Integrating Primary Care and Brief Behavioral Health/Substance Abuse Treatment

Bill McFeature, Ph.D., Director of Integrative Behavioral Health Care Services

ASU DBH Conference – Fall, 2013
Objectives

- Evaluate process of integrated care, PCP-BHC performance outcome, and cost factors that support change to an integrated services approach.
- Apply population care concepts to the design of integrated behavioral health programs versus case by case as seen in traditional mental health.
- Learn core features of the Primary Care Behavioral Health (PCBH) model of care.
- Appreciate applications of the PCBH model to chronic conditions, i.e., Diabetes, Depression, Bipolar condition, Cardiovascular, and COPD/asthma, Fibromyalgia, Neuropathy, ADHD, and Substance Abuse/Dep etc.
PCP-BHC CULTURE

- PATIENT POPULATION VERSUS CASE BY CASE PATIENT CARE.

- UNDERSTAND PRIMARY CARE PHILOSOPHY WITH A MIND-BODY APPROACH.
Why Integrate Primary Care and Behavioral Health Consultation?

- **Cost and utilization factors:**
  - 50% of all BH care delivered by PCP
  - 70% of community health patients have BH or SA disorders
  - 92% of all elderly patients receive BH care from PCP
  - Top 10% of healthcare utilizers consume 33% of outpatient services and 50% of inpatient services
  - 50% of high utilizers have BH or SA disorders
  - Distressed patients use 2X the health care yearly
Why Integrate Primary Care and Behavioral Health?

**SVCHS Stats:**
- 70% of all PC visits have psychosocial drivers
- 80% of antidepressants are prescribed by SVCHS PCP
- 40% of diabetics experience depression
- 70% of individuals who complain of heart problems are actually experiencing a panic attack
- 40% of the population is obese and nearly 70% live sedentary lifestyles
- 70% of the population smokes
- 50-65% of population who are on prescription medication are non-adherent
- 17% suffers from chronic pain syndrome
- 14% of the population is suffering from a substance abuse problem
Why Integrate Primary Care and Behavioral Health?

- **Health outcome factors:**
  - Medical conditions and co-morbid sx’s of BH & SA conditions correlate with higher mortality rates
  - 50-60% non-adherence to psychotropic medications within first 4 weeks
  - Only 1 in 4 patients referred to specialty BH or SA make the first appointment
Benefits of Integrating Primary Care and Behavioral Health

- **Primary care practitioner and behavioral health provider integrative services:**
  - Improved diagnostics of BH and SA disorders (Kathol et. al., 1990)
  - Improved PCP skills in psychotropic medication prescription practices (Kathol et. al., 1995)
  - Increased PCP referral reasons and rationale for behavioral health consultation (Mynors-Wallace, et. al., 1998)
  - Increased PCP confidence in managing a patient’s “whole being” from a health conscious domain (Robinson et. al., 2000)
  - Patients like one-stop shopping
Clinical Outcome and Service Quality Benefits of Integration

- Improvement in depression remission rates: from 42% to 71% (Katon et. al., 1996)
- Improved self management skills for patients with chronic conditions (Kent & Gordon, 1998)
- Better clinical outcome than by treatment in either sector alone (McGruder et. al., 1988)
- Improved consumer and provider satisfaction (Robinson et. al., 2000)
Economic Benefits of Integration

- **Cost Effectiveness of Treatment:**
  - Measure of impact of adding additional dollars to a medical procedure for value received (e.g. better diagnostic accuracy, clinical effectiveness)
  - Treatment success rates nearly double with this integrative/bundling expenditure
  - Result is a positive cost effectiveness index of $491 per case of substance abuse treated.
Economic Benefits of Integration

- **Increased Productive Capacity:**
  - PCP capacity is shackled due to frequent management of behavioral health and substance abuse conditions (50% of medical practice time directed toward BH conditions)
  - Integrated behavioral health “leverages” BH patients out of PCP practice schedules
Economic Benefits of Integration

- **Medical Cost Savings:**
  - Meta-analysis: 57 controlled studies show a net 27% cost savings (Chiles et al., 1999)
  - 40% savings in Medicaid patients receiving integrated treatment (Cummings & Pallack, 1990)
  - In older populations, up to 70% savings in inpatient costs (Mumford et al., 1984)
Population-based Care: The Framework for Integration

- Based in Public Health & Epidemiology:
  - Focus on raising health of population
  - Emphasis on early identification & prevention
  - Designed to serve high percentage of population
  - Provide triage and clinical services in stepped care fashion
Population-based Care: The Framework for Integration

- Employs evidence based behavioral health consultation/brief psychotherapy:
- Primary care is fast pace, action oriented, and directed towards acute intervention
- Goal is to employ the most simple, effective, diagnosis-specific treatment
- Treatment is brief, targeted with a “warm hand off” approach
- BH provider has basic knowledge of psychopharmacology
- Critical pathways are designed to support best practices
Analysis of Behavioral Health Needs in a Primary Care Population

- **Vertical Integration Program**
  (Critical Pathways)
- **Horizontal Integration Program**
  (General Consultation)

**Cohort of 52,000 patients**

Combined 73,000 medical and behavioral health encounters

- Panic Disorder Generalized Anxiety Somatoform Disorders Major Depression Alcohol/Drug Problems 35% (8,750 Patients)
- No Behavioral Health Need 30% (7,500 Patients)
- Depressive & Anxiety Symptoms Life Stress 35% (8,750 Patients)
## Integrative Model of Care

<table>
<thead>
<tr>
<th>Model</th>
<th>Attributes</th>
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<td>Co-location</td>
<td>On-site BH Unit</td>
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<tr>
<td>Collaborative Care</td>
<td>On-site/shared cases with BH provider (Electronic Medical Record)</td>
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<tr>
<td>Integrated Care</td>
<td>BHC as PC Team Member</td>
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# Two Perspectives On Population-Based Integrative Care

<table>
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<tr>
<th>Horizontal Integration</th>
<th>Vertical Integration</th>
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<tbody>
<tr>
<td>Patient Populations</td>
<td>BHC &amp; PCP Co-development of Clinical Pathway, ie, Diabetes, Cardiovascular, Major Depression, Recurrent Schizoaffective, Bipolar Disorder, Major Depression, Single Episode, Panic Disorder, Minor Depression, Substance Abuse/Dependence, Alcohol Abuse/Dependence</td>
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<tr>
<td>Specialty Consultation</td>
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<td>Brief Psychotherapy</td>
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<td>Consultant Services</td>
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Common Vertical Integration Targets

- Depression
- Anxiety and Panic
- Chronic Pain
- Somatization
- Alcohol and Drug Abuse
- Frail Elderly
- ADHD
- Obesity Prevention
- Obesity Intervention
- Hypertension
- Post MI
- Diabetes
- Alzheimer’s
- COPD
Integrated Care:

- The Dilemma:
  - Integrated care has different meanings for different people.
  - Different models of integrated care lead to different costs and outcomes.
  - How do we pick an approach?
Consider:

- The program must be able to address tremendous unmet demand among PC patients associated with SA issues at time of patient presentation.
- Additional staffing resources are likely to be scarce; BHC providers must have high population impact.
- The service should be consistent with the mission, objectives, and form of primary care services.
Consider:

- By definition, the less separation of services, providers and infrastructure, the better.
- The greater the opportunities for co-training/learning, the more skillful the PCP and BHC i.e., monthly site meetings and quarterly meetings, and of course, daily feedback/EHR.
- The service needs to be “patient centered ” and organized to be culturally competent.
Primary Care Behavioral Health (PCBH) Model: Primary Goals

- Behavioral Health Consultant (BHC), as new PC team member:
  - Supports PCP decision making
  - Teach PCP “core” behavioral health skills
  - Educates patient in self management skills through training
  - Manage chronic patients with PCP in primary provider role
PCBH Model:
Primary Goals

- Effective triage of patients in need of specialty behavioral health, i.e., Mood Disorder, unstable
- Simultaneous focus on health and behavioral health issues, i.e., Diabetes and Depression
- Make PCBH services available to large percentage of eligible population
- Improve PCP-patient working relationship
- Improve monitoring of “at risk” chronic patients
PCBH Model: Referral Structure

- Patient referred by PCP only
- “Warm handoff” to BHC on same day basis
- PCP screens BHC appointment schedule to “leverage” medical visits per patient overtime
- Referral defined by pathway (e.g., initial DX of Diabetes: high risk for obesity onset at 12, smoker, co-morbid sx’s of depression/anxiety. initial DX of ADHD and ages 5-9 and + screen for parent-child relationship problems), Initial DX of COPD, smoker,
- panic episodes, Initial DX of Cardiovascular/HTN problems, Comorbid sx’s of depression and substance use..
PCBH Model:
Session Structure

- Limited to 1-4 visits in typical case
- 15-30 minute visits
- Chronic disease management/1x-per month
- Critical pathway programs may involve 4-8 appointments or require on-going monthly BHC visits
- May participate in group care /open access
- Multi-problem patients (Diabetic, COPD, Depression, Anxiety, and Substance Abuse) seen regularly but infrequently over time
PCBH Model: Intervention Structure

- Informal, revolves around PCP assessment and health goals (both physical and psychological)
- Low intensity (targeted goals /functionality/DLA’s versus process)
- Between sessions intervals are longer
- Relationship important, but not primary focus
- Visits timed around contact with PCP
- Long term follow up reserved for high risk patients
PCBH Model: Intervention Methods

- Limited face to face contact, i.e., 15 min in the exam room or 30 min BHC/MI Intervention or brief psychotherapy/behavioral health consultation service.

- Uses patient education model, i.e., diabetic mgmt, cardiovascular mgmt, COPD, and substance use disorder mgmt.

- BH Consultant is a resource to patient

- Emphasis on home-based practice to promote change/Family support to produce change.
PCBH Model: Cultural Competency

- Program design recognizes cultural competence requirement.
- Symptoms evaluated using culturally appropriate methods
- Interventions tailored to cultural practice
- Use of community resource supportive of culture
- Services available for mono-lingual patients
PCBH Model: Termination and Follow-up

- Responsibility returned to PCP/Gatekeeper.
- PCP provides relapse prevention or maintenance treatment/referral to BHC
- BHC may see patients for more chronic conditions over lifetime (no “termination”)
PCBH Model:
Primary Information Products

- Brief Consultation report to PCP
- Part of medical record
- “Curbside consultation”/EHR Feedback/Exam Room
- Written relapse prevention plans
- Behavioral Health Prescription Pads
- Exam Room Posters
- Brief screening and assessment tools
- Patient education handouts (for examples, see Robinson & Reiter CD 2007)
Qualities of A Successful PCBH Service

- Provides timely access for PCP
- Service is integrated with primary care setting
- Service is viewed as a form of primary care
- Service is provided in collaboration with the PCP
- Service is provided as part of the health care process and one plan of care
Qualities of a Successful PCBH Service

- BHC used by all PC providers
- PCPs use MI interventions targeted by BHC, brief CBT or Solution Focused treatment
- BHC will average 2-4 visits with exception to chronic patients in need of maintenance treatment
- PCP, BHC, and patient satisfaction improve
- Clinical outcomes (health related quality of life improved (SVCHS and Radford University study on Depression measures utilizing Behavioral Health Consultation within integrative practices.
- PCP-BH integration productivity improves patient care.
- Documentation streamlined between the PCP and BH providers (one electronic medical record)
BHC Clinical Note

Patient: Jack Soul

Complaint: Depression, mild-moderate sx’s today. Experiencing mild panic as well, duration- 10-20 min. reports frequent alcohol and cannabis use.

Medical History: COPD, Tobacco use, Bronchitis, recent Hospitalization/Pneumonia, Stress/hx of depression/panic attacks, Diabetes I, Comorbid sx’s of depression and anxiety, alcohol dependent, continious, cannabis abuse.

Family Hx: NF- Cardiovascular/Stents ; NM- Asthma.

Medications: Proventil, Adair Diskus, Wellbutrin XL, Campral

Assessment: Major Depression, Recurrent, melancholic type-296.30, 300.4 Panic Disorder with Agoraphobia, alcohol dependent, and cannabis dependent.

Treatment: Discussed stress reduction techniques and conducted imagery work/mindfulness intervention with patient, receptive, cope 1-10-7, fair-good. Compliant to psych med regime and reports of benefit in reduction of sx’s. reports less frequent panic episodes with shorter duration, reports decrease in ethanol use per week and continues to be compliant to Campral tx. Discussed checking glucose sugar levels routinely, self- monitoring.

Plan: Patient will be seen every 2 weeks for BHC/COPD mgmt. Follow up with Joan Mullin FNP for med mgmt, mild-moderate predominate depressive sx’s mixed anxiety, suggest titrate up on patient’s Wellbutrin XL, tolerating the med well. will monitor sx’s next scheduled appt.
Recommended Readings


Integrative Alcohol and Drug Use Disorder Treatment and Use of SBIRT Codes and Interventions

by

Bill McFeature, PhD
ASU DBH Conference – Fall, 2013
Why integrate primary care and substance abuse services?

- Substance abuse has medical consequences
- Substance abuse is a medical illness
- Increases likelihood of treatment adherence
- Simultaneous treatment of co-occurring disorders increases positive outcomes
- Quicker access to treatment
Medical Consequences of Alcohol Abuse

- Brain damage
- Liver disease
- Ulcers
- Cancers
- Esophageal hemorrhage
- Kidney damage
- Fetal alcohol syndrome
- Alcohol related accidents
- Etc.
Medical Consequences of Drug Abuse

- Brain damage
- Cancer
- Heart damage
- Lung disease
- Nervous system
- Digestive system
- Drug exposed infants and children
- Drug related accidents
Is Substance Abuse a Voluntary Behavior or a Medical Illness?

- *Initial use*: mostly voluntary
- *Continued use*: moves toward medical disease

“When drug abuse takes over, a person’s ability to exert self control can become seriously impaired.”
Medical roots of addiction behavior

Brain imaging studies from drug addicted individuals show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.

Scientist believe that these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction.

Addiction is considered a “chronic, relapsing brain disease.”
Comparison of Addiction and Heart Disease

- Disrupt the healthy functioning of underlying organ
- Lead to other health issues
- Preventable
- Treatable with medical and behavioral interventions
- Can last a lifetime if untreated
- Relapse is likely
Relapse comparison for addiction and other chronic illnesses.

Relapse rates for drug-addicted patients are compared with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention.

Source: JAMA, 284:1689-1695, 2000
Quicker Access to Treatment

- PCP often first health provider contacted
- Less stigma going to PCP office
- No delay in referral for outside services
- Often can access Behavioral Health Consultant same day of PCP visit.
- Appointment can also be made prior to leaving PCP office.
Increases Treatment Adherence

• Less stigma for SA issue when going to PCP office.
• All services in one location.
• PCP has direct awareness of patient’s attendance at SA visits.
• Less denial of issue when treated as a health issue as opposed to a moral or willpower issue.
• In rural communities, increases access to SA services.
• Community Health Care Centers reduce cost barrier for services.
Treatment Benefits of Integrated SA and PCP Services

- In-exam-room consult available to PCP. Begins rapport process and identifies any immediate needs.
- Specifically identify withdrawal or overdose issues that may need outpatient or inpatient treatment.
- Integrates treatment of co-occurring disorders.
- Comprehensive treatment of intersecting diagnoses.
Defined by SAMHSA

A comprehensive, integrated, public health approach to delivery of services pertaining to **Screening**, **Brief Intervention**, and **Referral to Treatment**.
SBIRT Codes

- **99408**: Alcohol and/or Substance Abuse structured screening and brief intervention services (15-30 min.)

- **99409**: Alcohol and/or Substance Abuse structured screening and brief intervention services (greater than 30 min.)
SBIRT Codes

• Can be used for reimbursement with VA Medicaid, Medicare, and some commercial insurance carriers.
• Credentialed BH providers and medical providers can both use codes same day of service (LCSW, psychologist, LPC, marriage and family counselor, licensed substance abuse counselor)
• Use of codes based on medical necessity: needs documentation by medical provider.
• Not all states allow BH providers to use SBIRT codes. Medicaid in some states only allow medical professional to use SBIRT codes.
• When a medical provider bills for an SBIRT code, he/she must also meet the minimum 15 min. timeframe. However, if a nurse does her general nursing functions and includes a substance abuse screening assessment, the PCP can include the nurse’s time in calculating the timeframe spent.
SBIRT Codes in Primary Care

New Patient

MD, PA, Nurse: Medical hx, current meds, health status exam including AUDIT-C

Refer to BHC (optional in exam room consult)

First visit to BHC for further screening and/or intervention (bill 99408 or 99409)

Follow-up visits to BHC for brief interventions (bill 99408 or 99409)

SA Screen Positive (Bill 99408 or 99409)

YES

NO

Continue with medical exam

Feedback to PCP provided throughout the entire process
Treatment Issues

“PHENOMENA”
EDUCATE PATIENT on
“HEALTH CONSCIOUSNESS”
Screening Tools for Medical Providers

- AUDIT-C
- Medical assessment for substance abuse related medical issues
- Drug screens
Screening tools for BHC

- AUDIT-C
- Biopsychosocial assessment
- Standardized screening instruments
  - **SASSI** (Substance Abuse Supplemental Screening Instrument)
  - **ASAM-PPC** (American Society Addiction Medicine Patient Placement Criteria)
  - others
Developed by the World Health Organization to be used by health workers.

Modified version of the AUDIT 10 question instrument.

Uses 3 questions to screen for persons who are hazardous drinkers or who have alcohol use disorders.

Scientifically validated for primary care screening.
1. How often did you have a drink containing alcohol? never(0), monthly(1), weekly(2), some days each week(3), most days each week(4)

2. How many drinks did you have on a typical day when you were drinking? 1-2(0), 3-4(1), 5-6(2), 7-9(3), more than 10(4)

3. How often did you have six or more drinks on one occasion? never(0), <monthly(1), monthly(2), some days a week(3), most days each week(4)
Standard Alcoholic Drinks

One mixed drink with
- 1.5 fl oz (44 mL)
of 80-proof liquor
(such as vodka, gin, scotch, bourbon, brandy, or rum)

5 fl oz (148 mL)
of wine

12 fl oz (355 mL) of
beer or wine cooler

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AUDIT C Scoring

• Women: positive score is 3 points or more.
• Men: positive score is 4 points or more.
• The higher the score, the higher the health and safety risk is for patient.
• False positive may occur if patient has history of hazardous drinking but no current use. (Needs further assessment and still refer for relapse prevention.)
SBIRT Brief Interventions

- Primary Care Provider
- Behavioral Health Consultant
Why do people abuse alcohol and other drugs?

Benefits

Feels good: self medicating emotionally and physically

Consequences

***Desire to feel better outweighs perceived consequences of use.***
Primary Care Provider
SBIRT Brief Interventions

- **Expressing concern** (unhealthiness of use)
- **Feedback** (linking use to health issues)
- **Education and recommended drinking limits** (How much is okay and how much is not okay for patient’s health)
- **Offer of explicit advice** (to cut down or abstain)
- **Follow-up** (return visit to assess client’s response to intervention)
- **Referral** (for more specialized SA services such as BHC, AA/NA, CSB, inpatient detox)

All can be used with SBIRT codes 99408, 99409.
Behavioral Health Consultant SBIRT Interventions

- Cognitive Behavioral Therapy
- Motivational Interviewing
- Relaxation Training
- Relapse Prevention Planning
- Transtheoretical Model of Change

All can be used with SBIRT codes 99408, 99409.
Transtheoretical Model of Change

- Focuses on how people change behaviors
- 5 stages of change: precontemplation, contemplation, preparation, action, and maintenance
- Clinician can identify stage of change and target interventions accordingly
- Can be used in 15-30 min. session format
- PCP assists with identifying medical reasons for change, BHC can use these to help address patient’s ambivalence.
Co-occurring Disorder Treatment Integration

- Includes SA, medical, and BH (whole person)
- Each disorder can improve or worsen symptoms of the other
- Improves overall wellness
- Treating one disorder while ignoring another is a disservice to the patient
- Manage co-occurring disorders as all being primary in regards to treatment planning

(cont.)
Co-occurring Disorder
Treatment Integration (cont.)

• PCP Role: Screen and refer to BHC as part of the PCP’s overall treatment plan for patient.
• BHC Role: provide SA assessment and treatment with feedback to PCP.
• Having BHC in-house provides quick and direct communication between BHC and PCP resulting in more effective treatment for both co-occurring disorders. (Use both face-to-face and EMR notifications.)
• Best treatment for complexity of intersecting diagnoses.
Patient/DOB/PCP:
Subjective: mixed low mood sx’s, opioid and benzo addiction, both in remission
Patient participates in the Drug Court program, reflects negative screens in the
past 6 months and opted for incarceration.

Medical Hx: Anxiety, diagnosed with bipolar condition, panic sx’s, ADHD.
Social Hx: single, 3 children, ages 2, 3, and 5, smoker-yes, drinks caffeine-yes,
sexually active-yes, familial system- limited.

Medications: Klonopin 1 mg tab 3 times a day, citalopram 20 mg tab once per
day, hydroxyine pamoate 25 mg cap 4 times a day, zofran 4 mg tab TID.
Objective: Assessment: Depressive Disorder NOS, Opioid Dependence-
Remiss- Patient reports abstaining from both opiod and benzodiazepine use for
past six months. Discussed prevention/abstinence measures and utilized brief
CBT with patient. Responding well to Celexa, PHQ-9- 4, cope 1-10-8 today,
progress noted.
Subjective: Patient reports hx of exposure to sexual molestation, family domestic violence, diagnosed with Hep-C –Type I, reports rule –out of seizure d/o /benzodiazepine withdrawal. Patient has been diagnosed with seizure do, has been prescribed Keppra, Depakote, Lamictal, and Gabapentin, mild –moderate depressive sx’s, increased irritable mood,, currently receiving suboxone treatment, 16 mg Daily, has been receiving tx for 1 year.

Medical Hx: Seizures, Bipolar, 3 Bulging Disc In Lumbar, Muscle Spasms
Social Hx: single, resides in section-8 housing, smoker-yes, caffeine-yes-drinks mellow yellow-3 a day., limited familial support.

Medications: Dep shot birth control, suboxone 8 mg Daily, has been receiving tx for the past 2 months, reports on no psychotropic medication regimen.

Assessment: Depressive Disorder NOS, Opioid Dependence, CONTIN

Discussed patient’s health issues revolving around her reported pain levels 1-10-6 today, Utilized mindfulness and cognitive –imagery work, reports Hep-c tx will be initiated by her PCP. Patient will be seen every 2-3 weeks for BHC /depression mgmt/ abstinence.

Follow up with Dr. Andrews for med mgmt.
Clinical Case Studies

Subjective: patient presents with mild- moderate depressive sx’s- hx of 2x- psych hospitalization in the past 3 years, exposed to severe physical abuse resulting in head trauma, reports suicidal ideations with no plan, reports disturbance- 4 hours or less, racy thoughts, irritable mood, can’t sleep at times, unexpected depression and agitation a.m., rapid cycle in nature, reports high liver enzymes, high ammonia levels, nausea and lower GI pain is frequent, reports long term ethanol abuse, reports in recovery since 2011.

Medical Hx: brain surgery to remove clots in 1997, diagnosed with Hep- c, diagnosed cardiovascular difficulties, received EKG, stress test, echocardiogram, and carotid us, right hemisphere stroke, complicated migraines and partial seizures, received MRI revealing chronic white matter ischemic changes.

Medications: Warfarin 1 mg tab 0.5 mg Daily, Warfarin Sodium 4 mg Daily, Zanaflex, Lortab, Dilantin, Keppra, Protonix, Chantix, and Celexa.

Objective: Assessment: Major Depressive Disorder, Recurrent,- Utilized brief CBT and Self-biofeedback with patient, focus on managing depressive sx’s(PHQ-9-15) and pain levels 1-10-4 today. Cope is good, Recommended 2-3 week for BHC/depression Mgmt. Follow up with Kim Murphy FNP for med mgmt, Celexa 20 mg Daily —helpful.
Patient visits PCP for high blood pressure.

- Nurse used AUDIT-C screen which is positive.
- PCP refers patient to BHC for SA assessment.
Patient visits BHC for SA assessment.

- BHC assessment reveals patient has Alcoholism.
- BHC assessment identifies symptoms of depression both current and prior to Alcohol abuse and a family hx of thyroid disease.
- BHC refers patient to PCP for thyroid testing and other possible medical conditions that may cause depression.
Patient visits PCP to screen for thyroid disease and other illnesses that may contribute to depression.

- PCP orders labs that reveal no thyroid disease, but evidence of hepatitis.
- Patient referred out to specialist for his hepatitis.
• BHC uses Beck Depression Screen that is positive for depression.
• Dx patient with Depression based on Beck, psychosocial assessment, family hx, and symptoms prior to alcohol abuse.
• BHC refers patient to PCP to consider antidepressant therapy.
Patient to PCP for consideration of antidepressant therapy.

• Patient receives antidepressant from PCP.
• Patient reveals a hx of witnessing family trauma and has nightmares and flashbacks of the event. “Occasionally” takes un-prescribed Xanax to help deal with these symptoms.

• BHC dx patient with PTSD and Xanax abuse and refers patient to CSB for PTSD group.

• BHC sends note to PCP about new dx and Xanax use by patient.
Patient’s Integrated Service Needs

- High Blood Pressure
- Hepatitis
- Alcoholism
- Depression
- PTSD
- Anxiolytic Abuse
Referrals

• Made if patient’s needs are greater than can/should be provided by PCP and BHC team. Examples include:
  – CSB for intensive outpatient, SA group therapies, and case management services
  – Inpatient treatment, often for detox or to begin recovery in supportive environment
  – Local support groups such as AA, NA, Al-anon
  – Psychiatrist
  – Alternative therapies such as massage therapy, acupuncture, methadone/suboxone
Self-medicating Pain

- Alcohol used by medical providers many years ago to relieve acute pain.
- Patients may use alcohol and/or street drugs for relief of medical pain.
- May become addicted to pain medications that were prescribed for chronic pain.
- Consider using pain management centers.
- Suboxone treatment has pros and cons.
- BHC can augment pain management by interventions such as relaxation techniques.
Patients often use substances of abuse because they can be a way to get relief from BH symptoms such as psychosis, depression and anxiety. (an unhealthy way)

As Clinicians, we need to help our patients understand that alcohol and other drugs can lead to increase in BH symptoms such as depression, anger, paranoia, memory loss, decline in cognitive functioning.
Anxiety Disorder Medications

- Anxiolytics generally not good for the addicted brain.
- Antidepressant therapy is a good alternative.
- With integrated services, the BHC can augment antidepressant therapy with interventions such as relaxation techniques and coping skills.
- Anxiolytics used as a last resort will need close monitoring by both the PCP and the BHC.
ADHD Medications

- Stimulants generally not good for the addicted brain.
- Strattera and Intunive generally preferred over the stimulants. Vyvance has less abuse potential among the stimulants.
- With integrative services, BHC can augment ADHD medications with interventions such as calming techniques and concentration exercises.
THANK YOU for your Time and Attention!
Financial Practices for Billing and Sustaining Integrative Care - SBIRT

Bill McFeature, Ph.D.

ASU DBH Conference – Fall, 2013
Why Integrative Care

- Parity legislation in 2008
- Health Care Reform- 2010
- The two converging now to profoundly effect behavioral health treatment within FQHC’s and CSB’s
FACT

- 2013 - FQHC Medicare – of the FQHC encounter rate, will percentage will increase to 100%.

- Recent estimates show that 30 million people who are currently lacking insurance will soon have insurance (Medicaid expansion dollars) - 2014.
Preparation For Future

• Contract with third-party payers (MCO’s).
• Improve Collections
• Grants-based reimbursement system
• All-Inclusive Encounter Rate for both medical and behavioral health provider.
• Strengthen Business Integrative Care Practices by being knowledgeable of MCO’s and ACO contracting that will be essential to the FQHC’s stability and growth.
Steps in the Billing Process

Utilization Review: admission, tx services, established patient, and discharge process:

- Verify Coverage
- Request prior to authorization
- Services
- Document services provided
- Bill for services
- Collections: paid or denied
- Monitor receivables
- Make corrections and resubmit
- Monitor Cash Flow
Need/Practice Gaps

• Build a case for integrated care systems that will show offset healthcare cost to the payers, extract data relevant to HEDIS reporting/CCNV and the effectiveness of utilizing BHC services in addressing depression, anxiety, and mood disorders, etc.
Consolidating medical and behavioral health budgets (correlates with adding behavioral health condition treatment products as a part in whole to a patient’s overall health). Proposed integrative care product services to MCO’s in your area NOW....carved in (global payment system) or carved out (FQHC all inclusive encounter rate based on the proposed the number of encounters on a annual basis).

REMEMBER...
Recognize models of medical and behavioral health care integration which has a potential to change health outcomes, meet criteria for PCMH model of care.
Cont.

- Appreciate the prevalence of concurrent physical and behavioral health conditions and their impact on healthcare utilization, and offset of healthcare cost.
Primary Care Philosophy.....

- Change from the common understanding (hour psychotherapy) billing to more brief interventions within your clinical systems sustainable for integrative care approaches within primary care settings.

- Behavioral health conditions are common in the medical setting, poorly treated, associated with treatment resistance, and high health and disability costs.
Cont.

• Integrative service delivery improves clinical outcomes and lowers total health costs.

• Meet criteria guidelines for patient-centered medical home model of care. Create dialogue with your Virginia Medicaid Regulatory and Policy Office.

• Make Integrative care proposals to area MCO’s.
Best Financial Practice

Integrated medical and behavioral health provider contracts with medical managed care companies (MCO’s) using a common coding/billing (90801, 90804, and 96150-2-health assessment and behavior codes, 99408 and 99409 alcohol and drug codes) for all health services within the FQHC (330) system. Accomodates to the PCP’s 15 and 30 min visit of daily practice.
Best Financial Practice

• Medical and behavioral health practitioners co-located using EHR that endorses a universal coverage approach, improving sustainability Integrative Care services.

• Should FQHC clinics be paid a fee for service, a global payment, or FQHC- all inclusive encounter rate for both medical and behavioral health services per patient seen (note: behavioral health reimbursement rate will be the same as the medical visit encounter rate by 2014. Encounter growth rate will dictate an increase percentage of the medical rate up to 2014.)
Best Financial Practice

• There will be more coverage for previously excluded benefits for wellness/prevention services/ case management services through PCP-BHC coordinated care = PCMH model.

• Use of health educators for screenings (PHQ-9, Audit-C, etc.) will reflect increased payments per patient per month-Medicare/Medicaid system for alcohol and drug codes used.
Best Financial Practices

• Patient-Centered Medical Homes (PCMH’s) attachment-template.

-PCP trained to provide first contact, continuous and comprehensive care with the BHC.

-Whole Person Orientation through providing and arranging patient care for all ages.
Best Financial Practices

- Coordinated Care and/or Integrated Care
- Quality and Safety
- Enhanced Access

NCQA requirements – PCMH model of care - DHHS will award contracts/grants to eligible entities who:

- Provide capitated payments to PCMHs.
Best Financial Practices

Eligible Entities are Community Health Teams who:

• Are state, state designed, or tribal organizations.
• Submit plans for financial sustainability
• Submit plans for integrated care
• Ensure multidisciplinary teams
• Agree to provide services with chronic conditions.
Best Financial Practices

- ACO- Accountable Care Organizations-2013
- Carilion Hospital.
- Teams of hospitals, physicians, and other professionals (behavioral health).
- Designated Medicare fee for service population that accepts the ACO as its caregiver.
- An organizational model and formula for sharing savings among the professionals when performance exceeds benchmarks.
Best Financial Practices

- Medicaid driven PCMH Demonstration Projects – health/wellness, bundled payments, and global payments.
- Safety-net hospitals (2012)-Cost-Sharing
- Psychotropic medication consultation to PCP’s – assistance to dual – disordered chronic patients.
Best Financial Practices

- Collaboration with your local CSB’s in managing co-occurring chronic mentally ill disordered patients- bi-directional dollars.

- CSB’s seeking to collaborate with a FQHC. Utilize BHC for triage with CSB case manager for referring CMI patients to CSB.
Best Financial Practices

• Strategic Framework for expanded integrated care payment opportunities as a NCQA or JCAHO accredited organization meeting criteria as a patient-centered medical home model of care.
• PCMH’s with capitated payments.
• ACO’s with integrated savings model.
• Bundled payment for episodes for integrated care services.
Best Financial Practices

“CRITICAL”

Managed Scheduling - Decentralized or Centralized System – Front Desk Registration/scheduling patients for 15 and 30 min appt based on complexity of patient need.

“CRITICAL”
Integrated Care Billing Codes

- Code
  - 99213 (E/M low)
  - 99214 (E/M Mod)
  - 99215 (E/M High)
  - 90801 (Psy Eval)
  - 90804 (Psy 30 min)
  - 96152 (B Health Consult) - 15 min increments
  - 90862 (Psy Med Check) - 15 min
  - 99408 (SBIRT code- 99408) - 20 min
  - 99409 (SBIRT code- 99409) - 30 min
  - 96101 (Psych Testing code)
Best Financial Practice

Chronic Disease Management (Integrated Care):
PCMH-NCQA – AIM Goals:

- Focus on coordinated care between the PCP and BHC targeting and panelizing patients with health complexity—chronic disease management, i.e.; depression, diabetes, asthma/COPD, and cardiovascular conditions. Note: 5% of patients use 50% of health resources.
Best Financial Practices

- Financial Goals of Integrated Care:
  - Decrease medical visits per patient.
  - Decrease emergency room visits.
  - Decrease hospital admissions.
  - Decrease hospital days.
  - Decrease pharmaceutical costs.

**Integrative Care Research Shows Improved Overall Health Outcomes.**
Conclusive Statement:

“Integrative Care will require an overall effort and understanding between your Board’s knowledge of Integrative Model of Care, Finance/Billing Department, “clinical champion leaders” (medical provider and behavioral health provider) and a Senior Management Team who thoroughly understands the impact of quick access, brief assessment, brief intervention, and quick feedback to the PCP; hence, the infrastructure of the BHC component of a FQHC system to address both BH and SA.”