DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

REQUEST FOR INFORMATION NO. HSS-11-077
DELAWARE SUBSTANCE USE AND CO-OCCURRING DISORDER SERVICE SYSTEM REDESIGN
August 1, 2011

A **Project Preview meeting** will be held on **August 16, 2011 at 10:00 A.M.** at **Herman Holloway Campus, 1901 N. Dupont Highway, 23 Mitchell Lane, Springer Building, Gym, New Castle, DE 19720. "**

I. Overview

The Division of Substance Abuse and Mental Health is currently examining its addictions treatment system in terms of its efficiency, effectiveness and recovery-orientation. The current array of services was created incrementally over the last ten years so, as the State prepares for health reform, now is an ideal time to evaluate the availability and configuration of residential and outpatient services. New developments in the field are driving this evaluation: 1) understanding of addictions has increased; 2) the sophistication of substance use disorder treatment has improved dramatically; 3) there is now recognition of the prevalence of co-occurring psychiatric and addictive disorders; and 4) there is a growing realization that integrated treatment is effective treatment. While once heavily dependent on residential resources, modern addictions treatment increasingly relies on outpatient, intensive outpatient, and medication-assisted treatment. Currently, though, Delaware experiences fixed, long lengths of stay in residential treatment, waiting lists for residential readmission, and extended stays in detoxification due to lack of residential access. Taking a page from health care, addictions treatment systems could benefit from closer alignment of residential and outpatient services, seamless handoffs, and mutual accountability for outcomes. Within this context, DSAMH is looking for ways to better manage resources, consider new payment methods that align financing and clinical objectives and reinforce client-driven care. Results of system redesign could potentially accrue much greater benefits for clients, more efficient resource utilization, and alignment of the State's clinical objectives and a recovery-oriented delivery system design.

As the Division develops its plan for system reengineering, it is interested in receiving input on potential key features of the redesign. DSAMH will consider this input as it finalizes the details on improving services in order to support effective client care.

II. Delaware's Addiction Services Continuum (DASC)

In 2006, SAMSHA/CSAT published TIP 47: *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* which included research comparisons of inpatient treatment with intensive outpatient treatment and concluded that, while some studies showed a modest increase in positive outcomes for inpatient treatment, level of care placement based on clinical need was by far the most significant indicator of treatment success (SAMSHA TIP 47 2006). The American Society for Addiction Medicine (ASAM)[1] offers a useful model for continuum of care placement within the treatment system and, when effective, clients move seamlessly between more intensive levels and less intensive levels of care according to their specific needs rather than predetermined treatment stays

[1] *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders,* American Society of Addiction Medicine, Inc., Chevy Chase, Maryland, 2001.
Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.
American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; To order ASAM PPC-2R: (800) 844-8948.

based on the type of program offered (SAMHSA, TIP 47). Delaware's Addiction Services Continuum uses ASAM criteria to determine the appropriate intensity of blending the benefits of residential and outpatient treatment in a setting that provides a sober living environment. The system will offer levels of care that include detoxification, variable length of residential treatment, partial hospitalization (PHP), intensive outpatient treatment (IOT), outpatient treatment (OP) and targeted care management. Treatment services will meet the clinical needs of consumers with co-occurring disorders in a trauma informed environment. All services must be able to treat individuals based on client need, the range of ASAM criteria and the ability to meet client needs through flexible service provision.

The DASC will offer medical and non-medical detoxification that assist clients in acute withdrawal from alcohol and other drugs through a stabilization phase that will vary in length according to medical client needs. Because supportive living environments will be a required component of the DASC, the ASAM levels of care range from ambulatory detoxification with or without on site monitoring to more intensive levels of detoxification up to and including Level III 7: medically monitored detoxification.

Clients who do not meet the criteria for ASAM levels II-D through III.7-D but are in need of short-term intensive treatment and stabilization will be provided residential treatment at ASAM Levels III.I through III. 7: Medically Monitored Intensive Inpatient Treatment. Treatment stays will be variable and limited to those individuals who need 24 hour monitoring and support.

Delaware's ASC will provide a range of supportive living environments that promote healthy and substance abuse-free living and recovery to a wide variety of men and women including those with co occurring disorders. This may include short-term crisis housing supports to divert people in early stages of change from utilizing expensive acute care medical, psychiatric and detoxification services. The Governor Bacon campus in Delaware City, DE, for example, provides ample living quarters for clients in substance use disorder (SUD) treatment at various stages of readiness for change and levels of care and the ability to move through the continuum with few barriers to appropriate levels of care. The continuum will use evidence-based services to provide a wide array of treatment opportunities that go far beyond the current 120 day residential program currently offered in the state.

Partial hospitalization (PHP) will be established for individuals who do not need 24-hour care but would benefit from treatment in a structured environment. Admission can occur within 24 hours for those who meet ASAM Level II.5 criteria. The PHP will offer stabilization, develop community support, and teach recovery and relapse prevention skills for both mental health and substance use disorders. Both this and other outpatient levels of care may be combined with Level III.1 which provides a 24-hour supportive living environment.

The DASC will offer intensive outpatient treatment (ASAM Level II.1) in a structured program where residents remain on the Governor Bacon campus in a supportive residential setting while receiving intensive treatment. The intensive outpatient treatment program will give residents the opportunity to begin looking for employment in the community and develop a strong support network. IOT will be designed for those individuals who are stable but may be at a high risk for relapse. Emphasis is placed on early stage relapse management, coping strategies for mental health and substance use disorders and establishing or re-establishing psychosocial support.

When an individual enters the DASC, an assessment will be conducted to determine his/her case management needs. Individuals needing ongoing case management will be provided with a single contact person who will be responsible for finding and mobilizing needed resources, negotiating formal systems, and linking with other service providers to gain access to appropriate services (e.g. clothing, long term shelter, entitlements etc.).

Group treatment will be provided across the continuum and will include groups such as: psycho-educational groups, "discovery", motivational enhancement groups, recovery skill groups, relapse and continued use prevention techniques, support groups, interpersonal process groups, co occurring groups and groups appropriate for families.

Individual sessions will address the immediate problems stemming from clients' substance use disorders; readiness to change issues; and their current or ambivalent efforts to achieve and maintain abstinence. Counseling will address problems related to social, psychological and emotional well-being. Medicated Assisted Treatment (MAT) will be offered as part of the treatment continuum and case management services will include linkage to MAT maintenance upon discharge from any level of care or from the system itself. Twelve-Step support groups will be offered on campus and include support groups for individuals with co occurring disorders.

The agency managing the DASC will have the capability of offering transportation to residents who may need to travel off campus for various reasons (e.g. medical treatment, registering for benefits, meeting with vocational counselors etc.). Transportation will also provide a means for residents to participate in IOT services at other locations within the state and help residents become established in outpatient treatment services and the community.

While the Governor Bacon campus provides a good example of the kind of seamless continuum and "one stop shopping" that promotes efficient and effective use of resources to facilitate recovery, other models and configurations of services may be just as effective. This is especially true if additional treatment and community services can be designed to meet the needs of all three counties in Delaware.

III. Current Resources

DSAMH currently obligates $6,700,786 for Residential services – which is a combination of state and federal funds.

IV. Features of the Redesign

DSAMH anticipates that the addiction services continuum of the future will:

1. Provide governance and management through provider networks, not individual providers;
2. Contain flexible, rather than rigid, residential capacity, within a model that is dynamic, not static, based on client needs;
3. Replace fixed program models with variable lengths of stay that are clinically-driven, person-centered and based on ASAM criteria;
4. Re-balance "time in treatment" from reliance on residential to shorter-term, more intensive residential for detoxification, stabilization, and linkage to longer-term outpatient and community recovery supports;
5. Offer a mix of short-term intensive residential treatment and less intensive services, including intensive outpatient services that are linked to outpatient treatment;
6. Have the ability to flexibly staff beds, depending on client demand;
7. Offer housing/supportive living for clients who need such services and to maximize the use of outpatient, intensive outpatient (IOT), and partial hospitalization (PHP) levels of care;
8. Have the clinical capacity to treat either Substance Use Disorders (SUD) or co-occurring Mental Health and SUDs and a broader range of clients than are currently served, using trauma-informed, recovery oriented treatment approaches;
9. Employ residential clinical staff to match the expected clinical intensity and client needs, e.g. nursing, consulting physicians;
10. Make Medication-Assisted Treatment (MAT) available during the residential stay and throughout other levels of care (i.e., Ambulatory Detoxification);
11. Create strong connections between residential and outpatient services that incentivize linkage with outpatient treatment and integration into the community;
12. Measure the successful course of residential treatment as well as the 'overall treatment episode' (through outpatient to recovery support);
13. Provide transportation to assure access to outpatient treatment; and

14. Use pay-for-performance mechanisms to incentivize client-driven, variable length of stay, including appropriate retention rates for those admitted to residential treatment and linkage rates for continuing outpatient treatment.

A treatment system with these features should produce:

- Shorter lengths of stay in detoxification and possibly the need for less capacity;
- Shorter residential episodes of care with an expected length of stay ranging from days to weeks, not weeks to months;
- Seamless connection between residential and outpatient; and
- Greater utilization of PHP and IOT for clients who no longer need residential treatment to be safe from immediate danger.

The Division is considering a model in which a single provider or an affiliation of providers would operate most or all components of the continuum of care. Because of that, and in the interest of collaboration, providers are encouraged to work together to submit responses to this Request for Information.

V. RFI Questions for Response

Please provide answers to the following questions, adhering to the page limits for each section.

Organizational Affiliations (2 pages)

1. DSAMH is interesting in considering an "Accountable Care Organization-like" model to integrate residential and outpatient levels of care and create at least a virtual clinical management structure that could share benefits and savings. How familiar are you with this organizational model? How would you see it successfully applied to addictions treatment? What would you anticipate as the challenges of applying the model to behavioral health?

2. Short of a full ACO approach, how would you create an affiliated network to manage the addictions continuum of care? Have you had previous experience creating provider networks?

3. How much of the service array should be operated by a single organization or affiliation? If part of the system weren't managed through a singular governance structure, what would the relationship between components be?

Clinical Services (2 pages)

4. What clinical capacities would an organization need in order to be able to effectively treat individuals based on client need and the range of ASAM criteria? What capabilities does your organization have to treat co-occurring disorders?

5. What Medication-Assisted Treatment do you see as critical in an effective addictions treatment system? How would you make that available throughout all levels of care?

6. How would you link clients in treatment to patient-centered medical homes? What clinical model would you use and who would you target as health care partners? What is your experience in this area?

Residential Treatment (2 pages)

7. What do you anticipate as the challenges of operating residential treatment programs that are clinically intensive with variable lengths of stay driven by client needs? How would you overcome those challenges? How would you "flex" residential capacity in response to demand? Have you had experience operating variable length of stay residential treatment?

8. With easy access to residential treatment from detoxification, how would the need for detoxification capacity potentially change? What do you see as the feasibility of initiating ambulatory detoxification? How would that affect the need for residential detoxification? What is your experience in operating detoxification services?

9. How would you make supervised or supportive housing available so that clients can appropriately step down from residential treatment to less intensive levels of care, e.g. intensive outpatient, partial hospitalization, outpatient treatment. How would you make supervised or supportive housing available to clients who may not need residential treatment initially, but do need supportive living bundled with their outpatient, intensive outpatient or partial hospital care. Have you previously had experience doing this?

10. How would you develop supervised or supportive crisis beds for people in early stages of readiness to change who may present to acute medical, psychiatric and/or detoxification services when they primarily want a safe place to stay for the night? How could you divert them from utilizing high cost acute care and meet their needs more efficiently and effectively?

Outpatient Linkage (1 page)

11. How would you design the relationship between residential and outpatient treatment in order to effect seamless handoffs?

Community Re-integration (1 page)

12. If you were creating a case management service/function to facilitate community re-integration, how would you structure it? What would be its essential elements? How would case management enhance outpatient treatment and recovery support? How would you avoid inherent conflicts of interest when treatment providers are also expected to provide individualized, advocacy based case management services?

13. What do you see as the roles of peers in the Addiction Services Continuum? What experience have you had in incorporating peers into a recovery-oriented system of care? How would you differentiate between Peers in recovery from an SUD from Peers in recovery for mental conditions?

Utilization Management (1 page)

14. What system would you use to assure that all residential and outpatient treatment was client-driven and clinically necessary? What methods would you recommend that DSAMH use to oversee a provider-administered utilization management system?

Financing (2 pages)

15. What do you believe would be the best method(s) for compensating providers to operate a full continuum of care?

16. If DSAMH were to finance the continuum of care through case rate funding, what factors should they consider in setting the case rate? What period of time should the case rate cover?

17. How would you structure financial rewards and penalties to encourage the appropriate use of residential treatment, facilitate step-down from residential treatment and create effective linkages with outpatient treatment?

18. If you were budgeting for the continuum, what would you see as the distribution of funds by level of care? Describe your rationale for this distribution (1 page). *Please paste this chart into your response.*

Level of Care	Percentage of Funds
Short-term Intensive Residential Treatment (ASAM Levels III.1 – III.7)	
Detoxification	
Housing to Support Residential Step-Down or For Individuals Not Needing	

Intensive 24-Hour Care	
Partial Hospitalization/Intensive Outpatient Treatment	
Outpatient Treatment	
	100%

Performance and Outcomes (1 page)

19. What performance and outcomes measures would you use to judge the effectiveness of the Addictions Treatment System?

VI. Respondents Background

Please supply a one page narrative description of your organization's history, with contact information, details on your corporate structure, number of employees, brief profiles of senior management and other pertinent information regarding your business.

VII. Purpose of this RFI

Using the responses to this RFI, DSAMH will evaluate its service system design for industry compatibility, feasibility, and its ability to innovate in support of improved client care. It may then revise the specifications for the Addiction Services Continuum accordingly. After finalizing the DASC features and expectations the Division may issue a Request for Proposal for some components or all services included in the DASC.

VIII. Proposed Time Table

Activity	**Date**
RFI Advertisement	08/01/2011
Project Preview Meeting	08/16/2011
Questions due	08/19/2011
Answers to Questions	08/24/2011
Closing Date	09/15/2011

Please feel free to contact the Division of Substance Abuse and Mental Health with any questions regarding this RFI. The main point of contact will be:

Ceasar McClain, Community Mental Health Program Contract Manager

Submit an electronic response to this RFI to: Darlene Plummer at ceasar.mcclain@state.de.us by Thursday September 15, 2011