MEDICAID & STATE TELEHEALTH POLICY:
The Webinar Series

MEDICAID TELEHEALTH POLICY & SUD

JUNE 24, 2022

Center for Connected Health Policy

THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

CENTER FOR CONNECTED HEALTH POLICY (CCHP)

is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.

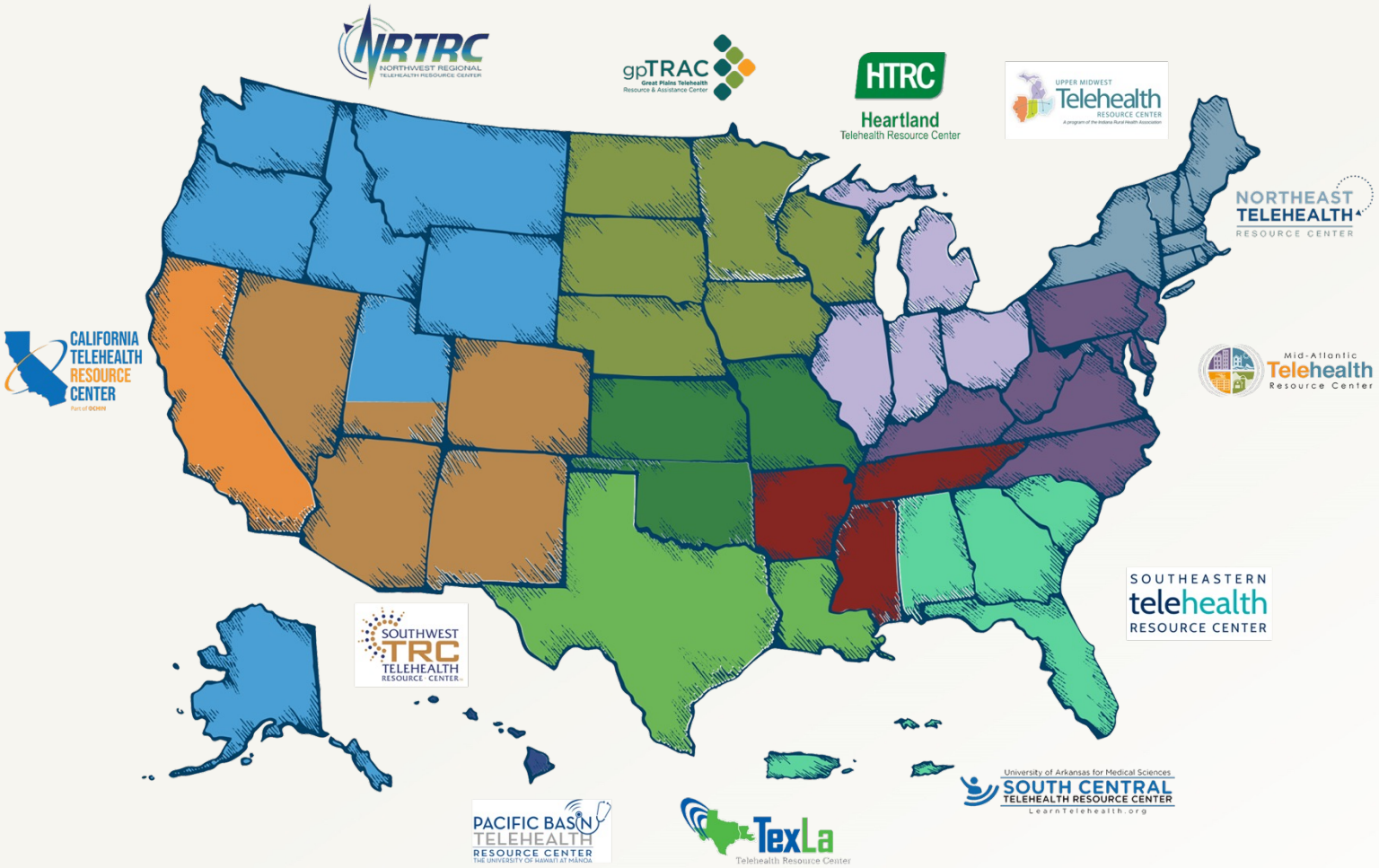
Disclaimers & Friendly Reminders

- Any information provided in today's webinar is not to be regarded as legal advice. Today's talk is purely for informational and educational purposes.
- Always consult with your organization's legal counsel.
- CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.
- Today's webinar will be recorded and slides presented here will be made publicly available as resources at cchpca.org.
- Closed captioning is available.
- Please refrain from political statements or advertising commercial products or services during this webinar.

ABOUT CCHP

- Established in 2009 as a program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
- Work with a variety of funders and partners on the state and federal levels
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition

NATIONAL CONSORTIUM OF TRCS



TRC

TELEHEALTH
RESOURCE CENTERS

Center for Connected Health Policy
The National Telehealth Policy Resource Center

Telehealth & Medicaid: A Policy Webinar Series

Image source: American Psychological Association

Previous CCHP webinars available on website or YouTube channel.

This webinar series was made possible by grant number GA5RH37470 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, U.S. Department of Health & Human Services.

TODAY'S SPEAKERS

Robert Baillieu
Physician and Senior Clinical and Practice Advisor
SAMHSA/CSAT/OD

Patricia Gann
Deputy Director, Division of Aging, Adult and Behavioral Health Services
Arkansas Department of Human Services

Jennifer Shuler
Nurse Practitioner, Division of Aging, Adult and Behavioral Health Services
Arkansas Department of Human Services

Elizabeth Pitman
Division Director, Division of Medical Services
Arkansas Department of Human Services

Jeffrey Hom
Medical Director of the Division of Substance Use Prevention and Harm Reduction
Philadelphia Department of Public Health

Telehealth – Necessary and Evolving

Robert Baillieu, MD, MPH
Physician and Senior Advisor
The Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

CCHP Webinar
Medicaid Telehealth Policies and SUD

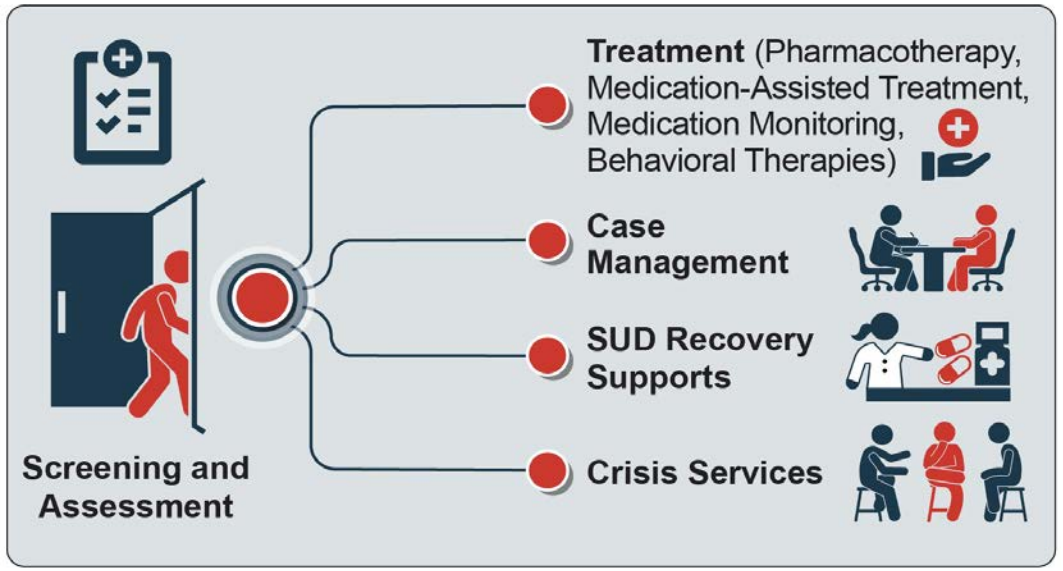
SAMHSA
Substance Abuse and Mental Health Services Administration

Overview

- Overview of Telehealth
- Implications
- Responses
- Future Directions

Defining Telehealth

The Health Resources and Services Administration (HRSA) defines telehealth as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.”



Telehealth To Overcome COVID-19 & Disparity

- Preliminary evidence suggests a sharp increase in the number of adults reporting adverse mental or behavioral health conditions during the COVID-19 pandemic compared to prior years.[1]

- Survey data indicate that racial and ethnic minority groups are experiencing higher rates of depression, substance use, and self-reported suicidal thoughts/ideation during the COVID-19 pandemic.[2]

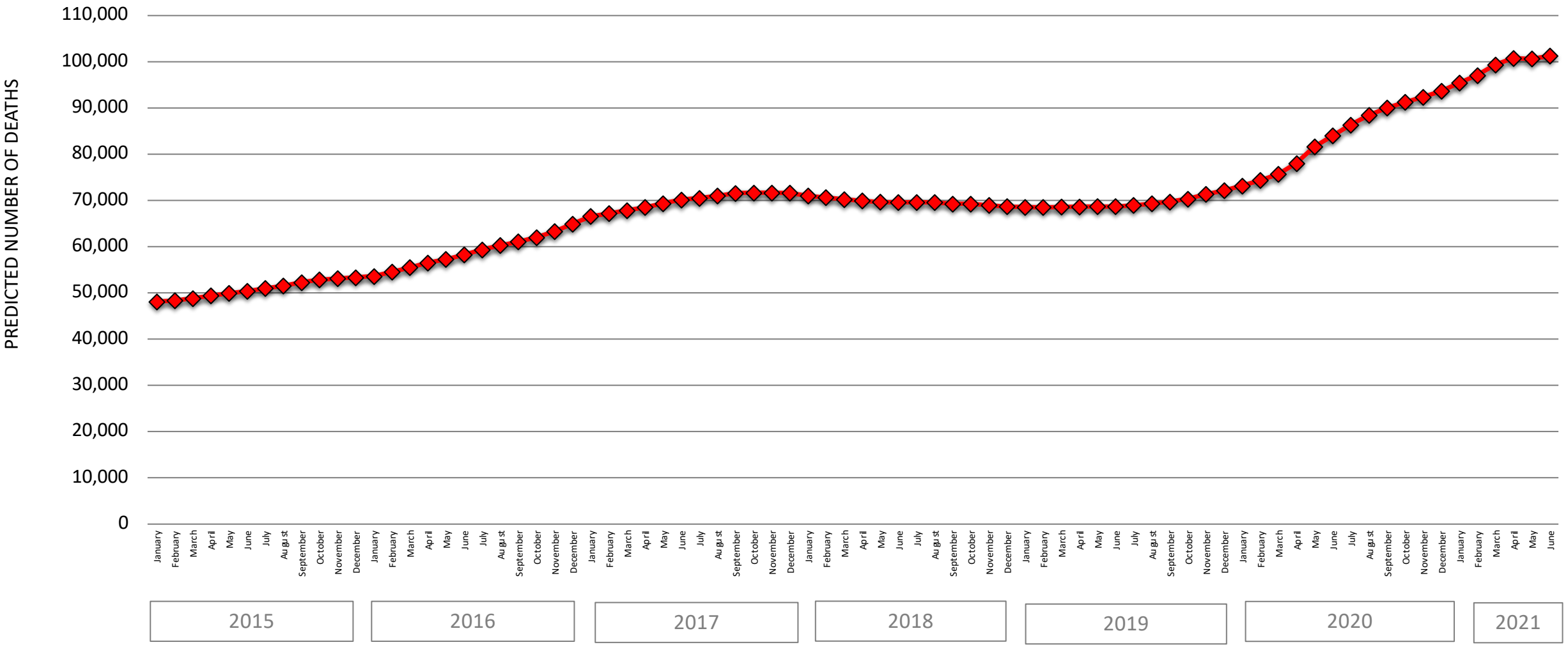
- Similarly, preliminary evidence indicates an increase in drug-related mortality during the COVID-19 pandemic.[3]

1 Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057.
DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external icon

2 McKnight-Eily LR, Okoro CA, Strine TW, et al. Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic — United States, April and May 2020. MMWR Morb Mortal Wkly Rep 2021;70:162–166. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7005a3.htm

3 Centers for Disease Control and Prevention (CDC). “Press Release: Overdose Deaths Accelerating During COVID-19.” December 17, 2020. Available at: Overdose Deaths Accelerating During COVID-19 | CDC Online Newsroom | CDC

Overdose Deaths Exceed 100,000



Source: National Center for Health Statistics/Centers for Disease Control and Prevention. *Vital Statistics Rapid Release Provisional Drug Overdose Death Counts*, available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (January 2022).

SAMHSA
Substance Abuse and Mental Health Services Administration

Most Overdose Deaths Involve One or More Illicit Drugs

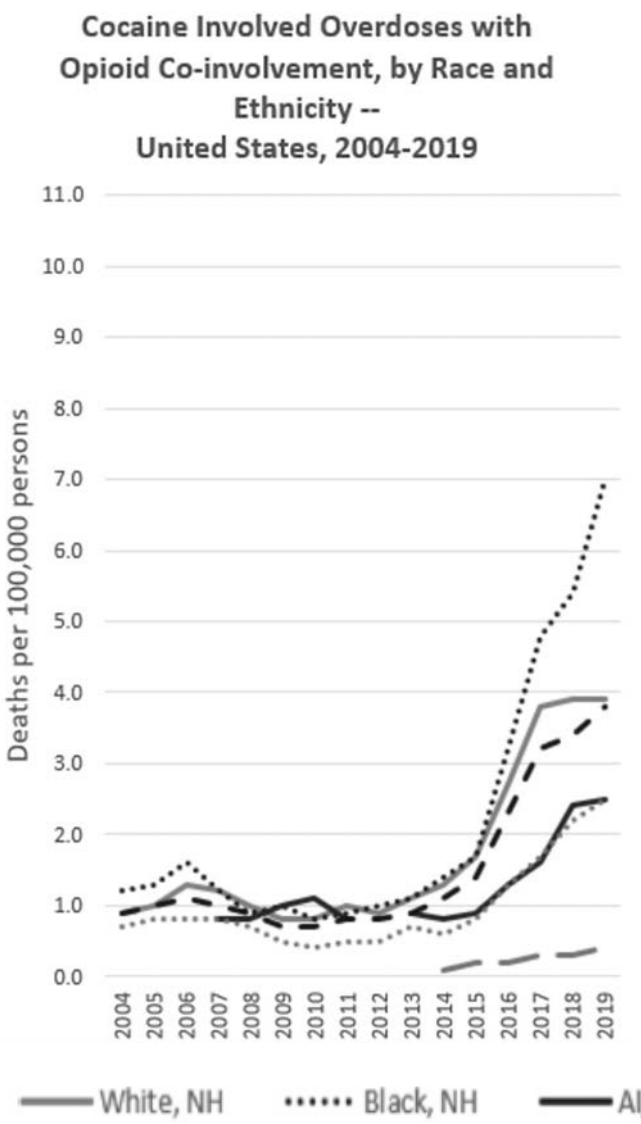
Co-involvement of other substances in drug overdose deaths involving Illicitly Manufactured Fentanyls (IMFs)	
IMFs only*	40%
Rx opioids	15%
Heroin	20%
Any opioids other than IMFs**	30%
Methamphetamine	20%
Cocaine	28%
Any stimulant***	42%
Benzodiazepines	15%
Gabapentin	5%
Xylazine	5%

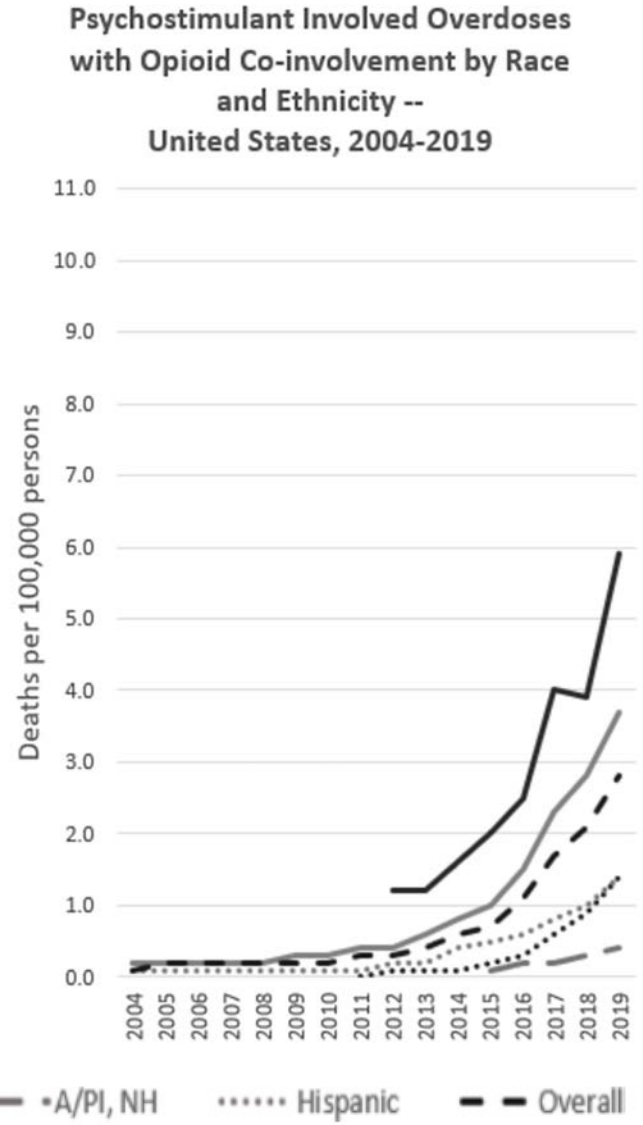
*Includes fentanyl and fentanyl analogs, **Includes heroin, prescription opioids, and other illicit synthetic opioids, *** Includes cocaine, amphetamines, cathinones, and other central nervous system stimulants (e.g., atomoxetine, caffeine).

- **The 10 most frequently occurring opioid and stimulant combinations accounted for over 77% of overdose deaths**
- **Buprenorphine and methadone are included as prescription opioids; however, they are used both for treatment of pain and for treatment of opioid use disorder. Fewer than 3% of deaths involved buprenorphine, and fewer than 4% of deaths involved methadone, across jurisdictions.**

SOURCE: State Unintentional Drug Overdose Reporting System (SUDORS), 40 jurisdictions, 2020

Concurrent Substance Use Overdoses By Race



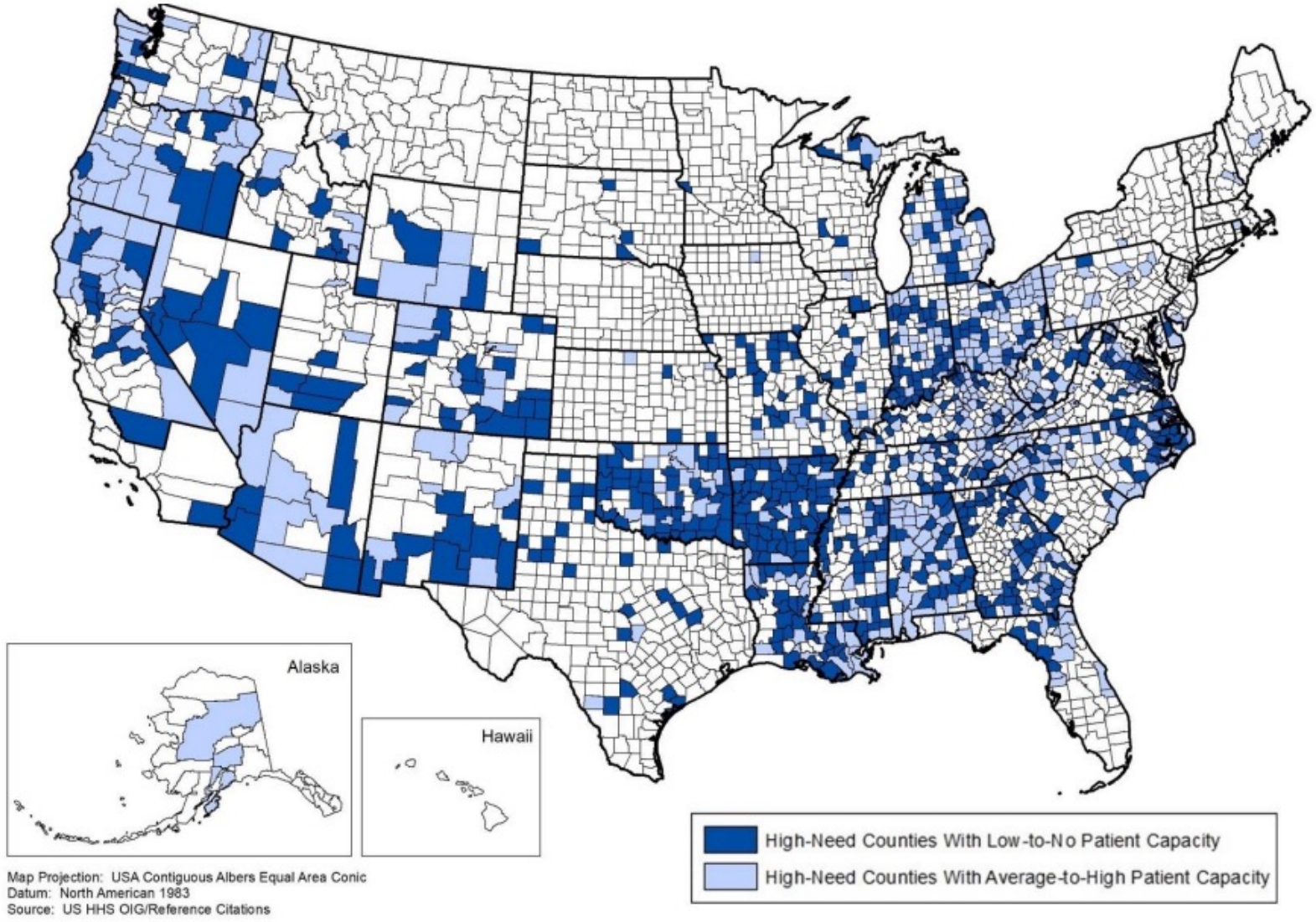


Source: Kariisa M, Seth P, Scholl L, Wilson N, Davis NL. Drug overdose deaths involving cocaine and psychostimulants with abuse potential among racial and ethnic groups - United States, 2004-2019. Drug Alcohol Depend. 2021 Oct 1;227:109001.

SAMHSA
Substance Abuse and Mental Health Services Administration

Disparities In Access To Treatment

High Need Counties and Buprenorphine Prescribing Capacity, 2018

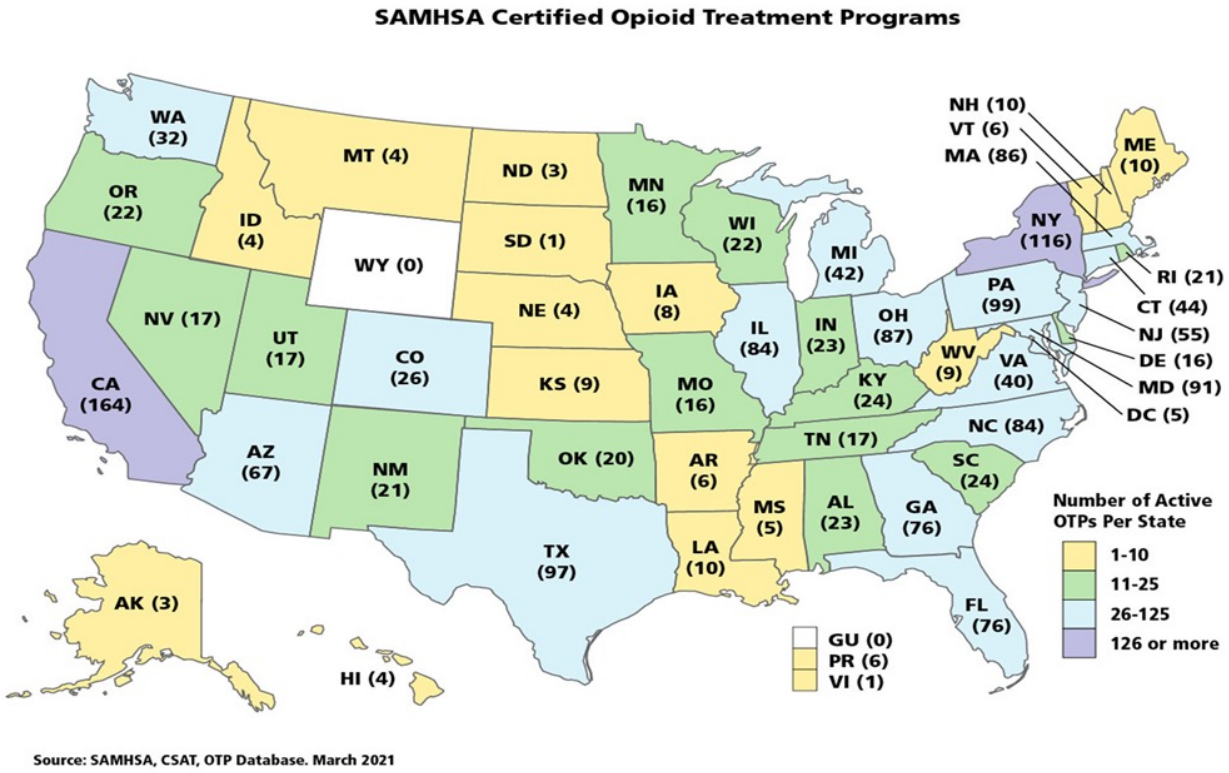


Source: OIG analysis of CDC and SAMHSA data, 2018

SAMHSA
Substance Abuse and Mental Health Services Administration

Opioid Treatment Programs

There are more than 1,900 OTPs across America, providing treatment to over 600,000 individuals each year



Research reveals:

- The rate of methadone treatment is highest in areas with low income and non-white residents.[1]
- This has remained unchanged for over 20 years.[2]

1. Strain EC, Stitzer ML, Liebson IA, Bigelow GE. Comparison of buprenorphine and methadone in the treatment of opioid dependence. Am J Psychiatry. 1994 Jul;151(7):1025-30. doi: 10.1176/ajp.151.7.1025. PMID: 8010359.
2. D'Aunno T, Pollack HA. Changes in methadone treatment practices: results from a national panel study, 1988-2000. JAMA. 2002;288(7):850-856. doi:10.1001/jama.288.7.850

SAMHSA
Substance Abuse and Mental Health Services Administration

SAMHSA's Telehealth Policies Enacted During the Pandemic

- In March 2020, the Secretary of HHS, with the concurrence of the Acting DEA Administrator, designated a telemedicine exception that applied to all schedule II-V controlled substances

- The DEA also granted a "temporary exception" to its regulations that allows practitioners to prescribe controlled substances in states in which they are not registered

- Telemedicine is also used by (and therefore overseen, in part, by SAMHSA):
  - DATA-Waivered providers to prescribe buprenorphine
  - Counselors, social workers and support staff to provide treatment activities
  - Providers to link clients into care

2020: COVID-19 Pandemic Changes Regulatory Landscape

3/11/20: WHO declares COVID-19 pandemic

3/16/20: SAMHSA releases blanket methadone take-home exceptions to states

And

3/16/20: HHS and DEA designate telehealth exceptions for all schedule II-V controlled medications

4/19/20: SAMHSA releases guidance on 42 CFR Part 2 confidentiality of patient records

4/21/20: SAMHSA clarifies exemption from requirement for an in-person physical examination for new patients starting buprenorphine in an OTP (but not methadone)

6/19/20: CMS clarifies allowance under Medicare for OTPs to use telehealth platforms for periodic patient assessments

2021: Building on Changes

4/27/21: HHS releases Buprenorphine Practice Guidelines

7/28/21: DEA releases guidance on mobile medication units

8/4/21: SAMHSA releases guidance on use of substance use treatment block grant funds for mobile units

9/21/21: SAMHSA releases guidance on mobile and non mobile medication unit establishment and allowable services

11/18/21: SAMHSA releases guidance on extension of blanket methadone take home exceptions for one year past end of COVID Public Health Emergency (PHE)

Telehealth Highlighted Disparities As Well…

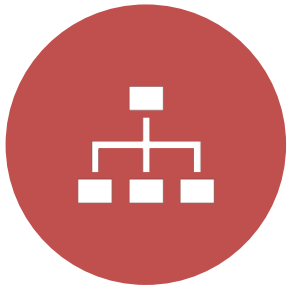
Technology Access Among Medicare Beneficiaries Varies Widely; Less Than Half of Black and Hispanic Medicare Beneficiaries Say They Own A Computer

	Have access to the internet	*Own a computer*	*Own a smartphone*
All beneficiaries	83%	64%	70%
Age category			
Under 65	82%	55%	73%
Age 65-74	89%	74%	80%
Age 75 and older	74%	56%	53%
Metropolitan status			
Urban	84%	66%	72%
Rural	78%	58%	60%
Race/ethnicity			
White	86%	71%	72%
Black	69%	42%	63%
Hispanic	67%	34%	61%

NOTE: Analysis among Medicare beneficiaries living in the community. Adults of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; All other groups are non-Hispanic. Tests of statistical significance can be viewed in accompanying tables.
SOURCE: KFF analysis of CMS Medicare Current Beneficiary Survey COVID-19 Fall 2020 Community Supplement Public Use File

KFF

Challenges and Concerns



Organizational challenges

Provider Concerns

Challenges for service recipients

Planning considerations

SAMHSA & Telehealth

Grants

- Discretionary grants
- Block grant

Technical Assistance and Education

- Addiction Technology Transfer Centers (ATTC)
- Mental Health Technology Transfer Centers (MHTTC)
- Prevention Technology Transfer Centers (PTTC)

Regulatory

- Permitted Opioid Treatment Providers and buprenorphine-waivered practitioners to prescribe buprenorphine through telehealth
- Supported flexibilities to allow audio-only technology, allowed for additional electronic platforms, and allowed for a patient's home to be the originating site
- Co-authored guidance with CMS on expanding telehealth coverage for behavioral health services

Ongoing Activities

- Working with AHRQ to develop a tool to assist consumers in selecting behavioral health mobile apps to manage mental health conditions
- Collecting surveillance data to monitor ongoing trends in telehealth delivery
- Assessing larger issues of health equity for underserved groups in behavioral health through data collection and policy

The Future

- Strong will on the part of providers and clients to maintain hybrid approach.
- Can greatly ease access for clients and decrease stigma.
- There are benefits with respect to provider recruitment and retention with telehealth flexibilities.
- Potential net gains for organizations with respect to cost reductions—decreased no shows, decreased overhead.

Take Home Points

- COVID-19 has had a negative behavioral health impact on the general population and disproportionately impacted more vulnerable populations.
- Baseline access challenges worsened with the pandemic despite efforts to relax regulatory restrictions.
- Economic hardships, isolation and access challenges have contributed to a significant increase in adverse outcomes over the past year.
- Survey results of behavioral health providers and clients, as well as needed ongoing efforts to mitigate treatment gaps, strongly favor continued modification of the regulatory environment to sustain telehealth, audio and video options, permit home-based telehealth services, and relax interstate service delivery.
- Telehealth has the potential to positively impact service delivery, to improve access for underserved populations, and can be used in conjunction with in-person services to develop tailored individualized service planning.

SAMHSA's mission is to reduce the impact of substance use and mental illness on America's communities.

Thank You!

www.samhsa.gov | @samhsagov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)

Telemedicine

Arkansas Policy

ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Medicaid COVID 19 Response

Several emergency policies were put into place pursuant to Executive Orders issued by Governor Asa Hutchinson.

1. Executive Order 20-05 and made the provision of telemedicine more flexible by allowing for:

    - The originating site to be the client's home.
    - A provider-client relationship to be established when the provider can access the client's records.
    - The service to be provided using audio-only technology, where line of site on the client is not required.

2. Executive Order 20-06 allowed State Agencies to change policies without going through public notice and comment or approval process.

Telemedicine

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Medicaid
COVID 19 Response

Using 20-06, DHS expanded use of telemedicine for these services:

- Marital and Family Counseling
- Crisis Intervention
- Behavioral Health Diagnosis
- Substance Abuse
- Applied Behavioral Analysis Therapy
- Occupational, Physical and Speech Therapy
- DME, Prosthetics and Orthotics Evaluations
- Rural Health Clinics and Federally Qualified Health Centers

Telemedicine

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Medicaid
COVID 19 Response

Additional “check-in” services were allowed through COVID, including:

- Physician/APRN virtual check-in (G2012)
- Early Intervention Day Treatment/Adult Developmental Day Treatment Well Checks (T1027, U2)
- Behavioral Health Well Checks (H2021, U4, GT)

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DHS TELEMEDICINE COVID-19 RESPONSE CONTENTS

https://humanservices.arkansas.gov/wp-content/uploads/DHS-Telemedicine-COVID-19-Response-Manual.pdf

COVID 19 Response

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Medicaid
COVID 19 Response

During the 2021 General Session, the Arkansas Legislature made these changes permanent.

- Act 767
- Act 829

Through these Acts, DMS made permanent:

- Originating site can be the client's home
- Audio only technology can be used where appropriate
- Provider-client relationship can be established if the provider can access the client's medical records

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Medicaid
COVID 19 Response

Medicaid continues to look at ways to use telemedicine and technology to better expand services:

- Use of technology in crisis response.
- Allowing enabling technology for individual being served in home and community settings.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Social Media

www.facebook.com/ArkDHS

@ARHumanServices

@arkansasdhs

Arkansas DHS

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Medication Assisted Treatment For Opioid Use Disorder

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Medication Assisted Treatment For Opioid Use Disorder

What is Medication Assisted Treatment, or MAT?

Substance Abuse and Mental Health Services Administration (SAMHSA) defines Medication Assisted Treatment (MAT) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.

This definition and other MAT Guidelines can be found at:
https://www.samhsa.gov/medication-assisted-treatment

Medication Assisted Treatment For Opioid Use Disorder

Program Overview

Arkansas Medicaid now supports clients with Opioid Use Disorder (OUD).

When receiving services associated with MAT, the program allows MAT clients to:

- Exceed the 12 physician visits per year limit
- Exceed the $500 benefit limit for laboratory and x-ray services
- Exceed the number of prescriptions allowed per month

Clients will not be charged a co-pay for covered MAT services.

Medication Assisted Treatment For Opioid Use Disorder

Program Overview

MAT is covered for eligible Medicaid clients who have an Opioid Use Disorder when diagnosis and clinical impression is determined in the terminology of International Classification of Disease (ICD).

Providers are required to follow SAMHSA guidelines for the full provision of MAT.

A Primary Care Physician (PCP) referral is not required to provide MAT, but care coordination is recommended to the extent possible.

Providers are encouraged to use telemedicine services when in-person treatment is not readily accessible.

Medication Assisted Treatment For Opioid Use Disorder

How to Enroll as a Medicaid Provider offering MAT Services

To provide Medication Assisted Treatment (MAT) services as a current Medicaid Provider, providers must submit:

- A written letter requesting their XDEA be added to their provider file
- A copy of their DEA certificate
- A copy of the XDEA approval letter from SAMHSA

Documentation should be uploaded on the Arkansas Medicaid HealthCare Provider Portal to qualify.

To enroll as a new Arkansas Medicaid Provider offering MAT services, submit your enrollment application online through MMIS-Provider Enrollment portal.

Upload your DEA certificate and SAMHSA approval letter as attachments to your application to ensure your XDEA is entered for your provider file.

Medication Assisted Treatment For Opioid Use Disorder

Who Can Obtain an XDEA?

Physician: Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO)

Physician Assistant: Physician Assistant services are services furnished according to Arkansas Statute 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physicians' Assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.

Advanced Practice Registered Nurses: Certified Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives.

Medication Assisted Treatment For Opioid Use Disorder

Who Can Prescribe Medication?

Only providers who have met the requirements of Section 201.500 of the Physician Manual may prescribe medication required for the treatment of opioid use disorder for Arkansas Medicaid clients.

> Coordinating all follow-up appointments and referrals for counseling and other services is also required.

The MAT program applies only to prescribers of FDA-approved drugs for treatment of Opioid Use Disorder. Prescribers of these drugs will not be reimbursed for the practice of pain management.

All MAT-related requirements outlined in the Physician Manual, other practitioner or agency rules for enrollment, and staffing requirements apply.

Medication Assisted Treatment For Opioid Use Disorder

Provider Responsibilities

In accordance with SAMHSA Guidelines, Arkansas Medicaid requires at minimum an initial evaluation and diagnosis of Opioid Use Disorder, including:

- Drug screening tests to accompany proper medication prescribing for MAT
  - Buprenorphine mono-therapy is typically reserved only for pregnant women and those with a documented anaphylactic reaction to other MAT medications like Buprenorphine/Naloxone Combinations
- Lab screening tests for communicable diseases based on the patient's history
- Use of all necessary consent forms for treatment and HIPAA compliant communication

Medication Assisted Treatment For Opioid Use Disorder

Provider Responsibilities

- Execution of Treatment Agreements or Contracts
  - SAMHSA's sample treatment agreement can be found under TIP 63 on the SAMHSA website
  - Providers may develop their own agreement or contract if all elements listed within SAMHSA's sample agreement are provided
- Development of a Person-Centered Treatment Plan
- Referral for independent clinical counseling or documented plan for integrated follow-up visit including counseling
- Identification of a MAT team member to function as the Case Manager to offer support services

Medication Assisted Treatment For Opioid Use Disorder

Minimum Requirements for Continuing Treatment

For the first year, the Provider must:

- Conduct regular outreach to the patient to determine need for assistance
  - Provide information on available programs and supports in the community
  - Provide referrals to other practitioners as needed

- Perform at least one follow-up MAT office visit per month for medication and treatment management

- Provide drug testing in conjunction with each monthly visit

- Perform at least one independent clinical counseling visit or documented plan for integrated follow-up visit including counseling per month.

Medication Assisted Treatment For Opioid Use Disorder

Quarterly Minimum Requirements for Continuing Treatment

During subsequent years, the Provider must:

- Conduct regular outreach to the patient to determine need for assistance
  - Provide information on available programs and supports in the community
  - Provide referrals to other practitioners as needed

- Provide at least one follow-up MAT office visit quarterly for medication and treatment management
  - Offer drug testing in conjunction with each quarterly visit

- Conduct at least one independent clinical counseling visit or documented plan for integrated follow-up visit
  - Visit must include counseling at an amount and duration medically necessary for continued recovery

Medication Assisted Treatment For Opioid Use Disorder

Compliance with SAMHSA Guidelines 230.100

Arkansas Medicaid, or its designated authority, will periodically review claims for MAT to ensure provider compliance with minimum requirements set forth by Medicaid and per the SAMSHA Guidelines.

Failure to comply with minimum requirements for the program may result in recoupment or other sanctions outlined in Section I of the Physician Manual.

Medication Assisted Treatment For Opioid Use Disorder

Compliance with SAMHSA Guidelines

MAT Providers are expected to adhere to the SAMHSA Guidelines; they are responsible for case management and adjusting the treatment plan for the client's maximum progress.

Documentation regarding how the MAT Provider is monitoring and addressing non-compliance will be reviewed.

The Patient/Prescriber Agreement shall reflect established expectations in accordance with SAMHSA Guidelines.

- If counseling or other components of treatment are being referred, providers' records are subject to post payment review and recoupment for undocumented services

Medication Assisted Treatment For Opioid Use Disorder

Special Billing Rules for MAT Program When Provided in a Physician Clinic or an Outpatient Behavioral Health Agency

Physician Manual, 272.600

Inclusive Rate – available only when participating MAT Providers can provide all MAT components per SAMHSA Guidelines within their own program and without referring to another provider.

The inclusive method of billing may be used when all SAMHSA Guideline services are set forth at a minimum in Section 230.000 of the Physician Manual and service is provided on the same date of service by the same billing group

- There must be at least one performing provider enrolled with Arkansas Medicaid that has a MAT program XDEA number on file.

Medication Assisted Treatment For Opioid Use Disorder

Special Billing Rules for MAT Program When Provided in a Physician Clinic or an Outpatient Behavioral Health Agency

For new patients, the provider group may use HCPCS code H0001, modifier X2, and list an Opioid Use Disorder ICD-10 code as primary.

For established patients requiring maintenance follow-up MAT treatment, the provider group may use HCPCS code H0001, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary.

Medication Assisted Treatment For Opioid Use Disorder

Special Billing Rules for Medication Assisted Treatment Program

The performing provider must be enrolled as a MAT provider, and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 of the Physician Manual (Office Visit, counseling and medication induction/maintenance, etc.).

Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.

Medication Assisted Treatment For Opioid Use Disorder

Reimbursement Rates

Patient Type	Billing Codes	Reimbursement Rate
New Patient	H0001, X2	$157.57
Est. Patient, Continuing Care	H0001, U8, X2	$139.62
Est. Patient, Continuing Care Telemedicine	H0001, U8, X2, GT	$139.62
Est. Patient, Maintenance Care	H0001, U8, X4	$139.62
Est. Patient, Maintenance Care	H0001, U8, X4, GT	$139.62

Special Billing Rules for MAT Program

- Allowable ICD-10 codes for Opioid Use Disorder may be found in the Physician Manual and are applicable for all provider types eligible to participate as a MAT Provider.

- Allowable lab and screening codes may be found in the Physician Manual and are applicable for all provider types eligible to participate as a MAT Provider.

- Providers utilizing telemedicine, regardless of method, shall adhere to telemedicine rules listed in Section 105.190 and Section 305.000 in addition to those above.
  - The Provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.

Find Us On...

@ArkDHS

@arkansasdhs

@ARHumanServices

ARHumanServices

Jennifer Shuler, Nurse Practitioner
Division of Aging, Adult, and Behavioral Health Services
Substance Abuse Treatment Services
Office of Drug Director

Jennifer.Shuler@dhs.arkansas.gov
501-396-6347

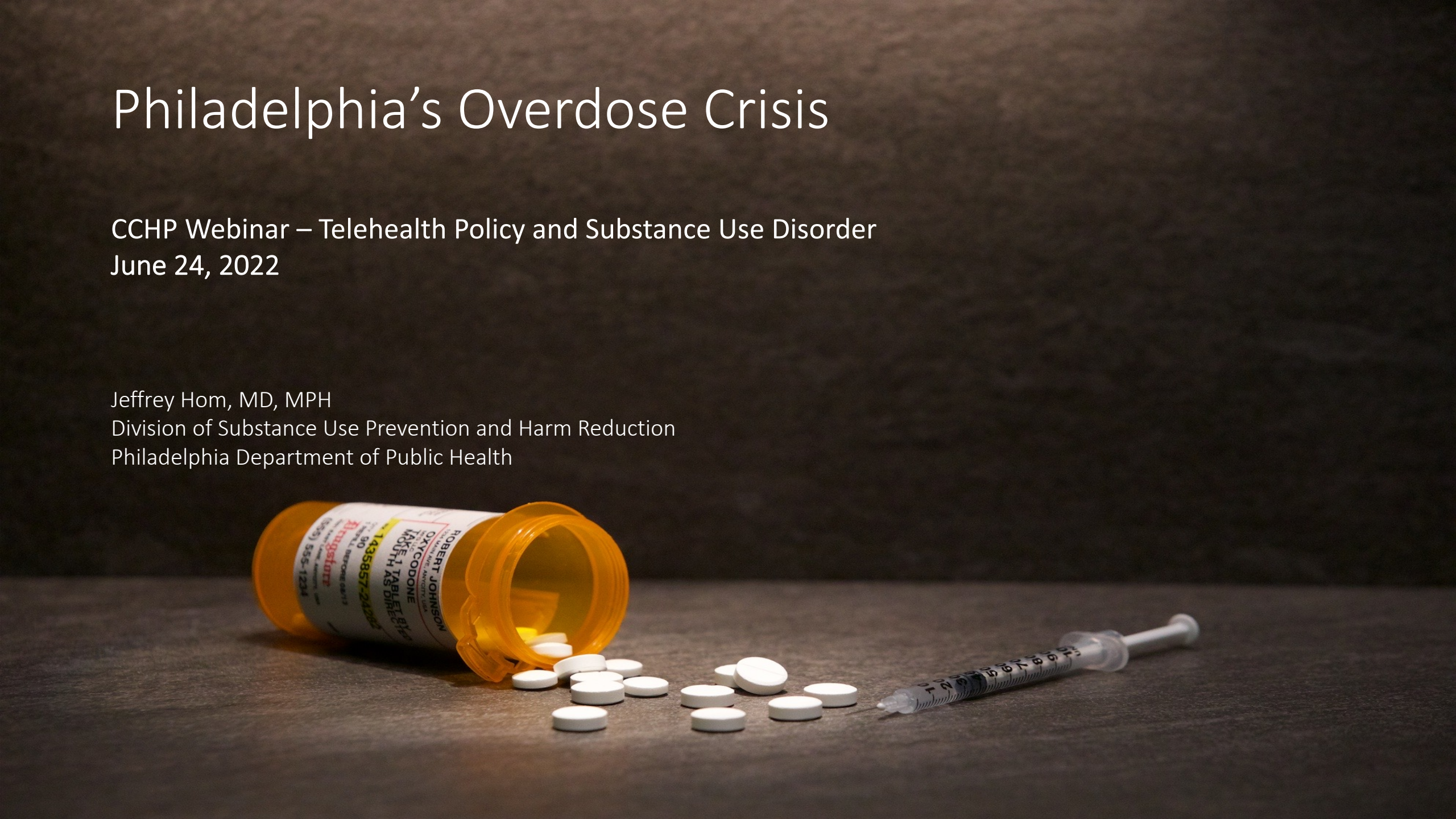
We Care. We Act. We Change Lives.

ARKANSAS
DEPARTMENT OF
HUMAN
SERVICES

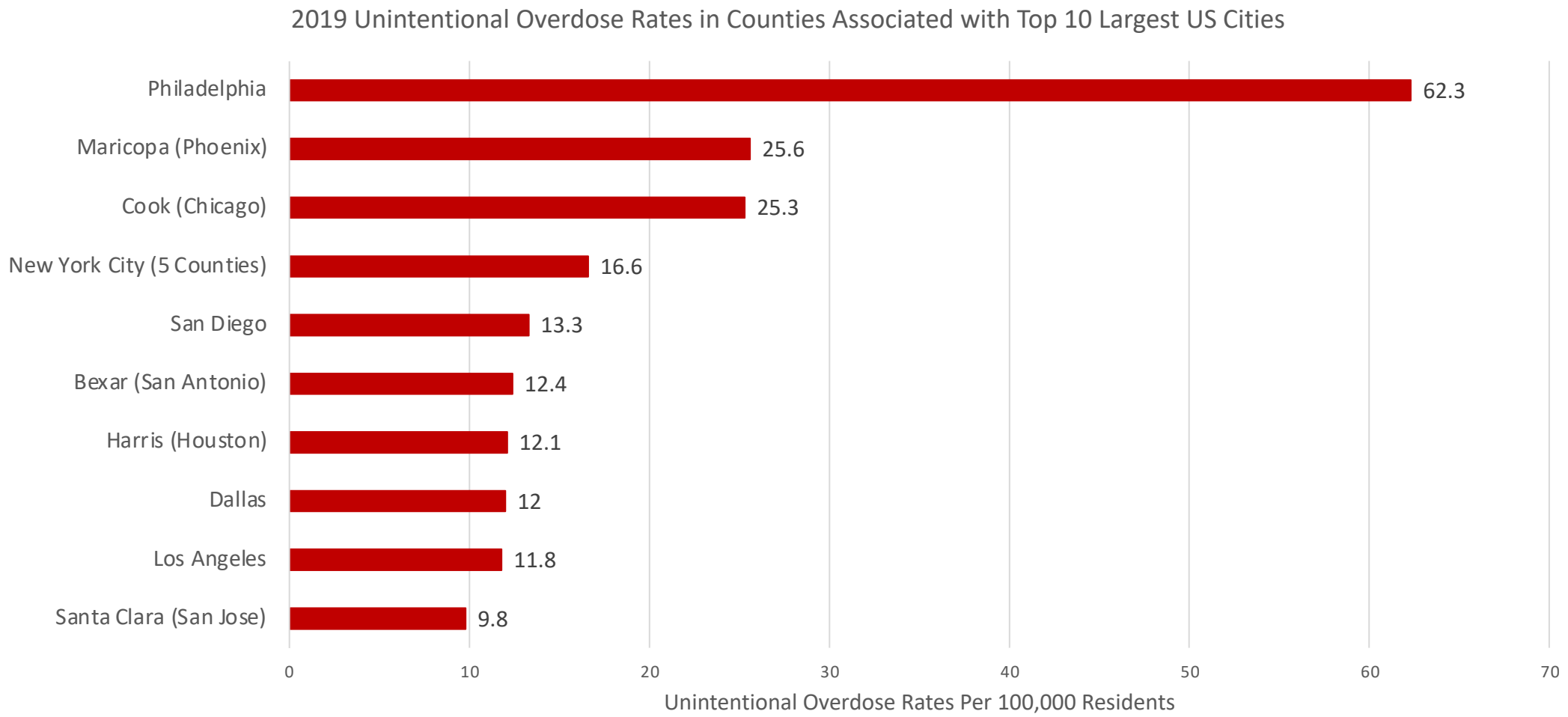
Philadelphia's Overdose Crisis

CCHP Webinar – Telehealth Policy and Substance Use Disorder
June 24, 2022

Jeffrey Hom, MD, MPH
Division of Substance Use Prevention and Harm Reduction
Philadelphia Department of Public Health



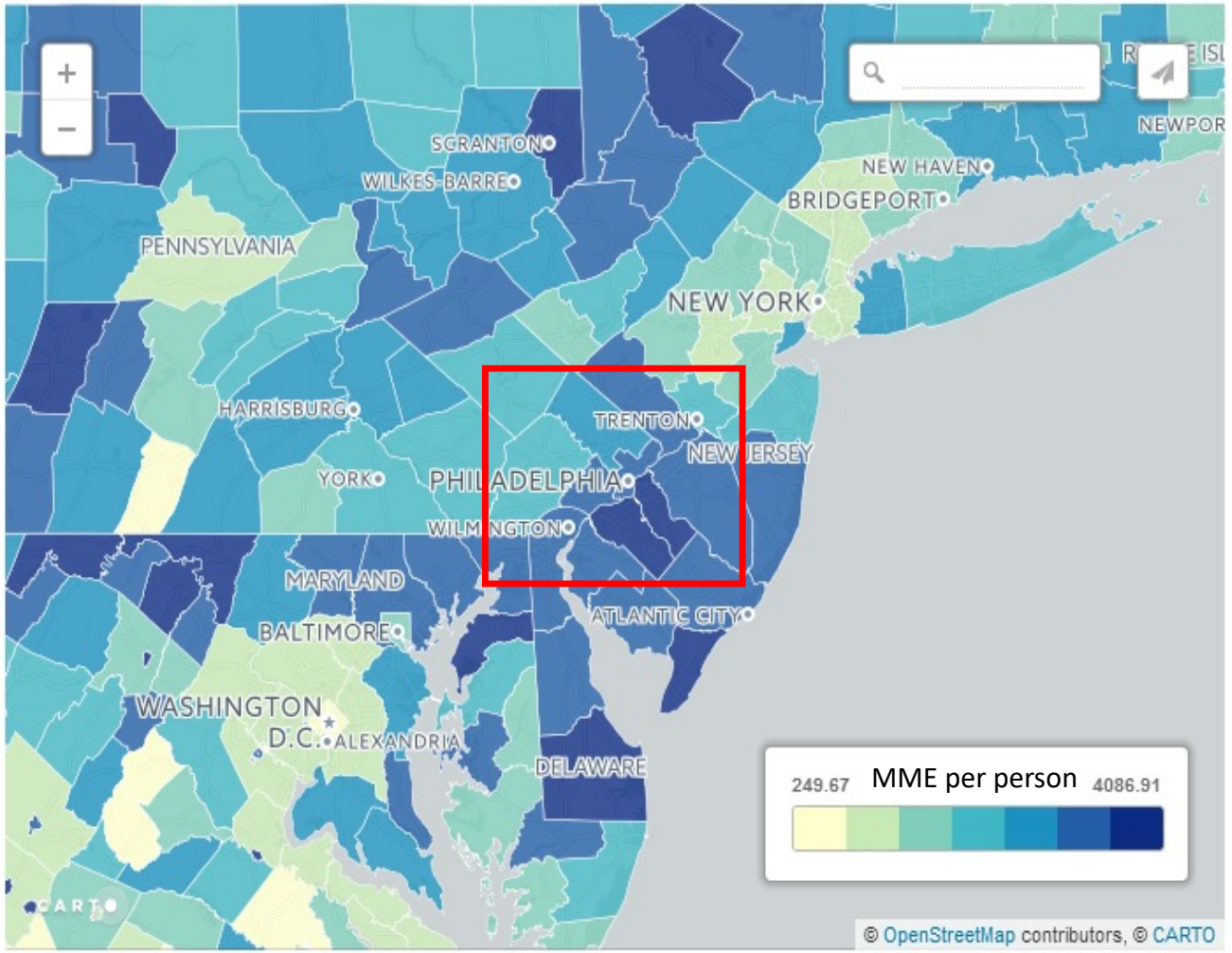
Philadelphia has the highest death rate of the top 10 largest U.S. cities



Department of Public Health

CDC WONDER 2020

High rates of opioid prescribing regionally

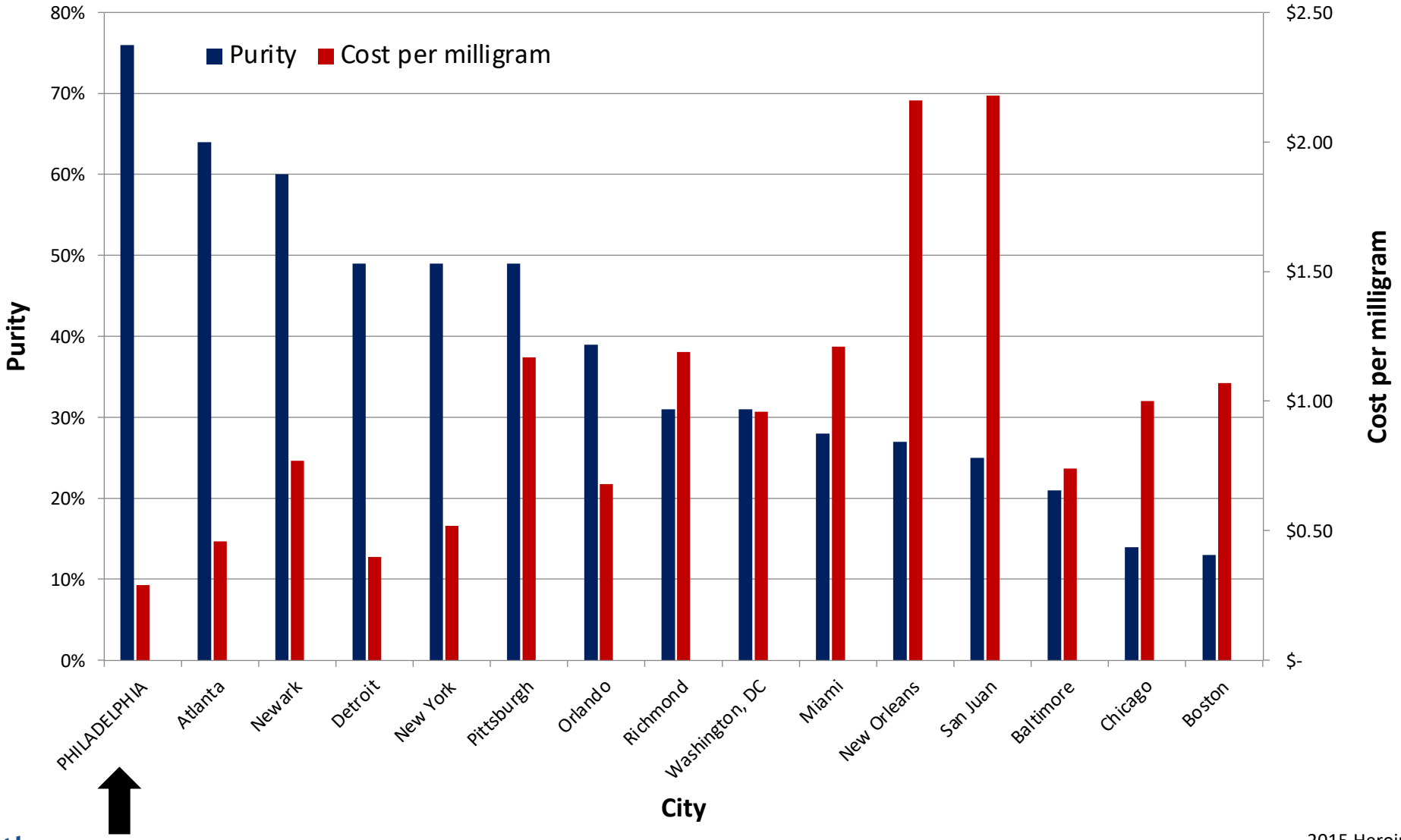


In 2015, enough opioids were prescribed in Philadelphia for every person to have **29 days of OxyContin**

Department of Public Health

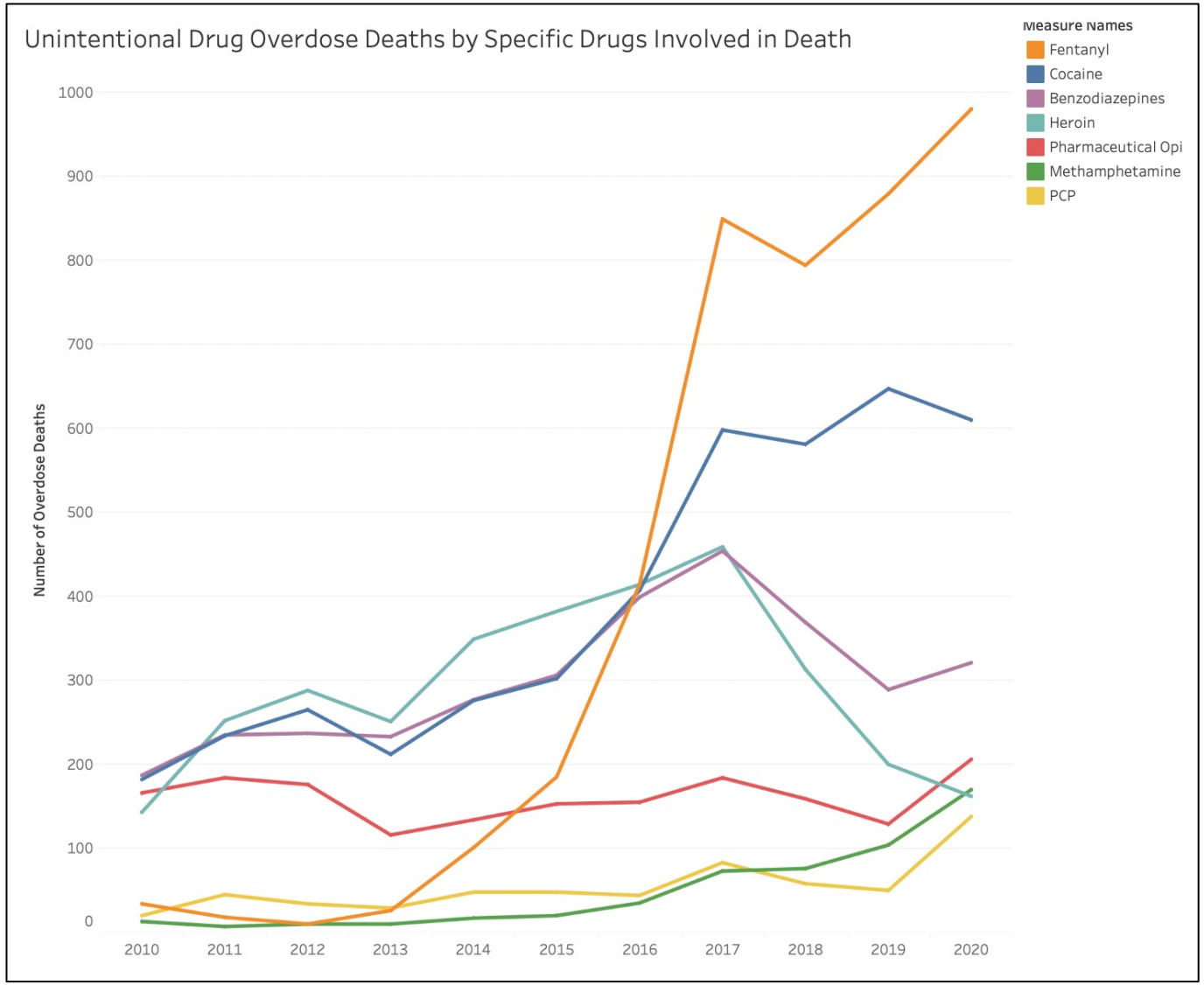
QuintilesIMS Transactional Data Warehouse, 2015.

Heroin is pure and cheap in Philadelphia



Department of Public Health

Fentanyl is involved in the majority of deaths



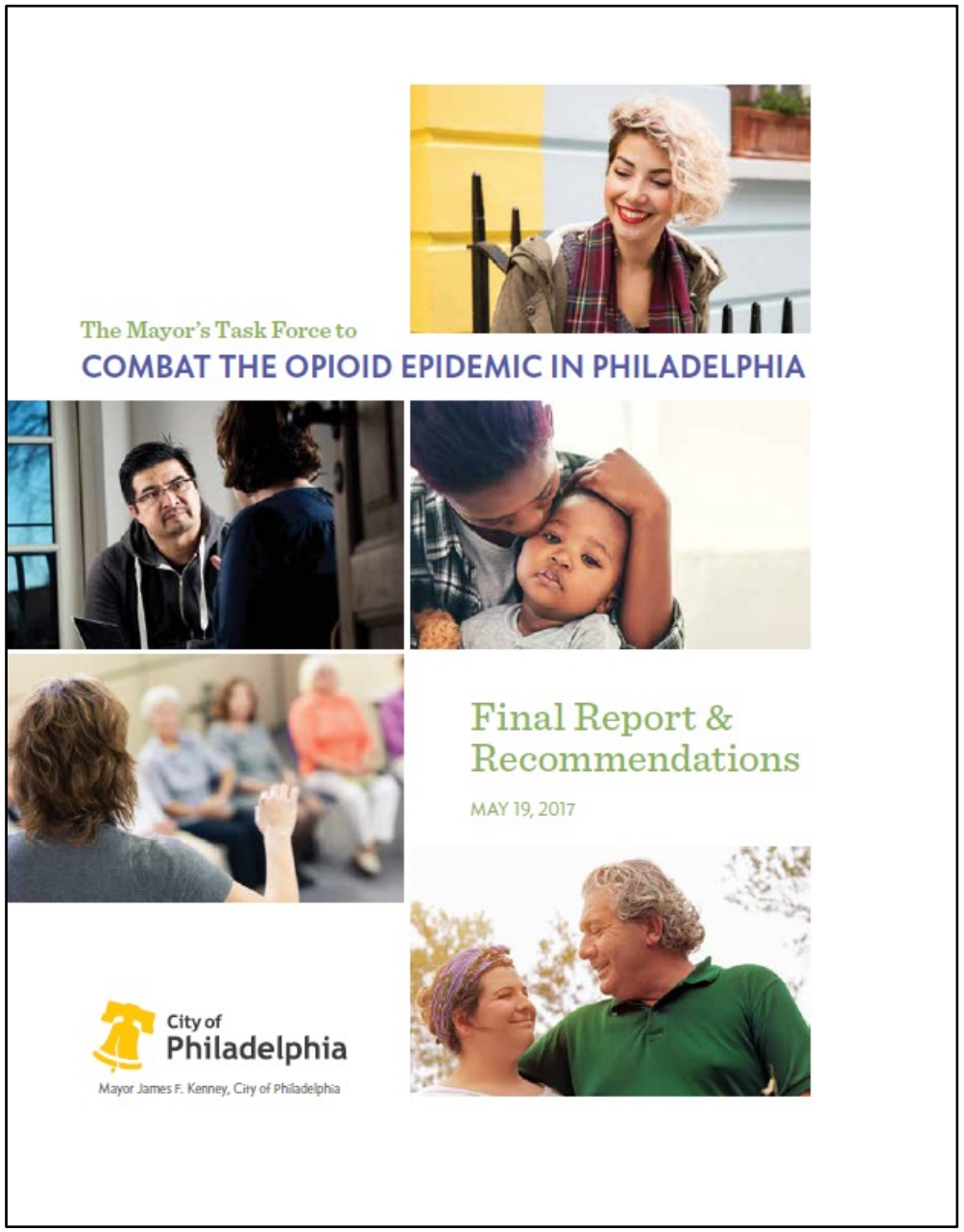
Department of Public Health

Medical Examiner's Office, Philadelphia Department of Public Health

Mayor's Task Force

- Convened January 2017
- 18 recommendations in five strategic areas:
  - Prevention and education
  - Treatment
  - Overdose prevention and harm reduction
  - Criminal justice
  - Data and surveillance

www.phila.gov/opioids



Reducing exposure to prescription opioids

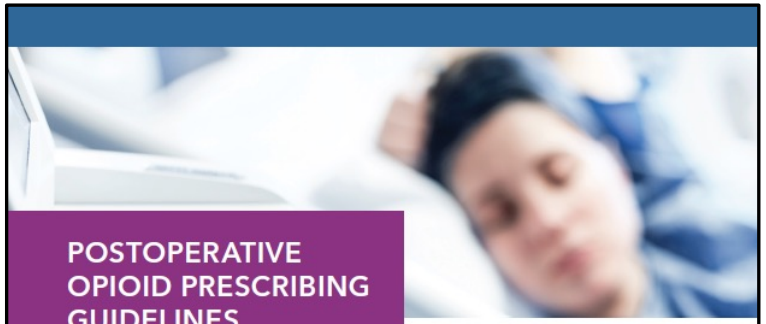
THINK NSAIDS

OPIOID PRESCRIBING

Key Recommendations

- Do not prescribe opioids for **chronic pain**.
- **3 days or less** is usually sufficient for acute pain.
- Prescribe the **lowest effective dose** and avoid increasing dose to ≥90 MME/day.
- **Avoid concurrent** benzodiazepine and opioid prescribing.

Department of Public Health
CITY OF PHILADELPHIA



POSTOPERATIVE OPIOID PRESCRIBING GUIDELINES

In the past, surgeons and other physicians were strongly encouraged to treat pain aggressively with opioids. It is now clear that the prescribing of opioids leads too often to side effects, dependence and addiction. At the same time, studies have shown that NSAIDS are as effective as opioids for treating many forms of pain, including acute postoperative pain. These guidelines, which are based on studies of analgesic needs postoperatively, attempt to balance the benefits and risks of opioids.

They recommend:

- Managing patient expectations about pain after surgery
- Maximizing the use of non-opioid pain treatments pre- and postoperatively
- Avoiding the use of opioids for minor surgical procedures
- Sharply limiting the duration of opioid use following major surgical procedures

Philadelphia law requires pharmacies to carry naloxone

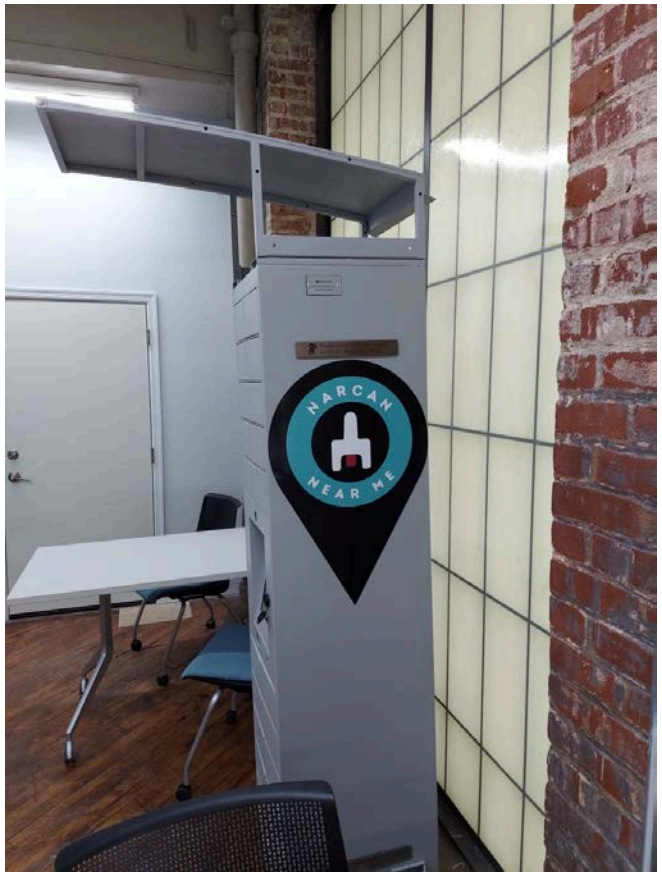
AN ORDINANCE

Amending Title 9, "Regulation of Businesses, Trades and Professions," of The Philadelphia Code to add a new Section 9-637, entitled "Opioid Antidote Availability," to require pharmacies to stock opioid antidotes and display signs giving notice of opioid antidote availability to customers, all under certain terms and conditions.

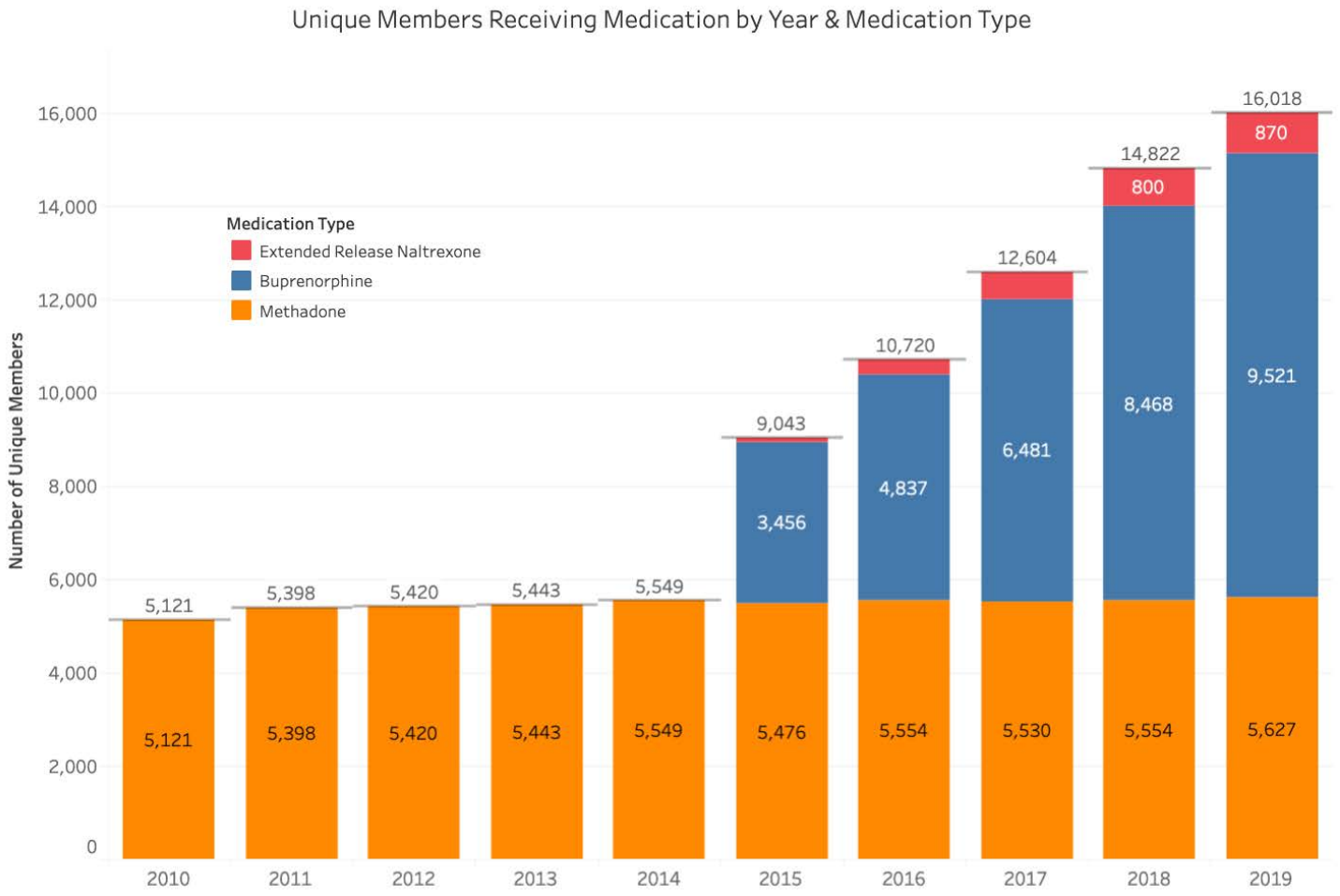
Department of Public Health

Low barrier naloxone via “naloxone towers”

- Naloxone kits available free of charge, 24/7
- First tower installed in West Philly
- User interface available in English and Spanish
- Can collect demographic information or survey can be overridden in event of an emergency
- Has 911 feature



Expanding access to treatment

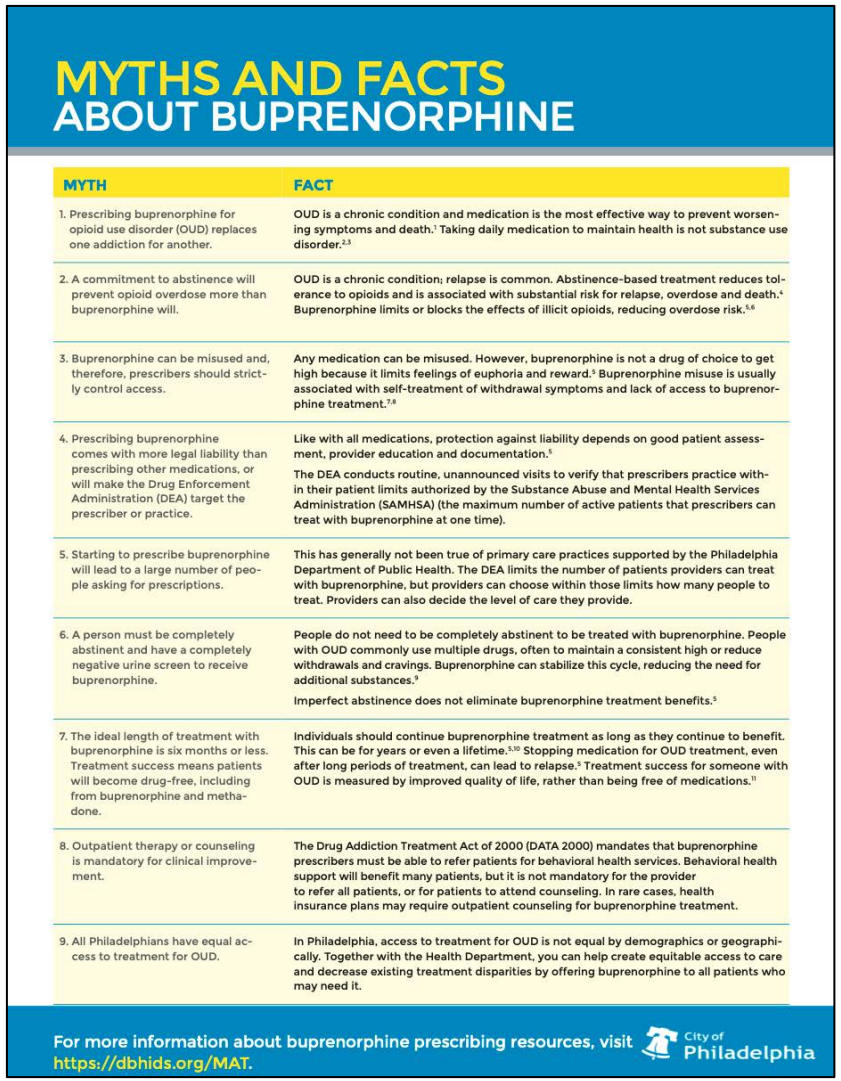


Department of Public Health

PA DHS

Buprenorphine initiatives in Philadelphia

- Buprenorphine mentorship program
- Academic detailing program
- Buprenorphine expansion in City's jail
- DA's decriminalization of buprenorphine possession



MYTHS AND FACTS ABOUT BUPRENORPHINE

MYTH	FACT
1. Prescribing buprenorphine for opioid use disorder (OUD) replaces one addiction for another.	OUD is a chronic condition and medication is the most effective way to prevent worsening symptoms and death.[1] Taking daily medication to maintain health is not substance use disorder.[2,3]
2. A commitment to abstinence will prevent opioid overdose more than buprenorphine will.	OUD is a chronic condition; relapse is common. Abstinence-based treatment reduces tolerance to opioids and is associated with substantial risk for relapse, overdose and death.[4] Buprenorphine limits or blocks the effects of illicit opioids, reducing overdose risk.[5,6]
3. Buprenorphine can be misused and, therefore, prescribers should strictly control access.	Any medication can be misused. However, buprenorphine is not a drug of choice to get high because it limits feelings of euphoria and reward.[5] Buprenorphine misuse is usually associated with self-treatment of withdrawal symptoms and lack of access to buprenorphine treatment.[7,8]
4. Prescribing buprenorphine comes with more legal liability than prescribing other medications, or will make the Drug Enforcement Administration (DEA) target the prescriber or practice.	Like with all medications, protection against liability depends on good patient assessment, provider education and documentation.[5] The DEA conducts routine, unannounced visits to verify that prescribers practice within their patient limits authorized by the Substance Abuse and Mental Health Services Administration (SAMHSA) (the maximum number of active patients that prescribers can treat with buprenorphine at one time).
5. Starting to prescribe buprenorphine will lead to a large number of people asking for prescriptions.	This has generally not been true of primary care practices supported by the Philadelphia Department of Public Health. The DEA limits the number of patients providers can treat with buprenorphine, but providers can choose within those limits how many people to treat. Providers can also decide the level of care they provide.
6. A person must be completely abstinent and have a completely negative urine screen to receive buprenorphine.	People do not need to be completely abstinent to be treated with buprenorphine. People with OUD commonly use multiple drugs, often to maintain a consistent high or reduce withdrawals and cravings. Buprenorphine can stabilize this cycle, reducing the need for additional substances.[9] Imperfect abstinence does not eliminate buprenorphine treatment benefits.[5]
7. The ideal length of treatment with buprenorphine is six months or less. Treatment success means patients will become drug-free, including from buprenorphine and methadone.	Individuals should continue buprenorphine treatment as long as they continue to benefit. This can be for years or even a lifetime.[5,10] Stopping medication for OUD treatment, even after long periods of treatment, can lead to relapse.[5] Treatment success for someone with OUD is measured by improved quality of life, rather than being free of medications.[11]
8. Outpatient therapy or counseling is mandatory for clinical improvement.	The Drug Addiction Treatment Act of 2000 (DATA 2000) mandates that buprenorphine prescribers must be able to refer patients for behavioral health services. Behavioral health support will benefit many patients, but it is not mandatory for the provider to refer all patients, or for patients to attend counseling. In rare cases, health insurance plans may require outpatient counseling for buprenorphine treatment.
9. All Philadelphians have equal access to treatment for OUD.	In Philadelphia, access to treatment for OUD is not equal by demographics or geographically. Together with the Health Department, you can help create equitable access to care and decrease existing treatment disparities by offering buprenorphine to all patients who may need it.

For more information about buprenorphine prescribing resources, visit https://dbhids.org/MAT.

City of Philadelphia

Department of Public Health

Health systems in Philadelphia commit to train all their PCPs to prescribe buprenorphine

VOICE

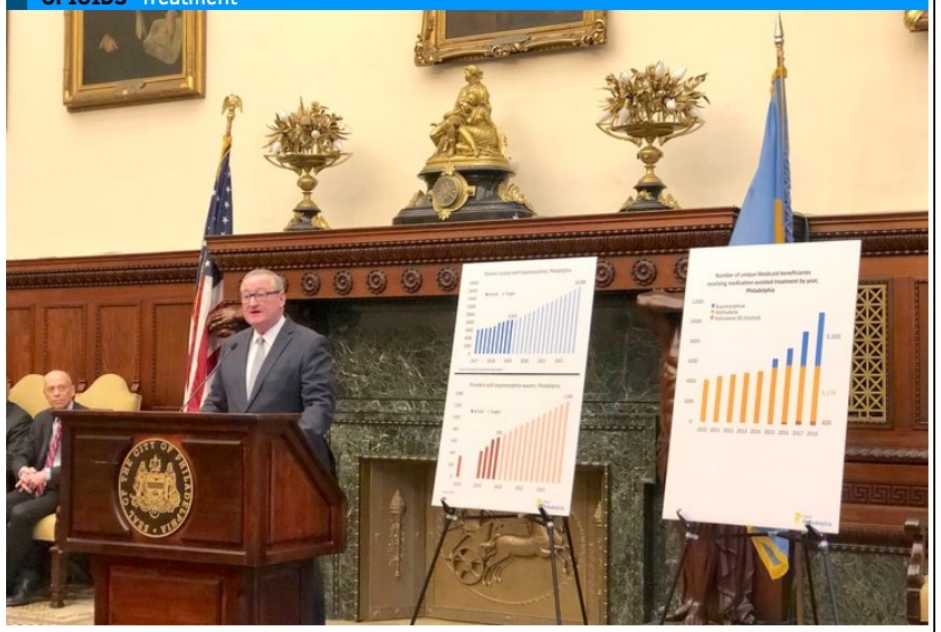
FEBRUARY 24, 2020

Philly takes 'major step forward' in opioid crisis by expanding buprenorphine access

Health systems commit to ensuring more primary care doctors prescribe drug used in medication-assisted treatment

BY **JOHN KOPP**
PhillyVoice Staff

OPIOIDS Treatment

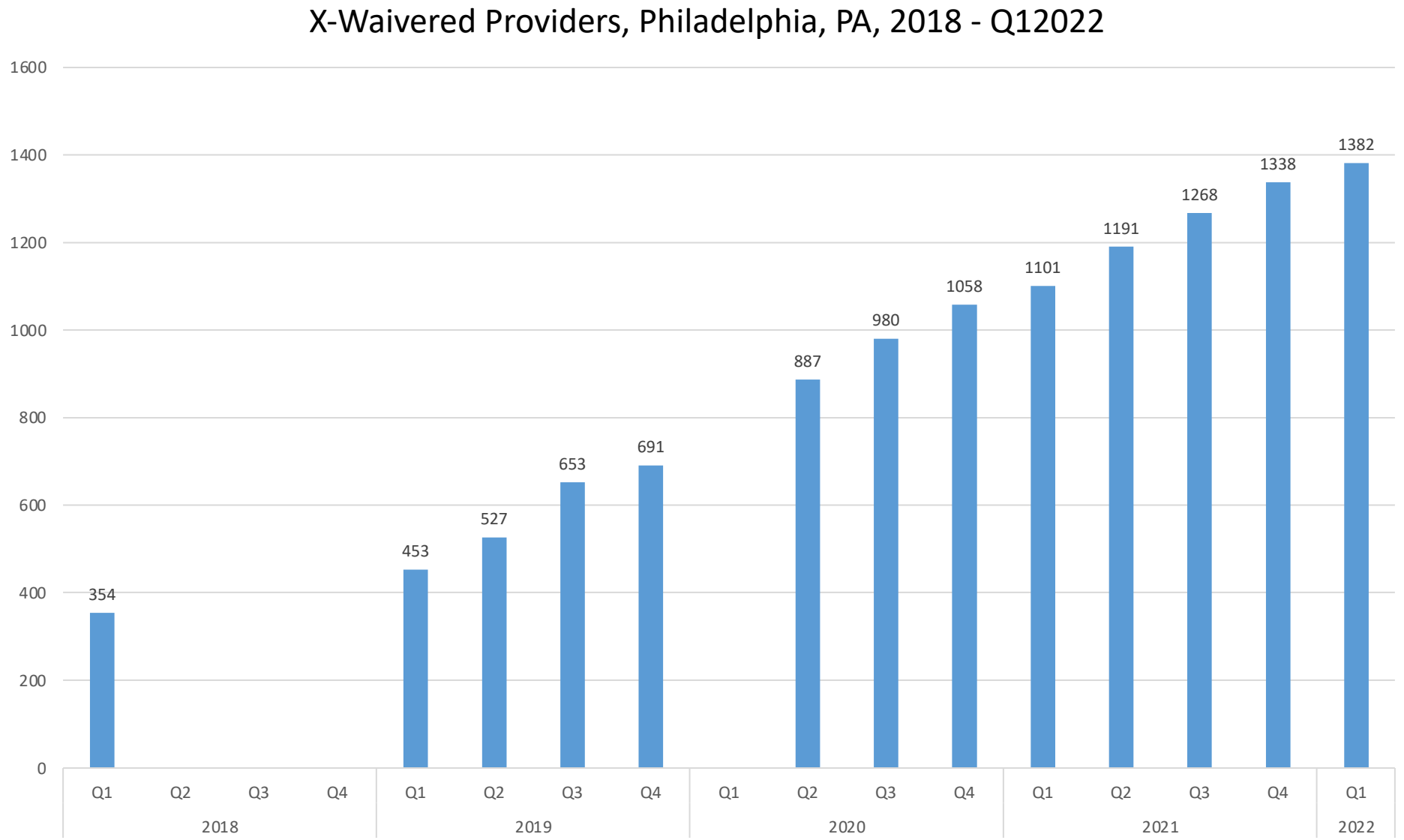


JOHN KOPP/PHILLYVOICE

In an effort to combat the opioid crisis, several Philadelphia health systems have committed to ensuring that their primary care physicians undergo training necessary to prescribe buprenorphine, a drug commonly used in medication-assisted treatment.

Philly Voice 2020

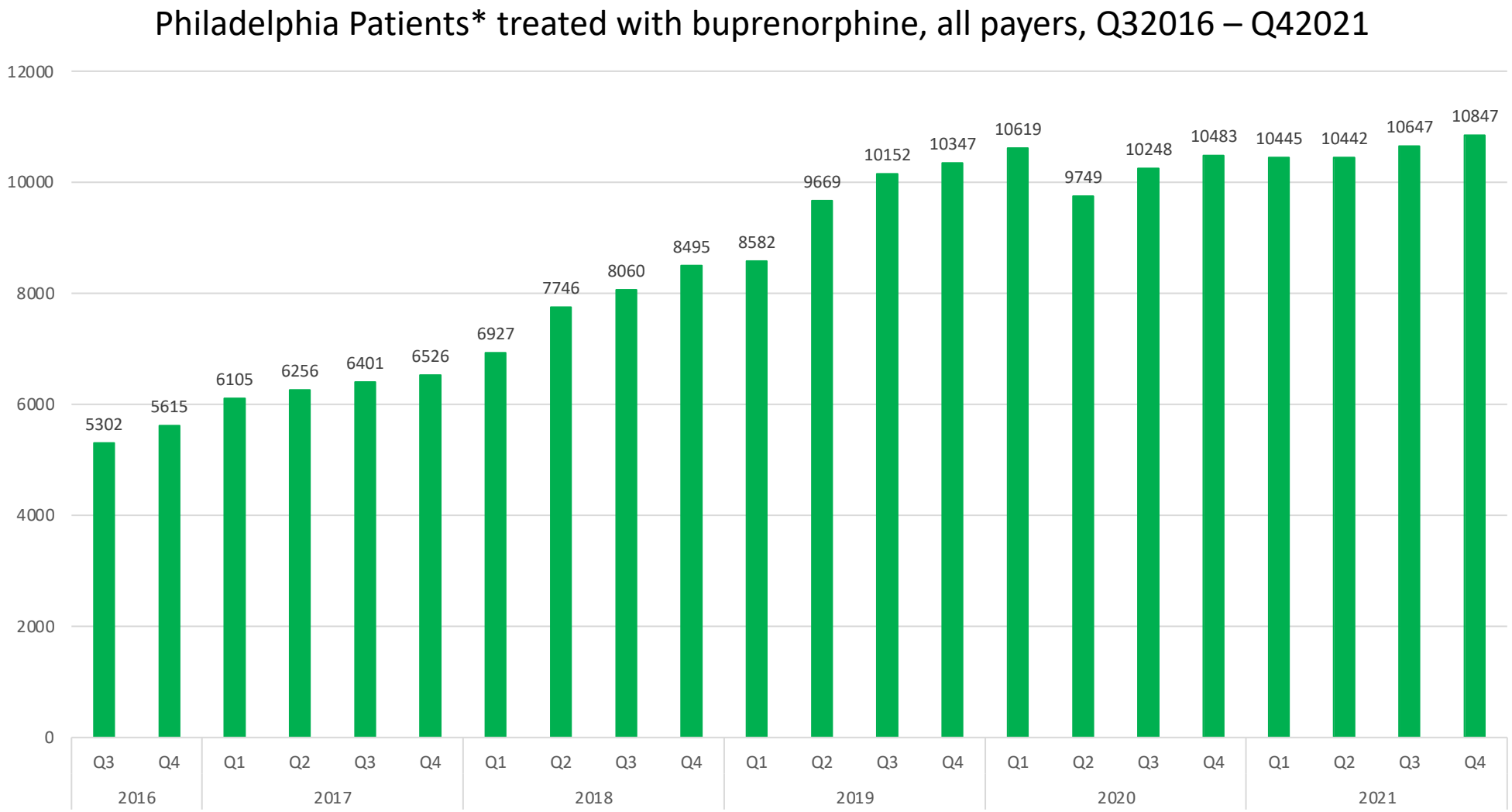
The number of prescribers have increased...



Department of Public Health

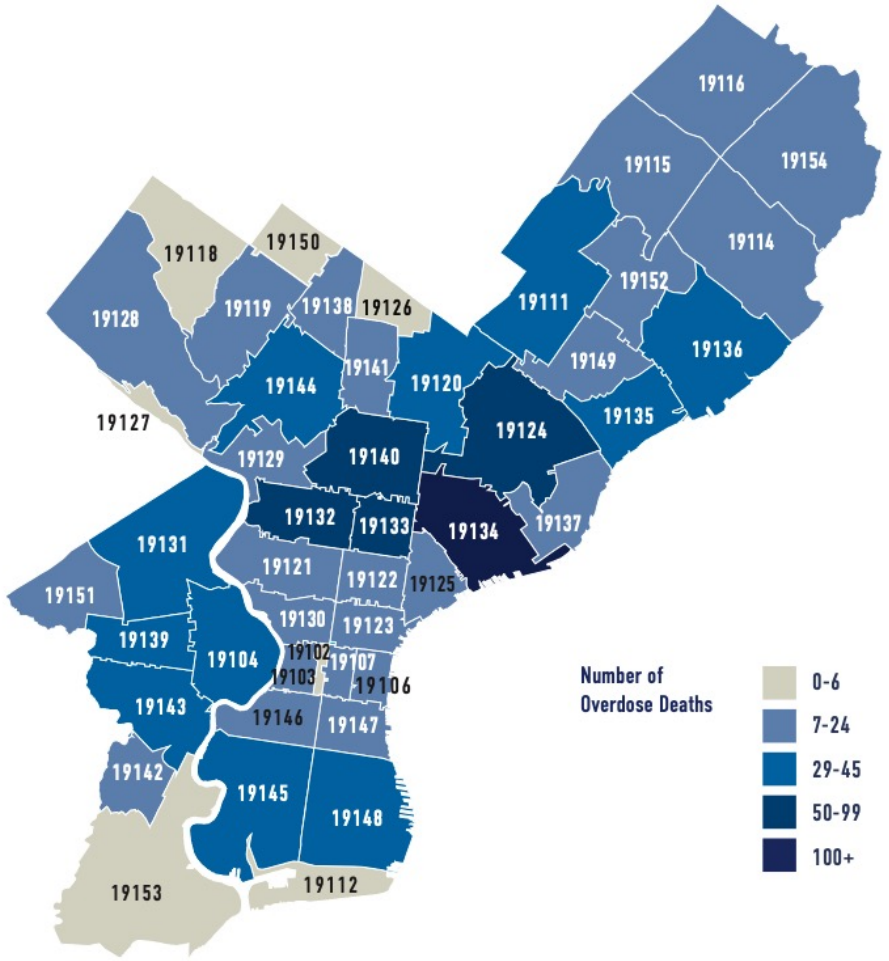
DEA

…though the number of patients has plateaued



While treatment capacity has increased, low barrier options needed

FIGURE 26
NUMBER OF OVERDOSES BY INCIDENT LOCATION, 2020



Department of Public Health

Early telemedicine and SUD care in Philadelphia

2020

Early in COVID, telehealth used to fill gaps in care created by disruptions in treatment access and decarceration

Penn Medicine's Virtual Bridge to Opioid Recovery

July 07, 2020 | by Frank Otto

In a word, **Nicole O'Donnell** is *personable*. As a recovery specialist for Penn Medicine's Center for Opioid Recovery and Engagement, she is, in many ways, the face of the program. When those with opioid use disorder enter a downtown Penn Medicine emergency room, she's often the person who first touches base with them about potentially starting recovery. She's also the one who keeps tabs on patients as they move forward. Sometimes, she'll stay in contact with a patient for years.

Early telemedicine and SUD care in Philadelphia

2021

- Closure of several high-volume buprenorphine clinics prompted use of telehealth to rapidly reconnect patients to care
- Collaboration with the state and local health departments

Department of Public Health
CITY OF PHILADELPHIA

Philadelphia Department of Public Health
Health Commissioner's Office

THOMAS A. FARLEY, MD, MPH
Health Commissioner

KENDRA VINER, PHD, MPH
Director, Division of Substance Use Prevention and Harm Reduction

Health Alert

Closure of Suboxone Practices in Philadelphia
March 1, 2021

If you are a patient who is prescribed buprenorphine (suboxone) and have lost access to care, help is available.

The **Patient Advocacy Program** can help you decide what to do next.

Monday through Friday 8:00 AM- 4:00 PM, email **ra-dh-advocacy@pa.gov,** or call **844.377.7367, option 3.**

Visit **bit.ly/patientadvocacyPA** for more information and resources.

Avoid Opioid Overdose	Find Drug Treatment
Naloxone can reverse an opioid overdose and is available through a state-wide standing order, which means you do not need a prescription. Most pharmacies carry naloxone. **For more information, visit: PA.gov/opioids**	24/7 help is available for those battling substance use disorder. **Call: 1.800.662.4357** **Or visit: ddap.pa.gov**

pennsylvania DEPARTMENT OF HEALTH

If somebody has taken drugs and becomes unresponsive, **call 911 immediately.**

Center for Addiction Medicine and Policy

PLEASE CALL: 267-584-2688 TO BE CONNECTED TO SUBOXONE/NARCAN NAVIGATION

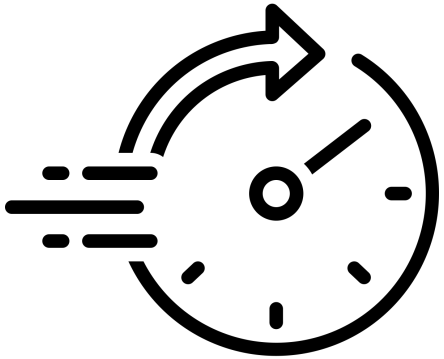
TO ACCESS MOBILE SUBOXONE VAN

Visit 60th & Market Streets
Wednesdays 1 pm - 4 pm

HARM REDUCTION TIPS:

- **DON'T USE ALONE**
- **CARRY NARCAN**
- **FENTANYL IS IN MOST STREET DRUGS**

Lessons learned



Same-day access to medication treatment

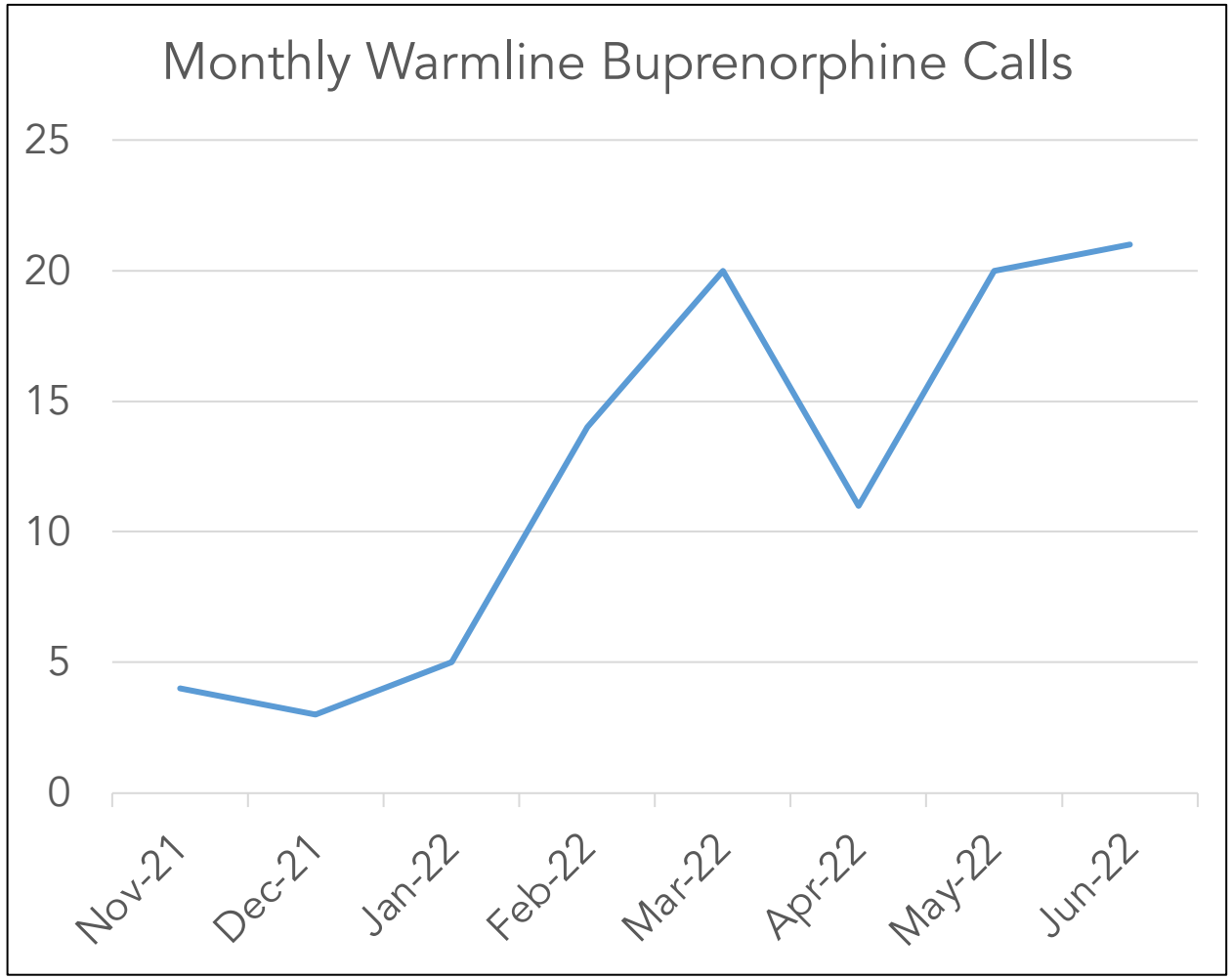
Close touch from experienced navigators

CareConnect Warmline

- Callers connected to Substance Use Navigators
- Same day access to buprenorphine
- Fill gap between patient call and community MOUD appointment
- Ensure patients do not lose access to medication
- Tailored referral to longitudinal treatment (specialty behavioral health or primary care-based)
- Harm reduction resources
- Patients or providers can call for help

Engagement with warmline increased during soft roll-out

- 184 total encounters
- 86 non-prescription encounters
- 98 buprenorphine encounters
- 125 prescriptions written



Caller Demographics (n=98)

Characteristics	%
Age (mean)	39.6
Male Gender	65%
Race	
Black	34%
White	54%
Other	12%
Hispanic Ethnicity	38%
Insurance	
Medicaid	79%
Commercial	5%
Medicare	2%
Other/None	13%
Housing Status	
Permanent	71%
Housed but Unstable	12%
Unhoused	4%
Other/Unknown	12%

Outcomes

- 100% of patients triaged to telehealth encounter received buprenorphine prescription
- 94% of patients picked up initial buprenorphine prescription within 7 days
- 57% of patients filled at least one additional buprenorphine prescription within 30 days of encounter
- 49% had an active buprenorphine prescription at day 30 (pending for recent patients)

Growth expected with programmatic expansion, beyond word-of-mouth

Penn Medicine partners with health department to expand virtual 'bridge clinic' for people with substance use disorder

By Zoë Read · May 20, 2022

A sign at the Hospital of the University of Pennsylvania in Philadelphia, Wednesday, Feb. 6, 2019. (AP Photo/Matt Rourke)

Observations and Conclusions

- Telemedicine SUD care is an important component of Philadelphia's efforts to ensure low-barrier access to evidence-based treatment for all city residents
- Supporting an experienced, innovative and thoughtful partner organization was key to the successful launch of the warmline
- Impact of substance use navigators/certified recovery specialists cannot be overstated
- Partnership between health system and health department opened doors to new referrals, both into and from the warmline
- Challenges include need to expand/enshrine telemedicine policy as well as sustainability

Thank you

Division of Substance Use Prevention and Harm Reduction
Philadelphia Department of Public Health
www.phila.gov/opioids

Department of Public Health

Panel Q&A

Please submit questions using the Q&A function.

THANK YOU!

Robert Baillieu
Physician and Senior Clinical and Practice Advisor
SAMHSA/CSAT/OD

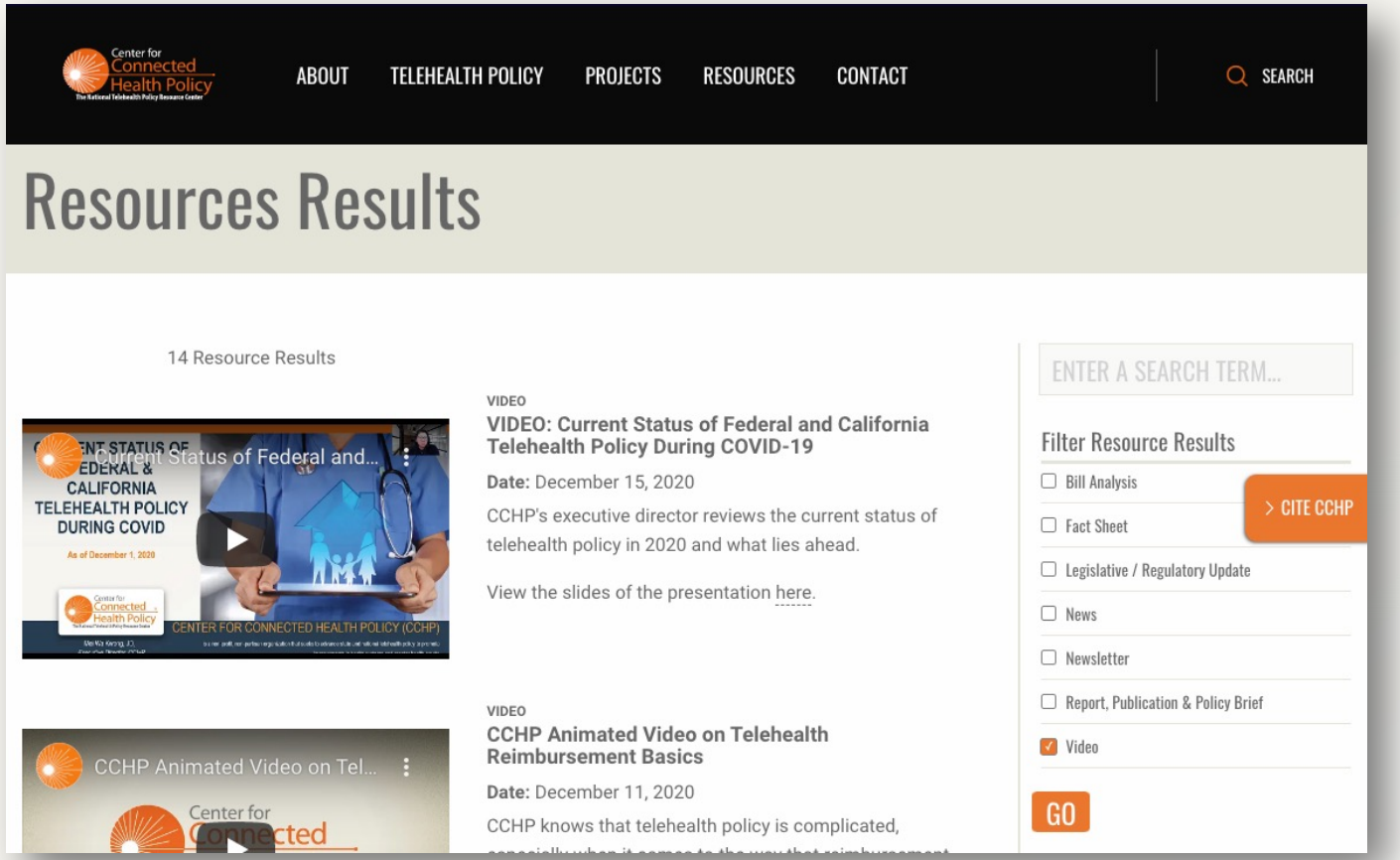
Patricia Gann
Deputy Director, Division of Aging, Adult and Behavioral Health Services
Arkansas Department of Human Services

Jennifer Shuler
Nurse Practitioner, Division of Aging, Adult and Behavioral Health Services
Arkansas Department of Human Services

Elizabeth Pitman
Division Director, Division of Medical Services
Arkansas Department of Human Services

Jeffrey Hom
Medical Director of the Division of Substance Use Prevention and Harm Reduction
Philadelphia Department of Public Health

Webinar Recordings and Resources



Subscribe to CCHP's email listserv or stay tuned to CCHP's resources page for recordings of this webinar and presentation slide decks!

Remember to fill out the evaluation form!

Previous CCHP webinars available on website or YouTube channel.

Center for Connected Health Policy
The National Telehealth Policy Resource Center

EVALUATION FORM

Please don’t forget to fill out your evaluation form!

Thank you and have a great day!

Center for Connected Health Policy
The National Telehealth Policy Resource Center