The Webinar will begin promptly at 12pm

Due to the number of participants, you will be automatically placed on mute as you join to ensure good quality sound. If you would like to comment or ask a question, please use the "chat feature"

Send your questions to the host via the chat window in the Zoom meeting.

Q+A will open at the end of the presentation.

Follow-up questions?

Contact

Samantha Di Paola
sdipaola@healthmanagement.com

TELEMAT PART 2: TREATING ADDICTION, INCLUDING MAT VIA TELEHEALTH. WHAT DOES YOUR CARE TEAM NEED TO KNOW?

HMA INTEGRATED CARE DC

PRESENTED BY:
Shannon Robinson, MD
Scott Haga, MPAS, PA-C

Tuesday,
January 25, 2022
12:00pm – 1:00pm EST

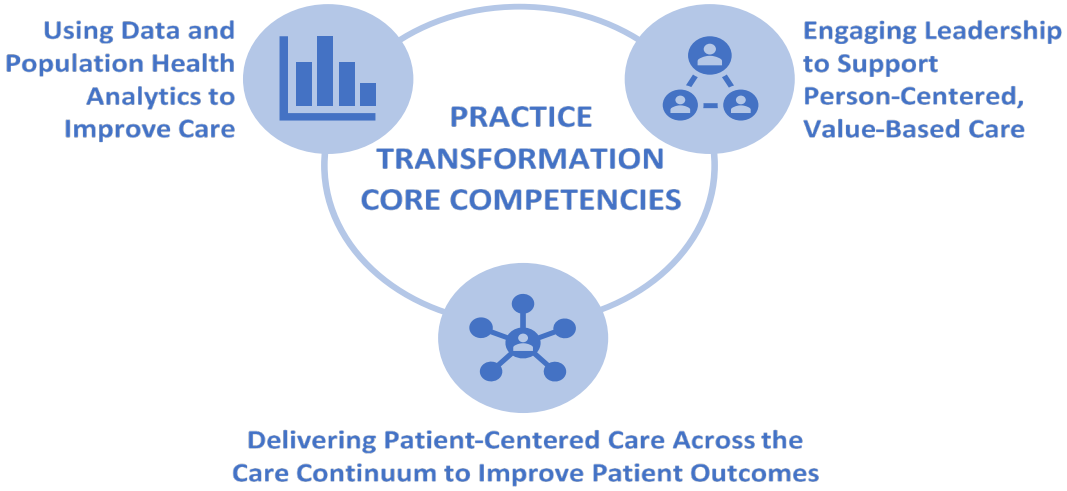
The Integrated Care Technical Assistance Program (ICTA) is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

WHAT IS INTEGRATED CARE DC?

- Integrated Care DC is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

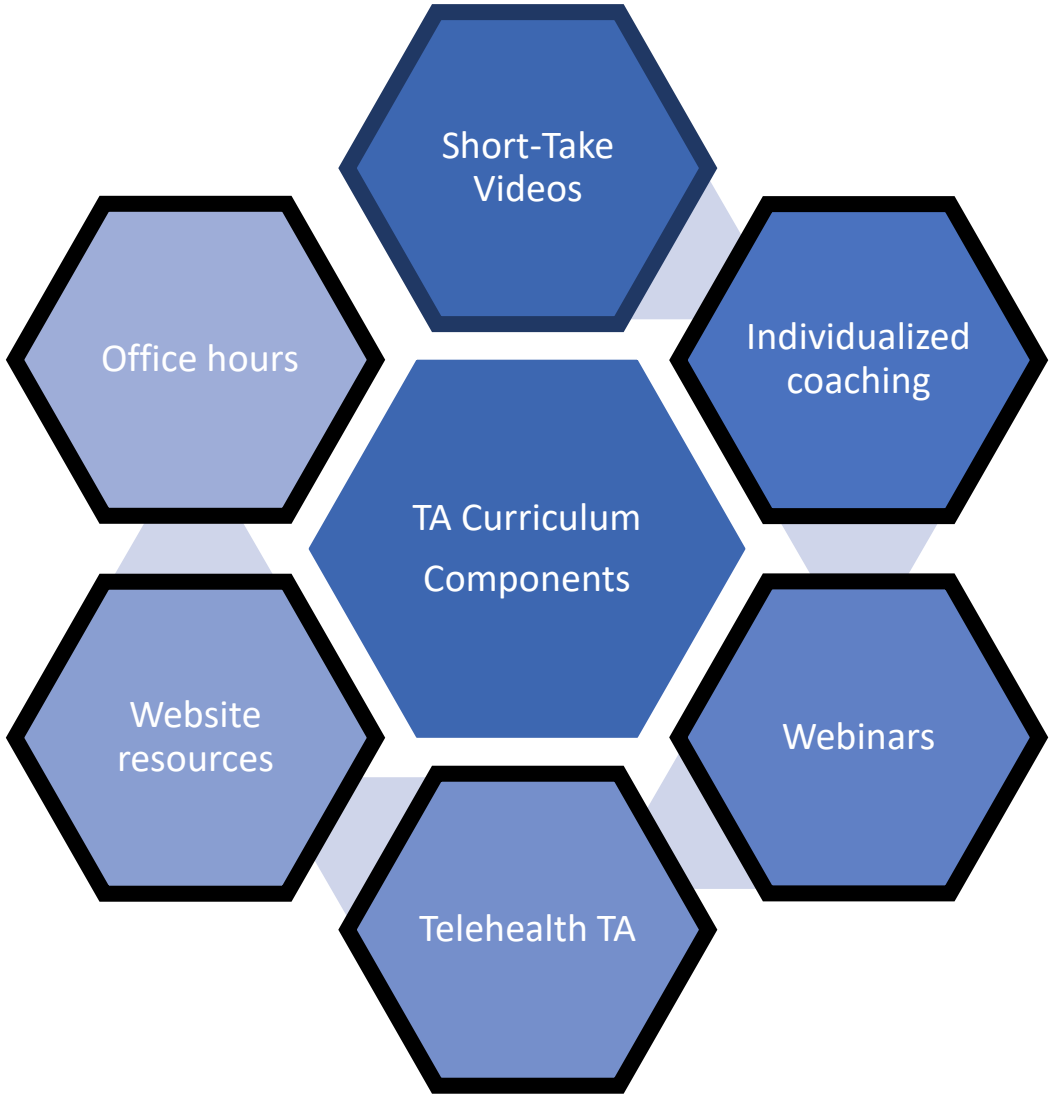
- Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



INTEGRATED CARE DC TECHNICAL ASSISTANCE

- The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.
- All material is available on the project website: Integratedcaredc.com
- Educational credit is offered at no cost to attendees for select elements.



INTEGRATED CARE DC UPDATES

Are you receiving our Integrated Care DC Newsletters?

Check your inbox at the beginning of the month for the Monthly Newsletter and around the 15th for the Mid-Month Update.

Got ideas?

Take this short survey to share suggestions and requests for trainings.
https://www.integratedcaredc.com/survey/

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DISCLOSURES

Faculty	Nature of Commercial Interest
Scott Haga, MPAS, PA-C	Scott discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients
Shannon Robinson, MD	Shannon discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
Elizabeth Wolff, MD, MPA CME Reviewer	Dr. Wolff discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.

TELEMEDICINE MEDICATION ASSISTED THERAPY (TELEMAT) 2021 GRANTEES

Grantees	Description
MedStar Health Research Institute	MedStar Washington Hospital Center (MWHC) in partnership with Unity Health Care, will implement *LINK-MAT*, a patient-centered program, embedded in the evidence-based SBIRT model employed at MWHC to address the increasing opioid-related overdose and mortality rates among DC's vulnerable and underserved populations by providing a more seamless experience of care that integrates continuing behavioral health care in the Emergency Department to improve treatment outcomes for OUD.
Howard University and Pennsylvania Avenue Baptist Church	The *Better Together TeleMAT Community Partnership*, a collaboration between Howard University and the DC Dream Center and Pennsylvania Avenue Baptist Church plans to provide MAT via telehealth to persons with OUD in Ward 7 and neighboring communities.

AGENDA

TeleMAT Part 2: Treating Addiction, including MAT via Telehealth. What does your care team need to know?

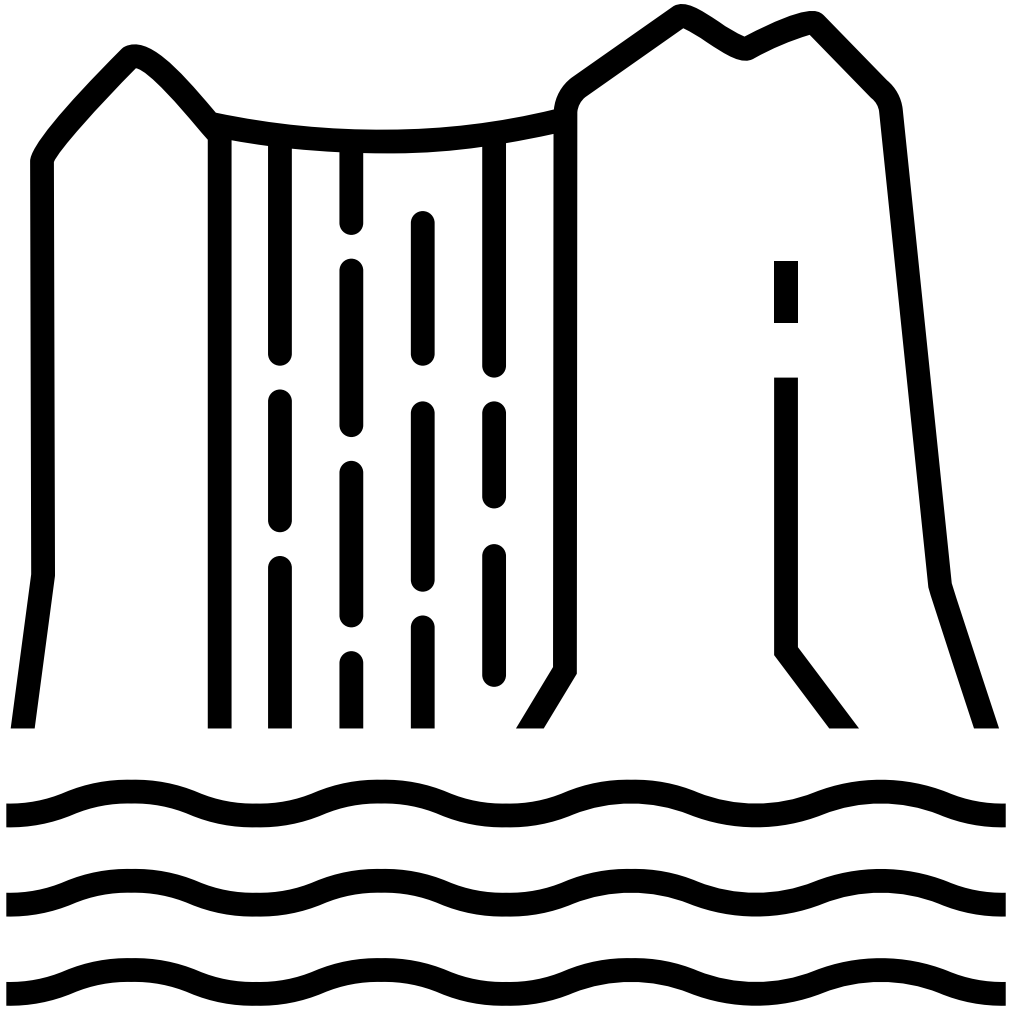
- Background
- Regulatory changes for SUD care, including prescribing controlled substances and MAT
- Home induction of buprenorphine
- Monitoring patients via telehealth
- Patient engagement in individual & group sessions
- Evidence base for tele-addictions work

OBJECTIVES

- Outline recent regulatory changes for SUD care, including prescribing controlled substances and MAT
- Compare home induction to office-based induction
- Differentiate monitoring patients via telehealth vs. in office
- Describe how to engage patients in individual and group sessions
- Review evidence base for tele-addictions work

Image permitted by DC Department of Health Care Finance

CHATTERFALL



- How have you been providing telehealth?
  - Phone
  - Audiovisual
  - Not providing telehealth

TELE-ADDICTIONS WORK

Key Feature

Real-time interactive, face-to-face with the distant provider

- Telemedicine is not new
  - Telepsychiatry has been used since the 1990s
- What has changed?
  - Even before COVID-19, telehealth has proved to be an effective way to increase access to care
    - Rural communities
    - Reduce unnecessary office visits & patient travel
    - Increase access to specialists across the country
  - The COVID-19 pandemic increased access to telehealth
    - Reserve PPE
    - Reduce patient and staff exposure

DC COVID AND TELEMED UPDATES

- DC Public Health Emergency extended until 3.17.22
- DHCF Final Rulemaking Section 910 (Medicaid Reimbursable Telemedicine Services) Amendment, chapter 9 (Medicaid) or title 29 (Public Welfare) District of Columbia Municipal Regulations
  - Continued access of services after the expiration of the Mayor's public health emergency (PHE) declaration adopted 10.28.21
  - Audio Only covered
  - Written or Verbal consent

Sources:
https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Telemedicine%2011.5.21%20Final%20Rule.pdf
https://dhcf.dc.gov/page/telemedicine

COVID AND TELEHEALTH REGULATORY CHANGES

- Changes with State Regulatory Agencies:
  - DC has followed recommendations of DEA and SAMHSA
  - American Society of Addiction Medicine (ASAM) is tracking state changes https://www.asam.org/quality-care/clinical-guidelines/covid
- Federation of State Medical Boards (FSMB):
  - Restrictions on Telehealth services across state lines has been removed in many states. Consider where the patient is located as well as the provider

    http://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensures-requirementscovid-19.pdf
- DC: On October 25, 2021 DC B 24-0399 was enacted, which amends Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) to allow healthcare professionals licensed in other jurisdictions to practice in DC without a "state" license until August 10, 2022, regardless of whether an emergency declaration is in effect. Prior declarations noted patients needed to be in a healthcare facility.

REGULATORY CHANGES FOR MAT

Office Based Opioid Treatment

- Under new regulations, prescribers can apply for a waiver to treat up to 30 patients without completing the 8/24-hour training and not attest to providing or referring for counseling and ancillary services
- Prescriber obtains waiver to prescribe buprenorphine (DATA 2000)
- Can treat 30/100/275 patients after receiving waiver
- Can also use naltrexone
- Apply for waiver: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

Opioid Treatment Program/Narcotic Treatment Program

- "Methadone Clinic"
- Can prescribe methadone, buprenorphine and naltrexone
- Highly regulated
- No limit on number of patients with a specified medication; clinic limits are based on staffing levels

OTP OPERATIONS DURING COVID-19 PANDEMIC

Guidance from SAMHSA, 3/19/2020

- **FOR ALL STATES:**
- The state may request blanket exceptions for all **stable** patients in an OTP to receive **28 days of Take-Home doses** of the patient's medication for opioid use disorder. The state may request up to **14 days of Take-Home medication** for those patients who are **less stable** but who the OTP believes can safely handle this level of Take-Home medication.

Source: https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

Guidance from SAMHSA, 3/19/2020

FOR ALL STATES and DC:

- **No in person exam required for buprenorphine, but still required for methadone**

OTP OPERATIONS - INDIVIDUALS IN QUARANTINE

Verify and obtain documentation of quarantine status in record of OTP.

Identify a trustworthy person (3rd party) to pick up and transport dose to individual using established chain of custody procedure.

If no one available, then OTP should prepare "doorstop" delivery of medication for patient.

Source: www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf

DEA CHANGES DURING PUBLIC HEALTH EMERGENCY

Prior to COVID-19 Emergency

- Restrictions on prescribing of controlled substances, most significantly with patients who had not previously been seen in person by the prescriber.
- These were commonly known as the Ryan Haight Act.

Current State

In light of the public health emergency the DEA has relaxed the requirements to prescribe controlled substances

DEA CHANGES DURING EMERGENCY 1/31/20

"...DEA-registered practitioners may issue prescriptions for **controlled substances** to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

1. The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
2. The **telemedicine** communication is conducted using an audio-visual, real-time, two-way interactive communication system.*
3. The practitioner is acting in accordance with applicable Federal and State law."

* See next slide

Source: https://www.samhsa.gov/sites/default/files/dea-samhsa-buprenorphine-telemedicine.pdf

DEA CHANGES DURING EMERGENCY

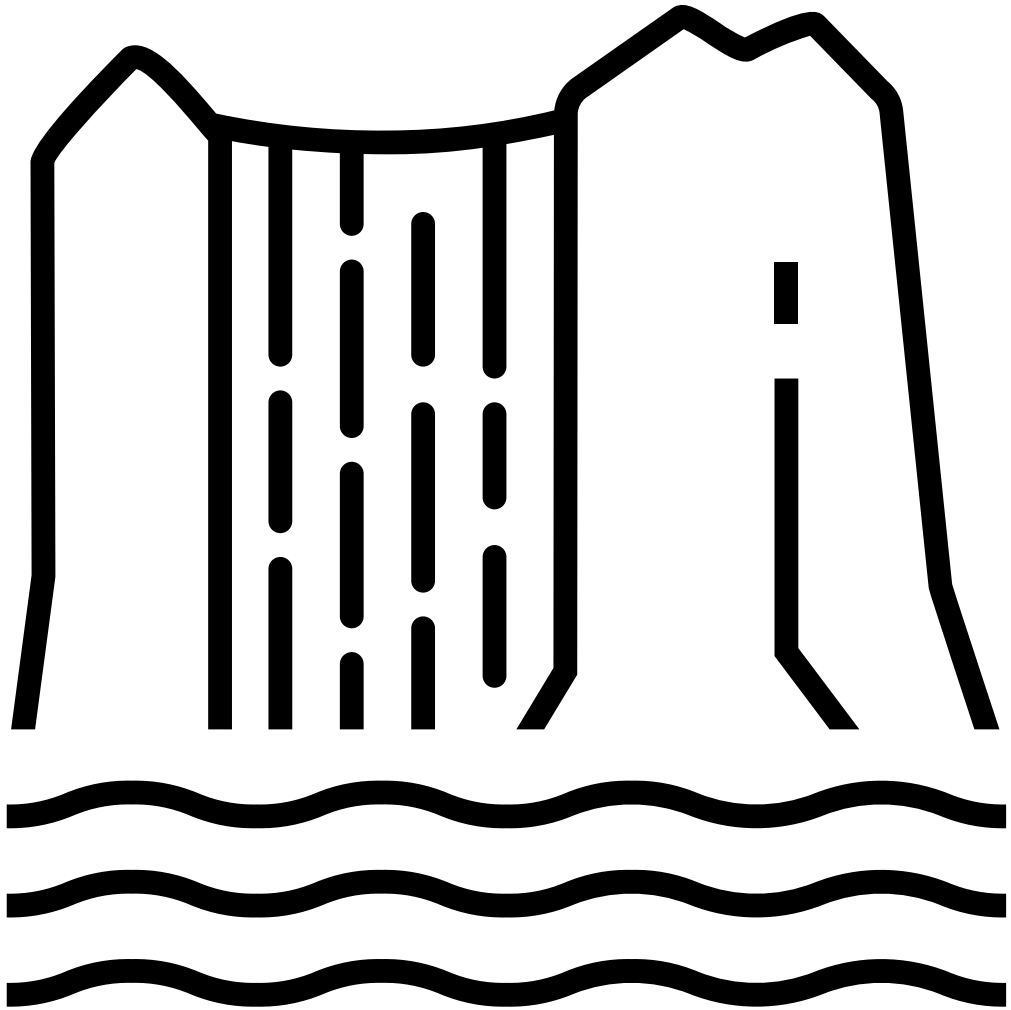
- Effective March 31, 2020:
- “Today, DEA notes that practitioners have further flexibility during the nationwide public health emergency to prescribe **buprenorphine** to new and existing patients with OUD via **telephone** by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the patient in person or via telemedicine.”

Source: https://www.samhsa.gov/sites/default/files/dea-samhsa-buprenorphine-telemedicine.pdf

TREATMENT DURING PANDEMIC

- SAMHSA and state agencies all strongly suggest using telehealth or phone intervention to **avoid** additional **face to face interaction** and possible spread of COVID-19

CHATTERFALL



- Have you been using telehealth/telemedicine for SUD care?
  - Yes
  - No

HOME INDUCTION BUPRENORPHINE LOW BARRIER CARE

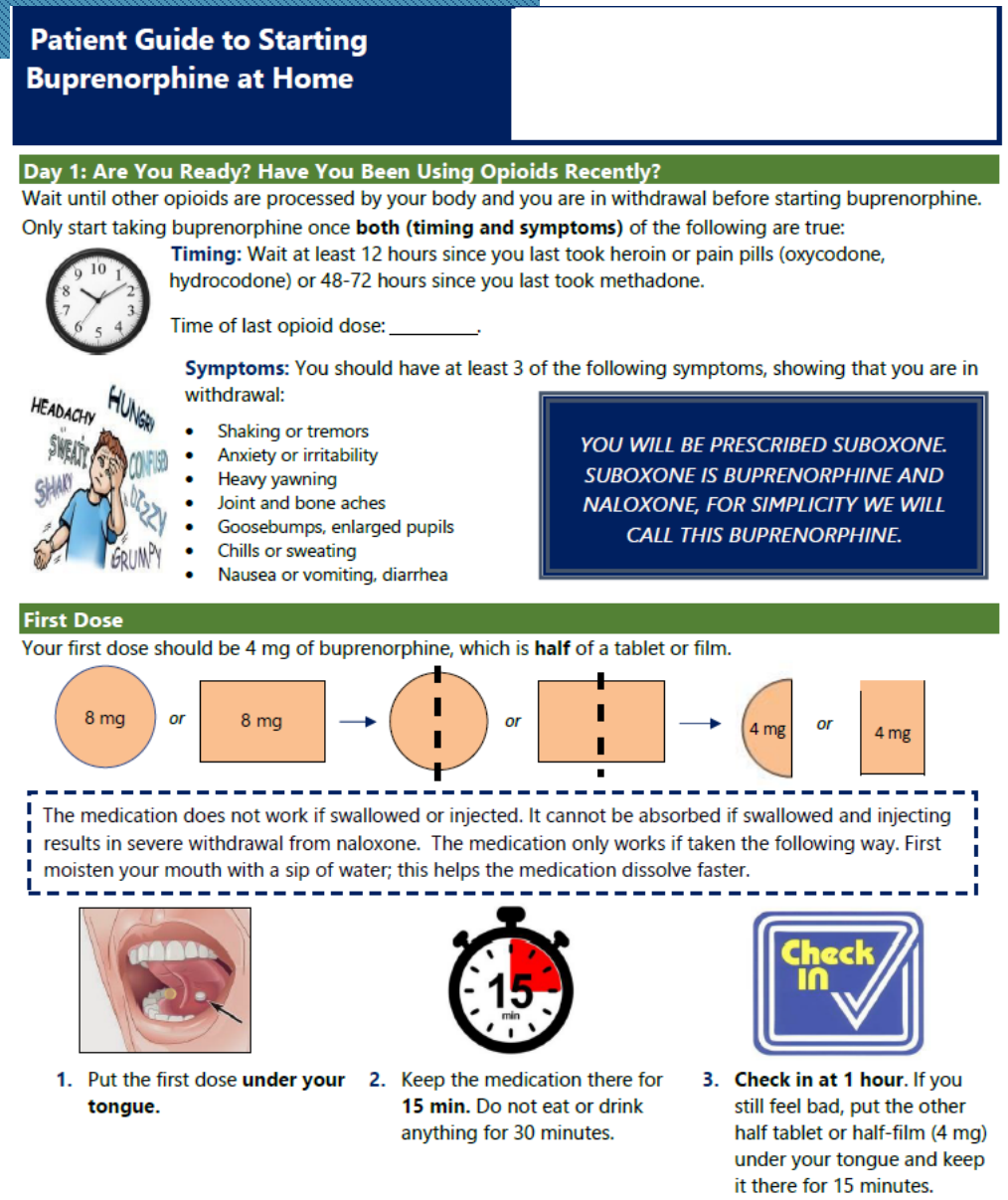
HOME INDUCTION: BALANCE RISKS AND BENEFITS

- Weigh the benefits of home induction for MAT with the risks of home induction for MAT with benefits of
  - Continued use of opioids
  - Requiring in office appointment
  - Requiring therapy first, housing first, psych treatment first, labs first
- Informed Consent can be conducted over the phone or telehealth
  - risks, benefits and alternatives
- Explanation of induction process can be over phone or telehealth
- Be available by phone or telehealth for questions
- Schedule follow up as would be scheduled for in office

Sources: https://www.bridgetotreatment.org/; https://www.asam.org/docs/default-source/education-docs/unobserved-home-induction-patient-guide.pdf?sfvrsn=16224bc2_0

BUPRENORPHINE HOME INDUCTION: PATIENT GUIDE

- Front
  - Are you ready to start buprenorphine
    - Timing
    - Symptoms
  - First dose
    - Medication does not work if
    - Instructions
- Back
  - Day 2
  - Follow Up
  - Additional information



Patient Guide to Starting Buprenorphine at Home

Day 1: Are You Ready? Have You Been Using Opioids Recently?

Wait until other opioids are processed by your body and you are in withdrawal before starting buprenorphine.

Only start taking buprenorphine once **both (timing and symptoms)** of the following are true:

Timing: Wait at least 12 hours since you last took heroin or pain pills (oxycodone, hydrocodone) or 48-72 hours since you last took methadone.

Time of last opioid dose: _____.

Symptoms: You should have at least 3 of the following symptoms, showing that you are in withdrawal:

- Shaking or tremors
- Anxiety or irritability
- Heavy yawning
- Joint and bone aches
- Goosebumps, enlarged pupils
- Chills or sweating
- Nausea or vomiting, diarrhea

YOU WILL BE PRESCRIBED SUBOXONE. SUBOXONE IS BUPRENORPHINE AND NALOXONE, FOR SIMPLICITY WE WILL CALL THIS BUPRENORPHINE.

First Dose

Your first dose should be 4 mg of buprenorphine, which is **half** of a tablet or film.

8 mg or 8 mg → or → 4 mg or 4 mg

The medication does not work if swallowed or injected. It cannot be absorbed if swallowed and injecting results in severe withdrawal from naloxone. The medication only works if taken the following way. First moisten your mouth with a sip of water; this helps the medication dissolve faster.

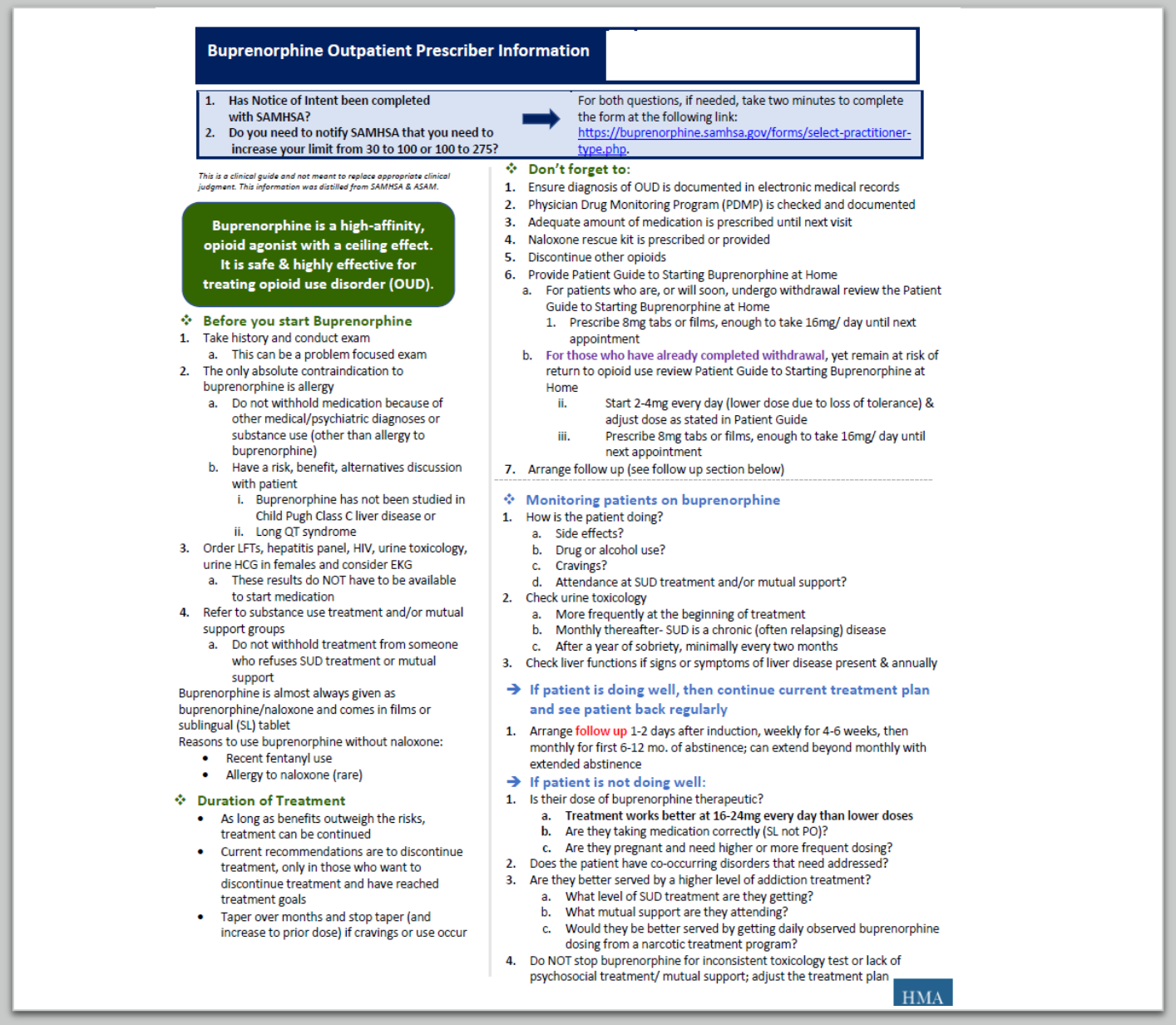
1. Put the first dose **under your tongue.**
2. Keep the medication there for **15 min.** Do not eat or drink anything for 30 minutes.
3. **Check in at 1 hour.** If you still feel bad, put the other half tablet or half-film (4 mg) under your tongue and keep it there for 15 minutes.

https://www.integratedcaredc.com/resource/patient-guide-to-starting-buprenorphine/

BUPRENORPHINE PROVIDER GUIDE

- Notice of Intent to prescribe
- Before you start Buprenorphine
- Don't forget to…
- Monitoring
- If your patient is doing well
- If your patient is not doing well
- Duration of Treatment

Source: https://www.integratedcaredc.com/resource/buprenorphine-outpatient-prescriber-information/



Buprenorphine Outpatient Prescriber Information

1. Has Notice of Intent been completed with SAMHSA?
2. Do you need to notify SAMHSA that you need to increase your limit from 30 to 100 or 100 to 275?

→ For both questions, if needed, take two minutes to complete the form at the following link: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php.

This is a clinical guide and not meant to replace appropriate clinical judgment. This information was distilled from SAMHSA & ASAM.

Buprenorphine is a high-affinity, opioid agonist with a ceiling effect. It is safe & highly effective for treating opioid use disorder (OUD).

❖ **Before you start Buprenorphine**

1. Take history and conduct exam
   a. This can be a problem focused exam
2. The only absolute contraindication to buprenorphine is allergy
   a. Do not withhold medication because of other medical/psychiatric diagnoses or substance use (other than allergy to buprenorphine)
   b. Have a risk, benefit, alternatives discussion with patient
      i. Buprenorphine has not been studied in Child Pugh Class C liver disease or
      ii. Long QT syndrome
3. Order LFTs, hepatitis panel, HIV, urine toxicology, urine HCG in females and consider EKG
   a. These results do NOT have to be available to start medication
4. Refer to substance use treatment and/or mutual support groups
   a. Do not withhold treatment from someone who refuses SUD treatment or mutual support

Buprenorphine is almost always given as buprenorphine/naloxone and comes in films or sublingual (SL) tablet

Reasons to use buprenorphine without naloxone:

- Recent fentanyl use
- Allergy to naloxone (rare)

❖ **Duration of Treatment**

- As long as benefits outweigh the risks, treatment can be continued
- Current recommendations are to discontinue treatment, only in those who want to discontinue treatment and have reached treatment goals
- Taper over months and stop taper (and increase to prior dose) if cravings or use occur

❖ **Don't forget to:**

1. Ensure diagnosis of OUD is documented in electronic medical records
2. Physician Drug Monitoring Program (PDMP) is checked and documented
3. Adequate amount of medication is prescribed until next visit
4. Naloxone rescue kit is prescribed or provided
5. Discontinue other opioids
6. Provide Patient Guide to Starting Buprenorphine at Home
   a. For patients who are, or will soon, undergo withdrawal review the Patient Guide to Starting Buprenorphine at Home
      1. Prescribe 8mg tabs or films, enough to take 16mg/ day until next appointment
   b. For those who have already completed withdrawal, yet remain at risk of return to opioid use review Patient Guide to Starting Buprenorphine at Home
      ii. Start 2-4mg every day (lower dose due to loss of tolerance) & adjust dose as stated in Patient Guide
      iii. Prescribe 8mg tabs or films, enough to take 16mg/ day until next appointment
7. Arrange follow up (see follow up section below)

❖ **Monitoring patients on buprenorphine**

1. How is the patient doing?
   a. Side effects?
   b. Drug or alcohol use?
   c. Cravings?
   d. Attendance at SUD treatment and/or mutual support?
2. Check urine toxicology
   a. More frequently at the beginning of treatment
   b. Monthly thereafter- SUD is a chronic (often relapsing) disease
   c. After a year of sobriety, minimally every two months
3. Check liver functions if signs or symptoms of liver disease present & annually

➔ **If patient is doing well, then continue current treatment plan and see patient back regularly**

1. Arrange follow up 1-2 days after induction, weekly for 4-6 weeks, then monthly for first 6-12 mo. of abstinence; can extend beyond monthly with extended abstinence

➔ **If patient is not doing well:**

1. Is their dose of buprenorphine therapeutic?
   a. **Treatment works better at 16-24mg every day than lower doses**
   b. Are they taking medication correctly (SL not PO)?
   c. Are they pregnant and need higher or more frequent dosing?
2. Does the patient have co-occurring disorders that need addressed?
3. Are they better served by a higher level of addiction treatment?
   a. What level of SUD treatment are they getting?
   b. What mutual support are they attending?
   c. Would they be better served by getting daily observed buprenorphine dosing from a narcotic treatment program?
4. Do NOT stop buprenorphine for inconsistent toxicology test or lack of psychosocial treatment/ mutual support; adjust the treatment plan

HMA

RISKS AND BENEFITS OF LOW BARRIER CARE, INCLUDING HOME INDUCTION

2003: Medication is	Outcomes: Continued use of opioids & possible death	2021: Medication is	Outcomes: Buprenorphine blocks opioid receptor & prevents OD & death
Contingent on attending therapy (1, 2)	☹	Not contingent	☺
Discontinued when using other substances, including concomitant use of CNS depressants (1, 3)	☹	Not discontinued	☺
Discontinued with relapse(1)	☹	Not discontinued	☺
Contingent upon being in clinic (1)	☹	Not contingent	☺
Contingent upon lab work (1)	☹	Not contingent	☺

1. ASAM 2020 OUD Practice Guideline Updates
2. National Academy of Sciences

MONITORING PATIENTS WITH SUD

- Frequency should be dictated by patient acuity
  - More frequently at the beginning
  - Less frequently once stable
  - Less frequently after a year of sobriety
- Components of monitoring patients with SUD
  - Use of drug of choice
  - Use of other drugs
  - Engagement in psychosocial treatment or mutual support
  - Recovery environment
  - Patient self report of use, cravings, recovery activities, attainment of sober living skills
  - Our assessment of use, cravings, recovery activities, attainment of sober living skills
    - MSE
    - Progress toward treatment goals
    - Toxicology

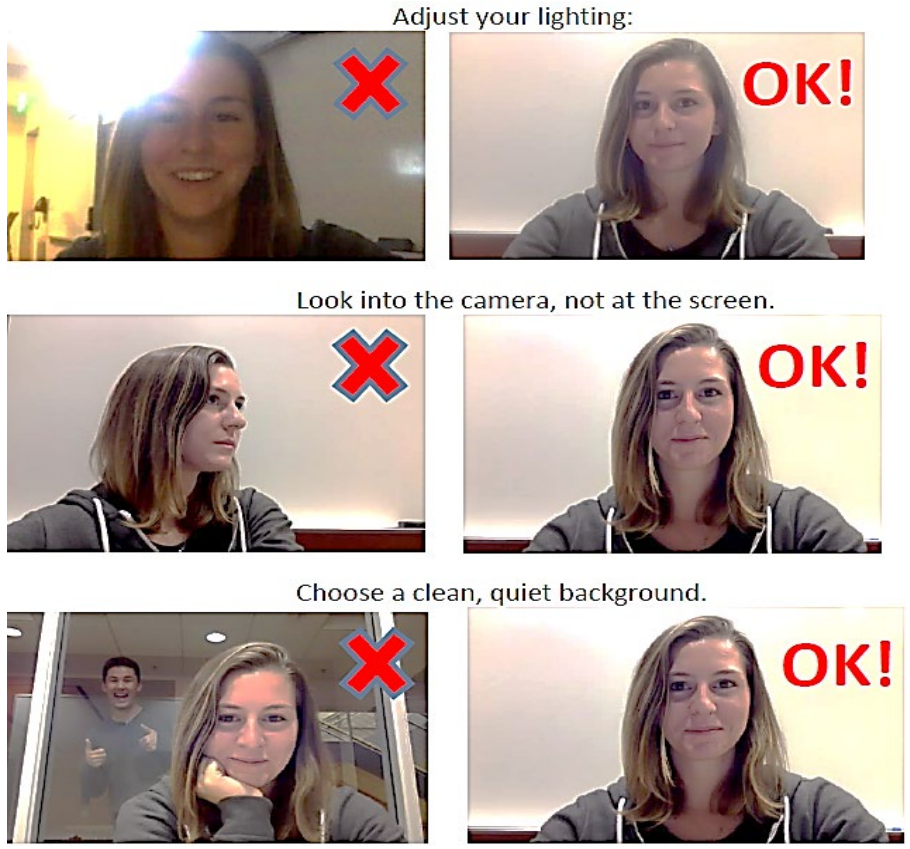
MONITORING AND TOXICOLOGY TESTING

- Toxicology
  - ASAM recommends monthly toxicology for patients stable on buprenorphine for OUD
    - Consideration for less frequent testing for those stable in recovery*
  - OTP requirement is at least 8/year
  - During emergency need to modify expectations for toxicology
    - Reserve for greatest need & when it would change management**
    - Consider mailing point of care tests to patients
- DO NOT WITHHOLD TREATMENT BECAUSE OF LAB TESTING***

Source: * 2017 ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine
** https://www.asam.org/quality-care/clinical-guidelines/covid/adjusting-drug-testing-protocols
*** ASAM 2020 OUD Updates

PATIENT ENGAGEMENT

PATIENT ENGAGEMENT



- Be aware of distractions
  - Lighting
  - Noise
    - Dog or others in the house
    - How loud is your typing…
- Background
  - Plain walls are best
  - Glass door
  - Open door
- Foreground
  - Pin stripes and patterns in clothing

PATIENT ENGAGEMENT

- Look at patients & minimize distraction
- Have information available for patients
  - about the telehealth process
  - download the platform before appointment
  - what to do for technology failure
  - What will happen if the appointment is hijacked
- Be prepared for
  - Consenting patients
  - Verifying identification
  - Suicidality
  - Angry patients that disconnect
  - Disruptive group members
- Generate and review group rules

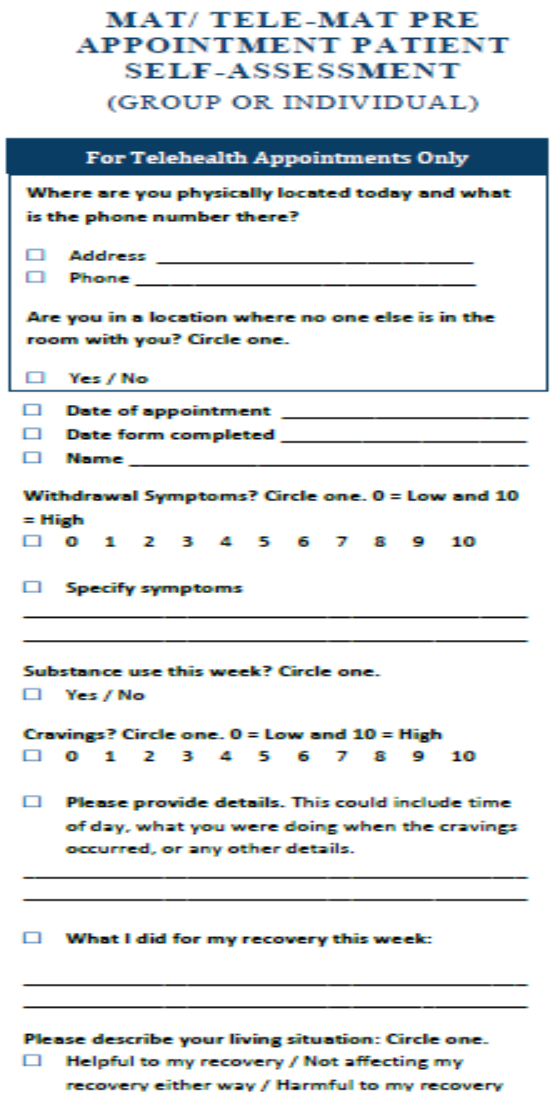
PATIENT ENGAGEMENT ROLES AND RESPONSIBILITIES

- Scheduler- Set up your virtual group (or individual appointment)
  - Password protect the group
  - Entry chime
  - Co-host/ Alternate Host permissions
  - Waiting Room
  - In meeting features
    - Annotation, whiteboard, break out rooms
  - Mute Upon Entry
- Who gathers info pre group and what to gather
  - Medical Records review
    - Any ED/hospital/surgeries visits since last visit
    - Updates to treatment plan from other providers
  - Recent Labs
  - Pre appointment self assessment
- Group facilitator/ host
  - Materials prepared to teach skills for the day
- Co-facilitator/ co-host/ alternative host
  - Prepared to teach skills if facilitator doesn't arrive
  - Prepared to handle emergencies

ROLES AND RESPONSIBILITIES
CHECK-IN/ PATIENT SELF ASSESSMENT

- Where is the patient today? Address?
- What is their phone number where they are today?
- Check in regarding privacy
  - It is critical for group members to ensure the privacy of entire group
- Check in regarding symptoms
  - Substance Use
- Any acute issues requiring additional assistance?
  - Medication refills needed
  - Suicidal ideation

https://www.integratedcaredc.com/resource/mat-and-tele-mat-pre-appointment-self-assessment/



MAT/ TELE-MAT PRE APPOINTMENT PATIENT SELF-ASSESSMENT
(GROUP OR INDIVIDUAL)

For Telehealth Appointments Only

Where are you physically located today and what is the phone number there?

☐ Address _____
☐ Phone _____

Are you in a location where no one else is in the room with you? Circle one.

☐ Yes / No

☐ Date of appointment _____
☐ Date form completed _____
☐ Name _____

Withdrawal Symptoms? Circle one. 0 = Low and 10 = High
☐ 0 1 2 3 4 5 6 7 8 9 10

☐ Specify symptoms
_____
_____

Substance use this week? Circle one.
☐ Yes / No

Cravings? Circle one. 0 = Low and 10 = High
☐ 0 1 2 3 4 5 6 7 8 9 10

☐ Please provide details. This could include time of day, what you were doing when the cravings occurred, or any other details.
_____
_____

☐ What I did for my recovery this week:
_____
_____

Please describe your living situation: Circle one.
☐ Helpful to my recovery / Not affecting my recovery either way / Harmful to my recovery

Are you experiencing any medication side effects?

Constipation? Circle one.
☐ Not Present / Mild / Moderate / Severe

Nausea, diarrhea, or other intestinal/stomach issues? Circle one.
☐ Not Present / Mild / Moderate / Severe

Sedation? Circle one.
☐ Not Present / Mild / Moderate / Severe

Dizziness? Circle one.
☐ Not Present / Mild / Moderate / Severe

☐ Specify any other side effects:
_____

Are you experiencing any of the following?

Pain? Circle one. 0 = Low and 10 = High
☐ 0 1 2 3 4 5 6 7 8 9 10

Depression? Circle one. 0 = Low and 10 = High
☐ 0 1 2 3 4 5 6 7 8 9 10

Anxiety? Circle one. 0 = Low and 10 = High
☐ 0 1 2 3 4 5 6 7 8 9 10

Trouble sleeping? Circle one. 0 = Low and 10 = High
☐ 0 1 2 3 4 5 6 7 8 9 10

Do you have other health issues that you need addressed? Circle all that apply.
☐ Medical Issues / Mental Health Issues

☐ Other concerns that I need addressed today:
_____

How motivated are you to continue with your substance use disorder treatment? Circle one. 0 = Low and 10 = High
☐ 0 1 2 3 4 5 6 7 8 9 10

VIRTUAL BEST PRACTICES

- Front
  - Before you go on camera
  - Have a plan for
- Back
  - Important Zoom Features

Source: https://www.integratedcaredc.com/resource/virtual-best-practices-for-providers-and-care-team-members/

VIRTUAL GROUPS: BEST PRACTICES FOR PROVIDERS

1/10/2022

HMA INSTITUTE ON ADDICTION

Group therapy is not a meeting, it is the delivery of healthcare.

Certain things may be acceptable during meetings that we avoid during group therapy. Examples of differences include wearing professional attire, limiting distractions such as email, phones and animals.

Before Going on Camera:

- ☐ Download the audio video application you intend to use.
- ☐ Test the internet/ Wi-Fi connection, video, and audio capabilities each day, prior to your first appointment.
- ☐ Ensure your internet is running at least 20 megabits per second, which you can check on sites such as Speedtest.net, or fast.com. If your internet is below 20 megabits per second, try turning off any other devices that are using the same internet source.
- ☐ Set up chargers so your computer and/or phone battery don't run low.
- ☐ Find an empty, quiet space with a door that closes to ensure privacy. Close the door and use a do not disturb sign to ensure no disruption.
- ☐ Minimize background noise as much as you can.
- ☐ Close all programs on your computer. This will reduce the chances of distractions, such as desktop notifications, as well as keep your email secure.
- ☐ Make sure you have anything you need such as medical records, and lab results.
- ☐ Understand how to use any technology tools needed to teach the skills you have planned for the day.
- ☐ Address biological issues such as hunger, thirst or restroom needs before the meeting starts.

- ☐ A simple background works best. There are digital backgrounds available on some telehealth platforms but think about the implications of using one with your patients.
  - Pros- you don't need to be concerned about distractions in your background.
  - Cons- your patients will be less inclined to show you their setting if they can't see yours. Also, hand gestures are harder to see, as your hands may blend into the background.
- ☐ Camera angle is important. Make sure your eyes are looking into the camera so the patients perceive you are looking at them.
- ☐ Position yourself so your patient is seeing you from the chest or waist up. This is especially beneficial to capture hand gestures when you talk.
- ☐ Dress appropriately. This is a medical appointment. Don't wear stripes or patterns as they can shimmer on camera and be very distracting.
- ☐ Position yourself so that most of the light is coming from in front of you (behind your monitor), instead of behind you. If you have a window behind you, shut the blinds.

Have a Plan for:

- ☐ Identifying patients
- ☐ Obtaining consent
- ☐ Technology failure, such as feedback
- ☐ Video-conference hijacking (such as Zoom bombing)
- ☐ Crisis interventions
- ☐ Disruptive patients

EVIDENCE FOR TELEHEALTH

EVIDENCE ON TELEHEALTH

- Telehealth is as effective as in-person care for adults with social phobia, post-traumatic stress disorder, ADHD, tics, depression, chronic pain, irritable bowel syndrome, obesity, substance use disorder including nicotine
- Medication Management and/ or psychotherapy
  - Symptom improvement
    - Decreased alcohol & drug use including nicotine
  - Patient and provider satisfaction
  - Improved quality of life
  - Medication and treatment adherence

Sources: Totten AM, Womack DM, Eden KB, McDonagh MS, Griffin JC, Grusing S, Hersh WR. Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews. Technical Brief No. 26. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No.16-EHC034-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2016.
Lazur, B., Sobolik, L., King, V., Telebehavioral Health: An Effective Alternative to In-Person Care. Millbank Memorial Fund, Issue Brief October 2020.
Pragmatics of Ethical and Effective Telepsychology Practice through Video Conferencing, Mary K. Alvord, Ph.D
Alvord, Baker & Associates, LLC and Resilience Across Borders, Inc., National Register of Health Service Psychologists, 2020.

EFFECTIVENESS OF TELE BEHAVIORAL HEALTH

- Strong Support for **individual** treatment delivered via telehealth & telephone
  - Medication Assisted Treatment (MAT)
    - 1 randomized controlled trial (RCT), 2 quasi experimental design trial (QED), 1 pre-post trial
  - Behavioral Activation (BA)
    - 3 RCTS, 1 pre-post trial
  - Cognitive Behavior Therapy (CBT)
    - 4 RCTs
  - Cognitive Processing Therapy (CPT)
    - 4 RCTs
  - Prolonged Exposure (PE)
    - 2 RCTs, 2 QEDs, 1 pre-post trial

- Substance Use Disorders groups
  - Relapse control therapy for person with opioid use disorders
  - Smoking cessation protocol
  - Therapy for substance use disorders

Source: SAMHSA. Telehealth for Treatment of SMI and SUD. 2021
Lazur, B., Sobolik, L., King, V., Telebehavioral Health: An Effective Alternative to In-Person Care. Millbank Memorial Fund, Issue Brief October 2020
Gentry MT, et al. (2019) J Telemed Telecare.

EFFECTIVENESS OF VIRTUAL SELF-HELP GROUPS FOR SUD TREATMENT

- Self Management And Recovery Training (SMART) online
  - Long history of virtual meetings and in person meetings
  - Also doing hybrid group
- AA and NA significantly increased access to virtual meetings during COVID-19 pandemic
  - Continues to offer
    - Virtual meetings
    - In person meetings
    - Hybrid in person/ virtual meetings

Source: Campbell, W et.al. (2016) Journal of Medical Internet Research.

Q&A

QUESTIONS AND DISCUSSION

» What are you most concerned about?

Leveraging telehealth is part of the
National Roadmap on State Level Efforts to End the Nation's Drug Overdose Epidemic

Leading-edge practices and next steps to remove barriers to evidence-based patient care
AMA and Manatt 12-2020

CMS guidance: telehealth services should be reimbursed at the same rate as face-to-face services
CMS Telemedicine Toolkit

MARY'S CENTER PROJECT ECHO

HMA INTEGRATED CARE DC

Mary's Center

Project ECHO

UNM SCHOOL OF MEDICINE

Every other Monday from 12:15pm-1:15pm.

2022 OUD ECHO Dates
January 10, 2022
January 24, 2022
February 7, 2022
February 21, 2022
March 7, 2022
March 21, 2022
April 4, 2022
April 18, 2022

Mary's Center's Opioid Use Disorder ECHO:

A collaborative, web-based mentoring community to increase and improve the treatment of patients with opiate use disorder (OUD) in community clinics in Washington, DC.

FREQUENTLY ASKED QUESTIONS:

Who should participate in this ECHO?

- Any provider at any level currently or those interested in working with Opiate Use Disorder patients should attend. That means waivered and non-waivered medical providers, nurses, medical assistants, community support workers, behavioral health providers – you name it!

How do I sign-up as a participant?

- Please e-mail Asallasbrookwell@maryscenter.org to sign up. This will ensure you receive ECHO updates, agendas, and Zoom links to participate.

What if I want to present a case?

- If you have a case, please e-mail dsmith@maryscenter.org and asallasbrookwell@maryscenter.org no less than one week prior to the consultation.

CONTACT US

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WRAP UP AND NEXT STEPS

- Please complete the online evaluation! **If you would like to receive CME credit, the evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar.

- The webinar recording will be available within a few days at: https://www.integratedcaredc.com/learning/

- **Upcoming Webinars:**
  - *How to Mitigate Workforce Burnout and Fatigue*, February 8, 2021, 12:00 pm – 1:00 pm EST
  - *Integrating Screening for Drug Use in General Medical Settings and Optimizing the Care Team*, February 22, 2021, 12:00 pm – 1:00 pm EST

- For more information about Integrated Care DC, please visit: https://www.integratedcaredc.com/