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RECOVERY

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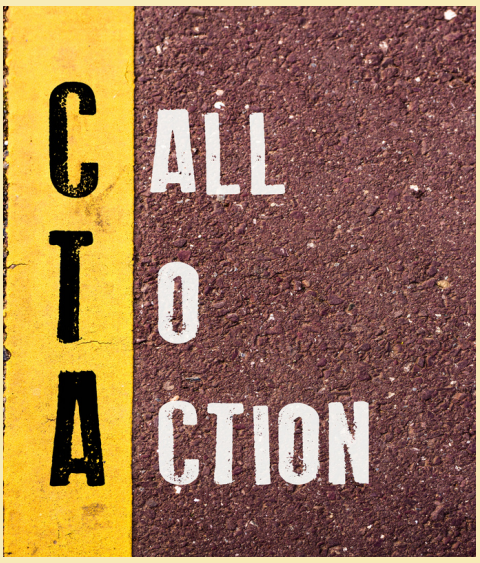

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A LONG TIME COMING

by Founder and Chief Medical Officer Dr. Ernie Fletcher

We've been at this for a while. The American Society for Addiction Medicine was founded nearly 70 years ago and released its first "patient placement criteria" just over 30 years ago. This past November ASAM endorsed a more "holistic, person-centered approach" (in other words the social model) and the "need for a safe environment" (in other words recovery housing).

Much as we might wish otherwise, ASAM's proposed integration of clinical and social models won't happen overnight. There are serious communication challenges (see page 2) and questions about how recovery housing can prove its value to insurers (see page 3). But there *are* steps you can take now to make sure funding comes your way as soon as possible (see page 4).

Good things, they say, take time. Great things—like bringing effective recovery housing to rural America—can sometimes take even a little longer.

FINDING COMMON GROUND

It’s hard to find common ground without a common language. That’s why recovery home operators will want to prepare themselves for the occasional blank stare when making their pitch for the funding made possible by ASAM’s most recent criteria changes.

Take the term *recovery capital*. It's the underlying concept driving ASAM's embrace of recovery housing and may also be the strongest card a recovery home can play when seeking financial support. But that doesn’t mean that every clinician you meet will understand it.

"Recovery capital can be a completely new concept for people who've never thought about addiction this way," says Anne Shields, the Fletcher Group's Rural Specialist in SUD and Recovery Housing. But it’s not the only concept Medicaid administrators, insurers, and other potential funders may have trouble with.

Chronic Care Model
"We’ve been using this term for 20 years," says Shields, "but I still hear people say, 'How is addiction a chronic condition if only some people relapse?' But ASAM’s firmly endorsed the Chronic Care Model, including its goals of sustaining long-term remission, facilitating regular checkups, incorporating remission monitoring in all treatment plans, and accepting relapse as a natural part of the disease process.

Measurement-Based Care
Often referred to by its acronym, MBC was mentioned in the ASAM criteria for the first time this past November—around the same time SAMHSA announced its own "Measurement-Informed Care." Both mandate regular checkups. "If you have diabetes, you don't go three months without seeing a provider or having your blood sugar checked," says Shields. "ASAM wants people to check in regularly, not just when they're having trouble."

Of course, terms like *remission monitoring* will continue to puzzle those who reject the idea that addiction is a chronic condition. "Those people,” says Shields, “will be equally skeptical when asked that relapse prevention and rapid response be built into standard treatment plans. We’ll need to be patient but persistent because the education process is going to take a while.”

WATCH THE VIDEO
of our March webinar with Anne Shields.

CLICK HERE

The Social Model
Yes, even the model we practice every day may need explanation.
And that goes for other terms like *Peer Support*, *Team-Based Care*, even *Recovery Ecosystem*. "The good news," says Shields, "is that all social model concepts point in the same direction. They all refer to and rely on a strong web of community support centered around safe, sober housing."

Full understanding hinges on the acceptance that humans are social animals in need of connection, particularly when healing. Only in the presence of kindred spirits can we access on the deepest levels the fears and feelings that have held us back and the hopes and dreams that can pull us forward.

MEASURING SUCCESS

Government agencies and insurers will want proof that recovery housing works. At the moment there is no universally accepted tool for quantifying recovery home outcomes, but there is one that looks promising: BARC-10, with BARC standing for *Brief Assessment of Recovery Capital*.

The BARC-10 is a strength-based, self-reported, ten-question survey that draws from a far more detailed 50-item standardized measure called the *Assessment of Recovery Capital*. Though it takes only two to five minutes to complete, pilot programs have shown that it provides a reliably useful assessment of an individual client's recovery resources. Once a baseline measure is established, support services can be customized to each person's needs for maximum effectiveness.

One attendee at our March webinar claimed over a year's experience using BARC-10 in adult drug courts and veteran treatment courts with clients filling out the form between each of five phases of an 18-month program.

How It Works

Clients rate their answers on a scale of one (strongly disagree) to six (strongly agree). Total scores range widely, from 6 to 60, with 47 and above indicating the ability to sustain long-term recovery. Those surveyed are not told the results but can be asked follow-up questions such as, "Why did you give yourself that rating?" and "What would it take for you to give yourself a slightly higher rating?"

"It's similar to PHQ 9, GAIN, or any of the other measurement tools we use in behavioral health," says Shields. "It's best to let clients fill out the form themselves rather than reading the questions and doing the scoring for them. That helps prevent any inadvertent influence."

BARC-10's fans include William White and David Best who said in a 2017 White Paper that BARC-10 "concisely measures a single, unified dimension of recovery capital that may have utility for researchers, clinicians, and recovery support services."

The hope is that BARC 10 can reliably demonstrate the ability of recovery residences to build the recovery capital residents need to stay the course.

"It's a given that insurers will want recovery homes to use this," says Shields. "It will help them determine what should be covered—whether the reimbursement is for a community resource, a recovery support service, or housing.

"I recommend that rural recovery homes use it at least periodically to measure any service they're offering. It's going to give you a huge leg up in demonstrating to insurers and other funders the value you add to a client's treatment plan."

WHAT TO DO NEXT (AND HOW WE CAN HELP)

Defining next steps is tricky when so much is still unsettled, but we'll give it a shot.

1. Contact Your State Medicaid Office
"Bring the new ASAM Chapter 15 criteria to the attention of your state Medicaid agency," says Shields. "Do so by building a good working relationship with someone in the program who understands the importance of recovery housing or is at least interested in listening. When you meet them, point out the fact that your work aligns with the findings and guidance of the American Society of Addiction Medicine."

2. Familiarize Yourself with CMS
The Centers for Medicare and Medicaid Services provides health coverage to more than 160 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. "It's the 900-pound gorilla when it comes to funding medical care," says Shields. "But don't forget: it moves at a glacial pace. I've worked on several CMS projects in behavioral medicine and it always took at least two years to get things going. But that just makes it all the more important to starting building relationships as soon as possible." One option is to develop your own pilot project to test and document how recovery housing might be financed through state addiction funding.

3. Do Your Homework
Insurance money always comes with strings. Read the fine print carefully and do the research needed to make sure you don't overlook something important or are caught off-guard by a lack of accurate documentation.

4. Ask for Help
Approaching new people is not easy, especially in unfamiliar settings where waiting times and administrative processes can make you feel like a lost puppy. There's an art to it, one that we at the Fletcher Group are well-practiced at. Let us know what you're hoping to do and we'll be glad to lend a hand or a connection. We can also help you develop an effective communications strategy, create the right materials and setting for a productive conversation, and help you with the data and documentation you may need to make your case.

We can also share with you lessons learned from a new pilot program in Kentucky where we will administer state Medicaid payments to recovery homes. And don't forget: our six-person research team has a wealth of data that can bolster your position while boosting your confidence.

5. Keep After It
The new era launched by ASAM's recent criteria changes is only now in its infancy and will continue for years to come. Given the amount of time it may take to affect change, patience and flexibility are in order.

Because nothing will happen all at once, take the long view by focusing on the incremental, day-by-day learning that will eventually make you an expert at maximizing all the new funding and other opportunities headed your way.

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