Primary Care, Mental Health, and Substance Use Integration
A Webinar Series Sponsored by:

California Institute of Mental Health
Alcohol and Drug Policy Institute
Integrated Behavioral Health Project

Addressing Substance Use Issues in Primary Care: SBIRT and Emerging Opportunities

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Center for Integrated Behavioral Health Policy
Department of Health Policy, The George Washington University Medical Center

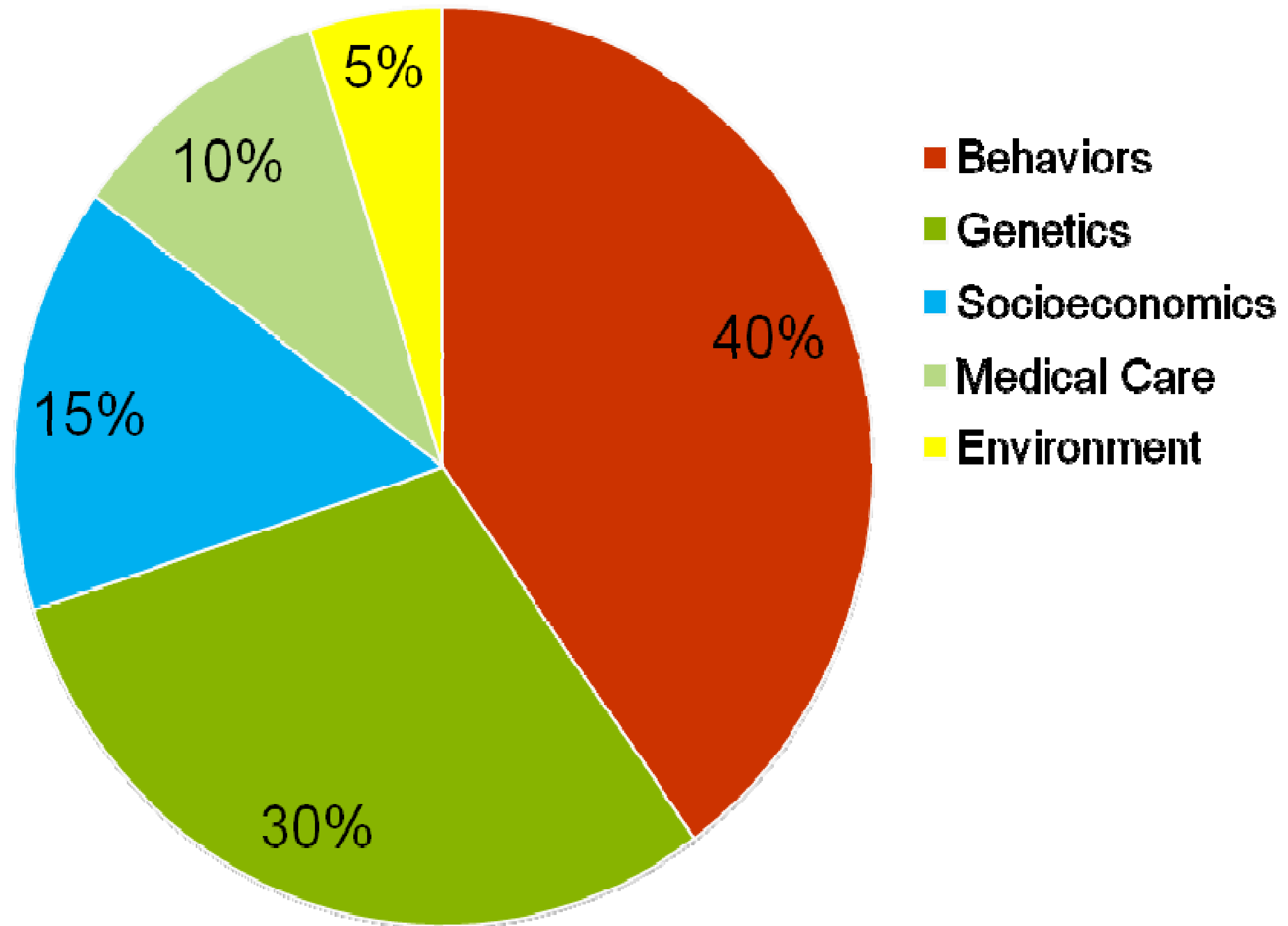
Integrating Substance Abuse Screening and Treatment into the Patient-Centered Medical Home

Eric Goplerud, Ph.D.
April 13, 2010

It’s important that SUD be addressed in PCMH

- Prevalence of SUD in Primary Care
- Unmet SUD Treatment Needs in Primary Care
- Cost of Unmet SUD
- Effective Screening & Treatment Models, but not Frequently Done
- Lower cost, Better Health when SUD Treated
- Patients and Providers like integrated care

Causes of Premature Mortality: Why People Die Early



1. McGinnis JM, Foege WH. Actual Causes of Death in the United States. JAMA 1993;270:2207-12.
2. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA 2004;291:1230-1245.

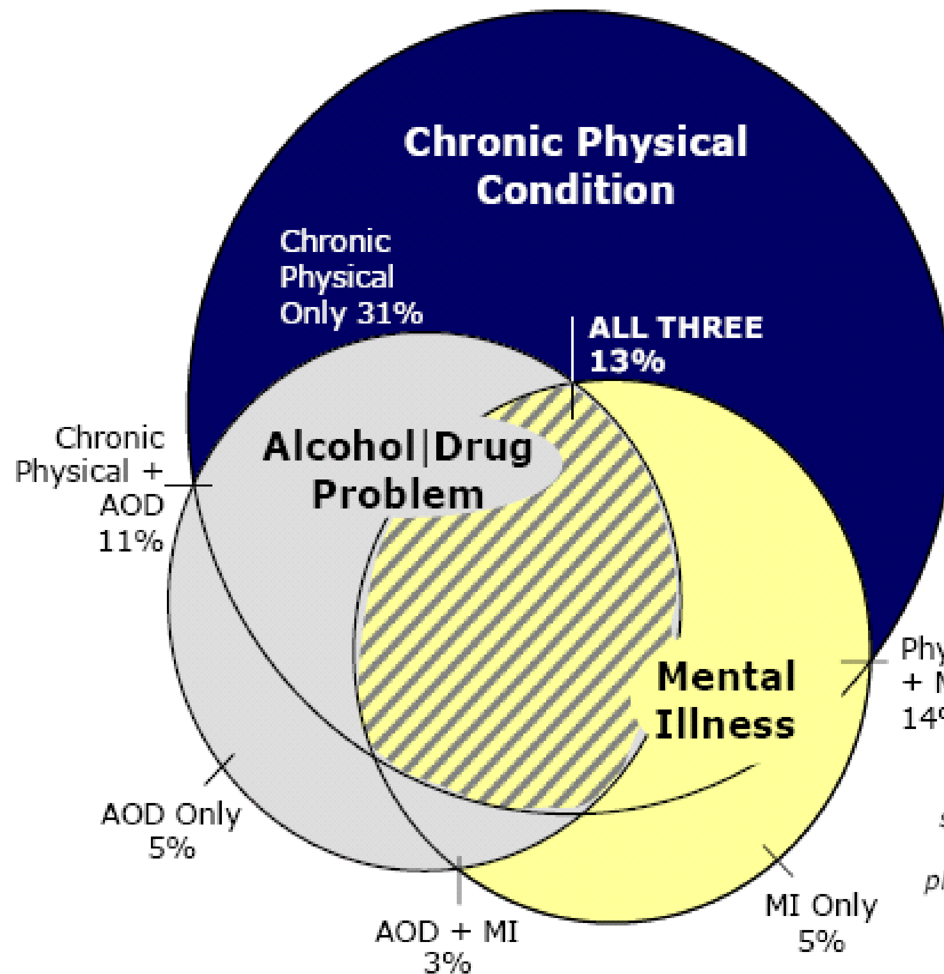
Co-morbidity ought to be expected: Washington State GA-U Project

(General Assistance Unemployable)

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



PRIMARY CONDITIONS

Chronic Physical	**69%**
Mental Illness	**36%**
Substance Abuse	**32%**

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper

*DSHS | **GA-U Clients: Challenges and Opportunities August 2006***

What drugs? Past month <u>use</u>

(millions of persons age 12+, US)

• Marijuana:	14.8
• All other drugs:	9.6
• Psychotherapeutics:	7.0
• Pain relievers:	5.2
• Cocaine:	2.4
• Methamphetamine:	0.7
• Heroin:	0.3
• Oxycontin:	0.3
Alcohol:	140

Source: NSDUH

12-Month and Lifetime Prevalence Rates - US

- Alcohol dependence
  - – 12 Mo: 4.3%
  - – Lifetime: 12%
  - – Annual mortality: 85,000

- Other (non-nicotine) drug dependence
  - – 12 Mo: 0.6%
  - – Lifetime: 2.7%
  - – Annual mortality: 17,000

Hasin et al., 2007; Compton et al., 2007

The Substance Use Cost Calculator

- www.alcoholcostcalculator.org\
- Computes the costs of untreated alcohol, drug and prescription opioid problems to companies, Medicaid and uninsured
- Identifies steps that employers and public sector can take
- No cost, anonymous
- Research-based, using 2005-2008 National Survey on Drug Use and Health epidemiology data with more than 210,000 respondents
- Endorsed and used by businesses, business groups and states

Ensuring Solutions to Alcohol Problems

The Substance Use Disorder Calculator

EMPLOYED & INSURED | MEDICAID & UNINSURED

ALCOHOL COST CALCULATOR

- Alcohol Use Disorders
- For Health Plans
- ▶ Substance Use Disorders
- For Kids
- About Us
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- Media Center
- Contact Us

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The Substance Use Disorder Calculator

The Substance Use Disorder Calculator is an online tool that can help you estimate the prevalence of alcohol, illicit drug, and prescription pain medication abuse or dependence in your population.

Alcohol is by far the most widely used drug in the United States: over 8% of employed adult workers and almost 11% of adults with Medicaid or no health insurance either abuse or are dependant on alcohol. Approximately 15% of Americans 12 years or older have used illegal drugs in the past year and approximately 6 million have used prescription pain medications non-medically.

By investing in substance use treatment, employers and payers can reduce their overall costs. Substance use disorders cost the nation an estimated $276 billion a year, with a significant amount of this expense resulting from lost productivity and increased health care spending.

Use this calculator to learn about the effects and costs of substance use disorders in both the workplace and in uninsured populations.

Learn about the Employed and Insured

Learn about Medicaid and Uninsured

www.alcoholcostcalculator.org

Ensuring Solutions to Alcohol Problems

The Substance Use Disorder Calculator

CONTRACTING | QUALITY | COST | PAYMENT | PARITY | RESOURCES | ABOUT

ALCOHOL COST CALCULATOR

- Alcohol Use Disorders
- For Health Plans
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Substance Use Calculator

Enter number of people.

Population: 12761544

Now:

Choose a State | **or Choose a Metropolitan Area**

Please choose the state where your population lives:

California

Calculate Now

Number could be county, sub-county

Could also do LA, SF, Riverside metro breakouts

www.alcoholcostcalculator.org

California

Population submitted: 12,761,544

Number of Individuals With a Problem

	Alcohol Abuse / Dependence	Illicit Drug Abuse / Dependence	Pain Medication Abuse / Dependence	Any Substance Abuse / Dependence Problem
Number with Problem	1,502,289	722,941	153,139	1,933,502

Total Health Care Costs

	Any Substance Abuse / Dependence Problem
Per Capita Cost	$201
Total Cost	$2,565,070,344

	Alcohol abuse/dependence Excess # w/social problem	Illicit drug abuse/dependence Excess # w/social problem	Pain Medication Abuse or Dependence	All Substance Abuse or Dependence
Serious pyschological distress	431,124	289,457	83,078	609,492
Major depressive episode (past year)	295,428	196,732	60,719	427,647
Anxiety (past year)	97,736	95,000	28,637	171,618
DUI alcohol or drugs (past year)	1,223,139	452,976	46,554	1,867,337
Ever arrested and booked	850,735	373,969	63,935	981,326

Cost Benefit of Treatment

Numerous studies have examined the costs and benefits associated with substance abuse treatment in the public sector. In order to better understand the relative contribution of medical and non-medical savings associated with substance abuse treatment, we have identified several recent, well-designed studies that estimate costs and benefits for substance abuse treatment in various public sector populations.

Medical Savings: The state of Washington recently reported that individuals receiving Social Security Insurance benefits who received substance abuse treatment services had medical, mental and nursing home costs* that were $6756 lower per year than individuals who did not receive substance abuse services. The average cost of the substance abuse services was $2660 per year. If you were able to achieve similar results in your population, here are the **yearly** costs and benefits that you could expect:

Percentage treated can be changed

Change the percentage treated here to see how this affects the amount saved:

Submit

Number of People Treated: 10% of People with a SA Problem:	*193,350*
Treatment Costs: ($2660 per person treated):	*$514,311,407*
Treatment Benefits (lowered medical, mental health and nursing home savings): ($6756 per person treated):	*$1,306,273,635*
Total Estimated Savings:	*$791,962,227*

Additional Savings: Studies completed in publicly funded substance abuse clinics in the state of Washington have also reported significant savings in employment and criminal justice costs associated with residential substance abuse treatment. A 2002 study of individuals receiving care at publicly funded substance abuse clinics found significant increases in income and reductions in legal costs following substance abuse treatment. Average six month savings associated with increases in employment and decreases in legal costs amounted to $26,144 and the average cost of treatment was $7319. If you were able to achieve similar results in your population, here are the **six month** costs and benefits you could expect:

Number of People Treated: 10% of People with a SA Problem:	*193,350*
Treatment Costs: ($7319 per person treated):	*$1,415,129,771*
Treatment Benefits (Increased employment income and decreased crime related costs): ($26144 per person treated):	*$5,054,946,404*
Total Estimated Savings:	*$3,639,816,633*

For more information on the studies presented here, and other cost-benefit studies that focus on public sector populations, see our methodology paper, here.

* All costs and savings are expressed in September, 2009 dollars.

Learn about the health care and productivity costs of untreated substance use problems

Learn about the social costs of untreated substance use problems

Identification Rates for Alcohol Use Disorders and Other Common Health Conditions

Alcohol use disorders	7% to 18%
Depression	45%
Diabetes	65%
Hypertension	70%

Unmet BH Needs in Primary Care

- 67% with a behavioral health disorder do not get behavioral health treatment[1]
- 30-50% of referrals from primary care to an outpatient behavioral health clinic don't make first appt[2,3]
- Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access[4]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Cunningham, Health Affairs. 2009; 3:w490-w501.

What we don't do that's effective!
SBI, CBT, Medications

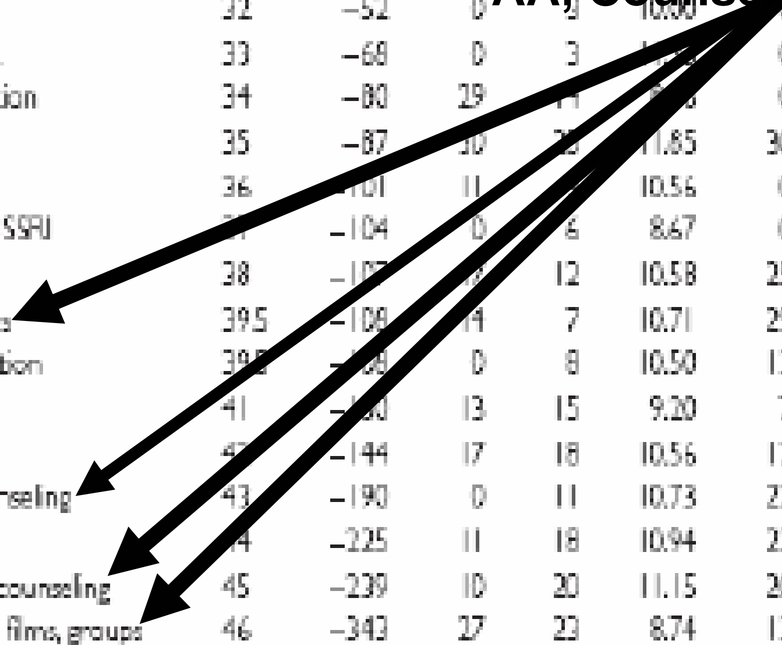
Table 3 Summary scores for treatment modalities with three or more studies.

Treatment modality	All studies, regardless of popu[illegible]							[illegible]		
	Rank order	CES	% +	[illegible]	Mean [illegible]	% MQS ≥ 14	% Clinical	Rank order	CES	% +
Brief intervention	1	280	[illegible]	31	12.68	48	48	1	136	73
Motivational enhancement	2	173	71	17	13.12	53	53	11	37	56
GABA agonist	3	116	100	5	11.60	20	100	3	116	100
Opiate antagonist	4	100	83	6	11.33	0	100	4	100	83
Social skills training	5	85	68	25	10.50	16	84	2	125	63
Community reinforcement	6	80	100	4	13.00	50	80	5	68	100
Behavior contracting	7	64	80	5	10.40	0	100	6	64	80
Behavioral marital therapy	8	60	62	8	12.88	50	100	7.5	60	63
Case management	9	33	67	6	10.20	0	100	7.5	60	67
Self-monitoring	10	25	50	6	12.00	50	83	18	–3	40
Cognitive therapy	11	21	40	10	10.00	10	88	9	41	50
Client-centered counseling	12.5	20	57	7	10.57	0	86	13	28	67
Disulfiram	12.5	20	50	24	10.75	17	100	10	38	50
aversion therapy, apneic	14.5	18	67	3	9.67	0	100	15.5	18	67
Covert sensitization	14.5	18	38	8	10.88	0	100	15.5	18	38
Acupuncture	16.5	14	67	3	9.67	0	100	17	14	67
Aversion therapy, nausea	16.5	14	40	5	10.40	20	100	14	20	40
Self-help	18	11	40	5	12.00	30	60	12	33	67
Self-control training	19	9	49	35	12.80	51	63	20	–8	45

Miller & Hester, Mesa Grande, 2006

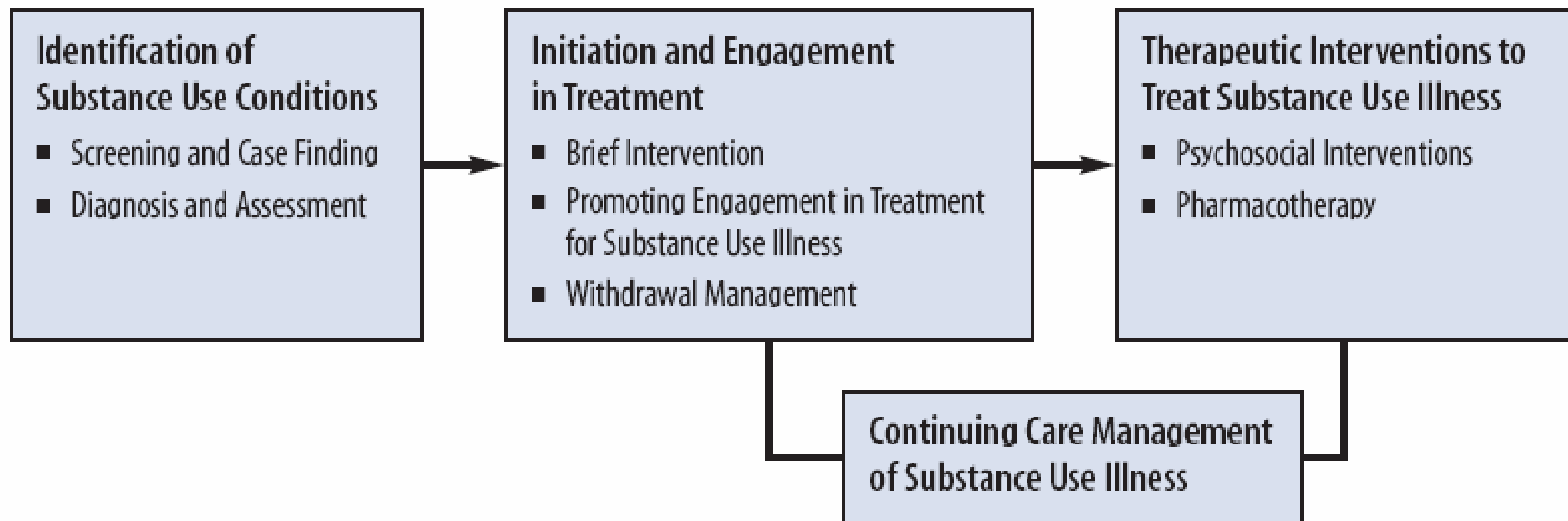
Treatment modality	All studies, regardless of population severity						Clinical populations only			
	Rank order	CES	% +	N	Mean MQS	% MQS ≥ 14	% Clinical	Rank order	CES	% +
Minnesota model	20.5	−3	33	3	11.33	33	33	25	−22	0
Exercise	20.5	−3	33	3	11.00	0	33	21	−11	0
Stress management	22	−4	33	3	10.33	0	66	25	−22	0
Family therapy	23	−5	33	3	9.30	15	100	19	−5	33
Aversion therapy, electric	24.5	−13	40	20	10.55	67	100	22.5	−13	40
Twelve-Step facilitation	24.5	−13	33	3	15.67	0	100	22.5	−13	33
Antidepressant, SSRI	26	−16	53	15	8.60	0	53	25	−22	50
Lithium	27	−32	43	7	11.43	29	100	28	−32	43
Marital therapy, other	28	−33	38	8	12.25	25	100	29	−33	38
Functional analysis	29	−36	0	3	12.00	33	66	27	−24	0
Hypnosis	30	−41	0	4	10.25	0	100	[illegible]	−41	0
Psychedelic medication	31	−44	25	8	10.12	0	100	31	−44	25
Calcium carbimide	32	−52	0	3	10.00	[illegible]	100	33	−52	0
Serotonin antagonist	33	−68	0	3	[illegible]	0	66	32	−46	0
Anti-anxiety medication	34	−80	29	[illegible]	[illegible]	0	100	35.5	−80	29
Relapse prevention	35	−87	30	[illegible]	11.65	30	85	34	−62	29
Metronidazole	36	−101	11	[illegible]	10.56	0	100	37.5	−82	11
Antidepressant, non-SSRI	[illegible]	−104	0	6	8.67	0	100	41	−104	0
Milieu therapy	38	−107	[illegible]	12	10.58	25	100	42	−107	17
Alcoholic anonymous	39.5	−108	14	7	10.71	29	86	35.5	−80	14
Video self-confrontation	39.5	−108	0	8	10.50	13	88	39	−84	0
Standard treatment	41	[illegible]	13	15	9.20	7	87	43	−111	10
Relaxation training	[illegible]	−144	17	18	10.56	17	66	40	−98	17
Confrontational counseling	43	−190	0	11	10.73	27	73	37.5	−129	0
Psychotherapy	[illegible]	−225	11	18	10.94	22	88	45	−185	13
General alcoholism counseling	45	−239	10	20	11.15	20	85	46	−211	6
Educational lectures, films, groups	46	−343	27	23	8.74	13	38	44	−161	0

What do we really do? What doesn't work!
AA, Counseling, Educational Lectures



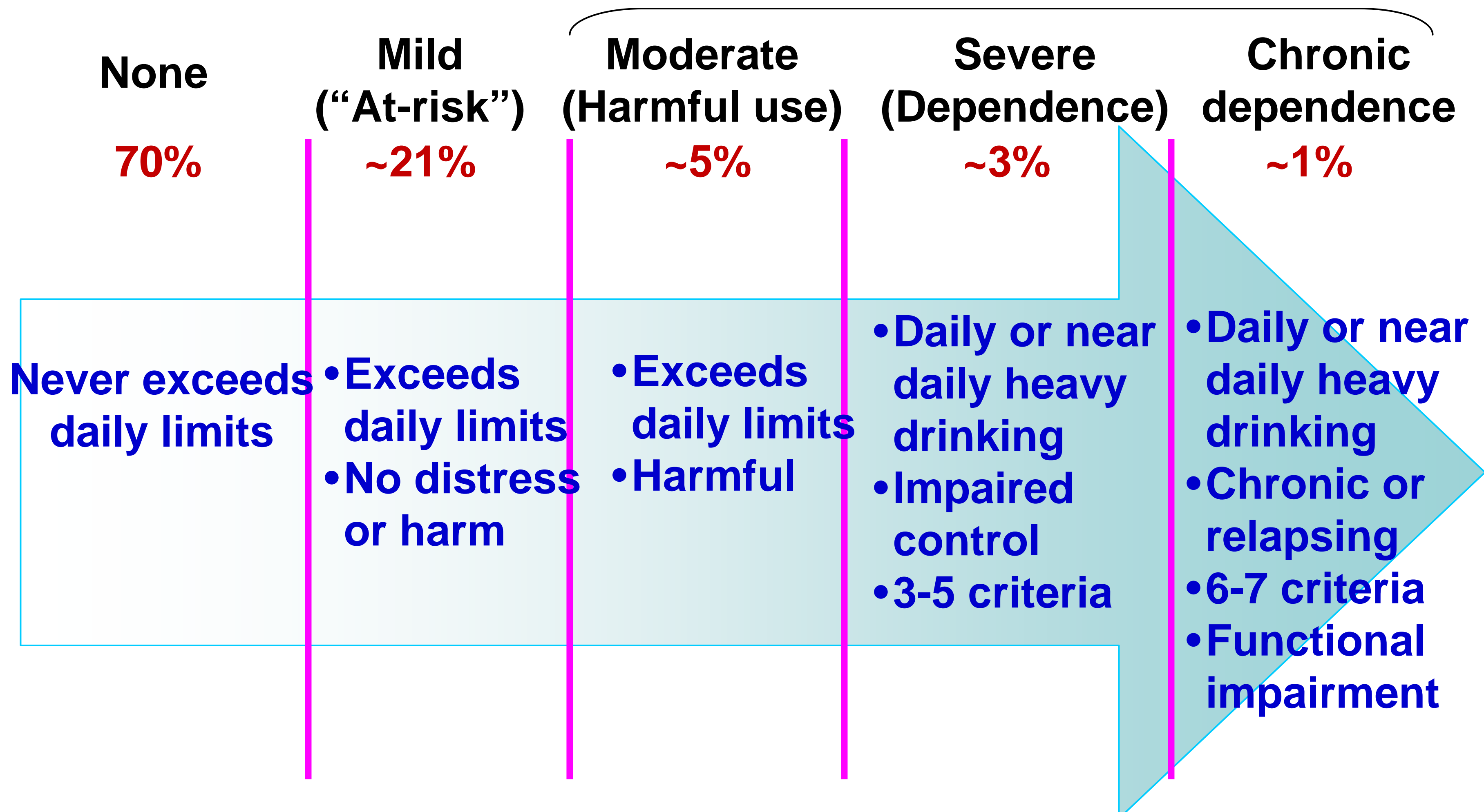
Evidence-Based Practices to Treat Substance Use Conditions:

National Quality Forum Consensus Standards (2007)

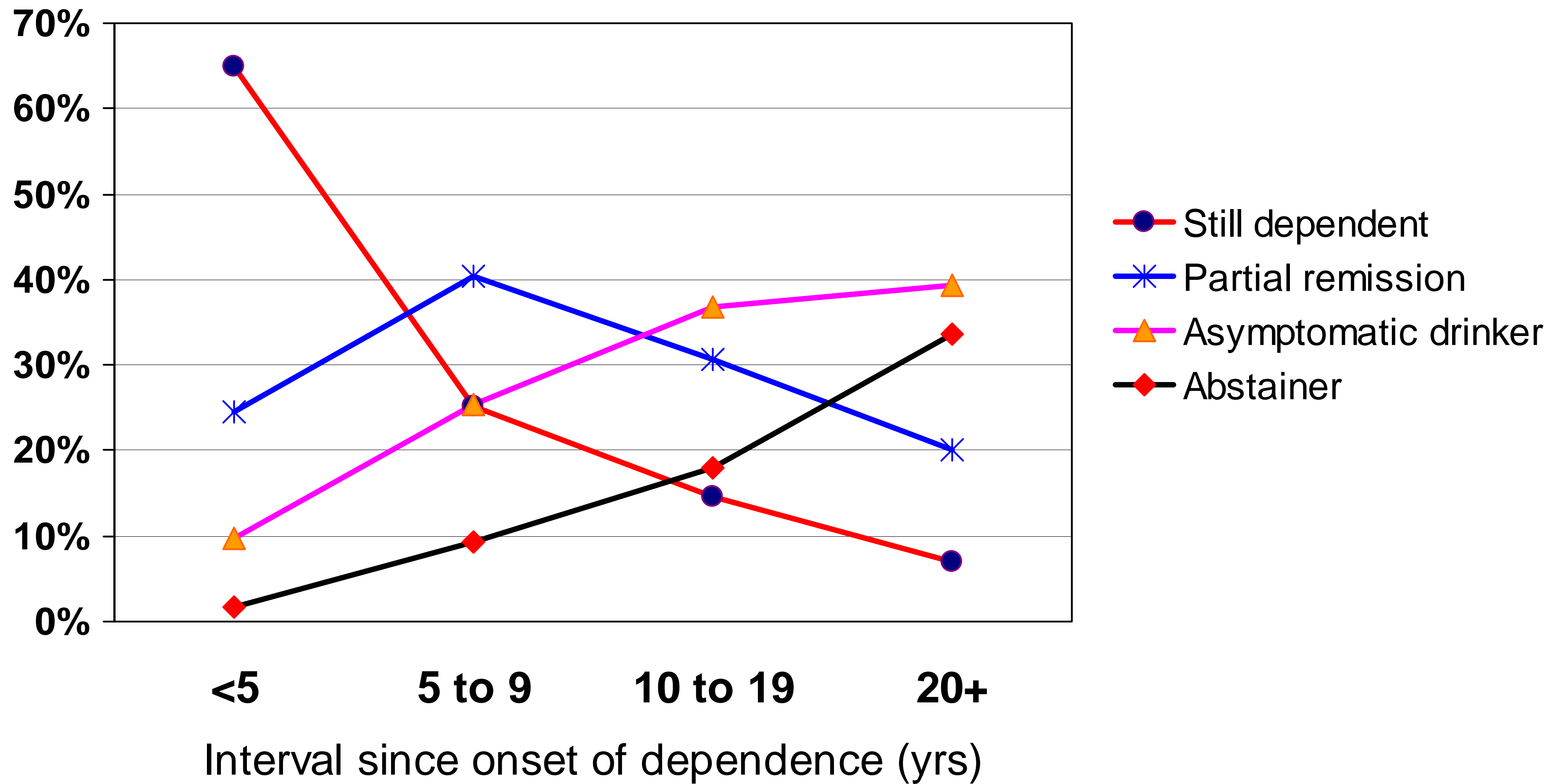


NQF
National Quality Forum

Heterogeneity of Alcohol Use: Diagnosis

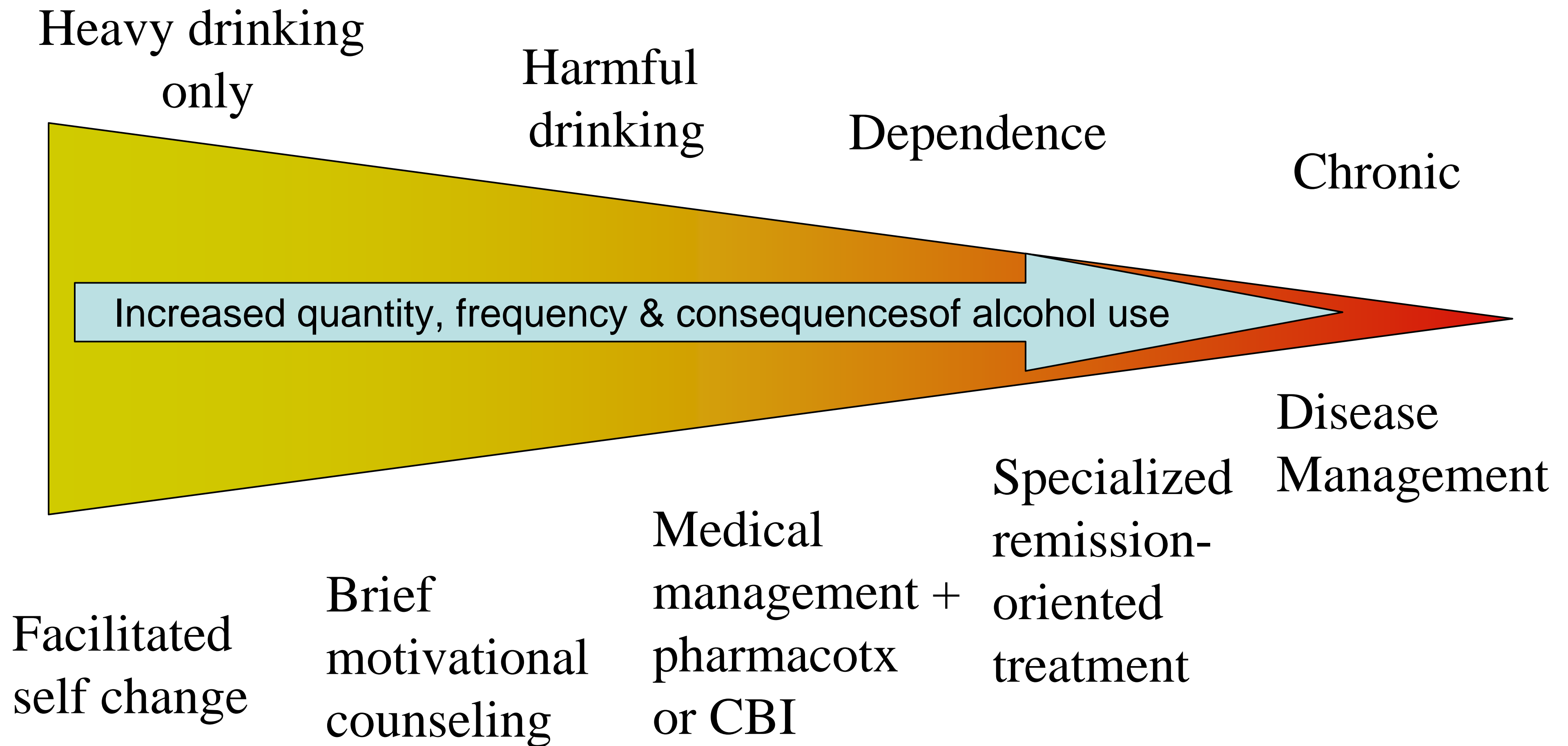


Many people with SUDs remit spontaneously



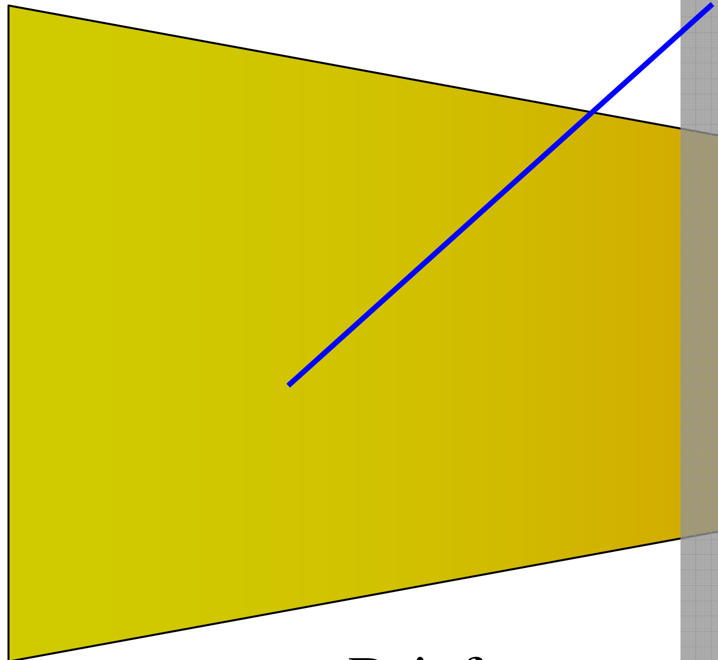
NESARC, 2003

Extended Continuum



Willenbring, 2009

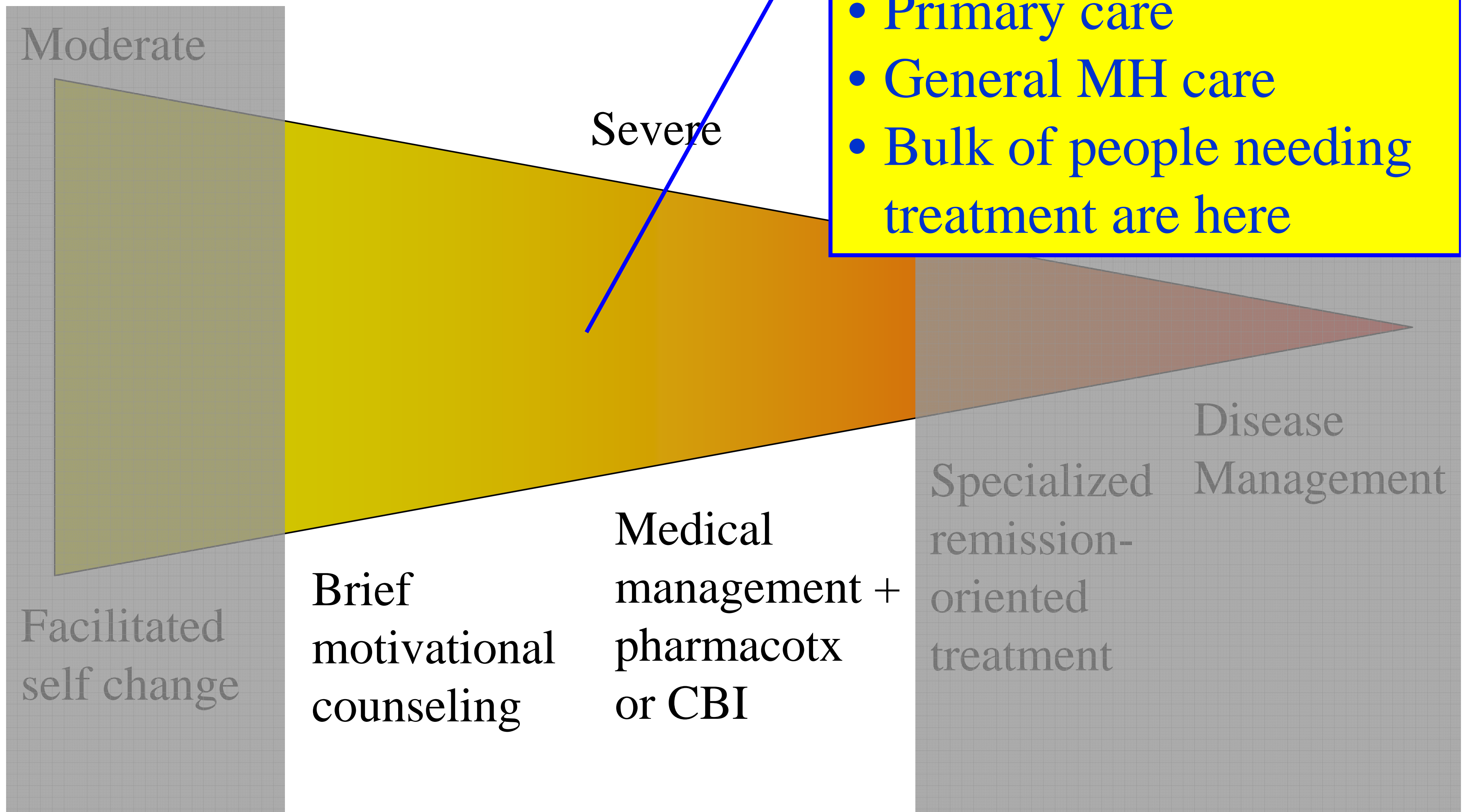
The extended continuum



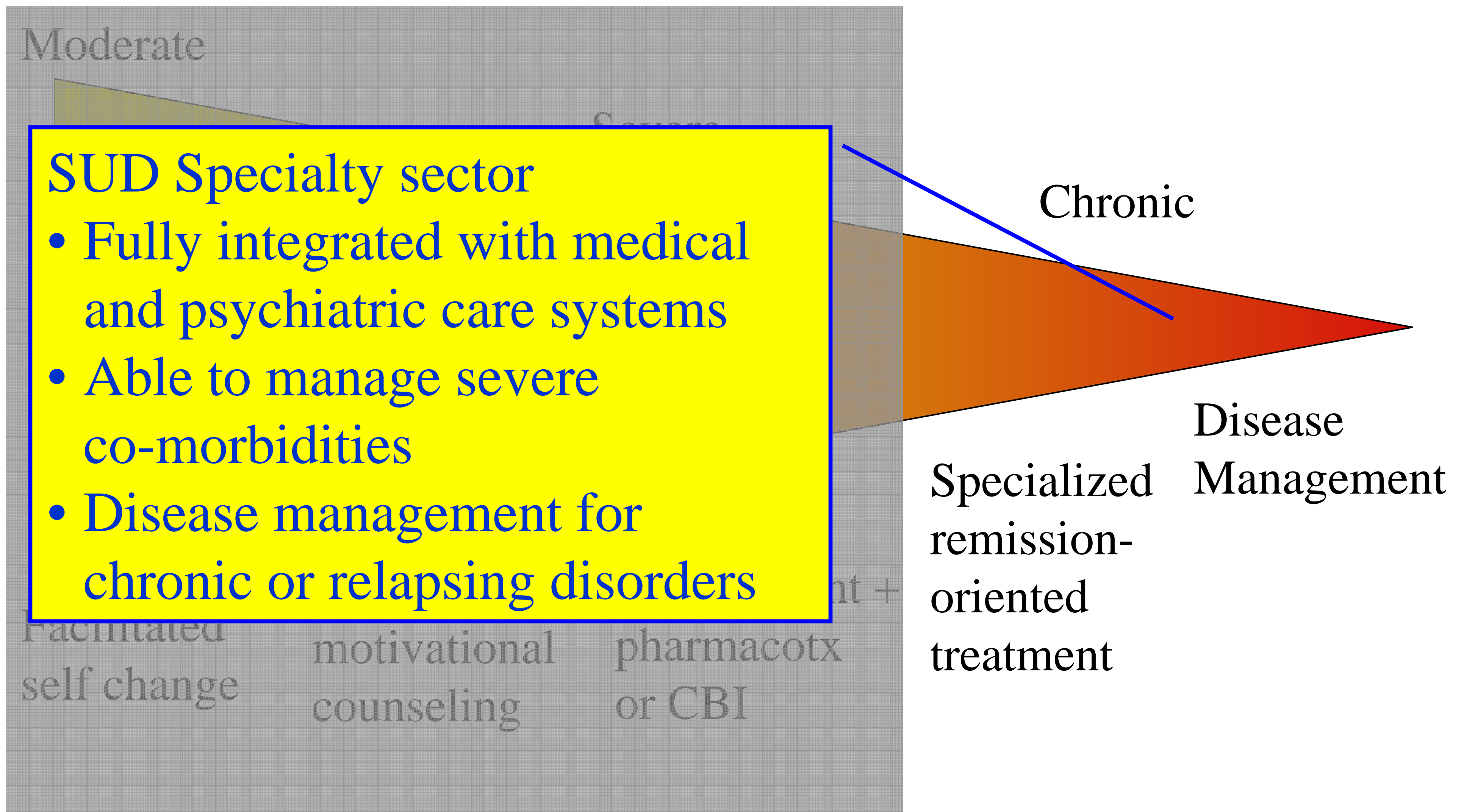
Widespread availability
- Internet
- Toll-free telephones (QUIT lines)
- EAP & occupational health
- Schools & workplaces
- Primary care, hospital emergency departments
- Criminal justice system

or CBI

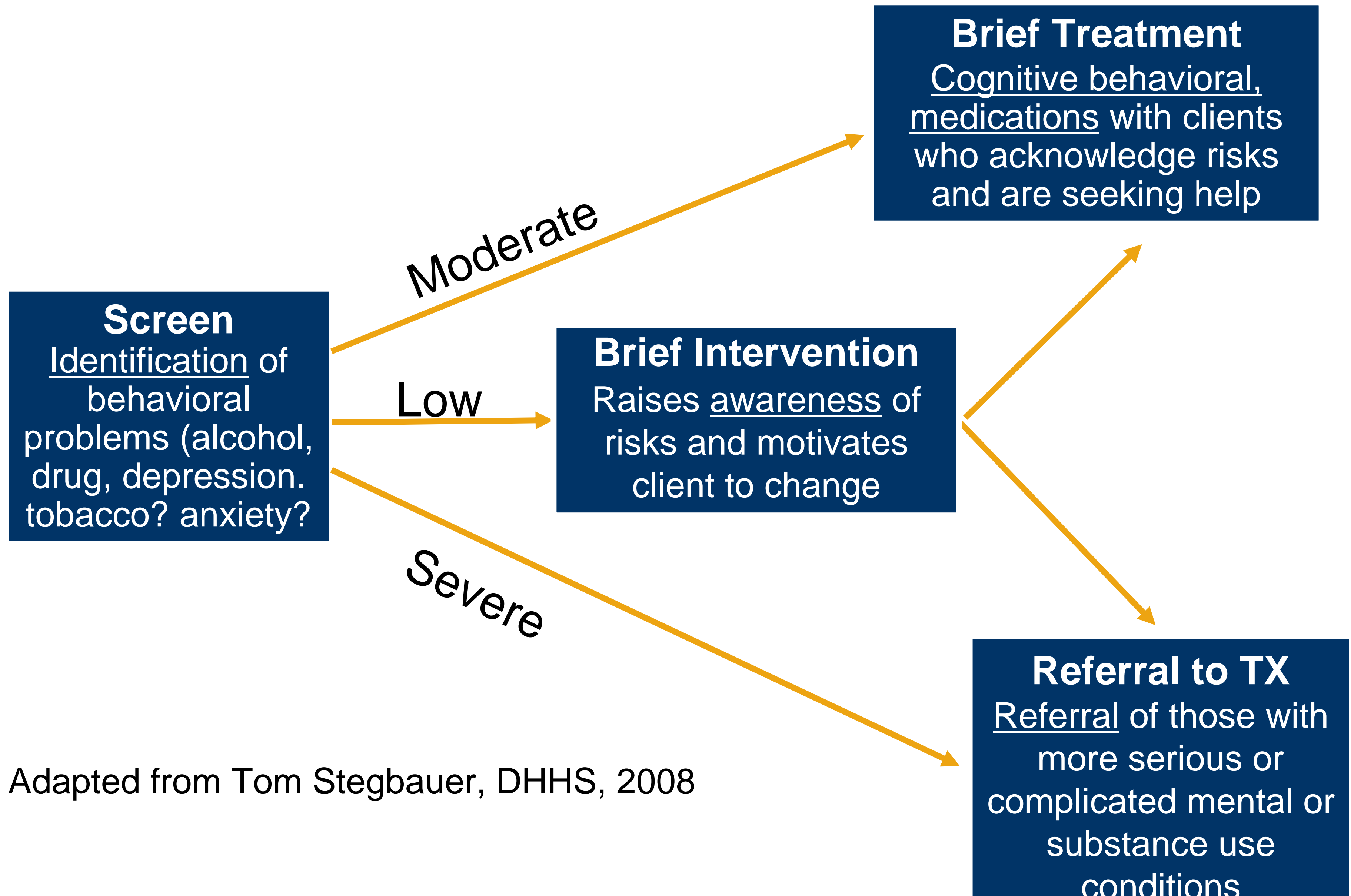
The extended continuum



The extended continuum



SBIRT Core Components



Adapted from Tom Stegbauer, DHHS, 2008

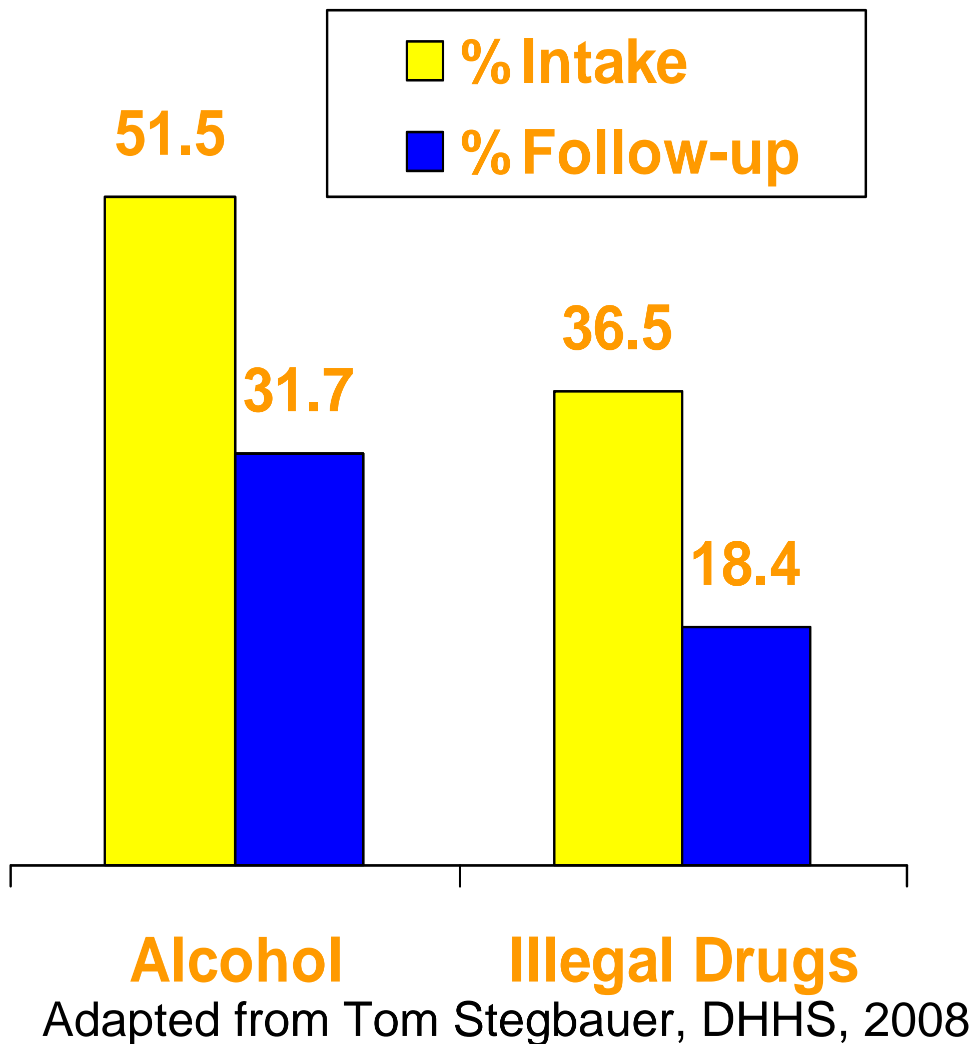
Federal SBIRT Demonstration Program Accomplishments

Area	As of 3/27/08	Percentage
Received Screen	638,576	100.0
Screened Negative	491,598	77.0
Brief Intervention	104,026	16.3
Brief Treatment	19,707	3.1
Referral to Treatment	23,245	3.6

N = 11 states

Adapted from Tom Stegbauer, DHHS, 2008

SBIRT Program Accomplishments

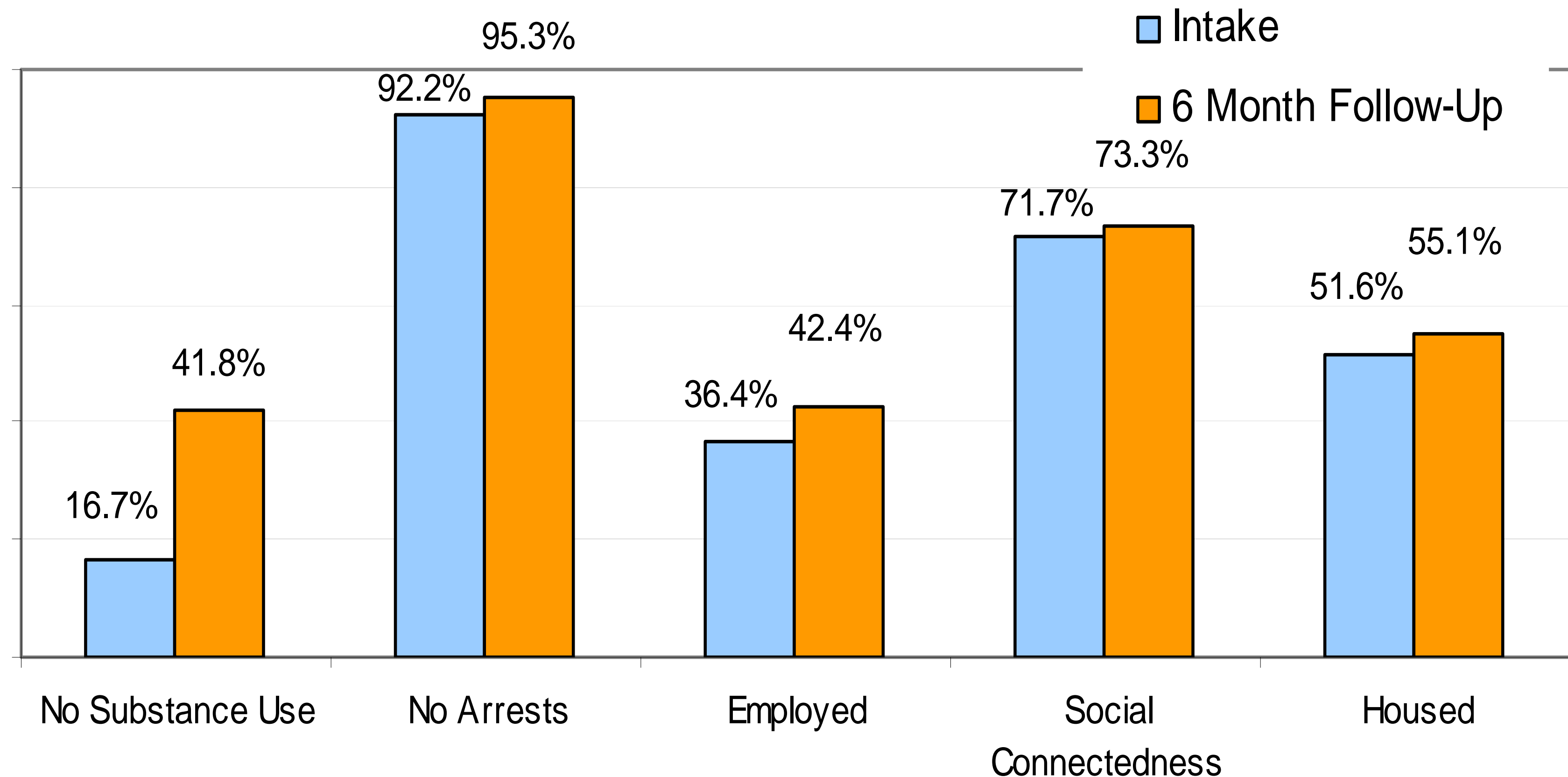


Adapted from Tom Stegbauer, DHHS, 2008

- Alcohol use to level of intoxication (5+ drinks) declined 38.4%
- Use of any illegal drugs decreased 49.6%
- Nearly 50% of those who received a brief intervention changed their patterns of misuse

N = 11 States

SBIRT Program Accomplishments



Adapted from Tom Stegbauer, DHHS, 2008

N = 11 States

Washington SBIRT Findings

- Reduction of $2.7 million per year assuming:
  - 22,000 patients per year in the same 9 hospitals
  - 1,200 Medicaid disabled clients who would receive at least a brief intervention
- Overall reduction in costs due to:
  - Fewer days of hospitalizations from ED admissions
  - Effects for injured patients (about -$500 PM/PM)
  - Effects for patients who get at least a BI but had no alcohol or drug treatment in past year

Brief interventions by health care professionals are effective

- Average reduction in drinking of 25% after one year
- Very brief (5”) intervention is effective in primary care settings
- Equally effective for men and women
- Use empathic, non-judgmental approach (e.g. FRAMES, 5A’s)
- USPFTF recommendation for adults

Ballosteros et al., ACER 28: 608-618, 2004

Ask

AUDIT-C: http://www.hepatitis.va.gov/vahep?page=prtop03-audit_c

Inform

Drinking guidelines: http://www.alcoholscreening.org/learnmore/consumption.asp

Motivate

Brief Negotiated Interview:
http://www.ensuringsolutions.org/usr_doc/BNI_Steps.pdf

RETHINKING DRINKING

Alcohol and your health

Search

HOW MUCH IS TOO MUCH?

- What counts as a drink?
- Is your drinking pattern risky?
  - What's your pattern?
  - What's "low-risk" drinking?
  - What's "at-risk" or "heavy" drinking?
- What's the harm?

THINKING ABOUT A CHANGE?

- It's up to you
- Strategies for cutting down
- Support for quitting
- Tools & resources

QUESTIONS?

- Q & As

TAKE IT with you

Home >

What's your pattern?

Answer these questions, then select "Click for feedback" to find out how your drinking pattern compares to those of other U.S. adults.

1. On **any day** in the past year, have you ever had
   - For MEN: more than 4 "standard" drinks? yes ○ no ○
   - For WOMEN: more than 3 "standard" drinks? yes ○ no ○
2. Think about your **typical week:**
   - On average, how many **days** per **week** do you drink alcohol? ☐
   - On a typical drinking day, how many **drinks** do you have? ☐

Click for feedback >>

This Web site does not collect or store any entries, email addresses, or information that would allow visitors to be personally identified. For details, see our Privacy statement.

<< Previous　　　Next >>

http://rethinkingdrinking.niaaa.nih.gov/IsYourDrinkingPatternRisky/WhatsYourPattern.asp

Brief Intervention In the "Real World" of Primary Care

REALSBIRT

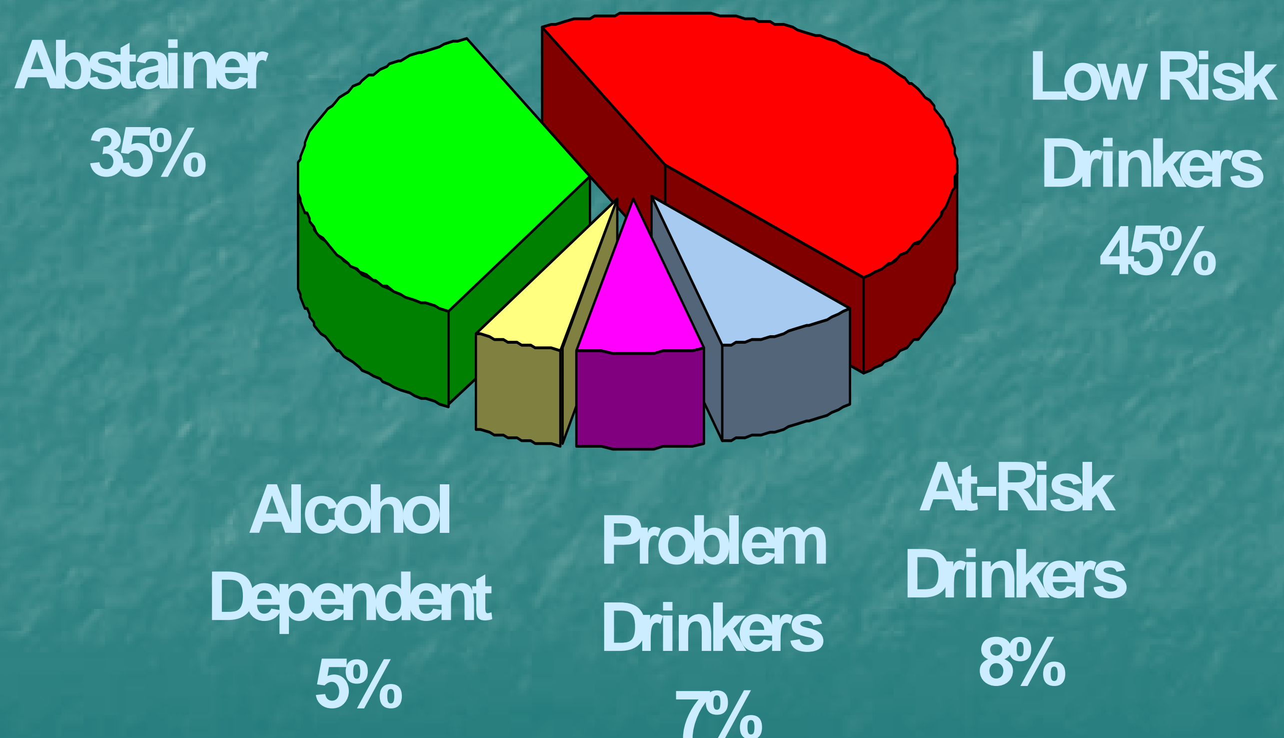
David Pating, MD
Kaiser, San Francisco
Assistant Clinical Professor, UCSF

Welcome to California… the Land of Prevention and Opportunity.

Rationale for Primary Care Screening

20% of Primary Care Patients At-Risk for Alcohol Use Problems.

80% of At-Risk, Problem or Dependent Drinkers seen only by Primary Care



(CSAT, TIP 24, 1997)

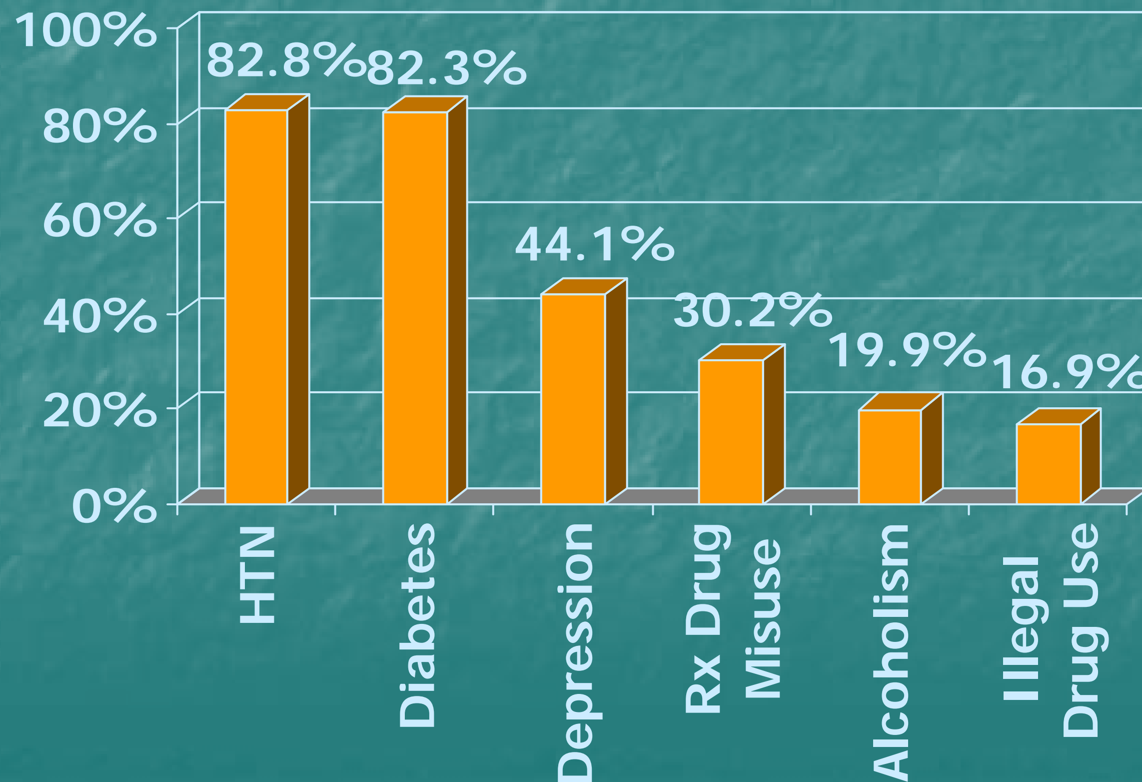
CASA 2000: Primary Care Alert

- Less than one-third of Primary Care Physicians (32.1 percent) carefully screen for substance abuse.

Center on Addiction and Substance Abuse (CASA) at Columbia University
N=648 physicians; 498 patients (CASA, 2000)

CASA 2000: Primary Care Alert

- Only 20% Primary Care Physicians feel "very prepared" to diagnose substance abuse



What Patients Say

- "Doctor's should ask about Substance Abuse…but Don't!"

Tobacco Cessation

Success: 90% physicians ask about Smoking !

Why?

Q: Yes/No

Why Physicians don't screen?

- Lack of adequate training in medical school.
- Skepticism about treatment effectiveness
- Patient resistance
- Discomfort discussing substance abuse
- Time Constraints
- Fear of Losing Patients
- Lack of Insurance Coverage
- Etc. (CASA, 2000)

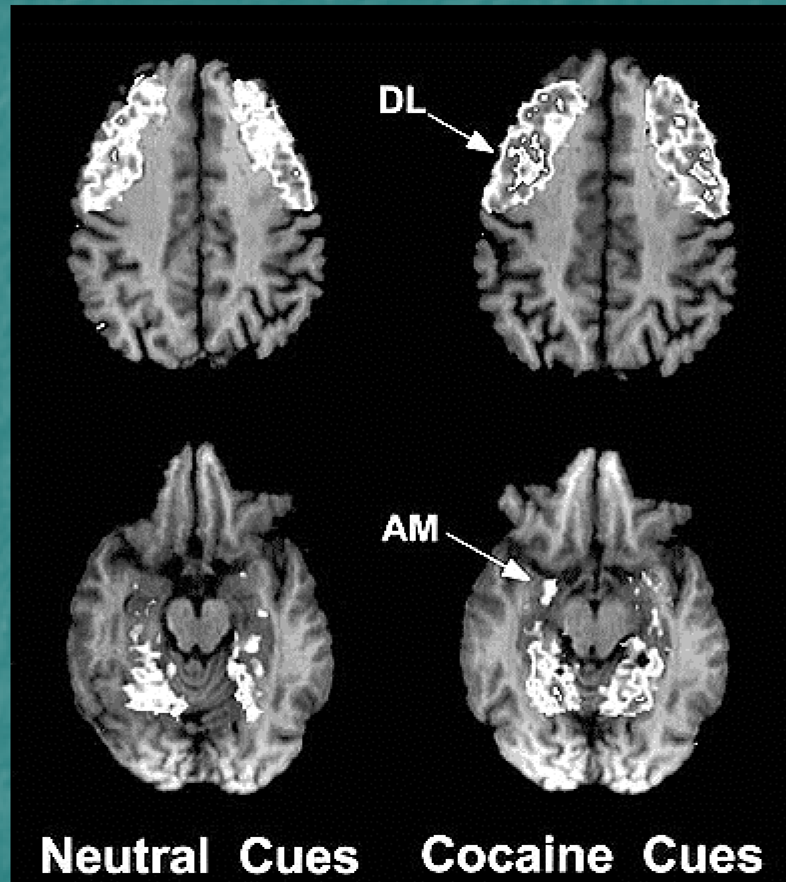
"Too Busy"
"Don't Know How"
Stigma!

Real World: Task

- Design a useful primary care intervention to:
  - Overcome Stigma?
  - Increase Knowledge?
  - Practical & expedient?

11 minutes...

The evidence for addiction as a brain disease



PET scans conducted at NIDA's Brain Imaging Center reveal selective activation of brain circuits during cocaine craving. Scans from volunteers who experienced a high level of cue-induced cocaine craving show activation of brain regions implicated in several forms of memory. The scans at right show activation of the dorsolateral prefrontal cortex (DL), which is important in short-term memory, and the amygdala (AM), which is implicated in emotional influences on memory. When these volunteers were exposed to neutral (non-drug-related) cues, this activation was not seen (scans at left).

London, E.D., et al. Cocaine-induced reduction of glucose utilization in human brain. *Archives of General Psychiatry* 47:567-574, 1990.

NIAAA 2005 Screening Guidelines

Helping Patients Who Drink Too Much

A CLINICIAN'S GUIDE

2005 Edition

Screening and Intervention Protocol for At-Risk Substance Use

- Ask: Two Questions?
- Assess: Risk Level
  - *At Risk*
  - *Problem Use*
  - *Dependence*
- Assist: Brief Intervention

Ask: Two Risk Screening Questions

NIAAA Screening Questions

1. In the past year, have you had 5 (4) or more drinks at any one time?
2. On average, how many drinks do you drink in a week?

46

Safe Drinking Guidelines

Moderate Drinking is…

For Men: no more than 2 day, 14 week or 5 drink tolerance

For Women/Elderly: no more than 1 day, 7 week or 4 drink tolerance

(M) 2 - 14 - 5 **(W) 1 - 7 - 4**

(NIAAA, 2000)

Substance Dependence Disorder

- **Tolerance & Withdrawal**
- **Loss of Control**
  - Larger/longer amounts than intended.
  - Desire/attempts to Cut Down.
  - Increased Time to Obtain/Recover.
  - Important Activities Reduced.
- **Persistent Use despite Negative Consequences** (DSM-IV, 1994)

Ask: Two Follow Up Questions

2 Item Conjoint Screener for Dependence

- In the past year, have you every drunk alcohol more than you meant to?
- In the past year, have you ever thought you should cut down on your alcohol use?

Sensitivity: ~70%, Specificity unknown

Two Better AUD Questions

2 Item Vinson Screener for Dependence

- In the past year, have you sometimes been under the influence of alcohol in situations where you could have caused an accident?
- Have there often been times when you had a lot more to drink than you intended to have?

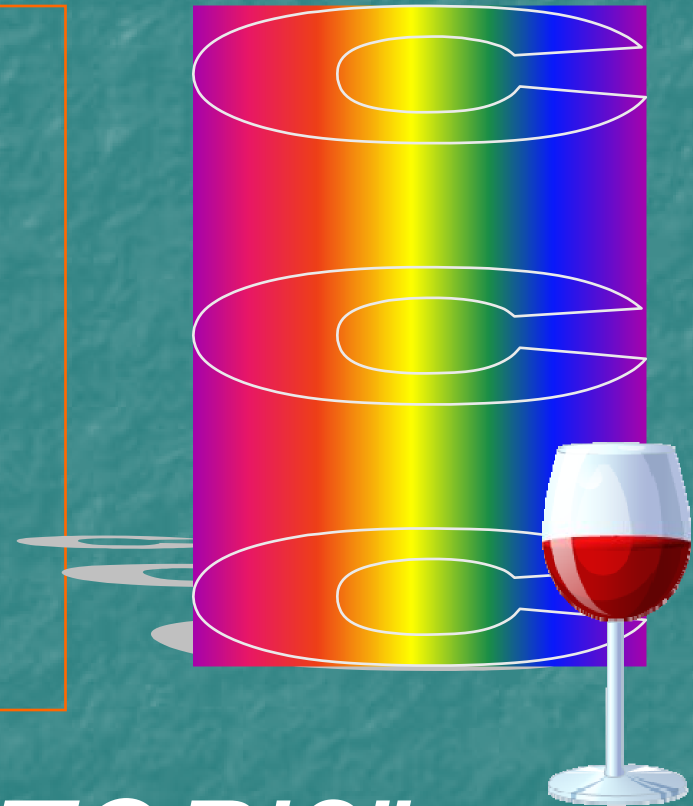
(Vinson, Alcohol Clin Exp Res, V31, No8, 2007)

- Sensitivity: 72-96%, Specificity: 81-95%

Dependence: Better Definition

Three C's...

- **Compulsion to Use**
- **Loss of Control**
- **Neg. Consequences**



"CAN YOU STOP!?"

Box 10

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

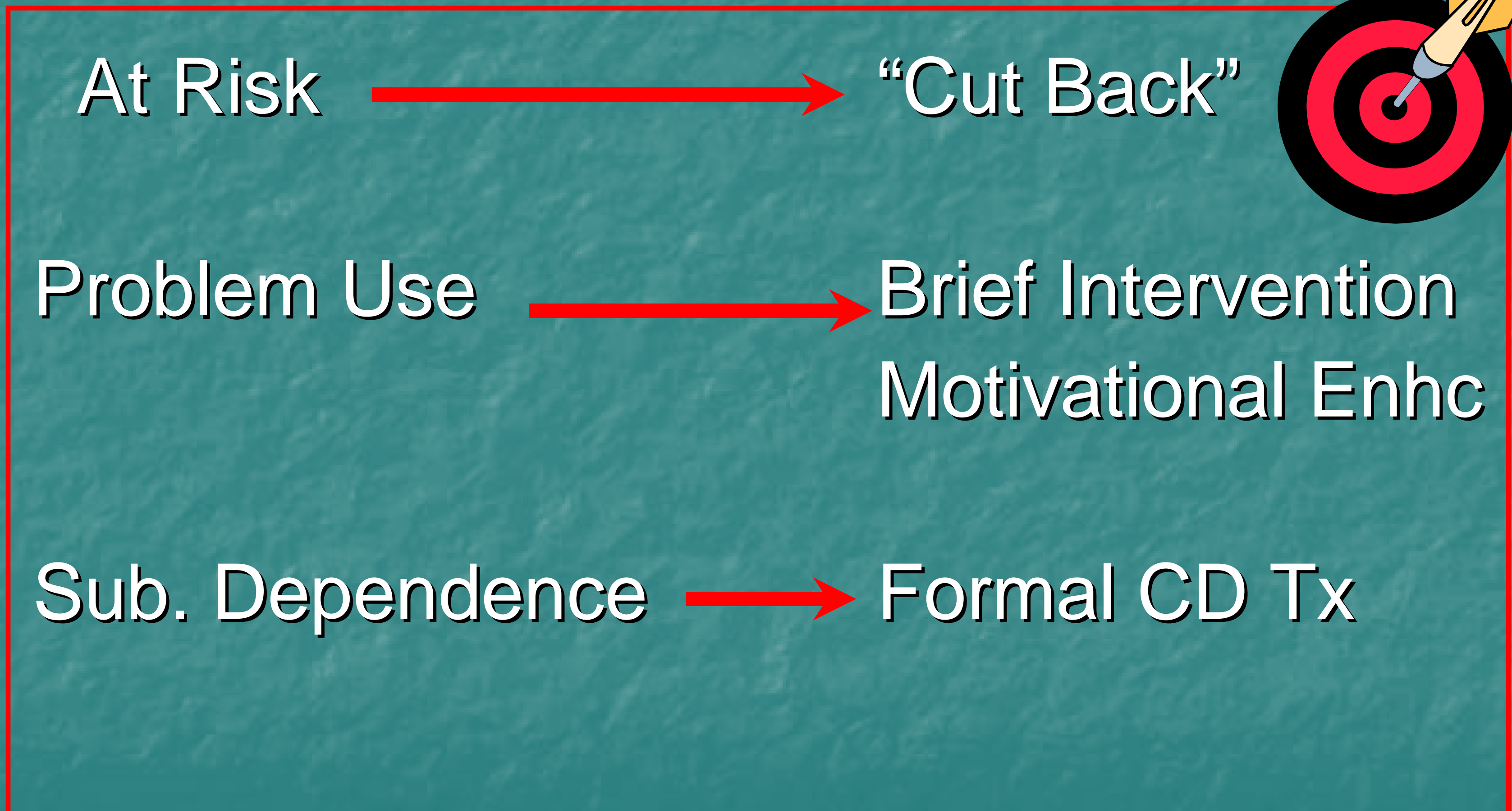
AUDIT Screen (WHO)

Positive Screen

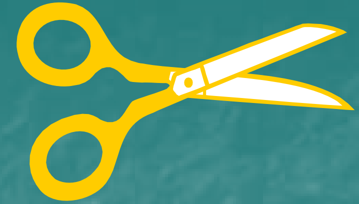
>8 for Men
>4 for Women

Different Systems = Different Tools

Step 3: Brief Intervention Targeting Substance Use



“Cut Back”/Moderation



“I advise you to Cut Back your (alcohol/drug) consumption”

- Recommend drinking or using at “moderate levels” which are safe.
- Not a request to Abstain/STOP.
- Alcohol: (m) 2-14 -5, (w) 1-7-4

(NIAAA, 10th Report to Congress 2000)

Brief Intervention

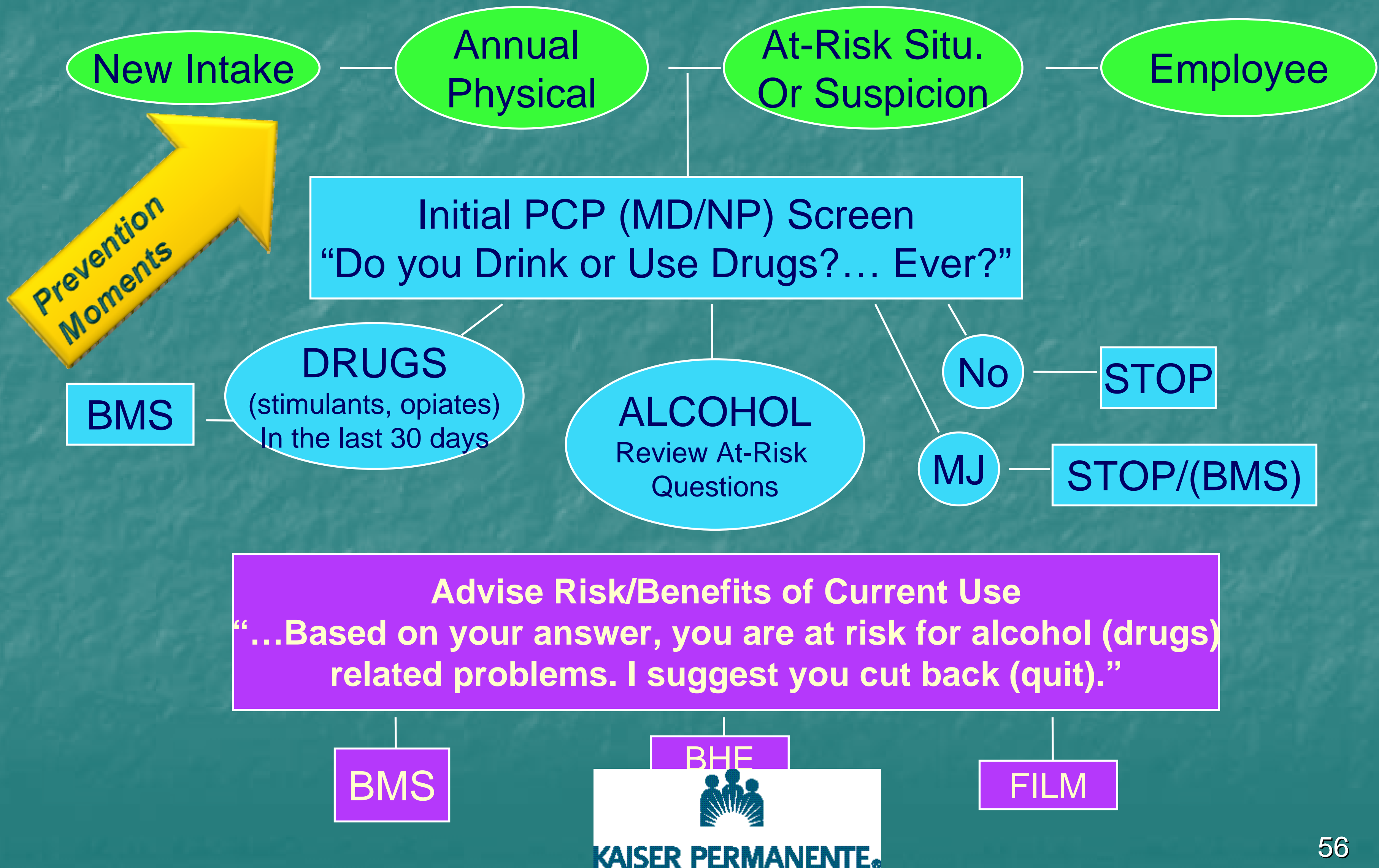
"Based on my assessment, you are at-risk for future health problems…

I advise you to "cut back"/quit."

- Non-Judgemental feedback or appraisal of risks by Primary Care Providers.
- 10-30% patients will significantly reduce (alcohol/tobacco/diabetic) risky behavior

(WHO, 1996; CSAT TIP 24, 1997)

Guidelines for Screening & Advising Patients for At-Risk Alcohol & Drug Use



Impact!

A Physicians Advice to "Cut Back"/Quit will <u>significantly impact 20%</u> of patients who are at-risk for alcohol/tobacco/diabetes related problems.

(Fleming, 1999; WHO, 1996)

Brief Intervention: 15 min (x2)

Effective

N=17000 patients, 17 clinics in Wisconsin Research Network

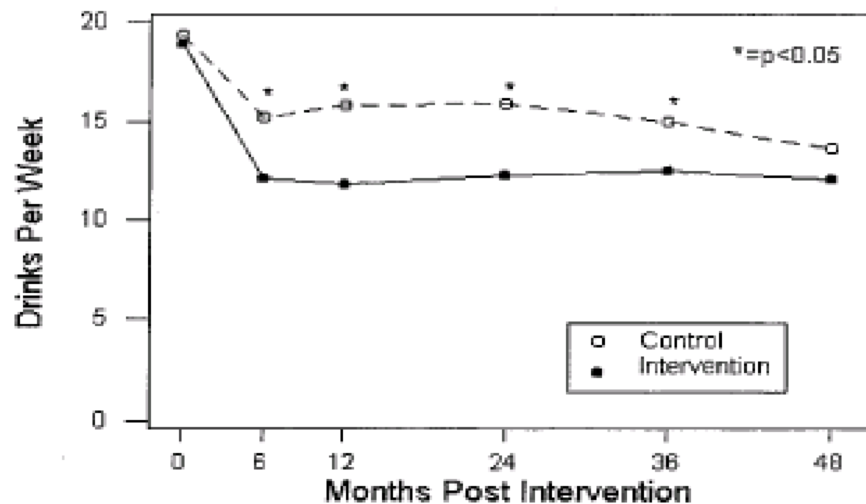


Fig. 1. Seven-day drinking comparison, treatment versus control. **48-month treatment effect, $p = 0.0018$ (repeated measures analysis of variance).

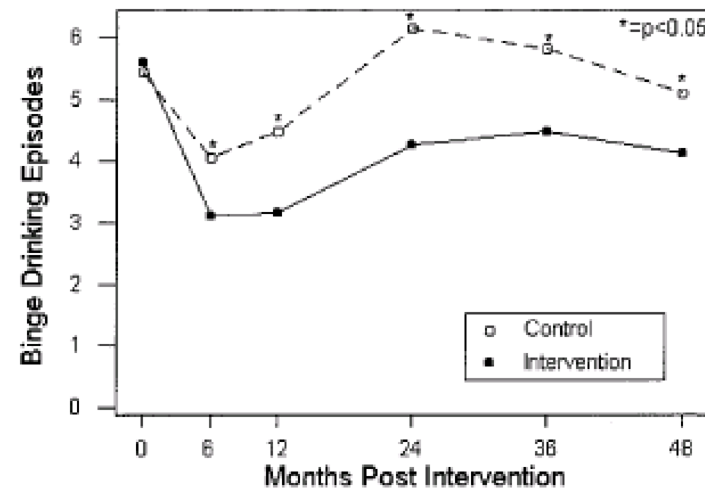


Fig. 2. Thirty-day binge drinking comparison, treatment versus control. **48-month treatment effect, $p = 0.0002$ (repeated measures analysis of variance).

(Project TrEAT: 17 HMO PC Clinics; N= 382 control, 392 interv; Fleming, Alc Clin Exp Res 2002)

Brief Intervention: 5 min

Effective

Table 5. Change in Prevalence and Odds Ratio of Excessive Weekly Drinking and Binge Drinking by Treatment Condition

	Usual Care	Special Intervention	Odds Ratio	P
Excessive weekly drinking	107 (100%)	190 (100%)	1.83	0.1
Safe weekly drinking at 6 months	66 (39)	102 (54)		
Binge Drinking @ baseline	174 (100)	192 (100)	1.24	.32
Non Binge drinking @ 6 mo.	61 (35)	77 (40)		
Excessive weekly or Binge	233 (100)	248 (100)	1.60	.02
Safe weekly or Non Binge drinking at 6 months	66 (28)	96 (39)		

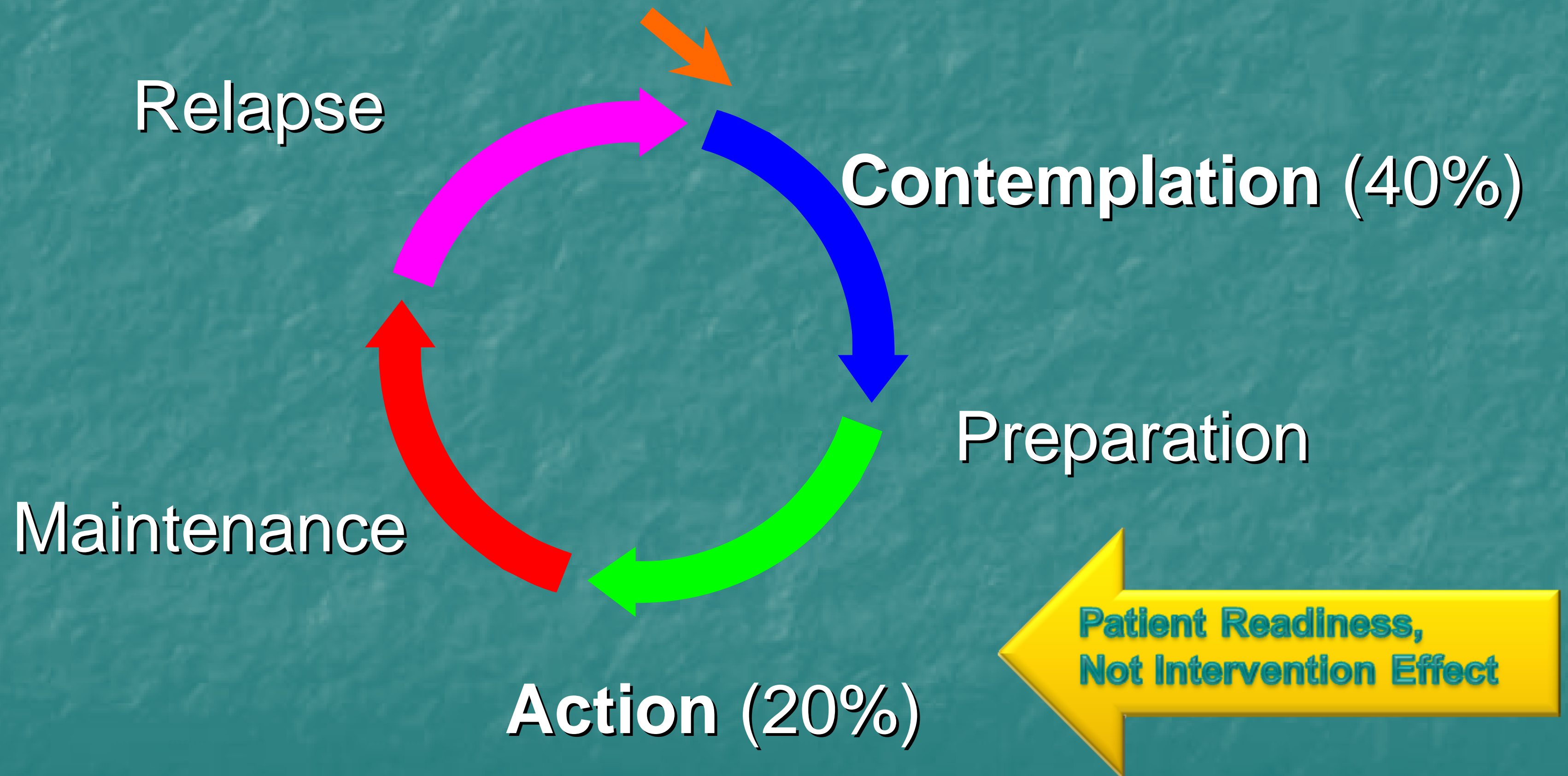
(N=530 @ 4 Academic PC sites; Ockene Arch Int Med 1999)

1997-2007 WHO ASSIST Effectiveness

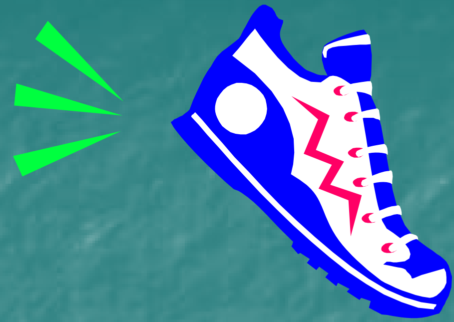
Total Illicit Substance Involvement

ASSIST, 3 mo follow up (N=628)

Readiness for Change



(Prochaska, DiClemente, Psychother Theory Res Pract. , 1982)



Just Do It!

SBIRT member utilization patterns:

▪ BH inpatient days decreased	63%
▪ Medical inpatient days decreased	51%
▪ ER visits decreased	20%
▪ Partial Hospital and IOP visits increased	81%
▪ Psychiatrist visits increased	31%
▪ Therapist visits decreased	22%
▪ **Net total medical cost savings**	**15%**

(N = 247, 12 month continuous enrollment prior and post suboxone)

Specialty treatment for complex or severe SUD

- Social and Behavioral Treatment
  - Brief motivational counseling
  - Cognitive-Behavioral
  - 12-Step (MN Model)
  - Motivational Interviewing
  - Contingency management
  - Behavioral marital therapy
  - CRAFT approach for families

Alcohol Disease Management Results

- Rehabilitation facilities days decreased 67%
- BH inpatient days decreased 68%
- Medical inpatient days decreased 4%
- ER visits decreased 24%
- Partial Hospital and IOP visits decreased 69%
- Psychiatrist visits increased 44%
- Therapist visits increased 35%
- AUDIT score decrease 80%
- **Net total medical cost savings (ROI 2:1) 34%**

(N = 358, 12 month continuous enrollment prior and post enrollment)

The Patient-Centered Medical Home: Principles of PCPCC

- **Personal Physician**
- **Whole person orientation**
- **Coordinated and integrated care**
- **Safe and high-quality care (e.g., evidenced-based medicine, appropriate use of HIT, continuous QI)**
- **Enhanced access to care**
- **Payment that recognizes the added value provided to patients who have a patient-centered medical home**

***** A Systems Approach: Access, Quality and Efficiency**

ACP, AAFP, AAP and AOA. Joint Principals of the Patient-Centered Medical Home, March 2007.

But –if Patient Centered Medical Home is so good, why is integrated SBIRTso rare?

- The advice from Deep Throat to Woodward and Bernstein:

  "Follow the Money"

- Silos
- Training
- Attitudes
- Time
- Privacy regulations, HIT

The Quality of Health Care in US

Table 4. Adherence to Quality Indicators, According to Mode.

Mode	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Encounter or other intervention	30	2843	4,329	73.4 (71.5–75.3)
Medication	95	2964	8,389	68.6 (67.0–70.3)
Immunization	8	6700	9,748	65.7 (64.3–67.0)
Physical examination	67	6217	19,428	62.9 (61.8–64.0)
Laboratory testing or radiography	131	5352	18,605	61.7 (60.4–63.0)
Surgery	21	244	312	56.9 (51.3–62.5)
History	64	6711	36,032	43.4 (42.4–44.3)
Counseling or education	23	2838	3,806	18.3 (16.7–20.0)

McGlynn et al, NEJM, 2003

What gets paid, gets done.

		RVUs
99203	Office/outpatient visit, new, 30 minutes	2.54
99283	Emergency dept visit, moderate complexity	1.68
99443 98968	Physician or healthcare prof. follow-up phone call 21-30 min (Not Medicare reimb.)	0.98
99420	Administration, interpretation of health risk assessment instrument (not Medicare reimb.)	0.23
99402	Preventive medicine, individual, 30 min (not Medicare reimb.)	1.48
38100	Removal of spleen, total	28.23
61514	Removal of brain abscess	48.04
99409	SBI 30 minutes or more	**1.67**

2008 RVUs for SBI and comparable clinical procedures (RVU = ~$40) RVUs

90804	Psychotherapy, office, 20-30 min	1.80
90816	Psychotherapy, hospital, 20-30 min	1.60
99202	Office/outpatient visit, new 20 min	1.77
99408	**SBI 15 to 30 min**	**0.85**
99203	Office/outpatient visit, new 30 min	2.54
99385	Prevention visit, new, age 18-39	2.66
99409	**SBI over 30 min**	**1.67**

Reimbursement for SBI

Payer	Code	Description	Fee Schedule
Commercial Insurance and Medicaid	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69

Reimburses, or will reimburse on SBI Codes 99408/99409

Aetna California PPO

Anthem California National PPO

BC of California HMO

BC of California PPO

CIGNA California PPO

Health Net of California HMO

Kaiser Northern California HMO

Kaiser Southern California HMO

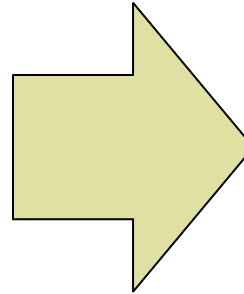
PacifiCare of California, Inc. HMO

UnitedHealthcare of California PPO

Payment Reform Needed

Current System: Structured Around Reimbursement

- Behavioral health, medications, general medical in separate payment silos
- Disincentivizes collaboration, communication and coordination among clinicians
- Payment is requires diagnosis and procedures
- Ignores behavioral needs of medical patients
- Ignores medical needs of behavioral health patients
- Focuses on individual siloed care delivery not on collaborative treatment
- No relationship to performance



Proposed System: Patient Centered

- Carve in to medical expense target (defragment payment system; blended payment systems)
- Payment related to collaborative medical psychological efforts
- Financing for broad spectrum of medical need for behavioral intervention including psychological treatments of medical problems
- Financing related to performance and quality

Kessler & Miller , 2009

Barriers to Adoption of PCMH with SBIRT

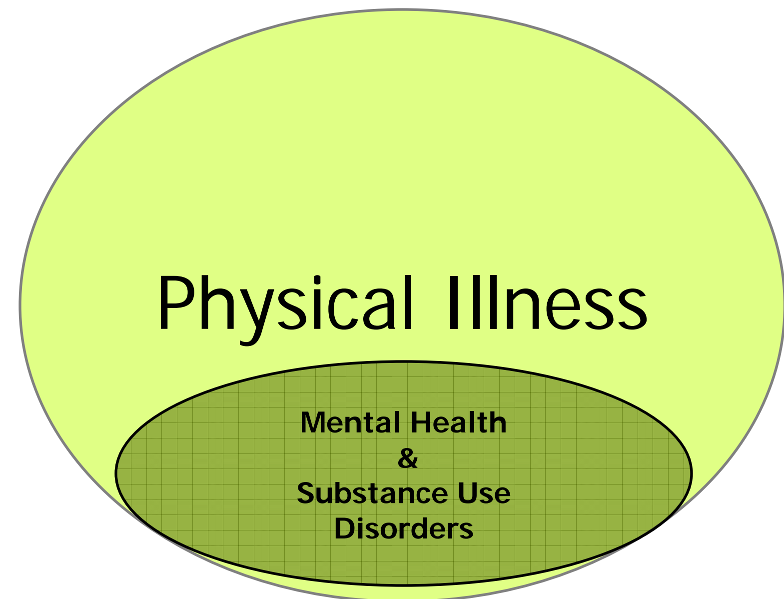
- **Clinical information sharing:**
  - Registries
  - Modify 42 CFR Part 2 and State Mental Health and Substance Use Records Privacy Laws
  - Shared information systems with patients – Personal health records, e-mail, tele-health, tele-counseling, telephone SBI, Skype life coaching, internet support groups
- **Physical facilities**:
  - Teams work best in close physical proximity
  - Some practices more amenable to integration -- FQHCs
- **Research and evaluation**:
  - Comparative effectiveness trials to determine the necessary components of PCMH, alternative configurations, supports
- **Performance measurement, accountability**

Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home, National Council for Community Behavioral Healthcare. 2009.

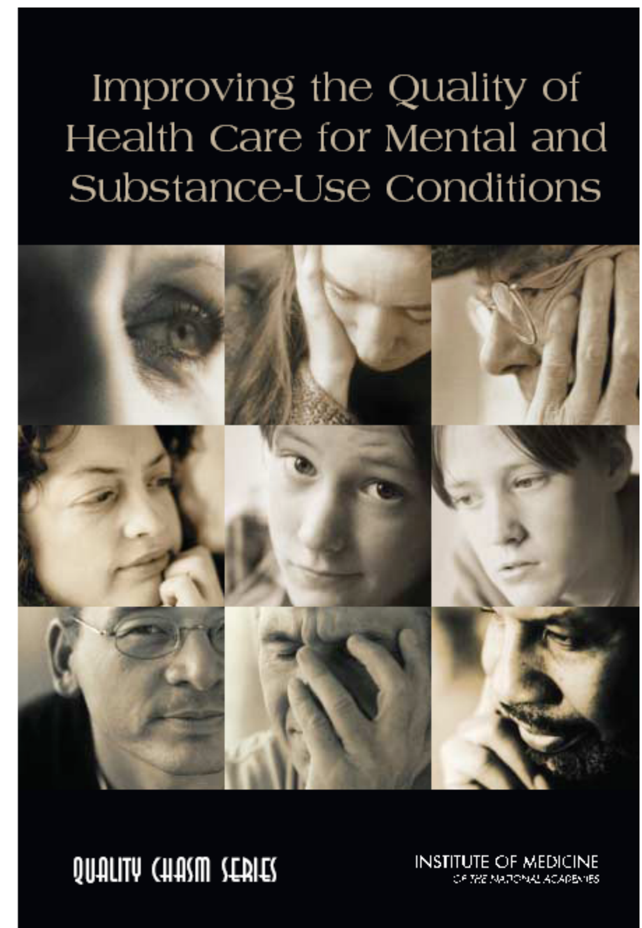
Challenge unique to SUD:

The intersection of health care quality and patient safety with protection of sensitive SUD diagnosis and treatment information

- HIPAA, 42 CFR Part 2
- Risks of potential misuse, and inappropriate disclosure
  - Job loss,
  - criminal prosecution,
  - health and life insurance coverage barriers



Mental and substance-use problems are pervasive, often unrecognized, and if not resolved, ultimately make themselves known – if not initially as mental or substance use problems, then as general health conditions. (IOM, 2005)



Primary Care, Mental Health, and Substance Use Integration
Upcoming Webinars

Addressing Mental Health Issues in Primary Care: IMPACT Model	**June 3, 2010**
Bridging Differences in the "Cultures" of PC/MH/SU	**June 10, 2010**
Paying for Integrated Services: FQHC, Medi-Cal and Other Funding Strategies	**June 24, 2010**

Please go to http://www.cimh.org/Learning/Online-Learning/Webcasts.aspx
for more information and to register for future webinars.

This free webinar series is supported through MHSA funding under contract with the CA State Department of Mental Health as well funding from the Alcohol and Drug Policy Institute. IBHP participation is supported by The California Endowment.