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A Chronic Care Approach to the Prevention, Treatment, and Management of Addiction

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Abstract

Addiction is a chronic health condition that affects 40 percent of the American public. It costs society more than $400 billion annually (excluding nicotine), is responsible for up to 45% of all hospital emergency room admissions and is implicated in 66% of incarcerations [1,2]. Of the estimated 23-25 million people who need addiction treatment, about 2.5 million (10%) receive it [3]. Stigma, insurance barriers, and the perception by many that they don't have a problem have limited access to care. Efforts to reduce stigma through awareness programs, the 2008 Mental Health and Addiction Parity Act, and the influx of newly insured patients through the ACA have sparked investor interest and led to rapid growth of inpatient rehabilitation programs. However, despite wider acceptance of addiction as a chronic brain disorder, treatment systems continue to be developed and defined by an emphasis on acute, time-limited treatments. For more than forty years, addiction treatment has been defined and judged by this misplaced perception that a fixed duration of treatment will "fix the problem". Patients and families have been led to believe that a month in rehab would "take care of the problem". This fragmented approach fails to provide the life-long management necessary to ensure sustained remission. The greatly underemphasized problem is the absence of substantial and comprehensive community based continuing care and the paucity of prevention, early identification and intervention efforts. Relegating follow-up care, prevention and early intervention to the sidelines contradicts the standard treatment of chronic disease. New ideas, innovative service delivery methods, alternative clinical interventions, and technological supports are not robustly developed, tested, and integrated. It is time for a new vision that addresses addiction as the chronic disease it is. This paper will describe an approach that incorporates prevention, early intervention, and extended engagement with traditional models of care to create a seamless, integrated system of care that addresses addiction as a chronic condition that can produce more favorable long term outcomes.

Introduction

Data from the Massachusetts Management Information System reveals that 87% of patients admitted to detox units have previous lifetime admissions; over half have been there more than five times. Of an estimated 215,000 detox days of care provided in 2014, about 100,000 were provided to patients who have five or more previous admissions. If those admitted 5+ times could be reduced from 53% to just 45%, it would free up nearly 10,000 beddays of care or enough to admit 2,000 additional patients [4]. Looking at this from a "one year only' perspective, in the single year 2014 more than 4,500 individuals utilized detoxification services more than three times. Had these patients been retained in ongoing treatment, at least 16,000 people could have received detoxification services [5]. Despite this compelling data, the existing system encourages and reimburses bed care and underinvests in community based care management. The current opiate crisis and the fear it generates are driving this growth and while the system may suffer from a temporary dearth of capacity, the greatly underemphasized problem is the absence of substantial and comprehensive community based continuing care and the paucity of prevention, early identification and intervention efforts.

The Failed Addiction Paradigm

For more than forty years, addiction treatment has been defined and judged by this misplaced perception that a fixed amount or duration of treatment will "fix the problem". Services designed to reinforce that perception, namely "thirty days in rehab" have been the prevailing model of care. Patients and families have believed that a month in rehab will "take care of the problem".

If the patient regresses or relapses after leaving rehab, the view is that it's the patient's fault or that treatment doesn't work. The acute detox and rehab model is an integral element of the treatment paradigm, but it is not the template of care for treatment of a chronic condition. Relegating follow-up care, prevention and early intervention to the sidelines contradicts the standard treatment of chronic disease. Yet, in our field, these areas have been, for the most part, ignored. Patients are admitted and discharged from "programs" instead of being treated in a seamless array of services matched to the severity of their condition or need.

While service design has been stuck in a one size fits all mentality, so too have the treatment approaches. New ideas, innovative service delivery methods, alternative clinical interventions, and technological supports are not robustly developed, tested, and integrated. Save the pharmaceutical advances of the last ten years, little has changed in our clinical approaches and too little is known about the efficacy of those approaches. Virtually no screening or early intervention occurs in a physician's office. And the addiction field has not adequately reached out to the medical community to help them understand and address this illness.

The fragmentation and isolation of addiction treatment is reflected in the structures that house "programs". From inner city detox centers to boutique waterfront rehabs, facilities are single service sites, further reinforcing the perception that a fixed duration of care in that facility will be remedial. There are few "centers of excellence" that strive to integrate treatment, prevention, early intervention, research, and innovation.

The Chronic Care Vision

The highly functioning program of tomorrow must bring all these elements together--treatment, prevention, early intervention, research, and innovation. It is a program that delivers core services across the spectrum of care--Inpatient and outpatient detoxification, rehabilitation and extended treatment, day and evening programs, outpatient services, medication assisted treatment, and other clinical elements. But it also provides comprehensive follow-up care with personalized coaching and technological supports through Smartphones and tele-health. It is a service that links more closely to the mainstream of healthcare, invested in prevention, early intervention, and integration with hospitals and primary and specialty medical practices. And, it advances addiction treatment through innovation and research--measuring the efficacy of clinical interventions, participating in clinical trials to find better approaches to care, and conducting outcome studies that tell us how patients fare over the long term. The need is a vison for something so profoundly different and unique that it will change the way addiction care is delivered.

The New Paradigm

Science has taught us that addiction produces profound changes in brain neurochemistry. Applying this fact and chronic disease management thinking is central to policy and care system development. Treatment, prevention and management need to reside on a single continuum that eliminates the barrier of "program" thinking. We must no longer consider a patient "discharged" with its implied message that they are "finished" with treatment. Many of the components of the continuum must be integrated into the mainstream of healthcare. Patients with this disease and those at greatest risk to contract it must be served in a system that enables them to be cared for or identified at any point on the spectrum be it a hospital, a doctor's office, a clinic, or a specialty treatment center.

The essential elements in the new addiction paradigm include all of the currently available services--detox, rehab, long-term inpatient and outpatient counseling. But to improve long-term outcomes these services must be augmented with customized and specialized services that can dramatically change how addiction care is provided. The seven elements summarized below are built on the premise that addiction can and must be treated as a chronic condition. Prevention and management must incorporate features on a scale necessary to effect real change.

Integration with Primary & Specialty Medical Care

Clinicians working side by side with professionals in the physician's practice enable universal screening, early identification, and intervention. Integrated care helps normalize the highly stigmatized condition of addiction. It provides opportunities to identify high risk patients and initiate treatments, and educate lower risk patients to appropriate lifestyle modifications to minimize future problems. Behavioral interventions in the management of chronic conditions that have high co-morbidity rates with addiction (diabetes, depression, chronic pain, GI disorders, etc.) can also be effective in early identification. This shift to an integrated system will require a shift in resource allocation, workforce development, improved reimbursement mechanisms, and modifications in regulatory and licensing standards. Our organization has, for the past three years, developed the expertise and capacity to deliver services in medical offices and presently operate in primary care practices, an ob/gyn specialty practice, a pediatric office, and a community health center. Because the necessary skill set is considerably different than traditional counseling methods, staff retraining is mandatory. Our experience has demonstrated that not every clinician can adapt to the fast pace of a medical practice. Short visits, frequent interruptions, an educational perspective, and a shared responsibility for patients are a departure from the fifty minute private session with which most clinicians are comfortable.

Addiction Specialists in Hospitals to Manage Patients undergoing Alcohol Withdrawal

Anecdotal information indicates that as many as 25% of hospital admissions have an underlying alcohol use disorder. Untreated alcohol and/or drug abuse increases costs, length of stay, service utilization, and stress on the medical staff. Yet many hospitals pay little attention to the condition, in part because of lack of training and an uncertainty about how to have this conversation with the patient. Addiction specialists can help improve screening tools and methods, oversee the management of withdrawal, and train staff to be more compassionate and better prepared to treat these patients. A project we led at a local hospital resulted in reductions in ICU transfers (down 90%) and shortened lengths of stay (14.2 to 6.1) for patients admitted with a diagnosis related to alcohol misuse [6]. The cost savings from reduced utilization are significant. The requirements are a willing hospital, training and work place learning by a subject expert, and hospital management support. With expertise in hospital staff training, consultation, program development and implementation, an addiction program can help hospitals manage these challenging patients, improve patient outcomes, reduce lengths of stay and readmissions, and lower costs.

Extended Engagement Services with Recovery Care Management

The present system lacks the comprehensive community supports and extended engagement that can reduce readmissions and improve remission rates. Personalized recovery coaching, technology based interventions, family involvement, and recovery socialization can help patients manage the difficult period following hospitalization. Several organizations are pioneering the use of recovery coaches who work with patients upon discharge from rehabilitation programs to ensure compliance with continuing care plans, help them develop and practice recovery management skills, engage with them to re-establish family relationships, and connect them to community resources for employment, academic pursuits, and recovery based socialization. Our experience with over 300 patients has shown promising results with significant reductions in detox and hospital admissions, legal offenses, as well as increases in employment and treatment compliance. While sustained remission is the primary goal, recovery coaches also help patients gain access to medical care, pursue employment or academic ambitions, build family relationships, experience drug and alcohol free re-socialization and other life skills.

Family access to coaches helps relieve family members of anxiety and fear and provides practical approaches to deal with the stress of early recovery. Our experience over the last three years had demonstrated that this approach can significantly improve remission periods, reduce hospital admissions, lower legal offenses, and improve overall functioning.

Medication Assisted Treatment

The use of anti-craving medications offers hope that patients in early recovery can find relief from the incessant and often overwhelming cravings that pose the greatest risk to sustained remission. Barriers of authorization, cost, specialty pharmacy requirement, etc. are gradually being eliminated to enable patients to get these medications. Yet, sadly less than 60% of addiction providers offer any of these medications. Ideological extremes have limited adoption of this important pharmacotherapy supports. Particularly with opioid addiction, injectable Naltrexone (Vivitrol), Suboxone, and Methadone offer the best chance of sustained remission. Our experience with over 400 Gosnold patients has not been without its problems, but overall it is improving patient lives.

Technology Based Interventions and Tele-Health

Smartphone apps, on-line treatment, and other technologies can give patients "real time" support. Our three years of testing with a patient support app, that provides patients with ready access to support, video counseling, crisis response interventions, and other features designed to aid patients are promising. These approaches are not perfect, but they offer the promise of creating a "digital loop" that keeps patients connected to helping resources. Similarly, the use of tele-health, especially for psychiatric care program can improve access which presently is in short supply.

Prevention that Engages Schools, Parents, and the Community

Counselors in elementary, middle, and high schools help students manage behaviors thus making it more possible for them to achieve academic goals. Intervention at the elementary level enables early identification of at-risk kids. In the higher grades, school based clinicians work with troubled students and conduct activities that influence school culture. While the school may be the base from which prevention activities spring, they must be extended to the family and to the larger community through awareness forums, educational lectures, and support groups. The community culture can be changed through participatory events such as Drug Take Back days, pre-prom anti-drinking campaigns, clergy training seminars, conduct "Parents who Host, Lose the Most" sessions, sponsor Sticker Shock initiatives, "Guiding Good Choices" seminars, and engage in other prevention activities.

These ideas are intended to create greater enthusiasm for providers to develop systems of care and prevention that address addiction as a chronic disorder. We wouldn't think twice about this approach for other chronic diseases like diabetes or hypertension. Early identification, education about lifestyle modification, prevention, and long-term management are accepted standards of care with these conditions. So also it should be with addiction. It is only stigma, short-term thinking, poorly designed reimbursement systems, and limited vision that prevent us from developing a system of care that can really make a difference for suffering patients.

References

1. National Institute of Drug Abuse (2011) Trends and Statistics.
2. National Center on Addiction and Substance Abuse (2010).
3. Open Society Foundation (2010) Closing the Addiction Treatment Gap.
4. Massachusetts Department of Public Health MIS Data Report (2014).
5. Recommendations of the Governor's Opioid Working Group (2015) Massachusetts.
6. Improving Outcomes for Hospitalized Patients- A Gosnold-Falmouth Hospital Collaboration (2012).

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