SAMHSA-HRSA
Center for Integrated Health Solutions

Workforce Issues Related to: Bi-Directional Physical and Behavioral Healthcare Integration

Specifically Substance Use Disorders and Primary Care

A Framework of Issue Briefs

ISSUE BRIEF #2

THE CRITICAL IMPORTANCE OF INTEGRATION & ADOPTING EVIDENCE BASED PRACTICES: IMPROVING ACCESS TO AND THE QUALITY OF SUBSTANCE ABUSE TREATMENT IN PRIMARY CARE SETTINGS

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THE CRITICAL IMPORTANCE OF INTEGRATION

As health care reform moves forward, it is critically important there be greater integration of substance use condition screening and treatment/intervention in general health care. First and foremost, a large group of persons do not qualify for a diagnosis of a substance use disorder but are at risk for such a disorder. Almost one in five adults in an HMO primary care sample met the criteria for risky drinking promulgated by the National Institute of Alcohol Abuse and Alcoholism of the National Institutes of Health. More recently, McClellan suggested the group with unhealthy use may represent tens of millions of people. Since this large group of persons at risk does not come to and are not appropriate for SA specialty care settings, they must be identified and assisted to modify their use and reduce their substance use elsewhere in the health care system (i.e. primary care and other medical care settings).

Primary care is the setting that offers the health care system access to the most people, and behavioral health is the area in which most impact on morbidity and mortality can be achieved.

The fact that a large majority of persons with substance use disorders do not seek or receive treatment in the specialty care substance abuse treatment system is well known. According to the 2009 National Survey on Drug Use and Health, of the almost 21 million people who needed treatment for illicit drug or alcohol use but did not receive it, 94% did not feel they needed treatment. Persons who needed but did not receive treatment reported their lack of treatment receipt was related to 1) not being ready to stop using or thinking that they could handle the problem on their own (51%), 2) having no health coverage and unable to afford the cost (34%), 3) possible negative effect on job or neighbors/ community (24%) and/ or 4) not knowing where to get treatment (11%). McLellan has recently suggested that part of this denial has to do with the stigmatization and segregation of the substance abuse treatment system from the rest of medical care.

Substance use conditions are associated with a higher risk for a variety of other medical disorders. This increased risk ranges from doubling the risk for hypertension and lower back pain, to a 9 times greater risk of congestive heart failure and a 12 times greater risk of liver cirrhosis. The risks for acid related peptic disorder, arthritis, chronic obstructive, pulmonary disease, headache, hepatitis C, and injuries and overdoses also increase. In addition, patients with narcotic addiction have more than 12 times the risk of developing pneumonia. Substance use conditions are not infrequent among those with disabilities; disabled non-elderly Medicare beneficiaries were more likely (17%) than elderly Medicare claimants (6%) to receive detoxification services, a reflection of the severity of their substance use problems. Injection drug users are almost ten times more likely and crack smokers more than twice as likely to become positive for HIV in comparison to non-drug using controls.

Although absolute estimates may vary depending on the definitions, methods and populations involved, mental and substance use disorders also co-occur, complicating the treatment of each.

SAMHSA's National Survey on Drug use and Health estimated that of 17.5 million adults who had a serious mental illness in the past year, 4 million were also dependent on or abused alcohol or an illicit drug. A more recent report from the same survey highlights the relationship between inhalant use and episodes of major depression among youths, aged 12-17. Using claims data, others have estimated that about 20% of patients with schizophrenia also have a co-occurring substance use disorder. When the prevalence of mental disorders in a sample of patients in chemical dependency treatment in an HMO were compared to matched controls, patients with substance use disorders were more than 18 times more likely to have a major psychosis, almost 15 times more likely to have depression, and almost nine times more likely to have an anxiety disorder. Poorer outcomes and higher costs are associated with co-occurring mental and substance use disorders.

Substance use disorders can complicate the management of other chronic disorders, such as HIV/AIDS, diabetes, hypertension, and others. A number of researchers have reported that that persons with HIV/AIDS who reported drug and alcohol use were more likely to be non-adherent to antiretroviral treatment. Others have reported that poorer adherence to medications for Type 2 diabetes are related to substance use disorder, depression and medical co-morbidities. Persons with substance use conditions are also more likely to receive inadequate care for their physical health problems. Only half of the patients in substance abuse treatment reported having a usual source of medical care and the quality of care they receive may be low. While linkages between substance abuse treatment organizations and primary care and/or mental health organizations are a possible pathway to improving the integration of substance abuse treatment, one study of 62 outpatient substance abuse treatment units showed that these linkages were limited. Barriers cited included client's financial problems, managed care restrictions and limited organizational capacity.

Moreover, there is general agreement that new types of patients with a broad range of substance use conditions will be identified as a result of changes in health insurance coverage as part of the Affordable Care Act and that patients are likely to need services not currently available in either the specialty or primary care systems. For example, Washington State has proposed expanding the use of brief intervention strategies for substance abusing clients who are not yet dependent, as a way to deal with the Medicaid expansion that will result from health care reform, so that the substance abuse treatment system is not overwhelmed.

Substance use conditions, especially when untreated, are costly to the health care system. One study of Medicaid beneficiaries readmitted within 30 days of discharge found that substance use disorders were among the top five diagnoses associated with readmission, accounting for almost 10% of readmissions. For the elderly, the rate of alcohol related admissions are similar to the admission rate for heart attacks. Receipt of substance abuse treatment has been shown to decrease medical care costs significantly, to more than pay for itself in savings, and investments

in expanding access to treatment for persons with substance use disorders may be one effective way of reducing the trend toward increased health care costs.

ADOPTING EVIDENCE-BASED PRACTICES: IMPROVING ACCESS TO AND THE QUALITY OF SUBSTANCE ABUSE TREATMENT IN PRIMARY CARE SETTINGS

The use of evidence based practices, including the use of appropriate medication is an essential component of efficient and high quality care. New medications have been developed to treat substance use disorders along with the expectation that substance abuse treatment availability can be expanded thru the application of these practices in primary care and other medical settings. In addition to expanding the availability of substance abuse services, their movement into primary care and other medical settings provides patients with a choice of treatment setting; some patients may be much more comfortable receiving treatment for a substance use condition within a medical setting. Three medications are currently approved and available for the treatment of alcohol dependence in primary care and other medical care settings: naltrexone, acamprosate and disulfram. They can help patients reduce drinking, avoid relapse to heavy drinking and support the maintenance of abstinence and their use in primary care is feasible. A recent report indicated that patients treated with alcoholism medications had fewer inpatient detoxification days, other alcoholism related inpatient days and alcoholism- related emergency room visits and lower costs over a six month period when compared to those who did not receive medication. However, these medications are significantly under-utilized.

In addition, burprenorphine for the treatment of opiate addiction became available in 2002. Because the regulations governing the use of buprenorphine for the treatment of opiate addiction allow for specially certified primary care and other physicians to provide office based treatment for opiate addiction, buprenorphine is seen as both an opportunity to significantly expand the availability of treatment for opioid addiction; it also offers patients a choice of a less stigmatized setting (in comparison to methadone programs). Primary care physicians have cited a need to develop confidence in its' use, especially during the more complex and demanding induction phase, and identified payment and reimbursement barriers. However, one study reported that primary care practitioners were the most frequent source of prescriptions for buprenorphine. Primary care practitioners may need a variety of supports to appropriately care for patients with opioid addiction, whether specialized induction centers that begin treatment, stabilize patients and provide ongoing consultation to primary care physicians who follow these stabilized patients, or a nurse care manager to assist in monitoring patients and consulting with the physician. While these models slowly evolve, buprenorphine diffusion has also been slower to diffuse into practice than many had hoped.

Beyond medication-assisted treatment, the adoption of other evidence based substance abuse services appropriate to primary care and other medical settings have also lagged. The US Preventive Services Task Force has ranked screening and brief intervention for alcohol use as a

high priority cost effective intervention. Yet, primary care physicians do not routinely screen for alcohol use conditions and offer treatment as appropriate. Neither specific screening and intervention for alcohol use nor broad screening and intervention to deal with a wider range of behaviors (tobacco use, unhealthy diet, physical inactivity, and risky alcohol use) are consistently provided in primary care practices One study estimated that only about 10% of patients with alcohol dependence were assessed and referred to appropriate care; another reported that only 20% of primary care physicians thought that treatment resources were adequate for early problem drinkers, and 72% preferred not to counsel these patients themselves. Another found that even when physicians were aware of an illicit drug use condition in a patient, up to 15% did not intervene and only 55% offered a treatment referral. Some have reported that for pediatricians, reimbursement is a primary barrier to behavioral counseling; others found that physicians' perceptions of the importance of the topic, their own self-efficacy, and likely effectiveness of the counseling were more powerful influences than either the time required or reimbursement. A number of alternative models for screening, brief intervention and behavioral counseling have evolved, many of which rely on others than the physician to perform these tasks.

Please Note that references supporting this brief may be found in the complete paper.