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Coordination of Care for Persons with Substance Use Disorders under the Affordable Care Act: Opportunities and Challenges

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Executive Summary

This document reviews the Affordable Care Act (ACA) and existing literature to consider what opportunities and challenges this new law and the extant scholarship present regarding enhanced integration/coordination of substance use disorder (SUD) treatments into the health care delivery enterprise. Given the high concentration of SUD morbidity and treatment that falls under the purview of local to federal government oversight, this review focuses on Medicaid and other public programs that administer medical care to substantial populations with SUDs.

Review of the 955-page ACA (combined U.S. Public Laws 111-148 and 111-152) and of approximately 50 recently published peer-reviewed or reputable web-based articles indicates that SUDs are sometimes the focus of current health care coordination efforts that include "medical homes." This is especially evident in the "essential benefits" list put forth by the ACA, which requires all insurance plans to include "mental health and substance abuse services" among their covered services. At the same time, it is clear from the law and the published literature that most coordination of care efforts center activities in the primary care domain or much less frequently on specialty mental health care, with no or little mention of SUDs. SUDs typically are targets of screening, prevention, and brief intervention or referrals, but not the primary disease of interest in establishing coordination of care efforts. Still, the emerging coordination efforts afford real opportunities to improve SUD treatment nationally via more integration into primary care and other medical care and also in special situations for high-morbidity SUD populations more directly. For example, it is plausible and perhaps efficient for some medical home efforts to organize themselves around intensive SUD treatment for persons with chronic SUD morbidity, such as those engaged in methadone therapy for heroin addiction.

Whatever the venue chosen, be it a primary care clinic, a community mental health center, or an outpatient SUD clinic, coordination of care activities and concepts include many common themes that are typically cross-cutting. This review of the law and literature puts forth information regarding components of such interventions that should be considered in the design, ongoing operation, and evaluation phases of most coordination of care efforts. It includes definitions, funding program descriptions, clinical program descriptions, framework descriptions, and state- and federal-level effort descriptions. Although much of the information is relevant to any coordination of care effort across the medical spectrum, particular attention is paid in this report to efforts germane to behavioral health disorders (i.e., mental health and SUDs), especially to SUDs.

Introduction: The Power of Cole

Acclaimed singer Natalie Cole is a recovered intravenous (IV) drug addict. Among the legacies of her addiction is that she became infected with the hepatitis C virus—a disease that can lie dormant for many years but that also is associated with high morbidity, including serious liver damage and death (Center for Disease Control and Prevention, 2012). Recently, Cole became a public spokesperson for an organization battling the scourge of hepatitis C (Tune in to Hep C, 2012). As part of her advocacy work, she spoke before the National Press Club in Washington, DC, in October 2011. There, a member of the audience asked her whether the new federal health care law would increase coverage access for persons with hepatitis C. With wide eyes and laughter, she answered, simply, "Beats me!" Despite her deep personal- and advocacy-level knowledge of hepatitis C, Ms. Cole can be forgiven for her naiveté regarding the new health care law, a federal statute that was only very recently upheld by a narrow Supreme Court ruling. She would not be alone in her ignorance. Though the law is a subject of intense partisan debate, it also is a lengthy and complex document which few have read or otherwise studied in any detail.

With that context in mind, this report explores the extent to which the new federal health care law, referred to generally as the Affordable Care Act (ACA), offers new opportunities and/or challenges regarding the coverage of persons with substance use disorders (SUDs) as a significant component of their overall health situation. Moreover, given the strong emphasis in the ACA and among health care advocates and scholars regarding concepts such as care integration, coordination, and medical homes, this report specifically considers the opportunities and barriers that the ACA presents regarding establishing medical homes for persons with SUDs in the context of Maryland's Medicaid program. The latter focus on Maryland is driven by local interests because this work is sponsored by Baltimore Substance Abuse Systems, Inc. (bSAS), the designated substance abuse treatment authority for Baltimore City, Maryland's largest municipality. The focus on Medicaid is more generally of importance because this joint federal/state program in Maryland and in most other states has a disproportionate responsibility to provide health care coverage for persons with significant behavioral disorders, which includes serious SUDs like chronic heroin addiction.

Thus, Natalie Cole's advocacy effort is exceedingly relevant to this discussion. Hepatitis C is principally a disease that results from IV drug use, but it is otherwise an illness that one would consider somatic (rather than a mental health or SUD) because the disease pathology is focused on the liver and not within the brain. Accordingly, when one is considering whether the ACA will help persons with hepatitis C, two types of health care coverage are germane: coverage targeting addiction and brain health and coverage targeting infection control and liver health. Some coordination of care between different branches of medicine is implied; otherwise, the care delivered may unwittingly address one illness while allowing the other to worsen. In fact, it is the case that the ACA will increase access for persons with hepatitis C by virtue of several provisions. Most notably, the new law explicitly requires essential benefits that must include mental health and substance use treatment coverage, and the law has already eliminated lifetime

limits and (in 2014) will prevent insurance companies from denying coverage to persons with preexisting conditions. These latter points mean that by 2014, a person with hepatitis C cannot be denied coverage, and if that person contracts cancer or cirrhosis of the liver, his or her treatment cannot be truncated because of dollar limitations.[1] Finally had Ms. Cole been more informed about the details of the ACA, she could have described for her National Press Club audience some of the provisions in the law that encourage SUD and primary care providers to collaborate more such that their patients with hepatitis C might have better access to care that optimizes overall (i.e., holistic) personal health. This report describes these opportunities, in addition to challenges to their realization.

Background: Why This Study?

In any given recent year, 4 to 9 percent of persons over the age of 12 years in the United States experience SUD (alcohol or illicit drug) morbidity (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Substance Abuse and Mental Health Services Administration, 2011), and within the context of state Medicaid programs (designed to provide medical care to the poorest and most disabled citizens), this rate is somewhat higher, at approximately 14 percent (Adelmann, 2003). Moreover, persons with SUD typically experience other forms of illness, including mental disorders such as depression or psychosis and somatic illness such as infectious disease and asthma (Dickey, Normand, Weiss, Drake, & Azeni, 2002; RachBeisel, Scott, & Dixon, 1999). According to Mark et al. (2005), direct costs for SUD treatments have been calculated at a mere 1.3 percent of national health care spending, even as overall economic costs (health care, productivity, crime/incarceration, and enforcement) attributed directly to illegal drug or alcohol abuse and addiction account for approximately 20 times that expenditure amount (National Institute on Drug Abuse, 2008). More than 18 percent of substance use treatment is financed through the Medicaid program, and another 52 percent is supported by other governmental dollars, especially state and local government dollars (Mark et al., 2005). As an indication of current public financing and expectations of such financing moving forward with Medicaid expansions and federal subsidies contained in the ACA, data from a 2010 national survey indicated that more than 27 percent of persons receiving specialized SUD services were partially or entirely supported by Medicaid for that purchase of care, 36.5 percent received other government subsidies excluding Medicare, and 41.5 percent reported using their own funds (National Institute on Drug Abuse, 2008). Although these percentiles are overlapping because the same person-claim may have multiple payers, they demonstrate that large portions of the SUD treatment are either covered by public funds (e.g., Medicaid) or uninsured (i.e., paid by the client "out of pocket," or unpaid and "written off" by the provider as uncompensated care).

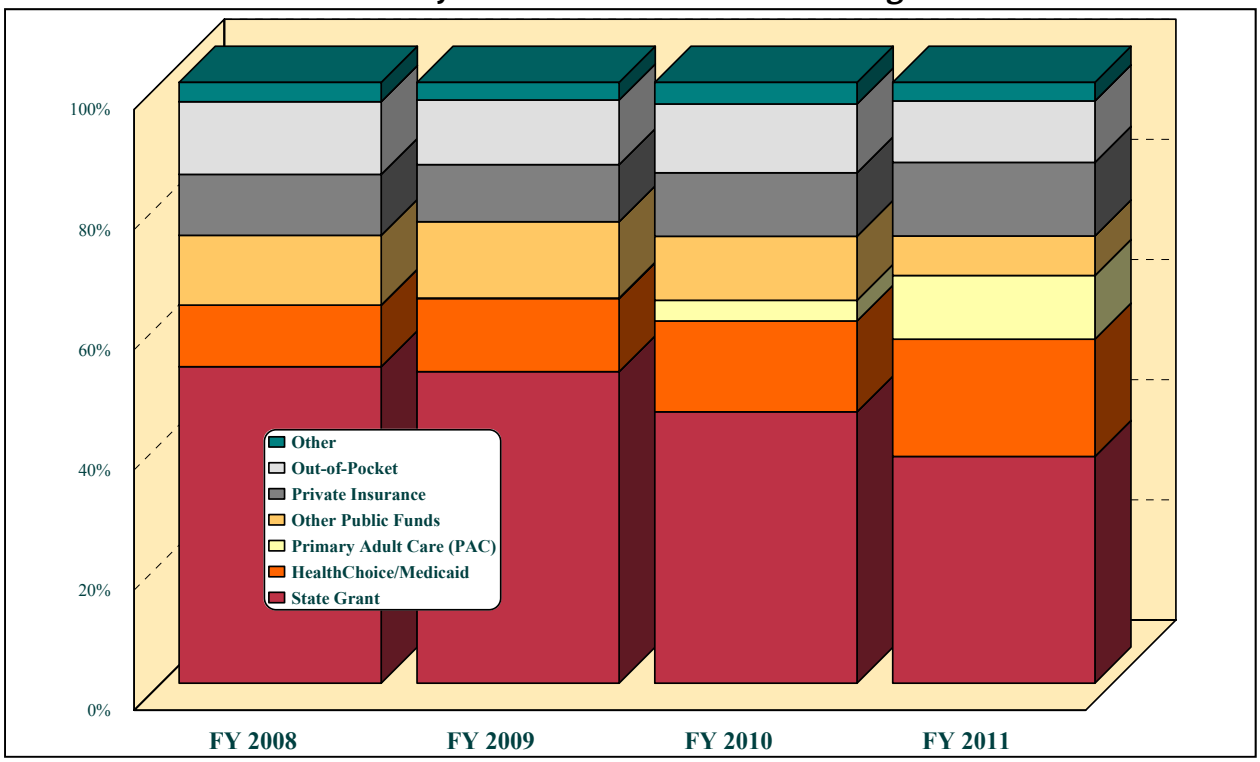
In Maryland during fiscal year 2011 (July 2010 through June 2011), 74 percent of the 42,795

[1] 80 to 90 percent of IV drug users contract hepatitis C (Edlin et al., 2005). Approximately 1 to 5 percent of those persons will die of liver cancer or cirrhosis of the liver per the CDC (http://www.cdc.gov/hepatitis/hcv/hcvfaq.htm).

admissions to state-supported treatment facilities tracked by the state's Alcohol and Drug Abuse Administration (ADAA) were primarily funded by Medicaid dollars or other public funds (such as state and federal block grants) not including Medicare. Moreover, this public funding has increasingly included Medicaid dollars by virtue of the full-benefit HealthChoice and the limited-benefit Primary Adult Care (PAC) managed care programs (see Figure 1). These numbers show that public funding is substantial and growing in the Medicaid domain so that Maryland maximizes its 50 cents on the dollar federal match on such treatment expenditures (Sharfstein, 2012). Such trends additionally will be increased by the Medicaid expansion, which remains part of the ACA and which has already partially occurred in Maryland in the form of the PAC program established in 2006 via a waiver from the federal Centers for Medicare and Medicaid Services (CMS).

Baltimore City is the jurisdiction in which 47 percent of all state SUD treatment expenditures (block grant and Medicaid) occur (Sharfstein, 2012). This concentration is largely correlated with population, but also may be connected to the relative prevalence of reported addiction and the availability of treatment facilities in urban versus rural areas. In Baltimore City, Baltimore Substance Abuse Systems, Inc. (bSAS), with substantial support from the state, is the controlling authority for all grant financed SUD treatment, and thus acts as a quasigovernmental entity in that metropolitan jurisdiction with substantial autonomy to oversee treatment and related administrative efforts. Under its oversight authority, bSAS hired The Hilltop Institute at the University of Maryland, Baltimore County (UMBC)—a non-partisan, not-for-profit health research organization—to address the following question: What opportunities and barriers exist in the recently passed federal health care law (the ACA) toward the development of overall health care coordination for persons with SUD?

Figure 1. Percentage of Payments by Source for Substance Use Treatment Providers in Maryland Who Receive Public Funding



Note: Bars Represent state fiscal years (FYs)*
*Begins six months earlier than each calendar year.
Source: Maryland's Alcohol and Drug Abuse Administration, Outlooks and Outcomes FY 2011, Slide #59, http://adaa.dhmh.maryland.gov/SitePages/Outlook%20and%20Outcomes.aspx

Methodology

This study relied on four sources of information. First was a detailed review of the ACA sections that referred either to SUD or addiction and/or to coordination of care concepts, including medical home mentions. Second, peer-reviewed and web-published literature was reviewed which addressed implications of the ACA with regard to SUD especially, but more generally with regard to behavioral health care, including provisions to enhance coordination of care within and beyond the domain of behavioral health (i.e., including substance use, psychiatric, and somatic domains of health care). Finally, this report benefits directly from knowledge gained from two ongoing efforts initiated by the Maryland policymakers in one case, and by bSAS in another. The state effort now underway is directed by the Maryland Department of Health and Mental Hygiene (DHMH) and is dubbed "Behavioral Health Integration." The effort comes at the request of the Secretary of DHMH and ultimately aims to coalesce stakeholder and best-practices information into a plan for the state to improve its publicly financed behavioral health care system by enhancing the linkages between traditional silos of care spanning the substance

use, other mental health, and general (somatic) health care domains (Sharfstein, 2011). In other words, this effort strives to increase cross-talk and overall coordination between addiction, other psychiatric, and general internal medical care to create a more unified and holistic care delivery system. The focus of this state-led behavioral health integration effort includes Maryland's Medicaid program, which is presently dominated by managed care for most substance use and somatic care but includes a substantial "carve-out" of most specialty mental health services into a fee-for-service (FFS) regime covered more directly by state and federal Medicaid funds (Oliver, 1998). Additionally, this behavioral health integration effort strives to complement the anticipated changes associated with the ACA, including the promotion of the medical home concept (Croze, Cohen, & Capoccia, 2011).

The bSAS effort influencing this report involves that entity's steerage of a work group of stakeholders from the various clinics, as well as from the state's overall substance use authority (ADAA), convened to design a novel approach for serving high-needs clients with both mental health and substance use morbidity. The work group is ad hoc and works informally under the guidance of bSAS President and CEO Greg Warren, MA, MBA, and substance use clinician and policy consultant, Yngvild Olsen, MD, MPH (formerly Medical Director and VP of Clinical Affairs at bSAS). To date, the group has engineered—via informal discussions, background research, and programmatic reviews—a framework regarding target populations and services designed to establish some form of a medical home for persons with chronic substance use issues (Baltimore Substance Abuse Systems Work Group, 2012b).

To prepare this report, all four aforementioned source types (ACA text, published literature, and state and bSAS integration efforts) are drawn upon.

What's in the Affordable Care Act?

Mentions of Substance Use Disorder

It would have been conceivable that the ACA (a compilation of Public Laws 111-148 and 111-152) avoids mention of any specific diseases or sub-disciplines of medicine or health care and instead referred in generalities to various aspects of the entire system of health care, leaving it to states and clinicians to delineate the details of appropriate care. Instead, however, the law offers numerous specifics about what is to be covered, and it makes several mentions of SUDs. A textual review of the ACA found that, of the 955 pages, 21 refer to SUDs, even as there is no use of the terms *drug use*, *drug abuse*, *addiction*, *drug dependence*, *alcoholism*, or *illegal drug use*. A description of SUD references made in the ACA follows. Review of those sections typically reveals that SUDs are lumped with or after mental health disorders in a clause that reminds readers that the treatment and prevention of behavioral health disorders is a written goal of health care reform. It is further notable that "behavioral health treatments" are explicitly mentioned as a component of "essential health benefits" in an apparent effort to thwart the notion that pharmaceutical or other more traditional medical services are the sole way to treat such illness (ACA § 1302(b)(1)(E) – p. 59). Specific references to SUDs throughout the text of the law are

summarized in the following paragraphs and referred to using parenthetical section referents embedded in the text as seen at the close of the previous sentence.

The law establishes several incentives in the form of grants or reimbursement options that explicitly mention SUD treatment and prevention among other behavioral health treatments and among other health care approaches. For example, the law requires the Secretary of the Department of Health and Human Services (HHS) to establish grants and contracts that encourage the formation of interdisciplinary teams, and such teams are further mandated to include "behavioral and mental health providers (including SUD and prevention providers)." (ACA § 3502 (a and b(4)) – p. 435). The law also requires the Secretary of the HHS (heretofore: the Secretary) to establish national centers of excellence targeting depression, with explicit notations that the centers "shall…foster communication with other providers attending to co-occurring physical health conditions such as…substance abuse disorders." (ACA § 10410(c)(2)(B) – p. 896). This phrase is interesting not only as a reference to SUDs, per se, but also as one that shifts such disorders into the somatic rather than the behavioral sphere, given that most other references connect it more tightly to mental health.

Essential Benefits

The legislation explicitly states that the "essential health benefits" packages that reflect minimal standards for health care coverage mandated by the ACA must include "mental health and SUD services" (ACA § 1302(b)(1)(E) – p. 59), in addition to other medical services listed as follows:

(A) Ambulatory patient services

(B) Emergency services

(C) Hospitalization

(D) Maternity and newborn care

(E) Mental health and substance abuse services, including behavioral health treatment

(F) Prescription drugs

(G) Rehabilitative and habilitative services and devices

(H) Laboratory services

(I) Preventive and wellness services and chronic diseases management

(J) Pediatric services, including oral and vision

It is worth noting that this listing of essential benefits by the legislation seems to have gone out of its way to mention "mental health and substance abuse services, including behavioral health treatment," even though such services and treatments are covered under the more general headings listed such as "ambulatory patient services." An analogous choice seems to have been made in the reference to "Pediatric services, including oral and vision." Presumably these

explicit organ-directed (i.e., brain, mouth/teeth, and eye) mentions are tied to concerns of members of Congress that such health care issues would be neglected if they were not specifically stated in the essential benefits listing. Indeed, mental health services researchers have noted the explicit inclusion of behavioral health among the essential benefits as a significant opportunity to increase access to such services, although caution is made that minimal essential benefits may fall short in providing the full array of mental health and SUDs advocated by evidence-based practices (Garfield, Lave, & Donohue, 2010).

Within the ACA, mention of SUD treatment and prevention efforts include language specifying the importance of training health professionals with proficiency in that domain (ACA § 5101 (i)(2)(A) – p. 526), and it also specifies that third-party payers must ensure parity of coverage between SUD and other medical benefits (ACA § 2001 (c)(3)(6)(A) – p. 184).

States wanting to maintain their Medicaid program (i.e., the federal match for health care coverage to low-income persons) are required by this new law to "outreach to and enroll vulnerable and underserved populations…including individuals with mental health and substance-related disorders" (ACA § 2201 (b)(1)(F) – p. 199), although this requirement is eliminated by the Supreme Court's ruling that the Medicaid expansion provision of the law cannot be enforced by threatening other Medicaid funding (Kaiser Family Foundation, 2012). Still, it represents additional evidence of the legislative intent to specifically include and enforce behavioral health coverage as part of the law, and some enforcement powers remain regarding the insurance plan exchanges (for individuals or families with financial resources placing them between 138 and 400 percent of federally determined poverty levels) and for the numerous states expected to opt for the Medicaid expansion.

State Plan Amendments, Pilot Funds, and Other Resources

As part of the ACA, states are offered the option to modify their official state Medicaid plans to allow reimbursement for health home services for enrollees with chronic conditions that include mental health and substance use conditions. A "health home" is defined as "a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services" (ACA § 2703 (e) and (h)(2)(A-B) – p. 231) (ACA § 2951 (b)(1)(A and C) – p. 245). Medical homes are discussed in more detail in the next section of this report, but the reference here is made to demonstrate that SUDs, per se, may be targets of such interventions, although most of the scholarship, pilots, and discussion to date have focused on primary care–centered medical homes or medical home strategies targeting populations with serious mental illness that is not defined by SUD alone (Alakeson, Frank, & Katz, 2010; Druss & Mauer, 2010).

Explicit provision in the ACA requires the issuance of grants for 5-year pilot studies on community interventions for persons age 55 through 64 (older adults) including "efforts to … reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles"

(ACA § 4202 (a)(3)(B)(ii) – p. 492). It further seems that the law requires these projects to target the "treatment/referral" or the referral process between behavioral health and other publicly financed health care programs (ACA § 4202 (a)(3)(D)(iii) – p. 494). This section is notable for at least two reasons. First, it touches on prevention and explicitly separates tobacco use from other SUDs. Second, it places "substance abuse" before "mental health" rather than tacking it on in the typical phrase "mental health and substance use disorders" such that SUDs, per se, might be de-emphasized relative to other psychiatric disorders (e.g., depression, anxiety, or psychosis).

In addition to grants such as those briefly described earlier, financial incentives are also built into the law for training programs for residents, fellows, and other SUD professionals along with funding for school-based health centers that include "mental health and substance use disorder assessment" (ACA § 4101 (a)(b)(a)(1)(B) – p. 472). In an explicit reference to coordination of care, the law states that preferential grants should be awarded to programs that serve communities or populations in which there are mutable barriers between primary care, mental health, and SUD services (ACA § 4101 (d)(1)(A and C) – p. 474).

Finally, prevention-oriented efforts in the law include the promotion of early childhood home visitation programs, programs that serve families with a history of substance use problems among other conditions (ACA § 2951 (d)(4)(E) – p. 250), and the establishment of a National Prevention, Health Promotion and Public Health Council that will "address lifestyle behavior modifications" including those germane to mental health and the prevention or mitigation of SUDs. President Obama signed an executive order creating this council on June 10, 2010. According to its webpage, the council "provides coordination and leadership at the federal level and among all executive agencies regarding prevention, wellness, and health promotion practices." Surgeon General Dr. Regina Benjamin chairs the council, which is composed of the heads of 17 federal agencies. Preventing drug abuse and excessive alcohol use are stated goals of the broad-reaching public health effort (National Prevention Council, 2010).

Mentions of Medical Homes/Coordination of Care

Separate, of course, from mentions of SUD as a target for strategies and mandates of the ACA are those pertaining to the integration of care across traditional medical silos such as mental health, addiction, and primary care. A review of the ACA for terms including *medical home*, *case management*, *care coordination*, *integrated care*, *patient-centered*, and *health home* found more than 955 mentions of such references, spread across 47 pages of the legislation. A summary of the context and semantics associated with these references follows.

Mentions of these phrases are frequent and often nested together as a means of emphasizing the general intent of the law to promote better connectivity and organization of health care from its current state. For example, the Secretary is instructed by the law to establish payment structures for insurance carriers that promote: "effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage" (ACA §

1311(g)(1)(A) – p. 77). This list, like so many published in recent times, is overlapping and culminates with the medical home reference—in part because such a reference has become to health care policy what baseball and apple pie are to American culture. Moreover, this and other references like it in the law promote the medical home, but also provide frequent mentions of alternatives or close cousins such as case management, care coordination, and chronic disease management. It would seem, then, that the law aims to promote medical homes, but not to be overly prescriptive that such constructs represent a panacea to achieve enhancements in holistic medical care and coordination in all venues or across all persons.

Several provisions in the law give priority or preferential treatment regarding loans and grants to insurance entities that demonstrate their plans to use "integrated care models" (ACA § 1322(b)(2)(A)(ii) – p. 87), or otherwise encourage such entities to "use of care coordination and care management programs for high risk conditions" (ACA § 1341(b)(2)(B)(ii) – p. 106). This mention is notable because SUDs specifically represent a clinically useful cluster of conditions that increase one's risk for increased morbidity and mortality (Abrams et al., 2012; Kelly et al., 2011).

State Plan Amendments: ACA Section 2703

The often-cited section 2703 of the law stipulates that states can modify their state Medicaid plan to facilitate the operation of certified medical homes, including those targeting mental health and substance use morbidity. More generally, this section stipulates the formation of medical homes for persons with chronic conditions. These medical homes could involve individual clinicians or teams of providers. Additionally, the law explicitly notes that Medicaid coverage (with the full budgetary support) would apply to the medical home add-on services, and that during the first eight quarters of the program's development that support would be enhanced up to 90 cents on the dollar (ACA § 2703(a)(c)(1) – p. 230). To encourage flexible funding strategies, the law stipulates that a state may propose any payment method they see fit and that the method need not "be limited to a per-member per-month basis" (ACA § 2703(a)(c)(2)(B) – p. 230).

CMS will only consider medical home state plan amendment proposals that include methodologies for: (i) tracking avoidable hospital readmissions, (ii) calculating cost savings resulting from improved chronic care, and (iii) measuring health care quality. Additionally, the amendment proposal needs to have a health information technology component (ACA § 2703(a)(f)(1 and 2)(g) – p. 231). Adjacent to the state plan amendment language in the law, the term *health home* is defined as one or a team of providers that directly delivers timely and high-quality care, including "(i) comprehensive care management; (ii) care coordination and health promotion; and (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings" among other services (ACA § 2703(a)(h)(4)(A)(B) – p. 232). A designated health home provider is defined as follows: "a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is judged by the State and approved by the Secretary to be qualified to be a

health home for eligible individuals with chronic conditions on the basis of documentation showing that the physician, practice, or clinic – (A) has the systems and infrastructure in place to provide health home services; and (B) satisfied the qualification standards established by the Secretary" (ACA § 2703(a)(h)(5)(A and B) – p. 232). Although this definition does not exclude SUD providers, it does not explicitly include them, even as it does mention other specialists or venues such as gynecologists or community health centers. Despite this apparent disease-specific omission, there is a section in the law that makes provision for the treatment of postpartum depression, including better care coordination and management of that specific type of illness (ACA § 2952(b)(b)(1-2) – p. 256).

Grant Mechanisms Including the Center for Medicare and Medicaid Innovation (CMMI) and the Patient-Centered Outcomes Research Institute (POCRI)

Several provisions of the law seem to have been crafted to afford health care policymakers and practitioners considerable flexibility to implement coordination of care solutions. Moreover, the language of the law seems to frequently admit that solutions regarding care fragmentation remain to be conceptualized, studied, and implemented. The law requires the Secretary to set national priorities that will "have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations" (ACA § 3011(a)(2)(B)(i) – p. 293). It requires the Secretary to award grants and contracts as well as establish other formal agreements that develop or expand quality measures to assess "the safety, effectiveness, patient-centeredness, appropriateness and timeliness of care" (ACA § 3013(a)(c)(2)(E) – p. 297-298).

The ACA also requires the establishment of the Center for Medicare and Medicaid Innovation (CMMI), which is charged with funding or otherwise promoting the following initiatives:

- "payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs" (ACA § 3021(b)(2)(B)(i) – p. 293)
- "care coordination between providers of services and supplies that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment" (ACA § 3021(b)(2)(B)(iv) – p. 307-308)
- "care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology" (ACA § 3021(b)(2)(B)(v) – p. 308)
- "community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities" (ACA § 3021(b)(2)(B)(viii) – p. 308)

- "home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams" (ACA § 3021(b)(2)(B)(xiv) – p. 308)
- Initiatives that utilize "a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project" (ACA § 3021(b)(2)(B)(xx) – p. 309-310)

From this array of goals, one can conclude that the ACA targets payment reform—largely encouraging conversion from unbridled FFS to more episode- or salary-based schemes—and care coordination via primary care, medical home, and chronic condition strategies (overlapping or otherwise). As of June 2012 the CMMI has awarded more than $899 million across 107 projects, however, published abstracts indicated that only 4 of these awards (totaling $35 million) have a substantial focus upon SUD treatment or prevention (see Table 1). Recent analyses of Maryland Medicaid data suggest that there are several large (>3,000 persons each) and statistically homogenous groups of patients with SUDs engaged in the program who could benefit from development of such initiatives including those with co-occurring affective disorders or psychosis, and/or co-occurring somatic illness in the cardiovascular domain (Abrams, Kim, & Miller, 2012). Moreover, even reports published by non-clinician legal experts in recent years have acknowledged both emergency room and inpatient diversion projects as important activities for the Maryland's public mental health system (Stefan & Cain, *circa* 2007).

Table 1. Summary of Centers for Medicare and Medicaid Innovation (CMMI) Grants as of June 2012

Concept*	Number of Unique Projects	Investment ($\times 10^6$)	Expected Return ($\times 10^6$)	Titles (Numbered) or Issues Addressed by One or More Grants
Substance Use Disorders	4	$35	$74	1. Patient-centered medical home for mental health services in Wyoming and Montana 2. Johns Hopkins Community Health Partnership (J-CHiP) 3. Using recovery peer navigators and incentives to improve substance abuse Medicaid client outcomes and costs 4. A recovery-oriented approach to integrated behavioral and physical health care for a high-risk population
Mental Health Disorders	12	$106	$188	1. Expanding and testing a nurse practitioner–led health home model for individuals with developmental disabilities 2. Prevention and Recovery in Early Psychosis 3. Using care managers and technology to improve the care of patients with schizophrenia 4. Parachute NYC: an alternative approach to mental health treatment and crisis services 5. Care management of mental and physical comorbidities: a TripleAim bulls-eye 6. Brooklyn Care Coordination Consortium 7. Capital Clinical Integrated Network (CCIN) 8. Optimizing health outcomes for children with asthma in Delaware 9. TIPPING POINT: Total Integration, Patient Navigation and Provider Training Project for Powers County, Colorado 10. Community-based health homes for individuals with serious mental illness 11. Race to health: coordination, integration, and innovations in care 12. Transforming pediatric ambulatory care: the physician extension team
Medical Homes	10	$112.2	$223.4	1. Expand Atlantic General Hospital's infrastructure to create a patient-centered medical home 2. Medicare and CareFirst's total care and cost improvement program in Maryland

Concept*	Number of Unique Projects	Investment ($\times 10^6$)	Expected Return ($\times 10^6$)	Titles (Numbered) or Issues Addressed by One or More Grants
				3. CCHP Advanced Wrap Network 4. Community oncology medical homes 5. Partners for Kids Expansion 6. Sanford One Care: transforming primary care for the 21st century 7. Advanced Illness Management 8. Multi-community partnership between TransforMED, hospitals in the VHA system, and a technology/data analytics company to support transformation to PCMH of practices connected with the hospitals and development of "medical neighborhood" 9. Comprehensive care provided in an enhanced medical home to improve outcomes and reduce costs for high-risk chronically ill children 10. Courage Center (for adults with disabilities)
Primary Care	21	$189	$388	Reduce inappropriate use of imaging technology; rural pharmacy practices; information technology; developing collaborations; developing better coordination; prison to community transitions; safe pharmacy practices; preventing readmissions; chronic pain treatment; workforce training; accountable care networks for complex Medicare patients; dementia care; post-ER care; high-risk infants
Other concepts	60	$457	$1,100	Patient navigation; home-based health care; nursing home care; shared decision making; oral health; diabetes care; frail patients on Medicare and Medicaid; high-risk asthma; quality management; sepsis reduction; delirium detection; geriatric emergencies; systems engineering; elder care; retooling pharmacists; paramedics; palliative care; early intervention; telemedicine; medication adherence for heart disease; comprehensive advanced illness; cancer; transitions for rural patients; school health initiatives; stroke care; dementia care; general health
Total	**107**	**$900**	**$1,973**	**—**

* Table rows are mutually exclusive and hierarchical (e.g., if a program has substance use disorder, mental health disorder, and medical home components, it will only be captured in the first row).
Source: Centers for Medicare and Medicaid Services, 2012b

Per descriptions provided on the CMMI website (Centers for Medicare and Medicaid Services, 2012b), one of the SUD grants targets 260 homeless persons with serious mental disorders or co-occurring mental and SUDs in San Antonio, Texas, by providing them with more integrated care across behavioral health, primary, and tertiary care domains. The program will train an estimated 24 new health care workers who will offer peer support toward patient readiness for change, motivation, and compliance. The second SUD program is based in Wyoming and Montana and creates patient-centered medical homes "with mental health and substance abuse" service delivery points in areas where there is a dearth of psychiatrists and psychologists. It utilizes various technologies (e.g., telemedicine, email) to address that provider supply gap, and it will involve the hiring of at least 24 new providers. A third program in Maryland targets high-risk adults in East Baltimore using a partnership between the Johns Hopkins Health System (a large private academic entity), their managed care underwriter (Priority Partners), a federally qualified health center (FQHC) (Baltimore Medical System), and local skilled nursing facilities. High-risk patients for this proposal are defined especially as those persons with mental health and/or SUDs who experience inpatient events. The intervention will include early screening, interdisciplinary planning, enhanced medication management, patient/family education, provider communication, post-discharge support and home care services, and improved primary care access. By year 3 of this $20 million project, Johns Hopkins University plans to train 111 new health care workers across the spectrum from educators to nurse screeners to pharmacists and physicians. Finally, a fourth project targeting SUDs based in Massachusetts uses "care coordination" to reduce detoxification services recidivism. The funding was extended to ValueOptions, Inc.—the Administrative Service Organization vender serving Maryland Medicaid and numerous other populations nationally—and will educate approximately 75 new health care workers including patient navigators and trainers and support staff. Although each of these interventions targets SUD in some way, they are different in the target population (e.g., homeless, rural) and in the principal strategy (e.g., peer support, telemedicine, consortium building, detox use reduction). Moreover, none of them appear to create a medical home for substance users, per se. Accordingly, at present, this sizable federal funding stream spawned by the ACA is rarely being used to cultivate care coordination for those with SUD morbidity as a principal component of their health status.

Review of the other efforts under the CMMI initiative support the conclusion that SUDs are, at best, a small target of the health care reform effort launched by the passage of the ACA. Mental health issues appear to be directly addressed in 12 of the 107 CMMI projects funded thus far (see Table 1). Those 12 projects account for nearly $106 million in funding and address issues such as health homes for persons with developmental disabilities, prevention of and recovery from psychosis, crisis services, and pediatric ambulatory care, including a provision for mental health professionals to be available for children with asthma. The CMMI has thus far invested another $112 million across 10 medical home projects including a $24 million project led by CareFirst BlueCross/BlueShield, Inc. that will engage 25,000 Medicare enrollees in a patient-centered medical home. The medical home initiatives also include more targeted populations such as children, cancer patients, and those with other forms of disability or advanced illnesses. In the

primary care realm, the CMMI has thus far funded 21 projects accounting for $189 million in grant investments and an additional 60 projects ($457 million) related to other concepts besides SUDs, mental illness, medical homes, or primary care. Attention to these other projects listed in Table 1 is useful here to delineate the competition and potential collaborations relevant to SUD efforts, per se. Accordingly, developers of SUD medical home efforts need to be mindful of at least two points: (1) substantial investment is being made in other sectors of medicine with little or no regard to substance use morbidity because such morbidity is either ignored or regarded as irrelevant, and (2) many generic efforts to enhance care implicitly include SUD treatment and prevention or otherwise present opportunities for inclusion of a SUD treatment component (e.g., comprehensive medical homes, school-based interventions, telemedicine). Whether SUD project funding by the CMMI is appropriate or otherwise (i.e., too large or small) is beyond the scope of this analysis.

Returning to the ACA text directly, beyond the establishment of the CMMI, there are numerous and eclectic references to the development of medical home or coordination of care strategies, and they include direct incentives as well as training and evaluation investments to encourage such programmatic development. Section 3022 of the law requires the Secretary to establish a shared savings program that increases coordination between Medicare parts A (hospitalization) and B (outpatient services), including the establishment of Accountable Care Organizations (ACOs) to monitor and be responsible for that effort (ACA § 3022(a)(1)(b)(2)(H) – pp. 313-314). In July 2012, 89 ACOs were approved by CMS, 5 wholly or partially based in Maryland, with a combined Maryland/Pennsylvania-based network of 652 physicians (Centers for Medicare and Medicaid Services, 2012c).

The ACA establishes a national Pilot Program on Payment Bundling to emphasize controlling costs for episodes of care surrounding hospitalization, including the use of care coordination and delivery strategies such as patient-centered medical homes (Centers for Medicare and Medicaid Services, 2012a). Another provision of the law requires the Secretary to evaluate and revise as necessary rate methodology pertaining to Medicare Advantage plans for persons with special needs, including those with mental illness, and absent any mention of those with SUDs (ACA § 3205(f)(iii)(III) – p. 375). A neighboring provision in the law requires the independent Medicare Payment Advisory Board to make recommendations to "improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement" (ACA § 3403(c)(2)(B)(ii)(I) – p. 410). The law also requires the Secretary to establish a grant program for the establishment of "Community Health Teams to Support the Patient-Centered Medical Home" described further as interdisciplinary and primary care focused (ACA § 3502(a) – p. 435). In this health team description, patient-centered medical homes were said to have the following attributes/components: (1) physicians or other primary care providers, (2) whole person orientations, (3) coordinated and integrated care, (4) evidence-based practices supported by information technology and continuous quality improvements, (5) maximizing access to care, (6) payment strategies that add value (ACA § 3502(c)(2)(A-F) – p. 436). The health team is further expected to attend to chronic disease management (ACA § 3502(c)(2)(A-F) – p.436) and provide

24-hour care management as well as transition management between care settings (ACA § 3502(c)(2)(A-F) – p. 436). Medication management is yet another specified provision of the ACA, again the target of grants to enhance the treatment of chronic diseases (ACA § 3503(c)(9) – p. 439). Overall, then, the ACA establishes several grant programs to support care coordination of one form or another, although it is unclear from the law how all of these different programs might interact with one another despite apparent overlap between them.

Workforce/Training/Research

Section V of the ACA turns to training initiatives to bolster the workforce required to implement many of the law's provisions. These include provisions for grants to train physicians and osteopaths "relevant to providing care through patient-centered medical homes" (ACA § 5301(a)(G)(i-iii) – p. 545) with preference for programs that innovate in the primary care domain (ACA § 5301(b)(3)(B) – p. 546). Additionally, these training efforts include geriatrics specialists, as well as public health practitioners, with the stipulation that those trained be required to specified service for 2 to 5 years after completion (ACA § 5302(d)(2) – p.547) (ACA § 5305(a)(e)(3) – p. 554) and that "Training under such a plan shall emphasize patient-centered, interdisciplinary, and care coordination skills" (ACA § 5315(d) – p. 568).

One training provision is entitled the Primary Care Extension Program, and it aims to "educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services)" (ACA § 5405(a)(2) – p. 582). This initiative is facilitated by "health extension agents" who offer assistance to primary care providers and practices toward adoption of principles of the patient-centered medical home (ACA § 5405(a)(3)(A) – p. 582). Its presence in the law underscores the focus on medical homes that can and do include SUD services, but more generally are anchored in the primary care domain of medicine.

Section VI of the law is entitled Transparency and Program Integrity, and contained in that section is a provision to establish a Patient-Centered Outcomes Research Institute (POCRI) (ACA § 6301(a)(2)(B) (c) – p. 665). As of April 2012, the POCRI has funded 50 two-year pilot projects across 25 states, including 3 projects in Maryland. These projects are designed to develop methods and frameworks for patient-centered outcomes research moving forward. For example, one project in Maryland (principal investigator [PI]: Clifton Bingham, Johns Hopkins University) received $655,944 in funding to test the impact of systematic patient-centered outcome monitoring on a clinical practice serving patients with rheumatoid arthritis as an example of a chronic disease. Perusal of the 50 project titles nationally indicates that only one focuses on SUDs, a $678,107 study evaluating a standardized instrument measuring alcohol use outcomes as a tool for comparative effectiveness research (PI: Paul Pilkonis, University of Pittsburgh). According to the POCRI website, funding for such projects is expected to be approximately $500 million per year between 2014 and 2019 owing to general fund appropriations and $2 per Medicare member fees assessed to support this program (Patient-Centered Outcomes Research Institute, 2012). As such, there is considerable opportunity here for

patient-oriented research for SUDs and other aspects of the health care delivery system.

Finally, under section X of the ACA, provisions are evident that provide financial incentives for states or community-based collaboratives to enhance lifespan coordination of care efforts, including the establishment of medical homes. One incentive targets community-based services as a long-term care alternative to skilled nursing facility placement. It further permits federal matching funds for such alternative services if they are part of "conflict-free case management services" and if ongoing monitoring confirms desirable outcomes (ACA § 10202(c)(5)(B) – p.847). Regarding community-based collaborative care more generally, a section of the law notes that the Secretary may award grants to support efforts, including those that "assist low-income individuals to obtain a regular primary care provider or a medical home" or to "provide case management and care management" (ACA § 10333(d)(A & B) – p. 880).

Summary of ACA Review

Overall then, there are numerous instances in the ACA that encourage greater use of medical homes and coordination/integration of care more generally, and especially as these concepts pertain to primary care. References to SUD treatments are far less frequent, although evident in the law, especially as an essential benefit along with mental illness and behavioral health care treatments. Accordingly, it can be said that the ACA offers numerous emblematic and financial incentives toward greater integration of SUD treatments into overall medical care, as well as toward the possible development of health homes specifically designed for those with SUDs. This latter prospect, however, is limited by the complexity of the law (i.e., its numerous options) and more immediately by the complexity of the medical care delivery enterprise, which remains focused on the primary care domain. Moreover, it must be admitted that a primary care focus is the goal, even as certain chronic conditions may warrant special attention in a minority of cases. The remainder of this report reviews published literature as it pertains to the development of medical homes or other coordination or integration of care efforts for persons with SUD-related morbidity especially.

Published Literature on Medical Homes and Substance Use Disorders

Peer-reviewed and other literature was accessed by Internet searches and with the assistance of several library databases to isolate publications from the past ten years that addressed concepts associate with health care coordination, integration, or medical homes, especially as such concepts pertained to behavioral health disorders. In total, more than 50 separate published items were reviewed in detail for this report. Particular attention was paid to the barriers, promoters, and general methods of such health care reorganization strategies. The following narrative reviews those articles and provides summary tables that highlight the definition of medical homes (Table 2), barriers and promoters regarding their achievement or the achievement of similar efforts (Table 3), and model or otherwise exemplary program descriptions of medical home or care coordination efforts that explicitly include some provision for the treatment or prevention of SUDs (Table 4).

Report Commissioned by Maryland's Health Department

In late 2011, Maryland's DHMH issued a report prepared by outside consultants entitled "Future Options for Integrated Behavioral Healthcare" (Croze, Cohen, & Capoccia, 2011). That report was commissioned under the premise that Maryland's current behavioral health care system, like that of most states, is too fragmented regarding coordination of care along various dimensions, including across distinct medical disciplines (e.g., substance abuse vs. other psychiatric) as well as different levels of care (e.g., inpatient vs. primary care). The options described include patient-centered medical homes, an option that is characterized as one that "At its basic level…rejuvenates the definition of primary care" (p. 7). (For a description of what defines a medical home, see Table 2.) The report further notes that medical homes should be primary care physician directed, whole person oriented, focused on coordination across all elements of health care, and quality and safety oriented. Moreover, the report states that such medical homes should strive to enhance access and be supported with payments that reflect their added value. The expanding role of FQHCs as medical homes is noted more than once in this report, as is taking advantage of the State Plan Amendment provision of the ACA to develop and fund medical homes. The report was based on a literature review, as well as direct stakeholder input. It concluded that for Maryland to achieve greater integration of behavioral health care into overall health care efforts, the DHMH needs to implement short-term reforms that develop performance risk for the specialty mental health ASO vender, as well as health homes for special populations with high behavioral health needs. In the long term, the report advocates for one of two options: (1) a complete, albeit protected, integration of behavioral and somatic health care services under a single financial and data management umbrella; or (2) a behavioral health carve-out moving mental health and substance abuse services from separate Medicaid managed care and FFS funded programs, respectively, under a single umbrella to directly connect those brain-based medical services together under the same protected behavioral health payment regime. These two options are currently being deliberated as principal models in a DHMH-orchestrated study process ongoing in Maryland and culminating with a fall 2012 report aimed at inspiring legislative action to forward the state's behavioral health integration efforts (Maryland Department of Health and Mental Hygiene, 2012).

Table 2. What Is a Medical Home?

Component	Evidence
Physician-directed	Primary Care Physician Group Support (Croze, Cohen, & Capoccia, 2011) Center for Medicare and Medicaid Advisory (Mann, 2010)
Whole person orientation	Primary Care Physician Group Support (Croze, Cohen, & Capoccia, 2011) Other stakeholder and expert consensus (Institute of Medicine of the National Academies, 2005; Takach, 2011; The Joint Commission, 2011; URAC, 2012) Family support included (Center for Health Care Strategies, 2011; Mann, 2010) Center for Medicare and Medicaid Advisory (Mann, 2010)
Care coordination, management	Primary Care Physician Group Support (Croze, Cohen, & Capoccia, 2011) Other stakeholder and expert consensus (Institute of Medicine of the National Academies, 2005; National Center for Quality Assurance, 2011; Takach, 2011; The Joint Commission, 2011; URAC, 2012) Transitional care and follow-up (Center for Health Care Strategies, 2011) Center for Medicare and Medicaid Advisory (Mann, 2010)
Optimize quality and access	Primary Care Physician Group Support (Croze, Cohen, & Capoccia, 2011) Other stakeholder and expert consensus (Institute of Medicine of the National Academies, 2005; National Center for Quality Assurance, 2011; The Joint Commission, 2011; URAC, 2012) Promotes overall health (Center for Health Care Strategies, 2011) Center for Medicare and Medicaid Advisory (Mann, 2010)
Primary care-centered	Primary Care Physician Group Support (Croze, Cohen, & Capoccia, 2011) Other stakeholder and expert consensus (Takach, 2011)
Data- and improvement-driven; tracking	Other stakeholder and expert consensus (Institute of Medicine of the National Academies, 2005; National Center for Quality Assurance, 2011)
Encourages self-support and community supports	Other stakeholder and expert consensus (National Center for Quality Assurance, 2011)
Health information technology	Expert opinion (Center for Health Care Strategies, 2011) Center for Medicare and Medicaid Advisory (Mann, 2010)
Adequate and flexible payment/funding	Primary Care Physician Group Support (Croze, Cohen, & Capoccia, 2011) Center for Medicare and Medicaid Advisory (Mann, 2010) Other stakeholder and expert consensus (Institute of Medicine of the National Academies, 2005)

Review of the ACA's Anticipated Impact on Substance Use Services

In mid-2011, Jeff Buck, writing as a senior advisor to CMS, reviewed the implications of the ACA on substance abuse services specifically (Buck, 2011). His analysis began with a reminder to readers that existing substance use treatments differed from other types of medical care in several significant ways. SUDs are frequently delivered in rehabilitation facilities rather than hospital-based or other medical clinics. Additionally, professionals at SUD treatment facilities typically have limited training (a bachelor's degree or less), and less than half (~40 percent) of these facilities accept Medicaid or private pay dollars. Buck's narrative notes that the Parity Act and the Medicare Improvement for Patients and Providers Act[2] of 2008 both substantially narrowed the gap between behavioral health and other medical services in terms of insurance coverage. Regarding the ACA directly, this policy review also described several provisions of the law, including medical homes "designed to increase health service delivery through various types of integrated systems, often based on primary care...including the integration of substance abuse and mental health services with general medical care."(p. 1404). The review cited scholarly works suggesting that $11 billion of ACA funding for FQHCs will increase case capacities of these safety-net centers to 44 million persons by 2015, up from just 18.8 million in 2009. Moreover, those new cases will have relatively high levels of persons with behavioral health morbidity. Other trends anticipated are declines in block grant money for SUD treatment efforts and increases in the pressure to overemphasize traditional biological aspects of SUD treatment regimes or other forms of therapy. Buck's review cautions, like other reviews of the ACA, that essential benefits definitions across programs may not always include the full array of SUD coverage desired, especially in the social support domains (Garfield et al., 2010; Ulmer C, Ball J, McGlynn E, & S., 2011). Overall Buck's review seems to suggest that moving forward both the principals of "mainstreaming" and "exceptionalism" (Frank & Glied, 2006) for SUD treatment are relevant, with parity legislation and the ACA encouraging common care themes that cross-cut from SUDs to other medical issues, but history and other aspects of the ACA that warrant some maintenance of the theory that SUDs (and other mental disorders) warrant special scrutiny and dispensation.

Medical Homes in 17 Different Medicaid Programs

Mary Takach of the National Academy of State Health Policy recently published a review of patient-centered medical home initiatives in 17 different state Medicaid programs (Takach, 2011). In that review, Takach described the medical home concept as follows:

[2] Part of this federal legislation reduced allowed patient copayments for mental health and substance abuse services under Medicare Part B from 50 to 20 percent.

> A patient-centered medical home is an enhanced model of primary care in which care teams, lead by a primary care provider, attend to the multifaceted needs of patients and provide whole-person, comprehensive, coordinated, and patient-centered care. (p. 1325)

The Takach report, detailed below, is a useful description of yet relatively new efforts to implement medical homes across a variety of geographic and clinical venues, and using several different design strategies.

Accrediting Organizations

Familiar concepts are expressed in the Takach's quote above including the principle that medical homes typically are centered in primary care. Most of the programs reviewed are less than two years old, are under the oversight of state officials with substantial stakeholder input, and are based on national standards from one of a small number of accrediting organizations. The accrediting organizations include the National Center for Quality Assurance (NCQA), URAC (formerly the Utilization Review Accreditation Commission), and the Joint Commission, all of which can be described as entities governed by health care stakeholders including clinicians, consumers (especially large employers), and industry representatives.

Review of the criteria from each of the preceding organizations yields numerous overarching constructs regarding the engineering of medical homes and long lists of specific criteria used to score a given program. Behavioral health issues are infrequently earmarked or noted, and SUDs even less so. The NCQA score sheet and scoring criteria was the easiest to obtain. It contains six standards (enhance access and continuity, identify and manage patient populations, plan and manage care, provide self care support and community resources, track care and coordination, and measure and improve performance). These six standards are measured across a total of 152 factors with weighted scoring attached to each, presumably reflecting their relative importance as components of the medical home. Moreover, basic medical home certification requires that minimal scores be achieved across the six standards, and different levels of certification (ranging from basic [Level 1, a passing grade] to the highest [Level 3, superior to other levels]) can be achieved based on cumulative score. The highest NCQA level requires a score of 85 out of 100 possible points. To pass basic NCQA standards, a program must maintain evidence that they do the following: provide adequate daily access, use data to manage patient populations, provide care management, support self-care processes, provide referral tracking and follow-up, and implement continuous quality-improvement actions (National Center for Quality Assurance 2011; National Center for Quality Assurance, 2011).

A closer look at the NCQA documentation reveals specific, albeit infrequent, notations about SUD treatments. Under the standards for plan and care management, they explicitly note that mental health and substance abuse conditions are among those that should be identified for targeted intervention. Additionally, with regard to self-care and community resources, NCQA writes that medical homes should "provide or arrange for mental health/substance abuse

treatment" (National Center for Quality Assurance, 2011, Table 1, p. 6).

Overarching medical home concepts put forth by the Joint Commission (The Joint Commission, 2011) and URAC (URAC, 2012) are similar to those of NCQA, with the possible exception that the NCQA uniquely and explicitly makes mention of self-care and community resources at the highest level of its description. Still, even this point should not be overstated because readily available Joint Commission documentation lists 176 performance elements composing their evaluative criteria, and URAC has 28 standards and 50 "optional standards" to characterize the same concepts. Perusal of all these guidance documents is a useful exercise, but also one that will identify considerable verbosity and redundancy. It may well suffice for a compliance officer to peruse each one to construct their own practical criteria or to settle on one of the three that best suits their needs and data management capabilities. Tailoring the criteria may be especially important for SUD treatment stakeholders because the aforementioned scoring resources are relatively sparse regarding such specific medical care efforts.

In terms of mentions of behavioral health generally in the Joint Commission and URAC materials, neither is very extensive. The URAC materials make no explicit mention of behavioral health, but the Joint Commission materials do in their references to comprehensive care (with explicit mention of substance abuse services) and in their reference to information technology. Overall then, mention of behavioral health issues in such documentation is quite limited, as they tend to focus on higher level systems of care issues.

Mary Takach's synthesis, after noting the various standardized criteria for medical homes described earlier (Takach, 2011), concluded that Maryland altered and adapted criteria for that state's purposes to emphasize information technology. Additionally, Takach concluded that 6 of the 17 states she reviewed created their own medical home criteria rather than adapt those proffered by accrediting organizations directly. Despite this suggestion that flexibility in design is doable, Ms. Takach cautioned medical home developers in Medicaid (and those dealing with multiple payers especially) to be mindful of national standards to insure access to available federal and other funding streams. Incentive payments for medical homes appear similarly variable per Takach's review. Care management fees range generally from $1.20 to $8.66 per member per month (except for Minnesota's program: $10.14 to$79.05). Minnesota has "complexity tiers" for additional payments based on the number of chronic conditions. Enhanced FFS payments have been tied to certain evaluation and management codes, lump sums have been used to encourage start-up, and pay-for-performance approaches have been used to reward successes.

Outcomes and Growth of the Medical Home Enterprise

Analyses conducted thus far indicate that medical homes can result in health care savings, although the reports do not consistently demonstrate such trends with control groups, but rather rely on time trends only—a method that is misleading if costs would have changed because of other factors. Still, at least the following types of health care savings were observed: In

Oklahoma between 2008 and 2010, savings of $29 per member per year were achieved. In Colorado between 2007 and 2009, savings of $215 per member per year were observed when comparing medical home enrollees with non-enrollees. Moreover, the Colorado program showed that pediatrician participation in Medicaid increased markedly from 20 percent to 96 percent of providers in the wake of their medical home intervention. Finally, in Vermont, inpatient utilization costs were said to have declined by more than 20 percent because of that state's medical home intervention.

The Takach's report makes no direct mention of mental health or SUD services. It does suggest that incentives coming directly from the ACA will advance the medical home development effort, but it also offers data suggesting that medical home development efforts were accelerating prior to the that legislation. As of 2010, the year the ACA was signed into law, more than 1,500 primary care medical home sites had received NCQA recognition, up from only 28 recognized as of December 2008 (National Center for Quality Assurance, 2011).

FQHCs as a Focal Point for Medical Home Partnerships

One recent case study described a pilot effort to better integrate primary care and behavioral health by way of a partnership between an FQHC, a community mental health center, and multiple substance abuse treatment facilities (Lindly, Skaff, Halima, & Fantacone, 2011). This effort took place in Grand Rapids, Michigan, and coupled the resources of facilities within one block of each other. A steering group and staff and patient focus reporting groups were used to qualitatively assess the effort. The chronic care model (i.e., that chronic illness should be addressed with both community and health system resources that encourage action toward health improvements by patients and their providers) was the overarching framework of this effort. The initiative was launched for adults with co-occurring chronic conditions including serious mental illness and SUDs, but not exclusively for such illnesses. For this pilot, 15 patients were engaged, 12 with serious mental illness. Noted Barriers to implementation were lack of understanding and cultural differences between primary care and behavioral health providers, limited leadership, lack of funding, difficulties standardizing operational and clinical procedures (reimbursement issues especially[3]), and strict confidentiality laws. Factors that were said to enhance the evolution of this integration effort were obtaining buy-in from stakeholders including support from leaders, collaboration, email communication, and provider training. (Additional challenges and opportunities to coordination of health care—especially SUD care—are summarized in Table 3.)

To conceptualize the spectrum of need for more integrated care, Lindly and colleagues used a four-quadrant model with two dimensions—low and high behavioral health morbidity needs and

[3] This includes the familiarity with public and private insurance billing, and constraints on such billing such as limits on same day billing for separate services, absence of cost centers for non-physicians, primary care physicians restricted from billing for mental health services, restrictions on billing by school-based health centers, and lack of reimbursement for screening and prevention.

low and high physical health needs—and suggest that fully integrated care may only be needed for those with high morbidity in one or both these dimensions. Their review of existing literature identified team approaches to achieve such integration, and those teams were often lead by primary care providers. They specifically recognize the Rhode Island Free Clinic for utilizing physician and nursing trainees as part of the team. They also recognize a community health center in Buncombe County, North Carolina, for using masters-level behavioral health therapists co-located with a team of physicians, and they note further than one behavioral health clinician is always available and the waiting room is shared with the physical health side. The final implementation team was composed of an internal medicine doctor, a psychiatrist, a registered nurse, a medical assistant, a pharmacist, and three health coaches. This is a prodigious team for only 15 patients (their pilot sample), but they were presumably assembled to design as well as test the intervention for eventual expansion.

Qualitative interviews with the steering committee, staff, and patients found that mundane practices and issues both presented challenges toward or facilitated the integration of care effort. E-mail, for example, was a noted communication facilitator, whereas shortages of time to deal with coordination of care and lack of shared space were inhibitors. Additionally, the authors of this analysis noted that lack of practice standards was problematic. In many ways, this case study stated the obvious. For example, they wrote that staff, stakeholders, and those steering the process:

> perceive their own buy-in to the initiative as well as support for the initiative among their colleagues and their abilities to effectively work with their colleagues as advancing the initiative's progress. (p. 32)

Accordingly, it seems they were compelled to write that they and others need to believe in the change and feel competent to implement that change prior to taking action. Though true, it does not seem very novel or instructive. Instead it states what appears to be an obvious fact of life: changing complex systems is difficult and often requires both inspiration and education/skill for that change to be executed. Unfortunately, this is only one example of the abundance of complex language that surrounds the coordination of care literature in health care, literature that is often full of glamorous ideas, but short on substance.

In summary, this case study by Lindly and colleagues was optimistic about integration of care for persons with physical and behavioral illness by connecting FQHCs with mental health and substance use providers, but their strategy for doing this was limited to straightforward organizational approaches, and their discourse was limited by a small sample and the qualitative methods they employed. Accordingly, the Lindly et al. report is of descriptive use mostly, but far less useful as a tool to encourage one option over another. That being said, it does describe a concrete effort to use FQHCs as a center point for medical home expansions. The FQHC focus has been noted by others as an important venue of such expansion (Abrams, Nuzum, Mika, & Lawlor, 2011).

Table 3. Challenges and Opportunities for Better Coordination of the Broad Health Care Enterprise*

Challenges		Opportunities	
Description	**Evidence**	**Description**	**Evidence**
Payment reform and funding	Primary care physician group support (Croze et al., 2011); stakeholder report (Finkelstein et al., 2011; Lindly et al., 2011)	Strong leadership	Stakeholder report (Lindly et al., 2011)
Inertia from status quo	Consultant's opinion (Croze et al., 2011)	E-communication/ Technology	Stakeholder report (Lindly et al., 2011)
Essential benefits limits	Expert opinion; review of status quo (Buck, 2011; Garfield et al., 2010; Takach, 2011)	FQHC expansion/leveraging	Stakeholder report (Lindly et al., 2011); per ACA details (Abrams et al., 2011)
Medical practice culture	Stakeholder report (Finkelstein et al., 2011; Lindly et al., 2011); practitioner comfort (Finkelstein et al., 2011; Kunins, Sohler, Roose, & Cunningham, 2009); expert opinion (Davidson & White, 2007)	Social justice argument	Vulnerable populations have high needs and benefit from coordinated care (Boyer & Indyk, 2006; Edlin et al., 2005; Secker et al., 2006)
Confidentiality laws and requirements	Stakeholder report (Lindly et al., 2011)		
Stigma	Expert opinion, high incarceration rates (Davidson & White, 2007); dark past (Davidson & White, 2007); patient opinion (Edlin et al., 2005)		
Burdens of quality data collection and monitoring	Suggestion of expert analysis (Medical Directors Council, 2005)		

* Emphasis placed on salient factors influencing substance use disorder care care

Simple Interventions that Coordinate SUD with Other Types of Medical Care

Not many of the peer-reviewed articles studied for this report provided quantitative indicators regarding factors that increased integration of care. One that did was a survey of HIV/AIDS providers regarding their comfort with prescribing buprenorphine for opioid-addicted patients (Kunins et al., 2009). With a 41 percent response rate (n=497), they found that only 16 percent of providers supported the use of buprenorphine in primary care and that family physicians and general internists were far more likely to support such care than infectious disease specialists. This difference likely reflects a discomfort that HIV infectious disease experts have with SUD therapy prescribing. The difference moreover also represents a strong contrast to the use of psychotropic drugs for mental disorders such as depression because these drugs are frequently prescribed by general practitioners (Garrison & Levin, 2000; Valuck et al., 2007).

Simpler interventions than medical homes have been tested that integrate SUDs and physical health care. One specific example is that of a tobacco cessation intervention coupled to inpatient admissions of all types (Buchanan & Likness, 2008). During such admissions, tobacco screening was implemented, and those who consented were admitted to an 8-week trial that involved brief counseling, a nicotine patch prescription, information booklet, telephone hotline, and facilitated identification of a support partner (i.e., someone selected by the patient to help them quit smoking). Follow-up drug testing found that tobacco use was reduced by this relatively simple intervention. It is not difficult to imagine expanding such efforts to other legal and illicit substances, although tobacco cessation is somewhat distinctive because its use is legal and arguably more tolerated by society than other forms of addiction.

Patient–Clinician Relationship

In one of the first studies of its kind, careful analysis of the components of primary care that yield the best addiction outcomes was conducted in a population of 183 persons who initiated primary care after discharge from a residential detoxification facility (Kim et al., 2007). Using a standardized instrument to measure the quality of the primary care received, this study found that such quality indicators are correlated with downstream addiction severity indices (a standardized measure for that pathology). More specifically, this research found that after adjusting for health insurance, gender, race/ethnicity, primary care utilization, or baseline addiction severity (all of which proved nonsignificant statistically), eight of nine primary care quality indicators were inversely correlated with addiction severity. Most notably, measures of patient trust in their clinician and the clinician's familiarity with the "whole person" were especially marked and significant predictors of better SUD outcomes. These results underscore the importance of the provider–patient relationship for good addiction outcomes in this primary care intervention for persons with SUDs, and it also indicates that generalists (rather than SUD specialists) can offer effective SUD treatment.

Recovery as a Framework for Integration

Davidson and White (2007) offer a reminder to the broad behavioral health field that the concept of recovery represents an important rationale for better integration of mental health and addiction services. The authors based their work on the premise that separate treatment of mental health and SUDs is ineffective and that more than 25 years of logic, scholarship, and expert consensus has supported the conclusion that increased integrated care is desirable, even as they also acknowledged the "uneasy relationship" that has long existed between the mental health and addiction treatment communities (p. 109). They also noted the "dark past" of ineffective and harmful treatments that have plagued both mental health and SUD treatment efforts in recent history (p. 110). The aim of such analysis is to shift the rational for integration from its usual anchor of common etiology/pathology to one of recovery. From that perspective, they argue that both mental health and SUD treatments have similar goals that include the pursuit of full, meaningful lives for patients who experience substantial and often chronic morbidity that broadly impacts their daily ability to function. With recovery as a framework, essential characteristics of any treatment programs for persons with mental health and/or SUD morbidity were suggested to include outreach/engagement, coaching/mentoring, assessment, rehabilitation, peer support, family education and support, legal advocacy, and intensive clinical intervention (crisis, pharmacological, and psychological). Many of these components are recognizable as medical home concepts, although Davidson and White did not use that terminology. They finally noted that treatment differences yet exist that might impede integration efforts. Those treatment modality differences include the fact that acute inpatient and assertive community treatment efforts are more akin to mental health treatment, whereas detoxification, contingency management, and motivational interviewing are more akin to addiction treatments.

Social Justice Rationale

More than one published article about patient-centered or integrated care used a social justice framework to argue that society has a responsibility to see that certain vulnerable populations have access to such care. One group of experts made this argument in their discourse about setting up regional health authorities for persons with chronic illness and disability in Ontario, Canada (Secker et al., 2006). A second set of experts focused on high-needs HIV patients as targets of comprehensive health care management (Boyer & Indyk, 2006). Their vignettes were demonstrative of such high needs.

One story was of a 37-year-old, active, woman discharged from inpatient treatment for her asthma on a Saturday without methadone for her heroin addiction. She suffered a heart attack the next day, which was likely related to injecting cocaine. She became bed-ridden, eventually suffered a second heart attack, and died en route to the hospital—all within days of her asthma-related discharge. A separate story had a far better outcome. It involved a 34-year-old woman with HIV and a history of heroin and cocaine use who underwent radical mastectomy in response to a breast cancer diagnosis. Her post-surgery experiences included incarceration, homelessness,

state-enforced separation from her 9 year old daughter, and at least one episode of major depression. Via "intense and unfailing" (p.161) clinical support from a hospital-based AIDS center in Manhattan, New York, this patient became adherent to her antiretroviral drug regimen and she also established herself and her daughter in an independent living situation. Both of these vignettes demonstrate the complex, indeed sometimes chaotic, array of medical and social challenges which SUD patients might face. Moreover, they demonstrate divergent outcomes- potentially catastrophic and deadly, but possibly favorable if intensive clinical interventions can be implemented, and if such interventions include consideration of both social supports and medical needs beyond a single acute episode of illness (Boyer & Indyk, 2006).

Yet another recent publication addressed hepatitis C treatments for IV drug users (their risk of infection is 80 to 90 percent). This report provided evidence that such IV users often avoid medical care because of negative experiences they have with the health care system, including condescension and unresponsiveness to their needs (Edlin et al., 2005). Moreover, this review provided numerous citations showing not only that SUD decreases adherence to infectious disease (hepatitis C, HIV, tuberculosis) treatments, but also that such a tendency can be completely reversed if the SUD is properly treated.

More on Definitions and Evaluation Criteria

The Center for Health Care Strategies released a fact sheet in March 2011 to advise interested parties about the health home opportunities in the ACA. It describes health home components thusly, reiterating definitions previously put forth: (1) comprehensive care management, (2) care coordination and health promotion, (3) comprehensive transitional care/follow-up, (4) patient and family support, (5) referral to community and social supports, and (6) health information technology (Center for Health Care Strategies, 2011). The advisory further notes that health homes are intended to cover persons who generally have two or more chronic conditions, explicitly including mental health and SUDs among other illness such as asthma, heart disease, and obesity. Additionally, a singular condition could be sufficient for eligibility if that condition is a severe and persistent mental illness or if that condition increases risk for a second chronic disease (e.g., heart disease, hepatitis C infection). Providers could be a team or an individual practitioner and may include hospital-based clinics or community mental health centers. This brief makes an explicit distinction between health homes and medical homes, stating that the former pertains to primary care, whereas the latter involves focus on a chronic condition and thus the central point of care delivery may not be a primary care venue. The terminology distinction does not always seem clear and useful as one could reasonably expect the responsibilities of a medical home or chronic health home to be similar with the key difference between them being that medical homes engage patients in good health, whereas the chronic health homes engage those with persistent and relatively serious illness. Accordingly, the distinction might be better conveyed by calling them both "medical homes", and stating simply that some be tailored for persons with special needs or a special condition, whereas others (indeed most) should target members of the general population without such needs.

In late 2010, CMS sent a letter to health officials in all 50 states regarding state options for health homes that are similar in content to the report noted in the preceding paragraph (Mann, 2010). That letter further noted that "adequate payment" is a guiding principal of medical homes, presumably payment for overarching as well as direct provision of care services connected to such efforts. Mann also wrote that home health agencies could be the designated medical home for certain subpopulations. The CMS letter cited a 2007 Commonwealth Fund definition of medical homes: "A healthcare system that offers patients a regular source of care, enhanced access to physicians and timely well organized care" (p. 2). The concepts implied thus are quite straightforward conceptually, but challenging in reality to achieve. The standards for program evaluation and development noted by Mann's letter include the Agency for Healthcare Quality and Research (AHRQ, www.pcmh.ahrq.gov) and the Substance Abuse and Mental Health Services Administration (SAMHSA), which has launched 56 integration projects across the country. Finally, this CMS letter provides a listing of evaluation points for medical homes moving forward, which include readmission rates, lessons learned, chronic disease management and coordination of care indicators, and emergency room and skilled nursing facility admissions. It is these sorts of measures and information that must be reported from the state to CMS in anticipation of ongoing reports CMS must then make to Congress. Accordingly, it is logical for similar information to be collected and analyzed by local programs interested in optimizing their coordination of care efforts.

Other literature pertaining to coordination of care for persons with SUDs or other conditions will heretofore be divided into the following clusters for analytic purposes: those targeting HIV, clinical level descriptions, and system/state level descriptions.

HIV/AIDS as a Coordination Focus

The Health Resources and Services Administration's (HRSA) Nine-Program Review

HIV is a frequent target of behavioral health integration discourse because the somatic impact of HIV/AIDS is substantial and because SUDs (especially IV drug use) are significant comorbidities and correlates of transmission for the disease. Noting that it has long been recognized by researchers, policymakers, and practitioners that integrated is superior to less coordinated care, one recent study reviewed the integration of buprenorphine pharmacotherapy (for opioid addiction) into HIV outpatient care processes (Finkelstein et al., 2011). This study focused on the 5-year experience (2004 to 2009) of nine separate integration efforts across as many different states (one at Johns Hopkins in Maryland). The article offers little programmatic detail, but instead emphasizes barriers to the use of buprenorphine therapy in the context of outpatient HIV/AIDS care. Financial barriers were key and as follows: (1) coping with limited and blended funding streams, as buprenorphine is costly per unit and as coverage for such therapy was spread across multiple payers, including public, private, federal block grant, and various other grant programs; (2) payers of somatic care (for HIV/AIDS) were separate from those for SUD care, and thus reimbursement by the former for addiction care was restricted or forbidden; and (3) even if buprenorphine services could be reimbursed to HIV/AIDS providers,

other important ancillary services such as psychotherapy or toxicological screens, were not similarly reimbursable (instead, for the demonstration projects reviewed, these types of services were typically reimbursed by Health Resources and Services Administration [HRSA] grant funds). Finally, limits on the duration of coverage were noted because many payers cover only detoxification services or because others (such as Medicaid) may require a lengthy enrollment process before therapy can be initiated.

The HRSA review further described workforce training issues that limit the integration of buprenorphine into HIV/AIDS care. Training requirements were noted as both a facilitator and as a detractor. They detracted from more physician involvement because such training raised clinician apprehension about buprenorphine, given the long-established ability of physicians to prescribe methadone for pain management. The article moreover stated that both physicians and other direct HIV/AIDS providers, such as nurse practitioners, were supportive of the need for nonphysician buprenorphine prescribers to be part of the HIV/AIDS treatment team. This suggestion was made along with their explicit conclusions that the nine programs reviewed did not experience any major problems with illegal diversion of buprenorphine. Instead, they wrote that the vast majority of diversion they observed was hording, a potential negative action, but alternatively one that marks prudent personal use rather than illegal drug dealing.

Programs established by the HRSA initiative were described as relatively nonjudgmental and accepting of patient noncompliance compared with traditional SUD programs (e.g., those that required "drug free" clients, including no use of opioid treatment drugs such as buprenorphine). On the reverse side, it was suggested that some programs might have been too permissive, as it was also noted that "Some HIV providers were initially reluctant to establish consequences for patients who persisted in their drug use, fearing that setting limits might deter patients from returning for HIV care" (p. S101). So, it seems, there is somewhat of a balance that HIV/AIDS providers of buprenorphine must establish to keep their patients engaged in care yet motivated toward improvements regarding drug dependency status.

To the surprise of the investigators, the HRSA program review did *not* confirm any shortage of pharmacies that were equipped and willing to dispense narcotics such as buprenorphine for opioid addiction therapy. Additionally, they did *not* find that patients were reticent or resistant to additional treatment if they relapsed. Instead they concluded, based on extensive questioning of providers and patients, that:

> most patients welcomed the opportunity to discuss their drug use openly with physicians … and did not feel judged or unwelcome to return when they relapsed. (p. S102)

This expressed patient sentiment should buoy somatic providers towards increased discussions about, and use of, SUD therapies for their patients.

In summary then, this HRSA review provides qualitative information regarding financial,

training, and clinical culture domains of care that tend to inhibit or encourage the delivery of buprenorphine treatment by HIV/AIDS providers. Despite being cast after the ACA was signed into law, this HRSA discourse makes little mention of the law other than to write that decreasing the number of uninsured adults with SUDs should reduce funding pressures that work against buprenorphine utilization.

Hepatitis C Treatment Interleaved with Methadone Care

At least one rather straightforward model for integrating somatic and SUD services has been implemented and described (Taylor et al., 2011). Based in Rhode Island, it involved a joint venture between an infectious disease and a methadone maintenance clinic to deliver hepatitis C virus treatment (pegylated interferon plus ribavirin) to 11 adult patients with that infection in addition to HIV/AIDS. Pegylated interferon injections were delivered by a nurse at the infectious disease clinic. Ribavirin was either administered with observed methadone doses, or patients self-administered the drug with their "take-home" doses of methadone. Persons with active psychosis, severe depression, or suicidality were excluded from the study suggesting that a comprehensive mental health treatment component was not tested. Hepatitis C RNA levels (as evidence of undesired viral propagation) were monitored throughout the 48-week study, and both physical and emotional status monitoring were part of the clinical visits. Of the 11 subjects initiated on the integration of care protocol, 7 discontinued their therapy because of side effects and nonresponse, 2 dropped out of the study, and 2 maintained an absence of hepatitis C RNA. Although this desired response rate is low (18 percent), it is comparable to that experienced by those not undergoing methadone maintenance treatment. The authors of this small study thus argue that integrating complex viral therapy into methadone-engaged populations is possible and may spare morbidity. More generally, this pilot study indicates that coordination of care between somatic and SUD therapies is possible and potentially productive.

Integration Outcomes Studies Suggest Many Approaches May Be Effective

Two other fairly recent studies offer general integration strategies and data regarding the coupling of HIV/AIDS and SUD care. One study published in 2003 is notable for its humanistic approach (Andersen et al., 2003). It enrolled 45 volunteers with HIV/AIDS and a SUD into care by a treatment team lead by a nurse who employed the LIGHT (Love the client, Intend to help, Give care gently, Help the client improve well-being, Teach the process) method to guide the intervention. The intervention lasted up to 90 days and consisted of the following:

> group counseling/education on topics related to substance abuse, health, and self-esteem; individual counseling at least weekly; recreational activities; weekly meetings with the nurse (medication education and review); visits to a physician treating the client's HIV; and domiciliary care for persons who want a clean, furnished housing unit while enrolled in the program (p. 852)

Outcomes were moderately persuasive. All 45 participants were interviewed 6 months after engagement in the program, but only 29 were available at 12 months. Compared with their baseline interviews, improvements were evident across three different standardized instruments, suggesting increases in well-being and overall functioning and decreases in somatic and psychological morbidity. Although this study suffers from the absence of any control group, it does lend observational support to the importance of intensive and comprehensive medical treatment engagement persons with HIV/AIDS and SUDs.

More recently, a study was published in 2010 that looked at integrated treatment models for persons (n=286) with HIV and SUD across three distinct venues (Proeschold-Bell, Heine, Pence, McAdam, & Quinlivan, 2010). Those venues were two academic medical centers and one community health center; one of the academic medical centers was described as fully integrated, whereas the other used a co-localization approach with few other integration strategies. The general form of the integration interventions were as follows. Primary care and SUD patient oversight developed and used existing and effective protocols, including assertive patient outreach with attention to each patient's social situation, a patient-centered harm reduction approach, and group therapy. Therapeutic approaches were eclectic (including cognitive behavioral, motivational, and stages of change approaches). Therapy at the most integrated academic health center site occurred in the identifying clinic, joint electronic medical records (EMR) were used, and weekly interdisciplinary team meetings were held to discuss each patient. By contrast, the two co-located clinics did not have a joint EMR, instead choosing to emphasize confidentiality, which was protected further by having group therapy sessions located away from the identifying clinic. Regression-adjusted findings at 12 months beyond baseline found that both standardized drug and alcohol severity scores declined significantly, but there was no difference across the three venues. Absent controls, these results offer tacit evidence that integration efforts are effective. Additionally, the results demonstrated no venue effect, indicating that different levels of integration (co-located vs. fully integrated in this experiment) may not yield different results. Instead, it may be sufficient to implement any of a variety of integration strategies which otherwise yield similar results.

In summary, these HIV/AIDS focused integration of care efforts suggest some promise for such efforts, but they also demonstrate that different approaches (e.g., co-localization, full integration) may all yield benefits and that comparative quantification of such benefits, to date, are limited.

Other (Non-HIV/AIDS) Clinical-Level Interventions

Brief Interventions

Outside of the HIV/AIDS domain, coordination or integration of SUD treatment with other branches of medicine is apparent, but it is arguably less intensive overall. Still, it does exist, and it predates the ACA. In 1999, one review of the clinical trials literature describes "brief interventions" by primary care physicians as an evidence-based method to discourage the formation or persistence of SUDs (Fleming & Manwell, 1999). Their conclusion:

> Brief interventions are counseling strategies that primary care physicians can deliver during routine office visits to help clients change their drinking behavior….Numerous studies have suggested that brief interventions can reduce alcohol consumption in a substantial number of at-risk or problem drinkers and can facilitate the referral of dependent drinkers into specialized alcoholism treatment. (p. 137)

Therefore, this simple solution of screening and brief informational therapy or referral by primary care physicians has an evidence base. The problem, identified as far back as 1999, is that these practices are not widely used by primary care physicians. Barriers to use of such straightforward strategies are familiar and include payer resistance to covering the service, training requirements, competing clinical priorities, and traditional separation between primary care and SUD treatment cultures. Moreover, this article notes that additional resources are necessary for successful referral to be made when serious pathology is identified by the brief intervention.

Contrasting Joint Ventures with Cooperative Agreements Using an Integration Framework

A useful qualitative analysis of two contrasting integration efforts was recently conducted (Brousselle, Lamothe, Sylvain, Foro, & Perreault, 2010). The analytic framework for this work included five key dimensions: (1) integration of care (i.e., practices that deal with ongoing, comprehensive patient health care needs), (2) integration of clinical teams (i.e., multidisciplinary professional efforts), (3) functional integration (i.e., coordination between support activities such as financial, management, and information technological services), (4) normative integration (i.e., coherence of values across providers), and (5) other organizational factors contributing to integration. These five factors were assessed using standardized interviews of leaders and staff members serving two separate integration efforts. The first was a joint venture yielding a new treatment clinic for persons with serious mental illness and SUDs, and the second was a strategic alliance that (by agreement) combined select resources of separate SUD and mental health clinics without creating a new single-treatment venue.

Qualitative analysis of the five-year operations of these two integration efforts yielded similarities and differences that are illustrative for others targeting such advances. The joint venture established provisions for evaluating patient health utilization and status, provisions for maintaining the therapeutic alliance, and follow-up/transitional care continuity. At the same time, however, the joint venture did not achieve a full network of collaborating providers with a shared vision for care (e.g., poor liaison and referral activities). The joint venture's integration team received a favorable rating regarding the clinic level; however, it was reported that inter-organizational team efforts (between the originating mental health and SUD entities) were not being developed. Functional integration was also characterized as weak, with staff from each originating agency adhering more to their historic procedures rather than to the new ones adopted for the joint venture. Organizational aspects of the joint venture that were highlighted included

the fact that the effort was championed by a single physician with ties to both parent organizations. Additionally, the venture resulted in the creation of a unified treatment protocol manual to be used by both the psychiatric and addiction professionals brought together.

Regarding the strategic alliance program reviewed, the five dimensions of integration were found to be qualitatively distinctive from the joint venture approach. Integration of care advances emphasized screening and motivational interviewing, thus suggesting that more intensive treatments were not adequately included. Integration of teams and functional integration were not observed. Normative integration was observed in the form of staff stating that they had developed increasing skill to treat persons with mental health and SUDs. Finally, the analysis determined that many informal links between mental health and SUD providers had actually existed before the initiation of the strategic alliance, suggesting building blocks or anchors were in place prior to the intervention.

Absent any outcome measures related to the two integration efforts described in this section, no conclusion was made regarding their relative effectiveness, but instead it was concluded that, as of approximately 2010 when the article was cast, "there is no preferred model for the organization of care for co-occurring disorders " (p. 221). Instead, they argued that the best one can do in engineering a program is to consider each key component noted in their framework for qualitative analysis. They further noted that whatever path is taken, changing a system is time-intensive, complex, and fluid.

Continuum of Integration: Realistic Goals and Ideals

Concepts for integrating care among persons with co-occurring mental health disorders and SUDs was the focus of a lengthy review published in 2011 by researchers at Kaiser Permanente (Sterling, Chi, & Hinman, 2011). That review is a useful referent for this report because it provides a solid summary of the rationale for more integration at the same time as it cautions that *full* integration for many important providers of care is simply not a realistic goal given available structures and resources. Models of mental health and SUD integration proffered by the authors are, from lowest to highest regarding level of coordination, as follows: (1) serial treatment of one disease then the other and so forth, (2) simultaneous treatment (also referred to as parallel treatment), (3) parallel, but well-coordinated treatment (i.e., various providers cross-talk to optimize overall care), and (4) fully integrated care in which a single provider is cross-trained and delivers all care related to mental health and SUDs. They noted that evidence does not presently exist to differentiate between these models, although overall their discourse suggests that higher levels are desired and their model 3 may be optimal in most instances. They also indicated that optimal level of coordination may well depend on level of morbidity, and despite the promise surrounding patient-centered medical homes, the construct's strengths and limitations are not yet fully understood. As a practical matter, this Kaiser Permanent research report also puts forth a useful summary of coordination of care criteria from a well-respected Institute of Medicine report on the topic (see Box A) (Institute of Medicine of the National Academies, 2005).

Box A. Coordination of Care Criteria

- Leadership and stakeholder involvement in creating a shared vision
- "No wrong door" for client entry
- Clear definitions for coordination of care
- Assertive outreach to engage patients
- Standardized performance indicators
- Comprehensive clinical assessment and screening
- Interdisciplinary staff
- Comprehensive services
- All types of disorders treated as important
- Motivational enhancement activities
- Continuity of care, long-term care available as needed
- Harm-reduction philosophy (i.e., goals emphasized over strict compliance)
- Patient information sharing between respective providers
- Flexible funding
- Co-location of providers and services
- Clinical integration when possible (i.e., same provider delivers multiple services)
- Linkages to social support programs (e.g., criminal justice, welfare, schools)

Sources: Institute of Medicine of the National Academies, 2005; Sterling, Chi, & Hinman, 2011

Medical Home Venue: Mental Health or SUD Clinic?

In considering better coordination of care for persons with severe mental health and/or SUDs, it is reasonable to consider either a mental health clinic or a SUD clinic as central to the intervention. One recent study offers empirical support for either venue being appropriate, at least as a recruitment source of persons with substantial morbidity secondary to the co-occurrence of a mental health and a SUD (Havassy, Alvidrez, & Owen, 2004). This study compared the diagnostic profiles of more than 100 persons with co-occurring mental health and SUD at a mental health clinic with a similar number of such patients at a drug treatment clinic. Few differences in these two groups were apparent when reviewing standardized diagnoses as well as addiction severity index scores, with two exceptions: The mental health clinic sample had slightly more schizophrenia spectrum clients (43 vs. 31 percent), and the substance use program had substantially more persons with drug use in the last 30 days (significant odds ratios reflecting higher use of substances ranged from 2.41 for opiates to 5.15 for alcohol). This latter finding likely reflects acute use corresponding with targeted treatment. Still, the conclusion of this work was that the similarities in diagnostic and SUD morbidity are substantial, suggesting that both types of clinics must be prepared in some measure to cope with this dual morbidity (e.g., to serve as a "no wrong door" to a coordinated treatment system for those with co-occurring disorders).

Team versus Individual Provider Management in Methadone Clinics

Another somewhat dichotomous choice that may face those planning an integration of care intervention at the clinic level is whether the responsible provider should be a team or an individual. A team-based approach was empirically supported by an observational study in Australia that compared persons in opioid replacement therapy settings receiving team-based case management with those receiving more traditional individual case management (Day et al., 2011). Both types offer similar supports to clients, but the team-based approach assigns a client to a group rather than a single nurse who manages their care. Client satisfaction ratings generally indicated that the team approach was superior. For example, on a scale of 1 to 10 with 10 being the best, staff quality median ratings were a perfect 10 for the team-based approach compared with 7.5 for the individual case management approach. Given that this design is neither experimental nor based on objective (rather than client report) indicators, the results should be considered cautiously, but they still indicate that traditional care coordination methods can be successfully shifted from a lone provider to a team approach. Indeed, it seems not only practical, but consistent with care coordination goals to construct multi-person care efforts rather than ones that rely on single providers.

Integrating Primary, Urgent, SUD, and Pediatric Care

One somewhat dated report, from 1998, described a structure coupling primary care, urgent care, SUD care, and pediatric care all under a single umbrella—the Deaconess Center, which services a poor inner-city neighborhood in Buffalo, New York (James, 1998). Their published description is interesting because it uses the "integration" lexicon somewhat earlier than others, but moreover because of the choice of programs it integrated. Under the auspices of the Buffalo General Hospital and the medical faculty at State University of New York at Buffalo, an integrated care network was formed to include the four components noted above with notable absence of mental health services. That mental health oversight may have been related to perceived need or jurisdictional issues, but its omission is remarkable.

Today if one visits the Deaconess website, mental health services do appear to be part of the health care package offered there, so it is possible this gap has been closed (http://www.deaconess.com/defaultDCP.cfm?id=8). Whatever the case, the Deaconess integration effort, as of 1998, was described as follows. The Deaconess Center was a designated outpatient unit of the 820-bed Buffalo General Hospital and also a medical teaching site for the State University of New York. The Center was governed by a hospital assistant vice president, a nursing coordinator, and a medical director. Hospital physicians were among the regular personnel attending to the primary practice work at the clinic. Laboratory and other specialty services necessary for clinic clients were delivered by the hospital. The Deaconess general practice included a full array of services such as pediatrics and obstetrics. The urgent care and substance abuse clinics were located on the ground floor of clinic, next to one another, and sharing a common entrance. The urgent care clinic was equipped to deliver emergency care (with a referral protocol to the hospital emergency room), and the substance abuse clinic was

principally one that delivered outpatient treatment for alcohol and drug abuse. Persons using these clinics who did not already have a primary care physician were invited to join the family medicine practice at Deaconess. The pediatric clinic was located in a Head Start program of a neighboring local church. These clinical entities were all joined together by a single medical record number such that all persons had a unique identifier maintained by the primary care site. Continuity care was provided five days per week, substance abuse services were available six days per week, and urgent care services were provided seven days per week. Patients were asked to seek care at the primary or urgent care clinics before using the hospital emergency department. The clinic maintained numbers regarding process and outcomes measures such as inpatient admission and preventative screenings, although this article does not consider whether they were on target or otherwise. The program also somehow (not specified) supported or accommodated community projects including home visit programs, diabetes education, and local health fairs.

Overall, this clinic is notable as a straightforward example of a horizontally integrated medical enterprise that includes an outpatient SUD treatment arm. It is not known how this integration effort has evolved beyond 1998, though the clinic with a full array of services yet exists.

Developing Integration Efforts in Maryland

Given the dearth of published literature about SUD clinic integration initiatives, it is useful to consider other sources of information regarding such programs. Chronic health home presentations to Maryland's Behavioral Health Integration effort (Maryland Department of Health and Mental Hygiene, 2012) offer three different pilot projects that aim to increase coordination of care for persons with high behavioral health care needs (mental health and SUDs). These and other model programs are summarized in Table 4. Moreover, in separate sections below, each of the three presentation to Maryland's Behavioral Health Integration effort are summarized so as to provide some details about their accomplishments as of June 2012.

Maryland's Behavioral Health Integration effort is an initiative launched by the state's Secretary of Health and Mental Hygiene to advance the state's publicly financed health care effort by better integrating mental health and SUD services into that program via various reforms, most recently focused on financial reform and the development of medical homes for persons with serious mental illness. Financial reform has recently been the focus in anticipation of full ACA implementation (January, 2014) and because the Medicaid program in Maryland has (since 1997) been dominated by a managed care structure that includes somatic and SUD services, but carves out (for direct state reimbursement) specialty mental health services. Accordingly, it is hoped that a new financial structure might yield better integration of behavioral health services (Maryland Department of Health and Mental Hygiene, 2012).

The chronic health home piece of this state-based behavioral health integration effort is a direct consequence of the ACA's promotion of medical homes for chronic conditions including serious mental disorders. In the following subsections, each of the three presentations to the behavioral health integration effort is summarized so as to provide some details about their efforts and

accomplishments as of June 2012.

Table 4. Model Programs for Addressing Substance Use Disorders with Some Type of Coordination of Care Enhancement

Entity	Strategy	Medical Home?	Outcomes
Baltimore Substance Abuse Systems, Inc., regulated outpatient SUD[a] clinics	Focus on persons who are high-needs because of multiple diagnoses, disability; or dually eligible for Medicare *and* Medicaid	Not yet deter-mined	Not yet implemented (Baltimore Substance Abuse Systems Work Group, 2012a)
Nine HRSA[b] sponsored clinics	Buprenorphine prescribed in HIV/AIDS clinics	No	Favorable qualitative reports (Finkelstein et al., 2011)
Infectious disease or methadone clinics	Hepatitis C antiviral therapy for persons with HIV and opioid addiction	No	2 of 11 responders, 9 of 11 completers (Taylor et al., 2011)
Intensive outpatient SUD[a] clinic	90-day intensive nursing for persons with HIV/AIDS focused on overall well-being	No	Addiction Severity Index, Short Form-36, and Global Well-Being standardized measurement improvements (no control group) (Andersen et al., 2003)
Infectious disease clinics at health centers	12-month engagement in integrated primary and SUD[a] care; assertive patient outreach; attention to social situation; group therapy; HIV focus	No	Addiction severity declined; fully integrated not different from co-located (Proeschold-Bell et al., 2010)
Primary care provider	Brief intervention to assess, counsel, refer regarding alcohol use/abuse	No	Meta-analysis and review (Fleming & Manwell, 1999)
Opioid treatment clinic—Australia	Team-based case management to address ancillary needs of clients	No	Client surveys indicated team approach is superior to traditional individual case management (Day et al., 2011)
Way Station, Inc.	Primary care for persons with serious mental illness in psychiatric rehabilitation	Yes	None yet (Maryland Department of Health and Mental Hygiene, 2012)

Entity	Strategy	Medical Home?	Outcomes
People Encouraging People	Nurse practitioner assigned as the primary care provider in the context of a clinic for high needs clients	Yes	Increased cardiovascular screening and increased clients with primary care coverage (Maryland Department of Health and Mental Hygiene, 2012)
Institute for Behavioral Resources, Inc./REACH[c]	New primary care clinic built adjacent to opioid treatment facility, also new intensive outpatient program developed	Yes	None yet (Maryland Department of Health and Mental Hygiene, 2012)

[a] SUD=Substance Use Disorder
[b] U.S. Health Resources Service Administration
[c] REACH=Recovery Enhanced by Access to Comprehensive Healthcare

Adding Medical Home Components to Psychiatric Rehabilitation: Way Station

The first provider presentation to Maryland's Behavioral Health Integration effort came from Scott Rose, president/CEO of Way Station, Inc. (www.waystationinc.org), a not-for-profit organization that provides broad services to persons with behavioral health issues including mental illness, developmental delay, and SUDs. The array of services offered by Way Station includes clinical, housing, and employment supports. They have recently added to their effort a three-county chronic health home intervention for persons with serious mental illness. That effort is based on criteria employed in the state of Missouri targeting a similar population under their State Plan Amendment. The Way Station program has three goals: (1) increase primary care access, (2) improve coordination, and (3) enhance client participation. The focus is on the mental illness, first and foremost. Services will either be delivered via co-location in an FQHC or directly at Way Station sites. There will be at least one full-time equivalent director for every 500 consumers. Health information technology will be bolstered by systems maintained by Sheppard Pratt (a large specialty mental health entity serving the region) and will include auto-notifications (e.g., drug–drug interaction alerts) to providers. The program is presently funded by grants for the pilot stage, but sustainability is anticipated via enhanced reimbursement rates for psychiatric rehabilitation services (the focus of the program), as well as compliance (e.g., Commission on Accreditation of Rehabilitation Facilities accreditation) to receive any health home funds that emerge from ACA-inspired actions. Mr. Rose anticipates that the novel services developed will cost approximately $70 to $80 per member per month to sustain.

Primary Care Nurse Practitioner: People Encouraging People

The second chronic health home presentation to the state Behavioral Health Integration effort came from Dimitrios Cavathas of People Encouraging People (www.peponline.org), a Baltimore City-based not-for-profit organization serving persons with various types of disability, including those who are blind, deaf, mentally ill, or homeless. Services this organization provides include psychiatric rehabilitation, assertive community treatment, intensive case management, and

vocational and housing supports. Based on funding from Maryland's Community Health Resources Commission, and billing through Amerigroup and UnitedHealthcare Medicaid managed care providers and Medicare, this initiative has established a primary care nurse practitioner for its clients. This program is said to have, in its first 12 months, serviced 158 Medicaid enrollees, established a nurse practitioner as the primary care provider for 53 of those clients, and demonstrated marked increases in the identification of cardiovascular risk factors among those clients as compared with such screening rates before the intervention was put in place. Regarding sustainability, Mr. Cavathas indicated that "chronic health home funding (from the ACA)" would be very important, but he also was optimistic that cost savings in terms of reduced morbidity would be realized to offset programmatic costs.

A Substance Use Disorder Clinic Medical Home: Institute for Behavioral Resources

The final presentation at the health home work group of Maryland's Behavioral Health Integration work group session came from Yngvild Olsen, MD, MPH of the Institute for Behavioral Resources, Inc./Recovery Enhanced by Access to Comprehensive Healthcare (IBR/REACH) program (www.ibrinc.org). This program is principally focused on addiction and moreover is the most ambitious of the three Maryland integration efforts described, based on capital investment and number of patients potentially served. It involves expanding their existing treatment efforts (approximately 1,200 persons in methadone or buprenorphine/naloxone treatment for opioid addiction) to broaden their primary care services. Presently, this program is constructing space to house a primary care facility in the building that their methadone clinic occupies; that "bricks and mortar" construction effort is being supported by private foundation funding. Additionally, they are developing an intensive outpatient program to complement their less intensive opioid addiction therapy effort. Components of the opioid treatment program ongoing that are to be leveraged moving forward include 3 nurses, a part-time clinician (Dr. Olsen; 16 hours per week), a part-time psychiatrist, 2 clinical directors acting as the management team, and 12 full-time counselors (licensed clinicians). Additionally, there is an intake director and a program director. Extensive cross-communication between staff is anticipated and will be facilitated by electronic health records that are available via secure channels on- and off-site. SUD is treated here as a chronic condition, and establishing patient trust and consistency of care are emphasized values of the care process. Dr. Olsen also noted her impression that a multidisciplinary team approach at IBR/REACH has the potential to spread patient care responsibility among the most proximal and qualified staff. Case management is the norm, and behavioral change is a constant goal. Sustainability of this effort is expected to come by establishing billing of large payers (Medicare, Medicaid, private) and by increasing their patient volume through partnerships with referring clinics.

These three nascent projects exemplify how some Maryland mental health and SUD providers are pursuing medical home type interventions for their patients. The commonalities are that they all bolster primary care and they are optimistic about quality of care and cost savings outcomes that can result from their efforts. This optimism may be reasonable, but it may alternatively spawn unrealistic expectations that medical homes for persons with mental illness or SUDs are a

panacea for their challenging and ongoing clinical needs. To avoid such miscalculations, it may be wise for Maryland medical home developers to be more cautious as they consider and develop such interventions for persons with mental health and SUDs. At the same time, it seems positive that local entities of different types are attempting to craft new efforts that advance such coordination efforts without being inhibited by the likelihood that such endeavors will almost certainly yield imperfect results (Rosenberg, 2011).

Framework for Regulated, Hospital-Based, Outpatient, Substance Use Disorder Clinics

Despite such challenges, the three initiatives described above and other efforts in Maryland and elsewhere continue. One additional example of such an effort is the design achievements of a work group convened by bSAS, the designated substance abuse treatment authority for Baltimore City.

That bSAS group has brought together several key leaders of regulated, hospital-based, outpatient SUD clinics to consider how such clinics can enhance their care efforts for the chronic substance abusers they treat on a regular basis. These "regulated" clinics are designated as such because they are hospital-based and thus they fall under the rate-setting regulatory authority of Maryland's unique all-payer hospital system (www.hscrc.state.md.us). This system determines clinic rate schedules based on program (e.g., outpatient methadone), venue (i.e., hospital address), and uncompensated care liability (i.e., the amount of billed dollars which are unpaid); and the rates assigned are mandated for all payers (public and private). Accordingly in Maryland, hospital-based programs must justify the pricing of their services to a state authority at regular intervals.

The bSAS work group has formulated an outline service delivery model for four groups of Medicaid patients with SUDs based on latent class analysis of Medicaid records from calendar year 2010: (1) adults with high somatic morbidity, (2) adults with high psychological morbidity, (3) adults dually enrolled in Medicaid and Medicare, and (4) disabled adults engaged in methadone or buprenorphine therapy for opioid addiction (Abrams et al., 2012). The work group further drew information from existing tools including Maryland's Assertive Community Treatment criteria, and the Charlson Comorbidity Index. The delivery model framework (yet fairly undeveloped) proposes comprehensive care services (including management of medical comorbidities) across the network of providers available either at the regulated clinic or within the hospital where a clinic resides.

To date, in addition to the program outline, the bSAS work group has developed and disseminated criteria for selecting patients for special health home type intervention, and crafted an intake/referral sheet that records baseline SUD, psychiatric, and somatic morbidity (Baltimore Substance Abuse Systems Work Group, 2012a). The proposed "Medically Necessary Criteria" for admission to the program, includes the presence of an unremitting SUD as well as the co-occurrence of one medical (e.g., heart disease, dementia, diabetes) or psychiatric condition (e.g., schizophrenia, major depression, panic disorder) (Baltimore Substance Abuse Systems Work

Group, 2012b).

System/State-Level Discourse and Scholarship

Finally, this section of the report reviews some state system-level analyses regarding medical homes with an eye toward SUD integration as an explicit component. It is notable that one recent review of medical homes on the state level made only a single mention of SUDs, and that was per tobacco use monitoring only (Kaye, Buxbaum, & Takach, 2011). This reference is noted because it underscores the reality that medical home interventions being implemented today (including Maryland's statewide initiative) are principally targeting primary care as a central point for care delivery and are not targeting serious behavioral health populations in any substantive way.

Despite this emphasis on general medical care, previous and contemporary discourse has considered strategies that specifically aim to bridge undesirable separations between behavioral and other aspects of health care, although those strategies typically do not say much about SUDs per se.

Centers for Medicare and Medicaid Advisory

A recent CMS-funded technical brief detailed state-level options for integrating physical and behavioral health (Hamblin, Verdier, & Au, 2011). Those options were divided into four models: (1) managed care, (2) primary care case management, (3) behavioral health organizations (BHOs), and (4) partnerships between BHOs and the other two. These four options have similarities, but differ regarding payment and contracting separation between primary care, other somatic care, and behavioral health services. The extremes are complete coordination of all three aspects of care, with full risk borne by some managed care entity on the one hand, and a behavioral health carve-out separate from somatic care and even financially managed by an FFS arrangement between care providers and the state (this being the current situation for specialty mental health services in Maryland) on the other hand. The technical brief rarely mentions SUDs specifically, but instead refers more obliquely to attending to serious behavioral health needs, which presumably include some SUD treatments.

As with many of the articles and concepts referred to throughout this report, the message from the CMS brief described in this section is that there are several potential solutions to the problem at hand. Specifically, the CMS brief seems to argue that any of the four payment regimes might work, but state governments need to determine which are best for them based on their status quo and their anticipated needs and expectations. No data are provided that rank a given plan's desirability or efficacy. Instead, subtle pros and cons of each are summarized using narratives. Key decisions that states must make in selecting one plan over another are whether to leverage existing infrastructure or build a more novel system; whether to aim for a comprehensive managed care approach that maximizes integration, at least financially, or instead build a separate behavioral health organization to cope with the idiosyncrasies of mental and SUDs; and

finally whether to consider special programs for certain populations like those with serious mental or SUDs. Health homes are mentioned as potential tools for the systems that emerge, but they are not characterized as essential components to achieve integration.

National Association of State Mental Health Program Directors

In 2005, well before the ACA was passed or even drafted, the National Association of State Mental Health Program Directors (NASMHPD) issued a technical report on integrating behavioral health and primary care services (Medical Directors Council, 2005). That report is yet a useful summary of integration strategies as they pertain to mental disorders especially, but with mention of SUDs as well. In fact, unlike many other published documents about mental health and/or SUDs in the context of health care delivery reform, this report explicitly defines behavioral health services as encompassing both mental health and substance abuse services—and it generally deals with them together. The language in the report further implies that mental health and substance abuse services are overlapping but also distinctive from one another, and distinctive but also overlapping with primary care services. Even in 2005, and influenced by the Presidential New Freedom Commission on Mental Health Report of 2003, this report noted that "integration of behavioral health and health care services is a priority at the national, state, local, and person levels" (p. 10). The report emphasizes the relevance of FQHCs as important targets for integration efforts. Such venue targets have emerged somewhat naturally because FQHCs are key points of medical care for persons with high levels of poverty and disability, and FQHCs are increasing their behavioral health care delivery enterprise (see Box B).

Box B. Federally Qualified Health Centers (FQHCs)

- As of 2004, there were more than 1,000 FQHCs in more than 3,500 communities serving 15 million patients (by 2006, these numbers were expected to more than double).
- In 2003, FQHCs employed more than 70,000 full-time equivalent (FTE) staff, 145 FTE psychiatrists, and more than 2,000 FTE behavioral health clinicians.
- In 2002, nearly 45 million patient visits were made to FQHCs, including 2 million behavioral health visits.
- In 2003, FQHCs received more than 250 behavioral health expansion grants from the Federal Health Resources and Services Administration, with 2006 targets as follows: 75 percent of FQHCs will provide mental health services, and 49 percent will provide substance abuse services.

Source: Tom Curtin, National Association for Community Health Centers, Inc, Bethesda, MD (Medical Directors Council, 2005)

The NASMHPD report described in this section also emphasized the importance of workforce training and readiness to deliver integrated care. Toward that end, they proffered a list of "key competencies" for such a workforce (see Box C). That list is useful, but also seems overly ambitious, especially for a single or small team of persons. Accordingly, it is likely intended as

an ideal to aspire toward and as a goal for relatively extensive teams of persons rather than just one or a pair of physicians or nurse practitioners.

Box C. Key Competencies for Behavioral Health Providers in Primary Care Setting

- Finely honed clinical assessment skills (mental health and SUDs)
- Cognitive behavioral intervention skills
- Group and educational intervention skills
- Consultation and communication skills
- Psychopharmacology and behavioral medicine knowledge base
- Flexible, independent, and action/urgency orientation
- Prevention orientation
- Team and collaboration orientation
- Clinical protocols and pathways orientation
- Focus on impacting functioning, not personality
- Experience with seriously mental ill populations and the workings of the behavioral health system
- Understanding of the impact of stigma
- Strong organizational and computer competency
- Language and cultural competency for group(s) served

Sources: Freeman D, Cherokee Health Systems, Talbott TN; Wilson S. Swope Health Services, Kansas City, MO; Mauer B, NCCBH Consulting, Seattle, WA (Medical Directors Council, 2005)

The NASMHPD review noted that empirical work has documented health care disparities for persons with serious mental illness (SMI), and they further noted that even among populations with SMI, there is considerable skewing of health expenditures. Specifically, they cite 2003 data obtained from the state of Missouri that demonstrated that among a cohort of individuals with schizophrenia (n=19,700), the top 2,000 individuals in terms of health care expenditures averaged more than $50,000 for such expenses in a year, whereas the bottom 10,000 individuals spent less than $5,000 per person. Analysis (not specified) indicated the following correlates to high expenditures: low medication adherence, comorbidities in the somatic domain, co-occurring alcohol or drug abuse, "lack of a stable 'Medical Home'" (p. 25), and complex medication plans. The observation that absence of medical homes and the presence of SUDs both appear to contribute to high utilization and costs is confirmatory that such interventions and targets are important.

The NASMHPD report noted an array of promising practices for persons with SMI that offer a menu of options for providers, including primary care physicians delivering psychiatric services, psychiatrists delivering primary care services, dually boarded physicians with both family/internal medicine and psychiatric training, case managers linking persons between psychiatry and general medicine, and general medical providers linked into specialty mental health provider organizations. These permutations appear complete and nonprejudicial to one or

the other as long as all necessary services are accessible. Accordingly, the report suggests that "the ends" is what is important rather than "the means," and the report moreover indicates that there is no strong evidence base favoring one method over another. Additionally, the discourse in this NASMHPD report, perhaps as expected given it is crafted by mental health authority experts and stakeholders, emphasizes traditional mental health over SUDs. Still, it is the case that chronic SUDs might be considered much the same way as SMIs because both types of disorders are brain- and behavior-based, and both are subject to considerable stigma relative to diseases classified in the somatic domain.

The NASMHPD report uses a typical two-by-two disease framework—with somatic disease on one axis and behavioral health disease on the other—to consider different priorities regarding care coordination dependent on holistic morbidity. For persons with high behavioral health morbidity, they advocate for case management, including targeted approaches and preventive screening for persons with SMI, and they further advocate for some preventive screening by specialty mental health providers directly (rather than by primary care providers). Finally, they make a point of noting that for those with both high somatic and high behavioral health morbidity, the "true" medical home needs to be developed by a team of behavioral health and somatic care generalists and specialists such that it is "individualized…and specifically identifies the responsibilities for each member of the team" (p. 27). This advice, although common sense, seems both succinct and wise. At the same time, however, it does not address financial constraints that certainly impede such intensive clinical actions. Regarding low-morbidity somatic and mental health needs, the NASMHPD recommendations are for co-location (without prejudice to specialty or primary care venue emphasis), and specific mentions often focus on care for depression reflecting its central importance as a treatable mental health condition.

The NASMHPD report summarizes first- and second-generation depression studies as showing that lectures and guidelines do not change behavioral outcomes, but that patient improvements can be promoted by tracking systems for care managers or inclusion of mental health specialists on integrated teams. Third-generation studies are not similarly summarized in the report, but authors noted that the most recent research indicates increased treatment efficacy secondary to on- or off-site specialists or care managers, intensification of the mental health referral process, the use of symptom scales to track patient progress/symptoms, and the use of prescription algorithms for medication management. Among the overarching conclusions derived from such work was that although cost savings are quantifiable in experimental studies, they are much more difficult to assess in the real world—an indirect call, it would seem, for better and more unified individual-level data collection. Additionally, the NASMHPD cited data from the states of Washington and Colorado suggesting that persons with low morbidity in the behavioral health domain may be inappropriately considered as *non*-users of specialty mental health services, even as they do use such services for acute or preventive care. In part on the basis of such data, a Washington State program invested in substance abuse treatment. This program yielded reductions in medical spending and dividends in terms of increased public safety. Moreover, a post hoc review of the Washington State project revealed that a principal barrier to increased savings was the absence of additional funding.

The 2005 NASMHPD review concluded that although there is an "exciting opportunity" to implement research about integrating specialty mental health into primary care, there "are tensions between the two 'safety net' systems." These tensions include competition regarding funding, and different "cultures, communication styles, and confidentiality rules" (p. 33). Although not mentioned in the report, SUD clinics may have some analogous discrepancies with both mental health and primary care clinics. Because separate billing codes for coordination of care services are cited by NASMHPD and elsewhere noted as a barrier to funding for such services, it is useful to put forth below a list of codes adapted by Medicare circa 2003 that aim to address that problem (see Box D). Such coding may be sufficient to ensure proper revenue for care coordination, or additional codes may be germane to SUD screening and therapy in the context of primary care or primary care and mental health services in the context of SUD clinics. It is also worth noting that here again, as in other policy review documents, same-day billing restrictions are cited as a significant barrier to enhanced care coordination.

Box D. Common Procedural Terminology Codes:
Service Description (used for Medicare billing since 2003)

96150: Behavior assessment, clinical interview, behavior observations, psychophysiological monitoring; face to face, 15-minute intervals
96151: Reassessment
96152: Behavior intervention; face to face, 15-minute intervals
96153: Group intervention (two or more patients)
96154: Family intervention with patient present
96155: Family intervention without patient present

Source: (Medical Directors Council, 2005)

Regarding funding, the NASMHPD document makes the optimistic suggestion that if specialty mental health providers work with primary care providers (e.g., FQHCs), shared savings and overall enhanced public health will result. In closing, the document puts forth a checklist for behavioral health/primary care integration efforts (see Box E), regardless of the central venue that is selected. Although vague, this list is as good as any brief mnemonic for programs seeking to improve their integration effort.

Box E. Basic Operation Checklist for Behavioral Health/Primary Care Integration Programs

- Staff orientation
- Steering group oversight
- Clarify roles and responsibilities
- Design and decisions using data
- Communication planning
- Patient education tools
- Physician leadership
- Relationship building
- Outcomes monitoring
- Policy development
- Fiscal and reporting issues
- Payor issues
- Consultative support

Source: Susan Wilson, Swope Health Services
(Medical Directors Council, 2005)

Substance Abuse and Mental Health Services Administration Tools

As a final source of information regarding the development of integration efforts as they pertain specifically to mental health and SUDs, this section reviews a SAMHSA website portal designed specifically to assist stakeholders in understanding and implementing aspects of the ACA that pertain to such integration (www.samhsa.gov/healthReform/healthHomes/index.aspx). The website can be divided into six sections.

The first offers information about consulting with SAMHSA to submit state plan amendments per ACA section 2703. The consultation process is limited to a single representative in each state, but is otherwise timely and facilitated by a four-page guidance document consisting of questions for states to answer as part of their application. The guidance document notes that health home services are composed of comprehensive care management, health promotion, transitional care, patient and family support, referral to community/social services, and health information technology. The questions posed to assess system readiness explore what conditions are being targeted, assignment/referral/outreach strategies, entry/exit/movement of patient strategies, screening and intervention measures, and policy and reimbursement expectations. Alcohol and other drug abuse/dependence screening and interventions are explicitly referenced, and the request for condition specificity does leave the possibility open for SUDs, per se, as such a target.

A second section of this SAMHSA site briefly describes Primary and Behavioral Health Integration Grants funded mainly by the ACA. The grant program's objectives are to improve access to primary care and preventive services and to increase overall health care. Maryland has one site in Gaithersburg (Family Services, Inc., a human services affiliate of Sheppard Pratt Hospital) among 64 grantees nationally. Details of the grant are not evident from the SAMHSA or the Maryland grantee's website, but the SAMHSA information notes that funded projects overall support the following types of services: screening and referral for primary care, development and implementation of registries or other tracking systems, wellness and prevention supports, and referrals to specialty somatic care.

The third section of the SAMHSA website provides a brief description and link to the SAMHSA-HRSA Center for Integrated Health Solutions. As the name implies, the center is a resource that "promotes the development of integrated primary and behavioral health services" with information about care models, workforce training, and financing, among other issues germane to the subject. The site appears to support such integration efforts "whether seen in specialty behavioral health or primary care provider settings" (www.integration.samhsa.gov/about-us).

The fourth section of the SAMHSA website is a listing and linkage of screening tools for behavioral health disorders. Among those tools are standardized screening instruments for alcohol use, depression, and tobacco use, with some separate tools for child and adolescent populations. The remaining sections of this website include models, outcomes, and other background information—some in slide form, others in report or publication form. Review of all the documents contained therein is beyond the scope of this report. What is apparent from perusal of the titles and some of those documents is that there are many recent efforts to conceptualize and pilot integration efforts connecting behavioral and other aspects of health, and those efforts are on-going. Additionally, it seems that the majority of these are centered on primary care venues, with infrequent mentions of SUDs compared with other mental health issues such as depression or psychosis. This emphasis may be appropriate given the relative prevalence of SUDs compared with other disorders, but it also should signal to stakeholders that SUD care, per se, may be at a disadvantage to connect to new resources tied to the ACA.

Conclusion

Review of the ACA language and of recent peer-reviewed or web-published literature referring to integration/coordination/patient-centered care for persons with SUDs reveals many opportunities. Those opportunities appear largely as rhetorical or logical arguments in favor of such coordination, but additionally and increasingly they are encouraged more substantially via grant investments (e.g., the POCRI) and quasi-experimental reviews of implementation efforts which, for example, have demonstrated that provider *team* approaches can be as effective as *individual* provider case management ones; or that brief interventions by primary care physicians can yield mitigation of alcohol-related morbidity.

Substantive or rhetorical promotion of care coordination concepts are typically inclusive of SUDs as a new or expanded component of primary care, but rarely are SUDs considered a central target of a coordination of care enterprise. This de-emphasis on SUD versus somatic and other mental health care might be appropriate given the relative prevalence of various diseases, but it also might reflect stigma and neglect for a class of illnesses that has substantial detrimental impact on public and personal health. Accordingly, a major challenge faced by SUD stakeholders moving forward is to ensure that proper emphasis is placed on SUDs relative to other health care issues. This challenge will be intensified by historical and cultural differences that exist between SUD and other aspects of medical care. Additionally, SUD stakeholders must

defend and develop health care solutions that more frequently mainstream SUD treatments into primary care, but also which at least sometimes (when appropriate) place SUD clinics at the center of an integration of care enterprise. To that end, the SUD field should consider unique aspects of its prevention and treatment endeavors that must be components of primary care health homes, and it further should consider specific SUD chronic health home solutions that might be developed in SUD venues such as methadone clinics or other outpatient SUD facilities that provide long-term therapy to persons with serious SUD morbidity. Simply stated, the concepts suggested throughout the ACA and much of the published literature indicate that coordination of care solutions are an ends which can be reached via number of different paths, and moreover, that patients with SUDs should be provided "no wrong door" access to medical care that is better coordinated.

Many resources exist to help SUD stakeholders stay current on medical home policies as they pertain to local, state, and federal governance issues and as they pertain to practice level issues. Specifically, these resources are in the form of guidelines and definitions which are summarized in this document in Tables 2 and 3; and boxes C and E. There are additionally several examples of historical and developing projects that can be studied or tracked regarding medical homes generally, and a small number SUD projects in that regard are also included (Table 4). A summary of work conducted thus far suggests that HIV/AIDS plus primary care and SUD interventions have become increasingly common and can be successful, or that FQHCs are a key venue where behavioral health and general medical care services are being integrated.

Challenges that will be ongoing include bridging cultural gaps between SUD and other aspects of medicine, securing appropriate funding to implement and sustain expanded SUD coordination efforts, and making sure that the funding stream is readily accessible by way of appropriate payment mechanisms and economic incentives for qualified providers. In many ways these concepts are common sense and not controversial, but the options are numerous and the entire system is complex across several dimensions including biomedical, financial, and sociological. Indeed, the possibilities are extensive enough that programs are not only faced with multiple implementation choices, they must be careful to avoid "double dipping" (i.e., double billing) for the coordination services they deliver (Integrated Care Resource Center, 2012).

Accordingly, one can easily excuse legendary musician and advocate Natalie Cole (see Introduction) for admitting total ignorance when asked about the relevance of the ACA for persons like her with a history of SUD and serious infection. The law is lengthy and complex. Nonetheless, in future press conferences, Ms. Cole and other advocates should be educated to notify the public that the ACA will likely increase public and private access and quality of care for people with SUDs and related or other illnesses by virtue of the essential benefits provisions, the expanded Medicaid and health exchange programs, and the many incentives the law offers regarding care coordination between traditional silos of medicine, such as addiction and infectious disease care. A big challenge may be what it has long been—that advocates struggle to

ensure that SUDs are not inappropriately eclipsed by many other aspects of medicine that also are targets of health care reform efforts.

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