Welcome and Meeting Information

- WebEx participants are muted
  - Please use Q&A feature for questions
  - Please use chat feature for technical issues

- Focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmas.virginia.gov/#/ARTS

- We are unable to offer CEUs for this webinar series
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DISCLAIMER

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,836,765 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey.

• Your name and contact information will not be linked to your survey responses.
• Your decision to complete the survey is completely voluntary.
• When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
• You are able to complete one pre and post survey per each webinar topic you attend.
• Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Naloxone Resources

• Get trained now on naloxone distribution
  ▪ REVIVE! Online training provided by DBHDS every Wednesday
  ▪ [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    ▪ Register and enter your zip code to access free online training

• Medicaid provides naloxone to members at no cost and without prior authorization!
• Call your pharmacy before you go to pick it up!

• Getting naloxone via mail
  ▪ Contact the Chris Atwood Foundation
  ▪ [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
  ▪ Available only to Virginia residents, intramuscular administration
Website Update

DMAS Home Page: https://www.dmas.virginia.gov/#/index
ARTS Home Page: https://www.dmas.virginia.gov/#/arts
SUPPORT Act Grant Website - https://www.dmas.virginia.gov/#/artssupport
• The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
• We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
• The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
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ARTS Billing Questions
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I believe in using “Person-Centered language” as much as possible, thus:

- Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
- Not “Addiction,” but Substance Use Disorder (SUD)
- Not “Clean,” but In Recovery or Testing Negative
- Not “Dirty,” but Testing Positive

At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms

Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)
TWO IMPORTANT THINGS YOU MUST DO BEFORE WORKING WITH ANY CLIENT

I. You must care! You must like people in general regardless of their circumstances, behaviors or opinions of you.

II. Find something to like in the person you are working with—connect with them on a human level.
NO ONE sets out to become addicted to chemicals or behaviors.
Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019
RECOVERY DEFINED

“…A lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in an ongoing quest for a better life.”

(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)
MISCONCEPTIONS ABOUT PHARMACOTHERAPY (VELANDER, 2018, P. 25 – 27)

1. Suboxone [and methadone] just substitutes one drug for another
2. Pharmacotherapy is a “failure of willpower” or “giving up”
3. Pharmacotherapy is incompatible with 12-step groups like Alcoholics Anonymous and Narcotics Anonymous
4. Patients can get “high” or “loaded” on Suboxone
5. Patients will just sell their medication
CARE COORDINATION DEFINED

A coordinated approach to the delivery of health, substance use disorder, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals.

(CSAT, 2000, p. xiii)
WHY IS CARE COORDINATION SO IMPORTANT IN SUD TREATMENT
(CSAT, 2000, P. XIII)

1. Retention in treatment is associated with better outcomes, and a principal goal of care coordination is to keep clients engaged in treatment and moving toward recovery.

2. Treatment may be more likely to succeed when a client’s other problems are addressed concurrently with substance use.

3. Comprehensive SUD treatment often requires that clients move to different levels of care or systems; case coordination facilitates such movement.
CARE COORDINATION IS ALL ABOUT BALANCE
WHAT IS **NOT** CARE COORDINATION
NOT CARE COORDINATION

1. SBIRT
2. “Here’s a list of resources, have a nice day”
3. “I’ll do it for you”
4. “You have to do this”
5. Care coordination as therapy
SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)

• **Screening:** A healthcare professional assesses a member for risky substance use behaviors using standardized screening tools
  - This can occur in any healthcare setting
  - Positive screening results can indicate the need for further assessment or a brief intervention by a professional

• **Brief Intervention:** A healthcare professional engages a member showing risky substance use behaviors in a short conversation, providing feedback and advice

• **Referral to Treatment:** A healthcare professional provides a referral to brief therapy or additional treatment to members who screen in need of additional services
RELATIONSHIP BETWEEN SBIRT & CARE COORDINATION

• SBIRT is important to first screen out those clients who clearly do not have a SUD, while funneling those clients who may have a SUD for assessment and possible treatment

• SBIRT is sometimes confused with Care Coordination but they are different
  • Think of SBIRT as the “first touch” of a client with a healthcare system that could lead to SUD treatment—this is usually a singular event
  • Care Coordination starts during the assessment (during any of the ASAM levels of care)—this is an ongoing process and is especially important as the client moves through the levels of SUD treatment
“HERE’S A LIST OF RESOURCES, HAVE A GOOD DAY!”

- Care coordinators need to be aware of up-to-date service availability in their communities, particularly services that are not available at their agencies.
- Simply handing a pre-printed list of services to a client is NOT care coordination.
- While having current lists of services can be helpful, good CC guides clients through services, facilitating contact when necessary and limiting barriers for clients.
“I’LL DO IT FOR YOU”

• Just as giving a piece of paper to someone is not Care Coordination, neither is doing everything for the client.

• Depending on their situation, clients should have at least some role in the coordination of their care.
  • However, there are times in which a CC needs to make connections with services on behalf of the client.
  • In this sense, the CC acts as a guide for the client in helping them navigate services.
“YOU HAVE TO DO THIS…”

• It is very important that Care Coordinators understand that recovery is person-centered and each individual determines what their recovery will look like.

• It is equally important that Care Coordinators understand that their views of SUD and recovery may not be the same as the client’s views—but the client is the one in charge of their recovery.
CARE COORDINATION AS THERAPY

• Good Care Coordinators listen when clients need to talk

• While they are perfectly situated to use motivational interviewing to help clients examine their motivations, CC itself is about helping clients engage in services they need to move forward in their recovery

• “The primary difference between case management and therapy is that the former stresses resource acquisition, while the latter focuses on facilitating intra- and interpersonal change” (CSAT, 2000, p. 3)
WHAT CARE COORDINATION IS
CARE COORDINATION FUNCTIONS

1. Assessment: What does the client need?
2. Planning: What do we need to do to meet the client’s needs?
3. Linkage: How can we help the client learn about and access needed resources?
4. Monitoring: How are things going?
5. Advocacy: How can we work with clients to reduce barriers to care?
CARE COORDINATION PRINCIPLES
(CSAT, 2000, P. 13 – 15)

1. Care coordination offers the client a single point of contact with the health and social services system
2. Care coordination is client-driven and driven by client need
3. Care coordination involves advocacy
4. Care coordination is community-based
5. Care coordination is pragmatic (entering treatment may not be as much of a priority as finding shelter)
6. Care coordination is anticipatory
7. Care coordination must be flexible
8. Care coordination is culturally sensitive
CARE COORDINATION

• The primary goal of care coordination is to help clients connect with services and resources that enhance their recovery

• CC starts by understanding the client’s Recovery Capital
Personal Recovery Capital: The client’s physical health, emotional supports and things that support recovery (housing, income, insurance, food, safety)

Family/Social Recovery Capital: The resources and support available to the client from their family and friends (emotional, financial, help with childcare, transportation)

Community Recovery Capital: Resources available in the client’s community (healthcare, childcare, transportation, housing, etc.)
Once you and the client have identified the recovery capital the client has access to, we then need to determine what the client needs.
Physiological needs: food, water, warmth, rest

Safety needs: security, safety

Belongingness and love needs: intimate relationships, friends

Esteem needs: prestige and feeling of accomplishment

Self-actualization: achieving one's full potential, including creative activities

Self-fulfillment needs
CARE COORDINATION: BASIC NEEDS

• Medical treatment of chronic or acute illness or injury, including pharmacotherapy for opioid use disorder
• Referral to shelter/services for people who are victims of inter-partner violence
• Housing or shelter
• Obtaining food vouchers
• Clothing
• Access food pantries
• Transportation
• Childcare
• Dental care
• Meeting legal system obligations (coordinate with probation/parole)
• Legal aid
CARE COORDINATION: PSYCHOLOGICAL NEEDS

- Job search
- Enrolling in job training
- Immigration needs
- Mental/behavioral/counseling health needs (non-acute)
- Medical appointments
- Obtaining health insurance
- Financial assistance
- Enrolling children in school
CARE COORDINATION: SELF-FULFILLMENT NEEDS

- Engage in continuing education
- Engage in spiritual or religious practices
- Identify recreational opportunities
- Examine ways to express oneself
- Establish healthy relationships
- Find ways to serve others
CARE COORDINATORS & CLIENT TRANSITIONS IN CARE

SUD treatment usually progresses through different levels of care

• Care coordinators are indispensable in helping clients move from one level of care to another, particularly in situations where this transition involves more than one agency (see ASAM levels of Care: next slide)

• Care coordinators are a key part of the Hub & Spoke model of service delivery (see slide 40)
<table>
<thead>
<tr>
<th>Level of Care</th>
<th>ASAM LEVELS OF CARE: Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)</td>
</tr>
<tr>
<td>1.0</td>
<td>Outpatient Services (fewer than 6 hours per week): Includes OTPs, OBOTs, Individual, family and/or group counseling</td>
</tr>
<tr>
<td>2.0</td>
<td>Intensive Outpatient Services [IOP] (minimum of 3 hours per day; 6 – 19 hours per week). Typically group counseling, with some individual counseling</td>
</tr>
<tr>
<td>2.5</td>
<td>Partial Hospitalization Services (minimum of 5 hours per day; 20 or more hours per week). Similar services to IOP</td>
</tr>
<tr>
<td>3.0</td>
<td>Residential/Inpatient Services. Usually about 30 days, and with varying levels of intensity and interaction with the outside community</td>
</tr>
<tr>
<td>4.0</td>
<td>Medically Managed Intensive Inpatient Services. Acute care settings for medically directed withdrawal management and related treatment</td>
</tr>
</tbody>
</table>
HUB & SPOKE MODEL OF SERVICE DELIVERY
ADDITIONAL CARE COORDINATION NEEDS (CSAT, 2000, P. XIV)

• Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits

• Understanding diverse cultures (and groups) and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice

• Understanding the value of an interdisciplinary approach to addiction treatment
REFERENCES


REFERENCES


