Inspiring and Sustaining Prescribers to Treat Opioid Use Disorders

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Disclosures

I have no financial relationships with commercial entities producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.
Objectives

By the end of this session, learners will be able to:

• Understand and apply a framework for understanding motivation using the mind, heart, and hand
• Using this framework, identify one or more barriers that prescribers face in your organization in providing care for opioid use disorder
• Using this framework, identify one or more ideas to address identified your identified barrier(s)
Insight is insufficient for change
Frame: three key motivating forces

In order to motivate and sustain prescribers, you must consider:

- **Mind**
- **Heart**
- **Hand**

Originally adapted from the works of Marshall Ganz, Harvard University
Breaking it down

**Understanding (The Mind)**
- “What?”
- Cognitive
- Knowledge
- Analysis

**Caring (The Heart)**
- “Why?”
- Affective
- Attitudes
- Motivation

**Doing (The Hand)**
- “How?”
- Logistical
- Behavior
- Support, Resources
Putting these concepts together

Originally adapted from the works of Marshall Ganz, Harvard University
Context matters

Primary care providers:
- Are busy!
- Face competing demands
- Have limited administrative time

Providers who feel like they can’t prescribe buprenorphine aren’t bad people!

How could I possibly do one more thing?
You have a worksheet!

With this framework of **Mind**, **Heart**, and **Hand**, use this worksheet to identify barriers your organization’s providers may face in starting or sustaining treatment of opioid use disorders in primary care.
Motivating the Mind

What barriers are there to providers understanding what makes this work important?

- If so, might providers benefit from more information about national or local trends in substance use mortality and access to care?
- Might providers benefit from more contextual knowledge about why medications are particularly important for opioid use disorder?
Idea: Giving a fact-based talk

These are all slides that I’ve presented to providers in our health system at Internal Medicine Grand Rounds, resident teaching sessions, and outreach to local service organizations.
## Accidental Deaths in the US, 2016

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>38,000+ people</td>
<td>38,000+ people</td>
<td>67,000+ people</td>
<td>43,000+ people</td>
</tr>
</tbody>
</table>

6 of 10 involve an opioid

From CDC, [https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf)
Has Severe Opioid Use Disorder (100%)

Received Treatment (21.5%)

Only 1 in 5 patients with severe OUD gets any care at all.

Only 1 in 10 patients gets prescribed medications, which is the standard of care (decrease mortality 50%).
Why Medications? Because They Work!

Patients are **much more likely to succeed** in remaining opioid-free if they are prescribed a medication as part of their treatment.

In some studies, the **chances of opioid-free recovery are lower than 10%** if patients are prescribed a placebo or “detoxed.”

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**Table 2**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Percentage opioid free on medication</th>
<th>Percentage opioid free on placebo/detoxification</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naltrexone ER</td>
<td>36</td>
<td>23</td>
<td>Krupitsky et al. (2011)</td>
</tr>
<tr>
<td>Buprenorphine/naloxone</td>
<td>20–50</td>
<td>6</td>
<td>Fudala et al. (2003)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Weiss et al. (2011)</td>
</tr>
<tr>
<td>Buprenorphine/naloxone</td>
<td>60</td>
<td>20</td>
<td>Woody et al. (2008)</td>
</tr>
<tr>
<td>Methadone</td>
<td>60</td>
<td>30</td>
<td>Mattick et al. (2009)</td>
</tr>
</tbody>
</table>

*Connery, Harvard Review of Psychiatry, 2015*
Idea: Highlighting local disparities

The Urban Institute has county-based reports across California on unmet treatment needs.

**County Estimates of Opioid Use Disorder and Treatment Needs in California**

**California County Spotlight: San Francisco County, March 19, 2018**

- In 2016, an estimated 5.8% of people ages 12 years and older (46,018 people) misused opioids in San Francisco, and 1.1% of people (8,284 people) had an opioid use disorder (OUD), defined as opioid abuse or dependence. Approximately one-fifth of those who misuse opioids have an OUD.
- The county had 91 opioid overdose deaths in 2016.

**County Estimates of Opioid Use Disorder and Treatment Needs in California**

**California County Spotlight: Alameda County, March 19, 2018**

- In 2016, an estimated 5.6% of people ages 12 years and older (79,186 people) misused opioids in Alameda, and 1.0% of people (14,254 people) had an opioid use disorder (OUD), defined as opioid abuse or dependence. Approximately one-fifth of those who misuse opioids have an OUD.
- The county had 47 opioid overdose deaths in 2016.

- There are **no people with OUD in the county without local access to opioid agonist treatment** (i.e., buprenorphine or methadone). Since there are no regulatory barriers to naltrexone and counseling treatments, this snapshot focuses on agonists.

- There are **5,890 to 8,889 people with OUD in the county without local access to opioid agonist treatment** (i.e., buprenorphine or methadone). Since there are no regulatory barriers to naltrexone and counseling treatments, this snapshot focuses on agonists.
Motivating the **Heart**

What barriers are there to providers **caring about why** this work is so important?

- Often, facts alone are insufficient. Are there patient cases or stories that might demonstrate the chance to make a difference?
- Is there work to do to discuss past experiences that might create anxiety or even stigma towards providing treatment to people who use drugs?
Idea: Sharing patient stories

Patient success story shared on our organization’s intranet

Stories motivate people in different ways and result in a “shared brain”
Idea: Discussing past experiences

What, if anything, from past experiences makes providers nervous about offering treatment for opioid use disorder? How might providers deal with vicarious trauma?

- Are there policies and procedures that can set clear expectations?
- Are there ways to debrief challenging experiences as a team?
Idea: Acknowledge and address stigma

People who use drugs are often dehumanized in the news and popular media. Taking care to avoid these pitfalls and to acknowledge the humanity of people who use drugs can be grounding—and motivating.

- How might we change the language that we use?
- Can a training on stigma be provided to providers and other staff?
Motivating the Hand

What barriers are there to providers acting to provide care? How would they be able to provide services at your organization in a joyful, sustainable way?

- How might you configure your team to take a bio-psycho-social approach to addiction treatment across team members?
- What visit models in a busy primary care would allow for high-quality, collaborative, and efficient care?
- How might you offer providers clinical support for complex cases?
Idea: Create a treatment team

A bio-psycho-social approach to treatment

- **Biological**
  - Physician

- **Psychological**
  - Licensed Clinical Social Worker

- **Social**
  - Community Health Worker
Highland Primary Care Addiction Treatment Team (PCAT)

Our Team: Addressing addiction as a chronic bio-psycho-social condition

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Tian, MD</td>
<td>Monica Rowden, LCSW</td>
<td>Catherine Carter, CHOW</td>
</tr>
</tbody>
</table>

Medications to prevent symptoms of withdrawal and craving
Behavioral interventions for substance use disorders, co-occurring conditions
Social determinants of health, linkage to community resources

A team approach to care:
- Decreases provider isolation
- Provides a way to harness training and expertise
- Increases joy of work!
Idea: Specify team roles

- Weekly team schedule:
  - Tuesday morning: Team meeting and huddle for 1 hour
  - Wednesday afternoon: Refill group visit and individual visits with full team present
  - Friday morning: Individual appointments with LCSW

<table>
<thead>
<tr>
<th>Biological – David</th>
<th>Psychological – Monica</th>
<th>Social – Cathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assesses concurrent medical conditions and triages urgent concerns</td>
<td>Screens all patients for depression and links to psychological, psychiatric care</td>
<td>Performs universal social needs screening and links patients to services</td>
</tr>
</tbody>
</table>
Idea: Consider alternative visit types

<table>
<thead>
<tr>
<th>Standard model</th>
<th>Carve out clinic</th>
<th>Group visit model</th>
<th>Non-medical visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrate buprenorphine patients into the standard schedule of a primary care provider.</td>
<td>One or more buprenorphine-focused half-day clinics. Allows streamlining of flow.</td>
<td>Patients appropriate for this visit type participate in a refill group model. Increases treatment capacity.</td>
<td>Have a non-physician, non-APP provider see a patient, such as a nurse, pharmacist, or behavioralist.</td>
</tr>
</tbody>
</table>

Across all models, consider:

What happens when a patient no-shows? What happens when a provider goes on leave? (Tip: Have a **provider buddy**!) Who is the point of contact with unexpected outcomes?
Idea: Formalizing clinical support

PRESCRIPTION ISSUES

- Partner with a pharmacy to set expectations
- Use a **stamp** on written prescriptions or a **note to pharmacy** on ePrescriptions: X-waiver number, F11.99 ICD-10 code, Bill Medi-Cal Fee for Service
- Who will troubleshoot pharmacy issues?

CLINICAL SUPPORT

- Linking with local resources (county providers, hub clinics, opioid treatment programs). Case conferences?
- UCSF Warm Line: [https://nccc.ucsf.edu/](https://nccc.ucsf.edu/)
- Additional training:
  - CSAM Conference: [https://csam-asam.org/](https://csam-asam.org/)
Summary: Motivating providers

Heart

Mind

Hand

Breakout Session A Worksheet

**Inspiring and Sustaining Prescribers to Treat Opioid Use Disorders**

In the table below, please identify any barriers your organization’s providers may face in starting or continuing the treatment of opioid use disorder in primary care.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Current Barrier</th>
<th>Potential Ways to Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mind</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand</td>
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</tbody>
</table>
Thank you!

Any questions?

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datian@alamedahealthsystem.org