SAMHSA-HRSA
Center for Integrated Health Solutions

Workforce Issues Related to: Bi-Directional Physical and Behavioral Healthcare Integration

Specifically Substance Use Disorders and Primary Care

A Framework of Issue Briefs

ISSUE BRIEF #3

Substance Abuse Treatment Integration into Primary Care and Other Medical Settings
&
Financing Integrated Care: Barriers and Solutions

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August 3, 2011

This document was developed for the SAMHSA-HRSA Center for Integrated Health Solutions with funds under grant number 1UR1SMO60319-01 from SAMHSA-HRSA, U.S. Department of Health and Human Services. The statements, findings, conclusions, and recommendation are those of the authors and do not necessarily reflect the view of SAMHSA, HRSA, or the U.S. Department of Health and Human Services.

SUBSTANCE ABUSE TREATMENT INTEGRATION INTO PRIMARY CARE AND OTHER MEDICAL SETTINGS: *WHAT DOES IT LOOK LIKE?*

While integration of medication assisted treatment and screening and brief intervention into primary care are critical to patients with substance use disorders, there are many varied and successful models of integration of substance use and physical health care. This section provides a brief overview of integration efforts and processes including the integration continuum, the four quadrant model, the five A's, and the person centered medical or health care home. Integration efforts can run the gamut from early steps such as improved communication between practitioners in primary care and specialty substance abuse treatment to collocation or to full integration, where the patient experiences a health care team which includes both mental health and substance use treatment services. Early evidence suggests that integrated care improve outcomes and in some instances can lower costs for specific patient populations. Comprehensive descriptions of specific model programs in which substance abuse treatment is coordinated or integrated with primary and other medical care are largely not included in this paper; readers interested in that information should consult the two reports from the Policy Forums on Integration, sponsored by SAMHSA. Collins and others describe eight different models of integration across the integration continuum (listed here in a progression from least to most integrated- not all of these may be appropriate to substance abuse treatment):

- improved collaboration,
- medical provided behavioral health care (consultative support from BH specialist),
- co-location (separate entities, but in same location/facility),
- disease management (close collaboration, some shared systems, regular contact between providers),
- reverse co-location (some medical care professional added to BH team)
- unified primary care and behavioral health (on same team),
- primary care behavioral health with close collaboration in a fully integrated system,
- collaborative systems of care with full or partial integration.

It is important to note that in real world implementation, attributes of one or another model are often combined. The choice of model will be influence by a number of factors including, the existing array and capacity of services available in a community, the population that is targeted for services, patient preferences (which setting are they more likely to accept care in), the skills of the workforce as well as reimbursement factors and others.

Another view of the possible organization of integrated services is the four quadrant model. (See Appendix A in complete paper). The four quadrant model was originally developed to facilitate discussion of care needs of patients with co-occurring mental health and substance use disorders. Mauer proposed that the four quadrant model could also be used to describe the types of needs patients had for care for mental and substance use conditions, and physical health conditions, as

well as some integrated care practices appropriate to each quadrant of patients. For example, even patients with low needs for care for both substance use and other health conditions (Quadrant I) may require screening and brief intervention delivered in a primary care setting. On the other end of the spectrum, patients with high needs for care for both substance use and other health conditions (Quadrant IV) may require specialty care, including hospitalization, detoxification or residential care, for their substance use condition, which will need to be coordinated with their other medical care for optimal outcomes to be achieved. In some settings, such as residential care or social detoxification, it might make sense to bring medical care into the specialty setting, but in the main bringing behavioral health expertise into medical settings is more common. Consistent with the notion of "stepped care", patients initially seen in Quadrant IV could be expected to transition to outpatient specialty care and continue to require some care coordination or management for their medical needs (Quadrant II). But it is possible those with other significant chronic medical problems, could also be managed within a primary care practice with a strong behavioral health component. Patients with high needs for care for a substance use condition, but low needs for care for other types of health conditions) may also initially need specialty care, but may be able to transition back to a primary care setting with behavioral support as their clinical status changes.

The Five A's is an organizational construct endorsed by the US Preventive Services Task Force for behavioral counseling interventions in medical care. The Five A's describe the processes that must take place: Assess, Advise, Agree, Assist, and Arrange; and imply that these process tasks may be performed by either the primary physician or shared with other healthcare staff. One full integration model with special significance within the context of health reform and incorporates substance use conditions as well as other health conditions is the person centered health care home. The concept of a person centered health care home (PCHC) reflects a shift from intermittent, acute care focused health interventions which are likely to be uncoordinated or poorly articulated to management of the broad healthcare of specific patient populations, with an emphasis on those with chronic health conditions. The promise of health care homes is in improving health care outcomes while containing costs. While some have proposed health homes for all types of patients with mental health and substance use disorders, others have suggested that it is important to target patients with multiple chronic disorders and related high costs. Thus, patients in quadrant IV with their chronic high behavioral and physical health needs are also likely to have lower medication adherence, a substantial incidence of co-occurring alcohol and drug abuse problems, complex medical plans and lack a stable medical home should be high priority candidates for person centered health homes, as described within the Accountable Care Act. While it might be appropriate that some patients with serious mental disorders have a primary care home within a mental health setting with integrated medical and health care services, it is expected that the majority of health care homes will have strong behavioral health components that will allow for the treatment of patients with multiple behavioral and physical health conditions within a primary care or other medical care setting.

The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association have agreed on seven principles to describe the characteristics of the PCHC. These reflect that each patient has an ongoing relationship with a personal physician, who along with the patient and the health care team, advocates for patients, and is responsible for addressing all the patient's health care needs using evidence based practices, either directly or by coordinating care with other qualified professionals. Care is coordinated and or integrated across the complex health care system; such coordination is facilitated by registries, information technology and health information exchange while other technologies such as clinical support systems may be used to facilitate quality care. Physician directed teams are accountable for continuous quality improvement; and involve patients and families in quality improvement activities.

Many of the reports have pointed out that primary care and other medical care settings have a different culture and language than the substance abuse treatment system. Primary care is characterized by a fast pace of brief interactions with patients, a high volume of patients, a setting where interruptions are okay, and constant balancing of needs and priorities is essential. The specialty substance abuse treatment system however, focuses on the 50 minute hour, a slower pace with few emergencies (at least in most outpatient settings). Bridges of understanding will no doubt need to be built, as well as appreciation for the differences.

New workers focusing on substance use disorders in integrated care

A number of specific kinds of new workers may be needed to successfully integrate substance abuse treatment services into primary care and other medical settings. A number of attendees at the SAMHSA sponsored Policy Forum on Integration commented that they were experimenting with the use of different types of workers to deliver behavior change services and support primary care practitioners including, health educators, behavioral health specialists, behavioral health interventionists, health coaches, patient navigator and case managers. The importance of the availability of substance abuse treatment expertise is also recognized through a variety of systems of consultation-liaison. The health educator, behavioral health specialist, and expanded role care manager positions are briefly described, and consultation-liaison functions and systems discussed.

Several models for implementing universal screening for risky substance use in busy primary care practices and other medical settings have been tried, often encompassing the use of a specific worker, such as a health educator, with a designated responsibility for the provision of screening, and brief intervention. The health educator role is still evolving and may vary somewhat across different models of integration, targeted populations, and types of health care setting; in general, health educators may screen patients for risky health behaviors, such as overuse of alcohol, nicotine use and/or depression using a standardized instrument, score the screening instrument, and provide feedback and or brief intervention for appropriate patients.

One example of the use of health educators is Wisconsin's Screening, Brief Intervention and Referral to Treatment Project focusing on risky substance use and tobacco use. In some Wisconsin primary care sites, health educators are also used to provide monitoring and support for patients receiving medication assisted treatment for substance abuse within primary care settings; primary care practitioners reinforce the health educator interventions and provide pharmacotherapy for patients as appropriate. Health educators use the same tools and interventions but the exact tasks and processes may differ across settings.

Wisconsin's health educators have a bachelor's degree, 2 years of experience in human services work and 60 hours of specific training on the use of screening instruments, motivational interviewing and cultural competence. A hallmark of Wisconsin's program is the intensive clinical supervision and feedback. Beyond providing screening and brief intervention, health educators can be trained to help with other types of patients who need motivational interviewing and/ or referral or case management; they also need competencies in quality improvement, and evaluation. Wisconsin is considering additions to curricula to stretch the competencies of health educators to a broader focus on screening and intervention for on multiple chronic health issues while also grappling with how the health educator model fits with professional licensing and certification in Wisconsin. Requirements for health educators are not identical across the country. For example, California used "peer health educators" to provide screening and brief intervention in a busy emergency room serving a high proportion of Spanish speaking patients. Requirements for these health educators included a high school diploma, bi-lingual in English and Spanish, several years of work experience, preferably with public contact, but they must also be:

> engaging, confident self-starters because they are going to be dealing not just with patients but with the doctors and other hospital staff.

Another type of new worker needed is the primary care behavioral health specialist. Working as part of the primary care team, the primary care behavioral health specialist would work with patients who not only have mental or substance use conditions, but also assist other patients who are having difficulty making or maintaining the behavior changes necessary to their improved health. This primary care based specialist needs to be competent in the assessment, treatment (especially brief cognitive behavioral intervention and motivational interviewing skills) and service planning for persons with mental and substance use disorders as well as consultation, communication, care management, team collaboration and orientation and an understanding of chronic disease and self-care requirements Successful behavioral health specialists in primary care should also be as flexible, independent and oriented to action and solution rather than process, along with having strong organizational and computer competencies. While it is likely that only large primary care practices could incorporate such a worker, sharing a worker across smaller practices or co-locating such services is another feasible approach. One study of behavioral health providers within integrated care settings showed that the types of interventions

employed included medical management, psycho-education, elements of cognitive behavioral therapy and supportive psychotherapy.

A third type of worker with a role in integrated substance abuse treatment services is an expanded care manager. Care management has been defined as:

> A set of activities designed to assist patients and their support system in managing medical conditions and related psychological problems more effectively.

Care managers may not be appropriate for all patients, but patients with multiple chronic conditions, certain types of chronic conditions, or patients who use a significant amount of high cost (and not necessarily appropriate care) are high priority patients for care management. Massachusetts used state funds to deploy nurse care mangers in 19 community health centers, each of which is partnered with a substance abuse specialty treatment provider. Because of their expertise in managing a specific population, such as persons with opiate addiction being treated with buprenorphine, these care managers also provide significant physician support for opiate treatment within primary care. Care mangers may serve a range of functions for a specific population of patients, including patient management care coordination, increasing self-efficacy in patients, tracking patients on a registry, linking patients with needed resources, consultation with health professionals and others.

Additionally, one old professional role is in the process of being resurrected in new ways: the consultation-liaison clinician. The consultation liaison role is concerned with the diagnosis, and treatment of the physically ill and generally involved contact with a patient for a problem, along with collaborative and educational work with the primary caregivers, including physicians, nurses and others. With its origins in acute care inpatient settings and psychiatrists, consultation liaison work has been broadened to that practiced by teams or clinicians, who may include psychologists, nurses, social workers and substance abuse treatment counselors. In some settings, substance abuse consultation teams are used to evaluate and intervene with patients, such as trauma victims.

The role of the consultation-liaison clinician also encompasses specific mentoring of other clinicians as they build confidence in the application of new practices; treating patients with buprenorphine is an example of one such process. A number of approaches have been taken to providing individualized expert advice to primary care physicians in relation to substance abuse treatment. The American Academy of Addiction Psychiatry and its partners, the American Osteopathic Academy of Addiction Medicine, and the American Psychiatric Association jointly sponsor an on line physician clinical support system supported by the Substance Abuse and Mental Health Administration; in addition to notices about trainings and easily accessible on--line resources, the site offers to link primary care physicians with mentors at no cost to assist with the appropriate use of buprenorphine. A similar site exists for primary care physicians who

want help with how to address alcohol, tobacco and drug screening and brief intervention and treatment referral in primary care settings.

San Francisco County, California significantly expanded the availability of treatment for opiate addiction through the use of buprenorphine in primary care and other medical settings by stretching the consultation-liaison model even further. In order to provide support to physicians and clinics, San Francisco County initiated a public health buprenorphine induction center, which includes consultation-liaison services with specialty physicians and a county behavioral health pharmacy. The opiate buprenorphine induction center trains practicing physicians as well as residents, hoping to create a new group of physicians knowledgeable about substance use disorders. With the reduction of the burdens related to buprenorphine induction, and the availability of ongoing consultation, San Francisco County has significantly increased access to treatment.

Wherever a medical care home for a patient is located in the health care system, it should be clear that the health care team must have the capacity to serve the needs of persons with substance use conditions and to work within that setting; ensuring that the workforce has the appropriate competencies is a key challenge to success. As all of these new types of practitioners and roles evolve, it will be important to come to some national consensus on titles, requirements and curricula for basic training, licensure, certification and continuing education.

Creative retooling and repurposing of the existing specialty workforce for treatment of substance use disorders will be required to support integration, with some workers in significantly expanded and changed roles and broader competencies. Leaps will need to be made in the adoption of evidence based practices, team work skills and collaboration. New or expanded roles and types of workers are also likely to be needed to facilitate integration, including health educators, behavioral health specialists, and care managers.

The substance abuse treatment workforce will not be singly affected by this sea change. For example, the American Academy of Pediatrics has identified a goal of pediatricians having the competencies to provide both mental health and substance abuse services in pediatric primary care settings. However, Van Hook and others identified a number of barriers to screening teens for substance abuse in primary care; which included insufficient time, lack of training in how to manage a positive screen, need to triage competing problems, lack of sufficient treatment resources, parents who would not leave the room for the confidential discussion, and unfamiliarity with screening tools. These are not significantly different than what has been reported for adult primary care.

FINANCING INTEGRATED CARE: BARRIERS AND SOLUTIONS

The current methods of health care financing can be at best cumbersome or at worst a barrier to the provision of integrated care is well documented. It is clear that this care and system integration cannot be initiated or sustained without aligned financial incentives; however, evidence about the most effective financing strategies for integration is lacking. While a full review of financing methodologies for integrated care is beyond the scope of this document, some issues and solutions which have been proffered or implemented are highlighted.

Organizations that receive capitated payments such as managed care organizations may have the least barriers to integrated care, as long as no carve out are included. Some health care organizations such as health maintenance organizations may already be integrated, and fewer reimbursement barriers to integrated care may exist. Organizations who receive a bundled rate may also be less constrained in the delivery of integrated care. Others have identified some purchasing options for increasing the design and rigor of contracting relationships with managed care organizations that could support integrated care. One is to contract with an existing managed care organization to develop and implement care management and coordination programs; incorporating behavioral health expertise such programs could be targeted to persons with specific types of disorders, such as persons with co-occurring mental health and substance use disorders. Going further, some have developed a public-private partnership entity which serve as the at risk care organization; this type of model allows for retention of public control of the care system for the most vulnerable, which facilitating integration.

Clearly, reimbursement must be available for collaboration and consultations, if integrated care is to occur. Some have suggested that reimbursement models for some behavioral health management, within the primary care setting can be developed and in a sense layered on top of existing fee for service or other payment mechanisms. While these models have been predominantly developed for depression, a per member per month payment, with adaptation, arrangement could cover screening and brief intervention activities or care management for persons with substance use disorders. The primary care physician's fee for medical services could remain the same. Medicaid payment innovations, notably in North Carolina and Vermont include paying networks or teams affiliated with patient centered health care homes that help connect patients to needed services and primary care providers to specialists, pharmacists and care providers. Performance based payments are also being used along with other payments to patient centered medical homes. For example, in Pennsylvania, provider practices that meet certain criteria can share in any savings generated. Missouri has changed the definition of rehabilitation services to include care coordination.

Reforming fee-for-service payments may also prove to be a viable approach. For example, in an attempt to provide more standardized payments and incentives for behavioral health services, especially outpatient services, New York adopted a payment system for Ambulatory Payment Groups. This system provides for consistent provider reimbursement and incorporates risk

adjustment and intensity of services received. It also requires and pays for better collection of clinical data that can be used for care management activities and care management costs.

In the short term, to the extent the fee-for-service system remains, States will want to review the recommendations of a number of groups regarding same day prohibitions on Medicare and some Medicaid payments for behavioral health and physical health problems, and work with Centers for Medicaid and Medicare (CMS) to change these rules or identify possible valid "work-arounds." Because these regulations initially were related to fraud prevention, providers are extremely reluctant to bill in a way that may place them at risk, so significant outreach to provider and provider billing systems is likely to be required to enhance uptake. Beyond official policy, billing for same day claims may be rejected due to the interpretations of various Medicaid managed companies or intermediaries who may have their own policies or interpretations. For example, Tennessee is one of 29 states that reimburse providers for separate primary care and behavioral health visit on the same day. This will facilitate coordinated care, while ensuring appropriate payment.

Another barrier to reimbursement relates to the provider of the service. Within the fee for service construct, only certain members of the health care team are able to be reimbursed for certain services in certain settings. Within integrated care, it is the team that is caring for the patient. If health care is to be efficient, i.e. providing the best outcome at the lowest cost, then payment structures need to be evaluated and revised to reflect that desired result. Many have suggested that to become more efficient, all health care workers will have to function at "the top of their license" or competencies for efficiency to be realized. Similarly, as the workforce essential to efficient care coordination evolves and may include recovery coaches, health educators and others, States and other payers will want to ensure that the most efficient workforce models are able to be recognized within payment structures, while maintaining appropriate minimum standards. It is important to recognize that this can be done; while limited to mental health peer support specialists, Tennessee succeeded in having Medicaid reimburse peer support specialists. Connecticut Medicaid will also reimburse certified recovery support specialists, supervised by a licensed clinician for services delivered in two specific programs serving persons with serious mental illness being discharged from nursing homes.

Notably, while CPT and HCPCS reimbursement codes are available for Screening, Brief Intervention, and Referral to Treatment (SBIRT), reimbursement barriers remain. Not all States have authorized Medicaid coverage of SBIRT. As part of its 2010 National Drug Control Strategy, the White House Office of Drug Control policy seeks to expand the adoption and reimbursement through the SBIRT billing codes. As SAMHSA works with the National Governor's Association, the National Association of State Medicaid Directors and the National Association of State Alcohol and Drug Abuse Directors, the fact that reimbursement is allowable only when certain types of clinicians deliver the screening and brief intervention should be addressed. While it is no doubt important that knowledgeable workers provide these services,

efficient health care can only be delivered by ensuring that the level of person performing the function is not more qualified (and expensive) than what is needed to ensure quality care.

In addition, even with appropriate codes, settings, and staff, reimbursement is challenged by the lack of universal coverage by major insurers within a region, and the related consequences for medical and hospital billing systems. For example, SBIRT sites even where "codes have been turned on" have not found getting reimbursement to be straightforward or easy. Leadership and collaboration with major industry benefits groups and their consultants and fiscal intermediaries for Medicaid and Medicare, could lead to a national recognition that SBIRT is essential for health and containment of health care costs; universal acceptance would be likely to bring about change in medical billing systems.

Another focus of care integration are Federally Qualified Health Centers (FQHCs). Along with other safety net providers in order to meet the needs of their patients, many FQHCs have evolved to provide a broad array of services. A number of SBIRT demonstration states include FQHCs, and a number of creative projects integrating physical health care and substance abuse treatment within FQHC's have also been identified. Because FQHCs to some extent receive cost reimbursement funding from HRSA, some have suggested that they are one of the best initial targets for fully integrated physical and behavioral health care.

Please Note that references supporting this brief may be found in the complete paper.