[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 [00:01:00] session, there will be a short survey regarding the webinar content. Your participation in that survey is greatly appreciated and will only take a few moments to complete.

Today's presenters are Beth Sanders. Founder of Hope Homes Recovery Residences and ASAM Fellow, Dr. Paul Earley. Beth Sanders has worked for over 30 years in clinical, counseling, and peer support capacities and holds licensure and certifications in social work, addictions counseling, supervision, and medication assisted therapy. She founded Hope Homes Recovery Residences. Hope, and now Lambda Hope, serving the LGBTQI community, has grown to be a leader in residential and recovery support facilitating community, home, and belonging in social model based recovery residence settings. In 2011, Beth was the founding president of the National Alliance for Recovery Residences.

Dr. [00:02:00] Early has been an addiction medicine physician for 30 years. He treats all types of substance use disorders and specializes in the assessment and treatment of health care professionals. His work was featured in the documentary series on addiction entitled Close to Home, by Bill Moyers. Dr. Early is a fellow of the American Society of Addiction Medicine and has been on the board of ASAM for over 14 years in several capacities. He is currently a Director at Large. He has been the medical director of two nationally acclaimed addiction programs specializing in the care of addicted healthcare professionals. Beth, Dr. Early, the floor is yours.

[00:02:45] **Beth Fisher:** Thank you. I think I speak for both of us when I say that we're excited to be here, that this is a true collaboration that has been in the works for 30 years. Wouldn't you say, Paul?

[00:02:59] **Dr. Paul Earley:** [00:03:00] Absolutely. We've been working on this for quite some time. Um, why don't you go to the slide for the objectives, and I'll dive in first, and then, uh, you'll have the better part of this from, uh, Ms. Fisher. So, what we hope to have you learn from this is to have some In just some really basic knowledge about the ASAM criteria and how it's used for a level of care placement. Because as we're moving into the future, recovery residences have been deeply integrated into this latest version of the ASAM criteria.

And we'll tell you more about that in a minute. To contrast medical and clinical services, uh, with a social model, recovery support services, and understand how both really work together for optimi effort, for an optimally uh, utilized continuum of care. And then we're going to talk a little bit about the different types of recovery residences as defined by the ASAM criteria and how they're implemented to align with an individual's treatment needs.

So let's get [00:04:00] started. So talking about the ASAM criteria, this is a document that has been around since 1991. It has undergone basically four significant changes during that time. And you see on the far right the latest edition of the ASAM criteria. Early on, this criteria just talked about more traditional treatment, whether that was outpatient treatment, medication management, uh, residential types of treatment. But this fourth criterion, importantly, really due to the work of, uh, Beth and her team and NARR, has been deeply integrated into the ASAM criteria. Next slide. So what does the ASAM criteria do? Basically, the ASAM criteria is an, is an effort to structure the care. And the way I look at it is, um, when I first started as a doctor almost 40 years ago, um, if you had a, [00:05:00] a cancer diagnosis, if you went to Doctor A, they might prescribe radiation, if you went to doctor B, they prescribed surgery. Um, and it, there was just this helter-skelter model. And what's happened with, with cancer is through the development of criteria, there's a significant and organized way of looking at the best possible care for cancer, and that has resulted in a dramatic improvement in the outcome.

We're hoping with the ASAM criteria to do the similar situation. Basically, by assessing a patient's biopsychosocial circumstances to develop a level of care, to make sure the treatment is holistic, individualized, and patient centered, and then defining that types of services that are provided so we can figure out how to match the right services with the right person. And most importantly, to ensure that, um, [00:06:00] the, uh, that the individual stays in care long enough to have the best possible outcome. We have to treat addiction as a chronic condition because it is a chronic condition. Even in its remission, it is still an illness. Next slide. So, the ASAM criteria basically has different components.

The first is a type of level of care assessment, which occurs when an individual decides they want to have a type of addiction treatment. That level of care assessment leads to specific decision rules, which then leads to, uh, putting that person into a continuum. And again, the word continuum is important. That means that the individual is placed into a system that molds, that the individual moves through to get the best possible care that's not only, uh, meets them where they need to be, but also it winds up being cost [00:07:00] efficient. Through the process of care, there's a reassessment. You see that line at the bottom, and that is dumped back in the decision rules and will lead to a change in the level of care.

That's really basically what the ASAM criteria is. Next slide. So, the ASAM criteria has specific principles, um, that treatment is based upon patient needs and not arbitrary prerequisites. That the assessment is multidimensional, and it looks at biological, psychological, social, cultural factors that contribute to addiction and its recovery. That treatment plans are individualized and based on a patient's needs and preferences. And that the care is interdisciplinary. Also that the treatment is evidence based and patient centered and is developed from a place of empathy. The other part that's important for all of us to

recognize is that addiction doesn't occur in a vacuum, that they're co [00:08:00] occurring conditions, whether that's childhood trauma, adult trauma, whether that's, uh, depressive disorders. Therefore, the care has to be integrated into the general medical, mental health care system as well. What happens is an individual moves along a continuum based on their progress and not dependent on a length of stay that is arbitrary. Next slide.

So, there are two types of assessments that occur in the ASAM criteria. The first is a Level of Care Assessment. And that means an individual goes and has an assessment which is used to determine where and what type of treatment is indicated. And then the criterion also lends itself to a Treatment Planning Assessment, which informs and directs in some ways the treatment that does occur. So it's twofold, bifurcated. Again, [00:09:00] Treatment Assessments are multidimensional. That means we look at every aspect of that patient's, that individual's life. And by the way, what, you're going to hear me call them patients, I'm sorry, I'm a doctor, it's just kind of something I'm just used to. You can call them clients, you can call them people, you can call them participants, um, but that's just, you know, what my training has led me to do.

So if you could translate that in your head, because I don't, I'm too old to change all that. Next slide. Next slide, please. In the fourth edition of the ASAM criterion, there's some significant changes. These are the four, uh, areas of concern or the four domains or the four dimensions, uh, that are evaluated. And you, I'm not going to go through them, uh, but you see that one has to do with their intoxication or withdrawal status. The second one is their biomedical conditions and medical issues, psychiatric conditions, substance related risks. What's happening in the recovery environment and Dimension 6 has been [00:10:00] remodeled and changed around, if you're familiar with the criterion, to be person centered considerations.

What, what about this person needs, how do, what about this person should direct the care? Next slide. And in these dimensions are even sub dimensions. I'm not going to go into this either because we need to focus on recovery residences, but importantly, um, yeah, it's important when you work in a recovery residence, you're spending most of your time looking at dimensions 4, 5, and 6. Um, the recovery residence looks at, um, that individual's likelihood of engaging in substance use, the likelihood of engaging in risky substance use behaviors, that sort of thing. And, importantly, the safety of the current environment, the support of the current environment. Creating safety and support being a central element of a safe and effective recovery residence.

[00:11:00] And for many of our participants, a place they have never felt in their entire life. Next slide. So, again, just to, real quickly, to look at when an individual enters treatment, you see on the left. Uh, they're placed in a continuum of care, a treatment plan is, uh, uh, is developed. That is reassessed. There's a continuing service criteria, so the individual, you can say, should this person remain here? If not, should they move along the, uh, along a path? And importantly, you'll see recovery residences are a central part of that process. Next slide. So if you haven't or are not familiar with the ASAM criteria, there are basically, um, uh, five levels of care, so to speak. An inpatient, a residential level, an intensive outpatient level of

care, an outpatient level of care where there's [00:12:00] not a group treatment, and a recovery residence.

Now what happens is these are blended together. So, uh, why don't you click the next slide so I can show you that. There you are, uh, and you can see this has been inserted into the, um, ASAM criteria as being an essential element. Next, click again. And an individual that's, for instance, in a residential level of care, uh, or an intensive outpatient level of care, might wind up transitioning rapidly into a recovery residence. Or in the case of an intensive outpatient or IOP level of care might be in a recovery residence simultaneous with a level 2.1 program. Click again. And that also, so either one of these individuals, uh, individuals at either one of these levels might wind up transitioning in or being in, um, uh, two, [00:13:00] two levels of care simultaneously.

So the recovery residence winds up creating this supportive after hours environment. The, uh, the, the availability of, um, a community which supports recovery rather than substance use and protects that individual, uh, from, and helps them deal with cravings, helps them deal with recovery skills in social model care. Next slide.

So that also might occur by the way, with long term remission monitoring. You could have an individual that's seeing a psychotherapist and going to support group meetings, AA, recovery, Rational Recovery, or, or, uh, Refuge Recovery. Uh, they could be going to a type of um, outpatient monitoring system and be in a recovery residence as well. So what you see here is you, the, those of [00:14:00] you that work in recovery residences are part of this community of care providers. Now, before I finish my part of the talk, I want to tell you there's an upside and a downside of that. The upside is that by being part of that community, you will be more heavily utilized than in the past.

You'll be considered part of the team of care that is provided. You will also, uh, what about the downside? Well, the downside is there's going to be, you know, there are going to be more oversight of you. Um, the upside is that, uh, the, uh, fees for, uh, programmatic care and recovery residents might hopefully in the future be reimbursed by third party payers such as insurance providers. The downside is when you have insurance providers, then all of a sudden you have oversight that is at times kind of a pain. So there's good [00:15:00] news in that the recovery residences will be part and parcel of this great community that we have of people caring for substance use disorders and be more central to that.

The downside is there's going to be a little more oversight. The upside is that you might be paid more for your work and that there will be more people will be funneled into your systems. The downside is people will be looking over your shoulder. So I, I, I think in general, it weighs out to be a great opportunity for all of us, and especially for our patients who need our care. And I think that's my part. Next slide. Yeah, I'm going to turn it over to Beth. Go ahead, Beth.

[00:15:40] **Beth Fisher:** Oh, thank you for that, Paul. And yeah, I agree with the upside and the downside, but the truth is that the collaboration between clinical levels of care and recovery support services, specifically recovery residences, which is what [00:16:00] we're

focusing on in this talk, that's been naturally occurring for always, hasn't it? And yeah, it's something that I, as a recovery residence provider, often feel like we're in an afterthought in the continuing care continuum that, um, what drives me crazy is this afterthought of a call on a Friday afternoon because I'm in detox or I'm in, um, residential and no thought has been given to that next step.

ASAM puts it down in writing for all providers that we need to be thinking about this right away. And what we're seeing, and you've alluded to it more, is the collaboration between IOP, DHP, and [00:17:00] recovery residences as well. And the slide here gets at some of this. So, we are formally put on this continuum in the Level 3 residential component, which we'll expand on as the slides go on. So let's click on to the next slide. So. When we contrast clinical to social model, I think that clinical has had a lot of attention and I would say preference because this is a funded level of care. Social model is, is a term not a lot of people understand, certainly not in the clinical world.

In recovery residences in the NARR spectrum, National Alliance for Recovery Residences, we talk about social model a lot because social model is what the national [00:18:00] standard has been built on for recovery residences. Social model is a complement to clinical. It's definitely a part of a good continuum of care for the individuals we serve. I'll call them residents because we're talking about recovery residences. But they're two different animals that when working together with intention, with collaboration, collaboration really serve the, our individuals in the best possible way that they're different. So a clinical model, when we look at an approach, we're talking about a, a professional staff, we're talking about, um, licenses, um, MDs, social workers. Whereas a social model is more of a community [00:19:00] based peer support. And it's actually foundational to all recovery support services when we look at this right column. Just to give you a little history, too, on social model, it came into popular use, the term, in the 70s, and it really emerged as a grassroots movement in California, and it's an extension, really of 12 step programs, and it can be seen in the evolution of AA to 12 step homes that emerged in the 40s and 50s, and those 12 step homes were peer to peer support. And it was systematically cultivated within the household community. So the social model emphasizes the acceptance of responsibility for self and [00:20:00] community and considers, and this is important, experiential knowledge, peer leadership in government, governance, and community based support as essential to sustained recovery.

So, recovery support services, recovery residences that employ the social model are integrated into these diverse community and treatment settings, and they are key ingredient to any recovery residence and certainly a certified recovery residence, which we'll talk more about. So then, contrasting further, we've got a care setting in a clinical model, and that can be a detox, it can be residential. Vital for establishing recovery, and then in a social model, we move into a home like setting in the recovery [00:21:00] residence, a true home in a neighborhood with a family of choice. Clinical model is characterized by time limitations, often dictated by those third-party payers. And, and then social model, the length of stay comes from the individual. I determine how long I stay in collaboration with my community and support system. Clinical, we use a treatment language to justify that stay and to talk about what happens in that level of care, whereas social model, we use a recovery, uh, empowered language.

Let's go to the next slide and talk about what a recovery residence is. So when we talk about recovery residence or recovery home, very simply, it says sober, safe and healthy living [00:22:00] environment that promotes recovery from alcohol and other drug use and related problems. And then, when it's a social model, it's a vital part of the recovery residence.

There are four primary characteristics for it, and that is that the setting is the service. And what I mean by that is that the space, the layout, the furnishings. Physical surroundings all contribute to that recovery experience. And that environment matters, the home-like setting promotes a feeling of safety, of family. And that related to that are the interconnections among the individuals and with the environment itself. That the recovery residence experience includes the chance to learn how to build [00:23:00] healthy connections with others. And that this is modeled and practiced in the residence and in my community. I'm practicing how to live, how to implement all the things that I learned in that clinical environment into my day to day life. That's what a recovery residence does. And the reciprocal responsibility and harmony. We're getting at congruence and culture there. That despite the individual differences in their backgrounds, the life experiences, the ages that residents unify around their mutual desire to sustain successful recovery.

And that that community culture is established and maintained through the shared responsibilities, the mutual obligations, the [00:24:00] activities, the rituals that happen in the house. And then lastly, we have the peer and the community, where we have peer governance, we have peer leadership, the community as wisdom, The Collective. And that through participation and the decision making, the residents come to learn that their opinions and their experiences are valued by others, and that residents cultivate a sense of pride and co ownership in the success of the community, and healthy communities generate opportunities for individuals to assume responsible service. And leadership roles. I learned how to have a voice and become empowered in this environment. It's life changing. Let's go to the next slide and talk [00:25:00] about what a recovery residence does. So when it's executed properly, a recovery residence provides an environment that protects the participant from substance availability.

I'm in a safe environment. I am free of social pressures to use, which for many we serve, is new. And I'm free from the substance cues, okay, my triggers for use. And then a recovery residence gives an essential ingredient, and that is time. We need time and space away from substances for the brain to reprogram and to establish a daily routine, engage in recovery activities, and I surmount those, those established patterns, those dysfunctional patterns of [00:26:00] substance use. And that in my home, I sustain a norm, and it's a norm that's different. It's free of mood altering chemicals. We don't have beer in the refrigerator. We don't ascribe to addictive behaviors of any kind, really. That's the culture of a recovery residence. And that recovery residence promotes mutual aid. And experiential learning, there's that word and phrase again, key element, experiential learning to build one's sense of connection, meaningfulness, and a pro social role, Taking Leadership.

It reinforces skills that are learned in the clinical environment, and supports efforts to improve health. [00:27:00] And it provides opportunities to practice those skills and, and establish new patterns. And we facilitate, ultimately, a transition from the expert guidance to

self directed, Empowered Recovery. And it should be noted that one size does not fit all. That this is really individually based, that there are different tools and techniques that are useful with different people and different, uh, Severities, different challenges that participants in recovery residences have the opportunity to explore different attitudes for recovery and different pathways of recovery. And, and try out different peer groups and different ways to model [00:28:00] recovery behavior. And that recovery residences do, this is important to note, that they do address the needs in all of the ASAM criteria dimensions. All recovery residences provide alcohol and illicit drug free living environments that foster a key element that we need of belonging and belonging in a community through mutually beneficial peer support.

And we borrow that peer support from mutual aid societies like AA. But that recovery environment is best described with a social model approach. Beyond that, the recovery residences do differ [00:29:00] widely in the type and intensity of services, including the recovery support they offer, the life skills development, and even the recovery services.

So let's get into that. Let's talk about the different types of recovery residences. Okay, those of you who are NARR affiliated, this is going to be a little different. And I want to give you a little backstory to this. NARR in 2011 was formed from 48 thought leaders. We all came together in Atlanta, Georgia, we represented um, 12 states, at least 12 states, and we created a, a national standard. But the first thing we had to do was, it was call, call the homes what they were. First of all, recovery residences. And then we had to [00:30:00] distill those homes into categories, and we opted for the term of Levels. Frankly, because we were modeling after ASAM levels, loosely, we knew about the six levels according to ASAM, so we decided levels would be a good term, and that was back in 2011.

When ASAM approached NARR leadership, and this really happened recently when we were going to print the manual, we concluded that our levels would be confusing with ASAM levels, so the ASAM, the NARR leadership opted to rebrand, if you will, according to types of recovery resident support. But I will say those of you that are familiar with levels, they are the same. They haven't changed according to the definition. [00:31:00] Those of you who are not familiar with the different types, I'll explain them. Okay, so the four recovery residence types or levels are distinguished by the nature and the amount of, of, of services and intensity of services that that residence provides.

And this lends itself to identifying the most appropriate intensity of support as the participants needs change, so it's fluid. And so, recovery residence is recovery housing that has, this is very important, recovery support services embedded in that housing. Okay, so recovery residence is equal to a recovery [00:32:00] support service, and that's what we're going to explain. What are each of these services? So, all four types are, of course, a recovery housing. All four types are based in a social model recovery support. All four, even the clinical one, the C, okay? That's important. They provide the home like settings that provide the opportunities to learn and practice the interpersonal and other life skills in a recovery supportive setting free of alcohol and drugs, not prescribed by a medical provider, of course.

So let's look at Type P. And this is, this was formerly a Level 1. Now we're calling it a Type P representing Peer Run. Okay. And peer run recovery residences [00:33:00] are democratically run. Alcohol and illicit substance-free recovery homes. And for those of you that are familiar with the Oxford Houses, this is the, uh, good representation of what a Type P. Looks like Oxford Houses are the most widely known example and researched for that matter, and they're included in SAMHSA's National Registry of Evidence Based Programs and Practices. And, um, they maintain a recovery supportive culture and community using house rules, peer accountability, and the key component of SAMHSA's National Registry of is that they are democratically governed. There, the oversight is the community itself.

Let's move on to Type M. Nope, stay on that side slide, [00:34:00] please. And Type M was formerly Level 2, and this is a Monitored Environment, and they're frequently called sober homes or sober living, and they're alcohol and illicit substance free recovery housing that utilize house rules and peer accountability to maintain the healthy living. And they're most often monitored by senior residents who are maybe appointed by the owner operator or a senior resident as head of household. And they're often called house managers or senior resident, either one. NARR does not dictate, nor does ASAM dictate how they're called. And to serve higher needs, or those with lower recovery capital, um, an example might be young adults, transition age youth, or those with opioid [00:35:00] disorders that might go into an S, maybe an S is not available. Some RR Type M's provide recovery support services and life skill development, but it's provided at a lower level, so you only just see that third bar of formalized recovery support services emerging in Type M. You're going to see it more in the Type S. And this is where we have formalized recovery support services, and they can be things like mutual support meetings, a meditation, a morning group, recreation, anything that's more in a schedule as part of a regular routine for that recovery residence. It's structured, so it's, it's a part of what they do there.

And you see that in both [00:36:00] Type S, Type C, and some Type Ms. So a Type S, we've renamed as a Supervised Recovery Residence. Supervised equals Type S, and this is where you see weekly structured programming, uh, peer based recovery support services, um, maybe a, a peer specialist on staff, might be a relapse prevention group, life skills development is a key component. It can be a curriculum, can be one on one peer services. The staff themselves are supervised, they are trained or credentialed, and they are often graduates, or, alumni of the recovery residence. And the Type S, as we describe it in the manual, they're designed to support populations who need a [00:37:00] more intensive support. And that they're just developing recovery capital, and it, so it's, it's more, it's not better, but it's more, and it, it addresses a different need in the individual. And I should note that Type S or Level 3, is licensed in some states, but most not, because it's not, it's still not a clinical environment.

That's what we get into with the Type C. Type C's, or a Level 4 in the NARR spectrum, are licensable. They are a clinical environment, and they integrate the social and the medical model, and they do this typically using [00:38:00] a combination of supervised peer and professional staff, and in addition to peer based recovery support, life skills development, the Type C's offer some kind of addiction treatment. While all Type C residences are licensed treatment programs. Not all licensed treatment programs would qualify as a social model based Type C recovery residence. That's a really important point, okay? So, throughout the

90s, historically, many treatment programs actually discontinued their social model elements, which was a departure from today's residential community milieu approach that the, this current edition of ASAM does [00:39:00] a nice job of describing. An example I can call out of a Type C is a recovery residence that implements social model care in a Therapeutic Community or a TC. And this is also most aligned with ASAM's level 3.1 Clinically Managed, Low Intensity Residential Services. Paul, is there anything you want to say more about that 3. 1?

[00:39:34] **Dr. Paul Earley:** 3.1 is just a lower level of intensive outpatient care and provides services that also ensure that remission status is active in that individual.

[00:39:58] **Beth Fisher:** Okay, now we can go on [00:40:00] to So, we could actually spend a couple hours, um, taking apart this slide. I just wanted to call, throw it up there so you could see it's actually in the manual. Okay, and, and what this shows you is how the recovery residence types can be placed on a continuum that spans those more or less intense types of services, and it's a nice comparison of them. And the choice of a residence type, it depends on the participant's different preferences, as well as their needs, right? So that recovery, because it's a non linear process, individuals can enter and move about these different types. To effectively and cost effectively [00:41:00] match their needs, which are ever evolving with the right type of support.

And that's what's listed here. So, so they differ in their bundled services, they differ in how they're governed, they differ in their staffing models. So, so they're, they're different. And that needs to be taken into consideration when we start thinking about placement. So, let's move on to the next slide and talk about that. So, we have individual needs for placement considerations, rather. Um, and, and there are 10 different considerations that would take a lot longer than we have to describe, so I would invite you just to go to the manual. I can list them for you. [00:42:00] But really, I think this, this 4 considerations will suffice for what we need to start thinking about when we're looking at placement.

And that's, first of all, the recovery capital, and when we talk about recovery capital, we're really referencing the resources an individual has to help them establish and maintain their recovery. And we're looking at their skills, their abilities, their experience, knowledge, resources, just to fulfill basic needs like health care, housing, of course, their transportation, education, um, employment, their social support, their community support, what they have around them. So the higher the person's recovery capital, the less [00:43:00] intensive the recovery residence we might want to consider, okay? The next is the onsite staffing of that recovery residence, and this is, of course, the amount and type of staffing necessary to support the person in recovery.

If I am a young adult who's never lived on their own before, I probably want to look at a Type S or C, which has that built in staffing help. Okay, the governance, how that recovery residence is governed is the degree to which the individual engages in the supportive community with their own agency. So the higher the level of governance, the greater the role of the recovery [00:44:00] residence staff in implementing that culture of community and accountability.

Um, And then lastly, the on site support, the structure of the recovery residences, the services. And to what degree does the resident self initiate their own recovery? And the different types of recovery residences denote the varying degrees of agency that the individual has over how the recovery services, the support and structure are accessed. So, integrating the NARR Types into the ASAM criteria recommendations, it promotes the access to both treatment and recovery support services, and it gives a blueprint, a roadmap [00:45:00] for how these services can be joined and unified to, and this, this helps outcomes, right? It gives a better outcome. And it reduces financial costs, social costs of addiction.

And this change to the ASAM criteria reflects the importance of recovery support services and treating it as a chronic, not an acute, but a chronic illness, and it helps those we serve develop and practice the life skills that promote resilience and help them to face their life challenges. Let's go to the last slide.

How do we implement this? Again, we can talk a lot more than we have time [00:46:00] for. But basically we embrace that this is a Chronic Care Model. Recovery Residences are a Recovery Support Service. and that our stakeholders. can now consider. I mean, we've been, we've been straight up legitimized, y'all, and so we can be an investment for those third party payers, for even grant funders. That this is on an even playing field in the continuum with treatment, okay? And that the types of recovery residences, particularly those that are standard based, defined by NARR, allow for this alignment, better alignment, defined alignment, of the individual [00:47:00] need to the services that are provided in that recovery residence. And it helps to really define a referral process. Okay, we're not winging it anymore, folks.

We are, we are on the radar and I do want to put in a shout for Certified Standards Based Recovery Residences. Paul didn't talk a lot about this, but the ASAM is a standards manual, okay? NARR also, National Alliance for Recovery Residences, is a standards certifying organization. Okay, and the primary function of NARR is to promulgate a standard for all types of recovery residences that the state affiliates implement as a quality assurance. And this also helps with [00:48:00] our outcomes data, because that's part of the standard. So, so this is a, a key ingredient to sustained recovery. I think this is a really exciting paradigm shift for recovery residence providers.

You can tell I'm very excited about it. I've been doing this work for, um, 28 years. I've had my own recovery residence and then worked before in one and never have I felt so, um, so just respected in my field. It used to be that my clinical peers would kind of scrunch their noses up and say, why on earth would you want to do that? But, well, why I want to do it is because this is where we actually get to see how recovery happens. And now we have a [00:49:00] book that outlines the recipe for how it happens. So with that, I'll stop. I know y'all have a lot of questions.

[00:49:10] **Janice Fulkerson:** Dr. Early, Beth, there are many, many, many questions that we have in the chat and in the Q & A. So many that we probably won't be able to get to all of them, but I wanted to first give a shout out.

There is kudos to Beth and Dr. Early. This is a real game changer for recovery residences and the people that we serve. Well done. So we'll start with a little, uh, feed, positive feedback and then jump into some questions. I think that there's a big one here that might be tough to answer. Um, but there's quite a few questions around how this model, the ASAM changes, would fit with a Housing First Model related to, you know, we, we oftentimes talk about Housing First models and then [00:50:00] Recovery Housing models. What are your thoughts about how the new ASAM criteria impacts Housing First models?

[00:50:08] **Dr. Paul Earley:** Uh, so thank you. That's a great question. So, 1st of all, um, Housing First is not yet been incorporated into these standards. So what, how that, what, but ASAM as an organization is a firm believer that for many people, Housing First is the first step towards remission. Um, how that would work is that when an individual is in the Housing First situation, that that would stabilize their life to a place. And then at some point during that, uh, during that stay, they might be assessed to determine, um, the clinical and recovery residents needs uh, for, for further care. So [00:51:00] basically it's outside the ASAM criteria. The ASAM criteria keeps expanding to look at more and more of the spectrum of the illness of addiction, but that is one area that is outside, as I say. Uh, but what would happen is someone would be in, as I say, in a Housing First situation, and then at some point, it, the, the organization that's supporting that individual along with that individual would talk about what the treatment needs would begin, and then the ASAM assessment process would occur, they would be placed in proper care, and they would be placed in the proper level of supportive housing, whether that's their current situation or a new situation, uh, that is, uh, that is for people a little further along their journey, if you will, in recovery. But the criterion is silent on this issue, but it doesn't mean the organization is silent on it. It means we couldn't encompass the entire [00:52:00] spectrum.

[00:52:00] **Janice Fulkerson:** Thank you for that. Um, I think about that oftentimes, and I think I put it in, uh, one of the answers I, I put on the chat is Yes/And. You know, when we talk about the recovery continuum, and we talk about the medical model and the social model, and all of the resources available, it really is a yes. And here's how we can move forward. So, um, great. Thank you for that. Another question, um, related to that, has the ASAM assessment criteria changed?

[00:52:29] **Dr. Paul Earley:** I'm sorry.

[00:52:33] **Janice Fulkerson:** Has the ASAM assessment criteria, has that changed?

[00:52:36] **Dr. Paul Earley:** Oh, absolutely. The criterion has changed, um, not necessarily in the, the way, the short answer is yes. We've become, um, the most important question is, the most important change has been a shifting around of the dimensions as we had more experience with ASAM criteria over time, um, uh, the [00:53:00] types of things that we've had to address have changed. We've become obviously more cognizant of, uh, of recovery residences and social model recovery, and that transition from kind of clinical recovery to social model recovery. Um, and the, we've learned enough from the, the decades of experience that each time the, uh, criteria, uh, undergoes another addition, we become more sophisticated in how we look at this chronic condition for the best outcome.

[00:53:33] **Janice Fulkerson:** Right. Thank you. Um, a follow up question to that. Is this available now? Is it live? Is there a phase in period? When is this effective?

[00:53:44] **Dr. Paul Earley:** So the, the, uh, Fourth Edition of the ASAM Criterion is now available. Uh, it is published by Hazelden, uh, Press. Uh, they were our partner in publishing the criteria. And it, again, it was a [00:54:00] collaborative work of hundreds of people, hundreds, probably, probably about 80 people, probably somewhat like that, including our good friends from NARR and, uh, and, and from the recovery residence community, contributed to the, uh, the, the document that, uh, you saw on my first slide.

So it is available now. Now, What, what does that mean for people? Does it mean that automatically that, for instance, third party payers and insurance providers and treatment providers just say, okay, we got this? No, everyone takes a while to swallow the whole thing to be able to kind of go, Oh, my goodness, there's some big changes here. Um, so, uh, so you're going to find that everything from providers to third party payers to governmental agencies will take some time in adopting and adjusting to the criteria and my guess is that time frame is will be measured in [00:55:00] a year or more. It's to make that transition. So we're the good news is we're on our way. We're not there yet.

[00:55:08] **Janice Fulkerson:** All right. Thank you for that. Do you have any good examples of recovery supportive service providers that are receiving formal 3rd party payer support? And then the follow up is, do you have recommendations on how to work with the third parties to ensure that as insurance carriers and payers roll out this chapter and then updates, um, that there's good collaboration.

[00:55:36] **Dr. Paul Earley:** So, Beth, do you have the answer to the 1st part of that question?

[00:55:38] **Beth Fisher:** I do. I do. The, the peer services are increasingly that we're seeing reimbursement for certified peers that work within a recovery residence. So those peer services broken out, even sometimes drug testing, or that's a, that's a sticky wicket in [00:56:00] itself, but ethically done some of the breakout services in the recovery residents we're seeing at. Uh, Type S, of course, the Type C. And occasionally, the life skills curriculum can be made a case for as well, and that's, you can find that in a type M as well sometimes. So, breakout, breakout recovery support services, yes, I am very hopeful that more and more we will see the bundled services as well.

[00:56:39] **Dr. Paul Earley:** As to what we can do in the future, you see a great comment by Gene. I'll mash up your last name, Gene. I'm sorry, but crucial opportunities for affiliates and operators to engage in conversations with policymakers, advocates and groups like FGI and NARR. That's a, that's what's important here. We, [00:57:00] we need you to get active on the political spectrum. Remember that third party payers are not necessarily, um, facile in adopting new, uh, standards. But the ASAM criteria is The Only, well, you know, regarded standard in figuring out about chronic addiction care. And by recovery residences being folded into this process, what you get is a standard. And what you get is an opportunity to be

part of the research of figuring out what works, what types of services work, what amount of services with what particular individual works.

So it's also being folded into a research base, which will validate the good care that you provide. So it is not only it's saying this is a generally accepted standard. And that what will happen as [00:58:00] researchers move forward is they will do more work of looking at this entire spectrum of services, including recovery residences, in the, uh, the necessary care, necessary care, but you're going to, it's going to need some lobbying. Um, it's going to need some policymakers. I will tell you that on the national level, um, many, uh, the, the federal government, for instance, uh, SAMHSA, um, uh, we know that SAMHSA is very interested in incorporating everything in the new criteria into its standards so that, um, Medicare, Medicaid may actually be the first place where this becomes, uh, more of a standard.

Insurance companies require pressure. They, um, well, let's just put it this way. They tend to feel like they need to take care of the funds that they have in front of them. And so they are going to require pressure to, uh, to adopt these [00:59:00] things. But, remember, the ASAM standard is the only standard and is the one that has the most proven efficacy and research base. So, you're joining, I think, a movement which will ensure that quality care is extended to all who suffer from this illness.

[00:59:18] **Janice Fulkerson:** A quick note, we are quickly coming up on time, so I'll want to just clarify one of the questions was related to unlicensed and licensed recovery residences eligible for Medicaid reimbursement, and how likely those things are available in the future.And Dr. Early, I think you answered it well. It's, you know, I think Medicaid, Medicare, CMS generally takes the lead. Um, a lot of times, private insurers then follow, um, when there's community pressure to make the, make similar changes. But I think, uh, the NARR organization, I know Fletcher Group, we are working [01:00:00] diligently in many states to get, um, recovery, supportive services and a lot of recovery um, things into, uh, Medicaid programs and payables.

So, um, with that, I know there are a lot of unanswered questions. So, a couple of follow ups. One, this webinar, um, recording and the slides will be on the Fletcher Group website, uh, for in the next week for people to access. Everybody who participated today will get an email with a link to that. Um, and we will also send out future information on how to get more information, how to follow up, how to get more training, um, and how to stay connected as this really, as Gene put it, crucial and important changes are being made and rolled out across the United States. So thank you for your leadership, Beth and Paul. Thank you for being here today. And we wish everybody a fabulous day. [01:01:00] Take care.