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

SUPPORT ACT GRANT
MONTHLY STAKEHOLDER MEETING
OCTOBER 19, 2020

Department of Medical Assistance Services

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.
Automated CC is available for this event with realtime captions that will run simultaneously with the presentation.

The streaming text is available through


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If you have any questions please send an email to CivilRightsCoordinator@DMAS.Virginia.Gov
Welcome and Meeting Information

• We have an ‘open’ meeting format to allow participation and questions

• Please make sure your line is muted if you are not speaking
  • We will mute all lines if there is a lot of background noise

• If you are having issues with audio, please type questions or comments in the chat box.
How to Mute and Unmute in WebEx

Everyone is muted at the beginning of the webinar – when you are ready to ask a question, please click the red microphone button to unmute. When you are finished, please click it again to mute your line.
## Agenda

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<tr>
<th>Item</th>
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<td>Webinar Set up</td>
<td>10:00 - 10:05</td>
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<tr>
<td>Welcome and SUPPORT Act Grant Overview</td>
<td>10:05 - 10:10</td>
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<tr>
<td>SUPPORT Act Grant Updates</td>
<td>10:10 - 10:25</td>
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<tr>
<td>Behavioral Health Updates</td>
<td>10:25 - 10:30</td>
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<td>Carilion Emergency Department Bridge Clinic</td>
<td>10:30 - 11:00</td>
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<tr>
<td>Break</td>
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<td>Peers</td>
<td>11:05 - 11:50</td>
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<tr>
<td>Q&amp;A</td>
<td>11:50 - 11:55</td>
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<tr>
<td>Next Steps</td>
<td>11:55 - 12:00</td>
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Overview of SUPPORT Grant Initiatives

Notice of Award: September 18, 2019

Period of Performance: September 30, 2019 to September 29, 2021 (18 months + 6 month no cost extension)

Approved Budget: $4.8 million

Components
1. Need assessment
2. Strengths-based assessment
3. Activities to increase provider capacity
Virginia Medicaid’s SUPPORT Act Grant Goals:

• Learn from Addiction and Recovery Treatment Services (ARTS) program
  ▪ Appreciate successes
  ▪ Learn from challenges
• Decrease barriers to enter workforce
• Focus on specific subpopulations
  ▪ Justice-involved
  ▪ Pregnant and parenting members
• Maintain our core values
  ▪ Person-centered, strengths-based, recovery-oriented
Grant Team

- Alyssa Ward, Ph.D., LCP, Director, Division of Behavioral Health
- Ashley Harrell, LCSW, Project Director & ARTS Senior Program Advisor
- Jason Lowe, MSW, CPHQ, Grant Manager
- Christine Bethune, MSW, Grant Coordinator
- Paul Brasler, MA, MSW, LCSW, Behavioral Health Addiction Specialist
- John Palmieri, Data Analyst
- Tiarra Ross, Budget Analyst
- Trenece Wilson, Policy and Planning Specialist
- Adam Creveling, MSW, CPRS, Grant Program Specialist
SUPPORT ACT GRANT UPDATES
OCTOBER 2020
SUPPORT Act Grant Updates: October

Upcoming CMS Submissions:
• Second Quarterly Progress Report
• Next Semi-Annual Narrative and Fiscal Reports
• Both due October 30

New CMS Terms & Conditions
• Acknowledgement of Sponsorship
• Review of Public Materials
Projects Underway

• Needs assessment: VCU Department of Health Behavior and Policy
  ▪ Continuum of care needs assessment
  ▪ Member surveys and interviews
  ▪ Buprenorphine-waivered prescriber analysis

• Brightspot assessment: VCU Wright Center
  ▪ Training pre/post-test implemented – take part for your chance to win an Amazon gift card!
  ▪ Project ECHO opportunities
  ▪ Data visualization - HealthLandscape in development
Projects Underway

- Policy Landscape Analysis – analyze policy options for Virginia in response to changes introduced by the SUPPORT Act
  - Manatt Health and State Health Partners continue to meet with workgroups and interview stakeholders to inform policy landscape
  - Deep dive into telehealth policies, post-discharge planning, treatment gaps
  - Upcoming workgroup schedule:
    - October 21 – Racial Disparities and Health Inequity
    - November 17 – Telehealth
    - December 15 – Benefits and Cost Sharing
Projects Underway

- Medication Assisted Treatment/Peer Recovery Services in EDs pilot – Virginia Hospital and Healthcare Association Foundation
  - Procurement and Contract Management has drafted Settlement Agreement that is with Office of the Attorney General for final approval
  - Grant team has tentative reallocation plan in place and is awaiting execution of Settlement Agreement to move forward
Projects Underway

• Justice-involved environmental scan and pilot
  ▪ Held kickoff meeting with Health Management Associates (HMA) on October 9
  ▪ Upcoming meetings will discuss details of environmental scan and pilot projects
  ▪ Grant team continues to dialogue with Virginia Department of Corrections about implementation of contract in light of COVID-19 pandemic
SUPPORT Act Grant Updates: October

Projects in Development

Subaward Applications

• Fifteen applications were received
• Team has scored applications and forwarded documentation to Procurement and Contract Management
• Awards will be announced as soon as possible
Projects in Development

Fall Technical Assistance Applications

- Thirty applications were received, emails have been sent to all applicants
- TA Team is reaching out to selected applicants to discuss details of individual applications
- Events will take place in November and December 2020
- Hoping to perform second round of TA in Spring 2021
New Website Location!
# SUPPORT Act Grant Website

## Information
- Hepatitis C Webinar: September 8, 2020 - Information and Registration [pdf]
- August 2020 SUD Webinar Series Schedule [pdf]
- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]
- July 2020 Substance Use Disorder Webinar Series Schedule [pdf]
- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia’s SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

## Monthly Stakeholder Meetings
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [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]
- 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]
- 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 De-escalation [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]
VIRGINIA MEDICAID
BEHAVIORAL HEALTH
UPDATES

Ashley Harrell, LCSW, ARTS Senior Program Advisor
Virginia Department of Medical Assistance Services
473,321 newly eligible adults enrolled as of 10/15/2020

37,263 received an ARTS Service!

Medicaid plays a critical role in the lives of nearly 1.7 million Virginians
Updates on COVID-19 Continuation and Timelines related to the Public Health Emergency (PHE)

Behavioral Health and Addiction and Recovery Treatment Services

DMAS Memo posted 9/30/20:

• On July 23, 2020, the Secretary of Health and Human Services (HHS) renewed the federal PHE due to the continued consequences of the Coronavirus Disease (COVID-19), effective July 25, 2020.
• This 90-day extension was set to expire on October 22, 2020.
Updates on COVID-19 Continuation and Timelines related to the Public Health Emergency (PHE)

Behavioral Health and Addiction and Recovery Treatment Services

- On October 2, 2020, HHS renewed the federal PHE due to the continued consequences of the COVID-19, effective October 23, 2020.
- This 90-day extension will expire on January 20, 2021 unless renewed.
- At the state level, Virginia Executive Orders (EO) 51 and 58 provide corresponding policy flexibilities associated with the state PHE declaration, which currently do not have an expiration date.

Most flexibilities that DMAS has implemented depend on both state and federal authorities. DMAS is required to unwind the flexibilities obtained when either the federal or the state PHE declarations expire.

Any flexibilities listed in these Medicaid Memos are still in effect during this current PHE unless explicitly stated otherwise.

DMAS will issue a memo at least thirty (30) days in advance of any changes to allow providers to adequately prepare their process and systems.

Providers delivering services via telehealth, including telephonic (audio only) communications, shall bill and submit a claim as they normally would in their regular practice.

The Place of Service (POS) that the provider usually bills for telehealth shall remain the same as well.

DMAS is not requiring use of telehealth modifiers in order to minimize systems errors during this critical time.

Providers using telehealth POS (02) or modifiers GT (interactive audio and video telecommunications system) or GQ (synchronous telecommunications system) based on guidance provided prior to COVID, shall continue to use these when billing for services.

DMAS will issue a memo on specific billing policies for telehealth delivery at a future date.
The Carilion ED Bridge to Treatment Program: Lessons Learned

ED Bridge team: John H. Burton, MD, Chair, ED Cheri W Hartman, PhD, Administrator, Office-based opioid treatment, OBOT; ED Bridge Quality Improvement Project Manager; David W Hartman, MD lead physician of the OBOT in Psychiatry Dept; Erin Casey, MA, Supervisor of the Peer Recovery Specialists program/Community Outreach Division, Carilion Clinic, Roanoke, VA
MAT in the ED: why or why not?

“Bridge to Nowhere - Concern”
It was important to establish rapid access to outpatient treatment portal.

“Open the flood gates”
EDs are already busy, might increase frequent flyers – in fact, we saw a decrease at first-none of first 44 patients returned to the ED in next 3 months; recently there has been an increase in return visits but not surpassing pre-bridge levels for addiction-related presentations in the ED. Reduces “pivoting” to suicidal ideation admissions.

“That’s not what we do”
Emergency physicians have historically not felt equipped to engage in addiction treatment.
MAT in the ED: why or why not?

Dr. John Burton: “Education around MAT was needed to address a **critical knowledge deficit** systemic in the ED culture:
(a) knowledge about addiction as a disease,
(b) MAT was misunderstood; knowing about the straightforward medical tool of buprenorphine countered the perception that treatment was hopeless and not appropriate for an ED provider to administer; We were convinced it was either outside of our skillset, or beyond our resources.”
(c) Waiver training has demystified MAT and provided a tool to be used by the ED physicians.
(d) “This replaced hopelessness with hope, frustration with a rewarding sense of accomplishment.”
Dr. Karen Kuehl, Emergency Medicine, Carilion Clinic
For those obtaining a waiver to prescribe buprenorphine, the following link accesses a free program by the **American Academy of Addiction Psychiatry.**

[https://learning.pcssnow.org/p/onlinematwaiver](https://learning.pcssnow.org/p/onlinematwaiver)

You can also find courses on **American Society of Addiction Medicine.** The ASAM course is:


The Federal requirement is an 8 hour course, and these can be take entirely online now. The courses are free.

Once training is complete, go to:


On the **SAMHSA site** you can apply for the waiver. - they will need your information and certificate of training proof.

The SAMHSA process takes a few weeks to clear.
Buprenorphine in the ED: why or why not? Bridge to .... Where?

(1) Importance of outpatient clinic partnership(s) offering rapid access to treatment and (2) triaging by ED case managers (or OBOT care coordinators) applying the ASAM principles and dimensions: treatment is not a one size fits all; using SBIRT methods that apply the motivational interviewing, patient-centered approach, to find the best fit for the patient using “warm” handoff best practices with:

(3) Peer Recovery Specialist supports and ongoing care coordination and interagency communications.

Transitions in Care = High Vulnerability
ED Bridge Protocol – Modeled on Dr. Andrew Herring’s Program*

- Patient assessed in ED with a moderate to severe opioid use disorder using the DSM-5 criteria

- Baseline Urine Drug Screen: don’t wait for results…but they become available to the outpatient clinic

- **COWS** Score in chart: mild/moderate withdrawal, if not in withdrawal, consider home induction (Wesson and Ling, 2003)

- Labs: Urine Pregnancy, LFTs, Hepatitis A/B/C – exclude patients who have severe liver disease, an active alcohol or benzodiazepine use disorder
- Screening for suicidality or psychosis

- Peer Counselor consult obtained – asap (Carilion embeds peers in ED, Mon–Fri, 9 to 5 pm)

- Social Work/Case Management: ED has case managers that help patients with problem-solving Rx issues, follow up

- Use discharge handout with phone numbers and instructions for accessing OBOT care coordinators for intake (typically next day phone appointment is arranged upon referral) and IF DEEMED APPROPRIATE patient’s chart is shared with the lead prescriber of the OBOT (Dr. David Hartman). Care Coordinators help navigate rapid access to treatment. Prescribers block time slots saved for ED referrals. During COVID19 emergency status the intake and the prescriber evaluation is done virtually: informed consents, releases, interdisciplinary care plans are approved virtually by patient and prescriber.

*Available in the public domain
Early Results in Carilion QI Study (November 2019)

From ED in 1st 6 mos. = 77 patients  
Crossed bridge- intake = 63 pts  
Success rate = 81.8%

Among the 77 patients, 61 (79.22%) received buprenorphine in the ED; they were 4x more likely to cross the bridge than patients not started on MAT.

As appropriate patients in withdrawal were more likely to be initiated on MAT and more likely to cross the bridge into treatment, than patients not in withdrawal.

Two of six overdose survivors expressed interest in referral to treatment, remained in ED long enough to go into withdrawal and were initiated on buprenorphine. Pts were provided Rx (for bup.) and one of them entered the OBOT. Other had a repeat visit to the ED and entered successfully into OBOT a month later. Four of six OD survivors refused referral to treatment. Two other ODs were deemed intentional.
Triaging: not everyone on our shores are where they need to be

Triage is done by Carilion Psych care coordinators using ASAM criteria (six dimensions) to assess level of care and type of program needed. We report on the 6 domains doing a chart review and engaging assistance of the nurse if needed, in addition to the patient interview:

1) Intoxication/acute medical condition: W/L; harm to self or others
2) Biomedical conditions (review chart)
3) Mental health diagnosis (review chart)
4) Readiness to change – motivational interviewing
5) Relapse, continued use, continued problem potential (OUD evidence)
   DAST is required at Carilion; treatment history
6) Recovery or living environment: supports, transportation, employment housing, phone/wifi access; finances, legal involvement, child welfare issue, insurance coverage: can they afford the medication – if not, Blue Ridge Behavioral Health can they participate in virtual care or in person care; is there a program in closer proximity – do they live in Virginia?
Lessons learned

• Triage is critical: triaged 63 patients in Phase I Study: 6 referred to higher level of care. Information gathered during triage informs IPOC development by the team, it is shared with the prescriber and nurse. We recommend triaging using an SBIRT approach that is billable.

• Rapid access to intake/care coordination appointment is as important as access to prescriber. This can be done successfully on the phone – there is built in flexibility this way; patient is less tied to a short window of appointment opportunities (the one-hour window, when patients had to come in person.)

• Peer linkage improved likelihood of navigating across the bridge by 300%; integrating peers into ED is a challenge. We now embed them in person.

• Care coordinators repeat the information about peers being available to support their care, whether they enter our OBOT or if it is decided that another program would be better for them. (Peer recovery center is right next to our outpatient offices – we could walk them over there to see it; coffee was provided and drop ins were welcomed. Similar to a “low threshold clinic” – our aim is to offer patient-centered support geared to the patients’ readiness level.)
Peer Recovery Specialists

• Carilion’s PRS’ are certified and are supervised by a very skilled, certified supervisor.
• Drop in nature of the center with coffee and snacks, a welcoming atmosphere has helped patients reach out for support there regardless of the transitions and challenges they are facing.
• Peers will diligently text, meet patients out in the community to support them (going to AA meetings, meeting up at the library to get on the computer, doing prosocial activities together – hikes, museum visits).
• Use WRAPs to help facilitate a patient’s approach to recovery
• Integrate with the OBOT care attending weekly meetings to give us updates; working toward EPIC integration so we can achieve better coordinated care (see upcoming appointments- though not the notes).
• Health care system still working on how to bill for the PRS services – Carilion now subsidizes these costs. We get no reimbursement.
• ED physicians report how beneficial it is to have peers available for the extended hours they provided during the summer even if by phone only.
Keys to OBOT success: ARTS Initiative improvements

• Care coordinators play a key role in monitoring the interdisciplinary plan of care; tracking new patient needs (medical, housing, relationship issues, transportation, child welfare, legal involvement) in the 6 domains affecting recovery.

• Co-located therapy provides integration of the psychosocial interventions into the MAT – treating addiction as a biopsychosocial disease. We are a training site for residents and Addiction Medicine fellows, which deepens our capacity to treat psychiatric co-morbidities, including both medications and relevant therapies.

• EPIC – a platform for sharing relevant EHR- information on all aspects of a patient’s medical and behavioral healthcare (inpatient and outpatient); including access to ED records.
Rapid access to intake: plotted for patients admitted to OBOT from ED Bridge

# of Days from ED Discharge to OBOT Intake/First Visit by # of Patients
Telemedicine/teletherapy impact?

- Patients have increased access to care coordinators – we use Google phones that patients can use to directly contact their care coordinators Monday – Friday (9-5); consents to treatment, IPOCs, releases – signed virtually.

- Patients benefit from “state of emergency” getting medical evaluations telephonically or using vidyo if prescriber prefers having visual input.

- Increased emphasis placed on chart review, oral history taking, significant others can be included in these visits if patient gives permission.
Telephonic Audio-Only Psychiatric/OBOT Evaluations*

Telephone interviews, relying on audio input only, are often sufficient to obtain a quality clinical evaluation.

- Mastering the art of a good psychiatric/psychosocial interview is the most important factor influencing the quality of evaluation information gathered, whether audio-only or audiovisual.

- 85 percent of a psychiatric/medical diagnosis is based on a good history. Asking open-ended questions during initial part of an evaluation provides much information, while later in the visit asking more focused questions clarifies one’s concerns. During the open-ended question period, observe how open the patient is, their comfort level. Giving short answers or evading questions is interpretable behavior.

- Tune into the audio elements you might typically overlook. Noting the rate of speech, the volume, and patient’s choice of words can indicate whether they are confident or insecure. A patient who gives short answers, such as responding with a curt yes or no, or patients who hesitate in their speech may be hiding important information. In forensic psychiatry it has been noted that a patient’s voice will reveal truth or lack of truth more so than the patient’s facial expression. People often learn how to present a poker face, while they are not always adept at controlling their voice.

- Use best practices for teletherapy – make sure patient is in a confidential setting as free from distractions as possible. These factors affect the quality of the interview and need to be safeguarded.

*Handout developed by Dr. David W. Hartman (visually impaired psychiatrist, OBOT lead physician)
More Tips for the audio-only interview

• A patient who talks excessively about their problems, may be an individual who tends to be more needy, while a patient who downplays their problems may be more autonomous.

• When patients hesitate, trying to find the correct word, they might be demonstrating their anxiety. The sounds of a patient moving around or tapping their fingers also displays their anxious nature.

• The pattern of pressured speech or frequent topic changes is well known to be a symptom of mania; the soft low voice with short answers might reflect depression. Loud aggressive voice tones can be expressions of an angry agitated individual. Being able to see an individual’s face may enable the examiner to more quickly determine the patient’s mood; simply listening to the patient’s voice and what they are saying might take more time. Too often a psychiatrist moves through an evaluation too quickly. With sufficient time, observing the quality of someone’s voice can relay clues about a person’s affect; evaluating whether a patient has a labile mood or is demonstrating a constricted affect through a flat tone. Taking more time to listen to the patient strengthens rapport and the quality of the evaluation.

• Embrace the opportunity to develop our listening skills during this era of COVID-19 and an increased reliance on telephonic interviews.
Retention in treatment: do we succeed at keeping the ED Bridge patients in our care?

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<tr>
<td>1 month</td>
<td>44/48</td>
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<tr>
<td>2 months</td>
<td>24/28</td>
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<td>3 months</td>
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<td>4 months</td>
<td>9/15</td>
<td>60%</td>
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<tr>
<td>5 months</td>
<td>5/9</td>
<td>55.56%</td>
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A general OBOT retention study is underway with all patients regardless of referral source. The overall retention rate in our OBOT for a 12 month period is 71%. It appears that retention of the ED Bridge patients is lower; studying what factors affect this is being explored as well as a study of the impact of the COVID 19 adaptations.
Conclusions to date

• The impact on the culture of the ED toward patients struggling with an opioid use disorder has been the most notable transformative change of the Carilion ED Bridge to Treatment.

• The ARTS Initiative and its impact on increasing the # of MAT providers, the ability to provide interdisciplinary care through care coordinators, and creation of the peer recovery specialist services, as a billable service, equips more health care systems to expand and facilitate access to treatment leveraging the opportunities provided through an ED Bridge to Treatment.

We have more lessons to learn – but the benefits are immediately evident: this program saves lives by providing access to buprenorphine that is protective (adhering strongly to the mu receptor) at a most timely juncture, relieving patients of the agony of withdrawal, and introducing them to the hope for recovery that medication-assisted treatment provides. Partnering with the Emergency Department is essential to their ability and willingness to venture into this new territory. Together with a PRS program and with partnering OBOTs, these bridges can be built in health care systems throughout Virginia and beyond.
Thank you!

Dr. Cheri Hartman:
cwhartman1@carilionclinic.org
BREAK TIME!

Please take a short – five minute – break
Tom Bannard, CADC, MBA
Program Coordinator for Rams in Recovery at Virginia Commonwealth University.

Tom is a Certified Alcohol Drug Counselor and has spent most of his career working in homeless services at CARITAS. A person in long-term recovery, Tom is an advocate for people in recovery or who are struggling with a substance use disorder. Tom has played a key role in the growth of Collegiate Recovery at VCU spending his first 2 ½ years as a volunteer on the project team until he was hired in October 2015 as the program’s first coordinator. VCU’s program has grown rapidly in the past 18 months with more than 60 students attending meetings on weekly basis, and 14 weekly recovery groups on campus, and 2 Family Education Programs. Tom is passionate about changing the way we treat substance use and firmly believes that we must improve our systems of care by focusing on long-term recovery supports, allowing easier access to treatment and recovery resources, educating and supporting family members, and reducing stigma around substance misuse.
BUILDING RECOVERY READY COMMUNITIES

DMAS Stakeholder’s Meeting
10/19/20

Tom Bannard, CADC, MBA
VIRGINIA COMMONWEALTH UNIVERSITY
My Lens and the Moments I would have missed
Collegiate Recovery Expansion Grant – 8 Schools

• Longwood
• Mary Washington
• Radford
• Richmond
• UVA
• Washington & Lee
• Virginia Tech
• Virginia Union University
What professions have the best substance use recovery outcomes?
Recovery Ally Training

- Recovery is a diversity and inclusion issue
- Recovery is a protected status
- There is a tremendous emotional toll around silence about mental health, substance use and recovery status
Recovery Ally Trainings

▪ Centers conversations around substance use on the human needs of those most impacted
▪ Demonstrate understanding of recovery as a long-term process and the way that impacts conversations with people
▪ Differentiate between myths and realities of substance use and addiction and understand how stigma impacts substance users.
▪ Employ appropriate language related to addiction and recovery.
▪ Use of empathy and openness with people in recovery
▪ Apply skills for interactions with people who are ambivalent about change and investigate resources for substance use treatment and recovery.
Top 10 Reasons why an approach centered on Allyship to those most impacted gives us the best hope for improving health of all
Reason #8
Focus must shift from individual responsibility to community recovery
Like all diseases, risk for SUD is impacted by genetics and environment.

Community recovery is a voluntary process through which a community uses the assertive resolution of alcohol and other drug (AOD)-related problems as a vehicle for collective healing, community renewal, and enhanced intergenerational resilience.

—William White
Reason #7
People often get better without professional help (but it takes a long time to thrive)
RESULTS

9.1% or 22.35 million Americans have resolved an alcohol or other drug problem.

PRIMARY SUBSTANCE
- 51% alcohol
- 11% cannabis
- 10% cocaine
- 7% methamphetamine
- 5% opioid

SAMPLE
- 60% male, 45% aged 25-49 years of age,
- 61% non-Hispanic White, 14% Black, 17% Hispanic
- 48% employed, 46% living with family or relatives
PATHWAYS TO RECOVERY

THREE BROAD RESOLUTION PATHWAYS WERE EXAMINED

54% ASSISTED RECOVERY

46% UNASSISTED RECOVERY

52% ABSTINENCE FROM ALCOHOL & ALL OTHER DRUGS

54% ABSTINENCE FROM ALCOHOL OR OTHER DRUGS IDENTIFIED AS PROBLEMATIC

46% SELF-IDENTIFY AS BEING IN RECOVERY

73% DO NOT IDENTIFY AS BEING IN RECOVERY
Many Pathways

- 28% Formal Treatment
- 9% Medication
- 22% Recovery Support Services
- 45% Self-Help Groups
- 17% Outpatient Treatment
- 9% Faith-Based
- 6% Recovery Community Centers
- 35% AA
- 18% NA
Many Pathways to Recovery

12-Step (AA, NA, Al-Anon, CA, MA, etc)
Recovery Dharma
Refuge Recovery
All Recovery
Life Ring
SMART Recovery
Women for Sobriety
Celebrate Recovery
Faith-based approaches
Natural recovery
IT GETS BETTER!
Reason #6

Recovery + Allyship are built on a system of social connectedness; our health system is built on a system of profit.
National Overdose Deaths
Number of Deaths from Prescription Opioid Pain Relievers (excluding non-methadone synthetics)

Source: National Center for Health Statistics, CDC Wonder
Opioid Epidemic

**Vein hopes**
United States, opioid deaths, by drug type, ’000
12-month moving total

Source: Centres for Disease Control and Prevention
Recovery Support Services

- Education
- Housing
- Social Support
- Peer Support
- Employment
Affirming Roles and Valuing Identity
How much of what we do is based on short term financial decisions vs what contributes to a person’s life? What is the long term impact of these on that person’s life?
Reason # 5
When addressing chronic diseases, early intervention is better; Allies are uniquely positioned.
Who plays these roles in your community?
Help Everywhere: No Wrong Door
Reason #4
Substance Use Isolates; Community Restores
HOW DO WE EVALUATE CHRONIC DISEASE TREATMENT?

Treatment for chronic diseases must be long term.
CHRONIC MEDICAL DISORDERS & STIGMA

CANCER

HEART DISEASE

ADDITION

SILENCE
Changing the norms of substance use
Gov. Terry McAuliffe 'dabbing' with students and VCU President Michael Rao

BY K. BURNELL EVANS Richmond Times-Dispatch  Feb 17, 2017
What do communication, support and social events look like in your workplace? Family? Friend group?
Reason # 3
The Systemic Racism that has driven drug policy, death and mass incarceration must be addressed societally to bring real change.
# Incarceration Rates

Comparing Virginia and Founding NATO Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate per 100,000 Population</th>
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<td>United States</td>
<td>698</td>
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<td>Canada</td>
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<td>France</td>
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<td>Italy</td>
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<td>Belgium</td>
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<td>Norway</td>
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<td>Netherlands</td>
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<td>Denmark</td>
<td>59</td>
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<td>Iceland</td>
<td>38</td>
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</table>

Incarceration rates per 100,000 population

Source: https://www.prisonpolicy.org/global/2018.html
Virginia’s prison and jail incarceration rates

Number of people incarcerated in state prisons and local jails per 100,000 people, 1978-2015

Jail populations were adjusted to remove people being held for federal and state authorities. For full sourcing, see: [www.prisonpolicy.org/reports/jailsotime.html#methodology](http://www.prisonpolicy.org/reports/jailsotime.html#methodology)
Racial and ethnic disparities in prisons and jails in Virginia

Whites are underrepresented in the incarcerated population while Blacks are overrepresented.

Compiled from 2010 Census, Summary File 1.
In 2017, 59.8 percent of opioid-related deaths involved fentanyl compared to 14.3 percent in 2010.
CURRENT DRUG POLICIES INHIBIT RECOVERY BY...

Perpetuating stigma
- Criminalization reduces help-seeking
- Changing the narrative from public health to crime

Encouraging higher potency drugs
Disproportionately excluding people of color from recovery opportunities
Reason # 2
Allyship elevates those most impacted as leaders and builds pipelines to power
Why Collegiate Recovery?

Students should not have to choose between their recovery and their education.
Nothing about us without us
Number of programs started each year

Chart 2. Number of programs started each year.

2017 Census and Definitions for Recovery Support in Higher Education, transformingyouthrecovery.org
Reason # 1
Allyship demands humility from those working in the field
What were we thinking???
“Dr. J. B. Bently prescribed cocaine by the pound as a treatment for alcohol and morphine addiction and reported, as a testament to the cocaine’s effectiveness, that his patients were requesting additional quantities of cocaine and that they had completely lost their appetite for alcohol and morphine.” – Bill White
WHAT MAKES A RECOVERY-READY COMMUNITY?

- No Judgment Everywhere
- Help
- Recovery-Informed Prevention
- Harm Reduction
- Treatment
- Recovery Support
Thank You!
VA DBHDS, Virginia Department of Health, Jonathan Kiser, Lauren Cummings, Northern Shenandoah Valley Substance Abuse Coalition, Roz Watkins, Emily Tompkins, Denise Carl, Carter Bain, Spirit Works Foundation, Rose Bono, Amanda Stephan, Faces and Voices of Recovery and all the students in Rams in Recovery
Adolescent Community Reinforcement Approach outcomes differ among emerging adults and adolescents


Baker KM. "I'm going to shut down all of your tricks": Depictions of treatment professionals in addiction entertainment. Subst Use Misuse. 2016;51(4):489-497.


Committee on Improving the Health, Safety, and Well-Being of Young Adults; Board on Children, Youth, and Families; Institute of Medicine; National Research Council; Bonnie RJ, Stroud C, Breiner H, editors. Washington (DC): National Academies Press (US); 2015 Jan 27.


"Emerging Adults in America: Coming of Age in the 21st Century," co-edited Arnette with Jennifer Lynn Tanner, PhD.

Nerad S, Hosni A. Recovery ally training: Recovery is spoken here. Oral presentation at: National Collegiate Recovery Conference. 8th Annual Conference of the Association for Recovery in Higher Education; 2017 July 11-13; Washington, DC.
Reasons for Quitting Among Emerging Adults and Adolescents in Substance-Use-Disorder Treatment Journal of Studies on Alcohol and Drugs, 71(3), 400–409 (2010).
Roth J, Hasan Y, Bannard T, Dick D, Barr P. A closer look at students in recovery in the Spit for Science sample. (April 2017). Poster #165 presented at the VCU Poster Symposium for Undergraduate Research and Creativity, Richmond, VA.


Questions and Answers

Please unmute yourself or use the chat feature in WebEx to submit your questions.
General Resources

- DMAS COVID-19 website
  - [https://www.dmas.virginia.gov/#/emergencywaiver](https://www.dmas.virginia.gov/#/emergencywaiver)
  - Includes policy updates and other agency responses and information

- DMAS ARTS/SUPPORT Act website
  - [https://www.dmas.virginia.gov/#/artstraining](https://www.dmas.virginia.gov/#/artstraining)
  - SUPPORT 101 webinar series slide decks
  - Monthly Stakeholder Group slide decks

- SAMHSA COVID-19 Resource Page
  - [https://www.samhsa.gov/coronavirus](https://www.samhsa.gov/coronavirus)
  - Guidance for providers and OTPs
  - Policy updates and grant opportunities
Naloxone Resources

• Get trained now on naloxone distribution
  ▪ REVIVE! Online training provided by DBHDS
  ▪ [https://getnaloxonенow.org/](https://getnaloxonенow.org/)
    • Register and enter your zip code to access free online training

• Getting naloxone via mail
  ▪ Contact the Chris Atwood Foundation
  ▪ [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
  ▪ Available only to Virginia residents, intramuscular administration

• Medicaid provides naloxone to members at no cost and without prior authorization!

• Call your pharmacy before you go to pick it up!
Peer and Member Resources

• Peers
  ▪ Virginia Peer Recovery Specialist Network
  ▪ [https://virginiapeerspecialistnetwork.org/resources/](https://virginiapeerspecialistnetwork.org/resources/)

• Harm Reduction
  ▪ Virginia Department of Health - Comprehensive Harm Reduction

• Advocacy
  ▪ Substance Abuse Addiction and Recovery Alliance (SAARA)
  ▪ [https://www.saara.org/](https://www.saara.org/)
  ▪ VOCAL Virginia
  ▪ [https://vocalvirginia.org/](https://vocalvirginia.org/)

• DBHDS Office of Recovery Services
Hepatitis C and HIV Resources

• **Hepatitis C**
  - Virginia Peer Recovery Specialist Network
  - [https://www.hepc.com/](https://www.hepc.com/)
  - American Liver Foundation – Hepatitis C Information Center
  - Virginia Department of Health – Treatment Assistance Program

• **HIV**
  - Centers for Disease Control and Prevention – Resources for Persons Living with HIV
  - [https://www.cdc.gov/hiv/basics/livingwithhiv/resources.html](https://www.cdc.gov/hiv/basics/livingwithhiv/resources.html)
  - Office of Women's Health – HIV and AIDS Resources
  - Eastern Virginia Medical School – Virginia HIV and AIDS Resource and Consultation Centers
  - [https://www.evms.edu/community/community_training/hiv_aids_resource_center/](https://www.evms.edu/community/community_training/hiv_aids_resource_center/)
Telehealth Resources

- Virginia Public Wifi Hotspot Map
  - https://virginiatech.maps.arcgis.com/apps/webappviewer/index.html?id=825546b05bba47048470e1cfa7364de3 – updated regularly

- HHS Website – Delivering Care Safely during COVID-19
Discover the rewards of treating patients with Opioid Use Disorders

While PCSS provides trainings on a broad range of substance use disorder treatments, its primary focus is on treatment of opioid use disorders (OUD). Opioids include a class of drugs often prescribed for pain—morphine, fentanyl, oxycodone, and hydrocodone—as well as illicit drugs, such as heroin. The Federal Drug Administration (FDA) has approved three medications for the treatment of OUD: methadone, buprenorphine, and naltrexone.
Provider Resources

Substance Use Warmline
9 am – 8 pm (ET), Monday – Friday

1.855.300.3595

Free and confidential clinician-to-clinician telephone advice focusing on substance use evaluation and management for primary care clinicians.

Consultants include addiction medicine-certified physicians, clinical pharmacists, and advanced practice nurses who are available to discuss options and approaches in clinical care, from the most common problems to particularly challenging and complex cases.

Learn more at http://nccc.ucsf.edu/clinical-resources/substance-use-management/

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30039-01-00 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA Bureau of Primary Health Care (BPHC) awarded to the University of California, San Francisco.
Addiction and Recovery Treatment Services (ARTS)

Background

Visit the DMAS ARTS website to locate providers with Google Maps: http://www.dmas.virginia.gov/#/arts

New! Indicates if ARTS providers treat pregnant members
Addiction and Recovery Treatment Services (ARTS) Contacts

ARTS Questions:
• ARTS Helpline number: 804-593-2453
• Email: SUD@dmas.Virginia.gov
• Website: http://www.dmas.virginia.gov/#/arts

SUPPORT Act Grant Questions:
• SUPPORTgrant@dmas.virginia.gov

ARTS Treatment Questions:
• SUD Behavioral Health: Paul Brasler
  ▪ Paul.Brasler@dmas.Virginia.gov
  ▪ 804.401.5241
• Addiction Medicine: SUPPORT Team
  ▪ SUPPORTgrant@dmas.Virginia.gov
Thank you for calling in!

Your participation in the Monthly Stakeholder meetings is vital to the success of the SUPPORT Act Grant in Virginia.

**Next Meeting**
Monday, November 9, 2020
10:00 AM – 12:00 PM
Want a copy of today’s slides?

Stakeholder meeting slides along with previous SUPPORT 101 webinar slides will be uploaded to the DMAS ARTS webpage under the “SUPPORT Act Grant” Banner.  
https://www.dmas.virginia.gov/#/artstraining