

IAP NDS Webinar

STRATEGIES FOR ENHANCING SUBSTANCE USE DISORDER WORKFORCE SKILLS

June 28, 2017

[Intro]

Tyler Sadwith (TS): Thank you and welcome to everyone joining us today. My name is Tyler Sadwith. I'm the project lead for the substance use disorder track of the Medicaid Innovation Accelerator Program. We're glad you could join us for this national webinar entitled Strategies for Enhancing Substance Use Disorder Workforce Skills.

Today's webinar is part of our effort to highlight what we've learned from working with states on SUD delivery system reforms under the Innovation Accelerator Program, or IAP for short. We know from our work in the IAP that as Medicaid agencies manage their SUD delivery systems, there's interest in aligning those systems with key benchmarks from the field and promoting evidence-based treatment in service provision.

The IAP is offering a series of webinars to provide information and highlight state approaches for implementing delivery systems in line with the full continuum of care and national criteria for addiction treatment published by the American Society of Addiction Medicine.

In April, IAP held a webinar where several authors from ASAM provided an overview of the levels of care and clinical standards outlined in the criteria, including the assessment framework used to identify the appropriate level of care for individuals with SUD. In May, IAP held a webinar where several states and leadership from SAMSA discussed strategies for assessing and developing provider and service capacity consistent with the national treatment guidelines and using those assessments as part of a larger provider network planning effort.

Today's webinar continues this dialog. Today, our speakers will discuss various approaches to developing the substance use disorder practitioner workforce, highlighting efforts that states and providers are undertaking to enhance clinical skill sets and competencies. The presenters will describe their approach for training providers to conduct assessments for patient placement and using those assessments to inform treatment planning. Our speakers will also describe various strategies for supporting providers to coordinate care and treatment for individuals receiving medication-assisted treatment.

Moving to our agenda:

- First, the state of California is partnering with a leading treatment provider to describe how they increased provider competencies using the ASAM patient needs assessment for country training efforts.
- The state of Missouri is also teaming up with a leading provider to share how they established training requirements and educational resources for counselors working with MAT clients to enhance care quality and to support plan treatment needs.
- Rhode Island will discuss statewide initiatives that expand SUD treatment access and provider competencies by establishing care coordination standards for working with clients receiving medication-assisted treatment.

We hope today's discussion is helpful to states interested in learning different approaches at the state, county, and provider level to enhance the substance use disorder treatment workforce as part of larger delivery system and provider planning efforts.

With that overview, I'd like to quickly introduce our speakers:

- Marlies Perez (MP), Division chief of the substance use disorder compliance division with the California Department of Healthcare Services. She oversees licensing and certification functions monitoring and compliance for narcotic treatment programs, outpatient, and residential providers.
- Vitka Eisen (VE) has over 24 years of experience in the human services field. Vitka has worked with the Walden House providing services to adolescents experiencing homelessness and substance use disorders for 20 years and was instrumental in a regional provider merger and rebranding. She currently serves as the chief executive officer for HealthRight 360.
- Mark Stringer (MS), director of the division of behavioral health within the Missouri Department of Mental Health, an integrated agency responsible for the treatment and recovery services for people with serious mental illness and substance use disorders. Prior to public service, Mark directed adult and adolescent addiction treatment programs, a psychiatric outpatient clinic, and an inpatient geriatric psychiatry unit. He's a licensed professional and nationally certified counselor with over 30 years of experiences.
- Cliff Johnson (CJ) has worked in the substance use treatment field for over 30 years. Cliff holds a degree in human services and is credentialed as a substance abuse counselor and compulsive gambling counselor. For the last 23 years, he has worked with Southeast Missouri behavioral health and currently serves as their director of clinical compliance and physician services.
- Rebecca Boss (RB) from Rhode Island serves as the acting director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. She has more than 20 years of experience working in the addiction treatment field as a clinical supervisor and program director. She has previously served as a state administrator for substance abuse treatment services, as a representative for NASADA, and as the state opioid treatment authority.
- Susan Stori (SS), administrator of the Rhode Island Opioid Treatment Program Health Home. Formerly, she led a research and practice initiative under NIDA and was the director for the Addiction Technology Transfer Center located at Brown University. Susan has been leading system change in the treatment of addictive disorders for over 25 years and is board certified as an advanced nurse executive and an advanced practice addiction registered nurse.
- Suzanne Fields, moderator for this webinar. Suzanne is a faculty member and senior advisor for Healthcare Policy and Financing at the University of Maryland. She 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, and managed care. Suzanne is a familiar voice on the IAP webinar series, having moderated several of our previous webinars.

SF: Thank you, Tyler. We know that there are many factors that support the delivery of effective and quality-driven substance use disorder treatment services. We know that ensuring a continuum of benefits across a range of services that are clearly defined, including prevention, treatment, and recovery are essential.

We also know that individual recipients seeking treatment need the right care at the right time and in order to facilitate obtaining the right care at the right time, there needs to be clarity about what their treatment needs are, an assessment of their treatment needs across multiple domains, certainly recognizing and understanding the implications of comorbid conditions, physical health, mental health, and substance use. The ability to assess and determine those needs is paramount.

Then, being able to use that information from an assessment and develop a meaningful treatment plan that reflects that full range of needs and issues that need to be supported and addressed. We also know that quality SUD services are really based upon being able to deliver evidence-based standards for services. That leveraging the latest knowledge from science and from practice is really key to effective care.

Finally, of course, creating a strategy with provider to deliver and execute and implement those services according to what we know from practice and from science is essential. Thus workforce development is a critical role for us as we development and as we implement services in the Medicaid continuum.

Provider competencies and skills and their ability to implement services requires partnerships across state agencies and provider organizations, as no one entity holds all of the pieces necessary to support skills and competencies in delivering care. But it's that shared partnership between state agencies and providers and provider organizations which allows bringing together different resources, bringing together different skills and knowledge, and really aligning those things that facilitates provider development.

Critical areas for the SUD workforce relate to assessing individual treatment needs. As we recognize the interrelatedness between a variety of conditions, we know that providers need to be able to identify a range of needs and development treatment plans that address those range of needs. Also, given the expanded use of medication-assisted therapy, states and providers have identified the need to address that particular benefit and the skills of providers within the Medicaid system. Both specific to providers who may be delivering MAT, but most importantly, for providers across the continuum delivering other benefits to understand how MAT fits in alongside other services that they themselves are offering.

Now, Marlies Perez and Vitka Eisen will share their experiences about California.

MP: Thank you so much. Here in California, we have developed our SUD 1115 waiver primarily around the ASAM criteria. The slides here show some of the services that we're providing. Just keep in mind that it's modeled after all the levels of care that the ASAM criteria identifies. Going through this process, we determined that we were going to be assessing beneficiaries to see what level of ASAM care that they needed. But we also needed to then see what level of care our providers could provide.

Right now, what we have done is we have created a designation for our residential facilities to designate if the facilities are providing services at 3.1, 3.3, and/or 3.5. What this slide shows is just some of our processes and designating of facilities.

As of about a month ago, we have received over 600 ASAM questionnaires. The residential facilities complete these questionnaires. They send it to us. We review it. We work with them. We talk back and forth and then the state designates that facilitate either one, two, or three of the level.

Here is some of the levels to date. You'll see here of all of these that we've received, the most that we have designated are in areas 3.1, which for California is our basic licensing requirements for residential facilities. You'll see we do not have as many facilities, but level 3.3 and then at 3.5 we have about half of the facilities compared to 3.1.

If you want information, we have all of this posted on our website and here's the link. All of our tools, you're more than welcome to utilize. Then, if you have any questions and more detailed questions, you can contact me directly and I can walk you through how we set this system up in California.

Moving forward with our waiver, we have each county that is participating in the waiver has to complete a challenge implementation plan. In this plan, they need to describe how they're going to be assessing those beneficiaries for not only medical necessity, but also for their ASAM placement. Then, how they're going to be training their providers and county staff as well.

So we have a lot of different variance. Some of the counties are doing regional assessments from centers. A lot of them are utilizing a form a brief ASAM screen and then they're going to be doing a full assessment at the provider level. Then, some of our counties are going to be utilizing the ASAM Continuum software.

What we really wanted to note in planning out the waiver is exactly how counties were going to use these different systems. We wanted to know not only for planning purposes, but also for training purposes. Here, you can see that there's a real variance in what counties are utilizing and it really depends on the county's experience, their prior experience with ASAM as well.

Then, we also surveyed them to see what type of technical assistance that they needed around the tool, but what we really saw was a lot of counties wanted that short 15-minute brief assessment. So we worked with the University of California Los Angeles and they created for us an ASAM short assessment tool. We worked with multiple stakeholders. We had one county that had been using a brief screening tool for 10 years. UCLA tested the fidelity of all those different tools. We really wanted the tool to be something with minimal staff time to complete. We also wanted to be optional in case counties already had a tool that met the requirements and wanted it to be free to use. When these assessments are being done, these are available services.

We are currently in the final stages of our testing and we will be having this tool rolled out. You can see the link here. You're all more than welcome to utilize this tool is this is something you're interested in. If you need more information, we can provide that as well.

We also really wanted to ensure that provides that were utilizing the ASAM were trained properly. We have basic training requirements that are listed in our waiver. We also provided state support to counties. As of last week, we have provided 100 ASAM trainings statewide. We've been rolling out the trainings based on the rollout of our waiver and we still have more trainings to come. Once again, the trainings that the state are offering are free and then we also offer free technical assistance.

With that, I'm going to turn it over to Vitka Eisen, who's going to give you more information about training and then the provider perspective with ASAM and the workforce.

VE: We really think about realigning our system of care according to the ASAM patient placement criteria. It's really strengthening and improving treatment across the state. That's a provider perspective. One of the things that it does is that aligning the system supports individualized treatment planning. The way historically treatment would often work in the state is county by county and a length of stay might have been determined based upon what a funder was willing to cover, as opposed to matched entirely to a participant's need. For an example, if drug court would send a participant to your program and the drug court might say I'd like to see this person get treatment for six months. So you would design a course of care that meant six months, but it didn't necessarily have to do with what the clinician assessment of care would demand.

So I think a court using the ASAM patient treatment criteria allows us to do a more uniform assessment across the state that allows us to tailor treatment to the needs of the person rather than to the needs of what funding allows for. The training really helps match the dosage to the need of the participant.

The other thing is that the training on deploying the ASAM screening tools really helps to build a whole-person care focus into treatment because the ASAM patient placement criteria assesses our patients or participants along six dimensions that includes readiness, health, and other kinds of risks and supportive environment. It really allows us to look much more closely at what patients' needs are and to really design treatment that is addressing what we all know to be a biopsychosocial condition.

We believe that this is ultimately going to result in improved outcomes because we're not just treating the use of a particular substance. We're actually treating all the conditions around that that improve people's care. That is one of the advantages and one of the ways that we're going to be lifting the system of care in the state.

There's a lot of training opportunities as Marlies talked about. To make the training convenient and easy to access, California is a big state with 58 counties, there are two modules of e-learning available. Those are about four hours each. One is an introduction to ASAM patient placement criteria. The other one is about care coordination and moving clients through systems of care. The trainings are good. The developer of the ASAM patient placement criteria, Dr. Dave Mee-Lee, did some scenario work within the training.

In addition to that, there are two-day face-to-face live all-day trainings available to providers. Beyond that, the state contracted with another training entity that provides individual consultation as needed.

Those trainings are available by using the ASAM tool, but they have other trainings available so that the system of care is better able to deliver care and organized delivery systems. Counties are also offering additional supports and trainings through regular provider meetings. Many of the counties that are implementing the waiver are having monthly meetings and those meetings are informational. They also take feedback, they provide training in those meetings. They're able to assess training needs. One of the more interesting things that the counties that are implementing the waiver are doing is that they're matching up providers together that have different strengths and they're forming essentially learning collaboratives. So some providers may have greater skills in certain areas and may be

developing some kinds of trainings and protocols and they're really encouraging some kind of cross sharing and cross training in that regard. That, in general, helps to lift the system of care.

SF: There are two things we're going to turn to now. We're going to have an opportunity for Q&A with Marlies and Vitka. While people have an opportunity to formulate and submit their questions, there is one polling question that we would like to survey for all participants, which is displayed here. Some of the information may not be coming out fully so I'm going to read through that.

Is your state providing any of the following supports to provider regarding patient assessment, treatment planning, or standards of care?

- Educational materials, such as guides and tip sheets;
- In-person training;
- Online training;
- Targeting technical assistance;
- Other supports;
- No supports offered.

Take a moment to complete that particular polling question. We can share that with the group and then use that as the basis for further discussion. As we can see, there's actually a lot of different activities happening across the state. We have a high percentage using various educational guides. A lot of focus on trainings, so in-person and online, with some incorporation of targeted technical assistance also.

In terms of questions that we have, first I'd like Marlies and then Vitka to share your perspectives.

But Marlies, as you begin to think about what you could share with your colleagues from other states, what specific tips would you offer them as other states consider creating provider skill enhancement trainings and focusing on the standards of care systematically as you all have done in California?

MP: Well, I would recommend to offer multiple trainings. Some of the level of detail we didn't get too far into, but when we provide ASAM training, we have different types of training. Some of them are geared more for clinical staff and then we also have administrative ASAM training. We require all of our counties to also be trained, as well as providers. They're going to have different needs in the sense of the different skills and ways they're going to be using the ASAM.

Also, while we have provided a lot of state training, I really encourage you to have them provide local training. Especially with ASAM, it's not a training where you do a one or two-day training and you're done. There really needs to be ongoing training, follow-up with ASAM. It's bound to be very helpful to have someone to check back in, a resource. That is really important.

I highly recommend that you train your internal state staff on how these work. We've done a lot of ASAM training at the state level, which is really important since your team will be interacting with providers and counties about this material.

SF: *Vitka, what would you add as recommendations to your colleagues cross the country about supporting training?*

VE: We operate in several counties. We've gotten to see different counties begin to implement the waiver and I do think, to the degree that counties involve and engage the provider network, it really is helpful both for the counties and it enhances the skills and abilities of the other providers. So for example, our organization developed some follow-on trainings to the trainings that the state has offered and the counties have offered. Then, we made those trainings available to the county and to the network of providers in our communities and it's a great way to keep in communication with the county.

I've seen LA begin to encourage that as well, that each provider begins to figure out ways to implement really a big change to a system. Each provider's coming up with new ideas, they're sharing them with the county, the counties are sharing them with the state. I would encourage the counties to really support that. Again, if one provider's come up with a great idea on how to do something, let's really spread that across the system as quickly as possible.

SF: As we reflect on where there are challenges in SUD treatment delivery systems, it often comes to the issues around transition between and across providers, whether that's within SUD treatment itself, so across providers delivering different levels of care, or certainly in coordination with providers that may be delivering complementary treatment.

Has there been some of the specialized or more focused attention on those issues around transitions and warm handoffs in California? How did you message and begin to address that particular need in your delivery system?

MP: Care transitions are really important, obviously, within the SUD part of the continuum of care. One way that we've addressed that at the state level, that's something the counties have to talk to the state about through their implementation plan. That's something we're reviewing, really seeing how those transitions happen. Since our counties all vary in sizes, each system does look a little bit different, but a lot of our counties are adopting more unified tools that they're using between providers' unified — like one treatment plan that all of the providers are using, as one example.

But they are also really concerned about care transitions into our physical health and mental health services as well. Once again, that's really county-specific, whether or not they're having an EHR that they're all using or if it's more that they're at the beginning steps and how they're sharing information to really ensure those warm handoffs.

VE: Again, if you look at aligning a system according to the ASAM criteria, the degree to which you are exploring on each of the dimensions encourages providers, and I believe the waiver itself encourages providers, to include linkages to a warmer handoff to primary care. That would also include a better connection between behavioral intervention-focused substance use disorder treatment providers and MAT providers because MAT is provided through primary care systems.

Using the assessment tool and because the design of the waiver itself really pushes providers to really have a whole-person care perspective, it encourages providers to really look to primary care partners or MAT partners if they're not direct providers themselves.

SF: As I was listening to both of you and how you've been focusing on that particular issue, I think it does also speak to the change that providers across the system are having to focus on. We're wondering and there are some questions coming in.

How did you go about in California supporting or incenting providers to engage different, whether it was to engage in need-specific trainings around the content or whether it was to reflect and engage in terms of collaborating across benefits or services in your system?

MP: For us, when we were initially designing our waiver, we met with our stakeholders. We actually had nine different meetings with them and what was great was this was the easiest topic. Everybody agreed that we needed to utilize ASAM criteria. So we had a lot of buy-off right from the beginning and so it's really an easy sell for those folks that weren't participating in those initial meetings. There was a lot of folks that experienced ASAM or knew of it.

But I think what is interesting is while it's the easiest sell, it's really probably going to be the most fundamental changes in our waiver. Because it really changes how care is given to our clients. We also are recognizing it's going to take a lot of time to implement, like I mentioned about the training. This is fundamentally going to shift how our services are delivered.

Of course with incentivizing, folks really wanted to participate in the waiver, so that was great. We really tried to make our training free, accessible. We've really been trying to listen to what our counties and providers needed and that's why we worked with UCLA to create this screening. We've been providing them with a lot of information. Then, of course, it is a requirement to participate in the 1115. So it is mandatory and so folks who want to participate in the waiver, they are going to have to use the ASAM.

VE: Our organization is active in the state provider associations. As a provider association, we talked to our other providers in the state and said if you're not a part of this, you may not be here at some point. That's kind of a perverse incentive, but it's a reality-based incentive. As a system, as more and more people that we serve are on Medicaid, on MediCal in California, and as the system begins to implement the waiver, that is what the system of care is going to look like. If you don't participate in that process, if you don't participate in the trainings, if you don't begin join learning collaboratives, if you don't work closely with your counties, potentially there is not a way for clients to come to your — you will not be serving your clients in the future. That is something that we in the provider community have tried to communicate in ways I think it's hard for the state to say. But I think other providers can say to our colleagues either you join this now and you participate in shaping it and if not, you may not be able to serve your clients in the future.

SF: There's one other question that I'd like to turn to and seeing a theme in some of the questions being submitted. It's participants really wanting to understand in California your focus is very much on ASAM — ASAM criteria, ASAM standards of care not being implemented by all of the providers in the system because perhaps they're delivering complementary services that are not within that ASAM framework. They may be doing other kind of complementary care.

Speak a bit more and revisit some of what you said, but perhaps this is our opportunity to hear a little bit deeper about kind of helping providers across that continuum understand how the benefits may be changing and how they're interfaced with certain services that need to evolve?

MP: Well, ASAM really creates the skeleton for our waiver. Like you mentioned, it doesn't touch on everything that we're providing. One example that is really important — because I know we work a lot us in the SUD field with the justice-involved population. One thing we've struggled with in California is judges sentencing folks based on what they feel that they want them to have, often residential. This is going to be a really interesting challenge and as we've rolled out our waiver and it's already been cropping up in some of our counties, it's no. We

have to utilize the ASAM. So we've really been working closely also with our partners with the court and, once again, showing them this is why it's so important. It's not just placement and I think that is what has been a critical message too. It's those six dimensions and those services that folks are receiving.

We're also adding into our waiver case management services, recovery services. There are tenets of both of those. As you review the ASAM criteria, there's also great sections about co-occurring and then, of course, working with youth. So there's a lot of these pieces that are really typically that really blend over into our other modalities that we're offering in our 1115 waiver. It also has been really great in working the counties with the managed care plans for physical health purposes. Because they have really been learning about ASAM as well and it's been a really great tool because the ASAM comes at addiction from a health perspective and it's something that they can relate to that we've been working with the medical directors of all the managed care plans, been speaking about this as well.

It really creates a neat opportunity to bridge with our other partners. ASAM _____ [00:37:43] can sometimes be that first step in and then really talking more about all of our services that we're offering under the continuum of care. It's something for the SUD field. We really don't have, unfortunately, a lot of tools that are really evidence-based and ASAM is one of them so we've really relied on that. Like I said, it's been really great, especially with our justice-involved and our courts to begin those discussions and how to make those changes that we've had issues with for a long time.

SF: Marlies and Vitka, thank you so much for sharing your work in California. We appreciate you taking the time to answer questions and we will have further time for questions at the end following our next presenter. I'm assuming that some of our themes may circle back to your efforts.

Now, I'd like to turn us to hearing about the work in Missouri with Mark Stringer and Cliff Johnson.

MS: Thank you. We're just going to talk briefly about our experience in adopting medication-assisted treatment in all of our publicly funded programs in Missouri. We were among the first states in the country to do that and so we'll talk about what transpired at the state level, at the provider level, and at the individual clinician level to make that possible.

The first slide is just the elements of addiction treatment. Again, we adopted medication-assisted treatment early. We still talk about medication-assisted treatment. I think there will come a day when we drop that language just because medications will be increasingly common in all addiction programs in the future and they'll simply be a part of addiction treatment.

Just going back to 2006, we, as a state, were awarded a Robert Wood Johnson Advancing Recovery Grant. It was a small grant, but it was our first effort to adopt medication-assisted treatment. To do that, we solicited some provider volunteers. I think our initial cohort was about 10. In order for them to begin using medications, though, we had to amend provider contracts, and I would be glad to send that contract language to anybody who's interested. But we amended contracts to include reimbursement for medications, for physician services, labs, and so on.

There were some other milestones here, but in 2008, we starting have change leader conference polls that were very helpful to our original cohort and then again expanded out to the other providers.

CJ: We have a slide coming up on those calls and the provider calls were for us to discuss as we were implementing medication-assisted treatment some of the things that we were running into as far as recruiting physicians and then how staff was or was not embracing medications. When we get to that slide, I'll comment further about some of the barriers that we faced and how we worked through those barriers.

MS: That's a really good point. In Missouri, early on, probably about 2009, began communicating with our providers that there would come a time when their certification and contracting with the state would require that they offer or be able to positively arrange for medication-assisted treatment so that this was going to become part of the fabric of our treatment system.

We're fortunate in Missouri in that we've got a very strong provider association and my department of mental health has an excellent relationship with our contracted providers. We simply said this is the evidence-based practice. This is what we have to do. This will save lives. Providers, for the most part, were on board. This organization was one of the first and best, but others came along. Now, any program you go to in Missouri, if you are a candidate for medication-assisted treatment, you will be able to get it there.

In 2010, another milestone. Missouri began credentialing for medication-assisted treatment specialty and that specialty could be earned by any type of clinician, doctors, nurses, counselors.

CF: The Missouri credentialing board put together, using national information from the ICRC and other entities, to establish a medication-assisted recovery specialist credential, a low-cost credential. We wanted to make it available and reachable for all disciplines. It involves in-person and online work by the person receiving the credential, but what it does is helps you prepare your staff so that they understand the medication. Like I said, it helps also some of the barriers that I'm going to talk about later. It helps them understand medication, its use, and that it's not switching somebody off a drug onto another drug, because that's one of the things we hear.

Most of our staff, I would say 60 to 70% of our clinical staff, that work with our clients have the MARS credential. We've invested our staff time into getting it. That's how valuable we feel that credential was for our staff to get so they understand this path to recovery.

Now, I'll let Mark finish these milestones and then we'll talk a little bit more about our agency's efforts in getting physicians and some of the issues that we faced there and how that came about. Then, like I said, I'll talk about the changes in our calls.

MS: I want to follow up on one point that Cliff made. We still, even in Missouri here, reference to switching from one drug to another drug. When people talk about medication-assisted treatment, we don't hear it often, but it's still around and people who believe that just need to get over it because that's not what the evidence says. In our experience here and in the literature, people who are on medication-assisted treatment along with more traditional therapies do really well.

Again, we made offering medication-assisted treatment a condition of certification by the state. We amended contracts to make it possible for providers to do it. All the FDA-approved medications are on the Medicaid formulary. So that's available. Then, we have a clinical utilization review process in which we not only monitor providers' lengths of stay, and so on, but provide some consultation. That was one of the tools we used to begin to switch our model from what was traditional acute care, kind of a 30-day model, fixed length of stay, to what it is now and what it is in Cliff's agency, for example, where care is truly individualized and people don't go some place for 28 days or whatever. It's completely variable, depending upon client needs.

CJ: Here's the slide on the changed leader conference calls. One thing I wanted to add for what Mark said about the milestones, part of the milestones is, yes, Medicaid is a supporting funding source for medication-assisted treatment. However, as we all know, there's a population of our clients that are uninsured and the Department of Mental Health in Missouri was very proactive in supplying for funding to help pay for the medications, doctors' appointments, lab results for the insured clients. So we were fortunate as a provider and all providers to have that funding available for our uninsured clients also.

So when a client came in, we didn't have to just focus on the individual that had some type of insurance coverage, such as Medicare or third-party payer or self-pay. The uninsured client had access so we were able to truly treat all clients that came in, especially now with the opioid crisis, that any client that shows up at our door can have access to medication-assisted treatment.

When the calls were initially held and we started medication-assisted treatment, the barriers that I definitely want to touch on are our staff — it wasn't like we started the medication and everything went smoothly, it was great. We went from in three years zero doctors to 15 doctors now that we have that we work with and either through agreements — we don't employ any of them so we have agreements with doctors in the community, and I'll talk about that in a slide. But one of the things that we ran into with our staff was they wanted to set up medication-assisted treatment programs. That's not what we want. Suzanne mentioned at the beginning about individualized treatment planning and person-centered treatment planning.

That still applies. Medication is just another option for our clients, just as if a client's going to go to AA and NA or faith-based support groups or during drug court. It's just another path to recovery, but sometimes our staff would set up a barrier. They would use medication as a carrot. If you come in to your 10 hours of group a week, see your nurse, and see your care coordinator, or whatever, then we'll look at medication. Well, that's absolutely not what we're about. Medication is available. It's not a carrot nor is it a punishment if you don't show up for treatment. Medication is an option that's available and it's not used for clients to earn when they come into treatment. It took us a while to get through that and we had low staff that would sometimes set up things that we had to intervene on because we're a rural provider. We have 20 locations. So we're spread out throughout southeast Missouri.

One of my areas is physician services. So I've set up the agreements with the physicians to provide this. I monitor how we're disseminating this information and how we're setting up our programming. That and educating the staff on how we're going to present this information to clients as an option. Really, we haven't run into barriers with the clients. It's more with staff. We had a nurse that wanted to put into effect that a client had to be clean for 30 days before they could be introduced to Vivitrol or naltrexone. It's things like that providers need to be aware of when they're introducing MAT into their treatment milieu.

Then, the Department of Mental Health, I don't want to say mandated, but they emphasized that MAT is going to be a path to recovery for all the providers. These _____ [00:51:26] recalls really helped and assisted us into sharing how it was going between providers and how we could help each other with ideas and working through barriers and finding physicians.

MS: Throughout this process, the state also provided a variety of training opportunities, technical assistance. We had some assistance from some of the pharmaceutical companies, which was actually very good quality assistance. We offered as much as we could to make this transition as sure as possible and something that would stick.

CF: This slide talk about the medication-assisted recovery specialist, the components of that training, as you see there. Forty hours. There's an overview of the medication. There's self-study modules. It's pretty intense training and you do have to make a commitment with your staff to allow them the time to complete it and we made that commitment, but it's made a great deal of help for our staff to understand medication and how it helps in treatment.

MS: We think there are opportunities, particularly in partnership with the state Medicaid director, to encourage the use of medication-assisted treatment. But at all levels, you have to have champions. Got to have a champion at the state level. I was fortunate in that my staff just very quickly got on board with this effort and set a great example. We had champions here. We have champions like Cliff in the field who talks in meetings with other providers about barriers and how in rural Missouri, he found 15 physicians to help prescribe medication-assisted treatment. That kind of provider testimony is just invaluable.

CF: I would like to add to that in the rural settings, what we had to do was look at three different things. We looked at three ways to get the medication to our clientele.

- We have local physicians, where the clients will go to the physician's office in the community and get their medication;
- We have physicians that come on site and prescribe the medication. Then, they may connect with our sites by telehealth;
- We have physicians that only connect to us by telehealth from some other location.

So telehealth has been key to bringing this medication and also psychiatric care to our rural locations. We have telehealth connectivity to all but two locations in our rural setting. So only two locations and they can get to some of our other locations together medication-assisted treatment. That's the commitment we had to make to get this medication and get this service to all of our sites. The physicians, in approaching them, some of them get waived and they only want to help a few clients. When I approached them, you'll hear from them, "I don't want an office full of 'those people' with my regular patients."

So I take it slow with them. I say, "Well, how many will you see? We'll provide the treatment if you'll provide the medication." Then, what they usually find out is their waiting rooms are already full of "those people." So they find out that they need to expand and see more of our clients. Then, we also have a funding source for the uninsured that may be seeing that are getting addicted to their opiates.

Then, we have some that are very eager to provide medication-assisted treatment. Those, of course, we can get set up and start the service immediately. It's ran the gambit [sic] as far as how I've elicited these services from these physicians. But the big key is getting them to do telehealth and taking that service to our other offices by telehealth, which has brought all of

our sites together, prevented the client from having to drive great distances, and kind of brought up a one-stop shop for them.

MS: I believe this is our last slide. We've talked some of the challenges, but, of course, everybody on this phone call knows that nationwide, we have a shortage of behavioral health clinicians in all disciplines. It's just becoming more critical all the time. There's that. There are the issues that Cliff talked about. There's the problem of relatively low reimbursement rates for substance use disorder treatment. Of course, always threats of budget shortfalls.

Despite all that, I've really been proud of our provider system. I would feel good about referring a family member. In fact, I have referred family members to some of our programs, and with great confidence.

CF: We're definitely willing to answer any questions from the provider or from the department's standpoint of how we got this going and what we're facing. The opioid crisis, we're trying now to treat the emergent client. We want to be able to have clients walk in and get immediate assistance from a physician instead of waiting. That's one thing we've started in the last month at our location. If an opioid-using client walks in, we will have them seen usually within a couple of hours to start on Suboxone so that we can — what we saw is great results because they're engaged and they're more likely — they've been coming back and staying in treatment.

SF: That's a great segue because we do want to open up for questions right now. While we give folks a moment to formulate and submit their questions, I do want to turn up to another polling question to help guide our discussion.

For which service delivery areas is your state providing provider skill enhancement strategy?

- Patient needs assessment, including use of standardized assessments such as an ASAM;
- Treatment planning, including transforming patient need assessment information into treatment planning itself;
- Medication-assisted therapy prescribing issues and needs;
- Handling care transitions and warm handoff;
- Other types of issues.

I'll give folks an opportunity to select all that apply here. What we can see a range of different issues and quite a bit of things happening, including a focus on needs assessment, treatment planning, specifics around medication-assisted therapy, and then a warm handoff in most care transitions.

Cliff and Mark, we have several questions coming in and I think first I want to turn to some of the last things you said, which you started to talk a bit about the needs of providers and some of those specifics around the provider trainings themselves.

You had briefly mentioned that, but I think this would be a good opportunity to elaborate further on:

- How you went about developing those trainings;
- How you consulted and involved providers in the development of that content;
- How you aligned that with what you've talked about in terms of expectations, leveraging contracts, authorization review, those other expectations in your system.

MP: We started with this RWJ Advancing Recovery Grant. It wasn't a lot of money. It was, like, \$250,000, I think. We solicited some provider volunteers and what we did was apply this walk-through process where all of these providers and us walked through to see what the barriers were to medication-assisted treatment, what the problems were, and so on. Also to identify then training needs and based upon those needs, there was some training that we, as a state agency, can provide. There was training that other providers could provide. Then, we also got assistance from some of the pharmaceutical companies. In all those ways, we have been able to get out and reach clinicians.

CF: I would add the pharmaceutical companies, you may think, well, they're just going to come in and push their product. That wasn't usually the case. We with the Suboxone rep and the Vivitrol reps that we have, they were very good informative trainings that we had to explain the medications, how they worked. So those helped greatly and we still have those folks come in and do in-services when we have staff turnover, new nurses that need to understand that medication and its effects on the system and the cross-effects with other medications, that type of thing.

Then, internally, we have physicians that have done trainings, pharmacists that have come in and done trainings locally. Some of it sell to the providers to make sure your staff is ready.

SF: Thank you. That's very helpful. One other question.

You mentioned leveraging telehealth. Can you talk about how you use telehealth as it relates to medication-assisted therapy? Do you use a hub and spoke approach? What's your approach in Missouri around that?

CF: For us, from the provider standpoint, we had to set up almost a virtual clinic. So we had to have medical staff coordinators, not the nurses. We had coordinators that worked with the client and with the doctor going from one site to the other. They may see two at one site, get off that system, be logged into another system at another location. That medical staff coordinator is making sure the doctor has all the information they need for that appointment. Then, when there's the prescriptions and all that, that's handled by the nurse. So the medical staff coordinators make sure that the nurses get all the information they need, the scripts and everything. They'll track some challenges that need to be done, any of the Suboxone initiations, all that. That's all done by the nurse on site.

One of the questions I saw was is that the nurse? Yes. The nurses are available at each location where the clinics are being done. It's almost daily now that we're doing telehealth and it takes a lot of work. It's neat having telehealth, but the system and implementing a system internally, it was a major challenge to set up a system where you go from site to site and keep everybody happy, because every doctor is different. Every doctor wants something different and this one wants his vitals before. This one wants labs before. They will want something different and it's up to our staff to make sure they have that. There's usually a medical staff coordinator in discussion with the client, making sure the doctor has everything.

SF: Thank you very much, Cliff and Mark for responding to those questions. I want to do a time check and move to our next presenter for Rhode Island. Again, Mark and Cliff, thank you so much for sharing Missouri's experience. Now, I'd like to hand it over to Rebecca and Susan.

RB: Good afternoon and thank you for giving us the opportunity to present. Rhode Island, like Missouri, has had medication-assisted treatment for a very long time. We've got a long history with it. While the rest of the country is experiencing a new opioid epidemic, I have to say that

Rhode Island has had an issue with heroin for a very long time. So a lot of our efforts in terms of workforce development and program expansion have to do with enhancing the services that have been provided at our opioid treatment programs and increasing the access to medication-assisted treatment.

One of the things that we took a look at when it was available was using actual Health Homes, which were available through the Affordable Care Act Section 2703 as an opportunity to enhance the services that individuals receiving medication-assisted treatment and our OTPs were able to get. What it really allowed us to do was capture and enhance Medicaid match of 9010 to provide Health Home services and opioid treatment programs that expanded who was eligible and who were the eligible providers for Health Home services.

It asked you to provide the six services that are identified below, which was:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support;
- Referral to community and support services.

We really felt that our OTP providers were ideally suited to be able to provide that. What we knew about our individuals who were receiving medication-assisted treatment was:

- They generally presented with multiple co-morbidities.
- They had fairly inconsistent care coordination efforts with poor connections to primary care and attending appointments.
- Oftentimes, feared the stigma that would be associated with their being on medication-assisted treatment in primary care settings.

We looked at the opioid treatment providers as natural allies in providing the kind of care coordination that we were looking for, which allowed them to build upon those relationships that are already established in clinical settings with medical professionals and to use the existing resources to increase their access to and benefit from primary care and other specialty care settings, as well as all the other pieces of the Health Home, which included things like:

- Tobacco cessation;
- Wellness promotion;
- Engaging in exercise;
- Monitoring chronic conditions.

Those things are what we have worked with our providers to do.

The state engaged in a process with our providers, which transpired over the course of about 18 months and looking at how we wanted to develop this Health Home systems in our opioid treatment programs. We started with a small group and then we brought in other experts as we needed from:

- The Medicaid office;
- Our Department of Health;
- The provider community;

- The physician community;
- The consumers themselves.

We engaged with consumer surveys and focus groups to look at:

- What is your experience with healthcare?
- Would you benefit from these kinds of services if they were offered at your opioid treatment program?
- How well do you access dental care?
- How well are you able to follow through with plans for care from these kinds of physicians and specialty providers?

From that, we gained at least the perspective that this would be a beneficial program and we brought in folks from the Health Information Exchange to talk about how we could best use data on our Health Information Exchange, how we could work with the hospitals, and we worked with our Medicaid office. So as we met, we continued to bring in different people. How can we best use meaningful use and use of the data information?

Then, we established this implementation advisory committee, which included a number of people. That advisory committee really devised the plan to create the Health Homes, which were defining the services that would be provided and defining the population who was going to be served. Really, what we did was we took a look at the state plan amendment required by CMS to create the Health Homes and used a projector and sat down at a table together and figured out what kind of Health Home program do we want? We actually created the application for that together.

Rhode Island had the experience of having Health Homes for its population with serious mental illness for the two years prior and we were able to really learn from our experiences there and create the kind of opportunities to fill in the gaps that we recognized from that program itself. So what we did was created three positions that were not state positions, but rather funded through the Health Homes in a coordinated effort across the state, to bring an administrative coordinator.

The administrative coordinator's purpose was really to:

- Bring the programs together;
- Create consistency in the Health Home delivery service;
- Really expand and monitor the progress of the Health Homes themselves and how they were delivering the service;
- To provide the access to technical assistance and to recognize the needs;
- To act as a liaison with the state as well in developing the kind of resources needed to be able to provide the services for patients participating in the Health Home.

We brought in a training coordinator across the state to look at what are the training needs for individuals who are going to be providing services in these Health Homes across the spectrum and all the different disciplines that are required because it's really a cross-discipline effort when we're looking at nurses. We're teaching them about substance use and the clinical aspects of substance use treatment that they might not be able to understand and the kind of recovery resources that are needed if we're working with clinicians. It's more of a medical focus. How do we interface with the medical community and what are the things that we need to be thinking about in helping patients really implement their care plan?

Finally, we looked at an HIT coordinator and consultant, which ended up being — turning that into bringing a combined resource together to host a platform to look at our outcomes. Because part of the Health Home system is the ability to monitor the program on outcomes. We created a Web-based platform where all of our outcomes, including Medicaid spend, hospitalization rates, and all the other things that we need to look at are put in together in a common platform for all the OTPs to share.

The implementation of this program began in October of 2013 and it was an auto-assignment. So people that were already in opioid treatment programs were considered to be in and then have the opportunity to opt out of Health Home programs. We gave them information and they signed forms and there was a rollout prior to it beginning, talking about what are the benefits of participating in a Health Home. Each participant was able to look at whether or not this was something they thought would benefit them or not.

We made referrals and we were able to receive referrals from different sources for the program, including hospitals, and getting out there and doing word of mouth and spreading the message about the opportunity for people to participate in Health Home services. We looked at the ability to engage participants who decided, yes, we want to participate in this, but then, as time went on, by show of action, decided that they didn't really want to. So we have a disenrollment process if individuals, after 90 days, aren't participating in Health Home services. Attempts have been made to reengage them in those services.

So we rolled it out October 2013, probably not necessarily the wisest thing to do before January 1st of 2014 when the Affordable Care Act had Medicaid expansion available and we had about 2,000 newly eligible Medicaid recipients, not all of whom wanted MAT, but some of whom did. Then, our program grew exponentially in January of 2014.

So at this point, I'm going to hand it over to Sue Storti, who can talk about some of the efforts that we had to move the program forward from them.

SS: Thank you. As Rebecca mentioned, we started the program just prior to the implementation of ACA. At that point in time, we were in the process of actually developing our team for each of the OTP clinics and those teams were comprised of:

- Physicians;
- Nurses;
- A full-time Health Home team coordinator;
- A small percentage of the time, a pharmacist;
- Two case managers, one who was specific to a role of a hospital liaison.

Unfortunately, in January, as you know, we were actually in the very beginning stages of the implementation. In addition to building all of these teams and trying to assess what their training needs were, we were also dealing with this substantial increase in the number of patients that were actually entering into the system.

So one of the ways that we identified that we might be able to not only utilize the expertise of the team members, get a handle on what type of training that they needed, but also to assist the OTP leadership in terms of who else needed to be hired to be able to deliver the service. I overlaid a stratification or a patient acuity model onto the entire population and basically divided it into three levels of care.

Really, the purpose for that is truly we wanted to be able to deliver the services that each patient needed in the best way and most cost-effective way that we could. I will tell you that as a result of overlaying the patient acuity levels, we really were and continue to tailor the services to each individual. So those individuals that would be identified at a level one were really those patients who:

- May have been involved in MAT for an extended period of time;
- Were stable;
- Had a very good support system at home;
- Had maybe already linked up with a primary healthcare provider;
- Wanted to be enrolled in the program, but it wasn't really "Please, don't make me come and meet you every single week for an hour because I don't need that level of care."

Our level two patients are those individuals who are just coming into treatment and/or have relapsed and may need much more supportive services.

Level three were those patients that:

- Have chronic conditions;
- Are stable;
- We've been able to link up with a specialist for the delivery of care.

However, if those individuals were to develop a crisis situation, we would move them down to a level two and provide them with the level of service that they need until they restabilize.

Over the course of time, what this acuity level model has done is helped the team members to work with the patients to move them to a place of self-sufficiency and self-care. So among each of the levels, there is a particular focus. Well, as we started to implement this patient acuity model, what we recognized is that we really needed to develop a course out of training, and those are the trainings that you see outlined on this particular slide.

As time has gone on, we continue to provide these trainings on a consistent basis for any new staff that enter into the Health Home program. In addition to that, what I found was that onsite technical assistance was extremely important. Six months into the program, we went out and we did mock audits to ensure that there was consistency across all of the clinics.

Throughout the implementation process, we had weekly meetings with the OTP leadership and the OTP Health Home team coordinators. During those meetings, we developed standardized guidelines, policies, procedures, et cetera.

We also do a lot of consultation and training to the community providers and one of the things that we have found to be most helpful is we had developed a very basic Health Home Resource Guide for all of our case managers. We found that there was a lot of duplicative work that was going on. That has really since grown and is being utilized by many members of the community at this point.

The most successful part of our implementation is the fact that we actually have 22 Health Home teams that provide services to more than 2,600 patients. We have the first _____ [01:19:48] accredited OTP Health Home in the U.S. We continue to provide statewide educational consultation to primary healthcare providers as well as other types of entities in the community.

Some of the lessons that learned from our implementation process is that

- Rearranging memorandums of understanding are incredibly important because the entire system throughout the state was hit with such a large number of patients. It became increasingly difficult to get appointments within FQHCs and other primary healthcare settings;
- Standardizing the forms and policies and guidance documents really was key as time went on;
- Monitoring the reporting systems and the outcomes for payment and payment tracking;
- In terms of the team building activities, that was one of the key areas that became incredibly important. When you have four and five disciplines working together all educated very differently coming together to provide services, it can be challenging.

RB: In response to the overdose epidemic, which Rhode Island has experienced as well despite having had a heroin problem for a very long time, the governor convened an overdose prevention taskforce and four strategic goals have been identified.

One of them was increased access to medication-assisted treatment, primarily buprenorphine and Vivitrol, which have been underused in this state, and methadone's been around for a long time.

What we did was created centers of excellence, which are places that people are able to get access rapidly to Vivitrol or buprenorphine and if it's an opioid treatment program, also methadone. Our centers of excellence actually started in our opioid treatment programs and increased their ability to provide buprenorphine and Vivitrol to patients for whom that was the appropriate medication and allowed them to use the work that has been developed as part of developing Health Homes to support those individuals. We developed procedures, guidelines, and certification standards. The key is that people need to be able to be admitted within 24 to 72 hours of referral. A level one is 24 hours.

These are just kind of things that you can take back, but we have recovery coaches as part of the center of excellence teams and the idea is that individuals are really looking to be stabilized in centers of excellence, which other people might call a hub. They get inducted on medication, whatever medication is appropriate, and when they're stabilized and able, they would be referred out into the community with primary care providers continuing either Vivitrol or buprenorphine, if those are the medications, with the continued support of the recovery supports, of the Health Home supports or the clinical supports of the center of excellence if it's appropriate for the patient and that's what they choose.

And, really, building up the capacity in the community to help them understand these centers of excellence are there for you. They're a hub. If and when individuals relapse, they can be rapidly readmitted if they need more enhanced care. What it does is establishes an enhanced rate of Medicaid for the centers of excellence to provide these services to people. We also have private insurers who are paying for the services at centers of excellence as well. So it's not just a Medicaid product.

What we've done has been to really build up the data waived physicians in the community because we know that in some other models where hub and spoke have been used, there have not been enough spokes, really, to refer people how to once they've been stabilized and don't need that kind of intensive treatment anymore. So Rhode Island has done a lot of work

to increase the number of data waived trainings. We have provided — I think we've doubled the number of data waived physicians that we have in the state.

One of the very interesting things that we have done is to work with our local medical schools. So Brown University is really the first school in the country that's offering data waiver in its medical school so that all medical students who graduate are able to be data waived upon completion.

So a lot of work has been done. We have provided what's known as half and half trainings. Our chief medical officer does four hours of in-person training followed by four hours of online Web-based training. It helps people to get their data waiver without having to dedicate a whole day of training. We find it easier to work with physicians in that regard.

We currently have five center of excellence sites across the state and we have a couple of hospital-based centers of excellence that are coming on, one level one. So we'll have the ability to get people into medication-assisted treatment if appropriate within 24 hours. We're really looking at connecting people post-overdose if they're in the emergency department and using some of our recovery coach outreach programs in the streets and the hotspots to help people access treatment. We really find that you need to be able to help people when they're in need and want of treatment. We if wait and we make people wait too long, then you're going to miss that opportunity.

So centers of excellence and the work that we've been doing around getting people access to treatment is really focused on providing:

- That access to care;
- The appropriate level of care;
- The appropriate medication;
- Making sure all options are available to the providers and to the patients who are looking for the care.

That's really what the work has been focused on. With that, I will end. Thank you.

SF: Rebecca and Susan, thank you so much. That was a lot of information just about the depth of work in Rhode Island. We do have a couple of questions for you.

Given that your effort was really leveraging your Health Home providers, how did you go about supporting the knowledge base or even training community providers working with your OTP Health Home?

SS: What we actually have done is members of the OTP leadership as well as the OTP Health Home team, such as the physicians and nurses, have gone out and done face-to-face community type of liaison work. We have provided training through our Department of Health. We have done grand rounds. We looked for every opportunity conceivable to work closely with the community providers. We also have the ability to provide consultation services. So if there is a physician in the community who is treating a patient and they are uncertain what to do, our physicians are more than happy to serve in that role.

We have also linked up with the American Academy of Addiction Psychiatry, whose national office is based here and also provides a lot of consultation services. Again, we look for all opportunities and expertise and as requests come in, we then defer to the appropriate individual to assist us in educating the community providers.

SF: Thank you very much, Rebecca and Susan. That was just a wealth of information and, obviously, based on the questions coming in, we could continue the discussion with all three states. But unfortunately, we're near the end of our time.

Clearly, I think what we've received from this discussion is just a rich set of issues that have been addressed through your various efforts, kind of specific to promoting quality substance use treatment, but also most interestingly included was the various mechanisms you went through to achieve that, from standards of care definitions to a kind of specific focus on medication-assisted treatment through collaborative efforts with Health Homes. You've all used these various mechanisms to support quality care and partnership.

Finally, just the expansiveness or diversity of the partnerships that you did and what was needed to bring about further support to providers delivering quality services. So thank you very much for that richness of information.

Participants, the slides will be available to you, but here, we also did provide all of the contact information for all of our speakers should you have any additional questions. They would certainly welcome sharing that information with you. Thank you very much for joining us today for this National Dissemination webinar.

At the conclusion of this, you will be receiving an evaluation form. We would welcome your feedback so that we can continue to provide information to you to support you in your work. Again, thank you all for joining us today and thank you to all of our presenters.

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