RECOVERY MAINTENANCE SERVICES

AND **CHRONIC DISEASE CARE MANAGEMENT**

Supporting Self-Sustained, Community-Based Recovery

CHRONIC DISEASES. . . .

Chronic diseases are long-lasting conditions that usually can be controlled but not cured.

***Common features** of chronic disease include*:

- **complex causality**, with multiple factors leading to their onset
- a long **development period**, for which there may be no symptoms
- a **prolonged course of illness**, perhaps leading to other health complications
- associated **functional impairment or disability**.

People living with chronic illnesses *often must manage daily symptoms that affect their quality of life*, and experience acute health problems and complications that can shorten their life expectancy.

ADDICTION AS A CHRONIC DISEASE

Addiction is a **primary, chronic disease of brain reward, motivation, memory and related circuitry characterized by:**

- **Inability to consistently Abstain**;
- **Impairment in Behavioral control (frontal lobe dysfunction)**; accompanied by functional impairments or disability
- **Craving**;
- **Diminished recognition of significant problems**; and
- **Dysfunction in Emotional capacity and response**.

SIMILAR TO OTHER CHRONIC DISEASES, there is a Persistent Risk of Relapse

(ASAM, 2013)

RECOVERY IS THE GOAL. . .

"**Recovery from alcohol** and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life."

It is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:

- **Health—managing one's disease(s) or symptoms** and making informed, healthy choices that support physical and emotional well-being.
- **Home**—having a **stable and safe place to live**.
- **Purpose**—conducting **meaningful daily activities** and having the independence, income, and resources to participate in society.
- **Community**—having **relationships and social networks that provide support, friendship, love, and hope** (SAMHSA, 2015)

WHAT HAVE WE LEARNED ABOUT CHRONIC DISEASE MANAGEMENT. . .

Chronic diseases require:

- Prolonged and Active Management
- Strategic, sustained stewardship of Personal, Family, and Community Resources

Core Strategies *for achieving Long-Term Recovery include:*

- Maintaining ***person-centered care and engagement*** strategies
- Establishing and ***sustaining recovery support***;
- Facilitating easy access to ***early re-intervention***;
- Increasing access and ***connection to recovery resources***, natural and institutional, in the community and culture;
- ***Enhancing*** the quality of personal, family, and social ***functioning***

START WITH A RECOVERY ORIENTED SYSTEM OF CARE (ROSC)

A **coordinated network of community-based services** and supports that is **person-centered** and **builds on the strengths and resiliencies of individuals, families, and communities** to achieve **abstinence, improved health, wellness, and quality of life** for those with alcohol and/or drug problems.

A ROSC is a continuum of ***services designed to be accessible, welcoming, and easy to navigate****.*

A CONTINUUM OF SERVICES WITHIN LEVELS OF CARE

As a performance measure of quality, continuity of care focuses on the extent to which clients receive appropriate levels of care across the treatment continuum. . .A measure proposed by the National Committee for Quality Assurance states that "Continuity of Care" refers to the percent of individuals who receive AOD Services within 14 days following discharge from a detox, residential, or inpatient stay, or after an assessment for each type of service or level of care separately (NCQA, 2009)

TESTED INTERVENTIONS demonstrating improved outcomes for transitions in chronic disease care include:

- **Enhanced communications** between care providers to assure critical information follows the patient through the transition;
- **Support** in execution of the post-discharge plan; and,
- **Transitional Care Coordination** utilizing a transitional coach or coordinator who is involved in discharge planning and helps patients to take a more informed, active role in their transition
- **Evidence-Based Practices** applied in treatment and RS services.

(Project BOOST; John Hopkins Care Transitions Intervention Model: North Carolina IOM Substance Abuse Comprehensive System of Care Report)

The DMC Organized Delivery System (DMC-ODS), Recovery Services describe the service element critical to providing an effective, evidence-based transfer/transition process within the Recovery Oriented System of Care

DEVELOPING YOUR RECOVERY SERVICES (RS) PROGRAM

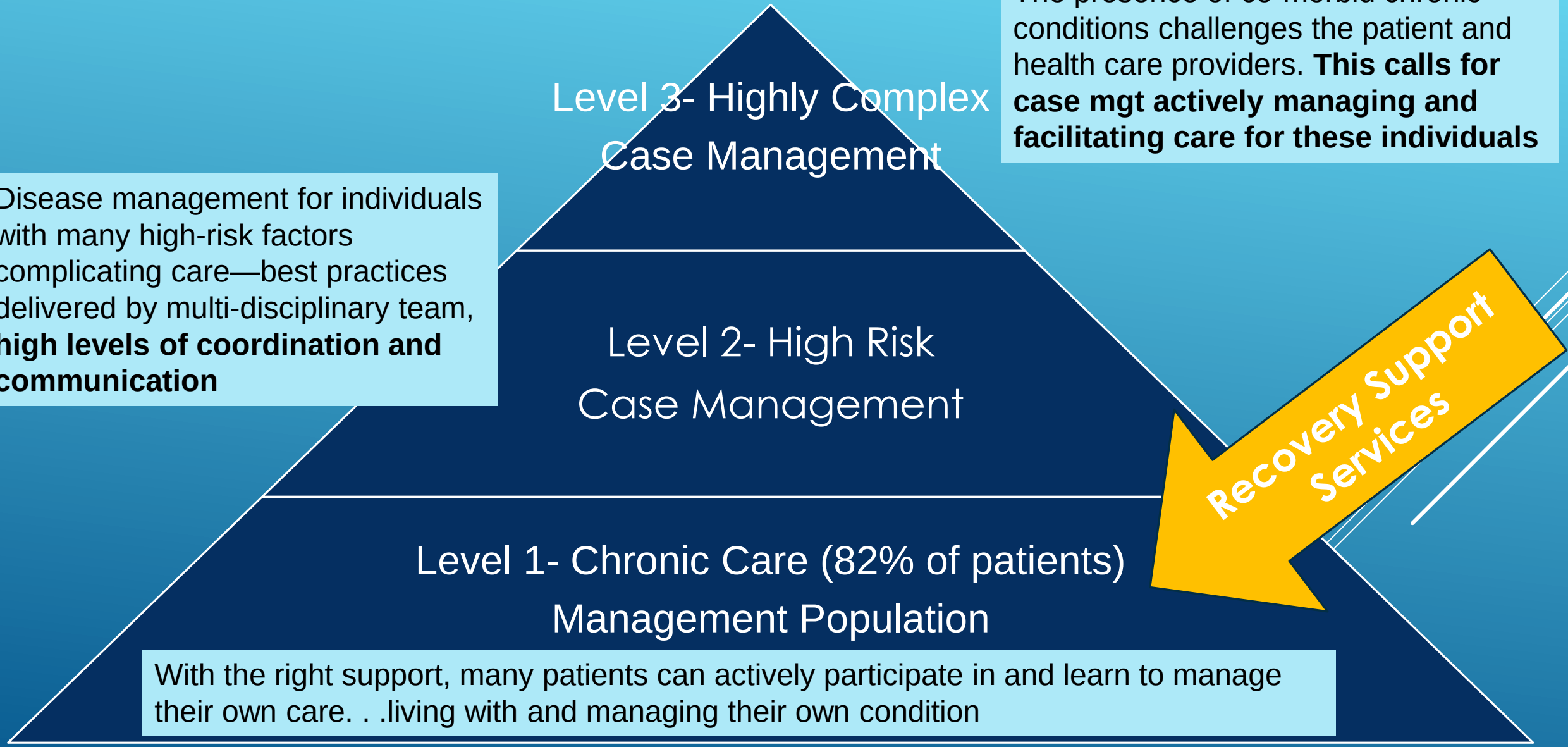
Become familiar with the DMC-ODS Waiver Rules for Recovery Services (sec. 138)

1. Beneficiaries may **access Recovery Services after** completing their course of **treatment**;
2. Services may be **provided face-to-face**, by **telephone or telehealth**, anywhere in the community;
3. Components include:
   a) **Recovery monitoring/coaching** (limited counseling)
   b) **Substance Abuse Assistance**: peer-to-peer services and relapse prevention
   c) **Linkages** to:
      - Education and job skills services
      - Family support services
      - Support groups
      - Ancillary services such as housing and transportation

WHAT DOES YOUR COUNTY PLAN APPROVE?

DECIDING THE RIGHT APPROACH TO MANAGE TRANSITIONS

The presence of co-morbid chronic conditions challenges the patient and health care providers. **This calls for case mgt actively managing and facilitating care for these individuals**



Disease management for individuals with many high-risk factors complicating care—best practices delivered by multi-disciplinary team, **high levels of coordination and communication**

With the right support, many patients can actively participate in and learn to manage their own care. . .living with and managing their own condition

1. DEVELOP YOUR PROGRAM AND PREPARE STAFF- INVOLVE THEM IN PROGRAM DEVELOPMENT AND TRAINING

Recovery Services are designed to emphasize the patient's central role in managing their own health and support their stable transition to a desired and appropriate level of care.

To function as mentors/coaches rather than counselors or assertive case managers, Staff will require training specific to:

- Maintaining a coach/mentor role
- Patient-centered continuing care planning
- Identifying and linking to community resources
- Applied Motivational and Trauma Informed Care strategies
- Use of telephone and telehealth technology

COACH/MENTOR ROLE IN RECOVERY SERVICES

Coach/Mentor	Counselor	Case Manager
Focus on current tasks and performance—tends toward present/future more than past A mentor is a wise and trusted guide and advisor Bias to improving performance or reaching greater heights Work in less structured environment—less formal Teamwork relationship	Counseling seeks to explore the underlying dynamics of individuals and their relationships—may have a greater focus on past goal for counseling is to promote self-understanding and self-acceptance Focus on problem(s) that, if uncorrected, may derail ability to succeed Patient-Therapist relationship	Like counseling, generally more structured in nature and meetings are scheduled on a regular basis Identifies, coordinates and monitors care services Ensures that care is provided in the most comprehensive and cost-effective manner for the individual and stakeholders

They all are helping professionals who create a positive, healing relationship and help patient achieve their goals

2. ASSERTIVE ENGAGEMENT

Recovery Services should be introduced at admit and supported throughout the treatment episode.

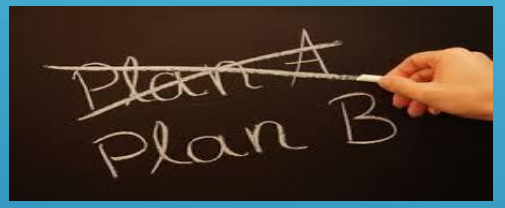
1. Introduce discharge planning and Recovery Services early. . .at the initial program orientation;
2. Include exposure to recovery support services and sustained community-based recovery during treatment; and,
3. Include Recovery Services Program Enrollment as a part of the discharge planning session

Eligible DMC-ODS clients receive a Discharge (DC) Planning Session within the 30 days prior to discharge. **The Discharge Plan becomes a part of RS Continuing Care Plan**

3. THE RECOVERY SERVICES PLAN

Recommended elements for a Recovery Support, Transitional Support Plan:

- **Patient-centered objectives** to be met during transition- these include continued action steps on unresolved treatment plan objectives; continuing support plan; and, linkages to needed resources (Extended Care Plan);
- **Status monitoring** plan- Include warning sign management and patient-centered objectives reviews
  - Face-to-face sessions
  - **Telephone/telehealth Contacts**
- **Assessments-** Plan for Level of Care (ASAM) **reassessment and rapid re-entry** into treatment (as required). Other assessments?



The idea (and challenge) is to keep the plan:

- *Reflecting strengths, Needs, and Preferences*
- *Extremely SMART. . .emphasis on the simple, manageable and flexible*

ASSESSMENT AND RS PLANNING

Each client should be assessed for continuing recovery strengths and needs and have a RMSP telehealth contact plan developed.

Tools used to develop the continuing recovery plan include:

- Information from the Enhanced Discharge Plan, ASAM rating, and The Stage of Recovery Questionnaire

Let's practice completing a Stage of Recovery Questionnaire. . . .

4. ENHANCED CARE COORDINATION

Enhanced Care Coordination uses a generalist, strength-based model of case management to build linkages to communities of recovery.:

- Coordinate post-treatment support services
- Enhance the post-treatment environment (build *Recovery Capital)*
- Collaborate to resolve barriers
- Coordinate re-admission to treatment as required

Strengths-based approaches concentrate on the inherent strengths of individuals, families, groups and organizations…."to focus on health and well-being is to embrace an asset-based approach where the goal is to promote the positive." (White, 2015)

ENHANCED CARE LINKAGES- CONNECTING TO COMMUNITY RECOVERY/WELLNESS RESOURCES

Recovery support focuses on the whole life rather that just the "disorder". This broad, integrated approach helps build RECOVERY CAPITAL:

Physical Capital- Tangible resources important to stability and wellbeing
- Employment; Housing; Transportation; Healthcare; Healthy diet

Social Capital- The pro-recovery social network
- Family; Church; Recovery Groups (A.A./N.A., etc.); Friends

Human Capital- Internal capacities and skills that help to sustain recovery
- Stress management; Pain management; Conflict resolution; Educational/vocational knowledge

It is the role of Recovery Support to coordinate access to resources and foster engagement

5. RECOVERY MONITORING AND SUPPORT

The goal of Recovery Services is to strengthen the bond between the individual, their recovery goals, and recovery resources. Frequent contact with monitoring and support are the primary tools used in this effort. Methods of contact include:

- ***Face-to-face***
- ***Telephone***
- ***Telehealth***

Increase and decrease the frequency, duration and intensity of check-ins and support based on each client's degree of problem severity and the depth of his or her recovery capital;

TELEPHONE/TELEHEALTH MONITORING AND SUPPORT

Phone contacts are regular and periodic with the frequency determined by the client's individual recovery needs. Telehealth calls :

- Provide encouragement, ongoing support and motivation toward the self-sustaining recovery goals established by the individual
- Give information and assistance in utilizing recovery assets Facilitate interventions and re-entry into treatment if required
    - Just "Check-in"

TYPES OF TELEHEALTH CALLS
THE "SCRIPTED CALL". . . .

Anna, this is John

Oh yeah, you're that Recovery coach guy!

So today I've got a few questions and some information to give you, is that okay?

…Sure, go ahead

TELEPHONE/TELEHEALTH MONITORING AND SUPPORT

Prepare

Primary ELEMENTS for a successful Telehealth Call. . .

1. **SET AN AGENDA-** The scripted call has an established agenda, content, and format/sequence for conducting the call. These calls are generally a prescribed assessment or information/ education oriented call
2. **INCLUDE A CHECK IN-** The “check in” for these calls is minimal, limited to checking if this is a good time for the call (does client have the time; is their status satisfactory)
3. **BRIDGE-** This bridge is generally a reminder that these types of calls would be included in support call menu (as discussed when they enrolled)
4. **SUMMARY-** Give a capsule summary of what was discussed during the call, include a quick check of the client’s perceptions

EFFECTIVE PRACTICES

Case Manager

Recovery support is a brief practice closely aligned with mentoring/coaching. . .when you put your counselor/case manager “hat” on think “I NEED TO ASSESS FOR TREATMENT NEEDS”

Counselor

Coach

Mentor

Best Practices follow those used in treatment. . .

- **MI**- Be aware that “self-determination” factors may challenge the “maintenance” stage of change. . .use FRAMES!
- **Problem Solving and Solution Focused techniques**
- **Trauma Informed Service**
- **Cognitive-Behavioral**

POST-TREATMENT CONTINUING CARE

More than Aftercare, Continuing Care is a facilitated group focused on continuing recovery and relapse prevention skills

Recovery App's are a useful way to extend support. . .

PARTING THOUGHTS. . . .

- ***The best single predictor of retention and dropout is the quality of therapeutic alliance established between the therapist and the client***. Retention rises in tandem with quality of therapeutic relationship. Rates of client retention for therapists vary dramatically (14-81% in one well-controlled study). Such differences exist even when patient characteristics (e.g., problem severity) and therapist backgrounds (e.g., education, recovery status, and years of experience) are controlled.

Studies in primary health care have found that health programs that utilize a patient self-management philosophy achieve superior outcomes and cost savings in the treatment of chronic illness. Such programs focus on enhancing the self-efficacy of the patient, improving problem solving skills, and empowering each patient as the expert on how self-management strategies can be refined to fit his or her own lifestyle.

Eight principles of patient-centered care highlighted in research conducted by the Picker Institute and Harvard Medical School