



ASAM American Society of
Addiction Medicine

Public Policy Statement on the Addiction Medicine Physician Participation in and Leadership of Multidisciplinary Care Teams

Note: Many addiction specialists provide addiction treatment in solo or small group specialist practices. They can and do provide excellent care. Others may employ a counselor or physician extender. ASAM supports these practices. Others practice in treatment centers with multiple professionals, and they work as teams. Others might work in primary care practice, providing leadership, training and consultation to the physicians, physician assistants and nurse practitioners in the practice. This policy is directed for those physicians who work in setting where there is team-based care.

Background

Addiction Medicine care in the United States has a long history of being delivered to patients using multidisciplinary teams of health care professionals. The most traditional 20th Century format for addiction treatment in America has often been referred to as "The Minnesota Model" and it drew from models in psychiatrist state hospitals which used multidisciplinary teams to offer patients professional interventions of different modalities and different perspectives, in order to meet the broad spectrum of bio-psycho-social-spiritual problems seen in the patient with addiction. Addiction counselors along with nurses, psychologists, recreation therapists, occupational therapists, and vocational rehabilitation counselors, among others, have perspectives that can be applied to the benefit of patients.

The role of the physician within the addiction care system has admittedly been mixed over the years. The American Society of Addiction Medicine amended its mission statement in 2007 to state that one of the core functions of the Society is to "promote the appropriate role of the physician in the care of the patient." The need to attend to this aspect of addiction delivery system design and treatment planning is a reflection of the reality that the role of the physician has been unclear or even awkward at times. In many settings, the care team has been led by non-physicians, and the main role of addiction assessment has fallen to the certified addiction counselor. Physicians at times had roles that were limited to general medical assessment of the patient such as conducting a physical examination; prescribing medications while others offered counseling or psychotherapy; evaluating the psychiatric needs of the patient with addiction; or doing nothing more than affirming the "medical necessity" of certain addiction services in order that the treatment agency might be able to confirm the appropriateness of the treatment plan and secure third party payment from Medicaid, Medicare or a commercial insurance plan for the treatment decided upon by the treatment team.

Medical care in the United States has been evolving in the first years of the 21st Century toward more appreciation of and application of team-based approaches to care. With the profound

shortage of primary care physicians and the clear need for a primary care orientation to understand the breadth of an individual patient's problems and their social, cultural and familial context, the role of non-physicians, including physician assistants, nurse practitioners and social workers, has expanded. In this time, the Patient Centered Medical Home (PCMH) concept has gained popularity as a coordinated and comprehensive model of primary care delivery and efficient deployment of health care workforce resources.

The American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA) have published a set of Joint Principles of the Patient-Centered Medical Home which address the role of the physician within such a comprehensive, coordinated care delivery system.¹ These principles state that "each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care" and that "the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients." Addiction care is analogous, and while these principles describe the key roles of the primary care physician in health care teams, they describe well the role of the addiction medicine physician within the addiction care team.

In 2013 the American Society of Addiction Medicine adopted a document describing the "Standards of Practice for the Addiction Specialist Physician."² In this document, the role of the physician in being a direct caregiver, including key responsibilities in the development of patient treatment plans, is described alongside the role of the physician in care management. The document recognizes the amount of care for substance use disorder and related health conditions that is offered to patients via health care teams, and the key role of the physician in coordinating that care and being ultimately responsible for that care. The Introduction to the document references some of the ways that physicians could be utilized within health care teams that would be viewed as suboptimal – such as the physician who simply sits in a meeting of multiple members of a multidisciplinary team and "signs off on" documents developed by others and submitted for quality assurance, program accreditation, or third party reimbursement purposes. The role of the physician should be central to evaluating and meeting the patient's needs.

It is also well understood that the addiction physician specialist workforce is small and will not in any reasonable future be large enough to directly meet all of the needs of the more than 20 million Americans with a diagnosable substance use disorder. As of 2013 only 10.9 percent of those needing treatment for an illicit drug or alcohol use problem received it,³ making it clear that in order to meet the treatment needs of patients, integration of addiction care into primary health care is a necessity. As such, more and more addiction evaluation and management services are being designed to be delivered in primary care settings and through multidisciplinary teams of professionals working in those settings, such as primary care medical homes.

Recommendations:

Addiction Treatment Programs

1. Within an addiction treatment program, the addiction physician should have a leadership role and have direct patient contact as time allows. The other members of the treatment team should respect the physician's opinion, but in turn the physician needs to respect

the viewpoint of other team members including social workers, psychologists, certified addiction counselors and community workers. At times a minimally trained community worker may have insight into a problem that a more highly trained professional may not have.

2. All views need to be respected. Various viewpoints may exist on what is the best treatment. The physician should respect the process of receiving input from all professionals on the team and, most importantly, input from the patient. If a given plan is not working, the physician should take leadership in having it changed.
3. Effective communication is a key component of any medical care and especially team-based care. The physician needs to listen carefully to the patient and other team members. The physician should also make sure that the treatment program communicates to referring primary care physicians and, in the case of inpatient programs, to referring outpatient programs. Discharging a patient back to an outpatient program or to a primary care practice without timely contact with those who will provide follow-up care is unacceptable. If possible, physicians should contact other physicians directly.
4. Physicians who supervise physician assistants (PAs) and nurse practitioners (NPs) should actually meet with them, discuss cases and provide guidance and education rather than simply signing off on their work.

Addiction Medicine and Primary Care

1. Addiction medicine physicians should support the increasing involvement of primary care physicians toward addressing the needs of patients with addiction. Addiction should be approached as a chronic disease like other chronic medical conditions, and physician involvement with the patient should extend over a significant duration of time, with a physician available to the patient for revisits over the course of the individual's lifetime as necessary--just as would be the case in the management of diabetes, hypertension, arthritis and other common chronic diseases.
2. As healthcare teams increase their receptivity and their capability to evaluate and manage the needs of patients with addiction and other substance related health conditions, addiction medicine physicians should make themselves available to collaborate with their medical colleagues and participate as members of healthcare teams.
3. Addiction medicine specialists should consider working with primary care groups in providing provider education, setting up screening programs, prescribing medication to treat addiction, and quality assurance programs related to addiction.
4. When specialty addiction care is indicated, addiction medicine physicians should lend their expertise to multidisciplinary clinical teams designed to evaluate and manage addiction, and addiction medicine physicians should recognize their training experience and expertise and assume leadership of clinical teams.

Adopted by the ASAM Board of Directors January 20, 2016.

© Copyright 2016. American Society of Addiction Medicine, Inc. All rights reserved. Permission to make digital or hard copies of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for commercial, advertising or promotional purposes, and that copies bear this notice and the full citation on the first page. Republication, systematic reproduction, posting in electronic form on servers, redistribution to

lists, or other uses of this material require prior specific written permission or license from the Society. ASAM Public Policy Statements normally may be referenced in their entirety only without editing or paraphrasing, and with proper attribution to the society. Excerpting any statement for any purpose requires specific written permission from the Society. Public Policy statements of ASAM are revised on a regular basis; therefore, those wishing to utilize this document must ensure that it is the most current position of ASAM on the topic addressed.

American Society of Addiction Medicine

4601 North Park Avenue, Upper Arcade Suite 101 Chevy Chase, MD 20815-4520

Phone: (301) 656-3920 | Fax: (301) 656-3815

www.ASAM.org

¹ American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA). Joint Principles of the Patient-Centered Medical Home. February 2007. Available at:

http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf Accessed November 5, 2015.

² American Society of Addiction Medicine (ASAM). Standards of Care for the Addiction Specialist Physician. 2014. Available at: <http://www.asam.org/docs/default-source/practice-support/quality-improvement/asam-standards-of-care.pdf?sfvrsn=10> Accessed November 5, 2015.

³ Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.