Virginia Opioid Addiction ECHO* Clinic

June 5, 2020

*ECHO: Extension of Community Healthcare Outcomes
Helpful Reminders

- Rename your Zoom screen, with your name and organization
• You are all on mute please unmute to talk

• If joining by telephone audio only, *6 to mute and unmute
Helpful Reminders

- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions
VCU Opioid Addiction ECHO Clinics

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
- Didactic presentations are developed and delivered by inter-professional experts
- Website Link: www.vcuhealth.org/echo
Hub and Participant Introductions

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<tr>
<th>VCU Team</th>
<th>Details</th>
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<tr>
<td>Clinical Director</td>
<td>Gerard Moeller, MD</td>
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<tr>
<td>Administrative Medical Director</td>
<td>Vimal Mishra, MD, MMCi</td>
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<tr>
<td>Didactic Presentation</td>
<td>Lori Keyser-Marcus, PhD</td>
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<tr>
<td></td>
<td>Courtney Holmes, PhD</td>
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<td>Albert Arias, MD</td>
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<tr>
<td>Program Manager</td>
<td>Ke'Shawn Harper, MS</td>
</tr>
<tr>
<td>Practice Administrator</td>
<td>Jessica Johnson, MA</td>
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<tr>
<td>IT Support</td>
<td>Bhakti Dave, MPH</td>
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<td></td>
<td>David Collins, MHA</td>
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<td>Vladimir Lavrentyev, MBA</td>
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</tbody>
</table>

- Name
- Organization

Reminder: **Mute** and **Unmute** screen to talk

*6 for phone audio
Use chat function for Introduction
What to Expect

I. Didactic Presentation
   Ke’Shawn Harper, MIS
   Jessica Johnson, MA

II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!
Didactic Presentation
Disclosures

Jessica Johnson, MA and Ke’Shawn Harper, MIS have no financial conflicts of interest to disclose.

There is no commercial or in-kind support for this activity.
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
ADDICTION AND RECOVERY TREATMENT SERVICES

Medicaid Reimbursement for Telehealth and Care Coordination

Jessica S. Johnson, M.A. NCC, QMHP-A
ARTS Service Coordinator
Virginia Department of Medical Assistance Services

Ke'Shawn Harper BA, MIS, GCertPPCM, GCertPAP, QMHP-A
ARTS Senior Policy Specialist
Learning Objectives

✓ To provide an overview of substance use care coordination
✓ To review service requirements within Preferred OBOTs and OTPs.
✓ To review provider requirements.
✓ To discuss documentation and billing basics for substance use care coordination.
Who Can Provide Substance Use Care Coordination?

✓ OBOTs

- Addiction treatment services for individuals with a primary opioid use disorder (OUD) provided by buprenorphine-waivered practitioners working in collaboration with CATPs providing psychotherapy and substance use disorder (SUD) counseling in public and private practice settings.

✓ OTPs

- Programs certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) that engage in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of members who are addicted to opioids (12VAC30-130-5020).
What is Substance Use Care Coordination?

✓ Collaboration of the interdisciplinary team who is involved in the member’s treatment. Working closely with the member and their families in organizing the member’s care and services across all treatment settings.

✓ Helping members navigate specialists, hospital departments, outpatient appointments, tests, procedures, medications, follow-up appointments.

✓ Care coordination help to reduce overall cost of treatment, while reducing time away from work and family.

✓ The purpose of care coordination is to help address physical needs, safety needs, social needs, individual values and personal needs throughout treatment.
A bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and
- One year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or;
- One year of clinical experience working with individual with co-occurring diagnoses of substance use disorder and mental illness

Licensure by the Commonwealth as a registered nurse with
- One year of direct experience providing services to individuals with a diagnosis of substance use disorder or;
- One year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness

Certified Substance Abuse Counselor (CSAC), CSAC-Supervisees or CSAC-Assistant under appropriate supervision as defined in 18VAC115-30-10 et seq.

Licensed or Registered Behavioral Health Professionals with the appropriate licensing board
Examples of Primary Staff Responsibilities

✓ Meet face-to-face and utilize telephonic/collateral contacts with the member and significant others to facilitate recovery.
✓ Act as the primary point of contact for the member and the interdisciplinary team in the Preferred OBOT or OTP setting.
✓ Engage members in Substance Use Care Coordination activities as identified in the ISP for OTP settings and the IPOC in Preferred OBOT settings.
✓ Communicate with the member about their ongoing or newly identified needs on at least a monthly basis (or a frequency as requested by the member).
Substance Use Care Coordination

Documentation Requirements

✓ Substance Use Care Coordination supports interdisciplinary care planning meetings between buprenorphine-waivered practitioners and licensed behavioral health professionals.

✓ Interdisciplinary teams can use the IPOC as a recovery oriented tool with planned interventions that align with the member’s identified needs and goals; it is regularly updated as the member’s needs change, and details progress throughout the course of treatment.

✓ Separate documentation must be completed to support and document activities that meet billing requirements.
Substance Use Care Coordination Service Delivery

✓ Participate in interdisciplinary treatment team meetings for care planning at least once every 30 days for each member.
✓ Monitoring the provision of services and assuring the coordination of services and service planning with other providers.
✓ Enhancing community integration and linking the member to community supports.
✓ Assisting the member directly to locate, develop, or obtain needed services, resources.
✓ Ensure that appropriate mechanisms are in place to receive member input, complaints and grievances.
✓ Soliciting and helping to support the member’s wishes.
✓ Knowing and monitoring the member's health status and providing education as needed to support informed decisions.
How to Bill Substance Use Care Coordination

✓ Preferred OBOTs or OTPs may bill for substance use care coordination if they meet all provider and documentation requirements. Providers must use the DMAS IPOC forms to support billing Substance Use Care Coordination (G9012).

✓ Substance Use Care Coordination may not be billed if the member is currently receiving Substance Use Case Management services (H0006) in the same month.

▪ CSBs, BHAs, or private providers with Substance Use Case Management licensing may choose to provide either Substance Use Case Management services (H0006) or Substance Use Case Coordination (G9012) and must follow the program requirements for billing.

▪ OBOTs should have documentation in members record indicating how they are working with the case management provider and how OBOT-related services are being coordinated.

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<tr>
<th>Service</th>
<th>Provider Requirements</th>
<th>Code/Unit</th>
<th>Who Provides the MAT?</th>
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<tr>
<td>Substance Use Care Coordination</td>
<td>OBOT</td>
<td>G9012</td>
<td>• OBOT</td>
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<tr>
<td></td>
<td>OTP</td>
<td>1 unit = 1 month</td>
<td>• OTP</td>
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Interdisciplinary Plan of Care (IPOC) Requirements

✓ The IPOC shall be developed and documented within 30 calendar days from the completed ISP by a Credentialed Addiction Treatment Professional to address needs specific to the member's unique treatment as identified in the initial ISP or the multidimensional assessment as applicable to the ASAM Level of Care. A licensed Credentialed Addiction Treatment Professional must sign off on the Initial IPOC if developed by a Certified Substance Abuse Counselor (CSAC).

✓ The IPOC is an essential documentation and planning tool required to bill Substance Use Care Coordination and shall be reviewed during monthly interdisciplinary treatment team meetings. Completion of the IPOC shall support the monthly billing of the Substance Use Care Coordination (G9012).

✓ Providers may use their own templates as long as all the required components of the care plans are included.
While the IPOC must be reviewed monthly during interdisciplinary treatment meetings, the minimum requirement to update the IPOC is at least quarterly or whenever there is a significant change in the member’s treatment goals and objectives.

The IPOC is considered meeting the comprehensive ISP requirements if it is reviewed and updated every 30 calendar days.

The IPOC must be added to the member's medical record no later than 7 days from the calendar date of the review.
Interdisciplinary Team Staff Requirements

- Physician, Physician Extender and Nurse Practitioner with buprenorphine waiver (required)
- Credentialed Addiction Treatment Professional (required)
  - Includes Residents and Supervisees under the licensed personnel
- Certified Substance Abuse Counselors (CSACs), CSAC-Supervisees (optional)
- Certified Peer Recovery Specialists (optional)
- Registered Nurses / Licensed Nurse Practitioners (optional)
- Pharmacists (optional)

*All staff must practice within their Va Board approved scope of practice.*
COVID-19 Flexibilities

Current state of emergency service & billing allowances

✓ DMAS will allow for telehealth (including telephonic) delivery of all behavioral health services via telehealth including: care coordination, interdisciplinary team meetings, and treatment planning.

✓ The provider must have emergency procedures in place to address the needs of any member in a psychiatric crisis.

✓ The provider should also ensure that the member continues to have access to medications to treat OUD, as well as care coordination activities as appropriate.

✓ OBOT and OTP providers may continue to bill for care coordination that is provided telephonically and in the absence of counseling services, if necessary and appropriate.
Questions?
We are Here to Help!

For more information:

Call the ARTS Helpline at **(804) 593-2453**
Email: **SUD@dmas.virginia.gov**

Check out the ARTS Webpage:
**http://www.dmas.virginia.gov/#/arts**

COVID-19 Flexibilities
**http://www.dmas.virginia.gov/#/emergencywaiver**
Case Presentation #1
Faisal Mohsin, MD

• 12:35-12:55 [20 min]
  • 5 min: Presentation
  • 2 min: Clarifying questions - Spokes
  • 2 min: Clarifying questions – Hub
  • 2 min: Recommendations – Spokes
  • 2 min: Recommendations – Hub
  • 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
Please state your main question(s) or what feedback/suggestions you would like from the group today?

How can we get this patient to give us negative urine screens for illicit opiates and Benzodiazepines?

Or, how can we get this patient to stop using Benzodiazepines?

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

Pt. is a 31 yr. single, unemployed, homeless Caucasian male.

DIAGNOSIS:

Generalized Anxiety Disorder
Sedative Anxiolytic Use Disorder
?Alcohol Use Disorder

Currently being prescribed Suboxone 12/3mg 1/2 strip BID.
Also being prescribed Gabapentin 900mg TID ? by his PCP for “Restless Legs”.
He was prescribed Requip for his restless leg last week at our clinic, 0.5mg BID. He was reluctant to take it.

History of domestic violence. Cannot return to his parents' home.

Refuses to take any non-benzodiazepine treatments for his anxiety. Claims these worsen his “restless leg”.

Reminder: Mute and Unmute to talk
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Use chat function for questions
Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Frequently tests positive for BZDs.

He has also tested positive for opiates and last year he was started on Suboxone. Treatment was brief since the patient sought only benzodiazepines. After a few visits, he became non-compliant and decided he no longer wanted to continue Suboxone.

He has had a very poor engagement with therapy services at the CSB. No attendance in any 12 step program.

Currently staying with a friend who reportedly drinks but not using opiates.

He presented to the clinic some weeks ago stating he had relapsed back on heroin and had been sniffing daily. Urine drug screen at the time was positive for Fentanyl only. However, negative for benzos and Et G. He was inducted into Suboxone with the understanding he would not resort to any benzos or alcohol while in treatment with Suboxone. He made the customary promises. Usually presents quite very meek and humble.

He presented last week positive for Fentanyl, Opi, BZDs, Bupg and THC.

Reported he was very stressed about both his parents being in the hospital and not having slept for 3 nights in a row. "I need something for sleep". Refused to consider any option other than a benzodiazepine. Request was declined to which he responded "I guess, then, I gotta do what I gotta do. I need to sleep". Mood was distinctly irritable and almost hostile needing redirection.
What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

Has been offered SSRIs, Buspirone, Hydroxyzine, Seroquel, Propranolol, trazodone.

Last year I did in fact prescribe him Clonazepam 0.5mg BID for safety/harm reduction purposes so that he would not buy these off the streets. Prescriptions were written every 2 weeks with no refills. After a couple of prescriptions the patient mysteriously stopped making his appointment visits.

What is your plan for future treatment? What are the patient's goals for treatment?

The goal is to keep him in recovery for his OUD.

The preferred goal is to keep him in recovery from all substances especially Benzodiazepines!

Other relevant information

He was incarcerated for some weeks last year after an incident of domestic violence where he caused property damage at his parents’ home and reportedly also assaulted his mother. They have a protective order against him and he can no longer return. It was reported to us by another patient that he had consumed alcohol and taken the clonazepam before the incident. After this, we stopped prescribing him benzodiazepines.

Reminder: Main Questions

Please state your main question(s) or what feedback/suggestions you would like from the group today?

How can we get this patient to give us negative urine screens for illicit opiates and Benzodiazepines?

Or, how can we get this patient to stop using Benzodiazepines?
Case Presentation #2
Ademola Adetunji, NP

• 12:55pm-1:25pm  [20 min]
  • 5 min: Presentation
  • 2 min: Clarifying questions - Spokes (participants)
  • 2 min: Clarifying questions – Hub
  • 2 min: Recommendations – Spokes (participants)
  • 2 min: Recommendations – Hub
  • 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
Please state your main question(s) or what feedback/suggestions you would like from the group today?

Is it appropriate to treat this client with the clonidine and Vistaril or no medications assistance needed for this encounter?

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

39 y/o Caucasian male, presented to detox center c/o using cocaine, alcohol, marijuana and opioid. Cocaine smoke/snort powder or rock about 1/2 oz daily relapse 2 mths ago after sobriety x 21/2 yrs. first use since high school, last use 5/31/2020 (2 days ago)
Marijuana use about couple g daily x 2 mths after sobriety x 1 yr, first use high school, last use 5/31/2020 (2 days ago)
Alcohol use: Vodka about 1/5th daily x 2 mths, no period of being clean. First use @ high school, last use 6/1/2020.
Opioid use: Non Rx Hydrocodone 30mg (1-2 tabs) po daily x 1 wk, first use 1 wk ago, last use 2 days ago
Heroin use: Snort 1/2g daily x 2 wks, first use 2 wks ago, last use 2 days ago (5/31/2020)
Tobacco use: 1PPD x 21 yrs
Allergies: NKDA, NKFA, Pollens and grass
Education: Some college (11/2 years). Currently work as a mechanic
Living situation: Lives with family

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Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Physical: Denies medical conditions including current or chronic pain except seasonal allergies.
Mental Health: C/o depression and anxiety in late 20s.
Medications: Wellbutrin XL 300mg daily
Vistaril 25mg BID PRN.
Per client, has not used medications in over 2 yrs
Client did not bring any medications to Detox clinic today.
Lab results at Detox clinic on admission
UDS- + COC, THC.
V/S: B/P 112/76, P 92, R 18, T 98.2, Pox 99%. BAC 0.0, CIWA 1, COWs 6

What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

Cocaine dependence: Monitor.
Cannabis dependence: Monitor
Withdrawal anxiety: Clonidine 0.1mg po BID PRN x 7 days
Vistaril 25mg po q6H PRN x 7 days
Difficulty Sleeping: Trazodone 100mg (1/2-1 tab) po qHS PRN
Melatonin 3mg (1-5 tabs) po qHS PRN
Seasonal allergies: Loratadine 10mg po daily
Teaching done
The importance of F/u with Psychiatric and therapist
Further discussion with clinical staffs at detox for resources for client
What is your plan for future treatment? What are the patient's goals for treatment?

Collaborative work with clinical team to refer and connect client to psychiatric and therapist within the network.

Reminder: Main Questions

Please state your main question(s) or what feedback/suggestions you would like from the group today?

Is it appropriate to treat this client with the clonidine and Vistaril or no medications assistance needed for this encounter?
Case Studies

• Case studies
  • Submit: www.vcuhealth.org/echo
  • Receive feedback from participants and content experts
  • Earn $100 for presenting
Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- Ademola Adetunji, NP from Fairfax County CSB
- Michael Bohan, MD from Meridian Psychotherapy
- Diane Boyer, DNP from Region Ten CSB
- Melissa Bradner, MD from VCU Health
- Kayla Brandt, B.S. from Crossroads Community Service Board
- Susan Cecere, LPN from Hampton Newport News
- Michael Fox, DO from VCU Health
- Shannon Garrett, FNP from West Grace Health Center
- Sharon Hardy, BSW, CSAC from Hampton-Newport News CSB
- Sunny Kim, NP from VCU Health
- Thokozeni Lipato, MD from VCU Health
- Caitlin Martin, MD from VCU Health
- Maureen Murphy-Ryan, MD from AppleGate Recovery
- Faisal Mohsin, MD from Hampton-Newport News CSB
- Stephanie Osler, LCSW from Children’s Hospital of the King’s Daughters
- Jennifer Phelps, BS, LPN from Horizons Behavioral Health
- Crystal Phillips, PharmD from Appalachian College of Pharmacy
- Tierra Ruffin, LPC from Hampton-Newport News CSB
- Manhal Saleebey, MD from VCU Health Community Memorial Hospital
- Jenny Sears-Cockram, NP from Chesterfield County Mental Health Support Services
- Daniel Spencer, MD from Children’s Hospital of the King’s Daughters
- Cynthia Straub, FNP-C, ACHPN from Memorial Regional Medical Center
- Saba Suhaib, MD from Ballad Health
- Barbara Trandel, MD from Colonial Behavioral Health
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Ashley Wilson, MD from VCU Health
- Sarah Woodhouse, MD from Chesterfield Mental Health
Claim Your CME and Provide Feedback

• [www.vcuhealth.org/echo](http://www.vcuhealth.org/echo)

• To claim CME credit for today's session
• Feedback
  • Overall feedback related to session content and flow?
  • Ideas for guest speakers?
Access Your Evaluation and Claim Your CME

Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes or ECHO, a virtual network of health care experts and providers tackling the opioid crisis across Virginia. Register now for a TeleECHO Clinic!

Network, Participate and Present

- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to submit your de-identified study for feedback from a team of addiction specialists. We appreciate those who have already provided case studies for our clinic.
- **Provide valuable feedback & claim CME credit** if you participate in live clinic sessions.

Benefits

- Improved patient outcomes.
- **Continuing Medical Education Credits:** This activity has been approved for **AMA PRA Category 1 Credit™**.
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo

- To view previously recorded clinics and claim credit
Access Your Evaluation and Claim Your CME

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Telehealth

About Telehealth at VCU Health
For Patients
For Providers
Opioid Addiction ECHO
Register Now!
Submit Your Case Study
Continuing Medical Education (CME)
Curriculum & Calendar

Previous Clinics (2018)
Previous Clinics (2019)
Previous Clinics (2020)
### Previous Clinics (2019)

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<th>Topic</th>
<th>Date</th>
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<tr>
<td>Trauma Informed Care and Treating Those Experiencing Opioid Addiction</td>
<td>01/04/19</td>
<td>Video of Clinic</td>
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<td>Slide Presentation</td>
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<tr>
<td>Learning Objectives:</td>
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<tr>
<td>1. Identify individuals who have experienced trauma.</td>
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<td>2. Understand the impact of trauma on human development particularly related to substance use and misuse.</td>
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<td>3. Learn components of trauma informed care.</td>
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<tr>
<td>Syringe Exchange</td>
<td>01/19/19</td>
<td>Video of Clinic</td>
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<td>Slide Presentation</td>
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<td>Learning Objectives:</td>
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<tr>
<td>1. Understand current legislative landscape in regards to syringe exchange in VA.</td>
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<td>2. List benefits to clients and community of syringe exchange.</td>
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<td>3. Define harm reduction.</td>
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VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

June 19: SUD Treatment for Individuals with Co-Occurring Mental Health Diagnosis
Paul Brasler, LCSW

July 17: OUD Treatment for Pregnant and Parenting Patients
Mishka Terplan, MD

July 31: Illicit Drugs: What Are They, Where They Are and USDOJ Response
Olivia Norman, JD

Please refer and register at vcuhealth.org/echo
THANK YOU!

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