2008 National Institute on Drug Abuse Blending Conference

"Long Term Recovery Management"

"The Perspective of a State Agency Providing Services and Funding Contracts for Services in a Recovery-Oriented Healthcare System"

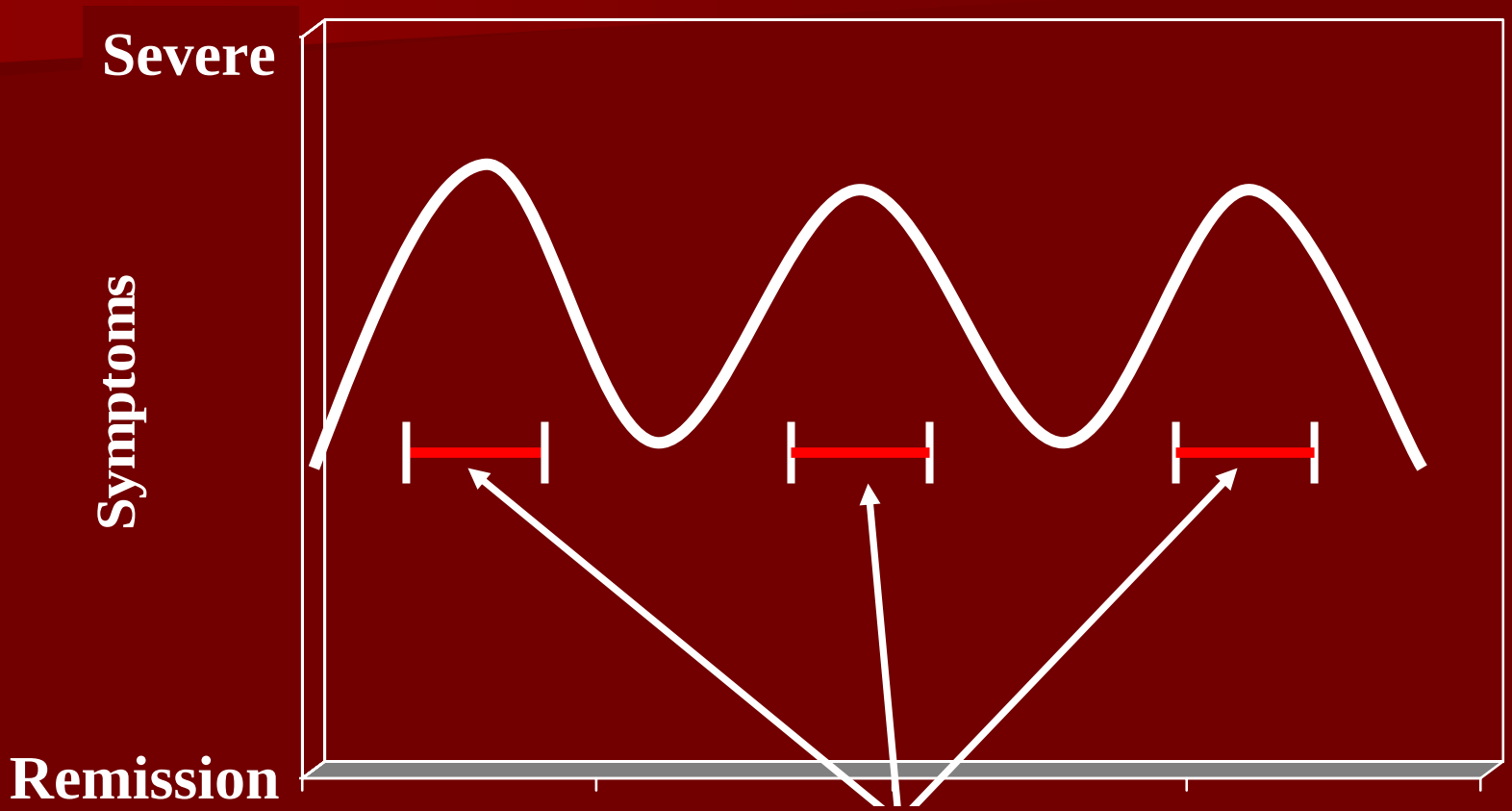
"Continuing Care, Long Term Recovery Management Service *SYSTEM*? What Will the Evidence Model(s) Look Like?"

Thomas A. Kirk, Jr., Ph.D. , Commissioner
Connecticut Department of Mental Health and Addiction Services
June 2, 2008
Cincinnati, Ohio

Continuing Care, Long Term Recovery Management System

- Why the system shift
- Route(s) taken
- Financing and reinvestment strategies
- Outcome measures in such a system
- Lessons learned – good and bad
- Recovery support services – types
- Evidence Based Practice? EB Delivery System?
- Work in progress and next steps

Substance Use Disorder
Typical service response?
Yes, too often



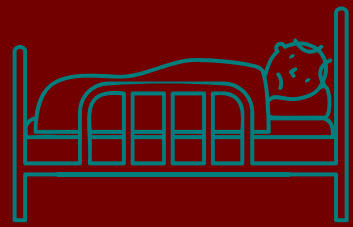
Acute symptoms

Discontinuous treatment

Crisis management

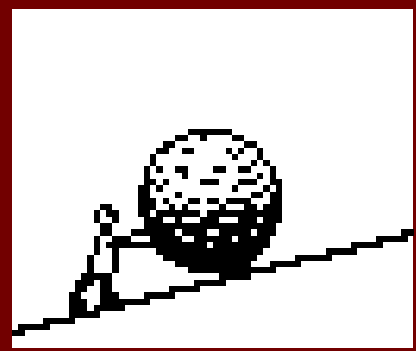
Doesn’t anybody ever get better?
What message are we conveying?

“addicts”



“a chronic, relapsing disease”

“severe persistent mental illness”

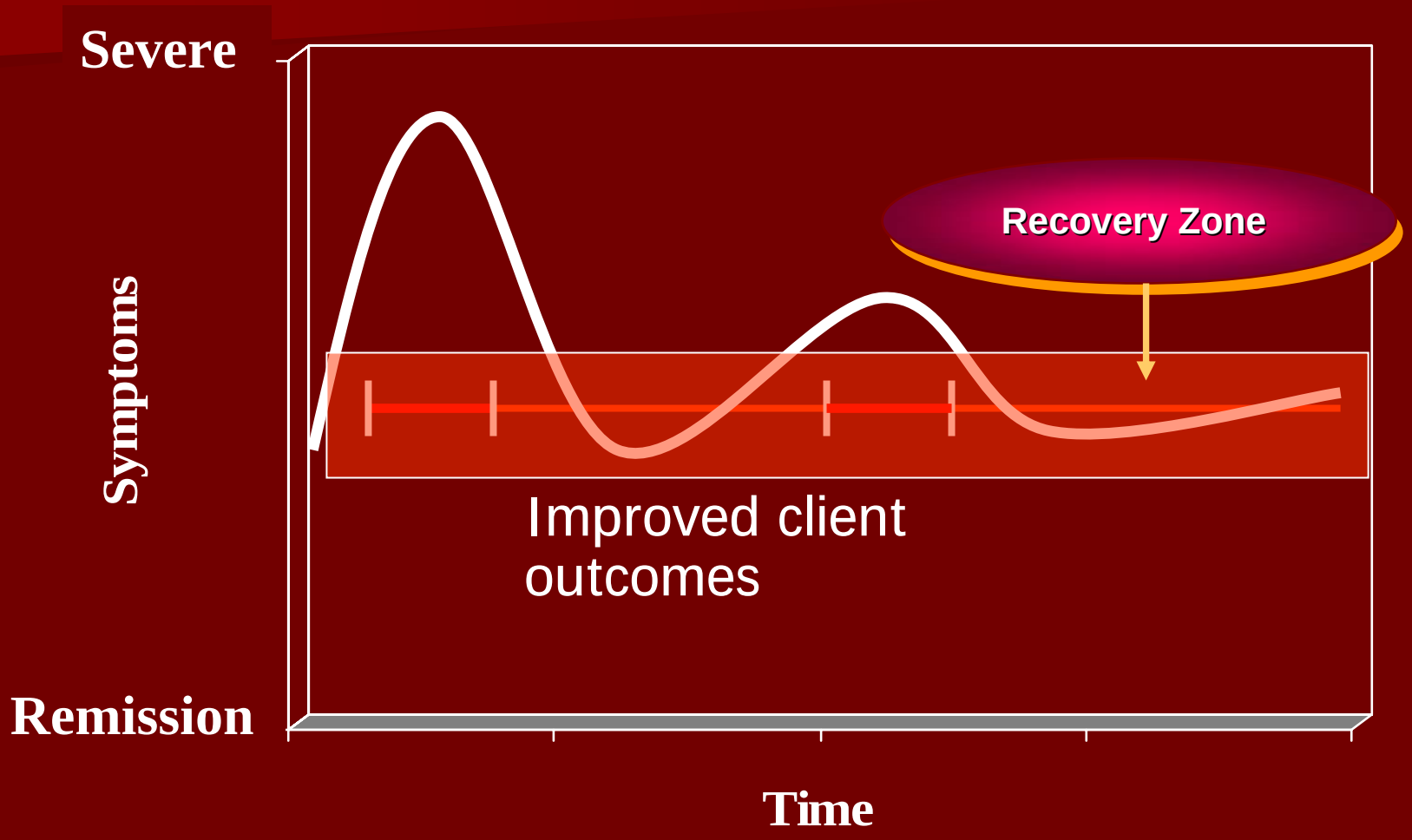


HEARD ALONG THE WAY

- **“WHEN I BEGIN TO GET REALLY FUNCTIONAL, I LOSE THE SERVICES THAT I WAS GETTING THAT HELPED ME TO GET THERE”**

(From conversation with client/consumer in Waterbury, Ct.)

Helping people move into recovery zone



WHAT IS RECOVERY?

REFERS TO THE WAYS IN WHICH A PERSON WITH A MENTAL ILLNESS AND/OR SUBSTANCE USE DISORDER

EXPERIENCES AND MANAGES HIS OR HER CONDITION(S)

IN THE PROCESS OF RECLAIMING OR REBUILDING HIS OR HER LIFE IN THE COMMUNITY.


Many Paths to Recovery

Why Move System to Recovery-Oriented Model?

- System-perpetuated stigma
- Acute care service is often wrong model
- Disproportionate funding allocations
- “Customers” vote with their feet
- Less than meaningful outcome measures
- Weak message to funder & policy makers
- Perception that “System” is irrelevant and/or doesn’t work in larger context

Recovery "From" vs. Recovery "In"

- **Recovery "from":** no longer interferes with daily functioning, the person resumes personal, social, and vocational activities within what is considered a normal range.

- **Recovery "in":** restoring or developing a positive sense of identity/meaningful sense of belonging apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition

- **Recovery Oriented System**: what practitioners offer in support of a person's long term recovery efforts.

- **Our Mission**: Assist people in regaining a meaningful, constructive sense of membership in the broader community

Recovery, Recovery-Oriented System = Continuing Care, Long Term Recovery Management Service System

MAJOR IMPLICATIONS FOR:

- CONTENT
- DELIVERY
- FINANCING
- OUTCOMES

What People Want from Healthcare System

- A welcoming healthcare setting, prompt access
- An expectation of “getting better,” not necessarily “cured”
- Hopeful, respectful atmosphere
- Tx and tools for the person to manage/own their recovery (“you can do it; we can help”)
- Show me somebody it worked for
- Have a life again...be renewed

Voices of Recovery

"Having hope"

"Getting well/getting better"

"Having same rights as others"

"Making choices"

"Doing everyday things"

"Making changes, having goals"

"Staying clean and sober"

"Starting over again"

"Be looked at as whole people"

"Looking forward to life"

Recovery Core Values

Direction

- Equal opportunity for wellness
- Recovery encompasses all phases of care
- Entire systems to support recovery
- Input at every level
- Recovery-based outcome measures
- New nomenclature
- System wide training culturally diverse, relevant and competent services
- Consumers review funding
- Commitment to Peer Support and to Consumer-Operated services
- Participation on Boards, Committees, and other decision-making bodies
- Financial support for consumer involvement

Recovery Core Values

Participation

- No wrong door
- Entry at any time
- Choice is respected
- Right to participate
- Person defines goals

Programming

Individually tailored care
Culturally competent care
Staff know resources

Funding-Operations

- No outcomes, no income
- Person selects provider
- Protection from undue influence
- Providers don't oversee themselves
- Providers compete for business

What Funder Wants

- Satisfied “customers,” get “better”
- Person centered vs. agency centered care
- Good “brand recognition”
- An effective care system with face validity
- Outcomes understandable to their funders
- Flexible, innovative and dynamic system
- High Value service, Value = Quality/Cost

THE FISCAL REALITIES OF

2008

2009?

2010?

Funder? What else?

- Maximize existing service capacity
- Identify “savings” from repeated crisis and acute care services with limited sustained benefit
- Maintain data tracking-decision system
- Reinvest savings into recovery support and clinical services that promote sustained stability in “recovery zone”
- Recognize providers with high Value services

Quality – The Driving Force in Creating a Recovery-Oriented System of Services

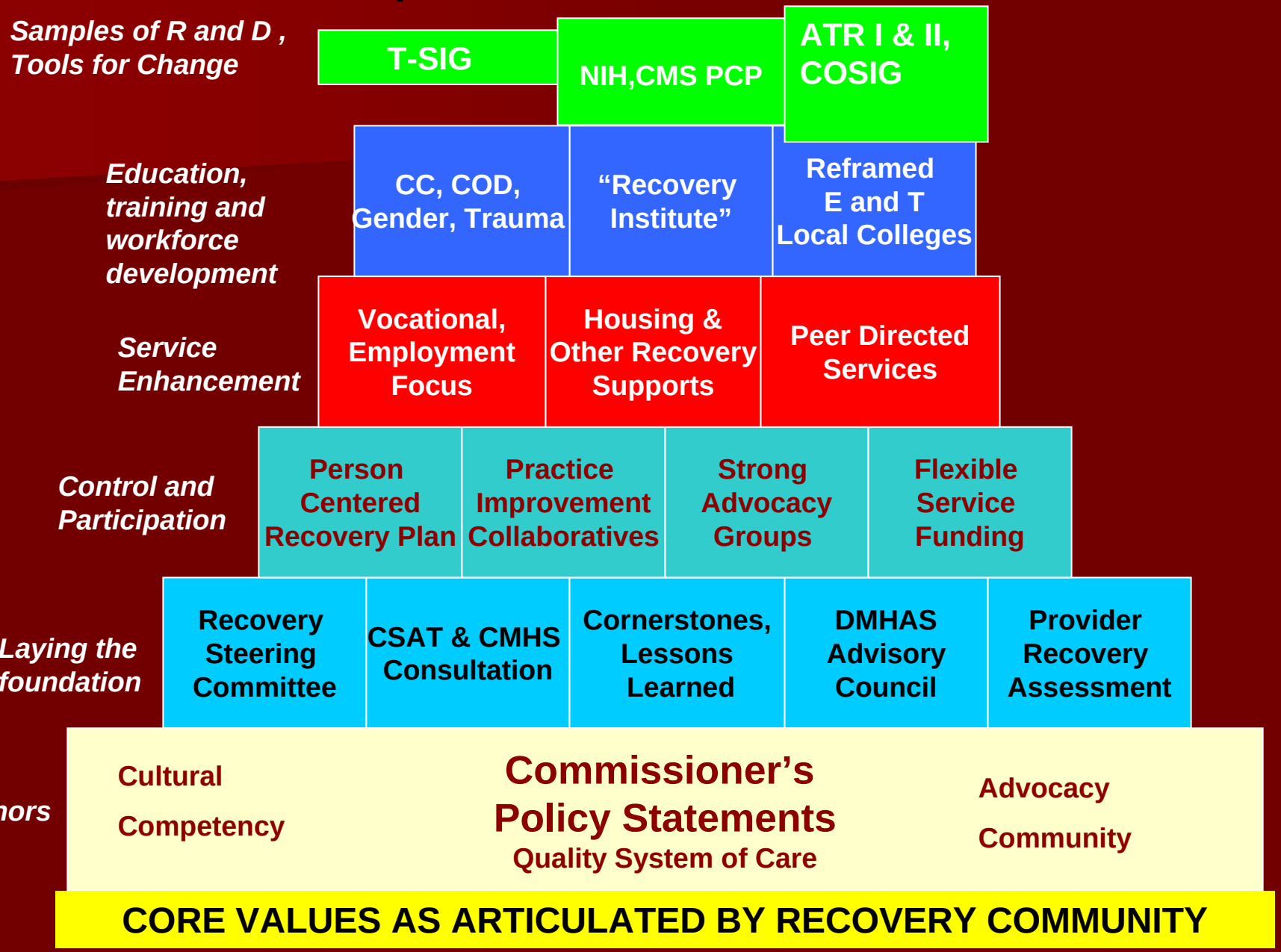
Increased attention to:

- **gender**
- **culture**
- **trauma**
- **co-occurring disorders**

Why?

To improve the effectiveness of care.

CT Implementation Process



Commissioner's Policy #83: **Promoting a Recovery-Oriented Service System (2002)**

- **Provides recovery vision for the system**
- **Establishes recovery and quality as overarching system goals**
- **Recovery – a process, not an event**
- **Emphasizes person centered, strength approach**
- **Guides policy and planning efforts**
- **Encourage hope and emphasize respect**
- **Highlights importance of meaningful community membership**

POLICY CONTINUED

- **“Embed the language, spirit and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who entrust us with their care”**
- **Being Reviewed and Updated by Multi-stakeholder group, Due July 2008**

Some System Change Tools

- Policies – **set a tone: ROSS, CC, COD, IRP**
- Values – **Recovery Community Core Values**
- Infrastructure – **Data system, "Automated Recovery Plan", "Recovery Mgt System," Home-grown Public Sector Managed Care Approach**
- Practice Requirements/Guides – **Provider Annual Recovery Assessment & Plan, Recovery-Oriented Practice Guidelines, Contract Language**
- Outcomes – **"Pilot" Measures, Consumer Survey**
- Finance Strategy – **Savings and Reinvest Model**

Manuscript available for download at:
www.**dmhas**.state.ct.us/documents/**practiceguidelines**.pdf

TOOLS AND RESOURCES

Practice Guidelines for Recovery-Oriented Behavioral Health Care

Connecticut Department of
Mental Health and Addiction Services

Practice Guidelines (138) (1st Edition, 2006)

Recovery Domains

1. Primacy of Participation (14)
2. Promoting Access and Engagement (13)
3. Ensuring Continuity of Care (15)
4. Employing Strengths-Based Assessment (17)
5. Offering Individualized Recovery Plan (27)
6. Functioning as Recovery Guide (16)
7. Community Mapping, Development, and Inclusion (8)
8. Identifying and Addressing Barriers to Recovery (28)

http://www.dmhas.state.ct.us/document/practiceguidelines.pdf

The Utility of Practice Guidelines

Guidelines can be a useful blueprint for desired change!

- **Promote increasing accountability among providers and system as a whole (*You'll know you're doing it when…)***
- **Provide a road-map for trainees/providers who WANT to make changes, but they feel un/under-prepared**
- **Assist in prioritizing state training & consultation objectives**
- **Educate clients and families re: what they can/should expect from supporters and the system at large**

System Change Tools
Recovery Support Services

Complementing the focus of treatment, outreach, engagement, and other strategies and interventions that assist people in establishing an environment supportive of recovery and in gaining the skills and resources needed to initiate and maintain recovery.

Yale PRCH

Treatment **Recovery Supports**

Aims of Recovery Support Services

- Remove personal and environmental obstacles to recovery (e.g., child care, transportation)
- Enhance access to & participation in the recovery community (e.g., connecting people to tx, 12-step and other mutual support / recovery-oriented groups)
- Enhance person's "recovery capital" (e.g., by assisting people with their basic needs, gaining employment, going to school, forming sober social relationships, etc.)
- Improve outreach and engagement through recovery coaching and mentoring

Recovery Support Services – ATR, GABHP

- Housing: Sober Housing, Recovery House, Independent
- Transportation – Peer service to & fro some tx setting, bus tokens
- Case Management – Recovery Guides, Coaches, Peers
- Employment services (from DOL certified employment provider)
- Basic needs (food, clothing, personal care items, utilities, etc.)
- Faith supports (individual mentoring/coaching and groups)
- Peer supports (same as above)
- Recovery clinical checkups
- Telephonic recovery support calls
- Voucher system for some of the above

GABHP – Must have received or is currently receiving clinical care

ATR – Can't require care; use case management/recovery coach to motivate/engage to care.

Sample RS Outcomes

- ATR – Effective outreach, 40% of 18,000 had no previous contact with DMHAS care system
- GABHP – 68% Connect to care post inpatient for those with RSS vs 38% without RSS
- Urban Initiative (housing) – 600% Decrease in ER visits, 375% decrease in detox days
- RS – 93% of 4,036 still in recovery one year later
- Recovery House – 69% Connect to care vs. 36% without Recovery House stay
- Supportive housing – 61% decrease in inpatient costs

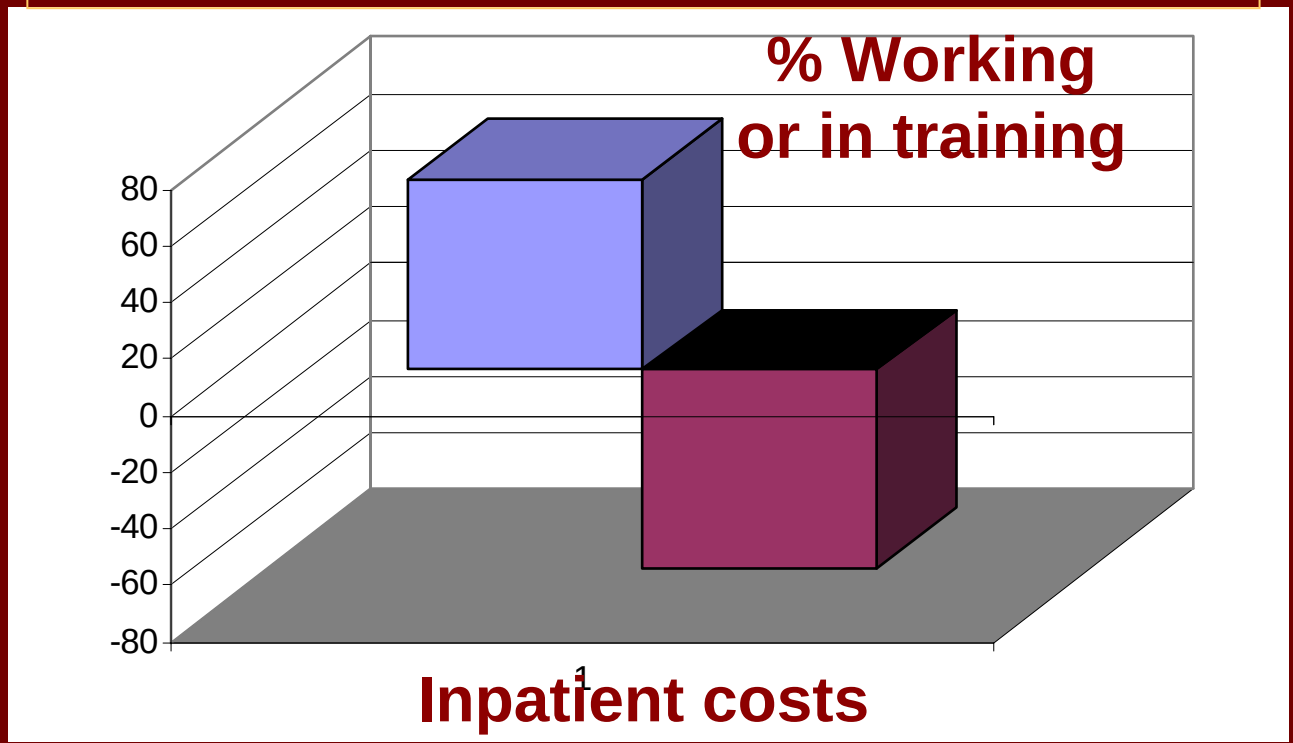
Systems Change & What Works: Lessons Learned

1. *Emphasizing community life and natural supports*
2. *Recognizing that people in recovery have valuable and useful contributions to make*
3. *Using multiple forms of "evidence" to guide policy*
4. *Using a combination of approaches to address cultural needs and elimination of health disparities*
5. *Establishing clear service expectations for providers and monitoring outcomes*
6. *Using "Practice Management Tools"adapted from the private sector to improve outcomes for people using public sector services*

Lesson 1

Focus on community life and natural supports – Example: Supported Housing and Employment

More people working, less inpatient costs



DMHAS established new supportive housing units for over 550 people with psychiatric or substance use disorders. OVER 60% OF THESE PEOPLE ARE NOW WORKING OR IN TRAINING, and their INPATIENT COSTS have DECREASED 70%.

Based on a Corporation for Supportive Housing study, these supportive housing units are projected to generate over $140 million in direct and indirect economic benefits for the state.

Financing Strategies

- "SAVINGS REINVESTMENT"- **Use "acute care savings" from existing Fee for Service funding for new admissions into existing service capacity, support new clinical levels of care, e.g., intensive outpatient co-occurring care or for recovery support services, e.g. Recovery Houses, Recovery Checkups, Peer Coaches**
- EXTERNAL, FEDERAL AND OTHER GRANTS – **Funds "research and development." Use lessons learned and funds to reframe existing funding allocations & services**
- FUNDING PARTNERSHIPS – **criminal justice and child welfare systems, private non-profits, academic communities, person in recovery community**

CCAR* Recovery Community Center

Recovery on Main Street

From "Heroin Town" to "Recovery Town"

Family Support Group

Spirituality and Recovery Meeting

Resources and Navigation

Recovery Asset Mapping Project

Generic Recovery Support Group

Assertive Telephone Follow up

*CCAR: Connecticut Community for Addiction Recovery

Value-driven Strategy – Improved Care, Better Value
OATP 4/01 – now (2000+ cases)

ADVANCED BEHAVIORAL HEALTH

Connecticut DMHAS
Department of Mental Health and Addiction Services
A Healthcare Service Agency

OATP
(Opioid Agonist Treatment Protocol)

Connecticut's program of alternative treatment opportunities for opiate-addicted persons who use residential detoxification programs over and over.

- Identification
- Education/Information
- Access
- Opioid Agonist Treatment
- Ancillary Treatment
- Support Services

Motivational Interviewing

Co-occurring Disorders

Recovery

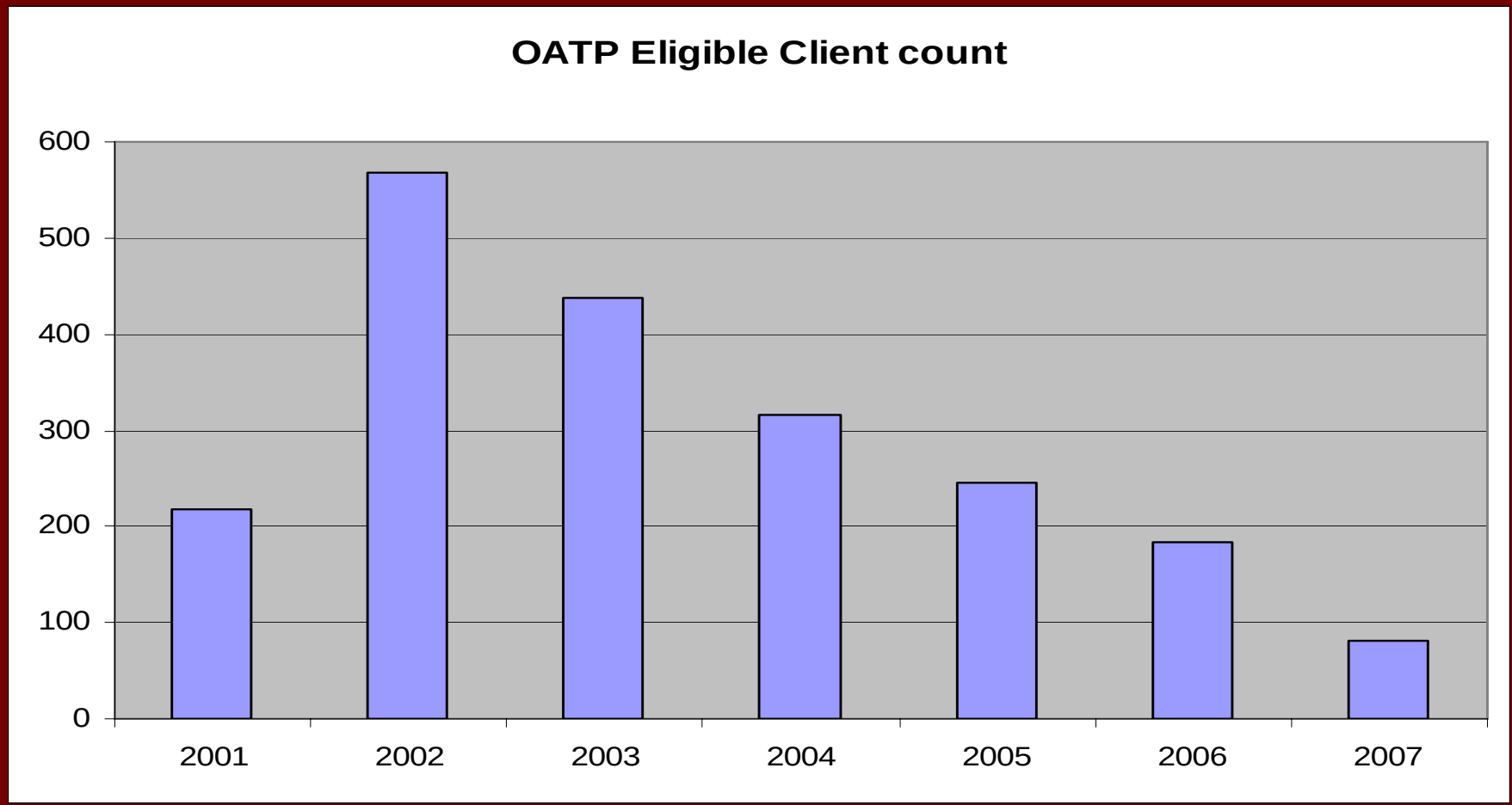
Cultural Competence

Trauma

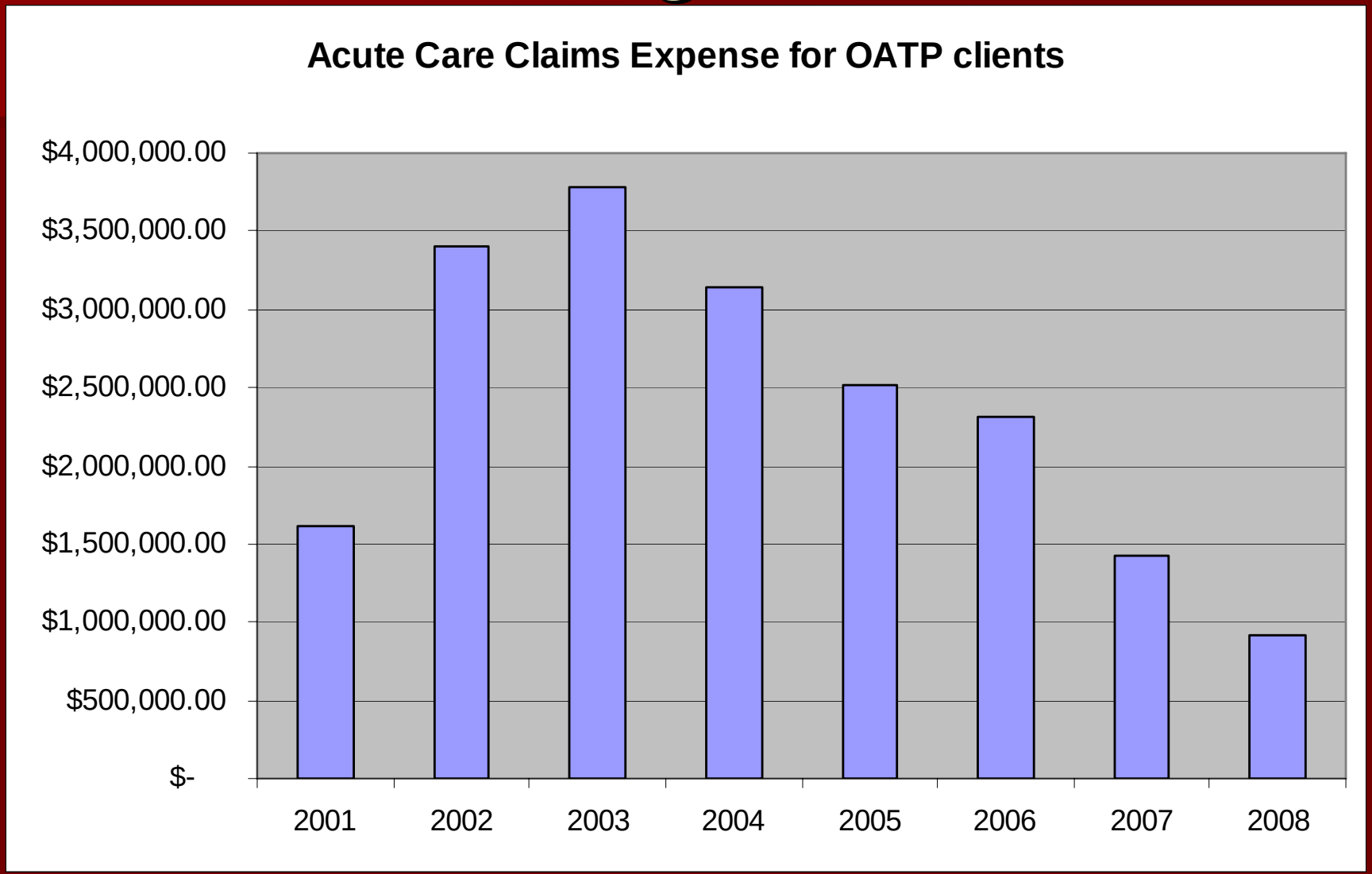
Service Coordination

OATP

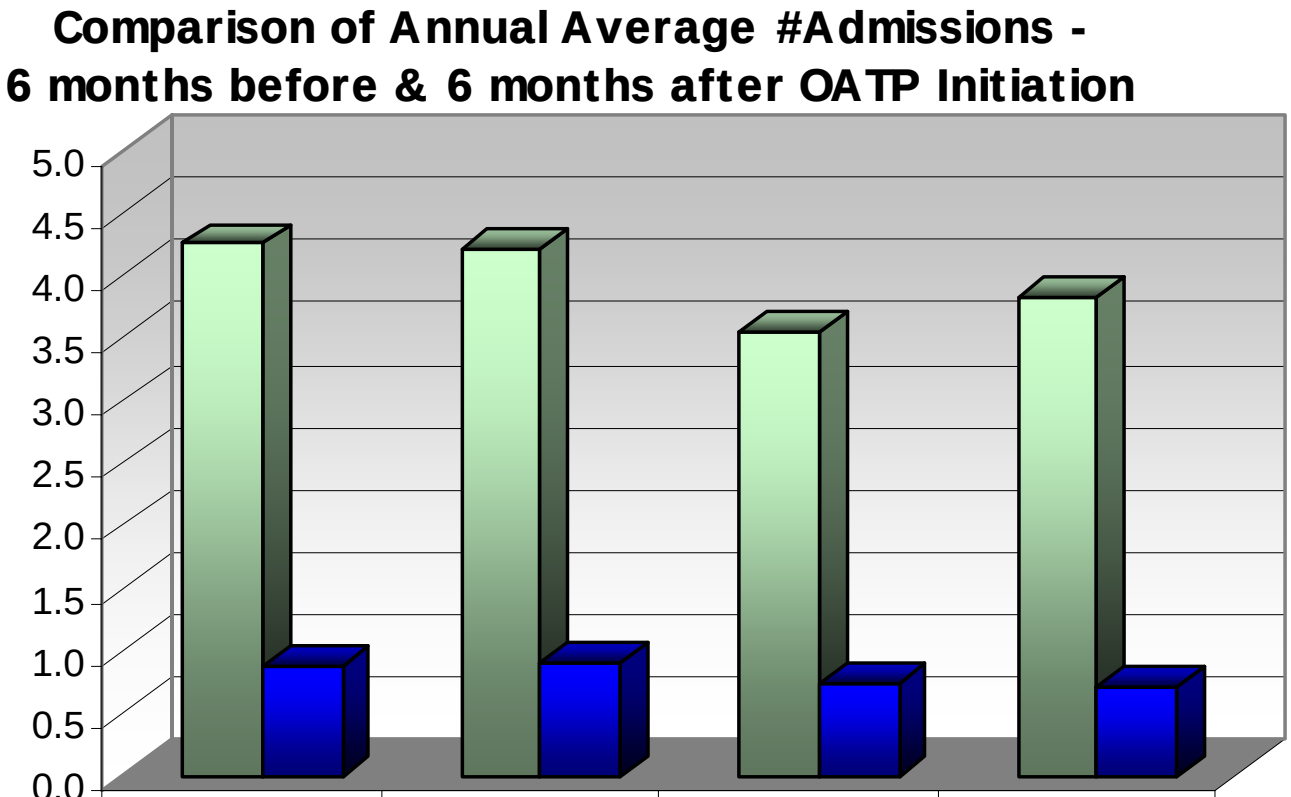
OATP Client Participants (2,000+ since April 2001)



Better Care, Resource Management

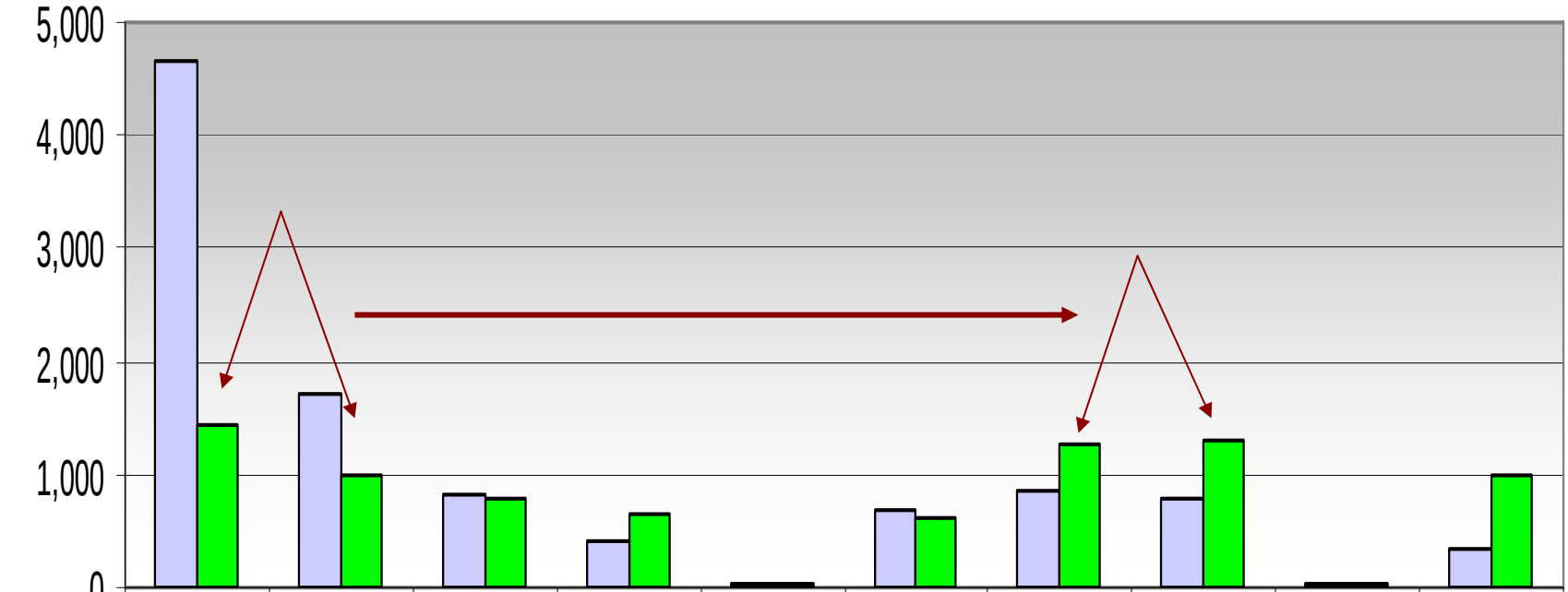


OATP – Pre-Post Admission Analysis



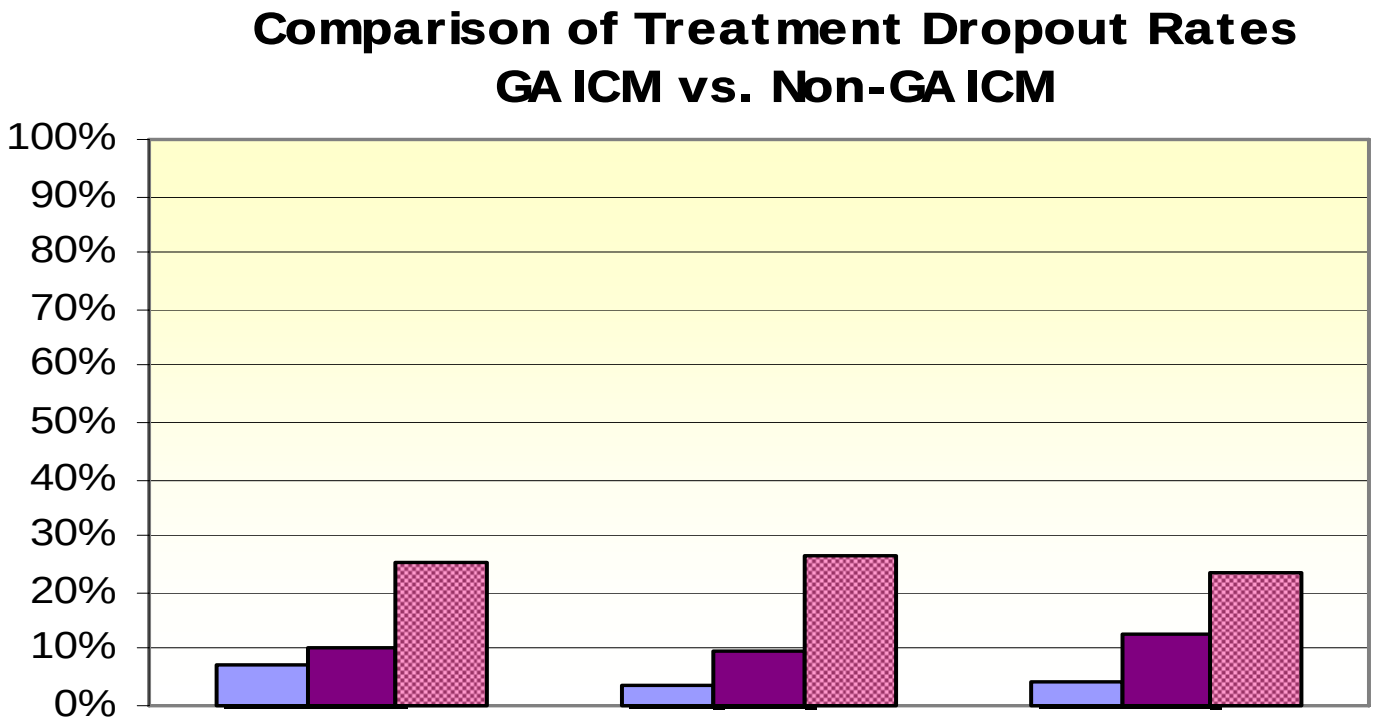
	End 9/30/04	End 9/30/05	End 9/30/06	End 9/30/07
6 Mos Prior	4.3	4.2	3.5	3.8
6 Mos After	0.9	0.9	0.7	0.7

Reallocation of Resources through Intensive Case Management (Recovery Specialists) N= 2185 Clients



	Inpt & Res Detox	Inpt MH	Inten Res	Long Term Res	Respite/ Obs Bed	PHP	IOP	OP	Ambi Detox	MethMaint/ MethDetox
BEFORE	4,644	1,721	834	413	50	676	869	801	24	329
AFTER	1,441	1,000	794	646	39	610	1,274	1,313	19	981

Cutting Treatment Drop-Out by More Than Half



	Feb-06	Feb-07	Feb-08
GA ICM HU	7.14%	3.42%	4.44%
NON-GA ICM HU	10.34%	9.77%	12.47%
SAGA w/o CM	25.39%	26.80%	23.38%

Sample Specialized Continuing Care, Long Term Recovery Management Service System Outcome Measures

- Overall Rate of Growth of Costs
- Percent of total costs for each LOC
- Access, Retention and Drop out indices
- Percent of Total Client Admissions into Each LOC
- Ratings on All or Specific Individual Practice Guideline Domains
- Percent of First Time Admissions within Existing System Capacity
- Pre/Post Recovery Support Service Cost and Service Comparisons
- Rate of Connecting to Lower Level of Care (LOC) – 7, 14, 30, 90 days from acute care episode
- Rate of Readmissions – to Same or a Higher LOC Acute Care within "x" Days of Discharge from a Detox, Inpatient or Acute Care Service
- Consumer Survey Results: Access, Appropriateness, General Satisfaction, Outcomes, Recovery, Participation in Tx, Respect

New/Cont'd Financing Strategies

- "Bundled Service Rates" – Currently under study based on analyses of several years of service data and outcomes for overall system and individuals in care.

- New state funding capitalizing on "brand recognition," need assessment data, and "Business Plan"

- Rate of Growth Controls - Capitalize on success in controlling growth of expenditures yet with more services, people served, lower overall costs/person, and more persons in "Recovery Zone."

- Value Index – Value = Quality Measure/Cost

Practice Guidelines for Recovery-Oriented Behavioral Healthcare, 2nd Edition June 2008 "Connecting The Dots"

Practice Guideline Domains
Now Linked to IOM Healthcare Measures And Gender, Culture, Co-Occurring and Trauma Guidelines

Recovery Oriented Care is:

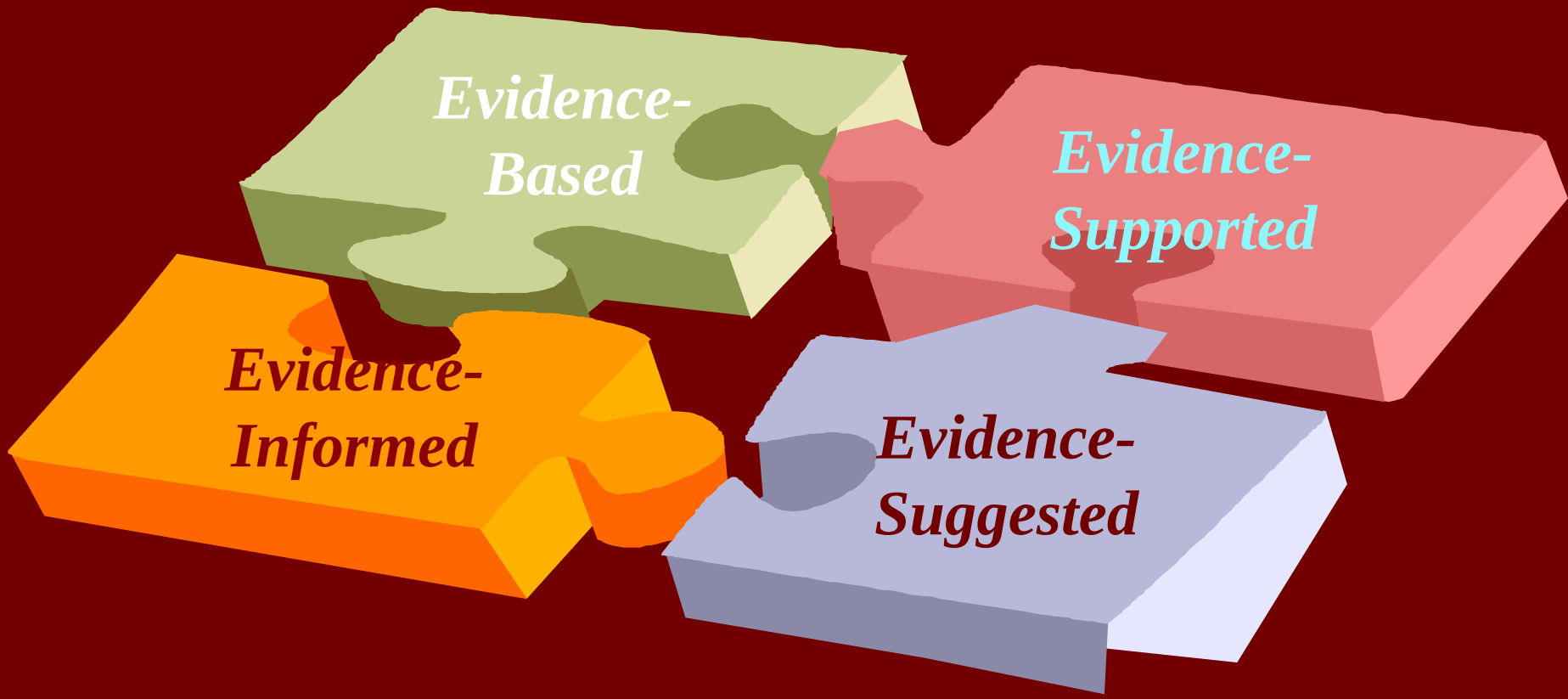
- Person and family driven
- Timely and responsive
- Person-centered
- Effective, efficient and equitable
- Trustworthy and safe
- Maximizes use of natural supports and recovery

The Continuing Goal?
Key Question for a State Agency Service Provider and Funder

An Evidenced…Continuing Care, Long Term Recovery Management Service and Delivery SYSTEM

What's the best "full" package, for whom, how delivered and when?

Not all best practices are evidence-based practices



Evidence-Informed

- Evidence of the effectiveness is inferred based on limited supporting data, or based on data from replication of an EBP modified or adapted to meet the needs of a specific population.
- Data is fed back into the system. New interventions are developed, traditional ones are modified, and ineffective interventions are eliminated.
- Provides a template/framework for other systems to modify their programs and interventions.

Ingredients for an Evidenced … Long Term Recovery Management System? What Else?

Strong Recovery Community Relationships

Data-Driven Decision Making

Person/Family Centered

Expanded Care Continuum

Dynamic Service Innovation Approach

"Best" Practices Tied to Episode of Care Model

Many Recovery Support and Peer Directed or Support Services

Local/Regional Service Collaboratives

Finance Reinvestment Strategies

Challenges Along The Way

- Redesigning in mid air
- Client Empowerment – Staff Reaction
- Hit the Wall…the plateaus
- “I’ve been wrong all these years”
- Advocacy…Chasing Windmills
- Too Complicated
- Project Du Jour. And I’ll Be Out of Business
- Buy in…Staff – you never asked me
- Who made you recovery champion?

Policy, Operational Or Planning Challenges

- Define “Episode of Care” in new way, e.g., service bundles
- Design Bundled Combinations of Services and Rate Methodology
- Anticipate and Combat System “Relapse” due to State Fiscal Climate
- Don’t Focus so Much on Continued Care That Neglect Early Identification, Intervention and primary care linkages
- Assess applicability and transfer to service system of findings from

  Ct’s NIDA Clinical Trials Node
- Talk about Spending Differently, Not Spending More or Less

CHALLENGES/OPPORTUNITIES

- New partnerships for employment, economic development, community asset mapping
- Wellness rather than disease and disability
- A larger “choir” for the field
- Our field is truly ***RELEVANT***
- ***People are respected, have hope, recovery, renewed lives***

Take Home Messages

- ***Creating a continuing care, long term recovery management service system is a marathon and requires system changes at all*** **levels…it's like redesigning a plane in the air**

- ***Maintain a sense of urgency for continuing care paradigm shift***

- ***Non-traditional or recovery-support services help people get better, must be matched with one's individual path to recovery and are efficient and effective per se and as ADJUNCTS to tx***

- ***Performance and outcome metrics for such a system, for state agency providers or funders, are not the traditional ones and require a well communicated "healthcare business plan" strategy***

"THANK YOU FOR THE CASSEROLE"

Thank You!

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“STARSHIP DMHAS”

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