Integrating Alcohol and Drug Treatment with Primary Care: A Medical Home Model

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Clinical Innovations in Substance Abuse Treatment Treatment Research Center Conference

May 18, 2012

Overview
Integrating AOD services with health care

- A conceptual model of integration using primary care
- Screening, Brief Intervention, and Referral to AOD Treatment
- Integrating care during AOD treatment
- Continuing Care following AOD treatment

Primary care as the anchor for ongoing medical care, monitoring of AOD and mental health problems

Disease Management/Chronic Care Approach

Individuals with a serious chronic problem (e.g., diabetes) are treated in specialty care, and when stabilized return to primary care for management and monitoring

Similarly, AOD dependence is a chronic condition requiring ongoing care or management delivered in more than one setting

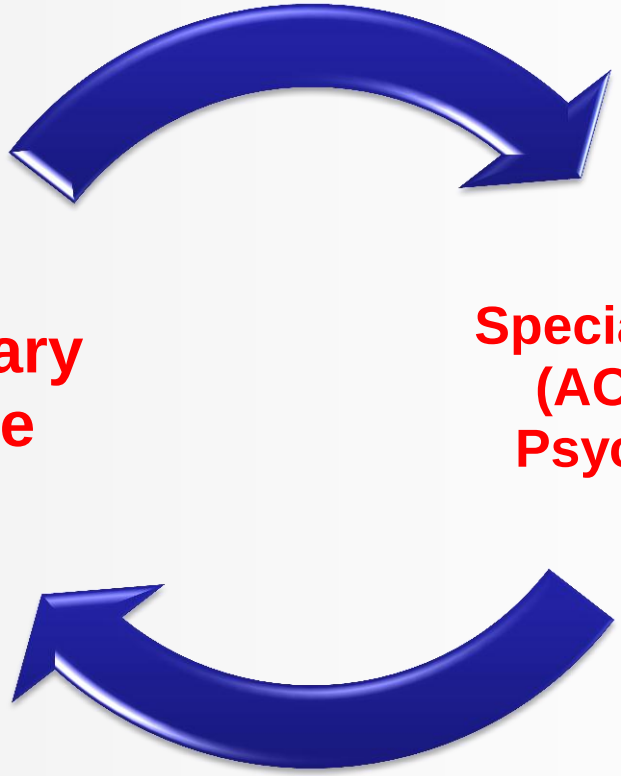
Von Korff M, Gruman J, Schaefer J, Curry SJ, Wagner EH. Collaborative management of chronic illness. *Ann Intern Med.* 1997;127:1097-102.

Institute of Medicine. Improving the quality of health care for mental and substance-use conditions: Quality Chasm series. Washington, DC: National Academies Press; 2005

What might a continuing care model for alcohol and drug problems look like?

Screen and treat in PC if moderate problem & continue monitoring

Refer to AOD treatment if needed



Back to PC for monitoring & possible readmission

Von Korff M, Gruman J, Schaefer J, Curry SJ, Wagner EH. Collaborative management of chronic illness. *Ann Intern Med.* 1997;127:1097-102. Bodenheimer T, Wagner EH, Grumback K. Improving primary care for patients with chronic illness. *JAMA* 2002; 288:1775-9

- Clinical Intervention to link AOD patients with primary care for ongoing monitoring
  - Merges what we know from chronic care of other diseases with what we know about recovery

✓patient activation sessions

✓linkage phone call with primary care physician

Why is now a good time?

Critical mass of circumstances affecting all health systems:

Opportunity to move the addiction field into health care

- Health reform
- Addiction treatment parity
- Electronic medical records
- Performance measures: HEDIS measure – CPT codes
- Medicaid Waivers in public health centers
- NIH/SAMHSA/ONDCP focus on training and treatment
- Concern in health systems about chronic pain and opioid prescribing

Why Primary Care?

Where are alcohol and drug problems found in a community?

Weisner C, Schmidt LA. Expanding the frame of health services research in the drug abuse field. *Health Serv Res.* 1995;30(5):707-26.

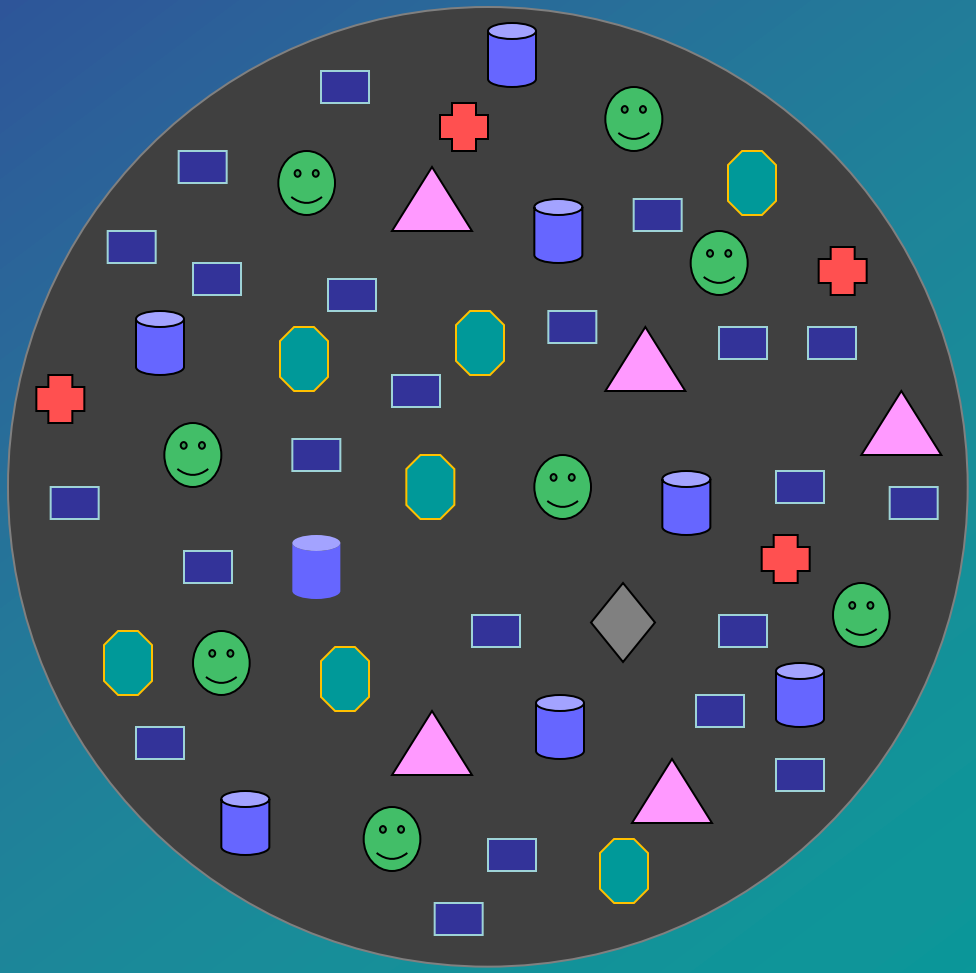
Weisner C, Schmidt L. (1995). The Community Epidemiology Laboratory: Studying alcohol problems in community and agency-based populations. *Addiction* 90(3):329-42.

Community Epidemiology Laboratory

General Population Survey

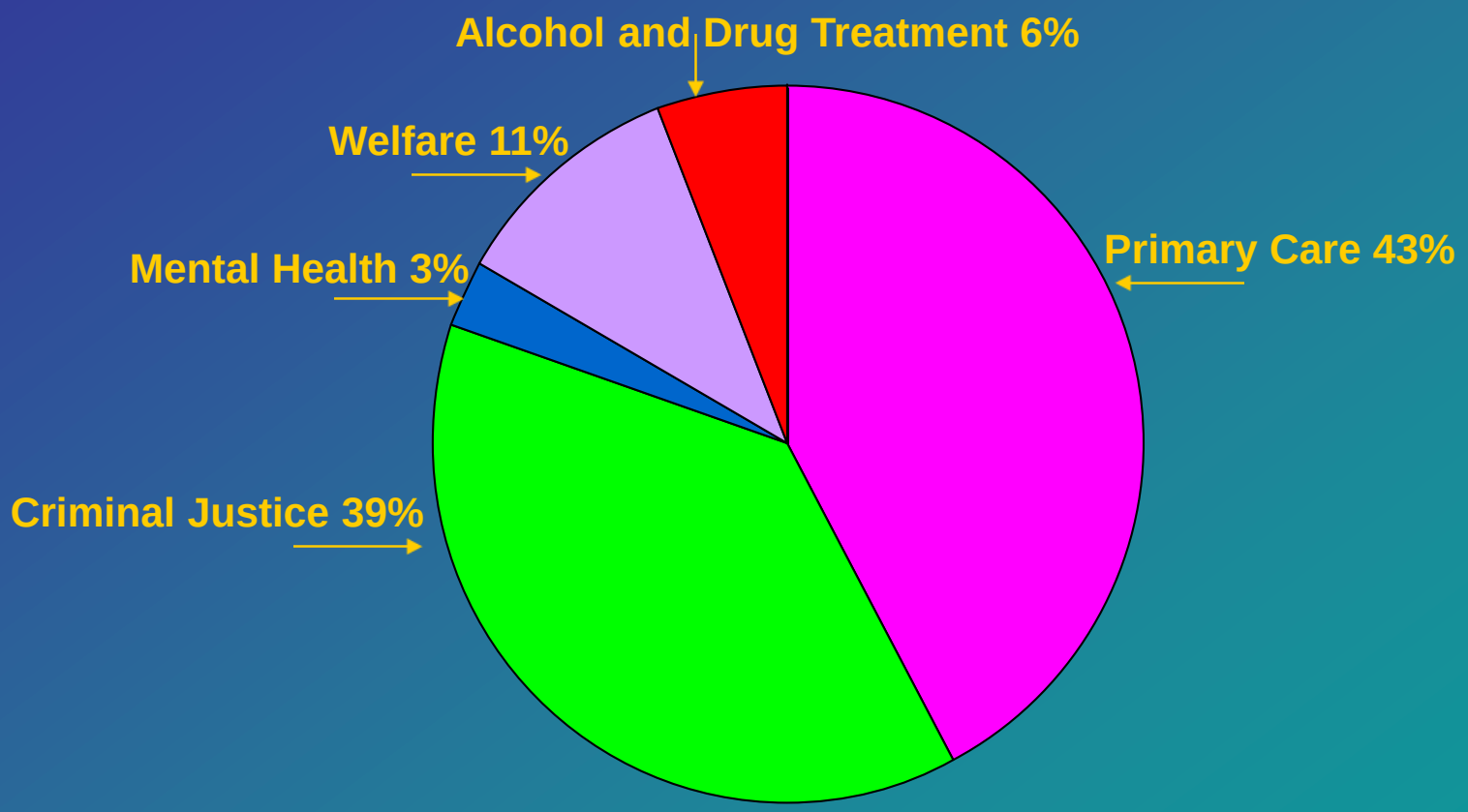
Agency Systems

- Alcohol Treatment (22)
- Drug Treatment (8)
- Mental Health (8)
- Welfare (7)
- Emergency Room (4)
- Primary Health Care (5)
- Criminal Justice (1)



Weisner, Schmidt & Tam. *Addiction*, 1995.

Distribution of New Admissions[1] of Weekly Drug Users[2] in Community Agency Systems



[1] Data weighed for design effects, non-response, and to a common fieldwork duration so that each agency system sample is shown to its size.

[2] Weekly drug use rates over a base of weekly drug users across all agency systems.

Why primary care?

- Screening
- Ongoing care
  - ✓Monitoring
  - ✓Referral back to AOD treatment when needed

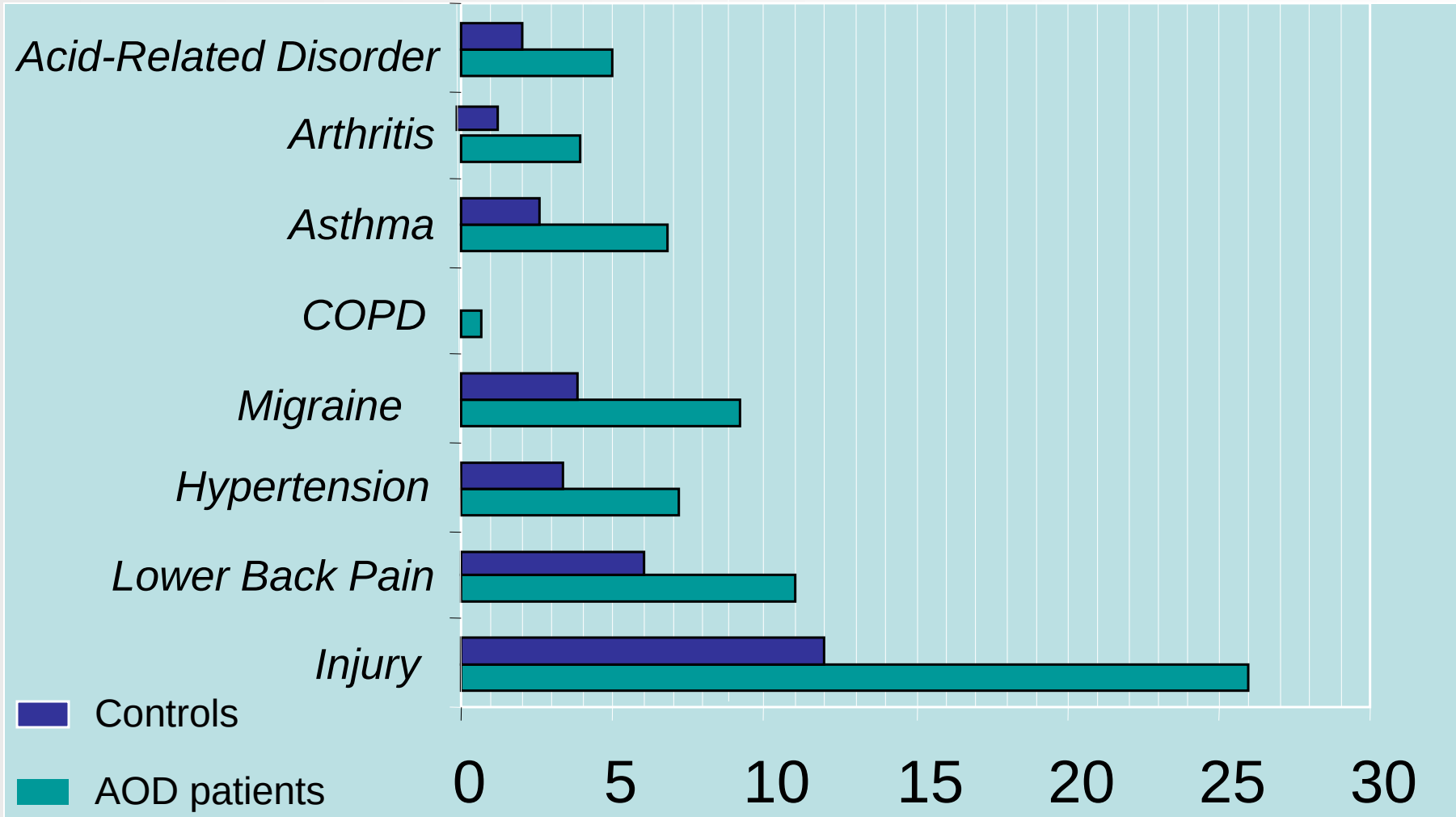
- Staff-model integrated health care delivery system (medical, psychiatry, AOD services)
- Serves 3.4 million members (about 40% of insured population in the region)
- 18 hospitals, 27 outpatient clinics
- Electronic medical record
- Starting to look similar to FQHC's

Primary Care “during and after” AOD Treatment

Because our patients have many co-occurring medical problems

Because our patients will use health care their entire lives

Prevalence in Adult AOD Treatment Patients Vs. Matched Controls (%)
(higher rates of more than 20 conditions)



Conditional Logistic Regression Results: $p<0.01$ for all conditions shown

Mertens et al. (2003). *Archives of Internal Medicine* 163: 2511-2517.

Medical Conditions: Example from a FHQC

Medical conditions	With any AOD	Without any AOD	P value
Psychiatric			
Depression	22.8	11.6	<0.0001
Major Psychosis	7.3	4.0	0.0184
Any Mental Health diagnosis	30.1	18.8	<0.0001
Medical			
Low back pain	28.5	10.0	<0.0001
Other pain/chronic pain	50.4	41.6	0.0096
Infectious/parasitic disorders	14.6	10.3	0.0436
Pulmonary /respiratory- COPD	3.7	1.3	0.0118
Hypertension	37.4	31.0	0.0446

Case for Primary Care Continuity after AOD Treatment

It’s unrealistic to expect that chronic health problems will disappear with successful AOD treatment

A Model of Continuing Care Following Treatment

Three components:

1) Regular primary care as anchor
2) Readmission to SU treatment when needed
3) Psychiatric services when needed

Data Sources

- Sample: 1951 patients entering Sacramento Kaiser AOD program

- Follow-up interviews at 1 year, 5 years, 7 years and 9 years, with response rates of 86%, 81%, 84%, and 75%, respectively
  - ✓ Addiction Severity Index (ASI)
  - ✓ “Need for specialty care”: having a non-zero ASI score for the corresponding problem domain at the prior interview time point

- Service utilization and cost data from the health plan’s administrative databases

Nine-Year Primary Care-Based Continuing Care Outcomes

- Patients receiving continuing care were more than twice as likely to be remitted at each follow-up over 9 years (p<.0001).*

Results were consistent by gender, medical and psychiatric severity, and all age groups except those older than 50 years.

* mixed-effects logistic regression model controlling for time/follow-up wave, demographic characteristics, severity, and completion of index AOD treatment

Chi FW, Parthasarathy S, Mertens JR, Weisner C. (2011). Continuing care and long-term substance use outcomes in managed care: initial evidence for a primary care based model. *Psychiatr Serv* 62(10):1194–200

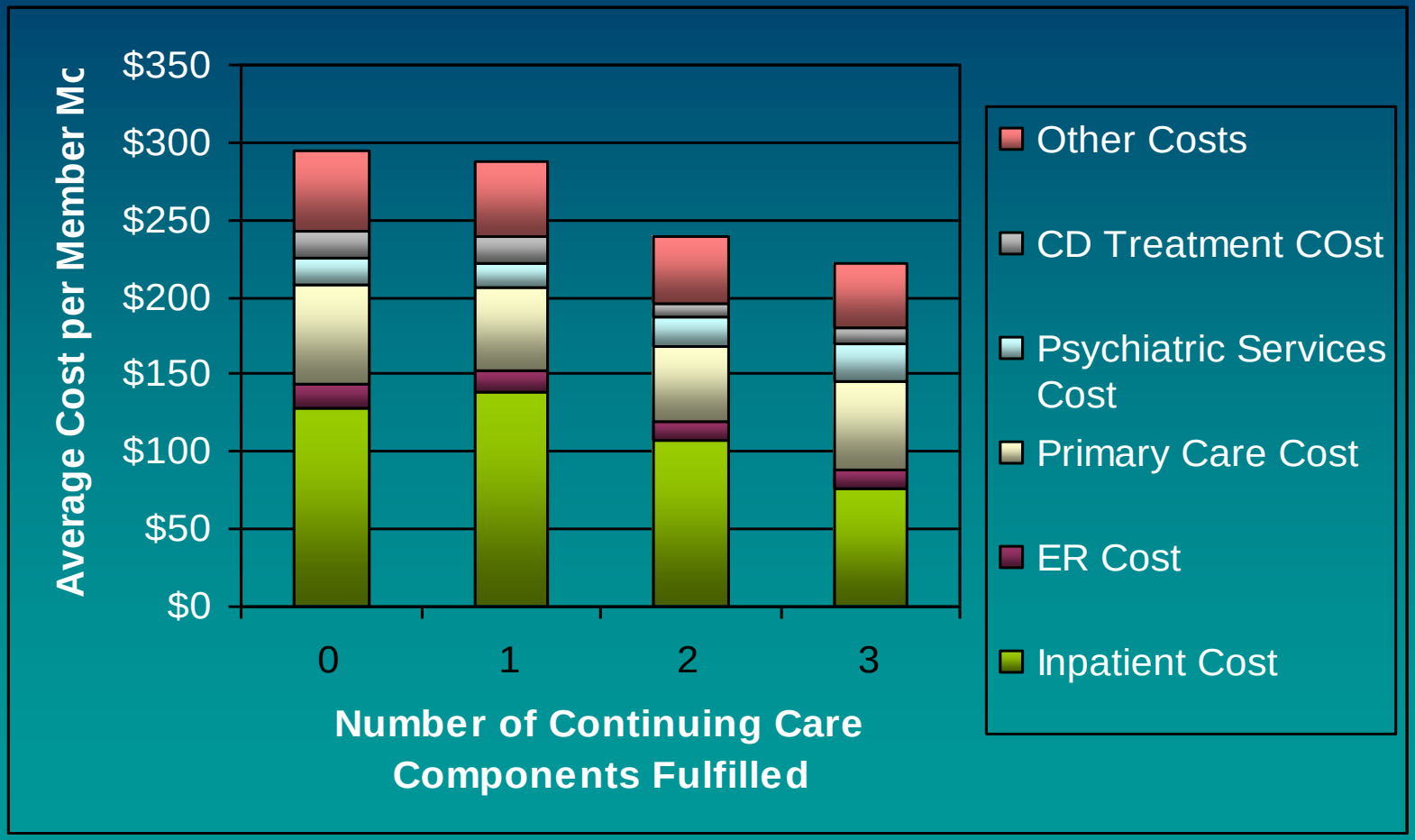
Nine-Year Primary Care-Based Continuing Care Costs

- Those receiving continuing care in the prior interval were less likely to have ER visits and hospitalizations subsequently ($p<.05$).*

*Linear mixed model controlling for age, gender, employment and marital status, whether completed treatment

Parthasarathy S, Chi FW, Mertens JR, Weisner C. (in press). The role of continuing care on 9-year cost trajectories of patients with intakes into an outpatient alcohol and drug treatment program. *Medical Care*.

Average Costs by Number of Continuing Care Components:



Summary

- Continuing care that includes regular primary care and specialty care predicted remission
- Those receiving all components of continuing care had lowest overall health care costs
  - ✓ Costs reductions from ER and hospitalizations
  - ✓ Promoting a continuing care model that integrates different elements of the health care system appears to be cost-effective

People used far less of the services to which they had access

What have we learned?

- Difficult to get people to use health care appropriately – even when they have access
- From SBIRT studies, training physicians doesn't always work.
- Health system realities: Patients may not see same physician over again.

Interventions Linking Primary Care and AOD Treatment Post-Treatment

- Uninsured individuals in detox from alcohol, heroin, and cocaine
- Medical and social work team in detox
- Primary care appointment made and letter sent to primary care provider

Samet JH, et al.. Linking alcohol- and drug-dependent adults to primary medical care: A randomized controlled trial of a multi-disciplinary health intervention in a detoxification unit. *Addiction.* Apr 2003;98(4):509-516.

Saitz R, et al. Linkage with primary medical care in a prospective cohort of adults with addictions in inpatient detoxification: room for improvement. Health Serv Res. Jun 2004;39(3):587-606.

Continuing Care Linkage Study

- Chronic Care/Disease Management Model merged with Recovery model
  - ✓Patient Activation/Empowerment
    - Wellness focus
    - Address stigma – relationship with physicians
    - Dealing with health care system

Patient Activation

- Building the belief that the patient plays an important role in his or her health
- Supporting patients to develop the confidence and knowledge necessary to take action
- Increasing patient motivation to actually take action to maintain and improve health, and
- Developing strategies to “stay the course” even under stress

Patient-centered Activation Curriculum
First Part: group sessions

- SESSION 1: Me and my health
- SESSION 2: Lifestyle and Prevention
- SESSION 3: Navigating the system
- SESSION 4: Prepare, Communicate and participate
- SESSION 5: Collaborate and integrate
- SESSION 6: Reduce your risk and maximize your health

Some examples: Using Health IT Aids

- Graphing blood pressure
- Planning prevention tests
- Preparing for doctor visit
- Emailing doctor
- Sleep/weight-loss programs
- Changing doctors

Linking with Primary Care
Second part: Linkage Phone Call

Therapist, patient, and primary care physician

Vignettes

One participant related to the group that he never would have found the courage to tell his PCP about his addiction and/or recovery. He related how he felt that this call changed his life and recovery program, as it not only allowed him to include his PCP in his recovery support system, but it also prevented him from attempting to seek opiates from this provider in the future (as he had done in the past). He also shared how empowering it was for him to talk to his doctor about what is working and his successes.

Vignettes

During the call, the PCP asked if he was testing his blood sugar daily. He reported some shame about not doing that as he has gained weight in early recovery - at which point he noted his desire to try nutrition and exercise classes. The PCP positively reinforced his behavior and said "why don’t you come in for some fasting blood tests this weekend and we can take a look to make sure you are doing ok.”

Coordination and Linkages: A Continuum

On-site program/out-stationing between AOD agencies and health clinics

Friedmann PD, D'Aunno TA, Jin L, Alexander JA. Medical and psychosocial services in drug abuse treatment: do stronger linkages promote client utilization? *Health Serv Res.* 2000;335(2):443-65.

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THANK YOU

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Funded by the National Institute on Drug Abuse Treatment Research Center, Joe Guydish, PI