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Application of CSWE Competencies in Process of Obtaining CARF Accreditation

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Alteri Behavioral Health is an outpatient Behavioral Health Services Organization (BHSO) with its main office located in Lexington, Kentucky. Additionally, there is a satellite office in Frankfort, Kentucky with another location set to open in Danville, Kentucky. Apart from BHSO licensure, Alteri is also licensed as an alcohol or other drug entity (AODE). These two licensures permit the agency to provide treatment for both mental health and substance use disorders. However, since its opening in 2018, the majority of Alteri's services have been centered on the treatment of opioid use disorders. At the time of this publication, Alteri serves 200 patients, all of whom are receiving treatment for opioid use disorder.

The treatment services offered at Alteri include individual therapy, group therapy, targeted case management, peer support services, intensive outpatient treatment and medication services. Medications offered by the agency are buprenorphine-naloxone (Suboxone), buprenorphine (Subutex) and naltrexone (Vivitrol).

These services are provided by an interprofessional team of varying disciplines. Medication management and other medical services are provided by two APRNs who have received specialized training in the treatment of substance use disorders (H. Schweder, personal communication, November 1, 2022). In cases where second opinions or additional medical consultation is warranted the agency collaborates with a

physician who is double board certified in primary care and addiction medicine. A medical assistant/phlebotomist supports the APRNs through completing administrative tasks, administering urine drug screens, and drawing blood for laboratory testing. Therapy services are provided by Social Worker's (LCSWs and CSWs). Case management services are provided by bachelor's level professionals whose degrees are in varying human service fields. The agency employees a peer support specialist (PSS) who has obtained a certification to provide peer support services to individuals with substance disorders. The PSS meets with patients in both group and individual settings.

The leadership of the agency is also composed of professionals with varying education and professional backgrounds. The owner of the agency is an attorney with 40 years of experience in business law (D.Smith, personal communication, October 27, 2022). His focus is primarily on financial aspects of the business in addition to business development matters. The medical director is an APRN with 10 years of experience in addiction medicine. She oversees all medical care provided by the agency and offers support to medical staff. The clinical services director is an LCSW who supervises all therapy and ancillary psychosocial services. I act as the executive director of the agency and hold a Bachelor's degree in Social Work. The entirety of my Social Work career has centered around the treatment of substance use disorders and improving access to evidence-based treatment.

In my role as Executive Director, I oversee all day-to-day operations of the office and ensure that policy and procedure is abided by. Additionally, my primary goal when I was promoted to this position was to obtain CARF accreditation for the agency. CARF, The Commission on Rehabilitation Facilities, is a national accrediting body that through a

peer-review process determines an agency's compliance, or lack thereof, with standards set forth by the commission. These standards are designed to ensure quality outcomes for clients served and continuous improvement for the agency (CARF, 2022). The process of obtaining CARF accreditation includes an in-depth look into the administrative and program components of the agency and determines conformance to an extensive set of standards outlined by CARF. This is done by providing all agency policies and procedures for review prior to the CARF survey. Then, a two-day survey is conducted in which surveyors visit the agency, meet with employees, clients, and community parties and continue to review agency policy and procedures. After the survey is complete, CARF issues a decision to the agency within 6 weeks. The potential outcomes include the following: 1.) Non accreditation 2.) Provisional Accreditation 3.) 1-year accreditation 4.) 3-year accreditation. These outcomes are based on the strengths and barriers of the agency and their overall conformance to CARF standards (CARF, 2022).

Alteri Behavioral Health achieved a 3-year CARF accreditation in July of 2022. This being the highest level of accreditation possible indicates that the agency demonstrated significant conformance to CARF standards and operates in a manner that is beneficial to clients served (CARF, 2022). The intention of this capstone is to demonstrate the application of CSWE competencies to the process undertaken by the interprofessional team to achieve the desired outcome of CARF accreditation. This process involved the development and implementation of agency policies and procedures. These policies and procedures were formulated based on input from the interprofessional team and application of evidence-based research.

Ethical and Professional Behavior

Assuming the role as executive director of the agency has allowed me to encourage communication from supervisees, be receptive of receiving feedback and utilize feedback in order to adapt to the needs of the individuals whom I supervise. This process was paramount in engaging the entire interprofessional team in working toward the shared goal of CARF accreditation.

Receiving open and honest communication from supervisees began with creating an environment where such communication is encouraged, and it's value demonstrated. This involves building rapport with supervisees and communicating in a way that exemplifies open communication. In meeting with supervisees for performance reviews or to address concerns I ensure to illicit feedback on how I, as a supervisor, could support the employee in achieving performance goals for growth or improvement.

As the agency began the undertaking of obtaining CARF accreditation I was very conscious of the amount of additional work placed on other individuals in the agency apart from their day-to-day job responsibilities. My goal in doing this was to mitigate the amount of stress experienced by supervisees. In place of delegating tasks, I worked to complete as many of these tasks on my own as possible. In an annual performance review of a targeted case manager, I opened discussion surrounding needs of the case manager and her thoughts on ways the agency and/or leadership could improve. At that point, the case manager brought up concerns related to my refusal to delegate tasks. She communicated that this type of leadership made her question my confidence in her abilities. Inadvertently, I was making her feel incompetent.

This feedback was not something I expected and initially, I was somewhat surprised. I did, however, thank her for being so honest prior to communicating what my intention

was in completing tasks independently. The supervisee and I reached an agreement that I would work to delegate tasks whenever possible, and she would maintain open communication regarding her workload and stress level related to additional tasks related to the CARF process.

The aftermath of this conversation led to communication with other staff members regarding tasks required and gauging their desire and/or willingness to undertake additional tasks needed for accreditation. The responses of staff members varied in what they were willing to do, however, it was evident that there was open communication reciprocated by all parties. Ultimately, this professional communication led to higher levels of productivity, better engagement of the entire interprofessional team in the process and increased employee morale. It also led to my own professional development in recognizing the gap that can sometimes exist between intention and the message that is communicated to supervisees.

Engaging Diversity and Differences

Opioid use disorder is widespread across the nation, and it seems that no population is immune to its far-reaching effects. From 2015-2017 all racial and ethnic groups experienced an increase in overdose rates from synthetic opioids (Lippold et al., 2019). Historically, the client population at Alteri has been predominantly white with less than 5% of clients reporting diverse racial or ethnic backgrounds. This has changed over the past 6 months as the percentage of racially diverse patients has increased to nearly 15%. This coincides with trends seen across the nation as research indicates that while overdose death is increasing across all populations, ethnic minorities are seeing increase at higher rates (Lippold et al., 2019).

Policies and procedures in place at Alteri reflect a commitment to serving clients of diverse cultural backgrounds. These policies include the conduction of a thorough assessment at treatment initiation. This assessment elicits information regarding the cultural background of the client so that information may be used to inform the client's treatment process. Examples of this include the desire of patients to have extensive involvement of family members in the treatment process, preference of religious approaches to recovery from substance use disorders and preference of either male of female service providers.

Another important aspect of engaging diversity and difference is employing professionals in the agency with diverse backgrounds so that varying perspectives may be utilized to ensure the best possible client care. When clients express a preference for a specific treatment approach or diverse service providers it is more likely that the agency can meet that need if the staff make up is diverse.

Advancing Human Rights and Social Justice

The process of CARF accreditation involved identification, in-depth reflection and plans to improve systemic issues impacting the client population served by Alteri. This was tied specifically to standards of client advocacy and community involvement. Individuals utilizing medications for the treatment of opioid use disorder face stigma and bias that have the potential to create discrimination in employment, legal systems, as well as within the families and communities of clients. This discrimination can contribute to negative impacts on goal achievement and upward mobility in the client population in addition to discouraging the use of medications for opioid use disorder (Richard et al., 2020).

The interprofessional team was able to recognize multiple cases in which clients had expressed issues with their family and/or support groups associated with their choice to utilize medications for opioid use disorder (MOUD). Clients have reported that families and/or loved ones believe they are trading one drug for another or are not truly abstinent. Additionally, there have been reported instances of clients being discriminated against in the legal system based on their use of MOUD. Research also confirms these experiences such as judges expressing disdain for the client's chosen route of recovery and required patients to discontinue utilization of MOUD. Child protective agencies and probation/parole services may also influence premature discontinuation of MOUD. (SAMHSA, 2019). When discrimination and bias contribute to discontinuation of MOUD prematurely clients are placed at increased risk for relapse and/or overdose (Timko et al., 2016).

Two main initiatives were developed to address the stigma associated with the use of MOUD and therefore advance the human rights and social justice of the client population.

The first of these initiatives was the development and implementation of an education program targeted at patient support systems and other professionals in the community for whom MOUD education would be beneficial. The program is presented by the Executive and Medical directors of the agency. There is information surrounding the science of addiction and how MOUD works. Common misconceptions of MOUD are addressed and participants are given the opportunity to submit questions anonymously to be answered. This program occurs on a monthly basis at the Alteri Behavioral Health office in Lexington. Information for the program is communicated to other community partners via email two weeks prior to the program. The information for the program is

also provided to clients via email, in office flyers and word of mouth from their providers. Special care is taken to ensure patients identifying stigmatizing behavior within their support systems are informed of the program so that they may invite loved ones as they see fit. Throughout the course of their treatment all clients are encouraged to include family and support systems in the treatment process. This program is one means of achieving that.

The second of the developed initiatives involves priority of case management services being given to clients reporting any current legal concerns or child protection involvement. While all clients are assessed for potential case management needs there are times when a waiting list must be utilized due to constraints on the caseloads of case managers. In the event that a client is experiencing legal or child protection involvement they are immediately moved to the top of the wait list. Case managers are well-versed in patient advocacy and are able to attend court appearances, case planning meetings, etc. if so desired by the client. Additionally, case managers work with clients to teach skills of self-advocacy.

Research Informed Practice and Practice Informed Research

CARF requires that agencies have documented policies regarding admission criteria, program requirements and discharge criteria and procedure (CARF International, 2021). Prior to beginning the accreditation process Alteri Behavioral Health had agency standards on these issues, however these policies were not effectively documented nor consistently shared with patients. As executive director I was tasked with ensuring that all agency policies are supported by current evidence-

based research. Policies regarding discharge and therapy requirements were two areas in which I was able to review relevant research and apply it to day-to-day agency practice.

The treatment of opioid use disorder with buprenorphine is grounded in research as there have been many studies conducted that support it's efficacy. Studies show that there is improvement in treatment retention and reduction in opioid related death for individuals taking buprenorphine for opioid use disorders (SAMHSA, 2016). Research supports that MOUD creates a reduction in risk to clients even in instances when they are not entirely abstinent from illicit opioids and other substances. This occurs through lessening misuse, injection related risks and overdose (Kresina & Lubran, 2011).

These key research findings have influenced the policies of Alteri Behavioral Health as the agency seeks to provide services that are evidence-based and proven to provide for client progress and safety. The agency seeks to ensure that approaches to treatment are in no way punitive. The decision-making process regarding patient admission and discharge is based on the above-mentioned research findings. There is no specific or arbitrary policy dictating the consequences of positive client urine drug screens. Instead, agency policy states that if a client continues to test positive for opiates or other illicit substances, an intervention process will be utilized. This process begins with a meeting with the client, their medical provider and therapist. This meeting is meant to assess current circumstances and psychosocial issues that are impacting the client's recovery. A plan is made to address those concerns. This may involve referrals to additional services including but not limited to case management, psychiatry and peer support. The client's current treatment plan may be modified to include more frequent medical visits, additional therapy or a higher level of care within the agency

(intensive outpatient group). A time period is then designated by the group to meet again in order to reassess. The client's progress is closely monitored during this period. If at the end of the period the client has not progressed (this does not necessarily mean complete cessation of use but can be evaluated in other ways such as reduction in UDS levels, program attendance, etc) the team may decide to refer the client to a higher level of care. When this occurs, an Alteri staff member works one on one with the client to find an appropriate treatment provider, make the referral and assist with the transition of services. The medical provider at Alteri will continue the client's medication in order to avoid withdrawal until they establish care with the other agency. If the client refuses referral, the medical provider will provide a two-week prescription of medication at discharge. This gives the patient time to establish treatment on their own. Medications to lessen withdrawal (Lucemyra) may also be provided. Narcan is kept within the office and provided to every discharged patient to be used in the event of an opioid overdose. SAMHSA recognizes that therapy and other interventions may be a beneficial tool to be utilized in conjunction with MOUD when it is targeted towards specific concerns. For example, cognitive behavioral therapy has shown effectiveness in use reduction for individuals receiving MOUD who present prescription drug use or poly-substance disorders. There have been no studies establishing improved outcomes of CBT for individuals receiving MOUD for whom heroin is the primary drug of use. (Moore et al.,2016). Motivational interviewing shows efficacy in the initiation and beginning stages of treatment as it works to overcome reluctance. There however has been no link between MI and long-term treatment outcomes. (Ling, 2013). Case management is another intervention with shown success in assisting clients in establishing stability and ensuring they are able to meet their basic needs. It would not, however, be indicated in

patients for whom stability and basic needs are not an issue (Roberts, 2011). There have been no studies showing differences in long-term outcomes for patients on MOUD tied to any specific behavioral interventions (Ling, 2013).

These studies support the notion should not be arbitrarily required for patients to receive medications for opioid use disorder (SAMHSA, 2019). To apply therapy requirements across the board in an arbitrary manner has the potential to prevent clients from accessing and maintaining MOUD treatment. Clients may experience barriers and hesitancies to engaging in a specific type of therapy. These barriers may include transportation issues, lack of childcare, trauma, additional mental health concerns, etc. Therapy and other psychosocial interventions should be used in an individualized manner that targets the unique needs of the clients and seeks to minimize identified barriers. While contracts with insurance providers often (and as is the case with Alteri) require that patients receiving MOUD engage in some form of supportive treatment, there is no specific requirement of what that must be.

Alteri's policy regarding therapy and psychosocial interventions is rooted in these research findings. Patients are required to participate in some form of recovery support on a monthly basis. The interventions, however, are dictated entirely by thorough assessment of the client. Factors such as stage of recovery, co-occuring conditions, logistical barriers, and client preferences are considered in determining what services the client will participate in. There is no "one size fits all" treatment program. Options for psychosocial intervention include various therapy modalities (ART, CBT, EMDR, CPT), targeted case management, peer support services, group therapy, intensive outpatient treatment, and peer led community-based meetings.

Policy Practice

CARF has very specific policy requirements that must be met by all agencies seeking accreditation. These policies are outlined in a 420-page manual provided to agencies prior to application. My role in this process was to review all current policies and compare those to CARF standards. At initiation of this process, many policies were already in place and in compliance with CARF standards. There were however many areas in which Alteri did not have a designated policy to address the standard or the current policy was not sufficient. I noted that policies regarding medications were vague in description and required further development and articulation. The development and implementation of these policies had to occur through working closely with the agencies interprofessional team.

One specific policy requiring development was that of how to proceed when there is suspected diversion of medication. Meaning, the client is suspected of not taking their medication as directed, selling it, or misusing it. This is typically indicated when a patient's UDS does not have appropriate levels of buprenorphine. This policy was brought up for discussion during an interprofessional team meeting in order to discuss its revision. This team was composed of myself, the medical director, clinical director, therapists, case managers and peer support specialist.

We began the discussion by discussing the issue needing to be addressed and how we have dealt with the issue historically. Overall, there have been few instances of this occuring. One nurse practitioner stated when patients do not have buprenorphine in their system at the time of their UDS she counsels the client on the issue and then provides one week of medication. She informs the patient that any further indication of

diversion will result in immediate discharge. A follow up UDS occurs in one week. The medical director expressed concerns that if patients are not taking medication appropriately such as, swallowing it instead of allowing it to dissolve) their UDS could be negative for medication. It would then be, inappropriate to discharge the patient. A therapist stated that in her experience working with MOUD clients, having the individual take their medication in front of a medical staff member had been effective in ensuring correct administration. Additionally, medical staff brought up the concern that some individuals may process medications differently based on a few biological factors. This could also account for fluctuating levels of buprenorphine in a urine drug screen.

Considering all these factors led the interprofessional team to develop the following policy, in the event that urine drug screens reveal levels of buprenorphine inconsistent with appropriate medication administration the following process will occur. 1.) Patients will receive counseling from their medical provider to ensure they are aware of how to take their medication. 2.) Patients will then complete 3 consecutive days of in person medication administration. This will involve the patient coming into the office and taking their medication under supervision of a medical professional. 3.) On the 3rd day a urine drug screen will be conducted to evaluate what level of buprenorphine is appropriate for the patient. 4.) Failure to complete in person dosing will result in discontinuation of medication services and referral to another service provider (Alteri Behavioral Health, 2022).

Following policy implementation, there were consequences for the patient population that were not previously considered. Adjustments had to be made in consideration of these impacts. The main concern was that logistical barriers experienced by clients may prevent them from being able to come into the office for 3

consecutive days. This concern was brought forth to the interprofessional team for consultation. The case manager on the team stated that for patients with Medicaid, there is the option for a bus to bring them to the office free of charge. That transportation must, however, be arranged 48 hours in advance. This was then added to the policy in the form of “patients receiving Medicaid will be offered help in arranging medical transportation in order to meet requirements. The policy was also adjusted to include that the 3-day period of daily dosing would occur 48 hours after medical staff notifies patient of the concern so as to allow time to set up transportation. It was then brought up that patients without Medicaid would not be able to access transportation. The owner of the company then stated that the agency has been provided transportation vouchers via a grant that can assist patients with gas or other transportation expenses.

This process of reviewing an issue, exploring all factors, developing a policy and then adjusting for unintended consequences occurred multiple times as the agency prepared for accreditation. Heavy reliance was placed on the knowledge and background of each member of the interprofessional team to order to minimize and mitigate negative consequences and provide quality client care.

Engagement, Assessment, Intervention and Evaluation Client Systems

CARF has various sections of program requirements which coincide with the generalist intervention model of Social Work as it pertains to micro practice (Kirst-Ashman and Hull, 2022).

Client orientation is outlined as a requirement of CARF (CARF, 2021). The definition of orientation of CARF was somewhat vague however, effective client

engagement skills allowed me to expand on the CARF requirement and implement agency wide polices ensuring consistent and comprehensive client engagement. The first of the policies and practices I developed in the area of client engagement was that of a client orientation. At the initial treatment appointment clients meet with their service providers and a detailed orientation process is conducted. This involves providing the client with a handbook and reviewing all agency policies and procedures with the client. They are informed of their rights and responsibilities and the grievance process to be undertaken in the event they are unhappy with services. During this time, clients will complete required consents and intake paperwork with the staff member to ensure understanding of all documents. Clients are also provided with a tour of the agency and introduced to various staff members with whom they will be interacting throughout the course of their treatment. This allows initiation of rapport building. The client is given an opportunity to discuss their preferences for treatment and ask any questions that they may have.

Following the orientation process the client will meet with a qualified mental health professional where engagement continues, and the assessment process begins. This assessment is then used to develop a person-centered plan of treatment for each client. Prior to the accreditation process assessment were occuring in a very inconsistent manner and did not always gather all client information needed to effectively inform treatment. My responsibility in this area was to develop a standard assessment form to be used with every intake. This was done in collaboration with all therapy providers within the agency.

The assessment tool developed gathers the following information in order to inform the treatment plan of the individual.

1.) Presenting Problem-

2.) Client Strengths

3.) Client needs and/or barriers

4.) Treatment Preferences

5.) Mental Health Treatment History (include previous diagnosis)

6.) Mental Status

7.) Current Medications

8.) Physical Health Diagnosis

9.) Individuals age, gender, sexual orientation, gender identity, spiritual and cultural beliefs

10.) Educational History

11.) Employment History

12.) Current Living Situation

13.) Legal Involvement (current or previous)

14.) Family History of Mental Health or substance use disorders

15.) Avenues of Social Support

16.) Trauma Either Witnessed/Experienced (I.e. abuse, neglect, violence etc.)

17.) Current and Historical Drug Use

18.) Risk Factors for Suicide, Violence and other harmful or self-harming behaviors

19.) Any identified diagnosis if applicable

Apart from the general psychosocial assessment, the assessment process for all patients seeking MOUD treatment entails administration and scoring of the Drug Abuse

Screening Test in order to identify potential substance use disorders. If indicated during assessment the clinician may also administer additional psychometrics. After completion of the assessment, in-depth conversation takes place with the client in order to develop a person-centered treatment plan. These plans consist of 3-4 SMART goals articulated in the client's words that will be addressed during the treatment process and targeted through intervention stage. Objectives for each goal lay out clear steps to be taken in order to reach the desired goal.

As discussed in the research section of this capstone, there is no specific intervention that patients undergo. Interventions are very person centered and individualized. Examples of this include some patients being referred for case management services in order to assist with the meeting of their basic needs. MOUD is only utilized for patients presenting with opioid use disorder that is either moderate or severe. Additional interventions offered by the agency include EMDR, ART and CPT therapies for trauma, group therapy, peer support services, etc.

Evaluation occurs in many different areas through the agency. For individual clients evaluation is based on treatment plan progress. This involves reviewing treatment plan goals in each session and documentation of progress. Every 90 days, a formal review of treatment goals is conducted, and treatment goals are changed as needed. Changes may need to occur if clients are struggling to achieve identified goals but are progressing. This may indicate that the goal is too broad or is unrealistic for the current time. Examples of this include failure to reach a goal of total abstinence but the client demonstrates a reduction in instances of use in each week or cessation of IV drug use. A smaller, more achievable goal may be more appropriate.

The process of preparing for, leading and ultimately obtaining CARF accreditation for Alteri Behavioral Health has been on that was greatly influenced by CSWE competencies and my Social Work education on both the Bachelor and Master's level. Additionally, this process has better prepared me for future Social Work practice.

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