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in this issue

Are You a Victim
of Identity Theft?

169

Coordinating Effort between
Behavioral, Primary Care

174

Osteogenesis
Imperfecta

178



Example of Coordinated Effort between Behavioral Health and Primary Health Care

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Introduction Substance abuse is a chronic brain disorder that is endemic and generally not addressed resulting in excessive health care and societal costs. The most recent National Survey on Drug Use and Health (NSDUH) in 2013 estimates that only 2.5 million (0.9 percent) of the estimated 22.7 million (8.6 percent) of Americans needing drug or alcohol treatment ever receive this care. It is likely that similarly low levels of engagement exist for the 7.7 million Americans (3.2 percent) with co-occurring mental health and substance abuse disorders.¹

Patients who are actively abusing substances are common in the hospital emergency departments (ED) and inpatient settings. Frequent users of both the ED and inpatient estimates vary from 58 to 77 percent.^{2,3} Untreated, substance abuse is associated with significant medical and psychiatric co-morbidities and their

resultant poor health outcomes and costly recurring overutilization of the hospital's health care resources.⁴ It is estimated that substance abusing frequent users result in 8.9 ED visits annually with average annual charges of \$13,000 per patient.² It is further estimated that substance abusing frequent users result in 1.3 inpatient hospital admissions annually — 5.8 inpatient days each — with average annual charges of \$45,000 per patient.²

To address this need, Project Engage (PE) was developed to engage and assist substance-disordered patients to transition into community based drug treatment. The program was launched in 2008 as a collaboration between Brandywine Counseling and Community Services (BCCS) — a major provider of addiction treatment in Delaware — and Christiana Care Health System (CCHS) — one of the largest health care providers in the US mid-Atlantic region. This innovative program utilizes Engagement

Specialists (ES) who are in recovery from drugs and/or alcohol use and are embedded into the various clinical settings within the health care system including the ED, inpatient floors, and outpatient clinics. Research conducted at CCHS has shown that PE results in reduced health care utilization and costs.⁵

ES utilize early engagement strategies such as motivational interviewing and, when appropriate, share their own story of recovery to quickly build a therapeutic relationship in order to focus on the needs of the patient. ES assess readiness to change and perform a brief intervention appropriate to the patient's willingness to change. Along with the PE Social Worker, PE staff provide a range of services from giving information or teaching about addiction and available community resources, to initiating specific drug treatment at the bedside and/or connecting patients with community resources including fellowship self-help groups or drug treatment (outpatient or inpatient).

A Community Engagement Specialist (CES), also a peer counselor, is available to continue providing ongoing continuing care for patients upon discharge from the hospital. The CES works in partnership with the PE Social Worker to provide a range of services such as relapse prevention and care coordination for substance abuse, physical, and mental health needs. This process allows a patient to start recovery in the hospital and then continue recovery once discharged from the hospital.

The following case presentation illustrates the critical interplay between PE, behavioral health, and primary health care in the hospital and the community to provide this patient an opportunity to recover and live a fulfilling life.

CASE DESCRIPTION

The patient is a 52-year-old white male with a 43-year history of continuous chronic alcohol abuse without any intervening episode of sobriety. His typical pattern of use consists of six 24-ounce beers and half a pint of vodka daily. He was unable to achieve abstinence despite numerous detoxification admissions and 12 outpatient and inpatient drug treatment attempts over the last 12 years. His other medical issues include diabetes, hypertension, COPD, gastric reflux, and an enlarged prostate. Mental health issues identified are anxiety disorder, bipolar disorder, depression, and PTSD. He has outstanding legal issues, no family support, no sober support network, and a lack of coping skills further complicating his ability to achieve and maintain abstinence. Before entering the PE Community Program on May 5, 2015, the patient had two inpatient episodes (total of 38 days) and 11 ED episodes at CCHS over the prior ten months. The patient moved to Delaware the fall of 2012. In addition to the hospital

episodes prior to entering the Community Program, the patient had four inpatient episodes (total of 49 days) and 19 ED episodes from December 2012 until May of 2014.

On April 20, 2015, he was again admitted to CCHS Wilmington Hospital with urosepsis complicated by alcohol withdrawal. He did well on IV antibiotics and stabilized on the Clinical Institute Withdrawal Assessment (CIWA) triggered protocol. After expressing to his nurse he was "tired of waking up in the hospital and ready for a change," he met with the Inpatient ES who began the substance abuse treatment referral process utilizing the PE Social Worker. He was subsequently transferred to the inpatient behavioral health unit at Wilmington Hospital four days later to adjust his psychotropic regimen.

Upon discharge on May 8, 2015, the psychiatric staff learned that he was no longer approved for his residential bed. Unfortunately there were no options and he was discharged to a temporary shelter while waiting for inpatient substance abuse treatment in order to provide a safe recovery environment. The CES transported the patient to the shelter and continued close contact to maintain engagement while alternative treatment plans were finalized. Through the collaborative efforts between the psychiatric staff, the PE Social Worker, and the CES, the patient was eventually enrolled in a local inpatient stabilization drug treatment program at Gaudenzia where he stayed until he was able to enroll in the Rockford Intensive Outpatient Program (IOP) on May 26, 2015. The IOP program provides patients the flexibility to attend three to four sessions per week on days of their choice. The program helps individuals identify the underlying causes of addiction, assists them in developing coping skills, and improving overall mental wellness. When the patient moved to his own apartment, the CES continued to meet with him two to three times weekly, providing encouragement and reviewing critical lessons learned at the Rockford IOP. While at the IOP, the CES escorted the patient to his psychiatric and primary care appointments where the CES helped the psychiatrist and other physicians better understand what the patient was experiencing but having difficulty articulating. He did well, remained abstinent, and eventually graduated from the IOP program on August 10, 2015.

After graduation from the Rockford IOP, the CES and the patient developed a treatment plan that included relapse prevention, improving life skills such as hygiene, housekeeping skills, and nutrition. Working closely with the CES, the patient reported gaining confidence and new insight into what was possible for him to accomplish, as well as practiced new skills to live a sober life. With this new confidence, the patient began utilizing critical community resources such as local transportation to attend social services, primary care, and ongoing mental health treatment. After

his mental health and primary care appointments, the patient and CES would process the appointments either by phone or in person.

Encouraged to address residual legal issues, the CES escorted the patient to court. The judge, who had seen the patient in the past, was so impressed with the patient's progress, he dropped all outstanding charges contingent upon him addressing any fines that remained. He was ordered to go to the cashier's office in the courthouse, and with the assistance of the CES developed a payment plan. With his legal issues resolved, the CES escorted the patient to the Department of Motor Vehicles (DMV) to obtain a state ID and assisted him through his successful application for social security disability income (SSDI).

The CES also helped the patient connect to a sober social network including introducing him to 12-Step meetings which he now attends daily. He continues to work on developing and practicing alcohol-free social and recreational skills critical to his improving confidence and self-esteem. Lastly, with CES support, the patient has identified a major goal of spending more time with his family from whom he had been estranged for many years. Recently he traveled with his brother to see his grandchild for the first time.

Due to close collaboration between the inpatient medical staff at Wilmington Hospital, the inpatient psychiatric staff at Wilmington Hospital, the PE social worker, the PE Inpatient ES, the PE CES, the patient's psychiatrist, and the patient's primary care physician, the patient was able to realize a number of positive changes and results in his life.

In the nine months working with the CES, the patient attended AA meeting and remained sober thus breaking a 43-year cycle of drinking. His personal care and his social support greatly improved. He became stable on his psychotropic medications. His diabetes and hypertension became well controlled, and his legal issues were resolved. Prior to entering the PE Community Program, the patient had two inpatient episodes and 11 ED episodes at CCHS over the past ten months. In the nine months following working with the CES, there have been no CCHS alcohol-related hospital visits. There was one ED visit due to a prescription medication interaction. After being contacted by the patient, the CES contacted

the PE Social Worker who set up emergency appointments with the psychiatrist and the PCP to have this issue addressed.

CONCLUSION

Substance abuse has a severe impact on the individual, the family, and society, including hospitals, the criminal justice system, and social services. Substance abuse is ubiquitous, destructive, and hard to address because users are hard to engage. Project Engage is effective. Experientially credentialed peer counselors, trained in early engagement strategies can forge therapeutic relationships with hospitalized patients helping them initiate and sustain recovery.

As this case presentation shows, success requires coordinated efforts of the hospital medical psychiatric teams, the Inpatient Engagement Specialist, the Project Engage Social Worker, and the Community Engagement Specialist. By working together this team helped facilitate a continuum of care that has enhanced long-term addiction recovery outcomes for this patient.

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