Philanthropy Profile

Integrating Substance Abuse Treatment Into the Medical Home

Changes in reimbursement have dramatically altered most outpatient behavioral health care. Today, 50% of all outpatient behavioral health care in the United States is provided in primary care offices, and 67% of all psychoactive medications are prescribed by primary care professionals [1]. Forty percent of patients in primary care present with complaints, such as insomnia and backache, that may have their origin in psychosocial issues [2]. Untreated behavioral health conditions are a crushing burden for patients and families and are costly to both the health care system and the economy.

Recent national studies show that life expectancy for patients with serious mental illness is 25 years less than that for the general US population [3]. Patients with a co-occurring substance abuse condition or alcohol or drug dependency or abuse make up a large subset of patients with mental illness. A 2009 report by the North Carolina Institute of Medicine revealed that "there are more than 250,000 people aged 12 years or older who report illicit drug dependence and more than twice as many...who report alcohol dependence or abuse" [4p15]. Of these, less than 10% and less than 5%, respectively, receive treatment from health care professionals funded through the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Overall, alcohol and drug abuse cost the North Carolina economy $12.4 billion during 2004 [4].

The growing number of patients with a previously unidentified and/or treated behavioral health, developmental, and substance abuse disorder has both operational and cost implications for health care institutions. In North Carolina emergency departments alone, the number visits by patients with a diagnosis of a behavioral health condition, developmental disability, or substance use disorder increased 11.3% in fiscal year 2007-2008 and 12.4% in fiscal year 2008-2009 [5]. Nationally, up to 60% of trauma patients tested positive for 1 or more intoxicants. Of these, 1 in 4 had a second drug- or alcohol-related injury in the same year [6].

Increasingly, clinical trials of integrated care have resulted in recommendations to "reconnect the mind and the body" to improve patients' health and well-being. In integrated care, medical and behavioral health professionals serve side by side to detect, treat, and manage patients with both medical and behavioral health conditions. The artificial separation of physical health and behavioral health is a result of reimbursement policies and practices that carved out behavioral health from third-party reimbursement and constrained access to substance abuse and behavioral health services. Yet research has repeatedly shown that integrated care is effective in identifying and treating patients with mild-to-moderate psychiatric issues, as well as in helping stable patients with chronic or severe behavioral health issues. Likewise, there is robust evidence that screening, brief intervention, and referral to treatment (SBIRT) is effective in the identification of patients with substance use disorders, the treatment of patients whose use puts them at risk, and the linking of patients with more-problematic use or dependence to specialized substance abuse services. Integrated care recognizes the interdependency between emotion and health behavior, symptoms, and chronic disease. Integrated care is also cost-effective. A 1999 meta-analysis of 91 studies of integrated care showed an average offset of 20% in medical costs when behavioral health was provided with medical treatment [7]. Randomized clinical trials found that integrated care produces improved medication management, reduced severity of depression, improved health status, decreased disability, better occupational function, improved patient satisfaction, and cost-effectiveness [8]. The Massachusetts Department of Public Health reported that implementation of the SBIRT tool, a simple tool for early identification of risky drinking, yielded savings of $4.30 for every $1 spent on emergency

department care [9]. Similarly, there are robust cost savings resulting from SBIRT services in other primary care settings.

In 2006, a broad coalition of more than 20 statewide medical and behavioral health associations, state agencies, health care associations, and patient advocacy groups formed the ICARE partnership, under the leadership of the North Carolina Foundation for Advanced Health Programs (NCFAHP). ICARE was funded concurrently by the Kate B. Reynolds Charitable Trust (hereafter, "the Trust"), The Duke Endowment, and AstraZeneca and had the following objectives: prepare primary care practitioners, behavioral health and substance abuse professionals, and their practices to undertake integrated care; fund and support pilot primary care practices testing integrated care; and pursue policies that reduced barriers to integrated care. The pilots were based in multiple primary care settings (ie, pediatric, family practice, and federally qualified health centers) serving diverse patient populations. At the same time, the North Carolina Office of Rural Health and Community Care, with funding from the North Carolina General Assembly, funded 64 grants to Community Care of North Carolina practices to co-locate medical and behavioral health services and 5 reverse co-location grants. At the end of the grant period, the North Carolina Division of Medical Assistance made modifications to allow same-day billing and created access to codes that allow health care professionals to receive payment for evidence-based screenings, SBIRT, and other behavioral health interventions.

During the next 4 years, ICARE created 15 training courses for online and Webinar access, conducted 1,500 training sessions, trained more than 7,000 health professionals, supported 17 pilot programs, provided technical assistance to 54 practices, and successfully lobbied to change policies that impeded integrated care. ICARE adopted or created evidence-based clinical protocols and trainings, algorithms, and patient tools for health care professionals; built a county-level online behavioral health and substance abuse resource listing; and amassed relevant research. Details about these efforts are accessible at the ICARE Web site (available at: http://www.icarenc.org). In 2010, the NCFAHP received a contract from the Division of Medical Assistance to extend ICARE's work further across the health system, transforming ICARE into the North Carolina Center of Excellence for Integrated Care.

TABLE 1.
Kate B. Reynolds Charitable Trust Substance Abuse Integration–Funded Cohort, May 2010

Organization	County	Tier 1[a]	Type of model
CenterPoint Human Services	Forsyth	Yes[b]	Co-location
BAART Community HealthCare	Durham	No	Integration
Community Clinic of Rutherford County	Rutherford	Yes	Co-location
Bakersville Community Medical Clinic	Mitchell	Yes	Integration
Duke University	Durham	No	Co-location
Gaston County Health Department	Gaston	No	Integration
Johnston County Mental Health Center	Johnston	No	Co-location
Guilford Adult Health	Guilford	No	Integration
SouthLight	Wake	No	Co-location
Rural Health Group	Halifax	Yes	Integration
Wilkes County Health Department	Wilkes	Yes	Co-location
Wilmington Health Access for Teens	New Hanover	No	Integration
Dare County Health Department	Dare	No	Co-location/reverse integration
Coastal Horizons Center	New Hanover	No	Reverse integration

Note. See the end of the body text for a description of the types of models.
[a]Thrive in North Carolina (available at: http://www.thrivenc.org) defines tier 1 counties as counties with the poorest economic well-being and tier 3 counties as those with the greatest economic well-being.
[b]Project is in tier 1 (Rockingham) and tier 2 (Stokes) counties.

On the basis of the early success of ICARE, the Trust further expanded its behavioral health agenda to include the integration of substance abuse care. In 2008, the Trust, the Governor's Institute on Alcohol and Substance Abuse, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funded the NCFAHP to perform a pilot study of the integration of substance abuse services into primary care. The pilots tested the efficacy of the SBIRT model for patients with substance abuse issues in eastern North Carolina through 2 federally qualified health centers, the East Carolina University Family Medicine Clinic and the Brody School of Medicine. Year 1 results were highly promising: clinics introduced screening tools, secured staff buy-in, and changed office policies and procedures. Clinics learned to identify patients with substance abuse conditions, to intervene effectively for most patients at the clinic, and to refer patients with more severe conditions to specialty substance abuse services.

To extend the number of primary care and behavioral health clinics integrating substance abuse and primary care services, the Trust approved a request for applications in 2010 for substance abuse integration projects conducted within or in affiliation with a medical home. The Trust sought projects that would demonstrate best practices, as identified in the 2009 North Carolina Institute of Medicine report [4], and that assured innovation, cross-sector collaboration, and/or potential for replication. Response to the request for applications was strong, with broad representation across the state. Applications featured various models, including co-location, in which the behavioral health practice is located in but remains separate from the primary care practice; reverse co-location, in which primary care services are co-located in a behavioral health practice, a model particularly effective for patients with severe and persistent mental illness; integration, in which the behavioral health professional is integrated into the staff of the primary care practice; and reverse integration, in which the primary care professional is integrated into the staff of the behavioral health practice.

The Trust funded 14 proposals, totaling $1,657,925, in June 2010. Thirteen projects focus on treatment, and the other project focuses on prevention (Table 1). The Trust has formed this new cohort of grantees into a learning collaborative, to share strategies and successes and to better advance our knowledge about effective integrated practice. The Trust looks forward to sharing the results of its newest endeavor to advance the goal of reconnecting the mind and the body. NCMJ

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