Treatment Innovations: Perspectives from Addiction Providers Integrating Primary Care
How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. (left)

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. (right)
Integrated Substance Abuse Treatment in a Federally Qualified Health Center

Genie L. Bailey, MD
Diplomate, American Board of Addiction Medicine
Director of Research & Medical Director of Dual Diagnosis Unit
Stanley Street Treatment & Resource Inc., Fall River, Massachusetts
Assistant Clinical Professor
Warren Alpert Medical School of Brown University, Providence, Rhode Island
## Conflict of Interest Disclosures

<table>
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<th>Commercial Interests</th>
<th>Relevant Financial Relationships: What Was Received</th>
<th>Relevant Financial Relationships: For What Role</th>
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Stanley Street Treatment and Resources, Inc. (SSTAR)
Introduction

- Overview of SSTAR
- Overview of SSTAR’s Family Health Center
- Overview of SSTAR’s Office-Based Buprenorphine Treatment Program
- Description of protocols
- Treatment outcomes
- Financial data
Overview of Stanley Street Treatment and Resources, Inc. (SSTAR)

Founded in 1977 as a private, not-for-profit organization

Original programs included: 20-bed alcohol detox, out patient alcohol treatment program and education program for persons convicted of DUI's

Currently, Fall River site provides:
- Inpatient detox, Dual Diagnosis detox and stabilization
- Open access IOP, MH and SA counseling
- Community support program
- ARISE family interventions
- Buprenorphine
- Primary health care services in TWO clinics
- Methadone maintenance clinic
- Population-specific services such as domestic violence counseling and HIV/HVC/STD counseling & testing

Two additional sites in Rhode Island: one providing inpatient detox and another providing long-term substance abuse treatment for mothers and their children
Overview of Family Healthcare Centers

- Established as leadership realized our patients were not receiving adequate primary medical care for:
  - Diseases related to substance use
  - Mental health issues
  - HIV/AIDS
- Opened primary site in 1996; second site in March 2012
- Currently classified as a 330 Federally Qualified Health Center (FQHC)
Overview of Family HealthCare Centers

- **Staffing**
  - 3 Family Medicine physicians
  - 3 Family nurse practitioners
  - 2 Psychiatric nurse practitioners
  - 0.2 FTE ID MDs
  - 0.6 FTE Pediatrician
  - 0.2 FTE Psychiatrist
- 118 total employees
- Provides chronic illness case management for diabetes, hypertension, asthma, chronic pain, HIV, and HCV
# HealthCare Center Statistics

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of unduplicated clients</td>
<td>4773</td>
<td>5152</td>
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<tr>
<td>Medical visits</td>
<td>21,511</td>
<td>21,353</td>
</tr>
<tr>
<td>Mental health visits</td>
<td>4281</td>
<td>3769</td>
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<tr>
<td>Unduplicated mental health</td>
<td>620</td>
<td>802</td>
</tr>
<tr>
<td>clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse visits</td>
<td>4861</td>
<td>17,107</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(MMP opened in 3/12)</td>
</tr>
<tr>
<td>Case management visits</td>
<td>3631</td>
<td>5462</td>
</tr>
<tr>
<td>Relapse prevention groups</td>
<td>1842</td>
<td>2276</td>
</tr>
<tr>
<td>Methadone group visits</td>
<td>2061</td>
<td></td>
</tr>
<tr>
<td>Total clinic visits</td>
<td>35,611</td>
<td>49,004</td>
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</table>
## Primary Diagnosis: Patients’ Presenting Problems

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2011 (Primary)</th>
<th>2012 (Top Three)</th>
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<tbody>
<tr>
<td>Alcohol disorder</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Substance abuse disorder</td>
<td>10%</td>
<td>29%</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>Anxiety disorder and PTSD</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Other mental disorders</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Totals for mental health and substance abuse</td>
<td>24%</td>
<td>60%</td>
</tr>
</tbody>
</table>
Screening in Healthcare Center

• All patients are screened with Cage-aid at initial visit and annual exams
• Nicotine use is monitored as a fifth vital sign and is one of our FQHC quality indicators
• Clinic is initiating carbon monoxide monitoring
• BAL's available on all clients and urine toxicology screens ordered when indicated to monitor prescription compliance as well illicit use
Medication Assisted Therapy (MAT)

• MAT for **Nicotine Dependency** is provided by individual practitioners
• All current, evidence-based smoking cessation aids are paid for by Massachusetts health plans
• Practitioners utilize Chantix, Wellbutrin, as well Nicotine Replacement Therapy (NRT)
• Individuals wishing to stop nicotine use are referred to QUIT WORKS
• Individual smoking cessation counseling is also available
Medication Assisted Therapy

- QuitWorks is a free, evidence-based stop-smoking service developed by the Massachusetts Department of Public Health in collaboration with all major health plans in Massachusetts.
  - Using a simple form, providers refer patients to the Massachusetts Smokers’ Helpline. The form is faxed or electronically transmitted to the Helpline.
  - Helpline counselors make up to five attempts to contact patients and offer quit smoking services. Counselors also screen patients for eligibility for 2 weeks of free nicotine patches.
  - Six months later, the Helpline evaluation team attempts to contact patients who completed an initial screener call. During this call, they assess smoking status and success with quitting.
  - Providers receive faxed reports from the Helpline after the initial and 6-month follow-up contacts with referred patients.

How it Works: QuitWorks at a Glance provides more details.

http://quitworks.makesmokinghistory.org

http://quitworks.makesmokinghistory.org
Medication Assisted Therapy

MAT for **Alcohol Dependency** is provided by individual practitioners

Oral naltrexone, Acamprosate, and Antabuse are paid for by Massachusetts health plans

Injectable naltrexone, or Vivitrol, is increasingly available, but often requires prior authorization and may not be covered

Health center nursing staff have been trained on the administration of Vivitrol and it occurs within the routine flow of our clinic
Medication Assisted Therapy

- MAT for **Opiate Dependency** is provided in specific clinics.
- SSTAR currently owns and operates a methadone clinic which is now located in our newest Family HealthCare Center site. We provide evening dosing.
- Methadone is paid for by Massachusetts health plans.
- Methadone is prescribed by an ASAM-certified physician and NPs who are supervised directly by this physician.
- Presently we are serving **603 clients**.
- Injectable naltrexone, or Vivitrol, is also an option but patient acceptance and insurance coverage issues are complex.
Why Buprenorphine?

How the decision was made

Agency philosophy
- Utilize evidence-based treatments

Community need
- High incidence of opiate addiction

Limited treatment access
- Inpatient detoxification and methadone maintenance only options

Our desire to expand treatment capacity
- Working people were unable to commit to inpatient admissions

Coverage available
- Buprenorphine was paid for by Massachusetts Medicaid

First induction: September 2004
SSTAR’s Healthcare Center Model

- **SSTAR is committed** to providing buprenorphine to Healthcare Center patients
- SSTAR requires that **every physician hired** obtain or currently possess a DEA waiver to dispense buprenorphine
- SSTAR has also hired:
  - 3 full time RNs
  - PT program assistant
  - PT medical assistant
SSTAR’s HealthCare Center Model

- Suboxone patients must also receive their primary health care at SSTAR
- Inductions occur on site, guided by written protocols
- Once inducted patient are seen weekly by buprenorphine provider or nurse for 12 weeks, with a pill count at each visit and UDS as indicated
- Client attends weekly relapse prevention group for 12 weeks and then if abstinent and adherent may begin monthly group and clinical visits
SSTAR’s HealthCare Center Model

- Once long-term sobriety established, may be given refills and seen in clinic every two months
- Individual counseling is offered and available to all patients.
SSTAR’s HealthCare Center Model

- Diversion = Immediate discharge
- Illicit use:
  - Random UDS and pill counts
  - Weekly visits
  - Increased SA treatment (1:1, IOP or detox)
  - Eventual taper or referral to methadone or daily buprenorphine
- Former clients can reapply at any time
Notable Features of SSTAR Model

- Collaborative care model

- **On-site induction, not in-home induction**

- Significant physician involvement

- Regular multi-disciplinary team meetings

- Psychosocial treatment done within SSTAR system

- **Harm reduction philosophy**
  - Goal is to keep patients in treatment
Whom Do We Treat?

- 75% Medicaid, 5.8% private insurance
- 26% Employed full- or part-time
- 55% Unemployed
- 49% Heroin users
- 37% Other opiates
- 47% IV use in last 12 months

Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau.
OBOT Admission/Enrollment Profile. July 1, 2011 through June 30, 2012:
Whom Do We Treat?


- Female: 40%
- Male: 60%

Age Distribution:
- <25 years: 0%
- 25 to 29: 5%
- 30 to 34: 10%
- 35 to 39: 15%
- >40 years: 20%

www.integration.samhsa.gov
Whom Do We Treat?
Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau.
OBOT Admission/Enrollment Profile. July 1, 2010 - June 30, 2012

Reported Race
- White: 88.00%
- Black: 2.50%
- Hispanic: 5.00%
- Other: 5.00%
- Other: 0.00%

www.integration.samhsa.gov
How Are We Doing?

Access
Average wait time between initial contact and enrollment:
State wide : 13.81 days
SSTAR : 3.88 days

Massachusetts Department of Public Health: Bureau of Substance Abuse Services and HIV/AIDS Bureau. OBOT Admission/Enrollment Profile, 7/1/2011-6/30/12, p40.
Dosing practice: # of patients receiving buprenorphine by dose

Patients, n=320

Dose (mg)

1mg  2mg  3mg  4mg  6mg  8mg  12mg  14mg  16mg  18mg  20mg  24mg  32mg

0   20   40   60   80   100   120   140   160

3%  8%  43%  11%
How are we doing?

Overall retention rate is the # enrollments reaching engagement (>12 months) / # total enrollments
How are we doing?

Disenrollment By Reason, 2008-2011

- Dropout: 49%
- Administrative Discharge: 20%
- Assessment Only: 12%
- Completed: 7%
- Relapsed: 5%
- Other: 5%
- Incarcerated: 2%

SAMHSA-HRSA Center for Integrated Health Solutions

www.integration.samhsa.gov
Time in treatment, in months

- 0-6 mos: 4%
- 6-12 mos: 7%
- 12-18 mos: 11%
- 18-24 mos: 14%
- 24-36 mos: 18%
- 36-48 mos: 21%
- 48+ mos: 25%

More than 24 mos: 64%
How are we doing financially?

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
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<tbody>
<tr>
<td><strong>Medical revenues:</strong></td>
<td></td>
</tr>
<tr>
<td>Billed to third-party insurance</td>
<td>$1,020,165</td>
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<tr>
<td>Net expected revenues</td>
<td>759,741</td>
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<tr>
<td>Actual payments collected</td>
<td>721,536</td>
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<tr>
<td>Uncollectible/bad debt</td>
<td>38,205</td>
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<tr>
<td>State OBOT grant</td>
<td>82,815</td>
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<tr>
<td><strong>TOTAL REVENUE</strong></td>
<td>$804,351</td>
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<tr>
<td><strong>Medical expenses:</strong></td>
<td></td>
</tr>
<tr>
<td>Nursing, MA and PA salaries</td>
<td>$255,342</td>
</tr>
<tr>
<td>Physician salaries</td>
<td>155,051</td>
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<tr>
<td>Patient supplies</td>
<td>24,000</td>
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<tr>
<td>Occupancy</td>
<td>22,000</td>
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<tr>
<td>Indirect (18%)</td>
<td>82,115</td>
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<tr>
<td><strong>TOTAL EXPENSES</strong></td>
<td>$538,544</td>
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<tr>
<td><strong>MEDICAL SURPLUS</strong></td>
<td>$265,807</td>
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How are we doing financially?

<table>
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<tr>
<th>2012</th>
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<tr>
<td><strong>Behavioral health revenues:</strong></td>
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<tr>
<td>Intakes and individual sessions</td>
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<tr>
<td>Group sessions</td>
</tr>
<tr>
<td><strong>TOTAL REVENUE</strong></td>
</tr>
<tr>
<td><strong>Behavioral health expenses:</strong></td>
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<tr>
<td>Counselor salaries (1 FTE LMHC, 0.8 FTE LICSW, 2 FTE CADACs)</td>
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<tr>
<td>Occupancy</td>
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<tr>
<td>Program support</td>
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<tr>
<td>Indirect (18%)</td>
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<tr>
<td><strong>TOTAL EXPENSES:</strong></td>
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<tr>
<td><strong>TOTAL DEFICIT</strong></td>
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### How are we doing financially?

<table>
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<td>Medical surplus</td>
<td>$265,807</td>
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<td>Behavioral health deficit</td>
<td>($100,302)</td>
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<td><strong>SURPLUS/PROFIT</strong></td>
<td><strong>$165,505</strong></td>
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How are we doing financially?

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<tr>
<td>HC Total Revenues</td>
<td>$7,179,124</td>
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<td>HC Total Cost</td>
<td>$6,701,204</td>
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<tr>
<td>HC Surplus/Profit</td>
<td>$477,920</td>
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<tr>
<td>% from Buprenorphine</td>
<td>34.6%</td>
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</tbody>
</table>
Visit us at SSTAR.org
If questions: Genie_Bailey@brown.edu

MANY THANKS!
Dee Wright, RN HealthCare Center Director
Colleen LaBelle RN, CARN, OBOT Coordinator
Nancy Paull, MA, CEO of SSTAR
Portia Thurmond, MD, Project Coordinator Sstar
Treatment Innovations: Perspectives from Addiction Providers Integrating Primary Care

Tarzana Treatment Centers
Los Angeles County
Tarzana Treatment Centers
Demographics

- Founded in 1972
- 501 (c) (3) Non-profit Corporation
- 600+ Employees and Contract Staff
- 9 locations in Los Angeles County
- Persons served in FY 2012:
  - Primary care = 10,507 persons
  - Substance use disorder specialty care = 5,325
  - Mental health specialty care = 1,472
  - HIV/AIDS specialty care = 996
Integrated Healthcare

- Primary Care
- Specialty Care
  - Substance Use Disorder Treatment
  - Mental Health Disorder Treatment
  - HIV / Medical Care and Related Services
  - Housing
  - Assessment & Referral Services in Hospital Emergency Depts
  - In Home Services
  - Telehealth Services
Tarzana Treatment Centers
Revenue Sources

- Federal, State, Foundation Grants
- Los Angeles, Inyo, Ventura County Contracts
- City of Los Angeles Contracts
- Medicare and Medi-Cal fee for service & Managed Care
- Managed Care Contracts with all major private insurance carriers
- Private Pay
- Sliding Fee and Charity Care
Integrated Healthcare

- Primary Care
  - Licensed as Community Health Centers
  - Not FQHCs / Look A Likes
  - At 5 of 9 Locations
    - Northridge
    - Tarzana
    - Lancaster
    - Reseda
    - Palmdale
  - 34,052 visits in FY 2012
- Payer Mix
  - Low Income Health Plan 78%
  - Managed Medicaid 7%
  - Fee-for-service Medicaid 4%
  - Medicare 3%
  - Other 8%
Integrated Healthcare

Specialty Substance Use / Mental Health Treatment

- Acute Psychiatric Hospital: 60 beds w/ 2300 discharges/Year

- Residential Treatment SU/MH and Co-occurring Disorders: 314 beds w/ 1275 discharges/Year

- Outpatient SUD/MHD and Co-occurring Disorders: 100,000+ group plus individual sessions / Year

- Medication Assisted SUD Treatment

- Sober Living and Transitional Housing

- Case Management
Integrated Healthcare

Specialty HIV/AIDS Care

- HIV/AIDS Medical Clinics
  - Palmdale
  - Reseda
- Prevention and Testing
- Case Management
- Jail In-Reach
- MH/SU Disorder Treatment
- Transitional Housing
- Home Heath Care
Accreditation / Certification

Accredited under Joint Commission:
- Hospital Standards
- Behavioral Health Standards
- Opioid Treatment Standards

Working toward:
- Joint Commission PCMH Accreditation
- NCQA PCMH Certification
Factors that Maintain Care Disintegration

• External
  • Separate Funding Streams and Regulations
  • Separate State and County Departments Purchasing Care
  • Patient Constituencies / Advocates
  • Behavioral Health Carved-Out

• Internal
  • Separate Funding / Programs
  • Separate Locations
  • Separate Medical Records
Factors That Will Drive Care Integration In 2014

- Funding streams that support integration
- Consolidation of State and County Departments Purchasing Care
- Patient Constituencies / Advocates for Care Integration
- Carved In Behavioral Health
- Partnership with Accountable Care Organizations
- Contracts to Provide Whole Person Care
- Incentives for Lowering the Total Cost of Care
Impact of Mental Illness & Substance Use Disorders on Cost and Hospitalization for People with Diabetes

**Per Capita Cost Per Year**

- Diabetes Only: $10,000.00
- Diabetes + MI: $20,000.00
- Diabetes + SUD: $30,000.00
- Diabetes + MI + SUD: $40,000.00

**Per Capita Hospitalization Per Year**

- Diabetes Only: 0
- Diabetes + MI: 0.5
- Diabetes + SUD: 1
- Diabetes + MI + SUD: 2.5

**Beneficiaries with Diabetes**

The Opportunity: Capitated and Incentivized Care

- Members of Health Care LA IPA (HCLA IPA)
- Composed of 40+ Safety Net Clinic Organizations in LA
- HCLA IPA Contracts with Safety Net Health Plans in LA County
- 200,000 Lives under capitated Managed Care contracts
- Clinic Compensation
  - Per Member Per Month Capitation
  - Quality of care incentives
  - Share of net revenue
Controlling Total Cost of Care

- Avoidable emergency department visits and hospital admissions largest visible contributor to cost
- Cost contribution of SUD/MI there but not made visible
- IPA notification of hospital admission dependent on claim processing
- Health information exchange solution to notification emerging
- TTC Case managers in emergency departments of 4 San Fernando Valley hospitals
Strategy for Integrated Care

- Communicate the vision
- Build and strengthen component services
- Win the opportunity to provide integrated care
- Reorganize Delivery of Care
- Use technology as a driver of change
- Execute on contracts
- Demonstrate how we contribute to bending the cost curve
Vision - Integrated Healthcare Home (IHH)

- Patient – Centered

- Primary Care and Specialty MHD / SUD treatment in a single organization

- Supplemented by services needed by Safety Net patients with MHD/SUDs
  - Case Management
  - Housing
  - Transportation
Vision: Patient Centered Care Principles in the IHH

- Whole-person care
- Team-based care
- Personal clinician provides first contact, continuous, comprehensive care
- Care is coordinated across the organizations and health care system
Reorganize Delivery of Care: TTC Primary Care Team Composition

Core
- MD / Physician Extender
- Medical Assistant
- Care Coordinator
- RN Care Manager
- Case Manager
- Pharmacist

Supplemented by MH / SU staff as needed
Reorganize Delivery of Care: NCQA PCMH Standards Applied to IHH

PCMH 1: Enhance Access and Continuity
PCMH 2: Identify and Manage Patient Populations
PCMH 3: Plan and Manage Care
PCMH 4: Provide Self-Care and Community Support
PCMH 5: Track and Coordinate Care
PCMH 6: Measure and Improve Performance
Technology: eConsult

- Links Primary Care Providers to Specialists
- Avoids Costly Visits to Specialists
- Lobbying to add Behavioral Health Specialists
Technology: Diabetes Home Monitoring Pilot

Reading Alert
Ideal Life <noreply@ideallifeonline.com>
Sent: Sun 6/23/2013 7:14 PM
To: Katia Chavarria; Leonard Dootson; Bertha Siguenza; Jim Sorg

Reading Alert
Glucose greater than 250 mg/dL - Glucose: 440 mg/dL, Jun 23 2013 7:13PM
Technology: Netsmart
Primary Care Module
Patient Check In
Technology: Netsmart
Primary Care Module
Patient Chart
Technology: Netsmart
Primary Care Module
Patient Chart
Technology: Telehealth
Next Steps

• Train staff about reconfigured EHR
• Collaborate with IPA and Health Plans to demonstrate how we bend the cost curve
Jim Sorg, Ph.D.
Tarzana Treatment Centers
18646 Oxnard Street
Tarzana CA 91356
jsorg@tarzanatc.org
Integration Partnerships

Les Sperling
Central Kansas Foundation
Salina, Kansas
Central Kansas Foundation
CKF is a not-for-profit corporation whose mission, since its inception in 1967, has been to provide both quality and affordable alcohol and other drug education and treatment services.

• Community Based
• 65 employees
• 5 locations
• Services include: All levels of Outpatient Therapy, Detox, Medication Assisted Withdrawal, Buprenorphine, (do not use Vivitrol) Residential Treatment, and Prevention/Education Programs
4% Dependent
25% Excessive
71% Low or No Risk

Presented with permission from Steven O’Neill
Georgia SBIRT
Our Three Guiding Principles For Integration

1) SUD providers possess expertise that is incredibly valuable to medical professionals.

2) When this expertise is available in acute and primary medical care settings, patient health improves and costs associated with chronic illness are reduced.

3) SUD services have a significant impact on health care costs and SUD work will be compensated adequately.
CKF STRATEGY

1) Become integral part of Health Home

2) Implement SBIRT in Primary and Acute Care Settings

3) Reduce recidivism to High Cost Care Settings

4) Demonstrate impact of SUD on general health

5) Increase capacity for SUD patients to access primary health and oral health care

6) Full integration of SUD services into Primary and Acute Care Settings
Integration Timeline

2009
- Initial discussions with FQHC leadership related to collaboration, SBIRT, and co-location

2010
- Formal review of patient data, reimbursement analysis, work flow mapping, staffing patterns, and other high level barriers

2011
- Collaboration agreement executed, staff hired, trained in MI, Brief Intervention and SBIRT.
- Co-location and universal screening begins.
- Planning for on-site Level I and II outpatient services begins.
- SUD staff participates in clinical staffings and patient treatment planning.
- Executed contract with acute care hospital to provide 24/7 coverage of ED and full-time staff on medical/surgical floors.
Integration Timeline

2012

- On-site Level I-II outpatient services at FQHC
- SBIRT screening data reviewed and work flows adjusted
- Brief Intervention training provided to faculty and residents
- Strategic discussions related to program expansion and establishment of clinic at SUD locations
- FQHC awarded grant to expand behavioral health services at the FQHC
- SBIRT codes approved in state Medicaid Plan
Integration Timeline

2013

- FQHC receives Person Centered Medical Home accreditation at highest level
- Clinic planning continues
- Integration of patient health information and medical records begins
- Active recruitment by Regional Health Center and FQHC of an Addictionologist begins
Integration Timeline

2013

- FQHC receives Person Centered Medical Home accreditation at highest level
- Clinic planning continues
- Integration of patient health information and medical records begins
- Active recruitment by Regional Health Center and FQHC of an Addictionologist begins
**Salina Regional Health Center**

- 199 Bed Acute Care Regional Health Center-Level III Trauma Center
- 27,000 ED presentations per year
- Alcohol/Drug DRG was 2nd most frequent re-admission

**Services provided**
- 24-7 coverage of ED
- Full time SUD staff on medical and surgical floors
- Warm hand off provided to all SUD/MH services
- Universal Screening and SBI beginning in 2013

**Outcomes**

- Re-admission DRG moved from 2nd to off the list completely
- 70% of alcohol/drug withdrawal LOS were 3 days or less
- 83% of SUD patients triaged in ED were not admitted
- 58% of patients recommended for further intervention attended first two appointments (warm hand off)
- Adverse patient and staff incidents decreased by 60%
- CKF detox admissions increased 450% in first year
- 300% increase in commercial insurance reimbursement
Salina Family Healthcare/Smoky Hill Residency Program

10,000 unique patients, 13 Family Medicine Residents, 10 dental chairs
Universal Screening of every patient annually
ASAM Level I and II provided on-site
2 FTE Licensed Addiction Counselors located at FQHC.

Outcomes

- 23% screening positive on Audit-C
- Average daily census in treatment groups is 12.5
- Residents and other practitioners becoming interested in SUD interventions
- Level III Person Centered Medical Home accreditation received
- SUD staff a key component of Medical Home
**Personnel**

- Licensed Addiction Counselors
- Licensed Clinical Marriage and Family Therapists
- Licensed Specialist Clinical Social Worker
- Person Centered Case Managers
- Recovery Coaches and Peer Mentors (Recovery Health Coaches)

**Essential Staff Attributes**

- Trained in motivational interviewing and brief intervention. (Stages of change, FRAMES)
- Able to thrive in fast paced medical settings
- Understand medical cultures and can adapt
Post Integration Issues and Concerns

1) Staff retention: Difficult to compete with salaries offered in medical settings.

2) Change in Reimbursement: At risk, shared risk, bundled payments, and other emerging systemic changes. How much of the health care dollar will be available for SUD services?
1) Research and understand the external and internal constraints experienced by safety net clinics and acute care hospitals.

2) Understand reimbursement and funding challenges for clinics and hospitals.

3) Develop a champion within the clinic staff. Ultimately has to be MD or CEO, but tell your story to nurses and mid-level practitioners.

4) Request data and use it.
CKF Lessons Learned

5) Be prepared to do the administrative work and be the “go to” person for all problem solving.

6) Be persistent, but lean instead of push. Double the time you think it will take to operationalize.

7) Don’t waste medical staff’s time. Be prepared for meetings. Keep e-mail and other communications focused and brief. Always respond to their requests immediately.

8) Focus on addiction as chronic illness.
9) Prepare and use cost-benefit data.
10) Have a good plan to increase income over the long term with specific billing codes, grants, etc. to shoot for.
11) Increase your capacity to effectively treat and manage co-occurring and chronic illness.
12) Build mental health services capacity via contract or staff.
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