Where Is Behavioral Health Headed?

Ideas to Help Facilities' Internal Strategic Planning Efforts

2012 Summary Report

from the 2011 strategic planning process of the National Association of Psychiatric Health Systems

ABOUT THIS REPORT

The following document summarizes the thinking of the National Association of Psychiatric Health Systems (NAPHS) Board of Trustees and key membership constituencies represented by the NAPHS committees on Youth Services, Addiction Treatment, and Behavioral Health Services within General Healthcare Systems. Each of these groups participated in an intensive discussion in 2011—moderated by health policy consultant James Bentley, Ph.D.—to help identify trends and their potential impact on behavioral health.

Below are some of the insights shared in these discussions. Use these ideas to jump-start your own strategic planning process. Included are questions to help you think through how—or if—trends may affect your own organization. Because all health care is local, these concepts and ideas will ultimately be shaped locally and customized for the unique characteristics of communities and providers (large/small, urban/rural, etc.).

Spring 2012
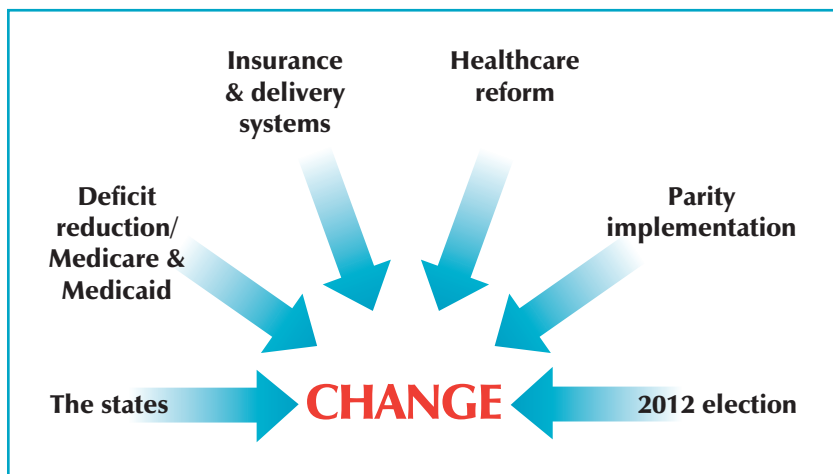National Association of Psychiatric Health Systems

INTRODUCTION

CHANGE IS INEVITABLE IN HEALTH CARE

There may be little consensus on where change may take us, but there is little doubt that a wide variety of forces—from the economy to consumer preferences to quality improvement and technology—are driving all segments of the health system to rethink fundamental strategies and partnerships.

Health reform is a broad umbrella under which change is being discussed in both the government and private-sector marketplaces.

Insurance & delivery systems

Healthcare reform

Deficit reduction/ Medicare & Medicaid

Parity implementation

The states **CHANGE** 2012 election

In behavioral health, changes are also being further shaped by two major—and interrelated—forces:

● The **mental health and addiction parity law and regulations** (for the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*).

● The **healthcare reform law** (the *Patient Protection and Affordable Care Act* or ACA), which is experimenting with fundamental changes/innovations focused on controlling costs and expanding access while maintaining quality. Mental health and substance use disorder (MH/SUD) benefits are explicitly addressed in various aspects of the law. For example, MH/SUD benefits have been named as one of the 10 "essential health benefits" required of health exchanges. By extending the federal parity law to those plans, Congress is extending parity coverage to small employers and individual health plans that had been previously exempted. The ACA also requires public reporting of quality psychiatric measures by both psychiatric hospitals and psychiatric units beginning in fall 2103.

Dramatic and positive changes have already resulted in the behavioral health arena in recent years. For example, arbitrary and discriminatory outpatient visit and inpatient day limits are a thing of the past for those covered under the parity law, which addresses both mental health and substance use disorders. Millions of Americans—previously uninsured—are expected to gain coverage in the next few years through Medicaid and other provisions of the ACA.

With behavioral health seen as integral to overall health, the focus has been intensified on finding ways to better integrate behavioral health within physical health.

How will behavioral health need to evolve as part of the healthcare system of the future? It's unclear exactly what will happen over time. Many reform ideas are untested—or tested only to a limited degree (for example, new initiatives looking to create accountable care organizations). Some ideas will "stick[1]"; some won't. It's an evolutionary process and one that will take shape—in both the public and private sectors. Nevertheless, the quality, cost, and transparency provisions embedded in the health reform law are policy directions that are likely to survive in the marketplace—no matter how healthcare reform evolves.
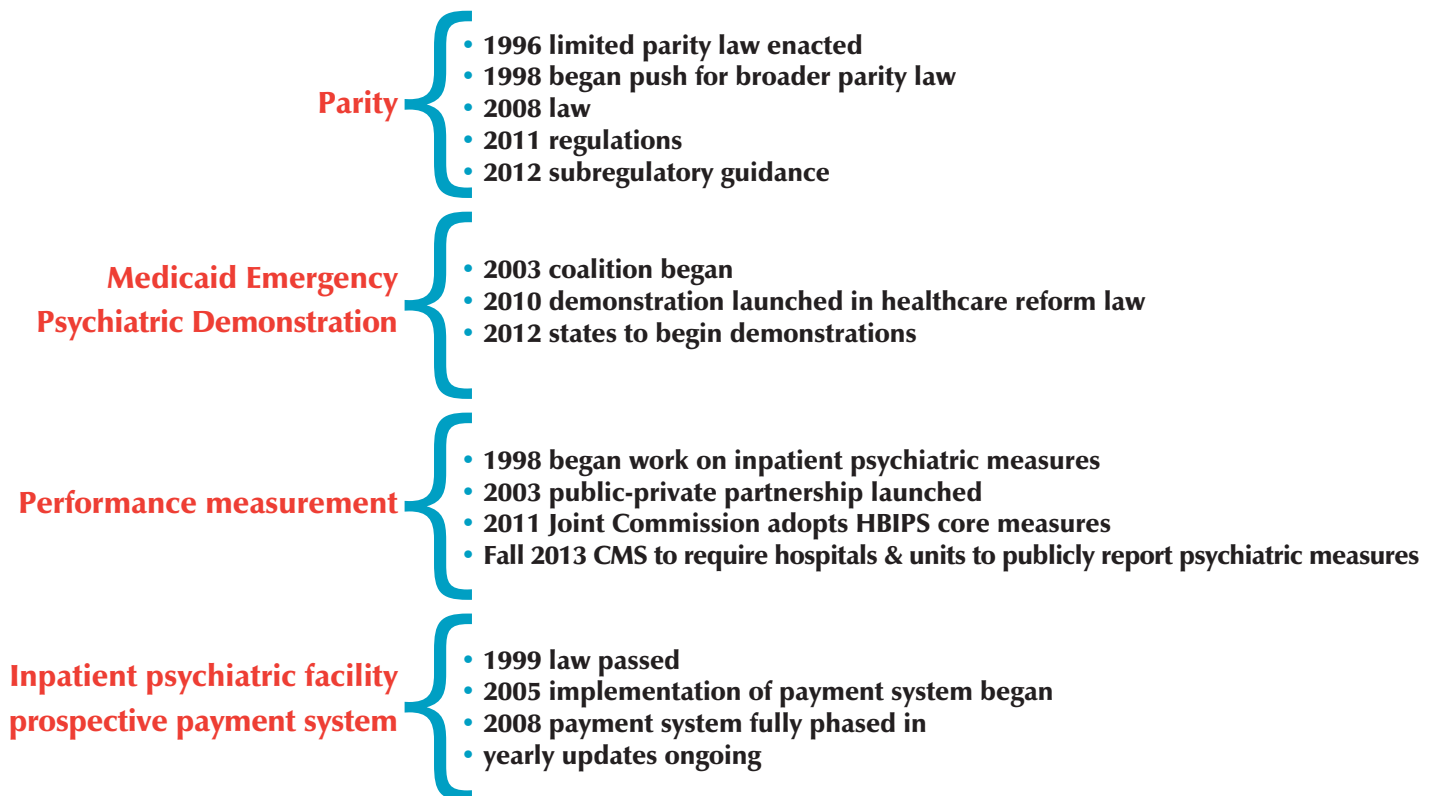
---

[1] *Made to Stick: Why Some Ideas Survive and Others Die*. Chip Health and Dan Heath. 2007.

Given the pace of change, how can behavioral health providers today think through, prioritize, and evaluate the potential impact of change on their patients, their facilities, their employees, and their communities?

One way to look at the issues is through three prisms: short-, mid-, and long-term.

Short-term
• quarter to quarter

Mid-term
• year to year
• election to election

Long-term
• decade or more

Some changes can occur in local markets with great speed. Other ideas require longer timeframes to evolve. For example, most "game-changers" affecting behavioral health have had long gestation periods...and continue with long-term implementation and follow-up:

Parity
• 1996 limited parity law enacted
• 1998 began push for broader parity law
• 2008 law
• 2011 regulations
• 2012 subregulatory guidance

Medicaid Emergency Psychiatric Demonstration
• 2003 coalition began
• 2010 demonstration launched in healthcare reform law
• 2012 states to begin demonstrations

Performance measurement
• 1998 began work on inpatient psychiatric measures
• 2003 public-private partnership launched
• 2011 Joint Commission adopts HBIPS core measures
• Fall 2013 CMS to require hospitals & units to publicly report psychiatric measures

Inpatient psychiatric facility prospective payment system
• 1999 law passed
• 2005 implementation of payment system began
• 2008 payment system fully phased in
• yearly updates ongoing

But the speed of change is difficult to predict. It can happen quickly, or it can take many years.

ANTICIPATING WHEN TO LEAP IS THE CHALLENGE

Our members have described the uncertainty of planning as a person straddling two peaks, uncertain which way to turn—and afraid of the pitfalls of moving at all.

Others have described the challenge as one of intersecting curves. You don't want to jump off your current path too soon...or too late.

Finding the right moment is the challenge.
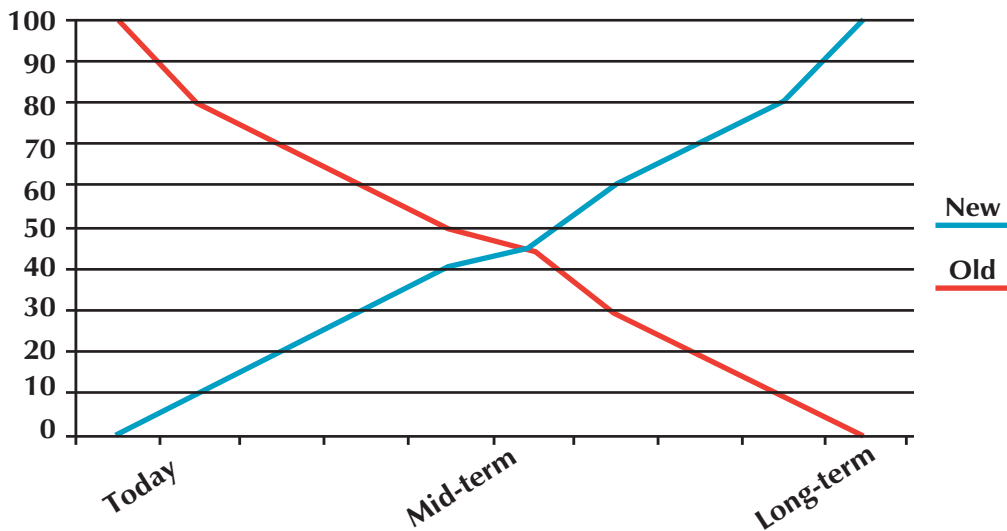
2013 is a year to watch. The year 2013 will be the year in which pressure intensifies on providers, insurers, and the healthcare cost issue—as many of the health reform initiatives take effect. Congress and the administration will likely move on deficit reduction, entitlement reform, and tax reform. Private-sector changes include new strategies being considered and tested by major insurers (such as pay-for-performance models, bundled payments, and risk-sharing arrangements).

The following section summarizes some of the ideas that resulted from consensus discussions throughout 2011 within the membership of the National Association of Psychiatric Health Systems.

This list is not meant to be all-inclusive. Use it as a framework for intensive discussion with your own teams to anticipate and prepare for changes that may be in your future.

TRENDS…AND QUESTIONS TO CONSIDER

THE ENVIRONMENT / BACKGROUND:

■ **Demand for treatment is high.**

- Millions of Americans of all ages face serious mental and addictive disorders. The need for treatment is only partially met by the existing treatment system. According to the Substance Abuse and Mental Health Services Administration (SAMHSA)[2], one in every five adults (45.9 million Americans aged 18 or older) experienced mental illness in the past year. In the past year some 5% of the adult population (11.4 million adults) suffered from serious mental illness (defined as one that resulted in serious functional impairment that substantially interfered with or limited one or more major life activities). Yet only about 4 in 10 people (39.2%) experiencing any mental illness in the past year—and only 60.8% of those experiencing serious mental illness—received any mental health services during that period.

- The use of illicit drugs among Americans increased between 2008 and 2010, according to the 2010 National Survey on Drug Use and Health (2010 NSDUH) released by the Substance Abuse and Mental Health Services Administration (SAMHSA). The study found that 22.6 million Americans age 12 or older (8.9% of the population) were current illicit drug users. According to the survey, 23.1 million Americans aged 12 or older (9.1%) needed specialized treatment for a substance abuse problem, but only 2.6 million (or roughly 11.2%) received it.[3]

- Prescription drug abuse is the nation's fastest-growing drug problem, and the Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic.[4] [5]

- Mental health disorders are "highly prevalent and persistent" in adolescents in the United States, and most adult mental disorders first present in childhood and adolescence.[6]

■ **Economic pressures remain.**

- A tough U.S. economy has added pressure to do more with less. Healthcare expenditures of all types have grown over recent years.[7]

---

[2] Substance Abuse and Mental Health Services Administration's (SAMHSA) 2010 National Survey on Drug Use and Health. January 2012. *See* http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/.

[3] *2010 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration*, September 2011. See http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm. Also see news release: "National survey shows a rise in illicit drug use from 2008 to 2010," September 9, 2011, at www.samhsa.gov/newsroom/advisories/1109075503.aspx.

[4] Office of National Drug Control Policy. "Epidemic: Responding to America's Prescription Drug Abuse Crisis." 2011. See http://www.whitehouse.gov/ondcp/prescription-drug-abuse.

[5] News release. "New report shows treatment admissions for abuse of prescription pain relievers have risen 430 percent from 1999–2009." Substance Abuse and Mental Health Services Administration. December 8, 2011. See http://www.samhsa.gov/newsroom/advisories/1112074117.aspx.

[6] Kessler, RC, et al. "Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement," *Arch Gen Psychiatry.* Published online December 5, 2011. doi:10.1001/archgenpsychiatry. 2011.160. See http://archpsyc.ama-assn.org/cgi/content/short/archgenpsychiatry.2011.160v1?rss=1.

[7] Martin AB, Lassman D, Washington B, Catlin A, and the National Health Expenditure Accounts Team. "Growth in US health spending remained slow in 2010; Health share of gross domestic product was unchanged from 2009," *Health Affairs,* 31, no. 1 (2012):208–219. January 2012.

National Health Expenditures (NHE) as a Percent of Gross Domestic Product

Year	Percent
1980	9.2
1990	12.5
2000	13.8
2007	16.4
2008	16.8
2009	17.9
2010	17.9
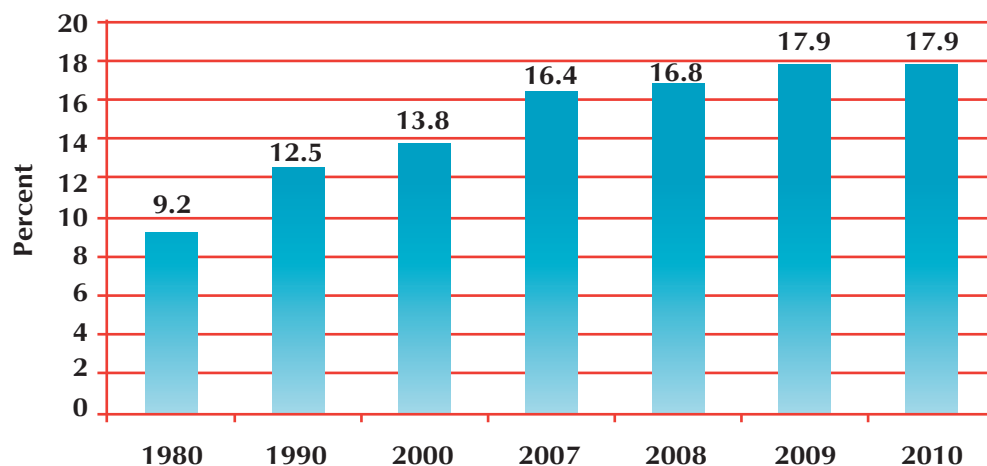
- Cost-cutting is a high priority for the federal government, states, and insurers.
- Providers are looking for ways to control costs while maintaining high-quality care.
- Consolidation is occurring as insurers, providers, and others look for ways to leverage economies of scale.

To consider
- ✔ What systems do you have in place to routinely review and control costs/expenses?
- ✔ What are the potential impacts of the economy on consumers? Will high unemployment and low wage growth encourage people to seek out high-deductible health plans? How will that impact their use of health services?
- ✔ How are your key customers (including insurers and employers) responding to economic pressures?

■ **Demographic trends help shape the environment.**
- The U.S. population is aging. According to the U.S. Census Bureau, "by 2030, all of the baby boomers will have moved into the ranks of the older population. This will result in a shift in the age structure from 13% of the population aged 65 and older in 2010 to 19% in 2030."[8] By 2020, the size of the population age 85 and over (the "oldest old") is projected to double to 7 million. The oldest old will again double to 14 million by 2040 as the survivors of the baby boom cohort reach the oldest ages.[9]

- The U.S. population is becoming more diverse by race and ethnicity, according to the U.S. Census Bureau.[10] Minorities, now roughly one-third of the U.S. population, are expected to become the majority in 2042, with the nation projected to be 54% minority in 2050. By 2023, minorities will comprise more than half of all children.[11]

---

[8] Vincent, GK and Velkoff, VA. "The Next Four Decades: The Older Population in the United States: 2010 to 2050. Population Estimates and Projections." U.S. Census Bureau. May 2010. From http://www.census.gov/prod/2010pubs/p25-1138.pdf.

[9] From http://www.census.gov/population/international/files/97agewc.pdf. U.S. Census Bureau.

[10] "Population Profile of the United States," U.S. Census Bureau. See http://www.census.gov/population/www/pop-profile/natproj.html.

[11] News release: "An older and more diverse nation by midcentury," U.S. Census Bureau, August 14, 2008. See http://www.census.gov/newsroom/releases/archives/population/cb08-123.html.

To consider

✔ How is your organization preparing to serve an older population with multiple needs—including medical illnesses? What partners will you need to serve this population?

✔ What are the implications of demographic trends (such as an aging population and multicultural diversity) on your own workforce? Do you have a plan to replace retiring workers? How are you reaching out to recruit from minority populations?

✔ How are you addressing the cultural needs of your patients?

■ **Societal changes influence the big picture.**

● There is a **lack of societal options for outplacements**; development of community-based behavioral health resources has not kept pace with the need.

✔ Backlogs of behavioral health patients in emergency departments have become an issue in some communities.

✔ Community hospitals have scaled back care for the mentally ill since the recession by closing unprofitable units.[12]

✔ A robust continuum of care is disappearing in many communities.

✔ There is a lack of coordination between the Medicare and Medicaid programs for dually eligible individuals.

✔ More mentally ill individuals are ending up in jails[13]—rather than in hospitals

● **Public-sector changes are occurring**.

✔ According to the National Association of State Mental Health Program Directors, approximately 4,000 psychiatric hospital beds have been eliminated since 2010.[14]

✔ The role of state mental health departments is changing. Public mental health funding is shifting to Medicaid. Discretionary public mental health dollars are shrinking.

● **Politicians and elections have an influence**.

✔ Politics is becoming increasingly contentious.

✔ Unresolved issues carry over from election to election.

■ **Financing**

● **New models of financing** are being tested, including bundled payments, capitation, or other shared-risk arrangements.

---

12 "Juggling the lineup: Seeking better financial results, providers change services; experts worry about access," by Melanie Evans. *Modern Healthcare*. January 14, 2012.

13 "Nation's jails struggle with mentally ill prisoners," National Public Radio/All Things Considered. September 4, 2011. See http://www.npr.org/2011/09/04/140167676/nations-jails-struggle-with-mentally-ill-prisoners.

14 Lutterman, T. The Impact of the State Fiscal Crisis on State Mental Health Systems [PowerPoint]. See http://www.nri-inc.org/reports _pubs/2011/ImpactOfStateFiscalCrisisOnMentalHealthSytems_Updated_12Feb11_NRI_Study.pdf. December 2011.

- **Managed care** is being expanded to help control costs (including in Medicaid/Medicare).

- **Public funding is a growing percentage of behavioral healthcare financing.**[15][16] Public Medicare/Medicaid funding will continue to be a major source of revenue for both private- and public-sector behavioral healthcare providers as will funding from non-traditional sources (e.g., juvenile justice, foster care, special education, and state and local funding).

To consider

✔ How are you responding to increasing demand?

✔ How is your payer mix changing?

✔ What can you do to lower your costs/become more efficient?

✔ What data could help you make a strong case for improved payment levels?

✔ What are the pros/cons of providing services that have little or no reimbursement, but that have the potential to improve health outcomes and save money in the longterm? For example, could you avoid costly readmissions by calling patients post-discharge, or providing case management or psychiatric home health care?

"STICKY" IDEAS / OPPORTUNITIES:

The following concepts are broad trends already moving forward in practice and helping to shape the environment for the future.

■ The **mainstreaming of behavioral health as an integral part of overall health** is an idea that has already "stuck" with policymakers as a result of the federal parity law victory. Insurers are beginning to change their practices to meet the law. It is now a matter of fully implementing parity. The field needs to continue to work to ensure that behavioral health is seen as a specialty (equal to all others) within overall health care (not something that is "separate, but equal").

■ There is an **opportunity to reduce stigma** (with general healthcare colleagues, the public, and policymakers). How the language of parity will play out at the ground level will be important.

To consider

✔ How are you communicating the importance of behavioral health to your community (including local legislators)? You may want to consider including articles in internal/external newsletters about the progress already made (e.g., through the federal parity law) and the changes that are still needed (such as elimination of the Medicare 190-day lifetime limit).

---

[15] *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2005*. DHHS Publication No. (SMA) 10–4612. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA). 2010. See http://store.samhsa.gov/shin/content//SMA10-4612/SMA10-4612.pdf.

[16] "Mental health financing in the United States: A primer," The Kaiser Commission on Medicaid and the Uninsured. Publication Number 8182. April 21, 2011. See http://kff.org/medicaid/8182.cfm.

✔ Are there opportunities to reach out to promote the importance of mental health in the community (for example, through school-based initiatives to make youth/parents aware of mental illness and addiction)?

✔ Consider emphasizing your value as an employer and economic engine[17] in your community.

✔ Invite your congressional representatives to visit your facility to learn more about the role you play in the overall health of your community. What would community life be like without you? What are the long-term costs of not treating behavioral disorders adequately?

✔ What opportunities are there to build stronger relationships with general healthcare practitioners in your community?

■ Mental health and substance abuse providers have an **opportunity to gain a seat at** *all* **healthcare tables**. NAPHS is working to do this on a national level, and facilities should consider stepping up to be part of larger healthcare-system planning at the local level.

To consider

✔ How can your organization build connections with groups (such as primary care physicians, community health centers, ACOs, and general hospitals/hospital systems) that will play a role in coordinating care for individuals with behavioral health needs in the future?

✔ What opportunities exist for you to be a central point of contact in your community for behavioral health referrals?

✔ What role can you play in community-wide efforts to better serve people with mental and addictive disorders in emergency departments? Can you provide consultation/referral services in emergency rooms?

■ **Integration** (of care, of information/data, of payment) **is an idea that is taking hold.**

• **New models of payment and delivery of care (bundled payments, capitation, or other shared-risk arrangements, medical homes, etc.)** are being tested by insurers and by government payers.

• Providers are developing models to better serve individuals who are **dually diagnosed with mental and addictive disorders**[18] as well as individuals **with medical comorbidities**[19].

---

[17] *The Economic Impact of Inpatient Psychiatric Facilities.* Dobson DaVanzo & Associates, LLC. Conducted for the National Association of Psychiatric Health Systems, Washington, DC. March 2010. Available at www.naphs.org/News/EconomicImpact.

[18] Medicare Payment Advisory Commission (MedPAC). "Chapter 5: Coordinating Care for Dual Eligibles." June 2011 Report to Congress. See http://medpac.gov/chapters/Jun11_Ch05.pdf.

[19] Druss BG and Reisinger WE. *Mental disorders and medical comorbidity.* The Synthesis Project. Research Synthesis Report No. 21. The Robert Wood Johnson Foundation. 2011. See http://www.rwjf.org/files/research/021011.policysynthesis.mentalhealth.report.pdf.

To consider

✔ Which types of "integration" make sense for your organization to pursue? Are there models in which you can be the key coordinator for care? Where will others (such as primary care providers) take a new role?

✔ How would such models benefit patients? Which services can you provide cost-effectively? Where would services be located (embedded in primary care networks or somewhere else)?

✔ Do you have the capacity to offer a full continuum of services to general health systems that want to outsource behavioral health services?

✔ What types of consultation-liaison services could you provide in medical settings (e.g., for transplant, cardiac, or diabetic patients)?

✔ Prepare your finance office to fully evaluate the potential pros and cons of various payment models. Identify the point person(s) who will be responsible for negotiations with insurers and health plans as new payment/delivery systems evolve.

✔ For children and youth, who is coordinating current efforts to ensure that payment follows the child through multiple funding streams (e.g., juvenile justice, special education, addiction services, mental health services)? What lines of communication need to be opened/maintained?

■ Payers, consumers, and providers are all focused on **quality and accountability** (through performance measurement, evidence-based practices, readmission data, and a focus on aftercare/post-discharge planning and continuity of care). For example, both public and private payers are rapidly moving to require public reporting of quality data. Psychiatric hospitals are now required by The Joint Commission to report Hospital-Based Inpatient Psychiatric Services (HBIPS)[20] data[21], which will be publicly reported. General hospital psychiatric units may choose to use HBIPS in their core measure reporting. By fall 2013, the *Affordable Care Act* (ACA) is mandating that both psychiatric hospitals and psychiatric units begin reporting data on at least six measures to the Centers for Medicare & Medicaid Services (CMS) for the purpose of public reporting, payment updates, and pilot pay-for-performance programs.

To consider

✔ How are you communicating the improvements you are achieving through quality initiatives and data analysis? Consider publishing results to share with multiple audiences. And ensure that your staff is aware of successes so that they can continue to share the news with their contacts.

✔ What new data will be needed to help advocate for necessary care? For example, what addiction treatment measures could provide improved evidence of outcomes?

✔ What can the field do to advance meaningful metrics for behavioral health?

---

[20] See www.jointcommission.org/hbips.

[21] The Joint Commission. *Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2011*. See www.jointcommission.org/assets/1/6/TJC_Annual_Report_2011_9_13_11_.pdf.

■ **Consumers and families** have an important role in shaping behavioral healthcare delivery.[22][23][24] According to the National Alliance on Mental Illness (NAMI), "people who live with mental illness can and do recover. Often, the process of recovery results in a spirit of service; of the need to 'give back' to others who are facing the same challenges one has overcome. Services like drop in centers, warm lines, peer-led education, and support programs are often foundational aspects of the recovery process."[25] According to Mental Health America, "Peer support programs provide an opportunity for consumers who have significantly recovered from their illness to assist others in the recovery process to direct their recovery process by teaching one another the skills necessary to lead meaningful lives in the community."[26]

To consider
- ✔ How are you addressing the needs and role of patients and families as consumers of healthcare services?
- ✔ What is the potential role for peers in your treatment services?
- ✔ How can patients/families be involved as resources to your clinical programs and management team?
- ✔ What role might social media play in communicating with consumers and families in the future?

■ Regulatory barriers and payment structures continue to impede integration of primary care and behavioral health care. There will be a need to **change regulations to allow for new approaches as they evolve.** Barriers continue to exist to achieving the concepts of parity and integration. For example, Medicare's 190-day lifetime limit is a vestige of discrimination that needs to be addressed legislatively. Legislation will be needed to extend federal health information technology funding to behavioral health providers. And lessons learned from the Medicaid Emergency Psychiatric Demonstration (now in progress) will need action to address conflicts in current law.

To consider
- ✔ Are there regulations that pose a challenge to your organization's ability to implement new ideas? Be certain to inform NAPHS of legislative or regulatory barriers you are facing.
- ✔ Are there ways to better streamline current regulations to meet efficiency goals? For example, the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission recently incorporated the psychiatric special conditions survey into The Joint Commission hospital survey.[27]

22   The Building Bridges Initiative. See http://www.buildingbridges4youth.org/.
23   Substance Abuse and Mental Health Services Administration. Recovery Support Web page at www.samhsa.gov/recovery/.
24   National Alliance on Mental Illness. Consumer Support Web page at http://www.nami.org/template.cfm?section=Consumer_support.
25   National Alliance on Mental Illness. Peer-Run Services Web page. See http://www.nami.org/Content/NavigationMenu/Find_Support/Consumer_Support/Peer_Run_Services.htm. Accessed 2/14/12.
26   Mental Health America. "Position Statement 37: The Role of Peer Support Services in the Creation of Recovery-Oriented Mental Health Systems." Approved June 8, 2008 (expires June 2013). See http://www.mentalhealthamerica.net/go/position-statements/37.
27   Final notice. *Federal Register.* "Approval of The Joint Commission for Deeming Authority for Psychiatric Hospitals." February 25, 2011. See http://edocket.access.gpo.gov/2011/pdf/2011-4294.pdf.

AREAS TO WATCH (EXPERIMENTING WITH):

■ **"Dual eligible" initiatives** are developing to address the needs of some 9 million Americans enrolled in both Medicare and Medicaid[28]. Two-thirds of dual eligible beneficiaries are low-income and elderly, while one-third are younger than 65 and disabled. Mental disorders disproportionately affect the dual-eligible population. Due to their complicated health conditions, dual eligibles incur a high rate of expenditures for both Medicare and Medicaid when compared to their enrollment in each program. For Medicare, dual eligibles represent 16% of the enrollees and 27% of the program's expenditures. For Medicaid, dual eligibles represent 15% of the enrollees and 39% of the expenditures.

To consider
   ✔ States are now testing new approaches[29] to coordinating and integrating services for dual eligibles. What is your state considering and/or doing? Which approach would best serve your patients?
   ✔ Are there opportunities for your organization to partner with others (such as local NAMI chapters) to communicate your ideas about the dual eligible concepts under consideration to state leaders?

■ **Accountable care organizations** (ACOs) are being tested in the public[30] and private[31] sectors. In ACO models, providers are typically incentivized to take responsibility for large groups of patients—receiving, in return, financial rewards for hitting quality and cost-saving goals.

To consider
   ✔ Are you or are others in your community operating ACOs? Who is considering applying to become an ACO under health reform?
   ✔ If others are developing these models, consider approaching these organizations to discuss a potential role for your organization.
   ✔ What regulations of the past need to be updated (e.g., antitrust laws as applied to ACOs) to allow these models to function?

■ **Technology** holds promise for better tracking and sharing of data. Behavioral health providers are already moving to implement new technologies, but federal action will be required to extend health information technology incentives/funding to behavioral health providers. Challenges also remain for all of health care (behavioral and general health care) to address issues related to interoperability and privacy.[32]

---

[28] Medicare Payment Advisory Commission (MedPAC). "Chapter 5: Coordinating Care for Dual Eligibles." June 2011 Report to Congress. See http://medpac.gov/chapters/Jun11_Ch05.pdf.

[29] See www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp.

[30] McGinnis T and Small DM, "Policy Brief: Accountable care organizations in Medicaid: Emerging practices to guide program design," Center for Health Care Strategies, Inc. February 2012. See http://www.chcs.org/usr_doc/Creating_ACOs_in_Medicaid.pdf.

[31] See www.healthcare.gov.

[32] "Medical records system still far from digital goal," *Washington Post*. January 30, 2012.

To consider

  ✔ Who is charged with reviewing your organization's technology needs and setting timetables and budgets for upgrading your systems?

  ✔ What are your primary payers requiring?

  ✔ What do you need—immediately and long-term—to respond to growing demands for data?

  ✔ How might your staffing needs change as you implement more technology?

  ✔ How might telemedicine[33] extend the reach of your professional services, particularly in rural and underserved areas?

CHALLENGES:

As broad changes in the health system evolve, a number of related factors are on the minds of behavioral healthcare providers.

■ **Workforce[34]/manpower needs of the future** must be addressed.

  • Ensuring an adequate professional staff (including psychiatrists and RNs) and para-professional staff (e.g., youth service workers) will be critical.

  To consider

  ✔ What are you doing to build core competencies in your current staff so that they will be able to advance to more clinically challenging roles in the future?

  ✔ Are your retention strategies effective?[35] What else could be done to retain the highly qualified staff you currently have?

  ✔ Who is responsible for considering new types of outreach to nursing schools, medical schools/residency programs, high schools, and technical training programs?

  ✔ How can workloads of clinical staff be better shared to improve efficiency and effectiveness?

■ Responding to the needs of **changing patient populations** will become a priority for behavioral health providers.

  • **Dual diagnoses** (concurrent addiction/mental illness) are prevalent.

  • **Medical comorbidities** are prevalent. With increasingly early identification (e.g. of cardiac patients with depression), more individuals with behavioral and medical comorbidities are being identified. Side effects of multiple medications can have psychiatric implications.

  • Other populations, such as those with **developmental disabilities** and concurrent mental and/or addictive disorders, are seeking behavioral health services.

  • **State hospital populations** (some without family supports) are increasingly **being treated in the private sector**. Some states are privatizing state systems; others are reducing the number of beds and encouraging more community-based care.

---

[33] The Joint Commission. *Hospital Accreditation Program (HAP) Telemedicine Requirements*. See http://www.jointcommission.org/ assets/1/6/PrePub_20111209_Telemedicine_HAP.pdf. Accessed February 7, 2012.

[34] The Annapolis Coalition on the Behavioral Health Workforce. See www.annapoliscoalition.org/.

[35] "Workforce 2015: Strategy Trumps Shortage," by American Hospital Association Long-Range Policy Committee. January 2010. See http://www.aha.org/advocacy-issues/workforce/workforce2015.shtml.

- **Forensic populations** are facing significant behavioral health challenges. Behavioral health providers are looking at ways to partner with the adult and juvenile justice systems to serve this growing need.

To consider
- ✔ What effect are public-sector changes having in your area?
- ✔ Have the characteristics of the patients you are now seeing changed from those in the past? In what ways? (Some have seen increasing populations of juveniles facing issues such as homelessness, lack of family involvement, or no family ties that pose challenges to smooth transitions from care.)
- ✔ What allies in your community can help you advocate for the resources needed for special populations (e.g., juvenile judges to help advocate for the needs of youth)?
- ✔ Are there services you can offer beyond the walls of your hospital or residential treatment program to support individuals in the justice system or in medical settings?
- ✔ How will your physical environment[36] need to change to accommodate new patient populations, expanding continuums of care, and increasing concern for environmental safety?

■ **Reform implementation** is an unknown quantity. To what extent will the federal government and states work together? Where will there be gaps? For example, states are planning for health exchanges required under the ACA, but unevenly[37].

---

[36] Hunt JM and Sine DM. *The Design Guide for the Built Environment of Behavioral Healthcare Facilities*. Published by the National Association of Psychiatric Health Systems. Edition 5.0 as of Februrary 2012. (Check periodically for the latest updates at www.naphs.org.)

[37] See "3 of 4 uninsured Americans in states that have yet to adopt overhaul plan" by The Associated Press. Published in the *Washington Post*. January 23, 2012.

CONCLUSION

To remain viable and successful organizations, we have to not only embrace change, but to also help shape it to best meet the needs of the individuals we serve.

Watch for news throughout the year from NAPHS that you can use to understand what is being considered, what is likely to come to pass, and what you need to do to create and advocate for systems that best serve individuals with mental and addictive disorders.

ACKNOWLEDGEMENTS

Our thanks to all of the National Association of Psychiatric Health Systems (NAPHS) members who shared their insights and experiences for this report.

National Association
of Psychiatric
Health Systems