

2023 UPDATE



# Addiction Recovery Medical Home Alternative Payment Model

**INCENTIVIZING RECOVERY. NOT RELAPSE.**

A CONSENSUS LEARNING MODEL

## ADDICTION RECOVERY MEDICAL HOME – ALTERNATIVE PAYMENT MODEL PUBLICATION HISTORY (ARMH)

Founded in 2017, The Alliance for Addiction Payment Reform (Alliance) is a cross-sector learning collaborative that has brought together leading health experts and stakeholders to support the design and implementation of alternative payment models for substance use disorder (SUD). In collaboration with over 40 clinical, addiction, information technology, primary care, social, regulatory, and policy experts, the Alliance published the Addiction Recovery Medical Home - Alternative Payment Model (ARMH), a consensus open learning model, in 2018 and companion operational definition in 2019. Since its initial publication, the model and accompanying work have become a core driver behind the components of federal and state Medicaid value-based payment policy, managed care, and self-funded pilot demonstration explorations across the country. For a list of the original contributing members, reviewers, and subject matter experts who helped develop the basis for this white paper, please see Appendix B.

### VALUE OPPORTUNITY CALCULATOR:

In 2023, the Alliance launched an interactive Value Opportunity Calculator to give payers, employers, providers, and government stakeholders an estimate of the economic opportunity available to them through the deployment of an alternative payment model (APM) for SUD in both commercial and Medicaid populations.

Visit [IncentivizeRecovery.org](https://www.incentivize-recovery.org) to learn more about the ARMH, the Learning Collaborative, or test the free Value Opportunity Calculator.

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## BACKGROUND AND INTRODUCTION

Before, during, and after the COVID-19 pandemic, overdoses and alcohol-related deaths have remained the leading and growing cause of death for those [under 50](#). According to the Centers for Disease Control and Prevention (CDC), drug overdoses claimed the lives of 106,699 Americans in 2021, while alcohol-related deaths account for nearly 140,000 deaths annually, with far less public attention paid to that substance problem. Substance use disorders (SUDs) have devastating effects on individuals, families, and communities and drive enormous inefficiencies in health care. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2021, [46.3 million Americans 12 and older](#) (or 16.5 percent) were estimated to be currently suffering from a SUD, and only 6.8 percent of those in need received any treatment at a specialty facility in the past year. This treatment gap for what is a widespread pervasive chronic health problem is unparalleled across the entire health care system. Despite the magnitude of SUDs throughout America, there is a lack of credible consumer and health system-focused information about what an integrated continuum of care approach looks like that could stem the growing prevalence of this 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 SUDs, unlike other primary chronic health conditions.

The human and economic cost of 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 to SUD. In late 2016, an entire chapter was dedicated in the United States Surgeon General’s seminal report on alcohol, drugs, and health: [Facing Addiction in America](#), issuing a call to action for mainstream health systems to integrate SUD services into their delivery networks.

In order to help more people recover from addiction, the health system 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 or substance-specific approaches to a sustained biopsychosocial model of recovery management comparable to the management standards and protocols for chronic physical disease. The [underlying philosophy](#) guiding this approach is one of sustained recovery management as a means of organizing SUD 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.

The health system needs a radical shift in how it pays for SUD care delivery and recovery services to improve recovery rates, lower unnecessary costs, and drive broader systemic value through the reduction of other comorbidities that become exasperated when addiction problems are not well managed. The rapid convergence of new data, contracting models, and evidence-based care models are poised to transform the nature of treatment and recovery services for SUD across the country. What is required now is unique innovation and collaboration to harness these converging forces and change the nature of treatment and recovery services.

**A system that incentivizes recovery. Not relapse.**

## OVERARCHING PRINCIPLES

Founded in 2017, The Alliance for Addiction Payment Reform (Alliance) is a cross-sector learning collaborative that has brought together leading health experts and stakeholders to support the design and implementation of alternative payment models for SUD. The Alliance published the Addiction Recover Medical Home - Alternative Payment Model (ARMH), a consensus open learning model, in 2018 and a companion operational definition in 2019. Since publication, the model and accompanying work has become a core driver behind components of federal and state Medicaid value-based payment policy and managed care and self-funded pilot demonstration explorations.

The ARMH assimilates evidenced-based treatment and evidence-informed recovery services with a payment system that integrates assets and incentives to treat SUD as 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 health and wellness, and live a meaningful life in a community of their choice while striving to achieve their full potential.
2. Care recovery has three critical, interconnected episodes: pre-recovery/stabilization, recovery initiation and active treatment, and community-based recovery management.
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.
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.
10. A dynamic treatment and recovery plan with the breadth and flexibility to engender increased recovery capital should be developed in collaboration with the patient, the patient's family, and other key social supports.

## ADDICTION RECOVERY MEDICAL HOME (ARMH) MODEL OVERVIEW

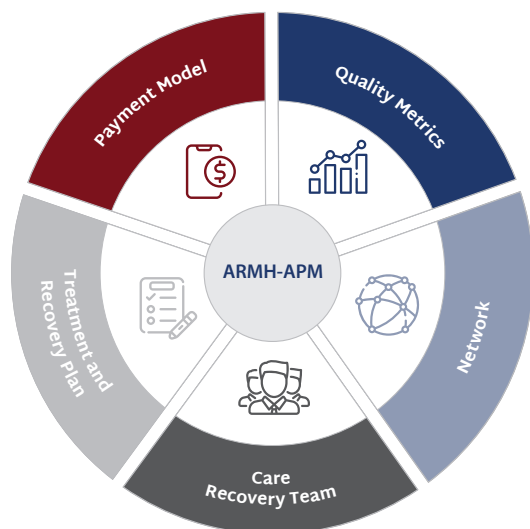
The ARMH is unique in its scope and transformative approach to long-term community-based treatment and recovery from all SUDs. The ARMH was established with the initial goal of organizing care principles most germane to opioid use disorder (OUD) and alcohol use disorder (AUD); however, the underlying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

contexts. The ARMH is not intended to be deployed for patients who primarily have a tobacco or nicotine use disorder without another co-occurring SUD.

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 SUD.

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 Intergrated Treatment and Recovery Networks (ITRN's) be developed. An ITRN is a defined network of acute, outpatient, home health, recovery supports, and virtual services, integrated through discharge planning, work flows, and technology. The Alliance acknowledges that 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 collaborate with other valued-based addiction treatment and recovery programs aligning with the core principles of the ARMH.

**FIGURE 1: FIVE ELEMENTS OF THE ARMH MODEL**



The five foundational elements as shown in Figure 1 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, earn 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
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 health services

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

Drawing from best current practices in the field, the ARMH demonstrations continue to refine entry and participation criteria for providers. These demonstrations explore both process and outcome measures that tie the provision of care to payment, incenting recovery and informing a national baseline of much-needed long-term SUD performance metrics. A description of potential metrics is outlined in this paper.

#### *Element #3 – Network*

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

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

A central team coordinates care, which focuses on long-term recovery. Working with patients on a

holistic recovery process, including the patient, family, peer support, community, social determinants, and other key environmental conditions that promote enhanced health and quality of life.

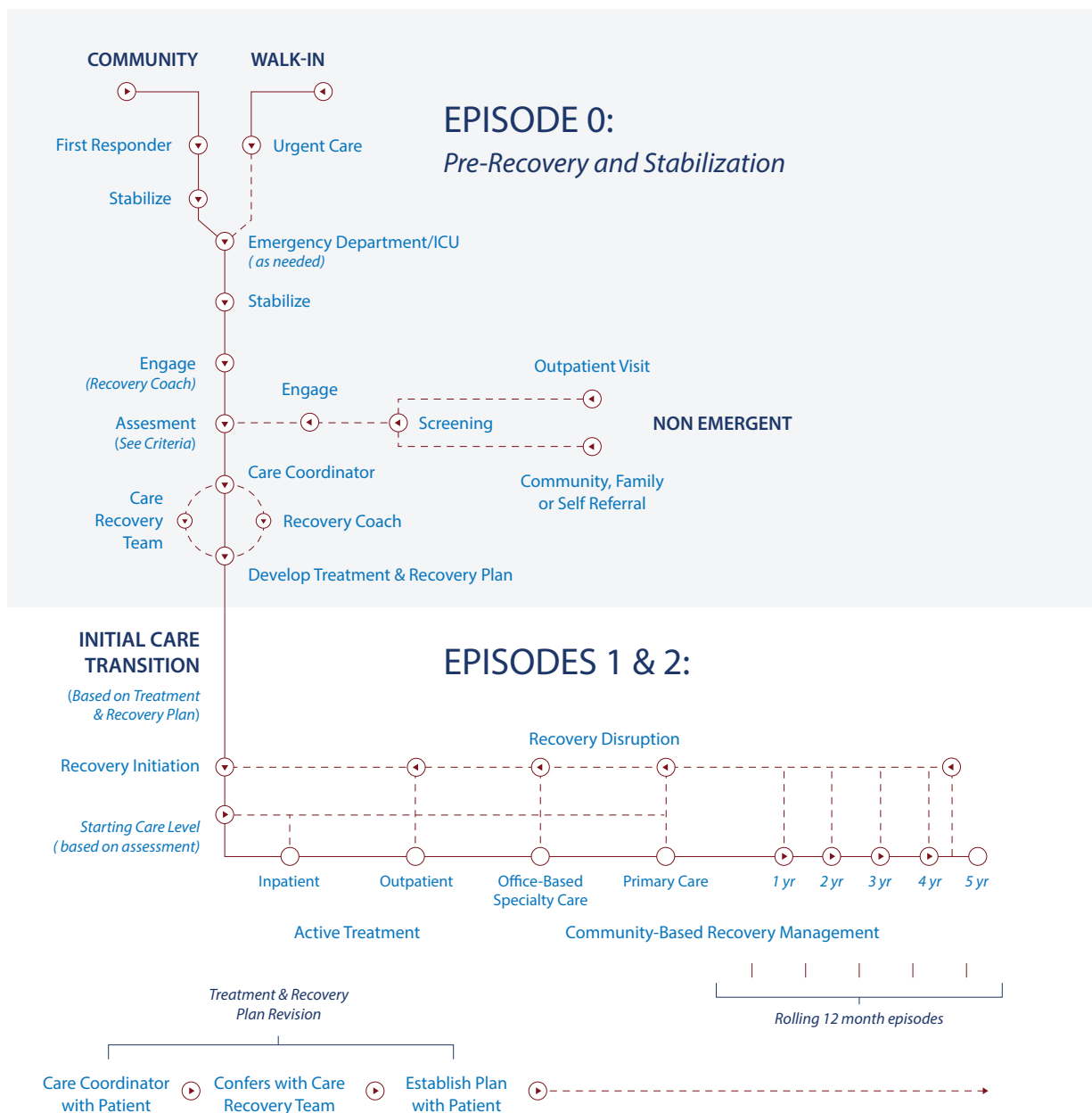
*Element #5 – Treatment and Recovery Plan*

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 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 their recovery carries significant value.

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

**FIGURE 2: PATIENT ON-RAMPS & CARE TRANSITIONS**



## ALTERNATIVE 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 improve integration of disparate parts of the delivery system to and foster collaboration and efficiency. In the case of the ARMH, the proposed APM is designed to improve 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 APM that shifts to 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 APM 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 benefitting participants.

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

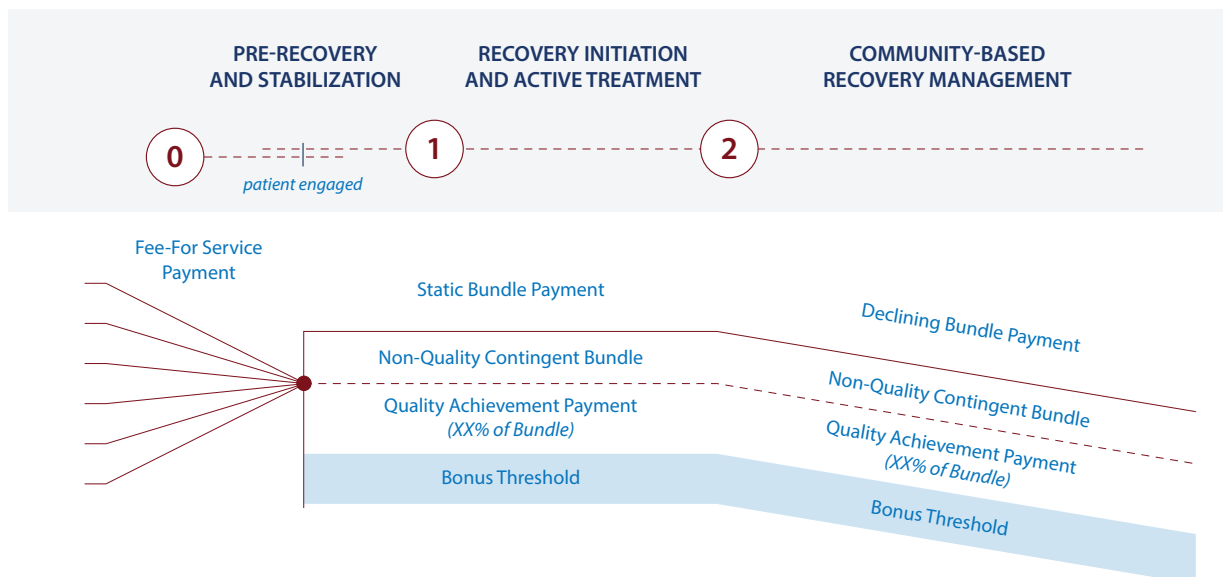
outcomes for payment. The ARMH payment covers comprehensive addiction health services and co-occurring mental health needs with optional co-morbid physical health modules. The shared savings fund, from which bonus payments to high-achieving providers are drawn, is created from the savings accrued as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

## ADDICTION RECOVERY MEDICAL HOME EPISODES OF CARE

In keeping with the principles developed by the Alliance, there are distinct phases of care: episodes 0, 1, and 2 (Figure 3).

The payment and the ARMH quality metrics will follow the patient across episodes of care. Participating providers must adhere to evidence-based treatment and evidence-informed recovery services but are not bound to specific services within the episode, unlike fee for service (FFS). All clinically appropriate care within the episode, as determined by the provider, is incorporated by the bundled payment. This structure is meant to provide a flexible approach to treatment and recovery services, recognizing that no single

FIGURE 3: PAYMENT TYPES FOR EPISODES OF CARE





pathway will work for all patients. Examples of patient journeys, including on-ramps and care transitions by episode, are shown in Figure 3.

The Alliance expects that the risk inherent in the APM 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 evidence-based treatment modalities, see [Facing Addiction in America](#), Chapter 4. Likewise, for a review of evidence-informed recovery support services, see [Facing Addiction in America](#), Chapter 5.

### ***Episode Zero: Pre-Recovery and Stabilization***

In this episode, the patient is being treated for conditions related to a 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.

Services under this phase, typically administered in the emergency department (ED), intensive care unit (ICU), or primary care settings, are paid on the basis of FFS, leveraging current coding and payment architectures. The Alliance would encourage adopters of the ARMH to introduce outreach and engagement payments or 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 episode is focused on the 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, withdrawal management, residential treatment, and

outpatient care. Episode One 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 specialty outpatient services or 12 months have elapsed, the patient will transition into Episode Two, Community-Based Recovery Management, and payment will shift to align correspondingly.

### ***Episode Two: Community-Based Recovery Management***

Episode Two of the ARMH does not rely on acute care settings, nor does it preclude the use of clinically appropriate services. 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 Episode Two. In other words, because recovery disruption is built into the bundled payment for this 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-based recovery management phase will not be adjusted upward to the rate under the higher-acuity Episode One. The Alliance believes this strategy will incentivize strong coordinated care and thoughtful transitions to reduce incentives that steer patients into a higher level of care when clinically unnecessary.

In addition, the ARMH quality measures will take into account avoidable recovery disruption. For illustration purposes, the Alliance has mapped how funds could flow between parties in both a state Medicaid Managed Care system and an Employer-Sponsored Insurance program (Figures 4 and 5).

FIGURE 4: PAYMENT FLOW ILLUSTRATION – COMMERCIAL INSURANCE

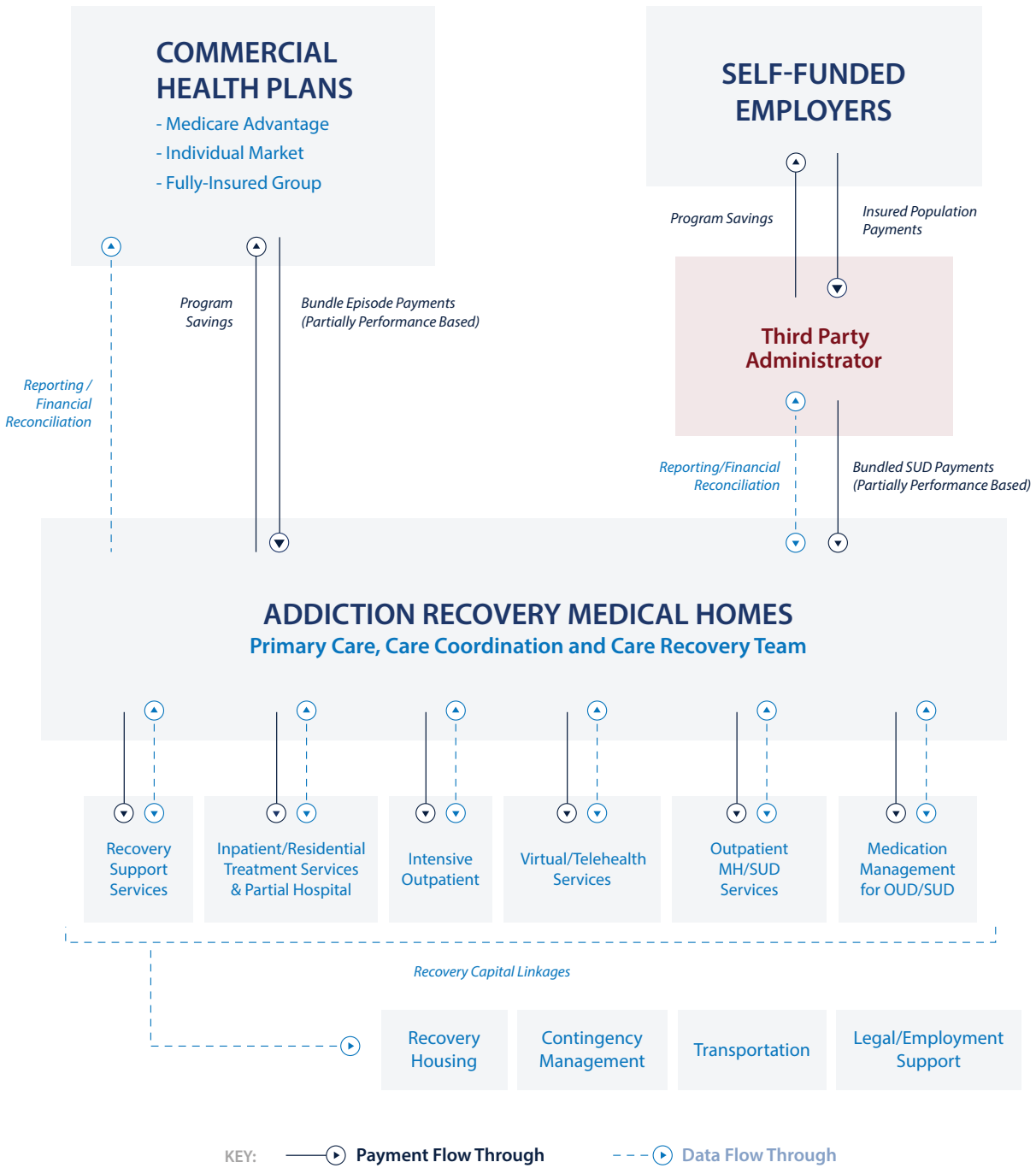
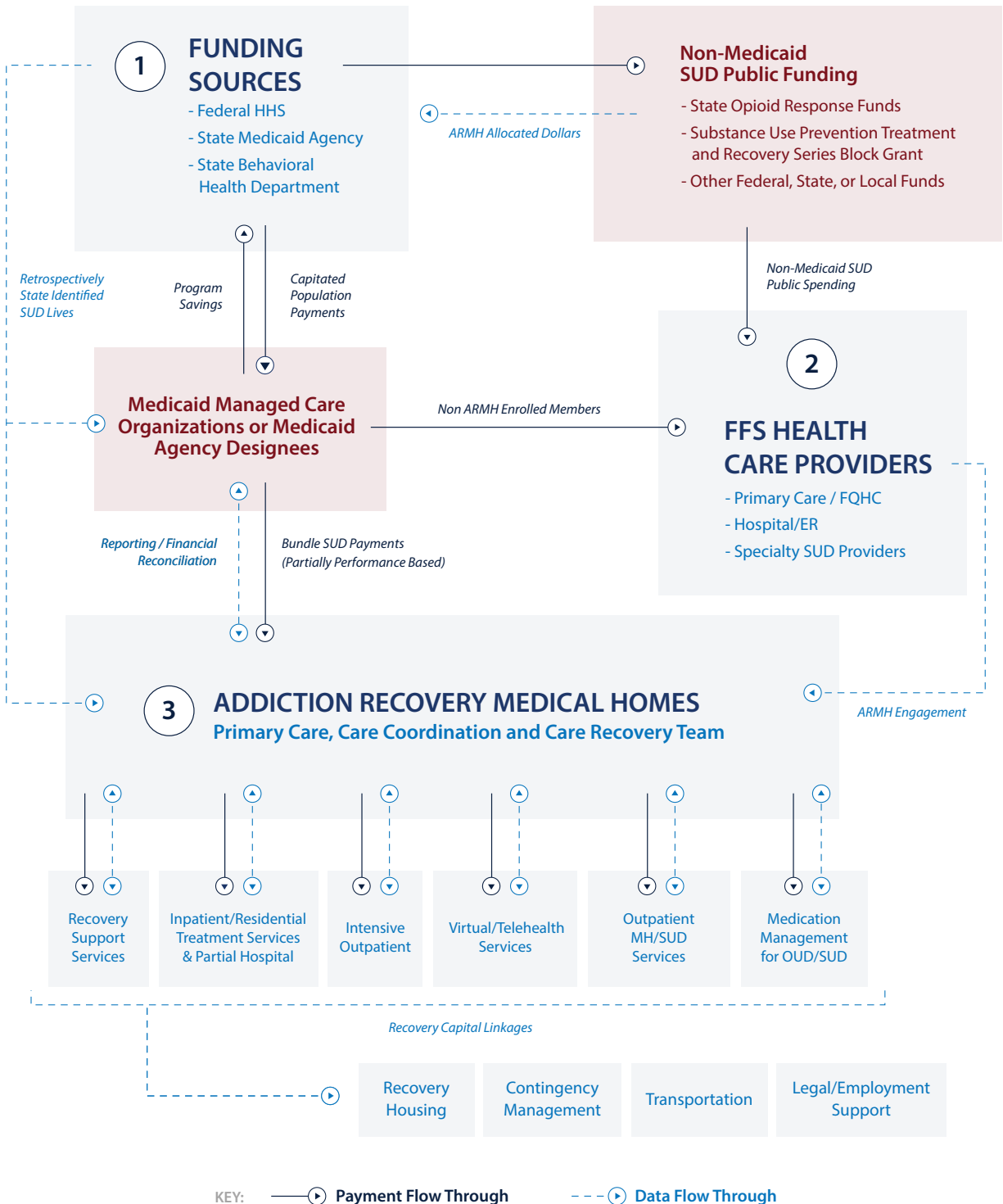


FIGURE 5: PAYMENT FLOW ILLUSTRATION – MEDICAID



## PAYMENT MODALITIES

The ARMH is a unique hybrid of several APMs 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 value of maintaining the integrity of this system in cases of emergent patient care requiring stabilization in the ED or ICU settings. The ARMH only leverages FFS payments for Episode Zero.

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

Bundled payments that can be risk-adjusted are at the heart of the ARMH, representing a financial vehicle designed to provide flexible economics to providers to incentivize person-centered care with parallel fiscal responsibility. Bundled payment rates are tied to population or per-patient-based severity criteria, adjusting the payment amount for patients with a higher risk of physical co-morbidities and/or co-occurring mental health conditions.

The ARMH model separates the bundled payment amounts between the two episodes of care: 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 that match performance periods for a given population, most often on a twelve-month basis, for up to five years. The episode of care payments would decline across the defined performance periods as the patient remains engaged in the ARMH.

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 – less a quality achievement withhold – for the Recovery Initiation and Active Treatment episode of care when the provider and patient initiate recovery under the ARMH on a cadence to be determined by between the payer and ARMH provider. The provider is budgeted a set amount in each episode of care, and is fully at risk for specialty SUD care costs that exceed the bundle price. The Alliance recommends that ARMH contracts between providers and payers require 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 the partnering MCO and provider conclude that a retrospective payment is most feasible, the provider would continue to code and claim services under existing FFS arrangements. Afterward, 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 would adjust the provider payment based on the total amount allotted under the severity-adjusted episode for patient care (periodic payment adjustment).

A third approach to the episode of care payments is to blend retrospective and prospective components to more equitably share risk between providers and payers. In this approach, a payer can pay a portion of the bundled payment prospectively, perhaps to support the operationalization of additional care management and peer recovery supports services the ARMH provider will be deploying that are not part of the existing FFS contracts, while providing clinical service payments in alignment with the retrospective approach. The parties

would then reconcile the performance period, and any prospective over-payments provided can be offset against the quality achievement payment or shared-savings bonus payment.

### ***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 with a quality achievement payment. 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 outcome 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). If an ARMH provider meets all the defined process and outcome quality metrics, the provider can receive the full quality achievement payment. This quality payment safeguards shared interest in patient recovery among providers and payers and ensures high quality care for the patient..

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

ARMH providers can also be eligible for a performance bonus equal to a defined percentage<sup>2</sup> of the overall savings achieved across the patient's total medical expense. Specifically, the pool of bonus funds comes from the actual shared savings attributable to the increased coordination and treatment of patients across all health care services: SUD, mental, 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 structures 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 where behavioral health and physical health funding streams are

separated, ARMH entities can consider a risk-bearing entity that can blend and braid 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 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.

### ***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 or existing risk-adjustment methodology to determine the patient-severity-based payment category. The Alliance expects that both payment amounts and the number of individuals within each category will vary by geography or insurance type (e.g. Medicaid/employer-sponsored/Medicare). The Alliance views the severity adjustment as adequately covering patient variation to alleviate adverse selection concerns.

## **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). The caregiver should facilitate enrollment at the expressed consent of the patient. The patient must be diagnosed with a SUD, notified of the opportunity to participate in the local ARMH program, and assertively provide their consent.<sup>3</sup>

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 to meet them 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 participating under the corresponding business line.
  - a. Note: participating providers under the ARMH 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 to facilitate enrollment and transitions for patients looking to participate in the ARMH.

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. There is a growing body of evidence that trained peer recovery coaches may provide the highest rates of engagement into treatment and recovery support services in emergency settings. For example, New Jersey's largest integrated health system, RWJ

Barnabas, [employs 70 Recovery Specialists available 24 hours a day seven days a week, to meet patients](#) in the ED or inpatient setting. Peer support is initiated bedside and continues for a minimum of eight weeks post-consultation. In 2019, 89.1 percent of patients who met with recovery specialists accepted services and 91.4 percent of those patients received services post-discharge. Additionally, the program saw reduced admissions and ED visits for participating individuals.

### **Payer Identification**

Payers or other market implementation supporters should perform advanced analytics on their historical claims data. Analytics will help to identify patients at high risk for a 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 Primary Care Provider (PCP), or enrollment personnel, to try and engage the patient introduce the ARMH.

In Appendix A the Alliance has prepared a specific proposed process for analyzing historical data using the the associated ARMH bundle definition logic.

### **Primary Care or Community Screening**

PCPs or their designated clinically trained staff can screen patients for SUD. In cases where these screenings affirm the existence of a 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](#)
- [Alcohol Use Disorders Identification Test \(AUDIT\)](#)
- [Alcohol Use Disorders Identification Test-C](#)
- [Brief Screener for Tobacco, Alcohol, and Other Drugs \(BSTAD\)](#)
- [CRAFT](#)
- [Drug Abuse Screening Test \(DAST-10\)](#)
- [DAST-20: Adolescent Version](#)

- [Drug Use Disorders Identification Test \(DUDIT\)](#)
- [Helping Patients Who Drink Too Much: A Clinician's Guide](#)
- [Opioid Risk Tool](#)
- [Screening to Brief Intervention \(S2BI\)](#)

## Volunteer

Patients and/or families may become aware of the ARMH. Further, ARMH providers 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.

## Unenrollment

Patients may be unenrolled from the ARMH through various conditions and circumstances. Payment would end and could be prorated under these circumstances:

- patient relocation outside of the ARMH geography
- patient death
- patient-elected termination of participation
- patient insurance eligibility changes between contracted parties

As providers or stakeholders are consider implementing an ARMH, they are encouraged to include as many local market payers as possible into the ARMH (e.g. multiple Managed Medicaid Plans serving the same region, multiple Commercial payers or lines of business, etc.). 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.

## Pathways for Patient Attribution

Patient attribution is a key component of enrollment and program implementation to consider. To date, there has been minimal industry guidance on how payers and provider networks should or could attribute patients in various regional deployments associated with [Level 3 HCP-LAN](#) models targeting SUD like the ARMH. This is a complex question as the National Quality Forum indicates in their [Final Report on Improving Attribution Models](#), “No universal standard currently exists for attribution models (generally).” However, the report

asserts that, “understanding who is responsible is essential to driving improvements in care as well as for securing long-term buy-in from providers and facilitating the ability of value-based purchasing and alternative payment models to influence provider behavior.”

In large part, traditional APMs operate on a calendar year or otherwise 12-month performance period due to the common annual underwriting cycle within managed care. During a performance period, it is the responsibility of a provider to accurately document an eligible patient condition(s) which triggers the start of the episode of care. Once the episode is triggered, the patient generally remains eligible for the remainder of the performance period. The start of a new performance period requires a provider to accurately document the patient's engagement which triggers the start of the new performance period.

The ARMH has three categories of patients that must be considered, based on a retrospective eligibility for APM-reimbursed services.

The first category is patients that are **known to be eligible** for and **actively engaged** in ARMH-reimbursable services. These are patients who, once identified as eligible for and engaged in the ARMH, remain connected to care throughout a performance period. Overall, the cost for these patients would be accounted for in a risk-adjusted episode of care payments and shared savings based on attribution.

The second category is patients **known to be eligible** for but **not actively engaged** in ARMH services. These are patients who have, at one point during a performance period, been identified as eligible but either faced barriers to engagement or chose against engaging in ARMH services. When identified as eligible for services, patients who remain not actively enrolled in the ARMH as described above would continue to receive substance use services outside of the APM structure, most likely on a FFS basis.

The third category is comprised of patients that are **not known to be eligible** for ARMH-covered services. These patients have not yet been identified as eligible for services during a previous performance period, either because they have disconnected from care, generally,

or have yet to present with a triggering condition that would identify them as eligible. When identified as eligible for services through an authorized enrollment pathway, cost for these patients would be accounted for in a risk-adjusted episode of care payments and eligible for shared savings. An ARMH can choose a prior authorization structure as desired for these individuals, similar to how some intensive specialty in-network SUD care is already authorized and managed today between parties.

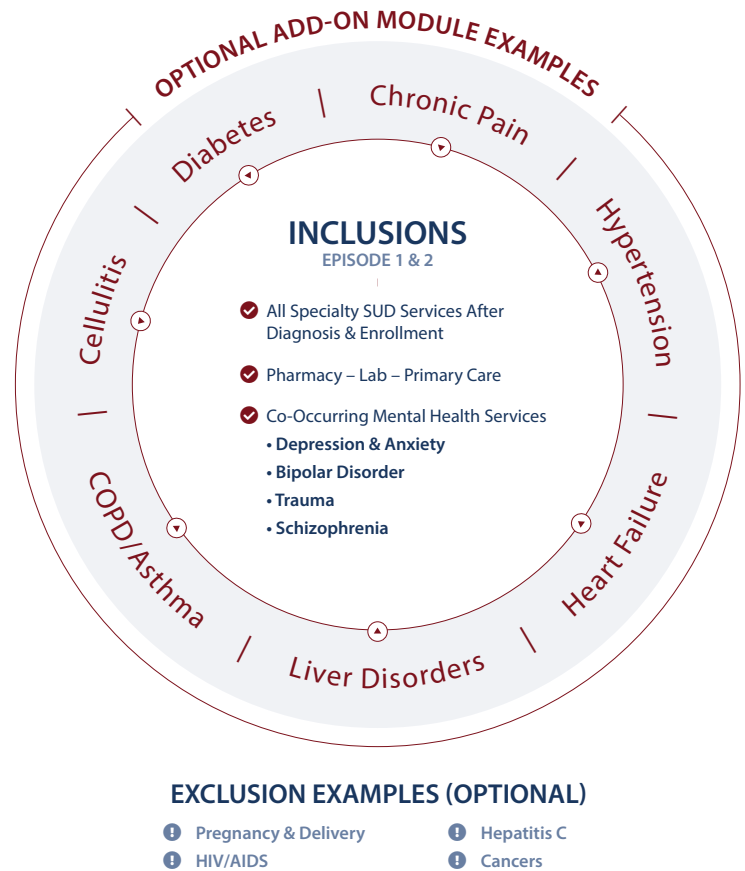
## SUBCONTRACTING

The ARMH 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 method 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 alternative 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 has prepared a specific bundle definition for the specific attributes of the proposed ARMH integrated bundle. These inclusions can be used to set target prices based on retrospective costs and forecast the new services required in the ARMH program that does not exist in historical claims (e.g. care management, peer recovery coaching, etc.). The main inclusions and exclusions of the bundle are summarized below (Figure 6), along with associated detailed standard code workbooks that can be used for implementation by a payer or risk-bearing entity.

FIGURE 6: EPISODE OF CARE INCLUSIONS



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 the severity of SUD
- geographically adjusted price for local patterns and variations
- uses empirical data analysis to provide an allowance for complications (i.e. recovery disruptions or actionable adverse events)
- includes allowances for care coordination, recovery coaching, and mobile technology needs not typically found in retrospective FFS claims analysis
- includes 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

### 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 companion bundle definition [worksheet](#):

TYPE OF SUD	LEVEL OF SEVERITY	EPISODE 1	EPISODE 2
Opioid Use Disorder	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Alcohol Use Disorder	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Cannabis Use Disorder	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Stimulant Use Disorder – Amphetamine-Type Substance	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Stimulant Use Disorder – Cocaine	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Sedative, Hypnotic, or Anxiolytic Use Disorder	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Other Hallucinogen Use Disorder	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Stimulant Use Disorder – Other/Unspecific Stimulant	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Phencyclidine (PCP) Use Disorder	MILD		YES
	MODERATE	YES	
	SEVERE	YES	
Inhalant Use Disorder	MILD		YES
	MODERATE	YES	
	SEVERE	YES	

\*All Polysubstance Use Disorders can also trigger either Episode One or Episode Two

In addition to diagnosis codes, certain specialty services that are very specific for substance use patients are used for triggering the episode independently as well. These can include procedure codes for withdrawal management, residential treatment, outpatient treatment, or medication management services that can be identified by their procedure 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 mental health conditions 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 to treat and manage a patient with a SUD in a more integrated fashion. Depending on the sophistication level of the payer and provider, 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 episodes 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	
Medications for Addiction 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 or have not been historically used in a given market. The ARMH bundle definition recommends that payers and providers agree to an average allowance for inclusion in the target price for both Episode One and Episode Two.

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
Mobile Engagement	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	EPISODE ONE & EPOSIDE TWO
<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 preventive 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

By comprehensively engaging a patient in treatment and recovery with SUD, there are many potential Actionable Adverse Events (AAE) that can be avoidable. While the patient is enrolled in the ARMH, the following sample list of identified AAEs can be used to adjust for the bundle price or shared savings paid to a provider. The baseline should 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 factored 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 proactive measures are taken by the provider to avoid the overdose, the resulting savings will help the provider come under budget and increase shared savings.

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

## Rules for Episode Inclusions and Exclusions

Each deployment has considerable flexibility on the specific inclusions and exclusions based on the market capabilities and provider interest. However, the Alliance recommends that 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 mental health condition, should be included in the core episode. These include services for depression, anxiety, bipolar depression, post-traumatic stress disorder, or schizophrenia. Relevant diagnosis codes for the underlying mental health conditions, as well as any adverse events related to them, would serve to steer relevant services into the episode.

Other physical health conditions could be triggered as modules around the SUD episode and may include modules for chronic conditions (e.g. hypertension, diabetes, asthma, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (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) can be added as additional care with additional allowances.

Major surgical procedures should 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 a SUD patient, will also be carved out but could be made available as a Maternity module if required.

## PAYER AND PROVIDER ARMH SPONSORS

There are no specific criteria to become a sponsoring ARMH provider or payer. Since its first publication, the Alliance has received development and interest from a wide variety of state governments, Medicaid Managed Care Organizations, self-insured products, Medicare Advantage, integrated delivery networks, primary care or multi-specialty groups, SUD specialty providers, and behavioral health organizations. Each adoption of the

ARMH allows for unique permutations and combinations in search of resolving specific challenges germane to populations and/or the business interests of the sponsoring entities. The Alliance operates an open learning collaborative, and its managers are prepared to provide specific technical assistance to interested parties.

## INTEGRATED TREATMENT AND RECOVERY NETWORK

The ARMH requires an integrated, seamless continuum of care across professionals (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. This integration 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 necessitates the kind of coordination envisioned by the ITRN. The Alliance believes enhanced community engagement, improved care coordination among addiction, mental health and physical health services providers, and planned and incented care transitions over an extended period 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, with limitations in referrals and/or requisite information sharing with other key parties. To bypass this structure, providers must either work together through shared accountability and shared risk or enjoy common ownership by a single entity that 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 health information can lead to a discussion of non-opioid pain management treatment alternatives for that patient.

The ARMH 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 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, only one in five adults, and even fewer adolescents, receive this type of continuing care.

## PROVIDER PARTICIPATION GUIDELINES

For piloting purposes, an ARMH provider is recommended to have the capacity 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 demonstration 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 an additional evaluation framework at the early stages of the ARMH 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. 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 well-supported evidence as described in [Facing Addiction in America](#) 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.”

A fundamental concept in care coordination between health care, SUD 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 SUD treatment is identified. The 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.

To define the required 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:
  - o Acute Intensive Services (Across multiple ASAM Levels of Care)
    - Mobile Crisis Services
    - Urgent Care Services
    - Medically Managed Intensive Inpatient Services (ASAM Level 4)
  - o Out-of-Home Residential Services (ASAM Level 3)
    - Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
    - Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
    - Medically Monitored Intensive Residential Services (ASAM Level 3.7)
- Clinical Support Infrastructure: Services provided on an outpatient basis but remain rooted in a strong clinical context, including:
  - o Intensive Support Services (ASAM Level 2)
    - Intensive Outpatient (ASAM Level 2.1)
    - High Intensity Outpatient (ASAM Level 2.5)
    - Medically Managed Intensive Outpatient (ASAM Level 2.7)
  - o Outpatient and Medication Assisted Treatment (ASAM Level 1)
    - Long term remission monitors (ASAM Level 1)
    - Individual Therapy (ASAM Level 1.5)
    - Group Therapy (ASAM Level 1.5)
    - Family Therapy (ASAM Level 1.5)
    - Medically Managed Outpatient (ASAM Level 1.7)
  - o 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:
  - o Engagement Services
    - Motivational Interviewing (ARMH On-Ramps)
    - Mobile Engagement
    - Evidence-based Assessment
    - Contingency Management

- o Recovery Support Services
  - Peer Recovery Coaching
  - Supports for Self-Directed Care
- o Prevention and Wellness Services
  - Screening, Brief Intervention, Referral to Treatment
  - Call Center
  - Public Education Activities
- o 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 component 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 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***

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 share the medical record and Personal Health Information (PHI) more seamlessly, facilitating ready access to the patient's medical record and treatment and recovery plan.

### ***Networked Providers***

The Alliance anticipates that providers who cannot solely offer the full range of the recommended addiction

treatment and recovery 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 accountable care organization (ACO) or an Independent Practice Alliance (IPA), with a central contracting entity organizing the network for 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.

## **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). However, in 2023, at the direction of Congress, [SAMHSA released new guidelines on Part 2](#) to closely link it to similar processes and protocols in greater alignment with certain aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Breach Notification, and Enforcement Rules that govern all other aspects of PHI removing a significant barrier for value-based care for SUD.

Shared patient records are coordinated across care settings through a technology intermediary. This connotes an interoperable approach where the core contracted entity either owns or has an arm's length technology relationship with sufficient Application Programming Interface (API) and infrastructure to exchange such information. The ARMH requires that a patient consents to the risk-bearing entity sharing the patient's medical record with affiliated parties under the ITRN. The care recovery team, depending on individual care team roles and responsibilities, should be able to access all other PHI through the EMR.

### **Clinical Information Sharing Systems**

The preferred approach to sharing clinical information is through a common EMR, most often found within an Integrated Delivery Network (IDN) or CIN. The EMR should have the capacity to support behavioral health and SUD-related information, including a mechanism to inculcate the evolving Part 2 consent requirements, 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.
- 2) An EMR overlay capable of integrating electronic data transmission (EDT) feeds of clinical information that comprises key patient-specific information. These systems could include population health management platforms and/or clinical information management tools.

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

### **Care Transition Management**

One of the most critical elements of promoting integrated treatment and recovery for patients is creating and managing a care continuum. Alongside the criticality of management, there are 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 the following:

- A 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 care coordinator, who can confer with the broader care recovery team and support the implementation of the treatment and recovery plan
- Where possible, the patient should be able to explore and interact with the new care setting in advance of their care transition

### **OPIOID ABATEMENT SETTLEMENT FUNDS**

The various [state and local opioid lawsuits](#) currently underway represent a unique opportunity for communities to fund the infrastructure that enables the implementation of sustainable and comprehensive programs that can provide services attuned to the chronic nature of opioid addiction and related conditions. The various settlement agreements specify approved usages for disbursed funds which includes expanding services and support for the prevention, treatment, harm reduction, and recovery of opioid use disorders.

Rather than distributing money into traditional FFS systems that perpetuate fragmentation, the unique nature of potential opioid settlement funding provides community leaders with the opportunity to invest in workforce, physical and data infrastructure, data collection, and coordination mechanisms needed to support more sustainable value-based models and broader system transformation. ITRNs should consider partnerships with fund recipients, such as state, municipal, and county leadership, to integrate the approved usages into ARMH deployments.

### **CLINICAL PATHWAYS**

Individuals living with a SUD experience the condition differently. Thus, the ARMH 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 PCPs 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 in 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 requires a comprehensive whole-person assessment to determine appropriate clinical placement. Under the ARMH model, the Alliance suggests adopting a standard assessment 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 recommends that the comprehensive evaluation occur 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 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.

Not all patients are equally engaged in the 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 interviewing technique that engages the patient early, providing the right communication and conditions to promote programmatic engagement. Often peer recovery coaches can be most successful in engagement techniques given their unique lived experience they can leverage during patient interactions.

### **PATIENT ACTIVATION AND TRANSITION PATHWAYS**

#### ***Acute***

The trigger required to initiate the 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. 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 level of care. 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 within seven days after the acute stabilization event in accordance with the [Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence \(FUA\)](#) measure. 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. A community partner organization, community-based health/behavioral health care facility, or employer may directly refer the patient to an ARMH participating provider. Upon patient contact, the provider will conduct the proper assessments and facilitate appropriate patient consent. Alternatively, the referring organization may obtain consent to release the patient's name and contact information to the ARMH for engagement. The 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. 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 a 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 themselves. As a result, they will be expected to seriously apply themselves to achieving the goals and objectives or work 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 into the program depends on the clinical level of care recommended by the professional assessment and patient preferences. At the point of entering these settings, the patient formally affirms their participation in the program, and the ARMH meets the [Initiation and Engagement of Alcohol and Other Drug Abuse or Treatment \(IET\)](#) performance measure.

### **Exiting the ARMH**

Participation in the ARMH 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 re-engagement efforts are required for patients who stop communicating but do not formally withdraw from care. A strict process or schedule is not suggested here, as providers will need the flexibility to reengage based on the patient's needs. Providers should consult best practices on effective engagement techniques, specifically when and how to focus efforts. The peer recovery coach may be a good option for initiating attempts at re-engagement because they may be the most likely to have the strongest relationship with the patient.

Further, a patient exits the program if they no longer participate in the benefit structure of the health plan they are working with unless a multi-payer ARMH network exists in the market.

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

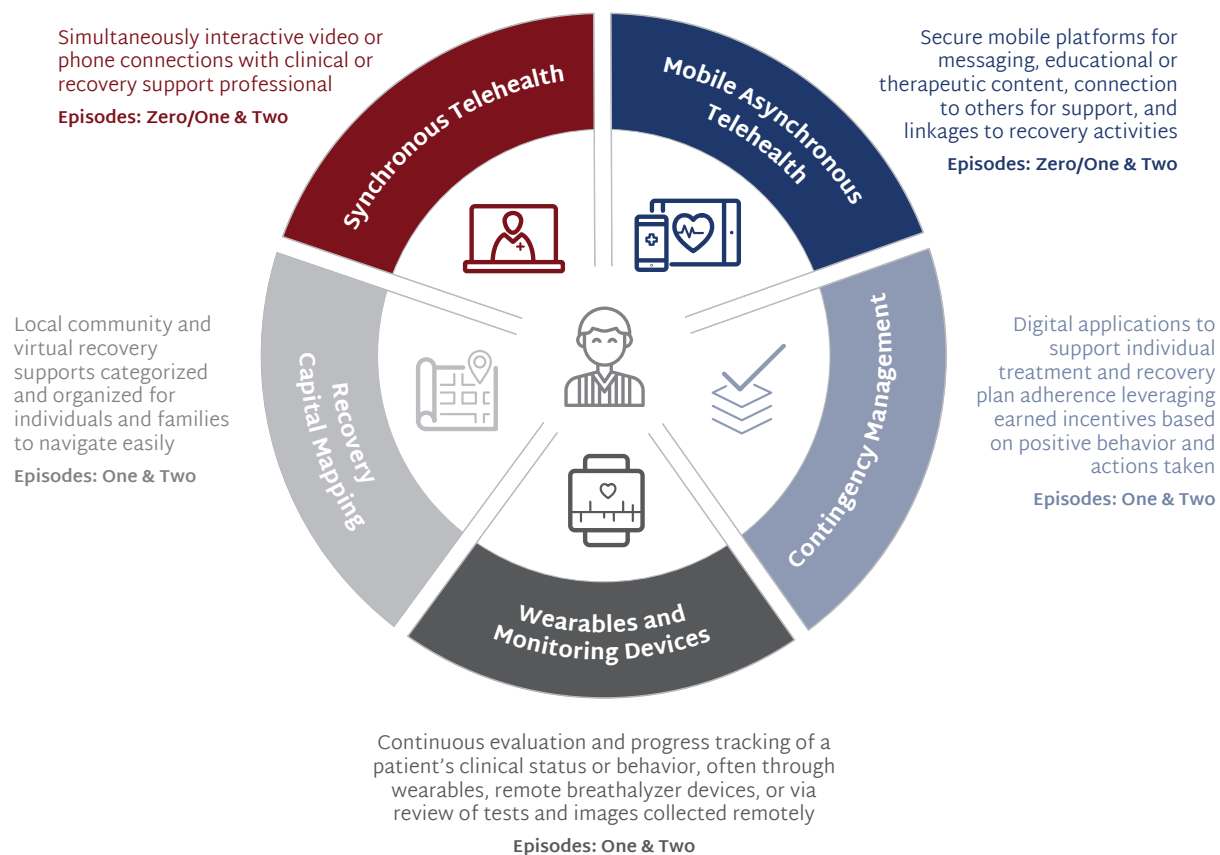
plan tailored for that moment in the patient's recovery journey. The team will also work with the patient to identify treatment resources that are accessible to the patient under the new coverage or treatment. In short, the care recovery team is responsible for ensuring that a patient exiting the program is positioned to be successful in whatever path they pursue

### MOBILE TECHNOLOGY PATIENT ENGAGEMENT

The COVID-19 pandemic has instigated an increase in access to telehealth services. However, it has not created the underlying shift in the care model or provider innovation needed to provide mobile SUD services and recovery supports to patients.

To connect patients throughout the episodes of care in the ARMH, the care recovery team should harness various existing and emerging techniques and tools shown in Figure 7.

FIGURE 7: FUNCTIONAL DOMAINS FOR MOBILE ENGAGEMENT



SUD treatment professionals and recovery coaches on the ground have long understood that connection, sustained engagement, and community-based linkages are the ultimate indicators of positive outcomes for patients. Clinical treatment and recovery supports must be personalized based on individual needs and preferences. The system must acknowledge that some people struggling with addiction may need a connection

to their care team weekly, while others daily, and some even hourly, depending on the severity of the SUD and the phase of the recovery journey a person is in currently. The deployment of mobile functionality is indispensable to meet individuals where they are on the longitudinal care journey. The following chart provides a few key characteristics of mobile engagement techniques that every ARMH provider should deploy.

FEATURES	POTENTIAL OPERATIONAL FUNCTIONS & SOLUTIONS
Synchronous Telehealth	<ul style="list-style-type: none"> <li>• Work with patients synchronously one-on-one or in groups from their home for counseling and/or peer support</li> <li>• Provide patient and family education trainings</li> <li>• Deploy engagement, assessment, and screening</li> <li>• Enable live chat features</li> <li>• Conduct virtual case load consults to enable providers and peers managing high-impact populations to collaborate with substance use experts and mental health experts on the latest treatments and case consultation</li> </ul>
Mobile Asynchronous Telehealth	<ul style="list-style-type: none"> <li>• Message patients inclusive of survey to monitor and trigger action for negative responses</li> <li>• Establish individualized plans of care</li> <li>• Distribute patient and family educational material</li> <li>• Provide chat based peer support monitored by artificial intelligence and natural language processing tools and escalated as appropriate</li> <li>• Stratify patients based on risk factors</li> <li>• Offer journal and tracking functionality</li> <li>• Integrate interdisciplinary practitioners on what platform</li> <li>• Offer online self-led therapy modules such as CBT or DBT</li> <li>• Identify other people in recovery nearby to provider support while in any location through GPS locator function</li> <li>• Personalize content and linkage to community-based support groups for specific demographics</li> </ul>
Contingency Management	<ul style="list-style-type: none"> <li>• Create a treatment and recovery plan complete with earned incentives contingent on positive behavior and adherence to care plan</li> <li>• Develop treatment and recovery plan in collaboration with patient</li> <li>• Push reminders for reward completion and behavior/activity tracking</li> <li>• Monitor status and tracking of earned of incentives</li> <li>• Determine financial spending using the rewards achieved by the patients</li> </ul>
Wearables and Monitoring Devices	<ul style="list-style-type: none"> <li>• Measure progress through breathalyzer and home-based saliva drug tests – performed through the phone, verified by selfie video</li> <li>• Measure medication adherence in medication assisted treatment (MAT) programs through wearables</li> </ul>
Recovery Capital Mapping	<ul style="list-style-type: none"> <li>• Map local community and virtual recovery supportive assets for utilization by provider networks and accessible to patients</li> <li>• Categorize and track services with details about restrictions, eligibility, required documents, languages spoken, and many other attributes</li> <li>• Integrate with existing EMRs to facilitate workflow and community-based closed loop referrals</li> </ul>

## CARE RECOVERY TEAM

The care recovery team (Figure 8) is comprised of licensed and experienced medical, addiction, and mental 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. Patients, for their part, are responsible for active participation in their treatment and recovery process.

### CARE TEAM COMPOSITION

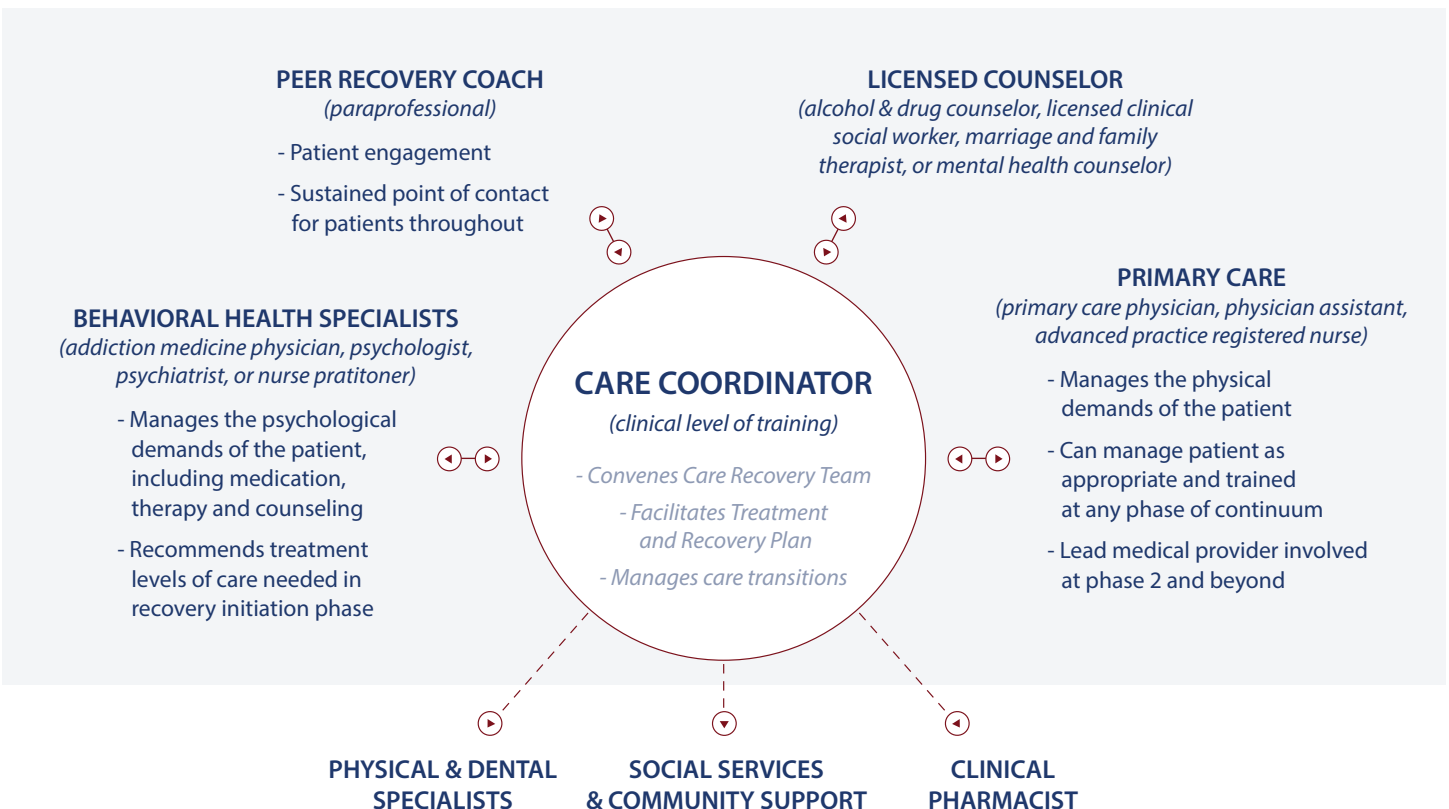
The core care team consists of a peer recovery coach, a care coordinator, a PCP, a licensed counselor, and a board certified addiction medicine physician, nurse practitioner, or psychiatrist.

### Peer Recovery Coach

According to [SAMHSA](#), “the terms mentoring, or coaching refers 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 SUDs 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 affiliations (introductions to healthy

FIGURE 8: THE CARE RECOVERY TEAM



social contacts and recreational pursuits). Peer recovery coaches are not SUD 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 of the paraprofessional role and [the prevalence of more than 23 million Americans living in recovery](#) from alcohol or other drugs, establishing 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 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 recovery from addiction, mental illness, or co-occurring substance and mental disorders.
- [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. Their life experiences and recovery allow them to provide recovery support in such a 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). CAPRSS accreditation can be deployed in an ITRN that has integrated an RCO to provide peer recovery coaching services.

In the ARMH, the peer recovery coach is a 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 a 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 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.”

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 patient's transition into care and 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 peer recovery coach is working directly with the patient on objectives and supports, the care coordinator ensures 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 the following:

- Coordinate patient care with other members of the care recovery team, ensuring the patient is receiving the quantity and type of care mandated by the treatment and recovery plan
- Maintain a current treatment and recovery plan (and further ensure 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 Provider (PCP), Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)***

The PCP and related staff are key members of the care recovery team. If the patient has a PCP during activation in the ARMH, efforts should be made to include the PCP (and their staff) in matters pertaining to the patient's recovery. Specific instances where the PCP should be notified include 1) the initial activation of the patient as a participant in the ARMH and 2) the development of the initial treatment and recovery plan with notifications of subsequent iterations of the plan.

In providing primary care for the patient, the PCP and their staff should have access to the patient's treatment and recovery plan, allowing for engagement with the care coordinator, the behavioral health specialist(s), 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 to communicate 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. It is important to note that The Consolidated Appropriations Act of 2022 [permanently eliminated the requirement for any authorized Drug Enforcement Agency \(DEA\) prescriber to possess a waiver from SAMSHA](#) to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000.

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

Another variation in the care team may be driven by workforce considerations. Physicians or psychologists with a focus on mental 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 SUDs 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

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

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 master's and doctoral-level programs. The Association for Addiction Professionals and The National Board for Certified Counselors provide certifications for professional counselors. Competencies expected of counselors, based on their level of credentials, may include the utilization of evidence-based 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 (master's 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 patient's choices 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 the patient, primary care team, and behavioral health specialists to develop and implement plans for optimizing medication therapy. They can help manage the patient's medication regimen by assessing medication-related needs, evaluating medication therapy, and being available at any phase of the continuum.



Clinical pharmacists 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 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 the 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 caseload 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

(Recovery Initiation and Active Treatment) and Two (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 utilizing 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 the 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 Episode Two (Community-Based Recovery Management) than in Episode One (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 toward 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 an 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 has policies to address patients who do not adhere to care plans.

## **TREATMENT AND RECOVERY PLAN**






Historically, "addiction treatment plans" connote short-term clinical interventions in isolation from long-term recovery planning. The ARMH 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 (Figure 9) 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.

**FIGURE 9: EXTENDING SOCIAL DETERMINANTS OF HEALTH TO INCLUDE RECOVERY ASSET CAPITALIZATION**

 <b>ECONOMIC STABILITY</b>	 <b>EDUCATION</b>	 <b>HEALTH AND HEALTH CARE</b>	 <b>NEIGHBORHOOD AND BUILT ENVIRONMENT</b>	 <b>SOCIAL AND COMMUNITY CONTEXT</b>
<b>HEALTHY OUTCOMES</b>				
Poverty Employment Opportunities Food Insecurity Housing Instability	Early Childhood Education and Development High School Graduation Enrollment in Higher Education Language and Literacy	Access to Health Care Access to Primary Care Health Literacy	Access to Foods that Support Healthy Eating Patterns Quality of Housing Crime and Violence Environmental Conditions	Social Cohesion Civic Participation Discrimination Incarceration
<b>RECOVERY CAPITALIZATION</b>				
Life and job skill training Re-entry support services Legal services	Recovery High Schools Collegiate Recovery Programs Recovery support services in secondary education	MH/SUD Assessment and Treatment Counseling and addiction professionals Care coordination and contingency management	Prevention and harm reduction services Recovery and transitional housing Access to alcohol-free stores and restaurants	Recovery and mental health treatment courts Peer recovery support Recovery Community Organizations Mutual aid support meetings

\*Sr4-DIS created this image using the five social determinants of health topics outlined in Healthy People 2020

[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.

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. 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 SUD recovery 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.

## FUNDAMENTALS 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 an 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 diagnose a 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 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 patient needs are being addressed, building towards long-term sustainable recovery outcomes. Most often, a peer recovery coach will lead the recovery management elements of the plan 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 [The FAVOR Upstate 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 the care team and the 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 recovery process. The treatment and recovery plan should also ensure physical and mental health are part of an integrated recovery.

### **Social Context**

The treatment and recovery plan should factor in exogenous and endogenous social factors that could influence a patient's recovery trajectory. The ARMH requires that three 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  
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.
- 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. 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  
The [ideas](#) under this category follow that the key elements 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 from substance use.

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.

## 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 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 with the care recovery team. More specifically, the care coordinator or peer recovery coach should be intimately involved in creating 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 make a 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 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. 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's condition.

The initial development of the plan occurs at the point of activation or induction into the ARMH with the appropriate care recovery team designated. 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, the treatment and recovery plan should be updated or revised by the care team 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.

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 SUDs, the ARMH will initially rely heavily on process measures as determined by individual ITRNs (e.g. patient consent to share their medical record, frequency of patient contact, care transitions, etc.). There are four existing short-term claims-based HEDIS measures that can be incorporated into most ARMH deployments:

- 1) Identification of Alcohol and Other Drug Services ([IAD](#))
- 2) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment ([IET](#))

- 3) Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence ([FUA](#))
- 4) Follow-Up After High-Intensity Care for Substance Use Disorder ([FUJ](#))

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

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

Additionally, there are emerging tools and technology to measure "Recovery Capital" that ITRNs can explore integrating into their models.

### **CONCLUSION**

For generations, our country has been plagued by addiction. It's worn different faces. It's ravaged communities and families. It's cost us incalculably lost lives and economic opportunity. It has seen millions unjustly prisoned. And yet, it persists.

We have lacked a system effective at treating addiction because we don't yet fully embrace the simple fact that addiction persists. Addiction *is* a chronic disease *because* it persists. We still treat it as an acute event.

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 ARMHs with aligned financial incentives is not easy, and challenges abound in creating a system comprised of the elements described in this paper.

But with the tremendous collective pain we are facing among our families and communities, our employers, our health systems, and 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 and acceptance that we no longer can do the same thing over and over and expect different results. The time has come for innovation and transformation.

## APPENDIX A:

### A Process Brief for Analyzing Historical Data to Assess the Potential Size and Scope of Addiction Recovery Medical Home – Alternative Payment Model Implementation

The Alliance for Addiction Payment Reform (the Alliance) established the Addiction Recovery Medical Home –Alternative Payment Model (ARMH) to pursue an integrated, team-based approach to addiction treatment and recovery services. The model is based on evidence-based principles and protocols, with high programmatic deference to the implementing parties and ideas sourced by private sector parties and their associated subject matter experts.

The first step in the implementation process is to assess the size and scope of a potential program for any given local Integrated Treatment and Recovery Network (ITRN). Due to the historical fragmentation of behavioral health services and various limiting policies, most specialty substance use disorder (SUD) programs still serve patients in limited volume programs. Given the underlying value-based principles and shared-risk elements central to the ARMH-APM, the Alliance recommends developing an ITRN capable of serving a minimum of 500 lives aggregated across the full continuum of care in a given geography annually. A program of this size would mitigate potential anomalies in risk-sharing for a complex patient population with an SUD.

After parties have aligned in interest to develop an ARMH-APM, they will need to conduct a historical data analysis of both payer claims data and provider electronic health record data. New data-sharing agreements will either need to be established or, in some cases, amended between parties. The Alliance has published a referral workbook that can facilitate the analyses required to set a baseline for operationalizing the ARMH-APM.

#### PROPOSED PROCESS FOR DETERMINING THE EXPECTED MEMBER VOLUME FOR THE PROGRAM AND ASSESSING THE RETROSPECTIVE COSTS FOR SERVICES:

- Payer Data Sharing Recommendation: Share retrospective full claims history for a minimum of two years for prospective members using ARMH-APM bundle trigger codes in the market with the provider. Given the nature of the condition and the reduced number of members with SUDs who may have a dedicated PCP associated with their care, the best practice is to use geographic regions or specific zip

codes for this data rather than members attributed to specific tax-IDs. However, evaluating eligible attributed members in large health systems may be desirable. Additionally, there is a need to analyze and develop a baseline for out-of-area spend/utilization of SUD services for both commercial and Medicaid populations, typically any service delivered over 75 miles.

- Provider Data Sharing Recommendation: Run a similar analysis using the existing electronic health record (filtered by the participating payer of interest for the program) for the simultaneous period as the claim's history provided by the payer. The provider can also use the ARMH-APM bundle trigger diagnosis codes. This exercise will help to identify patients who have interacted with the health system and may be eligible for the ARMH-APM program that previously had not been coded in claims.

Either mutually or using a third party, the payer and provider will then compare the similarities and differences in the respective data sets. This data should be analyzed in a multi-dimensional way to inform the future phases of work in the development of ARMH-APM:

- Assessing the prevalence of members with a primary SUD, secondary SUD, or other diagnoses likely related to SUD.
- Determining total SUD and non-SUD specific claims paid for a unique member over the defined period.
- Applying a risk stratification methodology to sort prospective program participants based on comorbid physical or co-occurring mental health challenges and assessing retrospective costs.

The final analysis should translate into a report that can be reviewed by the parties and inform a decision on the proposed size and scope of the ARMH-APM program.



## APPENDIX B:

### ORIGINAL ALLIANCE CONVENER COUNCIL

- American Hospital Association
- Healthcare Financial Management Association
- The Patient-Centered Primary Care Collaborative
- The National Council on Behavioral Health
- Duke Margolis Center for Health Policy
- The Center on Addiction
- The Kennedy Forum
- Third Horizon Strategies
- Leavitt Partners

### ORIGINAL CONTRIBUTING ALLIANCE MEMBERS

- Anthem
- Amerihealth Caritas
- CareSource
- Superior HealthPlan
- FAVOR Greenville
- Remedy Partners
- NuVance Health
- Appalachian Regional Health
- Intermountain Healthcare
- Eleanor Health
- WeConnect Health Management
- Facelt Together
- eTransX
- Altarum Institute
- The Association of Behavioral Health and Wellness
- Association of Health Insurance Plans
- American College of Clinical Pharmacy
- American Psychiatric Association
- Capitol Decisions
- Caron Treatment Centers
- Magellan Health
- The National Committee for Quality Assurance
- TransformCare
- Recovery Research Institute
- Utah Support for Addiction Recovery Awareness
- Well Being Trust

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## WORKS CITED

- W. White, Recovery management and recovery-oriented systems of care: scientific rationale and promising practices, Philadelphia: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center., 2008.
- Center for Substance Abuse Treatment, "Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856 Findings)," Substance Abuse and Mental Health Services Administration, Rockville, MD, 2010.
- W. White, "Recovery management and recovery-oriented systems of care: scientific rationale and promising practices.," Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services, 2008.
- Y. Hser, "Predicting long-term stable recovery from heroin addiction: findings from a 33-year follow-up study.," *J. Addict Dis.*, 2007.
- M. L. Dennis, M. A. Foss and C. K. Scott, "An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery.," *Evaluation Review*, 2007.
- Surgeon General of the United States, "Facing Addiction in America: Chapter 4," [Online]. Available: <https://addiction.surgeongeneral.gov/sites/default/files/chapter-4-treatment.pdf>.
- Surgeon General of the United States, "Facing Addiction in America (Chapter 5)," [Online]. Available: <https://addiction.surgeongeneral.gov/sites/default/files/chapter-5-recovery.pdf>.
- A. McLellan, D. Carise and H. Kleber, "Can the national addiction treatment infrastructure support the public's demand for quality care?," *Journal of Substance Abuse Treatment*, vol. 25, pp. 117-121, 2003.
- M. Sobell and L. Sobell, "Stepped care as a heuristic approach to the treatment of alcohol problems.," *J Consult Clin Psychol*, vol. 68, pp. 573-579, 2000.
- M. JR., "Effectiveness of continuing care interventions for substance abusers: implications for the study of long-term treatment effects.," *Eval Rev*, vol. 25, pp. 211-232, 2001.
- J. McKay, "Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term treatment effects," *Evaluation Review*, vol. 25, pp. 211-232, 2001.
- Surgeon General of the United States, "Health Care Systems and Substance Use Disorders," [Online]. Available: <https://addiction.surgeongeneral.gov/executive-summary/report/health-care-systems-and-substance-use-disorders>.
- Substance Abuse and Mental Health Services Administration, "Description of a Good and Modern Addictions and Mental Health Service System," [Online]. Available: [https://www.samhsa.gov/sites/default/files/good\\_and\\_modern\\_4\\_18\\_2011\\_508.pdf](https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf).
- National Center for State Courts, "Substance Abuse and Confidentiality: 42 CFR Part 2," [Online]. Available: <http://www.ncsc.org/sitecore/content/microsites/future-trends-2012/home/privacy-and-technology/substance-abuse.aspx>.
- Substance Abuse and Mental Health Services Administration, "42 CFR Part 2," [Online]. Available: <http://www.ncsc.org/sitecore/content/microsites/future-trends-2012/home/privacy-and-technology/substance-abuse.aspx>.
- L. Kaplan, Substance abuse treatment workforce environmental scan., Rockville, MD: Center for Substance Abuse Treatment, 2003.
- International Certification & Reciprocity Consortium, "IC&RC's Credentials," [Online]. Available: <https://internationalcredentialing.org/creds/pr/>.
- NAADAC - The Association for Addiction Professionals, "National Certified Peer Recovery Support Specialist (NCPRSS)," [Online]. Available: <https://www.naadac.org/ncprss>.
- Council on Accreditation of Peer Recovery Support Services, "Mission and Philosophy," [Online]. Available: <http://www.caprss.org/content/caprss-mission>.
- Agency for Healthcare Research and Quality, "Care Coordination," [Online]. Available: <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>.
- Substance Abuse and Mental Health Services Administration, "Qualify for a Physician Waiver," [Online]. Available: <https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver>.
- R. Cloud and W. Granfield, The social process of exiting addiction: a life course perspective, Helsinki, Finland: Addiction and life course, 2004.

- I. Wheaton and B. Gotlib, *Trajectories and turning points over the life course: concepts and themes.*, New York City: Cambridge University Press, 1997.
- W. White, "The mobilization of community resources to support long-term addiction recovery.," *J. Subst Abuse Treat*, vol. 36, pp. 6-158, 2009.
- T. Hirschi, *Causes of delinquency*, Berkeley, CA: University of California Press, 1969.
- K. Carpenter and D. Hasin, "Drinking to cope with negative affect and DSM-IV alcohol use disorders: a test of three alternative explanations.," *J Stud Alcohol*, vol. 60, pp. 694-704, 1999.
- W. Bickel and R. Vuchinich, *Reframing health behavior change with behavior economics.*, Mahwah, NJ.: Erlbaum, 2000.
- B. Moos and R. Moos, "Protective resources and long-term recovery from alcohol use disorders.," *Drug Alcohol Depend.*, vol. 86, pp. 46-54, 2007.
- American Society of Addiction Medicine, "Appropriate Use of Drug Testing in Clinical Medicine," [Online]. Available: <https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>.
- B. J. H. K. Kaskutas LA, "Social networks as mediators of the effect of Alcoholics Anonymous.," *Addiction*, vol. 97, no. 7, pp. 891-900, 2002.
- M. M. S. R. Kelly JF, "How do people recovery from alcohol dependence? A systmatic review of the research on mechanisms of behavior change in Alcoholics Anonymous.," *Addiction Research and Theory*, vol. 17, no. 3, pp. 236-259, 2009.
- M. JR, "Continuing care research: what we've learned and where we're going," *J Subst Abuse Treat*, vol. 36, pp. 131-145, 2009.
- B. M. W. W. C. P. L. DL., "Behavioral health recovery management: a statement of principles," 20 November 2009. [Online]. Available: [www.bhrm.org/papers/principles/bhrmprinciples.htm](http://www.bhrm.org/papers/principles/bhrmprinciples.htm). [Accessed 2009 November 2009].
- National Institute on Alcohol Abuse and Alcoholism, "Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide," [Online]. Available: <https://www.niaaa.nih.gov/publications/clinical-guides-and-manuals/alcohol-screening-and-brief-intervention-youth>.
- World Health Organization, "AUDIT," [Online]. Available: <https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf>.
- Substance Abuse and Mental Health Services Administration, "AUDIT - C Overview," [Online]. Available: [https://www.integration.samhsa.gov/images/res/tool\\_auditc.pdf](https://www.integration.samhsa.gov/images/res/tool_auditc.pdf).
- National Institute of Drug Abuse, "Brief Screener for Alcohol, Tobacco, and other Drugs," [Online]. Available: <https://www.drugabuse.gov/ast/bstad/#/>.
- The Center for Adolescent Substance Abuse Research, "The CRAFFT Screening Interview," [Online]. Available: [http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT\\_English.pdf](http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_English.pdf).
- Boston University, "Drug Abuse Screening Test, DAST - 10," [Online]. Available: [http://www.bu.edu/bniart/files/2012/04/DAST-10\\_Institute.pdf](http://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf).
- European Monitoring Centre for Drugs and Drug Addiction, "Drug Abuse Screening Test (DAST - 20)," [Online]. Available: <http://www.emcdda.europa.eu/html.cfm/index3618EN.html>.
- National Institute on Alcohol Abuse and Alcoholism, "Helping Patients Who Drink Too Much," [Online]. Available: <https://pubs.niaaa.nih.gov/publications/practitioner/cliniciansguide2005/guide.pdf>.
- National Institute on Drug Abuse, "Resource Guide: Screening for Drug Use in General Medical Settings," [Online]. Available: <https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen>.
- National Institute on Drug Abuse, "NIDA Quick Screen V 1.0," [Online]. Available: [https://www.drugabuse.gov/sites/default/files/files/QuickScreen\\_Updated\\_2013%281%29.pdf](https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf).
- National Institute on Drug Abuse, "Opioid Risk Tool," [Online]. Available: <https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf>.
- National Institute on Drug Abuse, "Screening to Brief Intervention (S2BI)," [Online]. Available: <https://www.drugabuse.gov/ast/s2bi/#/>.

