Webinar Tips & Notes

- Your phone &/or computer microphone has been muted
- Time is reserved at the end for Q&A
- Please fill out the post-webinar survey
- Webinar is being recorded
- Recordings will be posted to our YouTube Channel: https://www.youtube.com/c/nctrc
SUD & OPIOIDS

Presenter(s)

Marwan Haddad MD, MPH, AAHIVS
Medical Director of the Center for Key Populations; Community Health Center, Inc.

David Kan, MD, DFASAM
Bright Heart Health, Chief Medical Officer
Objectives

• Overview of telehealth policies related to the provision of substance use disorder services.
• Different types of models in providing services to treat substance use disorders through telehealth.
• Understanding of challenges and solutions to the use of telehealth to treat substance use disorders in a CHC setting.
Any information provided in today’s talk is not to be regarded as legal advice. Today’s talk is purely for informational purposes.

Always consult with legal counsel.

CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.
MEDICARE – Communication Technology-Based Services

Services furnished remotely using communications technology are not considered “Medicare telehealth services” and are not subject to the restrictions articulated in section 1834(m) of the Act. ~ CMS, Federal Register, November 1, 2018.

• Brief Communication Technology-based Service or Virtual Check-In
• Remote Evaluation of Pre-Recorded Patient Information
• Interprofessional Internet Consultation
G2012 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

- May be done over phone
- Only for established patients
- Must have verbal consent
- Patient will be responsible for any co-payment/deductible
• G2010 - Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

• Only for established patients

• Patient will be responsible for any copayment/deductible
The SUPPORT for Patient and Communities Act required CMS to adjust their reimbursement policy of telehealth for treating individuals with SUDs or a co-occurring mental health disorder.

Removed the originating site geographic requirements for telehealth services on or after July 1, 2019 for any existing Medicare telehealth originating site (except for a renal dialysis facility).

Home was made an eligible originating site for purposes of treating these individuals, however the home would not qualify for the facility fee.

Within 5 years a report of the impact of telehealth services on SUD must be submitted by the Secretary.
OTHER SUD/OPIOID RELATED POLICIES

• Within one year the DEA must have final regulations for a special registration to remotely prescribe Suboxone/Buprenorphine through telehealth.

• DEA will likely not finalize regulations until at the deadline of the end of 2019.

• Possibly see drafts/proposed regulations late-September/October.
State Legislation

2019 State Legislation

- Broadband: 18%
- Cross-State Licensing: 20%
- Demonstrations, Grants & Pilot Projects: 16%
- Medicaid Reimbursement: 8%
- Network Adequacy: 12%
- Online Prescribing: 9%
- Other: 10%
- Private Payer Reimbursement: 4%
- Other: 1%
Medicaid Reimbursement - Modality

Live Video
50 states and DC

Store and Forward
Only in 11 states

Remote Patient Monitoring
20 states
39 states and DC have telehealth private payer laws. Some go into effect at a later date.

Parity is difficult to determine:
- Parity in services covered vs. parity in payment
- Many states make their telehealth private payer laws “subject to the terms and conditions of the contract”
Medicaid & FQHCs/RHCs

• MD Medicaid allows FQHC to register as a distant site provider
• GA allows FQHC to be both originating and distant site provider
• WV explicit prohibition on FQHC & RHC to serve as distant site providers
• Other state Medicaid programs are vague about FQHCs and RHCs
CCHP Interactive Policy Map

Search by Category & Topic

Medicaid Reimbursement
- Live Video
- Store & Forward
- Remote Patient Monitoring Reimbursement

Private Payer Reimbursement
- Private Payer Laws
- Parity Requirements

Professional Regulation/Health & Safety
- Cross-State Licensing
- Consent
- Prescribing
- Misc (Listing of Practice Standards)
Integrating Medication-Assisted Treatment (MAT) with Use of Telehealth: a Community Health Center Experience

Marwan Haddad MD, MPH, AAHIVS
Medical Director, Center for Key Populations
Community Health Center, Inc.
Connecticut
June 28, 2019
CHC Profile:
- Founding year: 1972
- Locations: 14
- Patients/year: 100,000

THREE FOUNDATIONAL PILLARS
1. Clinical Excellence
2. Research and Development
3. Training the Next Generation
The Weitzman Institute works to improve primary care and its delivery to medically underserved and special populations through research, innovation, and the education and training of health professionals.
The Center for Key Populations is the first center of its kind that focuses on key groups who experience health disparities secondary to stigma and discrimination and who belong to communities that have suffered many barriers to healthcare.

The Center brings together healthcare, training, research, and advocacy for: **People who use drugs, the LGB and Transgender populations, the homeless and those experiencing housing instability, the recently incarcerated, and sex workers.**

HIV Primary Care & Testing

Hepatitis C Screening and Treatment

Medication Assisted Treatment for Substance Use Disorders

Health Care for the Homeless

LGBTQ-focused Health Care

Community Drop-In Center

HIV PrEP (Pre-Exposure Prophylaxis and PEP Post-Exposure Prophylaxis)

Sexually Transmitted Infections

CENTER FOR KEY POPULATIONS — Reimagining Primary Care
MAT Program Models at Community Health Centers

CHCI Program Model
- Induction, stabilization and maintenance done onsite.
- MAT patients are booked as any other patient in providers’ schedules.
- MAT providers handle primary care in addition to MAT.

Other Models
- Hub and spoke model:
  - Induction/stabilization done externally; maintenance continued onsite.
  - If relapse/complications, sent back to expert hub.
- Prescribers have set times/days only for MAT patients.
- MAT clinic co-located but separate from primary care clinic.
  - Patients go to the MAT clinic for SU treatment only.
  - Prescribers rotate through the MAT clinic.
- Telemedicine model
Program Philosophy

- Attitudes and Approach:
  - Chronic disease model of care (e.g. diabetes)
  - Harm reduction

- Recognizes the imperative to:
  - Engage individuals in care
  - Address immediate health risks (e.g. decrease overdose risk, decrease HIV/HCV transmission, decrease other injection-related infections)

- Harm reduction principles = primary care principles
  - Being pragmatic
  - Espousing humanistic values
  - Focusing on harms
  - Balancing costs/benefits to individual/society
  - Establishing hierarchy of goals
Interdisciplinary Pods Promote Team-Based Care

- MAT Prescriber
- Behavioral Health
- Care Coordinator
- Nursing (RN, LPN)
- Medical Assistant
Common Challenges for MAT Programs in Primary Care

**Buy-In**
- Administrative
- Financial (MAT patient averages 2-3 visits a month to health center)
- Clinical Champions

**Time and Support**
- Team-based approach
- Cross coverage/voucher system

**Polysubstance Use and Diversion**
- Toxicology screening/risk mitigation

**Training/Expertise**
- Project ECHO
- Harm Reduction

Community Health Center, Inc. Where health care is a right, not a privilege, since 1972.
"The mission of Project ECHO is to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes."

Dr. Sanjeev Arora, University of New Mexico

NEJM 6/2011

- Prospective cohort study comparing HCV Rx at UNM with Rx by primary care clinicians at 21 ECHO sites in rural areas and prisons in NM.
- 407 patients with no previous treatment
- Primary endpoint was SVR.
- 57.5% at UNM and 58.2% at ECHO sites achieved SVR.
- Serious adverse events occurred in 13.7% at UNM and 6.9% at ECHO sites
What Does Project ECHO Do?

- Builds communities of practice
- Connects primary care providers with a panel of expert multidisciplinary faculty
- Improves access to specialty care
- Creates a force multiplier
Technology Infrastructure

Using the Zoom® cloud-based teleconferencing system

Participants are encouraged to use the chat functionality of the zoom platform

Zoom Group Chat

Share More. Everyone can find that article and discussion on Fanci® here:
http://www.janet.econ/psychiatric-education/get/article-support/psychiatric-
information-share/
ECHO Session Format

**Case Presentations**
- Submitted by participants
- Around 2-3 cases per ECHO session
- Complex cases
- Multi-disciplinary consultation
- Valuable for discussion and teaching
- Total time = 1-1.5 hour

**Didactic Presentations**
- When time allots, 1 per session
- Focused and topical
- By expert faculty
- Total time < .5 hour
Weitzman ECHO Buprenorphine Didactic Curriculum

Core Didactic Curriculum

1. Principles of Harm Reduction and Addiction as a Chronic Disease
2. Buprenorphine Overview – An Introduction to Buprenorphine Prescribing, Induction, and Stabilization
3. Nonpharmacological Treatment Including Motivational Interviewing
4. Substance Use Comorbidities
5. Toxicology Screening and Pharmacology
6. Mental Health Comorbidities

Additional, Brief Didactics

1. Drug-drug Interactions
2. Buprenorphine in the Setting of Chronic Pain
3. Overdose Prevention
4. Pregnancy
Project ECHO Buprenorphine Provider Survey Study

- N= 13 Medical Prescribers (MPs) and 10 Behavioral health providers (BHPs)
- Answered baseline and 6 month follow-up surveys

**Results Summary:**

- All questions improved, many trended toward significance
- **Skills** (achieved statistical significance)
  - MP: 14 of 16 skills
  - BHP: 9 of 12 skills
- **Team-based approach** (achieved statistical significance)
  - MP: RN and BHP collaboration
  - BHP: MP communication
- **Attitudes and approaches** (achieved statistical significance)
  - MP: BMT appropriate in PC; more disruptive, improved professional satisfaction
  - BHP: none
Weitzman ECHO Learning Community
MAT ECHO since February 2013 (Monthly for 1.5 hours)

- In 2007, 4-5 DATA-waivered MDs at CHCI.
- In 2019, >50 DATA-waivered MDs/NPs/PAs at CHCI.
- Over 2,000 patients started on buprenorphine at CHCI since ECHO.
THANK YOU!

Marwan Haddad MD, MPH, AAHIVS
haddadm@chc1.com
INNOVATIVE STRATEGY:
TELEMEDICINE
BUPRENORPHINE VISITS
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total # unique patients</strong></td>
<td>38</td>
</tr>
<tr>
<td># seen in cross-coverage</td>
<td>22</td>
</tr>
<tr>
<td># seen in self-coverage</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total # of telemedicine visits</strong></td>
<td>63</td>
</tr>
<tr>
<td># visits in cross-coverage</td>
<td>46</td>
</tr>
<tr>
<td># visits in self-coverage</td>
<td>17</td>
</tr>
<tr>
<td><strong>During coverage period</strong></td>
<td></td>
</tr>
<tr>
<td># patients seen once</td>
<td>19</td>
</tr>
<tr>
<td># patients seen twice</td>
<td>13</td>
</tr>
<tr>
<td># patients seen three times</td>
<td>6</td>
</tr>
<tr>
<td>Survey Questions</td>
<td>Results</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Q1: Overall how satisfied were you with the session?</td>
<td>95% Satisfied/Very Satisfied</td>
</tr>
<tr>
<td>Q2: How easy was it to talk with the provider?</td>
<td>95% Easy/Very Easy</td>
</tr>
<tr>
<td>Q3: How much did the provider seem to care about you as a person?</td>
<td>98% Cares Much/Very Much</td>
</tr>
<tr>
<td>Q4: How did you feel during the session?</td>
<td>92% Relaxed/Very Relaxed</td>
</tr>
<tr>
<td>Q5: Do you think use of telemedicine helps with delivery of your care?</td>
<td>100% Same-Very Much</td>
</tr>
<tr>
<td>Q6: Do you think your session was as good as a regular in-person visit?</td>
<td>95% Same-Much Better</td>
</tr>
<tr>
<td>Q7: How did the equipment work today?</td>
<td>94% Well/Very Well</td>
</tr>
<tr>
<td>Q8: How likely are you to recommend telemedicine to someone else?</td>
<td>95% Somewhat Likely-Very Likely</td>
</tr>
</tbody>
</table>
Weitzman Institute
National ECHO Learning Network

- 307 practices
- 753 ECHO sessions
- 2,608 case presentations
- Primary care providers from 33 states, PR, and DC
  - 782 Medical Providers
  - 299 Behavioral Health Providers
  - 301 Care Team Members

Weitzman ECHO® Pain
Weitzman ECHO® Hepatitis-C/HIV
Weitzman ECHO® Buprenorphine

Weitzman ECHO® Pediatric and Adolescent Behavioral Health
Weitzman ECHO® Complex Care Management
Weitzman ECHO® LGBT Health
Weitzman ECHO® Complex Integrated Podiatry
Telemedicine Defined

- Improve patient health
- Real-time interactive communication
- Physician and patient distantly located
- Audio and Video equipment
Telemedicine Outcomes

• High treatment retention
• Addresses treatment gap
• Outcomes comparable to in person care
• OUD MAT outcomes comparable to in person care
• Patient satisfaction as good as or better than in-person care

2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347527/
Mobilizing Technology

• Internet Enabled Devices
  – Smartphones, tablets, computers
  – Device availability > Data plan
  – Many hotspots

• Most people have internet-enabled devices
  – >90% homeless have an internet enable device\(^1\)

• Federal program to subsidize internet connectivity
  – 135%-150% of Federal Poverty Level

Telemedicine platforms

• HIPAA Compliant
  – Numerous
  – BAA agreement
  – Sufficient Encryption

• Bandwidth requirements
  – Variable upload and download requirements 600Kbps to 15+mbps

<table>
<thead>
<tr>
<th>Data Connection</th>
<th>4G LTE</th>
<th>3G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upload</td>
<td>2-3 Mbps</td>
<td>350-500 Kbps</td>
</tr>
<tr>
<td>Download</td>
<td>6-8 Mbps</td>
<td>600 Kbps - 1.4 Mbps</td>
</tr>
<tr>
<td>Peak</td>
<td>25 Mbps</td>
<td>3.1 Mbps</td>
</tr>
</tbody>
</table>
State Coverage – Outpatient MAT

Actively serving patients in CA, NM, TN, GA, NC, VA, OH, NY, MI, WI, WA
Patient Experience – Group Encounters
Apps to Track and Coordinate Care

- Video Appointments
- Symptomatology Tracking
- Referral Management
Telemedicine in Practice
Male/Female, and all age patients come from across the state to access treatment. By removing geographic constraints, more people access treatment and reduced motor vehicle usage.
Primary Care Case Study

Results

• Implemented in less than 7 days
  – Trained Staff
  – Wall posters in breakrooms
  – Handouts & Brochures

• 25+ interventions in 5 weeks
• Assisting with 90 MME and patients on full agonist > 6 months
Outcomes
Quality Measures: Substance Usage

Across the three types of BAM Usage Factors, patients showed an improvement were higher in case of heavy alcohol (98%) or any illegal/street drugs (97%) than in case of any alcohol use (86%).

<table>
<thead>
<tr>
<th>BAM Substance Usage</th>
<th>N</th>
<th>%</th>
<th>Magnitude of improvement</th>
<th>Time to improvement by probability of improvement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy alcohol use</td>
<td>68</td>
<td>64</td>
<td>1 (0.5-2)</td>
<td>20 (15-25)</td>
</tr>
<tr>
<td>ANY illegal/street drugs or abuse any</td>
<td>154</td>
<td>100%</td>
<td>2 (1-4)</td>
<td>141 (22-224)</td>
</tr>
<tr>
<td>prescription medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANY alcohol use</td>
<td>99</td>
<td>85</td>
<td>1 (0.5-2.1)</td>
<td>41 (12-148)</td>
</tr>
<tr>
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</tbody>
</table>

Figures: Kaplan-Meier plot showing the probability of improvement in ANY illegal/ street drugs or abuse any prescription medications by duration of follow-up.
Patients showed improvement in all the protective factors with abstinence confidence (63%) and positive social support (61%).

<table>
<thead>
<tr>
<th>Protective Factors</th>
<th>N (%)</th>
<th>Magnitude of improvement</th>
<th>Time to improvement by probability of improvement (%)(Min., max.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence Confidence</td>
<td>144 (89)</td>
<td>1 (2)</td>
<td>0 (2)</td>
</tr>
<tr>
<td>Positive Social Support</td>
<td>116 (71)</td>
<td>0 (4)</td>
<td>0 (4)</td>
</tr>
<tr>
<td>Work School Volunteering</td>
<td>127 (58)</td>
<td>1 (2)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Income Stability</td>
<td>175 (43)</td>
<td>1 (2)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Spirituality in Recovery</td>
<td>184 (64)</td>
<td>0 (1)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Self-help meeting attendance</td>
<td>352 (53)</td>
<td>1 (2)</td>
<td>0 (1)</td>
</tr>
</tbody>
</table>

Figure: Kaplan-Meier plot showing the probability of improvement in Abstinence Confidence by duration of follow-up.
Quality Measures: Risk Factors

There was an improvement in all the risk factors with patients showing highest improvement in craving withdrawal (85%), and negative social support (82%).

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>N</th>
<th>%</th>
<th>Min (IQR)</th>
<th>Median</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cravings Withdrawal</td>
<td>200</td>
<td>85%</td>
<td>0 (1, 1)</td>
<td>0 (2)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Negative Social</td>
<td>187</td>
<td>82%</td>
<td>0 (1, 1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Family Conflict</td>
<td>170</td>
<td>74%</td>
<td>0 (1, 1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Anger</td>
<td>170</td>
<td>74%</td>
<td>0 (1, 1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Sleep Issues</td>
<td>227</td>
<td>69%</td>
<td>0 (1, 1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0 (1)</td>
</tr>
</tbody>
</table>
Patient retention at 30 days at 81% (D’Onofrio 73%). 90 Day retention at 56%, below goal of 75%. Further investigation reveals issues related to referrals with low patient motivation who identify as “Chronic Pain”.
Quality Measures: 30 Day & 90 Day Results

84% patients negative for opioids (except Bup) at 30 days; 93% patients negative for opioids (except Bup) at 90 days.
Summary

• Telemedicine is accessible
• Rules are changing to expand access
• Payment matters
• Satisfaction is high
• Outcomes are comparable
• Innovation is easier

Questions?

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(925) 953-3822
The NCTRC FQHC Webinar Series

Our Next Webinar

Telehealth Topic: Mental/Behavioral Health
Date: August 2019
Your opinion of this webinar is valuable to us.

Please participate in this brief perception survey (will also open after webinar):

https://www.surveymonkey.com/r/XK7R72F
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