Bureau of Substance Abuse & Addiction Services
ROSC Policy-Financial Survey Results

Responder	Obstacles	Current Favorable Policies/Practices	Recommended Policies/Practices	Financial Support	Other Suggestions
	Eliminate "double-dipping" for assessments. While this practice does not seem as prevalent as it used to be, the more assessment data can be shared and utilized across disciplines is a practice that should continue to be strongly supported.	That anyone who has a CCJP (usually District Court Probation Officers) and conducts assessments - that those assessments are recognized as valid with respect to diagnosis and recommended level of intervention.	See the above answers.		
	1) Inflexibility with regard to licensing regulations (e.g. unwilling to license providers to utilize H0014 Ambulatory Detox) when a modification of those rules would permit enhanced services. Some federal and state regulations will need to be modified. Licensing rules may need to change. **2)** Community/Provider Agency (professionals) "buy-in" to the principles and features of a ROSC environment **3)** Lack of unified clarity surrounding ROSC itself among state and regional/local entities. **4)** Data will need to be captured differently. **5)** Weaving prevention terminology (and services) into the ROSC model.	**1)** State initiated change talk is a very favorable practice. Many groups at many levels are discussing ROSC. **2)** Licensing rules that include the expanded service array, Medicaid allows the service array to be billed. **3)** Some treatment agencies have been doing similar work using Stages of Change.	**1)** MDCH could open up currently unaccepted service codes such that they might better be used to facilitate momentum through the exploration of "test cases." **2)** Integrated funding streams would help facilitate the same at local levels. **3)** Training policy for Recovery Specialists. **4)** Development of a funding process that recognizes the creative process -- there is a need for flexibility; including some unsuccessful attempts, without losing staffing support dollars.	**1)** Allow for payment of buprenorphine (Suboxone) medication for block grant clients as studies show that medication-assisted treatment for opioids works better than traditional detox followed by outpatient services. **2)** Use set-aside funds for each CA to allow CAs to try new combinations of service codes (open up service codes heretofore not allowed) so they can test what would be the best combinations for better individualized services. Let some CAs choose a specific pilot or demonstration project based on narrative submission request. **3)** Invest time in grant writing at CA/provider level	Do not lose prevention as we move to ROSC. If we change the language from treatment outcome focus to health/wellness language, prevention does play a role.
	1) Ability to bill for peer services under Medicaid as there isn't a certification for this yet. **2)** Clarify agency licensing requirement for peer and case management services and allow SARF to provide these as well.	Human Services Coordinating Body could be used to spread ROSC message and concepts. Their Executive Board could drive new policies and practices.	Encourage coalitions to actively recruit recovering individuals. Our coalitions attempt to have all 12 sectors represented so we might ask them to include this 13th sector (people in recovery).	We should not have a minimum spending requirement. It should be handled like previous priority areas (i.e., case management). BSAAS might want to provide grant proposals for entire system, so all CAs can continue to expand ROSC locally.	This survey was difficult to answer because ROSC is not well defined at this point in time.
	The culture of control especially in residential treatment programs makes it very difficult to inculcate a recovery framework.	Cross system collaboration, as evidenced in this ROSC effort.	Revamp and beef up the rights system.	I don't have the experience base to intelligently comment on this.	Not right now.

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	1) The local procurement of services via the bid process pits providers against one another. It seems that the providers are all competing for the same limited dollars which may create obstacles. I think who the lead agency will be could be a barrier, in that the system implementation may be more dictated than a collaborative process. **2)** In our area there is currently not a billable code for peer recovery specialists which seems key to implementing ROSC. **3)** Currently a client has to be admitted and discharged at each level of care. This opening and closing of records seems to send the wrong message that one is somehow done with treatment. **4)** The current power structure presents a barrier to people in recovery in that there is no MEANINGFUL role for their input at all levels care including policy and administrative. **5)** Current members of the provider network do not utilize the same and/or similar and complementary electronic record systems. Not having a unified records management system results in consumers being required to complete extensive intake procedures and provide duplicate information at each point of service. Current practice of reporting and coordinating consumer information is labor intensive.	**1)** Our new EMR allows for SUD and MH to communicate/collaborate more easily, which will help with keeping track of consumers. There have been communication improvements between SUD residential providers and ACT/IDDT providers for mutual consumers. **2)** Current practices of case coordination and provision of after care services has promoted provider interaction and set the stage for standardization of assessment and record keeping policies.	**1)** Local CAs should be required to provide services through a Continuum of Care whereas providers would have to collaborate in the provision and coordination of services. **2)** Implementation of a standardized electronic record would promote a 'no wrong door' practice of system access that allows consumers to initialize services directly through any member of the network of providers. **3)** The standardization of screening and assessment protocols through a shared electronic record would reduce the level of redundancy in information gathered and develop synergy in treatment provisions.	**1)** Yes I think there should be set-aside funds targeted at areas that are in the contemplation or preparation stages of moving towards a ROSC. Setting aside funding for pilot projects would improve the likelihood of building workable electronic systems that could then be replicated throughout the state. **2)** We should look at program provider consolidation and administration consolidations and the modification of Access Assessment Services to a no wrong door policy via a Continuum of Care for more financial and access efficiencies. **3)** Increased coordination between the state and provider networks to seek and apply for grant funding to promote the development and improvement of electronic records management systems. Current funding is available for those that promote the improved collection of baseline data and outcome measurements.	

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	Our comments are a collection of thoughts by various team members at Network180. Not all comments will necessarily be consistent with each other. - Mark Witte, Network180 • If you believe (as we do) that a Recovery Oriented System of Care involves the work of aligning all community systems and services that are needed to assist individuals, families and communities to achieve and sustain recovery for a person with a substance use disorder, then the most significant obstacle (apart from funding, which is in fact an obstacle – despite your instructions to the contrary) is the lack of a relationship (let alone alignment) within DCH relative to mental health services. There is no imperative within the very system controlled and managed by DCH to spend any time or energy on working to accommodate persons with SUD. • Fee for service funding – too risky for start up of new "ROSC like" programs. • Reporting rules such as the requirement that clients be discharged after a period of no contact – not at all ROSC friendly because it doesn't support timelines of actual engagement efforts or continuous care. • The barriers at the state level that interfere with a reasonable level of cooperation, collaboration, and communication between BSAAS and DCH. • Anything that is a barrier to integrated treatment is a barrier to ROSC, this would include differences in rights, confidentiality, credentialing, all of which need attention, clarification. • There are no current credentials and formalized trainings for recovery coaches. • Recovery/sober houses do not have uniform standards or licensure which could help with quality issues. These homes encounter zoning obstacles when it comes to population density zoning rules, which makes it difficult for them to portray themselves as legitimate entities. • I would say it is lack of organization within the state in regards to including the DOC in the ROSC since they have treatment funds and their clients are our clients as well. This includes Office of Community Corrections funds and clients as well. Maybe DHS as well…better involvement.	• Local communities have incredible capacity to spring into action to achieve positive change, including local alignment (but again, only if supported by administrative structures at state and local levels). • There are organizations and community systems around most of the services that are needed by people in recovery. • We have experience at the local level in coalition development. • There are bright and motivated people ready and willing to work on this for almost nothing in order to help the field mature to its next shape.	• I think the large assortment of technical advisories that are all rolled up in our contracts are due for a rethink. Clarity with respect to peer supports and recovery coaches is very needed, but can't wait a year to be issued. We need to move Methadone into the ROSC framework. The most important thing that BSAAS can provide is central visible leadership; engaging the field to construct tools, policies, elements that help to change the game. Recovery housing needs to be brought into the fold. Licensing should be revised to both advance the needs of people and protect them from being mistreated. The state must provide a philosophical framework for what's needed, and facilitate the collection (as in this survey) of pieces that are needed to transition to ROSC. • Transformations cannot be mandated, they require a solid foundation based on partnerships, shared vision and quality improvement. BSAAS needs to model this capacity in its interactions with all stakeholders, including DCH. • Transparency is key to building trust, so there needs to be clear communication about the barriers, successes along the way, so this includes the current issues with DCH. • Development of infrastructure (role description, training requirements, etc.) for Recovery Coaches. • Creation of the opportunity for people in recovery to organize at the state and local level. • Inclusion/utilization of existing work groups with ROSC like mission/vision such as the ITC and the Change Agent Leaders. • The addition of billing codes for recovery supports.	• I don't think that all changes require new funds. Robbing one part of your service array to pay for something else that's also desperately needed is a hard way to do business in the community. We need to spend our time and limited resources on getting everyone (and I mean everyone) familiar with the concepts that ROSC consists of and the actions that it implies for them. • Develop capacity within BSAAS to help CAs/providers with Medicaid billing for SUD - the growth in ROSC like programs can come from Medicaid for those CAs that are part of PIHPs. • Ask existing CAs to share the ROSC like programs they are currently doing that could be replicated in other CAs, why start all over? • Ask volunteers CAs to propose a plan/commitment for the redirection of funding to the development of a ROSC like service: **1)** A minimum/maximum percent of total funding could be required to be redirected. **2)** Clear ROSC like service criteria could be set by BSAAS. **3)** If funds are available, BSAAS could award funding to the top 3 proposals. • BSAAS may want to consider the reactivation of the "revolving loan" fund which helped recovery/sober homes with their startup expenses. • Set aside for pilots would be good…or set aside for pilots for all CAs to try new ROSC like activities. I don't think it helpful with minimum spending requirements since at some point all spending will be on ROSC like services.	

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	1) Perceived or real obstacle: Providers of substance use disorder services think that to receive reimbursement for services they have to provide the services in a clinical setting rather than in the person's home. In the mental health system the ACT teams often go to a person's home. A recovery oriented system of care allows for choice. **2)** Policies which allow for the person to be locked out of their residential setting if they use substances. This creates homelessness and is not recovery oriented.		A policy that would require residential providers to have a plan in place for housing/providing services to the people who use substances.		
	All encounters must have open, matching TEDS for those dates of service. Have two programs that have emerged that implemented peer services in the welcoming (Minkoff/Cline) model. Based on a pre-screen of individuals including their readiness level may indicate that an assessment is not warranted at that time and pre-treatment or peer services may be the better option to help motivate the individual. The length and type of data elements required for the TEDS admission are a barrier to the type of work being done at that level ; pre-treatment services (including peer interventions prior to admission, motivational groups, outreach) do not fit well into the TEDS Admission requirements either.	Expanded policies and codes for peer recovery services and early intervention.	Allow for certain codes to happen outside of the TEDS admission/discharge process such as peer recovery and early intervention.	Pilot projects would help to assist those that have started working on the ROSC model but would not assist in moving other areas along. Minimum spending requirements could be helpful if termed as spending targets for this year since some areas may not be as far along as others. System barriers should be addressed at the state level prior to setting minimum spending requirements otherwise it will be treatment as usual just called something else. BSAAS may want to consider funding set-aside funding open to all CAs that propose ROSC implementation models for FY 2011, prorated based upon number of months codes identified in the CA's ROSC plan are submitted (not on the number of encounters but the number of months encounters contain those ROSC identified codes). This would incentivize all CAs to get programs going as soon as possible.	

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	Since funding levels will not change, I think you should define the services available under a ROSC model in broad categories, assign a reimbursement rate to each category, distribute funds to CAs as always and then let providers decide which services each client should receive. The authorization process is an obstacle. The people doing the authorizations are not in touch with the changing client needs. ROSC must be flexible and creative and the authorization process works against this - services should be determined by providers. If you eliminate the authorization process you could put all that money towards client care. Cut down on redundant audits, reporting, paperwork etc. – it's killing the field.		Require all CAs/PHIPs to do things the same way. When a provider works in more than one region it's a nightmare to keep up with the varying requirements, contracts, rates, audits, software systems etc. Allow for flexibility of movement from service category to service category with need for prior authorization.	You should start by making sure each region receives funding on an equitable basis. Funds should then be made available to providers to be used flexibly as noted in item #1. Providers also need to be paid what it really costs to provide services. The bottom line is that none of this is going to work unless there is a large infusion of additional funding into the system. There might be some minor changes but if there's no additional funding providers will continue to provide the piece(s) of the ROSC pie they are currently providing with little change. If you spread the money too thinly providers will not be able to sustain the services programs currently in place. Also, fewer people will be served. Someone from DCH has to sell the value of SUD and MH services to the legislature - when you look at ROI it's really a no-brainer. Until this happens, I think all the time and effort put into developing a new system will be wasted.	

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	42 CFR Part 2	It's not updated to reflect current technology or coordinated health care practices.	The state would need to champion this at the federal level. Maybe with assistance of AMA?		
	Easy access to services		Issue clients a debit card for recovery services that they would swipe when they received certain services. Could use for transportation, housing, legal, caregiver assistance, etc. (What do you need to obtain recovery? And base amount on what we would spend on a client in a year of SA services) If services are in a standard range no involvement of case manager, but if it went out of standard range then case manager would contact the client to see what assistance they need. Case manager could control the funds on the debit card. Could extend from substance abuse access to mental health and eventually maybe even to medical. Data would be instantaneous. Goal would be to keep people connected. Could use navigators to assist. This is not a new concept--just using a debit card instead of a fiduciary controlling the money. Keep in the boundaries of the service plan.	Could do a pilot project for this. Would be better on local level--local case managers or use Access Center as the case manager. On local level, can work with local landlords, housing agencies, and other local agencies etc. in the pilot.	
	Current licensing rules don't accommodate ROSC		Allow community grant and liquor tax funds to be used without requiring licensed services or provide a separate pot of money.	If they fully implement the statewide allocation formula then yes, there could be a minimum spending requirement, but if not, then no minimum should be required.	
	PI data		Change standard to an 'outcome-based' standard because the current indicators are based on 'system' performance, and not on how successful the client's outcome was.		