

Course 3B – Managing Change Within The Traditional Chemical and Substance Dependence Culture

**a.k.a., Our Interpretation of
'Need for AOD Treatment' and
Our 'Interventions' – How
They've Changed!**

**Part A of Lesson 1. New Business
Arrangements – Partners, Collaborators,
Staffing, and Funding Arrangements. Yes,
These DO and WILL Affect How We Deliver
Treatment . . . Now and in the Evolving
Implementation of the Affordable Care Act
(ACA). Adapting to Change: It's Now Part
of the Job, Now More Than Ever.**





You say that you don't plan to have anything to do with Managed Care? Regardless of WHAT type of program you are working in, Managed Care concepts pertaining to 'control of cost' are now a fact of health care delivery.

This applies to State Block Grants, and to Medicaid and Medicare, and to all other forms of health care payment which depend upon a contract or provider agreement. Managed Care concepts apply to private practice, too, if the individual plans to pay for counseling with any form of insurance.

Working within a managed care environment – including State and local contracts, and any insurance- or agreement-based arrangement – involves major clinical and programmatic CHANGES. This course is an introduction to what has changed in the AOD field and what providers need to do to work effectively within the cost-conscious Health Care Reform movement.

So, is this course simply an 'introductory business course' about the paperwork involved in doing business with a healthcare contractor? No. Understanding how behavioral health Managed Care works and 'thinks' – and all of the clinical changes that go with it – is the key to continuing the treatment of your clients in a 'post-recession', 'pro-recovery' Health Care Reform environment.



There Are Major Treatment Issues and Changes Within the Substance Abuse Culture, In a Managed Care Environment



- **There's a Need to Be Mission Driven and Business Smart – 'The Way We Have Always Done It' Is No Longer Enough.**
- **There Are New Reasons to Be Part of a Provider-Managed Network – and New Benefit in Partnerships. Like What? There Is 'Safety in Numbers', and Improved Treatment Through Network Coordination**
- **There's a New Emphasis On Outcome Measurement and Quality Management . . . Know Their Role In Treatment and Funding**
- **There Are Many Programmatic and Counselor-Level Therapeutic Changes, Requiring a Shift.**

These are the main professional and treatment issues that impact CD providers under Managed Care . . .

- Necessary Shifts in Program Design and Treatment Approach – ***‘But we have strong traditions in the CD field, about what works and what doesn’t. Now you’re telling us to do WHAT?’***

- Credentialing – ***‘Are you qualified to do addiction treatment?’*** ***“Well, certainly we are. Why wouldn’t we be?”***

- Documentation of Treatment – ***‘But in your progress note, did you make it clear that?’***

“It’s Out of The Box!”

- Care Management – ***‘How sick is he, and will he actually benefit from additional treatment, given his relapse history?’***

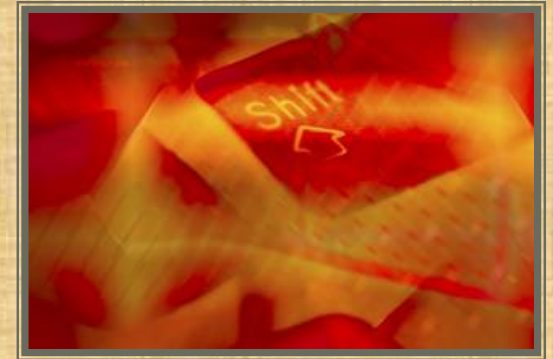
We will explore these issues in Lessons 2 and 3.



The shifts include new-style financial arrangements – which can be challenging.

- **What is different about FUNDING DECISIONS, i.e., who gets the contract and how is it funded?**

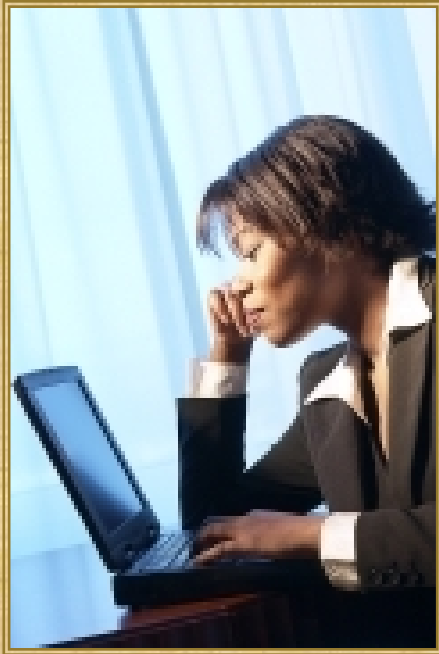
↪ **It's competitive – NEW PLAYERS – and ultimately, the contract may be bid out or awarded to those with BETTER OUTCOMES. This has clear implications for how we provide treatment – how we establish goals for our clients and for our programs.**



↪ **And NEW CONTRACT FORMATS, too (bye-bye to fixed, dependable General Revenue Allocations and Block Grants, and hello to Fee-For-Service initially . . . and then movement to Bundled Reimbursement), prompting the need to seek and integrate new funding streams into your mix.**

Therefore, Providers Must Explore New Opportunities and Approaches

- **Adapt, Come 'Out-Of-The-Box' – think FLEXIBILITY in what you do and how you do it, in terms of treatment for clients and coordination with other providers.**
- **DIVERSIFY YOUR INCOME STREAMS – It provides long-term protection from vanishing and shifting funding streams (which ultimately include managed care contracts – and now 'Medical Homes' in which funding for addiction may be blended in with primary health care by State or Federal Government).**
- **ANTICIPATE changing trends.**





It's a new day in health care planning, service delivery, and funding!

Translation: It's not your 'same old' health care system. Or your 'same old' CD Counselor. Not your 'same old' Addiction Treatment approaches, either. Whether in private practice or program operation, CD treatment providers must find ways to gain some leverage within a managed care environment. Some shifts may need to occur in who provides services (e.g., 'Medical Home' team vs. free-standing CD Program), who directs services, who sits on Boards of Directors, and with whom we partner. For CD provider networks and consortiums, some will seek new partners to fill in the gaps in services, and some network partners may choose to leave the scene entirely.

. . . Bringing new program survival issues.



But there is no need to swim in those unfamiliar waters alone! There is comfort and safety in coming out of isolation, collaborating with other behavioral health providers in ways that were unheard of 5 years ago [and *only recently – or never – in some states and counties*].

And believe it or not, these changes can actually improve treatment options for clients.



But First You Need to Know About the Impact of the Affordable Care Act (ACA) Upon Providers, Including Some New Twists That Are Likely Coming.



Yes, you heard correctly. Coverage for everyone. No matter how sick they are. At a reduced cost.

When the Affordable Care Act (ACA) was passed in 2010, the idea was to REDUCE the COST of ALL types of health care, and AT THE SAME TIME, to ensure that uninsured individuals became insured, *regardless of their 'pre-existing conditions.* Treatment to the entire US Population was to be paid for – at a significantly *reduced cost.*

The ACA ...

To support the Affordable Care Act, the Federal Government and some States have put into place an array of contracted healthcare insurance companies and other such organizations (referred to as 'The Marketplace' or 'Health Insurance Exchange') to assume the responsibility of providing comprehensive health care at a significantly reduced cost.

The Marketplace's Health Insurance Exchange Companies then contract with selected provider networks to deliver the care at a reduced cost.

To reduce the cost of care, the 'Marketplace' or 'Exchange' companies must contract with a LIMITED NUMBER of providers – particularly NETWORKS of providers – who are willing to deliver care at a reduced rate of reimbursement . . . with the emphasis being upon QUALITY, OUTCOMES, and 'VALUE-BASED' (rather than upon a 'fee-for-service' model where 'more' is better for the provider).

Value-Based? What's That?

It means an emphasis upon 'Value – NOT Volume'.

- **It means employing *evidence-based* approaches and *proven* treatments and techniques,**
- **as well as *expected outcomes* – in deciding on a treatment intervention, and**
- **taking into account the *patients' wishes and preferences, and the cost of the care.***

In other words, you don't simply have a 'standard list' of treatments and interventions that you employ for every person with a particular diagnosis.

A focus of health reform in hospitals has been to more closely track 'value' measures such as complications, hospital-acquired infections, and readmissions. Hospitals now face financial penalties if their rate of readmissions is too high, for example.

In *behavioral health*, we would track complications and adverse incidents, admissions or re-admissions to more intensive levels of care, ability to work if appropriate, ability to live independently if appropriate, medication compliance, results of drug usage screens, rate of appointments kept, and so forth.

Limited Networks. Is this a new concept? No, it's not.

Is limiting the number of networks a new concept? And contracting for specific outcomes? No. Some states (such as Texas, Oregon and several others) have been doing this in Medicaid behavioral health for more than 20 years.

Naylor & Associates (now CEU By Net – Pendragon Associates, LLC) began working with Medicaid Managed Care Companies (HMOs, MCOs, and BHOs) *and* with behavioral health providers in 1992 about these issues. The idea was to ensure that NETWORKS and comprehensive care agencies delivered cost effective treatment under a 'Care Management**' scenario.**

Care Management?

Care Management is designed to ensure that the care that is delivered and paid for actually **WORKS . . . at a CONTROLLED REIMBURSEMENT rate.**



Under this arrangement, the care that you provide to your client is reviewed and approved on an ongoing basis by a 'Care Manager'. And rather than being paid for each instance of service provided to your client, your payments were oftentimes 'bundled' - aka, paid according to a 'case rate'. A 'case rate' is a type of 'flat rate' plan. Like, payment per week of treatment. Or per month. Or per 'episode of care.'



This shift in delivery of care resulted in FEWER contracts with individual providers and small agencies, and MORE contracts with NETWORKS of providers and larger agencies – both of which agreed to provide COMPREHENSIVE CARE. It was the beginning of today’s ‘NARROW NETWORKS’, referred to in those days as ‘PREFERRED PROVIDER NETWORKS’.

Is this a good thing?

Such arrangements bring about many good things – including ‘wrap around’ services, intensive case management of recidivistic clients, more day and evening Intensive Outpatient Programs, 24-hour observation units, reduced waiting lists, and so forth.

Outcomes have differed, however, depending upon the State and the design of the plan. NOTE: Although not ‘new’, in some states this movement is *just now beginning, with the advent of the ACA.*

So What Is Different with the Arrival of ACA, Compared to Prior Initiatives?

For one thing, enrollment in an insurance plan is mandated for all, to avoid a Federal tax penalty. This inherently means many more people to serve, despite a fluctuating funding base.

Therefore, the use of 'NARROW NETWORKS' is becoming the norm in most states, to reduce ACA cost. Further, it is clear that the ACA is moving toward 'VERTICAL INTEGRATION OF CARE'.

VERTICAL INTEGRATION OF CARE? WHAT IS THAT?

It means that the insurance companies which are taking on more (and sicker) patients would like to move to a NEW form of BUNDLED PAYMENTS. In these new scenarios, ALL care would be coordinated and provided to individuals under *one provider umbrella*, so to speak. And in this situation, VALUE-BASED PAYMENTS would be SHARED among all providers who deal with a patient's total health condition, WITHIN A 'HEALTH HOME' or 'Medical Home'.

Vertical Integration of Care Would Mean ‘What’ for Mental Health and AOD Providers?

- **In a sense, this could be a step backward for mental health and addiction providers who worked hard to bring about the “Behavioral Health Carve-Outs” for Medicaid. The carve-outs ensured that behavioral health would receive dedicated funds in the Medicaid budget, separate from physical health. In fact, AOD providers wanted (but did not always get) separate funds apart from the mental health side.**

The current planning calls for a Primary Care Physician to serve as the gatekeeper for all care which a patient receives, including behavioral health. Many question whether the behavioral health issues would receive needed attention.



Anything Good About Vertical Integration of Health Care?



It is fairly well recognized on both sides of the healthcare fence (physical health and behavioral health) that many treatment situations are sorely lacking in integration between the two areas.

Examples in support of vertical integration:

For example, an individual may have one or more *medical problems* that exacerbate his or her use of drugs and/or alcohol, but the AOD treatment provider is unaware of the medical issues. Or, the PCP may prescribe medication for insomnia but is unaware of both the client's *SUD issues* and of other medications the client may be taking to reduce the use of substances. From this perspective, integration of health care is a good thing.

So How Will This Work – for Behavioral Health?

It's unclear at this point exactly HOW this will work with a person who has significant medical (physical) conditions AND also has a Substance Use Disorder (SUD) and/or a mental health disorder. Some pilot projects at the State and National level are in the first stages of implementation, seeking the best way to VERTICALLY INTEGRATE care for the physical, behavioral and social aspects of health care.

To what extent these pilot programs integrate AOD and Mental Health treatment with physical health treatment has not yet been demonstrated.



- **However, the very concept of INTEGRATION OF CARE speaks directly to the need for behavioral health providers to begin thinking 'NETWORK'. And 'SERVICE COORDINATION'. And 'FLEXIBILITY' in service design. And working with NEW PARTNERS. And OUTCOMES!**

**'But . . . They're Changing
Up So Much of What We Do
– and How We Do It. Why?'**

OK - yes, they are. Those who hold the behavioral health funds (public or private) are making some serious changes in how they spend the money. And even the commercial insurance carriers are following suit. But WHY do they have to change how we deliver care?

**The reason is the need for 'Cost Containment.'
Which sounds OK, but . . . is that always a good
thing?**

Cost Containment . . . Is it always good? **MAYBE! It depends on how they do it!**

Some goals in Healthcare Reform are good and may be attainable. Some may not be successful. If a major goal of a new healthcare plan is to immediately “fix” the system, it’s unlikely to succeed, and it could in fact damage the system.



Regardless of what you have heard, Managed Care is NOT the solution to a grossly under-funded behavioral health care system!

Concerns About The 'Cost Control' Element

With the coming of Managed Care to several states, a decade ago the National Alliance for the Mentally Ill (NAMI) expressed concerns that the emphasis would be placed upon the element of COST CONTROLS instead of upon the element of CARE. And of course, the State legislatures typically ARE most concerned about the element of COST, as their primary reason for implementing a managed care model.

NAMI's concerns were first clearly expressed in 'Grading the States 2006: A Report on America's Health Care System for Serious Mental Illness.' An example is this statement (and similar statements since then) in their 2006 *Report Cards of the States*:: "Managed care models sometimes turn into *managed cost models*."

Concerns of NAMI . . .

And further, NAMI has reflected the thought that managed care companies' corporate emphasis upon *profit* could result in harm to the delivery system [and this would apply to Mental Health and to CD-AOD.]

For example, one comment made in the 2006 report is that too often “ people's needs are sacrificed in favor of private profit incentives.” That concern has not changed, in terms of how NAMI and many other behavioral health advocates see the potential problems.

However, the Principles of the Affordable Care Act Have the Support of NAMI.

Says NAMI on its website:

“The Patient Protection and Accountable Care Act (ACA) addresses many of the challenges people have in getting and keeping health care coverage. [There are] . . . key provisions of the law that offer meaningful benefits to individuals living with mental illness and their families.

NAMI identifies the following ‘Patient Protection’ provisions of the ACA as particularly positive for persons with mental health and addiction disorders:

- **Pre-existing Medical Conditions – care cannot be denied based upon such.**
- **Extension of Dependent Coverage**
- **Prohibits lifetime limits**
- **Prohibits annual limits for certain types of plans**



A CD Issue Related to Care Management Decisions

Special Note: Standardized Level of Care protocols (such as those typically used by Insurance Companies and MCOs in their Care Management process) are believed by many to result in 'questionable clinical outcomes' for Chemically Dependent consumers. Reason: These 'Care Management' protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery.



A CD Issue Related to Care Management Decisions . . .

What to do here? For your most relapse-prone clients – especially those who are recycling in and out of detox frequently – ask for a ‘Case Rate’, where you can make treatment decisions more freely – where you ‘hold the cards’. (More about that in the second half of this course.)

Health Care Reform – There's So Much To Do!

Whether you are in private practice or work in a program or agency, if you accept managed healthcare contracts, you will have to find ways to perform all of the functions required by managed care – most of which are clinical and treatment related, but much of which relates to 'paper' (or now more than ever, 'Electronic Health Records' or EHR). This section provides some answers to 'What are these functions and some ways we can handle them – i.e., must we go it alone, or can it be in concert with others?' (Hint: Forget 'alone'.)



Provider Networks and Strategic Partnerships – It Can Be a Winner Under Managed Care. And Eventually, It Will Be a Standard Part of the Design, for Those Who Want Contracts.



PROVIDER NETWORKS: Providers *working together* – a workable ‘ticket’ to surviving the shifts in the Behavioral Health industry. A way to gain ‘collective leverage’ and facilitate productive SA-CD Provider Agreements with managed care companies. A way to cope with the managed care phenomenon with less pain and more gain. [Some call it ‘safety in numbers’! Others call it ‘rising to the occasion’!]

OK. But How to Organize Your Program or Practice? Arrangements to Consider:

Option #1

You, conducting all of your business operations on your own, perhaps purchasing some services from other sources through contract

VS.

Option #2

You, operating as a partner or collaborator with others . . . in a network and/or 'health home' arrangement

Consider Membership In a SA-CD Network . . . Maybe Even Split Up Some Tasks Among Providers In The Network

- Centralized credentialing of providers – let one agency take the lead
- Centralized telephonic triage
- Referral to 'best fit' specialized services within the network
- Coordinated IUM for high risk cases (more on that later)
- Some joint Quality Management (QM) across the system of care
- Data (MIS) and billing system coordination & collaboration
- Joint addressing of public policy
- Planning, advocacy as a group
- Outpatient services, including CD IOP for adults and youth, and Dual DX
- Non-inpatient detox
- Crisis respite – 23 hour obs in non-medical setting
- Short term CD residential
- Crisis stabilization
- Wrap-around services
- Specialty CD services for pregnant women and youth

Who will do what?

Network Coordination and Collaboration Has Many Advantages – Such As Leverage and Enhanced Stability!



- Enables *coordinated* negotiation and discussion with the managed care company about problematic aspects of delivering services to your clients within this new type of contract. Although no joint fee-setting talks may be allowed, there CAN be joint discussion of such things as problematic contract language and unrealistic outcomes expectations.
- Collaborative discussion with the MCO may also result in higher rates for specialized treatment services due to the bargaining power of a group of diverse 'specialty treatment' providers. Leverage, leverage, leverage!

Yes, leverage – and special roles.



Multiple network agencies and individual practitioners working together as a 'provider consortium' or 'provider advisory council' can lead to designation of the network participants by the MCO as 'Core CD Providers' – or 'Specialty Providers' for Chemically Dependent adults or adolescents, as well as for Dual Diagnosis treatment. May also lead to improved rates for specialty providers, for specialized CD services!

Improved Image for SA-CD



A network approach can reverse some traditional system biases which have unfairly labeled CD programs and providers.

Community Perception: Collaboration and strategic coordination among competent CD practitioners undeniably brings in new visibility and new business within the community, for all concerned. Why? Because there is a fresh perception of network participants, a change-up of the way that the community views you, and thus improved referral relationships. Also, working outside of an isolated box tends to bring about enhanced professionalism for all – because we tend to sweep the cobwebs out of the corners when we become more visible! Treatment improves!

And Other Advantages As Well . . .

Specialization. Interagency collaboration and creative partnerships may also make it possible to consolidate or centralize the provision of some specialized treatment services within the network – making use of the *unique talents* of the individual agencies or practitioners within the network. Examples: A medication clinic may be offered by *one* CD agency or practice for the clients of *several* agencies; specialty services for dual diagnosis MH/CD clients may be offered by one or two network providers for the entire network; a walk-in CD / SA crisis clinic may be offered at one or two strategic locations instead of at all agency locations; IOP for CD/SA adults and adolescents may be offered by a couple of network providers for the entire network; detox may be offered by one specialty provider, and perhaps residential by that same provider as a ‘step-down’ from detox.

Retention of clients: Making good use of the unique talents of individual CD providers in a network also makes it possible for practitioners and agencies to retain difficult clients when a higher level of care is *temporarily* needed . . . rather than to lose them outright to another provider when the client requires 'something more' than what you provide. How does this work? With responsible coordination agreements in place, clients may be referred to 'step-up' services within the network during a crisis, to a provider who offers **SHORT-TERM STEP-UP SERVICES** – things like detox, 23 hour non-medical observation, short term residential units, and rehabilitative day treatment. When the crisis is past, the client returns 'home' to your practice or agency.



Advantages . . .



Optimizing Resources. With strategic alliances and agreements in place between providers, we may also be able to consider certain program shifts or expansions that seemed impossible before, without the support of a collaborative partner. You can **OPTIMIZE** your own resources and efforts. Like, you might off-load or downsize certain low-volume services by referring that piece to a network partner, so that you can focus on starting that CD Intensive Outpatient Program (CD-IOP) that you have been wanting to start.

Advantages . . .

- ***Efficiency and Cost Management.*** ***Everyone*** does not have to do ***everything!*** Explore centralized and coordinated performance of some crucial clinical services – such as centralized 24/7 telephone triage which can be ‘purchased’ by several network agencies or practitioners, from one network agency or practitioner who can more easily perform this after-hours task. This makes impossible tasks do-able . . . collectively.



Advantages . . .

Alliances also are a ready-made source for accepting referrals of clients who need specialized care – network partners refer among themselves.

For EAP providers, this type of networking is critical, because CEAPs may not deliver the clinical services themselves – but rather refer the EAP employee clients elsewhere, and oversee continuity of care. Knowing how to access treatment programs – where? to whom? – is a key to effective functioning of a CEAP.



Advantages . . .



- **Consider consolidated purchase of certain expensive CLINICAL SERVICES, e.g., joint purchase of telephonic on-call after-hours backup from a psychiatrist, or several hours of a psychiatrist's time to do medical assessments and medication for Dual Diagnosis clients, for several agencies. These can be purchased at a major 'group' discount – much less expensive than if each agency or practice purchased these services independently.**



Indirect Advantages

- We can learn from our partners' experiences – both positive and negative.
- Enhanced Credibility – automatically expanded by virtue of 'association' of quality providers.
- A closely-knit network of providers working together is perceived as 'one stop shopping' for contractors who wish to purchase CD treatment and SA education and prevention services – and demonstrates better coordination of care than a fragmented collection of providers.

Day-to-Day Business Operations Required For Managed Health Care

- Dealing with new 'Payer Organizations' (e.g., HMOs and other contractors); contract issue discussions
- Telephonic triage, 24 hour response
- Intake, or referral to external appropriate services
- Internal credentialing of agency providers
- Internal Utilization Management (IUM) – determining need for treatment according to the new criteria
- Case management (tracking) of high-risk cases
- Data and billing systems operation; dealing with snafus
- Quality management – including measuring OUTCOMES0
- Provision of 'managed care friendly' services to consumers – including Primary Care and psychiatric services and specialized services like Intensive Outpatient, Detox & Short Term Residential Rehabilitation.



Consider Some Shared Non-Clinical Expenses?

Possible non-clinical network expenses to share:

- Legal expenses to establish a basic network structure, such as a 501(c)(3), Board Rules, and incorporation documents if you go that route.
- Contracted consultant to do a myriad of tasks that no one agency has the time or expertise to do (mutual proposals to managed care companies, policies and procedure development, initial contacts with managed care companies, trouble shooting systemic billing problems and provider issues, etc.)
- Liability insurance – joint exploration of rates



Non-Clinical Expenses to Share . . .



- Brochures, printing, office supplies at volume prices
- Even joint purchase of janitorial services or supplies, and toilet paper, at a group bulk discount!

“So is this ‘partnership’ stuff a bed of roses?”



**Well . . . no.
So let’s just
mention a
few of the
challenges,
on the next
slides.**

Anticipated Barriers to Network Coordination

Like we said – it has its challenges! Like what?

- Senior staff and board leadership – or practice partners – who don't want to give up power and control through a strategic collaboration or expanded partnership
- Fear of needing to come 'out of the box' – clinging to 'tradition.'
- Fear of losing 'the gold' through forming a partnership or collaboration with others, having to share clients and contracts



Anticipated Barriers, cont. . . .

- **Paranoia – jealousy – mistrust of motives of other agencies**
- **Suspicion of other partners' pursuit of their own goals, in addition to network goals**
- **Fear of being out-done by network partners or collaborators – losing the limelight in a particular niche of service delivery**



Anticipated Barriers, cont. . . .

- **Less productive partners:**

Resentment can fester when one or more network partners fails to 'do its share' in regard to assigned tasks or shared activities.



New Partnerships Prompt Innovative Links Between Unlikely Parties

- **Two or more State agencies as partners**
- **For-profit MCOs partnering with trade associations (CMHCs) and other not-for-profit providers and 'private provider' networks**
- **CD/SA education and prevention providers, partnering with CD/SA treatment providers – how often did you see THAT, in the past?**
- **Not-for-profit agencies partnering with other not-for-profits, and perhaps even with for-profits – forming provider managed networks**
- **Advocacy groups partnering with treatment**



**But make
sure that
your ethics
MATCH!**

Partnership and Collaboration Truths

- New incentives make new partnerships
- New partnerships make **STRANGE BEDFELLOWS**
 - Public-private and profit with not-for-profit partnerships are sweeping the nation, even MCOs are partnering with provider networks.
 - Find 'suitable' partners, as divorce is hard
 - Track records are a prerequisite in choosing partners
 - Look for 'interlocking' or complimentary strengths, avoid wholesale duplication of services and talents
- Strategic partnership is different than interagency collaboration
 - Is any of it easy? **NO** – there are challenges to everything.



The Rules of Strategic Partnering and Agency Collaboration

- **Expect 'real' obligations and benefits from one another. The community sees through sham arrangements, and these tarnish your reputation.**
- **Expect and give commitment to each other's well being – and this goes beyond avoidance of professional pirating of clients. True strategic partnerships are stronger than interagency coordination.**



Choose partners or collaborators for more than politics – do you 'fit'? Do you share a common set of ethics?

The Rules . . .



- **Formalize all decision making techniques – no ‘off the cuff’ decisions allowed – include review & modification workgroups.**
- **Formalize the ‘rules’ of partnership, such as ‘it’s fine to pursue a contract on your own – but just tell us about it up front.’**
- **Forget courtesy ‘on-paper-only’ collaborations which have no real function. It’s meaningless, and is eventually seen for what it is by the community and contractors.**

This is sounding a lot like Big Business. Is that what we are saying here? Yes.

- **Prompts strategic partnerships between providers, and even between providers and Managed Care Companies.**

↳ **just like big business!**

- **Has survivors and quitters**

↳ **just like big business!**

- **Comes out of the box to compete and stay viable**

↳ **just like big business!**



The time is now!

- **Move from 'Mom & Pop non-profit' to a corporate management philosophy**
- **Secure strategic alliances - merge & grow**
- **Capture a corner of the market - become a "niche" leader**
- **Focus Board of Directors upon leadership, vision, and strategic thinking – versus operations**
- **Prepare for a potential need to change Board composition, and even internal management in order to deliver treatment under these new service environment**

**Think Like the
'Big Guys' at
Apple. Google.
Amazon. Yahoo.**



In other words, become a business, or expand these characteristics!



- **Learn to recognize where CD and SA practices are ripe for “business-ization”**

↳ **Recognize that your survival depends upon it, and make a decision about survival**

- **Start to think like Apple – or Amazon; allow yourself to say “If this was Amazon, would I do it this way?” At the same time, you must maintain good treatment ethics! Crucial!**

↳ **New Business Thinking has a place in your organization, and is the key to survival in the new age!**

Example: Restructuring the SA-CD Workplace Like Innovative Businesses

Old Thinking

- Fulltime jobs, permanent employees
- Deployed to one program, single focus
- Bigger is better, large staff = success
- Mainly 'recovering' staff as employees, few clinicians



New Thinking

- Small, core, long-term staff for stability and vision
- Job sharing, job flexibility, use of p.r.n. staff and contracted licensed clinicians to fill in the gaps and meet MCO credentialing expectations
- Contracting and outsourcing segments of the work
- Performance-based expectations of staff and program components

Like conflicts in which brings additional problems to the workplace.

- **Perspectives**
- **Priorities**
- **Values**
- **Image**
- **Corporate Culture**



- **Conflict of perspectives between recovery and non-recovery staff – a ‘traditions’ thing.**
- **Introduction of managed care ‘bottom-line oriented’ culture – management and line staff may see money and budgets differently.**
- **Increased emphasis on ‘image’, credentials, and professional presentation – a ‘values’ and ‘priorities’ thing.**

Leadership Styles Can Dictate Corporate Culture Adversely

- **The General**

↳ **Don't worry... I'm in control**

- **The Visionary**

↳ **It's my baby and I know what it needs**

- **The Bean Counter**

↳ **Don't bother me with the mission.... what's the bottom line?**



These insightful analogies are attributed to Ms. Brandy Wismer, one of the most forward-thinking women we have known in the CD field!

↳ **When all hell breaks loose go to a meeting**

- **Laissez-faire**

- **The True Leader**

↳ **Stops, listens, reflects and acts**

Substance Abuse Programs Are Often Led by People With Passion

- Recognize the biases
- Build on the strengths
- Be open to new ideas, even if initially painful.
- Balance passion with good management
- Practice good recovery principles from a **MANAGEMENT** point of view. Recognize that not everything will be accomplished in one day, but that consistency and ultimate attention to your reality situation is **CRITICAL TO PROGRAMMATIC SURVIVAL.**



**It's a new day.
Rise to the
occasion.**





We'll now move on to Part B of Lesson 1, where we will look at some basic impacts upon HOW we do treatment, and also the growing emphasis upon OUTCOME MEASUREMENT – i.e., what do we actually achieve in terms of recovery of our clients? Please return to your [My Home Page](#) and click on Lesson 1B for Course 3B. Or just close this page and return later.

Preview: In Lesson 2 of Course 3B, we will move on to the heavier programmatic changes we are called to make under managed care – including changes in how we document treatment, and some of the contracting opportunities that providers may wish to pursue.