IT TAKES A TEAM TO CARE FOR ONE

Yamini Teegala MD, MPH
Kent Youngman EdD, LPCC-s
Surgeon General’s Advisory on Naloxone and Opioid Overdose

I, Surgeon General of the United States Public Health Service, VADM Jerome Adams, am emphasizing the importance of the overdose-reversing drug naloxone. For patients currently taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, knowing how to use naloxone and keeping it within reach can save a life.

BE PREPARED. GET NALOXONE. SAVE A LIFE.
From 1999 to 2016, more than 630,000 people have died from a drug overdose.

Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid.
We are a Federally Qualified Health Center A.K.A Community Health Center.

- Located in Springfield, OH and London, OH
- In 2017, we served a total of 13,200 patients.
- We operate 4 sites, and are located in 2 counties.
- We are a PCMH as accredited by the Joint Commission.
- We have a multi-disciplinary team of professionals.
WHAT WE OFFER?

- Physical health services (just like any other doctor’s office)
- Mental health services (counseling, psychiatry)
- Women’s health services (inclusive of prenatal care and LARCs)
- Dental services
- Chiropractic services
- A0D services
- Case management
- Care coordination
- Support services (On-site Medicaid eligibility, navigation and outreach, patient navigation, patient advocacy, material assistance and classes, numerous community activities)
WHO BETTER THAN US FOR OUR PATIENTS?

WHO WOULD OUR PATIENTS TRUST?

WHO WOULD BE ABLE TO ADDRESS THEIR AoD NEEDS WHILE TAKING CARE OF THEIR COMPLEX MEDICAL NEEDS?

ARE THERE ENOUGH RESOURCES IN THE COMMUNITY TO HELP EVERYONE IN NEED?

DO WE HAVE RELATIONSHIPS WITH OTHER KEY ENTITIES IN THE COMMUNITY?

“Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences”

Nora D. Volkow, M.D., Director, NIDA

**Selected Mental Health and Substance Abuse Conditions**

<table>
<thead>
<tr>
<th>18. Alcohol related disorders</th>
<th>F10, G62.1</th>
<th>504</th>
<th>193</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Other substance related disorders (excluding tobacco use disorders)</td>
<td>F11- through F19- (exclude F17-), G62.0, O99.32-</td>
<td>1,191</td>
<td>501</td>
</tr>
<tr>
<td>19a. Tobacco use disorder</td>
<td>F17-</td>
<td>829</td>
<td>411</td>
</tr>
<tr>
<td>20a. Depression and other mood disorders</td>
<td>F30- through F39-</td>
<td>7,443</td>
<td>1,965</td>
</tr>
<tr>
<td>20b. Anxiety disorders including PTSD</td>
<td>F06.4, F40- through F42-, F43.0, F43.1-, F93.0</td>
<td>8,710</td>
<td>2,137</td>
</tr>
<tr>
<td>20c. Attention deficit and disruptive behavior disorders</td>
<td>F90- through F91-</td>
<td>6,161</td>
<td>1,386</td>
</tr>
<tr>
<td>20d. Other mental disorders, excluding drug or alcohol dependence</td>
<td>F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0</td>
<td>7,677</td>
<td>1,896</td>
</tr>
</tbody>
</table>
BEGINNINGS

2017
- Assess the need, establish intent, wait for a funding opportunity.
- Chiropractic solutions - 2017 Fall
- Applied for the Access Increase in Mental Health and Substance Abuse Services (AIMS) grant.
- 175K awarded for MH and AoD services
- Identifying patients
- Getting the team ready

2018
- Recruit the team
- DATA waiver training for prescribers
- Gathering educational materials
- Establish protocols and policies
- Weekly team meetings
- Staff training
- Actual patient visits
- Ongoing education, training and support services.
PROGRAM STRUCTURE AND TEAM MEMBERS

- Supportive leaders
- Staff buy-in

- Patient
  - Prescribers
  - Case managers
  - Mental health specialist
  - Peer support specialist
  - Counselors
  - Nursing
**PROCESS**

1. Patient is identified to be in need of AoD services at a primary care visit.
2. PCP refers the patient to the AoD team.
3. AoD team member meets with the patient same day.
4. Case manager schedules the patient for a diagnostic assessment.
5. DA is used to assess the needs by the medical, mental health and AoD providers.
6. Treatment plan is formulated.
7. Patient is seen by an AoD provider for mediations and counseling.
8. Case manager schedules the patient for a diagnostic assessment.
9. Weekly follow-up for patients.
10. Peer support specialist stays in contact with the individual at all times.
11. Weekly review treatment plan as a group.
12. Peer support specialist stays in contact with the individual at all times.
13. AoD team reviews treatment plan weekly as a group.
14. 1. Individual and group counseling
15. 2. Routine AoD visits
16. AoD team member meets with the patient same day.
Failed urine drug screens for substances other than being treated for.

Treatment continues with a step up in counseling for 8-12 weeks

If fails after 12 weeks, reassess the need for higher level of care.
**DO’S & DON’TS**

- Educate and engage **ALL STAFF**
- Prescriber buy-in
- Establish philosophy of care
- Hire the right team
- Use evidence-based models
- Update staff on progress
- Celebrate small wins.
- Case reviews and team meetings

- Relationships with agencies in the community that serve similar needs.
- Bite more than you can chew
- Practice out-of-your scope
- Fail to document every patient contact event.
- Fail to adhere to protocol. (this is a disease of manipulation and rationalization)
- Take a patient's inability to recover as a personal failure.
CASE REVIEW

- B. B is a 44 year old Caucasian male from Dayton who moved to Springfield in early 2017. I saw him as a new patient in our clinic at the permanent supportive housing unit.
  - HPI: anxiety, depression and chronic pain
  - PMSH: PTSD, depression, anxiety, chronic pain from multiple gunshot and stab injuries, chronic back pain, polysubstance abuse in sobriety for 9 months (early remission)
  - Social: Mother had him at age 16, grandmother raised him, had a brother 10 years younger than him, dropped out of 7th grade, currently living in the permanent supportive housing, works in a auto garage. Multiple partners through the lifetime, total of 3 children from 2 partners. Very close to his mom.
  - Addiction history: TCH at age 11, crack cocaine, BZDs, opioids (pills). Multiple incidents with law enforcement, served 10 years for home invasion at age 18. Came out and became a dealer more than user, got raided and lost everything. Fell deep into addiction. Younger brother dies in a motorcycle crash, B. B is devastated; voluntarily joins a rehab program.

- We start treating him for his mental and physical health.
- EVERYTHING IS GOING GREAT….. Until……
May of 2017: Patient’s mother gives him 5K to take care of his long due debts. He is untraceable for 2 weeks, comes back active in addiction.

June 2017 - November 2017: constant struggle to stay drug-free

November 2017: Receives eviction notice from the management, hits rock bottom

Nov 2017- Dec 2017: RHCHC works with him to get him into AOD services, starts back in rehab, on suboxone, in groups, back working in the garage, able to keep his apartment, eventually gets employed by the housing unit as the custodian.

Spring 2018: Enrolls at Clark State Community College

March 2018: AOD services transferred from outside facility to RHCHC.

EVERYTHING IS GOING GREAT….. Until……
CASE REVIEW

- Late March, 2018: His daughter is in active addiction, patient goes to get her out of Dayton, brings her and his own addiction back.
- March – May 2018: Active addiction, constant struggle
- May 2018: Patient re-initiated into treatment program.
MORAL OF THE STORY

- Addiction is a complex disease.
- It is a commitment for life, and just like a normal life, it has successes and failures.
- Treatment needs to be comprehensive and integrated.
- As in most cases, this disease and its treatment also follows the 80:20 rule.
- Medication services only account for 20% of the treatment, in contrast to case management, peer support and mental health accounting for the 80%.

Bottom line my team did way more than me as the prescriber.
PREVENTION STRATEGIES

- Continuous review of prescribing practices.
- Expansion of alternate pain treatment services (Chiro, Medical massage...etc)
- Addition of addiction specialists to the team.
- Identification of at-risk children and adults with the intent to provide counseling.
- Supportive services for families and loved ones who have suffered a loss.
- Adolescent group sessions to focus on self-awareness, self-regulation and coping.
Primary care is the best place to screen for mental health and addiction disorders.

There is a huge overlap between mental health and substance abuse disorders.

Integrated care is THE model. Team based approach is ideal.

Recovery is different for each individual.

Structure and flexibility are equally important.

Boundaries are meant not to be punitive.

Addiction treatment is a philosophy and it truly takes a team to care for one.