Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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Volume 25 Number 38
October 7, 2013
Print ISSN 1042-1394
Online ISSN 1556-7591

In This Issue...

Chronic care management in a primary care office with intensive counseling is no better than meeting with a physician every three months and getting referrals to treatment in terms of abstinence at the end of a year, a new study shows. However, the results for both groups are excellent — 42 and 44 percent abstinence rates.
. . . See top story, this page

New alcoholism medication may come from obesity research
. . . See page 3

CRC celebrates Recovery Month, has high hopes for parity, ACA
. . . See page 5

Health insurance exchanges open as government shuts down
. . . See page 6

Alison Knopf, Editor, winner of CADCA Newsmaker Award

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DOI: 10.1002/adaw.20396

Chronic care management gets good results; so does minimal management

Chronic care management (CCM), in which primary care patients with substance use disorders (SUDs) are given as much counseling as they need, is no more effective than minimal management in terms of outcomes, according to results of a random clinical trial published last month in the *Journal of the American Medical Association*. That is not to say that CCM is ineffective — both the treatment group and the control group had astoundingly good results, with almost half of this severely addicted population abstinent by the 12-month endpoint of the study.

> ### Bottom Line...
> *Having a primary care team give intensive services to patients with alcohol or drug dependence is no better than minimal services in terms of outcomes — but outcomes for both groups were good.*

But the results were controversial, not only because they run against a growing sense that it's essential to offer such services, but also because the lead author, Richard Saitz, M.D., has been one of the lead proponents of such interventions. And Saitz termed the results negative, saying they showed that CCM was not effective compared to no CCM.

A. Thomas McLellan, Ph.D., a

See **CCM** page 2

The Business of Treatment

In an evolving marketplace, centers seek new skills for staff

The job-description text that Preferred Family Healthcare's vice president of human resources was poring over last week reflects an ongoing change in the mind-set of addiction treatment organizations about the kinds of skills they need to attract in a changing healthcare marketplace.

> ### Bottom Line...
> *As many addiction treatment facilities become more diversified businesses, some have begun to look well outside the traditional industry base when filling key staff positions.*

Preferred, now the largest addiction services provider in the state of Missouri, has embarked on a search for a new position of regional marketer. And according to its human resources chief, Stacey Hudson, it is not beyond the realm of possibility that the organization could end up selecting someone with no background in substance use or mental health services.

"We're not going to say in the job description that experience in behavioral healthcare is recommended," Hudson told *ADAW*. "We'll probably say instead that an understanding of the subject is preferred."

As the Affordable Care Act (ACA), parity implementation, and

See **Skills** page 6

CCM from page 1

guru in the field of addiction treatment research, challenges Saitz's interpretation of his study, saying that rather than showing CCM is ineffective, it shows the opposite. The conclusion at the end of the article — that CCM did not decrease use or consequences — is simply incorrect, said McLellan, who is chief executive officer of the Treatment Research Institute in Philadelphia. "These seriously affected patients were able to engage in chronic care," he told *ADAW*. "The physician team used the same methods they now use on other chronic illnesses. The patients were retained in care and showed better than the predicted improvements on almost all measures — but so did the controls," said McLellan. "To me it is the improvement of the controls that is so unpredicted."

If the Saitz study had been done with a single group — no control group — it would have been called a resounding success, according to McLellan. Both the participation — 95 percent made it until the completion of the study — and the outcomes are "remarkable," he said. In general, under 10 percent of addicted patients who get detoxification are abstinent even six months later — one of the most replicated findings in the field, said McLellan. Without the comparison with the control group, Saitz looks "like the Jonas Salk of the addiction field."

How the study was done

The study was conducted among 564 people with alcohol or drug dependence in a Boston hospital-based primary care practice; 282 were assigned to CCM and 281 to no CCM. CCM included care coordinated by a primary care clinician; motivation enhancement therapy; relapse prevention counseling; on-site treatment for medical, psychiatric and addiction conditions; and referrals to specialty care and self-help groups. People in the CCM group could drop in anytime. The no-CCM group received a primary care appointment every three months and a list of treatment resources, including a telephone number.

> **'To me it is the improvement of the controls that is so unpredicted.'**
>
> A. Thomas McLellan, Ph.D.

Ninety-five percent completed the follow-up at 12 months, with the main outcome self-reported abstinence from opioids, stimulants or heavy drinking. Drug tests were performed as secondary outcomes.

The results found that 44 percent of the CCM group and 42 percent of the no-CCM group reported abstinence at 12 months. Both groups had access to treatment, including medications and inpatient and outpatient treatment.

Not ready to change?

Saitz, who is a professor of medicine and epidemiology and the director of the Clinical Addiction Research and Education Unit at the Boston University Schools of Medicine and Public Health, and his coauthors were surprised by the results, which he insisted show that CCM is not effective compared to no CCM. "All of the things that the chronic care model does should improve their condition," he told *ADAW*. "We see evidence for this in other chronic diseases, including medical, mental and tobacco." Why might it not have worked here? One possibility is that the patients weren't at a stage where they were ready to enter treatment, he said.

Most (74 percent) of the people in the study were recruited from detoxification, which they had entered voluntarily. But that doesn't neces-

ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the second Monday in July, the second Monday in September, and the first and last Mondays in December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: $695 (individual, U.S./Can./Mex.), $839 (individual, rest of world), $5787 (institutional, U.S.), $5931 (institutional, Can./Mex.), $5979 (institutional, rest of world); Print & electronic: $765 (individual, U.S./Can./Mex.), $909 (individual, rest of the world), $6658 (institutional, U.S.), $6802 (institutional, Can./Mex.), $6850 (institutional, rest of the world); Electronic only: $555 (individual, worldwide), $5787 (institutional, worldwide). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Subscription Distribution US, c/o John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; (201) 748-6645; e-mail: subinfo@wiley.com. © 2013 Wiley Periodicals, Inc., a Wiley Company. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden.

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sarily mean they wanted full-blown addiction treatment or were sufficiently motivated for long-term change, said Saitz. "Many are in detox because they have gotten to the end of the line and feel they have to do something," he said.

The researchers did measure readiness for change, and on a scale of 1 to 10, most of the participants scored a 9, said Saitz. "But those scales usually reflect how badly someone feels about their situation at the moment," he said. "It doesn't mean that they intend to change and are committed to change." That's why the study included training in motivation interviewing for all of the clinicians working with the patients.

Interventions

Below are the treatment (in addition to CCM for the study group) interventions that study and control patients have received over the course of 12 months:

- Addiction medications (21 percent of study group, 15 percent of control group)
- Mutual self-help groups (54 percent of study group, 56 percent of control group)
- Any addiction treatment (49 percent of study group, 44 percent of control group)
- Any inpatient addiction treatment (18 percent of study group, 18 percent of control group)

Noting that the people in both groups who got specific interventions self-selected for those, Saitz said that what is really needed is effective treatment in the community. "Care management relies not only on helping to convince you to get into treatment, but it almost entirely relies on that treatment working," he said. "And let's be objective, these are people with cocaine, opioid or alcohol dependence. How effective are treatments in the community for these?" For people with opioid addiction, the most effective treatment is methadone or buprenorphine, said Saitz, adding that these treatments far outpace the effectiveness of any other treatment for any addiction.

Costly intervention

One of the problems may be that chronic care management needs a more specific target than generic addiction, said Saitz. For example, there is no model for chronic care management for heart disease, but there is for congestive heart failure in certain circumstances. "You may need to select certain people," said Saitz. An equally important part of the equation, in addition to effectiveness, is that treatment must be accessible and covered by health insurance, said Saitz.

The study is also important because of cost-benefit implications. "Chronic care management is very expensive," said Saitz. There is a clinic that is open all the time, with a full-time nurse, a full-time social worker and a half-time physician. There are four sessions of motivational enhancement therapy, psychiatric medications, buprenorphine, referrals to methadone, an electronic health record designed specifically for the program and drug testing. "It's great if it helps people," said Saitz. "But any sensible healthcare system manager would say, 'I still believe in CCM for chronic diseases, but it's not for everybody.'"

That said, Saitz isn't sure exactly who it is for. For people with opioid dependence, pharmacotherapy would be most likely to be effective, said Saitz. Beyond that, his advice to primary care providers is this: "people with addictions do get better, so there's reason for some optimism just in prognosis." But over time, there has to be a change of attitude, so that addiction is treated as a chronic health problem. But not all SUDs are the equivalent of addiction — they aren't chronic — but they still could be treated in primary care. "There are many people who don't meet the criteria for addiction but are still having health harms from SUDs," said Saitz.

McLellan is not saying to forget about the control group, but rather to question why the behavior of the control group was what it was. Both groups showed "equal but significant benefits," he said, stressing the "significant."

McLellan suggests that in the real world, CCM is something that clinicians can offer to patients. But the patients should know that while they might do well with CCM, they might do equally well with a simple referral to community resources, he said.

Like Saitz, McLellan doesn't know what the reason for the null finding was. But it was not due to lack of ability of the staff to do CCM or the patients to accept it, he said. He wonders if there was something that the interviewers did at the three-month intervals that kept the control group coming back and also motivated them to stop. •

New alcoholism medication may come from obesity research

Two weeks ago, the lead article in *ADAW* looked at the connections between drug abuse and food addiction (see *ADAW*, September 23). This week, we look at the links between alcoholism and eating behavior, focusing on new research on ghrelin, a hormone produced by the stomach that may be the key to a new medication for alcoholism.

In an interview with *ADAW*, Lorenzo Leggio, M.D., Ph.D., chief of the Section on Clinical Psychoneuroendocrinology and Neuropsychopharmacology at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), described how scientists in his lab are using information coming from obesity science on feeding behavior to understand how

Continues on next page

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Continued from previous page

addiction works. The overall goal of NIAAA, as well as the National Institute on Drug Abuse (NIDA), is to identify new medications, and the one that is most intriguing now is related to ghrelin, said Leggio.

Ghrelin, which increases appetite and food intake, is so named because it was first discovered as a peptide able to produce growth hormone. It was discovered in 1999 by a group in Japan; the receptor had already been discovered.

Ghrelin is present not only in the stomach, but also in the brain (although whether the brain makes it or not is still unknown), and that's the area that Leggio is interested in. "We're looking at the areas which are related to reward — that's the reason why people take drugs, including alcohol," he said.

Amplifies reward

One group in Sweden has been looking at ghrelin and alcohol-seeking behavior, he said. These researchers found that when they gave ghrelin to mice, dopamine levels in the brain increased, as did locomotor stimulation, and the mice preferred the room with alcohol to the room without alcohol. "This is the first step — in an animal model, it means ghrelin is amplifying reward," said Leggio.

The second step was to use genetic models. Researchers developed animals who did not have the ghrelin receptor, so that even with ghrelin in their body, they couldn't feel the effects of it. These lab animals — the "knockout" mice — had a lower dopamine release, less locomotor stimulation, less preference for alcohol and a lower alcohol consumption than the white mice with the drank much less alcohol, less dopamine release, less locomotor stimulation, less preference to alcohol. There was no loss of appetite or change in behavior, which was possibly due to compensatory mechanisms, said Leggio.

Antagonists of the ghrelin receptor were also given to laboratory mice; in these mice, there was again less dopamine release, less locomotor stimulation and less alcohol consumption, said Leggio. "So either knocking out the receptor or antagonizing it produced the results."

The animal data has been confirmed by other groups and looks consistent, he said.

Appetite link to drinking

The first animal studies on ghrelin were conducted in 2006, when Leggio, a psychiatrist and internal medicine physician, was still in Italy. He had already heard about a study involving alcoholics who had higher ghrelin levels in the blood and also had a higher craving for alcohol. The sample was very small — but then the study from Sweden was published. "This was the start of my research interest," he said. "I thought, 'Can we use information about appetite to look at neuroscience as a way to treat our alcoholism patients?'"

> **'We found that those patients who had lower ghrelin levels had lower craving and were more likely to maintain abstinence.'**
>
> Lorenzo Leggio, M.D., Ph.D.

So he conducted a study looking at ghrelin levels in alcoholics in treatment for 12 weeks, taking measures at 2, 6 and 12 weeks. "We found that those patients who had lower ghrelin levels had lower craving and were more likely to maintain abstinence," said Leggio. Patients with higher ghrelin levels were more likely to relapse.

Drinking cues and IV ghrelin

When Leggio joined the faculty at Brown University, he started getting funding from NIAAA and NIDA to do another ghrelin study, this time looking at cue activity. Alcoholics who were not in treatment were enrolled in the study and exposed to alcohol cues and neutral cues. "This was a very small, proof-of-concept study," said Leggio. "We were the first group to propose to give ghrelin intravenously to a population with an addictive disorder," he said. The hypothesis was that the ghrelin would increase alcohol craving. The Institutional Review Board process was "challenging," he said, because of the obvious concern that the researchers were inducing a symptom of the disease.

The study was approved, with specific rules, such as making sure that all participants were examined by a physician before being sent home. If anyone had needed to be hospitalized, provisions were in place for that as well. "We completed the study a few months ago, and the results look consistent," said Leggio. The double-blind placebo-controlled study found that ghrelin increased the urge to drink alcohol. It did not increase the urge to drink fruit juice.

The gastric bypass question

There are increasing reports that following gastric bypass surgery — probably the most effective, although an extreme, treatment for obesity — there is an increase in alcohol use. "This concept interested my lab, because ghrelin is mainly produced by the stomach," said Leggio. In lab animals who undergo gastric bypass, there is a reduction in how much they eat, but it's not clear whether this is because they feel less ghrelin-related reward from eating or have a smaller stomach. "Gastric bypass is effective not only because it's changing the anatomy of your system, but because it's changing the signaling, called the gut-liver-brain axis," said Leggio. "In-

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stead of having a reduced appetite, you start to crave more food, especially sweet food."

One recent study found that gastric bypass increased drinking in lab animals compared to animals without the surgery. Giving a ghrelin antagonist reduced drinking alcohol — but only in the animals that had gastric bypass. To make it more complicated, another group found the opposite — that after gastric bypass, animals drank less alcohol. "It's a big open question," said Leggio.

NCATS

Leggio's ghrelin antagonist work has just received an award from the National Center for Advancing Translational Sciences (NCATS) — a pilot project for partnership between academia and industry — that involves Pfizer's ghrelin antagonist, already used in humans. "We're hoping to use this drug in alcoholism treatment," said Leggio. "It's very exciting research, but I have to make clear that it's early stage."

The study follows the National Institutes of Health's mission of "high risk, high reward," he said. "We may be wrong about the ghrelin pathway." But if not, ghrelin antagonists could help treat not only alcoholism, but also other addictions. •

CRC celebrates Recovery Month, has high hopes for parity, ACA

Having insurance coverage for treatment for substance use disorders (SUDs) is critical for patients, but it only works if treatment providers accept insurance. CRC Health Group is unusual in listing the insurance companies it contracts with on its website, and officials of the Cupertino, California–based national treatment chain talked to *ADAW* last month about the role of the Affordable Care Act (ACA) in increasing census rates thanks to improved insurance coverage.

Andy Eckert, CEO of CRC, said the chain's 140 programs, including the more than 40 that are residential, are geared toward commercially insured patients with a focus on the young adult population. This is the group that under the ACA can be insured under their parents' plans. "That's giving a tremendous uplift" to the ability to provide treatment to this age group, said Eckert.

"We're investing heavily in this," said Eckert. "This year alone we're adding more than 200 beds, particularly in our programs that are geared toward commercial insurance." When the ACA is fully implemented in January, an even larger segment of the population will be covered, he said.

Insurance battles

But insurance companies do not always want to pay what treatment costs. "To some extent, the insurance business is always in tension with the medical requirement to provide treatment the right way," said Barry McCaffrey, CRC board member, and a retired U.S. general and former director of the Office of National Drug Control Policy. He noted that at Life Healing Center, CRC headquarters for National Recovery Month, the staff-patient ratio is one-to-one. This is important "if you're going to provide clinically, scientifically based, outcome-based therapy, and deal with people who have serious trauma issues, compounded by drug and alcohol abuse, and if you're going to ensure their safety," McCaffrey told *ADAW*. "We also want a workplace where our professionals get an adequate salary and have healthcare themselves."

CRC has been very active in Washington about what levels of care will be included under the Mental Health Parity and Addiction Equity Act — the parity law, said Eckert. There is still no final rule. "We're advocating that residential treatment be included in the benefits package," he said. "At the same time, we are aggressively trying to respond to today's marketplace."

"Let me add a caution," said McCaffrey. "One program that is universally powerful is art therapy, and that doesn't sound like a medical procedure." And it's an example of the kind of program that is not likely to be funded by insurance. "We know we can get people into sobriety, detox them safely and do relapse prevention — but a lot of it is an art," he said. "The ACA needs to take that into account."

> **'This year alone we're adding more than 200 beds, particularly in our programs that are geared toward commercial insurance.'**
>
> Andy Eckert

Partial hospitalization

Many programs are paid by insurance at the partial hospitalization but are actually residential. CRC is working with an insurance company on an innovative program for opioid addiction in rural California, setting up partial hospitalization programs where the provider is already active. The program runs five hours a day, five days a week, and is designed and customized for this payer. "We're hoping this will be a creative way that we are addressing a need," said Eckert. "The reality is that we have to

Continues on next page

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Continued from previous page
continue to find out how to meet folks where they are." In other words, the treatment has to be affordable.

Also attending the September 20 news conference in Santa Fe: Robert Garcia, sheriff of Santa Fe County; Alexis Duprey, reigning Miss New Mexico 2013; Barak Wolff, former director of the New Mexico Public Health Division and current policy analyst, New Mexico Senate Public Affairs Committee; Andrew Black, field representative to U.S. Senator Martin Heinrich (a Democrat); Jennifer Manzaneres, field representative and tribal-substance abuse liaison to U.S. Congressman Ben Ray Luján (a Democrat); and recovery advocate Steve Brugge, himself in long-term recovery. •

Health insurance exchanges open as government shuts down

In the standoff between House Republicans on the one side and the Senate and the White House on the other, the health insurance exchanges appear relatively unscathed. On October 1, they opened for business on schedule, and even though the government was shut down for the first time in 17 years, people flocked to the exchange websites and real locations to sign up for health insurance. That part of the Affordable Care Act (ACA) is off to a good start, by all reports, with premiums far lower than expected.

The shutdown was a result of the Tea Party faction of Congress refusing to pass a Continuing Resolution (CR) to keep the government running unless the Senate would agree to cutbacks and delays in the ACA. The Senate wouldn't, and President Obama made it clear that he wouldn't either.

But the shutdown is only one piece of a huge three-part problem — the fiscal year 2013 budget includes cuts of sequestration, the debt ceiling is looming in the middle of this month and there is no budget for fiscal year 2014, explained Andrew Kessler, principal of Slingshot Solutions, an Alexandria, Virginia–based consulting firm that represents addiction and mental health treatment organizations. "People are acting as if all we need is a one-month CR — but we still have to deal with the fact that we have no appropriations for fiscal year 2014," he said. "Even if the shutdown ends, none of these problems goes away." He added that it's hard to see many of his close friends out of work.

'Even if the shutdown ends, none of these problems goes away.'

Andrew Kessler

It's impossible to get work done during the shutdown, especially for people like Kessler, who work closely with federal employees. "The key thing is staff," he said. "In our field, our work is heavily reliant on the people who staff the agencies we work with," he said — for example, the Substance Abuse and Mental Health Services Administration, the National Institute on Drug Abuse, the Centers for Disease Control and Prevention and the Health Resources and Services Administration. "Except for the highest-level people, nobody is at work," he said.

Kessler said that nothing can get accomplished during a shutdown. "Forget the budget, which is quite a disaster," he said. "All the stuff we've been working on, whether it's electronic health records, the workforce — we can't work on any of it now."

The shutdown was not a surprise, at least to veteran Hill watchers like Kessler. "Many of us saw this coming," he said. The last two shutdowns, in 1989 and 1995 (when Kessler was working on the Hill), were about economic policy, he said. "They couldn't come to an agreement about the budget itself," he said. This time, it's worse. "It used to always be about revenue and spending and how are we going to make this work," Kessler said. "This time, it's about holding the ACA out as a boogeyman for all the country's problems." •

Skills from page 1
other changes in healthcare and behavioral health cause addiction treatment facilities to pursue greater diversification of their revenue base, many are finding that they need to take a broader-minded approach in their hiring. For some, this might mean that applicants who once stood little chance of being hired because they had worked largely or exclusively in other industries now could find themselves moving to the "A list" of applicants.

"We're looking for a marketer who can help us meet benchmarks for some of our sites; that's not necessarily someone with a clinical skill set," Hudson said.

Marketing new facilities

Preferred Family Healthcare delivers both addiction and mental health services, with the mental health side of its business operating largely along a community mental health model. The vast majority of its residential, intensive outpatient and outpatient addiction treatment services have been Medicaid- or state-funded, but it has been a priority since the hiring of a new chief financial officer in 2007 to look at greater

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penetration into the private insurance market. The expected emergence of newly insured populations under the ACA increases that sense of urgency today, Hudson says.

To assist in this effort, the Kirksville, Mo.–based Preferred will be looking for a regional marketer with skills not often sought after for the organization's administrative-level staff in the past: a public relations background, an extroverted personality — altogether a "people person," as Hudson puts it.

A major focus of the new marketer's effort will involve Preferred's new 28-bed adolescent residential facility in Joplin, a project that has been several years in the making because the original building that was to house it was destroyed in the tornado that ravaged Joplin in 2011. Preferred also has been expanding significantly into Kansas, and a new adult treatment site in that state also will make up a primary component of the regional marketer's effort.

Hudson added that changes in the organization's anticipated payer mix also are having an effect on which skills it is seeking for other job titles. With most of the current staff having a broader understanding of public-sector funding, it will be important for newly hired administrators and insurance care managers to have a greater knowledge of private insurance, and eventually of the ins and outs of the insurance exchanges being established under the ACA.

Also, the mere growth of the organization (it has doubled in size since 2004) will probably require the hiring of additional personnel to tout the value of its various facilities and to keep them both full and focused to the needs of their communities. "We may need to hire a navigator and another marketing person to reach insurance companies and referral sources," Hudson said.

Entering a new arena

Stacy Blumberg undertook the type of career move that might continue to benefit the addiction treatment field with more regularity. De Paul Treatment Centers in Portland, Ore., hired her as the director of marketing and development with the express purpose of broadening its private insurance base. Prior to arriving at De Paul, Blumberg had spent six years in account management and strategic planning on a Nissan account for an advertising agency.

She eagerly sought the opportunity to trade in selling cars for contributing to saving lives, and soon she realized that De Paul was equally enthusiastic about bringing someone in from outside the behavioral health community.

"I did a group interview during the hiring process, and out of the four people who were being considered, not one of us had a healthcare background," Blumberg told *ADAW*.

Once she came on board, she says the CEO of the organization urged her never to lose that outsider's perspective. "She told me, 'I want you to speak up on all the things you are seeing, because no one else here will share the same fresh-eyed perspective you have,'" Blumberg recalled.

It appears that the prevailing wisdom is becoming that for certain positions in an addiction treatment organization, it's more desirable to acquire new skills that the organization needs, and then to train the person in addiction-related subject matter once they're on board. At last month's National Conference on Addiction Disorders (NCAD) in Anaheim, Calif., Blumberg gave breakout session attendees in the Behavioral Healthcare Leadership Summit a detailed primer on achieving success with third-party insurance contracting in addiction and mental health organizations (see *ADAW*, Sept. 30).

Blumberg adds that the lines between the business world and the healthcare community continue to cross more frequently. When she was pursuing her MBA in the mid-2000s, business schools were just beginning to look to nonprofits as viable destinations for their graduates. Today, most of these academic programs have a specific nonprofit track, she said.

In addition, growing investment in and attention to healthcare operations nationally is making the profession more attractive to outsiders, Blumberg believes.

'We're looking for a marketer who can help us meet benchmarks for some of our sites; that's not necessarily someone with a clinical skill set.'

Stacey Hudson

She said that organizations such as hers also will be looking to other newer standards for the types of individuals they hire, such as demonstrated ability or accomplishment in collaborating with other individuals or entities (as behavioral health and general medical services become more coordinated and integrated).

Blumberg said that having competitive compensation and benefits will be a factor in the hiring process as well, but added that some individuals may be willing to sacrifice some of these tangible benefits for greater work satisfaction. She for one harbors no regrets about the career change she made.

"I've learned a ton," Blumberg

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Continued from previous page

said. "I was kind of burned out selling new cars, and was looking for something more fulfilling." •

Briefly Noted

'Skinny' networks may prevail as a result of lower premiums

A report in the September 29 issue of *The New York Times* found that while health insurance will be less expensive under the Affordable Care Act, this may come at a cost of fewer choices of providers. While the report did not specifically mention substance abuse treatment providers, it did say that specialty care in general is likely to be restricted. That is the way insurance companies keep costs down. And Gary Cohen, who heads the CCIIO, the federal agency within the Department of Health and Human Services responsible for the health insurance marketplaces, said in a September 30 press call that the trend of restricting networks to keep costs down is not new, and is expected to continue. The message to substance abuse treatment providers is that there is some safety in size — in other words, if several providers in one geographic area can merge, the new provider is more likely to be able to win an insurance contract; it may be even more likely to do so if it can merge with a mental health provider, and therefore provide both mental health and substance abuse treatment services. The reimbursement may be low, but the new provider would be guaranteed patients from that network.

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Coming up...

The annual conference of **NAADAC, The Association for Addiction Professionals** will be held **October 11–14** in **Atlanta, Georgia**. For more information, go to **http://naadac.org/conferences**.

The national conference of **INCASE** (**International Coalition for Addiction Studies Education**) will be held **October 11–14** in **Atlanta, Georgia**. Go to **www.incase.org** for more information.

The conference of the **American Association for the Treatment of Opioid Dependence (AATOD)** will be held **November 9–13** in **Philadelphia**. For more information, go to **www.aatod.org**.

Resources

SAMHSA funds free online course on the business of healthcare

BHbusiness: Mastering Essential Business Operations, first offered last year, is a free online course designed to help executives prepare for the challenges of the healthcare marketplace as health insurance expands starting January 1. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the course is taught by behavioral health leaders and experts, and led by the State Associations of Addiction Services (SAAS), in partnership with NIATx, the National Council for Behavioral Health and Advocates for Human Potential. Topics focus on strategic business planning, third-party billing and compliance, eligibility and enrollment, third-party contract negotiation and meaningful use of healthcare technology, as well as dedicated coaching, peer networking and access to many resources. "Our first set of course offerings was incredibly successful," said Becky Vaughn, CEO of SAAS. "We enrolled close to 900 participants into learning networks in which coaches guided them through the curriculum. However, the crowning achievement is the actionable business plan that each organization created and can actually put into operation to develop new capacity for impending changes in the healthcare system." Apply online at www.bhbusiness.org/application. For more information on BHbusiness: Mastering Essential Business Operations, visit www.bhbusiness.org or email info@bhbusiness.org.

For more addiction information, visit **www.wiley.com**

In case you haven't heard...

Kudos to the medical team working in a mobile methadone clinic in Dartmouth, Nova Scotia. A 32-year-old man was severely attacked by a group of people, and nurses and clinicians from the mobile clinic went to the man's aid while waiting for the ambulance, helping emergency medical workers. The police are investigating. "He was severely beaten and unconscious," Cindy MacIsaac of Direction 180, the mobile van, told CTV on October 2. "His personal belongings were taken from him and he was… in rough shape," she said. "One of the nursing members who was onboard doing blood work today was able to assist the gentleman and help him until the ambulance and police arrived." Neither the victim nor the attackers were patients. Police are using a nearby security camera to try to track down the five to seven suspects, who fled.