Integrating Primary Care within an Opiate Treatment Program
Models of Integrated Care

• Many different models exist but most can be separated into two main types.
  – Integration of Behavioral Health into Primary Care
  – Integration of Primary Care into Behavioral Health
Behavioral Health Integration into Primary Care

• Significant medical evidence to support this model
• Focus is primarily on Mood disorder and SUD screening, brief intervention and referral to treatment.
• Evidence supports improved patient outcomes and decreased health care costs and utilization.
• Embedded behavioral health specialist in Primary care office handles brief interventions and referral to treatment with ongoing follow up.
Primary Care Integration into Behavioral Health or Substance abuse treatment

- Most studies focus on MH or Substance Abuse but not both!
- Several studies show improved retention in treatment as well as decreased relapse rates.
- 2 studies show evidence of improved health outcomes and decreased ED use as well as overall medical costs but only with fully integrated programs using Care Managers and Joint treatment plans.
- Fewer studies have been completed on this model and research completed does not support it.
  - Low Support of model: Co-location of services alone does not have any outcome on severity of addiction, costs or utilization.
  - High Support of Model: Successful models have integration of EHR, programs, staffing, etc.
Meridian Health Care

• Primary Care Integration into Behavioral Health System
  – Counseling Engagement
    • Assessment
    • Health History Questionnaire
    • Behavioral Health Liaison

  – Primary Care Engagement
    • SBIRT
    • Mental Health Screenings (GAD-7, PHQ9)
    • SUD screening (DAST, CAGE-AID)
    • Behavioral Health Liaison
Demographics of Clients

41% Female
59% Male
Median Age: 33.4 years

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>0.26%</td>
</tr>
<tr>
<td>10-19</td>
<td>8.79%</td>
</tr>
<tr>
<td>20-29</td>
<td>35.01%</td>
</tr>
<tr>
<td>30-39</td>
<td>30.62%</td>
</tr>
<tr>
<td>40-49</td>
<td>14.47%</td>
</tr>
<tr>
<td>50-59</td>
<td>8.79%</td>
</tr>
<tr>
<td>60-69</td>
<td>1.94%</td>
</tr>
<tr>
<td>70-79</td>
<td>0.13%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Baseline Health Questionnaire

• Assessments 3/17-5/17
  – Out of 658 assessments, only 34.8% of patients had a primary care provider.
  – Out of those patients who do not have a primary care provider, only 21.5% were interested in seeing a primary care provider at the time of admission to program.
  – However, 40% reported having physical health concerns unrelated to their addiction diagnosis.
Baseline Health Questionnaire

• 8% of female clients were pregnant at time of admission
• 89% of female clients reported not having routine gynecology evaluations.
• 68% did not have a dentist
• 88% reported tobacco use but only $\frac{1}{3}$rd were interested in tobacco cessation.
Primary Care Areas of Focus

<table>
<thead>
<tr>
<th>Area of Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Cessation</td>
</tr>
<tr>
<td>Contraceptive Care/STD</td>
</tr>
<tr>
<td>Hepatitis C</td>
</tr>
<tr>
<td>Preventative Medicine</td>
</tr>
<tr>
<td>Over-utilization of emergency and hospital services</td>
</tr>
<tr>
<td>Prenatal Care</td>
</tr>
<tr>
<td>Chronic Illness Management</td>
</tr>
</tbody>
</table>
Full Agency Integration

• Services provided to OTP clients
  – Clients on Medication Assisted Treatment are participants in any of the following programs:
    • Primary Care
    • Residential Treatment
    • Co-Occurring Treatment
    • Criminal Justice Programming (TASC)
    • Outpatient Treatment
    • Housing
Client Example

• Presentation at Assessment

• Services Provided

• Treatment Engagement

• Outcome
Initial Steps of Integration

• Initial Physicals for all new Clients.
• Annual Physicals for existing Clients.
• Offering office gynecology and Contraceptive Care.
• Preventative Health issues addressed at all physicals (colonoscopies, mammograms, cholesterol, diabetes testing etc.).
• Clients who do not identify us as PCP, are still encouraged to utilize our medical department for “Immediate Care” purposes (coughs, colds, sprains etc.).
• EHR utilization by MAT Medical staff
Reaching Out

• Develop Collaboration with Community Resources (Health Department, hospitals etc.).
• Partnering with an Infectious Disease Specialty group to provide **ONSITE** Hepatitis C workup and treatment.
• Partnering with local Obstetricians to provide gynecology and prenatal care for our clients.
• Plans for Dental, Eye care, podiatry services as demand increases.
• Met with MCO’s to determine shared resources (Case Managers, etc.).
Continued Integration

• Encouraging Collaboration among BH and PCP by staffing difficult patients.
• Added medical office space to Residential sites.
• Train Medical Staff in SBIRT, Stages of Change, Motivational Interviewing.
• Train BH staff to ask about health, medication compliance and regular PCP visits.
• Training of Client Care Coordinators of when to call an ambulance, when to transport to ER and when to send clients to PCP.
• Nurse Liaison: One contact person to link residential programs and Primary Medical. Visits all residential sites on a daily basis. Arranges visits, obtains old records, reviews medication lists, calls for refills and triages medical complaints.
Continued Integration

• Full system wide integration of EHR.
• On Call service for Primary Medical.
• Establish Joint Clinical/Medical trainings.
• Improve Medical presence at staff meetings.
• Implemented a Peer Review process by which all charts are assessed for documentation of appropriate screenings.
• Behavioral Health Liaison position
• Joint Treatment Plans
• Primary care walk-in hours
Problems Encountered

• Cultural Difference between BH/SA and PH.
• Concerns regarding compliance with health information privacy laws.
• Getting sufficient “buy-in” from providers and counselors.
• Growth, demand for and availability of providers and counselors.
• Limitations of office space.
Benefits

- Goal is for patients to feel as though they are being cared for by a “team”.
- Improved access to both medical and clinical services
- Improved transition of care between all settings.
- Observed individual improvements in physical health
- Improved understanding of behavioral healthcare as Health Care
- Enhanced wellness programming throughout treatment programs
- Collaboration with local University on “Impacts Grant” to place counseling interns in an agency with Integrated programming
- Reduced fear of making referrals to “unknown” providers where the stigma of being a recovering person/addict may impact treatment, or client’s willingness to engage.
Agency Preparedness, Changes

• Administration
• Clinical Staff
• Medical Staff
• Health Information/IT