# BHI COLLABORATIVE PRESENTS


April 22, 2021

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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.*

***American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Osteopathic Association, and the American Psychiatric Association.*

# 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

MASTER ACP American College of Physicians

UNMC

# I have no disclosures

# Behavioral Health in the U.S. Health Care System

Historically separate systems of care for the mind and body.

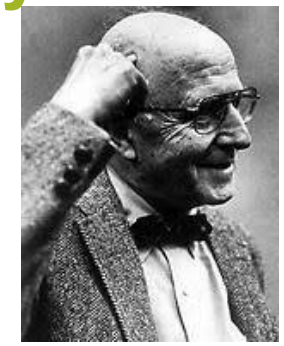
Access to traditional behavioral health care has been limited by:

- 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 Biopyschosocial 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."

  (Engel GL. The Need for a New Medical Model: A Challenge for Biomedicine. *Science* 1977;196:129-136)

More recent calls for focus on behavioral health integration

- Institute of Medicine (1996, 2006)
- Agency for Healthcare Research and Quality (2008 & 2015)
- World Health Organization (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

https://bipartisanpolicy.org/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R02.pdf [bipartisanpolicy.org]

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

(Malatre-Lansac A, et al. Factors Influencing Physician Practices' Adoption of Behavioral Health Integration in the United States. Ann Intern Med 2020; doi: 10.7326/M20-0132)

# Recent report from the Bipartisan Policy Center

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

TASK FORCE RECOMMENDATIONS

March 2021

https://bipartisanpolicy.org/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R02.pdf [bipartisanpolicy.org]

# 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*

UNMC[SM]

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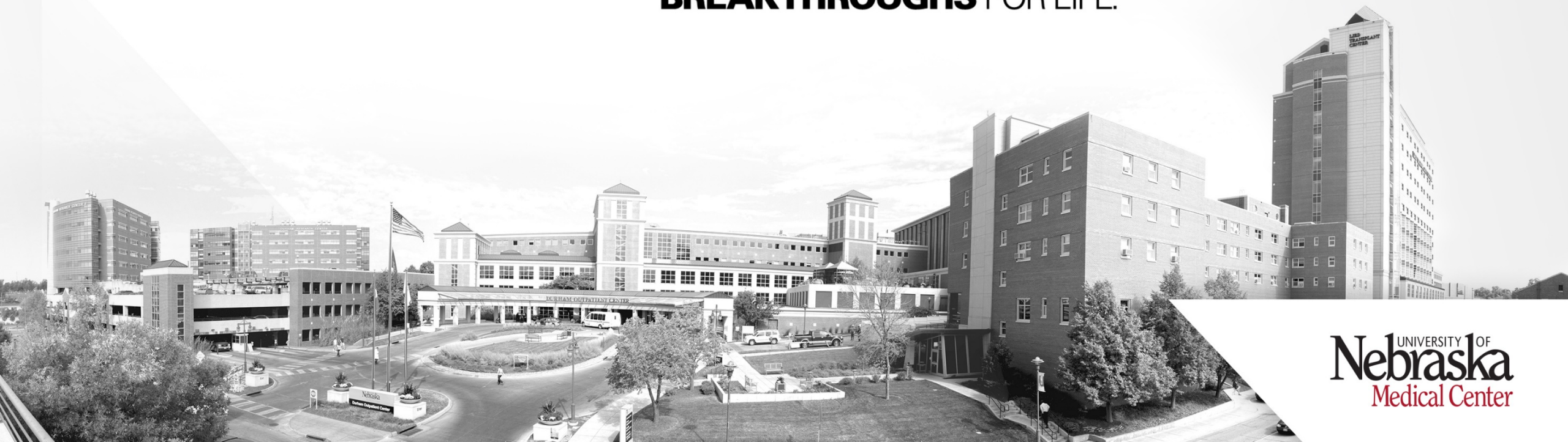
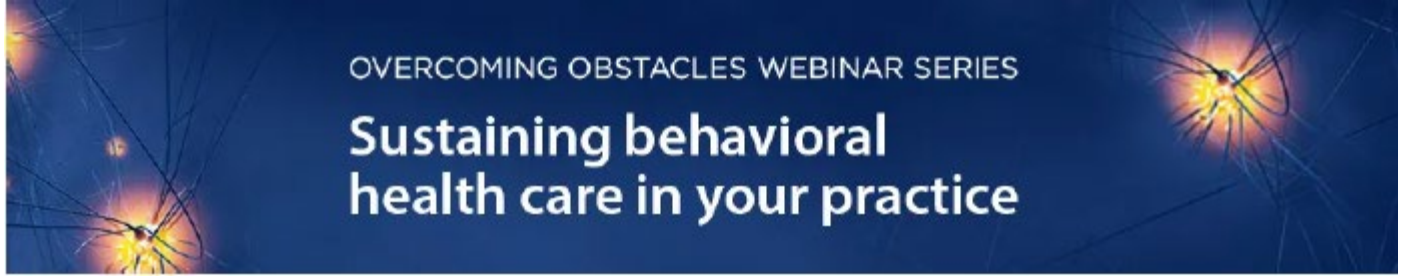



University of Nebraska Medical Center




**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"*

Centers for Disease Control and Prevention

Emergency Preparedness and Response

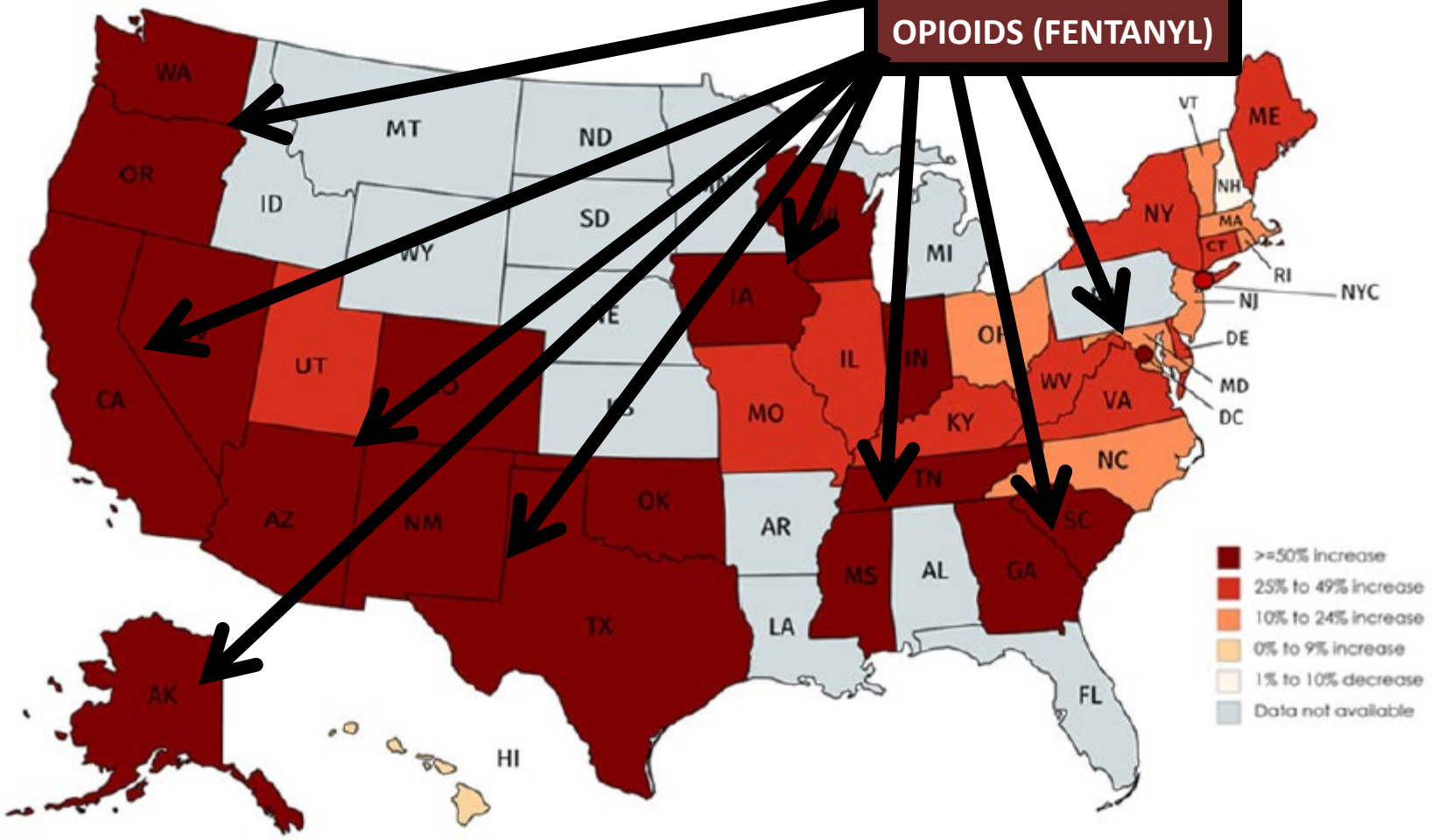
# Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic

HAN HEALTH ALERT NETWORK

This is an official CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
December 17, 2020, 8:00 AM ET
CDCHAN-00438

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

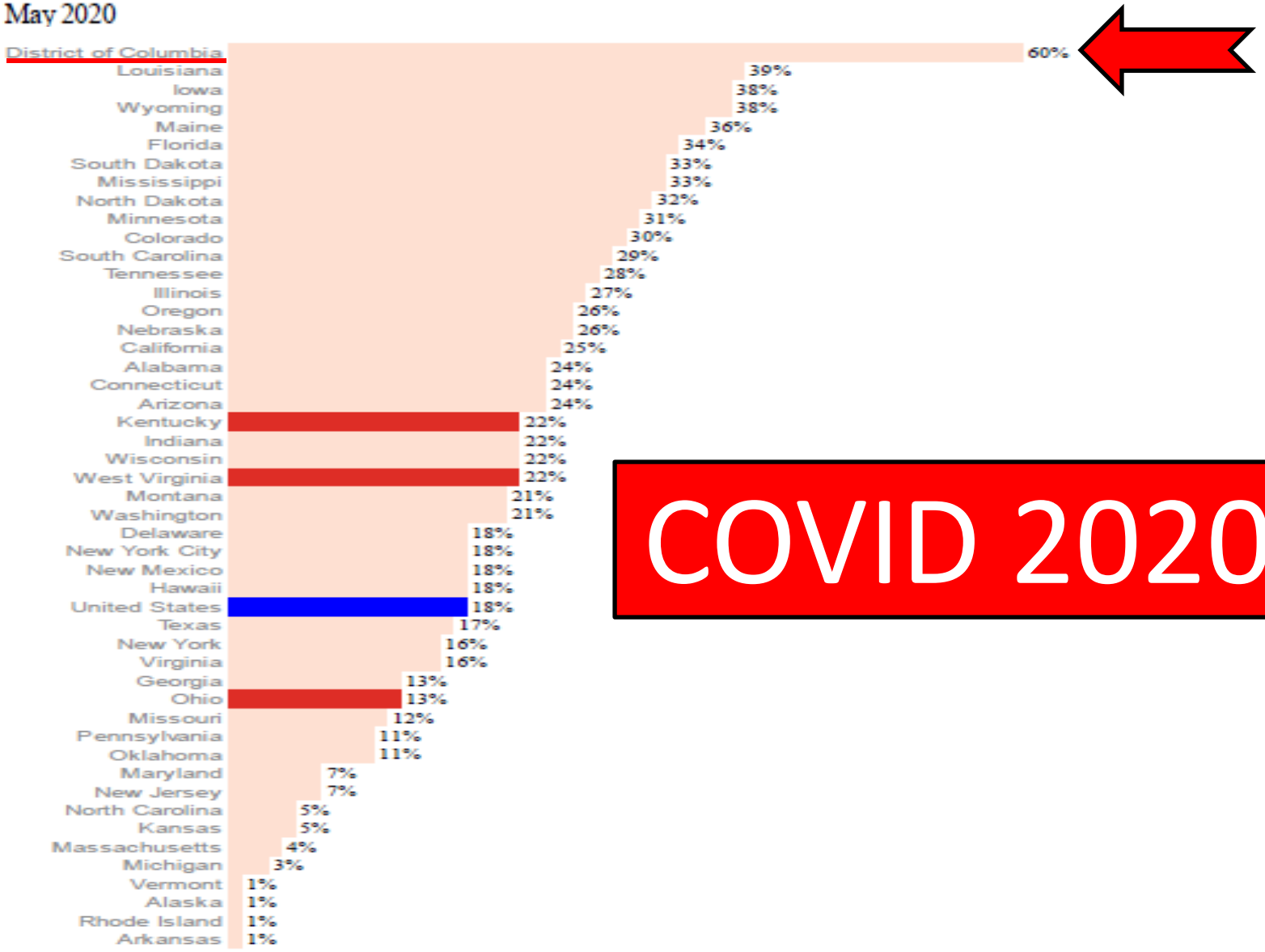


# Overdose Deaths Hit New Highs As Pandemic Worsens Opioid Crisis

*By Suhail Bhat (https://wfpl.org/author/sbhat/)*

## 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




COVID 2020

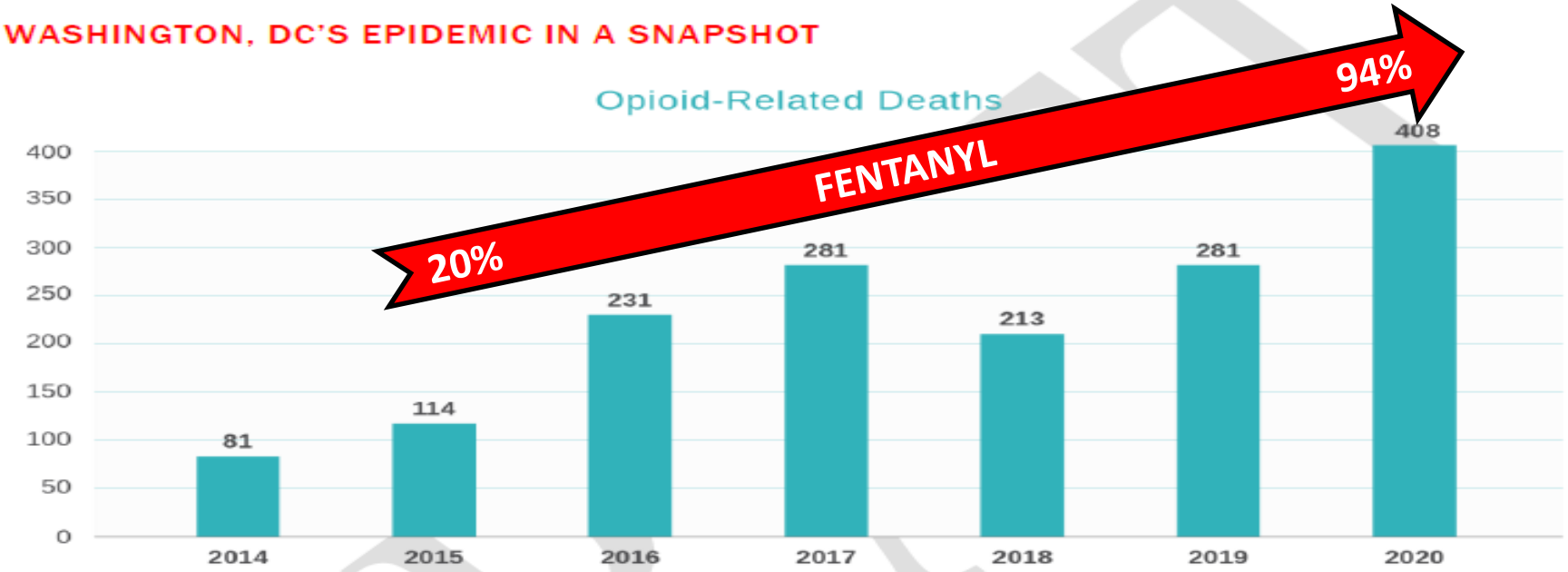
Source: Centers for Disease Control and Prevention

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).

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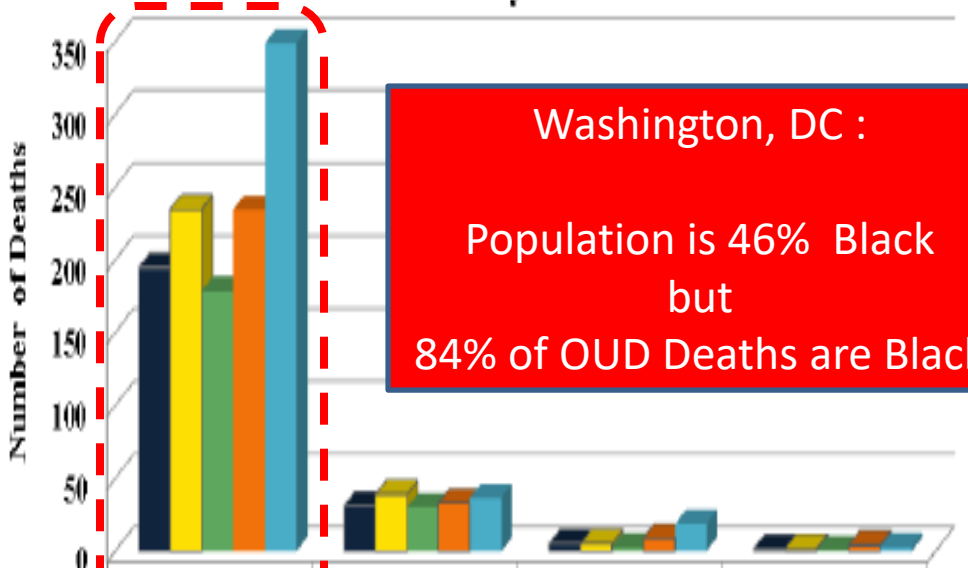
## Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2020

*Race/Ethnicity*

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

Fig. 6: Number of Drug Overdoses due to Opioid Use by Race/Ethnicity and Year




| | Black | White | Hispanic | Other |
|---|---|---|---|---|
| 2016 | 195 | 31 | 5 | 2 |
| 2017 | 235 | 39 | 5 | 2 |
| 2018 | 179 | 30 | 3 | 1 |
| 2019 | 235 | 33 | 9 | 4 |
| 2020 | 349 | 37 | 19 | 3 |

Washington, DC :

Population is 46% Black
but
84% of OUD Deaths are Black

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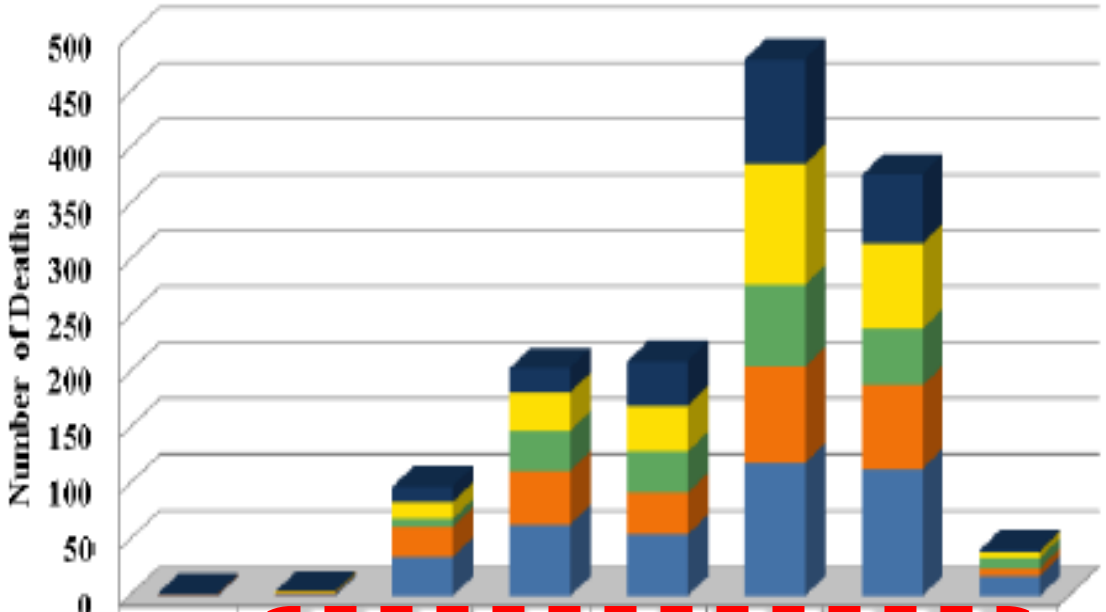
# Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2020

## 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%).

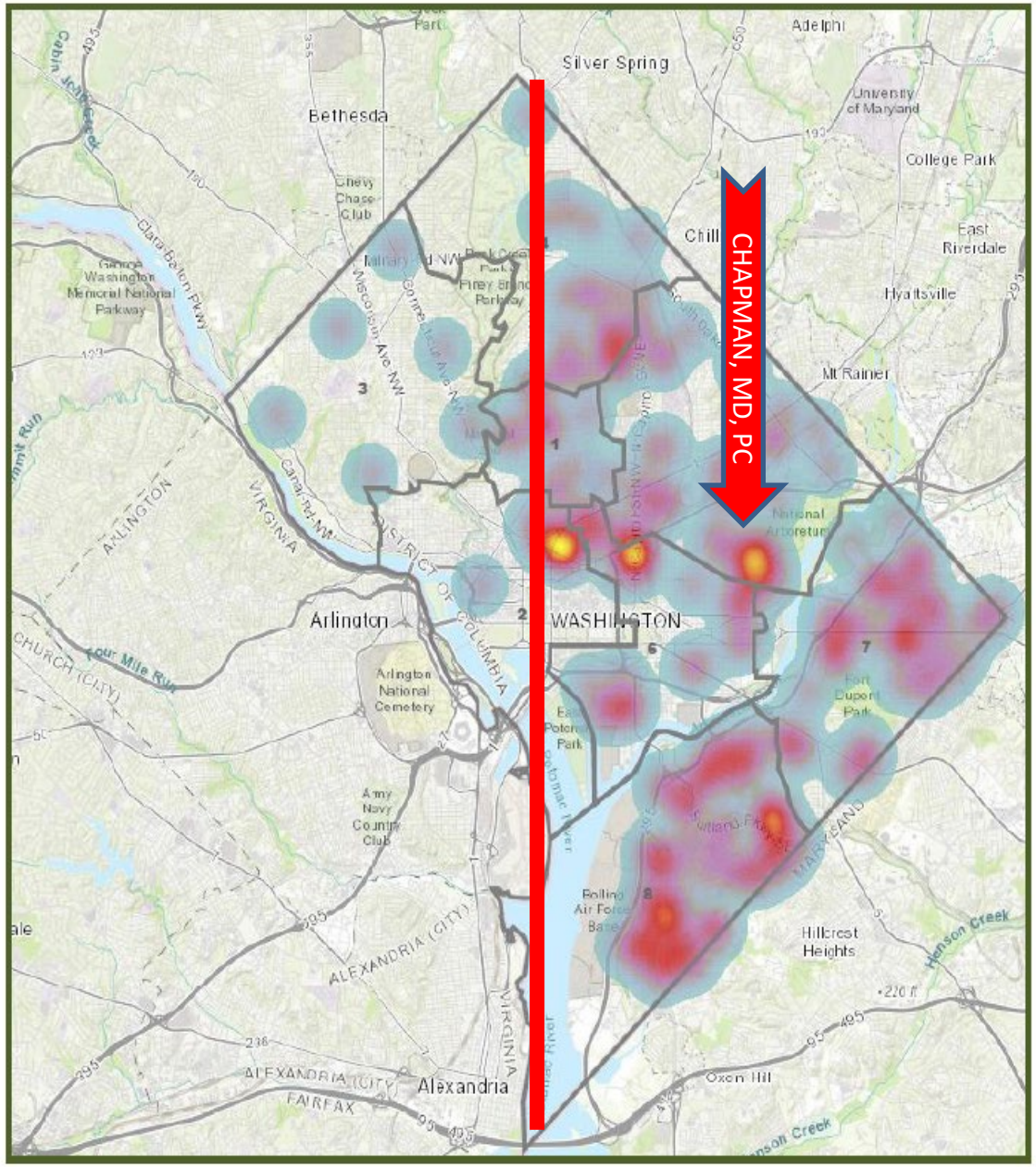
Fig. 5: Drug Overdoses due to Opioid Use by Age




| | <16 | 16-19 | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 | 70-79 |
|---|---|---|---|---|---|---|---|---|
| 2016 | 0 | 0 | 14 | 22 | 40 | 94 | 62 | 1 |
| 2017 | 0 | 1 | 15 | 34 | 41 | 108 | 76 | 6 |
| 2018 | 0 | 0 | 7 | 36 | 37 | 73 | 51 | 9 |
| 2019 | 1 | 1 | 27 | 48 | 37 | 86 | 74 | 7 |
| 2020 | 1 | 2 | 35 | 64 | 55 | 119 | 114 | 18 |

**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.




WEST

EAST

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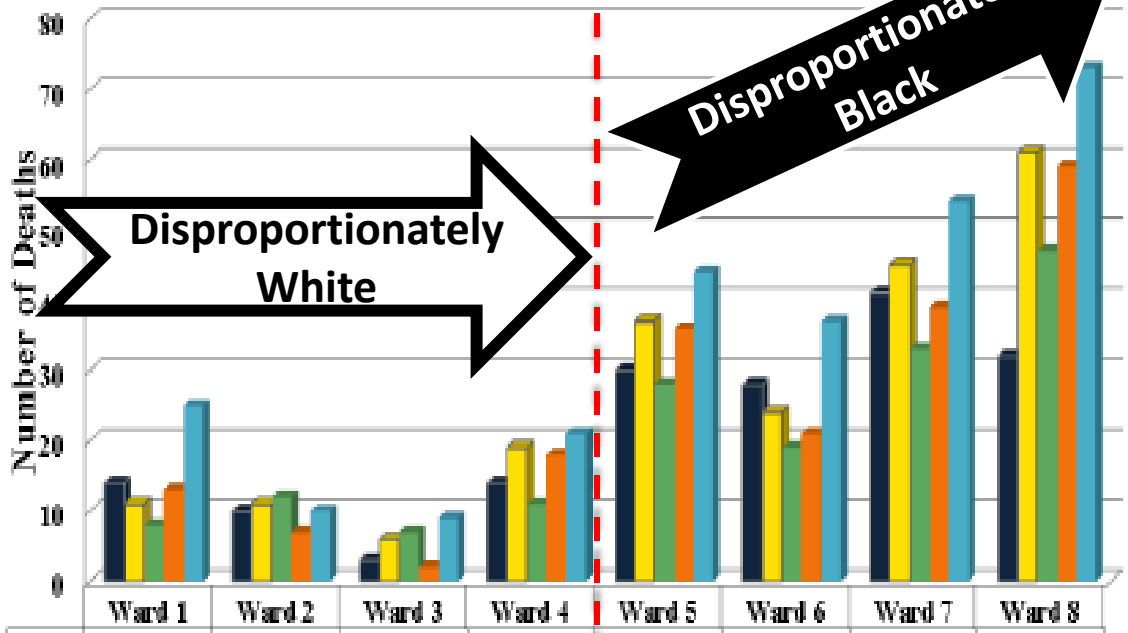
## Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2020

### Fig. 9: Number of Drug Overdoses due to Opioid Use by Ward of Residence and Year

WEST

EAST




| | Ward 1 | Ward 2 | Ward 3 | Ward 4 | Ward 5 | Ward 6 | Ward 7 | Ward 8 |
|---|---|---|---|---|---|---|---|---|
| 2016 | 14 | 10 | 3 | 14 | 30 | 28 | 41 | 32 |
| 2017 | 11 | 11 | 6 | 19 | 37 | 24 | 45 | 61 |
| 2018 | 8 | 12 | 7 | 11 | 28 | 19 | 33 | 47 |
| 2019 | 13 | 7 | 2 | 18 | 36 | 21 | 39 | 59 |
| 2020 | 25 | 10 | 9 | 21 | 44 | 37 | 54 | 73 |

The Washington Post
*Democracy Dies in Darkness*

# 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)

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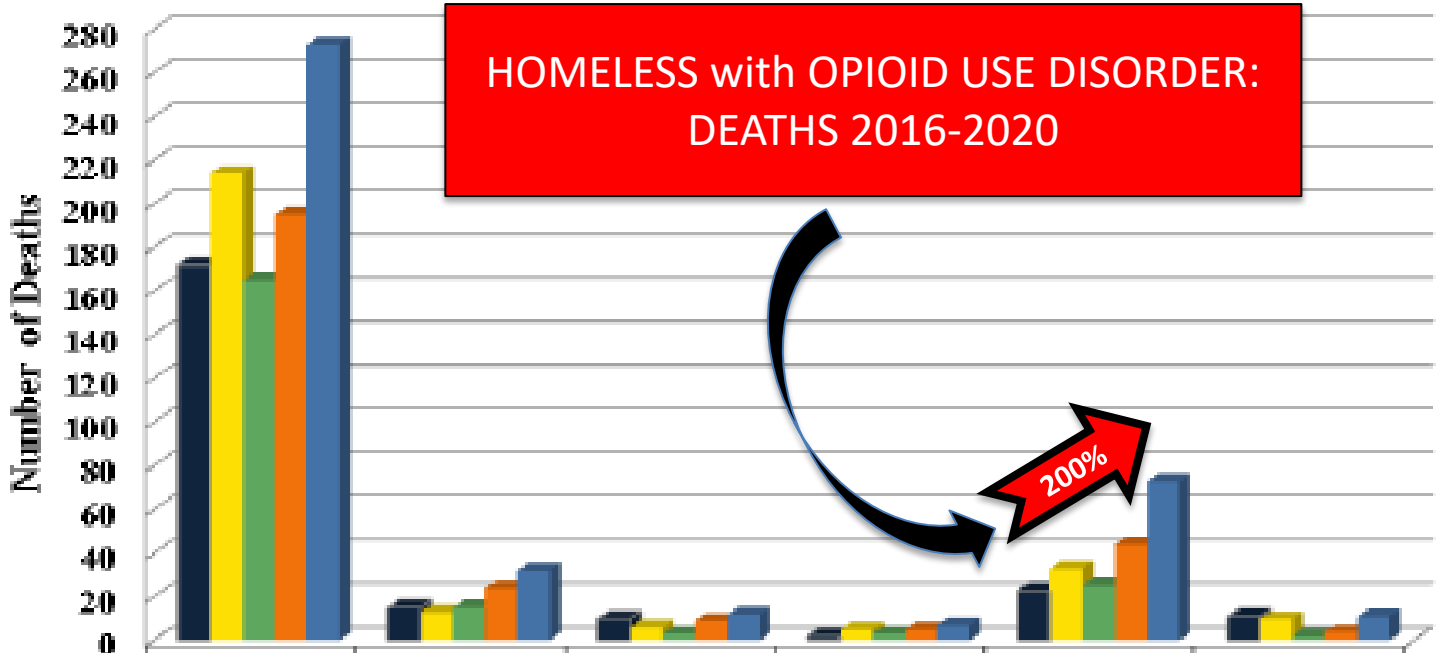
## Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2020

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

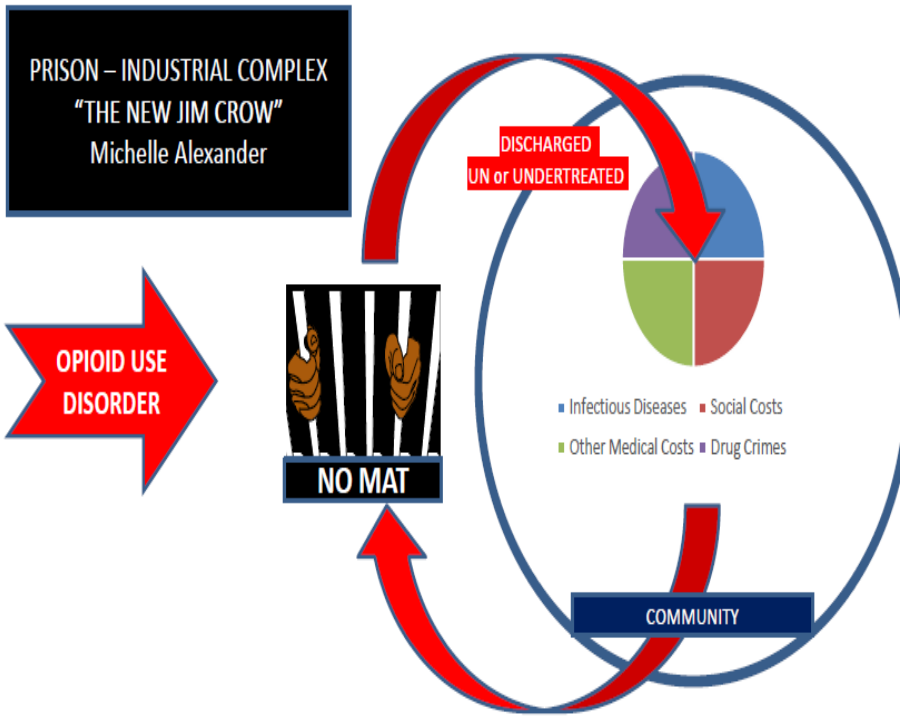
HOMELESS with OPIOID USE DISORDER:
DEATHS 2016-2020




| | DC | MD | VA | Other | Undomiciled | Unknown |
|---|---|---|---|---|---|---|
| 2016 | 172 | 15 | 10 | 2 | 23 | 11 |
| 2017 | 214 | 13 | 6 | 5 | 33 | 10 |
| 2018 | 165 | 15 | 3 | 3 | 25 | 2 |
| 2019 | 195 | 24 | 9 | 5 | 44 | 4 |
| 2020 | 273 | 32 | 12 | 7 | 73 | 11 |

# REVERSE ENGINEERING 401 YEARS of SYSTEMATIC OPPRESSION

## MASS INCARCERATION

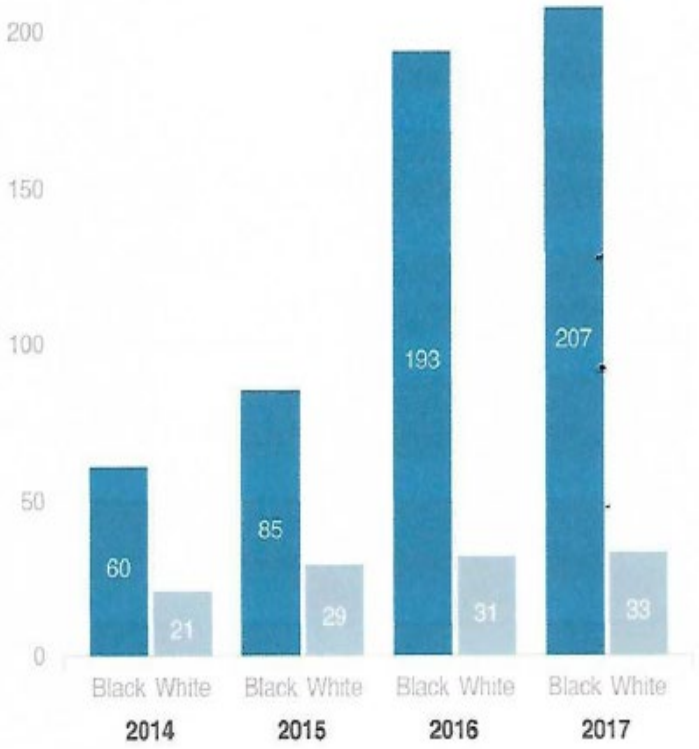


# CHAPMAN, MD, PC

## 230 Current Patients on Buprenorphine:

### 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.

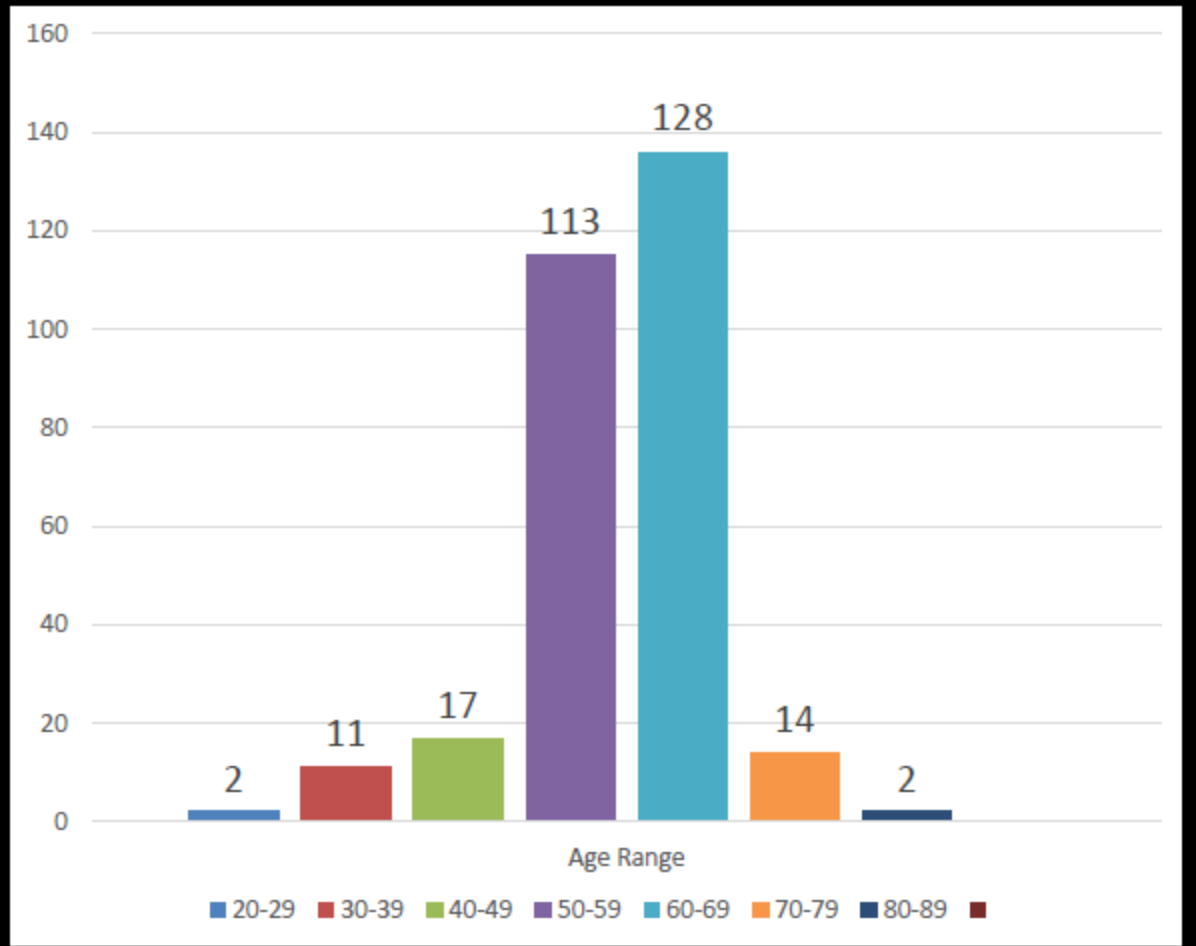



*Source: District of Columbia Office of the Chief Medical Examiner*

*Credit: Katie Park/NPR*

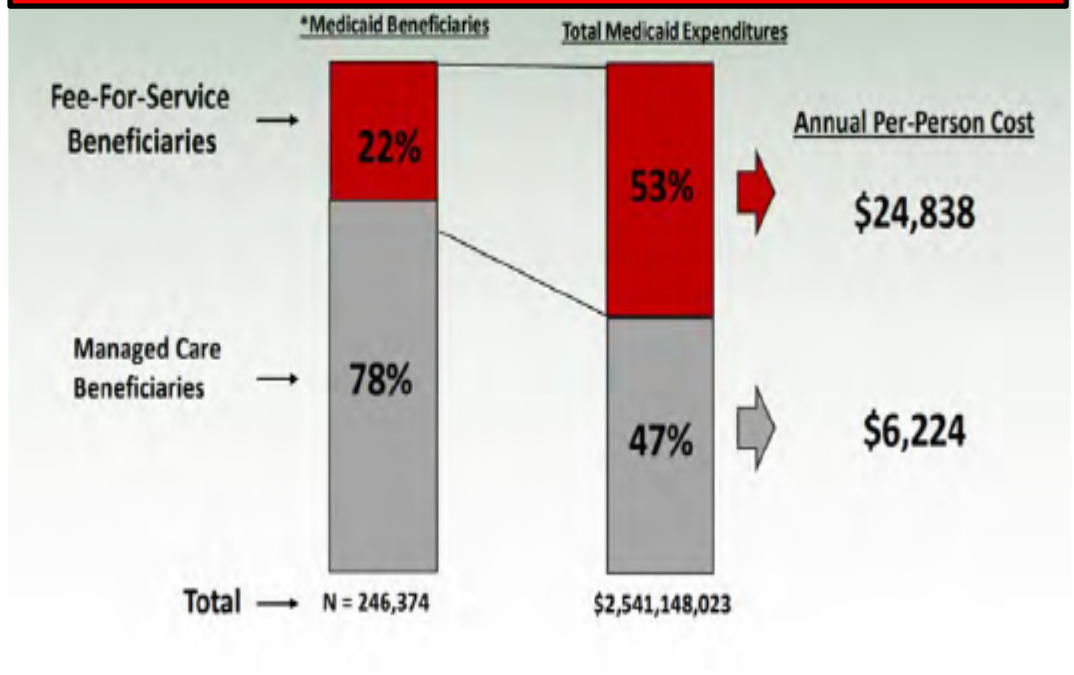
Dr. Chapman in his office at the end of the day on Friday. He waits for the last patient to come in, not wanting them to have to spend the weekend without medication. The walls are covered with awards, certificates, newspaper clippings and

# PATIENTS by AGE RANGE



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

WASHINGTON, DC as a Generic Exemplar




Highlighting the need to drive greater value through improved care coordination for the FFS beneficiaries who account for $25K annual per-person cost.

Table. Demographic Characteristics Associated With Buprenorphine Prescribing in Outpatient Care in the United States in 2004-2007 and 2012-2015

| Variable | 2004-2007 | | 2012-2015 | | |
|---|---|---|---|---|---|
| | Visits Without Buprenorphine (n = 244 274), %[a] | Visits With Buprenorphine (n = 183), %[a] | Visits Without Buprenorphine (n = 204 527), %[a] | Visits With Buprenorphine (n = 718), %[a] | Adjusted OR (95% CI)[b] |
| Race/ethnicity[c] | | | | | |
| White | 83.5 | 90.5 | 83.1 | 94.9 | 1.00 |
| Black | 11.5 | 6.5 | 10.6 | 2.7 | 0.23 (0.13-0.44) |
| Other | 5.0 | 3.0 | 6.3 | 2.4 | 0.27 (0.08-0.90) |
| Payment method | | | | | |
| Private insurance | 52.0 | 19.8 | 49.2 | 33.9 | 1.00 |
| Medicare/Medicaid | 35.1 | | | | 1.16 (0.74-1.82) |
| Self-pay | 4.5 | | | | 12.27 (6.86-21.91) |
| Other or unknown | 8.5 | 11.0 | 8.2 | 7.5 | 1.35 (0.78-2.35) |
| Sex | | | | | |
| Female | 58.8 | 47.5 | 58.3 | 39.7 | 1.00 |
| Male | 41.2 | 52.5 | 41.7 | 60.3 | 2.22 (1.82-2.70) |
| Age, y | | | | | |
| <30 | 29.9 | 40.0 | 25.4 | 30.3 | 1.00 |
| 30-50 | 23.8 | 47.5 | 21.4 | 47.2 | 1.68 (1.33-2.12) |
| >50 | 46.3 | 12.5 | 53.2 | 22.4 | 0.38 (0.27-0.52) |

BUPRENORPHINE MEDICATION DIVIDE

Abbreviation: OR, odds ratio.

[a] Analyses were completed using survey design elements accounting for visit weight, clustering, and stratification to generate nationally representative estimates.

[b] 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.

[c] 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).

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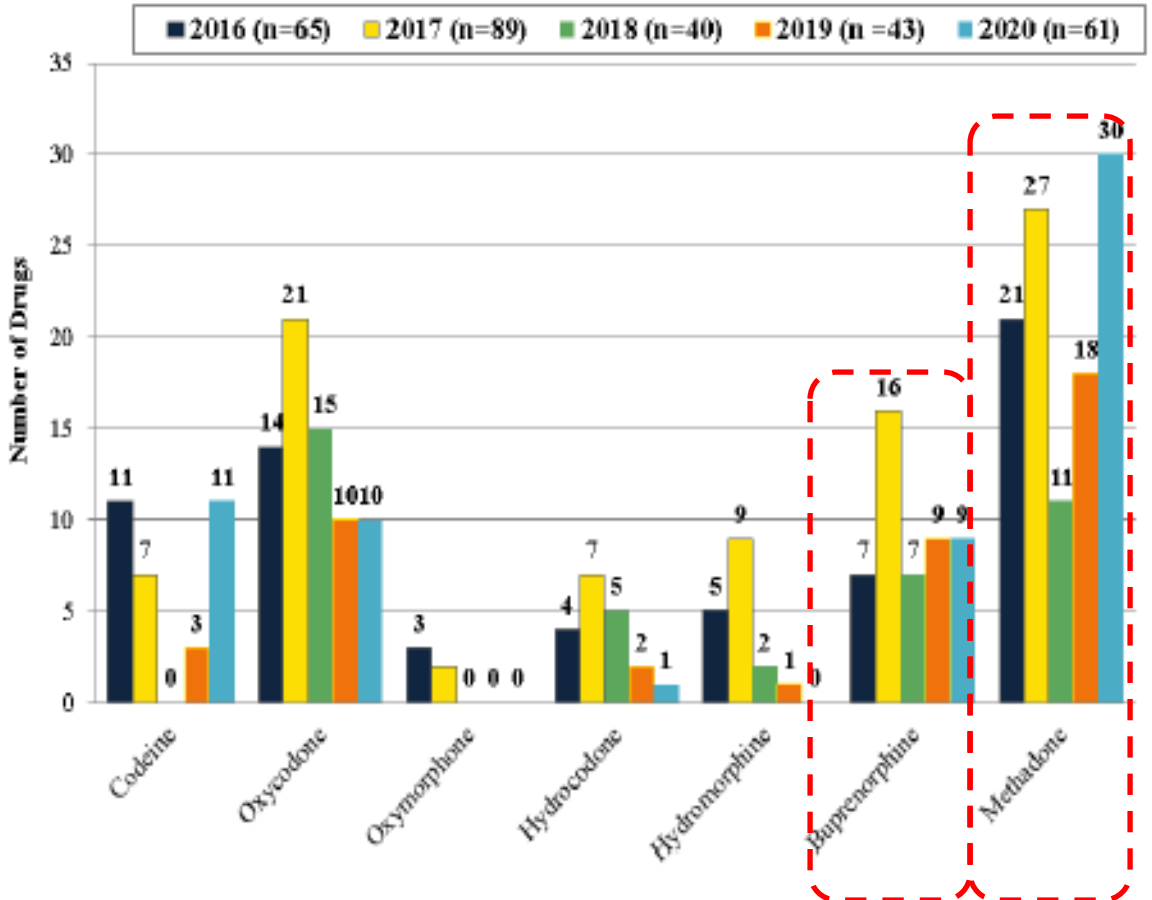
# Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2020

## 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.

Fig. 4: Number of Prescription Opioids Contributing to Drug Overdoses by Year (n=298)



| AIRAC date | State | City | Airport | FDC No. | FDC date | Subject |
|---|---|---|---|---|---|---|
| 3-Dec-20 | CA | Riverside | Riverside Muni | 0/8633 | 9/22/20 | VOR RWY 9, Amdt 1B. |
| 3-Dec-20 | CA | Riverside | Riverside Muni | 0/8634 | 9/22/20 | VOR–A, Orig-A. |

[FR Doc. 2020–23958 Filed 10–30–20; 8:45 am]

BILLING CODE 4910–13–P

## DEPARTMENT OF JUSTICE

### Drug Enforcement Administration

### 21 CFR Parts 1301 and 1306

[Docket No. DEA–499]

RIN 1117–AB55

# Implementation of the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018: Dispensing and Administering Controlled Substances for Medication-Assisted Treatment

**AGENCY:** Drug Enforcement Administration, Department of Justice.

**ACTION:** Interim final rule with request for comments.

**SUMMARY:** The "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (the SUPPORT Act)," which became law on October [illegible] Controlled [illegible] the condition[illegible] to provide med[illegible] treatment and exp[illegible] available for a physi[illegible] considered a qualifying [illegible] SUPPORT Act removed t[illegible] for a nurse practitioner or p[illegible] assistant to be considered a qu[illegible] other practitioner, and revis[illegible] definition of a qualifying [illegible] The SUPPORT Act also[illegible] pharmacy to deliver [illegible] controlled substan[illegible] registered locati[illegible] maintenance [illegible] to be admi[illegible] conditi[illegible] Enfo[illegible] regulations to make them consistent with the SUPPORT Act and implement its requirements.

**DATES:** This interim final rule is effective on October 30, 2020. Electronic comments must be submitted, and written comments must be postmarked, on or before January 4, 2021.

**ADDRESSES:** To ensure proper handling of comments, please reference "RIN 1117–AB55 Docket No. DEA–499" on all correspondence, including any attachments.

- *Electronic comments:* The Drug Enforcement Administration encourages that all comments be submitted electronically through the Federal eRulemaking Por[illegible] ability to type sh[illegible] into the commen[illegible] or attach a file fo[illegible] Please go to *http:*[illegible] and follow the or[illegible] that site for subm[illegible] completion of your submission, you will receive a Comment Tracking Number for your comment. Please be aware that submitted comments are not instantaneously available for public view on *http://www.regulations.gov.* If you have received a Comment Tracking Number, your comment has b[illegible] successfully submitted, and th[illegible] is no need to resubmit the same co[illegible] Commenters should be aware [illegible] electronic Federal Docket Ma[illegible] System will not accept comme[illegible] 11:59 p.m. Eastern Time on th[illegible] of the comment period.
- *Paper comments:* Paper c[illegible] that duplicate the electronic s[illegible]

Please note that all commen[illegible] received are considered part o[illegible] public record. They will, unle[illegible] reasonable cause is given, be [illegible] available by the Drug Enforcer[illegible] Administration (DEA) for pub[illegible] inspection online at *http://www.regulations.gov.* Such in[illegible] includes personal identifying [illegible] information (such as your nam[illegible] address, etc.) voluntarily submitted by the commenter. The Freedom of Information Act applies to all comments received. If you want to submit personal identifying information (such as your name, address, etc.) as part of your comment, but do not want it to be made publicly available, you must include the information you want redacted.

If you want to submit confidential business information as part of your comment, but do not want it to be made publicly available, you must include the phrase "CONFIDENTIAL BUSINESS INFORMATION" in the first paragraph of your comment. You must also prominently identify the confidential business information to be redacted within the comment.

Comments containing personal [illegible]dentifying information and confidential [illegible]siness information identified as [illegible]d above will generally be made [illegible]vailable in redacted form. If a [illegible]s so much confidential [illegible]nation or personal [illegible]nation that it cannot be [illegible] all or part of that [illegible]nade publicly [illegible]ted to *http://* [illegible]clude any [illegible]n (such [illegible]nber) [illegible]ic

[illegible]–AB55/ [illegible]or ease of

[illegible]*ons of the SUPPORT*

[illegible]ber 24, 2018, the President [illegible]e SUPPORT Act into law as [illegible]c Law 115–271. Sections 3201 and [illegible]02 of the SUPPORT Act amended certain provisions of 21 U.S.C. 823(g)(2), which is the subsection of the Controlled Substances Act (CSA) that sets forth the conditions under which a practitioner may, without being separately registered under subsection 823(g)(1), dispense a narcotic drug in



written for the treatment of addiction.[54] However, the primary reason for prescription buprenorphine (Subutex) and buprenorphine combined with naloxone (Suboxone) diversion is the failure to access legitimate addiction treatment.[55] This finding suggests that increasing, not limiting, buprenorphine treatment may be an effective response to the diversion of buprenorphine.[56]

The diversion of buprenorphine for self-treatment is also supported by studies of abuse rates of buprenorphine [illegible]

[illegible]PORT Act only [illegible]ecific group of [illegible]ments, and will [illegible]ration with or [illegible] a qualified [illegible] any added risk [illegible]ould not be

naloxone in the formula).[57] This preference is notable because the naloxone blocks the agonist effect of the buprenorphine, and therefore users of buprenorphine with naloxone are less likely to experience euphoria from the drug.[58] The low endorsement [59] of the use of buprenorphine with naloxone and the low prescription rate of buprenorphine (without naloxone) in the United States indicates that the potential for abuse of these drugs is relatively low.[60] Another study of untreated injection drug users found that three out of four respondents said their intended use of buprenorphine or buprenorphine combined with naloxone was to self-medicate for addiction and/or to treat withdrawal.[61] While buprenorphine and buprenorphine combined with naloxone are schedule III narcotics with a potential for diversion and abuse, academic literature seems to indicate that the diversion is not motivated by addiction to buprenorphine, but rather as a method to treat opioid addiction problems.[62] Additionally, since NPs, PAs, CRNAs, CNS, and CNMs seeking to obtain the authority to dispense under the SUPPORT Act already have the authority to dispense controlled

significant.

### Cost to DEA

As part of its core function, DEA's Diversion Control Division manages over 1.9 million DEA registrations (processing new and renewal registration applications, processing registration modification requests, issuing certificates of registration, issuing renewal notifications, conducting due diligence, maintaining and operating supporting information systems, etc.). DEA does not anticipate it will incur any additional costs as a result of conducting due diligence and processing 19,659 registration modifications for DATA-waived status over five years. DEA's Registration Section and field office representatives conduct similar registration-related due diligence and process registration modifications as part of their routine operations. As of August 2019, DEA has absorbed any extra work in processing over 5,600 registration modifications related to this interim final rule with preexisting resources, without an increase in cost to DEA. Likewise, DEA anticipates it will continue to absorb any additional work in processing the registration modifications for the duration of the analysis period.

### Summary of Benefits and Costs

As described above, DEA estimates the total benefit (in the form of economic burden reduction and other cost savings) is $63 million, $139 million, $227 million, $3,349 million, and $3,400 million in years 1, 2, 3, 4, and 5, respectively; the total cost of treatment is $39 million, $86 million, $140 million, $2,070 million, and $2,102 million in years 1, 2, 3, 4, and 5, respectively; the total treatment cost savings is $2 million, $5 million, $8 million, $118 million, and $120 million in years 1, 2, 3, 4, and 5, respectively; and the total cost of obtaining DATA-waived status is $1 million, $1 million, $1 million, $1 million, and $0 in years 1, 2, 3, 4, and 5, respectively; resulting in a net benefit of $25 million, $57 million, $94 million, $1,396 million, and $1,418 million in years 1, 2, 3, 4, and 5, respectively. The table below summarizes the benefits and costs.

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|
| Total benefit ($MM) | 63 | 139 | 227 | 3,349 | 3,400 |
| Cost of treatment ($MM) | 39 | 86 | 140 | 2,070 | 2,102 |
| Treatment cost savings ($MM) | (2) | (5) | (8) | (118) | (120) |
| Cost of obtaining DATA-waived status ($MM) | 1 | 1 | 1 | 1 | |
| Total cost ($MM) | 38 | 82 | 133 | 1,953 | 1,982 |
| Annual net benefit ($MM) | 25 | 57 | 94 | 1,396 | 1,418 |

Figures are rounded.

DEA recognizes that accurately calculating the benefits of this rule rests primarily on the number of FTE patients in treatment. While DEA considers its primary estimates presented above to be reasonable, there are also inherent uncertainties in predicting these figures over time. Therefore, DEA varied its estimated number of FTE patients treated per provider plus and minus 10 percent in order to capture the likely range of benefits surrounding the primary estimate. These results are detailed in the following table. The impact of varying additional inputs are summarized in the sensitivity analysis section below.

[54] Lofwall MR and Havens JR, Inability to access buprenorphine treatment as a risk factor for using diverted buprenorphine, Drug Alcohol Dependence, Dec. 1, 2012.

[55] Id.

[56] Id.

[57] Martin, Judith, Providers' Clinical Support System for Medication Assisted Treatment Guidance, January 10, 2014. *https://pcssnow.org/wp-content/uploads/2014/02/PCSS-MATGuidanceAdherence-diversion-bup.Martin.pdf.*

[58] Id.

[59] "Low endorsement" means that the Suboxone is not as highly sought after because the naloxone in the formula acts as an antagonist to the buprenorphine, meaning patients cannot experience the euphoria from the drug.

[60] Id.

[61] Diversion and Abuse of Buprenorphine: A Brief Assessment of Emerging Indicators, JBS International, Inc., Maxwell, Jane C. November 30, 2006.

[62] Cicero, Theodore J., Matthew S. Ellis, and Howard D. Chilcoat. "Understanding the Use of Diverted Buprenorphine." Drug and Alcohol Dependence 193 (2018): 117–23. *https://doi.org/10.1016/j.drugalcdep.2018.09.007.*

$7,500
ANNUAL
BUPRENORPHINE
TREATMENT
COST

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.

SAVES MONEY

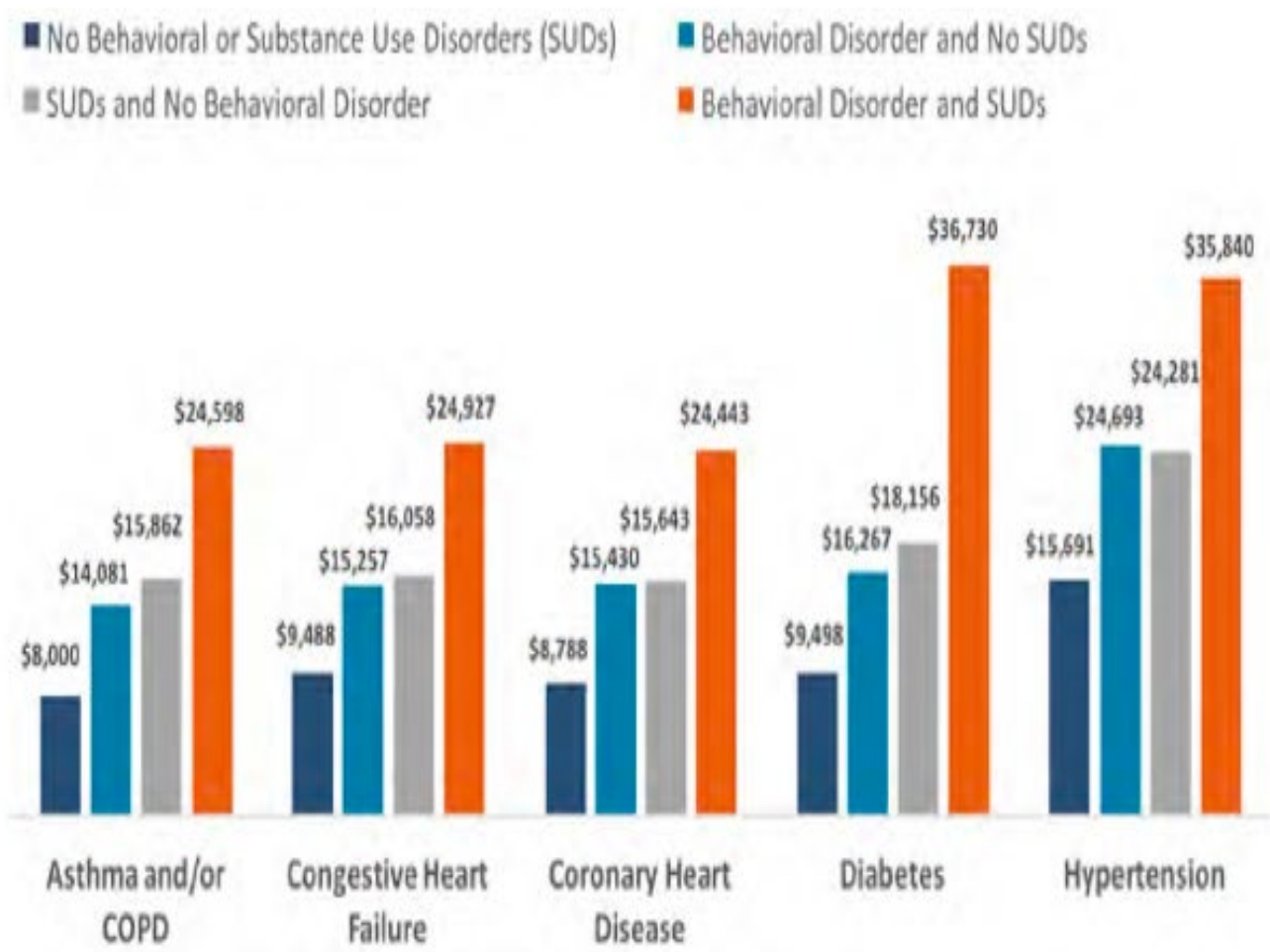
DEA estimates the total economic burden to be $75.7 billion ($82.14 billion USD in 2018).[35] Dividing this total economic burden by the number of patients, DEA estimates the annual economic burden of prescription opioid abuse is $42,000 per person (USD in 2018).

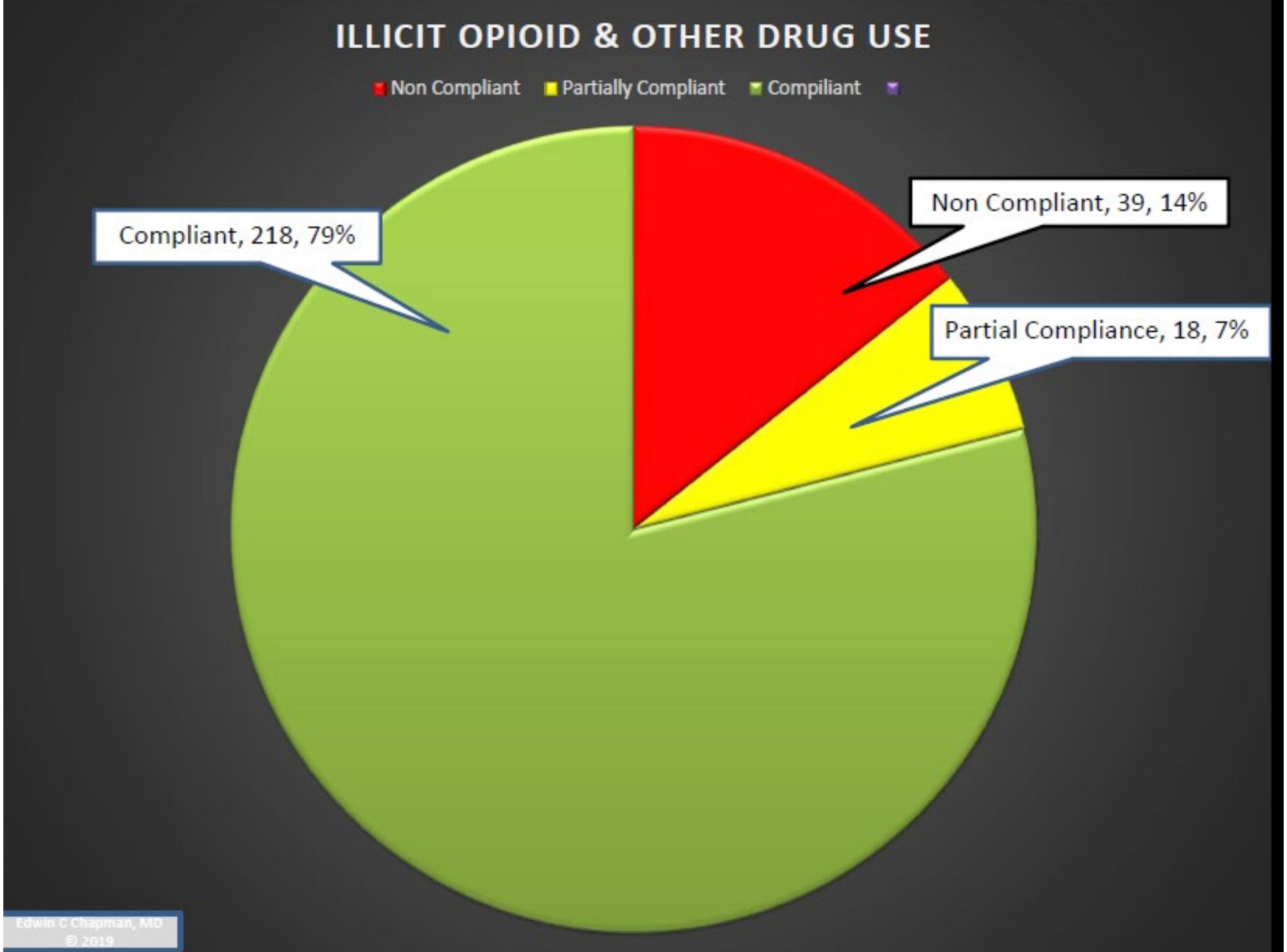
$42,000

UNTREATED ANNUAL
MEDICAL COSTS

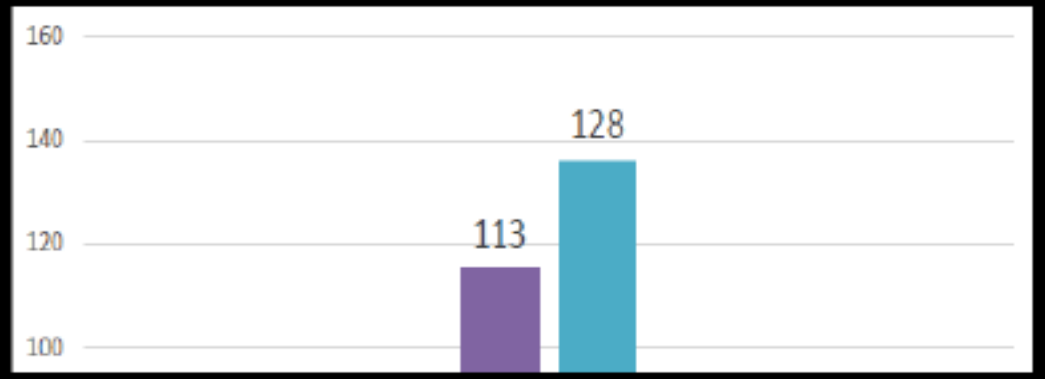
# Annual Per Capita Cost of Behavioral Health Comorbidities

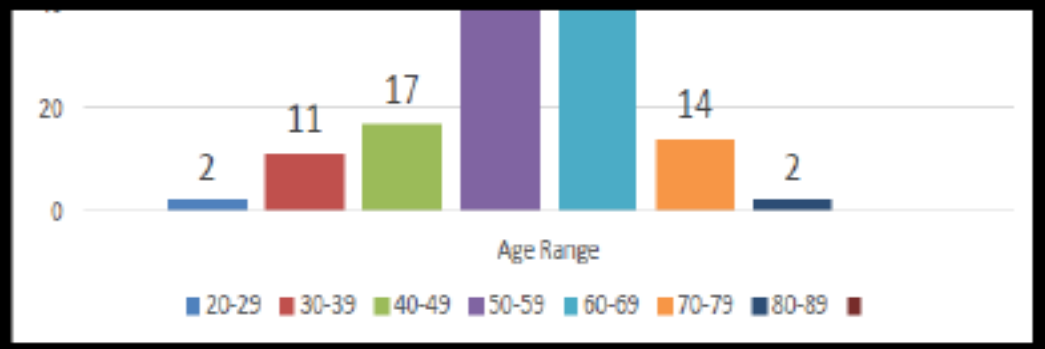
*Medicaid-only Beneficiaries with Disabilities*

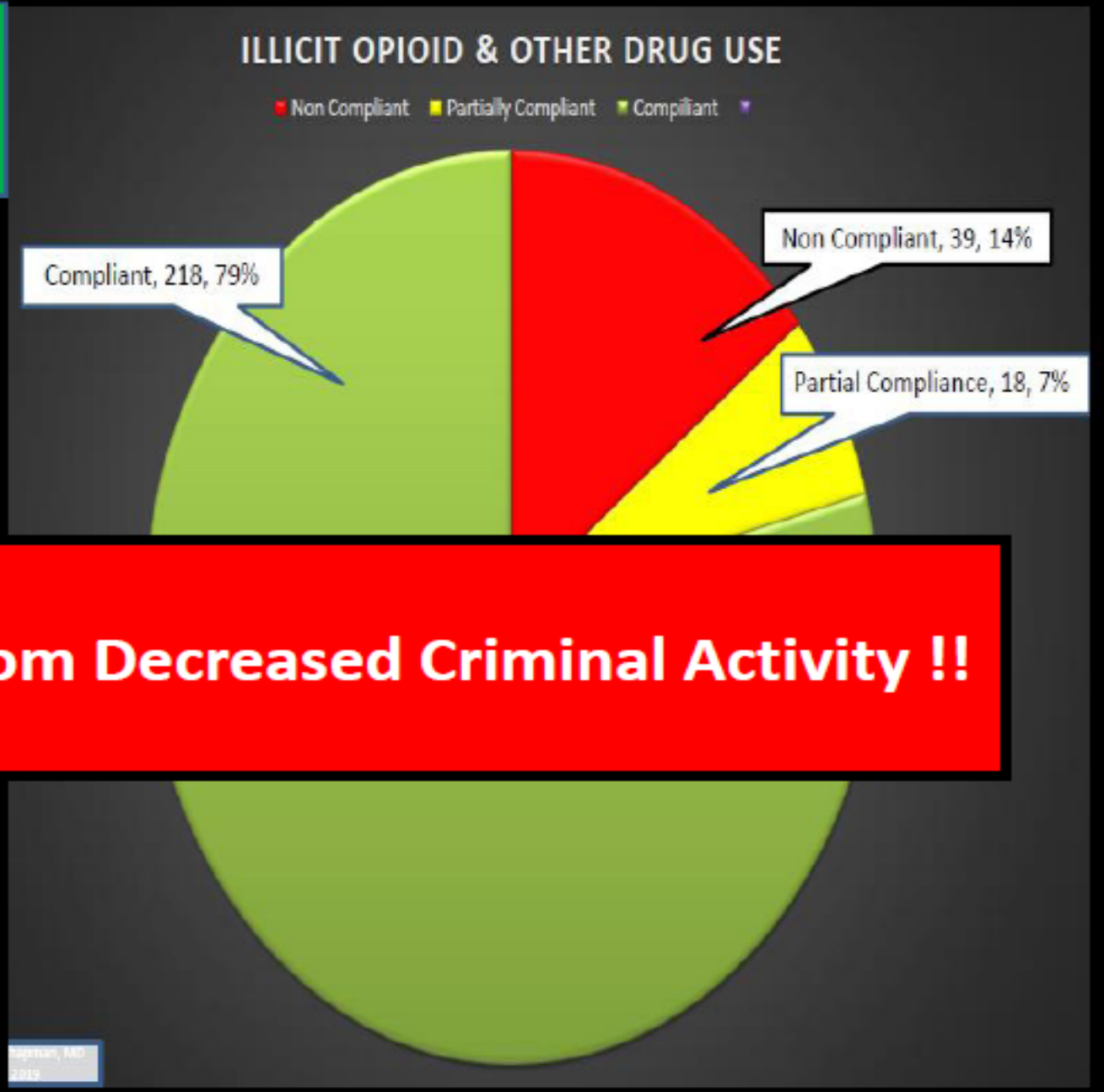



ILLICIT OPIOID & OTHER DRUG USE
Non Compliant
Partially Compliant
Compiliant
Non Compliant, 39, 14%
Partial Compliance, 18, 7%
Compliant, 218, 79%
Edwin C Chapman, MD
© 2019

# PATIENTS by AGE RANGE

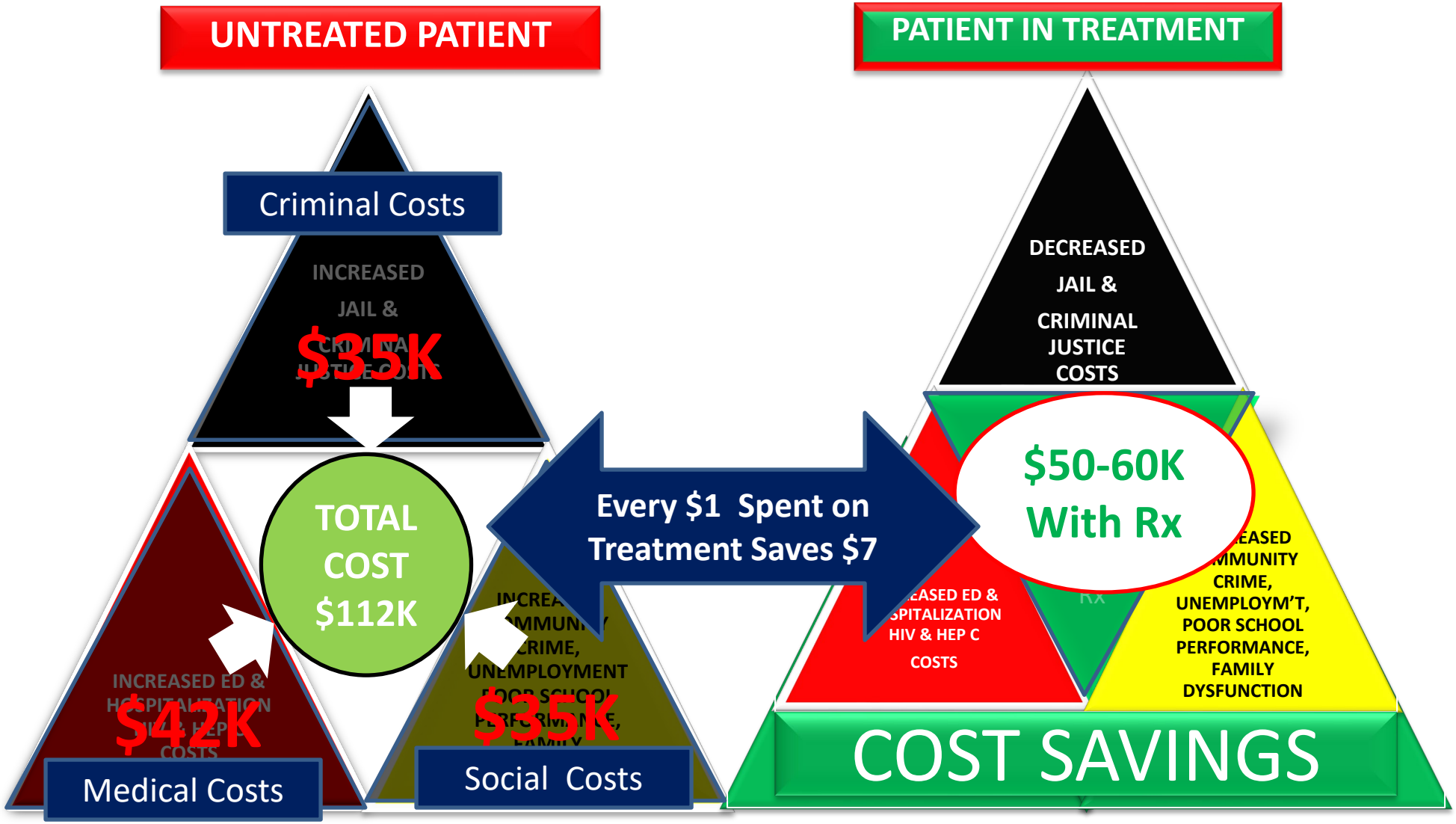


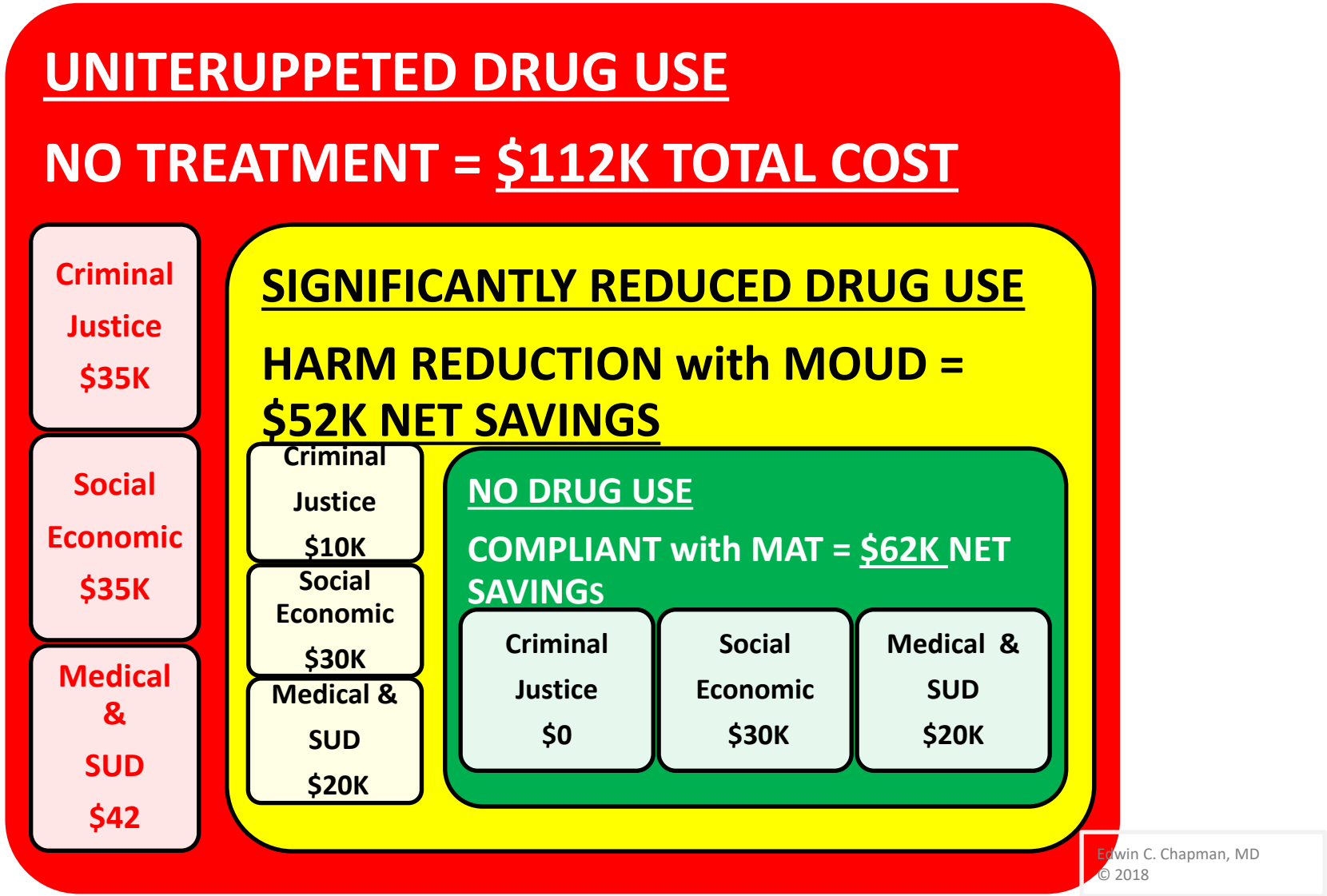




**Equals $8 Million in Savings from Decreased Criminal Activity !!**

# TOTAL IMPACT of an INDIVIDUAL PATIENT on COMMUNITY



# HARM REDUCTION-LOSS MITIGATION MODEL
# using
# MEDICATION for OPIOID USE DISORDER (MOUD)



# RYAN WHITE CARVEOUT PAYMENT MODEL

**KNOWLEDGABLE SPECIALTY NETWORK**

Edwin C. Chapman, MD

# MOUD TREATMENT CARVEOUT PAYMENT MODEL

**KNOWLEDGABLE SPECIALTY NETWORK**

Edwin C. Chapman, MD

Carlos del Rio, MD

Executive Associate Dean
Emory School of Medicine & Grady Health System

Distinguished Professor
Department of Medicine, Division of Infectious Diseases, Emory University School of Medicine

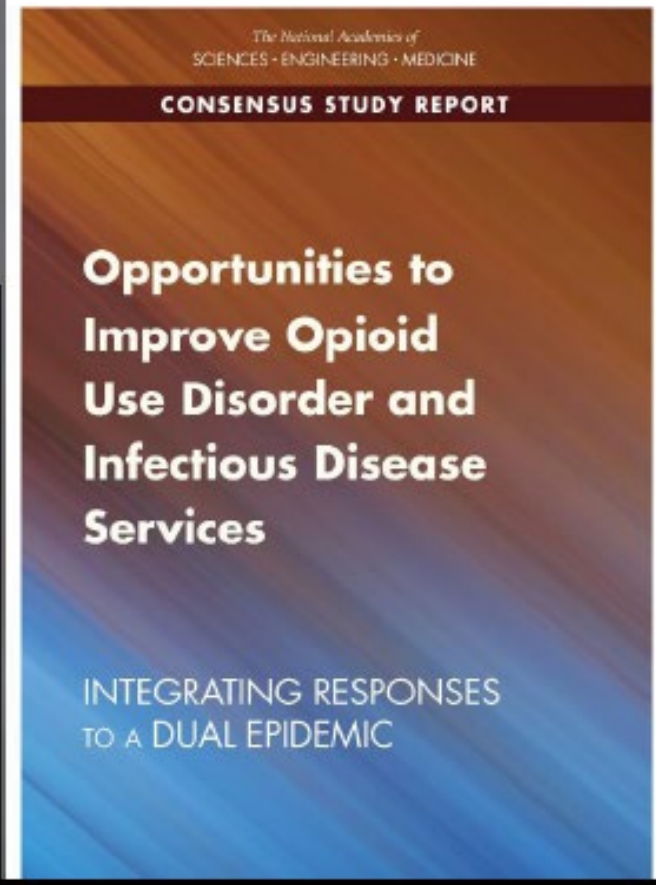
Professor
Rollins Department of Global Health-Rollins School of Public Health

Co-Director
Emory Center for AIDS Research

Co-PI
Emory CDC HIV Clinical Trials Unit and the Emory Vaccine and Treatment Evaluation Unit

# January, 2019- January, 2020


**EMBARGOED**
Not for public release before
**THURSDAY, JANUARY 23, 2020, AT 11:00 A.M. (ET)**




**END FEDERAL PROVIDER-PATIENT CAPS & REGULATORY BARRIERS; INCONSISTENT TECHNOLOGY as well as LOCAL TRANSITIONAL CARE GAPS REMAIN as MAJOR OBSTACLES to QUALITY MOUD**

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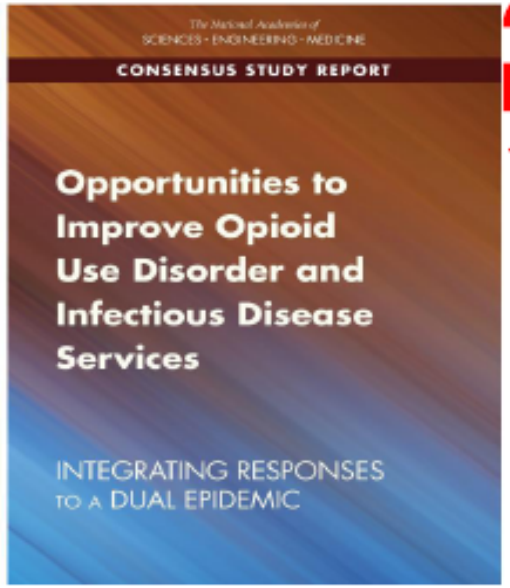


COMMITTEE ON THE EXAMINATION OF THE INTEGRATION OF OPIOID AND INFECTIOUS DISEASE PREVENTION EFFORTS IN SELECT PROGRAMS

CARLOS DEL RIO (Chair), Hubert Professor and Chair, Hubert Department of Global Health, Rollins School of Public Health, Emory University, and Professor of Medicine, Emory University School of Medicine
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ANNA MARTIN, Administrative Assistant
MISRAK DABI, Financial Business Partner
ROSE MARIE MARTINEZ, Study Director

## BOX S-2
## Barriers to Integration of Opioid Use Disorder and Infectious Disease Services

**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 patients' information surrounding substance use and treatment, thereby inhibiting comprehensive care plans.

**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.

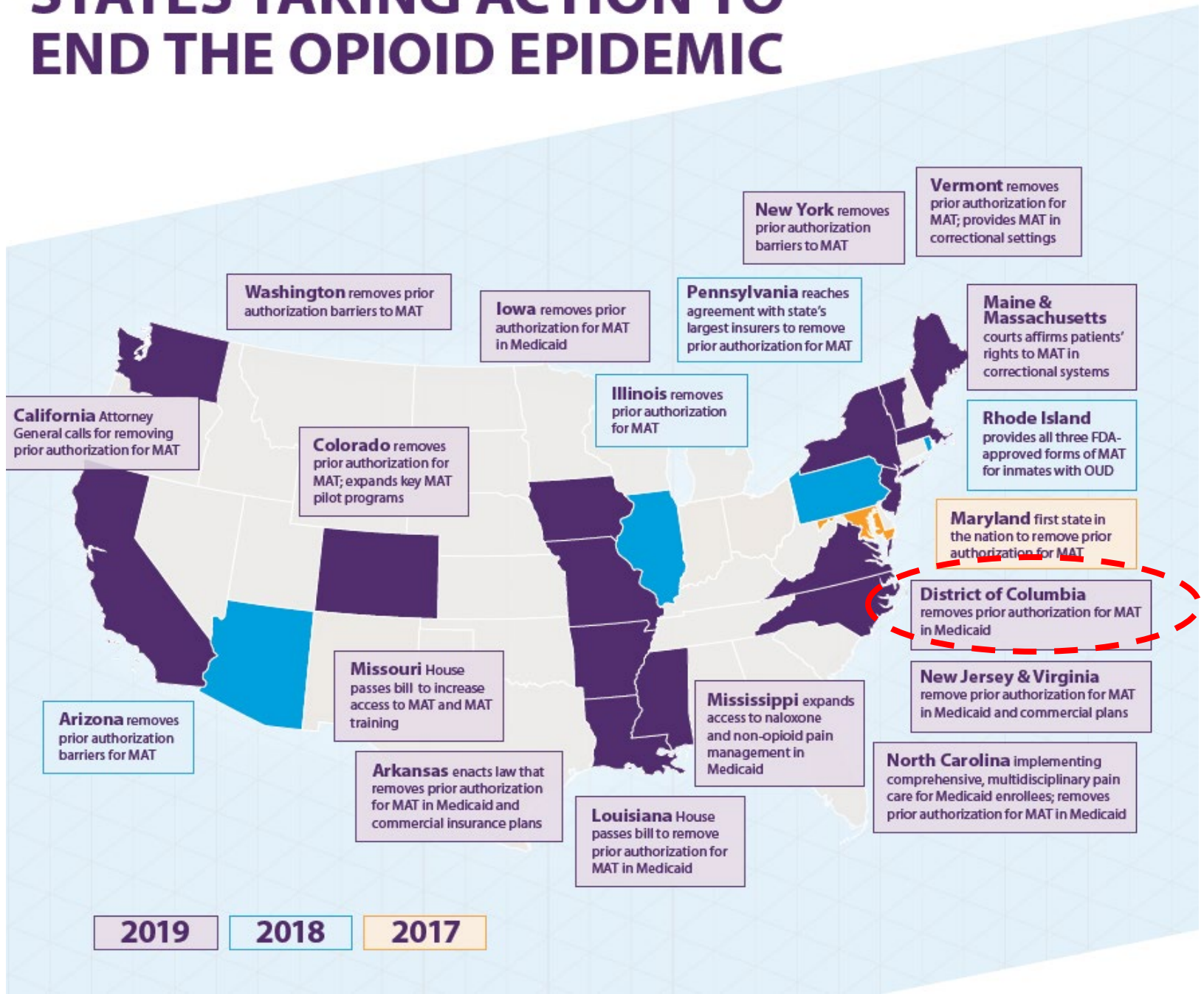
**Same-Day Billing Restrictions:** Some states do not allow providers to bill for a physical and a behavioral health visit in the same day, thereby requiring patients to return for care another day or forcing programs to provide care without the opportunity for reimbursement.

**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; the process of maintaining coordinated care while patients enter and exit the criminal justice system is inadequate.

OPIOID TASK FORCE 2019
PROGRESS REPORT

# STATES TAKING ACTION TO END THE OPIOID EPIDEMIC




AMA AMERICAN MEDICAL ASSOCIATION

JAMA Network | Open

Original Investigation | Substance Use and Addiction

# Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries

Tami L. Mark, PhD; William J. Parish, PhD; Gary A. Zarkin, PhD

Table 4. Association of Removal or Addition of Prior Authorization With Health Care Outcomes[a]

**PRIOR AUTHORIZATIONS for BUPRENORPHINE IMPEDES ACCESS to CARE**
**and**
**INCREASES ED VISITS and HOSPITALIZATIONS**

| | | | | |
|---|---|---|---|---|
| All-cause emergency department visits | −12.6 (−25.9 to −0.5) | .04 | 32.2 (10.2 to 57.6) | .004 |
| Substance use disorder-related emergency department visits | −1.4 (−3.2 to −0.1) | .04 | 3.6 (0.8 to 7.5) | .005 |
| Prescription drug expenditures, $ | 48.7 (3.1 to 96.0) | .04 | −124.7 (−214.2 to −40.6) | .003 |
| Nondrug expenditures, $ | −479.2 (−942.7 to −21.1) | .04 | 1236.9 (434.2 to 2055.0) | .003 |

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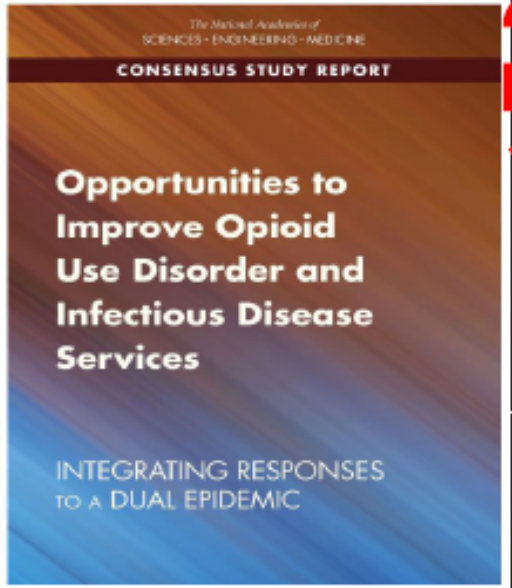


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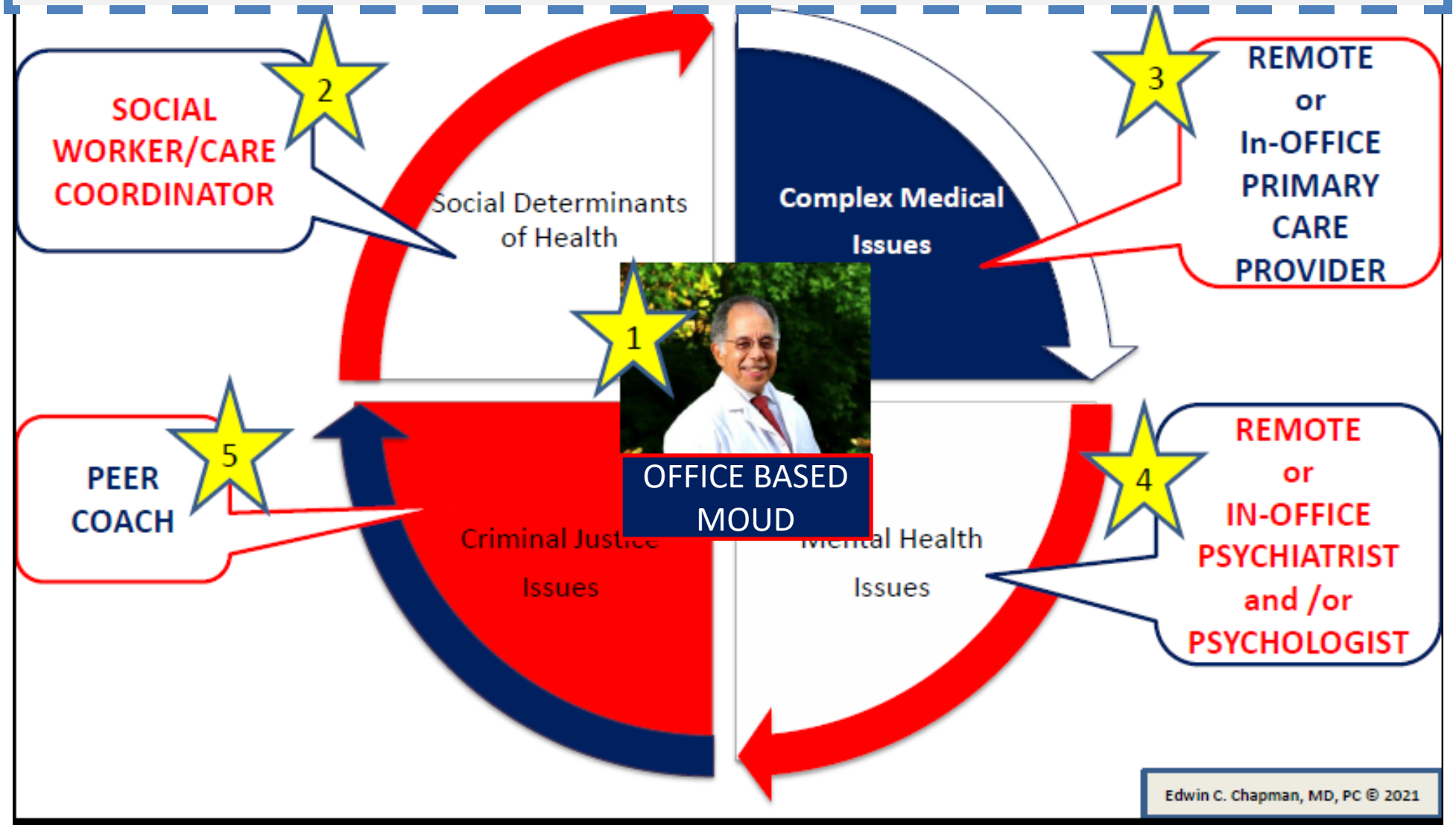


NW

Geographically Distributed Medical Practices"

NE

**SAMHSA CCBHC URBAN EXPANSION MODEL:**
**MENTAL HEALTH + SUBSTANCE USE DISORDER + PRIMARY CARE + SOCIAL DETERMINANTS of HEALTH thru VIRTUAL CARE**

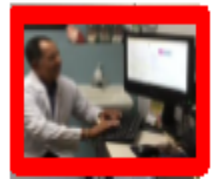
Geographically Distributed Medical Practices

**SERVICES**

- PRIMARY CARE
- PSYCHIATRY
- SUD
- SOCIAL WORKER
- INFECTIOUS DISEASE
- COMMUNITY NAVIGATORS

COMMUNITY HOSPITAL

FAITH INSTITUTION WRAPAROUND SERVICES



WALKS & ASSOCIATES

CHAPMAN, MD, PC
COMMUNITY PRACTICE



Geographically Distributed Medical Practices

Geographically Distributed Medical Practices

SW

SE

Geographically Distributed Medical Practices

# BOUTIQUE (CASH ONLY) BUPRENORPHINE PROVIDER

100 Patients x
$250/month =
$300,000/year

# POTENTIAL URBAN MEDICARE or MEDICAID BUPRENORPHINE COMPLEX PATIENT

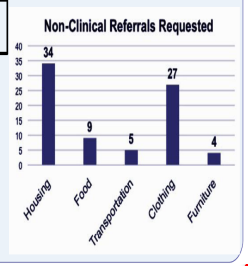
# EPIGENETIC SUSCEPTIBILITY & BIOLOGICAL FOOTPRINT

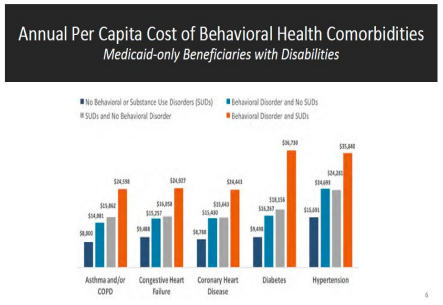
# MEDICARE or MEDICAID BUPRENORPHINE OFFICE-BASED COMPLEX PROVIDER ISSUES

## BARRIERS TO SUCCESSFUL TREATMENT

**Figure 4. Social determinants of health that impact successful opioid treatment**

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

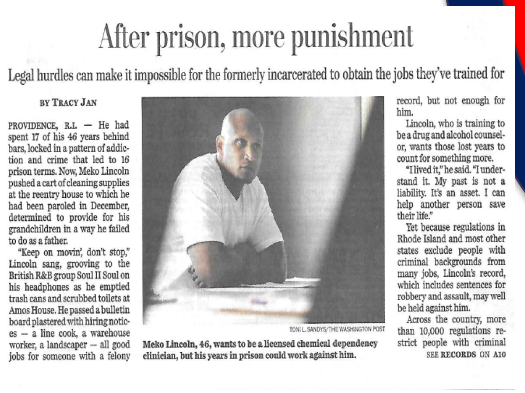










After prison, more punishment

Legal hurdles can make it impossible for the formerly incarcerated to obtain the jobs they've trained for

BY TRACY JAN

PROVIDENCE, R.I. — He had spent 17 of his 46 years behind bars, locked in a pattern of addiction and crime that led to 16 prison terms. Now, Meko Lincoln pushed a cart of cleaning supplies at the reentry house to which he had been paroled in December, determined to provide for his grandchildren in a way he failed to do as a father.

"Keep on movin', don't stop," Lincoln sang, grooving to the British R&B group Soul II Soul on his headphones as he emptied trash cans and scrubbed toilets at Amos House. He passed a bulletin board plastered with hiring notices — a line cook, a warehouse worker, a landscaper — all good jobs for someone with a felony record, but not enough for him.

Lincoln, who is training to be a drug and alcohol counselor, wants those lost years to count for something more.

"I lived it," he said. "I understand it. My past is not a liability. It's an asset. I can help another person save their life."

Yet because regulations in Rhode Island and most other states exclude people with criminal backgrounds from many jobs, Lincoln's record, which includes sentences for robbery and assault, may well be held against him.

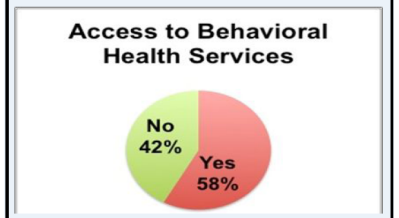
Across the country, more than 10,000 regulations restrict people with criminal

SEE RECORDS ON A10

TON L. SANDYS/THE WASHINGTON POST

**Meko Lincoln, 46, wants to be a licensed chemical dependency clinician, but his years in prison could work against him.**

**Figure 1. Nearly half (42%) of the participants reported a lack of access to behavioral health care services. N=99**




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

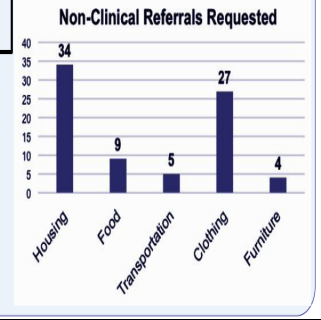
# MEDICARE or MEDICAID BUPRENORPHINE OFFICE-BASED PROVIDER COMPLEX PATIENT TREATMENT SUPPORT NEEDS


**SOCIAL WORKER/CARE COORDINATOR**

## BARRIERS TO SUCCESSFUL TREATMENT

**Figure 4. Social determinants of health that impact successful opioid treatment**

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




"I JUST LOST MY HOUSING… I'AM LIVING IN THE 2nd and D st SHELTER!"

# MEDICARE or MEDICAID BUPRENORPHINE
# OFFICE-BASED PROVIDER
# COMPLEX PATIENT TREATMENT SUPPORT NEEDS

"MY _____ JUST DIED and I CAN'T SLEEP…!"



Black Mental Health Alliance

**REMOTE or IN-OFFICE PSYCHIATRIST and /or PSYCHOLOGIST**


4%
OF U.S.
PSYCHOLOGISTS
ARE BLACK
INEQUALITY IN AMERICA
BLACK AMERICANS FACE MENTAL HEALTH CARE CRISIS
NIGHTLY NEWS


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

**PEER COACH**

**"I RELAPSED LAST MONTH CELEBRATING MY BIRTHDAY WITH OLD FRIENDS!... MY PAROLE OFFICER IS GOING to STEP ME BACK"**


After prison, more punishment

Legal hurdles can make it impossible for the formerly incarcerated to obtain the jobs they've trained for

BY TRACY JAN

PROVIDENCE, R.I. — He had spent 17 of his 46 years behind bars, locked in a pattern of addiction and crime that led to 16 prison terms. Now, Melo Lincoln posted a cart of cleaning supplies at the reentry house to which he had been paroled in December, determined to provide for his grandchildren in a way he failed to do as a father.

"Keep on movin', don't stop," Lincoln sang, grooving to the British R&B group Soul II Soul on his headphones as he emptied trash cans and scrubbed toilets at Amos House. He passed a bulletin board plastered with hiring notices — a line cook, a warehouse worker, a landscaper — all good jobs for someone with a felony record, but not enough for him.

Lincoln, who is training to be a drug and alcohol counselor, wants those lost years to count for something more.

"I lived it," he said. "I understand it. My past is not a liability. It's an asset. I can help another person save their life."

Yet because regulations in Rhode Island and most other states exclude people with criminal backgrounds from many jobs, Lincoln's record, which includes sentences for robbery and assault, may well be held against him.

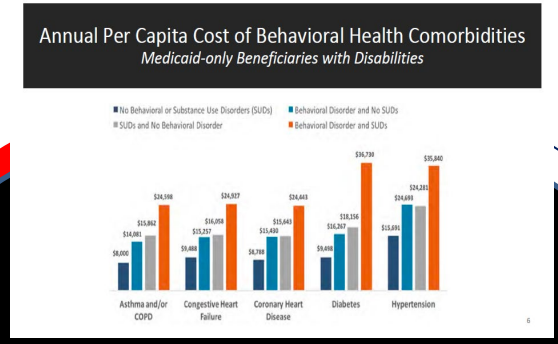
Across the country, more than 10,000 regulations restrict people with criminal

SEE RECORDS ON A10

TON L. SIMONS/THE WASHINGTON POST

**Melo Lincoln, 46, wants to be a licensed chemical dependency clinician, but his years in prison could work against him.**

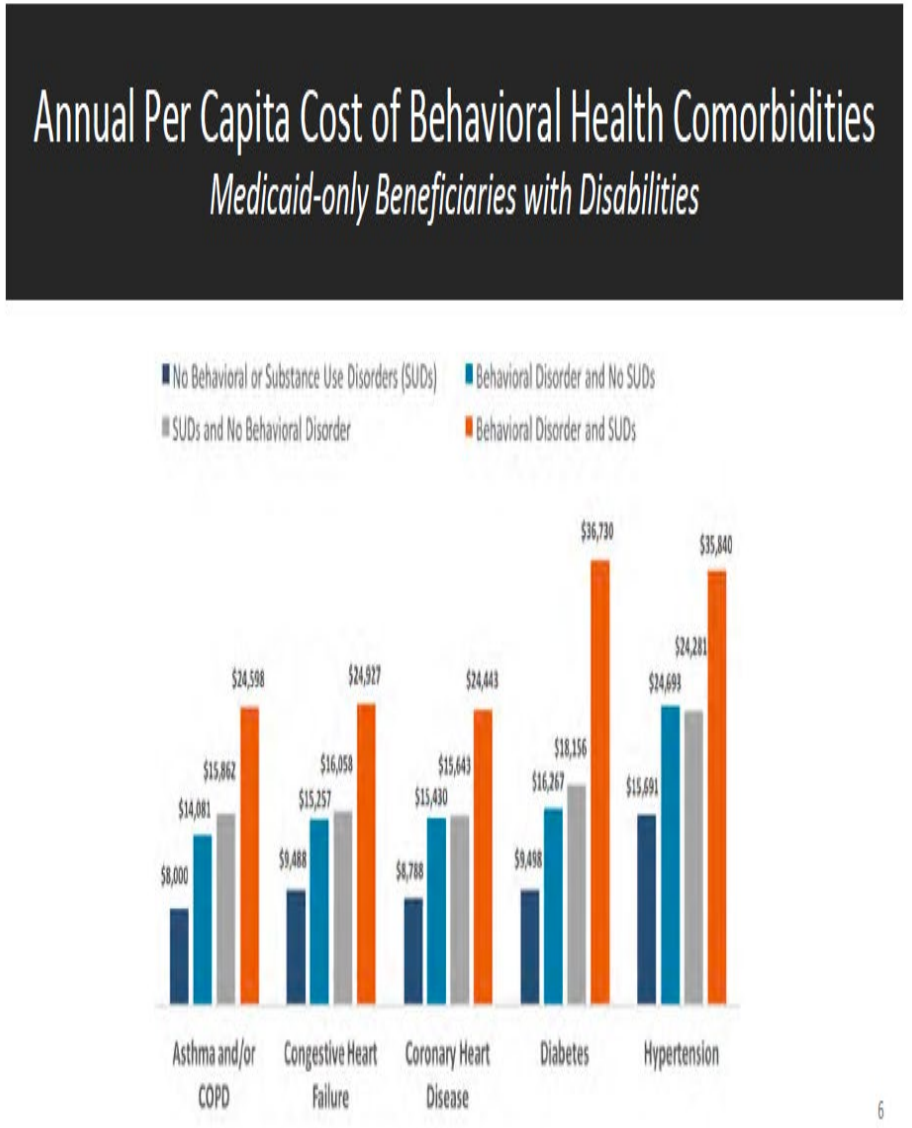
# MEDICARE or MEDICAID BUPRENORPHINE OFFICE-BASED PROVIDER COMPLEX PATIENT TREATMENT SUPPORT NEEDS



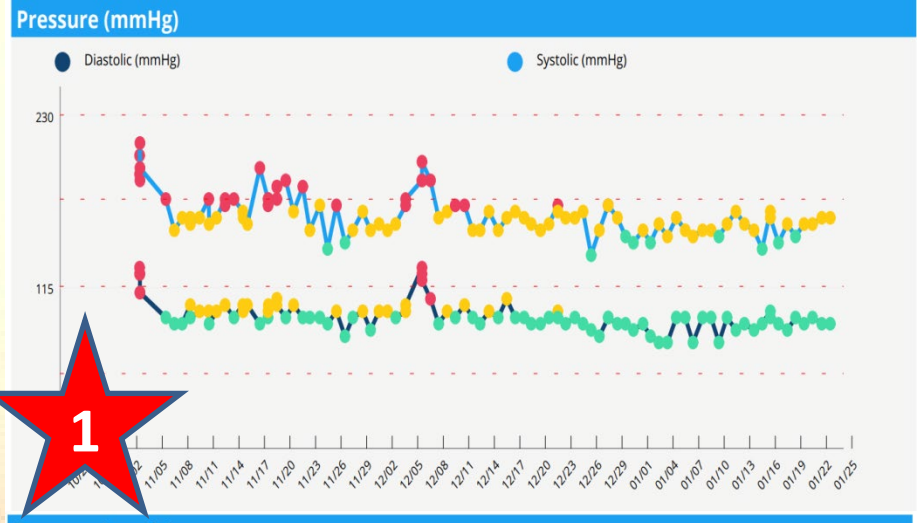

"I RAN OUT of MY BLOOD PRESSURE MEDICATION and CAN'T FIND MY NEW PRIMARY CARE PROVIDER"!

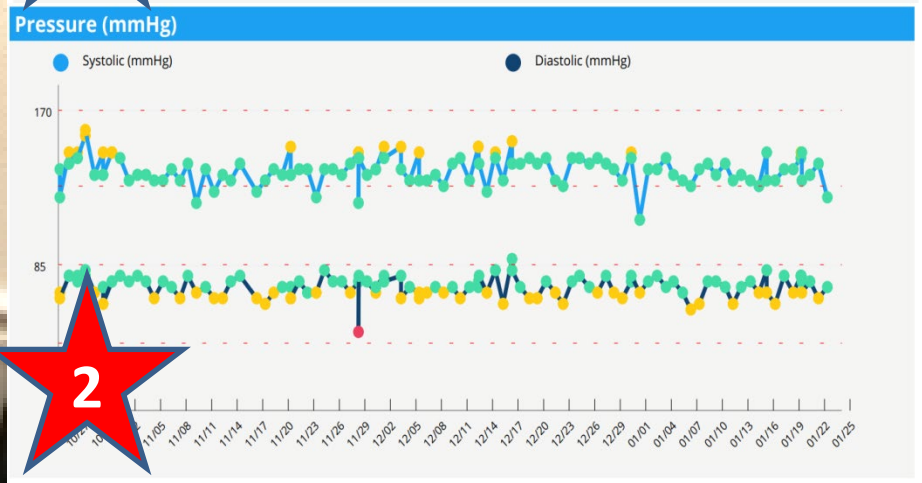
**REMOTE or In-OFFICE PRIMARY CARE PROVIDER**

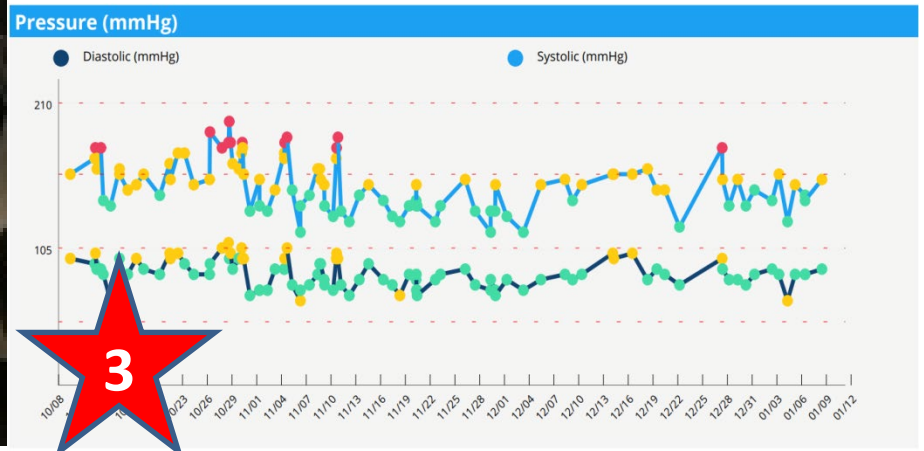
# HOME TRACKING CHRONIC DISEASE MONITORING
# In HIGH RISK, COMPLEX POPULATIONS

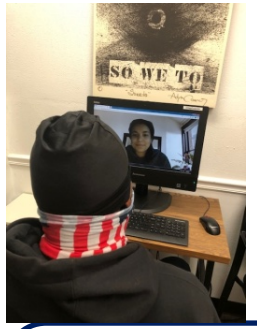
# EXAMPLE: HOME MONITORED BLOOD PRESSURE TRACKING

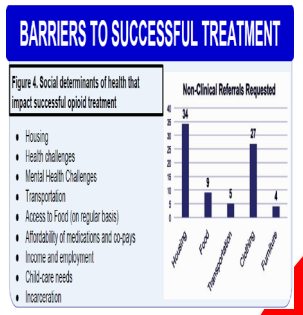



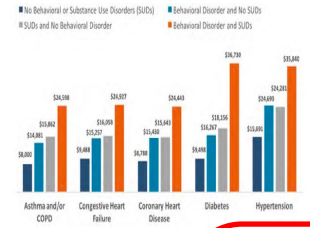



# MEDICARE or MEDICAID BUPRENORPHINE OFFICE-BASED PROVIDER COMPLEX PATIENT TREATMENT SUPPORT NEEDS






**SOCIAL WORKER/CARE COORDINATOR**

Social Determinants of Health

Complex Medical Issues

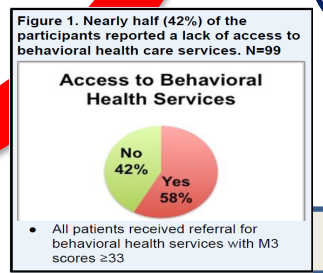
**REMOTE or In-OFFICE PRIMARY CARE PROVIDER**

**PEER COACH**

Criminal Justice Issues

Mental Health Issues

**REMOTE or IN-OFFICE PSYCHIATRIST and /or PSYCHOLOGIST**

Foundation *for*
Opioid Response Efforts

forefdn.org

**Webinar:** Integrating MOUD into Primary Care: Medicaid Strategies for Improving Treatment Engagement and Outcomes and Reducing Disparities (4/28/2021)

**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**



February 2016

Edwin C. Chapman, Sr., MD, DABIM, FASAM
301 538-1362
echap1647@aol.com

# Behavioral Health Integration in Primary Care

Sreela Namboodiri MD ABOIM

Heartland Health Centers


HEARTLAND
HEALTH CENTERS
HEALTHCARE FROM THE HEART
HEARTLAND ALTH CENTERS
1300

# 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

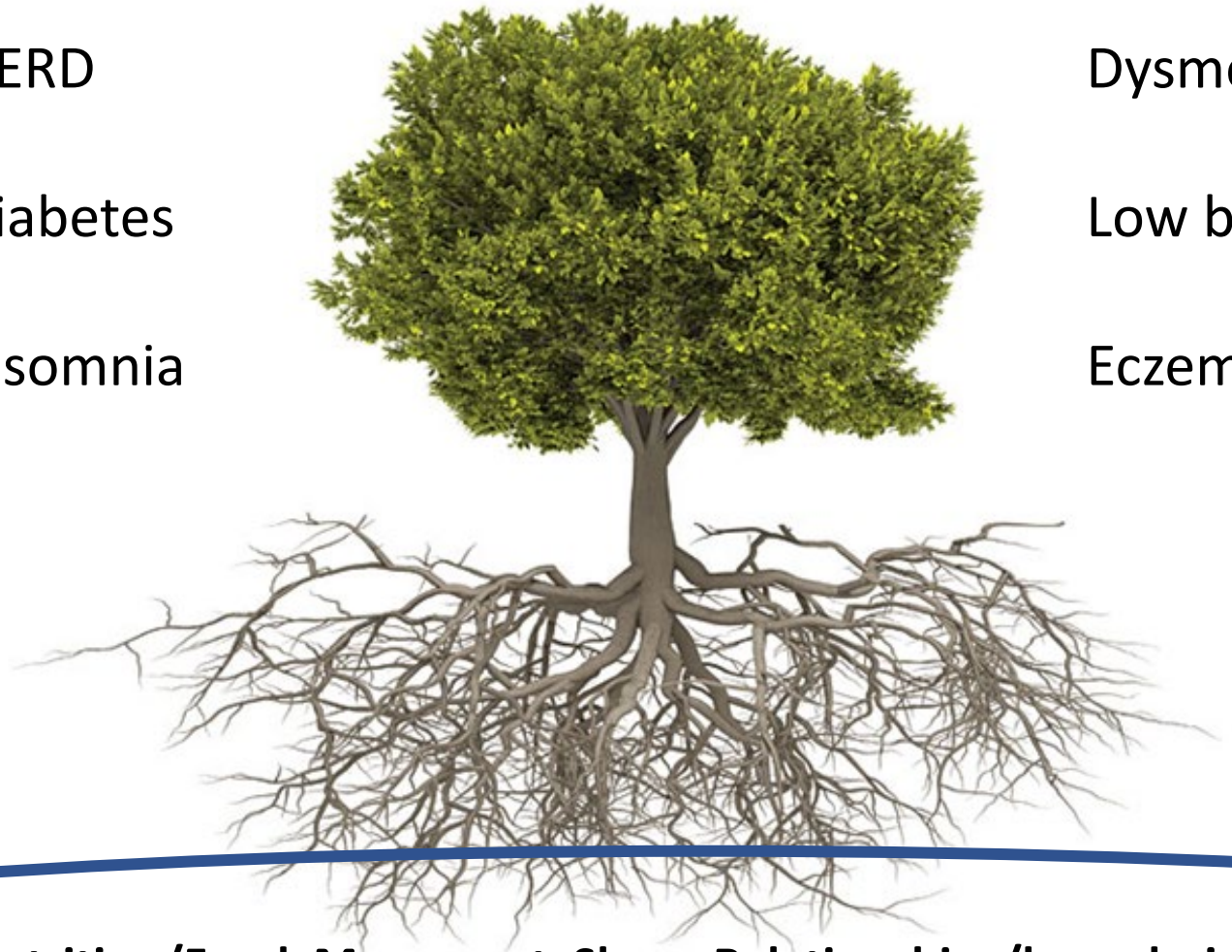
- **Integrated care:** Care that involves close collaboration among primary care and behavioral health clinicians, working together with patients and families to provide patient-centered care.

  *Adapted from 2013, Peek & National Integration Academy Council

# Integrative Medicine

Anxiety
Asthma
Hypertension

GERD
Diabetes
Insomnia



Dysmenorrhea
Low back pain
Eczema

Constipation
Migraine
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 | Neighborhood and Physical Environment | Education | Food | Community and Social Context | Health Care System |
|---|---|---|---|---|---|
| Employment | Housing | Literacy | Hunger | Social integration | Health coverage |
| Income | Transportation | Language | Access to healthy options | Support systems | Provider availability |
| Expenses | Safety | Early childhood education | | Community engagement | Provider linguistic and cultural competency |
| Debt | Parks | Vocational training | | Discrimination | Quality of care |
| Medical bills | Playgrounds | Higher education | | Stress | |
| Support | Walkability | | | | |
| | Zip code / geography | | | | |

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

https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

# 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?

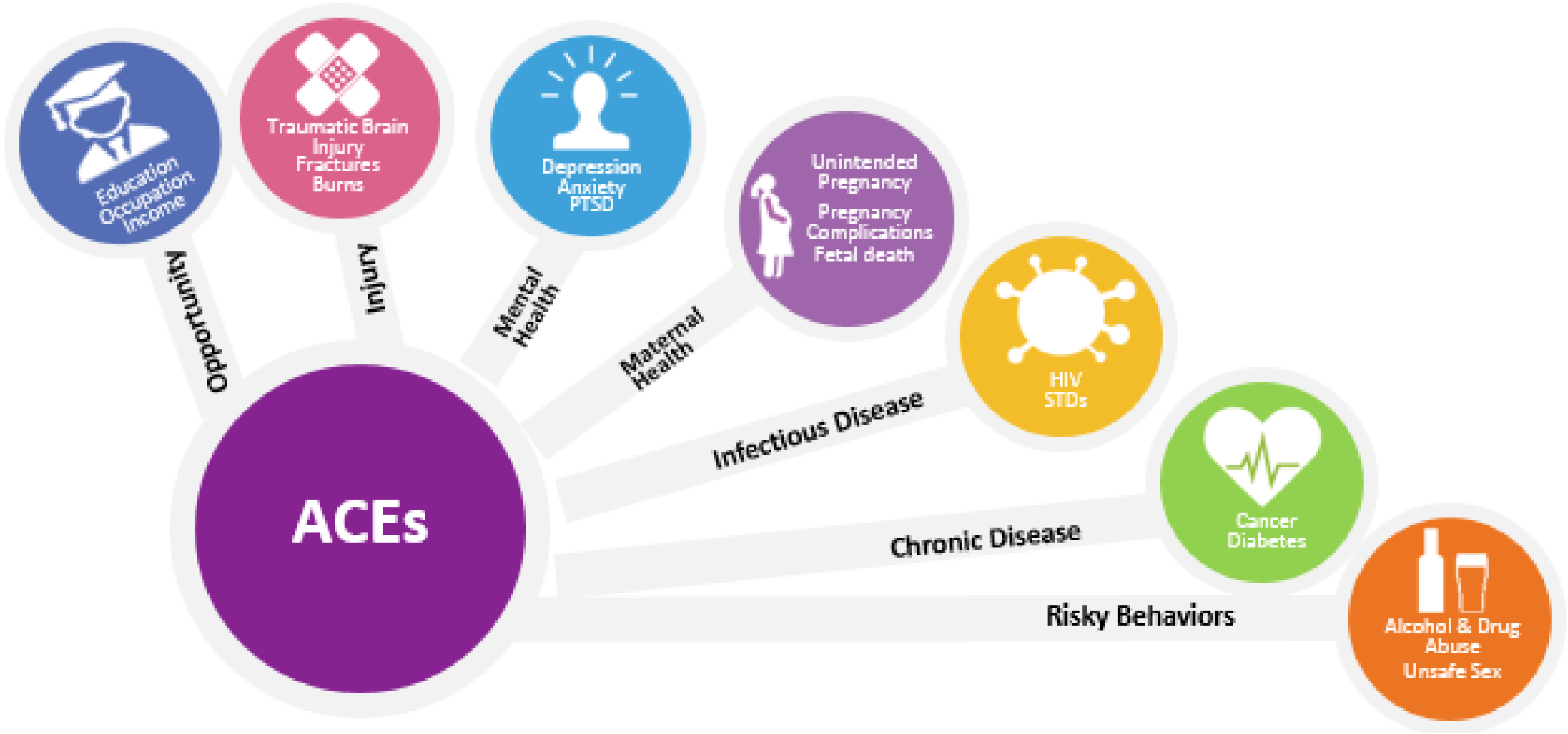
- External environment
  - Impacts access
  - Impacts resources
  - Exposure risk (toxins, violence)
- Internal environment
  - Health Behaviors
  - Increased stress -> Allostatic load


McKinney, R. and Geller, J. (2018). Integrative Medicine for the Underserved. In D. Rakel (Ed.), *Integrative Medicine* (p 1088-1095). Location: Elsevier.

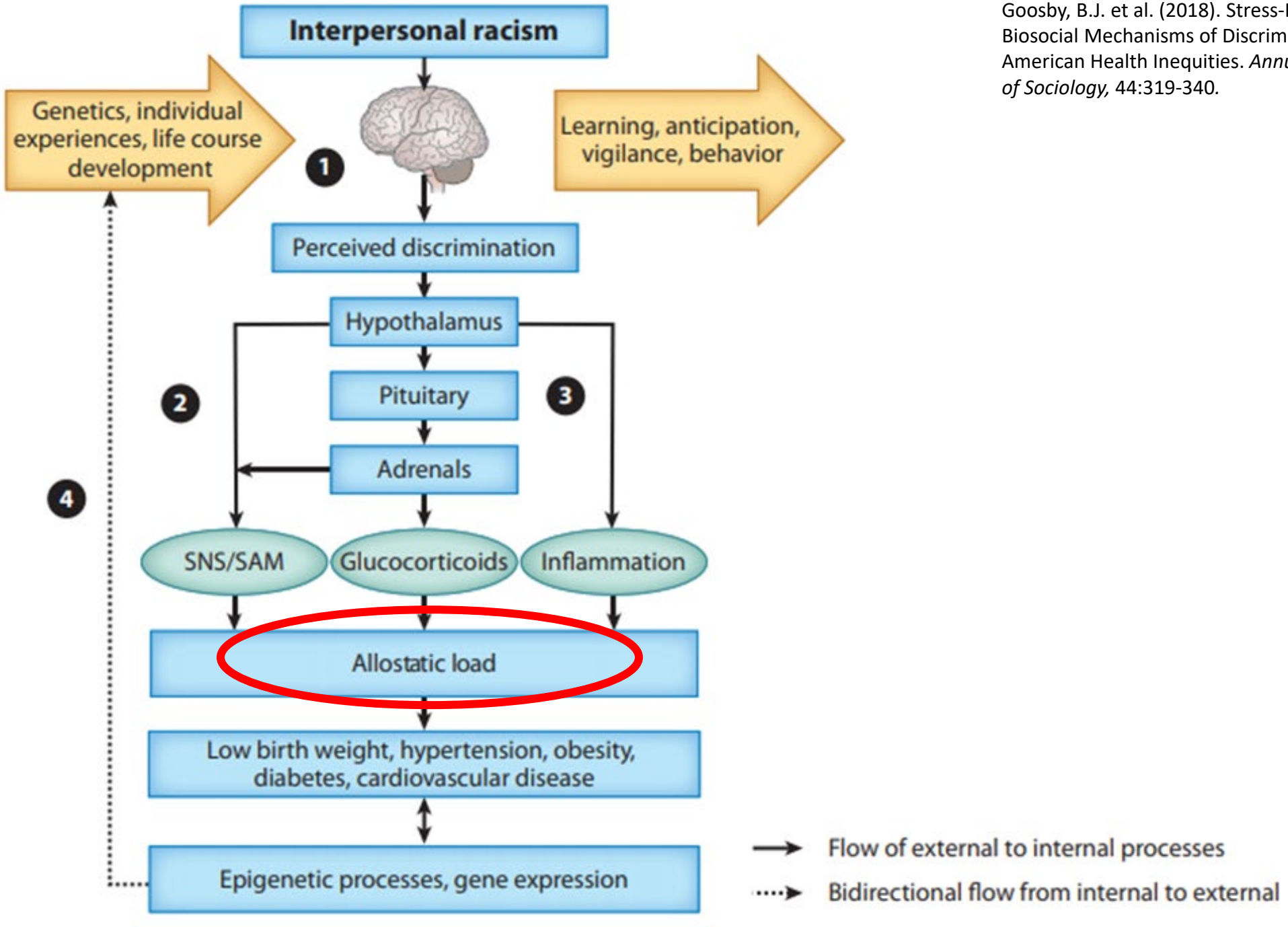
# Stress and Trauma

# 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.




https://www.aaip.org/programs/aces-toolkit/




Goosby, B.J. et al. (2018). Stress-Related Biosocial Mechanisms of Discrimination and African American Health Inequities. *Annual Reviews of Sociology,* 44:319-340.

# 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 October 27th - December 15th

**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 25 - December 18 ~ drop in

**ENERGÍA POSITIVA (SP)**
Un grupo para manejar mejor el estrés y utilisar practicas de meditación, respiración, y fortalecer energía positiva.
Mondays 6:30-7:30 pm ~ September 21- 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)

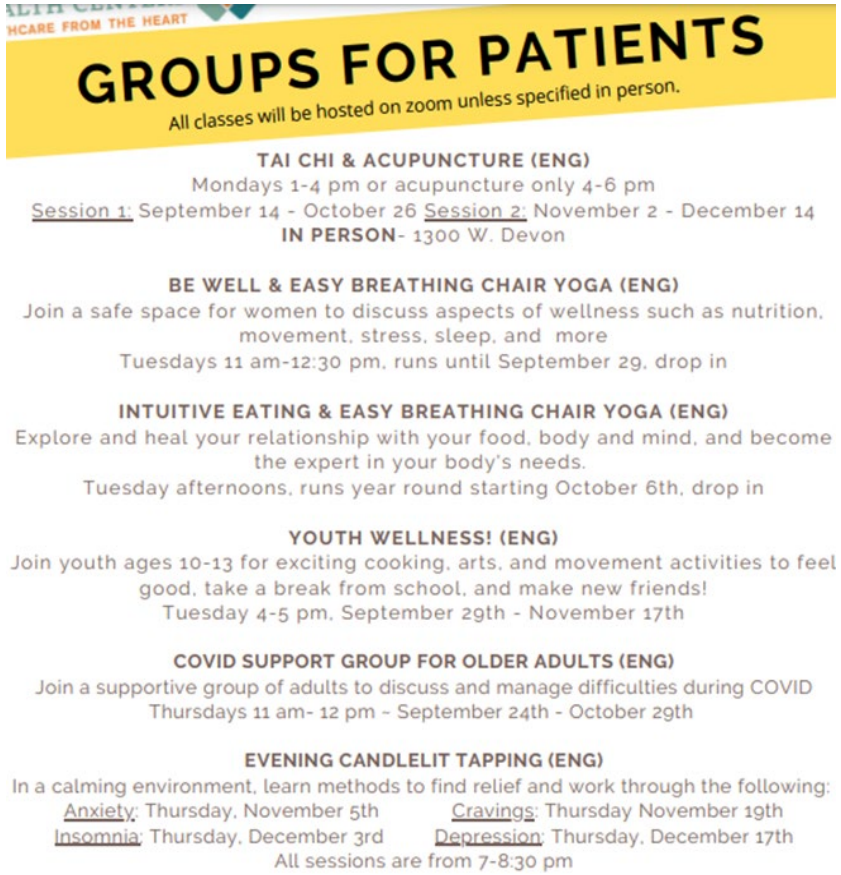
## GROUPS FOR EVERYONE

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

**YOGA SUAVE (SP)**
Martes 6-7 pm ~ Corre todo el ano
https://us02web.zoom.us/j/86267148140

**ZUMBA (eng/sp)**
Saturdays 10-11 am ~ Runs year round
Zoom link: https://zoom.us/j/96920241457

**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.)



HCARE FROM THE HEART

## GROUPS FOR PATIENTS

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

**TAI CHI & ACUPUNCTURE (ENG)**
Mondays 1-4 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

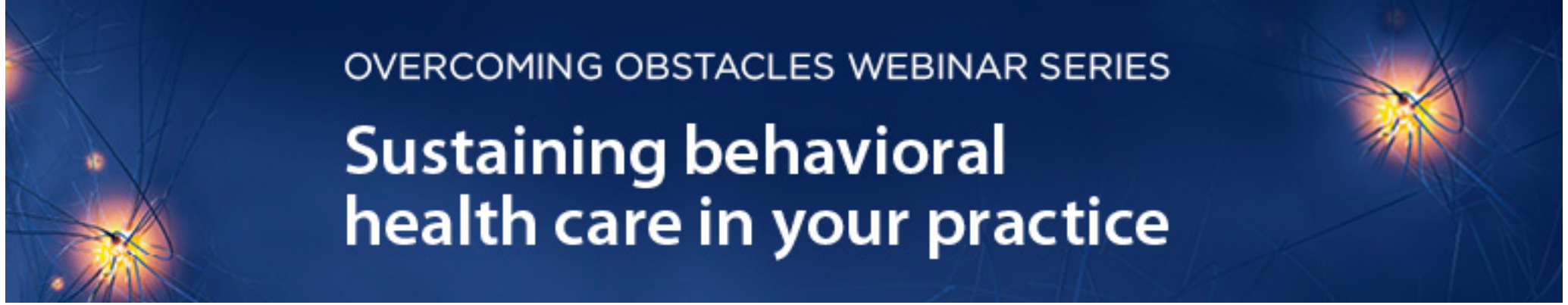
**EVENING CANDLELIT TAPPING (ENG)**
In a calming environment, learn methods to find relief and work through the following:
Anxiety: Thursday, November 5th Cravings: Thursday November 19th
Insomnia: Thursday, December 3rd Depression: Thursday, December 17th
All sessions are from 7-8:30 pm

# 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.*

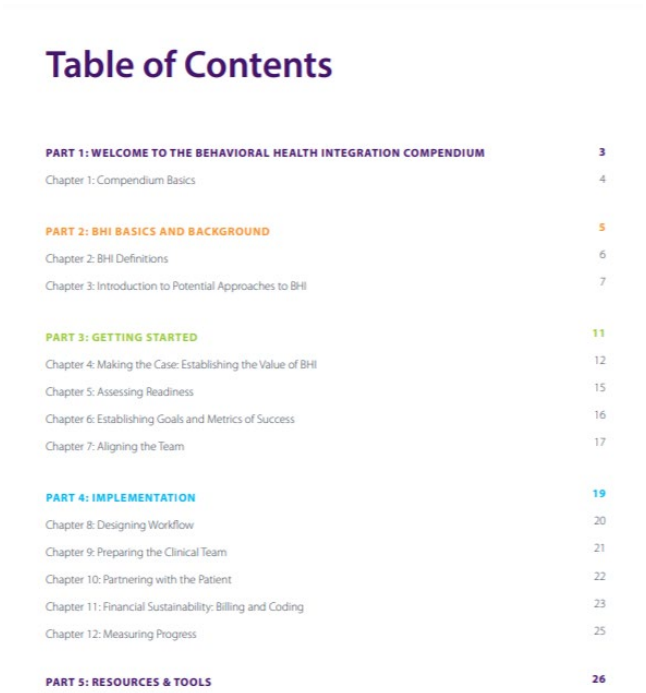
# BHI Collaborative *"On Demand"* Webinars

- 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.*

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**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

# References


- Chao, M.T. and Adler, S.R. (2018). Integrative Medicine and the Imperative for Health Justice. *The Journal of Alternative and Complementary Medicine*, 24(2),1-3.
- Geller, J.S. et al. (2015). Pediatric Obesity Empowerment Model Group Medical Visits (POEM-GMV) as Treatment for Pediatric Obesity in an Underserved Community. *Childhood Obesity*, 11(5):638-646.
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- Peek, C.J. and the National Integration Academy Council. (2013). Lexicon for Behavioral Health and Primary Care Integration: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality.

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/

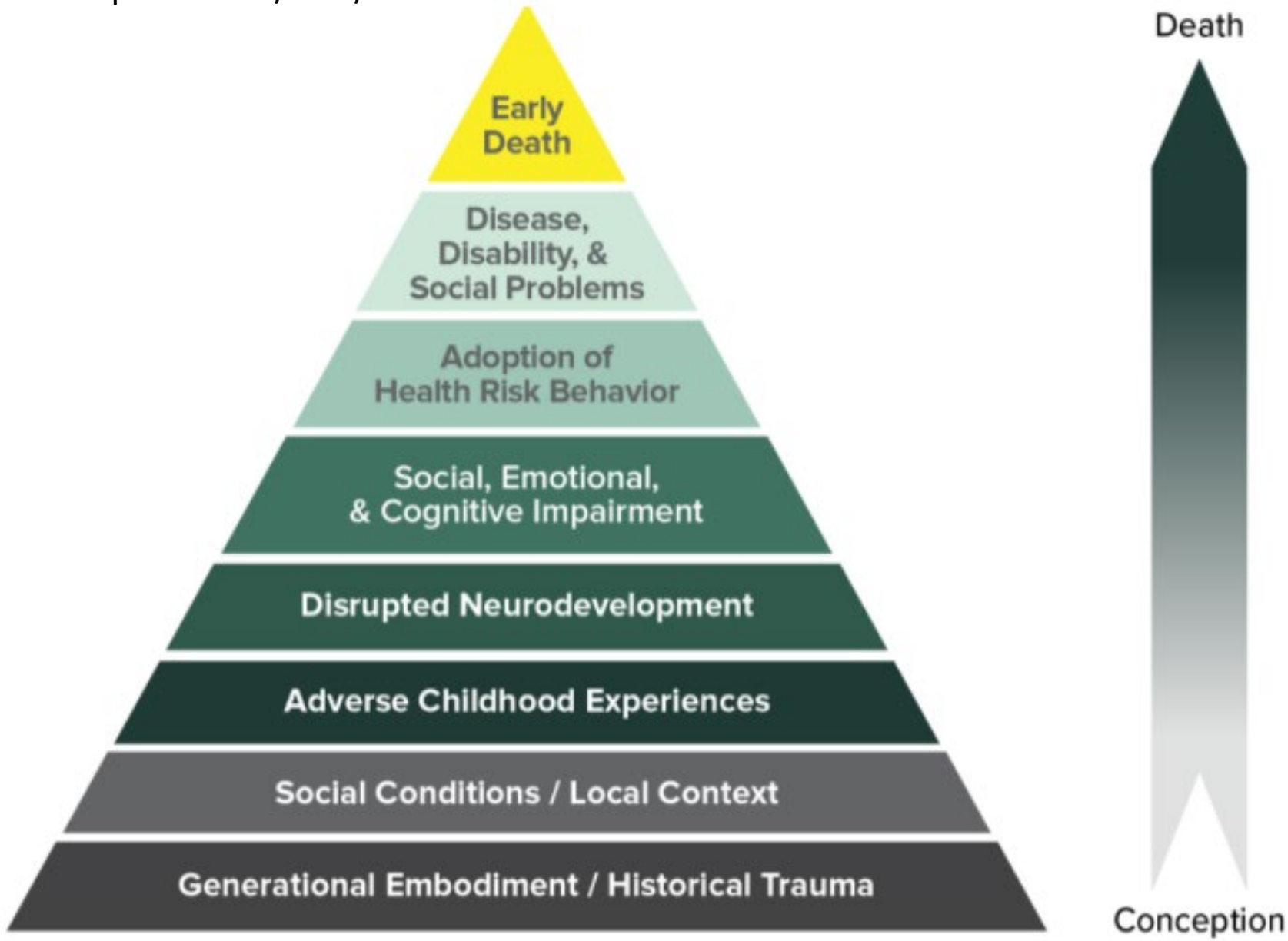
- Integrative Medicine for the Underserved:

https://im4us.org/

# Book Recommendations

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

https://www.cdc.gov/violenceprevention/aces/about.html




Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

"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/