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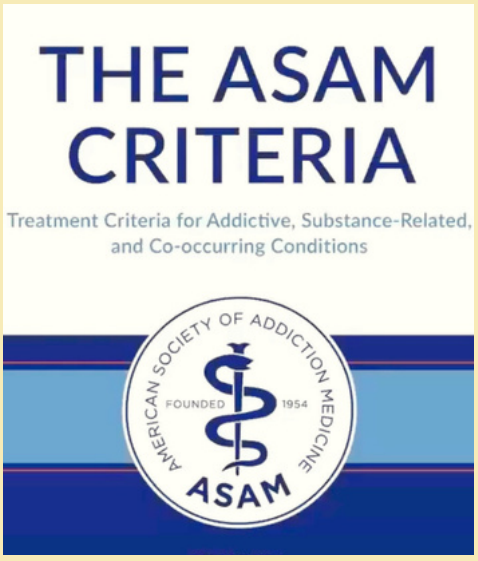
RECOVERY

The official newsletter of the Fletcher Group Rural Center Of Excellence



INTO THE FUTURE

Fletcher Group
The Fletcher Group Rural Center of Excellence

by Founder and Chief Medical Officer Dr. Ernie Fletcher

Talk about collaboration! Roughly 80 people contributed to the latest criteria changes issued by the American Society of Addiction Medicine and, given the chance, I would heartily shake the hand of each and every one.

Thanks to them, recovery housing is no longer fighting for a seat at the table. For the first time ever, your work is now fully and formally recognized as an essential element in the nation's evidence-based continuum of care.

It's a milestone we can all be proud of and one that promises at least some relief from the gaps in funding, research, and acceptance that have hampered recovery housing, particularly in the rural communities we serve.

We have good cause to celebrate, especially when we consider how many people fought so hard and for so long to reach this point. But this is no time to rest on our laurels. Insurance providers and the other major players in our field are not eager adopters of new standards and will need both encouragement and guidance.

Lastly, let's not forget the many no longer with us who dreamed of this day. May their persistence, devotion, and love of humanity live on in each of us.

RECOGNITION AT LAST

"I've never felt so respected *or* so excited" says Beth Fisher Sanders, the 30-year social model practitioner who helped integrate recovery support services, including recovery residences, into ASAM's latest criteria.

"My clinical peers used to scrunch up their noses and say, 'Why are you working with the social model?' And I'd say, 'Because that's where the action is; there's nothing like it. That's why it's so great to see it and recovery housing get the recognition they deserve."

A Long Time Coming

The social model of recovery took root in the 70's as a grassroots movement providing affordable therapy and a sober, safe living environment. Its embrace of experiential knowledge as the basis of authority and its preference for peer-to-peer support over practitioner-client learning didn't always sit well with clinicians, but that didn't stop the peer-to-peer model from becoming the norm in recovery homes across the country. It's also stood the test of time with numerous studies showing similar or better outcomes than more expensive, clinically-oriented programs.

"It's the institutional funding that made the clinical model so dominant," says Sanders. "The social model never had that and has been challenged by gaps in funding, research, and acceptance from the very beginning."

The ASAM criteria in 1991 and the National Alliance for Recovery Residences in 2011 were created to address those challenges. They continue to work hand-in-hand with ASAM focused on structuring care and NARR on standardizing housing.

Dr. Paul Early, who presented with Sanders at the Fletcher Group's February webinar, recalls ASAM's initial goal—to do for recovery what diagnostics criteria had done for another chronic illness. "When I started as a doctor almost 40 years ago, cancer diagnosis was helter-skelter," says Early. "The same patient with the same symptoms could be prescribed radiation by one doctor and surgery by another. But evidence-based criteria eventually changed that and led to dramatically improved outcomes. Our hope was that evidence-based criteria would have the same effect in the field of addiction recovery."

WATCH THE VIDEO
of our webinar with Beth Fisher Sanders and Dr. Paul Earley.

CLICK HERE

Initially thought of as rivals, the social and clinical models have actually been complementing each other for decades now, says Sanders.

"There was a time when we were just an afterthought, like when you'd get a call late on Friday saying, 'I'm in detox but I have no place to stay.' The clinical model just didn't take that into account. Thankfully, the social model does. It's taken a while but the two are working better together now than ever before. It's true they're two completely different animals, but when used collaboratively with intention they can do wonders. And now, thanks to ASAM, we have all the components of a complete continuum of care down in writing so providers can understand the value of each component and how to use them to achieve the best possible outcome."

WHAT'S CHANGED...AND WHAT HASN'T

ASAM has long believed that housing is a first step toward remission. Now it's been codified. And with that stamp of approval comes a wealth of new opportunities, including insurance renumeration (see page 4).

An additional major change regards nomeclature. Until recently, NARR, like ASAM, used numbers to identify its "Recovery Residence Levels of Support" with Level I for peer-run housing, Level II for monitored housing, Level III for supervised housing, and Level IV for housing supervised by a service provider. But in talks between NARR and ASAM just before the printing of ASAM's fourth and most recent edition, NARR realized that using too many numbers might confuse people and decided to 'rebrand" its levels using letters instead.

As a result, “P” now stands for peer-based support (an Oxford House, for example), “M” for managed support (as when overseen by a manager of residents lacking recovery capital), “S” for supervised support (by trained or certified staff who provide more structured services), and “C” for clinical (referring to a licensable facility that leverages both clinical and social models to treat residents in dire need of recovery capital).

According to Dr. Early, the change helps ASAM align more closely with NARR's levels of resident support. He is also quick to note, however, that "only the labels have changed. Those familiar with NARR and ASAM will notice that the definitions in each category haven't changed at all."

All the labels, definitions, and hard work that go into them have a single purpose, says Early. "It's all about providing the proper continuum of care so people can build the recovery capital they need to establish and maintain recovery. That means looking carefully at all the skills, abilities, experience, knowledge, and resources people rely on to fulfill their basic needs such as healthcare, housing, transportation, education, employment, and social support.”

The trick, of course, is to provide those supports and services with the flexibility required by a chronic disease notoriously resistant to remission. ASAM's new criteria acknowledge what so many people have long known—that a safe, supportive living environment is essential. "Sadly," says Early, "that's something many people have never experienced."

When talking of housing, Early often uses the phrase, “the setting is the service" to highlight the embedding of support services that occurs naturally in a recovery residence. Whether it's level P, M, S, or C, the goal of recovery housing is to provide the kind of flexible, pro-active support that can literally save lives.

WHAT IT MEANS TO YOU

How will ASAM's new criteria affect you? Only time will tell. But here's what we know as of now.

Hot Off the Presses
The Fourth Edition of the ASAM Criteria has been published by Hazelden Press and is available to all. Its effects, particularly its embrace of recovery housing and the social model, are already rippling across the country. But as with any change, there will be both pros and cons.

The Obvious Upside
As a result of being recognized as a legitimate component of the nation's evidence-based continuum of care, your rural recovery home is likely to grow. That's because residents may in the future be reimbursed by third-party payers such as insurance companies. With more residents able to pay for your services, your recovery home's income may increase significantly as more and more people come your way.

The Likely Downside
With insurance money comes oversight. "The downside is you'll have people looking over your shoulder," says Dr. Early. "But even taking that into account, the ASAM criteria changes will create opportunities for everyone, especially the residents who desparately need our care."

How Might It Work?
Will third-party payers, treatment providers, insurance companies, and government agencies immediately jump on board? "No," says Sanders. "It takes everyone a while to swallow something this big. My guess is it will be a year or more before we see the ground-level effects. We're on our way, but we're not there yet."

Is Anyone Already Benefitting?
Asked during our February webinar for examples of supportive service providers receiving third-party payer support, Sanders said, “Yes, we're seeing more reimbursement for certified peers that work within a recovery residence, particularly when those services, like drug testing, are broken out. That naturally tends to happen more at Level S (professionally supervised houses) and Level C (clinically supervised treatment), but there's a case to be made for life skills training at Level M (a managed recovery home). I'm also confident that, at some point, we'll see bundled services covered as well.”

Some Lead, Some Follow.
If tradition holds, Medicaid and Medicare will be the early adopters with private insurers following their lead. One example is the success NARR and the Fletcher Group have had in helping state Medicaid programs incorporate supportive services.

Engage Now!
"Now’s the time to engage policymakers, third-party payers, and politicians who typically need a push to adopt new standards,” says Early. “But because ASAM has officially recognized the role of recovery homes, you’re no longer talking about a hypothetical. You’re simply insisting that a standard be followed. And be sure to mention SAMHSA; they’re already incorporating our new criteria and carry a lot of weight.”

“One more thing,” says Early. “Be sure to participate in research. That will validate the care you provide and help define best practices going forward.”

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