

Lessons from the front lines: Treating pain and opioid use disorder in primary care – Considerations for subspecialty collaboration

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Division of General Internal Medicine



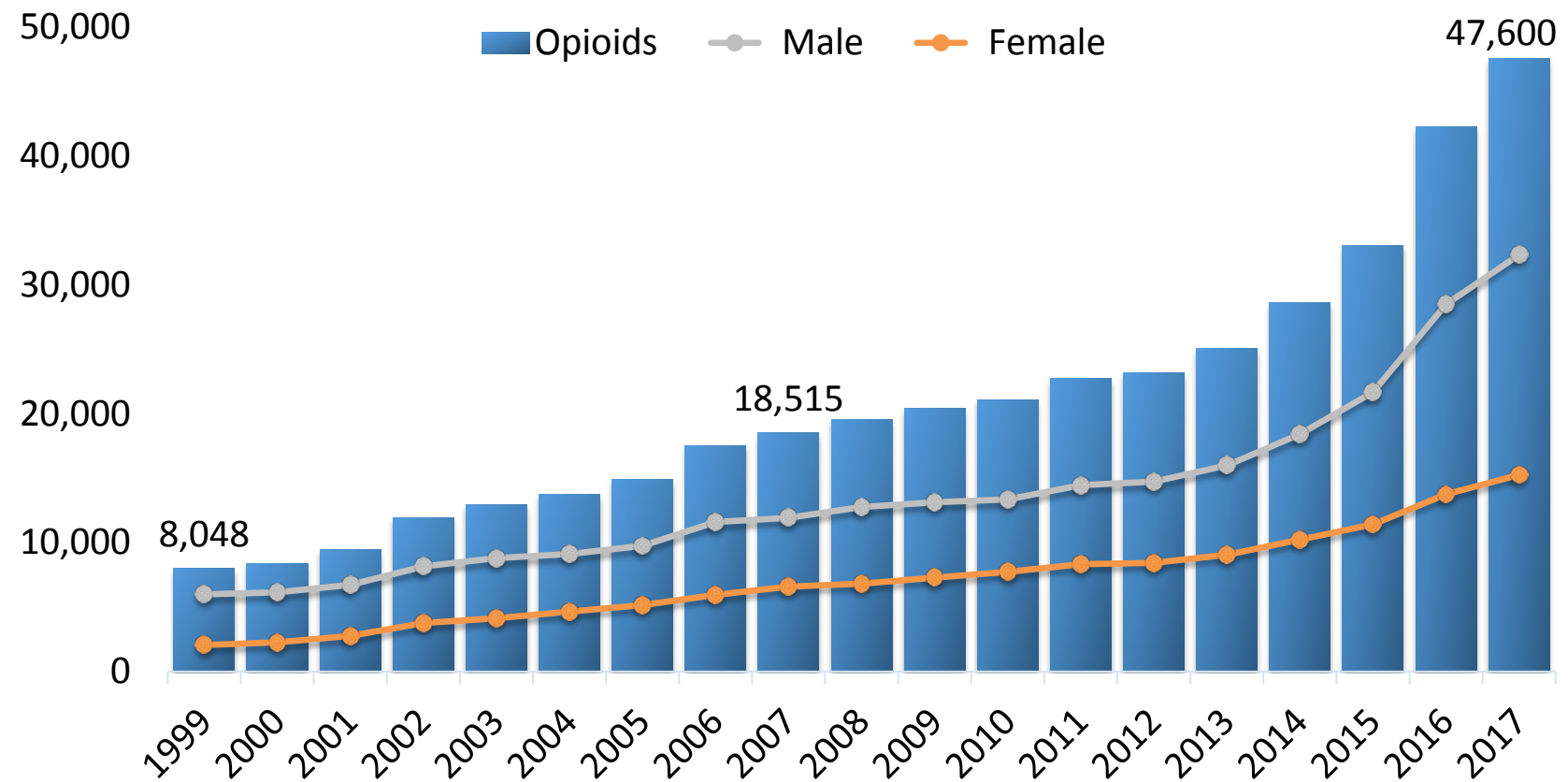
Learning Objectives

1. Identify factors impacting the treatment of opioid use disorder (OUD) with medication-assisted treatment (MAT) in primary care.
2. Outline models for the integration of OUD treatment in primary care, and describe a current model at MUSC integrating OUD treatment in primary care.
3. Explore future opportunities in for OUD treatment in primary care



Introduction

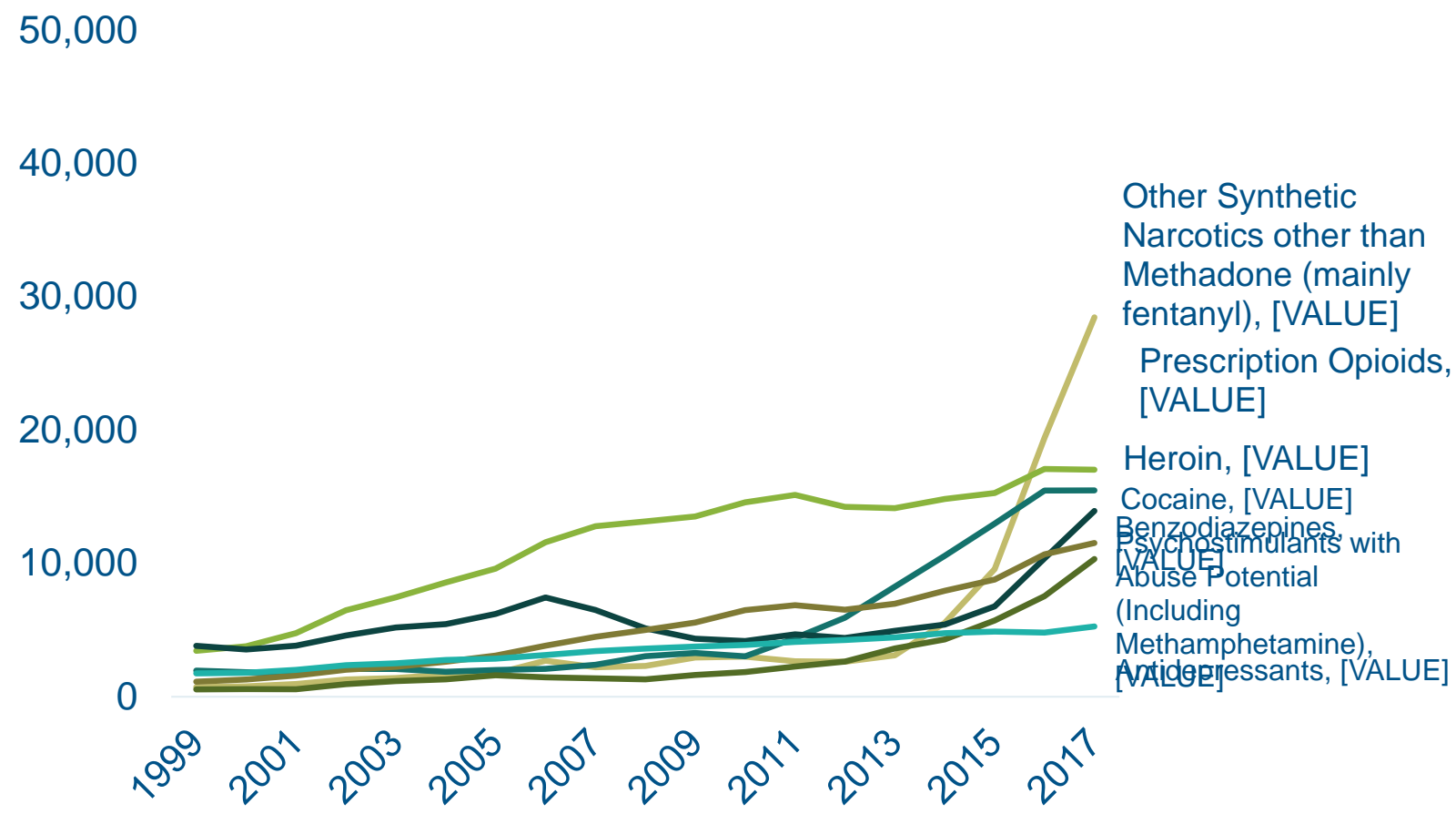
National Drug Overdose Deaths Involving Any Opioid,
Number Among All Ages, by Gender, 1999-2017



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Introduction

National Drug Overdose Deaths Number Among All Ages, 1999-2017

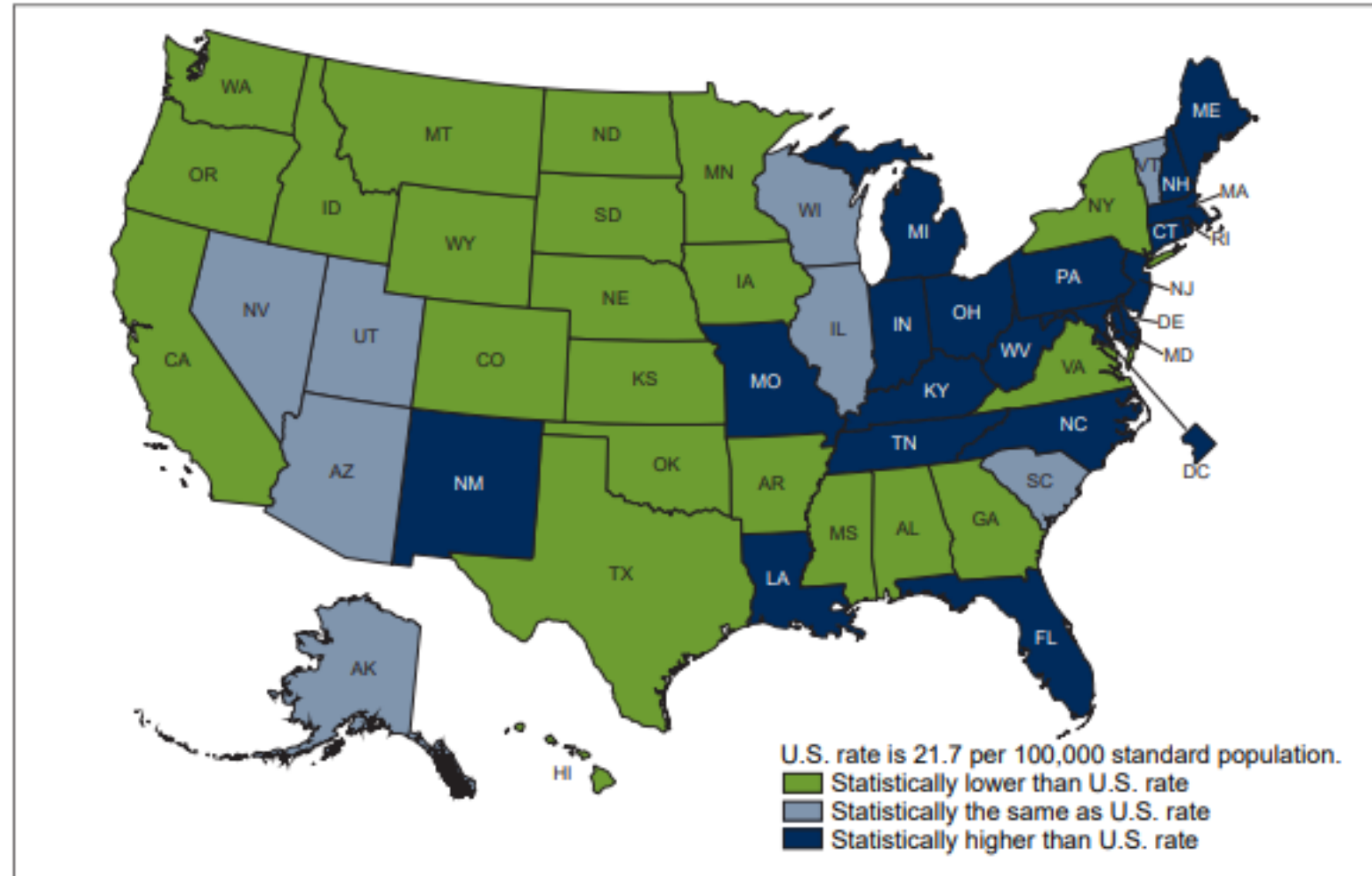


Source: : Centers for Disease Control and Prevention, National Center for Health Statistics.
Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018



Introduction

Age Adjusted Overdose Death Rate: USA 2017



NOTES: Deaths are classified using the *International Classification of Diseases, 10th Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Access data table for Figure 3 at:

https://www.odc.gov/nchs/data/databriefs/db329_tables-508.pdf#3.

SOURCE: NCHS, National Vital Statistics System, Mortality.



Introduction

- OUD increases odds of overdose by 12
- There are large gaps in the treatment of OUD and the availability of providers
- Primary care providers prescribe the majority of opioid in the US
- Primary care is a major gateway into the US health system
- As the primary care infrastructure is in place, expansion of OUD in primary care is feasible



Case Presentation

63 y/o F presented to MUSC University Internal Medicine clinic for establishment of care with a complaint of uncontrolled pain.

- Worsening lower back pain with increased frequency of visits to Columbia area ED for evaluation and treatment of pain
- Patient asks for transition from oxycodone to hydromorphone
- Accompanied by husband who reports increasing sedation from medications and inability to complete iADL's
- Had been tried on methadone in the past for chronic pain but stopped due to nausea

Case Presentation (continued)

Past Medical History:

- Seronegative inflammatory arthritis
- Bipolar disorder (follows with psychiatrist) with 2 prior suicide attempts by overdose
- Heart failure with preserved ejection fraction

Social History:

- Lives with current husband
- History of abuse in prior relationships
- Everyday smoker
- No illicit drug or EtOH use

Medications:

- Oxycodone 10mg TID,
- Venlafaxine XR 150mg Daily
- Lamictal 200mg Daily
- Benztropine 0.5mg Daily
- Clonazepam 1mg TID prn anxiety
- Sulfasalazine 1gm BID
- Hydroxychloroquine 200mg BID
- Torsemide 20mg Daily



Case Presentation (clinical course)

Assessment / Plan

- Patient diagnosed with **opioid use disorder (OUD)**
- Collateral information obtained from psychiatrist and discussed case with local mentor
- Patient returned **within 1 week for buprenorphine counseling and successfully completed outpatient buprenorphine induction**



What Factors Contributed To This Outcome?

Primary Care Provider MAT Training

- › Attitudes toward MAT in primary care
- › X-waiver training

Primary Care Delivery Models

- › Office Based Opioid Treatment
- › Hub and Spoke
- › ECHO

Identifying Patients

- › Screening For Opioid Use Disorder



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Attitudes Toward MAT in Primary Care

Sarah Oros, MD

Lillian Christon, PhD

Kelly Barth, DO

Carole Berini, MS

Bennie Padgett

Vanessa Diaz, MD, MSCR

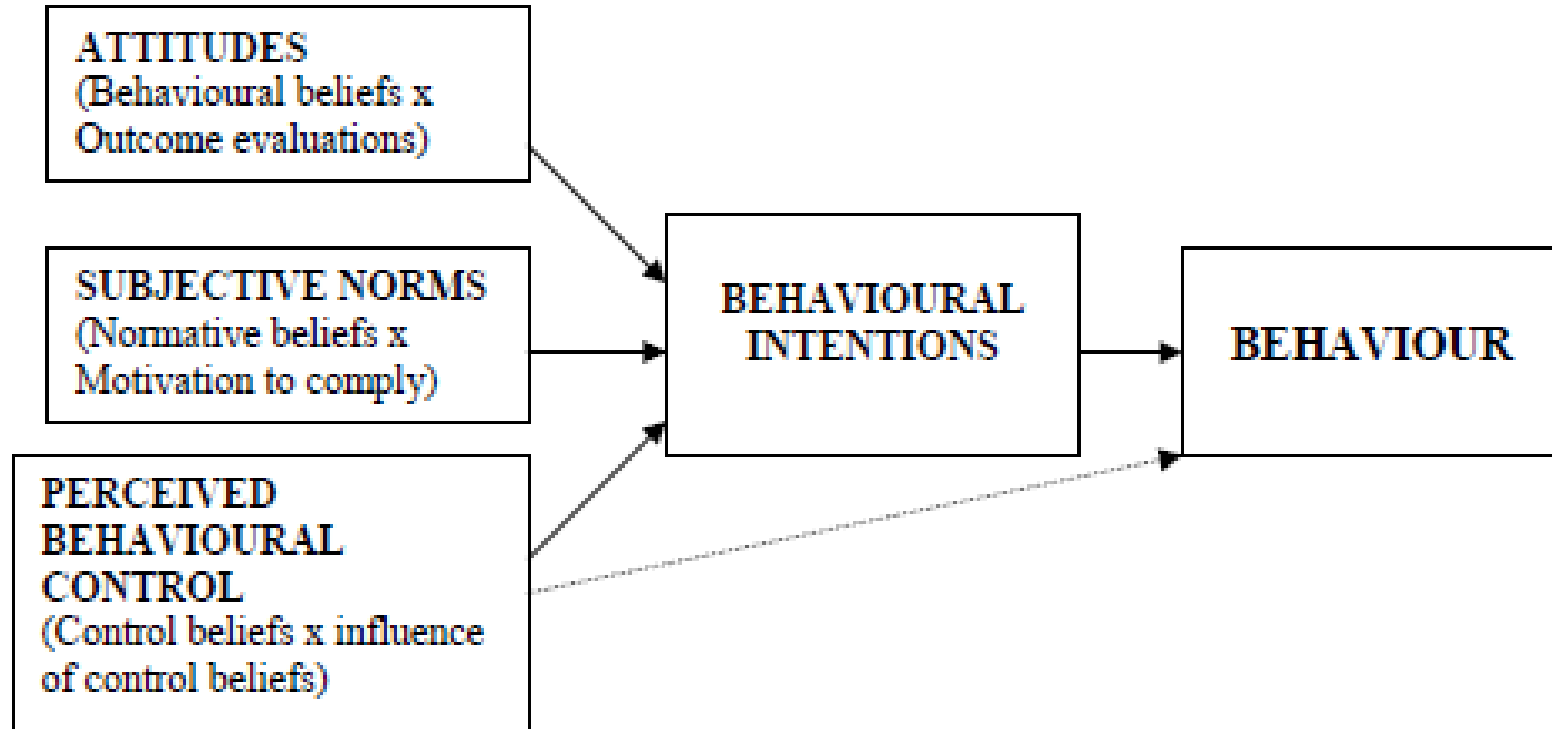


Theory of Planned Behavior

Intentions precede behavior

Qualitative and quantitative questions can be formulated to capture attitudes, subjective norms and perceived behavior control

Translate to intentions in order to affect interventions



Methods

Participants were elicited through email

- › \$40 gift card for participation

7 focus groups conducted, limited to 10 participants each

- › 15 minute survey eliciting subjective norms, perceived behavioral control, and attitudes through Likert-scale questions
- › 45 minutes in semi-structured TPB guided questions

Themes were identified throughout the transcribed focus groups

Internal Medicine
Faculty

Internal Medicine
Residents

Family Medicine
Faculty

Family Medicine
Residents

PA Faculty

PA students

Medicine/Psychiatry
Residents



Main Themes Identified

General Attitudes toward Buprenorphine and Naltrexone

- › Attitudes supportive of MAT in Primary Care
 - › Alleviate craving, patient motivation, treats a disease, capitalize within established patient-provider relationship, within PCP scope of practice
- › Expressed challenges toward MAT use in Primary Care
 - › Stigma, diversion of intended use, “replacing one drug for another”, time limitation in PCP visits

Subjective Norms toward MAT

- › Groups that would approve or disprove MAT
 - › Community, patients, colleagues, institution, society

Perceived Behavioral Control

- › Identifying barriers and enablers to utilization of MAT
 - › Education, system, dedicated protocols, financial, legal

Quantitative Results

General attitudes did not differ significantly among the different focus groups for Buprenorphine (5.6/7) or Naltrexone (5.8/7)

For subjective norms (3.4/7) and perceived behavioral control (3.9/7), participants' perspectives were more neutral, indicating less perceived pressure and self-efficacy in actually prescribing.

Differences between Faculty (IM, FM) and Residents regarding Buprenorphine

- › Faculty reported lower subjective norms (2.43 vs 3.18, $p < 0.04$)
- › Faculty reported higher controllability (4.89 vs 3.15, $p < 0.01$)

Residents reported higher intention to prescribe Naltrexone (4.8 vs 3.6, $p < 0.02$)



Conclusion from focus groups

Primary care providers identified benefits to prescribing MAT

Several identified barriers limit its use

- › Education is a commonly identified need
- › Residents and PAs identified need for supervising physician support
- › Faculty identified need for practice and colleague support

Future Directions

- › Integrate buprenorphine waiver training into residency education
- › Provide protected time for faculty to get waived
- › Will need an integrated system of care and protocols to introduce MAT into primary care practices



Waiver Resources



PCSS waiver training materials and training grants available

At MUSC Dr. Barth and colleagues have conducted 11 waiver training sessions and trained 346 health professionals in SC

- Additional funding for protected time through SC Department of Alcohol and Other Drug Abuse Services (DAODAS; via 21st Century Cures Funding)



What Contributed To This Positive Outcome?

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Primary Care Delivery Models

- › **Office Based Opioid Treatment**
- › **Hub and Spoke**
- › **ECHO**

Identifying Patients

- › Screening For Opioid Use Disorder



Office-Based Opioid Treatment in Primary Care

Practice-based Model

- Any provider with waiver training can offer OBOT
- Advantage
 - Offer treatment immediately to patients already established with a PC clinic
 - “One-Stop Shop”
 - Coordinate treatment of HIV, HCV or prenatal care
- Disadvantage
 - Variable Support Staff and Systems
 - Relationship with addiction specialist for complex patients
- 38% retention at 2 years

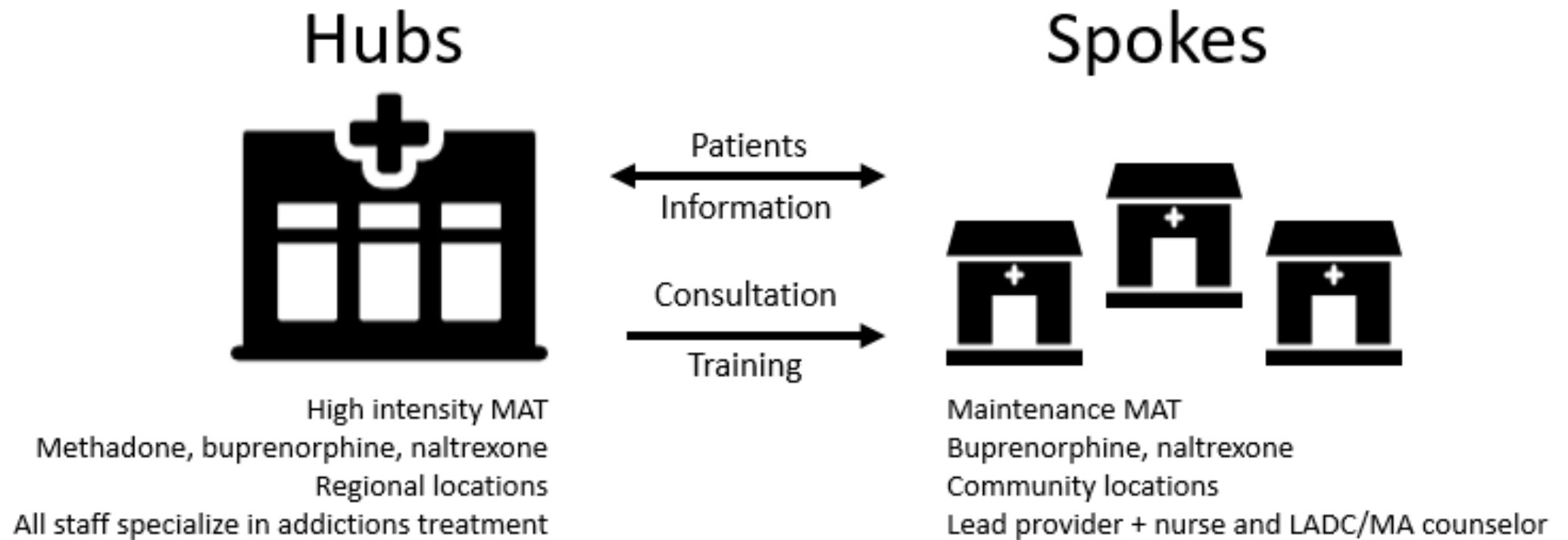
- Korthuis PT, et al. *Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review*. Ann Intern Med. 2017
- Fiellin DA, et al. *Long-term treatment with buprenorphine/naloxone in primary care: results at 2-5 years*. Am J Addict. 2008



Hub and Spoke

Systems Based Model

- Ex. Vermont



<https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke>



Project Extension for Community Healthcare Outcomes (ECHO)



Since initiation of the teleECHO clinic focused on SUDs in 2005 New Mexico has:

- One of the highest number of X-waivered physicians per capita.
- Experienced rapid growth of waived physicians practicing in traditionally underserved areas

Komaromy M, et al. *Project ECHO :A new model for educating primary care providers about treatment of substance use disorders*. Subst Abus. 2016

<https://echo.unm.edu/about-echo/model/>



WHAT IS SC MAT ACCESS ECHO?



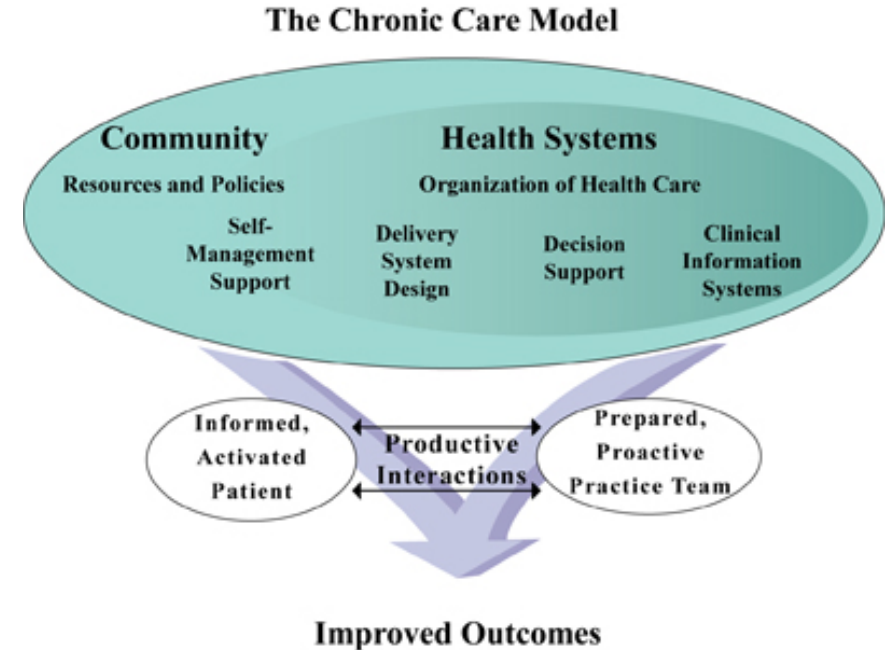
SC MAT Access

<https://scmataccess.org/>

Date	Series #1 High-Quality Medication Assisted Treatment (MAT) December 11, 2018 - March 12, 2019	Presenter
12/11	What is High-Quality MAT?	Dr. Kelly Barth
12/18	Screening/SBIRT	Carolyn Bogdon, FNP
1/08	Treating OUD During Pregnancy	Dr. Connie Guille
1/22	Counseling Techniques for Primary Care: Medication Management from POATS Trial	Dr. Kelly Barth
2/12	Opioid and Benzodiazepine Tapering in Primary Care	Dr. Megan Pruitt
2/26	Determining Level of Care and Patient Perspective	Caitlin Kratz, MSW, LISW-CP, CAC-I
3/12	Peer Recovery	Richard Jones, CEO/COO of FAVOR Greenville

Current MUSC Primary Care MAT Delivery Model

- Office-Based Opioid Treatment
 - “Local Champion”
 - Addiction Medicine Support
 - SC MAT Access Support
- Future
 - Chronic Care Model
 - Partnership with ED for Fast Track
 - Inpatient Induction



Developed by The MacColl Institute
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http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2



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Identifying Patients

- › **Screening For Opioid Use Disorder**



Guidelines: Screening For Dysfunctional Opioid Use

Chronic Opioid Use

- Evaluate benefit and harms of opioid therapy q3months – CDC
- Evaluate risk and benefit of opioid therapy q3mons – VA / DOD
- Patients using opioid therapy > 6 weeks need evaluation for opioid misuse – CMS/MIPS



Health Resource and Services Administration (HRSA) Primary Care Training and Enhancement Grant

Dr. Bill Moran – Division Chief General Internal Medicine

Dr. Bill Basco – Director of General Pediatrics

Dr. Vanessa Diaz – Department of Family Medicine

Supplemental Funding from HRSA PCTE grant

- Improve student and resident education on identification of OUD
- Improve faculty training on identification of OUD
- Improve Treatment of OUD by expansion of MAT



University Internal Medicine - Screening for Opioid Use Disorder Quality Improvement Project

Aim: Identify primary care patients with opioid use disorder and start MAT.

Population: UIM Patients receiving chronic opioid therapy (≥ 6 opioid prescriptions from UIM in the past year) ~ 274 patients identified

- Patients enrolled in Sickle Cell Medical Home were excluded

Change Idea: Standardize OUD evaluation in patients on chronic opioid therapy

Intervention:

1. Screen all patients on chronic opioid therapy for OUD using Current Opioid Misuse Measure (COMM)
2. Internal referral for OUD evaluation in patients who screen (+) = score ≥ 9



Current Opioid Misuse Measure (COMM)[®]

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	0	0	0	0	0
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	0	0	0	0	0
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	0	0	0	0	0
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	0	0	0	0	0
5. In the past 30 days, how often have you seriously thought about hurting yourself?	0	0	0	0	0
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	0	0	0	0	0
7. In the past 30 days, how often have you been in an argument?	0	0	0	0	0
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	0	0	0	0	0
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	0	0	0	0	0
10. In the past 30 days, how often have you been worried about how you're handling your medications?	0	0	0	0	0
11. In the past 30 days, how often have others been worried about how you're handling your medications?	0	0	0	0	0
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	0	0	0	0	0
13. In the past 30 days, how often have you gotten angry with people?	0	0	0	0	0
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	0	0	0	0	0
15. In the past 30 days, how often have you borrowed pain medication from someone else?	0	0	0	0	0
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	0	0	0	0	0
17. In the past 30 days, how often have you had to visit the Emergency Room?	0	0	0	0	0

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COMM survey

Sensitivity: 77%

Specificity: 66%

Positive Predictive Value : 66%

Negative Predictive Value: 95%

Completion Time ~ 10 min



Balancing Measures

- Loss of confidentiality
 - Do not screen patients until roomed (ie. Not at registration)
- Patient Survey fatigue
 - Only screen once per year
 - Incorporate survey into visit
- Staff / Provider fatigue
 - Post scripting through clinic on how to respond to patient questions
 - Documentation aid



FYI Flag: Medication Agreement

Link to medication
agreement pdf

Last UDS

The screenshot displays a medical chart interface. On the left, a sidebar shows 'Recent Visits' with dates and times. The main content area is titled 'Patient Chart Advisories' and includes a section for 'Patient-Level Medication Agreements' with a link to a PDF. Below this is a 'Comments - Medication Agreement' section. The 'Last Urine Drug Screen' section contains a table with columns for Date/Time, Component, Value, Flag, and Lab Status. The table lists various drug tests, with 'OXYOXYUR' showing a 'POSITIVE' result and an 'Abnormal' flag.

Patient Chart Advisories

Take notice of the following advisories for this patient before you continue.

Patient-Level Medication Agreements:

- > Scan on 4/3/2018 6:24 PM : LONG TERM CONTROL SUBSTANCE

Comments - Medication Agreement

Last Urine Drug Screen

Date/Time	Component	Value	Flag	Lab Status
07/31/18 0729	LABOPIA	NEGATIVE	-	Final result
07/31/18 0729	AMPHETAMINE	NEGATIVE	-	Final result
07/31/18 0729	LABBARB	NEGATIVE	-	Final result
07/31/18 0729	LABBENZ	NEGATIVE	-	Final result
07/31/18 0729	COCAINE	NEGATIVE	-	Final result
07/31/18 0729	CANNABINOIDS	NEGATIVE	-	Final result
07/31/18 0729	LABPHEN	NEGATIVE	-	Final result
07/31/18 0729	OXYOXYUR	POSITIVE	Abnormal	Final result
07/31/18 0729	LABMETH	NEGATIVE	-	Final result



Safe Prescribing



University Internal Medicine clinic wants to treat chronic pain in the safest way possible.

Starting January 2019, every patient who receives pain medication through University Internal Medicine clinic will receive a confidential survey about their pain and their medication use.

This will allow us to provide the safest care.

If you have any questions or concerns, please feel free to ask any of your healthcare team members

Patient Flyer posted through the clinic

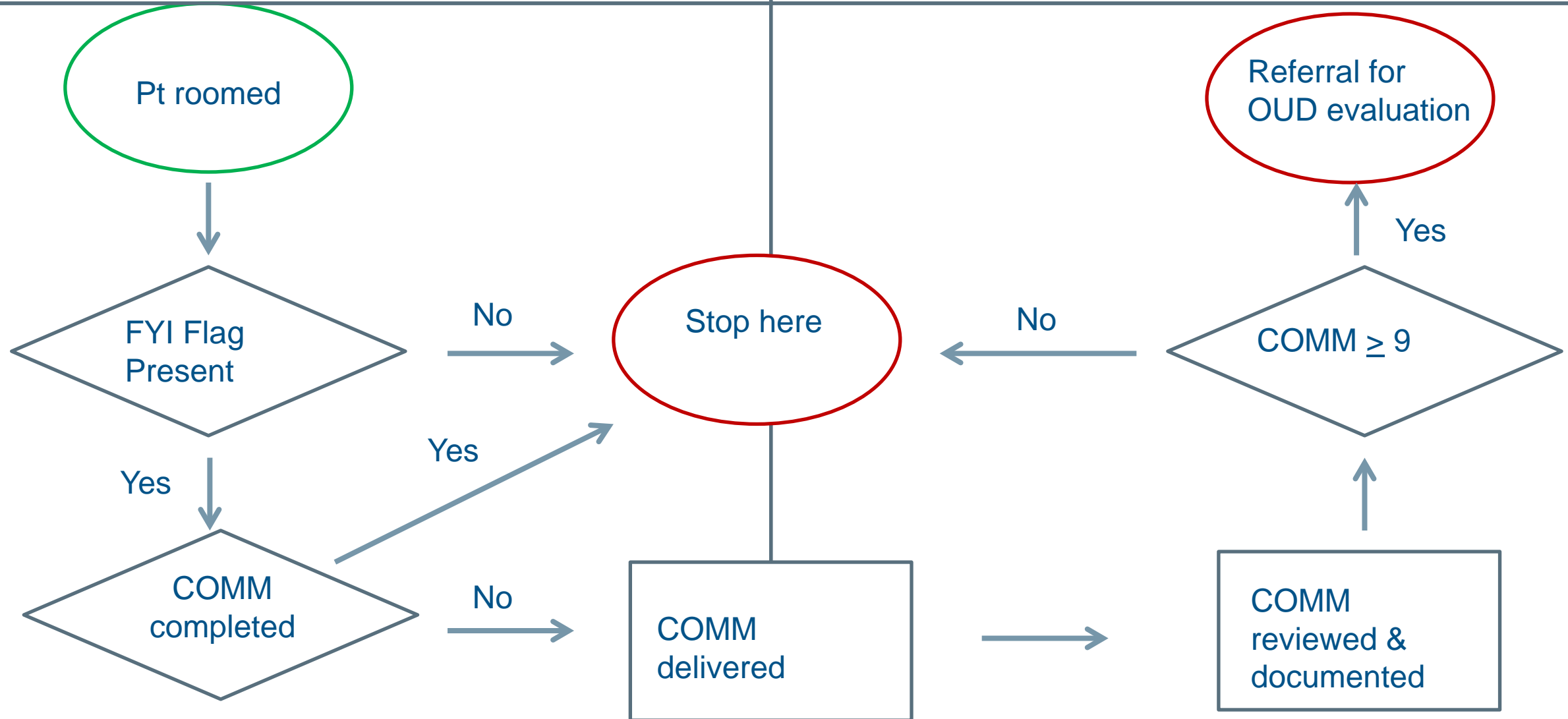


OUD Screening Workflow (next slide)



RN / LPN / CMA

MD / APP



FYI Flag: Medication Agreement

Link to medication
agreement pdf

Document COMM
score

The screenshot displays a patient chart interface. On the left, a sidebar contains a list of 'Recent Visits' with dates and times. A blue arrow points from the text 'Link to medication agreement pdf' to a link icon in the sidebar. Another blue arrow points from the text 'Document COMM score' to a blue button labeled 'More...' in the sidebar. The main content area is titled 'Patient Chart Advisories' and includes a section for 'Patient-Level Medication Agreements' with a link to a scan from 4/3/2018. Below this is a 'Comments - Medication Agreement' section. At the bottom, there is a 'Last Urine Drug Screen' table with columns for Date/Time, Component, Value, Flag, and Lab Status. The table shows results for various substances, with 'OXYOXYUR' marked as 'POSITIVE' and 'Abnormal'.

Date/Time	Component	Value	Flag	Lab Status
07/31/18 0729	LABOPIA	NEGATIVE	-	Final result
07/31/18 0729	AMPHETAMINE	NEGATIVE	-	Final result
07/31/18 0729	LABBARB	NEGATIVE	-	Final result
07/31/18 0729	LABBENZ	NEGATIVE	-	Final result
07/31/18 0729	COCAINE	NEGATIVE	-	Final result
07/31/18 0729	CANNABINOIDS	NEGATIVE	-	Final result
07/31/18 0729	LABPHEN	NEGATIVE	-	Final result
07/31/18 0729	OXYOXYUR	POSITIVE	Abnormal	Final result
07/31/18 0729	LABMETH	NEGATIVE	-	Final result

.UIMCOMMCOMPLETE

- Tagged Smart Phrase
- Please enter in comments section of FYI Flag

The Common Opioid Misuse Measure (COMM) was completed on : ***

Score: ***

Instructions

A score of ≥ 9 indicated that a patient is at risk for opioid use disorder. This patient warrants further evaluation for opioid use disorder and possible benefit from treatment with Medication-Assisted Treatment (MAT) with suboxone (buprenorphine / naloxone):

- 1) Please send an Epic Message to Dr. Samuel O. Schumann III noting COMM score and requesting evaluation for opioid use disorder***
- 2) Please order BMP, LFT's, hepatitis C Ab, urinary beta-hcg (female only), and UDS and forward the results to Dr. Schumann (or assign as co-signer)***
- 3) Please delete these instructions and do not include in the final note***

Example of Scripting for resident / faculty reviewing COMM

Positive COMM (≥ 9)

- › Thank you for completing the survey on your pain and how you are taking opioid pain medications. The results of this survey show that:
 - › The current opioid medications you are taking, and
 - › The way you are taking your medicationsmay be unsafe
- › This places you at risk for opioid medication complications, such as overdose.
- › We would like for you to meet with another doctor in our office / practice about your pain and the medications used to treat you pain.
- › At this appointment, the physician will either continue your current opioid pain medication, and / or discuss additional options for pain treatment.
- › I will place a referral to get this appointment schedule and a nurse from our clinic will call you to help you schedule this appointment.
- › I will continue to address all of your primary care / internal medicine, pain and prescription needs.
- › What questions do you have?



Additional Preparation

- Prior to start all 274 patients were chart reviewed
 - Any patient without an FYI Flag had it added
 - Hospice and those no longer receiving opioids were excluded
 - Patients receiving chronic opioids through other clinics (ex. Rheumatology and Pain Management) were included
- Bi-monthly Education for Residents / Students
- Monthly Detailing for Faculty
- Dr. Katie Anderson, MD
 - UIM Junior Faculty
 - X-waivered during residency at U Penn



Results

- Start Date: Jan 7th, 2019
 - 47 patients (17%) were screened and had “dot phrase” documentation
 - 13 (28%) patients had COMM \geq 9 and referred for further evaluation
 - 10 patients evaluated to date (most completed 2 appointments)
 - 0 patients diagnosed with OUD
 - 0 patients agreed to attend pain rehab
 - 3 have completed chronic pain psychologist assessment
 - 2 patients completely weaned off opioids
 - 2 additional patients were found to have heroin abuse and fast tracked to buprenorphine therapy in UIM



Process Limitations

- Low Delivery of COMM by staff
 - Staff Turn Over
- Detailing of clinical providers
 - Some residents rotate q2weeks
 - Technology: Dot Phrase and Comments Section
- Dot Phrase Report
 - Initial trouble capturing information
 - Report 2nd Edition – Dot Phrase must be used AND use in the comment section or not captured
- Low Faculty Uptake
- Scheduling Challenges



Future Directions

UIM Opioid Patients With 6 or More Orders_051919 to 052519 - Excel

	A	B	C	D	E	F
1	UIM Opioid Patients with 6 or More Orders					
2	PATIENT MRN ID	PATIENT NAME	ACTIVE FYI FLAG	FYI COMM SCREEN	PCP PROVIDER NAME	NEXT APPOINTMENT
3			NO		NORRED, MICHAEL A	
4			YES		LICHTENSTEIN, LEONARD S.	8/29/2019 10:30:00 AM
5			YES		STEWART, JOHN T	
6			YES		SCHMIDT, JENNIFER N	6/12/2019 10:45:00 AM
7			YES	YES	RUSSELL, COLIN J	5/31/2019 2:30:00 PM
8			YES		VORA, HAILY S	6/7/2019 11:00:00 AM
9			YES		PANDYA, KARAN P	
10			YES	YES	STOERMANN, MARY	6/3/2019 1:45:00 PM
11			YES		SCHUMANN III, SAMUEL O	
12			YES		LICHTENSTEIN, LEONARD S.	7/16/2019 7:45:00 AM
13			YES		JAMES, ANDREA S	5/29/2019 1:00:00 PM
14			YES		STOMSKI, CHLOE WOJNAROWSKI	10/10/2019 11:30:00 AM
15			YES		MORRISON, MARGARET E	
16			YES		WALGRAVE, MASON J	
17			NO		BENZING, TRAVIS R	6/13/2019 11:00:00 AM
18			YES		MARWELL, JULIANNA GEORGE	7/29/2019 9:00:00 AM
19			YES		JABEN, ISAAC L	6/4/2019 9:00:00 AM
20			YES		ENGLISH, JESSICA A	6/6/2019 2:30:00 PM
21			YES		BAKOS, JONATHAN K	6/3/2019 2:00:00 PM
22			YES		BENZING, TRAVIS R	6/21/2019 1:15:00 PM
23			YES	YES	SCHUMANN III, SAMUEL O	
24			YES		HARVEY JR, WILLIAM K	
25			YES		PROPHET, MALSHUNDRIA S	6/17/2019 9:45:00 AM
26			YES	YES	SHAYTO, RANI	
27			YES		STOMSKI, CHLOE WOJNAROWSKI	6/21/2019 3:45:00 PM

3rd Edition of Report - Amanda Williamson

- Identify Deficient
 - Medication agreement
 - COMM screen
- Next Appointment
 - Huddle report

Staff / Provider
Education with feedback
(report)



MAT in Primary Care Conclusion

Case Follow up

- Adherent with buprenorphine therapy for **18 months to date**
- **Completing all iADLs and returned to driving**
- Navigated 2 orthopedic surgeries and successfully transitioned back to buprenorphine
- She is **now caretaker of husband** who suffered an unexpected health decline

MAT in Primary Care

- Education of Trainees and Faculty is needed
- Offering MAT in primary care does not have to change patient demographics
- Office-Based Opioid Treatment is a reasonable model
 - An office “Champion” may help streamline treatment
 - Practice support and System support is needed
- Identifying and reaching patients with OUD is a limitation

Questions?



Sample Quotes

General Supportive Attitudes:

- › *“Right, like our patients that go into DKA in the hospital, we don’t say ‘no more insulin,’ right?”*
–Family Medicine Resident
- › *“Well I have seen the advantages that it brings in that some people who are not functional, losing jobs, can actually go back to work and live a normal life.”*
–Internal Medicine Resident

General Challenges:

- › *“I think the other disadvantage I see is that we don't want to simply treat opioid use disorder [...] because we don’t want to be known for maybe a Center for Opioid use disorder and we want to still be focusing on other comorbidities.”*
–Internal Medicine Faculty
- › *“... pills without skills is a fool’s errand. The medicines are fine, they’ll help, but if you don’t have a context for treating, you’re wasting your time [...] it’s a problem at the clinic level, but at these larger political, economical levels it’s really a problem.”*
–Family Medicine Faculty



Sample Quotes

Subjective Norms

- › *“Maybe the folks in the waiting room wouldn’t want to be surrounded by drug addicts.”*
– Family Medicine Faculty
- › *“I think with PAs too, our dependence on supervising physicians, somewhat has a huge influence over, [...] whether that becomes part of our scope of practice.”*
–PA Faculty

Perceived Behavioral Control

- › *“Training and tools for me on misuse, so that I could identify patients. Feeling like I could send him to a support system of care, so if I were prescribing and they also had counseling wrapped in that would be big and just better training about monitoring use of the medications.”*
–Internal Medicine Faculty
- › *“... seeing it and doing it in real life is a lot better than reading it [...] because that's not real life cause it takes nuance, you know, it's an art and a science, so I think going there, being there, give us more of the art.”*
–Internal Medicine Residents

