ARTS
Addiction and Recovery Treatment Services

The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant

SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: STARTING UP AN OFFICE-BASED OPIOID TREATMENT PROGRAM

MARCH 15, 2021

Department of Medical Assistance Services

Welcome & Meeting Information

- WebEx participants are muted
  - Please use Q&A feature for questions
  - Please use chat feature for technical issues
- Focus of today's presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmas.virginia.gov/#/ARTS
- We are unable to offer CEUs for this webinar series

Disclaimer

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,836,765 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey.

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!

Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training
  - https://getnaloxonenow.org/
    - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422
  - Available only to Virginia residents, intramuscular administration

Website Update

DMAS Home Page: https://www.dmas.virginia.gov/#/index

ARTS Home Page: https://www.dmas.virginia.gov/#/arts

SUPPORT Act Grant Website - https://www.dmas.virginia.gov/#/artssupport

SUPPORT Act Grant Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

Grant Components

- Needs assessment
- Strengths-based assessment
- Activities to increase provider capacity

Period of Performance

September 2019 - September 2021

Grant Email

SUPPORTgrant@dmas.virginia.gov

Information

- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia's SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

Resources

- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]

Monthly Stakeholder Meetings

- October 2020 [pdf]
- September 2020 [pdf]
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [pdf]

Fall 2020 Webinars

- Video: How to Set Up a Preferred OBOT Webinar
- Slide Deck: How to Set Up a Preferred OBOT Webinar [pdf]
- Video: Hepatitis C Treatment Webinar
- Slide Deck: Hepatitis C Treatment Webinar [pdf]
- Fall 2020 Webinar Schedule [pdf]

SUPPORT 101 Webinars

- Session Twenty: "Novel" Substances [pdf]
- Session Nineteen: SUD & LGBTQ+ Clients [pdf]
- Session Eighteen: SUD & Legally-Involved Clients [pdf]
- Session Seventeen: Alcohol & Cannabis [pdf]
- Session Sixteen: SUD and The Family [pdf]
- Session Fifteen: SUD & Cultural Humility [pdf]
- Session Fourteen: Addressing SUD Stigma and Building Provider Empathy [pdf]
- Session Thirteen: Group Therapy Skills [pdf]
- Session Twelve: Individual Therapy Skills [pdf]
- Session Eleven: Co-Occurring Disorders [pdf]
- Session Ten: Screening and Assessment for SUD [pdf]
- Session Nine: SUD Treatment Introduction [pdf]
- Session Eight: Opioids and Stimulants Overview [pdf]
- Session Seven: Substance Use Disorders (SUD) Overview [pdf]
- Session Six: Providing Trauma-Informed Care [pdf]
- Session Five: Withdrawal Syndromes [pdf]
- Session Four: Crisis and Deescalation [pdf]
- Session Three: Suicide Assessment and Screening [pdf]
- Session Two: Client Engagement [pdf]
- Session One: Tele-Behavioral Health in the time of COVID-19 [pdf]
- Dr. Mishka Terplan - Pregnant and Postpartum Care for SUD during COVID-19 [pdf]
- Dr. Mishka Terplan - HIV and HCV Updates [pdf]
- Dr. Mishka Terplan - Chronic Pain and Addiction Treatment [pdf]

Hamilton Relay Transcriber (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.

Presenters

- **Paul Brasler**, MA, MSW, LCSW. Department of Medical Assistance Services (DMAS) SUPPORT Grant Team Behavioral Health Addiction Specialist
- **Ke'Shawn Harper**, BA, MIS, GCertPPCM, GCertPAP, QMHP-A. DMAS Addiction & Recovery Treatment Services (ARTS) Senior Policy Specialist
- **Adam A. Creveling**, MSW, CPRS. Department of Medical Assistance (DMAS) SUPPORT Act Grant Program Specialist

Program Content

I. Why Start an OBOT?
II. What You Need to Have to Start an OBOT
III. Getting the Ball Rolling
IV. Challenges You May Face
V. Integrated Care & Care Coordination
Peer Recovery Specialists
Contingency Management

Language

- We believe in using "Person-Centered language" as much as possible, thus:
  - Not "Addict," but **Person who uses drugs** or **Person with a substance use/behavioral disorder**
  - Not "Addiction," but **Substance Use Disorder (SUD)**
  - Not "Clean," but **In Recovery** or **Testing Negative**
  - Not "Dirty," but **Testing Positive**
  - Not "Relapse," but **Recurrence** or **Return to Use**
- At the same time, out of habit, we may inadvertently use some of these older words/terminology—and some of the sources we quote use older terms
- Be cognizant that some people may describe themselves as "alcoholics," "junkies," etc.

Two Important Things You Must Do Before Working With Any Client

I. **You must care!** You must like people in general regardless of their circumstances, behaviors or opinions of you
II. **Find something to like** in the person you are working with—connect with them on a human level

NO ONE

sets out to become addicted to chemicals or behaviors

Myths & Stereotypes

- Drug exposure alone causes SUD
- Drug treatment does not work
- We are winning the "War on drugs"
- Addiction is completely a choice
- Addiction is totally due to genes
- A person can love someone enough to change them
- Most people with SUD are homeless and/or unemployed
- A person will only stop using drugs when they "hit bottom"

Addiction Defined: ASAM

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

Recovery Defined

"…A lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in an ongoing quest for a better life."

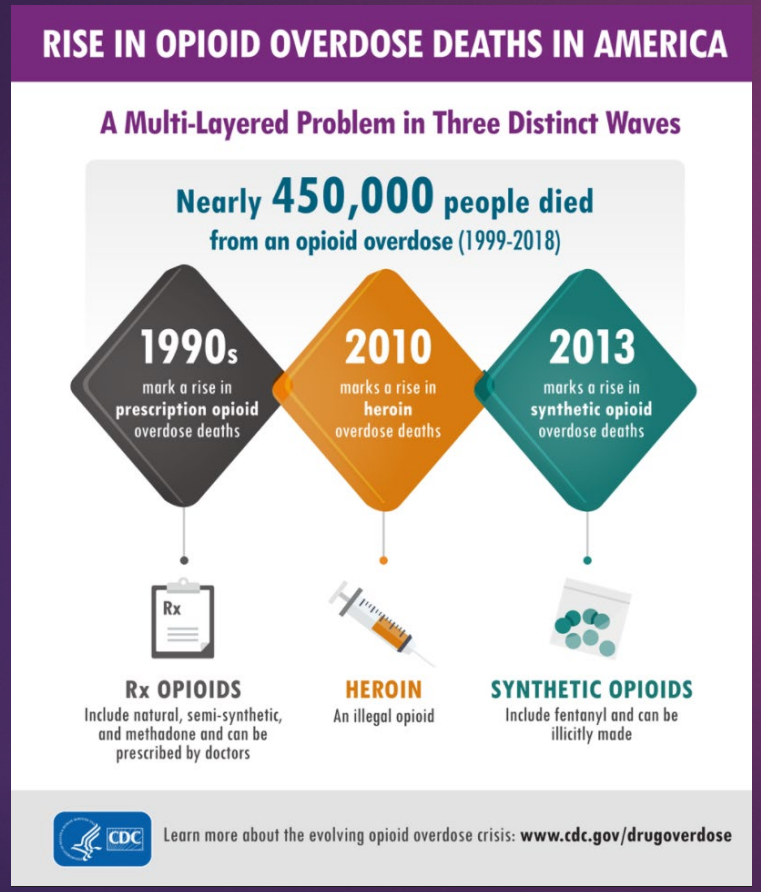
(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)

I. Why Start an OBOT?

Opioids: Mortality & Morbidity (ASAM, 2020)

- In 2019, an estimated 10.1 million people in the U.S. misused opioids, with 3 million meeting criteria for Opioid Use Disorder
- In 2019, 49,860 people died of overdoses that involved opioids
  - Fentanyl and fentanyl analogs accounted for 36,359 of these deaths
- Drug overdose deaths involving heroin rose from 1,960 in 1999 to 15,469 in 2016. Since 2016, the number of deaths has trended down with 14,019 deaths reported in 2019
- Drug overdose deaths involving prescription opioids rose from 3,442 in 1999 to 17,029 in 2017. From 2017 to 2019, however, the number of deaths dropped to 14,139

Opioids: Mortality & Morbidity continues



- Over 81,000 drug overdose deaths occurred in the United States in the 12 months ending in May 2020
  - The highest number of overdose deaths ever recorded in a 12-month period.
- 128 People every day from an opioid overdose
- Drug overdose deaths now exceed those attributable to firearms, car accidents, homicides, or HIV/AIDS
- More Americans died from a drug overdose in 2017 alone than died in the entire Vietnam War

Stigma Defined

"Stigma is a social phenomena whereby individuals who deviate from the accepted norm are perceived by society as less desirable and are judged or punished accordingly"
(Avery & Avery, 2019, p. 94)

Why is This Important?

Remember what we started with: People matter, regardless of what they are going through

Stigma is the main reason that people with SUD do not seek treatment

Bias/Stigma → Prejudice → Discrimination

Ways Stigma Manifests (Avery & Avery, 2019)

- Self-Stigma
- Family Stigma
- Language
- Stigma in the Medical Community
- Stigma in SUD Treatment
- Stigma & Race
- Stigma in the Legal System
- Stigma in the Workplace
- Stigma in the Media

Model of SUD Dictates the Approach to Treatment/Intervention

Moral Model (Avery & Avery, 2019, p. 96)

Model of SUD Dictates the Approach to Treatment/Intervention

Biopsychosocial Model (Avery & Avery, 2019, p. 96)

Stigma of MAT & SUD

- Stigma kills people by reducing the likelihood of their seeking treatment
- Treatment providers should model positive behavior by treating people with SUD like anyone else who has a chronic medical illness
- Early on in treatment, educate everyone on the medical aspects of addiction to help focus on improved health instead of the stigmatizing concept of moral choice
- Encourage positive language such as saying “You are a person in recovery” instead of “You’re an addict”
- Educate staff and community about addiction and MAT treatment
- Reinforce confidentiality with your patients and explain how you would interact with them in a public setting

Pharmacotherapy
(Medication-Assisted Therapy)

Pharmacotherapy for Opioid Use Disorder

- Methadone and Buprenorphine (the active ingredient in Suboxone) are both opioids—human-made chemicals that are like opiates (medicines made from opium)
- Methadone was approved for opioid use disorder treatment in 1947 and Buprenorphine in 2002
  - Used for opiate withdrawal management in inpatient settings and maintenance treatment in outpatient settings
  - Given by a licensed provider and administered in oral form (an injectable form of buprenorphine is available)
- Behavioral health treatment is an important part of MAT, but clients should **not** be forced to receive counseling to be able to receive pharmacotherapy

Methadone & Buprenorphine Therapies

- The use of either chemical as part of opioid treatment is called Medication-Assisted Treatment (MAT) and has been recognized and accepted by the medical community for decades
- Methadone and Suboxone act as opioid agonists: They keep the client from experiencing opioid withdrawal symptoms (also called "dope sickness") and block the euphoric effects should the client use heroin or another opioid, thus discouraging the client from continuing use
  - **Neither of these chemicals, when used as prescribed, will get the client high**
- Both chemicals allow the brain to heal from opioid misuse and provide opportunities for the client to address the underlying causes of their SUD

Buprenorphine

- An **opioid agonist** in low doses and an **antagonist** in high doses, often combined with Naloxone: Suboxone®
  - In this formulation, should the patient try to inject the drug (instead of taking it orally), they will theoretically go into withdrawal symptoms (but people have found ways around this)
  - Suboxone is delivered in a buccal film or pill
  - Less respiratory depression than Methadone
- Has a "ceiling effect" (at 32 mg) which makes overdose less likely—except when mixed with alcohol
- In 2017, the Food and Drug Administration approved Sublocade®, an injectable form of buprenorphine

Buprenorphine
(Andraka-Christou, 2020, p. 44)

- "Buprenorphine has greater affinity for the brain's opioid receptors than other opioids, meaning it binds more tightly to the receptors, so it displaces other opioids already on the brain's receptors, after which it blocks the effects of subsequent opioids"
- "Even though buprenorphine has greater *affinity* for the opioid receptor, it actually has weaker intrinsic *activity* [italics in original] at the opioid receptors relative to methadone, meaning it creates less cellular activity, so people with OUD taking buprenorphine as prescribed are less likely to feel euphoria than people taking methadone as prescribed"

Barriers in Buprenorphine Treatment

- Not enough providers prescribing medication
- Stigma
- Concerns about diversion-related dangers (often unfounded)
- Rigid program requirements (Jakubowski & Fox, 2020):
  - Abstinence as a treatment goal/No positive UDS
  - Must attend counseling (either before starting medication or to continue medication)

(ASAM highly recommends same-day treatment access)

  - Must attend outside/peer-support groups

Naltrexone & Naloxone

- These opioids only have antagonistic properties; they will cause an opiate user to go into withdrawal (Naloxone) if administered while the person is using opioids or will block the effects of opioids (Naltrexone)
- **Naltrexone** (Vivitrol®) is a deterrent, and is used to prevent relapse by limiting cravings
  - Also blocks the euphoric effects of opioids, cocaine, and alcohol
  - Time-release injectable versions and implant versions are available
- **Naloxone** (Narcan®) is injected or used intra-nasally to reverse an opiate overdose

II. Requirements to Start an OBOT

ARTS OBOT Requirements for Preferred OBOT Providers

- **Setting:** Primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHC), Community Services Boards (CSB), Health Departments, and physician offices
  - **No separate licensing requirement is required**
- **Support Systems:** Access to emergency medical and psychiatric care and connections for referrals to higher levels of care
- **Staff Requirements (minimal):**
  - Licensed buprenorphine-waivered practitioner
  - Licensed behavioral health professional

ARTS OBOT Requirements (continued)

- **Therapies:**
  - Individualized patient centered assessment and treatment
  - Max dose buprenorphine/naloxone dose of 24mg (unless documented rationale)
    - Mono-product used only with a few exceptions
  - Medications for physical or mental health disorders are provided onsite or referred out
  - Cognitive, behavioral, and other SUD psychotherapies are provided on an individual, group, and/or family basis
  - Screening for HIV, Hepatitis B and C, TB at treatment initiation and annually
  - Care coordination with interdisciplinary care planning
    - Can be done by treatment team or a specific Substance Use Care Coordinator that then meets with the interdisciplinary team monthly)

ARTS OBOT Requirements (continued)

- Risk Management and Adherence Monitoring:
  - Routine and/or random urine drug screens a minimum of 8 times per year (UDS are used to engage clients in treatment and should not be punitive)
  - Check Virginia Prescription Monitoring Program (PMP) at least quarterly on all patients
  - Opioid overdose prevention education and naloxone prescription for all patients
  - Patients see Medical or BH practitioner at least weekly for first 3 months, then with documented stability can space out to minimum of monthly visits
  - Maintenance therapy for transfer and existing patients
  - Periodic monitoring of unused meds and opened medication wrapper counts when clinically indicated

Assembling Your OBOT Team

- **Medical and Licensed Behavioral health practitioners are required**
- **Optional but helpful team members:**
  - Substance Use Care Coordinator
  - CSAC
  - Nurse; Medical Assistant; Lab tech
  - Pharmacist
  - Peer Support Specialist (Highly recommended!)
- **Design time for team to work closely together:**
  - Improves individualized integrated treatment planning
  - Reduces patients' ability to manipulate staff
- **Qualities to look for:**
  - Knowledgeable about substance use disorder treatment
  - Understand SUD as an illness and not a moral failure
  - Team Players
  - Manage difficult patient personalities well

Setting Up Services

- **Referrals:** How will they come in, who will be responsible for them?
  - **How quickly can we initiate treatment for new clients?**
- Orientation/Intake/Triage: Walk-in or scheduled? Who is the first contact? How are current clients able to access the program?
- Behavioral Health Assessment: Includes ASAM multidimensional assessment, substance misuse history, mental health history
- Physical Health Assessment: Includes medication management (dosing, withdrawal management, induction and required medical screenings)
- Risk management: When and how many drug screens are utilized? Which lab is used? Who handles PMP monitoring, overdose education, counting opened med wrappers?
- Channels of communication between team members
- Community Supports: Will you require them?

Customizing Your OBOT

Take the OBOT requirements and examples of functioning OBOTs and then design a program that works for your clinic and patient needs

III. Getting the Ball Rolling…

…AND DEALING WITH ISSUES AS THEY ARISE

Treatment: An Introduction

People with SUD may engage and dis-engage in treatment during their illness; knowledge gained during treatment can be cumulative, therefore this back-and-forth pattern should not be viewed as treatment failure

Creating an Inviting Atmosphere

- The clinic/practice environment needs to be warm and inviting to participants
- Think about what makes you feel at ease when you are at a medical provider—the same thing goes for your clients!
- All staff at your clinic need to be on board and supportive in meeting the needs of clients with SUD

ASAM Assessment Recom-mendations (ASAM, 2020, p. 26)

Comprehensive assessment of the patient is critical for treatment planning

However, completion of all assessments **should not delay** or preclude initiating pharmacotherapy for opioid use disorder

If not completed before initiating treatment, assessments should be completed soon thereafter

Medication Induction

- When OBOTs were initially set up, medication was always started (also called induction) in the office
- As providers became more comfortable with clients starting medication, the pattern shifted to home induction, which is evidenced-based practice at this time
- Following an assessment, the medical provider writes a prescription, which the client fills and the client then starts taking the medication **after** they begin to experience withdrawal symptoms

Behavioral Health Therapies

- Can be Group or Individual therapy
- Weekly for at least 3 months and then minimum monthly, but can be more
- Groups can be process-based or use a variety of SUD treatment approaches such as skills building, relapse prevention, addiction education
- Some programs use a phase system that has clients start with weekly (or more) contact with the clinic, and contacts decrease as the client progresses through the program

Individualized Treatment Planning

- Individualized Service Plan (ISP)
  - Completed within 24 hours of admission to OBOT
  - Roadmap for the IPOC
  - Completed by a Credentialed Addiction Treatment Professional based on the ASAM multidimensional assessment done at intake.
- Individualized Plan of Care (IPOC)
  - Completed within 30 days from the ISP by a Credentialed Addiction Treatment Professional
  - Reviewed every 90 calendar days
  - Written representation of the interdisciplinary treatment team meetings
    - This can be done using a progress note
  - Supports the monthly billing of the Substance Use Care Coordination
  - Counts towards the 90 day ISP review requirement

Drug Screens

Purpose of Drug Testing

- **No form of drug testing is accurate 100% of the time**
- Drug testing can be a part of the therapeutic process, and should **not** be used punitively in therapeutic settings
- From a therapeutic standpoint, a drug test can be used to verify the client's transparency and provide opportunities for more effective treatment:
  - "I am glad that you consistently keep your appointments and you are working hard. I noticed that your UDS indicated that you have recently used cocaine. You mentioned to me last week and today that you stopped using weeks ago. Remember, I am not the police, so the results stay here, so help me understand what's going on."

Urine Drug Screens

- The cheapest and easiest-to-use form of drug testing
- There should be a testing protocol in place for your agency before you use these tests
- UDS have limited value if the person is not directly observed giving the sample
- Randomized sampling, as opposed to scheduled testing, is more likely to limit tampering

UDS: Point of Care

Point-of-Care [POC] urine drug testing (e.g., immunoassay) uses antibodies to locate metabolites of drugs the person may have used

The possibility of a false-positive (or a false negative) varies, so POC tests should be verified by lab tests (see next slide): **Do not make treatment or legal decisions based on a POC test alone!**

Be aware that many chemicals/agents are available to add or substitute in a sample to create a false reading

Lab Testing

- Gas Chromatography/Mass Spectrometry Combined (GC/MS) is the industry-standard for drug testing
  - Very sensitive and accurate
  - Expensive and time-consuming
  - GC/MS can also provide levels of a drug in the sample
- Understand that levels can decrease and increase without the client consuming more of a substance between tests
  - This variation in levels depends on several factors, including the person's metabolism
- Once a specific cut-off for the test is established the test should only be read as **positive or negative**

IV. Challenges You May Face

Continued Use of Substances

- See recovery as a process, therefore stopping misuse of opioids could take time
- Conduct regular and random UDS
- Structure your setting to limit the possibility of people tampering with their sample (e.g., observed screens, colored water, limited hiding spaces, etc.)
- Encourage transparency with clients and extra support after relapse instead of appearing punitive
- No specified limit of positive screens (no "three strikes and you're out!")
- Treatment team should see continued positives as a sign for a need for a possible higher level of care and refer patient out with opportunity to return when complete

Client Relationships

- Encourage group members to be supportive of each other
- Do not place people who are related to one another, who are roommates with each other, who are in a romantic relations with one another, or have a violent or traumatic history with one another in the same group
- In situations where romantic relationships develop in a group, ask one of the participants to move to another group

Not Taking Prescribed MAT Medications

- Testing negative for MAT medications indicates that the client may be diverting their medication
- Check in with the client to see if they taking the medication correctly
- This could indicate a need for a higher level of care

Termination/Discharge from the OBOT

If a client is terminated or discharged, the decision should be among the treatment team facilitating a warm hand-off to another program or a higher level of care, unless violence or other presenting issues as mentioned below

Termination/Discharge from the OBOT

Don't be quick to discharge patients

- See continued use of substances a possible part of the client's illness: Would you stop treatment for a person with asthma, hypertension or diabetes because of treatment non-adherence
- A client's use of benzodiazepines should not keep them from entering an OBOT and they can be gradually tapered
- Recovery takes time and has relapses like most chronic illnesses
- However, there are times when discharge can be considered:
  - Violence or threats of violence against staff or patients can warrant discharge
  - Brining illicit substances onto clinic property
  - Repeated incidents of not following program requirements after much encouragement and support

Community Resistance to MAT Services

- Have a clear message ready to articulate the structure, goals and evidence of MAT programs
- Emphasize the risk management strategies used by your OBOT
- Personally reach out to community organizations and offer education on your OBOT, SUD, and the OPIOID epidemic
- Provide details about your OBOT to possible referral sources
- Share success stores with local media outlets with press releases or radio spots
- Personally visit local pharmacies to explain your program's medication controls and polices and build communication channels with pharmacists
- Faith communities can be an important ally in their communities

V. Integrated Care & Care Coordination
Peer Recovery Specialists
Contingency Management

Primary Care & Other Services

- Clients should have a primary care provider
- If PCP is not in the clinic/practice, you will need to coordinate care and inform PCP of MAT treatment (with consent)
- OBOT is a prime location to facilitate Hepatitis C treatment
- Birth control information and contraceptives are strongly encouraged
- Dental services are also very helpful for clients
- Housing services can also be helpful

Clinic Huddles/Treatment Team Meetings

- The interdisciplinary team needs to meet on a regular basis to staff each patient for treatment planning and any concerns
- This can be done with or without the patient present
- It is important to schedule this so it doesn't get left up to chance
- Also schedule time for discussing program concerns and needs

SUD Care Coordination

- Insure interdisciplinary care planning and communication
- Assess patient's needs and available resources
- Refer to community resources such as support groups, social services, CSBs
- Support patient's medical, behavioral health, and other care needs with referrals for overall biopsychosocial needs such as food, child care, housing, employment, transportation
- Track and support patient's services outside the OBOT
- Refer to higher levels of care and discharge planning if/when necessary

Recovery Along the Treatment Continuum of Care

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Recovery Orientated Systems of Care (ROSCO)

- *A ROSCO is a network of community-based services and supports that is person-centered and builds on strengths and resiliency of individual, family and communities to achieve abstinence, and improved health, wellness and quality of life for those with or at risk of alcohol and drug problems.*
- Person-Centered Approach
- Self-Directed Approach
- Strengths-based Approach

http://www.williamwhitepapers.com/pr/CSAT%20ROSC%20Definition.pdf

Recovery Orientated Systems of Care (continued)

- Participation of family members, care givers, significant others, friends and the community
- Collaborative Decision Making
- Individualized and comprehensive services and Supports
- Community based services and supports
- Continuity of services and supports
- Recovery community/peer involvement

Integrating a Culture of Recovery

- Lived experience with SUD and MH viewed as an asset not liability to advance programs and influence policies
- Micro-aggressions and unconscious bias:
  - Not letting individuals have access to the computer system in the same way a similarly-trained employee would)
  - Individuals are tokenized
  - Not hiring individuals with a criminal record

Integrating a Culture of Recovery (continued)

- Hiring former clients to be part of the treatment team (recovery champions)
- Reinforcing recovery language throughout the agency:
  - Language and tone can significantly impact clients retention in treatment in addition to enhancing the therapeutic relationship
- Treatment setting atmosphere also conveys a message of hope and resiliency

Peer Recovery Support (PRS)

Peer support workers are people who have been successful in the recovery process and help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

Peer Recovery Support (PRS) (continued)

- Peer support interventions can positively benefit substance use outcomes and quality of care
  - Reduce inpatient services
  - Improve relationships among provider and patient
  - Sustain engagement in care
  - Increase levels of resiliency and empowerment
  - Higher levels of hope in recovery outcomes
  - Higher levels of patient participation in treatment
  - Additional goal obtainment after treatment

Benefits of Peer Support

- Increase access and engagement in primary care in lieu of emergency services
- Bridge capacity from emergency services into treatment
- Reduce Psychiatric Rehospitalization
- Reduce Criminal Justice involvement and recidivism
- Increasing Harm Reduction Life Saving Practices
  - Naloxone (Narcan)
  - Needle exchange services
  - HIV and HEP C interventions

https://link.springer.com/article/10.1007/s10597-013-9616-4

IS PEER RECOVERY COACHING EFFECTIVE?

People who have worked with peer recovery coaches provide strong testimonies of the positive impacts of peer recovery support on their own recovery journeys. The research supports these experiences. While the body of research is still growing, there is mounting evidence that people receiving peer recovery coaching show reductions in substance use, improvements on a range or recovery outcomes, or both. Two rigorous systematic reviews examined the body of published research on the effectiveness of peer-delivered recovery supports published between 1995 and 2014. Both concluded that there is a positive impact on participants (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Reif et al., 2014).

Two rigorous systematic reviews examined the body of published research on the effectiveness of peer-delivered recovery supports published between 1995 and 2014. Both concluded that there is a positive impact on participants (Bassuk, Hanson, Greene, Richard & Laudet, 2016; Reif et al, 2014) ...Taken as a whole, the current body of research suggests that people receiving peer recovery support may experience:

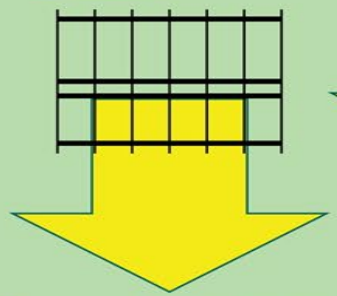
Improved relationship with treatment providers
(Sanders et al., 1998; Andreas et al., 2010)

Increased treatment retention
(Mangrum, 2008; Deering et al., 2011; Tracy et al., 2011)

Increased satisfaction with the overall treatment experience
(Armitage at al., 2010)

Improved access to social supports
(O'Connell, ND; Boisvert et al., 2008; Andreas et al., 2010)

Decreased emergency service utilization
(Kamon & Turner, 2013)



Decreased criminal justice involvement
(Rowe, et al., 2007; Mangrum, 2008)

Reduced relapse rates
(Boisvert et al., 2008)

Reduced re-hospitalization rates
(Min et al., 2007)

Reduced substance use
(Bernstein, et al., 2005; Boyd et al., 2005; Kamon & Turner, 2013; Mangrum, 2008; O'Connell, ND; Rowe, et al., 2007; Armitage at al., 2010)

Greater housing stability
(Ja et al., 2009)

REFERENCES

Armitage, E. V., Lyons, H., & Moore, T. L. (2010). Recovery Association Project (RAP), Portland, Oregon. *Alcoholism Treatment Quarterly, 28*(3), 339–357.

Bernstein, E., Bernstein, J., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence, 77*(1), 49–59.

Boisvert, R. A., Martin, L. M., Grosek, M., & Claire, A. J. (2008). Effectiveness of a peer-support community in addiction recovery: Participation as intervention. Occupational Therapy International, 15(4), 205–220

Boyd, M. R., Moneyham, L., Murdaugh, C., Phillips, K. D., Tavakoli, A., Jackwon, K., . . . Vyavaharkar, M. (2005). A peer-based substance abuse intervention for HIV+ rural women: A pilot study. *Archives of Psychiatric Nursing, 19*(1), 10–7.

Ja, D. Y., Gee, M., Savolainen, J., Wu, S., & Forghani, S. (2009). Peers Reaching Out Supporting Peers to Embrace Recovery (PROPSPER): A final evaluation report. San Francisco, CA: DYJ, Inc., for Walden House, Inc., and the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Kamon, J., & Turner, W. (2013). Recovery coaching in recovery centers: What the initial data suggest: A brief report from the Vermont Recovery Network. Montpelier, VT: Evidence-Based Solutions.

Mangrum, L. (2008). *Creating access to recovery through drug courts: Final evaluation report for the Texas Department of State Health Services.* Austin, TX: University of Texas Addiction Research Institute. Retrieved from http://view.officeapps.live.com/op/view.aspx?src=http%3A%2F%2Fwww.utexas.edu%2Fresearch%2Fcswr%2Fnida%2Fdocuments%2FATRFinalEvaluationReport-Final.doc

Min, S. Y., Whitecraft, E., Rothbard, A. B., & Salzer, M. S. (2007). Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal, 30*(3), 207–213. doi: 10.2975/30.3.2007.207.213

O'Connell, M. J., Flanagan, E. H., Delphin-Rittmon, M. E., & Davidson, L. (2017). Enhancing outcomes for persons with co-occurring disorders through skills training and peer recovery support. *Journal of Mental Health,* Epub ahead of print. Retrieved from http://dx.doi.org/10.1080/09638237.2017.1294733

Rowe, M., Bellamy, C., Baranoski, M., Wieland, M., O'Connell, M. J., Benedict, P., . . . Sells, D. (2007). A peer-support, group intervention to reduce substance use and criminality among persons with severe mental illness. *Psychiatric Services, 58*(7), 955–961.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Implementing Peer Services

- Setting Peers up for success within your agency:
  - Successfully pass PRS training
  - Apply and pass certification through the Virginia Certification Board or the National Association of Alcohol & Drug Addiction Counselors
  - Apply to register with the Dept. of Health Professionals Board of Counseling
  - Accredited direct supervisor completes DBHDS Supervisor training as outlined in ARTS manual

Implementing Peer Services (continued)

- Job description and duties reflect scope of practice and core competencies within training and skill set
- Internal training opportunities to bring staff and leadership up to speed on current best practices on peer support
- Track data that tells a story of recovery outputs and outcomes
  - Evidence Based Practices outline peer services as always volunteer

https://link.springer.com/content/pdf/10.1007/BF03391703.pdf

Recovery, Resiliency, and Wellness Plan (RRWP)

- Individualized goals and strategies shall be focused on the member identified needs for self-advocacy and recovery
- Developed by the individual, PRS and direct supervisor within 30 days of the initiation of services describing how the PRS will assist the individual meeting their identified needs
- Reviewed and signed every 90 days as applicable

Recovery, Resiliency, and Wellness Plan (continued)

- Wellness Plan goals may be rendered in the provider's office or in the community, or both
- Rendered on an individual basis or in a group
- Billing shall occur only for services provided with the individual present
- Progress note summarizing purpose and content related to RRWP

Contingency Management

- Capacity to enhance and expand Evidence-Based Practices within a treatment modality
- Program impact potential to be more effective than standard treatment
- Adaptive program structure to match treatment adherence objectives

https://pdfs.semanticscholar.org/24be/8c5af734e7227faa271cf4dcfd741aefa14e.pdf

Contingency Management (continued)

- Magnitude of incentives correlated to drug abstinence
- Long-term behavioral change
- Low program threshold all-inclusiveness celebrating each client along their treatment experience:
  - Everyone who attends treatment today is a success regardless if they consumed chemicals

Contingency Management Benefits

- Incentivizing continuum care utilization
- Improving retention in treatment
- Reduction of drug consumption and regression of drug use intervals
- Fostering and developing a supportive environment within a group treatment setting

Contingency Management Benefits (continued)

- Promoting pro-social, non-chemical related activities:
  - Recovery capital
  - Incentive capability transcends treatment to the outside family
  - Deeper sense of self-worth and achievement
  - Client quote: "*This was the only Christmas gift I received and I earned it*"

SUPPORT Act Grant OBOT Workgroup

- The SUPPORT Act Grant is hoping to convene a workgroup of professionals to look at provision of MOUD in the Commonwealth, including strengths and challenges. The discussion will include:
  - Challenges getting waivered
  - Why some clinicians get waivered but don't prescribe
  - Learn from OBOT successes
  - Identify other problems that SUPPORT Act Grant team can help address
  - Review of relevant data to guide conversations

SUPPORT Act Grant
OBOT Workgroup

We are hoping to convene an initial meeting of this workgroup in November.

We anticipate 3-4 sessions, each lasting 90 minutes

Interested? Want more information?

Please email SUPPORTgrant@dmas.virginia.gov

Resources & References

Our Contact Information

- Paul Brasler:
  paul.brasler@dmas.virginia.gov
- Adam Creveling:
  adam.creveling@dmas.virginia.gov
- Ke'shawn Harper:
  Keshawn.harper@dmas.virginia.gov

Post-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

Post-webinar survey link is in the chat box

Similar to the pre-webinar survey:

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- You are able to complete one post survey per each webinar topic you attend.
- Your completion of the post-webinar survey will enter you into a separate drawing (from the pre-webinar survey) to win a $50 Amazon gift card!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!

References

- American Society of Addiction Medicine. (2020). *The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update*. Rockville, MD: Author.
- American Society of Addiction Medicine. (2017). *Consensus statement: Appropriate use of drug testing in clinical addiction medicine*. https://www.asam.org/quality-practice/guidelines-and-consensus-documents/drug-testing
- Avery, J.D. & Avery, J.J. (eds.). (2019). *The stigma of addiction: An essential guide*. Springer Publishing.
- Herron, A.J. & Brennan, T.K. (2015). *The ASAM essentials of addiction medicine, 2nd Ed.* American Society of Addiction Medicine. New York: Wolters Kluwer.
- Morgan, O.J. (2019). *Addiction, attachment, trauma and recovery: The power of connection*. New York: W.W. Norton & Company.