



WV Health Innovation Collaborative  
November 2015

# Presentation Overview

- GACSA and RTF Process
- Policy and Practice Improvements
- Service Capacity
- Current Data

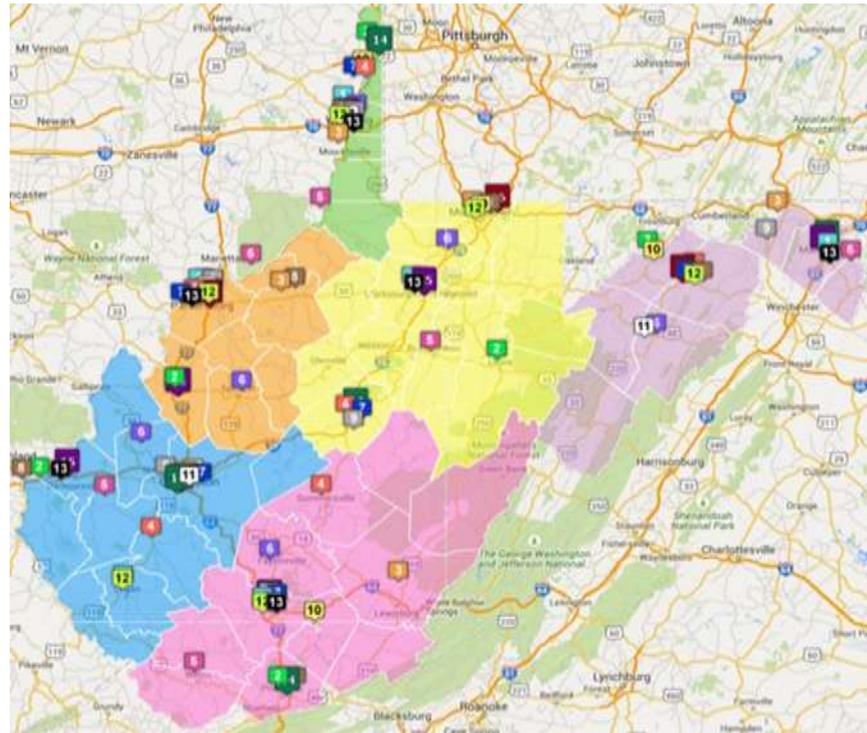
# Governor's Regional Task Force Meetings

## *Beginning Barriers Determined*

- Education & Stigma
- Access & Navigation
- Cost

17 Rounds

102 Meetings



# Policy & Practice Improvements

- SB437
  - Required Physician Education
  - Opioid Treatment Center Rules (Therapy Requirement & Increased Oversight)
  - Pain Clinic Rules (Increased Oversight)
  - PDMP (24 Hour/ CSM Group)
  - \$7.5 M New Funding
- SB371 - Justice Reinvestment - \$3.5 M Community Treatment & Recovery
- SB 335 - Expanding Access to Narcan
- SB 419 - Good Samaritan Law to Prevent Overdoses
- HB2880 - Vivitrol Pilot (Drug Court & Corrections)

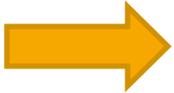


# Additional Improvements

## *Changes in Medicaid Coverage*

- Buprenorphine, Mono-Buprenorphine, Vivitrol
- Expanded Medicaid Coverage to Provide Behavioral Health Services Via Telehealth (F-A)
- Added LISCW as Approved Provider
- Added LPC for Primary Care (*Out for Comment*)

# MAT / Pain Clinic Changes

- Methadone Cash Clinics -- Opioid Treatment Centers
- 8 of 9 Licensed Behavioral Health Programs (Medicaid)
- 7 of 9 purchased by Acadia once owned by CRC
- Number of Physicians Providing Buprenorphine  
46  187 Physicians Waivered (164 Medicaid)
- 11 Pain Clinics Closed - 7 Licensed

# Service System Capacity

## Number Of Certified Recovery Coaches

- 0  201

## Local Prevention Capacity

- 17  55 counties

## Services/Capacity Change

- Treatment & Recovery Beds 409  759
- Regional Youth Service Centers 0  6

## Justice Reinvestment

- Substance use services have been expanded in 22 counties
- 242 individuals served through Treatment Supervision as of October 2015



# Physician Engagement & Education

## Prescriber Education

- Appalachian Addictions Conference-287 (Doubled)
- Face to Face (Hospital/School Based) 600
- Integrated Behavioral Health Conference 700
- 3-hour CME license renewal requirement - 8400  
*(Physicians, Physician Assistant's & Podiatrist's)*
- SAMHSA Med School Region III Workforce Group
- BPH/WVU-Pain Management Guidelines *(Expert Panel)*



# WV Discretionary Funding

- Strategic Prevention Framework \$11 M - 5 Years
- Drug-Free Communities \$1.1 M (*9 Communities*)
- Suicide Intervention \$736,000 + \$102,000
- Primary Care BH Integration \$1M *2014-2015*
- Primary Care Service Expansion \$7 M (*26 Sites*)
- Opioid Overdose Rural Communities \$200,000 (*2 Sites*)

# Current Data

- ✓ Overall decrease in the misuse of prescription drugs 3 years in a row
- ✓ Significant decrease in marijuana use and other drugs among young people ages 12-17 and 18-25
- ✓ Decrease in non-medical use of pain relievers in every age group with significant decreases for West Virginians ages 12-25
- ✓ Synar lowest buy rate at 8%
- ✓ 25% decrease in oxycodone and hydrocodone overdose deaths
- ✓ In 2012, WV had a suicide death rate of 17.6 (4.7 above the national rate) ranking 11th in the Nation for all ages combined. According to the Centers for Disease Control and Prevention those rates decreased to 16.4%



# Current Data

- Overall substance use in West Virginia is **consistent with national trends**. 87,000 persons aged 12 or older were dependent on or abused alcohol and 48,000 persons aged 12 or older were dependent on or abused illicit drugs.
- NSDUH Data Review- #1 reason for not receiving substance use treatment among people 12 years and older 1) they were not ready to stop using and 2) could not afford the cost of treatment
- Physicians and hospitals have noted a continued increase in the number of babies born with substance exposure over the past 5 years yet WVBCF-only 106 cases of Neonatal Abstinence Syndrome reported to tracking system in 2014
- According to the AFCARS 2013 Foster Care Data File, WV ranks higher than the national Average (31%) for substance use as a reason for removing children from the home and the third highest in the nation for child removal from parents' custody with parental alcohol and or drug use as a reason for removal at a rate of 52.7%

# Current Data

- WV has the 2<sup>nd</sup> highest rate in the nation for binge drinking intensity (9 or more drinks per episode).
- In 40% of fatal automobile accidents, alcohol was a factor.
- Centers for Disease Control-“more than one in 10 pregnant women admitted drinking alcohol in the previous month, including about one in 33 who acknowledged at least one episode of binge-drinking”
- The top presenting drug across all years at the 13 WV Comprehensive Behavioral Health Centers was alcohol. The number of patients presenting with alcohol as their primary drug has increased an estimated 28% from 2012 to projected 2015 numbers (based on data through 7/31/15).
- While smoking rates have decreased for youth in WV, pregnant women smoke more than those individuals who smoke in the general population.

# Heroin in WV

- Heroin as the primary presenting drug at the 13 WV Comprehensive Behavioral Health Centers has increased an estimated 215% since 2012, from 903 to an estimated 2,841 cases.
- There were 628 total overdose deaths in WV in 2014, with 165 having heroin in their system.
- 3 Top Counties (Berkley, Kanawha and Cabell)

# WV Poison Center Calls

Highest number of calls to Center regarding poisonings of **opiates** 2011-2015

- Berkeley
- Cabell
- Fayette
- Harrison
- Jefferson
- Kanawha
- McDowell
- Mercer
- Ohio
- Raleigh
- Wood



# Hepatitis B Increases

Although WV has shown a 12% increase in Hepatitis B cases from the first half of 2014 to the first half of 2015, several counties have been identified as “hot spots,” with a larger percentage increase than the state as a whole. The number of cases is quite small and the numbers are provisional.

Hepatitis B "Hot Spots": WV Counties with the Greatest Percentage Increase, First 26 Weeks of 2014 vs. 2015

County	First 26 Weeks 2014	First 26 Weeks 2015	Percent Increase
Cabell, WV	10	27	170.0%
Harrison, WV	4	10	150.0%
Jackson, WV	1	7	600.0%
Kanawha, WV	31	47	51.6%
Logan, WV	5	10	100.0%
Wood, WV	2	9	350.0%

# Access & Navigation

# Access and Navigation

- The two most prevalent issues raised by the Task Forces and citizens statewide
- Both have been/are barriers to treatment by consumers and service providers
  - Individuals attempting access to services share that they need assistance in understanding the varying levels of care that exists, understanding what they need or what service option will be most effective in supporting them or their loved one
  - Individuals report that the process of seeking treatment is complicated and need support to make calls, get appointments, figure out how to get there, etc.



# GACSA-RTF - Efforts that make a difference..

- The Governor's Advisory Council on Substance Abuse listened to RTF recommendations and partnered with the DHHR to fund the first ever statewide call line
- The GACSA tasked DHHR-BHMF with developing a strategy for simplifying access to our treatment options statewide and identifying service gaps that support on-going system improvements
- DHHR-BHMF issued an Announcement of Funding Availability (AFA) in May 2015





- In July 2015 First Choice Services (FCS), based in Charleston, WV, was chosen to operate the program.
- FCS's parent company, First Choice Health Systems (FCHS), has operated the statewide 1-800-Gambler helpline for the past 15 years



**1-844-HELP4WV**

**ONE Call. ONE Text. ONE Click.  
INSTANT HELP.**

**Get connected with community-based substance abuse treatment programs and behavioral health services near you.**

# Call Line Goal

*Excerpted from Call Line Funding Announcement:*

*“improve access and immediate referral to appropriate levels of care and improve consistency in referral mechanisms and access needed to appropriate community supports,”*



# Program Objectives

- Provide 24 hour, year round (365 days per year) call center with in-person call taking
  - No one is placed on hold
  - Service connections are made during the call when feasible with minimal delay in access coordination
- Expanded community outreach to support callers to have a single point of contact to learn about and access statewide substance abuse and mental health resources
- Provide **immediate in-call** crisis support linkage (example: 911)
- Overcome barriers to support timely access to services
- Identify service gaps in behavioral health services in WV
- Provide data collection and analysis with the goal of highlighting service gaps, outcome measures, and supporting data-driven decision making of providers.



# Program Objectives

- Develop and maintain an up-to-date database of all behavioral health providers in WV
- Monitoring of treatment bed capacity daily
- Increase awareness of behavioral health issues and resources
- Establish a consumer feedback system to identify areas for improvement
- Establish a peer-run warm line

# How The Call Line Works

- When someone calls, they are immediately connected with a live person 24/7.
- Clinical supervisors are always available for crisis consultation.
- Full range of resources are identified, and when possible a warm-line transfer is made.
- Callers receive continued follow-up calls to ensure their needs were met.

# Connect to Help!

- Visit our website [www.Help4WV.com](http://www.Help4WV.com) and access our searchable online database of providers
- Add to our resource directory by contacting us
- Help us to keep the directory current by notifying us of changes
- Call, text, or chat online with us to ask for help finding treatment
- Follow us on Facebook and Twitter



# Spread the Word

- We will be doing statewide outreach, and we can:
  - Come to your local health fair
  - Present at your professional conference
  - Do a “Lunch & Learn”
  - Mail you posters/brochures
  - Visit your agency/facility and provide info to staff



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**ONE** Click.

**INSTANT HELP.**

Get connected with community-based substance abuse treatment programs and behavioral health services near you.

**CALL or TEXT**  
1-844-HELP4WV  
(1-844-435-7498)

**OR VISIT**  
HELP4WV.com



# 1-844-HELP4WV

- Web: [www.help4wv.com](http://www.help4wv.com)
- Twitter: @Help4WV
- Email: [Help4WV@1stchs.com](mailto:Help4WV@1stchs.com)
- Facebook:  
<https://www.facebook.com/Help4WV>

# Program Challenges

- Lack of dissemination of Naloxone for use by law enforcement, family members and communities at large due to barriers of cost, availability in pharmacies, and preference for using the Evzio device vs. the method (syringe) that is currently covered by Medicaid
- Short-Term Residential Treatment Programs for all populations are not available in all regions
- Lack of acceptance in recovery community and some provider groups for Medication Assisted Treatment
- State standards and monitoring do not exist for MAT physicians that are not Medicaid providers
- Lack of MAT services in primary care and behavioral health centers particularly for pregnant women



# Program Challenges

- Inconsistent protocols and guidance on diagnosis and referral for women using substances
- Recovery Networks need developed
- As recovery facilities expand for women without any in-house clinical staff there are increased technical assistance needs regarding protocols for accepting and caring for the children that may be substance exposed or have trauma associated issues
- Inconsistent cross-system service resource sharing particularly with individuals with complex needs
- Drop-In Centers are currently located regionally but not accessible at the local level
- Supportive service shortages areas include: transportation, mobile crisis services, and peer recovery support groups particularly for medication assisted recovery and youth in recovery

# Workforce Challenges

- Only 50% of Prevention Specialist are certified through IC& RC
- Lack of Child Psychiatrist and clinical staff providing best practices for youth and young adults
- Insufficient number of Credentialed and Licensed Counselors to provide therapy in coordination with Physicians providing medication assisted treatment
- Barriers continue for individuals in recovery entering the workforce
- Physician best practice in prescribing still not implemented including reporting to the PDMP (Carrot vs. Stick)
- Universal Screening of Pregnant Women not implemented
- Behavioral health education courses are limited in community and technical schools
- Behavioral Health education courses are limited in higher education (social work, medical)

# Innovative System Infrastructure Challenges

- Telehealth is limited across provider organizations particularly with regard to screening and treatment service provision and needed with youth, pregnant women, and ALL individuals living in rural areas of the State
- Cross-system collaborations and information sharing are necessary for data collection, program service definitions and population program development
- Social media and marketing is inconsistent across agencies and organizations to increase public education messaging and service engagement
- On-site program monitoring standards are inconsistent to reinforce the utilization of best practices and quality standards
- Lack of standardized quality measures for consumers to review programs
- Antiquated business practices continue to inhibit sustainability and overreliance on federal and state funding (partnerships, grant-writing capacity, administration, funding diversification)



# SAMHSA Priority Areas

## 1. Opioid Prescribing Practices to reduce opioid use disorders and overdose

- Improve clinical decision making to reduce inappropriate prescribing
- Enhance prescription monitoring and health IT to support appropriate pain management
- Support data sharing to facilitate appropriate prescribing

## 2. Naloxone development, access and distribution

- Accelerate development and availability of new formulations and products
- Identify and disseminate best practice delivery models
- Expand utilization

# SAMHSA Priority Areas

## 3. Medication Assisted Treatment (MAT)

- Support research that informs effective use and dissemination of MAT and accelerates development of new treatment medications
- Increase access to clinically effective MAT services

# SA/MH Block Grant Priorities

## *Promote emotional health and wellness*

1. Prevent and reduce suicide attempts and deaths
2. Integrate prevention and promotion efforts to reduce substance use and promote good mental and physical health
3. Improve response time to emerging trends and timely data sharing

# SA/MH Block Grant Priorities

*Support coordinated care and services across systems*

1. Promote a recovery-oriented service system includes coordinated clinical treatment and recovery support services
2. Improve the physical health outcomes of individuals with substance use and mental health disorders and developmental disabilities
3. Implement a behavioral health network for youth and young adults
4. Implement a trauma informed approach across systems



# SA/MH Block Grant Priorities

5. Create behavioral health capacity in the criminal justice system
6. Provide technical assistance and foster opportunities for innovative telehealth practices
7. Increase the number of individuals who provide behavioral health services in WV
8. Reduce the impact of disasters on the behavioral health of individuals, families and communities
9. Remove financial barriers and incentivize effective care coordination and integrated service delivery for all populations
10. Implement quality indicators to advance BH outcomes in alignment with National quality measures



# Regional Recommendations

## Region 1 Recommendations

Stop old laws of felons paying the rest of their life. (job housing etc.)

Social workers in the schools

Ob-gyn online training for sub-exposed pregnancy/ protocol

Increase alcohol tax

Utilize lottery/alcohol/tobacco tax to fund social workers in schools

# Regional Recommendations

## Region 2 Recommendations

Increased availability/access to detox and crisis stabilization; Long term in-patient detox and 60-90 day program

Help us to make treatment sustainable rather than dependent on grants

Youth crisis unit (residential) 12-25 y/o

Increase in recovery/treatment centers

Treatment longer than 28 days and address every aspect of lifestyle-dependent on treatment level needed

# Regional Recommendations

## Region 3 Recommendations

Address laws that prevent individuals in recovery from obtaining positions in the workforce; address barriers to HUD/SNAP benefits

Expansion of school-based mental health centers

Alcohol tax to be put back into prevention programming

Institutional transitional recovery housing

Outreach/education strategies to improve the network in the area – clear, consistent message

# Regional Recommendations

## Region 4 Recommendations

Increase availability of drop-in centers to provide alternative activities and prevention

Mandate prevention and early intervention education with Prevention Funding-County level

Recovery housing for people coming out of treatment/prison; Recovery housing in-recovery or not!

Prevention education for healthcare and community figures and communities

Additional treatment centers that are age appropriate (youth focused)

# Regional Recommendations

## Region 5 Recommendations

Remove barriers for individuals in recovery re-entering workforce including leniency in background checks for employment

High need for MH counselor/social worker in each school, with minimum of 1 per county to address needs of whole child

Professionalize and fund recovery coaches more

Implement evidence-based prevention and interventions/programs in the schools Pre-K to 12 including school based outpatient services

Alcohol/tobacco tax to be put back in the system for prevention, treatment, recovery

# Regional Recommendations

## Region 6 Recommendations

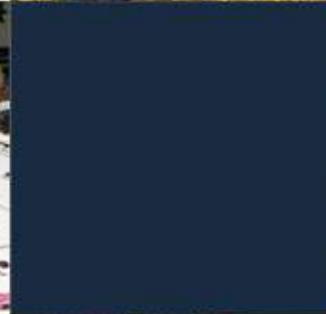
Increased funding for youth peer-to-peer prevention

More recovery centers (women)

Improve communication among families, child welfare, education, providers and intervene early for substance exposed children

Increased Recovering Housing

Community resource person (or SW) in every school



[www.WVSubstanceFree.org](http://www.WVSubstanceFree.org)