HealthierHere

Clinical Summary
Expanding Access to Opioid Treatment

Project Goal

Immediate:
Increase screening for opioid use disorder (OUD) and improve access and accessibility to appropriate and sustainable treatment including both modalities of medication-assisted treatment (MAT), office-based opioid treatment (OBOT) and opioid treatment programs (OTP).

Long-term: Reduce deaths, non-fatal overdoses, onset of OUD, and harm to King County residents from prescription and non-prescription opioids.

Focus Populations

Medicaid members with or suspected of having OUD (e.g., presenting with signs/symptoms of OUD in emergency departments, needle exchanges, primary care settings, behavioral health centers). Individuals may not yet be identified as having OUD but through system engagement can be screened, diagnosed, provided with a pathway to treatment.

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 the 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 providers), 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 in medical and behavioral health settings as part of a robust person-centered care approach.
- Utilize motivational interviewing to encourage individuals to participate in treatment, as appropriate.

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 (members could include a nurse care manager, recovery coach, peer support specialist, or other appropriate provider).
- Link individuals with OUD to a primary care medical home with an integrated care team**.**
- Increase low-barrier access points for treatment induction and access to MAT through onsite providers and/or new partnerships with treatment providers.
    - Expand access to buprenorphine in primary care and behavioral health settings by increasing the number of waivered prescribers (physicians, nurse practitioners, physician assistants) and the number of new prescriptions originating in office-based settings.
    - Expand access to OTP providers (e.g., methadone treatment) by increasing the number of referrals to OTP for individuals who are most appropriate for that treatment modality.
- Refer individual to community support specialist (e.g., recovery coach, peer support specialist), 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 all individuals with OUD 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 and 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:

- 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).
- The integrated care team will work with the individual and community support specialists to support selected activities. 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.

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 Treatment project will agree to help HealthierHere with 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

Bree Collaborative Opioid Use Disorder Treatment Report and Recommendations.
http://www.breecollaborative.org/wp-content/uploads/OUD-Treatment-Final-2017.pdf

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