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Ideas for Treatment Improvement

Healthcare Reform and Behavioral Health Part 2 - New Designs for Service Delivery

"The most exciting innovation in the field of addictions is happening right now – today. It is the process of replacing an acute care model with a chronic care model and we are right in the midst of it."

Michael T. Flaherty, "Resource Links", Winter 2010, www.ireta.org

For the past decade the field of behavioral health – and healthcare to some degree – has been moving toward a shared vision of addiction as a chronic condition. A hope and promise of the 2010 healthcare legislation, the Affordable Care Act, is to catalyze this vision by moving healthcare from fragmented acute "episodic" care models toward holistic "chronic-care" approaches.

Much of the Affordable Care Act deals with coverage expansion, more prevention for healthy communities, and insurance reform for consumers. Yet there are substantial parts of the Act that focus on creating better integrated and efficiently administered care. There are models identified in the legislation to improve care and lower projected costs, and those models are already advancing on their own.

In this article we will explore the integrative models of Health Homes (HH) and Accountable Care Organizations (ACO), particularly in light of their evolving relationship to behavioral health. Both models tackle current fragmented payment and delivery systems; and refocus the system on improved outcomes, better quality, and reduced costs.

Health Homes

The 2010 Affordable Care Act (ACA) allows states to apply to establish health homes (HH) programs to enhance integration and coordination of care for Medicaid enrollees with chronic conditions (beginning January of 2011). It includes mental health/substance use disorders (MH/SUD) in its list of chronic conditions. The HH model is directed at those with chronic illnesses, whose healthcare tends to involve multiple providers who may not communicate well and too often don't have holistic knowledge of their patient's health.

HH are built on a number of key ideas, one being that providing good care for people with chronic health issues requires a whole series of structural pieces being in place. A well-developed HH is designed to put those pieces together. Specifically, all Medicaid health homes must include six services: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support; and use of information technology to link services. There is state flexibility in identifying providers, but clearly the Affordable Care Act identifies that care should be provided by a team of health

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Next Issue:

*System Change
and Service
Integration*

providers, although the linkage can be “virtual”. As an added incentive for the states, the federal government provides a 90 percent match for these services for two years into a program.

Key Terms and Principles. The term “medical home” has been in use for decades, but was first used in pediatrics to describe a care model designed to address the needs of children with multiple, complex medical issues. As the model gained broader use, the terms “health” or “healthcare” began to replace “medical”. Also, “patient-centered” or “person-centered” is being used to underscore an approach whereby decisions reflect patient wants, needs, and preferences; and care teams ensure patients have the necessary education and support to participate in decisions and other aspects of care. The multiple names – sometimes used interchangeably – can be confusing, but a useful new publication by the National Council for Community Behavioral Healthcare (NCCBH, 2011) includes a helpful historical explanation. Here we’ll use the term Health Homes (HH), a term used in the Affordable Care Act.

Notably, HH don’t require that all services be integrated or co-located, although this is permissible, but leave room for innovation around how partnerships occur, and what populations might be areas of focus. Although there is no single standard definition for HH, several major physician groups came together in 2007 and agreed upon a set of key principles that are now broadly endorsed (AAFP, et al, 2007), as summarized below:

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs, or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end-of-life care.

- **Care is coordinated and/or integrated** across all elements of the complex healthcare system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services).
- **Care is facilitated by registries, information technology, health information exchange** and other means to assure that patients get the indicated care when and where they need and want it, and in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Implementation and Evaluation. Health Home programs have already been taking root across the U.S. To get a feel for the momentum, more than 100 HH demonstration projects, in both private and public sectors, have already been launched (RWJ, 2010); and many have shown positive results related to cost reductions and improved outcomes across a variety of approaches and populations (Patient-Centered Primary Care Collaborative, 2010). The PCPCC is a national organization that has united major employer groups, health plans, physician groups, and consumer representatives to move the HH model forward on a fast track; its website (www.pcpcc.net/) includes an interactive map of private and public HH projects, plus a recently added Center for Public Payer Implementation. Per PCPCC, some 44 states and the District of Columbia have passed more than 330 laws relating to the HH (or have executive level activity referencing HH), and federal agencies actively pursuing demonstration projects and rollouts include the VA and armed services.

Bi-Directional Integration:

Primary Care ↔ Behavioral Health

The Affordable Care Act requirements for HH

programs recognize the importance of addressing MH/SUD by the inclusion of these conditions among the six conditions specifically mentioned. But guidance from the Centers for Medicare and Medicaid Services (CMS) makes clear that states may include other chronic conditions not mentioned in the Affordable Care Act. States may also have multiple health home programs, each directed at different diagnostic groups or restricted to a geographical area. All Medicaid HH programs must serve all age groups. Prior to requesting CMS approval for a HH program, states must consult with SAMHSA regarding the prevention and treatment of mental illnesses and substance use disorders.

However, dedicated vigilance is needed to ensure all indicated providers are included in models for integration; and that there is attention to include needed MH/SUD screening and treatment services. The concept of bi-directional integration is to assure not only that behavioral health care services should be available in the primary care site; but also that primary care should be available in the behavioral health specialty settings. To this end the National Council for Community Behavioral Health (NCCBH) has developed “Person-Centered Healthcare Homes”, planning models for pursuing bi-directional integration of Primary Care (PC) and Behavioral Health (BH) services (NCCBH, 2009) and PC-SUD care (NCCBH, 2010). In the NCCBH “four-quadrant” models, each quadrant suggests key components of care, depending on combined BH/physical condition risk and severity; and shows how PC capacity might be embedded in MH/SUD teams, and vice versa.

“Medical homes and care management are the keys to healthcare delivery system redesign; they are seen as necessary to address the fact that 45% of Americans have one or more chronic health conditions and treating these conditions accounts for 75% of direct medical care in the United States” (NCCBH, 2010). Given the financial, health, and other costs related to MH/SUD – including costs of providing treatment and costs resulting from a lack of treatment – it is imperative that behavioral health be included as models for service integration continue to develop and take root. The following are just some of the reasons bi-directional integration makes sense:

- Many people served in specialty SUD

treatment have no primary care provider;

- Health evaluations and linkages to PC can improve MH/SUD status;
- MH/SUD interventions can reduce healthcare utilization and cost; MH/SUD are prevalent in primary care, often go unrecognized, and can lead to and exacerbate other chronic (and acute) health conditions;
- Like other physical and mental/emotional problems, SUD are chronic conditions that progress slowly, so PC physicians are in an ideal position to screen for emerging problems and monitor status; and,
- Repeated Screening and Brief Interventions (SBI) and Medication-assisted Therapies are promising and evidence-based practices that can be expanded. Both are optimized by the addition of psycho-social components and the existence of strong PC-BH linkages.

Accountable Care Organizations

Beginning in 2012, the Affordable Care Act provides for piloting and evaluating Accountable Care Organizations (ACO) through Medicare for adults and seniors, and a pediatric ACO demonstration under Medicaid. ACO are partly based on lessons learned from a substantial movement already underway that includes both public- and private-sector ACO projects. It allows providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. “The ACO model is built on the principle that in placing the responsibility for a population’s entire care continuum within a single entity with aligned clinical and financial incentives, care quality and patient experience will improve and costs will go down.” (NCCBH, 2011)

ACO are envisioned as large primary care based partnerships that integrate other provider groups – e.g. hospitals, PCPs, MH/SUD and other specialists (some gathered in health homes) – who are tasked with shared and coordinated responsibility for a patient’s care from beginning to end. To get a feel for their structure, Affordable Care Act requirements for pilot sites call for at least one hospital, a minimum of 50 physicians (a mix of primary care and specialists), and a commitment to operate for three to five years and serve at least 5,000 patients. ACO (as do HH) also require robust

(continued on Page 4)

IT to track patients within and across primary and specialty care and to manage and mediate some new payment methods. A dedicated administrative staff is needed as well, to integrate and align interests of all members, and to continuously analyze patient experiences and lead the way on quality improvement strategies.

Payment Reform

Inverting the "Pyramid of Care": Payment reform is, in part, about inverting the resource allocation triangle. The bulk of national healthcare funding currently goes to acute care, then specialty care, and leaves a small amount allocated to prevention and primary care. The new legislation aims to flip this around by expanding prevention and primary care, thereby reducing the resources needed for acute and specialty care. "When you look at data from other countries", says Barbara Mauer (May 2010), "and look at the relative proportion of primary care providers to specialists, what you see is that there's actually better health status in other countries and in parts of this country where the proportion of primary care doctors balances the proportion of specialty physicians. There's data that shows that in this country, if you take a regional health area, the greater the proportion of specialists the lower the health status of the people who live there."

Also, while we know addiction treatment saves costs and lives, only a small percentage of those who need treatment are able to access it, and addiction often goes untreated in earlier stages. Additionally, a much higher percentage of people are using substances at risky (versus dependent) levels, and research shows providing SBI during stages of risky use is cost-efficient and can help curb or stop use – the potential of which is largely untapped. Moving more SUD resources into prevention and intervention – treating addiction as a mainstream health issue and including these services in primary care settings – should optimize care, lower costs, and reduce the burden of those needing treatment, ultimately saving lives and years lost to addictions.

Conclusion/Next Issue

As the new healthcare legislation gets translated into action, extremely important questions remain to be answered. Namely, how healthcare providers can expand partnerships through integrative service models in order to improve patient healthcare and lower projected costs; and whether MH/SUD providers will strategically advocate and position themselves to achieve bi-directional integration. The next article in this series will focus on workforce and organizational issues related to system change and service integration.

Sources provided by Lynn McIntosh, TTS, NFATTC and University of Washington Alcohol and Drug Abuse Institute

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