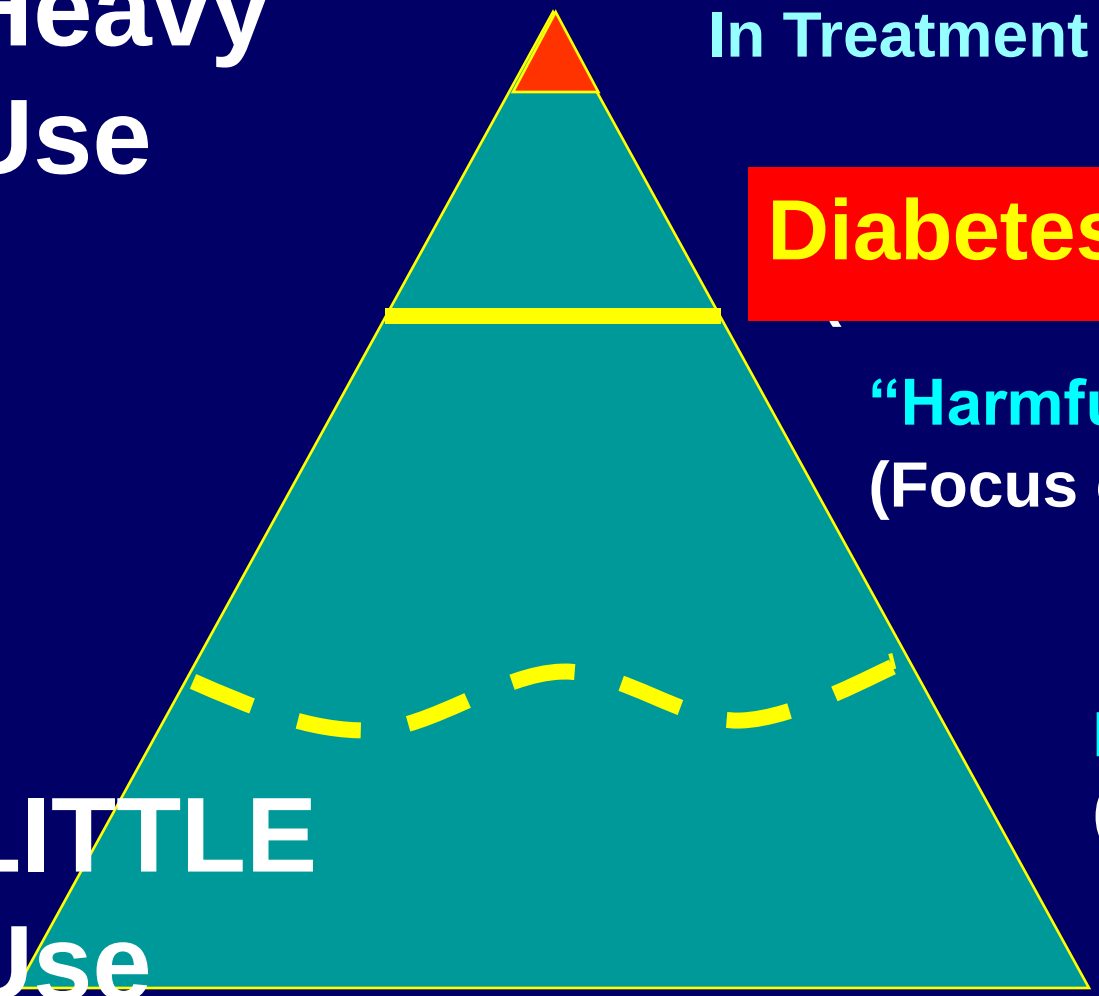
Different policies for different levels of Severity

Heavy Use



In Treatment ~ 2,300,000

Diabetes ~24,000,000

"Harmful Use" – 40,000,000
(Focus on Early Intervention)

Little or No Use
(Focus on Prevention)

LITTLE Use

Building a Better System

What are Effective Elements of Addiction Treatment?

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

Behavioral 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

Medications

- Tobacco (NRT, Varenicline, Vaccine)
- Alcohol (Naltrexone, Accamprosate, Disulfiram)
- Opiates (Naltrex., Methadone, Buprenorphine)
- Cocaine (Disulfiram, Topiramate, Vaccine)
- Marijuana – Nothing Yet
- Methamphetamine – Nothing Yet

But

There are problems in Addiction Specialty Care

Specialty Care Today

~ 12,000 specialty programs in US

31% treat less than 200 patients per year

44% have NO Doctor or Nurse

75% have NO Psychologist or SW

Major Prof Group is Counselor

But 50% Turnover each year

Why the Disconnect?

The solution depends on How you see the problem!

Addiction has been perceived as a bad habit or willful misconduct

That perception led the design of treatments, insurance coverage and outcome expectations

A Nice Simple Rehab Model

Substance Abusing Patient

Treatment

Therapies,
Accreditations
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**

How Do Treatments For Other Illnesses Work?

Chronic Illness & Continuing Care

In Chronic Illnesses….

1 – There is no Cure - the effects of treatment do not last very long after care stops

2 – Patients who are out of contact are at elevated risk for relapse: Retention is essential

In Chronic Illnesses….

3 – Early, intensive stages prepare patients for less intensive care:

– ultimately Self-Management

4 - Evaluation is a *clinical* duty:

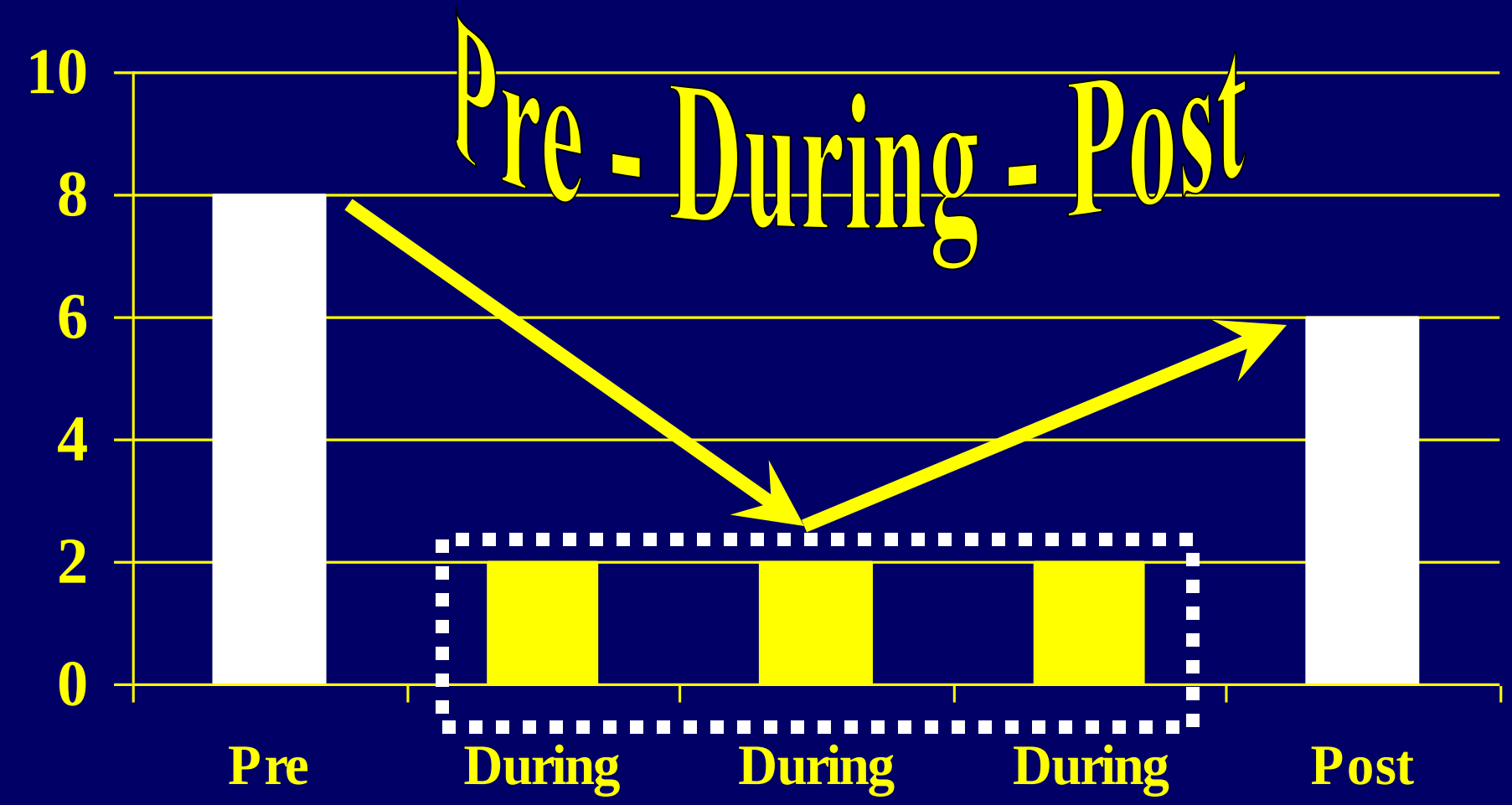
Good function = continue care

Poor function = *change care*

So What?

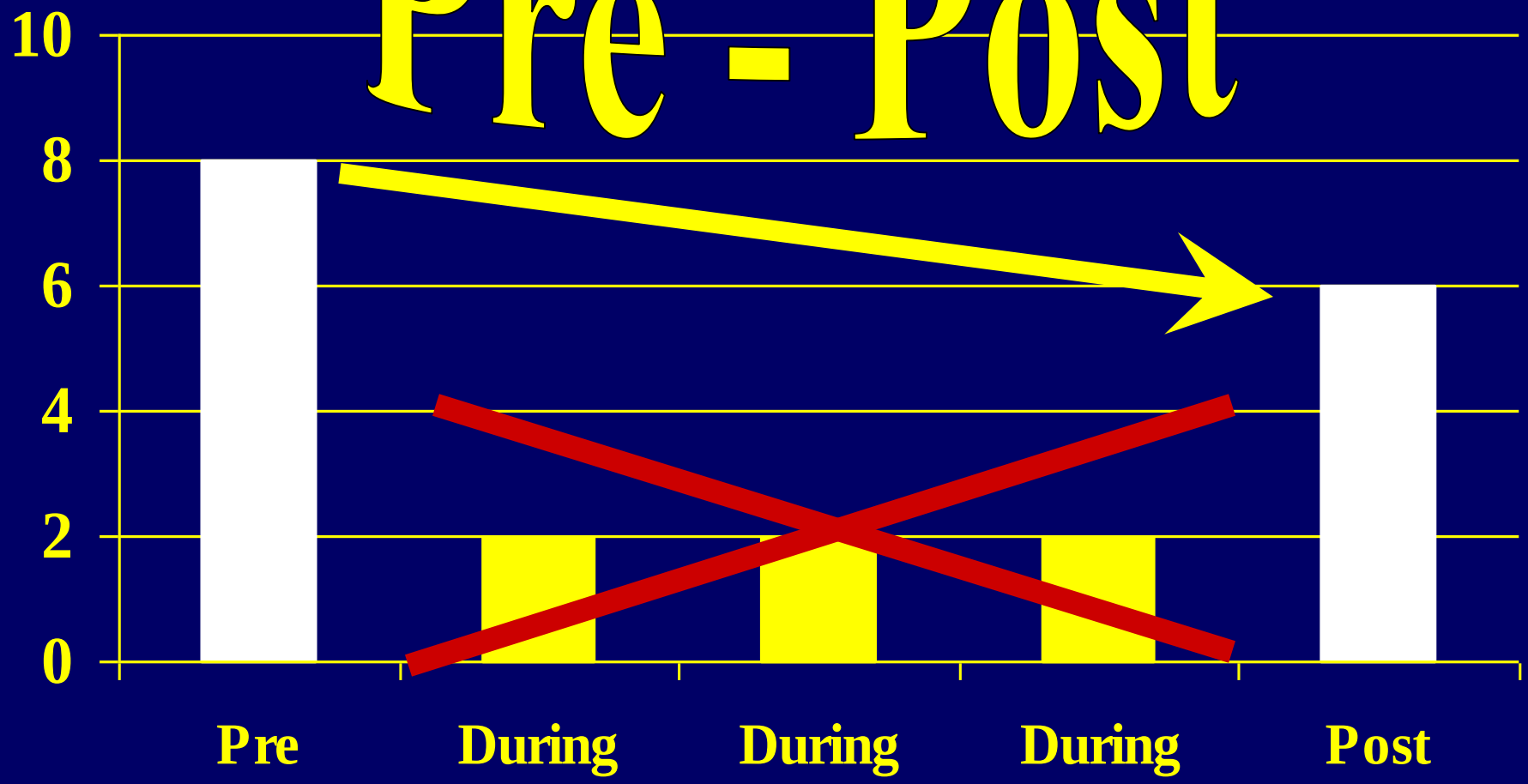
It makes a big difference in outcome expectations!

Outcome In Hypertension



Outcome In Addiction

Pre - Post



Points:

1. "**Substance Use Disorders**" range in severity and are prevalent in every medical setting
   a. Only "**Addiction**" has been recognized
2. "**Addiction**" has been conceptualized, insured, and treated like a curable, acute condition.
3. But "**Addiction**" is better viewed as **chronic illness** – not yet curable but able to be managed as other chronic illnesses.

But

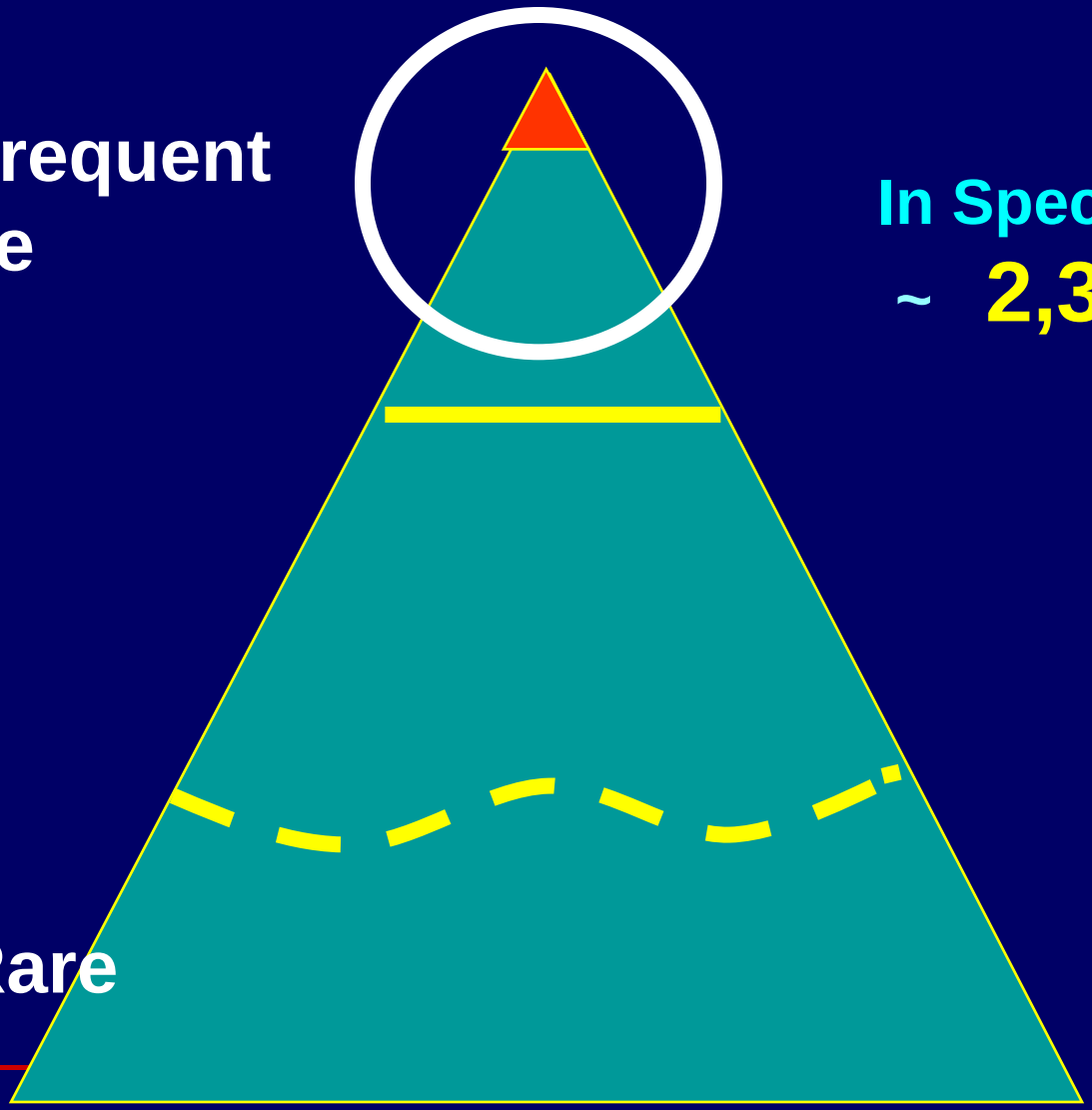
Substance Use Disorders

Have never been insured

Or treated that way

"Addiction" Treatment

Very Frequent Use



In Specialty Treat.

~ 2,300,000

Very Rare Use

Current Benefit in Addiction

- **Detoxification – 100%**
  - Ambulatory – **80%**
- **Opioid Substitution Therapy – 50%**
- **Urine Drug Screen – 100%**
  - 7 per year

Note – Great variability state to state

Addiction Benefits

- All are program – not visit benefits
- Very few care options, poor access
- Little regard for patients' rights
- No effort to make care attractive

Compared to What?

Medicaid Diabetes benefit

Medicaid Benefit in Diabetes

- Physician Visits – 100%
- Clinic Visits – 100%
- Home Health Visits – 100%
- Glucose Tests, Monitors, Supplies – 100%
- Insulin and 4 other Meds – 100%
- HgA1C, eye, foot exams 4x/yr – 100%
- Smoking Cessation – 100%
- Personal Care Visits – 100%
- Language Interpreter - Negotiated

Diabetes Benefits

- Virtually all these are in **primary care**
- Most are “visit benefits” not “program”
- Note patients clearly have **rights.** The **benefit** is designed to promote access and retention

2010 Healthcare Reform
The "Affordable Care Act"

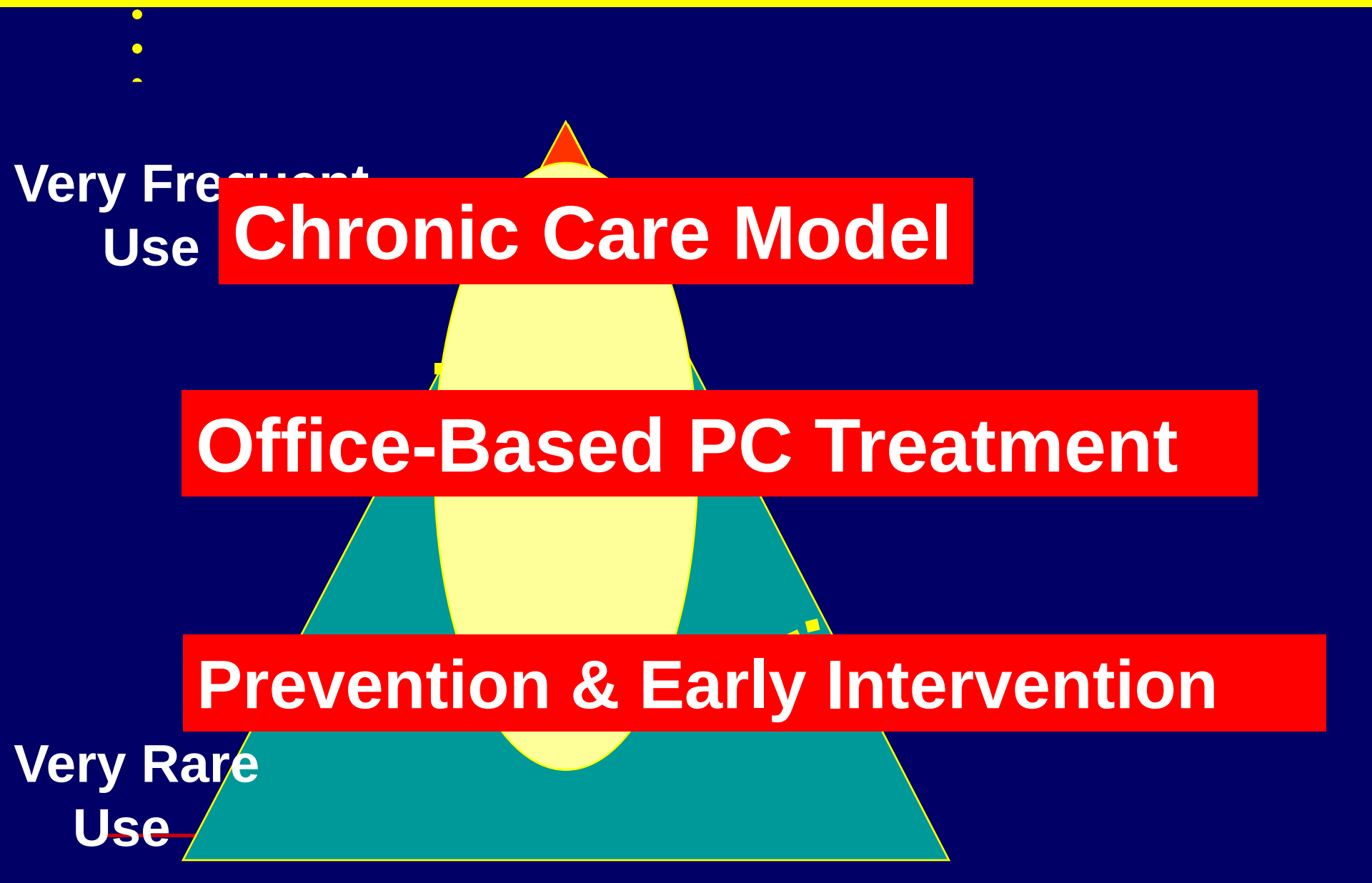
Transformative for MH/SA

- SA care is "Essential Service"
- Funds full continuum of care
  - Prevent, BI, Meds, Spec Care
- Focus on Primary Care
- All Prevention & most Essential services are 90% Fed Pay

ACA Benefit for SUDs

- **Physician Visits – 100%**
  - Screening, Brief Intervention, Assessment
  - Evaluation and medication – Tele monitoring
- **Clinic Visits – 100%**
- **Home Health Visits – 100%**
  - Family Counseling
- **Alcohol and Drug Testing – 100%**
- **4 Maintenance and Anti-Craving Meds – 100%**
- **Monitoring Tests (urine, saliva, other)**
- **Smoking Cessation – 100%**

Care of Substance Use Disorders



Care Continuum

~ 500,000 Primary Care Physicians + CNPs

1. **Prevention Services**
   Screening and Brief Intervention
2. **Early Intervention**
   Brief Counseling / Treatment
3. **Office-Based Treatment**
   Medications, Monitoring, Management
4. **Referral to Specialty Care**
   Referral Back for Continuing Care

Concluding Points

1. Drug “Addiction” treatment will become integrated into healthcare.
2. Care for “Substance Use Disorders” will involve different patients, providers, and methods – information exchange will be key.
3. Model is Patient Centered Medical Home – diabetes example


Thank You

Story 2

SBI in Middle & High School

A Partnership Between TRI and Phoenix House

Issues

- ***What MIGHT work?***
  - SBI
- ***Who should do health screening – can they pay?***
  - Health Department – Yes, part of recurring budget
  - But **NOT** in schools – ONLY in "Registered Health Clinic"
- ***Who should do the BI and RT?***
  - SA Treatment program – but only if it is reimbursed
- ***Why would a kid self disclose substance use?***
  - PERHAPS if it were engaging, useful, confidential

Solutions Round 1

- ***Create a "Health Clinic" in the School –***
  - Get specifications for minimal requirements
  - Get architect and builder and inspector
  - Get license and billing authorization - Phoenix House
  - Get agreement that this is Prevention
    - No need for Parent consent
    - No record of "substance abuse treatment"
- ***Credit - Phoenix House NY***
- ***Credit – NYC DoH (OASAS) & DoE***

Solutions Round 2

- ***Create an engaging, anonymous screen***
  - Begin with CRAFFT – NYC regulations
  - Use computer – private, multi-language, audio
    - Tailored Software
    - Anonymous & Confidential
    - Personalized Feedback (BAC)
  - Provide Tailored Guidance to Counselor for BI
  - Develop detailed clinical protocol – manual – billing
- ***CREDIT – Brenda Curtis, PhD – Annenberg Sch.***

Solutions Round 3

- ***Create tailored BI sessions and decision criteria***
  - **Remember this is anonymous**
  - **1 - Kids with no problems**
  - 2 – Kids with emerging use – to problem use
  - **3 – Kids with significant problems**
    - **Fundamentally different – Parent Involvement**
  - Develop confidentiality protections
  - Develop billing and administrative procedures

Alpha Testing – 2 months

- **Insurance problems**
  - Ultimately need parental consent - insurance
- **School scheduling problems – too much time out**
  - Screen only during non-academic classes
- **Computer problems**
  - Better, faster forms generation
- **Training problems**
  - Two counselors could not learn MI

Beta Testing – 12 Months

- **No teacher, admin or parent problems – BUT** absolutely NO teacher or parent involvement
- **Screened 480 kids – 16 weeks**
  - Over-reporting of substance use (**53%**)
    - **42** % students received **2** MI sessions
    - **4** students & **9** parents referred to treatment
- **Financially viable at 2 counselors @ 5-6 per day in schools of 500+**
- **Now want depression, bullying, diabetes screens**