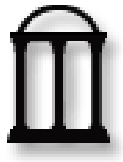
Involvement of physicians in community treatment programs: Structural barriers and implications for the use of pharmacotherapies

Lori J. Ducharme, Ph.D.
University of Georgia



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From research to practice

- Health services research on the "evidence-based practice" movement in addiction treatment
  - EBPs include pharmacotherapies, behavioral therapies, counseling approaches, and wraparound services
    - e.g., NIDA's *Principles of Drug Abuse Treatment*
  - Organization, management, financing, and human resource issues influencing service delivery
- Barriers to diffusion of EBPs
  - Program/clinician philosophy ("staff resistance")
  - Financial constraints (billable services, client ability to pay)
  - Training & education of staff
  - Access to medical infrastructure (critical for pharmacotherapies)
    - Availability of physicians and prescribing staff

Research platform

- Continuation of ongoing studies examining diffusion, adoption & implementation of EBPs in specialty addiction treatment settings
  - Not examining primary care or office-based practice settings
- National data (SAMHSA) unable to explore beyond simple percentages of adopters
  - No data on program infrastructure that may explain adoption
- Collected detailed data from private sector treatment providers to examine correlates of adoption and barriers to use of pharmacotherapies
  - Availability of prescribing staff & prescribing patterns

Study description

- Ongoing NIDA-funded study of private-sector, specialty addiction treatment programs
  - Nationally representative sample drawn from SSA directories, yellow pages, and association membership lists
  - Community-based programs offering at least ASAM Level I outpatient treatment.
    - Excludes private practice, correctional facilities, VA settings, methadone-only, detox-only
  - Programs receive less than 50% of annual operating revenues from SAPT block grants & other public grant/contract sources
    - Sample averages 18% of revenues from such sources
  - On-site, face-to-face interviews conducted with administrator and clinical director of each sampled program
  - N=225 completed to date (target N=350 by summer ‘08)

Characteristics of sampled programs

	Mean or % (N=225)
For profit	29.3%
Hospital-based	36.9%
Accredited (JCAHO or CARF)	64.4%
OP only	32.4%
Dual diagnosis-enhanced	24%
Dual diagnosis-capable	54%
% Master's counselors	53.1 (0-100, sd=34.1)
Annual admissions (mean)	969 (9-6000, sd=1216)
% alcohol-dependent clients	68.3
% opioid-dependent clients	38.1
% private insurance clients	35.6
% public pay clients	36.9

Characteristics of Prescribing Staff

- Of N=225 treatment programs...
  - 66.7% have rx staff who prescribe addiction meds
  - 16.9% have rx staff but do not prescribe addiction meds
  - 16.4% do not have access to rx staff
- Of those with any prescribing staff...
  - 56.4% have Rx staff on payroll (regular employees)
  - 27.2% retain Rx staff on contract
  - 16.4% have formal referral processes in place
- Of those with any prescribing staff...
  - 26.6% have one or more MD physicians
  - 13.8% have one or more addiction psychiatrists
  - 58% have at least one physician and at least one psychiatrist
  - 1.6% have a nurse with prescribing privileges

Barriers to hiring/retaining Rx staff

- 16.4% of programs have no access to Rx staff. Why not?
  - Percent "strongly agree" to the following statements:
    - 61% said "we have adequate referral relationships"
    - 39% said "lack of resources to hire/retain medical staff"
    - 25% said "Rx meds are inconsistent with our tx philosophy"
    - 16% said "center is not licensed to provide medical services"
    - 8% said "lack of evidence that meds are more effective"
- If you had an MD on staff, how likely would you be to use addiction meds in treatment?
  - 50% said "very likely"
  - 23.5% neutral
  - 26.5% said "not at all likely"

Characteristics of programs having Rx staff

	Odds ratio
For profit	.476
Hospital-based	2.91
Accredited	9.74
Dual diagnosis-enhanced	4.33
Outpatient only	.165
Past year admissions	1.001 [+237% per additional SD]
Master's level counselors	n.s.
% private insured clients	n.s.
% public pay clients	1.014 [+60.5% per additional SD]
% alcohol dependent clients	.976 [-41.8% per additional SD]
% opioid dependent clients	1.027 [+104% per additional SD]

Binary logistic regressions, N=225 treatment programs

Barriers to the use of Rx meds

- 21.9% of centers with MDs do not prescribe addiction meds. Why not?
  - Percent "strongly agree" to the following statements:
    - 54% said state regulations prohibit the use of addiction/Rx meds
    - 31% said meds are inconsistent with program's tx philosophy
    - 26% cited reimbursement issues (for meds or docs)
    - 23% said there were "better tx alternatives" available
    - 21% said addiction meds just substitute one drug for another
    - 15% cited staff resistance to the use of addiction meds
    - 13% said they have inadequate information about using meds
    - 10% cited lack of clinical evidence supporting addiction meds

Addiction meds as “technology clusters”

- Current usage in N=147 prescribing programs (not mutually exclusive):
  - 97% prescribe psych meds
    - SSRIs, other antidepressants, antipsychotics
  - 77% prescribe opioid meds
    - methadone, buprenorphine (Subutex or Bup/nx), tablet naltrexone
  - 78% prescribe alcohol meds
    - disulfiram, tablet naltrexone, acamprosate, Vivitrol (injectable naltrexone)
- Only 9.5% prescribe exclusively psych meds
- Only 1.4% prescribe exclusively opioid meds (bup)
- None prescribe exclusively alcohol meds

Current use: Detailed meds list

- Of the N=147 programs prescribing any addiction meds:
  - Psych meds:
    - 95.2% SSRIs
    - 88.4% other antidepressants
    - 86.4% antipsychotics
  - Alcohol meds:
    - 55.1% acamprosate
    - 46.9% tablet naltrexone
    - 42.2% disulfiram
    - 27.2% Vivitrol
  - Opioid meds:
    - 60.5% buprenorphine
    - 30.6% tablet naltrexone
    - 26.5% methadone

Characteristics of programs prescribing meds

	Odds ratio
For profit	n.s.
Hospital-based	n.s.
Accredited	4.09
Dual diagnosis-enhanced	3.38
Outpatient only	.29
Past year admissions	1.001 [+237% per additional SD]
Master's level counselors	1.015 [+66.8% per additional SD]
% private insured clients	n.s.
% public pay clients	n.s.
% alcohol dependent clients	n.s.
% opioid dependent clients	1.015 [+50.9% per additional SD]

Binary logistic regressions, N=188 treatment programs

A note on prescribing frequency

- Rates of prescribing within programs are notably low, especially for alcohol pharmacotherapies.
- What percent of clients with [condition] are currently receiving [medication]?
  - Psych meds:
    - 69.6% of clients with co-occurring psych conditions receive meds
  - Opioid dependence:
    - 34% of clients receive methadone (maintenance)
    - 36% of clients receive buprenorphine (maintenance)
    - 11% of clients receive tablet naltrexone
  - Alcohol dependence (avg 67% of clients are alcohol dependent):
    - 12% of clients receive naltrexone
    - Sample mean (n)= 6 clients on acamprosate, 3 on disulfiram
    - Sample mean (n)= 7 clients ever received at least 1 Vivitrol injection

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Summary & Conclusions

- These data are based entirely on private sector; trends in public sector treatment settings are markedly different
  - Much less access to physicians overall
  - Greater reliance on contingent staff / referrals
  - Much lower use of pharmacotherapies
  - More structural barriers ($, state regs, reimbursement)
- Still, private sector is not isomorphic with respect to either physician availability or prescribing behavior
- Low rates of implementation of opioid and especially alcohol pharmacotherapies
  - Suggests differential medicalization of psychiatric conditions, opioid dependence, and alcohol dependence
- Closer look at structural barriers appears warranted

For more information...

National Treatment Center Study information and publications may be accessed at:

www.uga.edu/NTCS