



***SAMHSA-HRSA
Center for Integrated
Health Solutions***

**Understanding the Disease of Addiction &
the Process of Recovery for Healthcare
Clinicians and Staff**

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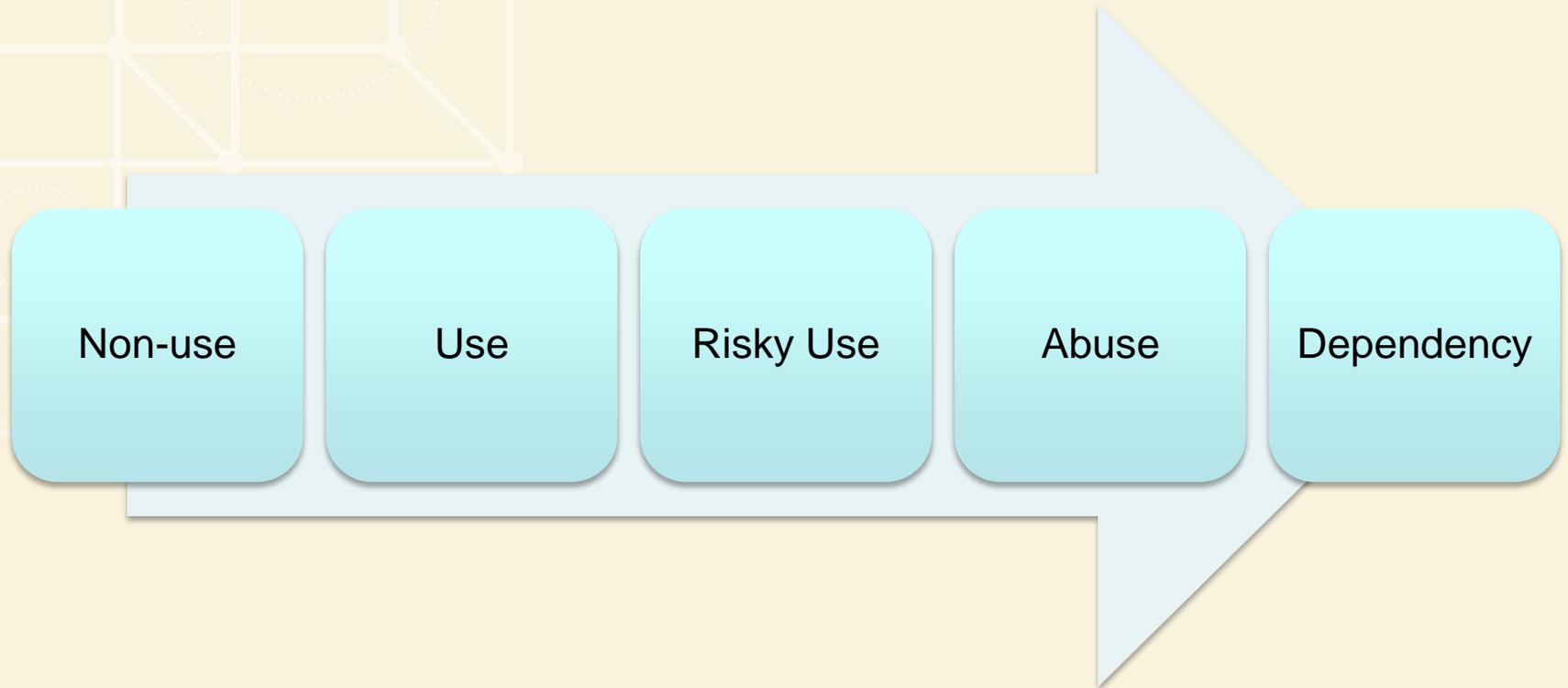


Basic Definition

...if it causes a problem, it's a problem...



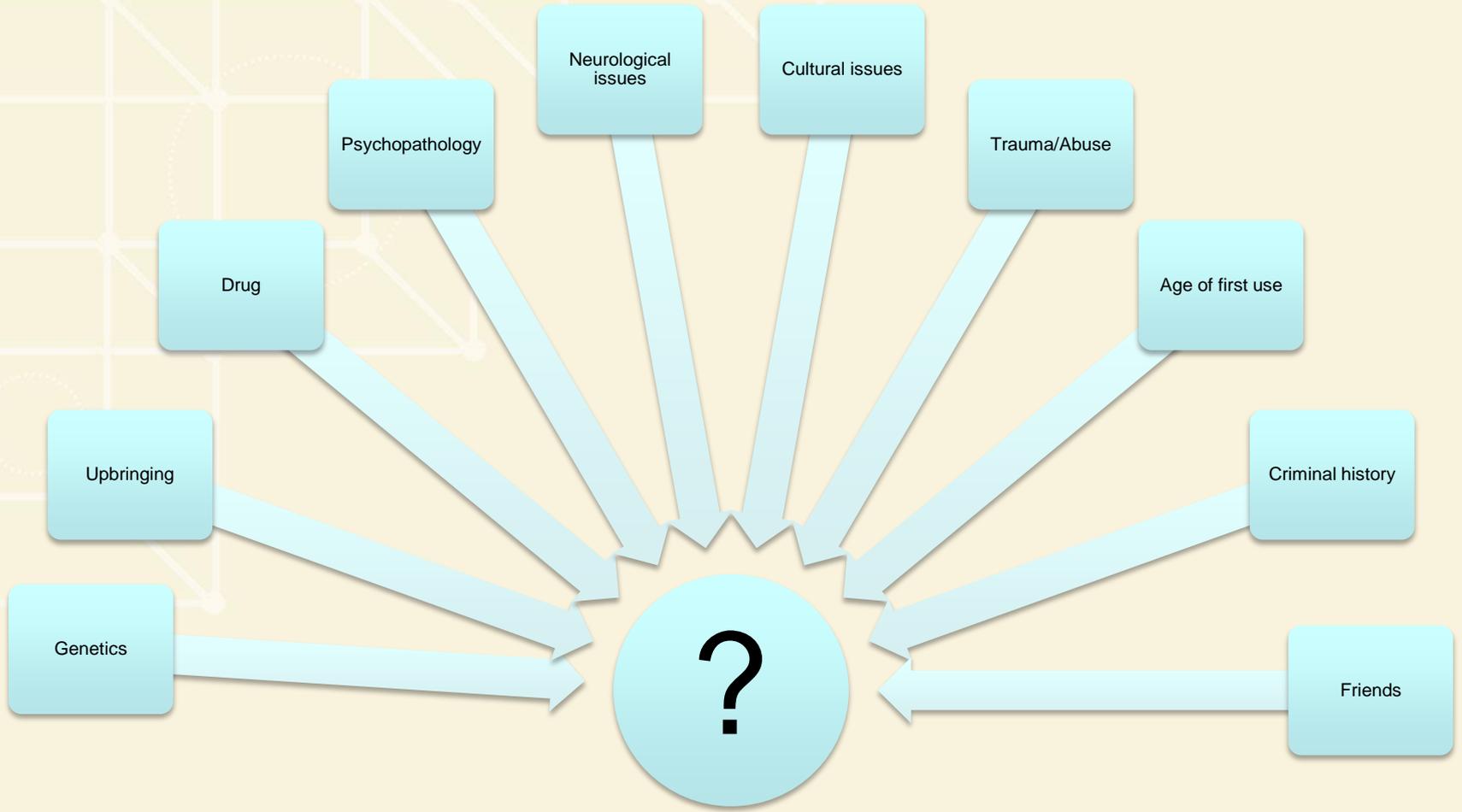
Drug use continuum



Risk of Addiction

	Risk
Tobacco	32%
Meth	31%
Heroin	23%
Cocaine	17%
Alcohol	15%
Cannabis	9%
Anxiolytics/Analgesics	9%
Psychedelics	9%
Inhalants	4%





**A substance use disorder is an
extremely complex disease**

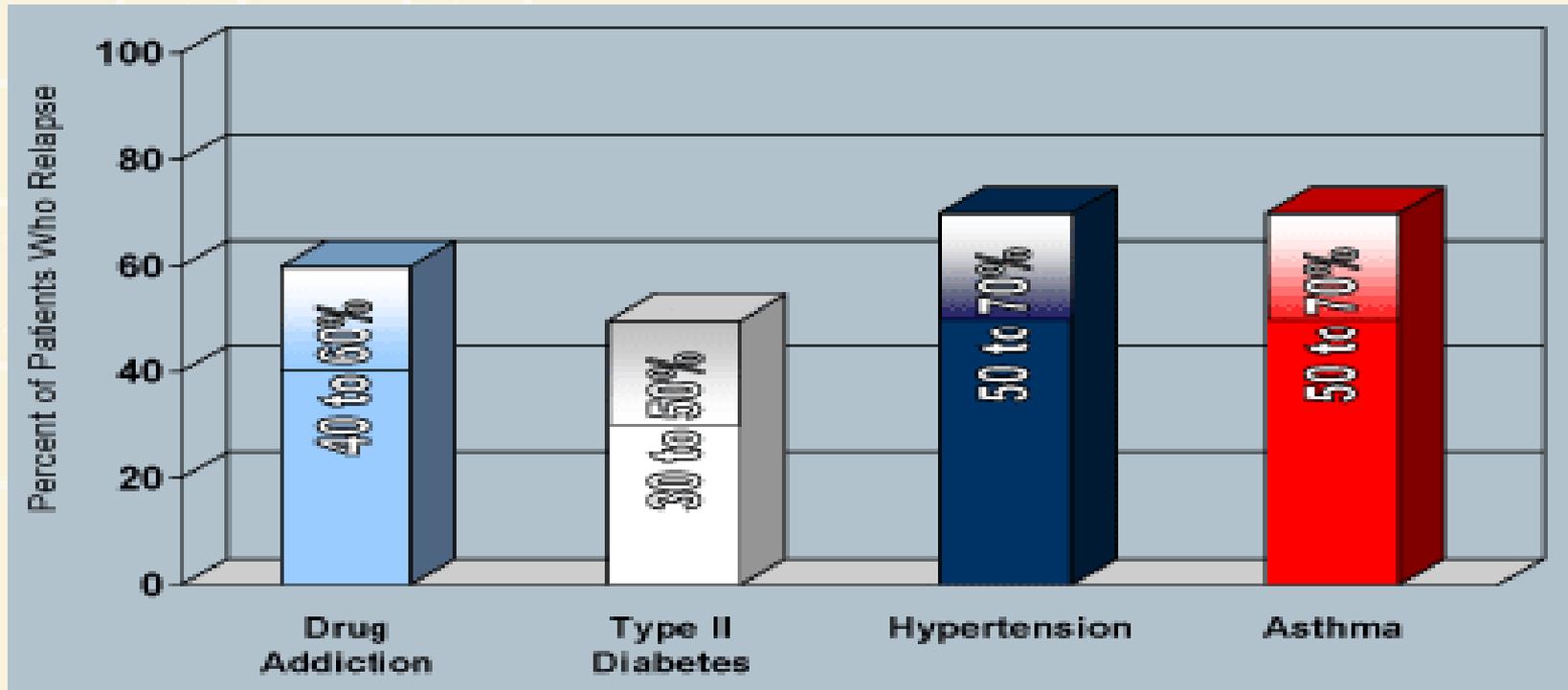


SUDs as chronic diseases

- Early acquisition with late onset of symptoms
- Individualized progression
- Complex causes
- Effectiveness of behaviorally-oriented care
- Comparable relapse rates
- Poor treatment compliance
- Psychiatric co-morbidities



Relapse Comparison



Substance dependency is a chronic disease



How big a problem is it?

- 6% of those 12 or older abuse illicit drugs*
- 16% of those 12 or older abuse alcohol*
- Less than 25% of those needing treatment get treatment**

*National Household Survey on Drug Abuse, SAMHSA, 2009

**Institute on Health Policy, 1993



Assessing burden

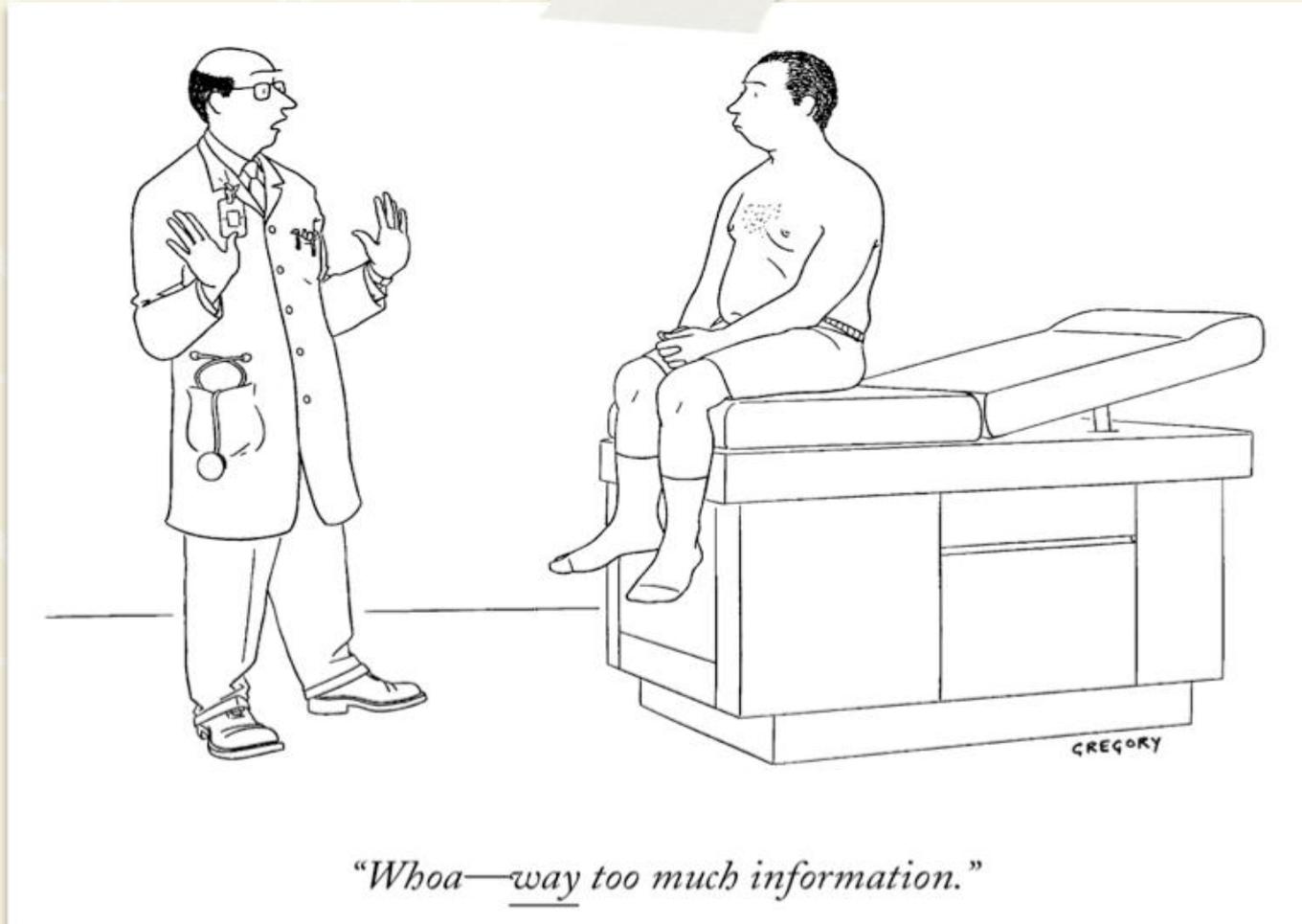
	Problem Drinkers	Alcohol Dependent	Daily Drug Use
Primary Care	42%	56%	43%
Criminal Justice	41%	24%	39%
Alcohol TX Clinics	4%	9%	3%
Drug TX Clinics	2%	2%	3%
Mental Health Clinics	3%	3%	3%



Why Bother with SUD in Primary Care?

- <10% of those with SUD seek treatment
- Perhaps 25% of all patients in primary care with a diagnosable ETOH and/or drug problem
- Patients with SUDs complicate medical care
- Patients with SUDs disrupt practices





Substance use disorders are widespread and significant factors in the lives of our patients



Drug Abuse Treatment – The Simple Way



Where is treatment provided?

Setting	Percent
Self-help Groups	80%
Outpatient SUD clinic	56%
Residential treatment	33%
Outpatient mental health clinic	33%
Inpatient hospital	23%
Outpatient medical practice	22%
Emergency Room	16%
Jail/Prison	11%





Effective treatment for SUDs

- Use of Evidence-based Treatments (CBT, CRA)
- Tailor the treatment to the patient
 - Adaptive (stepped) care
- Involve the patient in setting clear goals
- Involvement of significant others
- Attention to controllable co-factors (work, healthcare, psychiatric issues)
- Use of medications



**Substance use disorder treatment –
like the treatment of all chronic disease
- involves behavior change
and behavior change is hard**



Next Steps

Contact your local addiction treatment
agency



Integration

- Integration vs collaboration
- Integration model – SBIRT or SBIRt
- Integration Issues
 - Clinical (What care is called for?)
 - Operational (How will the care be provided?)
 - Financial (Is the care a good value?)



Clinical Issues

- Controlled substances and medication contracts
- Screening tools or brief interview?
- Pain patients
- Providing addiction, mental health, behavioral medicine
- Non-compliant patients
- Use of EBPs



Operational Issues

- Who is the BHC?
- Coordinated vs co-located vs integrated care
- Targeted vs non-targeted
- Specified vs non-specified
- Medical staff training
- Scheduling and “meet and greets”
- Charting and confidentiality



One example of outcomes

- Screened approx. 2,000 pts/yr (20% of total)
- Provided treatment to 15% (50% Medicaid)
 - 25% SUD; 35% MH; 40% COD
- 30% of Medicaid provided 70% of utilization
- 64% showed significant improvement
- Overall medical utilization by Medicaid decreased 13%
- “Frequent flyer” Medicaid patients decreased medical utilization by 33%



What we learned

- Medical assistants drive it
- Overbooking necessary
- Increased appropriate use of psychotropics
- Better management of pain patients
- Sessions of 15-20 minutes
- Use of Behavioral Medicine billing codes (96150-96154)



Continuing Challenges

- Constant retraining of medical assistants
- Training issues with providers
- Scheduling challenges
- Unable to use same-day appointments for Bmed
- Poor penetration of SUD involved patients
- eMR and confidentiality
- Billing issues



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