Addiction Messenger

Healthcare Reform and Behavioral Health
Part 3 - Organizational Partnering to Improve Care

Entrepreneurs are simply those who understand that there is little difference between obstacle and opportunity and are able to turn both to their advantage. ~ Niccolò Machiavelli ~ (Italian Renaissance diplomat, politician, and philosopher, 1469–1527)

This series has aimed to clarify the Affordable Care Act and to give providers a glimpse into how behavioral health services are evolving. This final article will focus on workforce and organizational issues, with a goal of giving agency administrators and the workforce a sense of some of the decisions they may face over the next several years, as final rules are clarified and implemented.

Workforce Impacts

Coverage Expansion. With full implementation of the Affordable Care Act approximately 32 million uninsured Americans are expected to gain health coverage by 2014, about half through Medicaid expansion (a 46% increase), and half through private or other insurance (an 8% increase). Of these, according to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2010), a fifth to a third – six to 10 million – will have untreated mental illnesses (MI) or substance use disorders (SUD). This is a higher rate than found in the general population – about one of every seven to 10 people – due to the demographics of those entering the system. Even more people may need services as screening and brief interventions for SUD increase. Such dramatic predictions not only demand more efficiency but an expanded workforce – in both primary care (PC) and behavioral health (BH).

Workforce Development. The Affordable Care Act aims not only to increase access to care, but to improve patient satisfaction and health outcomes. To do so it includes provisions to develop the healthcare workforce in terms of both quantity and quality. Scholarship and loan repayment programs for behavioral health specialists are part of the legislation. Factors to qualify relate to service settings (such as loan repayment for work in underserved areas and/or in schools), and skills development in areas that include cultural competence, child and adolescent services, and evidence-based practices. The Department of Labor considers substance abuse a "distressed profession", meaning it lacks sufficient workforce to address public need. DOL proposes to recruit and train 60,000 new counselors over the next decade, at a cost of $500 million, though plans depend on future funding (ATTC/Kessler, 2011).

Billing and Block Grants. "Expansion will also trigger changes in SAMHSA's Mental Health Services Block Grants and Substance Abuse Prevention and Treatment Block Grants. With more people receiving coverage for behavioral health services via Medicaid and the new (health insurance) exchanges, SAMHSA will redirect that funding to whatever gaps in coverage and services remain. 'We have to figure out

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Next Series:
Trauma-Informed Services

how to direct the dollars differently,' says Mr. O'Brien (SAMHSA's Senior Advisor for behavioral health financing)" (SAMHSA, 2010). Plus, with the federal government shifting toward pay-for-service modes (e.g., Medicaid and private/other insurance), future block grant funding levels remain to be seen.

Agencies that don't already bill for services may find it increasingly important to learn how, and to develop business models that allow for deferred payments and are oriented to consumers with more choice. Agencies might begin by identifying things they're already doing that may become billable in the future. The Network for Improvement of Addiction Treatment (niatx.net) has a strong focus on assisting agencies adapt business and billing models for reform.

Integrated Care Skills Development. Evidence-based programs and practices have emerged as a standard of care in recent years. An additional set of skills related to the provision of integrated or coordinated care was developed by Jeffrey Borkan (2008), Chair of the Department of Medicine at Brown University. It summarizes essential skills or "domains of competency" for effective health homes (see Pt. 2 of this series). Other integrated models require many of the same skill sets. You might think about how you stack up with Borkan's list:

- Patient centered/whole person care
- System-based care
- Practice-based learning
- Communication and professionalism
- Teamwork
- Chronic disease management
- Practice and population management
- Coordination and transitions of care
- Integration of care
- Quality, performance, and practice Improvement
- Information technology (e.g., for electronic health records, disease registries, integrative administration, patient tracking, confidentiality requirements, etc.)

Service Integration
"Behavioral health providers should already be preparing for the integration of behavioral health and primary care," says Rita Vandivort-Warren, MSW, a public health analyst in the Division of Services Improvement at SAMHSA's Center for Substance Abuse Treatment (SAMHSA, 2010), adding there are various models for integration. Integration is considered key to overcoming problems of quality and cost in the current healthcare system. By some estimates as much as 30 percent of health care costs – over $700 billion per year – could be eliminated without reducing quality!

"Integration – this is a word that you find all through healthcare reform, and it does not just apply to substance abuse, it applies to all aspects of healthcare," said Andrew Kessler, in a national webinar on reform (ATTC, 2011). It helps to realize that both PC and BH providers are learning new integrative skills, and that it will require not only systematic but shared efforts to overcome barriers across systems. Barriers include differing practice cultures, styles, and language; differing code and billing systems; lack of knowledge by BH providers about PC and vice versa, and provider resistance.

The Milbank Foundation has developed a great resource to help organizations consider where they might want to go with integration. Free and downloadable, the document (Collins et al, 2010) presents eight models, including health homes, across a continuum for coordinating physical and behavioral care. Descriptions for each model include evidence base, implementation and financial considerations, and many real-life examples of programs from across the country.

Partnering with Health Homes and Accountable Care Organizations. Part 2 of this part series discussed two emerging service-integration models (HH and ACO) identified in the Affordable Care Act as likely candidates for improving care while lowering costs. The National Council for Community Behavioral Healthcare just released a concise publication about ways BH providers can prepare to participate in HH and ACO to address reform's triple aim of improved quality, patient experience, and reduced costs. "Neither HH nor ACO will be able to reach that goal without effectively addressing MH/SU; MH/SU providers must determine what kind of relationship they want with these entities and what they need to do to qualify as partners" (Alexander, 2011).

Watch for local opportunities to be involved with HH (and other partnerships) and consider that ACOs, bringing together provider and hospital systems, may develop around HH initiatives. The NCCBH publication includes several key action steps to ensure readiness to participate in HH and ACO; the steps (applicable to other integrative approaches) fall under four main categories: 1) Prepare now for participation in the larger healthcare field; 2) Establish credentials as a high performer relative to the "triple aim"; 3) Ensure information technology readiness; and, 4) Plan for an extended period of change.

NCCBH (www.thenationalcouncil.org) will also soon launch the Center for Integrated Health Solutions through joint funding from SAMHSA and HRSA (Health Resources Services Administration).

CIHS aims to improve care for those with MI/SUD conditions by supporting PC and BH integration efforts; efforts will include providing training and technical assistance to 56 organizations piloting SAMHSA-funded integration models, and to other agencies seeking assistance.

Key Partners. Federally Qualified Health Centers are important entities to learn about and consider for partnerships. FQHCs are safety net providers, such as community health centers, that receive federal funds (section 330 grants) to provide care to underserved populations. Importantly, FQHCs must provide comprehensive services, either directly or, for some services (including SUD and MI treatment), by arrangement with other providers. Their role as safety net providers will greatly increase with Medicaid expansion, and funding is available for new sites (a target goal is to double the patients served by FQHCs to 40 million by 2015). They are also likely sites for HH/ACO development. Some BH organizations have become FQHCs, an involved process but one with financial benefits. It's been said that "if you've seen one FQHC, you've seen one," meaning they vary greatly depending on area, population served, and other factors. To locate FQHC's by zip/state/county: http://findahealthcenter.hrsa.gov/.

Federal/State/Local Partners
While the Affordable Care Act is federal legislation, much is left to states in terms of how it is enacted. It can't be emphasized enough how critical it is to look to states for guidance, and for opportunities to partner, provide input, and advocate so that SUD treatment and recovery services are included as integration progresses. States will also be setting up and managing health exchanges (see Pt. 1); and in doing so they'll decide how plans meet basic standards, including coverage for SUD services. States also have variability regarding who can bill Medicaid, and what types of services are billable. For example, what will be billable in states where addictions professionals are certified, but not licensed? Can peer specialists be reimbursed? These are just some examples of questions that will be resolved in the coming months.

It has been said that "all healthcare is local" and it is still true. Key partnerships are forming at regional, county, and community levels. Talking to state agencies is a great place to start. Another is having conversations with local BH and PC providers to raise awareness and share information. Where might linkages be formed or strengthened? Are PC sites in your area conducting screening and/or brief intervention for SUD, or using medication-assisted

treatment? Physicians, nurses, psychiatrists, psychologists, MH counselors and social workers all have addiction sub-specialty credential/certification groups or associations to tap for potential relationships and referrals. Agencies involved in developing a community-based recovery-oriented system of care may have a leg up in establishing relationships and developing skills and values (i.e., serving a whole person rather than a specific condition) in line with service integration.

Across the nation literally thousands of BH and PC providers are partnering to develop useful websites, publications, and other resources. For example, California's Integrated Behavioral Health Project (Demming Lurie, 2009) has distilled lessons learned into an easy to understand, comprehensive primer including general information on healthcare reform, integration models, statements from the field, job classification templates, and more. Oregon shares news and resources through the *Health Services Integration* website. Washington State has just released a long-range planning document that acknowledges a decade of continuing work toward integration. *Vision for a System of Integrated Meant Health/Substance Use/Primary Care Treatment Services in Person-Centered Healthcare Homes* describes a vision for service integration, identifying HH as Washington's foundational model and providing information about current and planned projects.

Conclusion
Where people will receive addictions service in the future could in great part be decided by the response and preparation of the current workforce**.** Overall points to keep in mind: The work is really just beginning, it is an ongoing process, we will learn as we go, and opportunities lie ahead for those prepared to meet them. The SUD treatment profession has a track record of evolving with trends and demands related to workforce development, service improvement, and community needs. Working toward an integrated healthcare system clearly requires ongoing systems change, but there are partners and resources at hand. A brief list of some you may find useful are on page 4.

Sources/Resources

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SAMHSA. http://www.samhsa.gov/HealthReform/

NFATTC WORKSHOPS in **April** through **June**

Cognitive Behavioral Therapy: Part 1
April 11-12, 2011 - Honolulu, HI
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1.5-day Course (10 CE Hours) - Focuses on building skills in the use of cognitive behavioral therapy for counseling interventions.

Clinical Supervision I: Building Chemical Dependency Counselor Skills
April 14-15, 2011 - Honolulu, HI
2-day Course (14 CE Hours) - designed to increase understanding and skill in assessing the clinical skills of counselors in addiction treatment settings and building learning plans for their continued professional growth and development.

Promoting Awareness of Motivational Incentives (PAMI)
April 12, 2011 - Honolulu, HI
3-hour Course (3 CE Hours) - designed to build awareness of the use of Motivational Incentives as an evidence-based therapeutic strategy to enhance client retention in addiction treatment. Principles, history, research, and suggestions for overcoming implementation barriers are discussed.

Group Counseling & Facilitation Skills
March 3-5, 2011 - Grants Pass, OR
3-day Course (18 CE Hours) - interactive training in how to establish and facilitate productive process-oriented and psycho-educational groups. Content includes stages of group development, resolving conflict in groups, and practicing interventions that facilitate group growth.

Advanced Motivational Interviewing
April 19-20, 2011 - Honolulu, HI
June 1-2, 2011 - Honolulu, HI
2-day Course (14 CE Hours) - designed for those who have had introductory MI training and want to further develop and refine their MI skills in the areas of identifying and eliciting change talk and using strategies to decrease resistance.

Methods for Enhancing Client Motivation in Groups
June 8-9, 2011 - Honolulu, HI
2-day Course (12 CE Hours) - Assumes a basic understanding of group counselin processes and designed to facilitate improvement in client readiness to change. Practice oriented and focused on interventions that address change and improve group process.

Buprenorphine Treatment: A Training for Multidisciplinary Addiction Professionals
April 27, 2011 - Sitka, AK
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o **Series 6** Vol. 5, Issues 4-6 "Co-Occurring Disorders"
o **Series 7** Vol. 5, Issues 7-9 "Trauma Issues"
o **Series 8** Vol. 5, Issues 10-12 "Cultural Competence"
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o **Series 29** Vol. 11 Issues 1-3 "Family Treatment In Addiction Treatment"
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TEST Series 41

1. Healthcare reform legislation (comprised of the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act of 2010*) is collectively referred to as:
_____ (*fill in the blank*)

2. Most reform provisions are to be enacted from _____ through _____ (*fill in the blanks*)

3. When fully implemented healthcare reform provisions are expected to expand coverage to an estimated 32 million currently uninsured Amercians. (*circle correct answer*)
       True   False

4. Reasons bi-directional integration (primary care into behavioral health and vice versa) is important, include: (*circle correct answer*)
   a. Many people served in specialty substance use disorder (SUD) treatment have no primary care provider.
   b. Like other physical and mental/emotional problems SUDs are chronic conditions that progress slowly, so PC physicians are in an ideal position to screen for emerging problems and monitor status.
   c. "a" and "b".
   d. none of the above

5. The "triple aim" of healthcare reform includes: (*circle correct answer*)
   a. Improving patient experiences.
   b. Achieving better health outcomes.
   c. Curbing the rising cost-curve of healthcare.
   d. b and c.
   e. All of the above.

6. Two models for service integration emerging as likely candidates for addressing reform goals are:
_____ and
_____. (*fill in the blanks*)

7. An emerging model for payment reform is a three-layered design mixing 1) case or capitated payments; 2) fee for service; and, 3) bonuses related to cost and quality performance. (*circle correct answer*)
       True   False

8. List four skills related to the provision of integrated or coordinated care:
1. _____
2. _____
3. _____
4. _____

9. The National Council for Community Behavioral Healthcare suggests several action steps behavioral health organizations can take to ensure readiness to partner and participate in integrated service models. List two of the four main categories for action steps.
1. _____
2. _____

10. The Affordable Care Act is federal legislation, but much is left to states in terms of how it is enacted. (*circle correct answer*)
       True   Fal se

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NAME_____

We are interested in your reactions to the information provided in **Series 41** of the *"Addiction Messenger"*. As part of your 2 continuing education hours we request that you write a short response, approximately100 words, regarding Series 41. The following list gives you some suggestions but should not limit your response.

What was your reaction to the concepts presented in Series 41?

How did you react to the amount of information provided?

How will you use this information?

Have you shared this information with co-workers?

What information would you have liked more detail about?

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