BlueDistinction®
Specialty Care

BlueCross BlueShield Association

Blue Distinction® Centers for Substance Use Treatment and Recovery Provider Survey

Printed version of this document is for reference purposes only.
Paper copies of the Provider Survey will not be accepted.
A completed Provider Survey must be submitted via the online web application Blue Distinction® Portal[s] (BD Portal[SM]).

Review the instructions below to complete the Provider Survey via the online web application, Blue Distinction® Portal[SM].

Provider Survey	Question Numbers
Facility Information	1-17
Substance Use Treatment and Recovery Program Information • Program Structure • Treatment and Recovery Management • Transition and Discharge Planning • Performance Improvement • Providers who bill separately from Facility Charges • Medication Assisted Treatment (MAT) Practitioners	 18 – 37 38 – 51 52 – 58 59 – 67 68 69
Terms & Conditions	Not Applicable

All question responses must be entered before you can advance to the next page.

To save your responses, click **Save.**
If you need to edit the survey at a later time, click on **Save and Exit**. This will save your responses and exit the survey. You must also “Check In” the survey on the Survey Actions tab, so other contacts at your facility can access the survey.
Once the survey is complete and ready to be submitted, click on **Submit**. Close the survey window to bring you back to the Survey Actions screen in BD Portal.

Program Materials
PDF version of Provider Survey for Substance Use Treatment and Recovery 2020

Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.
BDCSUTR06_REVISED_021919

A PDF copy of the Provider Survey is available so you can gather the necessary information ahead of time, prior to completing the online application through BD Portal.

Note: Facilities **must** submit an electronic version of the Provider Survey in BD Portal; paper responses will not be accepted.

Additional program information regarding the Blue Distinction Centers for the Substance Use Treatment and Recovery program are available at: bcbs.com

PROVIDER SURVEY

Please complete all Provider Survey information pertaining to your facility's current and active substance use treatment and recovery services for **adults** (18 years and older). Please be sure that your Survey responses are complete before submitting.

Please pay attention to all special instructions for formats when entering numerical responses. Here are a few examples:

Percentages: The response of five percent should be entered as a whole number:

5	% NOTE you should **NOT** enter this as 0.05

FACILITY INFORMATION

FACILITY ADDRESS AND IDENTIFIERS WILL BE PRE-POPULATED IN THE ONLINE VERSION OF THIS SURVEY.

FACILITY NAME:
ADDRESS:
CITY:
STATE:
ZIP:

If any of the information shown above is incorrect, please contact your local Blue Cross and/or Blue Shield Plan representative directly to have the information corrected.

Questions in this section that refer to "my," "your," "my facility's" or "your facility's program" all refer to your facility's own substance use treatment and recovery program (not the Blue Distinction Centers for Substance Use Treatment and Recovery program).

1. Please provide the following information for the person responsible for completing and submitting this Provider Survey:

Primary Contact
Name:
Title:
Phone:
Email:

2. Please provide your facility's legal contact. This individual may be contacted in the event there are questions related to potential brand conflicts that need to be addressed.

   Facility Legal Counsel/Representative Contact:
   Name:
   Title:
   Phone:
   Email:

3. The Blue Distinction Centers for Substance Use Treatment and Recovery designation is given only to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses). Any facility with multiple locations (different addresses) must complete a separate *Provider Survey* for each location. Health systems and other groups of multiple facilities will not be designated collectively.

   Is the information submitted in this Provider Survey (e.g., accreditations, program information, services offered) **only for the single facility whose name and address are listed in the Provider Information Section above**, and for no other facilities or locations?

   ☐YES ☐ NO

   If NO, please explain.

4. Evaluation of Blue Plans' healthcare claims data requires distinct provider identifiers to be present on submitted claims in order to match them back to your facility's application.

   Are claims submitted by your facility to your Blue Plan clearly distinguished from other facilities by using a **distinct** facility name, **distinct** Tax ID, **distinct** NPI, and **distinct** Plan Provider ID?

   If you do not have insight on this question, simply answer DO NOT KNOW. *This is for informational purposes only.*

   ❍ YES
   ❍ NO
   ❍ DO NOT KNOW

   If NO or DO NOT KNOW, please provide guidance on the best method for distinguishing your facility's claims.

5. Is this facility part of an integrated delivery system that includes other facilities? **(If 'YES' continue to Questions 6; If 'NO' Skip to Question 7)**

   ❍ YES
   ❍ NO

6. If this facility is part of an integrated delivery system, please provide the name of the facilities within your integrated system and indicate which type of substance use treatment

services are available at that specific location. If you are not part of an integrated delivery system, please select "No" in question 5 to skip this question.

Reminder: The Blue Distinction Centers for Substance Use Treatment and Recovery designation is given only to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses). Any facility with multiple locations (different addresses) must complete a separate *Provider Survey* for each location. Health systems and other groups of multiple facilities will not be designated collectively.

The information submitted by your facility will help to identify other potential applicants for the Blue Distinction Centers for Substance Use Treatment and Recovery program and inform the expansion to include regular outpatient providers in a future program offering.

Facility Names in Integrated System	**National Provider Identifier (NPI)**	**Detox - Hospital Inpatient, Residential and/or Outpatient** (similar to ASAM Levels IV-D, III.7-D, III.2D, or I-D and II-D)	**Inpatient and/ or Residential** (similar to ASAM Levels IV and III.7, III.5, III.3 and III.1)	**Intensive outpatient or Partial hospitalization** (similar to ASAM Level II.5 or Level II.1)	**Regular Outpatient** (similar to ASAM Level 1)
Alphanumeric – Free Text	Alphanumeric – Free Text	☐	☐	☐	☐
Next Row should appear after first row is complete		☐	☐	☐	☐

***Note**: ASAM is the American Society of Addiction Medicine. For more information on ASAM please go to www.asam.org.*

7. What is your facility's National Provider Identifier (NPI), Federal Tax Identification Number (FEIN) and CMS Certification Number (CMS ID)? If unknown, leave the response blank.

[Response Not Required]

National Provider Identifier (NPI)	
Federal Tax Identification Number (FEIN)	
CMS Certification Number (CMS ID)	

8. Does your facility share a National Provider Identifier (NPI) with another facility (or facilities)? **(If 'YES' continue to Question 9; If 'NO or Do not know' Skip to Question 10)**

❍ YES
❍ NO
❍ DO NOT KNOW

9. If your facility shares a NPI with another facility (or facilities), please provide each facility's name(s) and address(es).

Facility Name	Main Address	City	State	Zip Code

10. Does your facility share a Federal Tax Identification Number (FEIN) with another facility (or facilities)? (**If 'YES' continue to Question 11; If 'NO or Do not know' Skip to Question 12)**

❍ YES
❍ NO
❍ DO NOT KNOW

11. If your facility shares a FEIN with another facility (or facilities), please provide each facility's name(s) and address(es).

Facility Name	Main Address	City	State	Zip Code

12. Does your facility share a CMS Certification Number with another facility (or facilities)? (**If 'YES' continue to Question 13; If 'NO or Do not know' Skip to Question 14)**

❍ YES
❍ NO
❍ DO NOT KNOW

13. If your facility shares a CMS Certification Number with another facility (or facilities), please provide each facility's name(s) and address(es).

Facility Name	Main Address	City	State	Zip Code

14. Which of the following substance use treatment services are offered at this facility? ***Mark all that apply.***

☐ Hospital inpatient detoxification (similar to ASAM Levels IV-D and III.7-D, medically managed or monitored inpatient detoxification)
☐ Hospital inpatient treatment (similar to ASAM Levels IV and III.7, medically managed or monitored intensive inpatient treatment)
☐ Residential detoxification (similar to ASAM Level III.2D, clinically managed residential detoxification or social detoxification)
☐ Residential short-term treatment(similar to ASAM Level III.5, clinically managed high-intensity residential treatment, typically 30 days or less)
☐ Residential long-term treatment (similar to ASAM Levels III.3 and III.1, clinically managed medium- or low-intensity residential treatment, typically more than 30 days)

☐ Outpatient detoxification (similar to ASAM Levels I-D and II-D, ambulatory detoxification)
☐ Outpatient methadone/buprenorphine maintenance or naltrexone treatment
☐ Outpatient day treatment or partial hospitalization (similar to ASAM Level II.5, 20 or more hours per week)
☐ Intensive outpatient treatment (similar to ASAM Level II.1, 9 or more hours per week)
☐ Regular outpatient treatment (similar to ASAM Level 1, outpatient treatment, non-intensive)
☐ None of the above

Note: ASAM is the American Society of Addiction Medicine. For more information on ASAM please go to www.asam.org.

15. Please indicate which of the following statements describes your facility's current accreditation status at the time of completing this Survey: **Mark all that apply.**

☐ My facility is fully accredited by **The Joint Commission (TJC)** in the **Hospital Accredited Program**. www.jointcommission.org

☐ My facility is fully accredited by **The Joint Commission (TJC)** in the **Behavioral Health Care Program**. www.jointcommission.org

☐ My facility is fully accredited by the **Commission on Accreditation of Rehabilitation Facilities (CARF)** in the **Behavioral Health Program**. www.carf.org

☐ My facility is fully accredited by **Healthcare Facilities Accreditation Program (HFAP)** of the **Accreditation Association for Hospital and Health Systems (AAHHS)** and is an **acute care hospital**. www.hfap.org

☐ My facility is fully accredited by **DNV GL Healthcare** in the **National Integrated Accreditation for Healthcare Organizations (NIAHO®) Hospital Accreditation Program.** www.dnvglhealthcare.com

☐ My facility is fully accredited by the **National Committee for Quality Assurance (NCQA)** in the **Case Management Accreditation Program.** www.ncqa.org

☐ My facility is fully accredited by the **Council on Accreditation (COA)** in the **Private Organization** or the **Public Agency Program**. http://coanet.org

☐ My facility is fully accredited by the **Center for Improvement in Healthcare Quality (CIHQ)** in the **Hospital Accreditation Program**. www.cihq.org

☐ My facility is in the process of becoming fully accredited by any of the above organizations.

☐ My facility is **not fully accredited** and **is not in the process of becoming fully accredited** by any of the above organizations.

☐ My facility is fully accredited from an organization not listed above. Please specify:

16. Please indicate which of the following statements describes your facility's current certification status at the time of completing this Survey. ***Mark all that apply.***

☐ My facility is a federally-certified Opioid Treatment Program (OTP). www.samhsa.gov

☐ My facility is certified by The Joint Commission (TJC) as a Behavioral Health Home (BHH). www.jointcommission.org

☐ My facility is participating in American Society of Addiction Medicine's (ASAM) Level of Care Certification. www.asam.org/resources/level-of-care-certification

☐ My facility is **not certified** by any of the above entities at this time.

☐ My facility is certified from an organization not listed above. Please specify:

17. Please indicate which of the following statements describes your facility's current licensure status at the time of completing this Survey. ***Mark all that apply.***

☐ My facility is fully licensed by the **State Department of Health**.
☐ My facility is fully licensed by the **State Mental Health Department**.
☐ My facility is fully licensed by the **State Substance Abuse Agency**.
☐ My facility is **not fully licensed** by any of the above organizations.
☐ My facility is fully licensed by an organization not listed above. Please specify:

SUBSTANCE USE TREATMENT AND RECOVERY PROGRAM INFORMATION

Questions in this section that refer to "my," "your," "my facility's" or "your facility's program" all refer to your facility's own substance use treatment and recovery program (not the Blue Distinction Centers for Substance Use Treatment and Recovery program).

PROGRAM STRUCTURE

18. Indicate which age groups are accepted for treatment at your facility. ***Mark all that apply.***

☐ Adults (18-64 years)
☐ Seniors (65+ years)
☐ Adolescents (13-17 years)
☐ Children (<12 years)

19. How many patients were admitted to this facility's substance use treatment program in 2018?

	Number of patients admitted to this facility's substance use treatment program in 2018	Unknown/Prefer not to answer
# of Patients	_____ (whole number only, zero is a valid response)	❍

20. What percentage of patients admitted to this facility's substance use treatment program in 2018 may be considered as 'out-of-area'? (i.e. program is not within their home community, county, state, etc.)?

	Percentage of Patients Admitted to Program in 2018 may be considered as 'out-of-area'	Unknown/Prefer not to answer
% of 'Out-of-area' Patients	_____% (whole number only, zero is a valid value)	❍

21. Which of the following substance use, abuse, or dependence disorder(s) are treated at your facility? ***Mark all that apply***.
If 'Other' is selected, please list **all** appropriate substance use, abuse, and dependence disorder(s) and, if available, the appropriate ICD-10 Code.

- ☐ Alcohol
- ☐ Cannabis
- ☐ Cocaine
- ☐ Hallucinogen
- ☐ Inhalant
- ☐ Opioids
- ☐ Sedative, hypnotic or anxiolytic (e.g., Benzodiazepines)
- ☐ Stimulant (e.g., Methamphetamines)
- ☐ Other (Specify:)

22. Does your program facilitate multidisciplinary care (either at your facility, within an integrated delivery system, or through coordination within a virtually organized 'medical neighborhood' delivery system), to ensure that the patient has timely access to care? ***Select applicable responses***.

Virtually organized 'medical neighborhood' delivery system includes facilities or providers with which your program coordinates multidisciplinary care without a formal relationship (i.e. integration, contract).

(If 'YES' continue to Questions 23 then 24; If 'NO' Skip to Question 25)

☐ YES; Clients with multiple diagnoses (e.g., mental health and substance use disorder) are managed at this facility by <u>onsite</u> providers

☐ YES; Clients are provided access to multidisciplinary care through an integrated delivery system or within a virtually organized 'medical neighborhood' delivery system

☐ NO; provision of or access to multidisciplinary care is not facilitated by this program at this time or prefer not to answer.

23. If your program facilitates multidisciplinary care, are the following disciplines available onsite or coordinated through either an integrated delivery system or virtually organized delivery system? **Mark the appropriate selection in each row.**

Discipline	Available Onsite	Coordinated through either integrated delivery system or virtually organized delivery system	Not Available or Unknown
Addiction Medicine	☐	☐	☐
Primary Care	☐	☐	☐
Counseling Services (e.g. patient and family counseling)	☐	☐	☐
Psychotherapy	☐	☐	☐
Case Management Services (e.g. housing assistance)	☐	☐	☐
Rehabilitation	☐	☐	☐
Referral Services to other Specialists/Centers with Expertise in Treating SUDs	☐	☐	☐
Assistance with obtaining social services (for example: Medicaid, WIC, SSI, SSDI)	☐	☐	☐
Domestic violence—family or partner violence services (physical, sexual or emotional abuse)	☐	☐	☐
Self-help groups (for example: AA, NA, SMART Recovery)	☐	☐	☐
Multiple diagnosis coping and counseling (for example: health education for HIV, AIDS, Hepatitis, etc.)	☐	☐	☐
Telehealth/telepsychiatry	☐	☐	☐

24. If your program facilitates multidisciplinary care, does coordination of multidisciplinary care occur <u>throughout the continuum of care</u> (i.e., promotion, prevention, referral, treatment, and recovery)?

❍ YES
❍ NO
❍ Prefer not to answer

25. For each type of evidence-based therapies listed below, please mark the box that best describes how often that approach is used at this facility for patients diagnosed with Substance Use Disorder (SUD).

If ‘Other’ is selected, please list the title of the Clinical/Therapeutic Approach and, if available, a link to a description/reference.

Clinical/Therapeutic Approach	Never	Rarely	Sometimes	Always or Often	Not Used or Unknown
Cognitive-behavioral therapy (CBT)	☐	☐	☐	☐	☐
Contingency management	☐	☐	☐	☐	☐
Community reinforcement approach (CRA)	☐	☐	☐	☐	☐
Motivational Enhancement Therapy (MET)	☐	☐	☐	☐	☐
The Matrix Model	☐	☐	☐	☐	☐
Twelve-Step Facilitation Therapy (TSF)	☐	☐	☐	☐	☐
MultiSystemic Therapy (MST)	☐	☐	☐	☐	☐
Multi-Dimensional Family Therapy (MDFT)	☐	☐	☐	☐	☐
Brief Strategic Family Therapy (BSFT)	☐	☐	☐	☐	☐
Functional Family Therapy (FFT)	☐	☐	☐	☐	☐
Behavioral Couples Therapy (BCT)	☐	☐	☐	☐	☐
Other treatment approach (Specify:__________________________)	☐	☐	☐	☐	☐

26. Does your facility employ any certified addiction counselors?
(If 'YES' continue to Question 27 then 28; If 'NO' Skip to Question 29)

Certification(s) such as:

- Certified Addictions Counselor (CAC)
- Certified Addictions Professional (CAP)
- Certified Addiction and Drug Abuse Consultant (CADAC)
- National Certified Addictions Counselor Level I (NCAC1)
- National Certified Addictions Counselor Level II (NCACII)
- Masters Addiction Counselor with Co-Occurring Disorders Component (MAC)

❍ YES
❍ NO
❍ Prefer not to answer

27. If your facility employs certified addiction counselors, what percentage of addiction counselors employed at this facility have a baccalaureate degree or higher from an accredited institution?

	Percentage of addiction counselors employed at this facility have a baccalaureate degree or higher	Unknown/Prefer not to answer
% addiction counselors with a baccalaureate degree or higher	_____ % (whole number only, zero is a valid response)	❍

28. What is the ratio of admitted patients to one (1) certified addiction counselor with a baccalaureate degree or higher at your facility?

	Enter of number of patients. Decimals are allowed.	Unknown/Prefer not to answer
# of admitted patients	_____ #	❍

29. Does your facility employ any trained peer counselors or recovery/peer coaches? **(If 'YES' continue to Question 30; If 'NO' Skip to Question 31)**

❍ YES
❍ NO
❍ Prefer not to answer

30. Please describe the training and/or certifications required for peer counselors or peer sober coaches at your facility.

(Text)

31. Does your facility have at least one (1) certified addiction medicine physician on staff?

Certification in addiction medicine through an organization acceptable to ASAM, such as American Board of Preventative Medicine (ABPM), American Board of Psychiatry and Neurology (ABPN), or American Board of Addiction Medicine (ABAM).
(If 'YES' continue to Question 32; If 'NO' Skip to Question 33)

❍ YES
❍ NO
❍ Prefer not to answer

32. How many certified addiction medicine physicians are currently on staff at your facility?

	Number of certified addiction medicine physicians on staff	Unknown/Prefer not to answer
# certified addiction medicine physicians on staff	_____ # (whole number only, zero is a valid response)	❍

33. Does your facility verify benefits and eligibility with the health plan, for substance use treatment and recovery services, prior to patient's admission to your treatment program?

❍ YES
❍ NO
❍ Prefer not to answer

34. Does your facility notify or make available, to the patient (or patient's support system, if appropriate), the patient's portion of the treatment costs, **prior** to admission to your treatment program? **(If 'YES' continue to Question 35; If 'NO' Skip to Question 36)**

❍ YES
❍ NO
❍ Prefer not to answer

35. How is information about the patient's portion of treatment costs communicated to the patient (or patient's support system, if appropriate), **prior** to admission to your treatment program? ***Mark all that apply***.
   - ☐ Website
   - ☐ Financial counselor
   - ☐ Coordination with Health Plan
   - ☐ Other (Specify:)

36. Please indicate how your treatment program delivers efficient, appropriate, and effective flow of necessary patient care information to providers and patients (e.g., use of Electronic Health Record [EHR]) or patient portal)? ***Mark all that apply***.
   - ☐ Use of Electronic Health Record
   - ☐ Use of a patient portal
   - ☐ Use of Health Information Exchange (HIE)
   - ☐ Other (Specify:)

37. If your treatment program utilizes a patient portal, what percentage of patients are currently enrolled in the patient portal?

	Percentage of patients currently enrolled in the patient portal	Unknown/Not Applicable
% patients currently enrolled in the patient portal	_____ % (whole number only, zero is a valid response)	❍

TREATMENT AND RECOVERY MANAGEMENT

38. Does your facility use an industry standard assessment and/or screening tool informed by The ASAM Criteria on **all** patients, **prior** to admission, to determine the appropriate level of treatment and guide patient placement?

   ❍ YES
   ❍ NO

39. Please indicate what assessment and/or screening tool(s) are used at your facility. ***Mark all that apply***.

   If 'Other' is selected, please list the title of the industry standard assessment and/or screening tool and provide a link to a description/reference.

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   - ☐ Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services
   - ☐ Addiction Severity Index (ASI)

☐ Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
☐ NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)
☐ Alcohol Use Disorders Identification Test-C (AUDIT-C)
☐ Alcohol Use Disorders Identification Test (AUDIT)
☐ Opioid Risk Tool (ORT)
☐ CAGE
☐ CAGE-AID
☐ CRAFFT
☐ The ASAM CONTINUUM™ Assessment
☐ The ASAM Co-Triage™ Screening Tool
☐ Drug Abuse Screening Test (DAST-10)
☐ Assessment/screening tool developed and validated by your facility
☐ Other (Specify: ______________________)
☐ This facility does not use an assessment and/or screening tool

40. Does your program routinely and systematically utilize a patient and family-centered Shared Decision Making Process (defined below) for patients undergoing substance use, treatment, and recovery, which includes **both** (1) an appropriate, high quality, and objective decision aid **and** (2) decision coaching? **(If 'YES' continue to Question 41 then Question 42; If 'NO' Skip to Question 43)**

Shared Decision Making

- Shared Decision Making is an approach where clinicians and patients consistently discuss all reasonable treatment options, the benefits and harms of those options, and which benefits and harms matter most to the patient, in order to jointly make treatment decisions that are consistent with both the best medical evidence and the patient's preferences.
- Patient-Centered Shared Decision Making aids (e.g., booklet, video) are tools that help people become involved in decision making, by providing information about the options and outcomes and by clarifying personal values. They are designed to *complement*, rather than replace, counseling from a health care professional.
- One key to success lies in training physicians to help them understand how to facilitate the Shared Decision Making process and to ensure that they appreciate the importance of respecting patient's values, preferences, and expressed needs. [1, 2] It is also helpful to use a team approach to Shared Decision Making so that the physician's time is used appropriately.

[1] AHRQ website accessed July 24, 2018 https://cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Communication/Shared-Decision-Making/index.html

[2] Towle A, Godolphin W. Framework for teaching and learning informed Shared Decision Making. BMJ 1999; 319(7212): 766-71.

❍ YES
❍ NO
❍ Prefer not to answer

41. If your program utilizes a patient and family-centered Shared Decision Making process, please describe how your program implements Shared Decision Making. Select **Not Applicable** if you program does not utilize a patient and family-centered Shared Decision Making process.

TEXT BOX

❍ Not Applicable

42. Have your program staff who are responsible for Shared Decision Making received training in the implementation and facilitation of Shared Decision Making?

❍ YES
❍ NO
❍ Prefer not to answer

43. If your program DOES NOT utilize a patient and family-centered Shared Decision Making process, please describe how your program involves patients, families, or support systems in treatment options and decisions.

TEXT BOX

44. Does your program systematically collect information in order to measure and improve your decision process or outcome quality, which includes soliciting patients on their decision making experience?

❍ YES
❍ NO
❍ Prefer not to answer

45. Does your program deliver individualized care planning (i.e., a flexible and customizable treatment plan that meets the unique needs of individual patients, based upon the severity of their condition and is modified regularly to determine when to transition patients to another level of care) throughout all stages of treatment?

❍ YES
❍ NO
❍ Prefer not to answer

46. Does your program perform patient and family-centered long-term planning and goal setting in order to address the continuum of care beyond treatment at your facility? **(If 'YES' continue to Question 47; If 'NO' Skip to Question 48)**

Patient and family-centered long-term planning and goal setting

- Healthcare providers and organizations are increasingly focused on a transition from provider-centered instruction to person-centered participation. This is driven by both the recognition of the value of person-centered care in helping individuals to achieve their desired outcomes[1], and in some cases by state and federal requirements.[2] Person-centered care begins with the individual's goals and respects and addresses their preferences and needs.[1]
- Techniques often used by health care providers delivering patient and family-centered long-term planning and goal setting include:
    - Identify what is important to the patient through goal-setting discussions
    - Negotiate set goals *(e.g. break long-term goals into steps, prioritize goals, identify complementary and supportive goals, document goals using SMART method, etc.)*

- Support goal attainment including recognizing and addressing barriers to success *(e.g. housing/place of residence placement; discuss employment or other vocational pursuits, barriers, considerations, and preferences and facilitate access to applicable resources, etc.)*
- Monitor goal attainment *(e.g. review goals, including progress and barriers, at regular intervals; document conversations in the electronic health record for multidisciplinary care team engagement, etc.)*

1. The National Committee for Quality Assurance (NCQA): https://www.ncqa.org/wp-content/uploads/2018/07/20180531_Report_Goals_to_Care_Spotlight_.pdf
2. Department of Health and Human Resources: https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf

❍ YES
❍ NO
❍ Prefer not to answer

47. Please describe how your program performs patient and family-centered long-term planning and goal setting in order to address the continuum of care beyond treatment at your facility.

TEXT BOX

48. Does your facility have a policy for drug testing that is based on best practices and standards of care for drug testing (Example: ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine)?

❍ YES
❍ NO
❍ Prefer not to answer

49. Does your facility treat opioid use disorder using medication-assisted treatment (MAT) at this location?

Medication-assisted treatment (MAT) is the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose. More information is available at Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.samhsa.gov

❍ YES
❍ NO

50. If your facility offers medication-assisted treatment (MAT) for opioid use disorder at this location, please indicate the best description of your approach to MAT. ***Mark all that apply.***

☐ This facility does not treat opioid use disorder using MAT.
☐ This facility accept clients using MAT, but the medications originate from or are prescribed by another entity? (The medications may or may not be stored/delivered/monitored onsite.)
☐ This facility provides detoxification from opioids of abuse with methadone or buprenorphine.
☐ This facility administers and/or prescribes naltrexone to treat opioid use disorder.

☐ This facility administers and/or prescribes buprenorphine to treat opioid use disorder.
☐ This facility administers and/or dispenses methadone to treat opioid use disorder.
☐ Other (Specify: ______________________)

51. If your facility offers or coordinates MAT, does your facility coordinate follow-up care for the continuation of MAT treatment following discharge, by providing facility information AND scheduling an appointment?

❍ YES
❍ NO
❍ Prefer not to answer

Transition and Discharge Planning

52. Does your facility have a policy to initiate transition and discharge planning, beginning at the time of admission?

❍ YES
❍ NO
❍ Prefer not to answer

53. When does your facility include the patient and the patient's support system (as appropriate) in the transition and discharge planning process? ***Mark all that apply.***

☐ At the time of admission
☐ After the treatment plan is determined
☐ When the discharge plan has been determined
☐ Prefer not to answer

54. Prior to discharge, are outpatient providers and services identified within your organization and the patient's local community? **(If 'YES' continue to Question 55; If 'NO' Skip to Question 56)**

❍ YES
❍ NO
❍ Prefer not to answer

55. If your facility identifies outpatient providers or services outside the patient's local community, please describe the process your facility uses to connect patients with those providers or services:

Text box

56. Does your facility coordinate or utilize case management services offered by the health plan to assist in aftercare planning and to follow up after discharge?

❍ YES
❍ NO
❍ Not Offered/Unknown if offered
❍ Prefer not to answer

57. When an outpatient service or provider is needed, does your provider schedule an appointment on behalf of the patient, **prior** to discharge?

❍ YES
❍ NO
❍ Prefer not to answer

58. Please describe steps your facility takes to connect patients (or family, as appropriate) to outpatient and community services in their home community.

Text box

Performance Improvement

59. Does your program participate in standardized Patient Satisfaction and Experience Surveys to evaluate and improve care delivery? **(If 'YES' continue to Questions 60-62 then; If 'NO' Skip to Question 63)**

❍ YES
❍ NO
❍ Prefer not to answer

60. If your program participates in standardized Patient Satisfaction and Experience surveying, which Patient Satisfaction and Experience Survey(s) are used by your program? ***Mark all that apply:***

If 'Other' is selected, please list the title of the Patient Satisfaction and Experience Survey and provide a short description and/or a link to a description/reference.

☐ Consumer Assessment of Healthcare Providers and Systems® (CAHPS®)
☐ CAHPS® Experience of Care and Health Outcomes (ECHO®)
☐ Standardized Survey, Other: __________
☐ CAHPS® Custom Survey unique to your facility
☐ Other (Specify: ______________________)

61. If your program participates in standardized Patient Satisfaction and Experience surveying, does your program incorporate Patient Satisfaction and Experience Survey results into feedback and quality improvement of the system of care?

❍ YES
❍ NO

❍ Prefer not to answer

62. If your program participates in standardized Patient Satisfaction and Experience surveying, which patient experience measure(s) do your facility's Patient Satisfaction and Experience Survey(s) track? ***Mark all that apply.***

    If 'Other' is selected, please list the Patient Satisfaction and Experience measure(s) and provide a short description of the measure(s) and/or a link to a description/reference.

    ☐ Overall client rating of counseling and treatment (e.g., CAHPS ECHO® Survey Question 28)
    ☐ Overall effectiveness of treatment at 12 months (e.g., CAHPS ECHO® Survey Question 29, "In the last 12 months, how much the client was helped by the counseling or treatment received")
    ☐ Accuracy of self-assessment 12 months (e.g., CAHPS ECHO® Survey Question 34, "Compared to 12 months ago, how do clients rate their problems or symptoms correctly")
    ☐ Other (Specify: ____________________)

63. Does your facility use quality measurement for the substance use and recovery program? **(If 'YES' continue to Question 64 then Question 65; If 'NO' Skip to Question 66)**

    ❍ YES
    ❍ NO
    ❍ Prefer not to answer

64. Which metrics does your facility use to measure the success of your substance use treatment and recovery program? ***Mark all that apply***
    If 'Other' is selected, please list the title of the metric provide a short description of the measure and/or a link to a description/reference.

    ☐ Access to care (e.g., time from first contact to admission to program)
    ☐ Coordination of care (e.g. time for notifications to multidisciplinary care team regarding admission, discharge, etc.)
    ☐ Program completion rate
    ☐ Relapse rate
    ☐ Re-engagement after a relapse
    ☐ Engagement in MAT continuation
    ☐ Engagement in regular outpatient and/or community based counseling
    ☐ Other (Specify: ______________________)

65. Does your program incorporate quality measurement results into feedback and quality improvement of the substance use, treatment, and recovery program and/or the system of care?

❍ YES
❍ NO
❍ Prefer not to answer

66. Does your facility (and/or providers in your facility's program) participate in value-based or alternative payment models? **(If 'YES' skip to 68; If 'NO' or 'Not Currently' continue to Question 67)**

☐ Yes, our facility (and/or the providers in our facility's program) participate or will be participating in the Patient-Centered Opioid Addiction Treatment (P-COAT) Alternative Payment Model (APM), outlined by American Society of Addiction Medicine's (ASAM) and American Medical Association (AMA)
☐ Yes, our facility (and/or the providers in our facility's program) participate or will be participating in an Addiction Recovery Medical Home Alternative Payment Model (ARMH- APM), outlined by Facing Addiction with NCADD (The National Council on Alcoholism and Drug Dependence) and Leavitt Partners
☐ Yes, our facility (and/or the providers in our facility's program) participate or will be participating in a different value-based or an alternative payment model (e.g., pay for value or quality, episode or bundled payment, Per Member Per Month, Shared Savings, capitated payments with performance targets, case rates with performance targets or other model (if 'other,' please describe model here: ____________________________)
☐ Not currently, but our facility (and/or our providers in our facility's program) are considering participating in a value-based or an alternative payment model.
☐ No, our facility (and the providers in our facility's program) are not ready to participate in value-based or alternative payment models at this time.
☐ Unknown or prefer not to answer

67. What are the **top 3** barriers to value-based or APM adoption? ***Select top 3 barriers:***
☐ Provider interest/readiness
☐ Electronic Health Record capability
☐ Health Plan interest/readiness
☐ Government influence
☐ Provider ability to operationalize
☐ Provider willingness to take on financial risk
☐ Potential financial impact to provider
☐ Market factors/Other (Specify: ___________________________)
☐ Unknown or prefer not to answer

68. **Providers who bill separately from Facility Charges**

For all patients receiving services in your facility's program under the specified level of care, list **all** providers who may bill separately from your facility's billed charges in the table below.

For example, this would include laboratory services, drug testing services, clinical therapies, professional providers, and pharmacy charges, etc.

Refer to the NPPES NPI Registry to find the facility's National Provider Identifier (NPI) number.

Provider/Facility Name	Address	City	State	Zip Code	National Provider Identifier (NPI)	Type of Service

69. **Medication-Assisted Treatment (MAT) Practitioners**

Please list **all** practitioners who are permitted to administer and prescribe specifically approved medications (e.g., Methadone, Buprenorphine or Naloxone), to patients within your program at this facility location **and/or** coordinated through your facility's organized delivery system.

Refer to the NPPES NPI Registry to find the facility's National Provider Identifier (NPI) number.

FIRST NAME	LAST NAME	NATIONAL PROVIDER IDENTIFIER (NPI)	PROVIDER TYPE

Designation under this Blue Distinction Program will initially only be offered to facilities that provide residential, inpatient, intensive outpatient, or partial hospitalization services. However, the designation may expand to include regular outpatient levels of care and outpatient providers who administer Medication Assisted Treatment (MAT) and information provided by your facility would assist with this anticipated expansion.

Once the survey is complete and ready to be submitted, click on **Submit**. Close the survey window to bring you back to the Survey Actions screen in BD Portal. After you have successfully submitted this Provider Survey, a read-only copy of the submitted application will be accessible on the 'Survey Actions' tab in BD Portal under the Provider column.

Thank you for your application to the Blue Distinction Centers for Substance Use Treatment and Recovery program. If you have any questions, please contact the Blue Distinction Help Desk at BDCAdmins@bcbsa.com.

Terms & Conditions

70. ATTESTATION

Attestation for Provider Survey Participation
Blue Distinction® Centers for Specialty Care Program(s)

By submitting its response to this Provider Survey for consideration as a participant in this Blue Distinction Centers for Specialty Care® Program(s) (the "Program(s)"), and, if accepted by BCBSA, as a condition to any designation and participation in the Program(s), this provider ("Provider") represents and agrees as follows:

1. All information that Provider provides in its response to BCBSA's Provider Survey for consideration as a participant in this Program(s) (including information provided in Provider's initial response, as well as any additional materials submitted throughout the evaluation and appeal process for this Provider Survey cycle) is and will be true and complete, as of the date Provider provides such information to BCBSA. Provider will advise BCBSA immediately of any material change in such information during this Provider Survey process, and if Provider is designated as a Blue Distinction Center under this Program(s), for the duration of such designation.

2. BCBSA may share Provider's individual Provider Survey responses ("Raw Data") and results ("Scores") with BCBSA's member Plans and, pursuant to a confidentiality agreement, member Plans' current and prospective accounts, for purposes of evaluation, care management, quality improvement, and member Plans' design of customized products and networks. BCBSA may combine Provider's Raw Data and Scores together with other Providers' data to create aggregate information for public dissemination, provided that such aggregate information will not identify Provider by name, and will not contain any Protected Health Information ("PHI"), as defined under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C. F. R. Parts 160-164). Provider's Raw Data and Scores will not be publicly disseminated beyond the extent permitted above without Provider's prior written consent, unless required by law (e.g., subpoena).

☐ **PROVIDER** attests that it has read, understands, and agrees with the terms set forth in the Attestation (Section A in the scroll down box, above) and represents and agrees that the statements therein are accurate.

Provider verifies that it responded to the Attestation above, by and through its duly authorized officer identified below:

☐ **Enter Officer's Name:** ____
☐ **Enter Officer's Title:**____
☐ **Date:** ____________