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Overcoming Obstacles
Webinar Series

This series is focused on enabling physicians to sustain a collaborative, integrated, whole-person, and equitable approach to physical and behavioral health care in their practices during the COVID-19 pandemic and beyond.
About the BHI Collaborative

The BHI Collaborative was established by several of the nation’s leading physician organizations** to catalyze effective and sustainable integration of behavioral and mental health care into physician practices.

With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients’ mental and behavioral health needs.

TODAY’S TOPIC:

Bolstering Chronic Care Management with Behavioral Health Integration
TODAY’S SPEAKERS

Thomas G. Tape, MD, MACP, FRCP
Professor & Chief General Internal Medicine
University of Nebraska Medical Center

Edwin C. Chapman, MD, DABIM, FASAM
Physician, Internal Medicine and Addiction Medicine

Sreela Namboodiri, MD, ABOIM
Integrative Family Medicine Physician
Heartland Health Centers
Bolstering Chronic Care Management with Behavioral Health Integration: Introduction and Overview

Thomas G. Tape, MD, MACP, FRCP
Chief, General Internal Medicine, University of Nebraska Medical Center
Chair Emeritus, Board of Regents, American College of Physicians
I have no disclosures
Behavioral Health in the U.S. Health Care System

Historically separate systems of care for the mind and body.

Access to traditional behavioral health care has been limited by:
- Stigma
- Historically less robust insurance coverage
- Provider shortages

Failure to fully appreciate the role of behavioral issues in traditional medical care practice.
- The frequent co-occurrence of mood disorders in chronic disease
  - ~30% of adults with physical health disorder have behavioral health conditions.
- The fruitless search for an etiology of “medically unexplained symptoms”
- The role of lifestyle behaviors in chronic disease
Recognition of mind-body interaction is not new but medical practice has been slow to effectively address care holistically.

George Engel introduced the Biopsychosocial model in 1977.

“By obliging ourselves to think of patients with diabetes, a ‘somatic disease,’ and with schizophrenia, a ‘mental disease,’ in exactly the same terms, we will see more clearly how inclusion of somatic and psychosocial factors is indispensable for both; or more pointedly, how concentration on the biomedical and exclusion of the psychosocial distorts perspectives and even interferes with patient care.”


More recent calls for focus on behavioral health integration

– Agency for Healthcare Research and Quality (2008 & 2015)
Levels of Behavioral Health Integration

Coordinated care
  – Behavioral and physical health clinicians practice in their respective systems with referral relationships and information exchange.

Co-located care
  – Behavioral and physical health clinicians deliver care in the same location but still in separate practices.
  – Patients experience a “one stop” visit with both disciplines.

Fully integrated care
  – Behavioral and physical health clinicians act together with a joint patient care plan.

(Crowley RA, Kirschner N. Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care. Ann Intern Med. 2015;163:298-299)
Benefits of Integrated Behavioral Health

Benefits of integration
- Improve Access to Care
- Improve Quality of Care
- Reduce Cost of Care

Review of 94 RCTs integrated care demonstrated improvements in:
- Depression
- Anxiety
- Quality of life
- Patient satisfaction

(Reed SJ et al. Effectiveness and Value of Integrating Behavioral Health into Primary Care. JAMA Internal Medicine 2016;176:691-692.)

Primary care collaborative treatment of depression in patients with CAD or DM led to lower total health care costs.

(Referenced in Crowley RA, Kirschner N. Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care. Ann Intern Med. 2015;163:298-299)
Barriers to Integrated Behavioral Health

Payment
- 2017: New CMS CPT codes for services furnished using the Collaborative Care Model
- Billing remains complex
- Among 30 practices, only 3 reported net-positive financial returns.

Cultural differences in practice and communication styles
Impediments to information flow

Recent report from the Bipartisan Policy Center

Tackling America’s Mental Health and Addiction Crisis Through Primary Care Integration

Task Force Recommendations

March 2021

Two Real World Examples of Behavioral Health Integration in Chronic Care

Dr. Chapman, Physician of Internal Medicine and Addiction Medicine

Dr. Namboodiri, Integrative Family Medicine Physician at Heartland Health Centers
Bolstering chronic care management with behavioral health integration
April 22, 2021, 1PM - 2PM CT

In this webinar, physician experts will share how they have used behavioral health integration within their practices to improve their management of key chronic conditions and provide whole person care to patients. This webinar will highlight the relationship between physical and behavioral health, the role it plays in the overall health of the patient, and how practices can use BHI to help manage, treat, and address acute and chronic conditions.

“Challenges Integrating MOUD Treatment in an Urban Private Practice”

Edwin C. Chapman, MD, DABIM, FASAM
Private Practice

“I Have No Financial Disclosures”
Emergency Preparedness and Response

Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic

≥50% INCREASE in OVERDOSE DEATHS DUE to SYNTHETIC OPIOIDS (FENTANYL)

Distributed via the CDC Health Alert Network
December 17, 2020, 8:00 AM ET
CDCHAN-00438
Increases in drug overdose deaths in West Virginia and Kentucky were greater than the overdose deaths increase nationwide.

Data shows year-over-year percentage increase in deaths due to drug overdoses in the 12-month period ending May 2020.

Source: Centers for Disease Control and Prevention

Suhail Bhat / Ohio Valley ReSource
The Crisis
As opioid-related deaths continue to rise across the nation, Washington, DC has also experienced an alarming increase in fatal opioid overdoses. National trends largely reflect new opioid users who are White (non-Hispanic) younger adults who begin their addiction by experimenting with prescription drugs, with the potential of progressing to heroin usage. However, Washington, DC’s epidemic affects a unique demographic and presents different trends in use. The graph below reflects the trend of fatal opioid overdoses since 2014. Fatal overdoses hit the first peak in 2017, with 279 overdoses, but declined in 2018 when we had begun implementation of an organized effort to combat the issue. In 2019, fatalities returned to the 2017 levels and hit an all-time high in 2020.

WASHINGTON, DC’S EPIDEMIC IN A SNAPSHOT

- From 2016 to 2020, approximately 76% of all fatal opioid overdoses occurred among adults between the ages of 40–69 years old, and such deaths were most prevalent among people ages 50–59 (35%). During this time period when there was a 50% increase in deaths overall, 50–59 year olds have seen a slight increase in deaths (6%), but other age groups have seen larger increases: 56% for 60–69 year olds; 129% 20–29 year olds; 155% for 30–39 year olds; 1,200% for 70–79 year olds.
- Overall, 84% of all deaths were among African-Americans. This trend has remained consistent across years.
- Fatal overdoses due to opioid drug use were more common among males (72% of deaths were males in 2020).
- From 2016 to 2019, opioid-related fatal overdoses were most prevalent in Wards 5, 6, 7, and 8, with 8 experiencing the most deaths.
- In 2020, 94% of fatal opioid overdoses involved fentanyl or a fentanyl analog (compared to 22% of cases in the first quarter of 2015).
Race/Ethnicity

Overall, 1193 or 84% of all deaths due to opioid use were among Blacks (Fig. 6). This trend remains consistent across years.

Washington, DC:
Population is 46% Black but 84% of OUD Deaths are Black
Demographics

Age
Approximately 76% of all fatal opioid overdoses occur among adults between the ages of 40-69 years old (Fig. 5). Deaths due to opioid use were most prevalent among people ages 50 to 59 (n=35%).
Map of Opioid Overdoses by Jurisdiction of Residence
The map below displays opioid overdoses in 2017 by jurisdiction of residence. As stated previously, opioid overdoses are prevalent in Wards 5, 6, 7 and 8. The map also highlights a hotspot in Ward 2.
Disproportionately White
Disproportionately Black

WEST

EAST
No room on the street: D.C. orders homeless out of underpass in fast-developing neighborhood

By Joe Heim and Justin Wm. Moyer

Jan. 10, 2020 at 5:41 p.m. EST

The tents of homeless people living in the K Street underpass. (Michael S. Williamson/The Washington Post)
Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2020

Fig. 8: Number of Drug Overdoses due to Opioid Use by Jurisdiction of Residence and Year

HOMLESS with OPIOID USE DISORDER: DEATHS 2016-2020
REVERSE ENGINEERING 401 YEARS of SYSTEMATIC OPPRESSION

MASS INCARCERATION

PRISON – INDUSTRIAL COMPLEX
“THE NEW JIM CROW”
Michelle Alexander

OPIOD USE DISORDER

COMMUNITY

INFECTIONOUS DISEASES
SOCIAL COSTS
OTHER MEDICAL COSTS
DRUG CRIMES
More Than 80 Percent Of D.C. Opioid Deaths Are Among Blacks

The number of opioid overdose deaths among blacks in D.C. more than tripled between 2014 and 2017.

Source: District of Columbia Office of the Chief Medical Examiner
Credit: Katie Park/NPR

Dr. Chapman in his office at the end of the day on Friday. He waits for the last patient to come in, not wanting them to have to spend the weekend without medication. The walls are covered with awards, certificates, newspaper clippings and other accomplishments.
PATIENTS by AGE RANGE

Age Range
20-29 30-39 40-49 50-59 60-69 70-79 80-89

- 2
- 11
- 17
- 113
- 128
- 14
- 2
WASHINGTON, DC as a Generic Exemplar

Medicaid Beneficiary Enrollment & Cost (from DHCF FY20 Budget Hearing)

**Fee-For-Service Beneficiaries**
- 22% of Medicaid Beneficiaries
- Total Medicaid Expenditures: $2,541,148,023
- Annual Per-Person Cost: $24,838

**Managed Care Beneficiaries**
- 78% of Medicaid Beneficiaries
- Total Medicaid Expenditures: $2,541,148,023
- Annual Per-Person Cost: $6,224

Total: N = 246,374

Highlighted the need to drive greater value through improved care coordination for the FFS beneficiaries who account for $25K annual per-person cost.
<table>
<thead>
<tr>
<th>Variable</th>
<th>2004-2007 Visits Without Buprenorphine (n = 244,274), %</th>
<th>2004-2007 Visits With Buprenorphine (n = 183), %</th>
<th>2012-2015 Visits Without Buprenorphine (n = 204,527), %</th>
<th>2012-2015 Visits With Buprenorphine (n = 718), %</th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>83.5</td>
<td>90.5</td>
<td>83.1</td>
<td>94.9</td>
<td>1.00</td>
</tr>
<tr>
<td>Black</td>
<td>11.5</td>
<td>6.5</td>
<td>10.6</td>
<td>2.7</td>
<td>0.23 (0.13-0.44)</td>
</tr>
<tr>
<td>Other</td>
<td>5.0</td>
<td>3.0</td>
<td>6.3</td>
<td>2.4</td>
<td>0.27 (0.08-0.90)</td>
</tr>
<tr>
<td>Payment method</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Private insurance</td>
<td>52.0</td>
<td>19.8</td>
<td>49.2</td>
<td>33.9</td>
<td>1.00</td>
</tr>
<tr>
<td>Medicare/Medicaid</td>
<td>35.1</td>
<td></td>
<td></td>
<td></td>
<td>1.16 (0.74-1.82)</td>
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<tr>
<td>Self-pay</td>
<td>4.5</td>
<td></td>
<td></td>
<td></td>
<td>12.27 (6.86-21.91)</td>
</tr>
<tr>
<td>Other or unknown</td>
<td>8.5</td>
<td>11.0</td>
<td>8.2</td>
<td>7.5</td>
<td>1.35 (0.78-2.35)</td>
</tr>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>29.9</td>
<td>40.0</td>
<td>25.4</td>
<td>30.3</td>
<td>1.00</td>
</tr>
<tr>
<td>30-50</td>
<td>23.8</td>
<td>47.5</td>
<td>21.4</td>
<td>47.2</td>
<td>1.68 (1.33-2.12)</td>
</tr>
<tr>
<td>&gt;50</td>
<td>46.3</td>
<td>12.5</td>
<td>53.2</td>
<td>22.4</td>
<td>0.38 (0.27-0.52)</td>
</tr>
</tbody>
</table>

Abbreviation: OR, odds ratio.

As analyses were completed using survey design elements accounting for visit weight, clustering, and stratification to generate nationally representative estimates.

Adjusted odds ratios (AOR) were generated using logistic regression (1 = buprenorphine prescribed; 0 = no buprenorphine), including the variables reported in the Table. The AOR reflects the OR for buprenorphine treatment for a given visit characteristic during 2012 to 2015. The 2004 to 2007 visit characteristics are provided for comparison; they are not included in the logistic regression.

White (Hispanic and non-Hispanic), black (Hispanic and non-Hispanic), and other (Asian, native Hawaiian/Pacific Islander, American Indian/Alaskan native, and multiple race, both Hispanic and non-Hispanic).
Prescription Opioids

There were 298 prescription opioids found in the opioid overdoses between January 2016 and December 31, 2020 (Fig. 4). The number of prescription opioids identified in fatal opioid overdoses had increased steadily between 2016 (n=65) and 2017 (n=89). However, the number of prescription opioids identified in fatal opioid deaths decreased to 43 in 2019. Figure 4 illustrates that methadone and oxycodone are currently the most prevalent prescription opioids identified.
ANNUAL NET SAVINGS to the FEDERAL GOVERNMENT by EXPANDING BUPRENORPINE TREATMENT NPs, PAs, etc

Federal Register November 2, 2020
The treatment cost of $7,529 per FTE patient estimated in the previous section includes $2,113 in opportunity cost, which accounts for transportation costs and forgone wages. The remaining treatment cost of $5,416 includes the cost of medication and physician visits. Because physicians set their own rates, there is no standard price of an office visit for buprenorphine treatment, so comprehensive data are not available.

DEA estimates the total economic burden to be $75.7 billion ($82.14 billion USD in 2018). Dividing this total economic burden by the number of patients, DEA estimates the annual economic burden of prescription opioid abuse is $42,000 per person (USD in 2018).
Annual Per Capita Cost of Behavioral Health Comorbidities

Medicaid-only Beneficiaries with Disabilities
PATIENTS by AGE RANGE

ILLEGAL OPIOID & OTHER DRUG USE

Compliant, 218, 79%
Non Compliant, 39, 14%
Partial Compliance, 18, 7%

Equals $8 Million in Savings from Decreased Criminal Activity!!
TOTAL IMPACT of an INDIVIDUAL PATIENT on COMMUNITY

UNTREATED PATIENT

Criminal Costs

INCREASED JAIL & CRIMINAL JUSTICE COSTS

$35K

TOTAL COST $112K

Medical Costs

INCREASED ED & HOSPITALIZATION HIV & HEP C COSTS

$42K

Social Costs

INCREASED ED & HOSPITALIZATION HIV & HEP C COSTS

DECREASED JAIL & CRIMINAL JUSTICE COSTS

COST SAVINGS

PATIENT IN TREATMENT

$50-60K With Rx

$50-60K

Every $1 Spent on Treatment Saves $7

EDWIN C CHAPMAN, MD
© 2017
HARM REDUCTION-LOSS MITIGATION MODEL using MEDICATION for OPIOID USE DISORDER (MOUD)

UNITERUPPETED DRUG USE
NO TREATMENT = $112K TOTAL COST

SIGIFICANTLY REDUCED DRUG USE
HARM REDUCTION with MOUD = $52K NET SAVINGS

NO DRUG USE
COMPLIANT with MAT = $62K NET SAVINGS
RYAN WHITE CARVEOUT
PAYMENT MODEL

KNOWLEDGABLE
SPECIALTY
NETWORK
January, 2019-
January, 2020

END FEDERAL PROVIDER-PATIENT CAPS & REGULATORY BARRIERS; INCONSISTENT TECHNOLOGY as well as LOCAL TRANSITIONAL CARE GAPS REMAIN as MAJOR OBSTACLES to QUALITY MOUD
Prior Authorization Policies: State-level policies often require providers to obtain permission from insurers to prescribe buprenorphine (a Food and Drug Administration [FDA]-approved medication for opioid use disorder). Prior authorization prevents the timely, effective delivery of evidence-based care for opioid use disorder, thereby increasing the risk of infectious disease through continued drug use.

Drug Addiction Treatment Act (DATA) Waiver Requirement: Providers are required to apply for the ability to prescribe buprenorphine under the Drug Addiction Treatment Act (DATA) of 2000 (which amended the Controlled Substances Act) and also undergo mandatory training on prescribing practices. Once the DATA waiver is received, providers are limited to a certain number of patients they can treat with buprenorphine. This requirement decreases access to effective medications for opioid use disorder and increases the risk for infectious disease.

Lack of Data Integration and Sharing: Due to infrastructural difficulties and federal policies, medical care providers—including infectious disease providers—may not be able to access comprehensive records of patients’ information, reducing the effectiveness of care.

Inadequate Workforce and Training: There are several barriers to integration from a workforce perspective, including the geographic distribution and inadequate training of providers who can treat patients with opioid use disorder and infectious disease and restrictions about which providers can deliver certain kinds of care in certain settings.

Stigma: Self-stigma and societal stigma surrounding both opioid use disorder and infectious disease may prevent patients from seeking or accessing care, and provider stigma may inhibit a productive patient-provider relationship.

Payment and Financing Limitations: Services that are helpful to patients seeking integrated care for opioid use disorder and infectious disease (e.g., harm-reduction services, case management, telemedicine, and peer-recovery counselors) are difficult to obtain or sustain financially.

Same-Day Billing Restrictions: Some states do not allow providers to bill for a physical and a behavioral health visit in the same day, thereby requiring patients to return for care another day or forgoing programs to provide care without the opportunity for reimbursement.

Limits on Harm-Reduction Services: Harm-reduction services serve as an entry point for further medical care, reduce the risk of infectious disease outbreaks, and allow for a culture of patient-centered care. Limiting these services, on the other hand, is a barrier to integrating opioid use disorder and infectious disease prevention and treatment.

Disconnect Between the Health and Criminal Justice Systems: Care for infectious diseases and opioid use disorder in criminal justice settings is fragmented and inconsistent, making the process of maintaining coordinated care when patients enter and exit the criminal justice system inadequate.
STATES TAKING ACTION TO END THE OPIOID EPIDEMIC

- **2019**
  - California: General calls for removing prior authorization for MAT
  - Colorado: Removes prior authorization for MAT pilot programs
  - Arizona: Removes prior authorization barriers for MAT
  - Kansas: House passes bill to increase access to MAT and MAT training
  - Arkansas: Enacts law that removes prior authorization for MAT in Medicaid and commercial insurance plans
  - Louisiana: House passes bill to remove prior authorization for MAT in Medicaid
  - Mississippi: Expands access to naloxone and non-opioid pain management in Medicaid
  - North Carolina: Implementing comprehensive, multidisciplinary pain care for Medicaid patients

- **2018**
  - Washington: Removes prior authorization barriers to MAT
  - New York: Removes prior authorization barriers to MAT (provides MAT in correctional settings)
  - Pennsylvania: Reaches agreement with state’s largest insurers to remove prior authorization for MAT
  - Vermont: Removes prior authorization for MAT
  - Maine & Massachusetts: Courts affirms patients’ rights to MAT in correctional systems
  - Maryland: First state in the nation to remove prior authorization for MAT
  - Rhode Island: Provides all three FDA-approved forms of MAT for inmates with OUD

- **2017**
  - Illinois: Removes prior authorization for MAT
  - Iowa: Removes prior authorization for MAT in Medicaid
  - District of Columbia: Removes prior authorization for MAT in Medicaid
**Table 4. Association of Removal or Addition of Prior Authorization With Health Care Outcomes**

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>Coefficient (95% CI)</th>
<th>p-Value</th>
<th>Mean (95% CI)</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause emergency department visits</td>
<td>-12.6 (-25.9 to -0.5)</td>
<td>.04</td>
<td>32.2 (10.2 to 57.6)</td>
<td>.004</td>
</tr>
<tr>
<td>Substance use disorder-related emergency department visits</td>
<td>-1.4 (-3.2 to -0.1)</td>
<td>.04</td>
<td>3.6 (0.8 to 7.5)</td>
<td>.005</td>
</tr>
<tr>
<td>Prescription drug expenditures, $</td>
<td>48.7 (3.1 to 96.0)</td>
<td>.04</td>
<td>-124.7 (-214.2 to -40.6)</td>
<td>.003</td>
</tr>
<tr>
<td>Nondrug expenditures, $</td>
<td>-479.2 (-942.7 to -21.1)</td>
<td>.04</td>
<td>1236.9 (434.2 to 2055.0)</td>
<td>.003</td>
</tr>
</tbody>
</table>

PRIOR AUTHORIZATIONS for BUPRENORPHINE IMPEDES ACCESS to CARE and INCREASES ED VISITS and HOSPITALIZATIONS.
Opportunities to Improve Opioid Use Disorder and Infectious Disease Services

INTEGRATING RESPONSES TO A DUAL EPIDEMIC

Committee on the Examination of the Integration of Opioid and Infectious Disease Prevention Efforts by Select Programs

CAROLYN DEL ROSS, Chair; Deborah Professor and Dean, School of Public Health, Boston University; and Professor of Medicine, Boston University School of Medicine

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EDWIN CHOI, MD, Internal Medicine, Medical House Call Group, LLC

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BRUCE DALL, Financial Services Partner

ROSIE MARIE MARTINEZ, Staff Assistant

BOX 5-2

Prior Authorization Policies: State-level policies often require providers to obtain permission from insurers to prescribe buprenorphine. These policies are often complicated and may extend the delivery of opioid treatment for opioid use disorder, thereby increasing the risk of opioid use disorder.

Drug Addiction Treatment Act (DATA) Waiver Requirement: Providers are required to register with the Drug Addiction Treatment Act (DATA) waiver, which is a federal program designed to help patients access substance use treatment. Providers must undergo mandatory training on prescribing practices. Once the DATA waiver is received, providers are limited to a certain number of patients they can treat with buprenorphine. This requirement decreases access to effective medications for opioid use disorder and increases the risk of infectious disease.

Lack of Data Integration and Sharing: Due to infrastructural difficulties and federal policies, medical care providers—such as infectious disease providers—may not be able to access comprehensive care plans.

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Disconnect Between the Health and Criminal Justice Systems: Care for infectious diseases and opioid use disorder in criminal justice settings is fragmented and inconsistent; the process of maintaining coordinated care while patients enter and exit the criminal justice system is inadequate.
Same-Day Billing Restrictions: Some states do not allow providers to bill for a physical and a behavioral health visit in the same day, thereby requiring patients to return for care another day or forcing programs to provide care without the opportunity for reimbursement.
100 Patients x $250/month = $300,000/year
POTENTIAL URBAN MEDICARE or MEDICAID
BUPRENORPHINE COMPLEX PATIENT
MEDICARE or MEDICAID BUPRENORPHINE
OFFICE-BASED COMPLEX PROVIDER ISSUES

BARRIERS TO SUCCESSFUL TREATMENT

Social Determinants of Health

- Housing
- Health challenges
- Mental Health Challenges
- Transportation
- Access to Food (or regular basis)
- Affordability of medications and co-pays
- Income and employment
- Child care needs
- Insurance

Complex Medical Issues

Mental Health Issues

Criminal Justice Issues

After prison, more punishment

Mental health issues can make it impossible for the formerly incarcerated to abide by the laws they’re charged with

Legal barriers can make it impossible for the formerly incarcerated to abide by the laws they’re charged with.

Nearly half (42%) of the participants reported a lack of access to behavioral health care services. N=999

All patients received referral for behavioral health services with M3 scores ≥33

Edwin C. Chapman, MD, PC © 2021
I JUST LOST MY HOUSING... I’AM LIVING IN THE 2nd and D st SHELTER!”

SOCIAL WORKER/CARE COORDINATOR
MEDICARE or MEDICAID BUPRENORPHINE
OFFICE-BASED PROVIDER
COMPLEX PATIENT TREATMENT SUPPORT NEEDS

“MY ______ JUST DIED and I CAN’T SLEEP...!”

REMOTE
or
IN-OFFICE
PSYCHIATRIST
and /or
PSYCHOLOGIST

Edwin C. Chapman, MD, PC © 2021
4% of U.S. psychologists are black.

Source: American Psychological Association

Inequality in America: Black Americans face mental health care crisis.
2% of U.S. psychiatrists are Black.

Source: American Psychiatric Association

Inequality in America: Black Americans face mental health care crisis.
MEDICARE or MEDICAID BUPRENORPHINE
OFFICE-BASED PROVIDER
COMPLEX PATIENT TREATMENT SUPPORT NEEDS

“I RELAPSED LAST MONTH CELEBRATING MY BIRTHDAY WITH OLD FRIENDS!...
MY PAROLE OFFICER IS GOING to STEP ME BACK”
“I RAN OUT of MY BLOOD PRESSURE MEDICATION and CAN’T FIND MY NEW PRIMARY CARE PROVIDER”!
HOME TRACKING CHRONIC DISEASE MONITORING
In HIGH RISK, COMPLEX POPULATIONS

Annual Per Capita Cost of Behavioral Health Comorbidities
Medicaid-only Beneficiaries with Disabilities

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Behavioral or Substance Use Disorders (SUDs)</td>
<td>$6,190</td>
</tr>
<tr>
<td>SUDs and No Behavioral Disorder</td>
<td>$6,500</td>
</tr>
<tr>
<td>Behavioral Disorder and SUDs</td>
<td>$7,230</td>
</tr>
<tr>
<td>Behavioral Disorder and No SUDs</td>
<td>$7,640</td>
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</tbody>
</table>

- Asthma and/or COPD
- Congestive Heart Failure
- Coronary Heart Disease
- Diabetes
- Hypertension
EXAMPLE: HOME MONITORED BLOOD PRESSURE TRACKING
MEDICARE or MEDICAID BUPRENORPHINE
OFFICE-BASED PROVIDER
COMPLEX PATIENT TREATMENT SUPPORT NEEDS

Complex Medical Issues

Mental Health Issues

Criminal Justice Issues

Social Determinants of Health

SOCIAL WORKER/CARE COORDINATOR

PEER COACH

REMOTE or In-OFFICE PRIMARY CARE PROVIDER

REMOTE or IN-OFFICE PSYCHIATRIST and /or PSYCHOLOGIST

EDWIN C. CHAPMAN, MD, PC © 2021
New Jersey’s Medicaid program has eliminated prior authorization requirements for buprenorphine, increased reimbursement for intake assessments, and now pays for navigation and peer support services. With a grant from FORE, Rutgers University has been assessing whether these changes have made opioid use disorder care more accessible and have improved treatment outcomes, helping to inform payers looking for ways to encourage more primary care providers to offer medications for opioid use disorder (MOUD).
SUMMARY: BUILDING “STRUCTURAL COMPETENCY”

- Medical Treatment vs. Incarceration → “Law Enforcement Assisted Diversion” (LEAD)
- Decrease Myths and Stigma thru Patient and Community Education with Understanding Principles of “Harm Reduction”
- Increase Provider Capacity thru Mentoring and Network Collaborative Care (“Braiding & Blending” Coordinated Care and/or Co-located Care = “Hybrid” Fully Integrated Care)
- Maximize Technical Access to Care by Expanding Telehealth
- Remove Regulatory Barriers to Care for MOUD (e.g. Buprenorphine Prior Authorization and Dosing Caps (16 and 24 mgs.))
- Provide Universal Housing Support as a Medical Necessity
- Update Payment System to Include Monthly Capitated Payment System (RYAN WHITE LOOK ALIKE: MOUD + Mental Health + Primary Care + Peer Support + SDoH)
“Only 10-20% of what determines how long you live happens in the hospital… 80-90% is determined by the neighborhood where you are born and where you happen to be living.”

LEANA WEN, MD, MPH
FORMER BALTIMORE COMMISSIONER of HEALTH

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Behavioral Health Integration in Primary Care

Sreela Namboodiri MD ABOIM
Heartland Health Centers
Definitions

• **Integrative medicine:** A whole person approach to health that includes the mind, body, spirit, narrative, and community. It emphasizes the therapeutic relationship between practitioner and patient, and it incorporates diverse healing modalities.
  *Adapted from University of Arizona Center for Integrative Medicine*

• **Integrated care:** Care that involves close collaboration among primary care and behavioral health clinicians, working together with patients and families to provide patient-centered care.
  *Adapted from 2013, Peek & National Integration Academy Council*
Integrative Medicine

Anxiety  GERD  Dysmenorrhea  Constipation
Asthma  Diabetes  Low back pain  Migraine
Hypertension  Insomnia  Eczema  Osteoarthritis

Stress  Trauma  Nutrition/Food  Movement  Sleep  Relationships/boundaries  Social connection  Rest
Let's meet Rosa
Let's meet Rosa

• 45yo cis-gender woman with HTN, Type 2 Diabetes, and chronic low back pain.

• She is here for her 3-month diabetes visit. Her A1c is 9.0. She has been having trouble sleeping and a flare of her low back pain recently.
Let's meet Rosa

- Single mother of 3 children
- Enjoys singing and spending time with her children
- Immigrant from Mexico and most of her family lives there
- Part of a church community here

- Domestic worker
- Takes 2 buses to get to work
- Lives in an area labelled as a food desert
- Does not have health insurance
### Social Determinants of Health

#### Economic Stability
- Employment
- Income
- Expenses
- Debt
- Medical bills
- Support

#### Neighborhood and Physical Environment
- Housing
- Transportation
- Safety
- Parks
- Playgrounds
- Walkability
- Zip code / geography

#### Education
- Literacy
- Language
- Early childhood education
- Vocational training
- Higher education

#### Food
- Hunger
- Access to healthy options

#### Community and Social Context
- Social integration
- Support systems
- Community engagement
- Discrimination
- Stress

#### Health Care System
- Health coverage
- Provider availability
- Provider linguistic and cultural competency
- Quality of care

#### Health Outcomes
- Mortality, Morbidity, Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations

Some examples of historical policies with ramifications on SDH today

- Homestead Act
- Red Lining
- Fair Labor Standards Act
- Forced sterilization laws
- Mandatory minimum sentencing disparity for crack cocaine
How does SDH contribute to chronic illness?

- **External environment**
  - Impacts access
  - Impacts resources
  - Exposure risk (toxins, violence)

- **Internal environment**
  - Health Behaviors
  - Increased stress -> Allostatic load

Stress and Trauma
What was Rosa's childhood like?

- Her older sister died when Rosa was 8 years old.
- She is a survivor of sexual abuse.
- She lives in a larger body and she was bullied by classmates and members of her family for her size.
ACEs

- Education
- Occupation
- Income
- Traumatic Brain Injury
- Fractures
- Burns
- Depression
- Anxiety
- PTSD
- Unintended Pregnancy
- Pregnancy Complications
- Fetal death
- HIV
- STDs
- Infectious Disease
- Chronic Disease
- Risky Behaviors
- Alcohol & Drug Abuse
- Unsafe Sex

https://www.aaip.org/programs/aces-toolkit/
What are Rosa's stressors?

• Making ends meet
• Having diabetes
• Chronic low back pain
• Loss of family and clients due to COVID-19
• Watching the news
• Limited time for rest and sleep
• Safety of her children
"Bodies don't just exist in social and physical space, absent any influence. Bodies are always being influenced by the social context in which they live."

-Dr. Anthony Ryan Hatch

https://www.risingupwithsonali.com/2016/05/20/blood-sugar-racial-pharmacology-and-food-justice-in-black-america/
How do we work with Rosa today?
Our Team at Heartland Health Centers

- THE PATIENT
- Medical Assistants
- Nurses
- Behavioral Health Consultants (BHCs)
- Primary Care Providers
  - Psychiatry
  - Medication-Assisted Treatment (MAT)
  - OB/GYN & Midwife
  - Integrative medicine
  - HIV & Hepatitis C
  - Dental
  - Transition of Care Specialists
- Patient Support Specialists
- NowPow
- Group medical visits
- Community classes
  - Health Educators (Americorps)
  - Title X program
  - Pacific College of Oriental Medicine & Community teachers
  - MHN E-consult
  - Outreach and Enrollment team
  - IT
  - County Care Case Managers
  - Innovation Center at Albany Park (ICAP)
Integrated Care

**Primary Care Provider (PCP)**
- Explore the context of her life
  - What's your work schedule?/What are your days like?
  - What is B/L/D?
  - How much sleep are you getting? What's your evening routine?
  - What are your stressors recently?
  - What has been bringing you joy recently?
- Set the stage for patient to see value in meeting with BHC to delve deeper

**Behavioral Health Consultant (BHC)**
- Warm hand-off same-day (15 min) and counseling (30 min)
- Information gathering
- Coping skills/self-management strategies
- Psychosocial assessment
- Brief, solution-focused interventions
- Referrals to community resources, using NowPow
Group Medical Visits and Community Classes

YOGA NIDRA (ENG)
Practice calming techniques to improve sleep, reduce stress and work on healing
Tuesdays 3-4:30 pm - October 27th - December 19th

ATENCION PLENA Y YOGA SUAVE (SP)
Practique respiración y movimiento para reducir el estrés y sentirse bien en su mente y cuerpo
Fridays 12-1 pm - September 25th - December 18th - drop in

ENERGÍA POSITIVA (SP)
Un grupo para manejar mejor el estrés y utilizar prácticas de meditación, respiración, y fortalecer energía positiva
Mondays 6:30-7:30 pm - September 21st - November 9

Gentle Yoga for Chronic pain @ WARREN PARK (ENG)
Thursdays 10-11 am - September 17 - November 12
Meets @ Southwest Corner of Warren Park (6601 N Western Ave)

GROUPS FOR EVERYONE
All classes will be hosted on zoom unless specified in person.

YOGA SUAVE (SP)
Mardes 6-7 pm - Corre todo el año
https://us02web.zoom.us/j/86267148140

ZUMBA (eng/sp)
Saturdays 10-11 am - Runs year round
Zoom link: https://zoom.us/j/96920241467

ZUMBA @ NEW FIELD (eng/sp)
Thursdays 6-7 pm - September 24th - November 19, then will move online
Meets @ New Field Elementary (1707 W. Morse Ave.)

GROUPS FOR PATIENTS
All classes will be hosted on zoom unless specified in person.

TAI CHI & ACUPUNCTURE (ENG)
Mondays 1-2 pm or acupuncture only 4-6 pm
Session 1: September 14 - October 26 Session 2: November 2 - December 14
IN PERSON: 1300 W. Devon

BE WELL & EASY BREATHING CHAIR YOGA (ENG)
Join a safe space for women to discuss aspects of wellness such as nutrition, movement, stress, sleep, and more
Tuesdays 11 am-12:30 pm, runs until September 29, drop in

INTUITIVE EATING & EASY BREATHING CHAIR YOGA (ENG)
Explore and heal your relationship with your food, body and mind, and become the expert in your body’s needs.
Tuesday afternoons, runs year round starting October 6th, drop in

YOUTH WELLNESS! (ENG)
Join youth ages 10-13 for exciting cooking, arts, and movement activities to feel good, take a break from school, and make new friends!
Tuesday 4-5 pm, September 29th - November 17th

COVID SUPPORT GROUP FOR OLDER ADULTS (ENG)
Join a supportive group of adults to discuss and manage difficulties during COVID
Thursdays 11 am-12 pm - September 24th - October 29th

EVENING CANDLELIT TAPPING (ENG)
In a calming environment, learn methods to find relief and work through the following:
   Anxiety Thursday, November 5th
   Cravings Thursday November 19th
   Insomnia Thursday, December 3rd
   Depression Thursday, December 17th
All sessions are from 7-8:30 pm
Gratitude & Acknowledgements

• Dr. Anuj Shah
• Dr. Julie Lu
• Abby Krumholz MPH
• Dr. Laurie Carrier
• Dr. Elizabeth Markle
• Dr. Jeffery Geller
Thank You!
QUESTIONS?
UPCOMING WEBINAR

How to Address the Growing Behavioral Health Concerns Among Children, Adolescents, and Families

May 20, 2021 1-2pm CT

In this webinar, physician experts will share how they identify behavioral health needs within their patient population and use BHI to provide comprehensive, whole-person care to children, adolescents, and families within the practice setting. Experts will provide case-study-like explanations of how they identify the need, assess practice readiness to address the need, train staff, and scale care delivery for positive patient outcomes.
BHI Collaborative “On Demand” Webinars

• The Value of Collaboration and Shared Culture in BHI
• Behavioral Health Billing & Coding 101: How to Get Paid
• Implementation Strategies for Virtual BHI
• Financial Planning: Quantifying the Impact of BHI
• Physicians Leading the Charge: Dismantling Stigma around Behavioral Health Conditions & Treatment
• Privacy & Security: Know the Rules for Communication of Behavioral Health Information

Watch these webinars on the Overcoming Obstacles YouTube playlist now!
New Resource – **BHI Compendium**

The **BHI Compendium** serves as a tool to learn about behavioral health integration and how to make it effective for your practice and patients.

Download Now
to learn how to make the best decisions for the mental health of your patients.
Thank you for joining!
APPENDIX
Behavioral Health Integration in Primary Care

Sreela Namboodiri MD ABOIM
Heartland Health Centers


Want to learn more about innovative integrative models of care?

• Open Source Wellness: https://www.opensourcewellness.org/

• Integrated Center for Group Medical Visits: https://icgmv.org/

• Integrative Medicine for the Underserved: https://im4us.org/
<table>
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<th>Book Recommendations</th>
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<tr>
<td><strong>Hunger by Roxane Gay</strong></td>
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<td><strong>Why Zebras Don’t Get Ulcers by Dr. Robert Sapolsky</strong></td>
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<td><strong>My Grandmother’s Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies by Resmaa Menakem</strong></td>
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<td><strong>The Body Keeps the Score: Brain, Mind, and the Body in the Healing of Trauma by Dr. Bessel van der Kolk</strong></td>
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<td><strong>Childhood Disrupted: How Your Biography Becomes Your Biology, and How You Can Heal by Donna Jackson Nakazawa</strong></td>
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<td><strong>The Politics of Trauma: Somatics, Healing, and Social Justice by Staci Haines</strong></td>
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<td><strong>Kitchen Table Wisdom: Stories that Heal by Dr. Rachel Naomi Remen</strong></td>
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<td><strong>How We Show Up: Reclaiming Family, Friendship, and Community by Mia Birdsong</strong></td>
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<td><strong>The Deepest Well: Healing the Long-Term Effects of Childhood Adversity by Dr. Nadine Burke Harris</strong></td>
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<td><strong>The Body is Not an Apology: The Power of Radical Self-Love by Sonya Renee Taylor</strong></td>
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<td><strong>Fatal Invention: How Science, Politics, and Big Business Re-create Race in the 21st Century</strong></td>
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<tr>
<td><strong>The Warmth of Other Suns: The Epic Story of American’s Great Migration by Isabel Wilkerson</strong></td>
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<tr>
<td><strong>See No Stranger: A Memoir and Manifesto of Revolutionary Love by Valarie Kaur</strong></td>
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Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

https://www.cdc.gov/violenceprevention/aces/about.html
"If we want to make a difference with the “diseases of despair” - suicide, substance misuse, alcohol related disease - and frankly with most chronic diseases, we need to be asking not “Why the disease?” but rather “Why the despair?”

What are the conditions of our psyches, our families, our communities, our society - that are producing despair? And then intervene in ways that both address the structural causes of the despair, and that also actively generate the opposites of despair: Hope. Connection. Play. Joy. Belonging. Inspiration. Vitality."

- Dr. Elizabeth Markle, Open Source Wellness

https://www.opensourcewellness.org/