Feature

Prescribing Opioids as an Incentive to Retain Patients in Medical Care: A Qualitative Investigation into Clinician Awareness and Perceptions

Kasey R. Claborn, PhD*
Elizabeth R. Aston, PhD
Jane Champion, PhD, DNP
Kate M. Guthrie, PhD

HIV treatment retention remains a significant public health concern. Our qualitative analysis used emergent data from a larger HIV treatment study to explore clinician perspectives on prescribing opioids to incentivize retention in HIV care. Data from individual interviews with 29 HIV and substance use clinicians were analyzed using thematic analysis. Prescribing opioids as a retention strategy emerged as a theme. Nine of 11 HIV clinicians reported prior knowledge of this practice; only one of 12 substance use clinicians indicated prior knowledge. Positive perceptions included: harm reduction approach, increased appointment attendance, and sustained engagement in HIV care. Negative perceptions included: addiction potential, increased engagement not leading to better health outcomes, and prescriptions becoming the appointment focus. Some clinicians used prescriptions as a strategy to improve treatment retention, which may be particularly problematic in light of the current opioid epidemic. Understanding motives, outcomes, and clinical decision-making processes is needed.

(Journal of the Association of Nurses in AIDS Care, ■, *1-13*) *Copyright © 2018 Association of Nurses in AIDS Care*

Key words: *adherence, addiction, engagement, HIV, opioids, prescribing behavior, treatment retention*

The World Health Organization and the Centers for Disease Control and Prevention have prioritized improving outcomes across the HIV care continuum with a goal of diagnosing 90% of all people living with HIV (PLWH), prescribing antiretroviral therapy to 90% of diagnosed PLWH, and 90% of all PLWH in treatment being virally suppressed by the year 2020 (Joint United Nations Programme on HIV/AIDS, 2017). Currently, less than half of PLWH receive consistent HIV health care (Bradley et al., 2014). Certain subpopulations of PLWH are at increased risk for treatment drop-out, including individuals with co-occurring substance use (Karch et al., 2016). In order to achieve targeted outcomes, it is imperative to better understand the range of strategies

*Kasey Claborn, PhD, is an Assistant Professor, Department of Psychiatry, The University of Texas Dell Medical School, Austin, Texas, USA. (*Correspondence to: kasey.claborn@austin.utexas.edu). Elizabeth Aston, PhD, is an Assistant Professor, Center for Alcohol and Addiction Studies, Brown University School of Public Health, Providence, Rhode Island, USA. Jane Champion, PhD, DNP, is a Professor, School of Nursing, The University of Texas, Austin, Texas, USA. Kate Guthrie, PhD, is a Professor, Department of Psychiatry & Human Behavior, Alpert Medical School of Brown University, and a Professor, Centers for Behavioral & Preventive Medicine, The Miriam Hospital, Providence, Rhode Island, USA.*

https://doi.org/10.1016/j.jana.2018.05.010

that providers use and the effectiveness of each strategy to retain high-risk patients in treatment throughout the life course.

HIV Care Retention Strategies

Multiple studies have focused on systems-level changes to improve HIV retention in care, including providing onsite comprehensive services and reducing structural barriers via patient navigation (Gardner et al., 2005; Higa et al., 2012; Willis et al., 2013). Financial-based contingency management approaches have also demonstrated efficacy in promoting treatment engagement and viral suppression in patients with comorbid HIV and substance use disorder (SUD; Stitzer et al., 2017). A recent systematic review reported that only three studies have tested contingency management interventions among PLWH with a comorbid substance use disorder (Herrmann et al., 2017). All of these studies used a variety of financial incentives to target medication adherence (Sorensen et al., 2007), reduce viral load (Farber et al., 2013; Solomon et al., 2014), and facilitate linkage to and retention in HIV care (Solomon et al., 2014). Contingency management improved the target behavior in each of these studies. Although evidence exists for the efficacy of contingency management models, implementing and sustaining these in real-world clinic settings has been limited, often due to the costs associated with the intervention (Petry, 2011). Lower-cost HIV retention strategies that have demonstrated positive results include patient education and enhanced patient contact (e.g., reminder calls), and digital health support tools (Gardner et al., 2014; Risher et al., 2017).

Prescriptions as an Incentive to Increase Treatment Adherence and Retention

DeFulio and Silverman (2012) conducted a review of incentives that were given to patients contingent upon medication adherence. Incentive-based medication adherence interventions demonstrated promising results, increasing adherence by a mean of 20%. Most incentives were financial; however, additional incentives for adults included methadone prescriptions and food. Two studies conducted in the 1970s used methadone as an incentive to increase adherence to disulfiram medication in methadone patients with an alcohol use disorder. These studies included very small sample sizes; results showed a lower percentage of drinking days and reduced arrest rates in the methadone-contingent groups. Similarly, two studies with methadone patients from the 1990s utilized daily doses of methadone as the contingency for taking isoniazid, a medication to treat latent tuberculosis (Elk et al., 1993; Elk et al., 1995). Patients in the methadone contingency group were retained in treatment about 3 months longer than control groups.

A recent qualitative study of HIV providers in New York investigated providers' perspectives on opioid prescribing. A theme emerged throughout the interviews, highlighting that some HIV providers believed that prescribing opioids could help engage and retain patients in care (Starrels et al., 2016). The authors noted that HIV treatment tended to supersede guideline-based opioid prescribing in an effort to retain patients in care, and that the focus on HIV care may have led providers to overlook opioid misuse.

Further, Calcaterra et al. (2013) conducted a qualitative assessment of hospital-based (non-HIV specialty) physician perspectives for prescription opioids. Physicians were recruited from hospitals in Colorado and South Carolina. Findings revealed that opioid-prescribing practices were shaped by clinical practice experiences due to lack of formal training. Similar to Starrels' findings (Starrels et al., 2016), these physicians reported that guideline-based opioid prescribing tended to be at odds with the priorities of current hospital care, which focused on patient-reported pain control rather than the potential long-term consequences of opioid use. Physicians reported feeling pressure from the institution to reduce hospital readmissions and facilitate patient discharges. As uncontrolled pain often prolonged hospital stays, "physicians viewed opioid prescriptions as a tool to buffer against readmission or long hospital stays" (Calcaterra et al., 2013, p. 539). Calcaterra et al. (2013) noted that physicians felt conflicted by this prescribing behavior, recognizing that "It may not be in the patient's best interest to receive a higher than necessary quantity of opioids at discharge" (p. 540); however, it would improve the efficiency of the organization. No studies have specifically investigated this phenomenon a priori.