SUD Data in Action: Data-Informed Population Management and Systems Change

Stacie Andoniadis, Kristen Lacijan-Drew, and Justine Pope

October 30th, 2019

Objectives for the day

1. Describe how a coordinated care organization used data to inform MAT expansion efforts.
2. Review one framework for organizing CCO membership into categories of OUD treatment using a cascade of care model, and identify a method to determine MAT initiation and engagement rates (low, moderate, high) from claims data.
3. Discuss tri-county regional efforts to improve and expand access to medication-assisted treatment (MAT) services via data-driven decision-making
4. Share CareOregon process for support and implementation of MAT across primary care and other service systems.

First, some reflection time…

Why Does This Matter?

- 5 Oregonians die from an opioid overdose each week
- Increasing access to Medication Assisted Treatment (MAT) across settings saves lives.
- Working together, across settings, to create community standards benefits: **patients, clinical teams and community.**

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Understanding our Members: MAT Initiation and Engagement through a Cascade of Care Framework

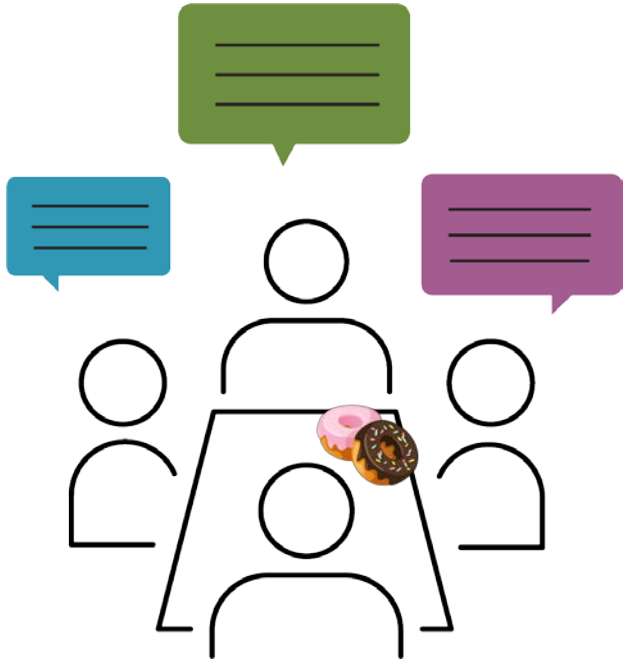
Kristen Lacijan-Drew, MS, MPH

Justine Pope, MPH

Health Share of Oregon

MAT Expansion: A Call to Action

- Health Share's MAT expansion investment
- MAT Data Workgroup: Specialty behavioral health providers, primary care providers, public health, plan partners.
- The process was:
  - Iterative
  - Collective
  - Focused on data integration



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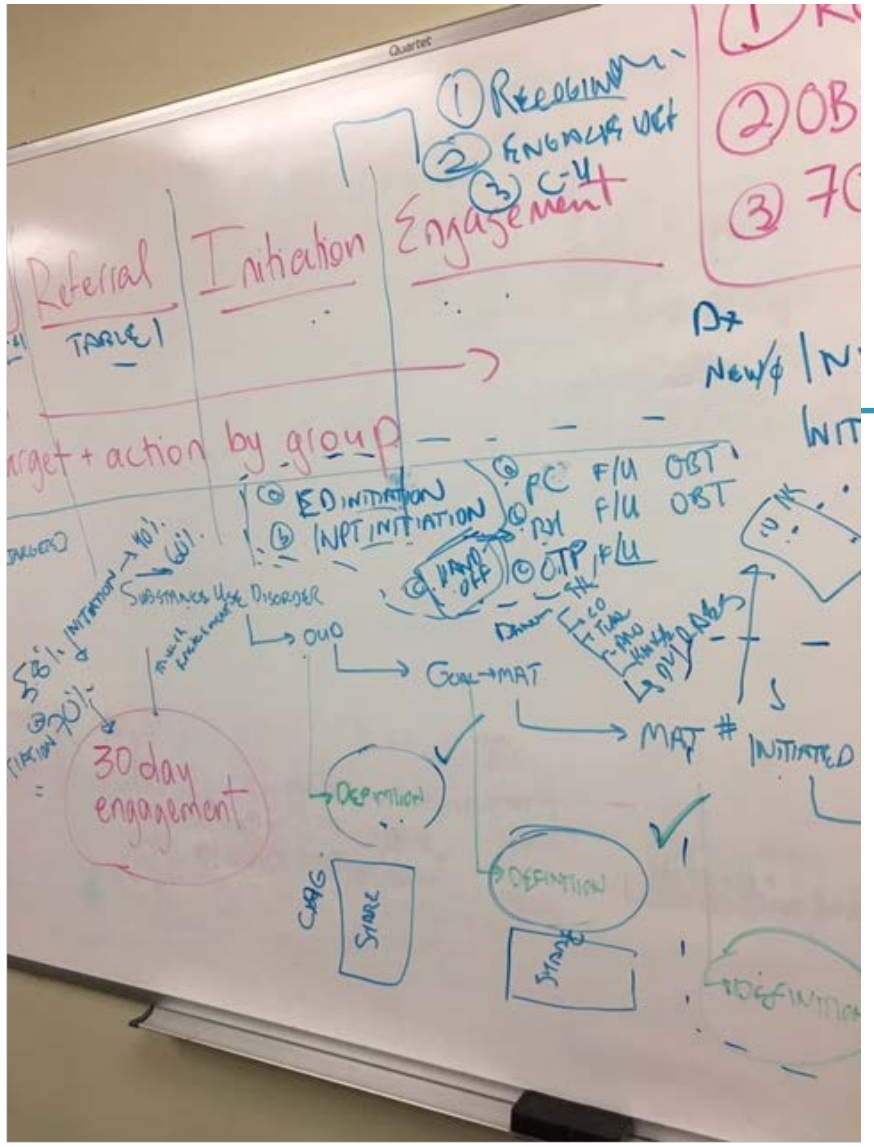
MAT Initiation and Engagement

- **Identification**: Who has OUD?
- What does it mean to **initiate** MAT services?
- What does it mean to **engage** in MAT?
  - Low/Med/High/ Early/Ideal/Realistic



MAT Cascade of Care

IDENTIFICATION

9,885

LINKAGE TO CARE

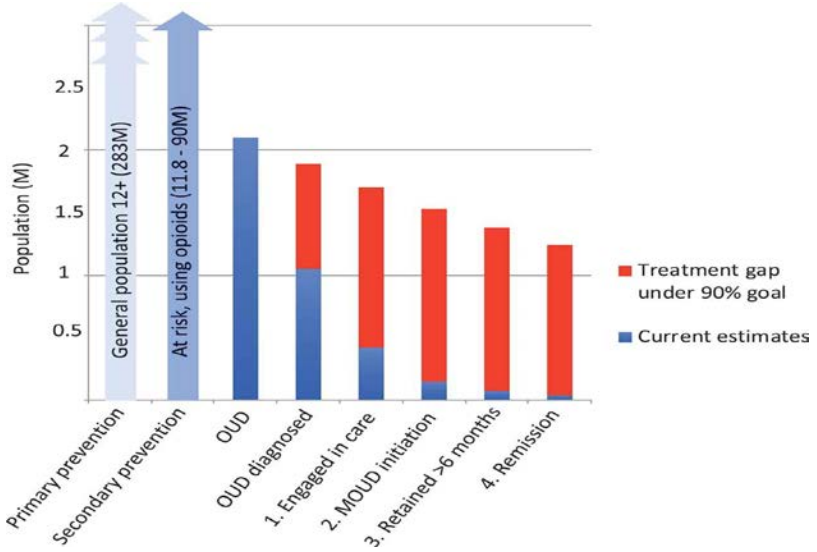
70%

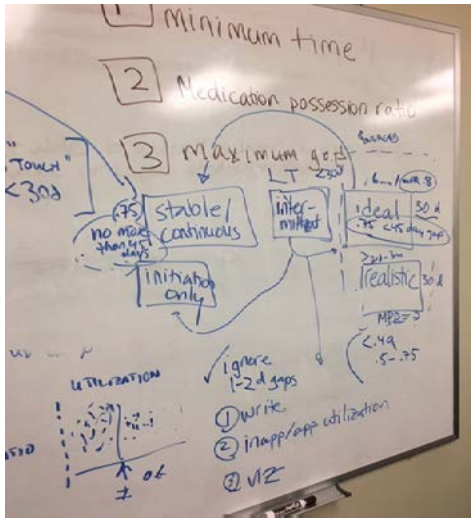
MAT INITIATION

58%

MAT ENGAGEMENT

37%





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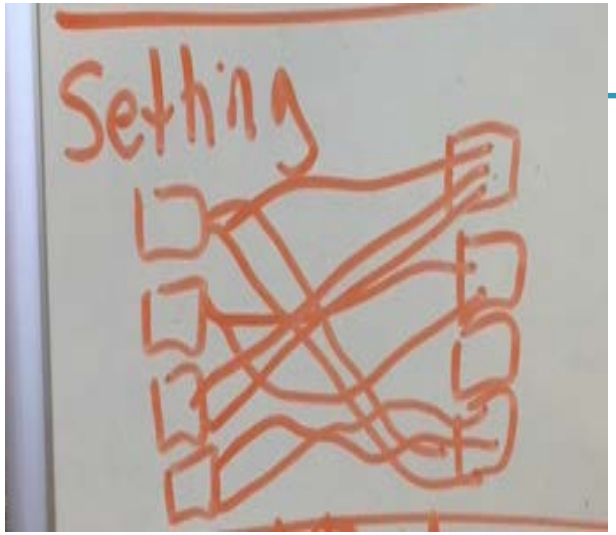
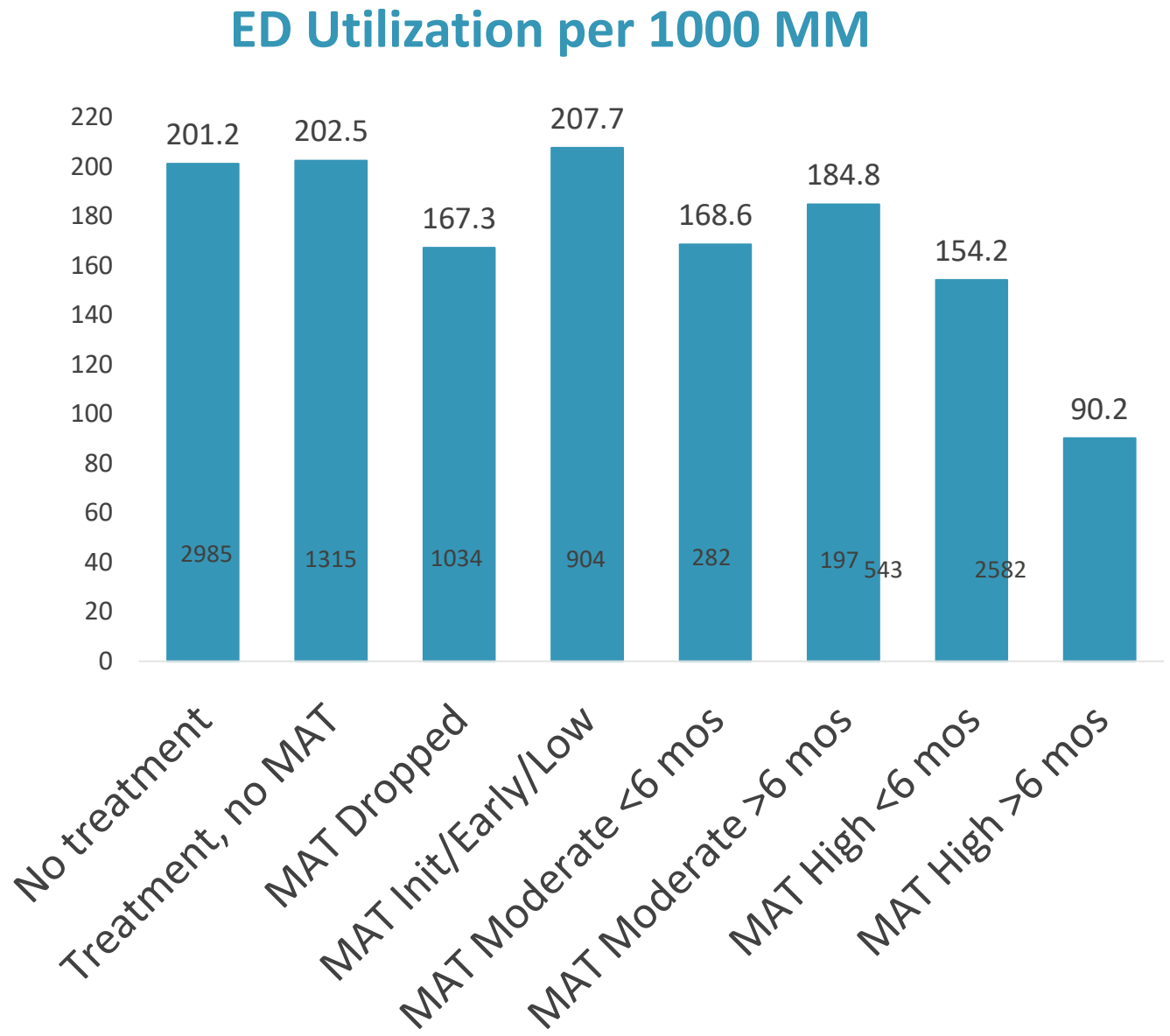
Data Analytics and Visualization

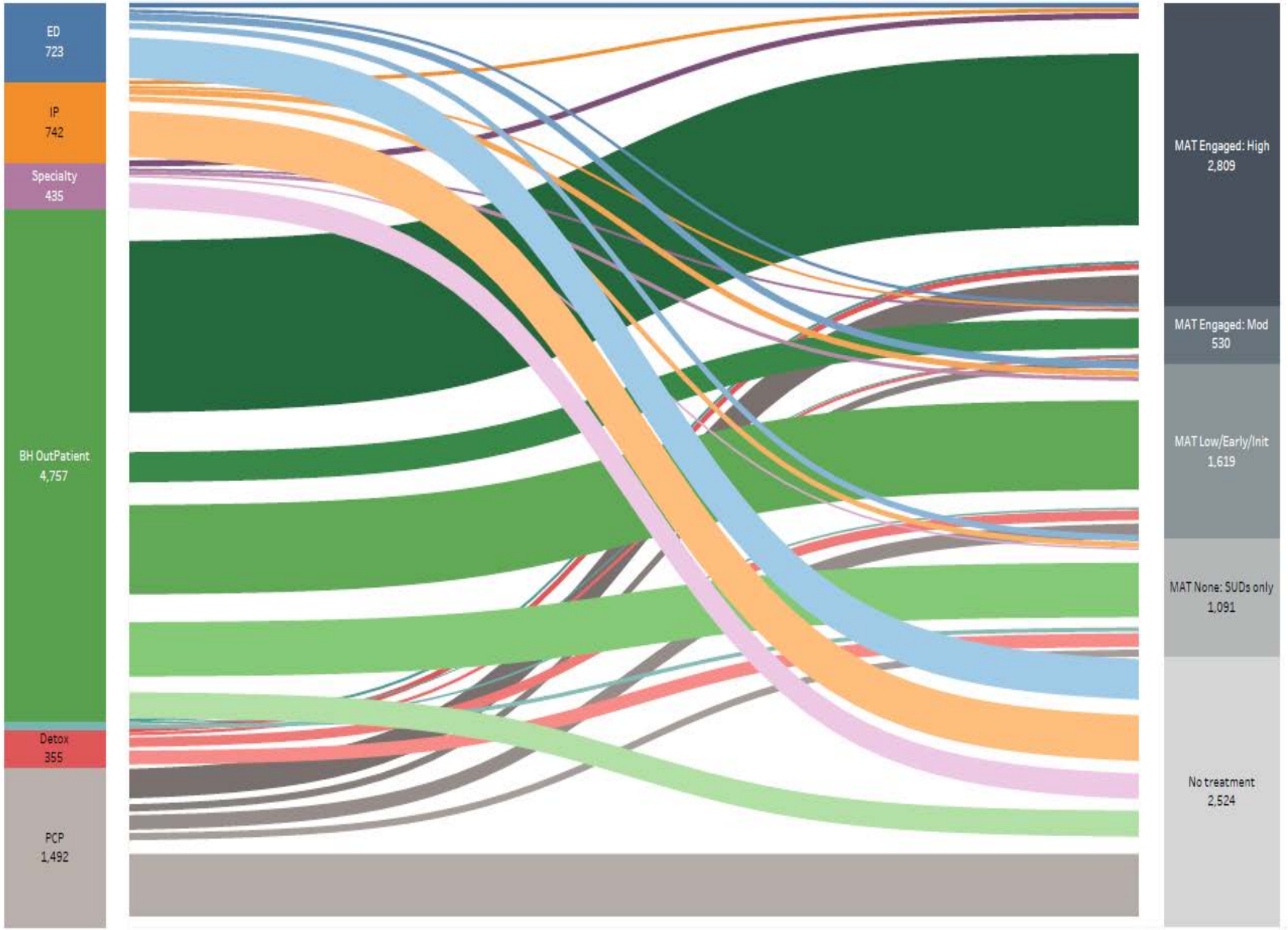
Engagement Categories used for ROI[3]:

- **Utilization**: ED/IP
- **Cost**: Cost Profiles
- **Quality**: Sankey Diagram, MAT Dashboard

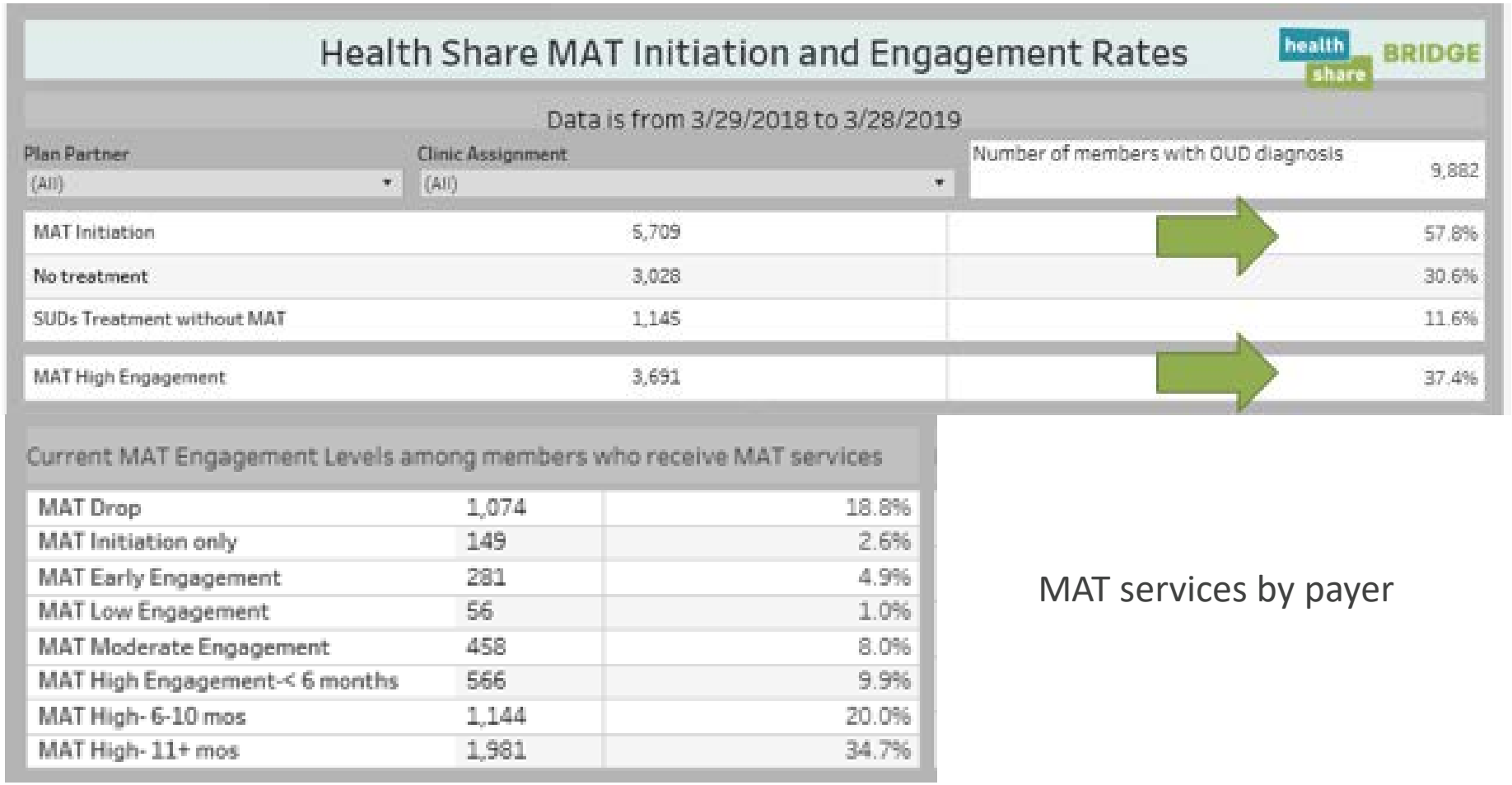


Members in the highly engaged MAT groups have a 51% lower ED utilization rate than members in the no treatment group.




ED
723
IP
742
Specialty
435
BH OutPatient
4,757
Detox
355
PCP
1,492
MAT Engaged: High
2,809
MAT Engaged: Mod
530
MAT Low/Early/Init
1,619
MAT None: SUDs only
1,091
No treatment
2,524

MAT DASHBOARD



Health Share MAT Initiation and Engagement Rates

health share BRIDGE

Data is from 3/29/2018 to 3/28/2019

Plan Partner	Clinic Assignment	Number of members with OUD diagnosis	9,882
(All)	(All)		

MAT Initiation	5,709	57.8%
No treatment	3,028	30.6%
SUDs Treatment without MAT	1,145	11.6%
MAT High Engagement	3,691	37.4%

Current MAT Engagement Levels among members who receive MAT services

MAT Drop	1,074	18.8%
MAT Initiation only	149	2.6%
MAT Early Engagement	281	4.9%
MAT Low Engagement	56	1.0%
MAT Moderate Engagement	458	8.0%
MAT High Engagement-< 6 months	566	9.9%
MAT High- 6-10 mos	1,144	20.0%
MAT High- 11+ mos	1,981	34.7%

MAT services by payer

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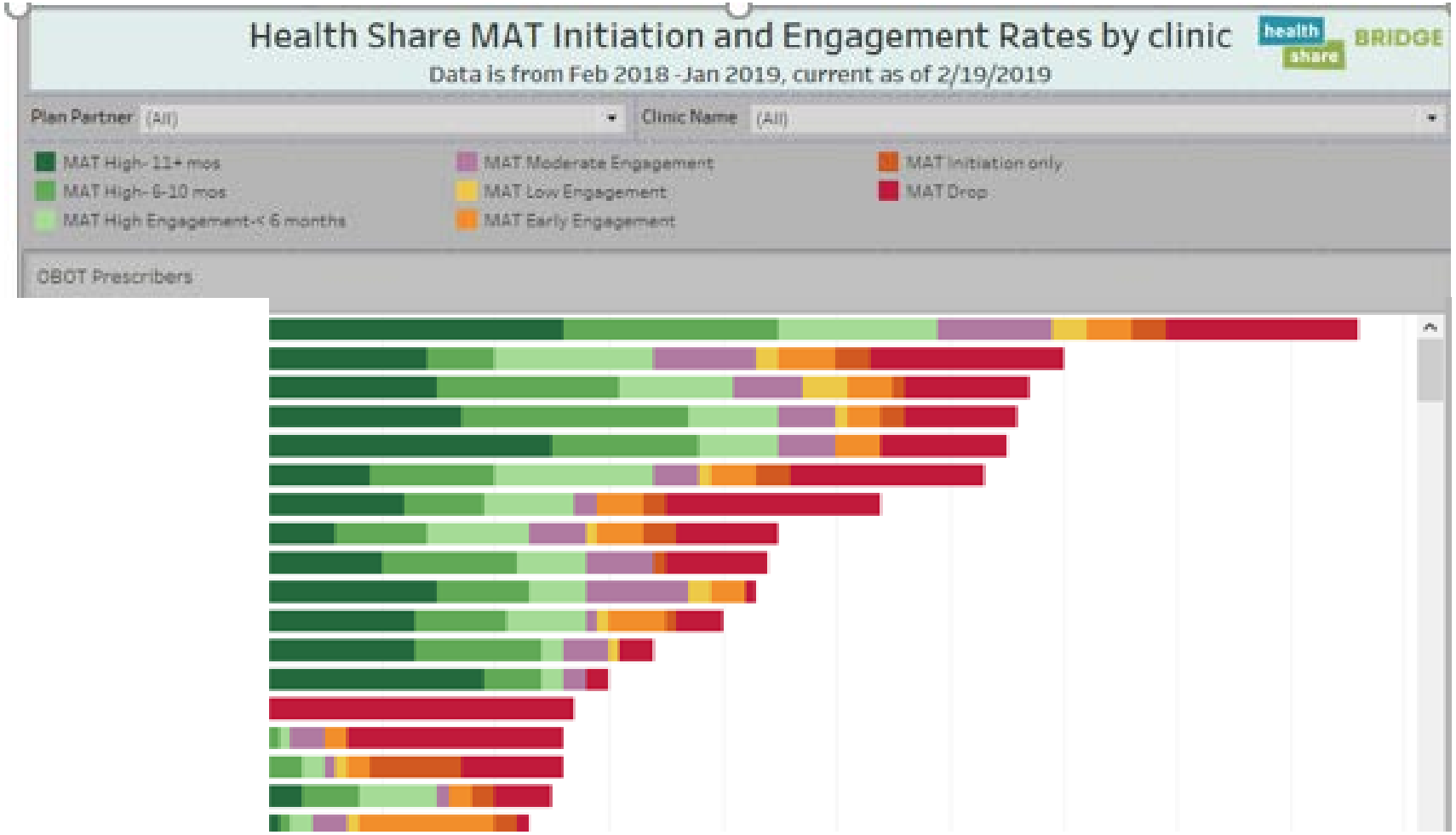
MAT DASHBOARD



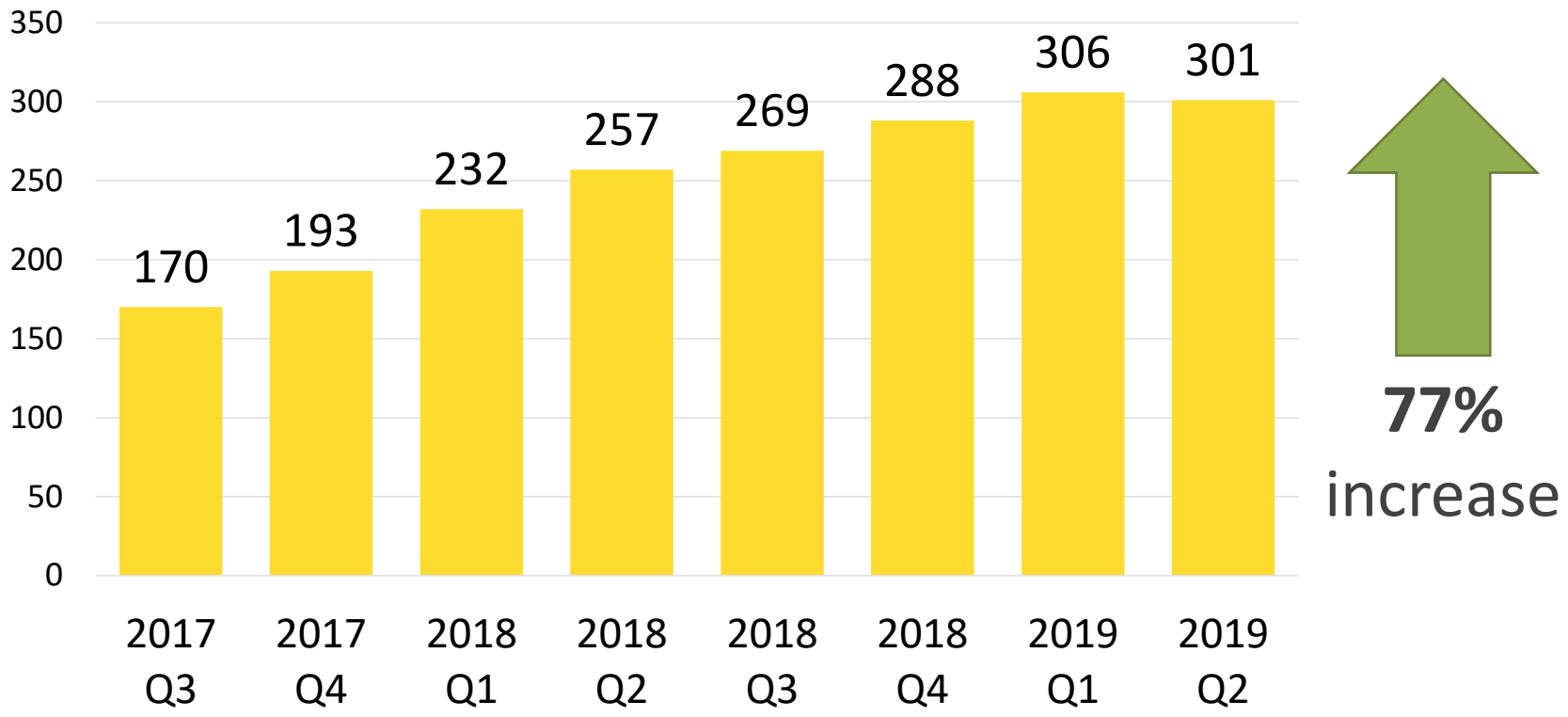
Page two has OBOT prescribers

Color indicates levels of MAT engagement

Medication Supported Recovery Trends

The number of MAT prescriptions written by spoke providers increased dramatically, from 120 in 2017 to 775 in 2018.

The % of members with a claim for MAT services within 6 months after their first detox event increased from 21% (first half of 2017) to 40% (first half of 2018).



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If you are wondering how to:

- Code for the MAT categories
- Make a Sankey diagram
- Make an MAT dashboard
- Talk about data or anything else geeky…

Contact Us!
Kristen@healthshareoregon.org,
JustinePope@codainc.org

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Thank you

Health Share of Oregon

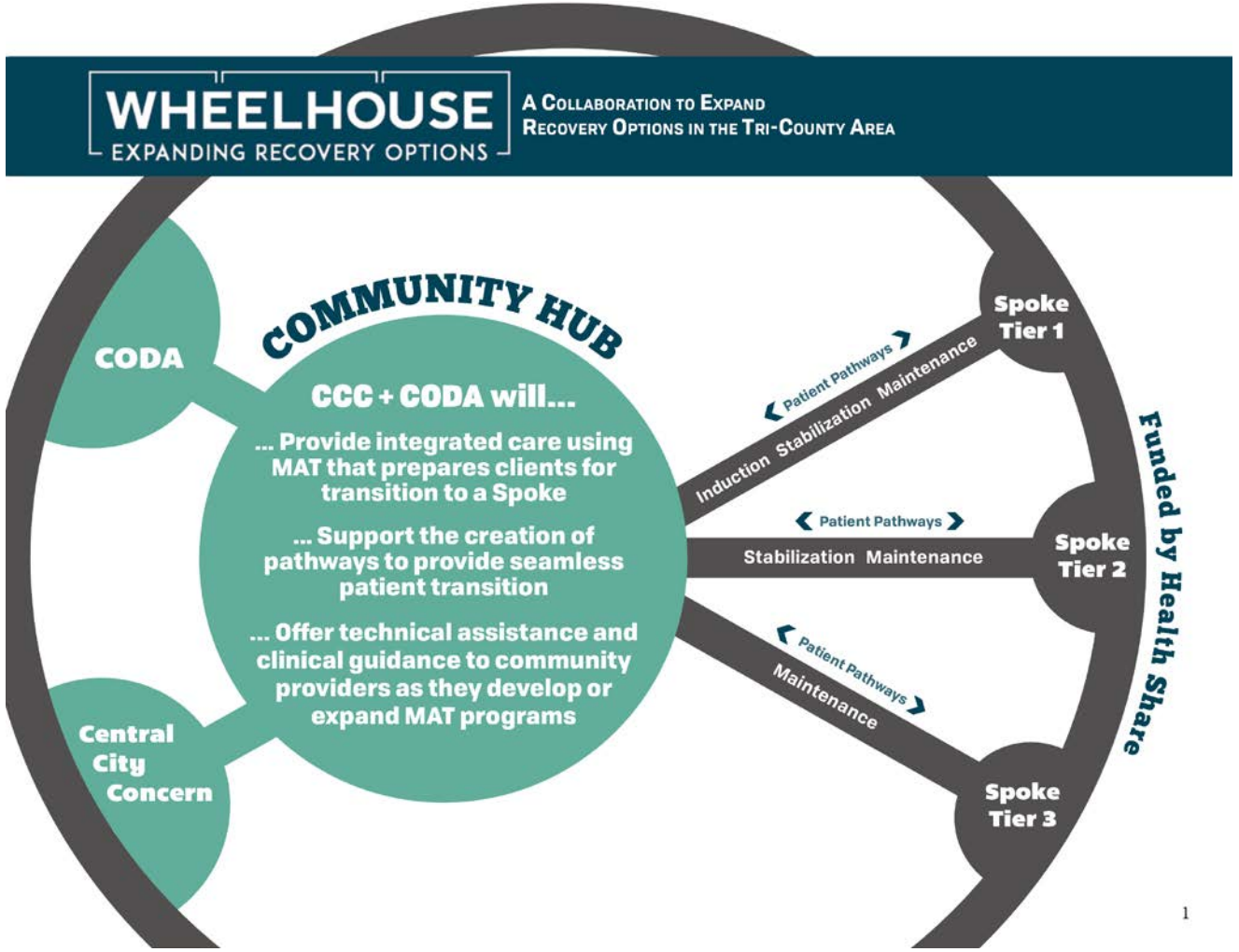
Objectives, Part Two:

- ✓Describe how a coordinated care organization used data to inform MAT expansion efforts.
- ✓Review one framework for organizing CCO membership into categories of OUD treatment using a cascade of care model, and identify a method to determine MAT initiation and engagement rates (low, moderate, high) from claims data.

3. **Discuss tri-county regional efforts to improve and expand access to medication-assisted treatment (MAT) services via data-driven decision-making**
4. **Share CareOregon process for support and implementation of MAT across primary care and other service systems.**

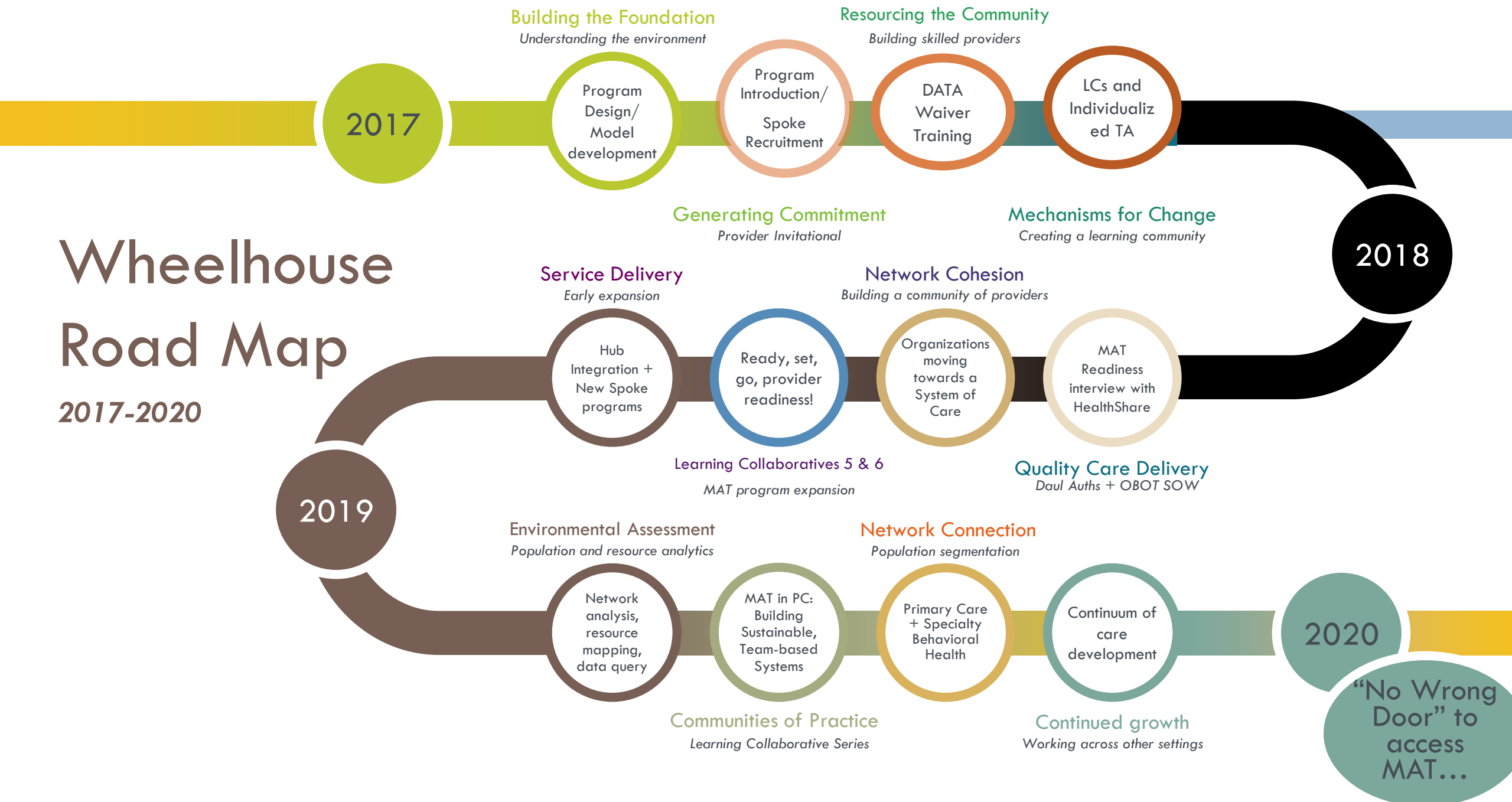
Wheelhouse, then…

- 2016 Health Share regional investment: Central City Concern (CCC) and CODA proposed a local Hub and Spoke pilot project in **Specialty Behavioral Health (SBH)**
- Worked with new SBH providers to develop MAT programs



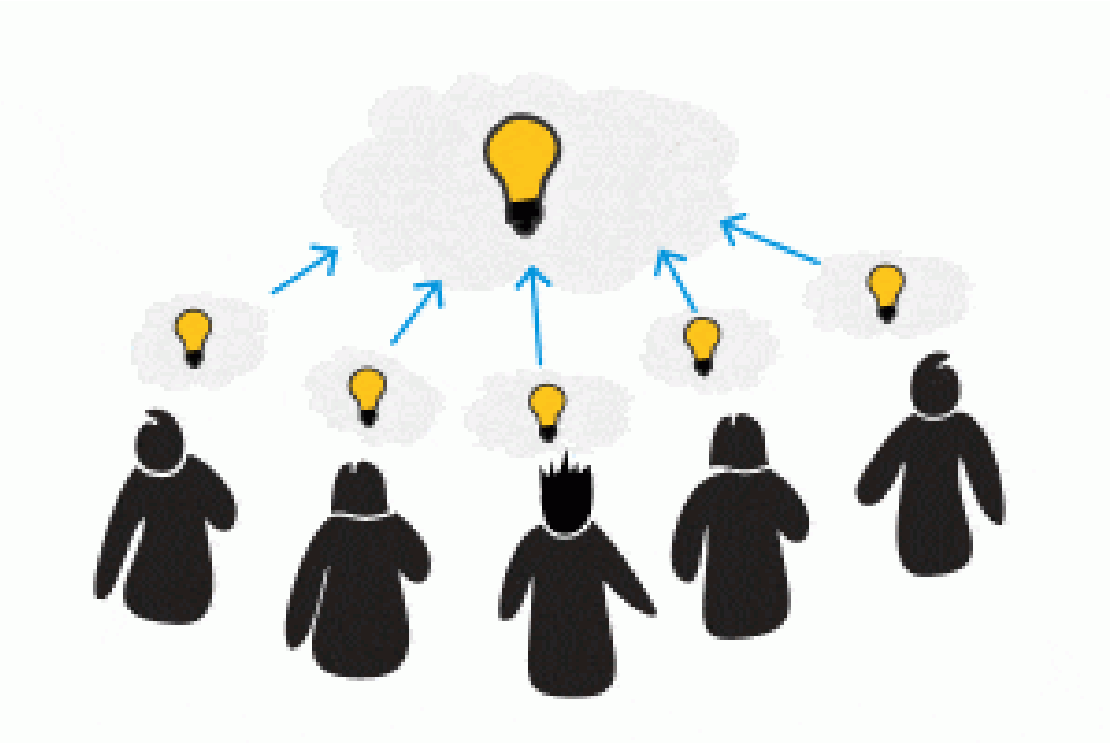
Wheelhouse Road Map

2017-2020



Wheelhouse today: Supporting availability of MAT in Primary Care in partnership with

Shared vision and goals

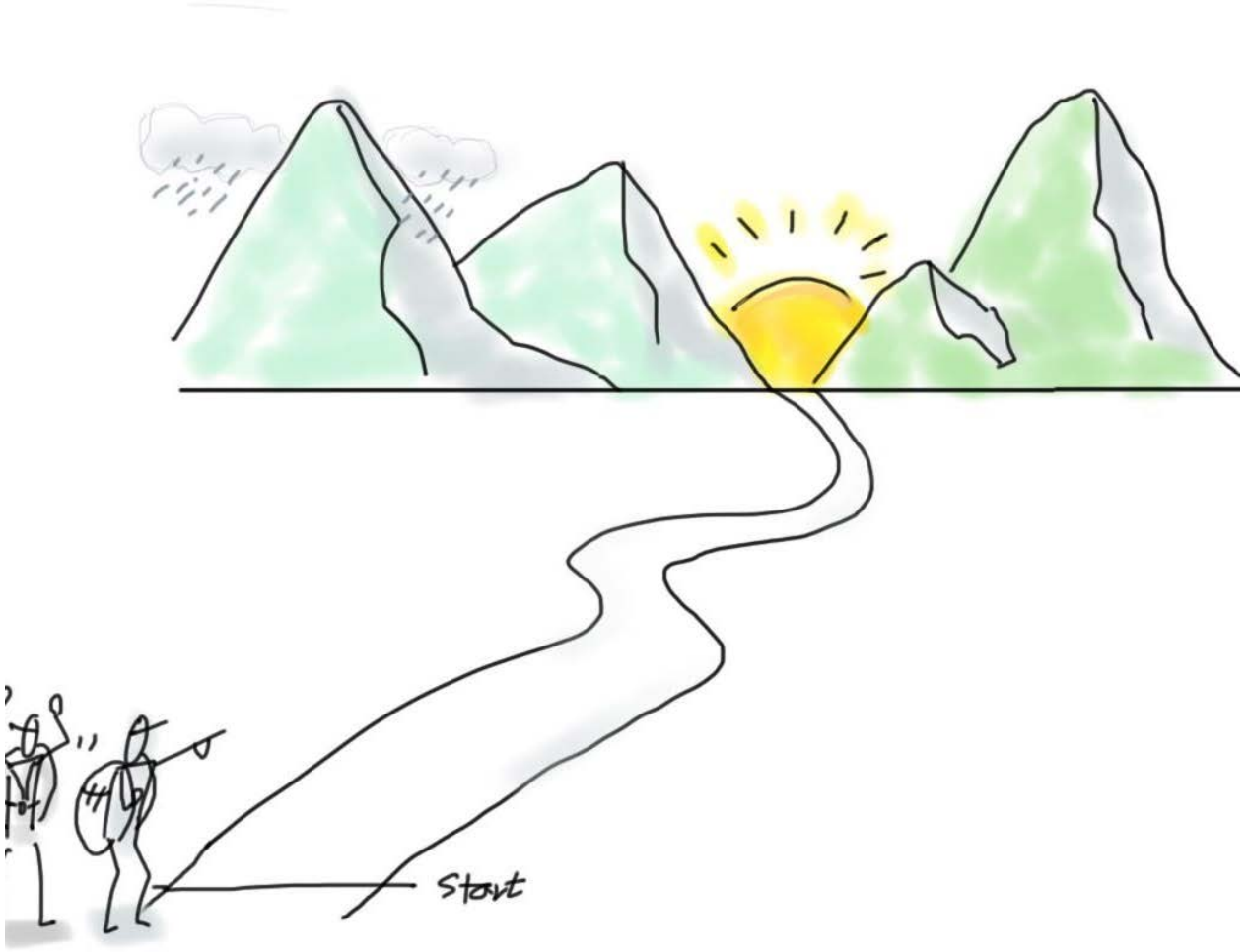


Mission

1. Build capacity where there is interest and need
2. Support providers and programs through
    - Training and education
    - Consultation
    - Patient pathways
3. Help articulate a regional network of MAT access points and recovery supports

How?

- In collaboration with health plans and providers: **develop and convene a regional Learning Collaborative series around MAT expansion in Primary Care**
- Develop and support **focused relationships** between Primary Care and Specialty Behavioral Health providers who offer MAT, with agreements around **patient-sharing, care coordination, and transitions of care**
- Offer other **community education events** that are responsive to provider, patient, and organization needs
- Work. Together.



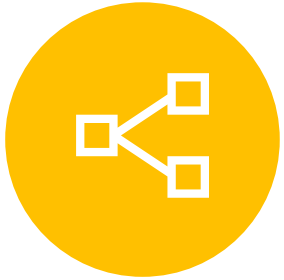
Current offerings, opportunities:

- Learning Collaboratives supported by Health Share and convened by Wheelhouse + Physical Health Plans
- Pooling and sharing resources to improve the capacity of services to match the need
- Strengthen partnerships and referral pathways between care settings.
- 1:1 targeted technical assistance
- Oregon ECHO Network – Addiction Medicine series

Care Oregon Foundation
Opioid Use Disorder is a Chronic Illness

Etiology and treatment has similarities with other conditions like diabetes

Requires long-term or lifelong treatment



If well managed, patients can continue to experience full, successful lives

Addressing barriers to prescribing and offering education, imperative to success and increased prescribing

Focus Areas:
No Wrong Door

Address and eliminate barriers, prejudice, stigma

Share benefits of medication for OUD- Decrease mortality and medication utilization

Increase treatment retention

Increase prescribing- Medication is under utilized

Encourage a network of medication access points and recovery services

Develop a payment structure to encourage sustainability and capacity build

Data driven improvement, utilization of population level data to inform system and patient care

Operationalizing a Cross Regional Strategy

- **Develop targets, track key metrics, monitor progress and provide guidance**
- **Support focused relationships between Primary Care and other service settings who offer MAT/SUD**
- **Coordinate to offer community education events that are responsive to provider, patient, and organization needs**
- **Provide targeted technical assistance to support capacity building and effective systems of care**

MAT in Primary Care: Building Sustainable, Team-based Systems

Help	Help establish community standards for the delivery of MAT in a primary care setting
Support	Support teams as they build or expand sustainable, effective MAT programs
Increase	Increase access to MAT for appropriate patients
See	See an increase in the total number of patients receiving MAT in primary care
Support	Support referral pathways between Primary Care and Specialty Behavioral Health

Objectives: Learning Collaboratives

- **Tools to implement change**: clinic culture, policies, workflow, reduce bias and become trauma informed
- Deepen your understanding of **team based care** and role optimization
- Ability to **use data and electronic tools to drive improvements**
- Structure to **increase the number of patients served per DATA-waivered prescriber** through team-based culture and practice

Learning Collaborative Topics:

#1: Foundations for best practices, team based care, using data

#2: Trauma Informed Care and Substance Use Disorder

- **Approaches for patient segmentation, risk tolerance and other substance use**
- **Inductions- office, home**
- **Implementation check-list, workflows, templating patient care**
- **Focused populations, including: Pregnancy, Intersection of pain/OUD/buprenorphine, culturally sensitive services**

#3: Real Examples from Integrated Primary Care teams

- **Referral pathways to BHC and peers**
- **Opioids and the Brain**
- **DEA and 42 CFR**
- **Modeling difficult conversations**
- **Trauma informed inductions**

#4: MAT Care across settings

- **Specialty behavioral health**
- **Corrections**
- **Transitions**
- **Inpatient, Emergency Room**

Targeted Technical Assistance

Target Technical Assistance

- ❑ Needs assessment for interested clinics to assess readiness for implementation of Medication program.

- ❑ Encourage the use of available data to inform patient care and clinical best practice.

- ❑ Support clinics in operationalizing Medication program.
  - ✓ Staffing models and workflow
  - ✓ Workflows,
  - ✓ Electronics health record tools
  - ✓ Screening for opioid use disorder and dependence.

- ❑ Assist clinics in developing partnership with specialty behavioral health for referral and coordination of shared patients, to include induction when not feasible in Primary Care.

Jackson Care Connect and Columbia Pacific CCO: Regional Specific needs

Created MAT Dashboard similar to Health Share Dashboard

Development of seven series MAT in Primary care and Behavioral Health learning series

- **Important to include didactics applicable for various settings**
- **Engage local community experts**

DATA waiver trainings

1:1 Technical assistance directed by regional needs

Focus on improving patient pathways between service settings

October 2017 - September 2018

Diagnosis mostly occurring in Primary care and Specialty Behavioral Health (SBH)- SBH includes chemical dependency programs
No Treatment and SUD only = no medication

Where first OUD Dx occurs

	Jackson
Behavioral Health	447
ER	74
Home Care	4
Inpatient	69
Other Ancillary	74
Outpatient Hospital	22
Primary Care	325
Referral Services	47

Quarterly MAT Opioid Engagement Rates for 12 month windows (date shown is the start of the window range)

Members with OUD Diagnosis

2017	2018			
Q4	Q1	Q2	Q3	Q4
1,130	1,110	1,163	1,199	1,203

	2017	2018			
	Q4	Q1	Q2	Q3	Q4
No Treatment	24.87%	25.95%	27.43%	27.86%	26.85%
SUD Only	17.96%	16.31%	15.13%	15.26%	16.79%
MAT Initiation	57.17%	57.75%	57.44%	56.88%	56.36%

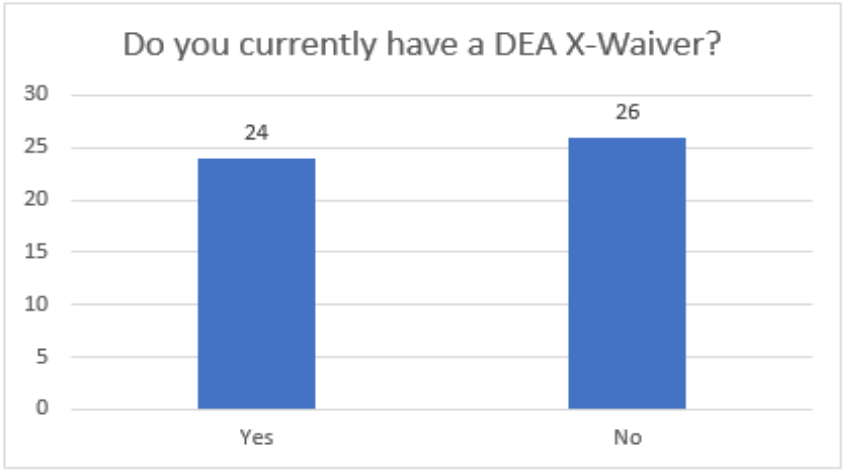
Capacity Building Survey-JCC

- Close connection with JCC Community Advisory Panel.

- Gain understanding of barriers and inform recommendations for Capacity Building grant

JCC CAP Outpatient Buprenorphine Treatment Capacity Survey
50 Jackson County Medical Provider Respondents-Fall 2019

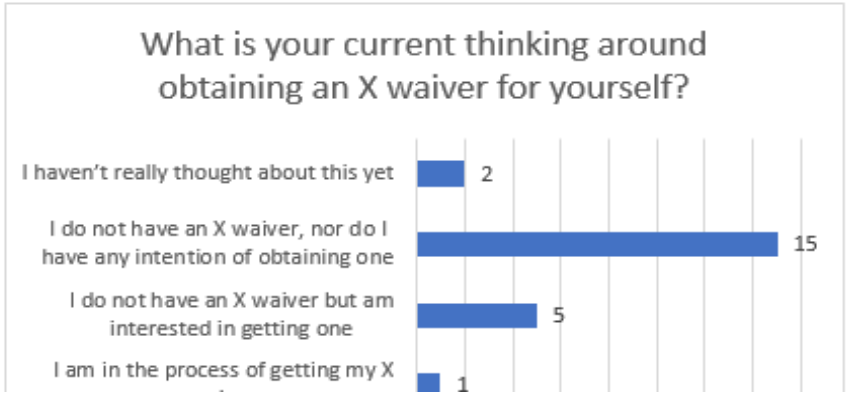
OF the 53 medical clinicians (per 5/2019 OHA report) in Jackson Co. w/ a data waiver, 24 (45%) responded to this survey.



50 respondents representing:

- La Clinica
- Other (Misc.)
- Rogue Comm. Health
- Providence

Of the 26 who did not have a data waiver 15 (58%) stated they had no intention of ever getting one.



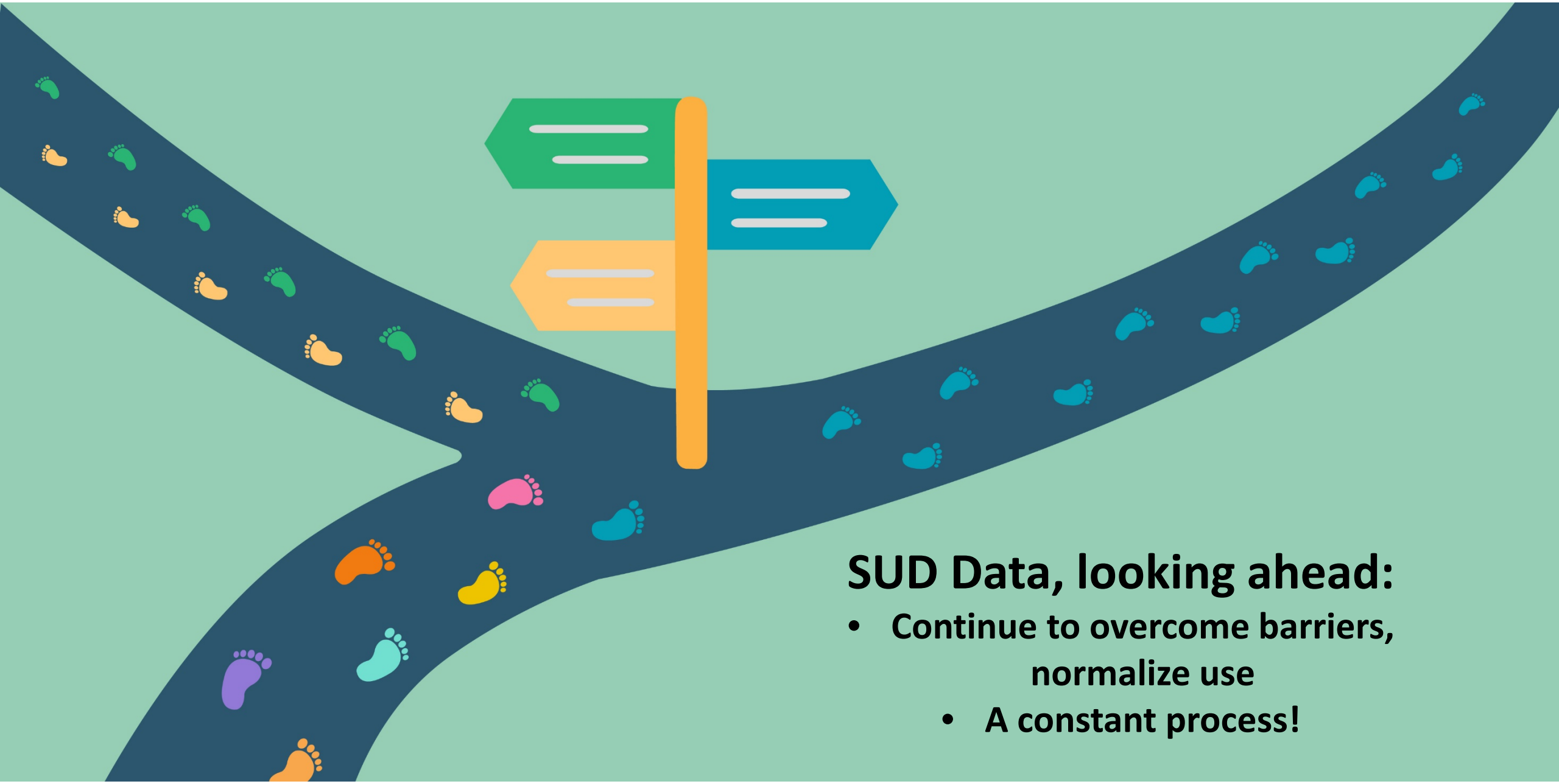
Payment and Financial Support

Capacity Building Grant- support implementation of Medication

Payment model- In development to support prescribing within Primary Care and specialty settings

Next Steps

- Continue Targeted Trainings:
  - Trauma Informed Care for Substance Use
  - Behavioral Health Core Competencies
  - DATA waiver trainings
- Continue to align best practices across services settings
  - Intentionally develop patient pathways
- Continue to partner and collaborate with SUD leaders



SUD Data, looking ahead:

- Continue to overcome barriers, normalize use
- A constant process!

Questions/Discussion