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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integration.samhsa.gov
Setting the Stage:
Today’s Facilitator

Aaron Williams
Director of Training and Technical Assistance for Substance Use
SAMHSA-HRSA Center for Integrated Health Solutions

integration.samhsa.gov
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


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/alkohls-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

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 measurable 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 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 stakeholders
• Seek out resources to enhance your efforts
• Ask questions
Integrated Care Assessment Tool

integration.samhsa.gov
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)

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<thead>
<tr>
<th>Coordinated</th>
<th>Co-located</th>
<th>Integrated</th>
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<tbody>
<tr>
<td><strong>KEY ELEMENT: COMMUNICATION</strong></td>
<td><strong>KEY ELEMENT: PHYSICAL PROXIMITY</strong></td>
<td><strong>KEY ELEMENT: PRACTICE CHANGE</strong></td>
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<tr>
<td><strong>LEVEL 1</strong></td>
<td><strong>LEVEL 2</strong></td>
<td><strong>LEVEL 3</strong></td>
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<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
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<tr>
<td><strong>LEVEL 4</strong></td>
<td><strong>LEVEL 5</strong></td>
<td><strong>LEVEL 6</strong></td>
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<tr>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
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**Behavioral health, primary care and other healthcare providers work:**

**In separate facilities, 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

**In separate facilities, where they:**
- 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

**In same facility not necessarily same offices, where they:**
- 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

**In same space within the same facility, where they:**
- 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

**In same space within the same facility (some shared space), where they:**
- 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

**In same space within the same facility, sharing all practice space, where they:**
- 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
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?
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