

Jessie O'Brien (NAADAC): All right, hi everyone, and welcome to today's webinar, Building an Intensive Outpatient Program, IOP, in an OTP Setting. Today, we're going to be hearing from Keisha Haynes and Bonnie Lou Roberts.

Jessie O'Brien (NAADAC): My name is Jesse O'Brien, I'm our Director of Training and Professional Development here at NADAC, the Association for Addiction Professionals, and with me behind the scenes, we have Carrie Martin Lane, who will answer any questions or issues you have that are not specifically for our presenter.

Jessie O'Brien (NAADAC): Today's webinar is sponsored by SoberLink, so stay tuned for a brief demo at the end of this webinar.

Jessie O'Brien (NAADAC): Just a reminder that we are using Zoom webinar for today's live event, so you are muted and you are off-camera, which will remain so for the duration of the webinar.

Jessie O'Brien (NAADAC): However, you can interact through a couple of ways. The first is the chat box, which I see most people, are using and have said hello there. Feel free to comment, or if the presenters ask sort of a short answer question, feel free to put your responses there. We also have the Q&A box, question and answer. If you have any content-related questions, please make sure you put your

Jessie O'Brien (NAADAC): questions in the Q&A box, that way we won't miss them. And then we will have a brief Q&A towards the end of this webinar today. And lastly, if you want closed captioning, just go to the live transcript button and click that little arrow and select show captions for captions.

Jessie O'Brien (NAADAC): Carrie's gonna pop a link in the, chat box that has instructions for CEs.

Jessie O'Brien (NAADAC): You will be eligible,

Jessie O'Brien (NAADAC): to get a CE certificate, once you finish viewing either the live or recorded webinar, you'll just have to complete the CE quiz and the survey evaluation to access the CE certificate.

Jessie O'Brien (NAADAC): Live virtual attendees can go right to this e-quiz from the thank you message in the live event box that will show up when this webinar is over. I think Carrie will also put a link to that.

Jessie O'Brien (NAADAC): in the chat box towards the end as well. Alright, let's meet our presenters. First.

Jessie O'Brien (NAADAC): Keisha Haynes, exemplifies strategic leadership and clinical quality improvement and regulatory compliance. As the National Clinical Director for Behavioral Health Group, she oversees company-wide clinical operations while directing the Eastern and South Central divisions, comprising of 36 MAT

Jessie O'Brien (NAADAC): treatment programs across 8 states. Through evidence-based decision making, she crafts and refines the clinical policies and procedures, identifies any systematic gaps, and implements robust solutions to enhance the patient outcomes. Additionally, Keisha consults with behavioral health organizations on quality optimization.

Jessie O'Brien (NAADAC): She's committed to advancing health equity, founded Black Open Space, a social justice initiative addressing the mental health ramifications of social disparities among African Americans.

Jessie O'Brien (NAADAC): Next, we have Bonnie Lou Roberts, who is the National Clinical Director for the West Area of Behavioral Health Group. Her experiences include multimodal counseling and training in residential treatment, community-based treatment, and private practice outpatient treatment.

Jessie O'Brien (NAADAC): While working in medication-assisted treatment facilities, she earned specialist recognition in MAT, as well as a master's degree in higher education.

Jessie O'Brien (NAADAC): She hopes to help move the field further by providing highly effective professional education. Since joining the National Clinical Leadership Team at BHG, she's had the privilege of speaking at both the state and national levels to further the discussion on SUD treatment and professional needs within the field.

Jessie O'Brien (NAADAC): So, they can go ahead and join me. I will turn myself off.

Jessie O'Brien (NAADAC): And mute myself, and hand this over to them.

Boni-Lou Roberts, MSHE, MATS, CADC II: Hello, everyone, and thank you for joining us, and thank you for your interest that you're taking in, our presentation that is focused on building an intensive outpatient program in an opioid treatment program type setting, so we're adapting to that expanding ASAM criteria with the fourth edition. I'm Bonnie Lou Roberts, and I'm going to pass this on to Keisha.

Keisha Haynes, LCPC, CPHQ: Hello, everybody. My name is Keisha Haynes, and thank you for joining us today. So, in our presentation today, participants will be able to get a

Keisha Haynes, LCPC, CPHQ: a good understanding of what the key changes are to the ACM 4th Edition, and how that impacts the OTPs and the levels of care that we serve. Next, we'll review and identify the clinical and operational benefits

Keisha Haynes, LCPC, CPHQ: of incorporating an IOP into an OTP setting. We'll also get into those regulatory and billing considerations that we'll have, while you ensure your compliance and financial sustainability. And then lastly, we'll review how to overcome strategies.

Keisha Haynes, LCPC, CPHQ: For common barriers, such as counselor capacity, patient engagement, and interdisciplinary collaboration.

Keisha Haynes, LCPC, CPHQ: So, I'm gonna try to do the impossible here, and squeeze in a two-day training's worth of information on the ACM 4th edition, and suggest a few slides.

Keisha Haynes, LCPC, CPHQ: So we do not have any affiliation with ASAM, but I highly recommend going online.

Keisha Haynes, LCPC, CPHQ: signing up for the various courses. NADAC has one as well, on the ACM

4th Edition to be able to get more information. But today, we'll get a brief, quick overview, and how that relates to OTPs.

Keisha Haynes, LCPC, CPHQ: So the ASAM, their definition for this fourth edition is that it is a comprehensive set of standards and decision rules that is going to utilize a holistic and person-centered approach.

Keisha Haynes, LCPC, CPHQ: And that keyword right there, person-centered, you'll hear that a lot in different ways throughout our presentation. But they utilize those approaches to determine the appropriate level of care and the treatment plan for patients who have been diagnosed with SUD or any co-occurring disorders.

Keisha Haynes, LCPC, CPHQ: So these standards, utilize now a, rigorous methodology for scientific review.

Keisha Haynes, LCPC, CPHQ: And consensus development. So, their goal is that this update is going to be easier to understand, and be able to apply it to improve your patient care.

Keisha Haynes, LCPC, CPHQ: So let's take a look at the core components of the ASAM 4th edition, and you'll see a sample walkthrough here of the patient's journey on that continuum here. So what has changed for the 4th edition is that

Keisha Haynes, LCPC, CPHQ: not all dimensions are going to be utilized to assess, and develop that level of care recommendation. So, in the fourth edition, we are only going to utilize dimensions 1 through 5, and with that, we'll develop a level of care recommendation.

Keisha Haynes, LCPC, CPHQ: And so then what we'll do in Dimension 6 is have a, different dimensional emission criteria that we're gonna have a shared decision-making process with the patient in this, Dimension 6.

Keisha Haynes, LCPC, CPHQ: So, in Dimension 6, we'll have a few assessment questions, we'll have a better understanding of where the patient is at, to be able to determine if they're able to engage in the recommended level of care, and then we'll go ahead and select

Keisha Haynes, LCPC, CPHQ: the level of care that the patient will be admitted into. And so, once we have the patient in the appropriate level of care, they'll be continuously reassessed throughout their treatment episode as normal, so that part stays the same. And then that transition and continued service criteria, we utilize that

Keisha Haynes, LCPC, CPHQ: To continue to determine the next appropriate level of cares.

Keisha Haynes, LCPC, CPHQ: So the dimensions are also updated in the fourth edition of the ASAM. And so you'll see here on the left-hand side, I have a little table here that you'll be able to see how the dimensions have changed.

Keisha Haynes, LCPC, CPHQ: So, 1, 2, and 3 are...

Keisha Haynes, LCPC, CPHQ: somewhat the same, their titles may have shifted differently, whereas we went from biomedical conditions and complications to just biomedical conditions.

Keisha Haynes, LCPC, CPHQ: So Dimension 4 is actually going to be integrated into all of the 6 dimensions. So that'll be something that is new for the 4th edition, so that is no longer a separate

Keisha Haynes, LCPC, CPHQ: level... I mean, sorry, separate dimension. So you'll see that in different questions throughout the six dimensions.

Keisha Haynes, LCPC, CPHQ: And then Dimension 5 has now been moved up to Dimension 4, and it's retitled as Substance Use-Related Risk. Dimension 6 has been moved up to Dimension 5, where it's Recovery Environment Interactions.

Keisha Haynes, LCPC, CPHQ: And then that person-centered, that keyword I told you about there, that is now going to be the sixth dimension. So, person-centered considerations.

Keisha Haynes, LCPC, CPHQ: So, as you can see in the second picture here, there are dimensions and subdimensions now for the fourth edition. And so, each sub-dimension that's highlighted and bolded in blue

Keisha Haynes, LCPC, CPHQ: They are going to be utilized to inform that level of care recommendation, and what we identify as that immediate need for initial treatment.

Keisha Haynes, LCPC, CPHQ: So, all of those subdimensions will have their own questions, and know that all sub-dimensions are going to be considered for your treatment planning purposes.

Keisha Haynes, LCPC, CPHQ: So when we get down to Dimension 6, since that's a new dimension, this is where we now start to identify what is the patient's barrier to care? What are those social determinants of health needs that we've been able to identify for the patient?

Keisha Haynes, LCPC, CPHQ: What are the patient's preferences, you know, for treatment? Maybe the patient has a full-time job, but they just got back, and they can't afford to take off for work. So there is no way that they'll be able to do, you know, a 10-hour programming level of care. You know, we also want to take a look at what is their motivational enhancement, whether it's internal.

Keisha Haynes, LCPC, CPHQ: Or external for those motivations for treatment.

Keisha Haynes, LCPC, CPHQ: And so, this is the overview of the dimensions and how those have shifted in the fourth edition, and utilizing those sub-dimensions that are, highlighted and bolded in blue to be able to inform the level of care recommendation.

Keisha Haynes, LCPC, CPHQ: But all of the subdimensions, even those right there in black, those are all going to be considered for your treatment planning purposes.

Keisha Haynes, LCPC, CPHQ: So, next we'll... oop, we skipped too fast. There we go. So now we'll look at the continuum for the fourth edition, and how they've restructured the different levels of care. So one

of the important things that I put here for you all to consider when you're, you know, looking to transition to the fourth edition of ASAM is that

Keisha Haynes, LCPC, CPHQ: They are recommending that all programs offer co-occurring hands, so they want every level of care to be able to have the capability

Keisha Haynes, LCPC, CPHQ: to treat co-occurring mental health conditions. So that is something new that has been incorporated into the ASAM continuum here, and you'll see those different level of cares, that offer the co-occurring enhanced.

Keisha Haynes, LCPC, CPHQ: As designated by COE. So, the patients in the fourth edition are going to move along this continuum based on their progress and their outcomes.

Keisha Haynes, LCPC, CPHQ: Typically, we will look at their lengths of stay, so for IOP, typically a program is 12 to 15 weeks in duration, and no longer, oh, you're successful because you completed all 5 weeks. Now, we are going to reassess the patients.

Keisha Haynes, LCPC, CPHQ: As identified in that initial walkthrough. And we're going to be able to base their...

Keisha Haynes, LCPC, CPHQ: Their transition between level of cares on their progress and the outcomes that they've made.

Keisha Haynes, LCPC, CPHQ: So, we... in the fourth edition, they've also,

Keisha Haynes, LCPC, CPHQ: designed this in a way that the Fulkin Continuum of care is going to be able to be addressed, even if the organization is medically managed. So, you can see that highlighted in purple. So, although

Keisha Haynes, LCPC, CPHQ: the organization may be a medically managed residential, they would still be able to have the design structurally, operationally, to be able to offer 3.5 and 3.1.

Keisha Haynes, LCPC, CPHQ: So, all levels of care, they're going to have their own scope of practice designed within it, to make sure that we can provide services on that main level. So, again, highlighted in purple, with the goal to simplify

Keisha Haynes, LCPC, CPHQ: That step down a transition process.

Keisha Haynes, LCPC, CPHQ: When we look at the level 1.0 level of care, this is now... it's called long-term remission monitoring, but it's going to promote a chronic care model of treatment, because at this specific level of care, we're going to be able to continue to provide ongoing monitoring for our stabilized patients.

Keisha Haynes, LCPC, CPHQ: That also includes medication management for patients who are receiving, addiction medication.

Keisha Haynes, LCPC, CPHQ: So when we take a look at that yellow highlight.

Keisha Haynes, LCPC, CPHQ: have there, those level of care within that highlight, that is where the ASAM 4th edition now has the clinical expectations aligned vertically. So, when we looked at 3.1 and the difference between 3.1 and 2.1, they're going to provide the same number of clinical services

Keisha Haynes, LCPC, CPHQ: It's just that 3.1 is now going to have the addition of a 24-hour structure and support, whereas level 2.1 will remain outpatient.

Keisha Haynes, LCPC, CPHQ: And then the same, looking at 3.5, is going to have

Keisha Haynes, LCPC, CPHQ: Same, number of service... clinical service hours for the patient as 2.5, but 3.5 is going to have that 24-hour residential supervision structure and support.

Keisha Haynes, LCPC, CPHQ: Another change that you'll notice with the levels of care for the fourth edition is that 2.5 is no longer called partial hospitalization. That has now been rephrased as high intensity outpatient

Keisha Haynes, LCPC, CPHQ: acronyms is HIOP, always trip myself up, and I want to say IHOP. I don't know why, but I always say IHOP when I look at that for some reason, but that is the new acronym for 2.5, HIOP, High Intensity Outpatient.

Keisha Haynes, LCPC, CPHQ: Looking at the levels of care that have .7 in their, numbers, that is a medically managed program. So, in these specific programs, we are able to integrate

Keisha Haynes, LCPC, CPHQ: withdrawal management services, in addition to providing biomedical and psychosocial services. So those are all going to be integrated with those level of cares, with the distinction of .7 in them.

Keisha Haynes, LCPC, CPHQ: For those who have the word BIO, B-I-O, that is for the Level 3.7 program, where it has enhanced biomedical capabilities.

Keisha Haynes, LCPC, CPHQ: So in these specific programs, we're able to do wound care. We know xylosine is, having a big uptick, so we'll be able to provide wound care, medication management again, and then provide IV fluids for those patients.

Keisha Haynes, LCPC, CPHQ: The fourth edition levels of care are also incorporating an ROSC,

Keisha Haynes, LCPC, CPHQ: which is a recovery-oriented system of care, and so this is going to be, again, provided at every level of care, or it can be provided via referral if you have those partnerships, which they encourage you to do. Then we also are promoting RMCs, which is Recovery Management Checkups at each level of care within the fourth edition, and this requires to have

Keisha Haynes, LCPC, CPHQ: ongoing remission monitoring for patients that have sustained remission.

Keisha Haynes, LCPC, CPHQ: And so, the overall goal is to promote that consideration of harm

reduction, whereas in the third edition, it was more likely geared towards abstinence-based as that overall goal. But here, we're considering harm reduction needs and increasing the engagement with the patients.

Keisha Haynes, LCPC, CPHQ: To better be able to understand their preferences and their goals.

Keisha Haynes, LCPC, CPHQ: So now, let's get into what is IOP, and how this, you know, adds into everything that we are discussing today. So for those of you who are not familiar what the IOP level of care is.

Keisha Haynes, LCPC, CPHQ: It is an ASAM Continuum of care that is designed to meet the needs of patients who have been diagnosed with substance use disorders.

Keisha Haynes, LCPC, CPHQ: It's an ambulatory care model, and so patients are able to gain entry or be admitted into IOP, whether it's

Keisha Haynes, LCPC, CPHQ: their first time coming into treatment, and they're being assessed at that level of care. They may be stepped down from transitioning from a higher level of care, such as a residential inpatient facility, or they can currently be at the outpatient level, or MAT level, and have been reassessed.

Keisha Haynes, LCPC, CPHQ: to be able to indicate a need for a more intensive and structured level of care. So, this is how IOP is phrased.

Keisha Haynes, LCPC, CPHQ: So, we want to know why, why would we want our patients to go into this IOP level of care? So, when we look at IOP compared to inpatient or residential care, research has identified that it has more comparable outcomes in patients with minimal risk.

Keisha Haynes, LCPC, CPHQ: Of acute withdrawal and health conditions and psychological symptoms.

Keisha Haynes, LCPC, CPHQ: It's also been shown to improve the abstinence rates in patients, while decreasing their sub-symptom severity and frequency of use.

Keisha Haynes, LCPC, CPHQ: It's also become even more popular because it's more intensive than your typical outpatient program, but it also allows the patient to return to their environment.

Keisha Haynes, LCPC, CPHQ: After each service delivery versus being an inpatient, where they would have to stay for a set determined number of days.

Keisha Haynes, LCPC, CPHQ: And so, when you compare IOP to inpatient, it also increases the duration of treatment, which is dependent on the patient's severity and their treatment response, because every patient is different. But it provides all an opportunity to engage and treat.

Keisha Haynes, LCPC, CPHQ: the patients while they remain in those environments. So, it helps patients be able to practice those newly learned behaviors more quickly and more efficiently, whereas in residential, you're in, like, a little bubble for 30 days, and then you step out to the world, and it's all changed, it's all new with different colors.

Keisha Haynes, LCPC, CPHQ: And we find that patients sometimes struggle.

Keisha Haynes, LCPC, CPHQ: With, moving back into that environment. And so IOP affords them that opportunity to come into session, learn these necessary tools, and go home and practice it immediately to be able to get that immediate feedback and response and more favorable outcomes in real time.

Keisha Haynes, LCPC, CPHQ: So, what has changed for IOP within the ASAM 4th edition?

Keisha Haynes, LCPC, CPHQ: So, in the third edition, we did a single rating per dimension. It was one score, 1 through 4 for each of the dimensions. Now, within the fourth dimension, each of those sub-dimensions are gonna have a risk rating as well.

Keisha Haynes, LCPC, CPHQ: In the third edition, like I mentioned, there was sometimes a minimum service hour requirement, so typically it's 9 to 19 hours. Now, the fourth edition has flexible guidelines, so although a program may say, oh, our IOP is 9 hours, our IOP is 15 hours.

Keisha Haynes, LCPC, CPHQ: This makes it a little bit more flexible with the 4th edition to be able to base it on the patient's functioning and need, in regards to those required service hours.

Keisha Haynes, LCPC, CPHQ: the level of care placement is no longer just solely based on the patient severity. It now takes into account the patient's functioning, their ability to engage in treatment, their safety, and their stability. So again, that person, patient care, patient-centered care treatment.

Keisha Haynes, LCPC, CPHQ: Again, as I stated, it's integrating the harm reduction models, more patient-centered goals.

Keisha Haynes, LCPC, CPHQ: the recovery-oriented systems of care, in addition to counseling. Whereas before, it just implied abstinence, and that's what we were moving towards in order to transition to a lower level of care.

Keisha Haynes, LCPC, CPHQ: So, we are now going to emphasize integrating co-occurring treatment at the same level of care, whereas prior, we may have been referring the patient out if we didn't have that mental health license.

Keisha Haynes, LCPC, CPHQ: The fourth edition makes it so easier for the patients, to utilize telehealth or hybrid models. We have programs at our organization that have

Keisha Haynes, LCPC, CPHQ: telehealth IOPs, and then we have those hybrid models where some are logged in, via telehealth while others are sitting in the room, but they're still engaging together in one group. So that's a great thing about this 4th edition, it supports that model.

Keisha Haynes, LCPC, CPHQ: The environmental and social determinants of health, they're going to weigh more heavily in our level of care placement, because again, we want to take a look at the patient's overall functioning and that ability to engage, so we need to take a look at their environment.

Keisha Haynes, LCPC, CPHQ: To be able to determine that need. And then lastly, OTPs, we can expand

IOP services without having to be set to a specific criteria, to be able to document and justify that placement level of care. We'll already have that incorporated.

Keisha Haynes, LCPC, CPHQ: So, a quick pit stop, for those who are not familiar with an OTP and what that is.

Keisha Haynes, LCPC, CPHQ: And so, an OTP is a federally regulated program titled Opioid Treatment Programs, that provides medications for opioid use disorders for patients.

Keisha Haynes, LCPC, CPHQ: So, OTPs are the only FDA-approved program that can dispense methadone, but they can also dispense buprenorphine and naltrexan, for the treatment of opioid use disorders.

Keisha Haynes, LCPC, CPHQ: And so, OTPs, along the lines of the fourth edition of ASAM, they emphasize that patient... I'm sorry, that person-centered care model, because it's going to include that comprehensive care of medication management.

Keisha Haynes, LCPC, CPHQ: Counseling, we have peer recovery support services, case management, and the coordination with primary care.

Keisha Haynes, LCPC, CPHQ: So, in an OTP, a patient may begin with daily visits.

Keisha Haynes, LCPC, CPHQ: to receive their medications for opioid use disorder, but then the new federal guidelines have changed to allow take-home privileges to be a little bit more flexible. So patients are then able to earn take-home medications as they continue to stabilize within treatment.

Keisha Haynes, LCPC, CPHQ: So, research has shown that patients who come to OTPs for treatment, overall, they have the ability to reduce overall overdose deaths.

Keisha Haynes, LCPC, CPHQ: Illicit opioid use and criminal activity while still improving their overall health care... health and stability.

Keisha Haynes, LCPC, CPHQ: So, how OTPs align with these changes is that

Keisha Haynes, LCPC, CPHQ: We're already federally required to provide both medical and psychosocial treatment services. We are already existing to provide that continuity care, so that way we can move between that continuum of level

Keisha Haynes, LCPC, CPHQ: 1.0 all the way through 2.7. So again, you want that patient to have that flexibility as far as those timelines within each level of care, and so we'll be able to offer it all. And we'll be able to address those complex needs.

Keisha Haynes, LCPC, CPHQ: and the levels of care that we offer, all within the same program, without having to refer patients out for this issue, for that issue. They'll be able to have that

Keisha Haynes, LCPC, CPHQ: Continuity of care all within one program.

Keisha Haynes, LCPC, CPHQ: OTPs also utilize group therapy counseling as a huge proponent of their engagement in treatment, and so group therapy alone has shown in research to improve outcomes related to use patterns and abstinence.

Keisha Haynes, LCPC, CPHQ: And then lastly, in 2024, Medicare has finally granted us

Keisha Haynes, LCPC, CPHQ: reimbursement for, IOP within OTPs for the first time. So now our Medicare patients, in addition to our Medicaid patient and self-paid patients, are able to benefit from this level of care and treatment.

Keisha Haynes, LCPC, CPHQ: So, taking a quick look at that Medicare shift that was in the OTP and IOP, so we went from a standard OTP programming of providing 1-2 hours a week, and now those Medicare patients can now receive 9 or more.

Keisha Haynes, LCPC, CPHQ: hours. Our focus isn't just on medication... medication management and basic counseling. We can now dive into deeper subjects with the integration of IOP as far as recovery skills, behavioral change, relapse prevention.

Keisha Haynes, LCPC, CPHQ: Group therapy now becomes a core component, so there's no longer an opt-out option for that.

Keisha Haynes, LCPC, CPHQ: Our staffing needs have, you know, vastly have increased as well, because again, we're taking a look at that holistic picture of the patient, so no longer do we just have nurses and counselors, but we have group facilitators, we have peer support specialists, we have case managers.

Keisha Haynes, LCPC, CPHQ: And all of this is to be able to enhance that patient experience, so we move from just those check-ins.

Keisha Haynes, LCPC, CPHQ: come in and get your medication, and we are now supporting that daily structure. They are able to enhance that therapeutic alliance with their counselors, and have that peer support, not only from their fellow peers that are in treatment, but their peer support specialists who have been where they are as well. And then our clinical goals have shifted from just stabilization to

Keisha Haynes, LCPC, CPHQ: therapeutic progress. We want to build and enhance their skills that we have, and then we want to make sure that we are providing them with support with any co-occurring issues.

Keisha Haynes, LCPC, CPHQ: So now we'll shift over to what are the clinical and operational benefits of IOP within an OTP.

Boni-Lou Roberts, MSHE, MATS, CADC II: Alright, thank you so much, Keisha. Can we all just kind of...

Boni-Lou Roberts, MSHE, MATS, CADC II: give a little bit of gratitude with her for that quick, breakdown of the changes from ASAM 3 to ASAM 4, and the changes in the dimensions and the level of care. I just, love that breakdown that she provided for us.

Boni-Lou Roberts, MSHE, MATS, CADC II: So let's go ahead and go into the next slide, where we're going to talk a little bit about the facts whenever it comes to understanding this shift that's taken place with the ACM criteria and the recommendations that they have provided for us.

Boni-Lou Roberts, MSHE, MATS, CADC II: So one of the things to really highlight when we talk about, implementing and integrating an IOP within the OTP setting is that we recognize, and we see it being strengthened with the updates to the criteria, that IOPs are often a one-stop on the continuum of care. So, this is just one of the many opportunities that we have to provide services to our

Boni-Lou Roberts, MSHE, MATS, CADC II: patients and help them in their process of recovery. It's often used as either a step up or a step down from where a patient has been in the past. So, moving from a stronger, medically managed type of program that may have had them be on-site for, you know, residential purposes, and kind of stepping down into that.

Boni-Lou Roberts, MSHE, MATS, CADC II: Or maybe they've been in a general IOP, or a general outpatient service. They've been more monitored type of system, and they start to struggle a little bit, so we're able to step up,

Boni-Lou Roberts, MSHE, MATS, CADC II: step up in that, and the changes within the ASAM criteria really allows for more fluidity, and it allows us to make those changes, or recommend those changes, and encourage our patients to engage with that, without having to step maybe outside of the programs that we're in. Clients should be assessed with an ASAM based on the criteria that's there

Boni-Lou Roberts, MSHE, MATS, CADC II: to help us determine what's most appropriate. So one of the things that we definitely want to make sure we're encouraging is throughout a patient's experience in treatment and recovery, there's consistent reassessment within each one of those dimensions to understand, is this appropriate for them, and do they maybe need another step up, or do they need another step down? Having,

Boni-Lou Roberts, MSHE, MATS, CADC II: Integrated programs really helps us to be able to assess regularly and address any shifts that need to take place in the course of treatment quickly in order to support that patient in the best way possible.

Boni-Lou Roberts, MSHE, MATS, CADC II: It also allows us to understand diverse, populations. So, Keisha mentioned, towards the end of our... her session there, the niche that is the OTP settings, where we're working with patients who, may be on medication for opioid use disorder, and, they... they may have been experiencing additional stigmas,

Boni-Lou Roberts, MSHE, MATS, CADC II: from other treatment providers that may be more abstinence-focused, and may not have that understanding of a harm reduction or medication-assisted treatment process. So it helps us to really be able to focus in with our patients.

Boni-Lou Roberts, MSHE, MATS, CADC II: To, to, to address that niche, that additional cultural,

Boni-Lou Roberts, MSHE, MATS, CADC II: shift that's there. As we're talking about that as well, we can... we can,

Boni-Lou Roberts, MSHE, MATS, CADC II: Really look at, building programs that do...

Boni-Lou Roberts, MSHE, MATS, CADC II: meet the needs of the patients that we have in front of us. So, if there's additional trauma that we see within this area that we need to address within the IOP, we can do that.

Boni-Lou Roberts, MSHE, MATS, CADC II: And then the client's choice is paramount, so we have to continuously encourage and engage the client into this and understand what are their preferences for treatment, and how can we support them through this process.

Boni-Lou Roberts, MSHE, MATS, CADC II: So moving to the next slide, we're going to talk a little bit more about those clinical benefits.

Boni-Lou Roberts, MSHE, MATS, CADC II: So, general OTP services are typically at a level 1, recommending less than 9 hours per week of the services that are being provided, and increasing our level of care offerings, so having the OTP with an IOP available to us.

Boni-Lou Roberts, MSHE, MATS, CADC II: Really helps us target enhanced services under one roof.

Boni-Lou Roberts, MSHE, MATS, CADC II: removing some of the barriers that take place, when we have to do referrals for additional services or step-up services. It allows that patient to maintain their engagement on medication for opioid use disorders while getting the enhanced services of an IOP.

Boni-Lou Roberts, MSHE, MATS, CADC II: I tend to think about this in the terms of...

Boni-Lou Roberts, MSHE, MATS, CADC II: going school shopping. So, I'm born in the 80s, child of the 90s, and I lived through the heyday of the mall, and I tend to think about this in terms of the difference between a standalone store versus going to the mall.

Boni-Lou Roberts, MSHE, MATS, CADC II: When we talk about implementing, IOPs within an OTP setting, we're really helping us

Boni-Lou Roberts, MSHE, MATS, CADC II: enhance the patient's experience to more of a mall experience. So rather than coming just for, individual counseling, a little bit of development of some skills in the individual counseling, as well as our medication-assisted treatment, it allows us to further enhance their skills through engagement with IOP groups.

Boni-Lou Roberts, MSHE, MATS, CADC II: To help them understand readiness to change, and where are they with their motivations.

Boni-Lou Roberts, MSHE, MATS, CADC II: What are some of their experiences with living with chronic conditions, and how are they able to relate to others who may be experiencing that as well? It helps them to understand those 12-step facilitations and mindfulness-based relapse prevention. It helps us to really engage the patient in those enhanced services, and really encourage use of those

Boni-Lou Roberts, MSHE, MATS, CADC II: It's under one space that is safe for them that they've

identified as being safe for them.

Boni-Lou Roberts, MSHE, MATS, CADC II: Moving to the next slide,

Boni-Lou Roberts, MSHE, MATS, CADC II: We also want to see patients engage with additional resources, so this is going to let them

Boni-Lou Roberts, MSHE, MATS, CADC II: practice life skills, outside... within the, IOP group, so they're developing a new routine. They'll come in, they'll have a regularly scheduled group that they're working with, they have new peers that they may be engaging with, working with those others to practice some of those communication skills.

Boni-Lou Roberts, MSHE, MATS, CADC II: thinking through emotions and the responses that they have with it. It also helps them to develop a community. Often they'll be able to identify within the community additional, recovery-specific, activities. I know locally we have a group that goes together, with,

Boni-Lou Roberts, MSHE, MATS, CADC II: a local Celebrate Recovery group, and they'll, you know, do movie nights, or bowling, or those types of things, so it helps them not only remove that isolation, but build a stronger community, and it may start within that IOP setting. It is also that natural step-down process, and maybe a step up into leadership. We often see individuals who may be

Boni-Lou Roberts, MSHE, MATS, CADC II: a part of an OTP, they're kind of...

Boni-Lou Roberts, MSHE, MATS, CADC II: actively moving along, they start to struggle a little bit. We encourage engagement within the IOP. They start to develop some of those,

Boni-Lou Roberts, MSHE, MATS, CADC II: They start to develop those, oh, goodness.

Boni-Lou Roberts, MSHE, MATS, CADC II: They start to develop some of those skills, they start to explore their emotions, explore understanding the course of their disease process in the groups.

Boni-Lou Roberts, MSHE, MATS, CADC II: and understand it better in a way that they can support others. So, we may see a transition through engagement of... in the IOP from a patient to... they start to kind of lead some of the groups and help support some of their... their cohorts that may be newer into the IOP program. So it helps us to generate... generate that natural step-up or step-down process in the groups.

Boni-Lou Roberts, MSHE, MATS, CADC II: And it helps us to encourage further engagement with, monitoring their medication for opioid use disorder. Individuals who are in an OTP setting and start to engage in their IOP services as well.

Boni-Lou Roberts, MSHE, MATS, CADC II: are more likely to talk about what they're experiencing when it comes to their medication, or their dosing, or challenges that they may have associated with that. So we have that strengthened connection with the treatment providers and that, strengthened,

Boni-Lou Roberts, MSHE, MATS, CADC II: Rapport that allows them to really open up a little bit more

in the process.

Boni-Lou Roberts, MSHE, MATS, CADC II: So moving next to talking about a few more, clinical benefits of integrating with OTPs.

Boni-Lou Roberts, MSHE, MATS, CADC II: Of course, in the ACM 4th edition, there's an amazing turn to further integrating substance use disorder and mental health care. This encourages our programs to be more co-occurring capable. We see a lot more in...

Boni-Lou Roberts, MSHE, MATS, CADC II: not enforcement, but we see a lot more recommendations that programs focus on being co-occurring, capable, and co-occurring enhanced in order to be able to support multiple diagnoses at one time and increase their abilities within the OTPs.

Boni-Lou Roberts, MSHE, MATS, CADC II: So programs should be providing more co-occurring capable care for patients, that may be experiencing those mental health concerns in the process.

Boni-Lou Roberts, MSHE, MATS, CADC II: So, flipping a little bit from our clinical side, over to the operational side, as we continue to explore those additional supports of IOP services within an OTP setting, you'll notice some additional operational benefits. Some of those may be, the same as the clinical benefit in that you have two levels of care all under one roof. So we have that mall experience for our patients. We can really

Boni-Lou Roberts, MSHE, MATS, CADC II: enhance it.

Boni-Lou Roberts, MSHE, MATS, CADC II: To help them eliminate that need for additional referral and engagement with multiple providers simultaneously. It allows them to,

Boni-Lou Roberts, MSHE, MATS, CADC II: Have that kind of one-stop shop to support what their medical, clinical, mental health needs may be at the time.

Boni-Lou Roberts, MSHE, MATS, CADC II: There's also an increase in the census that we may see with the operational, as an operational benefit, so we're able to see clients, be retained through multiple levels of care, as opposed to just having kind of the one niche that we're able to work... work with.

Boni-Lou Roberts, MSHE, MATS, CADC II: And then, of course, we have additional marketing opportunities. We're able to create a unique niche within our OTPs and demonstrate that we're doing more than, the minimum. We really want to support you through your full course of recovery as much as we possibly can.

Boni-Lou Roberts, MSHE, MATS, CADC II: So next, we're going to talk a little bit about the phases of development for an IOP. So anytime that there's exploration of additional service line areas, it's a big project.

Boni-Lou Roberts, MSHE, MATS, CADC II: So, we're gonna start first by, what do we do before implementation?

Boni-Lou Roberts, MSHE, MATS, CADC II: One of the first things that we're going to do is actually make sure we gather the teams and start our assignments. So, I tend to think about this as making sure that you have your A team there and ready.

Boni-Lou Roberts, MSHE, MATS, CADC II: This may be working, with larger organizations.

Boni-Lou Roberts, MSHE, MATS, CADC II: With a department that's focused on credentialing, or a department that's focused in accreditation, having a good marketing team on your side, being able to pull them in to understand the services and understand how this is going to help our community.

Boni-Lou Roberts, MSHE, MATS, CADC II: Walking through operations, and what is it gonna look like on a day-to-day operations and, kind of overall program monitoring, process, making sure we're in compliance.

Boni-Lou Roberts, MSHE, MATS, CADC II: with all of the regulations that we have to follow. And of course, we all know that there's a ton, and they change from state to state.

Boni-Lou Roberts, MSHE, MATS, CADC II: We also want to look at identifiable and actionable items for each one of those teams. So, if it is looking for credentialing, what needs to be in place for us to be able to be licensed as an IOP provider, as well as an OTP provider? What does it mean for our counselors to be licensed and credentialed appropriately for that?

Boni-Lou Roberts, MSHE, MATS, CADC II: For our billing team, what are the billing codes that we can use? Which can we use at the same time as IOP? Do they need to be separate? With the changes in the implementation and our ability to bill for Medicaid? Are there any parameters that we need to look around for that?

Boni-Lou Roberts, MSHE, MATS, CADC II: Making sure that we have the IT, capabilities available, and do we... do they know, hey, we're gonna need, to have some TVs available, or a projector available to use with the teams?

Boni-Lou Roberts, MSHE, MATS, CADC II: We want to identify which phase in the process each of the team is going to be heavily involved in, and what's going to be their role in this process of implementation with the new program.

Boni-Lou Roberts, MSHE, MATS, CADC II: Next, you're gonna wanna start to do your research. If you are...

Boni-Lou Roberts, MSHE, MATS, CADC II: a program of one, or you are a very small program looking to grow and launch. Congratulations! You now have a to-do list that is longer than a CVS receipt.

Boni-Lou Roberts, MSHE, MATS, CADC II: Ultimately, you're going to have a lot of things that you'll have to research and review. You'll have lots of things that you want to make sure you're well organized with in order to maintain fidelity to the appropriate level of care for that patient as they've been assessed.

Boni-Lou Roberts, MSHE, MATS, CADC II: but also to our ethics and boundaries as professionals, and

to any state regulations or billing regulations that we have to do. So I recommend doing a lot of research at the very beginning. Make sure that you have a full understanding of the licensing and accreditation requirements within your state in order to make sure that we are doing things by the book.

Boni-Lou Roberts, MSHE, MATS, CADC II: Looking at program structure and any structure requirements or limitations that may be in place.

Boni-Lou Roberts, MSHE, MATS, CADC II: Can we only have 12 patients in a group at a time? If our program grows larger than 12 patients, how are we going to navigate through that, or what are our...

Boni-Lou Roberts, MSHE, MATS, CADC II: recommendations for it. And then, what are the projected outcomes and facility needs that we may have

Boni-Lou Roberts, MSHE, MATS, CADC II: prior to this implementation process. Do we need additional rooms, or do we need to consider alternate time opportunities for our client engagement to allow for us to have the space for our IOP groups to take place?

Boni-Lou Roberts, MSHE, MATS, CADC II: While not interrupting other services for patients who may not be involved in that IOP process.

Boni-Lou Roberts, MSHE, MATS, CADC II: As you're doing your research, I do have 3 questions that I highly recommend. When you go into doing your research, you want to ask, should we, can we, and how do we? So, when we're talking about should we, we're really looking into, next slide.

Boni-Lou Roberts, MSHE, MATS, CADC II: Looking into things like, is there a need in this area? So, do we have a potential population that we would be able to support with this? Do we have any community connections that already have this in place that we could probably strengthen our connections with?

Boni-Lou Roberts, MSHE, MATS, CADC II: Do we have them as a possible referral source that we can use, or, do we have them as, do we have additional individuals that, may not

Boni-Lou Roberts, MSHE, MATS, CADC II: meet that niche, but we can kind of support within other ways. The other thing that we should ask whenever we're looking at should we, is what's going to be the focus of this? Is it going to be co-occurring enhanced as much as possible, as ACM does recommend, or are we going to have to partner in other ways, and what's going to be the focus?

Boni-Lou Roberts, MSHE, MATS, CADC II: Is this going to be mental health focused with additional substance use groups that are added, or is it mostly substance use groups that'll have some, mental health,

Boni-Lou Roberts, MSHE, MATS, CADC II: elements added in, or do we have a well-balanced program that we're looking at? And then the additional question is, how is this going to contribute and align with the mission, vision, and values, in our organization and in our,

Boni-Lou Roberts, MSHE, MATS, CADC II: In our community, as we're focused in on really supporting the people who need us the most.

Boni-Lou Roberts, MSHE, MATS, CADC II: Next, you want to ask yourself, can we?

Boni-Lou Roberts, MSHE, MATS, CADC II: So, is this something that we can do? Are we authorized? This process could take several months, up to a year, depending on multiple factors, including licensing requirements, accreditation requirements, and any credentialing with insurance providers that takes place.

Boni-Lou Roberts, MSHE, MATS, CADC II: You also want to see if you have the means. Do we have what we need to support patients and staff through the process and through that first year of implementation of the program with our goals of really expanding what we can offer to those who need it the most?

Boni-Lou Roberts, MSHE, MATS, CADC II: Do we have the materials that we need? Are we well aware of the evidence-based practices that we're looking to offer? Are we well equipped to provide those in support of those IOPs? And then, do we have the manpower? Do we have the people that we would need to be able to provide these services to our patients?

Boni-Lou Roberts, MSHE, MATS, CADC II: One of the saddest things is to, really have the goals, talk with the patients, start to look at implementing this program, and then we realize we don't have the manpower to really support it in the process.

Boni-Lou Roberts, MSHE, MATS, CADC II: And then the last question is, of course, how are we gonna do this?

Boni-Lou Roberts, MSHE, MATS, CADC II: how do we implement this program? How do we launch this? So, looking at patient-facing decisions, so what are going to be the hours? What is the evidence-based curriculum going to look like? So, are we going to put together notebooks for our patients? Are we going to have printouts available for them regularly? What is the patient or client experience really going to

Boni-Lou Roberts, MSHE, MATS, CADC II: look like? And what is the team experience going to look like? What will their day-to-day structure be as they come into the program and as they start to engage with these offerings?

Boni-Lou Roberts, MSHE, MATS, CADC II: On the background, we're going to look at authorizations, making sure that our billing is set up, and making sure that your EHR is developed in a way that the billing and claims process goes streamlined. Do we have contracts and partnerships with our community partners?

Boni-Lou Roberts, MSHE, MATS, CADC II: For example, do we talk to the local probation officers and seeing if there's a connection there? Talk with local hospitals and say, hey, if you have someone who is stepping down, this may be an opportunity for them, and how have we got those in place?

Boni-Lou Roberts, MSHE, MATS, CADC II: Final step whenever we're talking about prior to implementation is getting prepped. So, making sure that we have a full marketing program set up and ready to launch with our clients, with our providers. Really making sure that those are divided and that we understand the different audiences that may be in place when we're talking about IOPs.

Boni-Lou Roberts, MSHE, MATS, CADC II: How we would talk to an OTP patient about engagement into an IOP program, it's going to be very different than how we would talk about community providers and partnership for referral for IOP programs for patients that need it.

Boni-Lou Roberts, MSHE, MATS, CADC II: Setting up the curriculum, making sure that we're very clear on, you know, what the evidence-based practice programs are that we're going to offer, what our everyday,

Boni-Lou Roberts, MSHE, MATS, CADC II: Groups will look like, making sure that we are well-staffed for this, that each staff member is trained appropriately for this.

Boni-Lou Roberts, MSHE, MATS, CADC II: And then getting ready for inspections and surveys. So any new program, of course, goes through the licensing request process, and can expect for there to be some type of review or inspection taking place.

Boni-Lou Roberts, MSHE, MATS, CADC II: Within the first year or several months of them being involved.

Boni-Lou Roberts, MSHE, MATS, CADC II: So once we've moved from that beginning, we're going to start the implementation process. So during implementation, a couple of things that we see is actual service delivery. So we start engaging with patients, we start holding our groups.

Boni-Lou Roberts, MSHE, MATS, CADC II: We want to make sure our counselors are documenting those services that are being provided, both the individual as well as the groups, any medication,

Boni-Lou Roberts, MSHE, MATS, CADC II: Any,

Boni-Lou Roberts, MSHE, MATS, CADC II: dosing and medication changes that are going on there. What is the daily running and reporting within the facility? So, seeing each one of those activities.

Boni-Lou Roberts, MSHE, MATS, CADC II: We also want to start fidelity monitoring, so we would have check-ins from our supervisors, making sure that our IOP counselors are following a curriculum, that they're documenting appropriately, and really looking at a continuous quality improvement. We want to make sure that,

Boni-Lou Roberts, MSHE, MATS, CADC II: throughout the process, we're growing and getting better, that we're offering the best to our patients in there. So, we don't notice, you know, we don't have that risk, of, you know, any type of drift that may take... take

Boni-Lou Roberts, MSHE, MATS, CADC II: pulled during the group process. And then we're exploring the patient experience. What is the flow like for them to come from, referral and that recommendation for our IOP process?

Boni-Lou Roberts, MSHE, MATS, CADC II: into them engaging into the IOP process. Do we have a good flow in place, or do we need to reevaluate?

Boni-Lou Roberts, MSHE, MATS, CADC II: how that's going. How is our retention? Are we maintaining our patients? Do we see that regular 9 patients coming in, each week, week to week, and are they sticking around through the duration of the program that we have? Also, doing some satisfaction surveys throughout the course of treatment, not just at the beginning, not just at the end, but throughout the process to understand what the patient

Boni-Lou Roberts, MSHE, MATS, CADC II: experience is like, and where we can continue to improve. And then looking at outcomes. So, do we see a change

Boni-Lou Roberts, MSHE, MATS, CADC II: from the initial ACM assessment that led to a recommendation for IOP services.

Boni-Lou Roberts, MSHE, MATS, CADC II: to completion of the program, and enhancement to where the patient is no longer meeting criteria for enhanced services. Maybe they've moved into more of a monitoring services level, and really evaluating if the program is actually

Boni-Lou Roberts, MSHE, MATS, CADC II: Doing what we would hope that it is for the patients as we're working through with that.

Boni-Lou Roberts, MSHE, MATS, CADC II: So once we've done the implementation process, we've actually got the one up and running for everything, we start the after implementation process. So one of the first things we want to do is, how can we scale this? If you are a larger organization, how can I take this and mimic it?

Boni-Lou Roberts, MSHE, MATS, CADC II: to be present in other areas. For example, building the program, what was the process? Reviewing what worked and what didn't work in that prior to implementation.

Boni-Lou Roberts, MSHE, MATS, CADC II: stage that we went in. Exploring, you know, where can we do things a little bit better? Perhaps we match our licensing request along with when our updated licensing is going forward. And then we identify our next steps and use that plan, do, study, act cycle. So, testing, a change on a smaller scale, seeing how it worked in our first program that we did.

Boni-Lou Roberts, MSHE, MATS, CADC II: Developing a plan to test that change, carrying out that test.

Boni-Lou Roberts, MSHE, MATS, CADC II: observing those outcomes, and then integrating any learning from that. So really.

Boni-Lou Roberts, MSHE, MATS, CADC II: Anything that we've identified that didn't work, that we may want to shift, how are we going to shift that and make that change? Things that did work really well, how can we re-implement that in a new program?

Boni-Lou Roberts, MSHE, MATS, CADC II: Next, we want to talk about implementation of the outcomes. One of the specific challenges that we experienced with, in launching a few IOP programs within our organization was really looking at

Boni-Lou Roberts, MSHE, MATS, CADC II: buy-in. So communication and accountability with our teams on understanding the importance of offering patients, the appropriate level of care to support them.

Boni-Lou Roberts, MSHE, MATS, CADC II: And making sure that there is fidelity to the assessments that are being provided to that, and maintaining some accountability behind that. But also, how are you talking with your patients about group engagement? One of the most challenging things for me was,

Boni-Lou Roberts, MSHE, MATS, CADC II: Seeing a shift, especially in a program where group culture may not have been very strong, and working with them to understand the importance

Boni-Lou Roberts, MSHE, MATS, CADC II: Of those connections and the groups, and... and really encouraging patients to, see this as an everyday part of treatment, and one of the things that would benefit them, as opposed to, like, this is... this is here if you want.

Boni-Lou Roberts, MSHE, MATS, CADC II: We'd love for you to engage, but no pressure or, you know, no explanation behind it, as to what the benefits are for it.

Boni-Lou Roberts, MSHE, MATS, CADC II: Couple of the things that are super successful, is making sure that you have kind of your IOP cheerleader, to help with patient engagement. Areas that already have a strong,

Boni-Lou Roberts, MSHE, MATS, CADC II: Focus on counseling and group counseling within their treatment providers.

Boni-Lou Roberts, MSHE, MATS, CADC II: tend to have a little more success with it, building that wraparound care, so not only do we want you to engage more with counseling, but we also want you to engage more with case management, peer support, your medication management, and any medical issues that you may have or need to talk with our providers about.

Boni-Lou Roberts, MSHE, MATS, CADC II: And I'm... Pass this back to Keisha.

Keisha Haynes, LCPC, CPHQ: All right, so next we will get into the level of care considerations for regulatory and billing compliance. There was already a few questions, in the Q&A box, so hopefully we will cover that for you.

Keisha Haynes, LCPC, CPHQ: So, some of the regulatory compliance considerations that you want to take into account is that they're going to consider variably, by state. You'll notice some states may have the same criteria. I work with about 8 states.

Keisha Haynes, LCPC, CPHQ: And we are... have IOP and 4, and they're all different.

Keisha Haynes, LCPC, CPHQ: And so it's even down to the credential license requirements.

Keisha Haynes, LCPC, CPHQ: That's gonna vary by, by state, and even sometimes your payer's state Medicaid may have, specific requirements that are a little bit more restrictive than the state regulations. So, it's very good to pay attention to that.

Keisha Haynes, LCPC, CPHQ: as well. Counselor to patient ratios, those are going to vary.

Keisha Haynes, LCPC, CPHQ: By state and payer as well. So you may have some, states that have a, you know, 1 to 10 ratio, others may have a 1 to 12. It's gonna vary.

Keisha Haynes, LCPC, CPHQ: So digging into those regulations are going to be key here, to be able to assure that you're in compliance. The assessment and treatment plan documentation, that was one of the questions, in the Q&A box.

Keisha Haynes, LCPC, CPHQ: As far as that documentation, again, what is required is going to vary differently by state.

Keisha Haynes, LCPC, CPHQ: And by payer, and so having a better understanding of what the assessment and reassessment frequency are, the same for the treatment plans, the frequency for that, and the content requirements.

Keisha Haynes, LCPC, CPHQ: Some individuals may be accredited with Joint Commission and CARF, and so some of those requirements we still want to blend in. For example, like,

Keisha Haynes, LCPC, CPHQ: Joint Commission requires, like, tobacco cessation, nicotine, education. So, that is something we'll still want to incorporate. So, having an understanding of what those requirements are for those documentation. Your clinical supervision requirements, that also varies

Keisha Haynes, LCPC, CPHQ: By state, and so that goes hand-in-hand with that credential and license requirement.

Keisha Haynes, LCPC, CPHQ: So, some states may require supervision because of the credential licenses that is allowed to facilitate IOP, whereas some states, they may want a master-level clinician that's independently licensed, whereas clinical supervision may not necessarily be required

Keisha Haynes, LCPC, CPHQ: But, you know, for your organization, it may be as well. And then the individual counseling and peer service requirements changes. I have a state where the individual counseling is required. It's a part of the 9 hours.

Keisha Haynes, LCPC, CPHQ: Whereas I have another thing, that's Rhode Island, and then I have Virginia, where Virginia, there is no individual counseling requirement for IOP. That's just something extra, that you can add into that requirement. So, going into your state regulations.

Keisha Haynes, LCPC, CPHQ: I'm a big tracker person, spreadsheets for everything to help you stay organized, of what is going to be required for each state, if you're working within multiple states.

Keisha Haynes, LCPC, CPHQ: And this is just an example of how those compliance considerations can change from state to state.

Keisha Haynes, LCPC, CPHQ: So here are two of my states that I have IOPs in. And you can see that the credential requirements are vastly different, whereas in North Carolina, I can hire a bachelor-level

counselor to facilitate my IOP groups.

Keisha Haynes, LCPC, CPHQ: Whereas in Virginia, they have to be a CATP, and this is a, a credentialed addiction treatment professional, so this means they have to have that master level license.

Keisha Haynes, LCPC, CPHQ: So, a licensed clinical psychologist, a licensed professional counselor, they have to have those master level licenses in order to facilitate IOP.

Keisha Haynes, LCPC, CPHQ: And then you see here that my group size ratios are different as well. So, in North Carolina, it's a little bit more relaxed. Like, I could use a bachelor-level credential.

Keisha Haynes, LCPC, CPHQ: counselor, I can have up to 12 people in the group, whereas in Virginia.

Keisha Haynes, LCPC, CPHQ: It's only up to 10 patients that have to be a master-level clinician. And then Medicare, they also have requirements as well, where, you know, their patients cannot do telehealth for IOP. It has to be in person. So there's a lot of different requirements that go hand-in-hand.

Keisha Haynes, LCPC, CPHQ: One of the questions was, you know, is there any specific type of documentation? And that's gonna depend on your payers, on your state.

Keisha Haynes, LCPC, CPHQ: As far as what they specifically require, we utilize that notes. North Carolina, they require a soap note component, so we've had to build that into our templates. So again, it's being, very well aware.

Keisha Haynes, LCPC, CPHQ: Of what those specific requirements are, as it varies by state to state and payer by payer. So getting to a little bit more of the billing component of these compliance considerations, we want to make sure that we are documenting medical necessity.

Keisha Haynes, LCPC, CPHQ: And in short, that is, can we justify why this person needs this level of care? When I train my teams, I like to train them and say that your documentation is advocacy.

Keisha Haynes, LCPC, CPHQ: For your patients. Insurance companies already don't want to pay these reimbursement rates, or give us money for these treatments for patients.

Keisha Haynes, LCPC, CPHQ: So our documentation, our ability to justify why they should pay us helps our patient, because the more we're able to do that, the more they're going to see that need for patients to have these services, which is, again, going to make them want to be able to pay for more of these services.

Keisha Haynes, LCPC, CPHQ: So that medical necessity documentation is key. Also, some states may have, insurance prior and concurrent authorization. So after we verify that their insurance does cover.

Keisha Haynes, LCPC, CPHQ: IOP, they're going to have that benefit of being able to attend. Some insurances take it a step further, where they want a prior authorization, so they may be eligible to have their IOP reimbursed, but we still need to submit that prior authorization to, again, show that medical necessity

Keisha Haynes, LCPC, CPHQ: of why the patient needs to be there. And some insurance companies, let's say our IOP program is a total of 36 sessions.

Keisha Haynes, LCPC, CPHQ: They may say, oh, I'm only going to authorize 12 sessions, and then you contact me as you get to that 12th session, and let me know why the patient still needs to be there after 12 sessions. Why aren't they cured? You know, that word.

Keisha Haynes, LCPC, CPHQ: So a concurrent authorization is required, where again, we're continuously justifying why the patient is medically appropriate. And so someone asked about the frequency of reassessments.

Keisha Haynes, LCPC, CPHQ: for IOP. And again, this is one of those parts that we take into consideration with the frequency of when we're doing those reassessments, because we're going to have to be able to justify, as of today, where that patient is, in their IOP.

Keisha Haynes, LCPC, CPHQ: We also want to work with our billing team and revenue cycle management team to ensure that we have the proper billing codes. So some, payers may have comprehensive claims.

Keisha Haynes, LCPC, CPHQ: And so that basically means there's a bundled per diem rate, for that. And so all services that are included in that day, IOP, individual.

Keisha Haynes, LCPC, CPHQ: it is all looped into one claim, whereas you have some states, they may operate as a fee-for-service, so they'll pay one rate for the patient attending IOP group. They'll pay another rate for the patient attending, IOP individual sessions.

Keisha Haynes, LCPC, CPHQ: So again, it's very, you know, you know...

Keisha Haynes, LCPC, CPHQ: proactive of you to be able to have this information, as Bonnie Lou said, working with those different, you know, laterals within your organizations to ensure that we are going to meet those compliance standards in all areas.

Keisha Haynes, LCPC, CPHQ: And then again, track it, you know, track the authorization, track your patient's progress, because again, if an insurance company isn't willing to reimburse all 36 of your sessions, you're going to have to be able to track when the patient has completed, you know, the X number of sessions that the insurance company has allowed. You're going to have to keep track of

Keisha Haynes, LCPC, CPHQ: Oh, they want the patient to attend 12 sessions, but only for this duration of time, so you have to track the dates.

Keisha Haynes, LCPC, CPHQ: You have to track the number of sessions attended. So having a tracking mechanism, in place definitely is key here.

Keisha Haynes, LCPC, CPHQ: And then we move into more compliance considerations for billing, so making sure that you use the appropriate procedure codes.

Keisha Haynes, LCPC, CPHQ: So, psychotherapy typically use, like, 90834. IOPs typically use the HPCS Level 2 codes.

Keisha Haynes, LCPC, CPHQ: That represents that bundled daily service, an H0015. So again, having a better understanding of if it's going to be a comprehensive claim, or is it going to be a fee-for-service claim that we are submitting.

Keisha Haynes, LCPC, CPHQ: Insurance companies will deny, or will underpay.

Keisha Haynes, LCPC, CPHQ: Your claims without proper billing.

Keisha Haynes, LCPC, CPHQ: I've even had, sites where they said, you know, I submitted this information, but the insurance company denied it, because they said they didn't see that it met medical necessity.

Keisha Haynes, LCPC, CPHQ: So we had to take a step back and really train our team members on how to complete these prior authorizations, because again, each

Keisha Haynes, LCPC, CPHQ: company, each payer is going to have different requirements. Some may have, you know, a form that you have to fax, another may have a portal that you have to log into to submit some information.

Keisha Haynes, LCPC, CPHQ: You know, others may want you to write a synopsis under each dimension, others just may want the billing codes that you want to use, and the dates.

Keisha Haynes, LCPC, CPHQ: So really training them to be able to understand how you're going to meet that medical necessity, how can you communicate that in writing to be able to justify that claim, whether it's a prior authorization or a concurrent authorization, that is definitely going to help with getting those claims approved.

Keisha Haynes, LCPC, CPHQ: But another thing to consider is some payers may require that 9 hours must be achieved in order to bill. So, for example, in North Carolina, I have to ensure and we have to track

Keisha Haynes, LCPC, CPHQ: If a patient showed up for 9 hours that week.

Keisha Haynes, LCPC, CPHQ: It doesn't include individual, this is group therapy. And so, if a patient only showed up one day that week, we cannot bill that as IOP. We have to switch that into a regular group therapy code. If a patient only attended 6 hours that week.

Keisha Haynes, LCPC, CPHQ: We cannot bill for IOP. If they did come on a third day, but they left early, so they didn't quite hit 9 hours, again, we cannot bill for IOP.

Keisha Haynes, LCPC, CPHQ: So we have to make sure that the patients are getting 9 hours minimum, to be able to ensure that we can bill IOP for those specific services.

Keisha Haynes, LCPC, CPHQ: So again, as Bonnie Lou mentioned, having those regular meetings, with your various departments, being able to identify those action items, those questions.

Keisha Haynes, LCPC, CPHQ: Who's going to be responsible for looking into what is definitely going to be key to ensure that you're hitting both the billing and the regulatory consideration.

Keisha Haynes, LCPC, CPHQ: So again, research your state's requirements. Contact your SOTA, your state's behavioral health license authority, health department.

Keisha Haynes, LCPC, CPHQ: Find out even if a separate IOP license is needed.

Keisha Haynes, LCPC, CPHQ: Some organizations have to have

Keisha Haynes, LCPC, CPHQ: a separate IOP license from their OTP license in order to provide IOP, so that is something you're going to loop in your regulatory affairs department, your credentialing department, to make sure that you have the proper documentation submitted to be able to practice

Keisha Haynes, LCPC, CPHQ: And be able to submit those IOP, claims, because the worst thing is that you're providing those services, and you don't even have the license for, and you have to recoup all of that money.

Keisha Haynes, LCPC, CPHQ: So definitely research all of your state requirements. Maintain... I'm sorry, ensure that you're maintaining clinical standards. So, once you're licensed, once you have everybody hired, you have everything structured out.

Keisha Haynes, LCPC, CPHQ: You want to make sure that you're able to maintain that minimum. So we know unexpected inspections or audits can happen, and you want to always prevent yourself from being caught off guard. So we are big on contingency plans, so, you know, if this person is out.

Keisha Haynes, LCPC, CPHQ: who's going to be able to come in and be able to facilitate this IOP so that there's no disruption of care, for those particular patients. And then lastly, stay updated. We know regulations can change at any time.

Keisha Haynes, LCPC, CPHQ: We know as our field continues, evolves, there's always updated rules and standards and guidelines for our OTP program, so make sure that you keep an eye out on any legislative or regulatory updates.

Keisha Haynes, LCPC, CPHQ: that may impact your IOP programs, and also be, you know, aware of any Medicaid or Medicare, changes or coverages. We know that's a lot of talk right now.

Keisha Haynes, LCPC, CPHQ: And, the House and Congress, to be... and the Senate to be able to change some of those things. And so we're... we're constantly advocating, for, you know, our field and for our patients to be able to maintain these coverages.

Keisha Haynes, LCPC, CPHQ: With insurance, and we know that insurance premiums are changing.

Keisha Haynes, LCPC, CPHQ: Patients may, you know, have, you know, their insurance dropped.

Keisha Haynes, LCPC, CPHQ: You know, so we want to make sure that we're mindful of all of that at any given time, and we're not providing IOP services for a patient that we can no longer bill for because they no longer have insurance.

Keisha Haynes, LCPC, CPHQ: So it's very, very, very...

Keisha Haynes, LCPC, CPHQ: important to ensure that you are updated, and stay updated, and connect with your regulatory or compliance team to ensure that you are always operating at the minimum requirements for your organization. Going above and beyond is always extra.

Keisha Haynes, LCPC, CPHQ: But we want to make sure that, at minimum, that we are, meeting our billing and regulatory clinical operational standards.

Keisha Haynes, LCPC, CPHQ: So that concludes the end of our presentation today. There are quite a few questions.

Keisha Haynes, LCPC, CPHQ: in the chat that we'll get to. Here you'll have my contact information and Bonn Lou's contact information if you have any additional questions outside, that you may not have thought of while we're in this session.

Keisha Haynes, LCPC, CPHQ: So we'll go ahead and get started on some of these questions. Bonnie Lou, I may throw some your way, and

Keisha Haynes, LCPC, CPHQ: answer some mine. One of the first questions that came in was, if a client truly meets the criteria.

Keisha Haynes, LCPC, CPHQ: for a higher level of care, but they don't want that level of care, what ethically do you suggest the counselor document and recommend? Do you have the counselor change their documentation to meet what the client wants versus what the client assessment shows?

Keisha Haynes, LCPC, CPHQ: I understand there has to be a discussion with the client and meeting them where they are at, but what does the counselor need to know about documenting the truth of the assessment? We're documenting everything.

Keisha Haynes, LCPC, CPHQ: In a nutshell there.

Keisha Haynes, LCPC, CPHQ: So the counselor should be documenting what that recommendation of level of care is, first of all. So what did we recommend based off of what we gathered from that assessment? And then from there, I'm going to have that conversation with the patient about what I recommended, and with the fourth edition that we're doing is that Dimension 6.

Keisha Haynes, LCPC, CPHQ: at person-centered considerations. We are taking into account the patient's environment, their social determinants of health, and identifying what is going to be the best fit for the patient. So, for example, they may not have childcare.

Keisha Haynes, LCPC, CPHQ: And they're unable to, you know, be in a residential level of care if that's what we identify for them, but they're able to get, you know, their mother or grandmother to come over to watch the kids for 3 hours, 3 days a week.

Keisha Haynes, LCPC, CPHQ: And in that case, the IOP is going to be the least restrictive, still providing some intensive support for the patient, but it's meeting them where they are. And so what we document in that case is what we agreed upon.

Keisha Haynes, LCPC, CPHQ: what are those factors? What are those, you know, assessing factors that we identified that is contributing to why the patient is going into this new level of care that is different from what we recommended, and how we believe that this level of care is going to still be able to address the patient's needs.

Keisha Haynes, LCPC, CPHQ: And so we want to document all of that. So we're documenting the recommendation, and we're documenting the placement. And we do that for the ASAN third level, you know, the third edition.

Keisha Haynes, LCPC, CPHQ: And the fourth edition is going to require you to do that as well. So that is a practice that you can already start getting in the habit of, of being able to document that patient. Bonnie, do you have anything to add there?

Boni-Lou Roberts, MSHE, MATS, CADC II: Yes, I do want to add just a little bit. So, one, I absolutely love this question, because I think that it highlights one of the major changes that we see in transition from ASAM 3 to ASAM 4, and that is the,

Boni-Lou Roberts, MSHE, MATS, CADC II: kind of disbursement of Dimension 4 from being its own readiness to change dimension into a readiness to change evaluation in each one of the six ASAM dimensions. So, one of the things as counselors and as practitioners that we can work on is, like, recognizing that readiness to change in each one of those six ASAMS dimensions.

Boni-Lou Roberts, MSHE, MATS, CADC II: Documenting that as,

Boni-Lou Roberts, MSHE, MATS, CADC II: how we're recognizing our risk levels, you know, patients who may have multiple problems identified in a dimension area, but are not ready to make changes in that does increase their risk level, and increase, you know, where we may want to work with them. And then using that understanding of their readiness to change for each one of those six ACM dimensions.

Boni-Lou Roberts, MSHE, MATS, CADC II: in how we're planning to work with patients. So, we note in our assessment and in our summary documents that this is, our recommendation is that you have a higher level of care. We understand that your readiness to change level is here for that area, and so our interventions may look a little bit different because we're really focusing in on motivation to change.

Boni-Lou Roberts, MSHE, MATS, CADC II: motivational interviewing to help move that readiness to change in those areas a little bit higher, and encourage further engagement into those higher level of care as necessary for that patient, and appropriate for that patient.

Keisha Haynes, LCPC, CPHQ: All right.

Keisha Haynes, LCPC, CPHQ: So there was another question about being curious about what their recommendations are when the courts do not support your treatment program because of stigma around some medications like methadone. In these instances, I have had to refer patients to IOP when they could have just increased engagement at OTP.

Keisha Haynes, LCPC, CPHQ: Bonnie Liu, you work more with the courts than I do. You want to take this one?

Boni-Lou Roberts, MSHE, MATS, CADC II: I will say one of the things that we do run into as a challenge as professionals is that, recognizing what's most appropriate for the patients, and then trying to meet the recommendations or meet the desires of all of the stakeholders who may be engaged.

Boni-Lou Roberts, MSHE, MATS, CADC II: I think in this particular instance, really focusing in on maintaining fidelity to what we're recommending versus this is what the courts are saying.

Boni-Lou Roberts, MSHE, MATS, CADC II: Strengthening connections with the court systems that you're working with, having regular encounters if you're supporting a local drug court program, having connections with those judges so that they understand, like, the assessment evaluation process, and how we come across those level of care recommendations, and really how the different programs can help to benefit them.

Boni-Lou Roberts, MSHE, MATS, CADC II: patient, to try and work through some of that stigma that may be, involved with it. In most situations that I've experienced,

Boni-Lou Roberts, MSHE, MATS, CADC II: Colorado is a state that comes to mind, where they are actually, written into the state's regulations, parameters for those who are criminally justice involved.

Boni-Lou Roberts, MSHE, MATS, CADC II: And so they have, actually noted that if there's a difference in what you're recommending versus what, the.

Boni-Lou Roberts, MSHE, MATS, CADC II: how do they determine it? The monitoring entity is requiring that we have to notate that, and we are offering this level of care because it's most appropriate to the patient, and really kind of strengthening in that. So a few things that I do recommend is, of course, you know, working and getting more involved with the courts and talking with those judges so they understand a little bit better

Boni-Lou Roberts, MSHE, MATS, CADC II: Probation and parole providers are also a good connection. And then your local state regulators, and the ones who actually write the regulations, and talking to them about, how this is truly a disservice, and this is outside of the ethical boundaries.

Boni-Lou Roberts, MSHE, MATS, CADC II: For ours, for our profession, but also for the care of those who are vulnerable and need the support, and, and really advocating. So this is one of those.

Boni-Lou Roberts, MSHE, MATS, CADC II: advocacy...

Boni-Lou Roberts, MSHE, MATS, CADC II: Advocating is, one of the biggest things we can do in our profession to, to help with, you know.

Boni-Lou Roberts, MSHE, MATS, CADC II: us not having these ethical issues come forward. So, so really kind of, maintaining fidelity to what you can offer, what is ethical to offer, what is, compliant with what we need, and then kind of communicating that with the courts.

Keisha Haynes, LCPC, CPHQ: All right, thank you for that. These are great questions.

Keisha Haynes, LCPC, CPHQ: Another question is, I really love all the added care services spoken to in the ASAM 4th edition. They're aware of, outpatient treatment centers only offering virtual groups. It decreases the quality of care, individual participation, and positive outcomes.

Keisha Haynes, LCPC, CPHQ: Are virtual group permissions, availability, and billing expected to change? I assume it will vary state by state. So many great additions for client care and success.

Keisha Haynes, LCPC, CPHQ: any particular guidelines or recommendations when the counselor is working a lot harder than the client? So, a few questions there. The first one is,

Keisha Haynes, LCPC, CPHQ: I'm not aware of any, you know, regulations on group permissions that are going to change. They kind of just got expanded for OTPs a little bit with the updated federal regulations.

Keisha Haynes, LCPC, CPHQ: As far as the quality of care and individual participation, I would say that's more of a training issue there that you might want to look into.

Keisha Haynes, LCPC, CPHQ: As far as, you know, your... the skill sets of your counselors who are facilitating those virtual groups and how they engage.

Keisha Haynes, LCPC, CPHQ: With patients during the group session to be able to enhance those positive outcomes.

Keisha Haynes, LCPC, CPHQ: We take our time to fully train our teams on virtual counseling and virtual group counseling specifically, and then virtual group IOP counseling. We break it down even further. So I would take a look, and do one of those PDSAs and identify what those root cause issues are of the quality of care decreasing for your groups.

Keisha Haynes, LCPC, CPHQ: And then being able to address that root cause once you identify it.

Keisha Haynes, LCPC, CPHQ: Any guidelines on the counselor working a lot harder than the client stop? You know, that's...

Keisha Haynes, LCPC, CPHQ: I don't know if there is any specific guideline or clinical process we can go there, but again, that's a training issue and a supervision issue that can be resolved in super, supervision, because what is it about that

Keisha Haynes, LCPC, CPHQ: particular counselor that they are working harder than their patients. You

know, what is transpiring in those sessions and in between sessions that is garnering this type of outcome? And I saw Bonnie Lee was about to chime in on that one as well.

Boni-Lou Roberts, MSHE, MATS, CADC II: Yeah, so with that one, I think, really kind of pulling back to a self-evaluation and understanding, why, for this particular client, there is that, that, that, that goal, and...

Boni-Lou Roberts, MSHE, MATS, CADC II: Is the activity that I am doing with this client, and me working harder, so to speak, as a clinician, benefiting the patient and helping them to generate autonomy? So, I had a co-worker say it to me one time, and it has left with me

Boni-Lou Roberts, MSHE, MATS, CADC II: Ever since, and that's, if we're not building a client towards autonomy, we're not helping... we are giving them a disservice. Because ultimately, our goal is that the patient or the client can work... can live without us.

Boni-Lou Roberts, MSHE, MATS, CADC II: You know, that they have developed the skills and the support and the things that they need, to where the counselor is just kind of there if you need it. So if we find that we are working a lot harder than the client is, for engagement and support, how are we doing that?

Boni-Lou Roberts, MSHE, MATS, CADC II: In a supportive manner, to encourage them, rather than, us, like you said, working harder than the patient.

Keisha Haynes, LCPC, CPHQ: All right, so I hope that answers it, and then Bonnie Lou, you have a few, but I know we also need to leave time, for some other things.

Boni-Lou Roberts, MSHE, MATS, CADC II: Yes.

Boni-Lou Roberts, MSHE, MATS, CADC II: We'll type responses, where we can with some of those questions, for sure, so that we have those responses available.

Keisha Haynes, LCPC, CPHQ: Alright.

Jessie O'Brien (NAADAC): Alright, thank you guys. I'll go ahead and start.

Jessie O'Brien (NAADAC): The closeout here, just a quick note from our sponsor, before we go any further.

Jessie O'Brien (NAADAC): Oh, you know what? Let me just make sure I shared the volume, I don't think I did.

Jessie O'Brien (NAADAC): Your person and your partner to

Jessie O'Brien (NAADAC): Get clean and get sober for you.

Jessie O'Brien (NAADAC): It's not about you.

Jessie O'Brien (NAADAC): But you want it so badly.

Jessie O'Brien (NAADAC): Scott, next.

Jessie O'Brien (NAADAC): My name is Max McPhee, I'm from Templeton, California, and, I would say I'm doing much better, but definitely an alcoholic community.

Jessie O'Brien (NAADAC): Ever since I met Max, he's been the love of my life. So, he's... he's the person I want to roll with, and he...

Jessie O'Brien (NAADAC): has such an amazing way to make me laugh and smile, and I knew that

Jessie O'Brien (NAADAC): It was gonna be something... that tested us, but I knew... ultimately that I wanted to...

Jessie O'Brien (NAADAC): Sticking out for him, because he was worth it.

Jessie O'Brien (NAADAC): I, first of all, am instantly already lying and drinking, because I'm telling everybody there's water and trying to hide it.

Jessie O'Brien (NAADAC): It's like, well, everything goes downhill.

Jessie O'Brien (NAADAC): feel yourself, like, just spiraling, saying... getting yourself into the same position again. Makes me... I say this, this gets caught, now I'm sad, now I'm drinking.

Jessie O'Brien (NAADAC): It all just spirals through again.

Jessie O'Brien (NAADAC): How do you keep a relationship going?

Jessie O'Brien (NAADAC): If that is what someone is doing in it.

Jessie O'Brien (NAADAC): I've said that a lot.

Jessie O'Brien (NAADAC): And... once Soberlink, entered into our lives, it took away a lot of anxiety.

Jessie O'Brien (NAADAC): When all of that trust in the...

Jessie O'Brien (NAADAC): And we were, you know, at a point where things were really tough between us. This brought it back.

Jessie O'Brien (NAADAC): Just blow until it clicks.

Jessie O'Brien (NAADAC): Says it takes about 30 seconds.

Jessie O'Brien (NAADAC): And there it goes, it says, test successfully sent.

Jessie O'Brien (NAADAC): Has the date, the time... my BAC, and then...

Jessie O'Brien (NAADAC): scent goes to Cammy, my mom and dad.

Jessie O'Brien (NAADAC): Everyone's situation is different, and you can't really, like, put a point on it.

Jessie O'Brien (NAADAC): Of what you're going through and what you're feeling while watching someone try to get sober. You want it so bad for them. You want it so bad.

Jessie O'Brien (NAADAC): And... To have a tool to help you with that.

Jessie O'Brien (NAADAC): Just... It's really amazing.

Jessie O'Brien (NAADAC): This is a note that I've kept for years next to my bed now, from Cammy to me.

Jessie O'Brien (NAADAC): You are the most amazing, sober person in the world, and can be the life of any party just the way you are. You mean the world to me, and I will always be your biggest fan to cheer you up and cheer you on.

Jessie O'Brien (NAADAC): Love something.

Jessie O'Brien (NAADAC): I would absolutely recommend Sober Link.

Jessie O'Brien (NAADAC): it has... Totally changed our dynamic, in the relationship.

Jessie O'Brien (NAADAC): It's helping on this journey of staying... sober.

Jessie O'Brien (NAADAC): We... we do things, and we can go out, and we can have fun, and... and kind of openly more talk.

Jessie O'Brien (NAADAC): And... it feels good. It feels really good.

Jessie O'Brien (NAADAC): Right?

Jessie O'Brien (NAADAC): All right, sorry about the volume issue, guys. Hopefully you were able to hear it. Just a reminder that once this webinar ends.

Jessie O'Brien (NAADAC): Excuse me.

Jessie O'Brien (NAADAC): You'll be eligible to take the CE quiz if you were here for the minimum attendance. A thank you message will appear in the live event box where you entered this live webinar. There'll be a link that says click here to access the CE quiz, and you should be able to then take the CE quiz, complete the survey evaluation.

Jessie O'Brien (NAADAC): And get the CE certificate. If you don't feel like doing it now, you don't have

to. You can always leave and come back.

Jessie O'Brien (NAADAC): search for this webinar in the Education Center, and then in the live section of the course, you will find the CE quiz waiting for you.

Jessie O'Brien (NAADAC): Just some information for you guys. The NBCC Foundation is pleased to announce that the 2026 application period for the NBCCF Minority Fellowship Program

Jessie O'Brien (NAADAC): is open. It will be open until June 30th, 2026, so if you know anyone, even if it's not you, the program will administer up to 43 master's degree level counseling fellowships of \$15,000 for addiction counseling students.

Jessie O'Brien (NAADAC): plus the travel expenses to participate in other program-related trainings. It's super cool, even if you are not...

Jessie O'Brien (NAADAC): appropriate for it. If you know anybody, let them know. It's \$15,000 towards, your education, so that's a pretty great thing, and really great mentoring program. It's a super cool program.

Jessie O'Brien (NAADAC): Just noting some of the upcoming webinars that are on our schedule. The next one is April 22nd, Unseen, Unheard, Untreated, a Disconnected Systems Call for the Medicine of Connection. That's with Dr. Ken Martz. You can see the other ones that are coming up as well.

Jessie O'Brien (NAADAC): We have also been running our, 2026 specialty online training series, Restoring Balance, Mindful and Holistic Practices in Addiction and Recovery.

Jessie O'Brien (NAADAC): The last one in this series of 6 is on April 16th, so that is tomorrow. Nourishing Recovery, Plant Forward Nutrition, and Faith-Informed Support.

Jessie O'Brien (NAADAC): The other ones are available on demand, so you can take all six, you can take one or two if you want to. It's a great series, so I invite you to check that out. We'll be back here tomorrow at 12 for that.

Jessie O'Brien (NAADAC): Just a reminder of all the benefits of joining NADAC as a member.

Jessie O'Brien (NAADAC): You get access to over 600 CEs for free, which are included as an exclusive NADAC member benefit. You'll also get discounts on many of our events, and then instantly become a part of our national initiative for advocacy for the addiction profession.

Jessie O'Brien (NAADAC): If you're not a member, you can join today before you take your C quiz for this webinar, and then the C's will be free.

Jessie O'Brien (NAADAC): So consider joining. You also get discounts.

Jessie O'Brien (NAADAC): On our... the registration price for our national conference, which is this August 29th through 31st in Kansas City, Missouri, which I had the opportunity to visit at the end of last

week. Super cool city, had never been to Kansas City before, don't know if anyone on here is from Kansas City, but highly recommend.

Jessie O'Brien (NAADAC): Anyway, so hopefully you'll join us.

Jessie O'Brien (NAADAC): And that's it. Thank you again to our presenters. I hope everyone has a great rest of your week. Hopefully, I'll see you tomorrow at our specialty training. Otherwise, see you again soon on an upcoming webinar. Take care, everyone.