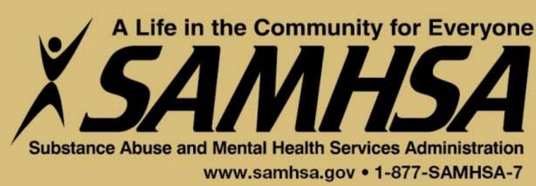
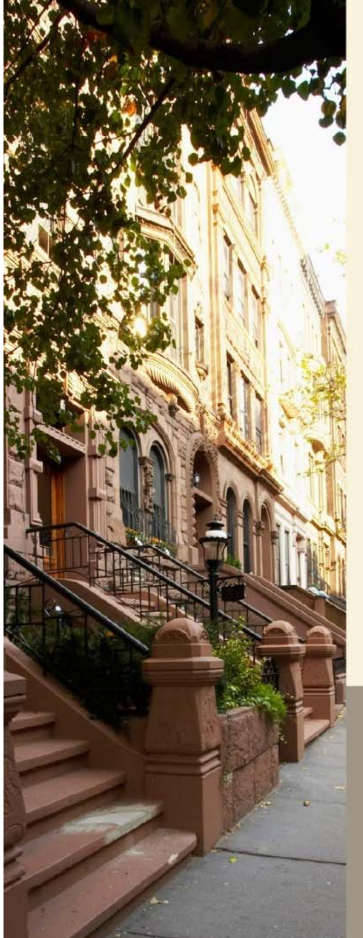
Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover





Healthcare Reform Impact: ROSC and COD Services

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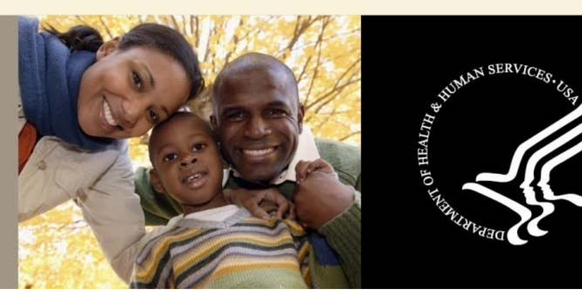

SAMHSA's Strategic Initiatives

- Prevention of Substance Abuse & Mental Illness
- Trauma and Justice
- Military Families
- Health Care Reform
- Recovery Support (including Housing)
- Health Information Technology, Electronic Health Records and Behavioral Health
- Data, Outcomes, and Quality: Demonstrating Results
- Public Awareness and Support

Treatment Does Not Equal Recovery

- Treatment is part of recovery – but it is not equal to recovery.
- The goal of treatment is absence of symptoms; the goal of recovery is holistic health.
- Recovery is different for each individual, and the social determinants of health need to be addressed before the recovery process can move forward.

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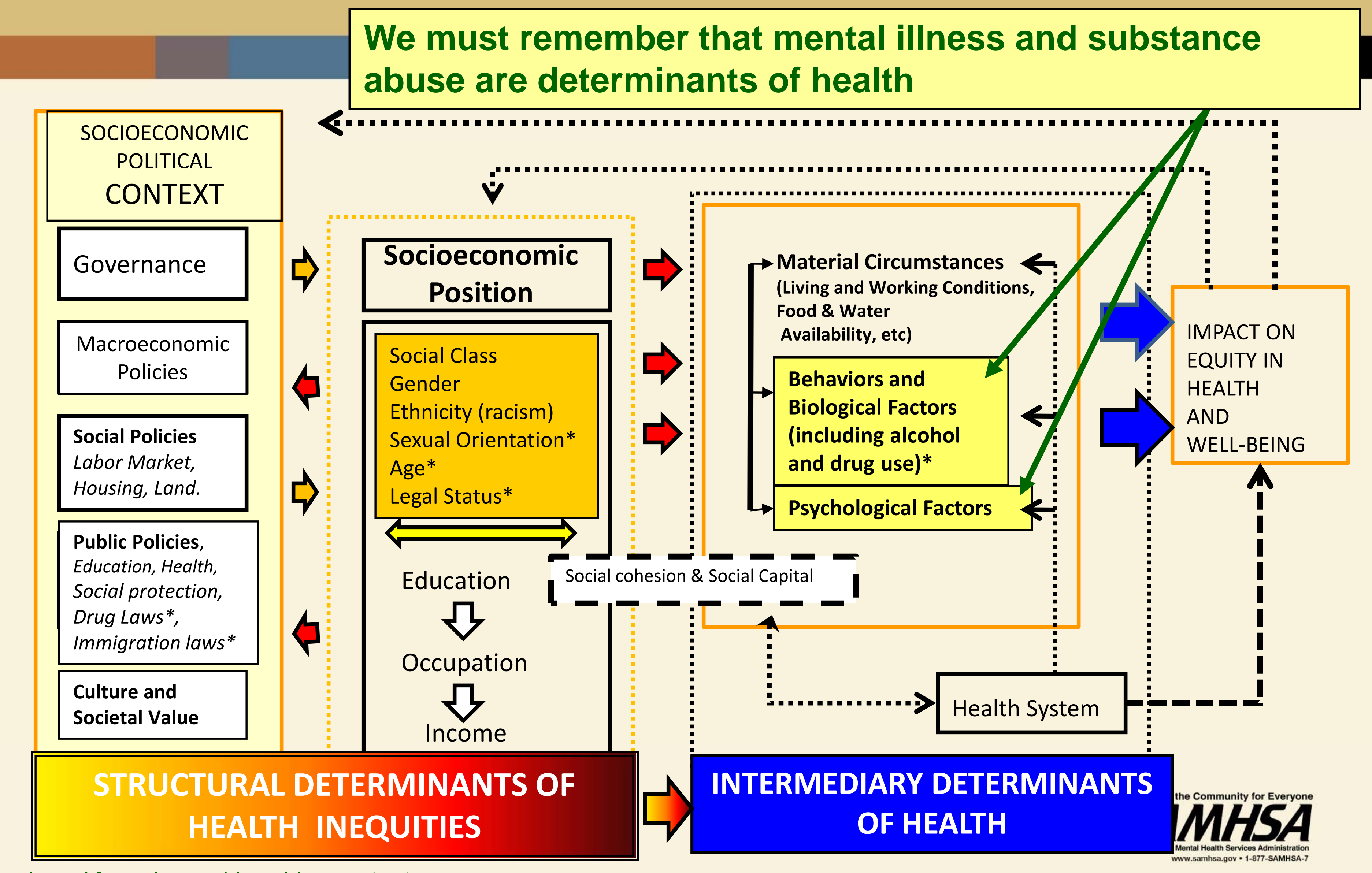
The Social Determinants of Health*



* Adapted from the World Health Organization

Four Quadrant Typology (TIP 42)

High Severity ↑ Alcohol and other drug abuse		
	III Less severe mental disorder/more severe substance abuse disorder	IV More severe mental disorder/more severe substance abuse disorder
	I Less severe mental disorder/less severe substance abuse disorder	II More severe mental disorder/less severe substance abuse disorder

Low Severity → Mental Illness → High Severity

Federal Government's Role

- The recovery-oriented systems of care approach is not a SAMHSA approach, or an HHS approach, or even a Federal government approach.
- The Federal government has a role, but the approach is much larger – encompassing a wide spectrum of State, local, community-based, faith-based, and peer-to-peer supports, services, and systems.
- Every resource, system, service, etc…

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Values Underlying ROSC

- Person-centered
  - Places the individual at the center of services and support
  - Recognizes that there are many pathways to recovery, including professional treatment, peer-to-peer support, faith-based recovery support, medication-assisted recovery, etc.
- Self-directed
  - The individual is encouraged and assisted in exercising the greatest level of choice and responsibility of which he or she is capable.

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Values Underlying ROSC (cont'd.)

- Strength-based
  - Identifies and builds on the assets, strengths, resources, and resiliencies of the individual, family, and community – rather than emphasizing the needs, deficits, and pathologies
- Participation of family members, caregivers, significant others, friends, and the community
  - Acknowledges the role of the family members, caregivers, significant others, friends and community can play in the recovery process.
  - Recognizes that these groups also may have their own needs for supports or services.

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Values Underlying ROSC (cont'd.)

- Individualized and comprehensive services and supports
  - Promotes a philosophy of individual choice.
  - Offers a broad array of supports to meet the holistic needs of the individual.
  - Services are designed to support recovery across the lifespan, with the understanding that needs and resources shift and change with age and life-stage, as well as over the course of recovery.

Values Underlying ROSC (cont'd.)

- Community-based services and supports
  - Situated within and draws on the strengths, **resilience**, and resources of the community, including professional and non-professional organizations and groups, such as community-based service agencies, recovery community organizations, faith-based organizations, schools, civic groups, and others.

Targeted Capacity Expansion (TCE)/Local ROSC Grants

- 22 TCE/Local ROSC grants serve to develop local recovery-oriented systems of care that will expand and/or enhance substance abuse services and promote recovery.
- The local recovery-oriented system of care must include linkages between substance abuse treatment/recovery services and primary health care and mental health care services – as well as additional linkages with systems/services appropriate to their population of focus.
- The focus is on providing support for local organizations, including grass-roots & faith-based.

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TCE/Local ROSC: Outcomes

Clients reporting…	At Intake	6-Month Follow-up	Difference
No substance use	32.2%	51.6%	⇧ 60.5%
Being employed	47.4%	57.8%	⇧ 21.8%
Being housed	28.7%	43.4%	⇧ 51.2%
No arrests	94.9%	96.5%	⇧ 1.7%
Being socially connected	76.6%	80.2%	⇧ 4.7%

Source: GPRA through 08/02/10

TCE/Local ROSC: Mental Health Outcomes

	Intake	6 Month Follow-up	Rate of Change
Experienced serious depression	42.7%	35.8%	⇩ 16.1%
Experienced serious anxiety or tension	50.4%	43.0%	⇩ 14.8%
Experienced hallucinations	6.0%	3.9%	⇩ 35.4%
Experienced trouble understanding, concentrating, or remembering	46.6%	32.9%	⇩ 29.4%
Experienced trouble controlling violent behavior	10.4%	9.4%	⇩ 9.2%

Source: SAMHSA, SAIS, data collected through August 3, 2010

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Examples of Recovery Support Services

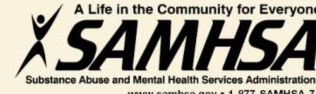
- Employment services and job training
- Case management individual services coordination, with linkages to other services
- Relapse Prevention
- Housing assistance & services
- Child care
- Parent education & child development support services
- Transportation to and from treatment, etc.
- Family/marriage counseling
- Education (including substance abuse education)
- Peer-to-peer mentoring and coaching

ROSC Services and Supports

- ROSC services and supports reflect these ROSC values. They are:
  - Evidence-based
  - Developmentally appropriate
  - Gender-specific
  - Culturally relevant
  - Trauma-informed
  - Family-focused, and
  - Appropriate to the person's stage of life and stage of recovery

Affordable Care Act (ACA)

- Affordable Coverage
- Better Care, Integrated Care
- Healthy People and Communities



Affordable Care Act

- Summary of Major Drivers
  - More people will have insurance coverage
  - Medicaid will play a bigger role in MH/SUD than ever before
  - Focus on primary care and coordination with specialty care
  - Major emphasis on home and community based services and less reliance on institutional care
  - Preventing diseases and promoting wellness is a huge theme
  - Outcomes: improving the experience of care, improving the health of the population and reducing costs

Impact of Affordable Care Act

Impact on Coverage

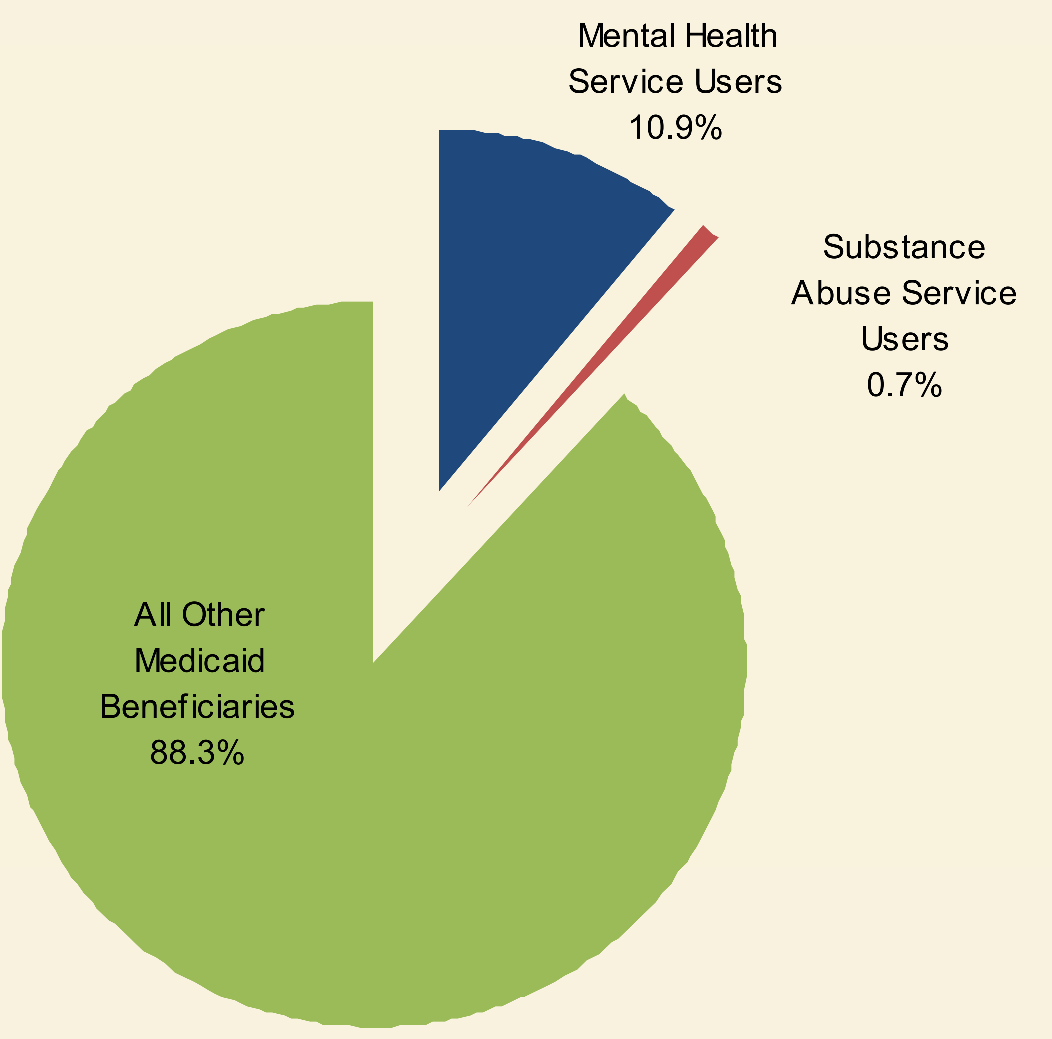
- 39% of individuals served by SA/MHAs have no insurance (CMHS)
- 61% of the individuals served by SSAs have no insurance
- Services for some of these individuals are purchased with BG funds
- Many individuals will be covered in 2014 (or sooner)—most likely by the expansion in Medicaid

Impact of Affordable Care Act

Impact on Coverage

- 12 M visits annually to ERs by people with MH/SUD
- 44% of all cigarette consumption by individuals with MH/SUD
- 70% of individuals with significant MH/SUD had at least 1 chronic health conditions, 45% have 2, and almost 30% have 3 or more

Medicaid



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Medicaid

- State and federal partnership—shared decision making
- Responsible for developing provisions regarding parity for individuals in Medicaid managed care plans
- Does not have extensive experience with individuals with SUD
- Operates much differently than State Substance Abuse Authorities

Coverage

Enrollment

- 32 million individuals—volume issues for 2014
- Skepticism—many haven't been enrolled—historical message that you will never be covered
- Challenges—doors to enrollment and challenging enrollment processes
- Churning

Coverage

Elimination of pre-existing condition exclusions for children currently (Adults in 2014)

High risk pools for those with pre-existing conditions (2010 – 2014)

Youth covered through parents insurance until they turn 26 years old (2010)

Expanded options in home and community-based services for individuals with mental health and substance use disorders supports recovery orientation

- 1915i
- Money follows the person extension
- Section 10202—increased FMAP for HCBS services
- Special need plans

Coverage

Changes in Medicaid to assist youth to maintain coverage in times of transition- option for states to continue coverage for former foster care children up to age 25

New home visitation program for young children and families – priority to families with history of SUD and to communities with capacity for treating SUD

- Request for Application closed August 18th
- SSA's must sign off on application

Grants for School-based health clinics to provide MH/SUD assessments, crisis intervention, counseling, treatment and referral

- Capitol Grant - $50Million appropriated for each fiscal year FY2010 – FY2013
  - Currently Released- RFA due December 1st, more information at www.hrsa.gov/grants/index.html
- Services Grant - Authorized for each fiscal year FY2010 – FY2014

List of other grants to keep an eye out for at www.samhsa.gov/healthreform

What Do We Know About the Newly Covered?

- Individuals Near the Federal Poverty Level—More diverse group than we think
  - 40% under the age of 29
  - 56% are employed or living with their families
  - Conditions are more acute when they present
  - Care is more costly

Source: Center on Budget and Policy Priorities

What Do We Know About the Newly Covered?

Traits	>100%	100-200%	200% + FPL
Poor or fair *physical* health	25%	18%	11%
Poor or fair *mental* health	16%	11%	6%

Source: Center on Budget and Policy Priorities

Implications

- Work:
  - Working with consumer/recovery organizations on roadmap
  - Developing SOAR-like approach to enrollment*
  - Work with HHS re: state exchange grants
  - Working with NIATx and providers to use technology for enrollment information*

Service Coverage

- Need to make decisions:
  - Benchmark plans for Medicaid
  - Essential benefits for exchanges
  - Scope of services for parity
  - How to use block grant dollars differently

ACA Promotes Primary Care Coordination

ACA Focus on primary care and specialty care coordination:

- Significant enhancements to primary care
  - Incentives for Accountable Care Organizations (ACOs)
  - Workforce enhancements, more funding for FQHCs
  - HITECH $ for Electronic Health records
- Bi-directional Integration
  - MH/SUD in primary care
  - Primary care in MH/SUD settings
  - Dealing with confidentiality to collaborate

Primary Care And Coordination

- Individuals with SMI die on average at the age of 53 years old
- Barriers include stigma, lack of cross-discipline training, and access to primary care services
- Have elevated (and often undiagnosed) rates of:
  - hypertension,
  - diabetes,
  - obesity
  - cardiovascular disease
- Community-based behavioral health providers are unlikely to have formalized partnerships with primary care providers

Importance of Integrated Care

- Focus on coordination between primary care and specialty care:
  - Significant enhancements to primary care
    - Workforce enhancements
    - Increased funding to SAMHSA, HRSA and HIS
    - Bi-directional
      - MH/SUD in primary care
      - Primary care in MH/SUD settings
      - Services and technical assistance

The Four-Quadrant Model

The National Council for Community Behavioral Healthcare

Quadrant II BH ↑ PH ↓ **Behavioral Health Setting with Primary Care Capacity**	Quadrant IV BH ↑ PH ↑ **Setting with Primary Care and Nurse Care Management**
Quadrant I BH ↓ PH ↓ **Primary Care Setting with Behavioral Health Consultation**	Quadrant III BH ↓ PH ↑ **Primary Care Setting with Behavioral Health Capacity**

The National Council's Four Quadrant Clinical Integration Model (MH/SU)

MH/SU Risk/Complexity (High ↑ / Low)

Quadrant II
MH/SU ↑ PH ↓

- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

Quadrant IV
MH/SU ↑ PH ↑

- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- Nurse care manager at MH/SU site
- MH/SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.

Quadrant I
MH/SU ↓ PH ↓

- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty prescribing consultation
- Wellness programming
- Crisis or ED based MH/SU interventions
- Other community supports

Quadrant III
MH/SU ↓ PH ↑

- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty medical/surgical-based BHC/care manager
- Specialty prescribing consultation
- Crisis or ED based MH/SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Physical Health Risk/Complexity

Low

High

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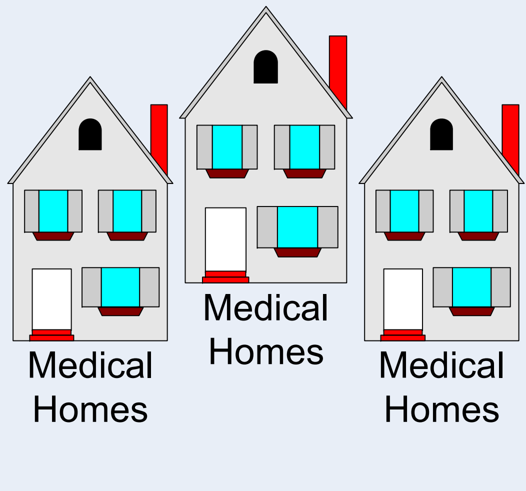
Impact of Affordable Care Act

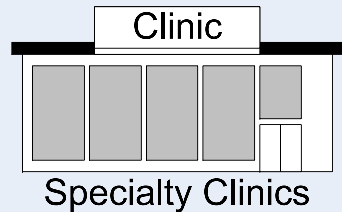
- Health Homes
  - Focus on chronic conditions (or at risk)
  - Start date: 4 months and counting
  - Medicaid state plan
  - 90% match initially—big incentives for states
- Several new services:
  - Comprehensive Care Management
  - Care Coordination and Health Promotion
  - Patient and Family Support
  - Comprehensive Transitional Care
  - Referral to Community and Social Support Services

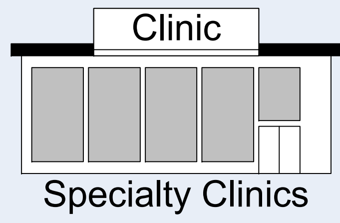
Patient-Centered Medical Homes in a Larger Healthcare System: Delivery System Redesign

Payment Model to cover Prevention, Primary Care and Chronic Disease Management; Bonus Structure for managing Total Health Expenditures

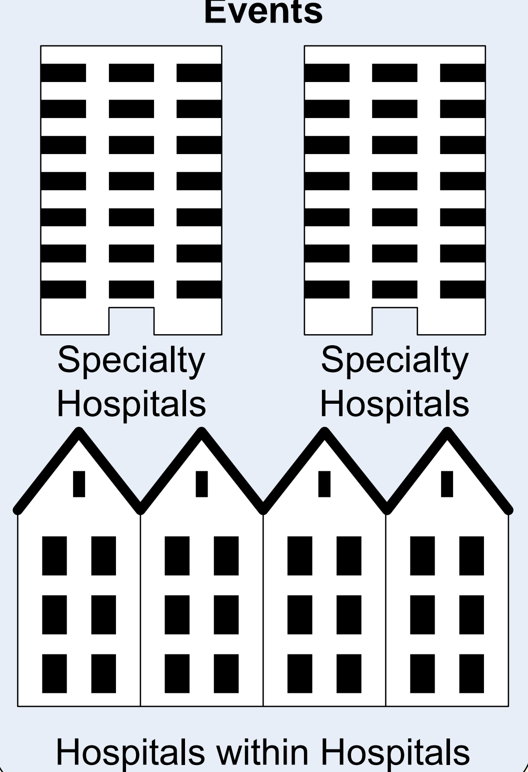


Linkages to High Performing Specialists that can support the management of Total Health Expenditures and minimize Defect Rates





Bundled Case Rates that pay a Percentage of PACs and Non-Payment for Never Events



Medical Homes → They are all about Improving Quality and managing Total Healthcare Expenditures!

Implications

- Work:
  - Robust TA Center*
  - Showcase the work of PCBHI
  - Evaluate PCBHI and Health Homes (with ASPE)*
  - Protocols for SAMHSA TA to Health Homes
  - Good SPAs that clearly identify MH/SUD*
  - TA to states re: health homes and behavioral health*

Long Term Care/Prevention

- SUD systems provide LTC
  - Multiple admission across years
  - Short term residential = long term residential (90+)
  - Long term residential = long term care (2 years+)
- Prevention
  - ACA focused on community and individual prevention services
  - Multi-billion $ Trust Fund and other grants

Prevention

- $100 million in grants for public health and prevention priorities
- $30 million in new resources to support the National HIV/AIDS Strategy
- $26.2 million to expand primary care to individuals with behavioral health disorders
- No cost sharing for preventive services for some plans

What's in the Affordable Care Act for Prevention?

- The Affordable Care Act requires health plans to cover a number of preventive services related to behavioral health without cost sharing (for plans effective on or after 09/23/10)
- Adults
  - Alcohol misuse screening and counseling
  - Tobacco use screening & cessation interventions
  - Depression screening
  - HIV screening for those at higher risk
  - Obesity screening and counseling
- Pregnant Women
  - Special, pregnancy-tailored counseling for tobacco cessation and avoiding alcohol use
- Children
  - HIV screening for those at higher risk
  - Sexually transmitted infection prevention and counseling for adolescents at higher risk
  - Alcohol and drug use assessments and screening for depression for adolescents
  - Behavioral assessments for children of all ages
  - Developmental screening (under age 3) and surveillance (throughout childhood)
  - Autism screening for children at 18 and 24 months
  - Obesity screening and counseling

New Prevention and Wellness

2010

No co-pay for prevention services: USPSTF list, immunizations

Medicare: Individualized Wellness Plans

2011

Medicaid increased federal share for prevention services

2014

Employers give incentives for programs to promote wellness

Small employer grants for Wellness Programs

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"Good and Modern" Benefit Vision

- The goal of a "good" and "modern" system of care is to provide a full range of high quality services meeting the range of age, gender, cultural and other circumstances.
- SAMHSA believes that a good system is achievable and a step to developing an "ideal" service system.
- The integration of primary care, mental health and addiction services is an integral part of the vision: Bi directional, so it is:
  - BH in primary care providers
  - Primary care in BH providers
- The vision for the system is grounded in a public health model that addresses:
  - System and service coordination
  - Health promotion and prevention, screening and early intervention
  - Treatment, and recovery and resiliency supports to promote social integration and optimal health and productivity.

Good and Modern Includes Prevention and Recovery

- **Children and Youth Services**
  - MH/SUD consultation
  - Parent/family/caregiver support
  - Respite
  - Therapeutic mentoring
- **Prevention**
  - Brief motivational interventions for alcohol and drug use for the elderly
  - Case management: facilitated referral
  - Parent training
  - SBIRT for drugs and alcohol
  - SBIRT for tobacco
- **Recovery Support Services**
  - Recovery support centers
  - Recovery support coaching
  - Relapse prevention/wellness recovery support
  - Self-directed care

Implications

- Work That Needs To Get Done
  - Service Definitions for Good and Modern
    - Workgroups further defined services in the continuum of care
      - Prevention Services
      - Recovery Services
      - Children and Youth Services

So What Should We Do?

- Many provisions are still needing further clarity (regulations, SMDs, Grants)
- Some opportunities now
- Three years + until some of the major provisions
- Information overload
- Economic challenges continue

Understand The Key Concepts

- Healthcare Exchanges
- Health Information Exchanges
- High Risk Pools
- Benchmark Plans
- Essential Benefits

Steps Toward Implementation for States

- Organize/Participate an Implementation Team
- Identify who in your state is the lead regarding implementation
- Identify a lead staff person that is your "ACA" expert
- Perform a scan on all in-state health reform initiatives (present and future)
- Develop a workplan that mirrors the ACA timeline
- Develop uniform talking points on HCR for your state

Steps Toward Implementation for States

- Develop a financial map of MH/SUD services across agencies to understand where money is now
- Create a stakeholder team regarding HCR—manage expectations and communication
- Understand the New Health Insurance Exchanges
- Integrating MH/SUD and Primary Care
- Develop a Coverage Crosswalk and Attempt to Close Remaining Gaps
- Translate Eligibility into a Consumer-Friendly Environment
- Have tools that can be used to determine provider capacity
- Assure Quality and Efficiency

Principles

- ➔ <u>We are part of health</u>: preventing and treating mental and substance use disorders is integral to overall health.
- ➔ <u>Services must address current health disparities</u> and be relevant to, and respond to, the culture of individuals and families.
- ➔ <u>Person centered care</u> is the framework is of shared decision-making in which the individual is the center of the health care system.
- ➔ <u>Continuum of services</u>: A wide range of services should be available based on a range of acuity, disability, and engagement levels.
- ➔ <u>Evidenced based purchasing</u>: Services proven effective or show promise will be funded; ineffective services will not be funded.
- ➔ <u>Beyond service widgets</u>: Reimbursement strategies must be implemented to align incentives and control costs.

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Providers: Build on a Strong Base

- Ready with alliances to primary care like community health clinics?
- Ready with the right mix of workforce with needed qualifications?
- Ready for insurance business practices like claims based billing?
- Ready for more documentation of individualized treatment planning and every service encounter?
- Ready with electronic health records, online enrollment and online claims systems?

What Else Should We Be Doing?

- Stay Excited
- Stay Informed
- Get and Stay Involved

Acknowledgments

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The Impact of Healthcare Reform on ROSC Perspectives from an FQHC

September 2010

ACCESS at a Glance

- 60 health centers in 2010 in Chicago, suburban Cook and DuPage counties
- 215,000 patients; 755,000 annual medical visits; 4000 deliveries
- 55% of visits covered by Medicaid
- 91% are African-American and Hispanic
- 75 % live under the federal poverty level
- 70,000 are uninsured--pay on a sliding scale

ACCESS Significance

- Largest FQHC in the country
- More primary care medical visits for low income patients than the Cook County system
- More primary care for uninsured patients than any private sector provider
- Largest provider of Medicaid primary care, both in the city and in the suburbs

ACCESS Quality

- Joint Commission accredited since 2000
- United Way Quality Award 2007, 2008
- 8 of 9 Blue Cross "stars" for quality
- 15 NIH supported research collaborations
- Specialty care, behavioral health, addictions medicine on site
- Affiliations and admitting relationships with 20+ hospitals and health systems

Access

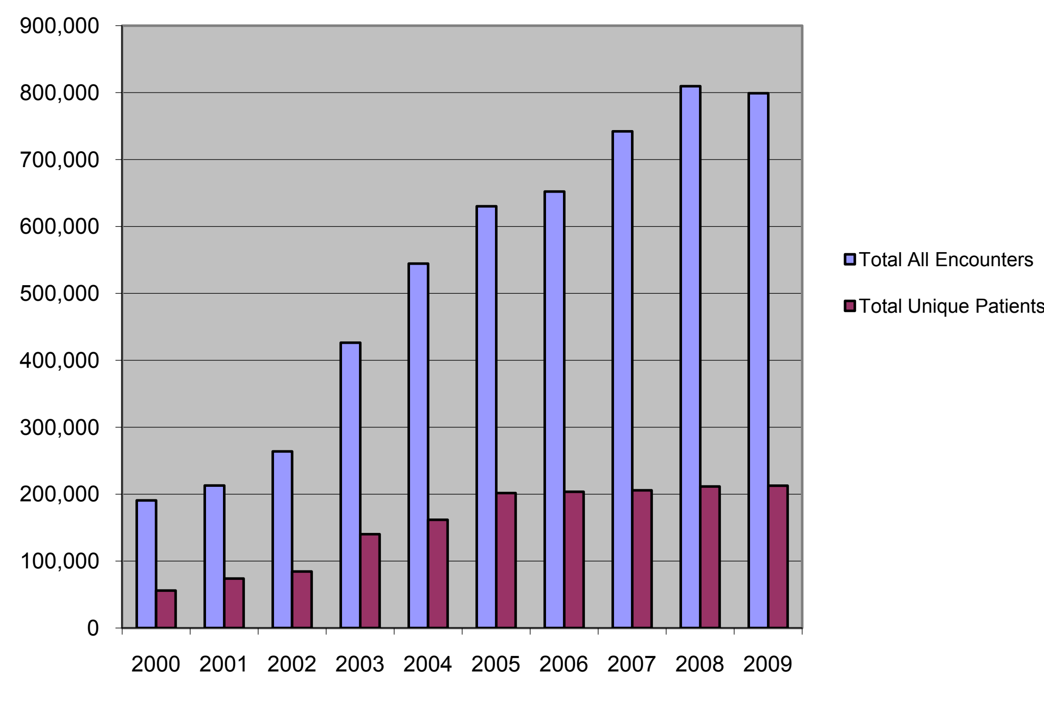
FQHC at a Glance

- 40-year old federal program
- Target for recent ARRA and health reform investment
- Unique characteristics
  - Community based board
  - Sliding fee scale for uninsured
  - Federal grant and enhanced Medicaid rate
  - Programs tailored to community need

Changing Face of Underserved

- Original 9 sites developed to serve public housing residents—some of the poorest areas in the nation
- Late 1990s—rise in immigrant patients, suburban underserved
- ACCESS physicians speak 34 languages including sign language
- Expanded hours—as late as 10 pm—reaching workers and their families

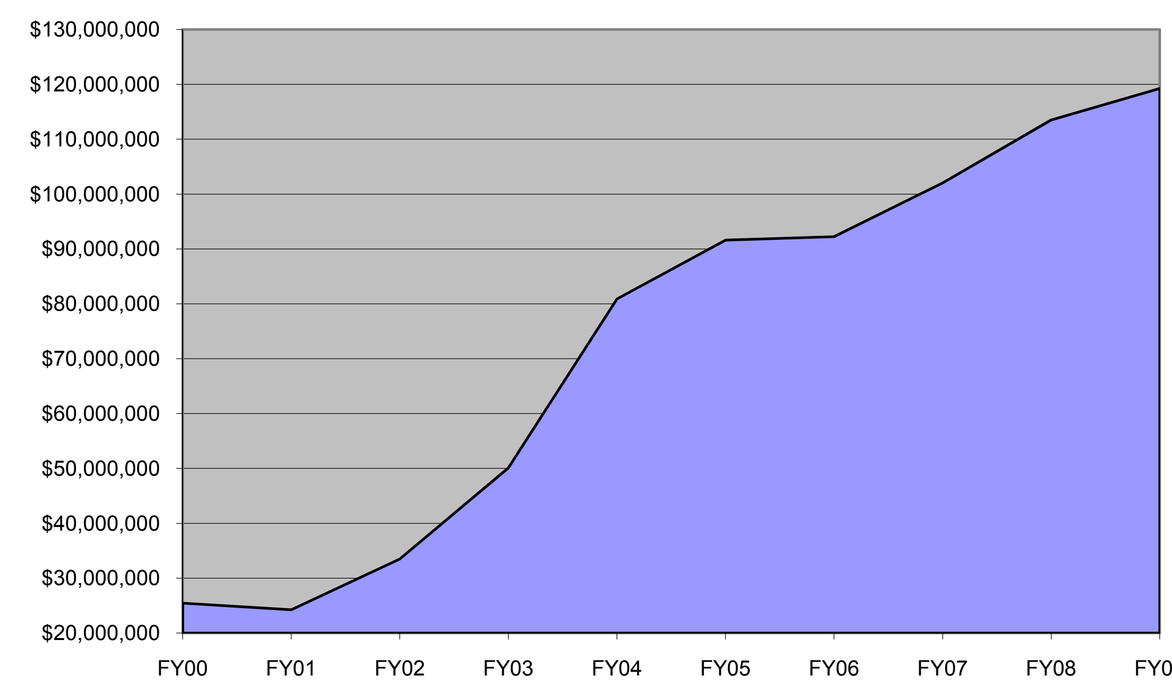
Growth History



Disciplined Business Model

- Strategic goals with organization-wide clinical, financial and growth metrics
- Baldridge process improvement framework
- Alignment of employee and physician compensation—tied to quality
- Business affiliations with hospitals and health systems with a financial stake in our success
- Employee career ladders; tuition reimbursement plus 10 annual $10K competitive scholarships

A Decade of Revenue Growth



Medical Home/Care Continuum

- Medical home model—prevention, wellness
- On-site behavioral health services, integrated into primary care
- Group visits; diabetes learning “grocery”
- ACCESS physicians/ midwives cover labor & delivery and newborn nurseries
- State of the art Epic electronic medical record by late 2010

ACCESS

Vision—Sustainable Delivery

- Continued growth to provide a high quality medical home for patients and families
- Expanded continuum of care through **partnerships with health systems—strong business models, sustainable together**
- Delivery of care aligned to changing population needs—
  language, culture, hours, scope of service
- Quality supported by research, teaching
- Infrastructure for national scale Pin-A-Sister/Examinate Comadre program

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