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INTEGRATING APPROPRIATE SERVICES FOR SUBSTANCE USE CONDITIONS IN HEALTH CARE SETTINGS

An Issue Brief on
Lessons Learned and Challenges Ahead

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Introduction

With funding from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT), the Center for Policy Research and Analysis at the Treatment Research Institute (TRI) is exploring the challenges, opportunities, and promising practices associated with financing appropriate treatment for substance use conditions inside primary and other health care settings. TRI is an independent, nonprofit research organization dedicated to science-driven reform of policy interventions for treating substance use conditions.

Historically, substance use conditions have been treated primarily in settings that are separate from traditional general medical practice. Often there is little, if any, ongoing communication about risks or progress between specialty substance use treatment and general health care providers who treat the same patients. Routine screening for substance use also is atypical in traditional health care settings, despite its established efficacy for identifying alcohol misuse. And, even when risky or dependent substance use is identified by a patient or the practitioner, the condition is too often ignored or patients are referred outside primary care for treatment and follow-up with little coordination with the rest of their health care providers.

This lack of connection and communication between specialty and general health care professionals who treat patients with substance use conditions unnecessarily impairs the health of individuals, populations, and whole communities, and contributes to income, ethnic, and gender disparities in health care, as well. In the last 10 years, neuroscientific and other research has laid the foundation to understand addiction as a chronic disease with characteristics and implications for treatment and recovery that are similar to other chronic diseases (McLellan, Lewis, O'Brien, & Kleber, 2000; Stout et al., 1999). This is not to imply that everyone who uses or abuses addictive substances develops a chronic disease. Indeed, studies have also shown that screening and early intervention can arrest use problems before they develop into a more serious chronic condition. For those who do develop a chronic condition, treatment typically should include an *acute* phase of patient-centered, adaptive care, followed by a *continuing care* phase that assists the patient to manage his or her disease and supports the patient in ongoing recovery in the community (McLellan et al., 2000).

We Can No Longer Continue to Isolate Substance Use Conditions

According to SAMHSA's National Survey on Drug Use and Health (NSDUH) report (2005), substance use conditions are chronic diseases, which have been identified in about 9.5 percent of the general population (about 24 million Americans over the age of 12). Yet only about 10 percent of those identified are ever treated in the specialty treatment system and over 40 percent who try to get help say they are denied treatment because of cost or

insurance barriers. Patients with substance use conditions, therefore, are more reliant on public funding sources for treatment than patients with other diseases. In fact, public funding constitutes the vast majority of addiction treatment expenditures—over 75 percent of all expenditures for treatment in 2003 and predicted to rise to 83 percent by 2014 (Levit et al., 2008).

About 22 percent of general health care patients report they have a comorbid substance use condition of some level of severity (SAMHSA, 2005). This large percentage of patients is likely related to the pervasiveness of a myriad of physical sequelae that result from untreated substance misuse and dependency. Additionally, the presence of substance use conditions often complicates the treatment of a variety of common medical disorders, such as diabetes. The data are clear that health care costs, particularly the costs of chronic disease, substantially increase annually and over the lifetime of individuals with untreated substance use, alcohol, and other drug disorders. Despite this finding, screening for substance use disorders historically has not been common practice in medical settings, even in emergency rooms, and treatment beyond emergency care has been provided separately from general medical care (Fleming, 2004/2005). The problem of separation has been compounded by the lack of communication between the specialty treatment system for substance use disorders and the general health care system, even when, as noted above, the systems are providing care for the same patient at the same time.

While treatment has generally occurred outside of primary and other health care settings, creative models for integrated care are being developed across the country. In the main, these models—some of which will be described in this briefing paper—do not rely on formal mergers between specialty and general health care organizations. Instead, to varying degrees they rely on service agreements among organizations, new and emerging staffing models, and patient care teams that are more reflective of the work that has been done in chronic disease management than acute episodic treatment.

Studies Support Integration, but Also Reveal Barriers

Two major Federally sponsored reports are relevant to this issue and support the case for increased integration of clinical services. The first, *Integration of Mental Health/Substance Abuse and Primary Care*, was sponsored by the Agency for Health Care Research and Quality as part of its Evidence Report/Technology Assessment Series. In general, integrated care led to positive outcomes for those with alcohol use disorders (other substance use disorders were excluded from the study), although those clinical outcomes themselves were not actually demonstrated to be linked to specific measures of integration. The report documented that the varying payment schemes across multiple health care plans were a barrier to adoption of this innovation (Butler et al., 2008).

The second report, *Reimbursement of Mental Health Services in Primary Care Settings* (Kautz, Mauch, & Smith, 2008), was sponsored by SAMHSA to respond to the goal of better integrating physical and mental health, as delineated in the 2003 President's New Freedom Commission on Mental Health, *Transforming Mental Health Care in America.* The report was

an outcome of the collaboration of SAMHSA, the Health Resources and Services Administration, and the Centers for Medicare & Medicaid Services (CMS). This report documents barriers in Medicaid and Medicare that inhibit the reimbursement of mental health services within primary care, and outlines actions that should be taken to minimize such barriers. While the report focused solely on mental health, similar barriers hinder reimbursement for integrated treatment for substance use disorders.

In 2006, CMS approved billing codes to allow Medicaid providers to bill for screening and brief intervention services. Current Procedural Terminology (CPT ®) codes were also approved by the American Medical Association in 2008 (Anderson, Aromaa, Rosenbloom, & Enos, 2008, p. 10). These two procedural changes *theoretically* made it easier for health care providers to receive payment for time spent identifying and counseling patients with substance use conditions. However, findings to date from our environmental scanning (described below) indicate that there is little use of these codes by health care providers (Fussell, et al., in press).[1] State agencies have to approve the adoption of codes after they are approved by Medicaid. Some State Medicaid agencies have not considered or activated the new screening codes, or have made them permissible only with very limited populations, such as pregnant women. Others have approved turning on the codes but have not actually acted to fund the services. Furthermore, health care providers may be unaware that the codes exist, or are unwilling to change their practice patterns to address substance use routinely and uniformly, whether in the public sector under Medicaid and Medicare or in the private sector.

A Forum Is Held on Integration

In 2009, the Center for Policy Research and Analysis at TRI was asked by SAMHSA/CSAT to create a Forum on Integration for State and county agency leaders to discuss and promote more integrated treatment of substance use conditions in a variety of health care settings. We began with an environmental scan to identify integrated programs that do exist in a wide variety of settings, including community health centers, primary care clinics, HIV clinics, health plans, and other medical settings. Specifically, we evaluated the extent to which care is said to be integrated and in what settings, and how substance use screening and treatment are financed in these settings.

Our first objective was to identify promising State and provider initiatives that have implemented appropriate identification, assessment, and treatment interventions for substance use conditions in a diverse array of health care settings. We found several program models that are currently operating across a broad range of State, local, and county governments, as well as within community-based organizations. We also found health plans that integrate substance use identification, assessment, and brief treatment within a broader framework of health care services and locations. In addition, we found a

[1] Rita 'Vandivort, CSAT, Division of Services Improvement, personal communication.

significant number of interventions occurring across diverse settings—perhaps more examples than most substance use treatment experts realize. The interventions are targeted at diverse populations, and sponsored by a wide variety of entities. For example, the Integrated Behavioral Health Project in California involved health care workers who were interested in integrating all of behavioral health care with physical health care.[2] Yet, while it may appear that many programs focus on integrated care for mental health and substance abuse, a substantial portion are focused primarily on mental health issues and have little, if anything, to do with substance use disorders. Moreover, when treatment for substance use conditions is included in such programs, the focus may be limited to alcohol use, excluding other forms of substance use, even alcohol use combined with other drug use.

Based on a search of the literature and expert contacts, however, the team also found programs using diverse models and sources of financing that show promise and appear to have the potential to serve as models of integration nationally. Financial practices supporting such programmatic innovations proved to be as varied in scope as the initiatives themselves. The most innovative programs were not necessarily created or developed by State agencies, but often were private programs launched in community organizations such as community health plans, community health centers (CHCs), or Federally qualified health centers (FQHCs). Some of the new integrative programs, however, were in States that have a strong single State agency presence, but these programs and the State agency leaders did not necessarily know of each other nor did they interact regularly; therefore, there was no mutual support.

Representatives from the most promising and geographically diverse initiatives were invited to the Forum on Integration (held in late April 2010) to discuss the challenges and opportunities they have faced in planning, implementing, and sustaining effective substance use screening and treatment programs in general health care settings. For their brief presentations at the Forum, participants were asked to focus in detail on their funding arrangements as well as to discuss organizational and service aspects of their programs. The remainder of this briefing paper identifies and briefly summarizes the themes that arose from these discussions at the TRI SAMHSA/CSAT Forum on Integration.

[2] Launched in 2006, the Integrated Behavioral Health Project was a 4-year initiative to accelerate the integration of behavioral health services into primary care settings in California (www.ibhp.org).

Theme I: It is critically important that there be greater integration of substance use condition screening and treatment or intervention in general health care.

Better integration of treatment for behavioral health conditions with general medical care and other medical specialties is important for a variety of clinical reasons. For example, Robinson and Reiter in their book, *Behavioral Consultation and Primary Care: A Guide to Integrating Services* (2006), have estimated that more than two thirds of primary care visits are related to *psychosocial issues.* Evidence also points to the sizeable presence in various mainstream general health care settings of persons with *substance use conditions*—both unidentified and identified. More than 1.5 million visits for treatment at hospital emergency departments in 2008 were found to be associated with some form of substance misuse or abuse (Drug Abuse Warning Network, 2008). Drug or alcohol disorders in 2006 were associated with about 3 percent of hospital stays in the United States, accounting for an estimated $12 billion in costs (Russo & Elixhauser, 2006; Kassed, Levit, & Hambrick, 2007). Significant increases have also been noted recently in the number of mental health and substance abuse visits to FQHCs—increasing almost 45 percent between 2001 and 2007 (Bureau of Primary Care, n.d.). FQHC staff deal with important health issues with their patients, sometimes including discussions related to the use of alcohol and tobacco (Carlson et al., 2001).

Yet, more than 90 percent of patients who meet the criteria for a substance use disorder may not independently perceive a need for specialty treatment and therefore do not seek it (SAMHSA, Office of Applied Studies, 2008). Sometimes patients recognize that they need some assistance but are not comfortable entering a specialty mental health or substance abuse treatment facility. Further complicating the ability of patients to obtain treatment is the limited capacity of the current substance abuse treatment system, which is often characterized by waiting lists, especially for some lower cost or publicly sponsored types of treatment. Even insured individuals may not seek specialty or general health care for substance use conditions, despite State and Federal parity laws.

An established evidence base has led the United States Public Health Service's Preventive Services Task Force to recognize screening and brief intervention (SBI) for alcohol use conditions as one of the most cost effective preventive interventions for adults (Maciosek et al., 2006). Studies show that routine screening in primary care and other medical care settings can be an essential public health approach to preventing or limiting the progression of patients' misuse to chronic substance use conditions. For example, one randomized trial in family physician health clinics that compared "problem drinkers" who received SBI to those who received usual care estimated that the intervention cost of $205 resulted in a total average benefit per patient of $1,151, including savings in emergency room and hospital use and costs due to alcohol-related crimes and auto accidents (Fleming et al., 2000). Still, SBI has not been universally adopted.

The SAMHSA screening, brief intervention, and referral to treatment (SBIRT) program[3] provides an opportunity for a wide variety of health care practitioners to proactively assist patients who may be at risk for a substance use disorder. It includes identifying those in need of specialty treatment and referring them for that treatment. Delay in early identification and provision of services appropriate for each patient with a substance use condition adds to the stigmatizing belief that all of these patients develop end-stage disorders from which they are unlikely to recover. The integration of substance abuse treatment services into general health care may be essential to the reduction of the stigma associated with these conditions. And reducing stigma encourages prompt and appropriate intervention and treatment.

Another rationale for integrating substance abuse treatment with other medical care is that persons with substance use conditions are quite likely to have a wide variety of other concurrent medical side effects and consequences such as kidney disease; diabetes; lung conditions such as emphysema, chronic obstructive pulmonary disease (COPD), and pneumonia; and gynecological/obstetric conditions. These persons also are likely to experience both routine and major depression, heightened anxiety, and even major psychoses. Patients who were hazardous drinkers and/or used illicit drugs were estimated to be about 10 percent of patients seen in a health maintenance organization (HMO) primary care practice (Mertens et al., 2005). In other research, adult substance use treatment patients compared to matched controls were more likely to have disorders such as injury, low back pain, hypertension, and headache, and were at increased risk for having other physical disorders. Higher health care costs were also documented among those with substance use disorders (Mertens et al., 2003; 2005).

As drug use patterns change, addiction specialty treatment programs in the United States are also seeing an increase in patients with serious medical problems, including HIV and Hepatitis B and C related to intravenous drug use (CDC, 2008; 2009), as well as patients with cardiovascular problems and lead poisoning associated with methamphetamine use (Burton, 1991). A study of adolescents entering chemical dependency treatment also reflected a similar increase among their group in health problems and health care costs (Mertens et al., 2007). In addition to the health problems associated with persons with substance use conditions and associated higher costs, recent research has demonstrated that family members of individuals with alcohol and/or drug use conditions are also more likely to have medical conditions and to have higher medical costs as a result of living with addicted persons (Ray, Mertens, & Weisner, 2007).

Researchers have documented the relationship between substance use and trauma, especially motor vehicle accidents that end in serious injury. Both emergency departments and trauma centers treat a high proportion of patients whose condition is related to alcohol

[3] SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

misuse (Gentilello, Donovan, Dunn, & Rivara, 1995; Maio, Waller, Flow, Hill, & Singer, 1997). About 30 percent of those admitted to a trauma center have a positive heightened blood alcohol level (Soderstrom et al., 2001). Pivotal studies by Gentilello and colleagues (1995; 1999) showed significant reductions in drinking and reinjury following a brief intervention that are consistent with findings from other emergency department research. In this research, the intervention group was also found to have fewer motor vehicle violations and arrests. Gentilello subsequently estimated that "The brief intervention resulted in $3.81 in health care costs saved for every $1.00 spent on screening and intervention" (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005). Based upon such research, the Committee on Trauma of the American College of Surgeons, which accredits trauma centers, adopted the following requirement in 2006:

> Trauma centers can use the teachable moment generated by the injury to implement an effective prevention strategy, for example, alcohol counseling for problem drinking. Alcohol is such a significant associated factor and contributor to injury that it is vital that trauma centers have a mechanism to identify patients who are problem drinkers. Such mechanisms are essential in Level I and II trauma centers. In addition, Level I centers must have the capability to provide an intervention for patients identified as problem drinkers. These have been shown to reduce trauma recidivism by 50 percent. (Committee on Trauma, 2006)

Persons living with HIV/AIDS are another special population with an especially significant link—injection drug use—between substance use and a medical disorder. In 2005, it was estimated that approximately one third of persons in the United States living with HIV/AIDS are indirectly (sexual partners) or directly linked to injection drug use (Kaiser Family Foundation, 2006). Federal funding provided by the Ryan White Care Act supports core medical care for uninsured and low income persons living with HIV/AIDS and support services necessary to achieve desirable medical outcomes. During the reauthorization of the Ryan White Care Act in 2006, core medical services were defined and included substance abuse treatment services, among others. Such services therefore should be available to patients being treated for HIV within Ryan White-supported clinics.

Additional research has shown that the quality of health care received varies significantly across conditions and that patients with alcohol dependence received only about 10 percent of the care recommended for them, while patients with hypertension, stroke, depression, coronary artery disease, and asthma all received at least one half of the recommended care (McGlynn et al., 2003). In recognition of this, and the linkage between substance use conditions and a variety of other health care problems, a number of other accrediting or care-sponsoring organizations have published or are considering creating expectations regarding the integration of substance use services in various health care settings. The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is working with others, including SAMHSA, on the development and pilot testing of performance measures related to the identification and management of persons with substance use conditions. While it is unknown if and when

the Joint Commission and the National Quality Forum[4] will include such standards in their requirements for hospital accreditation, at a minimum, the performance standards and definitions as finalized will be available to hospitals to use as performance measures in their own quality improvement efforts and conform with the Joint Commission's accreditation requirements (Curley, 2009).

Substance abuse treatment has also been found to be associated with individuals' decreased subsequent health care costs, compared to the time before treatment. One study found a decline of more than one third in both per capita inpatient and emergency room costs following the receipt of treatment (Parthsarathy, Weisner, Hu, & Moore, 2001), while another reported more than a 50 percent drop in total per patient per month medical costs (Parthasarathy, Mertens, Moore, & Weisner, 2003). Other similar studies have focused on cost savings for Medicaid patients with substance use conditions. A study of Medicaid patients in Washington State found a decrease in overall Medicaid costs of 5 percent for patients who received indicated substance abuse treatment, compared with those who did not receive it (Luchansky & Longhi, 1997). Another study of Medicaid patients in a comprehensive HMO found substance abuse treatment was associated with a reduction of just under one third of medical costs per treatment member (Walter, Acerson, & Allen, 2005). Even more important, for patients who achieve abstinence after treatment, family members' health care utilization and costs are similar to that of control families, 5 years after treatment (Weisner, Parthasarathy, Moore, & Mertens, 2010).

There is growing evidence to support the cost benefit of integrated care as a way to achieve more treatment of substance use conditions and to improve access. One study showed that integrated care (in comparison to independent care) led to significantly lower total medical costs, while others have demonstrated that integrated care leads to improved outcomes and cost effectiveness (Humphreys & Moos, 2001; Smith, Meyers, & Miller, 2001). For example, receipt of integrated care during and after substance abuse treatment has also been shown to improve the outcomes of substance abuse treatment, most specifically the likelihood of abstinence following treatment. Weisner and colleagues found that in comparison to "usual care," patients with substance abuse medical conditions who received integrated services during treatment had almost twice the odds of abstinence (Weisner, Mertens, Parthasarathy, & Moore, 2001). Moreover, receipt of primary care (defined as having received 2 to10 visits) by chemical dependency patients with associated medical conditions was predictive of chemical dependency remission at 5 years (Mertens, Risher, Satre, & Weisner, 2008).

Compared to receipt of primary care, detoxification shows a less impressive pattern. In one study, less than 20 percent of patients who received detoxification services in inpatient settings later received related primary care (Saitz et al., 2004). Researchers have reported improvement in the rate at which public substance abuse patients are linked to primary

[4] The National Quality Forum (NQF) is a Federally-chartered organization responsible for endorsing standards of care and performance measures for all health care; it is the organization that published the NQF Standards of Care for Substance Use Problems.

care after detoxification when medical and social work teams are stationed and colocated within the detoxification setting. More of these patients were linked to primary care, and patients who had two or more visits to primary care following diagnosis were less likely to use drugs or be intoxicated with alcohol and more likely to have lower alcohol and drug problem severity after linking (Samet et al., 2003).

Substance use disorders are now viewed by clinical experts as chronic diseases with outcomes similar to other chronic diseases (McLellan et al., 2000). Others have suggested that the chronic disease concepts of *disease management* and *continuing care* may also be especially useful to the substance abuse treatment field, whether provided in primary care or in specialty care settings. These concepts embody the notion of ongoing care as dictated by the patient's condition, accounting for the need for easy movement between the primary care and specialty care settings, as clinically appropriate. Use of at least similar paradigms of care in the primary care and specialty care sectors may facilitate better integration of services and improve outcomes. There is some observational evidence to suggest that the receipt of ongoing primary care (over 9 years) was associated with substance dependence remission, even in the absence of specialty counseling or medications (Chi, Mertens, Parthasarathy, & Weisner, 2010; Parthasarathy et al., 2003).

In addition, the integration of substance abuse treatment in primary care is crucial to allow for the expanded use of indicated, evidence-based pharmaceuticals to treat substance dependence, as they are developed. A case in point is buprenorphine, a medication used to treat opiate addiction in office-based settings and some outpatient methadone clinics. Four medications are available to treat alcohol addictions; three are oral and one is injectable naltrexone. Given the limited, although slowly increasing, availability of physicians and advanced nurse practitioners in substance abuse treatment settings, it will be impossible to fully utilize these and other new discoveries without including physicians in general health care settings, who can identify patients for whom these medications would be indicated, prescribe them, and monitor their use. Primary care is an appropriate setting for such an effort, although brief counseling, at the least, needs to be coupled with the medications in any setting.

Despite the longstanding research that has shown obvious benefits of a variety of medications in the treatment of addictions, office-based specialized medication-assisted treatment (MAT) for substance dependence is still far from established. Indeed, office-based medical management (whether for buprenorphine maintenance or for the medications available to treat alcohol addictions) is available only on a limited basis for a variety of reasons, including the following:

- Payer, patient, and family opposition to the need for long-term, even lifetime, medication maintenance;
- Resource constraints and income constraints, as well as managed care utilization review and pharmacy review obstacles;
- Availability and accessibility of prescribing physicians who are willing to treat patients with substance use disorders with medications; and

- The capacity of office- and clinic-based practitioners and their staff members to manage patients across the health care and specialty sectors and to deal with insurers who are reluctant to approve the treatment and cover the costs.

One of the barriers identified in much of the published literature on office-based MAT is the lack of understanding by clinicians about how to obtain available reimbursement for office-based management (the processes can be complicated and multilevel), and how to assure that, in addition to their medications, patients are receiving appropriate related clinical services. Clinicians tend to view this type of coordination as costly and difficult to achieve. Nevertheless, the move to more outpatient and office-based care of substance abusers is a critical undertaking and has been identified as one that requires a national level focus.

The current barriers to increased implementation of office-based MAT also include the following:

- The costs of the medications themselves;
- The cost of evaluation or reporting on their efficacy with populations in the real world in order to get payers to approve reimbursement;
- Obscure rules regarding sources of financing within States;
- Funding needed by providers for the medications themselves, if they must buy and bill for them, and for medication management;
- Limited availability of insurance coverage even for eligible patients in the public and private sectors regardless of parity laws; and
- Financing of intensified professional education for clinicians who wish to provide MAT.

These barriers increasingly have determined who receives office-based MAT and who does not. Currently, the bulk of such treatment is provided to commercially insured patients or those with the ability to pay out of pocket. This disparity disproportionately affects Medicaid-insured and other individuals with low incomes who must rely on public sector health and specialty services for treatment or management of substance use conditions.

Lastly, it may also be important to integrate the provision of substance abuse screening, intervention, and treatment services with other needed behavioral services, such as depression treatment, violence prevention, recovery support, or case management, in order to generate a sufficient workload for a behavioral health specialist, particularly in rural areas or small practices with a slower flow of patients. In several States and in the private sector, behavioral health specialists (with varying titles and differing professional backgrounds) are now being used inside health care clinics and group practices to support the ongoing behavioral work that is required for patients with chronic diseases such as diabetes, asthma, high risk pregnancies, and hypertension, as well as for substance use and mental disorders.

Summary of the Forum Discussion

Participants in the Forum on Integration uniformly agreed that building, refining, and disseminating the business case for the integration of substance abuse services into primary and other medical settings, as well as better connecting specialty care to primary care services, are extremely important. Participants supported the idea that the improved patient outcomes and decreased costs are most likely to influence others to engage in similar integration efforts. The extension of the research to also examine effects on family members of integrated services for the index patient was of great interest to the group and was identified as an area where more work is needed.

Expert participants additionally stressed the notion that it was important to consider who might benefit from cost savings accrued through integrated substance use conditions screening and treatment in health care settings. Those who might benefit include patients and their households, employers, and the public sector especially health, criminal justice, and or social service organizations. These experts also indicated that it was important to structure the information and reporting related to these efforts so that it is appropriate for differing types of payers. Participants did note that potential cost savings are unlikely to influence some organizations, especially behavioral health managed care or substance abuse treatment carved out by managed care organizations. In such arrangements, many of the cost savings would accrue to an organization other than the behavioral health or substance abuse treatment carve-out vendor; hence, the financial incentives are not in favor of integration for those organizations.

There was also general agreement among the participants that accrediting and other oversight bodies could play a leadership role in assisting others in recognizing the clinical, policy, and fiscal relevance to primary care and other health care settings (including both inpatient and outpatient facilities) of substance use conditions and of providing screening and treatment interventions.

Theme II. Many different models of integration and enhanced coordination of physical health and substance abuse treatment services can be successfully implemented with a wide variety of patient populations.

There was general agreement among participants that current clinical practices in much of the nation reflect a lack of coordination of care between physical health services and behavioral health services, but this is especially true for substance abuse treatment services. The systems were seen as currently quite separate and independent of each other and communication between them, if it occurred, was likely to be episodic, at best, rather than continuous. This barrier exists despite the fact that integration has been shown to be successfully implemented (and financed) via many models, across the continuum of care, and with many patient populations. The programs highlighted at the Forum represented models across the spectrum of integration approaches.

A number of reports have suggested that health care programs can be roughly categorized

by the level of collaboration/integration in their clinical service models (Butler et al., 2008; Collins, Hueson, Munger, & Wade, 2010). Even though the *level of integration*, when operationalized as a research variable, was not shown to be related to improved outcomes for persons with mental illness, this organizing concept may provide a helpful rubric for understanding the diversity in the programs being implemented. Thus, the organization of service programs can be arrayed descriptively across levels of integration, suggesting that there is a continuum of integration from less- to more-integrated programs. Three levels of coordinated or integrated care and some related characteristics are briefly summarized in the table below.

Collaborative/Integrated Care Continuum

Coordinated Care	**Colocated Care**	**Integrated Care**
Independent organizations, each with its own systems and culture.	Independent organizations, but may have some agreements related to sharing.	One organization; all providers use the same systems; behavioral health screening is routine.
Routine screening for behavioral health conditions may be conducted by the physician or other staff.	Behavioral health and medical services available in the same physical location.	May be located in the same or different physical locations.
Referral relationship between medical care setting and behavioral health care setting.	Referral relationship between medical care setting and behavioral health.	One treatment plan for the patient, including both medical and behavioral components.
Uses normal processes (although they may be standardized) and communication may be more frequent than in standard care.	Normal processes used for communication but may be enhanced due to proximity of providers.	Team working together to deliver care.
Primary physician or other health care provider may deliver brief behavioral interventions. Referral to community resources may be actively facilitated.	Enhanced communication increases the skills of each practitioner type.	Teams composed of a physician and some or all of the following: nurse, nurse practitioner, physicians assistant, case manager, family advocate, behavioral health therapist.

Adapted from Blount (2003) as cited in Collins et al. (2010); and Doherty (1996).

Collaborative care or integration can take place at each of these levels. Each level of coordination encompasses the practices of the less integrated levels, but each may look quite different in implementation and in many instances, a variety of levels are combined in a single implementation model.

At the upper end of this continuum is full clinical integration within a *health home*. A medical care home incorporates the concept of person-centered care delivered by a team led by the individual's personal physician. This team provides continuous and comprehensive care, coordinated across all elements of the complex health system, along with increased responsibility to improve overall public health by improving the health status of its patient populations (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2007). This concept of a medical care home (and fully integrated care) is a prominent component of the recently passed health care reform bill, the Affordable Care Act (Casalino, Rittenhouse, Gillies, & Shortell, 2010).

One example of a medical care home with full clinical integration of physical health and substance abuse and mental health services is in operation at the Summer Street Community Clinic for the Homeless (and those at risk for becoming homeless) in Bangor, Maine. Within this FQHC, patients have an integrated bio-psychosocial home. They receive a myriad of health care services, all provided at one location and from the same team. Services that patients might receive include health screening; preventive health care; acute primary care; chronic disease management and recovery support; individual counseling (including substance abuse treatment); chronic disease integrated medical/psychiatric groups for diabetes, nicotine dependence, and substance dependence; psychiatric medication management and consultation; dental screens and services; a day program; group psychotherapy for substance abuse and other conditions; and referral and liaison to other services. These services are delivered by the same team of physicians, nurses, and others who work together in the clinic, and use the same clinical and administrative systems and patient chart, in a setting that does not distinguish between physical and mental health/substance abuse treatment services.

A number of other programs are similar to the Maine program described above utilizing service delivery models at the full integration end of the continuum. For example, La Clinica de La Raza is a family-centered nonprofit FQHC, which operates at 27 sites in 3 counties in California. About three quarters of the patient population are low income and Latino or from other immigrant groups, and many are ineligible for Medicaid. Services provided include primary care; dental and optical services; specialty mental health and substance abuse screening and early intervention services (chronic dependence services are referred out); and health education and preventive medicine services, including chronic disease management for diabetes, asthma, and other disorders. Patients use age- and culture-adjusted self-screening tools developed by La Clinica, and a behavioral medicine specialist (BMS) is available to each primary care team currently scheduled in participating clinics 3 days a week, with funding from a community hospital foundation. Services have expanded to include adult, pediatric/adolescent, and geriatric patients, depending upon the clinic site.

BMS staff are supervised by a master's level clinician manager who reports to La Clinica's head of mental health services. Expansion of the full range of services to all clinic sites is a goal for this program. In addition to these BMS services, La Clinica has its own cross-clinic social work department with services provided to most clinics, and also offers health promotion counselors who follow high-risk pregnancies and chronic disease patients in local communities in the three counties. La Clinica also has a centralized medical record system, and a database specific to the BMS program for evaluation and quality improvement purposes. When possible, patients who screen positive for a substance use condition and indicate an interest in receiving BMS services are referred immediately by the physicians to an on-site BMS, using a "warm handoff"[5] approach. Patients may receive up to 10 visits with a BMS per occurrence.

Commonwealth Care Alliance, an at-risk managed care entity in Massachusetts, also uses a team approach, including a nurse practitioner, community health worker, and behavioral health manager as a bridge between the primary care physician and patient. Substance use is identified in a screening for all chronic illnesses and the team is responsible for following each patient to assure appropriate referrals and telephone monitoring with continued tracking and coaching. The behavioral health care manager manages a customized network of behavioral health clinicians, coordinates patient interventions with the primary care team, reviews all patients with urgent behavioral health issues, and is responsible for monitoring, assessing, and modifying individualized treatment plans as needed. Throughout specialty treatment, members of the primary care team continue to keep informed about the patient's progress through a shared electronic medical record and the continued consultation of the behavioral health care manager.

The Core Center in Chicago, which provides treatment for infectious diseases, including HIV/AIDS, is built on a similar model of care, but combines a full bio-psychosocial integration model with additional colocated social services. Sponsored by Cook County, the Core Center provides not only primary care services, but also a wide range of specialty medical services such as obstetrics and gynecology (including a clinic for screening for sexually transmitted diseases), hematology, oncology, dentistry, psychiatry, and others. Substance abuse treatment services delivered include screening, brief intervention, individual and group counseling, intensive outpatient services, psychiatric consultation for opiate substitution treatment or comorbid mental health and substance use disorders, or referral to outside community resources, facilitated by a social worker. The Core Center uses a team approach to integration, with a centralized medical record. In addition to these integrated medical services, the Core Center provides critical wrap-around services to patients through medical case management, and mental health and substance abuse treatment services. Additional wrap-around services are available on-site through a variety of on-site partners, including the AIDS Legal Council of Chicago, the Illinois Department of Human Services (public aid), the Illinois Department of Child and Family Services, the

[5] A "warm handoff" provides face-to-face communication of patient information from one treatment program or level of care to another to facilitate continuity of care.

Illinois Department of Corrections, Cook County Jail (Corrections Clinic), as well as CVS Caremark and Walgreens pharmacies with delivery services.

Other integration efforts have focused on SBI in primary care and treatment for substance use conditions in a variety of other clinical settings, rather than full integration as described above. SBI for substance use disorders has been found to be a clinically and cost effective preventive health intervention and has been endorsed by the Preventive Health Care Task Force for patients with alcohol misuse disorders (Maciosek et al., 2006). Since 2003, SAMHSA has provided grants to States for the implementation of SBI and brief treatment within medical care settings, as well as referral to treatment as appropriate (i.e., SBIRT). Both Wisconsin and Colorado, recipients of SAMHSA grants for work in this area and participants in this Forum, have focused on the implementation of screening, brief intervention and treatment across multiple settings, including inpatient hospitals, emergency rooms, trauma centers, and primary care and other medical care settings, as have other States with SAMHSA SBIRT grants.

Under the auspices of the Governor's Office, the Colorado Department of Human Services/Division of Behavioral Health, and the Colorado Department of Public Health and Peer Assistance Services, Inc., the Colorado SBIRT is aimed at making SBIRT a standard of care within primary care practices. SBIRT has been implemented in a number of Levels I, II, III, and IV trauma centers, and in community health clinics (some of which are FQHCs). In addition, while not directly supported by the grant from SAMHSA, Colorado has taken this opportunity to also place SBIRT in publicly supported HIV care settings, an additional 12 FQHCs, and in the Colorado State Employees' Assistance Program. Across the SBIRT sites in Colorado, a variety of integration models are used, including medical case management, colocation, and integration, tailored to each setting. A health educator is used in some but not all sites. Warm handoffs are used to support patients during transitions across individual providers or appropriate levels of care. In the HIV sites, collaboration/integration is practiced through the use of a medical case management model. It is of particular interest that the Colorado legislature passed a law, effective January 1, 2010, which requires all Colorado health plans to pay for several preventive services, including alcohol misuse screening and intervention.[6]

Wisconsin's SBIRT program, called the Wisconsin Initiative to Promote Healthy Lifestyles, is also implemented in diverse settings—some of which are also sites for residency training of primary care practitioners—including private large group primary care practices and smaller independent practices, FQHCs, a Tribal primary care clinic, and the emergency room and inpatient areas of a hospital. In primary care settings in Wisconsin's SBIRT program, the receptionist asks patients to complete a health lifestyle screen (alcohol/drug use as well as tobacco) while waiting for their appointment. As at La Clinica, the screen is reviewed by a medical assistant; patients who respond positively for substance use issues are seen by a health educator either before or after being seen by the primary care

[6] Colorado House Bill 09-1204; Colorado Revised Statue 10-16-104.

provider. Within inpatient and emergency room settings, the health educators introduce themselves and conduct the screening and brief intervention and/or referral to treatment if the patient agrees. Wisconsin has estimated that the break-even point for covering the costs associated with a health educator's salary is seeing about 14 SBIRT patients per day. While currently involved in screening for substance use and tobacco use, Wisconsin envisions broadening the screening to include obesity and other disorders, which are significantly affected by lifestyle choices. Ancillary staff such as health educators can also be utilized to provide the counseling and other support needed by patients in primary care settings who are being treated with buprenorphine for opiate addiction or other medications approved for the treatment of alcohol addiction.

Integration efforts have also been focused on special populations or treatments. Another long-standing, well evaluated integration project focuses on reducing substance use in pregnant women who receive their health care through Kaiser-Permanente. This program, named *Early Start*, is aimed at motivating women to stop using alcohol and drugs during pregnancy (Armstrong et al., 2001). First begun as a pilot program, Early Start is now operational at all Kaiser Obstetrics-Gynecology (OB-GYN) departments in Northern California, with each site having an Early Start specialist who ensures screening, and early intervention using a variety of counseling techniques, with services provided at the OB-GYN site itself during regular visits. A study of this program showed favorable outcomes regarding stillbirths, neonatal birth weight, and gestational age (Goler, Armstrong, Taillac, & Osejo, 2008).

With a similar interest in special populations, the States of Wisconsin and Massachusetts, and the City of Baltimore, Maryland, have undertaken integration projects to facilitate access to office-based opiate treatment using buprenorphine. In Massachusetts, following efforts to increase the knowledge base among health care providers on addiction treatment, a colocation model utilizing a nurse care manager, in addition to the primary care physician and regular clinic staff, has been introduced. A nurse is employed by the Massachusetts Department of Substance Abuse Treatment Services and out-placed to primary care clinics. The nurse performs the initial patient intake including labs, consults and contracts with the patient, and offers patient education. The intake results are reviewed by the team prior to the initial buprenorphine visit with the physician. Following this, the nurse may also manage induction, stabilization, and ongoing assessment with the patient, consulting with the prescribing physician as necessary. Baltimore Substance Abuse Systems (BSAS) has focused on integrating treatment with primary care following buprenorphine induction in outpatient specialty treatment settings for substance use disorders. BSAS has been able to utilize entitlement advocates employed by Baltimore HealthCare Access, who assist patients in becoming eligible for public health insurances such as Medicaid and also enable patients to qualify for other needed services. This is a unique collaboration among three systems: specialty treatment programs, primary care clinics, and a health insurance advocacy program.

Other programs we reviewed rely primarily on a colocation model of integration. For example, Finger Lakes Migrant and Community Health (FLMCH) is an FQHC that focuses on

assessing and meeting both the physical and behavioral health needs of its patients in 14 counties of New York, primarily through colocation of services and case management. FLMCH primary care physicians identify substance use problems, as well as mental health and/or domestic violence concerns. Working in partnership with the Finger Lakes Alcohol Counseling and Referral Agency (FLACRA), substance abuse treatment services provided on-site include buprenorphine induction and substance use counseling provided by certified substance abuse counselors located at four clinic sites. In 2010, this program is expanding and FLACRA will rent space from FLMCH at each site. For patients who enter specialty substance abuse care, a system of patient scheduling and case conferencing has been devised to foster communication and return of the patient to the Health Center for ongoing health care services.

The Priority Partners Managed Care Organization (PPMCO), following Maryland Medicaid's mandated Managed Care Organization (MCO) enrollment, is responsible for providing carved-out mental health services via a statewide vendor-provided program. To improve services for persons with high-risk, chronic medical problems who also have a substance use condition, this project also implemented a colocation integration model that linked the staff from behavioral health to the disease management staff. Staff from each section are dedicated to the project: Behavioral health staff screen for the disease management enrollment and disease management staff for behavioral health. Staff consult on a regular basis, hold bimonthly clinical case conferences, and enter integrated notes. The patient database was also enhanced to allow for better coordination of behavioral health and disease management. However, persons needing MAT with naltrexone and several other medications are in the hands of their Medicaid MCOs for pharmaceuticals and pharmaceutical management; methadone is also separate from the service.

San Mateo County (California) Behavioral Health and Recovery Services has focused on working with its County Medical Center, which includes 11 primary care clinics including a methadone site and five full service outpatient clinics for youth and adults with mental health and/or substance use disorders. Primary care physicians provide health services and direct support to behavioral health clinics and nurse practitioners in large behavioral health clinics. In primary care, an integrated psychiatric/medical care team, if appropriate, provides up to three visits for patients with substance use disorders. A case manager for substance use disorders, located in the primary care clinic, is available to provide up to an additional 10 visits for individuals with substance use conditions. Patients needing more than 10 visits are referred to specialty treatment.

North Carolina also has an extensive system for implementation of screening and brief interventions in primary care settings. Through the Governor's Institute on Alcohol and Substance Abuse, a medical and nursing school substance abuse curriculum has been implemented. Partnerships have been developed with primary care specialty groups and medical societies in North Carolina to support implementation of SBI (including local technical assistance), and a coordinating body has been created for a number of SBI and integrated care initiatives in the State, including some MAT in certain primary care settings.

In one county in North Carolina, at Western North Carolina Community Health Services,

two FQHCs have implemented different models for integration of substance use identification and treatment. In one site, a treatment specialist is on site to work with 12 primary care physicians who provide chronic and urgent care. In the other site, a family physician, who is also board certified in addiction medicine, is colocated with two psychiatric nurse practitioners and three substance use treatment specialists to provide not only screening and brief interventions, but also some individual and group treatment. Electronic health records are shared among primary care and behavioral health teams to support this effort.

Summary of the Forum Discussion

For a full discussion of process issues related to the integration of behavioral health care in medical and other health care settings, the reader is referred to two reports: *Integration of Mental Health/Substance Abuse and Primary Care* (Butler et al., 2008), sponsored by the Agency for Health Care Research and Quality, and *Evolving Models of Behavioral Health Integration in Primary Care* (Collins et al., 2010), sponsored by the Milbank Memorial Fund. The issues briefly covered here are those that participants endorsed as key issues for the integration of substance abuse assessment and treatment in medical settings in which they are involved. While some of these issues may be the same as those for mental health, some may also differ.

A significant number of large and small integration innovations related to providing substance abuse screening and treatment in diverse health care settings can be identified nationally. Such programs use a variety of integration models, and may also combine two or more models to provide services to their particular populations of patients. Participants recognized that it might be easiest to integrate services within organizations that already provide a full range of health care services, including behavioral health. One example of such an organization would be an HMO, such as Kaiser Permanente. However, even when circumstances seem ideal, as evidenced by the Kaiser Early Start program, the following dynamics are necessary to provide integrated care:

- Substantial persistence;
- Acceptance by patients and by staff;
- Sustained creativity; and
- Proactive leadership.

Within settings that may seem optimal, integrated care is still a paradigm shift for patients, practitioners, and the health care system itself.

From the variety of models implemented in similar settings, it seems to be clear that each setting must use a model tailored to that individual setting and population to be served. In general, the participants in the meeting saw integration as primarily occurring within medical sites, but there was acceptance that for some specific populations, such as persons with chronic and severe psychoses, medical care services may need to be integrated into existing behavioral health sites. The experiences reported here reflect that it may be especially important to integrate services within FQHCs or other community health clinics

serving low-income patients, who often have multiple chronic conditions. Documenting the value of substance abuse screening and service integration may be most appropriate for this population.

All agreed that, theoretically, information technology could also facilitate integration, but noted the scarce resources available for information technology improvements in addiction treatment. The group also discussed how privacy regulations are often seen as an insurmountable barrier to integration. While there still are challenges to be overcome, both patient consent and agreements between organizations (qualified service organizations or QSOs) can and have been used to facilitate information sharing. It was also noted in the discussion that within fully integrated organizations, information may already be appropriately shared within the normal processes of limiting access to information to only that which is needed by other clinicians treating the patient and which the patient has consented to be shared. The reader is referred to the most recent guidance issued by SAMHSA on sharing information relative to substance use within computerized systems of medical records (SAMHSA, n.d.).

Not unlike other innovations, participants agreed that integration efforts were most likely to succeed when there was a respected and persistent internal champion for the effort. Some commented that integration was not as difficult as it might seem and that some challenges that may seem large are really "molehills." Similarly, there were almost universal reports that integration efforts (like other complex health care system changes) took time to mature, and that it could take as long as 2 years before a new program fully matured. Programs that begin with grant funding also take a great deal of outreach, planning, and effort to sustain after special funding ends, even with demonstrated positive outcomes, including cost savings and enhanced health.

Theme III: Retooling and creative use of the existing workforce and creation of new roles facilitate the integration of substance use conditions within medical care and other health care settings.

Major barriers to the prompt dissemination of integration models involving substance use screening and treatment are the preparation, incentives and willingness to participate of the health care workforce and the medical organization for which it works. These barriers involve issues on both the general medical and substance abuse treatment sides of the aisle. In general, meeting participants agreed that primary care and other medical practitioners[7] are not well prepared as of 2010 to deal with substance use screening and issues, and in fact are often uncomfortable raising such issues with patients or referring them to a specialty care system they may not know (Yoast, Wilford, & Hayashi, 2008). On

[7] For brevity, the term "medical practitioners" is used to refer to a wide variety of professional and ancillary staff (including nurses, social workers, addiction counselors, physician assistants, medical assistants, and others) working in medical care settings.

the other side of the aisle, the addictions workforce itself has been described as being in crisis with shortages to meet the need for ongoing patient treatment, high turnover rates, insufficient professional development, and a lack of defined upward career paths (McLellan, Carise, & Kleber, 2003). Many staff members have had little, if any, training in physical health or even mental health, and may not easily accept collaboration with others trained differently or those who may look at problems from a different perspective.

Participants were in general agreement that each side of the aisle has its own language and set of cultural expectations and that successful integration happens only when it is possible to build a bridge across this divide. It may also be important in some fully integrated models of care that the behavioral health staff is competent in the provision of both mental health and substance abuse treatment in order to maximize their ability to detect and treat both types of disorders and to allow them to use their time most efficiently. Even when licensed practitioners have had some basic training in both mental health and substance abuse treatment, many have been clinically focused only on one or the other. They may need retraining or refresher courses via the CEU mechanisms. Finally, the training for most addiction counselors (as opposed to other addiction staff) may not include any training in mental health.

In recognition of the gap in physician and nurse practitioner training SAMHSA/CSAT has recently awarded funds to 11 medical schools to create additional training initiatives for medical residents, with a specific focus on screening and brief interventions in primary care settings. The goal is to establish SBIRT training as a core component of residency programs in a variety of specialties such as emergency medicine, trauma, and others. These projects are works in progress from which there will be much to learn.

In the private sector, some managed care organizations and health insurers are training behavioral health specialists (generally social workers and/or psychologists) to work in primary care settings alongside physicians and nurses. These new types of professionals often provide assessments, brief interventions, and various care management services to assure that patients receive the treatments and referrals they need.

All of the integration models described by participants involved one or more workforce challenges: training of current staff in new skills and acceptance of new roles and responsibilities, time to carry these out, availability of cross-trained staff with real dual expertise, and creation and use of new types of health care workers. For example, initially, some believed that it was possible to integrate SBIRT into existing care systems, using existing providers by just adding on this intervention. However, others have recognized that primary care providers (whether nurses or doctors) are already extremely burdened by existing patient loads, especially in times of economic stress. One researcher estimated that on average, providers address only three health concerns per 15 minute visit; thus, it seems unrealistic to think that more can be squeezed into the existing time in primary care visits (Beasley et al., 2004). Moreover, as the number of science-based preventive services has increased, some have estimated that it would take 7.4 hours a day per patient to provide all preventive services to an average patient panel (Yarnall et al., 2003).

One solution has been to expand the role of other traditional providers such as nurses, social workers, health promotion workers, or medical assistants. In each of the programs identified as integrated, at least one practitioner was responsible for the delivery of brief interventions and ongoing care management. Titles for these new types of professionals included health educator, community health worker, medical assistant, nurse care manager, behavioral health care manager, behavioral medicine specialist, and patient navigator. All of the participants agreed that without creative use of additional clinicians beyond the primary care physician or nurse practitioner, the timing difficulties of implementing screening and brief interventions in most health care settings would be nearly insurmountable.

Of interest is the emerging role of the health educator. While the specific responsibilities of health educators may differ across sites, in general, health educators (1) screen patients for risky behaviors such as nonclinical substance use using a specific instrument, (2) determine the patient's score on the instrument, and (3) provide a brief intervention or referral for appropriate patients. Wisconsin also uses health educators to provide support and monitoring for patients who are receiving MAT in primary care. In the Colorado SBIRT program, some sites use health educators, some prefer medical social workers, and some employ behavioral health professionals. In New York, the FQHC uses substance abuse counselors and patient navigators to assist in the treatment of individuals with substance use disorders. In La Clinica's clinics, both medical assistants and behavioral medicine specialists (most with master's or doctoral degrees in a core behavioral health science and fluency in English and Spanish) provide the interventions in partnership with the patient's doctor. The adult patients have been able to complete the screening instruments themselves, even with limited literacy, although they can ask the medical assistants for help.

As the field is evolving and new workers are emerging, there is a lack of uniformity among position titles and responsibilities, as well as education, training, and other qualifications of individuals involved in integration initiatives. In Wisconsin, health educators are persons with bachelor's degrees and a minimum of 2 years in human services work, who receive a minimum of 60 hours of training in SBIRT, motivational interviewing, and cultural competence. The health educators function with ongoing support, including weekly conference calls, one-on-one consultation, audiotape review, and updates and seminars. Alternatively in Colorado, where SBI is provided as part of HIV care in public health clinics, health educators administer screening and brief interventions. HIV primary care practices are assisted in training clinical staff such as the health educators. Colorado also assists with training staff in other settings such as FQHCs, rural and urban hospitals, and urban clinics. In Colorado, medical social workers are trained and provide brief interventions and motivational interviewing, along with brief therapy, when appropriate.

While recognizing the long-term wait for payoff, participants also generally endorsed more and better education related to substance use disorders for a wide variety of general health care practitioners (physicians, nurses, and others), but especially for those health care practitioners who will enter primary and family care practices and emergency care.

Theme IV: It is possible for these programs to be successfully financed, but barriers also exist that can threaten the initiation and/or sustainability of integrated programs.

Participants reported that their integrated programs were financed by a wide variety of sources, including private insurance; Medicaid; Medicare; self-pay (which requires fees to be collected most often on a sliding fee scale); grants; Federal funding for FQHCs; Federal funding through the Ryan White Act for patients with HIV; special State funds, such as the California Mental Health Services Act funds; and other sources of fiscal support, some recurring, some not. Many programs knew or could estimate the per person cost of their current integrated care program. The discussion that follows will briefly summarize some of key issues related to financing of integrated substance use disorder care initiatives.

It appears that medical care settings that are *not* funded by fee-for-service arrangements may have some greater flexibility (at least initially) to financially support substance abuse screening, assessment, and routine treatment. Examples include FQHCs and HIV clinics funded under Ryan White, which are financed as line item budgets, and at Kaiser Permanente, where care is supported through a capitated fee arrangement. To the extent that behavioral health care services, such as substance abuse treatment, are seen as central to the care of the patient, they may be funded through existing health care funding mechanisms. That said, however, there are also barriers. For example, FQHCs can only be reimbursed for behavioral health services provided by licensed professional staff including staff with Ph.D.s, M.D.s and L.C.S.W.s. And, in some instances, FQHCs may have bundled charges, making it impossible to bill for a single brief intervention. It is difficult to recruit and retain this level of staff, especially those who are bilingual, particularly when other staff might provide the services at lower cost. There was general agreement that a variety of Federal policies related to who could be reimbursed for providing a substance use disorder screening or other service should be revised to allow other persons to provide the service under the supervision of a licensed professional.

Participants generally agreed that categorical public funding, while important in ensuring some funding for substance abuse treatment when facing scarce resources, also presents a barrier to integration. Some participants suggested that increasing flexibility in funding to allow implementation of evidence-based practices could be tremendously helpful, even if only temporarily as the country moves toward implementation of health care reform and innovation. Another similar approach suggested was to suspend regulations regarding mixing categorical funds for pilot projects in integrated substance use disorder health care with measured outcomes. Many participants also echoed that there need to be dedicated funds available for public sector improvements in information technology related to substance abuse treatment, whether integrated or just coordinated with health care. New systems should provide flexible and adequate support for reimbursement and reporting, while also facilitating quality patient care and far greater patient participation.

While a small amount of progress may have been made in fee-for-service reimbursement, many significant issues remain. For example, one approach to financing SBIRT services has

been to create billing codes through which providers can bill private insurance, Medicaid, or Medicare for the services. While creation of a billing code for such services was an essential first step, it does not guarantee reimbursement; nor are the reimbursement rates accepted by all providers as sufficient to cover the costs of services. Moreover, not all States have added or funded such services with their approved Medicaid codes. Some States have authorized the provision of services only for very limited populations, such as pregnant women.

Above and beyond these issues, Medicaid and Medicare Federal regulations, which allow only one medical or behavioral health service to be billed on the same day, do not support the concept of patient-centered integrated care or one-stop shopping. For Medicaid patients, even when a service is covered, processors unfamiliar with the codes or unwilling to implement them due to budget deficit situations, deny payment resulting in the patient being directly billed for services. The same problem exists in relation to copayments and deductibles. Another issue is that Medicaid/Medicare reimbursement is based on a procedure code and *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) diagnosis. Patients at risk (who need a brief intervention) do not have a DSM-IV diagnosis, which complicates reimbursement and puts patients in the position of being labeled and stigmatized unnecessarily in order for the provider to get paid for screening. Similar issues exist within the Medicare program, including lack of a diagnosis, same-day medical and behavioral health visit, 15-minute time minimums for codes, and coverage of services delivered by ancillary staff.

Discriminatory copays for substance abuse treatment within Medicare and many private insurance plans are well documented, but health care reform and parity will remove them gradually as issues are identified and probably litigated (Ostrow & Manderscheid, 2010). The participants uniformly supported exempting substance abuse treatment services from copays and deductibles. This recommendation, which the Affordable Care Act supports, would facilitate screening as a recommended clinical practice.

A problem affecting physicians is the variation among States in Medicaid primary care reimbursement rates for doctor visits. Some rates, even in large States, are so low that there are few doctors who will accept them; thus, many doctors do not accept Medicaid patients, codes or no codes. This could also become an issue with Medicare if doctor reimbursement falls substantially. Similar issues exist related to reimbursement by private and public insurers and those issues are even more difficult to resolve when there is a wide variety of insurance plans and coverage billed by an integrated provider. Plan-to-plan differences and utilization review protocols complicate coverage and reimbursement requirements. Whether a service is covered can depend on the plan, the service, the provider of the service, and the setting in which the service is delivered, as well as how the plan's protocols instruct the reviewer to assess the appropriateness of care to be preauthorized. Moreover, large and complex billing systems that currently exist (such as those in hospitals) may not be flexible enough to avoid billing the patient when the charge is denied. Willing providers may not be expert in navigating these complex payment systems and therefore opt out of providing services. Other participants further suggested

that the reimbursement system could and should be changed to offer incentives for primary care personnel to provide integrated care.

Finally, it seemed clear that patient volume was also a key to adequate dollar support to sustain integration. For example, in Massachusetts, it was estimated that about 30 patients needed to be receiving buprenorphine in a primary care practice for the reimbursement to become roughly equal with the costs of the additional nurse manager needed. Similarly, in Wisconsin, health educators may need to take on additional responsibilities in small practices to get to the break-even point. In rural areas, integrated services need to be located where there is a public transportation hub (a larger town) or be brought to remote area residents through mobile services or via telepsychiatry.

Summary of the Forum Discussion

Financing screening, brief interventions, brief treatment, and referral poses significant fiscal and organizational challenges regardless of the model implemented or the type of setting. Multiple funding streams are necessary, requiring knowledge of a remarkable number of Federal, State, and local regulations. And, inflexibility in many of the financing and reimbursement arrangements, credentialing requirements for reimbursable clinicians functioning in health care settings, and integrating public and private insurance coverage, are all issues that require significant attention by clinical and policy leadership at all levels.

Conclusion

There is growing evidence that integrating substance abuse screening and treatment in health care settings is an important, appropriate, and cost effective approach to improving the quality of care. Real world experience has shown that substance abuse treatment services can be successfully integrated into medical and other care settings. In some settings, existing staff have been trained to take on new roles and new ways of relating to the physical health practitioners; in other settings new types of positions have emerged, such as health educators and behavioral medicine workers. Further integration of substance abuse treatment and general health care will depend on provider readiness to change; adoption of the continuing care model for treatment of patients with both medical and substance use conditions; development of new attitudes, expertise, and roles for the existing workforce; and new types of workers. Also critical will be changes in a number of financing and reimbursement policies, which could provide a significant push towards sustainability for existing and future integration projects. Participants felt strongly that instead of waiting for the implementation of health reform, it was essential for them to be engaged now in thinking about system redesign to incorporate integration of substance use disorder screening and treatment within the mainstream health care system.

Next Steps and Plans for a Future Forum on Integration for States

The Treatment Research Institute will use the findings from this meeting, lessons learned, and participant-suggested changes for effective policy reform to launch the full Forum on Integration for State leaders later in 2010 and throughout 2011. The goal for the Forum on Integration is to bring together small teams of State leaders to develop pilot projects that create comprehensive financing mechanisms to support the delivery of substance use treatment in health care settings. In developing this Forum on Integration, TRI expects to work with States to develop several models that demonstrate change and improvement in the financing, diagnosis, treatment, and outcomes of those with substance use disorders. The Forum on Integration will provide a continuing venue for leaders at the forefront of the integration of substance abuse services to move the agenda forward and to discuss ideas and outcomes on an essential component of broader health care reform.

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Appendixes

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Appendix 1.
Sample Position Description

Health-Related Behavioral Counselor in Primary Care Practices and Clinics

Background:

There is a growing recognition that depression and substance use often co-occur with serious medical illness. Research has shown that primary care practices can play a significant role in improving the health of patients by attending to the behavioral aspects of health in addition to the physical aspects. Of particular importance is that, while primary care practices may address unhealthy behaviors with their patients, most practices lack the integrated approaches needed to effectively assist patients to change these behaviors. The purpose of this position is to provide health-related behavioral services for persons within the context of the patient's primary medical home.

The management of chronic medical conditions such as heart disease, diabetes, chronic obstructive lung disease, poorly controlled asthma, cancer, and HIV place significant management demands on patients and families. Such disorders may be complicated by comorbid substance use problems or depression which may lessen the patient's and family's successful management of the chronic health condition.

Keys to improving overall health, especially for persons with chronic medical illnesses, may be health-related behavioral counseling and support provided within the context of the patient's chosen medical home.

The behavioral health counselor will work with patients who are unable to successfully meet the behavioral demands of their chronic illness or whose behavior adversely affects their chronic illness. The health-related behavioral counselor will practice all five key components of health-related counseling including *assess, advise, agree, assist, and arrange.* More specifically it is expected that the health-related behavioral counselor will use a wide range of intervention components including assessment, brief intervention, brief treatment, monitoring, and support, directed at optimizing the patient's and family's management of the chronic health disorder.

Duties

- Screen targeted population for depression and substance use (including tobacco).
- Provide a brief intervention for appropriate patients.
- Conduct assessments and provide counseling services, as appropriate, for the targeted patient and family, using a motivational/brief therapy model or other model that facilitates the patient and family capacity for self-care and partnership with the health care providers.
- Maintain a simultaneous focus on health and behavioral health issues, including being able to assist the patient to better understand the purposes of various medications and treatments prescribed or recommended, basic dietary guidelines for various disorders, and so forth.

- Provide proactive collaborative services to patients and families face-to-face, by telephone or as otherwise appropriate.
- Provide individualized and enhanced coordination of care across the treatment spectrum with goals of maximizing functioning with the community and decreasing the likelihood of the need for emergent care.
- Demonstrate respect and cultural competence in interactions with patients, clinic staff, and project staff.
- Collaborate with staff in the primary care sites to contribute to the design of the processes used to identify the targeted population and facilitate patient and family acceptance of health-related behavioral counseling.
- Function independently as the sole behavioral counseling specialist in a primary care practice.
- Lead patient support, education, or counseling groups. Co-lead such groups with other practice or external staff, as appropriate (for example, with a dietician or specialized nurse).
- Develop and maintain a partnering relationship with assigned patients in order to assist in the success of the treatment plan.
- Collaborate with the primary care provider and other staff to monitor targeted patients.
- Utilize the practice information system as appropriate, and follow practice guidelines regarding documentation of care provided.
- Make appropriate referrals to outside entities, including specialists and others to provide additional appropriate supports, especially for the care of patients with complex or severe mental or substance use disorders.
- Develop educational training materials and disseminate information to all of the primary care practice team on the behavioral aspects of health and disease as well as on health-related behavioral counseling.
- Communicate effectively with patients, family members, and members of the primary care practice and other health care professionals.

Qualifications:

- Bachelor's or master's degree in counseling, nursing, social work, health education, or a related field
- Two to five years of experience interacting with patients in health care or mental health or substance abuse care settings
- Excellent interviewing skills
- Demonstrated ability to function both as a team member and as an independent service provider in a health care, mental health, or substance abuse care setting

Appendix 2.
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2010 Spring Meeting

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