Treating Addiction as a Chronic Illness: Moving from Concept to Practice

A. Thomas McLellan
Treatment Research Institute
Very Soon:

1. We will have access to reimbursement for more and different types of care than ever
   - Addiction Specialty Care referrals could triple

2. Prevention and Intervention will spread to schools, justice and medical settings

3. Market forces will shape the nature and effectiveness of addiction treatment
   - Purchasing changes, patient incentives, consumer info.
Substance Use Among US Adults

- Very Serious Use: Addiction ~ 23,000,000
- Harmful Use: Harmful Use - 40,000,000
- Little / No Use: Little or No Use
- In Treatment: ~ 2,300,000
Part 1
Conceptual Issues

Historical and Modern Treatment Approaches
What Does Addiction Look Like?

• Irresponsible behavior
• Anti-Social behavior
• Poor Impulse Control
• Inability to Delay Gratification
• Erratic and unpredictable moods/behavior

In short – a **Character Disorder** and a threat to public health and safety
How to Control Character Disorders?

- Society must shame/censure them
- Justice must force them to change
  - harsh penalties
- Treatment should teach them:
  - Discipline  Gratitude
  - Honesty  Humility
- Patients should remain anonymous

In short – a Character Disorder
SUD Benefits Today

- Addiction ~ 2,300,000
- Addiction ~ 23,000,000
- "Harmful – 40,000,000 Use"
- Little or No Use
A Nice Simple Rehab Model

Substance Abusing Patient

Treatment

Non-Substance Abusing Patient
How Do Treatments For Other Illnesses Work?

Chronic Illness & Continuing Care
A Continuing Care Model

Primary Care

Specialty Care

Primary Continuing Care
Part 2
Why Concepts Matter
Effects on Research and Evaluation
A Real World Example

Two Similar Matching Studies With Very Different Results
Project MATCH

- RCT - 3 Research-Derived Therapies
  - $27 Million Dollar NIAAA Study
- Different Mechanisms of Action
- Fixed Interventions – All Patients
- **Goal** – Achieve Lasting Abstinence Post Completion
Project Match
Fixed Time - Fixed Content – Rehab Oriented

Treatment Type

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Post Treatment Evaluations

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ALLHAT

The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack

Treatment Research Institute
ALLHAT

- $63 million – 61 sites
- Three Groups – Different drug actions, Different drug costs
  - Diuretic - $0.10 / pill
  - Calcium Channel Blocker - $1.50 / pill
  - Ace Inhibitor - $4.00 / pill

- Goal – Improvement on Pre-Specified Criterion DURING TREATMENT
ALLHAT
Pre-Specified Criteria – Adjustment Oriented

Start: 27% Control

DURING Treatment Evaluations:

- Step 1: 42%
- Step 2: 55%
- Step 3: 64%

Diuretic
CCB
ACE
A “Bad Habit” not an Illness
Leads to a Special Approach

These concepts have also affected Insurance benefits
Part 3
ACA & SA

Fundamentals of the Affordable Care Act
Without all the Political Crap
Substance Use Cost in Healthcare

Very Serious Use

Little/No Use

In Treatment ~ 2,300,000

Addiction ~ 23,000,000

“Harmful – 40,000,000 Use”

Little or No Use

$80B Yr

$40B Yr
SUD Benefits Today

Addiction: ~ 23,000,000

In Treatment: ~ 2,300,000

“Harmful – 40,000,000

Use”

Very Serious Use

Little or No Use

Little/No Use
Detoxification – 100%
  - Ambulatory – 80%

Opioid Substitution Therapy – 50%

Urine Drug Screen – 100%
  - 7 per year

Note – Great variability state to state
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
2010 Healthcare Reform

The “Affordable Care Act”

Major Elements (Contd.):

• Health Insurance Expansion 22m
  – Required Participation (payment)
  – Medicaid the major mechanism

• Focus on Accountability
  – Restore Primary Care – PCMH
  – Focus on Prevention
  – Focus on “Essential Benefits”
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
  - Part of “Medical Home”
- Information management
SUD Benefits Under ACA

**Very Serious Use**

- **Addiction** ~ 23,000,000
- **Use**
  - Little or No Use
  - Very Serious Use
  - In Treatment ~ 2,300,000

**“Harmful – 40,000,000 Use”**

**Benefit for “Substance Use Disorders”**

**Little or No Use**
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%
Part 4
Practicality

What can be done now?
Care of Substance Use Disorders

Very Frequent

Specialty/Chronic Care

Office-Based Primary Care

Prevention & Early Intervention

Very Rare Use
Proven Methods in Prevention
1. Addiction has an “at-risk” period

2. Risks have common antecedents – Single Interventions can produce multiple effects

3. Combined interventions provide enhanced impact
   - Now 12 Evidence Based Interventions
Proven Methods in Early Intervention
Major Advances in Brief Interventions

• “Harmful substance use” is accurately identified with 2 – 3 questions.
  – Prevalence rates of 20 – 50% in healthcare
  – 60% of all ER admissions (10 million/yr)

• Brief counseling (5 – 10 minutes) by produces lasting changes & savings
  – Medicaid savings $8 million /year Washington
Medicaid Costs Following SBIRT in Washington State

SBIRT patients = 1557
Matched controls = 1557

$4,000 Savings PM/PY

Estee et al. Medical Care. 2010.
Continuing Addiction Treatment

Very Serious Use

Addiction

Little/No Use
Medications

- Tobacco (NRT, Varenicline)
- Alcohol (Naltrexone, Accamprosate, Disulfiram)
- Opiates (Naltrex., Methadone, Buprenorphine)
- Cocaine (Disulfiram, Topiramate, Vaccine)
- Marijuana (Rimanoban)
- Methamphetamine – Nothing Yet
Is there a working model of Continuing Care?

Treatment of Addicted Physicians
Physician Health Plans

- **49** PHPs
  - All authorized by state licensing boards
  - Most treat many types of health professionals
- **Do NOT provide treatment**
  - Assess, Intervene, Evaluate, Refer, Monitor, Report and Advocate
  - All under authority of Board

McLellan, DuPont, Skipper 2008, BMJ
Evaluation and Contracting

• Phase 1 - Evaluation (1 month)
  • Evaluate/diagnose referred physician
  • Explain PHP and Contract

• Result is signed contract
  • 3 – 5 years in duration
  • Protection from immediate adverse actions
  • Monitoring with report to Board – 4 yrs
Treatment and Monitoring

• **Phase 2 – ~1 yr**
  - Selected residential treatment 30 – 90 days
  - Referral to IOP or OP ~ 6 months
    - Return to practice ~ month 3
  - Aftercare program ~ 3-6 months

• **Phase 3 – 4 yrs**
  - AA attendance - Caduceus Society meetings
  - Family Therapy

• **Urine Drug Screenings - throughout**
  - Weekly - monthly (random during weekdays)
  - Worksite visits
Results Through Five Years

No Positive Urine Over 5 Years

78%
Results *Through* Five Years

Second Positive Urine After One Slip

26%
New Purchasing Methods
Performance Contracting In Delaware
Addiction Specialty Care

~12,000 specialty programs in US

- 31% treat less than 200 patients per year
- 77% primarily government funded
  Private insurance <12%
Delaware’s Performance Based Contracting

- 2002 Budget – 90% of 2001 Budget
- Opportunity to Make 106%
- Two Criteria for Outpatient Providers
  - 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
% Attending

- >30 days
- >60 days

Years: 2001 to 2007

Graph showing the percentage of attending over the years with bars for >30 days and >60 days.
New Purchasing Methods

Buying a Continuum of Care: Not the Pieces
The Current Continuum of Care

Continuing Care
2x per mo.

Outpatient Care
1 – 2 x per wk.

Intensive OP
3x per wk.

Residential Care
7 – 30 days

Purchaser
Functional Continuum of Care

- Purchaser
- Continuing Care: 2x per mo.
- Outpatient Care: 1 – 2 x per wk.
- Intensive OP: 3x per wk.
- Residential Care: 7 – 30 days
- Sober Housing
Very Soon:
1. We will have access to reimbursement for more and different types of care than ever
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Thank You