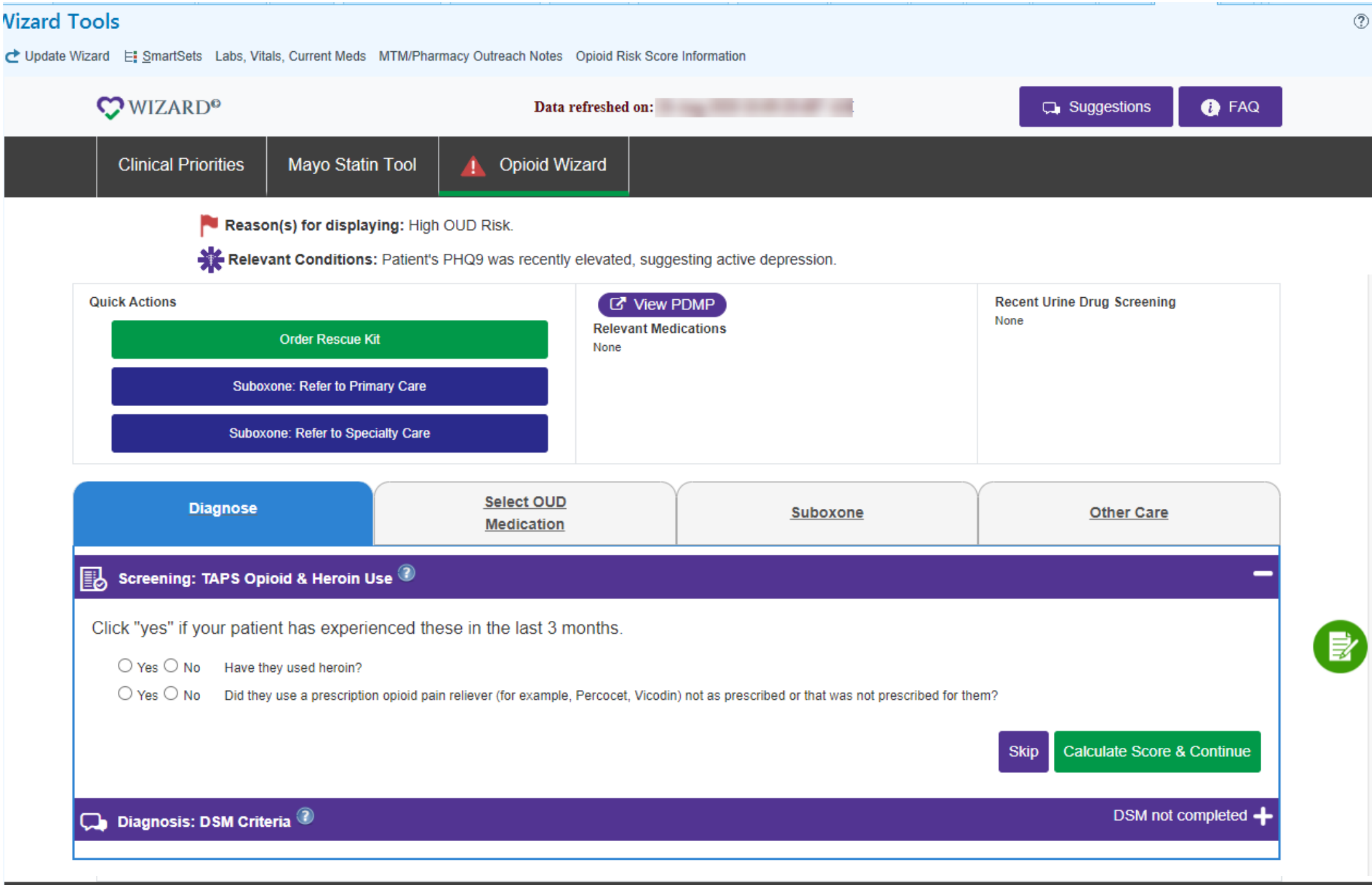
Start the conversation! Use the priorities below as a guide to take action to better your health.

Most potential to improve your health	More potential to improve your health	Potential to improve your health	Needs Attention	Doing well

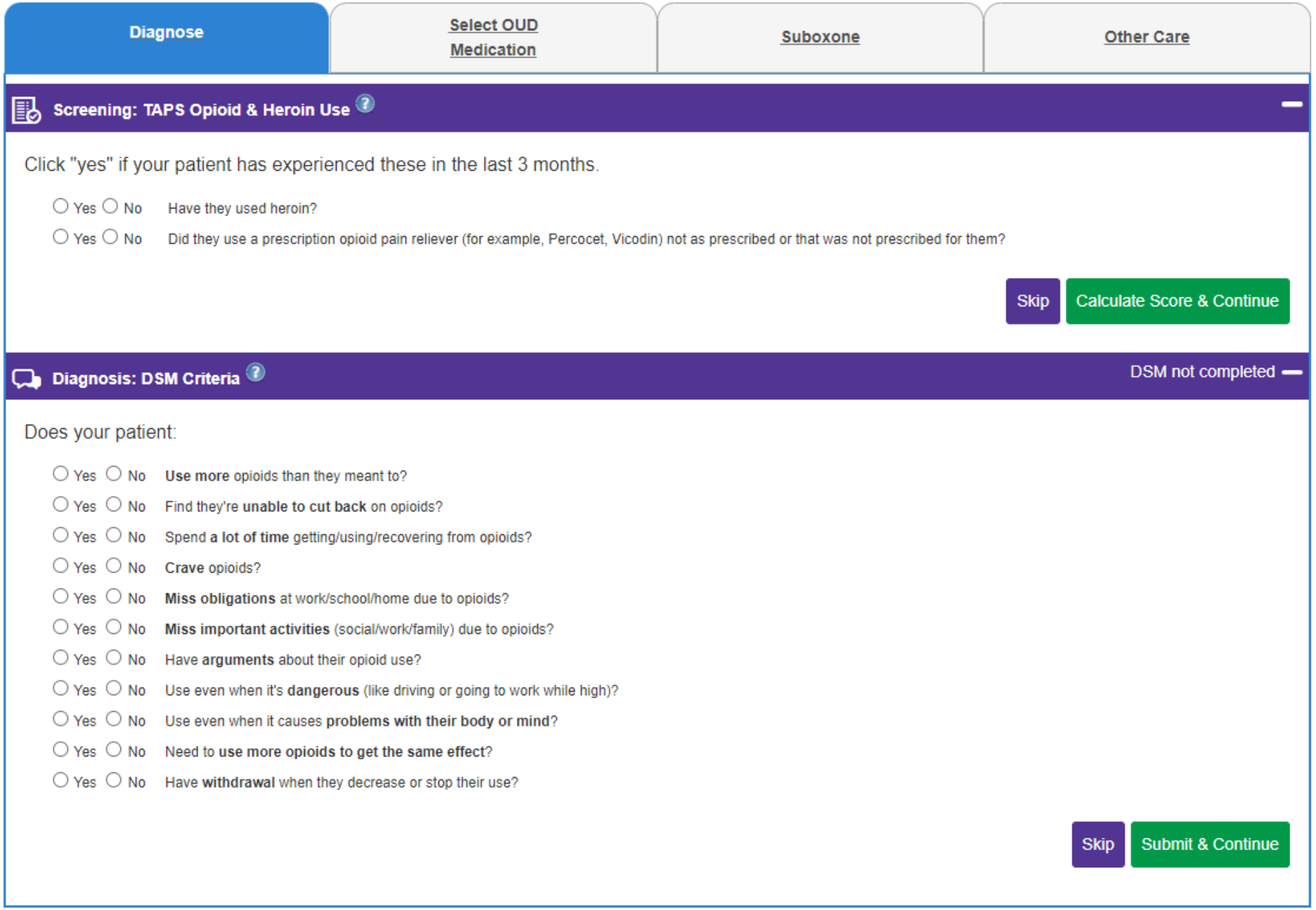
Medications can be costly. We encourage you to talk with your care team about the cost of your medications.

OPIOID SCREENING	Recommended	If you are concerned about opioid use, treatments are available to help you and keep you and your friends and family safe from overdose. Talk to your clinician.
TOBACCO	Current Tobacco User	For help stopping tobacco use, consider calling HealthPartners at 1-800-311-1052, or the smoking hotline at 1-800-784-8669 (1-800-QUIT NOW). Or visit www.quitpartnermn.com.
WEIGHT	Your Weight: 220	Weight loss is recommended. For support with weight management contact: HP Nutrition Services (952-967-7616), or visit www.healthpartners.com/healthyliving, or call your clinic.
BLOOD PRESSURE	Your Blood Pressure :(140/90)	**Experts recommend BP goals ranging from less than 130/80 to less than 140/90** Talk to your provider about how to lower your blood pressure and schedule a BP recheck in 2-4 weeks. If your blood pressure reading changes from what is shown here, you can ask your care team to print an updated version of this report.
BLOOD SUGAR		**Good Work!**
CHOLESTEROL		**Good Work!**

CDS Tool in Epic



CDS Tool in Epic



Diagnose | **Select OUD Medication** | Suboxone | Other Care

Print OUD medication overview for your patient to consider.
Order a rescue kit.

Yes / No Is your patient ready for treatment?

Please review treatment options below.

Patient Education Materials
- OUD Medication Overview
- Suboxone
- Methadone
- Naltrexone
- Naloxone
- Safer Use of IV Drugs

Treatment Selection

Do any of these clinical conditions apply to your patient?

Severe liver disease?
Yes / No

Severe respiratory disease?
Yes / No

Active alcohol use disorder? (Use the TAPS to screen)
Yes / No

Benzodiazepine or Z-drug (Zolpidem, Zopiclone, Eszopiclone, Zaleplon) use?
Yes / No

Chronic pain?
Yes / No

Is the patient at risk for suicide?
Yes / No

GO **Suboxone: Prescribe** — Select and Continue

GO **Suboxone: Refer to Primary Care** — Refer and Continue

GO **Suboxone: Refer to Specialty Care** — Refer and Continue

GO **IM Naltrexone: Referral to Specialty Care** — Refer and Continue

GO **Methadone: Print list of Community Clinics** — Print and Continue

Diagnose | **Select OUD Medication** | Suboxone | Other Care

Print OUD medication overview for your patient to consider.
Order a rescue kit.

Yes ◉ No Is your patient ready for treatment?

Consider prescribing a ⊕ rescue kit and asking patient to return to clinic soon to reassess readiness for treatment. Click here to document and exit the wizard.

Patient Education Materials
- OUD Medication Overview
- Suboxone
- Methadone
- Naltrexone
- Naloxone
- Safer Use of IV Drugs

Treatment Selection

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Yes ◉ No

Chronic pain?
Yes ◉ No

Is the patient at risk for suicide?
Yes ◉ No

GO **Suboxone: Prescribe** — Select and Continue

GO **Suboxone: Refer to Primary Care** — Refer and Continue

GO **Suboxone: Refer to Specialty Care** — Refer and Continue

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- Safer Use of IV Drugs

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( ) Yes (●) No

Benzodiazepine or Z-drug (Zolpidem, Zopiclone, Eszopiclone, Zaleplon) use?
( ) Yes (●) No

Chronic pain?
( ) Yes (●) No

Is the patient at risk for suicide?
( ) Yes (●) No

IMPORTANT TREATMENT CONSIDERATIONS

- Specialty care or methadone clinic recommended for patients with severe liver disease due to risk of further hepatic compromise.

Suboxone: Prescribe — Select and Continue

- Specialty or Methadone Clinic recommended.

Suboxone: Refer to Primary Care — Refer and Continue

- Specialty or Methadone Clinic recommended.

GO **Suboxone: Refer to Specialty Care** — Refer and Continue

IM Naltrexone: Referral to Specialty Care — Refer and Continue

- Contraindicated. Suboxone in Specialty Care or Methadone Clinic recommended.

GO **Methadone: Print list of Community Clinics** — Print and Continue

HealthPartners

Diagnose | Select OUD Medication | **Suboxone** | Other Care

Suboxone Initiation | Suboxone Maintenance

Relevant diagnoses:
Severe liver disease.

Relevant labs:
None

Relevant current medications:
None

Clinical Opiate Withdrawal Scale:
Score: none

Date:
Not administered within the last 12 hours

Educational Materials for Patients:

IMPORTANT TREATMENT CONSIDERATIONS

- Specialty care or methadone clinic recommended for patients with severe liver disease due to risk of further hepatic compromise.

Do you want to perform an in-clinic induction or an at-home induction?
(•) At-home ( ) In-clinic

Place Orders

- Order Suboxone 2mg if patient has a low tolerance for opioids: Print induction instructions (2mg)
- Order Suboxone 4mg if patient has a moderate tolerance for opioids: Print induction instructions (4mg)
- Order Suboxone 8mg if patient has a high tolerance for opioids: Print induction instructions (8mg)
- Order Rescue kit
- Order LFTs
- Consider Clonidine for breakthrough withdrawal symptoms for patients without hypotension
- Consider Zofran for breakthrough withdrawal symptoms
- Refer patient for additional substance use disorder resources

Optional

Print Subjective Opiate Withdrawal Scale (SOWS) for patients to use at home to assess withdrawal

CONTINUE TO OTHER CARE

Buprenorphine (Suboxone): Beginning treatment at 4 mg/day

Day 1:

Before taking any buprenorphine (Suboxone) you need to make sure you are in withdrawal. You should feel very lousy. It should be at least 12 hours from your last heroin or pain pill use and at least 24 hours from your last methadone use. If you take it too early it will put you into SEVERE withdrawal.

You should have at least 3 of the following symptoms:

- Restless, can't sit still
- Yawning
- Large pupils (the black part in the center of your eye)
- Runny nose, teary eyes
- Stomach cramps, nausea, vomiting, or diarrhea

If you have at least 3 of these symptoms, you can start buprenorphine

Buprenorphine should be taken under the tongue. If you swallow it, it will not work.

1) Take 4mg. This is either a ½ of an 8mg tab or film, two 2mg tabs or films or one 4mg film.
2) How do you feel 1-3 hours after your first dose?
    a. If you feel lousy, take another 4 mg under your tongue
    b. If you feel fine, don't take any more buprenorphine right now
3) How do you feel 6-12 hours after your first dose?
    a. If you feel lousy, take another 4 mg under your tongue
    b. If you feel fine, don't take any more buprenorphine right now

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Day 2:

1) If you took a total of 4 mg on Day 1:
    a. If you feel fine this morning, take 4 mg and stay there
    b. If you feel lousy this morning, take 8 mg
        i. How do you feel 1-3 hours after your first dose?
            1. If you feel ok, don't take any more buprenorphine right now
            2. If you feel lousy, take another 4 mg (for a total today of 12 mg)
2) If you took a total of 8 mg on Day 1

Patient Buprenorphine Instruction Sheet (3 starting doses)

Diagnose | Select OUD Medication | **Suboxone** | Other Care

Suboxone Initiation | **Suboxone Maintenance**

Relevant diagnoses:
Severe liver disease.

Clinical Opiate Withdrawal Scale:
Score: none

Date:
Not administered within the last 12 hours

Educational Materials for Patients:
Suboxone

IMPORTANT TREATMENT CONSIDERATIONS

- Specialty care or methadone clinic recommended for patients with severe liver disease due to risk of further hepatic compromise.

Does the patient have active symptoms of withdrawal or severe cravings?
○ yes ○ no

Is the patient using more Suboxone than prescribed?
○ yes ○ no

Is the patient under-using their Suboxone to use opioids or heroin?
○ yes ○ no

Recommendations

- Maintain current dose
- Schedule follow-up based on clinical need

CONTINUE TO OTHER CARE

Diagnose | Select OUD Medication | Suboxone | Other Care

Yes No Does your patient use IV drugs?

Related Information

Relevant vaccinations:
None
Relevant current medications:
None

Infectious Disease Care

Consider these screenings and vaccinations. Rule out active infection before ordering any vaccination.

- Hepatitis A vaccination
- Hepatitis B vaccination
- Hepatitis C screening
- TDAP vaccination
- Tuberculosis screening
- Chlamydia and gonorrhea screening
- Syphilis screening

Mental Health and Other Substance Use Care

- Screen for other substance use disorders
- Screen for depression using the PHQ9
- Screen for anxiety using the GAD7
- Refer for behavioral health consult

Patient Handout re:
Safer IV Drug Use

Safety when using IV Drugs

Infection Prevention:

- Never share needles, syringes or other equipment, such as cookers, cottons, or spoons
- Never share water. Use sterile water (available at drug stores) or water freshly boiled for 10 minutes to dissolve drugs
- Never reuse needles or syringes
- Never reuse cotton or other filters or try to cook drugs out of old cotton
- Any method of cleaning needles or other equipment is not adequate to prevent infections like HIV or hepatitis C
- Do not buy needles or other equipment on the street; they may be repackaged and sold as new
- Carry alcohol wipes with you and clean your skin with alcohol before injection.
- Wash your hands with soap and water prior to injecting
- Get tested for HIV and Hepatitis

Overdose Prevention:

- Never use alone
- Have Narcan (naloxone) available whenever and wherever you use. There should be 2-3 doses available per person using

Mixed Methods Results

PCC Perceptions of OUD Care

- N=8 PCCs; 2 waivered and 4 non-waivered MDs; 2 non-waivered PAs; 5 female; in practice 3 to 25 years
- Prior to study go-live
- Themes:
  - Primary care is the right place to address OUD
  - Clinician-patient and clinician-clinician relationships affect how and whether PCCs address OUD at a visit
  - Main challenges are limited time and competing priorities for these complex patients
  - CDS for OUD could be very helpful but must meet different needs for different clinicians and clinical situations and be simple to use
  - CDS needs to be complemented by supportive organizational policies and systems for optimal benefit

Solberg, L. I., Hooker, S. A., Rossom, R. C., Bergdall, A., & Crabtree, B. (2021). Clinician perceptions about a decision support system to identify and manage opioid use disorder. *Journal of the American Board of Family Medicine, 34,* 1096-1102. https://doi.org/10.3122/jabfm.2021.06.210126

PCC and Leader Perceptions of the Tool

- N=13 (6 PCCs, 7 health system leaders); 6 female; 7 MDs, 5 APs and NPs
- 9-12 months after study go-live
- Themes:
  - PCCs prefer to minimize conversations about OUD risk and treatment;
  - PCCs are enthusiastic about a CDS tool that addresses a topic of interest but lack interest in treating OUD
  - Contextual barriers in primary care limit PCCs' ability to use CDS to manage OUD
  - CDS needs to be simple and visible, save time, and add value to care
  - CDS has value in identifying and screening patients and facilitating referrals

Hooker, S. A., Solberg, L. I., Miley, K. M., Borgert-Spaniol, C. M., & Rossom, R. C. (in press). Barriers and facilitators to using a clinical decision support tool for opioid use disorder in primary care: Insights from clinicians and clinic leaders. *Journal of the American Board of Family Medicine*.

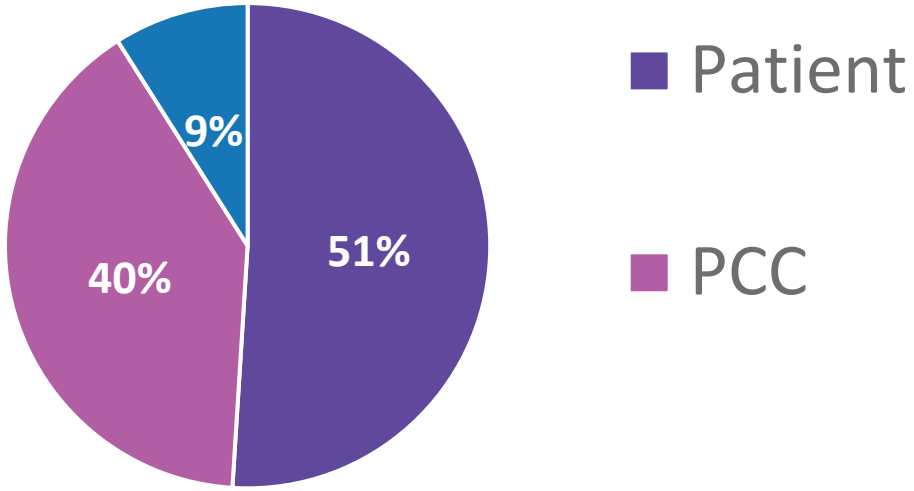
Patient Perceptions of OUD Care

- N=20 patients interviewed; mean age 53.5 years; 65% male
- Themes:
  - Patient relationships with opioids (long-term opioid use, acute opioid use, OUD in treatment, OUD no treatment) require different approaches in discussing opioid risks
  - Patients develop a sense of a PCC's wiliness to prescribe opioids
  - Patients are open to talking about opioid risk but have diverse preferences for how, with whom and with what terminology
  - Most think primary care is appropriate setting to discuss opioid risk
  - Patients have limited awareness of overdose rescue medications
  - Handouts are more welcome if perceived to come from the PCC's assessment instead of a computer algorithm

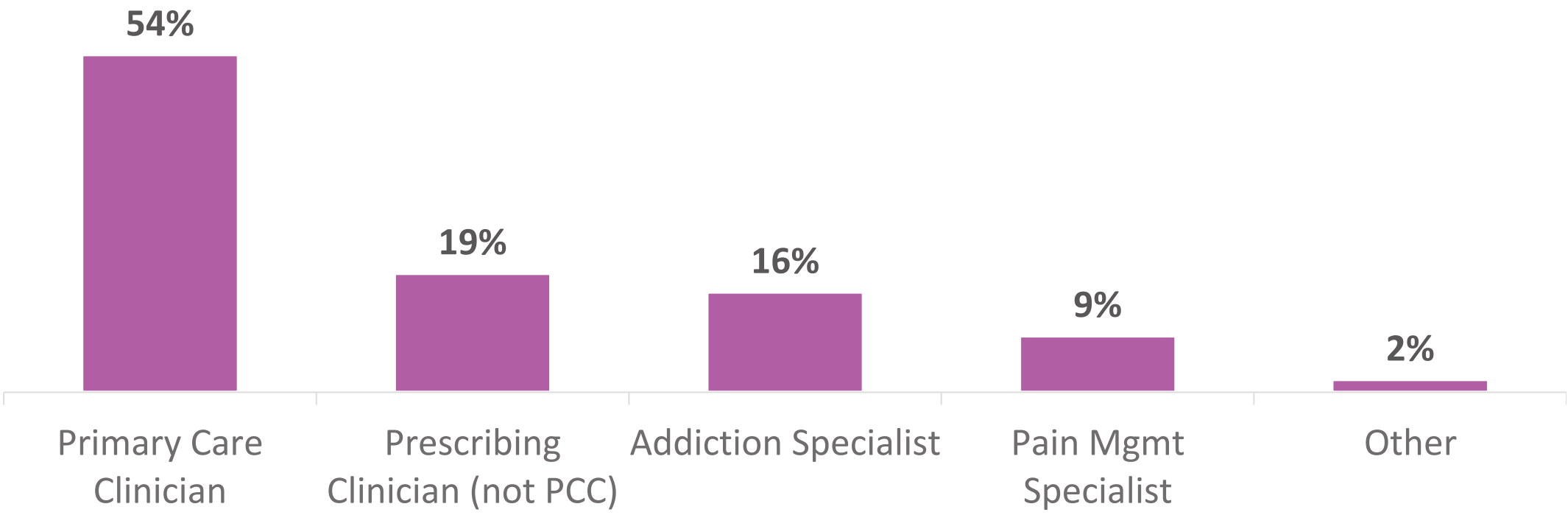
Hooker, S. A., Essien, I. J., Borgert-Spaniol, C. M., Rossom, R. C., Olson, A. W., Romagnoli, K. M., & Solberg, L. I. (2022). Patient perspectives on opioid risk discussions in primary care. *Journal of Patient Centered Research & Reviews, 9,* 253-262.

Patient Perceptions of OUD Care

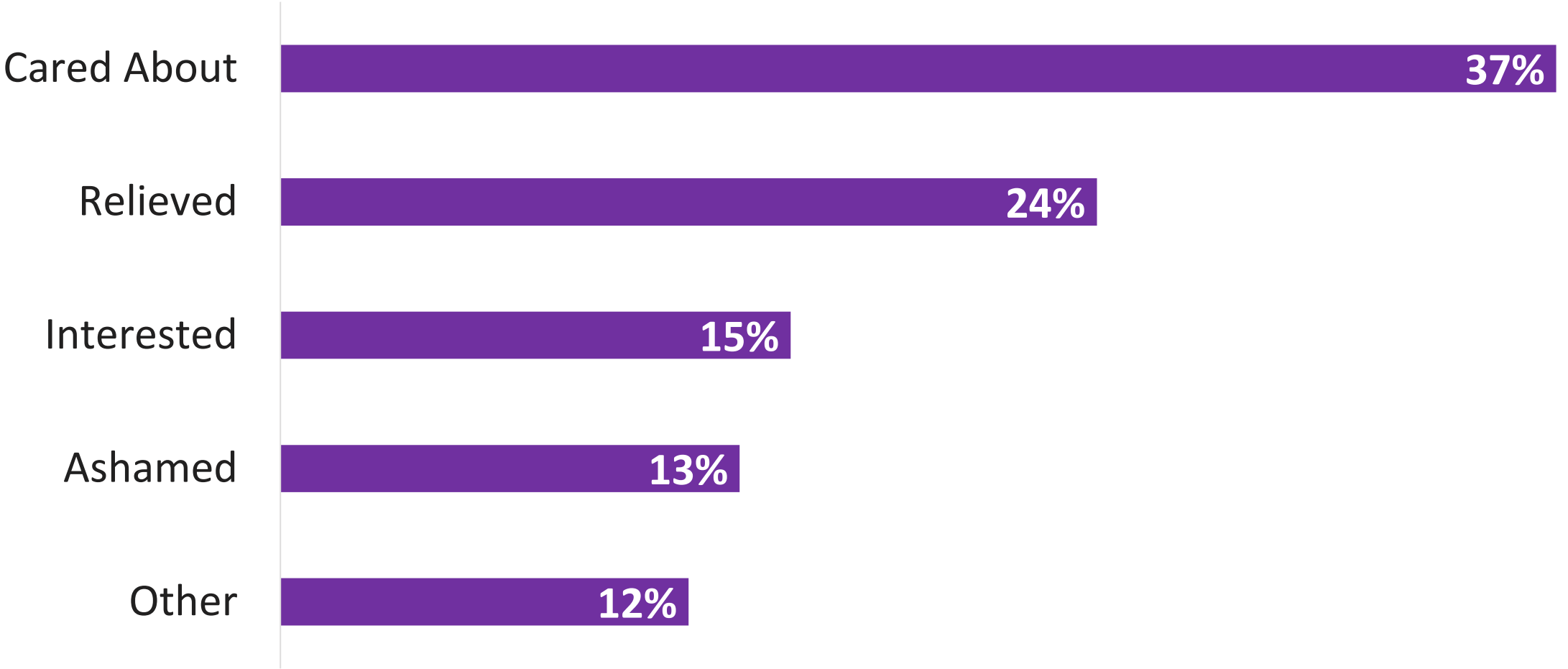
- N=127 patients surveyed; mean age 48.5 years; 52% female; 36% had OUD, and of those, 75% were receiving treatment
- 44% (N=55) of patients recalled having a conversation about opioids at a recent visit with their primary care clinician
- Who initiated the conversation?



Who should have conversations with patients about opioids?



How did the conversation about opioids make you feel? (N=55) *participants could select more than one option



Patient Testimonials: Conversation about opioids with primary care clinician

"[My clinician] cares about me!!!"

"It keeps an open running dialogue with my physician about the risk of addiction with opioids."

"…[clinician] cared that I wouldn't abuse the meds and that she cared about my health."

"Just the fact that I was being cared for."

"I had back surgery and was on [opioids] for a while. I didn't want to take [opioids] anymore and my doctor and I made a plan to get off of them."

"Concerned. I did not plan to become an addict to opioids."

"When you have to beg for some sort of relief, it is very demeaning."

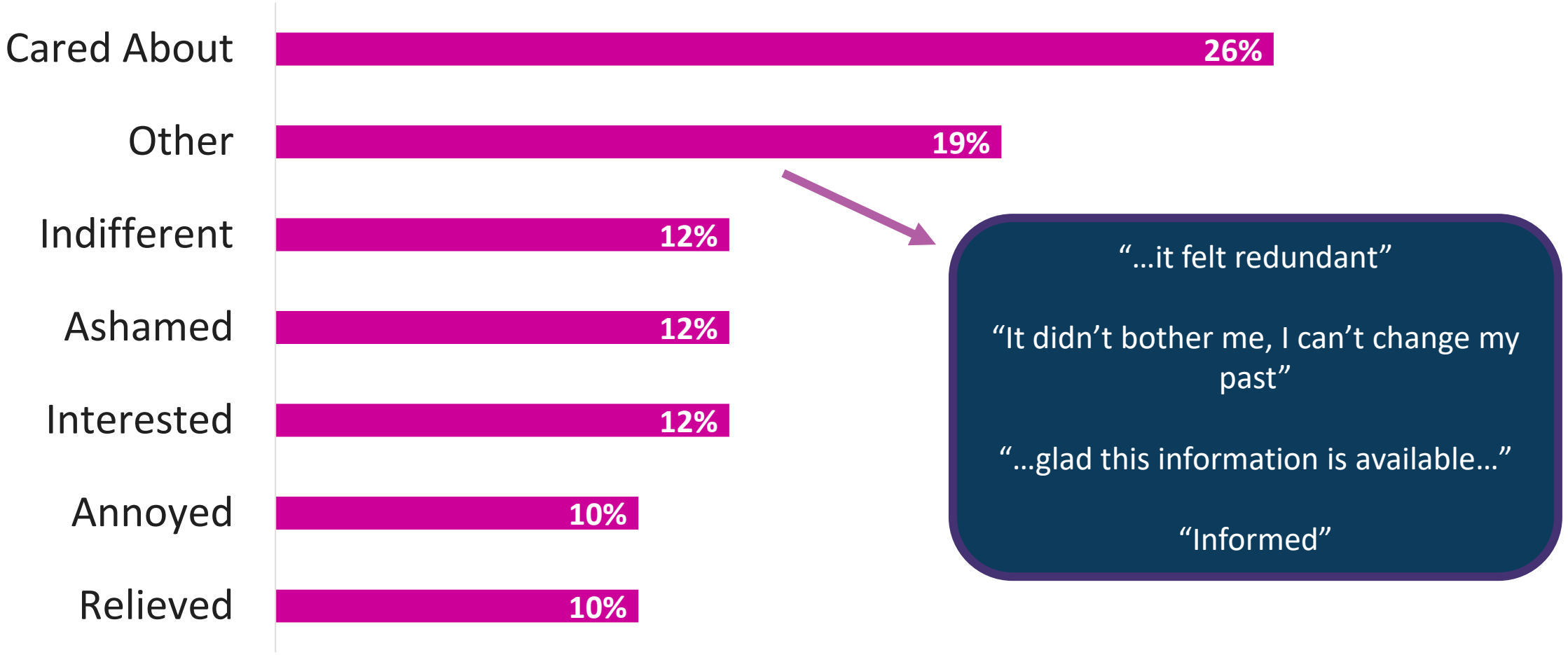
"I was furious because [the clinician] didn't listen to my situation."

The Patient Handout

25% (N=32)	Recalled receiving the handout
56%	Received the handout from the PCC
38%	Received the handout from the nurse or medical assistant
22%	Received the handout when talking with the PCC
56%	Received the handout at the end of the visit when getting ready to leave
63%	Said they had enough time to review the handout before speaking with the PCC
22%	Did not review the handout
83%	Agreed that the handout made them feel more comfortable talking about opioids with their PCC

How did the handout make you feel? (N=32)

***participants could select more than one option**



"…it felt redundant"

"It didn't bother me, I can't change my past"

"…glad this information is available…"

"Informed"

Patient Testimonials: The Handout

- “…realizing how lucky I am that I chose to get the help and treatment needed before I became a statistic.”
- “I appreciate the information and it let’s me know that my doctor understands my pain and has empathy.”
- “It’s always the same annoying information. People hear about this all the time on multiple formats.”
- “I just felt like the physician automatically put a label on me as someone who would potentially abuse narcotic medications. I was treated like I was a drug addict.”

Study Status

- Enrollment ended 12/31/2022; 10k+ patients enrolled
- Observation ended 12/31/2023
- Preliminary study results being finalized in partnership with Emmes
- Papers
  - 7 published
  - 3 under review
  - 7 in process, including main results

CTN-0095-A-2: Reducing Stigma Toward People with Opioid Use Disorder Among Primary Care Clinicians

Stephanie A. Hooker PhD MPH, Lauren Crain PhD, Amy LaFrance MPH, Sheryl Kane, J. Konadu Fokuo PhD, Gavin Bart MD PhD, & Rebecca Rossom MD MS

HEAL Supplement grant to CTN-0095 (COMPUTE 2.0)

HealthPartners

Final paper published in *Addiction Science & Clinical Practice*

Hooker, S. A., Crain, A. L., LaFrance, A. B., Kane, S., Fokuo, J. K., Bart, G., & Rossom, R. C. (2023). A randomized controlled trial of an intervention to reduce stigma toward people with opioid use disorder among primary care clinicians. *Addiction Science & Clinical Practice, 18*:10. https://doi.org/10.1186/s13722-023-00366-1

Stigma is a barrier to care

Primary care clinicians (PCCs) carry many of the same stigmatizing beliefs as the general public

e.g., patients with OUD are responsible for their illness, undesirable, angry, and dangerous

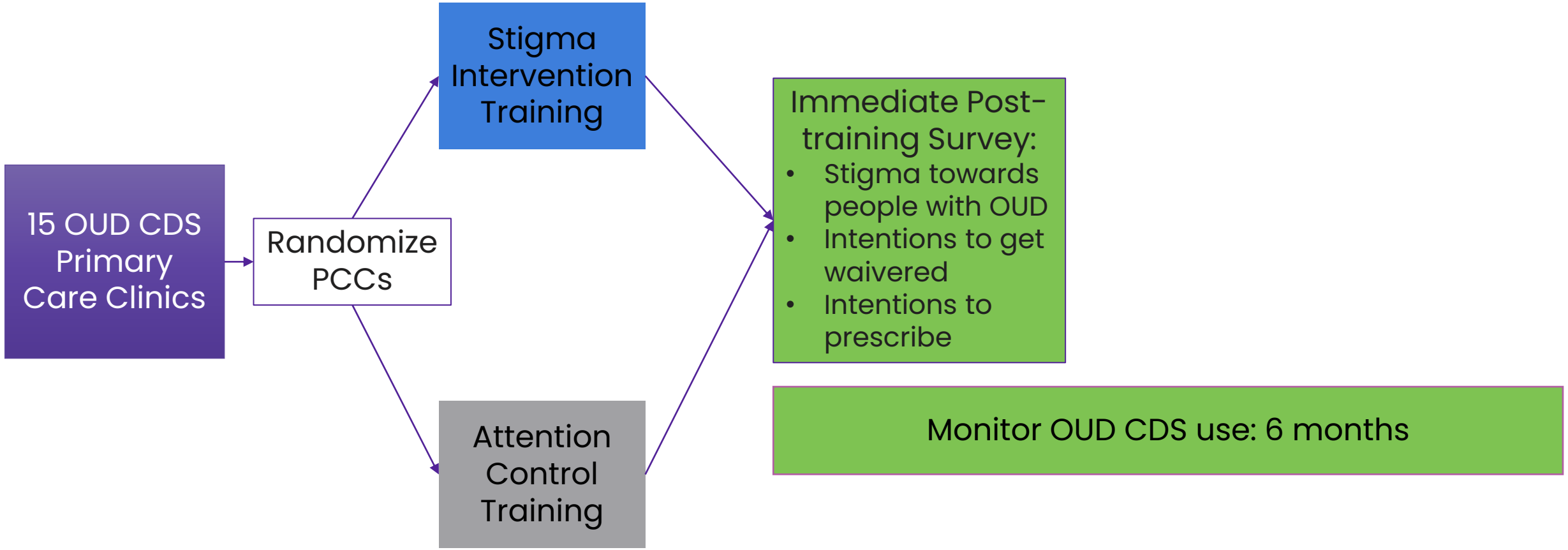
Few interventions have directly tried to reduce PCC stigma

Best approaches: Direct contact, positive narratives

Purpose

- The *overall goal* of this project was to determine whether stigma reduction training
  - reduces PCC stigma
  - increases intention to get waivered to prescribe buprenorphine or likelihood to prescribe it if a waiver were no longer required
  - increases the likelihood that PCCs use the OUD CDS
- In a second aim, examine whether stigma is related to:
  - PCC intentions to get waivered
  - Use of the OUD CDS

Study Design: RCT



Intervention

- Both
  - Delivered via online learning platform at health system
  - Evidence-based education about OUD and MOUDs
  - Guides through 4 patient scenarios to use the OUD CDS
- Stigma Intervention Only
  - See videos of patients telling their stories, integrated with CDS training
    - Based on real patients (worked with Amy Sullivan, local medical historian)
    - Hired actors and videographer to create videos

Debra

Jamilah

Sam

Louis

Debra

Measures

- Stigma: Difference, Disdain, and Blame Scale (8-items)
  - *How responsible do you think people with opioid use disorder are for their illness?* (Blame)
  - Range 1-9, with higher scores corresponding to greater stigma

- Intentions (2 single-item measures)
  - To get waivered in the next year
  - To prescribe buprenorphine the next year if a waiver were no longer required
  - Range 1-5, higher scores correspond to greater intentions

Secondary Measures

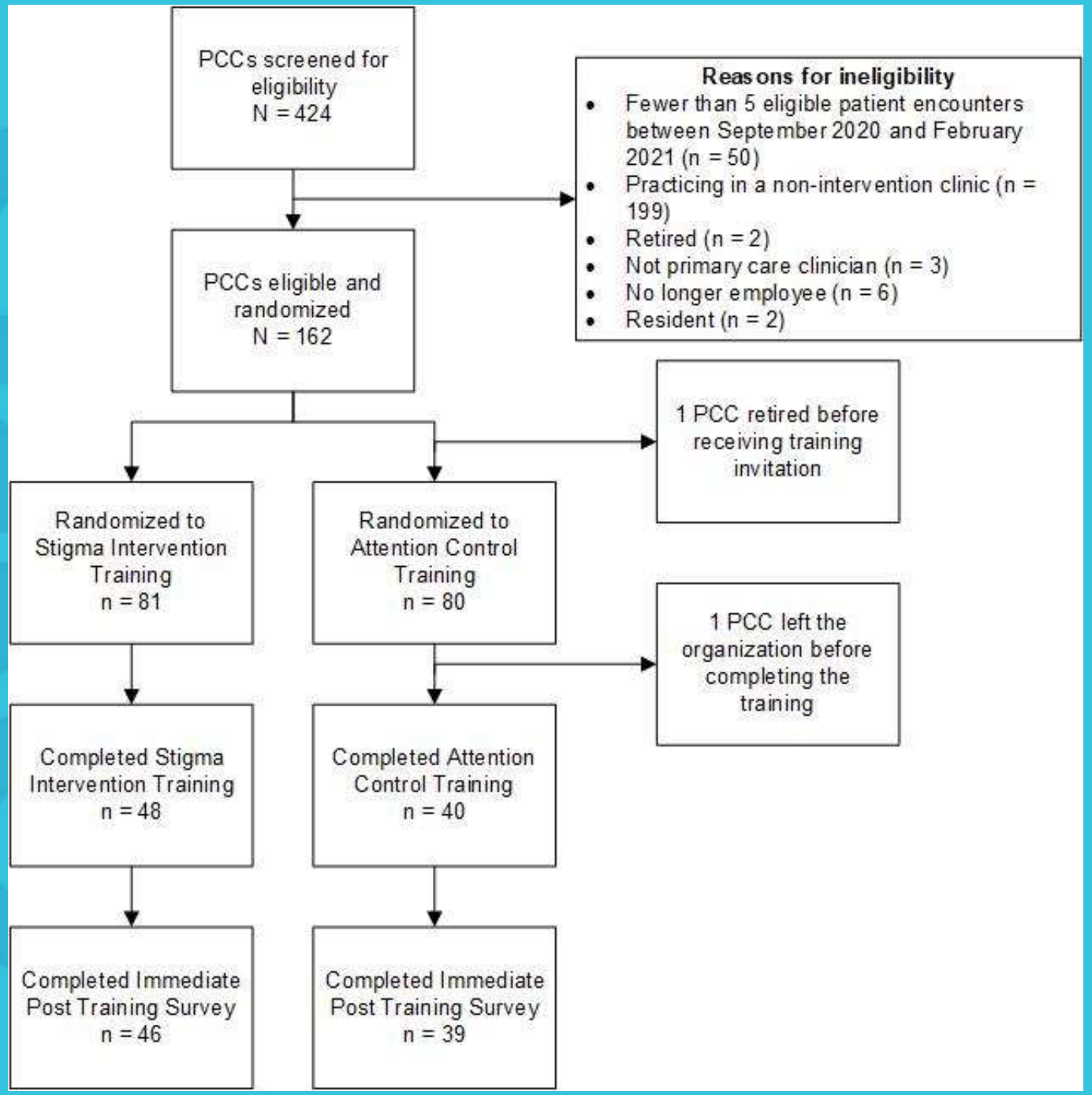
- Willingness to work with OUD (3 items)
  - *I would enjoy my job more if I could stop working with patients with opioid use disorder.* (Reversed)
  - Range 1-5, higher scores correspond to greater willingness to work with OUD

- Treatment Futility (2 single item measures)
  - Believe OUD treatments are effective (range 1-4, higher scores more effective)
  - Believe patients will comply with treatment (range 1-4, higher scores more compliant)

CONSORT CHART

N = 88

N = 85



Sample Characteristics

M age = 47.4
(*SD* = 11.5, *range* 29-70)

Variable	N	n	%
Gender	84		
Male		31	36.9%
Female		49	58.3%
Not listed		1	1.2%
Prefer not to answer		3	3.6%
Ethnicity	83		
Not Hispanic or Latinx		80	96.4%
Hispanic or Latinx		3	3.6%
Race	85		
Asian		9	10.6%
Black or African American		6	7.1%
White		58	68.2%
Other		1	1.2%
Prefer not to answer		11	12.9%
Days in Clinic	84		
1-2 Days		3	3.6%
3-5 Days		81	96.4%
Waivered (Self-Report)	86	8	9.5%
Frequency of Treating People with OUD	86		
A few times a year or less		64	72.1%
At least monthly		22	25.5%

No differences between intervention and control groups on any outcome measures

	Stigma Reduction M (SD)	Attention-Control M (SD)	t	p	Cohen's d
Stigma	4.1 (1.3)	4.3 (1.2)	-0.48	0.63	-0.11
Intentions to Get Waivered	2.3 (0.7)	2.1 (0.8)	1.11	0.27	0.26
Intentions to Prescribe Buprenorphine	3.2 (1.0)	3.0 (0.9)	0.90	0.37	0.21
Willingness to Work with OUD	3.0 (0.7)	3.1 (0.9)	-0.83	0.41	-0.18
Perceived OUD Treatment Effectiveness	2.6 (0.8)	2.7 (0.7)	-0.74	0.46	-0.16
Perceived OUD Treatment Adherence	2.5 (0.6)	2.4 (0.6)	0.15	0.88	0.03

Associations between Stigma and Other Measures

- PCCs who reported more stigma towards people with OUD reported
  - lower intentions to get waivered (r = -0.25, p = .03)
  - lower intentions to prescribe buprenorphine if a waiver were no longer required (r = -0.25, p = .03)
  - less willingness to work with patients with OUD (r = -0.40, p = .0002)
  - OUD treatment is less effective (r = -0.32, p = .003)
  - patients with OUD will be less likely to comply with treatment (r = -0.39, p = .0002)

- Stigma was not significantly related to likelihood of using the CDS tool in the 6 months following the training, OR = 1.75 (95% CI = 0.86, 3.57)

Discussion

- Stigma intervention did not reduce stigma or increase CDS tool use
  - Too brief? Online delivery?
- Stigma likely plays a role in access to care for patients with OUD
- Effective interventions to combat stigma among healthcare providers are needed
  - This work is challenging

Strengths & Limitations

- Strengths
  - Randomized design
  - PCCs blinded to intervention assignment
  - Targeted practicing PCCs
  - Narratives written with input from medical anthropologist with expertise in OUD

- Limitations
  - No measure of training engagement or treatment fidelity
  - Self-report measure of stigma

Future Directions

- Clear need to find effective approaches to reduce stigma towards OUD among healthcare professionals

- Interventions should include:
  - More educational and skills-based components
  - Reflection on own biases and challenging them
  - Repeated intervention exposure

Thank You!