Report on the Detoxification Services Planning Process and Resulting Recommendations as per the Save Medicaid Access and Resources Together (SMART) Act Senate Bill 2840- Public Law 97- 0689

From the Illinois Departments
of
Healthcare and Family Services
and
Human Services, Division of Alcohol and Substance Abuse

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Report On
Detoxification Services Planning Process and Resulting Recommendations as Per SMART Act (SB-2840)
Public LAW 97-0689

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I. Introduction

Julie Hamos, Director
Department of Healthcare and Family Services

The Save Medicaid Access and Resources Together (SMART) Act (P.A. 97-689) made two changes in the Illinois Medicaid Program for our clients with substance use disorders who are admitted to hospitals for in-patient detoxification services.

First, the new law placed limitations and required concurrent review for every hospital detoxification stay within 60 days of a previous detoxification stay. Second, it required the Department of Healthcare and Family Services (HFS), along with our sister agency, the Division of Alcoholism and Substance Abuse (DASA) of the Department of Human Services (DHS), to "convene a workgroup to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification". Pursuant to P.A. 98-104 and stakeholder involvement, these recommendations are being published.

We understood from the outset that restrictions on hospital admissions and readmissions would not alone achieve the State's goal: to facilitate access to medically appropriate detoxification services, in the most appropriate setting, with appropriate linkages to community based substance abuse treatment and recovery support services. That is why we are working with providers and managed care entities to build integrated delivery systems around these clients, which will offer a network of health, behavioral health and social services, with assistance from a care coordinator to help navigate the system. In the short term, we will test the effectiveness of these linkages through a demonstration program which partners hospitals and community-based providers.

This report is the product of a deliberative process that included representatives from hospitals, community-based providers, managed care entities and state agencies. We invite your feedback and comments, as we set about to implement these new policies. We are convinced that the implementation of new policies, programs and protocols with greater access to medication assisted treatment, and a cohesive and coordinated approach to care will improve health outcomes for these clients with behavioral health needs.

Thank you to Sharron Matthews, the Assistant Director of HFS, and to DASA and Mental Health Divisions Director Theodora Binion and her staff for their excellent work in convening these workgroups and keeping everyone focused and on track. We look forward to our continued work together.

Julie Hamos
Director, Illinois Department of Healthcare and Family Services

II. Executive Summary

Sharron D. Matthews, Assistant Director,
Illinois Department of Healthcare and Family Services

In the fall of 2011, the Illinois Department of Healthcare and Family Services (HFS) researched client data for evidence of any possible over- utilization of medical services being paid by the State of Illinois Medicaid program. (The review and processing of payments for Medicaid Program services is a primary mission of HFS.)

Medicaid claims data initially indicated that approximately 2,400 individuals were cycling in and out of certain Metropolitan Chicago-based hospitals. These persons were entering through emergency rooms and being admitted for an average stay of 3 days receiving various treatments of detoxification services at a cost of almost $ 2,100 per stay (from 2009 to 2011) with no decisive indications of better health outcomes. Approximately 600 of these individuals were utilizing these services at a higher rate with 200 at a significantly increased rate in comparison to their cohorts.

Based on additional research, further analysis, and discussions among the Department's executive and senior management, it was determined that a change in policy was needed. Change was needed not only to reduce over-utilization but also to develop a more comprehensive and effective system of healthcare delivery for individuals challenged by alcohol and substance abuse in Illinois.

In the spring 2012 session of the Illinois General Assembly, major legislation was passed to reduce the state's budget deficit. The bill included decreases in Medicaid spending through utilization management procedures, reduced rates, changes in eligibility and the inclusion of other policy changes to facilitate the implementation of state and federal healthcare reforms. The legislation was the Save Medicaid Access and Resources Together Act (SMART Act) - Senate Bill 2840, now Public Law 97-0689. This Act included a specific section on Detoxification Services paid for by the state's Medicaid program. The law specifically cited what actions the Department should employ to prevent further over-utilization of hospital-based inpatient detoxification services. It also authorized the initiation of a planning process for the development of recommendations for a more enhanced continuum of services to include both hospital and community –based providers working in a more coordinated collaboration to assist individuals towards sustainable recovery.

Two major actions were taken by HFS to comply with the SMART Act regarding detoxification services. The first, as of July 2012, individuals seeking inpatient hospital-based detoxification services paid by Medicaid were restricted to one pre-approved stay every 60 days, as compared to unlimited admissions and readmissions. (Note that individuals could then and still can at any time seek in-patient hospital care for medical reasons not diagnosed as detoxification only.)

The second, in August of 2012 HFS initiated the first in a series of internal management meetings to discuss the detoxification services planning process, staffing and timetable. Next joint agency meetings with DASA/DHS executive and senior staff were conducted to review client data, agree on the planning process and began the identification of DASA providers and other stakeholders to

recommend for Workgroup membership. Working together on this issue for the first time, both agencies committed providing the staff and other resources needed to complete the planning for a more comprehensive and coordinated system for the delivery of services the State of Illinois could offer its alcohol and substance abuse challenged residents seeking assistance.

The legislative language was very specific as to whom the two departments were to engage in high level on-going participation throughout the planning process. In September 2012, separate work committee meetings were initiated with management representatives of the 11 most impacted hospitals and 33 recommended DASA service provider agency and stakeholders' organizations. Management of 4 HFS Coordinated Care Entities in Chicago were included later (November 2012) as they were awarded contracts.

You will note the use of the word "first" several times in this report because none of this work had been accomplished before by those prescribed to participate in the planning process as cited in the legislation. Working separately and together over an 11 month period, Workgroup members reviewed HFS and DHS/DASA client data; identified and discussed the major issues; shared current policies, practices and ideas for innovative approaches to treatment and new service delivery models; observed and reported on the impact of the new HFS policy changes in their service areas; and began to develop a working knowledge of and relationship with each other.

Eighty- six (86) individuals participated in the planning process from August 2012 through June 2013. These teams of experts working with state agency staff not only produced additional areas of recommendations but also developed a design for a model of an enhanced continuum of detoxification service delivery. The model will be initially tested and evaluated for replication through state funding of at least 3 different demonstration projects by June 2014 year.

What follows is a report on the planning process, and more importantly, its results of proposed recommendations for the next level of changes in policy, services and programs for the development of a continuum of comprehensive detoxification services leading to sustainable recovery for thousands in our State needing such vital support.

III. Results of Research and Data Analytical Study of Utilization of Inpatient Detoxification Services Conducted By HFS

A. The Problem

In 2011, HFS observed very high rates of readmissions for substance abuse diagnostic related groups (DRGs), specifically detoxification admissions. Upon further research, HFS found that the readmissions were primarily occurring in 10 Cook county hospitals and that clients were cycling between these hospitals. Initial research data from 2010 indicated that approximately 2,400 individuals were involved in this behavior averaging 3 days per stay at a cost of $ 2,100 to the state's Medicaid program.

There were approximately 600 clients with more than six 3-day detoxification admissions per year; those 600 clients had 24 admissions a year – two per month. Of the 600, there was a subset of 200 clients with more than 24 admissions a year; those 200 had 48 admissions a year – 4 per month. The top group of clients had approximately 100 admissions week to week. They were traveling from hospital to hospital with little to no time out of a hospital. It was noted that many of the clients had been utilizing these services in this manner for several years. The typical high-volume of stays client was middle-aged, African American, male, disabled and had some contact with the Division of Alcohol and Substance Abuse (DASA) of the Department of Human Services.

One of the key issues with this target population is the need for immediate medical attention and services, along with their history of chronic dual disorders of mental health and substance abuse problems. This "complex" diagnosis presentation requires a high degree of differential diagnosis and triage within the medical setting, while simultaneously working with community providers and the client towards engaging the individual with available services. It is of note that many of these clients are reluctant engage in community-based substance abuse and mental health recovery services and require a more proactive approach on the part of the hospital and community providers. This lack of engagement in services upon discharge manifests itself in the frequent cycling of emergency room and hospital detox admissions throughout the year.

Based on these data, it was projected that the State could save $26 million in over-utilization costs for these services within the first 12 month period of full implementation of the policy changes which were subsequently included in the SMART Act. See the following three charts (Exhibits 1, 2 and 3) for details.

Exhibit 1

IL Department of Healthcare and Family Services

Medicaid Inpatient Detoxification Stays

Source: HFS EDW 3/18/2012 unless otherwise noted

Summary:

The same patients are recycling repeatedly through detox stays at a handful of hospitals

This is expensive, multi-year problem (only CY 2010 shown)

		Calendar Year 2010							
General Hospital Name	**County**	**Unique Patients**	**Admis-sions**	**Days**	**Cost**	**Admits/ Patient**	**Days/ Admit**	**Cost/ Admit**	**Cost/ Patient**
ST MARY OF NAZARETH HOSPITAL	200	817	2,892	7,970	$5,996,453	3.5	2.8	$2,073	$7,340
THOREK MEMORIAL HOSPITAL	200	614	2,368	6,855	5,405,123	3.9	2.9	2,283	8,803
SACRED HEART HOSPITAL	200	464	2,335	5,369	4,959,408	5.0	2.3	2,124	10,688
ST BERNARD HOSPITAL	200	503	1,772	5,103	3,184,661	3.5	2.9	1,797	6,331
NORWEGIAN AMERICAN HOSP	200	443	1,695	4,792	3,079,431	3.8	2.8	1,817	6,951
JACKSON PARK HOSP FOUNDATION	200	637	1,503	3,818	2,890,981	2.4	2.5	1,923	4,538
ROSELAND COMMUNITY HOSPITAL	200	400	1,498	4,023	2,850,856	3.7	2.7	1,903	7,127
HOLY CROSS HOSPITAL	200	419	1,467	4,014	2,347,857	3.5	2.7	1,600	5,603
SOUTH SHORE HOSPITAL CORP	200	392	1,223	4,918	2,067,614	3.1	4.0	1,691	5,275
INGALLS MEMORIAL HOSPITAL	200	285	767	2,111	905,412	2.7	2.8	1,180	3,177
Any Patient with a Substance Abuse Stay in the Above Hospitals		2,427	17,520	48,973	$33,687,796	7.2	2.8	$1,923	$13,880

Exhibit 2

Substance Abuse (Detoxification) Stays 2009-2012

Data taken from Top 10 most impacted hospitals:

Holy Cross Hospital, Ingalls Memorial Hospital, Jackson Park Hospital,
Norwegian American Hospital, Roseland Community Hospital, Sacred Heart Hospital,
South Shore Hospital, St. Bernard Hospital, St. Mary of Nazareth, Thorek Memorial Hospital

Source: HFS EDW Claims Adjudicated through Sep. 26th, 2012

Admission	**Substance Abuse Admissions**			**All Other Admissions**		
Quarter	**Admissions**	**Days**	**MedicaidPaid**	**Admissions**	**Days**	**MedicaidPaid**
Q1 2009	3,072	8,667	5,650,649	12,410	59,389	35,276,942
Q2 2009	3,323	9,200	5,992,261	12,423	61,060	36,160,327
Q3 2009	3,927	10,894	7,187,190	12,608	61,144	36,748,816
Q4 2009	3,703	10,474	6,960,348	12,138	59,439	35,270,126
Q1 2010	4,191	11,844	8,210,830	12,792	64,412	37,945,330
Q2 2010	4,277	11,867	8,236,926	12,617	62,240	37,537,732
Q3 2010	4,699	13,135	8,858,411	12,487	61,746	36,251,356
Q4 2010	4,363	12,149	8,395,093	12,158	60,527	37,526,799
Q1 2011	4,210	11,818	8,182,913	12,227	62,172	37,414,296
Q2 2011	4,432	12,356	8,552,013	11,422	57,032	34,570,499
Q3 2011*	4,487	12,366	8,714,182	11,593	56,843	34,515,407
Q4 2011*	4,237	11,879	8,302,013	10,584	51,674	31,660,664
Q1 2012*	4,126	11,573	8,020,067	9,905	50,251	30,131,017
Q2 2012*	3,756	10,284	7,168,874	8,256	41,082	24,926,802

*Incomplete data

Exhibit 3

Note: This Exhibit concentrates on geography rather than specific hospitals.
1) This is a Cook County problem
2) About 600 recipients are affected by the 60 day restriction
3) 200 utilize these services at a significantly higher rate
4) Most recipients are in Chicago
5) Most detox stays are associated with 10 hospitals
6) Most of the hospitals are in Chicago

HFS Medical Programs
Demographics for Inpatient Detoxification Stay Recipients
Service Year 2010
Source: CCIP Data Mart

Recipient Status	Number of Recipients					Percent of Recipients				Average	
	Total	DASA Claim*	AABD Status	Black	Male	DASA Claim*	AABD Status	Black	Male	Stays	Age
All Recipients with 2010 Detoxification Stay	5,047	1,585	3,383	2,503	2,824	31%	67%	50%	56%	4.4	44.9
Non-Cook County Recipients	1,854	575	843	254	933	31%	45%	14%	50%	1.5	39.6
Cook County Recipients	3,193	1,010	2,540	2,249	1,891	32%	80%	70%	59%	6.0	48.0
Cook County Recipients with More than 6 Detox Stays	593	365	524	502	387	62%	88%	85%	65%	24.3	48.9
Cook County Recipients with More than 24 Detox Stays	200	161	189	178	134	81%	95%	89%	67%	48.4	48.3

* One or more DASA claims during 2010, indicating DASA relationship.

Recipient Status	Number of Recipients			Detox Stays		
	Total	Chicago	% Chicago	Total	Top 10 Hosp*	% Top 10 Hosp
Cook County Recipients with More than 6 Detox Stays	593	536	90%	14,416	13,467	93%
Cook County Recipients with More than 24 Detox Stays	200	179	90%	9,687	9,060	94%

* 9 hospitals are in Chicago: Thorek, Sacred Heart, St. Bernard, Norwegian, Roseland, Holy Cross, Jackson Park, South Shore
1 Hospital is Suburban Cook: Ingalls

B. The Impact of the SMART Act In-Patient Detoxification Services Utilization Policy Change on Client/Patient Behavior and Hospital Admissions

HFS included new detoxification admission rules into the SMART Act. The new rules limited clients to one detoxification admission every 60 days totaling a maximum of 6 admissions per year. The policy change also stipulated concurrent approval of each hospitalization for reimbursement by the Medicaid program. The impact was immediate and dramatic. Detoxification admissions in the ten (10) hospitals with the most readmissions dropped by 60% and have to date remained at that level.

Furthermore, being concerned about the possibility of hospital stays shifting to other diagnoses for members of this group, HFS has been tracking and monitoring the clients who had the most detoxification admissions in 2011. It was found that there had been only a nominal increase in psychiatric and medical admissions post-SMART Act new admissions policy implementation. There also had been a decrease in emergency room admissions (these clients frequently use the emergency room) and a modest increase in the use of DASA residential day services. See Exhibit 4 for admissions data by month for 2010, 2011 and 2012 for the 10 most impacted hospitals.

Exhibit 4

		Substance Abuse Admissions			Acute Psych Admissions			All Other Admissions			Emergency Room**		DASA*
				Medicaid			Medicaid			Medicaid		Medicaid	Medicaid
	Month	Admits	Days	Cost	Admits	Days	Cost	Admits	Days	Cost	Visits	Cost	Costs
1	2010_01	663	1,823	$1,355,994	20	108	$61,761	9	28	$41,051	164	$47,364	$18,030
2	2010_02	575	1,592	1,188,366	19	119	73,211	12	40	49,506	147	36,590	16,035
3	2010_03	683	1,882	1,405,087	15	96	51,892	6	13	31,002	150	33,372	11,277
4	2010_04	652	1,796	1,333,857	12	76	47,274	8	24	30,947	176	43,045	6,315
5	2010_05	664	1,817	1,348,081	18	124	77,292	13	45	58,031	155	49,146	10,037
6	2010_06	674	1,819	1,356,043	12	97	53,315	11	63	72,805	157	31,998	8,735
7	2010_07	716	1,987	1,409,239	9	66	39,987	13	33	36,790	146	38,323	10,894
8	2010_08	709	1,950	1,408,836	16	123	73,982	14	31	42,572	160	53,906	10,909
9	2010_09	714	1,983	1,422,641	12	90	51,805	12	30	72,918	160	50,569	10,343
10	2010_10	752	2,064	1,528,322	16	106	64,851	16	52	128,942	167	46,321	15,434
11	2010_11	698	1,918	1,427,726	19	136	85,392	14	44	58,173	167	43,034	14,910
12	2010_12	747	2,063	1,527,851	14	115	70,825	5	16	16,365	188	46,139	6,689
13	2011_01	780	2,175	1,595,546	15	111	67,780	10	31	41,744	167	53,013	10,034
14	2011_02	692	1,917	1,425,854	17	99	81,035	7	25	28,385	134	37,805	4,462
15	2011_03	833	2,296	1,701,417	15	106	65,931	8	34	53,693	161	43,964	12,154
16	2011_04	819	2,243	1,671,412	17	158	86,692	11	52	77,740	180	62,282	6,806
17	2011_05	874	2,380	1,783,749	24	150	88,178	14	33	59,212	231	61,030	4,389
18	2011_06	838	2,287	1,711,943	19	123	73,806	14	46	43,033	204	49,522	12,015
19	2011_07	895	2,466	1,802,707	27	175	100,452	10	32	79,773	189	58,289	5,488
20	2011_08	850	2,327	1,731,098	20	151	88,862	10	39	53,413	156	55,831	3,556
21	2011_09	819	2,247	1,682,961	19	134	84,424	8	22	35,632	162	42,878	10,214
22	2011_10	821	2,262	1,696,136	34	205	126,238	9	36	52,099	201	51,159	13,606
23	2011_11	767	2,156	1,600,251	25	189	117,719	9	44	30,849	161	55,195	8,117
24	2011_12	720	1,977	1,498,387	24	139	89,701	15	72	80,472	123	33,237	13,125
25	2012_01	753	2,072	1,545,292	27	167	106,126	7	52	64,784	127	29,987	6,624
26	2012_02	661	1,835	1,361,110	15	73	47,234	11	48	59,479	115	41,234	6,989
27	2012_03	718	2,013	1,471,413	8	44	28,221	6	20	18,097	110	29,877	12,097
28	2012_04	655	1,808	1,348,737	16	104	67,052	11	34	33,804	143	38,692	12,095
29	2012_05	662	1,811	1,347,014	12	95	61,909	18	67	58,318	120	49,355	7,702
30	2012_06	571	1,577	1,172,954	16	83	55,156	13	45	48,950	135	42,558	8,746
31	2012_07	104	278	208,209	50	401	261,395	16	48	65,867	138	105,240	10,805
32	2012_08	48	138	91,598	50	307	189,902	20	65	76,255	127	36,660	9,251
33	2012_09	104	296	210,180	40	289	176,478	7	36	34,401	113	44,905	16,058
34	2012_10	53	162	82,873	35	255	164,256	15	75	124,264	125	47,124	13,587
35	2012_11	107	311	218,052	37	235	149,512	12	48	97,918	112	36,432	25,741
36	2012_12	46	135	72,407	42	315	199,424	16	64	71,860	131	33,626	19,594
37	2013_01	97	286	185,671	42	284	175,417	16	53	68,799	126	36,767	20,188
38	2013_02	52	147	82,574	36	244	153,557	16	68	103,059	117	38,932	21,009
39	2013_03	82	225	153,759	38	268	168,621	13	76	89,576	102	43,879	18,057
40	2013_04	60	169	97,891	45	316	190,985	13	44	68,349	117	39,050	17,893
41	2013_05	64	187	111,979	49	325	201,400	18	54	82,270	145	37,423	10,154
42	2013_06	54	159	111,317	29	215	135,773	17	48	61,402	98	34,142	14,850

200 Recipients with Most Substance Abuse Detox Stays

(48 stays on average)

Source: HFS EDW Adjudicated + Pending Through 8/16/2013

* Some DASA costs may be missing as interagency claims are historically slow to report.

** Pending Emergency Room claims are not easily identifiable and therefore not included; ER is therefore less complete with respect to recent months than inpatient admissions.

IV. The Smart Act Legislation , the Formation of the Workgroup and Committees, and the Planning Process

SB2840 Enrolled LRB097
15631 KTG 62714b

Public Act 097-0689
(305 ILCS 5/5-5f new) Section 5–5f, (b) (vi)
Regarding Detoxification Inpatient
Hospital–Based Services

(vi) effective July 1, 2012, the Department(HFS) shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60 days of a previous inpatient detoxification stay.

The Department shall convene a workgroup of hospitals, substance abuse providers, Care Coordination Entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification.

The above legislative language served as the authorization for and the mission of the Workgroup and its committees while also providing a guide for design of the planning process in which they participated. The Workgroup was comprised of six (6) different work committees of executive and senior management representatives from eleven (11) of the most impacted hospitals, thirty-three (33) recommended DASA service provider agencies and stakeholder organizations, and four (4) HFS Chicago-based Manage Care Entities (MCEs). A total of sixty-one (61) individual experts worked over an 11 month period with twenty–five (25) DASA/DHS and HFS staff on the following six (6) areas of Detoxification Services Planning:

Quality Standards for Services Delivery
Admission Criteria for Detoxification Services
Diversion to Alternative Service Settings
Recovery Support Services
Standing Orders, Protocols and Guidelines
Innovations, Best Practices and Future Strategies

Although the legislation cited only three (3) areas for recommendation development, the group agreed to include three (3) additional areas to allow for the production of a more comprehensive plan of enhanced and coordinated services delivery. "Recovery Support Services" was added to complete the flow of appropriate services that need to be available from hospitals, to treatment facility to community and home. The topic area of "Standing Orders, Protocols and Guidelines" was included to better inform and update all participants on what was being done within hospitals and by DASA/DHS service provider agencies for their patients and clients, respectively. Most participants were not aware of each others' internal operational procedures since they had not been working in a systemic collaborative manner though their target populations included some of the same individuals. The area of "Innovations, Best Practices and Future Strategies" was added to capture the most creative thinking of experts "at the table and in the field" to assist the State in moving towards instituting policies, services and programs that are designed to address both short and longer term issues faced by those afflicted with alcohol and substance abuse addictions and related life issues.

Six (6) different groupings of participants were organized for the completion of this work and subsequent report: 1) HFS Internal Planning Team; 2) DHS/DASA and HFS Interagency Planning Group; 3)Most Impacted Hospital Administrators; 4)DASA Provider Agency and Stakeholder Managers; 5) Coordinated Care Entities (CCEs) Managers; and 6) Mixed Services Provider Committee.

From September through December 2012, over 30 different meetings were conducted culminating with the sharing of the results in the first HFS and DHS/DASA sponsored conference on Detoxification Services Planning in Illinois held February 2013. This was the first time all participants met together and reviewed what each had produced from their separate committee planning sessions. Also, DHS/DASA and HSF management presented policy, services and programmatic improvements for consideration by the Workgroup. The next sections of this document include the information submitted on each of the six topical areas by the work committees and the subsequent proposed changes in policy, programs and services recommended.

Note that another 10 meetings were held from March 2013 through June 2013 to review, refine and finalize the Workgroup's recommendations. These meetings were held with an eye towards implementation as the next logically sequential phase and outcome of the group's planning process.

V. Summaries of Work Committees' Information Submitted for an Enhanced Continuum of Detoxification Service Delivery

Over one hundred (100) providers and other stakeholders, and DASA/DHS and HFS staff were invited to provide information and share ideas for the development of recommendations in each of the six designated topic areas. Eighty six (86) accepted the invitation (see Appendix I for a listing of all participants).

Each hospital and DASA services provider agency and stakeholder organization representative was requested to create an Ad Hoc work committee at their facility to develop and submit their information on each of the six topical areas. **Attached as Appendices II, III and IV are the summaries of what was submitted.** Note that these information summaries were shared and reviewed along with initial policy improvements/recommendations during the first Detoxification Services Planning Conference conducted in February 2012.

VI. Impact of Policy Changes and the Planning Process on Hospitals, DASA Service Providers and Client/Patient Behavior

During and as a result of the planning process, several changes were noted in hospital services, service provider relations, and client/patient behavior.

- Early on during the planning process, one of the most impacted hospitals made the decision to no longer offer in- patient detoxification services. Towards the end of this group planning process, a hospital with one of the highest in-patient detoxification services over utilization rates closed.
- Hospitals began discontinuing and/or revisiting contracts with companies which provide/manage delivery of on-site in-patient detoxification services.
- Hospital administrators started to identify and develop relationships with DASA providers in their service areas for patient referral and follow up purposes.
- Hospital administrators requested the development of a universal assessment tool and staff training for referring patients who do not need hospitalization but are experiencing health issues related to alcohol and substance abuse.
- DASA service provider managers shared their issues and ideas on how to work better with hospitals and offered co-location as an option for assessment and referral purposes.
- Hospitals, DASA provider agencies and Coordinated Care Entities began discussions on how their organizations will be working in collaboration to provide detoxification services to Medicaid clients within Coordinated Care Networks.

- All hospitals reported drastic decreases in inpatient detoxification admissions and stays. When asked about what happened to their former patient population, however, few could respond definitively. Some hospitals shared anecdotal reports of increases in arrests for petty crimes and loitering. It was stated that some individuals were being caught on purpose to access food and shelter, especially during their non- authorized periods for inpatient detoxification services.

- Some hospitals were experiencing a slight uptake in mental health admissions. Hospitals were informed that these admissions are being monitored closely to identify early any significant trends in former inpatient detoxification patients shifting into this category of admissions under the Medicaid program.

The planning process offered an historic forum of unprecedented opportunity during which much was shared and learned, and more is now to be done in the provision of detoxification services in Illinois.

VII. Recommendations for Policy, Services and Program Improvements

A. Hospital-Based In-Patient Services, Medications, Protocols Standing Orders

The following are presented to identify the problems with current policies, services and programs, as well as to recommend changes which, when implemented, will aid in the recovery of the client first and foremost, increase the quality of services, improve access and reduce costs. The strategic manner in which these potential changes are phased in without disruption and the effectiveness with which they are communicated to all parties will determine the success of all of these efforts.

1. **Problem Identified**: Suboxone (Buprenorphine + Naloxone) and Buprenorphine, an approved expensive medication for treatment of opiate addiction, has the potential for misuse, abuse or diversion, and was being used for maintenance purposes without any counseling, sometimes by prescribers who may not have met the DEA qualification to prescribe this medication.
   Recommendation: HFS and DASA staff and our pharmacy consultants worked together to develop **Suboxone and Buprenorphine Prior Authorization Criteria**, which were put into effect earlier this year. Those criteria limit the dosage, dispensable quantity initially and upon renewal, and specify a 12 month lifetime duration of therapy. Additionally, the prescriber must be qualified and along with the patient would develop a treatment, counseling and tapering plan. Urine drug testing, provider review of the Illinois Prescription Drug Monitoring Program, coordination with inpatient detoxification admissions and drug/alcohol related Emergency Department (ED) visits as well as use of the same pharmacy to fill prescriptions is required. These criteria will also make it safer for patients to use Suboxone and Buprenorphine.

2. **Problem Identified:** Significant inconsistency and variability (unexplained) in existing protocols for admission at various detox facilities creates confusion among the unit staff, ED staff and others responsible for referrals and admissions.
   Recommendation: Adopt/support the use of agreed upon standards for admission criteria such as ASAM which serves to place individuals in the appropriate level of care in the most appropriate settings.

3. **Problem Identified**: The populations served in a hospital based detox facility are not frequently defined and there is significant variation in who is served. For example, pregnancy is an excluded condition in a facility, yet a pregnant patient is sometimes admitted. In addition, there is no protocol or standing order to require a pregnancy test prior to or even during hospitalization. Other examples are exclusions by age, cocaine use, alcohol use, co-morbid medical conditions, and certain insurance types in some inpatient detox units, again creating confusion among the unit staff, ED staff and others responsible for referrals and admissions. Some inappropriate admissions which the facility is not prepared to serve may be avoided if the problem is resolved.
   Recommendation: Specified pre-defined populations which are served or excluded at an acute detox unit should be a requirement for purposes of consistency and statewide planning purposes. Exceptions and deviations for cause must be justified.

4. **Problem Identified**: The capacity of a detox facility, i.e. the number of clients who can be treated simultaneously and efficiently at any given time due to staffing or resource limitations, is not always clear; some facilities already have a maximum number while others do not. A pre-defined capacity can serve as a Quality Assurance (QA) measure.
   Recommendation: Pre-defined Capacity of an acute detox unit should be a requirement for quality assurance (QA) and monitoring purposes.

5. **Problem Identified**: Polypharmacy (use of multiple medications in the same patient, sometimes for the same condition) is a problem evident on many of the hospital standing order sets which were made available. Accordingly, the standing/routine orders initiated upon admission and continued until discharge may contain orders for multiple and sometimes conflicting medications without a specified indication, such as: Methadone and Suboxone for withdrawal in the same patient; more than one tranquilizer and multiple anti-depressants dispensed regularly to every patient admitted; multiple as necessary (PRN) medications, 15 in one instance, for sleep, pain (some opioids); constipation and diarrhea for the same patient; cough, congestion, acid reflux, and an eye ointment in the absence of any documented symptoms. These orders are implemented by the unit staff even before an attending physician has evaluated the patient. This practice puts patients at risk due to higher incidence of falls/other injury, drug-drug interaction, drug-disease interaction and a higher than average incidence of side-effects. Additionally, unnecessary medication orders represent avoidable cost and waste of resources.
   Recommendation: The practice of prescribing by way of standing orders should be eliminated and that each medication order should be prescribed individually by an attending physician upon or after patients' admission.

6. **Problem Identified**: The problem of unjustified laboratory tests ordered by way of routine or standing orders, promotes waste and avoidable costs. Sometimes, a test may lead to unnecessary or harmful further testing and treatment.
   Recommendation: The practice of routine testing in hospitals by way of standing orders without a specific physician order and without a diagnosis or reason should be eliminated. Those requirements are a norm in the outpatient world.

7. **Problem Identified**: There is insufficient evidence that discharge planning is being done in advance of the patient's release at most locations. Arrangements for after-care, patient compliance and incidence of recovery are negatively impacted in the absence of such planning.
   Recommendation: A written post-discharge plan should be required upon or shortly after admission, subject to modifications until hospital discharge.

8. **Problem Identified**: Few facilities currently require a psychiatric or psychological evaluation or even counseling during a detox admission. The chance of recovery is increased if co-morbid mental health problems are identified and treated timely.

Recommendation: At a minimum, a screening psychological or psychiatric evaluation should be required early upon hospital admission; outliers identified on that screening should be seen by a psychiatrist or a psychologist prior to discharge.

9. **Problem Identified**: Many patients do not get connected for outpatient follow up; that enhances their risk of readmission and decreases the chances of recovery.
   Recommendation: Completed arrangements/appointment for follow up visit, within an appropriate time frame after discharge, must be documented in patient's discharge orders, and the patient should receive a prescription no longer than 30 days upon discharge. The inpatient detox units may arrange appropriate outpatient follow up by one of their team members or another designated provider if unable to secure a follow up appointment for continued outpatient care after discharge. The processing of detox inpatient payment claims could be approved based on at least one post discharge outpatient visit by way of attestation.

10. **Problem Identified**: There is insufficient evidence that the IL Prescription Drug Monitoring Program is accessed by the treating staff team to verify that the patient is getting controlled medications filled via a single provider and a single dispenser. There is an existing state law to that effect.
    Recommendation: The IL Prescription Drug Monitoring Program must be accessed and documented during each detox admission.

11. **Problem Identified**: There is inconsistency among hospitals in ordering a urine drug screen test upon detox admission. Few require it. The treating providers do not know if a patient is using other than prescribed medications, complying with or diverting what has been prescribed.
    Recommendation: Urine drug testing should be a requirement upon each detox admission, as well as a provider review and documentation of that result prior to discharge. In appropriate cases, a blood alcohol level or a blood toxicology test to detect abuse of Benzodiazepine class of tranquilizers should also be required, since urine drug testing may miss these medications.

12. **Problem Identified**: All team members in a detox unit should be appropriately qualified, credentialed/re-credentialed and subjected to criminal background checks. There is insufficient evidence of this process currently in all detox treatment facilities.
    Recommendation: Timely and pre-determined credentialing of all detox unit staff should be required and posted.

13. **Problem Identified**: Systemic barriers surfaced during the many discussions among participating hospital and DASA community provider managers. The need for enhanced collaboration, and integration of targeted mental health, substance abuse, and medical health care services was identified as the key systemic modification needed in order for these services to effectively engage this target population.
    Recommendation: Develop an integrated services design and offer service providers the opportunity to participate in model implementation as a pilot project. Increase promotion and direct of the development of skills and evidence based practices that have shown

effective at engaging this high need homeless dual diagnosis population into recovery based sources.

B. Consideration of Coverage for Methadone Treatment Services Under Illinois Medicaid Program

Today, Methadone is not covered by Illinois Medicaid. Methadone is an opioid pain reliever that is used with medical supervision and counseling to treat opiate drug addiction and to help control withdrawal symptoms in patients being treated for opiate addiction. Methadone treatment is currently listed on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices (NREPP). It has been proven to be an effective treatment for helping patients maintain long-term recovery from addiction and years of research provide evidence that this treatment significantly reduces the costs of healthcare, criminal justice services, and other social welfare costs associated with opiate addiction.

Methadone programs are certified by the federal Department of Health and Human Services' Center for Substance Abuse Treatment (HHS/CSAT), registered by the Drug Enforcement Administration (DEA), and licensed by the Illinois Department of Human Services' Division of Alcoholism and Substance Abuse (IDHS/DASA). In addition, CSAT requires Methadone treatment programs to be accredited by one of the private accrediting organizations, i.e., Joint Commission for the Accreditation of Healthcare Organizations (Joint Commission), Commission on the Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA), within one year of regulatory approval.

Methadone has been utilized for opiate treatment in Illinois since the 1960s and supported by the state with the creation of the Illinois Drug Abuse Program (IDAP) in 1969. IDAP evolved to become, in turn, the Illinois Dangerous Drugs Commission, the Department of Alcoholism and Substance Abuse, and the current Division of Alcoholism and Substance Abuse within the Illinois Department of Human Services.

There are currently 63 opiate treatment (Methadone) programs in Illinois. Thirty-two programs receive funding through a combination of Federal Block Grant and state General Revenue Funds. Thirty-one programs are fully private, self-pay. Of these 63 programs, 27 are in Chicago, 17 are in suburban Cook County, 8 are in the collar counties, and 11 are located in Alton, Champaign, Decatur, East St. Louis, Galena, Normal, Peoria, Peoria Heights, Rockford, Rock Island, and Springfield.

There are approximately 11,600 patients currently receiving Methadone services in Illinois, with approximately 5,500 of these patients in a DASA-funded Methadone slot. It is expected that nearly all of the 11,600 current Methadone patients will be eligible for Medicaid-funded services in 2014. For patients receiving outpatient methadone services, continued stay reviews occur every 30 days for

patients during their first 90 days of treatment, and every 90 days thereafter for patients who demonstrate 90 days of stable participation.

The State is considering methadone coverage for Medicaid clients with an opiate addiction. In development of that policy, the following issues should be first addressed:

- Should programs seeking to become certified to deliver Methadone services have two years or more experience delivering outpatient methadone services? What types of agency training are needed to support Medicaid coverage of Methadone medication?

- Should Methadone dosage and continuation on Methadone be limited by administrative rule, or at the discretion of the treatment program's physician, and if so, with what conditions and utilization controls?

- For patients receiving Methadone for longer than one year, should there be a requirement that they test negative for illicit drugs?

- What is the estimated cost per treatment, and total cost to the Medicaid Program?

- What should be the requirements for Methadone programs to join Care Coordination or Managed Care networks?

- What community input should be required for the placement of Methadone clinics?

C. Overview of a Recommended System Delivery Design to More Effectively Serve Clients/Patients Receiving Hospital and Community-Based Provider Substance Abuse Services and Treatment

In developing a plan for detoxification that utilizes a broader, more clinically diverse continuum of substance abuse treatment and recovery support services, significant challenges were identified during the planning process. These challenges include:

- Availability of housing and transportation
- Availability and efficacy of case management
- Creating incentives for programs to improve patient linkage to next appropriate level of care

In addition to the challenges listed above, hospital-based detoxification programs and substance abuse treatment providers reported difficulty in identifying and addressing the varying levels of patients' openness to change and willingness to accept treatment. The workgroup developed a service model that would address these issues, given that they all have a direct impact on the state's ability to successfully reform detoxification services in Illinois. What follows is a description of a recommended model for service delivery improvements for "Individuals Presenting to Hospital-Based Detoxification and Community- Based Provider Programs."

Tier 1: Recommendations for the Hospital-Based Program Setting

1.1 All hospitals should be required to provide linkages to community-based treatment. Hospitals should have linkage agreements with community substance abuse agencies in their communities and there should be a mechanism to monitor that linkages are being made.

1.2 Patients who are appropriate for DASA detoxification services per the American Society of Addiction Medicine (ASAM) admission criteria should be referred to a DASA provider of Level III.7 services. Training and technical assistance should be provided to hospital staff so that medical detoxification is provided to patients requiring medical stabilization, but less expensive services (ambulatory detox and social setting detox) are provided to those not requiring medical stabilization.

1.3 Patients need a high level of engagement in the recovery process, especially in the first weeks of care. Patients should be screened for their readiness for change and patients who are not ready to accept a referral for substance abuse treatment should be provided Brief Intervention (BI) services. Those who are ready to accept a referral to treatment should receive a preliminary level of care placement prior to discharge from hospital-based detoxification.

Tier 2: Recommendations for Substance Abuse Treatment Program Service System

2.1 Increased Capacity for Residential Treatment.

2.2 Increased Capacity for Recovery Homes, Halfway Houses and Oxford Houses.

2.3 Increased Capacity for Medication Assisted Treatment. It is now widely understood that for some addicted persons, medications are critical to treat drug-induced brain deficits in order to help sustain a symptom-free lifestyle and long-term recovery. Given the gap between when patients are discharged from hospital-based detoxification programs and when they are able to enter methadone treatment, there is a need for **interim methadone services**, to bridge this gap in services. In addition, there is a need for greater access to other medications used to treat addictions, including Suboxone (Buprenorphine) and Vivitrol (Naltrexone).

Tier 3: Recommendations for Recovery Support Service System

3.1 Increase Capacity for Supportive Housing for Individuals with Substance Use Disorders. Increased capacity for supported housing for individuals in recovery should include a variety of housing settings, including the following:

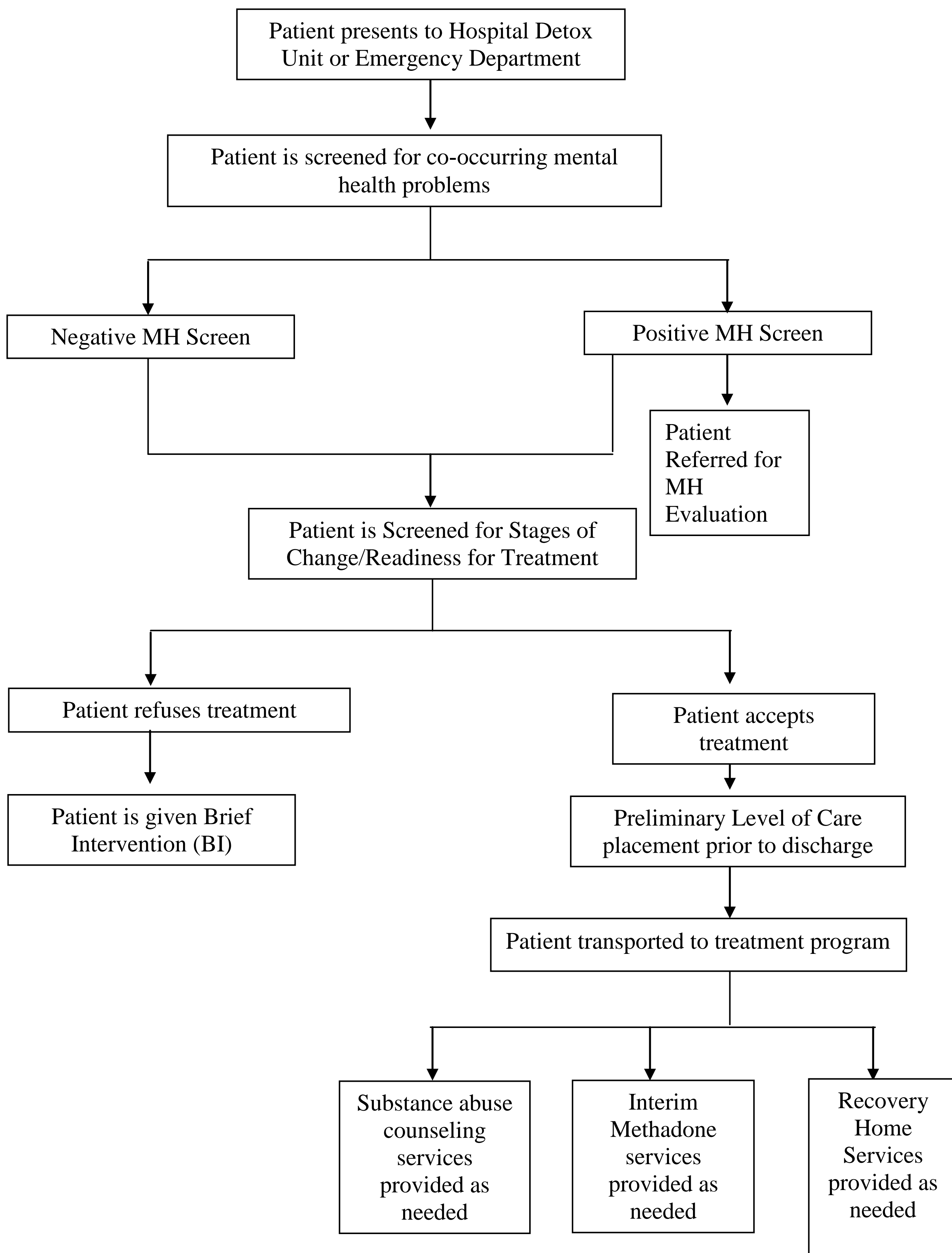
- Apartment or single-room occupancy (SRO) buildings, townhomes or single family homes that exclusively house formerly homeless individuals;
- Apartment or SRO buildings or townhouses that mix special-needs housing with general affordable housing;
- Rent-subsidized apartments leased in the open market;
- Long-term set-asides of units within privately owned buildings.

3.2 Increased Access to Recovery Coaching. Recovery coaches have been found to play an instrumental role in helping people in addiction treatment acquire the resources and skills they need to sustain recovery over time. In this model, a recovery coach meets with clients individually at least once a week for six months, which bridges their transition from treatment into the community, and then at least once a month for an additional six months.

3.3 Increased Access to Recovery Supports, including Vocational Services, Peer-to-Peer Services, and Pastoral Counseling.

The workgroup recommendations resulted in the Screening, Intervention and Engagement (SIE) Continuum of Care service model which will be piloted in Cook County beginning in January 2014. The full description of model components and timeframe may be found in the SIE Pilot Project Description (Section D). The following flowchart details key elements of the proposed model:

Screening, Intervention and Engagement (SIE) Continuum of Care Service Model for Patients Receiving Hospital-Based Detoxification Services



D. A Continuum of Care Model for the Future:

Screening, Intervention and Engagement Continuum of Care Pilot

To implement the proposed new delivery system, the Illinois Department of Human Services Division of Behavioral Health (inclusive of DASA and DMH) will implement a Screening, Intervention and Engagement Continuum of Care pilot project. Services are designed to assist patients discharged from acute care detox programs in selected Cook County Hospitals into an appropriate level of substance abuse or mental health treatment and recovery support services.

Partners in the pilot project include: the Illinois Department of Human Services, Division of Behavioral Health; selected substance abuse treatment programs, hospital based detox programs, recovery support programs, Great Lakes Addiction Technology Transfer Center and the Illinois Department of Healthcare and Family Services.

Statement of Need

In developing a plan to meet the treatment and recovery support needs of individuals receiving inpatient detox services, several significant challenges were identified by hospital detox staff, substance abuse providers and state agencies.

These challenges include the following: 1) lack of access to substance abuse treatment services, including medication assisted treatment; 2) ineffective linkages to the next appropriate level of care; 3) problems with transportation; and 4) lack of access to recovery homes or other sober housing.

In addition to the challenges listed above, hospital-based detoxification programs and substance abuse treatment providers reported difficulty in identifying and addressing the varying levels of patients' openness to change and willingness to accept treatment.

Objectives

The general objectives of the Screening, Intervention and Engagement Continuum of Care pilot project are designed to reduce barriers to accessing substance abuse and primary care and enhance opportunities for long term recovery.

1. Identify hospital detox patients who are willing to accept the next appropriate level of substance abuse treatment using Stages of Change Model before discharge.

2. Provide preliminary level of care placement for patients ready to enter community based treatment.

3. Link individuals with co occurring and substance use disorders to mental health programs.

4. Transport willing patients from hospital site to substance abuse treatment programs.

5. Link individuals to recovery support services.

6. Link individuals in substance abuse and recovery support treatment to primary care services

7. Provide medication assisted treatment as appropriate.

Requirements of Substance Abuse Treatment Programs Participating in the Pilot Project

Treatment programs participating in the Pilot must adhere to the following conditions.

1. Provider organizations must have an agreement with the hospital detox program to:
    a. Alert the provider organization once a patient has been admitted.
    b. Provide private space for the Screening, Intervention and Engagement counselor to meet with the patient.
    c. Include the provider organization as appropriate in developing the patient's discharge plan.

2. Provider organizations must identify dedicated clinical staff to provide screening, intervention and engagement (SIE) service to patients on the detox unit (weekdays and Saturdays). The SIE counselor will use the Stages of Change Model to identify where patients are in their "readiness" to progress in the change process. Screening will be used to build rapport, decrease resistance and promote change.

3. Staff must provide screening, intervention and engagement services to patients prior to discharge from inpatient hospital detox unit.

4. Staff must undergo Stages of Change and Brief Intervention training.

5. Provider organizations must provide transportation upon discharge for individuals from hospital-based detoxification to community-based services.

6. Provider organizations must demonstrate linkages and/or the ability to integrate substance abuse services with ongoing primary medical care.

7. Provider organizations must have access to full continuum of treatment services, including Level III.5, Level II, Level I, opioid treatment and recovery support services either provided directly or through linkage agreement.

8. Provider organizations must have access to mental health services for individuals with co-occurring substance abuse and mental health services (either provided directly or through linkage agreement).

9. Provider organizations must have the ability to place individuals in recovery home and/or halfway house (provided directly or through linkage agreement).

Illinois Department of Human Services, Division of Behavioral Health Screening, Intervention and Engagement (SIE) Continuum of Care Pilot Project Activity Timeline

	Pilot Project Year(months) Start Date: January 2014											
	1	2	3	4	5	6	7	8	9	10	11	12
Objective 1: Identify hospital detox patients who are willing to accept the next appropriate level of substance abuse treatment.	X	X	X	X	X	X	X	X	X	X	X	X
Activity 1.1: Train hospital staff and treatment provider staff on Stages of Change Model	X											
Activity 1.2: Select screening tool to be used to identify patients' readiness for change and train provider staff on administering and scoring the screening tool	X	X										
Activity 1.3 Screen all detox patients at selected hospitals using the readiness for change screening tool			X	X	X	X	X	X	X	X	X	X
Objective 2: **Provide preliminary level of care placement for patients ready to enter community based treatment.**	X	X	X	X	X	X	X	X	X	X	X	X
Activity 2.1: Provider organizations identify clinical staff to provide SIE services to patients on detox units	X											
Activity 2.2: Train provider clinical staff on Brief Intervention (BI) Model	X	X										
Activity 2.3 Provide BI services to patients unwilling to enter substance abuse treatment service			X	X	X	X	X	X	X	X	X	X
Activity 2.4: Provide level of care placement prior to hospital discharge for patients willing to enter substance abuse treatment			X	X	X	X	X	X	X	X	X	X
Objective 3: Link individuals with co-occurring and substance use disorders to mental health programs.	X	X	X	X	X	X	X	X	X	X	X	X
Activity 3.1: Identify mental health screening tool to be used with all hospital detox patients and train provider staff on administering and scoring the screening tool	X											
Activity 3.2: Provide full mental health evaluations		X	X	X	X	X	X	X	X	X	X	X

	Pilot Project Year(months) Start Date: January 2014											
	1	2	3	4	5	6	7	8	9	10	11	12
(by psychiatrist or LPHA) for patients with a positive mental health screen												
Objective 4: Transport willing patients from hospital site to substance abuse treatment programs.	X	X	X	X	X	X	X	X	X	X	X	X
Activity 4.1: Establish discharge hand-off procedures between hospitals and treatment providers	X	X										
Activity 4.2: Provide transportation on day of discharge for all patients willing to enter substance abuse treatment			X	X	X	X	X	X	X	X	X	X
Objective 5: Link individuals to recovery support services.	X	X	X	X	X	X	X	X	X	X	X	X
Activity 5.1: Identify recovery homes to participate in SIE pilot	X	X										
Activity 5.2: Provide 90 days of Recovery Home services for 75 patients discharged from hospital-based detox			X	X	X	X	X	X	X	X	X	X

E. Conclusion: A Process That Worked

In conclusion, the planning process to establish a more comprehensive detoxification service delivery system in Illinois was completed as per legislative mandate. The results are described in the details of this document. It is of note that this Report provides the State of Illinois with the "first" plan for the designing of a much more integrated detoxification services delivery system and was developed collaboratively by those working in both hospital- based and community -based provider settings with state agencies.

HFS and DHS/DASA will continue to work together in the provision and monitoring of the different aspects of these particular clients' healthcare services. Both agencies will provide full support to those providers whose proposals are selected to implement the first three pilots of the enhanced comprehensive service delivery model. To those hospital and agency representatives that participated who are serving thousands of current Medicaid clients and also the thousands of newly eligible individuals joining as of January 2014, thank you for your expertise, service and on-going commitment in support of sustainable recovery for those challenged by alcohol and substance abuse in our state.

Appendix I

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Appendix II

Summary of Information on 6 Areas of Detoxification Planning by Hospital Work Committee

Information from
Most Impacted Hospitals Work Committee
On 4 Topical Areas of
Detoxification Services

Section I: Quality Standards for Services Delivery
Section II: Admission Criteria for Detoxification Services
Section III: Diversion to Alternative Service Settings
Section IV: Recovery Support Services

November 2012

Section - I

Quality Standards for Services Delivery

Holy Cross Hospital

- Assess patient history with prior admission data
- Assess individual commitment and motivation
- Assess and validate support system (family, friends, programs)
- Reinforce assessment based on behavior change

Ingalls Hospital

- Standardized Detox Protocols
  - Opiate
  - Alcohol

Jackson Park Hospital

- Rates of Engagement
- Attendance Rates
- Retention
- Abstinence
- Quality of Life Indicators
- Client Satisfaction

- Inpatient Medical Stabilization is the first step of a comprehensive program.

  - Rates of Engagement

    Clients who are motivated and who are compliant with drug screening and treatment plans are more likely to remain in a treatment program.

    Looks at the number of clients who remain in a treatment program for the 3rd, 4th and 5th appointments.

    Calculated By

    The t*otal number of clients who attend a 3rd session divided by the total number of clients who were admitted during the initial intake.*

    Goal

    50 % of clients will keep their 3rd appointment.

  - Attendance Rate

    Measures the number of treatment program sessions that are attended by a client versus the number of sessions that were scheduled for a client during a given period.

    Calculated By

    T*otal number of sessions attended divided by total number of sessions scheduled.*

    Goal

    Clients will attend 50 % of their scheduled sessions

  - Retention Rate

    Measures the percentage of clients that remain in treatment.

    Calculated By

    T*otal number of weeks each client remains in active treatment divided by The total number of clients admitted.*

    Goal

    Clients will remain in active treatment and drug free for ninety (90) days (Hospitals and outpatient programs must establish and agree upon what constitutes active treatment.)

  - Abstinence Rate

    This is an extremely important measure as clients may have a high rate of engagement or attendance while they continue to use. This is most easily monitored or measured through urine drug screens and behaviors that would indicate relapse. This process must be inclusive of random drug screening when recommended by the Treatment Team

    Calculated By

    Total number of negative test results divided by total number of tests administered.

    Goal

    Client will remain drug free for ninety (90) days

  - Quality of Life Indicators

Most often coordinated through Case Management efforts that look to determine how well clients are functioning. Questions that would be useful in a monitoring tool include:

- Support group participation
  - Family, clergy etc…
- Reduction in arrests
- Reduction in hospitalizations
- Enhanced employability based on assessment by a Rehabilitative Counselor
- EAP collaboration (with appropriate release of information from clients)
- Births of drug free babies

- Client Satisfaction

  High levels of client / patient satisfaction with the program and the program providers, determined through a client satisfaction survey, is most often linked with higher percentages of engagement attendance and compliance with treatment. The following focus areas are key to the success of the client/ patient.

  - Satisfaction with
    - Educational Materials
    - Counseling
    - Groups
    - Educational Sessions
    - Amount of Individual Attention

Loretto Hospital

- Excellent Patient satisfaction scores
- Regulatory Compliance (Joint Commission, DASA)

Norwegian American Hospital

- Increased Client Access to Care
- Increased Client Capacity
- Increased Client Satisfaction
- Increased Clients in Long Term Treatment
- Increased Clients Referred for Treatment i.e. Methadone, Suboxone
- Increased Clients Continuing Treatment
- Reduced Client Recidivism

Roseland Community Hospital

- Staff Competency & Credentialing

- Counselors/Intake Coordinators or Screeners

  - All intake staff must be Certified (i.e. Certified Assessment and Referral Specialist Certification (CARS), or Certified Alcohol and Drug Counselor Certification (CADC).
  - Intake staff required to undergo 40 hours of CEU's every two years (i.e. 20 hours per year) for Substance Abuse or related topics in order to maintain his/her certification status.

- Nursing Staff
  - Initial Validation

    Upon hiring, all Nursing Staff shall undergo Orientation & Competency assessment by validated trainer (i.e. CADC) and must demonstrate a working knowledge of the following core curriculum

    - Signs and symptoms of the withdrawal process
    - Signs of intoxication versus withdrawal
    - The role of alcohol/drugs on the central nervous system
    - The importance of vital signs while the patient is in
    - intoxication/withdrawal
    - Withholding medication and its consequential impact on behavior and AMA
    - Impact of alcohol/drugs on behavior
    - Care of Pregnant Patients
    - Facts Behind Some Re-Admissions
      - Chronic nature of addictive disorder
      - Environmental stimuli
      - The lack of family support

  - Competency tests for Nurses on Assessment & Pain Management to include the following:

    - CIWA/CINAS Scale
    - Documentation of patient's reaction to the medication protocol

  - Demonstration of Annual Competency for all Nursing staff

- Physician Competency
  - Twenty (20) hours of Continued Medical Education (CME) by the hospital relative to alcohol and substance abuse.
  - Recommended that physicians providing treatment for medical detox, should also obtain Suboxone Certification.

■ Quality Assessment & Performance Improvement (QA/PI)
- Monthly Indicators to include
  - AMAs

- Referral Follow-up Rate (to decrease recidivism)
- Patient Satisfaction Survey (HCAHPS) Scores
- Screening for Psychiatric co-morbidities with appropriate referral &/or consultations

- Participation in hospital wide QA/PI meetings

Sacred Heart Hospital

None Submitted.

South Shore Hospital

- Detoxification department and hospital
  - Abide with HIPPA laws, such as confidentiality
  - Have safety standards in place (emergency code designations, fire safety etc).
  - Encourage patient surveys for service improvement
  - Provide Patients' Rights forms
  - Patients' signed consent for treatment and rules and regulations
  - Review medical records through utilization review team
  - Hospital to maintain accreditation to improve safety and quality of care
  - Conduct education classes for CDC
  - Detox staff availability to patients

St. Bernard Hospital

(In collaboration with Family Guidance Centers, Inc)

- Principles of Effective Treatment [National Institute on Drug Abuse]

  - No single treatment is appropriate for all.
  - Treatment needs to be readily available.
  - Effective treatment attends to the multiple needs of the individual.
  - Treatment plans must be assessed and modified continually to meet changing needs.
  - Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
  - Counseling and other behavioral therapies are critical components of effective treatment.
  - Medications are an important element of treatment for many patients.
  - Co-existing disorders should be treated in an integrated manner.
  - Medical Detoxification is only the first stage of treatment.
  - Treatment does not need to be voluntary to be effective.
  - Possible drug use during treatment must be monitored continuously.

- Treatment programs should assess for HIV/AIDS, Hepatitis B & C, Tuberculosis and other infectious diseases and help clients modify at-risk behaviors.

St. Mary and Elizabeth Hospital

Submitted recommendations for Recovery Support Services (Section IV)

Thorek Memorial Hospital

- Treatment Access
- Equality
- Follow Up Care

Section - II

Admission Criteria for Detoxification Services

Holy Cross Hospital

- Admission allowed every 61 days for Medicaid patients.
- Admission allowed every 30 days for Medicare and commercial insurance patients.
- Counselor screening over the telephone to obtain insurance type.
- Admitting department verifies insurance. Uses EO system for Medicaid patients.
- Urine drug screen is submitted for opiate withdrawal.
- Blood specimen obtained for ETOH withdrawal patients.
- Lab turnaround time is 1 hour.
- Patient is allowed admission into the 3-day program if positive for opiates or ETOH level above the legal limit.
- Patient all processed in an intake room.
- Personal belongings are checked by hospital security and patient is escorted to assigned room by security.
- Admission database completed by nursing staff.
- Medical Stabilization Pathway will be ordered by physician.
- Medical Stabilization Program admits patients 7 days a week 8a-530pm.

Ingalls Hospital

- Standardized
    - Opiate/Alcohol testing prior to in-patient admission
    - Standard time interval between admissions
    - Assessment of other current health conditions
    - Treatment plans while hospitalized
- Admission pre-approval available 24/7 from the State

Jackson Park Hospital

- Criteria for Inpatient Medical Stabilization
    - Positive Urine Drug Screen (UDS)
    - Symptoms of acute withdrawal or intoxication
    - Positive Chemical Intervention Withdrawal Assessment (CIWA)
    - Comprehensive medical, psychiatric and drug addiction history that identifies co-morbid conditions i.e. uncontrolled diabetes and uncontrolled hypertension.
    - Dual Diagnosis i.e. behavioral and chemical dependence

Loretto Hospital

- Established in accordance with ASAM criteria, Level IV-D, Medically Managed Intensive Inpatient Detoxification inpatient center. This level provides 24-hour care in acute care inpatient settings.

Norwegian American Hospital

- Admission Criteria for Detox-Inpatient - Only INTERQUAL

- Withdrawal, Severe and Alcohol or Drug Detoxification, Both
  - Finding, ≥ One
    - Hallucinations (auditory, visual, tactile)
    - History of delirium tremens or seizures
    - Medical Co-Morbidities, ≥ One
      - Cardiac
      - Head Injury within 1 week
      - Renal
- Seizures
  - T> 99.4 F
  - Vomiting, protracted or dehydration
  - Withdrawal score, One
    - 8-14 and heart rate > 100/min
    - 15
- Treatment, Both
  - Detox management protocol (includes PO)
  - Neurological Assessment

Roseland Community Hospital

- Admission Criteria for Detoxification Services (Medical Settings) / Interqual Criteria Adherence

All detoxification services should firmly adhere to the standardized criteria set forth by Interqual. Interqual is the most widely utilized criteria in several states to-date. It has recently transformed from the long used Severity of Illness (SI) and Intensity of Service (IS) philosophies, to an integrated process focused on evidence-based measures. Particular attention should be focused on the following symptoms:

- Tremors (arms extended and fingers spread apart)
- Agitation co-morbidities and other substances abused, leading to addiction.
- Neurological Assessment

Sacred Heart Hospital

None Submitted.

South Shore Hospital

- Admission to inpatient level of care requires meeting Severity of Illness specifications. Admission to inpatient hospital detox for heroin withdrawals patients are required to have had (normally 24 hours or less) recent usage of heroin and has significant withdrawal symptoms. Patient appears to be healthy enough to take the medications that are protocol for detox. Detox services will admit patients that tested positive to heroin with other drugs such as marijuana, cocaine and alcohol.

  - Dimension 1: Evidence of Physical and Psychological Withdrawals

    Profuse sweating
    Vomiting
    Tremors
    Nausea
    Diarrhea
    Muscle aches
    Joint pain
    Extreme restlessness
    Rhinitis

  - Dimension 2: Medical Conditions and Complications

    Patient is considered for inpatient detoxification also because of other medical conditions that would make admission to an outpatient program inappropriate. Inpatient care is considered also because of the specific treatments that may be administered based on severity of health problem. Because of the medications and treatments that some patients will need to be administered they cannot be served as outpatients. Some complications are COPD, HIV, seizure disorder, CHF-congestive heart failure, and diabetes and asthma patients.

  - Dimension 3: Discharge Criteria

    - When withdrawals are diminished, patient is encouraged to seek treatment for drug addiction.
    - A referral is provided for patient. Linkage agreements have been made with treatment facilities to lessen the delay for admission.
    - Linkage agreements for South Shore Hospital Detoxification are listed in section IV.
    - Encourage patient to fill out patient survey.
    - Connect patient with other recovery support services that will be conducive to their recovery; Narcotics Anonymous, Alcoholics Anonymous, Al Anon, Alateen, etc.

  Use the “facility home team” to direct patient to quality healthcare [CCEs] during recovery.

St. Bernard Hospital

(In collaboration with Family Guidance Centers, Inc)

- An instrument like the L.O.C.U.S., which is currently utilized to determine the level of care for mental health patients, may need to be developed for the substance abuse population, beyond the C.I.W.A. and Opioid Withdrawal Scales which are now utilized.
- Re-admission should be based on need and not some arbitrary number of days. Perhaps a compromise could be struck where a $100 per day/per patient penalty could be imposed should re-admission be necessary sooner than the current 60 day rule.

St. Mary and Elizabeth Hospital

Submitted recommendations in Section IV

Thorek Memorial Hospital

- Acute Care Setting / 23 Hour Observation
    - Active DTs
    - High CINA / CIWA Scale
    - Dehydration
    - AMS
- Out Patient Setting
    - Post Detoxification
    - Readiness to take the next step

Section - III

Diversion to Alternative Service Settings

Holy Cross Hospital

- 24 hour hospital stay - Methadone or Alcohol drying out (ETOH) Ativan or Librium as therapeutic
- Follow-up referral to overnight step down facility with counseling services (2 week maximum)
- Mandatory participation
- Then follow up with outpatient and recovery support Services

Ingalls Hospital

- Referral to Appropriate Out-patient setting if Admission Criteria not met
  - Counseling
  - Out-patient clinic
  - Other appropriate setting

Jackson Park Hospital

- Jackson Park Hospital currently provides medical stabilization for patients who are addicted to Alcohol and Opiates only.
- Patients who are addicted to other substances, for example cocaine or meth amphetamines, currently require diversion to alternative settings in the community that specialize in support for these types of addictions.

Loretto Hospital

- Residential Rehabilitation
- Intensive Outpatient Services

Norwegian American Hospital

- Submitted listing of providers for the following services

  - Residential Treatment 30-90 day
  - Methadone Treatment
  - Suboxone
  - Outpatient
  - Recovery & Halfway Homes

Roseland Community Hospital

- Protocols
  - When the Intake Coordinator screens the caller to determine appropriateness for admission and determines that the caller should be referred to an alternative service setting with accompanying protocols.
  - Patient should be referred to the least restricted level of care according to the rules set forth by the American Society of Addiction Medicine (ASAM) i.e., a social detox service, residential care or outpatient.
  - Appropriate Referrals
    - Consent to release requested information is obtained
    - A collaborative contact effort should be made between the screener and patient

Sacred Heart Hospital

None Submitted.

South Shore Hospital

Submitted list of Recovery Support issues in lieu of Alternate Service Setting.

St. Bernard Hospital

(In collaboration with Family Guidance Centers, Inc)

- Agreement upon a standardized assessment tool would be beneficial.
- Creation of a decision-making, L.O.C.U.S.-like instrument could drive diversion to alternative service settings. In Illinois DMH Region 1-South, the E.D.A. gatekeeper, in consultation with the Illinois Mental Health Collaborative, determines the most appropriate level of care, based upon standardized clinical assessment.

St. Mary and Elizabeth Hospital

Submitted recommendations in Section IV

Thorek Memorial Hospital

- 23 Hours observation Status
- Out Patient [Services]

Section - IV

Recovery Support Services

Holy Cross Hospital

- Residential homes/services
- Counseling services
- Work/study programs
- Available N/A, A/A meeting sites and times

Ingalls Hospital

- Family Guidance Centers (Ingalls Partnership)
  - Counseling
  - Treatment
  - Post Discharge Placement Centers
  - Follow up Medical Care

Jackson Park Hospital

- At Jackson Park Hospital (JPH) care coordination is our greatest opportunity for improvement, primarily related to the lack of exchange of information from referral sources. As a result patients throughout the community experience a high rate of recidivism across all healthcare facilities.

  After care referral resources must be **specific** to each client's needs. At Jackson Park Hospital a wide range of community or after care referral options exist. Examples are

  - Haymarket House
    A 28- day in patient treatment program for pregnant women. Haymarket also accepts male clients.
  - Family Guidance Center
    Offers an IOP (intensive Out Patient treatment program).
  - Jordan House
    A transitional living program that focuses on the mentally ill substance abuser (MISA)

  - Suboxone Services
    JPH has five (5) Board Certified Suboxone Physicians

JPH makes every effort to maintain continuity of care where applicable and provides for referrals to support resources within the clients / patients community.

Loretto Hospital

- IOP - Intensive Out-Patient
- AOP - Aftercare Out-Patient
- Outpatient Mental Health (OPMH)
- Self-Help Groups NA, AA, CA
- Alumni Group

Norwegian American Hospital

- Submitted listing of providers for the following services

    - Residential Treatment 30-90 day
    - Methadone Treatment
    - Suboxone
    - Outpatient
    - Recovery & Halfway Homes

Roseland Community Hospital

- Submitted listing of providers for the following services

    - Methadone Facilities
    - Suboxone Clinics
    - Drug-Free Outpatient
    - Drug-Free Residential
    - Recovery Homes
    - Self-Help Support Groups
    - Family-Based Groups

Sacred Heart Hospital

- Long Term Recovery

  Long term recovery treatment would primarily provide daily group meetings, community information, and recreations introducing patients to computer usage. Encouraging patients to seek employment. Providing information about expunging felony/criminal records.

    - Employment

The State of Illinois should review criminal records of patients with a Medicaid card. Patients with felonies should be encouraged to seek employment through Illinois Department of Rehabilitation Job Training Program.

- Education

  Patients should be recommended, registered and attend institutions that focus on Auto Mechanics, Sewing (Fashion Design), Cosmetology, or Barbering School.

- Training

  Establishing linkage agreements with companies like Sears, Wal-Mart, Target, Four Seasons, Home Depot, and Menards, in an effort to train, certify and possibly provide them with job opportunities (either part-time or full-time) for those who are willing to discontinue receiving disability (SSI) income.

- Housing

  There are thousands of abandoned/vacated buildings on Chicago's South/West/East sides of town. The State of Illinois and the City of Chicago can work with banks or building contractor companies to build affordable or renovate buildings. The renovated buildings can be rented to these patients. Rental payments could be directly deducted from their SSI Income through banking.

- Outpatient Treatment Center

  Addiction is a lifetime battle. The urge to use can be most difficult to overcome. Therefore, patients should be encouraged to attend outpatient meetings, and meet with professionally qualified counselors.

South Shore Hospital

- The patient might relapse while waiting for an assigned inpatient treatment bed after detox.
- Loss of wages while in treatment
- The need for a babysitter for children while the mother or father is in outpatient or inpatient treatment
- Some patients are afraid to leave their belongings too long while away at treatment.
- Some outpatient Methadone programs charge client fees that the client does not want to pay.
- The stigma of needing treatment can be a problem in the family.
- Submitted listing of providers and agencies with linkage agreement:

  - South Shore Hospital Facility home team
  - Inpatient Programs
  - Outpatient Programs
  - Recovery Houses

St. Bernard Hospital

(In collaboration with Family Guidance Centers, Inc)

- Development of a case management entity to shepherd the client through the stages of recovery and to facilitate addressing of the many social factors substance abuse clients experience will be critical to stabilizing their lives and contribute to full recovery. Some of these social factors are employment and permanent housing. Restoration of the 'whole' person is essential to recovery.
- The Recovery Community Services Program (RCSP) should be faithfully supported and implemented. The RCSP Initiative funds local recovery community organizations to provide peer recovery support services and promote the development of peer leaders.

  This model espouses the belief that recovery from mental and substance abuse disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

  This model goes beyond the role of a 'sponsor.' The Illinois Division of Mental Health has over the past 5-7 years moved forward with this type initiative, and it merits further consideration and adaptation for the substance abuse recovery movement.

Reference: S.A.M.H.S.A. News, Fall 2012, Volume 20, Number 3, provides an extensive conversation on this topic.

St. Mary and Elizabeth Hospital

- Next Level of Care
  - Significant barriers to access
  - Limitations based on
    - Medical benefit funding
    - Patient's inability to follow up
    - Intake process
    - Support system
- Innovations-Future Detoxification Services Delivery

  - Housing
    - Recommendation
      - Development of pre-admission assessment to identify patients who may be at risk of homelessness due to substance use.
      - Create a housing program to include both scatter-site and location-based recovery focused housing for patients at risk of homelessness.

    - Expected Outcome

- Patients that are homeless or at risk of being homeless have their needs addressed to refer them to housing providers that are supportive of their recovery plan.

- Transportation
  - Recommendation
    - Develop formal linkages with public e.g. Chicago Transit Authority and private e.g. Yellow Cab Company to provide transportation to and from needed healthcare services at a discounted rate to patients.
    - Case Manager can transport patient to/from substance abuse program.
  - Expected Outcome
    - Patient would have access to transportation to get to their medical and substance abuse services.

- Case Management
  - Recommendation
    - Require agreement of patient, while in treatment, to participate in case management services upon discharge focusing on a service plan to address housing and supportive counseling services.
    - Meet with Certified Alcohol Drug Counselor (CADC) to prevent relapse and readmission into a treatment program.
  - Expected Outcome
    - Patient will have, upon admission, the ability to develop a plan to address their psychosocial needs and access financial and other tangible assistance prior to their discharge.

- Lack of Incentive for Providers
  - Recommendation
    - Develop a "managed" care system which would provide an incentive for patients that complete medical detoxification program and appropriately refer patient to next level of care upon discharge. If the program does not appropriately refer the patient to the next level of care, then the provider would be given a penalty in the form of the program recovering a specific percentage/dollar amount which was given for the patient's treatment and aftercare needs.
    - Waive precertification requirements for providers that achieve and maintain 90% or above in linking patients with aftercare treatment.

  - Expected Outcome
    - Program providers have the incentive to appropriately refer patients to aftercare programs.

Thorek Memorial Hospital

- 28 Days In-patient Program
- Methadone Program
- 90 Days Outpatient / Residential Extended Care

Appendix III

Summary of Information on 6 Areas of Detoxification Planning by DASA Providers and Other Stake Holders Work Committee

Information from
DASA Providers and Other Stakeholders Work Committee
On 4 Topical Areas of
Detoxification Services

Section I: Quality Standards for Services Delivery
Section II: Admission Criteria for Detoxification Services
Section III: Diversion to Alternative Service Settings
Section IV: Recovery Support Services

November 2012

Section – I

Quality Standards for Services Delivery

Work Committee Participants:
Joe Lokaitis, DASA; and Jacome Marco, Healthcare Alternative Systems, Inc.

DHS/DASA Detoxification Quality Standards (Licensure Requirements)

- The staffing pattern for any patient receiving ambulatory (ASAM Levels I-D and II-D) or clinically managed residential detoxification (ASAM Level III.2D) is authorized by organization's Medical Director. Medically monitored detoxification (ASAM Level III.7-D) must have at least two staff persons provide 24 hour observation, monitoring and treatment, one of whom must be a either a registered nurse, a licensed practical nurse, or a emergency medical technician.

- A registered nurse shall plan, assign, supervise and evaluate all nursing care.

- Any patient admitted to a DHS/DASA licensed detoxification services must be medically screened prior to admission. At a minimum, the screening shall assess acute intoxication and/or withdrawal potential, biomedical conditions or complications, and emotional/behavioral conditions and complications. The medical screening shall include, but not be limited to, inquiry in the following areas: A) Primary complaint per patient; B) Date of last physical exam and the name of the patient's primary care physician; C) History of substance use; D) History of past withdrawal symptoms; E) History of concurrent medical symptoms, complications or conditions, including sexual activity and risk for pregnancy; F) History of concurrent psychiatric symptoms, complications or conditions, including suicide/homicide potential; G) History of recent trauma (including physical/sexual abuse); H) Hospitalizations; I) Medications currently prescribed and any allergies to medications; and J) Infectious or communicable diseases.

- The Medical Director shall designate the factors in a medical screening, including a determination of the patient's risk for HIV and tuberculosis infection, and the specific medications prescribed or used by a patient that would require physician review if such medical screening is not conducted by a physician.

- Pregnant women admitted for any type of detoxification shall be subject to physician review no later than 48 hours after admission.

- Any patient admitted to a DHS/DASA licensed detoxification services must be diagnosed either substance abuse or substance dependence and meet the ASAM admission criteria for the specific level of care. This diagnosis and placement must be confirmed by the organization's physician within 72 hour of admission.

- Any patient admitted to clinically managed residential detoxification (ASAM Level III.2D) or medically monitored detoxification (ASAM Level III.7-D) shall undergo a physical examination within 72 hours after admission if on prescription medication or pregnant. All other patients in such care shall undergo a physical examination within 7 days after admission.

- Detoxification patients shall be referred for medical, surgical, obstetric, prenatal or psychiatric

treatment or laboratory services when determined necessary by organization's physician.

Along with licensure standards, organizations who provide detoxification services should also maintain excellence in the following clinical practices:

- Engaging patients in the treatment process to maximize continued service participation upon discharge. This would include evidence base practices such as motivational interviewing, stages of change, and the use of culturally appropriate and trauma informed services.

- Patient education regarding the risks associated with substance abuse.

- The development and effective use of a community referral network upon discharge.

Section – II

Admission Criteria for Detoxification Services

Work Committee Participants:
Jayne Antonacci, DASA; Seth Eisenberg, Medical Director, DASA; Marco Jacome, Healthcare Alternative Systems, Inc.; David Johnson, Cornell/Abraxas; Kathie Kane-Willis, Roosevelt University; Dan Lustig, The McDermott Center; Brian Shaw, Macon County; Timothy Sheehan, Lutheran Social Services; Bruce Suardini, Prairie Center ; and Ronald Vlasaty Jr., Family Guidance Centers

Admission Criteria for Detoxification
(Notes from Work Committee Meeting on 10/30/12)

- **Suggested Changes to Illinois Medical Assistance Program Detoxification Criteria Guidelines**

  - Ensure that all individuals who are presenting for detoxification in hospitals are assessed by DASA providers and/or individuals knowledgeable about substance use disorders.

  - Those patients who are appropriate for DASA detoxification services per the American Society of Addiction Medicine (ASAM) admission criteria should be referred to a DASA provider of Level III.7 services.

  - Determination of other acute medical or psychiatric conditions should be determined by medical staff at the hospital. Individuals who are experiencing chronic medical conditions must be stabilized. Individuals who are experiencing serious health or psychiatric conditions should be treated in the hospital, as DASA funded providers are not equipped to treat certain medical conditions (e.g. “active gastrointestinal bleeding” or “ventilator dependent”).

  - Those patients presenting at hospitals or referred from DASA providers who do not meet criteria for ASAM level III.7 and need more medical care will need to be treated in a hospital. Some individuals (e.g. late stage alcoholics or benzodiazepine users) may require medication assistance. Individuals who require these medications should NOT be placed in DASA level III.7 detoxification services.

  - Patients who present in hospitals with benzodiazepine use or late stage alcoholism should be carefully assessed and monitored for extended, life threatening withdrawal symptoms. Utilization management of these cases should allow for the possibility of lengthier hospitalizations to monitor for these withdrawal symptoms, especially where medications are necessary to help with withdrawal.

  - Ensure that patients are stabilized before releasing them (e.g. ensure that no medication for detoxification had been given for 24 hours) and assess their condition before releasing them. They must have a period of no medication in order to be properly assessed as stabilized.
  - Consider linkages for Opioid dependent individuals to detoxification services in the community or Methadone maintenance programs, if the person has no other medical problems.

- **All hospitals should be required to provide linkages to community based treatment to stop patients from revolving through the system.**
  - Real time access to treatment slots need to be made available and detoxification services followed by treatment and aftercare. This infrastructure needs to be developed.
    - Monies and workforce should be set aside to help build this capacity.
    - Technology grants or other infrastructure grants might be used to fund this capacity building under Medicaid.
  - Assessment of need for substance use disorders should be completed by a DASA provider and/or someone with a high knowledge of substance use disorders.
  - Evaluation of the continuum of care must be maintained in order that the hospital remains Medicaid eligible.

Section – III

Diversion to Alternative Service Settings

Work Committee Participants:
Margaret Egan, Office of Cook County Sheriff (Tom Dart); Marco Jacome, Healthcare Alternative Systems, Inc.; Kathleen Kane-Willis, Roosevelt University; Marvin Lindsey, Community Behavioral Healthcare Association of Illinois (CBHA); Maureen, McDonnell, TASC; Rick Nance, DASA; Arun Pinto, Human Service Center and White Oaks; Allen Sandusky, South Suburban Council On Alcoholism & Substance Abuse; and Timothy Sheehan, Lutheran Social Services of Illinois

From Detox Cycling to Community Stabilization & Recovery

Recommendations from the Diversion to Alternative Services Group
Presented to HFS & DHS/DASA on November 9, 2012

Our Responsibility

- Inform understanding of the dynamics among frequent users of hospital detox
- Recommend strategies, especially regarding necessary community services and linkage strategies
- Challenge: Timeline
  - Gathering more data and evidence base analysis of the clinical presentation and service needs of the highest-cost frequent users.

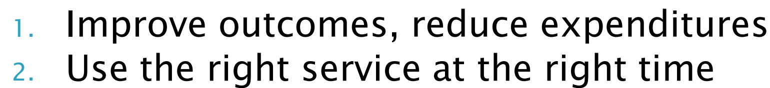
Building Systems Solutions

Goals for Patients

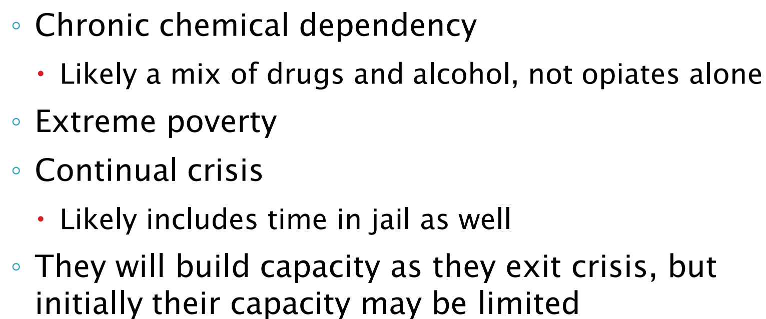
1. Less inpatient detoxification, unless medically necessary
2. More connection to the community treatment and recovery support system
3. Exit chronic crisis & begin to build durable recovery

Goals for Systems

1. Improve outcomes, reduce expenditures
2. Use the right service at the right time



Understanding the Population



- What we see:
  - Chronic chemical dependency
    - Likely a mix of drugs and alcohol, not opiates alone
  - Extreme poverty
  - Continual crisis
    - Likely includes time in jail as well
  - They will build capacity as they exit crisis, but initially their capacity may be limited

Understanding the Population

- Mental health issues are part of the picture, even if not the overt reason for SSI/SSDI disability
- Must partner with patients to develop readiness for change
  - Providing new options (housing, services) and care coordination are key
  - It is also enacted in the style of clinical work

Questions to Clarify Patient Needs

- Degree of medical complexity present when admitted
  - Could these patients be handled in a community detox setting? A free-standing medical detox?
  - Both are less expensive
- Range, severity and duration of medical and mental health problems and basic needs
  - Determines service needs
  - *Note: The amount of each service needed will depend on greater data/clinical information*

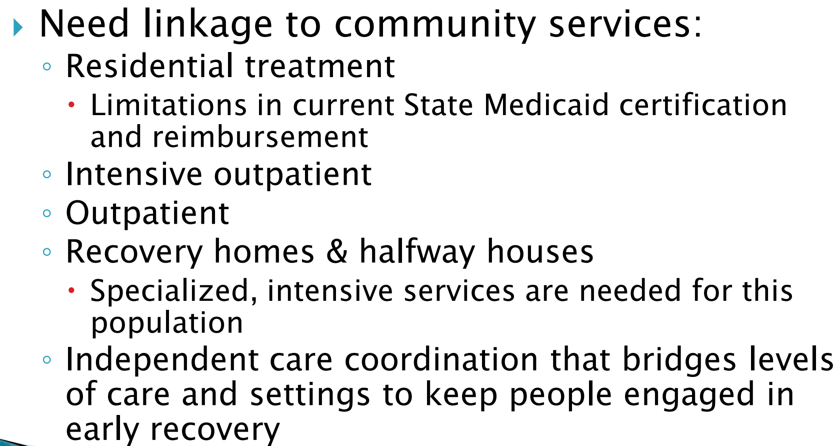
What is needed?

- Systems to link crisis behavioral health patients from hospitals to community services
  - Especially in high-volume communities like Chicago
- Crisis services, then services that help change behavior
  - Integrated care addressing medical, substance abuse, mental health, trauma, homelessness
- Full spectrum of community substance abuse interventions
- Housing
- High level of engagement, especially in the first weeks of care
  - Frequent contact – daily in some cases
  - Services targeted to stages of change
  - ACT-like services at the beginning for the most disabled patients

Spectrum of Care for Community Stabilization & Recovery

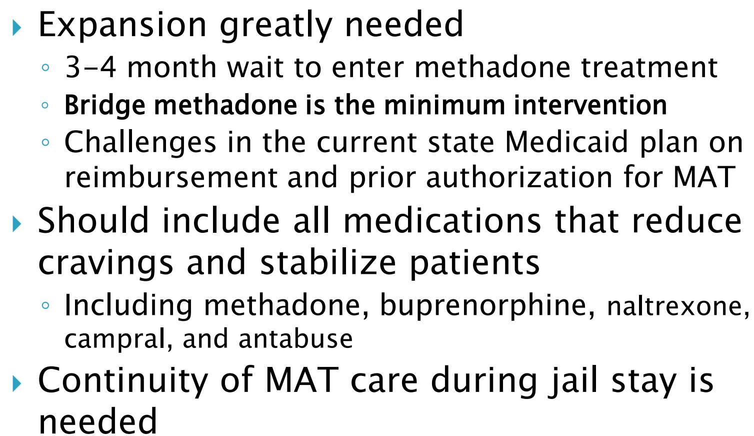
- Crisis Stabilization
  - Medical detox for those requiring medical stabilization
    - Less expensive alternatives for non-medical detox:
      - Ambulatory detox & social setting detox
      - Medical clearance is required
  - Housing:
    - Crisis beds/Sanctuary
  - Medication to control cravings
  - Care coordination to engage people in services

Addressing Behavior Change through Community Substance Abuse Services



- Need linkage to community services:
  - Residential treatment
    - Limitations in current State Medicaid certification and reimbursement
  - Intensive outpatient
  - Outpatient
  - Recovery homes & halfway houses
    - Specialized, intensive services are needed for this population
  - Independent care coordination that bridges levels of care and settings to keep people engaged in early recovery

Medication-Assisted Treatment (MAT)



- Expansion greatly needed
  - 3-4 month wait to enter methadone treatment
  - **Bridge methadone is the minimum intervention**
  - Challenges in the current state Medicaid plan on reimbursement and prior authorization for MAT
- Should include all medications that reduce cravings and stabilize patients
  - Including methadone, buprenorphine, naltrexone, campral, and antabuse
- Continuity of MAT care during jail stay is needed

Care Coordination

- Some can be provided by newly funded CCEs
  - Capacity may be limited during the first implementation year and limited by target populations of funded CCEs
- Some may be provided by Medicaid MCOs
  - More likely to be office-based rather than intensive, outreach-oriented, community based care coordination
- More/more intensive care coordination will be needed
  - Illinois Medicaid Plan for Substance Abuse does not reimburse for independent case management
    - This service is in the state Medicaid Mental Health Plan & Targeted Case Management in the Medical Plan
    - This gap also presents problems for compliance with the Illinois Parity law and the parity requirements of the ACA

Community Recovery Supports

- Supportive housing
  - Transitional and permanent
- Targeted vocational support to build capacity for self-reliance
- Extensive recovery supports

Effective Hospital Linkage Approaches

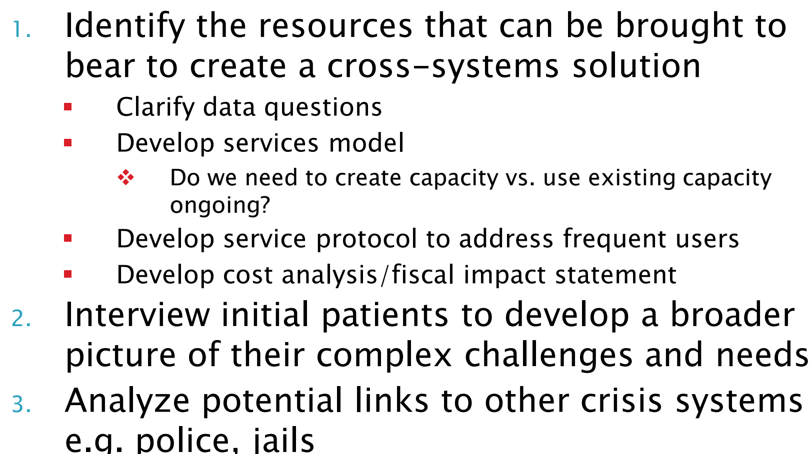
- Hospitals state that it is difficult to connect with the community substance abuse treatment system
- Effective models:
  - Emergency Department Diversion: EDAs + crisis beds (as was done by DHS in the Tinley Park project)
  - SAAS for mental health admissions
  - SBIRT (as was done at Stroger Hospital 2004-2008)
- Hospitals should be required to have ongoing linkage agreements with community substance abuse treatment agencies in their communities

Tinley Park EDA - Early Results

- 25-30 crisis clients intercepted at South Suburban hospitals each month
- 80% have co-occurring substance use disorders and psychiatric disorders
  - Major depression is the most common
- 70-75% are engaged in services within 14 days and are still engaged after 30 days

Additional Recommendations

1. **Avoid continued cost shifting**
   - Accurate assessment of clinical needs
   - Targeting services to address these needs
   - Tracking patient participation in related systems (criminal justice, homeless, emergency room) to evaluate any cost shifting
2. **Build a Bridge to the 2014 Medicaid Expansion**
   - Need to address limitations in current state plan
     - MAT, care coordination, residential treatment
   - Need to expand community infrastructure
     - Additional provider certifications may be needed
   - Prior authorization and continued stay review processes need to be adjusted
   - How does this new system become institutionalized in the implementation of Medicaid managed care?



Section – IV

Recovery Support Services

Work Committee Participants:
Maria Bruni, DASA; Jeffrey Collard, Haymarket Center (McDermott Center); Marvin Lindsey, Community Behavioral Healthcare Association of Illinois (CBHA); and Peter McLenighan, Stepping Stones, Inc.

Information on Recovery Support Services
(HFS/DASA Recovery Support Work Committee)

▪ Supportive Housing for Individuals with Substance Use Disorders

In May, 2009, the Journal of the American Medical Association (JAMA) published research findings confirming that the costs of providing housing and case management to chronically medically ill homeless individuals are more than offset by the reduced costs of emergency department services, inpatient hospital services, nursing home services, and other social services (Sadowski, et al., 2009). Called the Chicago Housing for Health Partnership (CHHP), the program formed in 2003 to scientifically test the efficacy of a "housing first" treatment model to improve the health of chronically ill homeless individuals. Participants who were provided housing with case management used one-third fewer inpatient hospital stays and one-quarter fewer emergency room visits than their peers who relied on the usual care system.

Research conducted by the Technical Assistance Collaborative found that in Illinois SSI monthly stipends are approximately $650, yet a typical one-bedroom apartment in the Chicago metro area rents for nearly $900 per month. If persons in permanent supported housing pay 30% of their monthly income on rent, the typical SSI recipient would pay $200 per month. Rent subsidies are not only needed, but cost effective, in reducing spending on publicly-funded health and social services.
Cost: Costs for supported housing coupled with other supportive services including case management vary depending upon the housing setting, which may include:

- Apartment of single-room occupancy (SRO) buildings, townhomes or single family homes that exclusively house formerly homeless individuals;
- Apartment or SRO buildings or townhouses that mix special-needs housing with general affordable housing;
- Rent-subsidized apartments leased in the open market;
- Long-term set-asides of units within privately owned buildings.

Cost estimate: Supportive housing subsidies for 100 persons @ $600 per month for 12 months = $720,000.

- ## The Recovery Coaching Model

The recovery coaching model is an evidence-based, manual-driven, community-based recovery management program for people who have entered substance abuse treatment. The program uses recovery coaches to help people in addiction treatment acquire the resources and skills they need to sustain recovery over time.

The *Manual for Recovery Coaching and Personal Recovery Plan Development* (Loveland and Boyle, 2005)--developed in Illinois through funding from the Illinois Division of Alcoholism and Substance Abuse (DASA)—incorporates the evidenced-based practices motivational interviewing, contingency management and strengths based case management which are included in the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration National Registry of Evidence Based Programs and Practices.
Following the *Manual*, a recovery coach meets with clients individually at least once a week for six months, which will bridge their transition from treatment into the community, and then at least once a month for an additional six months.

The recovery coach works individually with clients to develop a written recovery plan that outlines strategies for building recovery capital. The plan contains specific action steps to achieve goals under each domain. For example, in the area of employment and education, the client may state: "I would like a job." The client and Recovery Coach will then develop an action plan with discrete steps necessary to get a job. For each of these steps, the client and Recovery Coach will develop weekly contingency management plans to ensure that each step in the action plan are completed.

An independent evaluation of a three-year, federally-funded, Recovery Oriented System of Care project conducted at Haymarket Center showed significantly positive outcomes. The project was implemented with 480 adult men who had already relapsed within one year of completing residential substance abuse treatment prior to enrollment in the project. The outcomes included **significant decreases in substance use and mental health symptoms, high-risk behaviors for HIV, and crime; and significant increases in recovery supports and overall health.** It is recommended that Medicaid reimburse programs for recovery coaching as well as case management services provided to support individuals' long-term recovery.
Cost: The project as implemented at Haymarket Center cost $2,000 per client for the full year of recovery support. This is slightly more than half of the cost of a typical 28-day residential treatment stay at Haymarket. Estimate: Recovery Coaching for 200 individuals for 12 months ($2,000 x 200) = $400,000.

Medication Assisted Treatment

There is a well-founded science-base for understanding alcohol and other drug dependence as a chronic, recurring brain disease (NIDA, 2010). An abundance of research has consistently shown that chronic drug use affects the brain in fundamental ways often remaining long after the drug using behavior has stopped. Using brain-imaging technologies, research demonstrates the biological basis for addiction and has provided the basis for a biopsychosocial perspective of chemical dependency. From this knowledge, it is now widely understood that for some addicted persons, medications are critical to treat drug-induced brain deficits in order to help sustain a symptom-free lifestyle and long-term recovery. In much the same way that research provided for medications development used for other chronic diseases such as hypertension, diabetes and asthma, addiction medicine is following the same course. Methadone, Buprenorphine (Suboxone), and Vivitrol are all effective medications found to be instrumental to initiating and sustaining the recovery process among individuals with histories of alcohol and other drug dependence. In terms of the length of time that patients should remain on these medications, the guidance from field of addiction medicine is for physicians to use the same considerations that would be applied to the care of patients with any other chronic disease treated with any other therapeutic regimen. That is, as with all other medications, medications used to treat addiction should be continued as long as they are effective and do not cause side effects, and as long as there is reason to believe that termination would be associated with risks to the patient. Cost: The cost of supporting 100 patients on Methadone for 12 months = $443,820; the cost of supporting 100 patients on Suboxone for 12 months = $600,000.

References:

- Loveland, D., & Boyle, M. (2005, July 25). *Manual for recovery coaching and personal recovery plan development*. Retrieved on March 18, 2010, from http://www.bhrm.org/guidelines/RC%20Manual%20DASA%20edition%207-22-05.doc

- National Institute on Drug Abuse. (2010). *Drugs, brains and behavior: The science of addiction*. NIH Publication No. 10-5605. Bethesda, MD: National Institute on Drug Abuse.

- Sadowski, L., Kee, R., VanderWeele, T., & Buchanan, D. (2009). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. Journal of the American Medical Association, 301: 17, 1771-1779.

Appendix IV

Summary of Innovations, Best Practices and Future Strategies from Hospitals and DASA Providers and Other Stake Holders

Information on Innovations, Best Practices and New Possible Strategies, Treatments and Approaches for Service Delivery

From: Most Impacted Hospitals, and DASA Providers and Other Stakeholders Work Committees

November 2012

HOSPITALS

Holy Cross Hospital

Best Practices

- Customer Service - Value Statement via Mission Statement
  - Respect
  - Excellence
  - Attitude
  - Compassion
  - Holistic Care

- Patient on Unit
  - Each patient will receive a minimum of 2 visits to their room to see if they are being treated in accordance with the value statement.
  - Respectively, in a concerted effort to support the nursing staff, nurses will receive the same visits to see if there are any patient related behavioral issues that need to be addressed.

- Discharge Protocol
  - Prior to being discharged each detox patient will have a follow-up discussion concerning their referral to the next level of care for continued service
  - Patients will receive a customized discharge folder with referral, recovery material, and NA/AA meeting locations in it.

New Possible Strategies/Treatments/Approaches

- ED Protocol for accessing appropriate patients that present through the ED

  - New Vision™ (NV) staff will respond in person within 15 minutes of notification from ED for potential patient(s), unless providing direct service to a NV patient(s) currently on unit 4S or in lobby. In that instance NV staff will notify ED immediately to inform them of an estimated time of service.

  - Patient(s) considered appropriate when Medical criteria (292.0 opiate, alcohol and cocaine or alcohol withdrawal 291.81 withdrawals) are met. **Patient(s) can never be admitted to NV with cocaine only diagnosis.**

- If patient(s) are not considered appropriate, NV staff will provide patient(s) with a referral to another service provider for medical service.

- If patient(s) are triaged in ED, patient(s) must be medically cleared with discharge documentation from the ED.

- Before NV admitting process can begin, patient must meet above-mentioned admission criteria.

- NV will provide marketing material to the ED and the other departments throughout hospital for distribution to those that need or request it.

Ingalls Hospital

No submission. Discontinued services in August 2012.

Jackson Park Hospital

Best Practices

- A service that focuses on *Coordination* and *Continuity* of Care

  Research has shown that programs that provide the following produce the best outcomes (Reference: National Institute on Drug Abuse Research, Series 176, Washington D.C. Author Richard I. Evans PhD Professor Emeritus Michigan State University)

  - Inpatient hospital based detoxification that focuses on acute care, co-morbidities, behavioral and cognitive problems; and also provides medication, education and counseling (addressing psychosocial issues).
  - Referral at discharge to an IOP (4 hrs per day for 2 to 4 weeks), or an OP Program (1-9 hrs /day for 8 weeks).
  - A program that provides for linkages to Community Support Resources i.e. A.A., N.A., MISA etc… with the goal of relapse prevention.
  - Allows for exchange of clinical information between providers.
  - Continuous oversight of the clients / patients management by the Primary Care Physician.
  - Coordinated by a hospital based case manager.

Loretto Hospital

No submission for Innovation section.

Norwegian Hospital

New Possible Strategies/Treatments/Approaches

- Looking Ahead: Comprehensive & Coordinated Care
    - To achieve sobriety and optimal health outcomes for patients with addiction disorder, the health system must move to a model of accountable care which is essentially a system wherein the patient is our patient at all times regardless of where they are in the community.
    - Calls for the development of what has been described as a "clinically integrated network" or a "community of practice".
    - The "Be Well Health Partners" and other local providers must be integrated and aligned to ensure that patients receive seamless, coordinated services across the continuum of clinical, behavioral and social services.

Sacred Heart Hospital

New Possible Strategies/Treatments/Approaches

- Medications:

  Medical Detoxification can be extended beyond 3 days. A 5 to 7 days Methadone tapered dosage. Then, the next seven days, could be minimal group activities plus anxiety medication (PRN) i.e. Ativan and Librium (No Xanax). Patients with high blood pressure could be monitored and possibly administered with Clonidine or Procadia. Diabetic patients would be monitored, medicated, and treated. Patients exhibiting psychiatric symptoms i.e. A/V hallucination, severe depression and anxiety would be recommended to seek psychiatric evaluation for a week or two with direct admission to prevent future usage of drugs on the street. Meanwhile, stable patients would be encouraged to continue treatment at 28 days to 90 days inpatient treatment [Residential Centers].

Roseland Hospital

New Possible Strategies/Treatments/Approaches

- Recommendations for Future Hospital-Based Services

  One of the most critical aspects of Recovery Support Services is to develop and implement hospital-based services that provide a continuum of quality care:

  - Medical Stabilization
  - Inpatient/Residential Services
  - Basic/Intensive Outpatient Services
  - Methadone/Suboxone Clinics
  - Designated Drug Screening
  - DUI Services/Remedial Education
  - Self-Help Groups: AA, NA, CA, Al-Anon
  - Dual Diagnosis Program
  - Women's Programs

    Many patients opt for a program that focuses on the distinctive needs of women who battle addiction
  - Peer Support

    Individual peer support is provided in the community. Peer Support Specialists and Recovery Coaches are powerful recovery role models that engage each individual served in a personal recovery program. Focus is on developing recovery plans and recovery-directed discharge plans, including strategies to reduce readmission.
  - Other Recommendations

    - Accessible services that engage and retain people seeking recovery
    - A continuum of services rather than crisis-oriented care
    - Care that is age, and gender-appropriate, and culturally competent
    - Where possible, care in the person's community and home, using natural supports
    - Change to a person-centered approach to recovery that offers clear choices to individuals
    - Increased involvement of grassroots faith, and community-based organizations that afford people multiple pathways to recovery
    - Providing referrals that are focused on comprehensive, individualized services for better outcomes
    - Create a more energized recovery community by the development of an extensive outreach component

- State Funded Recovery Support Services Include:
    - Family, Marital and Life Skills
    - Transportation
    - Alcohol and Drug Testing
    - Childcare
    - Adult Staffed Safe and Sober Housing
    - Case Management

Clients should be eligible for recovery support services for up to twelve months following the successful discharge/completion of a clinical treatment episode. In the event of relapse during a clinical treatment episode or recovery support services, an individual will remain eligible for all services. However, they will be referred to a higher level of care or regress within their current level of care as appropriate based on provider assessment. Lastly, in the event there is a transfer to another level of care from recovery support services or within a clinical treatment episode, the client will be a priority referral.

South Shore Hospital

Best Practices

- Involve the patient in recovery discussions. Encourage patient to seek further help at time of admission. Give lists of treatment programs to patient and allow patient to use the telephone. Be of service with the patient.

New Possible Strategies/Treatments/Approaches

- Connect detoxification services with basic treatment programs and Methadone programs. Involve community shelters, churches, religious organizations, criminal justice agencies and schools in possible strategies to help in the recovery and drug-free lifestyles of recovering people.

- Provide Crisis Centers for time between detox discharge and admission to treatment programs.

St. Bernard Hospital

Best Practices

- Mapping-Enhanced Counseling

  Developed by a team at the Institute of Behavioral Research at Texas Christian University [Simpson et al] in Fort Worth, Texas, is listed on S.A.M.H.S.A.'s National Registry of Evidence-based Programs and Practices. Mapping-Enhanced Counseling is a communication and decision-making technique which was designed to support delivery of treatment services by

improving client and counselor interactions through graphic visualization tools that focus on critical issues and recovery strategies. It helps address problems more clearly than relying strictly on verbal skills. It incorporates client assessments of needs and progress with the planning and delivery of interventions targeted to client readiness, engagement, and life-skills building stages of recovery. The technique centers on the use of “node-link” maps to depict interrelationships among people, events, actions, thoughts and feelings that underlie negative circumstances and the search for potential solutions.

St. Mary and Elizabeth Hospital

Refer to Recovery Support Services (Section IV) of Hospital Recommendations on Detoxification Services.

Thorek Hospital

No submission for Innovation Section.

PROVIDERS

Whitman Medical Unit (Human Service Center)

Best Practices

- Consult SAMHSA's TIP 45 on detoxification
- Pregnant women remain a priority
- Use of standard tools (CIWA, etc)

New Possible Strategies/Treatments/Approaches

- Increase office based ambulatory detox for opioids (medical resources and reimbursement issues).
- Increase number of physicians downstate who are credentialed to prescribe Buprenorphine; find ways to incent physicians to become credentialed.
- Ask programs to track the high utilizers, limit number of detox events if the person is not engaging in other treatment options. (Don't allow a person to repeatedly be detoxed but not go on to treatment).
- Possibly separate issue from detox, but explore ways to make it easier for Naloxone to be available.

Jefferson County Comprehensive Services, Inc.

Best Practices

- Clinical Institute Withdrawal Assessment (CIWA) Scale
- Motivational Interviewing
- Behavior Modification

New Possible Strategies/Treatments/Approaches

- Recognition of management of non-medical detox as safe and cost effective
- Transportation provided by Vantage Point to and from detox services
- Immediate access to services assists in the timely interruption of the drinking/drug use cycle, provides a safe place for withdrawal, and is the entry and re-entry point into the continuum of care.
- Open to Medication Assisted Therapies as deemed necessary.

Lake County Addictions Treatment Program

Best Practices

- The Lake County Addictions Treatment Program (ATP) has adopted two best practices techniques to improve treatment outcomes. The first of these is the use of Suboxone as the preferred protocol for opioid withdrawal.

  - In 2005, we initiated a project to improve the retention rate of opioid dependent clients. During the first two quarters of 2005, we discovered that the AMA rate for opioid dependent clients fluctuated between 34% - 49%. At this time, we were using a Clonidine protocol to detox opioids. Clonidine was not found to be particularly effective in relieving withdrawal symptoms, therefore, a considerable percentage of these clients left treatment against medical advice (AMA).

    In May 2005, we instituted a Suboxone protocol for opioid detox. Between May 2005 - February 2006, we compared the differences between the AMA rates for those clients being detoxed with Clonidine compared to those detoxed with Suboxone. At the end of the study, the AMA rate for the Clonidine group was 36% and the AMA rate for the Suboxone group was 25%.

    We determined that Suboxone was much more effective in relieving withdrawal symptoms, so we instituted it as the primary method for detoxing opioids. We continued to study the AMA rate for opioid dependent clients until 2009. At this time, the AMA rate for these clients was reduced to 12%.

  - Second best practices technique instituted was the introduction of skill-building groups that utilize principles from CBT and DBT. We have discovered that clients frequently relapse due to a lack of coping/survival skills. Motivational interviewing/stages of change techniques are also utilized to encourage the client to see a need for change without creating a power struggle.

New Possible Strategies/Treatments/Approaches – Challenges

- During the past two to three years, the percentage of opioid dependent clients that enter our program has increased (43%) and the average age of our clients has decreased. The majority of our clients are in the 18 - 34 age range. This has created some new challenges in treating this population since younger clients tend to be more impulsive. We have recently seen an increase in AMA rates, increased drug use on the unit, and attempted subversion of Suboxone doses.

- Although Suboxone has been successful in lessening withdrawal symptoms, it is not always helpful in reducing the client's cravings. Medications such as Naltrexone/Revia have shown some efficacy in reducing cravings, but it is cost-prohibitive ($200 - $250 per month). The development

of affordable medications that could be used in adjunct with therapy would most likely improve the treatment outcomes of this population.

- Another challenge facing our field is the increase in staff - client ratio due to funding cuts. Research stresses the importance of positive client-staff relationships and frequent interaction with staff members, as a means of increasing client retention. Unfortunately, the majority of AMAs occur on the shifts that are minimally staffed, i.e., evenings and weekends.

Leyden Family Services

Best Practices

- Using a multidisciplinary team approach.

- Using a central nervous system depressant for alcohol detox due to raising the client's seizure threshold.

- Benzodiazepine detox should be treated with close monitoring. The client needs to be slowly weaned off of their Benzodiazepine of choice, often using a different Benzodiazepine, in particular Diazepam (Valium) as it has the longest half-life of all Benzodiazepines.
- When using Buprenorphine for opiate detox, it is best practice to use Suboxone rather than Subutex as it contains Naloxone (a reversal agent) therefore making it difficult to abuse or get high from.

- Information about use of Buprenorphine in pregnant women is limited and currently Methadone remains the standard of care for medication assisted treatment of opiate dependent women in the U.S.

New Possible Strategies/Treatments/Approaches

- Clients stable in a 'medically managed' intensive inpatient detox whose signs of withdrawal can be safely managed in a 'medically monitored' inpatient detox setting should be transferred appropriately. This would require both inpatient levels working more closely together and communicating client's current needs to transition to the next appropriate level of care.

- Outpatient facilities prescribing Suboxone would be strongly recommended to perform UA testing on current clients, provide structured group therapy, and immediately refer any client who relapses to inpatient treatment for detox and stabilization before continuing in an outpatient setting.

- Performing a more thorough assessment on clients going through opiate withdrawal for the need for Suboxone. As our experience has shown us, it had become more readily available for purchase

and clients are familiar with it; they are buying it off the streets and using it to self-detox or in combination with other opiates. It should be reserved for clients in medical need, who would otherwise become medically unstable without it. We have seen through our experience that many clients come into our facility looking for Suboxone for detox and leave AMA/ ASA when their dosing has tapered/completed. Many clients express concern due to the cost of Suboxone and cannot afford to continue it for a long term period; this makes it more financially appropriate to prescribe it only during the acute withdrawal period, and only for a short period of time. Any client prescribed Suboxone in an inpatient setting that is going to be weaned off of it before treatment is completed, should be weaned off of it long before discharge to allow for proper length of time to process any mild withdrawal symptoms and any triggers while still in an inpatient setting.

- With such limited information on new abused drugs, such as synthetic marijuana and bath salts, clients who require detox from these substances are best treated in a hospital/psych setting. This will allow for proper staff/trained staff to respond to situations when restraints and seclusion become necessary due to common risk of hallucinations, paranoia and aggressive behavior.