Journal of Substance Abuse Treatment 69 (2016) 9–18

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

Organizing Publicly Funded Substance Use Disorder Treatment in the United States: Moving Toward a Service System Approach

Howard Padwa, Ph.D. [a,*], Darren Urada, Ph.D. [a], Patrick Gauthier, B.A. [b], Traci Rieckmann, Ph.D. [c], Brian Hurley, M.D., M.B.A. [d], Desirée Crèvecouer-MacPhail, Ph.D. [a], Richard A. Rawson, Ph.D. [e]

[a] University of California, Los Angeles, Integrated Substance Abuse Programs, 11075 Santa Monica Boulevard, Suite 200, Los Angeles, CA, 90025
[b] Advocates for Human Potential, Inc., 490-B Boston Post Road, Sudbury, MA, 01776
[c] Oregon Health & Science University, School of Medicine, School of Public Health 3181 S.W. Sam Jackson Park Rd., Portland, OR, 97239
[d] Robert Wood Johnson Foundation Clinical Scholars Program, David Geffen School of Medicine, University of California, Los Angeles, 10940 Wilshire Boulevard, Suite 710, Los Angeles, CA, 90095
[e] Vermont Center on Behavioral Health, Department of Psychiatry, University of Vermont, 1 South Prospect Ave., Burlington, VT, 05401

ARTICLE INFO

Article history:
Received 7 December 2015
Received in revised form 29 March 2016
Accepted 27 June 2016
Available online xxxx

Keywords:
Organized delivery systems
Substance use disorder services
Medicaid
Public policy

ABSTRACT

Historically, publicly funded substance use disorder (SUD) treatment services in the United States have been disorganized and inefficient. By reconfiguring and linking services to create systems of care—services, structures, and processes that are purposively interconnected to treat SUD systematically—health systems can transform discrete service components into cohesive service systems that comprehensively and efficiently treat SUDs. In this article we: (1) articulate the potential benefits of organizing publicly funded SUD services into systems of care; (2) review basic principles underlying theories of SUD system organization; (3) describe the mix and configuration of services needed to create comprehensive, integrated systems of publicly funded SUD care; (4) elucidate how patients can flow through systems of SUD services in a clinically sound and cost-efficient manner, and; (5) propose eight steps that can be taken to create systems of care by identifying and leveraging the strengths, assets, and capacities of SUD service providers already operating within their health care systems. In July 2015, the Centers for Medicare and Medicaid Services (CMS) announced opportunities for states to redesign their Medicaid-funded SUD service systems. This paper provides considerations for SUD system design and development.

© 2016 Elsevier Inc. All rights reserved.

1. Introduction

The substance use disorder (SUD) treatment field in the United States is undergoing historic transformation. A host of effective behavioral and pharmacological interventions to treat and manage SUDs has been developed and tested over the last two decades (Carroll & Onken, 2005; Dutra et al., 2008; Ling et al., 2005; O'Malley, Garbutt, Gastfriend, Dong, & Kranzler, 2007; Prendergast, Podus, Chang, & Urada, 2002; Prendergast, Podus, Finney, Greenwell, & Roll, 2006; Rawson et al., 2006), and recent health policies are creating opportunities to make these treatments available to a wider patient population than ever before. Approximately 12% of the U.S. population with SUDs will gain insurance coverage under the Affordable Care Act (ACA; McLellan & Woodworth, 2014), and the integration of SUD services into primary care and other health settings under the ACA will create more opportunities for health care providers to identify individuals with SUDs and engage them in treatment (Buck, 2011; Humphreys & Frank, 2014; Humphreys & McLellan, 2010; McLellan & Woodworth, 2014). Moreover, SUD services are among the 10 essential health benefits insurance plans are required to provide (Buck, 2011; Pating, Miller, Goplerud, Martin, & Ziedonis, 2012), and insurers will need to cover SUD treatment in parity with other medical and surgical benefits (Barry & Huskamp, 2011; Jost, 2015; Pating et al., 2012). As a greater share of SUD services becomes reimbursed by insurance, they will need to become more outcome-driven, clinically oriented, and evidence-based (Buck, 2011; Pating et al., 2012; Roy & Miller, 2012). Consequently, there is an unprecedented opportunity to provide more empirically supported and effective SUD services to a much larger portion of the population that needs treatment.

Approximately 21.6 million people over the age of 12 (8.2% of that population) are estimated to meet diagnostic criteria for an SUD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), putting them at increased risk for myriad physical, mental health, criminal justice, and socio-economic problems (National Center on Addiction and Substance Abuse at Columbia University [NCASACU], 2012). Though some non-specialty settings (e.g., primary care) offer integrated services that are able to adequately treat individuals with SUDs (SAMHSA, 2013; Treatment Research Institute, 2010), most medical providers do not deliver comprehensive SUD care (Shin, Sharac, Alvarez,

* Corresponding author. Tel.: +1 310 968 3914.
E-mail addresses: hpadwa@ucla.edu (H. Padwa), durada@ucla.edu (D. Urada), pgauthier@ahp.net (P. Gauthier), rieckman@ohsu.edu (T. Rieckmann), bhurley@ucla.edu (B. Hurley), desireec@ucla.edu (D. Crèvecouer-MacPhail), rrawson@mednet.ucla.edu (R.A. Rawson).

http://dx.doi.org/10.1016/j.jsat.2016.06.010
0740-5472/© 2016 Elsevier Inc. All rights reserved.

Rosenbaum, & Paradise, 2013). Moreover, a growing body of evidence indicates that individuals with the most challenging problems related to substance use—heavy alcohol users and drug users—do not adequately respond to the types of interventions that are commonly delivered outside of specialty SUD treatment settings (Hingson & Compton, 2014; Roy-Byrne et al., 2014; Saitz, 2010, 2014, 2015; Saitz et al., 2014). Thus it will remain incumbent on specialty SUD treatment providers to continue addressing the patient population's most acute and complex substance use service needs in the era of health care reform.

In spite of the opportunities presented by the ACA, most SUD treatment systems in the United States remain disorganized, inefficient, and poorly configured to provide evidence-based care in a cost-effective manner (Lundgren & Krull, 2014; NCASUCU, 2012). Since publicly funded programs deliver the majority of specialty SUD treatment services (Buck, 2011; NCASUCU, 2012), improving how public treatment systems function could enhance the quality and efficiency of SUD care. Reconfiguring and linking services to create systems of care—collections of services, structures, and processes that are purposively designed and interconnected in order to treat SUD systematically (Babor, Stenius, & Romelsjo, 2008; Klingemann & Hunt, 1998; Klingemann, Takala, & Hunt, 1992; Wellisch, Prendergast, & Anglin, 1995)—can maximize the clinical impact and cost efficiency of SUD treatment. We propose that if policymakers and administrators organize existing SUD service components into functional SUD service systems, they can allocate resources and support to increase capacity to meet the patient population's SUD treatment needs in the era of health care reform.

To inform policymakers and administrators as they consider reorganizing their publicly funded SUD systems, in this paper we: (1) provide an overview of how SUD systems can be redesigned to improve their clinical impact and cost effectiveness; (2) review the basic principles underlying theories of SUD system organization; (3) describe the mix and configuration of services needed to create organized and comprehensive SUD service delivery systems; (4) elucidate how patients can flow through a system of SUD services in a clinically sound and cost-efficient manner; and (5) propose eight steps that administrators and policymakers can take to create systems of care that meet the public's SUD treatment needs. We conclude with an overview of a recently announced Centers for Medicare and Medicaid Services (CMS) 1115 demonstration opportunity that can be used to facilitate system transformation, and a discussion of how it can help fill long-standing gaps in publicly funded SUD service systems.

2. The need for SUD system organization

Evidence shows that SUDs are chronic health conditions that often require ongoing care, but more often than not, they are treated as acute conditions that can be "cured" with one episode of treatment (Dennis & Scott, 2007; McKay, 2009; McLellan, Lewis, O'Brien, & Kleber, 2000). Between 40% and 90% of the individuals who require detoxification in publicly funded SUD treatment systems receive no follow-up rehabilitation or treatment services within two weeks of discharge (Campbell et al., 2010; Garnick, Lee, Horgan, Acevedo,, & Washington Circle Public Sector Workgroup, 2009; Mark, Dilonardo, Chalk, & Coffey, 2003; McLellan, Weinstein, Shen, Kendig, & Levine, 2005; Nosyk et al., 2014; Stein, Kogan, & Sorbero, 2009), thus increasing the risk for relapse and readmission for detoxification in the future (Lee et al., 2014; Mark, Vandivort-Warren, & Montejano, 2006). Furthermore, fewer than half of individuals leaving residential SUD treatment receive follow-up services within two weeks of discharge (Garnick et al., 2009), even though continuity of care following residential treatment is associated with longer periods of abstinence and decreases in substance-related problems (Moos & Moos, 2003; Sannibale et al., 2003). Consequently, a large portion of patients who utilize publicly funded specialty SUD services cycle in and out of the most intensive and expensive treatment programs, but with limited lasting clinical benefit (Carrier et al., 2011; Lundgren & Krull, 2014; Lundgren, Sullivan, & Amodeo, 2006; McLellan, 2006). SUD services are already grossly underfunded compared to other parts of the health care system (Mark, Levit, Vandivort-Warren, Buck, & Coffey, 2011; Mark et al., 2007), and the inefficient use of costly services exacerbates the scarcity of treatment resources.

Though the implementation of the ACA promises to facilitate access to SUD services (Ali, Teich, Woodward, & Han, 2014; McLellan & Woodworth, 2014), experience suggests that changes in insurance coverage alone may not be sufficient to increase utilization of SUD treatment. In 2006, when Massachusetts instituted universal health care coverage and included SUD treatment as an essential benefit, challenges related to service eligibility, financing, policy, and system design prevented rates of SUD service utilization from increasing (Capoccia, Grazier, Toal, Ford, & Gustafson, 2012). As the authors of a 2012 study examining the impact of Massachusetts' health expansion on SUD service utilization concluded, "the absence of redesign in the Massachusetts addiction treatment system dampened the potential impact of universal coverage" (Capoccia et al., 2012; p. 1007). Thus to maximize the impact of reform on SUD services under the ACA, administrators and policymakers will need to ensure that publicly funded SUD services are not only covered by insurance, but also well-organized. A publicly funded specialty SUD treatment system that is designed to facilitate the delivery of services in a manner that is both clinically effective and fiscally efficient will be critical in order to maximize the opportunities that the ACA has created for the SUD treatment field.

3. SUD systems of care: Basic principles

Literature on SUD treatment systems is sparse, in part because in most countries SUD services have not been organized into discernible "systems." (Babor, 2015; Bergmark, 2010; Glaser, 1994; Klingemann & Hunt, 1998; White, 1998). In addition, inconsistent terminologies, complicated monitoring protocols, and complex evaluation tools have hindered the development of studies that assess the functioning and effectiveness of SUD services at the system level (World Health Organization, 2006). Nonetheless, two major principles have emerged from scholarship on SUD system design and structure: (1) that SUD services can be organized into a continuum of care, and (2) that SUD services can be organized by function.

3.1. Organizing SUD services into a continuum of care

In schemas describing SUD services as a continuum of care, specialty services are configured sequentially, with patients flowing between higher, or more intensive, levels of care and lower, or less intensive, levels of care as indicated by clinical needs (Babor, 2015; Babor et al., 2008; McKay, 2005; McKay et al., 2002; Mee-Lee et al., 2013). Many depictions of SUD services as a continuum of care describe "stepped care" approaches, with patients being assigned to the least intensive level of care necessary initially, and then being "stepped" up to a higher level if they are not progressing, or "stepped down" to a lower level if they show improvement (Babor, 2015; Mee-Lee et al., 2013; Schippers, Schramade, & Walburg, 2002; Sobell & Sobell, 2000; Uchtenhagen, 2015). The concept of a continuum has been used not only to describe the specialty services that individuals with diagnosed SUD receive, but also the entire range of preventive and aftercare services related to substance use that may be offered outside of specialty SUD treatment settings (Babor, 2015; Mee-Lee et al., 2013; Watkins, Farmer, De Vries, & Hepner, 2014). This paper focuses on specialty SUD services and the need for intentional design of the system, service mix review, and creation of effective care model and patient flow standards.

3.2. Organizing SUD services by function

Work describing the organization of SUD services by function has described ways that components of SUD systems can be conceptualized by their roles in service delivery and/or the populations they serve.

Download English Version:

https://daneshyari.com/en/article/329555

Download Persian Version:

https://daneshyari.com/article/329555

Daneshyari.com