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Recovery-focused Addiction Medicine: An Interview with Dr. Corey Waller

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Introduction

Recovery-focused behavioral health system transformation efforts are emerging as the future of addiction treatment and mental health service delivery, but very little has been written about the role of addiction medicine specialists within such transformation processes. I recently conducted a series of interviews on the development of recovery-oriented systems of care (ROSC) in Western Michigan and had the opportunity to discuss with Dr. Corey Waller what these transformation efforts indicated for the future of addiction medicine. I hope you find the interview as informative and engaging as I did.

Background

Bill White: Dr. Waller, could you describe your current position?

Dr. Corey Waller: I am the Medical Director of an integrated clinic operated by Spectrum

Health that sees patients who are in the emergency department ten or more times per year, admitted two or more times per year for inpatient care or who are pregnant and on a controlled substance. I direct the clinical care of those patients. Spectrum Health is an integrated healthcare system that operates eleven hospitals. It has a payor as well as a medical group, and I work for the medical group.

Bill White: How did you come to be involved in the ROSC efforts in Western Michigan?

Dr. Corey Waller: Well, I started to get involved as our state system began the development of recovery-oriented systems as an alternative to the old standardized silos of care. I also just finished writing the medication-assisted treatment guidelines for opioid use disorder for the state of Michigan and wanted to make sure that what I wrote was not only evidence-based, but also aligned with what the recovery-oriented systems of care vision that we were moving towards.

ROSC and Primary Care

Bill White: What do you see as the role of the primary medicine specialist in these ROSC efforts?

Dr. Corey Waller: The primary physicians, P.A.s, and nurse practitioners that I've worked with all come to me very frustrated with the disease of addiction. They have not had appropriate addiction-related education in their training to help them deal with patients whose medical systems are complicated by addiction. They also were not trained to understand the significant social implications of the disease—its effects on family, housing, transportation, and even one's ability to communicate by telephone or face-to-face with a caregiver. These can be the major reason that a patient doesn't get well. The best thing primary caregivers can do is understand that addiction is a chronic neurobiological disease that is not based on a bad decision, but in a malfunction of the reward system in the brain. Their challenge is to stop bullying patients with this disease and begin caring for them within a chronic care framework. I think that's the biggest role that they can play at this time.

And, as we move forward, the utilization of office-based medication assisted treatment in conjunction with appropriate behavioral health supports will become a mainstay for the treatment of addiction. Right now, the biggest problem I find is that many physicians who've done the eight-hour training and obtained the waiver to provide buprenorphine still resist prescribing buprenorphine for patients because they don't feel comfortable seeing these patients. They are asking for a lot more education for themselves and their staff about the disease and the behavioral management of these patients. These issues are critical to getting a primary care office ready to deal with addiction as a disease as well as the more persistent and pervasive mental health disorders.

Bill White: Are there sources of resistance beyond the lack of education of primary caregivers?

Dr. Corey Waller: One is reimbursement, because you have to find ways to get reimbursed for the behavioral care that needs to happen in conjunction with the medication. The other one is figuring out how to not have these patients disrupt an otherwise calm office. Then there are the more detailed clinical issues, like using toxicology results and addressing concomitant drug use (e.g. continued cocaine or marijuana) when you're treating an opioid use disorder. In general, primary care providers feel it is very high-risk for them to take on this population without extra education and systems support for the collateral services that are needed by this population.

Bill White: You've referenced combining medication with other psychosocial or behavioral supports. Do you see that integration of pharmacotherapy and recovery supports as the future of medication-assisted treatment?

Dr. Corey Waller: I see it as the future of all medicine. Such broad spectrum supports should not be confined to a specific disease entity. I think that if you have a poorly-controlled diabetic, that person would significantly improve with the integration of the kinds of supports we are advocating for patients with substance use disorders. We should be striving for such integration in all of medicine.

Progress and Future of ROSC in Michigan

Bill White: What has been the progress to date in Michigan in bridging ROSC and medication-assisted treatment?

Dr. Corey Waller: Well, it's been slow going mainly because we still have a lot of people making clinical decisions based on an emotion and a perception of a disease, rather than the evidence behind the treatment of the disease and some are people who have been in the bureaucracy

for many, many years. There are still people who write policy and who are responsible for developing benefit packages who still see addiction as a choice and who see recovery as only in a person who's not on any medication. These are significant barriers that are not overwhelming, unless you have someone who is completely against being educated into the new science of addiction, but providing such education does require a substantial effort. There are a lot of people very motivated to change the system, but they're hampered by not wanting to be the person who makes a decision that leads to runaway expenses for a treatment of a disease that, at present, has the cheapest per patient cost for care delivery.

Part of the problem is that the delivery of treatment for addiction has been based in group therapies and self-help interventions that generate little if any costs to the system. But as we've medicalized the treatment of addiction through things like evidence-based practice and best practice guidelines and the use of toxicology, treatments become more expensive--appropriately expensive. Our medications are still very cheap compared to many blood pressure meds, cholesterol meds, and psychiatric meds, but we get significant pushback in utilizing these medications. People have to realize that a chronic disease requires chronic treatment. If Suboxone has been successful in the treatment of a patient with the disease of addiction, you don't just stop it at one year or two years without evidence that recovery can be sustained without such medication. To force somebody off of a medication that is stabilizing their disorder is really not ethical, but that's the position that Michigan has taken: you get one year of benefit from buprenorphine, required prior authorization to continue to eighteen months, and no approval after that. I've had patients relapse and I've had one opioid overdose during these forced transitions.

The biggest, behind closed door fear, is the worry that addiction treatment may get too expensive and then it will bust the budget, which I don't think it will. We only have like five medications we can use for all

of addiction, so it's not like we have three hundred thousand medications sitting out there. It's tough because I have naloxone, buprenorphine, and methadone for opioids. And I have Topamax, Acamprosate, and Vivitrol for alcohol and I kind of have Citalopram and maybe Provigil for stimulants and Acetylcysteine for marijuana. But few of those I just mentioned are really consistently paid for to treat addiction and the only ones that are FDA-approved are methadone, buprenorphine, Vivitrol, and Camperal. The rest of them are all off-label. These are policy constraints that any state is going to have to really work through and I feel that it's the responsibility of the ATTCs, SAMHSA, CSAT, and ASAM, all of us, to build a tool kit for the states to help develop standards of addiction care.

Bill White: From your perspective, what are some of the most important achievements that have been made in the ROSC efforts in Western Michigan?

Dr. Corey Waller: I think one of the biggest achievements has been the cohesive interaction between the methadone clinics, the outpatient treatment providers, and everyone's willingness to adopt the ASAM Standards of Care that just came out. Also important has been finally coming together at the same table to develop our local continuum of care with an understanding that we don't need to pay for treatments lacking evidence when there are treatments that have good evidence of their effectiveness. The ROSC effort has been helpful in helping coalesce conversations around recovery and how we can move support of the patient to the larger arenas of family, neighborhoods, and community.

Bill White: I've been very impressed with the people I've talked to so far about the level of community mobilization involved in the ROSC initiative.

Dr. Corey Waller: Yes, we have great recovery resources, we have a good approach to overdose prevention, and we

have a good coalition to expand recovery supports in the future. We still have some heavy lifting to do, but I feel like we're starting to pull ahead of the vast majority of places as far as our service delivery model and long-term recovery supports.

Bill White: What do you see as the important next steps for the ROSC initiative?

Dr. Corey Waller: The biggest thing is in October when our state is regionalizing the coordinating agencies. The ROSC effort will need to take on a more regional focus as we proceed, which will present challenges but will also be a real opportunity.

I think the next step for the ATTCs and the ROSC movement would be to make sure that we coalesce with the national level agencies, like the American Society of Addiction Medicine and work more closely together so that we can develop and collaborate on implementation strategies at national and local levels.

Bill White: There is a lot of discussion about the integration of primary medicine with addiction treatment and mental health services as part of the Affordable Health Care Act. Do you think healthcare reform elevates the importance of ROSC?

Dr. Corey Waller: I think ROSC has been a very big step in understanding the value of integrated care, and when I say integrated, I don't mean that you have a bunch of clinical medical specialties. I mean integrated in the sense that you have clinical and behavioral and social specialties all located in one place. And that they actually coordinate care. I think that as we move toward the ACA model of care we are going to see many problems addressed through the doctors' office, including social and behavioral aspects of these problems.

Bill White: Do you think there's a point we'll reach where we'll have a broad range of psychosocial services delivered through primary care physician offices?

Dr. Corey Waller: I don't think we can add one more thing to the very large and complicated plate of a primary care doctor and I think the one thing that we can add to the office is someone who can help deliver those services for the physician rather than trying to expect that in another fifteen or twenty minute visit that they're going to be able to do all of these things. I think one of the bigger focuses for integrated systems and even private physicians will be to have the capacity to provide case management and counseling services. And I think if we do that, you're going to be able to take patients who have been labeled as "difficult" and turn them into patients who are very successful and who can get the most out of what we can offer.

Lessons Learned

Bill White: Are there any lessons learned to date for other physicians or for communities that you could share?

Dr. Corey Waller: Don't burn any bridges. Those are really hard to repair even if you don't agree with the way in which they're approaching care. Bring everyone to the table and allow everybody to sit around and have a conversation about evidence and outcomes and performance rather than hope or desires or emotions or feelings or beliefs. I think that is the biggest piece of advice I can give. If you coalesce around evidence, then you can transcend issues of emotion or financial self-interest that have often driven decision-making. We need coalitions focusing on helping people get better so that their communities are safer and more productive and kinder to people who have this disease.

Bill White: Let me ask a final question and that's just really what your involvement in this has meant to you personally or professionally.

Dr. Corey Waller: I'm one of the luckiest people ever. I started my career in medicine really disliking my job as an Emergency

Medicine Physician, but finding this population and the treatment pathways and the science behind addiction disease, I wake up every day exceptionally happy and motivated to go to work. The people who do this for a living do it because they love it, not because they get paid a lot for it or because they get a lot of praise due to the difficulty of the job. Providing this care makes every day pretty cool.

Bill White: Dr. Waller, I appreciate you taking the time to share your experience with the ROSC initiative in Michigan.

Dr. Corey Waller: Thanks Bill, it's been a pleasure.

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