Part Three Perspectives on the Substance Abuse Treatment System in Chicago-Area Hospitals

Lee R. Hamilton, M.P.H.

Introduction

The following report summarizes the views of providers and other experts regarding the substance abuse treatment system, largely from the perspective of staff of Chicago-area hospitals. The report focuses on several key issues:

- Changes in behavioral health care coverage (i.e. benefits) and financing (payment) have transformed the way substance abuse services are delivered.
- Improving substance abuse services will require retooling current treatment programs into a system of coordinated services.
- ▶ Diverse attitudes and beliefs regarding substance abuse have been major obstacles in developing coherent and consistent policies.
- Bridging the gaps in substance abuse education and training will advance knowledge, promote tolerance and encourage professionalism.

Variations in substance abuse services their delivery and assessment affect the quality and outcomes of treatment.

This report is organized around the major themes that emerged from discussions with substance abuse professionals, most of whom work in or with hospitals. Interviewees included physicians, program administrators, state agency personnel, staff of professional associations, health care advocates and others. Recommendations aimed at strengthening the treatment system are offered at the conclusion of the report. It is our hope that this paper will simulate discussion and debate in the hopes of finding ways to address obstacles to developing stronger substance abuse approaches and policies.

Methodology

Roosevelt University s Institute for Metropolitan Affairs completed numerous interviews, both formal and informal, with over 20 substance abuse professionals. Formal interviews took place as part of case studies and involved substance abuse staff at six facilities in Chicago and Cook County. The individuals interviewed were administrators with primary responsibility over substance abuse services at the facilities. Their names are not specified and the names of their institutions have been changed to protect confidentiality. Included were two community-based hospitals (West Side and Hughes), an academic health center (Memorial), a teaching hospital (North Woods), a VA hospital (Eisenhower), and a community-based outpatient treatment facility (Waters Center).

Interviews took place during the summer and fall of 1998. The interviews were usually held at the interviewees

office. Prior to the interview each participant was given information about the study and a set of questions to be addressed during the interview.

Interviews averaged about one and one half hours in length. With the permission of the interviewee, all interviews were taped to assure accuracy. The information contained in the case studies reflects what was occurring at the individual institution at the time of the interview and does not reflect changes that may have occurred in the interim.

In addition to the formal case study interviews, less formal interviews were carried out with an additional 15 individuals who represented professional organizations, state agencies, health care advocates and others. Also, one patient in recovery for alcohol and drug abuse and a parent of a long-time drug user with mental health problems contributed their perspectives on substance abuse services.

Coverage and Financing

Changes in behavioral health care coverage (i.e. benefits) and financing (payment) have transformed the way substance abuse services are delivered.

Hospital providers have seen the health care pendulum swing from a system that supported a broad array of services aimed at reducing drug abuse, to a system that is far more restrictive one that limits inpatient stays, outpatient visits and allowable charges. There are a number of reasons why limits have been imposed by third party payers and the federal government (Medicare and Medicaid), the most prevalent one being that insurers saw the need to institute controls on costs. For many years mental health services, which include substance abuse services, were excluded from cost controls. But when their costs escalated, substance abuse services became an obvious target for control initiatives.

While controls may be justified for financial reasons, there is also belief that sentiments against drug abuse patients have negatively influenced cost control policies. This sentiment is based on an assumption that substance-abusing patients are the product of their own lack of discipline and therefore are not entitled to the same level of services available to people whose afflictions fit more widely accepted definitions of what constitutes illness.

Whatever the motivation, the imposed changes in benefits and payment levels are seen as the most important factors in diminishing availability and overall quality of hospital-based services for substance abusing individuals. This has been especially notable over

the last five years. As a result, all five hospitals studied for this report have reduced or restructured their substance abuse services. Four of the hospitals had to close their dedicated substance abuse units and, as a consequence, lost critical staff. According to information from the Illinois Health Facilities Planning Board, there has been a 50 percent reduction in substance abuse/detoxification beds between 1990 and 1997 in Chicago and Cook County hospitals. Further reduction is expected.

The establishment of payment and benefit limits has placed arbitrary constraints on the level of services available to substance abusing patients that are often at odds with the special needs of the individual patient. As observed by staff at one hospital, these limitations reflect a one-treatment-fits-all approach to care an approach that is inconsistent with managing substance abuse as a complex chronic relapsing disease. It was also noted that limiting services results in fragmented treatment that impedes recovery.

Benefits and payment levels vary by insurer and plan. Some insurers carve out mental health services essentially subcontracting these services to other entities a practice viewed as disruptive to the coordination of overall health care. Public and private payers differ in the scope of services they cover. There is no standard package of benefits or levels of payment. The exceptions are HMOs, which are mandated by the state

to provide a specific set of addiction services. While mandating substance abuse treatment services is a good thing, it is argued that the currently

mandated services are less than what addiction professionals feel are necessary.

Funding, Structure and Planning

eorgani ing current treatment programs into a system of coordinated services would improve substance abuse services.

On a national level, for a variety of historical, political, and economic reasons, substance abuse treatment has been fragmented, under-funded, less than comprehensive and poorly planned and structured. To varying degrees, these weaknesses are reflected in what some interviewees described as the non-system that has developed in Chicago and Cook County.

Interviewees argued that a high quality drug treatment system would have as its goal to bring about optimal outcomes for substance abusers. Such a system would have adequate resources to generate comprehensive integrated services that are structured to provide a continuum of care matched to the individual needs of the client. A good system should also have collaboration, accountability, ability to monitor progress, assessment of outcomes, and the capability of evolving new therapies.

In contrast to this ideal, interviewees described the current system as fragmented, under- and inconsistently funded, less than comprehensive, poorly planned and not well integrated.

Impediments to developing a comprehensive substance abuse treatment system abound, and a number of specific examples came out of interviews. Patient Placement Criteria (PPC) is an initiative of the American Society of Addiction Medicine aimed at matching the addicted individual to the appropriate level of care. These levels represent four points of a continuum of treatment services. The use of PPC, in general, is

considered valid. The state, in fact, has mandated PPC in all its licensed treatment facilities. Providers have, or are working toward, integrating PPC into their practices. But it was noted that not all PPC levels of service are adequately funded. These funding gaps limit availability of needed services and can disrupt the patient s treatment.

Inconsistencies in the system of funding drug treatment that produce fragmented service delivery were noted in other areas as well. Providers spoke of how federal and state funding priorities change and how increased funding in one area of service can lead to less funding in others. For example, competition for funding often exists between outpatient and inpatient services, or between services for women versus men. Providers also spoke of how new funding requirements put additional burdens on their treatment programs. Many requirements are put into place to assure quality or as cost control measures but frequently mean the providers must retool their operations. Often this is costly and distracts from the provider s primary mission. One community-based treatment provider mentioned that reductions in funding from the Illinois Office of Alcohol and Substance Abuse (OASA), their primary funding agency, resulted in a significant reduction in staff requiring that they restructure some of their services.

Rigidly defined funding categories dictate program content, which may or may not respond to provider or commu-

nity needs. The challenges to obtaining funding are many. One hospital provider located in a high-risk community noted that they lack the staff needed to pursue funding and feel their hospital is not in the mainstream and just not in the running for these funds.

Interviewees also identified gaps in the current organization of treatment services that reflect structural and planning weaknesses. Several individuals noted that there is an imbalance in treatment services, with some communities having more resources and some less than needed. Interviewees pointed out gaps in the type of services available, especially services directed toward adolescents and women. The needs of pregnant women were a particular concern. Residential beds are also badly needed. Overall, in Chicago, the current capacity of publicly funded substance abuse treatment programs meets only a fraction of the need. Many patients are placed on waiting lists that may mean a few days, weeks or months delay in receiving needed services. For many, delays translate into services denied. It was suggested that service imbalances require further study and that problems should be addressed through collaborative planning.

There was a common view that there is a lack of collaborative planning between the various parts of the current delivery system. Providers tend not to know what other providers are doing. Cross linkages between hospitals, or between a hospital and community-based providers are weak or sometimes absent. While substance abuse is considered a major public health problem, it was observed that in Illinois public

health entities have not played a strong role in planning. There was a shared perspective that a stronger public health presence would help develop a system that is more coherent, responsive to changing needs, could more adequately address policy issues, evaluate policy impact, measure treatment outcomes, promote and test new treatments and, in general, help unify various components of the system.

Interviewees identified obstacles to collaborative planning:

- ▶ Partitioning of current substance abuse funding and agency missions. Funding for substance abuse services originates from federal, state and local governments, and various special grants. The dollars are channeled through several sources in Illinois that include Department of Mental Health, Office of Alcohol and Substance Abuse, Department of Education, Public Aid (Medicaid/Medicare), and Department of Justice. They cover prevention/awareness, treatment and criminal justice initiatives. These agencies have different missions, resulting in little coordination of efforts and, seemingly, little desire to achieve coordination.
- ▶ Diverse nature of interested parties.
 Collaborative planning is complicated by differences among the substance abuse treatment providers themselves. For instance, providers often differ in their attitudes regarding how to provide treatment or how to measure outcomes. Competition between providers for increasingly limited funds and fear of loss of program autonomy can also make collaboration difficult.

Attitudes and Beliefs

Il informed attitudes toward substance abusers have been a ma or obstacle to developing coherent and consistent policies.

Generating public support for substance abuse treatment has historically been made difficult by the ambivalence of both service providers and the public toward this population. Substance abuse continues to be viewed as a choice made by the abuser showing a level of moral weakness. Interview participants spoke about the stigma attached to the addicted population especially illicit drug users. Unfortunately, negative perceptions too often are directed toward substance abusers rather than at the illness. They are often seen as weak, sometimes corrupt, and generally as flawed or inadequate people.

Interviewees noted that even health professionals can hold negative, stereotypical perceptions of substance abusers a problem also observed in the academic literature on this matter. These negative attitudes can interfere with the health management of patients. Negative attitudes are reinforced because patients can be unpleasant, disruptive and unrewarding to work with. With the elimination of many dedicated hospital units and their trained staffs, the needed structure for managing these patients has been weakened or in some places entirely lost.

Attitudes also affect how addiction is defined. There is not uniform acceptance that addiction is a chronic relapsing disease and, as with other chronic diseases, requires extensive, sometimes life-long, treatment. The prevailing view is that drug and alcohol use is

a voluntary activity and that one can stop anytime if one has the discipline to do so. It is hard for people to understand that, while initially drug use is a voluntary behavior, at some point, as a person becomes addicted, use is no longer voluntary. Functional changes take place in the brain that cause compulsive, uncontrollable drug use. Adding to the physical complexity of the problem are historical, environmental and psychological factors that contribute to addiction.

The hypercritical view held by the public has resulted in adoption of drug policies that are often considered by providers and advocates as punitive more focused on punishing the addict than on treating the underlying disease. An example that illustrates how attitude impacts policy was given by an Illinois lobbyist who is working on mental health parity legislation (i.e. benefits/ coverage for mental health problems should equal those for other illnesses). He believes that proposals for parity legislation did not include substance abuse because the preponderance of legislators hold negative opinions toward this population. In his view, passing any parity legislation would be difficult: to demand that it include addicts would assure its failure.

Another issue that has interfered with the development of coherent treatment policy is the belief held by many, including policy makers, that substance abuse treatment does not work. Frequently treatment success is measured by total abstinence. As pointed out by many participants, this is not a realistic outcome when dealing with a chronic relapsing disorder. Success can be defined by increasing time between relapses, reduction of destructive behavior (i.e., harm reduction) or greater productivity. Interviewees also emphasized that just as substance abusers vary, so must their treatment. Matching the treatment to individual needs is critical.

Differences among providers regarding approaches to treatment add to the challenge of developing coherent and consistent policies. There are varying levels of disagreement in the provider community regarding treatment around issues such as whether a social model of intervention is preferable to a medical model, or whether methadone treatment is appropriate. Many interviewees felt that entrenched views around such issues are obstacles to policy development and system reforms.

Education and Training

ridging nowledge gaps through substance abuse education and training will promote better systems and programs.

A variety of types of education and training need to take place in order to improve drug abuse policies and their implementation. Policy makers and the general public would benefit from a more nuanced understanding of the nature of drug abuse and the most effective approaches to prevention and treatment. More is known about the nature of substance abuse than ever before. but evidence suggests that much of the public does not understand or wholly believe the scientific findings. The interviewees noted that there needs to be a continuing effort to better inform the public as to the nature of substance abuse. It was felt that substance abuse policies and strategies need to be realigned in accordance with facts and this can only be done by aggressive education and training.

Interviewees also noted that education and training efforts need to be directed toward health professionals. In the opinion of several who were interviewed, physicians, nurses and other

medical support staff frequently lack the knowledge required to adequately manage substance abusing patients. One interviewee pointed out that, in their opinion, even many mental health workers do not have the requisite skills necessary to deal with certain clients, in particular those who are dually diagnosed (i.e., patients with a mental health problem in combination with drug and/or alcohol use).

Health care professionals also need to develop better skills for earlier identification of addiction problems in the general hospital population. Simple screening procedures are available for this purpose but are not widely used.

Interviewees mentioned that more and better dissemination of substance abuse research findings is vital. Substance abuse professionals are frequently entrenched in models of care they have used for years and are unaware of or do not yet accept new, scientifically tested approaches.

Quality

ariations in substance abuse service delivery and assessment affect the uality and outcomes of treatment.

Quality is a common thread that ties together all the themes presented in the preceding sections. Although introduction of the Patient Placement Criteria (PPC) facilitates use of standard criteria for patient placement and treatment of substance abusing patients, large variations in content, depth, availability and mode of delivery of services remain among hospital-based and community-based treatment providers.

The substance abuse treatment system must offer a range of services appropriate for clients and assure that providers remain accountable for service quality. Interviewees noted that substance abuse providers have established different treatment philosophies and models of intervention. While variety per se is not problematic, the concern is that many treatment approaches lack the necessary research to validate their effectiveness and efficiency. It is problematic when providers offer services based on their particular philosophies that may no longer be supported by science. O Brien and McLellan emphasized this problem in a 1997 article. They state, Some who work in the drug

abuse prevention and addiction treatment fields also hold ingrained ideologies that, although usually different in origin and form from the ideologies of the general public, can be just as problematic. For example, many drug abuse workers are themselves former drug users who have had successful treatment experiences with a particular treatment method. They therefore may zealously defend a single approach, even in the face of contradictory scientific evidence. In fact, many drug abuse treatments have been shown to be effective through clinical trials. To assure quality in services it is important to make sure that practices are supported by good science.

Participants identified another major quality issue referred to as the current two-tiered delivery system that consists of publicly sponsored substance abuse services and privately sponsored services. It is felt that private systems provide superior levels of service, treatment quality and outcomes than do public systems. Possible inequities between what a patient might receive from public versus private providers need to be examined and addressed.

Recommendations

- 1. Expanding and improving treatment programs for substance abuse needs to be established as a priority issue at the state and local levels.
- Providers across the continuum of care need to collaborate more and jointly participate in a planning process that moves toward a system of connected services.
- 3. Departments of public health could make an important contribution to improving substance abuse planning and evaluation.
- 4. There needs to be a continuing effort to educate legislators and others who make or influence policy about the nature of addiction and the importance of treatment. More specifically, they need to understand that substance abuse is a chronic disease.

- Treatment models should be reevaluated and restructured consistent with viewing substance abuse as a chronic disease.
- Greater efforts are required to adequately train healthcare professionals in managing the addictive patient.
- 7. Insurance coverage for substance abusers should be restructured to assure parity of services for substance abusers.
- 8. Current managed care mandates are not broad enough and should be modified to reflect the best standards of practice.
- Sufficient resources must be made available to provide quality treatment irrespective of community, income or gender.

Hospital Case Studies

North Woods Hospital

- Hospital type: Teaching/tertiary hospital
- Number of staffed beds: Approximately 577
- Location: Near north suburbs of Chicago.
- ► Service Area: Community with some regional patient draw, white collar
- ▶ Reimbursement: largely private, third party payers
- Network linkage: Part of a hospital network
- ► ER: Level I trauma center
- Number of discharges: in 1997 over 27,700 hospital discharges
- Number of drug and alcohol related discharges: In 1997,
 246 drug-related discharges and 364 alcohol-related discharges.

Services

Historically North Woods Hospital has had a strong institutional commitment to treating the addicted population and has developed a full continuum of care services as defined by American Society of Addiction Medicine s (ASAM) Patient Placement Criteria (PPC). These services include screening of all trauma patients, follow-up testing and consultation, medically managed detoxification, partial hospital program, intensive outpatient treatment, sober living facility, independent living, intervention services, family services, adjunct consultative services (medical, psychiatry, psychology, social services, family therapy). They also have consultative liaison services with an addiction counselor who is supervised by the medical director. The addiction counselor also provides case management.

A separate program offered through the North Woods Hospital medical group focuses on treatment of professionals with addiction problems.

In the recent past North Woods Hos-

pital had a large, stand-alone residential program for addicted patients. This program was discontinued in the early 1990s in part because of pressure from third party payers and the federal government, who were de-emphasizing inpatient treatment services in favor of less costly outpatient, community-based treatment programs. Administrators of indemnity (fee-for-service) and managed care insurance plans seeking cost savings reduced the number of inpatient treatment days they would cover.

Once the residential program closed, many of the services were integrated into the main hospital and a separate substance abuse unit was established. However, after several years it too has closed because patient volume fell below the minimum of twelve needed to sustain it. Census was reduced to six or seven when the average length of stay was reduced to an average of three days.

Medical detoxification formerly done in the independent unit is now being done on the medical floor. The loss of

the designated unit has meant that there is more difficulty in establishing the expertise in dealing with the special needs of the detox patient. North Woods experience has been that it is difficult to train the general nurse in the additional skills that are needed to manage substance abuse patients. Management of detox is more difficult when you do not have the right milieu of staff. The substance abuse unit also provided a 24-hour observation room that helped get the substance abuser out of the emergency room and into an observation bed where these patients could be assessed by a specialist and disposition made by a team experts. Closing the detox unit has meant that substance-abusing patients stay in the emergency room, which is much less desirable. Managing the addicted patient becomes an added responsibility to an already over burdened the emergency room staff.

Organization of Services

Addiction services are under the department of behavioral health. A behavioral health leadership group brings together hospital administration and the chair of behavioral health oversees program development. A program manager is responsible for non-medical staff issues and day to day operations.

Linkages

North Woods Hospital has informal linkages to community-based addiction treatment providers. In addition, referrals are made to residential facilities and halfway houses. North Woods Hospital also has links to the schools. However, it was noted that, in general, adolescent addiction services have been

reduced in the community the hospital serves.

North Woods Hospital is part of a multiple hospital system and participates in a networked behavioral health service line group. This group pulls together providers across the system to share their expertise and develop standard protocols. This group plays no centralized oversight function for networkwide addiction services.

Problems with Patient Placement

Application of ASAM's Patient Placement Criteria can be difficult for community-based providers licensed by the Office of Alcohol and Substance Abuse (OASA). These providers may not have the right combination of services available to match the patient's needs and must refer the patient elsewhere. It was suggested that some providers, to avoid losing a client, will not refer them to a needed social service.

Problems Related to Funding

There is not adequate funding to support all aspects of the continuum of care in the community. Many institutions that once provided addiction services no longer consider them economically viable and have discontinued them. Because of their cost, increasingly addiction services are only being provided by institutions that see it as part of their core mission. As the number of institutions with substance abuse programs decreased, there has been an increasing burden placed on publicly supported hospitals, i.e. disproportionate share hospitals those that receive additional funding for the uninsured.

West Side Hospital

- ► Hospital type: Community-based hospital
- Number of staffed beds: Approximately 354
- Location: West Side of Chicago.
- Service Area: Local community, economically disadvantaged, high incidence of substance abuse
- ► Reimbursement: disproportionate share funded, high volume of public payer patients (i.e., Medicaid and Medicare)
- Network linkage: Part of a hospital system that includes a network of community-based health centers.
- ► ER: Level I trauma center
- Number of discharges: in 1997 over 14,700 hospital discharges
- Number of drug and alcohol related discharges: In 1997, 979 drug related discharges (ranked tenth among Chicago and Cook County hospitals) and 556 alcohol related discharges (ranked fourteenth).

Services

The addicted patient in this community often has additional health and socioeconomic stresses that complicate treatment and recovery. The goal of the substance abuse program at West Side Hospital is to enhance continuum of care and provide a much-needed service to our designated target communities, as a staff member put it. West Side Hospital uses ASAM criteria in the assessment and placement of patients into appropriate levels of treatment.

Until several years ago, West Side was certified by OASA as a subacute medical detox, residential, intensive outpatient program and outpatient Medicaid provider. It had a designated inpatient unit that had about 18 beds. The original inpatient program had two phases, an acute care phase and an inhospital residential phase. Following the hospital stay patients were linked to an intensive outpatient (IOP) treatment program at the hospital. Following

the IOP, patients could attend evening programs. The inpatient treatment part of the program lasted about 12 days. There was a dedicated addiction staff of 12 to 18 that served both the inpatient and outpatient portions of their program. The program was viewed as beneficial and cost effective.

West Side Hospital lost the designated inpatient unit several years ago when a change in OASA policy eliminated funding to hospitals for subacute medical detox and residential services.

OASA now only funds outpatient, community-based treatment providers. As a result, West Side Hospital's current program provides an intensive outpatient (IOP) program followed by a less intense outpatient program. There are currently four, four-hour groups that meet each week. There are about 14 patients in the two programs.

West Side Hospital also has a program run by the Chicago Department of Health that works with addicted moth-

ers and their families. The Department of Children and Family Services (DCFS) is part of the team and works with these families. The families are part of the program for two years. This program started at West Side Hospital and is now in at least two other urban hospitals. West Side Hospital also supports self-help groups (i.e., Alcoholics Anonymous and Narcotics Anonymous).

There are approximately 100 patients admitted to West Side Hospital each month that have substance abuse problems. Most of these patients are admitted to the hospital through the emergency room and are primarily placed in the psychiatry or medical surgical units. Staff interviewed felt that the referral process for substance abuse consultations needed to be improved. In some respects this process is problematic because emergency room physicians generally concentrate on the patient s medical condition and so no systematic assessment of a possible underlying substance abuse problem is done.

For patients with dual diagnoses or those who come into the emergency room intoxicated, the hospital has an informal agreement with Haymarket House to take everybody who has been medically cleared. A mental health worker is available 24 hours a day to facilitate referrals. If a patient is psychotic and later diagnosed with an addiction problem, the patient is first treated and then linked to the hospital s IOP programs.

Organization of Services

West Side Hospital s substance abuse program is part of the department of psychiatry. An internist serves as the program s medical director. He is board certified in adult substance abuse and has many years of experience. Staff from the psychiatry department assists him.

Linkages

West Side Hospital has mostly informal relationships with other community-based providers.

Problems Related to Funding

Many of the critical issues raised by staff interviewed at West Side Hospital result from shortages of funding.

Staff at West Side believe there are insufficient substance abuse services to meet local demand. They believe that the impact of crack cocaine and the damage it has done to the community has been underestimated as more women, younger children and teens are now abusing drugs than ever before. They also believe that there are fewer services available on the West Side than in other parts of the city. Local professionals believe community-based treatment providers are generally lacking in West Side s service area.

There is an impression that the state mental health facilities are seeing an increasing number of addicted patients in part because hospitals have reduced services to this population. Madden Mental Health Center has seen a dramatic growth in the last year as hospitals spend available funding for indigent care, i.e., Loretto, St. Anthony and St. Mary of Nazareth. Admissions from these hospitals to the state hospital facilities have increased 10 to 30 percent. Hospitals that have been given state mental health funding have spent their

entire allocations in six months.

Many substance abuse patients, unless they also have a co-morbidity of mental illness, no longer can receive SSI benefits and SSI-linked medical coverage. These patients who were at one time covered, have become indigent, and available supplemental indigent funds for psychiatric services are being expended at a faster rate.

HMOs are mandated to deliver substance abuse services but the level of treatment they are willing to cover is sometimes less than what addiction professionals feel is needed. HMO service mandates should be adequate to achieve best practice. West Side staff do not support short-term (48 to 96 hours) medical detox and are concerned that this is becoming the typical treatment strategy for the future. They believe that patients need at least 10 days of treatment followed by placement in a safe living environment and then IOP (coupled with other safe housing situations) to make recovery a possibility.

Staff are concerned that outpatient treatment programs are supplanting inpatient programs and that outcomes of outpatient programs will be inadequate. The multiple problems exhibited by substance abuse patients require a range of well-structured, well-connected services delivered by well-trained professionals. Staff were also concerned that mental health workers, to whom drug abuse patients had often been assigned, were not trained to manage addicted patients.

Summing up his view of the root of many of the problems, one interviewee explained: From the state side there still is not the organization for substance abuse services that is needed. You ve got to go back to the seventies when there was one behavioral health entity. You ve got to get rid of OASA and Office of Mental Health (OMH) and make it one. One person in charge with one mandate to use all resources that the providers have, bringing them together into a seamless system of care for this population.

Hughes Hospital

- Hospital type: Community-based
- Number of staffed beds: Approximately 250
- Location: South side of Chicago
- Service Area: Local community, economically disadvantaged, high incidence of substance abuse
- Reimbursement: largely through public payers (Medicaid, Medicare)
- Network linkage: No hospital network linkages
- ► ER: Comprehensive level ER
- Number of discharges: in 1997 over 10,700 hospital discharges
- Number of drug and alcohol related discharges: In 1997, 5,063 drug related discharges (ranked first among Chicago and Cook County hospitals) and 928 alcohol related discharges (ranked second).

Services

The stated goal of Hughes Hospital s substance abuse program is to provide quality care based on our resources to as many clients as possible. Our philosophy is not to put people out on the street. If we cannot provide the services they need, we try to get people to the services they require wherever those services are.

Until the unit was closed in 1998, Hughes Hospital had a substance abuse unit and did a large number of short-stay medical detox procedures. In large part the unit closed for reasons related to loss of reimbursement: patients were being referred from other institutions to Hughes Hospital after they had exceeded their inpatient behavioral health benefits; and, because of changes in SSI eligibility, many substance abuse patients no longer qualified for SSI linked medical benefits. The hospital has lost a great deal of money trying to absorb the costs for treating these unfunded patients.

With the loss of the unit, patients needing detox are now being admitted to the medical/surgical unit. This has presented a problem because medical/surgical admissions have priority and beds are not always available for patients who need detox services.

Hughes Hospital has a partial hospital program (day program) that serves patients with mental illnesses and patients that have both mental illness and substance abuse problems. The program is a full day starting at nine and lasting until about two in the afternoon. There are between 18 and 20 participants. Hughes Hospital also has outpatient programs for adults, an intensive outpatient program, and graduated programs that are less intensive. There are between 60 and 100 people in these programs. Hughes Hospital also provides outpatient medical detox services and, in some cases, uses acupuncture as part of the treatment protocol a somewhat unique practice locally. The hospital uses ASAM criteria in the development of its services and treatment protocols. Culturally sensitive counseling is provided to its substance abuse patients. Hughes Hospital follows a substance abuse screening protocol for all emergency room patients. Currently the hospital sees a need to develop onsite programs for adolescents or women. It has tried unsuccessfully to get grant funding for a program for pregnant women.

Organization of Services

At the time of the interview, Hughes Hospital was undergoing a major reorganization and had lost key substance abuse staff. The substance abuse services are located in the department of medicine. A substance abuse-trained physician reports to the director of medicine as does a psychiatrist and substance abuse staff who also report to the director of mental health. The program manager works under nursing. A collaborative team develops programs and evaluates service. The team includes representatives from nursing, hospital administration and the departments of medicine and psychiatry.

Linkages

One of the major referral sources Hughes Hospital has in the community is a local mental health center. Patients who have mental health problems and are abusers (i.e., dually diagnosed) are sent to Hughes Hospital for the substance abuse part of their treatment. In turn, Hughes Hospital sends substance abuse patients needing mental health services to the mental health center.

Problems Separating Mental Health and Drug Abuse

Many of their substance abuse patients have a strong trait for mental illness or a mental illness that has not been diagnosed which contributes to a low recovery rate. Often community based agencies find it difficult to assess a patient with both a substance abuse and mental health problem because most agencies treat either substance abuse or mental illness but not both. Often people running the programs are ill informed and minimize the complexity of dealing with a patient having both conditions.

Additional Resource Needs

- ▶ It was noted that the staff members in the medical/surgical unit are not comfortable dealing with detox patients, who can often be disruptive. Staff tend not to be oriented to the needs of the substance abuse patient. More staff training is needed.
- ► Hughes Hospital has attempted to get outside funding for substance abuse programs but feels it is not in the mainstream and just not in the running for these funds.
- ► There are gaps in services for adolescents and pregnant women in the community served by Hughes.
- ► Better tracking systems are needed to assure continuity of services for substance abuse patients.

Memorial Hospital

Hospital type: Academic/tertiary hospitalNumber of staffed beds: Approximately 670

Location: ChicagoService Area: Regional

Reimbursement: largely private, third party payers
 Network linkage: Medical hub of a large hospital

network

▶ ER: Level I Trauma Center

 Number of discharges: in 1997 over 30,000 hospital discharges

Number of drug and alcohol related discharges: In 1997, 674 drug related discharges (ranked fourteenth among Chicago and Cook County hospitals) and 710 alcohol related discharges (ranked seventh). Among its peer academic hospitals Memorial Hospital saw the largest volume of both drug and alcohol related discharges.

Services

Memorial Hospital uses ASAM s Patient Placement Criteria and has a wide range of services to offer patients with substance abuse problems. Patients may enter substance abuse treatment through either the hospital or the department of psychiatry. Memorial Hospital s philosophy is that recovery is an on-going process that may require extended treatment. Memorial Hospital utilizes the twelve-step philosophy. This concept is introduced as a recovery tool and its use is strongly encouraged.

Patients entering the hospital through the emergency room are screened for medical complications of substance abuse. Depending on the nature and severity of the problems, they will be admitted to either the medical unit or psychiatry. Patients in the medical unit with substance abuse problems are usually, but not always, referred for consultation to the substance abuse team in the department of psychiatry.

A second entrance point is through the department of psychiatry. The chairman of the department of psychiatry at Memorial Hospital has been a leader in establishing addiction psychiatry as a subspecialty in psychiatry. Strong leadership has placed Memorial Hospital at the forefront of addiction education for physicians, medical students and residents.

The Department of Psychiatry has a crises intervention unit and an individual who does the majority of addiction intakes. The department decides whether to admit the patient to the hospital or refer them to outpatient services. Most people admitted are at significant risk for withdrawal complications, or have co-morbidity problems that need to be addressed such as major psychiatric symptoms (homicide or suicide) or medical complications.

The substance abuse patients admitted to psychiatry are placed in the general psychiatry unit. This is a 40-bed

unit with cross-trained staff that can manage the general psychiatry patients, substance abuse patients and dually diagnosed patients. Because Memorial Hospital is a tertiary facility, it sees a large percentage of patients who are dually diagnosed.

Memorial Hospital provides both inpatient and outpatient detox services. Staff physicians use different pharmacological treatment approaches and provide methadone detoxification as well. Doctor s preferences and the patient s clinical profile determine the approach that is used. The detoxification program is flexible. If an inpatient is doing well they can be moved to the outpatient setting to complete detoxification and the reverse is also done.

Substance abuse outpatient services include a day/partial hospital with day and evening programs tailored to the patient. The length of time a patient stays in the program depends on individual need and also the type of coverage a patient has. Insurance companies tightly manage the length of time a patient receives services. There are about 15 people in the outpatient programs at one time. There is also a less intensive outpatient program and an early recovery group. The early recovery group lasts 16 weeks. A patient is as-

signed to one staff member who knows the patient, can access needed resources, and is available for one-on-one counseling. In addition to the early recovery group, patients are placed in self-help groups, or with private substance abuse counselors, psychotherapists, or psychiatrists as needed.

Staff at Memorial Hospital share a common philosophy regarding their approach to treating the addicted patient, but because it is a private hospital, the patient s private physician can manage the patient s treatment as he or she wishes. In some cases physicians try but fail to manage treatment services for their substance abusing patients on their own. Some patients never get a substance abuse referral that could help determine their underlying problem and inform the appropriate treatment protocol.

Five years ago Memorial Hospital had a dedicated 20-bed unit for the treatment of substance abuse patients. As with the other institutions, this unit was closed and these patients have been integrated into the general psychiatric unit. As has been the case in other hospitals, this was due to changes in patient treatment philosophy and insurance company reimbursement policies.

This change is not believed to have diminished the quality of services to these patients.

Organization of Services

Substance abuse services are part of the department of psychiatry under the section for addiction psychiatry. All phases of inpatient and outpatient treatment are coordinated. Memorial Hospital uses one universal evaluation form that follows the patient from one treatment site to another. Referrals for substance abuse services come from the psychiatric system, hospital, attending physicians and informal relations with other facilities.

Linkages

Memorial Hospital has a few informal arrangements with other substance abuse providers such as Hazelden, Gateway and Interventions. A staff psychiatrist provides consultative services to the City of Chicago s Target program, an addiction assessment, intake and placement initiative. Other staff provide professional support to an outpatient methadone treatment facility. The hospital also provides consultative services to a large mental health center. Memorial Hospital s ability to outreach

to the community is influenced by financial and academic imperatives. Commitments must be financially sound and also meet the service, teaching and research missions of the institution.

Memorial Hospital is part of a large hospital network. The network is structured loosely with no program coordination or centralized oversight services. The hospitals that are part of this network have a friendly but informal relationship. There is no overarching program that influences practice standards or policies across the network of hospitals for the delivery of substance abuse services. A local forum that brings together substance abuse program administrators and medical directors to discuss and work on common issues seems to be missing in Chicago and would be helpful.

Additional Resource Needs

According to staff, a need remains for some patients to be in a hospital setting for a longer period of time than the three to four days currently allowed. Patients who have repeatedly failed as outpatients because of the complexities and challenges they face in their living environment need longer, more intensive care in a stable setting in order to optimize chances for recovery.

Eisenhower Hospital

- ► Hospital type: Veterans Administration Hospital (largely tertiary with an academic affiliation)
- ► Number of staffed beds: Approximately 700
- ▶ Location: West side
- Service Area: Veterans living western suburbs and throughout the state of Illinois
- ► Reimbursement: Federal government with some third party recovery
- Network linkage: Part of Veterans Integrated Network 12 (VISN) and has community-based clinics located in Joliet, Elgin, Aurora and Oak Park
- ► ER: Basic
- Number of discharges: Data not available
- Number of drug and alcohol related discharges: Data not available.

Services

Eisenhower Hospital provides a full range of substance abuse services that include inpatient detox, dually diagnosed inpatient treatment, residential services, and outpatient treatment programs tailored to the patients needs. Many of the patients seen at Eisenhower Hospital for substance abuse treatment are indigent. Frequently they are homeless living in shelters or halfway houses. Childhood physical, mental and sexual abuses are not uncommon to this population of patients. The VA system is known for its successful approaches to treating the addicted patient.

VA hospitals have gone through a major restructuring in the last several years that affects the way services are being delivered. The restructuring has involved developing a budget based on a capitated or flat-line approach. For each patient, a hospital receives a specific amount each year for the provision of services, about \$2,600. It is responsible for approximately 35,000 patients. As veterans relocate from the rust belt to the sun belt and as veterans from World War II and the Korean War die. there are fewer and fewer who seek services at Eisenhower Hospital. These changes have meant that it has had to reduce costly inpatient days and is now

emphasizing outpatient services. It is also working to maintain as many clients as possible by moving services closer to where their customers live.

Prior to 1990, Eisenhower Hospital had eight units for psychiatric and substance abuse patients four 30-bed substance abuse units and four 30-bed psychiatric units (which included dually diagnosed patients). With the opening of a new facility, the number of units was reduced to six 30-bed units. Last year the hospital closed two substance abuse units and one psychiatric unit and introduced a new concept called Psychiatric (or Substance Abuse) Residential Rehabilitation Treatment Program (PRRTP or SARRPT). With this new approach patients are housed or lodged from 4:30 p.m. to 8:00 a.m. in what were the old inpatient units. Patients have their own room and are provided meals. In this model staffing requirements are significantly reduced. During the day patients receive intensive services for eight hours that include group therapy, visual training, special testing, individual counseling and compensated work. This program provides the patient with the day-to-day living structure and therapeutic support they need.

Eisenhower Hospital provides inpatient and outpatient methadone treatment. Currently it has 250 patients in its outpatient methadone treatment program.

Organization of Services

Substance abuse services are under the department of psychiatry. The department has a consultative team that works with other units of the hospital. Staff psychiatrists provide substance abuse services at the hospital s community-based clinics.

Linkages

Eisenhower Hospital uses a variety of resources to find living accommodations for its patients after they have completed their hospital-based treatment. These are informal arrangements with nursing homes, halfway houses, group housing and the like. The hospital currently provides the majority of services for its substance abuse patients within its service network. Eisenhower Hospital is, however, establishing capitated contracting for other services (cardiovascular surgery) and may, in the future, contract out certain substance abuse services if it is shown to be cost-effective.

The Waters Center A Community-Based Treatment Provider (CBTP)

- Organization: Community-based substance abuse provider
- ► Location: Two sites Near South Side of Chicago and a residential facility

Background

Waters Center is a not-for-profit organization that was established in 1976 after a statewide study determined that there was a significant and increasing need for substance abuse services. Waters Center was among the first organizations to contract with the state to provide those substance abuse services. It is licensed, monitored and funded by the Illinois Department of Human Services Office of Alcoholism and Substance Abuse (OASA). Waters Center s patients experience high rates of recidivism related to the time of year, the availability of street drugs or work/home life issues.

Services

The mission of Waters Center is to provide comprehensive treatment services to individuals and families who experience or may experience problems associated with the use of psychoactive substances. Waters Center provides adult services in two settings - one south of the Loop and the other through a residential facility located outside Chicago. The services include residential services, regular outpatient, intensive

outpatient, case management, HIV counseling and testing and aftercare. Also provided are physician assessment, psychological and social assessment, mental health consultation, individual counseling, group therapy, supervised group activities, vocational counseling and training. Special programs include didactic seminars, workshops, prenatal referral, and transportation. The provision of services to addicted pregnant women is a priority for Waters Center.

Waters Center has a central intake process where patients are evaluated and placed into appropriate levels of treatment based on the Addictions Severity Index (ASI) and American Society of Addiction Medicine (ASAM) placement criteria. Patients who need services outside those that are available through CBTP receive case management to assist in obtaining those services.

Waters Center provides methadone detoxification and methadone maintenance services for heroin-based addiction on both an inpatient and outpatient basis. The philosophy is to reduce harm

and stabilize an addict rather than to achieve total abstinence. Harm reduction means an individual no longer engages in harmful activities associated with obtaining illicit drugs. Waters Center staff believe that some patients will never be able to reach complete abstinence. By controlling the craving for heroin, methadone enables a patient to work and maintain a stable home life. Waters Center recognizes that in most instances addiction is a chronic disease and, as with diabetes, requires continued treatment. Waters Center uses other medical detox approaches as well depending on the specific type of addiction.

Waters Center's residential facility has a capacity of eighty individuals. Patients stay in the residential facility from 30 to 90 days. In the outpatient setting CBTP sees over 500 patients a day.

Organization of Services

A board of directors comprised of community leaders governs Waters Center. An executive director oversees operations of the agency. Medical services are supervised by a medical director supported by a physician staff including a psychiatrist and a full time nursing staff. Full and part-time staff have recently been reduced from 110 to between 80 and 90 because of budgetary constraints. Most of the Center's funding for services comes from OASA and is based on a contracted case rate.

Linkages

Waters Center has no formal linkages with other providers and is not part of a provider network. It does participate in the Advanced Behavioral Care group (ABC) which was formed by the South Side Consortium to contract with managed care organizations and hospitals to provide behavioral health and substance abuse services. Waters Center has no specific hospital linkage. Level IV patients who need inpatient care are not easily placed because they frequently lack insurance coverage. Stronger hospital linkages would help strengthen services.

Problems Related to Funding

Funding priorities often favor services for one population at the cost of service provision for another population. Often this tradeoff is between services for men or for women.

Changes in funding priorities can be a problem for community-based providers who must adjust their delivery programs to meet demands of their funders. The impact of policy changes on community providers delivery systems has not been sufficiently evaluated.

Treatment success is defined differently by different groups. Success is defined as abstinence by some while others consider reducing drug use from every day to once a week as a sign of success. Variations in definition are problematic when evaluating program productivity.

List of Interviews

Academic hospital Psychiatrist , head of substance abuse program

Teaching hospital Primary Care Physician/Addiction Specialist , head of substance abuse program

VA hospital Psychiatrist, head of substance abuse program

Community hospital Psychologist, head of substance abuse program; also included nurse and social worker

Community hospital Psychologist, head of continuing education and substance abuse training

Director of Mental Health Services collar county

American Medical Association Psychiatrist, formerly at an academic hospital

American Hospital Association

Illinois Hospital and Health Systems Association

Illinois Department of Public Health

Illinois Office of Alcohol and Substance Abuse three staff

Illinois Department of Public Aid

Illinois State Medical Society

Safer Foundation

Parity Legislation Lobbyist

Substance Abuse Researcher

Chemical Dependency Counselor

Family member of substance abusing patient

Dually diagnosed patient in recovery

Former prevention program staff member