OFFICE OF THE STATE ATTORNEY

FIFTEENTH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY

DAVID ARONBERG
STATE ATTORNEY

Sober Homes Task Force Meeting Minutes

Sober Home Task Force Tip Line 1-844-324-5463

Meeting Location: WPB Police Community Room 600 Banyan Blvd, West Palm Beach, FL 33401

Meeting Date: June 20, 2019

Welcome/Introductions:
Al Johnson opened the Task Force Meeting at 1pm. All attendees informed that meeting minutes are taken and the meetings are audio-recorded. The audio file for this meeting can be found at http://www.sa15.org.

Sign in sheets are available upon request.

"Sunshine Law" Overview:
Mr. Johnson reviewed and highlighted the importance of the Sunshine Law and its implications for this Task Force. As an example, he cautioned the group not to use "reply all" in the use of email, regarding what is coming or will be coming before the Task Force.

Next Month's Meeting: July 30, 2019

The theme for this meeting was housing

Updated: 9/20/2019

<u>Meeting Agenda – June 28, 2019 -SHTF</u>

1. <u>Introductions:</u>

2. <u>FARR:-information and handouts presented by Steve Farnsworth</u>

   a. <u>Certified housing update: State-Wide Trends</u>

   b. <u>Denials/Suspensions/Revocations</u>

   c. <u>Retention of Property: Patient Rights</u>

   d. <u>Res 5/Day-Night component licenses: July 1, 2019 deadline</u>

3. <u>Oxford House Presentation:-Powerpoint presentation</u>

4. <u>FADAA update:</u>

   a. <u>Background screening</u>

   b. <u>Drug Policy Advisory Report (December 2018)-handout material</u>

   c. <u>Executive Order creating a state-wide Opioid Task Force-handout material</u>

   d. <u>Center for Medicare and Medicaid Services (CMS) –handout material</u>

      i. <u>Behavioral Health and Supportive Housing Assistance Pilot</u>

5. <u>Addiction Policy Forum draft: Questions for Treatment Providers</u>

6. <u>Future Agenda items:</u>

   a. <u>Legislative proposals</u>

   b. <u>Emergency Room Warm Hand-Offs-handout material</u>

7. <u>Public comments.</u>

8. <u>Closing remarks.-the meeting was adjourned by Al Johnson at 3:45pm</u>

The following materials were not posted on the Sober Homes Task Force website prior to the meeting, but were distributed at the meeting for discusstion, pertaining to Item 6

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ADDICTION RECOVERY MEDICAL HOME - ALTERNATIVE PAYMENT MODEL

INCENTIVIZING RECOVERY. NOT RELAPSE.

CONSENSUS LEARNING MODEL DESIGNED BY THE ALLIANCE FOR RECOVERY-CENTERED ADDICTION HEALTH SERVICES

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Facing Addiction
with NCADD

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Advancing Health in America

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BACKGROUND AND INTRODUCTION

The United States is in the middle of a major public health challenge: since 1999, the rate of overdoses involving opioids nearly quadrupled. As startling as this number is, before, and during this period alcohol-related deaths still out-paced opioids. Addiction has now become the leading cause of death in America for those under 50. Substance use disorders (SUD) have devastating effects on our communities and drive enormous inefficiencies in health care. Despite the magnitude of addiction, there is a lack of credible consumer and health system-focused information about an integrated continuum of care that could stem the growing prevalence of this public health challenge.

Unlike many other chronic conditions — where "standards of excellence" inform consumers, health systems, and payers about best practices and services that should be available — today's recovery services are delivered through a system often lacking alignment or integrated economic structures that incentivize long-term recovery. Mental health services are generally not aligned with a patient's physical health and the underlying circumstances that may have prompted a recovery journey in the first place. Primary care physicians (PCPs) are typically not equipped with the tools and resources to facilitate sustained treatment and recovery services. Worse still, unscrupulous actors are continuing a wholesale proliferation of "recovery centers" engaged in a scheme to defraud insurance companies.

If addiction is a chronic disease, our system's current organization does not promote long-term recovery and wellness. The human and economic cost for this fragmentation and inefficiency is unsustainable. A vacuum exists for both health systems and patients as to what is the "gold standard" for an integrated, comprehensive medical and community response for addiction. In late 2016, the U.S. Surgeon General issued the seminal report on Alcohol, Drugs, and Health: *Facing Addiction In America* (http://addiction.surgeongeneral.gov). In the report, a call for mainstream health systems to begin integrated substance use services was afforded an entire chapter.

Acute care and intensive clinical settings remain important to the composition of our delivery system, but must create reasonable and clear pathways to clinically appropriate community-based integrated health services. To intervene early and help more people recover from addiction, we need to shift from a short-term, episodic 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, incorporate all relevant clinical disciplines, and unequivocally and compassionately place the patient at the center. The aspiration here is for the development of a model that goes beyond stabilization to a biopsychosocial sustained model of recovery management comparable to the management standards and protocols for physical chronic disease.

The underlying philosophy guiding this approach is one of sustained recovery management as a means of organizing addiction treatment and recovery support services to enhance early pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery [1].

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

THE ALLIANCE FOR RECOVERY-CENTERED ADDICTION HEALTH SERVICES

In August 2017, Leavitt Partners, Facing Addiction with NCADD (The National Council on Alcoholism and Drug Dependence), and a community of private, non-profit, and public-sector (participating as observers) institutions joined in common cause to explore the creation of a long-term system of care capable of organizing payment and delivery for services more consistent with chronic disease management. The Alliance for Recovery-Centered Addiction Health Services (Alliance) convened clinical, addiction, information technology, primary care, social, regulatory, and policy expertise with the collective

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objective of developing an alternative payment model (APM) that corresponds with an integrated treatment and recovery network (ITRN) care model.

The work of the Alliance has consisted of:

1. Evaluating the existing evidence-base to identify clinical, psychological, and social recovery tenets corresponding with higher success in long-term recovery.

2. Establishing a risk-based payment methodology that aligns the interests of payers, providers, and patients.

3. Creating structural requirements for network and information integration, care team protocols and composition, quality metrics, and patient-centered treatment and recovery plans.

4. Facilitating agreements amongst and between key managed care organizations (MCO) and delivery system partners to pilot a line of business and population-specific application of the model.

Alliance members, volunteer institutional contributors, and subject matter experts were deeply engaged and involved in this effort, logging hundreds of hours of work group meetings, ratifying principles and outputs through monthly gatherings. Alliance members approved this work product and proudly consented to associate their institutional brand with the work. Agreement was achieved through consensus-based principles, indicating broad support for each element of the model that was advanced.The Alliance organized around guiding principles that bound the conditions and protocols of our work:

1. Recovery from substance use disorders (SUD) is a process of change whereby individuals achieve SUD remission, work to improve their own health and wellness, and live a meaningful life in a community of their choice while striving to achieve their full potential [2].

2. Care recovery has three critical, interconnected stages: pre-recovery/stabilization, recovery initiation and active treatment, and community-based recovery management [3].

3. Recovery management requires a multi-disciplinary care recovery team who can provide the diverse biopsychosocial elements of treatment needed and 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 to 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 a 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 a 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, requiring a model sufficiently malleable to accommodate for multiple pathways and styles of alcohol and other substance problem resolution, including a subclinical focus. I.e., there are multiple pathways and styles of SUD problem resolution as there are in the resolution of subclinical alcohol and other drug problems.

8. Integrating economic benefits and risks between payers and the delivery system will promote greater accountability and care design to facilitate holistic and comprehensive care recovery environment for the patient.

9. SUD recovery 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 [4] [5].

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10. A dynamic treatment and recovery plan with the breadth and flexibility to engender increased recovery capital should be authored in collaboration with the patient, the patient's family, and other key social supports.

The convergence of these principles and the collaborative process facilitated by the Alliance has resulted in the Addiction Recovery Medical Home (ARMH) model, (ARMH APM or ARMH model) an APM engineered to provide patients with a long-term, comprehensive, and integrated pathway to treatment and recovery.

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

ADDICTION RECOVERY MEDICAL HOME (ARMH) MODEL OVERVIEW

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

This document presents the foundational elements of the ARMH model in hopes that interested parties can adopt the principles in developing patient-centered, chronic-disease management programs that improve the outcomes for patients seeking recovery from addiction.

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

Additionally, the Alliance intends to pilot the ARMH model in two to three markets beginning in 2019. A rigorous research methodology will be developed and leveraged to study the effects of the model on recovery when compared to non-ARMH models of care and to study correlations between specific model tenets and the corresponding outputs.

The ARMH-APM has deliberate flexibility for various operational permutations, permitting pilot partners or other interest 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 five foundational elements of the ARMH-APM are as follows:

ELEMENT #1 – PAYMENT
The payment model, which adopts elements of both capitated and bundled payments, rewards performance based on recovery-linked quality measures. Risk-bearing providers have three mechanisms through which they assume risk and can achieve a non-traditional payment adjustment from the model:

1. Capitated/Bundled Payments: risk/reward is tied to the provision of more integrated and personalized care

2. Quality Achievement Payment: a portion of the capitated/bundled payment is tied to achievement of successful patient outcomes

3. Performance Bonus: providers may be eligible to share in additional savings created from better coordinating patient care across all health care services, including addiction, behavioral, and physical services

ELEMENT #2 – QUALITY METRICS
In partnership with the National Committee for Quality Assurance (NCQA), Alliance participants are refining entry and participation criteria for providers and developing both process and outcomes measures that will tie the provision of care to payment, incenting recovery and providing a national baseline of substance use disorder performance metrics.

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ELEMENT #3 – NETWORK

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

ELEMENT #4 – CARE RECOVERY TEAM

Care is coordinated by a central team whose focus is a long-term process that is inclusive of the patient, family, peer support, community, social determinants, and other key environmental conditions to recovery capital development that promotes enhanced health and quality of life.

ELEMENT #5 – TREATMENT AND RECOVERY PLAN

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

Within the ARMH-APM framework, providers and payers are encouraged and incentivized to tailor the approach to each patient to optimize recovery.

PAYMENT MODEL

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

> **A risk-based payment model that aligns stakeholder objectives will advance the creation of conditions and engagement protocols that materially improve the patient's likelihood of long-term recovery, generating savings for the system and providing a benefit to participants.**

Like any risk 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 a risk-based payment model that aligns stakeholder objectives will advance the creation of conditions and engagement protocols that materially improve the patient's likelihood of long-term recovery, generating savings for the system and providing a benefit to participants.

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

The ARMH-APM payment is for addiction health services. Similarly, the quality metrics are associated only with addiction care processes and outcomes. Physical health and other behavioral health treatment are not expressly included in the payment, though effective coordination and communication with the patient in the context of co-morbidities or co-occurring mental illnesses improves the likelihood of sustained recovery. The shared savings fund from which bonus payments to high-achieving providers are drawn is created from the savings accrued as a result of better coordinated whole-person treatment. When providers can integrate addiction treatment with

> **When providers can integrate addiction treatment with treatment for underlying behavioral or physical health disorders, shared savings result from more efficient resource use and better outcomes.**

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Exhibit 1

PRE-RECOVERY AND STABILIZATION — RECOVERY INITIATION AND ACTIVE TREATMENT — COMMUNITY-BASED RECOVERY MANAGEMENT

0 — patient engaged — 1 — 2

Fee-For Service Payment

Static Capitated Payment $XX PMPM

Declining Capitated Payment $XX PMPM

Non-Quality Contingent Capitation

Non-Quality Contingent Capitation

Quality Achievement Payment (XX% of Capitation)

Quality Achievement Payment (XX% of Capitation)

Bonus Threshold

Bonus Threshold

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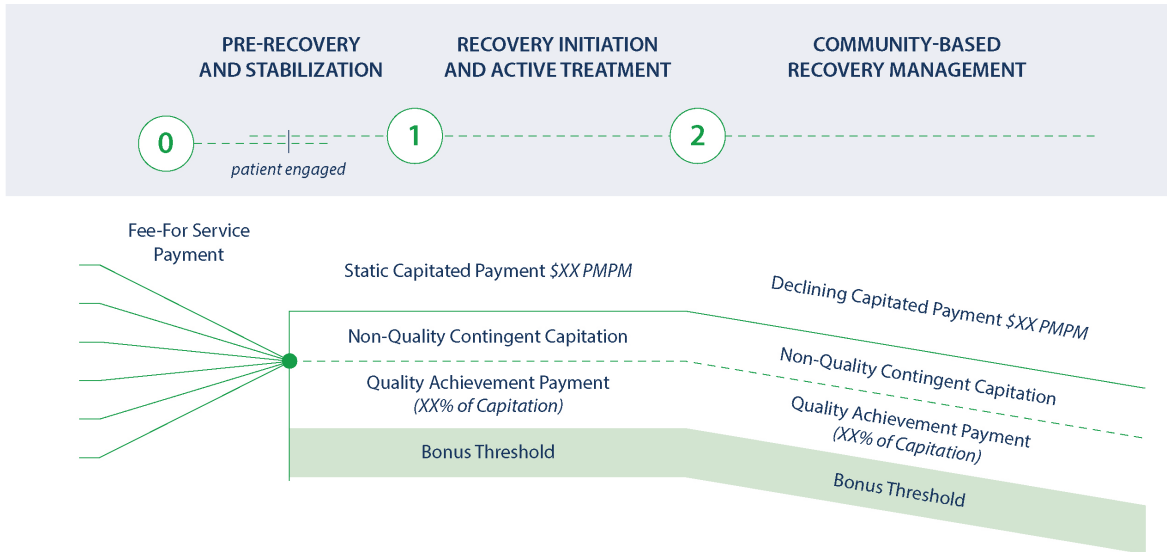
treatment for underlying behavioral or physical health disorders, shared savings result from more efficient resource use and better outcomes.

PAYMENT MODALITIES

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

Fee-for-Service (FFS) Payments

While the ARMH-APM 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 stabilizing activities in the emergency department (ED) or intensive care unit (ICU) settings. FFS payments are only leveraged in the ARMH-APM for pre-recovery engagement and stabilization services.

Capitated, Episodic Payments

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

The capitated payments will be used to adjust the bundled payment for the two episodes of care in the ARMH model: Recovery Initiation and Active Treatment, and Community-Based Recovery Management. The Alliance chose not to prescribe the duration of the episodes or dictate the treatment options available within each episode, opting instead to prioritize provider flexibility to treat the patient with evidence-based tools most suited to that patient's transitions and recovery. The Alliance 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, providers will receive payment on a six-month basis, for up to five years under the Community-Based Recovery Management episode.

Capitated bundled payments can be paid either prospectively or retrospectively, depending on any risk stabilizing features installed by the provider and MCO, or

> **The Alliance chose not to prescribe the duration of the episodes or dictate the treatment options available within each episode, opting instead to prioritize provider flexibility to treat the patient with evidence-based tools most suited to that patient's transitions and recovery.**

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the administrative sophistication required to fully managed a capitated payment for SUD-related recovery services.

As a prospective payment, the MCO would pay the coordinating provider the severity-adjusted bundled payment for the Recovery Initiation and Active Treatment episode of care when the provider and patient initiate recovery under the ARMH-APM. The provider must use the allotted funds to provide care to the patient and is fully "at-risk" for care costs above the payment amount related to SUD-centric services. The Alliance recommends that ARMH-APM contracts between providers and payers include a requirement for provider excess or stop-loss coverage that protects the provider from the corrosive financial conditions correlated with higher-risk patients. At a time contractually identified by the payer and provider, (*e.g.* annually or at the time 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 outcomes measures. If a provider has not met quality measure requirements, they will remit payment back to the payer as a penalty.

If the partnering MCO and provider conclude a retrospective payment is most feasible, the provider would continue to code and claim services as under FFS, and at a time contractually identified by the payer and provider, (e.g. annually or at the time the patient transitions to the next episode of recovery) the payer will adjust the provider payment based on the total amount allotted under the severity-adjusted episode for patient care (periodic payment adjustment). This may result in funds flowing back from the provider to payer. Optionally, this periodic payment calculation can be merged with the provider's potential "quality achievement payment," under which the provider is rewarded for achievement on process and outcomes measures. Through this payment, a percentage of the total base payment is tied to a provider's performance on process and outcomes measures. This amount may be fully recognized as a separate payment or, in instances where the provider owes the payer funds at periodic payment adjustment, the provider can use the incentive payment to offset the cost of care above the severity-adjusted episode amount allotted under the

model. The Alliance recommends that ITRN contracts between providers and payers include provider excess/ stop loss provisions consistent with their agreements, particularly for small patient populations.

Quality Achievement Payment
The ARMH-APM is quality-adjusted. The base payment is a population-based patient severity payment for defined episodes of care. For providers who succeed across the NCQA process and outcomes measures, there is a "quality achievement payment," under which an agreed upon percentage of the total payment is tied to performance on process and outcomes measures. The ARMH-APM 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 (the agreed upon percentage of the total base payment)). If an ARMH provider meets the NCQA process and outcome quality metrics, the provider will receive the full quality achievement payment. This quality adjustment safeguards shared interest in patient recovery among providers and payers.

Shared-Savings Performance Bonus
Those ARMH entities who obtain the full quality achievement payment are also eligible for a performance bonus equal to a defined percentage[2] of the overall savings that are achieved across the patient's entire continuum of care. Specifically, the pool of bonus funds comes from the expected shared savings attributable to the increased coordination and treatment of patients across all health care services – addiction, behavioral, and physical. While the majority of savings are expected on the medical side, better coordination of addiction treatment is also expected to generate savings for the insurer across all care.

For operational purposes, the payer must be an ARMH participating entity accountable for addiction treatment payment under ARMH and also the payer for behavioral and physical health services. For Medicaid programs in states in which behavioral/addiction and physical health

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[2] ITRN suggests that provider bonuses are 50 percent of the achieved shared savings. ITRN expects overall savings to account for 5-10 percent of the overall claims total.

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Exhibit 2: ARMH-APM Phases of Recovery

	PRE-RECOVERY AND STABILIZATION	RECOVERY INITIATION AND ACTIVE TREATMENT	COMMUNITY-BASED RECOVERY MANAGEMENT
	0 --- *patient engaged*	**1**	**2**
Duration	0-1 Month	0-12 Months	12-60 Months
Payment Architecture	Fee-For Service	*Static* Bundled (Prospective or Retrospective) Quality Achievement Payment Performance Bonus	*Declining* Bundled (Prospective or Retrospective) Quality Achievement Payment Performance Bonus

funding streams are separated, ARMH entities can consider a risk-bearing entity who serves in a role similar to that of the payer with risk bearing entities who receives carve-out funds and merges physical health payment.

SEVERITY ADJUSTMENT

The ARMH-APM is a hybrid of capitated payments and bundled payments for episodes of care. To ensure payments are commensurate with the underlying risk factors of the population, the ARMH incorporates a severity adjusted model that provides for tiering in the payment. This methodology contemplates a series of key biopsychosocial determinants to ascertain the relative risk of a patient receiving services under the ARMH model.

Severity Categories

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

Global Claims

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

Payers and providers will need to use the appropriate data sets for target populations and coverage types to determine payment amounts for each episode and the corresponding patient-severity adjustment by category of low, moderate, and high, which will determine total capitated episodic payment. Operationally, ARMH payers expect that codes for services delivered will be taken into account for "valuing" the bundles/episode payments, but not to pay providers or to restrict or require types of care delivered under the treatment plan.

Patient Risk Evaluation Criteria

In addition to the claims-based patient severity stratification, the provider can also use Patient Risk Evaluation Criteria, such as the factors listed below, to evaluate each patient and the appropriate clinical recommendations and episode movement. The Alliance recommends drawing from these criteria where data are available. After pilots have been established, the Alliance will amend this document to provide sample methods and pathways for creating a severity adjustment model.

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1. Readiness for treatment/readiness for change:

    • How many recovery attempts has the patient made?

    • What are the number of ED/ICU discharges for the patient over the previous two-year period?

    • To what degree has the patient been an active and participatory collaborator in the creation of their treatment and recovery plan?

2. Severity of Illness and related Impairment:

    • Type of substance use disorder

    • Co-morbid behavioral health disorders

    • Co-morbid physical issues

    • Pregnancy

3. Social/Functional Determinants of Health/Recovery Capital:

    • Job status

    • Home status

      - Living Situation

      - Family Support

      - Community-based support

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

ARMH-APM RECOVERY PHASES AND EPISODES OF CARE
In keeping with the principles developed by the Alliance, there are distinct phases of recovery for the patient, comprising episodes.

The payment and the ARMH quality metrics will follow the patient across both episodes. Participating providers must adhere to the ARMH treatment and recovery model, but are not bound to specific services within the episode. All clinically-appropriate care within the episode, as determined by the provider, is covered by the bundled (capitated episodic) payment. This structure is meant to provide a flexible approach to treatment, recognizing that no single treatment path will work for all patients.

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

Pre-Recovery and Stabilization—pre-ARMH-APM
In this phase, the patient is being treated for conditions related to a SUD, such as withdrawal management. There are myriad pathways to this phase, including emergency care, acute care, or the patient voluntarily seeking treatment and recovery support. This phase is intended to support the stabilization and engagement of the patient and support their transition to the ARMH model.

Services under this phase, typically administered in the ICU or ED are paid on the basis of FFS, leveraging the current coding and payment architectures in place today, such as the Diagnosis-Related Group (DRG).

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

Episode One:
Recovery Initiation and Active Treatment
This first episode is focused on the initial inclusion of the patient into the ARMH model, following the stabilizing features of Pre-Recovery and Stabilization—pre ARMH APM phase. The care administered under this episode is intended to be for higher-acuity patients who have increased benefit from institutional care settings. As such, the institutional spectrum ranges from post-ED inpatient care to residential treatment to intensive outpatient care delivery. This first episode is designed to promote strong connectivity between clinically appropriate institutional settings and the underlying care recovery team working to promote active recovery with the patient (See also Key Network Requirements).

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The care recovery team and the patient will collectively conclude when the need for institutional care has diminished. Once the patient has left the lower-most institutional care setting, the patient will transition into the second episode of care, the Community-Based Recovery Management episode, and payment will shift to align correspondingly.

Episode Two: Community-Based Recovery Management

This second episode of the ARMH model does not rely on institutional care settings, though it does not preclude the use of clinically appropriate institutions. Instead, this episode focuses on the patient's integration back 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 that highest risk to the provider, as a failure to adequately engage and support the patient could lead to a high-cost, avoidable recovery disruption. If recovery disruption occurs requiring a transfer of the patient to a higher-acuity setting, the patient will receive the clinically appropriate treatment under the payment rate for the second episode. In other words, because recovery disruption is built into the bundled payment for the second episode (population-based patient-severity adjusted payment for the episode of care), the payment for a patient who has a recovery disruption while in the community recovery phase will not be adjusted upward to the rate under the higher-acuity first episode. The Alliance believes this strategy will incent coordinated care and thoughtful transitions and will reduce incentives to steer patients into a higher level of care when clinically unnecessary.

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

PATIENT ENROLLMENT

ARMH payment begins at patient enrollment, represented in the model as the transition from the Pre-Recovery and Stabilization phase to Recovery Initiation and Active Treatment (episode one). Enrollment should be facilitated by the care giver at the express consent of the patient. The patient must be diagnosed with a SUD, notified of their participation in the ARMH model, and provide their consent to:

1. Adhere to a material portion of the clinically recommended treatment; and

2. Allow for the sharing of the patient's medical information (PMI) within the ITRN, meeting the restrictions of 42 CFR Part 2 requiring patient consent.

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

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

1. There must be a participating provider and payer offering ARMH services in the community. More specifically, a patient must be an enrollee under a licensed provider who is participating under the corresponding business line. (Note: participating providers under the ARMH model could offer a commensurate portfolio of services on a cash basis. This circumvents several of the protections and standards under the program).

2. The provider and payer must jointly support and underwrite recovery coaches able to facilitate enrollment and transitions for patients looking to participate in the ARMH model.

The four patient pathways are below.

Emergency Department or Intensive Care Unit

It is anticipated that some individuals with addiction identified in the ED or ICU will elect participation in the ARMH model. Others, who are less inclined to begin a treatment and recovery process may decline participation in the model. Coordinating providers in the ARMH are encouraged to utilize care team members to actively outreach and use evidence-based motivational strategies for patients receiving treatment in the ED or ICU about benefits of ARMH participation. Separate performance

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payments or incentives for screening, identification, and enrollment are not included under the ARMH-APM; 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 recovery coach is sufficiently integrated with the ED or ICU so as to have identification and proximity to patients so they can facilitate counsel and education regarding the ARMH model. Coordinating providers can perform this peer support role in-person or virtually, in collaboration with the ED/ICU. Alternatively, the ARMH-coordinating provider could separately remunerate the ED/ICU for supporting the transition of the patient or begin recovery coaching. As noted above, services provided to the patient in this setting are paid under FFS.

Payer Identification
Payers will be encouraged to perform advanced analytics on their claims data to identify patterns of high utilization of services and resources related to treatment and recovery. In these cases, the payer can work closely with the patient's PCP or enrollment coach to engage the patient and introduce the ARMH program.

Primary Care or Community Screening
Both PCPs and community health workers (CHWs) can screen patients for SUD. In cases where these screenings affirm the existence of a SUD, PCPs and CHWs 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-APM can use their discretion in deploying evidence-based screening tools, including:

- Alcohol Screening and Brief Intervention for Adolescents and Youth: A Practitioner's Guide [16]
- Alcohol Use Disorders Identification Text (AUDIT) [17]
- Alcohol Use Disorders Identification Test-C [18]
- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD) [19]
- CRAFFT [20]

- Drug Abuse Screen Test [21]
- DAST-20: Adolescent Version [22]
- Helping Patients Who Drink Too Much: A Clinician's Guide [23]
- NIDA Drug use Screening Tool [24]
- NIDA Drug Use Screening Tool: Quick Screen [25]
- Opioid Risk Tool [26]
- S2BI [27]

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

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

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

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

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

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

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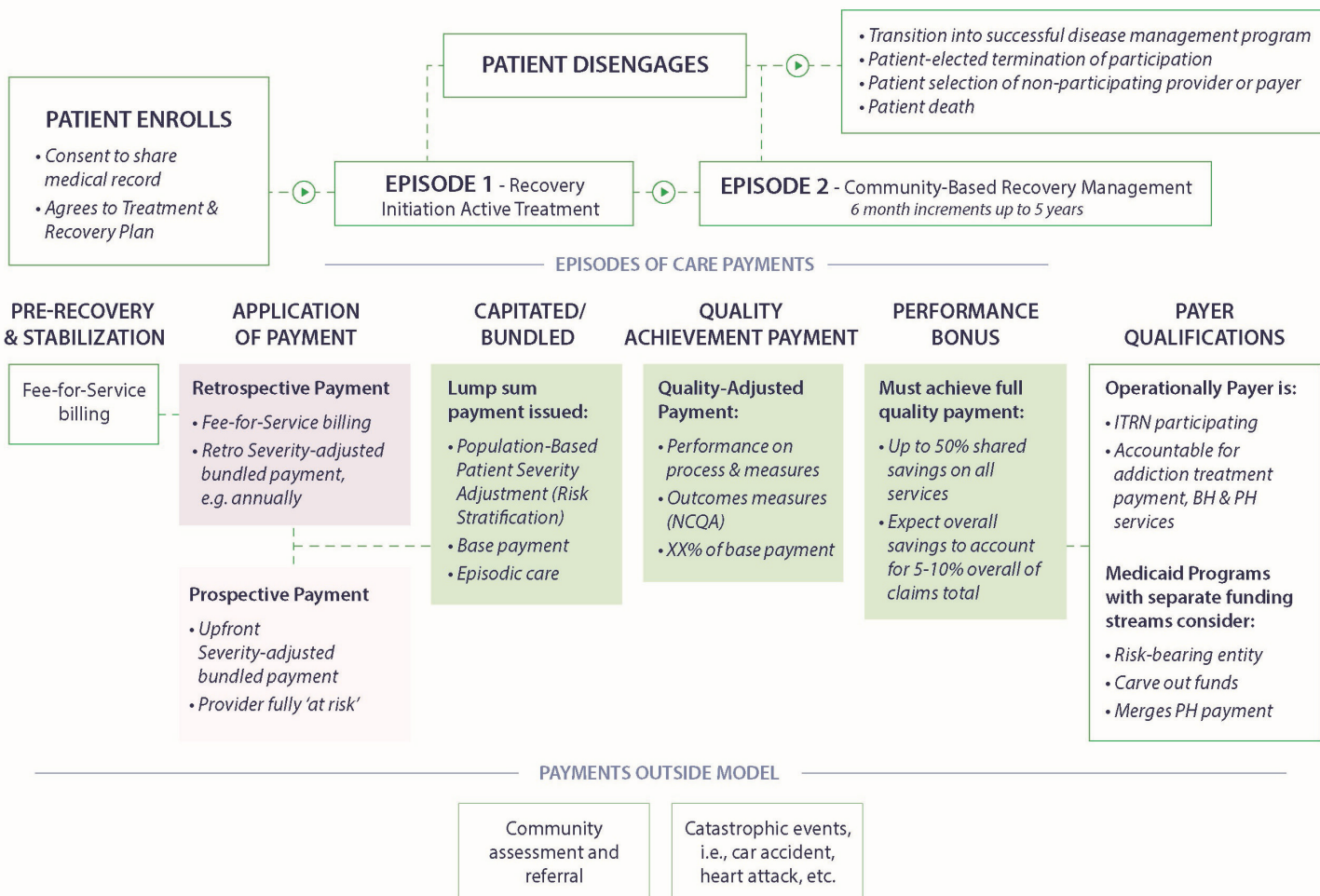
SUBCONTRACTING
The ARMH-APM allows for subcontracting arrangements among parties under which other participating entities can contract with a partner to provide certain ARMH treatment and recovery services. The subcontracting arrangement may utilize a payment model or quality metrics that differ from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

Exhibit 3

ARMH-APM PAYMENT MODEL

PATIENT DISENGAGES
- *Transition into successful disease management program*
- *Patient-elected termination of participation*
- *Patient selection of non-participating provider or payer*
- *Patient death*

PATIENT ENROLLS
- *Consent to share medical record*
- *Agrees to Treatment & Recovery Plan*

EPISODE 1 - Recovery Initiation Active Treatment

EPISODE 2 - Community-Based Recovery Management
6 month increments up to 5 years

EPISODES OF CARE PAYMENTS

PRE-RECOVERY & STABILIZATION	APPLICATION OF PAYMENT	CAPITATED/ BUNDLED	QUALITY ACHIEVEMENT PAYMENT	PERFORMANCE BONUS	PAYER QUALIFICATIONS
Fee-for-Service billing	**Retrospective Payment** • *Fee-for-Service billing* • *Retro Severity-adjusted bundled payment, e.g. annually*	**Lump sum payment issued:** • *Population-Based Patient Severity Adjustment (Risk Stratification)* • *Base payment* • *Episodic care*	**Quality-Adjusted Payment:** • *Performance on process & measures* • *Outcomes measures (NCQA)* • *XX% of base payment*	**Must achieve full quality payment:** • *Up to 50% shared savings on all services* • *Expect overall savings to account for 5-10% overall of claims total*	**Operationally Payer is:** • *ITRN participating* • *Accountable for addiction treatment payment, BH & PH services* **Medicaid Programs with separate funding streams consider:** • *Risk-bearing entity* • *Carve out funds* • *Merges PH payment*
	Prospective Payment • *Upfront Severity-adjusted bundled payment* • *Provider fully 'at risk'*				

PAYMENTS OUTSIDE MODEL

Community assessment and referral	Catastrophic events, i.e., car accident, heart attack, etc.

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INTEGRATED TREATMENT AND RECOVERY NETWORK

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

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

One of the greatest impediments to sustained recovery for patients is that various programs and treatment settings operate in isolation from one other with limitations in referrals and/or requisite information sharing with other key parties [8].To bypass this structure, providers must either work together through shared accountability and shared risk or enjoy common ownership by a single entity who may be better positioned to facilitate the

desired integration. This will include shared access to information, shared treatment and recovery goals for the patient, shared quality measurements, and shared performance and outcomes-based payment. A clear example of this principle can be seen when a patient's physical health provider is alerted to the patient's recovery process through coordinated care measures and sharing of the PMI and can discuss nonopioid pain management treatment alternatives for that patient as a means of supporting their recovery.

The ARMH-APM 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 [9] as a patient's needs evolve in nature and intensity across the stages of recovery. This is the aspirational ideal of the treatment system yet today, only one in five adults and even fewer adolescents receive this type of continuing care [10].

SPONSORSHIP TYPES

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

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Payer Sponsors

Medicaid Managed Care Organizations

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

SUCCESS FACTORS	CHALLENGE FACTORS
• Many Medicaid beneficiaries will remain with a single managed care plan in the absence of financial or premium-based incentives to "shop around." • MCOs may be over-paying for addiction-related services as a result of the inefficiency that corresponds with a fragmented and diffuse delivery architecture.	• Behavioral health carve-outs vary across states, creating discontinuity between physical and mental health services. Where carve-outs exist, the managed care or risk-bearing entity may lack the appropriate infrastructure to administer the ARMH-APM. • Payments in Medicaid tend to be lower, rendering less room for upside benefits for downstream value generation. • Medicaid administrative systems (state and MCO) may lack the required sophistication to administer and manage risk-based contracts, quality measures, and other important elements of the ARMH-APM.

Self-Insured Group

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

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

SUCCESS FACTORS	CHALLENGE FACTORS
• Increased autonomy for the purchaser to direct their benefits spend toward APMs that more directly benefit their employees. • Higher consistency and continuity in coverage through many forms of employer-sponsored coverage, particularly in higher-skill industries with less turnover. • Employers see broader economic benefits that transcend higher health care costs, primarily in productivity gains.	• Requires a concentrated employee population. • Partnering with other employers for common purchasing objectives is difficult. • Benefits consultants and brokers often lack the technical sophistication to negotiate and pursue APM models.

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Medicare Advantage

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

SUCCESS FACTORS	CHALLENGE FACTORS
• Stable, relatively well reimbursed commercial coverage. • MCOs that participate in MA have become established in the program and tend to be well capitalized and shrewd operators of the business. • While consumerism is higher for MA plans than its government-sponsored plans, there remains a degree of coverage consistency and continuity within the program.	• SUD prevalence is not as high in MA populations as it with other government-sponsored programs.

Commercial Coverage

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

SUCCESS FACTORS	CHALLENGE FACTORS
• Higher pain point for the risk-bearing insurance companies whose financial benefits are contingent on decreased claims. • A broad spectrum of population types and needs that range socio-economic conditions.	• Limited group purchasing power of enrollees that limit pressure for expanded benefits. • Much higher churn and cyclicality of benefit, inherently limited by the annual underwriting cycle.

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

Provider Sponsors

Provider institutions vary in their size, sophistication, and clinical breadth. Importantly, a sponsoring provider partner for the ARMH-APM must hold unique and differentiated

assets in the marketplace that enable it to organize the appropriate resources to administer the model, bear the required financial risk, and administer non-owned enterprises when applicable.

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

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Integrated Delivery Network

In many ways, the integrated delivery network (IDN) is the ideal ARMH-APM participant. A true IDN often owns a health plan and includes a breadth of clinical assets that could qualify as the ITRN (*e.g.*, a hospital). While common ownership does not necessarily imply efficiency or integration, a true IDN possesses the fundamental elements needed to organize a care recovery system for SUD.

SUCCESS FACTORS	CHALLENGE FACTORS
• Commonly owned assets under an enterprise model with the inherent possibility of faster decision-making and integration than non-IDN entities in the market. • Market stature and presence that might render more expeditious contracting with payer sponsors or other affiliates. • Larger balance sheets, resources, and access to capital required to administer the provider's responsibilities under the ARMH-APM.	• Common ownership does not automatically mean enhanced efficiency. • Larger organizations with a multitude of different payment and delivery initiatives may be administratively or operationally over-extended and unable to devote the required resources to the ARMH-APM. • Gaining consensus and buy-in from various parts of the organization can render longer decision-making cycles.

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

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

SUCCESS FACTORS	CHALLENGE FACTORS
• Closer proximity to the primary care physician and the patient. • Increasingly agile and responsive to programmatic changes and care transformation. • NCQA has launched a "Distinction in Behavioral Health Integration" program laying out standards to help primary care practices better integrate behavioral healthcare into their practices and acknowledges practices that excel in this area.	• Financial limitations that may impede the organization to bear material financial risk. • Higher burden in the identification of a payer partner and high-value ancillary clinical settings required for the network.

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Behavioral Health Organization

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

SUCCESS FACTORS	CHALLENGE FACTORS
• A deeper understanding of the behavioral tenets of treatment and recovery, germane to SUD. • Broader access to the continuum of care supporting behavioral health and community resources.	• Financial limitations that may impede the organization to bear material financial risk. • Limitations in establishing networks that would support physical health integration.

PROVIDER PARTICIPATION GUIDELINES

For initial piloting purposes, NCQA's proposed ARMH model provider entry criteria may serve as a proxy for provider participation qualifications. As networks evolve and pilot data are analyzed, the Alliance anticipates exploring more formal accreditation and/or recognition criteria over the long-term.

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

However, when ARMH network participants cannot meet the process or outcomes measures for the model, network partners or the network's risk-bearing entity may attempt to remediate that provider's deficiencies in order to maintain requisite levels of performance. Provider low performance is not only a detriment to patient recovery, but to both the provider and network through forgone quality payments and reduced shared savings potential respectively.

The NCQA quality metrics serve as a central, uniform measure against which participating entities can gauge provider performance. This will help standardize performance and contracting decisions across networks.

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-APM. Qualification criteria for both integrated (under common-ownership) and networked providers (affiliated through contract) are below.

Key Network and Service Requirements

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

> **A fundamental concept in care coordination between health care, substance use disorder treatment, and mental health systems is that there should be "no wrong door."**

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A fundamental concept in care coordination between health care, substance use disorder treatment, and mental health systems is that there should be "no wrong door." This means that the patient should be effectively linked with appropriate services no matter where in the health care system the need for substance use disorder treatment is identified. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) emerging vision for transforming the substance use disorder health system is that it must be multi-faceted and "grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support."[1]

The Alliance has adopted an evidence-based structure laid out by SAMHSA that defines the clinical and services structure of a behavioral health system that incorporates the necessary breadth and depth of resources to support recovery [13].

For purposes of defining network assets needed to deliver the ARMH-APM, 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-APM criteria to match this model are noted.

- Institutional Infrastructure: Services provided in emergent or specialty care settings, including:
  - Acute Intensive Services
    - Mobile Crisis Services
    - Urgent Care Services
    - Medically Managed Intensive Inpatient Services (ASAM Level 4)
  - Intensive Support Services (ASAM Level 2)
    - Intensive Outpatient (ASAM Level 2.1)
    - Partial Hospital (ASAM Level 2.5)

- Clinical Support Infrastructure: Specialty services that can be delivered either inpatient or outpatient, including:
  - Out of Home Residential Services (ASAM Level 3)
    - Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
    - Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)

- Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
    - Medically Monitored Intensive Inpatient Services (ASAM Level 3.7)
  - Outpatient and Medication Assisted Treatment (ASAM Level 1)
    - Individual Therapy
    - Group Therapy
    - Family Therapy
    - Medication Management
  - Health Homes
    - Primary Care
    - Comprehensive Care Management
    - Care Coordination and Health Promotion
    - Medication Management
    - Laboratory Services
    - Connections/Linkages to Community Supports

- Non-Clinical Services and Supports: Services accessible to the patient outside of a clinical setting and complement that treatment and recovery plan, including:
  - Engagement Services
    - Motivational Interviewing (ARMH-APM On-Ramps)
    - Evidence-based Assessment
  - Recovery Support Services
    - Peer Recovery Coaching
    - Supports for Self-Directed Care
  - Prevention and Wellness Services
    - Screening, Brief Intervention, Referral to Treatment
    - Call Center
    - Public Education Activities
  - Community Support and Other Living Supports
    - Recovery Community Center
    - Recovery Housing
    - Linkage to Community Recovery Support and Mutual Aid
    - Supportive Employment
    - Supportive Education
    - Skill Building
    - Transportation

The ARMH-APM requires each of these components to be in place.

The patient's treatment and recovery plan will include specific timeframes and objectives for the patient as they move through a continuum of care matched to their

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needs. The recovery plan is dynamic and designed to be consistently updated as the patient achieves specific milestones, clinical conditions shift, or the general composition of the plan is unsuccessful.

Integrated Providers

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

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

Networked Providers

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

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

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

CLINICAL INTEGRATION REQUIREMENTS
Clinical Information Sharing Guidelines

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

In January 2018, SAMHSA issued a final rule [15] that made new changes to the federal rules that govern Part 2, specifically expanding the methods whereby a patient's information may be shared. The final rule was effectuated on February 2, 2018.

Specifically:

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

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

Common patient records are coordinated across care settings through a technology intermediary. Clinical interoperability within the ITRN is required, including the capacity to acknowledge 42 CFR information-sharing consent and the technology that can appropriately share sensitive information. This connotes a setting where the core contracted entity either owns or has an arm's length technology relationship with sufficient APIs and infrastructure to exchange such information.

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A requirement for a patient's participation under the ARMH-APM is to consent for the risk-bearing entity to share the patient's medical record with affiliated parties under the ITRN. (This consent *only* extends to the confines of the ITRN and any patient consent should be necessarily restricted from non-ITRN facilities to invoke the protections afforded to the patient under Part 2.) The patient's consent should be open-ended from a timing perspective, while automatically terminating when the patient's enrollment under the ARMH ceases, either voluntarily or through the other separation events listed previously.

All other non-protected clinical information should be accessible to the care recovery team through PHI or clinical systems.

Clinical Information Sharing Systems

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

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

1. Sufficient API connections between system EMRs. The success of this is highly correlated with fewer EMRs requiring connectivity and the systems' EMRs possessing the capacity to share clinical information in the required formats. (The same requirements pertaining to the ability to store, share, and distribute the Part 2 consent, the treatment and recovery plan, etc. remain in place.)

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

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

Discharge and Care Transition Management

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

- A robust technology infrastructure that interfaces with the clinical information system and facilitates a connection to the new clinical setting.

- A stipulation that all discharges require the partnership of the recovery coach, who is able to confer with the broader care recovery team and support the implementation of the treatment and recovery plan. All discharge planning should aspire to provide sufficient time to the care recovery team to engage the patient.

- Where possible, the patient should be able to explore and interact with the new care setting in advance of their discharge.

CLINICAL PATHWAYS

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

Assessments and Referrals

The Alliance views community engagement, assessment, and referral of individuals with substance use disorders 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

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for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services under traditional fee-for-service codes (*e.g.* screening and intervention code). The ARMH-APM does not include community assessment and referral as part of the treatment and recovery plan. However, in recognition of the vital role that community entities play referring patients for further clinical evaluation (and thus to ARMH-APM participating entities), participating entities could be engaged and remunerated to provide proactive screening, education, and referral for individuals with a SUD.

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

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

• American Society of Addiction Medicine (ASAM) Placement Criteria

• Addiction Severity Index (ASI)

• Substance Abuse Module (SAM)

• Global Appraisal of Individual Needs (GAIN)

• Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

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

All information collected through the assessment should be captured and indexed to the patient's medical record. The assessment should be linked to the treatment and recovery plan. Participating entities can re-assess the patient at their

consent to track progress. Subsequent assessments are not required to be codified in the medical record.

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

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

Patients are considered active for six months after initial consent unless they deliberately remove themselves from the program; and engagement efforts should be designed for the six-month timeframe.

PATIENT ACTIVATION AND TRANSITION PATHWAYS
Acute
The trigger required to initiate transition from an acute stabilization event to the ARMH-APM 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 life-saving or life-stabilizing services in the ED or ICU where a doctor makes or confirms a diagnosis required for the ARMH model. If the ED/ICU provider is not associated with an ARMH provider, ARMH providers are encouraged to contract with the ED/ICU to coordinate and train staff on patient recognition criteria and referrals.

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In integrated networks, the diagnosis can trigger an alert in the health record for 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 the patient into the ARMH-APM 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 and to their first treatment planning meeting. The treatment and recovery plan may include items like accessing and taking medications, connection to safe housing, or a visit to medical care specialist. The first treatment planning meeting should occur between 72 hours and two weeks after the acute stabilization event. Providers will be required to meet the appropriate process quality measures associated with the transition.

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

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

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

- Participation in the ARMH-APM requires a consent for the patient's medical information to be shared amongst and between a highly-skilled professional team of health professionals across a myriad of different clinical settings.

- The patient will be the regular co-author of a treatment and recovery plan focused on 12 domains of wellness and will be expected to seriously apply themselves to achieving the goals and objectives or working collaboratively with the care recovery team to make ongoing adjustments as needed.

- The patient will make himself/herself available for regularly-scheduled check-in appointments with their care recovery team and commit to responsively engaging in their care.

- The patient will be made aware that dis-enrolling from their health insurance carrier or switching coverage domains could have an adverse impact on their participation in the ARMH-APM.

Following this notification, the patient can be enrolled in the ARMH-APM 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

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objectives, ultimately working with the patient to move them to a more stable care environment.

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

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

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

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

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

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

resources that are accessible to the 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.

CARE RECOVERY TEAM
The care team is comprised of licensed and experienced medical professionals and para-professionals who are committed to working collaboratively and with the patient on SUD recovery. Together the care team leverages the evidence-base 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 [28]. Patients, for their part, are responsible for active participation in their treatment and recovery process.

CARE TEAM COMPOSITION
The core care team consists of a peer recovery coach, care coordinator, a PCP, and a behavioral health specialist (psychiatrist or an addiction medicine doctor).
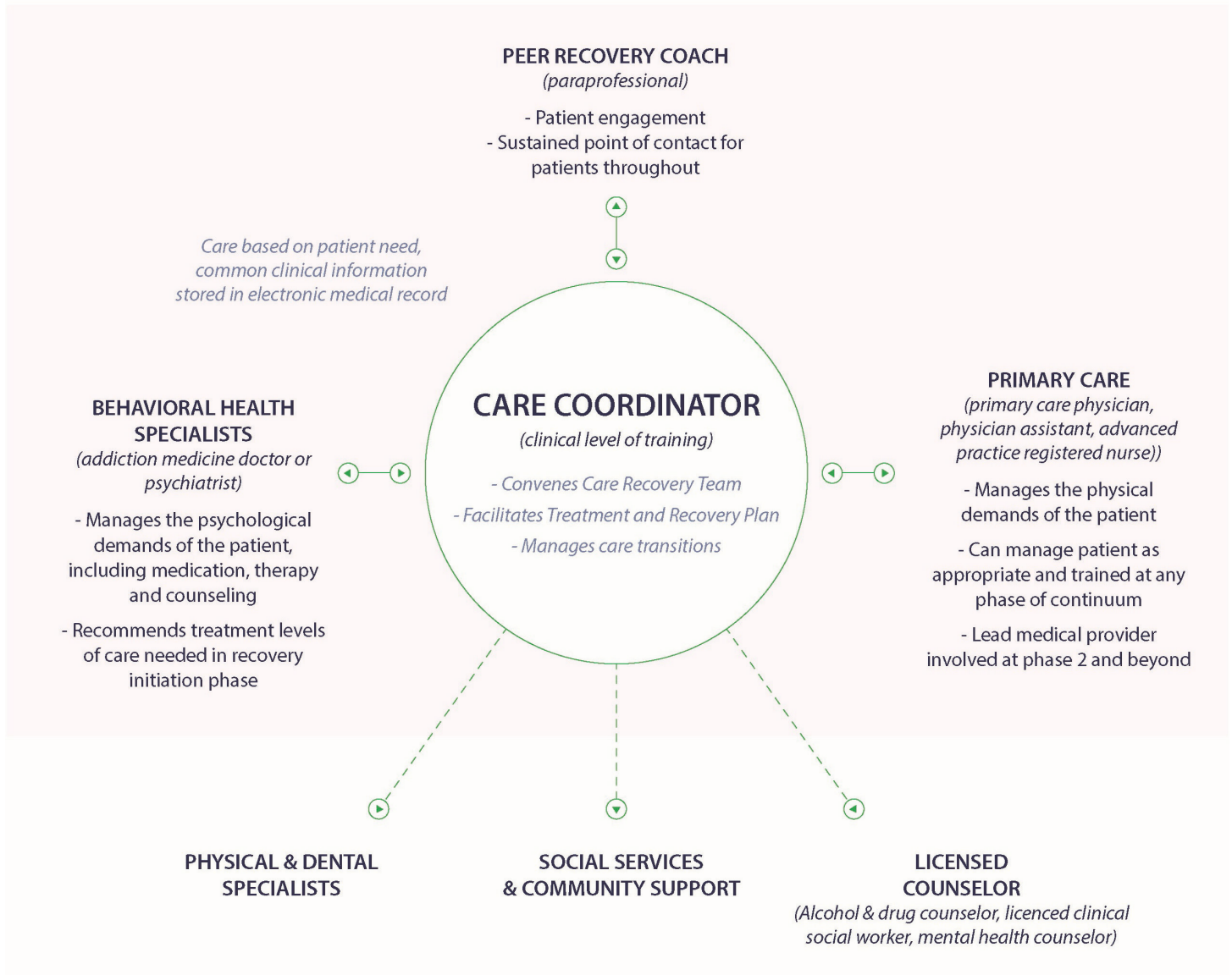
Peer Recovery Coach
According to SAMHSA, "the terms mentoring or coaching refer to a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery. Generally, mentors or coaches assist peers with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding sober housing, making new friends, finding new uses of spare time, and improving one's job skills. The relationship of the peer leader to the peer receiving help is highly supportive, rather than directive.[3]"

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

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[3] https://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf

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Exhibit 4

CARE RECOVERY TEAM

PEER RECOVERY COACH
(paraprofessional)

- Patient engagement
- Sustained point of contact for patients throughout

Care based on patient need, common clinical information stored in electronic medical record

CARE COORDINATOR
(clinical level of training)

- Convenes Care Recovery Team
- Facilitates Treatment and Recovery Plan
- Manages care transitions

BEHAVIORAL HEALTH SPECIALISTS
(addiction medicine doctor or psychiatrist)

- Manages the psychological demands of the patient, including medication, therapy and counseling

- Recommends treatment levels of care needed in recovery initiation phase

PRIMARY CARE
(primary care physician, physician assistant, advanced practice registered nurse))

- Manages the physical demands of the patient

- Can manage patient as appropriate and trained at any phase of continuum

- Lead medical provider involved at phase 2 and beyond

PHYSICAL & DENTAL SPECIALISTS

SOCIAL SERVICES & COMMUNITY SUPPORT

LICENSED COUNSELOR
(Alcohol & drug counselor, licenced clinical social worker, mental health counselor)

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

Peer recovery coaches are an important part of the care team in terms of providing both support and education about the recovery process. Peer recovery coaches in the ARMH-APM will likely play a key role in the front-end activation responsibilities, including educating the patient about providing consent to share their medical record among treating providers. State-level regulations govern the extent to which they can be included in the sharing of treatment information. In states with more restrictive approaches, providers may coordinate with peer recovery

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coaches by segmenting data into two groups: less sensitive data which the peer recovery coach can access and more sensitive or protected health information for clinical, licensed professionals only.

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

- IC&RC - The Peer Recovery (PR) credential is designed for individuals with personal, lived experience in their own recovery from addiction, mental illness, or co-occurring substance and mental disorders [29].

- 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 [30]. Their life experiences and recovery allow them to provide recovery support in such way that others can benefit from their experiences.

- CAPRSS - The Council on Accreditation of Peer Recovery Support Services (CAPRSS) is the only accrediting body in the US for Recovery Community Organizations (RCOs) [31]. CAPRSS accreditation can be deployed in an ITRN that has integrated an RCO to provide the peer recovery coaching services.

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

- Maintain a current recovery plan (and further ensuring the plan is electronically captured in the resident EMR system)

- Assume the role of key contact for the patient during their recovery experience

- Facilitate a robust and thorough hand-off to another peer recovery coach when he/she is no longer able to support the patient

- Provide transportation services to patients who have a clear, recovery-based objective; otherwise patients are encouraged or trained to ride the bus or acquire other forms of transportation

- Engage family and friends in the treatment planning process to help patients address recovery-based activities

- Coordinates services with counselors and assign responsibility for achieving specific objective

- Provide in-service training to counselors about the goal of recovery coaching

Care Coordinator
Per the Agency for Healthcare Research and Quality (AHRQ), "Care Coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means the patient's preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient [32]."

The care coordinator is the main point of contact for patients entering from non-acute care pathways. The care coordinator is responsible for bridging the transition into care for the patient and for completing pre-assessments. Generally, the care coordinator acts as the point of contact for and manager of the information exchange between any medical care specialists and the remainder of the care team, although in some critical cases it may be important for the specialist to have direct access to the patient's treatment plan.

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Systemic care coordination roles have been deployed for the management of a variety of physical health conditions, however, the 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 case load size for a care coordinator working with an exclusive SUD population and the pilot projects will work to establish specific guidelines on this issue.

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

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

The primary responsibilities of the care coordinator consist of:

• Coordinate patient care with other members of the care recovery team, ensuring the patient is receiving the quantity and type of care mandated by treatment and recovery plan

• Manage discharge and care transitions in close collaboration with medical staff and the patient, ensuring the patient's experience is properly managed to promote continuity

Primary Care Physician (PCP), Physician-Assistant (PA), or Advanced Practice Registered Nurse (APRN)
A key member of the care recovery team is the PCP and related staff. If the patient has a PCP during activation in the ARMH-APM, then efforts should be made to include the PCP (and their staff) on matters pertaining to the

patient's recovery. Specific instances where the PCP should be notified include:

• The initial activation of the patient as a participating in the ARMH-APM

• The development of the initial treatment and recovery plan with notifications of subsequent iterations of the plan

In the course of providing primary care for the patient, the PCP and their staff should have ready access to the patient's treatment and recovery plan and should be able to engage with the care coordinator and/or 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. The ideal scenario would be that the PCP had clinical connectivity to the ITRN. Where this is not possible, the core care recovery team should abide by the communication parameters above using whatever means are at their disposal of communicating key recovery information.

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

Finally, if the ARMH-APM is engineered for OUD, then the care recovery team will require the PCP to possess a waiver from SAMSHA to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000 [33]. If the PCP is unable to attain this waiver, the care recovery team should add a physician with this waiver.

Addiction or Behavioral Health Specialist
Another variation in the care team may be driven by workforce considerations. Physicians with a focus on behavioral health, who can prescribe medications for SUD,

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(*e.g.* addiction medicine doctor, primary care physician, psychiatrist) are specially-trained clinicians who can provide prevention, screening, intervention, and treatment for substance use disorders and their psychiatric 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 addiction medicine training who has oversight over the ARMH-APM. These specialists should be certified in the field; acceptable certifications for participation in the ARMH-APM include the following:

- Certification by the American Society of Addiction Medicine or the American Board of Addiction Medicine

- Subspecialty certification in Addiction Medicine by the American Board of Preventive Medicine

- Subspecialty certification in Addiction Psychiatry by the American Board of Psychiatry and Neurology

- Certificate of Added Qualification in Addiction Medicine conferred by the American Osteopathic Association

- Completion of an accredited residency/fellowship in Addiction Medicine or Addiction Psychiatry

Certified Addiction Counselor[4] or Licensed Clinical Social Worker[5]

Certified Addiction Counselors (*e.g.* Alcohol and Drug Abuse Counselors) are professionals trained in evaluation and to implement specific therapeutic techniques. Counselors' educational requirements range from certificate level programs to masters and doctoral level programs. The Association for Addiction Professionals

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[4] http://www.nbcc.org/, https://www.drugabuse.gov/node/18877, Taleff, M and Swisher, J. (1997) The seven core functions of a master's degree level alcohol and other drug counselor. Journal of Alcohol and Drug Education. Spring 1997, 42(3),

[5] https://abecsw.org/clinical-social-work/clinical-social-work-described/, https://pcmh.ahrq.gov/sites/default/files/attachments/pcpf-module-4-practice-management.pdf, https://www.socialworkers.org/LinkClick.aspx?fileticket=ICxAggMy9CU%3d&portalid=0

and The National Board for Certified Counselors are bodies that provide certifications for professional counselors. Competencies expected of counselors based on their level of credentials may include the applying of the evidence-based to counseling, completing assessments and matching patients to the appropriate treatments, individual or group counseling, evaluation of the effectiveness of care, and collaboration with team members and other organizations.

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

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

- ASAM

- SAMHSA

- The Recovery Research Institute – provides a brief recovery assessment tool

- The National Institute on Drug Abuse

- The University of Washington Alcohol and Drug Abuse Institute

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Ancillary Specialists

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

Case loads should be based on the functions described in this section, with specific case load designations for the peer recovery coach, the care coordinator, the behavioral health specialist, 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 all episodes of care (Recovery Initiation and Active Treatment, Community-Based Recovery Management), the patient will shape the treatment and recovery plan and participate in strategies designed to promote readiness to change, motivation/resistance, and engagement in care. Participation in the Community-Based Recovery Management episode will involve utilization of community resources and peer-recovery communication about any recidivism risks. Patients are also responsible for providing appropriate feedback through their peer recovery coach regarding whether ARMH care is meeting their needs. To the extent possible, the provider should take into account a patient's

wishes regarding level of care, so long as the decision is consistent with the evidence base. A higher emphasis on patient preference and input is possible in the second episode (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 on, for instance, reasons why the clinically appropriate level of care will aid in the patient's progress towards recovery. Active engagement with the peer recovery coach may be a good resource for the patient during level-of-care transitions.
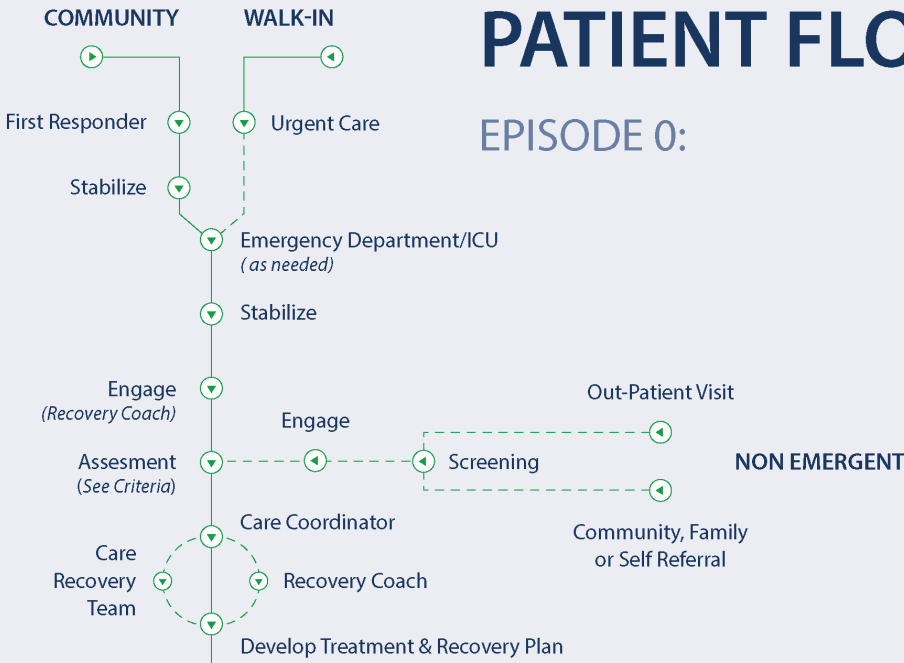
Patients are expected to adhere to the treatment recommendations, and at a minimum participate in care that ensures patient safety and limits provider liability. The exact treatment plan can remain flexible, as the provider and patient pursue agreement. In considering the situations under which a provider may seek to sever an ITRN relationship with a patient, the Alliance recommends that the ARMH provider have a policy to address non-compliant patients which includes peer support efforts as a prerequisite and a robust communication (including a written/technology-based correspondence with the patient) protocol around unenrollment. Further, recovery disruption must be held separate from noncompliance as the ARMH model considers any engagement with ITRN providers as attempted compliance.

TREATMENT AND RECOVERY PLAN

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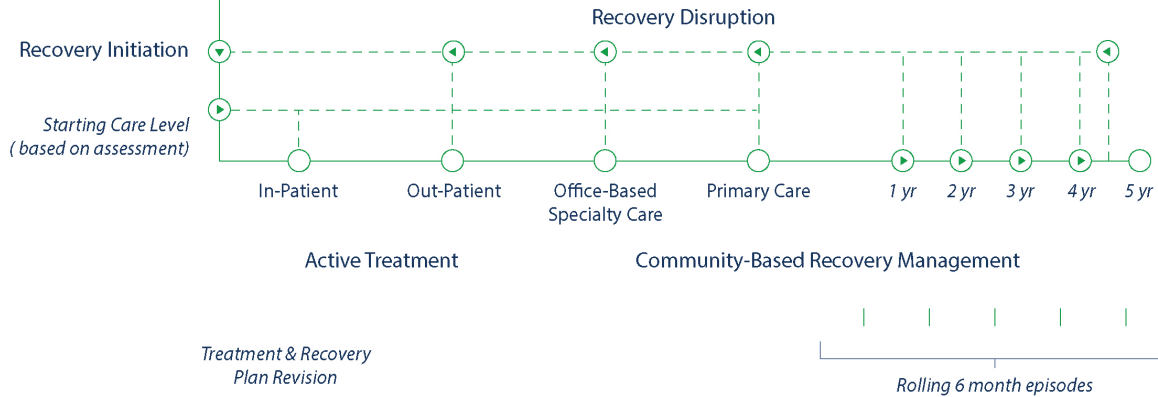
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PATIENT FLOW

COMMUNITY   WALK-IN

EPISODE 0:

First Responder   Urgent Care

Stabilize

Emergency Department/ICU
(*as needed*)

Stabilize

Engage
(*Recovery Coach*)

Engage   Out-Patient Visit

Assesment
(*See Criteria*)   Screening   **NON EMERGENT**

Care Coordinator

Care
Recovery   Recovery Coach   Community, Family
Team   or Self Referral

Develop Treatment & Recovery Plan

INITIAL CARE
TRANSITION   EPISODES 1 & 2:
(*Based on Treatent
& Recovery Plan*)

Recovery Disruption

Recovery Initiation

Starting Care Level
(*based on assessment*)

| In-Patient | Out-Patient | Office-Based Specialty Care | Primary Care | 1 yr | 2 yr | 3 yr | 4 yr | 5 yr |

Active Treatment   Community-Based Recovery Management

Treatment & Recovery
Plan Revision

Rolling 6 month episodes

Care Coordinator   Confers with Care   Establish Plan
with Patient   Recovery Team   with Patient

ARMH-APM
DISRUPTORS

Member Severs
Coverage   Provide
Cash-Based Option   Final Treatment
Recovery Plan   Notify Primary
Care Physician

Recovery
Disruption   Stabilize   Meet with Care
Coordinator   Revised Treatment
& Recovery Plan

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

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

Social capital is critical because personal change does not occur in isolation but is strongly influenced by the social environment and context of the patient's environment [34].

As the treatment and recovery plan supports the patient in their development of recovery capital, the care recovery team is working in collaboration with the patient to influence their trajectory and manage turning points. Turning points are a wholesale redirecting of trajectory cultivated on a long-term basis as opposed to a brief or convenient flash in the pan [35]. Today's treatment and recovery programs largely provide for brief detours instead of seminal redirection.

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

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

- Capacity for recovery from a substance use disorder exists on a continuum of motivational readiness and skills.

- The goal of addiction treatment is to teach individuals how to achieve their own recovery.

- Full recovery is not essential at completion of treatment as long as individuals leave with the capacity to eventually achieve recovery without additional treatment interventions.

- 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 [36].

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

Treatment and Recovery Plan Components
The most urgent activity that will be undertaken for any patient after any emergency medical stabilization needs are met is a clinical assessment to determine both the severity of substance use disorder and appropriate clinical recommendations. A trained professional will diagnosis 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

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the treatment plan." There are four evidenced-based assessment tools outline in the report that can be used:

• Addiction Severity Index (ASI)

• Substance Abuse Module (SAM)

• Global Appraisal of Individual Needs (GAIN)

• Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

Clinical treatment needs should be personalized and will generally use patient placement criteria already currently utilized by the payer 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, but also concurrently to any treatment services being delivered to begin to work with the patient on their recovery goals. It can help to ensure a holistic set of a patient needs are being addressed building towards long-term sustainable recovery outcomes. The recovery management elements of the plan most-often will be led by a peer recovery coach in collaboration with the patient.

Community-based recovery is multi-dimensional. It's important that patients and the care team explore the people, places, and things that can either help, or hinder, long-term recovery. The template the Alliance has chosen to build from is a FAVOR Greenville Recovery plan that covers 13 components of everyday wellness that should be evaluated and 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 (parents, peer coaches, etc.) align around goals for each relevant component of the plan and incorporate a process for ensuring compliance with the agreed upon plan. Each goal should be accompanied by a time frame so that patients are regularly checking in on their progress. Various technology applications can be utilized by both care team and patient to track progress.

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

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Social Context

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

- Promoting Social Controls (Treatment and Recovery Section #3, #9, #10)
  This tenet provides that a network of strong bonds with family, friends, work, religion and other related societal aspects regulates and motivates the patient to act responsibly in addition to increasing risk aversion. Conversely, when such social bonds are weak or fragmented, individuals are less likely to adhere to conventional norms and standards, tending to engage in behaviors that could lead to the onset of a recovery disruption [37].

- 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 [38]. These situations can arise from stressful life circumstances such as interpersonal conflict, work and financial problems, and physical and sexual abuse.

- Behavioral Economics and Behavioral Choice (Treatment and Recovery Section #3, #4, #8, #9, #10, #12)
  The ideas under this category follow that the key element of the social context is the alternative rewards provided by activities other than substance use. Providing access to rewards through involvement in educational, work, religious, and social or recreational pursuits reduces the likelihood of choosing alternative rewards, such as those that might derived by substance use [39].

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 [40].

ENGAGEMENT PRINCIPLES AND PROTOCOLS FOR THE TREATMENT AND RECOVERY PLAN

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

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

1. The plan is only official when it has been developed in conjunction with the care recovery team. More specifically, the care coordinator or peer recovery coach should be intimately involved in the creation of the plan, with final approval rights.

2. Patient preferences should be strongly deferred to in the creation of the plan. The Alliance believes patients understand their environments, triggers, and recovery parameters quite well. Though the patient will not be suited to offer clinically legitimate recommendations, their very specific insights should be strongly incorporated into the treatment and recovery plan.

Engagement Method

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

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

- Initial development of the treatment and recovery plan – 2 hours

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- 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 proprietary and the care recovery team designate should take great effort to ensure the patient perceives an environment of trust and security.

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

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

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

The patient should sign or authorize the finalized treatment and recovery plan along with the designate.

The designate bears responsibility for the safe transport and codification of the plan in an electronic format that can be shared within the ITRN for the patient's benefit.

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

The initial development of the plan occurs at the point of activation or induction into the ARMH-APM with the appropriate care recovery team designate. As described above, this initial interaction should be lengthy *and* should include as many of the care recovery team members as are feasibly available. The initial plan is of critical importance as it seeks to balance a range of clinical, social, and other considerations that orient that patient's recovery.

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

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

Finally, in the event of a material or significant recovery disruption, the care recovery team should immediately engage with the patient to make the appropriate adjustments to the plan. This may involve a general resetting of key clinical services, moving the patient back to a setting more appropriate for that particular moment in their care. However, it may just 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 measure for substance use disorders, the ARMH-APM will initially rely heavily on process measures as determined by individual ITRN's (*e.g.* patient consent to share medical record, frequency of patient contact, care transitions, etc.). Learnings will also be drawn from Collaborative Care Model currently being used to integrate behavioral health services into Primary Care savings that has been shown to improve patient outcomes considerably. Additionally,

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there are emerging tools and technology to measure a patients "Recovery Capital" that ITRN's can explore integrating into their models.

Aside from that, the ARMH-APM seeks regular reconciliation and recovery determination. To do this, the Alliance has relied on a consensus document developed by ASAM that focuses on the appropriate use of drug testing in recovery.

ASAM created a consensus document on the Appropriate Use of Drug Testing in Clinical Medicine [41] to provide guidance on the effective use of drug testing in the identification, diagnosis, treatment, and promotion of recovery. Generally it is anticipated a patient would be tested weekly during the first six months (episode one: Recovery Initiation and Active Treatment), monthly during the second six months (episode two: Community-Based Recovery Management), and then either monthly or eight times a year in the remaining episodes of the ARMH model. The testing should be administered by a trained clinical professional on the team and not the peer recovery coach. The care recovery team should factor these guidelines into the patient's particular needs while adhering to this general cadence.

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Psychiatry & Behavioral Health Learning Network

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Peer Specialists Beginning to Boost Florida's Service System

May 13, 2019 by Gary A. Enos, Editor

In a state with traditionally low public funding support for addiction treatment and uneven quality of care, peer specialists are beginning to make a difference in bolstering substance use service systems. Progress has been particularly strong in Florida's northeast and north central regions, but that soon could extend into other areas due in part to state legislation that is expected to be signed into law.

Pilot efforts launched through government grants have largely been responsible for the growth of peer support services in the region of Florida where behavioral health care is overseen by managing entity LSF Health Systems. Peer specialists are making inroads working directly with hospital emergency department staff and with first responders on the streets during overdose calls, says Christine Cauffield, CEO of LSF Health Systems (a division of Lutheran Services Florida).

"Peers serve as a critical component to an interdisciplinary treatment team," Cauffield tells *Addiction Professional*.

Their role in Florida is expected to be clarified further through state legislation (House Bill 369) that was adopted overwhelmingly in this year's just-completed session and will take effect in July pending Gov. Ron DeSantis's signature. Among its assortment of provisions, the legislation will require peer specialists to be state-certified in order to provide state-funded support services, and will reduce the number of prior criminal offenses that make an individual ineligible to become a certified peer specialist. The latter has been seen as a considerable impediment to expanding the peer specialist workforce in Florida.

Succeeding in new settings

LSF Health Systems was able to see the first major inroads for peers in its region around 2015 when a grant from the federal Health Resources and Services Administration (HRSA) allowed it to partner with Jacksonville University to establish a curriculum for certifying peer specialists.

"We graduated 55 peer specialists in the first year," says Cauffield. A subsequent grant is allowing for the training of an additional 70 peers each year. "The peers are also assigned a mentor to help connect them with the workforce," Cauffield says.

She adds that treatment programs are eager to introduce peers into their operations, Besides the fact that their services can be reimbursed, "The [research] literature fully supports that peers are an integral part of the treatment team, and often the linchpin for encouraging people to enter treatment," she says.

A pilot effort funded by the city of Jacksonville is allowing peers to play a major part in the response to the opioid crisis. A partnership with Gateway Community Services has established Project Save Lives, in which peers are placed in hospital emergency settings as the first main contact point for an individual who has been rescued from an overdose. An effort that was launched at Ascension St. Vincent's in Jacksonville is now being expanded to three more hospitals, says Cauffield. She points out that convincing hospital staff of peers' potential ability to engage patients in follow-up treatment took some time at first.

"Hospital systems are not accustomed to credentialing a non-clinical individual," Cauffield says. But with return visits to the ER now down considerably at the pilot site, the outlook among hospital personnel is changing. To break through the initial resistance, "You need a champion" in a high-ranking role at the hospital, she says, such as the medical director or the CEO.

"Even if the person refuses to go into formal treatment, they can choose to engage in peer services," Cauffield says. Around 40% of patients at the ER take this option, which at least leaves the door open for an outpatent or inpatient treatment referral later.

The regional authority also has received a grant from insurer Florida Blue to allow peers to accompany emergency response workers on calls, with the mission of that effort going beyond the scope of the opioid crisis alone.

Adopted legislation

The new legislation affecting the peer workforce adopts the state's traditional definition of a peer, which is an individual with at least two years of recovery from a substance use or mental health disorder who is using his/her lived experience to serve others. Cauffield says the law was a major priority of the state's association of managing entities for behavioral health services.

She says the legislation will ease the process of hiring peer specialists by standardizing and shortening the procedures for conducting background checks on these individuals. Some nonviolent felony offenses, such as burglary offenses, will no longer immediately disqualify an individual in recovery from becoming certified as a peer specialist.

"In the past it was taking at least six months for the background screening, and then if someone was denied it would take another six months for an appeal process," Cauffield says. "The provider then had to find someone else to fill an opening, and the peer needed work." Under the new legislation, peer specialists will be able to join the employing organization during the review process.

The legislation, which is soon expected to be signed into law, also clarifies some provisions related to recovery housing in the state. It includes a new requirement that most community housing operated by licensed treatment centers will have to become a state-certified recovery residence in order to be eligible for referrals from the treatment facility.