Integrated Substance-Related and Addictive Disorders Clinicians on Multidisciplinary Care Teams

Part 2: Collegial Consultation & Addiction Counselors

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Defining Health Care

- what is holistic health care and who needs it

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

- who are the professionals delivering services

Co-occurring SU/AB Disorders

- 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 ongoing behavioral health problems.

- Collaborative care: an opportunity to improve the accessibility and delivery of SUD services in primary care through multidisciplinary collaboration. Primary and SUD care integration is the systematic coordination of primary and specialized behavioral health care. Does not require co-location but co-location has advantages.

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

- Multidisciplinary healthcare

- Need for collegial consultations
Why study this ???

• C/LACs (certified and licensed addiction counselors) are specialists within the body of behavioral health professionals.

• C/LACs are professionals with behavioral health degrees who pursued additional education, training, skills, and supervised experience specific to substance abuse and addictive behaviors.

• Relationships among the three major cultures: primary care, mental health and addictive disorders – must be cultivated and sustained. Healthcare must embrace C/LACs as members of a multidisciplinary care team.

• Workforce development is a priority: we must change our practices to provide the best client-centered multidisciplinary health care to our patients.

Client/Patient-Centered Care

Creating a New Roadmap

• Systems transformation, recovery practice and more client/patient-centered approaches to delivering services and supports

• The struggle:
  – to implement strengths-based shared decision making AND
  – client/patient-centered planning AND
  – meet recipient expectations WHILE ALSO
  – satisfying regulatory and payer requirements.
Health Care Landscape

- Introduction:
  - Holism, integration, empowerment, self-management, recovery, wellness

- Implementing client/patient-centered care requires knowledge, skills and abilities

- Berwick: 3 maxims of client-centered care:
  1. The needs of the patient come first.
  2. Nothing about me without me.
  3. Every patient is the only patient.

Institute of Medicine (IOM)

- Client/patient-centeredness is 1 of 6 core aims of a quality health care system.

- Providers of MH/SU treatment are called to have in place policies that implement informed, client/patient-centered participation and decision making in treatment, illness self-management, and recovery plans as well as involve persons served and their families in the design, administration, and delivery of treatment and recovery services.

- OM defines MH/SU integration as a comprehensive approach to promoting the health of individuals, families and communities based on communication and coordination of evidence-based primary care & MH & SU treatment services.

Person-Centeredness & Recovery-Oriented

- Need for comprehensive approach
- Understand each individual and their family
- Within the context of their history, needs, strengths, recovery hopes and dreams, culture, and spirituality.

✓ Assessments, recovery plans, services and supports, and quality of life outcomes are tailored to respect the individual preferences, strengths, vulnerabilities, trauma history, and dignity of each whole person.

✓ Being truly client-centered offers a far more profound shift in attitudes, policies, and practices across a broad spectrum of health care services/settings than if often realized or achieved.

✓ Address organizational blind spots.
**Wagner Care Model**

- Understanding whole health and wellness
- Shared decision-making
- Provider team
- Collaborative
- Empowered

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**Provider Teams Promote Personalized Care**

- **Health System**: create a culture, organization and mechanisms that promote safe, high-quality care.
- **Delivery System Design**: assure delivery of effective, efficient clinical care and self-management support.
- **Decision Support**: promote care that is consistent with scientific evidence and individual preferences.
- **Clinical Information Systems**: organize person-level and population-based data to facilitate efficient and effective care.
- **Self-management support**: empower and prepare individuals to manage their health and health care.
- **The Community**: mobilize community resources to meet needs of individuals.

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**Health Care Reforms**

- Better care
- Healthy people – healthy communities
- Affordable care

- Essential benefits
- Equity coverage
- Cannot apply separate cost sharing requirements
- Increased consumer involvement in decision making
- Transparency
- Delivery system redesign
**Practical Action Steps**

- Adopt the Mental Health Care Model as the standard of delivery of personalized services that promote shared decision making, recovery, and social inclusion.
- Explicitly include shared decision making and person-centered care competencies as provider performance measures with a focus on clinical supervision.
- Routinely monitor key performance indicators of person-centered care and initiate data-driven efforts at quality/process improvement.
- Include peer providers and self-help resources as part of routine care to explicitly help support and promote person-centered services.

**Multiple Reasons to Pursue Integrated Team**

- burden mental health/substance use disorders great
- MH/SU and physical health problems interwoven
- treatment gap for MH/SU disorders is enormous
- collaboration and integration enhance access
- collaboration, co-location, integration reduces stigma and discrimination
- treating common MH/SU disorders as a team is cost-effective
- majority of clients in collaborative integrated care have good outcomes, especially when linked to a network of services at a specialty care level and in the community
Primary Care...

- most patients with physical illnesses turn to their medical providers or an ER for services
- 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 providers (including social workers) 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

Behavioral Health ...

- Medicaid is the single largest payer for mental health services in the United States
- Medicaid is increasingly playing a larger role in the reimbursement of substance use disorder services
- Individuals with a behavioral health disorder also utilize significant health care services—nearly 12 million visits made to U.S. hospital emergency departments in 2007 involved individuals with a mental disorder, substance abuse problem, or both.
- Congress enacted several laws designed to improve access to mental health and substance use disorder services under health insurance or benefit plans that provide medical/surgical benefits.

Substance Abuse & Addiction...

- 40 million or 1 in 7 people ages 12 and older have addiction
- 11% of people in need receive any form of treatment
- Genetics accounts for 50 – 75% of addiction
- > 90% began smoking, drinking, using other drugs prior to age 18
- 1 in 10 who need treatment for addiction receive it
- Mild addiction: 2 or 3 symptoms
- Moderate addiction: 4 or 5 symptoms
- Severe addiction: 6 or more symptoms
- 1/3 of all inpatient hospital costs are linked to addiction and risky substance use
- 16% ages 12 and older meet medical and clinical criteria for addiction
- 1 in 6 of those with addiction have addiction involving multiple substances
- 1 in 4 Americans who began using any addictive substances before age 18 is addicted
Team Approach to Collaborative Integration

- **Interdisciplinary Integration:** team; not necessarily integrated care
- **Multidisciplinary Integration:** team making group decisions about client
- **Fully Integrative:** true team; non-hierarchical; shared plan for care
- **Full collaboration in a transformed integrated practice:** team-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

7 Reasons for Integrating Care

1. The burden of substance use disorders is great. They produce significant economic and social hardships that affect society as a whole.
2. Behavioral and physical health problems are interwoven.
3. The treatment gap for substance use disorders is enormous.
4. Settings where multidisciplinary care teams are integrated enhance access to care.
5. Co-delivering behavioral health and primary care services reduces stigma and discrimination.
6. Treating common behavioral health disorders alongside primary health care services is cost-effective.
7. The majority of people with behavioral health disorders treated in collaborative settings have good outcomes – particularly when linked to a network of services at a specialty care level and in the community.

Effective multidisciplinary team...

- learn and practice the new culture of consultation: new language and respect
- utilize evidence-based therapies and substance abuse treatments designed for primary care environments
- seek behavioral health care strategies for chronic illnesses
- develop a specialized toolbox: quick screening instruments, handouts. Techniques
- introduce multidisciplinary knowledge of psychotropic and common medications
- promote behavioral medicine techniques
- support families and culture on team
Addiction-Specific Disorders

NIDA Statistics: Addictive Disorders: U.S.

- 52 million people 12 or older have used prescription drugs non-medically in their lifetime. 6.1 million people used prescription drugs non-medically last month.
- The United States is home to 5% of the world's population & consumes 75% of the world's prescription drugs. In 2010, enough prescription painkillers were prescribed to medicate every American adult every 4 hours for 1 month.
- 60% of 12th graders do not view regular marijuana use as harmful. Marijuana was recently legalized in Colorado and Washington state with more states to come.
- According to SAMHSA, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3% of all persons aged 12 or older). Of those who need treatment, only 2.6 million (11.2%) received it at a specialty facility.
- In 2011, 18.9 million adults in the US had a past year substance use disorder (8%) and 41.4 million adults (18% population) had a mental illness in the past year. 6.8 million adults had both mental illness and substance use disorder in 2011. Among adults with a SUD, 36.1% had a co-occurring mental illness.

Treating addictive disorders...

- Stigma within health care system prevalent and unspoken
- Stigma and bias: adulterate assessment, diagnosis, treatment
- Stigma: moral weakness, moral failing, no boundaries, impulse issues
- Dependence develops along a continuum from misuse to regular use to dependence
- Addiction is a disorder of the brain – drugs and addictive behaviors modify the 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!
- Behavioral health is an essential facet of health. Prevention works. Treatment is effective. People recover (SAMHSA)
Poly-substance Abuse

Among people with addiction, approximately 17% have addiction involving multiple substances:

- Approximately 21% of those with addiction involving nicotine also have addiction involving alcohol or other drugs.
- Approximately 30% of those with addiction involving alcohol also have addiction involving nicotine or other drugs.
- Approximately 62% of those with addiction involving illegal drugs also have addiction involving nicotine, alcohol or controlled prescription drugs.
- Approximately 75% of those with addiction involving controlled prescription drugs also have addiction involving nicotine, alcohol or illegal drugs.

Risky Users: Individuals Who Aren't Addicted But:

- Exceed the following guidelines for alcohol use:
  - Women - more than one drink a day for most women
  - Men - more than two drinks a day for most men
- No alcohol consumption for:
  - Persons under the age of 21
  - Pregnant women
  - Individuals taking prescription or over-the-counter medications that can interact with alcohol
  - Individuals with certain medical conditions such as liver disease or pancreatitis that maybe negatively affected by alcohol use
  - Individuals who plan to drive, operate machinery or take part in other activities that require attention, skill or coordination, or in situations where impaired judgment could cause injury or death, like swimming
- Misuse controlled prescription drugs
- Use illegal drugs
- Use tobacco or nicotine products
- Engage in some combination of the above

WHAT SUBSTANCE ABUSE AND ADDICTIVE BEHAVIOR DISORDER COUNSELORS DO
Substance abuse and behavioral disorder counselors typically do the following:

- Assess and evaluate clients’ mental and physical health, addiction or problem behavior, and readiness/motivation for treatment;
- Help clients develop and engage in treatment goals and plans;
- Review and recommend treatment options with clients and their families;
- Help clients develop skills and behaviors necessary to recover from their addiction or modify their behavior;
- Work with clients to identify behaviors or situations that interfere with their recovery;
- Teach families about addiction or behavior disorders and help them develop strategies to cope with those problems;
- Refer clients to other resources and services, such as job placement services and support groups; and
- Conduct outreach and prevention programs to help people identify the signs of addiction and other destructive behaviors, as well as steps to take to avoid such behavior.

TAP 21: Scope of Practice of Addiction Service Providers

8 Practice Dimensions of Addiction Counseling

2. Treatment Planning
3. Referral
4. Service Coordination: implementing the treatment plan; consulting; ongoing assessment & revised treatment planning
5. Counseling: individual, group, couples
6. Client, Family, and Community Education
7. Documentation
8. Professional and Ethical Responsibilities

COMPETENCIES

C/LACs offer core competency skills across 6 domains:

1. clinical practice skills
2. practice management skills
3. consultation skills
4. documentation skills
5. team performance skills
6. administrative skills
C/LACs are Multidisciplinary Care Team Members and Collaborative Consultants. C/LACs can provide a broad range of services including assessment, education, and brief intervention to primary care patients.

THERAPIES WITH DEMONSTRATED EFFECTIVENESS:
- Motivational Interviewing
- Motivational Enhancement Therapy
- Acceptance and Commitment Therapy
- Cognitive Behavioral Therapy
- Community Reinforcement
- Contingency Management
- Behavioral Couples/Family Therapy
- Family Therapy for Adolescents
- Trauma-Informed Care
- Culturally-Sensitive Care

C/LACs
- Mental Health Disorders
  - depression, anxiety, panic
  - ADHD, bipolar, PTSD, OCD
- Emotional Symptoms
  - sadness, worry, fear
  - lack of supports
  - shame, guilt, unworthy
  - difficulties coping with stress
  - marital problems
  - child behavior problems
  - other family problems
  - chronic pain management
  - tension-migraine headaches

- alcohol or other substance misuse/dependence
- addictive behaviors
- opiate abuse
- over-utilisation of healthcare
- coping with chronic or terminal illness
- managing hypertension
- anxiety interfering with medical care
- non-compliance with treatment recommendations
- cultural nuances of presenting issues

C/LACs
- chronic insomnia
- grief and loss - bereavement
- non-compliance with medications
- tobacco use – wants to quit
- tobacco use – does not want to quit
- overweight – obesity
- sedentary lifestyle impacting health
- stress-related medical conditions
- self-esteem issues
Colorado: Credentialing of C/LACs

- Colorado Certified Addiction Counselors Level III (CAC IIIs)
  - have a Bachelor's degrees or higher in behavioral health
- Colorado Licensed Addiction Counselors (LACs)
  - have a Master's degrees or higher in behavioral health
- DORA registry: 2,413 CAC IIIs and LACs throughout Colorado

Collegial Consultants

Implications

- PC/MW/SUD clinicians has been educated and trained differently.
- Silos of care were erected as means of control of the respective professions and their direction.
- Paradigm shifts: will have to change business models and types of business partnerships or arrangements that are made in the best interest of client care.
- Need to navigate increasingly complex, multidisciplinary, highly-regulated healthcare environments. Dismantling silos and collaborating require change – change leads to resistance!
- Clinicians may have difficulty seeing how to unite seemingly different visions, missions, and organizational structures.
### Potential Cultural Barriers

- 50 minute hour to 15 minute encounter
- Warm hand-offs and drop-in scheduling
- New staff and credentials to interface with
- Co-located offices and shared use of examination rooms
- Dedicated appointment times versus immediate availability
- Harm reduction versus abstinence
- Increased use of medication-assisted treatment
- Documentation: electronic health records
- Telehealth and e-medicine
- Confidentiality: CSACs can’t hide behind 42CFR and HIPPA
- Communication styles and language are different
- Differences in treatment goals/delivery and case management
- Payor sources, insurance panels, billing and payment
- Accountability to other credentials
- Inappropriate competition between credentials
- Stigmas, discrimination, biases, preconceived assumptions

### Reasons for Resistance

- Lack clear vision and mission regarding role changes
- Ambiguity about the mechanics of integration and teamwork
- Perceived loss of identity – fear of not being the expert
- Overly confident about their place in the current delivery of health care services
- Stigma and discrimination regarding PC and other BH clinicians
- May not feel that they were consulted about changes needed
- Have not promoted communication, innovation, and collaboration within the field
- Do not see benefits and rewards for changing delivery
- Seems like a lot of work – more trouble than it is worth
- Seems expensive
- Worried won’t get paid fairly for their knowledge, skills and experience
- Don’t want accountability – don’t want to use evidence based practices
- Overly confident in their abilities to produce positive outcomes and don’t need input and collaboration with others?

### Collegial Consultant: Core Competencies

**Clinical Practice Skills:**

- Applies principles of population-based care
- Defines role accurately
- Identifies problem rapidly – limits problem definition
- Uses appropriate assessments
- Focuses on functional outcomes
- Uses self-management/home-based practice
- Interventions are simple, concrete, supportable by PC team
- Shows understanding of relationship of medical/psychological systems
- Shows basic knowledge of medicines
- Shows knowledge of best practice guidelines
- Provides primary care lifestyle groups or classes
Collegial Consultant: Core Competencies

Practice Management Skills:
- uses brief sessions efficiently
- stays on time when conducting consecutive appointments
- completes treatment episode in 4 sessions or less
- uses intermittent visit strategy
- uses flexible patient contact strategies
- appropriately triages to mental health & addictive disorder issues
- uses primary care behavioral health case management strategies
- uses community resources appropriately

Consultation Skills:
- focuses on and responds to referral question
- tailors recommendations to work pace of medical units
- conducts effective curbside consultations
- assertively follows up with physicians, when indicated
- focuses on recommendations that reduce physical visits and workload
- presents brief lunch hour presentations in primary care

Documentation Skills:
- writes clear, concise chart notes
- gets chart notes and feedback to physicians on same-day basis
- chart notes are consistent with curbside consultation results
- is able to embrace EHR and telemedicine
- healthcare initiatives and reforms dictate greater access
- does not hide behind 42CFR or false understanding of HIPAA
Collegial Consultant: Core Competencies

Team Performance Skills:

✓ understands & operates comfortably within primary care culture
✓ shows awareness of team roles
✓ readily provides unscheduled services when needed
✓ is available for on-demand consultation by text/beeper/cell phone

Administrative Skills:

✓ understands relevant policies and procedures
✓ understands and applies risk management protocols
✓ routinely completes all billing activities

Providing the Right Care, for the Right People, at the Right Time

Family Medicine Behavioral Health Consultant

Services: Consultation/ 30 minutes for assessment and behavioral health treatment planning, recommendations, and interventions.

Referral: ANYTHING you think might be helped through habits, behavioral, cognitive, or emotional changes.

Goals of Service: To help you and your patients develop practical knowledge and skills to promote and improve physical and emotional health.

The following is a list of common problems for which I may be helpful to you, your patients, and your families:

General Mental Health Problems:
- Stress
- Anxiety/Phobia
- Anger
- Relationship Problems
- Grief or Bereavement
- Diet (weight/dietary adherence problems)
- Exercise
- Chronic Illness Management
- DID, PTSD

Clinical Health Problems:
- Insomnia
- Chronic Pain
- Diabetes, A1C problems
- Fibromyalgia
- Multiple Sclerosis (MS)
- Low Back Pain
- Tobacco Use
- ET/ID or Other Drug Use/Abuse
- Diabetes, All Problems, COPD
- Medication Adherence
Learn the Culture

- Be as available, flexible, and accommodating as possible.
- Have confidence that you are well-qualified.
- Quickly demonstrate your value. Be concise.
- Pushing too hard and/or demanding too much before colleagues are persuaded of the specialist’s value may obstruct integration efforts.
- REMEMBER: entering a world and a culture that “belongs” to other professions requires learning.
- Professionalism and respect matter! Being succinct matters!
- Specialists keep their scope of practice as broad as possible within the limits of their training and experience. Accept all referrals and do your best to assist. Collaboration is key to successful integration. Do not refer out if possible.
THE END