Medicaid Innovation Accelerator Program (IAP)

IAP Learning Collaborative: Substance Use Disorders (SUD)

Integrating SUD Into Primary Care Settings

Targeted Learning Opportunity #5
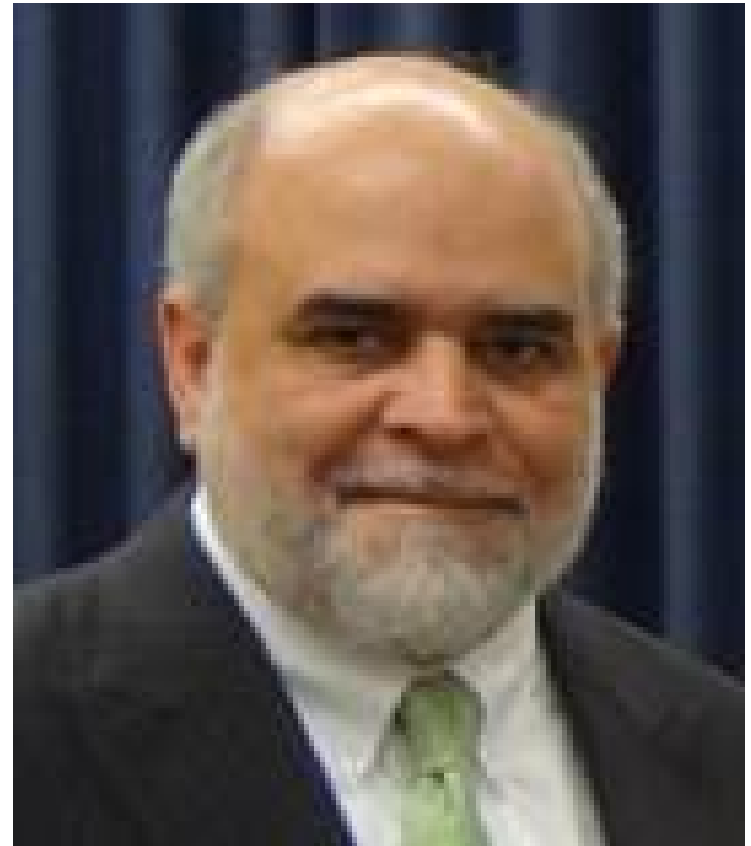
7/13/15

Logistics Placeholder

Facilitator

- **Colette Croze, MSW**
- Private consultant, Croze Consulting

TRI *Science Addiction*

Speakers

- **Mark Stringer, MA, LPC, NCC**

- Director, Missouri Department of Mental Health

Speakers (1)

- **Beth Tanzman, MSW**
- Assistant Director, Vermont Blueprint for Health

Speakers (2)

- **Anthony Folland**
- Clinical Services Manager and Opioid Treatment Authority Director, Alcohol and Drug Abuse Programs, Department of Health, Vermont

Speakers (3)

- **Jim Sorg, PhD**
- Director of Care Integration, Tarzana Treatment Centers
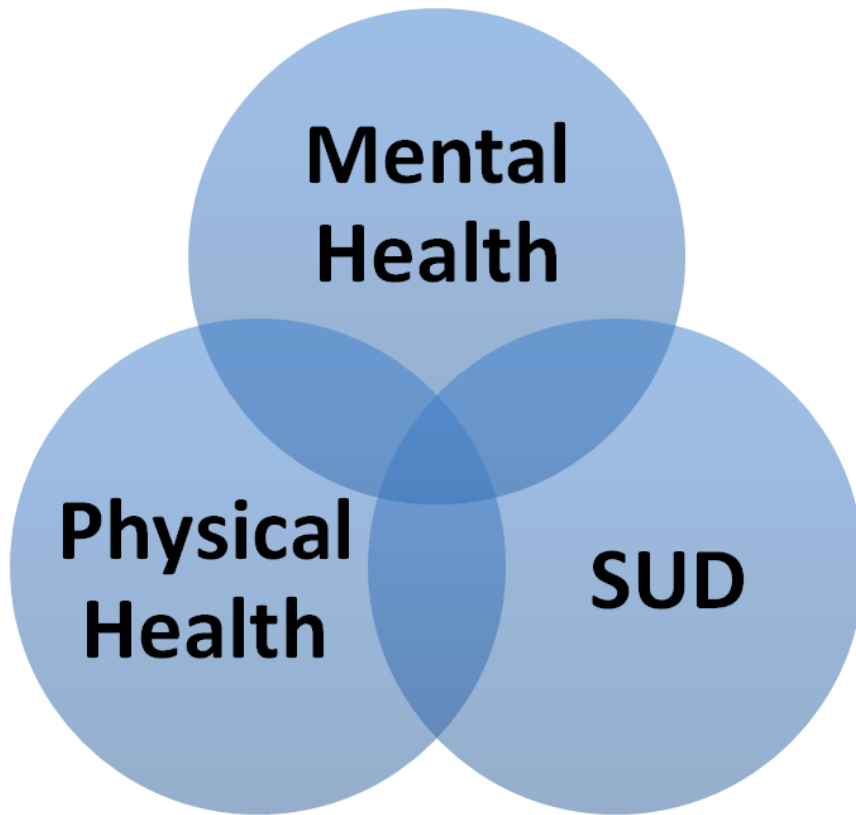
Agenda

- Importance of SUD in primary care settings

- Examples of successful integration models

- State experience: Missouri

- State experience: Vermont

- Provider experience: Tarzana Treatment Centers, California

Goals of Webinar

- Participants will better understand how SUD treatment can be integrated into primary care settings including FQHCs, rural health clinics and primary care practices

- Participants will gain knowledge of successful integration model components

- Participants will examine case study examples of different integration models in Missouri, Vermont and California

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

Importance of SUD in Primary Care Settings

Mental Health

Physical Health

SUD

- Behavioral health disorders occur with chronic medical conditions at a significant rate

- Increases preventable mortality and healthcare costs

- Unmet behavioral health needs complicate the treatment of other medical conditions

Importance of SUD in Primary Care Settings (cont.)

Mental Health

Physical Health

SUD
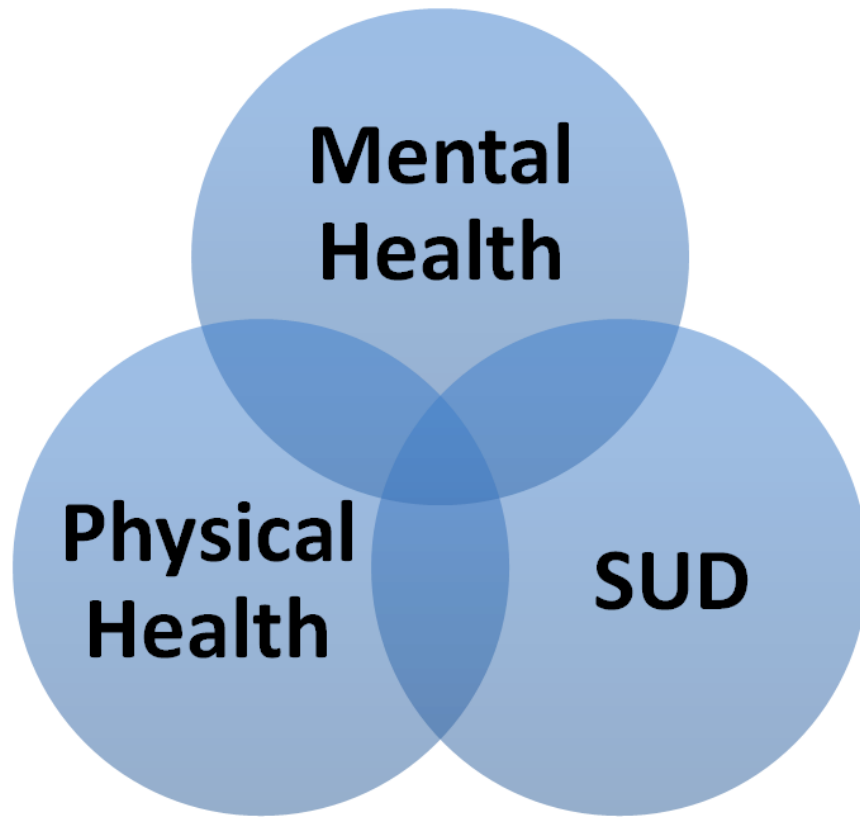
- People with SUD have a range of health conditions directly related to their SUD

- 35% of the Medicaid population have a chronic mental health and/or SUD, with healthcare spending that is 60%-70% higher than for those without a behavioral health disorder
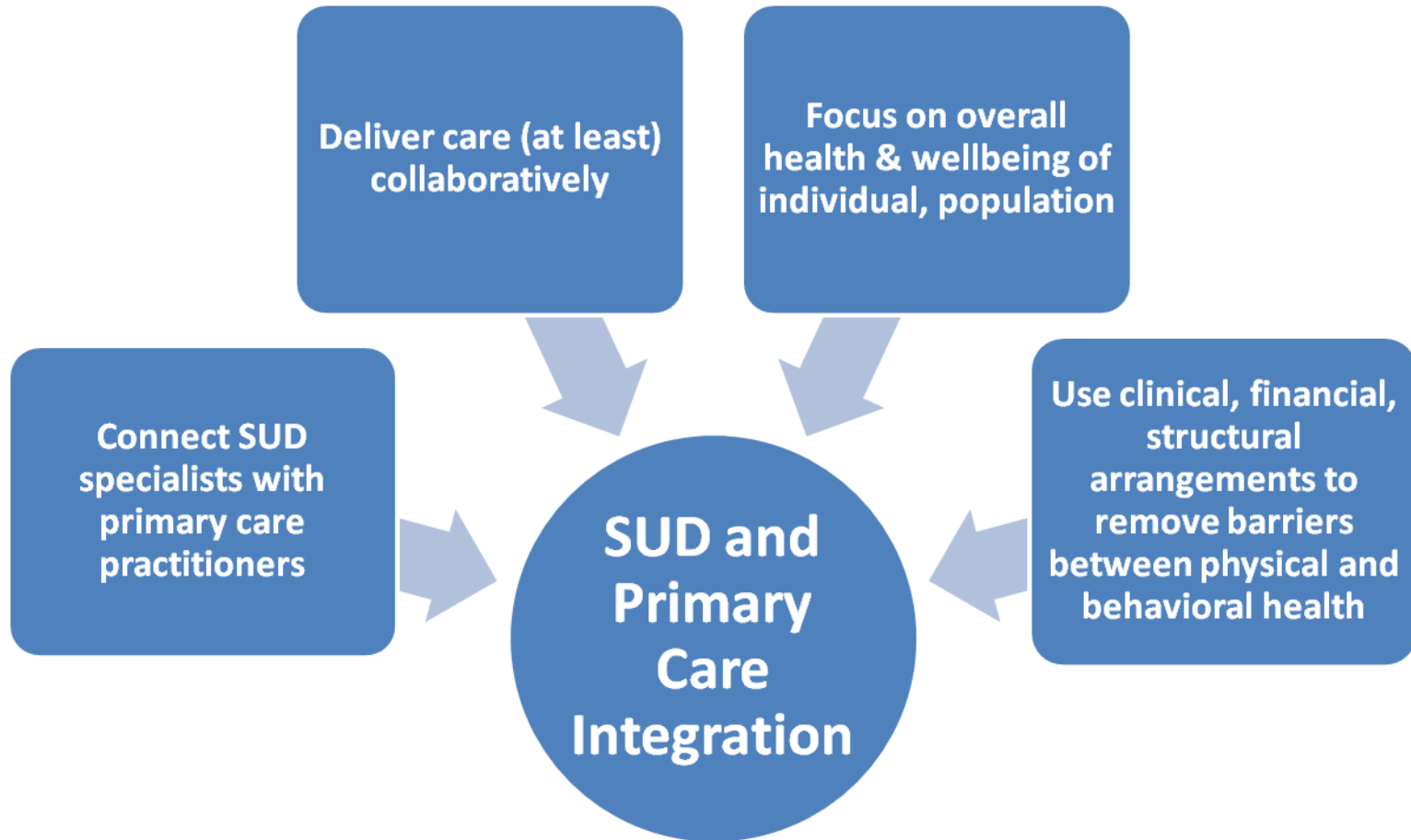
Variety of Models

- Train primary care providers to identify and intervene with SUDs

- Screen for medical conditions in SUD treatment settings

- Provide SUD consultation in healthcare settings

- Co-locate SUD treatment and primary care

- Offer integrated, team-based SUD treatment and primary care

- Use health homes that specifically focus on persons with SUDs

Polling Question 1

- Which of the following models is your state predominantly using? (Select all that apply)
    - (1) Medical screening in SUD setting
    - (2) SUD consultation in healthcare
    - (3) Co-locating SUD and primary care
    - (4) Health Homes that focus on SUDs
    - (5) Integrated, team-based treatment
    - (6) No SUD integration to date

Hallmarks of Successful Models

Deliver care (at least) collaboratively

Focus on overall health & wellbeing of individual, population

Connect SUD specialists with primary care practitioners

SUD and Primary Care Integration

Use clinical, financial, structural arrangements to remove barriers between physical and behavioral health

Agenda: History

- Brief history of MAT in Missouri

- How providers rose to the challenge and integrated SUD with physical health care

- Treatment outcomes with MAT

MAT Milestones in Missouri

2006 → **2007** → **2008** → **2009**

2006	2007	2008	2009
November Awarded the Robert Wood Johnson Advancing Recovery Grant for Use of Naltrexone and Acamprosate to Treat Alcohol Dependence	**November** Provider Contract Amendments added Medication Services	**April** First use of Vivitrol **October** Advancing Recovery Grant ended; Vivitrol Leader Conference calls begin	**May** Secured general revenue funding for addiction treatment medications **August** Allowed medication services via telehealth

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

MAT Milestones in Missouri (cont.)

2010

September
Began credentialing for MAT specialty

2011

October
Results published on Vivitrol study in Michigan and Missouri drug courts (Journal of Substance Abuse Treatment)

2012

Partnered with drug manufacturer to provide Vivitrol to St. Louis Drug Court participants prior to release from city jail

Present

Implementing a pilot project to provide Vivitrol to incarcerated offenders nearing release and continuing treatment in the community post-release
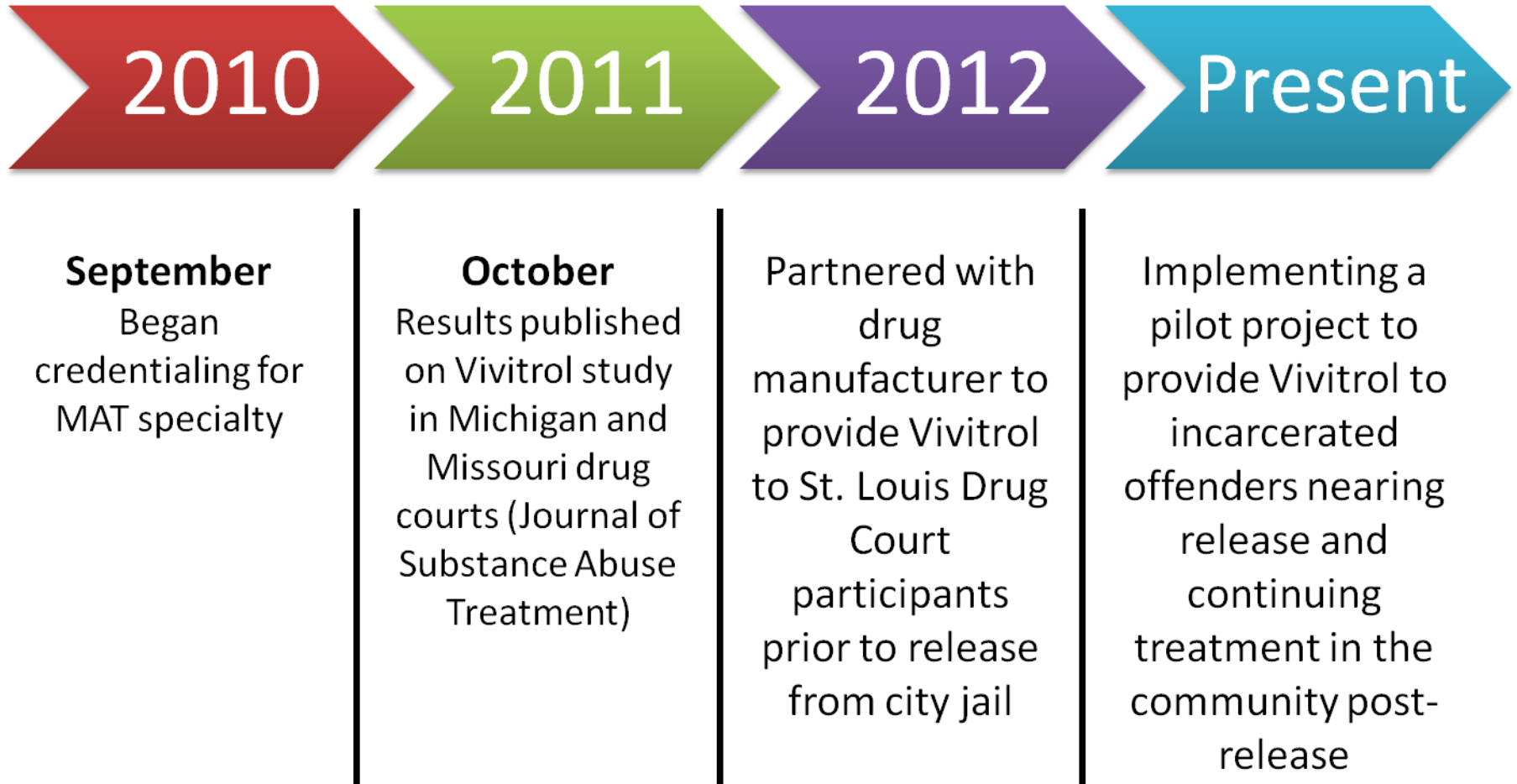
Agenda: Integrating SUD

- Brief history of MAT in Missouri

- How providers rose to the challenge and integrated SUD with physical health care

- Treatment outcomes with MAT

Requiring MAT Promotes Integration

- Reinforces the concept that addiction is a medical disorder

- Increases the need for on-site nursing services, which further promotes whole health focus

- Requires relationships with prescribers, which many providers traditionally do not employ

- Creates opportunities for relationships with FQHCs and improves care coordination

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

Provider Outreach

Contract Amendments
- Reimbursement for medications, physician time, laboratory services, etc.

Certification
- Condition of certification

Change Leader
- Initial focus of "Change Leader" conference calls with program directors

Treatment Extension
- Increased support for treatment extension by clinical utilization review

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

Different Models Used to Provide MAT

- Use of on-site prescriber
  - A few SUD providers have employed physicians
  - If they do, may use telehealth to connect with satellite offices

- Establish relationships with FQHCs
  - Two-way referrals (primary care and SUD)
  - Co-location

- Contract with community physicians
  - In person or via telehealth
  - Care coordinated by SUD provider

How Providers Overcame Challenges

- Funding Challenges
    - DMH secured dedicated funding through legislative budget process
    - State Medicaid agency pays for all addiction medications, except methadone
    - Providers able to utilize current allocations
   - Samples from pharmaceutical company

How Providers Overcame Challenges (cont.)

- Prescriber Challenges
  - "Beat the bushes" to find community providers (yellow pages)
  - Establish relationships with FQHCs, other health centers

- Provider and Client Culture Challenges
  - Training, training, training
  - Increased exposure to options (intake, client groups, counseling)
  - Success stories
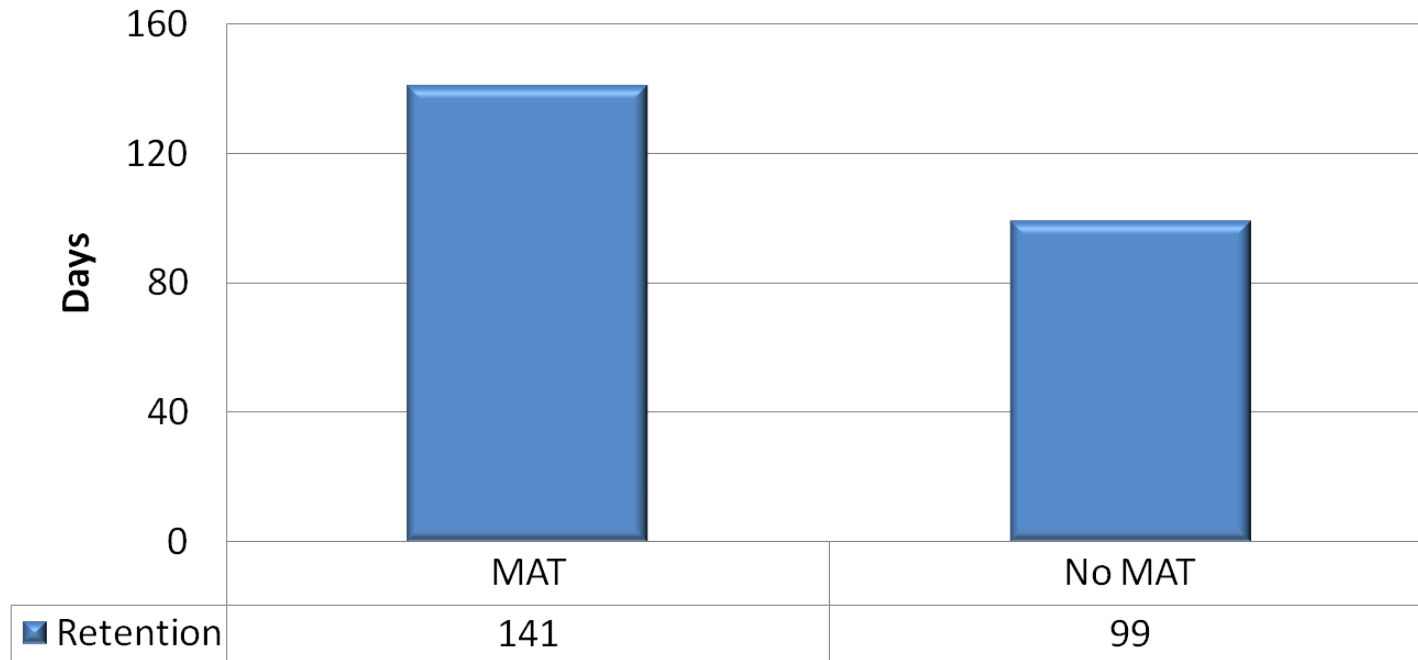
Agenda: Treatment Outcomes

- Brief history of MAT in Missouri

- How providers rose to the challenge and integrated SUD with physical health care

- **Treatment outcomes with MAT**

# Number Served and Discharged
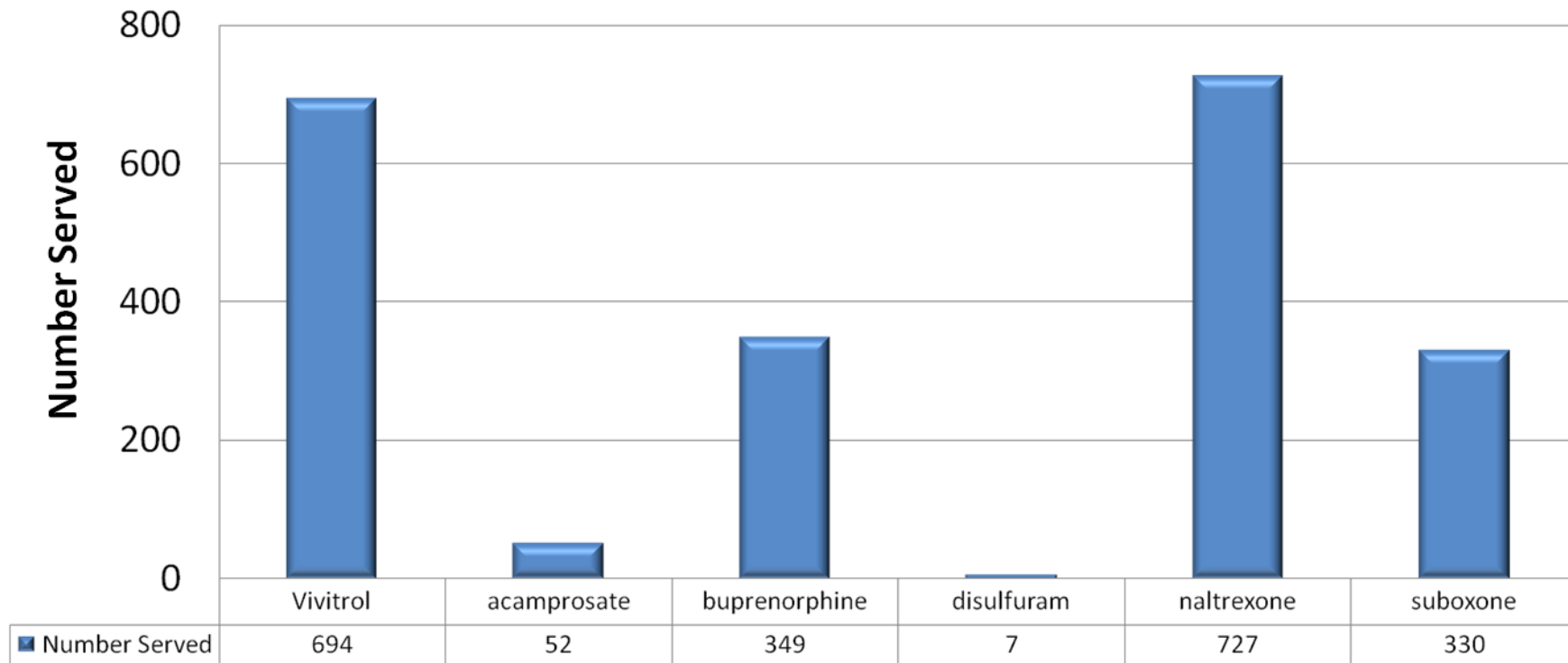
Notes: Based on discharges in FY 2014

Retention in Treatment

Retention	MAT	No MAT
	141	99

Significance: Research indicates that most addicted individuals need at least three months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment

Notes: Based on discharges in FY 2014 MAT group (n=1,723) and No MAT group (n=22,139)

Employed in Past 30 Days

	MAT	No MAT
■ Intake	9.7%	23.8%
■ Discharge	14.0%	25.3%
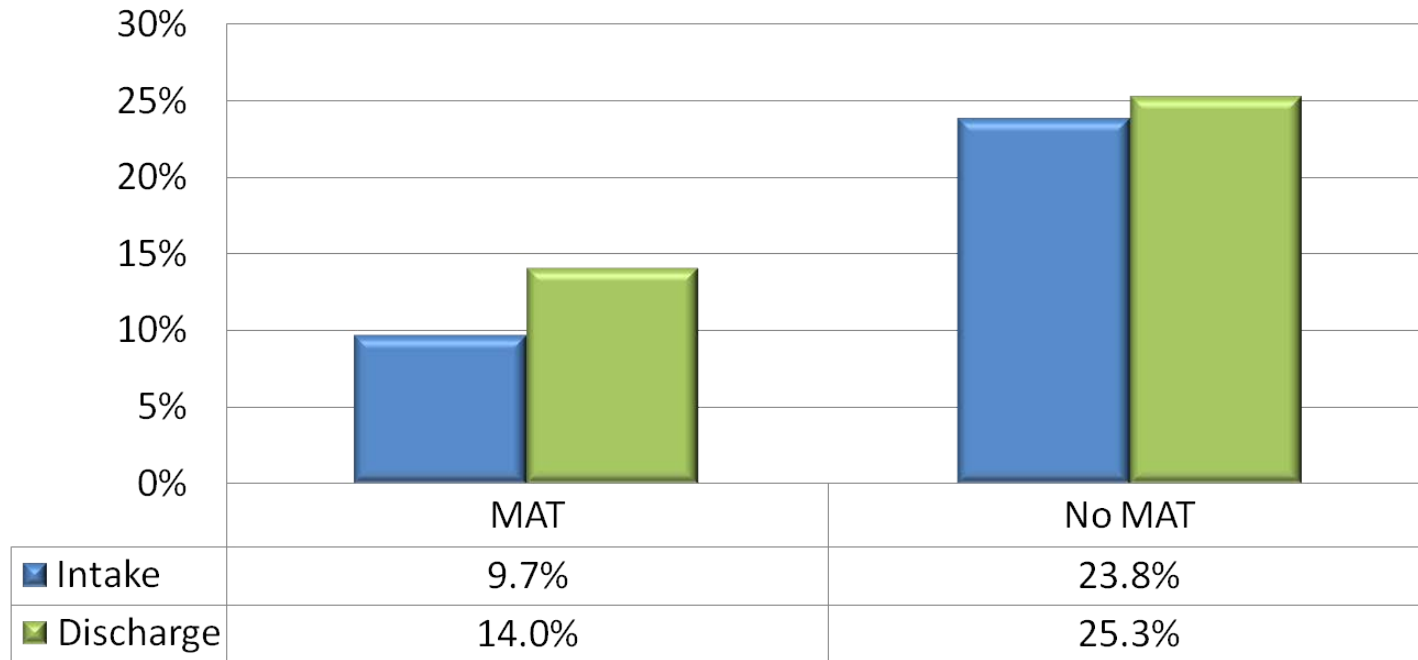
Significance: Although MAT group was less likely to be employed at intake, the group had greater improvement compared to control

Notes: Based on discharges in FY 2014 MAT group (n=1,717) and No MAT group (n=22,027)

Polling Question 2

- Has your state used any of the following methods to provide MAT?
  - (1) OPT
  - (2) OBOT
  - (3) SUD setting prescribers, not OTP
  - (4) OBOT affiliated w/ SUD providers
  - (5) Telehealth
  - (6) Relationships w/ FQHCs
  - (7) None of the above

Questions and Discussion (1)

Vermont

State Experience Integrating SUD into Primary Care Settings

Beth Tanzman, MSW, Assistant Director, Vermont Blueprint for Health

Anthony Folland, Clinical Services Manager and Opioid Treatment Authority Director, Alcohol and Drug Abuse Programs, Vermont Department of Health

Agenda: Overview

- Overview of Patient-Centered Medical Home initiative and behavioral health integration

- Health home "Hub & Spoke" for medication assisted treatment (MAT)

- Strategies to change infrastructure

- Strategies to change payment

- Strategies to change culture

- Challenges and opportunities

Leveraging Resources: Community Health Team

- "Utility" supported by all payers

- Local control

- Care coordination for complex patients

- Population health management and outreach infrastructure

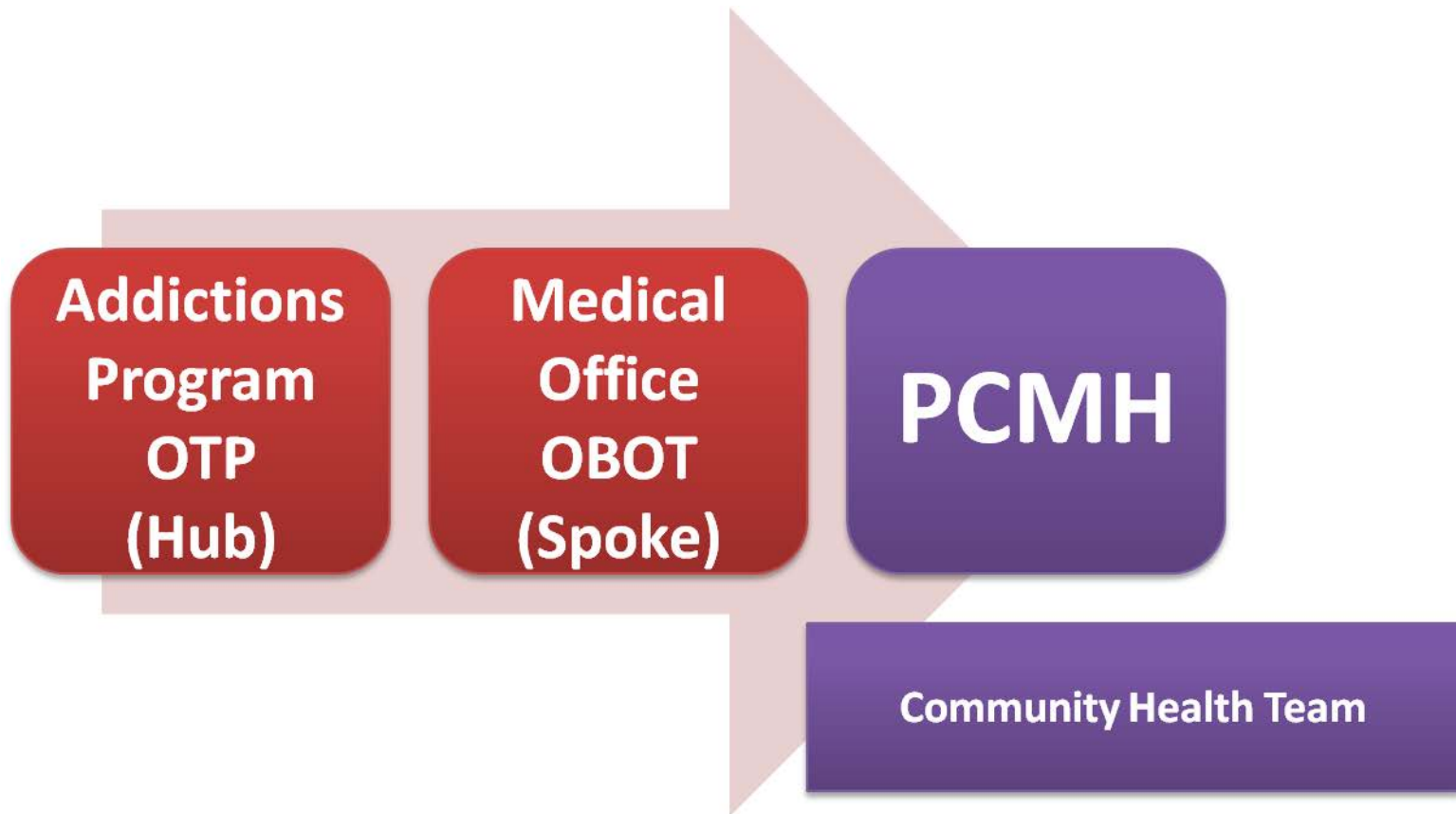- Bridges health, human services, community resources

Agenda: "Hub & Spoke"

- Overview of Patient-Centered Medical Home initiative and behavioral health integration

- Health home "Hub & Spoke" for medication assisted treatment (MAT)

- Strategies to change infrastructure

- Strategies to change payment

- Strategies to change culture

- Challenges and opportunities

Policy Goals

- For beneficiaries with opioid addiction at risk of developing another SUD and with cooccurring mental health issues in OTP and OBOT settings
    - Improve access to addictions treatment
    - Integrate health and addictions care for health home beneficiaries
    - Better use of specialty addictions programs and general medical settings
    - Improve health outcomes, promote stable recovery

Health Home for Opioid Addiction

Enrollment Process

- Auto-assignment with opt-out

- Initial outreach to beneficiaries in MAT

- Ongoing enrollment of any Medicaid beneficiary seeking MAT in either OTP or OBOT

- Triage to OTP or OBOT based on severity

- Offered Health Home services, individual plan of care drives services

Agenda: Strategies for Infrastructure

- Overview of Patient-Centered Medical Home initiative and behavioral health integration

- Health home "Hub & Spoke" for medication assisted treatment (MAT)

- Strategies to change infrastructure

- Strategies to change payment
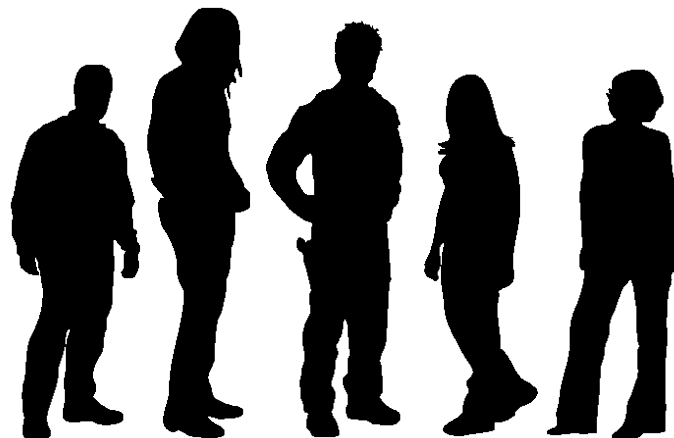
- Strategies to change culture

- Challenges

Interagency Collaboration

- Collaboration between Medicaid, Division of Alcohol & Drug Abuse Programs, and Vermont Blueprint for Health was critical to design, political support and implementation

- Key team members:
  - Hub
    - Designated provider: regional OTP
    - Team: RN, MA level licensed clinician case manager, program director (employed by the Hub)
  - Spoke
    - General Medical Setting: OBOT
    - Team: RN & MA level licensed clinician case manager (employed by Blueprint Community Health Team)

Spokes: Office-Based Opioid Treatment (OBOT)

Hub: Specialty Addictions Program, Opioid Treatment Program (OTP)

Expand to 5 Regional Centers in 7 Locations

Dispense Methadone & Buprenorphine

Complex Addictions Care

Intensive

Consultation to Spokes

Health Home Services

Health Home

Implementation Statistics

- First region approved July 2013
  - Expanded statewide in January 2014

- Current member enrollment (4,931)
  - 2,706 in Hubs
  - 2,225 in Spokes4

- Provider enrollment
  - 5 Hub providers
  - 133 Spoke providers

- Opt-out rate
  - Not tracked

Agenda: Strategies for Payment

- Overview of Patient-Centered Medical Home initiative and behavioral health integration

- Health home "Hub & Spoke" for medication assisted treatment (MAT)

- Strategies to change infrastructure

- **Strategies to change payment**

- Strategies to change culture

- Challenges and opportunities

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

Payment Model

Hub
OTP

PMPM: $493.97
(30% of rate is HH specific)

F-F-S for Buprenorphine

Spoke
OBOT

PMPM: 163.75
(100% of rate is HH specific)

Payment through Blueprint Community Health Team
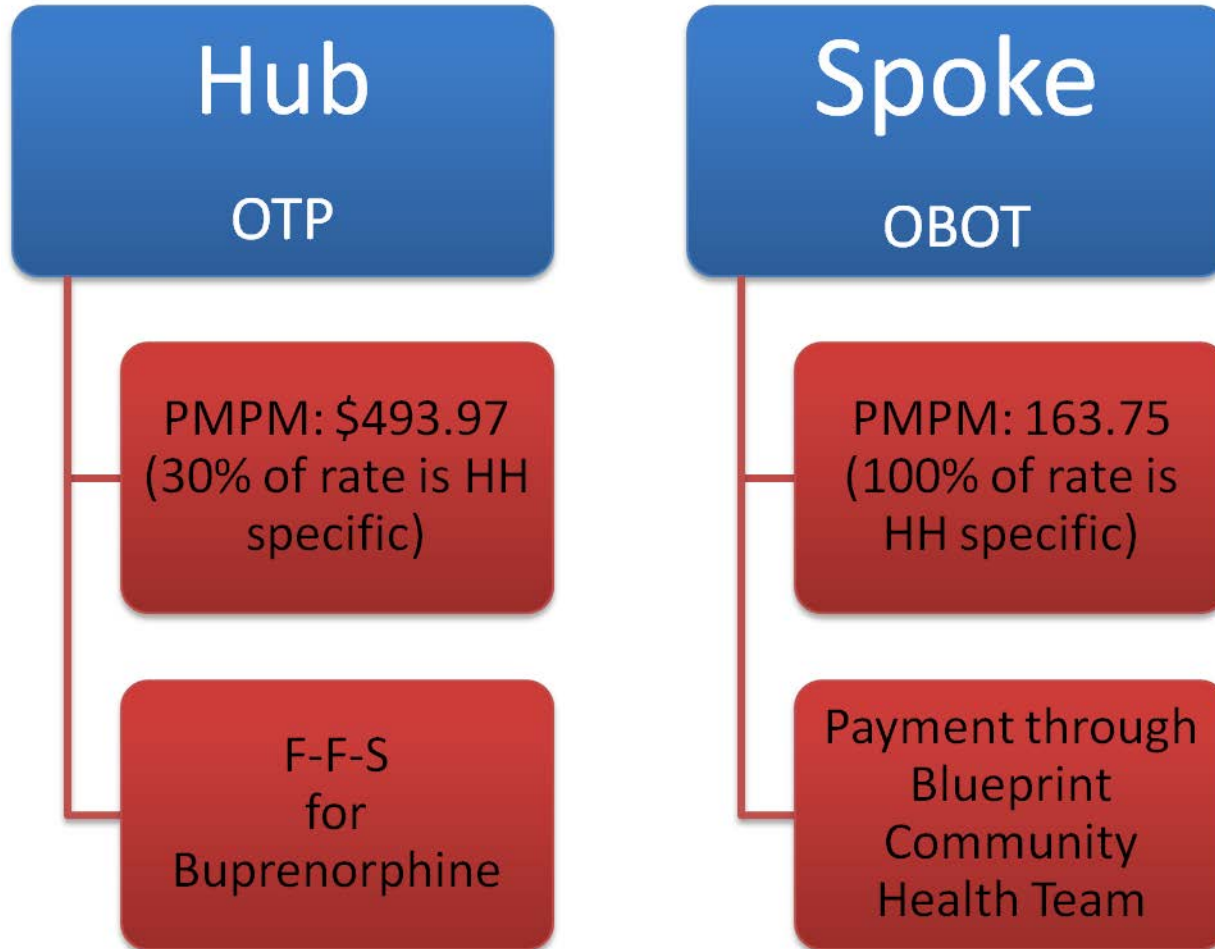
Agenda: Strategies for Culture

- Overview of Patient-Centered Medical Home initiative and behavioral health integration
- Health home "Hub & Spoke" for medication assisted treatment (MAT)
- Strategies to change infrastructure
- Strategies to change payment
- **Strategies to change culture**
- Challenges and opportunities

Culture: Work in Progress
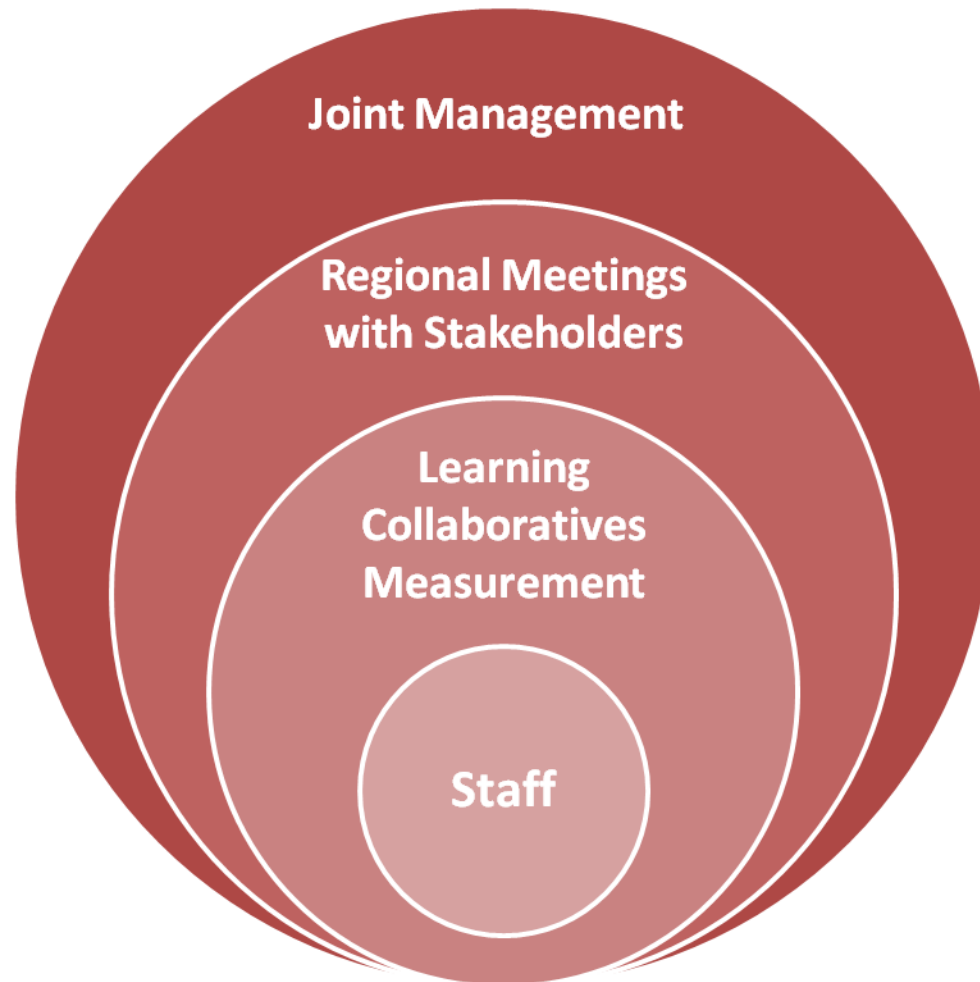
MAT in Primary Care Settings

- Appropriate setting for chronic condition

- Complex care, consistent, organized protocols

- Team and administrative support is crucial

- More than one provider: 30-40 patients/provider

- Access to addictions specialists, higher levels of care

- Rewards: Building relationships and witnessing stable recovery

- Health homes framework is helping improve OBOT and increase providers

Agenda: Challenges and Opportunities

- Overview of Patient-Centered Medical Home initiative and behavioral health integration

- Health home "Hub & Spoke" for medication assisted treatment (MAT)

- Strategies to change infrastructure

- Strategies to change payment

- Strategies to change culture

- Challenges and opportunities

Challenges and Opportunities

- 42-CFR limits exchange of information between SUD providers and health system
  - OTP programs do not report to Prescription Monitoring Systems
  - General medical settings have difficulty sequestering SUD clinical information
  - Solutions: Adoption of 42 CFR Part II compliant release forms, Health Home staff work with beneficiaries to obtain consent
- Culture of "separateness" in OTP programs
- Integration of Spoke staff in different practice settings
- Network capacity / workforce

Challenges and Opportunities: Buprenorphine in OTPs

- Opportunity
  - Allows for Buprenorphine to be offered in either structure (OTP or OBOT) depending upon patient's assessed needs

- Challenge
  - How to provide buprenorphine in OTPs
    - Reimbursement
    - Costs
    - Defining stabilization/Blending cultures

- Solutions
  - Worked with multiple regulatory agencies for reimbursement
  - Learning collaboratives discussed above
  - Finding correct balance and triage of patients to OTP/OBOTs

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

Polling Question 3

- Which of the following represents the greatest challenge to your state's integration efforts?
  - (1) Financing / reimbursement
  - (2) Infrastructure
  - (3) Availability of providers
  - (4) Culture
  - (5) Not a high priority for state
  - (6) Other challenges

Questions and Discussion (2)

Agenda: Overview of TTC

- Overview of Tarzana Treatment Centers (TTC) and history of care integration efforts

- Why integrated care at TTC?

- Models of SUD treatment integration with Primary Care at TTC

- Extending the integration of SUD treatment into Primary Care

Overview of TTC

- 501(c)(3) non-profit corporation
- 9 locations throughout Los Angeles County
- Revenue sources
  - Grants: federal, state, foundations
  - Contracts: county, city, VA, US Probation, SASCA, managed care with private insurers, Medicare and MediCal FFS and managed care
  - Private pay
  - Sliding fee and charity care
- Joint Commission accreditations and certifications

Overview of TTC Services

Integrated Services and Care Coordination

SUD Services
- Detoxification
- Residential Rehabilitation
- Partial Hospitalization/ Day Treatment
- IOP/ Outpatient
- Maintenance/ MAT
- Housing

Mental Health
- Acute Psych Hospital/Stabilization
- Intensive Outpatient
- Outpatient
- Housing

Primary Care
- 3 General Clinics
- 2 Specialty HIV

HIV Services
- Medical Clinics
- Prevention & Testing
- Case Management
- Jail In-Reach
- Mental Health
- SUD Services
- Home Health Care
- Housing

IT/EHR/A VATAR
- Integrated Treatment Plan
- Care Coordination
- Electronic Prescribing
- Telemedicine

Assessment / Case Management
- Community Assessment Service Centers
- Case Management in Hospital EDs

TTC's History of Care Integration Efforts

- 1995: Opened primary care clinic co-located with SUD treatment

- 2002: Opened HIV/AIDS primary care co-located with SUD treatment

- 2010-2014: Improve Care Integration within TTC

- 2014-2018: Improve Care Integration for external organizations

  - Embedding TTC Primary Care in LA County Department of Mental Health San Fernando Mental Health Center

  - Strengthening referrals from FQHCs for SUD treatment

  - Embedding TTC Primary Care with CMHCs
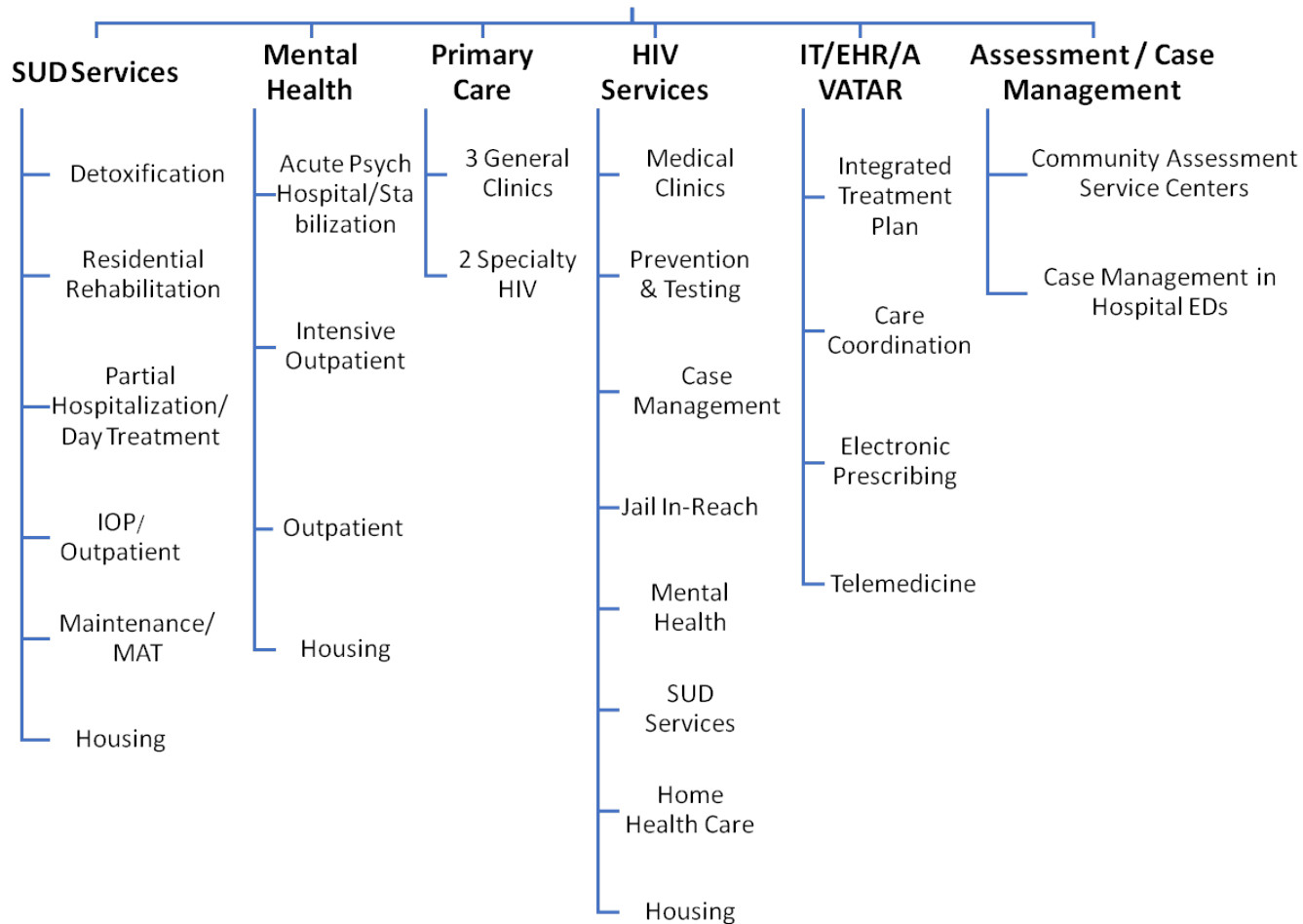
Agenda: Why Integrated Care?

- Overview of Tarzana Treatment Centers (TTC) and history of care integration efforts

- Why integrated care at TTC?

- Models of SUD treatment integration with Primary Care at TTC

- Extending the integration of SUD treatment into Primary Care

Reducing ER and Hospital Admissions and Readmissions

Table 1. Potentially Preventable Readmission (PPR) Rates per 100 At Risk[1] Admissions by Medicaid Recipient Health Condition at Initial Admission and Region: New York State, 2007

Recipient Health Condition	New York City			Rest of the State			New York State		
	Initial Admissions[1]	At Risk Events[2]	PPR Rate	Initial Admissions	At Risk Events	PPR Rate	Initial Admissions	At Risk Events	PPR Rate
Mental Health	6,808	79,815	8.5	3,715	52,116	7.1	10,523	131,931	8.0
Substance Abuse	4,111	35,578	11.6	1,523	19,291	7.9	5,634	54,869	10.3
Mental Health and Substance Abuse	13,043	62,409	20.9	7,833	54,081	14.5	20,876	116,490	17.9
All Others	6,485	132,269	4.9	2,567	56,234	4.6	9,082	188,503	4.8
Total	30,447	310,071	9.8	15,638	181,722	8.6	46,115	491,793	9.4

[1] Non-excluded admissions followed by at least one clinically related readmission.
[2] All inpatient events that were not excluded according to defined PPR criteria.

Source: Lindsey, M., Patterson, W., Ray, K. & Roohan, P. (2007). Potentially preventable hospital readmissions among Medicaid recipients with mental health and/or substance abuse health conditions compared with all others: New York State, 2007. Available at: New York State Department of Health Division of Quality and Evaluation Office of Health Insurance Programs

Medicaid.gov
Keeping America Healthy

IAP Medicaid Innovation Accelerator Program

Impact of Mental Illness and & SUD on Cost and Hospitalization for Diabetics
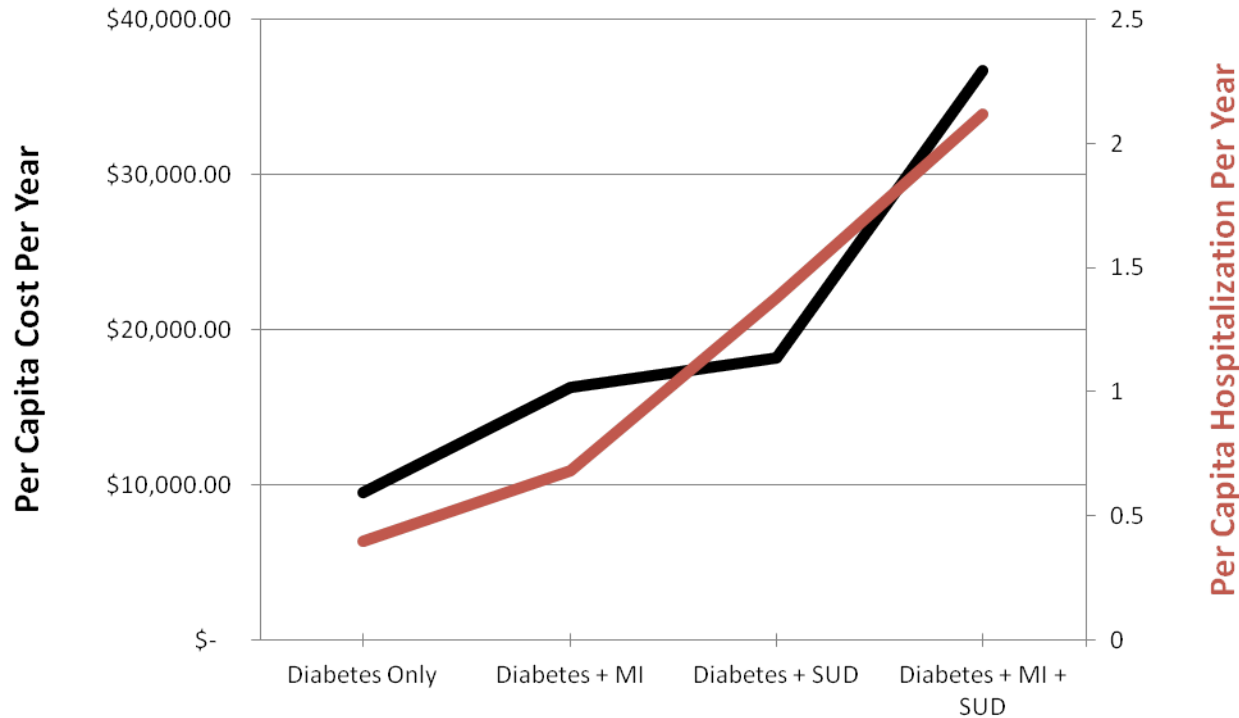
Source: Boyd, C., Leff, B., Weiss, C., Wolff, J., Hamblin, A. & Martin, L. (2010). Faces of Medicaid: Clarifying multimorbidity patters to improve targeting and delivery of clinical services for Medicaid populations. Available at: Center for Health Care Strategies, Inc.

Agenda: Models of SUD Integration

- Overview of Tarzana Treatment Centers (TTC) and history of care integration efforts

- Why integrated care at TTC?

- **Models of SUD treatment integration with Primary Care at TTC**

- Extending the integration of SUD treatment into Primary Care

Models of SUD Treatment Integration with Primary Care at TTC

- Examples of Primary Care led integration
  - Primary Care and HIV/AIDS patients
  - Primary Care and ISM Model
- Examples of Behavioral Health led integration
  - SUD inpatients, residential, outpatient including MAT

Primary Care Care Team

Lead: Physician, Nurse Practitioner, Physician Assistant

Team Members: Nurse, Behavioral Health Clinician, Case Manager, Medical Assistant, Psychiatrists, Pharmacist

Behavioral Health Care Team

Lead: Behavioral Health Clinician / Supervisor

Team Members: Psychiatrist, Addiction Counselor, Case Manager, Nurse, Nurse Practitioner, Physician Assistant, Primary Care Physician

Medicaid.gov
Keeping America Healthy

IAP | Medicaid Innovation Accelerator Program

Models of Primary Care Team Led Integration at TTC

- Primary Care Led Integration for HIV/AIDS patients with SUDs
  - Target
    - Patients with HIV/AIDS with SUD diagnoses and their at risk partners
  - Design
    - Cross-training of primary care and SUD treatment team members
    - Care Coordination to navigate patient through medical and SUD/MHD care
    - Primary Care and SUD treatment staff case conferences 2x month
    - Primary Care provider involved in SUD treatment planning, relapse prevention, and relapse response

Models of Primary Care Team Led Integration at TTC

- Primary care led integration for Latino patients with SUD and mental health disorders
  - Target
    - Individuals not currently seen in behavioral health
    - Focus on Latinos who are monolingual
  - Design
    - Patients enrolled in TTC's primary medical care services
    - Integrated care team
    - Engagement in non-traditional health settings (e.g. faith-based institutions)
    - Wellness classes, group education, counseling, psychiatric services, non-traditional services, integrated case management

Model of SUD Treatment Team Led Integration at TTC

- Behavioral Health Home Model
  - Target
    - Patients with SUD and mental health conditions with chronic physical health conditions
  - Purpose
    - To make the "home" in behavioral health rather than in primary care
    - To bring primary care in-house or link patients with primary care providers
  - Benefits
    - Patients may feel more comfortable in behavioral health setting
    - Able to coordinate and integrate care as would be done in primary care
    - Psychiatrist or behavioral health clinician may be lead rather than the primary care physician

Integrating Chronic Disease Management Into Behavioral Health Homes

Self-Medical History
- Review chronic diseases
- Review medications
- Assess if patient is receiving medical care for chronic diseases

ASI/Mental Health Assessment
- Note chronic diseases identified in self-medical history form
- Identify how these chronic diseases impact SUD and MH issues

Integrated Summary
- Capture chronic diseases information from ASI – plan is for it to drop into Integrated Summary for SUD programs
- MH programs may not use this form

Treatment Plan
- Add chronic diseases as a problem
- Add problem page for chronic diseases with goals, objectives, interventions

Treatment
- Address chronic diseases as part of your overall care with the patient
- Follow the objectives and interventions on the treatment plan and document progress in the medical record
- Reinforce medical provider orders and recommended treatment

Case/Care Management
- Communicate with the PCP
- Monitor and assess if patient is seeing the medical provider and following the care plan
- Coordinate care as needed with PCP

Whole Person Care
- Emphasize that managing chronic diseases is similar to managing addiction and MH disorders
- Point out the similarities in terms of how taking better care of oneself promotes recovery and improved health

Financing Integration at TTC

- Overcoming financial obstacles to integrated care
  - Challenges of siloed public contract funding
    - California's history of siloed public funding for healthcare
    - Handling audits when integrating care
  - Challenges of siloed primary care funding
    - Capitation in Managed Medi-Cal and care for the undocumented
    - Segregation of primary and behavioral health care
  - Coordinating care without funding for care coordination
    - Education of funding sources
    - Piecing together resources for integrated care
    - Hope on the horizon

Using HIT as a Driver for Integration

- Using Health IT as a driver for integration
  - Provide tools for referrals and HIE
  - Provide tools for integrated care
    - Assessment for medical , MH, SUD conditions, integrated problem list, diagnosis, summary, treatment plan, view of record, registries
  - Provide ability to bill for integrated services
    - Procedure codes, guarantors, claims

- Technology
  - Netsmart Avatar, Primary Care Module, Integrated Treatment Plan, Order Connect ePrescribing, Care Connect Lab interfaces and HIE, MyHealthPoint Patient Portal

Agenda: Extending the Integration

- Overview of Tarzana Treatment Centers (TTC) and history of care integration efforts

- Why integrated care at TTC?

- Models of SUD treatment integration with Primary Care at TTC

- Extending the integration of SUD treatment into Primary Care

Extending the Integration of SUD into Primary Care

- Population health

- Treating to target

- Measurement to improve the degree of integration
  - Chronic physical conditions included in Integrated Treatment Plan
  - Cross-Selling Ratio

Polling Question 4

- Using the ReadyTalk platform options, select the 'raise your hand' tool if your state has used or is using information technology as a component of your integration

Questions and Discussion (3)

Polling Question 5

- Is your state interested in participating in an informal call with the speakers to ask additional questions?
  - (1) Yes
  - (2) No

Resources (1)

- [Guide to Medicaid Health Home Design and Implementation](), Centers for Medicare & Medicaid Services

Resources (2)

- [Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States](#), Centers for Medicare & Medicaid Services

Resources (3)

- [Community Clinic and Health Center Case Study Highlights: Integrating Substance Abuse and Primary Care Services in Community Clinics and Health Centers](), CalMHSA, Integrated Behavioral Health Project

Resources (4)

- [Mental Health, Primary Care and Substance Use Interagency Collaboration Tool Kit](#), 2nd Edition, CalMHSA, Integrated Behavioral Health Project

Contact

- Colette Croze, MSW, Croze Consulting
  - crozec@aol.com, (302) 378-7555
- Mark Stringer, MA, Missouri Department of Mental Health
  - mark.Stringer@dmh.mo.gov, (573) 751-9499
- Beth Tanzman, MSW, Vermont Blueprint for Health
  - beth.Tanzman@state.vt.us, (802) 654-8934
- Anthony Folland, Vermont Department of Health
  - anthony.Folland@state.vt.us, (802) 652-4141
- Jim Sorg, PhD, Tarzana Treatment Centers
  - jsorg@Tarzanatc.org