



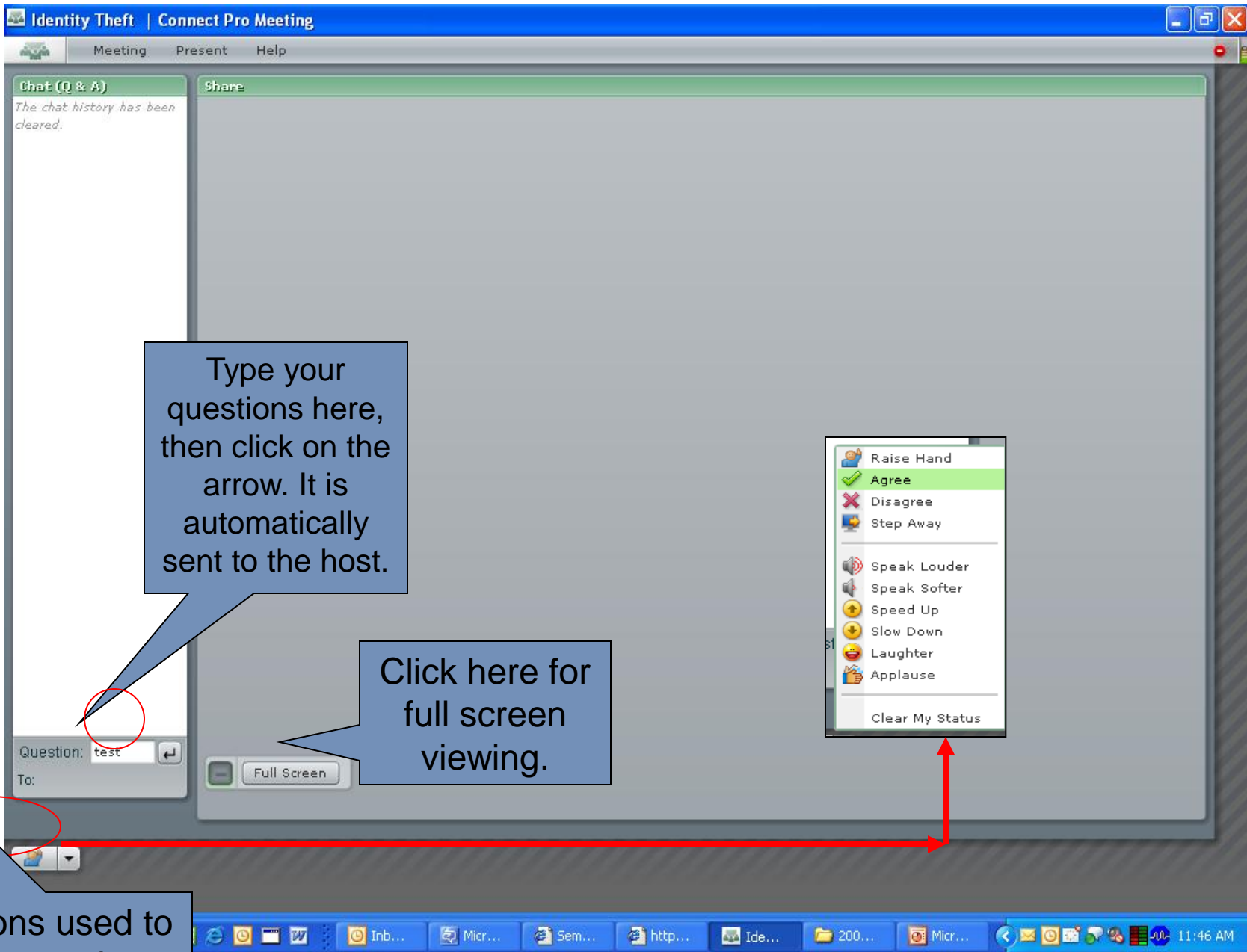
Welcome!

Substance Use Disorder Treatment, New
Technology, and Care Coordination

Presented by Mr. Mike Morris and
Gary Henschen, M.D.

The webinar will begin shortly.





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Icons used to communicate with the host.

Webinar Agenda (all times Eastern)

- 2:00 – Welcome, Housekeeping, Instructions to Participants
- 2:05 – Introduction
- 2:10 – Presentation by Mike Morris and Gary Henschen, MD
- 3:10 – Question and Answer Session
- 3:25 – Instructions for CE Credits
- 3:30 – Webinar concludes

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Learning Objectives

1. Participants will be able to name at least five medications used to assist in the treatment of substance use disorders
2. Participants will be able to understand the effective use of naltrexone in alcohol use disorders
3. Participants will be able to understand the use of acamprosate in alcohol use disorders
4. Participants will be able to understand the use of buprenorphine in the treatment of opiate use disorders
5. Participants will be able to understand the role of medication assisted treatment in the continuum of care for substance use disorder patients
6. Participants will be able to understand medication reconciliation.
7. Participants will be able to understand at least 3 ways 42 CFR Part 2 affects care coordination.
8. Participants will be able to understand aspects of the American Recovery and Reinvestment Act of 2009 (ARRA) / HITECH Funding related to 'Meaningful Users' of an electronic health record (EHR).

Presenter Disclosure

Dr. Henschen has no conflict of interest in making this presentation.

Mr. Morris may have a conflict of interest in making this presentation.

About the Presenter

Michael Morris is Co-Founder and CEO of Anasazi Software, Inc., one of the largest BH EHR software vendors. Anasazi was started in 1989 as a classic sweat equity software company by Mike and Eric Morris who jointly designed, developed and implemented a full behavioral health practice management application that met all requirements for automatic claiming, receivables management, and state reporting. Starting in 1996 Mr. Morris had the lead role in both the design and development of the Anasazi EHR application that supports all requirements of mental health, substance use, developmental disability, and specialty behavioral health and human services providers.

Mr. Morris pioneered an EHR implementation methodology designed to assure a timely and successful implementation that reflects the unique requirements of behavioral health entities. Since 1996 Mike has had a lead role at Anasazi in developing and bringing to market additional BH specific software products including a BH Managed Care Organization/Authority application and BH specific ePrescribing system. Mr. Morris' current focus is on the unique requirements of BH interoperability especially as it relates to consents, privacy, EHRs, Health Information Exchanges (HIEs), and Personal Health Records (PHRs). Mr. Morris established himself as a leader in the BH community on these topics by co-leading the BH Interoperability Conferences held in January and March of this year.

About the Presenter

Gary M. Henschen, MD is Chief Medical Officer-Behavioral Health of Magellan Health Services, a specialty health company offering oversight of care in behavioral health, radiology, and specialty pharmacy. Prior to this position, he was Medical Director, Southeast Care Management Center of Magellan in Alpharetta, GA, near Atlanta.

In his current role, he directs a team that develops medical necessity criteria, new technology assessments, and clinical practice guidelines for behavioral health. He provides clinical expertise in new product development and the quality improvement program of Magellan.

Prior to his joining Magellan, Dr. Henschen was Chief Medical Officer of Charter Behavioral Health Systems, LLC. He was in private practice of psychiatry and psychoanalysis in Greensboro, North Carolina for fifteen years. He received the MD degree from the University of North Carolina at Chapel Hill. Dr. Henschen completed his residency and chief residency in psychiatry at Duke Medical Center, and completed psychoanalytic training at the UNC-Duke Psychoanalytic Institute.

His research interests have included the assessment and prevention of suicide; psychiatric consultation and liaison with primary care physicians; and the development of quality metrics.



Substance Use Disorder Treatment, New Technology, and Care Coordination

Goal

The goal of this training program is to provide clinicians with tools and education designed to enhance their knowledge about medications, and to increase awareness around new technologies in the treatment of substance use disorders, particularly with medication assisted treatment.

At the conclusion of this exercise, the participant will....

1. Be able to name at least five medications used to assist in the treatment of substance use disorders
2. Understand the effective use of naltrexone in alcohol use disorders
3. Understand the use of acamprosate in alcohol use disorders
4. Understand the use of buprenorphine in the treatment of opiate use disorders
5. Understand the role of medication assisted treatment in the continuum of care for substance use disorder patients



Role of Medications in Treatment of Substance Use Disorders



- APA & NCQA-performance measures
 - Psychosocial interventions
 - Pharmacologic interventions
- Medications mandated in VA
- SWCMC & SECMC have ongoing interventions
- Magellan's OBOT initiative
- Medications highly underutilized
- Barriers to utilization of these medications
 - Lack of education of clinicians
 - Perceived ineffectiveness
 - Medications will reduce motivation for psychosocial treatment
 - Side effects
 - Cost
 - Lack of time in management of patients
 - Reluctance to take medications
 - Formulary status in health plan
 - Lack of education in SUD facility staff

Office-Based Opioid Treatment (OBOT)

Physicians must achieve DEA certification to prescribe

Suboxone must begin post detox

Induction can take several days



Detox with Suboxone can take 2-4 weeks on outpatient basis

Patient should be engaged in psychosocial treatments as well

Barrier-lack of sufficient buprenorphine prescribers



Substance Use Disorders-Opiates




Drug Class	Drug	Starting Dose	Usual Titration/Withdrawal	Usual Therapeutic Range	Max Dose
Partial Opioid Agonist	Subutex (Buprenorphine) 	<u>Induction:</u> 8mg on day 1; 16mg on day 2; Target dose = 16mg daily (range 4-24mg daily); Give first dose at least 4 hrs after last use of opioids			24mg daily Cost: 2mg \$153 for 30 tabs 8mg \$279 for 30 tabs
	Suboxone (Buprenorphine/naloxone) 		<u>Maintenance:</u> Titrate to individual response; adjust in increments/decrements of 2-4mg daily	4-24mg daily	24mg daily Cost: 2/0.5mg, 109 for 30 8/2mgmg \$201 for 30

Medications for Alcohol Use Disorders





- Alcohol affects several neurochemical systems in brain
 - GABA
 - Glutamate
 - Dopamine
 - Opiate
- These systems involved in stimulation, sedation, intoxication, reinforcement, reward, craving, sustained use of alcohol, relapse
- Naltrexone blocks receptors
- Acamprosate blocks receptors
- Use of these medications has been shown to reduce drinking
- Antabuse works as a deterrent by causing reaction when combined with alcohol

Substance Use Disorders-Alcohol

Drug Class	Drug	Starting Dose	Usual Titration/Withdrawal	Usual Therapeutic Range	Max Dose
Opioid Antagonist 	Revia (naltrexone) 	Must be opioid free 7-10 days Consider naltrexone challenge if not sure- 25mg po x1, repeat in 1 hour if no withdrawal symptoms	<u>Maintenance</u> 50 mg per day, higher doses have been reported, side effects must be monitored	<u>Maintenance:</u> 50-150mg daily.	150 mg per day Cost: Generic: \$104 for 30 ReVia::\$248 for 30
	Vivitrol (naltrexone extended release injection)		380 mg delivered intramuscularly every 4 weeks or once a month.		380 mg IM every 4 weeks Cost: \$993.49 per dose

Substance Use Disorders-Alcohol

Drug Class	Drug	Starting Dose	Usual Titration/Withdrawal	Usual Therapeutic Range	Max Dose
	Campral (acamprosate)	After withdrawal, begin 666mg 3x/day, lower if renal impairment	Same as starting dose	333 Tid to 666mg Tid	666mg Tid Cost:\$161 for 180 tabs
	Antabuse (disulfiram)	Patient alcohol free for 12 hrs or more Begin 500 mg per day if tolerated	500 mg per day	500mg per day Cost: \$118 for 30	500 mg per day Alcohol- antabuse reaction with alcohol

Co-occurring Disorder Awareness

- Many consumers with SMI have SUD as well
- Many SUD consumers have SMI
- Medications for these can interact
 - Suboxone+antipsychotics
 - Suboxone+antidepressants
 - Suboxone+benzodiazepines
 - Naltrexone+antipsychotics



Imperative that clinicians communicate regarding medications!

Exchange of critical information facilitated by EHR

References / For Further Reading

- Anton RF. Naltrexone for the Management of Alcohol Dependence. *New England Journal of Medicine*. 2008; 359:715-21.
- Harris AHS, Kivlahan DR, Bowe T, Humphreys KN. Pharmacotherapy of Alcohol Use Disorders in the Veterans Health Administration. *Psychiatric Services*. April 2010. 61:4: 392-398
- American Psychiatric Association: manual of Clinical Psychopharmacology. American Psychiatric Publishing, Inc. 2010
- Practice Guideline for the treatment of patients with substance use disorders, 2nd edition. *American Journal of Psychiatry* 2006; 164-suppl A5-A124.

Medication Reconciliation

- The ability to provide support for;
 - comparing the list of prescriptions and OTC medications that another provider is aware of
 - versus those reported to you by the consumer
 - And merging them into a single medication list is called medication reconciliation
- Once reconciled, Computerized Physician Order Entry (CPOE) systems commonly provide the capability of performing drug to drug and drug to allergy interaction warnings for the reconciled medication list
- Medication Reconciliation is considered very important to reducing medication errors and to lowering cost of treatment which are primary goals of ARRA/HITECH

American Recovery and Reinvestment Act of 2009 (ARRA) / HITECH Funding

- Each Eligible Professional (EP) employed by a behavioral health facility is potentially eligible for a total of \$63,750 in Medicaid funding for becoming “Meaningful Users” of an Electronic Health Record (EHR)
 - \$21,250 would be awarded in the first Payment Year merely for the purchase, upgrade or *implementation* of a “Certified” “Complete” EHR
 - \$8,500 a year for up to 5 more years would be awarded for the EP’s actual Meaningful Use of the EHR
- Each EP could voluntarily reassign their payments to their employer

Meaningful Use and Interoperability

- Meaningful Use is defined by DHHS and CMS as the;
 - set of standard operating procedures that an EP must adhere to
 - and the quality measure reports they must provide,
 - and that their EHR software must support,
 - to be eligible for HITECH funding
- Interoperability of EHRs;
 - is a primary focus of HITECH,
 - is central to Meaningful Use and
 - is expected to contribute to the goals of improving healthcare and reducing costs

Meaningful Use and Interoperability

- Outpatient Meaningful Use has 15 core requirements, including among others;
 - Electronic care coordination (2011/2012 - test ability)
 - The ability to electronically create and send an electronic summary of clinical information including medications, diagnoses, labs, etc.
 - The ability to receive and electronically import into your EHR that same information received from another provider

Meaningful Use and Interoperability 2011

- Menu Set requirements – select 5 of the 10 which include these two interoperability criteria;
 - Medication Reconciliation (2011/2012 - 50% of transitions of care)
 - Electronic access via a Personal Health Record (PHR) or a portal (2011/2012 – 10% of all unique patients - subject to EPs discretion to withhold certain info)
- It is reasonable to expect all Menu Set requirements will be Core requirements by 2013
- So, interoperability of virtually all health providers will likely become an accomplished fact over the next two to four years

Interoperability is subject to federal and state privacy laws

- Health Information Portability and Accountability Act (HIPAA) is a federal regulation that has significant privacy and security rules and applies to any entity that submits or accepts electronic claims
- HIPAA establishes minimum national standards for privacy and does not supersede more stringent laws;
 - It allows disclosure of Protected Health Information (PHI) without an authorization to third parties that are involved in “treatment, payment or health care operations”
 - ARRA modified HIPAA such that an individual has the right to prevent disclosures regarding specific treatment by paying for that treatment out of pocket

Subject to federal and state laws

- HIPAA originally had a limited enforcement mechanism
- ARRA modified HIPAA to include;
 - A notification requirement in the case of breach
 - Significant civil monetary penalties in the case of breach ranging from;
 - \$100 per violation to
 - \$50,000 per violation for “willful neglect” and up to \$1,500,000 per calendar year
 - Willful neglect is the “conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision violated.”

Subject to federal and state laws

- 42 CFR Part 2 is a federal regulation (rules enacted in 1987) that primarily applies to “federally assisted alcohol or drug abuse programs”
 - Each entity should consult with counsel to make its own determination as to whether 42 CFR Part 2 applies to it or to any of its units
 - The 42 CFR Part 2 privacy controls apply to the entire medical record and “record” is defined as “any information, whether recorded or not, relating to a patient that is received or acquired by a federally assisted alcohol or drug program”
 - It specifically restricts disclosing that a person has received treatment at a SA facility or component

Subject to federal and state laws

- 42 CFR Part 2 has more restrictive provisions than HIPAA
 - Provides that a consumer can restrict redisclosure
 - Applies to persons who receive a record from a 42 CFR Part 2 program and are notified of the restriction on redisclosure (notice of which is required for non-emergency treatment disclosures)
 - Requires a valid consent for all non-emergency disclosures, even those for treatment, that includes (among other things);
 - The purpose of the authorized disclosure
 - The specific list of entities to which a disclosure can be made

Subject to federal and state laws

- A disclosure for treatment can be made in the case of bona fide emergencies without consent but the Part 2 program must document;
 - Each such disclosure in the patient record
 - The name of the person to whom the disclosure was made (not just the name of the facility)
 - The date and time of the disclosure
 - The nature of the emergency
- No restriction on redisclosure applies to Part 2 covered information disclosed in an emergency and
- No redisclosure notice is then required

Subject to federal and state laws

- Enforcement of 42 CFR Part 2
 - \$500 for a first offense
 - \$5,000 for each subsequent offense
 - There is no “private right of action” that would allow an individual to sue for damages
 - Violation is a crime

State laws can be even more restrictive

- For example;
 - 42 CFR Part 2 provides that a consent for disclosure automatically terminate on an event, condition or a date
 - California Civil Code §56 requires a consent for release of outpatient mental health treatment information for purposes other than treatment and requires that the consent have an expiration date
 - A person receiving both MH and SA treatment at a single California provider that wished to have the combined information disclosed would need to execute a consent consistent with both Part 2 and Civil Code §56

Back to interoperability of medication lists

- There is considerable justification for strict controls on disclosure of substance use related information
- Yet we must all prepare for assisting those consumers that find value in exchanging treatment information, including SA treatment, among specific providers
- The impetus of HITECH Funding for Meaningful Use provides additional motivation to embrace interoperability and establishes interoperability standards
- One of the required electronic transactions for Meaningful Use is the Continuity of Care Document (CCD) that contains medication and diagnosis information that can potentially indicate SA treatment

Sample Continuity of Care Document (CCD)

Exported CCD Documents

Exported CCD Documents Document Viewer

CENTER FOR MHMR SERVICES Continuity of Care Document

Patient	JILL CORDNER		
Date of birth	September 9, 1970	Sex	
Contact info	100 FOREST GROVE ROAD ABILENE, TX 79601 Tel: 732 999-7676	Patient	
Document Id	ba1564c5-5b0b-4c1c-bc12-c271795b89b7		
Document Created:	August 19, 2010, 12:59:28, CST		
Performer (primary care physician)	STEVEN RIDBURG		
Author	STEVEN RIDBURG,		
Document maintained by	CENTER FOR MHMR SERVICES		

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Summary Purpose

Continuity of Care Management

Problems

Axis	Rank	ICD-9 Code	Diagnosis
Axis I (Primary)	1 (Primary)	309.81	POSTTRAUMATIC STRESS DISORDER
Axis I	99	308.3	ACUTE STRESS DISORDER

Exported CCD Documents

Exported CCD Documents Document Viewer

Axis IV	1	F	Economic Problems	10/19/2009	current
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Functional Status

Axis	Rank	GAF	Date	Type
Axis V	1	49	03/11/2010	current
Axis V	1	49	12/11/2009	inactive
Axis V	1	49	10/19/2009	inactive

Allergies and Adverse Reactions

Substance	Reaction
penicillin	
Sulfazine	

Medications

Medication	Instructions	Status
Xanax 1 mg tablet	Take 1 tablet(s) by mouth 1 time a day	completed
Zoloft 100 mg tablet	Take 1 tablet(s) by mouth 1 time a day	completed
clonazepam 1 mg tablet	Take 1 tablet(s) by mouth 1 time a day	completed

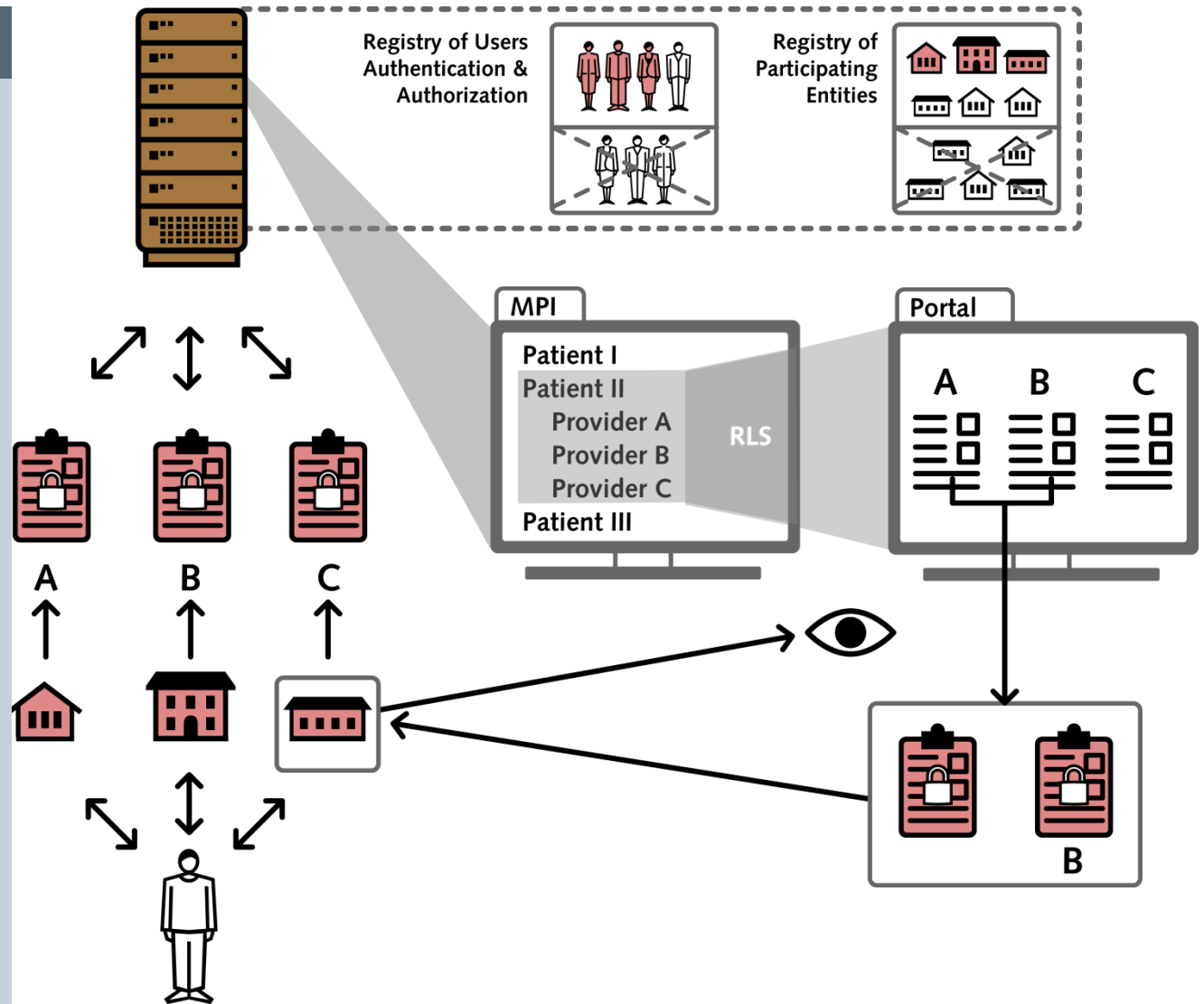
Vital Signs

Date / Time	Temperature	Pulse	Respirations	Blood Pressure
03/15/2010	99.2	72	14	150/90
03/15/2010	98.6	66	55	144/88
03/15/2010	99.9	75	77	100/65
03/12/2010	99.2	55	60	150/45
03/11/2010	98	not recorded	not recorded	125/85
01/20/2010	not recorded	not recorded	not recorded	124/88
12/02/2009	99	not recorded	not recorded	120/70

National Health Information Network (NHIN)

NHIN Connect

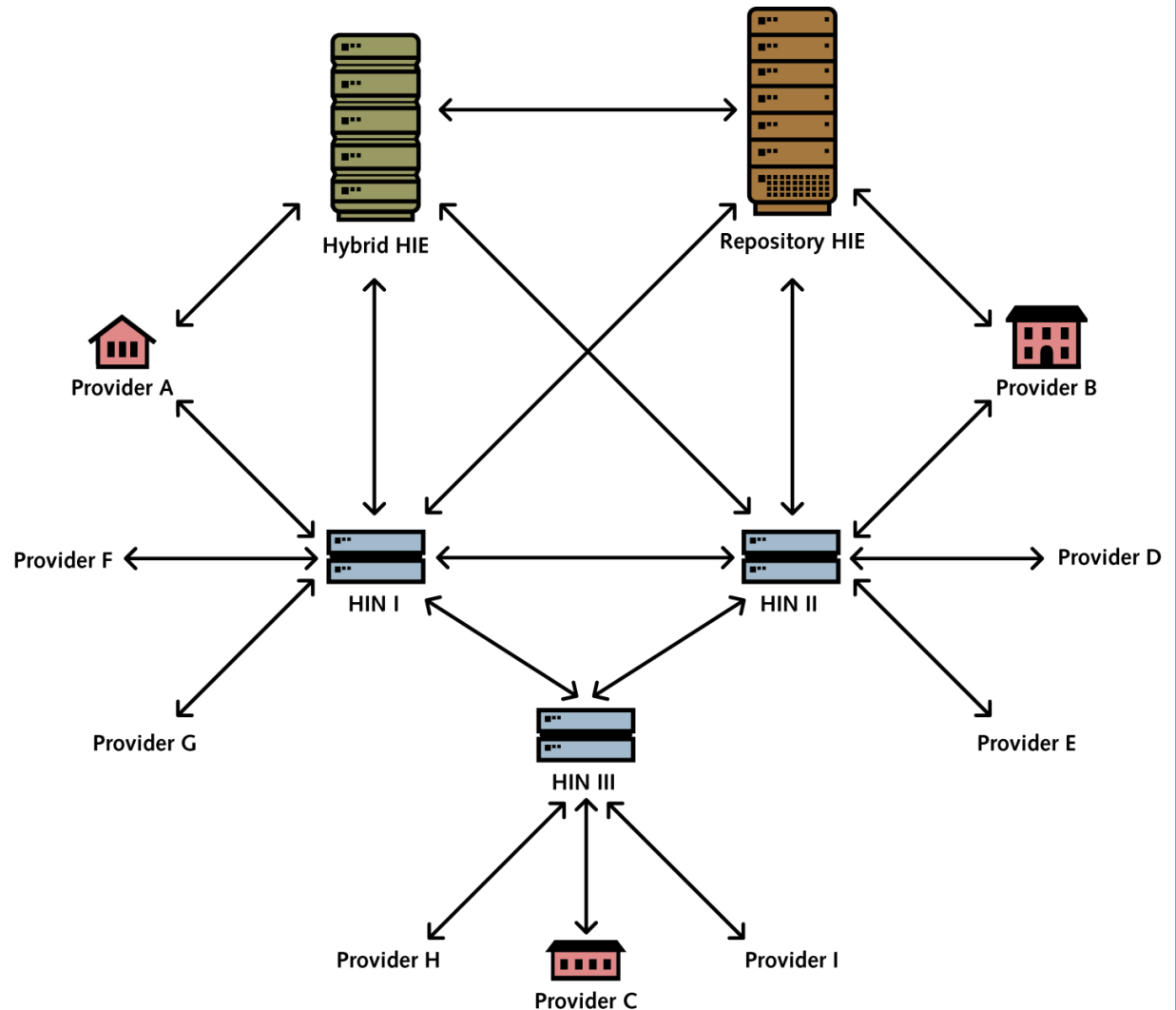
- Health Information Exchanges (HIEs) are being created on a regional basis
- HIEs would receive CCDs or the like and display or forward that information to their participant providers



National Health Information Network (NHIN)

NHIN Direct

- Health Information Nodes (HINs) are now being called Health Internet Service Providers (HISPs)
- A provider could have multiple access points to NHIN Direct
- It is not necessary for clinical information to be retained by the HISPs or for them to have Record Locator Services



NHIN Direct vs. NHIN Connect

- NHIN Direct does not depend on a central repository of clinical information and does not need a Record Locator Service to achieve interoperability so the privacy considerations are significantly lessened
- NHIN Direct does not depend on the establishment of a nationwide HIE network so it has the potential for more rapid adoption
- Almost all current HIEs are based upon the NHIN Connect model so it is more mature
- Considerable ARRA funds have been awarded to development of NHIN Connect HIEs
- NHIN Connect HIEs can fulfill multiple purposes such as data mining for policy and health improvement

Is your potential HIE compliant with Part 2?

Within a few years virtually every provider will find it necessary to connect to an HIE to support interoperability.

Most HIEs tout that they are HIPAA compliant, but 42 CFR Part 2 is more stringent. You might ask:

- Does the HIE have the ability to maintain a specific list of providers that your consumer has consented to have access to their Part 2 protected information?
- Does the HIE have a filtering mechanism such that the names of SA providers are excluded from the Record Locator Service when presented to providers not on that list?

Is your potential HIE 42 CFR Part 2 compliant?

- What is the support for making Part 2 information available in a medical emergency?
 - Can it provide you a notice to support your requirement to document that disclosure?
 - Can it document the person(s) the information was disclosed to?
 - Can it document specifically the nature of the emergency?
- What is the HIE's support for including the notice regarding redisclosure required by Part 2? If the HIE supports a Patient Portal, how is this notice presented to the viewer?

Is your potential HIE 42 CFR Part 2 compliant?

- What is the HIE's support for deleting or filtering presentation of Individually Identifiable Health Information (IIHI) upon expiration of the consent?
- What is the HIE's approach to consent expirations for each of event, time and condition? How does this comport with your agency's consent provisions?

Interoperability will be significant benefit

- My personal belief is that interoperability will change the face of all medical treatment - for the better - as much as the internet has changed banking, news outlets, and mail
- I also expect that the pace of adoption of medical interoperability will move at about the same speed as those changes

Interoperability will be significant benefit

- My belief is that adoption of interoperability of BH information would accelerate if;
 - The Office of the National Coordinator for Health Information Technology (ONC) developed a standard consent that is compliant with all state and federal laws and defined its use for EHRs as part of Meaningful Use for 2013
 - They similarly required HIEs to;
 - adopt complementary Meaningful Use support
 - and adopt all BH consent and disclosure support
 - for both NHIN Connect HIEs and NHIN Direct HISPs.

Question and Answer Session

- We will attempt to address as many questions as possible.
- Follow the operator's instructions for submitting questions to the presenters.
- Questions submitted during the presentation via chat feature will be addressed first.

Please note that sending a question does not guarantee its inclusion in the webinar.

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You must complete the post-test and CE evaluation **by 7 p.m. Eastern today.**

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Integration

