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The Role of Addiction Medicine in the Transformation of an Urban Behavioral Health Care System

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Abstract

Considerable effort is under way at national, state and local levels to transform addiction treatment and the larger behavioral health care arena into "recovery-oriented systems of care." The emphasis on complex, multi-organization service integration processes, new service roles, and new service delivery sites can obscure the crucial role addiction medicine specialists should play and are playing in such system transformation processes. This article draws from our experiences within the Philadelphia behavioral health system to discuss that role.

I. Introduction

There is a long and distinguished history of addiction medicine in the United States. Physicians have played a leadership role in addiction-related policy reform and clinical innovation since the late eighteenth century writings of Dr. Benjamin Rush, advocacy for the creation of inebriate asylums (1830s-1860s), and the subsequent organization of the American Association for the Study and Cure of Inebriety (1870). Physicians have continued such efforts through the twentieth century, particularly through the efforts of such groups as the American Medical Association's Subcommittee on Alcoholism, the American Society of Addiction Medicine (ASAM), and the American Academy of Addiction Psychiatry (AAPAA) (White, 1998; White, in press).

During the modern coming of age of addiction treatment (1970present), physicians have played important roles in drug policy leadership within the White House and at the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the Center for Substance Abuse Treatment (CSAT). Physicians have also led the call for greater neurobiological research on addiction, pioneered improved detoxification protocol, and advocated the use of new pharmacological adjuncts in the treatment and long-term management of addiction.

At a national level, addiction medicine specialists are part of two historical shifts. The first is the emergence of *recovery* as an organizing concept for the design and delivery

of addiction treatment and other behavioral health services (White, 2005). The second is a related call to extend addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (McLellan, Lewis, O'Brien & Kleber, 2000). These twin shifts have sparked:

- Growing interest in recovery research at NIAAA and NIDA,
- New recovery-focused federal services initiatives, e.g., the White House initiated Acces to Recovery Program and CSAT's Recovery Community Services Program.
- State and local recovery-oriented systems transformation efforts
    - (Boyle, 2007, Evans, 2007, Kirk, 2007)
- Private foundation initiatives, e.g., Robert Wood Johnson
    - Foundation's Advancing Recovery initiative, the Betty Ford Institute's consensus conferences on defining recovery and posttreatment recovery support services.

In 2004, the City of Philadelphia launched a major recovery-focused transformation of its behavioral health care system. Table 1 presents several distinguishing elements of what is emerging as the "Philadelphia Model" of behavioral health systems transformation. It can be seen from Table 1 that systems transformation involves fundamental changes in service philosophies and service practices.

Table 1: Creating a Recovery-oriented System of Care: The Philadelphia Model

System Dimension	**Philadelphia Model**
Recovery Vision	Resources are allocated to support the recovery vision (wellness, wholeness, quality and meaningfulness of life) for individuals, families and neighborhoods. All policy-makers and clinical decision-makers undergo ongoing, recovery-focused training and supervision.
Varieties of Recovery Experience	Service planners and providers acknowledge the legitimacy of multiple pathways and styles of long-term recovery from behavioral health disorders and promote a philosophy of choice within their service relationships.
Systems Level Recovery Management	Behavioral health care is managed by a publicly-owned entity responsible for the effective stewardship of public behavioral health care dollars and the strategic allocation of resources to support the long-term recovery of individuals and families whose lives have been disrupted by behavioral health disorders.
Behavioral Health Care Integration	Recovery is used as a conceptual bridge for the increased integration of professionally-directed mental health services, professionally-directed addiction treatment services, peer-based recovery support services and primary health care.

Systems Integration	Federal, state, county and municipal resources are coordinated to generate increased resources, strategically allocate resources and provide regulatory relief.
Service Accessibility	Service entry is accessible, efficient, warmly welcoming and respectful: all system elements are devoted to the goal of rapid and gracious service engagement.
Global Assessment	Assessment is comprehensive, strengths-based, continual, family-inclusive, and encompasses assessment of each client's recovery environment.
Service Quality and Responsiveness	Services are developmentally appropriate, genderspecific, culturally competent, trauma-informed, familyfocused and evidence-based.
Indigenous Resources	Services at all levels of care include assertive linkage to indigenous communities of recovery (recovery support groups) and recovery community service institutions (recovery community centers, recovery homes, recovery ministries, recovery advocacy organizations).
Continuity of Support	All primary treatment services are followed by post-treatment monitoring and support, stage-appropriate recovery education, active recovery coaching and, when needed, early re-intervention.
Systems Performance Monitoring and Evaluation	Recovery-focused systems performance data and the ongoing guidance of key stakeholders are used to guide the continued systems transformation process.
Systems Health:	The ability of a behavioral health care system to enhance the health of those it serves is only as good as the health of service providers and the service infrastructure. Active efforts are made to enhance the health and performance of service providers and service organizations.

Table 2 summarizes some of the key ideas that guided facilitation of this process of system-wide change.

Table 2: Philadelphia System Transformation Implementation Principles/Strategies

1. Partnership Model: Relationships within the system—from service relationships to institutional relationships—shift from authority-based to respect-based and emphasize stakeholder representation, participation, collaboration and multi-directional communication. 2. New Ideas, New Language, New Technologies: Systems transformation is driven by a set of kinetic (change-eliciting) ideas, a new language and new planning and service technologies that are all recovery-focused. 3. Core Values: Decisions are based on the values of hope; choice; empowerment; peer culture, support, and leadership; partnership;

community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach.

4. Openness and Transparency: Decisions at all levels of the system—from clinical decisions to policy and funding decisions--are transparent and consistent with previously defined values, policies and plans.

5. Planned Synergism: Multiple, staged initiatives are used to complement one another for dramatically magnified effects.

6. Minimalism: Existed structures are used or renewed when possible; the goal is the minimal level of organization needed to achieve a task; wide use of short-term ad hoc groups to study, decide, design, create and disband; preference for use of local expertise.

7. Management of Resistance: Resistance to change at all levels is viewed as normal and is actively managed.

8. Change Facilitation: System transformation is facilitated by training, process consultation and technical assistance at all levels of the service delivery system.

As these tables illustrate, the behavioral health systems transformation process in Philadelphia is one of aligning system policies and relationships, aligning organizing concepts, and aligning service practices and service policies to support the process of long-term recovery. The history, goals and strategies of this process have been described in earlier publications (Evans & Beigel, 2006; Evans 2007; DBH/MRS 2007a; DBH/MRS/2007b; White, 2007). The purpose of this article is to describe the evolving and anticipated roles of addiction medicine in this ongoing recovery-focused system transformation process.

Physician Leadership and Systems Transformation

Physicians occupy key roles in the Philadelphia behavioral healthcare system and in the systems transformation process that is underway. The Medical Director of the Department serves as the lead physician for all the components of the system and as the medical director for mental retardation services. The Associate Medical Director for children and youth oversees activities related to that population throughout the behavioral health components in the system. The managed care component (CBH) has a Chief Medical Officer who has oversight of all clinical activities in that component. Three adult psychiatrists, three child psychiatrists, and three doctoral level psychologists serve as final reviewers for clinical case work in the managed care component.

Physician involvement in systems transformation is based on seven key principles.

1. *Physician leaders can play a critical role as systems transformation advocates and leaders, particularly in elevating and managing quality of care.* Conscious efforts have been made to involve physicians in the systems transformation process as leaders, policy advisers and as role models of recovery-oriented clinical practice. Physicians have also played important roles in program monitoring, training and technical assistance through the transformation process. The Medical Director for the Department has been responsible for establishing an education track in recover for the physicians both within the DBH/MRS and for the psychiatric community at large. The Chief Medical Officer and the physician advisors and psychologists at CBH have played leadership roles in advancing evidence based practice, program monitoring, quality management, and training for the Department and the provider community.

2. *Physician leaders have the responsibility of assuring that quality of direct care is maintained and elevated and that resources are effectively allocated through the systems transformation process*. Leaders in the Philadelphia transformation process emphasized that quality and effective stewardship of resources is even more critical during times of tightening

financial resources. Community Behavioral Health manages care for its membership with an emphasis on the quality of care and ensuring that the membership receives the care that is indicated. 24/7 levels of care and Behavioral Health Rehabilitation Services for children are actively managed. Other outpatient care is not managed. Care managers are Master's prepared individuals who conduct both precertification and concurrent review of care. Some cases require physician/psychologist review and these terminally degreed individuals are available 24/7 for consultation.

3. *Physicians can offer needed expertise on applying principles and techniques of chronic disease management to the addiction treatment context.* Physicians within the Philadelphia behavioral healthcare system have helped shift the focus from intensity of care to extensity of care, legitimize the concepts of "partial recovery" and "medication-assisted recovery" and have offered valuable consultation to clinical directors and frontline clinicians on how to transition from an acute care model of addiction treatment to a model of sustained recovery management.

4. *Physicians are crucial to efforts to build integrated, recoveryfocused treatment systems for co-occurring medical, psychiatric and substance use disorders*. In Philadelphia, physicians have advocated more holistic and continuing client assessment processes, the development of specialized programs for co-occurring psychiatric and substance use disorders, and the treatment of primary medical/health problems within addiction treatment settings or through assertive linkages to primary health care resources.

5. *Physician leaders can play an influential role in wrapping existing and new pharmacotherapies within a larger and more sustained rubric of recovery support services*. That has been achieved by:

- Facilitating the movement of new addiction pharmacotherapies from the arena of clinical research to widespread clinical practice via informal collegial exchanges and formal teaching and consulting related to the role of pharmacological adjuncts in recovery initiation and recovery maintenance,
- Advocating a recovery-focused model of medication-assisted treatment, and
- Conducting regularly meetings with medication-assisted treatment providers to discuss quality of care issues.

6. *Physician leaders need to be intimately involved in discussions of how to move from decision-making models of behavioral health care management that focus solely on managing episodes of care or managing dollars to models that promote assertive management of addiction and recovery careers*. The goals are to escape prolonged patterns of recycling through serial episodes of acute stabilization and to achieve active management of the long-term recovery process. Physicians can offer valuable clinical expertise related to level of care placement, length of stay decisions and appropriate use of service combinations and sequences. The managed care process can be used to transition the focus of providers from on the assertive management or addiction and recovery careers. This process can be enhanced by the development of recovery-focused protocol to guide the decision-making of clinical case managers

7. *An essential component of systems aimed at long-term recovery management is promoting addiction medicine as a legitimate and fulfilling medical specialty*. Toward that end, we are encouraging physician involvement in the promotion of addiction medicine via recruitment, teaching, and mentoring activities. ASAM certified physicians within the DBH/MRS and in the provider community have participated in training the fellows in the University of Pennsylvania's Community psychiatry fellowship.

System Transformation Leadership Strategies

In reflecting on our experience with the systems transformation process in Philadelphia, the authors would recommend eight strategies to physicians who wish to play a leadership role in recovery-focused behavioral health systems transformation efforts.

1. Build a foundation of personal/institutional credibility based on fairness, reasonableness, consistency of communication, assertive problem solving, availability, candor and humor. That credibility will be essential for negotiating the multiple partnerships involved in successful systems transformation.
2. Link recovery-focused systems transformation efforts to aspirational values that have long-permeated primary medicine and addiction medicine (for latter, see White, 2008b). We have linked the systems transformation process to high standards of medical and psychiatric practice and as a way for physicians to actualize the early visions he or she hoped to be able to have in the lives of individuals and families.
3. Demystify basic recovery concepts by linking these concepts to existing medical/psychiatric concepts and to physicians' own struggles and life experiences.
4. Develop a recovery education strategy specifically for physicians. Such a strategy should include physicians in system-wide training events and provide training developed exclusively for physicians. The latter should education physicians on the stages and styles of long-term recovery, the empirical evidence supporting models of sustained recovery management, and the changes implicit in the practice of recovery-focused addiction medicine (White, 2008a).
5. Communicate and process the stages of system transformation through regularly scheduled meetings with physicians and other health care providers working at multiple levels within the system. Create time in these meetings for questions and commentary on the progress of systems transformation. Systems transformation is stressful for all involved and is best managed within a supportive environment characterized by transparency and openness of communication.
6. Use local and outside experts to build credibility for system transformation. Bring in leaders in addiction medicine and addiction psychiatry who will both respect and educate the local medical community. Physicians have been under siege from multiple quarters and have witnessed their authority and sphere of practice shrinking. It must be emphasized that recovery-focused systems transformation is not another step in the demedicalization of addiction treatment and that physicians are key to the success of such transformation efforts. Support for transformation efforts increases when physicians can be given tangible tools through which they can integrate a recovery orientation within their service practices.
7. Conduct outreach (site visits) to local service providers with focus on engaging and involving key institutions and institutional leaders in the transformation process. We have found individual meetings with clinical directors to discuss recovery philosophy and to review clinical charts for recovery practices to be very helpful.
8. Provide feedback to physicians on those who do not return and who achieve significant progress or full recovery. Physicians see those who repeatedly re-enter treatment, but often do not see those who achieve successful long-term recovery. We found it very helpful to create opportunities for physicians to witness long-term personal and family recovery, e.g., participating in recovery celebration events and recovery conferences.

Addiction Medicine and the Future of Addiction Treatment

We anticipate an increased pace of system transformation efforts in the United States led by state, regional and local behavioral healthcare authorities and supported by grassroots recovery advocacy organizations. Such system transformation efforts will exert a significant influence on the practice of primary medicine and addiction medicine. Primary care physicians will be increasingly called upon to screen their patients for alcohol and other drug (AOD) problems, conduct brief interventions to resolve such problems, assertively link more serious

AOD problems to addiction treatment specialists, and provide recovery check-ups as a routine part of the care of patients with a history of AOD problems. Addiction medicine specialists are playing a critical role in training primary care physicians to perform these screening, brief intervention, and monitoring functions. As primary care physicians become more involved in mild to moderate AOD problems, the addiction medicine specialists are developing greater expertise in the long-term monitoring and support of individuals and families experiencing AOD problems of great severity and complexity. Both primary care physicians and addiction medicine specialists are playing increasingly important roles in local behavioral health transformation efforts. We expect that influence to increase in the coming years.

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