Medicaid Innovation Accelerator Program (IAP) Substance Use Disorder Program Area
National Dissemination Webinar #2: Substance Use Care Continuum
Audio-Only Recording Transcript

Hannah Dorr (HG): Good afternoon, everyone. I am Hannah Dorr from NASHP and welcome to today's second national dissemination webinar on the substance use care continuum.

Tyler Sadwith (TS): Thank you. Hello, and thanks for joining us today. My name is Tyler Sadwith and I'm a health insurance specialist at CMS and the project lead for the Substance Use Disorder (SUD) Initiative of the Medicaid Innovation Accelerator program. I will quickly provide some context for today's discussion, and then we can get started.

The Medicaid Innovation Accelerator Program, or the IAP for short, was launched in 2014 with the goal of improving health and healthcare for Medicaid beneficiaries by supporting state efforts to accelerate payment and service delivery reforms. To kick off the IAP, CMS held a series of in-person listening sessions in regions across the country, to hear from our state colleagues and stakeholders, including our provider and health plan partners, about how the IAP can be most useful. From the feedback we heard, we identified SUD as the first area of focus. The goal of the SUD Initiative, under the IAP, is to support states to introduce policy, program, and payment reforms to better identify individuals with SUD, expand coverage for effective treatment, enhance care and practices delivered to beneficiaries, and develop payment mechanisms for SUD services that will provide better outcomes.

We knew that states were starting in different places, and our goal is to meet states where there are, and tailor our IAP resources in ways that support states to meet shared goals. Based on an office hours conversation that we held with 27 states that raised their hands to participate, we developed two tracks of technical support for SUD.

The first track was a high intensity learning collaborative, which is a cohort of six states where they're rolling up their sleeves and committing to designing and implementing program reforms. These states defined measurable goals and had a wide range of researchers to assist them, including virtual monthly meetings, in-person workshops, and one-on-one technical support. We also offered a second set of SUD related support, called the Targeted Learning Opportunities, or TLOs for short. The TLOs were designed to meet the needs of more states across a broader group of topics. The TLO center had a monthly web-based learning series and follow-up deep-time sessions where states to learned from, and engaged in discussions with some of the permanent SUD experts and obtain insights from other state Medicaid agencies through peer-based discussions and state-to-state learning.

Now that the High Intensity Learning Collaborative (HILC) and the TLOs have ended, we are focusing our efforts on rolling out and sharing what our partner states have learned from our first year of activity within the IAP. Through these national dissemination efforts, we are hosting national webinars on a quarterly basis targeting states and our key partners in the states as the primary audience. They also rolled out tools and resources developed during our first year that we can share broadly. To kick off our national dissemination efforts, last April we invited several of our high intensity states to participate on a virtual panel and discuss their IAP experience. These states shared an overview of their activity, planned trajectory, and discussed and shared key takeaways.

For today's webinar, we've invited several partners to discuss the continuum of care for SUD treatment, with the focus on recovery support services. Through our work with states, at CMS we support states to

design a robust Medicaid benefit package that covers the full continuum of care. Today's discussion is really an opportunity to learn more about that full continuum of care within a chronic care model with an emphasis on the recovery support services that are being delivered to individuals with SUD.

Turning to the agenda, first we will hear from Tom McLellan from the Treatment Research Institute who will discuss SUD and addiction treatment within a chronic disease model. Following Tom, Kimberly Johnson from the Substance Abuse and Mental Health Services Administration, or SAMHSA, will discuss recovery support services within a recovery-oriented model of care. And to carry the discussion into the field, we will hear from Beverly Haberle who is leading advocacy and recovery support service provision in Pennsylvania.

Let me introduce our speakers then we can go ahead and get started.

Thomas McLellan is a co-founder and chair of the board at Treatment Research Institute (TRI), as well as an experienced substance abuse researcher. From 2009-2010, he was Science Advisor and Deputy Director of the White House Office of National Drug Control Policy, a congressionally-confirmed presidential appointment to help shape the nation's public policy of drugs to illicit drug use. Dr. McLellan has more than 35 years of experience in addiction treatment research. In 1992 he co-founded and led TRI to transform the way research is employed in the treatment of, and policy making around, substance use and abuse.

Kimberly Johnson is the Director of the Center and Addiction Services at SAMSHA. Prior to this position, Kimberly was the Deputy Director for Operations of the Comprehensive Health Enhancement Support System, a research center at the University of Wisconsin, Madison. She has also served as the Director of the Office of Substance Abuse in Maine. Kimberly is a recipient of the Federal Department of Health and Human Services Commissioner's Award for child welfare efforts, and the National Association of State Alcohol and Drug Use Directors' Recognition for Service to the field of substance abuse treatment and prevention.

Beverly Haberle is the Executive Director of the Council of Southeast Pennsylvania Incorporated, a non-profit education advocacy association. She is also the Project Director for the Pennsylvania Recovery Organization/Achieving Community Together, or PRO-ACT, which is a grassroots organization mobilizing the recovery community, family members, and other interested advocates. Beverly serves as vice president on the board of directors for Faces and Voices of Recovery and is a person in long-term recovery.

Suzanne Fields will serve as our moderator for this webinar. She is a faculty member and peer advisor for healthcare policy and financing at the University of Maryland School of Social Work. Suzanne is also a clinical social worker with 20 years of experience. Her work has spanned multiple settings, including Medicaid, mental health and substance use, children's services, child welfare, as well as managed care. She is a familiar voice on our IHE webinars, having moderated several of our previous sessions.

And, with that, I would like to turn it over to Suzanne to get us started.

Suzanne Fields (SF): Thank you very much, Tyler, and hello everyone.

Historically, the approach to the treatment of SUDs had been to use an acute episode approach. We have learned that the acute treatment episode approach has not been sufficient to prevent relapse and support individuals through recovery. There is a recognition that SUD is a chronic condition for many that requires

a full continuum of services and support to meet the varied needs of each individual. The graphic here displays the care continuum as developed by the American Society of Addiction Medicine or ASAM. ASAM has established a set of evidence-informed guidelines to inform level of care decisions within substance use facility treatments.

There are five broad levels within this ASAM categorization, from early intervention all the way through to intensive inpatient services. Within those five broad levels of care, various decimal points, or delineations, are used to further express gradations of intensity of services to be available to individuals in SUD treatment. The ASAM criteria encourage the use of an assessment to understand the unique needs of each individual, risks to their situation, the skills and supports they have to leverage to further their treatment goal. That level of care is matched to meet the unique needs of each individual.

Implied within this level of care framework, are the evidence-informed therapies and treatments that are used within these levels of care and across these levels of care. An example of that would be opioid maintenance therapy, methadone treatment to support individuals. And while these specific treatments are not a focus of today's particular discussion, the inclusion of these treatments and the incorporation of those treatments into a Medicaid program are essential components within an effective continuum of care that our three presenters will speak to today.

Within the continuum are also recovery support services, which is the key focus, is a core focus, of our webinar today. These are non-clinical services that further support the individual to address a range of needs that are impacted by substance use. Some of these services are Medicaid reimbursable and others may not be. All have an important role in inclusion of a continuum of care and Medicaid programs have an opportunity to ensure coordination of these recovery support services with Medicaid benefits that are available in your system. That coordination can be financial in nature, such as weaving with other funding that can be available, but also, it can be based on memorandums of agreement between state agencies, requirements and supports to health plan partners and providers to ensure coordination. Again, our three presenters today will be highlighting these opportunities and providing specific examples about the inclusion of recovery support services within an effective continuum. With that, I would like to turn it over to Dr. Tom McLellan.

Tom McLellan (TM): Hi, and thank you all for joining us. I'll be talking about the treatment of SUDs; not just addiction, but SUDs. And, I will be trying to discuss it in terms that are, perhaps, more common to mainstream healthcare. Lots of people who are gaining new responsibility in the field of mental and SUDs have been trained in general medicine, and, as you'll see, our two fields have been quite segregated for a long while. This presentation is really an effort to try to bridge that gap and use common terms.

What you see now is a picture of what substance use looks like in the U.S. among U.S. adults 12 and older. The data comes from the NSDUH discovery from SAMSHA, 2014. It's a pyramid. What is represented is the amount and severity of substance use; any substance: alcohol, opiates, cocaine, marijuana, except cigarettes are represented here. These are actual numbers. As you can see, if you start at the base, most people in the U.S. use very few substances and they use them very infrequently; alcohol, perhaps, with dinner or a glass of wine at a wedding. Those are people who do not have a SUD. As you go up the pyramid, you increase the amount, duration, intensity and number of substances used. The first line you see, the wavy white line with the breaks in it, is where SUDs start. Right there is what is called "harmful use."

Harmful use is defined as that. It's also called misuse. But, harmful use is the use of any substance in any amount that produces a problem: a health problem, a relationship problem, a functioning problem. You

can see there are 50 million people who drinking too often or too much; using marijuana too often or too much for their own good. They are not addicted, but they have a pending problem. The reason that line has dashes in it, is that people go back and forth over the lifespan as to whether they are drinking or using too much too often and whether they are not.

If you keep going up the pyramid, you come to that first solid line. That is where you have more severe SUDs, called addictions. By the latest count there are approximately 21,400,000 people in the U.S., adults 12 or older, who meet criteria for DSM-5 Serious Substance Use Disorder.

What characterizes addiction is loss of control. That is making new information to people. For many, many years, addiction has meant you were using a "hard" drug, like heroine, or were using an injectable drug. You can have a very serious SUD, commonly termed an addiction, to any substance from marijuana, through stimulants, tranquilizers, sedatives, and, of course, including any kind of opioid. We now know that you have this illness, called an addiction, when your voluntary control over your desire and ability of use is impaired. That's the common denominator. We further know that that is due to progressive changes in the brain in area circuits that control motivation, stress tolerance, learning, and inhibition.

At the very top of this pyramid, you will see that only about 4,100,000, less than five percent of all those with the serious form of the illness, are receiving any kind of treatment. This has been called the treatment gap. We are going to talk about that.

Let me focus on the top part of the pyramid. I want to give you three points about that.
The people who are in treatment for serious addiction are not representative of the broad set of people with an SUD. They are more serious, more chronic, and usually more complex to treat than the rest.

Second, these are people who have a profound loss of control over their substance use.

Third, is that you probably have not heard much about harmful use. It hasn't been defined very much except for alcohol, and it hasn't been a useful concept because there has never been insurance coverage for it. I want to talk about that next. The most people, for most of their lives, you either use substance or you don't, and if you use substances, you may have an addiction or you don't. But, there were no gradations. That has all changed now and it has some very important implications for how we think about, approach, treat, and prevent SUDs.

One reason we are talking about this in the context of health insurance, is that alcohol and drug use, especially harmful use, contribute to major problems throughout the rest of healthcare: misdiagnoses, poor adherence to prescribed care, things that you can read right there. Alcohol and other drugs interfere with prescribed medications usually. People who are misusing or using in a harmful manner, not necessarily the severely addicted, but even people who are using too often, let's say, alcohol, may be requiring more physician time; their use of alcohol may be interfering with some of their medications, such as medications that may be given for other chronic illnesses, like diabetes or hypertension. People who use in a harmful way or more severely have poorer outcomes and larger costs throughout healthcare; particularly among people with chronic illnesses. So, if you think, as a member of a primary care team, emergency room, or diabetes team, you think I don't have to pay any attention to this because I know about addiction and they treat those down across the railroad tracks in a separate program. You're wrong because you may be missing people who are not yet, frankly, addicted, but whose use is compromising the care that you are trying to provide.

What does all that mean?

It hasn't meant much to the rest of healthcare because, until very recently, 2012, SUDs were explicitly segregated from the rest of healthcare. With 2012, or really 2008 and the Parity Act, but much more functioning with the Affordable Care Act, SUDs were never covered by most healthcare insurance programs. That is the most important point.

The second important point is virtually all the care that was available was restricted to just those with the most severe disorders, and that care was done in programs that were generally segregated from the rest of healthcare. If you wanted to get care for your cocaine problem, you would have a hell of a hard time getting that care from the same hospital where you got your diabetes treatment. If you are saying to yourself, "Why does this guy keep talking about that," here's why: that is not the way you would treat any other chronic illness and it has led to problems at a conceptual, financial, programmatic level.

As is described in this slide, the insurance for SUDs applied only when you were so severe that you met criteria for a significant addiction.

Second, it was only available through specialty care. Primary doctors did not, and still do not, offer many services for people for lower level, but still significant, harmful use. The financing of SUD treatment was segregated; it came out of a different bucket of funds. While you will often hear conversations about dual disorder patients, meaning patients with mental health and substance use problems, they're the majority. The reason it's been an issue is because the care comes out of different financing options.

The final thing is addiction treatment has been historically given through programs. These programs have been necessary; they have been the only kind of care, other than recovery self-support, that's been available. But, it's not the kind of care that has been given for other chronic illnesses. This has not been a communist plot; it was simply a fact that addiction was understood to be a character disorder, quite different from other chronic illnesses. We now know that's not true. It's another chronic illness that when you get it in its most severe form, you can manage it, but you can't cure it.

Why am I talking about that? Let's talk about an illness that may be more familiar to a lot of you; and that is diabetes. Diabetes is a very good comparison condition for a lot of reasons. First, like most SUDs, most diabetes is an acquired chronic illness; you lose control of your illness, you lose control of your ability to exercise and remain active, and, at a point, they way you metabolize sugar changes. Once that happens, you no longer can get it back; you have an illness that you'll have to manage that you can't yet cure. But, there's an entire continuum of insurance benefits and an entire continuum of care that's available for people with diabetes. It's illustrated there in the box below. Prevention is critical to managing diabetes. You don't want to let early stage glucose metabolism problems turn into diabetes. There are many prevention and early intervention options. Screening and early intervention are all fully funded. There's a full range of treatment services available and they include: educational programs, dietary programs, all manner of medications, and some exercise programs. Care in diabetes treatment is not regimented; it is individualized. It is recognized that individual patients have specific constellations of problems and they need care that will be delivered and adjusted, as that care is delivered by the results of monitoring, usually hemoglobin A1c. And, there are many support services.

Why am I talking about that? What relevance does that have? Let's take a look at the federal Medicaid benefit in diabetes. This is an abbreviation, but it serves to illustrate a point. Look at the nature of those benefits: physician visits, clinic visits, home health visits, all manner of tests and FDA approved

medications, more tests to see the progress of the illness and the effectiveness of care. You can even get a language interpreter, if you need one, in many states. What you don't see there is programmatic care. There is no 30 days of diabetes care. That would be ridiculous. You know you can't effectively deliver the kind of continuing care necessary in a 30-day acute period. That's the way addiction has always been treated. Notice that there are purposefully lots of options for patients, but also for providers. Lots of medications are covered. Lots of interventions are covered. The reason for that is, the goal in diabetes treatment is to keep people engaged in care. You don't want them to fall out of care because relapse will happen and if relapse happens, they are going to have to start all over again and it's going to be expensive and could lead to really severe consequences: amputations, blindness, etc.

Let's talk about that in a more specific way. What I want to show here is what I call a Spectrum of Illness and the Care Continuum. What the slide really should say to start is diabetes. For diabetes, the question, "what is needed," and, if you look on the left part of the slide, you will see three stages. Before you get diabetes, you're at risk. Maybe you have a family member, or are overweight, or both, and you're at risk, but don't yet meet diagnostic criteria for diabetes. You need certain kinds of services. Once you get diabetes, you need to have clinically managed sets of services. The goal of both of these it to get to the point where the diabetic patient, with the aid of his family and his recovering support network, can personally manage the care and the continued managed maintenance of the recovery from diabetes. Those are the three stages I've laid out, and they roughly correspond to the way diabetes and many other chronic illnesses are managed.

In the middle, you see the kinds of services that are provided at each of those. There is a lot of overlap. For example, monitoring, medications; these are the active ingredients of treatment. What you don't see is, you go from program one, to program two, to program three. That's not how they manage other chronic illnesses.

If you say to yourself, "Wow. That's very different than how you manage contemporary addictions," you're right. The system was never set up like that. The point of this slide is that it could be; it's not that foreign. If you don't have familiarity with SUDs, but you do know quite a bit about other chronic illnesses, you're not in completely foreign territory. Just as there is pre-diabetes, that stage where you haven't yet contracted the illness, there's the harmful use period that we saw in the earlier pyramid. The same kind of services are needed to prevent advancement to the next stage, to reduce the symptoms, and to restore function. If that doesn't work and the disease occurs, you get significant SUD, and then you clinically manage services. We'll talk about those in just a minute. The goal of those clinically managed services, regardless of whether you get those services in a residential program, an outpatient program, or where you get them, is to get you to the point, not that you're cured, because we don't yet have a cure for SUDs, like we don't have a cure for diabetes, or asthma, or hypertension either. The goal is to get you to the point where you can personally manage your illness with your own resources. I will skip over the next slide for the sake of time.

Let's talk about clinical management of SUDs in a manner that would comport with how you manage other kinds of chronic illnesses. In the clinical managed stage, the goals are very similar to those in management of other illnesses: reduce symptoms, improve function, educate patient and family about threats to relapse, engage the patient into continuing care. How do you do it? With combinations of individual family and group behavioral therapies, medications where appropriate, lots of regular monitoring, using urine screens or breathalyzers or both, to see what the nature of care is and whether it's working. The outcomes that are ideal are total elimination of substance use and active engagement into continued management.

You don't always get the ideal, but what you really want to avoid is a serious relapse, or an overdose, that requires emergency or residential treatment.

Let's talk about patient self-management. This is where people who are in recovery maintain their recovery. In the interest of time, the goal there is to bring patients who have been stabilized to reduce their substance use or gotten eliminated, to continue their medications if they need it, to continue monitoring, to get involved with Alcoholics Anonymous (AA) or Narcotics Anonymous, Rational Recovery or some other form of continuing care. Get available peer assistance services. The ideal goal is the maintenance of your reduced substance use or your abstinence, as well as improved personal function and social function. Again, that doesn't always happen. An intermediate kind of an outcome is when there's a lapse and the patient agrees to it, and he agrees to increase the severity of his clinical monitoring and management. That's an intermediate outcome, but the one you really want to avoid, again, is a serious relapse or an overdose that occasions re-hospitalization.

An ideal clinical flow across the stages of care is illustrated here. First, you get emotionally and physically stabilized, usually in a hospital or residential setting; you get monitored and managed in some kind of treatment program or by a competent clinical team; and you gradually transition into personal management with your family and recovering associates.

If that doesn't work, an intermediate outcome is that you catch relapses early and intensify care.

The thing you want to avoid most of all is a relapse going undetected and becoming so severe that it leads to having to start all over.

The last slide illustrates that, like other chronic illnesses, prevention is important for people at risk who have not yet started to show signs of any harmful use; early interventions for people who you can detect very easily in any clinical setting and they're using too much for their health; and treatment for patients who have advanced.

I think I've covered all the summary points, so I won't go on and will stop there.

SF: Thank you so much, Dr. McLellan, for your overview and the information that you provided.

Now we'd like to turn for the opportunity for some question and discussion. As we make the segue to that, we do have one polling question for everyone participating in the webinar that we do ask you to complete. The polling question is:

Which of the following levels of care comprising the SUD care continuum does your state cover?

You can select all of those that do apply to your state. If we could please have you take a moment to complete this polling question, again, we are looking at withdrawal management, outpatient, intensive outpatient, partial hospitalization, residential, intensive inpatient, and, then, whether you are not sure what is covered.

We can see here, based on the respondents, thank you very much for responding to this polling question, that we have a range of different services covered within the care continuum, with an emphasis on outpatient, as well as residential, treatment; some withdrawal management; and some across the board of some level of those services in the care continuum.

In terms of discussion, we would encourage you all to submit questions through the chat feature. We will also have the opportunity to unmute and do some group discussion as well. As some of those questions come through, Tom, we do have one that I would like to turn to you.

If you could talk a bit about some of these successful strategies that Medicaid programs, health systems, can use to transition from treating SUD with an acute care model to moving to treating it as a chronic care model? What are some of the successful strategies that you have seen that you can recommend?

TM: One of the more effective payment strategies has been the bundling of payments and giving increased payments to facilities that have the entire continuum of care. Most states and most treatment programs in the United States (about 13,000 of them) have only one modality of care; they may be outpatient, but not residential; they may not be able to provide detox; they may be residential, but don't have any outpatient. If a patient is supposed to move through the transition, it's neither at the financial advantage of a program nor is it in the fiscal capability of a program to transfer a patient. That's not good care. So, payment systems that preferentially reward organizations that have put that kind of care continuum together and have a seamless transition, are programs that spend their money a lot more wisely and have better outcomes.

SF: Thank you so much. We do have one question that I wanted to turn to next from a participant, which is a clarification question as you're talking about an approach to a treatment system.

Are you suggesting that the current treatment system be done away with and that the entire system move towards integration within primary care, or are you talking about both of those existing within the continuum of care?

TM: I'm going to dodge that question. I will say this. There's a lot of research that indicates clearly that addiction is like most other chronic illnesses; it has a genetic component, a behavioral component, people with serious chronic illnesses usually also have other physical and, often, psychiatric illness. You would not want to wait until a person has full-blown diabetes before you made any kind of service available; it wouldn't be financially or clinically smart. Second, you wouldn't want to treat that diabetic patient without the ability to address their psychiatric or medical co-current problems. Third, you would want to assure that there were staff available there who knew all the kinds of treatment components that were known to be effective and as the patient begins care, adjust the care to meet the specific needs of the patient. That is called personalized medicine in the rest of healthcare. I think you can see how I think things are going to go.

What I want to be clear about, because I'm not saying all addiction treatment programs are bad or wrong. It's not their fault. They have been set up decades ago, before all this was known, but I do think the system is ultimately going to transition to a place where better specialty care treatment programs become part of, affiliated in many different kinds of ways, with the rest of healthcare. I think it is best for the patients and best for the economy.

SF: Thank you very much for offering up your perspective on how to think about the future of SUD and the care continuum.

We do need to transition, so I would like to move on to our second presenter. I would like to introduce Dr. Kimberly Johnson.

Kimberly Johnson (KJ): Thanks. I am going to start with a response to the question Tom thought he was dodging, but I don't think he really was.

If you think about how we treat diabetes, what we do really well is the medical aspect. If a physician can't manage a diabetic patient's diabetes, he will send that person to a specialist; if I can't manage my patient's diabetes, I'll send him to an endocrinologist who is a specialist who knows more about it than I do. I think that is the response to your question; there are generalists and there are specialists and the system as we have it now has only specialists and we haven't engaged generalists, so it is really hard to do prevention and early intervention because it is not part of the medical lexicon.

One other thing I will say what we don't do well in diabetes care, or in the care of any chronic disease, is address the social determinant of those diseases. We have historically done a slightly better job in the treatment of SUDs with that, but, as both Suzanne and Tom were saying, the structure of how the system has been designed has made it hard to do that in a fully supportive way. If our system is designed in this episodic or acute care model, then you can't really treat a chronic disease, so it only works for the people for whom the disease isn't necessarily chronic. I am saying, "we have," because my notes say "historically," but I don't think it is the past yet; I think our system really still functions very much this way.

A lot of our mental model has moved, but we haven't necessarily moved how we do treatment, how the system functions, and part of that is the issue of how reimbursement is done. Programs do what they get paid for and our historic reimbursement structures paid them for what they are doing, and that's why we're talking to you.

I am going to talk a little bit about recovery-oriented systems of care because it's not exactly the same as a chronic disease model, but it's a parallel. This is where we add the social determinants and how you address the aspects of an illness that are not necessarily medical in nature. I am going to read something here: "The definition of recovery-oriented systems of care is based on recovery as a self-directed process of change that integrates a multi system, person-centered approach that includes a comprehensive menu of coordinated services and support tailored to an individual's recovery stage needs and chosen recovery path." That is a little jargony.

I just, literally, this morning got back from Africa and it was interesting seeing the contrast and the similarities. I met with a group of mostly men, and one woman, who were actually at an HIV testing site, but they mostly had SUDs as well. When we asked them what they needed, what they said was sober housing. That kind of took us aback because we were thinking about methadone treatment, and they said they needed that too, but what we need is a safe place to live where we are not confronted with drugs all the time. It was so interesting to me how similar that was to what happens in the U.S.; that those social issues, like housing, your social network, your friends, your family, all of that, plays into how severe your SUD is, how well you can maintain your recovery, and whether you even get into treatment or not.

When we say recovery-oriented system of care we're really talking about a whole approach. Whether we are talking about the levels of care, the ACM levels of care model, or whether we talk about Tom's model of early intervention treatment for people that are at different stages, what we're saying is that for people who actually need some level of treatment we need to take a recovery approach and look at the whole person and those social determinants.

One aspect of a recovery-oriented system of care is recovery support services. My slide here says non-clinical services, but I think what we are saying is services provided by people who don't have clinical training per se; not medical staff, social workers or family therapists. Not always, but often people who are in recovery themselves, but with this experience. It should be available at all stages of recovery, starting from very early on when someone identifies or gets identified as having a SUD, through the process of their treatment and recovery.

What does recovery support services even mean? It could be a lot of different things. There are a lot of different words here. What is aftercare services? That depends on the program you went to and if we really have a chronic care or disease management kind of approach, then aftercare doesn't even mean anything. Those services that help a person with those social issues, whether it's finding sober housing, creating a social network, engaging family, or getting other kinds of healthcare services like mental health services, making those linkages. I have highlighted a couple here.

Employment is a huge issue for people with behavioral health, both mental illness and SUDs; it's a huge issue for many people. It gives meaning to people's lives and the employment ends up being something that is a very important recovery support for many people who have severe SUDs. While Medicaid may not purchase employment services, recovery support services can provide linkages to those kinds of services. That's also true with housing support and sober housing. A Medicaid recovery support worker can provide linkages to those kinds of service, help fill out forms, guide people through the frequently complex systems to access those kinds of services.

I want to make a couple of points here about where services are available. A lot of those kinds of recovery supports are provided by peer support workers, as I mentioned. In 29 states, Medicaid does reimburse for mental health workers to provide peer supports that are very similar to the kinds of things we're talking about for SUDs in a recovery oriented system of care. At this point, Medicaid only covers peer support for SUDs in 14 states; same services, just different diagnoses. I don't know if they cover those kinds of services for diabetes, but they should because for people who are very severe and unmanaged, there are probably social determinants that are related to their inability to manage it. We are not talking about diabetes today.

Here is the other point. In 36 states, there are certification programs for peer support workers in the SUD arena. There is a credentialing process that would make people eligible to provide those services, so there is a standardization of peer support that could be used by Medicaid the same way that they use it for mental health. Forty-two states have peers working in the treatment system, but funded by other resources like the block grant.

Moving forward and thinking about how we treat SUDs in the way that Tom described, that is very different in terms of how we think of the model of care, is very important. We need to remember that what Tom calls self-management, which people in recovery would call recovery, that whole process is critically important to care and we need to add that to the array of services that are funded. We all need to work together to do that.

I will turn it back to Suzanne.

SF: Dr. Kim Johnson, thank you so much for the information you provided.

We are now going to move to question and answer period. Again, to start that off while you all formulate your questions and submit them through the chat function, we do have another polling question that we ask that you respond to.

Is your state currently reimbursing any of the following recovery support services? You can select all that apply. If you all could take a moment, please, to respond to if your state is currently covering any of these recovery support services that have been highlighted so far during this webinar.

It is important to note as we think about inclusion of these recovery support services in a continuum of care that Medicaid may not be able to cover all of these services listed. For example, Medicaid does not cover room and board, does not offer rental subsidies, but Medicaid can cover certain aspects such as housing-related activities and services under certain Medicaid authorities they have. Medicaid can coordinate services, either specifically braiding or blending funding with other resources and certainly working to ensure their system is coordinated across the various support services that could be available.

We can see here in terms of the response, a range of recovery support services that are being funded, including peer support, peer management, case management, and various other types of supports. The predominant respondents are not certain of the range of services and supports that are being covered in the state.

In terms of questions, just to start us off, could you please offer up recommendations and best practices states may consider when thinking about how to ensure outcomes for individuals who are receiving recovery support services? What are some strategies that states can use related to understanding the outcomes and tracking the outcomes?

KJ: I think we should skip back to one of Dr. McLellan's slides around the outcomes for self management. Those are the kinds of things we need to be looking at; this is just part of a package. If you think about what are the outcomes that you are trying to assess? Whether the person uses again or not is something that can be measured in a number of different environments: the doctor's office or the recovery support program, if it was a program. That would be one thing. You would want to measure "what are the outcomes you are trying to achieve with the recovery support?" Is it stable living environment, a stable family relationship, or a stable work or school activity? If you're talking about measurements, those are the kinds of outcomes. It is both the lack of relapse and whatever the individual needs in terms of stability in their life in order to maintain recovery.

SF: Thank you. A question that we've received from participants has to do with making a business case to funders, policy makers and others, regarding the inclusion of recovery supports within a continuum of care, whether it is specific to SUD peer supports or the other supports that we've been highlighting today. Can you talk a bit about any recommended approach, inclusion of certain outcome studies or information as people go about building that business case to policy makers?

KJ: There is a little bit of research, though I don't know that it's necessarily cost benefit research at this point. The research is still looking at outcomes. I think if you look at, actually on the mental health side, there is more literature about improved outcomes and cost effectiveness, and I would just draw from that because it is already being reimbursed in more states than not, so there is evidence there, in your own state potentially, whether it's working or not. Although I know this is heresy, I think if you can talk about SUD as another behavioral disorder or another mental illness and that we are already treating a whole

bunch of them this way and it's working, I think you can make the same argument. The research on SUDs specifically is still a little scant.

SF: Kim, when you think about the inclusion of recovery support services in a continuum of care, we do have a participant asking how they should be positioned within a continuum. Are recovery support services only meant for those who are actively engaged in a treatment approach? Have they been used effectively with persons who may be more in a pre-contemplative stage, an early stage, of change in the recovery process?

KJ: I think the idea is, and the next group is going to talk about this a little bit, to think about how you can use strictly peer supports throughout the whole process. For example, there was one study where peer support workers were placed in a hospital setting and they were engaging people who had overdosed; people that may have been pre-contemplative an hour ago and may be contemplating now or not. Engaging people at that moment of crisis to try to get them to go into treatment services, you can see how you could use that model and that peer support model, the recovery support model, even from the beginning stages of trying to engage people in care. You have to think about it as part of the whole continuum and how can you use that model and those services at various points throughout the whole continuum. To get to one other part of that question, I think there are people who may not "go to treatment," and I say that in quotes, because we have a weird definition of treatment, where what we really need is counseling, either in a residential setting or an outpatient setting, we always say treatment and mean counseling. People may not engage in counseling and still benefit from recovery support.

SF: Thank you, Kim. That was very helpful.

We'd like to turn to a question for the audience, the participants on the webinar, and you can respond by unmuting your line by hitting star seven. For states that are wanting to implement recovery support services, for states that have implemented recovery support services, what were some of the biggest obstacles in doing this for the Medicaid population and what lessons did you learn that can be helpful to other colleagues that are on this call with us today?

If you could please unmute your line by hitting star seven, we would very much like to hear from states here on the phone that are navigating these issues and have navigated them, so we can hear the lessons learned that you've had.

We have a shy group today. I do have somebody who's offered up a question via the chat function, kind of specific to this issue of trying to navigate the obstacles that are not just financial, but that also have to do with the issues around how to navigate and engage health plan partners, managed care partners, in this process as well. I open this question to any of our presenters.

I know we haven't heard from Miss Beverly Haberle yet, but Kim, Tom or Beverly, what strategies or recommendations would you have related to the engagement of the health plan partners in this process as well?

Beverly Haberle (BH): I can speak a little bit about engaging at the emergency room level and also at the private practitioner level, private physician practices and such. I think that for us, it's really having a conversation with the emergency room doctors that we've worked with. We have certainly been able to demonstrate how we can be helpful and how we can help really engage some of the people that they see quite often and really make a difference. I think it's that creating the one win that really begins the process

of getting more integrated within that facility. We started out earlier trying to work with the administrators, and I think it's the social workers or the physicians who are the ones who really get it and then lobby or really be your best allies in helping to integrate. We have had some great success with nurses within physician groups being able to really be supportive of us being a part of their services.

TM: I'll just add this. Historically, in many states, there are the same old problems incorporating recovery support services, which I completely agree with Kim, are a vital part of a continuum. You will spend a lot of clinical dollars and if you don't have proper recovery support you will have wasted them. The barriers have been financing restrictions and training restrictions; sort of guild issues about who is allowed to give what kind of service and what the proper coding is for that service and by whom, and with what level of training. Peer recovery support services are often quite different than clinical support services and those have been the problems. The creative, sensible city and state governments have been able to overcome them, but those have been the problems.

KJ: This is an arena where Medicaid is actually the leader in terms of payors, so community support workers are funded in many systems, and community health navigators, but there are other kinds of employees within the healthcare infrastructure that are reimbursed to do similar work and I think that's the thing to look at within your system, who does that kind of work and who does the linkages; who does the case management and hand holding and walking people through processes and engagement. There are probably titles that are reimbursable within your structure already. That's the other way to look at it; what are we already paying for and how does this kind of work fit into that.

SF: Thank you to all three of our presenters for responding to that audience question. That is a great segue to Miss Beverly Haberle from Pennsylvania, who will be presenting next. Beverly, I would like to hand it over to you please.

BH: Thank you and good afternoon, everybody. I'd like to start off by giving you a little bit of context of who the organization is that I work for. It is the Council of Southeast Pennsylvania, which has a 41-year-old history in community mobilizing and prevention, intervention, and recovery support services. We provide the services throughout the five counties of southeast Pennsylvania, which is the largest population density in the state of Pennsylvania. Nineteen years ago, the council founded PRO-ACT, which is a grassroots initiative that provides advocacy in peer-to-peer recovery support services. Through our PRO-ACT project, we provide a wide range of peer recovery support services, some within the five recovery community centers that we have throughout the five county area and others in facilities within the community in other ways connected with specific target populations that we provide the services to. We provide an average of about 2,500 individuals with services every month through our PRO-ACT project.

Pennsylvania, to also add to the context, is one of the states that provide peer services through the mental health system as an in-plan service. It is also approved to provide supplemental services for SUDs through Medicaid reimbursement, Medicare reimbursement. As of April 2016, services are provided in 27 different counties and we have 570 certified recovery support service workers who are providers of those services. There is a separate certification program for both mental health and substance use people. Mental health certification is provided through the training providers and the SUD certified recovery specialist is provided through a Pennsylvania certification board. Both services include services to individuals with co-occurring disorders.

The recovery support services differ in many ways from clinical treatment services and it certainly comes from a strength-based service as opposed to a deficit perspective in helping individuals initiate, stabilize

and sustain recovery. The questions that we have already dealt with around when to initiate recovery support services, we believe they are the non-clinical services that remove barriers and help people through the entire continuum of recovery, and that's before, during, after and, sometimes, in lieu of clinical treatment. There are a lot of examples of where that can be appropriate. Many of the people that we see are people who see themselves as clinical treatment failures or 12-step failures. One of the things that is very beneficial is being able to step back and work with people from a multiple pathway to recovery perspective and letting them see that there are many other things that they might want to try. Sometimes they will try them and begin their recovery journey only to access other, more traditional services, at another time.

The peer based recovery support services really is based on people with experience in support and engagement. They also provide hope and role model healthy recovery. One of the things that happens many times with our recovery support specialists is someone that they may know in the community who will say, "Wow, if you can do it, maybe I can too." The foundation of this kind of work is their own experience and how they are able to role model.

We provide practical problem solving options for people, and its options; it's not telling people what to do; it's helping them to problem solve for themselves and learning problem solving skills. Coaching, advocating, linking to resources, and helping people access and grow their recovery capital, sort of the strengths that they already have, helping them really expand some of them or tap in to ones that they didn't know they had that they can use as tools to support long-term recovery management. We use recovery pooling for everybody that we work with, all the services stepping in to develop their own recovery plan.

There are 10 different domains that the recovery plan covers. Some of them, from getting a job, and you've heard the importance of fulfilling that. There are some struggles in some of the work that we do in getting a job because people within the recovery community have heard concerns like, how do I explain that I've been missing in action for many years, or I don't have an email address and I have to provide applications on line. The domains really help act as a road map for people to look at where they want to go and then develop the needs and supports and resources they need to get there. There are some case management functions up front in helping people get connected to resources and advocacy as an immediate, short term, or transitional service. Many times there are those roadblocks keeping people from being able to access the services they need and the recovery support specialist will help walk them through and overcome some of those barriers as they move on in their journey.

We provide services to a wide variety of specific target populations. We have had pregnant women's programs, people who need DDD supports, Latinos and African Americans in recovery, and there are many people who have, as well as all of their other issues: a lot of financial and budgeting literacy problems, so helping provide some support in a group or individual budget planning; smoking cessation; an array of health-related programs that are provided; record expunging; and support for individuals with co-occurring disorders.

There are also some specific projects or programs and supports for the LGBT population. I wanted to just emphasize the programs and services within the range of recovery support services can meet the needs of individuals within specific populations; some of those needs are addressed individually and some within groups.

There are some essential elements within recovery support services. One thing we talk about is this being a relational service and developing and engaging that relationship and making sure that it's a good match and people are really engaged in providing services that are helpful for someone because they can identify or relate to that individual. The relationship, many times, we guide people through the entire continuum of service. We will see people in pre-treatment and going through the various stages of treatment that Tom was talking about, and also back out in the community and into many other functions in their lives. The ongoing planning and goal development can change as the relationship continues, so people in early recovery may have one set of goals and as they grow their recovery, they may have many other aspirations or needs that they didn't know. Many times healthcare issues will come up during their addiction that they weren't aware of, and as they get into their recovery, a lot of the health things become more prominent and they need help navigating that.

Ongoing recovery checkups are held to review recovery plans, celebrate progress, and adjust to accommodate new ideas and support that growing in recovery.

I also mentioned the multiple pathways to recovery. Just learning about that from people who have been multiple times in treatment and have a great deal of family guilt and feel like such failures to find out that, maybe, something else may help them. If they aren't quite a good fit in 12-step programs, there are other kinds of programs, mutual support programs that might be helpful to them.

Also, they need the skill building opportunities. Many times, people have had long learning gaps, depending on when they started their addiction, so things that the rest of society expects someone may know how to do, many of our folks don't know how to do. Providing opportunities for them to learn the skills that they somehow bypassed can be really helpful in helping them sustain their recovery.

In Pennsylvania we established peer based recovery support services. Usually, it's reimbursed through Medicaid. It starts out as a reinvestment grant. Pennsylvania is a commonwealth; most things happen at the county level, so a county will initiate a plan that they want to have this role. Pennsylvania is also is Managed Care/Medicaid, and so within that, each county will have a collective MCO so it's a relationship, when they are reinvesting dollars, they will develop plans in order for the programs to be initiated. Once they are initiated, the process to become reimbursable will begin, so most times the reinvestment plans are 18 months to two years to get the program up and running and, within that time, be able to get it reimbursed. Within the areas we serve right now, Medicaid reimbursement is available in two counties and we have two other of the five counties that are in the start-up phases through reinvestment.

One of the things we have learned that's very important is reaching out with a lot of other community organizations and institutions. They have not been able to figure out how to be able to provide all of the services through the reimbursement that you get through Medicaid. Being able to have all of these other resources available is very helpful.

There are some challenges and lessons learned as we have been doing this. The support needs to be very individualized; this isn't a kind of cookie cutter program. We meet people where they're at. We've had people in the pre-engagement stage, sometimes we are able to move people who have overdosed through; not through the engagement stage, but really help them move further along in their recovery journey.

The other thing is that this really benefits providers as whole when we can engage as early as possible with the individual; this is not an aftercare program. Sometimes we are asked to really help make sure

that people continue from one level of treatment to the other and if we haven't had a relationship with the person, it's really hard to step in and do that. Through a relationship, we're able to make sure people stay with their plans and also get the kinds of services and follow through with prescriptions and all of the other things that many times are the fall-downs for people who need support for their recovery.

Combining experience plus structure:
This is an important piece. There are certain structures around developing recovery plans, assessing recovery capital, and really providing skill-building in conjunction with all of that for those who are struggling. It can be a real important missing piece. I am always shocked at the things that one would assume someone knows and they don't and are too ashamed to tell you.

Providing an ongoing sense of supervision:
This is a role that really needs good supervision because it covers from pre-engagement all the way through. People are accessing or are entering treatment, are exiting treatment, and through the entire continuum, so good supervision is really important. Yes, it's not a clinical service and so it's anti-clinical supervision for this role, so the supervisor needs to be very aware of what the parameters of the role are. There is a high potential for burnout and people who are delivering this service have a great deal of passion, and self-care is very important. This is a process.

We have now worked with a number of providers in integrating these services in treatment centers and facilities and this is not what I call a "bug and flame" service. It is something that really needs to be planned for and looked at how this can be integrated throughout the service delivery system that's in that organization.

Thank you.

SF: Beverly, thank you so much for the information you provided to us about the implementation of peers in Pennsylvania. That was very helpful.

As we turn to some final questions, from audience participants through the chat function, we do have one more polling question that we'd like you to respond to.

"Which of the following statements accurately describes recovery support services?" Select all that apply.

So we are seeing from respondents, thank you so much, that recovery support services are really seen and perceived as impacting a variety of those factors or all of those factors, from initiating recovery all the way through stabilization.

We do have several questions that have come in and I know that we're near time.

Beverly, one specific question that has come through is, you had talked about some of the challenges, you had a great slide with the challenges and lessons learned, and you think about the strategies that helped you deal with those challenges and lessons learned. What are some of those specific strategies that you would want to elevate for people to be thinking about using?

BH: A couple of things that we have learned the hard way:

I mentioned the importance of supervision and the importance of the supervisor really understanding what this role is all about, and the challenges that are within the role, but also ongoing training and support for our certified recovery specialists. We do a once a week supervising with individuals and then we pull everyone together once a month in order to be able to help people really get supported by the other people delivering the same role, as well as expanding on training topics that someone is struggling with. We get an opportunity to do some case reviews and some time to learn other resources and things like that. That has been very helpful.

The other is having ongoing meetings with the referral sources and making sure everybody is clear what the role is. I mentioned that we are embedded in a couple of facilities and, with that embedding, making sure that everyone understands what this role is about.

Also, really having an open policy around ongoing correcting of things that may have gone wrong. In most healthcare it takes about three years to integrate new practices within the field and I think there is sometimes expectation that all of a sudden, it's going to be once and done; and this is not at all. There are things that come along as the program grows within organizations and within the counties and states and so being open to continually having dialogue around that and dealing with issues as they come up, we have found to be very helpful.

KF: Thank you. Also, Beverly, specific to what's happening in your state, are the concentrations of the peer recovery supports specific to urban locations? As indicated from this audience question, we have states that are rural, that have frontier, and trying to figure out what are some of the best ways to ensure this type of recovery support for both rural and frontier situations.

BH: I can speak to that in a number of ways. Across Pennsylvania, we certainly have some very rural areas, where this role is where we are doing some very positive work and is able to be implemented. Transportation and how you implement that work is certainly much more face-to-face in meeting people and patients where they can. Peers are much more mobile, so this is not something that's coming to the office, but in Southeast Pennsylvania we also have some very rural areas. Our staff, as I mentioned, are able to go to different locations. In one of the rural counties in the state, that I am aware of, actually covers three counties, they have people embedded in each of the hospitals and are able to engage people at that level and are able to follow them out into the community they go back to and provide the relationship there.

KJ: Suzanne, can I respond to that a little bit too?

SF: Please, Kim, go ahead.

KJ: Some of the things are easily delivered telephonically; many of these services can be done by phone. There has been research that recovery management check-ups can be done by phone. Before I came to this position, I was involved in research using mobile applications for recovery support, so that is another mechanism you can use. People are available by phone, but some of the services are actually automated. There are lots of different ways you can think about this.

SF: Thank you so much, Kim, for offering up that information as well. We do need to transition in terms of the webinar. With these webinars, we are able to offer an opportunity for those states who are interested, to potentially participate in a post-webinar discussion with the three speakers we've had today. This is an informal time to allow additional questions to be asked and to have discussion around

specific content. If you all would please indicate if you would be interested in being offered an opportunity for a post-webinar discussion to further pursue these specific items that were raised today.

We do see some varied interest in this. We do have a core group of the folks who are interested. Thank you very much for replying to that; that is something that we can pursue. Please do look for information about that opportunity.

As a wrap-up, there are a number of resources that we've identified and provided here that offer up additional information regarding recovery support services and the inclusion of those in a continuum of care and we will also have available to you the contact information for all of our presenters today for any questions you may have. To also let you know, the slides and a recording of this webinar will be posted and available to you following this webinar.

I want to thank Dr. Tom McLellan, Dr. Kim Johnson, and Miss Beverly Haberle, for their excellent presentations and sharing of information. Thank you all for participating in today's discussion.

As you exit the platform, you will see an evaluation. We ask that you please complete that evaluation that continues to inform these webinars and how we can make them effective. Thank you again for participating today.

[end of tape]