Healthcare Reform is Coming to the Southwest... But What About Substance Use and Co-Occurring Disorder Treatment Providers?

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What are the implications for Organizations that provide SU/COD Services?

- SU/COD Provider organizations need to become deeply embedded in the healthcare ecosystem with a choice of three doors they can walk through
  1. Integration with Health Homes
  2. High Performing Specialty MH/SU/COD Provider (being seen as the Mayo Clinic of Behavioral Health in your Community)
  3. High Performing Specialty Substance Use Disorder Treatment Provider
My Hypothesis about SU/COD Providers

<table>
<thead>
<tr>
<th>Point A</th>
<th>&quot;As Is&quot; Programs and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Healthcare Reform Readiness Assessment and Improvement Plan</td>
</tr>
<tr>
<td></td>
<td>Internal Improvement Activities (Rapid Access, Treat to Target, Recovery Successes...)</td>
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<tr>
<td></td>
<td>External Initiative Activities (Best Friend with HC CEOs, ACO Building, etc...)</td>
</tr>
</tbody>
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| Point B: January 2014 |
| --- | --- |
| Internal Failure/External Success |
| Early Success with Health Homes, ACOs; Not Sustainable |
| Health Home Involvement, High Performing Health Neighbor, Valued ACO Member |
| Internal/External Failure |
| Loss of Funding, Loss of Referrals, Death Spiral |
| Less Funding, Fewer Referrals; Partial Success as a Health Neighbor |

Door 1: The Integration of SU/COD/Primary Care
Substance Use Disorders and the Person-Centered Healthcare Home

The “Other” Four Quadrant Clinical Integration Model

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/SU Risk/Complexity Low</td>
<td>MH/SU Risk/Complexity High</td>
</tr>
<tr>
<td>Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP</td>
<td>Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP</td>
</tr>
<tr>
<td>MH/SU clinician/case manager or responsibility for coordination at PCP</td>
<td>Nurse case manager at MH/SU site</td>
</tr>
<tr>
<td>Specialty outpatient MH/SU treatment including medication-assisted therapy</td>
<td>MH/SU clinician/case manager</td>
</tr>
<tr>
<td>Residential MH/SU treatment</td>
<td>External care manager</td>
</tr>
<tr>
<td>Crisis/ED based MH/SU interventions</td>
<td>Specialty medical/surgical</td>
</tr>
<tr>
<td>Wellness programming</td>
<td>Specialty outpatient MH/SU treatment including medication-assisted therapy</td>
</tr>
<tr>
<td>Other community supports</td>
<td>Residential MH/SU treatment</td>
</tr>
<tr>
<td>Crisis or ED based MH/SU interventions</td>
<td>Crisis/ED based MH/SU interventions</td>
</tr>
<tr>
<td>Detox/sobering</td>
<td>Detox/sobering</td>
</tr>
<tr>
<td>Medical/surgical inpatient</td>
<td>Medical/surgical inpatient</td>
</tr>
<tr>
<td>Nursing home/home based care</td>
<td>Nursing home/home based care</td>
</tr>
<tr>
<td>Wellness programming</td>
<td>Wellness programming</td>
</tr>
<tr>
<td>Other community supports</td>
<td>Other community supports</td>
</tr>
</tbody>
</table>

Each quadrant considers the behavioral health and physical health risk and complexity (low to high) of the population.

Generally...

Persons in Quadrants I and III should receive BH services in Primary Care.

Persons in Quadrants II and IV should receive PC services in Behavioral Health.
The Importance of Bi-Directional Integration

Person-Centered Healthcare Home Development

- Fully Integrated or Focused Partnership Healthcare Home
- Supporting Mental Health and Substance Use Services in Primary Care

- CBHO with Embedded Medical Clinic
- Providing Primary Care Services in Community Behavioral Healthcare Organizations

Bi-Directional Primary Care/SU Services

SU Services in Primary Care

- Diffusion of screening and brief intervention (SBI) is underway
- Motivational interviewing with fidelity should be a consistent component of SBI
- Repeated BI in primary care is a promising practice
- Medication-assisted therapies in primary care can be expanded
Bi-Directional Primary Care/SU Services

Primary Care in SU Settings
- Many individuals served in specialty SU have no PCP
- Health evaluation and linkage to healthcare can improve SU status
- On-site services are stronger than referral to services
- Housing First settings can wrap-around MH, SU and primary care by mobile teams
- Person-centered healthcare homes can be developed through partnerships between SU providers and primary care providers
- Care management is a part of SU specialty treatment and the healthcare home

Key Integration Tasks and Skill Sets

Patient Centered Healthcare Homes
- Cradle to Grave Well Care (Prevention) and Sick Care

Community Health Teams
- Connect patients to primary care, get to appointments, transition from hospital, stay in their homes, etc.

Hot Spotting
- Identify and engage the 5%/50% population

Complex Care Management
- Help patients with chronic health conditions self-manage their care and move toward health

Housing, Social Supports
- Efforts to Address the Social Determinants of Health
Community Health Teams
(The Vermont Blueprint for Health)

- Connect patients to primary care
- Track patients overdue for appointments or tests
- Help patients being discharged from hospitals
- Health and nutrition coaching

Camden NJ’s Hot Spotting
Camden NJ: Hot Spotting

- Police Hot Spotting: Jeffrey Brenner turned the idea towards the analysis of patient flow and healthcare expenditure patterns.
- Two most expensive city blocks, 900 people, accounted for 4000 hospital visits, 200 hundred million in healthcare costs over a 5 year period.
- 1% of 100,000 people used 30% of costs
- Implemented the equivalent of Ambulatory ICUs

Care Management in Missouri

Mental Health Community Case Management and Its Effect on Healthcare Expenditures

After a brief spike in costs during the CMHCM enrollment month, the graph shows a steady decline over the next year of $500 PUPM, even with the overall costs now including CMHCM services.

Joseph J. Parks, MD; Tim Swinford, MS; and Paul Stuve, PhD
Doors 2 & 3: Being Seen as a High Performing Specialty Provider

1. Relationship Building
2. Local Health Assessment and Improvement Plan
3. Local Accountable Care Organization Development
4. State Planning and Decision-Making
5. Internal Education
6. Community Education and Awareness
   1. Resilience & Recovery are Deeply Embedded in Our Culture
   2. Rapid Access to Care
   3. Use of Evidence-Based Practices and Programs
   4. Consumer Engagement and Person-Centered Care Planning
   5. Care Management for High-Need Consumers
   6. Trust to Target
7. High Performing Mental Health/Substance Use Provider
8. Health Home Development
9. Information Technology
10. Quality Improvement Infrastructure
11. Revenue Cycle Management
12. Value-Based Purchasing
13. Compliance Plan
   1. Workforce Expansion
   2. Federal Policy Implementation
   3. Enrollment Strategy

Success in the New Healthcare Ecosystem
Five Readiness Areas

High Performing Specialty Providers

Health homes and payors will be looking to buy services from centers of excellence in MH/SU/COD services. Goal Statement: We aspire to be seen as the Mayo Clinic of MH/SU and/or COD services in our community and are widely recognized as a high-performing provider of quality services. We are able to demonstrate our effectiveness through the widespread use of clinical tools that measure key performance indicators.
The Role of SU/COD Providers as Wellness and Recovery Centers

- Distinctive Competence and Competitive Advantage for SU Providers
  - Ability to provide a true “holding environment” for persons with serious SU/COD disorders
  - That help consumers towards wellness and inclusion in society
  - Which are the two components necessary to bend the cost curve

Like a Good Neighbor...

The Behavioral Health Provider community can accelerate their efforts by tapping into the work of the medical home folks, medical specialists, and ACO designers
The Health Home Neighbor

- A provider that partners with a health home to deliver specialty, subspecialty, or inpatient care
  - Health homes’ mission is to provide and coordinate comprehensive care
  - Specialty, subspecialty, and inpatient care are beyond many health homes’ delivery capabilities

American College of Physicians’ PCMH-N principles

- The health home & the specialist should:
  - Determine type(s) of clinical relationships they are willing to enter into:
    - Preconsultation exchange ("curbside consult")
    - Formal consultation
    - Co-management
    - Transfer to specialty care
  - Formalize the structure of these relationships through care coordination agreements
    - With financial and nonfinancial incentives to encourage specialist’s participation
ACP’s PCMH-N principles

- To be recognized as a neighbor, specialists must demonstrate competency around:
  - Communication, coordination, & integration
  - Timely consultations & referrals
  - Timely, effective exchange of clinical data
  - Effective participation in co-management situations
  - Patient-centered care, enhanced care access, and high levels of care quality and safety
  - Supporting the health home practice’s work

Two Essential Components: Access and Outcomes

Area II: High Performing Providers – Access and Outcomes

1. Readiness and Resource are Deeply Embedded in Culture: Every person who works in our organizations has a deep understanding of the business and financial costs or disease and discrimination, and peers work with mental health and substance use disorders, along with other conditions, to build a culture of care that is centered on the patient. To build trust, articulating the themes and barriers are important components of MHS conditions, and ensuring continuity is essential to building resiliency and recovery for therapy and medication.

2. Real Access to Care: Now or anytime circumstances can lead access to appropriate care. Video conferencing is an important way to ensure care can be delivered in multiple settings and contexts.

3. Two Elements of Readiness and Performance: We have seen a trend toward increasing access to care in our organization. Access to care is increasing for our patients.

4. Focus on Specific Patient Groups: We have identified access in multiple settings and contexts.

5. Target Goals: Most of our objectives are a “priority target” approach to planning, service delivery, and evaluating the specific plan. However, the majority of our objectives are also evidence-based, focusing on the goals of our patients. This can involve a qualitative evaluation of care and programs, identifying the challenges and strengths of our programs, and working with patients to complete the care plan if needed.
Rapid Access to Care

- Can ACOs and Health Homes get their patients into specialty SU/COD care with same day/next day access for high risk, high need patients?

New Patient’s first Visit to PCP includes behavioral health screening

Possible BH Issues? 

YES

Behavioral Health Assessment by BH Professional working in primary care

Need BH Svcs?

YES

Clients with Low to Moderate BH need enrolled in Level 1: to be case managed and served in primary care by PCP and BH Care Coordinator with support from Consulting Psychiatrist and other clinic-based Mental Health Providers

Clients with Hi Moderate to High need referred to Level 2 specialty care; PCP continues to provide medical services and BH Care Coordinator maintains linkage; this is a time-limited referral with expectation that care will be stepped back to primary care

Referrals to other needed services and supports (e.g. CSO, Vocational Rehabilitation)

Demonstrable Outcomes

- Are we helping our clients get better (symptom reduction, functional improvement, recovery) and can demonstrate this improvement with data?
A New Standard of Care - Treat To Target

Collaborative Care for Patients with Depression and Chronic Illnesses

New England Journal of Medicine, December 30, 2010

• Research is showing that co-location of primary care and behavioral health is critical for addressing the needs of persons with complex health and behavioral health conditions
• The emerging standard of care is Evidence-Informed, Team-Based, Treat to Target Clinical Interventions
  – Multi-dimensional assessment and diagnosis
  – Evidence-Informed care plan with collaborative self care plan and measurable targets
  – Frequent measurement (labs, PHQ-9, etc.) (every visit for some!)
  – Change the care plan if targets are not being met

Community Health Center Outcomes
(6 clinics; over 2,000 clients served)

<table>
<thead>
<tr>
<th>Population</th>
<th>Mean baseline PHQ-9 depression score</th>
<th>Follow-up (%)</th>
<th>Mean number of care coordinator contacts</th>
<th>% with psych consultation</th>
<th>% with significant clinical improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disab. Lifeline</td>
<td>16 / 27</td>
<td>92%</td>
<td>8</td>
<td>69%</td>
<td>43%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15 / 27</td>
<td>83%</td>
<td>8</td>
<td>59%</td>
<td>50%</td>
</tr>
<tr>
<td>Older Adults</td>
<td>15 / 27</td>
<td>92%</td>
<td>8</td>
<td>55%</td>
<td>43%</td>
</tr>
<tr>
<td>Vets &amp; Family</td>
<td>15 / 27</td>
<td>92%</td>
<td>7</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Mothers</td>
<td>15 / 27</td>
<td>81%</td>
<td>7</td>
<td>50%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Data from Mental Health Integrated Tracking System (MHITS)
But What About Free Standing Addictions Providers?

- Is there a place for you in the new healthcare ecosystem?
- Will you simply be road kill as the wheels of disruptive innovation turn?
- Let’s look at a few Tom McLellan slides and then decide

Current Referral Sources (National Data)

<table>
<thead>
<tr>
<th>Source</th>
<th>1990</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Justice</td>
<td>38%</td>
<td>59%</td>
</tr>
<tr>
<td>Employers/EAP</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Welfare/CPS</td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>Hosp/Phys</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Expect a major increase in referrals from the healthcare system and primary care becomes responsible for outcomes!
The Achilles Heels of the System

**Why CAN’T Programs Deliver Quality Care?**

- The Infrastructure
- Acute Care Treatment Model
- The Evaluation Model

Infrastructure Challenges

**STAFF TURNOVER!**

- Counselor turnover 50% per year
- 50% of directors have been there Less Than 1 year

**Other Staff**

- 54% Had no physician
- 34% Had P/T physician
- 39% Had a Nurse (part of full time)
- < 25% Had a SW or a Psychologist
- Major professional group - Counselors
The Acute Care Model

Contrasted with a Continuing Care Model

- Modeled on the approach use to treat chronic health conditions such as hypertension, diabetes and asthma.
FDA-Level Evidence

**Therapies**
- Cognitive Behavioral Therapy
- Motivational Enhancement Therapy
- Community Reinforcement and Family Training
- Behavioral Couples Therapy
- Multi Systemic Family Therapy
- 12-Step Facilitation
- Individual Drug Counseling

**Medications**
- Alcohol (Disulfiram, Naltrexone, Acamprosate)
- Opiates (Naltrexone, Methadone, Buprenorphine)
- Cocaine (Disulfiram, Topiramate, Vaccine?)
- Marijuana (Rimanoban)
- Methamphetamine – Nothing Yet

- Treatment is moving from the residential setting to the outpatient setting
- There will be much more treatment with a significant portion being provided in Health Homes

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Questions

- Are you transitioning from an acute treatment model to a chronic care model? (e.g. do you have what the payors are wanting to buy)
- Are you partnering with Health Homes (both primary care and CMHC Health Homes)?
- Do you have the attributes of a good Health Neighbor?
- Are you seen as the Mayo Clinic of specialty addictions treatment in your community?