Changing Addiction Treatment

Moving From

Placement to Management

Thinking

The Acute Care Model

- The Concept of “Cure”

A Nice Simple Rehab Model

Substance Abusing Patient

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Treatment

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Non- Substance Abusing Patient

The way it Will be…

A Continuing Care Model

- Like Treatments for Other Illnesses

Continuum of Care – Circa 1980

Screening/Brief Interventions
(10-30 min. in Med settings, Schools, etc.)

Detoxification
(3-5 Days in Hosp, Res or MH Centers)

Residential Recovery-Oriented Treatment
(28-180 Days, Hosp, Res or MH Center)

IOP/ Outpatient Continuing Care (30-180 Days, Outpatient program of declining intensity, 3-5 sessions/week to 1-2 sessions/month)

AA/Mutual Help

Tele/Internet Continuing Care
(1-2 contacts/mo.)

Medications:
- Alcohol – 2 or 3 Medica
- Opiates – 2 or 3 Medic
- Barbit/Benz – 1 or 2 Me

Medications:
- Essentially None

Continuing Care Practices

Medications – Several Addiction and Psychiatric Meds (See Chapter X for Review)

Interventions– Tel/Web Monitoring & Support, Recovery Check-Ups, Recovery Homes

Family Involvement – BCT

Therapeutic Goals – Sustain Abstinence, Monitor & Support Signs of Relapse, Support Improved Health & Social Function

A Nice Simple Rehab Model

Substance Abusing Patient

Treatment

Medications,
Therapies,
JCAHO, CARF, WC
Ev. Based Prac.

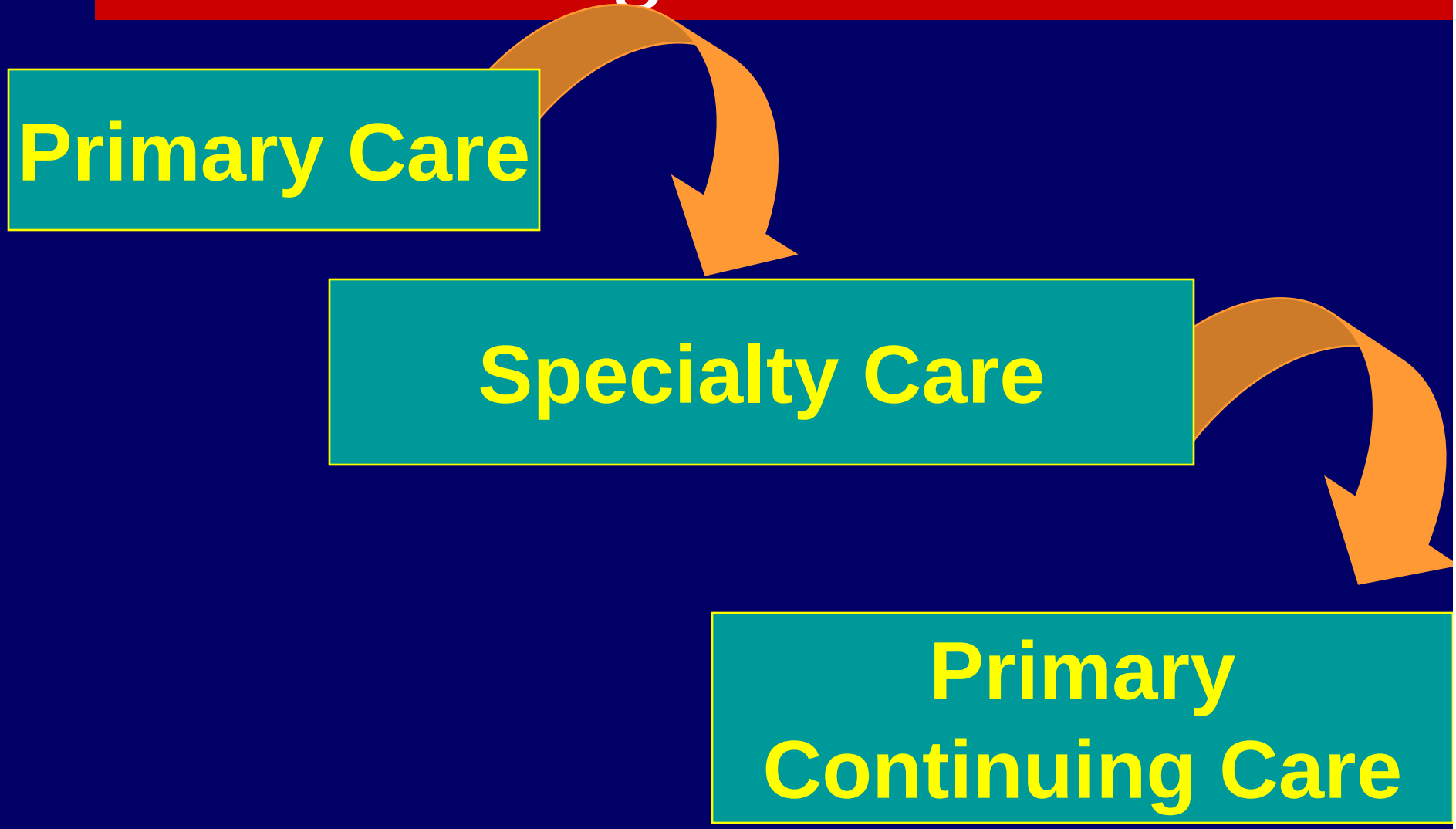
Non- Substance Abusing Patient

ASSUMPTIONS

- Some fixed amount or duration of treatment will resolve the problem
- Clinical efforts put toward correctly placing patients and getting them to complete treatment
- Evaluation of effectiveness should occur following completion
  - Poor outcome means failure

The Continuing Care Model

A Continuing Care Model



In Chronic Illnesses….

1 – The effects of treatment do not last very long after care stops

2 – Patients who are out of treatment/contact are at elevated risk for relapse

So, For Treatment….

1 – One goal is to retain patients at an appropriate level of care and monitoring

2 – Another goal is to prepare patients to do well in the next level of care

3 - The effects of treatment are evaluated during treatment – not post-discharge

But Addiction Isn't Like Other Diseases

....Is it?

A Comparison With Three Chronic Medical Illnesses

Hypertension

Diabetes

Asthma

Why These?

- No Doubt They Are Illnesses
- All **Chronic** Conditions
- Influenced by Genetic, Metabolic and Behavioral Factors
- **No Cures -** But Effective Treatments Are Available

HYPERTENSION

Adherence to **medication** regime: **< 60%**

Adherence to **diet and exercise**: **< 30%**

Retreated in 12 months: **50 - 60%**

(by Physician, ER, or Hospital)

DIABETES (Adult Onset)

Adherence to **medication** regime: **< 50%**

Adherence to **diet and exercise**: **< 30%**

Retreated in 12 months: **30 - 50%**

(by Physician, ER, or Hospital)

ASTHMA

Adherence to **medication**: **< 30%**

Retreated in 12 months: **60 - 80%**

(by Physician, ER, or Hospital)

RELAPSE

Predictive Factors - All 3 Illnesses

#1 - Lack of Adherence to diet, medications, or behavior change
#2 - Low Socioeconomic status
#3 - Low Family Supports
#4 - Psychiatric Co-Morbidity

Sources: Natl Ctr Health Stats; Harrison, 13th Ed.; 30+ studies

Implications

The Way it is Evaluated

- Implications of How I Evaluate
- Differences in Outcome Expectations

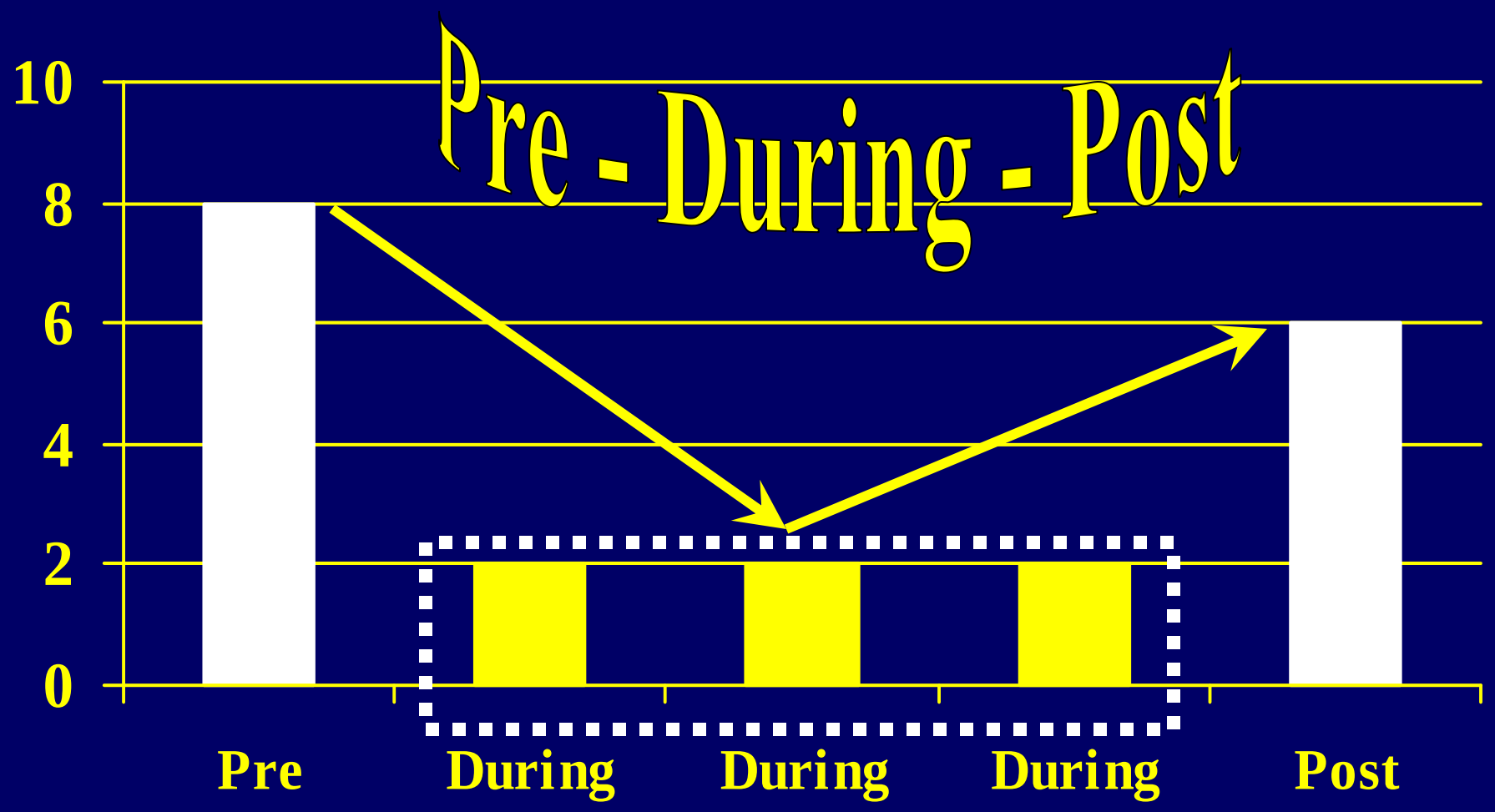
If many or most cases of addiction are really chronic then:

1) We may be evaluating the effectiveness of addiction treatments <u>in the wrong way</u>.

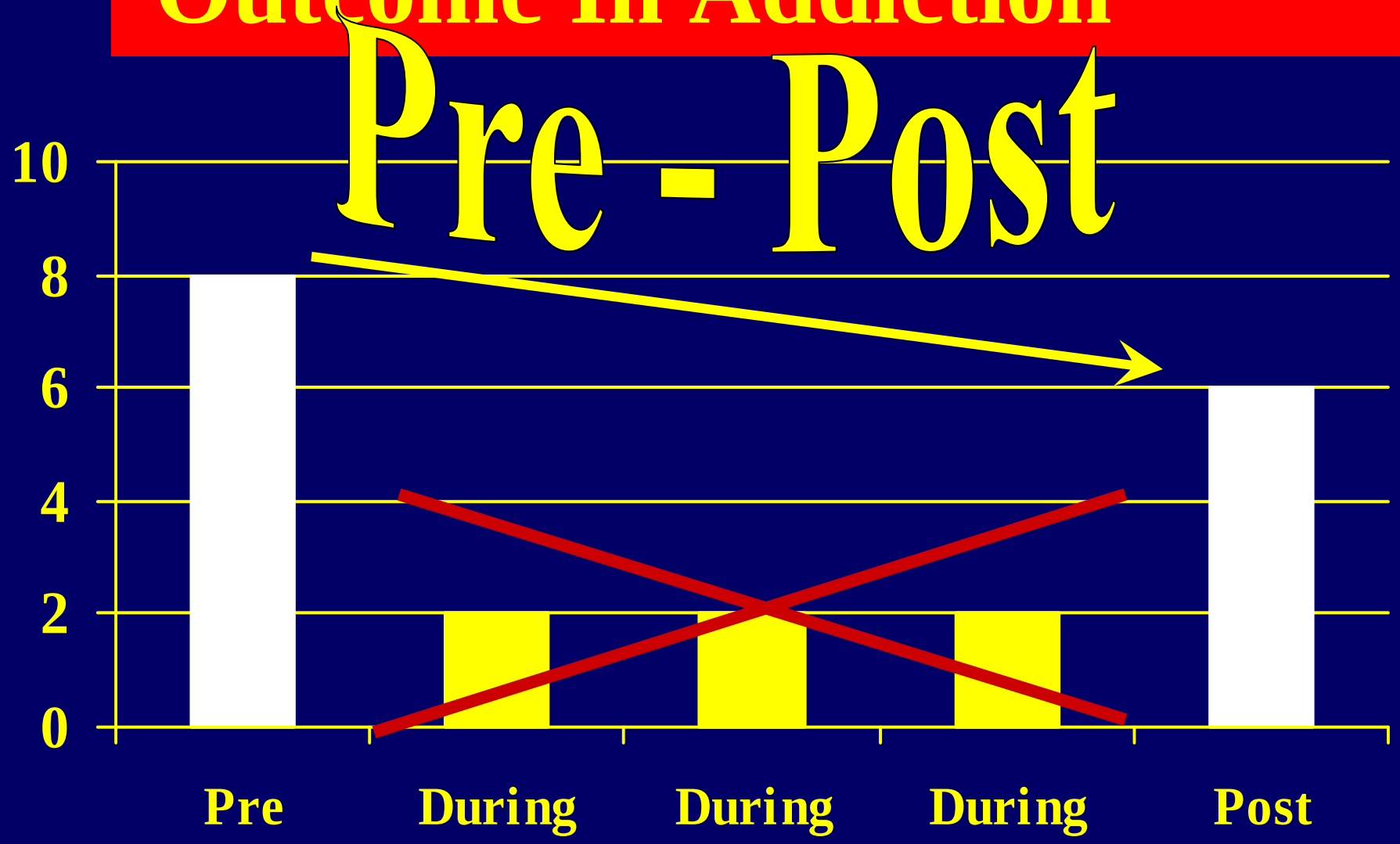
Studies show few differences between…

- Brief and Intensive Treatments
- Inpatient and Outpatient Treatments
- Conceptually Different Treatments
- “Matched” and “Mismatched” Trt.
- Gender or Culturally Oriented Trt.

Outcome In Hypertension



Outcome In Addiction



Treatment Research Institute

Maybe this is why…

Studies show few differences between…

- Brief and Intensive Treatments
- Inpatient and Outpatient Treatments
- Conceptually Different Treatments
- “Matched” and “Mismatched” Trt.
- Gender or Culturally Oriented Trt.

What is needed for effective continuing care in addiction?

Things you'll need….

1 – Attractive Treatment Choices – in levels, components and services of care.

2 – Patient/Family participation – in treatment planning and treatment changes

3 – Regular Clinical Information – to track progress and to guide care changes

Part I

Do We Have Effective Components of Care?

- FDA standards of effectiveness
- Do substance abuse treatments meet those standards?

An FDA Perspective

A Drug is Approved for "An Indication"

2 -Randomized Clinical Trials:

Often ask for separate investigators

Placebo Control:

Movement to test vs approved medication

FDA-Level Evidence

- **Therapies**
  - Cognitive Behavioral Therapy
  - Motivational Enhancement Therapy
  - Community Reinforcement and Family Training
  - Behavioral Couples Therapy
  - Multi Systemic Family Therapy
  - 12-Step Facilitation
  - Individual Drug Counseling

FDA-Level Evidence

- **Substance Use Medications**
  - Alcohol (Disulfiram, Naltrexone, Accamprosate)
  - Opiates (Naltrexone, Methadone, Buprenorphine)
  - **Cocaine (Disulfiram, Topiramate, Vaccine?)**
  - **Marijuana (Rimanoban)**
  - **Methamphetamine – Nothing Yet**
- **Psychiatric Medications**

FDA-Level Evidence

- **Other Interventions**
  - Comprehensive Assessment
  - Negotiated, Individualized Treatment Plans
  - Family Involvement and Training
  - Case Management
    - Service – to – Problem Matching

Can We Provide Services?

- Serving the Customer
- Helping the Counselor

Demands on Counselor

- Do Comprehensive Assessement
- Develop Individual Treatment Plan
- Provide Services to Meet Needs of Patient
- Be Culturally and Gender Sensitive

Computer Assisted System for Patient Assessment and Referral

CASPAR

- Start with Computer Assisted ASI
  - **Reduced training & administration time**
  - **Generates, state forms, JCAHO narrative and treatment plan**
- Add Free or Low Cost Service Referral
  - **From United Way's First Call for Help**
  - **Easy match of services to problems**

Problem-Services Linkage

- Alcohol
- Drugs
- Medical
- **Employment**
- Family
- Psychiatric
- Legal

From United Way

- GED training
- Resume Development
- Job Finding
- Mentoring Sessions
- Training Loans

Problem-Services Linkage

- Alcohol
- Drugs
- Medical
- Employment
- **Family**
- Psychiatric
- Legal

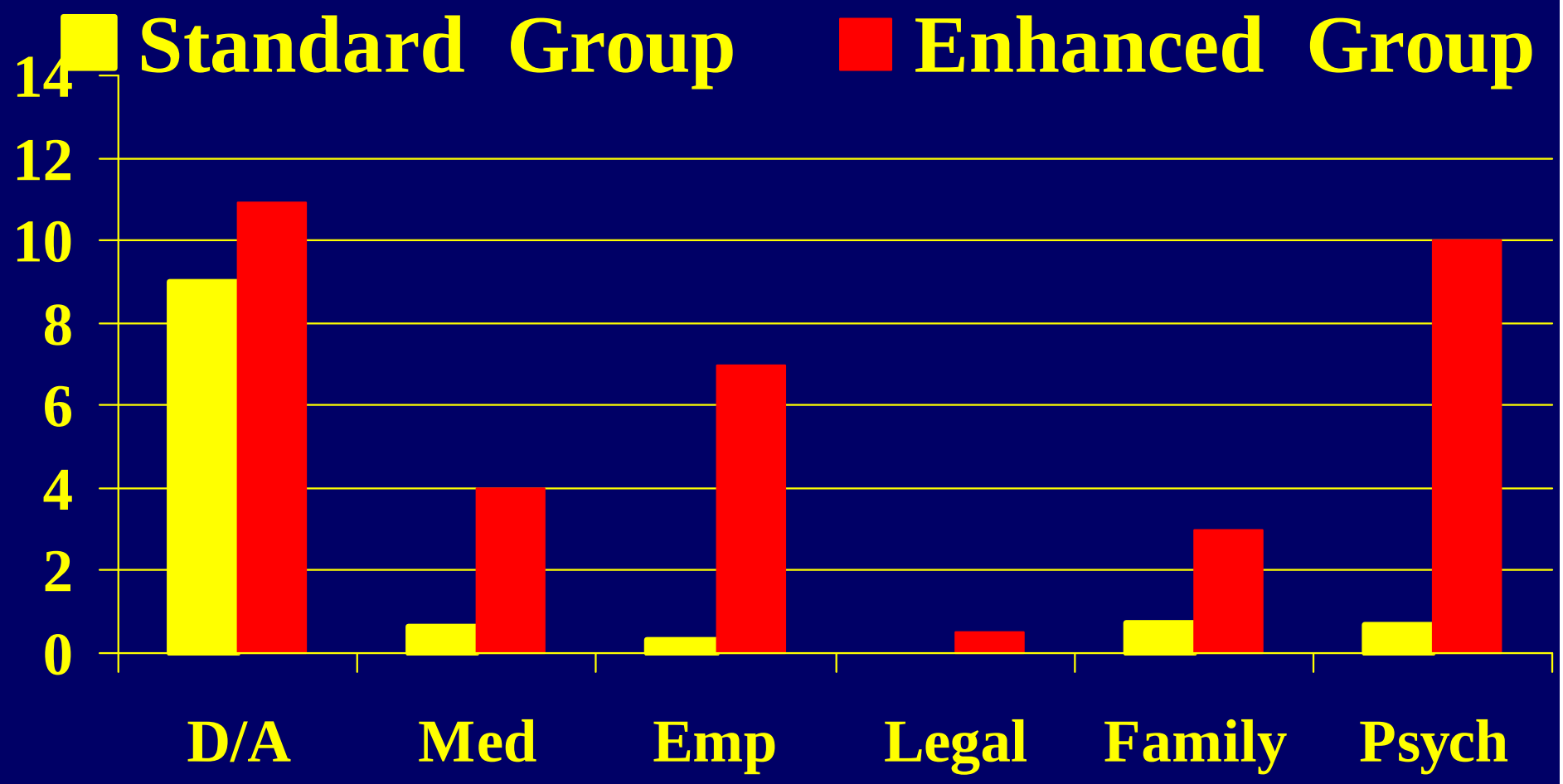
From United Way

- Domestic Violence
- Parenting Skills
- Specialized Babysitting
- Safe Housing
- Legal Aid

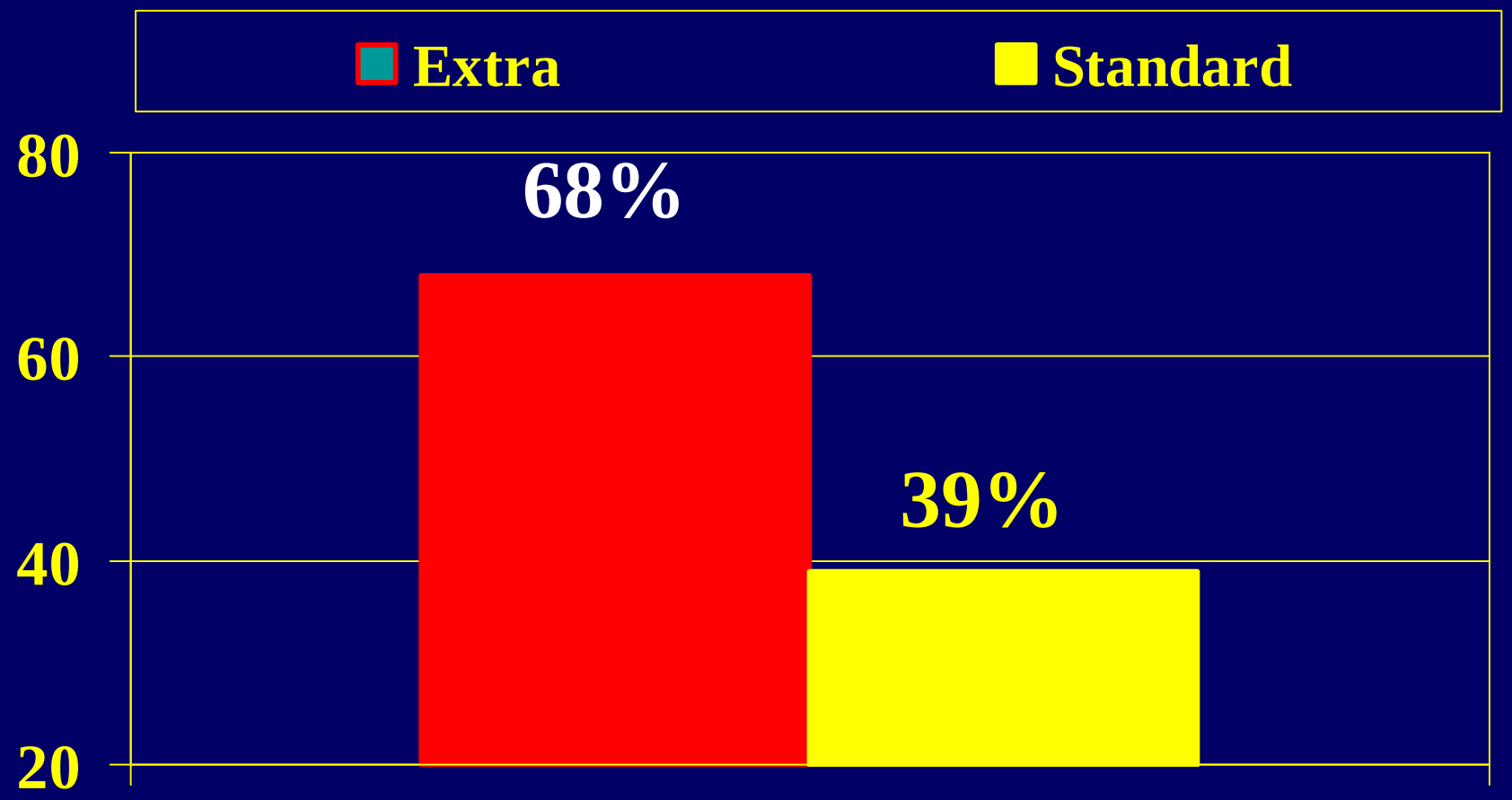
Results of CASPAR Training

- Counselors now “get” ASI
  - Now seen as part of engagement
- They love United Way services
  - Most counselors use it for most patients
  - Many counselors use it themselves
  - Patients who get more services stay longer

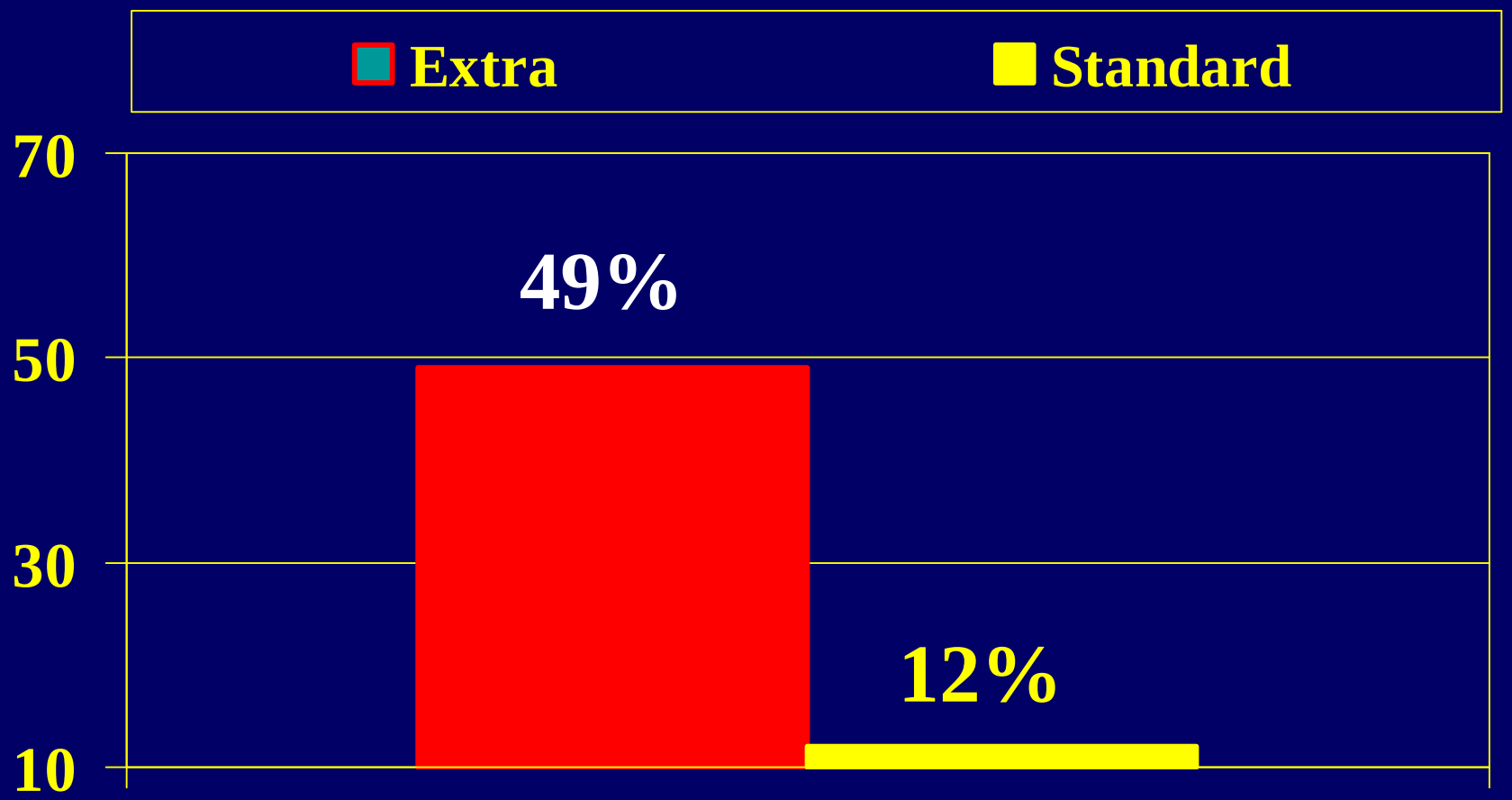
Mean Number of Services Received



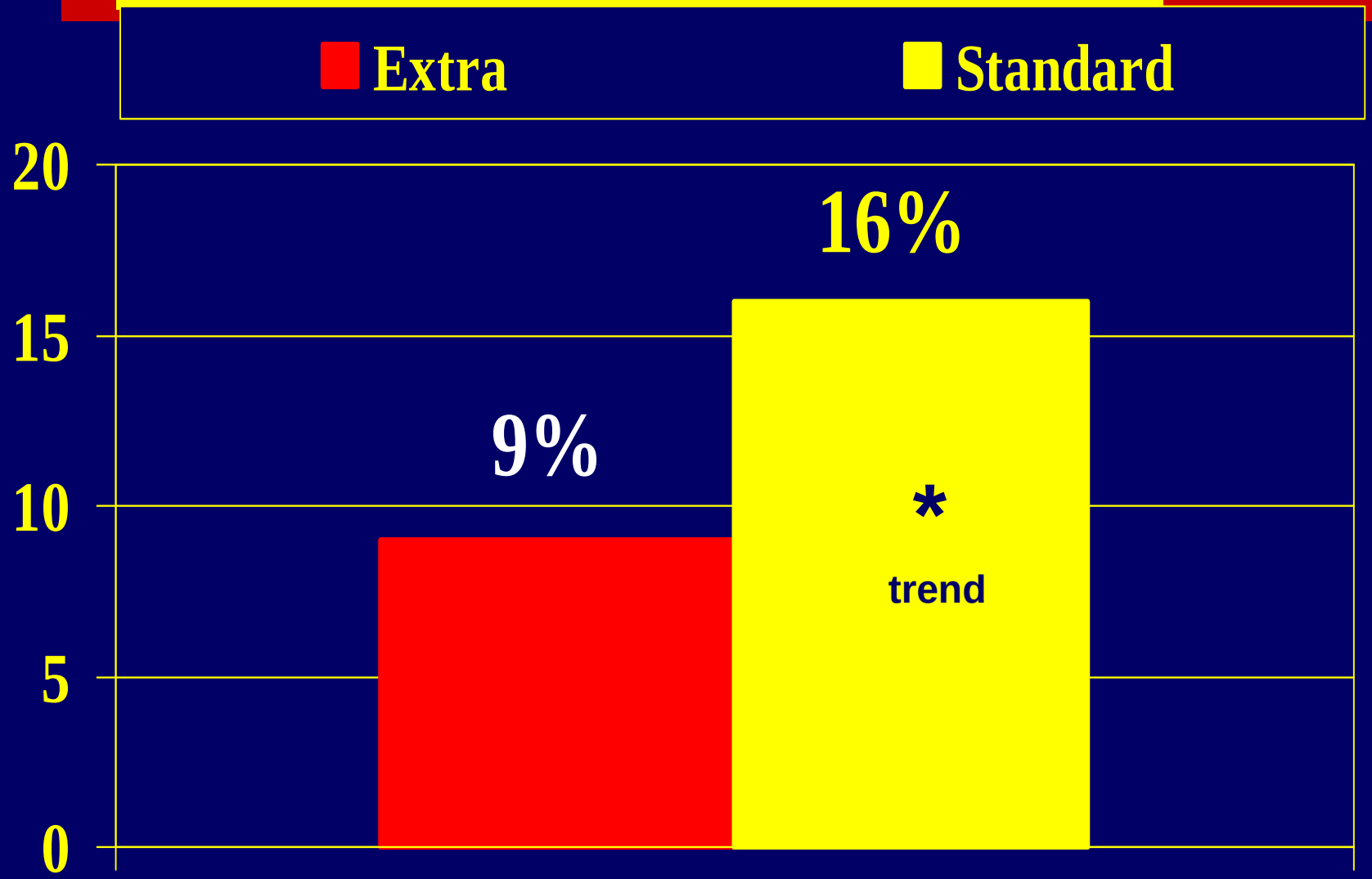
Percent Retained at 30 Days



Percent Retained at 60 Days



Average Percent Positive



Can We Manage and Monitor Care?

- Serving the Customer
- Concurrent Recovery Monitoring

A Nice Simple Rehab Model

Substance Abusing Patient

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Treatment

↓

Non- Substance Abusing Patient

NEW Assumptions

- Program is Responsible for Outcomes DURING Treatment
- Patient Agrees on Treatment Goals
- Treatment Offers Choices!
- Evaluation is a Clinical Activity Designed to Guide Care
  - Every Patient is Evaluated

The Blood Pressure Model

Using CRM and EBP to Adapt and Improve Treatment

Concurrent Recovery Monitoring

- From the Start of Outpatient Care
  - @ Weeks 2, 4 – Monthly thereafter
- Clinician as Evaluator
  - Brief "Check Up" Starts Sessions
- Patient works on a Few Goals

The Measures

- Very Few, Clinically Relevant
- Patient Status 9 items
  - Substance use (urine/breath testing)
  - Health status (ASI/NOMS items)
  - Social Function (ASI/NOMS items)
- Service Utilization – 6 items
  - Risk and Protective Factors

The Clinical Process

- Clinical status "Check-Up"
- If <u>Some</u> Progress:
  - Communicate encouragement
  - Ask how they achieved it
- If <u>No</u> Progress:
  - Check for effort/activities – explore
  - Check for goal importance
  - Suggest alternative goals/treatments

An Example

- Concurrent Recovery Monitoring

A Continuum of Care – The Tools

Levels of Care

Start →

Cont Care
2x per mo.

Outpt
1x per wk.

IOP
3x per wk.

Resid Care
7 – 30 days

EBPs in Each

6 - Case Mgmt
5 - MH Meds
4 - SA Meds
3 - Fam Involve
2 - Ind Therapy
1 - Group Couns

A Continuum of Care – The Tools

Levels of Care

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A Continuum of Care – The Rules

Progress Depends on Behavior

Sustained Improvement (2 mos):

Move Up Level

Problem: Stay in Level but…

Add/Change EBPs

Significant Setback:

Move Down One Level

Care Continuum– The Measures

Keep it Simple – Only a Few

Consider:

Attendance, Urine Screen

Why?

Clinically Important
Objective
Easily, Rapidly Measured

CRM – An Example

Court Referred, Cocaine/Alcohol Patient – Resistant

Clinical Goals

- Abstinence (Court Requirement)
- Employment
- Family Reunion

Starts IOP, Grp Couns – 3X weekly

A Continuum of Care – The Tools

Month 1

Start →

Cont Care
2x per mo.

Outpt
1x per wk.

IOP
3x per wk.

Resid Care
7 – 30 days

EBPs in Each

6 - Case Mgmt

5 - MH Meds

4 - SA Meds

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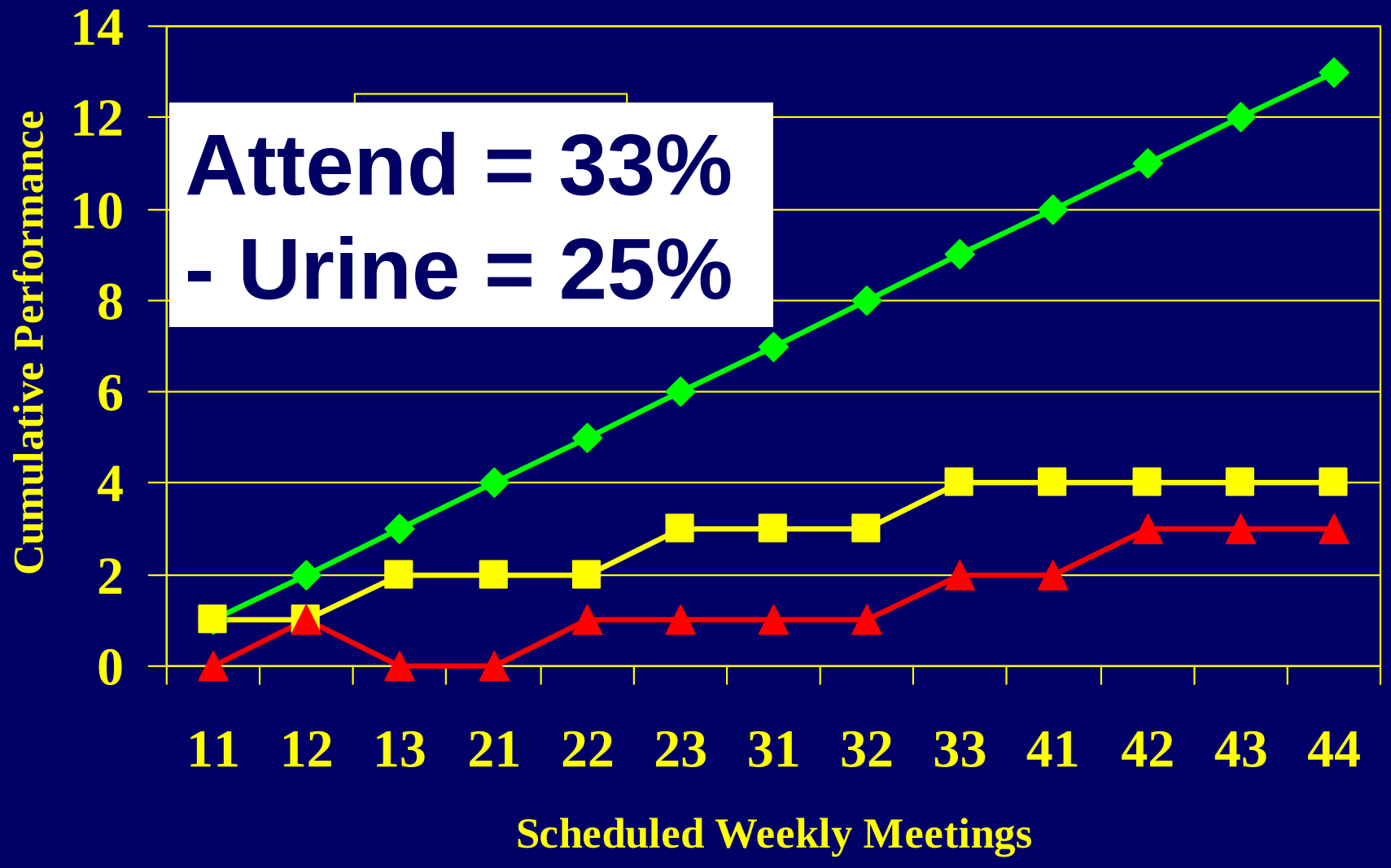
2 - Ind Therapy

1 - Group Couns

CRM – First Month



A Continuum of Care – The Rules

Progress Depends on Behavior

Sustained Improvement (2 mos):

Move Up One Level

Problem: Stay in Level

Add/Change EBPs

Significant Setback:

Move Down One Level

A Continuum of Care – The Tools

Month 2

Cont Care
2x per mo.

Outpt
1x per wk.

IOP
3x per wk.

Resid Care
7 – 30 days

Remain

EBPs in Each

6 - Case Mgmt

5 - MH Meds

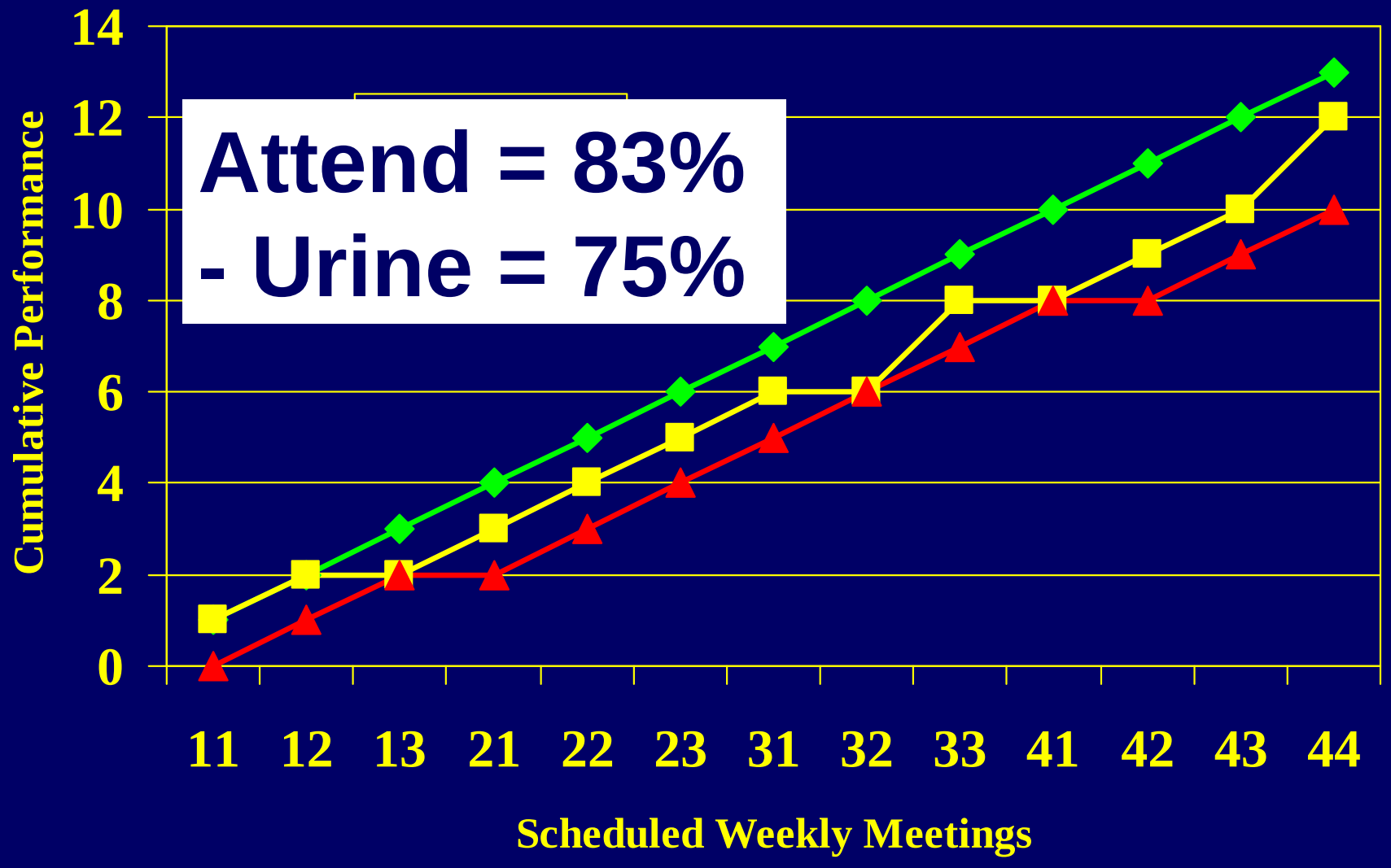
4 - SA Meds

3 - Fam Involve

2 - Ind Therapy

1 - Group Couns

CRM – Second Month



Things you'll need….

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Does This Happen Anywhere?

Lessons from Physician Health Plans

Physician Health Plans

- **49 PHPs**
  - **All authorized by state Licensing Boards**
  - **Most treat many types of health professionals**
- ***Continuously Manage***
  - **Assess, Intervene, Evaluate, Refer, Monitor, Report and Advocate**
  - **All under authority of Licensing Board**

DuPont et al., 2008, (J. Substance Abuse Treatment).

Formal Treatment

- **Signed contract 3 – 5 years**
  - **Protection from adverse actions**
  - **Diagnostic evaluation – w/Family**
  - **Monitoring with report to Board – 4 yrs**
- **Formal Treatment ~1 yr**
  - **Residential 60 days – IOP ~ 6 months**
  - **Return to practice ~ month 3**
  - **Aftercare ~ 6 months**

DuPont et al., 2008, (J. Substance Abuse Treatment).

Monitoring & Support

- **Monitoring & Support** **4 yrs**
  - AA
  - Caduceus Society
  - Worksite visits
  - * Personal Therapist
  - * Family Therapy
- **Urine Drug Screenings**
  - Weekly (random during weekdays)

DuPont et al., 2008, (J. Substance Abuse Treatment).

Results During Contract

802 Physicians
Consecutively Enrolled into
16 state Physician Health Programs

Completed

448 - No Longer Being Monitored
67 - Completed but monitored voluntarily

515 (64%)

Continuers

132 - Still being monitored

132 (17%)

Non-Completers (Failed)

85 –Voluntarily stopped / Retired
48 – Failed, License Revoked
22 - Died (6 suicides)

155 (19%)

Results *Through* Five Years

No Positive Urine Throughout 5 Years

81%

Results *Through* Five Years

Second Positive Urine After One Slip

26%

Results *After* Five Years

Practicing Medicine

Completers	92%
Continuers	73%
Non-Completers	28%

Results *After* Five Years

Revoked License

Completers	2%
Continuers	11%
Non-Completers	32%

Results *After* Five Years

Untoward Patient Incidents

~ 500 Physicians 6,000,000 Patients

Recorded incidents	55
Patient Harm	5

New Purchasing Methods

Performance Contracting In Delaware

Addiction Specialty Care

13,200 programs in US

- 65% private, not for profit
- 80% primarily government funded
  Private insurance <12%
- 31% treat less than 200 patients per year

Sources – NSSATS, 2002; D'Aunno, 2004

Delaware Situation 2002

- 11 Outpatient Providers
- Limited Budget
- No success with outcome evaluation
- Providers won’t/can’t use EBPs

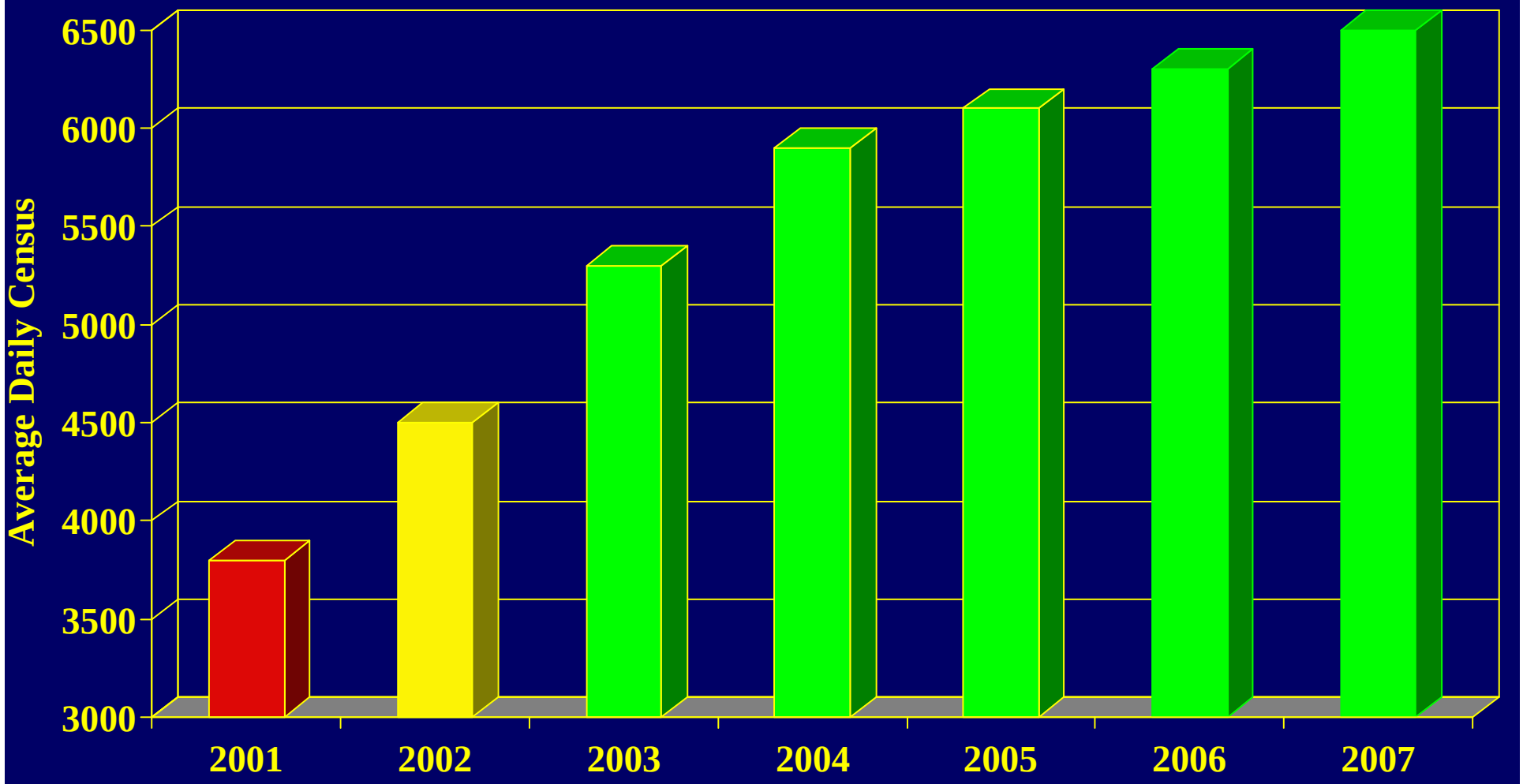
Delaware's Performance Based Contracting

- **2002 Budget – 90% of 2001 Budget**
- **Opportunity to Make 106%**
- **Two Criteria:**
  - Full Utilization
  - Active Participation
- **Audit for accuracy and access**

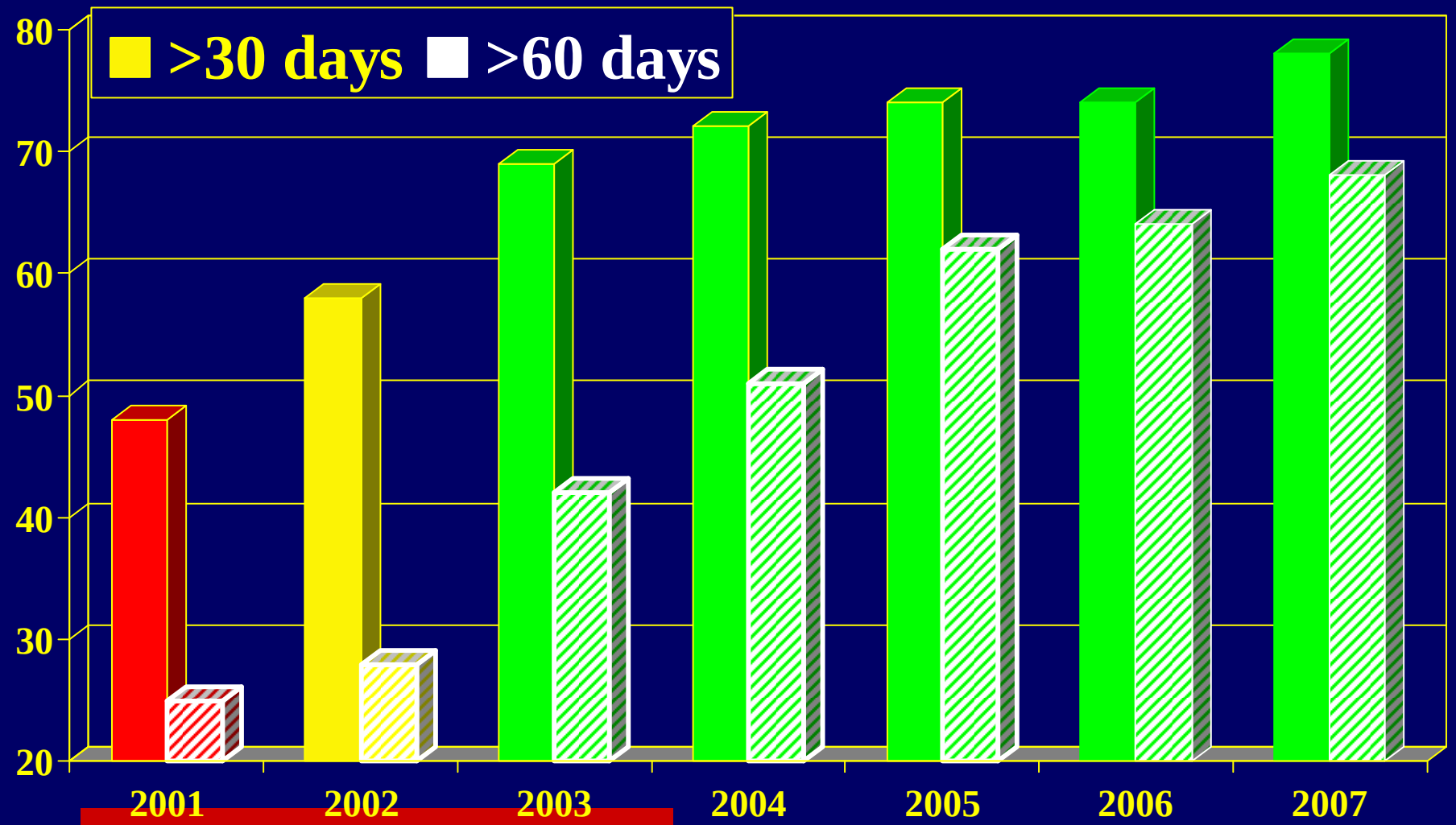
Delaware's Results Years 1 & 2

- One program lost contract
- Two new providers entered, did well
  - **Mental Health and Employment Programs**
- Programs worked together
  - **First, common sense business practices**
  - **Second, incentives for teams or counselors**
- 5 programs learned MI and MET

Utilization



% Attending


>30 days
>60 days
80
70
60
50
40
30
20
2001
2002
2003
2004
2005
2006
2007

CONCLUSIONS

- **Addiction presently has no cure – But it can be managed effectively**
- **Management takes a different model**
  - Continuing Care Model
- **Requirements**
  - Clinical Choices,
  - During Treatment Monitoring
  - Clinical Information Systems

CONCLUSIONS

- **Specialty care system is in trouble**
  - Customers Do Not Want the Product
  - Ruled by Gov, Not Market Forces
- **The System Must Change:**
  - Is isolated and insular
  - Restricts population willing to enter
  - Cannot produce quality care

CONCLUSIONS

- **Purchasers CAN Change**
  - Meet Customer Needs – Offer New Options
  - Public Health Value thru Patient Value

Continuum of Care – Circa 1980

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- The End -