Chronic Disease Management in Medical Homes for Patients with Substance Use Disorders

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Time to ask. WIPHL WISCONSIN INITIATIVE to PROMOTE HEALTHY LIFESTYLES

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STATE ASSOCIATIONS OF ADDICTION SERVICES
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Outline

1. Primary care
   - Definition
   - Importance
   - Drawbacks for patients with SUDs
   - Rationale for medical homes
2. Challenges in chronic dz tx
   - Common chronic dz in adults without and with SUDs
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3. Merging chronic dz & SUD tx
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   - Changing financing models
4. Summary & recommendation
   - Staffing
   - HIT

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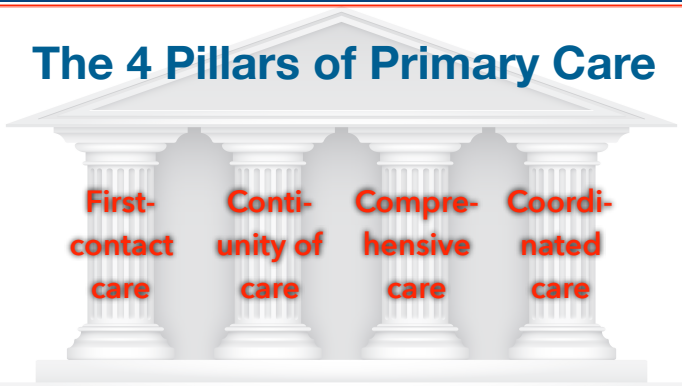
The 4 Pillars of Primary Care



Starfield, 1992

Studies of PCP Supply vs. Health Outcomes

- 10 studies with 20 analyses:
  PCPs per 10,000 vs:
  - All-cause death rates by state
  - Mortality for whites and blacks by state
  - Low birthweight and infant mortality by state
  - Stroke mortality by state
  - Heart disease deaths, cancer deaths and all-cause deaths for all counties and for rural counties
  - Self-rated health

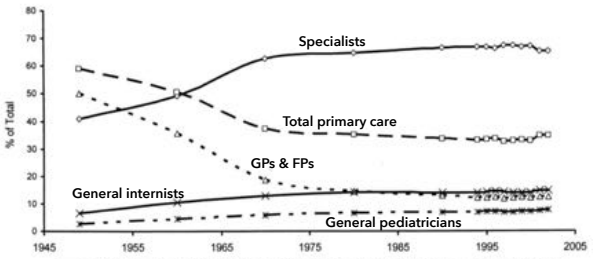
http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/Publications_PDFs/2007_IJHS_Macinko.pdf

Primary Care Saves Lives!

1 additional PCP per 10,000 people → 5.3% reduction in mortality

http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/Publications_PDFs/2007_IJHS_Macinko.pdf

Primary Care Physician Supply - USA



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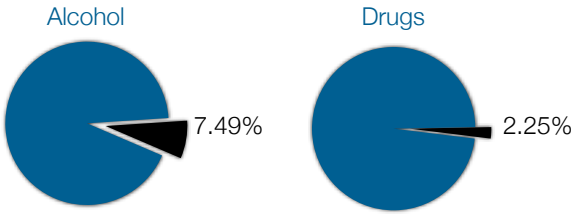
Primary Care: Poor care for SUDs

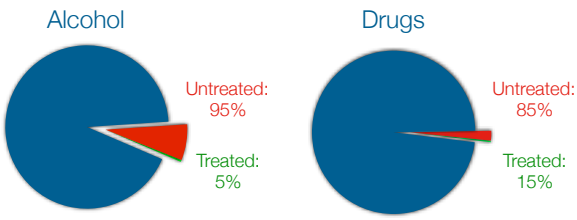
Prevalence of Alcohol/Drug Disorders – US Adults –



Abuse or Dependence

Primary Care: Poor care for SUDs

Receipt of Alcohol/Drug Treatment – US Adults –



Primary Care: Poor care for SUDs

Receipt of Alcohol Screening by Adults Who Received Ambulatory Care **72%**

Receipt of Alcohol Intervention or Referral

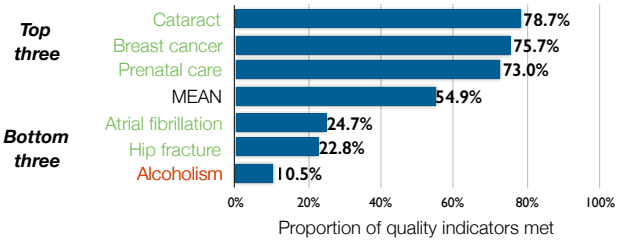
- Dependence **26%**
- Abuse **10%**
- Binge drinkers without SUD **5%**

Glass, Bohnert & Brown, Journal of General Internal Medicine, 2016

Primary Care: Poor care for SUDs

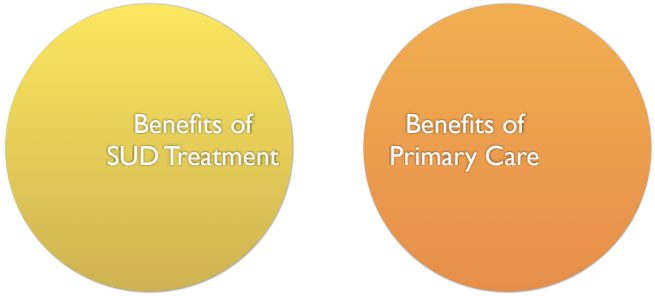
Quality of care for alcoholism - US adults

Study of 439 quality of care indicators for 30 acute and chronic conditions:



McGlynn, NEJM, 2003

Medical Homes for Pts with SUDs



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Leading Causes of Death - USA

1. Heart disease
2. Cancer
3. Chronic lung disease
4. Unintentional injury
5. Stroke
6. Alzheimer's disease
7. Diabetes
8. Influenza & pneumonia
9. Chronic kidney disease
10. Suicide

http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

Chronic Diseases:
Leading Causes of Death & Disability

- 7 of top 10 causes of death are chronic diseases
  - Heart disease and cancer account for 48% of all deaths
- Diabetes - leading cause of kidney failure, lower limb amputations and blindness; frequent contributor to heart disease and stroke
- Arthritis and depression are the most common causes of disability

http://www.cdc.gov/chronicdisease/overview/index.htm

Chronic Diseases:
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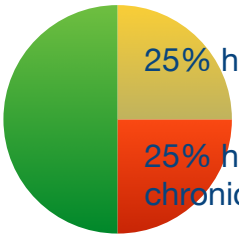


25% have 1 chronic disease

25% have 2 or more chronic diseases

http://www.cdc.gov/chronicdisease/overview/index.htm

Key Primary Care Goal: Cardiovascular Dz Prevention

- Many important risk factors are uncontrolled
  - Hypertension: 48%
  - Type 2 diabetes: 52%
  - High LDL: 67%
- 47% of US adults have at least one of the following CV Dz risks
  - Uncontrolled hypertension
  - Uncontrolled high LDL
  - Smoking

http://www.cdc.gov/chronicdisease/overview/index.htm

Chronic Dz Prevention & Management:
Key Issues are Behavioral

- Smoking
- Obesity
- Diet - sodium, fruits/vegetables, fat
- Physical activity
- Alcohol
- Medication adherence
- Depression

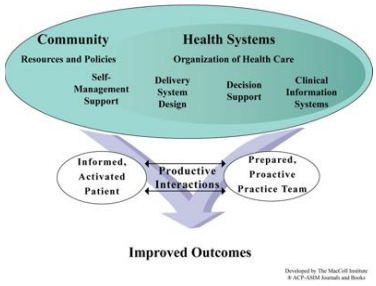
http://www.cdc.gov/chronicdisease/overview/index.htm

Common Gaps in Chronic Disease Management

- PCPs lack time, do not adhere to evidence-based practices
- Care is not planned, not coordinated
- Follow-up is not proactive
- Patients are not engaged
- Behavioral issues are poorly addressed

www.improvingchroniccare.org

Chronic Care Model



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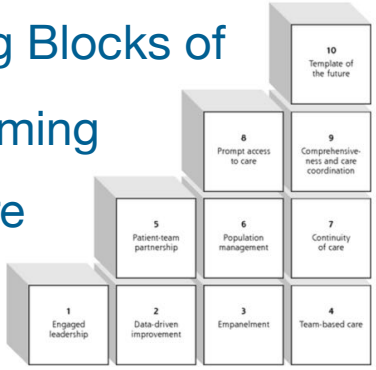
The Building Blocks of High-Performing Primary Care



Bodenheimer et al, Annals of Family Medicine 2014; 12: 166-171

1. Engaged Leadership
   - Practice-wide vision for excellence
   - Concrete, measurable goals and objectives

2. Data-Driven Improvement with HIT
   - Data systems that track key metrics
   - Performance tracking and improvement

Bodenheimer et al, Annals of Family Medicine 2014; 12: 166-171

3. Empanelment
   - Patients assigned to PCPs and teams
   - Workload and quality tracking

4. Team-Based Care
   - Additional staff to address behavioral issues
   - Workflow that incorporates additional staff

Bodenheimer et al, Annals of Family Medicine 2014; 12: 166-171

5. Patient-Team Partnership
   - Patients set goals
   - Shared decision making

6. Population Management
   - Registries to track populations at risk
   - Staff to work with patients between visits

Bodenheimer et al, Annals of Family Medicine 2014; 12: 166-171

7. Continuity of Care
   - Patients usually see their assigned clinician and his/her team members

8. Prompt Access to Care
   - Same-day access for urgent concerns
   - Control of panel size and team configuration

Bodenheimer et al, Annals of Family Medicine 2014; 12: 166-171

9. Comprehensiveness and Care Coordination
   - Identification of referral resources
   - Minimization of barriers to referrals

10. Preparation for the Future
   - Readiness for reimbursement based on process and outcome metrics

Bodenheimer et al, Annals of Family Medicine 2014; 12: 166-171

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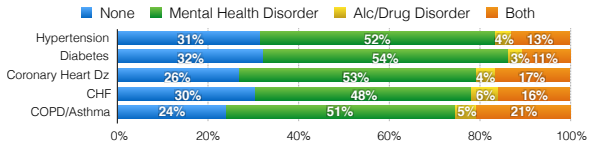
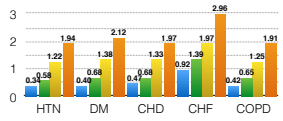
Co-morbidity in Dual-Eligibles

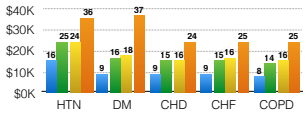


Hospitalizations Per Pt Per Year



3 to 6 x hospitalizations

Total Cost of Care Per Pt Per Year

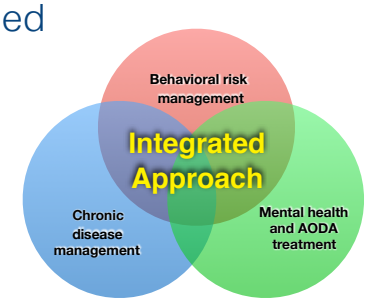


2 to 4 x total cost of care

Boyd C, Faces of Medicaid Data Brief, Center for Health Care Strategies, December 2010

What's Needed

- Many patients need multiple services
- Their behavioral issues are usually interrelated

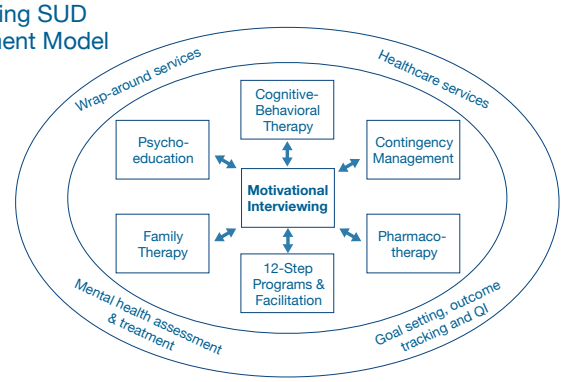


Conventional SUD Treatment

- Inadequate time, does not adhere to evidence-based practice
- Care is not planned, not coordinated
- Follow-up is not routine or proactive
- Patients are not engaged or activated

www.improvingchroniccare.org

Emerging SUD Treatment Model



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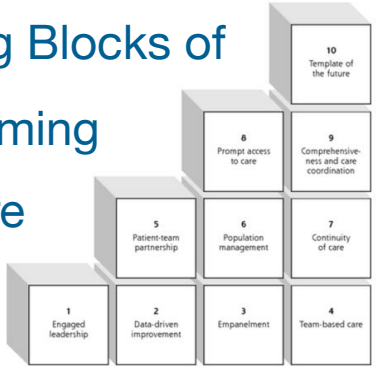

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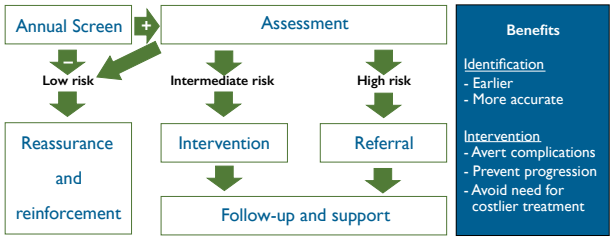
BSI - The Overall Concept



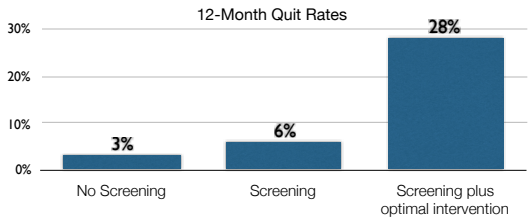
Promoting Healthier Behaviors

To promote commitment to change:
Motivational Interviewing

To implement and sustain change:
Behavior Change Planning

BSI Works for Smoking

– Candidates: 19% of American adults –



Fiore, AHRQ Smoking Cessation Guideline, 2008

BSI Works for Binge Drinking

– Candidates: 23% of American adults –

ED visits

20%

Injuries

33%

Hospitalizations

37%

Arrests

46%

Crashes

50%

Fleming, JAMA, 1997

Collaborative Care for Depression

Health coach

- Measures severity of depression (PHQ-9)
- Educates about depression and instills optimism
- Promotes behaviors that reduce depressive symptoms

- Refers for medications and/or counseling
- Promotes engagement in treatment during contacts every 1 to 4 weeks
- Reassesses severity (PHQ-9) every month and alerts providers when treatment plans may need modification

Psychiatrist (most helpful for severe disorders)

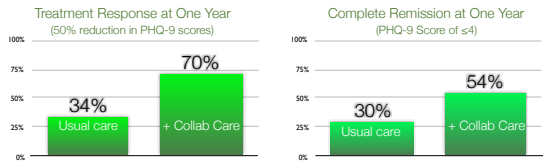
- Reviews cases and advises on diagnosis and treatment

Thota, American Journal of Preventive Medicine, 2012

BSI Works for Depression

– Candidates: 7% of American adults –

- Without screening, 30% to 50% of depressed patients are missed
- 69 RCTs: 75% higher odds of remission at 6 and 12 months
- One-year results of BSI for depression



- Effective for several other mental health disorders

Thota, American Journal of Preventive Medicine, 2012; Institute for Clinical Systems Improvement, www.icsi.org; Woltmann, American Journal of Psychiatry, 2012

BSI can address MH/SUDs, chronic diseases and more

Patients' age, gender and diagnoses determine what topics are addressed

		28 yo ♀ with IVDU and hepatitis C	48 yo ♂ with alc dep, hypertension & diabetes	68 yo ♂ with sedative dep & lung dz
	Patients' goals	✓	✓	✓
Behavioral issues	Alcohol and drugs	✓	✓	✓
	Smoking	✓	✓	✓
	Healthy diet	✓		✓
	Diabetic diet		✓	
	Sodium intake		✓	
	Physical activity	✓	✓	✓
	Obesity	✓	✓	✓
	Medication adherence	✓	✓	✓
Mental health	Depression	✓	✓	✓
	Anxiety	✓	✓	✓
	Safe sex/contraception	✓	✓	✓
Other issues	Indication for aspirin		✓	✓
	Cognitive function			✓
	Fall risk			✓

(List is not comprehensive)

BSI: The Front End of PC/BH Integration

Tier	Unhealthy Behaviors	Mental Health Disorders
1 Health Coach	Screening	
	Brief Assessment	
	Motivational Interviewing	Behavioral Activation
	Change Planning & Support	Collaborative Care
2	Rx – Physician, Psychiatrist, NP/PA	
	Other Specialists, Treatment Programs, Psychotherapy	

Benefits of Tier 1:
- Earlier recognition, less expensive intervention, and fewer costly consequences
- More efficient utilization of scarce and more expensive Tier 2 resources

Brown, Population Health Management, 2011

BSI Would Help with **16** CMS Quality Metrics

BSI would help ACOs excel on:

- 5 - Health promotion & education
- 13 - Fall screening
- 16 - BMI screening & follow-up
- 17 - Tobacco screening & intervention
- 18 - Depression screening & intervention
- 30 - Ischemic vascular disease: Aspirin use
- 40 - Depression remission

BSI would help ACOs improve on:

- 8 - All condition readmission
- 9 - COPD/asthma readmission
- 10 - Heart failure readmission
- 27 - Diabetes: HgbA1C ≤ 9
- 28 - HTN: BP < 140/90
- 29 - IVD: LDL < 100
- 36 - Unplanned admission - diabetes
- 37 - Unplanned admission - CHF
- 38 - Unplanned admission - multiple chronic diseases

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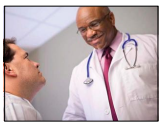
Basic Primary Care Team



Primary Care Clinician

Health Coach

Nurse and/or MA

Recep-tionist

Ideal HIT Systems

- Administer & score behavioral screens and assessments
- Guide health coaching
- Engage patients
- Print summaries for patients - goals, risks, change plans
- Track behavioral issues - prevalence, services, outcomes
- Enable comprehensive population health management for all behavioral issues relating to SUDs and other chronic diseases

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