Inspiring and Sustaining Prescribers to Treat Opioid Use Disorders

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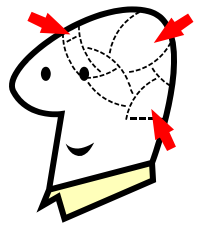
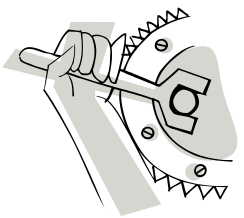




Disclosures

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

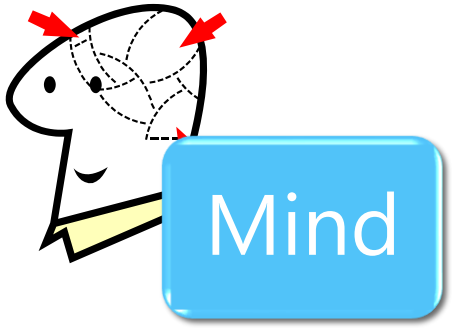
By the end of this session, learners will be able to:

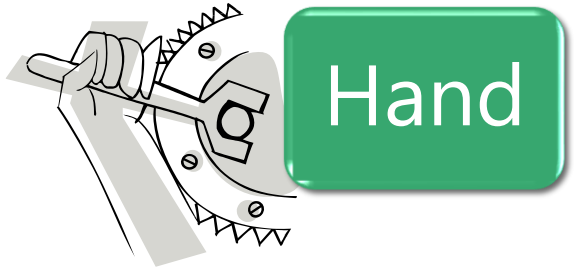
- Understand and apply a framework for understanding motivation using the mind, heart, and hand
- Using this framework, identify one or more barriers that prescribers face in your organization in providing care for opioid use disorder
- Using this framework, identify one or more ideas to address identified your identified barrier(s)

Insight is insufficient for change

Frame: three key motivating forces

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



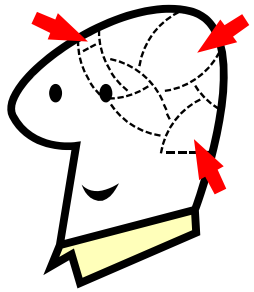


Marshall Ganz

Breaking it down

Understanding (The Mind)

- "What?"
- Cognitive
- Knowledge
- Analysis

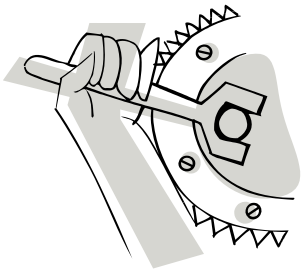


Caring (The Heart)

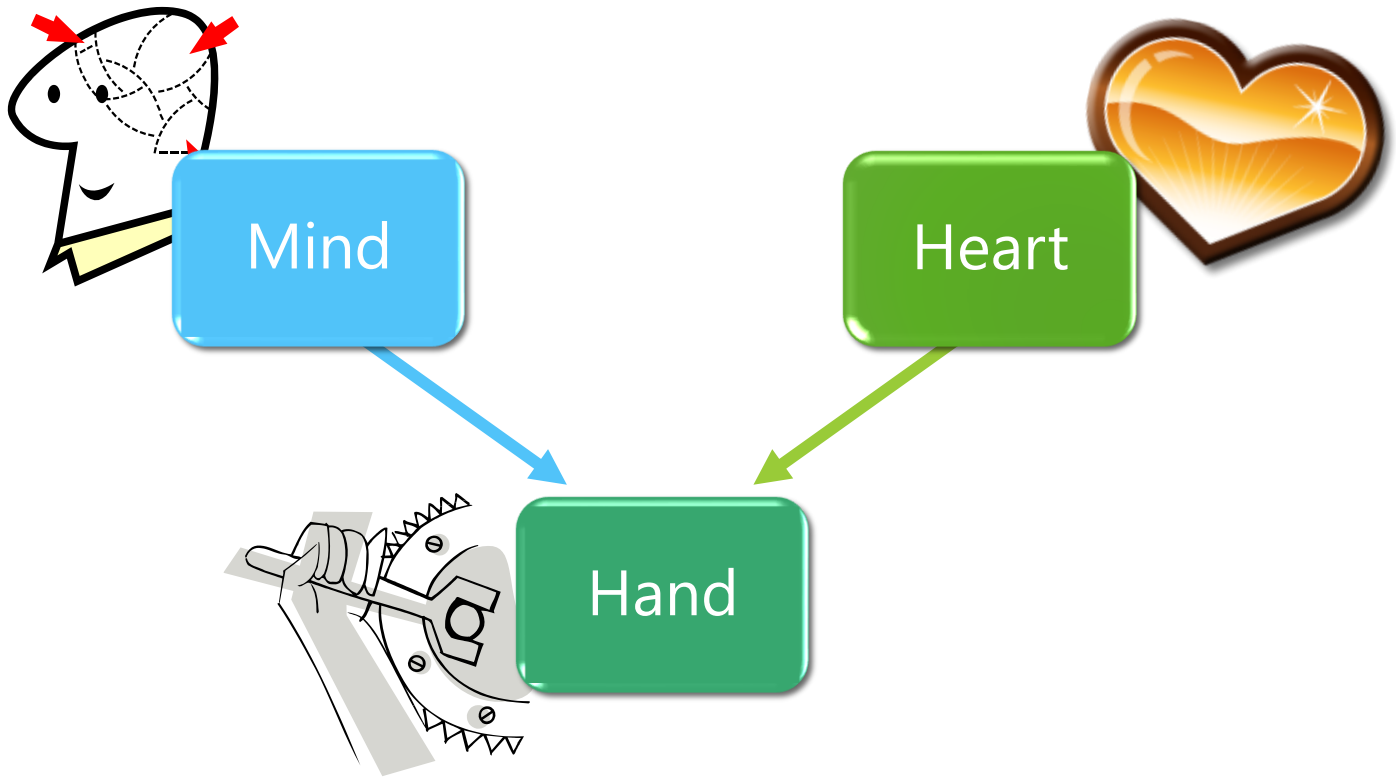
- "Why?"
- Affective
- Attitudes
- Motivation

Doing (The Hand)

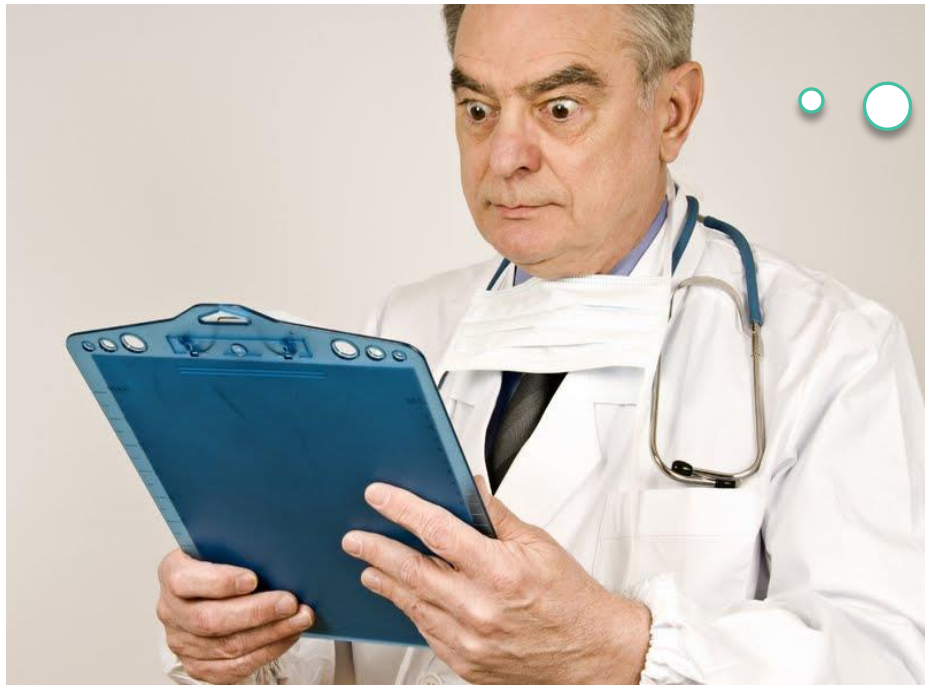
- "How?"
- Logistical
- Behavior
- Support, Resources



Putting these concepts together



Context matters



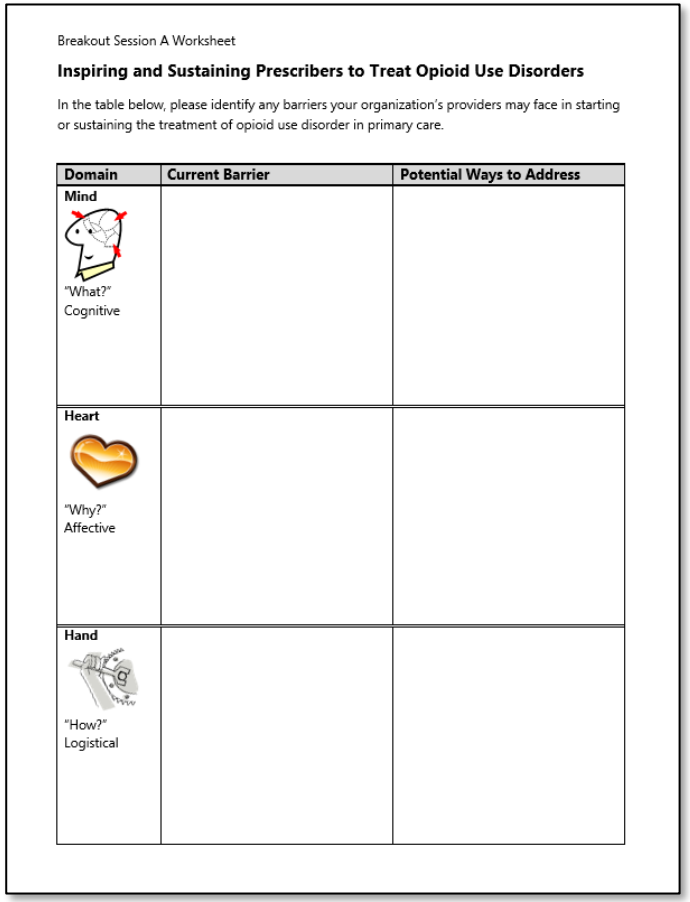
How could I possibly do one more thing?

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!

You have a worksheet!



Breakout Session A Worksheet

Inspiring and Sustaining Prescribers to Treat Opioid Use Disorders

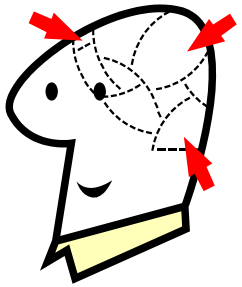
In the table below, please identify any barriers your organization's providers may face in starting or sustaining the treatment of opioid use disorder in primary care.

Domain	Current Barrier	Potential Ways to Address
Mind "What?" Cognitive		
Heart "Why?" Affective		
Hand "How?" Logistical		

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

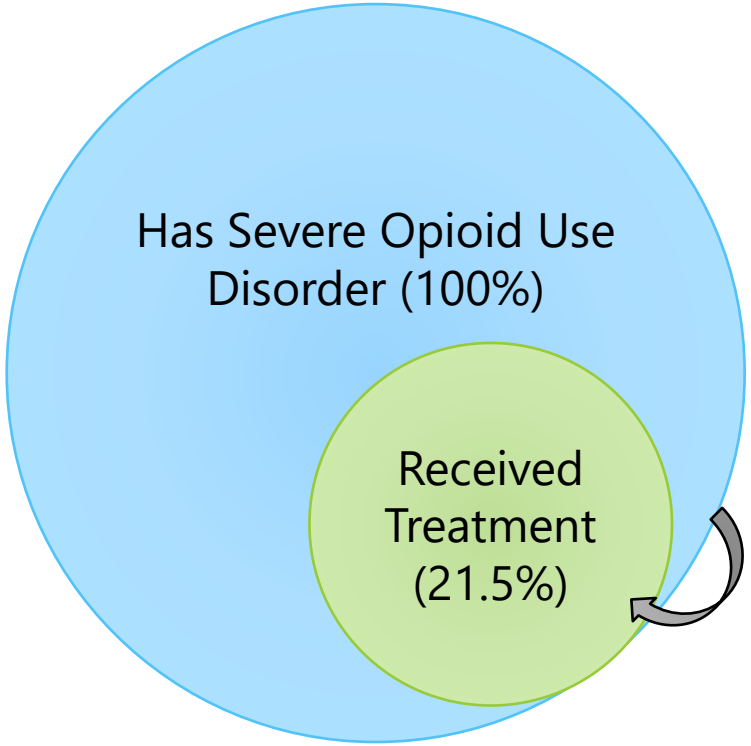
These are all slides that I've presented to providers in our health system at Internal Medicine Grand Rounds, resident teaching sessions, and outreach to local service organizations.

Accidental Deaths in the US, 2016

Car Crashes	Gun Violence	Drug Overdose	HIV Deaths (1995)
38,000+ people 	38,000+ people 	**67,000+ people**  ***6 of 10 involve an opioid***	43,000+ people 

From CDC, https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf

Treatment Cascade



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%).

National Survey of Drug Use and Health (NSDUH) Data 2004-2013, Analyzed by Saloner and Karthikeyan, *JAMA* 2015
Williams, Nunes, and Olfson, *Health Affairs,* 2017: https://www.healthaffairs.org/do/10.1377/hblog20170313.059153/full/

Why Medications?
Because They Work!

Table 2

Opioid-Abstinence Rates with Medication Compared to Nonmedication[a]

Medication[b]	Percentage opioid free on medication	Percentage opioid free on placebo/detoxification	Study
Naltrexone ER	36	23	Krupitsky et al. (2011)[23]
Buprenorphine/naloxone	20–50	6	Fudala et al. (2003)[24] Weiss et al. (2011)[25,c]
Buprenorphine/naloxone	60	20	Woody et al. (2008)[26,d]
Methadone	60	30	Mattick et al. (2009)[27]

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."

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** percent of people ages 12 years and older (**46,018** people) misused opioids in **San Francisco**, and **1.1** percent of people (**8,284** people) had an opioid use disorder (OUD),[a] 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.
- 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 snap-shot focuses on agonists.

California County Spotlight: Alameda County, March 19, 2018

- In 2016, an estimated **5.6** percent of people ages 12 years and older (**79,186** people) misused opioids in **Alameda**, and **1.0** percent of people (**14,254** people) had an opioid use disorder (OUD),[a] 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 **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.

California County Fact Sheets: Treatment Gaps in Opioid-Agonist Medication Assisted Therapy (OA-MAT) and Estimates of How Many Additional Prescribers Are Needed, Urban Institute, May 2018.

Motivating the **Heart**

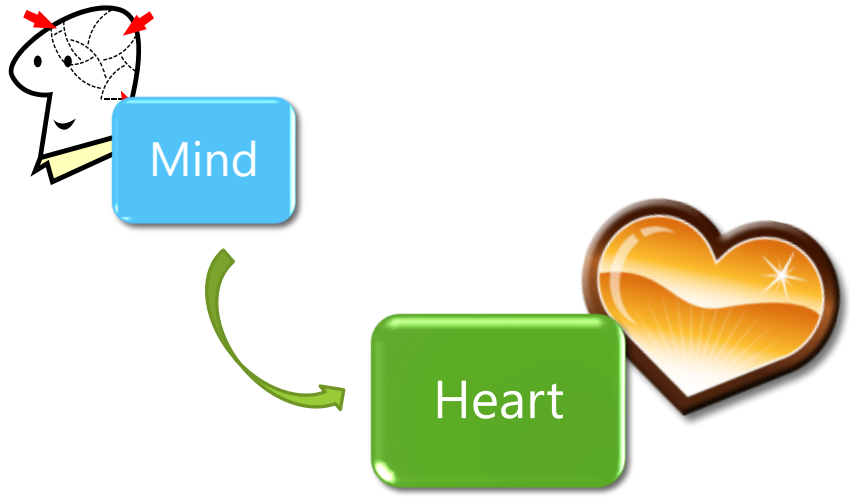
What barriers are there to providers **caring** about **why** this work is so important?

- 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

STEP BY STEP. DAY BY DAY.

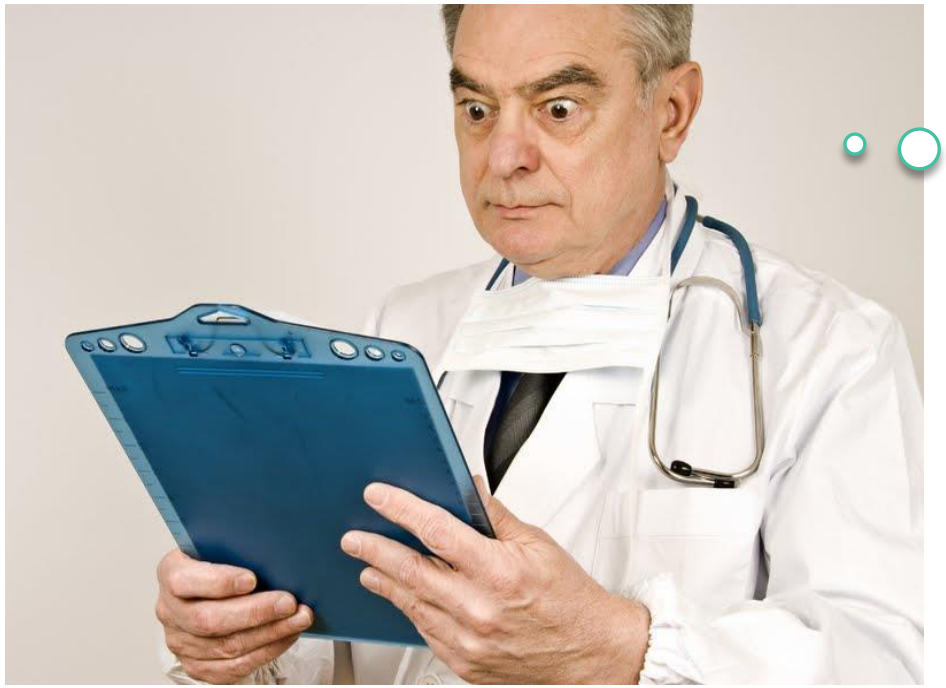
Patient success story shared on our organization's intranet



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?

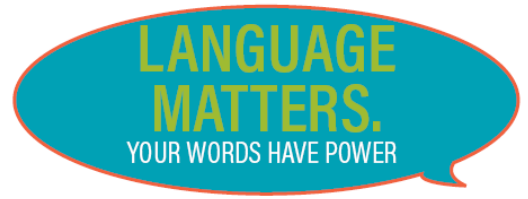


I don't want to have another experience like that!

- 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

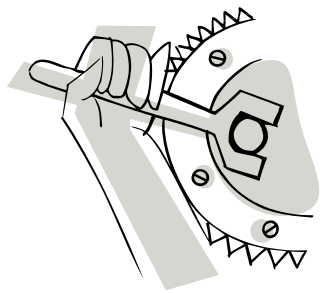
People who use drugs are often dehumanized in the news and popular media. Taking care to avoid these pitfalls and to acknowledge the humanity of people who use drugs can be grounding—and motivating.



- 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

Biological David Tian, MD	Psychological Monica Rowden, LCSW	Social Catherline Carter, CHOW
		
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

Biological – David	Psychological – Monica	Social – Cathy
 Assesses concurrent medical conditions and triages urgent concerns	 Screens all patients for depression and links to psychological, psychiatric care	 Performs universal social needs screening and links patients to services

Idea: Consider alternative visit types

Standard model

Integrate buprenorphine patients into the standard schedule of a primary care provider.

Carve out clinic

One or more buprenorphine-focused half-day clinics. Allows streamlining of flow.

Group visit model

Patients appropriate for this visit type participate in a refill group model. Increases treatment capacity.

Non-medical visit

Have a non-physician, non-APP provider see a patient, such as a nurse, pharmacist, or behavioralist.

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?

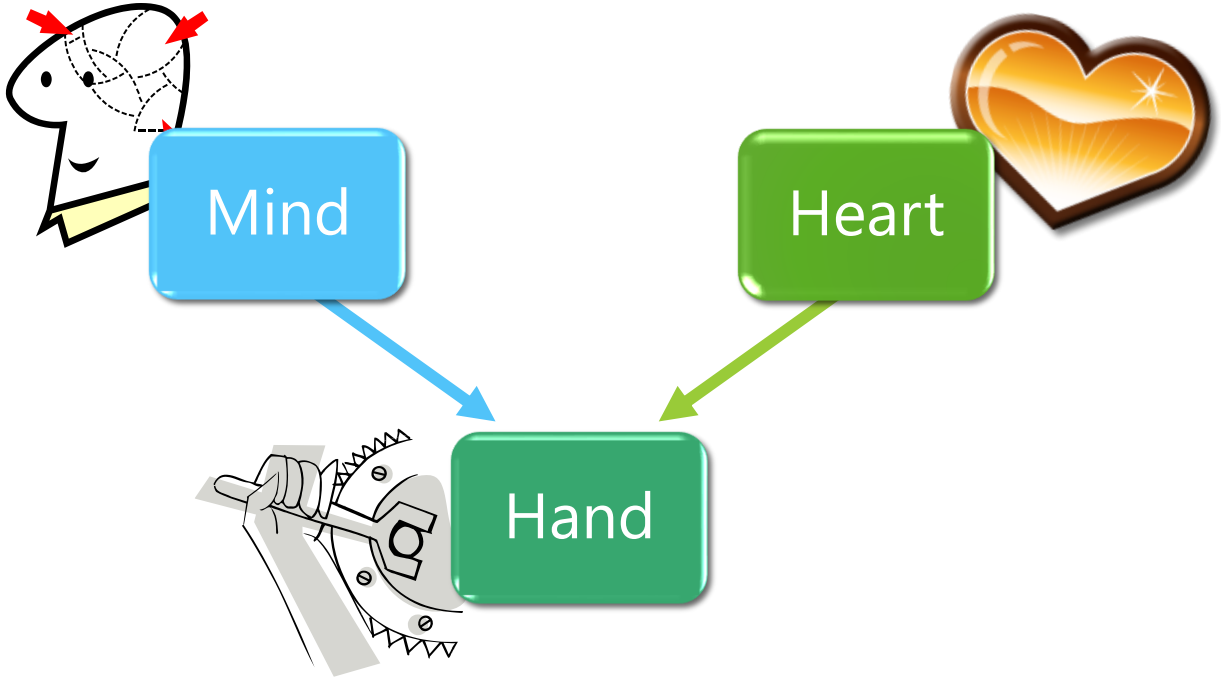
CLINICAL SUPPORT

- Linking with local resources (county providers, hub clinics, opioid treatment programs). Case conferences?
- UCSF Warm Line: https://nccc.ucsf.edu/

CLINICIAN CONSULTATION CENTER

- Additional training:
  - MERF Mates: http://www.merfweb.org/2019-mentored-mat-learning-experience-scholarships
  - CSAM Conference: https://csam-asam.org/

Summary: Motivating providers



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Thank you!

Any questions?

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