DATA-Informed Expansion of MAT Services: 
Process, Framework, and Clinical Transformation

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Disclosures

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Overall Objective

Understand the role of data in addressing the opioid epidemic, innovative strategies to use data for action, and review tools to support implementation with consideration to patient segmentation
Data and the Opioid Epidemic

- Epidemiologic
- Geographic: State and county
- Organization
- Provider
- Pt
Data and the Opioid Epidemic

Epidemiologic

Geographic: State and county

Organization

Provider

Patient

Highlights Trends And Population Level Problems/Opportunities
Epidemiologic Data: The Opioid Epidemic

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016

Data and the Opioid Epidemic: The Organization/Provider

- Epidemiologic
- Geographic: State and county
- Organization
- Provider
- Patient

Highlights areas needed for organizational change and improvements in practice.
# Organization Level Data: Opioid Prescribing

## CPCCO Opioid Dashboard

<table>
<thead>
<tr>
<th>Q4 2017</th>
<th># of Members w/ Chronic Opioid (Any MEI)</th>
<th>Assigned Members w/ Chronic Opioid (Any MEI) per 1,000 Members</th>
<th># of Members at MED ≥ 50</th>
<th>Assigned Members at MED ≥ 50 per 1,000 Members</th>
<th># of Members at MED ≥ 90</th>
<th>Assigned Members at MED ≥ 90 per 1,000 Members</th>
<th># of Members at MED ≥ 120</th>
<th>Assigned Members at MED ≥ 120 per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia Pacific CCC TOTAL</td>
<td>578</td>
<td>26.9</td>
<td>192</td>
<td>8.3</td>
<td>93</td>
<td>4.3</td>
<td>36</td>
<td>4.3</td>
</tr>
</tbody>
</table>

### CPCCO 2017:

- **# of Members w/ Chronic Opioid (Any MEI)**: 578
- **Assigned Members w/ Chronic Opioid (Any MEI) per 1,000 Members**: 26.9
- **# of Members at MED ≥ 50**: 192
- **Assigned Members at MED ≥ 50 per 1,000 Members**: 8.3
- **# of Members at MED ≥ 90**: 93
- **Assigned Members at MED ≥ 90 per 1,000 Members**: 4.3
- **# of Members at MED ≥ 120**: 36
- **Assigned Members at MED ≥ 120 per 1,000 Members**: 4.3
Data and the Opioid Epidemic: Patient

Patient lists/registries: Highlights need for individual care plans
The Missing Piece: Data for Action for OUD

- Epidemiologic
- Geographic: State and county
- Organization
- Provider
- Pt
Understanding our Members: MAT Initiation and Engagement through a Cascade of Care Framework

Amit Shah, MD
Justine Pope, MPH
Kristen Lacijan-Drew, MS, MPH
Objectives

Describe how a Coordinated Care Organization (CCO) 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 (low, moderate, high) from claims data.

Produce visual displays of information that show population-level utilization and treatment engagement.
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
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%
Data Analytics and Visualization

Engagement Categories used for ROI:

- **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.
## Health Share MAT Initiation and Engagement Rates

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

<table>
<thead>
<tr>
<th>Plan Partner</th>
<th>Number of members with OUD diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>9,882</td>
</tr>
<tr>
<td>MAT Initiation</td>
<td>5,709</td>
</tr>
<tr>
<td>No treatment</td>
<td>3,028</td>
</tr>
<tr>
<td>SUDs Treatment without MAT</td>
<td>1,145</td>
</tr>
<tr>
<td>MAT High Engagement</td>
<td>3,691</td>
</tr>
</tbody>
</table>

### Current MAT Engagement Levels among members who receive MAT services

<table>
<thead>
<tr>
<th>MAT Service</th>
<th>Number of members</th>
<th>Engagement Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT Drop</td>
<td>1,074</td>
<td>18.8%</td>
</tr>
<tr>
<td>MAT Initiation only</td>
<td>149</td>
<td>2.6%</td>
</tr>
<tr>
<td>MAT Early Engagement</td>
<td>281</td>
<td>4.9%</td>
</tr>
<tr>
<td>MAT Low Engagement</td>
<td>56</td>
<td>1.0%</td>
</tr>
<tr>
<td>MAT Moderate Engagement</td>
<td>458</td>
<td>8.0%</td>
</tr>
<tr>
<td>MAT High Engagement - &lt; 6 months</td>
<td>566</td>
<td>9.9%</td>
</tr>
<tr>
<td>MAT High - 6-10 mos</td>
<td>1,144</td>
<td>20.0%</td>
</tr>
<tr>
<td>MAT High - 11+ mos</td>
<td>1,981</td>
<td>34.7%</td>
</tr>
</tbody>
</table>

MAT services by payer
• Page one has OTP providers
• Color indicates levels of MAT engagement
Page two has OBOT prescribers
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,
shaha@careoregon.org,
JustinePope@codainc.org
Thank you
Transforming Opioid Use Disorder Data Into Action

Melissa Brewster, PharmD, BCPS
Safina Koreishi, MD, MPH
Stacie Andoniadis

Columbia Pacific CCO
Objectives

• Describe how a CCO has used Opioid and OUD data to develop targeted strategies for high-risk cohorts and patients not engaged in treatment

• Understand ways a CCO can support development MAT programs within primary care through learning collaboratives, technical assistance, and alternative payment models
Columbia Pacific CCO SUD Vision

Develop a local trauma-informed network for all substance use disorders that ensures timely equitable access, reduces stigma, and promotes extensive cross-organizational coordination with a community of long-term recovery support.
2019 SUD Goals
Advised by CPCCO Clinical Advisory Panel

- Identify, publish, and maintain a list of currently available MAT and addiction services in the CPCCO region
- Develop and implement a Columbia Pacific MAT Collaborative with a focus on developing referral pathways and improving coordination, creating a community of practice for providers, and spreading best-practices in the region
- Use OUD data to create an RCT strategy that identifies sub-populations for focused outreach and develops protocols for unique interventions to address the population's needs
- Create a regional, comprehensive overdose response strategy
- Develop and implement a community education campaign to address stigma and educate on MAT
Columbia Pacific Driver Diagram for Opioid Use Disorder

Driver Diagram for Opioid Use Disorder Treatment

Reduce Opioid-Related Harms

- Reduce inappropriate opioid prescribing
- Reduce Overdose Deaths
- Identify and Intervene on High-Risk Members

Treat Opioid Use Disorder and Dependence

- Build a System of Care for Opioid Use Disorder
- Coordinate Care Among System Components
- Community Education and Clinical Training
- Data Informed Strategy
- Develop Payment Mechanism to Support MAT Services
- Identify and Develop Community Partnerships to Provide Non-Clinical Services

- Detox
- Residential
- MAT in Primary Care
- MAT in CMHPS
- Opioid Treatment Program (CODA)
- System Mapping
- Risk Share Leveraging
- PDSAs for intersections
- RCT/Community Paramedic for coordination
- MAT Fundamentals- trainings for clinics
- How to assess for and diagnose OUD
- Stigma Busting
- Summit
- Data Report for OUD in second phase
- Proactive outreach
- Coordinated tracking
- APM Workgroup for MAT
- Define how to incentivize coordinated care
- Housing
- Harm Reduction
- Public Health
- Law Enforcement
- Recovery Community
2016: CPCCO MAT Services
2019: CPCCCO MAT Services
CPCCO OUD
Initial Data

Identification: Opioid Use Disorder on one or more claim
705 members

Receive SUD Treatment: includes one or more claim for medication or non-medication treatment
508 members (72%)

Gap: no treatment
197 members (28%)

SUD Treatment without MAT
140 members (20%)

Received MAT
368 members (52%)

MAT Drop/ Low Engagement
111 members (30.2%)

MAT Moderate Engagement
42 members (11.4%)

MAT High Engagement
215 members (58.4%)

MPR <0.5
MPR 0.5 – 0.74
MPR > 0.75
Overdose Data Analysis

A suboptimal response to a growing problem

Overdoses in Columbia Pacific 2015-2018

Overdose Response

- Overdose Event: 48
- Heroin: 19
- Still receiving Rx opioids: 18
- Naloxone fill post overdose: 5
- Receiving Buprenorphine: 3
Data Limitations
And OUD Data Version 2.0

• Lower than estimated with OUD diagnosis
  • Many get diagnosis at the time of entering treatment
  • Does not include patients with opioid dependence
• No understanding of type of MAT
  • Does type of MAT impact engagement or retention in treatment?
• 42 CFR limitations for members already in some types of treatment
• Additional asks for next reporting round
  • Assigned primary care clinic and date of last engagement
  • Member demographics
Data Into Action

Strategies to Utilize OUD and Overdose Data

- Use Regional Care Teams to engage patients with a diagnosis but no evidence of treatment
- Develop a comprehensive, coordinated overdose response among all system components
- Create registries and coordinated tracking of members with overdose or OUD diagnosis
- Develop protocols for Community Paramedic to proactively engage or follow-up on overdoses, provide naloxone and teaching
- Develop an APM for providing MAT services, engagement, and retention in primary care
Regional Care Teams – Unique Opportunity

What is a Regional Care Team?

Patient-focused multidisciplinary team, dedicated to working with clinical partners to coordinate services and resources for patients and providers.

colpachealth.org
RCTs & Overdose Follow-up

Proactive identification of all overdoses within the corresponding county

911 Response – EMS/PD:
Dispatch Report

Emergency Department:
PreManage Cohort/Report

Case review referral received by RCT Triage Coordinator

RCT multidisciplinary team reviews overdose and selects appropriate pathway

Community Paramedic and Health Resilience Specialist does follow-up co-visit at place of residence

Schedule follow-up with PCP in clinic and BHC assessment

Required Components:
1. Provide Naloxone and training on use
2. Safe drug use plan (harm reduction)
3. Offer options for treatment
4. Connect with Recovery Ally (peer support specialist)
High Risk Cohort Strategy

**High Dose (>90 MED)**
- Opioid Therapy Audit
  - New Dashboard build
  - Patient lists

**ED or IP related to Opioid Use**
- Quarterly review of all ED visits related to opioids
  - Mandatory therapy audit
  - RCT review

**Adolescents with Multiple Prescriptions**
- Identify in data
  - Review and refer to PCP for follow-up

**Multiple Naloxone Fills, Prescribers, or Pharmacies**
- PA on dose 3 of naloxone, workflow for notification
  - Opioid therapy audit
  - PDMP review by PCP

**Dangerous Co-Ingestants**
- Adding data to dashboard
  - Gathering state benzo data for review and trending

**Diagnosed SUD with Opioid Use**
- Premanage flags
  - RCT review
Develop a Framework: Primary Care Implementation

• Engaged leadership- Foundation for change, leads the way for whole clinic culture shift
• Core champion team- Clinical, operation, and support staff
• Offer support and educational opportunities for entire clinic staff:
  • Address fear of patient population, bias, judgement, and misinformation
  • Trauma-Informed Care
  • Harm Reduction
  • “MAT 101”- what are the medications and how do they work
Review Practice Resources and Needs

• Scale your practice to current resources, provider interest, and patient population
  • Focus on quality and sustainability
• Decided which tools, policies, and workflow align with your clinics staff and population prior to prescribing
• Utilize team-based care model
  • Leverage current staff interest and abilities
  • Adopt workflow for other chronic conditions
• Have an understanding of available resources and tools for successful implementation
  • PCSS, SAMSHA Tip 63
  • Oregon ECHO Network Addiction Medicine ECHO’s- free learning opportunity
MAT In Primary Care: Building Sustainable, Team-based systems

Goals of regional learning collaborative include:

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

Engaged leaders are a must; offer education opportunities to clinics

Develop a sustainable program that accounts for need, interest, staffing ratio and patient population

Standardize what you can and leave room for clinician/team experience and discretion

Provide individualized, patient-centered care

Develop connections for mentorship and referral pathways between systems of care
Thank you!
Clinical Best Practice

Structuring Patient Care

Andrew Mendenhall, MD, DABAM, DABFM
Chief Medical Officer– Central City Concern

Stacie Andoniadis
Primary Care MAT Specialist, CareOregon

Andrew Suchocki, MD, MPH
Clackamas County Health Department Medical Director
Objectives

• Provide overview of “Cascade of Care” and integrated delivery system.

• Discuss clinical approaches to population segmentation, review risk stratification tools
Foundation:
Access to Medication is Best Practice

• As care providers, goal is to actively remove barriers for patients seeking care.

• Clinical tools are available to support patient care and manage clinical pivots.
# Broad Philosophic Context

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevention Type</th>
<th>NNT</th>
<th>NNH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Tight Glycemic Control</td>
<td>A1C&lt;7.0%</td>
<td>NNT 250</td>
<td>NNH 6</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>NNT 29-118</td>
<td></td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>Primary Prevention</td>
<td>NNT 22-80</td>
<td>NNH 63-167</td>
</tr>
<tr>
<td></td>
<td>Secondary Prevention</td>
<td>NNT 7-9.1</td>
<td></td>
</tr>
<tr>
<td>Alcohol Use Disorder</td>
<td>Acamprosate</td>
<td>NNT 12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Naltrexone</td>
<td>NNT 20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Naltrexone</td>
<td>NNT 12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Abstinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Abstinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zero Heavy Drink</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Retention in Treatment</td>
<td>NNT 2-4</td>
<td></td>
</tr>
</tbody>
</table>
1. Supports the use of medication to help patients improve their probability of abstinence.
   • Data has been around for nearly 50 years.
   • Alcohol Use Disorders
   • Opioid Use Disorders

2. Supports the attendance of fellowship groups as increasing the probability of sustained abstinence.
   • Less than 15% of patients who attend 12-step meetings will continue to be active at 12 months.
   • 90 meetings in 90 days is as effective as a 28 day residential treatment.
     • Very poor outcomes data-self reported “success” rates of 80% or more
The Medical Literature

3. Demonstrates that treatment of depressive disorders markedly reduces substance use but have a minimal effect on the probability of total abstinence.

4. Informs clinicians that the disease of addiction is a chronic relapsing brain disease.
   - Spectrum disease – mild, moderate, severe
   - Vastly less expensive to treat than it is to ignore or to provide less effective treatment modalities.

Edward V. Nunes, MD; Frances R. Levin, MD
What an Integrated Care Delivery system might look like

• **Medication** to break the intoxication-withdrawal-craving cycle
• Safe place to receive Medical Care
• A Safe Place to Call **Home**
• Living Wage **Employment**
• Meaningful **Relationships**
• Behavioral Therapy

Courtesy: Dr. Paul Lewis
Severe SUD Patient Experience

- Crime
- Drug Using Community
- Employed
- Family
- Law Enforcement
- Insurance Payer
- Outpatient Tx.
  - (+/ - MAT)
- Residential (MSR?)
- Sober Living (MSR?)
- Outpatient Tx. (+/- MAT)
- DETOX CTR
- Buprenorphine/Vivitol Outpatient
- Methadone OTP
- CJ/Restitution STOP Courts (MSR?)
- Residential (MSR?)
- Outpatient Tx. (+/- MAT)
- Death
- Emergency Room/Intensive Care for OD
- Emergency Room/Intensive Care for Pills
- Admission for Hosp. Medical
- Deliver NAS Baby
- DETOX CTR
- Methadone OTP
- Buprenorphine/Vivitol Outpatient
- Outpatient Tx. (+/- MAT)
- Residential (MSR?)
- Sober Living (MSR?)
- CJ/Restitution STOP Courts (MSR?)
- Death
A Fully Integrated Medical Home for Recovery

A FULLY DEVELOPED SYSTEM: Accountable Care Organization

ER
IC
Clinic

Inpatient
Medication Support from a Medical Clinic

Day Tx

IOP

OP

Sober Housing
Restitution Center (CJ)

Case Management/Recovery Management

G4P (methadone) and/or Suboxone
Medication Support Allows More Patients To Enter Treatment:

SUD = Substance use disorder

New Outpatient Treatment Methods, MAT; allow more people access to treatment

- Treat earlier = Less Severe
- Less impact on work and family
- More outpatient, less inpatient
It is critical to consider clinical stage of change and your program’s threshold for management of a pre-contemplative patient population. This is particularly important considering cannabis and/or episodic alcohol use.

It is ALSO critical to have an expedited pathway for clinical non-responders to Medication Support.
Population Segmentation

Concept: In healthcare, populations of patients may be separated into discrete cohorts by a variety of different features:

- Gender, age, racial or cultural background, insurance payer etc
- High vs. low utilization
- High vs. low acuity
- Opioid contract vs. no opioid contract
- Mental Health vs. no mental health diagnosis
- ACE-score (adverse childhood events)
Population Segmentation

- Why is this consideration important?
  - Who are you serving?
  - Who are you not serving (or are serving in an inadequate fashion)
  - Understanding care or other service continuum gaps.
  - Develop a clinical model or deploy resources to better serve the population of interest.

- Critically important for the development of new SUDS continuum due to the need to establish clinical standards and define boundaries for inclusivity vs. exclusivity in clinical treatment milieu.

- Who are you going to care for, when?..... and if not, how will you coordinate care?
Clinical Tools for Population Segmentation: Approaches for Managing Cycles of Relapse and Recovery

Goal: Guide patient care, reduce practice variation

• Tools exist which can offer structure
• Reduce barriers for patients
• Support frequency and type of patient care “touch points”
  • Prescriber and care team visits
  • Urine Drug Screens
  • Cadence of refill or medication
Clinical tools: Provide Structure for Clinical Pivots

Support challenging clinical pivots- “if/then”
- Patient refuses referrals
- No available daily dispense
- Active diversion
- Sole provider
- Limited clinical response
  - On-going use despite access to medication, recovery services
  - Active intoxication
  - Need for medically managed withdrawal
Opiate Assessment Risk (OARS)
Primary Care MAT- Need for Standardization

- Opiate Assessment Risk (OARS) tool was created to guide MAT patient care at Clackamas Health Centers
- OARS:
  - Assumes the patient will be managed in primary care
  - Created by drawing on both anecdotal primary care based MAT experience, and two MAT guides:
    - OHSU-Richmond\(^1\)
    - Treatment Needs Questionnaire\(^2\)
- Need was driven by behaviorists calling out a wide spectrum of provider variation in MAT practice
- Intended for patients who will be treated within primary care vs decision making tool for placement
- Used as a framework to guide patient visits, with a focus on care initiation/care plan creation
- Can be administered by prescriber or integrated behavioral health clinician
- Has been distributed to five Oregon FQHCs for review of potential use and integration into OCHIN-EPIC is in discussion

# Opiate Assessment of Risk Score (OARS)

## 1. Medical Risk Stratification Score

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Points</th>
<th>Protective Factors</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-occurring alcohol disorder</td>
<td>15</td>
<td>Prior MAT experience</td>
<td>5</td>
</tr>
<tr>
<td>Significant Psych history, but reasonably stable</td>
<td>5</td>
<td>Active support system - clinical/family/community</td>
<td>5</td>
</tr>
<tr>
<td>No prior addictions treatment</td>
<td>5</td>
<td>Consistent Hx, UDS, PDMP</td>
<td>5</td>
</tr>
<tr>
<td>Chronic Pain, poorly controlled</td>
<td>10</td>
<td>ACES* &lt;4</td>
<td>5</td>
</tr>
<tr>
<td>Other active substance use</td>
<td>5</td>
<td>Stable housing</td>
<td>5</td>
</tr>
<tr>
<td>&lt;25 years old</td>
<td>10</td>
<td>*Adverse Childhood Event Score</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 2. Induction Details

- **Buprenorphine naive:** Prior buprenorphine use
- **Suggest in-person induction done over 2 days.** Home induction recommended
- **If not possible, home induction with 24 and 48 hour follow-up**

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Opiate Assessment of Risk Score

3. Medical Management Details - Based on Medical Risk Stratification Score from #1

<table>
<thead>
<tr>
<th>Refill Duration</th>
<th>Red (&gt;15)</th>
<th>Yellow (&gt;5, &lt;15)</th>
<th>Green (&lt;5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly, add by qWeek as appropriate. Max duration 1 month total (no RF)</td>
<td>Start with 1 week, then 2 weeks, extend to 1 month. Max RF is 2 mos (1 RF)</td>
<td>See Yellow for initiation. After 2, 2 month cycles (4 mos total) progress to total duration of 3 mos (2 RF)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Screen (UDS) Frequency</th>
<th>Red (&gt;15)</th>
<th>Yellow (&gt;5, &lt;15)</th>
<th>Green (&lt;5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At every appointment in first month, extend to q3 months</td>
<td>At initiation, 1 month follow-up, ok to q6 mos after 3 affirming UDS (q6 applies for Red score graduates)</td>
<td>At initiation and 1 month follow-up, consider extend to yearly after 6 mos of affirming UDS</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visit Frequency</th>
<th>Red (&gt;15)</th>
<th>Yellow (&gt;5, &lt;15)</th>
<th>Green (&lt;5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly x 2, bi-weekly x 2, monthly if care team in agreement</td>
<td>After initiation, q 2 weeks x 2, monthly, then driven by RF frequency</td>
<td>After initiation, q 2 weeks x2, monthly, then driven by RF frequency</td>
<td></td>
</tr>
</tbody>
</table>

After 3 months or clinical judgement, graduate to lower risk category. If issues, consider increasing risk.

4. Behavioral Health - Independent of Medical Risk Stratification Category and Induction Setting

Please note all patients receiving primary care based MAT should receive a behavioral health and needs assessment

Would enrollment in intensive BH program impede SDH needs?

Start Here

Pt willingness to engage in behavioral health?

Yes

No

Referral to speciality behavioral health,

When Complete

'BH lite'- primary care (or established partner) remains MH

Yes

No
Clinical Approach to Addressing Patient Response to MAT for OUD

- Created to reduce variance between 150 DATA waived providers
- Offer direction during clinical pivots
- Provides structure for the medical management of patients
- Reduce abstinence only mentality - driving patient to get worse
- Supports increase in access to medications
Tested within a large privately held system in the Northeast

- 1500 MAT patients
- 150 DATA waived providers
- 52 centers

Use to support patient segmentation, management of Cycle of Relapse and Recovery:

- Support patient and provider accountability
- Provide structure for cadence of care team visits, urine drug screen, prescription
- Framework for consistent communication with patients
- In coordination with Stages of Change, and referral pathways for more structured care
Managing the Cycle of Relapse and Recovery requires:
- Uniform Clinical Interpretation and Response
- Consistent communication with the patient
- H.A. Panel Management
- High-Risk Care Coordination Assignment
Purposefully and actively remove barriers for your patients

MAT for OUD in Primary Care is manageable and rewarding

Understand where your practice fits within the “Cascade of Care” for SUD patients

Population segmentation- Utilize clinical tools to reduce barriers and provide a safety corridor for patient care