

Getting Patients to Addiction Treatment: Perspectives of the Regional Opioid Epidemic

David W. Stroom, MD

Gregory Collins, MD Endowed Chair
in Alcohol and Drug Recovery

Advanced Management Issues in
HIV Care

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Objectives

- Discuss how Motivational Interviewing can encourage healthy behaviors better than more directing approaches.
- Discuss how different models of IDU treatment in the setting of OPAT can improve outcomes.

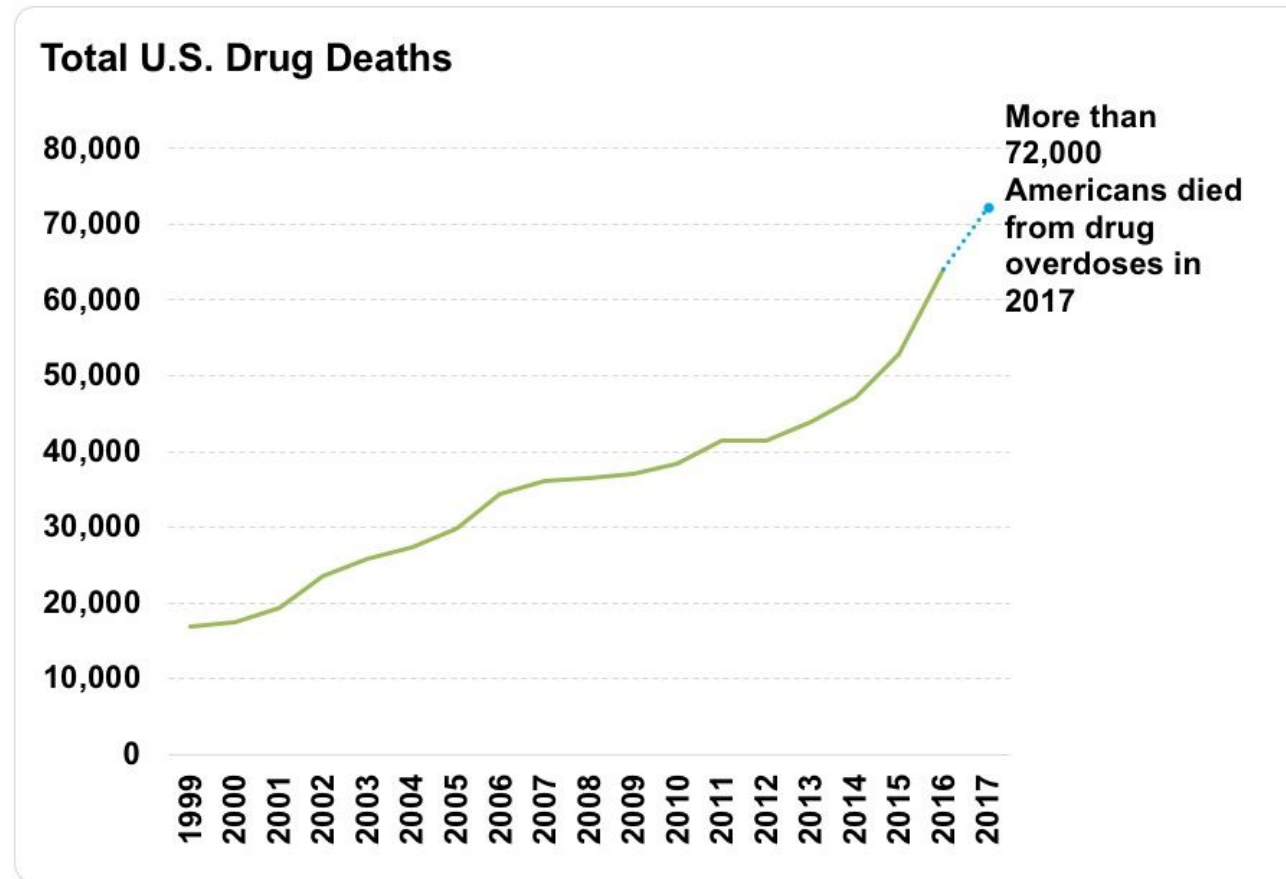


Disclosures

- None
- Neither I nor my spouse/partner have any financial relationships relevant to my role in this educational activity with any commercial interests



Drug Overdose Mortality



So

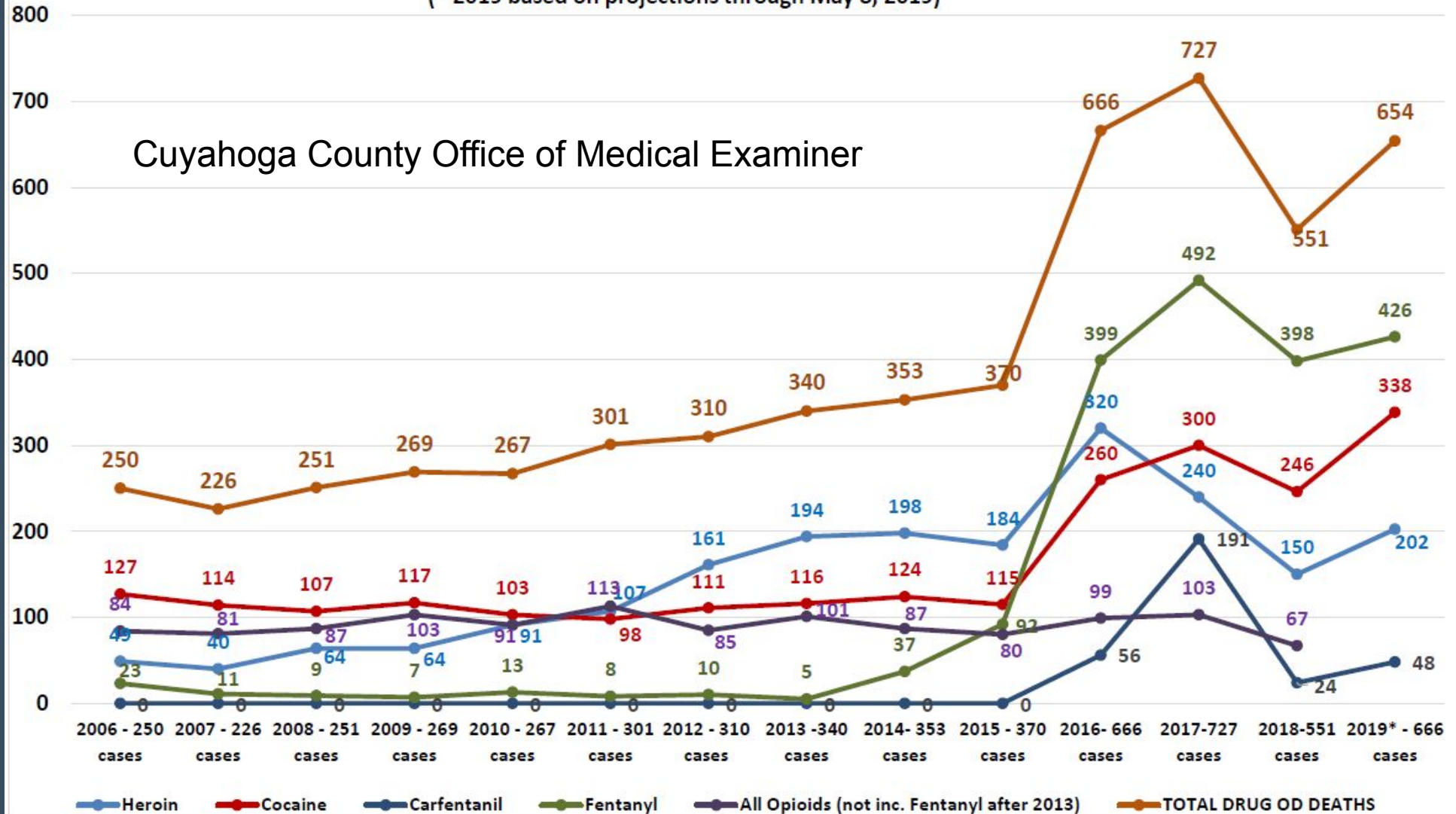


Cuyahoga County Overdose Deaths 2006-2019*

Most Common Drugs

(* 2019 based on projections through May 8, 2019)

Cuyahoga County Office of Medical Examiner



Increased Hospital Admissions related to Opioid Use Disorder

- Infective endocarditis
- Osteomyelitis
- Septic arthritis
- Epidural abscess

Ronan MV, Herzig SJ :Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002-12. Health Aff (Millwood) 2016; 35(5):832–837



Increased Hospital Admissions in Patients with IDU

- Skin and soft tissue infections
- Bones and joints infections
- Central nervous system infections
- Endovascular system infections (e.g. infective endocarditis, septic phlebitis)



Centers for Disease Control and Prevention (CDC). Soft tissue infections among injection drug users--San Francisco, California, 1996-2000. *MMWR Morb Mortal Wkly Rep.* 2001 May 18;50(19):381-4.

Irish C, Maxwell R, Dancox M, Brown P, Trotter C, Verne J, Shaw M. Skin and soft tissue infections and vascular disease among drug users, England. *Emerg Infect Dis.* 2007 Oct;13(10):1510-1. doi: 10.3201/eid1310.061196.

Collier MG, Doshani M, Asher A. Using Population Based Hospitalization Data to Monitor Increases in Conditions Causing Morbidity Among Persons Who Inject Drugs. *J Community Health.* 2018 Jan 5. doi: 10.1007/s10900-017-0458-9.

Wurcel AG, Anderson JE, Chui KK, Skinner S, Knox TA, Snyderman DR, Stopka TJ. Increasing infectious endocarditis admissions among young people who inject drugs. *Open Forum Infect Dis.* 2016 Jul 26;3(3):ofw157.

Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act*

Type of Exposure	Risk per 10,000 Exposures
Parenteral	
Blood Transfusion	9250
Needle-Sharing During Injection Drug Use	63
Percutaneous (Needle-Stick)	23
Sexual	
Receptive Anal Intercourse	138
Insertive Anal Intercourse	11
Receptive Penile-Vaginal Intercourse	8
Insertive Penile-Vaginal Intercourse	4
Receptive Oral Intercourse	Low
Insertive Oral Intercourse	Low

Patel P, Borkowf CB, Brooks JT. Et al. Estimating per-act HIV transmission risk: a systematic review. AIDS. 2014. doi: 10.1097/QAD.0000000000000298

Cost of Total Care

- Easily exceeds \$50k
- Total cost of hospitalizations for SUD/IVDA-related endocarditis increased 18x from 2000-2015

MMWR Weekly, June 9 2017, 66(22);569-573





Ulas Camsari, MD
Psychiatry Resident
Cleveland Clinic
2007-2011



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Contents lists available at [ScienceDirect](#)

IDCases

journal homepage: www.elsevier.com/locate/idcr



Case report

The cost of a recalcitrant intravenous drug user with serial cases of endocarditis: Need for guidelines to improve the continuum of care



Claudia R. Libertin^{a,d,*}, Ulas M. Camsari^{c,d}, Walter C. Hellinger^a, Terry D. Schneekloth^c,
Teresa A. Rummans^{b,c}

^a Division of Infectious Diseases, Mayo Clinic, Jacksonville, FL, United States

^b Department of Psychiatry & Psychology, Mayo Clinic, Jacksonville, FL, United States

^c Department of Psychiatry & Psychology, Mayo Clinic Rochester, MN, United States

^d Mayo Clinic Health System in Waycross, GA, United States

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ABSTRACT

We report a case of an intravenous drug user (IVDU) patient who had 4 episodes of endocarditis within a 2-year time period in rural Georgia. The institutional cost was approximately \$380,000. The lack of an established transitional care plan for IVDUs to outpatient care is a common phenomenon at institutions. Guidelines are essential to optimize the quality of care rendered to IVDUs with such infections, to assist providers in utilizing limited resources, and to limit the cost to the institutions.

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The cost of a recalcitrant intravenous drug user with serial cases of endocarditis: Need for guidelines to improve the continuum of care

- Case of a single 45y.o. woman with four episodes of endocarditis in two years
- Seven total related hospitalizations
 - One mitral valve replacement
- Pt declined addiction treatment programs, or was denied by the programs due to her medical conditions
 - Residential programs
 - Methadone Maintenance

The cost of a recalcitrant intravenous drug user with serial cases of endocarditis: Need for guidelines to improve the continuum of care

- Psychiatry recommended entire course of IV antibiotic therapy to occur in hospital
 - Psych involved in five out of seven hospitalizations
 - Authors judged no compliance with psych recommendations
 - Pt left AMA two out of the seven admissions

The cost of a recalcitrant intravenous drug user with serial cases of endocarditis: Need for guidelines to improve the continuum of care

- Institutional cost \$380,000
 - Patient was uninsured
 - Cost did not include provider fees and cardiothoracic surgery costs
 - Eventually lost to follow-up
- No availability of buprenorphine MAT
- Cited lack of established transitional care plan for SUD treatment to outpatient care

What is Motivational Interviewing?

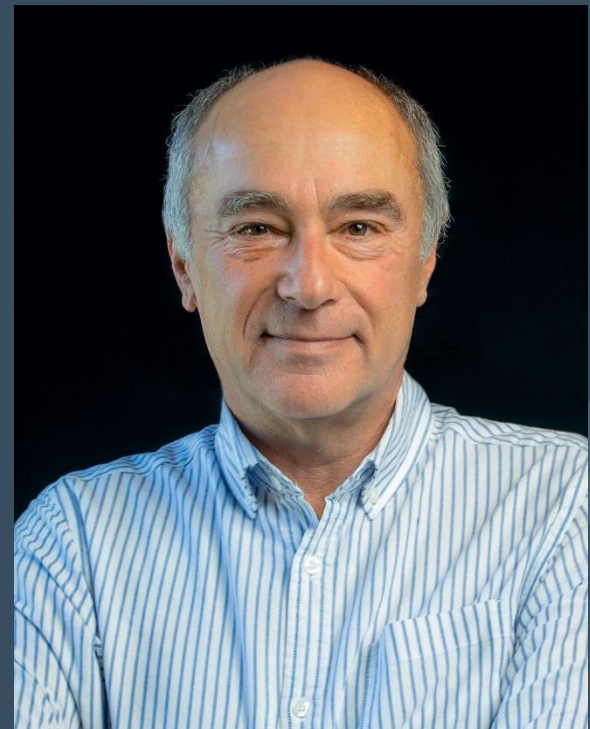
A collaborative, person-centered form of guiding to elicit and strengthen motivation for change



William R. Miller, PhD



Stephen Rollnick, PhD



What's it for?

- MI is a collaborative conversation to strengthen a person's motivation for and commitment to change.
- Begins with the understanding that all people contemplating any behavior change experience ambivalence to some degree

The “spirit” of MI

- Collaboration, not confrontation
 - Therapist focuses on mutual understanding, not the therapist being right.
- Evocation, not imposition
 - Lasting change is more likely to occur when the client discovers their own reasons and determination for change.
- Autonomy, not authority
 - True power for change rests within the client.
 - MI requires a detachment from outcomes.



The Righting Reflex

- The urge in a therapist/helper to correct another's course of action
- Often has a paradoxical effect
- People (especially today) have a tendency to resist persuasion, regardless of how well-meaning or expert the source. Why?
- ***It is the patient who should be voicing the arguments for change.***



Guiding Principles of MI--RULE

- Resist the Righting Reflex
- Understand Your Patient's Motivations
- Listen to Your Patient
- Empower Your Patient



Principles of MI

- Develop Discrepancy
- Express Empathy
- Support Self-efficacy
- Roll with Resistance
 - De-escalate and de-emphasize points in conflict between client and therapist



Communication Styles in MI

- Directing
- Following
- Guiding



Communication Styles

- Directing
 - The “director” does more speaking than listening.
 - Gives advice and makes decisions
- Following
 - The “follower” does more listening than speaking.
 - No agenda, advice, instruction, or analysis
- Guiding
 - Offers alternatives
 - “I can help you solve this for yourself.”



Core Communication Skills

- Asking
 - Eliciting information or the patient's opinion or perspective
- Listening
 - Demonstrating respect for the patient's position and reflecting that position back
- Informing
 - Providing options, information and encouragement

Communication Skills

- Asking
 - Closed vs. Open questions
 - Can overly control an interaction
 - Can convey concern
- Listening
 - Expresses empathy
 - Evocative
 - Active Reflection
- Informing
- How much time do you spend in each of these?

Skills

- Open-ended questions (Asking)
- Affirmations (Listening)
 - Statements that recognize client strengths, or can reframe resistant energy into self-efficacy
 - Assist in building rapport
 - “You’ve done tough things before.”
- Reflections (Listening)
 - Guides the client to resolving ambivalence
 - Expresses empathy
- Summaries (Listening)
 - Communicate interest and understanding
 - Can be used to shift attention and prepare the client to “move on.”

Strategies for Evoking Change Talk

DARN

- Desire
 - “What do you want?”
- Ability
 - “What is possible? What are you able to do?”
- Reasons
 - “Why would you make this change?”
- Need
 - “How important is this change?”



More Strategies for Evoking Change Talk

- Ask for elaboration/examples: When was the last time that happened?
- Look back: Ask about a time before the behavior emerged. Were things better?
- Look forward: What's likely to happen if things continued as they are? What would be different if you made the change you want?

More Strategies for Evoking Change Talk II

- Query Extremes: What's the worst thing that'd happen if you don't change? What's the best thing that'd happen if you do change?
- Use a Change Ruler: 1-10, how important is change to you? Why not a higher number? Why not a lower?
- Come Alongside: Explicitly side with the status quo side of ambivalence.



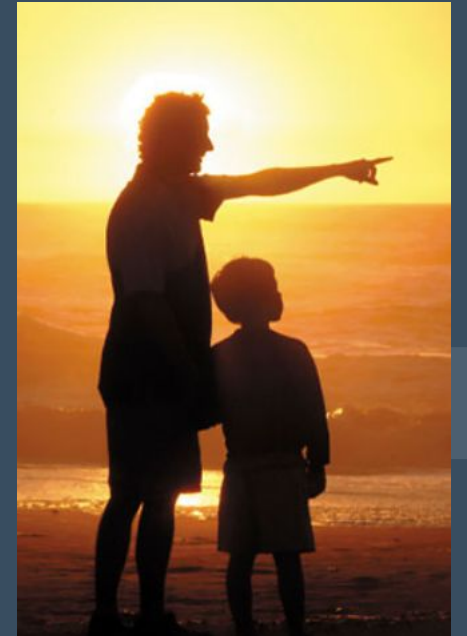
What is your goal?



The Sage on the Stage?

or

The Guide on the Side?



Asking

- What's worrying you most today?
- What concerns you most about this treatment?
- What exactly happens when you get that pain?
- What did you first notice about this problem?
- Tell me more about...



Listening

- Silence
- Facilitative Responses
 - “I see”
 - “Tell me more about that.”
- Reflection
- Problems with listening
 - Can go in circles, no direction
 - Getting the worms back in the can



Informing

- Informing can be a two-way street
- Positive messages matter
- Taking time to elicit reflection, questions and reaction from the patient can increase information retention.
 - Changes the interaction from a “brain dump” into a real relationship.
- Chunk—Check—Chunk

Common Traps

- Creep to directing
- “The hard sell”—Guiding too far in front leads to resistance
- Rescuing the patient—can reinforce the expectation for an imposed solution the patient can then resist.
- Just following the patient and getting lost
- Overinforming
- Focusing on problems/weaknesses instead of strengths/aspirations



Let it go...

- Feeling responsible for changing behavior in others is wearing, and ultimately encourages patient resistance.
- MI absolves the therapist of this responsibility.
- Focus is more on eliciting and understanding what the patient's goals are.
- Then the patient's successes (and failures) are theirs, not ours. We are only facilitators and guides.

A New Approach

Opportunities to improve model of care



How Can We Improve?

- Increase Buprenorphine MAT availability
 - Cost of this should be viewed in light of total cost per case of care.
- Ensure that case management occurs as patients transition through levels of care
 - Cost <<< OHS
- Use SUD counseling to encourage treatment retention
 - Cost<<<OHS

Treatment of Opioid Use D/O

“A Bundled Model of Care”

- “We treat both problems...or neither.”
 - Gosta Pettersson, MD
 - Steve Gordon, Chair ID
 - David Stroom, Medical Director ADRC
 - Alice Kim, ID physician and Select JV lead
 - Leo Pozuelo, Head C/L Psychiatry
 - Sue Rehm, Tom Fraser, Nabin Shrestha, ID
 - Raphael Silver, Center for Connected Care
 - Paul Ford, Bioethics



Treatment of Opioid Use D/O

“A Bundled Model of Care”

- Prerequisites:
 - A team capable of assessing for OUD and starting MAT treatment
 - Consultation Liaison Psychiatry with DATA Waiver
 - Relationship with LTACH for continued IV antibiotic Rx and physical rehabilitation
 - Select Medical

Joint Venture

CLEVELAND CLINIC AND SELECT MEDICAL FORM JOINT VENTURE TO EXPAND INPATIENT REHABILITATION IN NORTHEAST OHIO

Tuesday, June 10, 2014, Cleveland: Cleveland Clinic and Select Medical have finalized an agreement to form a joint venture to enhance inpatient rehabilitation services in Northeast Ohio and improve access for patients with complex rehab needs.



Treatment of Opioid Use D/O

“A Bundled Model of Care”

- Addiction Treatment Caregivers integrated with LTACH to provide necessary services
 - Urine toxicology Medical Review
 - Buprenorphine adjustment and Prior Auth for discharge Rx
 - 12-step education and facilitation counseling
 - Identification and treatment of co-occurring psychiatric disorders
 - LTACH discharge planning



Treatment of Opioid Use D/O

“A Bundled Model of Care”

- Regular interaction between ID, Care Management, LTACH team, C/L Psychiatry and Addiction Treatment Caregiver makes successful treatment of both conditions possible



Results (so far)

- 15 patients admitted and discharged from Select LTACH from 7/2017 through 9/2018
- One patient with septic arthritis
- One patient with septic arthritis and endocarditis
- One patient with epidural abscess
- Remaining group all with endocarditis

Results (so far)

- 12/15 had valve surgery
- All but one was transferred already transitioned to buprenorphine MAT
 - Signed treatment agreement/Informed Consent
 - Required labwork (hepatitis B and C, plus HCG if appropriate)

Results (so far)

- Four were transferred to SNF
 - usually due to insurance demands, although increasingly with SUD treatment available
- Two expired at LTACH—one likely OD, the other more likely arrhythmia
 - Former case was only one of the group not on buprenorphine MAT prior to transfer

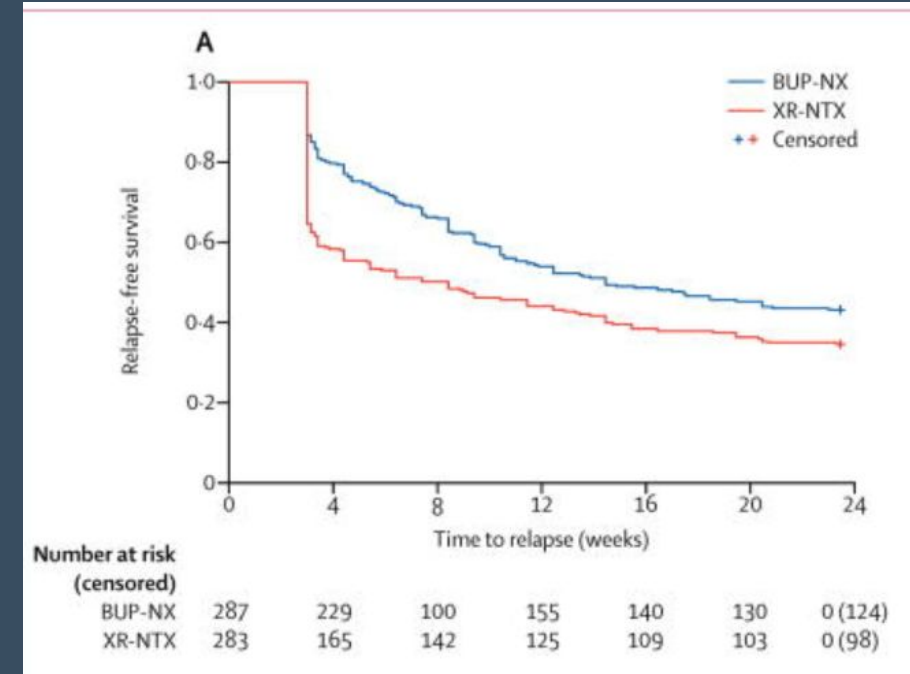
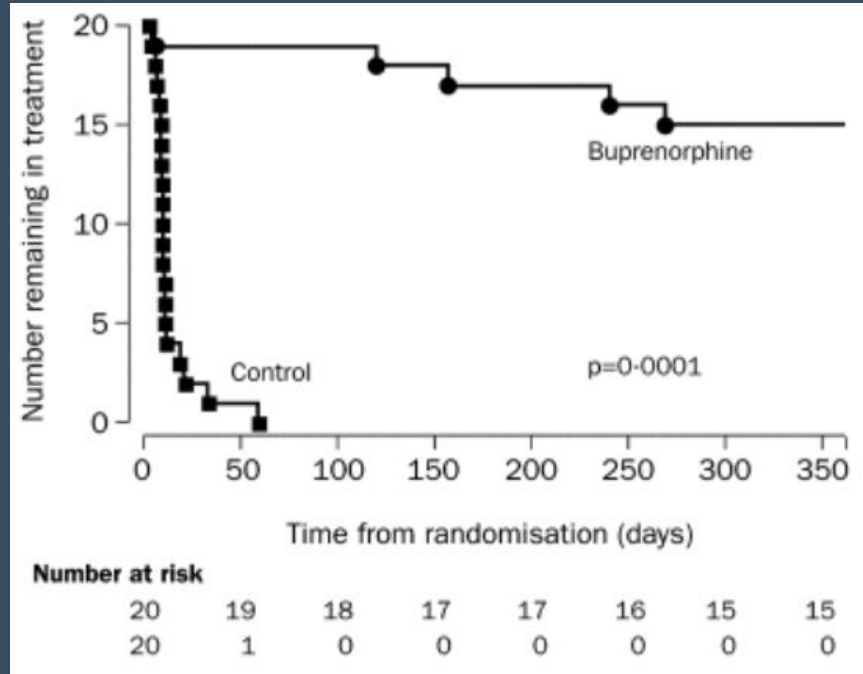
Results (so far)

- Three were lost to follow-up, didn't fill any buprenorphine Rx post-discharge
 - Includes the only redo surgery case of the group
- Not including SNF-transferred group (4) and the fatalities (2), six out of nine had good outcomes

SNF Transfers

- One SNF transfer was spinal abscess case
 - Transferred to SNF out of state and lost to follow-up
 - Likely needed additional surgery re: hardware infection
- Of the remaining three SNF transfers, two filled buprenorphine Rxs after discharge and seemed to be good outcomes


Lessons Learned So Far



**Kakko. *The Lancet* 361 Issue 9358 (2003)
ISSN: 0140-6736**

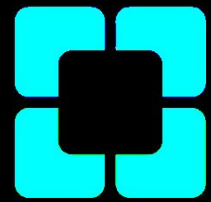
- *Lancet* 2018 Jan 27;391(10118):309-318.

Lessons Learned So Far

- “Treat both conditions or neither” means MAT OUD treatment
 - Starting MAT prior to LTACH transition is key
 - “Starting MAT” means treatment agreement signed with communication among team
- 

Lessons Learned So Far

- More recovery-related activities in LTACH the better
- Educating LTACH staff, esp nurses and aides, will reduce stigmatization and improve treatment acceptance/retention
- Communication within the team is essential
- Discharge planning from LTACH critical



Cleveland Clinic

Every life deserves world class care.