CAAP News and Events

Announcing New Scope of Practice for LADCs

The Connecticut Association of Addiction Professionals

Announces New Scope of Practice for LADCs

The Connecticut Association of Addiction Professionals' Board of Directors is delighted to announce that its 2018 Legislative Initiative- A *New Scope of Practice for the Licensed Alcohol and Drug Counselor,* unanimously passed the General Assembly on May 9, 2018.

The new Scope will be included in the CT Alcohol and Drug Licensure Statue. The Statue: Sec. 514. Section 20-74s of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2018*).

The Scope of Practice for the workforce of LADCs contains the following revised statutory

language:

(4) "Practice of alcohol and drug counseling" means [the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems] (A) the clinical evaluation by a licensed alcohol and drug counselor of substance use disorders and co-occurring disorders, including screening, assessment and diagnosis, treatment planning, counseling, therapy, trauma-informed care and psychoeducation with individuals, families and groups in the areas of substance use disorders and co-occurring disorders. (7) "Supervision" means the regular on-site observation, by a licensed alcohol and drug counselor or other licensed mental health professional whose scope of practice includes the screening, assessment, diagnosis and treatment of substance use disorders and co-occurring disorders, of the functions and activities of an alcohol and drug counselor in the performance of his or her duties and responsibilities to include a review of the records, reports, treatment plans or recommendations with respect to an individual or group;(8) "Substance use

disorder" means the recurrent use of alcohol or drugs that leads to clinically and functionally significant impairment, including, but not limited to, health problems, disability and failure to meet major responsibilities at work, school or home; and(9) "Co-occurring disorder" means the presence of a concurrent psychiatric or medical disorder in combination with a substance use disorder.

These practice activities are the "National Gold Standards" for states that have licensure statues governing the practice of alcohol and drug counseling for the Independent Practitioner, who possesses the required educational credentials, training modules, and supervised work or internship experience. The SAMSHA scope of services standards are based upon a tiered-system of workforce professional development, like professional models used in the behavioral health fields of Social Work, Marriage and Family Therapy, and Nursing. Connecticut's LADC statutory regulations and requirements meet the highest professional SAMSHA Tier -Tier IV, the Independent Clinical Substance Use Disorder Practitioner.

For well over a year, the CAAP Board and members with the valued support of their partners in the state legislature worked tirelessly to achieve this professional advancement that CT LADCs fully deserve. The new Scope expands access to best practice treatment for women and men with active substance abuse and co-occurring disorders in CT.

Susan Campion LADC LMFT

CAAP President

Posted: 2018-05-18 17:55:06

Creating Groundbreaking Public Policy

The CT Association of Addiction Professionals' Innovative 2016 Public Policy on the Collaboration between the Addiction Specialist and the Primary Care Provider in Fighting the Opioid Epidemic Becomes Law

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CAAP's Role in Creating Groundbreaking Public Policy to Meet the Challenge of the State's Opioid Epidemic Becomes Law.

In June 2016, the CT General Assembly passed Governor Malloy's Omnibus Opioid Abuse legislation. Over 50 bills on opioid abuse were submitted- only 10 proposals were included in the final legislation. CAAP's bill was included in the legislation. The bill was the **only treatment section** contained in the final legislation.

The law provides the statutory authority for Licensed Alcohol and Drug Counselors (LADCs), within their scope of practice, to offer state residents evidence-based, early prevention and intervention services to halt the development of dependence on pain meds. As the law states, primary medical providers will be able to refer their patients, who exhibit early warning signs of opioid abuse, to addiction LADCS for evaluation and treatment recommendations.

Introduction to CAAP.

The Connecticut Association of Addiction Professionals (CAAP) represents over 850 credentialed addiction specialists. It is the State Affiliate for the National Association of Alcohol and Drug Abuse Counselors. The Association is served by an all-volunteer Board of Directors, who advocate for public policy that empowers the State's workforce of addiction specialists, and most importantly, the substance abusing consumers whom the workforce serves**. The licensed addiction specialist, LADC, is the statutorily recognized professional provider of addiction services in Connecticut, who has met credentialing requirements, which encompass best practice standards of care in the treatment of addictions.**

In the 2015 Spring Edition of NAADAC's publication, "Advances in Addiction and Recovery", Connecticut 's license, LADC, was nationally recognized as one of the five state licenses that established the national

standard and precedent in meeting the fundamentals of excellence in the licensure of addiction specialists.

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An Example of an Intervention: How the Addiction Specialist/LADC, as a member of a primary care interdisciplinary team, meets the challenge of CT's prescription opiate and heroin epidemic

In 2017 Connecticut's prescription opiate and heroin epidemic is ravaging cities and towns with overdoses and deaths. The state's heroin-related deaths have shot up from 174 in 2012 to **over 1,000** this year. The use of Fentanyl has invaded the state's towns and cities spreading its lethal power.

Research has clearly shown that for many active opioid addicts the first step to heroin addiction began with a visit to their doctor/MD for **pain management**.

As an intervention for the pain, many well-intentioned MDs routinely prescribe a prescription for an opiate with the unintended consequences of initiating a deadly relationship between the prescription pill and the vulnerable patient.

The LADC/addiction specialist, as a key provider in meeting the challenge of active substance use disorder, will utilize his or her skill sets to conduct rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for opiate addiction. By intervening at the time of the patient's entry into the primary care setting, the threat of overdose and/or death can be immediately addressed.

The specialized services of a licensed alcohol and drug counselor (LADC) can offer valuable interventions, like **specialized prevention and early intervention services to halt a dependence on prescription opioids. The cost of these specialized services will be covered by private or public insurance carriers with no burden to the State of CT.**

If opioid dependence is diagnosed, the LADC will provide the **crucial compliance oversight guidance** to determine the level of clinical intervention- tapering of meds under the PCP's supervision and/or referral to medication- assisted therapy. The LADC will submit to the PCP a **Opioid Medication Consultation/ Referral Report**. In addition, the LADC will facilitate referrals to specialized services for patients encountered and treated by CT pediatricians, school –based clinics, internal medicine MDs, community health centers, and hospital clinics.

The Licensed Alcohol & Drug Counselor's Contribution to CT's New Advanced Medical Home Model of Primary Care- Enhanced Medical and Behavioral Health Patient Outcomes

The Connecticut Association of Addiction Professionals submitted an extensive document to the State's ***SIM initiative (*Connecticut Healthcare Innovation Plan Public Comments)** in 2014.The reader may refer to CAAP's comments via the CT Healthcare Advocate's websitehttp://www.ct.gov/oha/site/default.asp. The document included evidence of the addiction specialist's essential scope of services which will enhance the patient's medical and behavioral health treatment outcomes.

HRSA (Health Resources and Services Administration) & SAMHSA have made the inclusion of the addiction specialist in emerging models of integrated,

multidisciplinary, and coordinated primary medical delivery systems a major advocacy goal.

In May 2013, SAMHSA-HRSA released the report; ***Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions).*** The report underscored the importance of this complement of services:

"**Alcohol and drug addiction cost American society $193 billion annually, according to a 2011 White House Office of Drug Control Policy report. In addition to the crime, violence, and loss of productivity associated with drug use, individuals living with a substance abuse disorder often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease, cancer**

and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia…

When persons with addictions have co-occurring physical illnesses, they may require medical care that is not traditionally available in, or linked to, specialty

substance abuse care. The high quality treatment needed by individuals with addictions requires a team of different professionals that includes both specialty substance abuse providers and primary care providers.

The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care. In fact, clinical trials have demonstrated that when someone has a substance abuse problem and one or more non related disorders, integrated care can be more effective than traditional treatment delivery (i.e., separate, siloed primary care and substance abuse programs) in terms of clinical outcome and cost. It results in better health outcomes

for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that result in up to 80% of individuals not receiving care… (SAMSHA- HRSA, May 2013 Report)

Addictions--- Second Tier Behavioral Health Disorder

There still remains an insidious and subtle barrier that CT residents, and their significant others, encounter in accessing care in both in-patient and out-patient settings. It is the frankly dangerous and unfair perception that addiction is a second tier disorder. **Addiction is a Primary Disease!**

In Connecticut, and many other states, the denial of prompt and critical SA treatment, based upon a blaming and the negative model of care that directs the access to services on a protocol of failure**,** continue to strengthen the barriers of shame and stigma related to SUD.

Through multiple reporting venues beginning in 2012, the state has identified adolescents and young adults as a key consumer group who are in greatest need of less problematic access to SA treatment. As an example of the synergy between shame and barriers to treatment, it is not unusual for youth and young adults to be denied inpatient treatment until these consumers have "failed " at out-patient and intensive outpatient treatment.

With this sector of the population presenting with ~~the~~ soaring rates of opioid addiction and overdoses leading to death, this model is an egregious and barbaric system of care. Dr. Sharon Levy in her presentation at the 2014 Harvard Medical School's Symposium on Addictions (March 1, 2014) cited the following evidence of the prescription to heroin epidemic. **"In adolescents, recreational use of prescription painkillers accounted for 17.1% of all illicit drug use initiations beginning in 2009- more than any other drug than marijuana. Dr. Levy further cited that 1 out of 8 high school seniors reported using a prescription opioid for recreational/ non-medical use.**

In contrast, Connecticut's health care treatment standards do not block or withhold necessary medical intervention and treatment from youth and young adults who have

diabetes by withholding insulin medication until the young patient has a diabetic induced shock, as it does with its current stigmatizing standard of "failure of SA treatment level" to gain a therapeutically appropriate level of care.

It is important to note that the **ACA (**Affordable Care Act) **cites credentialed addiction specialists as required members of the ACA's Workforce-*Mental Health Professionals.* With the State's implementation of the advanced medical home, the credentialed addiction professional's highly specialized skills and expertise in providing evidence-based SA Treatment will be vitally important to ensure residents' successful health/behavioral health outcomes.**

CAAP's new law has a vital long-range goal. Through the collaboration of specialized addiction services and medical services delivered in a primary medical setting, the shame and stigma of addiction will be replaced by a new and accepted societal norm- Addiction is a primary disease and needs to be recognized and treated with new understanding and acceptance.

Recorder:

Susan C. Campion LADC, LMFT, President

for CAAP

Posted: 2017-12-16 16:17:03

2017 White Paper

CONNECTICUT ASSOCIATION

for

ADDICTION PROFESSIONALS

"A Strong Workforce of Addiction Professionals = Best Standards of Addiction Treatment for Connecticut Residents."

WHITE PAPER

The Connecticut Association of Addiction Professionals' 2017 Legislative Advocacy to Resolve the Scope of Practice Crisis for the Workforce of LADCs

Submitted by:

Susan Campion LADC, LMFT

President

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New Haven, CT 06512

www.ctaddictionprofessionals.org

To: CAAP Members and Supporters,

On behalf of the Connecticut Association of Addiction Professionals Board of Directors, I am submitting a "**2017 *White Paper".*** The Paper presents a synopsis of CAAP's investigation, action steps, and legislative remedy for the LADC matter, which contributed to resolving the crisis affecting the workforce of the state's LADCs

Legislative Remedy

On June 3, 2017, the CT General Assembly passed the following legislation that included new language for the LADC License's Statue, Scope of Practice Section under the Department of Public Health's 2017 Reviser Legislation. The following information contains the new language and the legislative citation.

Nothing in this section shall prohibit or limit the ability of a licensed alcohol and drug counselor from practicing alcohol and drug counseling with an individual diagnosed with a co-occurring mental health disorder other than alcohol and drug dependency provided the licensed alcohol and drug counselor works within the scope of practice outlined in CGS 20-74s(a)(4

Section 22, https://www.cga.ct.gov/2017/BA/2017HB-07222-R01-BA.htm

The CAAP Board of Directors gained many valuable lessons during this very difficult process. Because of the complexity of the matter and the severity of impact on our state's addiction specialists' workforce. CAAP wanted to formally submit and post key information on its website with its membership, supporters, professional colleagues, and state residents.

CAAP's 2017 Advocacy to Support the Workforce of the State's LADCs

Background and History

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At the beginning of the 2017 General Assembly, CAAP was approached by the Alliance of Non-Profits regarding the licensed addiction counselor's (LADCs) scope of practice.

The Alliance representatives provided information to CAAP that a DPH auditor at an agency in CT had cited an agency several months earlier. The auditor determined that an LADC had provided treatment to a client with a co-occurring disorder. The auditor's "**interpretation"** of our license's scope of practice stated that LADCs cannot provide co-occurring treatment and sign off on it. This "interpretation" ignited a series of severe unintended consequences, which involved many agencies and the Department of Social Services and most importantly, put the state's addiction specialists' professional future in jeopardy.

It is CAAP's practice to thoroughly investigate matters, which seriously impact the state's workforce of addiction professionals' capacity (as stated in the CT Practice License Statue) to deliver best practice treatment to state residents, who are struggling with Substance Use Disorder, and their families, partners, etc.

The information gathering's range was broad and detailed with fact-finding, beginning in the last days of December 2016 throughout the first six months of 2017. CAAP Board Members received reports from LADCs across the state. TheseT providers were representative of the diversity of our state's workforce of LADCs. Affected LADCs in an out-patient behavioral health & even SA agencies, criminal justice & DOC programs, IOPs in various venues, state colleges' addiction training programs, and independent practitioners reached out to the Association for help and guidance.

It is also important to note that a damaging collateral consequence was an intense process of disseminating misinformation about the incident, the professional credentials and scope of practice of a LADC, as defined in the CT licensure statue, and other standards for the profession. Individuals engaged in these discussions were poorly informed and at no time during this crisis reached out to CAAP for assistance. This misinformation was presented at a variety of venues, including local and regional behavioral health meetings and public meetings with state Senators and Representatives at the Legislative Office Building. This misinformation contributed to the exacerbation of the LADC matter.

Impact

LADCs reported harmful professional consequences regarding their current employment and ability to provide treatment for substance use disorders due to the DPH

"interpretation" of LADCs' Scope of Practice. CAAP identified activities and actions that harmed the LADCs' professional integrity and employability. The following are the chief issues which negatively impacted the workforce of addiction professionals during a six month period.

- *Many agencies across the state ceased hiring LADCs, even for the treatment of SA.*
- *Although the DSS Commissioner rescinded his December 2016 Bulletin that restricted LADCs' delivery of services to Medicaid clients, CAAP continued to receive complaints that DSS was not reimbursing LADCs for services rendered to the Medicaid consumer.*
- ***Update-** CAAP and its supporters' advocacy to DSS finally resulted in the correction of DSS reimbursements. LADCs are receiving payment for their services to Medicaid clients, effective April 17th.*
- *Alcohol and Drug educational programs in state community colleges experienced serious difficulties in placing interns at agencies, which had previously accepted interns, because of the "professional cloud surrounding LADCs.*
- *The DPH "interpretation" caused a severe fracture of necessary, seamless behavioral treatment for residents with co-occurring disorders. Residents were faced with seeking two providers- one for SUD & one for mental health disorders. Thus, the state was time-traveling backwards-returning to the old days of the 1950s- the unconnected treatment separation of addiction disorders and mental health disorders*
- **CT residents with SUDs lost the assurance that they will be treated by the statutorily identified licensed provider, LADC, who is the specialist in best practice and evidence- based treatment for addictions.**

In a key evidence and information sharing activity, during this period, I had a meeting with Chris Andresen, Section Chief of the DPH Licensing Division to review the salient points of the Scope of Services' issue. We had a comprehensive and productive conversation regarding the unintended consequences of the interpretation and potential remedies. Mr. Andresen was both very empathetic and helpful to the process.

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ACTION

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At the beginning of May, the CAAP Board of Directors held an emergency meeting. The Board examined all the evidence relative to the matter. The Board perceived that the crisis was escalating. The Board also considered that with the state's budget crisis, the

destructive impact on LADCs would likely intensify. The CAAP Board voted to take immediate action on the worsening situation and charged me with implementing the Board's Plan of Action.

Following the CAAP Board of Director's vote and recommendation , I reached out to Senator Terry Gerratana, Chair of the Public Health Committee, whom I had kept apprised of the LADC matter. I also wrote to the leadership of the Public Health Committee to ensure transparency in all communication. In my electronic reports, I presented the **facts---**history, evidence, and severe unintended consequences that necessitated finding a timely solution to the problem.

At this time, I also contacted Senator Martin Looney, President of the Senate. I had a lengthy conversation with Sen. Looney that covered the background of the issue and serious impact on the state's addiction specialists. I emphasized the severe problems that it caused for LADCs to provide best practice treatment to individuals with SUD and their families and partners during these challenging times. Senator Looney was most concerned and offered his support in finding a remedy.

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RESOLUTION

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Senator Gerratana and Senator Looney went to DPH the following week to meet with Chris Andresen and other DPH staff. The afternoon of the meeting, Mr. Andresen contacted me with proposed language that presented a reset on LADCs' authority to treat individuals with co-occurring disorders. On behalf of CAAP, I accepted the language. We also discussed the submission of the SAMSHA Tier IV Scope of Practice during the DPH allotted date. The following is the corrective language. It would be included in the DPH Revisor Bill.

Nothing in this section shall prohibit or limit the ability of a licensed alcohol and drug counselor from practicing alcohol and drug counseling with an individual diagnosed with a co-occurring mental health disorder other than alcohol and drug dependency provided

the licensed alcohol and drug counselor works within the scope of practice outlined in CGS 20-74s(a)(4

A week later, Mr. Andresen sent a copy of a letter that he distributed to Connecticut's substance abuse treatment agencies, programs, and other venues providing SA TX. I am attaching the correspondence for the record.

The CAAP Board of Directors knows that its members, supporters, and state residents, who are consumers of SA TX services will agree that this remedy is of great benefit to the state's substance abuse professionals at a time of severe financial crisis for all state behavioral health service providers.

This outcome demonstrates one of CAAP's guiding principles- **Collaboration.** On behalf of CAAP, I want to express our gratitude to Senator Gerratana, Senator Looney, the leadership of the Public Health Committee, Chris Andresen and staff of DPH's Licensing Division, and the dedicated members of CAAP, for their valued support.

APPENDICES:

1. **1. COPY OF DPH LETTER SENT TO LICENSED MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT AGENCIES**

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H. Commissioner Dannel P. Malloy Governor

Nancy Wyman Lt. Governor

May 16, 2017

Dear Connecticut Licensed Mental Health and Substance Abuse Treatment Agencies,

It has come to the Department's attention that there may be some confusion regarding the statutory scope of practice for Licensed Alcohol and Drug Counselors (LADCs) in Connecticut and the types of clients that the Jaw permits LADCs to serve. The scope of practice for LADCs in the Connecticut General Statutes, pursuant to Section 20-74s (a)(4) reads:

"*Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems, and may include, as appropriate, (AJ conducting a substance use disorder screening or psychosocial history evaluation of an individual to document the individual's use of drugs prescribed/or pain, other prescribed drugs, illegal drugs and alcohol to determine the individual's risk/or substance abuse, (BJ developing a preliminary diagnosis for the individual based on such screening or evaluation, (CJ determining the individual's risk for abuse of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol, (DJ developing a treatment plan and referral options for the individual to ensure the individual's recovery support needs are met, and (EJ developing and submitting an opioid use consultation report to an individual's primary care provider to be reviewed by the primary care provider and included in the individual's medical record. "*

he statutes related to LADCs do not restrict the type of client that a LADC can serve. LADCs may provide services to individuals with a substance use disorder, to individuals with co-occurring disorders or to individuals without a substance abuse disorder diagnosis who are affected by alcohol and drug dependency problems. However, like any licensed professional, LADCs must work within the boundaries of the scope of practice for their profession established in statute. Please be aware that a statutory scope of practice delineates the boundaries of the services a licensed professional can provide within their practice and the services allowed by licensure may or may not align easily with reimbursement decisions by third party payers. We hope that this information is helpful.

s~ Christian D. Andresen, Section Chief,

Practitioner Licensing and Investigations Section Connecticut Department of Public Health

2.Copy of DSS Notification on Reimbursement Policies for *Psychiatric Diagnosis Evaluation/ 90791*

Department of Social Services:

interChange Provider Important Message

Attention: Licensed Alcohol and Drug Counselors (LADCs) The Department of Social Services (DSS) has approved procedure code 90791 “Psychiatric Diagnostic Evaluation” to be covered for Licensed Alcohol and Drug Counselors (LADCs) effective for dates of service October 1, 2016 and forward. DXC Technology updated their system on Thursday, April 13, 2017 to allow these services to be processed. LADC providers can resubmit any previously denied claims containing procedure code 90791 starting Thursday April 13, 2017. Prior Authorization (PA) is required for this service and any claims submitted without a PA from Beacon Options will be denied with Explanation of Benefits (EOB) code 3003 “Prior Authorization is Required for Payment of this Service”. **For additional information on the scope of practice for LADC providers, please refer to Provider Bulletin 2017-01 “Scope of Practice for Licensed Alcohol and Drug Counselors – Updated Policy Transmittal”.**

Posted: 2017-07-14 17:26:28

CAAP’s 2016 Legislative Advocacy Achieves Goals!

CONNECTICUT ASSOCIATION

for

ADDICTION PROFESSIONALS

Announcement

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CAAP's 2016 Legislative Advocacy to Address Connecticut's Opioid/ Heroin Epidemic Achieves Goals!

The Connecticut Association of Addiction Professionals' Board of Directors is pleased to announce:

After almost a year's duration, CAAP's 2016 legislative advocacy a achieved a new and vita role for LADCs in the Connecticut's 2016 Opioid Legislation-H.B. 5053! Governor Malloy signed the legislation into law at the end of May.

LADCs achieved new professional standing. Section 6 of the new law provides *the statutory authority for Licensed Alcohol and Drug Counselors (LADCs), within their scope of practice*, *to offer state residents evidence-based, early prevention and intervention services to halt the development of dependence on pain meds.* It is the only treatment strategy besides the distribution and use of NARCAN in the new legislation!

The CAAP Board is thrilled because it is clearly a solid step in acknowledging that Addiction is a primary disease! We think that it strengthens the collaboration of addiction specialists and primary care providers in addressing a patient's symptoms of addiction in the context of a medical visit. From this clinical/medical service, we think that this ground-breaking public policy will begin the process of breaking thru the huge obstacles of Shame & Stigma, which are major blocks to access to SA Tx.

Section 6 of the new law is now posted on the CAAP Website.

Posted: 2016-06-08 07:00:06

2016 HB 5053

AN ACT CONCERNING OPIOIDS AND ACCESS TO OVERDOSE REVERSAL DRUGS. 2016 HB 5053

Sec. 6. Subdivision (4) of subsection (a) of section 20-74s of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(4) "Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems, and may include, as appropriate, (A) conducting a substance use disorder screening or psychosocial history evaluation of an individual to document the individual's use of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol to determine the individual's risk for substance abuse, (B) developing a preliminary diagnosis for the individual based on such screening or evaluation, (C) determining the individual's risk for abuse of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol, (D) developing a treatment plan and referral options for the individual to ensure the individual's recovery support needs are met, and (E) developing and submitting an opioid use consultation report to an individual's primary care provider to be reviewed by the primary care provider and included in the individual's medical record;

Posted: 2016-06-08 06:54:43

Flash Report: Raised Bill S.B. 353- Opioid Abuse

CONNECTICUT ASSOCIATION

for

ADDICTION PROFESSIONALS

"A Strong Workforce of Addiction Professionals = Best Standards of Addiction Treatment for Connecticut Residents."

Flash Report*: Raised Bill S.B. 353- *Opioid Abuse

Connecticut Association of Addiction Professionals' 2016 Legislative Advocacy to Address the Prescription Opioid & Heroin Epidemic

Submitted by:

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Connecticut Association of Addiction Professionals: Proposed 2016 Legislation to Address the State's Prescription Opioid and Heroin Epidemic

Introduction

In 2015, the statistics for deaths due to overdose caused by opioids/heroin has risen to **727 Connecticut residents**. There is not one town or city in our State that has not experienced the horrific impact of the opioid and heroin epidemic. Since 2015, Connecticut opioid addicted residents are now at even greater risk due to the addition of the drug Fentanyl to street supplies of heroin. Fentanyl is significantly more potent that heroin , which it increases its desirability to addicted individuals. It has been identified as a major contributing factor in the stunning rise in deaths by overdose.

On a daily basis, the workforce of CT's credentialed addiction specialists are confronted with the daunting challenge of treating opiate addicted women and men, many between the ages of 16- 30 years old, with

few treatment options. The current treatments produce outcomes less than promising.

Beginning in 2015, the Connecticut Association of Addiction Professionals conducted an informal statewide survey of addiction specialists, primary care providers, licensed behavioral health providers, and consumers. Respondents described a bleak picture for consumers with an opiate addiction . In Connecticut and across the nation, clients, who seek treatment, have two treatment options- medication assisted therapy or abstinence.

In multiple national research studies there is universal consensus that the origin of opioid addiction begins in the office of the primary care provider- **80% of individuals addicted to opioids/heroin report that their addiction began with a prescription of pain meds from their MDs.**

Respondents were in agreement that unfortunately, often the first point of service for the opiate addicted individual is the local ER. The consumer is rushed in by a family member or first responders due to an overdose. If lucky, the individual is revived with NARCAN. The sad fact is that the individual is restored to exactly the same state of addiction at the time of the overdose.

Given the harsh reality and complexity of the heroin epidemic in 2016, CAAP proposes legislation, which contains prevention and treatment recommendations, as beginning steps to reduce the great suffering of CT individuals, their families, partners, and friends caused by this epidemic.

Note: The two proposed legislative policies will incur NO COST to the State of Connecticut.

Summary Statements of CAAP's Two Legislative Proposals

I. A Team Approach to the Prevention, Intervention, and Treatment of Opiate Addiction in Primary Care Settings- An Addiction Specialist and Primary Care Provider Collaboration

CAAP's first recommendation centers on preventing and intervening in opiate abuse by integrating the services of an addiction specialist into primary care practices across our State.

At a high-powered meeting of CT Senators, State Officials, consumers, and the Acting Director, Office of National Drug Control Policy, held in April 2014 at the Cornell Scott Hill Health Center, the Director of the Drug Control Policy, Michael Botticicelli shared that his addiction to prescription drugs began in his Dentist's office with a prescription for Percoset (*New Haven Independent,* April 18, 2014). There appears to be a consensus among MDs, Addiction Specialists, and opiate addicted consumers that prevention of opiate addiction needs to begin on the front line, at the office of a primary care provider

In 2014, the Connecticut Association of Addiction Professionals submitted an extensive document to the State's ***SIM initiative*-Connecticut Healthcare Innovation Plan Public Comments**. The reader may refer to CAAP's comments via the **CT Healthcare Advocate's Website.** The document included evidence of the addiction specialist's essential scope of services, which will enhance the patient's medical and behavioral health treatment outcomes.

In May 2013, SAMHSA-HRSA released the report; ***Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions).*** The report underscored the importance of this complement of services:

"The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care."

Throughout the 2015 legislative session, several proposed bills were raised to provide basic training to MDS, APRNS, PAs, and LCSWs in specialized addiction screening methods and brief intervention strategies in substance abuse treatment. CAAP offered

compelling evidence that proved that LADCs already possess the requisite training and skill sets to provide these services!

Today, CT PCPs are challenged daily by the limitations of time and fiscal resources in providing a comprehensive evaluation of their patient's substance

abuse history and current substance usage. The ICER **2014 Draft on *Treatment of Patients with Opiate Dependence* cites** numerous studies that

a "comprehensive assessment by a clinical addiction specialist to determine a patient's overall risk, presence of co-morbid disorders, including chronic pain or co-occurring substance abuse… and extent of dependence is crucial… in designing a comprehensive, individualized care plan to address the patient's needs. (ICER 2014 pp.73-74). By the inclusion of an addiction specialist, as a key provider, in primary care settings, or referral to an independent practioner, this specialist will provide the patient with a rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for the prevention or treatment of all forms of Substance Abuse Disorders (SUD)."

CAAP strongly recommends that the General Assembly and Governor Malloy

endorse a 2016 public policy initiative to prevent the onset of opiate addiction by supporting the integration of credentialed addiction specialists into primary care settings.

CT PCPs will need to develop a protocol for standard of care and referral of patients, whose opiate med prescriptions exceed medical need for their presenting condition. This referral to an addiction specialist is, as critical as, medical protocols for referrals of patients with diabetes, cardiac disease, depression, etc. Opiate addiction is a primary disease. CAAP advocates for best practice treatment of these patients throughout Connecticut's diversity of Primary Care settings. Following this protocol, the opiate abusing/dependent patients would be routinely referred to a licensed addiction specialist, who will offer comprehensive evaluation, diagnosis. referral, and specialized treatment. **By intervening at the time of the patient's entry into a primary care setting, the threat of opiate dependence, which may ultimately lead to overdose and/or death can be promptly addressed and effectively treated.**

II. The Implementation of Uniform, Best Practice Guidelines in the Use of Suboxone (buprenorphine) for Medication- Assisted, Office-Based Treatment by Certified Physicians in Independent Practices.

In Connecticut and across the nation, clients, who seek treatment, have two treatment options- medication assisted therapy or abstinence. Consumers are given highly addictive medications, agonist agents, Methadone or Suboxone (buprenorphine/naltraxone) that are offered at specialized clinics or thru private physicians. These medications are "replacements" transferring the dependence from a street drug to a prescribed drug with the long –term goal of abstinence. The Institute for Clinical and Economic Review's *"Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Reports",(cepac,icer review)* May 2014 presented a cohort model of 1,000 hypothetical patients entering treatment . The model 's results of efficacy of treatment between Methadone Maintenance and Subxone & Subxone taper were remarkably similar (pp.7-10). Around 28% were drug free in two years, but each group had similar %s of relapses, **55%**-a dangerously high rate. Unfortunately, these treatments are currently **all** addiction science has to offer.

When Suboxone (buprenorphine) was introduced in the early 2000s, it was lauded as a "silver bullet" to address opioid addiction- a safe, less addictive, and short-term medication- assisted treatment with specialized counseling. Suboxone researchers described the medication as a promising alternative to long-term methadone maintenance. Fast forward to 2016, Suboxone's fidelity to its original treatment assurance has been severely tarnished. Suboxone is now a financially hot property on the street for drug trafficking, and also, by less than scrupulous MDs in private practice, who can boost their revenues by thousands of dollars with little external oversight. The loser is the opioid dependent client.

As respondents to the CAAP 2015 survey stated, their experiences with individuals treated with Suboxone showed a critical lack of uniform standards for treatment. As an example, clients, who participate in a Suboxone program at a not-for profit substance abuse treatment setting, hospital-based IOP, or criminal justice diversion program receive more structured and consistent monitoring of their medication and specialized therapy. In these programs, clients are required to attend specialized recovery management groups and undergo random urine toxicology screening. Also, clients in these settings, who present with co-occurring disorders, are much more likely to gain access to additional behavioral health services thru the agency's or program's referral network- thus boosting a client's treatment outcomes.

Individuals, who choose to seek Suboxone treatment from a certified private physician are often likely to receive treatment that lacks structure, compliance oversight (ex., random UAs), and no counseling except a brief check-in session conducted by a nurse or practice assistant. CAAP respondents report that many physician- based Suboxone private practices have a caseload of **80- 100 patients** receiving the medication. These programs, due to the size of client caseloads, are unable to diligently monitor signs of relapse, use of other drugs, and the critical psycho-social factors, which will positively or negatively impact the client's path to recovery.

CAAP found that survey respondents were unanimous in the need for conjoint specialized counseling for clients being treated with Suboxone. It is important to note that when Suboxone was introduced, the protocol advocated 6- 18 months of treatment with a target of successful tapering of doses till the client gained abstinence. Currently in Connecticut, Suboxone therapy now mirrors methadone-maintenance.

Clients average 4 years of treatment on Suboxone with treatment interruptions due to non-compliance, illegal activity, etc. The message for the possibility of a drug-free

life seems to be minimized. CAAP supports the position posted an article in *Addiction Treatment Magazine:*

" Studies have shown individuals who are being treated with prescription Suboxone and also take part in counseling have a much better outcome than those who continue on Suboxone alone. Counseling would prove more effective at helping the individual begin to make changes in their behavior and lifestyle so that he or she can focus on long-term recovery goals.. The counseling occurs in tandem with Suboxone treatment makes the process easier and more effective." (Nov. 2011).

In a 2013 study on the lack of essential specialized psychotherapy services for individuals engaged in MAT, Robert Lubran, director of Pharmacologic Therapies at the Substance Abuse and Mental Health Services Administration (SAMHSA), was quoted as saying:

"**The array of state legislation reflects concerns that some for-profit clinics, which distribute the synthetic narcotic to help patients beat addictions to heroin and other opiates, don't provide enough services. We know for-profit providers often provide a lower level of service" than nonprofit counterparts. Additionally there have been reports that the**

“group therapy” provided in some clinics is inconsistent in terms of frequency and may not be appropriately balanced between psychoeducational and psychotherapeutic

services.

The evidence is conclusive, as presented in many studies beginning in 2010 to the present, effective buprenorphine treatment should include a psycotherapeutic component in the induction, stabilization phases, and maintenance phase till taporing off the meds.

As one CAAP Board member stated: “Clients who are on Suboxone with no specialized counseling, are missing an essential process for their recovery. The treatment is inferior. It is like asking an individual with a broken leg to use only one crutch for his or her rehabilitation”!

III. Supportive Evidence for 2016 Public Policy Initiatives to Meet the Challenge of Prescription Opioid Addiction and Heroin Addiction

Introduction:

The Connecticut Association of Addiction Professionals represents over 850 credentialed addiction specialists. It is the State Affiliate for the National Association of Alcohol and Drug Abuse Counselors. The Association is served by an all-volunteer Board of Directors, who advocate for public policy that empowers the State’s workforce of addiction specialists, and most importantly, the substance abusing consumers whom the workforce serves**. The licensed addiction specialist, LADC, is the statutorily recognized professional provider of addiction services in Connecticut, who has met credentialing requirements, which encompass best practice standards of care in the treatment of addictions.**

In the 2015 Spring Edition of NAADAC’s publication, “Advances in Addiction and Recovery”, Connecticut ‘s license, LADC, was nationally recognized as one of the five state licenses that established the national standard and precedent in meeting the fundamentals of excellence in the licensure of addiction specialists.

An Example of an Intervention: How the Addiction Specialist/LADC, as a member of a primary care interdisciplinary team, meets the challenge of CT's prescription opiate and heroin epidemic

Connecticut's prescription opiate and heroin epidemic is ravaging cities and towns with overdoses and deaths. The state's heroin-related deaths have shot up from 174 in 2012 to to **727** in 2015. Meanwhile, the use of heroin doubled nationally from 2007 to 2012. It would be highly presumptuous to infer that addiction specialists alone can solve this multi-faceted health crisis.

Research has clearly shown that for many active opioid addicts the first step to heroin addiction began with a visit to their doctor/MD for **pain management**.

As an intervention for the pain, many well-intentioned MDs routinely prescribe a prescription for an opiate with the unintended consequences of initiating a deadly relationship between the prescription pill and the vulnerable patient.

With the proposed legislation, the PCP may refer his or her patient to an Addiction Specialist. The specialized services of a licensed alcohol and drug counselor (LADC) can offer valuable interventions, like **specialized counseling,** and **compliance oversight,** and if necessary, the specialist will enhance treatment outcomes of medication assisted therapies. This legislation will expand the capacity to meet the challenge of prescription opiate and heroin abuse/addictions in patients encountered and treated by CT pediatricians, school –based clinics, internal medicine MDs, community health centers, and hospital clinics.

The LADC/addiction specialist, as a key provider in these settings, will utilize his or her skill sets to conduct rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for opiate addiction. The recommended treatment plan will be conveyed to the referring medical provider to ensure continuity of both medical and behavioral health care. By intervening at the time of the patient's entry into the primary care setting, the threat of opioid dependence, overdose and/or death can be immediately addressed.

The Licensed Alcohol & Drug Counselor's Contribution to CT's New Advanced Medical Home Model of Primary Care- Enhanced Medical and Behavioral Health Patient Outcomes

The Connecticut Association of Addiction Professionals submitted an extensive document to the State's ***SIM initiative (*Connecticut Healthcare Innovation Plan Public Comments)**. The reader may refer to CAAP's comments via the CT Healthcare Advocate's website http://www.ct.gov/oha/site/default.asp. The document included evidence of the addiction specialist's essential scope of services which will enhance the patient's medical and behavioral health treatment outcomes.

HRSA (Health Resources and Services Administration) & SAMHSA have made the inclusion of the addiction specialist in emerging models of integrated, multidisciplinary, and coordinated primary medical delivery systems a major advocacy goal.

In May 2013, SAMHSA-HRSA released the report; ***Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions).*** The report underscored the importance of this complement of services:

"**Alcohol and drug addiction cost American society $193 billion annually, according to a 2011 White House Office of Drug Control Policy report. In addition to the crime, violence, and loss of productivity associated with drug use, individuals living with a substance abuse disorder often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease, cancer and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia…**

The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care. In fact, clinical trials have demonstrated that when someone has a substance abuse problem and one or more non related disorders, integrated care can be more effective than traditional treatment delivery (i.e., separate, siloed primary care and substance abuse programs) in terms of clinical outcome and cost. It results in better health outcomes

for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that result in up to 80% of individuals not receiving care… (SAMSHA- HRSA, May 2013 Report)

Addictions--- Second Tier Behavioral Health Disorder

There still remains an insidious and overwhelming barrier that CT residents, and their significant others, encounter in accessing care in both in-patient and out-patient healthcare settings. It is the frankly dangerous and unfair perception that addiction is a second tier disorder. **Addiction is a Primary Disease!**

In Connecticut and many other states, the denial of prompt and critical SA treatment, based upon a blaming and the negative model of care that directs the access to services on a protocol of failure**,** continue to strengthen the barriers of shame and stigma related to SUD(Substance Use Disorder

Through multiple reporting venues beginning in 2012, the state identified adolescents and young adults as a key consumer group who are in greatest need of less problematic access to SA treatment. As an example of the synergy between shame and barriers to treatment, it is not unusual for youth and young adults to be denied inpatient treatment until these consumers have "failed " at out-patient and intensive outpatient treatment.

With this sector of the population presenting with ~~the~~ soaring rates of opioid addiction and overdoses leading to death, this model is an egregious and barbaric system of care. Dr. Sharon Levy in her presentation at the 2014 Harvard Medical School's Symposium on Addictions (March 1.2014) cited the following evidence of the prescription to heroin epidemic. **"In adolescents, recreational use of prescription painkillers accounted for 17.1% of all illicit**

drug use initiations beginning in 2009- more than any other drug than marijuana. Dr. Levy further cited that 1 out of 8 high school seniors reported using a prescription opioid for recreational/ non-medical use.

In contrast, Connecticut's health care treatment standards do not block or withhold necessary medical intervention and treatment from youth and young adults who have

diabetes by withholding insulin medication until the young patient has a diabetic induced shock, as it does with its current stigmatizing standard of "failure of SA treatment level" to gain a therapeutically appropriate level of care.

It is important to note that the ACA (Affordable Care Act) cites credentialed addiction specialists as required members of the ACA's Workforce-*Mental Health Professionals.* With the State's implementation of the advanced medical home, the credentialed addiction professional's highly specialized skills and expertise in providing evidence-based SA Treatment will be vitally important to ensure residents' successful health/behavioral health outcomes.

If the state chooses not to give full parity to licensed addiction specialists in its behavioral health provider, public and private payer network, the greatest risk will be to CT residents. Consumers, whoseek substance abuse treatment, will be in jeopardy of loosing access to evidenced-based treatment and the highest standards of care for their addictions by the statutorily identified behavioral health provider- the licenced Alcohol & Drug Counselor (LADC). **Thispoint is particularly relevant, as it applies to the extremely complex and unfortunately limited treatment options for opioid addiction.**

Current Barriers to Best Practice SA Treatment

Parity of Substance Abuse Treatment Services

and

Public and Private Reimbursement

for

Provider Fees

Addiction professionals and consumers from across CT regularly report to CAAP Board Members that insurance carriers' current practices create severe barriers to SA treatment. The barriers are all about money in the form of savings to Private Insurance Carriers in an array of fiscal defense strategies! These strategies include:

- **Ratione utilization methods for course of treatment and length of stay to inpatient and outpatient treatment**
- **Questionable protocols for denial of claims.**
- **Network of providers, who may not possess the credentialing standards of educational and professional experience in the treatment of SUD.**
- **Low rates of reimbursement with no increases to providers in several years.**
- **The 2015 Connecticut Budget proposal that attempted to eliminate Medicaid reimbursements to licensed behavioral health providers!**
- **Flawed access to SA treatment. Examples include; many Medicaid patients who often present with the most complex medical and behavioral health disorders receive marginal treatment or encounter serious systemic barriers to care- lengthy waiting periods for healthcare appointments; language issues; complicated and uncoordinated referral processes to specialists; patient stigmatization due to life-style and misinformation about the disease of Addiction.**

- **<u>The current issue that impacts residents with private insurance in Connecticut-</u>**

Across the state, a significant number of private practioners, psychiatrists, APRNS, Masters level licensed behavioral health providers are opting out of accepting private insurance but operating their independent practices on a fee for service system. This shift in payer reimbursement has created the Perfect Storm that wages havoc on residents, families, and partners, who seek SA treatment in Connecticut's fractured Access to Care system.

CT has a moral obligation to provide its residents, families, and partners impacted by the disease of addiction, with insurance coverage that promotes swift access to evidence-based levels of care, qualified specialists, and fiscal coverage and reimbursement policies which are equal to the complexities inherent to the disease.

If the state of Connecticut is serious and determined to address the growing numbers of its residents' addiction to prescription opioid and heroin, it is time to pass enlightened and robust public policy that saves lives and supports recovery. Let us always remember that addiction is a treatable disorder, but if not treated with appropriate standards of practice, addiction **is a terminal illness.**

Posted: 2016-04-15 02:57:01

OLR Bill Analysis- Proposed Legislation SB 353

AN ACT CONCERNING OPIOID USE DISORDER.

SUMMARY:

This bill contains various provisions on opioid abuse prevention and treatment and related issues.

It (1) adds up to six members to the state's Alcohol and Drug Policy Council, (2) specifies components that may be included in the council's required plan for substance abuse treatment and prevention services, and (3) makes other changes affecting the plan's development.

It specifically allows a physician, advanced practice registered nurse (APRN), or physician assistant (PA) (collectively, “primary care providers”) to refer a patient to a licensed alcohol or drug counselor (LADC) for an assessment of opioid abuse or an intervention to prevent such abuse. It allows such a primary care provider to prescribe opioids to a patient on the condition that the patient agree to accept a referral to an LADC.

The bill specifies several steps that an LADC may take in treating a client, such as developing a preliminary diagnosis based on a substance abuse screening.

The bill also allows certified individuals to practice auricular acupuncture to treat alcohol and drug abuse in any setting under a physician's supervision, not just Department of Public Health (DPH)-licensed freestanding substance abuse facilities or facilities operated by the Department of Mental Health and Addiction Services (DMHAS), as under current law. It makes a conforming change to the DPH commissioner's duty to adopt regulations on this practice.

EFFECTIVE DATE: October 1, 2016

§ 1 – ALCOHOL AND DRUG POLICY COUNCIL

Membership

By law, the council consists of more than 20 public officials or their designees. In addition, current law allows the council's co-chairpersons (the DMHAS and children and families commissioners) to jointly appoint up to seven members. The bill allows the co-chairs to appoint an additional six members (for a total of 13), including:

1. an LADC,

2. a pharmacist,

3. two municipal police chiefs,

4. an emergency medical technician, and

5. the executive director of the Health Assistance Intervention Education Network or her designee (HAVEN is the professional assistance program for DPH-regulated professionals).

Integrated Plan

By law, the council is charged with (1) reviewing state policies and practices on substance abuse treatment and prevention programs, referrals to such programs, and criminal sanctions and programs, and (2) developing and coordinating a statewide, interagency, integrated plan for these matters.

The bill provides that the plan may include:

1. a strategy for providing information on, and referrals to, medication-assisted treatment at every location where opioid users are found in the health care or criminal justice systems, drug treatment programs, and elsewhere in the community;

2. overdose rescue strategies that include the use of opioid antagonists as a standard of care;

3. methods for safer drug prescribing and dispensing, including training and education on opioid prescribing for physicians, APRNs, PAs, and dentists;

4. recovery supports, such as peer recovery services;

5. an evaluation of, and recommendations for, in-state long-term recovery treatment services and facilities;

6. developing a website that offers information about opioid use disorder, lists available in-state recovery treatment services, and allows for surveys or other community input; and

7. developing a program to allow local police officers and emergency medical technicians to connect with people in the community seeking recovery from addiction and to offer immediate help.

The bill also:

1. requires each plan component to be evidence-based, data-driven, sustainable, and responsive to changes in the nature of drug addiction and drug overdoses;

2. requires the plan to contain outcome-driven and measurable goals, including reducing the number of opioid-induced deaths; and

3. allows the council, in developing the plan, to consult with local, national, and international experts on substance abuse and to hold forums for public comment.

§ 4 – LICENSED ALCOHOL AND DRUG COUNSELORS

The bill allows an LADC to:

1. conduct a substance use disorder screening or psychosocial history evaluation to document a patient's use of pain medications, other prescribed drugs, illegal drugs, and alcohol, to determine the patient's risk for substance abuse;

2. develop a preliminary diagnosis based on this screening or evaluation;

3. determine the patient's risk for prescription drug abuse and, if necessary, develop a treatment plan and referral options;

4. take this action after providing services to a patient to ensure the patient has received the recommended services and treatment and necessary recovery support; and

5. submit an opioid use consultation report to a patient's primary care provider to be reviewed by that provider and included in the patient's medical record.

BACKGROUND

Related Bills

Several other bills reported out of committee contain provisions on opioid abuse and related topics.

sSB 129, as reported out of the Insurance and Real Estate Committee, requires the insurance commissioner to study and report on abuse-deterrent and nonabuse-deterrent opioid analgesics.

sSB 352, reported favorably by the Public Health Committee, (1) allows opioid prescribers to issue standing orders allowing pharmacists to dispense opioid antagonists administered nasally or by auto-injection, without a patient-specific

prescription, and (2) limits the circumstances in which authorized practitioners may prescribe more than a seven-day supply of opioids.

sHB 5053 (File No. 7), also reported favorably by the Public Health Committee, contains various provisions on access to opioid antagonists, such as expanding to any licensed health care professionals existing law's immunity for prescribers when administering the drug.

HB 5301 (File No. 143), reported favorably by the Committee on Children, subject to certain exceptions, sets requirements for practitioners when prescribing opioids to minors, including obtaining specific written consent from the parent or guardian.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 28 Nay 0 (03/21/2016)

Filed April 5, 2015

Posted: 2016-04-15 02:52:08

CAAP 2014 White Paper

Dear Reader,

The Connecticut Association of Addiction Professionals CAAP posts a **2014 White Paper** on the State's workforce of credentialed addiction specialists.

The paper will discuss the recent past, present, and future of the field relative to the role of the addiction specialist in Connecticut's new paradigm of a healthcare services-Advanced Medical Home model. The new healthcare system is founded upon a patient-centered, primary medical care offered by a multidisciplinary team of medical and behavioral health providers.

On behalf of CAAP. I invite you to share your thoughts, questions, and comments on CAAP's mission, goals, and objectives. We are here to serve you.

Best Regards,

Susan Campion LADC, LMFT

President

CONNECTICUT ASSOCIATION for ADDICTION PROFESSIONALS

"A Strong Workforce of Addiction Professionals = Best Standards of Addiction Treatment for Connecticut Residents."

Presents

Connecticut Association of Addiction Professionals 2014 White Paper

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The Importance and Contribution of a Credentialed Workforce of Addiction Professionals to the Success of Connecticut's New Paradigm of Healthcare Delivery

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Submitted by, Susan Campion LADC, LMFT

President

New Haven, CT

Spring 2014

www.**ctaddictionprofessionals**.org

Introduction to CT's Addictions Specialists- Licensed Alcohol and Drug Abuse Counselor

The primary element of successful SA treatment is the highly skilled, educated, and compassionate qualified provider. This provider needs to be prepared and ready to meet the intrinsic complexities and challenges inherent in the treatment of active addictions. This paper will present commentary and evidence to underscore the importance of Licensed Alcohol & Drug Abuse Counselors, LADCs participation in the State's Advanced Medical Home Model of Primary Care.

The LADC's Evolution from a Near Death Experience to a Thriving Health Care Specialty

The Connecticut Association of Addiction Professionals (CAAP), which represents over a 1000 credentialed addiction professionals led the 2013 legislative initiative on the LADC license, which suffered a near fatal assault in passage of a 2012 law that stripped the license of its standards and requirements. This legislation threatened the survival of the profession. CAAP fought to sustain and regain our profession's deserved stature as necessary, equal, and statutorily empowered behavioral health provider in Connecticut' s public and private mental health/substance abuse service system.

CT's credentialed specialists entered a new era with the passage of the 2013 LADC Licensure. The most important outcome was the achievement of ensured statutory best practice standards for substance abusing consumers.

Evidence Based Need for Addiction Specialists in Meeting the Growing Demand for Access to SA Treatment:

CAAP's legislative initiative identified a worrisome trend in CT's network of behavioral health delivery system that we contended may taint access to critical standards of SA treatment.

Over the past several years, CT behavioral health care public and private providers have leaned towards hiring social workers (LCSWs) and other licensed masters' level behavioral health providers, as not only the primary clinical provider of substance abuse services, but also the supervisor of licensed addiction specialists.

The CT Association of Addiction Professionals' research on social work, marriage and family, and professional counseling academic requirements in state public and private masters programs found the following information. **These behavioral health, professional academic programs' requirements, have few if any courses , specific to addiction theory and treatment. The course work covers broader areas of study in generally the same number of graduate hours, and requiring fewer, if any specific post-graduate training hours in substance abuse**. **Although competent within their respective mental health professional standards, LCSWs, LMFTs, and LPCS , few of these professions have the specific graduate and post-graduate training , work experience , and supervision in the treatment of substance abuse disorders .**

The Association's findings reflect the evidence in **a 2004 report from SAMSHA.** The Report offered compelling evidence of the lack of education and experience in the treatment of addiction by PCPs and ancillary providers in a medical practice:

"A significant problem is the lack of education and training on substance use disorders for primary health care and other health and human services professionals. The NationalCenter on Addictions and Substance Abuse (CASA) at ColumbiaUniversity

reported that 94 percent of primary care physicians and 40 percent of pediatricians, when presented with a person with a substance use disorder, failed to diagnose the problem properly (CASA, 2000). If similar studies were available for other health professionals (e.g., nurses, psychologists, pharmacists, social workers, dentists), the results would likely be similar."

"Curricula in most health education programs and professional schools either inadequately address substance use disorders or exclude discussion of them altogether." 2004 US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Report to Congress: Addictions Treatment Workforce Development* [Section D, Education and Accreditation Priorities]. "

If CT persists in maintaining the current provider paradigm of doctors, nurses, social workers and or professional counselors, SA TX will be returning to the old workforce *Medical Model*, which was the standard 35- 40 years ago!

Past and current research has provided well-documented studies demonstrating the obstructions to access to healthcare due to the stigma associated with active substance users by providers from both the medical and behavioral health professions. The complexity of the disease of addiction brings multiple barriers to an effective and honest relationship between the provider and the substance user. The inadvertent consequences of these dynamics include, the worsening of the patient's health status through impact of substances of choice on the pre-existing health and psychiatric co-morbidities, the patient's required medications, increased cessation of SUD treatment, and most importantly, a skewed provider-patient relationship plagued by mutual mistrust and frustration.

In Connecticut we are fortunate to have a workforce of highly screened and qualified LADC's who have met uniform state-specific standards. These rigorous standards for credentialing prepares them to sort through complex mental health symptoms, health issues, and social factors in order to discern how active Substance Use Disorder (SUD) may be affecting the whole picture, hence to deal with patients having co-occurring disorders (dual diagnosis and medical conditions.). LADCs have the knowledge and professional skill sets to identify and deal with the manipulation that comes with this primary disease, as well as to evaluate the stage of progression of the disease and determine the type of treatment needed. In addition, they have the skills to provide consultation to other providers (MDs, APRNs. RNs, and Masters Level Behavioral Health Providers) who may be frustrated, fearful, and bewildered in their treatment of clients, who present with active addictive behaviors.

Current Barriers to Best Practice SA Treatment

Utilization of Treatment Services and Public and Private Reimbursement for Provider Fees

Addictions professionals and consumers from across CT regularly report to CAAP Board Members that insurance carriers' current practices create severe barriers to SA treatment. The barriers are all about money in the form of savings in an array of fiscal defense strategies!

These strategies include:

- Rationed utilization methods for course of treatment and length of stay to inpatient and outpatient treatment
- Questionable protocols for denial of claims.
- Network of providers, who may not possess the credentialing standards of educational and professional experience in the treatment of SUD.
- Low rates of reimbursement
- Flawed access to SA treatment. As an example, many Medicaid patients, who often present with the most complex medical and behavioral health disorders, receive marginal treatment, or encounter serious systemic barriers to care- lengthy waiting periods for healthcare appointments, language issues, complicated and uncoordinated referral processes to specialists, and patient stigmatization due to life-style and misinformation about the disease of Addiction.

CAAP supports a robust utilization review of provider and insurance carrier practices. **The guiding principle calls for a payment system that rewards and not punishs providers, whose performance outcomes are driven by treating a panel of patients, who are notable for its high numbers of individuals with serious, severity of health, psychiatric, and social issues. Otherwise, the present practice of major**

insurance carriers to "cherry pick" the healthiest patients by means of diverse and subtle mechanisms thus resulting in the exclusion of clinically challenged patients, and the Providers, who treat them, from their insurance plan will prevail.

Addictions- Second Tier Behavioral Health Disorder

There still remains an insidious and subtle barrier that CT residents and their significant others encounter in accessing care on both in-patient and out-patient settings. It is the frankly dangerous and unfair perception that Addiction is a second tier Disorder. **Addiction is a Primary Disease!**

In Connecticut and many states, the denial of prompt and critical SA treatment based upon a blaming and negative model of care that directs the access to services on a protocol of **Failure,** hence, the barriers of shame and stigma related to SUD are strengthened.

Through multiple reporting venues beginning in 2012, the State has identified adolescents and young adults as a key consumer group, who were in great need of less problematic access to SATX. As an example of the synergy between shame and barriers to treatment. it is not unusual for youth and young adults to be denied inpatient treatment until these consumers have "failed " at out-patient and intensive outpatient treatment.

With this sector of the population presenting with the soaring rates of opioid addiction and over doses leading to death, this model is an egregious and barbaric system of care. Dr. Sharon Levy in her presentation at the 2014 HarvardMedicalSchool's Symposium on Addictions (March 1.2014) cited the following evidence of the prescription to heroin epidemic.

" In adolescents, recreational use of prescription painkillers accounted for 17.1% of all illicit drug use initiations beginning in 2009- More than Any Other drug than Marijuana. Dr. Levy further cited that 1 out of 8 High School Seniors reported using a prescription opioid for recreational/ non-medical use.

In contrast, Connecticut's health care treatment standards do not block or withhold necessary medical intervention and treatment from youth and young adults who have diabetes by withholding insulin medication until the young patient has a diabetic induced shock, as opposed to the current stigmatizing standard of "failure of SA treatment level" to gain a therapeutically appropriate level of care.

Our state has the 4th highest insurance costs in the nation. CT has a moral obligation to provide its residents, families, and partners impacted by the disease of addiction with insurance coverage that promotes swift access to evidence-based level of care, qualified specialists, and fiscal coverage and reimbursement policies which are equal to the complexities inherent to the disease. Let us always remember that Addiction is a treatable disorder, but if not treated with appropriate standards of practice, **Addiction is a terminal illness.**

In Connecticut, reimbursement of LADCs ' services have been weakened in recent years. There were egregious legislative attacks at the field by attempting to strip the LADC license of its critical educational and training standards. As previously noted, a trend in the state's behavioral health network of providers was a perception that addiction professionals are "second class" behavioral health providers.

It is important to note that **ACA cites Credential addiction specialists as required members of the ACA's Workforce-*Mental Health Professionals.* With the State's implementation of the Advanced Medical Home, the credentialed addiction professional's highly specialized skills and expertise in providing evidence-based SA Treatment will be vitally important to ensure residents' successful health/behavioral health outcomes.**

If the State chooses not to give full parity to licensed addiction specialists in its behavioral health provider, public and private payer network, the greatest risk will be to CT residents. Consumers, who seek substance abuse treatment, will be in jeopardy of loosing access to evidence-based treatment and the highest standards of care for their addictions by the statutorily identified, behavioral health provider- the Licensed Alcohol & Drug Abuse Counselor.

The Licensed Addictions Specialist's Contribution to CT's New Advanced Medical Home Model of Primary Care- Enhanced Medical and Behavioral Health Patient Outcomes

The Connecticut Association of Addiction Professionals submitted an extensive document to the State's ***SIM initiative*-Connecticut Healthcare Innovation Plan Public Comments**. The reader may refer to CAAP's comments via the CT Healthcare Advocate's Website. The document included evidence of the addiction specialist's essential scope of services , which will enhance the patient's medical and behavioral health treatment outcomes.

Throughout the 2014 legislative session there were several proposed bills to provide basic training to MDs, APRNS, PAs, and LCSWs in specialized screening methods and brief intervention strategies in substance abuse treatment. CAAP offered compelling evidence that proved the LADC **already possesses this requisite training and professional screening to provide this first line of SUD TX intervention!**

HRSA & SAMHSA have made the inclusion of the addiction specialist in emerging models of integrated, multidisciplinary, and coordinated primary medical delivery systems a major advocacy goal.

In May 2013, a SAMHSA-HRSA released the report; ***Innovations in Addictions Treatment-Addiction Treatment Providers Working in Integrated Primary Care Services (SAMHSA-HRSA Center for Integrated Health Solutions).*** The report underscored the importance of this complement of services-

"**Alcohol and drug addiction cost American society $193 billion annually, according to a 2011 White House Office of Drug Control Policy report.1 In addition to the crime, violence, and loss of productivity associated with drug use, individuals living with a substance abuse disorder often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease,and cancer and mental disorders such as depression, anxiety, bipolar**

disorder, and schizophrenia.2 In fact, research has indicated that persons with substance abuse disorders have:

8- Nine times greater risk of congestive heart failure.

8- 12 times greater risk of liver cirrhosis.

8 -12 times the risk of developing pneumonia.

When persons with addictions have co-occurring physical illnesses, they may require medical care that is not traditionally available in, or linked to, specialty substance abuse care. The high quality treatment needed by individuals with addictions requires a team of different professionals that includes both specialty substance abuse providers and primary care providers. The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care. In fact, clinical trials have demonstrated that when someone has a substance abuse problem and one or more non related disorders, integrated care can be more effective than traditional treatment delivery (i.e., separate, siloed primary care and substance abuse programs) in terms of clinical outcome and cost.4 It results in better health outcomes for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that result in up to 80% of individuals not receiving care… (SAMSHA- HRSA, May 2013 Report)

An Example of an Intervention=How the Addiction Specialist, as a member of a primary care interdisciplinary team, meets the challenge of CT's prescription opiate and heroin epidemic

Connecticut's prescription opiate and heroin epidemic is ravaging cities and towns with overdoses and deaths. The state's heroin-related deaths have shot up from 174 in 2012 to 257 in 2013. Meanwhile, the use of heroin doubled nationally from 2007 to 2012. It would be presumptuous to infer that addiction specialists, alone, can solve this multi-faceted health crisis. Research has clearly proved that for many active opioid addicts- the first step to heroin addiction began with a visit to their MDs for **pain management**. As an intervention for the pain, many well-intentioned MDS routinely prescribe a prescription for an opiate- with the unintended consequences of initiating a deadly relationship between the prescription pill and the vulnerable patient.

The specialized services of a licensed addiction specialist can offer valuable interventions, like prescription assisted medication and specialized counseling, to meet the challenge of prescription opiate and heroin abuse/addictions in patients encountered and treated by CT pediatricians, school –based clinics, internal medicine MDs, community health centers, and hospitals clinics.

The addiction specialist as a key provider in these settings will utilize his or her skill sets to conduct rapid diagnosis, assessment of disease progression, and develop a treatment plan based upon best practice standards for opiate addiction. By intervening at the time of the patient's entry into the primary care setting, the threat of overdose and/or death can be immediately addressed.

Promising 2014 New Legislative Remedy

Throughout 2014, CAAP strongly advocated for the expansion of Medicaid reimbursements to include licensed alcohol & drug abuse counselors. We were thrilled with a new legislative remedy.

At the conclusion of the 2014 General Assembly, the Legislature passed a very important law:

Sec. 220. Section 17b-28e of the 2014 supplement to the general statutes is amended by adding subsection (c) as follows (*Effective July 1, 2014*):(NEW) (c) Not later than October 1, 2014, the Commissioner of Social Services shall amend the Medicaid state plan to include services provided by the following licensed behavioral health clinicians in independent practice to Medicaid recipients who are twenty-one years of age or older: (1) Psychologists licensed under chapter 383, (2) clinical social workers licensed under subsection (c) or (e) of section 20-195n, (3) alcohol and drug counselors licensed under section 20-74s, (4) professional counselors licensed under sections 20-195cc and 20-195dd, and (5) marital and family therapists licensed under section 20-195c. The commissioner shall include such services as optional services covered under the Medicaid program and provide direct Medicaid reimbursements to such licensed behavioral health clinicians who are enrolled as Medicaid providers and who treat such Medicaid recipients in independent practice settings. The commissioner may implement policies and procedures necessary to implement this subsection in advance of regulations, provided the commissioner prints notice of intent to adopt the regulations in

accordance with section 17b-10 not later than twenty days after the date of implementation of such policies and procedures. Such policies and procedures shall be valid until the time final regulations are adopted.

With the passage of this legislation, substance abusing young adults will have a new pathway to attaining best practice treatment for their addictions other than hospital-based and out-patient services thru accessing SA Treatment by qualified specialists in independent, private practices. The collective wisdom of the leaders of Medicaid, Dept. of Mental Health and Addiction Services, and the Office of the State Healthcare Advocate and other key influencers of CT's healthcare policies supported this remedy. The new law will hopefully assist in mitigating systemic obstacles of lack of treatment slots and admission policies, which exclude this sub-group, as well as substance users of all ages with addictions.

Conclusion

The Connecticut Association of Addiction Professionals is eager to actively participate in all study & review, investigation, and oversight committees and venues, which are charged with the advancement and enhancement for the treatment of substance abuse in our state.

CAAP stands ready to represent the workforce of addiction professionals through robust and rigorous advocacy on current and emerging best practice and value-driven initiatives for the prevention and intervention of the disease of addiction. This commitment advances the higher purpose of serving the thousands of CT residents and their significant others, harmed by substance abuse, in beginning and sustaining their journey of Recovery.

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