SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Best Practices in Integration of Substance Use and Primary Care Service: Models from the field

February 26, 2016

Setting the Stage:
Today's Moderator

Madhana Pandian

Associate

SAMHSA-HRSA Center for Integrated Health Solutions

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

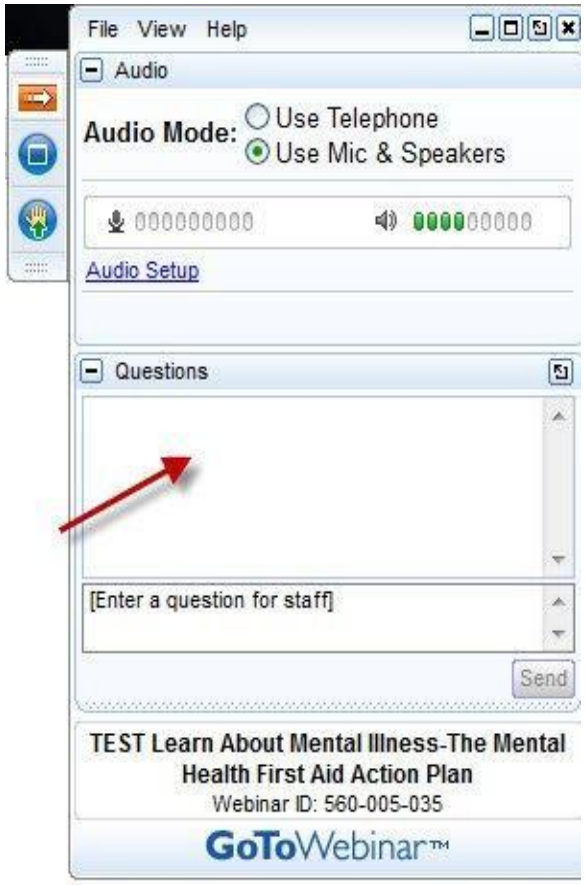
To download the presentation slides, please click the dropdown menu labeled "Event Resources" on the bottom left of your screen.

Slides are also available on the CIHS website at:

www.Integration.samhsa.gov

under About Us/Webinars

Our format:



Structure

Presentations from experts

Polling You

At designated intervals

Asking Questions

Responding to your written questions

Follow-up and Evaluation

Ask what you want/expect

and presentation evaluation

Setting the Stage:
Today's Facilitator

Aaron Williams

Director of Training and Technical Assistance for Substance Use

SAMHSA-HRSA Center for Integrated Health Solutions

Today's Purpose

- Help inform behavioral health providers that are adding primary care and health promotion services.
- Highlight essential implementation strategies for integrating primary care and health promotion into addiction treatment.
- Discuss a model for sustaining primary care and wellness services
- Reference resources and tools to support integration efforts

Today's Speakers

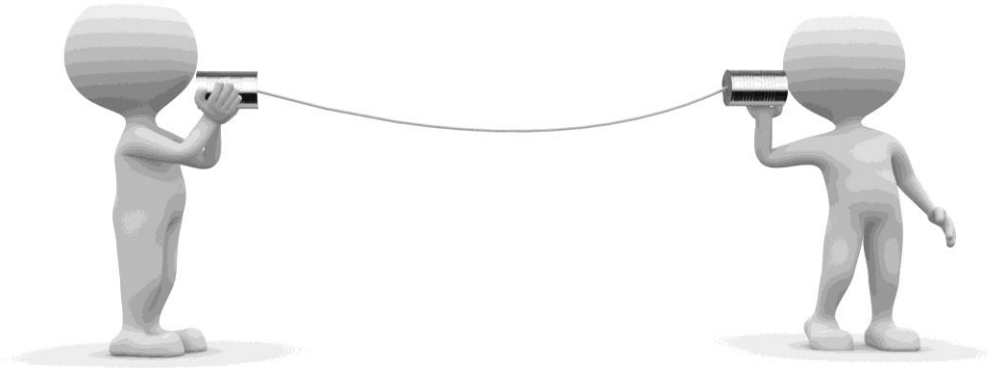
- Aaron Williams, Director of Training and TA for Substance abuse, CIHS
- Jim Sorg, Director of Care Integration, Tarzana Treatment Centers Inc.

SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

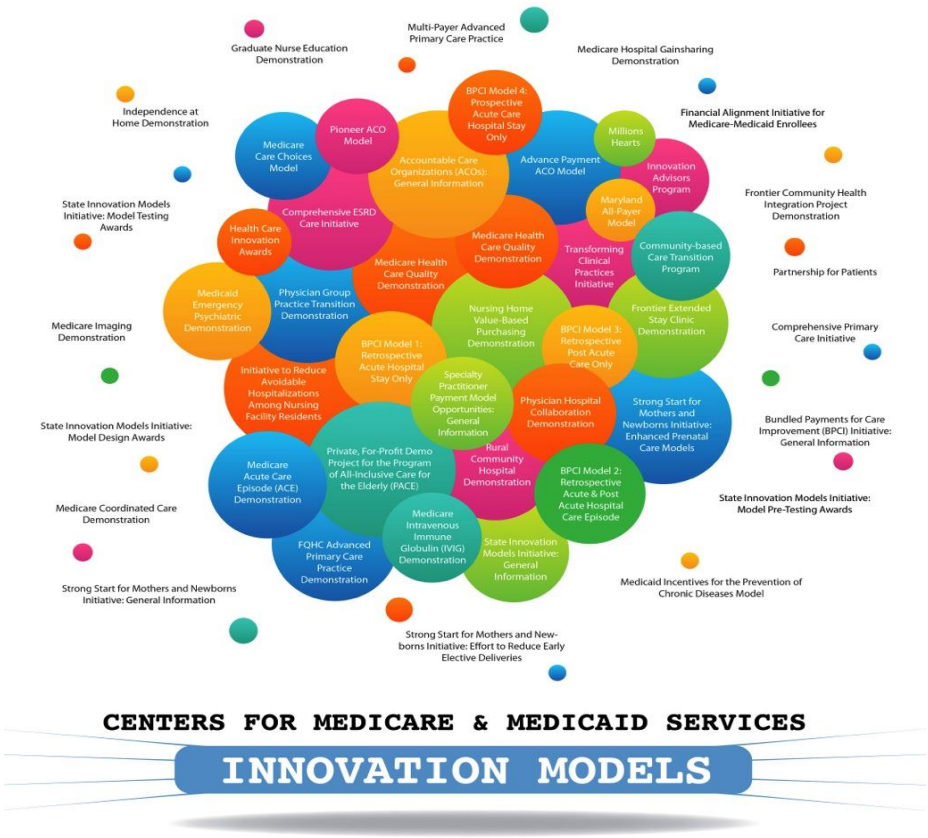
Five Essential Elements of Primary Care Implementation

Five Implementation Essentials

- Leadership and organizational culture
- Data driven care for effective population health management
- Activating self-management for wellness
- Sustainable health promotion/wellness activities
- Workforce Training and Task Shifting



Desired changes aligns with current health care delivery system changes



- Medicaid Health Home
- Integrated Care for Individuals with Dual Eligibility
- High Utilizer Projects
- Accountable Care Organizations (ACOs)

Leadership and Organizational Culture

Organizational culture is a lens through which an organization views their work.

- Shared value system, mission, vision, and purpose
- Common language that facilitates communication internally and externally
- Policies and procedures that reflect/reinforce a shared vision
- Activities, services, physical, and emotional environment aligned with the vision
- How power, decision making, allocation of resources are distributed

Leadership and Organizational Culture

Tips

- Share your team's vision of what your integrated program is/will be often with your organization
- Increase our shared sense that physical health is part of our work
- Build hope that people want to take care of their health
- Design clear roles & responsibilities of each team member
- Have your team assess your baseline using assessment tools
- Set goals & take actions aligned with the aims of integrated care

Resource

- CIHS' **Standard Framework for Levels of Integrated Healthcare** is a six-level framework that can be used for planning
- **Culture of Wellness Organizational Self-Assessment (COW-OSA)** can help increase an organization's awareness of the key components of a wellness-focused culture
- **Assessment Tools for Organizations Integrating Primary Care and Behavioral Health**
  - Organizational Assessment Toolkit for PC/BH Integration (OATI)
  - Integrated Practice Assessment Tool (IPAT)
  - Behavioral Health Integration Capacity Assessment (BHICA)

Data driven care for effective population health management

Addressing the health risks of adults with addiction and existing healthcare disparities between different populations, requires an organizational infrastructure for collecting and monitoring health data.

*Health outcomes were documented and shared with patients and staff. We also used the data to get buy-in from our executive leadership to seek additional funding and expand the program.-**Integrated care provider***

Data driven care for effective population health management

Tips

- Use a registry to track clinical outcomes and key process steps for outcome measurement
- Use tools to target specific interventions to appropriate populations
- Use EHR to generate condition-specific reports to use for CQI, reduction of disparities, research & outreach
- Implement protocols for sharing client-level data across BH & PC systems
- Treat to target – systematic tracking of medical severity
- Use your data analytics to inform future opportunities, leadership, strategic goals

Resource

- **Population Management in Community Mental Health** provides 10 essential steps to being a provider with successful population health management practices
- **Exploring the Promise of Population Health Management Programs to Improve Health** covers the concepts and components of population health management (PHM) .
- **PBHCI Population Health 101 Webinar**

Activating Self-Management for Wellness

Self-management is essential to achieving health and wellness; recognizing that treatments, services, supports and interventions are of little value without individuals setting and achieving person-centered goals that change and sustain their health behaviors.

Customer Reaction to Integrated Primary and Behavioral Health Services

"Outstanding, I am learning that it is not only my mental health but also my physical health that needs to be attended to." – Patrick

Activating Self-Management for Whole Health

Tips

- Introduce the concept of self-management support to clients and staff
- Ask what support and wellness services consumers need
- Implement evidence-based wellness activities based on culturally relevant practices
- Work with individuals to set visit/exam agenda, become informed, and create a health action plan that can be added to an individual's treatment plan
- Link clients with system and community resources and be proactive about follow-up
- Have Fun - Smoking Cessation classes became "Bye, Bye Butts"

Resources

- **Health Promotion Resource Guide** informs providers on how to make informed decisions regarding evidence-based programs and practices designed to improve fitness and reduce obesity for people with SMI; it includes two checklists.
- AHRQ's **Self-Management Support Resource Library** helps providers teach people how to take informed responsibility for their own healthcare
- SAMHSA's **Bringing Recovery Supports to Scale Technical Assistance Center Strategy** has a wealth of resources

Workforce

The care a patient experiences as a result of a team of PC & BH clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.*

Workforce

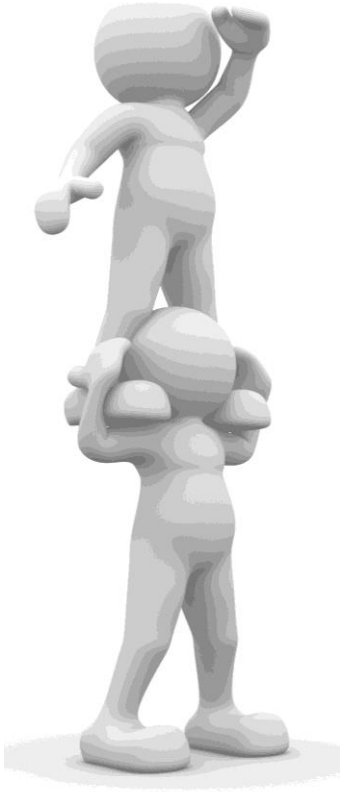
Tips

- Establish team-based care
- Learning about something is not learning to do it
- To break old habits, new behaviors need to be modeled and reinforced
- Invest in routine huddles, caseload review, and de-briefs
- Cross train again and again
- Maximize the skills of non-physician staff in care team
- Expand the role of peer support specialist
- Convene “Lunch and Learns” so providers can introduce themselves to consumers, present different health topics, and encourage discussion
- Care Managers buy-in is critical - cultural broker, health educator, lifestyle coach, interpreter, care coordination and more

Resources

- Core Competencies for Integrated Care - provide practical and logistical assistance to building an integrated care workforce
  - Shape Workforce Trainings
  - Inform Job Descriptions
  - Guide Staff Orientation
- Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams summary reviews team development within effective integrated primary and behavioral healthcare teams.
- Education and Training Program - Integrated care requires revisions and additions to the traditional way in which healthcare providers are educated and trained to practice

Sustainability



Sustaining integrated care over time is a significant concern for most providers of behavioral health and primary care services. Sustainability requires organizations to imbed both organizational practices and expectations for integrated care in the fiber of its operations and to maximize every possible revenue source

Sustainability

Tips

- Start early in the process
- Focus on efficient delivery of primary care services and effective billing to cover the cost of PC services
- Identify your true costs
- Seek opportunities for value-based purchasing
- Creating workable workflows, logistics, and financial break-even point with primary care partners

Resources

- Sustaining Integrated Services Report - Lessons Learned from PBHCI Alumni
- The Primary Care and Behavioral Health Integration Sustainability Checklist lists many of the most important elements of your clinical organization that need to change to support integration in your clinic.
- Using Data for Sustainability explores the link between data and sustainability to maintain the vitality in internal structure, processes and strategies.

Setting the Stage:
Today's Presenter

Jim Sorg, PhD

Director of Care Integration

Tarzana Treatment Centers, Inc.

Outline of Presentation

Description of Tarzana Treatment Centers

Why TTC Integrated Care

How TTC Integrated Care

Tarzana Treatment Centers (TTC)

- Founded in 1972
- 501 (c) (3) Non-profit Corporation
- 600+ Employees and Contract Staff
- 15 locations in Los Angeles County
- Persons served in Calendar 2015
  - Primary care = 4739
  - Substance use disorder specialty care = 4273
  - Mental health specialty care = 1,627
  - HIV/AIDS specialty care = 1019

Revenue Sources

- City and County Contracts
- Federal, State, Foundation Grants
- Medicare and Medi-Cal fee-for-service
- Managed Care Contracts – Private Insurance
- Medi-Cal Managed Care - Behavioral Health and Primary Care
- Private Pay
- Sliding Fee and Charity Care

Specialty Care

- Substance Use Disorder Treatment
- Mental Health Disorder Treatment
- HIV / Medical Care and related services
- Housing
- Assessment and Referral Services in Hospital EDs
- In Home Services

Medication Assisted Treatment

- Detoxification, Anti-Craving, Maintenance
  - Methadone
  - Buprenorphine
  - Injectable Naltrexone
- Inpatient, Residential, Outpatient

Primary Care

- First clinic opened in 1995
- 5 Primary Care Clinics integrated with Other TTC Services
- 2 Clinics integrated with BH services provided by other organizations
  - LA County Department of Mental Health San Fernando Mental Health Cente
  - San Fernando Valley Community Mental Health Center, Inc.
- All primary care clinics organized as medical homes

Specialty HIV/AIDS Care

- First HIV Services in 1986 and first HIV/AIDS Medical Clinic opened in 2002
- HIV/AIDS Medical Clinics
- MH/SU Disorder Treatment
- Prevention and Testing
- Case Management
- Jail In-Reach
- Transitional Housing
- Home Heath Care

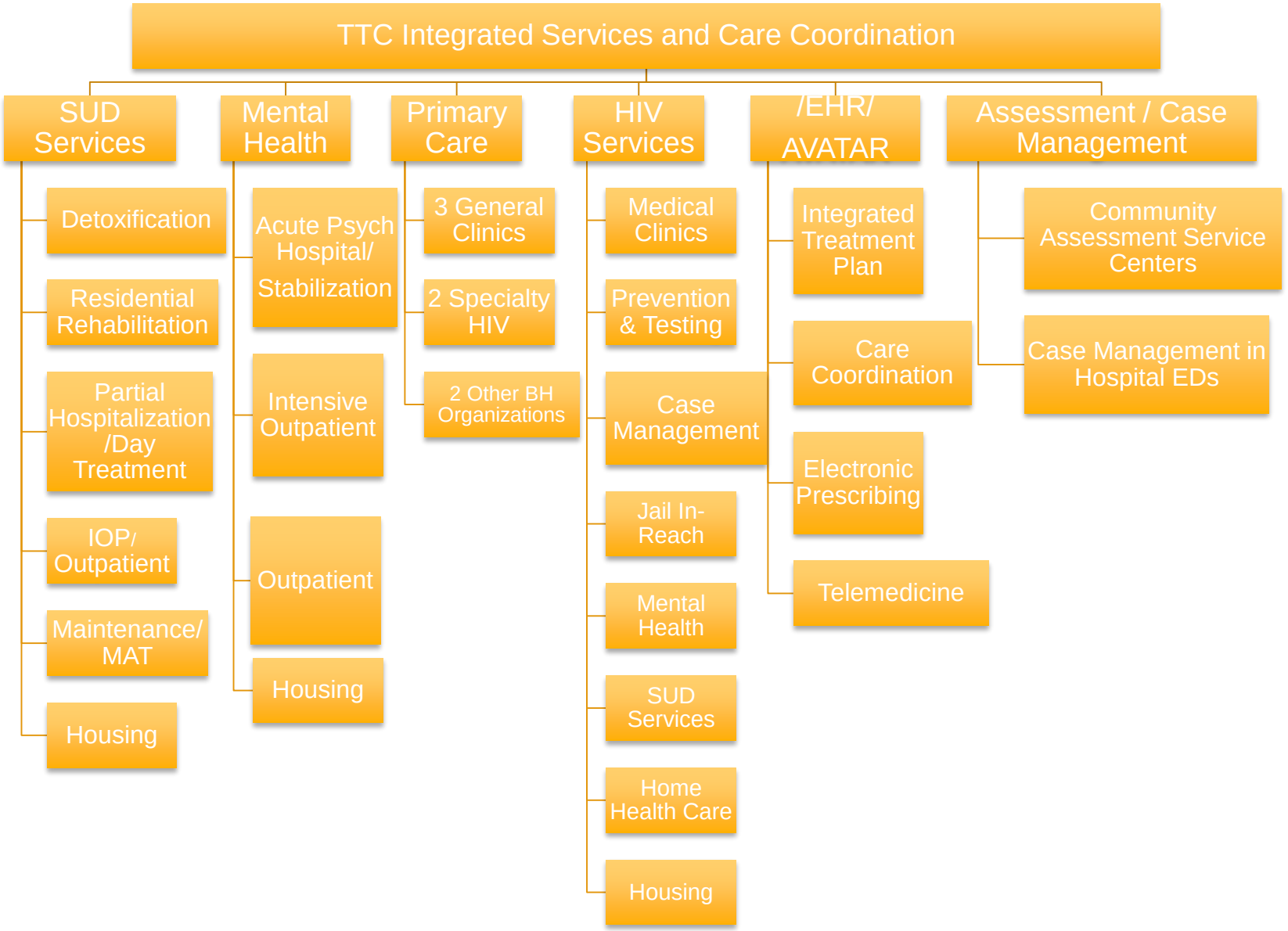
Joint Commission Accreditation and Certification

Accredited under:

- Hospital Standards
- Behavioral Health Standards
- Opioid Treatment Standards

Certifications awarded in 2015:

- Primary Care Medical Home
- Behavioral Health Home


TTC Integrated Services and Care Coordination
SUD Services
Detoxification
Residential Rehabilitation
Partial Hospitalization /Day Treatment
IOP/ Outpatient
Maintenance/ MAT
Housing
Mental Health
Acute Psych Hospital/ Stabilization
Intensive Outpatient
Outpatient
Housing
Primary Care
3 General Clinics
2 Specialty HIV
2 Other BH Organizations
HIV Services
Medical Clinics
Prevention & Testing
Case Management
Jail In-Reach
Mental Health
SUD Services
Home Health Care
Housing
/EHR/ AVATAR
Integrated Treatment Plan
Care Coordination
Electronic Prescribing
Telemedicine
Assessment / Case Management
Community Assessment Service Centers
Case Management in Hospital EDs

Why TTC Integrated Care?

TTC Mission

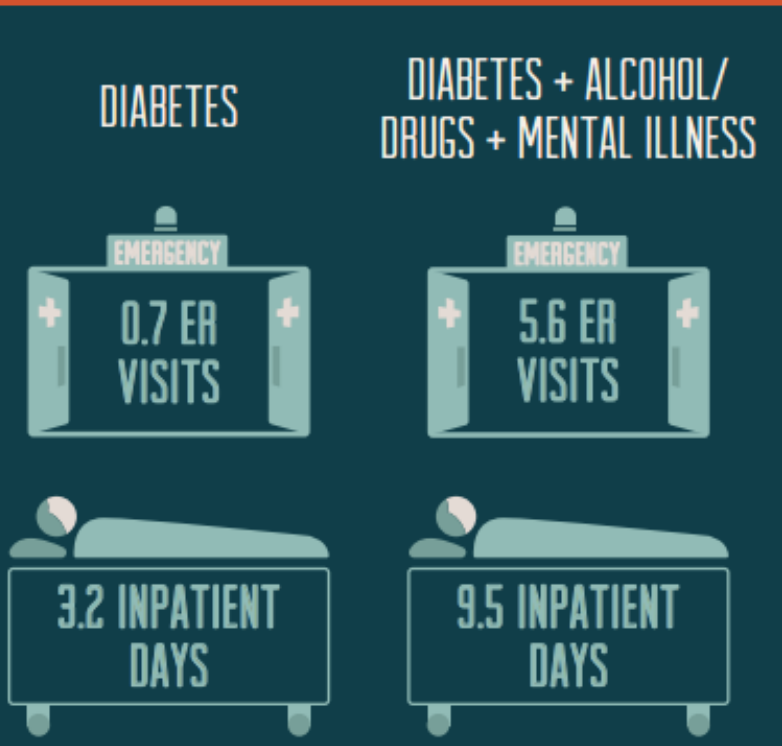
- To provide high quality, integrated healthcare for substance use disorders, mental illness, and chronic physical health disorders

- that improves the quality of life and health of patients regardless of financial resources, and

- contributes to a reduction in the total cost of healthcare, negative social impacts and criminal justice involvement

WHEN CHRONIC ILLNESS & MENTAL/BEHAVIORAL ILLNESS COMBINE, UTILIZATION & COSTS RISE

Of the 5% costliest enrollees, 45% have a serious mental illness.



Annual per member

ANNUAL SPENDING PER MEMBER

Source: California Department of Health Care Services
www.chcf.org/medi-cal-matters

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)
HRSA
Health Resources & Services Administration
integration.samhsa.gov

Type 2 Diabetes and Alcohol Use Disorder

Persons with type 2 diabetes and a coexisting alcohol use disorder (AUD) compared to diabetics without AUD:

- Have higher rates of type 2 diabetes-related complications and hospitalizations
- Have lower odds of full adherence with measures of quality for type 2 diabetes

Udi E Ghitza, Li-Tzy Wu, Betty Tai, “Integrating substance abuse care with community diabetes care: implications for research and clinical practice”, Substance Abuse and Rehabilitation 2013:4 3–10

Reducing ER and Hospital Admissions and Readmissions

Table 1. Potentially Preventable Readmission (PPR) Rates per 100 At Risk[1] Admissions by Medicaid Recipient Health Condition at Initial Admission and Region: New York State, 2007

	New York City			Rest of the State			New York State		
Recipient Health Condition	Initial Admissions [1]	At Risk Events [2]	PPR Rate	Initial Admissions	At Risk Events	PPR Rate	Initial Admissions	At Risk Events	PPR Rate
Mental Health	6,808	79,815	8.5	3,715	52,116	7.1	10,523	131,931	8.0
Substance Abuse	4,111	35,578	11.6	1,523	19,291	7.9	5,634	54,869	10.3
Mental Health and Substance Abuse	13,043	62,409	20.9	7,833	54,081	14.5	20,876	116,490	17.9
All Others	6,485	132,269	4.9	2,567	56,234	4.6	9,082	188,503	4.8
Total	30,447	310,071	9.8	15,638	181,722	8.6	46,115	491,793	9.4

[1] Non-excluded admissions followed by at least one clinically related readmission.

[2] All inpatient events that were not excluded according to defined PPR criteria.

Source: Lindsey, M., Patterson, W., Ray, K. & Roohan, P. (2007). Potentially preventable hospital readmissions among Medicaid recipients with mental health and/or substance abuse health conditions compared with all others: New York State, 2007. New York State Department of Health. Available at: http://on.ny.gov/1NkFaCU

How TTC Integrated Care

Primary Care Business Plan

- Use county contracts to open and sustain clinics
- Use Ryan White Part C funds to subsidize clinics
- Use private insurance funded BH to subsidize primary care
- Use grants as seed money to open new clinics
- Emphasize fee for service in payer mix when possible
- Minimize cost of care, especially for capitated patients

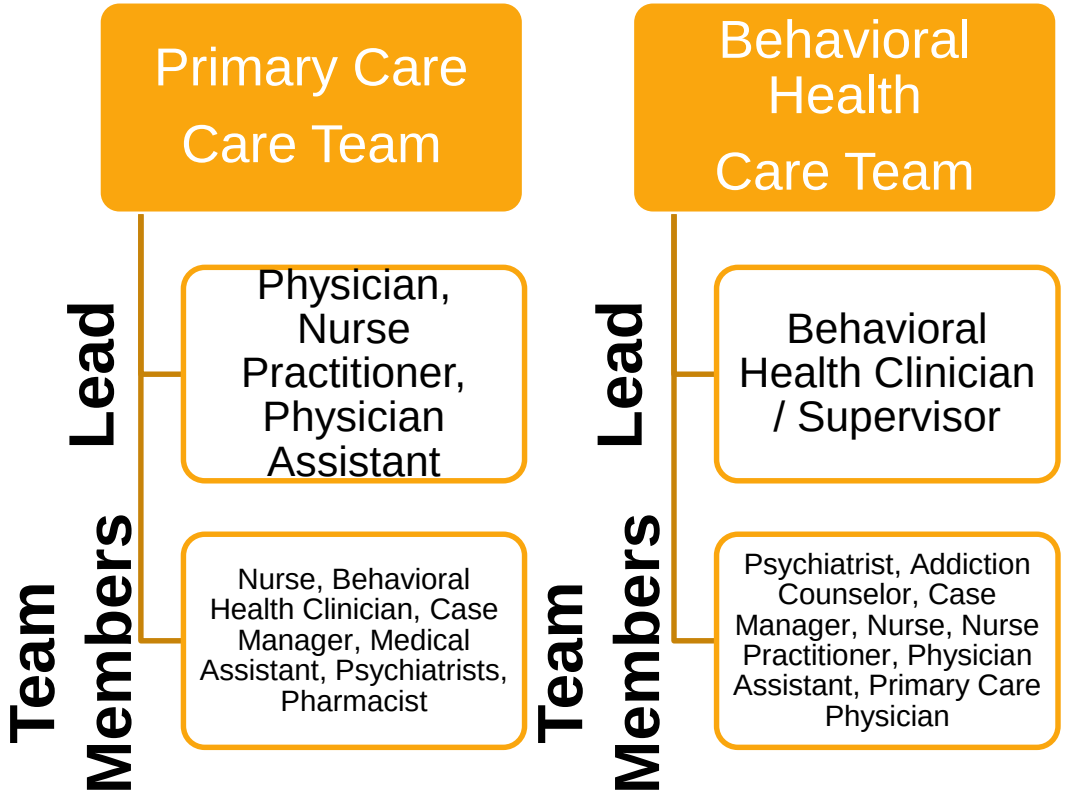
Models of SUD Treatment Integration with Primary Care at TTC

Examples of Primary Care led integration

- Primary Care and HIV/AIDS patients
- Primary Care and ISM Model

Examples of Behavioral Health led integration

- SUD inpatients, residential, outpatients including MAT



Models of Primary Care Team Led Integration at TTC

Primary Care Led Integration for HIV/AIDS patients with SUDs

- Target
  - Patients with HIV/AIDS with SUD diagnoses and their at risk partners
- Design
  - Cross-training of primary care and SUD treatment team members
  - Care Coordination to navigate patient through medical and SUD/MHD care
  - Primary Care and SUD treatment staff case conferences 2x month
  - Primary Care provider involved in SUD treatment planning, relapse prevention, and relapse response

Model of SUD Treatment Team Led Integration at TTC

Behavioral Health Home Model

- Target
  - Patients with SUD and mental health conditions with chronic physical health conditions
- Purpose
  - To make the “home” in behavioral health rather than in primary care
  - To bring primary care in-house or link patients with primary care providers
- Benefits
  - Patients may feel more comfortable in behavioral health setting
  - Able to coordinate and integrate care as would be done in primary care
  - Psychiatrist or behavioral health clinician may be lead rather than the primary care physician

Capitated and Incentivized Care

- Members of Health Care LA IPA (HCLA IPA)
- Composed of Safety Net Clinic Organizations
- HCLA IPA Contracts with Safety Net Health Plans in Los Angeles County
- 350,000 Lives under capitated Managed Care contracts
- Clinic Compensation
  - Per Member Per Month Capitation
  - Quality of care incentives
  - Share of net revenue

Risk-Based Framework for Managing Care

- Identifying all patients eligible for management by using a registry
- Monitor and report for entire population
- Increasing patient and provider awareness
- Providing an effective diagnosis and treatment guideline
- Systematic follow-up of patients for initiation and intensification of therapy
- Clarifying roles of healthcare providers to implement a team approach
- Reducing barriers for patients to receive and adhere to medications as well as to implementing lifestyle modifications
- Leveraging the Avatar EHR to provide care guidance to the integrated team.

Risk Score Assignment

Primary Prevention (Level 1 and 2): Patients who are healthy and have no known chronic diseases could be assigned to a low risk category, or Level 1. Patients who are healthy but showing warning signs of potential health risks may be assigned to Level 2.

Secondary Prevention (Level 3 and 4): A patient who has one or more chronic diseases, but are managing them well, and meeting their desired goals, may be assigned to an intermediate category (Level 3). Those who are not in control of his/her chronic disease(s) but have not developed complications may be assigned to Level 4.

Tertiary Prevention (Level 5): If a patient's chronic disease(s) have progressed, become unstable, or new conditions and/or significant complications have developed, they may progress to the tertiary category (Level 5).

Catastrophic (Level 6): An additional, non-public health Level 6 category is reserved for extreme situations, such as a pre-term baby who needs intensive long-term care, a patient who has a severe head injury, or anyone requiring highly complex treatment.

Chronic Care Management

- Medicare Part B
- Two or More Chronic Conditions
- Risk Score Assignment
- Requires patient consent
- Provided under direction of primary care provider
- Requires 20 minutes of non-face-to-face service per month under direction of primary care provider
- CPT 99490: $46.87 / Month * 12 months * 100 patients = $56,244

Transitional Care

- Medicare Part A Patients Discharged from Hospital are eligible
- Service billed to Medicare Part B
- Within 30 days of discharge
- Provided under direction of primary care provider
- CPT 99495: Face to face visit within 14 days = $182.33
- CPT 99496 : Face to face visit within 7 days = $255.67

SBIRT

- SBIRT performed by Primary Care providers
- Reimbursement by Medi-Cal Fee for Service and Managed Care Plans since January 2014
- Referral to SUD Treatment
- Responsibility for screening vs. responsibility for brief intervention

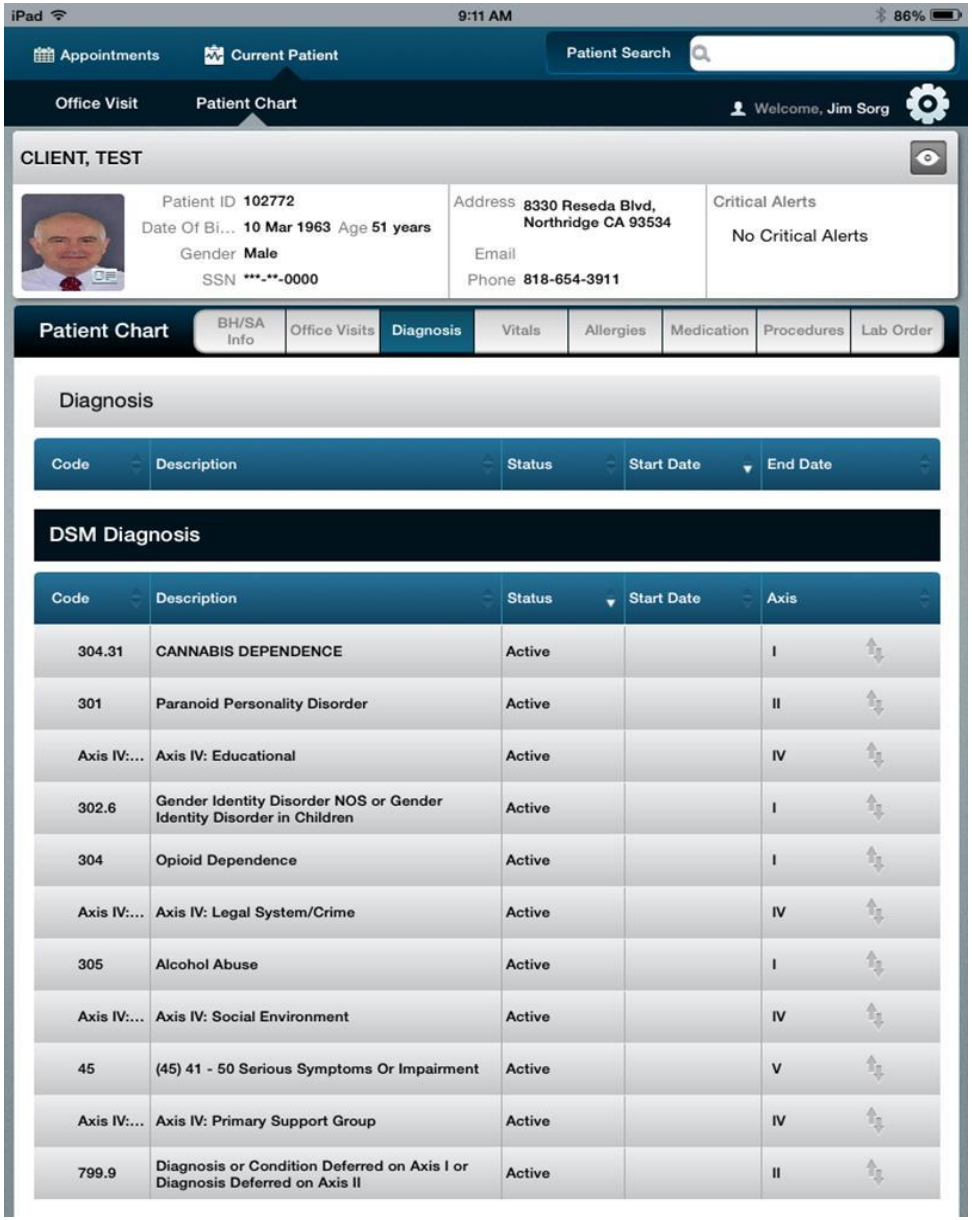
Activation to Reach Healthcare Goals

Treating to Target

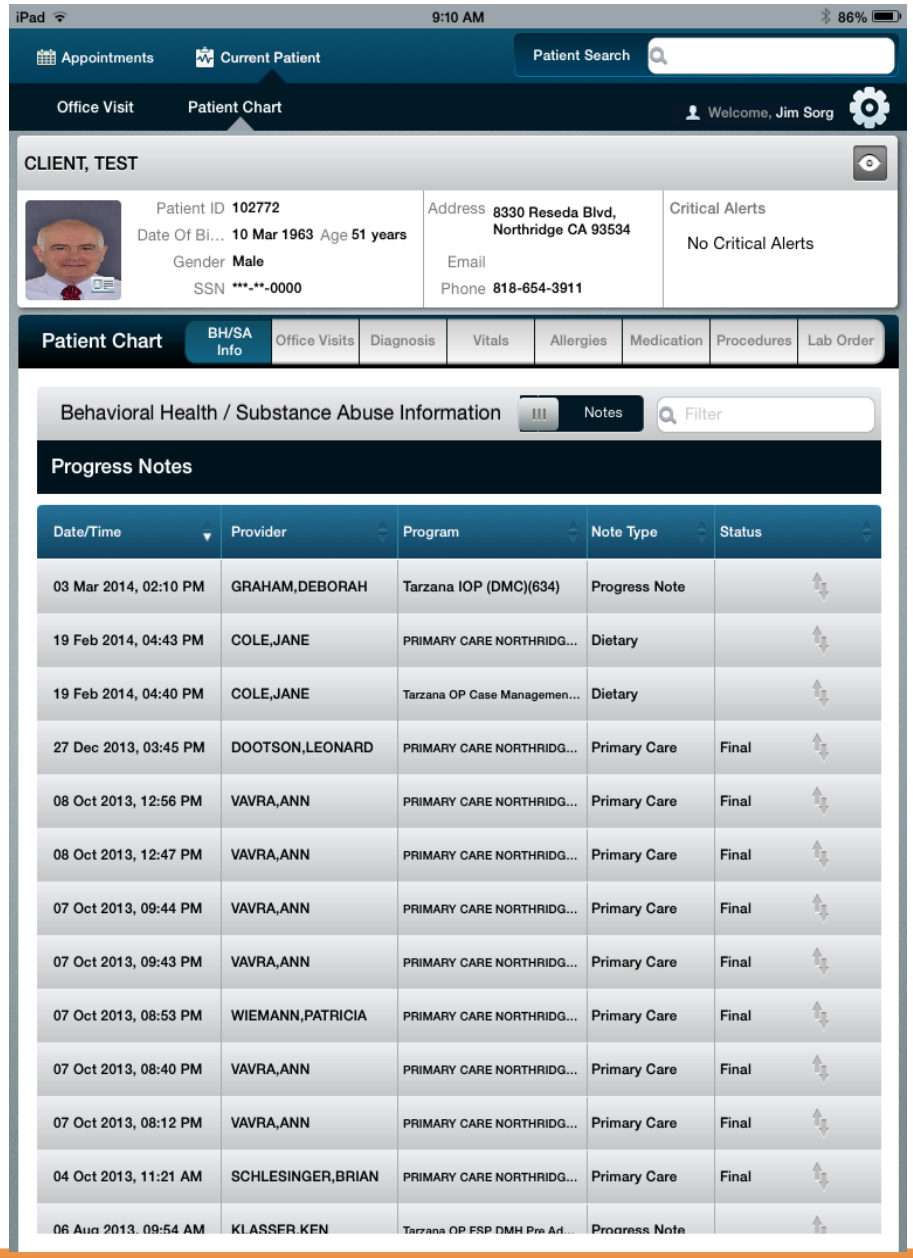
- Diabetes
  - Hemoglobin A1c < 7%
  - 100 % of Preventive Services Received
- Mental Health
  - PHQ 9 < 5 (Minimal depression)
  - GAD 7 < 5 (Mild anxiety)
- Subtance Use
  - Audit C < 4 males and < 3 females
  - DAST < 1

Tarzana Treatment Centers, Inc.
Integrating Chronic Disease Management into Behavioral Health Homes

iPad with DSM Diagnosis



iPad with SUD/MH Progress Notes



Using HIT as a Driver for Integration

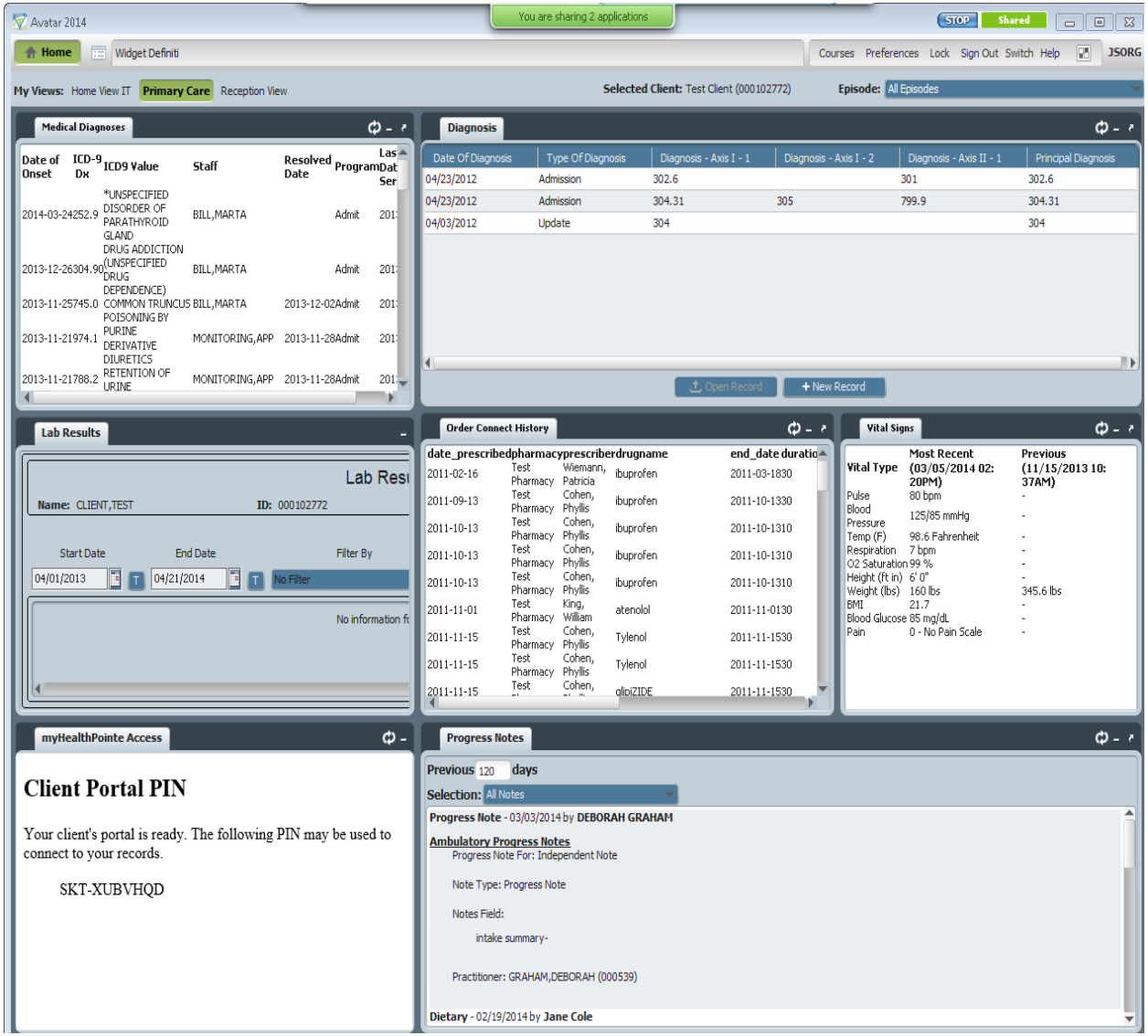
Using Health IT as a driver for integration

- Provide tools for referrals and HIE
- Provide tools for integrated care
  - Assessment for medical , MH, SUD conditions, integrated problem list, diagnosis, summary, treatment plan, view of record, registries
- Provide ability to bill for integrated services
  - Procedure codes, guarantors, claims

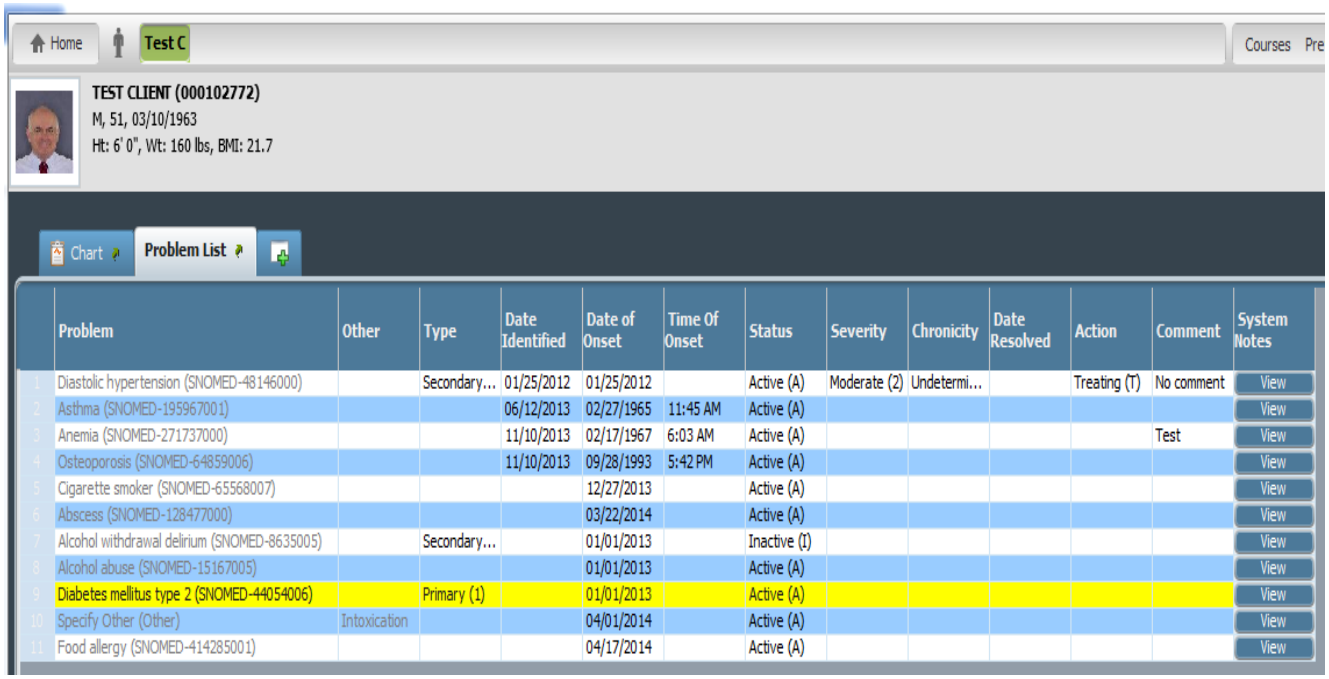
Technology

- Netsmart Avatar, Primary Care Module, Integrated Treatment Plan, Order Connect ePrescribing, Care Connect Lab interfaces and HIE, MyHealthPointe Patient Portal

Primary Care Console View

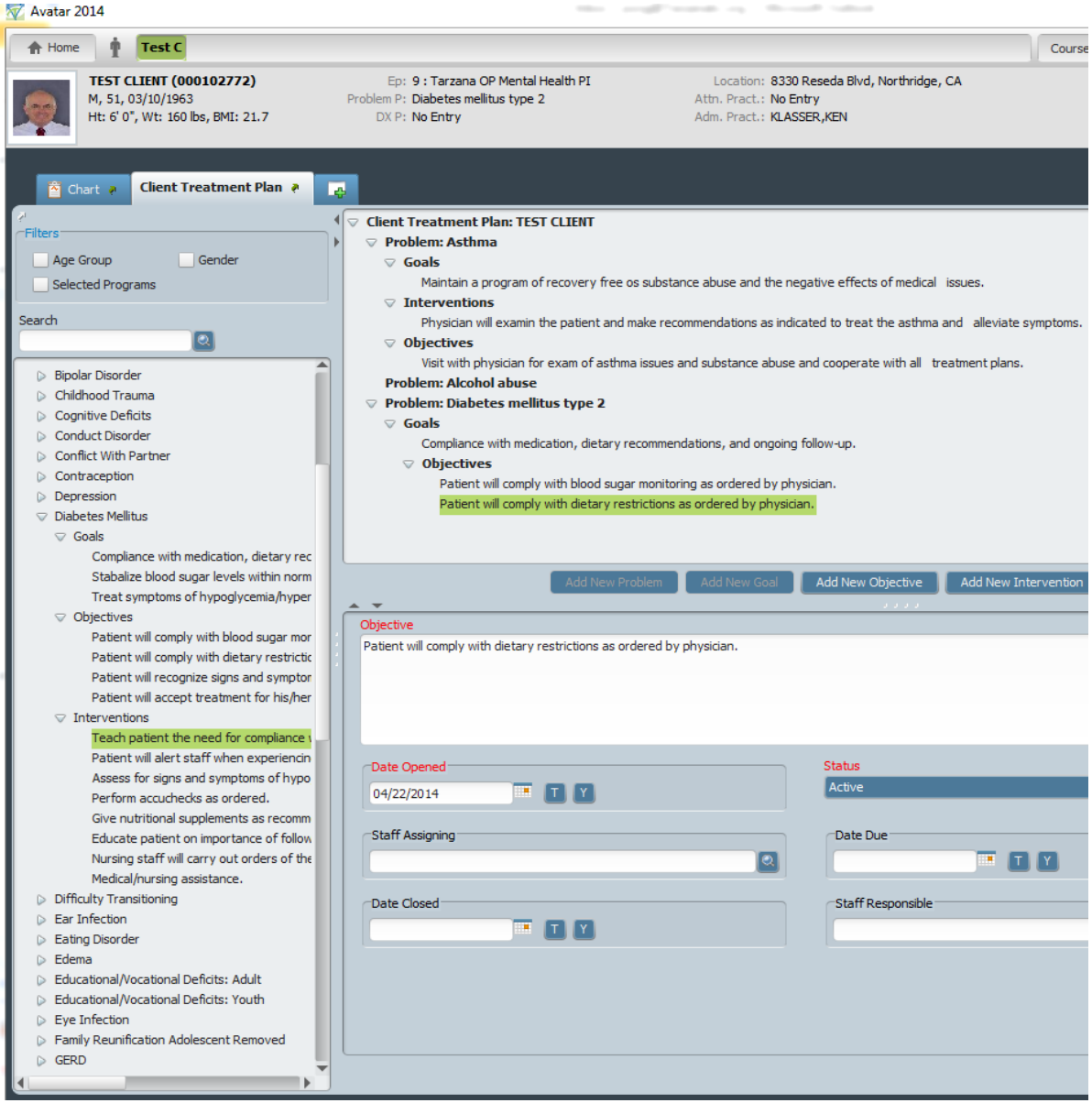


Problem List with all Conditions



	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes
1	Diastolic hypertension (SNOMED-48146000)		Secondary...	01/25/2012	01/25/2012		Active (A)	Moderate (2)	Undetermi...		Treating (T)	No comment	View
2	Asthma (SNOMED-195967001)			06/12/2013	02/27/1965	11:45 AM	Active (A)						View
3	Anemia (SNOMED-271737000)			11/10/2013	02/17/1967	6:03 AM	Active (A)					Test	View
4	Osteoporosis (SNOMED-64859006)			11/10/2013	09/28/1993	5:42 PM	Active (A)						View
5	Cigarette smoker (SNOMED-65568007)				12/27/2013		Active (A)						View
6	Abscess (SNOMED-128477000)				03/22/2014		Active (A)						View
7	Alcohol withdrawal delirium (SNOMED-8635005)		Secondary...		01/01/2013		Inactive (I)						View
8	Alcohol abuse (SNOMED-15167005)				01/01/2013		Active (A)						View
9	Diabetes mellitus type 2 (SNOMED-44054006)		Primary (1)		01/01/2013		Active (A)						View
10	Specify Other (Other)	Intoxication			04/01/2014		Active (A)						View
11	Food allergy (SNOMED-414285001)				04/17/2014		Active (A)						View

Treatment Plan



Jim Sorg, PhD

Director of Care Integration and Information Technology

Tarzana Treatment Centers, Inc.

jsorg@tarzanatc.org

Questions

For More Information & Resources

Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Thank you for joining us today.
Please take a moment to provide your feedback by completing the survey at the end of today's webinar.

If you have additional questions/comments please send them to:

Aaron Williams – aaronw@thenationalcouncil.org
Madhana Pandian – madhanap@thenationalcouncil.org