New York Association of Alcoholism and Substance Abuse Providers

The Crucial Role of Substance Use Disorders Services In a Health Home: Improving Outcomes and Reducing Costs

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I. Introduction

The passage of the Affordable Care Act (ACA) presents an historic opportunity to transform the current fragmented and segmented health care system into a more person-centered, integrated whole. Recognizing that chronic care delivery models are more attuned to meeting actual patient needs, and that accessible primary care, with its emphasis on preventive care, case finding and care management, is essential to quality care, is essential to assure that the transformed systems of care are at once more effective and less expensive. The New York Association of Alcoholism and Substance Abuse Providers, Inc (ASAP) welcomes the paradigm shift underway in New York that views addiction as a chronic relapsing disorder that should be addressed by scientifically sound public health policies.

Substance use disorders (SUDs), and related substance use conditions, have profound effects on the health of individuals, families and communities. The extent of these effects on health care quality and costs has only recently come into clearer focus. A study by the Center for Health Care Strategies of 30 day hospital readmission rates among 941,000 persons receiving Medicaid coverage, for example, found that SUDs were the third most prevalent chronic condition accounting for readmission. Persons with a substance use disorder diagnosis were 37% more likely to be readmitted. Alarmingly, New York State was ranked in the second highest tier of state 30 day readmission rates (Gilmer and Hamblin, 2010). The New York State Department of Health's own analysis revealed that 82% of the Medicaid patients readmitted to the hospital within 30 days had mental health/substance abuse conditions (MH/SA), with 59% of those patients readmitted for medical reasons (NYSDOH, 2011). To reverse the negative health and fiscal consequences of untreated addiction, it is imperative that screening, brief intervention, referral, and a comprehensive continuum of SUD treatment services become a core service in the delivery in health homes and other primary care settings.

The Health Home state plan option of the ACA, which encourages states to establish comprehensive health homes for individuals with one of six chronic conditions (including SUDs) who are at risk to develop another chronic condition, is an enormous opportunity to change the way care is currently delivered in New York. The "health home model of service delivery", as described in the November 6 CMS letter to the State Medicaid Director, encompasses "…all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions". Consistent with the aims and recommendations of the Institute of Medicine's Crossing the Quality Chasm series (IOM, 2006), the ACA's creation of the health home option pushes the health care industry to integrate the behavioral health needs of individuals with chronic health conditions into its service mix, and to address the destabilizing effects of social factors such as homelessness and vocational preparation in treating the "whole person".

The prevention, treatment, and recovery services organizations represented by ASAP are prepared to play an essential role in New York State's transformation process. The continuum of services that we represent has significant strengths that can be employed in the creation of health homes:

- It is the second largest substance abuse service delivery system in the country (NYSOASAS, 2010):
    - The OASAS-certified system consists of more than 1,700 prevention, treatment, recovery, and other programs from 665 provider agencies:
    - 1,070 chemical dependence treatment programs;
    - 337 chemical dependence and gambling prevention programs;
    - 27 gambling treatment programs
    - 56 program support programs (Including Criminal Justice Intervention/DWI, Road to Recovery and AIDS Resource Services);
    - 67 permanent supportive housing programs, operated by 48 voluntary agencies (including 46 Shelter Plus Care programs and 6 upstate permanent supportive housing programs);
    - 218 treatment support programs (Including Case Management, Vocational Rehabilitation and Managed Addiction Treatment Services [MATS]).
- Its providers cover the full continuum of care for SU-related conditions, and many have complementary health and mental health licensures to their OASAS certification.
- It has expanded its programming to address the frequent correlates of addiction, such as HIV/HCV infection, co-occurring mental health disorders, housing and vocational deficits, and alternatives to incarceration services.
- It has adopted a "whole person" paradigm as expressed in the principles of a Recovery Oriented System of Care (ROSC).
- It occupies a strategic position at the interface of social service, criminal justice and child welfare services, all of which impact on health care costs and outcomes.
- Its OASAS-required data reporting system, the Client Data System, provides a detailed profile of each individual in its care, which, when linked to DOH's EMed data sets, creates a multi-dimensional view of individuals with a chronic SUD.

Given the strengths enumerated above and significant empirical data supporting the ability of our service system to accomplish better health outcomes while driving down costs, ASAP envisions a critical role for its service providers in the development of health homes in New York. This paper will outline health home models that capitalize on the unique strengths and capabilities of ASAP service providers, deliver better health outcomes for persons suffering from chronic diseases targeted by the ACA, drive down the number of unnecessary hospital admissions, and drive down the cost of healthcare for persons previously consuming services at levels of care that were inefficient and ineffective.

While more detailed descriptions of the operating methods and inter-agency structures governing health homes must await further discussion among the state agencies and their provider networks, articulation of guiding principles for the delivery of substance use care within health homes can provide some early consensus on future direction. ASAP's recommendations for Guiding Principles follow.

II. Guiding Principles for Implementing Health Homes for Persons with Substance Use Conditions

1. **All Health Homes must have the capacity to screen all members for substance use conditions, provide brief counseling where indicated and effect referrals to treatment where necessary.**
   The success of HHs in providing comprehensive care management and reducing costs hinges, in part, on the capacity of these entities to conduct case finding and preventive services for all populations with chronic health conditions. A consistent finding in studies of persons with chronic health conditions is that people with either a chronic behavioral or physical health condition are more likely to have both a chronic behavioral and physical health condition, when compared with individuals who do not have a chronic condition. Furthermore, it is common for persons with substance use disorders to minimize or deny that their use is a problem. In SAMHSA's 2009 National Survey on Drug Use and Health, of the 23.5 million people in need of addiction treatment, 95% reported they did not feel they needed treatment (SAMHSA, 2010). For the HHs to provide the comprehensive care management needed for persons with any of the 5 targeted chronic conditions other than SUDs, it is essential that an active screening, case finding, intervention and referral process for substance use conditions be in place. The HH can provide these services directly or partner with an OASAS certified provider to deliver these services on site.

2. **The full continuum of treatment options, from Detox through Intensive Residential and Recovery Support Services must be available within the HH. Similarly, the HH must offer a full range of treatment options, including Medication Assisted Treatment and psychosocial counseling services.**

3. The National Quality Forum's publication, *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices* specifies standards that can serve as a basis for determining the adoption of evidence-based practices in the treatment of substance use conditions in HHs (NQF, 2007).**Given the prevalence of SUDs and conditions among the target populations, substance use-related measures must be included in the core set of quality and performance metrics for Health Homes.** A failure to include substance use-related measures in the core set for monitoring and evaluating HH performance will almost certainly diminish the quality and the availability of these services for these target populations. The National Quality Forum and the AHRQ measures clearinghouse have candidate measures that can be used to monitor the quality of substance use care delivered within the HH.

4. **Substance abuse services to HH patients must be delivered by OASAS-certified providers.**
   The ACA statute and the CMS guidance seem clear that the purpose of the health home is to create a comprehensive, integrated care management structure for persons with

complex chronic conditions. Hiring a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) onto a primary care team that operates outside of the legal authority of OASAS to monitor, regulate and evaluate the delivery of substance abuse care does not meet the stated purpose of the health home. Suitable inter-agency agreements, such as out-stationing an OASAS certified provider's staff into a primary health care setting, or the reverse co-location strategy of primary care personnel working at an OASAS provider site, can meet the standard of integrated care management and utilize the strengths of the primary and the specialty care systems.

III. Health Home Models

Given the prevalence of unhealthy substance use and substance use disorders among persons with chronic health conditions and/or serious mental illness, OASAS providers will play an essential role in whatever HH models are adopted.

This paper will outline three models in which OASAS-certified providers play distinct roles: The Behavioral Health Home Operator (BHHO: SUD), in which an OASAS-certified provider becomes the operator and care manager for a particular set of patients; the Behavioral Health Home Partner (BHHP: SMI), in which an OASAS-certified provider joins with an OMH provider to deliver care management services to persons with serious mental illness, addictive disorders and chronic health conditions; and the Health Home Partner(HHP: PH), in which an OASAS-certified provider joins the care management team of an established Health Home to provide a range of substance use and related services to the HH members.

It is important to note that there is considerable variability in the type of arrangements and the range of services that fit within these basic descriptions. For example, a BHHO may be a hospital-based opioid treatment program, or a community based treatment provider with multiple licenses and a long history of providing primary care and wraparound services. The HHP models may offer even greater opportunity for variations based on provider capacity and expertise. For example, an HH might include an OASAS-certified provider with a strong Permanent Supportive Housing component that may provide ongoing case management services for persons in early stages of recovery. Alternatively, an OASAS-certified outpatient provider may offer an outstationed behavioral health consultant to conduct SBIRT services and manage the bidirectional flow of information between the primary and specialty care sites.

Behavioral Health Home Operator Model: Substance Use Disorders (BHHO: SUD)

A BHHO operated by an OASAS-certified provider would provide care management services to individuals with a chronic Substance Use Disorder and an accompanying chronic health condition or serious mental illness. What differentiates the member profile of this substance abuse BHHO from other Health Homes is the complex case management needs of the patients, as evidenced by their long history of addiction and their ongoing involvement with the criminal justice, social welfare, housing and vocational systems of New York. This BHHO will have extensive experience in navigating these systems with their clients, and have established strong

relationships with these systems' providers so that an integrated care team is possible. Some of the attributes of this BBHO are:

1. Certification by OASAS and DOH, (and possibly OMH);
2. A full continuum of substance abuse services and modalities, and the ability to manage particularly difficult care transitions (e.g., inpatient Detox to outpatient specialty care settings; transition from prison or jail to community-based primary and specialty care);
3. A medical staff knowledgeable about addictive disorders, including the use of all FDA-approved addiction medications, and trained in recovery-oriented interventions;
4. Implementation of Recovery Oriented System of Care Principles, including peer-based services and recovery coaches;
5. Dual Disorder Capable programming;
6. A direct capacity or strong networked capacity to deliver essential wraparound services, including, housing, social welfare and vocational services;
7. A direct capacity to integrate criminal justice representatives into the BHH care team, where necessary;

The BHHO would have a primary care capacity, including an assigned primary care physician for each patient, care managers, wellness programming, tracking and disease registries for health status reporting and an EHR to facilitate communication among the primary care team with specialty care services. The BHHO would have sufficient psychiatric capacity to meet the mental health needs of its patients, and strong affiliations and collaborative arrangements with community-based mental health services, including psychosocial support programs.

The Behavioral Health Home Partner Model: Serious Mental Illness (BHHP-SMI)

This model is specifically designed to respond to the complex needs of persons with severe mental illness and substance use disorders. In this model, the OASAS-certified provider would join with an OMH-licensed provider to deliver integrated substance abuse treatment services within the community behavioral health clinic that is also a BBHO. The attributes of the BHHP will be similar to the substance abuse BHHO described above, however the delivery arrangements and responsibilities might be different. For example, the BHHP may provide opioid treatment services at the mental health clinic for those patients with opioid dependence, or arrange to provide screening and brief intervention services at the clinic to all HH members without an SUD diagnosis. An OASAS-certified provider with a strong housing program may join with the mental health BHH to provide a more comprehensive continuum of housing options to clients, including recovery-oriented housing and community residences.

The exact set of arrangements and services in this partnership is contingent to a large degree upon the capacities and resources of the individual providers. As a model, however the Behavioral Health Home for persons with serious mental illness in which OASAS-certified providers are partners (i.e., BHHP) is a viable and important structure for the most complex patients to be served by a Health Home.

The Health Home Partner Model: Physical Health (HHP: PH)

OASAS-certified providers will be vital partners in Health Homes designed to treat patients with two chronic physical health conditions. In this model the HHP: PH may provide services to manage substance use conditions at the pre-diagnostic (such as unhealthy alcohol use) as well as the diagnostic level (such as prescription drug abuse). It may provide pre-consultation and consultation services or SBIRT services to Health Homes whose patients have mild to moderate substance use conditions but complex physical health needs. It may outstation a behavioral health consultant to the primary care HH site to conduct on-site consultation, counseling services and referral facilitation between the HH and the HHP. Alternatively, it may enter into an arrangement with the HH to accept on-site primary care personnel to address the primary care needs of HH patients enrolled in the HHP's substance abuse treatment.

The HHP may accept higher levels of care management responsibilities for a cohort of HH patients, based on the HHP's unique capacities. For example, an HHP with a strong family association may take on added responsibility for educating HH family members about their loved one's conditions. An HHP with a strong housing component may take on added case management duties for HH patients with housing needs. The collaboration between the physical health home and the HHP would build on the unique capacities of each partner to meet the complex needs of these patients. Since many OASAS-certified HHPs will have strong relationships with the criminal justice system, they may play a key role in transitioning individuals from prison or jails to community-based health care, and interfacing with the criminal justice agencies such as parole and probation on the status of the HH member.

III. Conclusion

The OASAS-certified services network is committed to working with OASAS, DOH, and the Governor's office to implement health home models in NYS that improve the health status of service consumers while making efficient use of services and resources, particularly as increased emphasis is placed on treatment for substance use disorders as a major strategy to reduce overall health care costs while driving better results. ASAP has outlined, in this document, health home models appropriate for each of the six chronic conditions targeted by the ACA. Substance use disorder service providers have already begun to develop service designs and partnerships as initial steps for building health homes and are willing to help establish a new reputation for NY as a visionary/early adaptor state that will produce desired health outcomes.

If adopted, the guiding principles proposed by ASAP provide an excellent cornerstone for functional, effective and sustainable Health Homes for persons suffering with one or more of the six chronic conditions targeted by the ACA. These principles would predispose NYS to have success with health homes.

The exciting promise of a transformed system of health care with behavioral health services and enabling social services woven together in a team-based approach that treats the whole

person will require the patience, sustained attention and resources of the state to make health homes a functioning reality. The transformation to an integrated HH model for persons with multiple chronic physical and behavioral health conditions will not be easy or immediate. It will require the adaptive resources of the state to foster a shared learning environment for HH providers and the rapid application of lessons learned. It will also require federal and state support to ensure that service providers have all resources necessary to staff new care management responsibilities and to create the required HIT infrastructure.

ASAP and its members welcome this opportunity, and applaud the state's pursuit of the State Plan Amendment needed to create health homes. ASAP members will be active proponents of integrated care solutions to meet the complex needs of persons with substance use disorders, and strong partners in bringing these solutions to scale.

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