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Gaps in the Substance Use Disorder Treatment Referral Process: Provider Perceptions

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Abstract

Objectives—The demand for substance use disorder treatment is increasing, fueled by the opioid epidemic and the Affordable Care Act mandate to treat substance use disorders. The increase demand for treatment, however, is not is not being met by a corresponding increase in access to or availability treatment. This report focuses specifically on the treatment referral process, which we have identified as one of the key barriers to timely and effective treatment. Difficulties in referral to substance use disorder treatment are examined through the lens of providers who make referrals (i.e., referral source) and individuals who work in substance use disorder facilities (i.e., referral recipient).

Methods—Administrative officials, emergency department physicians, addiction physicians, government officials, providers, insurance officials, and mental health advocates (n=59) were interviewed on the referral process protocol, challenges for providers and others making referrals, and issues with substance use treatment facility intake procedures.

Results—Several main themes were identified as barriers in the process: difficulties in determining patient eligibility, lack of transparency regarding treatment capacity, referral source knowledge/understanding of options, and issues with communication between referral source and recipient. We then propose several solutions to address specific barriers.

Conclusions—Current gaps in the referral process cause delays to care. Improving systems would involve addressing these themes and expanding the use of appropriate treatments for the many patients in need.

Keywords

substance use disorder; inpatient detoxification; emergency medicine; treatment

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1. Introduction

The prevalence of substance use disorders remains high in the United States. Substance misuse produces over $166 billion in health care costs and strains hospital capacity (National Institute on Drug Abuse, 2015). Overdose deaths have more than doubled since 2002: over 52,000 overdose deaths were reported in 2015 (National Institute on Drug Abuse, 2017). Costs related to crime, lost work, productivity and health care exceed $700 billion, or $2195 per person (Centers for Disease Control and Prevention, 2014; National Drug Intelligence Center, 2011; Rehm et al., 2009). The CDC and NIDA consider substance use disorders a 'treatable chronic disease', citing evidence that treatment is as effective and sustainable as treatment for chronic diseases such as diabetes (McLellan et al., 2000; National Institute on Drug Abuse, 2016; Open Society Foundation, 2010). Unfortunately, the gap between need for substance use treatment and receiving treatment in the US is widening (Open Society Foundation, 2010; Substance Abuse and Mental Heath Services Administration, 2014). Despite the morbidity and societal costs associated with drug and alcohol use, treatment is inaccessible to many (Open Society Foundation, 2010). Of the 21.7 million identified in need of treatment, only 2.35 million were treated at a specialty facility (Substance Abuse and Mental Heath Services Administration, 2016).

Barriers to substance use treatment referral and access can be evaluated from three vantage points: (a) individual level, (b) the intra-organization level, and (c) the across-organization level (D'Aunno, 2006). For individuals, access to care is known to be interrupted by wait time, motivation for treatment, beliefs about availability or efficacy of treatment, the experience of physiological withdrawal symptoms, insurance limitations, financial concerns, transportation difficulties, lack of social support, and difficulty taking time off work for treatment (Digiusto and Treloar, 2007; Peterson et al., 2010; Rapp et al., 2006; Redko et al., 2006; Strathdee et al., 2006). Treatment organizations are plagued with funding and contractual difficulties, and staff training and turnover concerns, which may limit care. The inter-organization level barriers, particularly those related to referral of patients, remains understudied, and a central limitation to the widespread receipt of substance use treatment.

The difficulty for providers referring patients between organizations is made more salient by the limited national capacity for substance use treatment. Indeed utilization rates of existing inpatient and outpatient services are increasing faster than capacity (Substance Abuse and Mental Heath Services Administration, 2015a). This is being driven, in part, by the Affordable Care Act's mandate that all health insurance sold on the exchange must cover substance use disorder treatment services. Notably, between 2003 and 2013, the number of facilities participating in the national survey of substance abuse treatment services (NSSATS) increased by 4% while clients served increased by 14% (Substance Abuse and Mental Heath Services Administration, 2015a).

An ever-widening group of organizations, offering a diverse set of treatments, contributes to confusion for patients seeking assistance and for clinicians directing referrals. While SAMHSA provides an online national treatment directory for providers search for information on local options (Substance Abuse and Mental Heath Services Administration, 2015b), an entirely separate SAMHSA web site lists over 350 evidence-based practices

(Substance Abuse and Mental Heath Services Administration, 2015c). The referral and access problem is further complicated by a lack of readily available information on organizational level treatment and clear guidelines on what constitutes evidence-based care (Substance Abuse and Mental Heath Services Administration, 2012).

In this study, we examined gaps in the treatment referral process affecting patient treatment access through qualitative interviews of providers, administrative professionals, and other stakeholders in several cities. Participants represented individuals who make referrals (i.e., referral source) and those who receive referrals (i.e., referral recipient).

2. Materials and Methods

Study participants were 59 stakeholders in the treatment referral process from December 2015 to March 2017 (65.9% male). We collected this convenience sample by contacting approximately 150 potential stakeholders by personalized email or phone call who were involved with substance use treatment or policy and informing them that we were conducting a NIDA-funded research study related to referral difficulties in the substance use treatment system, and requested 20-30 minutes of their time to discuss their specific difficulties in hopes of developing a more effective referral system. Additionally, existing participants often referred potential participants to research staff. We spoke to individuals in person, by phone, or webinar. Specifically, we spoke to emergency department physicians (n=15), addiction physicians (n=2), other medical providers (n=8), substance use treatment facility staff and administrators (n=23), government officials (n=9), an insurance official (n=1), and a mental health advocate (n=1) from Indiana, Washington DC, West Virginia, Connecticut, and Massachusetts. Stakeholders represented a variety of types of organizations: urban and academic (n=28), urban and non-academic (n=12), rural community non-academic (n=6), government-related (including Veterans Administration, n=11), and other (for-profit insurance company and state nonprofit organization, n=2). Among stakeholders who were housed within a healthcare organization (n=46), organizations ranged in size: 32 stakeholders were employed by a large organization, 4 within a medium-sized organization, and 12 within a small organization. These stakeholders represented individuals who provide referrals (i.e., referral source) and those who provide the substance use treatment (i.e., referral recipient). In interest of obtaining more relevant data from individuals who were familiar with the referral process, all providers were asked how frequently they made drug or alcohol addiction treatment referrals (never, rarely, regularly, often, or all the time), and each respondent answered at least “regularly.” Participation was voluntary and no compensation was provided.

The purpose of interviews was to gather information on difficulties in the referral process (both referral from medical services to substance use services (e.g., from emergency room to detoxification) and from substance use services to other substance use services (e.g., from detoxification to outpatient care) in an effort to develop and implement a new referral system. During interviews, clinical providers (i.e., those who referred patients to treatment) were asked the frequency in which they make referrals, the process in which referrals are made to substance use treatment, and barriers and challenges for medical providers in making referrals. Stakeholders employed by a substance use treatment facility (i.e.,

recipients of referrals) were asked a series of questions about referral to their services and other substance use service providers: how patients are referred, how referrals become aware of capacity data, information obtained upon referral, issues with intake and referral process, typical capacity, reimbursement, and insight into ways to streamline the referral process. Discussion by research staff with stakeholders began with the formal questions above, and led to more specific barriers and additional themes emerging. Detailed notes (including verbatim quotes) were recorded from these conversations. Independent coders then extracted themes, based on review of notes. Themes that were substantiated by multiple (i.e., 3 or more) stakeholders and agreed upon by both coders were retained.

3. Results

Table 1 displays results from qualitative interviews of stakeholders in the substance use disorder treatment referral process. Barriers can be divided into four broad themes: patient eligibility, treatment capacity, referral source knowledge/understanding of options, and communication between referral source and recipient.

The first theme, Patient Eligibility, describes the difficulties referrers face in determining whether a patient meets a particular treatment center's admission criteria. As an emergency department physician described, "Each referral site seems to have different requirements and it would be nice if it were standard or if requirements were readily available." Several administrators and providers reported that eligibility may depend on co-occurring medical conditions, substance of choice, patient insurance, psychiatric condition, legal history, suicidality/homicidality, and/or language barriers. For example, a government official explained "We don't want to make a referral and send [a patient] only to have the person rejected because of the wrong [insurance] coverage." A substance use facility administrator described the need for "a standard assessment tool for levels of care at different facilities – everyone does this differently and the intake process and requirements are different, which is confusing." Even if eligibility criteria are known, it is often difficult to determine whether a patient fits those criteria. A medical provider reported that referral sources often "do not have a good way to evaluate people as to whether they have an underlying medical of psychological issue that is manifesting as a drug problem." In summary, eligibility requirements may prevent a patient from entering a treatment center, and there are no universal treatment eligibility criteria.

A second and related theme, Treatment Capacity, measures the extent to which referral sources are able to judge a recipient organization's capacity, once a patient was determined to be eligible to transfer. A medical provider reported on the process for determining capacity as "Lots of phone calls," and a physician reported that providers "have to repeat information when submitting referral requests… [often] redoing the paperwork." As such, despite the need for services, treatment centers may not run at capacity, because of frustrations encountered and time wasted on the referral and admission process. A provider reported that facilities that are under capacity may reduce staff, and another provider responded that treatment centers would likely respond (i.e., by fully staffing operations) "once facilities see that they can fill beds."

The third theme, Provider Knowledge and Misunderstanding of Options, emerged because there are a variety of substance use treatment options, depending on level of care needed (e.g., outpatient therapy or counseling services, partial hospitalization programs or intensive outpatient programs, inpatient services and residential programs). It can be difficult for some referral sources to understand and select the most effective options and/or services for their patient, particularly in an ever-changing services environment. As a government official describes, before capacity data is checked and a referral can be made, “The first step is letting [providers] know what the appropriate service is.” As an administrator a mental health advocate reported, there is a “difficulty in referring clients to some other provider due to lack of understanding of what services are provided by a provider,” a sentiment echoed by a substance use treatment facility administrator “even providers don’t understand the levels of care continuum.” As an emergency department physician described, “The biggest problem is knowing what sites are available. I don’t know all of the referral sites.” Even available online directories are not updated and rarely provide all options. After determining appropriate level of care, a provider must then find a program that meets the patient needs, which becomes more difficult with the differences in terminology and program guidelines. A treatment facility administrator described the “different acronyms and nomenclature” that can vary across programs, which can add to the challenges in educating providers on treatment options.

A fourth theme, Communication, articulates the difficulties in communication infrastructure and process between referrers and recipients, which theoretically increase the time between when a patient announces their desire for treatment and the patient’s entry into treatment. An emergency department physician elaborated that “people show up at the ED wanting immediate help or admission. They want someone to take care of them. Best we can do is give a list of referrals. It’s still up to the patient to go, make the call or physically admit themselves. This rarely happens. They usually get discharged from ED and continue to abuse.” A provider described this difficulty as “the time lapse between when a patient expresses desire to enter treatment, and then they are discharged, and [treatment facility intake staff] can’t reach them again after they are discharged…[We] need direct referral from ED to a bed.” This need appears to be especially apparent among opioid users: a government official explained an ideal system for heroin overdose response as “a system to get people from the emergency department who overdose into care directly… from ED, to transport, to treatment.” After a referral has been made, it is often uncertain if the patient had been contacted by the treatment center or received substance use treatment. As an emergency department provider described, “[The] process relies on patient following up. [We receive] no feedback on patient’s progress or treatment outcome.”

4. Discussion

Access to substance use disorder treatment is often a maze that can be difficult to navigate for both providers and patients. Results from qualitative interviews with persons involved daily in the treatment referral process describe the twists and turn to entering or continuing care. An increasing number and variety of entry points to substance use disorder treatment coupled with the many different types and intensities of care will continue to compound their problem. Policy-makers should be made aware of these current organizational

difficulties and provided with effective solutions that lead to improved care. Below is a discussion of these difficulties and recommendation for improvement.

A database of clearly articulated eligibility criteria may help streamline the treatment referral process. Currently, there is no single set of universal eligibility criteria for substance use disorder treatment, which may be due in part to the many and varied treatment options. As such, time and resources are spent on both determining what the eligibility criteria are for a particular treatment facility and in determining if a patient meets them. This difficulty is compounded by insurance and/or Medicare requirements. The CDC and the Department of Health and Human Services (HHS) strongly recommend expanding screening and treatment access and integrating some forms of drug treatment into health care systems, especially medication-assisted treatment into primary care settings. This integration would eliminate the need for determining eligibility criteria because receipt of services would occur within the existing system. But substance use disorder treatment remains specialized, often geographically separated from medical care sites, and therefore gaps in referral prominent.

Effectively capturing *real-time* treatment capacity and making it transparent to referring organizations may help inform the case for funding additional treatment capacity, expanding resources at existing facilities, and introducing policies and programs to improve coordinated care. Treatment centers often lack digital systems to communicate service provision and availability, intra-organizational changes, and treatment outcomes. Patients are too often referred for care based on the referrer's expectation of recipient capacity and need rather than what might actually be available or the most effective care for the patient. For instance, many patients are referred for inpatient treatment; however, referral to medication-assisted therapy (MAT) on an outpatient basis may be the most appropriate in some cases. Digital decision support tools and online, real-time availability sources are good starting points to improve the current situation.

Practitioner education and training may help bridge the substance use treatment gap (Anderson, 2009), and potentially increase the ability for a provider to detect substance use problems, determine the appropriate treatment. Despite the fact that substance use disorder is a medical illness, the treatment for substance use is not standardized. Evidence-based practices for substance use treatment include: thorough assessment of needs using empirically-supported measures, either linking patients to or providing medical and social services, retention of patients throughout the course of treatment, appropriate use of medication, and follow-up and referral to aftercare (D'Aunno, 2006). Lack of provider education regarding substance use and mental health treatment options (particularly evidence-based treatment) may lead to referral to inappropriate care (e.g., Crowley & Kirschner, 2015; Grimshaw et al., 2001). For instance patients are often referred to inpatient care when they may be appropriate for outpatient services. However, clinicians often lack training regarding empirically-based practices for substance use treatment. On average, medical school students receive 12 hours or less or substance use education, most of which involves the biological bases of substance use disorder rather than empirically-supported treatment (Ram and Chisolm, 2016). Non-physicians, such as social workers and case managers, often make referrals and have little to no required training in empirically-supported treatment of substance use disorder (Russett and Williams, 2015).

Difficulties in communication are indicative of an inefficient system, and lead to delays in treatment receipt. One way to improve this communication and reduce wait times is to implement new information technologies (IT). HHS strongly advises leveraging health IT to improve clinical care and access (Centers for Disease Control and Prevention, 2015; US Department of Health and Human Services, 2013). An IT solution may address across-organization barriers to treatment by developing a provider-facing platform to facilitate the referral and placement of patients in need of treatment with special emphasis on appropriateness of the referral. Timely access is critical and longer wait times increase attrition: half of substance misusers drop off a waiting list between an initial step toward intake and treatment entry (Donovan et al., 2001; Festinger et al., 1995; Hser et al., 1998). Quicker treatment entry increases the likelihood of completing treatment (Hoffman et al., 2011). Substance use disorder treatment too often falls outside of the health care continuum due to the involved treatment finding logistics and lack of provider education.

Although administrators and providers addressed similar barriers, several trends emerged. Administrators tended to focus on time and resources spent on determining eligibility and capacity, inconsistencies in eligibility status, and the need for better tools to address these issues. Providers focused on inability to get people into treatment and difficulties in communication – specifically, knowing if a patient received care. Thus, when determining solutions to these barriers, it will be important to continue to include both administrators and providers in the process.

The current study has several limitations. First, since participants were recruited via convenience sampling, results may not generalize to a larger population. However, themes were substantiated by multiple respondents, which increases the likelihood that they represent true barriers. Second, given that stakeholders were not equally represented, it is possible that additional themes were missed (e.g., from mental health advocate standpoint or insurance official standpoint). Third, several themes were endorsed by respondents but were beyond the scope of the paper, such as individual-level barriers (e.g., childcare, transportation, and motivation) and physician-specific barriers (e.g., burn-out). These themes are worthy of future study.

5. Conclusions

Substance use treatment providers lack true population-level data, including patient need, organizational capacity, referral processes (where and for what conditions), and long-term tracking of treatment outcome. By improving systems that enhance communication across organizations, patient referrals may be more easily completed, improving access to care and expanding the use of appropriate treatments for the many patients in need.

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Table 1

Barriers Identified from Qualitative Interviews

Barrier Theme	**Specific Difficulties**
Patient Eligibility	Time and resources spent on determining patient eligibility
	Lack of clear eligibility criteria
	Difficulty determining eligibility
Treatment Capacity	Time and resources spent on determining capacity
	Facilities not running at capacity also lose, financially
Provider Knowledge, Misunderstanding of Options	Lack of provider education on appropriate SUD treatment
	Lack of provider knowledge of the treatment options
	Options are not present in available online directories
	Inconsistent terminology. No standardized rules or guidelines.
Communication	Inefficient systems increase patient waiting time – patients need treatment on demand
	Lack of direct, committed communication and communication technology between sites means that there is no way to know if patient received care