Monday Memo – October 29, 2018

Publications


Wellness Moment

**Physician Work Environment and Well-Being:** The September 17, 2018 edition of JAMA Internal Medicine (JAMA Intern Med. doi:10.1001/jamainternmed.2018.3956) includes a study on the impact of scribes on workflow and doctor-patient interactions in two Internal Medicine practices at Kaiser Permanente Northern California medical center facilities. Quoting from the paper: “Compared with nonscribed periods, scribed periods resulted in less self-reported afterhours EHR documentation, . . . higher likelihood of PCP-reported spending more than 75% of the visit interacting with the patient, . . . and less than 25% of the visit on a computer.”

“61.2% of patients reported that scribes had a positive bearing on their visits; only 2.4% reported a negative bearing.”

Department Retreat

We had a terrific faculty retreat on Friday. Thanks go out to everyone who presented on a variety of topics highlighting success stories from across the Department. Next week’s Monday Memo will give proper credit to all.

A highlight of the retreat was a keynote by Dr. Sarah Wakeman, Medical Director of the Substance Use Disorders Initiative at Mass General Hospital, followed by a panel discussion moderated by Dennis Dimitri reviewing Department activities related to residency teaching (Stacy Potts), ongoing training (Dan Mullin), and treatment for substance use disorder within primary care settings (Pam Tsinteris). There’s no question that we are providing high quality care and training across the Department, work that was the basis for Friday’s panel, as well as a presentation at last spring’s STFM annual meeting that had faculty from across the country in a line that went out the door to ask questions of our panelists.

From the questions I hear, It’s obvious that there’s still lots of work to be done to change attitudes and train primary care physicians in the treatment of this chronic disease. In this light, we have developed a “Statement about the Department’s Engagement in Opioid Use Disorder Prevention, Treatment, and Workforce Training:

Opioid Use Disorder is a chronic, lethal, stigmatized disease with a significant public health impact. Consistent with our vision and mission statement, we strive to accomplish the following goals to respond to the opioid epidemic:
1. To provide a standardized model for care across our clinical ambulatory and hospital sites that provides the best care for our patients and our communities, while fulfilling the Quadruple Aim
2. To evaluate the effectiveness of the model
3. To disseminate the model, including training, presentation, and publication
4. To advocate for regulatory and payer support for best practices

Our approach will require engagement of clinical leaders, an array of clinical services, including safe prescribing practices and treatment programs for opioid use disorder integrated into the fabric of our primary care practices, education and training, and advocacy.

We support the following principles to guide our work in responding to the Opioid Epidemic:

1. Opioid use disorder is a treatable chronic disease.
2. The approach to the management of long-term opioid use and opioid use disorder starts with safe prescribing practices.
3. Reducing access to prescription opioids without simultaneously increasing access to replacement therapy contributes to the harms associated with opioid use disorder, such as increases in the use of heroin laced fentanyl.
4. There is an epidemic of opioid use disorder. Epidemics cannot be adequately addressed through specialty services alone. Primary care and public health efforts must be mobilized to respond to epidemics. A comprehensive approach should include:
   - Low threshold MAT provided across a wide distribution of outpatient and inpatient care
   - Naloxone distribution
   - Development of safe-needle exchange and safe injection facilities
   - Immediate access to MAT for patients discharged from the hospital or released from correctional facilities
5. Buprenorphine needs to be available to patients in primary care, emergency departments, and hospitals, including inpatient services. Patients should be able to walk through any door, any time and be offered immediate treatment - not a referral. Patients under treatment should have their treatment continue when they are admitted to the hospital.
6. In some cases, diversion of buprenorphine is associated with harms. However, delayed treatment, undertreatment, and termination from treatment are, in general, associated with greater harms.
7. No one should be denied access to MAT because they refuse counseling.
8. Patients with substance use disorders have better health outcomes when they encounter health care providers who demonstrate clinical empathy. Low empathy is toxic to patients and CAHPS scores. A serious investment in increasing clinical empathy will save lives and improve CAHPS scores.