SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Integrating Primary Care into Substance Use Treatment Provider Services Innovation Community

Kick-Off Webinar

12/22/2015

Setting the Stage:
Today's Moderator

Madhana Pandian

Associate

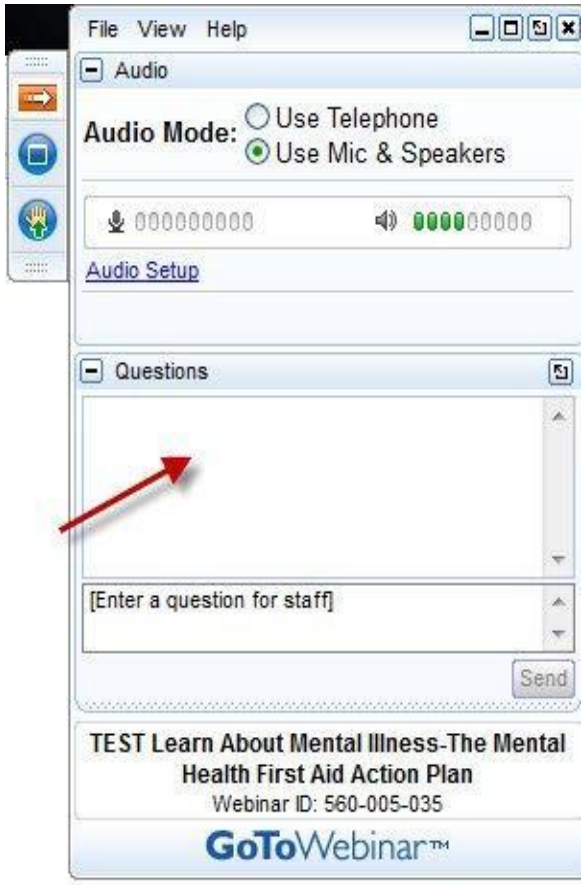
SAMHSA-HRSA Center for Integrated Health Solutions

Slides for today's webinar will be available on the CIHS website:

www.integration.samhsa.gov

Under About Us/Innovation Communities

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

Innovation Community Participants

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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 Agenda

- **Drivers of Integration**
  - Affordable Care Act (ACA)
  - Mental Health and Substance use Parity
  - Medication Advances
- **Why Integrated SUD and Primary Care?**
- **CHIS Innovation Community**
  - What is it
  - How will it work
  - Responsibilities
  - Activities
  - Schedule
- **Questions**

Current Trends in Healthcare

- Triple Aim Focus (cost/pop. health/customer focus)
- Accountable Care
- Multi-disciplinary Team Base Care Approaches
- Continued Focus on Use of EBP (e.g., MAT)
- Provider Consolidation
- Increased Focus on Workforce Roles for People in Recovery & Their Families
- Integrated Behavioral Health and Primary Care

Drivers of Integration

- HealthCare Reform
- SU/MH Parity
- Advances in Medications

Affordable Care Act

SUD treatment and prevention services are a key component of the future of health care…

- The ACA includes substance use disorders as one of the ten elements of essential health benefits.
- Affordable Care Act result in a significant increase in the need for addiction treatment professionals who are capable of providing care for individuals with substance use disorders in a variety of healthcare settings.
- Most members of the safety net will have may have some sort of coverage, including mental health and substance use disorders.
- Under the new law, in new plans and policies, preventive services with a US Preventive Task Force grade of A or B will be covered with no cost sharing requirements…

Substance Use and Mental Health Parity

- The Mental Health Parity and Addiction Equity Act requires insurers that pay benefits for mental health and addiction treatment to make those benefits equal to their reimbursement for medical and surgical care.

- Enforcement of this law will change the nature of provider networks and service offerings

Integrated Health Care

- Goals
  - IHC = efficient, effective, and high-quality
  - Treating the whole person, focus on prevention and wellness
  - Team-based care/enhanced collaboration
  - HIT, data collection → population health management
- But what's in the ACA?
  - Demo program: Health Homes, ACOs, dually eligible population

Advances in Medication

Advances in Addiction Treatment Medications

Over the past decade, the Food and Drug Administration approved three new medications for the treatment of substance abuse disorders:

- Buprenorphine- to treat opioid addictions in 2002
- Acamprosate-to treat alcohol addiction in 2004
- Extended-release naltrexone- to treat alcohol addictions in 2006 and opioid addiction in 2010

Advances in Addiction Treatment Medications

- With efficacy comparable to treatment for other chronic conditions such as diabetes, asthma, and hypertension, substance abuse medications give providers new tools to fight addiction by expanding the range of treatment options for individuals with alcohol and drug addictions

Yet, 54% of addiction treatment programs have no physician

Why Integrate SUD Treatment and Primary Care?

Background

The societal costs of addiction are as much as **$555 billion***

In addition to the crime, violence and loss of productivity associated with addiction, individuals living with an addiction often experience a number of physical health problems, including:

- Lung disease
- HIV/AIDS
- Cardiovascular disease
- Cancer
- Hypertension
- Asthma
- Psychoses
- Ischemic heart disease
- Pneumonia
- Chronic obstructive pulmonary disease
- Cirrhosis
- Hepatitis C

*U.S. Department of Justice National Drug Intelligence Center, The Economic Impact of Illicit Drug Use on American Society. 2011. http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf

Bouchery EE1, Harwood HJ, Sacks JJ, Simon CJ, Brewer RD. "Economic costs of excessive alcohol consumption in the U.S., 2006" American Journal of Preventive Medicine. 2011 Nov;41(5):516-24.

U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

Medical conditions made worse by excessive alcohol use or illicit drug use

Diabetes

Depression

Hypertension

Hepatitis C

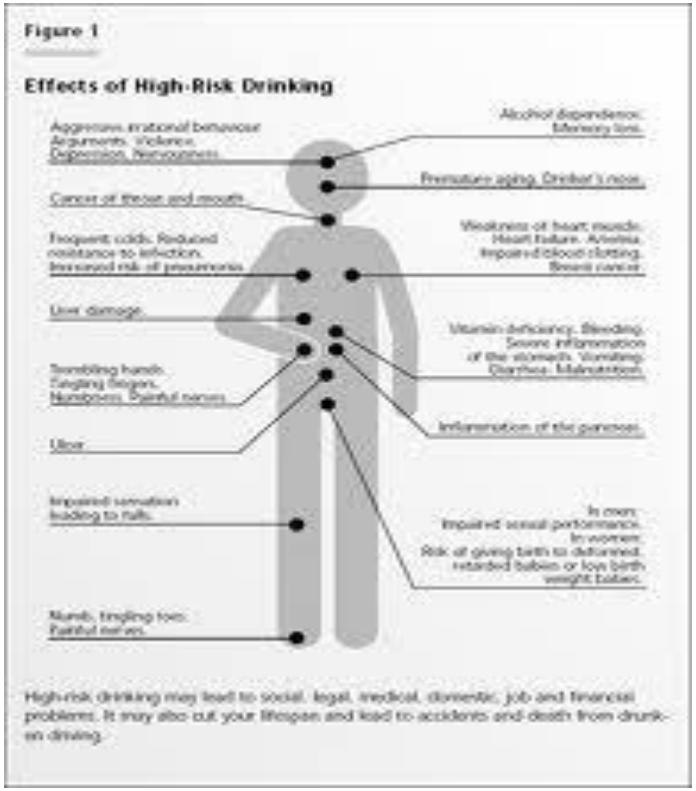
Breast Cancer

HIV/AIDS

Lung disease

http://www.drugabuse.gov/related-topics/medical-consequences-drug-abuse

www.niaaa.nih.gov/alcohol-health/alcohols-effects-body

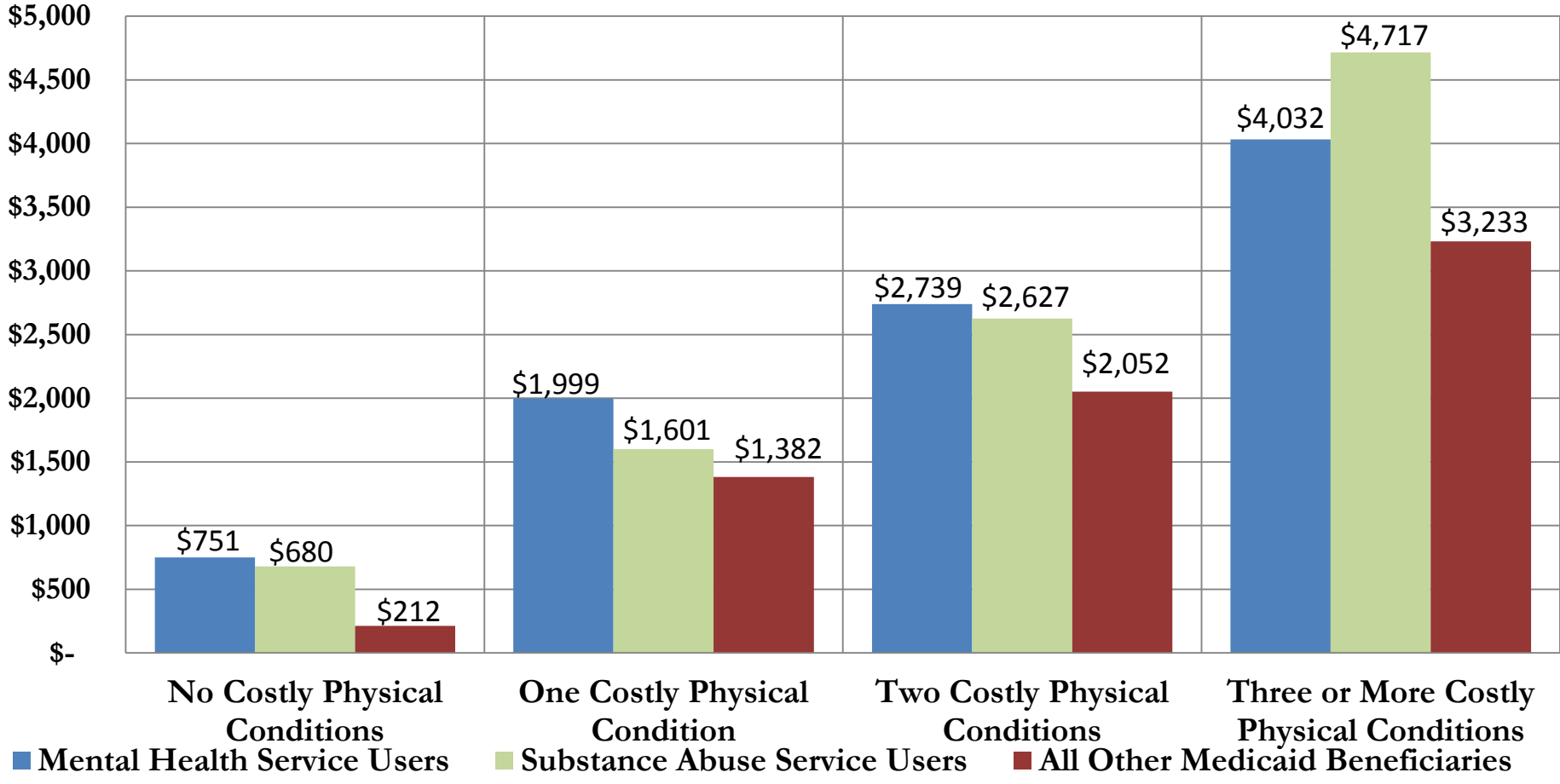


Substance Abuse and Chronic Health Problems
Alcohol is especially a problem…..

- Drinking four or more drinks per day has a negative effect on diabetes, hypertension and possibly depression.
- Illnesses such as a variety of cancers, risk for osteoarthritic fracture, sleep disorders and general medication adherence are negatively related to greater quantity and frequency of alcohol consumption.

- **Yet more than 80 percent of adults say they've never discussed alcohol use with a health professional, a survey finds. (CDC Morbidity and Mortality Weekly Report (MMWR)**

Substance Use increases costs



SAMHSA. (2010). Mental health and substance abuse services in Medicaid, 2003: Charts and state tables. HHS Publication No. (SMA) 10-4608.

Poll Question #1

What are the most significant chronic health conditions among the clients you serve that could likely be the focus of your efforts?

A. Diabetes
B. Hypertension
C. Hepatitis
D. HIV
E. All of the above

Innovation Communities

What are Innovation Communities (IC)?

- Innovation Communities are designed to engage organizations in acquiring knowledge and skills and applying their learning to implement measureable improvements in a high priority area related to healthcare integration

- Lessons learned over the course of the IC are compiled and shared with the healthcare field so other organizations can benefit

CIHS 2015 -2016 Innovation Communities

- Advanced Behavioral Health Integration in Primary Care: Implementing Trauma-Informed Care
- Integrating Primary Care and Wellness: Sustaining Integrated Services
- **Integrating Primary Care into Substance Use Treatment Provider Services**
- Hiring and Supervising Peers to Support Integrated Care

Integrating Primary Care into Substance Use Treatment Provider Services

Primary goal of the SUD/PC Innovation Community

To improve the health and well being of their clients with substance use disorders by assisting addiction treatment agencies/programs in taking meaningful steps to integrate primary care services and manage chronic health conditions.

How will we accomplish the primary the goals of this IC?

Over the next 9 Months we will:

- Conduct a comprehensive assessment of integration needs
- Develop a work plan for all integration activities
- Host didactic trainings/webinars
- Conduct individual coaching calls with facilitation team
- Host group galls with subject matter experts

What are your Responsibilities?

- Develop an integration work plan
- Attend all prescribed activities
- Convene all relevant internal and external stake holders
- Seek out resources to enhance your efforts
- Ask questions

Integrated Care Assessment Tool

CIHS' Standard Framework for Levels of Integrated Healthcare

- Helps primary and behavioral healthcare provide organizations improve outcomes by helping them understand where they are on the integration continuum
- Can be used for planning; creating a common language to discuss integration, progress, and financing; supporting assessment and benchmarking efforts
- Explaining integration efforts to stakeholders
- Clarifying differences in vision between two or more partnering organizations

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.:SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Poll Question #2: What best describes your current relationship with the primary care provider(s) of your clients with chronic health conditions?

A. We are co-located
B. Not co-located but have working relationship with a primary care organization
C. We will need to reach out to and engage various primary care providers who serve our clients
D. We are still trying to decide whether to co-locate primary care or coordinate with community primary care providers

Integrated Practice Assessment Tool (IPAT)

- IPAT is a descriptive, qualitative instrument intended to categorize practices along the integration continuum
- Focuses on qualitative change; the elements that comprise a high degree of integration are difficult to tease apart and do not occur separately in the real world setting, but are intertwined
- Designed to be user friendly, quick to administer, and equally applicable for both medical and behavioral health settings
- Practices find that IPAT is a team undertaking to fill out, and serves a “conversation starter” for integration

Didactic Webinars

Webinars will be designed to provide useful information from practice experts to help facilitate your integration efforts. Webinar topics will include:

- **Best practices in Integration of Substance Use and Primary Care services: Lessons from the field**
- **Financing integrated care services**
- **Use of medication assisted treatment in integrated care settings**
- **Population Health Management in integrated care settings**
- ***TBD-Topic of your choice***

9-Month Activity Schedule

- IPAT Assessments (due Friday **January 15th,2016**)
- 4-Bi-monthly didactic webinars (First webinar will be in **February,10th 2016 3pm est.**)
  - April 21ST
  - June 23rd
  - August 25th
- Individual coaching calls: January, March, May, July, September
- Group Calls: February, April, June , August
- September Close out Webinar.

Facilitation team

Faculty will be comprised of 2 CIHS staff (i.e., a lead and coordinator), and up to 3 subject matter experts who will provide webinar content and coaching in collaboration with the CIHS staff.

Facilitator: Aaron Williams (aaronw@thenationalcouncil.org)

Coordinator: Madhana Pandian (madhanap@thenationalcouncil.org)

The Innovation Community is Dynamic

- The proposed structure, process and content is a starting point!
- The experience, needs and wants of Innovation Community members helps to shape how the Community evolves over time!

Questions?

CONTACT INFORMATION

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