THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

FUNDERS FORUM on Accountable Health

Leveraging Accountable Communities for Health to Address Substance Use Disorder
Meeting Summary

September, 2018

Communities and policymakers across the country are struggling to address the nation's devastating epidemic of substance use disorder (SUD), which includes opioid misuse and overdose. With growing need for a spectrum of services, spanning prevention, treatment, and recovery support, along with an increased understanding that the community and social context of SUD must be addressed along with medical needs, a number of communities are using the Accountable Communities for Health (ACH) model as one potential solution. The ACH multisector partnerships allow delivery of more holistic care, integrating clinical treatment with community and social services that address social determinants of health (SDOH). Specifically, ACHs may provide assistance with housing, food, employment, transportation, and other needs, which may help to prevent substance use disorder (SUD) and improve treatment outcomes.

On September 5, 2018, the Funders Forum on Accountable Health, with support from the Conrad Hilton Foundation, sponsored a full-day convening of experts and stakeholders to discuss the appropriateness and feasibility of expanding ACHs and similar models to address SUD.

Accountable Communities for Health are multi-faceted, multi-stakeholder interventions seeking to improve the health of communities they serve by addressing unmet health and social needs. By fostering unique partnerships and targeting both the upstream and downstream factors that impact an individual's and community's health, ACHs seek to improve health outcomes and reduce health care costs.

Meeting participants included representatives from ACHs, advocacy groups, trade associations, foundations, and federal health officials from the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and Centers for Disease Control and Prevention (CDC). A full list of attendees is attached as Appendix 1.

The timing for the meeting was purposeful as federal (and state and local) officials are making key decisions about investments in SUD prevention and treatment: SAMHSA will award a total of $2 billion for state targeted response grants, as well as smaller grants to support naloxone availability, medication-assisted treatment (MAT), and

Milken Institute School of Public Health
2175 K Street, NW | Suite 500 | Washington, DC 20037
t 202-994-4100

community recovery. CMS has announced an upcoming ACH model—*Integrated Care for Kids (InCK)*—that will award up to $16 million each for up to eight grantees for activities that will prioritize SUD. HRSA is investing $350 million in expansion of mental additional funding for behavioral health workforce education and training. HRSA's Office of Rural Health Policy is funding rural communities to develop an opioid response plan for providing community based comprehensive services.

States are already making decisions regarding allocation of these new federal resources as an immediate response to the public health SUD crisis. However, many health officials have or will be considering longer-term strategies to respond to SUD, namely identifying the actions and investments needed to ensure a sustained response.

The ACH model is one promising approach for that sustained response that builds upon a broader system of care and services for SUD in general. Indeed, a review of an inventory of existing ACHs across the nation showed that 62 ACHs in 18 states are tackling behavioral health, which includes preventing and treating SUD, as part of their core mission. The September 5 meeting featured three ACHs addressing SUD:

- Camden Coalition. This Camden, NJ, based ACH works with pregnant women who have tested positive for illicit drug use. Additionally, the Coalition has partnered with a managed care organization to waive prior authorization and allow delivery of suboxone to patients being seen in primary care settings.
- Communities that Care Coalition. Located in western MA, this ACH sponsors a range of SUD initiatives including drug "take back" days, school-based Screening, Brief Intervention and Referral to Treatment (SBIRT), and Preventure, a teen addiction prevention program.
- Humboldt Community Health Trust. As part of the California Accountable Communities for Health Initiative, Humboldt County's ACH is organized around the central goals of reducing drug deaths and injuries, creating a sustainable funding mechanism to support community strategies, and increasing collaboration and community efficacy around substance use issues.

This memo describes key issues and related policy considerations that must be addressed to enable full expansion of the ACH model for SUD intervention.

Policy Issues

An increasing number of policymakers are seeking to determine if and how the ACH model can be deployed in their communities to address SUD. Key issues include the following:

- **Appropriateness of ACH model for SUD**

The ACH model seeks to bridge clinical and community care to address more effectively the SDOHs that increase risk for chronic illness and affect treatment outcomes. ACHs

tackling SUD integrate traditional "disease care," such as medication assisted treatment (MAT), with interventions outside of clinical settings, including behavioral and mental health services, "wrap-around" addiction treatment (such as treatment of co-occurring disorders like HIV/AIDS), and assistance with housing, food, and employment. For highly stigmatized conditions such as SUD, certain elements of the ACH model are especially critical, notably community empowerment and engagement. Although challenging to implement because of the time to create trusted relationships and the need to ensure true representation of affected (and often marginalized) groups, there are successful examples of consumer engagement in large, community-based programs: The Ryan White HIV/AIDS Program has achieved meaningful consumer representation on planning bodies and consumer advisory boards, which helps to ensure that services reflect the needs of clients and mitigate the impact of stigma. A second example relates to the requirement that the majority of board members for a FQHC are actual users of the health center.

Another potential benefit to the ACH model for SUD is the model's focus on prevention. Specifically, ACHs' focus on upstream SDOHs will improve the health of communities in the long-term, which may reduce risk of SUD. Of note, SAMHSA has found that many evidence-based prevention techniques are not being implemented by states, leading the agency to modify their funding announcements to encourage state adoption. A number of current ACHs are in various stages of implementing these prevention techniques, and their efforts could be expanded.

- **ACH Infrastructure**

Creating, building, and sustaining ACH infrastructure requires both political and financial capital. Acquiring political capital requires advocacy and support from strong coalitions of diverse stakeholder groups representing community members, community based organizations, clinical and community providers, and elected officials. Engaging some of these stakeholder groups for the purpose of creating trusting relationships and productive partnerships may require a culture shift, which may take significant time.

Among the various stakeholders, the community members are especially important for ACHs to engage, which may require capacity building and implementing interventions through community based organizations as opposed to health systems. ACHs must ensure that their priorities are aligned with those of the community, including allocation of resources and health system design. In addition, ACHs must avoid inadvertent harm to the existing community infrastructure. [Of note, the National Institutes of Health will examine community impact as part of its new HEAL (Helping to End Addiction Long-term) Initiative).]

With respect to financial capital, ACH implementation requires a meaningful investment of categorical funds upfront to build the infrastructure, as well as ongoing "maintenance" funding to sustain the infrastructure. In both cases, identifying mechanisms to braid and blend dollars will allow maximization of resources and provision of seamless care for accountable community members. Importantly, if ACHs are funded through alternative

payment models (APMs) and shared savings, their financing arrangements must be structured in such a way to capture the savings. Adequate Medicaid and Medicare reimbursement for SUD services is critical as well.

As a practical matter, a number of meeting participants recommended that ACHs tackling SUD build upon successful initiatives already underway. Suggestions included that funders of ACHs prioritize the fifteen states that have an opioid epidemic section 1115 waiver. (These states are: CA, MA, VA, MD, WV, IN, NJ, KY, UT, LA, IL, VT, NH, PA, and WA.) Another possibility suggested by a SAMHSA official was that ACHs partner with certified community behavioral health clinics, which have broad requirements for both SUD and mental health care. (SAMHSA is expanding this program with an additional $100 million.) A third suggestion—funders may consider collaboration with the Law Enforcement Assisted Diversion Program that receives both Medicaid payment for health services and DOJ money for wraparound services. The ongoing affinity groups and communities of practice sponsored by SAMHSA and HRSA are final examples of potential partners for ACHs.

- **Supportive Policies**

Creating and implementing ACHs to address SUD may require a change in "business as usual." ACH efforts to integrate and expand services and programs may help to identify challenges that can be resolved through policy change.

At the state level, changes to payment policy could be effectuated through section 1115 waivers or modified Medicaid contracting language. At the federal level, CMS could consider drafting a model State Plan Amendment (SPA) that would clarify the appropriateness of and requirements for creating ACHs to address SUD. In addition, CMS officials could consider new policies to close recognized gaps in SUD care for Medicare beneficiaries.

Not all supportive policy changes may be payment related. Another helpful policy change at the federal level could be complementary funding opportunity announcements across relevant federal agencies. Additionally, meeting participants suggested that harmonization of programmatic and regulatory requirements for SUD programs would be useful, both to provide unified direction and minimize administrative burdens for state and local officials.

- **Data Collection and Evaluation**

Given the relatively new and variable implementation of ACHs within and across states, data collection and evaluation are critical to determine if and how ACHs are a successful model for addressing SUD. As a baseline consideration, ACH participants must have the necessary funds for this work, and must reach agreement on the types of data to collect and appropriate frameworks for evaluation. Evaluations must be rigorous but sufficiently flexible to allow adaptation for individual communities with unique constituencies and concerns. In addition, the evaluation design must allow assessment of a portfolio of mutually reinforcing interventions, which may vary across ACH sites

depending on community need. It may not be possible (or necessary) to disentangle or quantify the contribution of individual interventions to the overall impact of an ACH.

Although the goal is for ACHs to employ evidence-based interventions, not all of the interventions selected by the community may have a strong evidence base. ACHs must balance this goal with the benefit of having authentic community voices included in the decision-making process. Further, the medical model and social model for SUD treatment are distinct and may require different evaluation frameworks. Given all of these challenges, a rapid cycle evaluation or continuous quality improvement (CQI) type of approach should be considered.

As a final note, there must be established mechanisms, with strong privacy safeguards, for accessing and sharing data within and across ACHs to facilitate quality improvement. An ACH Health Information Exchange could be a viable tool for data sharing. Such data exchange should include local and regional data, which may not be captured through major health IT vendor products that are not commonly used by community-based providers. Additionally, data from non-HIPAA covered entities, particularly social service agencies, would facilitate greater understanding of community need and integration of care.

- **Technical Assistance and Dissemination of Best Practices**

New ACHs addressing SUD would benefit from technical assistance (TA) resources, albeit with the recognition that a "one size fits all" approach to TA will not be effective. Importantly, there will need to be an overlay of best practices for ACHs with evidence informed interventions for SUD, requiring collaboration between the clinical, community, and mental health/SUD providers. Importantly, the TA should include best practices and resources for treating diverse populations, including racial and ethnic minority groups.

One federal resource cited in the meeting is the National Institutes for Health's National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment, which outline a comprehensive list of ancillary services needed for recovery. A second resource is the FQHC patient-centered medical home model for addressing medical, psychological, and social issues with a multi-disciplinary team in a primary care setting. These FQHCs have experience caring for complex patient populations, including those with SUD. Also of note, SAMHSA has established the SUD Prevention Technology Transfer Centers (PTTCs) to enhance TA and regional partnerships. However, overall, there is an acknowledged need for robust "hands on" TA, which could be supported by public or philanthropic entities.

Next Steps

The ACH multi-sector partnerships and initiatives offer a comprehensive and promising approach to address SUD. To expand use of the ACH model, communities and policymakers will need to resolve a number of challenges relating to the ACH

infrastructure; payment and programmatic policies; data collection and evaluation; technical assistance and dissemination of best practices.

As an early next step, the Funders Forum will work to communicate to state and local SUD policymakers and providers, as well as those in the ACH movement, the potential to use new federal funding to support ACHs tackling SUD. Several well-established ACHs that are currently addressing SUD, including through SDOH initiatives, will be invited to share their experience and perspective.

In the long-term, meeting participants should continue the dialogue regarding the role of ACHs in addressing SUD. Specifically, it will be important to monitor and highlight case studies for ACH best practices, as well as challenges to overcome. ACH financing, particularly strategies to braid and blend funding streams for SUD activities, will be an ongoing priority for discussion. Related, exploring mechanisms for transitioning ACH SUD dollars from categorical to mandatory funding should be a longer-term focus, which may include working with CMS to develop model SPA language. Finally, and perhaps most importantly, understanding how to encourage, support, and sustain genuine community engagement for all ACHs but especially those tackling SUD, is paramount.

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Appendix 1: Leveraging Accountable Communities for Health to Address SUD Meeting Attendees

September, 2018

First Name	Last Name	Organization
Kat	Allen	Communities That Care Coalition
Kirsten	Beronio	Center for Medicare and Medicaid Services
Mary Ann	Cooney	Association of State and Territorial Health Officials
Allan	Coukell	Pew Charitable Trusts
Martha	Davis	Robert Wood Johnson Foundation
Anne	De Biasi	Trust for America's Health
Abby	Dilley	Resolve
Greg	Dwyer	George Washington University
Alexa	Eggleston	Conrad Hilton Foundation
Hilary	Eiring	Centers for Disease Control and Prevention
Clese	Erikson	George Washington University
Jan	Heinrich	George Washington University
Katie	Horton	George Washington University
Dora	Hughes	George Washington University
Nafisa	Jiwani	Centers for Disease Control and Prevention
Christopher	Jones	Substance Abuse and Mental Health Services Administration
Sherry	Kaiman	Resolve
Aaron	Karacuschansky	George Washington University
Amy	Killelea	National Alliance of State and Territorial AIDS Directors
Carolyn	Wang Kong	Blue Shield of California Foundation
Jeff	Levi	George Washington University
Karen	Linkins	Desert Vista Consulting
Teresa	Manocchio	Substance Abuse and Mental Health Services Administration
Barbara	Masters	Masters Policy Consulting
Tiffany	McNair	Center for Medicare and Medicaid Services
Barbara	Midura	The California Endowment
Marie	Mongeon	George Washington University
Kathleen	Noonan	Camden Coalition
Jessica	Osborne-Stafsnes	Humboldt Independent Practice Association
Andrew	Philip	National Council for Behavioral Health
Michael	Rhein	Institute for Public Health Innovation
Judith	Steinburg	Health Resources and Services Administration
Kimá	Taylor	Ankara Consulting
Ellen	Weber	Legal Action Center