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Integrating Substance Use Disorder Treatment & Mainstream Medical Care: *Four Ground-Level Experiences*



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Introduction: The Continuing Evolution of Substance Use Disorder Care

In the course of just two generations, the delivery of medical care has evolved from small-group community practices to more corporately organized and specialized forms of care. During this same period, the treatment of substance use disorders (SUDs) has evolved from a marginalized social support service to a more broadly recognized specialty health service. This shift in SUD treatment has been propelled by neurobiological and social science research that firmly establishes SUDs as a treatable health condition. Yet even patients whose SUD is correctly diagnosed often experience missed connections and fragmentation in dealing with their overall health status.

“Integration” has become a health care buzzword used to describe a wide spectrum of approaches to remedying the fragmentation experienced by many patients. Integrated treatment, or addressing the ‘whole person’ in their social and cultural context, makes immense common sense — but the forces that organize the delivery, financing, training, and other aspects of health care too often push against this obvious logic, leaving patients frustrated with ‘the system.’ So what *does* it really mean to integrate SUD treatment and general medical care? What constitutes integration? Operationally, there are as many definitions as there are practical examples. All are based on recognizing the co-occurrence of substance use disorders with other conditions that determine health status.

This brief offers four examples of the integration of SUD treatment and mainstream medical care. Rather than searching for a uniform set of requisite traits, we decided to show why and how four very different groups of providers moved toward integrated care, asking, “What is the context in which integrated care occurred? Why did integrated care occur? How did it happen? Is integrated care better for the patient? Are there lessons to be learned from these experiences? What more should we know about integrated care?”

Care Integration — Not Standard Yet

More and more often, patients are finding that their visit to their primary care physician will include being asked questions about their alcohol and drug use. Asking patients about their alcohol, drug, and tobacco use is a standard of care endorsed by the World Health Organization, the United States Preventive Services Task Force, the American Medical Association, the American College of Surgeons, and the American Academy of Pediatrics. Indeed, the first practice standard for SUD providers endorsed by the American Society of Addiction Medicine is a comprehensive assessment that includes a physical exam and a complete medical and pharmacological history. Compliance with these standards varies widely, however, reflecting significant variations in the degree of care integration found in both SUD and general medical settings.

Integration in Diverse Contexts

To illustrate the context for integration, we introduce four providers and health systems that have taken differing approaches to the integration of SUD services into primary care:

- Finger Lakes Community Health in New York, a Federally Qualified Health Center (FQHC) with nine satellite clinics
- Boston Medical Center, an urban public hospital system with SUD screening, medication, treatment, and follow-up included in all inpatient, outpatient, and affiliated health center settings
- BayCare Medical Group, a 14-hospital health system with a large specialty behavioral health department in the Tampa Bay, Florida area
- Chestnut Health Systems, an Illinois-based behavioral health organization that operates an FQHC

These examples represent two hospital-based health systems that incorporated SUD treatment services as part of their systems; one FQHC that incorporated behavioral health into its service array; and one

behavioral health center that incorporated an FQHC. All of these entities obtained the requisite state licenses or met other federal and state regulatory requirements to deliver both SUD and general medical care.

The Motivation to Integrate Care

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It was the observation of *patient need* that first moved all four organizations to integrate SUD and basic medical care. For the Finger Lakes FQHC, integration began more than 20 years ago in a partnership with the Finger Lakes Counseling and Recovery Agency as a response to the SUD and medical care needs of uninsured farm workers. Similarly, Boston Medical Center brought addiction treatment into its emergency department and prenatal and HIV clinics in the 1960s, '70s, and '80s because patients, many of whom were uninsured, were presenting with alcohol and drug use in addition to the other conditions that brought them to those settings. Boston Medical Center has since incorporated SUD assessment, medication, and counseling and follow-up into all services. Florida's BayCare system started its integration journey more recently in 2010. Its goal was to improve health outcomes in patients who presented with comorbid SUD and mainstream health conditions. Chestnut Health Systems has employed Advance Practice Registered Nurses (APRNs) in its mental health and addiction programs since the early 2000s, and these providers soon recognized the untended health conditions presented by their behavioral health patients. Nurse-practitioner-staffed primary care clinics were introduced into the agency's services through funding from the Health Resources and Services

Administration in 2012; this initiative brought new staff (physicians and APRNs) to focus on primary care.

Research on integration indicates that patients with chronic health conditions and SUD diagnoses who are treated for the SUD as well as the other health conditions use fewer health service resources overall than those whose SUD conditions remain unaddressed.^{1,2,3} In all four of our examples, recognition of the multiple needs presented by patients was the initiating force to integrate SUD and general medical care.

The second and related reason for moving toward integrated care is the presence of an individual or group with the *vision and leadership* to recognize and act on the multiple needs of patients. In all four cases, one or more champions saw the connection between SUDs and chronic illness, HIV, or other conditions, and changed the practice of a clinic or other setting to screen, counsel, prescribe, or refer in addition to treating the presenting condition. Potential financial opportunity represented a third reason for integration at BayCare and Chestnut Health Systems. The opportunity was seen in the diversification of the payer mix associated with SUD treatment at BayCare, and at Chestnut in an opportunity to match each provided service appropriately with an optimal payer in either an SUD or health care setting. The recent trend toward bundled, pre-paid, and capitated payment systems supports such thinking by providing an incentive to intervene early with appropriate intensity, in the hope of deterring the more expensive episodic care associated with untreated acuity.

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1 Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., & Lu, Y. (2001). "Integrating primary medical care with addiction treatment: A randomized controlled trial. *JAMA*, 286(14):1715-23. doi:10.1001/jama.286.14.1715

2 Clark, R., Samnaliev, M., & McGovern, M. (2015). Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. *Psychiatric Services*, 60(1):35-42. doi: 10.1176/appi.ps.60.1.35

3 Open Society Institute (2009). *Unforeseen benefits: Addiction treatment reduces costs*. <https://www.opensocietyfoundations.org/reports/unforeseen-benefits-addiction-treatment-reduces-health-care-costs>

None of the four organizations reviewed moved toward integrated care because of external directives such as contractual or performance standards or regulatory requirements.

How Integration Happens

Incremental Development

The integration of SUD and general medical services, motivated by a growing awareness of patient needs, is usually incremental in execution. At both BayCare and Finger Lakes Community Health, integration began with the placement of SUD-certified clinical staff in physician practices, later expanding to include medication-based treatments (e.g. buprenorphine, methadone) and related care. Chestnut Health Systems started out by hiring APNs in its mental health clinics to enhance psychiatric prescribing and then extending that function through its FQHC designation. The origins of integration at Boston Medical Center reach back to staffing “Room 5,” adjacent to the emergency department, where nursing and recovery aides monitored patients’ alcohol withdrawal symptoms. Room 5 no longer exists, having been replaced by comprehensive assessment, triage, inpatient addiction consultation and follow-up services connected to the emergency department, primary care and Office Based Opiate Treatment clinics and specialty SUD services of the Grayken Center for Addiction Treatment. In three of these cases, patients were first provided access to SUD treatment through their contact with the general medical system, while the reverse is true of the fourth, where patients were provided access to general medical care through the SUD system. As each system evolved over time, patient access to integrated care became bi-directional, accessible through any point of entry.

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The development of integrated care at the four sites advanced concurrently with the introduction of

empirically based screening and intervention tools — specifically Screening, Brief Intervention, and Referral to Treatment (SBIRT) and medications that treat addiction to alcohol and other drugs. BayCare adopted a disease management model at its primary care clinics that focused on diagnosing SUD accurately, formulating treatment, and designing a follow-up plan with the patient. BayCare is continuing their efforts to have primary care teams perform consistent screenings for SUD and to develop strategies for emergency department interventions. Boston Medical Center has expanded integrated care that includes medication-based treatment to primary care and family medicine as well as its adolescent and HIV specialty outpatient clinics and 14 related community health centers. Finger Lakes, in addition to screening and medication-based interventions, introduced a telehealth component for specialty care in HIV, hepatitis, and other targeted conditions. Patients can enter any behavioral health or FQHC door at Chestnut Health Systems and expect to have comorbid conditions identified and treated within one system.

Staffing

The staffing of settings in which SUD and general medical care are integrated follows the context in which integration was initiated. At Finger Lakes and BayCare, SUD counselors were introduced into primary care settings, while at Chestnut Health, APNs were introduced into mental health settings. Chestnut Health went on to utilize licensed practitioners (MDs, Osteopathic Doctors, and APNs) to deliver “primary health care” through its Primary Care Medical Home certification framework, using a comprehensive approach that fully integrates primary and behavioral health services. In either direction, cultural adaptation is required. General medical settings usually have more explicit and formal protocols and hierarchies than do behavioral health settings. When licensed and professional staff move between different health care settings, they must adapt to cultural differences as well as acquiring a new body of knowledge. For instance, physicians and other physical health staff were exposed to clearer protocols for screening individuals with SUDs and in-house clinicians rather than being referred to specialty SUD providers offering treatment that is more intensive and recovery services could serve determining which ones. Meanwhile, SUD clinicians embedded in

primary care gained a better understanding of co-occurring physical health conditions. All of the organizations in our examples described in-house training opportunities for staff, with one, Finger Lakes, referencing financial assistance for staff to become certified.

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Patient Records

In fully integrated systems of care, providers of any service have access to the full medical records of each patient. Boston Medical Center has a single electronic medical record (EMR) that covers all services and patients. The software developer Epic Systems built a behavioral health add-on component for Boston Medical Center that supports state-required SUD reporting as well as provider needs. Chestnut Health tried a unified EMR, but costs were prohibitive, resulting in one EMR for the FQHC and another for behavioral health. Chestnut has worked around this discontinuity by granting login privileges to a high proportion of its staff in both systems. BayCare has implemented a fully integrated EMR system (Cerner). Finger Lakes is currently implementing a single health center EMR. Electronic medical records that are equally appropriate for general medical and behavioral health use have been challenging to develop and implement for several reasons:

- The behavioral health market is smaller than the general medical market and has not commanded the full attention of the biggest EMR system developers such as Epic, Medtronic, GE, and Athena.
- EMR systems are expensive to purchase, learn, and implement. SUD providers seldom have capital reserves and are not always eligible for federal infrastructure funds from the Affordable Care Act.
- Federal confidentiality regulations (CFR 42) require either privacy zones or translational workarounds to mingle SUD data with general medical data.

- Regulations and standards that govern reporting requirements for management, performance, and financial data are different in general health and SUD systems.

Health systems that integrate SUD and general medical care often pursue workaround or translational patches to link parallel EMR systems, or adapt a single system to meet the needs of both types of care. The development of workarounds consumes an inordinate amount of staff resources, while significant financial investment is necessary to procure and operate two separate systems.

Paying for Integrated Care

To pay for the costs of integrating care, our example organizations drew on three sources of revenue: grants, third-party reimbursement, and self-funded operating sources.

Finger Lakes used operating funds provided by the Health Resources and Services Administration (HRSA) to purchase bilingual services from its partner SUD agency. The integration of SUD and general health at Finger Lakes is further supported by third-party billing (Medicaid) and a HRSA grant. At Boston Medical Center, some of the funding that supports integration of SUD care into the emergency department and primary care clinics comes from state and federal contracts and grants for research conducted by affiliated medical school faculty. Boston Medical Center also supports clinic services through third-party billing at enhanced disproportionate-share hospital rates, and subsidizes some overhead and administrative costs through its general operating budget. Research grants and third-party reimbursement are primary sources of financing at Chestnut Health Systems. One notable quality at Chestnut Health is its explicit choice of optimal reimbursement sources to account for diagnosis, intervention, and license (SUD or FQHC); the agency strategically selects services to provide through the FQHC in order to maximize revenue sources while minimizing regulatory conflicts between purchasers. BayCare currently receives reimbursement from private payers and Medicare for its integrated strategies. The current reimbursement structure for its Medicaid beneficiaries makes it challenging for BayCare to offer these patients both SUD and primary care services.

Challenges

All incremental processes involve refinements and continuous improvement, often in response to challenges encountered in execution. The following challenges were encountered by the four organizations as they moved toward greater degrees of care integration:

- **Provider (physician) reluctance** is not uncommon due to several factors: growing pressure on available time for patient visits and providers' resulting hesitation to take on additional functions; incomplete understanding of the interaction effects of addiction and other chronic illnesses; lack of information or resources to make appropriate referrals for patients identified with SUDs; and limited understanding of the relapsing and recurring nature of addiction disorders.
- **Regulations and policies** governing billing insurance plans sometimes discourage the provision of multiple services in one session. For example, some states' Medicaid policies do not allow billing a physician visit and a behavioral health counseling session for one patient on the same day if the latter service is included in the Prospective Payment System rate for the FQHC. Other states have not included the costs of their behavioral health practitioners in their rates and allow FQHCs to bill for behavioral health services covered by each state's Medicaid plan.
- **Accounting for revenues and expenses** within a single system can be problematic when departmental or subcorporate budgets are expected to meet predetermined margins. For example, if a behavioral health organization or department places clinicians in the offices of health-system-owned physician practices, to which entity does the revenue generated accrue? How are overhead expenses distributed among the entities?

These issues are not insurmountable, but are problematic until resolved. *Information sharing and technology* under EMRs was also discussed. The inability to share patient information not only inhibits progress toward integration, but more importantly can also result in ineffective patient care. *Staff skills and availability* are other potential challenges. Professionals working in all settings require a more flexible orientation, broader knowledge, and a specific skill base to fully cover the breadth of issues presented by patients. Finally, *licensing* can often be

problematic if state regulations require redundant facility licensure for health care and SUD treatment services or make the delivery of integrated care difficult. For instance, some states require that FQHCs obtain an additional license to offer behavioral health services before they can deliver integrated care.

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Patient Outcomes

As cited above, research indicates that simultaneous treatment of SUD and other health conditions results in reduced utilization of health services. Unfortunately, these studies assume that this means the patient has better health, rather than directly documenting whether this is the case. This dilemma exists with all of our case examples as well, as none of the four profiled organizations gathers or tracks data that directly measures the health status of patients whose care is integrated. Rather, several collect and track data elements such as patient volume; service utilization (type and amount of service, e.g. number of patients receiving SBIRT); revenue for integrated services; show/no-show/dropout rates; warm hand-offs; and follow-up appointments kept. At this point, most of what is tracked is process-of-care data, not patient well-being data. Therefore, the question 'Are they healthier?' remains unanswered.

Key Lessons Learned

Each example discussed in this brief highlights that there are many different definitions of integration and as many forms that integration takes. All, however, share the recognition that patients' health status is impacted by the co-occurrence of substance use disorders with other medical conditions. The approaches set forth in these examples provide some key takeaways for providers and health systems considering greater integration of primary care and SUD care:

- Patient need is the prime reason to integrate SUD and general medical care.

- Leaders in these organizations recognize that patients have multiple needs; the vision to address those needs is an essential ingredient of integration initiatives.
- Integration initiatives can be financially solvent due to efficiently caring for complex cases that would otherwise be high-cost — however, the financial success of these models is directly related to sufficient reimbursement rates.
- Integration initiatives are not static or dichotomous and reflect different degrees of integration over time.
- Staff recruitment and ongoing staff training are needed to implement integration initiatives.
- Unified patient records, especially in the form of EMRs, are not yet fully developed to focus on integration. Patches, bridges, or other translational mechanisms are often necessary to incorporate both SUD and general medical records.
- Financial support for integration requires providers to be adept at blending and braiding research/grant monies, third-party reimbursement, and general operating revenues.
- The incremental process of executing integration over time is likely to encounter challenges associated with: provider hesitance; billing regulations or practices; accounting for revenue; and information-sharing technology.
- While measures that track patient utilization and service system performance are available and indicate improvements in integrated care initiatives, they assume but do not directly reflect improvement in patient health status.

And finally, we could benefit from identifying lean models of integration. Specifically, how can other medical professionals supplement or even supplant physicians who are often overburdened with high patient caseloads and productivity expectations? Some of the models discussed above use nurse care managers and others to identify diagnose and facilitate access to SUD treatment.

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The efforts highlighted here offer solid examples of steps providers can initiate to design and implement care integration. For those interested in moving toward care integration in their own systems, there is much to be learned from these cases about the buy-in necessary to success, and about realistic timeframes for implementation. Providers are key to spreading integration practices, since many payers have little experience with developing integration strategies to address the co-morbidities of individuals with substance use disorders.

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What More Should We Know?

The models presented in this brief provide a synopsis of four different approaches to integrating primary care and SUD treatment, but they are certainly not the universe of strategies for integration. Other models must be identified, and additional insights into why and how integration is introduced will be important. Perhaps the most important information still lacking is the impact that integration has on patient outcomes. While process measures are important, we need more information on the improvements in overall health status and to even venture into identifying whether integration impacts social determinants of health such as safe and affordable housing, obtaining and maintaining employment, and reducing interaction with the criminal justice system.