OPPORTUNITY KNOCKS

Utilizing **Treatment Coordination, Peer Recovery Support &** 245G Substance Use Disorder Reform to **Revitalize the Treatment Continuum**

presented by **Justin Scharr, LADC CDCC**

2018 MARRCH ANNUAL CONFERENCE

INTRODUCTIONS - About Me

I've worked in SUD treatment for 10 years, as a clinician, clinical supervisor, treatment director, and consultant for various ages, genders and levels of care.

Certified Co-Occurring Disorders Clinician, Board Approved LADC Supervisor, Integrated Dual Disorder Treatment Team Lead – Working toward Graduate Degree

Served as 245G SUD Reform Impact Analyst/Subject Matter Expert in my role at People Incorporated Mental Health Services

Currently Program Director at Roots Recovery and owner of DaVinci Solutions Addiction Treatment Business Consultants

DISCLAIMER

I am not affiliated with or employed by the Department of Human Services. I am merely an interested professional who is excited about the long overdue changes to the SUD treatment industry in Minnesota.

The information presented was taken directly from DHS' various reform documents, legislative reports, statutes, FAQ's, white papers, etc, and, whenever possible, conclusions drawn were vetted by staff from DHS' licensing or policy divisions. The conclusions are my own, however, and subject to interpretation.

Since this information is still developing rapidly, it is subject to change. Please check the SUD reform website and contact DHS directly to ensure you are up to date on information before taking any action.

INTRODUCTIONS - About You!

So I can better tailor the presentation to the audience, please provide your:

1. **Name**
2. **Job Role (Direct Care, Supervisor, Owner, etc)**
3. **Agency/Program**

LEARNING OBJECTIVES

Objective 1

Learn the difference between acute/episodic care and longitudinal care, and why this matters.

Objective 2

Learn how to utilize the SUD services and reform elements to create longitudinal systems of care, with robust continuing care and follow-up.

Objective 3

Discuss integrating these new services into existing systems of care, including how to create dynamic multidisciplinary teams that work together to create better outcomes

YOUR LEARNING GOALS

What new knowledge do you hope to gain from this presentation?

MORE ABOUT SUD REFORM

Session 21 **Managed Care Delivery of Substance Use Disorder Reform Services for Medical Assistance in Minnesota**
Lucas Peterson – Managed Care Policy Lead, DHS
Today, Monday 10/29 – 3:30-5:30pm

Session 55 **Minnesota's Substance Use Disorder Reform Matters**
Brian Zirbes – Deputy Director, DHS ADAD
Wednesday, 10/31 – 1-3pm

OBJECTIVE 1 – LIGHTNING FACTS

Minnesota's Paradigm Shift

Minnesota has shifted its substance use disorder care model from an episodic, acute care model to a longitudinal, recovery-oriented model with fewer restrictions, more client choice, and better care options.

Evidence-Based Need

While effective in the past, the dominant model of the past several decades has not served the complex needs of a modern population effectively.

Recovery-Oriented Systems of Care

The new model of care promises better outcomes for clients and programs, and provides new and exciting opportunities for Addiction treatment businesses and professionals.

OBJECTIVE 2 – LIGHTNING FACTS

Exciting New Billable Services

The new model of care allows the delivery of new billables services, including Comprehensive Assessments, Treatment Coordination, Peer Recovery Support and, in 2019, Withdrawal Management.

New Direct Reimbursement for LADC Clinicians

Licensed Alcohol & Drug Counselors are able to practice privately, and receive reimbursement for treatment services provided they meet criteria outlined in statute.

Streamlined & Updated Care Pathways

The new system is designed to give clients the right service, at the right time, in the right amount, with few barriers. This will allow clients to move through levels of care with fewer limits.

OBJECTIVE 3 – LIGHTNING FACTS

New Multidisciplinary Team Members

Treatment Coordinators, Peer Recover Specialists will become integral members of the multidisciplinary treatment team, and help integrate recovery-oriented principles into the treatment continuum.

Counselors Can Counsel More

The new model of care allows many of the common LADC job duties to be completed by other competent staff, allowing counselors more time to work directly with clients on their recovery goals.

True Integration of Care

The new reform elements allow for better integration of SUD services into treatment programs, primary care, and mental health settings, allowing for true integration of care.

WHY CONSULTATION?

This session is classified as most-applicable to the "Consultation with other professionals" core-function.

We will cover so much more ground that just consultation, including assessment, treatment planning, referral, case management, etc.

But the FUNDAMENTAL impact 245G SUD Reform has on the MN treatment industry can be viewed through the lens of CONSULTATION, as the reform elements primarily serve to break down "Silos" and "compartmentalized" care and allow LADCs and treatment programs more opportunity to truly consult with other professionals frequently to meet client needs.

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Objective 1:

Learn the difference between acute/episodic care and longitudinal care, and why this matters.

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MINNESOTA'S TREATMENT MODEL

The "Minnesota Model" of treatment has largely dominated the industry here for decades.

- "Acute-Care"
- "Episodic-Care"
- "Incremental"
- "One-Size Fits All"

- Was "normed" and studied on a very narrow client demographic, and did not translate well to other populations

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MINNESOTA'S TREATMENT MODEL

MINNESOTA'S TREATMENT MODEL

The model failed to effectively serve the needs of many clients who needed comprehensive, dynamic and individualized care.

Your Examples!

MINNESOTA'S TREATMENT MODEL

The model failed to serve clients with complex needs:

- Homelessness
- SPMI
- Personality Disorders
- Social Engagement Barriers
- Mobility Issues
- Complex Medical Needs
- Low Motivation
- Trauma
- Frequent Lapse
- Cultural Differences
- Language Barriers
- LGBTQ Needs

TOWARD A BETTER MODEL OF CARE

DHS has been hard at work since 2012 researching and developing a model of care that embraces:

- Recovery-Oriented Systems of Care
- Longitudinal Care for All Levels of Need
- Better Integration of SUD/Med/MH Services
- Increased Access to Care Statewide
- Streamlined Assessment/Intake
- More Culturally-Specific Options
- Outcome & Quality Measurement

TOWARD A BETTER MODEL OF CARE

The theoretical underpinnings of the new model of care stem from work by SAMHSA and progressive recovery industry pioneers like William White, Michael Boyle, David Loveland, Dr. Westley Clark -- just to name a few.

It reflects SAMHSA's definition and principles of recovery, and emphasizes the importance of a person-centered approach that preserves choice, autonomy, the recognition that recovery is a journey, not a destination with a discernable beginning and end.

The ROSC/Longitudinal model has been implemented successfully in full or in part by many other states like Oregon, Washington, New York, California, Pennsylvania,

Successful implementation is inevitably followed by improved outcomes, reduced treatment costs, industry expansion and growth, and lower overall health care costs.

Taken from "Approaches to Recovery-Oriented Systems of Care at the State and Local Levels: Three Case Studies," by SAMHSA

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INTEGRATING THE SIX C's OF THE NEW CARE MODEL

CONSULTATION

COLLABORATION

COMMUNITY

COMMUNICATION

CONTINUITY

COMPREHENSIVE CARE

SAMHSA'S DEFINITION OF RECOVERY

A process of change through which individuals improve their health and wellness, live a self- directed life, and strive to reach their full potential.

SAMHSA'S 10 GUIDING PRINCIPLES OF RECOVERY

RECOVERY-ORIENTED SYSTEMS OF CARE

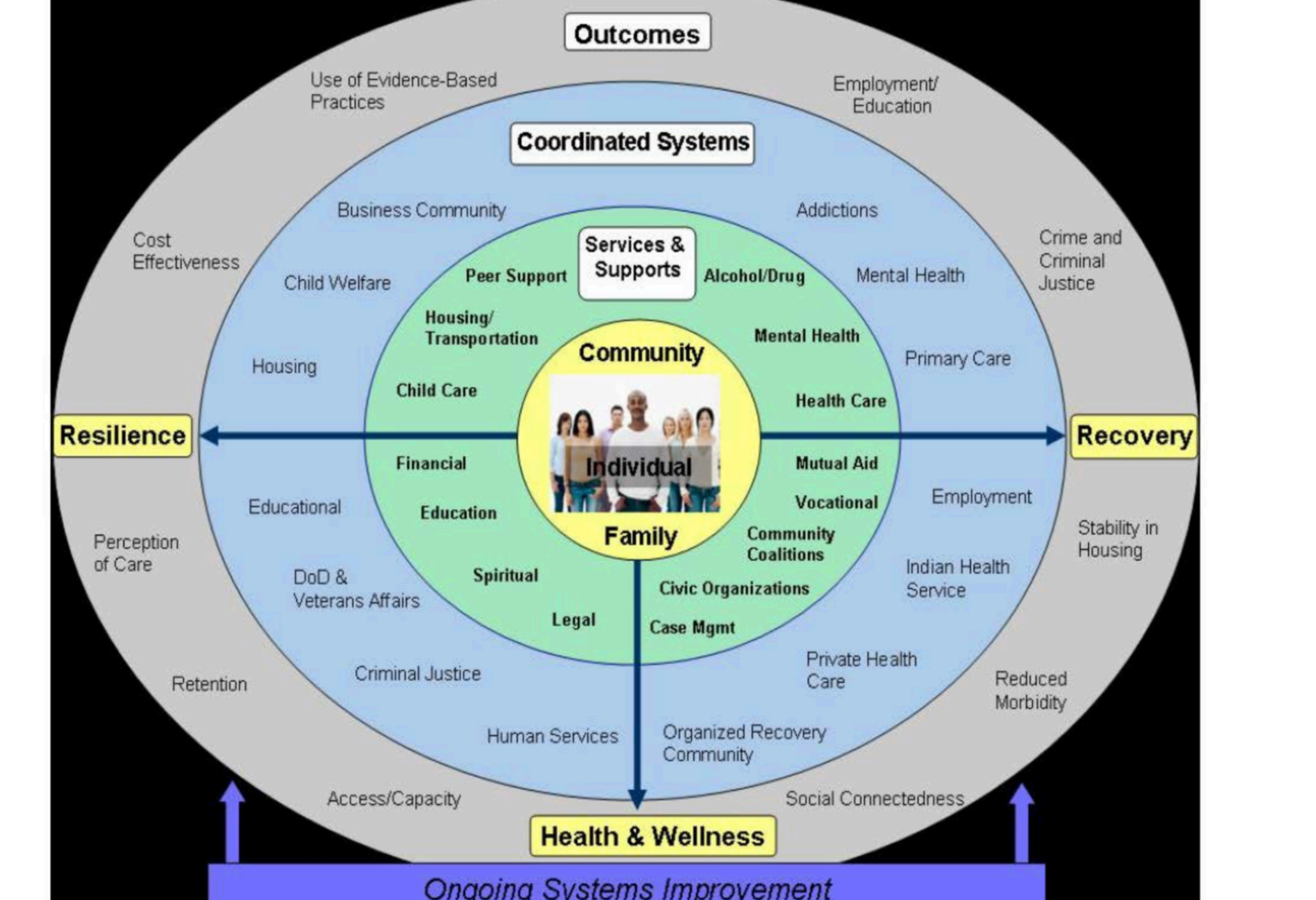
Key Points

- Designed to support recovery across the lifespan.
- There is no ”wrong door” to recovery
- Must provide “genuine, free and independent choice.”
- Key Values underlying ROSC are:
  - Person-Centered
  - Self-Directed
  - Family/Community Participation
  - Strengths-Based
- Adequate & Flexible Funding
- Adaptable and Individualized

RECOVERY-ORIENTED SYSTEMS OF CARE

Operational Elements

- Collaborative Decision Making – person-centered
- Individualized & Comprehensive Services and Supports
- Community-Based Services & Supports
- Continuity of Services & Supports – "Natural Supports"
- Multiple Stakeholder Involvement
- Recovery Community/Peer Involvement
- Outcomes-Driven


Outcomes
Use of Evidence-Based Practices
Employment/ Education
Coordinated Systems
Business Community
Addictions
Cost Effectiveness
Crime and Criminal Justice
Services & Supports
Peer Support
Alcohol/Drug
Child Welfare
Mental Health
Housing/ Transportation
Mental Health
Community
Housing
Primary Care
Child Care
Health Care
Resilience
Recovery
Individual
Financial
Mutual Aid
Educational
Employment
Education
Vocational
Stability in Housing
Perception of Care
Family
Community Coalitions
DoD & Veterans Affairs
Indian Health Service
Spiritual
Civic Organizations
Legal
Case Mgmt
Private Health Care
Retention
Criminal Justice
Reduced Morbidity
Human Services
Organized Recovery Community
Access/Capacity
Social Connectedness
Health & Wellness
Ongoing Systems Improvement

RECOVERY COMMUNITY ORGANIZATIONS

Independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services.

From “The Recovery Community Organization” by Valentine, White and Taylor

Objective 2:

Learn how to utilize the SUD services and reform elements to create longitudinal systems of care, with robust continuing care and follow-up options.

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NEW SUD SERVICES

Comprehensive Assessment

Treatment Coordination

Peer Recovery Support

Telehealth/Telemedicine

Withdrawal Management

INTEGRATING THE SIX C's OF THE NEW CARE MODEL

CONSULTATION

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COMMUNICATION

CONTINUITY

COMPREHENSIVE CARE

COMPREHENSIVE ASSESSMENT - 245G.05

Bye-Bye Rule 25!

- Rule 25 is being phased out by 2020.
- It will be replaced by the Comprehensive Assessment, a single assessment used for both treatment placement and planning
- Will allow for direct access to treatment, without "pre-authorization" or clinical review (more on that later)
- Can be provided via telemedicine, and mobile

COMPREHENSIVE ASSESSMENT

- Must include the requirements outlined in 245G.05
- Completed in intake session for outpatient, within 3 days for residential
- If completed for placement within previous 45 days, only a summary is needed at intake
- Reimbursable at $162.24 when used for placement
- Can be provided in private practice for direct reimbursement by an LADC supervisor

COMPREHENSIVE ASSESSMENT

- Assessment data (dimensions and demographics) will be uploaded to a central database (likely MN-ITS) & will be available to any program the client chooses.
- A new assessment will not be needed after each "level" of care, only when significant clinical changes occur and funding changes.
- Does NOT require collateral sources if enough info is received from client and referent
- In many cases, will allow for same-day placement

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PEER RECOVERY SERVICES – 245G.07 Subd 5

Recovery-Oriented Mentoring & Support

- Peer support services provided by a Certified Peer Recovery Support Specialist
- MCB and NAADAC provide certification, training by MRC and others
- Billable in outpatient, pre-treatment and recovery maintenance at $15.02 per 15 minute increment
- Must receive supervision by an ADC or other certified staff approved by the commissioner

PEER RECOVERY SUPPORT SERVICES

- Can be provided on a mobile basis.
- Peers cannot facilitate groups for reimbursement but can accompany clients to a group, which is billable time.
- Are not "CD Techs" or clinical assistants but rather part of the treatment team and primarily client advocates.
- Eligible vendors are licensed programs, Community Recovery Organizations.

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PEER RECOVERY SUPPORT SERVICES

- Peer Recovery Specialists receive training in recovery mentoring, Wellness & Recovery Action Plan (WRAP), boundaries, ethics, pharmacology, and more.
- Workforce development will be needed, and there are already plans in the works to develop more training opportunities, new Community Recovery Organizations, and cultivate infrastructure for professional development.
- Every major study evaluating the impact of PRSS has demonstrated significant benefit to client outcomes and the cost of care.

PEER RECOVERY SUPPORT SERVICES

- **245G.07 Subd 1 (a) (5) outlines the type of support that qualifies for reimbursement:**
  - **Education, advocacy, mentoring through self-disclosure of personal recovery experiences;**
  - **Attending recovery and other support groups with a client;**
  - **Accompanying the client to appointments that support recovery;**
  - **Assistance accessing resources to obtain housing, employment, education, and advocacy services;**
  - **Non-clinical support to assist the transition from primary treatment into the recovery community.**

TREATMENT COORDINATION – 245G.07 Subd 6

Finally!!

- A billable service if completed by an ADC, or a person qualified as per 245G.11 Subd 11., via an eligible vendor
- Billable in 15 minute increments, up to 8 units per day, at $11.71 per unit. Client does NOT need to be present
- Can be provided immediately upon completion of comp assessment if clinically appropriate
- Time unlimited, can be part of pre-treatment, continuing care, and recovery maintenance

TREATMENT COORDINATION

- **Qualifying Activities per 245G.07 Subd 6:**
  - Coordination with significant others to help in the treatment planning process whenever possible;
  - Coordination with and follow-up for medical services as identified in the treatment plan;
  - Facilitation of referrals to substance use disorder services as indicated by the client's medical provider, comprehensive assessment, or treatment plan;
  - Facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;
  - Assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;
  - Life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed, and
  - Documentation of the provision of care coordination services in the client's file.

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TREATMENT COORDINATION

- **Qualifications, per 245G.11subd 7 are:**
  - Skilled in the process if identifying and assessing a wide range of client needs;
  - Knowledgeable about community resources;
  - Completion of 30 hours of training on treatment coordination
  - Has either a BA/BS in behavioral sciences or related field or is an alcohol and drug counselor or ADC-1 per UMICAD
  - Has at least 2,000 hours of supervised experience working with individuals with SUD
  - Must receive 1 hour of weekly supervision by an ADC

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BILLING CODES FOR NEW SERVICES

- Comprehensive Assessment
  - Code H0001
  - Rate is $162.24 per encounter
- Peer Recovery Support Specialist
  - Code H00038, Modifier U8
  - Rate is $15.02 per 15 minute unit
- Treatment Coordination
  - Code T1016, Modifiers U8 and HN
  - Rate is $11.71 per 15 minute unit

TELEHEALTH/TELEMEDICINE -

- All individual services may now be provided via telehealth/telemedicine per MHCP guidelines
- Up to 3 individual services per week, per client
- Providers must submit updated telemedicine assurance statements with MHCP.
- Must use approved platform/technology and have policy and procedures that identify how tele services will be provided and when they are appropriate.

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WITHDRAWAL MANAGEMENT

- On July 1, 2019, or upon CMS approval, whichever is later, WM will be reimbursable to help individuals who are intoxicated or in withdrawal stabilize and prepare for treatment interventions.
- The plan is to allow the service to be provided by licensed residential 245G programs, and stand-alone programs.
- Ambulatory (outpatient) detox/withdrawal management is NOT part of the planned service

KEY SUD REFORM COMPONENTS

Direct Reimbursement

Direct Access

Documentation/Paperwork Reduction

Location of Service Changes/Options

Client Choice in Level of Care

DIRECT REIMBURSEMENT

- 245G.01 Subd 17 allows for the provision of, and payment for SUD treatment services delivered by a "licensed professional in private practice."
- This means that an LADC/ADC can provide SUD counseling in a solo practice, hospital, primary care, mental health setting, etc, and be paid for those services via CCDTF/MCO reimbursement.
- Comprehensive Assessment, Group and Individual Counseling, and Treatment Coordination

DIRECT REIMBURSEMENT

- LADC/ADC in private practice will have to apply for a Type-1 NPI number and enroll with MHCP as an individual provider.
- The LADC/ADC must meet 245G.11 Subd 4 definition of an Alcohol & Drug Counselor Supervisor, which includes:
  - Three or more years of experience counseling;
  - Know and understand the implications of applicable laws/statutes

DIRECT ACCESS– Streamlining Treatment Intake

Current system

Person seeks help from a placing authority

20 days max

In-person assessment

10 days max

Approved for treatment

Up to 30 days
between seeking help and being approved for treatment

Direct access

Person can seek help directly from a treatment provider

~~20 days max~~

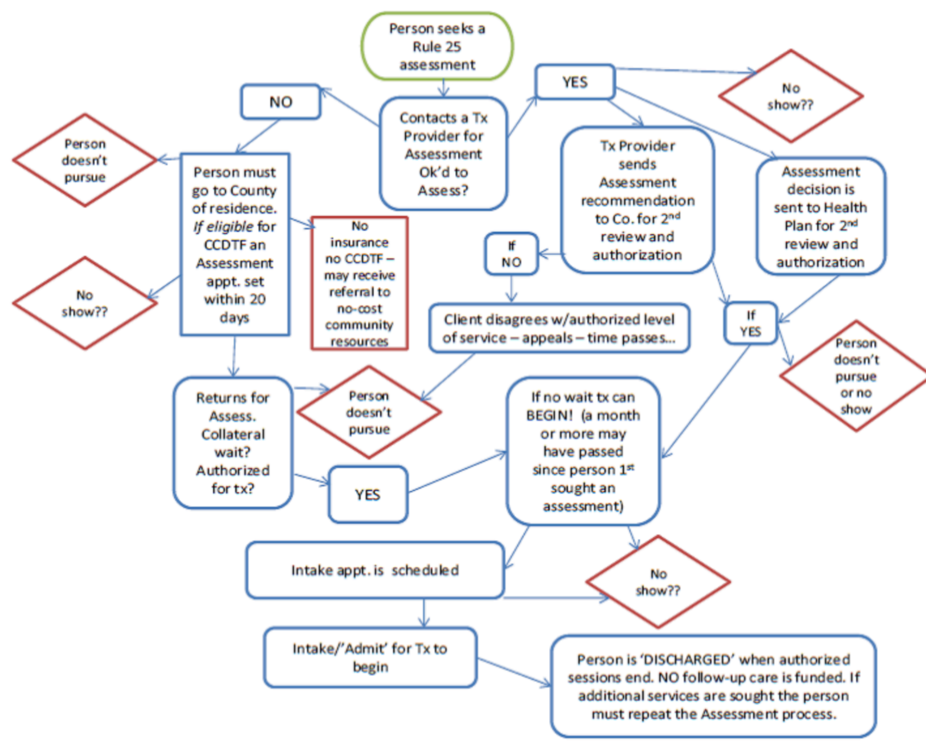
In-person assessment

10 days max

Approved for treatment

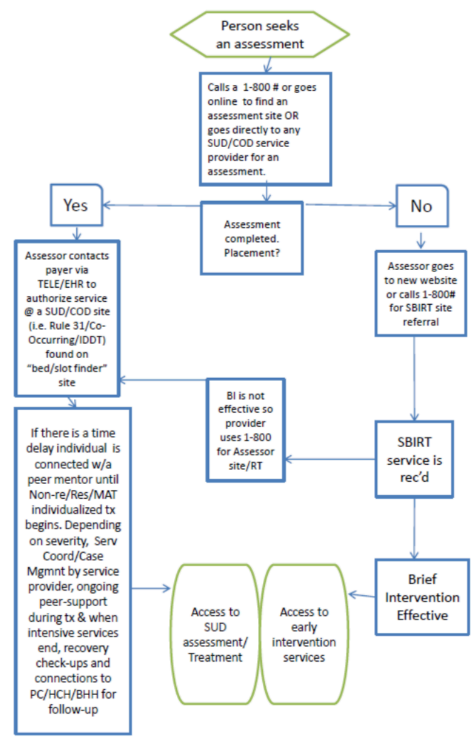
Up to 10 days
20 days less than the current system

CURRENT ASSESSMENT & REFERRAL PROCESS



REFORMED ASSESSMENT & REFERRAL PROCESS

Figure 3.



FAST TRACKER – SUD TREATMENT LOCATOR

Home About

IN AN EMERGENCY DIAL 9-1-1 NATIONAL SUICIDE PREVENTION LIFELINE (NSPL): 1-800-273-8255 CRISIS TEXT LINE: TEXT MN TO 7

Engaging the Mental Health and Substance Use Disorder Communities Throughout Minnesota

Your Link to Mental Health Resources

Mental Health

What is Fast-Tracker?

Fast-Tracker is a virtual community and health care connection resource. We connect individuals, families, mental health and substance use disorder providers, physicians, care coordinators, and others with a real-time, searchable directory of mental health and substance use disorder resources and their availability within Minnesota

Read more...

Your Link to Substance Use Disorder Resources

Substance Use Disorder

DOCUMENTATION/PAPERWORK REDUCTION

In addition to the removal of the Rule 25, several other changes to documentation were made, including:

- **No need for service termination/discharge summary for every level of care, in favor of one summary when all services are completed**
- **Treatment plan/service reviews have been streamlined and condensed**
- **Comprehensive Assessments do not need to be updated as frequently to navigate through the treatment continuum, only when clinically appropriate**

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LOCATION OF SERVICE CHANGES

- 245G includes new elements allowing for the provision of outpatient services at locations outside the licensed program, without the need for a separate license.
- The separate locations should represent specific, sporadic solutions for serving a convenient need, such as a group home or within schools
- A specific form is in development for submission and registration of secondary locations
- Will allow for greater flexibility and mobility

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CLIENT CHOICE – DOWNWARD DEVIATION

- CHOICE is key!
- The reform package places an additional emphasis on allowing client choice in treatment services, including level of care.
- This means that clients have the right to choose, and engage in any level of care below that which is recommended by a Comprehensive Assessment, a practice known as downward deviation.
- This choice should be respected, and included in treatment planning in order to respect the client as the director of their own care

YOUR THOUGHTS ON THE NEW MODEL

Considering your personal experience, what you've just learned, and the Six C's of the new model, what thoughts do you have?

Do you feel prepared to integrated the new services and elements?

CONSULTATION	COMMUNICATION
COLLABORATION	CONTINUITY
COMMUNITY	COMPREHENSIVE CARE

Objective 3:

Discuss integrating these new services into existing systems of care, including how to create dynamic multidisciplinary teams that work together to create better outcomes.

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CASE SCENARIO - DEREK

- 36 year old Army veteran, lost 2 friends and injured by IED in Iraq
- Received a medical discharge, was devastated to leave the Army
- PTSD, chronic pain, agoraphobia and anger management issues
- Abusing pain medications and Alcohol, difficulty maintaining abstinence for more than 2-3 weeks at a time
- Has been to 4 residential programs where he is usually discharged for lapsing or fights/arguments with staff and peers
- Does not relate with or want to be around his treatment "peers"
- Feels "the program" has let him down
- Divorced with two teenage sons who are "his world"
- Has a good relationship with his MH therapist and physical therapist

CASE SCENARIO - DEREK

Why do you think traditional treatment programs have not worked well for Derek?

Let's use SUD reform services and elements to create a better care pathway.

But first…….

INTEGRATING THE SIX C's OF THE NEW CARE MODEL

CONSULTATION

COLLABORATION

COMMUNITY

COMMUNICATION

CONTINUITY

COMPREHENSIVE CARE

TOOLS AT YOUR DISPOSAL

- Peer Support Services
- Telemedicine Sessions
- Embedded Suboxone Rx
- Treatment Coordination
- Withdrawal Management
- Fast Tracker
- Individual/Group
- Psychiatric Care via Telehealth
- Downward Deviation
- Time Unlimited Services
- Location of Service Options
- Direct Reimbursement
- Culturally Specific Options

INTEGRATING SUD REFORM

- What are the challenges to integrating the new model and services into existing systems of care?
- What is the incentive?
- How will you breathe life into the longitudinal model in your program/practice?
- How will our biases and "preconceived notions" about what "treatment" looks like impact our ability to pursue integration?
- Are we prepared to let go of some control?

BUILDING A BETTER TREATMENT TEAM

- What does a multidisciplinary team in the new care model look like?
- How will we cultivate a workforce and attract talent?
- How can we better collaborate, and communicate with our new team members?
- How can we be role models and thought leaders in the new industry landscape?
- How will continuing care and recovery maintenance be integrated into team collaboration?

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FINAL THOUGHTS AND REFLECTIONS

- What concerns do you have?
- How do you think the reform will impact your professional life? Your program?
- How do you expect the industry change?
- What are you hoping will change the most?

CONSULTATION
COLLABORATION
COMMUNITY
COMMUNICATION
CONTINUITY
COMPREHENSIVE CARE

QUESTIONS

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