[00:00:00] **Michelle Day:** Good afternoon everyone, and welcome to the Fletcher Group, rural Center of Excellence's webinar series. Today's session is scheduled to run from 2 p. m. to 3 p. m. Eastern Standard Time. My name is Michelle Day and I am your moderator for the session, along with Janice Fulkerson and Erica Walker. A couple of brief housekeeping items and then we'll begin.

You entered today's session on mute and your video was off and will remain so for the entirety of the webinar. Your chat feature is located at the bottom right of your screen. Use the drop down feature to communicate with either the panelists only or panelists and attendees. Please direct all questions regarding the webinar content to the Q&A section. Be advised that this meeting is being recorded and will be available to you on our website once it has been transcribed. You can access our website at www. fletchergroup. org. Also, at the conclusion of today's session, there will be a short survey regarding the [00:01:00] webinar content. Your participation in that survey is greatly appreciated and will only take a few moments to complete.

Joining us today are Fletcher Group's CEO, Dave Johnson, and Milena Stott, Outreach and Engagement Specialist. Dave has over 35 years of experience leading program development with a specific focus on holistic service models that address physical health. Mental Health, Substance Abuse, and Social Determinants of Health. His successful grant writing experiences include being awarded over 7 million in funding from federal and state agencies and private foundations. A healthcare systems expert, Milena has held numerous titles within the industry, including Chief of Strategy, Chief of Transformation and Innovation, and Director of Healthcare Integration.

She currently serves as an adjunct faculty. At the University of Washington's School of Social Work. where she teaches advanced [00:02:00] practices regarding policy and reform. She is also an integrated care consultant and supports work at regional accountable communities of health, all of which promise to serve her well as an Outreach and Engagement Specialist for the new Fletcher Group Recovery Center of Excellence.

Dave, Milena, the floor is yours.

[00:02:24] **Milena Stott:** Hi, everybody. Good afternoon. I know that I speak for both Dave and myself when I say that we are very excited to have you here today talking about this very important topic. Today's presentation is about building value based models for recovery housing. During our conversation today, we're going to learn the definition of value based care models.

We're going to discuss the relationship between value, quality, outcomes, and cost in these models. We're going to understand how recovery housing is a valuable fit for this model. And then we're going to explore how we can align clinical [00:03:00] and social approaches in care that support service engagement. So why are we talking about this today?

Well, according to the National Survey of Drug Use and Health, 46. 3 million Americans age 12 or older, or 16. 5 percent of our population, met the criteria for having a substance use

disorder in the past year. In 2021, 94 percent of those individuals with a substance use disorder did not receive any treatment. So it's not surprising that our drug overdose rates continue to rise with 106, 000 drug overdose deaths reported in 2021. Additionally, more than 140, 000 people die from alcohol related causes annually, making alcohol the fourth leading cause of preventable deaths. And this situation is further complicated by the fact that over half a million people, or 18 out of every 10, [00:04:00] 000 people in our nation, are experiencing homelessness.

Now, while not every person who has a substance use disorder is homeless, or every homeless person that, or every homeless person has a substance use disorder, there's a strong correlation between homelessness and substance use. Recovery Centers of America recently published a report on the economic cost of substance use.The costs for this nation total in over 3.73 trillion dollars annually. Some of these costs. are associated with direct costs, such as health care expenditures or loss in productivity, and other costs are more indirect, um, related to illness, um, preventable, um, death, um, that really take a toll on the lives of people.

These costs impact the quality of life of individuals. So, for [00:05:00] example, a child who loses a parent due to an overdose and enters a child welfare system, um, experiences some intangible costs. This next slide here looks at the annual economic cost of the illness to the healthcare system. So, as you can see, substance use disorder is the second largest cost to our health system, only second to heart disease. However, When you consider smoking as a substance use disorder, or the co occurrence of some of these conditions with substance use, you can see that the costs add up.

This graph here looks at the distribution of costs of substance use across our health care system. The top two thirds, or 58 percent of this chart, represent totaling 118.5 billion annually. And these costs are driven primarily by hospital [00:06:00] inpatient and outpatient spending on substance use disorders. The bottom third of the chart represents specialty care and substance use disorder treatment.

However, despite the size of this problem, treatment access remains low. Insurance substance use treatment requires that services along a continuum of care are provided and that they are covered by insurance companies, affordable, and designed to meet the unique needs of the populations that we serve.

That care must also be provided. When it is needed, according to a Medicaid report of state agencies across the US that was published in 2019, only 12 states across the United States pay for the full continuum of clinical services for substance use disorders. The largest gap in these clinical services are for partial hospitalization and [00:07:00] residential treatment. This challenge is further exacerbated by the lack of recovery housing for those exiting treatment in need of housing.

So how do we solve some of these problems? Well, the promise of value based care is one of the models that the nation is looking at to be able to address this dilemma. Value based care is a healthcare delivery model that pays providers based on the quality of services and health outcomes of their patients.

The mission of value based care is to link healthcare payments to the quality of care that people receive. And the goal of this... Is to change the financial incentives of a system that pays for transactions like fee for services to one that pays providers for doing more rather than, um, doing better. So we're [00:08:00] trying to change the system to 1 that allows for outcomes to come into the payment model when we're delivering services.

For people with substance use disorders now, since we're talking. About delivering services that meet the needs of people, I'd like to take a moment to share Sabrina's story. Before I share Sabrina's story, I'd like to say a few things about adverse childhood experiences. For those of you who have never heard about the study called the ACES study, it's a study that looked at common conditions.

That happen, um, in folks that experience chronic stress or stressful events, including abuse and neglect. When children are exposed to chronic stressful events, their development can be disrupted. As a result, that child's functioning or ability to cope with negative or disruptive emotions can be impaired. Over time, and especially during adolescence, [00:09:00] that child may adopt unhealthy coping mechanisms, such as substance use and self harm. As a way to feel good and cope with the disease that they're experiencing. Eventually, coping, um, these negative coping mechanisms can contribute to disease, disability, and social problems, as well as premature mortality.

One of the things that I've learned in my career is that, um, the average person who develops a substance dependence diagnosis, their average onset of use is around age 12 or 13. So this means that services and interventions must start early. When we look at Sabrina's story of heartbreak and trauma, I'd like for us to think about the impact of these adverse childhood experiences on Sabrina's life. Here's a little bit about her personal story.

By the age of 5, Sabrina had experienced a long history already of abuse and trauma. By [00:10:00] the age of 15, she had begun to use substances to escape an already traumatic past. At age 18, she found herself pregnant. And sought sobriety because she wanted to care for her child and decided to become a police officer. At age 19, she had 4 close friends die in a car accident, suffering another loss, and for the next several years, saw periods of both sobriety and recurrence. mixed with involvement with the criminal justice system and experienced her first jail stay. At age 29, after the death of her grandmother, she survived a domestic assault and was provided, was provided narcotic pain medication for her injuries, which led to another recurrence.

In 2010, seeking faith and pursuing recovery while in jail, she found a program where she met her now estranged husband. In [00:11:00] 2018, her 12 year old son was killed in a car accident, a day after her birthday, and a day before she was to regain custody of him. The driver of the car was high. This led to another recurrence and some severe mental health struggles. By 2020, she had lost custody of her two children. In July of 2021, she fought hard to pursue her recovery again through the revolving doors of the system. In 2021, her cousin was murdered. And she began a medication assisted treatment program to try to avoid recurrence, followed by a short stay in a recovery center.

It wasn't until 2022, where she found recovery housing, the longest recovery program that she has participated in, and she is thriving because she feels a sense of belonging in that community. As we think about Sabrina's story and building a [00:12:00] system of care that helps us address some of the challenges that people like Sabrina experience.

I want to challenge us to think about the most common gaps and barriers that you or our consumers face in their journey to wellness and recovery. I would love for each of you to take a moment while I'm reading common barriers in rural communities on the next slide to use our chat feature and encourage you to share your experience with us related to gaps and barriers that you or those that you serve face in your communities.

This information allows us to design interventions that are appropriate to addressing those barriers in hopes of helping people like Sabrina. Please take a moment to use the chat feature to describe your experience. This slide here illustrates barriers to preventing and treating substance use [00:13:00] disorders in rural communities. So, in addition to the services, we also have to design systems that support people and providers effectively. Some common barriers that we hear across the nation include complicated systems of care. People don't know the resources that are out there. The resources change on a day to day basis. There's a lack of interagency coordination and communication.

People receiving services don't necessarily have their providers connecting with one another about the services that are being received and provided, so it's often challenging to understand gaps. There is also limited resources and personnel. Reimbursement rates can be low. There's a workforce shortage. And organizations are frequently chasing grants to try to set up programs that are effective for the people they serve. We also know that there's a lack of mental health services and case management services [00:14:00] across communities and insufficient capacity in hospital to treat substance use disorders. So, oftentimes what happens is people come into contact with the hospital system or an emergency room, but they fail to be connected to the appropriate services in the community, either because they're not available or folks are unaware of them.

To complicate things further, some folks really struggle with transportation barriers. They have a hard time reaching the services that they need because they don't have transportation to get there. Homelessness and substandard housing complicates this even further. It is hard to find people in the community um, when they are homeless and it is hard to establish and engage in a recovery program when you have daily stressors, like, where am I going to sleep tonight? And how am I going to eat? Motivation for change and isolation can also be a complicated barrier. People can [00:15:00] feel hopeless and isolated. They don't know where to turn for help or the help that they receive isn't the help they need.

So they lose motivation to seek more help because they haven't had a positive experience. And lastly, stigma and confidentiality concerns prevent people from sharing their true needs and what they need from their providers. They're afraid that they will be judged or stigmatized. Upon entering a health care setting, I'm going to take a moment to look to Janice to see what we have in our chat around common barriers that you may have reported in your communities.

[00:15:38] **Janice Fulkerson:** Milena, we have quite a lot. The lack of transportation is 1 of the common ones. We're seeing their local activities to support a recovery lifestyle things that you know, are supportive of people in recovery in healthy activities. Complicated and fractured systems. And you know, I've heard this [00:16:00] quite a lot lately is that funding often drives the activities. So, with a huge focus on opioid use disorder and funding towards opioid use instead of global substance use, that's become a barrier and added some to the fractured systems. Rural communities without reliable transportation, and then stigma is a theme in the chat as well. It's the ongoing fear of what it means when someone's in recovery. Seeking treatment.

[00:16:37] **Milena Stott:** Thank you, Janice. So these barriers are common in rural communities and abroad. So how can we address this dilemma? One of the models that I've studied very closely in my career is person centered care. [00:17:00] This model offers promise because it's guided and informed by individuals goals, preferences, and values. Its success is measured by outcomes that are reported by the individual. The services are integrated and coordinated across service systems.

And providers in care settings, not just the health systems. Support is given to individuals for managing their chronic and complex conditions. It provides education and support and is founded based on trust and commitment to long term well being. I like to describe person centered care, um, as personal rather than transactional interactions. Transactional interactions are common in a fee for service system, whereas in a coordinated, person centered system, those transactions focus on the relationship and engaging people in care.[00:18:00]

So, how do we integrate a person centered care approach within a value based health system? In a value based health system, doctors and other health care providers deliver high quality care using a person centered approach. It differs from the fee for service system that is siloed, where specialists work alone, and they don't integrate with one another and other community settings to provide for the holistic needs of individuals.

So when we talk about this, I also like to refer to the value proposition canvas. Um, when we think about, uh, what's the value proposition in healthcare, the marketing field defines this as an innovation, service, or feature that's intended to make a company or product attractive to its customers. In healthcare, value proposition assumes that the balance between price and quality is maximized.

I think one of the [00:19:00] challenges within the health care system is that there are multiple customers to satisfy. You have the payers who pay for services and develop contracts with providers. You have providers who deliver care, and you have people who receive services. Oftentimes in the health system, a lot of decisions are made between those who pay for services and those who provide for services.

And one of the propositions that we offer to you here is how do you engage people in that service design to truly address the issues that they're trying to have resolved and develop a

product that is attractive to them to use. As a treatment provider, I often worked with clinicians who found it difficult to engage people in care.

Sometimes it's because the service that we were offering wasn't the service that people were looking for. As a health system, we pay for stabilization and [00:20:00] clinical services. We don't always address the social needs. And so, there's often a disconnect between social and clinical systems, and this is why we see individuals with health related social needs having adverse patterns of health care utilization, as payers like to say, and increasing cost of care.

So, individuals whose needs aren't met, they continue to utilize services that aren't meeting those needs in a time of crisis, leading to increased cost. So, the promise of value based care, tying the amount that a health care provider earns to services that they deliver to address quality, equity, and cost of care is one of the potential solutions in our system.

Through financial incentives, like bundled payments, the goal of value based care is to improve person centered outcomes while giving greater flexibility to deliver the right care [00:21:00] at. The right time, because quality is a significant component of this discussion. I'd like to spend a little bit of time on understanding quality measurement.

Some ways that we can look at quality measurement include clinical or patient measures, such as engagement. There's the assumption that if a person keeps coming in, they like the care they're receiving or the outcome of patient interactions with providers. This is a more advanced measure when you're looking at the actual, um, interactions and satisfaction with those interactions.

Sometimes we look at the use of evidence based practices. Those are practices that have been researched to be effective. At achieving a particular outcome. Some financial ways to look at quality is the allocation of resources or waste or reduction of practices that waste time and money. [00:22:00] Um, a common practice that is used in the healthcare field is utilization management.

An example of utilization management is not approving something that costs more to try to save money, but when it does not work, you have to pay again for something different, and that can increase the cost. Another example that is common in the substance use treatment field is restricting the intensity or services in certain settings, um, to reduce costs, which can increase individual suffering.

In substance use disorder treatment, authorizing shorter high intensity residential stays does not allow an individual to secure housing prior to discharge, making it more likely they'll return to use without an absent supportive environment. It's important to note that the human brain takes 6 months to heal from substance use. So, finding the appropriate setting where an [00:23:00] individual can stay for 6 months or longer to begin to not only work to rebuild their lives, but for their brains to heal is an important consideration. Finding housing and other support services takes a long time, and we are often discharging people into less desirable situations.

So, how does quality impact costs? Well, sometimes higher quality services may cost more, but they can lower the cost of care when that care is managed in ways that ensure the right services and resources are used at the right time, coordination of care is in place to ensure continuity in care, That support recovery outcomes and care navigations in place to support access to both medical and social needs that impact health outcomes.

I'm going to turn it over to Dave Johnson, who's going to talk about some of the work that our community does to measure quality outcomes for people receiving substance use [00:24:00] services and how those outcomes compare to recovery health outcomes. Dave?

[00:24:06] **Dave Johnson:** Thank you, Milena. And, uh, again, my greetings to everyone on this call today as well. And, you know, in talking about quality, there are a number of things that we need to consider, uh, you know, as Milena has addressed in the prior slides, that, you know, quality really impacts Uh, two major factors. One is the health outcomes, uh, what is it that the person, uh, what their personal goals are, what they would like to achieve, uh, and then what are the costs of those services.

So, you know, when we think about quality, we think both about in terms of the outcome and the cost. So we're looking at, you know, uh, adequate, uh, Allocation of resources for the outcome that's achieved. When we start to look at quality measures, um, you know, the, the major entity that sets quality standards for the healthcare industry is the National Community for Quality [00:25:00] Assurance, uh, NCQA, and they have set, um, a number of quality metrics for all kind of healthcare conditions, access to prevention, uh, as well as treatment and recovery services, which In the volume of quality metrics, there are really only 5 that address SUD specifically, and those address both outpatient services as well as the CMS sudden issues disorder health homes model, which we'll talk a little bit more about as well later.

But those, uh, five, um, measures are the initiation and engagement of alcohol or other drug, uh, abuse or dependency treatment. Use of opioids at high dosages in persons with cancer. So, for the most part, that one doesn't really impact, uh, SUD treatment providers, but really looks more at, uh, medical providers in other settings. The concurrent use of opioids and benzos. [00:26:00] The use of pharmacotherapy for Opioid Use Disorder, i. e. MAT. And then the follow up after an emergency department visits for alcohol or other drug abuse or dependence. So for health plans that are reporting under Medicaid and Medicare, uh, health care utilizations, they're held to report on these five measures, uh, in terms of assessing the quality of that health plan and addressing SUD.

Uh, programs and services for the members that they cover. So we look at, um, next slide, Milena um, at the whole issue around initiation, uh, and engagement, um, of treatment, uh, we start to look at what do we know about, uh, retention and initiation engagement. So from a standpoint of randomized clinical trials, about 33 trials were, uh, documented in the review of the literature, and we find that, uh, [00:27:00] retention is defined by how long the person was staying in treatment.

So, where 1 month, the retention rate was about 72%. 3 months, it ranged, you see, this is a real wide range from 19 to 94%. It's like, where is it really? Uh, and that was really a small number of studies, only 9. 4 months, 46 to 92%. Um, 13 studies found between 3 and 88. Uh, and 6 studies, uh, found between 37 and 91 percent of the population in the study remained in treatment for over 12 months.

But when we look at the real kind of the data in the field, if you will, when you get away from the research environment, where there's really kind of an extra kind of focus on those measures, we find that with the HEDIS measures in a little box in the right hand side here, the initiation is from 33 to 44%. Now, the initiation is defined by HEDIS as a [00:28:00] single visit, 14 days, within 14 days after the index visit. Thank you. So the index visit means that the person has been identified by a health care professional as having an alcohol or substance use disorder diagnosis, and there's a follow up appointment within 14 days.

Engagement is defined as two visits within 34 days. Uh, of that, uh, uh, initiation. So we're really looking at a very low bar for engagement here, and we find only 13. 9 percent at the high end, the highest performing, uh, Medicaid, uh, Medicare plan. Uh, with that kind of engagement rate, and as Milena already indicated, uh, 6 months is kind of the, the magic number, if you will, uh, to really, uh, have a Recovery oriented system of care.

So we looked at, uh, data from a, uh, [00:29:00] a program in West Virginia that had over 15 years of data that they had literally been collecting in an Excel file, and they had not been able to analyze it, uh, and asked us to look at this data for over 560 residents had been through their program. We kind of redefined, uh, what initiation engagement, uh, means in recovery housing.

So we defined, uh, initiation as being in the recovery house for at least one week. Um, and engagement we defined as being in recovery house for 30 days. Uh, and then we define retention as being in the recovery house for 6 months or longer. Um, and so you see here that 82 percent of the residents entering this home met the criteria for engagement.

Um, and you know, 44 percent for retention. So, when you look at kind of the outcomes, just on the basis of initiation and engagement. The recovery house far [00:30:00] exceeded that of other outpatient treatment programs, uh, as indicated by NCQA data. Other studies have found, you know, kind of similar kinds of results, actually a little more positive in terms of, again, research studies on a consistent basis.

Find about 50 percent of individuals staying in recovery for six months or longer, and that's, you know, that really becomes kind of the benchmark for us to look at, you know, do you get about a 50 percent retention rate? And within that, then you find about a third of the people will be in abstinence, and about 52 percent is in the last bullet here. Are in some type of, uh, remission rate, which means they may not have achieved abstinence, but there's a significant reduction in the symptomatology. So as we look to kind of shift gears, we really need to keep in mind that, uh, that [00:31:00] one, uh, size does not fit all, uh, that there are many pathways to recovery.

And it really is kind of looking at those pathways of how do we engage people? Uh, how do we retain them in treatment? How do we achieve their goals, uh, for recovery, uh, in addition, in addressing their substance use disorder? And thinking again about what are those barriers that we identified a lot of health related social needs that are barriers to ongoing care and to recovery.

So we start to look at alternative payment model models and value based care. We really have to look to, uh, what has been defined by this, uh, Center for Medicaid Services. And really the, uh, APMs and value based care has been driven by, uh, the Center for Medicaid Innovation, uh, in payment models to try to move from volume to value. So again, um, you know, we look at mental [00:32:00] health and substance use treatment services. You get paid by how many patients you see, um, not by, you know, what are the outcomes that are achieved, uh, by those services that are provided. So how do we start to move forward then? And how do we define value? Uh, is it reduction in high cost services?

Is it preventing the development of other, uh, health conditions? So, you know, is it a prevention kind of inter, uh, intervention for value? Does it increase longevity and reduce premature mortality? And does it increase the satisfaction of the health care services that the person receives? And does it increase their self perception of their health and well being? Are they achieving their goals of what they want to achieve around their health and well being and sense of purpose and meaning? How do you define value for you in your own personal kind of life and for the individuals you serve, you know, kind of what are the values that, uh, for a health outcome that you would strive for and would like [00:33:00] to see?

So we look at the Center for Medicaid and Medicare Services, uh, and the Center of Innovation. They really have worked to drive service models that improve both patient care, lower cost, and align the systems to remote person centered practices. So, you know, it's, again, it's working to get the individual engaged.

In defining what they want to have happen for them, for their health and well being, and what can be achieved in an economical and efficient kind of manner. So, the center has been, uh, driving a number of innovations and demonstration projects around the country, uh, you know, that include both case rates, bundled rates, Uh, Um, cost sharing, uh, kinds of risk management, kinds of arrangements, et cetera, that make it somewhat difficult for mental health and substance use treatment providers because we often work in fairly [00:34:00] small practice, um, models that do not have that population focus at a larger health plan.

Or larger accountable care organization might have to manage overall health care costs. So one way maybe to look at this is the health home model. And in 2019, CMS added the SUD health home program, which at the present only has five states who participate in that program. Uh, they include Maine, Maryland, uh, Michigan, Rhode Island, and Vermont, uh, are the 5 states that offer the SUD Health Home Model.

And when you stop and think about the Health Home Model, it maybe is a model for recovery housings to, uh, to participate in because it does Um, provide literally a health home for the individual, uh, where there's an opportunity to, um, coordinate with other care

providers, uh, to care manage, uh, what the person may need in terms [00:35:00] of, uh, additional programs and services to be engaged with, to facilitate their transition from the, uh, recovery house to community living, uh, circumstances, to community services.

To ongoing, uh, support of their health and well being through, uh, educational types of program, life skills models, et cetera, getting them engaged in other community services and supports, which would include, uh, recreational opportunities, uh, as well. And ongoing support of the family. Research suggests that engaging the family is really key in promoting long term recovery as well as the person achieving meaningful work in employment.

Uh, states submit a waiver to participate in the Health Home Program. Uh, and it's one that I think we should be looking at as we think about recovery, uh, housing, uh, recovery support services. How do we get to the door, uh, to participate in this model, [00:36:00] uh, to support funding for health related social needs in a literal way?

Milena, I'll turn it back to you to kind of move to how we look at the clinical model as well as the social model, uh, and kind of start to blend those together for a value based purchasing arrangement.

[00:36:24] **Milena Stott:** Thank you, Dave. Sorry, had to unmute myself there for, um, so one of the things that we've done with this presentation is really borrow from the best practices that we know to exist out there and put them in the framework around recovery housing. So, in this next part of the webinar, we're going to talk about how recovery housing fits as a value based care model. And really, the core of that is, as Dave mentioned, it's allow, it's aligning those social and clinical activities that really contribute to the recovery of an individual. [00:37:00] So, when I was doing some research, I found this great report that the United Nations put together, um, uh, their Office of Drugs and Crime.

Now, when you're looking at this graphic, what it illustrates is some of the common challenges of the vicious cycle that people with substance use disorders experience. And if we're going to create models that serve those individuals, we need to look at their daily challenges. So, while not all persons with substance use disorders are homeless, there is a strong relationship between chronic and severe substance use and homelessness and poverty.

After long term use, you can see consequences such as job loss, criminal justice activity and disrupted relationships as a few of those consequences. This is further challenged by the fact that health and mental health have the impact on an individual's ability to work. Um, and their ability to work impacts their ability to afford housing and other social needs.

So if we're going to disrupt the [00:38:00] cycle, we have to address those common elements and downstream effects of substance use disorders. And so when we look at recovery housing, and try to understand how recovery housing creates value for individuals, we really think about This idea that the house prioritizes people's outcomes by creating a supportive and structured environment that allows them to engage in long term recovery.

It provides residents with a community of peers who have shared experience and can help address and reduce the stigma while offering support and guidance based on their personal experience. A key element to recovery housing is that the nature of the model in and of itself focuses on the health related social needs, including housing, employment, and social connection, and removing barriers that allow the individual to work through their recovery.

Recovery houses have a relationship with the community of healthcare providers, um, [00:39:00] as well as individuals. And the criminal legal system. So when you look at who's entering a recovery house, um, the criminal legal system is a common referral source, but we also see people who are self directed or providers who refer to recovery housing.

In many states, there's continuums being developed that allow individuals to access recovery housing once they discharged from a residential treatment facility. So they can be in a setting where they're receiving those core services in the health home model that include the peer support, the case management, connection to clinical services, but really has this emphasis on life skills and employment support so that we're addressing the long term and chronic consequences of substance use.

Many people who exit recovery housing, and they've shared a little bit of the research on engagement, um, but many people who exit recovery housing, and we have some statistics at the end to discuss with you, [00:40:00] are exiting to employment and to housing. Because recovery homes build a relationship with other housing in the community, um, and employers in the community to help people access, um, first employment and then housing.

So, for those of you in the clinical world, you may be familiar with ASAM criteria. Well, ASAM has recently pulled recovery housing into its continuum. The National Alliance for Quality Recovery Housing and SAMHSA have adopted this model. And so what you see here are the 4 levels of recovery housing that are out there. What they all have in common is that they're alcohol and drug free living environments that people have chosen to live in because they know the value of that environment and supporting their recovery. And they utilize the social model of recovery support to achieve outcomes. As you increase in levels, you see additional services being added.

So level two homes often have the [00:41:00] recovery support services. In the level 3 homes, you're adding the formal life skills development, which includes employment support and housing support and relational support. And then level 4, you see the clinical component where there's often a clinician on staff or through partnership that is helping address the comorbid conditions that happen in individuals who suffer from substance use.

So, what you can see here is the recovery housing alternative payment model service mix. So, because recovery houses offer a range of services, these are the common services that you find that are standard in recovery houses. The higher the level of the recovery house, the more of these services you will find within the recovery house. So you have the peer support, the group, the life skills, medication support and service coordination, vocational assessment and job training and job coaching. Some homes [00:42:00] even have social enterprises and

partnerships with local employers. And they provide the support of transition to employment and help address some of the challenges that persons encounter.

When returning to work, this next slide here is illustrating the service mix from a level perspective. It's also crosswalks with the ASAM levels. Um, what you see in a higher level home, which is the level 3 home is that and even ASAM has a recovery house level. Is this additional support, um, that includes the standardized curriculum, the life skills, the health home services, your typical length of stay is anywhere from 4 to 36 weeks, depending on where you're coming from and the opportunities downstream and the level of intensity is 10 hours per [00:43:00] week.

Now, we currently pay for a lot of these services. Um, under our current payment models, but they're more clinical in nature. And so what we do is we increase the intensity of clinical services, um, within these models. What a recovery house does, it embeds the social support, um, to address the health related social needs.

In a Level 2 home, these are typical transitional housing settings where the services are more like five hours per week. And similar to the other model, they're less clinical in nature and more social support in nature, to really focus on all of those barriers that an individual is facing to achieving self sufficiency and recovery.

So, this next slide here looks at the cost between recovery housing and treatment as usual. So, as you can see here that, um, 2, uh, 2, [00:44:00] 30 day stays at a residential treatment center is about $13,500. Intensive outpatient, 90 days as typical is about $11,250. In a recovery house in a lower intensity, 200 days at $54 a day is about the same cost as intensive outpatient. The difference is that it offers a roof over your head and the social support and the community engagement that allows for you to fully achieve recovery and wellness.

So what's, what are some important considerations? When we're talking about aligning these medical and social models. So here we focus on how the social model and the medical model are similar and different because this is important to know when we're contracting for Medicaid. So, in these next few slides, we're going to look at staffing, [00:45:00] program, policies, procedures, billing, and outcomes as the key components to address when we consider contracting with Medicaid or developing programs that allow for the treatment of substance use disorders.

So, we know that there's currently funding out there for the medical model based on ASAM. The only difference between a ASAM residential treatment and recovery house is that the medical model really relies on license and credential staff and that these credentials are what trigger eligibility for payment.

So, typically in these settings. You have psychiatric staff, social work staff, or licensed counselors. In contrast, the social model expands your workforce to partner with clinical services, but also offers a house manager that supports the milieu and the daily management of activities and [00:46:00] services. A program coordinator who is able to engage with the community to get folks access to the services they need.

A recovery coach who's managing the service plan and a peer support specialist who's guiding through personal experience. So, how are these program components both similar and different? In a medical setting, you know that, um, there are intakes assessment and treatment planning. In the recovery community, what we do is we assess for recovery capital and develop a recovery support plan.

Um, medical settings are able to offer supervised withdrawal With medications, whereas the recovery house is able to offer socially supervised withdrawal. In both settings, you have individual and group counseling. The difference is who's delivering the curriculum. Um, in both settings, you're addressing medications either by [00:47:00] prescribing in the medical model or by helping people adhere to their medication program.

Um, in the medical setting, you're also really relying on physician consultation and case management, whereas in the social recovery setting. You're really focusing on housing, transportation, and employment support, mutual aid, aid groups, and linkage to coordination and services. In both settings, you have policies and procedures.

The National Alliance for Recovery Residences, um, set forth the standards for accrediting recovery homes through a designated set of criteria. Those criteria, similar to residential settings, address policies and procedures related to background checks. discrimination, admissions processes, grievance processes, drug screening protocols, return to use protocols.[00:48:00]

They both have document and files that, um, guide the clinical care and document the clinical care, and they both have program requirements. So, when we talk about billing for these services, what we've put forward here is a set of codes that are often adopted by state Medicaid agencies and CMS that allow for the payment of the delivery of these services. So, many states have adopted the Peer Support Service Code, and we see those codes expanding.

A lot of states are looking at adopting case management codes and educational services codes to support the social activities that happen, um, that, uh, contribute to, um, the medical outcomes. And because outcomes are important to discuss in any model, this here is a sample of the Recovery Kentucky outcomes. There's [00:49:00] 1800 substance use recovery beds. And... one of the things that the research team does in Kentucky is they measure people's substance use at intake, housing status, and arrest status at intake.

They also look at anxiety and depression, which are common comorbid conditions that happen in people who are using substances. They look at risk of suicide and they look at employment. They also do a follow up at 12 months with the people who have gone through the program and they remeasure those same things To see the achieved change that you can see outlined here, as you can see, many folks have a reduction in recidivism, a significant reduction in homelessness.

An increase in employment and a decrease in drug use and mental health symptoms.[00:50:00] So, in summary, recovery housing has engagement and outcome rates that meet or exceed the current standard of practice while delivering person centered care.

For Despite its social and economic value, recovery house programs and services have not widely been covered because current funding models haven't allowed for it, and payer contracting is evolving to allow for it. Alternative payment models, such as bundled payments, offer promise in supporting long term recovery programs to help individuals both recover from substance use after stabilizing and secure housing and employment. States that are developing these models have found that it's important to bring together the people who provide care, the people who pay for care, and the people who need care, in order to be able to align on a model that gives both flexibility, [00:51:00] um, and focuses on person centered approaches and outcomes.

There's a lot of states that are moving forward with these models, and so we see that housing vouchers are being paid for through substance abuse block grants. Um, new codes are being adopted through Medicaid waivers, and other funding is being invested to be able to pay for health related social needs. So, at this time, we invite questions from the audience and also invite you to help us build and expand these models to help people recover from substance use disorders.

[00:51:41] **Janice Fulkerson:** Thank you, Milena. Thank you, Dave. We do have a couple of questions from the audience. Um, home health models. Uh, there's a question about, uh, from the audience, um, directed, uh, at Dave, or for Dave. How do we find out if we can implement [00:52:00] or introduce home health models in our state if we're not one of the focus states?

[00:52:06] **Dave Johnson:** So, the Health Home Model is, uh, really funded through a Medicaid waiver. So, the state, uh, uh, Office of Medicaid Services needs to file a waiver for that, at that program. There's a real advantage for the state to do so, as there's an enhanced match for the Health Home Program. It's a 90/10 match, uh, for those Health Home Model services. So, you know, there's an advantage for the state to do that. Uh, but it really has to go through the state. Uh, through their Medicaid agency filing a waiver, uh, and I think it's, it's always the importance of, you know, kind of being at the table to talk about these alternative funding models, uh, to, uh, encourage your state to participate.

[00:52:51] **Janice Fulkerson:** Great. Thank you, Dave. Um, follow up question, uh, what data should recovery houses gather to have a strong value based care? [00:53:00] Type, uh, program or payment. How can recovery house operators develop the data sets?

[00:53:09] **Dave Johnson:** Maybe both of us take a shot at that, uh, uh, going forward. And I think sometimes we make it more complicated than it needs to be. And I would go back to the slide on initiation, uh, engagement and retention, you know, given that that's the kind of the benchmark for, uh, HEDIS, um, outcomes, that's a pretty easy one to track. Then also to track just basic demographics that we were really interested in, Uh, equity, inclusion, diversity, uh, so just knowing who you're serving, how long they're staying in your homes, uh, you know, is, is kind of the basics to start with.

I think then you can start to look at other outcomes, such as maintaining employment, being stably housed in the community, avoiding contacts with the criminal [00:54:00] justice

system. So those are other kinds of outcomes that could be looked at. But we also recommend looking at recovery capital, which is kind of a standardized instrument to get to those issues as well. Milena, I don't know if you want to add to that.

[00:54:17] **Milena Stott:** I mean, I think one of the things that some individuals are measuring is changes in patterns of service use. Um, that, you know, when individuals enter recovery house, they're able to access more outpatient based services rather than crisis. of those measures look at the, the financial savings on shifting the cost of care to the right care. Um, one of the things that we talked about is it's not just the services that you receive. It's when you receive them, how often you receive them. And so you want to see a shift of people, um, in lieu of receiving. A high cost crisis services to being able to receive [00:55:00] the services that appropriately address their health conditions.

Um, one of the things that state Medicaid programs have begun to study is where those substance use related costs live. What we see is that individuals who have a substance use disorders cost Medicaid. three to four times more, um, in health services, not behavioral health services than, um, those who don't have a substance use disorder. So oftentimes we're measuring utilization on the behavioral health side when in reality what we're trying to address is whole person health. And so we want to see a reduction in chronic health conditions that become expensive with long term use. Um, I know that Dave's research team, some of whom are on this call, have developed, uh, protocols, both, uh, small, medium, and large data sets to be able to measure outcomes. And, you know, we are available to, to support those of you who are interested in learning more. [00:56:00]

[00:56:00] **Janice Fulkerson:** Thank you for that, Milena. In the chat, we have put a lot of resources and links in there for attendees to focus on and look at if they'd like. Anybody on the call can go to FletcherGroup.org and submit a technical assistance implementation support request, and we can share any of the resources that have been talked about today. So, follow up question, it sounds like 1st off is to find out if a state is a Medicaid waiver state. And then reach out to the local experts and find out if there's a pilot program or opportunities underway, or gauge the interest of that as well, um, and move forward in promoting alternative payment methodologies for communities. Is that the best 1st step? This person is asking is really reach out and start a [00:57:00] conversation.

[00:57:03] **Dave Johnson:** Yes, I would say it is.

[00:57:05] **Milena Stott:** Yeah, Medicaid plan information is available. Um, and so is waiver information on the website. You can go to the CMS website and explore, um, what waivers are in place. Um, and then we're also happy to help and answer questions, um, on Medicaid state plans and what services are covered.

[00:57:27] **Dave Johnson:** You know, I think one of the things that we might want to tackle just briefly about, Milena, is something you and I talked about preparing for this is that difference between the kind of social model language and the clinical language and the challenge kind of on both sides to understand each other's language of how we talk about the services that we provide, either from a social recovery model or a clinical model.

[00:57:53] **Milena Stott:** Yeah, I think having a common language is really important, um, especially when Medicaid services are [00:58:00] defined based on medical necessity. Um, but there is a shifted focus towards health related social needs, and so states are looking at ways to engage. Both services and codes that address those elements, because for a subset of the population, those are the services that yield in the most outcomes. Um, and so we're happy to, to help translate some of that language, um, with state agencies and partners.

[00:58:30] **Janice Fulkerson:** Thank you, Milena. Thank you, Dave. Um, that, those are all the questions that we have gathered in the chat and in the Q&A box, um, and via text message. Um, thank you all for attending today. Um, thank you, Dave and Milena for sharing, um, information about alternative payment methodologies and how They can be used in the recovery community. Um, for more information about this, anybody can reach out to Fletcher Group via our website. And this [00:59:00] video and the related sources, resources will be made available on our website next week. Thanks everybody for attending.

[00:59:08] **Milena Stott:** Thank you.

[00:59:12] **Michelle Day:** This concludes our webinar session. Thank you so much for joining us today. Also please tune in on the first Thursday of each month from 2 p. m. to 3 p. m. Eastern Standard Time where we will be hosting subject matter experts from across the nation to bring you valuable tools and resources for rural recovery house operators and SUD professionals.

If you would like information on technical assistance, you can go to our website, again, www.fletchergroup.Org, which I have also copied in the chat, and submit a technical assistance request. Lastly, please take a moment to respond to the survey questions once they become available on your screen. Your feedback is very important and greatly appreciated. Thank you, and have a blessed day.