HealthierHere

Clinical Summary
Prevention of Opioid-related Overdoses

Project Goal

Immediate:
Reduce opioid overdose deaths by providing at-risk individuals, and those who frequently interact with them, with take-home naloxone kits and supporting education and awareness around overdose prevention.

Long-term: Reduce deaths, non-fatal overdoses, onset of opioid use disorder (OUD), and harm to King County residents from prescription and non-prescription opioids through promotion of safer use strategies and harm reduction.

Focus Populations

Medicaid members who are at risk for prescription and non-prescription opioid abuse or who have a history of opioid-related overdoses as well as the individuals and service providers who are likely to encounter them.

Key Project Elements

The following interventions are recommended for participating provider organizations. Pursuing the recommended strategies as appropriate for specific focus populations is likely to help Practice Partners achieve their goals related to HealthierHere's 2019 pay for progress incentives.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

implementing organizations are encouraged to utilize the following key strategies.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers, behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Screen for OUD and individuals at risk of overdose in medical and behavioral health settings as part of a robust person-centered care approach.
    - Organizations should use a recognized screening tool and have a standard protocol for screening.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification.

- Establish protocols for referring individuals with OUD to the appropriate modality of medication-assisted treatment (MAT) -- opioid treatment programs or office-based opioid treatment.
- Utilize motivational interviewing to encourage individuals to participate in treatment, as appropriate.
- Refer individual to community support specialist (e.g., community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide overdose education to individuals seen or at risk for opioid overdose.
- Provide all individuals seen or at risk for opioid overdose with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals who are ready to begin recovery to a community support specialist with common lived experience (e.g., a recovery coach or peer support specialist) who can assist individuals to regain control over their lives and their own recovery process. A community support specialist or a member of the integrated health care team will conduct in-person visits and follow-up by phone and/or telehealth options in service of the following goals:
    a. Increase self-management skills
    b. Ensure personal goals are congruent with individual's self-efficacy
    c. Improve continuity of care with primary care follow-up
    d. Ensure medication management and reconciliation with primary care or other providers including pharmacists
    e. Practice advocacy by identifying key questions for primary care providers/specialists
    f. Educate on health system navigation
    g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why.

Link to Community Resources:

- Provide take-home naloxone kits to individuals seen for opioid overdose.
- Encourage individuals with OUD entering MAT to get a naloxone kit or prescription.
- Identify community partners, social service organizations, and other organizations who come into contact with individuals at risk of opioid overdose and partner with those organizations and provide them with training and access to naloxone kits.
- Encourage partners to safely distribute naloxone kits to prevent overdose deaths due to OUD.
- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter).
- For applicable individuals, the community support specialist will communicate with primary care provider and/or specialist(s) regarding the individual's treatment and progress. In such cases, the community support specialist will follow-up after referrals to determine whether resources are accessed and needs are met.

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Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Opioid Prevention project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Patients Prescribed High-Dose Chronic Opioid Therapy	Percent of Medicaid beneficiaries prescribed chronic opioid therapy according to the following thresholds: 1.) Doses >50 mg morphine equivalent dosage (MED) in a quarter; 2.) Doses >90 mg MED in a quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
Patients with Concurrent Sedatives Prescriptions	Among Medicaid beneficiaries receiving chronic opioid therapy ≥60 days, the percent that had ≥60 days of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
Substance Use Disorder Treatment Penetration (Opioid)	The percent of Medicaid beneficiaries with an identified opioid use disorder treatment need who received medication assisted treatment (MAT) or medication-only treatment for opioid use disorder in the measurement year.

References/Guidelines

Harm Reduction Coalition's Guide to Developing & Managing Overdose Prevention & Take-Home Naloxone Projects
http://harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/

King County Heroin and Prescription Opiate Addiction Task Force, Final Report and Recommendations. September 15, 2016.
https://www.kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-_Force-Report.ashx?la=en