

TREATMENT WORKGROUP REPORT TO SUBSTANCE ABUSE TASK FORCE

GAPS, BARRIERS, AND RECOMMENDATIONS

May 13, 2016

CONSORTIUM'S TREATMENT WORKGROUP GOALS, GAPS, RECOMMENDATIONS

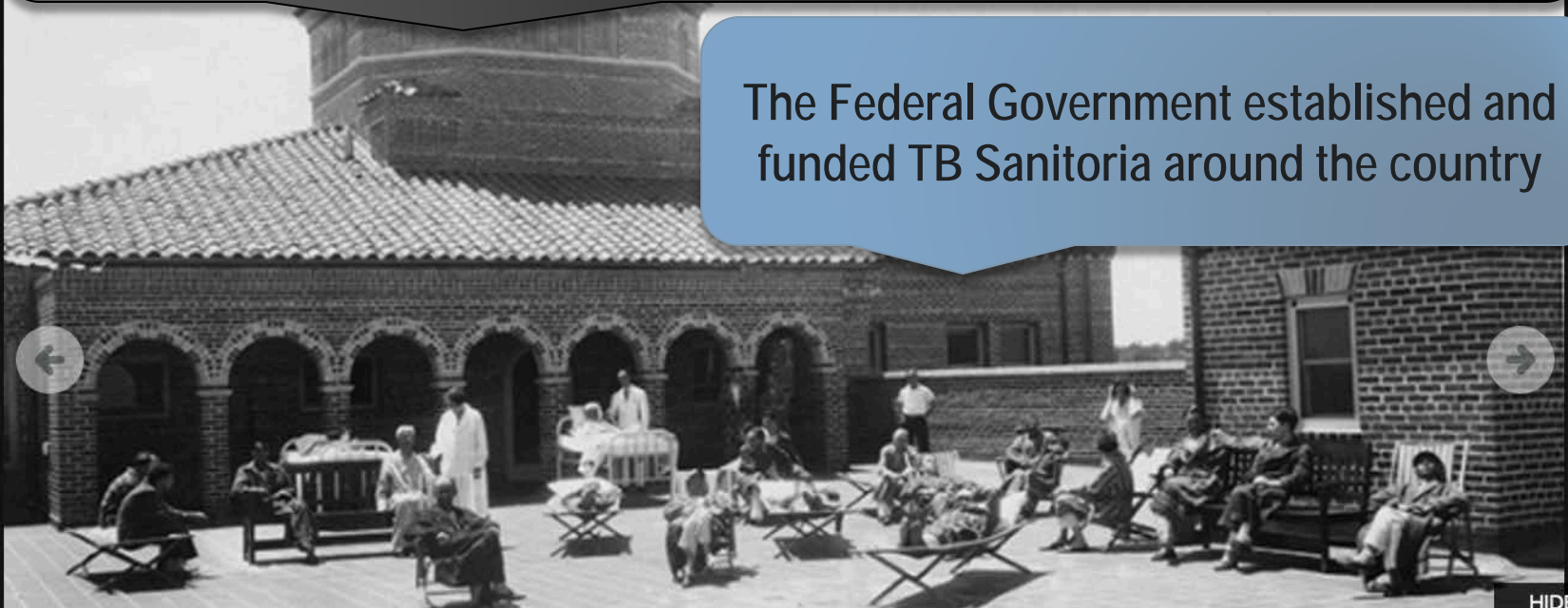
Main Goals

- Identify gaps and barriers that impede the effectiveness of existing treatment system to address the opioid epidemic in Colorado
 - Develop recommendations to overcome barriers and gaps
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Tuberculosis was the most common cause of death late 1800s- early 1900s

- Treatment of tuberculosis moved into mainstream medicine.
- Once identified as a medical disease, the stigma associated with TB rapidly dissipated

The Federal Government established and funded TB Sanatoria around the country



HIDE CAPTION

“ Instead of working to help them, the medical profession blamed the disease on immigrants being “exceedingly dirty”. Irish people were refused medical care Until Dr. Robert Koch discovery of Tubercule Bacillis 1882

Parallels Between Addiction Treatment and Tuberculosis Treatment In the 1940s



After TB treatment moved to its rightful medical home, former TB sanatoria became 'homes' for mental health and addiction treatment programs—funded by Federal Block Grants

Ample research has unequivocally established that addiction and most other psychiatric disorders are neurobiologically-based medical illnesses

Addiction is defined as a chronic relapsing **brain disease** that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a **brain disease** because drugs change the **brain** – they change its structure and how it works.



Treatment Workgroup recommends that these gaps be addressed in ways that are consistent with national health care reforms (ACA, 2010; Mental Health and Addiction Parity Act, 2008) calling for integration of behavioral health care into mainstream medical care. for integration of behavioral health care services into mainstream medical care and systems of care and which are aligned with ACA (2010) and the Mental Health and Addiction Parity Act (2008)

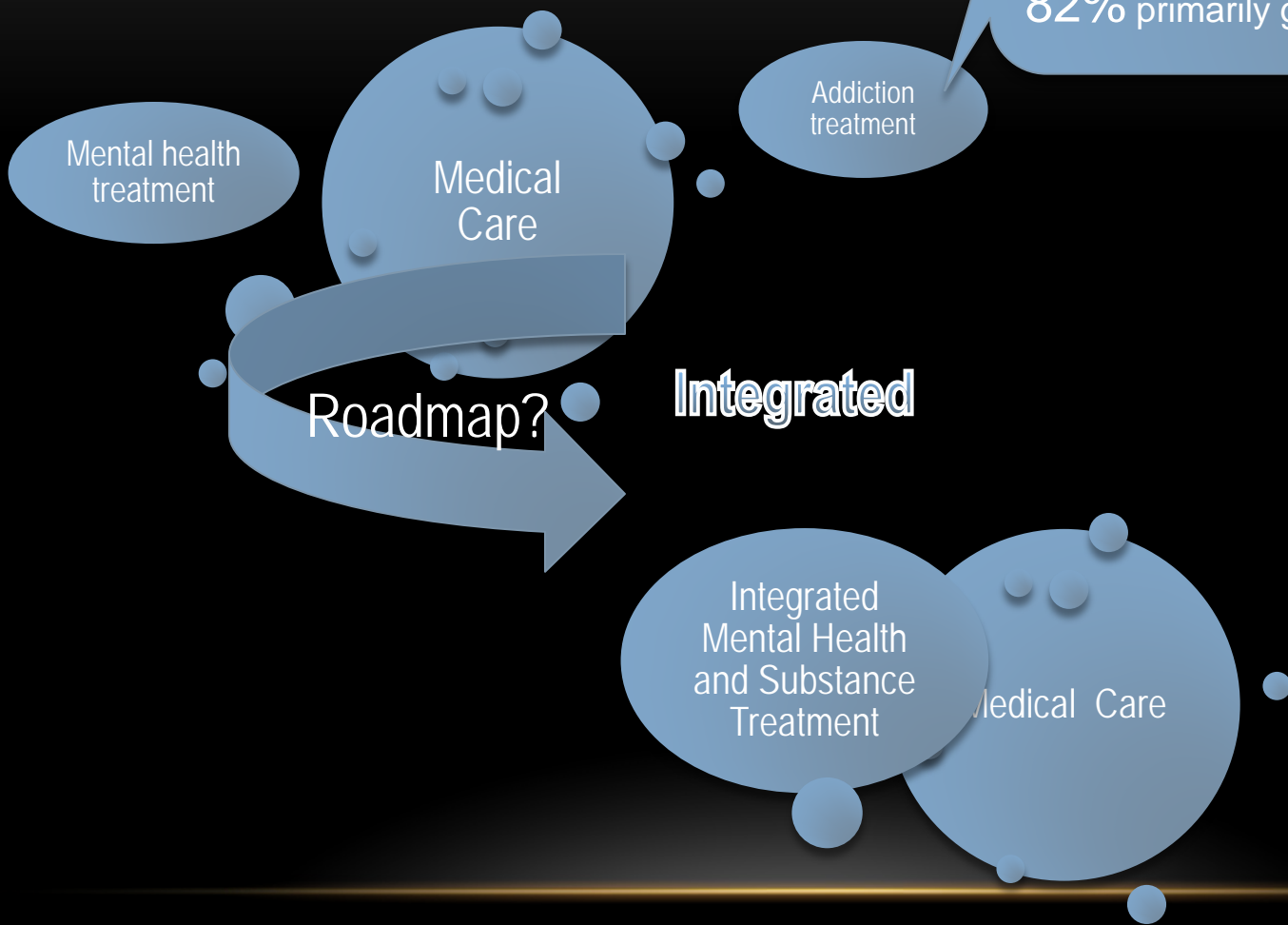
- Clinicians ~~usually~~ trained in mental health/addiction; pain management
- Buprenorphine licensed physicians
 - < 10 % of those licensed are at cap
 - <6% Medicaid patients.
- SBIRT--Screening Brief Intervention Referral Treatment (SBIRT)
- Poor treatment access (e.g no centralized ~~portal~~ or ~~patient~~ navigator)

**Affordable Care Act (ACA) 2010
Mental Health and Addiction Parity Act (MHAPA) 2008
Have Paved the Way**

- SAMHSA and the Centers for Medicare & Medicaid Services (CMS) have issued the “final rule” on mental health and substance use disorder parity for Medicaid and CHIP.
- This rule implements the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) for 23 million beneficiaries enrolled in Medicaid managed care organizations (MCOs), Medicaid alternative benefit plans (ABPs), and the Children's Health Insurance Program (CHIP), ensuring that benefits for mental health and substance use disorder treatments and services are offered on equal footing with medical and surgical benefits.

EXISTING FRAGMENTED SYSTEMS OF CARE ARE NOT FIXABLE OR SUSTAINABLE

13,600 specialty programs in US
50% have NO physician
38% have NO nurse, SW or psychol.
Counseling is the major profession
82% primarily government funded



2010 Medicaid Benefit

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

SUD

- Detoxification – 100%
- Ambulatory – **80%**
- Opioid Substitution Therapy – 50%
- Urine Drug Screen – 100%
 - 7 per year

2017 Medicaid Benefit

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

SUD

- 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%

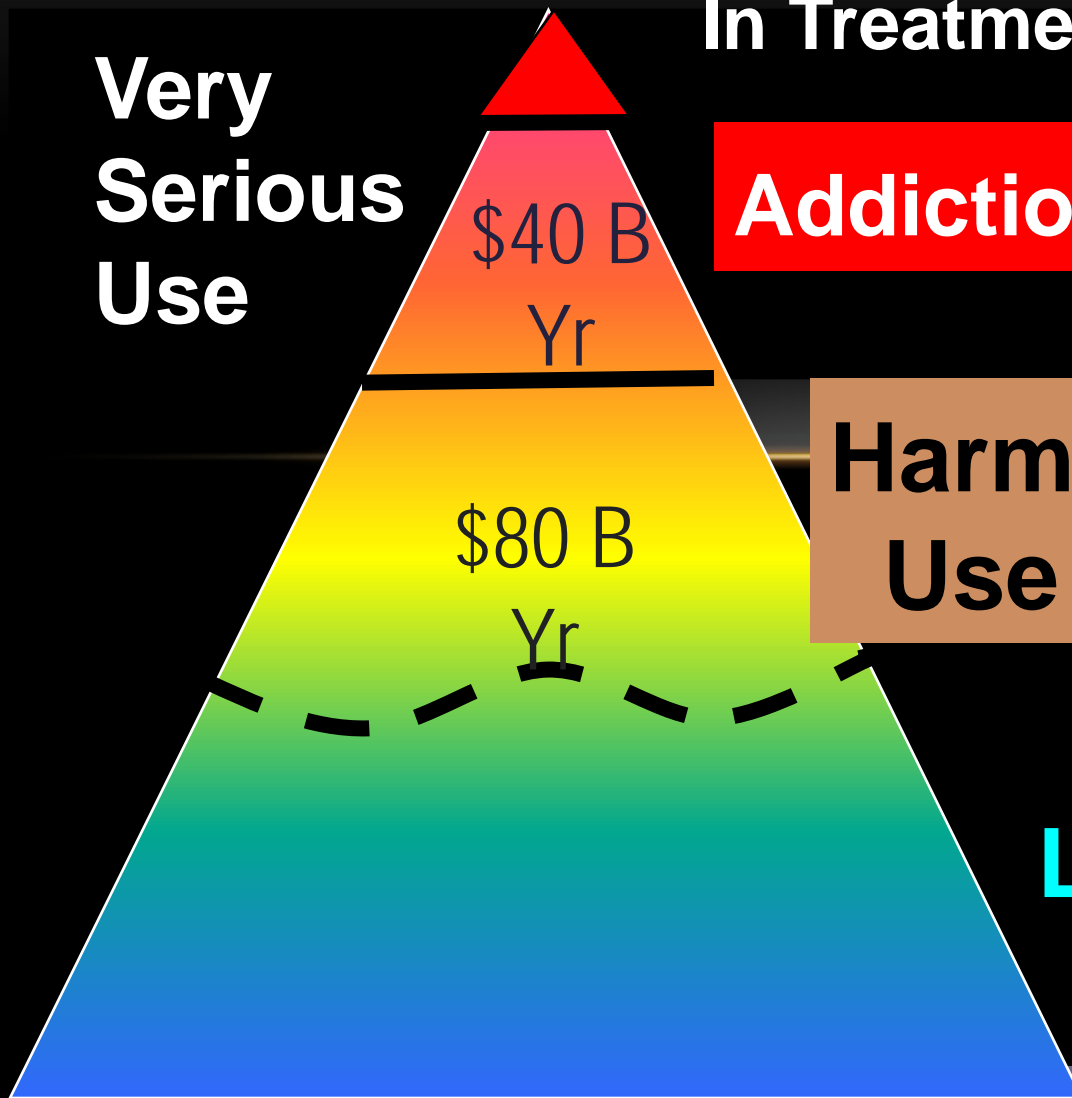
SUBSTANCE USE PREVALENCE

In Treatment ~ **2,300,000**

Addiction ~ 23,000,000

Harmful – 40,000,000 Use

Little or No Use

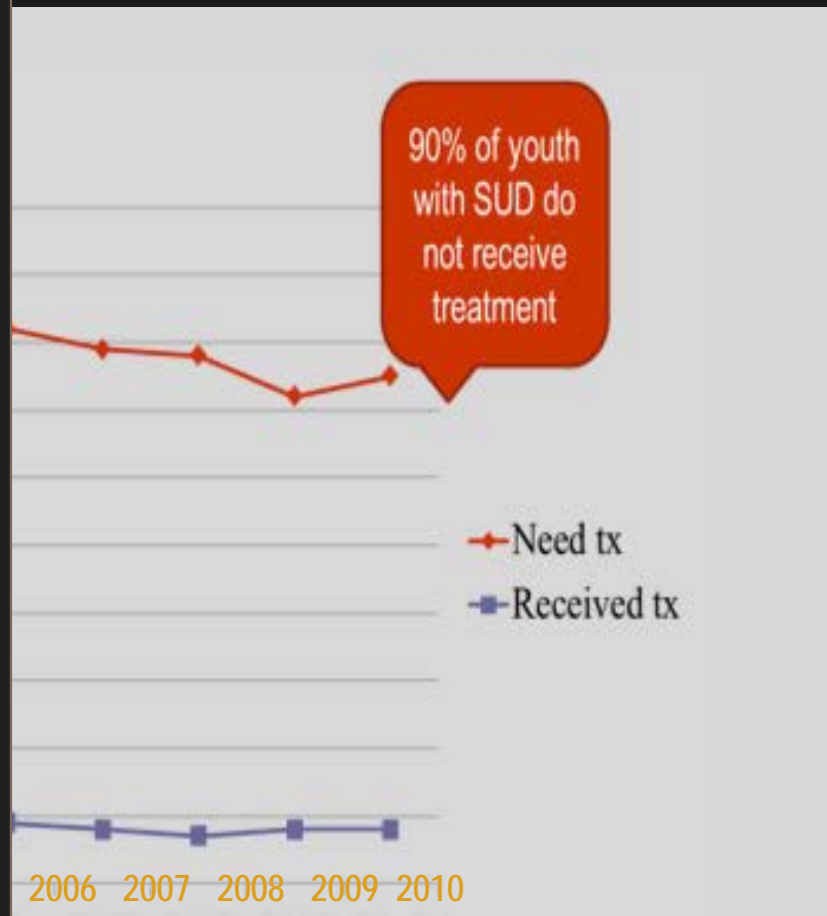


THE GAP BETWEEN TREATMENT NEED, AND TREATMENT RECEIVED

An estimated 10-15% of high school students meet criteria for a substance use disorder

Treatment options are extremely limited for youth who are not (yet) involved with juvenile justice

80% of young adult IV heroin users report that they started with non-medical use of Rx opiates during adolescence while still in high school. Nearly 10% of HS students are using MJ at levels associated with 6-8 point reduction in adult IQ

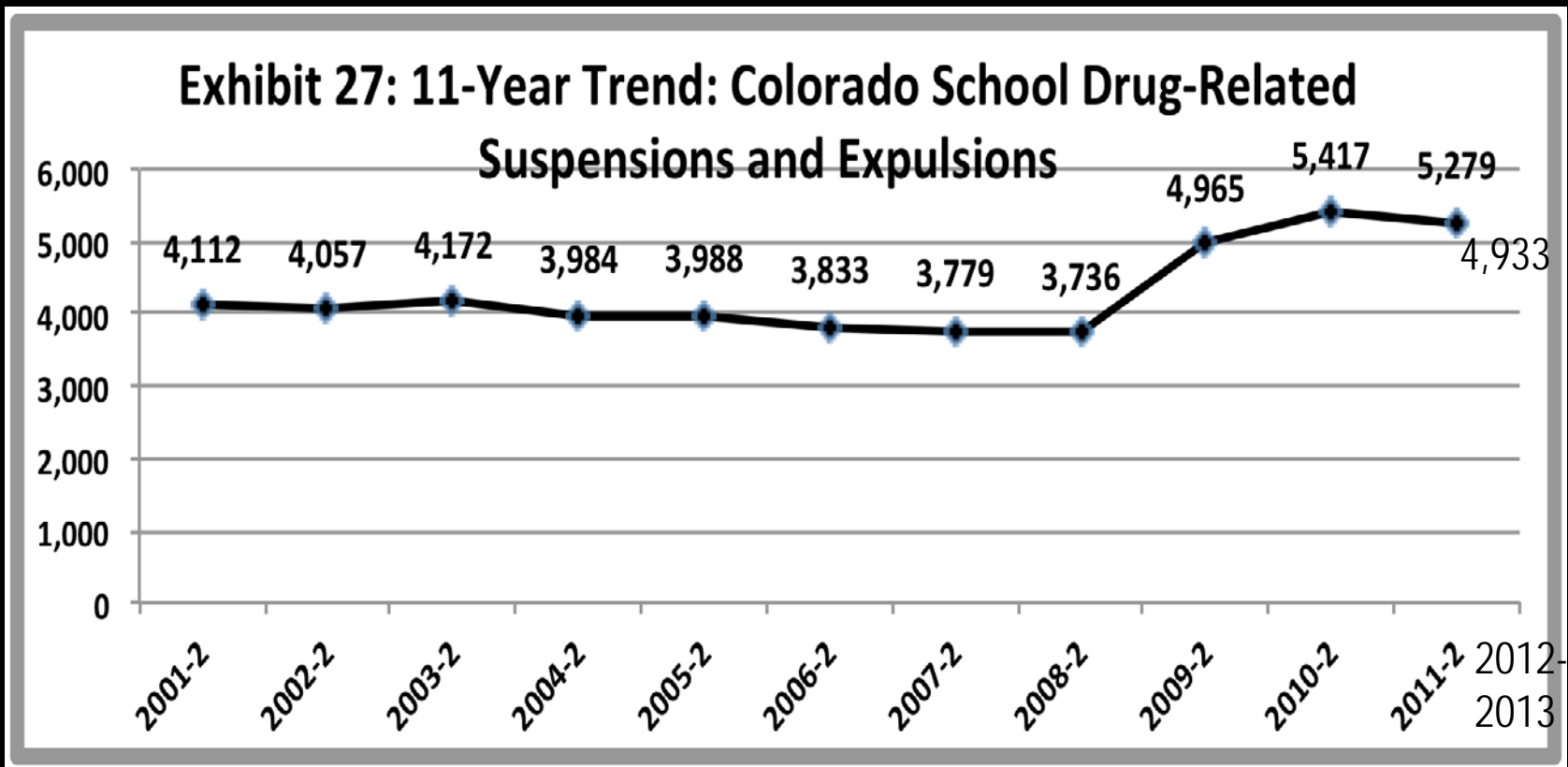


COLORADO

Since 2009 : 32% increase in drug-related suspensions and expulsions

2012-2013---33% of all school expulsions related to MJ violations

72.5% are HS 9-12



Very
Serious
Use

In Treatment ~ 2,300,000

Treatment

ation ~ 23,000,000

Benefit

**Early
Intervention**

armful – 40,000,000

Use”

Prevention

ittle or No Use

Lit
Use

stigma

What's holding us back

What can we do to accelerate integration?

- 1) Progress towards development of integrated treatment models impeded by excluding addiction treatment from Colorado SIMS grant
- 2) School-based health clinics will implement eSHQ next fall but co-located behavioral health clinicians lack training in substance assessment and treatment
- 3) Enormous increase in federal resources and funding for MAT/treatment expansion for more severe spectrum but few resources targeting earlier intervention/ treatment for adolescents

As medical illness training in addiction /chronic pain management will be integral to medical student/ resident/physician education will include training in addiction pain management in medical student, resident education /mental

If you want more physicians to prescribe MAT go where physicians are

SBIRT works w/ medical subspecialty consultation model

Informed implementation
Mental Health Addiction Parity
Medicaid feedback/consultation

School-based health clinics
universal screening /co-located
dually trained clinicians

WORKGROUP RECOMMENDATIONS

#1. The Treatment Workgroup's over-arching and primary recommendation is to address the identified gaps in existing substance treatment services (*ie critical shortage of adolescent and adult substance treatment including MAT and psychosocial treatment for individuals with opioid use disorders and chronic pain*) in a manner aligned with national health care reforms (ACA, 2010; Mental Health and Addiction Parity Act, 2008) calling for full integration of behavioral health care (*mental health and addiction treatment*) into the mainstream medical healthcare system.

WORKGROUP RECOMMENDATIONS

#2 INTEGRATED CARE

A. OBH, HCPF, CDPHE, recovery support programs, and other relevant entities should collaborate with FOHCs, AHEC, and other primary care medical entities in grants, proposals, and plans for treatment expansion (including MAT) to align with health care reforms and facilitate sustainability.

B. Demonstration Models of Integrated Care

The omission of substance treatment from Colorado SIMS grant has impeded progress towards i) the integration of mental health and addiction treatment (integrated behavioral health care) AND ii) the integration of behavioral health care into the medical healthcare system. There is an urgent need to develop functionally adaptable and sustainable translational models of integrated care as demonstrated by rigorous outcomes assessment to accelerate the pace of integrating behavioral health care into mainstream medical care.

Development of integrated care models could be further accelerated by leveraging and expanding existing integrated care models (listed below), all of which provide a continuum of care for patients with chronic pain and opioid use disorders including MAT

- Sheridan Health Clinic
- University Hospital-CeDAR model
- Children's Hospital—Child Adolescent Psychiatry/Adolescent Medicine/Division of Substance Dependence---mental health substance treatment integrated with primary medical care
- School-Based Health Clinics. Colorado has made significant progress in co-locating licensed mental health clinicians in school-based health clinics. School-based drug/alcohol screening will be enhanced starting in the fall 2016 (CDPHE grant). Currently < 1% of licensed behavioral health specialists co-located in school-based health clinics are trained in substance evaluation and treatment. The workgroup strongly recommends that behavioral health specialists co-located in school based health clinics receive adequate clinical training in evidence-based substance evaluation and treatment to build clinical competency for students referred for problematic substance use. This would significantly increase access and availability of integrated behavioral health treatment services for Colorado's youth and families. This would also provide earlier intervention for youth with problematic substance use and address the critical shortage (90% treatment gap) of substance treatment services for the estimated 10-15% of high school students who currently meet diagnostic criteria for cannabis and other substance use disorders including opioid use disorders (ie. 80% of young adult injection heroin users report initiating with Rx opioid medication abuse as adolescents).

WORKGROUP RECOMMENDATIONS

3. PROJECTS /PROPOSALS TO EXPAND MAT ACCESS/AVAILABILITY by enhancing/augmenting existing substance treatment services*

- PAARI pilot projects to be introduced/discussed by Jose Esquivel and others