Boundaries NOT Barriers

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Boundaries NOT Barriers

- **Boundary** = Limitation; Extent; Scope; Confines
- **Barrier** = Obstacle; Hinders; Blocks; Prevents

So, why say “No” to barriers?

Because we cannot afford to, with the epidemic we are facing.
Male predominence

2015 - 2016 21.4%
2016 - 2017 10.4%

Figure 1. National Drug Overdose Deaths Number Among All Ages, by Gender, 1999-2017

Figure 3. National Drug Overdose Deaths Involving Any Opioid Number Among All Ages, by Gender, 1999-2017

2015-2016 27.6%
2016-2017 12.6%
Synthetic Opioids are the culprit

- Tramadol
- Fentanyl
- Methadone

Figure 4. National Drug Overdose Deaths Involving Prescription Opioids, Number Among All Ages, 1999-2017

Figure 5. National Drug Overdose Deaths Involving Heroin, Number Among All Ages, 1999-2017
Annual opioid prescribing rates overall and for high-dosage prescriptions\(^a\) (≥ 90 MME/day)\(^b\) — United States, 2006–2017

**Source:** IQVIA™ Transactional Data Warehouse.

\(^a\) High-dosage prescriptions were defined as opioid prescriptions resulting in a daily dosage of ≥ 90 morphine milligram equivalents.

\(^b\) Temporal trends from 2006 to 2017 were evaluated by applying joinpoint regression methodology. This modeling approach simultaneously identified statistically significant trends as well as shifts in trends that occurred within a time series. A maximum of two joinpoints was allowed, and the permutation method was used for model selection. Different line dashes correspond to year groupings as determined by joinpoint regression.
10 mg oxycodone tablets x (120 tablets/30 days) x 1.5 = 60 MME/day.
25 μg/hr fentanyl patch x (10 patches/30 days) x 7.2 = 60 MME/day
Current drugs of choice

Cocaine
Meth
Figure 2. 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
A little about us (Rocking Horse)

We are a Federally Qualified Health Center located in Clark and Madison counties.

We operate a total of 4 sites.

In 2018, we provided 62,955 visits across all disciplines for 13,549 patients.

We started Addiction treatment services in 2017.

We provided high quality integrated care in a PCMH delivery model.
Our Journey

➢ Prequel (2015) Setting tone

▪ Active participation in both the Community Health Needs Assessment and Community Health Improvement Plan.
▪ Build strong relationships with local Alcohol and Drug Rehab facility, Local hospital system, Mental Health Agency, EMS, DJFS, Health district etc.
▪ Shared Case management with local AoD agency.
▪ Educating our Board members and staff about the opioid crisis and measures to combat.
▪ Provider prescribing practices were reviewed and shared.
▪ OARRS registration made mandatory.
<table>
<thead>
<tr>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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</thead>
<tbody>
<tr>
<td>Peer reviews conducted around Opioid prescribing practices.</td>
<td>All staff training on how to respond to an overdose scenario</td>
<td>Team in place 2 providers complete DATA Waiver</td>
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<tr>
<td>Rocking Horse pledges to treat pain in a safe and effective way using opioid alternative modalities.</td>
<td>Hands-on Narcan administration competency training for all licensed individuals</td>
<td>Policies and procedures established</td>
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<td><strong>Chiropractic services started on-site</strong></td>
<td>Weekly AoD meetings to review cases for standard of care</td>
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<td></td>
<td>175 K secured via Access Increase in Mental Health and Substance Abuse Services (AIMS) grant</td>
<td>Ongoing staff updates</td>
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<td></td>
<td>Identifying patients and recruiting the team</td>
<td>A total of 6 providers complete DATA Waiver</td>
</tr>
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Our guiding principles

- Integrated not isolated (No special day for AoD services)
- Tailor to the needs of the patient (Not a cookie-cutter approach)
- Manage medical, mental health and substance abuse needs concurrently.
- Team-based
- When to say “NO” (Link patients that need higher level of care with our partners in the community)
- Clearly distinguish boundaries from barriers
2016-2018 Growth

SUD encounters

- 2016: 0
- 2017: 498
- 2018: 1,147
AoD Service 2018 (Snap shot)

Treatment mix

- Buprenorphine: 30%
- Vivitrol: 27%
- Acamprosate: 2%
- Non MAT: 41%
SUD services

- Integrated physical, mental health and SUD services
- Individual and group counseling
- Peer support services
- Case management/Care Coordination
- Medication-Assisted Treatment
- Rocking Horse is a Project Dawn dispensing site (3 trained employees)
Setting boundaries

"Say what you mean, mean what you say, just don't say it mean."

Al-Anon

Don’t make boundaries sound like barriers

Its all in the tone and approach
Stretching the limits (fine balance)
Ohio rule changes spark debate about addiction treatment.

Montgomery County saw a reduction in overdose deaths from 566 in 2017 to 292 in 2018. More access to treatment, including more doctors able to prescribe Suboxone in their practices, has been credited with helping to move the needle on opioid deaths.

There is no “one size fits all” approach to OUD treatment. Many people with OUD benefit from treatment with medication for varying lengths of time, including lifelong treatment. Ongoing outpatient medication treatment for OUD is linked to better retention and outcomes.

Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method.

What's the right approach?

“Four randomized trials found no extra benefit to adding adjunctive counseling to well-conducted medical management visits delivered by the buprenorphine prescriber,” it says.
Choose the right words and approach

Vs.

- Return of use
- Return of symptoms of the disease
- A person with SUD
- Relapse
- “Used”, “relapsed”, “failed”, “dirty”
- User/Addict
30 year old Caucasian male with more than 15 years of GAD and depression, treated with BZDs for more than 10 years (prescribed). Patient suffered a wrist and hand fracture in his late teen years, started using prescription opioids and has been since.

- **Provider**: “We need you to stop taking the BZD in order for us to treat your Opioid Use disorder”

- **Patient**: “I have been on the BZD for more than 15 years and I am very worried to come off of it”

- **Provider**: “We cannot prescribe a Buprenorphine while you are on BZD, sorry”.

- **Patient**: “This is very disappointing that I can seek treatment for only one of my illnesses”.
Same Scenario; different approach

▪ Provider: “I see that you are on a BZD, Can we talk a little more about your need for this medication, duration of use, any misuse, and your concerns about a possible replacement or taper if need be”.

▪ Patient: “I am willing to explore other options, but this medication has helped me become functional as to gaining full-time employment, maintaining relationships etc, so I am always very anxious about stopping it”

▪ Provider: “Buprenorphine, the medication we are trying to start you on for your OUD has shown to have higher risk of suppressing your respirations when used along side of a BZD. We might have to build a treatment plan for you that needs additional monitoring.

▪ Patient: “I am willing to follow any and every step of the program that will allow me to take care of both my illnesses; Thanks for working with me”.
Scenario # 2

- 40 year old Caucasian Male who is being treated for OUD with Buprenorphine is at his routine MAT visit. A urine drug specimen is obtained.

- **Patient**: “I do not understand why you don’t trust me, and why I need to give my urine each time. Are we not past that yet?”

- **Provider**: “It is our policy and this was clearly explained to you before you started our “program”. Failure to comply with our policies will lead to us discontinuing the medication.”

- **Patient**: Ok

Urine tests positive for cocaine.

- **Provider**: “As explained to you early on, any failed urine drug test results in tapering of the Buprenorphine, which we will begin today”.
Same Scenario; different approach

- **Patient**: “I do not understand why you don’t trust me, and why I need to give my urine each time. Are we not past that yet?”

- **Provider**: I’m not checking the urine to catch you or because I don’t trust you. I trust you. But I don’t trust the addiction because I know how powerful addiction can be, too

- **Patient**: Ok

- **Urine tests positive for cocaine.**

- **Provider**: Your urine tested positive for cocaine. Can we talk about it. Can you tell me what led to this in terms of situations or stressors? (using open ended questions)

- Patient responses may vary

- **Provider**: Let us discuss how we can step up your treatment plan to help your recovery (more frequent visits with the counselor and provider etc)
Why we need an alternate approach

- If we agree that Addiction is a chronic illness...... because it is

![Relapse Rates Chart]

Source: McLellan et al., 2000
Then we need to treat it as such

Chronic Care Model

- Community
  - Resources and Policies
  - Self-Management Support

- Health System
  - Health Care Organization
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Productive Interactions:
- Informed, Activated Patient
- Prepared, Proactive Practice Team

Improved Outcomes

Chronic Care Model; Dr. Edward Wagner, Improving Chronic Illness care, RWJF
Essential Element of Good Chronic Illness Care

Patient-centered longitudinal care

Informed Activated patient

Productive Interactions

Prepared Practice Team

Motivation
Information
Skill
Confidence

Patient information
Decision support
Necessary resources

Chronic Care Model; Dr. Edward Wagner, Improving Chronic Illness care, RWJF
Essential elements in addiction treatment

- Addiction is a chronic, treatable illness, so general principles of good care for chronic diseases can guide OUD treatment.

- Patient-centered care is ideal (there is no “one size fits all” approach)

- People can achieve remission without OUD medications (Just like a diabetic can manage their illness with diet and exercise.)

- The typical course of OUD treatment is varied. There is often not a direct pathway from heavy illicit opioid use to no illicit opioid use.
Essential elements in addiction treatment

- Durations and types of treatment vary as it is a chronic relapsing illness.
- If a patient does not discontinue all illicit drugs for extended periods, it doesn’t mean treatment has failed.
- Forcing a patient to taper off of medication for nonmedical reasons or because of ongoing substance misuse is generally inappropriate.

JUST RESUME, MODIFY or CHANGE TREATMENT PLAN
Take home

Set healthy boundaries.

Break unfounded barriers.

Know the difference between boundaries and barriers.