SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 28—INCREASING ACCESS TO TREATMENT IN OBOT SETTINGS

OCTOBER 12 & 14, 2021

Department of Medical Assistance Services
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- Last revision: September 28, 2021
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 $4,997,093 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.
SUPPORT Grant Team

Disclaimer

- This template is a *suggestion* about how agencies can reduce unnecessary barriers to treatment for patients with opioid use disorder seeking medication-assisted treatment.
- This is not intended to be a replacement for Medicaid or DBHDS requirements.
- This template is designed as a dynamic tool, to be revised and adapted to meet the specific needs of your agency.
- This template is not designed as a substitute for official ASAM training, nor is this to serve as a substitute for any ASAM training that is required by any local, state, or federal regulatory agency or certifying organization. *This material is not sponsored or endorsed by ASAM.*
Naloxone Resources

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

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

- Call your pharmacy before you go to pick it up!

- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
    - [https://thecaf.acemlnb.com/l.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/l.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
  - Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website -
https://www.dmas.virginia.gov/#/artssupport
Hamilton Relay Transcriber (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Fall 2021 Webinars

- Increasing Access for Opioid Treatment in OBOT Settings: 10 – 12, 10 – 11 AM & 10 – 14, 1 – 2 PM
- Co-Occurring Disorders—Part 1: 10 – 19, 10 – 11 AM & 10 – 21, 1 – 2 PM
- Co-Occurring Disorders—Part 2: 10 – 26, 10 – 11 AM & 10 – 28, 1 – 2 PM
- Mental Status Exam: 11 – 4, 1 – 2 PM & 11 – 9, 10 – 11 AM
- Urine Drug Screens: Purpose & Practice: 11 – 16, 10 – 11 AM & 11 – 18, 1 – 2 PM
- Behavioral Addictions: Gambling, Gaming & More: 11 – 23, 10 – 11 AM & 11 – 30, 1 – 2 PM
- Stigma in SUD & SUD Treatment: 12 – 7, 10 – 11 AM
- Contingency Management: 12 – 14, 10 – 11 AM & 12 – 16, 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
Contact Information

Paul Brasler:
Paul.Brasler@dmas.virginia.gov

SUPPORT Act Grant Questions:
SUPPORTGrant@dmas.virginia.gov

ARTS Billing Questions
SUD@dmas.Virginia.gov
Glossary of Acronyms

- **ASAM**: American Society of Addiction Medicine
- **COWS**: Clinical Opioid Withdrawal Scale
- **CSB**: Community Services Board
- **DBHDS**: Department of Behavioral Health and Developmental Services
- **ED**: Emergency Department
- **EMS**: Emergency Medical Services (ambulance)
- **MAT**: Medication-Assisted Treatment (older term)
- **MOUD**: Medication for Opioid Use Disorder (current term; replaces MAT)
- **OBOT**: Office-Based Opioid Treatment
- **PMP**: Prescription-Monitoring Program
- **PRS**: Peer-Recovery Specialist
- **SDA**: Same-Day Access
- **SUD**: Substance Use Disorder (preferred term over addiction)
- **UDS**: Urine Drug Screen
A Brief Word on SUD Treatment

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

“Across all diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5], fewer than 25% of persons with addictive disorders enter professional treatment in their lifetimes. With smoking, the deadliest of addiction, fewer than 10% ever participate in a professional treatment program.”
(Herron & Brennan, 2020, p. 356)
Our Operating Assumptions

- DBHDS Guidelines
- ASAM Assessment Criteria Dimensions
- DMAS ARTS Supplement Revision: 7/07/2021
Virginia Administrative Code section for DBHDS on initial assessments:
https://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section650/
E. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual’s authorized representative, if applicable, the provider shall complete an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual’s:
DBHDS Assessment Regulations

1. Diagnosis;
2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems;
3. Current medical problems;
4. Current medications;
5. Current and past substance use or abuse [sic], including co-occurring mental health and substance abuse [sic] disorders; and
6. At-risk behavior to self and others
## ASAM Criteria Assessment Dimensions
(Herron & Brennan, 2015, p. 174)

<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment &amp; Treatment Planning Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute intoxication and/or withdrawal potential</td>
<td>Assessment for intoxication or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services</td>
</tr>
<tr>
<td>2. Biomedical conditions and complications</td>
<td>Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services</td>
</tr>
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## ASAM Criteria Assessment Dimensions
(Herron & Brennan, 2015, p. 174)

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<tr>
<td>3. Emotional, behavioral, or cognitive conditions and complications</td>
<td>Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services</td>
</tr>
<tr>
<td>4. Readiness to change</td>
<td>Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change</td>
</tr>
</tbody>
</table>
## ASAM Criteria Assessment Dimensions
(Herron & Brennan, 2015, p. 174)

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<td>5. Relapse, continued use, or continued problem potential</td>
<td>Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies</td>
</tr>
<tr>
<td>6. Recovery environment</td>
<td>Assess need for specific individualized family or significant others, housing, financial, vocational, educational, legal, transportation, childcare services. Identify any supports and assets in any or all of the areas</td>
</tr>
</tbody>
</table>
Comprehensive assessment of the patient is critical for treatment planning.

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

If not completed before initiating treatment, assessments should be completed soon thereafter.
DMAS ARTS Supplement Guidance

- The ARTS manual has been updated to allow providers to do an initial assessment, prescribe medication, and complete the assessment within seven days.

- As we will see, this can be helpful in engaging clients quickly and retaining them in treatment.
NOTE: This information is for planning purposes only.

Implementation within DBHDS and local guidelines falls on individual agencies.
1. Patient presents for services

2. Registrar collects demographic information

3. Is patient asking for OBOT services?
   - Yes: OBOT clinician paged
     - No: SDA referral
   - Yes: Initiate Crisis Response
     - No: Continue with assessment

5. Is patient suicidal?
   - Yes: Initiate Crisis Response
     - No: Continue with assessment

4. Triage Screening

6. Is patient experiencing psychosis or inability to care for self?
   - Yes: Initiate Crisis Response
     - No: Continue with assessment
7. Is patient demonstrating acute intoxication or withdrawal symptoms from alcohol and/or benzodiazepines?
   - Yes: Consider summoning EMS
   - No: Continue assessment

8. Gather information on presenting problem

9. Make a diagnosis

10. Is primary diagnosis Opioid Use Disorder?
    - Yes: Continue assessment
    - No: Refer for appropriate services

11. Is patient willing to enter your OBOT?
    - Yes: Continue assessment
    - No: Refer for appropriate services & provide Narcan

12. Is patient experiencing moderate to severe opioid withdrawal symptoms?
Yes: Continue fast-track assessment
No: Consider completing full assessment

13. Patient is provided with a brief orientation to the OBOT

14. Patient meets with nurse/medical assistant for vital signs

15. UDS collected and recorded

16. Patient meets with prescriber for medical screening

17. Is patient appropriate for MOUD?

No: Appropriate referrals made
Yes: Patient is prescribed 2-4 days of MOUD

18. Patient fills prescription and begins induction

19. Patient returns to the agency to complete full assessment and receive prescription for rest of the week
Patient Flow—Registration & Initial Disposition

- Patient presents for services
- Demographic information is gathered by registrar:
  - Identifying information
  - Qualification for services (e.g., patient lives in the areas served by the agency)
  - Insurance information (if available)
  - What patient would like to be called (this is important to build rapport and for clients to feel heard and respected)
- Presenting problem: *If client is requesting treatment for opioid use disorder, OBOT triage clinician is immediately notified.* If patient is presenting for anything other than this, patient is referred for standard intake
Patient Flow—Triage Screening

► Completed by an OBOT clinician, registered nurse, care coordinator or other designated mental health professional

► Most clinics will not have this available all day, every day
  ► I recommend designated times for this: perhaps three days per week (e.g., Monday, Tuesday & Thursday, from 8 – 11 AM)

► When not available, clients would follow the usual patient flow
Patient Flow—Triage Screening

- Following the ASAM Criteria Assessment Dimensions, the triage clinician assesses the following:
  - Presenting problem
  - Suicide and homicide screening
    - The Columbia Suicide Rating Scale (If suicidal or homicidal—STOP HERE)
  - Mental Status Exam (If psychotic or unable to care for self—STOP HERE)
  - Alcohol use disorder & other drugs of use screening
    - AUDIT-C; CAGE
    - DAST-10
  - Substance Use Disorder Assessment
    - Includes assessing for withdrawal management needs
  - Provisional diagnosis
Patient Flow—Triage Disposition

- Patients who are suicidal and/or homicidal with intent and a plan should be sent to the nearest appropriate emergency department for further assessment.

- Patients who are psychotic and unable to care for themselves or consent to treatment due to a mental illness should be sent to the nearest appropriate ED for further assessment.
  - Some CSBs may have their crisis teams handle this process.
  - Patients should be transported to the ED safely and are NOT allowed to drive themselves.
Patients who demonstrate alcohol or benzodiazepine withdrawal symptoms or who report sustained use of these substances, may need to be referred to emergency departments for further assessment, treatment, or admission to provide medically-managed withdrawal.
Alcohol/Depressant Withdrawal Symptoms

- Nausea/vomiting
- Cravings
- Malaise & weakness
- Tachycardia
- Delirium, including hallucinations
- Anxiety rebound and agitation
- Sweating

- Irritability
- Orthostatic Hypotension
- Tremors
- Insomnia
- Seizures possible
- Depersonalization
- High fever
- Depression
Alcohol Withdrawal Course

- Begins within 4 – 24 hours after the last drink
- In mild forms of withdrawal, the symptoms resolve after 48 hours
- Tremulousness is the earliest symptom and many people with AUD know that this indicates a need to drink again to avoid more pronounced symptoms
  - This appears within hours after drinking stops and peaks in 1 – 2 days but can persist for weeks
- In more severe forms, visual hallucinations can occur within 24 hours of cessation—to the patient these are real
Alcohol Withdrawal Course

- Between 6 – 48 hours after stopping ETOH use, 3 – 4% of untreated patients will have a seizure.
- 30 – 40% of patients who have a seizure will progress into Delirium-Tremens if they are left untreated.
- Delirium-Tremens are fatal in up to 25% of people who are not treated.
- D-Ts can precede or follow a seizure.
- Repeated withdrawal episodes seem to “kindle” more serious withdrawal episodes.
Substance Use Assessment
(Brasler, 2019)

A. **Substances** used (including tobacco, alcohol and caffeine) [“Tell me about your drug use”]

B. **Last use** (for each drug) [“When did you last use?”]

C. **Current drug** use [“What is your drug use like during an average week?”]

D. **Routes** of use (for each substance: inhaling, injecting, snorting, etc.)

E. **Durations** of use (for each substance) [“How long have you been using?”]

F. **Amounts** of use (for each substance) [“How much do you use?”]
Substance Use Assessment (Brasler, 2019)

G. **Tolerance** (having to use more of a chemical to get the same reaction as before)

H. **Withdrawal** symptoms

I. **History** of overdose

J. **Impact** on education, job, relationships, health, legal problems

K. **Past treatment**: periods of sobriety or recovery

L. **Motivation** for treatment

M. **Family history** of substance use
Patient Flow—Triage Disposition

- Patients who meet the diagnostic criteria for opioid use disorder, and who do not have suicidal/homicidal concerns, who do not evidence a severe mental illness that keeps them from being safe and who do not have withdrawal potential from alcohol and/or benzodiazepines remain at the agency.

- Further assessment, including a full psychosocial assessment, is completed if the patient is not experiencing acute opioid withdrawal syndrome (OWS) symptoms.

- The COWS may be used here to examine OWS severity.

- If the client is experiencing mild to severe OWS symptoms, the full assessment is completed once they are no longer experiencing acute OWS.
Opioid Withdrawal Symptoms

- Cravings
- Irritability
- Depression, anxiety
- Nausea, vomiting, stomach cramps, diarrhea
- Lacrimation
- Rhinorrhea
- Piloerection
- Muscle (and possibly bone) aches and pains
- Hot and cold flashes
- Uncontrolled sweating
- Yawning
- Anorexia
- Insomnia
- Fever
- Dilated pupils
Opioid Withdrawal Course

- Symptoms appear within 6 – 8 hours of last dose of most opioids
- Symptoms peak on the 2\textsuperscript{nd} or 3\textsuperscript{rd} day
- Symptoms usually disappear within 7 – 14 days
- Duration is much longer with methadone or buprenorphine (about twice as long as heroin takes)
- Methadone withdrawal can last at least three weeks after the last use if the patient was using a large amount of Methadone
- Post-acute withdrawal symptoms continue for many months afterward
This portion could be completed by the clinician, an RN, care coordinator or peer recovery specialist.

The basic aspects of the OBOT program, including what is required from patients, is introduced to the client.

**Patients need to have the opportunity to ask questions.**

It is important not to overwhelm patients with too much information; focus on answering questions related to MOUD and basic program requirements.

PRS could share some of their lived experience as it relates to MOUD, treatment and recovery, and starting to build a relationship through mutuality and hope (explaining their role within the MOUD clinic).
Patient Flow—Meet with RN/Medical Assistant

- Patient’s vital signs are taken and recorded
- Prescription Monitoring Program website is consulted to see if patient is already receiving MOUD and/or prescriptions for medications that could pose risk when combined with MOUD
- Urine drug screen is taken
- Patient is provided with information on how to utilize Naloxone and how to teach others to recognize the signs of opioid intoxication/overdose
Patient Flow—Meet with Prescriber

- The patient then meets with the medical prescriber
- The prescriber should have information already gathered about the patient; the triage clinician, RN and/or PRS could help facilitate this process and remain with the patient
- A basic medical history is completed
- A basic medical exam, as deemed necessary by the prescriber, is completed
- **Patients are again encouraged to ask questions**
- If the prescriber determines that the patient is appropriate for the OBOT, a prescription is sent to the patient’s pharmacy
Patient Flow—Induction

- Medical consensus at this time is that office-induction for Suboxone is not necessary.
- In addition, the mono-product (buprenorphine without naloxone) is also not necessary for most patients, including pregnant and nursing patients.
- If the clinic has not been able to complete a full psychosocial assessment due to acute OWS symptoms, a prescription for Suboxone for less than a week should be provided, along with an appointment for the patient to return to the clinic to complete their full assessment.
- PRS can follow-up with patient 24 – 48 hours after initial intake to check-in with them.
Patient Flow—Complete Full Assessment

- A full psychosocial assessment should be completed within seven days of the patient coming to the clinic.
- This includes an Initial Service Plan (ISP) and appropriate diagnoses of other needs per **ASAM Criteria Assessment Dimensions**.
- Once this assessment is completed, the patient is provided with a prescription for Suboxone that will last them until their next regular appointment.
- Patients have to be seen weekly by the prescriber for at least the first three months of services (unless transitioning to a new prescriber).
- Patients should also be connected with mental health/psychiatric providers to meet their needs.
Example

- “Jo” comes to the clinic seeking treatment for their OUD
- This occurs during a day/time when the OBOT triage program is running
- Jo completes registration process
- Jo is seen by the triage clinician
- There is no evidence of harm to self or others and Jo can complete activities of daily living
- Jo does not appear to be psychotic
- They do not report any alcohol or benzodiazepine use…
- …but Jo says they feel sick and they have vomited once this morning and afraid they could experience diarrhea; Jo appears physically uncomfortable (sweating profusely, unable to sit still)
Example

- Jo completes the basic assessment and program orientation
- They meet with the RN/MA and there are no contraindications from the UDS or PMP
- Jo meets with the medical prescriber, who confirms the presence of opioid withdrawal syndrome
- Since Jo was unable to complete a full assessment due to acute OWS, Jo agrees to complete the psychosocial assessment by returning to the clinic in three days
- In the interim, they are provided with a prescription for 3 days of Suboxone
- Upon their return to the agency and completion of the full assessment, Jo is given a prescription for 4 additional days of Suboxone before seeing their prescriber again
<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Description (Herron &amp; Brennan, 2020, pgs. 174 – 175)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td><strong>Medically managed intensive inpatient.</strong> 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage patient in treatment</td>
</tr>
<tr>
<td>3.7</td>
<td><strong>Medically monitored intensive inpatient.</strong> 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours per day for counselor availability</td>
</tr>
<tr>
<td>3.5</td>
<td><strong>Clinically managed high-intensity residential treatment.</strong> 24-hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment; able to tolerate and use a full active milieu or therapeutic community</td>
</tr>
<tr>
<td>3.3</td>
<td><strong>Clinically managed-population-specific high-intensity residential.</strong> 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use a full active milieu or therapeutic community</td>
</tr>
<tr>
<td>3.1</td>
<td><strong>Clinically managed low-intensity residential.</strong> 24-hour structure with available trained personnel with emphasis on re-entry to the community; at least 5 hours of clinical service per week</td>
</tr>
<tr>
<td>2.5</td>
<td><strong>Partial Hospitalization.</strong> 20 hours of service or more per week in a structured program for multi-dimensional instability not requiring 24-hour care</td>
</tr>
<tr>
<td>2.1</td>
<td><strong>Intensive Outpatient.</strong> Average of 9 - 19 hours of service per week (adults); 6 – 19 hours per week (adolescents) in a structured program to treat multi-dimensional instability</td>
</tr>
<tr>
<td>1.0</td>
<td><strong>Outpatient Services.</strong> Less than 9 hours or service per week (adults); &lt;6 hours per week (adolescents) for recovery or motivational enhancement therapies/strategies</td>
</tr>
</tbody>
</table>
Q: What if I think the patient needs a level of care higher than 1.0 but lower than 3.5 but identifying a program, and the program having an opening, will take time?

A: Consider starting the patient in your program as a ‘bridge’ to a higher level of care; they will need a step-down placement following the higher level of care so this is a good way to help them ‘bridge back’ when they are ready. Also, clients can continue to receive MOUD from an OBOT if they are in a higher level of care that does not provide MOUD.

Q: What if the patient continues to use opioids once they are in the program?

A: Every person is different. Some people will stop quickly, some take more time, and others may not stop using. Continued, sustained use is a sign of needing a higher level of care. Clients should not be terminated without follow-up services simply for continuing to use.
References


