Behavioral Health and Physical Health Integration: A Primary Care Perspective

Behavioral Health Transformation Task Force

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Qualifications and Experience

- Internal medicine primary care provider x 19 years
  - Referral provider for Mental Health Center of Denver (MHCD)
  - Practice with wide range of mental health and substance use conditions
- Managed patients in all models of care (referral, co-location, integrated)
- Supervised implementation of co-located primary clinic at community mental health location (MHCD)
- Implemented integrated substance use program and expansion of access to medication assisted therapy (MAT)
- Oversee Corrections Transitions workgroup

Models of Care (SAMHSA, HRSA)

Coordinated care (specialty referral model)	Co-located care	Integrated care
• Standard model of care • Referral • Basic coordination	• Primary care co-located in specialty clinic practice or conversely behavioral health specialists co-located in primary care • Onsite collaboration • Systems integration	• Close collaboration • Co-manage patients • Shared schedules, ability for “warm handoff”

Different Models of Care Meet Different Needs

Coordinated care

- Requires a level of motivation on part of patient
- Bigger challenge for providers to communicate and coordinate care
- Often pursued by patients who prefer a separation between their primary care and mental health providers
- Often no shared medical record

Co-located care

- Co-location of primary care in mental health center optimal for patients with serious mental illness (SMI) who require intensive mental health treatment
- Co-location of mental health providers in primary care reduces barrier to access—familiarity, transportation, stigma
- Ability to talk to one another
- Shared or access to medical records
- Ability to provide teaching one another

Integrated care

- Brief interventions (e.g., grief counseling, adjustment disorder)
- Patients in crisis
- Patients with moderate severity mental health conditions—who don't get sick enough to get into specialty care
- Clarify diagnoses when PCP will be providing treatment
- Helpful model when patients are less accepting of a mental health diagnosis
- Expand the types of conditions that a PCP can manage

Integrated Substance Use Treatment

- Old model
  - Diagnose SUD condition, brief counseling, refer to external resources
  - Burden on patient to access resources, navigate ‘rules’/intake process
  - Go to separate location for services
  - Patient has to be motivated to access care (accepting of diagnosis, treatment)
  - Can lose the window of opportunity
  - Care coordination further restricted by 42 CFR part 2
  - When primary care providers were DATA waivered, they seldom prescribed because of lack of support structure
- Integrated model
  - Addiction counselor imbedded within primary care to provide counseling
  - Warm handoffs, integrated visits, support MAT program

Integrated Substance Use Treatment

- Provider perspective:
  - Integration of substance use counselors makes addressing SUD possible
    - Counseling—time and expertise
    - Coordination of care—CAC/LAC keeps track of testing, assessments
    - Ensure patient follow up
- Improved quality, more guideline concordant care
- Integrated substance use counselors can address the broad range of SUD seen in primary care beyond opiates (alcohol, tobacco, cocaine, stimulants)
- Patient perspective:
  - Less stigmatizing, therefore more accessible
  - Continue to receive care even with SUD relapses

Hub and Spoke Model of Care—the Vermont Model

- Hubs—specialty opioid treatment program (OTP) clinics
  - Dispense medication, daily dosing
  - In Vermont 9 regional hubs
- Spokes—general medical setting
  - Medications prescribed, patient seen weekly or monthly
  - In Vermont 86 spoke practices
- Patients inducted on treatment in both settings
- Ability to escalate or de-escalate care
- Hubs provide consultation to the spokes
- Vermont has demonstrated improved access, quality and cost savings
- Denver Health has implemented this model of care
  - "Spokes" have accounted for ~6000 visits for SUD for ~2000 unique patients

Summary

- Both in mental health and substance use we need strong hubs and spokes
- Lack in any one area pushes back on other areas
- No wrong door approach to care improves access

Barriers/Gaps and Recommendations

- Reimbursement models that support:
  - Peer support
  - Navigation
  - Care coordination
- Support for primary care practices (financial incentives, and practice support)
- Workforce strategy to support these models
- Residential treatment facilities
- Housing first initiatives, permanent supportive housing