Translating Coverage into Quality Treatment

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For most Americans, access to treatment for substance use begins with health insurance coverage. The combination of the Affordable Care Act (ACA) and Mental Health Parity and Addiction Equity Act (MHPAEA) have been positive steps to open access to equitable insurance coverage for substance use and mental disorders. However, coverage is only the first step in providing access to quality care. For coverage to work, there have to be providers who accept the coverage and can provide the right care in the right place at a convenient time.

The challenge for the behavioral health community as we go forward is two-pronged: first, ensuring that treatment is available and, second, that it is effective — preferably evidence-based. It's a tall order that requires a collaborative effort between payers, regulators, providers and advocates. If we accept that only 10 percent of those identified as needing substance use disorder (SUD) treatment actually receive it[1], then we have a long way to go to reach the goals of health care reform. If 20 million more people decide to use the current specialty care treatment to address their SUD, the system will not be able to accommodate them. As it is, many locations have waiting lists for all levels of care. The ACA and MHPAEA have set the stage for a brighter future, but it is now our responsibility to make that future an achievable reality.

Increasing Access

It's important to remember that expanding access to *insurance* does not necessarily mean expanding access to *treatment*. To achieve that we need to have a sufficient provider workforce and have the members of that workforce placed in high need, underserved communities. Attracting a dedicated, qualified behavioral health workforce is not a new concern; however, the ACA and MHPAEA have created a greater sense of urgency. In its 2013 *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues,* the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that high turnover, an aging workforce, and lack of diversity continue to plague the behavioral health workforce.[2] In addition, according to a 2012 report conducted by the Addiction Technology Transfer Center Network (funded by SAMHSA), approximately a third of clinical directors at the time were only somewhat proficient in web-based technologies, and almost half of substance use disorder facilities did not have an electronic health record (EHR) system in place.[3]

Based on this data, it is clear that one important focus needs to be attracting and retaining highly qualified, and ethnically and culturally diverse behavioral health workers who are comfortable with utilizing technology to increase access to care. With this in mind, SAMHSA included Workforce Development in its six strategic initiatives for 2015–2018 to develop training, guidance, and competencies for behavioral health workers.

We need to continue developing and expanding the behavioral health workforce in racial and ethnic minority communities, which are underrepresented in the workforce and over-represented in the treatment population compared to their prevalence rates. Since its inception in 1973, SAMHSA's Minority Fellowship Program (MFP) has helped to enhance services for racial and ethnic minority communities. Through stipends given to post-graduate students, the program seeks to increase culturally competent behavioral health professionals who often then serve in key leadership positions in their communities.

In 2014, President Obama enacted the "Now is the Time" initiative in response to the Sandy Hook Elementary School tragedy. Activities funded under the initiative include training for behavioral health professionals and paraprofessionals, as well as teachers and other adults who interact with youth. Under the initiative, SAMHSA received $5.2 million to expand the Minority Fellowship Program to support Master's level trained behavioral health professionals in the fields of psychology, social work, professional counseling, and other areas that serve children, adolescents, and transitional youth.

Of course, the challenge remains of how to keep behavioral health professionals in communities with the highest need when salaries and working conditions are often inferior to those in resource-rich communities. With a large number of the behavioral health workforce aging out, qualified graduates have their choice of jobs. Those of us in positions of leadership need to develop mechanisms to distribute the available workforce in a way that reaches those most in need. Models to consider are those that have been used in other areas of medicine and in education.

Reaching Rural Communities

Slightly more than 57 million people live in rural or frontier counties in the U.S. — that accounts for approximately 18 percent of our total population.[4] Rural communities have had historic shortages in health professionals, and this shortage is particularly evident in the distribution of the behavioral health practitioners.[5] Seventy-five percent of those counties have no advanced behavioral health practitioners.[6] To add to what is already a disturbing situation, the southern and western states with the least access to treatment are also the ones with the highest rates of mental and substance use disorders. SAMHSA is looking to the effective use of technology to expand access to areas where the population size may limit the ability of organizations to support regular specialty care staff. Telehealth is not new, but it is finding an increasingly vital role in the post-ACA world. In rural communities, the use of technology has increased the ability of providers

to "see" their clients without requiring them to travel long distance to their facilities. SAMHSA's Targeted Capacity Expansion program's Technology Assisted Care in Targeted Areas of Need (TCE-TAC) grants are designed to assist practitioners in expanding their reach through the use of smart phones, tablets, web-based technologies, and applications. Of course, providing the technology is only helpful if the providers and the clients make beneficial use of it. Telehealth programs need to include technical assistance and education as part of their plans to be truly effective.

Where telehealth is used properly, however, it cannot only save time but also reduce cost. In West Virginia, Prestera Center, a TCE-TAC grantee, has significantly increased productivity of its psychiatrists while at the same time reducing "no-shows" by adopting telehealth technologies. Prestera doctors make virtual appointments with patients living in remote areas, making it easier to keep appointments, refill medications, and provide more effective care to all patients, regardless of where they live.

As more treatment providers experiment with integrating technology into their treatment models, the demand for resources to help use the technology effectively and efficiently is rising. SAMSHA's Addiction Technology Transfer Centers offer Telehealth Tuesdays on the second Tuesday of each month to discuss models and address issues in the delivery of SUD treatment and recovery services via telehealth and other electronic media. An archive of previous webinars is also available on their website. Topics are diverse and are not limited to only the tech-savvy.

SAMHSA is supporting a pilot project with the American Society for Addiction Medicine and Project Echo at the University of New Mexico to train and support rural physicians in the use of buprenorphine, a medication approved by the Food and Drug Administration for the treatment of opioid use disorder. The Echo model links highly trained specialists with physicians practicing in the field and via webinar training, case consultation and mentoring. Research has demonstrated that patients that receive care from generalists who are supported by Project Echo have care that is as safe and effective as care by a specialist[7] and that participation in Project Echo improves the skills and confidence of general practitioners to provide specialty care in rural areas that cannot support full time specialists.[8]

Peer support workers can fill in many of the gaps created by the lack of trained clinical workforce. In addition to the special level of social support and systems navigation that can be provided by peers, peer specialists and other para-professionals can act as clinician extenders much as physician assistants (PAs) and nursing staff work with physicians. To ensure the success of such delivery models, however, two challenges need to be addressed: first, what competencies are required to ensure quality care, and second, what reimbursement models best support this team based care. Building on the Peer Support Policy guidance issued in the August 15, 2007, State Medicaid Director Letter (SMDL #07-011), the Center for Medicare and Medicaid Services (CMS) has continued to encourage states to develop behavioral health models of care under the Medicaid program that offer peer support services as a component of a comprehensive mental health and substance use service delivery system. SAMHSA, working with CMS, continues to review state Medicaid waivers as part of the interagency review board that makes suggestions and offers guidance to states on effectively providing services through their Medicaid delivery systems. These efforts to encourage effective use of peer support services have the potential to expand the reach of treatment, but the challenge of ensuring quality standards remains.

The challenge of creating quality standards for peer support workers is compounded by the inconsistencies in requirements state-to-state. Generally, a peer support provider has a determined amount of time in recovery and some type of training, but deciding on standard requirements for each of these areas is difficult. Just as not all subject matter experts make good teachers, not all people with "lived experience" and training make good peer support providers. It is essential to find consensus on a set of basic skills, knowledge, and attitudes that each peer support provider should possess.

In response to this need, SAMHSA, in conjunction with subject matter experts, conducted research to identify core competencies for peer workers in behavioral health and later posted the draft competencies developed with these stakeholders online for comment. Over 120 stakeholders, including treatment providers, peer organizations, and family and youth organizations, participated in the summits. They include: recovery-oriented, person-centered, voluntary, relationship-focused, and trauma-informed. Although they are not binding, the competencies can be used by providers to integrate peer recovery services into their treatment programs, while ensuring a level of program quality and integrity.

As the behavioral health field looks further into how closely to regulate peer support providers, it is important that we remember the goal of increasing access and avoid creating barriers for those wishing to enter the peer workforce or utilize peer support services in their treatment programs. Peer support providers have a role alongside other treatment providers; they do not and should not replace them. Each brings unique knowledge, experience, and perspectives that result in a more comprehensive treatment approach.

Ensuring Quality

Offering effective, quality treatment should be the goal of every treatment program. Individuals come to treatment with a myriad of issues and experiences; they are vulnerable and dependent on the skills and compassion of the treatment providers. With the increased access offered by expanded Medicaid and newly offered coverage through post-ACA insurance programs, ensuring quality treatment and identifying a standard of care that is evidence-based and sustainable are key components of a successful future for providers and clients.

The ACA very clearly puts an emphasis on evidence-based treatment programs, particularly for cost-reimbursement of services. For some in the behavioral health industry this is a new requirement, and one that may seem overwhelming. Resources such as SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) can provide a good starting point for those who are seeking to integrate evidence-based programs into their treatment models. In response to the increased emphasis on evidence-based programs, SAMHSA is in the midst of improving the content and structure of NREPP to better reflect users' needs and more clearly reflect evidence-based treatment criteria.

Access and Quality for Opioid Treatment

No discussion of quality and access would be complete without touching upon medication-assisted treatment (MAT) and, in particular, opioid treatment programs (OTPs). In March 2015, Health and Human Services Secretary Sylvia Burwell announced a targeted initiative to address the nation's opioid crisis. In support of the initiative, SAMHSA launched a new grant program called Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA). The goal of MAT-PDOA is to assist states in increasing access to MAT in their communities of most need. Although still in its early days, MAT-PDOA is already showing results. The Washington State Department of Social and Health Services, for instance, is funding three providers who are using a number of evidence-based treatment models to facilitate collaboration between OTPs and primary care clinics, making MAT part of the regular service menu provided

through primary care. Not only does this increase access in high risk, underserved areas, it allows providers to share information, lessons learned, and resources.

In Missouri, the Department of Mental Health, Division of Behavioral Health, is providing funding to two providers who are integrating the use of MAT-trained peer specialists to help new clients develop support networks. The providers are also using telehealth services to provide MAT to rural clients. Building on the early success of MAT-PDOA, SAMHSA plans to expand the program to an additional 23 grantees in FY 2016, which will bring the total number of states with grants to expand access to quality MAT to 45.

Under the Drug Addiction Treatment Act (DATA) of 2000, SAMHSA is responsible for approving physician applications for a waiver to treat opioid dependency with approved buprenorphine products in any settings in which they are qualified to practice. While the waiver process ensures a level of quality, there have been concerns expressed about its client limits and how that might limit access. In response to those concerns, new regulations are being created that would increase the 100 limit to 200, under certain conditions. The proposed change in rules is designed to increase access while assuring quality.

Building for the Future

In 2015, the Institute of Medicine issued a report, "Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards,"[9] outlining a framework and strategy for better incorporating evidence based practices in counseling services. They recommend changes in research, translation, training and implementation processes. SAMHSA has begun to discuss how to incorporate this guidance into our efforts regarding improving the quality of care. We are eager to engage the field in a discussion of how to better measure patient outcomes, provide services that reach those outcomes, and ensure that the cycle of research to practice addresses the questions that are of most concern to patients and families.

In addition, to further establish and expand alcohol screening and brief counseling as a permanent component of primary care services, SAMHSA is currently collaborating with the National Committee on Quality Assurance to conduct additional field testing of the "Unhealthy Alcohol Use: Screening and Brief Counseling" measure to include it in the Healthcare Effectiveness Data and Information Set (HEDIS) core measure set. This work is a high priority for SAMHSA and will build the foundation for a more comprehensive approach to measuring treatment access and improving the quality of care and health outcomes for individuals with substance use disorders.

As more medical treatments for SUDs become available and service delivery becomes more integrated, we need to continue to recognize and support the critical role that behavior change therapies and social supports play in helping patients achieve recovery. While we have reached a milestone in access to insurance coverage, translating coverage into access to quality treatment remains a work in progress.

ENDNOTES

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