INTEGRATION OF CREDENTIALED SUBSTANCE-RELATED AND ADDICTIVE DISORDERS CLINICIANS ON INTERDISCIPLINARY CARE TEAMS

PART I: Silos versus Collaborative Integrative Care

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INTRODUCTION

- what is health care and who needs it (Blount, Hunter et al., SAMHSA)
- who: delivery of services (Blount, Robinson & Reiter, SAMHSA)
- integration (PPACA, SAMHSA, HRSA, DHHS, OBH)
- Primary objective: to understand the root causes of challenges faced by patients in accessing integrated health care services across the continuum of care

WHAT IS “HEALTH CARE”? 

According to the World Health Organization (1948):

- “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

Health care has advanced over the years to propose and administer interventions designed to prevent disease, eradicate illness, and/or reduce symptomology.

Health care: bio-pyscho-social-emotional-spiritual = holistic care
HEALTH CARE = BALANCE

HEALTH CARE PROFESSIONALS

• Substance-related and addictive disorders care: LACs, CACs, IIs, IIIs, interns (aka behavioral health professionals)

• Mental health care: psychologists, counselors (LPCs, LMFTs, CMHCs), social workers, case managers, registered psychotherapists, interns (aka behavioral health professionals)

• Primary care: physicians, nurses, psychiatrists, physicians assistants, case managers, residents, interns, specialists

HEALTH CARE DELIVERY

• The United States is the only wealthy, industrialized nation that does not have a universal health care system. (Institute of Medicine of the National Academy of Sciences)

• More than 40 million adults stated that they needed but did not receive one or more of these health services (medical care, prescription medicines, mental health/addiction-related care, dental care or optical care) in 2005 because they could not afford it. (National Center for Health Statistics)

• 75% of all health care dollars are spent on patients with one or more chronic conditions, many of which can be prevented, including diabetes, obesity, heart disease, lung disease, high blood pressure, and cancer. (Health Affairs)
WHAT IS CARE INTEGRATION?

• Primary and behavioral health care integration is the systematic coordination of primary and behavioral health care.

• Since physical and behavioral health problems often occur at the same time, interdisciplinary care professionals seek to consider all health conditions at once.

• Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

INTEGRATIVE CARE = INTERDISCIPLINARY CARE TEAM

• Common medical problems treated in primary care involve behaviors and health habits that initiate, exacerbate or perpetuate the patient’s symptoms and contribute to poor functioning.

• Medical professionals, while well-trained in physical medicine, often lack the training or the time to manage behavioral health problems, like addiction, in an optimal manner.

• Collaborative care: an opportunity to improve the accessibility and delivery of MH and addiction-specific services in primary care through interdisciplinary collaboration.

• Integrated care model: addiction and MH specialists and PCPs work together in a shared system, and the specialists functions as a member of the primary care team to address the full spectrum of presenting concerns.
MENTAL HEALTH PARITY ACT
ADDICTION EQUITY ACT

• The Mental Health Parity and Addiction Equity Act of 2008 requires insurance groups offering coverage for mental health or substance use disorders to make these benefits comparable to general medical coverage.

• Deductibles, copays, out-of-pocket maximums, treatment limitations, etc. for mental health or substance use disorders must be no more restrictive than the same requirements or benefits offered for other medical care.

KEY DEFINITIONS

• integrated care: close proximity

• interdisciplinary care teams

• collaborative care: co-located versus integrative

✓ collegial consultation: team member with addiction-specific specialty

• CAC/LACs: credentialed substance-related and addictive disorders clinicians

TRADITIONAL CONSULTATION MODEL

• Chief complaint: history of present complaint, past medical history, family history, personal and social history, drug and allergy history, symptoms review

• Physical examination

• Biological diagnosis

• Disease Management: investigation, prescribing, follow-up appointment if needed
AREAS OF CONCERN

- Patients: poor compliance, unsatisfied patients related to expectations and feelings, high need for reassurance, uncertainty of biological diagnosis, short (5–10 minute) consults, unsatisfied doctors
- Risk assessment
- Scope of practice: psycho-social-emotional-spiritual diagnoses
- Patient management
- Management of time and resources in practice - housekeeping
- Management of physician’s feelings and needs

WHY STUDY THIS?

- With or without PP-ACA, the train already left the station: health care reforms are going to happen regardless.
- Health care providers have not been taking reforms seriously.
- A focus on what behavioral health specialists need to remain relevant in the changing landscape is of utmost importance if LPCs, LMFTs, and CAC/LACs want to survive reforms.
- Relationships among the three major cultures must be cultivated and sustained.
- Workforce development is a priority: how do we change our practices towards a team identity in order to provide client-centered care?
TRADITIONAL HEALTHCARE

1. Healthcare fragmentation refers to the tradition where multiple care providers make healthcare decisions without the benefit of an interdisciplinary decision making process (Elhauge, 2010).

2. According to Blount (2010), healthcare has entered a chapter where the following challenges will have to be addressed:
   a. The importance of variability within a system that has to learn and improve as compared to the importance of fidelity to a specific model.
   b. The importance of interdisciplinary approaches versus the importance of a client’s relationship with one primary care provider.
   c. The importance of new sets of skills that can be learned by people from different disciplines to be able to work in new ways that fit new approaches versus the importance of specific disciplinary training matched to a prescribed role.

WHO PROVIDES SERVICES?

• Harvard Medical School: At the beginning of the 21st century, nearly 60% of people with behavioral health disorders (anxiety, mood, impulse-control, addictive behaviors, substance misuse) were getting no treatment and most of the treatment was inadequate due to physicians’ lack of time, training, and experience to persuade clients to keep taking their medications and make return visits.

• NIDA and SAMHSA: Between 50 - 58% of people with substance misuse/addictive behavior disorders turn to their primary care physician for help.

• According to NAMI, 1 in 17 Americans suffers from a serious mental illness.

ONE in FIVE

• “The co-occurrence of chronic physical conditions and alcohol, drug or mental health (ADMH) is an important public health concern. Prior studies have found that adults who have a chronic physical condition are more likely to have a mental health and/or substance use disorder than those who do not, and that persons with an ADMH problem are more likely to develop a physical condition than those who do not.” (Han, Gfroerer, Batts & Collier, 2011, p.1)

• According to Han et al. (2011), approximately 20.3% of adults (1 in 5 people) in the US had a past year ADMH problem.

• Most are below the Federal Poverty level, are unemployed, have no health insurance, have been hospitalized, visit ERs, and have not received mental health services.
PRIMARY CARE

- Many patients with physical illnesses see medical professionals.
- Primary care treats approximately 75% of the patients diagnosed with depression (Gersh, 2008).
- Primary care treats a significant portion of the population presenting with mood and anxiety disorders, and other behavioral health complaints.
- As a result, majority of primary care patients are not accessing behavioral health services for psychological concerns (Gersh, 2008).
- Primary care providers: 12–15 minutes = 1 unit of care = time to assess, diagnose and treat.
- It is not realistic to expect PCP to address biopsychosocial concerns in limited time frame.

TREATING ADDICTIVE DISORDERS

- Stigma alive and well - stigma within health care system prevalent.
- Stigma and bias have adulterated assessment, diagnosis, treatment SRAD.
- Stigma: moral weakness, moral failing, no boundaries, impulse issues.
- This stigma and bias led to some of the silos we now need to tear down.
- Addiction occurs along a continuum from misuse to regular use to dependence.
- Addiction is a disorder of the brain - drugs and addictive behaviors change the organic brain's ability to communicate and function.
- Addiction is a disease that has physiological, genetic, environmental, social, and psychological roots.

Science-driven evidence-based treatments: they work!

MODELS OF TEAM PRACTICE

- Parallel: co-located, independent.
- Consultative: expert advice from one professional to another.
- Coordinated: co-located, work through case manager.
- Multidisciplinary: team; not necessarily integrated care.
- Interdisciplinary: team making group decisions about client.
- Integrative: true team; non-hierarchical; shared plan for care.
SIX LEVELS OF COLLABORATION

• Minimal collaboration: separate systems, no appreciation for other
• Basic collaboration offsite: separate systems, considered outside resource
• Basic collaboration – onsite: separate systems, some appreciation
• Close collaboration – partly integrated: some shared systems
• Fully integrated: shared systems, influence-sharing, expertise-sharing, physician-centric
• Full collaboration in a transformed integrated practice: shared systems, same location, integrated communication that is consistent, collaborative with formal and informal meetings, everyone “works alongside” one another, roles and cultures blurred or blended, patient-centric

THE CHALLENGES FOR CSACs AND INTERDISCIPLINARY TEAMS

GETTING FROM HERE TO THERE!

PRIMARY CARE: BARRIERS TO COLLABORATION

✓ brevity of admission assessment
✓ lack of guidance on follow-up actions
✓ questionable compatibility of screenings
✓ competing priorities and goals
✓ logistical issues
✓ lack of time
✓ task prioritization
✓ lack of client privacy
✓ medical staff overwhelmed by presenting issues & lack of training/time
TO BE EFFECTIVE INTERDISCIPLINARY TEAM MEMBERS

- primary culture and needs: culture of consultation, language, respect
- evidence-based therapies and substance abuse treatments designed for primary care environments
- behavioral health care strategies for chronic illnesses
- the toolbox: quick screening instruments, handouts, techniques
- knowledge of psychotropic and common medications used in primary care
- behavioral medicine techniques
- families and culture in primary care

challenge: not your standard “50 minute” session – not your standard office

PATIENT CHALLENGES AND BARRIERS

- the patient/client needs support and advocacy from at least one provider in order to successfully access much needed services and programs
- patient engagement in and ownership of their care is important
- younger patients want increased access to information to make informed decisions
- rigid admission criteria held by many programs/services that restrict access particularly for complex patients who may not meet every requirement perfectly, but still require service
PATIENT CHALLENGES AND BARRIERS

- Long wait times to access services and once in the providers’ offices
- Health care system “confusing” and “difficult to navigate” for people with complex issues
- Websites that are difficult to navigate
- Overall, patients perceived a disconnect between physicians, hospitals, community behavioral health facilities, treatment providers, and community services – patients feel they would be better served if providers were aware of other resources around them
- Providers are generally unaware of their patients’ interactions with other providers; integrated care plans seldom exist – even though providers acknowledge their benefits

PATIENT CHALLENGES AND BARRIERS

- While a few patients felt comfortable relaying their health information, most reported that they did not feel they possessed the medical know-how to accurately communicate information about their care to their various providers.
- Another issue reported by many was the need for greater focus on the other issues (i.e. social determinants of health) and how they impact patient health.
- A care coordinator who is resourced with all provider resources would be value-added care.

CULTURAL BARRIERS IMPEDING INTEGRATION?

- Brevity of admission assessment
- Lack of guidance on follow-up actions
- Questionable compatibility of screenings
- Competing priorities and goals
- Logistical issues
- Lack of time
- Task prioritization
- Lack of client privacy
- Medical staff overwhelmed by presenting issues & lack of training/time
MENTAL HEALTH CONCERNS

- Some patients want mental health concerns addressed alongside physical care planning, however, others wanted mental health care to remain distinct from physical care.
- A more holistic approach to care.
- Providers and all clinical staff need training on how to interact (appropriate behavior and service provision) with all patients, including mental health patients, since each patient encounter has the ability to impact his/her health.
- Strengthening the ties between hospital and community services, and between community mental health and other community service providers.

INTENT

- Intent is to build collaborative partnerships between all providers within a community/medical home.
- Partnerships are integral to building a sustainable health care system.
- Need to create clinical care pathways that integrate behavioral health providers with primary health care providers – create care networks.
- Develop scope of practice documents so that everyone understands “who is able to provide what.”
- Facilitate continuity of care, transitions between providers/services and reduce service-specific variations and hassles.

Questions ...
Comments ...

Thank you for attending!