WELCOME

LINDA MAHONEY (RI), TREATMENT COORDINATOR PRESIDENT
&
JOHN MCILVEEN (OR), SOTA PRESIDENT
TREATMENT LEARNING COMMUNITY ACTIVITY UPDATES

KEN SAUCIER (LA)
NICK SVETLAUSKAS (IN)
STATE PROFILES – CONTINUUM OF CARE LEARNING COMMUNITY

KEN SAUCIER
At the 2019 Annual Meeting, Treatment Coordinators expressed interest in developing State Profiles on cross-cutting issues that impact system changes across the continuum of care.

The Continuum of Care Learning Community determined that these would be considered living documents, and their scope would initially include:

- How states work with MCOs
- Patient placement criteria
- SSA and state Medicaid agency location
- Initiatives that combine prevention & recovery services
There is significant variation in where the SSA is located in relation to Medicaid agency in each state’s organizational structure.

“If you’ve seen one state substance use treatment system, you’ve seen one state substance use treatment system”
MEDICAID EXPANSION

State Status of Medicaid Expansion

- **Adopted and Implemented**
- **Not Adopted**
- **Adopted but not Implemented**

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MANAGED CARE ORGANIZATIONS (MCOS)
The most common functions of MCOs noted were:

- Billing
- Prior authorization
- Performance measurement
- Data collection
- Utilization management
- Community and member engagement
- Provider network operations
- Quality management
- Claims management
- Access management
- Systems management
MANAGED CARE ORGANIZATIONS (MCOS)

Challenges:
- Issues with preauthorization and late payments
- Lack of continuity for people with changing eligibility
- Problems with billing codes
- Continuity of services as different MCOs begin and cease operations
- Providers and beneficiaries are sometimes not well informed about available benefits and coverage

To effectively work together, states note that ongoing communication and regular meetings between the SSA, Medicaid, and MCOs is key. Other states have developed standard terms and conditions or performance measures to assess MCO performance and drive improvement.
MANAGED CARE ORGANIZATIONS (MCOS)

Improvements:

- Expansion of covered services
- Extensive data analysis
- Enhanced oversight, coordination and performance management
- Development of specialty and alternative programs
- Training and technical assistance
- Increased provider support of MAT

Example:

- Colorado’s Managed Service Organizations require all residential providers to be supportive of MAT. They also provide regular training on ASAM criteria and assess proper application during annual contract monitoring of providers
PATIENT PLACEMENT CRITERIA

Patient Placement Criteria

- ASAM
- State
- State & ASAM
- No PPC
- No data available

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Rhode Island - **Community OD Engagement (CODE) unit**, composed of prevention, recovery, law enforcement, and other stakeholders, has designed an action plan when the median range of overdoses is exceeded in their area. They have received SOR funding for implementation and growth at the community level.

Connecticut - **“Recovery Friendly Community”** initiative developed by recovery advocates and facilitated by prevention partners.

Colorado – uses SOR funding for the **Community Reinforcement and Family Therapy (CRAFT) model**, which provides support to families, helping family members take care of themselves and support their love one’s treatment and recovery

Alabama, Alaska, and North Carolina support **recovery communities in colleges**. They aim to bring forth education, awareness, and support to students in recovery so that they can continue to grow, develop and fulfill their academic and adult potential without sacrificing or feeling the need to sacrifice overall well-being or academics or both.
SUSTAINING AND COORDINATING TREATMENT INITIATIVES - SUSTAINABILITY LEARNING COMMUNITY

NICK SVETLAUSKAS
Last year, the Sustainability Learning Community focused on sustainable programs and Medicaid expansion efforts.

Webinar on Sustaining the Treatment System

- Evolution of Medicaid-covered SUD Services in Virginia
- Washington’s 1115 SUD IMD Waiver Amendment
- Hawaii’s Habilitat: How to Maintain a Self-Sustaining Treatment and Vocational Center
The Treatment Sustainability Learning Community has consistently explored how SSAs can take steps to ensure that their SUD treatment services are sustainable.

The LC sought to develop an inquiry to ask respondents to consider broadly, across all its state initiatives:

- Which would be sustainable in the absence of federal funding
- What alternative funding sources would be used
- State processes for coordinating substance use services
- SSA authority to coordinate SUD services
The majority of states responded that little to no federally-funded initiatives would be sustainable without that funding.

States noted that they rely on federal funding to fill service gaps.

Medicaid expansion:

- States without Medicaid expansion cited more difficulty in having to sustain services without federal funding.
- States with Medicaid can maximize Medicaid benefits, but they depend on other federal funding sources to support individuals and services not covered by Medicaid.
<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Sustainable Services without Fed. Funding</th>
<th>State Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Eligible treatment and recovery services</td>
<td>CA, DE, KS, MD, NH, UT</td>
</tr>
<tr>
<td></td>
<td>Some prevention services</td>
<td>CT</td>
</tr>
<tr>
<td></td>
<td>Residential treatment</td>
<td>CO, MT</td>
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<tr>
<td></td>
<td>Medication-assisted treatment (MAT)</td>
<td>AK, AR, NE, NH</td>
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<td></td>
<td>Peer support initiatives</td>
<td>IN, MT, OH</td>
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<tr>
<td></td>
<td>ACT Grant project</td>
<td>NM</td>
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<tr>
<td>Medicaid/private insurance</td>
<td>Emergency department case managers</td>
<td>OH</td>
</tr>
<tr>
<td>State funds</td>
<td>Drug overdose prevention program</td>
<td>IL</td>
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<td></td>
<td>Helpline for Opioids</td>
<td>IL</td>
</tr>
<tr>
<td>Local funds</td>
<td>MAT for the uninsured</td>
<td>DC</td>
</tr>
<tr>
<td>Alcohol tax</td>
<td>Peer support groups</td>
<td>MT</td>
</tr>
<tr>
<td>Business ventures</td>
<td>Recovery cafes and recovery centers</td>
<td>IN</td>
</tr>
<tr>
<td></td>
<td>Programs where participants learn skills in products and/or services</td>
<td>HI</td>
</tr>
<tr>
<td>Individual Income</td>
<td>Oxford Homes</td>
<td>DC, IN</td>
</tr>
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</table>
INDISPENSABLE SERVICES

- MAT
  - MAT for the uninsured
  - MAT in correctional facilities
  - MAT transportation services
  - MAT hub and spoke

- Services for specific populations
  - Services for pregnant women or women with dependent children
  - Youth treatment and recovery services
  - Tribal opioid outreach
  - Tribal law enforcement assisted diversion
  - Maternal health care management at public health departments

- Clinical and treatment services
  - Treatment services
  - Withdrawal management and stabilization
  - Residential treatment
  - Outpatient treatment

- Recovery services
  - Recovery support services
  - Recovery coaches in emergency departments
  - Recovery coaches in MAT clinics
  - Recovery coaches in outpatient clinics
  - Recovery residences
  - ROSC pre- and post-services

- Overdose prevention programs
  - Naloxone training and distribution
  - Harm reduction services
  - Outreach services for syringe exchange programs
  - Overdose survivor follow up

- Prevention
  - School-based prevention
  - HIV/Hep C prevention and outbreak infrastructure
  - Suicide prevention
  - Prevention media campaigns
  - Stigma reduction efforts

- State infrastructure
  - Training and technical assistance
  - State epidemiological outcomes workgroups (SEOWs)
  - 211 and OpenBeds
  - Workforce training

- Other
  - Housing services
  - Landlord mitigation
  - Crisis response
  - Mobile crisis response
  - 24/7 triage walk-in center
  - Community outreach
  - Re-entry programs
  - Court-based diversion services
TREATMENT SYSTEM COORDINATION

- States use a variety of mechanisms to ensure their state’s substance use services are coordinated and not duplicative, including:
  - Maintaining communication with other state agencies and stakeholders
  - Participating in internal and external advisory groups, workgroups, task forces, etc.
  - Working with grantees or providers to identify gaps
  - Staff liaisons or coordinator positions
  - MCOs coordinate services
  - Using billing data to coordinate services
  - State coordinating office
  - All funding for SUD services are communicated through the SSA
In the majority of states, the SSA has the authority to coordinate substance use services throughout the state using a variety of mechanisms including:

- MOUs/MOAs
- Business agreements
- Statutory authority
- Contracts with MCOs
- Contracts with subgrantees
- Data sharing agreements
- Interagency agreements

<table>
<thead>
<tr>
<th>SSA Authority</th>
<th>States</th>
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<tbody>
<tr>
<td>Yes</td>
<td>AL, AK, AR, CA, HI, IL, KS, MD, MN, MO*, NE*, NH, NY, NC, SC, RI, TN, TX, WV, WY</td>
</tr>
<tr>
<td>No</td>
<td>CO, CT, DC, IN, VT</td>
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*noted true only for the publicly-funded service system
Q&A
STATE OPIOID TREATMENT AUTHORITIES (SOTA)
LEARNING COMMUNITY ACTIVITY UPDATES

JOHN MCILVEEN (OR)
ADAM BUCON (NJ)
BELINDA GREENFIELD (NY)
JESSICA BLOSE (WA)
Opioid Treatment
Access Learning
Community

JOHN MCILVEEN (OR)
In 2019, the Increasing Opioid Treatment Access Learning Community asked SOTAs the following questions:

- Does your state require the provision of MAT in non-OTP outpatient settings, residential facilities, jails, or prisons? If so, how does your state require this?
- Which of the three FDA approved medications do you require? Is it required to be provided in-house or coordinated?
- When did you start requiring this and would you be able to provide data on referrals or admissions reflecting this change?
- Do you have any mechanisms to monitor or enforce the provision of MAT in these settings? If so, what are they?
We received responses from 47 states

Non-OTP Outpatient Programs
- Does Not Require MAT 53%
- Requires MAT 47%

Residential Facilities
- Does Not Require MAT 53%
- Requires MAT 47%

Jails
- Does Not Require MAT 83%
- Requires MAT 17%

Prisons
- Does Not Require MAT 94%
- Requires MAT 6%
SOTA Inquiry on Requiring MAT in Non-OTP Settings

- After discussions within the Opioid Treatment Access Learning Community, we realized that the questions for this inquiry may have been confusing.
- Instead of presenting these results in our traditional form, it was decided to develop short vignettes for a few states that showed exemplary work in this area.
Disaster Preparedness Learning Community

ADAM BUCON (NJ)
SOTA Disaster Preparedness Learning Community

- Adam Bucon, Co-Chair (NJ)
- Jennifer Babich, Co-Chair (MA)
- Belinda Greenfield (NY)
- Corine Stancil (FL)
- Crystal Sanchez (CA)
- Jessica Blose (WA)
- John McIlveen (OR)
- Karla Thompson (KY)
- Laurie DeLong (TX)
- Linda Mahoney (RI)
- Phil Hall (AR)
- Richard Massatti (OH)
- Richard Moldenhauer (MN)
- Smith Worth (NC)
- Zach Talbott
The Disaster Preparedness Committee was formed after SOTAs presented at a CSAT-SOTA meeting at the 2016 AATOD Conference, describing state responses to Hurricane Sandy, Baltimore riots, the Boston Marathon bombing, and Floods. It was felt that there was a continued need to develop guidance on best practices.

After a series of LC calls, the committee decided to develop a Fact Sheet, containing recommendations for how all states might best prepare for the wide variety of emergencies they might face. Interviews were conducted with SOTAs from six states (California, Florida, New Jersey, New York, North Carolina, and Texas). In July 2018, the Final Report was published containing a two-page Fact Sheet, as well as in-depth reports from each state describing their disaster management systems and lessons learned from recent experiences.
The Disaster Preparedness Learning Community held a webinar in January discussing five states' experiences with disasters and how they responded.

- **Massachusetts** experienced a gas explosion causing displacement of patients.
- **Connecticut** experienced OTP closures due to a ransomware attack.
- **Oregon** experienced an OTP closure due to compliance and legal issues.
- **Ohio** experienced emergency closures of OBOT offices and pain clinics.
- **Washington** experienced a large power/internet outage forcing a large OTP to hand-dose.
Disaster Preparedness: Lessons Learned

- Massachusetts Gas Explosion
  - Both clinics had dosing information in the cloud so they could work with IT specialist to dose at separate location. Staff were stationed at both the disaster site and at host OTP site to inform patients and make them comfortable. It was important to identify the state official responsible for managing the disaster so patients could be updated (and this identification required help from the SOTA).

- Connecticut Ransomware Attack
  - The provider had a cybersecurity insurance policy and was able to contact the insurance company who handled negotiations and contacted the FBI. It is recommended that OTPs consider buying such a policy.
Disaster Preparedness: Lessons Learned

- Oregon OTP Closure Due to Legal Issue
  - An initial complaint about an abusive staff person led to a further investigation finding chart inconsistencies, missing medications, and problems with the physical facility. In a similar situation, it is recommended that SOTAs rely on help from SAMHSA and DEA, using the resources available and SOTAs’ knowledge as special subject matter experts.

- Ohio OBOT Closures
  - The circumstances of the incident included Medicaid fraud and too many prescriptions being written. Key questions to ask in a similar situation: Which county(s) is involved?; Is OBOT closure permanent or temporary?; How many patients are affected and are they from other states?; Do the physicians also provide primary care?; Will Medicaid billing be turned off?.
Disaster Preparedness: Lessons Learned

- Washington Power Outage
  - Washington experienced a large power/internet shortage, lasting almost 72 hours, that shut down electronic dispensing machines and electronic health records. Recommended solutions included obtaining a generator, developing paper template to complete data entry for later inclusion into the EHR, and devising temporary privacy barriers or alternative spaces to ensure client confidentiality for patients waiting in line to dose outside of building.
Opioid Treatment Programs: New York State’ Response to COVID-19

Belinda Greenfield, PhD
New York State’s Opioid Treatment Program (OTP)~~ General Description ~~~
Challenges to OTP system

- Rapidly decant OTPs by providing copious take homes and creating designated other requests
- Patients ability to access medications / services when quarantined/isolation
- Use of telehealth services by both staff and patients
- Performing home deliveries of medication
- Outdoor / curbside dosing
- Workforce becoming ill; staff deaths; staff burnout
- Lack of PPEs
- OTP management of increased take home medication and designated other requests
- Fiscal Concerns
- Negative media coverage
- Patient, family and locality complaints – OTPs targeted for either being open, not appropriately social distancing, not giving enough take homes, for giving too many take homes, c/o diversion, etc.
- Need to increase in daily hours of medication dispensing
Regular OTP Office Hours with OTPs Statewide + OTP Medical Directors

1. Office Hours WebEx Meetings – always set up 2 meetings in order to make sure all OTPs can attend and ensure as many staff will hear NYS’ messaging

2. Office Hours have also targeted Medical Directors, who need guidance regarding medical considerations during the height of the epidemic and recently, as part of NY Forward.
Coordination with OTP Coalition Group: COMPA

- 2-3 x per week initially
- Current frequency – weekly meetings
- Worked on the following:
  - Billing issues
  - Assessing needs of the OTP community in relation to COVID-response
  - Developed the NYC Medication Delivery System
NYC Medication Delivery System

❖ Developed in tandem with COMPA, NYC DOHMH, DHS

❖ Home deliveries:
  • 7, 14, 21 or 28 day deliveries
  • Daily deliveries began 6/29/2020

❖ Target the following OTP patients:
  • COVID + diagnoses
  • COVID symptoms
  • Vulnerable/At risk populations: 50+ years old, COPD, …
OTP COVID Emergency Billing and Telehealth Guidance
OTP COVID Billing and Use of Telehealth Services
Key OTP Guidance Topics / Tenets

1. This is a public health crisis – “Not Business as Usual!”
2. Provide generous, flexible take homes to reduce patient volume
3. Need for social distancing for patients who come to the clinic
4. Use of scheduled dosing as a strategy so that numerous patients were not coming into the clinic at the same time
5. Only most pertinent OTP services to be done in person; all other services to be done via telehealth or defer until later
Moving Forward: Current and Proposed Activities

➢ Baseline take home schedule and weekly take home data
➢ Use of COVID bundled rates
➢ Use of new Medicaid Transportation platform
➢ Telehealth / telephonic service utilization
Washington State COVID-19 Response for OTP
WA OTP landscape

- 29 OTPs in Washington State including
  - For profit OTP
  - Non-profit WA Based OTP
  - OTP Run by County Health Dept.
  - 4 tribally owned and operated OTPs
  - 2 VA OTP sites
  - One mobile medication unit

- Over 13,600 Washingtonians
- 100% of all WA OTPs participate with the WA AATOD Chapter WSATOD
- WA first state in nation to have a confirmed COVID-19 case
What worked?
Use of transparency and collaboration with OTP Medical Directors to craft OTP specific guidance

- WA was the first state to get formal guidance out to OTPs regarding COVID-19 and this couldn’t have been done without OTP Medical Directors.
- SOTA asked OTP Medical Directors for their feedback before COVID-19 even came to Washington State/America.
- OTP Medical Directors at some of Washington State’s largest OTPs began to develop ideas and concepts for guidance materials, ideas for safety protocols using risk stratification for clients, promotion of social distancing, how to give take homes safely and individualized care continuity. OTP Medical Directors shared those ideas with the SOTA.

- SOTA let good ideas rise to the top - no need to reinvent the wheel.
- SOTA combined feedback from OTP Medical Directors in WA and sought feedback from other SOTA colleagues.
- That work is what WA moved forward to SAMHSA, and then was replicated nationwide.
Importance of developing a clear incident command structure for COVID-19 response

- Regulatory structures over OTPs are different from State to State.

- In Washington, a number of parties play a regulatory role over OTPs that needed to make decisions together quickly:
  - SSA
  - Medicaid
  - WA DOH - Regulatory body for OTP state licensure and in WA also a federal accreditation body for over 80% of all WA OTPs
  - SOTA
  - All needed to make decisions together.

- SOTA recognized as Subject Matter Expert and best individual to coordinate with stakeholders including providers, Local Health Jurisdiction (LHJ), State agency staff and federal government.
Importance of developing a clear incident command structure for COVID-19 response

- SOTA named the head and communications lead of WA ICM for OTP topics.
- SOTA leads the efforts, keeps all parties looped in with one another and is designated “authority” to make executive decisions when necessary.
- Streamlined the process
- Having physician staff consultation for SOTA is key. SOTA in WA is not a MD; however, she had access to several MDs at HCA and DOH, some of whom have an Addiction Medicine background, which was key to moving things forward and ensuring feedback is accurate and safe.
- Supportive Governors Office
WA Develop Guidance Documents

- Develop OTP **and** OBOT guidance
- Published links to SAMHSA and DEA guidance

Set up website where updated guidance could be posted, so any emails being sent out about updates could reference the same website and therefore remain timely and relevant. Information is updated and removed if no longer accurate.

- WA circulated guidance widely to OTP and OBOT partners/DATA 2000 waiver prescribers, payer systems (MCOs), regional LHJ, etc. via website, email blasts, list servs, and webinars and phone conferences.
- WA also circulated widely guidance to other stakeholders external to Washington State.
  - SAMHSA
  - DEA
  - SOTA
  - AATOD
SOTA set up regular weekly communication opportunities with OTPs

- SOTA set up weekly telephone call with all WA OTPs to deal with emerging issues, provide updates, answer Q&A, have guest speakers, peer to peer problem-solving, etc.
- SOTA set up at least weekly email communications with OTP providers to send out updates on rapidly evolving technical assistance/guidance documents/resources.
- SOTA fully utilized AATOD chapter in WA- WSATOD- Made sure they were helping to amplify the message, and feed concerns and questions to SOTA
- SOTA even invited prospective OTP program applicants, new to WA, to join in on calls and emails. If they open in WA in the next year or so, they need to be prepared, because COVID-19 is not going away anytime soon.
- SOTA designated a back up SOTA, had them registered with SAMHSA DPT and the SAMHSA OTP Extranet website, had them introduced to all OTPs, and provided emergency numbers for internal and external state partners so they can be contacted if current SOTA gets sick.
WA Medicaid and the SSA Office

- WA State Medicaid office in WA moved quickly to pay for:
  - Telehealth (audio visual and telephonic) services authorized for payment, same rates, no PA
  - Gave out phones to clients
  - Purchased and gave out Zoom licenses to over 200+ behavioral health providers to offer telehealth audio-visual services
  - Worked to set up and advertise rural broadband access points in communities across WA
  - Set up billing guide, and rule change webinars for providers on changes
  - SSA for SUD and MH set up weekly call for all behavioral health providers (SUD/MH and problem gambling).
Connected each OTP with Local Health Jurisdiction (LHJ)

- County LHJ and Tribal LHJ in Washington State

- Encouraged OTPs to follow WA COVID-19 ICM structure as most other healthcare providers would. This means coordinating with their respective LHJ

- OTPs in WA connected with LHJ for:
  - PPE requests
  - SME on up to date information on regional risks of community spread of COVID-19
  - Coordination for clients who need to go into isolation and quarantine (I&Q) facilities
  - Support if a program needed to close unexpectedly
SOTA peer to peer discussions

- SOTAs met with one another through:
  - NASADAD
  - NASADAD – SOTA Disaster Preparedness Learning Community
  - Emails
  - Phone calls
  - Skype meetings!

- Good ideas rise to the top, no need to re-invent the wheel

- A real highlight and bright spot of such a difficult year has been the collaboration and camaraderie of SOTAs working with other SOTAs to share lessons learned and to problem solve.
Strong collaboration between SOTA and SAMHSA DPT and DEA staff

- SAMSHA DPT staff answered emails and phone calls.
- SAMHSA DPT staff worked to alleviate mid-level practitioner exemption backlogs to bring relief to OTPs in rural areas and/or who had medical directors who could not be onsite at OTPs.
- SAMHSA DPT staff set up calls between SOTA and SAMHSA and DEA staff.
- SAMHSA DPT staff put out published guidance.
- DEA put out published guidance.
- SAMHSA requested feedback on the impacts of the increased flexibility afforded to States and practitioners during the COVID-19 emergency.
SOTA takes on the role of TA for continuity of care needs regarding OUD medications

- SOTA does TA with Isolation and Quarantine Facilities- with the federal government, with counties, with Tribal partners, with hospital overflow I&Q facilities
- SOTA does TA with shelters
- Discussion of both OTP and OBOT client needs
- Developed protocols and decision trees for technical assistance, sent them to SAMHSA DPT and DEA and then to other SOTAs.

- SOTA also participated with media requests about all things OUD related during COVID-19:
  - Opioid use disorder treatments
  - COVID-19 disaster planning
  - Safe medication disposal
  - Overdose prevention
  - Accessing our WA Recovery Helpline, and it’s MOUD Locator
  - Suicide Prevention Hotline promotion etc.
WA OTPs encouraged to do their own autonomous planning as well

- Encourage OTPs to have MOUs with one another.
- OTPs in LHJ regions met with one another and LHJ weekly
- Update internal disaster protocols
- Clinical documentation during these exceptional times is imperative- Continual quality improvement on documentation in clinical records and electronic health record system highly promoted
- Liberal use of WA AATOD chapter WSATOD for promotion of coordination between OTPs
- Creation of optional universal guest dosing form, so popular it will formally be adopted by all OTPs in WA starting July 1
- Shared with OTPs the NASADAD SOTA Disaster Preparedness Learning Community documentation as technical assistance materials
SOTA prepares disaster closure protocols for OTP and OBOT

- SOTA is Health Care Authority lead for Washington State Drug Response Team (DRT).

- Goal of DRT is for WA HCA/DOH to have disaster planning protocols in place for following scenarios:
  - Unexpected OTP closure
  - Unexpected OBOT closure
  - Pain Management Clinic Closure
  - Drug Overdose event that exceeds the ability of local LHJ to respond to

- COVID-19 pushed up the need for State specific protocols for how to respond to unexpected OTP and OBOT clinic closures.

- SOTA connected with DOH/LHJ/DEA/SAMHSA staff to develop protocols.
Bring in Extra Resources to Support OTP

- WA SOTA looked for additional resources to bring extra naloxone and lock boxes to OTPs as all were providing more take home doses of medication than usual.
- SSA authorized use of SABG funds to help support OTP and reduce risk of overdose in both OTP clients, their families and communities.
- SABG funds for naloxone – Enough to cover all 13,600 OTP patients in WA State
- SABG funds and lockboxes - Enough to buy each OTP 200 lockboxes for indigent clients

Look to the future: WA Health Care Authority (State Medicaid) also looking to do the following by 2021
- Bring OTP Central Registry to WA for support for future emergency planning via Light House vendor
- Change existing OTP payment model to match weekly Medicare rates
- Implement 3-year plan to introduce standardized set of services for all WA OTPs accepting Medicaid funds, to focus on quality improvement and “modernizing” OTP.
Outcomes
OTP Anecdotal Outcomes

- All OTPs are using telehealth delivery of services for both medical and psychosocial counseling services.
- No staff have been confirmed COVID-19 positive.
- No staff deaths from COVID-19.

- Very few clients had gotten sick with COVID-10 in WA OTP.
- Between 0 and 3 confirmed COVID-19 client cases at each OTP.

- All WA OTPs to date have reported zero client deaths confirmed from COVID-19.

- No programs have had to close unexpectedly, except for one program, for one weekend at the beginning of the pandemic.
OTP Anecdotal Outcomes

- OTPs have reported having very few PPE concerns compared to other behavioral providers.
- Inquiries from AATOD and WA Legislature on this topic resulted in all OTPs reporting they were at a manageable baseline with PPE.
- No report of increase in OTP client overdoses related to take home dosing.
- No report of community overdoses on methadone medications related to OTP take home dosing.
- Eager to have a forum to share confidently with federal partners that WA State has outcomes to support a long-term paradigm shift in treatment of OUD in OTP settings.
Data Being Collected
Information we have been collecting in WA

- Biweekly data request from all WA OTPs, tracking percentage of overall client census that receives different amounts of take-home dosing. How many clients are on:
  - Daily dosing
  - 2-3-day dosing
  - 4-day dosing
  - Weekly
  - Biweekly
  - Monthly

- Client census at each OTP over time, across all types of insurance
- Agency dates and hours of operation for clients
- OTP client deaths (for any reason, on-site and off-site) at each OTP
Information we have been collecting in WA

Partnering with University of Washington’s Alcohol and Drug Institute to look at “What is the impact of COVID-19 on OTP treatment and OTP patients?” A look at one Opioid Treatment Program.

Research questions

How was OTP treatment impacted?

To examine this, we review descriptive statistics outlining changes in OTP operations as a result of COVID-19. Variables include:

- Number of take-home doses provided before and after March 13, 2020
- Proportion of patients at various take-home phases
- Number of services provided before and after March 13, 2020
  - Dose adjustments
  - Counseling visits
Information we have been collecting in WA

Research questions

How were OTP patients affected?

- Qualitative description about how the OTP landed on policy changes regarding take home dosing. Variables include:
  - Meeting minutes, written policy and procedures, communication between leadership and staff.
  - Interviews with key staff in decision making roles, as well as those executing new P&Ps.

What are the potential harms to patients in providing more take home doses than usual (see hypotheses for specific variables)?

- Increased rates of ED visits.
- Increased mortality rate/increased incidents of methadone-implicated poisoning.
- Increased level of impairment incidents.
- Increased rate of discharges (AWOL and Deceased discharge types)
Information we have been collecting in WA

How were OTP patients affected?

What are the potential benefits to patients in providing more take home doses than is usual?

- Better retention/fewer discharges
- Increased satisfaction with treatment
- Better engagement (e.g., higher attendance at counseling sessions)
Information we have been collecting in WA

Hypotheses:

- OTP Retention rates will be different after March 13, 2020 (non-directional hypothesis here).
  - Variable: EHR-indicated discharge rates during “before” and “after” specified time periods.

- Rates of ED visits will be different after March 13, 2020.
  - Variable: Number of OTP patient ED visits according to EDIE/Collective Medical data from King County; data available from July 2019 onward

- Patients feel more engaged in OTP treatment because the OTP responded with quick and decisive patient-centered action during COVID-19 crisis. This could be demonstrated by reduction in the discharge rate, a reduction in no show appointments, and by patient report.
  - Variables:
    - Discharge rate (this repeats Hypothesis #1)
    - EHR data indicating “No show” appointment for counseling and medical appointments; AWOL dosing appointments.
    - Patient interviews (This could be an entirely different project.)
Information we have been collecting in WA

Questions:

- Will rates of methadone-implicated poisoning incidents will show an increase after March 13, 2020?
  - Variables to review:
    - Medical visits that concerned drug poisoning incidents (EDIE/Collective Medical data).
    - Death due to drug poisoning: OTP EHR data (discharge type=deceased) in combination with ME report.

- Will rates of impairment incidents increase after March 13, 2020?
  - Variables to review: OTP EHR data on incident reports.
Information we have been collecting in WA

Implications:
- Results may suggest a review and update of existing OTP guidelines around take home medication.
- Lessons learned from immediate implementation of new policies could help inform OTP practices around making organization-level decisions quickly in the face of extenuating circumstances.
- We can take the opportunity to critique the use of substance use outcomes as the primary outcome in research and clinical practice. UA results cannot be included in this inquiry, and instead of listing this as a “limitation”, we can make the point that treatment retention is the key outcome.
- Here, we can encourage clinicians and researchers to shift focus away from substance use and towards treatment retention.

Questions:
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Alcohol and Drug Abuse Institute University of Washington
calebbg@uw.edu
Contact Information

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Washington State Opioid Treatment Authority and Manager of Behavioral Health Clinical Supports

Work Cell: 360-485-2895
Work Email: jessica.blose@hca.wa.gov
SAMHSA & NASADAD Annual Meeting

VIRTUAL EVENT
July 13, 15, & 17, 2020

Time for a Break
STATE SPEAKERS – INITIATIVE UPDATES

JULIENNE GIARD (CT)
TIFFANY WYNN (NM)
DEDE SEVERINO & SMITH WORTH (NC)
KEVIN MASUDA (CA)
JULIENNE GIARD
DIRECTOR
COMMUNITY SERVICES DIVISION
DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES
CONNECTICUT
SAMHSA – NASADAD
CO-OCCURRING DISORDER SERVICES IN NEW MEXICO
TIFFANY WYNN, MA, LPCC
MISSION

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

GOALS

We help NEW MEXICANS

1. Improve the value and range of services we provide to ensure that every qualified New Mexican receives timely and accurate benefits.

We make access EASIER

3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We communicate EFFECTIVELY

2. Create effective, transparent communication to enhance the public trust.

We support EACH OTHER

4. Promote an environment of mutual respect, trust and open communication to grow and reach our professional goals.
NM RECEIVED A SAMHSA GRANT IN THE EARLY 2000S THAT WAS FOCUSED ON IMPROVING INTEGRATION OF THE MENTAL HEALTH AND THE SUBSTANCE USE SYSTEM.
SINGLE STATE AUTHORITY & PARTNERS ADDRESSING COD

- Oversee substance use and mental health treatment and prevention efforts
- Work in collaboration with the Board of Pharmacy, Children Youth and Families Department, Drug Enforcement Agency, and the Department of Health to address needs
- Co-occurring training is also integrated at the state board level.
- The Consortium for Behavioral health Training and Research (CBHTR)
WHO & WHERE

Mental Disorder Only: 79%
Substance Use Disorder Only: 14%
Mental and Substance Use Disorder: 7%

Proportion of Clients with Comorbidity Substance Use Disorder and Mental Illness

Investing for tomorrow, delivering today.
EXECUTIVE SUMMARY NMBHNA 2020

SNAPSHOT OF THE
New Mexico Behavioral Health Needs Assessment 2020

AMONG NEW MEXICO MEDICAID CLIENTS

Behavioral Health Disorders

<table>
<thead>
<tr>
<th>Most Common Disorders</th>
<th>Substance Use</th>
<th>Mental Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Use Disorders</td>
<td>Alcohol Use Disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depressive Disorders</td>
<td>Anxiety Disorders</td>
</tr>
<tr>
<td></td>
<td>Trauma-Related Disorders</td>
<td>Stressor-Related Disorders</td>
</tr>
</tbody>
</table>

55% of Medicaid Clients with a behavioral health disorder also have a chronic physical condition

Behavioral Health Treatment Services

Substance Use Disorders (SUDS)

DIAGNOSES AMONG MEDICAID CLIENTS WITH SUDS, NM, 2018/2019

% of Medicaid Clients

<table>
<thead>
<tr>
<th>Substance Use Disorder</th>
<th>0.0%</th>
<th>20.0%</th>
<th>40.0%</th>
<th>60.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Use Disorder</td>
<td>52.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Use Disorder</td>
<td>36.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamine Use Disorder</td>
<td>17.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Stimulant*Use Disorder</td>
<td>17.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis Use Disorder</td>
<td>13.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Substance Use Disorder</td>
<td>4.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine Use Disorder</td>
<td>3.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogen Use Disorder</td>
<td>0.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*besides Cocaine
DEMOGRAPHICS & POPULATION NEEDS

**Demographics**

190,835

26,009 (13.6%) had a Substance Use Disorder

14,528 (7.6%) had a Mental Health Disorder

150,298 (78.8%) had both

NM Medicaid clients with behavioral health diagnoses received health care for their physical or behavioral health needs in 2018/2019*

*Claims data represent April 1, 2018 to March 31, 2019

**Population Needs**

**Behavioral Health Conditions**

Since 1981 NM’s suicide mortality rate has been 1.5 to 1.9 times higher than the national rate

**Chronic Physical Conditions**

**Chronic Conditions Among Clients with Active Behavioral Health Diagnoses, NM, 2018/2019**

- **Total**:
  - Diabetes with Complications: 8.0%
  - Liver Disease: 8.4%
  - Obesity: 14.7%
  - Chronic Pulmonary Disease: 17.3%

- **Mental Disorder Only**:
  - Diabetes with Complications: 8.1%
  - Liver Disease: 5.4%
  - Obesity: 7.7%
  - Chronic Pulmonary Disease: 10.1%

- **Mental Disorder and SUD**:
  - Diabetes with Complications: 6.2%
  - Liver Disease: 16.0%
  - Obesity: 14.1%
  - Chronic Pulmonary Disease: 17.5%
ALCOHOL RELATED DEATHS NM AND US 1990-2017

Deaths per 100,000 Population

- NM
- US

<table>
<thead>
<tr>
<th>Year</th>
<th>NM</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>46.6</td>
<td>30.9</td>
</tr>
<tr>
<td>1991</td>
<td>46.2</td>
<td>30.6</td>
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<td>1993</td>
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<td>28.2</td>
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<td>28.0</td>
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<tr>
<td>2005</td>
<td>40.6</td>
<td>27.8</td>
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<tr>
<td>2008</td>
<td>39.4</td>
<td>27.2</td>
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<tr>
<td>2016</td>
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<td>25.6</td>
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<tr>
<td>2017</td>
<td>35.8</td>
<td>25.4</td>
</tr>
<tr>
<td>2018</td>
<td>35.4</td>
<td>25.2</td>
</tr>
</tbody>
</table>

70.3

Investing for tomorrow, delivering today.
DRUG OVERDOSE DEATH RATE NM & US 1990-2018

Investing for tomorrow, delivering today.
SUD THEN SUD/MH/PHYSICAL CONDITIONS

- Metastatic Cancer
- Lymphoma
- HIV/AIDS
- Hypertension with Complications
- Renal Failure
- Congestive Heart Failure
- Peripheral Vascular Disorders
- Diabetes with Complications
- Liver Disease
- Obesity
- Chronic Pulmonary Disease

- Mental Disorder Only
- SUD Only
- Mental Disorder and SUD

- 2+ Chronic Physical Conditions
- 1 Chronic Physical Condition
FUNDING HIGHLIGHTS

$48+ million
allocated federal grant funding from the Substance Abuse & Mental Health Services Administration (SAMHSA) for Mental Health and Substance Abuse Prevention and Treatment

$107+ million
allocated federal grant funding from the Health Resources & Services Administration (HRSA) for programs that provide health care to people who are geographically isolated, economically or medically vulnerable

PERCENTAGE OF DISCRETIONARY GRANT DOLLARS BY TREATMENT TYPE, NM, 2018

- Substance Abuse Treatment: 43%
- Mental Health: 43%
- Substance Abuse Prevention: 14%
In 2019, HRSA’s Health Professional Shortage Area data, reported:

- 12% of the need for mental health care in NM has been met
- 27.27% of the need for mental health care in the United States has been met

leaving 1,246,744 New Mexicans without adequate access to mental health care

**Cost of Treatment in 2018/2019**

- **Medicaid Claims by Category**
  - Substance Use Clinicians, 771, 8%
  - Prescribers, 473, 5%
  - Non-Independently Licensed Psychotherapy Providers, 3,464, 37%
  - Independently Licensed Psychotherapy Providers, 4,723, 50%

$787,710,231 in Acute Care Costs
HRSA FUNDING ALLOCATION IN NEW MEXICO BY YEAR, 2013-2018

$60,000,000  $65,000,000  $70,000,000  $75,000,000  $80,000,000  $85,000,000  $90,000,000  $95,000,000  $100,000,000  $105,000,000  $110,000,000
2013  2014  2015  2016  2017  2018
$70,466,058  $82,837,463  $93,770,389  $100,373,587  $98,742,365  $107,056,371

HRSA funding in New Mexico has increased by over $36 million dollars from 2013 to 2018.

Deborah Altschul, PhD.
Vice Chair of Community Behavioral Health Research
daltschul@salud.unm.edu  |  505-272-6238
NETWORK OF CARE RESPONSES

▪ Accessibility – Treatment Connections, NM BH Referral Network

▪ Quality – Integrate Quality Service Review, Medicaid requirement for continuous quality improvement, free trainings for service delivery models

▪ Workforce – Gap analyses about the rural and frontier nature of NM, distance between need and available services, privacy concerns in small communities, hiring and maintaining fully staffed workforce, multiple workforce strategies occurring across the state

▪ Medicaid reimbursing AARTCs; can treat COD

▪ Increased IOP services across the state – always COD

▪ Increase CCSS services across the state
NEXT STEPS

▪ Connect more New Mexicans with available care
▪ Focus treatment expansion on counties with the greatest unmet needs
▪ Integrate SUD, MH and COD screening into primary care settings, EDs, and the criminal justice system
▪ Increase access to EBP for AUD and stimulant use disorders
▪ Work with all payors to enhance tracking of SUD, MH and COD to increase tracking
QUESTIONS?

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ACTING DEPUTY DIRECTOR, TREATMENT & PROGRAMS
BEHAVIORAL HEALTH SERVICES DIVISION
HUMAN SERVICES DEPARTMENT, NM

TIFFANY.WYNN@STATE.NM.US
NC Department of Health and Human Services

MAT Services and Expansion in NC

DeDe Severino, Section Chief
Smith Worth, SOTA Administrator

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

July 17, 2020
Overview

• Who We Are
• NC Stats
• Strategies for Fighting the Opioid Crisis
• Dedicated Funding
• Opioid Treatment Programs
Overview of DMH/DD/SAS

• Located within DHHS

• Provide clinical, programmatic and fiscal oversight of state and federal funds designated for uninsured individuals with mental health, intellectual/developmental disabilities and substance use disorders

• Contract with LME-MCOs and other community-based providers for the delivery of care
Addictions & Management Operations

State Opioid Treatment Authority
Problem Gambling Program
Adolescent Services
Women’s Services
SABG

Discretionary Grants – SOR, PPW, MAT-PDOA, Emergency COVID
Prevalence – Opioid Misuse

Based on a population estimate for NC of 9,021,806 individuals aged 12 or older, the following totals indicate prevalence of prescription opioid misuse and heroin use, respectively:

<table>
<thead>
<tr>
<th>Population Ages 12+</th>
<th>Rx Opioid Use</th>
<th>Heroin Use</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevalence</td>
<td>Persons</td>
<td>Prevalence</td>
</tr>
<tr>
<td>9,021,806</td>
<td>3.63%</td>
<td>327,492</td>
<td>0.27%</td>
</tr>
</tbody>
</table>
NC Stats

• Number of opioid pills dispensed to North Carolinians is decreasing
  ➢ 2017 – 518,401,000
  ➢ 2018 – 445,002,000
  ➢ 2019 (2nd quarter) – 210,046,000 – trending

• Number of ED visits for opioid overdose is increasing
  ➢ 2017 – 5777 visits
  ➢ 2018 – 6769 visits
  ➢ 2019 – 6236 visits – trending
NC Stats

- Confirmed opioid-related deaths are decreasing
  - 2017 – 1884
  - 2018 – 1718
  - 2019 (3rd quarter) – 1107 – trending

- Percentage of deaths involving heroin or fentanyl is increasing
  - 2017 – 75.4%
  - 2018 – 78.62%
  - 2019 (3rd quarter) – 86% - trending
Strategies for Fighting the Opioid Epidemic

1. The PDMP and The STOP Act

2. 911 Good Samaritan Law

3. Syringe Exchange Programs

4. NC Opioid Action Plan 2.0
Dedicated Funding

1. State Opioid Response (SOR) Grant
2. SOR Supplement Grant
3. MAT-PDOA Grant
4. SABG
Medication Assisted Treatment

• 78 Opioid Treatment Programs in NC
• 3 pending approval
• Provide MAT to over 20,000 individuals daily
• Medications available at OTPs include:
  – Methadone
  – Buprenorphine products – mono and combination
  – Naltrexone
• OBOTs
Opioid Treatment Programs in North Carolina

Urban areas may have fewer capacity issues, but there isn’t sufficient funding.

Rural areas struggle with both capacity and funding restricting access to quality care.
California Tribal MAT Project: Supporting Tribal Telehealth

Kevin Masuda
Department of Health Care Services
Community Services Division
Agenda

• California Tribal MAT (TMAT) Background
• TMAT Partners and Projects: 2018-2022
• Additional Tribal Telehealth Supports
TMAT Background

[ Tribal MAT ]

A unified response to the opioid crisis in California Indian Country
In 2015, CA received first 1115 SUD waiver in country

Phased implementation staggered geographically

CA engaged Tribal stakeholders per Phase 5 of the 1115 SUD waiver

Foundation for planning Tribal MAT under STR & SOR

Tribal MAT is a collaborative and stakeholder-driven “bottom-up” process for designing ways to address Tribal and Urban Indian community needs regarding the opioid crisis.
California Indian Pre-contact Tribal Territories
Tribal Background

• State and Tribal governments are both federally recognized political jurisdictions with similar scope and authority.
• A State is sovereign to the extent that its powers are defined and limited by the Constitution as interpreted by the Congress and the Supreme Court.
• The same is true for Tribes.
• Both governments are on equal footing and have a government-to-government relationship with the Federal government.
The Opioid Crisis in California Indian Country

AI/ANs are underrepresented due to racial misclassification. A study from Washington suggests that CDC data underestimate drug overdose mortality counts and rates among AI/AN by approximately 40%.

An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure. Seven Directions: A Center for Indigenous Health Policy. September 2019.

Source: CA Opioid Surveillance Dashboard
https://discovery.cdph.ca.gov/CDIC/ODdash/
Long-standing DHCS investment in TMAT

- STR
  - May 2017 to April 2019

- SOR (first round)
  - September 2018 to September 2020

- SOR (second round)
  - September 2020 to September 2022
  - Opioid use disorder and stimulant use disorder
TMAT Background

Designed to meet the OUD prevention, treatment, and recovery needs of California’s Tribal and Urban Indian communities with special consideration for Tribal and Urban Indian values, cultures, and treatments.

→ Promote opioid safety

→ Improve the availability of MAT

→ Facilitate access to naloxone
TMAT Partners and Projects: 2018-2022

[Tribal MAT] A unified response to the opioid crisis in California Indian Country
TMAT Partners

http://www.californiamat.org/matproject/tribal-mat-program/
TeleWell: Tribal Telehealth

• Tele-MAT clinical services
  – Clinical assessment, drug screening, induction, prescribing, counseling, case management, cultural recovery supports, co-occurring psychiatry, discontinuation
  – Expand access; jumpstart capacity; complex cases

• Clinical consultation
  – “Office hours” calls for Tribal and Urban Indian providers re: MAT consultation and discussion
TeleWell: Tribal Telehealth (cont’d)

• Educational webinars
  – Monthly presentations on OUD prevention, treatment, and recovery for Tribal and Urban Indian providers
  – Didactic presentation and case discussion
• MAT implementation technical support

https://www.telewell.org/indian-health-program-mat-project
Tribal MAT Project ECHO: Tribal Telehealth

• Project ECHO model for Tribal MAT (UCLA)
  – Monthly 60-minute virtual clinics
  – Didactic presentation
  – De-identified case presentation
  – Facilitated discussion
  – Traditional healing and cultural practices

• Curriculum informed by Tribal MAT Advisory Board and targeted needs assessment
Tribal MAT Project ECHO: Tribal Telehealth (cont’d)

- Collaboration with SUD-related Project ECHO clinics across Indian Country
  - Northwest Portland Area Indian Health Board
  - Indian Health Service
  - UNM Echo Institute
  - First Nations (Canada)

CRIHB and CCUIIH: Supporting Tribal and Urban Indian providers

- Community Opioid Campaign
- Naloxone distribution
- MAT Champions
- Opioid Safety Coalitions
Additional TMAT Partners

Two Feathers – Native American Family Services

• Tribal Youth and Family Services Consortium
• Evaluating culturally–appropriate service modalities

USC Keck School of Medicine

• Tribal needs assessment
• Evaluating TMAT
Spotlight: CCUIH Materials
TMAT Accomplishments

California Consortium of Urban Indian Health
- 881 naloxone units distributed
- 18,000 booklets ready for distribution
- 29 staff and community trainings

California Rural Indian Health Board
- 14 Tribal Local Opioid Coalitions
- 50 tribes trained on naloxone
- 950 posters distributed

TeleWell Behavioral Medicine
- 12 training webinars
- 11 Tribal MAT programs supported
- 25 tele-MAT patients treated
TMAT Accomplishments

Two Feathers Native American Family Services
- Developed Tribal Youth & Family Services Consortium
- Utilize Native American Mental Health Theory of Change
- Provide OUD prevention & intensive case management

University of California, Los Angeles
- 250 Tribal MAT ECHO participants
  “Tribal ECHO has provided an opportunity to be a part of the caring community of MAT teams in Indian Country.”
  Tribal ECHO participant

University of Southern California
- 279 AI/AN people surveyed
- 36 focus groups (21 adult & 15 youth)
- 10 counties represented
TMAT 2.0 Goals

• Continue the successful trajectory of TMAT projects

--and--

• Expand the breadth and scope of resources available to Tribal and Urban Indian organizations to achieve further progress on addressing the SUD needs in California Indian Country.
TMAT 2.0 New Project Overview

• Tribal Community-Defined Best Practices
  – Grant opportunity for Tribal and Urban Indian organizations
  – Support the integration of culturally-validated traditional healing practices in the health program
  – Readiness assessment and strategic planning track option
  – Implementation track option
  – Community-based participatory research approach for evaluation
• TMAT Data Analytics
  – Stratify Medicaid performance by racial/ethnic group
  – Examine prevalence and unmet need
  – Review characteristics and utilization of MAT and SUD treatment
  – Assess follow-up care
  – Produce rates specific to MCOs and counties
  – Support strategic planning and engagement efforts
TMAT 2.0 New Project Overview

• Tribal MAT Learning Community
  – Learning community for Tribal and Urban Indian health programs delivering or interested in MAT
  – Individualized technical assistance on MAT needs assessment, planning, and implementation
  – Facilitated peer-to-peer exposure and supports
California Indian Harm Reduction Workgroup

- Convene statewide workgroup
- Articulate AI/AN harm reduction approaches and principles
- Provide funding/support/training to Tribal and Urban Indian programs and communities on harm reduction practices
- Coalition-building with harm reduction organizations
- Supporting direct outreach
• SUD Policy Training Opportunity
  – Support individuals in Tribal and Urban Indian communities to improve advocacy and communication approaches regarding SUD to local, state, and Tribal policymakers
  – Leverage USC Needs Assessment, TMAT Data Analytics, and other data
Provider Trainings
- Regional, in-person training opportunities
- Offered to Tribal, Urban Indian, and DMC providers
- Learn about community-defined and tribal best practices
- Develop competencies for culturally-driven treatment modalities
• TMAT partners provide telehealth equipment directly to Tribal and Urban Indian providers
  – Support participation in TeleWell and Tele-MAT services and Tribal MAT Project ECHO
• Separate SOR-funded grant opportunity for Tribal and Urban Indian providers to support infrastructure and capital development.
• Awardees receive telehealth equipment, software and support.
California Medicaid issued guidance regarding telehealth payment policies in response to COVID-19.

For Tribal 638 programs, limited to:
- "established" patients per FFS/MCO criteria
- Audio and visual communication has been approved as billable.

https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth_Other_Virtual_Telephonic_Communications_V4.0.pdf
Contact

• Kevin Masuda: Kevin.Masuda@dhcs.ca.gov
Q & A