

National Association of County Behavioral Health and Developmental Disability Directors

The voice of local authorities in the Nation's capital

NEWSLETTER

June 2011

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OPTUMHEALTH PROMOTES INNOVATIVE, PEER SUPPORT SERVICES: ACMHA 2011 POSTER SESSION

Sue Bergeson, Vice President of Consumer Affairs
OptumHealth Behavioral Solutions

The 2011 ACMHA - The American College of Behavioral Leadership (www.acmha.org) summit was designed to explore how disruptive innovations are able to help transform the way behavioral health care is organized and provided. OptumHealth was pleased to present recent work in the poster session on Creating Replicable and Sustainable Peer Support Services. This innovative presentation focused on how new models of peer support services can be delivered in a managed care setting to improve the quality of care in effective and efficient ways. OptumHealth is committed to the transformation of behavioral health care to systems that are person centered and foster recovery.

Recently there has been a proliferation of peer support services in behavioral health care and the Centers for Medicare & Medicaid Services (CMS) has recognized them as reimbursable forms of care. Despite the expansion of these services, the evidence base for peer support services has not kept pace with this growth. OptumHealth partnered with Wisconsin Grassroots Empowerment Project and Tennessee Mental Health Consumers' Association to develop a pilot program for peer support services with a goal of understanding and documenting the components necessary for implementation, replication and sustainability. Two sites were selected for this pilot project and an independent evaluator was selected to help design the operational activities from pre-pilot to post-pilot review and to examine the empirical evidence gathered through the pilot.

The Peer Bridger model of support services was selected as the approach to be implemented in the pilot. Peer Bridger services are provided by individuals with lived experiences of mental health and substance use conditions who are trained in peer support, or certified as Peer Support Specialists or peer wellness coaches. This model was originally developed in the mid 90's by the New York Association of Psychiatric Rehabilitation. Peer Bridger services are provided for individuals who are leaving inpatient treatment or other confined levels of care. These services provide individualized support to promote effective independent living, social skills, and coping strategies. The goal is to promote an effective return to the community through engagement in wellness focused peer support services, and reduce the need for recurrent higher levels of inpatient care. A recovery focus meets the goals of promoting hope and fostering strength, and improving well being.

For the PeerLink pilot, sites were selected in Southeast Wisconsin and West Tennessee. OptumHealth partnered with the Wisconsin Grassroots Empowerment Project (GEP) and the Tennessee Mental Health

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Teddi Fine, MA, Editor

Consumers' Association (TMHCA). The pilot ran from December 2009 through August 2010. The PeerLink quality goals were to provide person centered services and demonstrate that Peer Bridger services can reduce the need for psychiatric inpatient days. In addition the pilots were designed to build on the established evidence base of the effective use of peer support services.

In order to evaluate the outcome of these services an independent review team was selected. Under the direction of Dr. Chyrell Bellamy, Yale University's Program for Recovery and Community Health conducted the independent program evaluation. This evaluation included a review of: 1) hospital authorization data; 2) Peer Support Specialist encounter data; 3) surveys from OptumHealth staff; 4) Peer Specialist focus groups; and 5) surveys and focus groups input from pilot participants. In addition, lessons learned were tracked and monitored throughout the pilot project.

The preliminary findings from this pilot were presented in the ACMHA poster session. They show that Peer Link services can be an effective resource for improving the quality and outcomes of care. Hospitalization data were analyzed for participating members in the pilot who had a history of at least one psychiatric hospitalization from December 2008 through the month preceding enrollment in the Peer Link program. The results of the pilot demonstrated a 73% reduction in hospital admission in Tennessee and a similar reduction of 44% in Wisconsin. These significant findings support the effective role of peer support services in the Peer Link pilot for the reduction of hospital days and the promotion of community integration and wellness.



The lessons learned from this pilot illustrate the importance of partnerships with consumer organizations. This includes providing ongoing collaboration with the leadership of consumer run organizations and demonstrating the value of peer delivered services across all levels of payer and provider systems. Clear and detailed contracting that outlines the commitments and expectations is also vital. Along with this, there is a need to provide technical assistance in administrative operations including billing and claims processing that are necessary for the pilot to succeed. Innovative programs that demonstrate effective peer support services are challenging to develop and require persistence and vigilance to maintain. Empirical testing of the results these services provide and the presentation of outcomes are also important.

The goal of the ACMHA summit was to promote examples of disruptive innovation in behavioral health care. OptumHealth is committed to transforming systems of care for those with mental and substance conditions and recognizes the vital role of peer support. While peer support is gaining in scope across the systems of care, their use in managed care programs is less well tested. The OptumHealth poster at the ACMHA summit outlined a unique pilot for the use of PeerLink services for peers to provide coaching and transition services to promote recovery and well being in community settings. This pilot included independent testing and evaluation which also helps to build the evidence base for these services. As new and additional findings are developed from the PeerLink project, OptumHealth is committed to sharing these with NACBHD, ACMHA and the field, and building on the innovations that support expanded peer services.

SIGN UP FOR NACBHDD SUMMER MEETING

July 18-19, 2011,

Paramount Hotel, Portland, Oregon

NACBHDD also will sponsor a reception on Monday, July 18, from 6-7 p.m., Portland Convention Center, Room D133 (Level 1).

PLEASE INVITE YOUR FRIENDS FROM NACo TO THIS RECEPTION.

The NACo Behavioral Health Subcommittee meeting will be held on Friday, July 15, at 12:45 pm at the Portland Convention Center, Room B 113-114 (Level 1). At that session, an award will be presented to NACo President Judge Glen Whitley. The NACo Behavioral Health Subcommittee will host a special session—Addressing the Crisis of Suicide in Our Counties—Portland Convention Center, Room B 115 (Level 1), on Monday, July 18, from 10:45 am – Noon.

BITS FROM DC



Dear Colleagues:

Yesterday, we completed our second annual county leadership course for county behavioral health leaders at the John Hopkins School of Public Health. I have written to Kathryn Power, Director, CMHS/SAMHSA, to express our special thanks for the resources she provided to make this course possible:

Kathryn:

This is to thank you for the support provided by CMHS/SAMHSA for our County Leadership Course, completed yesterday at the Johns Hopkins School of Public Health. We hosted 12 county directors from 8 States (MD, TX, VA, MI, OR, CA, NY, and IA). Many of the attendees were new directors who had recently replaced directors of long-standing (20-30 years). We will be following up the classroom experience with monthly telecons to help participants develop effective planning in a difficult environment, and to adapt to the new demands of national health reform. We will also be featuring the work of this group in our monthly e-Newsletter.

Perhaps you would like to join us at the beginning of our very first follow-up call scheduled for July 8 at 2 PM EDT.

Thanks again.

Future issues of our Newsletter will include articles based on this training experience.

We are currently in the midst of the debate on Capitol Hill over the federal budget for 2012. As I have already communicated several times in the recent past, this is an epic struggle over the future of behavioral health, health, and social services. I also have already asked you to weigh in on previous House votes; now I need you to weigh in with your Senators. Let them know exactly where you stand on the proposed Medicaid block grant, on funding for SAMHSA and HRSA, and on funding for the Affordable Care Act.

We are looking forward to our summer board meeting in Portland Oregon on July 18-19. This meeting will include important presentations by Barbara Edwards of CMS on Medicaid, by Kana Enomoto from SAMHSA on county-focused programs; and by John Agosta of HSRI on developments in the developmental disabilities field. If you are a board member, I hope to see you there.

Finally, I am very pleased that this issue of our e-Newsletter is being hosted by OptumHealth, a valued and critical corporate partner of NACBHDD. They have included in this issue an article on essential development work they are doing on recovery-oriented services.

Do enjoy the coming summer.

Ron Manderscheid, PhD
Executive Director

NACBHDD OFFICER SLATE PROPOSED

The NACBHDD Nominations Committee has developed the following slate of officers to be presented to the Board at the upcoming summer meeting: our

- ✓ Dan Ohler, Past President (Automatic assumption upon completion of term as President)
- ✓ Patrick Fleming, President (Automatic assumption upon completion of term as Vice President)
- ✓ Patricia Ryan, Vice President
- ✓ Mary Ann Bergeron, Treasurer
- ✓ Larry Carroll, Secretary.

Nominations remain open. If you would like to nominate another NACBHDD member (including a self-nomination) for NACBHDD Vice President, Treasurer, or Secretary please be in touch with Ron as soon as possible.



NEW HEALTH INFORMATION COORDINATOR ASSUMES POST



With the departure of Dr. David Blumenthal, HHS has named a new leader for national health information technology policy and program. Farzad Mostashari, MD, ScM, steps up to head the Office of the National Coordinator for Health Information Technology at the HHS. Before joining the ONC, he served as Assistant Commissioner for the Primary Care Information Project, New York City Department of Health and Mental Hygiene, facilitating adoption of prevention-oriented health information technology by over 1,500 providers in underserved communities. Dr. Mostashari also led the Centers for Disease Control and Prevention-funded NYC Center of Excellence in Public Health Informatics and an Agency for Healthcare Research and Quality-funded project focused on quality measurement at the point of care.

OBAMA ADMINISTRATION RELEASES NATIONAL PREVENTION STRATEGY

On June 16, the Administration unveiled its National Prevention and Health Promotion Strategy, a comprehensive plan, called for under the ACA and designed to help increase the number of Americans who are healthy at every stage of life. The strategy was developed by the National Prevention Council, which is composed of 17 federal agencies who consulted with outside experts and stakeholders.

Designed to help public and private partners come together to build healthier communities using evidence-based prevention strategies, the National Prevention Strategy outlines four policy and program directions that, together, are fundamental to improving the Nation's health:

- *Building Healthy, Safe Community Environments:* Prevention of disease begins in our communities and at home, not just in the doctor's office.
- *Expanding Quality Preventive Services in Clinical and Community Settings:* When people receive preventive care, such as immunizations and cancer screenings, they have better health and lower health care costs.
- *Empowering People to Make Healthy Choices:* When people have access to actionable and easy-to-understand information, they are empowered to make healthier choices.
- *Eliminating Health Disparities:* Eliminating disparities in achieving and maintaining health can help improve quality of life for all Americans.

To read more, go to: <http://www.healthcare.gov/news/factsheets/prevention06162011a.html> information on the National Prevention Strategy and the National Prevention Council can be found at www.HealthCare.gov/center/councils/nphpphc.

HILL HAPPENINGS: THE GOOD, THE BAD, AND THE UGLY

- **FY 2012 HHS Appropriations:** Earlier this month, the House Appropriations Committee released FY 2012 spending caps based on the budget resolution passed by the House in April. The Labor-HHS-Education allocation, \$139.2 billion, is a 13% cut from FY 2011 and a 30% cut from the President's FY 2012 request. The allocation brings public health spending back to 2004 levels or lower, cuts that place many HHS Agency programs at agencies at risk. The FY 2012 appropriation bill is scheduled to be considered by the Subcommittee on July 26 and by the full Committee on August 2 with full House action awaiting the bill after the tradition August recess. *Contact your Representative and Senators to register concern over cuts.*
- **Czars NOT killed off:** On June 23, The Senate *voted down* an amendment by Sen. Vitter (R-La.) to end the ability of the White House to appoint policy "czars," and to prohibit use of federal funds for the salaries and expenses of existing "czars," including R. Gil Kerlikowske, head of the ONDCP, a leadership role and office created in 1988.
- **House Approves Military Construction Bill, Including Funding for New VA Mental Health Center:** The June 14 House approval of the FY 2012 military construction and VA appropriation provides \$589 million for FY 2012 military construction, a \$600 million reduction from current funding levels, and a \$2.84 million appropriation to build a VA mental health clinic in Fort Wayne, Indiana. [A good thing, but is it a dreaded earmark?]



- **Medicare as a Block Grant:** While Senator Coburn (R-OK) introduced legislation (**S. 1031**) to convert most Medicaid funding into state grants on May 19, the overall Senate just a week later flatly *rejected* the House-approved FY 2012 budget to reduce spending by \$6.2 trillion over 10 years and limit FY2012 domestic spending to \$360 billion. That means the Senate also rejected a proposal to Medicaid into a block grant program beginning in 2013 and Medicare into a private health insurance premium support program in 2022. It also saved most of the national health care reform law's health coverage provisions from repeal, including the individual mandate, the Medicaid expansion, and the establishment of health exchanges with coverage subsidies.
- **Recent Hearings:** House Energy and Commerce, Dual Eligibles: Understanding This Vulnerable Population and How to Improve Their Care (June 21); Senate Finance Committee, Health Care Entitlements: Medicare and Medicaid's Role in Deficit Reduction (June 23).

HEALTHCARE REFORM ONE YEAR LATER: WHAT TO EXPECT

[Reprinted with permission of NACo]

Anita Cardwell
Senior Associate
National Association of Counties

One year after passage of the Patient Protection and Affordable Care Act (PPACA), many insurance reform provisions have gone into effect, including ones related to health benefits that counties provide to their employees. Implementation efforts concerning other parts of the law are also moving forward.

Considering the legal challenges to the law, however, the states' differing stances on moving forward with implementation and a changed political climate, uncertainty remains about how future provisions will be put in place and how counties will be involved.

During NACo's February webinar, *Implementing the Affordable Care Act: Updates and Upcoming Issues*, Kathleen Nolan of the National Governors Association commented that the current political environment clearly affects state decision making and that all states are also facing fiscal constraints that limit the capacity of their planning and implementation efforts.

Of particular concern for states is the sustainability of their Medicaid programs, which continue to experience increasing enrollment and costs.

In 2014, when the PPACA expands Medicaid to include all eligible individuals who have incomes up to 133 percent of the federal poverty level, Nolan noted that the program will most likely look different than it currently does. It could operate more like commercial insurance and less like a safety net program, and the newly eligible population may have other types of health needs. With the need to rein in rising Medicaid costs and enhanced federal aid (FMAP) ending in June, states are currently determining where to make cuts that will not damage the program in the long term.

They are finding this task challenging because of the health reform law's maintenance of effort (MOE) requirements, which mandate that states maintain Medicaid eligibility levels until the expansion of the program in 2014, and for the Children's Health Insurance Program (CHIP) the MOE provision extends to 2019.

In late February, the Centers for Medicare and Medicaid Services (CMS) provided further guidance to state Medicaid directors about the MOE provisions in the law, and CMS is working directly with states as they assess their Medicaid programs. Nolan emphasized that decisions made now are critically important as "...what happens in the program in the next three years is going to impact the [Medicaid] expansion," and that states must also keep in mind the crucial issue of ensuring access to care providers.

NACo opposes Medicaid cuts, particularly proposals by some states to transform the program into a block grant, and if states reduce Medicaid eligibility rules this will most likely result in a shifting of the costs of services to counties.

Health Insurance Exchanges

Another major focus for states concerns plans for the development of the health insurance exchanges which will serve as eligibility portals in 2014 for individuals to find Medicaid or private plan coverage. Last year the Department of Health and Human Services provided nearly \$49 million in exchange planning grants to 48 states and the District of Columbia. As of February of this year at least 31 states and the District of Columbia had formed commissions or other entities to lead implementation efforts and begin planning for the exchanges.



Some of the significant state decisions regarding the exchanges concern:

- how to govern and structure them
- how to develop and enhance the IT system infrastructure needed for enrolling individuals, and
- how to meet the requirement that the exchanges be financially self-sustaining by 2015.

Currently four states — California, Massachusetts, Utah and Washington — have passed laws creating exchanges, and Indiana established its exchange through an executive order from the governor. Others are moving forward with legislation to set up the exchanges.

However, states are also waiting on further guidance from the administration on the exchanges, such as what constitutes an essential health benefits package for plans offered through the exchanges.

There are unanswered questions about:

- how coverage will be maintained for individuals with incomes that fluctuate causing their eligibility for Medicaid and plans on the exchanges,
- whether wrap-around services traditionally provided through Medicaid will be available to individuals who qualify for private plan coverage on the exchange, and
- how an exchange will be structured if a state chooses not to operate one and the federal government must run the exchange. This will be the case in Louisiana, which recently decided to not establish an exchange.

Also, the role that county agencies may have in determining eligibility and enrollment is uncertain, although they will most likely be involved to some degree in assisting individuals in finding coverage through the exchange.

Because county human services agency staff already have significant expertise in conducting outreach and helping individuals enroll in Medicaid and other programs, they may be able to provide this assistance by participating in the official Navigator program called for in the PPACA. The program will

provide grants to entities that can conduct outreach and help the application process, although at this point the criteria to be able to serve in this capacity have not been defined.

Public Health Issues

NACo will continue to work with Congress and the Obama administration to improve the provisions of the PPACA, so that they reflect county priorities and implement the provisions that help counties build healthy communities and ensure affordable access to health care.

In particular, NACo supports efforts to strengthen the county public health infrastructure through the Prevention and Public Health Fund (PPHF). The PPHF provides dedicated funding for state and local prevention and public health activities, totaling \$15 billion in funding over 10 years.

County public health department programs will be eligible for many of the potential funding opportunities, and NACo advocates that public health programs which are administered at the state level — whether they are new PPHF-funded initiatives or other federal programs — should require concurrence by localities regarding both the budgets and objectives of any of these grant programs.

While the PPHF requires mandatory spending and the administration has indicated that it is prepared to issue grant funding announcements as soon as possible, the monies could be reallocated for other non-health-related programs or priorities. At recent hearings of the House Energy and Commerce Committee's Health Subcommittee, legislation was introduced to convert the fund and other mandatory funding streams into discretionary funding, and NACo submitted a letter to the committee leadership opposing the efforts to reclassify the PPHF.

To view the Feb. 24 webinar, find out about upcoming webinars and for other health reform implementation information, visit www.naco.org/healthreformimplement. To send health reform implementation questions or sign up for updates, email healthreforminfo@naco.org.



HHS NEWS AND NOTES



Mental Illnesses: A recent SAMHSA data analysis reports that alcohol dependence is four times more likely to occur among adults with mental illness than among adults with no mental illness (9.6% versus 2.2%). Based on a nationwide survey, the report also shows that the rate of alcohol dependency increases as the severity of the mental illness increases.

Alcohol Dependency and



The report is based on data from the 2009 NSDUH. For more, go to:
<http://oas.samhsa.gov/spotlight/Spotlight027AlcoholDependence.pdf>

- **New Medicare CMHC Standards Proposed:** On June 16, CMS issued a proposed rule designed to help improve the quality and safety of treatment provided to more than 25,000 Medicare beneficiaries who receive care at Community Mental Health Centers (CMHCs) each year by establishing conditions of participation (CoPs) for CMHCs for the first time. The proposed rule includes health and safety standards for CMHCs that participate in the Medicare program. Perhaps most critically the proposed new conditions focus on a client-centered, outcome-oriented approach by establishing a treatment team, developing an active treatment plan, and coordinating services to ensure an interdisciplinary approach to individualized client care. *Public comments are being accepted until August 16, 2011.* To submit comments, visit <http://www.regulations.gov> and search for rule “CMS-3202-P.” The draft rule is available online from the Federal Register at <http://www.ofr.gov/inspection.aspx#regular>
- **HHS Announces High-Risk Pool Enrollment Exceeds 21,000; HHS Reports Health Reform Regulations Were Reviewed too Recently to Duplicate Review:** On June 10, U.S. Department of Health and Human Services (HHS) officials announced that enrollment in the national health care reform law’s high-risk health insurance pools reached 21,454 on April 30, up from approximately 18,000 in March. HHS officials originally anticipated that 375,000 individuals would have enrolled in the pools by the beginning of 2011. Beginning July 1, HHS will reduce premiums by up to 40 percent and simplify the application process in 18 of 24 federally-administrated high-risk pools as part of an effort to spur enrollment
- **ACA Waiver Change:** On June 17, the HHS announced it is changing the way it approves waivers to the healthcare reform law. Instead of approving a new batch of year-long waivers every month, CMS is giving plans until September 22 to apply for a waiver that will carry through 2013. Waivers are for a single provision of the healthcare reform law: its restrictions on annual benefit limits. Beginning in 2014, all plans will have to comply with the provisions of the law and the waivers will be moot.
- **ACA funding to help health providers improve care:** HHS announced on June 22 that up to \$500 million in Partnership for Patients funding under the ACA is available to help hospitals, health care provider organizations and others improve care and stop millions of preventable injuries and complications related to health care acquired conditions and unnecessary readmissions. Funding will be awarded by the CMS Innovation Center through a solicitation for federal contracts. For more, go to: <http://www.hhs.gov/news/press/2011pres/06/20110622a.html>.
- **Workplace health programs to get ACA support:** On June 23, HHS announced the availability of \$10 million to establish and evaluate comprehensive workplace health promotion programs to improve the health of American workers and their families. The initiative, supported by the ACA’s Prevention and Public Health Fund, seeks to improve workplace environments to support healthy lifestyles and reduce risk factors for chronic diseases like heart disease, cancer, stroke, and diabetes. For more, go to: <http://www.hhs.gov/news/press/2011pres/06/20110623a.html>.

NACBHDD COMMENTS ON NATIONAL BEHAVIORAL HEALTH QUALITY FRAMEWORK

On June 23, the NACBHDD wrote to SAMHSA to provide comments on the Agency’s quality improvement initiative, an essential component of the ACA. In particular, the comments expressed concern that, while the focus of health reform is at the local level, the framework itself contains scant mention of the key role of counties and communities in promoting quality improvement and best practices. The letter itself follows:

We wish to express publicly our appreciation that SAMHSA has developed a specific agency-wide focus on quality improvement going forward. Quality improvement will be an essential feature of the health reforms being implemented through the Affordable Care Act (ACA). For example, the cost curve cannot be bent without dramatic quality reform and improvement. We also wish to provide several comments on the current draft of the National Behavioral Health Quality Framework:

- Only a single allusion occurs in the entire document to the very important role that county programs will play in quality improvement. Clearly, under the ACA, counties will play a progressively more important role as organizers, regulators, deliverers, and evaluators of local health care, including behavioral healthcare. We fully expect that counties will become Accountable Care Organizations, and will organize local providers into Health Homes.

- The current draft is heavily focused on clinical prevention interventions, which is appropriate, but is only weakly focused on population and community interventions. Over time, we fully expect this balance to change. A major feature of the ACA is moving dollars upstream toward population and community prevention and promotion interventions, most of which will have a behavioral health focus. This transition holds considerable promise for behavioral healthcare, the field of behavioral change, which will be at the core of these interventions. We strongly encourage that SAMHSA review the work of Sir Michael Marmot and Dr. David Satcher, who have led the development of conceptual work on community interventions around social and physical determinants of health.
- We recommend that SAMHSA review the work that HHS is currently doing on Leading Health Indicators and on the National Prevention Strategy. Whenever possible, we recommend that the indicators and measures chosen by SAMHSA correspond to those being deployed in these broader initiatives.
- Finally, we hope that the SAMHSA has plans to incorporate the National Behavioral Health Quality Framework into the HHS Quality Framework. At a time when integration and collaboration are prized, it would be unfortunate if these were to remain parallel efforts.

LEGAL HAPPENINGS

- **Healthcare Reform:** The court saga continues. The 6th Circuit Court of Appeals (Cincinnati, OH) heard arguments in a case that contends the ACA's individual mandate violates personal freedom. The court is the second appeals court to hear oral arguments in an ACA case, following the earlier frosty reception by the 4th Circuit in Richmond. The 6th Circuit's 3-judge is expected to be more divided: One was appointed by President George H.W. Bush and 2 by President Clinton, one of whom is a Republican. The Obama administration argued that the plaintiffs don't have standing, especially since one had employer-sponsored coverage and presumably wouldn't be penalized under the law's mandate.
- **Administration Argues Individuals Cannot Sue over Medicaid Reimbursement Reductions:** In a May 26 amicus brief filed before the Supreme Court in a suit challenging Medicaid rate reimbursement cuts in California, the Administration argued that private individuals lack standing to sue states to enforce the federal standard. Federal law requires that Medicaid rates ensure that Medicaid beneficiaries have access to the same level of care as the privately insured. Under the case at hand—*Douglas v. Independent Living of Southern California*-- private individuals and providers sued California over Medicaid reimbursement reductions made in 2008 and 2009. The administration argues that federal law's requirement of equal access to care is "broad and nonspecific," leaving it largely to the discretion of policymakers. The court will likely hear oral arguments in the case this fall.



SAMHSA BLOCK GRANT CHANGES ANNOUNCED: INPUT SOLICITED

Through a *Federal Register* posting, SAMHSA announced a new approach for both the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Community Mental Health Services Block Grant (MHSBG). Under the new approach, redesigned state and territory plans must consider new factors, such as:

- Reaching beyond the populations historically served through block grants.
- Painting a more complete picture of the behavioral health system by conducting a needs assessment and developing a plan to identify and analyze strengths, needs, and priorities of the state's/territory's behavioral health system.
- Designing and developing collaborative plans for health information systems, including grants and other funding.
- Forming partnerships to provide individuals better access to high-quality, modern behavioral health services.
- Increasing focus on recovery for persons experiencing mental health problems and substance use problems.
- Redesigning systems and services to be more accountable for improving the caliber and performance of services funded.
- Describing tribal consultation activities.



While the 60-day comment period closed on June 9, 2011, the application and reporting sections have been revised

based on the comments received. The application has been reposted in the *Federal Register*; **SAMHSA is accepting comments until July 18, 2011.** Go to: <http://www.gpo.gov/fdsys/pkg/FR-2011-06-17/pdf/2011-15070.pdf>.

AROUND THE STATES: AN UPDATE

- √ **Illinois: How Do You Make a \$30 Million Error?** When the Illinois House a few weeks ago approved its version of the Illinois fiscal year 2012 budget, House Bill 3717, the legislation inadvertently slated funding for mental health care grants at \$114.2 million instead of \$143.6 million or 98.6% of the current year's funding. A big fix is needed, or \$30 million will be lost to needed behavioral health care in the State.
- √ **Louisiana:** By restoring \$200 million in funding cut by the State House from the governor's budget proposal, the Louisiana State Senate voted to maintain current outpatient mental health services and to finance implementation of a plan to use coordinated care to reduce Medicaid costs. The budget now goes back to the Louisiana House. A compromise is likely.
- √ **Maine:** The Maine State Senate has joined the House in rejecting Governor Paul LePage's budget cuts that would have closed 10 residential substance abuse treatment facilities and reduced for tobacco prevention services. The budget now goes before the governor to either sign or veto.
- √ **North Carolina:** On June 15, the North Carolina *Legislature overrode Governor Beverly Perdue's (D) June 12 veto* of a 2-year budget that will reduce funding for community mental health services by \$27.2 million. Taking effect July 1, the budget also will impose a 2% reduction for most Medicaid providers and eliminate automatic inflationary increases in Medicaid reimbursement rates. The budget will achieve additional Medicaid savings by expanding the use of managed care, the increased use of generic drugs, and changing pharmacy services.
- √ **Oregon:** Gov. John Kitzhaber's effort to transform Oregon's low-income health care plan is moving through the legislature. The governor hopes that a focus on preventive care and keeping chronic care patients out of the hospital would create both healthier patients and lower costs. That comes, for example, by carefully managing diabetes properly and ensuring patients with mental health conditions are diagnosed and treated.
- √ **Texas:** The U.S. Department of Justice hopes to be able to intervene in a federal lawsuit filed against the State of Texas that alleges poor treatment for developmentally disabled nursing home residents in the State. Advocates who filed the suit on behalf of nearly 4,500 Texas with developmental disabilities allege their clients neither receive proper treatment nor are given the opportunity to transfer more appropriate, community-based facilities.



AIMING HIGHER WITH COLLABORATIVE CARE

Ron Manderscheid, PhD
Executive Director, NACBHDD



Seattle, the Rainy City, boasts brilliant sunlight and crystal-fresh air. It also hosts the AIMS (Advancing Integrated Mental Health Solutions) Center, known broadly for brilliant work on integration and collaborative care, and a crystal-clear sense of the future. On May 2-3, the Center convened almost 100 national and local leaders to develop the national agenda for collaborative care over the next year.

Collaborative care refers to the coordinated delivery of mental health/substance use care and medical care. Both controlled and field studies conducted by Jürgen Unützer, the AIMS Center Director, show dramatic improvements in outcomes for consumers with

behavioral health conditions when primary care programs actually coordinate care effectively with specialty providers. At present, the Center is working with more than 570 primary care and/or behavioral health practices across the United States to improve the delivery of coordinated care, including a state-wide program in Washington in which community health centers and community mental health centers collaborate to care for a population of patients with medical and behavioral health needs (<http://integratedcare-nw.org>). For more than a quarter century, Seattle also has been known as the home of Wayne Katon and Ed Wagner, the intellectual fathers of collaborative and chronic care.

Of great importance for the Summit, collaborative care was described from the primary care point of view.

Hence, the short term agenda set forth for collaborative care refers to actions that need to be taken in that setting. This is very important for us from the specialty fields, because it can frame our perspective on how we need to approach primary care in the future. The meeting considered 17 different areas that will need attention in the short-term future if care outcomes are to be improved. Here, I will discuss just a few key examples.

Screening. Effective screening tools for behavioral health conditions are very important in primary care settings that seek to do collaborative care. At present, the most common tool used is the Patient Health Questionnaire-9 (PHQ-9) which screens for depression. Primary care providers see many consumers with depression or anxiety, and they also are seeing greater numbers with bipolar disorder. Of significance, the PHQ-9 is used not only for screening, but also to assess changes in symptom severity over time and to facilitate consultation, change in treatment, and engagement of more experienced behavioral health specialists if clients are not improving as expected. There are two questions going forward: Should screening tools be changed? Are these tools adequate to assess treatment outcomes?

Standards. To be able to implement collaborative care effectively, one needs to be able to describe the services which will be essential for success, e.g. care coordination. One way to put this issue into the context of national health reform is to determine the essential services of a medical/health home and use these services as a frame to elaborate the services of collaborative care. Once this relationship is clearly specified, then standard setting organizations can be engaged in defining the future standards for care.

Parity. A primary question is whether the services required for behavioral health-primary care collaboration are actually available and paid for like

services required for care coordination in other fields. Three services stood out in this dialogue: care coordination, screening, and services offered through telemedicine or other electronic connections. An important future step will be to use the Wellstone-Domenici parity legislation to test and move this agenda.

Payments. Because collaborative care moves beyond traditional clinical care delivered in primary care settings to include a broader array of services, a very important question is whether the services delivered are reimbursable, and whether better mechanisms are available for making payments, e.g. case rates versus encounter payment systems. It also would be very useful to have toolkits available to help primary care providers through the complex array of payment systems currently used, e.g., payments by both a managed care carve-out and a managed health care entity.

Consumer-Friendly

Environment. Shared decision making, peer supports and a strong recovery orientation are essential features of modern specialty care that will need to be imported into the collaborative care environment. Over the next year, work will need to be undertaken to operationalize these elements in collaborative care settings. It is recognized broadly that these key features of specialty care are a major contribution to national health reform and very important for achieving good consumer outcomes.

The AIMS Center (<http://uwaims.org>) and Jürgen Unützer are to be commended for stepping forward to undertake development work of national import for collaborative care in particular and integrated care in general. Our hats are off to them for the leadership and foresight that they have demonstrated. Other entities would do well to emulate this type of leadership, which is so important for the field.



PERSONAL EXPERIENCE:

WORKING WITH BEHAVIORAL HEALTH INMATES IN A CRIMINAL JUSTICE SETTING

Katie Bess, MSW
NACBHDD Senior Policy Intern

As a graduate MSW intern I worked as the Release Planning Coordinator in the Butte County Jail, which was a new position created for my placement. The Butte County Jail is located in Oroville, California, which is also the County seat. I worked with inmates who had mental health, substance abuse, or dual diagnosis issues and based on my assessment I formed a discharge/community reentry plan for inmates to prepare for release into the community. Among the issues that discharge planning/community reentry presented for inmates returning to the community was not having

transportation to treatment groups, to health resources, and to appointments with social service organizations that would be in their interest to attend. In rural communities, in particular, transportation is a key to accessing resources.

According to Title 15, the California Code of Regulation, anyone in a California county jail who is treated for mental health issues is required to be given an individualized treatment plan completed by one of the treatment staff in the setting. This plan is to ensure the coordination and cooperation of care to individuals' while he or she is in custody and upon release. The individualized treatment plan includes treatment referral to an outside agency based on the treatment staff's discretion.

The focal point is on "continuity of care," which focuses on high-quality as well as cost-effectiveness within the jail and in the community. A large portion of expenses are determined based on the cost of medications and doctor(s) to which the inmate is referred. In the case of mental health services, medications are prescribed to individuals while in custody and afterwards as they transition to the community. The individualized release plan consists of three to six weeks of prescription medication support due to the length of time it can take for a released inmate to be seen by a behavioral health specialist (Title 15: California Code of Regulation).

While individuals would be released with a certain amount of prescriptions, there was no follow-up to make sure their medications were picked up from a pharmacy, as well as no follow-up to see if the individual met with a behavioral health specialist in the community. A related issue is the absence of collaborative and coordinated efforts that include wraparound services for inmates in the facility and once released to the community that addresses a range of needs from employment, to housing and finally to healthcare.

Having financial assistance benefits such as Medicaid, Medicare, and Veteran's Assistance cut while in custody, makes it difficult for individuals to be seen by a mental health specialist or to afford the cost of their medications after release. It is important to also note that while working with individuals who were in need of a substance abuse program; it was difficult for them to get into a community-based program in that they did not have financial assistance or personal resources.



ON THE BOOKSHELF: RECENT POLICY PUBLICATIONS OF NOTE

- **Kaiser Commission on Medicaid and the Uninsured:** *Ensuring Access to Care in Medicaid Under Health Reform* outlines issues related to increasing primary care provider participation; specialist and mental health access; safety-net capacity; managed care plans, team-based care, and integrated service delivery; and coordinating Medicaid and exchange coverage. Go to: <http://www.kff.org/healthreform/upload/8187.pdf>.
- **Robert Wood Johnson Foundation:** *What Shapes Health-related Behaviors: The Role of Social Factors* explores how education, income, and neighborhood conditions affect stress levels and access to healthy choices and medical care, and shape health-related behaviors. Go to: <http://www.rwjf.org/files/research/sdohwhatwhapeshealthrelatedbehaviorsissuebrief20110324.pdf>.
- **Urban Institute:** *Implementing National Health Reform: A 5-Part Strategy for Reaching the Eligible Uninsured* suggests outreach strategies for Medicaid and subsidies, e.g., identifying the eligible through tax forms, partnering with states to give hands-on assistance and improve interagency coordination, and designing consumer-friendly enrollment systems. Go to: <http://www.rwjf.org/files/research/72371urban201105.pdf>.
- **SAMHSA:** *Staying Focused in Changing Times: Challenges and Opportunities*, a presentation by the SAMHSA Administrator, discusses drivers of change related to behavioral health in America and new opportunities change can bring to promote recovery. Considers health reform, budget, emerging science and the role of behavioral health in public life. Go to: <http://store.samhsa.gov/product/SMA11-PHYDE060911>
- **Georgetown University Health Policy Institute:** *Active Purchasing for Health Insurance Exchanges* explores whether exchanges could be purchasers that contract with carriers, set stricter criteria and negotiate discounts to leverage high-quality, affordable care. Go to: <http://www.rwjf.org/files/research/72457healthexchange201106.pdf>
- **Commonwealth Fund:** *Assessing Financial Health of Medicaid Managed Care Plans* examines the costs, quality and stability of publicly traded health plans contracted to manage Medicaid beneficiary care and compares findings with those of non-publicly traded plans. Go to: http://www.commonwealthfund.org/~media/Files/Publications/IssueBrief/2011/May/1511_McCue_assessing_financial_hlt_Medicaid_managed_care_plans_ib.pdf.





ACMHA: The College of Behavioral Health Administration continues its 12-month critical issue webinar series on the new health reform legislation and what it means for behavioral health.

NEXT SESSION: July 13, 2011,

Performance Based Case Rates and Mental Health and Substance Use Parity Richard Frank, HHS Office of Disability, Aging, and Long-Term Care Policy
John O'Brien, SAMHSA

To register, go to: http://www.surveymonkey.com/s/HCR_060811
For upcoming events or to see past presentations, check the ACMHA website:
http://www.acmha.org/current_events_critical_issues.shtml

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