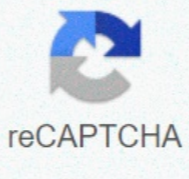




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that applying to getting members to both initiate and continuously engage in care. Key barriers identified by community stigma toward SUD and treatment, providers' lack of addiction training and comfort treating individuals with a SUD, plan members' readiness for behavioral change, and service limitations of health plan benefit arrays. Because many of these findings already have been summarized in response to qualitative research Questions 1 and 2, the following section highlights key barriers and their associated facilitators. Barrier: Community stigma toward SUDs and behavioral health treatment prevents members from initiating and remaining engaged in treatment. Facilitator: Health plans are focusing on integrating primary care and substance use treatment. Health plan representatives described substance use-related stigma as communities' rejection and alienation of individuals with an SUD. Interviewees said that communities do not regularly engage in conversations about substance use so it becomes a taboo subject when a community member has an identified need for SUD treatment. Interviewees described stigma around substance use as one of the most significant barriers to encouraging members to initiate and remain engaged in treatment. Health plan representatives identified substance use-related stigma as greater and more isolating than stigma around mental health conditions. Although interviewees noted that alcohol use disorder was less stigmatized than illicit SUD involving heroin or opioid analgesics, they identified overcoming stigma as a challenge to bringing beneficiaries into treatment. Health plan representatives frequently described considering substance use-related stigma when developing strategies to successfully initiate beneficiaries in treatment. Most commonly, they focused efforts on co-locating SUD treatment services with primary care. Health plan interviewees identified member concerns about attending SUD-specific treatment facilities. Members did not want to be seen entering these facilities or have medical records specifically list the name of an SUD treatment facility. Interviewees noted that these concerns were particularly troubling for individuals who have not accepted their diagnosis, because they were more likely to perceive SUD treatment facilities as places for individuals with more severe treatment needs. Co-locating SUD treatment services within primary care and other physical health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health patient. WARM HAND-OFFS Providers were more comfortable having conversations about substance use risk behavior and treatment initiation with members knowing that they could perform a warm hand-off with the co-located counselor down the hall. Specifically, most health plan representatives identified embedding SUD treatment counselors within primary care offices as their greatest facilitator to overcoming the beneficiaries' stigma around engaging in treatment. Interviewees said that providers were more comfortable having conversations about substance use risk behavior and treatment initiation with members knowing that they could perform a warm hand-off with the co-located counselor down the hall. Counselors were seen as being able to step in to talk to newly diagnosed members or members with risky behavior about the benefit of initiating some type of treatment. Interviewees also described how embedding counselors improved trust and communication between physical health and SUD treatment providers. Simply having these individuals in the same facility promoted regular conversations about integration and care coordination planning to support members' holistic needs. Interviewees described this integration as key to engaging in routine check-ins with members who are reluctant to initiate treatment or become disengaged over time. Primary care providers are able to repeatedly advise at-risk members about treatment and invite the counselor into the exam room to talk with members about their specific reluctance to initiating treatment. Similarly, co-located substance use counselors can check on members who come in for physical health appointments and make a subsequent effort to engage them in care. Health plan interviewees described some initial pushback from providers regarding embedding SUD treatment counselors and other integration activities. Some providers told the health plan they felt that the behavioral health counselors were monitoring or infringing on their practice. Health plans responded by having plan leadership reach out to convince providers of the potential benefits of primary and substance use care integration. Barrier: Providers lack sufficient training in addiction medicine to effectively initiate members in treatment. Facilitator: Health plans are routinely engaging providers in education opportunities to promote evidence-based practices with substance use treatment. Health plan interviewees identified primary care providers' lack of addiction training as a critical barrier to identifying risky substance use behavior in members as well as a barrier to encouraging members to initiate and engage in treatment. Interviewees described providers as generally reluctant to conduct screening for risky substance use. Interviewees said that providers reported not feeling comfortable asking the screening questions or knowing how to advise individuals who screened positive. Plan representatives acknowledged that early intervention activities were difficult for providers because substance use risk screening and motivational interviewing techniques were not adequately covered in medical school training. As a result, health plan interviewees described developing a variety of educational opportunities directed at enhancing providers' knowledge of best practices for substance use screening and treatment. Health plans that require providers to conduct universal SBIRT with plan members reported developing training modules specific to using the screening tool and to conducting the brief intervention component for members with an identified risk. One plan representative reported holding provider training sessions on how to conduct motivational interviews with members. Providers practiced motivational interviewing techniques in person to develop confidence with the early intervention practice. Another plan reported abandoning the traditional motivational interviewing component of SBIRT in favor of having providers simply offer advice about reducing substance use. After providers reported feeling unsuccessful with the original motivational interviewing requirement, local plan leadership provided them with risk reduction talking points that mimic how providers counsel diabetic patients about glucose levels. Members are advised on the safe range of alcohol consumption and how much they would need to reduce consumption to be considered within safe medical guidelines. Health plan representatives also reported developing electronic referral, messaging, and reporting tools to facilitate providers' efforts to initiate and engage beneficiaries in treatment. Multiple health plans invested in creating provider portals or other electronic systems to promote effortless communication between the provider and the health plan. Such systems are enabling providers to refer plan members to care coordination services and follow-up care with a single click. When this referral is made, health plans are alerted to the request in real-time and begin conducting outreach with the plan member. Health plan representatives said that they were motivated to create these tools to partially remove the burden of treatment initiation from primary care providers. Instead, the plan can outreach members directly to encourage treatment uptake. Half of the health plan representatives interviewed also described generating provider reports on the number of members with an identified SUD and their follow-up treatment status. Interviewees noted that plan staff meet one-on-one with providers to discuss their performance and identify next steps for engaging members in treatment. Similarly, health plans are developing regularly scheduled meetings with providers to discuss best practices in SUD treatment. Plan interviewees described these in-person and webinar meetings as opportunities to inform providers about practices that close the gap between SUD diagnosis and treatment initiation. Meetings highlight the importance of referring members for care coordination and case management. Meetings also highlight best practices regarding MAT and ASAM criteria regarding level of care and care transitions. Health plans also are promoting materials developed by SAMHSA to augment provider knowledge around evidence-based practices in SUD treatment. Two of the health plans also reported partnering with local subject matter experts and university researchers to promote providers' understanding of the local populations' needs and attitudes toward SUD treatment. Overall, health plan representatives noted that their many efforts to educate providers about substance use issues and treatment processes are helping them engage members in treatment. Most interviewees described wanting to serve as a support for providers and viewed the health plan and providers as part of the same team trying to bring members into care. Health plans are promoting this team sentiment by carefully scripting the way that they approach education with providers. Interviewees said that they were cognizant of not wanting to come off as telling physicians how to operate, but they want providers to see best practices and electronic systems as valuable tools for their patients. Barrier: Members are not ready to abstain from substance use or other related risk behaviors, which results in an unwillingness to initiate traditional SUD treatment. Facilitator: Health plans are promoting harm reduction techniques and "no wrong door" and "no wrong time" approaches to engage members in conversations about substance use. Health plan interviewees identified beneficiaries' readiness to abstain from substance use as a significant factor affecting their ability to initiate or sustain engagement in treatment programs. They described treatment programs and care management as historically focused on an abstinence-only approach with sobriety as a key requirement for continued engagement. Interviewees generally agreed that promoting abstinence-only treatment environments did not facilitate initiating members in treatment. As a result, health plan interviewees reported gradually shifting their approach to promoting harm reduction environments as well as abstinence programs. Representatives from several plans identified this shift to harm reduction as a significant facilitator for both initiating members in treatment and maintaining long-term engagement. WHEN HEALTH PLAN MEMBERS DO NOT FEEL READY FOR TREATMENT Health plans are more frequently promoting harm reduction techniques and "no wrong door" and "no wrong time" approaches to engage members in conversations about substance use. Health plan representatives reported offering a variety of harm reduction initiatives to members. One plan began sponsoring group sessions that promote conversations between members who are reducing their use but have not fully quit. The plan representative noted that these groups have been useful for bringing more people into service who did not previously self-identify as needing treatment. The harm reduction groups were described as a place for members to begin thinking about what treatment would mean for them and what healthful behaviors are helpful to them in achieving their personal goals. Health plan representatives also described having care managers and outreach workers identify community-based harm reduction programs for members to participate in as a first step to reducing risky behavior. Plans described harm reduction strategies as an extension of their intent to promote patient-centered care coordination and a "no wrong door" approach to SUD treatment. Health plan representatives described their no wrong door approach as enabling members to engage in any kind of treatment services, whether it be physical or behavioral health-focused, and then building a trusting relationship with the member to support initiation and engagement in SUD treatment. In developing an ongoing relationship with members, health plan interviewees noted that they can engage beneficiaries in treatment as soon as members express an interest. Thus, the no wrong door perspective also is facilitating a "no wrong time" approach to getting members into SUD treatment. Discussions around the no wrong door approach focused on asking members about their priorities and health goals. Health plan representatives acknowledged that this approach was more easily promoted through their own care management and care coordination staff than through their contracted providers. The challenge with adopting this approach, according to interviewees, is that it requires a culture change from the way SUD treatment is traditionally viewed. Health plans are using their staff to promote a patient-centered philosophy rather than a program-centric approach. Barrier: Health plan benefit arrays do not sufficiently cover the continuum of SUD treatment; this limits members' ability to initiate treatment or continue engaging in services that appropriately support their recovery needs. Facilitator: Health plans are investing in staff that support members' access to community-based recovery supports and perform outreach to support treatment initiation and engagement. One of the most significant themes identified in the health plan interviews is how health plans are focused on promoting a care coordination model that is based in mission statements about individualized and patient-centered care. This approach enables health plans to stretch beyond their stewardship of plan benefits to support beneficiaries with care management and outreach and to facilitate engagement in community-based recovery supports. Plan-employed care managers, care coordinators, community health workers, and other outreach workers were identified as critical to successfully initiating and engaging members in treatment. Health plan interviewees repeatedly acknowledged that their ability to bring members into SUD treatment was contingent on their understanding that members have needs beyond traditional health services. Health plans are staffing their care management, coordination, and outreach teams with clinicians who are experienced and licensed and have a master's degree. Health plans expect these clinicians to conduct face-to-face visits as well as telephonic outreach with members wherever they are in the community. When plans learn of member admissions to detox or other inpatient facilities, these clinicians are expected to conduct immediate outreach with the member. Clinicians in these roles described reaching out to members to participate in discharge planning and care transitions and to coordinate community-based treatment postdischarge. Interviewees reported sharing their care plans with members' providers to facilitate ongoing treatment efforts and to integrate members' physical and behavioral health care. Interviewees also reported a consistent expectation from their health plans to understand members' holistic needs across substance use, mental health, physical health, and necessities such as housing and food. Interviewees consistently described clinicians in these roles as "going above and beyond" for health plan members. But health plan representatives repeatedly described this level of member outreach as the primary facilitator of getting members to the initial SUD treatment visit and ensuring that they continued engaging long-term. Health plan interviewees noted that focusing on their members' individual needs enables their plans to identify key moments when members are receptive to treatment. COMMUNITY PARTNERSHIPS Interviewees reported establishing relationships with community-based peer support services, educational and employment support agencies, sober housing agencies, and other tenancy support organizations. Additionally, interviewees at all five Medicaid plans identified limits on their covered services as restricting access to necessary treatment and recovery supports. As previously discussed, health plan representatives expressed frustration about not always being able to link their beneficiaries to partial hospitalization and residential treatment. Some of the Medicaid plans also were unable to reimburse for peer support services, which their representatives unanimously felt would facilitate their members' engagement in recovery. Because of service limits within their own benefits, representatives from all five Medicaid plans reported cultivating community partnerships to expand their access to recovery supports across systems. Although they reported being unable to reimburse for these services directly, they can refer members to the services and help identify grant or donation funding for members when necessary. Interviewees reported establishing relationships with community-based peer support services, educational and employment support agencies, sober housing agencies, and other tenancy support organizations. Care managers, care coordinators, community health workers, and other plan-employed outreach workers are expected to cultivate these community relationships to increase supports available to members. Health plan leadership frequently described these non-reimbursable services as key to promoting stability in members' lives and thus promoting their continued engagement in SUD treatment. Representatives from half of the plans interviewed reported encouraging their staff members to inform leadership about the success of these community partnerships. They described efforts to track and report on member progress as a means of producing evidence that might support possible inclusion of these services in the plan benefit array in the future. Facilitators and Barriers to Measurement for HEDIS IET The primary aims of the qualitative interviews and analyses were focused on identifying characteristics, strategies, and other factors that affect the ability of successful health plans to initiate and engagement members in care. However, several health plans also wanted to discuss ways in which they view the criteria of the HEDIS IET measure as affecting their measured success in initiating or engaging members in treatment. The following themes are drawn from brief conversations with health plans around the structure or calculation of the HEDIS IET measures. Health plan representatives expressed concern about the timeline by which the IET measure requires them to meet the initiation and engagement phases of the measure. The initiation phase requires individuals to receive inpatient or outpatient treatment within 14 days of an initial SUD diagnosis. Health plans have a total of 30 days from the member's first visit in which to complete two additional treatment visits and achieve engagement. Health plan representatives indicated that they often did not receive claims data on their members within those time frames, and thus they were unable to ensure that members receiving an initial diagnosis completed initial and follow-up visits in time to count toward the measure. Plan representatives noted that if they failed to receive timely notice of a member's initial detox admission, they likely would fail both the initiation and engagement phases of the measure. Health plans also commented on the measure's requirement that the initial diagnosis and initial outpatient or inpatient visit occur with different providers if they are completed on the same day. Representatives from two of the health plans commented that they had previously encouraged diagnosing providers to walk members into follow-up appointments with different providers in order to meet the initiation phase. One reported having financially incentivized providers to conduct this warm hand-off. Health plans enjoyed the option to count same-day appointments toward the measure requirements and expressed concern over the criteria being changed to require that all visits occur on different dates. Finally, one health plan representative noted that the measurement criteria used for commercial and Medicaid beneficiaries should differ. Plan representatives described how general sociodemographic differences between commercial and Medicaid beneficiaries should alter the expectations for treatment initiation and engagement timelines. The health plan interviewees specifically highlighted challenges in locating Medicaid beneficiaries who are homeless or otherwise hard to reach. Plan interviewees noted that the timeline for meeting the initiation and engagement phases of the measure should be extended for Medicaid populations.

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