CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid Innovation Accelerator Program (IAP)

Strategies for Enhancing Substance Use Disorder (SUD) Treatment Workforce Skills

National Dissemination Webinar Series

June 28, 2017

3:30pm - 5:00pm EDT

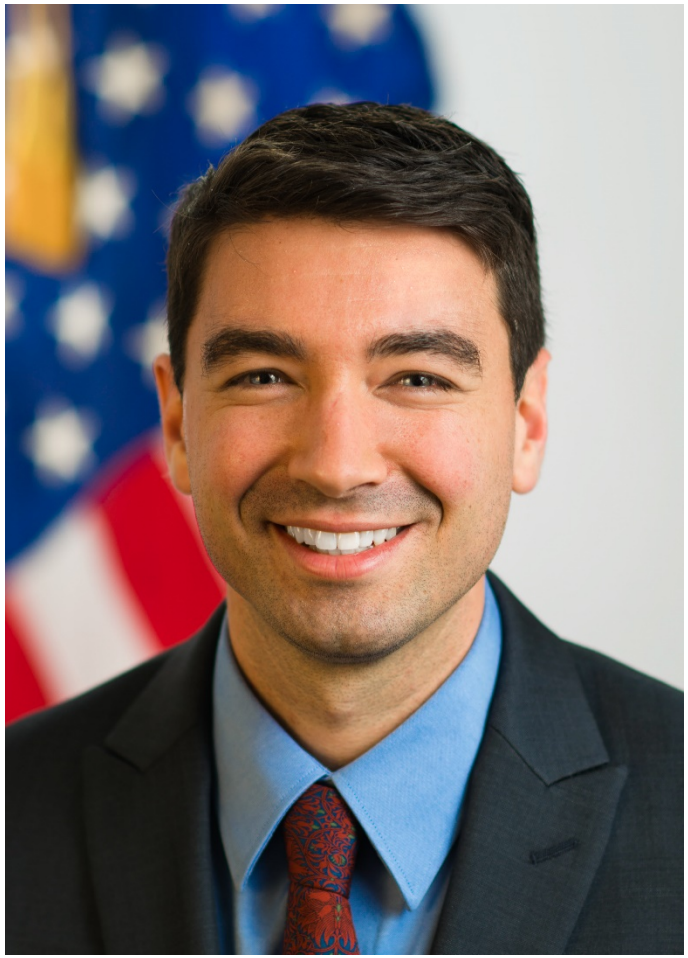
IAP Medicaid Innovation Accelerator Program

Logistics

- Please note that all participant lines are muted
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in “full screen” mode
  - Please also exit out of “full screen” mode to participate in polling questions
- When spreadsheets are shared “full screen” mode is recommended
- Moderated Q&A will be held periodically throughout the webinar
  - Please submit your questions via the chat box
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Welcome & Overview

- **Tyler Sadwith**
- Medicaid Innovation Accelerator Program SUD Lead, Health Insurance Specialist, Disabled & Elderly Health Programs Group, CMS



Purpose & Learning Objectives

- Identifying strategies to enhance the SUD treatment workforce
- Understanding the role of states & providers in workforce development
- Discuss efforts to support providers' efforts to assessing client needs & developing treatment plans
- Describe innovative approaches to support providers in the delivery of Medication-Assisted Treatment (MAT)

Agenda

- Overview of Provider Development Strategies
- State Experience: California
  - *Discussion Break*
- State Experience: Missouri
  - *Discussion Break*
- State Experience: Rhode Island
  - *Discussion Break*
- Wrap Up & Resources

Speaker (1/6)

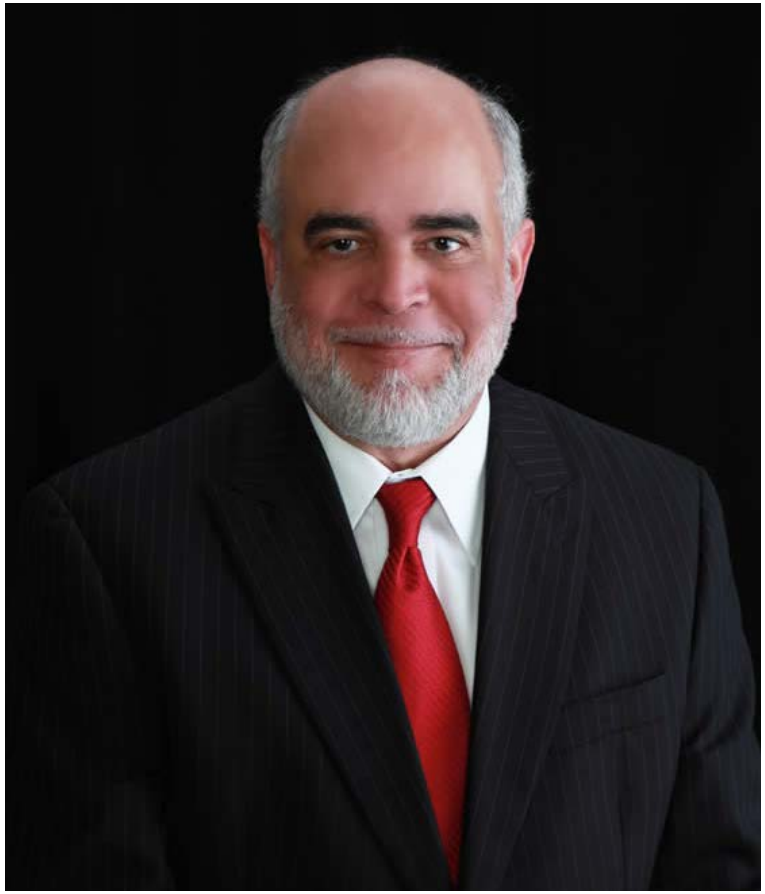
- **Marlies Perez, MA**
- Division Chief
  - Substance Use Disorder Compliance Division, California Department of Health Care Services

Speaker (2/6)

- **Vitka Eisen, EdD, MSW**
- Chief Executive Officer
  - HealthRIGHT360

Speaker (3/6)

- **Mark Stringer**
- Director
  - Missouri Department of Mental Health



Speaker (4/6)

- **Clif Johnson, CRAADC**
- Director of Clinical Compliance & Physician Services
  - Southeast Missouri Behavioral Health

Speaker (5/6)

- **Rebecca Boss, MA**
- Director
  - Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

Speaker (6/6)

- Susan Storti, PhD, RN, NEA-BC, CARN-AP
- Administrator of the Opioid Treatment Program Health Home
  - The Substance Use & Mental Health Leadership Council of Rhode Island

SUMHLC
The Substance Use and Mental Health Leadership Council of RI

Moderator

- **Suzanne Fields, MSW**
- Senior Advisor for Health Care Policy & Financing, University of Maryland

UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

Overview of Workforce Development Strategies

Suzanne Fields, MSW

Senior Advisor for Health Care Policy & Financing

University of Maryland

Delivering Substance Use Disorder (SUD) Treatment

- Several factors support quality SUD treatment
  - Ensuring the continuum of prevention, treatment & recovery supports
  - Assuring individuals seeking treatment:
    - Are appropriately diagnosed
    - Have their needs assessed (across all domains)
    - Are involved in developing a treatment plan that reflects their needs & is actionable
  - Developing evidence-based standards for services
  - Creating a strategy for providers to understand & meet these standards

Delivering SUD Treatment

- Workforce development plays a critical role in delivering quality services.
- States & providers should partner in their workforce development effort.
- Possible workforce development activities include:
  - Having clear information regarding expectations for services delivery (e.g. provider manuals, contracts)
  - Offering educational opportunities to understand provider standards
  - Developing strategies to review provider's efforts to meet standards or other expectations

Critical Areas for SUD Workforce Development

Assessing Individual Treatment Needs

- Skill development related to conducting multidimensional patient assessment
- Translating patient needs assessments into individualized treatment plans

Supporting MAT

- Developing provider competencies for counseling, care coordination, & managing patients receiving MAT

State Experience: California

Marlies Perez, MA

Division Chief, Substance Use Disorder Compliance Division, California Department of Health Care Services

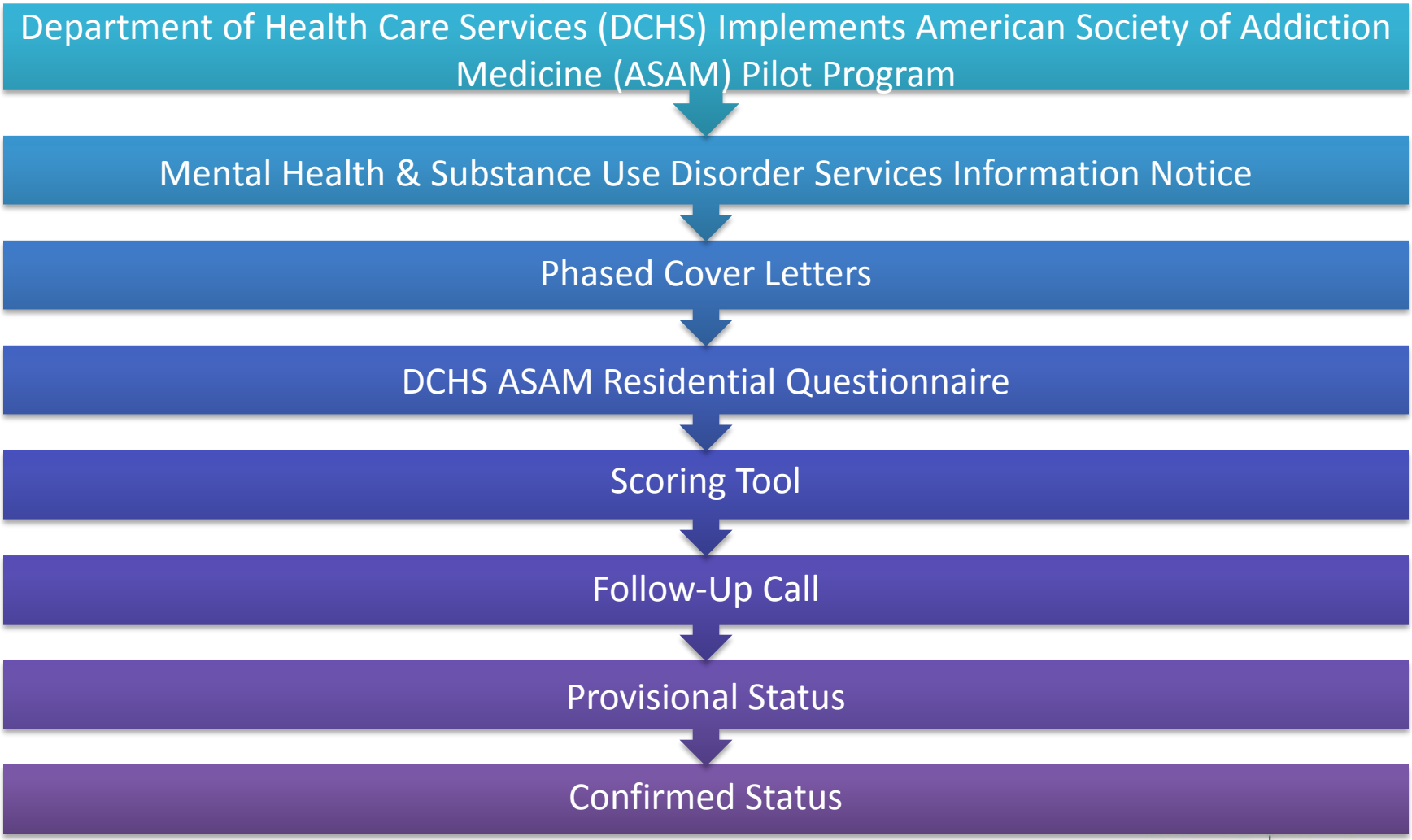
Vitka Eisen, EdD, MSW

Chief Executive Office, HealthRIGHT360

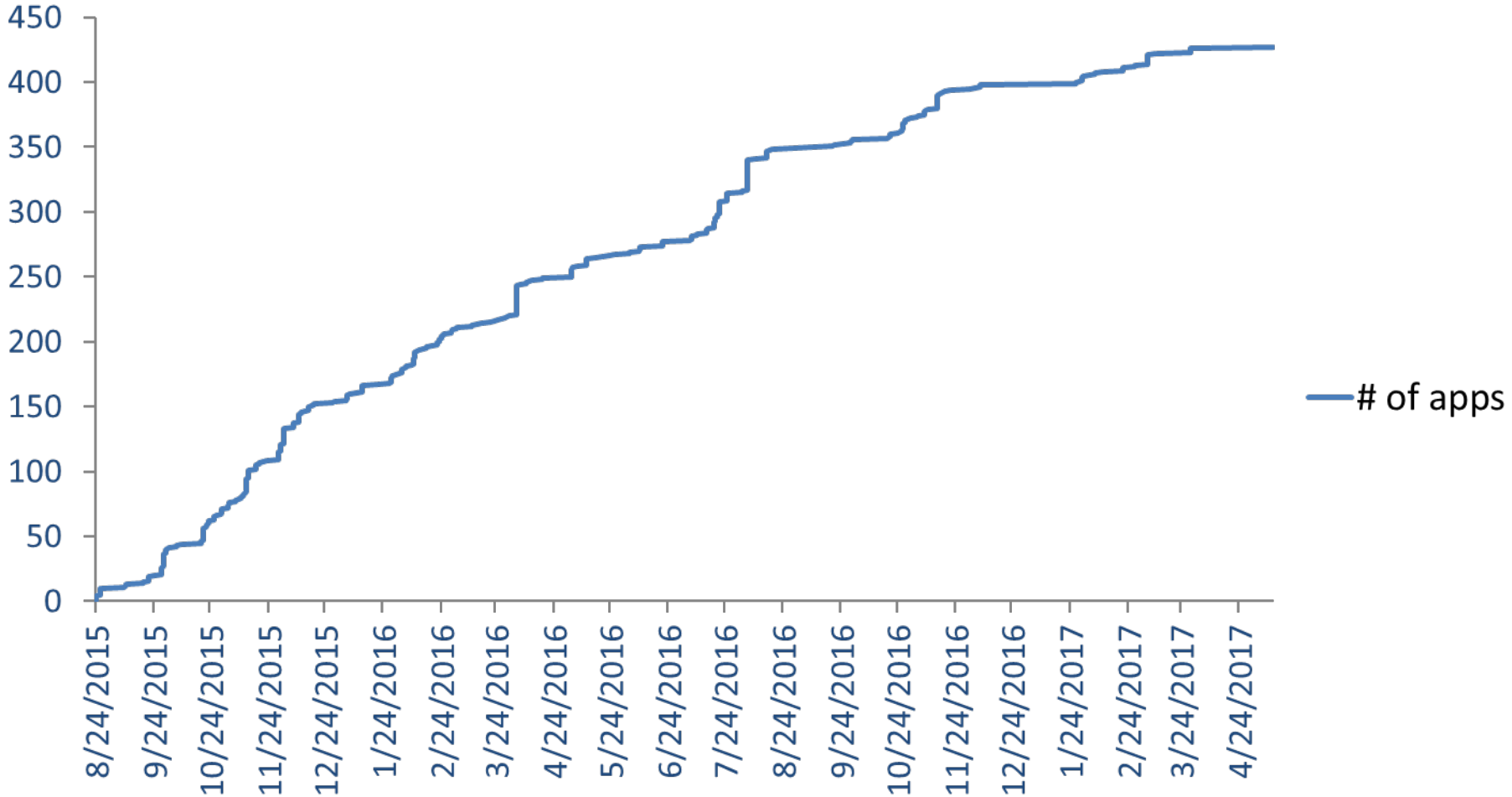
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver

Service	Required
Early Intervention (Screening, Brief Intervention, Referral to Treatment)	• Provided & funded through fee-for-service (FFS)/managed care
Outpatient Services	• Outpatient (includes oral naltrexone) • Intensive Outpatient • Partial Hospitalization (optional service)
Residential	• At least one ASAM level of service initially • 3.1, 3.3, & 3.5 are all required within three years • Coordination with ASAM Levels 3.7 & 4.0 (provided & funded through FFS/managed care)
Narcotic Treatment Program	• Required (includes buprenorphine, naloxone, disulfiram)
Withdrawal Management	• At least one level of service
Recovery Services	• Required
Case Management	• Required
Physician Consultation	• Required

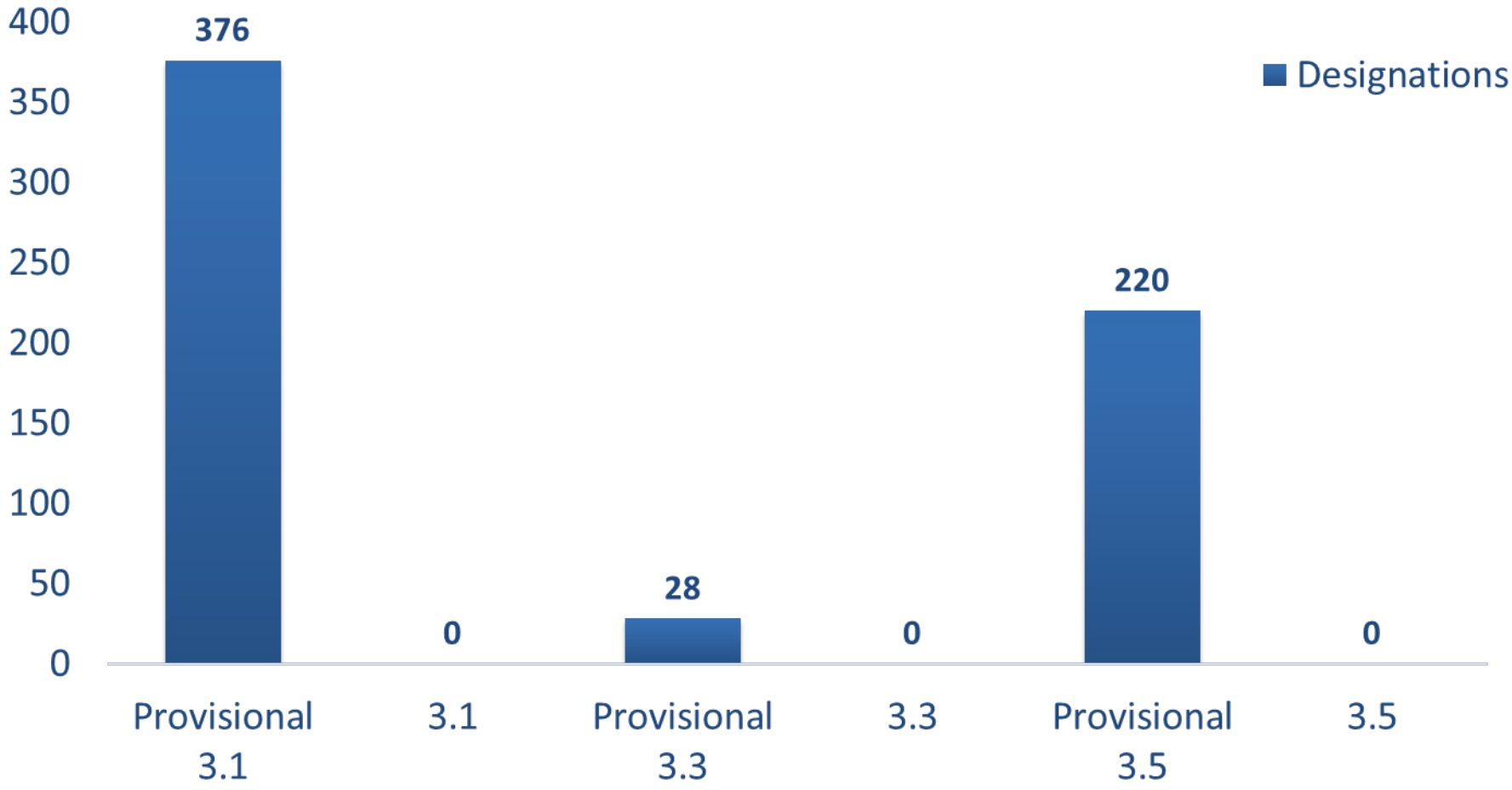
Designation Process



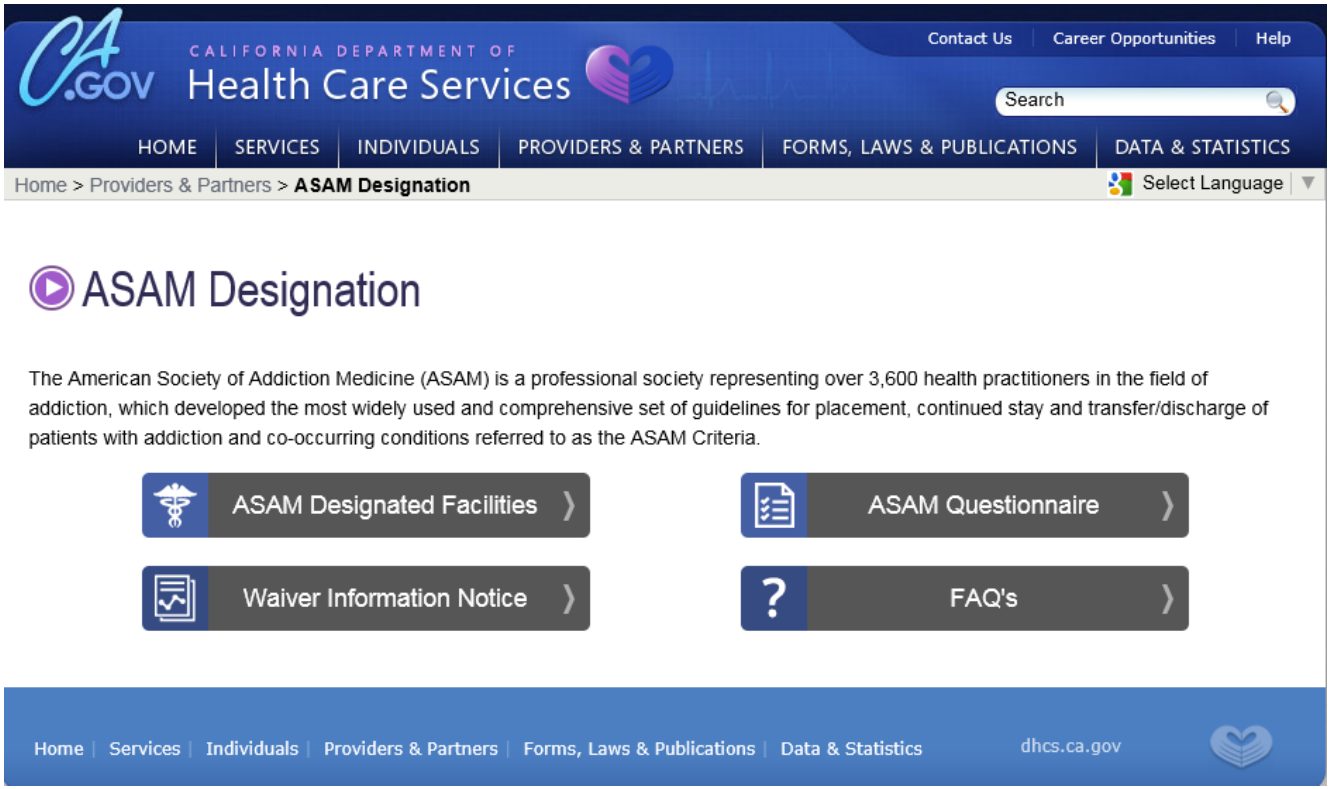
DHCS ASAM Questionnaires Received



ASAM Designations To Date



DHCS ASAM Designation Website

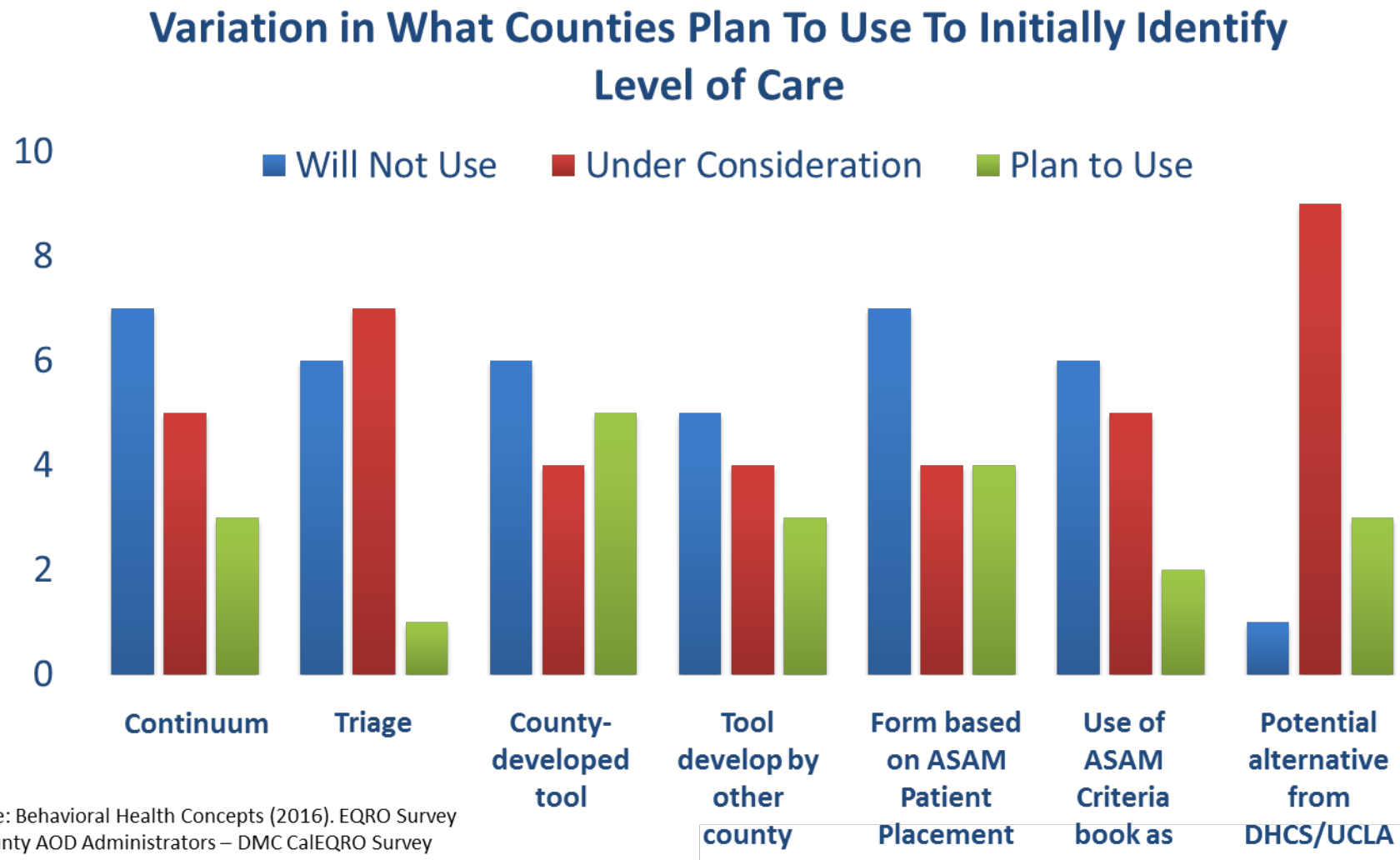


[DHCS ASAM Designation Website]

County Implementation Plans

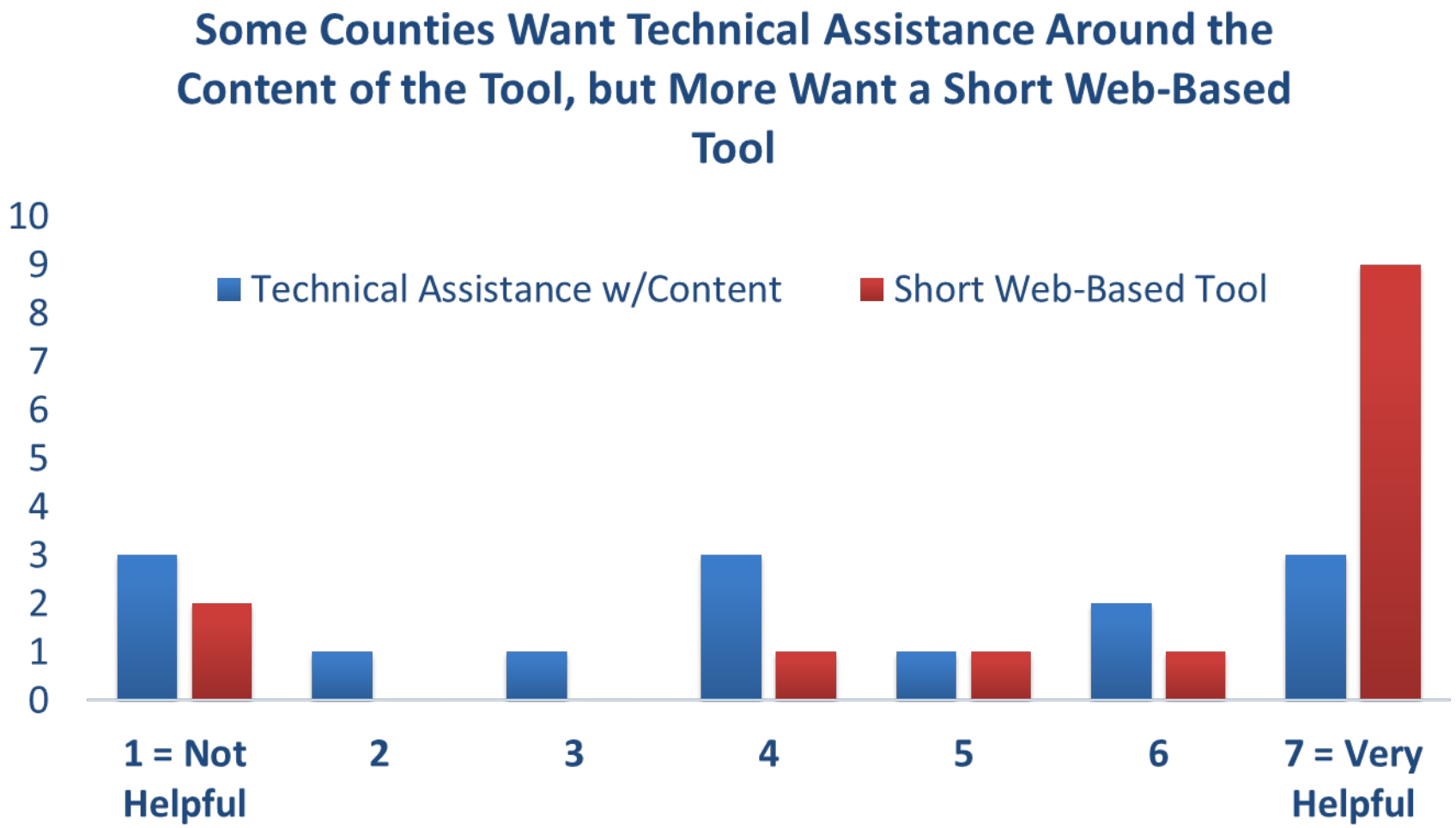
- County Implementation Plans are required to:
  - Describe how & where counties will assess beneficiaries for medical necessity & ASAM Criteria placement. How will counties ensure beneficiaries receive the correct level of placement?
- Answers to this question vary widely:
  - Regional assessment centers
  - Brief ASAM screen then full assessment at the provider
  - CONTINUUM software

What We Know



Source: Behavioral Health Concepts (2016). EQRO Survey of County AOD Administrators – DMC CalEQRO Survey (Preliminary Results).

What We Know Cont'd



ASAM Assessment Tool

- University of California, Los Angeles created an ASAM Short Assessment Tool
  - Developed considering multi-stakeholder input
  - Designed for initial client placement into level of care, considering all six assessment dimensions in the ASAM Criteria
  - Minimal staff time to complete
  - Optional and free to use
  - Assessments for initial placement using a short ASAM tool will be billable
  - Currently in testing phase with rollout anticipated shortly
    - ASAM Assessment Tool Link

ASAM Training Requirements

- At a minimum, providers & staff conducting assessments are required to complete 2 e-Training modules
  - ASAM Multidimensional Assessment
  - From Assessment to Service Planning & Level of Care
- 'Introduction to the ASAM Criteria' module is recommended for all county & provider staff participating in the waiver
- State support to counties
  - State contractor provides free ASAM trainings
  - State is providing technical assistance
  - Ongoing monitoring to ensure training completion

How Can Training the Workforce in the ASAM Criteria Improve SUD Treatment?

Supports Individualized Treatment Planning

- Shifts the focus away from specific program influenced determinations of services, lengths of stay, & completion criteria to more individualized services that precisely match client needs

Supports Whole Person Care

- The use of ASAM screening forms & assessments organized around the six dimensions can aid in the development of more comprehensive treatment planning & improved whole person care
- Considering all of the dimensions, the model can foster greater awareness of biological, psychological, & social factors that influence addiction and recovery

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Additional ASAM Training Opportunities

- Other available ASAM training opportunities for providers & counties:
  - ASAM eTraining series educates clinicians, counselors & other professionals involved in standardizing assessment, treatment & continued care
  - One-on-one consultation is also available to review individual or group cases with the Chief Editor of the ASAM Criteria
  - Two-day training which provides participants with opportunities for skill practice at every stage of the treatment process: assessment, engagement, treatment planning, continuing care & discharge or transfer

ASAM Training Resources

- The Contractor is providing county/regional, provider specific & supplemental trainings, & technical assistance
- Topics include:
  - **ASAM Criteria:** General overview of ASAM, instruction related to proper utilization of ASAM Criteria, guidance for using ASAM to determine appropriate treatment of patients based on their level of care
  - **Continuum of Care:** Addresses each ASAM level of care, services provided in each level, appropriate interaction between providers when transitioning patients within the continuum of care to levels appropriate to meet their needs

Polling Question (1/2)

- Is your state providing any of the following supports to providers regarding patient assessment, treatment planning or standards of care? Select all that apply.
  - Educational guides/tips
  - In-person trainings
  - Online trainings
  - Targeted TA
  - Other
  - No support offered

Discussion & Questions (1/2)

State Experience: Missouri

Mark Stringer

Director, Missouri Department of Mental Health

Clif Johnson, CRADDC

Director of Clinical Compliance & Physician Services, Southeast Missouri Behavioral Health

Expanding Missouri's SUD Treatment Array to Include MAT

Screening & Assessment

- Substance use patterns, medical history, mental health issues, family & social relationships, employment, housing problems

Detoxification

- Managed withdrawal symptoms

Addiction Treatment

- Counseling including motivational enhancement, cognitive-behavioral therapy, 12-Step facilitation
- Medication including opioid agonists (e.g. buprenorphine, methadone), opioid antagonists (e.g. naltrexone)
- Coordinated care for co-occurring medical conditions

Recovery Support

- Peer support, spiritual counseling, recovery coaching, family & parent education, self-help groups

Efforts to Incorporate MAT Into MO's SUD Care Continuum

November 2006

- Awarded Robert Wood Johnson Advancing Recovery Grant: Use of Naltrexone & Acamprosate to Treat Alcohol Dependence

November 2007

- Provider contract amendments added medication services

April 2008

- First use of Vivitrol

October 2008

- Advancing Recovery grant ends
- Vivitrol Change Leader conference calls begin

May 2009

- Secured general revenue funding for addiction treatment medications

MAT Milestones in Missouri

August 2009

- Allowed medication services via telehealth

September 2010

- Began credentialing for MAT specialty

October 2011

- Results published on Vivitrol study in Michigan & Missouri Drug Courts

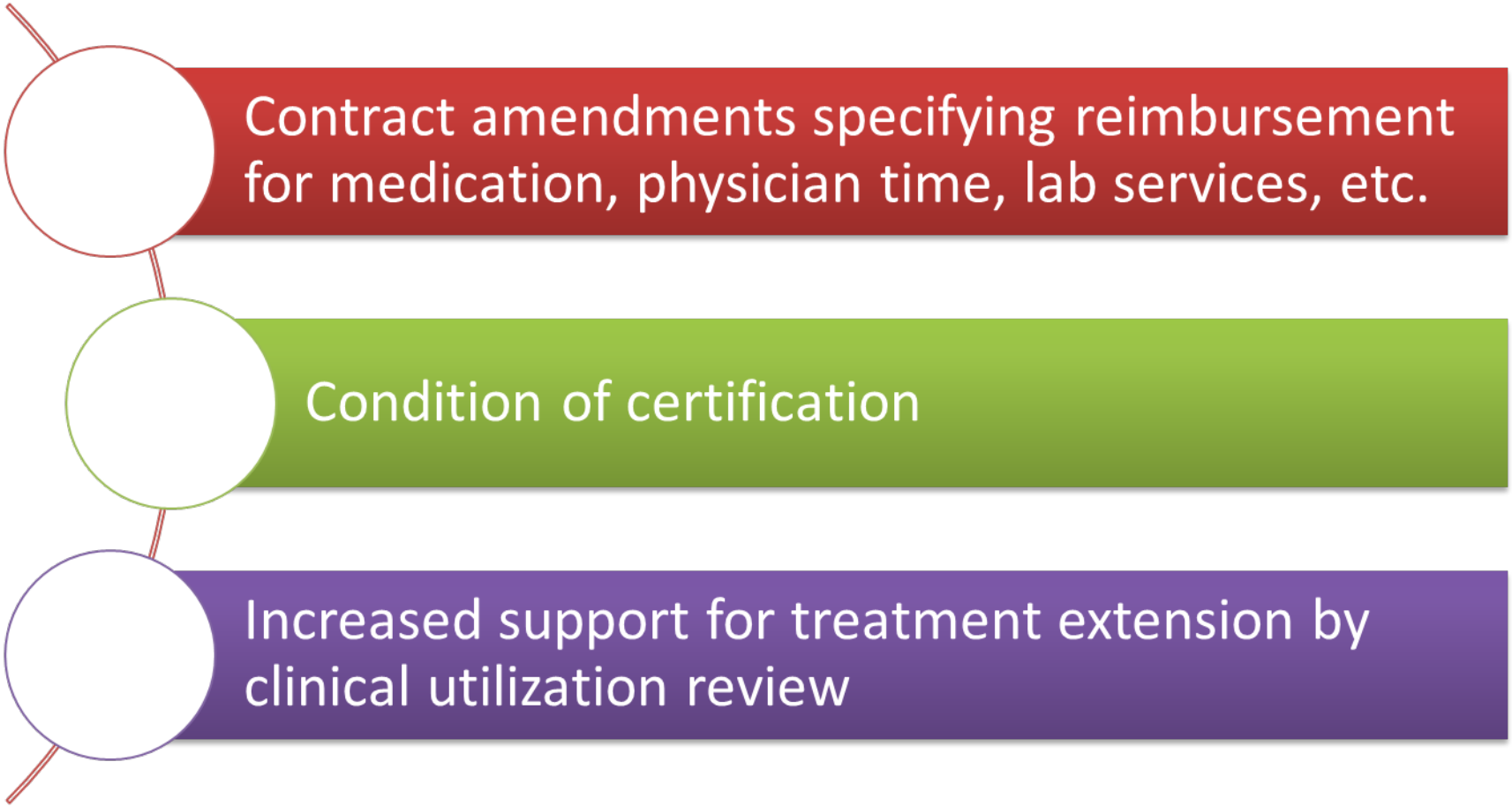
2012

- Partnered w/ drug manufacturer to provide Vivitrol to St. Louis Drug Court participants prior to release from city jail

Present

- Implementing a pilot project to provide Vivitrol to incarcerated offenders nearing release & continuing treatment in the community post-release

Encouraging Providers to Understand & Prescribe MAT



“Change Leader” Conference Calls

- “Change Leader” calls were initially held with program directors
- Goal: To create a forum where providers could exchange ideas & concerns about supporting clients receiving MAT
  - Strategies for effective treatment planning & monitoring
  - Barriers to effectively working with MAT clients
  - Success stories
- Calls were another opportunity to reinforce the message that providers are expected to become MAT prescribers

Training & Technical Assistance for Providers

- Trainings
  - Becoming an MAT prescriber
  - Trainings for other clinical support staff
  - Communicating with MAT clients
- Technical assistance
  - Messaging the importance of providing MAT
  - Providing patient-centered rather than program-centered MAT treatment planning
    - Highly structured, program-driven treatment is not appropriate for the presenting population. Providers needed to understand their unique recovery needs when planning & monitoring treatment
    - Ensuring information systems are not barriers

Credentialing MAT Specialty

Medication Assisted Recovery Specialist (MARS)

- 40 hours of training on MAT
- Overview of all medications approved for alcohol & opioid use disorders
- Eight self-study modules
- Training requirements are uniform for all provider and licensure types
- 611 MARS credentialed providers to date including physicians, nurses, faith-based providers, peers, counselors, social workers

Building Support for MAT in Healthcare SUD Treatment

Strategies to mobilize support for integration of SUD treatment in healthcare settings:

State Substance Abuse Authority & Medicaid Director can convey a new vision of addiction, recovery & the role of MAT

Internal & external champions must be identified to assure implementation

Education is critical for treatment providers, clients, families, primary healthcare providers & sister state agencies

Challenges to Expanding the Skilled MAT Workforce

- Provider challenges
  - Difficult to secure physician & nursing services
  - Physician & nursing shortage
  - Prescriber time is limited
  - Buy-in from both SUD treatment & primary care providers is slower than it should be
    - Workforce trainings need to comprehensively address all provider issues, including stigma & how to communicate MAT risks & benefits with patients
- External factors
  - Lower reimbursement rates than in primary care
  - Ongoing threat of reduced funding due to state budget shortfalls

Polling Question (2/2)

- For which service delivery areas is your state providing provider skills enhancement strategies? Select all that apply.
  - Patient needs assessment
  - Treatment planning
  - MAT prescribing
  - Care transitions
  - Other

The Substance Use and Mental Health Leadership Council of RI

State Experience: Rhode Island

Rebecca Boss, MA

Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

Susan Storti, PhD, RN, NEA-BC, CARN-AP

Administrator of the Opioid Treatment Program Health Home, The Substance Use & Mental Health Leadership Council of Rhode Island

Recognizing an Opportunity with Medicaid Health Homes

- Affordable Care Act, Section 2703
  - Medicaid State Plan benefit providing a comprehensive system of care coordination for individuals with chronic conditions
  - Health home providers integrate & coordinate all primary, acute, behavioral health, long-term services & supports to treat the "whole-person" across the lifespan
  - Opportunity to provide Health Homes at an enhanced Federal Medicaid Participation Rate (90-10)
  - Expands eligibility of patients & provider types
- 6 required service domains:

Improving MAT Care with Health Homes

- Patients receiving MAT
  - Present with multiple co-morbidities
  - Lack consistent care coordination
  - Have poor connections for primary care, do not attend wellness appointments, & are not connected to specialists
  - Fear stigma associated with MAT & substance use histories
- Working with Opioid Treatment Providers (OTPs) as health home providers allows:
  - Heightened contact between medical & clinical professionals who have on-going therapeutic relationships with patients
  - Providers to use existing & enhanced resources to improve patient health, decrease inadequate, ineffective medical care

Collaborative Steps to Create OTP Health Homes

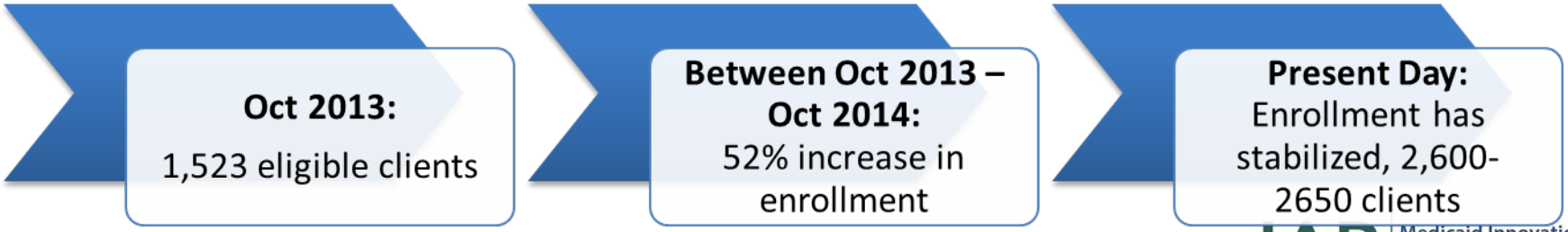
- Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (DBHDDH) convened a statewide planning partner group
- Developed surveys & focus groups to gain patient perspective
- Focused on key requirements of Medicaid Health Homes
- State Opioid Treatment Authority (SOTA) developed Implementation Advisory Committee including: SOTA, OTP leadership, BHDDH leadership, RI Medicaid office

Collaborative Efforts to Create Health Homes

- Devised a clear plan to create the OTP Health Home
  1. Define the services
  2. Define the population to be served
  3. Define the provider configuration
  4. Create reimbursement rates/payment methodology
  5. Determine health information technology (HIT) requirements
  6. Define outcome measures
- Created three new positions in the State Plan Amendment
  - Administrative Coordinator: 1.0 Full time equivalent (FTE)
  - Training Coordinator: 0.5 FTE
  - HIT Coordinator/Consultant: 0.5 FTE

Reaching the OTP Health Home Population

- Enrollment began October 2013
  - Auto assignment with opt-out
  - Participants identified via provider/community partner & outreach efforts
  - Referrals from physicians, managed care organizations (MCOs), criminal justice system
- Extensive process to engage potential participants
- Participants may be unenrolled after 90 days of not engaging



Developing Patient Acuity Levels to Improve Care

	LEVEL 1	LEVEL 2	LEVEL 3
Risk Type	**Low Risk:** Practice healthy behaviors; involved in primary care **Moderate Risk:** Borderline results from blood analysis; inconsistent practice of healthy behaviors	**High Risk:** Blood analysis indicates development of disease process; high risk behaviors; frequent ED visits, missed appointments	**Chronic Conditions:** Involvement with primary/specialty care; disease process requires community supportive programming/assistance
Focus	Prevention, maintenance	Refer to appropriate provider(s), prevent further progression of disease process, reduce high risk behaviors	Maintain or improve level of functioning
Activities	Individual coaching or counseling, group participation, etc.	Case management activities including referrals, transition to other levels of care, monitor medication adherence, engage family, community supports	Monitoring, re-evaluating patient needs, medication adherence, coordination of care w/ providers

Statewide Training Efforts for OTP Health Home Implementation

Core trainings for all Health Home staff

Health Home 101, Confidentiality & HIPPA, Trauma-Informed Care, ASAM Criteria, Cultural Competency, MAT, Co-Occurring Disorders, Crisis Intervention, Ethics & Risk Management, How to Conduct Groups, Mental Health Exam, Motivational Interviewing, Recovery Oriented Systems of Care, Whole Health Action Management

Additional supports

- Onsite technical assistance
- Mock audits to ensure consistency
- Development of standardized guidelines, procedures, policies, etc.
- Consultation & training to community providers
- Development of Health Home Resource Guide

Implementation Highlights

Successful Implementation of Health Home Model in 13 Clinics

- 22 Health Home Teams provide services to more than 2,600 patients
- Overlay of patient acuity model for patient risk stratification allows Health Home Teams to better address patient needs
- Creation of OTP Health Home Database
- First Commission on the Accreditation of Rehabilitation Facilities (CARF) accredited OTP Health Home in the U.S.

Promoting Education & Collaboration

- Development or enhancement of collaborative relationships with MCOs, community health centers, recovery services, private practitioners
- Development of statewide educational & consultative network

Lessons Learned from OTP Health Home Implementation

Collaborate

- Pre-arrange memorandums of understanding, qualified service agreements with community agencies, hospitals, MCOs, etc.
- Understand how Health Home clinical features align with current practices

Standardize

- Develop standardized forms, policies, guidance documents

Monitor

- Identify and/or develop reporting systems needed for outcomes, payment & payment tracking

Educate

- Provide education to existing & new staff that clarifies their roles, expectations, responsibilities
- Include team-building activities
- Establish communication guidelines to facilitate implementation

Developing OTP Centers of Excellence (COE)

- Developed out of Governor's Overdose Prevention Action Plan's goal to increase access to MAT
- COE Goals
  - Expand role of OTPs to include buprenorphine & Vivitrol
  - Admit patients through OTPs & transfer to waivered physicians within 6 months
  - Expand the role of the Health Home Team
  - Establish new procedures, protocols & guidelines
- Ensuring care quality with COE Certification Standards
  - Admit within 24-72 hours of referral in Level 2, within 24 hours for Level 1

How COEs Work

Service delivery & continued supports:	Not required for all MAT clients – just one treatment option
	Time-limited treatment is meant to stabilize patients
	Success stems from coordination with primary care & ability to build on the capacity of community providers
	Clinical & support services at COEs can continue after patient is referred to a primary care provider
	Recovery coaches plan an important role in delivering services, especially during care transitions
	COEs are able to rapidly re-admit patients who again require more intensive services & interventions
	COE Services: Comprehensive evaluation, treatment referral, medication induction & stabilization, enhanced treatment services, support to community providers for transferred patients

Supporting Providers Working with COE

- DATA 2000 waiver trainings
  - Assist physicians in obtaining DEA waiver
  - Provide training to support staff to better prepare practices for OUD
  - Two 8-hour trainings
  - Over 300 trained
- Continue DATA 2000 waiver trainings using Half & Half format as requested
  - Collaboration with RI Board of Medical Licensure & Discipline, RI Department of Health to determine where trainings are wanted
  - Provide at least 4 trainings annually

Current Status & Next Steps

- State certified the first COE in October 2016
- Five COE sites across the state
  - Providence (2)
  - East Providence
  - Wakefield
  - Newport
- RI received federal grant to provide start-up funding for more COEs
- Funding is available for one additional hospital-based program in 2017

Discussion & Questions (2/2)

Webinar Summary: Key Take Away Points

- Workforce development is critical to delivering quality services including client needs assessment & treatment planning
- Providers at multiple levels may need to be supported with in-person/virtual trainings, technical assistance
- Change leaders can help encourage local adoption & sustained practice of the intervention
- Develop a shared understanding of how the proposed initiative aligns and differs from current practice

Speaker Contact Information

- Marlies Perez
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