

2019 UPDATE



**ALLIANCE FOR ADDICTION  
PAYMENT REFORM**

**INCENTIVIZING RECOVERY. NOT RELAPSE.**

# Addiction Recovery Medical Home Alternative Payment Model

**INCENTIVIZING RECOVERY. NOT RELAPSE.**

**A CONSENSUS LEARNING MODEL**

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## INTRODUCTION

In 2017, The President of the United States declared the opioid epidemic a public health emergency. Overdoses have risen to become the leading cause of accidental death for those under 50. According to the Centers for Disease Control and Prevention (CDC), drug overdoses claimed the lives of 65,800 Americans in 2018, while alcohol-related deaths out-paced those from opioids at approximately 220 per day with far less public attention paid to that substance problem. Furthermore, over the last three years, life expectancy for Americans has started to decline for the first time in decades. Substance use disorders (SUDs) have devastating effects on our communities and drive enormous inefficiencies in health care. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), over 20 million Americans 12 and older are estimated to be currently suffering from an SUD. Despite the magnitude of addiction, there is a lack of credible consumer and health system-focused information about an integrated continuum of care that could stem the growing prevalence of this public health challenge.

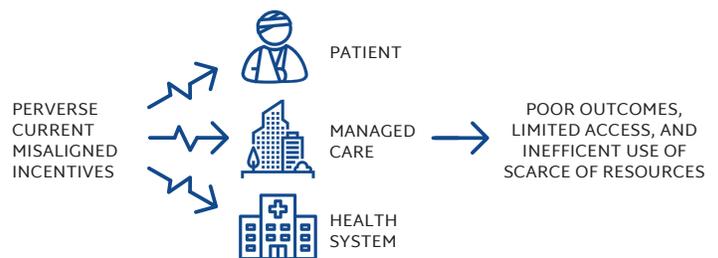
Unlike many other chronic conditions – where “standards of excellence” inform consumers, health systems, and payers about best practices and services that should be available – today’s recovery services are delivered through a system often lacking alignment or integrated economic structures that incentivize long-term recovery. Behavioral health services have largely been developed in isolation from physical health services and continue to be disconnected for most consumers. Primary care physicians (PCPs) are typically not equipped with the tools, training, and resources to manage SUD, unlike other primary chronic health conditions.

The human and economic cost for this fragmentation and inefficiency is unsustainable. Payers, health systems, and patients face a vacuum as to what a “center of excellence” might look like for an integrated, comprehensive medical and community response for addiction. In late 2016, an entire chapter was dedicated in the United States Surgeon General’s seminal report: *Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs and Health*, issuing a call to action for mainstream health systems to integrate substance use services into their delivery networks.

In order to help more people recover from addiction we must shift from a short-term, acute treatment response to a comprehensive, sustained patient-focused solution that traverses the health care continuum and provides effective primary and secondary prevention efforts, clinical treatment, and ongoing recovery support services for individuals and families. Such care should be evidence-based and evidence-informed, incorporate all relevant clinical and recovery support disciplines, and unequivocally and compassionately place the patient at the center.

This paper aspires to outline a model that goes beyond stabilization to a biopsychosocial sustained model of recovery management comparable to the management standards and protocols for physical chronic disease. The underlying philosophy guiding this approach is one of sustained recovery management as a means of organizing addiction treatment and recovery support services to enhance early pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.<sup>1</sup>

We have evidence that informs us what interventions work best for initiating and sustaining recovery. We have the talent to grow/build a workforce to encircle patients in advancing their recovery. We have an evolving payment culture that is progressively moving financial accountability closer to the primary care physician (PCP) and the patient. What we require now is unique innovation and collaboration to harness these converging forces and change the nature of treatment and recovery from addiction. **A system that incentivizes recovery. Not relapse.**



## OVERARCHING PRINCIPLES

In August 2017, the Alliance for Recovery-Centered Addiction Health Services convened over 40 clinical, addiction, information technology, primary care, social, regulatory, and policy experts with the objective of developing an alternative payment model (APM) that corresponds with an integrated treatment and recovery network (ITRN) care model. The initial one-year collaboration, facilitated by Leavitt Partners and Third Horizon Strategies, resulted in the publication of the Addiction Recovery Medical Home - Alternative Payment Model (ARMH) in September of 2018. In 2019, Third Horizon Strategies continued to manage the work on behalf of The Alliance for Addiction Payment Reform (Alliance). The release of this paper coincides with the announcement of pilot explorations of the ARMH in local communities.

The ARMH assimilates evidenced-based treatment and evidence-informed recovery services with a payment system that integrates assets and incentives in a way to treat addiction like a chronic disease. The model has the flexibility to meet providers and patients where they are, while honoring chronic disease management principles that will improve the coordination and application of care and recovery. There are 10 guiding principles that bound the conditions and protocols of the ARMH:

1. Recovery from SUD is a process of change whereby individuals achieve SUD remission, work to improve their own health and wellness, and live a meaningful life in a community of their choice while striving to achieve their full potential.<sup>2</sup>
2. Care recovery has three critical, interconnected episodes: pre-recovery/stabilization, recovery initiation and active treatment, and community-based recovery management.<sup>3</sup>
3. Recovery management requires a multi-disciplinary care recovery team who can provide the diverse biopsychosocial elements of treatment needed. Subsequently, it is critical in creating optimal conditions for recovery and improving personal, family, and community recovery capital.
4. A well-managed and broad continuum of care, ranging from emergent and stabilizing acute-care settings to community-based services and support, is essential in managing patient needs across the stages of personal and family recovery.
5. Clinical and non-clinical recovery support assets, across a continuum of care, should be integrated, allowing for the sharing of patient information, high-functioning care transitions, and commensurate clinical and safety standards.
6. Co-morbidities and co-occurring mental health challenges must be managed in concert with the underlying treatment and recovery of SUD, with a care recovery team facilitating timely and consistent feedback and appropriate information sharing within the patient-centered medical community.
7. Recovery support strategies must accommodate and support the growing varieties of SUD recovery and the broader spectrum of alcohol and other drug problem solving experiences. There are no static SUD cases. As a result, the model must be sufficiently malleable to accommodate for multiple pathways styles of alcohol and other substance problem resolution, including a subclinical focus (i.e., there are multiple pathways and styles of SUD problem resolution, as there are in the resolution of subclinical alcohol and other drug problems).
8. Integrating economic benefits and risks between payers and the delivery system will promote greater accountability and care design. This will assist in facilitating a holistic and comprehensive care recovery environment for the patient.
9. Recovery from addiction is a life-long process, with five years of sustained substance problem resolution marking a point of recovery stability in which risk of future SUD recurrence equals the SUD risk within the general population.<sup>4,5</sup>
10. A dynamic treatment and recovery plan with the breadth and flexibility to engender increased recovery capital should be authored in collaboration with the patient, the patient's family, and other key social supports.

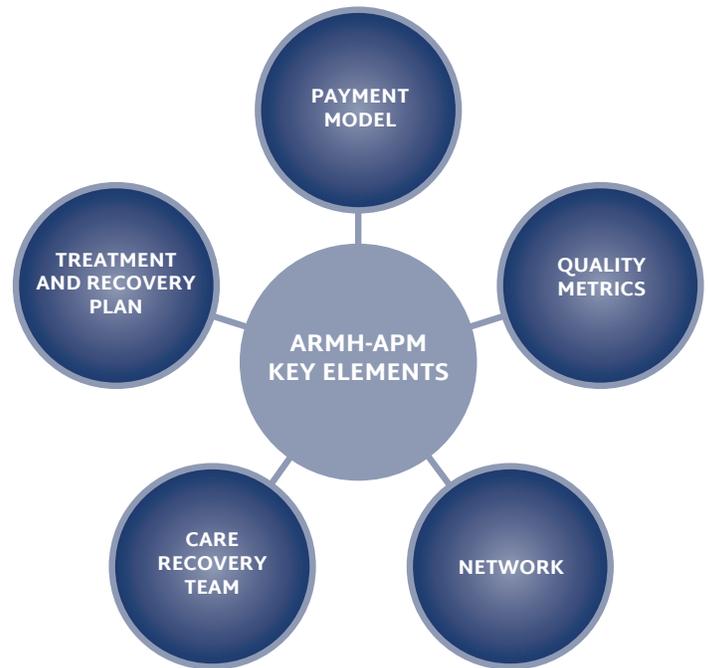
# ADDICTION RECOVERY MEDICAL HOME (ARMH) MODEL OVERVIEW

The ARMH model is unique in its scope and transformative approach to long-term community-based treatment and recovery from all SUDs. The ARMH model was established with the initial goal of organizing care principles most germane to opioid use disorder (OUD) and alcohol use disorder (AUD); however, the underlying principles traverse the substance spectrum and are intended to be sufficiently modular to support recovery in other contexts.<sup>1</sup>

This document presents the foundational elements of the ARMH model in hopes that interested parties can adopt the principles in developing patient-centered, chronic-disease management programs that improve the outcomes for patients seeking recovery from addiction. Additionally, the Alliance is now supporting pilots of the ARMH model in a variety markets beginning in late 2019 and 2020. A rigorous research methodology will be developed and leveraged to study the effects of the value-based model on recovery outcomes when compared to fee-for-service or other value-based models of care. This methodology will also study correlations between specific model tenets and the corresponding outputs.

The ARMH model is deliberately flexible for various operational permutations, permitting pilot partners or other interested parties to tailor the model to their contracting, resource, and patient needs. While the Alliance welcomes and encourages such flexibility, the principles and requirements codified in this document should be adhered to for basic coordination with ARMH principles. The specific ARMH model provides an aspirational vision for how the Alliance recommends ITRN's be developed, however, the Alliance acknowledges for each market and geography the evolution to value-based alternative payment models will be different and may need to be implemented in a phased approach. The Alliance

is proud to be collaborating with other valued-based addiction treatment and recovery programs aligning with the core principles of the ARMH.



The five foundational elements of the ARMH are as follows:

## *Element #1 – Payment*

The payment model, which adopts elements of episodes of care and bundled payments, rewards performance based on recovery-linked quality and process measures. Risk-bearing providers or providers in pay-for performance arrangements have three mechanisms through which they assume risk, achieve bonus payments, and achieve a non-traditional payment adjustment from the model:

1. Episodes of Care: risk/reward is tied to the provision of more integrated and personalized care using the defined ARMH bundle definitions and optional modules

<sup>1</sup> Note that the Alliance explored whether to extend the principles of the ARMH to patients with tobacco or nicotine use disorder (NUD), ultimately electing to forgo the application. The variation of the clinical resources required for substance use disorder was one disqualifying factor. Further, the recognition that some patient's recovery can be hastened by allowing for tobacco use as an intermediate step was also considered. While controversial, the Alliance gained consensus to proceed without expressly including NUD as a key tenet of the ARMH model.

2. Quality Achievement Payment: a portion of the bundled payment is tied to achievement of successful patient outcomes
3. Performance Bonus: providers may be eligible to share in additional savings created from better coordinating patient care across all health care services, including addiction, behavioral, and physical services

#### *Element #2 – Quality and Process Measures*

Drawing from best current practices in the field, ARMH pilot demonstrations will refine entry and participation criteria for providers. The pilots will also develop both process and outcomes measures that will tie the provision of care to payment, incenting recovery and informing a national baseline of much needed long-term substance use disorder performance metrics.

#### *Element #3 – Network*

Care is integrated across clinical (acute, out-patient, behavioral/mental health, virtual health) and community recovery support resources. Treatment and recovery support services are delivered in as close proximity to the patient's natural living environment, circumstances permitting.

#### *Element #4 – Care Recovery Team*

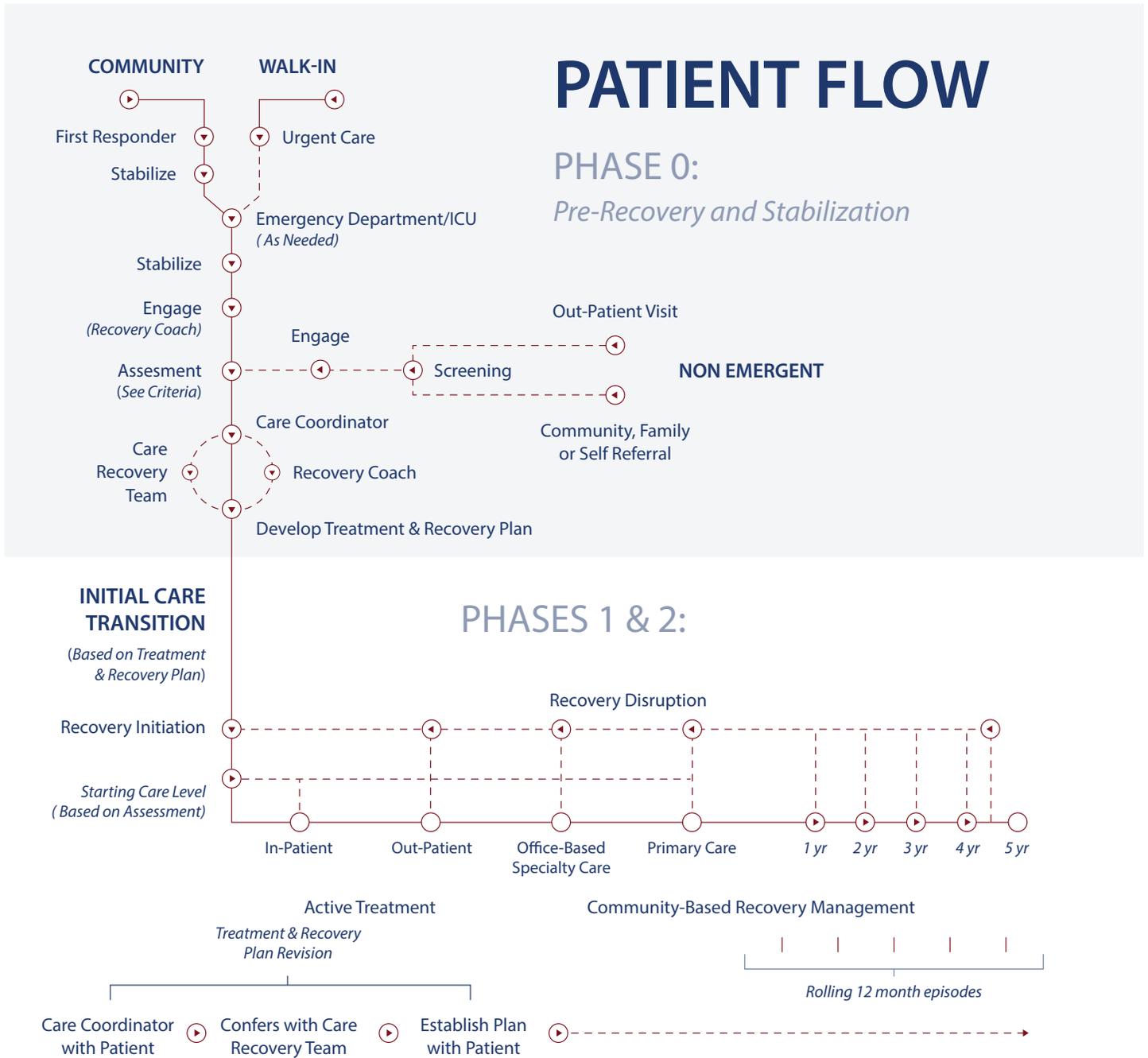
Care is coordinated by a central team, which focuses on long-term recovery. Working with patients on a wholistic recovery process including the patient, family, peer support, community, social determinants, and other key environmental conditions that promote enhanced health and quality of life.

#### *Element #5 – Treatment and Recovery Plan*

The ARMH model recommends linking broadly used, evidenced-based treatment placement and assessment tools with concurrent longer-term, recovery-focused patient planning. Similar to other chronic diseases, the treatment and recovery plan is individualized and designed according to combined input from both the patient and the care team. While mindfulness of clinical evidence is key to recovery planning, deferring to the patient as the expert in his or her recovery carries significant value.

Within the ARMH framework, providers and payers are incentivized to tailor the approach to each patient to optimize overall wellness.

# PATIENT ON-RAMPS & CARE TRANSITIONS



## PAYMENT MODEL

The Alliance views the disintegration of economic resources as chiefly responsible for the fragmentation of addiction treatment and recovery services. In recent years, government and commercial payers have increasingly introduced payment demonstrations designed to promote improved integration of disparate parts of the delivery system to foster improved collaboration and efficiency. In the case of the ARMH, the proposed payment model is designed to promote improved integration of treatment and recovery resources with corresponding financial incentives that inure to the stakeholders' benefit when the patient is on a sustained path to recovery.

Like any value-based payment model, providers and payers are unable to control or directly influence all facets of a person's recovery, including the various manifestations of addiction and recovery disruptions. However, the operating thesis is that an alternative payment model aligned with stakeholder objectives will create conditions and engagement protocols that materially improve the patient's likelihood of long-term recovery, generating savings for the system and providing a benefit to participants.

The ARMH relies on severity-adjusted criteria and various payment modalities to mitigate exogenous risk factors and compartmentalize specific processes and outcomes for payment.

The ARMH payment is for comprehensive addiction health services and co-occurring mental health needs with optional co-morbid modules. The shared savings fund, from which bonus payments to high-achieving providers are drawn, is created from the savings accrued as a result of better coordinated, whole-person treatment. When providers can integrate addiction treatment with treatment for underlying behavioral or physical health disorders, savings result from more efficient and targeted resource use, driving better outcomes for all stakeholders.

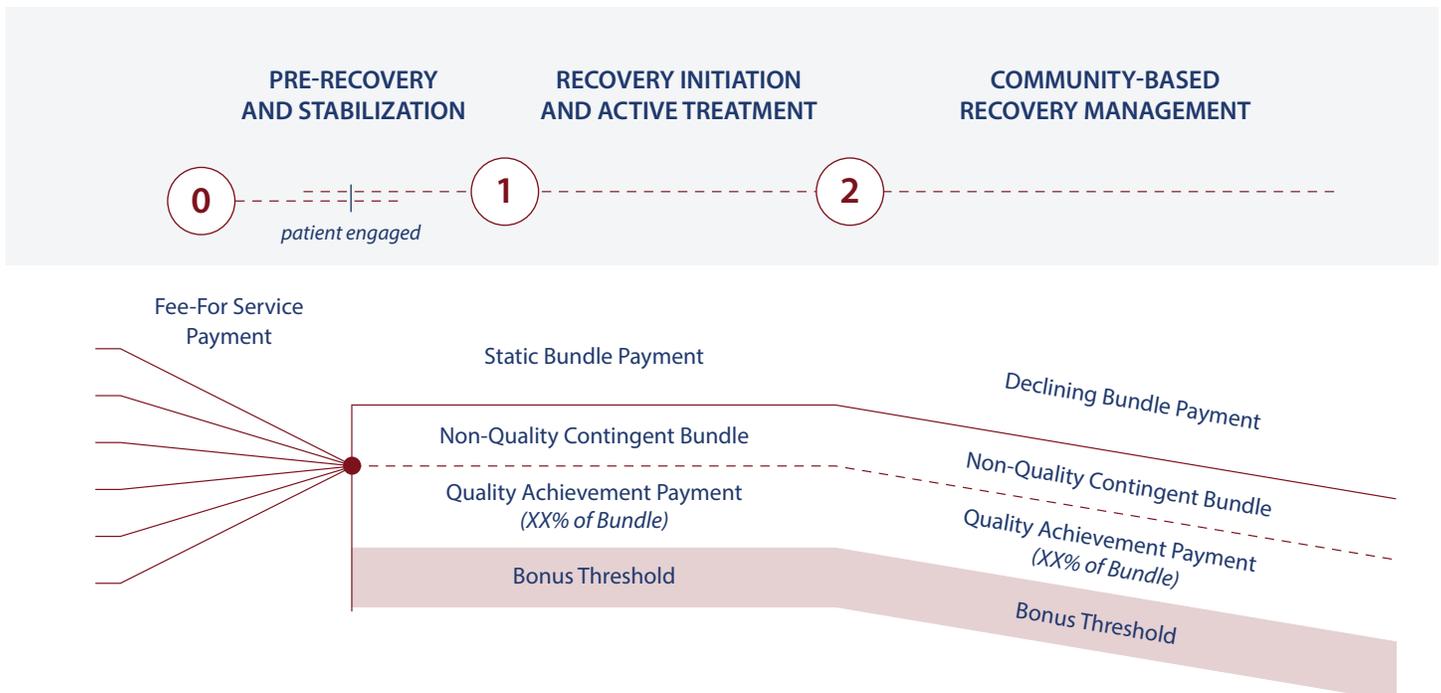
### PAYMENT MODALITIES

The ARMH is a unique hybrid of several payment models that correspond with the critical domains of a patient's recovery. The model leverages three key payment modalities across different phases of recovery.

#### *Fee-for-Service (FFS) Payments*

While the ARMH is specifically designed to circumvent the ongoing use of FFS payments in addiction treatment and recovery, the Alliance recognizes the

## PAYMENT TYPES FOR EPISODES OF CARE



value of maintaining the integrity of this system in cases of emergent patient-care requiring stabilization in the emergency department (ED) or intensive care unit (ICU) settings. Fee-for-service payments are only leveraged in the ARMH for pre-recovery engagement and stabilization services.

### ***Bundle Payments Corresponding to Defined Episodes of Care***

Full risk-based payments are at the heart of the ARMH, representing a financial vehicle designed to directly tie economics to patient success. Bundled payment rates are tied to population or per-patient-based severity criteria, adjusting the payment amount for patients with a higher-risk of SUD and/or co-complicating factors (co-morbidities and/or co-occurring mental health challenges).

The bundled payment amounts would be separated between the two episodes of care in the ARMH model: Recovery Initiation and Active Treatment, and Community-Based Recovery Management. While providers are given the flexibility to treat the patient with the evidence-based tools most suited to each patient's specific transitions and recovery needs, the ARMH does, however, provide certain guidelines regarding the clinical settings for each episode and the process boundaries for care transitions, screenings, assessments, and other related matters. For operational purposes, the Alliance recommends that providers receive episode of care payments on a six or twelve month basis, for up to five years.

Bundled payments can be paid either prospectively or retrospectively, depending on any risk stabilizing features installed by the provider and Managed Care Organization (MCO), or the administrative sophistication required to fully manage the episode of care payments for SUD-related treatment recovery services and optional modules.

As a prospective payment, the MCO would pay the coordinating provider the severity-adjusted bundled payment for the Recovery Initiation and Active Treatment episode of care when the provider and patient initiate recovery under the ARMH. The provider must use the allotted funds to provide care to the patient and is fully "at-risk" for care costs above the payment amount related to SUD services. The Alliance

recommends that ARMH contracts between providers and payers include a requirement for provider excess or stop-loss coverage that protects the provider from the corrosive financial conditions correlated with higher-risk patients. At a time contractually identified by the payer and provider (e.g. annually or when the patient transitions to the next episode of recovery), the provider's quality achievement payment will be determined. Specifically, an agreed upon percentage of the total base payment is tied to a provider's performance on process and outcome measures. If a provider has not met quality measure requirements, they will remit payment back to the payer as a penalty.

If the partnering MCO and provider conclude that a retrospective payment is most feasible, the provider would continue to code and claim services as under FFS. Afterwards, at a time contractually identified by the payer and provider (e.g. annually or when the patient transitions to the next episode of care), the payer will adjust the provider payment based on the total amount allotted under the severity-adjusted episode for patient care (periodic payment adjustment). This may result in funds flowing back from the provider to payer. Optionally, this periodic payment calculation can be merged with the provider's potential "quality achievement payment," under which the provider is rewarded for achievement on process and outcomes measures. Through this payment, a percentage of the total base payment is tied to a provider's performance on process and outcomes measures. This amount may be fully recognized as a separate payment or, in instances where the provider owes the payer funds at periodic payment adjustment, the provider can use the incentive payment to offset the cost of care above the severity-adjusted episode amount allotted under the model. The Alliance recommends that ITRN contracts between providers and payers include provider excess/stop loss provisions consistent with their agreements, particularly for small patient populations.

### ***Quality Achievement Payment***

The ARMH is quality-adjusted and can be implemented in a variety of flexible ways to meet the needs of the local market conditions. The base payment is a population or per-patient-based severity payment for defined episodes of care. For providers who succeed across process and outcome measures, there is

a “quality achievement payment,” under which an agreed upon percentage of the total payment is tied to performance on process and outcomes measures. The ARMH model proposes a sliding scale that correlates the percentage of the quality achievement payment to the provider’s metric achievement (e.g. 75 percent metric achievement should correlate to a payment of 75 percent of the maximum possible payment of the agreed upon percentage of the total base payment). For example, if an ARMH provider meets the defined process and outcome quality metrics, the provider can receive the quality achievement payment. This quality adjustment safeguards shared interest in patient recovery among providers and payers.

### ***Shared-Savings Performance Bonus***

Those ARMH entities who obtain the quality achievement payment can also be eligible for a performance bonus equal to a defined percentage<sup>2</sup> of the overall savings that are achieved across the patient’s entire continuum of care or total medical expense. Specifically, the pool of bonus funds comes from the expected shared savings attributable to the increased coordination and treatment of patients across all health care services: addiction, behavioral, and physical. While the majority of savings are expected on the medical side, better coordination of addiction treatment is also expected to generate savings for the insurer across all care. There are a variety of different types of structure in how a payer and ITRN can operationalize this element of the model.

For operational purposes, the payer must be accountable for addiction treatment payment under the ARMH. For commercial or Medicaid programs in states in which behavioral health and physical health funding streams are separated, ARMH entities can consider a risk-bearing entity that can convene and merge both the physical and behavioral health payments for identified patients.

## **SEVERITY ADJUSTMENT**

To ensure payments are commensurate with the underlying risk factors of the patient in the defined population, the ARMH model incorporates a severity-adjusted model that provides for tiered payment.

This methodology contemplates a series of key biopsychosocial determinants to ascertain the relative risk of a patient receiving services under the ARMH model.

### ***Severity Categories***

The episode of care payment can be stratified per patient or at the population level. Populations are separated into categories of low, moderate, and high patient-severity. The payer will use global claims to determine the patient-severity-based payment category. The Alliance expects that both payment amounts and number of individuals within each category will vary by geography or type of insurance (e.g. Medicaid/employer-sponsored/Medicare). The Alliance views the severity adjustment as adequately covering patient variation and allaying the concerns of adverse selection.

### ***Global Claims***

While global claims data is a good starting point for patient-severity stratification, it may not always be sufficient to quantify the underlying severity of the illness or the clinical care required by the patient. Population-based averages will ultimately help even out the margins, but under circumstances in which patient severity is higher or lower than predicted, the payer and provider can contemplate a retrospective adjustment that will better characterize miscategorized patients.

Payers and providers will need to use the appropriate data sets for target populations and coverage types to determine payment amounts for each episode and the corresponding patient-severity adjustment by category of low, moderate, and high, determining total per episode payment. Operationally, ARMH payers expect that codes for services, delivered as defined in the bundle definition, will be taken into account to set target pricing for the episode of care payments, but not used to restrict or require specific types of care delivered under the treatment and recovery plan, leaving those determinations up to the properly incentivized provider.

### ***Patient Risk Evaluation Criteria***

In addition to the claims-based patient severity stratification, the provider can also use Patient Risk

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2 The ARMH suggests that provider bonuses are 50 percent of the achieved shared savings.

Evaluation Criteria, such as the factors listed below, to evaluate each patient and the appropriate clinical recommendations and episode movement. The Alliance recommends drawing from these criteria where data are available. In 2020 and 2021, the initial pilots will begin to spin off outcome data, and the Alliance plans to amend this document to provide sample methods and pathways for creating a severity adjustment model.

1. Readiness for treatment/readiness for change
  - How many recovery attempts has the patient made?
  - What are the number of ED/ICU discharges for the patient over the previous two-year period?
  - To what degree has the patient been an active and participatory collaborator in the creation of their treatment and recovery plan?
2. Severity of Illness and related Impairment
  - Type of substance use disorder
  - Co-morbid behavioral health disorders
  - Co-morbid physical issues
  - Pregnancy
3. Social/Functional determinants of health/Recovery capital
  - Job or educational status
  - Home status
    - Living situation
    - Family support
    - Community-based support

As the model matures, the Alliance expects that many of the criteria will be used in conjunction with claims data to stratify patient risk and appropriately calibrate the bundle payments.

## **ADDICTION RECOVERY MEDICAL HOME EPISODES OF CARE**

In keeping with the principles developed by the Alliance, there are distinct phases of recovery for the patient, comprising episode zero, one, and two.

The payment and the ARMH quality metrics will follow the patient across episodes of care. Participating

providers must adhere to the ARMH treatment and recovery model but are not bound to specific services within the episode. All clinically appropriate care within the episode, as determined by the provider, is covered by the bundled payment. This structure is meant to provide a flexible approach to treatment, recognizing that no single pathway will work for all patients.

The Alliance expects that the risk inherent in the payment model will incentivize risk-bearing providers to employ evidence-based treatment tools that are best tailored to each patient's recovery. As a result, the Alliance has not prescribed specific treatment or therapeutic requirements. For a review of medication and behavioral evidence-based treatment options, see *Facing Addiction in America*, Chapter 4 [6, pp. 4-14 through 4-31]. Likewise, for review of evidence-informed recovery support services, see *Facing Addiction in America*, Chapter 5 [7, pp. 5-7 through 5-15].

### Episode Zero: Pre-Recovery and Stabilization

In this episode, the patient is being treated for conditions related to an SUD, such as medical stabilization or primary care chronic disease management. There are a myriad of pathways to this phase, including emergency care, acute care, physician screening and identification, or the patient or family voluntarily seeking treatment and recovery support. This episode is intended to support the stabilization and engagement of the patient into the ARMH model.

Services under this phase, typically administered in the ED, ICU, or primary care settings are paid on the basis of FFS, leveraging the current coding and payment architectures in place today.

The Alliance would encourage adopters of the ARMH model to introduce pay-for-performance incentives to providers and clinicians. These incentives can encourage the clinically-appropriate identification (through evidence-based screening tools) and support the facilitation of a patient from pre-recovery engagement to recovery initiation.

### Episode One: Recovery Initiation and Active Treatment

This first episode is focused on initial inclusion of the patient into the ARMH, following the stabilizing features of Pre-Recovery and Stabilization. The care administered under this episode is intended to be for higher-acuity

patients who have a moderate to severe SUD. As such, the institutional spectrum ranges from post-ED inpatient care to residential treatment to intensive outpatient care delivery. This first episode is designed to promote strong connectivity between clinically appropriate institutional settings and the underlying care recovery team working to promote active recovery with the patient (see also Key Network Requirements).

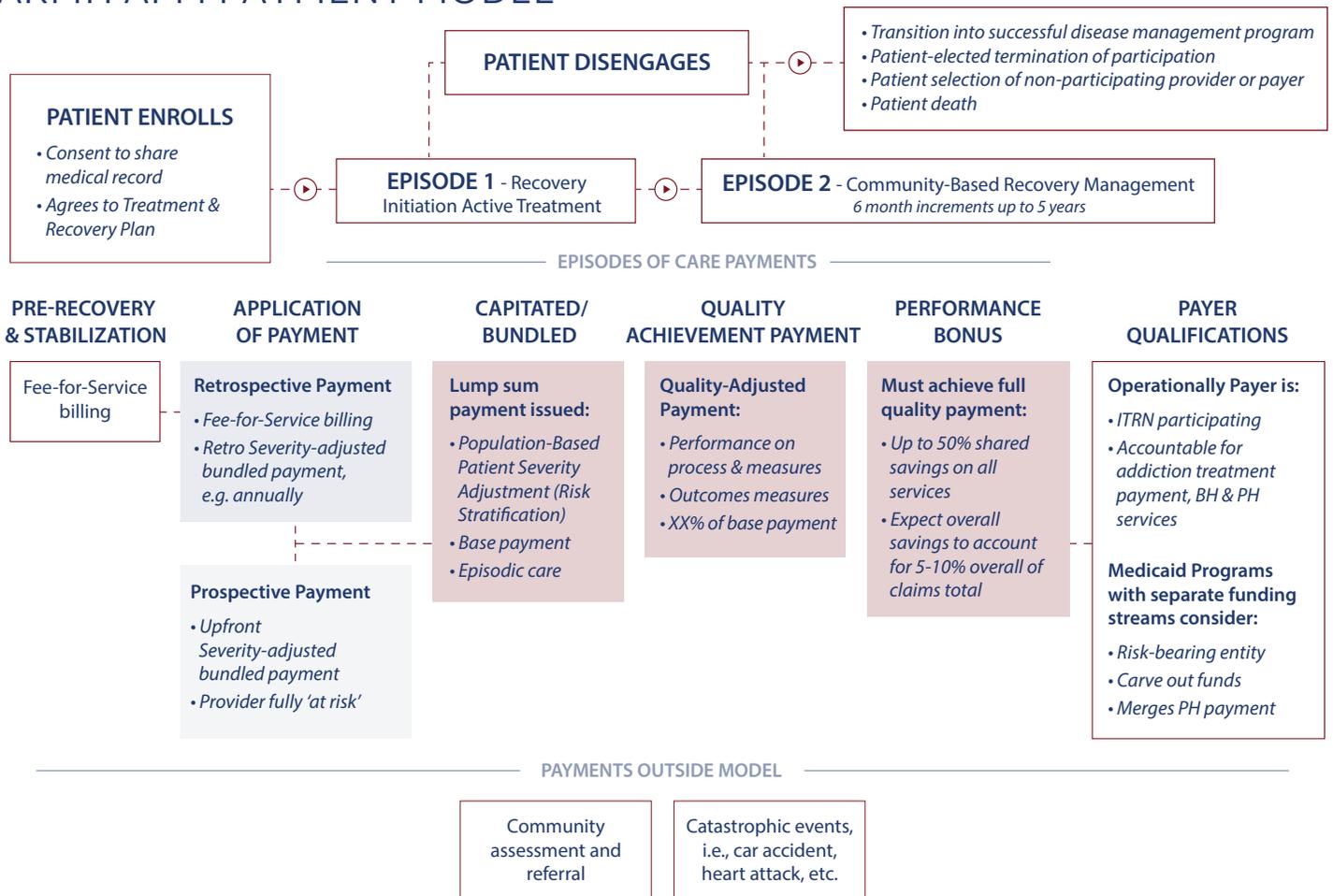
The care recovery team and the patient will collectively decide when the need for high acuity care has diminished. Once the patient has successfully completed intensive outpatient services or 12 months have elapsed, the patient will transition into the second episode of care, the Community-Based Recovery Management episode, and payment will shift to align correspondingly.

### Episode Two: Community-Based Recovery Management

This second episode of the ARMH model does not rely on acute care settings, though it does not preclude the use of clinically appropriate institutions. Instead, this

episode focuses on the patient's integration into their community and the continuation of a treatment and recovery plan that sustains the patient in their living, vocational, spiritual, and recreational environments. This episode is critical and represents the highest risk to the provider, as a failure to adequately engage and support the patient could lead to a high-cost, avoidable recovery disruption. If recovery disruption occurs, requiring a transfer of the patient to a higher-acuity setting, the patient will receive the clinically appropriate treatment under the payment rate for the second episode. In other words, because recovery disruption is built into the bundled payment for the second episode (population-based patient-severity adjusted payment for the episode of care), the payment for a patient who has a recovery disruption while in the community recovery phase will not be adjusted upward to the rate under the higher-acuity first episode. The Alliance believes this strategy will incentivize coordinated care and thoughtful transitions and will reduce incentives to steer patients into a higher level of care when clinically unnecessary.

## ARMH-APM PAYMENT MODEL



In addition, the ARMH model quality measures will take into account avoidable recovery disruption.

## PATIENT ENROLLMENT

ARMH episode one or two payment begins at patient enrollment, represented in the model as the transition from the Pre-Recovery and Stabilization phase into either Recovery Initiation and Active Treatment (episode one) or Community-based Recovery Management (episode two). Enrollment should be facilitated by the caregiver at the express consent of the patient. The patient must be diagnosed with an SUD, notified of their participation in the ARMH model, and provide their consent to:

- 1) Adhere to a material portion of the clinically recommended treatment; and
- 2) Allow for the sharing of the protected health information (PHI) within the ITRN, meeting the specific SUD regulations governed by 42 CFR Part 2 requiring specific patient consent.

This active enrollment is an important part of the ARMH, as it carries key information and conditions required to establish a reasonable risk-based payment for subsequent services.

The Alliance's objective is to safeguard against a "wrong door" for a patient, ensuring the identification and engagement of patients where they are. There are four general pathways into the ARMH model, which are subject to certain conditions and limitations:

- 1) There must be a participating provider and payer offering ARMH services in the community. More specifically, a patient must be an enrollee under a licensed provider who is participating under the corresponding business line.
  - a. Note: participating providers under the ARMH model could offer a commensurate portfolio of services on an FFS or cash basis. This circumvents several of the protections, principles, and standards under the program.
- 2) The provider and payer must jointly support and underwrite care coordination and recovery coaches able to facilitate enrollment and transitions for patients looking to participate in the ARMH model.

The four patient pathways are below.

### Emergency Department or Intensive Care Unit

It is anticipated that some individuals with addiction identified in the ED or ICU will elect participation in the ARMH. Others, who are less inclined to begin a treatment and recovery process, may decline participation in a comprehensive treatment and recovery plan. Coordinating providers in the ARMH are encouraged to utilize care team members to actively outreach about the benefits of participating in a comprehensive addiction treatment and recovery network, using evidence-based or evidenced-informed motivational strategies for patients receiving stabilization services in the ED or ICU. Separate performance payments or incentives for screening, identification, and enrollment are not included under the ARMH; however, the ARMH framework does not preclude such incentives so long as they are not structured to promote conditions for adverse selection, gaming, or the general enrollment of patients who do not meet the clinical conditions for participation. Regardless, it is expected that the enrolling support personnel is sufficiently integrated with the ED or ICU. This is necessary so they have identification and proximity to patients when facilitating counsel and education regarding the ARMH model. Coordinating providers can perform this role in-person or virtually, in collaboration with the ED/ICU. Alternatively, the ARMH-coordinating provider could separately remunerate the ED/ICU for supporting the transition of the patient or initiating recovery coaching. As noted above, services provided to the patient in this setting are paid under FFS until they enroll in the program.

### Payer Identification

Payers will be encouraged to perform advanced analytics on their claims data. Analytics will help to identify patients at high risk for an SUD or those who have patterns of utilization of services and resources related to treatment and recovery. In these cases, the payer can work closely with the patient's PCP, or enrollment personnel, to try and engage the patient introduce the ARMH program.

### Primary Care or Community Screening

PCPs, recovery coaches, and community health workers (CHWs) can screen patients for SUD. In cases

where these screenings affirm the existence of an SUD, these providers can discuss ARMH services with the patient and contact the care coordinator or enrollment specialist. The care coordinator can provide an overview of the program to the patient and their family. Parties that administer the ARMH can use their discretion in deploying evidence-based screening tools, including:

- Alcohol Screening and Brief Intervention for Adolescents and Youth: A Practitioner's Guide<sup>16</sup>
- Alcohol Use Disorders Identification Text (AUDIT)<sup>17</sup>
- Alcohol Use Disorders Identification Test-C<sup>18</sup>
- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)<sup>19</sup>
- CRAFFT<sup>20</sup>
- Drug Abuse Screen Test<sup>21</sup>
- DAST-20: Adolescent Version<sup>22</sup>
- Helping Patients Who Drink Too Much: A Clinician's Guide<sup>23</sup>
- NIDA Drug use Screening Tool<sup>24</sup>
- NIDA Drug Use Screening Tool: Quick Screen<sup>25</sup>
- Opioid Risk Tool<sup>26</sup>
- S2BI<sup>27</sup>

#### Volunteer

Patients and/or families may become aware of the ARMH program. Further, providers of the ARMH program may see value in marketing their services to prospective patients. In either event, patients can access these services on a volunteer basis, reaching out and discussing their options with the enrollment team.

Patients may be un-enrolled from the ARMH program through various conditions and circumstances. Payment would terminate under these circumstances:

- Patient transition into successful disease management
- Patient death
- Patient-elected termination of participation
- Patient selection of non-participating provider or payer
- Payer/provider termination of the program

At the discretion of ARMH network payers, a patient may transfer coverage and payment from his/her current payer to a new payer, without a disruption in treatment or payment to the provider, if the two ARMH participating payers can agree to the arrangement in advance.

Payers may also be incentivized to recruit additional providers groups to the ARMH for the purpose of expanding their ability to treat individuals with addiction, in a given market. A wider network of participating providers could alleviate payment disruption from patient selection of a non-participating provider.

At patient departure, unless the departure occurs at the successful conclusion of an established treatment and recovery plan, the provider and payer may need to adjust payments to account for the early termination of the episode of care.

Finally, ARMH participants will be required to provide a final version of a treatment and recovery plan that can be used by the patient and/or future caregivers (at the discretion of the patient).

## **SUBCONTRACTING**

The ARMH model allows for subcontracting arrangements, among parties under which other participating entities can contract with a partner, to provide certain ARMH treatment and recovery services. The subcontracting arrangement may utilize a payment model or quality metrics that differ from the ARMH-adopted payment model or quality metrics. However, the risk-bearing entity facilitating the ARMH program will remain bound by the ITRN treatment and recovery plan, quality metrics, and payment model. In the case of subcontracting and establishing a network of integrated delivery sites that meet ARMH guidelines, the risk-bearing provider or payer will be responsible for claims management and adjudication, payment, and other regulatory requirements for administering the payment.

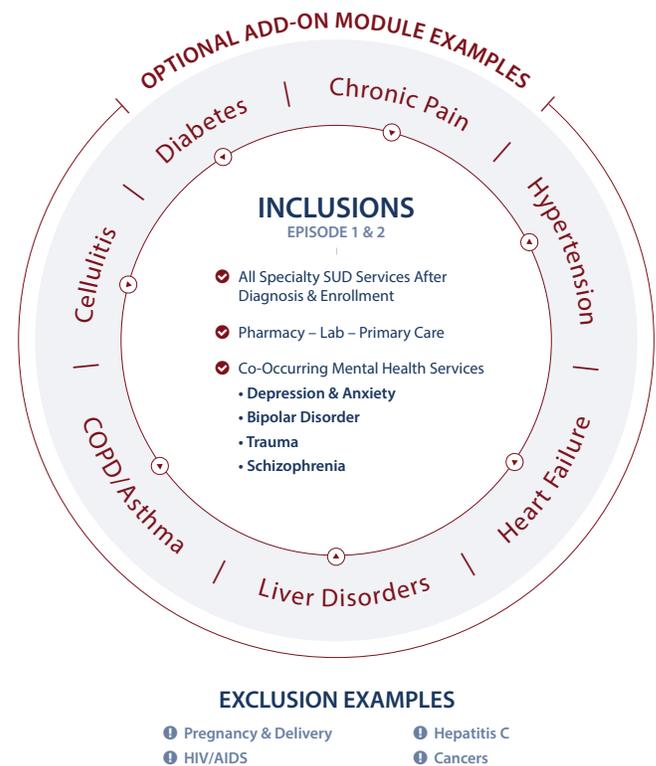
## **SETTING TARGET BUNDLE PRICE AND DEFINING THE BUNDLE**

In every deployment of the ARMH, there will be unique geographic, insurance-type, population size, severity adjustments, and optional integrated health modules, providing variances in the ultimate contracted bundle

price. The Alliance worked throughout 2019, with significant in-kind support provided by Remedy Partners, to define the specific attributes of the proposed ARMH integrated bundle. The main inclusions and exclusions of the bundle are summarized below, along with detailed standard code workbooks attached in the appendix that can be used for implementation by a payer or risk-barring entity. The general principles for arriving at a mutually agreeable bundle price, between payers and providers, are as follows:

- Informed by best-practice or evidence for services delivered based on severity of SUD
- Geographically adjusted price for local patterns and variations
- Uses empirical data analysis to provide allowance for complications (i.e. recovery disruptions or actionable adverse events)
- Allowances included for care coordination, recovery coaching, and mobile technology needs not typically found in retrospective FFS claims analysis
- Allowances for subcontracting to community-based services and other recovery supports
- Patient accountability bundle pricing is recommended to be annualized
- Significant evidence exists that demonstrates the connection between co-occurring mental health conditions and SUD to also include the treatment and management of associated mental health disorders as a mandatory inclusion in the ARMH bundle definition
- Emerging evidence suggests that including co-morbid conditions along with optional modules, as a component of the scope of the bundle, will further improve outcomes through enhanced physical health integration

## ARMH-APM BUNDLE INCLUSIONS



To Download The Supplemental ARMH-APM Bundle Definition Code Workbook Visit:

<https://www.incentivizerecovery.org/download-armh-apm-documents>

## Defining Triggers

In accordance with the current Diagnostic and Statistical Manual of Mental Disorders, DSM-5, a sample of the variety of triggering types of SUD diagnosis for each episode are listed below with the detailed full comprehensive codes found in the appendix:

TYPE OF SUD	EPISODE 1	EPISODE 2
Alcohol Abuse	YES	YES
Alcohol Dependence	YES	
Cannabis Dependence	YES	
Cocaine and Amphetamine Use Disorder	YES	YES
Cocaine and Amphetamine Dependence	YES	
Hallucinogen Dependence	YES	
Inhalant Abuse	YES	YES
Inhalant Dependence	YES	
Opioid Abuse	YES	YES
Opioid Dependence	YES	
SUD in Remission		YES
Polysubstance Dependence	YES	
Sedative, Hypnotic or Anxiolytic Abuse	YES	YES
Sedative, Hypnotic or Anxiolytic Dependence	YES	

In addition, certain services that are very specific for substance use patients would be used for triggering the episode independently as well. These include rehabilitation and detox stays that are identified by their procedure codes, as well as definitive drug screening and quantitative drug testing services that are identified by CPT and HCPCS codes.

## Episode Co-Occurring and Co-Morbid Inclusions

Based on the composition and capacity of the ITRN, the ARMH bundle has the potential flexibility to focus solely on SUD and co-occurring issues a patient has, while incentive risks and rewards can be tied to performance on associated physical health conditions. Alternatively, in an ideal scenario the ARMH provider would include modules for any co-morbid physical health conditions that a patient may have, in order to treat and manage a patient with an SUD in a more integrated fashion. Depending on the sophistication level of the payer, risk adjustment models can adjust the target price for each patient based on severity and the presence of co-occurring and co-morbid conditions.

COMORBIDITIES (INCLUSIONS)	EPISODE 1 & 2	CORE / OPTIONAL
<b>Underlying BEHAVIORAL HEALTH conditions</b>		
Depression & Anxiety	YES	Core
Bipolar Disorder	YES	Core
Trauma & Stressors Disorders	YES	Core
Schizophrenia	YES	Core
<b>Associated PHYSICAL HEALTH conditions</b>		
Diabetes, Chronic Pain	YES	Optional
Hypertension, Lipid Disorders	YES	Optional
GERD, Peptic Ulcer Disease, Pancreatitis	YES	Optional
Liver Disorders, Esophageal Varices	YES	Optional
Skin Rashes, Cellulitis, Poor Healing Ulcers	YES	Optional
COPD / Asthma	YES	Optional

### Episode Service Category Inclusions

As part of a continuum of care, a variety of services are needed for a patient enrolled in the ARMH. The full detailed service list is outlined in the Participating Provider Guidelines section of the paper. Here is a brief overview of the service categories that would be included for pricing episode one and two.

SERVICE CATEGORIES	EPISODE 1	EPISODE 2
<b>PSYCHIATRIC SERVICES – SPECIALIST CARE</b>		
Acute Intensive Management, Urgent care	YES	
Inpatient Residential / Withdrawal Management / Intensive Outpatient Services	YES	
MAT (Medication Assisted Treatment)	YES	YES
Psychiatric Counseling	YES	YES
Home Health, Lab services, Screening for relapses	YES	YES
Care Coordination, Comprehensive Care Mx	YES	YES
<b>PCP / PHYSICAL HEALTH</b>		
Prevention and Wellness Services	YES	YES
Screening Services for associated conditions	YES	YES
Management of comorbidities	YES	YES

### Community-Based Inclusions

Some patients may require some services that fall outside of the traditional clinical claims coded for a patient. In the ARMH bundle definition it is recommended that payers and providers agree to an average allowance for inclusion in the target price for both episode 1 and 2.

COMMUNITY BASED SERVICES	EPISODE 1	EPISODE 2
Cognitive Behavior Therapy	YES	YES
Recovery Coaching	YES	YES
Telemedicine / Counseling	YES	YES
Social Services / Recovery Support Services	YES	YES

### Pharmaceutical Inclusions

A sample list of prescribed pharmaceutical drugs a patient would need while enrolled in the ARMH is as follows:

DRUG CATEGORIES	CORE / OPTIONAL
<b>PSYCHIATRY RELATED DRUGS</b>	
Opioid reversal medicines, e.g., naloxone	YES
Antidepressants, antipsychotics, anxiolytics	YES
Drugs used in addictive disorders	YES
Drugs for poisoning	YES
Alternative pain relief medicines	YES
<b>DRUGS THAT ARE PATIENT CENTERED</b>	
Drugs for preventative care – immunizations, vitamins	YES
Drugs to manage patient's diabetes & other comorbidities	Optional Module
Drugs for smoking cessation	Optional Module
Hepatitis C drugs	Carved Out

## Actionable Adverse Events

Without comprehensively engaging a patient in treatment and recovery with SUD, there are many potential Actionable Adverse Events (AAEs) that can be avoidable. While the patient is enrolled in the ARMH program, the following sample list of identified AAEs can be used to adjust for the bundle price paid to a provider. We use the historical occurrence of complications / AAEs and their costs, incorporating that into the target budget. As a result, an allowance for AAEs is already baked into the budget. If providers perform better than the historical average, they win and will realize savings. For example, if a patient needs to be stabilized after an avoidable overdose once engaged in care, then the provider can be held responsible for the costs associated with that AAE. If the overdose is avoided by proactive measures taken by the provider, the savings that result will help the provider come under budget.

ACTIONABLE ADVERSE EVENTS (AAE)	EPISODE 1 & 2
Relapse, ED visits, Readmissions	AAE
Overdose, Poisonings, Intoxication	AAE
Attempted Suicide, Self-inflicted injuries	AAE
Trauma, Falls, Burns, Frostbites	AAE
Stroke, AMI, Heart Failure	AAE
Kidney Failure, Respiratory Failure	AAE
Sepsis, DVT, Endocarditis	AAE
Sexually Transmitted Diseases	AAE
HIV / AIDS (include limited services)	AAE

## Defining the Business Rules for the Episode Engine

An episode for SUD would be triggered if any of the trigger diagnosis or procedure codes are present on any claim in any position. Once the episode is triggered, relevant services for SUD, as well as for an underlying behavioral health condition, would be included in the core episode. These would include services for depression, anxiety, bipolar depression, post-traumatic stress disorder or schizophrenia. Relevant diagnosis codes for the underlying behavioral health conditions, as well as any adverse events related to them, would serve to steer relevant services into the episode.

Other physical health conditions would be triggered as modules around the SUD episode and may include modules for chronic conditions (e.g. hypertension, diabetes, asthma, COPD, GERD, etc.) that may bring additional allowance to the budget for SUD. Services for other physical health problems common in SUD patients (anemia, cellulitis, liver disease or for migraine / headaches and chronic pain) will also be added as additional care with additional allowances.

Major surgical procedures will not be included in the SUD episode, along with care for co-existing cancers, HIV /AIDs, and Hepatitis C (unless added as a separate module). Pregnancy and delivery, if co-occurring in an SUD patient, will also be carved out but could be made available as a maternity module if required.

## INTEGRATED TREATMENT AND RECOVERY NETWORK

Care is integrated across professional (acute, inpatient, outpatient, behavioral/mental health, primary care, and telemedicine) and community recovery support resources. When possible, all treatment and recovery support services are delivered as close as possible to the patient's natural living environment. The ARMH model requires an integrated, seamless continuum of care that allows for information sharing, commensurate clinical standards, and a common platform for the care recovery team to engage the patient.

The provider risk-bearing nature of the ARMH model necessitates the kind of coordination envisioned by the ITRN. The Alliance believes enhanced community engagement, improved care coordination among addiction, behavioral, and physical health services providers, and planned and incented care transitions over an extended period of time, will create highly favorable conditions for patient engagement and recovery outcomes.

One of the greatest impediments to sustained recovery for patients is that various programs and treatment settings operate in isolation from one other with limitations in referrals and/or requisite information sharing with other key parties.<sup>8</sup> To bypass this structure, providers must either work together through shared accountability and shared risk or enjoy common ownership by a single entity who may be better positioned to facilitate the desired integration. This will include shared access to information, shared treatment and recovery goals for the patient, shared quality measurements, and shared performance and outcome-based payment. A clear example of this principle can be seen when a patient’s physical health provider is alerted to the patient’s recovery process through coordinated care measures and sharing of the PHI can lead to a discussion of nonopioid pain management treatment alternatives for that patient.

The ARMH model requires not just the composition of these clinical resources but a “stepping” process that moves the patient from higher to lower intensity of service through the integrated continuum of care,<sup>9</sup> as a patient’s needs evolve in nature and intensity across the stages of recovery. This is the aspiration of the treatment system yet today, as only one in five adults, and even fewer adolescents, receive this type of continuing care.<sup>10</sup>

## SPONSORSHIP TYPES

There is no specific criteria to become a sponsoring ARMH provider or payer. The Alliance anticipates that any adoption of the ARMH model will follow along unique permutations and combinations in search of resolving specific challenges germane to populations and/or the business interests of the sponsoring entities. Below, the seven sponsorship types are described as well as success and challenge factors that will impact the sponsor’s ability to support the ARMH model.

## Payer Sponsors

### Medicaid Managed Care Organizations

As of 2017, Medicaid managed care spending represented 51.9 percent of total Medicaid spending, accounting for over two-thirds of Medicaid beneficiaries. Medicaid MCOs are paid a fixed payment to establish networks and administer services for state Medicaid beneficiaries. Because Medicaid is a state-established insurance offering, there is high variation across the country in eligibility, reimbursement rates, payment and delivery exemptions, and ancillary non-acute care services. Historically, Medicaid MCOs have been adept at managing utilization and access to services. The trend of driving payment integration with primary care services for Medicaid beneficiaries matches the objectives of the ARMH nicely.

SUCCESS FACTORS	CHALLENGE FACTORS
<ul style="list-style-type: none"> <li>• Many Medicaid beneficiaries will remain with a single managed care plan in the absence of financial or premium-based incentives to “shop around.”</li> <li>• MCOs may be overpaying for addiction-related services as a result of the inefficiency that corresponds with a fragmented and diffuse delivery architecture.</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health carve-outs vary across states, creating discontinuity between physical and mental health services. Where carve-outs exist, the managed care or risk-bearing entity may lack the most effective integrated structural elements to administer the ARMH.</li> <li>• Payments in Medicaid tend to be lower, rendering less room for upside benefits for downstream value generation.</li> <li>• Medicaid administrative systems (state and MCO) may lack the required sophistication to administer and manage risk-based contracts, quality measures, and other important elements of the ARMH model.</li> </ul>

Self-Insured Group

Most employers with greater than 5,000 employees are self-funded, relying on MCOs for administrative services only (ASO). In these instances, the employer will commission a broker or benefits consultant to work with a third-party administrator (TPA) in the architecture and establishment of the employer’s benefit and plan design structure. Most employers have high deference to these intermediaries; and for their part, most intermediaries have high deference for their contracted TPAs. However, employers are increasingly asserting their preferences and purchasing power to drive organization-specific considerations for benefits.

In the case of the ARMH, a self-funded employer with a threshold prevalence of associates with SUD, or a purchasing cohort of self-funded employers, could institute the model through a common TPA. The TPA would be responsible for working with the employers to engage with a provider able to meet the standards and requirements of the model.

SUCCESS FACTORS	CHALLENGE FACTORS
<ul style="list-style-type: none"> <li>• Increased autonomy for the purchaser to direct their benefits spend toward APMs that more directly benefit their employees.</li> <li>• Higher consistency and continuity in coverage through many forms of employer-sponsored coverage, particularly in higher-skill industries with less turnover.</li> <li>• Employers see broader economic benefits that transcend higher health care costs, primarily in productivity gains and reductions in liability.</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a concentrated employee population.</li> <li>• Partnering with other employers for common purchasing objectives is difficult.</li> <li>• Benefits consultants and brokers often lack the technical sophistication to negotiate and pursue alternative payment models.</li> </ul>

Medicare Advantage

A form of managed care for the Medicare program is found with Medicare Advantage (MA). Medicare-eligible seniors can elect private sector coverage that in some cases is more expansive than its Medicare FFS counterpart. Of particular interest for the elderly is an increasing reliance on pain management techniques and medications that correspond with specialty surgical procedures or to stem the effects of disease and aging. Poorly administered pain management resources can be a catalyst to the onset of an SUD.

SUCCESS FACTORS	CHALLENGE FACTORS
<ul style="list-style-type: none"> <li>• Stable, relatively well reimbursed commercial coverage.</li> <li>• MCOs that participate in MA have become established in the program and tend to be well capitalized and shrewd operators of the business.</li> <li>• While consumerism is higher for MA plans than its government-sponsored plans, there remains a degree of coverage consistency and continuity within the program.</li> </ul>	<ul style="list-style-type: none"> <li>• SUD prevalence is not as high in MA populations as it with other lines of insurance.</li> </ul>

Commercial Coverage

Commercial insurance will be defined more broadly than its predecessors for purposes of this document. In short, any coverage or insurance avenue where the carrier aggregates enrollees into separate and distinct risk pools would qualify as commercial coverage. In these instances, the risk-bearer is the insurance business. Coverage in this category spans from the individual market (Affordable Care Act marketplaces) to group coverage (predominately small groups because most mid-market and large group business is self-funded).

Hence, different parts of this market will bear the unique dynamics of geography and the underlying population.

SUCCESS FACTORS	CHALLENGE FACTORS
<ul style="list-style-type: none"> <li>• Higher pain point for the risk-bearing insurance companies whose financial benefits are contingent on decreased claims.</li> <li>• A broad spectrum of population types and needs that range across socio-economic conditions.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited group purchasing power of enrollees that limit pressure for expanded benefits.</li> <li>• Much higher churn and cyclical of benefits, inherently limited by the annual underwriting cycle.</li> </ul>

Participating entities are both those that offer the full continuum of care and those providers that will contract with other entities in a virtual model similar to an Accountable Care Organization (ACO), sharing accountability and patient attribution to offer the full scope of care. Patient attribution is expected to be geographically limited.

### Provider Sponsors

Provider institutions vary in their size, sophistication, and clinical breadth. Importantly, a sponsoring provider partner for the ARMH must hold unique and differentiated assets in the marketplace that enable it to organize the appropriate resources to administer the model, bear the required financial risk, and administer non-owned enterprises when applicable.

These institutions may range from systems that are fully integrated under common ownership to those institutions capable of organizing a network and creating the effects of integration by establishing something akin to an ACO.

### Integrated Delivery Network

In many ways, the integrated delivery network (IDN) is the ideal ARMH participant. A true IDN often owns a health plan and includes a breadth of clinical assets

that could qualify as the ITRN (e.g., a hospital). While common ownership does not necessarily imply efficiency or integration, a true IDN possesses the fundamental elements needed to organize a care recovery system for SUD.

SUCCESS FACTORS	CHALLENGE FACTORS
<ul style="list-style-type: none"> <li>• Commonly owned assets, under an enterprise model, with the inherent possibility of faster decision-making and integration than non-IDN entities in the market.</li> <li>• Market stature and presence that might render more expeditious contracting with payer sponsors or other affiliates.</li> <li>• Larger balance sheets, resources, and access to capital required to administer the provider's responsibilities under the ARMH.</li> </ul>	<ul style="list-style-type: none"> <li>• Common ownership does not automatically mean enhanced efficiency.</li> <li>• Larger organizations with a multitude of different payment and delivery initiatives may be administratively or operationally over-extended and unable to devote the required resources to the ARMH.</li> <li>• Gaining consensus and buy-in from various parts of the organization can render longer decision-making cycles.</li> </ul>

### Primary Care Physicians, Multi-Specialty Groups, and Primary Care Groups

Primary care and specialty group practices represent a unique platform to foster and facilitate the ARMH. These groups are the personification of a medical home and, when combining the right behavioral health resources and integration with other key service providers, can be a powerful force for promoting the ARMH. In the vast majority of cases, these groups will not own a plan or clinical enterprises capable of administering more clinically intensive treatment and recovery for patients. However, their role as the medical home increases their capacity to build a relationship with the patient and extend that leverage to establish a common network of high-value services and supports for the patient.

SUCCESS FACTORS	CHALLENGE FACTORS
<ul style="list-style-type: none"> <li>• Closer proximity to the primary care physician and the patient.</li> <li>• Increasingly agile and responsive to programmatic changes and care transformation.</li> <li>• NCQA has launched a “Distinction in Behavioral Health Integration” program, laying out standards to help primary care practices better integrate behavioral healthcare into their practices and acknowledges practices that excel in this area.</li> </ul>	<ul style="list-style-type: none"> <li>• Financial limitations that may impede the organization to bear material financial risk.</li> <li>• Higher burden in the identification of a payer partner and high-value ancillary clinical settings required for the network.</li> </ul>

### Behavioral Health Organization

Publicly and privately-run organizations that are focused exclusively on behavioral health can play the role of a sponsor. Such entities included are state or county’s mental health authority or private sector companies that administer behavioral health services for government or commercial payers. These organizations are expert at assembling key behavioral health resources and supports but may lack the same proximity and administrative competency needed to drive integrated physical health services.

SUCCESS FACTORS	CHALLENGE FACTORS
<ul style="list-style-type: none"> <li>• A deeper understanding of the behavioral tenets of treatment and recovery, germane to SUD.</li> <li>• Broader access to the continuum of care supporting behavioral health and community resources.</li> </ul>	<ul style="list-style-type: none"> <li>• Financial limitations that may impede the organization to bear material financial risk.</li> <li>• Limitations in establishing networks that would support physical health integration.</li> </ul>

## PROVIDER PARTICIPATION GUIDELINES

For initial piloting purposes, an ARMH provider is recommended to have the capability to serve a minimum of 500 covered lives annually across a continuum of care. This would occur in a given geography and from a single or combination of payers in a given market. As networks evolve and pilot data are analyzed, the Alliance anticipates exploring more formal accreditation and/or recognition criteria over the long-term.

The Alliance also expects that many ARMH providers may in fact already be credentialed or certified by third-party bodies, and additional evaluation framework at the early stages of the ARMH model implementation poses the risk of unnecessarily dissuading providers from entering the model. In addition, the Alliance expects that operationalizing the model will provide clear insight into useful provider pre-qualifications, and about the operation of the metrics themselves (in an effort to find criteria that will not limit innovation).

Finally, there are various efforts underway to better qualify and assess care recovery institutions across certain clinical and biopsychosocial guidelines. The Alliance strongly encourages these activities and intends to collaborate with this work’s progenitors as it becomes more available and accessible. Such efforts aspire to qualify, score, grade, or otherwise assess the relative quality of provider institutions providing addiction treatment and recovery services.

As previously described, there are various provider entities that can participate in the ARMH model. Qualification criteria for both integrated (under common ownership) and networked providers (affiliated through contract) are below.

### *Key Network and Service Characteristics*

The Alliance subscribes to the opinion that “effective integration of prevention, treatment, and recovery services across health care systems is key to addressing substance misuse and its consequences and it represents the most promising way to improve access to and quality of treatment. Promising scientific evidence suggests that integrating care for substance use disorders into mainstream health care can increase the quality, effectiveness, and efficiency of health care.”<sup>11,12</sup>

A fundamental concept in care coordination between health care, substance use disorder treatment, and mental health systems is that there should be “no wrong door.” This means that the patient should be effectively linked with appropriate services no matter where in the health care system the need for substance use disorder treatment is identified. The Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) emerging vision for transforming the substance use disorder health system is that it must be multi-faceted and “grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support.”

The Alliance has adopted an evidence-based structure laid out by SAMHSA that defines the clinical and services structure of a behavioral health system, incorporating the necessary breadth and depth of resources to support recovery.<sup>13</sup>

For purposes of defining network assets needed to deliver the ARMH, the Alliance categorizes these nine domains into three categories, as outlined below. Services that fall under the American Society of Addiction Medicine’s (ASAM’s) Patient Placement Criteria, requiring ARMH criteria to match this model are noted.

- Institutional Infrastructure: Services provided in an emergent, inpatient, or residential context, including:
  - Acute Intensive Services
    - Mobile Crisis Services
    - Urgent Care Services
    - Medically Managed Intensive Inpatient Services (ASAM Level 4)
  - Out of Home Residential Services (ASAM Level 3)
    - Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
    - Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)
    - Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
    - Medically Monitored Intensive Inpatient Services (ASAM Level 3.7)
- Clinical Support Infrastructure: Services provided on an outpatient basis but remain rooted in a strong clinical context, including:
  - Intensive Support Services (ASAM Level 2)
    - Intensive Outpatient (ASAM Level 2.1)
    - Partial Hospital (ASAM Level 2.5)
  - Outpatient and Medication Assisted Treatment (ASAM Level 1)
    - Individual Therapy
    - Group Therapy
    - Family Therapy
    - Medication Management
  - Health Homes
    - Primary Care
    - Comprehensive Care Management
    - Care Coordination and Health Promotion
    - Medication Management
    - Laboratory Services
    - Connections/Linkages to Community Supports
- Non-Clinical Services and Supports: Services accessible to the patient outside of a clinical setting and complement that treatment and recovery plan, including:
  - Engagement Services
    - Motivational Interviewing (ARMH On-Ramps)
    - Evidence-based Assessment
  - Recovery Support Services
    - Peer Recovery Coaching
    - Supports for Self-Directed Care
  - Prevention and Wellness Services
    - Screening, Brief Intervention, Referral to Treatment
    - Call Center
    - Public Education Activities
  - Community Support and Other Living Supports
    - Recovery Community Center

- Recovery Housing
- Linkage to Community Recovery Support and Mutual Aid
- Supportive Employment
- Supportive Education
- Skill Building
- Transportation

The ARMH requires each of these components to be in place and/or available via linkages and contracted partnerships.

The patient's treatment and recovery plan will include specific timeframes and objectives for the patient as they move through a continuum of care matched to their needs. The recovery plan is dynamic and designed to be consistently updated as the patient achieves specific milestones, clinical conditions shift, or the general composition of the plan is unsuccessful.

### ***Integrated Providers***

We expect that integrated treatment and recovery networks will be well endowed with the resources required to coordinate patient care and manage transitions across the continuum. To be considered an integrated provider, qualifying required services must be housed within the system. Further, services should be geographically and otherwise available to the patient on-demand.

In addition, integrated provider systems operate on a single, common electronic medical record (EMR) system that can be used to share the medical record and PHI more seamlessly, facilitating ready access to the patient medical record and treatment and recovery plan.

### ***Networked Providers***

The Alliance anticipates that providers who cannot solely offer the full range of addiction treatment and recovery recommended services will vet and contract with a tiered network of other community providers. These providers could be able participants of the ARMH, or simply paid by the risk-bearing provider on an FFS or pay-for-performance basis for services rendered. This networked care arrangement is likely to structure like an ACO, with a central contracting entity organizing

the network for purposes of patient attribution, quality measure achievement and payment.

Absent a waiver, Stark and anti-trust rules should guide the network's composition and direction of patients. This cohort must meet the guidelines to functioning as a clinically integrated network (CIN), with the ability to share clinical information, coordinate discharge planning and care transitions, and work across primary care and specialty physicians to collaborate on the multi-faceted dynamics faced by a patient.

In the situation where subcontracting is taking place, the primary risk-bearing entity still bears ultimate responsibility for the financial liabilities and quality measures associated with managing the patient.

## **CLINICAL INTEGRATION REQUIREMENTS**

### ***Clinical Information Sharing Guidelines***

A traditional challenge in managing patient care in the context of mental and behavioral services is a regulatory limitation of information sharing codified under 42 CFR Part 2 (Part 2). This regulation was designed to protect patients from intra- or inter-system discrimination by obfuscating underlying behavioral and/or mental health conditions. It applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance use program that is conducted, regulated, or directly or indirectly assisted by any United States department or agency.<sup>14</sup>

In January 2018, SAMHSA issued a final rule [15] that made new changes to the federal rules that govern Part 2, specifically expanding the methods whereby a patient's information may be shared. The final rule was effectuated on February 2, 2018 although the federal government and lawmakers continue to review this regulation for making further modifications pending in 2019.

Specifically:

- 1) Disclosures with a patient's consent can be granted for payment or health care operations purposes. A recipient must be empaneled by the patient through a consent form and can share SUD-centered contractors, sub-contractors, and legal representatives as necessary to fulfill payment and operational obligations.

- 2) Disclosures may be made to contractors, subcontractors, or legal representatives for auditing and evaluation purposes without new patient consent.

Common patient records are coordinated across care settings through a technology intermediary. Clinical interoperability within the ITRN is required, including the capacity to acknowledge Part 2 information-sharing consent and the technology that can appropriately share sensitive information. This connotes a setting where the core contracted entity either owns or has an arm's length technology relationship with sufficient APIs and infrastructure to exchange such information.

A requirement for a patient's participation under the ARMH is to consent for the risk-bearing entity to share the patient's medical record with affiliated parties under the ITRN. (This consent only extends to the confines of the ITRN and any patient consent should be necessarily restricted from non-ITRN facilities to invoke the protections afforded to the patient under Part 2.)

All other PHI should be accessible to the care recovery team depending on individual care team roles and responsibilities through the EMR.

### ***Clinical Information Sharing Systems***

The preferred approach to sharing clinical information is through a common EMR, most often found within an IDN or CIN. The EMR should have the capacity of supporting behavioral health and SUD-related information, including a mechanism to inculcate the Part 2 consent form, the treatment and recovery plan, the assigned members of the care recovery team, connections with technology resources being deployed by the network, and certain access to community supports. The EMR must also have the capacity to collect the required clinical and process information required to validate quality measures.

In situations where the network cannot operate on a common EMR, certain similar connectivity requirements are required. There are two primary options for this:

- 1) Sufficient API connections between system EMRs. The success of this is highly correlated with fewer EMRs requiring connectivity and the systems' EMRs possessing the capacity to share clinical information in the required formats. (The same requirements

pertaining to the ability to store, share, and distribute the Part 2 consent, the treatment and recovery plan, etc. remain in place.)

- 2) An EMR overlay capable of integrating electronic data transmission (EDT) feeds of clinical information that comprises key patient-specific information. These systems could consist of population health management platforms and/or clinical information management tools.

Lastly, it is required that all patient encounters, changes to the treatment and recovery plan, and other key information required by quality measures are electronically captured.

### ***Discharge and Care Transition Management***

One of the most critical elements of promoting integrated treatment and recovery for patients is found in creating and managing a care continuum. Alongside the criticality of management, there is also the associated discharge planning and care transitions that ensure a patient assimilates to the subsequent environment. Care transitions should be multi-faceted, and should include:

- A robust technology infrastructure that interfaces with the clinical information system and facilitates a connection to the new clinical setting.
- A stipulation that all discharges require the partnership of the recovery coach, who is able to confer with the broader care recovery team and support the implementation of the treatment and recovery plan. All discharge planning should aspire to provide sufficient time to the care recovery team to engage the patient.
- Where possible, the patient should be able to explore and interact with the new care setting in advance of their discharge.

### **CLINICAL PATHWAYS**

Individuals living with a substance use disorder experience the condition differently. Thus, the ARMH model recognizes that multiple settings for identification and referral are possible and desirable. Emergency departments, first responders, hospitals, community mental health centers, schools, prisons, employers (and employee assistance program counselors), families, and primary health physicians are all sources of community assessment and referral.

## ***Assessments and Referrals***

The Alliance views community engagement, assessment, and referral of individuals with SUDs as an integral part of increasing the identification and treatment of those living with addiction. Community partners with existing MCO contracts may be able to bill for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services under traditional fee-for-service codes (e.g. screening and intervention code). The ARMH model does not include community assessment and referral as part of the treatment and recovery episodes. However, in recognition of the vital role that community entities play referring patients for further clinical evaluation (and thus to ARMH participating entities), participating entities could be engaged and remunerated to provide proactive screening, education, and referral for individuals with SUDs.

## ***Whole-Person Assessment***

Once a patient has been referred for further evaluation, the ARMH model requires a comprehensive whole-person assessment to determine appropriate clinical placement.

Under the ARMH model, the Alliance suggests adoption of a standard evaluation process that validates and authenticates the severity of a patient's SUD to establish the appropriate treatment and recovery plan. There are a variety of evidence-based screening tools for SUD that can be considered and employed by the ARMH model:

- American Society of Addiction Medicine (ASAM) Placement Criteria
- Addiction Severity Index (ASI)
- Substance Abuse Module (SAM)
- Global Appraisal of Individual Needs (GAIN)
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

This evaluation must be completed by a licensed health professional, as defined by the state. The ARMH model recommends that the comprehensive evaluation take place within 24-48 hours of a patient referral and serve as a means of placing the patient with the right provider and/or level of care. The ARMH model allows for virtual interactions using technology to assess patient challenges and facilitate initial referrals and program placement.

All information collected through the assessment should be captured and indexed to the patient's medical record. The assessment should be linked to the treatment and recovery plan. Participating entities can re-assess the patient at their consent to track progress. Subsequent assessments are not required to be codified in the medical record.

## **PROGRAM ENTRY**

The fundamental basis for the ARMH is in the principles of risk prediction and quantification. Risk factors for patients with substance use disorders are incredibly variable and complex. They are often less clinical in nature, dealing with a host of social and temporal issues often out of the purview of the traditional clinician. As a result, it is important to mitigate as much risk variability as possible while also ensuring the key attributes that drive integration and coordination in the model are permissible.

To do this, the patient must first be stabilized, as previously described. Stabilization begins the process of withdrawal management and initiates a dialogue regarding recovery goals. Not all patients are equally engaged in a process of recovery. Patients cannot be coerced or overly persuaded to participate in the ARMH. Instead, the ARMH envisions a compassionate and strength-based motivational incentives and contingency management that engage the patient early, providing the right communication and conditions that would promote programmatic engagement.

## **PATIENT ACTIVATION AND TRANSITION PATHWAYS**

### ***Acute***

The trigger required to initiate transition from an acute stabilization event to the ARMH is an appropriate SUD diagnosis, either confirmed or made by the ED/ICU physician and the intent to discharge (and consistent with one of the assessment methods previously identified). The patient undergoes lifesaving or life-stabilizing services in the ED or ICU, where a doctor makes or confirms a diagnosis required for the ARMH model. If the ED/ICU provider is not associated with an ARMH provider, ARMH providers are encouraged to contract with the ED/ICU to coordinate and train staff on patient recognition criteria and referrals.

In integrated networks, the diagnosis can trigger an alert in the health record. This would signal the team care coordinator, who dispatches members of the ITRN care team to the ED/ICU once the patient is ready for discharge from the unit. The activated staff (a peer recovery coach or addiction specialist) and the care coordinator conduct or review preliminary assessments, review treatment recommendations listed by the ED/ICU doctor, review relevant care history, explain the available treatment options, and work with the patient to transition them into the ARMH at the patient's consent (described below). At this point the patient receives a preliminary severity classification that places them into a payment category.

The patient and the care team create a treatment and recovery plan prior to or at the time of discharge. The purpose of the treatment and recovery plan is to address the essential needs and next steps required to successfully matriculate the patient from the acute stabilization event to their first treatment planning meeting. The treatment and recovery plan may include items like accessing and taking medications, connection to safe housing, or a visit to medical care specialist. The first treatment planning meeting should occur between 72 hours and two weeks after the acute stabilization event. Providers will be required to meet the appropriate process quality measures associated with the transition.

### ***Non-Acute***

For non-acute cases, a referral from a partner organization or another unit within the ARMH-participating entity will initiate the entry-process into the ARMH. The patient will then complete the appropriate assessments and consents described. A community partner organization, community-based health/behavioral health care facility, or employer may directly refer the patient to an ARMH provider. Upon patient contact, the ARMH provider will conduct the proper assessments and facilitate appropriate patient consent. Alternatively, the referring organization may obtain a consent to release the patient's name and contact information to the ARMH provider for engagement. The ARMH provider completes the assessments and facilitates patient consent.

The referring organization, particularly if they have a contract or agreement with the ARMH provider, may also complete preliminary assessments and facilitate patient consent along with the referral. Regardless of the way in which the referral is made, the ARMH provider is expected to follow up within 72 hours to two weeks of receiving the referral. Providers will be required to meet the appropriate entry criteria and process quality measures associated with the transition.

### ***Initiating Patient Engagement***

Following a confirmed diagnosis of an SUD (leveraging the application and screening tools referenced under Clinical Pathways), the patient should be extended an invitation to participate in the ARMH. The description of this program should responsibly include the following qualifiers:

- Participation in the ARMH requires a patient's consent for their medical information to be shared amongst and between a highly skilled professional team of health professionals across a myriad of different clinical settings.
- The patient will be the regular co-author of a treatment and recovery plan focused on 13 domains of wellness. As a result, they will be expected to seriously apply themselves to achieving the goals and objectives or working collaboratively with the care recovery team to make ongoing adjustments as needed.
- The patient will make himself/herself available for regularly scheduled check-in appointments with their care recovery team and commit to responsively engaging in their care.
- The patient will be made aware that unenrolling from their health insurance carrier or switching coverage domains could have an adverse impact on their participation in the ARMH.

Following this notification, the patient can be enrolled in the ARMH and assigned a care coordinator. The care coordinator then can assign a recovery coach who can begin engaging with the patient in establishing goals and objectives, ultimately working with the patient to move them to a more stable care environment.

The clinical point of entry in the program depends on the clinical level of care recommended by the professional assessment combined with preferences of the patient. At the point of entering these settings, the patient formally affirms to their participation in the program.

### Exiting the Program

Participation in the ARMH program is completely voluntary and at the ongoing discretion of the patient. A patient can leave the program at any point if they conclude their treatment and recovery objectives are no longer consistent with the program's structure.

Ongoing provider reengagement efforts are required for patients who stop communicating but do not formally withdraw from care within the six-month period. A strict process or schedule is not suggested here, as providers will need flexibility to reengage based on the needs of the patient. Providers should consult best practices on effective engagement techniques, specifically, around when and how to focus efforts. The peer recovery coach may be a good option for initiating attempts at

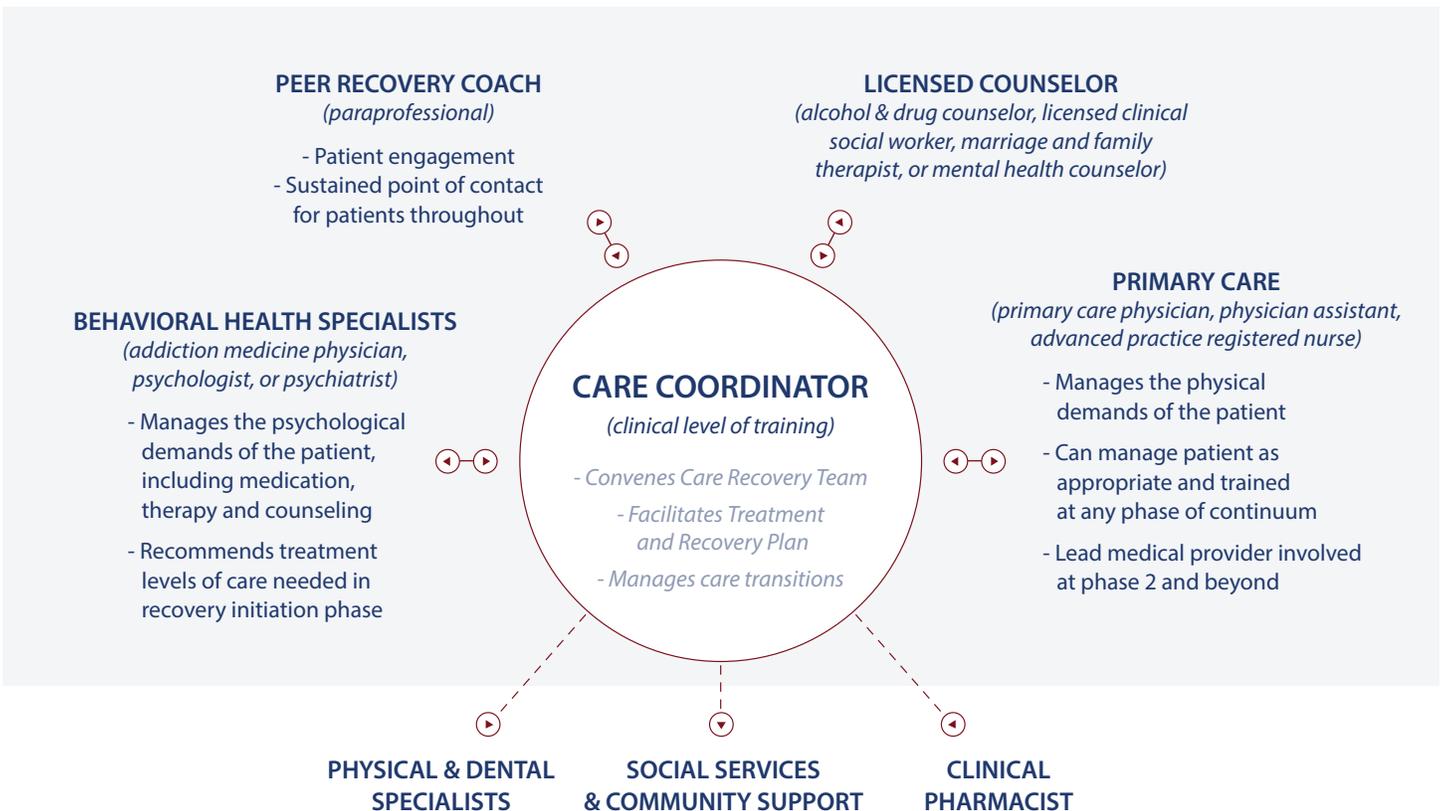
reengagement because they may be the most mobile of the team and are likely to have the strongest relationship with the patient.

Further, a patient exits the program if they are no longer a participant in the benefit structure of the health plan they are working with. (Note: The model can be constructed to provide services on a cash basis and is at the discretion of the contracting entity as to whether to provide services in this way).

Lastly, the risk-bearing provider can terminate participation by the patient if there are serious breaches in ongoing communication or activity that could put the patient or others at some kind of risk.

Irrespective of a patient's exit from the program, the care recovery team will be responsible for providing the patient with a final, updated treatment and recovery plan tailored for that moment in the patient's recovery journey. The team will also work with the patient to identify treatment resources that are accessible to the

## INTEGRATED CARE RECOVERY TEAM



patient under the new coverage or treatment. In short, the care recovery team is responsible for ensuring that a patient exiting the program is positioned to be successful in whatever path they pursue.

The care team is comprised of licensed and experienced medical and behavioral health professionals and para-professionals who are committed to working collaboratively with each other and with the patient on SUD recovery. Together the care team uses evidence-based treatments to provide comprehensive recovery treatment and support services. They recognize the importance of follow-up and active engagement and are prepared to engage the patient at each point on the recovery continuum. Care team members operate as consultants to the patient and family in the recovery process.<sup>16</sup> Patients, for their part, are responsible for active participation in their treatment and recovery process.

## CARE TEAM COMPOSITION

The core care team consists of a peer recovery coach, care coordinator, a PCP, licensed counselor, and a behavioral health specialist (psychiatrist, psychologist, or an addiction medicine doctor).

### *Peer Recovery Coach*

According to SAMHSA, “the terms mentoring, or coaching refer to a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery. Generally, mentors or coaches assist peers with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding sober housing, making new friends, finding new uses of spare time, and improving one’s job skills. The relationship of the peer leader to the peer receiving help is highly supportive, rather than directive.”

Peer recovery coaches are individuals in recovery who help others with substance use disorders achieve and maintain recovery using four types of support: emotional (empathy, caring, concern); informational (practical knowledge and vocational assistance); instrumental (concrete assistance to help individuals

gain access to health and social services); and affiliational (introductions to healthy social contacts and recreational pursuits). Peer recovery coaches are not substance use disorder treatment counselors. They do not diagnose or provide formal treatment. Rather, they focus on instilling hope and modeling recovery through the personal, lived experience of addiction and recovery. Peer recovery coaches do not espouse any specific recovery pathway or orientation but rather facilitate all pathways to recovery.

Peer recovery coaches are an important part of the care team in terms of providing both support and education about the recovery process. Peer recovery coaches in the ARMH will likely play a key role in the front-end activation responsibilities, including educating the patient about developing a comprehensive treatment and recovery plan. State-level regulations govern the extent to which they can be included in the sharing of treatment information, although a peer recovery coach typically does not require full access to health records to perform their duties.

As peer recovery coaching is an emerging field and practice, the workforce is not heavily saturated; however, because the paraprofessional role and the prevalence of more than 23 million Americans living in recovery from alcohol or other drugs, the establishment of a peer recovery coach workforce, in an ITRN, is easier than any other professional role on the care team. Given the emerging nature of the practice in various settings, there is insufficient evidence on a specific recommended caseload size for an individual recovery coach. The pilot projects will work to establish specific guidelines on this issue. The following credentials, which are now available with many states also providing licensure in specific jurisdictions, should be used:

- IC&RC - The Peer Recovery (PR) credential is designed for individuals with personal, lived experience in their own recovery from addiction, mental illness, or co-occurring substance and mental disorders.<sup>17</sup>
- NAADAC - National Certified Peer Recovery Support Specialists (NCPRSS) – Peer Recovery Support Specialists are individuals who are in recovery from substance use or co-occurring mental health disorders<sup>18</sup>. Their life experiences and recovery allow

them to provide recovery support in such way that others can benefit from their experiences.

- CAPRSS - The Council on Accreditation of Peer Recovery Support Services (CAPRSS) is the only accrediting body in the US for Recovery Community Organizations (RCOs).<sup>19</sup> CAPRSS accreditation can be deployed in an ITRN that has integrated an RCO to provide the peer recovery coaching services.

In the ARMH, the peer recovery coach is the central figure in the patient's recovery, with ever-increasing prominence and importance as the patient's recovery moves to the second episode. The peer recovery coach bears the following functional responsibilities:

- Assume the role of key contact for the patient during their recovery experience, often including front-end engagement into an ARMH program
- Assist patients in navigating transportation, employment, housing, and other social determinants of health needs specific to addiction recovery
- Engage family and friends in the recovery process to help patients address recovery-based activities
- Coordinate services with counselors and assign responsibility for achieving specific objectives
- Provide in-service training to counselors about the goal of recovery coaching
- Facilitate a robust and thorough hand-off to another peer recovery coach when he/she is no longer able to support the patient

### **Care Coordinator**

Per the Agency for Healthcare Research and Quality (AHRQ), "Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means the patient's preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."<sup>20</sup>

The care coordinator is the main point of contact for patients entering from non-acute care pathways. The care coordinator is responsible for bridging the transition into care for the patient and for completing pre-

assessments. Generally, the care coordinator acts as the point of contact for, and manager of, the information exchange between any medical care specialists and the remainder of the care team, although in some critical cases it may be important for the specialist to have direct access to the patient's treatment plan.

Systemic care coordination roles have been deployed for the management of a variety of physical health conditions, however, this promising practice has had minimal utilization in traditionally fragmented (not integrated) behavioral health care services. Given this reality, there is insufficient evidence on a specific recommended caseload size for a care coordinator working with an exclusive SUD population.

The care coordinator and peer recovery coach should be viewed as inextricably linked partners who serve different, but related, functions in supporting the patient's experience. While the recovery coach is working directly with the patient on objectives and supports, the care coordinator is ensuring that appropriate care is being administered at all points in the care continuum.

The level of engagement of these two functions are inversely correlated. The care coordinator should play a much larger role in the early stages of a patient's recovery, due to the attendant clinical intensity and the need to manage various care transitions. The peer recovery coach will have a larger role as the patient moves towards primarily utilizing community-based supports, with a decreased need for clinical resources.

The primary responsibilities of the care coordinator consist of:

- Coordinate patient care with other members of the care recovery team, ensuring the patient is receiving the quantity and type of care mandated by treatment and recovery plan
- Maintain a current treatment and recovery plan (and further ensuring the plan is electronically captured in the resident EMR system)
- Manage discharge and care transitions in close collaboration with medical staff and the patient, ensuring the patient's experience is properly managed to promote continuity

### ***Primary Care Physician (PCP), Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)***

A key member of the care recovery team is the PCP and related staff. If the patient has a PCP during activation in the ARMH, then efforts should be made to include the PCP (and their staff) on matters pertaining to the patient's recovery. Specific instances where the PCP should be notified include:

- The initial activation of the patient as a participating in the ARMH
- The development of the initial treatment and recovery plan with notifications of subsequent iterations of the plan

In the course of providing primary care for the patient, the PCP and their staff should have ready access to the patient's treatment and recovery plan, allowing for engagement with the care coordinator, the behavioral health specialists, and the peer recovery coach as needed.

In cases where the patient does not have a PCP, the care recovery team protocol would not require induction. The patient should be encouraged and supported in selecting a PCP from the network structure of the managed care plan they participate in. In an ideal scenario, the PCP would have clinical connectivity to the ITRN. Where this is not possible, the core care recovery team should abide by the communication parameters above, using whatever means are at their disposal of communicating key recovery information.

The PCP can either be regarded as the general medical home for non-SUD related treatment and services or be integrated and manage behavioral health, SUD, and physical health needs throughout the ARMH. Each ITRN can determine, based on current infrastructure and PCP training, the appropriate utilization of primary care throughout the patient's recovery journey.

Finally, the care recovery team will require the PCP to possess a waiver from SAMSHA to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000.<sup>21</sup> If the PCP is unable to attain

this waiver, the care recovery team should ensure a practitioner with this capability is part of the team.

### ***Addiction or Behavioral Health Specialist***

Another variation in the care team may be driven by workforce considerations. Physicians or psychologists with a focus on behavioral health and addiction (e.g. addiction medicine doctor, primary care physician, psychologist, psychiatrist) are specially-trained clinicians who can provide prevention, screening, intervention, and treatment for substance use disorders and their psychiatric, psychosocial, and medical complications, and may not serve networks in sufficient numbers to participate in every ITRN care team. To the extent that these professionals are not available, the care team would benefit from a physician with specialty addiction training who has oversight over the ARMH. These specialists should be certified in the field; acceptable certifications for participation in the ARMH include the following:

- Certification by the American Society of Addiction Medicine or the American Board of Addiction Medicine
- Subspecialty certification in Addiction Medicine by the American Board of Preventive Medicine
- Subspecialty certification in Addiction Psychiatry by the American Board of Psychiatry and Neurology
- Certificate of Added Qualification in Addiction Medicine conferred by the American Osteopathic Association
- Completion of an accredited residency/fellowship in Addiction Medicine or Addiction Psychiatry

### ***Certified Addiction Counselor, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, or Licensed Mental Health Counselor***

Certified Addiction Counselors (e.g. Alcohol and Drug Abuse Counselors) are professionals trained in the evaluation and implementation of specific therapeutic techniques. Counselors' educational requirements range from certificate level programs to masters and doctoral level programs. The Association for Addiction Professionals and The National Board for Certified Counselors are bodies that provide certifications for

professional counselors. Competencies expected of counselors, based on their level of credentials, may include the utilization of the evidence-based to counseling, completing assessments and matching patients to the appropriate treatments, individual or group counseling, evaluation of the effectiveness of care, and collaboration with team members and other organizations.

Licensed Clinical Social Workers (LCSWs) are professionals with advanced degrees (masters or doctoral degrees) and many hours of supervised post-graduate experience (from 1,500 to 4,000 hours depending on the state), who are trained to assist individuals and families with psychosocial needs. LCSWs use strengths-based approaches, develop treatment relevant to the patient's environment, respect patient rights, and advocate, all through a strong therapeutic alliance. They may provide direct services including assessment, diagnosis, treatment planning and treatment or intervention, and case management. LCSWs are very versatile and can practice in a number of settings. LCSWs trained to address substance use disorders may provide leadership or collaboration as part of an interdisciplinary care team.

The care team is responsible for sharing with the patient the evidence and science around various treatment modalities, while honoring the choices of the patient during patient activation and subsequent engagement. As the evidence-base is constantly changing, the care team maintains the responsibility for assessing trusted sources of evidence-based practice and treatment such as the following:

- ASAM
- SAMHSA
- The Recovery Research Institute – provides a brief recovery assessment tool
- The National Institute on Drug Abuse
- The University of Washington Alcohol and Drug Abuse Institute

### ***Clinical Pharmacists***

Clinical Pharmacists are an important member of a comprehensive care team most often collaborating with patient, primary care team and behavioral health

specialists to develop and implement plan for optimizing medication therapy. They can help manage the patient's medications regimen by assessing medication-related needs, evaluating medication therapy, and being available at any phase of the continuum.

Clinical pharmacists are practitioners who provide comprehensive medication management and related care for patients in all health care settings. They are licensed pharmacists with specialized advanced education and training who possess the clinical competencies necessary to practice in team-based, direct patient care environments. Accredited residency training or equivalent post-licensure experience is required for entry into direct patient care practice. Board certification is also required once the clinical pharmacist meets the eligibility criteria specified by the Board of Pharmacy Specialties (BPS).

### ***Ancillary Specialists***

Patients with co-morbidities and co-occurring mental health issues should be under the clinical care and supervision of other specialists and medical professionals. The ARMH model should not disrupt the flow of patient care to these other critical practitioners. Instead, it should establish a linkage through the care coordinator to ensure continuity of information related to the patient. Hence, specialists are not considered structurally necessary in the care recovery team but should be closely conferred with.

### ***Panel Size***

Given the various roles and functions in the care recovery team, it is important to set a minimum threshold for the caseload of recovery team professionals.

Caseloads should be based on the functions described in this section, with specific case load designations for the peer recovery coach, the care coordinator, the behavioral health specialist, counselors, and the PCP.

Because each phase of care requires different functional contributions by the care recovery team, a design is necessary to establish panel size boundaries. There is a danger in over-subscribing any member of the care recovery team, as engagement with the patient could be negatively affected.

## PATIENT

Patients who opt into treatment are expected to take an active part in the planning and implementation of their care and recovery plans. In both episodes one and two (Recovery Initiation and Active Treatment, Community-Based Recovery Management), the patient will shape the treatment and recovery plan and participate in strategies designed to promote readiness to change, motivation/resistance, and engagement in care. Participation in the Community-Based Recovery Management episode will involve utilization of community resources and peer-recovery communication about any recidivism risks. Patients are also responsible for providing appropriate feedback through their peer recovery coach regarding whether ARMH care is meeting their needs. To the extent possible, the provider should take into account a patient's wishes regarding level of care, so long as the decision is consistent with the evidence base. A higher emphasis on patient preference and input is more accessible in the second episode (Community-Based Recovery Management) than in the first episode (Recovery Initiation and Active Treatment). To remain consistent with the evidence base, providers may recommend a higher level of care based on sound clinical assessment and the best available evidence and educate the patient. For instance, reasons why the clinically appropriate level of care will aid in the patient's progress towards recovery. Active engagement with the peer recovery coach may be a good resource for the patient during level-of-care transitions.

Patients are expected to adhere to the treatment recommendations, and at a minimum, participate in care that ensures patient safety and limits provider liability. The exact treatment plan can remain flexible, as the provider and patient pursue agreement. In considering the situations under which a provider may seek to sever an ITRN relationship with a patient, the Alliance recommends that the ARMH provider have a policy to address non-compliant patients, which includes peer support efforts as a prerequisite and a robust communication (including a written/technology-based correspondence with the patient) protocol around unenrollment. Further, recovery disruption must be held separate from noncompliance because the ARMH model considers any engagement with ITRN providers as attempted compliance.

## TREATMENT AND RECOVERY PLAN

Historically, "addiction treatment plans" connote short-term clinical interventions in isolation from long-term recovery planning. The ARMH model requires linking broadly used evidence-based treatment placement and assessment tools with concurrent longer-term recovery-focused patient planning. Similar to other chronic diseases, the treatment and recovery plan is individualized and built according to combining goal input from both the patient and the care team. The fundamental design of the treatment and recovery plan is engineered to support the patient in developing, maintaining, and expanding recovery capital. Recovery capital is derived from biopsychosocial origins.

Biological capital is focused on the physical attributes of a patient's recovery. Here, the focus is on appropriate pharmacotherapies and clinical supports that manage a patient's physical symptoms, withdrawal, and stabilization.

Psychological capital is focused on mental supports as the patient balances experiences, prejudices, fears, perceptions, or chemical imbalances that influence the mental state and attendant recovery of the patient.

Social capital is critical because personal change does not occur in isolation but is strongly influenced by the social environment and context of the patient's environment.<sup>22</sup>

As the treatment and recovery plan supports the patient in their enhancement of recovery capital, the care recovery team is working in collaboration with the patient to influence their trajectory and manage turning points. Turning points are a wholesale redirecting of trajectory cultivated on a long-term basis as opposed to a brief or convenient flash in the pan [23]. Today's treatment and recovery programs largely provide for brief detours instead of seminal redirection.

In addition, it is important to consider culturally and linguistically appropriate services that are respectful of, and responsive to, the health beliefs, practices and needs of diverse patients. When programs embed culturally responsive approaches to treatment, patients are more engaged in their care, including recovery services, therapeutic relationships between providers

and patients are improved, and disparities in behavioral health treatment outcomes are reduced.

The Alliance also borrows from key elements of recovery management as a framework for promoting interventions for those who are less likely to achieve recovery on their own:

- Capacity for recovery from a substance use disorder exists on a continuum of motivational readiness and skills.
- The goal of addiction treatment is to teach individuals how to achieve their own recovery.
- All individuals are capable of achieving sufficient recovery capital if given the skills or access to the resources.
- Addiction treatment is one of the multiple resources used to help individuals achieve a sustainable recovery.<sup>24</sup>

## FUNDAMENTAL OF THE TREATMENT AND RECOVERY PLAN

### *Patient-centered Planning*

For a treatment and recovery plan to be most effective, it must be tailored to individual patient needs, goals, and circumstances. It must therefore be developed in direct collaboration with patients and their families, physicians, care coordinators, and peer recovery coaches, so that each member of the patient's core support team can contribute to, and be aware of, the components of the plan. Patients should feel empowered to take control of their recovery by utilizing the plan. However, the full care team will be relied on to help the patient adhere to the various components of the treatment and recovery plan. Importantly, the treatment and recovery plan will help the patient through treatment in the clinical setting, but simultaneously provide smooth transitions to active, community-based recovery supports.

### *Treatment and Recovery Plan Components*

The most urgent activity that will be undertaken for any patient, after any emergency medical stabilization needs are met, is a clinical assessment to determine both the severity of substance use disorder and appropriate clinical recommendations. A trained professional will diagnosis an SUD based on 11 symptoms defined

in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). According to the Surgeon General's Facing Addiction in America report, "conducting a clinical assessment is essential to understanding the nature and severity of the patient's health and social problems that may have led to or resulted from the substance use. This assessment is important in determining the intensity of care that will be recommended and the composition of the treatment plan." There are four evidenced-based assessment tools outlined in the report that can be used:

- Addiction Severity Index (ASI)
- Substance Abuse Module (SAM)
- Global Appraisal of Individual Needs (GAIN)
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

Clinical treatment needs should be personalized and will generally use patient placement criteria already utilized by the payer and/or provider in a given geography. As also evidenced in the Surgeon General's report, "Engagement and retention strategies to promote participation, motivation, and adherence to the plan. Research has found that individuals who received proactive engagement services such as direct outreach and a specific follow-up plan are more likely to remain engaged in services throughout the treatment process." It is imperative for the care recovery team to work proactively with each patient to engage them in the clinical services recommended based on the outcome of the assessment. Also, concurrently with any treatment services being delivered, work with the patient on their recovery goals needs to begin. It can help to ensure a holistic set of a patient needs are being addressed building towards long-term sustainable recovery outcomes. The recovery management elements of the plan most-often will be led by a peer recovery coach in collaboration with the patient.

Community-based recovery is multi-dimensional. It's important that patients and the care team explore the people, places, and things that can either help, or hinder, long-term recovery. The template the Alliance has chosen to build from is a FAVOR Greenville Recovery plan. This plan covers 13 components of everyday wellness meant to be evaluated, along with goals established when a patient and care team are

outlining a patient-centered plan for long-term success:

1. Living (e.g., evaluate your living situation)
2. Recovery (e.g., build a support network)
3. Relationships (e.g., find sober friends)
4. Healthy Body (e.g., pay attention to your body; co-morbid physical conditions)
5. Healthy Mind (e.g., focus on mental well-being; underlying behavioral health concerns)
6. Counseling (e.g., continue to see a therapist)
7. Medication (e.g., transition to a new doctor)
8. School (e.g., do your homework)
9. Work (e.g., return to work)
10. Compliance (e.g., stick with your treatment plan)
11. Spirituality (e.g., heal your spirit)
12. Interests (e.g., discover new ways to have fun)
13. Coping Skills (e.g., practice healthy coping skills)

All components of the care plan may not be relevant for every patient, and each component may mean something different to each individual. It is important that the patient, care team, and support system (family, peer coaches, etc.) align around goals for each relevant component of the plan and incorporate a process for ensuring compliance with the agreed upon plan. Each goal should be accompanied by a time frame so that patients are regularly checking in on their progress. Various technology applications can be utilized by both care team and patient to track progress.

The importance of recovery-focused portions of most treatment plans used today are often overlooked. However, by placing more structure around quality of life measures, all parties involved will have a greater sense of control and will be able to anticipate factors that may impede progress toward long-term recovery, minimizing recovery disruptions. The treatment and recovery plan can promote consistency of care, ease care management (for providers), and provide a concrete setting and task to help family, friends, and other members of an individual's support system understand their role in the process of recovery. The treatment plan should also ensure physical and behavioral health are part of an integrated recovery.

## **Social Context**

The treatment and recovery plan should factor both exogenous and endogenous social factors that could influence a patient's recovery trajectory. The ARMH requires that four key categories are factored when assembling the patient's treatment and recovery plan. The sponsoring organizations should, in some way, factor each of these categories to control for specific opportunities and threats to the patient's recovery capital.

- Promoting Social Controls (Treatment and Recovery Section #3, #9, #10)

This tenet provides that a network of strong bonds with family, friends, work, religion and other related societal aspects regulates and motivates the patient to act responsibly in addition to increasing risk aversion. Conversely, when such social bonds are weak or fragmented, individuals are less likely to adhere to conventional norms and standards, tending to engage in behaviors that could lead to the onset of a recovery disruption.<sup>25</sup>

- Managing for Stress and Coping

Life stressors are highly likely to impede progress and could impel substance use among impulsive individuals who lack adaptive coping skills and/or are motivated to avoid facing problems or their associated negative effects.<sup>26</sup> These situations can arise from stressful life circumstances such as interpersonal conflict, work and financial problems, and physical and sexual abuse.

- Behavioral Economics and Behavioral Choice (Treatment and Recovery Section #3, #4, #8, #9, #10, #12)

The ideas under this category follow that the key element of the social context is the alternative rewards provided by activities other than substance use. Providing access to rewards through involvement in educational, work, religious, and social or recreational pursuits reduces the likelihood of choosing alternative rewards, such as those that might be derived by substance use.<sup>27</sup>

The specific social context of each of these areas, taken individually or together, have been shown to predict the maintenance of abstinence and freedom from substance-related problems.<sup>28</sup>

## ENGAGEMENT PRINCIPLES AND PROTOCOLS FOR THE TREATMENT AND RECOVERY PLAN

The treatment and recovery plan is designed to be a living, dynamic document that adapts to the patient's needs in real time. For the patient, it should represent an atlas to their recovery and should be consulted regularly. The plan can be documented with paper or be facilitated by a technology resource that meets certain connectivity criteria.

In all cases, the formal plan should abide by two core principles:

- 1) The plan is only official when it has been developed in conjunction with the care recovery team. More specifically, the care coordinator or peer recovery coach should be intimately involved in the creation of the plan, with final approval rights.
- 2) Patient preferences should be strongly deferred to in the creation of the plan. The Alliance believes patients understand their environments, triggers, and recovery parameters quite well. Though the patient will not be suited to offer clinically legitimate recommendations, their very specific insights should be strongly incorporated into the treatment and recovery plan.

### *Engagement Method*

In abiding by these principles, an authorized (and legally permitted) care recovery team designate should confer with the patient regarding their specific treatment and recovery plan. Prior to this interaction, the designate should have conferred with the broader care recovery team and included professionally or clinically oriented recommendations consistent with that patient's needs. The designate should have documentation describing the rationale for these recommendations.

The care recovery team designate and the patient should accommodate sufficient time for each meeting to establish, refine, or altogether alter the treatment and recovery plan. Time allotments should follow these standards:

- Initial development of the treatment and recovery plan – 2 hours
- Regular refinement of the treatment and recovery plan – 1 hour

- Reestablishing the treatment and recovery plan (in cases of recovery disruption) – 1.5 hours

These meetings should be established on a one-on-one basis in a quiet setting designed to provide comfort and ease to the patient. These discussions are highly sensitive, and the care recovery team designate should take great effort to ensure the patient perceives an environment of trust and security.

The designate should make notes and edits to the plan in plain sight of the patient, allowing the patient to provide reactions and insights as the plan is being developed. The designate should understand key boundaries and should not violate any of the core clinical recommendations put forth by other members of the care recovery team without their direct involvement or consent.

At the conclusion of the meeting, the patient should be provided with immediate access to the plan. This can be done by printing a copy or leveraging any technology adopted by the ITRN.

If certain parts of the treatment and recovery plan cannot be completed as a result of time constraints or dissonance in the process, the current edited form of the plan should stand as a “draft” treatment and recovery plan. The ITRN providers are expected to finalize the plan within 72 hours of initiating the meeting.

The patient should sign or authorize the finalized treatment and recovery plan along with the designate. The designate bears responsibility for the safe transport and codification of the plan in an electronic format that can be shared within the ITRN for the patient's benefit.

### *Timing and Cadence*

The treatment and recovery plan should be updated as regularly as there are changes in the patient condition.

The initial development of the plan occurs at the point of activation or induction into the ARMH with the appropriate care recovery team designate. As described above, this initial interaction should be lengthy and should include as many of the care recovery team members as are feasibly available. The initial plan is of critical importance as it seeks to balance a range of

clinical, social, and other considerations that orient that patient's recovery.

Each time a care transition takes place, a revised treatment and recovery plan should be developed in close collaboration with the patient prior to discharge. This process will not be as lengthy, as the primary shifts are in clinical or environmental settings.

If a care transition has not taken place in a six-month period, the treatment and recovery plan should again be revisited by the care recovery team designate. Key changes should be made to reflect the progress both the designate/care recovery team and the patient observe are taking place. Where progress is slow or uneven, adjustments should reflect areas of pressure or difficulty.

Finally, in the event of a material or significant recovery disruption, the care recovery team should immediately engage with the patient to make the appropriate adjustments to the plan. This may involve a general resetting of key clinical services, moving the patient back to a setting more appropriate for that particular moment in their care. However, it may simply look to adjust settings or other recovery determinants, without a need to materially redress a defect in the plan.

## MEASURING RECOVERY & PROPOSED QUALITY METRICS

Given the current non-existence of long-term quality measurements for substance use disorders, the ARMH will initially rely heavily on process measures as determined by individual ITRN's (e.g. patient consent to share medical record, frequency of patient contact, care transitions, etc.). Learnings will also be drawn from Collaborative Care Model currently being used to integrate behavioral health services into Primary Care savings that has been shown to improve patient outcomes considerably. Additionally, there are emerging tools and technology to measure "Recovery Capital" that ITRN's can explore integrating into their models.

Aside from that, the ARMH seeks regular reconciliation and recovery determination. One way to do this is to rely on a consensus document developed by ASAM that focuses on the appropriate use of drug testing in recovery.

ASAM created a consensus document on the Appropriate Use of Drug Testing in Clinical Medicine<sup>29</sup> to provide guidance on the effective use of drug testing in the identification, diagnosis, treatment, and promotion of recovery. Generally it is anticipated a patient would be tested weekly during the first six months (episode one: Recovery Initiation and Active Treatment), monthly during the second six months (episode two: Community-Based Recovery Management), and then either monthly or eight times a year in the remaining episodes of the ARMH model. The testing should be administered by a trained clinical professional on the team and not the peer recovery coach. The care recovery team should factor these guidelines into the patient's particular needs while adhering to this general cadence.

Clinical levers of success identify opportunities and provide ways to help providers 'win' within episodes. Validation of levers include a clinical validation where a verified operational opportunity with physicians and specialists exist. Some examples of these levers might include:

- Use of in-network providers and facilities
- Use of evidenced-based medicines
- Successful development of treatment and recovery plan
- Patient adherence to care plan
- Appropriate use of drug testing
- Screening for underlying depression, other behavioral health conditions
- Use of individual and group therapy
- Development of a relationship and follow-up visits with PCP
- Identify and tracking patients risk for reoccurrence of symptoms
- Ongoing engagement with peer recovery coach
- Integration into community

## CONCLUSION

For generations, our country has been plagued by addiction. It's worn different faces; ravaged communities and families; sent millions to prison; compromised economic opportunity; and unjustly claimed hundreds of millions of lives. And yet, it persists.

It persists in part because we still treat it as an acute event rather than a chronic disease. This distinction matters. Managing a chronic disease takes a well-coordinated village that includes care teams, case managers, high-tech devices and apps, community support systems, seamless information sharing, and increasingly, economics that reward the medical infrastructure for coordinating and connecting these resources well.

The landmark Surgeon General's Report, Facing Addiction In America, provides us with decades of research and clear protocols about what does and

doesn't work in treatment and recovery. More needs to be discovered, but we do know a lot about what the science tells us.

Developing Addiction Recovery Medical Homes with aligned financial incentives is not easy and challenges abound in creating a system that is comprised of these elements described in this paper. But with the tremendous collective pain we are facing among our families and communities, our employers, our health systems, our insurers, never before has there been an opportunity for a revolution in how we respond to addiction as there is today. We have an opportunity for the first time to conceive, construct, and deploy an integrated system for addiction health services that will save countless lives and produce tremendous economic value.

What's required from us?

**Persistence.**

To Download The Supplemental ARMH-APM Bundle Definition Code Workbook Visit:

<https://www.incentivizerecovery.org/download-armh-apm-documents>

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