Behavioral Health Provider Implementation of Whole Health Integrative Treatment Services

Maryland Integrative Learning Community
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Maryland Health Home Program
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MADC in Partnership with The National Council for Behavioral Health has been engaged in a year-long learning community to expand the integration of addiction specialty services, mental health specialty services and primary care services in local communities.

• The project is based on the premise that whole health integration are, evidence-based, and effective components of treatment and support and facilitate recovery for people with multiple chronic conditions such as addictive disorders, mental health disorders.

• 11 health teams are participating to expand their capacity to provide integrated behavioral health and primary care services. Each team includes behavioral health and primary care providers.
Primary Goal:
To increase the number of communities in Maryland where the addiction and mental health specialty programs are implementing bi-directional behavioral health and primary care integration.

Specific Goals:
• Establish the foundation for the business case for the integration of addiction and mental health services in Maryland based on national initiative review and models.
• Provide a model that will address the merging of the addiction and mental health cultures at the provider level.
• Provide a tool kit for provider organizations to assess administrative partnership compatibility at the provider level.
• Provide a framework for effectively integrating clinical work that respects the uniqueness of providers and their services while addressing the needs of those that are served.
• Provide a framework for incorporation of peer supports and recovery coaches in the integration.
• Prepare strategic plan for the Associations in supporting and implementing association based integration activities.
Participants receive technical assistance through

- In-person meetings
- Webinars, onsite consultations
- Individual coaching calls
- Group technical assistance and training.

Teams are developing action plans that present the goals, objectives, methods and benchmarks for advancing integration, and will implement these plans over the course of the project and beyond.
Maryland Integrative Learning Community
Content Areas

- Developing the Business Case for Integration
- Choosing your Model: An Overview of Integration Strategies
- Partnership Development Strategies: Building on Members' Strengths
- Workforce Development Strategies
- Implementing and Learning from Health Homes in Maryland
- The Role of Substance Use Disorder Professionals, Medication-Assisted Treatment and ROSC in the Health Home
Maryland Health Home Project
Provider Example: Opioid Treatment Program (OTP)

Institutes for Behavior Resources, Inc.
REACH – Substance Abuse Treatment
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Maryland Health Home Program Objectives

- Further integration of behavioral and somatic care through improved care coordination
- Improve patient outcomes, experience of care, and health care costs among individuals with chronic conditions
- Enable Health Homes to act as locus of coordination for SPMI and OTP populations through provision of additional care coordination services
1. Individuals with serious and persistent mental illness (SPMI)

2. Children and adolescents with serious emotional disturbance (SED)

3. Individuals with Opioid Substance Use Disorders, at risk for an additional chronic condition due to one of the following risk factors:
   - Current tobacco, alcohol, or other non opioid substance use
   - A history of tobacco, alcohol, or other non opioid substance dependence
Health Home Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support
Provider Enrollment: Eligibility

- Provider types eligible to become Health Homes:
  - Psychiatric Rehabilitation Programs
  - Opioid Treatment Programs
  - Mobile Treatment Providers

- Specialized Criteria
  - Providers serving children must demonstrate a minimum of 3 years of experience providing services to children and youth.
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Population Characteristics

- Total patient population of 580 adults
- 2/3 of patients between 40 and 59 years old
- Primarily opioid dependent
- Over 60% have other SUDs including abuse or dependence on alcohol, nicotine, cocaine and benzodiazepines
- Over 50% of patients reside in five zip codes around REACH
- Mix of insurance coverage
  - Uninsured (grant-funded) -- 29%
  - Medicaid PAC -- 36%
  - Medicaid Health Choice -- 33%
  - Commercial insurance -- 2%
- 23% employed
Current Services

• Assessment
• Pharmacotherapy with methadone and Suboxone®
• Limited somatic care
• Case management
• Psychiatric evaluations
• Individual and Group Counseling with Step Care Model
• Intensive Outpatient Services
• On-site HIV and Viral Hepatitis Testing
Why Integration of Care?

• Evidence for faster attainment and maintenance of abstinence with integrated substance-use treatment & medical services*

• Substance-use treatment services at REACH not currently integrated with primary care

• Effects include:
  – Failure to prevent and treat acute & chronic conditions
  – Waste of healthcare resources
  – Reduced recovery rate

• SU conditions add to Medicaid health care costs*

• SU conditions can cause or exacerbate chronic health conditions*

*SAMHSA-HRSA
More Cause for Integration
The National Council for Behavioral Healthcare – Substance Use Disorders and Health-Care Home

- SUD interventions can reduce healthcare costs and utilization
- Many individuals served in specialty treatment centers have no PCP
- Continuing care should link the continuum of SUD services together and support individual’s change process
- Health evaluation and linkage to healthcare can improve SUD status
- On-site services are stronger than referral services
Integrated Care Model

– Use classic counseling techniques to engage and motivate patients
– Make use of incentives
– Sharing of feedback between patient and the counselor
– Caseload consultation and supervision
– Recovery support in the community
– Take advantage of technology
Barriers to Implementation

• Financing models that place enormous demands on programs with inadequate resources
• Lack of BH knowledge in PC providers and lack of health knowledge in BH providers
• Different coding and billing systems
• Fragmented clinical documentation
Integrated Care Model

- Medications (methadone, Suboxone, naltrexone, acamprosate) are important adjunctive components added to levels of care
- Multi-disciplinary team approach essential
- Communication is critical – secure emails, phone calls, web-based IT system, weekly team meetings, and joint patient visits
- Documentation is critical – the expectation is that clinical staff will read team members’ notes
Integrated Care Model

• Each team member owns responsibility for patient care and participates in case management
• Treat SUDs as a chronic condition which allows for establishment of trust, effective rapport and consistency
• Relapse does not mean discharge but increased frequency of clinical contacts, additional visits with MD/NP, changes in medication administration, referral
• Broad behavior change messages
Integrated Care Model

- Identify simultaneous conditions and educate patients about them
- Patient is an active participant in the process
- Coordination of care with other providers is critical and often time consuming and frustrating
- Focus on recovery, health, and wellness via language, approaches to care, and strategies of engagement
Expected Benefits

- Positive patient outcomes, reduced drug use and more stable, productive lives
- Lower rates of emergency room use
- Reduced hospital admissions/re-admissions
- Reduced health care costs
- Less reliance on long term care centers
- Improved patient care experience – less stigma
- Improved access to social services and community supports
Are You Ready?

- Provider team with a range of expertise?
- Coordination of care with specialty providers in other organizations?
- Engaging patients in shared decision-making?
- Collect and use data?
- Report on a broad range of outcomes?
- A sustainable business model?