# Integration of care bringing physical & behavioral health together

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# Integration of Substance Abuse & Mental Illness

A little bit of history about the
Division of Behavioral Health's integration efforts:

## Why

- Co-Occurring Disorders (Mental Health and Dependence on Alcohol/Other Drugs)

## How

- Funding/Resources
- Policy

AK DHSS Integrated Regulations for Behavioral Health Services [1]

# Reasons Not To Work Toward Integration

- I don't want to deal with disruptive and difficult people who won't listen to me (if they show up at all).
- I'm not trained to do this.
- Our clients don't have resources – no one will take them.
- This is opening me up to liabilities I am not comfortable with.
- I didn't choose that field.
- I am already working at capacity.
- I'm not getting paid to do this.
- That's not my job.

WHY

# Integration of Physical Health and Behavioral Health Care

Why?

WHY

# WHY?

- Philosophy of Care: Mind and Body
- Meeting Unmet Need
- Reduce Expensive Care Down the Road
- Potential to Achieve Better Health Outcomes

WHY

# Philosophy of Care: Mind and Body

"60-70% of visits to primary care are either reflecting psychological issues and emotional distress through physical symptoms that mimic physical disease, or they have psychological and lifestyle problems that are interfering with medical treatment or contribute to their non-compliance with medical regimens."

*- Nicholas Cummings, et. al. (2009)*[2]

WHY

# Meeting Unmet Need

People with serious mental illnesses
die on average 25 years earlier:

Meaning, a man with serious mental illness is likely to die at the age of 53.[3]

An estimated 20.5 million needed treatment for illicit drug or alcohol use but did not receive it[4] (approx 53,000 Alaskans[5]).

WHY

# Reduce Expensive Care Down the Road

*A 2003 review of Medicaid utilization in NY found:*

"**Mental health** beneficiaries' spending on physical health services ($21,002) was 32 percent higher than comparable spending for non-mental health beneficiaries."

"**Substance abuse** beneficiaries' mean Medicaid spending on physical health services ($21,053) was 17 percent higher than comparable spending for non-substance abuse beneficiaries."[6]

WHY

# Potential to Achieve Better Health Outcomes

- 2010-11 trial in PA compared patients with co-morbid type 2 diabetes and depression receiving integrated care and usual care in primary care settings.

  **RESULT**: patients receiving integrated care were more likely to achieve target $HbA_{1C}$ levels and reduce depression.[7]

- 2007-08 study in WA looked at treating individuals with depression and co-morbid Chronic Heart Disease and/or Diabetes with multi-condition collaborative care intervention.

  **RESULT**: improved health outcomes and lower costs.[8]

WHY

# Adverse Childhood Experiences (ACEs)

ACEs: Abuse (emotional, physical, sexual), witnessing DV, growing up with substance abusing, mentally ill, or criminal household members, parental separation or divorce…

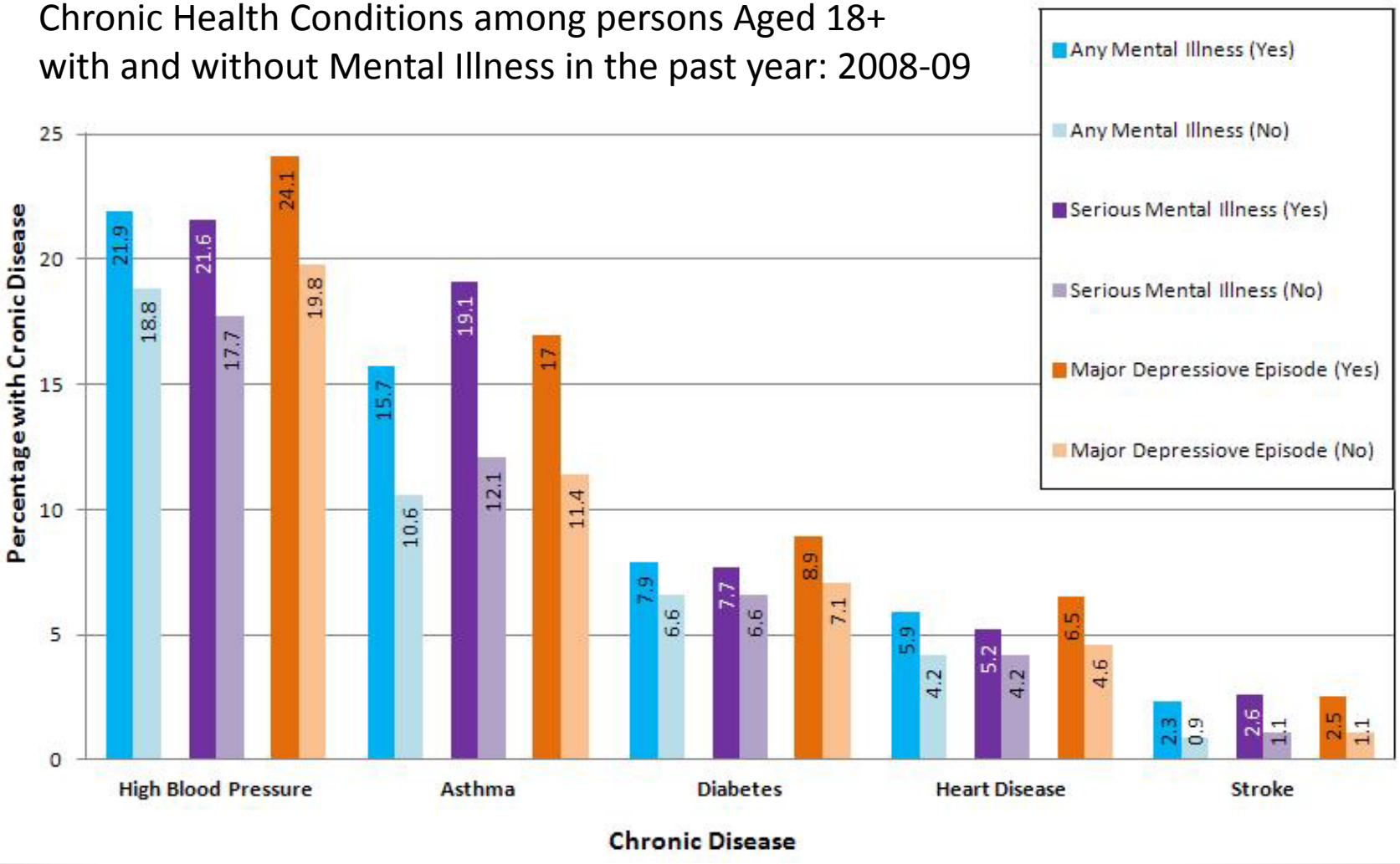
**Number of ACEs has been shown to be a reliable predictor of future adverse health consequences.**[9]

Example: Compared to those without ACEs, those with 6 or more Adverse Childhood Experiences were 3-fold more likely to develop lung cancer.[10]

WHY

# PREVALENCE

Chronic Health Conditions among persons Aged 18+ with and without Mental Illness in the past year: 2008-09




Data Source: [Physical Health Conditions among Adults with Mental Illness. The NSDUH Report. (April 5, 2012)](#)[11]

WHY

# UTILZATION

In FY11, Community Behavioral Health Centers served 20,700 clients (unduplicated count from AKAIMS).[12]

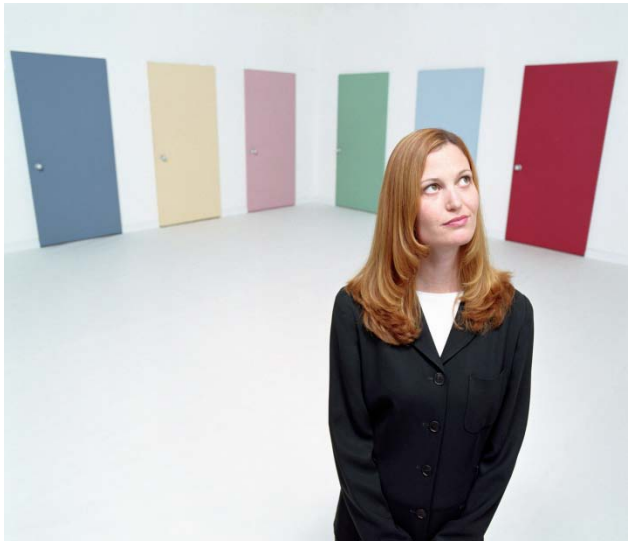
But we know that more behavioral health services are being provided outside of behavioral health centers (in FQHCs, clinics, ER, physicians offices…).

In 2010, HRSA reports 6,099 patients in Alaska received mental health services from a Community Health Center (about 5% of the total services provided)[13]

WHY

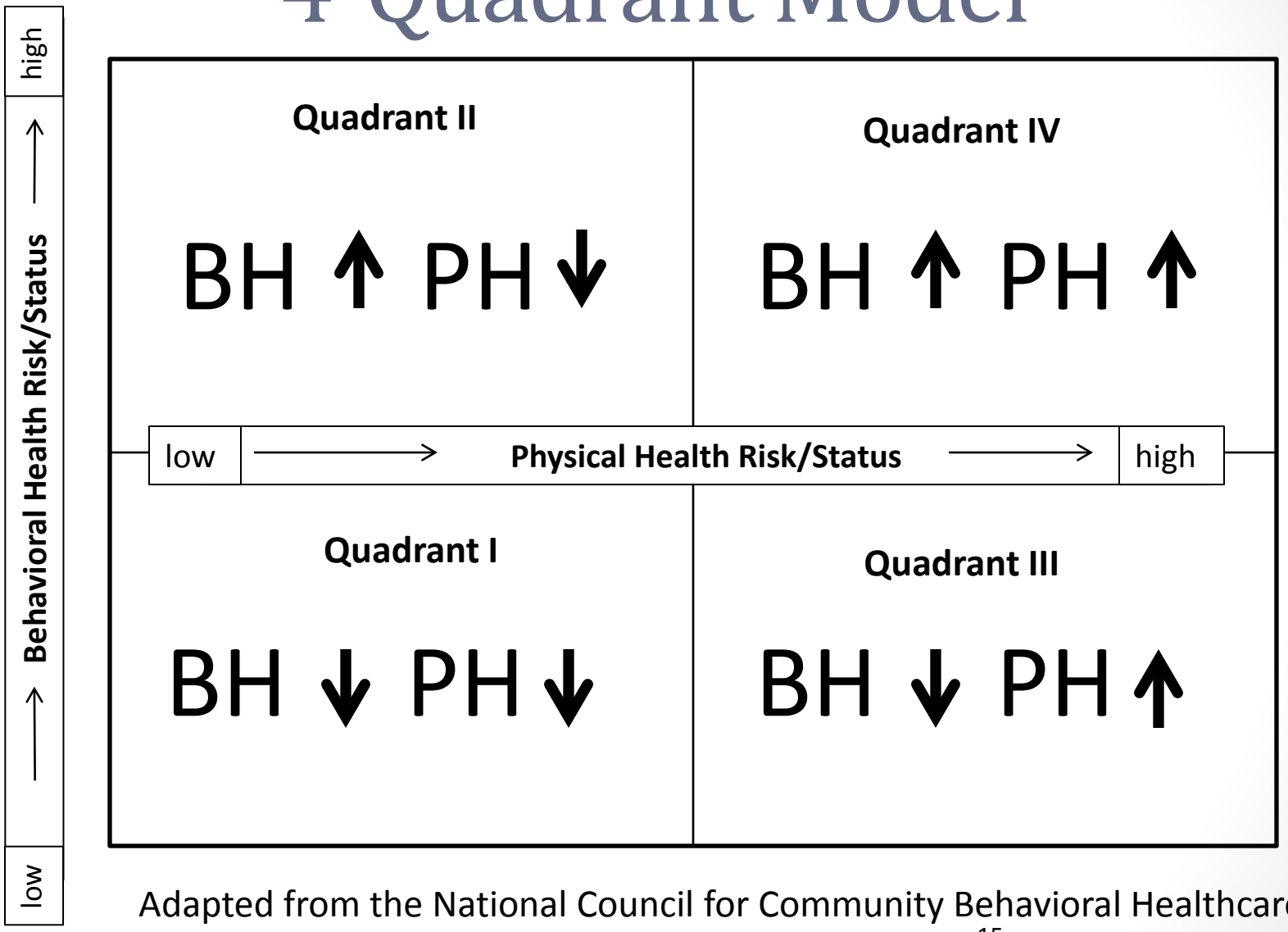
# ACCESSIBILITY

Persons with Medicaid coverage were more likely to report at least one ED visit and multiple ED visits in a 12-month period than those with private coverage or the uninsured.[14]



WHY?

# 4-Quadrant Model




Adapted from the National Council for Community Behavioral Healthcare's Behavioral Health/Primary Care Integration (Feb 06) [15]

# 4-Quadrant Model

## Quadrant I : BH ↓ PH ↓

**Description:**

- Patients/Clients served in primary care with behavioral health staff on site
- PCP uses standard BH screening tools and practice guidelines
- System for tracking referrals

**Roles and Responsibilities:**

BH: formal/informal consultation; triage and assessment, brief treatment services (including indiv/group, cognitive behavioral therapy, psych-education, brief SA treatment, limited case mgmt; community referrals, education)

PCP: prescribes psychotropic medications and has access to psychiatrist consultation for med management

# 4-Quadrant Model

## Quadrant I : BH ↓ PH ↓

**National Guideline Clearinghouse:** (www.guideline.gov)

- Disease/Condition Specific Guidelines

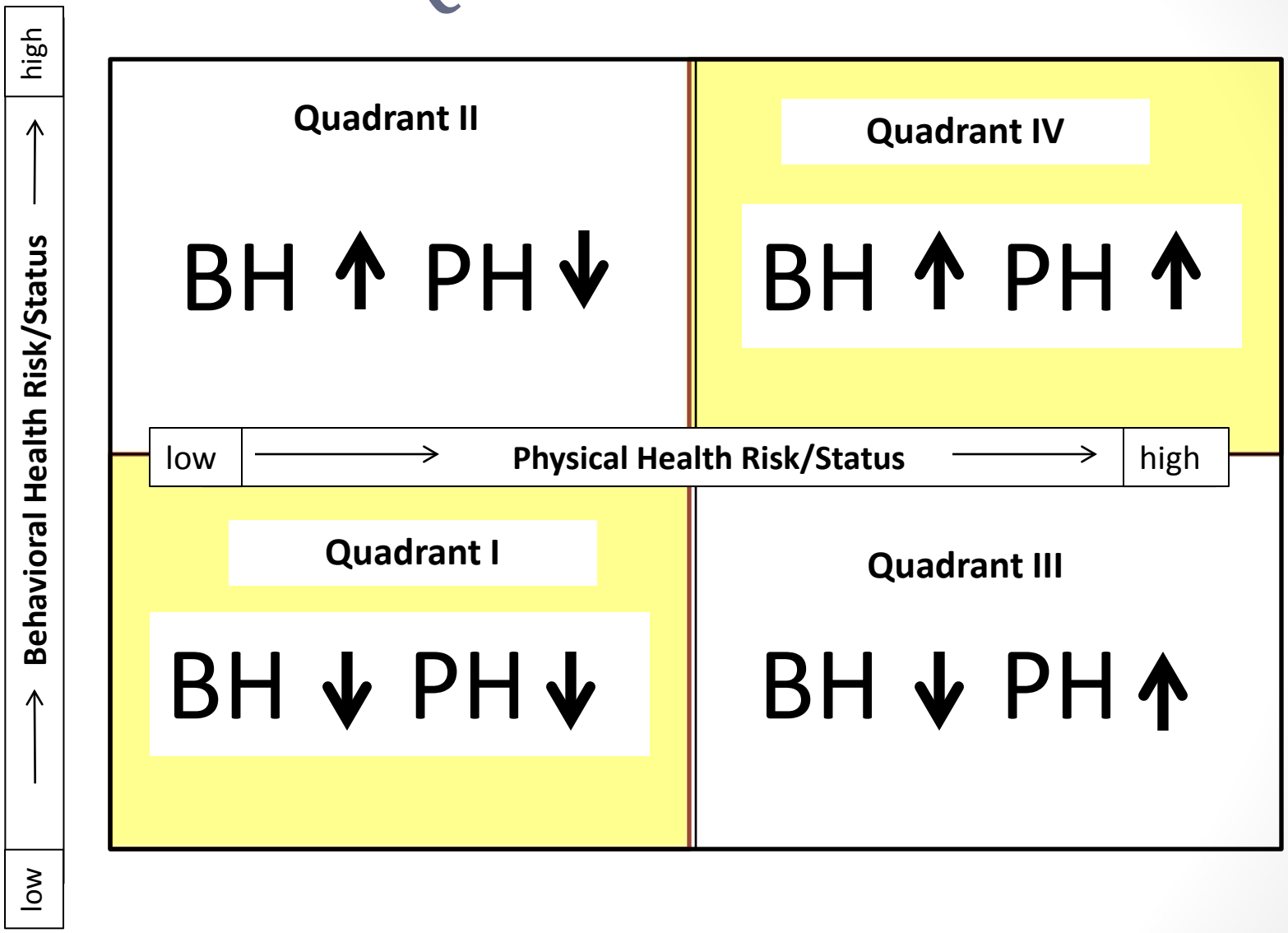
**SAMHSA:** (www.nrepp.samhsa.gov)

- Illness Management and Recovery
- Medication Management Approaches in Psychiatry
- Assertive Community Treatment (ACT)
- Family Psychoeducation
- Supported Employment
- Integrated Dual Disorders Treatment

**HRSA:** (www.hrsa.gov)

- Chronic Care Model for Depression
- Chronic Care Model for Diabetes, Asthma, Cardiovascular, and others

# 4-Quadrant Model

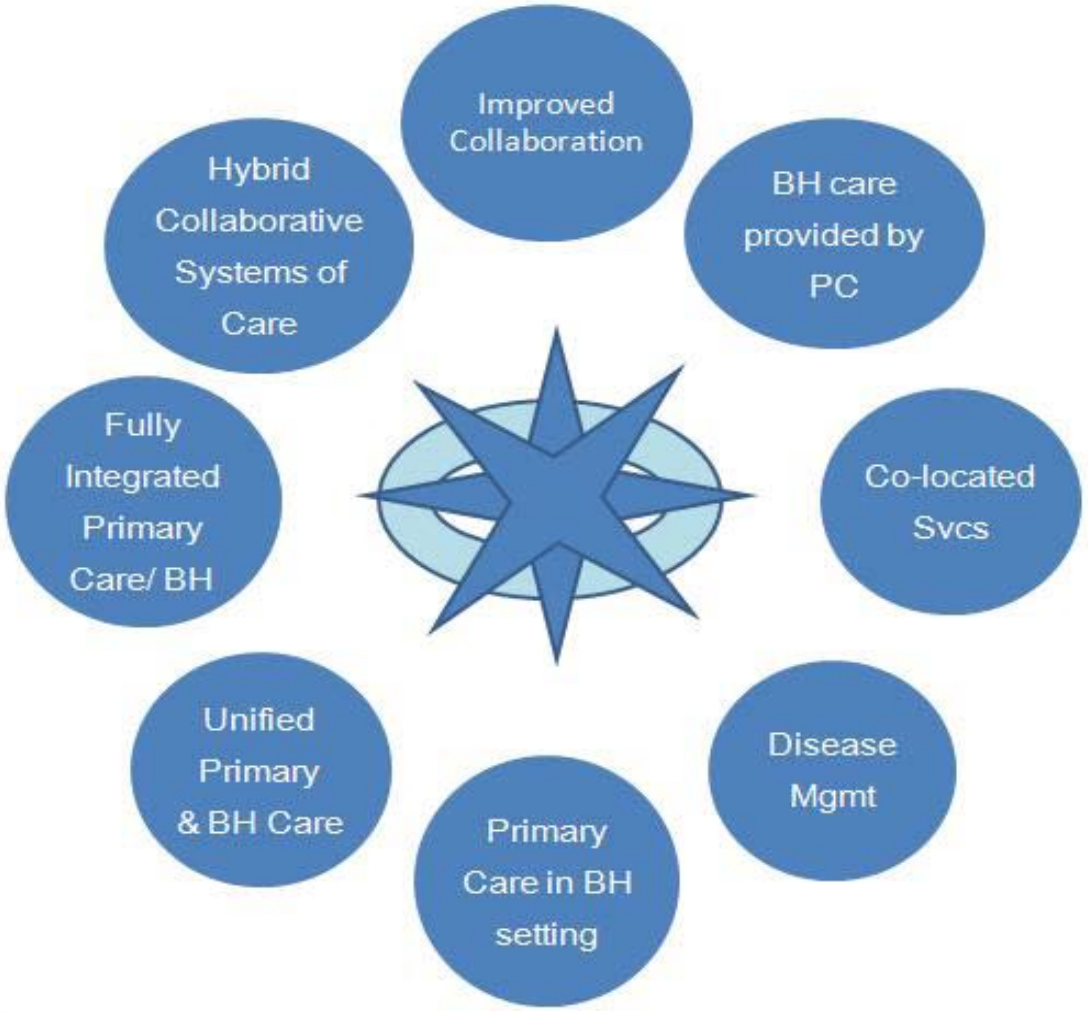


# 5-Levels of Primary Care/ Behavioral Healthcare Collaboration

| ***Minimal*** **Collaboration** | **Basic Collaboration *at a Distance*** | **Basic Collaboration *On-Site*** | **Close Collaboration in a *Partly* Integrated System** | **Close Collaboration in a *Fully* Integrated System** |
|---|---|---|---|---|
| BH and PC work separately, Communicate sporadically | BH and PC work separately, Communicate periodically on shared patients (usually driven by specific client needs) | Same facility, Separate systems | Same facility, share systems (like appts, EHR, etc.), Collaborate as a team on shared patients | BH and PC are part of the same team, BH treatment is part of primary care |

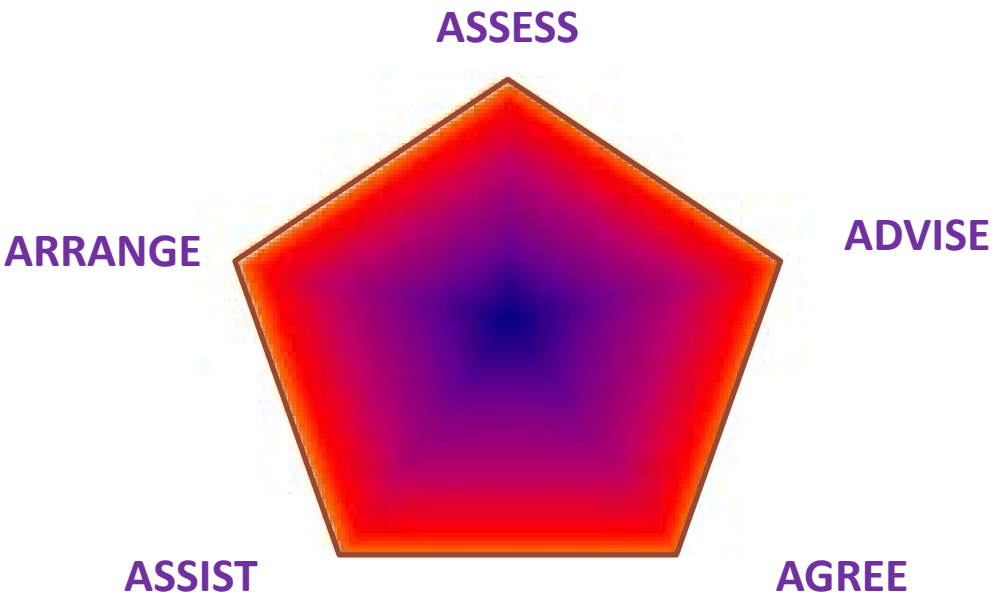
Adapted from Bill Doherty's *Five Levels of Primary Care/Behavioral Healthcare Collaboration*.

# Evolving Models of Behavioral Health Integration in Primary Care




Adapted from Collins, Hewson, Munger, & Wade (2010) *Evolving Models of Behavioral Health Integration in Primary Care.*[17]

# The 5 A's Model for behavioral health counseling and intervention in medical care[18]




A model adapted the National Cancer Institute (adding "agree").

The U.S. Public Health service used the construct to test effectiveness of tobacco pop-level intervention.

Learn more at: www.uspreventiveservicestaskforce.org

# More Models…

"Not surprisingly, there are almost as many ways of 'doing' collaborative mental health care as there are people writing about it." [19]

*- Canadian Collaborative Mental Health Initiative (CCMHI)*

# After the Models

Models focus on themes: patient needs, training required, staffing required, roles and responsibilities, process…

*"Models such as the BH/PC four-quadrant model are not intended to be prescriptive but to serve as a conceptual framework for collaborative planning with a local service system."* [20]

The models provide a structure that is helpful in beginning to think about integrated care. Local factors (provider capacity, available funding, population needs, workforce…) will ultimately determine what this looks like. We will however have to agree on outcome benchmarks and other requirements for payments and incentives.

HOW

# IMPACT

"The IMPACT Study is the largest collaborative care program for late-life depression ever conducted."

**RESULT**: IMPACT Participants 2x as likely to experience substantial improvement in their depression over 12 months, less physical pain, better social and physical functioning, better overall quality of life. Strongly endorsed by patients and primary care providers.[21]

**Initial Cost = $522. Net Cost Savings over 4 years = $3,363.**

**Return on Investment (ROI) = $6.50 per dollar spent.**[22]

Learn more at http://impact-uw.org

HOW

# SBIRT

- Started in 2005, public health approach to early intervention and treatment
- Reimbursable Medicaid Service[23]
- A recent article highlighted the importance of having drug and alcohol specialists as part of the integrated health team[24]

Learn more about SBIRT at:

- http://www.integration.samhsa.gov/clinical-practice/sbirt
- http://sbirt.samhsa.gov

HOW

# PCMH

Ongoing Activities:

- Alaska Primary Care Association's efforts

  Webinars (visit www.alaskapca.org)

  Join the Workgroup!

- T-CHIC: Tri-state Child Health Improvement Consortium (WV, OR, AK)

  Learn more at:
  http://hss.state.ak.us/dph/healthplanning/tchic.htm

- Department of Health & Social Services

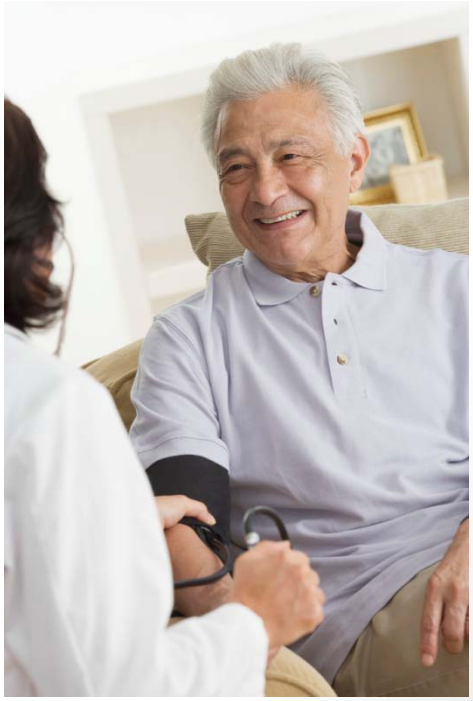
  Public Consulting Group (PCG) is working to define what will work best in Alaska. Stay tuned for opportunities to provide input.

HOW

# Integrated Care for Seniors

National Council on Aging provides information on Evidence-based programs such as IDEAS and PEARLS as well as others to help with prevention and management of alcohol problems with older adults.

Visit the National Council on Aging's site for more information at: http://www.ncoa.org



I want to do this but…

CHALLENGE

# Transitional Costs

- New Staff
- Training/Ed for existing staff
- Health Information Technology (HIT)
- Reconfigure office space/client flow
- Other…

HOW

# Transitional Costs

- Ongoing Demonstration Projects
- NEW: $437,500 in the FY13 Capital Budget
- NEW: $500,000 in the FY13 Operating Budget

- Incentives flowing from HITECH (ARRA) for:
  - ✓ Critical Access Hospitals
  - ✓ Hospitals
  - ✓ Providers

- Sep 2011 – HHS announces Rural Health Information Technology Grants:[25]

  ANTHC $300,000; ASHNA $300,000;  TCC $300,000

CHALLENGE

HOW

# Ongoing Costs

**SAMHSA identified 7 priority barriers related to reimbursement of mental health services in primary care settings:**[26]

1. **[ - ]** State Medicaid limitations on payments for same-day billing for a physical health and a mental health service or visit;
2. **[H]** Lack of reimbursement for collaborative care and case management related to mental health services;
3. **[H]** Absence of reimbursement for services provided by nonphysicians, alternative practitioners, and contract practitioners and providers;
4. **[ - ]** Medicaid disallowance of reimbursement when primary care practitioners submit bills listing only a mental health diagnosis and corresponding treatment;
5. **[L]** Level of reimbursement rates in rural and urban settings;
6. **[L]** Difficulties in getting reimbursement for mental health services in school-based health center settings; and
7. **[H]** Lack of reimbursement incentives for screening and providing preventive mental health services in primary care settings.

HOW

# Ongoing Costs

- Types of billing mechanisms (PMPM, Quality Incentives (benchmarking)…) remain largely undefined.
- Some anticipated savings from greater efficiency.

*System* Savings from:

- Prevention
- Early Intervention
- Reduction in Emergency Department utilization and other acute settings
- Reduction in length of stay

CHALLENGE

# Workforce Availability

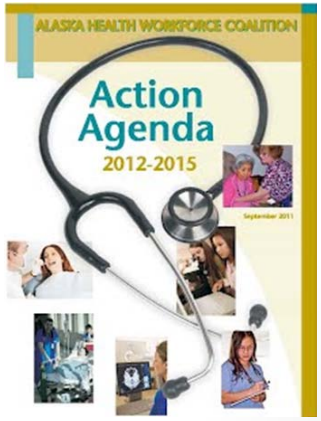
- Medical/Psycho/Social Model
- Alaska Health Workforce Vacancy Study [2007] [2009]

  Current collaboration between Alaska Center for Rural Health and the Department of Labor and Workforce Development.
- Workforce Issues Related to Bi-Directional Physical and Behavioral Healthcare Integration: Specifically Substance Use Disorders and Primary Care

HOW

# Workforce Availability

1. Kenaitze's Dena'ina Health Clinic - Nakenu Wellness Model Care Teams with less of a central emphasis on the role of physicians and mid-level providers.[27]
2. Telemedicine billable service delivery from a distance
3. Primary and Behavioral Health Integration: Guiding Principles for Workforce Development
4. Alaska Health Care Workforce Planning & Development
5. Alaska Health Workforce Coalition



CHALLENGE

# Data Systems

- Different Systems (between providers, EMR and billing)
- Expertise not readily available
- Security
- Privacy

HOW

# Data Systems

1. Proposed Meaningful Use (Stage 2 Proposal)
2. Electronic Health Record Incentive Programs
3. AeHN (www.ak-ehealth.org)
4. HIT/AKAIMS Workgroup


CHALLENGE

# Patient Privacy

- Health Insurance Portability and Accountability Act – HIPAA

  Learn about the Rules' protection of individually identifiable health information and the rights granted to individuals

- The Federal Drug and Alcohol Confidentiality Law – 42 CFR (Part 2)

HOW

# Privacy Challenges

- Alaska Primary Care Association webinar on HIPAA and 42 CFR Part 2
- SAMHSA – Health Information Privacy
- SAMHSA –HRSA Center for Integrated Health Solutions

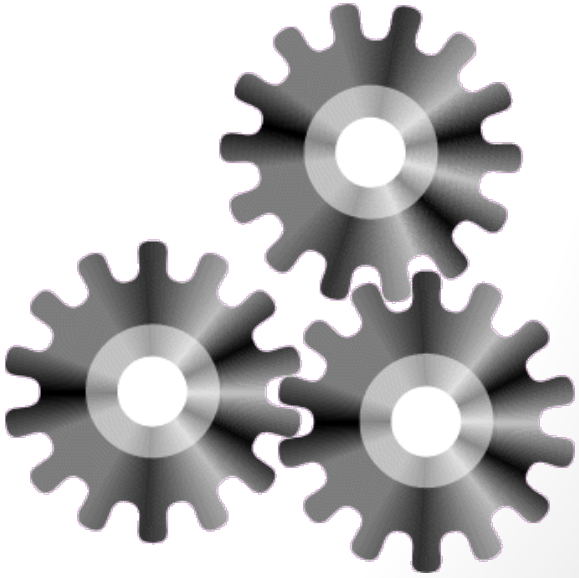
SAMHSA: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange
http://www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf

# Bottom Line

There are ***a lot*** of moving parts.

Coordination and communication will be key.

Also remember, without client satisfaction, any changes made will likely fall short of their intended goal.



# Thank You!

## Questions??

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