BENEFITS AND IMPACTS OF SUD INTEGRATION WITH PRIMARY AND ACUTE MEDICAL CARE

Les Sperling
Central Kansas Foundation
Salina, Kansas

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CKF is a not-for-profit corporation whose mission, since its inception in 1967, has been to provide both quality and affordable alcohol and other drug education and treatment services.

- Community Based
- 65 employees
- 5 locations
- Services include: All levels of Outpatient Therapy, Detox, Medication Assisted Withdrawal, Residential Treatment, and Prevention/Education Programs

Our Three Guiding Principles For Integration

1) SUD providers possess expertise that is incredibly valuable to medical professionals.
2) When this expertise is available in acute and primary medical care settings, patient health improves and costs associated with chronic illness are reduced.
3) SUD services have a significant impact on health care costs and SUD work **will** be compensated adequately.

CKF "OLD" STRATEGY

1) Become integral part of Health Home
2) Implement SBIRT in Primary and Acute Care Settings
3) Reduce recidivism to High Cost Care Settings
4) Demonstrate impact of SUD on general health
5) Increase capacity for SUD patients to access primary health and oral health care
6) Full integration of SUD services into Primary and Acute Care Settings

CKF NEW STRATEGY

Salina Regional Health Center

- 300 Bed Acute Care Regional Health Center-Level III Trauma Center
- 27,000 ED presentations per year
- Alcohol/Drug DRG was 2nd most frequent re-admission

- **Services provided**
  - ✓ 24-7 coverage of ED
  - ✓ Full time SUD staff on medical and surgical floors
  - ✓ Warm hand off provided to all SUD/MH services
  - ✓ Universal Screening and SBI

Outcomes

- Re-admission DRG moved from 2nd to off the list
- 70% of alcohol/drug withdrawal LOS were 3 days or less
- 83% of SUD patients triaged in ED were not admitted
- 58% of patients recommended for further intervention attended first two appointments (warm hand off)
- Adverse patient and staff incidents decreased by 60%
- CKF detox admissions increased 450% in first year
- 300% increase in commercial insurance reimbursement

Salina Family Healthcare/Smoky Hill Residency Program

- 10,000 unique patients, 13 Family Medicine Residents, 10 dental chairs
- Universal Screening of every patient annually
- ASAM Level I and II provided on-site
- 2 FTE Licensed Addiction Counselors located at FQHC.

Outcomes

- 23% screening positive on Audit-C
- Average daily census in treatment groups is 12.5
- Residents and other practitioners becoming interested in SUD interventions
- Level III Person Centered Medical Home accreditation received
- SUD staff a key component of Medical Home

Personnel

- Licensed Addiction Counselors
- Licensed Clinical Marriage and Family Therapists
- Licensed Specialist Clinical Social Worker
- Person Centered Case Managers
- Recovery Coaches and Peer Mentors (Recovery Health Coaches)

Essential Staff Attributes

- Trained in motivational interviewing and brief intervention. (Stages of change, FRAMES)
- Able to thrive in fast paced medical settings
- Understand medical cultures and can adapt

Integration Timeline

2009

- Initial discussions with FQHC leadership related to collaboration, SBIRT, and co-location

2010

- Formal review of patient data, reimbursement analysis, work flow mapping, staffing patterns, and other high level barriers

2011

- Collaboration agreement executed, staff hired, trained in MI, Brief Intervention and SBIRT.
- Co-location and universal screening begins.
- Planning for on-site Level I and II outpatient services begins.
- SUD staff participates in clinical staffings and patient treatment planning.
- Executed contract with acute care hospital to provide 24/7 coverage of ED and full-time staff on medical/surgical floors.

Integration Timeline

2012

- On-site Level I-II outpatient services at FQHC
- SBIRT screening data reviewed and work flows adjusted
- Brief Intervention training provided to faculty and residents
- Strategic discussions related to program expansion and establishment of clinic at SUD locations
- FQHC awarded grant to expand behavioral health services at the FQHC
- SBIRT codes approved in state Medicaid Plan

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Integration Timeline

2013

- FQHC receives Person Centered Medical Home accreditation at highest level
- Clinic planning continues
- Integration of patient health information and medical records begins
- Active recruitment by Regional Health Center and FQHC of an Addictionologist begins

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Integration Timeline

2014

- 24/7 staffing of the Emergency Department
- Additional 700 acute care beds acquired
- SBIRT in two school districts
- Management of ten bed acute detox in hospital

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Think Big, Act Small!

"The delivery of medical care is a very personal, relationship-driven, trust-based, *local* phenomenon. The intimate relationship between a caregiver and a patient occurs in small places like examination rooms, procedure rooms, operating rooms, hospital rooms, and in other similar settings. When "bigness" trumps rather than supports "smallness" – whether in the name of efficiency, economy, policy, branding, reimbursement or even compliance – that most important and intimate relationship is violated, damaging both clinical care and caring."

Halley, Marc D. 2012. "Think Big. Act Small." *Healthcare Financial Management* September: 50-54.

What do you need in the Integration Development Toolbox?

- Effective and persistent advocacy
- Corporate sense of urgency
- Look for new meetings
- Understand internal and external constraints
- Know DRG's, CPT's, and Dx. codes
- Data, Data, Data
- Always carry a good crisp apple
- Do what you do in 8 minutes or less…
- Relationships, Relationships, Relationships
- Find a champion
- Seek out residency programs/teaching locations
- Understand Health Homes and PMPM

Challenges

- Volume to Value
- Will ACO $$ be sufficient to fund SUD
- Quality workforce
- Small window of opportunity to make the transition
- Nurture Entrepreneurial Staff
- Take calculated risks
- Integration of emerging technology

CKF Lessons Learned

1) Research and understand the external and internal constraints experienced by safety net clinics and acute care hospitals.
2) Understand reimbursement and funding challenges for clinics and hospitals.
3) Develop a champion within the clinic staff. Ultimately has to be MD or CEO, but tell your story to nurses and mid-level practitioners.
4) Request data and use it.

CKF Lessons Learned

5) Be prepared to do the administrative work and be the "go to" person for all problem solving.
6) Be persistent, but lean instead of push. Double the time you think it will take to operationalize.
7) Don't waste medical staff's time. Be prepared for meetings. Keep e-mail and other communications focused and brief. Always respond to their requests immediately.
8) Focus on addiction as chronic illness.

CKF Lessons Learned

9) Prepare and use cost-benefit data.
10) Have a good plan to increase income over the long term with specific billing codes, grants, etc. to shoot for.
11) Increase your capacity to effectively treat and manage co-occurring and chronic illness.
12) Build mental health services capacity via contract or staff.

Contact Information

Les Sperling

Central Kansas Foundation

1805 S. Ohio

Salina, KS 67401

785-825-6224

620-242-7923 cell

lsperling@c-k-f.org