

# Integrating Behavioral and Physical Healthcare Systems in the Care of Tobacco Dependence

Report of the Southeastern  
Pennsylvania Regional Behavioral  
Health Tobacco Summit

University of Pennsylvania

June 21, 2019

## I. Executive Summary

Senior decision-makers representing a variety of stakeholder organizations within both the behavioral (BH) and physical health (PH) spheres met to brainstorm potential means of improving inter-system integration in pursuit of more effective tobacco dependence treatment. Policies and operational procedures were examined to improve the reach of tobacco dependence treatment within the respective service areas, and extend the penetration of treatment resources into the lives of BH clients. The purpose of the meeting was to outline the easily accomplished means of integration, and to assess their feasibility on a larger, state-wide scale.

Representation included:

- The PA Department of Health and the Philadelphia Department of Public Health,
- The PA Department of Human Services (OMHSAS),
- Single County Authorities serving the Southeast region of PA,
- Provider and patient advocacy organizations that operate across county lines, and
- Behavioral and Physical Health Managed Care Organizations serving Medical Assistance clients.

Insights into the strengths of the current system, the perceived opportunities for development, and the functional obstacles to progress were consolidated thematically. Several strategic and tactical recommendations are offered to guide efforts toward a future coordinated approach to tobacco.

## II. Problem Statement

Smoking is a major contributor to premature mortality among people with mental illness and substance abuse. Historically, Pennsylvania's Mental Health and Substance Abuse Service organizations have not included treatment of tobacco dependence within their missions. Recent developments in our understanding of the functional overlap between these disorders have reversed this trend, with an increasing number of national administrative and regulatory organizations seeking to facilitate change.

We know that the treatment of Tobacco Dependence among BH clients is both effective and cost-effective; adding significant healthcare value by:

1. reducing life-years lost due to tobacco related disease (1),
2. improving mood disorders, stress and quality of life – at least as effectively as antidepressant and antipsychotic therapy (2),
3. reducing severity of negative symptoms of schizophrenia (3,4),
4. improving probability of sustained sobriety following Substance Abuse (SA) treatment (5),
5. increasing likelihood of SA treatment completion (6),
6. improving BH clients' employability and financial stability (7), and
7. increasing client satisfaction with services. (8)

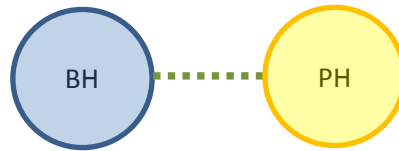
*Most importantly, treating BH clients' tobacco dependence does not worsen BH outcomes. (9–11)*

On the other hand, we also know that services, when available, are typically brief, localized to primary care or public health settings, and serve mainly the highly motivated smoker. There is evidence BH clients experience barriers in accessing health care due to disorganized lifestyles and difficulty communicating needs - making it likely that they face similar barriers when trying to access PH system based tobacco treatments.

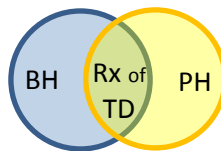
In addition, BH clients have an increased difficulty quitting tobacco, which often warrants a specialized treatment approach, including multiple medications, intensive counseling / coaching, and prolonged treatment duration.(12) For this reason, systematic policies and procedures designed to meet the needs of the general population frequently fall short when applied to the BH client.(13)

**The goal of the 2019 summit was to mobilize SEPA regional policymakers and stakeholders, exploring available avenues for developing collaborative, more tightly integrated tobacco treatment policies, consistent with the complex needs of the BH client community.**

A. **The Premise:** *BH and PH systems are loosely affiliated, with “dotted line” inter-system integration that requires significant client input to navigate.*



B. **The Promise:** *Tobacco Dependence (TD) is a chronic illness that fundamentally affects both BH and PH. Effective treatment for this complex biopsychosocial disorder crosses traditional interdisciplinary boundaries and requires coordinated resources.*



### III. Meeting Description

The meeting was held on June 21st, 2019 in the Jordan Medical Education Center of the Perelman School of Medicine, University of Pennsylvania (3400 Civic Center Blvd, Philadelphia).

The attendees and organizations they represent are listed in **Table 1** below.

Discussion was facilitated by Frank Leone with the following goals in mind:

- *Introduce the region’s decision-makers and key partners to each other; identify areas of existing expertise as well as important stakeholders not yet brought to the discussion.*
- *Create a neutral forum for continued conversation; cut across geographic and institutional boundaries.*
- *Explore the elements of a “shared vision” for integrating the BH and PH systems, maximizing our effectiveness in reducing the burden of the tobacco epidemic among BH clients.*

<b>Attendee</b>	<b>Organization</b>
Leslie Zachariah	Aetna Better Health
Patrice Faust	Aetna Better Health
Monica Gaffin	Bucks County Behavioral Health
Carol Larach	Community Behavioral Health
Chris Tjoa	Community Behavioral Health
Mark Modugno	Division of Tobacco Prevention & Control - PA DOH
Elizabeth Shime	Health Partners Plans
Jamie McGee	Health Promotion Council
Katie O'Connor-Jenkins	Health Promotion Council
Sean McCormick	Health Promotion Council
Jessica Locusen	Lower Merion Counseling and Mobile Services
Andrew O'Brien	Magellan Behavioral Health
Lauren Keane	Magellan Behavioral Health
Deb Hodges-Hull	Office of Mental Health and Substance Abuse Services – PA DHS
Jarma Frisby	Tobacco Policy and Control - Philadelphia Dept of Public Health
Shandra Banutu-Gomez	U Penn - Comprehensive Smoking Treatment Program
Tierney Fisher	U Penn - Comprehensive Smoking Treatment Program
Frank Leone	U Penn – Comprehensive Smoking Treatment Program
Sarah Evers-Casey	U Penn – Comprehensive Smoking Treatment Program

**Table 1** – Regional Tobacco Summit attendees representing state and local government agencies, single county authorities, provider organizations, patient advocacy groups, BH/PH managed care organizations, and academics.

#### IV. Insights

Participants were presented with three discussion questions regarding their views on the current and future state of BH/PH tobacco treatment integration. In formulating their responses, attendees were encouraged to shed feasibility or funding constraints at this stage. Attention was paid to ensure that a variety of stakeholder perspectives were represented for each discussion point.

Q1: "What do we imagine constitutes the 'perfectly integrated' system for managing tobacco dependence within the communities we serve?"

With this question, participants were challenged to articulate what they believed would constitute the core components of future systems that would optimize the BH impact on tobacco dependence. Attendees were encouraged to consider human resource needs, systematic requirements, and cultural context, among others. The group identified the following **opportunities for integration**:

- *To maximize ease of access, and minimize administrative barriers to effective pharmacotherapy, SEPA Regional providers will be required to participate in a unified formulary, scheduled to go into effect in 2020.*
- *The unified formulary – or preferred drug list (PDL) - will be accompanied by a common "administrative policy" to improve consistency in access to pharmacotherapies between MCOs.*
- *Provider Organizations will need to develop formalized lines of communication to prescribing clinicians in order to maximize the potential benefit of the unified formulary.*
- *Collaborative arrangements already exist between some BH/PH MCOs. The terms of the relationships are contained within "Program Standards and Requirements (PSR)." The potential for developing more formal tobacco collaboration within PSR is a matter of programmatic development within MCOs.*
- *Reimbursement for pharmacotherapy costs incurred by inpatient providers may be either bundled or unbundled within the global fee – creating uneven constraints across the BH system. The Office of Medical Assistance Programs (OMAP) is currently working with the Office of Mental Health and Substance Abuse Services (OMHSAS) to re-evaluate these policies and consider bundling tobacco pharmacotherapy costs within the fee reimbursement structure.*



*Improved care coordination for patients requiring both physical and mental health services is a major step forward in Population Health Management, and could save the U.S. healthcare system \$26 billion annually - while improving quality, outcomes, and patient lifestyle.*

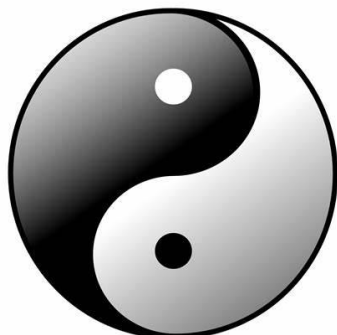
<https://www.bdcadvisors.com/integrating-physical-and-behavioral-health/>



Q2: “Based on your view of the perfectly integrated system, what do you see as the resources already operational in SEPA that might facilitate our goal?”

Here, participants were challenged to connect their understanding of the evolutionary pressures at play within the current healthcare systems to their forward-reaching views on tobacco-related integration efforts within the SEPA region. The group was asked to imagine how we might incorporate at-hand resources to achieve integration goals. The following **Systems and Resources** are already operational:

- *There are a growing number of educational resources currently being employed by MCOs to guide provider behavior toward pre-defined quality targets. A number of stakeholder organizations described well-developed educational vehicles, including email listserv, webpages, and interval mailings.*
- *Several stakeholders demonstrated familiarity with commercially available smartphone apps that could potentially be re-purposed to achieve integration goals; e.g. access to clinical pathways, registry workflows, preferred drug lists, etc.*
- *The regional health plan medical directors already engage in regular meetings to discuss shared goals and obstacles. Access to the meeting agenda, perhaps including formation of a workgroup, could provide a vehicle for accelerating formal integration objectives and policies for achieving the goal.*
- *Regional MCOs participate in a routine Southeast Regional BH/PH meeting, within which shared challenges are discussed, as well as potential strategies for addressing them. While the medical director meeting (above) would be important for gaining organizational buy-in, this venue would be of critical importance in understanding and addressing implementation challenges.*
- *The Commonwealth continues to engage in state-wide efforts to shift the prioritization of tobacco dependence within both the BH and PH contexts. The southeastern region is currently heavily involved in this effort.*
- *High-quality training is available to ensure provider organization technical assistance during the integration process.*
- *Clients have access to free, high-quality quitline services through the PA DOH. Services can be integrated directly into treatment pathways using the Ask, Advise, Connect framework.*
- *PA is home to a large network of engaged and motivated clients and families. Advocacy efforts aimed at quality improvement are commonplace.*



***System-level integration of services and fiscal accountability underpins truly person-centered, holistic care and represents the most advanced model on the integration continuum. A fully integrated system for Medicaid beneficiaries is one that directly provides and is at financial risk for the entire complement of acute physical and behavioral health services covered by Medicaid.***

Q3: “What are the most important resources or connections we will need to build/find in order to reach our integration goals?”

Maximizing the region’s potential for success requires a better understanding of the structural connections important to implementing change. In the third phase of discussion, participants were challenged to think through the critical variables that will be required to guide implementation, measure progress, and change systems. The group identified the following **Potential Needs**:

- *Though substantial work has gone into creating educational tools, the impact on the audience is difficult to quantify. Future success will depend on developing methods for estimating both the reach, and the penetration, of educational interventions.*
- *Tobacco has not traditionally been within the Drug and Alcohol Treatment community’s purview. Significant resistance to engaging tobacco dependence stems primarily from cultural norms within the field. To achieve D&A buy-in, we will need a more robust understanding of methods for changing cultural norms, and redefining normative behavior.*
- *Private plan administrators also have an interest in standardizing procedures and facilitating integration. Regional change will require participation of private plans in addition to Medical Assistance plan MCOs.*
- *We have paid insufficient attention to resources within the Department of Insurance. Understanding the regulatory environment within would be an important prerequisite, and might offer additional means of influencing system evolution.*
- *Large regional employers, particularly self-insured employers, represent a potential source of evolutionary pressure, finding cost savings and improved subscriber satisfaction if system integration is more complete / seamless.*
- *Efforts that proceed without careful attention to provider input will likely fail.*
- *A state-wide mandate is required to focus attention on this important, but complicated, integration goal. The SE Region continues to support Harrisburg’s effort at reform.*



*A majority of Medicaid’s highest-need, highest-cost beneficiaries have multiple physical conditions, co-occurring mental illness, and/or substance use disorder. Most of these individuals, however, are in fragmented systems of care with little to no coordination across providers — often resulting in poor quality and high costs. Better care coordination for this population has the potential to improve health outcomes and control spending, as well as reduce homelessness and criminal justice system encounters.*

<https://www.chcs.org/topics/physical-behavioral-health-integration/>

## V. Action Items

1. Key evidence-based pharmacologic treatments, including varenicline and bupropion are currently slated to appear on the PDL, as are non-branded, over-the-counter nicotine products, including the patch, gum and lozenge. At this point, prescription nicotine nasal spray and inhaler are NOT included on the draft PDL. Given the severity of dependence in the BH population and the complexity of adherence, it will be important for providers to have access to all forms of nicotine replacement. Summit participants and their constituents can provide feedback on the development of the Universal Formulary (PDL): public input can be provided via email to [c-bstarr@pa.gov](mailto:c-bstarr@pa.gov).
2. Participants agreed to assist the PDL selection process by ensuring their respective organization's pharmacy representatives are made aware of the priority of tobacco dependence, and carry the message to Harrisburg decision makers.
3. MCO participants in the Southeast Regional BH/PH meeting have begun producing a 1-page information sheet in an effort to unify client messaging about tobacco dependence treatment. Summit participants agreed to disseminate this material with key stakeholder leadership upon completion.
4. Summit participants agreed to begin identifying available mechanisms for running data queries within their organizations - in anticipation of future justification requirements, policy assessment needs, or external communications.

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Contact: [frank.tleone@uphs.upenn.edu](mailto:frank.tleone@uphs.upenn.edu) 1-888-PENN-STOP





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