



## Regular articles

# The affordable care act and treatment for “Substance Use Disorders:” Implications of ending segregated behavioral healthcare

A. Thomas McLellan\*, Abigail Mason Woodworth

Treatment Research Institute, Philadelphia PA

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## ABSTRACT

The Affordable Care Act (2010) and the Mental Health Parity and Addiction Equity Act (2008) are expected to transform substance abuse prevention and treatment in the United States. In this paper, we outline the potential disruption to the existing specialty care delivery system, and describe the opportunities for treatment providers and health services researchers.

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## 1. Introduction

The longstanding segregation of substance use disorders from the rest of healthcare is scheduled to change this year with the implementation of the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (Parity Act, 2008) (Patient Protection and Affordable Care Act, 2010; Paul Wellstone, Pete Domenici Mental Health Parity, & Addiction Equity Act of 2008). The legislation requires health insurers to cover; and healthcare organizations to provide, prevention, screening and brief interventions for the full spectrum of substance use disorders, not just “addiction.” Together these two pieces of legislation require that care for substance use disorders have the same type, duration, range of services and patient financial burden as the care currently available to patients with comparable physical illnesses.

Beyond the new range of coverage available, this legislation expands the venues for care delivery into mainstream medical settings such as primary care; and also integrates the insurance coverage for this care into general medical insurance policies. These too are remarkable changes. In the past, addiction services were almost always provided in a separate specialty care addiction treatment program, and the financing of that care was also separated from other healthcare coverage, typically ‘carved out’ and managed separate from the larger healthcare plan. Under the new legislation, most healthcare plans will be ‘carving in’ behavioral healthcare under their major medical benefit with the goal of improving total health outcomes, and reducing overall healthcare costs (Federal Register, 2013).

The implications are enormous. For the first time, substance use disorders will be treated like other physical illnesses, increasingly by the same providers now practicing general healthcare, and under the same insurance financing conditions. At last, there is the

opportunity for consumers to receive care for many of their mental and substance use problems where they receive the rest of their healthcare. This should improve access, choice and quality of care for individuals and society.

## 2. History of addiction treatment financing

It is easy to miss the full significance of the new legislation as it merely applies the same standards of care for substance use disorders that have long been in place for other physical illnesses. But addictions have never been considered, treated, or insured like other illnesses. Most private insurance plans never covered addiction treatment at all. Over 80% of addiction treatment financing has come from government sources (State Block grants, VA, etc.) with only about 12% from private insurance (NSSATS, 2008). But even government insurance coverage has always been restricted to just the most advanced and severe form of a substance use problem: addiction. Coverage for the less severe but far more prevalent forms of substance use disorders has never been included.

At first blush this approach seems reasonable and even prudent as a way to save scarce healthcare resources for those with the most serious need. But upon closer examination this well-intentioned effort has produced a truly segregated system that has profoundly shaped both public and general medical understanding about the illness and how to address it. In fact, this system is so deeply engrained in our culture and understanding that the full impact of these insurance and financing policies may only be clearly appreciated by considering their effects if applied to another, acquired chronic physical illness – such as adult onset diabetes.

### 2.1. Understanding addiction policy impact by comparison with another illness

Suppose that in a well-intentioned effort to save healthcare dollars, insurance reimbursement was reserved for just those on the

\* Corresponding author. Tel.: +1 215 399 0980.

E-mail address: [tmclellan@tresearch.org](mailto:tmclellan@tresearch.org) (A.T. McLellan).

most severe, complex and chronic end of the “glucose regulation disorder” continuum. For example, care might be restricted to just those who had lost their eyesight, or had lost toes or fingers as a result of the condition; the “truly diabetic.” A seemingly beneficial result of such a policy would be to eliminate the 79 million adults with early signs of diabetes (pre-diabetes) and at least two thirds of the 26 million adults meeting current diagnostic criteria for diabetes – down to about 6–9 million of the most severely affected adults (National Diabetes Information Clearinghouse, 2011); and with it the direct costs of providing diabetes care.

But let’s look more closely at how that insurance decision would affect how we think about and address diabetes. Such a policy would essentially eliminate prevention and early intervention efforts with what is now known as “pre-diabetes.” In contrast, a restricted insurance/treatment policy would be a boon for the instrument and measurement developers – particularly those concerned with diagnosis. Efforts to create instruments and criteria to identify “true diabetics” with perfect sensitivity and specificity would be highly sought after by insurers. There would likely be heated psychological and sociological discussions about the importance of not “labelling” as diabetic – those who merely had less severe “glucose regulation problems.”

These policies would also have broader effects on the type of insurance available for treating diabetes over the years that followed the policy change. Remember that in the United States, most health insurance decisions have come from employers and their human resources (HR) departments. Because the suggested health insurance policy would increase the severity and complexity of the defined patient population, it would reduce the proportion of them who were employed. Responsible HR department managers would correctly question the need for diabetes coverage for such a small number of their employees. In turn, the reductions in covered patients would reduce the size of relevant commercial healthcare services markets that drive discovery and production of new medications, psychosocial therapies, medical devices and clinical support software. These types of innovation are critical forces for progress in treating any disease. Soon the differences between the diabetic population and the general medical population would be so significant that it would make both financial and clinical sense to “carve out” reimbursement for this group; and to make special credential requirements for treatment sites and providers of this type of “specialty care.”

Beyond the market changes described, there would be an important perceptual change among healthcare professionals and the public at large. Those who qualified for diabetes treatment using the new definition would be moderately to severely obese, have multiple co-occurring physical and psychiatric problems, demonstrate poor self-management and scattered treatment compliance, and have failed to heed the stern warnings of families, friends and clinicians over the years.

These chronically ill diabetic patients would come to define and represent the illness of diabetes. Individuals still early in the course of diabetes would not believe that they had anything in common with the “true diabetics,” fostering problem denial and treatment refusal. Of equal importance, generalist clinicians would have less involvement and experience with the full spectrum of “glucose regulation problems” during their training and likely only come into contact with (or at least recognize) the most severe, “true diabetics.” That kind of distorted clinical experience could leave clinicians mistakenly thinking that they had learned about diabetes and understood the illness; that they could easily recognize those affected without screening tools; and that they would have little to offer patients with any form of the disease.

## 2.2. What’s the point

The purpose of comparing addiction with a chronic physical disease is to illustrate how profoundly healthcare insurance decisions

can influence the very core of public and professional understanding about a disease. By extension, many of the characteristics of addicted patients now thought to be cardinal *clinical* features of the illness may actually be sociological and character features of the non-representative segment of the affected population eligible for the available, segregated insurance and treatment. Hopefully, this hypothetical example also sets the context for the following discussion about the key elements of the Parity Act and the ACA, and how their implementation may affect the nature and types of care for substance use disorders in the near future – and potentially the way in which these disorders will be understood by the public over the long term.

## 2.3. The basic elements of the Affordable Care Act

The year 2014 is the first year of national implementation of the Affordable Care Act (Patient Protection and Affordable Care Act, 2010); a highly controversial piece of legislation generally designed to reign in double-digit rates of increases in annual healthcare expenditures and to improve the overall quality of US healthcare. Five key provisions of the ACA signal a broad and dramatic change in the general approach to healthcare financing and purchasing:

- A. Requirement for all Americans to purchase healthcare insurance. This has been the most contentious of the many provisions but is central to the overall goal of increasing insured individuals who have access to healthcare benefits (from about 20 million to approximately 32 million);
- B. Increase in the scope and authority of the Centers for Medicare and Medicaid Services (CMS). CMS is the government agency responsible for expanding healthcare coverage through expanded Medicaid eligibility (133% of federal poverty levels in most states). But their authority is limited and complicated. Federal CMS designs most insurance provisions; but federal CMS provides *only about half of the Medicaid funding for any state*. The remainder comes from the state CMS agency. For these reasons, federal control over coverage is limited, and states vary substantially in the nature and amounts of coverage;
- C. Significant investment in primary prevention through financial incentives. Specifically, there are no co-pays for patients; and no state matching requirements for CMS insurance funds (100% federal funding) for any approved prevention intervention. Approval of prevention interventions is based on a grade of B or higher from experimental evidence reviews by the US Preventive Health Taskforce;
- D. Reorganization of chronic disease management. Because chronic illnesses are the most pervasive and expensive conditions in medicine, the ACA provides incentives to treat chronic illnesses using the proactive, team-based chronic care management model (Bodenheimer, Wagner, & Grumbach, 2002; Wagner E, Austin BT and Von Korff M., 1996). That model relies upon team-based, proactive management of chronic illness to reduce relapses and hospitalizations, through an electronic health record, patient registries, and improved outcomes monitoring systems;
- E. Requirements for health insurance plans and healthcare systems to cover ten “essential health benefits” – including “substance use disorders.” ACA includes special recognition of certain “essential services” that are considered most important for public health and cost savings. These ten benefits will become a required part of all health insurance plans and all accountable healthcare organizations. They include ambulatory patient care; emergency care; hospitalization; maternity and newborn care; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; pediatric services – and mental

health and substance use disorder services. The financial incentives to patients include waived co-pays for most of these services. Incentives to state CMS programs include very low state matching requirements (10% for the first 10 years) to provide these health services.

Beyond the expectable political controversies associated with any social plan of this scope and importance, the ACA brought to light deep ideological divides about the appropriateness of federal government influence in private decisions about whether or how individuals should manage their personal health and wellness. Immediately questioned was whether access to healthcare was a fundamental right of citizens (like defense and education) and whether it should be a privilege earned through employment. Also questioned was a key premise of the legislation: that if the public had greater access to healthcare they would proactively manage their health.

Three key provisions of this act were immediately enacted and broadly applauded. The first was an end to the then common private insurance practices of denying coverage to individuals with a chronic disease; and dropping individuals who acquired a chronic disease. The second was assured portability of health insurance when changing jobs. The third provision enabled families to maintain coverage on their college aged children through age 26. While virtually all Americans appreciated these changes, many were skeptical that any federal agency would be able to administer such a complex benefit without massive fraud and expense.

2.4. Expectable effects on the prevention and treatment of substance use disorders

The broad package of incentives, regulations and initiatives within the ACA will dramatically change all of healthcare in this country – but no illness will be more affected than substance use disorders. Here we discuss three specific aspects of this legislation that should have immediate implications for research, prevention and treatment in this field.

2.4.1. New populations covered

Fig. 1 is an adapted diagram from the 1990 Institute of Medicine report called “Broadening the Base for Alcohol Treatment” (Institute

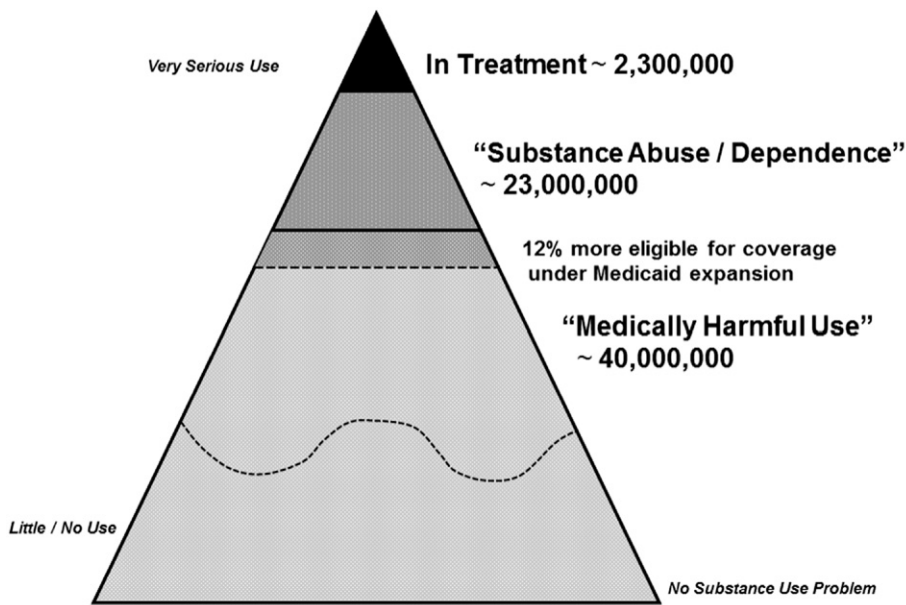
of Medicine (IOM), 1990). The diagram provides a graphic illustration of the number of US adults who use alcohol, illicit and non-prescribed licit drugs at various levels of frequency and intensity. Notably cigarette and other tobacco use are not represented. As can be seen there are about 23–25 million adults that meet the diagnostic criteria for DSM IV substance abuse or dependence, but only about 10% of them receive any type of treatment – usually from the 11,000-specialty care “programs” in the US.

The dashed line below the solid “diagnostic threshold” line represents one estimate of 12% more “addicted” adults who will likely be eligible for addiction coverage –through expansion of Medicaid benefits. This increase in addicted patients who have access to healthcare insurance coverage has been much-discussed within the addiction treatment field. But what has been missed is the much larger segment of patients below the diagnostic threshold that also have a “substance use disorder” which will also be covered by health insurance. This is by far the largest segment of affected – and now insured – individuals. It is likely that traditional addiction services will not be relevant to or accepted by this new population of adults with substance use problems. But aside from screening and brief interventions, there has been little research on the clinical characteristics and needs of this very large “pre-addiction” population, with premorbid or early manifestations of less severe/chronic alcohol and other drug problems. This is an obviously important area for future research.

2.5. New settings and providers of care will offer accessible care

The addition of care for potentially 40 million additional adults with varying degrees and types of “medically harmful substance use” represents an enormous clinical challenge. At a purely quantitative level it is not possible for the current specialty care treatment system to accommodate these newly eligible patients. At a qualitative level, it is likely that the type of intensive care currently available in that system would neither be necessary nor appreciated by the newly eligible population.

At a systems level, the obvious setting for new types of early identification and intervention for this population will be primary care. It has always been in the clinical interests of primary care providers to address emerging substance use problems. This is because unaddressed “medically harmful substance use” is pervasive



Adapted from “Broadening the Base of Treatment for Alcohol” National Academy of Sciences, Institute of Medicine, 1990

Fig. 1. Prevalence of substance use disorders in US adults. Note: Estimates include alcohol, illicit and non-prescribed illicit drugs – but not cigarettes – for US population 12 years of age or older. Adapted from “Broadening the Base of Treatment for Alcohol” National Academy of Sciences, Institute of Medicine (IOM), 1990.

throughout all parts of medicine – from ~20% prevalence in most primary care clinics to over 60% prevalence in more intensive, expensive settings such as hospitals and emergency room settings (Reid, Fiellin, & O'Connor, 1999; Saitz, Horton, Sullivan, Moskowitz, & Samet, 2003). But with ACA implementation it will be in the regulatory and financial interests of primary care to do so. Of course it is well documented that most currently practicing physicians and nurses have not been well-educated or trained to screen, identify or treat these “new” problems. But the new financial and regulatory incentives will soon be in place, and they have been historically important motivators for change and innovation.

This is an obviously important area for expanded clinical, implementation and health services research. How can the new screening interventions fit into contemporary care structures, systems and provider efficacy and workflow? What are the nature, duration, prevalence and severity of substance use problems among general medical and surgical patients? To what extent do those substance use problems interfere with general medical and surgical procedures; and their costs? What types of substance abuse interventions, therapies and medications are most acceptable to general medical and surgical patients – and to the healthcare staffs that treat them? Does the concurrent treatment of low to mid severity substance use problems interfere with or complement general medical and surgical care – does it improve general medical outcomes and costs?

#### 2.6. New types and components of care will be reimbursed

Because care for the full spectrum of substance use disorders is now a mandated, essential part of the ACA; and because substance use disorders are recognized within ACA as chronic illnesses, it follows that many of the diagnostic, assessment, treatment planning and management procedures now used by primary care teams will be adapted for the care of substance use problems. Evidence-based guidelines, standing orders for treatments and tests, chronic disease management strategies and outcomes monitoring will be used for substance use along with the other 9 physical conditions. This of course will require substantial training of primary care teams and likely create opportunities for counselors, social workers and psychologists to work in primary care settings. Again, there are important opportunities for research in the best methods to train and sustain clinical behavioral change among healthcare professionals. There are additional opportunities for operations research on the most effective organizational and institutional incentives to make these new clinical care activities a routine part of the work day.

This is an area where the Parity Act will also become increasingly important as a force for shaping the nature and amount of care provided for substance use disorders. The Parity Act mandates that care options now covered under another comparable physical illness – say diabetes – will have to be made available on the same basis for those with mental or substance use problems. The exact specifications regarding which therapies, medications and other interventions will be covered in each state – and at what duration/dose/frequency or financial rate – have yet to be decided. This process will likely be a lengthy, contentious and potentially litigious one. However, the guiding principles of coverage have been clearly stated in the CMS “Final Ruling” (Federal Register, 2013). This rule offers a blueprint for estimating what will likely be covered when the ACA and Parity Acts are fully implemented.

For example federal Medicaid guidelines for diabetes care cover a wide variety of individually administered screening and preventive services, delivered by various professionals (e.g. nurse educators, nurses, social workers, etc.) – now covered as “pre-diabetes” services. Diagnostic and assessment, again by a variety of professions – are also covered. All FDA-approved medications for the treatment of diabetes are covered, albeit there are many state

restrictions on payment arrangements. Laboratory testing for disease progression medication side effects, for disease monitoring, and to detect commonly co-occurring health problems is covered. Individual patient visit benefits are also covered at hospital clinics, outpatient private offices, in-home visits and even through tele-monitoring. Clinical evaluation of outcomes is covered to both determine disease progression, but also to adjust treatments based on individual patient response.

### 3. What will happen to specialty addiction treatment as we know it

There are many factors that affect each sector of the healthcare industry, and it is difficult to predict how contemporary specialty addiction treatment will evolve. On one hand this should be a time of real opportunity for the specialty addiction treatment field: there will be many more insured and eligible “addicted” patients than there are currently available treatment slots. Moreover, there will be new insurance benefits to pay for these services – at parity with rates for other chronic illnesses. This could be a renaissance era for the traditional addiction treatment providers – *if they adapt* to meet the opportunities and challenges of the new market forces. Once again, these new insurance provisions create an important opportunity for implementation research on how traditional addiction treatment providers can best adopt and implement practices more in tune with traditional medical care.

But the market for substance use treatment services is likely to change significantly due to ACA. First, as care for substance use disorders becomes integrated into mainstream healthcare, addiction treatment providers will have to become proficient in understanding insurance coding and billing procedures and will likely have to have dedicated personnel who handle these important tasks on-line. This could be a very significant cultural and operational change for many traditional addiction treatment providers since less than one third currently bill for Medicaid or other health insurance (NSSATS, 2010). This is likely to be a resource problem for contemporary addiction treatment providers because estimates that are less than one third have the personnel and information systems capacity to bill for Medicaid or other forms of insurance.

As the market expands it is likely that traditional mental health providers and perhaps providers of general rehabilitation medicine services will expand to reach out and serve the newly eligible populations of patients with substance use disorders. Though these sectors have less direct clinical experience with addicted patients, they are more sophisticated than many traditional addiction treatment programs in working with other medical specialties and medical care organizations. Thus, with the new insurance coverage will come new sources of competition in the health care marketplace.

Of particular importance to all providers will be the ability to offer an attractive and evidence-based set of treatment services to the new and more diverse, educated and consumer savvy population of insured patients. The well-established failure of the traditional addiction specialty programs to offer evidence based medications, individual therapies and continuing care services (Knudsen, Abraham, & Roman, 2011; McGlynn et al., 2003; McLellan, Kleber, & Carise, 2003) has been variously attributed to treatment philosophy, ideology, inadequate economic resources, and/or workforce limitations. Regardless, the new marketplace is likely to be much more sophisticated, and payers and referral sources are likely to know more about state-of-the-art care methods; and justifiably ask for proof of effectiveness. Again, traditional addiction treatment providers currently have the clear historical and experiential advantage – but Kodak and Polaroid once held similar technological and experiential precedence in the camera industry (Kimberly & McLellan, 2006).

It is also likely that all providers of substance use disorder care will have to be able to integrate their care into the chronic care

management model that has become the standard for managing virtually all other chronic illnesses (Bodenheimer et al., 2002; Wagner E, Austin BT and Von Korff M., 1996). This will not be easy; one early trial of an adapted CCM model had only limited success with alcohol and opioid addicted patients (Saitz et al., 2013). The traditional addiction treatment programs will have to “medicalize” their care, adopting more of the methods and language and clinical specialties to their care patterns. At the same time the rest of healthcare and particularly chronic illness care, may wish to adopt many of the kinds of inexpensive but effective peer assistance and behavioral change strategies that have been mainstays of addiction treatment for decades (See White & Evans, 2014).

#### 4. Summary and conclusions

Addiction has long been considered the product of poor behavioral choices, an irresponsible hedonistic lifestyle, or an impulsive and antisocial personality. Based on these early concepts the US designed and financed a separate treatment system for this “condition” that was purposely independent from the rest of mainstream healthcare. In short, the system and the patients treated within it were stigmatized, segregated and marginalized.

While this approach was likely necessary to initiate and organize care, those policy decisions have had longer-term negative consequences including poor understanding and acceptance of “substance use disorders” among mainstream healthcare professionals, and an acute care-oriented treatment and insurance model that has made it virtually impossible for the specialty care system to meet the public's demands for enduring reductions in substance use and the associated public health and public safety problems that plague our society (REF).

The recent legislative changes in healthcare organization and financing through the Affordable Care Act and the Parity Act have been specifically designed to end the separate and unequal treatment of substance use disorders. Skeptics may reasonably note that mainstream healthcare has never shown either the ability or the inclination to integrate care for these stigmatized disorders. Many may doubt that true integration will ever happen. This is a bad bet. At least four powerful forces will push for full integration.

First, the failure to identify and address harmful substance use within general medicine now accounts for over \$120 billion in wasted medical care, rapid re-hospitalizations, poor adherence to treatment plans and drug–drug interactions requiring emergent care (Obama, 2011). The country can no longer afford this willful neglect, and the ACA has included substance use disorders as one of only nine “essential services”. This designation carries substantial financial incentives. Thus there will be significant pressure on health plans and healthcare systems to integrate and provide the full spectrum of care.

Second, integration of previously segregated illnesses into mainstream healthcare has happened before – many times. Examples include tuberculosis, breast cancer, depression and AIDS. History shows that a combination of new scientific findings, innovative and effective treatment options, improved technology and promotional legislation produced this type of integration before.

Third, the re-organization of care under the chronic care management model has created new, larger and more coordinated care teams and new recognition of the importance of behavioral health in comprehensive treatment. Many of these teams now include “behavioral health specialists” making them more capable of managing complex behavioral health problems such as substance use disorders.

The final and perhaps most important force for integration is the creation of new and very powerful market forces. The current national treated population is approximately 2.5 million patients annually, treated in approximately 11,000 sites and involving fewer than 5,000 specialist physicians (NSSATS, 2010). With the provisions of ACA and the Parity Act, over 50 million individuals with “substance use disorders” will be eligible for a new range of services, potentially involving 500,000 primary care physicians – a twenty-fold increase. This is the kind of patient and provider market that could inspire creation of new screening tools, medications, therapies, monitoring systems, and other clinical management services. Again, these unprecedented markets provide important incentives for greater access, innovation and quality – all proven drivers of consumer demand. These forces are simply too powerful, and the clinical needs are simply too great for things to continue as they have for the past 40 years.

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