



FORUM ON INTEGRATION

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PURCHASING INTEGRATED SERVICES FOR
SUBSTANCE USE CONDITIONS IN HEALTH
CARE SETTINGS

An Issue Brief on
Lessons Learned and Challenges Ahead

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Acknowledgments

Mady Chalk, M.S.W., Ph.D.
Director
Center for Policy Research and Analysis
Treatment Research Institute

Joan Dilonardo, Ph.D.
Consultant

Suzanne Gelber Rinaldo, M.S.W., Ph.D.
President
The Avisa Group (Consultant)

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Introduction

With funding from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT), the Center for Policy Research and Analysis at the Treatment Research Institute (TRI) is exploring the challenges, opportunities, and promising practices associated with financing, purchasing, and implementing appropriate treatment for substance use conditions in primary care and other health care settings. TRI is an independent, nonprofit research organization dedicated to science-driven reform of policy and treatment for substance use conditions.

This report summarizes the discussions of the second TRI Policy Forum on Integration, held in February, 2011. The first Forum held in 2010 focused on successful program models that integrate substance abuse services into a variety of health care settings serving diverse populations with the goal of learning more about the clinical arrangements and the business case for this innovation. This second Forum was more broadly directed at identifying how purchasers and payers including States, Counties, and large health plans are purchasing and promoting integration. Moreover, the Forum was aimed at understanding the leadership processes, alliances, and financing arrangements that could facilitate integration as well as common barriers and how these might be overcome, with the hope that such lessons would assist other purchasers who embark on integration efforts.

For specific details about each State, County or health plan program the reader is referred to the matrix in Appendix 1; Appendix 2 lists the Forum participants. What follows below is a summary of the major themes that emerged during the Forum discussions.

Integration and Primary Care

The integration of mental health and substance use (behavioral health) screening and treatment into primary care and other health care settings continues to represent a sea of change for substance use and/or mental health/ behavioral health services and workers. The move away from services that are largely segregated and separated from the rest of health care into close collaboration, co-location and/or integration in health care with a workforce in a similar relationship to primary care as is seen in other medical specialties, i.e. cardiology, neurology, endocrinology, represents perhaps the largest system level change to occur in the last decade.

Care integration implies the elimination of the separate and disparate systems of care for mental health and substance abuse disorders that often operate independently of each other with little communication or collaboration. Some believe that bi-directional integration is critical for improving patient care and containing costs, although State authorities may differ in the extent to which they see full integration as desirable. While after passage of health care reform some debate remains, there is a clear expectation that the changes brought about by health care reform are likely to significantly impact the way mental health and substance use services are delivered and financed. Although health care

reform legislation only mentions mental health and substance use services briefly, Forum attendees generally endorsed the emphasis of the Affordable Care Act (ACA) on system expansion, payment and delivery reform, and the elimination of poorly delivered care and pointed out its exceptional significance for mental health and substance use treatment and prevention.

Clearly, the emphasis on health homes (fully integrated, patient-centered care) found in the ACA is being viewed by the fields of healthcare, mental health and substance use treatment as a move toward integration. In addition to such full integration, the other types of substance use treatment services which have received a significant amount of attention in integration initiatives are SBIRT (screening, brief intervention, and referral to treatment), brief counseling in primary care, medication-assisted treatment (MAT), especially the use of buprenorphine and injection naltrexone for opioid addiction, and treatment of co-occurring mental health and substance use disorders.

As we move towards integration, a number of questions become important: What are the successful financing and purchasing models that support and underpin successful and continuing implementation of integrated care? What leadership processes at the State, County and health plan level lead to successful integration? As treatment services are integrated, who are the new patients that health care and behavioral healthcare settings will be serving that they are not currently serving in their separate and isolated services configuration? What kind(s) of care will these “new” patients need, how will that care be financed, and how many and what types of workers are and will be needed to deliver care and implement these new models? How can the workforce be developed? What will the continuum of care look like and what are the care pathways? How will care be facilitated by technology and how will quality be monitored and improved?

Theme I: Understanding the View from the Primary Care Perspective.

The first and most important theme identified during the Forum related to the importance of understanding the primary care perspective of integration. Successful attempts by State, County and large private insurers to integrate mental health and substance use treatment services into primary care are those in which the needs of the medical care setting are considered primary.¹ More simply, the needs of these medical care settings drive successful integration processes; the mental health and substance use services and

¹ The group took the position that with the exception of small specific groups of patients with very serious MH/SA disorders, the direction of integration would be predominantly into other health care settings, rather than integration of primary care in MH/SA settings.

workers need to be viewed and to view themselves as supporting implementation in medical care settings. Thus, an essential aspect of successful integration is to assess the characteristics of integration that primary care and other medical settings view as essential to their efforts, *i.e.*, how can integration be seen as solving an existing problem in primary care. Approaches based on how substance abuse treatment services can be shoehorned into primary care and other medical settings are likely to fail. Specialty treatment services and clinicians need to be able to support primary care settings and staff with what providers and clinicians think they need to support integrated care. This may involve new services or an enhanced workforce and may not be what specialty care thinks primary care needs. Of necessity, this may also involve educating primary care or other medical settings and their staff about the efficacy and cost effectiveness of the practices to be integrated. And, each of the integration models will need to be implemented in a way that fits with relative ease (at least initially) and presents a minimal burden on the existing primary care organizations and clinicians and does not present a significant challenge to the treatment culture of the primary care or other medical care setting.

Bringing Value to Primary Care: Comprehensive Services and Quality Mandates

Strong support was expressed for providing more comprehensive behavioral health services (combining substance use services with mental health or other behavioral health/behavior change services, such as services for depression, smoking cessation, and obesity). Provision of comprehensive services is viewed as more efficient and increasingly is valued more highly in primary care and other health settings than are screening and brief treatment for substance use services alone. For example, if a primary care practice, community health center, or Federally Qualified Health Center (FQHC) has a group of patients who is opiate addicted, integration of medication-assisted treatment into such a setting may be viewed as assisting the staff to deal with problematic patients. Or, screening and brief interventions for at risk substance use patients may be accompanied by screening for nicotine use or depression if that is the way the problems of the patient population are experienced by the staff within a specific medical care setting. This may be especially true as integration focuses on broad processes and whole patients, rather than narrow interests or segmented parts of patients.

Emphasizing the benefits for providers with challenging patients or patients with specific types of disorders is essential, as is collaboration between organizations that routinely share a significant number of the same patients. In the public sector, we can do much more than we are currently doing to encourage closer collaboration and development of networks between Federally Qualified Health Centers, Community Mental Health Centers, and specialty substance abuse treatment programs located in the same general geographic area to facilitate integration.

Providers in primary care and other health care settings are also likely to respond more positively if we can help them identify how integrating substance use screening and treatment into their primary care and other health settings will help them meet current or expected mandates or quality measures, improve patient health outcomes (especially

through improvements in patient compliance and adherence) and/or give them a competitive edge over other provider organizations. It is important to note that primary care and other medical settings have a different organizational culture (and language) and practice pace than do mental health and substance use treatment settings. Medical settings also confront varied time and space constraints, regulatory restrictions and minimal practitioner knowledge and comfort in dealing with behavioral health issues, substance use in particular.

A number of barriers will continue to exist for a considerable time related to workforce attitudes and comfort. Some administrative and clinical staff may be concerned about unruly patients in the common waiting area. Clinicians may be concerned that primary care patients will object to being asked about their alcohol/drug use, and primary care staff may think that drinking limits contained in current best practice screening tools are too low, perhaps related to a community or staff drinking culture. Clinicians in medical settings may have a sense that provider autonomy is being encroached upon by required screening and brief interventions. In general, Forum participants agreed that time (and competing demands) and lack of knowledge are the most significant barriers to integration.

Success Factors: Pilots, Consultation, and Integrated Public and Private Financing

Success was seen as more likely if considerable work is done in choosing sites with the fewest barriers to participate in pilot efforts. Some also suggested that it is helpful to begin by targeting innovators or mission-driven sites and that it is important not to “oversell” the ease of implementation. The identification of a champion in each site, organization or primary care setting was uniformly considered to be crucial to success in addition to support from purchasers and payers. A number of purchasers and payers noted that beginning with a pilot site was instrumental in building support and working out bugs in their systems. In addition, education, ongoing support, regular feedback, sharing best practices, emphasizing the benefits to patients and the site and creating some friendly competition among sites were strategies which were helpful to maintaining integrated practices. Monitoring key quality and performance indicators such as service delivery volume, patient and provider satisfaction, and patient outcomes by site and by provider was also seen as critical to quick problem identification and development of solutions as integrated care is implemented.

Beyond providing direct services in specialty care settings either on a contract basis or through co-location with primary care organizations, substance use treatment providers must come to see themselves as ongoing consultants and educators for staff in primary care and other medical settings. This is a significant challenge for the specialty treatment and delivery system and its associated workforce which has been historically segregated and isolated. Because the needs of health care settings should drive the integration process, integration efforts must be designed broadly enough to work across the majority of payers that operate in each setting. It is important to recognize that merely the removal of barriers, such as isolated physical locations, funding silos, benefit structures, and lack of

reimbursement, will NOT of themselves result in integration, without leadership, planning, and collaboration, along with financial and, perhaps, reputational incentives.

Intermountain HealthCare

Some real world models do exist in which a full range of care is being financed and provided, including integrated behavioral health services. For example, Intermountain HealthCare in Utah made behavioral health integration a Community Stewardship Goal for 2010 and 2011 and is incrementally implementing team-based mental health services (including services for substance use conditions) across all of its clinics. At Intermountain, approximately 2/3 of patients with complex chronic diseases, including diabetes, asthma, substance abuse, heart disease and others are cared for routinely by the primary care team, including the patient, family, primary care provider and care manager, with only one patient in six requiring services from both the primary care provider and a specialist behavioral consultant. Within such comprehensive models, supports for providing evidence-based care and efficient care are somewhat seamless with integrated leadership, workflow processes, information system and financial and economic incentives for providers.

Purchasing Co-located Care in Washington State and Washtenaw County, Michigan; and SBIRT in Colorado

Washington State has also undertaken a somewhat more limited Medicaid integration in which the care for disabled adults (SSI) is provided through co-location of a medical clinic and chemical dependency services in a mental health center. Financing and reimbursement for integrated services is provided through managed care arrangement with the County. Also using a co-location model, Washtenaw County in Southeast Michigan is integrating care for persons seeking substance abuse services through the use of a core provider who is responsible for providing or arranging for the provision of services using a Recovery Oriented System of Care. Within this context, primary care services are offered at the Community Mental Health Center for patients with serious mental illness or co-occurring mental health and substance abuse conditions; in addition, medical care as well as mental health and substance abuse services are provided at a homeless shelter.

Colorado has focused on integrating screening, brief intervention and referral to treatment (SBIRT) into a large variety of health care settings, including rural health clinics (some FQHCs), a rural hospital, urban clinics and hospitals, a dental clinic, primary care physician practices, and the Colorado State Employees Assistance Program. The extensive integration of SBIRT in Colorado financed through public insurances and the other revenue streams is rare among States, Counties and health plans.

Theme II: Supports are the Key to Successful Integration: Tools for Clinicians and Patients, Workflow Improvements, Medication-Assisted Treatment.

A second and closely related theme is that for integration to be successful some additional supports need to be provided in primary care and other healthcare settings. Forum participants identified a wide variety of supports that can facilitate the integration of treatment services for substance use disorders into primary care and other medical settings. Some supports may be required to overcome perceived or real barriers to integration in primary care and other health care settings; other supports are essential to support continued and sustained implementation and to insure quality services based on evidence-based practices. “Supports” can come in all shapes and sizes, and frequently involve creation of a new type of health care worker. Supports other than workforce development are discussed in this section. Workforce development as such is discussed as a separate theme.

Written tools for clinicians and patients such as hard copy or computerized screening questions or guides to brief intervention have been used to promote SBIRT. Decision-support tools or protocols can assist and support the primary care provider in appropriate management of persons with substance use conditions. Training a wide variety of primary care and other staff in SBIRT, motivational interviewing, medication-assisted treatment, or other clinical services related to treatment of substance use disorders is another type of support. States often support such training, either independently or in alliance with the regional Addiction Technology Transfer Center (ATTC). Wisconsin reported the successful use of web-based training to build staff capacity, especially in motivational interviewing. Training is often followed by regular contact and consultation for continued support, as providers gain confidence in their skills. Different training and support may be necessary to help develop a new workforce deployed for behavioral SBIRT (rather than substance use-only SBIRT) and care coordination and ongoing behavioral management, especially if these individuals practice in settings isolated from peers. Ongoing and regular Webinars, conference calls, and clinical supervision as occurs in Massachusetts for medication-assisted treatment can provide the necessary support and prevent practice drift.

The purchaser, be it the State, County or health plan, has a significant role in facilitating or providing training for an integration innovation, whether it is a behavioral health specialist training for implementation of SBIRT, staff to provide care coordination and assist with workflow, or staff that can implement the site analyses necessary for customization of an integrated care innovation to “fit it” to a specific site. There may be reluctance by primary care clinicians to engage in screening and identification of substance use treatment needs when there are existing waiting lists for specialty care or other significant access barriers to behavioral health treatment settings such as inadequate coverage and benefits or copays that the patient can ill afford. A process to prioritize referrals coming from primary care settings, or to provide services while waiting for admission to an appropriate treatment service, may need to be developed as supports to primary care. Thus “supports” include

not only sufficient and appropriate training but also patient flow studies, the development of processes to smooth or facilitate workflow, and new types of staff to support needed changes in workflow processes.

San Francisco County, State of Massachusetts, and Magellan Health Services

A number of areas with significant opiate addiction have been interested in working towards expansion of office based opiate treatment (primarily with buprenorphine and methadone but with new cost-effective medications as well), using practicing physicians in primary care and/or mental health clinics. However, often the initial reaction of physicians is that the time required, especially for induction onto the medications for addiction treatment, is more than is available in a busy primary care clinic. To solve this problem and provide support for the physicians, San Francisco County has created and financed an Induction, Stabilization and Support Clinic (OBIC) for a group of participating primary care physician practices located in primary care clinics (FQHCs) and mental health clinics for dually diagnosed patients. A central goal of integrated medication-assisted treatment supported by San Francisco County is to create a better service model for patients and partnerships between service providers. In this model, after patients are stabilized, they are then continued in medication-assisted treatment in primary care with the induction center providing ongoing physician training and support.

Another model for improving implementation of medication-assisted treatment is being supported by the State of Massachusetts. Nurse care managers are being used to assist primary care physicians in Federally Qualified Health Centers with buprenorphine induction, ongoing counseling, and patient care management. Magellan Health Services also has undertaken a national initiative to integrate medication-assisted treatment into all of Magellan's comprehensive services programs, including intensive case management, ambulatory follow-up, disease management and targeted case management. Care managers receive intensive training in medication-assisted treatment and medical directors work directly with physicians. Training for primary care physicians is accomplished primarily through Webinars.

Models such as these which begin in primary care in some sense replicate what is a familiar system in other types of medical care: after an initial screening, specialists provide a more extensive work-up and diagnosis if appropriate, initiate treatment and stabilize the patient, who then returns to primary care for ongoing treatment, while the specialist remains available for consultation to the patient and/or provider as necessary. In other models of this type of integrated care, patients continue with their primary care physicians while they are in outpatient specialty treatment for substance use disorders, maintaining a critical relationship with their primary care physicians throughout the treatment process. Consultation and liaison with primary care requires consideration of the new role (or return to an old role) for mental health and substance use treatment practitioners.

Supports will need to be provided for the current specialty workforce to understand and adopt these new roles in new settings. Additional training in brief therapy, workflow

processes in primary care and other medical care settings, and providing consultation in a primary care setting may be needed as well. Working through the patient consent issues in general and the confidentiality issues specific to substance use treatment in 42CFR will require a continuing dialogue between consumers, providers, and regulators and examination and dissemination of strategies with positive outcomes for consumers.

Integrating mental health and substance use into the mainstream of health care implies that “mental health and substance use” providers will not be in control of the system of care to the extent they have been in their specialty treatment programs and system. To refocus on wellness, prevention and early intervention, and population wellness, all current threads in health care reform will require some new *quid pro quos*, changes in the structure and functioning of specialty providers, and attention to financing that does not destroy needed capacity to provide both specialty and primary care services. Many States have moved to improve integration through new organizational arrangements at the State level and to eliminate the disparate systems that historically operated both independently and in isolation from each other. Such challenges will be met neither easily, nor without rancor, but the dialogue and examples discussed in the Forum suggest that integration is both desirable and possible.

Theme III: Leadership Processes Facilitate Success.

Articulating a Vision and Bringing Others Along: Messaging, Use of Data, Dissemination of Data Analyses

State, County and other leaders’ vision for the future system of care, public statements, and leadership are critical. One way in which States and Counties work to actualize their vision is by convening relevant parties for discussions – for integration, “relevant parties” may not be the traditional partners. It is important that State leaders see themselves as having a key role in guiding (not controlling) where the State is going, have a clear vision of what they want to purchase, and what type of evidence is needed throughout the process to show patients, employers, and payers that the changes being made in infrastructure, payment, use of workforce, and treatment service are positive. States and Counties and large health plans may also play a pivotal role in helping the larger health care system and other decision makers understand the State of the science---first and foremost, that substance use integration is essential for cost effective care for which we are paying already, but not paying smartly.

Many Forum participants stressed the importance of using data to persuade others to take on integration. A key function of leadership, which may not have been sufficiently emphasized in the past, is to see that the right data is collected and presented in a simple and compelling way at the right time. In addition, data is most effective when combined with personal stories about specific people and their experiences with integrated care. Attention also needs to be paid not only to readiness to change, but also to the business cycles of public or private organizations. For example, at Aetna Behavioral Health, analysis

and use of data is helping to build the quality and cost case for increasing utilization of medication-assisted treatment. The data document that, among Aetna members, health services costs are significantly lower on average for the buprenorphine and Vivitrol medication-assisted patients than controls due to lower hospital use both for detoxification and substance-related inpatient stays.

States, Counties and others can engage State academic experts as partners in educating others. For example, in Wisconsin, the SBIRT program's clinical director is a faculty member at the School of Medicine and Public Health at the University of Wisconsin, while the University of Michigan is partnered with Washtenaw County, Michigan in integration efforts. With such partners, States, Counties and health plans can evaluate their programs, analyze their data, and play a critical role in disseminating the positive health outcomes and the business case for integration – showing how healthcare utilization, workplace function, crashes and arrests can be decreased by broadening the availability of services for substance use conditions. Such analyses are especially critical to Medicaid funding for integrated substance abuse services and academic participation adds to the credibility of such work. An inability to demonstrate that integrated services are cost effective is a barrier unlikely to be overcome in the short term.

There is a critical role for States, Counties and health plans in dissemination of information supporting the case for different types of integration and the efficacy and appropriateness of SBIRT, short term treatments, and medication-assisted treatment within the context of primary care. State, County and other leaders may also need to assist the substance use treatment system to understand screening and brief intervention, the benefits of use of medications for treatment of addictions, and other evidence-based practices as well as the benefits of integration. Specialty treatment providers will also need assistance in understanding medical necessity criteria and clinical care guidelines, as well as their place in an evolving workforce as Medicaid becomes more involved in paying for treatment services and integration becomes more of a reality. Over the long haul we will have to invest significantly in integrating new ways of doing business and educating physicians about substance use and addiction into medical education. It has been heartening to see that ten university medical schools have now had their curricula accredited by the American Board of Addiction Medicine.

Creating Broad Alliances

Without exception, all Forum participants spoke about the importance of leaders creating broad alliances. The particular efficacy of the role of State or County authorities as facilitators and conveners of discussions was noted. One participant noted that broader alliances allow for more amicable negotiations and solutions. Also frequently mentioned was the need to rethink the sphere of influence of each State or County agency and create new relationships, based on an understanding of the constituents who need to be involved or will be affected by the change. Not only do organizations and systems need to see that integration is of value to consumers, they must also see a value in integration for themselves. Convening potential partners is as important as are alliances with the State

Medicaid agency, State public health agency, and strong leadership from primary care with a focus on the whole person, including mental health, smoking cessation, and related chronic illnesses. Some alliances have been formalized by the use of written agreements: Washtenaw County, Michigan has formal contractual relationships with integrated health clinics, community settings, such as homeless shelters, and other healthcare systems as well as memoranda of understanding for collaboration with drug courts, the State human services department and others. However, Forum participants thought that the more likely form of alliances would be through workgroups, reflecting the particular payer, provider and consumer constituents in each State and region.

As an example, one Michigan County leader involved the following extensive group of agencies in an alliance: County and State Alcohol/Drug Agencies, Mental Health and Medicaid Agencies, Department of Health, health care authority, Governor's Office, State Legislature, Statewide Provider Associations for Primary Care, Federally Qualified Health Centers (FQHC's), Alcohol/Drug Provider Association, Mental Health Provider Association, consumers, local government, and hospitals. Wisconsin's program to integrate SBIRT into primary care and other healthcare settings included all of these organizations in the public sector initially and later a number of private organizations as well as the business community, as represented by the State Safety Council, human resource benefits organizations, chambers of commerce, health care purchasing and advisory groups, third party administrators and benefits consultants. Wisconsin reported that the interest of the private employers in providing an SBIRT benefit was tremendous and that they wished they had keyed in on the importance of these private groups earlier. In Colorado, alliances that included the State Legislature led to the enactment of legislation requiring insurance companies to pay for preventative services, including alcohol and drug screening, and supported activation of the SBIRT reimbursement codes by Colorado Medicaid.

Within the context of a large private health plan, the constituents may be only slightly different and may emphasize employers that purchase services, network providers, leadership internal to the health plan, legal/regulatory representatives, and consumers. Lastly, in thinking through the alliances needed, one may want to consider including not only those from whom cooperation is needed, but those who can kill your change.

Realigning Payment Incentives

It is important to recognize that most payment systems are not currently aligned to provide integrated care. Behavioral health services may be "carved out"; billing is complex, services provided on the same day may not be reimbursed, and co-pays may exist at a sufficiently high level that they prevent patients from accessing care. States, Counties and health plans need to understand at a highly detailed level the complexities of health care financing, including the "nitty-gritty" of billing and payment, as well as the impact of managed care, bundled payments, case rates, and other forms of payment versus traditional fee-for-service reimbursement mechanisms. State officials from a number of locales suggested that it would have been easier to solve some of these issues, especially billing and reimbursement problems, if they had involved knowledgeable billing and reimbursement

staff with the State agency earlier. Engagement with Medicaid is pivotal, but engagement with other insurers and their payers (such as employers) is also essential. A number of participants commented on the difficulty of bringing programs such as SBIRT and medication-assisted treatment that start out as grant funded to full scale, noting that relying on grant funds does not provide sufficient incentives to motivate primary care providers to implement integrated care. States, Counties and health plans as purchasers of care have a key role in realigning payment incentives (paying for performance), especially as behavioral health treatment is more often than not financed by the public sector. There are special implications for publicly-funded managed care: a reduction of costs this year may lead to reduced rates next year, perhaps not a desirable outcome for a State-level managed care entity with a multi-year contract. Who receives the financial gain from integrated care - the insurer, the managed care entity, or the provider - and how States, Counties and private purchasers can use “gain sharing” needs to be addressed if integrated care is to reach its potential.

It will also be critical to ensure that the payment mechanisms change in primary care to incentivize primary care practitioners to adopt integrated best practices. More needs to be done to increase understanding of how payment mechanisms can be changed so that integration financially benefits primary care organizations and clinicians. Some with SBIRT experience noted that payment for SBIRT might be required to bring about change, but in and of itself was not sufficient to produce or sustain SBIRT. Payment mechanisms also need to be made consistent with the workforce delivering the services which will require a close look at licensing, credentialing and certification requirements. Answering these questions and meeting these challenges requires policy and billing and reimbursement staff capacity and knowledge, as well as system testing and feedback.

It is often less about who is paying or will pay or about who is responsible for designing the mechanisms that facilitate and articulate payment in a cost effective way, than who will not pay. We need to do a better job of educating others about how we will pay for treatment of mental health and substance use disorders under health reform, and how we can be smarter about the use of those dollars.

Wisconsin’s SBIRT program stressed the need for reimbursement reform beyond billing codes to increase effective reimbursement. Assuring that each State’s Medicaid plan will reimburse for needed primary care services such as screening and treatment services and medications and that most, if not all, commercial plans in a geographic area commit to paying for these services are important implementation strategic goals. Effective financing requires the availability of claims submission technical assistance and funding to assure that the required technical and technology changes to support billing and reimbursement are made.

Theme IV: Workforce Development is Critical to Implementing Integrated Care.

For public and private purchasers and payers, workforce development needs considerable attention if implementation of integrated care is to succeed. Substance use disorders are not only a chronic illness in and of themselves, but substance use complicates the treatment and management of other chronic conditions such as, for example, diabetes, hypertension, and breast cancer. All of these conditions are most often seen and treated in primary care clinics in both the private and public sectors.

There was general agreement in the discussion that new types of patients with a variety of substance use conditions will be discovered both in primary care and as a result of changes in insurance coverage and benefits under the Affordable Care Act. These patients are unlikely to be as seriously and chronically ill with long-standing, chronic addictions as are those being treated currently in the specialty sector. They also are likely to need services of many types not readily available in the current system---either in primary or specialty care.

Providing workforce support to primary care clinics and clinicians can mean many things. As defined by the participants at the Forum, workforce support meant:

1. Development of new types of professionals who can function in primary care and other medical settings to provide services focused on behavior change for a variety of chronic conditions as well as brief counseling services for individuals with substance use disorders.
2. Identification of credentialing processes for new professionals.
3. Continuing education for new professionals functioning in primary care settings and health homes, including specialty staff redeployed to healthcare settings, in care coordination, functioning in medical settings, assessment, and brief treatment.
4. Standardized curriculum for each of the professions, *i.e.*, medicine, social work, nursing, psychology, and counseling in substance use and addiction, including use of medications and medication management.
5. Consultation/liaison from specialty physicians as appropriate.
6. Incorporation of recovery support and peer-to-peer services at all levels of the treatment system, in both the public and private sectors. A number of State, County, and private sector health plans are experimenting with workforce models in support of screening and treatment of individuals with substance use conditions in primary care.

Standardizing a Curriculum for Training of Clinicians on Screening and Brief Interventions and Training for Work in Medical Settings – Wisconsin

The Wisconsin Initiative to Promote Healthy Lifestyles has implemented a model in primary care that depends upon full-time, on-site “health educators” with bachelor degrees who receive intensive training including seminars, audiotape reviews of assessments and clinical interventions by a master’s degree nurse as well as regular conference calls for ongoing support. The training, which has been standardized for all health educators at 60 hours, uses evidence-based protocols. Health educators provide assessments and clinical interventions, make referrals and provide basic case management services; primary care providers reinforce health educator interventions and offer pharmacotherapy. In hospital emergency departments throughout the State, health educators and clinicians deliver services together, although in some of their emergency departments clinicians themselves implement screening and brief intervention services.

In Wisconsin, intensive training and supervision is viewed as a *sine qua non* for health educators to deliver SBI and other services. It is interesting to note that, according to Forum participants, “new professionals” are receiving intensive training, continuing education and supervision that have been discussed but in most instances are absent for treatment counselors. It may be wise to consider such training and supervision if counselors want to work in medical settings as integrated care emerges.

Wisconsin is considering additions to existing health education curricula that result in a “Certified Health Education Specialist (CHES)” that can function in primary care settings and provide behavioral screenings and interventions for multiple chronic diseases rather than focus on SBIRT in isolation. Wisconsin is beginning to focus on how a “specialist” or “interventionist” would fit into professional licensing and certification laws and regulations. Increasingly, Wisconsin is also trying to encourage substance use specialty providers to train some of their staff to work in primary care settings to provide behavioral health screening and intervention services.

Experimenting with New Types of Professionals in Primary Care Settings – Aetna

Aetna has been experimenting with training of various types of professionals to implement screening and brief interventions in primary care settings. For professionals who have worked in specialty settings to function in medical settings, retraining has been necessary to achieve the desired results. As Aetna pointed out, in primary care and other medical settings patients present with a variety of conditions that need coaching and perhaps brief treatment related to behavior change, *e.g.* primary insomnia, diabetes, hypertension, gastrointestinal problems, and headaches. “New professionals” who focus on behavior change may be employed most cost-effectively if they are able to provide services for all of the conditions that require behavioral health interventions of this type.

In the Lessons Learned White Paper that TRI published in 2010, which focused on integrated treatment programs for substance use disorders, a job description was proposed with a set of functions and appropriate knowledge, skills, and abilities for new

professionals dealing with behavior change in primary care settings. The proposed job description was developed from a review of the literature about health professional functions and responsibilities in health care settings. A number of payers at the Forum commented that they were experimenting with the use of different types of workers to deliver behavior change services in primary care, *e.g.*, health educators, behavioral health specialists, behavioral health interventionists, health coaches and others. Managed care organizations and several State and County purchasers suggested that such individuals need not come from the traditional professions if they were supported by training, continuing education, and regular supervision. In fact, there was general agreement from the primary care programs at the Forum that some combination of functions that includes what has become known as “patient navigation,” care management, and counseling related to behavior change that is focused on self-management needs to be considered.

All States, Counties, and private sector health plans are paying considerable attention to workforce development to ensure that competent, trained people deliver needed services. Performance measures need to be put in place to ensure that purchasers are carrying out workforce development activities that will support the recruitment and retention of qualified and trained staff. Measuring the availability and accessibility of e-learning tools, clinical decision tools, videoconferencing (as is used by one of the States that presented at the Forum to support nurse clinicians delivering OBOT services), cross-agency training, and the like was noted by participants as important to improving quality in primary care settings (more about performance measures appears later in this report).

Utilization of Medications in Primary Care as a Workforce Issue

An issue of particular concern to purchasers and payers at the Forum was the continued difficulty in achieving widespread use of medications in treatment of individuals with diagnosed substance use disorders. The issue rises to a level of public policy because published research is showing significant cost saving related to inpatient medical care and utilization of emergency rooms. Practicing physicians have been reluctant in the context of a busy primary care clinic and in mental health clinics to implement medication-assisted treatment. Training and support for physicians, especially those who are concerned about induction onto buprenorphine and those concerned about the detoxification necessary prior to induction onto injection naltrexone (“Vivitrol”) was identified as a critical need. Managing pharmacotherapy is going to be a central focus of integrated care. Combined pharmacotherapy for individuals with multiple chronic conditions including mental illnesses and HIV requires exquisite attention to how medications interact and the nuances of their administration.

An effort to increase the use of medications in treatment in the States of Missouri and Connecticut has required the approval and implementation of a “new” credential called Medication-Assisted Treatment Specialist (MATS) that, with additional training, is accessible to any type of professional working in treatment of addictions.

Using State Funds to Purchase Nurse Care Manager Positions to Deliver Medications and Provide Physician Support for Opiate Treatment in FQHCs – Massachusetts

In Massachusetts, nurse care managers are deployed in 19 community health centers, each of which is required to partner with a substance use specialty treatment provider. A pilot program was carried out prior to full implementation including financial modeling to identify full costs for the program; technical assistance for health centers related to billing for medication-assisted treatment was also provided as part of the pilot.

During full implementation, funding for technical assistance and partial support for the salary of a nurse care manager staff position have been provided by the State substance abuse agency. Community health centers can bill for the services nurses deliver and other administrative overhead such as supplies to cover the salary expense as the care managers become fully engaged in managing patients. Evaluation of early pilots showed that costs for one full-time RN could be covered with a 1:100 staff-to-patient ratio which was attainable during full implementation.

Essential to the success of nurse care managers in these positions is maintaining continuous contact with all of the nurse care managers through regular conference calls and web-based continuing education across sites in which they are deployed. Training to work in medical settings and provide physician support has been a central element tied to the effectiveness of the nurse care managers. Educating all staff in primary care settings about both the usefulness of the medications and how effective collaboration across settings can occur is a central component of the program.

Data reporting has been a requirement that has taxed the program; however, collection and use of data has been critical to show policymakers and payers the results they are interested in: increased access to care, particularly minority access, reduced rates of returns to treatment in costly high levels of care, increases in training and numbers of waived physicians that prescribe buprenorphine, and the impact of medication-assisted treatment on reducing health care costs through reductions in the number of hospitalizations and emergency room visits.

During the course of this program, interestingly, a number of community health centers have developed internal behavioral health counseling services; many others send patients to specialty treatment programs for counseling while maintaining their primary care and medication management in the health center.

Providing Continuing Education for Primary Care Clinicians in Public Programs in the Context of an Opiate Buprenorphine Induction Center (OBIC) – County of San Francisco

Fully implementing medication-assisted treatment in primary care and mental health clinics in San Francisco has taken 5 years and many regulatory changes. As in other places, the initial reaction of practicing physicians to supporting medication-assisted treatment

including medication management was “no way I can do this in a busy practice.” In order to provide support to physicians and clinics, a public health buprenorphine induction center was opened which, importantly, also includes other support services for physicians such as training and consultation/liaison services with specialty physicians.

The buprenorphine and methadone model implemented by San Francisco County required significant Federal (CSAT, DEA) and State involvement related to regulatory changes and exceptions. To be implemented it also needed support and affiliate agreements from prescriber organizations, *e.g.*, physicians and medical associations; memoranda of understanding for Boards of Pharmacy and pharmacy associations; and counselor, nursing, and social work associations. The pilot also required contracts with service providers; an electronic database to document all services and notes, and work with narcotic treatment programs to mobilize support. OBIC not only trains practicing physicians but has focused as well on MD residents to create a new wave of physicians knowledgeable about substance use and dependence.

In this model, the pharmacy plays a critical role in client care. All buprenorphine patients receive their medication at the County Behavioral Health Pharmacy; the only limitation on number of patients that can receive medications is financing of the medications themselves and reimbursement for the procedures. Having the pharmacy play a key role in client care has led to increased compliance for multiple medications that patients may be taking for complex chronic diseases. Pharmacies, it was noted, seem to be enjoying their expanded service role with this population.

A monthly meeting of an oversight committee composed of representatives of all provider disciplines and focusing on a few important programmatic outcomes supports San Francisco’s efforts to continually improve medication-assisted treatment. Outcomes include the number of clients referred, enrolled, transitioned to primary care, and retained in treatment; the number of clinics with eligible providers and the number of providers who actively provide medication-assisted treatment; the volume of non-methadone prescriptions; and direct provider feedback on “comfort” of primary care physicians with providing opiate treatment services and working with opiate-addicted patients.

In summary, workforce issues filled a considerable part of the discussion at the Forum. Who will deliver the services needed to implement substance use screening, brief interventions, brief counseling and medication-assisted treatment in primary care settings was talked about in great detail with no specific type of professional being identified--- health educators, behavioral health specialists, behavioral health interventionists, health coaches, recovery coaches, patient navigators all may play a role in primary care settings.

Theme V: Information Technology Support is Essential to Achieve Integrated Care.

Integrated data systems – pharmacy, disability, health information in one system – data that matters to different groups of people, particularly consumers

The need for software systems that support many functions was discussed by a number of Forum participants. Software is needed to guide service delivery, automate business tasks (*e.g.*, document in the medical record, track appointments and time), track patients and populations and engage consumers in their own treatment.

Participants talked about the continuing confusion about privacy issues (*e.g.* 42 CFR, Part II and HIPAA), patient consent, and consumer transparency. It remains unclear to both primary and specialty care providers how privacy and consent affect implementation of integrated care. A great deal of work needs to be done on these issues to support implementation of health homes, coordination of care, and other aspects of health reform that include behavioral health.

Theme VI: Performance Measurement and Management is Necessary in Order to Drive Movement toward Inclusion of Substance Use Conditions in Integrated Care and Quality Improvement Initiatives.

Purchasers and payers identified performance measures as a critical element in driving quality improvement in primary care for treatment of substance use disorders and moving toward integrated care. Measurement and public reporting of the way treatment is delivered (*i.e.*, treatment process) as well as of the effects of treatment on the patient both during treatment and across an episode of care (*i.e.*, patient outcomes) is needed to support quality improvement in care of individuals with substance use conditions.

A paper published by McLellan, Chalk, and Bartlett (JSAT, Vol. 32, 2007) stated that an essential point in identifying the delivery of quality care is “that all practitioners treating individuals with substance use disorders need to be held to a quality standard that includes knowledge of the development and symptoms of addiction [and unhealthy use of substances], clinical assessment, the variety of treatment interventions available, the role of relationships in treatment of addictions, and how to plan for recovery with a patient.”

Purchasers and payers at the Forum identified licensing, credentialing, core competencies, and continuing education with CEUs as significant factors in determining whether a practitioner will be capable of providing a specific type of evidence-based care. While there is no guarantee that licensed and credentialed individuals who also receive continuing education will deliver evidence-based practices, evidence (measurement) of these activities might indicate indirectly the likelihood that evidence-based practices were being used in treatment.

All the purchasers and payers, whether public or private, pointed out throughout the Forum that the major efforts to improve treatment quality and move toward integrated care were reliant upon use of administrative information systems to derive performance indicators at the organizational and systems level (hospital, managed care organization, health plan, County or State). Management uses of these indicators as a means of monitoring practice and identifying treatment policy issues during treatment are critical to quality improvement of integrated primary care.

A set of core functions in primary care related to screening and interventions for substance use conditions need to be carried out and measured. These core functions include:

- Referral processes
- Screening and assessment requirements
- Care coordination, including communication
- Care management especially focused on care transitions
- Collaborative work with recovery support and peer-to-peer staff and organizations
- Behavior change coaching

Although not all of these functions are being implemented in every primary care clinic, measuring the extent to which they exist in any setting may be useful in driving quality improvement.

Providing incentives for the increased use of medication-assisted treatment was discussed by participants. The discussion focused on the possibilities of withholding CEUs from physicians until they see their first five patients after having been trained or rewarding physicians with additional CEUs after they see their first five patients. Both alternatives would require discussion with CSAT which maintains the physician waiver program.

Incentives for Management Teams through Salary Withholds in a Nonprofit Health Plan – Intermountain

Quality incentives have been put in place at Intermountain that includes both group and individual goals. The dollars are not large; however, the incentives also serve as a sanction when it becomes evident that an individual or group of physicians does not receive incentive pay. At the management level, the incentives play a larger role. For the entire management team at Intermountain, 25% of salary is withheld each year until management goals have been met.

A number of State agencies are also experimenting with a variety of performance incentives at the provider organization and clinical team levels to improve access and engagement in treatment, movement from one level of care to another, and to increase access to medications.

Conclusions

This is a time of great opportunity for inclusion of mental health and substance use screening and treatment in primary and other healthcare settings. The opportunity, if realized, will create large cost savings to the healthcare prevention and treatment system, and may not only improve the lives of people with these potentially chronic disorders, but likely save lives as well. Reconfiguring the workforce as well as organizational and financing arrangements will take leadership and political will. The Lessons Learned from the purchasers and payers who participated in the TRI Forum, we hope, will inform those efforts.

Appendices

Appendix 1.
Matrix of Purchasing Initiatives by Theme

Capacity Issues

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|---|--|--|---|---|--|--|---|
| <ul style="list-style-type: none"> • Physical plant limitations prevent co-location • Compatible clinicians • Physician time | <ul style="list-style-type: none"> • OBOT Methadone NTP requires higher level of staffing (MD, Counselor) • Dearth of interested pharmacies for methadone dispensing | <ul style="list-style-type: none"> • Difficult to bring pilot grant programs to scale • Inadequate workforce trained in MI-based interventions • Budget/fiscal retrenchment • Behavioral health treatment access issues due to wait lists • Lack of clinic space to add new team members such as Health Educators/Chronic care managers & behavioral health professionals | <ul style="list-style-type: none"> • Health Homes for persons with SUDs are limited to individuals connected to the CMHC or who currently receive services at primary care clinics | <ul style="list-style-type: none"> • Physicians certified but not prescribing • Lack of nurse support • Lack of office support | <ul style="list-style-type: none"> • Integrated data systems are needed - pharmacy, disability data, etc. You can't co-locate, you need a structure in place to virtually connect | | |

PURCHASING INTEGRATED SERVICES FOR SUBSTANCE USE CONDITIONS IN HEALTH CARE SETTINGS

Alliances

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|---|--|---|--|--|--|--|--|
| <p><u>State level:</u></p> <ul style="list-style-type: none"> Alcohol/Drug SSA Mental Health SSA Medicaid Agency Dept. of Health Health Care Authority Governor's Office Legislature <p>Statewide Associations (primary care, alcohol/drug, mental health, local gov't, consumers, hospitals)</p> <p><u>Local level:</u></p> <ul style="list-style-type: none"> Health Plans & Managed Care Community Health Centers Hospitals Providers: primary care, mental health, chemical dependency Local government Consumer orgs. Tribes | <ul style="list-style-type: none"> CSAT, DEA and State ADP approval State legislation required for OBOT methadone (SB 1807-2000) Need support from prescribers and their organizations (MD, psychiatrists) Narcotic treatment programs Pharmacists, Corporate level, Board of pharmacy Counselors and nurses Drug Enforcement Agency (diversion concerns/public safety) | <ul style="list-style-type: none"> Strong co-leadership from primary care Working relationship with State Medicaid Agency Relationship and support from Public Health leadership in State Alliances with MH and tobacco cessation efforts allows for focus on the whole person Umbrella organizations - e.g., multi-site group administration, IRBs, legal, privacy officers, HR Professional organizations Referral resources - treatment programs and counties | <ul style="list-style-type: none"> Partnership between University of Michigan and Washtenaw County Relationships with major healthcare systems Joint projects with public health, human services, courts, ED's, law enforcement, and recovery community Psychiatric consultation and case management at local primary care clinics SUD, CMH, and Medical Services at local homeless shelter | <ul style="list-style-type: none"> State collaboration with public health hospital for pilot MA League of Community Health Centers | | <ul style="list-style-type: none"> Alliances were formed with health plans and providers to implement integrated services | |

Were Alliances Documented?

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|---|--|--|---|---|--|---|--|
| <ul style="list-style-type: none"> • Mostly informal, but some were by MOU or contract | <p><u>Methadone</u></p> <ul style="list-style-type: none"> • Formal OBOT exceptions to State regs. documented • State board of pharmacy • Physician affiliation agreement letter to CSAT • Contracts with service providers <p><u>Buprenorphine</u></p> <ul style="list-style-type: none"> • DEA "X" number • Comply with DATA 2000 and ONDCP 2006 | <ul style="list-style-type: none"> • Contracts or MOUs with all | <ul style="list-style-type: none"> • Formal contractual relationships: integrated health clinics, community settings such as shelter or jail, provider run sobering facility, Healthcare Systems • MOUs for some collaborations: drug courts CMH providers, State human services department, County human service collaborative body • Less formal alliances are developed through various community initiatives | <ul style="list-style-type: none"> • Request for Information (RFI) • Request for Proposal (RFP) | | | |

PURCHASING INTEGRATED SERVICES FOR SUBSTANCE USE CONDITIONS IN HEALTH CARE SETTINGS

Strategies to Mobilize Support

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
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| <ul style="list-style-type: none"> • Individual meetings with key players – within & across silos • Coordinated meetings with key players together across silos • Share data that shows value & opportunity • Discuss/resolve barriers • Offer incentives (funding, training, regulatory relief, flexibility) • Implement pilots • Define integration, describe integration • Build relationships & find a champion • Organizations & systems must see the value for themselves, not just consumers | <ul style="list-style-type: none"> • Creating better service model for existing clients • Creating partnerships between service providers • Developing neighborhood resource networks • Sharing data on client outcomes | <ul style="list-style-type: none"> • Make reduction of unhealthy substance use a key public health issue • Engage State academic experts as partners - lends credibility, can provide research that shows integration is evidence-based and cost effective • Use cost-effectiveness research as evidence for potential benefits and cost savings • Reach out to payers (employers & insurance companies), not just primary care providers • Partner with substance abuse prevention coalitions • First target innovators and mission-driven sites • Emphasize benefits for providers • Emphasize that it gives larger organizations competitive edge among purchasers | <ul style="list-style-type: none"> • Work directly with health providers to support their efforts in serving this population • Partner with health professionals who are in recovery | <ul style="list-style-type: none"> • Re-procurement of Medicaid: MBHP carve out • Talks with Medicare: medical homes • Addressing medical home with providers: focus of Joint Commission • Treating addiction as a "chronic relapsing disease" | <ul style="list-style-type: none"> • Need to tell stories to engage constituents (employers, consumers, providers, internal constituents) • Combination of data and personal stories establishes leadership buy-in for integration • Pilot projects are a great way to build support. Do pilots for free - creates a business case and a business opportunity • Use data to build the public health case, the quality case and the business case | <ul style="list-style-type: none"> • Provided 3 levels of COD training that were available on provider website for CEUs • OBOT online physician resource • Claims coding adjusted • Ambulatory Detox protocol developed • Developed specialty rates • Expanded network of ambulatory detox providers • Used education to confront barriers about MAT • Ongoing bibliography available to medical directors and providers • Ongoing education via provider forums, webinars | |

Threats to Overcome

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
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| <ul style="list-style-type: none"> • Budget crisis - silos were long established • Financing strategies vary • Data collection systems vary • Philosophies vary • Power/control issues | <ul style="list-style-type: none"> • Resist dominance of one field over another • Cross-field fears and mistrust • Funding stream turf issues • Novel intervention in the clinic culture • "Medical model" vs. "Recovery model" | <ul style="list-style-type: none"> • "Not our job" mentality • Fears that patients might object • Low drinking limits • Staff drinking culture • Staff shortages, stresses • Other projects • Strong provider autonomy • No QI experience • Early failure • "We're too busy" attitude | <ul style="list-style-type: none"> • Funding limitations • Stigma and lack of understanding of need • Workforce needs to be trained to develop broader skills and understanding of integrated issues | <ul style="list-style-type: none"> • Substance abuse provider system upset: using \$\$ to engage CHCs instead of treatment provider • Medicaid financing the drug: UMass study • Contractual and reporting requirements of CHCs - getting nurses to fill out forms is never easy | <ul style="list-style-type: none"> • Employer skepticism of health and wellness programs | <ul style="list-style-type: none"> • Health plan acceptance of strategies varies • Reluctance of certified physicians to take referrals • Limited number of certified (waivered) physicians in network • Coding issues with some health plans makes payment difficult • Fee structure not aligned with market • Health plan approval difficult to obtain • Formulary issues | <ul style="list-style-type: none"> • Leadership & cultural integration • Workflow Integration • Information Systems Integration • Financial & economic integration • Community Resource Integration |

Strategies to Neutralize Opposition

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
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| <ul style="list-style-type: none"> • Relationship building - identify win-win opportunities • Use data to show value • Offer incentives • Implement pilots • Leadership is key | <ul style="list-style-type: none"> • Insure that everyone is at the table - the more vulnerable partner should be in charge/take the lead • Mandating inclusive planning • Go where you are wanted - expanding the toolkit • Mutual training and partnership development | <ul style="list-style-type: none"> • For skeptics concerned about unqualified people doing interventions, encourage them to partner with primary care, share outcomes - allows you to find people that wouldn't necessarily reach out for treatment • Collaborate with sites with the fewest barriers • Education, ongoing support, regular feedback • Emphasize benefits to patient and site • Share best practices • Generate friendly competition among sites | <ul style="list-style-type: none"> • Invite key community stakeholders to participate in the design of programs or initiatives • Develop and disseminate concept paper • Presentations at community groups (hospital staff, judges, community leaders, service providers, recovery community, etc.) • Factsheets and information dissemination • Use data that reflects the impact of substance abuse on each system as a way to identify opportunities for partnering to improve mutual populations • Invite members of each system to serve on committees, workgroups and boards | <ul style="list-style-type: none"> • Technical assistance to sites and State agencies • Data collection and analysis • Methadone vs. Buprenorphine comparison: who is coming in to care | | <ul style="list-style-type: none"> • Coverage decisions can be influenced with data | <ul style="list-style-type: none"> • Engage and train all staff • Workflow integration - look at the method of allocating resources • Information systems integration: reciprocal monitoring of quality improvement data and financing and clinic operations needs • Incentives and sanctions need to be in place • Local participants have say in modifying methods and incentives |

Financing

| <p>Washington Medicaid Integration Project (WMIP)</p> | <p>San Francisco Office-Based Opiate Treatment (OBOT) Services</p> | <p>Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL)</p> | <p>Washtenaw Community Health Organization</p> | <p>OBOT-Buprenorphine Initiative, Boston Medical Center</p> | <p>Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders</p> | <p>Magellan Integrated Substance Use Solutions</p> | <p>Intermountain Healthcare's Mental Health Integration Program</p> |
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| <ul style="list-style-type: none"> • Main issues involve economic downturn, siloed funding, and variance across financing strategies, eligible populations, and data systems • Must decide who pays for what: crisis services, outreach, recovery supports, copays • Broader alliances allow for more amicable negotiations around financing strategies • Discussing moving SU and MH to integrated managed care contracts with primary care | <ul style="list-style-type: none"> • Pilot study was done with grant funding - need to develop strategy for sustainability • Target homeless/low income/greatest need • Decide who will pay for what services based on what reimbursement is available (FQHC for MD/RN visit, Drug MediCal for NTP) | <ul style="list-style-type: none"> • Payment systems not aligned to provide integrated care • Understand complexities of health care financing that will impact how specific integration efforts can proceed • Research impact of managed care vs. FFS financing on budget process and Medicaid rate setting • Research State's Medicaid or insurance companies' policies • Bring in detail people who understand billing and reimbursement • Effective reimbursement = reimburse under special codes, no co-pays or deductibles, reimburse provider/paraprofessional, reimburse both for different services at same visit • Payer recognition program • Claims submission and advocacy program | <ul style="list-style-type: none"> • Disparity in financial resources between CMHC, SUD and healthcare systems • Difficulty assessing health services for Indigents with no insurance • How do you decide who will pay for what services? Joint agreements and MOUs, grant support for identified populations, insurance coverage, identified "home system" • Alliances lead to joint creativity and networking possibilities, which impact financing strategies | <ul style="list-style-type: none"> • Funding - State provided startup money with RFR • Sustainable in settings that can bill for: medication, nursing, and physician visits | | | <ul style="list-style-type: none"> • Allocate resources using very thorough assessment process |

PURCHASING INTEGRATED SERVICES FOR SUBSTANCE USE CONDITIONS IN HEALTH CARE SETTINGS

Workforce Issues

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
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| <ul style="list-style-type: none"> • Licensing or certification of counselors or programs or both? • Training for work in medical settings and vice versa for medical professionals • Training in MAT • Role of the State | <ul style="list-style-type: none"> • Substance Abuse Counselors and RNs require training for work in medical settings • "X" coursework, NTP regulations | <ul style="list-style-type: none"> • State licensing/certification laws and how new positions fit into the professional regulations • Requirements to be trained on evidence-based SBIRT may improve outcomes but limit workforce capacity • Medication-assisted treatment can provide important bridge to specialty treatment • Need large workforce of health educators • Additional bachelors track needed on screening, intervention, referral, motivational interviewing, QI, evaluation and clinical practicum | <ul style="list-style-type: none"> • Cross training professionals • Peer certifications to increase legitimacy/value added • Credentialing standards for specialty areas should be decided jointly • Training in addictions and recovery principles for medical staff • Training in SBIRT • Overcoming resistance to MAT by SUD staff • Increase use of best practice interventions | <ul style="list-style-type: none"> • Licensing or certification: physicians waived with X number • Training for work in medical settings • Training related to implementation of MAT treatments for both physicians and substance abuse treatment staff | | <ul style="list-style-type: none"> • Licensing and certification of OBOT providers • Training for work in medical settings • Training related to implementation of MATs for both physicians and substance abuse treatment staff | |

Performance Measures

| <p>Washington Medicaid Integration Project (WMIP)</p> | <p>San Francisco Office-Based Opiate Treatment (OBOT) Services</p> | <p>Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL)</p> | <p>Washtenaw Community Health Organization</p> | <p>OBOT-Buprenorphine Initiative, Boston Medical Center</p> | <p>Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders</p> | <p>Magellan Integrated Substance Use Solutions</p> | <p>Intermountain Healthcare's Mental Health Integration Program</p> |
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| <ul style="list-style-type: none"> • Patient Health Outcomes • Compliance • Utilization • Cost shifts/offsets | <ul style="list-style-type: none"> • Not applicable - State monitors NTPs | <ul style="list-style-type: none"> • Focus on HEDIS measures - light on integration and behavioral health • MA preference for only a few measures & no interest in expanding measures • MA considered reduction in capitation rate for managed care a projected savings from SBIRT • Possible measures using encounter data - % of enrollees who had annual screening, % of those screened positive who received intervention, completed intervention/eligible for intervention, received referral/eligible for referral, offered pharmacotherapy and onsite support/declined referral | <ul style="list-style-type: none"> • Developed a dashboard of outcome indicators • Create opportunities to compare data and information • Partnering with University of Michigan on "Medicaid Match" demonstration projects | <ul style="list-style-type: none"> • NQF Standards of Care • Data collection is part of the treatment process | | <ul style="list-style-type: none"> • Promote APA's Consortium on Performance Improvement • NCQA performance measures • Internal measures with coaching, ICM programs • Monitor re-admission rates at 90, 180 days | |

Things Crucial to Implementation

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
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| <ul style="list-style-type: none"> • Use administrative data - demonstrated medical costs of not treating substance use, demonstrated value of treating substance use, packaged and disseminated data Statewide across disciplines • Established relationships with key champions across disciplines • Encouraging co-location through leadership and incentives (fund services/training) | <ul style="list-style-type: none"> • Induction clinic/support groups • On-going physician training/support in early phases with CMEs • Training of new residents in SBIRT/"X" - new generation of MDs • Pharmacy role - key component in critical care, increased compliance for multiple medications | <ul style="list-style-type: none"> • Partner with leader in primary care • Partner with Medicaid agency • Use more comprehensive behavioral health focus • Policy people and detail people must be involved • Strong leadership from primary care is essential • Must understand that health care systems change is hard and takes more time than you think • Begin work on sustainability from the start • Involve environmental "levers" earlier • Implement multi-behavioral screening and intervention rather than SBIRT in isolation • Delay service delivery until truly ready • Don't oversell ease of implementation • Require that sites have "skin in the game" | <ul style="list-style-type: none"> • Data collection, review and analysis • Development of solid relationships with community partners • Information sharing to the broader community and key stakeholders for expansion and future sustainability | <ul style="list-style-type: none"> • Piloted the initiative; surveyed providers • State funding of nurse care manager • Training and technical support | <ul style="list-style-type: none"> • Build support using constituent perspectives and needs • Be sensitive to organizational strategy, structure, and culture • Reimbursement strategies are needed for sustained implementation • Infrastructure development and maintenance • Consumer engagement is key • Need for relevant and timely outcomes measures | <ul style="list-style-type: none"> • Health plan support - access to primary care network, formulary • Include health plan medical directors in discussion early • Demonstrate ROI • Encourage health plans to provide access to the newest and most effective pharmacological treatments for SUD • Build out network capabilities to offer innovative and effective services • Encourage providers to provide evidence-based approaches to SUD treatment • Develop outcomes for SUDs | |

Things to Avoid

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|--|---|--|--|--|---|---|---|
| <ul style="list-style-type: none"> • Do not plan in a vacuum - include key stakeholders up front • Don't assume others will see the value of integration • Don't assume co-location will result in integration • Don't assume integration of revenue streams will result in integration • Don't assume integration will result in better outcomes | <ul style="list-style-type: none"> • Would not attempt jail treatment in early phase • Would require more stringent data collection • Would set up model to facilitate billing options | <ul style="list-style-type: none"> • Not bringing in detail billing/reimbursement expert early • Relying on grant funds to motivate primary care providers • Delayed focus on Statewide provider training | <ul style="list-style-type: none"> • Starting projects without fully developing the logistical aspects of implementation (data system supports development, financing and contract language development) • Not making sure there is "buy in" and inclusion of all impacted parties prior to implementation • Not ensuring that expectations and outcome indicators are clearly delineated and understood, not having a system in place for capturing that information | <ul style="list-style-type: none"> • Not providing technical support on billing upfront • Not providing financial modeling at start-up | | <ul style="list-style-type: none"> • Delay in providing provider education • Reach out to PCP groups earlier • Lack of incentives to providers | |

PURCHASING INTEGRATED SERVICES FOR SUBSTANCE USE CONDITIONS IN HEALTH CARE SETTINGS

How will you know you've achieved success?

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|--|--|---|--|---|---|--|---|
| <ul style="list-style-type: none"> • Coordinated treatment planning • Integrated treatment record • Improved health outcomes • Decreased acute care (long term care) costs | <ul style="list-style-type: none"> • Increased # of patients accessing and being retained in treatment • Reduced demand for treatment • Increased # of providers in PC comfortable with OBOT • Increased prescriptions for SA medications in PC • Increased licensed OBOT NTPs • Services get reimbursed | | <ul style="list-style-type: none"> • Use qualitative analysis and community feedback to determine if identified outcome indicators show trends pointing toward achievement of goals | <ul style="list-style-type: none"> • Increase in number of providers waived/trained: buprenorphine • Increase in number of patients able to access care • Higher number of Latinos and African Americans seeking treatment | | | |

What data will need to be reported regularly?

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|---|--|--|--|---|---|---|---|
| <ul style="list-style-type: none"> • Utilization/access measures (consumers showing up, compliance) • Process measures (clinicians sharing information, cross discipline treatment planning) • Outcomes (consumer - reduced use, system - reduced acute care utilization) • Consumer satisfaction • Staff satisfaction | <ul style="list-style-type: none"> • # clients referred, enrolled, transitioned to PC, and retention in treatment • # clinics with eligible providers, # of providers (active vs. not) • Volume of prescriptions (non-NTP) • Provider feedback | <ul style="list-style-type: none"> • Service delivery volume and penetration • Patient and provider satisfaction • Behavioral outcomes - e.g., substance use, PHQ-9 • Analyses by site, HE, demographic group • HE performance on audiotaped interviews • Documented outcomes to support business case: healthcare utilization, workplace function, crashes, arrests | <ul style="list-style-type: none"> • Service utilization trends • Cost comparisons • Satisfaction by consumer, staff, and other stakeholders • Recidivism • Timely access to services • Exploration of barriers • Critical issues | <ul style="list-style-type: none"> • Capacity: number of patients started weekly and number discharged (reason) • Outcomes: housing, employment, age, race, retention | | <ul style="list-style-type: none"> • Standardized assessment tools show continuous data - SF-BH, CHI, CHI-C, and PHQ-9 • Specific program metrics: mental and physical health functional improvement, depression, alcohol and anxiety symptom improvement, productivity improvement in days missed from work, general health improvement • Network provider profiles: # outreach, # recruitment, # authorized, # treated each month, total # patients in OBOT, average # sessions • Utilization data: # of opioid patients in IP, OP and residential, # of patients diverted from IP to LLOC, total medical costs, cost savings for IP, readmission rates, # COD cases identified | |

PURCHASING INTEGRATED SERVICES FOR SUBSTANCE USE CONDITIONS IN HEALTH CARE SETTINGS

What mechanisms will be established to monitor performance and results?

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|---|---|--|--|---|---|--|---|
| <ul style="list-style-type: none"> • Self Report Questions/Mini Surveys • Lab Tests (including U-As) • Mine administrative databases | <ul style="list-style-type: none"> • Monthly oversight committee • All provider disciplines represented | <ul style="list-style-type: none"> • Payer databases will be used to measure service delivery volume/penetration • Periodic surveys will be used to measure patient and provider satisfaction • Need software system to guide service delivery, engage patients, automate business tasks and track patients and populations | <ul style="list-style-type: none"> • Dashboard model that looks at data at varying timeframes on an ongoing basis | <ul style="list-style-type: none"> • Data collection & analysis • Weekly tracking | | <ul style="list-style-type: none"> • Will monitor PCP ability to provide evidence-based substance abuse treatment within the medical home environment • Will monitor compliance with NQF and HEDIS measures for Substance Abuse Identification and Treatment • Monitor outcome data that is collected regularly | |

Strategies to Reward Quality Performance

| Washington Medicaid Integration Project (WMIP) | San Francisco Office-Based Opiate Treatment (OBOT) Services | Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) | Washtenaw Community Health Organization | OBOT-Buprenorphine Initiative, Boston Medical Center | Aetna's Health Plan Based Intervention for Alcohol and Substance Use Disorders | Magellan Integrated Substance Use Solutions | Intermountain Healthcare's Mental Health Integration Program |
|---|--|---|--|--|---|---|---|
| <ul style="list-style-type: none"> • Cost sharing of savings • Bonus payments for targeted performance • Reduced regulations/oversight • Pay for training | <ul style="list-style-type: none"> • Client success is rewarding • Growth in skills is reinforcing | <ul style="list-style-type: none"> • Fold quality rewards into provider contracts, including medical/health homes and accountable care organizations | <ul style="list-style-type: none"> • No incentives or rewards have been developed - this will be looked at once they have more information on performance | <ul style="list-style-type: none"> • Moving to unit rate payment to incentivize volume • Developing performance bonus "rate" based on key outcomes | | <ul style="list-style-type: none"> • Work with health plans to identify incentives for PCP's • Premium for providers with best outcomes | <ul style="list-style-type: none"> • Physicians can pick quality incentive projects - group quality goals and individual quality goals. • Sanctions are also used • Entire management team of Intermountain has 25% of salary withheld until goals are met |

**Appendix 2.
Participant List**

**Forum on Integration
2011 Winter Meeting**

Joyce Allen

Director, Bureau of Prevention Treatment & Recovery
Division of Mental Health & Substance Abuse Services
WI Department of Health Services
1 W. Wilson St., Room 850
Madison, WI 53707
Phone: 608-266-1351
Email: Joyce.Allen@wisconsin.gov

Sheila Barbee

Project Director
Florida Office of Substance Abuse and Mental Health
1317 Winewood Boulevard
Building 1, Room 202
Tallahassee, Florida 32399-0700
Phone: 850-528-2674; Fax: 850-414-7474
E-mail: Sheila_Barbee@dcf.State.fl.us

Virginia (Ginna) Trotter Betts

State of Tennessee
Council on Children's Mental Health
Andrew Johnson Tower, Ninth Floor
710 James Robertson Parkway
Nashville, TN 37243-0800
Phone: 615-532-6500; Fax: 615-741-5956
Email: Ginnabetts@aol.com

Richard L. Brown

Associate Professor
Department of Family Medicine, School of Medicine and
Public Health, University of Wisconsin
Clinical Director
Wisconsin Initiative to Promote Healthy Lifestyles
5901 Research Park Boulevard, Suite 110
Madison, WI 53719
Phone: 608-263-9090; Fax: 608-263-8529
E-mail: rlbrown@wisc.edu

Mady Chalk

Director
Center for Policy Research and Analysis
Treatment Research Institute
600 Public Ledger Bldg, 150 S. Independence Mall West
Philadelphia, PA 19106
Phone: 215-399-0980 x 103; Fax: 215-399-0987
E-mail: mchalk@tresearch.org

Joan Dilonardo

Consultant
19104 Olney Mill Road
Olney, MD 20832
Phone: 301-774-2706
E-mail: dilondoty@verizon.net

Trina Dutta

Public Health Analyst
Center for Mental Health Services/SAMHSA
1 Choke Cherry Road, Room 6-1076
Rockville, MD 20857
Phone: 240-276-1944
Email: Trina.dutta@samhsa.hhs.gov

Suzanne Gelber

President/Consultant
The Avisia Group
1576 Fell Street, Number 2
San Francisco, CA 94117
Phone: 415-875-9392; Fax:
E-mail: sgelber@avisagroup.com

Alice Gleghorn

County Alcohol and Drug Administrator
San Francisco Department of Public Health
Community Behavioral Health Services
1380 Howard Street
San Francisco, CA 94103
Phone: 415-255-3722
Email: alice.gleghorn@sfdp.org

Renata J. Henry

Deputy Secretary
Behavioral Health and Disabilities
Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2301
Phone: 410-767-3167
Email: rhenry@dhhm.State.md.us

Gary Henschen

Chief Medical Officer-Behavioral Health
Magellan Health Services
6950 Columbia Gateway Drive
Columbia, MD 21046
Phone: 410-953-2301; Fax: 410-953-5210
Email: gxhenschen@magellanhealth.com

Jack Kemp

Senior Policy Associate
Center for Policy Research and Analysis
Treatment Research Institute
600 Public Ledger Bldg, 150 S. Independence
Mall West
Philadelphia, PA 19106
Phone: 215-399-0980 x122; Fax: 215-399-0987
E-mail: jkemp@tresearch.org

Colleen LaBelle

Program Director STATE OBOT B
Boston Medical Center
801 Mass Ave Suite 1053
Boston, MA 02118
Phone: 617-414-7453; Fax: 617-414-4134
Email: Colleen.Labelle@bmc.org

Brenda Reiss-Brennan

Mental Health Integration Leader
Primary Care Clinical Program
Intermountain Health Care
36 South State Street
Salt Lake City, UT 84111
Phone: (801) 442-3012; Fax: (801) 442-3026
Email: Brenda.Reiss-Brennan@ihc.com

Alexander F. Ross

Senior Health Policy Analyst
Office of Special Health Affairs
Health Resources and Services Administration
5600 Fishers Lane, Room 12B-17
Rockville, MD 20857
Phone: 301-443-1512
E-mail: ARoss@hrsa.gov

Marci Scalera

Coordinator, Drug and Alcohol Abuse Services
Livingston and Washtenaw Counties and
Washtenaw County Community Health Organization
555 Towner Boulevard
Ypsilanti, MI 48197
Phone: 734-544-2916
Email: scaleram@co.washtenaw.mi.us

Ken Stark

Director
Snohomish County Human Services
3000 Rockefeller Avenue MS 305
Everett, WA 98201
Phone: 425-388-7204; Fax: 425-259-1444
Email: Ken.Stark@snohomish.wa.us

Hyong Un

National Medical Director
Behavior Health Aetna Healthcare
1425 Union Meeting Road
Blue Bell, PA 19422
Phone: 215-775-2647
Assistant: Tim McDonald; Phone: 215-775-2712
Email: mcdonaldt5@aetna.com