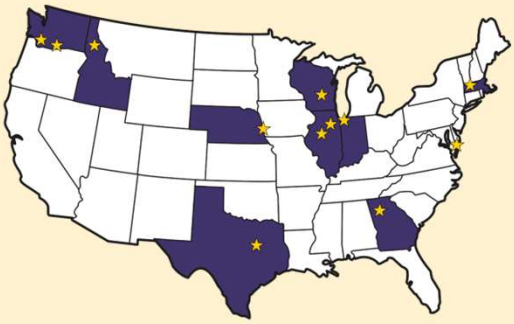
CHAMP

Collaborating to Heal Addiction and Mental Health in Primary Care

The Problem:
The gold-standard treatment for opioid use disorder (OUD) is medication for opioid use disorder (MOUD), less than a quarter of people with OUD receive MOUD.

The Solution:
Expanding Collaborative Care Model (CoCM) to include primary care patients with OUD could improve access to MOUD. This trial compares the effectiveness of a CoCM to manage OUD and co-occurring mental health symptoms (MHS) (intervention) to CoCM for MHS only (control).



Conducted in **34** Clinics

254 patients enrolled who screened positive for mental health symptoms (MHS) and OUD.

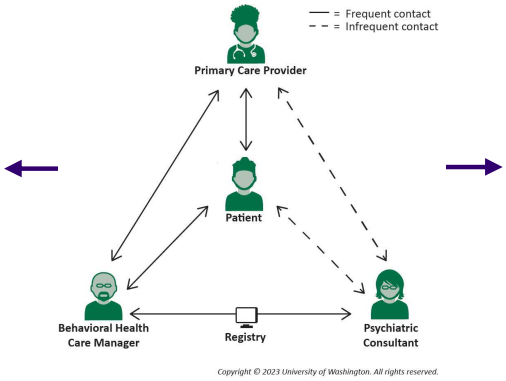
The Research Questions

First to determine if OUD screening can be effectively incorporated into primary care mental health screening protocols we compared the percentage of primary care patients who are newly diagnosed with OUD before and after implementation of universal screening for OUD. Second to determine if implementing Collaborative Care for OUD and mental health symptoms can improve outcomes compared to patients with MHS and OUD at clinics randomized to the control. We hypothesized that patients at clinics randomized to the intervention group would report better engagement in, OUD treatment, less opioid use (primary outcome), better mental health functioning (primary outcome).

Control

Members of the CoCM team (care managers, primary care providers, psychiatric consultants) .

CoCM for treatment of mental health symptoms and were free to treat OUD consistent with current treatment options (usually referral).



Intervention

Members of the CoCM team (care managers, primary care providers, psychiatric consultants).

CoCM for treatment of mental health symptoms and treatment for OUD. Primary care providers become waivered to deliver Medication Assisted Treatment (MAT) for OUD.

Baseline Characteristics of Clinic Patients Screening Positive for OUD and MHS

254 TOTAL PATIENTS

Poverty Threshold:

Above: **55.5%**
Below: **44.5%**

Housing Status:

No, not living in stable housing: **11.2%**
Yes, living in stable housing: **88.8%**

Non-Opioid Drug Use: Any use in the past 30 days

Cocaine and/or crack use	**7.4%**
Other stimulant use	**11.8%**
Sedative and/or tranquilizer use	**22.2%**
Cannabis use	**39.4%**
Other illegal drug use	**8.8%**

Opioid Use:

Any opioid use in the past 30 days: **30.4%**
Number of days of opioid use in the past 30 days: **4.9**

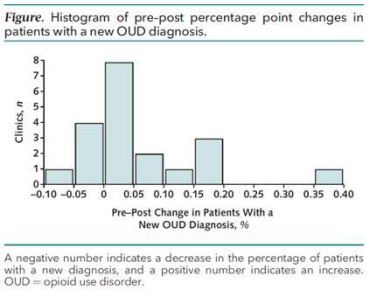
Opioid Craving:

Not at all	**37.9%**
Slightly	**28.2%**
Moderately	**13.7%**
Considerably	**11.9%**
Extremely	**8.4%**

Recent Overdose Experience:

Ever overdosed: **47.6%**
Number of previous overdoses per person: **3.5**
Overdosed in the past 6 months **12.7%**
Number of overdoses per person in the past 6 months: **1.4**

Opioid Use Screening: Did real-world screening actually increase identification of OUD?



The median pre–post increase in the number of patients with a new OUD diagnosis was 1.5 patients per clinic (range, 4 to 17).

OUD screening in routine care did **not** increase the percentage of patients with new OUD diagnoses In a clinically meaningful way.

CONCLUSIONS: While all clinics had the goal of implementing population-based OUD screening, most experienced barriers related to the complexity of the screener, staff discomfort, added burden on primary care teams, workflow complexity, low yield from screening, and stigma

Healthcare Systems/Clinics:

*Clinics were located in all regions of country including in urban, suburban, and rural areas.
*6 of the healthcare systems were private, non-profit, 3 were Federally Qualified Health Centers, 2 were Academic Medical Centers, and 1 was a for-profit, publicly traded Managed Medicaid Plan.
*The size of the healthcare systems and clinics range from small to very large.
*Payor mix varies substantially, with some healthcare systems primarily treating uninsured and Medicaid patients, and others treating mostly commercially insured patients.

Clinical Outcomes:

Intervention resulted in a small, but statistically significant, decrease in the number of days using opioids, but there was no group difference in SF MCS scores.

Qualitative Outcomes: Screening

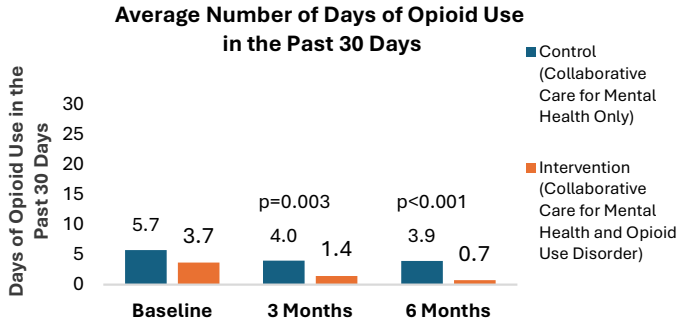
"Maybe some of our screening could actually come out differently if people knew as part of our advertisement that we offer buprenorphine. There's a lot of reasons not to disclose, but one of the reasons to disclose is if you know treatment is an option." **[Primary Care Provider]**

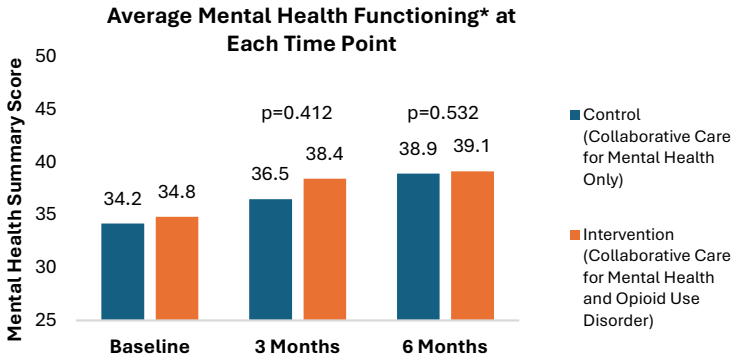
"You know, if I'm being really honest, I think that the screener probably isn't especially effective because it doesn't take into account how difficult it is for people to work through their denial and accept that, "I have a problem," and be willing to ask for help, and be ready to take action." **[BHCM]**

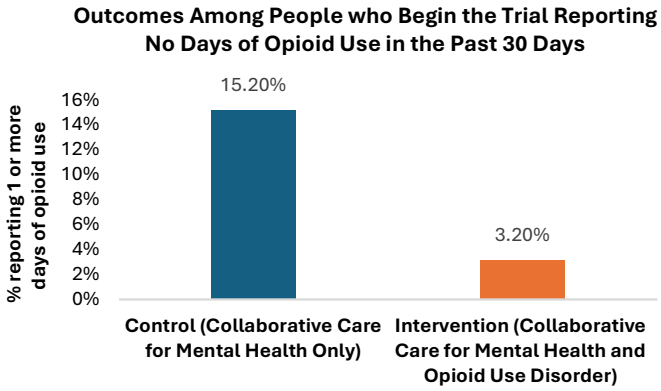
Qualitative Outcomes: Treatment

"It is the most satisfying part of my job. After doing it, I was like, wow, why does anyone not do this? This is amazing because of such a difference that you can make for people." **[BHCM]**

"I just think that there's a lot of value in that. And just being able to come and take care of yourself all in one place." **[BHCM]**







PUBLICATIONS

- Does Screening for Opioid Use Disorder in Primary Care Increase the Percentage of Patients with a New Diagnosis? DOI: https://doi.org/10.7326/M23-1369
- Integrating Opioid Use Disorder Treatment Into Primary Care Settings; DOI: doi:10.1001/jamanetworkopen.2023.28627
- Integrating Routine Screening for Opioid Use Disorder into Primary Care Settings: Experiences from a National Cohort of Clinics; DOI: https://doi.org/10.1007/s11606-022-07675-2

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