Better Government Nomination
March 29, 2010

2010 BETTER GOVERNMENT COMPETITION

ENTRY TEMPLATE

1. **Program Name: Addiction Medicine Associates, Inc.**
2. **Administering Agency: Preventive Medicine Associates, Inc.**
3. **Contact Person (Name & Title): Dr. Punyamurtula S. Kishore MD., MPH.**
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7. Please provide a brief overview of the issue at hand, the problem that the proposal addresses, including relevant background information on its nature and scope.
Suggested length: up to up to ¾ page.

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The scope of our country's drug problem is disturbingly clear: drug overdoses outnumber gunshot deaths in America and are fast approaching motor vehicle crashes as the leading cause of accidental death (1).

As a result of the failure to prevent and treat addiction with effective models, nine percent of the U.S. population has a clinical substance use disorder, the burden of which falls substantially upon federal, state, and local government taxpayers. Alcohol-related costs alone are over $185 billion in health care, lost productivity, and in criminal justice.

(1) The total cost of substance abuse and addiction to the Commonwealth of Massachusetts in 2005, the most recent year for which aggregate data is available, was over $4.5 billion, which represented 21.8 percent of the total state budget in 2005.

(2) A number of models for the understanding and treatment of addiction have been proposed and modified since the colonization of the Americas in the 16th and 17th century. The earliest settlers of New England brought the moral model with them from England. In this model addiction is considered sinful and a matter of choice. The addict is a depraved individual who abandons God, family and community, with no concern for their own well-being. Vestiges of this model can still be found today.

In the early nineteenth century Benjamin Rush of Philadelphia and Thomas Trotter of Scotland, independently proposed that alcoholism should be regarded as a disease. Rush is considered to be the first physician to call alcohol dependence an addiction.

(3) The medical profession resisted the proposal. In the mid-nineteenth century, however, a fellowship of six hard drinkers embraced the central concept of Rush's proposal that chronic inebriation was a disease and abstinence from alcohol was the goal of treatment. They founded the Washingtonian movement in 1840 with the belief that by relying on each other, sharing their alcoholic experiences and relying upon divine help, they could keep each other sober. In 1857, they joined a new trend in the country and opened Washingtonian Homes in Boston and Chicago becoming a part of a loose network of facilities offering treatment to drunkards. The Boston facility which was the last survivor of the group closed in 1980.

Alcoholics Anonymous (AA) was founded in the 1930s by Bill W and Dr. Bob, who apparently had little knowledge of the Washingtonian movement. They introduced the first modification in the treatment model of the 20th century using two books, Alcoholics Anonymous(the "Big Book") and Twelve Steps and Twelve Traditions, to explain AA's model and fundamental principles. Resistance by the medical

the first modification in the treatment model of the 20th century using two books, Alcoholics Anonymous(the "Big Book") and Twelve Steps and Twelve Traditions, to explain AA's model and fundamental principles. Resistance by the medical community continued, and AA launched a vigorous public relations campaign to change the profession's
position.

In 1956 an American Medical Association resolution stated: "Hospitals should be urged to consider admission of such patients witha diagnosis of alcoholism based upon the condition of the individual patient, rather than a general objection to all such patients"..

(4) The American Hospital Association and the American Psychiatric Association also passed formal resolutions advocating more medical oriented approaches to the problem of alcoholism, and the Minnesota Model was developed which introduced 30 day inpatient treatment in specialized hospitals. This model proved to be an expensive alternative. Only the wealthy or those with generous health insurance could afford this treatment. As a result, substance abuse/addiction treatment became a public health problem for the poor and a medical problem for the more affluent. Since the 1950's, drug abuse treatment has followed a similar pattern, with a public system for heroin and crack addiction among the poor and a private system for marijuana, cocaine, and prescription drug dependence among the more wealthy.

In truth substance abuse and addiction treatment is a community health problem requiring close collaboration between the public and private health systems. A new model for the twenty-first century is clearly needed.

8. An explanation of the proposed/effective solutions and how it would, or has, changed current practice. Detail the way the problem was, or is, proposed to be addressed. If applicable, cite examples of similar approaches in places elsewhere around the United States.
Suggested length: ¾ page.

The founding and development of Preventive Medicine Associates, Inc. (PMAI) represents such a model. Recognizing that addiction was a major community health problem and chronic relapsing medical disease poorly served by the existing healthcare system in the United States, Punyamurtula S. Kishore MD, MPH founded PMAI in the 1990's. With addiction being stigmatized and avoided by mainstream medicine, he set out to design PMAI as an ongoing effort to improve this situation. Building the practice around a model of primary care rather than addiction treatment programs, Dr. Kishore chose to adopt a model based on community oriented primary care (COPC) utilizing the Community Responsive Care (CRC)

treatment programs, Dr. Kishore chose to adopt a model based on community oriented primary care (COPC) utilizing the Community Responsive Care (CRC) training he received in a fellowship at Carney Hospital in the early 1990s.

A primary care approach to substance abuse is relevant because almost 90% of the general population have been prescribed medications with addiction potential (opioids, tranquilizers, sedatives, or stimulants), have drunk alcohol, or have experimented with recreational drugs (marijuana, inhalants, hallucinogens, cocaine, and heroin). As a result of this use, a significant segment of the population is at risk of developing addictive disorders. Approximately a quarter of the general adult population has experienced a substance use disorder at some time in their lives. About ten percent have a disorder at any given time.

Moreover, addiction is a chronic disease marked by cycles of relapse and recovery requiring long-term monitoring, continuity of care, and repeated treatment. Despite the widespread prevalence, chronic nature of substance use disorders, and urging of medical experts, primary care providers have historically neglected or ignored the problem to a great extent. Too often, they have not attempted to diagnose or treat these problems, perhaps because they lack the training and methods they thought they needed.

Instead, patients were referred to specialists for treatment on a short-term basis. New developments in medicine have now provided the treatment tools that make a primary care approach practical and highly effective. Moreover, the holistic primary care model solves some shortcomings of specialty treatment, especially with regard to continuity of substance-related medical and psychiatric complications, treatment resistance, and family involvement and support.

Dr. Kishore found that using this model made it possible to operate as a private practice, but continual modifications of the practice were required to meet the frequently changing demands of the current health care system. By using the results of annual audits to modify and improve the practice, we have made adjustments in structure and process based upon pragmatic assessments of what was possible in private medical practice.

As a result, PMAI has grown dramatically from its early days as a single office in Brighton with a small library on the second floor and is currently a statewide organization with 30 clinical sites, a research center, and two library/education centers.

The treatment network has a full spectrum of services, which are available to all individual patients in the practice, and the network provides access to sober housing in all areas of the Commonwealth, thereby enhancing the continuity of care. The National Institute on Drug Abuse estimates the return on such an investment in treatment may exceed 12:1 by reducting drug-related crime and

care. The National Institute on Drug Abuse estimates the return on such an investment in treatment may exceed 12:1 by reducting drug-related crime and criminal justice and health care costs.

(5) Dr. Kishore established the network's research center to increase the understanding of substance use disorders and how it could help to develop and guide future cost-saving initiatives.

The work of the PMAI Neuroscience Center has helped increase the understanding of substance abuse and addiction through genetic, biological, and social science research; established a baseline against which to measure progress and document impact at regular intervals; and developed best practices for prevention and treatment of substance use and co-occurring disorders.

In addition, Dr. Kishore founded the National Library of Addiction, which was initially designed to provide a non-profit structure for addiction professionals to exchange ideas and to further the development of treatment methodologies. The Library later developed an "Ambassador Program" which provides educational programs to local community groups and schools.

The Library also became an intellectual gathering place for health care professionals and community members working to overcome the effects of addictions. As the program developed, selected young patients who were in stable sobriety began to participate as part of the team that was making presentations in the ambassador program. This prevention effort enhances the return on investment to the community and is consistent with the Office of National Drug Control Policy's combined, coordinated public health and public safety strategy that recognizes the most promising drug policy is one that includes preventing drug use in the first place.

9. What were the start-up costs associated with the program or policy? Or, if the submission is an "idea," describe the projected start-up costs. Suggested length: ¾ page.

The current staffing model for each site includes one or more part time physicians and one or more full time nurse practitioners and/or physician assistants and nursing assistants at each site. There are different arrangements at each site for group facilitators and counselors. As they have become clinically available, the extensive use of anti-craving medications has been adopted in the practice.

The start-up costs per practice are similar to any primary care practice: About $250,000 is required to open a facility. This money is generally recouped within the first six months of the clinic's opening. Basic labor costs for retraining physicians for this practice is approximately $100,000

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The approximate annual cost breakdown is as follows:
- Office Manager: $40,000
- Nurse Practitioner: $90,000
- Part Time Physician: $60,000
- Receptionist: $32,000
- Medical Assistant: $33,000
- Group Leader: $15,000
- Counselor: $55,000
- Office Expenses: $20,000
- Medical Supplies: $20,000
- Phone / Fax / Internet: $3,000
- Ambassador Program: $5,000
- Rent & Utilities: $30,000

10. How is the program or policy funded, or how will it be funded?
Suggested length: up to ½ page.

The program is funded based on the primary care treatment model. Patients and/or their insurance companies pay for each visit as they would a routine doctor's examination. In order to grow his practice, Dr. Kishore must deliver successful outcomes so that his colleagues and satisfied patients will refer others in need to the practice. This approach is in contrast to current state policy, which provides grant money to institutions but offers little incentive to perform.

In the crucible of free enterprise, the public health challenge—such as addiction treatment—could be fashioned into a successful working model that is easily duplicated.

11.Describe the positive outcomes generated by the program or policy, or the projected outcomes from the idea submitted.
Suggested length: up to ¾ page.

PMAI has developed a network of community-responsive health clinics throughout the state, the focal point being the needs of the community. Many of the sites have been requested by members of the community or by the political leaders of the community. Each clinic, rooted in primary care, reflects the needs of the community. In these clinics, the principles of preventive medicine, community responsive care, and primary care are combined for the treatment of substance abuse.

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PMAI staff continuously reviews scientific advances to aid in the development of better treatment methods. As a result, PMAI accepts the broad agreement within the clinical research community that addiction is best characterized as a chronic disease.

(6) Just as diabetes, hypertension, asthma, and congestive heart failure require medical and behavioral interventions, the treatment of addiction involves embedded, behavioral and social components. Best treatment methods for addiction include a biological, behavioral and social aspect of treatment.

(7, 8) In the treatise, Alcohol Treatment Approaches by Hester and Miller - the brief interventions approach, as part of patient visits - is ranked as the most effective form of treatment.

(9) All PMAI practices use this treatment method initially and a modified form in follow-up visits as an additional feature of sobriety maintenance and relapse prevention in long-term treatment.

Sober individuals who have abused drugs and alcohol have specific health-related problems that often continue into their new lives of living sober. With their network of offices, PMAI continues to provide primary care services to the patient regardless of where in the commonwealth a patient may relocate.

In community-responsive clinics, the needs of people, living and working in the area, are better understood. Here, a better understanding of patient's needs translates into enhanced personalized service and patient care. This is the cornerstone for the PMAI treatment philosophy.

In the Springfield area, the practice is an active member in a community coalition. PAMI provides space for their meetings at the National Library of Addictions branch located in Springfield. On numerous occasions, medical and other health related students spend time in the practice for internships or elective course work.

12. Will/Did the program or policy require the passage of legislation, executive order or regulations? If yes, please cite:

No. Dr. Kishore's program will not require the passage of legislation, executive order, or regulations. Dr. Kishore has mainstreamed addiction care into his primary care practice, which does not require bureaucratic legislation, executive order or

order, or regulations. Dr. Kishore has mainstreamed addiction care into his primary care practice, which does not require bureaucratic legislation, executive order or regulations. Patients need care and Dr. Kishore's practice treats them as such. The state's role would be to recognize the effectiveness of this model and encourage its adoption by other care providers across the state.

13. If applicable, how has the program or policy expanded or changed since its inception?
Suggested length: up to ¾ page.

The program started in September of 1996 with a one-room office in Brighton. Over the last 14 years, the practice has grown to 30 centers. This expansion is a testament to the popularity and effectiveness of Dr. Kishore's primary model.

This highly integrated primary care preventive medicine, addiction medicine and mental health model staffed by primary care providers with enhanced skills has stood the test of time. Starting with home detoxification and outpatient detoxification in a primary care setting, the practice has evolved to provide a comprehensive array of services encompassing sobriety maintenance, sobriety enhancement and primary care services for a complex group of patients.

Many of our patient panels exhibit addiction related health problems such as Hepatitis C, HIV and other chronic diseases common in the service population. During the past year, PMAI has developed an innovative program with the Malden School System at our Malden Wellness Center which builds on the city's ten year experience with the Healthy Malden initiative. The program combines both prevention and treatment capabilities and is directed at both individuals and groups in the community.

The practice is currently servicing the judicial system with a court clinic in the Barnstable District Court. Initial contact has been made with the District Courts in Taunton and Quincy, and this partnership is slated to expand over the coming months into other Courts in the communities of the commonwealth. This program is being developed without an additional cost overlay from the state.

14. Does Massachusetts face the same problem addressed in this proposal? If your entry describes a program or policy already in place in Massachusetts, please provide additional relevant detail about current practices.
Suggested length: up to ¾ page.

Current traditional rehabilitation methods cost $12,250 to $23,500 for each

Current traditional rehabilitation methods cost $12,250 to $23,500 for each addicted patient. In contrast, the PMAI brief intervention-sobriety maintenance treatment model successfully used in the practice sites across the state costs $2,800 per patient year. Individuals with substance abuse are initially evaluated and detoxified on an outpatient basis. Frequency of patient visits varies with the needs of the patient.

Each patient is also counseled individually and/or in groups. Additionally, patients are not taken out of their community. Instead, they are taught coping skills and given positive incentives to self-modify their lifestyle towards healthier personal goals. As with all chronic diseases, periodic monitoring through primary care visits is essential to prevent relapse.

In 2005, the most recent year for which aggregate data is available, the cost of substance abuse treatment to the commonwealth was over $4.5 billion, which represented 21.8 percent of the total state budget.

(2) As troubling as that number may seem, it does not reflect the true loss in economic prosperity and the greater loss to our communities within the commonwealth.

In cities across Massachusetts an average of 70% of police calls and arrests are associated with drugs and/or alcohol. The same percent involve youths in our juvenile court system. Some 75% of middle/high school dropouts have substance abuse problems, and approximately 62% of the episodic or chronically homeless also struggle with this problem. (10). Many studies have shown that drug treatment reduces crime and the spread of infectious diseases. Additionally, those receiving treatment can re-enter society, thus reducing the drain on public resources (11, 12, 13).

The PMAI experience of inviting community involvement and local input into the planning of the delivery of healthcare services may be one method of affecting a more responsive, efficient and effective system of health services delivery.

15. What are your future goals?
Suggested length: up to ½ page.

Currently, the practice is serving every zip code in Massachusetts and PMAI would like to expand to the other New England states as well.

PMAI would like to increase its presence in the judicial system, homeless centers, and sober living communities.

PMAI would also like to start a training institute to train other doctors in this model

and sober living communities.

PMAI would also like to start a training institute to train other doctors in this model of care. Pain-pill addiction is a major problem in the state. PMAI wishes to establish a close collaboration with the pain centers in the state to reduce this epidemic by education, training, and de-addiction services.

Lastly, PMAI would like to enhance the Ambassador Program through the National Library of Addictions, which is a not-for-profit, intellectual gathering place for health care professionals and community members who are working to overcome the effects of addictions. The Library serves as a research facility, continuing medical education institute, and gathering place for professionals to exchange ideas and develop treatment methodologies.

REFERENCES

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DEADLINE: All applications must be postmarked or e-mailed by March 29th @ 4:30 PM EST, to be considered for a 2010 Better Government Competition award.