CMS Quality 2023 Conference

Building Resilient Communities:

Having an Equitable Foundation for Quality Healthcare

Best Practices in Mental Health and Substance Use Disorders Services

May 1, 2023












INTRODUCTIONS (1)

Dr. Elisabeth Kato
Medical Officer, Agency for Healthcare Research and Quality

Dr. Yngvild Olsen
Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration

Moderator
Dr. Meena Vythilingam
Senior Mental Health Advisor
HHS Office of the Assistance Secretary for Health

Dr. Marsden McGuire
Director, Continuum of Care and General Mental Health, Department of Veterans Affairs

Dr. Jessica Walker
National Clinical Suicide Prevention Telehealth Coordinator, Department of Veterans Affairs

OBJECTIVES

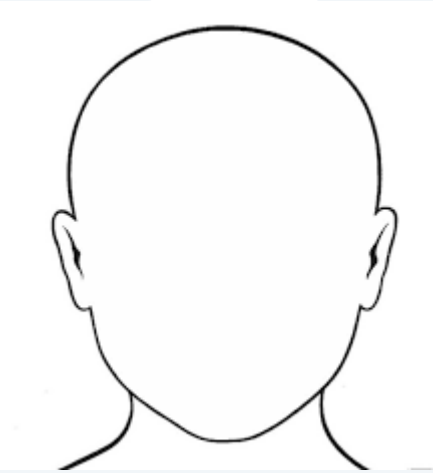
- Examine the evidence related to behavioral and physical health integration
- Highlight current best practices in various settings
- Discuss opportunities for future growth

- State of the evidence, Dr. Elisabeth Kato
- Best practices in SUD and mental health, Dr. Yngvild Olsen
- In practice at Veterans Affairs with Dr. Marsden McGuire
- Telehealth at Veterans Affairs with Dr. Jessica Walker

Elisabeth Kato, M.D., M.R.P

- Medical Officer
- Agency for Healthcare Research and Quality

The Evidence: Integrating Behavioral Health and Primary Care



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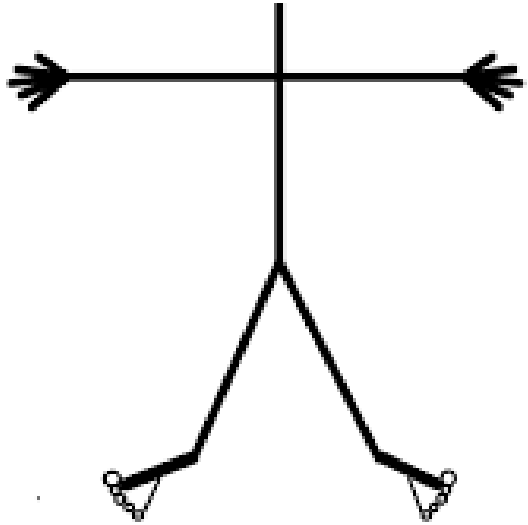
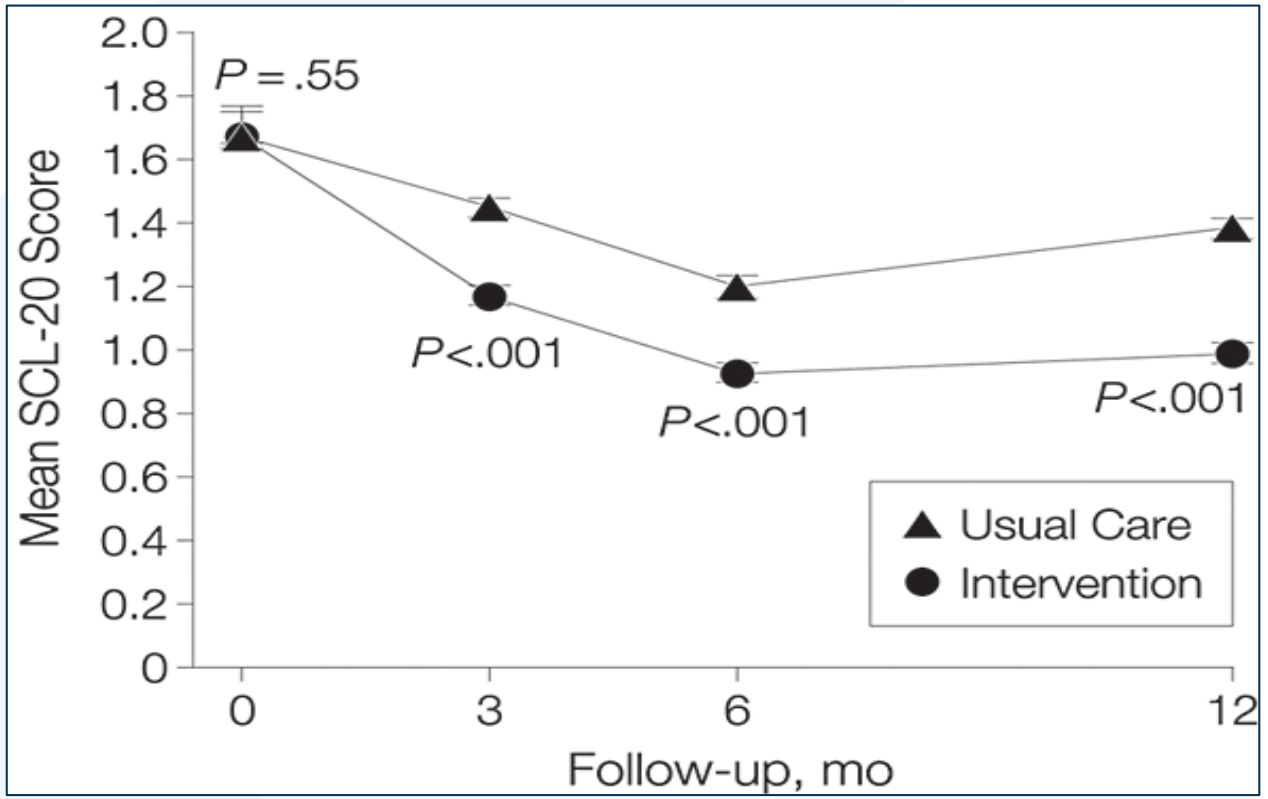


Why Primary Care?

What is the evidence for integrating behavioral health into primary care?

Mean SCL-20 Depression Score



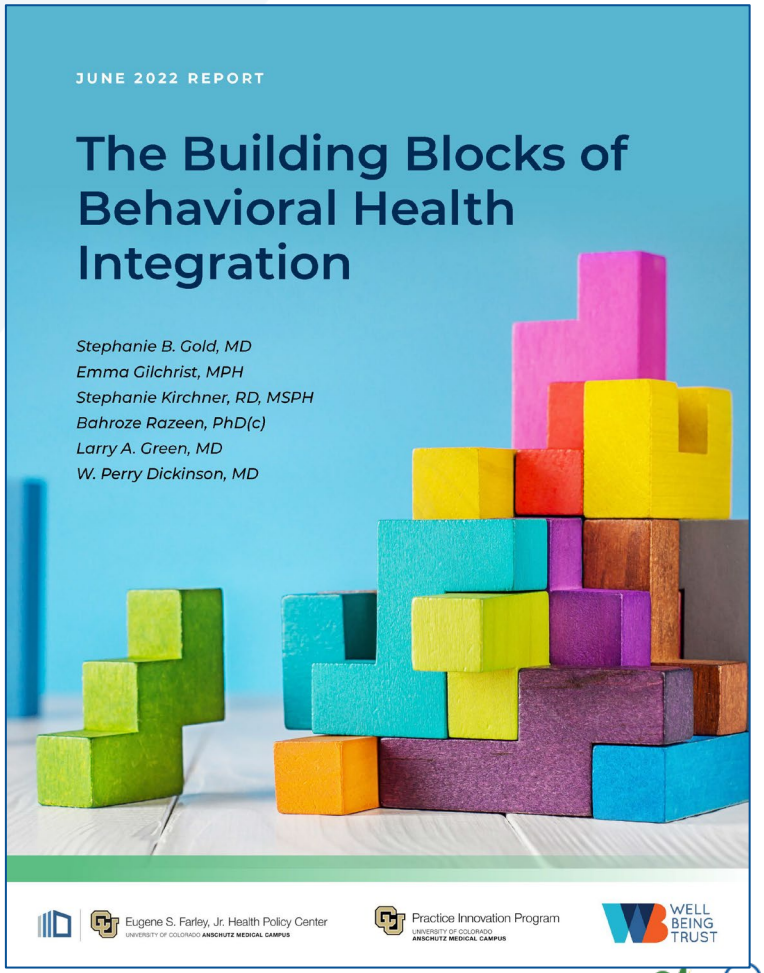
Unitzer et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting. JAMA. 2002;288(22):2836-2845. doi:10.1001/jama.288.22.2836

2013: Six Levels of Collaboration/Integration

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

10 years later



2023 Systematic Review on Strategies for Integrating Behavioral Health and Primary Care

Intermountain Health

The Academy
Integrating Behavioral Health & Primary Care

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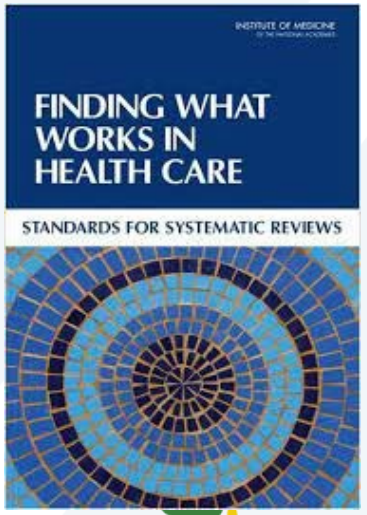
What is an AHRQ EPC Systematic Review?

Summary of Overall Evidence to Address a Set of Key Questions



- Protocol-driven
- Comprehensive search of existing peer-reviewed studies
- Critical appraisal of each study identified
- Summarize findings for each key question across important outcomes, including benefits and harms

1) What approaches have been used to integrate behavioral health and primary care?

How do these approaches vary by:

(i) patient characteristics (e.g., clinical focus/conditions/patient subgroups)
(ii) core components of the approach
(iii) practice/care delivery setting characteristics such as the policy environment, and geographic location.
(iv) resources and infrastructure required, such as staffing, payment models, financing, and technology
(v) mechanisms of care integration

2) How effective are approaches to integrating behavioral health and primary care?

Does effectiveness vary by:

(i) patient characteristics (e.g., clinical focus/conditions/patient subgroups)
(ii) core components of the approach
(iii) practice/care delivery setting characteristics such as the policy environment, and geographic location.
(iv) resources and infrastructure required, such as staffing, payment models, financing, and technology
(v) mechanisms of care integration

3) What are the barriers to and facilitators of implementing and sustaining different approaches to integrating behavioral health and primary care?

How do the barriers, facilitators, and other factors involved in the implementation of behavioral health and primary care interact to affect implementation and sustainability?

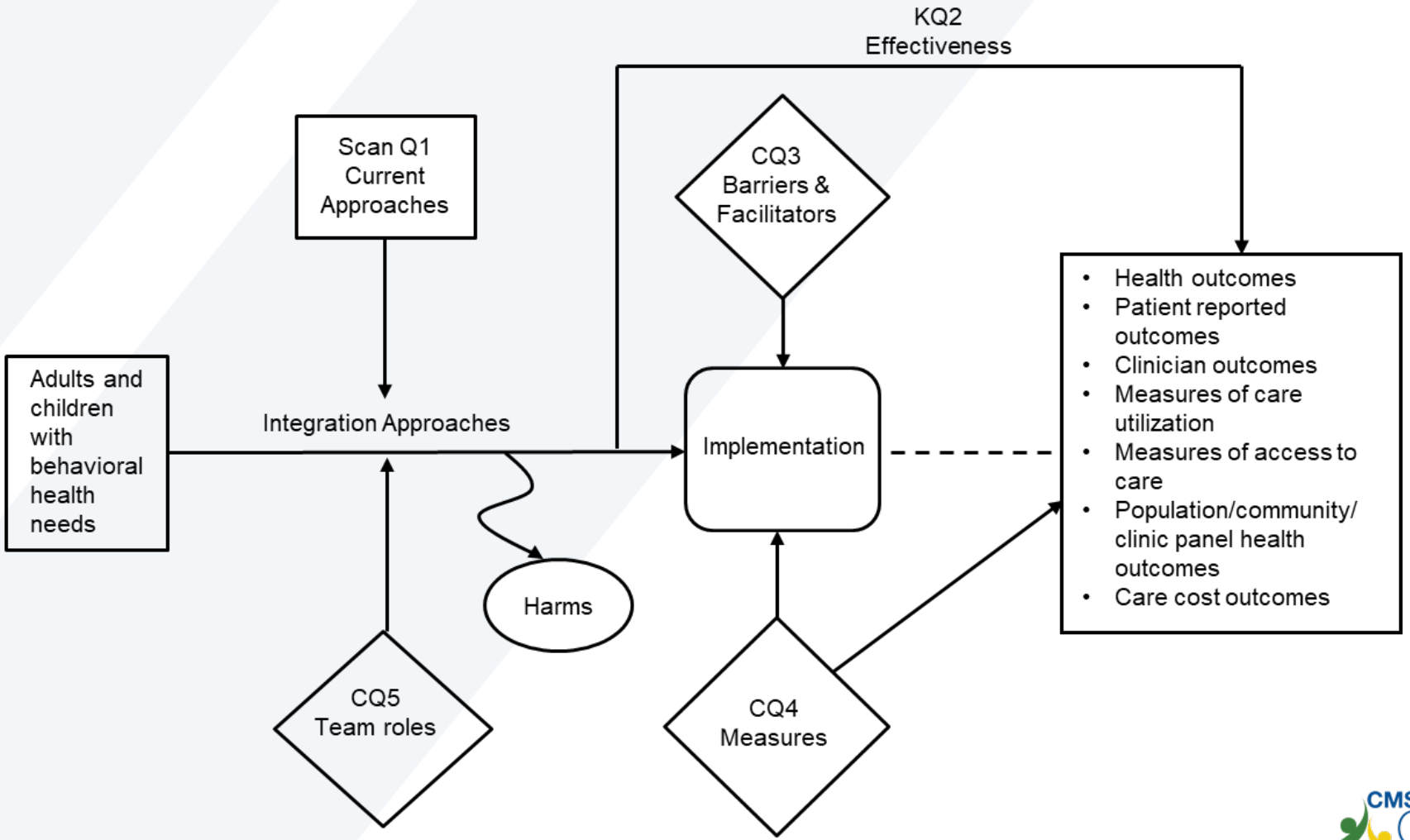
4) What reliable, valid, clinically meaningful, and/or patient-centered measures and metrics are available to monitor and evaluate integration approaches?

a. How is measurement integrated into clinical care and the ongoing monitoring and evaluation of integration?
b. Are the measures or metrics specific to characteristics; level of complexity; or the structure, process, or outcomes of care integration?
c. Are there models or standards for how frequently the effectiveness of approaches to integration should be reassessed?
d. What are the gaps in measurement and what are the implications for our current ability to measure and assess integration?

5) How are care team member roles and their work flows defined in different approaches to integrating behavioral health and primary care?

What training interventions (e.g., mode and content, trainee credentials, dose and timing of training) are effective in facilitating integrated care team functioning?

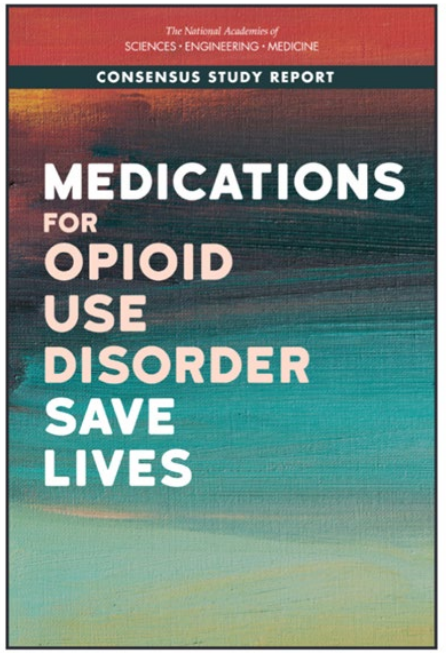
Analytic Framework



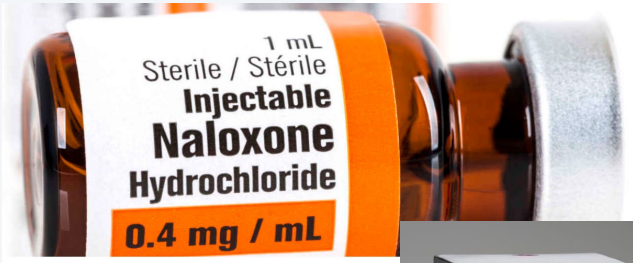
Yngvild Olsen, M.D., M.P.H.

- Director of the Center for Substance Abuse Treatment
- Substance Abuse and Mental Health Services Administration (SAMHSA)

Intervention is Critical – and We Have Solutions



More than 3 in 5 people who died from drug overdose had an identified opportunity for linkage to care or life-saving actions – SAMHSA supports EMS training, peer support specialists, and integrated care



Treatment with effective medications is not addiction by another means.

SAMHSA funds support purchase and distribution of naloxone

SAMHSA grant support purchase of Fentanyl Test Strips

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Policy Changes Present New Opportunities

On December 29, 2022, the President signed into law H.R. 2617, the "Consolidated Appropriations Act, 2023."

Mainstreaming Addiction Treatment (MAT) Act	Medication Access and Training Expansion Act (MATE)
Removes the DATA-2000 Waiver to prescribe buprenorphine	Requirement for a non-recurring, 8-hour training on substance use disorder for practitioners applying for registration from the DEA
Lifts caps on number of patients who can be treated; removes counseling and reporting requirements	Met through addiction board certification, as part of or post-healthcare professional degree training

Implementation of MAT and MATE requires close collaboration and coordination between the DOJ/DEA and HHS/SAMHSA

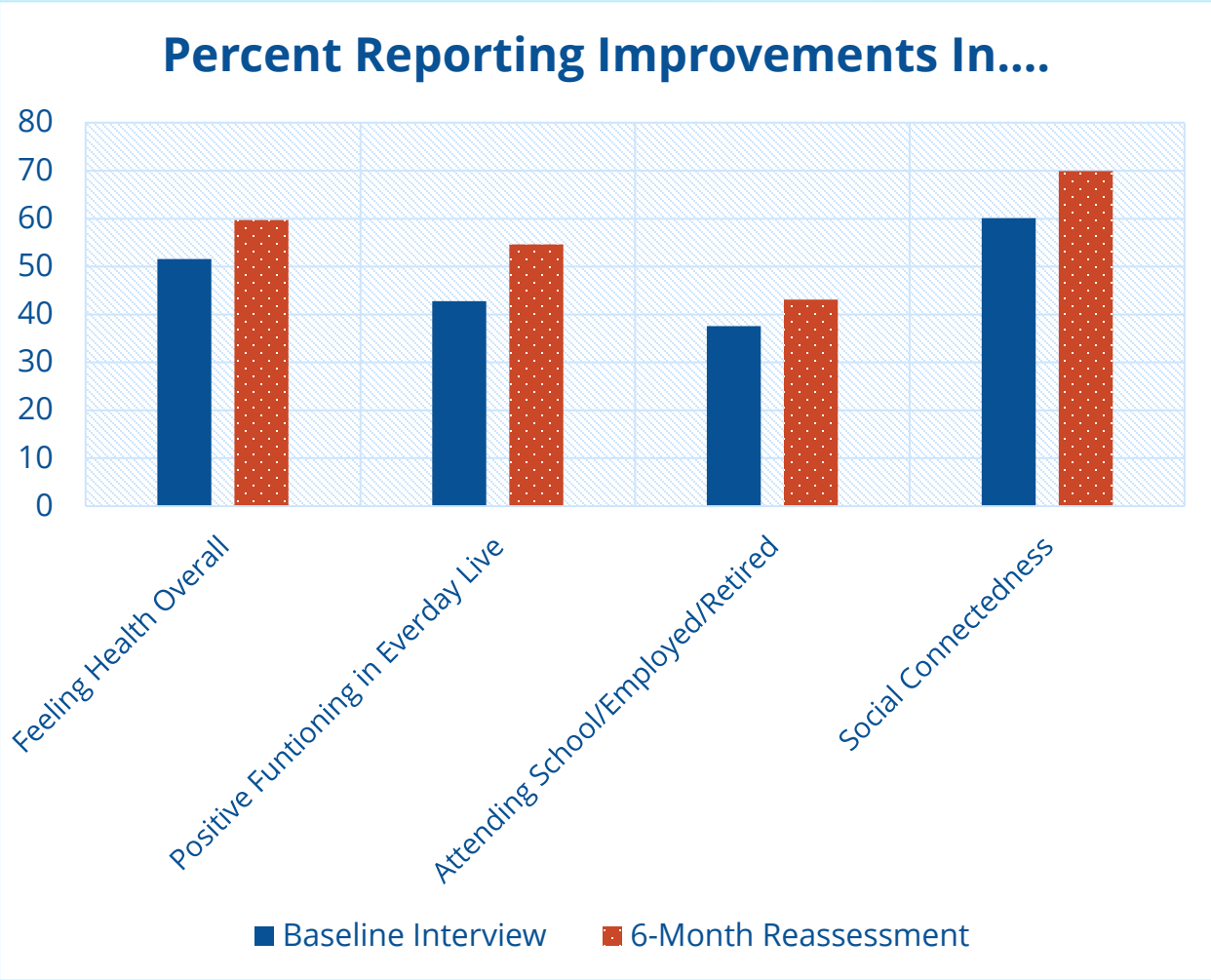
Integrated Behavioral Health Care in CCHBCs

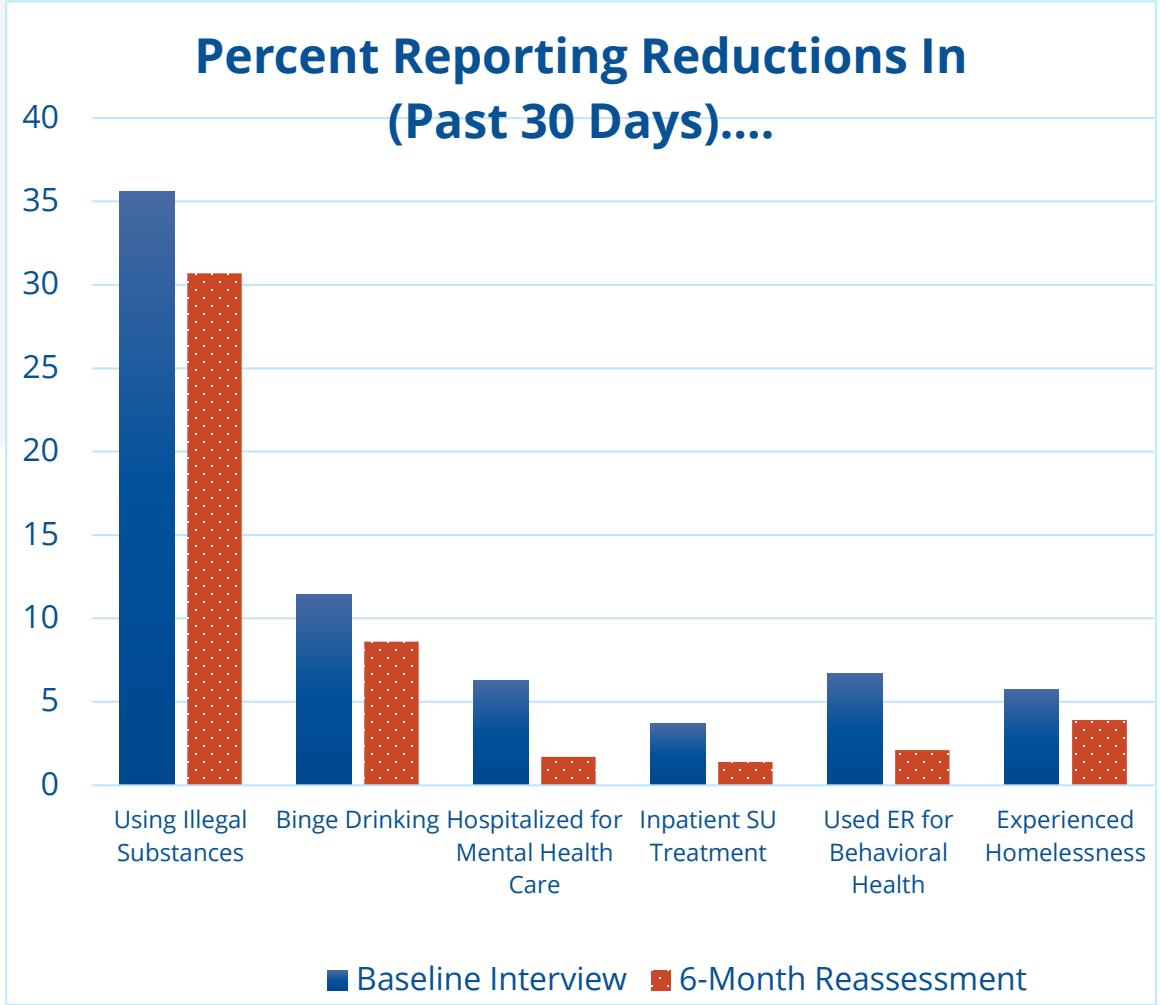
- Brings a comprehensive range of services together, incorporating evidence-based practices and other supports based on a community needs assessment
- CCBHCs must meet a minimum standard for access to MH/SUD services, including increased capacity to respond to MH+SUD crises
- They provide a comprehensive range of nine required services, incorporating evidence-based practices and other supports based on a community needs assessment
- Serves individuals across the lifespan with mental health and/or substance use disorders

Three Certified Community Behavioral Health Center (CCBHC) types:

1. Medicaid Demonstration
2. SAMHSA CCBHC Expansion Grants
3. Independent State Programs

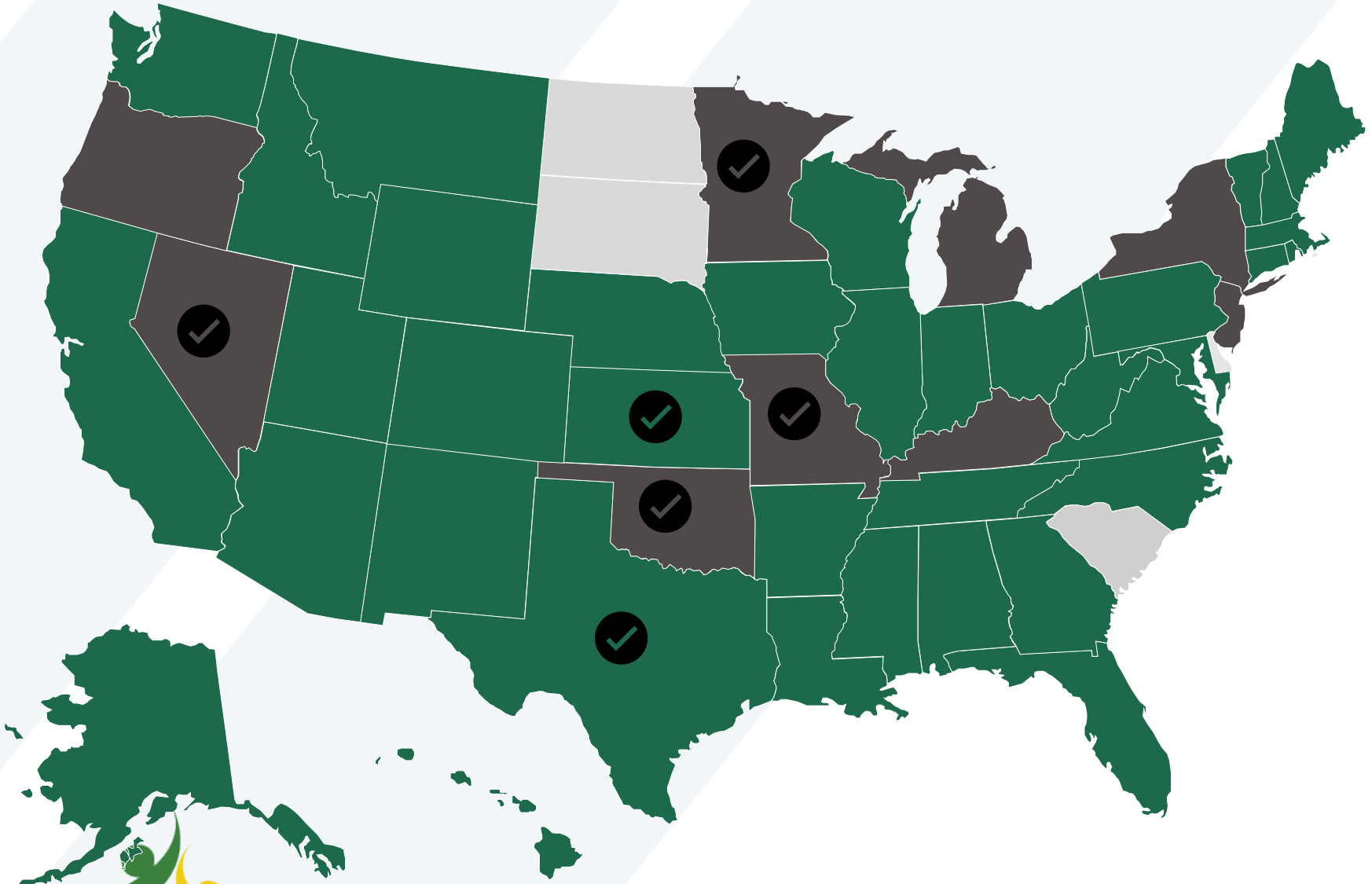
Key Findings: CCBHC-Expansion Sites





Data from FY2022 SAMHSA SPARS

CCBHCs Across the United States (as of Sept 30, 2022)



- Federal CCBHC Medicaid Demonstration (and SAMHSA Expansion Grants)
- States with at least one SAMHSA CCBHC-E grantee
- CMS-approved payment method for CCBHCs via a SPA or 1115 waiver

Words Matter: What we say and how we say it makes a difference to people with substance use disorder

✓ Non-stigmatizing language

- Use disorder (DSM) or addiction (ASAM); Person first language: person with/who…
- At risk, risky, hazardous
- Unhealthy, excessive, heavy use, episode
- Misuse (Rx drug only)
- Person in recovery
- Toxicology Screen Results:

  positive, negative
- Agonist treatment, medication
- Medication for addiction
- Heavy use, episode
- Return to use
- Low risk use/use

✗ Stigmatizing language

- Abuser, user, addict, alcoholic
- Drunk, junkie
- Clean, dirty
- Relapse
- Binge*
- Dependence*
- Abuse or problem
- Inappropriate
- Moderate
- Substitution, replacement
- Enabling
- (misuse*, relapse*)

Adapted from R. Saitz

Marsden McGuire, M.D.

- Director, Continuum of Care and General Mental Health
- Department of Veterans Affairs (VA)

Jessica Walker, Ph.D., L.P.

- National Clinical Suicide Prevention Telehealth Coordinator
- Department of Veterans Affairs (VA)

U.S. Department of Veterans Affairs

Veterans Health Administration CMS Quality Conference 2023

VA Office of Mental Health and Suicide Prevention (OMHSP)

Suicide Prevention Program

Pre-decisional Draft. For internal use only.

Introductions (2)

- Marsden McGuire, MD, MBA
  - Director, Continuum of Care and General Mental Health
- Jessica A. Walker, PhD, LP
  - National Clinical Suicide Prevention Telehealth Coordinator
- Office of Mental Health and Suicide Prevention (OMHSP), Veterans Health Administration

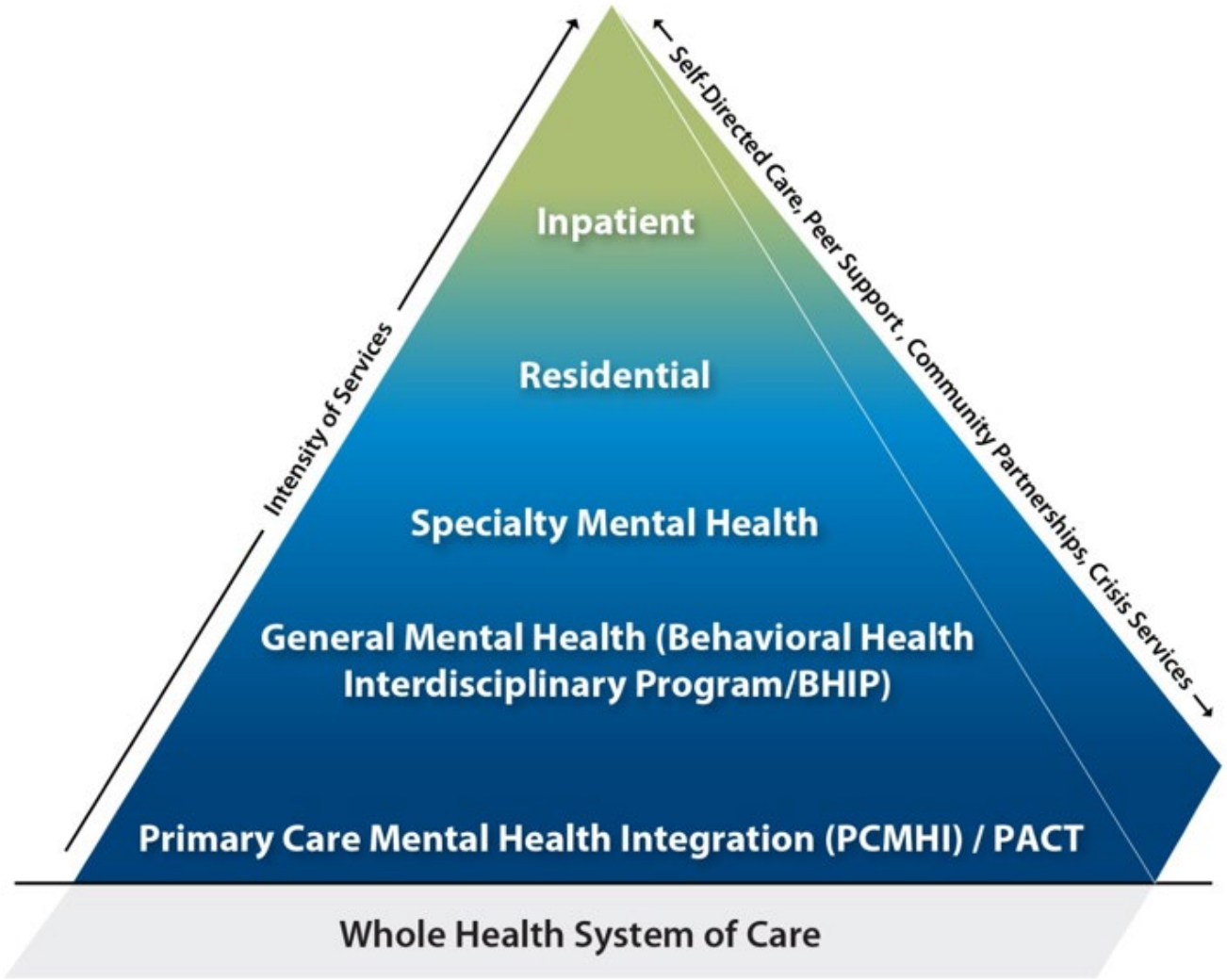
VHA Strengths

- Mental Health Continuum of Care
- Virtual Care
- Measurement Based Care
- Suicide Prevention 2.0 (SP2.0) Clinical Telehealth:
  - a program example integrating VHA strengths for suicide prevention efforts

Selected FY23 OMHSP Strategic Priorities

- Advance suicide prevention through implementation of the full public health approach
- Continued expansion of stepped care, team-based care and integrated care across the continuum, with a focus on national Behavioral Health Interdisciplinary Program implementation
- Continued collaboration with Office of Patient Centered Care and Cultural Transformation for full implementation of whole health
- Promote the full implementation of Measurement-Based Care (MBC) and Clinical Practice Guidelines (CPG)
- Continue to create a culture of inclusion

Mental Health Continuum of Care



VHA mental health services are delivered across a continuum of care, ranging from self-help apps, to outpatient care, residential treatment, and acute inpatient programs.

Our approach prioritizes recovery through evidence-based treatment.

Continuum of Care

- Stepped-care model to promote mental health treatment at the least intensive level of care appropriate
- Full range of inpatient, residential and outpatient specialty and general mental health services available in VA and through community partners
- Mental health integration into primary care
- Self-directed options such as mobile apps and online programming
- Transition between levels of care according to their Veteran needs

Telemental Health (TMH) Services

- **In FY22, >992K Veterans received >5.87M video TMH visits**—a 13.7% increase in Veterans and 4% increase in visits over FY21
  - Of these, >910K Veterans received nearly 5.7M VA Video Connect (VVC)-to-home visits

- **In FY22, approximately 40% of total MH care has been in-person, while 34% of total MH care has been via video**
  - VA MH providers and Veterans continue to gain experience and comfort using VA Video Connect, VA's secure video platform
  - Now, telehealth is not just a secondary strategy but is **becoming a universal, primary consideration for Veterans seeking MH care**

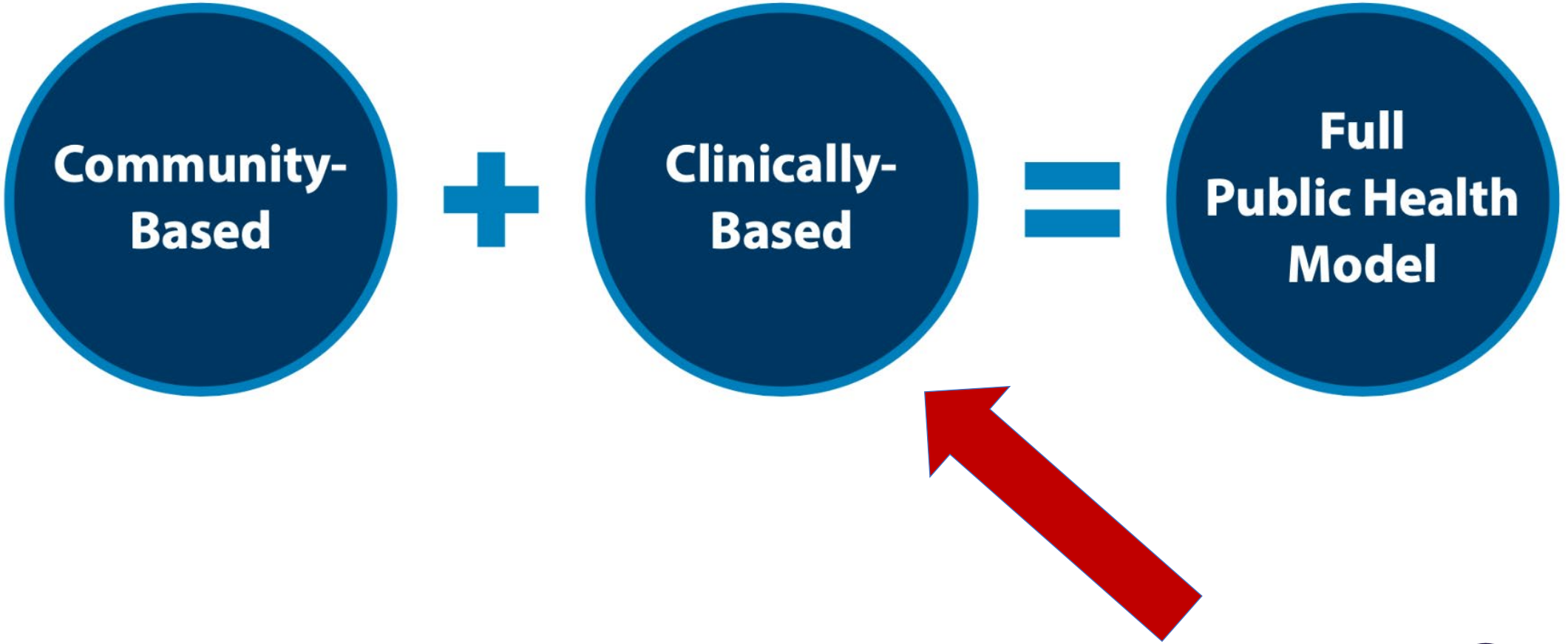
Measurement Based Care (MBC)

- Veterans and providers to collaborate on goal setting and treatment planning. MBC is defined as a three-part clinical model explained below:
    - **Collect**: Veterans complete Patient Reported Outcome Measures (PROMs) routinely and repeatedly throughout care to track progress over time.
    - **Share**: Measure results are shared and discussed with the Veteran in a timely manner to ensure a shared understanding. Recording data in the medical record allows other providers involved in the Veteran's care to benefit from the information.
    - **Act**: Together, providers and Veterans use outcome measures to have meaningful conversations about individualized goals, collaboratively develop treatment plans, assess progress over time and inform shared decisions about changes to the treatment plan
- Required in many but not all VA Mental Health settings

Public Health Strategy

VA's public health strategy combines partnerships with communities to implement tailored, local prevention plans while also focusing on evidence based clinical strategies for intervention. Our approach focuses on both what we can do now, in the short term, and over the long term, to implement VA's National Strategy for Preventing Veteran Suicide.

Public Health Strategy: SP 2.0 Clinical Telehealth



Clinical Resource Hub (CRH) Deployment

- **OMHSP/SPP partners with national CRH system to support virtual, evidence-based treatment for suicide prevention for Veterans at risk for suicide**
  - Aligns VA care with updated VA/DoD Clinical Practice Guidelines
  - Provides clinicians with training in evidence-based protocols
  - Offers Veterans access to evidence-based treatment for suicide prevention
  - Facilitates hiring of clinicians and support staff to implement the initiative and integrate within the national CRH infrastructure

VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide (2019)

Suicide Prevention Telehealth Program

- Time-limited adjunctive psychotherapy for Veterans with a history of suicidal self-directed violent behaviors (i.e., suicide attempt or preparatory behavior in the past 12 months)
  - Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)
  - Problem-Solving Therapy for Suicide Prevention (PST-SP)
  - Dialectical Behavior Therapy (DBT)
  - Safety Planning Intervention (SPI)
- **All interventions are delivered through Video Telehealth**
- **Integrates Measurement-based care throughout treatment**

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Questions?

Thank You!

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