

## BEHAVIORAL HEALTH CARE RECOVERY SERVICES

The Center for Financing Reform & Innovations (CFRI), under contract with the Substance Abuse and Mental Health Services Administration (SAMHSA), developed a series of issue briefs to highlight information on key topics from the 2013 *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies (State Profiles)* project. This series focuses on the organizational structure, major policy initiatives, services provided, and financing of single state agencies (SSAs) for substance abuse services and state mental health agencies (SMHAs). The goal of this series is to allow readers to identify common national trends in services for individuals with mental and substance use disorders (SAMHSA, 2013). The information was collected and integrated from federal, state, and other data systems. This issue brief is based on the latest information about and from states compiled and analyzed in 2013. States may have changed their intended services, plans, and policies since this report was written.

The State Profiles 2013 report was created with guidance from an expert panel of federal officials, SSA and SMHA leaders, and stakeholder groups such as national mental and substance use disorder provider associations, consumers, and other potential data users. It was developed using existing information sources whenever possible, and those sources were supplemented by information compiled directly from SSAs and SMHAs by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) and the National Association of State Alcohol/Drug Abuse Directors (NASADAD).

Information collected as part of the State Profiles 2013 project included data on recovery and consumer-oriented services offered by SMHAs and SSAs. Evidence is mounting on the benefits of recovery support, and recovery services are the focus of this issue brief. SAMHSA defines *recovery* as a “process of change

through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012).

The importance of recovery support and services for individuals with mental disorders has been reported. Chang, Heller, Pickett, and Chen (2013) found that individuals with psychiatric disabilities experience more progress in their recovery and improved quality of life when they receive social support. The long-term benefits of supported employment for individuals with serious mental illness in terms of long-term job retention, fewer psychiatric admissions, and fewer days in the hospital also has been documented (Hoffman, Jäckel, Glauser, Mueser, & Kupper, 2014).

SAMHSA’s Strategic Initiative #4, *Recovery Support*, “will promote partnering with people in recovery from mental illnesses and substance use disorders and their family members to guide the behavioral health system and promote individual, program and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education and other life goals; and secure necessary social supports in their chosen community” (SAMHSA, 2014). This issue brief summarizes what was learned from the State Profiles 2013 project about implementation of programs in support of this strategic initiative.

### Recovery Support

#### State Mental Health Agencies

Many SMHAs are actively engaged in promoting health, wellness, and resilience through recovery-oriented service systems for individuals in recovery from mental

and substance use disorders. Recovery services include helping individuals (1) make informed healthy choices; (2) find a safe, stable home; (3) find meaningful daily activities, such as a job or school; and (4) establish relationships in the community (SAMHSA, 2012). Examples of peer support services include parenting classes, job readiness training, childcare, transportation, and wellness seminars (Center for Substance Abuse Treatment, SAMHSA, 2009). As shown in Table 1, most states are promoting health and recovery through a number of different services and supports.

**Table 1. SMHA Promotion of Health- and Recovery-Oriented Service Systems, 2013**

Activity	Number of States
Promoting recovery-oriented service systems	51
Promoting health, wellness, and resiliency	50
Engaging individuals in recovery and their families in self-directed care, shared decision making, and person-centered planning	49
Promoting self-care and alternatives to traditional care	46

Almost all SMHAs in the 50 states and the District of Columbia ensure that permanent housing and supportive services are available to consumers. SMHAs in 48 states are improving access to mainstream benefits (those not specific to individuals with mental illnesses), such as housing assistance programs and supportive behavioral health services. Forty-nine states are building leadership, promoting collaborations, and supporting the use of evidence-based practices related to permanent supportive housing for individuals and families who are homeless or at risk of homelessness and for individuals who have mental disorders, substance use disorders, or both. Forty-seven states are working on initiatives to provide people in the behavioral health field with more information and awareness about homelessness.

Nearly all SMHAs are working to increase gainful employment and educational opportunities for individuals in recovery:

- Forty-five SMHAs are working to increase the proportion of individuals who are gainfully

## KEY TERMS

**State Mental Health Agency:** SMHAs organize, coordinate, and directly operate some mental health services and reimburse community providers for other mental health services. They provide direct psychiatric treatment and medication as well as housing, employment, education, and primary care coordination to help consumers recover and live in their own communities.

**Single State Agency for Substance Abuse Services:** SSAs dedicate most of their resources to providing substance use disorder treatment to individuals who are uninsured or have low income. They also provide substance use disorder prevention services and leadership to all state residents.

**Recovery:** SAMHSA has identified recovery as a primary goal for behavioral health care and identified four dimensions that support a life in recovery: (1) overcoming symptoms and making informed, healthy choices; (2) having a safe, stable place to live; (3) having meaningful daily activities and the means to participate in society; and (4) having relationships in the community (SAMHSA 2012).

**Recovery-Oriented System of Care:** ROSC is a person-centered coordinated network of services and supports that is community based and “builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems” (SAMHSA, 2011b, p. 2).

**Consumer-Operated Services:** COSs are “peer-run service programs that are owned, administratively controlled, and operated by mental health consumers and emphasize self-help as their operational definition” (SAMHSA, 2011a, p. 1).

**Access to Recovery:** SAMHSA funds Access to Recovery grants to support the development by SSAs and tribal program officials of a system of care for substance abuse clinical treatment and recovery (SAMHSA, n.d.).

**Peer Recovery Support Services:** These services are intended for individuals who are in or are seeking recovery. Those who design and deliver the projects are in recovery, and the goal is to help individuals stay in recovery and reduce the likelihood of relapse (Center for Substance Abuse Treatment, SAMHSA, 2009).

employed, participating in self-directed educational endeavors, or both.

- Forty-six SMHAs are working to improve consumers' employment and educational outcomes through new and expanded programs and support for education coursework.
- Almost all SMHAs promote peer support and active community participation. SMHAs are working to increase the number and quality of consumer and peer recovery support specialists (n=48), promote social inclusion (n=44), and increase the number and quality of recovery support service provider organizations operated by consumers and run by peers (n=46).

## Community Mental Health Systems

Community mental health systems provide a comprehensive array of mental health services and supports that are designed to help individuals with mental illness get into recovery and live productive lives in their own communities. In 2012, 6.84 million individuals (96 percent) received community mental health services from the state and territorial SMHAs. The providers of these services included community mental health centers (CMHCs), psychosocial rehabilitation centers, various consumer-operated services, Access to Recovery teams, outpatient clinics, and day programs.

SMHAs offer an array of community mental health services, including outpatient testing and treatment (n=39); extensive and intensive outpatient treatment (n=39); crisis services, which include mobile crisis teams (n=39); residential support services (n=38); case management (n=38); supported employment (n=38); Assertive Community Treatment (n=37); co-occurring mental health and substance use disorder services (n=36); residential room and board (n=35); school-based mental health services (n=35); wraparound services (n=35); collateral treatment (n=31); and peer or consumer-operated services (n=32).

### Restructuring Community-Based Mental Health Services

Twenty-four states are restructuring their delivery of community-based mental health services (see

Appendix). For example, in Connecticut, the traditional case management for adults was replaced by rehabilitation-specific, recovery-oriented community support programs. In the District of Columbia, the SMHA, in coordination with the state Medicaid agency, is developing a Health Home State Plan Amendment with the expectation that the majority of community mental health providers will become health homes; thus the majority of the SMHA's consumers with serious mental illnesses will be served through a health home model. This will lead to better coordination for all consumers' medical and mental health needs.

### Consumer-Operated Services

Forty-three SMHAs provide resources to support consumer-operated services; of these, 33 states provided \$168.7 million to support 369 consumer-operated programs. SMHAs funded a variety of consumer-operated services. As depicted in Table 2, the most commonly funded services were peer and mutual support, advocacy, drop-in centers, wellness and prevention services, leadership skills training, and promotion of positive public attitudes.

**Table 2. Types of Consumer-Operated Services Funded by SMHAs, 2013**

Services	Number of States
Peer and mutual support	43
Advocacy	37
Drop-in centers	35
Wellness and prevention services	35
Leadership skills training	30
Promoting positive public attitudes	26
Technical assistance	22
Social services	21
Policy development	17
Vocational rehabilitation and employment	16
Transitional and supported housing	13
Residential crisis facility	11
Case management	11
Client-staffed businesses	11
Nonresidential crisis intervention	11
Research activities	5

## **Alternative Recovery Support Services**

Recovery support is one of a variety of strategies that SMHAs are using to improve community-based services. Forty-seven states are developing and/or supporting alternative forms of mental health treatment to reduce the need for hospitalization. For example, in Alabama the SMHA promotes the expansion of crisis services among providers and the adoption of evidenced-based services such as assertive community treatment and Peer Recovery Services. Some providers also use or share clinical staff with local jails, courts, and hospitals to provide and coordinate alternative treatment through diversionary practices.

Services are provided with a focus on mobility across a variety of community settings, which include homes, and in partnership with other community organizations such as schools and health clinics. Providers also incorporate the use of telemedicine and wraparound services to expand service capacity. In Colorado, the SMHA is developing crisis services to rely less on hospitalization. In Missouri, the SMHA is developing hospital diversion programs and programs to reduce 30-day recidivism rates. In Oregon, the SMHA is working with acute care hospitals to transition individuals back to community-based services.

## **Single State Agencies for Substance Use Disorder Services**

Substance use disorder recovery services typically are provided in conjunction with treatment, but small minorities of individuals receive only support or recovery services. According to data in Annual Block Grant Reports filed by the states, the substance use disorder treatment system that SSAs support served 2.5 million individuals from 2011 through 2012. About 1.6 million of these individuals were new admissions in 2011 or 2012, whereas 710,000 had initiated their treatment in a prior year. Of that total served, 160,000 individuals used only support or recovery services—such as those provided through the Access to Recovery (ATR) initiative—and never accessed formal treatment services. These individuals largely were served through Recovery Community Centers, which offer a number of peer-provided services—for example, mentoring those in recovery, helping connect them to resources, and providing support and educational groups (Center for

Substance Abuse Treatment, SAMHSA, 2009). These 160,000 individuals probably are a minority of those who accessed recovery services (reported by fewer than half of SSAs); most individuals who receive support or recovery services also receive treatment.

Most states support recovery-oriented services, and nearly all states have given consideration to Recovery-Oriented System of Care (ROSC) transformation or embarked on the initial stages of reforms. However, only a few states have completed comprehensive reform (NASADAD & Abt Associates, 2011, p. 8).

A survey of 47 SSAs by NASADAD found that virtually all states are engaged in reforming their systems of care. A total of 96 percent of SSAs participating in the survey have implemented one or more recovery-oriented services, such as peer support services, employment services, case management, faith-based support, or recovery housing (NASADAD & Abt Associates, p. 8).

About 94 percent of SSAs have considered (or are considering) implementing a systems change effort on ROSC; of these SSAs, 14 first were addressing systems barriers and 22 already were taking action such as seeking technical assistance. Other SSAs are engaged in activities such as changing state policies to be aligned with ROSC values and reforming billing processes to be inclusive of recovery-oriented services. These initiatives might suggest that states are far along in their undertaking of systems reform; on closer examination, most acknowledged that they are just in the developmental phase or in the early process of reforming their systems of care.

More than half of states have completed or are in the process of performing ROSC-related readiness assessments, needs assessments, specification of some of their ROSC conceptual elements, strategic planning, and implementation. About one-third of SSAs noted that they need technical assistance for ROSC advancement; 10 states requested training; and 11 states indicated a need for financial resources to advance ROSC transformation and health care reform.

Nearly all states have reported high rates of “consideration of implementation of a systems change effort.” However, in examining the SSAs closely, we found that only six states are fully engaged in comprehensive ROSC reform,

and an additional seven states have made significant effort toward systems change. In addition, the current context of health care reform makes continued education, training, and technical assistance on ROSC and health care reform essential to promoting progress toward systems change.

## Limitations

The 2013 State Profiles project includes the voluntary submission of information from SMHAs and SSAs. Although there was a high overall response rate, some states did not provide answers to all questions; therefore, some information presented in this report is based on responses from fewer than the total number of reporting states. The information is current as of 2013, and some states may have made changes since that time.

In addition, although this report includes SMHA- and SSA-controlled expenditures, it should not be assumed that the revenues and expenditures reported here include all expenditures for mental health and substance use disorder services within a state government. State governments expend considerable resources for mental health and substance use disorder services through other state government agencies such as community health centers and justice agencies that are not included in this report.

Much of the mental health data in the SUD profiles only pertain to “public-sector” services and to individuals who are medically indigent and lack adequate insurance coverage, those who have low income, or both. It should be noted that states have different standards as to eligibility for subsidized public-sector treatment services; to a large extent, this is reflected in the major differences across states in the amount of funds dedicated to public treatment and prevention. Another major issue is that very few SSAs capture Medicaid-related data on spending or services delivered.

## Conclusions

Information gleaned from the State Profiles 2013 project sheds light on the significant extent to which most SMHAs and SSAs are actively engaged in promoting health- and recovery-oriented service systems for individuals in recovery from mental and substance use

disorders. These recovery services include housing, employment, and education support; outpatient testing and treatment; crisis services; and peer- or consumer-operated services. Most SSAs have embarked on reforming their systems of care to include recovery services, and some have gone so far as to change state policies so that processes include recovery-oriented services. Progress on this SAMHSA initiative is particularly important given the promise of recovery services to improve outcomes for individuals with mental and substance use disorders.

These state efforts also are supported by two SAMHSA initiatives: Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) and the Transformation Transfer Initiative (TTI). These initiatives support states (1) by providing technical assistance and training to SMHAs and SSAs, providers of mental health and substance use disorder services, and consumers and families and (2) by helping to implement and improve recovery-oriented service systems.

## References

- Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. (2009). *What are peer recovery support services?* (HHS Publication No. (SMA) 09-4454). Rockville, MD: U.S. Department of Health and Human Services. Retrieved from <http://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf>
- Chang, Y. C., Heller, T., Pickett, S., & Chen, M. D. (2013). Recovery of people with psychiatric disabilities living in the community and associated factors. *Psychiatric Rehabilitation Journal*, 36(2), 80–85. doi:10.1037/h0094975
- Hoffman, H., Jäckel, D., Glauser, S., Mueser, K. T., & Kupper, Z. (2014). Long-term effectiveness of supported employment: 5-year follow-up of a randomized control trial. *American Journal of Psychiatry*, 171(11), 1183–1190. doi:10.1176/appi.ajp.2014.13070857
- National Association of State Alcohol and Drug Abuse Directors & Abt Associates Inc. (2011). *State progress toward recovery-oriented systems of care* (unpublished report).

Substance Abuse and Mental Health Services Administration. (n.d.). *Access to Recovery toolkit*. (HHS Pub. No. (SMA) 10-ATRKIT). Retrieved from <http://store.samhsa.gov/product/Access-to-Recovery-Implementation-Toolkit/SMA10-ATRKIT>

Substance Abuse and Mental Health Services Administration. (2011a). *Building your program: Consumer-operated services* (HHS Pub. No. (SMA) 11-4633). Retrieved from <http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/BuildingYourProgram-COSP.pdf>

Substance Abuse and Mental Health Services Administration. (2011b). *SAMHSA strategic initiatives fact sheet* (HHS Pub. No. (SMA) 11-4666). Retrieved from <http://store.samhsa.gov/shin/content//SMA11-4666/SMA11-4666.pdf>

Substance Abuse and Mental Health Services Administration. (2012). *Working definition of recovery*. Rockville, MD: Author. Retrieved from <http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf>

Substance Abuse and Mental Health Services Administration. (2013). *Funding and characteristics of single state agencies for substance abuse and state mental health agencies, 2013* (HHS Pub. No. (SMA) 15-4926). Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA Leading Change 2.0: Advancing the behavioral health of the nation 2015–2018*. Retrieved from <http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2>

## Notes

<sup>1</sup> In this brief, the term state is used to refer to the 50 states, the District of Columbia, U.S. Territories and Freely Associated States.

## Appendix

# State Mental Health Agency Activities to Restructure the Delivery of Community-Based Mental Health Service

### California

California implemented Katie A class action court settlement services for children in foster care. The state conducted this activity in coordination with the California Department of Social Services (CDSS) and County Welfare Agency (CWA) and close coordination with physical health Medi-Cal Managed Care Plans.

### Connecticut

In state fiscal year (SFY) 2012, traditional case management was replaced by rehab-specific, recovery-oriented community support programs. In this program as well as others, the Department of Mental Health and Addiction Services (DMHAS) has increased the role of peer-support and peer-run services.

### Delaware

Delaware provides a number of specialized services. In the area of crisis diversion, 24/7 mobile crisis services are fully staffed statewide. The state also has a new crisis walk-in center, and they have reorganized their crisis apartments as well as restructured their crisis stabilization services. They provide 350 housing subsidies to date for individuals with serious and persistent mental illness (SPMI), and they have an increased focus on supported employment and peer support services. Community Reintegration Program (CRISP) contracts have been awarded to two providers. This project is directed to move 70+ individuals out of the Delaware Psychiatric Center (DPC) and to provide more individualized services to some community clients who are frequently hospitalized. Ten Assertive Community Treatment (ACT) teams are in place to serve up to 100 clients per team who require multiple services weekly. Five Intensive Care Management (ICM) teams are in place to serve up to 200 clients per team that require less frequent services. Regarding Targeted Care Management (TCM), the original DPC team of four state staff serving the first 60 clients leaving DPC has now been supplemented by contracts awarded for two additional teams: one each for the northern and southern parts of the state. The purpose of TCM is to ensure that clients leaving acute care are firmly connected to after-care and continuing treatment services. This is especially important for clients who are receiving treatment for the first time. Delaware gained two new service providers, Recovery Innovations and Anka.

### District of Columbia

The District of Columbia State Mental Health Agency (SMHA), in coordination with the State Medicaid Agency, is developing a Health Homes State Plan Amendment. The expectation is that the majority of community mental health providers will become Health Homes; thus the majority of SMHA consumers with serious mental illness (SMI) will be served through a Health Homes model. This new model will lead to better coordination for all of the consumer's medical and mental health needs, and it also will replace the use of community services for most consumers. Additionally, with the merger of the District's SMHA and single-state agency (SSA) effective October 1, 2013, integrated care for co-occurring mental and substance use disorders will become more widespread.

## Georgia

Per a Department of Justice (DOJ) Settlement Agreement, Georgia is restructuring community-based services for adults. Medicaid is restructuring their mental health and addictions (MH/ADs) services for children and adolescents needing foster care and adoption assistance.

## Idaho

Medicaid managed care contracted with OptumHealth in July 2013. Medicaid managed care services were implemented September 1, 2013.

## Illinois

Rebalancing has occurred in two areas of the state relative to the closure of two state hospitals in the past year. Additionally, individuals not enrolled in Medicaid are receiving limited service packages because of budget reductions.

## Kansas

Community-based mental health services are directed by the state's Mental Health Reform Initiative.

## Louisiana

Beginning 03/01/12, The Louisiana Behavioral Health Partnership, which is managed by the Louisiana Department of Health and Hospitals Office of Behavioral Health (DHH-OBH), was implemented to oversee the Behavioral Health Statewide Management Organization (SMO). This SMO operates the prepaid inpatient health plan (PIHP) for Louisiana's mental health and substance use disorder services.

## Massachusetts

Since 2009, the Massachusetts Department of Mental Health (DMH) has been engaging in a systematic redesign of the community-based systems serving adults and youths. To date, the DMH has redesigned and procured Community-Based Flexible Supports (CBFS) and respite services for adults and Individual and Family Flexible Support Services (IFFSS) for children and adolescents. The DMH is currently procuring Clubhouse services for adults and a joint procurement of child and adolescent residential services with the Department of Children and Families. This redesign effort is grounded in promoting recovery and resiliency and providing services that are consumer and family driven and youth guided, where appropriate. In addition, DMH service system planning for children and adolescents is intertwined with planning and implementation of the Children's Behavioral Health Initiative (CBHI). This initiative is the Commonwealth's long-term, interagency effort to establish a service system for families of children with serious emotional disturbance that addresses child and family needs regardless of the family's insurance status or agency involvement. An overarching goal of the CBHI is to improve access to mental and behavioral health services for all children and adolescents in the Commonwealth and to increase the availability of community-based services for this population.

## Michigan

Effective January 1, 2014, there are now 10 PIHPs instead of 18.

## Minnesota

Minnesota received a Centers for Medicare & Medicaid Services (CMS) planning grant to develop behavioral health homes. Additionally, 2013 legislation allowed the state to restructure coverage policy of Adult Rehabilitation of Mental Health Services (ARMHS).

## Nebraska

Nebraska is not undergoing any formal restructuring; however, there are efforts in their regions to work with Federally Qualified Health Centers (FQHCs). They are also attempting to integrate physical and behavioral health as well as results of their peer support and peer-run services, trauma-informed care, and co-occurring initiatives.

## Nevada

Nevada is in the process of standardizing their outpatient services delivery system statewide.

## New Hampshire

New Hampshire is planning to implement Medicaid Managed Care (NH Care Management).

## New Jersey

New Jersey will be moving away from contract-based funding to fee-for-service funding. The Administrative Service Organization and Managed Behavioral Health Organization (ASO/MBHO) will manage most services.

## New York

Medicaid Managed Care was implemented in 2014 in New York State. For more information see <http://www.omh.ny.gov/omhweb/bho/>.

## North Carolina

The SMHA and the Division of Medical Assistance (state Medicaid agency) are collaborating to expand the Medicaid 1915(b)/(c) waiver. This waiver has transformed local management entities into managed care organizations with capitated funding. Through mergers, the 23 local management entities have been reduced to 11 local management entity managed care organizations (LME-MCOs). The state is currently planning to develop a Medicaid 1115 Waiver to integrate primary care with care for mental health, developmental disabilities, and substance use. They plan to continue the capitated funding model and expand each MCO's responsibilities to statewide coverage.

## Oregon

Regarding Medicaid transformation, a public process led by Governor Kitzhaber and the Oregon Legislature helped implement health system transformation to provide better care for people who rely on the Oregon Health Plan (Medicaid). The passage of House Bill 3650 and Senate Bill 1580 created a statewide system of coordinated care organizations (CCOs). A CCO is a network of all types of health care providers (physical health care, behavioral health care and, in 2014, dental health care providers) who have agreed to work together in their communities to serve people who receive health care coverage under the Oregon Health Plan. Better care brings lower costs and minimizes the likelihood of higher costs over time. CCOs have the flexibility to provide the services and supports that help people stay healthy or get healthier: preventive care coordination to limit unnecessary tests and medications, integration of physical and mental health and addictions services and supports, chronic disease management to help people avoid unnecessary hospitalization, and person-centered care. CCOs are focused on prevention and on helping people manage conditions such as diabetes, asthma, mental illness, and addictions. This focus helps reduce unnecessary emergency department visits and gives people support to be healthy.

CCOs are replacing a fragmented system of care that relied on different groups to provide physical health, dental health, mental health, and addictions care. CCOs are set up to put an emphasis on person-centered care, where all care providers are coordinating efforts to make sure that service plans complement each other. CCOs strive to increase health equity and to ensure that everyone in Oregon has the care they need to stay healthy. CCOs are locally governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk to address community needs.

CCOs are required to complete a community health assessment and develop a community health improvement plan to address the needs and gaps identified in the assessment. CCOs are accountable for the health outcomes of the populations they serve. To provide the flexibility needed to support new models of care that are patient-centered and team-focused and to reduce health disparities, CCOs have a global budget that grows at a fixed rate. They have flexibility within their budget to provide services utilizing Oregon Health Plan (OHP) benefits with the goal of meeting the Triple Aim of better health, better care, and lower costs for the populations they serve. A competitive application process was implemented on March 2012, and it resulted in 15 CCOs operating in communities around Oregon. The majority of OHP members now receive care through a CCO.

OHA has initiated a strategy to partner with CCOs that will identify dynamic Transformation Plan milestones, deliverables, and targets for becoming a fully integrated CCO in the communities they serve. The Transformation Plans address eight key components: (1) developing and implementing a health care delivery model that integrates mental health and physical health care and addictions; this plan must specifically address the needs of individuals with serious mental illness; (2) continuing implementation and development of Patient-Centered Primary Care Homes (PCPCHs) for eligible individuals; (3) implementing consistent alternative payment methodologies that align payment with health outcomes; (4) preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with 2012 Oregon Laws; (5) developing electronic health records, health information exchanges, and meaningful use; (6) assuring that communications, outreach, member engagement, and services are tailored to cultural, health literacy, and linguistic needs of populations served; (7) ensuring that provider networks and staff members are able to meet culturally diverse needs of the community (cultural competence training, provider composition reflecting member diversity, nontraditional health care workers composition reflecting member diversity); and (8) developing a quality improvement plan focused on eliminating racial, ethnic, and linguistic disparities in access, quality of care, experience of care, and outcomes. Each CCO has submitted a Transformation Plan to OHA for final approval. The Transformation Plan consists of two parts: a detailed narrative that describes the CCO's plan to transform the health care delivery system, including a description of how the CCO will address the eight key components

mentioned above; and contract deliverables, which use a standardized template that incorporates the key plan milestones with measurable targets from the plan's detailed narrative. These deliverables will result in a tool for monitoring progress and serve as the contract amendment.

To encourage continuous quality improvement—recognizing that transformation is an iterative process and that Transformation Plans will and should evolve over time—a process has been established for OHA to review draft Plans, provide feedback, and finalize the OHA CCO contract amendment. Additionally, a process for ongoing review of CCO progress toward achieving the objectives and timelines identified in the Transformation Plans will be developed.

Senate Bill 1580, which implemented the CCOs, requires OHA to provide CCOs with innovator agents. These individuals will help champion and share innovation ideas, either within the CCOs or the state agency, in support of the Triple Aim. The innovator agents are critical in linking the needs of OHA, the community, and the CCO. They will work closely with the community and the CCO to understand the health needs of the region and the strengths and gaps of health resources in the CCO. One role of the innovator agents is to serve as the single point of contact between the CCO and OHA, thereby providing an effective and immediate line of communication, allowing streamlined reporting, and reducing the duplication of requests and information. Other roles of the innovator agents are to inform OHA of opportunities and obstacles related to the system, process improvements through ad hoc phone and written communications and meetings, and summarize these opportunities and obstacles in monthly reports. The agents also assist the CCO in managing and using data to accelerate quality improvement and work with the CCO and its Community Advisory Council (CAC) to gauge the impact of health systems transformation on community health needs. The innovator agents will observe meetings of the CAC and keep OHA informed of the CAC's work. They will assist the CCO in developing strategies to accelerate quality improvement and the adoption of innovations in care. They will build and participate in a statewide learning collaborative to share information with other innovator agents, CCOs, community stakeholders, and/or OHA. Information will be shared through the following mechanisms: weekly in-person meetings and/or phone conversations with OHA and other innovator agents; daily contact with the CCO and/or community stakeholders; community meetings and/or forums; secure website with a database into which the innovator agent will log all CCO and community stakeholder questions and answers; and in-person meetings with OHA not less than once every calendar quarter to discuss the ideas, projects, and creative innovations planned or undertaken by their assigned coordinated care organizations for the purposes of sharing information across CCOs.

Regarding the focus on children's mental health, current health and education system transformation and agency reorganization will affect how the state's most vulnerable children receive services. The Department of Human Services (DHS) and OHA are responsible for services and programs that serve the state's most vulnerable children. Interagency coordination and a children's health policy strategy is necessary to ensure that the needs of these children and families are met. The Children's Health Policy Team (CHPT) was created to ensure a coordinated, child- and family-focused health policy strategy for the children and their families served by both agencies. The Team meets monthly, and it is comprised of representatives from Child Welfare, Self-Sufficiency (TANF), Developmental Disabilities, Addictions and Mental Health, Public Health, Office for Oregon Health Policy and Research, Office of Equity and Inclusion, both DHS and OHA Health/Data Analytics Groups, and Vocational Rehabilitation. It is co-led by the Children's Medical Director for OHA and the DHS Medical Director.

Regarding residential addictions and mental health services, AMH is transitioning Medicaid funded addictions and mental health residential treatment for adults and youths to Oregon's CCOs in promotion of behavioral and physical health coordination. To aid in this transition, an advisory group comprised of consumers, CCOs, community mental health program representatives, alcohol and drug residential providers, and mental health residential providers was established to advise the Oregon Health Authority on the transition. Outreach efforts are underway to inform CCOs of the importance of behavioral health stabilization, including detoxification services and residential capacity within the continuum of care in Oregon communities.

In addition to the work to develop CCOs, Oregon's Addictions and Mental Health Services (AMH) has undertaken a parallel but separate system change effort with Oregon's county governments to restructure the publicly funded addiction and mental health system for people who are not eligible for the Oregon Health Plan. The goals for this system change are similar to those of CCOs and include emphasizing prevention and early intervention to promote independence, resilience, recovery, and health and to avoid long-term costs including loss of employment, damage to family stability, increased health care costs, and criminal justice involvement. Other goals are (1) providing flexibility to local communities to help them better serve people with addictions and mental health needs, (2) improving accountability in the community-based addictions and mental health system, (3) ensuring consumer and family involvement in both the planning and ongoing governance of the system, (4) reducing reliance on high-cost institutional care, and (5) increasing the availability of high quality, community-based addictions services and mental health care.

Integration of primary and behavioral health represents another major system change initiative for AMH and continues as a major focus during the next biennium. CCOs and local mental health authorities have been asked to collaborate in serving the residents of their communities. This collaboration will ensure that individuals with or without Medicaid services will receive coordinated care. As part of this system change, residential treatment services for individuals who are eligible for Medicaid will transition to CCOs by July 1, 2013. Providers will continue to serve those without Medicaid using Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) funds. AMH will work with stakeholders to prepare for this transition and ensure that SABG funds continue to be used to serve priority populations.

Primary to this integration is the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for individuals with substance use disorders as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences can occur. The SBIRT model holds promise in expanding the continuum of addiction services beyond specialty addiction service providers. AMH is exploring the SBIRT model with partners in primary care: CCOs, primary care providers, Oregon Health and Science University (OHSU), and others.

AMH monitors the SAMHSA discretionary grant programs website for release of SBIRT funding announcements and maintains formal and informal contacts with stakeholders who have expressed an interest in partnering with AMH. These improvements to the addictions and mental health system are driven by the discretion afforded by flexible funding, which allows counties to allocate resources where they are most needed to serve people in their communities. The budgeting flexibility is balanced by outcomes-based management that holds counties and providers accountable for the overall behavioral health of the populations they serve rather than just the quantity of services provided or the number of people served. To protect the integrity of block grant funds, performance and utilization requirements aligned with block grant priority areas are included in the flexible funding agreements.

AMH will continue to realign investments to support strategies and services (including prevention, early intervention, and recovery support services) that are not included in health benefit packages under OHP and for people not covered by Medicaid. Oregon Revised Statute requires that local mental health authorities (LMHAs) submit Biennial Implementation Plans for operation of each community mental health provider (CMHP) to AMH for approval. As CMHPs are receiving more flexibility in their use of addictions and mental health funding, it is important that there is a mechanism to inform AMH and the community about the plans to administer those funds. The new Biennial Implementation Plan process facilitates that accountability. Additionally, the Biennial Implementation Plan is designed to ensure compliance with statutes, block grants, and other federal requirements. Information is required in three areas: system narrative, performance measures, and budget information. To support success, AMH will provide further guidance and resources

to develop plans that meet each community's needs. A designated AMH staff member is assigned to assist each LMHA and CMHP in answering questions, connecting with resources, and providing technical assistance as needed. AMH and CMHP directors will continue to meet to monitor the process and discuss opportunities to align Biennial Implementation Plan requirements with CCO operations.

### **Rhode Island**

Rhode Island's goals include ensuring a better interface with Medicaid managed care programs, reviewing overall relationships between community mental health centers (CMHCs), and assessing the potential to transform payment methodologies to ensure the right service at right time for appropriate cost to the state. The state is continuing implementation of Health Home Services. The SMHA has promoted incorporation of peer specialists on CMHC Health Home teams along with other efforts to create or sustain a recovery-oriented system of care.

### **South Carolina**

In response to changes in the Medicaid State Plan, the South Carolina Department of Mental Health (DMH) separated activities of care coordination from the treatment component. The Office of Care Coordination functions independently from the CMHCs under its own direction and supervision by the Director of Quality Management and Compliance.

### **South Dakota**

South Dakota's primary goal is to improve access to mental health services by using recommendations from the behavioral health services work group. This group was created during the reorganization of the Division of Community Behavioral Health.

### **Vermont**

Vermont is working to combine all human services for children and families under one funding stream and organization (Integrated Family Services). The state is always trying to increase access to community-based and hospital diversion services.

### **West Virginia**

The West Virginia Comprehensive Behavioral Health Commission has laid out a series of recommendations that include some aspects of restructuring behavioral health services, with a heavy emphasis on integration of physical and behavioral health care.

### *In Brief*

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