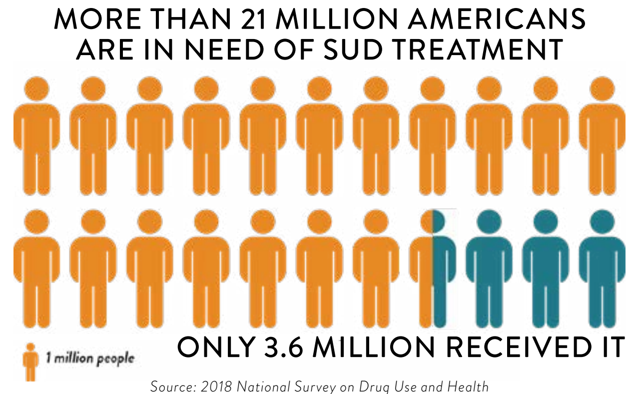
SCALING TREATMENT CAPACITY THROUGH TEAM BASED CARE

groups
recover together

A solution to meet demand for SUD treatment against a national workforce shortage

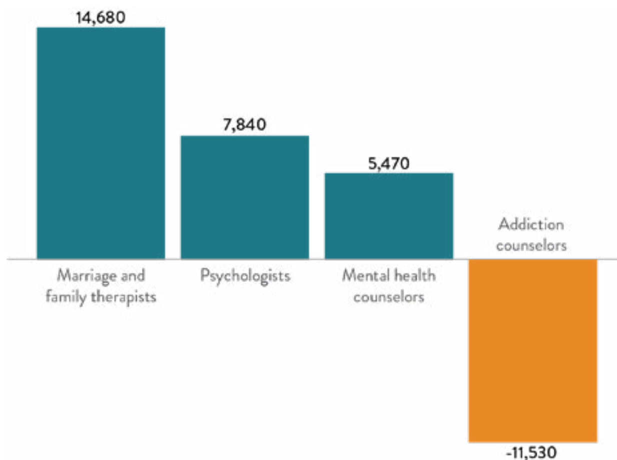
BY: COURTNEY DEWOLFE | NOVEMBER 2021

Deaths from drug overdose have reached the highest point in recorded history, and the majority can be attributed to opioids[1]. This ongoing public health crisis has received increased attention during the last decade, but very few people are actually receiving treatment. According to the 2018 National Survey on Drug Use and Health, 21.2 million Americans needed Substance Use Disorder (SUD) treatment, but only 3.7 million received any form of treatment during that year[2].



Source: 2018 National Survey on Drug Use and Health

One of the most significant factors impacting access to treatment is the national shortage of SUD counselors, and addiction medicine practitioners. According to the Office of National Drug Control Policy there are fewer than 5,000 medical doctors who hold addiction medicine or addiction psychiatry credentials[3]. The most recent Health Resources and Services Administration (HRSA) projections revealed that there are only 91,340 SUD counselors in the United States[4] and it has been reported that one in every four SUD counselors leaves the field each year due to inadequate compensation, below average opportunities for upward mobility, and burnout[5]. Even more concerning, the predicted demand for counselors is expected to increase by more than 20 percent in the next decade, but projected supply is expected to increase by only 6 percent[6]. HRSA published behavioral health workforce projections for 2017-2030 and estimates that we will need around 12,000 more addiction counselors in the US to meet demand[7]. This is in contrast to other professions including marriage and family counselors, psychologists, and mental health counselors where capacity is projected to exceed demand.



Source: The National Center for Health Workforce Analysis HRSA Behavioral Health Workforce Projections, 2017-2030

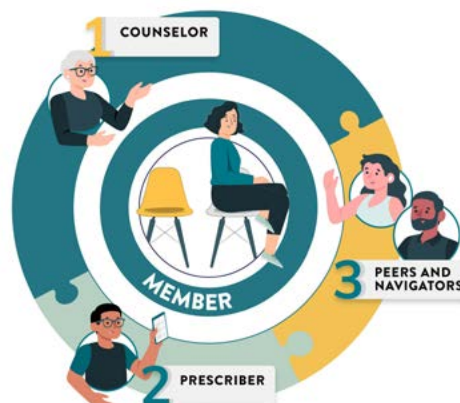
In order to build capacity for the more than 20 million Americans living with SUD, policy makers have allocated federal funding to incentivize counselors, clinicians, and prescribers to engage in addiction medicine. This comes in the form of loan forgiveness programs[8], new addiction medicine fellowships[9], and investment in training and education[10]. While promising, this effort must be complemented by increased financial investment in effective, evidence-based models of care that motivate professionals

to participate in the SUD workforce, specifically models that leverage team-based care. Team-based care is critical to serving the needs of those with SUD as the clinical complexity and social service needs of this population are beyond what most independent counselors or prescribers can manage alone[11]. Against the backdrop of the addiction workforce crisis, organizations dedicated to addressing the opioid crisis hold responsibility for developing solutions to strengthen and maintain the existing workforce to scale access to care. Groups Recover Together has focused on doing just that.

TEAM BASED CARE IS CRITICAL TO SERVING THE NEEDS OF THOSE WITH SUD AS THE CLINICAL COMPLEXITY AND SOCIAL SERVICE NEEDS OF THIS POPULATION ARE BEYOND WHAT MOST INDEPENDENT COUNSELORS OR PRESCRIBERS CAN MANAGE ALONE.

Since 2014, Groups has delivered outpatient opioid use disorder treatment in some of the most underserved communities in the United States. The Groups model of care includes medication, weekly group therapy delivered by licensed counselors, and additional recovery support delivered by care navigators, case managers, and peers. **Today, more than 90% of Groups' sites, which amounts to greater than 100 total locations, are in Mental Health Professional Shortage Areas (MPHSAs), most of which are located in a county with a three-year drug overdose death rate greater than the national average**[12]. Perhaps even more important than the number of locations, Groups serves some of the most vulnerable populations in need: since 2014 Groups has served tens of thousands of members and over sixty percent are covered by Medicaid. This work would not have been possible without a team-based model of care.

The Groups care team includes counselors, clinicians, prescribers, and recovery support professionals (navigators, peers, and case managers). Each person holds responsibility for a specific component of the recovery journey and the team structure allows every individual to provide effective care with support and autonomy. Groups builds local treatment capacity where it previously did not exist by enabling community based prescribers to engage in care with the support of addiction medicine specialists. **Most importantly, the Groups model of care brings together an interdisciplinary team of professionals with diverse and complementary skill sets and allows them to fill clearly defined roles in service of providing holistic, member centered care with dignity and respect.**



THE GROUPS INTERDISCIPLINARY CARE TEAM

COUNSELOR AND CLINICIANS

Central to the interdisciplinary model are the counselors who deliver weekly group therapy and serve as the leaders of the care team. The primary focus of counselors is helping members to develop skills necessary for long term recovery. Every member at Groups receives one hour of therapy per week in a group setting that is led by a licensed counselor. Counselors set the tone for the group and have the ability to decide what to present each week based on the needs of the members and Groups clinical guidelines. Meeting weekly gives counselors the opportunity to monitor progress and better identify when a member needs additional support. **This is significantly more therapeutic service than most traditional models are able to deliver[13], especially for the Medicaid population who have lower rates of engagement in therapy but make up the majority of the adult population with opioid use disorder (OUD)**[14]. The group modality of care is also proven to be more successful than individual therapy for many with SUD because the group setting reduces isolation and enables members to witness, and play a role the recovery of others—which in turn folds them into a culture of recovery[15].

Historically, team-based models of care are often led by prescribers but at Groups, counselors marshal the care team. When a counselor is working with a member who has complex needs, they leverage the support of their prescribers, care navigators, and certified peers. The intake process is managed by a specific team of clinicians responsible for conducting initial biopsychosocial assessments, the counselors that lead groups are not responsible for intake. This structure has reduced the amount of time between when a member calls for help and their first appointment. It also ensures that all counselors can focus on utilizing their specialized clinical skill set to support member progress rather than holding responsibility for all aspects of member recovery.

In addition to overseeing member care through clearly defined roles, counselors receive support from clinical supervisors and clinical directors who ensure consistency of care delivery through group observations, documentation review, supervision, and consultation on difficult cases. Consistent clinical supervision has been proven to support counselors' professional advancement, the development of clinical proficiencies, and helps to ensure consistent high quality member care[16]. To promote work life balance, Groups has made an effort to ensure that counselors have a voice in creating schedules and feel comfortable prioritizing their personal wellness. This is critical because substance use disorder counselors are at increased risk for experiencing burnout, vicarious trauma, and secondary traumatic stress[17].

Beyond supervision and mentorship, counselors at Groups receive training to ensure that they are equipped with the right tools and strategies to manage a range of factors that influence recovery. This occurs through a monthly series titled the Road to Excellence that covers topics including trauma (Seeking Safety), co-occurring issues, and crisis management. Outside of the internal training efforts, team members can use up to 40 hours of paid time off for professional development and an annual stipend for courses outside of the Groups curriculum. Combined, these efforts ensure that counselors have support, opportunities for professional growth, and the skills to manage opioid use disorder according to best practice with confidence.

Groups understands that provider organizations hold responsibility to attract, nurture, and maintain the counselor and clinician workforce and is dedicated to cultivating an environment where counselors feel safe, supported, and proud to deliver care.

RECOVERY SUPPORT PROFESSIONALS: NAVIGATORS, CERTIFIED PEER RECOVERY COACHES, AND CASE MANAGERS

Many of the members at Groups have significant needs related to social determinants of health including housing, food security, economic stability, transportation, and access to healthcare. Addressing social determinants has been recognized as an essential component of effective substance use disorder treatment[18] and including recovery support professionals in this work has been proven to reduce rates of relapse, increase treatment retention, and improve member satisfaction across diverse patient samples[19].

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At Groups, care navigators, case managers and peers are embedded as part of the care team and work alongside counselors, clinicians, and prescribers to give members the best chance at sustained recovery. Navigators and case managers provide member centric, tailored one-on-one assistance to guide members towards services and access resources necessary to building a foundation for recovery. Certified peers are typically professionals with lived experience who offer social and emotional support during recovery. These services act like velcro, and have been proven effective in keeping members engaged in recovery in ways that traditional care does not [20] because most models lack regular engagement with these professionals .

Incorporating non-specialist health workers like peers, navigators, and case manager has been proven to expand access to evidence-based treatment for OUD[21] and this layer of support allows members to receive more 1:1 evidence-based care without overcommitting any single member of the care team. Leveraging the effort of recovery support professionals is essential to maintaining a motivated workforce and meeting demand for care.

PRESCRIBER

The Groups approach leverages the expertise of addiction medicine specialists to empower non specialist prescribers to feel comfortable prescribing medication for opioid use disorder (MOUD). Groups engages local prescribers to participate in the delivery of team-based treatment under the guidance of addiction medicine specialists. When entering a new community, Groups identifies local advanced practice prescribers including MDs, DOs, PAs, and NPs who are willing to participate in OUD treatment, but lack support to do so as part of their existing practice. At Groups, prescribers receive training and support from addiction medicine specialists and work alongside counselors, care navigators, and office support staff to deliver services as part of a holistic team.

Connecting advanced practice providers to addiction medicine specialists is key to improving treatment capacity as recent data demonstrates that buprenorphine prescribing is underutilized by advanced practice providers who hold DEA X-waivers that allow them to MOUD in a "qualified practice setting". As of April 2021, there were just over 100,000 X waivered prescribers in the US, but the majority do not prescribe to capacity[22]. **Close to 50% of waivered physicians prescribe buprenorphine to 5 or fewer patients**[23] and **less than 10 percent of prescribers treat more than 75 patients**[24]. The two primary reasons that independent prescribers are reluctant to engage in substance use disorder treatment are a lack of support for managing medical comorbidities and social determinants and a lack of professional education or training to feel comfortable managing substance use disorder. Prescribing as part of a care team allows advanced practice providers to participate in substance use disorder treatment, even part time, without giving up their regular clinical practice.

Prescribing with support of addiction medicine specialists not only encourages new prescribers to participate in treatment but also ensures protocol driven practice that improves quality of care. Until recently, specialized training to manage OUD was not required or standardized for health care providers in the United States[25] and even today, many schools and training programs have limited access to experts in addiction medicine who can develop the curriculum and clinical support necessary to empower medical students to deliver SUD treatment. One study found that the majority of providers feel unprepared to screen, diagnose, refer, or even discuss treatment options with patients with SUD[26].

By creating opportunities for advanced practice providers to participate in team-based OUD treatment, Groups has increased capacity for community based care in some of the most underserved regions of the country. This approach improves access to high quality community based care for a broad spectrum of members with opioid use disorder in some of the most underserved communities in the United States.

COMMITMENT TO TEAM-BASED CARE

Team-based care is critical to addressing the growing demand for treatment. It is proven to have a positive impact on quality of care, member experience, sustainability of practice, and retention of front line providers[27]. Perhaps most importantly, team-based care increases quality while expanding access. Groups has found this to be true, members at Groups are retained in treatment 3x longer, and maintain abstinence from illicit opioids at a rate 5x higher than patients that receive MAT from independent prescribers.

The acute shortage of trained SUD providers is an epidemic within an epidemic. Increased investment in team-based care is critical to addressing this need. However, key to this effort is a commitment from provider organizations to prioritize the wellbeing of those delivering care. Groups understands this and is dedicated to maintaining an environment where all counselors, clinicians, prescribers, and recovery support professionals are supported not only with evidence-based protocols, but also with a community that cares for them as they care for those struggling with addiction. After all, without the care team, there is no care.

Endnotes

1 Includes: as Heroin, Natural, semi-synthetic, synthetic opioids, and methadone. As reported by NCHS, National Vital Statistics System, and published by the CDC

2 Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. SAMHSA August 2019

3 Executive Office of the President of the United States, National Drug Control Strategy. National Treatment Plan for Substance Use Disorder. February 2020.

4 US Health Resources and Services Administration's Behavioral Health Workforce Projections 2017-2030

5 Shortage Of Addiction Counselors Further Strained By Opioid Epidemic. NPR Shots. February 24, 2016

6 HRSA, Behavioral Health Workforce Projections. https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health

7 US Health Resources and Services Administration's Behavioral Health Workforce Projections 2017-2030

8 https://nhsc.hrsa.gov/loan-repayment/nhsc-sud-workforce-loan-repayment-program.html

9 https://www.hrsa.gov/grants/find-funding/hrsa-20-013

10 https://www.samhsa.gov/grants/grant-announcements/fg-20-001

11 (Nutting, 2011; Torrey 2017) as cited in OPTIMIZING THE PSYCHIATRIC WORKFLOW WITHIN A TEAM-BASED CARE FRAMEWORK. The National Council Medical Director Institute. January 2021

12 Based on the three-year average from the 2017-2019 Centers for Disease Control and Prevention (CDC) County Overdose Mortality Rate data

13 Report to Congress T-MSIS Substance Use Disorder (SUD) Data Book Treatment of SUD in Medicaid, 2017 (Note: Only beneficiaries with ICD code of OUD are included in denominator. Actual receipt of services amongst beneficiaries in need is lower.).

14 Feder KA, Mojtabai R, Krawczyk N, et al. Trends in insurance coverage and treatment among persons with opioid use disorders following the Affordable Care Act. Drug Alcohol Depend. 2017;179:271-274.

15 Center for Substance Abuse Treatment. Substance Abuse Treatment: Group Therapy. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 41.) 1 Groups and Substance Abuse Treatment. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64223/

16 Rothrauff-Laschober, Tanja C et al. "Effective Clinical Supervision in Substance Use Disorder Treatment Programs and Counselor Job Performance." Journal of mental health counseling vol. 35,1 (2013): 76-94. doi:10.17744/mehc.35.1.50n6w37328qp8611

17 Rothrauff-Laschober, Tanja C et al. "Effective Clinical Supervision in Substance Use Disorder Treatment Programs and Counselor Job Performance." Journal of mental health counseling vol. 35,1 (2013): 76-94. doi:10.17744/mehc.35.1.50n6w37328qp8611

18 Alegría, Margarita, et al. "Transforming Mental Health And Addiction Services: Commentary describes steps to improve outcomes for people with mental illness and addiction in the United States." Health Affairs 40.2 (2021): 226-234

19 Eddie, David, et al. "Lived experience in new models of care for substance use disorder: a systematic review of peer recovery support services and recovery coaching." Frontiers in psychology 10 (2019): 1052

20 Dennis M., Scott C. K., Funk R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. Eval. Program Plann. 26, 339–352. 10.1016/S0149-7189(03)00037-5 [PMC free article] [PubMed] [CrossRef] [Google Scholar]

21 Magidson, J. F., Jack, H. E., Regenauer, K. S., & Myers, B. (2019). Applying lessons from task sharing in global mental health to the opioid crisis. Journal of Consulting and Clinical Psychology, 87(10), 962–966

22 Huhn, Andrew S, and Kelly E Dunn. "Why aren't physicians prescribing more buprenorphine?." Journal of substance abuse treatment vol. 78 (2017): 1-7. doi:10.1016/j.jsat.2017.04.005

23 Sigmon SC. The untapped potential of office-based buprenorphine treatment. JAMA Psychiatry. 2015 Apr;72(4):395-6. doi: 10.1001/jamapsychiatry.2014.2421. PMID: 25671806.

24 Stein, Bradley D et al. "Physician Capacity to Treat Opioid Use Disorder With Buprenorphine-Assisted Treatment." JAMA vol. 316,11 (2016): 1211-1212. doi:10.1001/jama.2016.10542

25 National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. 5, Barriers to Broader Use of Medications to Treat Opioid Use Disorder. Available from: https://www.ncbi.nlm.nih.gov/books/NBK541389/

26 Wakeman, S. E., G. Pham-Kanter, and K. Donelan. 2016. Attitudes, practices, and preparedness to care for patients with substance use disorder: Results from a survey of general internists. Substance Abuse 37(4):635-641.

27 OPTIMIZING THE PSYCHIATRIC WORKFLOW WITHIN A TEAM-BASED CARE FRAMEWORK. The National Council Medical Director Institute. January 2021