Disclaimers & Friendly Reminders

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- CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.
- Today’s webinar will be recorded and slides presented here will be made publicly available as resources at cchpca.org.
- Closed captioning is available.
- Please refrain from political statements or advertising commercial products or services during this webinar.
• Established in 2009 as a program under the Public Health Institute
• Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
• Work with a variety of funders and partners on the state and federal levels
• Administrator National Consortium of Telehealth Resource Centers
• Convener for California Telehealth Policy Coalition
Telehealth & Medicaid: A Policy Webinar Series

Previous CCHP webinars available on website or YouTube channel.

This webinar series was made possible by grant number GA5RH37470 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, U.S. Department of Health & Human Services.
TODAY’S SPEAKERS

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SAMHSA/CSAT/OD

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Arkansas Department of Human Services

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Arkansas Department of Human Services

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Arkansas Department of Human Services

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Medical Director of the Division of Substance Use Prevention and Harm Reduction  
Philadelphia Department of Public Health
Telehealth – Necessary and Evolving

Robert Baillieu, MD, MPH
Physician and Senior Advisor
The Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Overview

- Overview of Telehealth
- Implications
- Responses
- Future Directions
Defining Telehealth

The Health Resources and Services Administration (HRSA) defines telehealth as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.”
Telehealth To Overcome COVID-19 & Disparity

• Preliminary evidence suggests a sharp increase in the number of adults reporting adverse mental or behavioral health conditions during the COVID-19 pandemic compared to prior years.¹

• Survey data indicate that racial and ethnic minority groups are experiencing higher rates of depression, substance use, and self-reported suicidal thoughts/ideation during the COVID-19 pandemic.²

• Similarly, preliminary evidence indicates an increase in drug-related mortality during the COVID-19 pandemic.³


Overdose Deaths Exceed 100,000

Most Overdose Deaths Involve One or More Illicit Drugs

<table>
<thead>
<tr>
<th>Co-involvement of other substances in drug overdose deaths involving Illicitly Manufactured Fentanyl (IMFs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMFs only*</td>
</tr>
<tr>
<td>Rx opioids</td>
</tr>
<tr>
<td>Heroin</td>
</tr>
<tr>
<td>Any opioids other than IMFs**</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Any stimulant***</td>
</tr>
<tr>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Gabapentin</td>
</tr>
<tr>
<td>Xylazine</td>
</tr>
</tbody>
</table>

*Includes fentanyl and fentanyl analogs, **Includes heroin, prescription opioids, and other illicit synthetic opioids, *** Includes cocaine, amphetamines, cathinones, and other central nervous system stimulants (e.g., atomoxetine, caffeine).

- The 10 most frequently occurring opioid and stimulant combinations accounted for over 77% of overdose deaths
- Buprenorphine and methadone are included as prescription opioids; however, they are used both for treatment of pain and for treatment of opioid use disorder. Fewer than 3% of deaths involved buprenorphine, and fewer than 4% of deaths involved methadone, across jurisdictions.

SOURCE: State Unintentional Drug Overdose Reporting System (SUDORS), 40 jurisdictions, 2020
Concurrent Substance Use Overdoses By Race

Disparities In Access To Treatment

High Need Counties and Buprenorphine Prescribing Capacity, 2018

Source: OIG analysis of CDC and SAMHSA data, 2018
There are more than 1,900 OTPs across America, providing treatment to over 600,000 individuals each year.

Research reveals:

- The rate of methadone treatment is highest in areas with low income and non-white residents.¹
- This has remained unchanged for over 20 years.²


SAMHSA’s Telehealth Policies Enacted During the Pandemic

• In March 2020, the Secretary of HHS, with the concurrence of the Acting DEA Administrator, designated a telemedicine exception that applied to all schedule II-V controlled substances.

• The DEA also granted a “temporary exception” to its regulations that allows practitioners to prescribe controlled substances in states in which they are not registered.

• Telemedicine is also used by (and therefore overseen, in part, by SAMHSA):
  • DATA-Waivered providers to prescribe buprenorphine
  • Counselors, social workers and support staff to provide treatment activities
  • Providers to link clients into care

3/16/20: SAMHSA releases blanket methadone take-home exceptions to states

And

3/16/20: HHS and DEA designate telehealth exceptions for all schedule II-V controlled medications

4/19/20: SAMHSA releases guidance on 42 CFR Part 2 confidentiality of patient records

4/21/20: SAMHSA clarifies exemption from requirement for an in-person physical examination for new patients starting buprenorphine in an OTP (but not methadone)

6/19/20: CMS clarifies allowance under Medicare for OTPs to use telehealth platforms for periodic patient assessments

2020: COVID-19 Pandemic Changes Regulatory Landscape
2021: Building on Changes

**4/27/21:** HHS releases guidance on use of substance use treatment block grant funds for mobile units

**7/28/21:** DEA releases guidance on mobile medication units

**8/4/21:** SAMHSA releases guidance on mobile and non-mobile medication unit establishment and allowable services

**9/21/21:** SAMHSA releases guidance on mobile and non-mobile medication unit establishment and allowable services

**11/18/21:** SAMHSA releases guidance on extension of blanket methadone take home exceptions for one year past end of COVID Public Health Emergency (PHE)
Telehealth Highlighted Disparities As Well...

Technology Access Among Medicare Beneficiaries Varies Widely; Less Than Half of Black and Hispanic Medicare Beneficiaries Say They Own A Computer

<table>
<thead>
<tr>
<th>Have access to the internet</th>
<th>Own a computer</th>
<th>Own a smartphone</th>
</tr>
</thead>
<tbody>
<tr>
<td>All beneficiaries</td>
<td>83%</td>
<td>64%</td>
</tr>
</tbody>
</table>

**Age category**

<table>
<thead>
<tr>
<th>Age category</th>
<th>Have access to the internet</th>
<th>Own a computer</th>
<th>Own a smartphone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>82%</td>
<td>55%</td>
<td>73%</td>
</tr>
<tr>
<td>Age 65-74</td>
<td>89%</td>
<td>74%</td>
<td>80%</td>
</tr>
<tr>
<td>Age 75 and older</td>
<td>74%</td>
<td>56%</td>
<td>53%</td>
</tr>
</tbody>
</table>

**Metropolitan status**

<table>
<thead>
<tr>
<th>Metropolitan status</th>
<th>Have access to the internet</th>
<th>Own a computer</th>
<th>Own a smartphone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>84%</td>
<td>66%</td>
<td>72%</td>
</tr>
<tr>
<td>Rural</td>
<td>78%</td>
<td>58%</td>
<td>60%</td>
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</table>

**Race/ethnicity**

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Have access to the internet</th>
<th>Own a computer</th>
<th>Own a smartphone</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>86%</td>
<td>71%</td>
<td>72%</td>
</tr>
<tr>
<td>Black</td>
<td>69%</td>
<td>42%</td>
<td>63%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>67%</td>
<td>34%</td>
<td>61%</td>
</tr>
</tbody>
</table>

**NOTE:** Analysis among Medicare beneficiaries living in the community. Adults of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; All other groups are non-Hispanic. Tests of statistical significance can be viewed in accompanying tables.

**SOURCE:** KFF analysis of CMS Medicare Current Beneficiary Survey COVID-19 Fall 2020 Community Supplement Public Use File
Challenges and Concerns

- Organizational challenges
- Provider Concerns
- Challenges for service recipients
- Planning considerations
SAMHSA & Telehealth

Grants
- Discretionary grants
- Block grant

Technical Assistance and Education
- Addiction Technology Transfer Centers (ATTC)
- Mental Health Technology Transfer Centers (MHTTC)
- Prevention Technology Transfer Centers (PTTC)

Regulatory
- Permitted Opioid Treatment Providers and buprenorphine-waivered practitioners to prescribe buprenorphine through telehealth
- Supported flexibilities to allow audio-only technology, allowed for additional electronic platforms, and allowed for a patient's home to be the originating site
- Co-authored guidance with CMS on expanding telehealth coverage for behavioral health services

Ongoing Activities
- Working with AHRQ to develop a tool to assist consumers in selecting behavioral health mobile apps to manage mental health conditions
- Collecting surveillance data to monitor ongoing trends in telehealth delivery
- Assessing larger issues of health equity for underserved groups in behavioral health through data collection and policy

Co-authored guidance with CMS on expanding telehealth coverage for behavioral health services
The Future

- Strong will on the part of providers and clients to maintain hybrid approach.
- Can greatly ease access for clients and decrease stigma.
- There are benefits with respect to provider recruitment and retention with telehealth flexibilities.
- Potential net gains for organizations with respect to cost reductions—decreased no shows, decreased overhead.
Take Home Points

• COVID-19 has had a negative behavioral health impact on the general population and disproportionately impacted more vulnerable populations.

• Baseline access challenges worsened with the pandemic despite efforts to relax regulatory restrictions.

• Economic hardships, isolation and access challenges have contributed to a significant increase in adverse outcomes over the past year.

• Survey results of behavioral health providers and clients, as well as needed ongoing efforts to mitigate treatment gaps, strongly favor continued modification of the regulatory environment to sustain telehealth, audio and video options, permit home-based telehealth services, and relax interstate service delivery.

• Telehealth has the potential to positively impact service delivery, to improve access for underserved populations, and can be used in conjunction with in-person services to develop tailored individualized service planning.
SAMHSA’s mission is to reduce the impact of substance use and mental illness on America’s communities.

Thank You!

www.samhsa.gov | @samhsagov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)
Telemedicine
Arkansas Policy
Arkansas Medicaid
COVID 19 Response

Several emergency policies were put into place pursuant to Executive Orders issued by Governor Asa Hutchinson.

1. Executive Order 20-05 and made the provision of telemedicine more flexible by allowing for:
   - The originating site to be the client's home.
   - A provider-client relationship to be established when the provider can access the client's records.
   - The service to be provided using audio-only technology, where line of site on the client is not required.

2. Executive Order 20-06 allowed State Agencies to change policies without going through public notice and comment or approval process.
Arkansas Medicaid COVID 19 Response

Using 20-06, DHS expanded use of telemedicine for these services:
- Marital and Family Counseling
- Crisis Intervention
- Behavioral Health Diagnosis
- Substance Abuse
- Applied Behavioral Analysis Therapy
- Occupational, Physical and Speech Therapy
- DME, Prosthetics and Orthotics Evaluations
- Rural Health Clinics and Federally Qualified Health Centers
Arkansas Medicaid
COVID 19 Response

Additional “check-in” services were allowed through COVID, including:

• Physician/APRN virtual check-in (G2012)
• Early Intervention Day Treatment/Adult Developmental Day Treatment Well Checks (T1027, U2)
• Behavioral Health Well Checks (H2021, U4, GT)
DHS Telemedicine COVID-19 Response

DHS TELEMEDICINE COVID-19 RESPONSE CONTENTS

<table>
<thead>
<tr>
<th>200.000</th>
<th>OVERVIEW</th>
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<tbody>
<tr>
<td>201.000</td>
<td>Authority</td>
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<tr>
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<td>Appeals</td>
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<tr>
<td>204.000</td>
<td>Severability</td>
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<table>
<thead>
<tr>
<th>241.000</th>
<th>Telemedicine for Developmental Therapy Telemedicine</th>
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<tbody>
<tr>
<td>244.000</td>
<td>Telemedicine for Occupational, Physical, and Speech Therapist and Assistants</td>
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<tr>
<td>245.000</td>
<td>Telemedicine for Applied Behavioral Analysis (ABA) by a BCBA</td>
</tr>
<tr>
<td>246.000</td>
<td>Telemedicine for Autism Waiver</td>
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<table>
<thead>
<tr>
<th>260.102</th>
<th>Telemedicine Originating site requirements for advanced practice registered nurses</th>
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<tr>
<td>260.103</td>
<td>Telemedicine originating site requirements to allow services to a beneficiary in his or her home through date of service December 31, 2021.</td>
</tr>
<tr>
<td>265.100</td>
<td>Behavioral Health Telemedicine Services</td>
</tr>
</tbody>
</table>

Arkansas Medicaid
COVID 19 Response

During the 2021 General Session, the Arkansas Legislature made these changes permanent.

- Act 767
- Act 829

Through these Acts, DMS made permanent:
- Originating site can be the client’s home
- Audio only technology can be used where appropriate
- Provider-client relationship can be established if the provider can access the client’s medical records
Arkansas Medicaid COVID 19 Response

Medicaid continues to look at ways to use telemedicine and technology to better expand services:

• Use of technology in crisis response.
• Allowing enabling technology for individual being served in home and community settings.
Medication Assisted Treatment For Opioid Use Disorder
Substance Abuse and Mental Health Services Administration (SAMHSA) defines Medication Assisted Treatment (MAT) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.

This definition and other MAT Guidelines can be found at: https://www.samhsa.gov/medication-assisted-treatment
Arkansas Medicaid now supports clients with Opioid Use Disorder (OUD).

When receiving services associated with MAT, the program allows MAT clients to:

- Exceed the 12 physician visits per year limit
- Exceed the $500 benefit limit for laboratory and x-ray services
- Exceed the number of prescriptions allowed per month

Clients will not be charged a co-pay for covered MAT services.
MAT is covered for eligible Medicaid clients who have an Opioid Use Disorder when diagnosis and clinical impression is determined in the terminology of International Classification of Disease (ICD).

Providers are required to follow SAMHSA guidelines for the full provision of MAT.

A Primary Care Physician (PCP) referral is not required to provide MAT, but care coordination is recommended to the extent possible.

Providers are encouraged to use telemedicine services when in-person treatment is not readily accessible.
To provide Medication Assisted Treatment (MAT) services as a current Medicaid Provider, providers must submit:

- A written letter requesting their XDEA be added to their provider file
- A copy of their DEA certificate
- A copy of the XDEA approval letter from SAMHSA

Documentation should be uploaded on the Arkansas Medicaid HealthCare Provider Portal to qualify.

To enroll as a new Arkansas Medicaid Provider offering MAT services, submit your enrollment application online through MMIS-Provider Enrollment portal.

Upload your DEA certificate and SAMHSA approval letter as attachments to your application to ensure your XDEA is entered for your provider file.
Physician: Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO)

Physician Assistant: Physician Assistant services are services furnished according to Arkansas Statute 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physicians’ Assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician’s service.

Only providers who have met the requirements of Section 201.500 of the Physician Manual may prescribe medication required for the treatment of opioid use disorder for Arkansas Medicaid clients.

Coordinating all follow-up appointments and referrals for counseling and other services is also required.

The MAT program applies only to prescribers of FDA-approved drugs for treatment of Opioid Use Disorder. Prescribers of these drugs will not be reimbursed for the practice of pain management.

All MAT-related requirements outlined in the Physician Manual, other practitioner or agency rules for enrollment, and staffing requirements apply.
In accordance with SAMHSA Guidelines, Arkansas Medicaid requires at minimum an initial evaluation and diagnosis of Opioid Use Disorder, including:

- Drug screening tests to accompany proper medication prescribing for MAT
  - Buprenorphine mono-therapy is typically reserved only for pregnant women and those with a documented anaphylactic reaction to other MAT medications like Buprenorphine/Naloxone Combinations

- Lab screening tests for communicable diseases based on the patient’s history

- Use of all necessary consent forms for treatment and HIPAA compliant communication
Medication Assisted Treatment
For Opioid Use Disorder
Provider Responsibilities

- Execution of Treatment Agreements or Contracts
  - SAMHSA’s sample treatment agreement can be found under TIP 63 on the SAMHSA website
  - Providers may develop their own agreement or contract if all elements listed within SAMHSA’s sample agreement are provided

- Development of a Person-Centered Treatment Plan

- Referral for independent clinical counseling or documented plan for integrated follow-up visit including counseling

- Identification of a MAT team member to function as the Case Manager to offer support services
For the first year, the Provider must:

• Conduct regular outreach to the patient to determine need for assistance
  • Provide information on available programs and supports in the community
  • Provide referrals to other practitioners as needed

• Perform at least one follow-up MAT office visit per month for medication and treatment management

• Provide drug testing in conjunction with each monthly visit

• Perform at least one independent clinical counseling visit or documented plan for integrated follow-up visit including counseling per month.
Medication Assisted Treatment  
For Opioid Use Disorder  
Quarterly Minimum Requirements for Continuing Treatment

During subsequent years, the Provider must:

• Conduct regular outreach to the patient to determine need for assistance
  • Provide information on available programs and supports in the community
  • Provide referrals to other practitioners as needed

• Provide at least one follow-up MAT office visit quarterly for medication and treatment management
  • Offer drug testing in conjunction with each quarterly visit

• Conduct at least one independent clinical counseling visit or documented plan for integrated follow-up visit
  • Visit must include counseling at an amount and duration medically necessary for continued recovery
Arkansas Medicaid, or its designated authority, will periodically review claims for MAT to ensure provider compliance with minimum requirements set forth by Medicaid and per the SAMSHA Guidelines.

Failure to comply with minimum requirements for the program may result in recoupment or other sanctions outlined in Section I of the Physician Manual.
MAT Providers are expected to adhere to the SAMHSA Guidelines; they are responsible for case management and adjusting the treatment plan for the client’s maximum progress.

Documentation regarding how the MAT Provider is monitoring and addressing non-compliance will be reviewed.

The Patient/Prescriber Agreement shall reflect established expectations in accordance with SAMHSA Guidelines.

- If counseling or other components of treatment are being referred, providers’ records are subject to post payment review and recoupment for undocumented services
**Physician Manual, 272.600**

Inclusive Rate – available only when participating MAT Providers can provide all MAT components per SAMHSA Guidelines within their own program and without referring to another provider.

The inclusive method of billing may be used when all SAMHSA Guideline services are set forth at a minimum in **Section 230.000** of the Physician Manual and service is provided on the same date of service by the same billing group.

- There must be at least one performing provider enrolled with Arkansas Medicaid that has a MAT program XDEA number on file.
For new patients, the provider group may use HCPCS code H0001, modifier X2, and list an Opioid Use Disorder ICD-10 code as primary.

For established patients requiring maintenance follow-up MAT treatment, the provider group may use HCPCS code H0001, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary.
The performing provider must be enrolled as a MAT provider, and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 of the Physician Manual (Office Visit, counseling and medication induction/maintenance, etc.).

Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.
<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Billing Codes</th>
<th>Reimbursement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td>H0001, X2</td>
<td>$157.57</td>
</tr>
<tr>
<td>Est. Patient, Continuing Care</td>
<td>H0001, U8, X2</td>
<td>$139.62</td>
</tr>
<tr>
<td>Est. Patient, Continuing Care Telemedicine</td>
<td>H0001, U8, X2, GT</td>
<td>$139.62</td>
</tr>
<tr>
<td>Est. Patient, Maintenance Care</td>
<td>H0001, U8, X4</td>
<td>$139.62</td>
</tr>
<tr>
<td>Est. Patient, Maintenance Care</td>
<td>H0001, U8, X4, GT</td>
<td>$139.62</td>
</tr>
</tbody>
</table>
Special Billing Rules for MAT Program

- Allowable ICD-10 codes for Opioid Use Disorder may be found in the Physician Manual and are applicable for all provider types eligible to participate as a MAT Provider.

- Allowable lab and screening codes may be found in the Physician Manual and are applicable for all provider types eligible to participate as a MAT Provider.

- Providers utilizing telemedicine, regardless of method, shall adhere to telemedicine rules listed in Section 105.190 and Section 305.000 in addition to those above.
  - The Provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.
Jennifer Shuler, Nurse Practitioner
Division of Aging, Adult, and Behavioral Health Services
Substance Abuse Treatment Services
Office of Drug Director

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501-396-6347

humanservices.arkansas.gov
We Care. We Act. We Change Lives.
Philadelphia’s Overdose Crisis

CCHP Webinar – Telehealth Policy and Substance Use Disorder
June 24, 2022

Jeffrey Hom, MD, MPH
Division of Substance Use Prevention and Harm Reduction
Philadelphia Department of Public Health
Philadelphia has the highest death rate of the top 10 largest U.S. cities

2019 Unintentional Overdose Rates in Counties Associated with Top 10 Largest US Cities

- Philadelphia: 62.3
- Maricopa (Phoenix): 25.6
- Cook (Chicago): 25.3
- New York City (5 Counties): 16.6
- San Diego: 13.3
- Bexar (San Antonio): 12.4
- Harris (Houston): 12.1
- Dallas: 12
- Los Angeles: 11.8
- Santa Clara (San Jose): 9.8
High rates of opioid prescribing regionally

In 2015, enough opioids were prescribed in Philadelphia for every person to have **29 days of OxyContin**.
Heroin is pure and cheap in Philadelphia

Cost per milligram

Purity

City

PHILADELPHIA  Atlanta  Newark  Detroit  New York  Pittsburgh  Orlando  Richmond  Washington, DC  Miami  New Orleans  San Juan  Baltimore  Chicago  Boston

2015 Heroin Domestic Monitor Program
Fentanyl is involved in the majority of deaths
Mayor’s Task Force

• Convened January 2017
• 18 recommendations in five strategic areas:
  • Prevention and education
  • Treatment
  • Overdose prevention and harm reduction
  • Criminal justice
  • Data and surveillance

www.phila.gov/opioids
Reducing exposure to prescription opioids

**OPIOID PRESCRIBING**

**Key Recommendations**

- Do not prescribe opioids for **chronic pain**.
- **3 days or less** is usually sufficient for acute pain.
- Prescribe the **lowest effective dose** and avoid increasing dose to ≥90 MME/day.
- Avoid concurrent benzodiazepine and opioid prescribing.

**POSTOPERATIVE OPIOID PRESCRIBING GUIDELINES**

In the past, surgeons and other physicians were strongly encouraged to treat pain aggressively with opioids. It is now clear that the prescribing of opioids leads too often to side effects, dependence, and addiction. At the same time, studies have shown that NSAIDS are as effective as opioids for treating many forms of pain, including acute postoperative pain. Thus, guidelines, which are based on studies of analgesic needs postoperatively, attempt to balance the benefits and risks of opioids.

They recommend:

- Managing patient expectations about pain after surgery
- Maximizing the use of non-opioid pain treatments pre- and postoperatively
- Avoiding the use of opioids for minor surgical procedures
- Simply limiting the duration of opioid use following major surgical procedures
Philadelphia law requires pharmacies to carry naloxone

AN ORDINANCE

Amending Title 9, “Regulation of Businesses, Trades and Professions,” of The Philadelphia Code to add a new Section 9-637, entitled “Opioid Antidote Availability,” to require pharmacies to stock opioid antidotes and display signs giving notice of opioid antidote availability to customers, all under certain terms and conditions.
Low barrier naloxone via “naloxone towers”

- Naloxone kits available free of charge, 24/7
- First tower installed in West Philly
- User interface available in English and Spanish
- Can collect demographic information or survey can be overridden in event of an emergency
- Has 911 feature
Expanding access to treatment
Buprenorphine initiatives in Philadelphia

- Buprenorphine mentorship program
- Academic detailing program
- Buprenorphine expansion in City’s jail
- DA’s decriminalization of buprenorphine possession
Health systems in Philadelphia commit to train all their PCPs to prescribe buprenorphine.
The number of prescribers have increased...
...though the number of patients has plateaued

Philadelphia Patients* treated with buprenorphine, all payers, Q32016 – Q42021
While treatment capacity has increased, low barrier options needed
Early in COVID, telehealth used to fill gaps in care created by disruptions in treatment access and decarceration.
Early telemedicine and SUD care in Philadelphia

2021

- Closure of several high-volume buprenorphine clinics prompted use of telehealth to rapidly reconnect patients to care
- Collaboration with the state and local health departments
Lessons learned

- Same-day access to medication treatment
- Close touch from experienced navigators
CareConnect Warmline

- Callers connected to Substance Use Navigators
- Same day access to buprenorphine
- Fill gap between patient call and community MOUD appointment
- Ensure patients do not lose access to medication
- Tailored referral to longitudinal treatment (specialty behavioral health or primary care-based)
- Harm reduction resources
- Patients or providers can call for help
Engagement with warmline increased during soft roll-out

- 184 total encounters
- 86 non-prescription encounters
- 98 buprenorphine encounters
- 125 prescriptions written
## Caller Demographics (n=98)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean)</td>
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<tr>
<td>Male Gender</td>
<td>65%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>34%</td>
</tr>
<tr>
<td>White</td>
<td>54%</td>
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<td>Other</td>
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<td>Hispanic Ethnicity</td>
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<tr>
<td>Insurance</td>
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<tr>
<td>Medicaid</td>
<td>79%</td>
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<tr>
<td>Commercial</td>
<td>5%</td>
</tr>
<tr>
<td>Medicare</td>
<td>2%</td>
</tr>
<tr>
<td>Other/None</td>
<td>13%</td>
</tr>
<tr>
<td>Housing Status</td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>71%</td>
</tr>
<tr>
<td>Housed but Unstable</td>
<td>12%</td>
</tr>
<tr>
<td>Unhoused</td>
<td>4%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>12%</td>
</tr>
</tbody>
</table>
Outcomes

- **100%** of patients triaged to telehealth encounter received buprenorphine prescription
- **94%** of patients picked up initial buprenorphine prescription within 7 days
- **57%** of patients filled at least one additional buprenorphine prescription within 30 days of encounter
- **49%** had an active buprenorphine prescription at day 30 (pending for recent patients)
Growth expected with programmatic expansion, beyond word-of-mouth

Penn Medicine partners with health department to expand virtual ‘bridge clinic’ for people with substance use disorder

By Zoë Read - May 20, 2022

A sign at the Hospital of the University of Pennsylvania in Philadelphia, Wednesday, Feb. 6, 2019. (AP Photo/Matt Rourke)
Observations and Conclusions

• Telemedicine SUD care is an important component of Philadelphia’s efforts to ensure low-barrier access to evidence-based treatment for all city residents

• Supporting an experienced, innovative and thoughtful partner organization was key to the successful launch of the warmline

• Impact of substance use navigators/certified recovery specialists cannot be overstated

• Partnership between health system and health department opened doors to new referrals, both into and from the warmline

• Challenges include need to expand/enshrine telemedicine policy as well as sustainability
Thank you

Division of Substance Use Prevention and Harm Reduction
Philadelphia Department of Public Health
www.phila.gov/opioids
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Thank you and have a great day!