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40<sup>TH</sup>

National Mental  
Health and Addictions  
Conference & Expo  
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NATIONAL COUNCIL  
FOR COMMUNITY BEHAVIORAL HEALTHCARE

## Substance Use Disorders and the Healthcare Home Webinar

3-30-2010

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See you in San Diego, May 2-4, 2011

# Patient-Centered Medical Homes/ Person-Centered Healthcare Homes

## Patient Centered Medical Home (PCMH) Principles

- Ongoing Relationship with a PCP
- Care Team who collectively take responsibility for ongoing care
- Provides all healthcare or makes Appropriate Referrals
- Care is Coordinated and/or Integrated
- Quality and Safety are hallmarks
- Enhanced Access to care is available
- Payment appropriately recognizes the added value

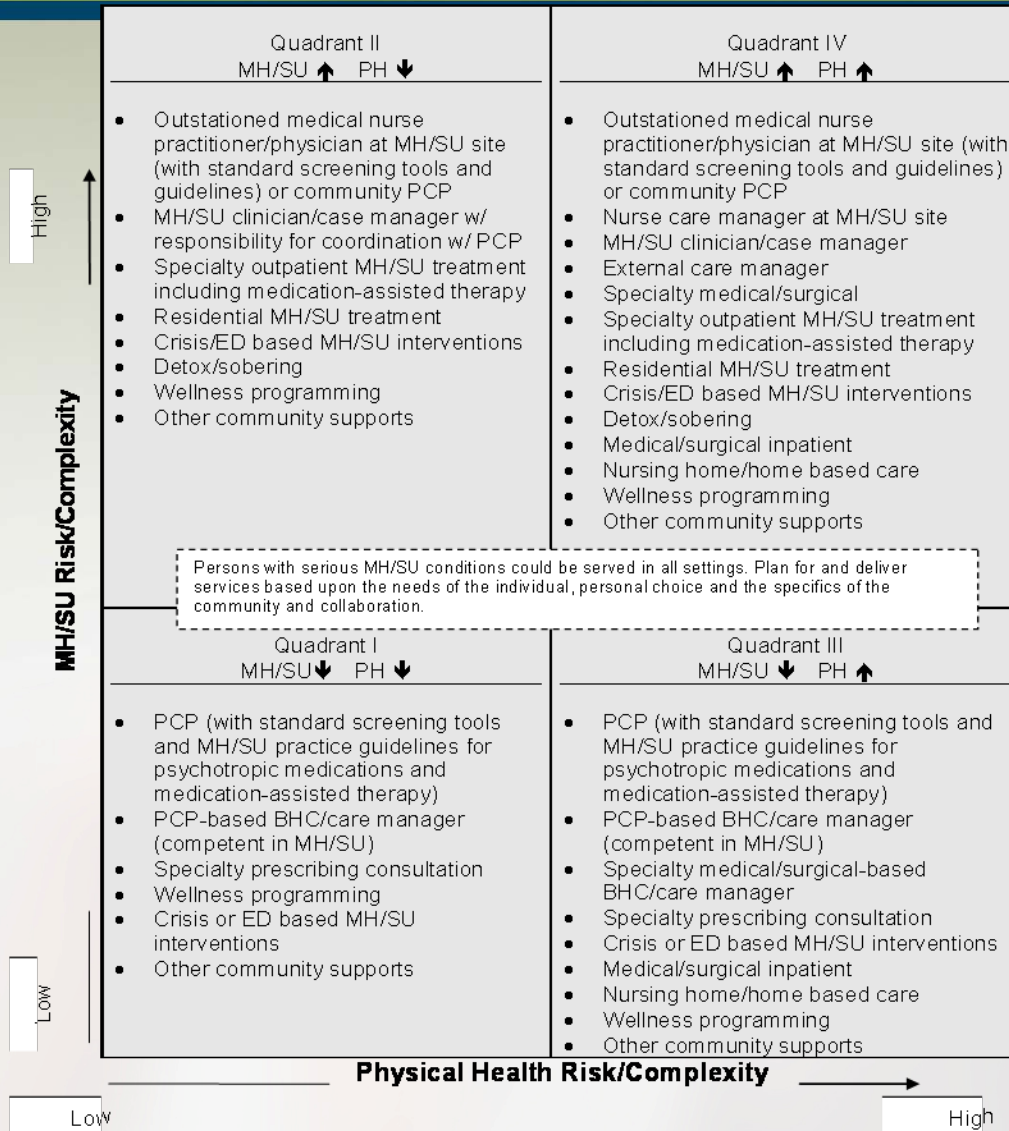
## Person-Centered Healthcare Home

- Not a clear articulation in the PCMH model of the role of MH/SU
- Change to Person Centered Healthcare Home signals that MH/SU is a central part of healthcare and that healthcare includes a focus on supporting goals for improved self management
- Use a bi-directional approach to address the integration of primary care services in MH/SU settings as well as the need for MH/SU services in primary care settings
- Build in the care manager/ behavioral health consultant and consulting prescriber functions that have proven effective in the IMPACT model and mirror this model to bring planned primary care into MH/SU settings

# Where Should Care Be Delivered? Stepped Care

- There is always a boundary between primary care and specialty care
- There will always be tradeoffs between the benefits of specialty expertise and of integration
- *Stepped care* is a clinical approach to assure that the need for a changing level of care is addressed appropriately for each person—IMPACT research demonstrates the effectiveness of a stepped care model and is the basis for the National Council Collaborative Care Project
- We need to implement this model bi-directionally—to identify people in primary care with MH/SU conditions and serve them there unless they need specialty care, and to identify people in MH/SU care that need basic primary care and step them to a full scope medical home for more complex care—the Four Quadrant model has been revised to reflect this thinking

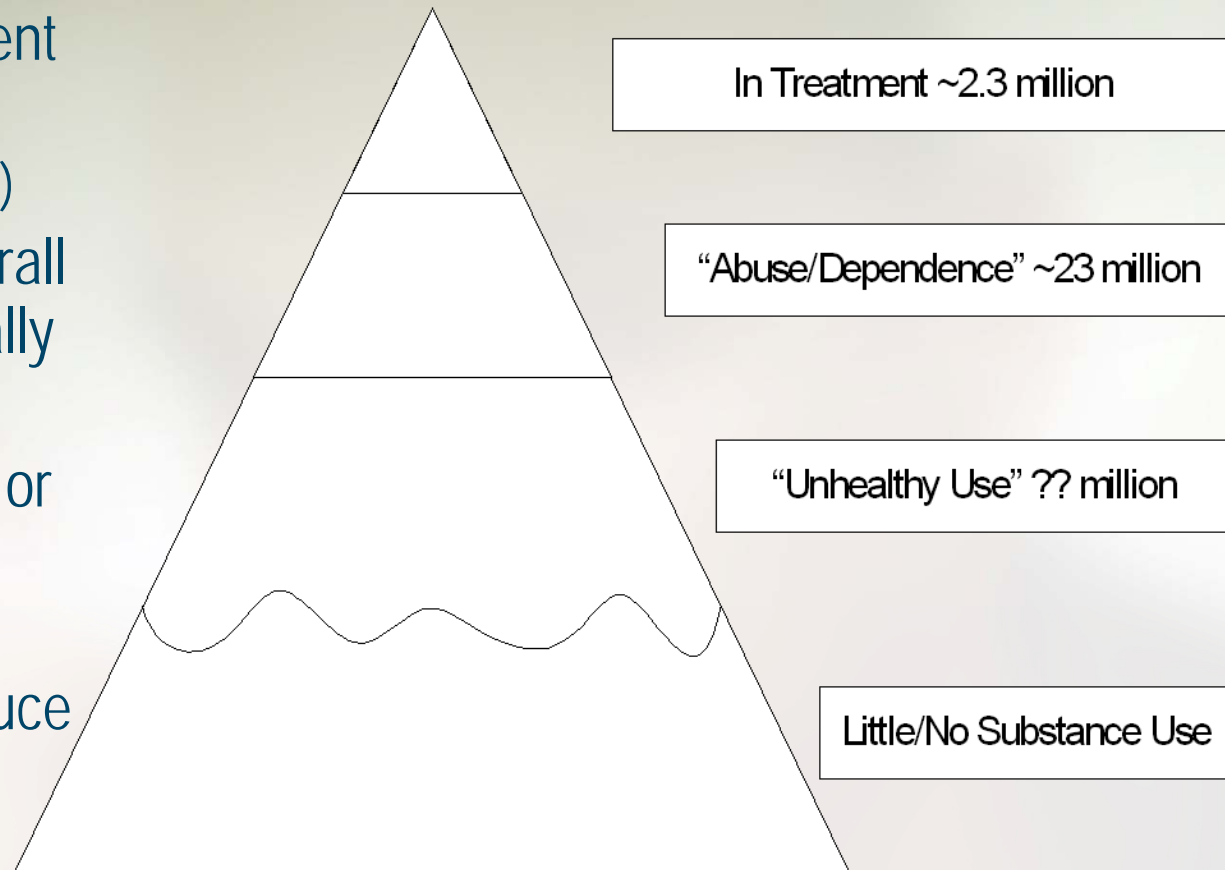
# The Four Quadrant Clinical Integration Model (MH/SU)



# Focus: Quadrants I and III

# SU Conditions are Relevant for Primary Care

- SU conditions are prevalent in primary care
  - Tens of millions (McLellan)
- SU conditions add to overall healthcare costs, especially for Medicaid
- SU conditions can cause or exacerbate other chronic health conditions
- SU interventions can reduce healthcare utilization and cost



## SU Impact on Healthcare Costs

- Willenbring suggests that at-risk alcohol use can be found in ~21% of the population, harmful use in ~5%, severe dependence in ~3% and chronic dependence in ~1%.
- In a screening study in three primary care clinics providing care for over 14,000 patients annually, 23% of the participants had a current SU disorder
- A 2007 federal report found that one in fourteen stays in U.S. community hospitals involved SU disorders, accounting for about 2.3 million hospitalizations, average stays of 4.6 days and a cost of \$2 billion nationally in 2004
- A New Mexico analysis concluded that “healthcare expenditures for the medical consequences of alcohol use and for the prevention and treatment of alcohol use disorders amounted to nearly \$415 million.”
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# SU Impact on Healthcare Costs

## Kaiser Permanente Northern California

- Kaiser studies reported are retrospective, using historical enrollee data
- Pre/Post SU Treatment and Medical Costs
  - Analysis of average medical cost PMPM in 18 months pre and post SU treatment using historical data
  - Treatment group had a 26% reduction in cost, from \$239 PMPM to \$208 PMPM, with reduced ER and hospitalizations post treatment compared to matched control group

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# SU Impact on Healthcare Costs

## Kaiser Permanente Northern California

- Analysis of continuing care (CC) and effect on remission, CC defined as:
  - SU treatment when needed
  - Psychiatric services when needed (for adults with psychiatric symptoms after SU treatment )
    - Those who received 2.1 or more hours of psychiatric services/year were 2.22 times more likely to be abstinent at five years after SU treatment
    - Those with high psychiatric severity at initiation of treatment had \$1000 PMPM, reduced to about \$300 PMPM at five years
  - Primary care at least every year
  - Patients receiving CC were more than twice as likely to be remitted at each follow-up over 9 years
  - Those receiving CC in the prior interval were less likely to have ER visits and hospitalizations subsequently (even when not in remission)

# SU Impact on Healthcare Costs

## Kaiser Permanente Northern California

- Analysis of the medical conditions and costs of family members of individuals with SU conditions using historical data
- Pre-treatment, families of all SU patients have higher medical costs than control families
- Adult family members have significantly higher prevalence of 12 medical conditions compared with control group; child family members have significantly higher prevalence of 9 medical conditions
- At 2-5 years post-intake for SU services, if family member w/SU condition were abstinent at 1 year, family members had similar average PMPM medical costs as control group
- Family members of SU patients who were not abstinent at 1 year had a trajectory of increasing medical cost relative to control group

# SU Impact on Healthcare Costs

- In Washington State studies, in which investment in expanded SU treatment was tested as an investment in healthcare cost containment and public safety, it was estimated that 20% of disabled individuals on Medicaid needed SU treatment (and 13% of TANF recipients)
- In the Washington State Medicaid population, two-thirds of frequent users (those with 31 or more visits in a year) of Emergency Departments (EDs) had SU disorders
- This same group of frequent users had an average of 42 narcotic analgesic prescriptions per person in a year

# SU Impact on Healthcare Costs

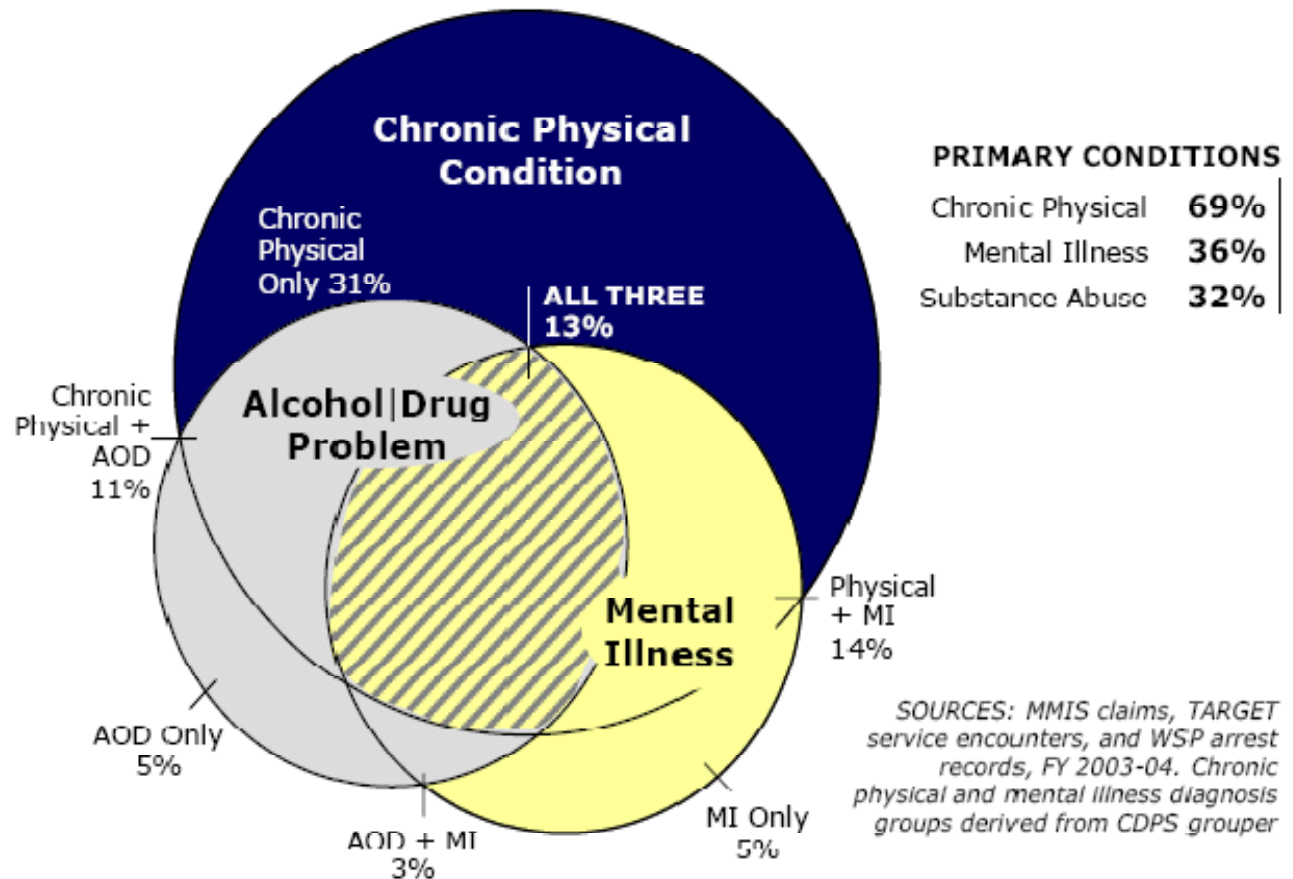
- For the SSI population, Washington studied the Medicaid cost differences for those who received treatment and those who did not
  - Average monthly medical costs were \$414 per month higher for those not receiving treatment, and with the cost of the treatment added in, there was still a net cost offset of \$252/month or \$3,024/year
  - The net cost offset rose to \$363 per month for those who completed treatment
  - Providing treatment for stimulant (methamphetamine) addiction resulted in higher net cost savings (\$296/month) than treatment for other substance
  - For SSI recipients with opiate-addiction, cost offsets rose to \$899/month for those who remain in methadone treatment for at least one year
  - In the SSI population, average monthly ED costs were lower for those treated—the number of visits per year was 19% lower and the average cost per visit was 29% lower, almost offsetting the average monthly cost of treatment
  - For frequent ED users (12 or more visits/year) there was a 17% reduction in average visits for those who entered, but didn't complete SU treatment and a 48% reduction for those who did complete treatment

# The Picture in Primary Care is Complex

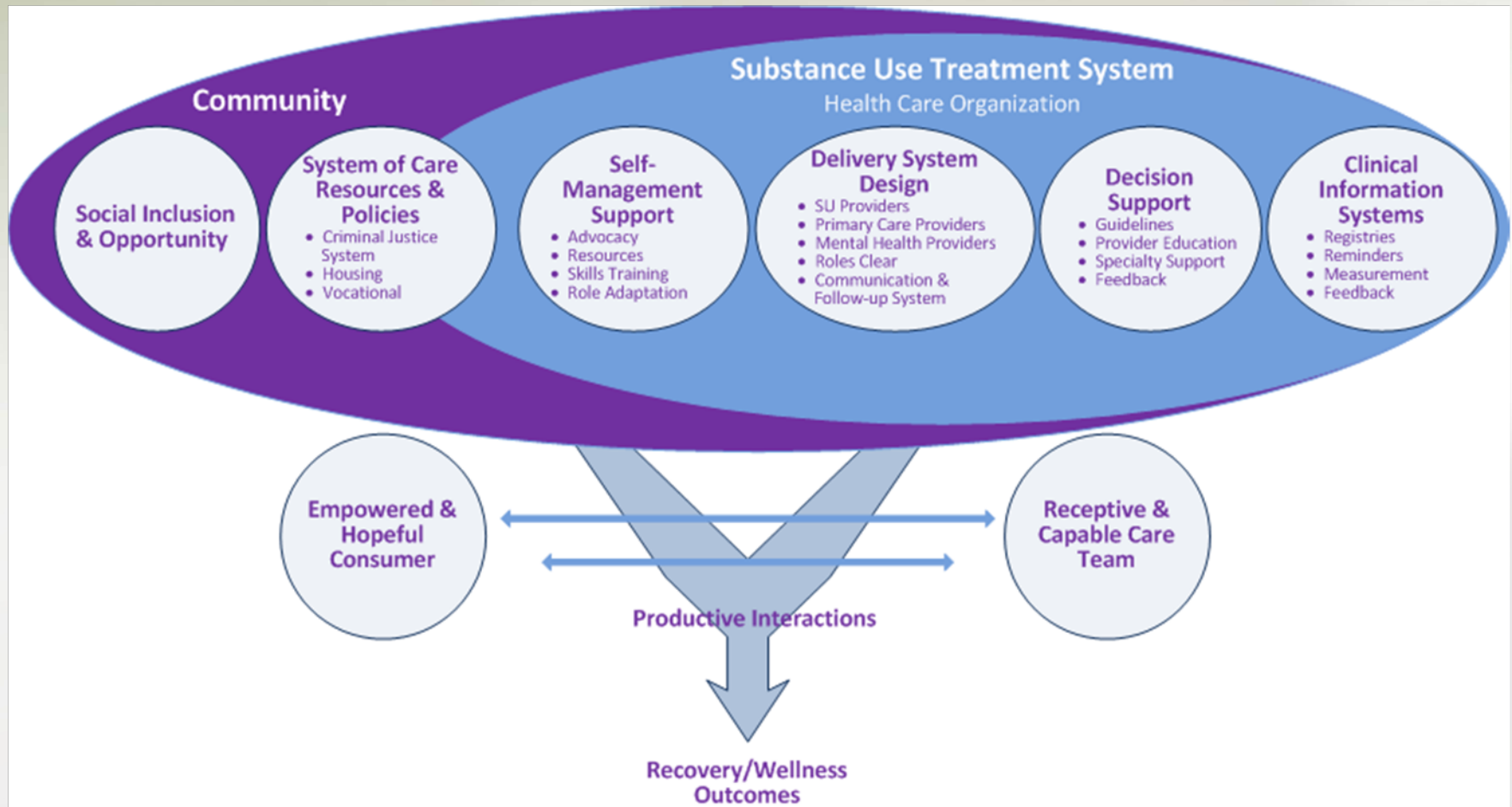
## Co-occurring Diagnoses and the GA-U Population

52 percent had substance abuse or mental illness identified

31 percent had a chronic physical condition only



# Model for Improving SU and Primary Care



# Primary Care and SU Services

- Diffusion of screening and brief intervention (SBI) is underway
- Motivational interviewing with fidelity should be a consistent component of SBI
- Repeated BI in primary care is a promising practice
- Medication-assisted therapies in primary care can be expanded

# IMPACT Collaborative Care in Primary Care

## TWO NEW 'TEAM MEMBERS'

### TWO PROCESSES

**1. Systematic diagnosis and outcomes tracking**  
e.g., PHQ-9 to facilitate diagnosis and track depression outcomes

**2. Stepped Care**

- Change treatment according to evidence-based algorithm if patient is not improving
- Relapse prevention once patient is improved

### Care Manager/BHC

- Patient education / self management support
- Close follow-up to make sure pts don't 'fall through the cracks'
- Support medication Rx by PCP
- Brief counseling (behavioral activation, PST-PC, CBT, IPT)
- Facilitate treatment change / referral to mental health
- Relapse prevention

### Consulting Mental Health Expert

- Caseload consultation for care manager and PCP (population-based)
- Diagnostic consultation on difficult cases
- Consultation focused on patients not improving as expected
- Recommendations for additional treatment / referral according to evidence-based guidelines

# The Person-Centered Healthcare Home: Q I and III

## Q I

- PCP (with standard screening tools and SU practice guidelines for medication-assisted therapy)
- PCP-based BHC/care manager (MH and SU competent)
- Specialty prescribing consultation
- Wellness programming
- Crisis/ED based SU interventions
- Other community supports

## Q III

- PCP (with screening tools/guidelines)
- PCP-based BHC/care manager (MH and SU competent)
- Specialty medical/surgical-based BHC/care manager
- Specialty prescribing consultation
- ED based SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

# The Person-Centered Healthcare Home: Q I and III

- Incorporate the lessons of the IMPACT model, explicitly building into the medical home the care manager/ behavioral health consultant (MH and SU competent) and consulting prescriber functions that have proven effective in the IMPACT model
  - DIAMOND project in MN—monthly case rate payments for covering these components in primary care practices, all major payors participating
- All healthcare is local—working out the details of who does what, for what levels of MH/SU services (Intermountain model), has to engage local partnerships—the California IPI Continuum is a guide for these dialogues  
<http://www.cimh.org/Services/Special-Projects/Primary-Care/Initiative-Feedback.aspx>

# California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative

## The IPI Continuum:

### A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population<sup>1</sup>

(This Continuum details the vertical MH/SU axis of the 4Q Model and does not attempt to span the horizontal axis, which considers the range of general healthcare services from prevention/health promotion to specialty medical/surgical and inpatient services. The supportive services and systems in the community are also not detailed here, however it is anticipated that development of a locally specific IPI Continuum would describe these as a part of defining seamless services.)

	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
<b>Characteristics of the population with MH/SU needs to be served in each level—for all ages (children, youth, adults, older adults)</b>	<ul style="list-style-type: none"> <li>No comorbidities</li> <li>Family/community supports OR</li> <li>Need for health behavior change related to medical presentation (e.g., sleep disorder, pain), chronic medical conditions (e.g., cardiovascular, diabetes), developmental/parenting concern</li> </ul>	<ul style="list-style-type: none"> <li>Medical comorbidity, including pain, or MH/SU comorbidity, and/or</li> <li>Isolated or chaotic family/community environment</li> </ul>	<ul style="list-style-type: none"> <li>Multiple, complex medical, MH/SU comorbidities, and/or</li> <li>Isolated or chaotic family/community environment, and/or</li> <li>Previous treatment ineffective</li> </ul>	<ul style="list-style-type: none"> <li>Adults 18 years and over, with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate (NIMH). (<i>In CA, referred to as Serious and Persistent</i>)</li> </ul>
	<ul style="list-style-type: none"> <li>Standardized assessment tool<sup>12</sup> indicates mild to moderate symptoms or developmental concern</li> </ul>	<ul style="list-style-type: none"> <li>Standardized assessment tool<sup>12</sup> indicates moderate to severe symptoms and their impact on functioning</li> </ul>	<ul style="list-style-type: none"> <li>Standardized assessment tool<sup>12</sup> indicates severe symptoms and their impact on functioning</li> </ul>	<ul style="list-style-type: none"> <li>Individuals with SU disorders that require ASAM Level III or IV services</li> </ul>
	<ul style="list-style-type: none"> <li>Diagnostic examples include V-codes, mild depression, mild anxiety, sleep disorder, somatic disorder, SU disorder</li> </ul>	<ul style="list-style-type: none"> <li>Diagnostic examples include moderate depression, moderate anxiety (including PTSD), sleep disorder, somatic disorder, SU disorder (abuse)</li> </ul>	<ul style="list-style-type: none"> <li>Diagnostic examples include severe depression, severe anxiety (including PTSD), schizophrenia, bipolar disorder, schizoaffective disorder, personality disorders, SU disorder (abuse/dependence)</li> </ul>	<ul style="list-style-type: none"> <li>Diagnostic examples include schizophrenia, schizoaffective disorder, bipolar disorder, SU disorder (abuse/dependence)</li> </ul>

# Focus: Quadrants II and IV

## Kaiser: Primary Care in SU Program

- Kaiser tracked a subgroup of patients with Substance Abuse-Related Medical Conditions (SAMCs)
  - Included depression, injury and poisonings/overdoses, anxiety and nervous disorders, hypertension, asthma, psychoses, acid-peptic disorders, ischemic heart disease, pneumonia, chronic obstructive pulmonary disease, cirrhosis, hepatitis C, disease of the pancreas, alcoholic gastritis, toxic effects of alcohol, alcoholic neuropathy, alcoholic cardiomyopathy, excess blood alcohol level, and prenatal alcohol and drug dependence
- SAMC integrated care patients had significantly higher abstinence rates than SAMC independent care patients
- SAMC integrated care patients demonstrated a significant decrease in inpatient rates and average medical costs (excluding addiction treatment) decreased from \$470.39 pmpm to \$226.86 pmpm.

# Primary Care in SU Settings

- Many individuals served in specialty SU have no PCP
- Health evaluation and linkage to healthcare can improve SU status
- On-site services are stronger than referral to services
- Housing First settings can wrap-around MH, SU and primary care by mobile teams
- Person-centered healthcare homes can be developed through partnerships between SU providers and primary care providers
- Care management is a part of SU specialty treatment and the healthcare home

# The Person-Centered Healthcare Home for People with SU Conditions

- For SU providers envisioning a future role as person-centered healthcare homes, there are two pathways to follow:
  - Providers who want to become full scope person-centered healthcare homes for people with SU conditions should seek to serve a broader community population as well as those receiving SU services
  - Providers who want to partner with full scope primary care organizations to create person-centered healthcare homes for individuals with SU conditions should organize on-site NP/PCP, collaborative care, care management, a designated PCP consultant, outcome measurement, and stepped care for primary care needs in SU settings

# The Person-Centered Healthcare Home for People with SU Conditions: Partnership

1. Assure regular screening and registry tracking/outcome measurement
2. Locate medical NP/PCPs in SU clinics—provide routine primary care services in the SU setting via staff out-stationed under the auspices of a full scope person-centered healthcare home  
SU organization hiring a nurse practitioner directly, without the backup of a skilled PCP and a full scope healthcare home cannot be described as providing a healthcare home, and is not a recommended pathway
3. Identify a primary care supervising physician within the full scope healthcare home to provide consultation on complex health issues
4. Assign nurse care managers to support individuals with chronic health conditions (e.g., HIV, Hepatitis C, hypertension, asthma, chronic obstructive pulmonary disease)
5. Use evidence-based preventive care practices, adapting these practices for use in the SU system
6. Create wellness programs

# The Person-Centered Healthcare

## Home: Q II and IV

### Q II

- Outstationed medical NP/PCP
- SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient SU treatment including medication-assisted therapy
- Residential SU treatment
- Crisis/ED based SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

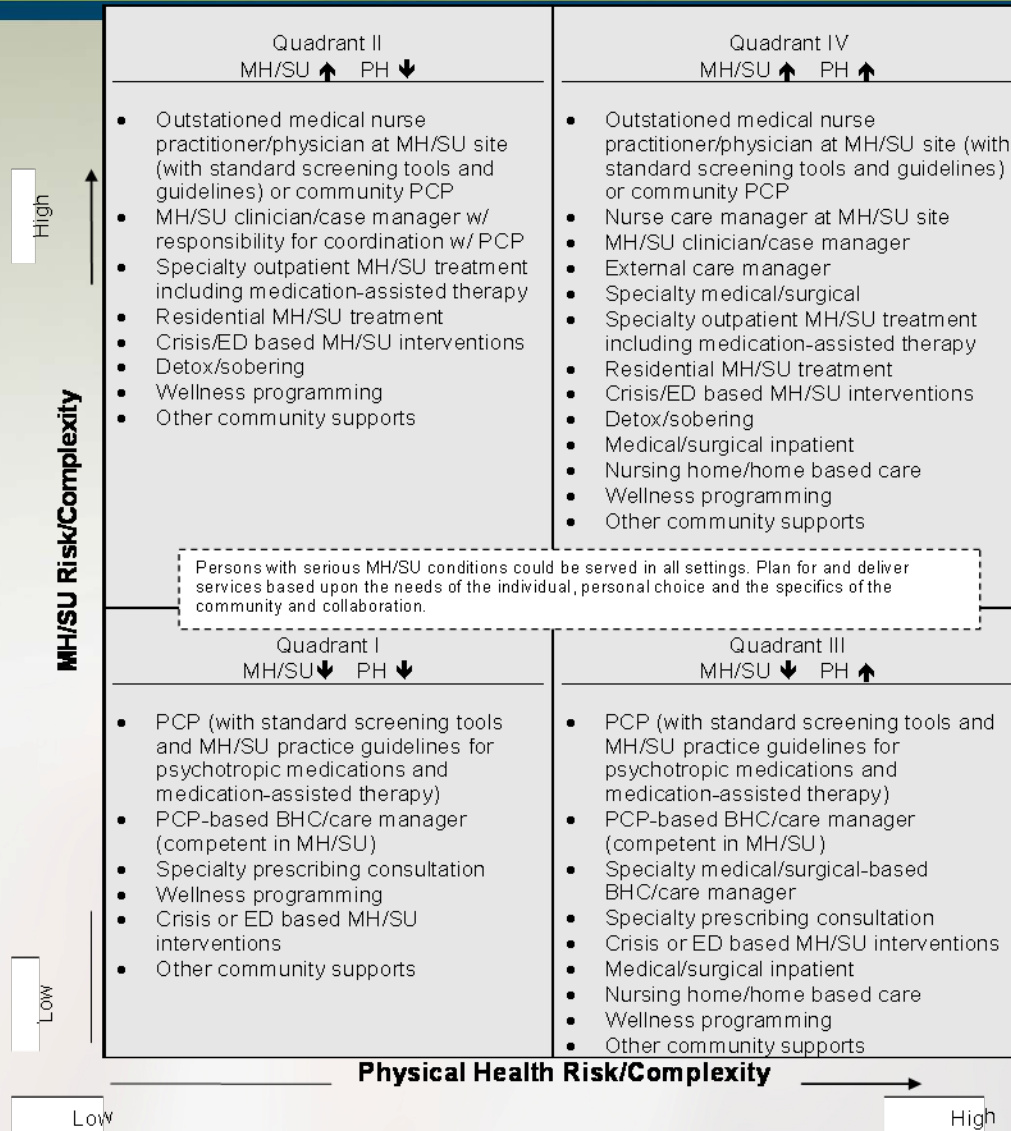
### Q IV

- Outstationed medical NP/PCP
- Nurse care manager/SU site
- SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient SU treatment
- Residential SU treatment
- Detox/sobering
- Crisis/ED based SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

# SU Providers Need to Rethink their Service Approaches

- Infrastructure development and process improvement are necessary
- Continuing care should link the continuum of services together and support the individual's change process
- NIDA principles provide the overall foundation
- Recovery Oriented Systems of Care support recovery as a process
- Motivational Enhancement Therapy or the Transtheoretical Model are effective, but must be delivered with fidelity
- Other approaches, including medication-assisted therapy are also effective
- Communities must work together to create a continuum of services and agreements about seamless access, stepped care and other transitions

# The Four Quadrant Clinical Integration Model (MH/SU)



# New National Council Resource

## Substance Use Disorders and the Person-Centered Healthcare Home

- Paper available at National Council Resource Center for Primary Care and Behavioral Health Collaboration
- [http://www.thenationalcouncil.org/cs/new\\_at\\_the\\_resource\\_center](http://www.thenationalcouncil.org/cs/new_at_the_resource_center)

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