Duke
MARGOLIS CENTER
for Health Policy

Session IV—
Future Directions for Treatment for Opioid User Disorder:
Defining Success and Identifying Outcomes that Matter

Moderator: Gregory Daniel, Duke-Margolis Center for Health Policy

Panelists:

Alexander Walley, Boston Medical Center & Boston University School of Medicine

Sarah Hudson Scholle, National Committee for Quality Assurance

Mady Chalk, The Chalk Group

Shawn Ryan, BrightView

Join the conversation at **#OUDTreatment #EndTheStigma**

Polling Question #5

What patient treatment outcome might be considered the most meaningful for OUD treatment? (Choose the best answer)

a) Continued abstinence
b) Decreased illicit substance use
c) Reduction in patient symptoms
d) Patient functionality and well-being (e.g., ability to hold a job, social functioning)
e) Reduction in harmful health outcomes (e.g., transmission of infectious diseases, ED admissions)
f) Other

In person attendees—participate by entering the following URL into your web browser on your phone or laptop: **http://bit.ly/dukemargolis**
Webcast—participate via chat box at the bottom right of your screen.

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Session IV: Future Directions for Treatment for Opioid Use Disorder: Defining Success and Identifying Outcomes that Matter

at

Expanding Access to Effective Treatment for Opioid Use Disorder: Provider Perspectives on Reducing Barriers to Evidence-Based Care

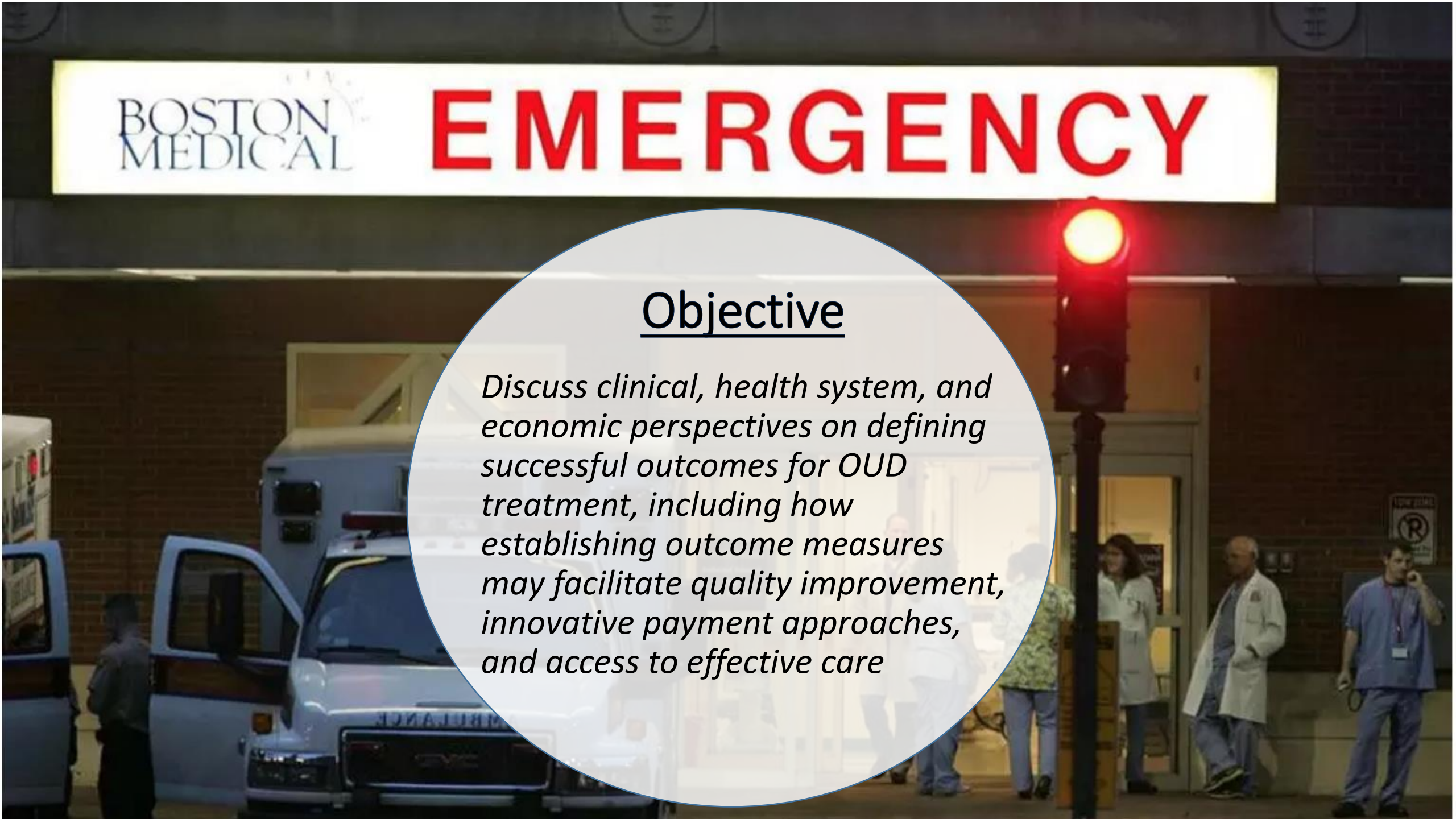
Alexander Y. Walley, MD, MSc

Associate Professor of Medicine, BUSM

Director, Addiction Medicine Fellowship, BMC

Medical Director, Opioid Overdose Prevention Pilot Program, MDPH

September 20, 2018

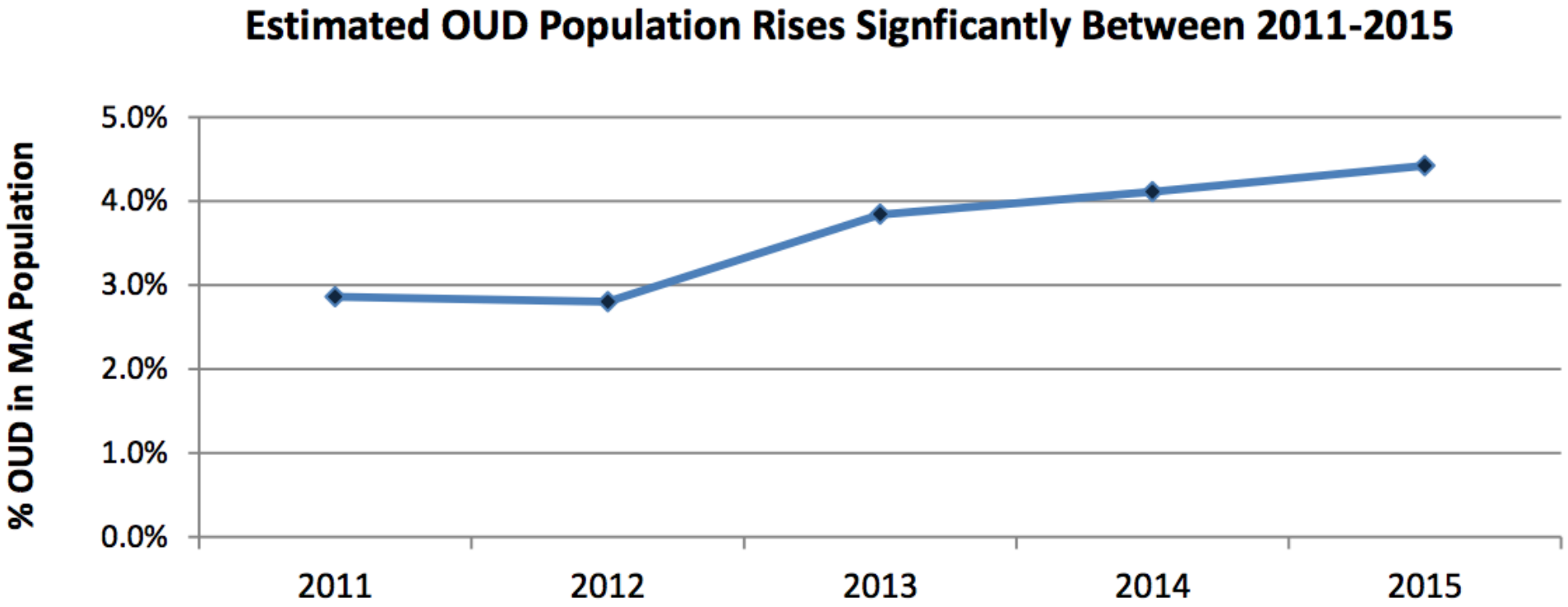


Objective

Discuss clinical, health system, and economic perspectives on defining successful outcomes for OUD treatment, including how establishing outcome measures may facilitate quality improvement, innovative payment approaches, and access to effective care

4.4% (~300K) of Massachusetts adults have opioid use disorder

- Using capture-recapture methods of 7-linked datasets with 45+% known



National survey estimate of OUD prevalence is **0.6%** = 2.1 million/326million adults in 2016

- newsletter.samhsa.gov/2017/10/12/samhsa-new-data-mental-health-substance-use-including-opioids/

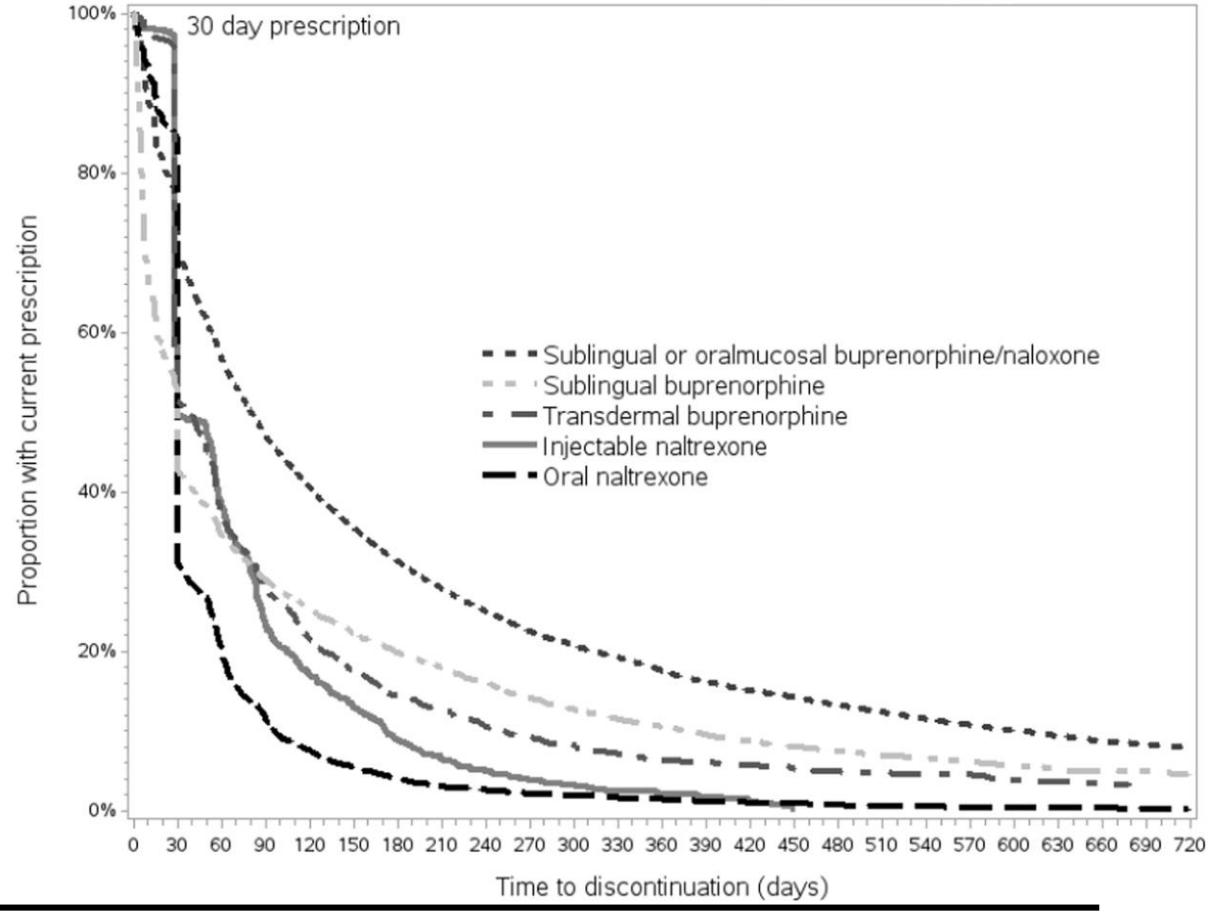
www.mass.gov/files/documents/2017/08/31/data-brief-chapter-55-aug-2017.pdf

Treatment has not kept pace with incidence

Discontinuation is common, especially with naltrexone

2010-14 claims database of >200 million commercially insured in US

- 4-fold-increase in OUD dx
  - 0.12% → 0.48%
- BUT, proportion treated decreased
  - 25% → 16%



Morgan JR, Schackman BR, Leff JA, Linas BP, Walley AY. Injectable naltrexone, oral naltrexone, and buprenorphine utilization and discontinuation among individuals treated for opioid use disorder in a United States commercially insured population. JSAT. 2017 Jul 3.

We are missing opportunities to engage people in prevention and treatment

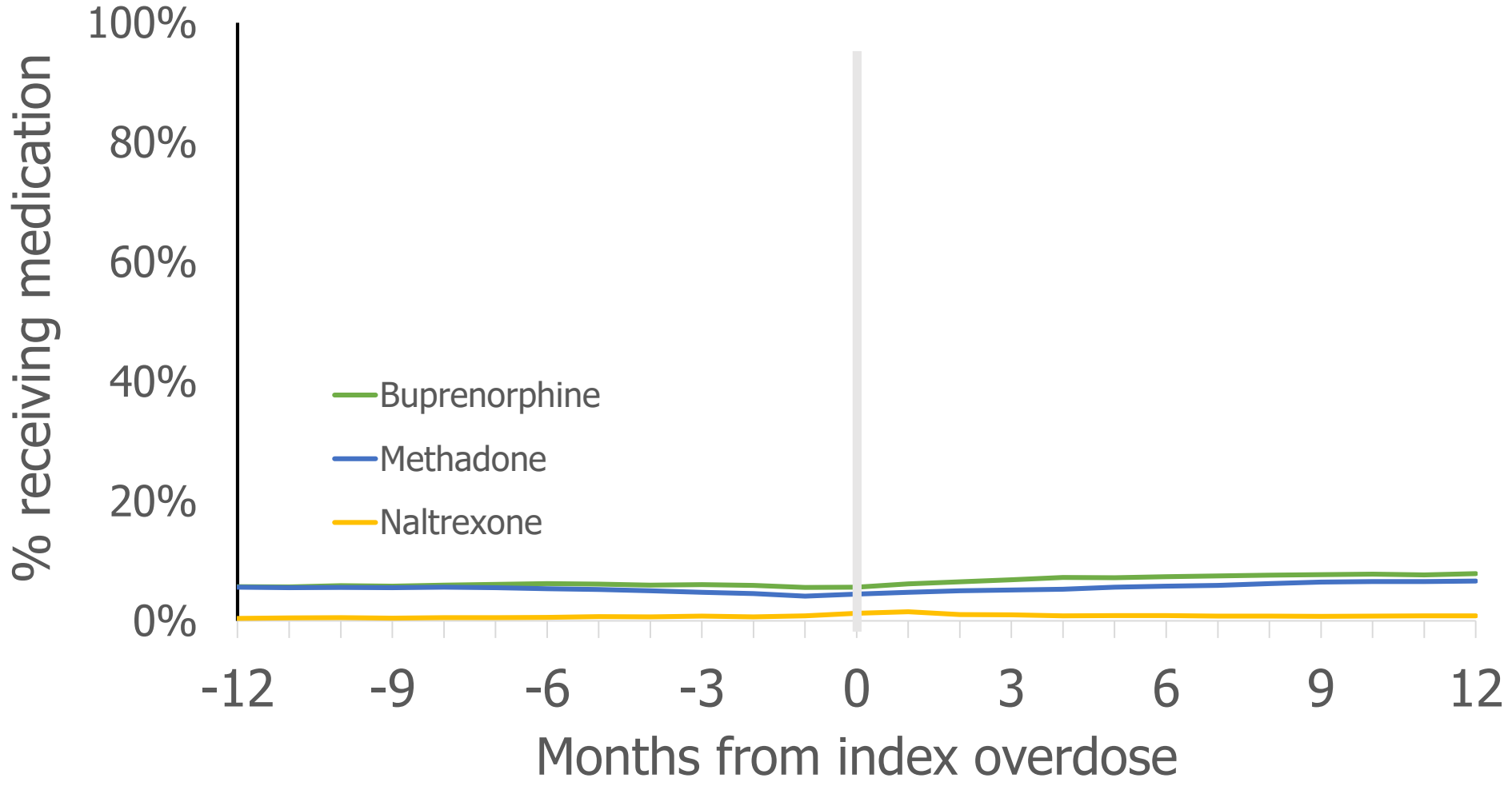
***Touchpoint - Our DEFINITION*:**

A health care, public health, or criminal justice encounter to:

- identify individuals at high-risk for opioid overdose death
- deliver harm-reduction services, and/or
- engage in treatment.

After overdose, few survivors receive medications for OUD

Cohort of 17,755 overdose survivors in MA, 2012-2014



Larochelle et al. Annals IM – *In press*

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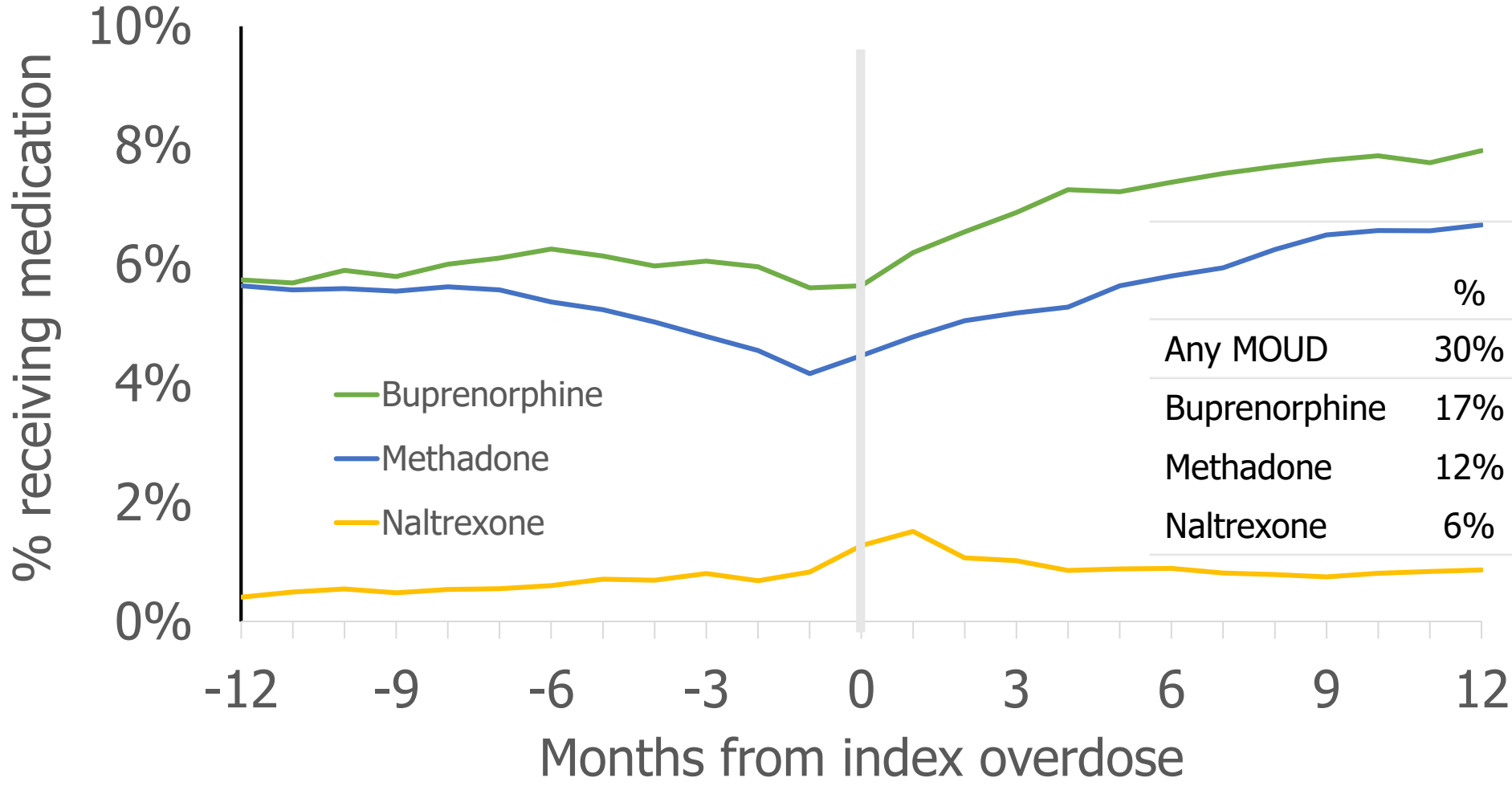

	%	Months Received (median [IQR])
Any MOUD	30%	
Buprenorphine	17%	4 [2,8]
Methadone	12%	5 [2,9]
Naltrexone	6%	1 [1,2]

Larochelle et al. Annals IM – *In press*

Overdose survivors who receive medications have better survival

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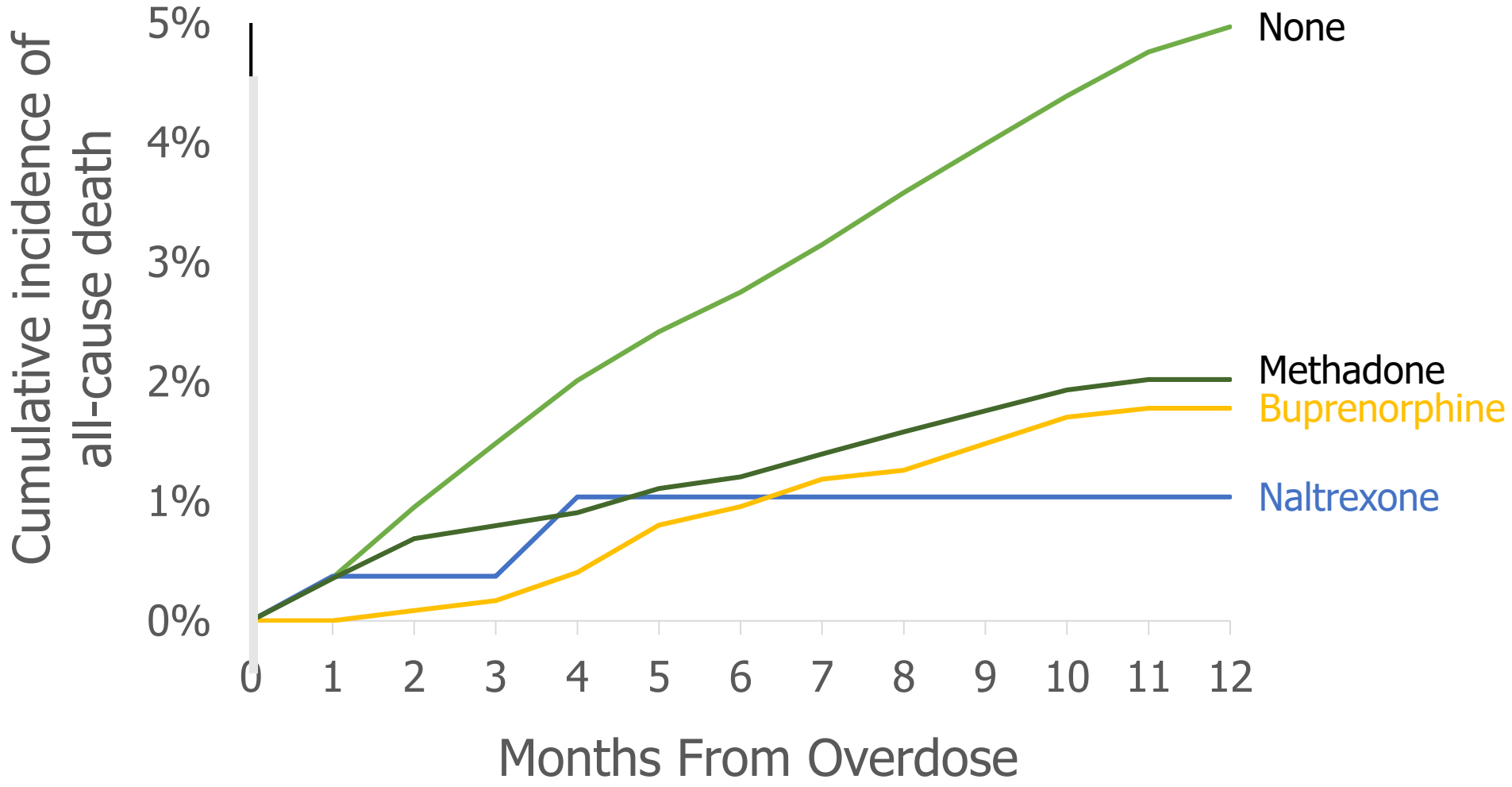

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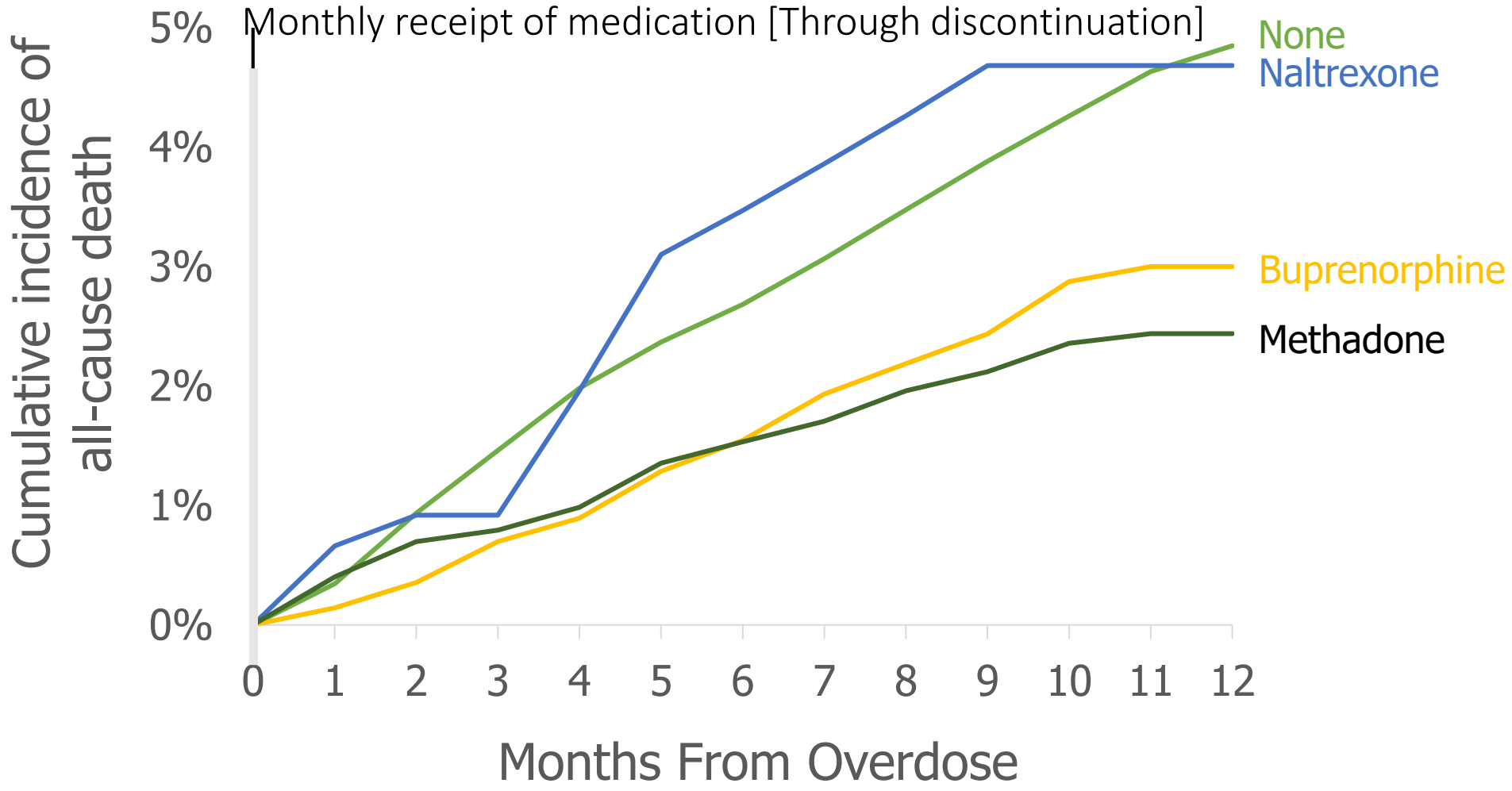


Larochelle et al. Annals IM – *In press*

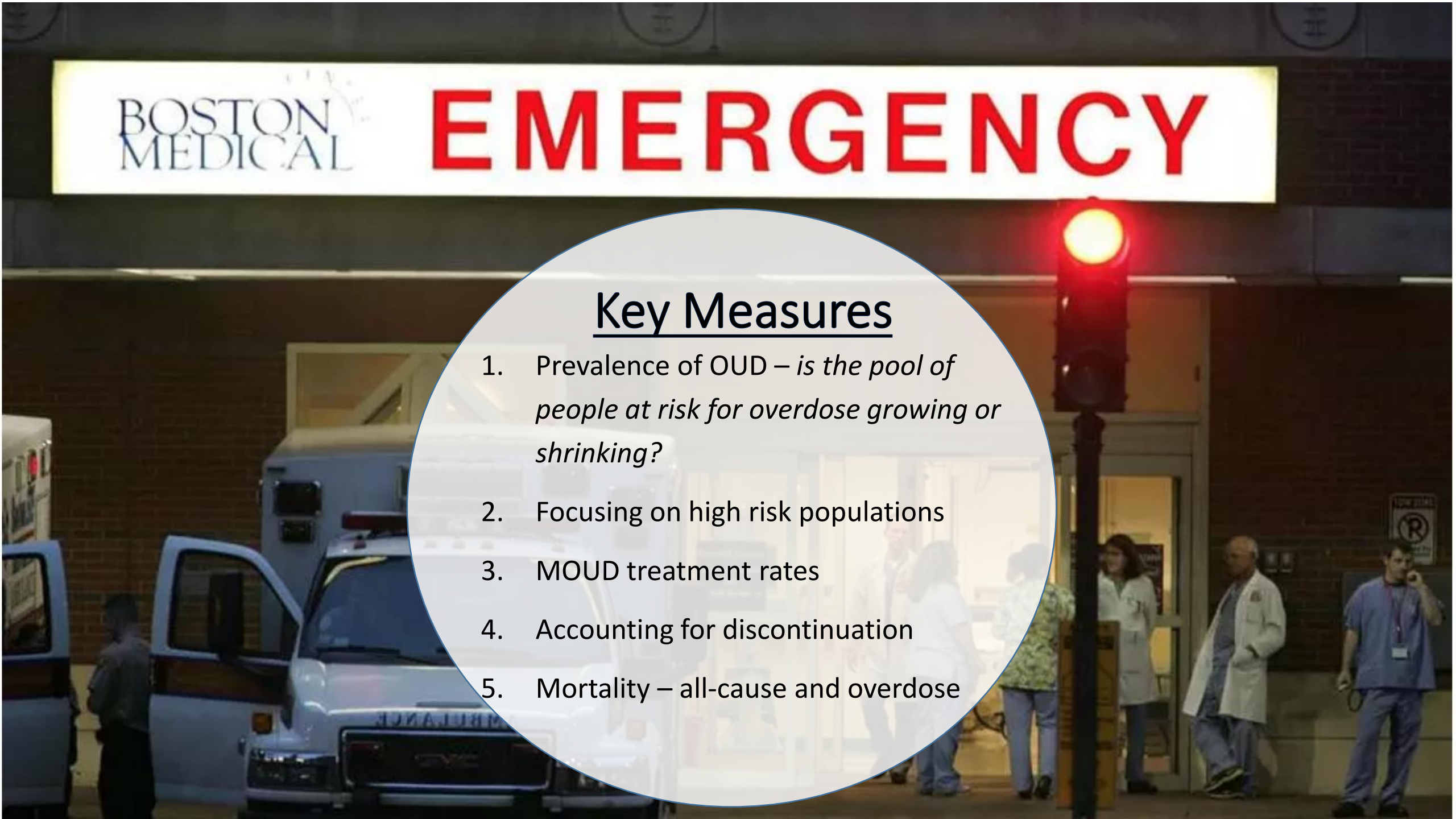
***Touchpoint - Our DEFINITION*:**

A health care, public health, or criminal justice encounter to:

- identify individuals at high-risk for opioid overdose death
- deliver harm-reduction services, and/or
- engage in treatment

Examples:

- Non-fatal overdose
- Detox treatment
- Hospitalization
- Incarceration
- High risk prescription



Key Measures

1. Prevalence of OUD – *is the pool of people at risk for overdose growing or shrinking?*
2. Focusing on high risk populations
3. MOUD treatment rates
4. Accounting for discontinuation
5. Mortality – all-cause and overdose

awalley@bu.edu

CARE

Grayken Center for Addiction
Boston Medical Center

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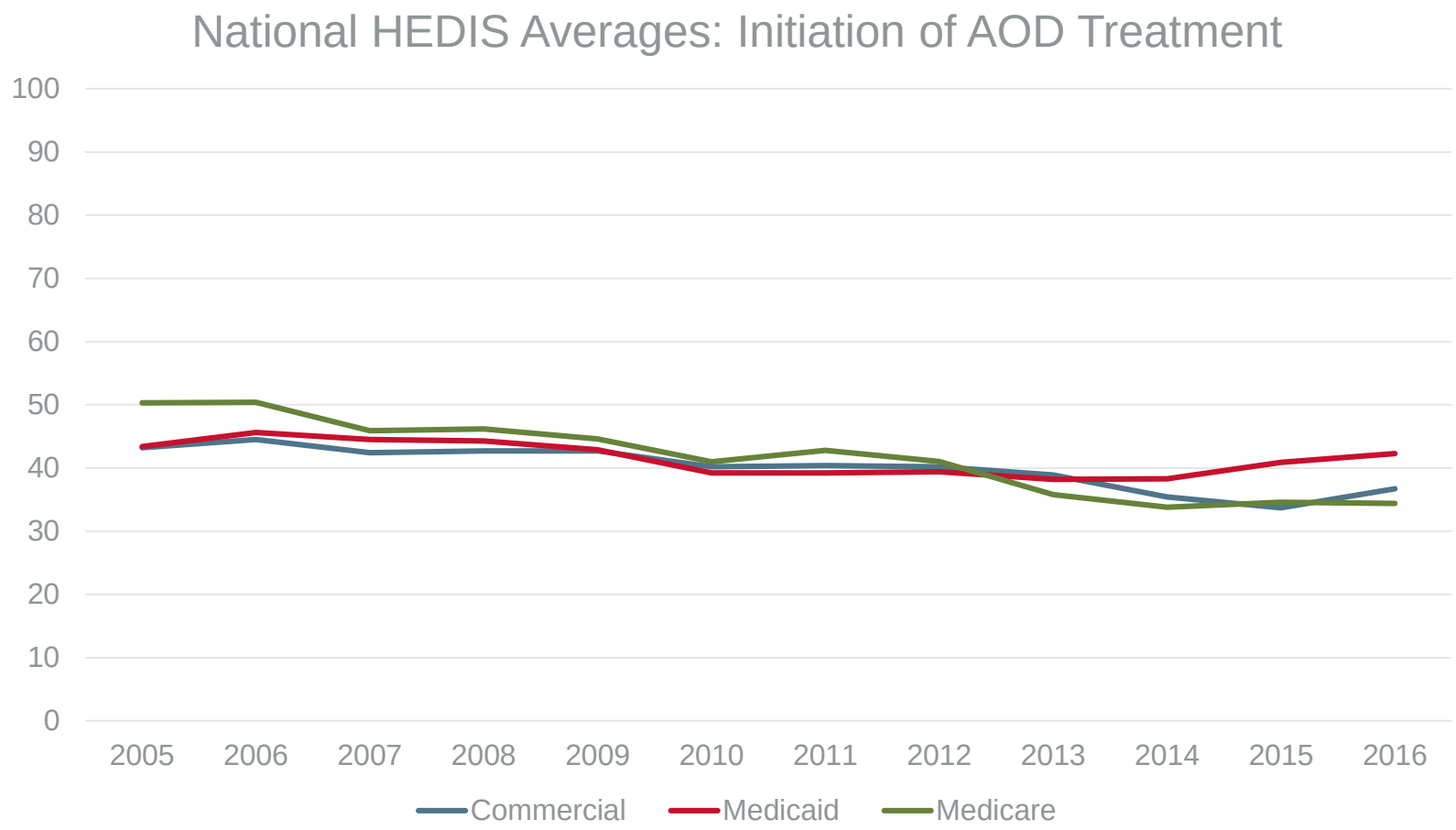
Improving Outcomes for Addiction

Sarah Hudson Scholle, MPH, DrPH

Expanding Access to Effective Treatment for Opioid Use Disorder:
Provider Perspectives on Reducing Barriers to Evidence-Based Care
September 20, 2018

Initiation of Addiction Treatment

Low performance and little improvement



National Committee for Quality Assurance. (2017). *The 2017 State of Health Care Quality Report.* Washington, DC: NCQA.

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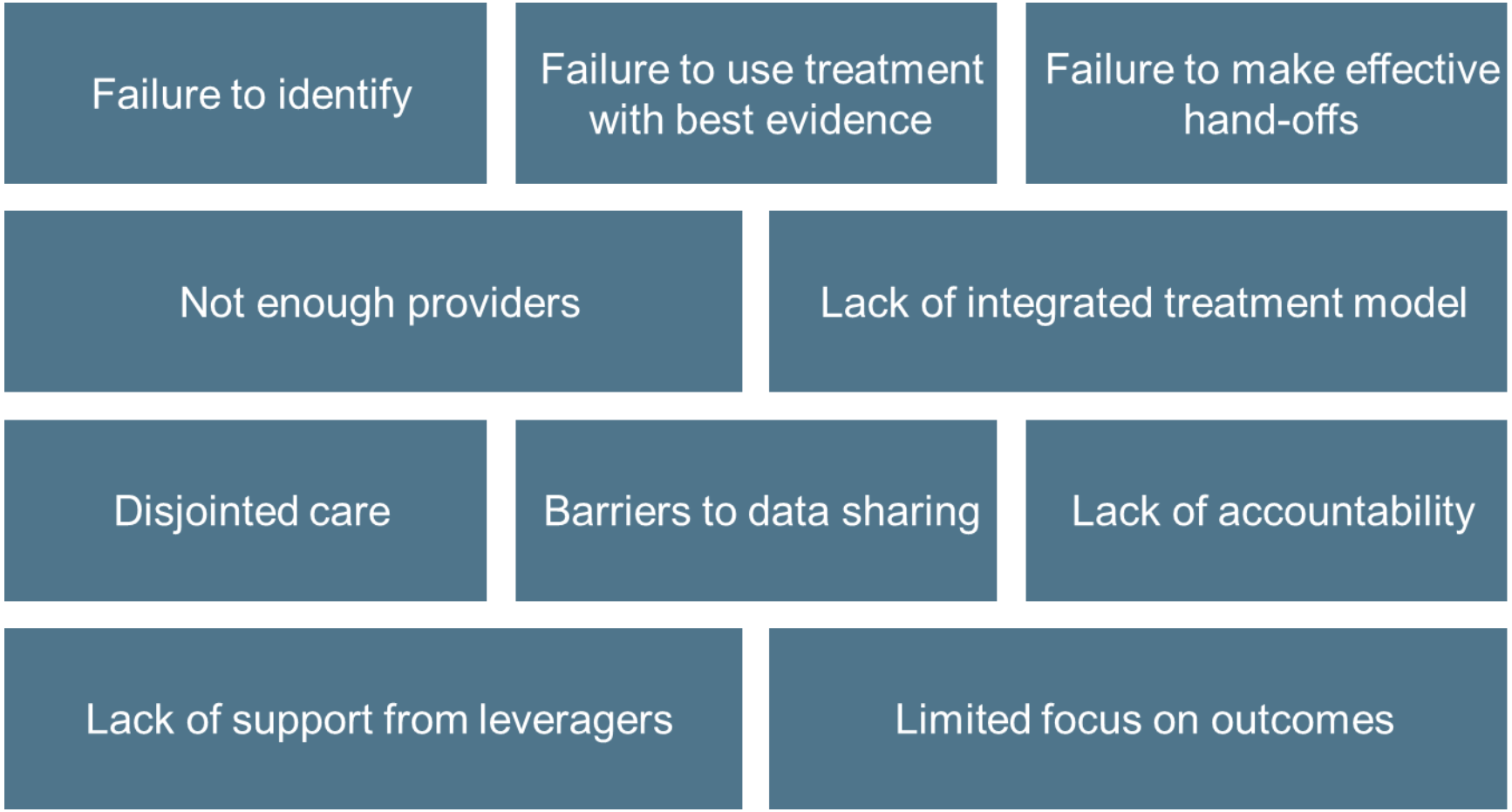
Challenges to Improving Addiction Treatment



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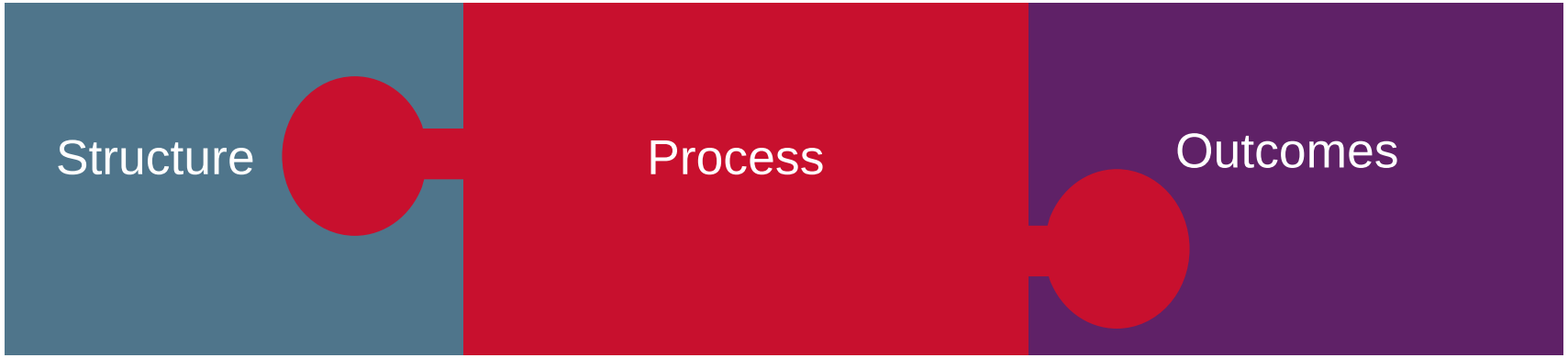
Improving Addiction Care through Quality Measurement

Present State

Structural evaluation and claims-based process measurement

Future State

Registry-enabled outcomes measurement and data linkage



Structure measures lay the foundation for quality

Limited number of process measures with strong evidence that can be assessed using existing claims data

Focus on outcomes important to patients and families

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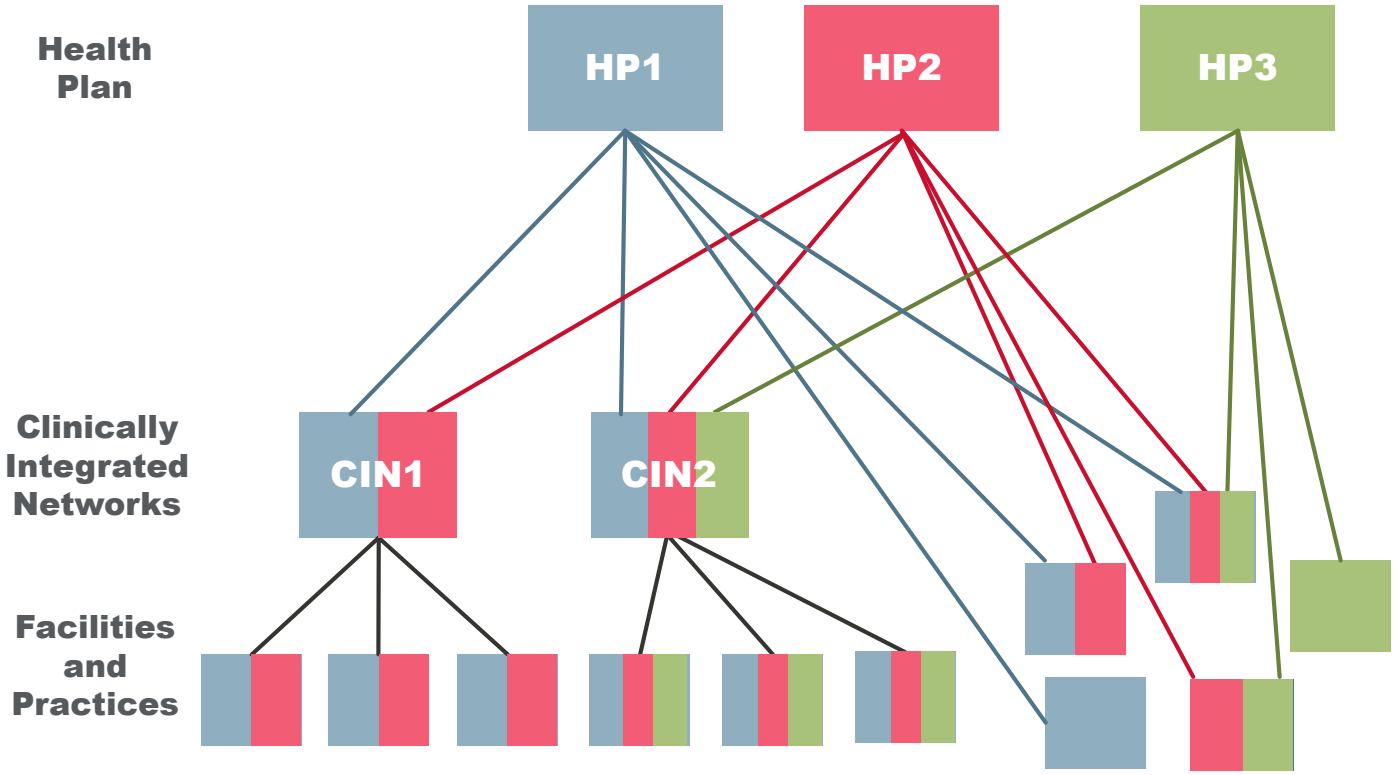
Improving Quality Requires Efforts at Multiple Levels



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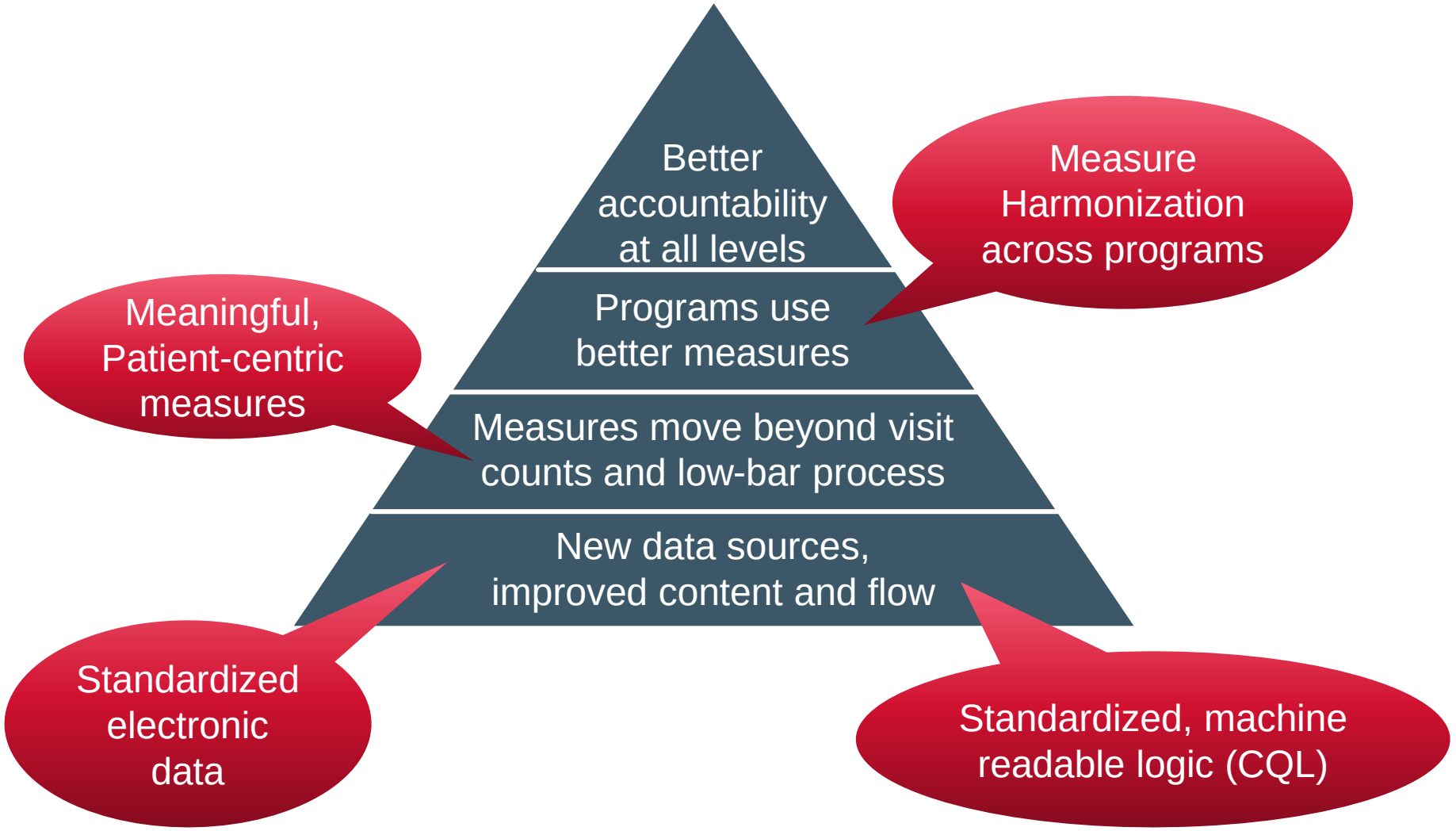
Vision for Quality Measurement

Guiding principles



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For more information: Scholle@ncqa.org

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FUTURE DIRECTIONS: DEFINING SUCCESS AND IDENTIFYING OUTCOMES THAT MATTER

Duke Center for Health Policy
Mady Chalk, Ph.D., MSW
The Chalk Group
September, 2018

CURRENT STATE OF MEASUREMENT

Keeping in mind that the ultimate goal of measurement is to improve access to care, treatment of patients and their families, and recovery the current state of measurement is not very assuring:

- Paucity of Measures
  - AHRQ and NQF databases include 3,000 measures of which for SUD and OUD there are 7 process measures focused on service delivery and 1 outcome measure
- Framework
  - Framework in current use (process, structure, outcome) tends to support individual process measures that do not afford us the detail needed to track patient progress into and through treatment and recovery, and across systems

CURRENT STATE OF MEASUREMENT

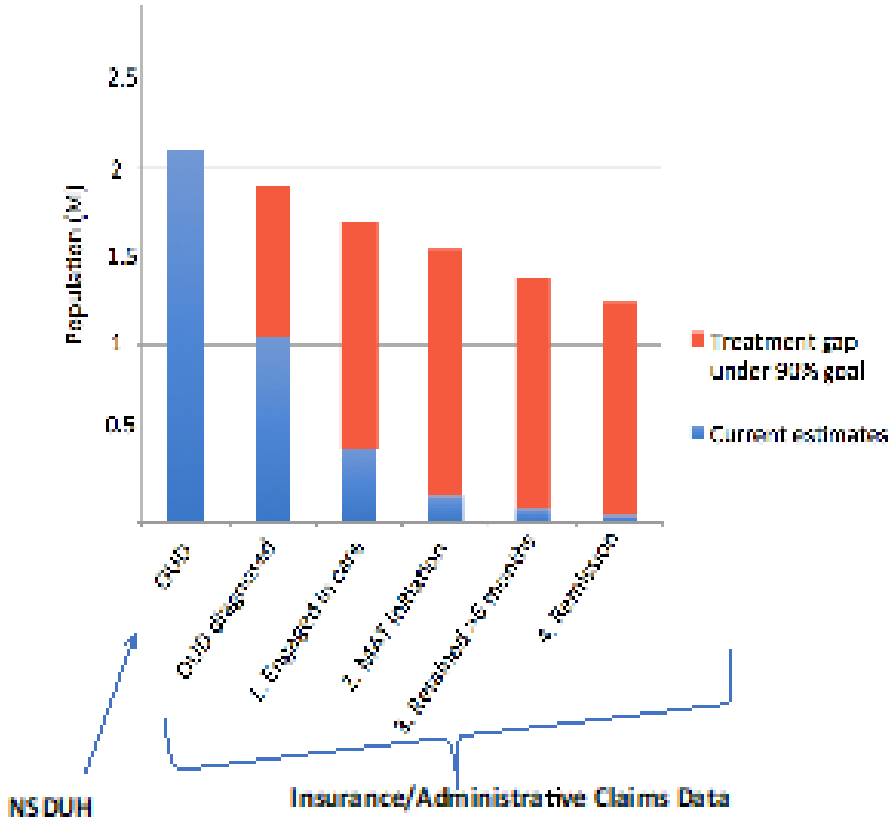
- Implementation of Measures and Use of Incentives
  - Reporting is at very low levels, no less use of measures for quality improvement at the provider level
- Accountability Structures
  - Simply requiring that plans and providers implement measures and report seems not to be producing the results we expect – do we need new accountability structures?
- Quality Improvement Processes
  - Currently, from identification through initiation to engagement there is low or no identifiable improvement at the health plan level whether public or private

A NEW FRAMEWORK for MEASUREMENT

The “Cascade of Care” for Substance Use and Opioid Use Disorder:

The Cascade of Care offers a model/framework that provides an opportunity to establish goals toward recovery, make comparisons both over time and in various settings to trend outcomes, identify critical gaps in care and resulting disparities, and develop systems improvement interventions.

THE CASCADE OF CARE



CASCADE OF CARE

- Key Stages for Measurement of Progress Toward Recovery
  - Identification, including at risk populations
  - Diagnosis among those identified
  - Engagement in treatment among those diagnosed – including tracking patients throughout care
  - Medication initiation among those entering care (an EBP)
  - Retention/continuity of medications (including clinical services) for at least six months for those with OUD (N.B. duration in care is the single treatment factor that most determines improvement for SUD/OUD outcomes)
  - Remission/recovery

IMPLEMENTING THE “CASCADE”

- There are a number of challenges in implementing the Cascade for SUD/OUD such as the available data sources and settings in which measurement can occur; nevertheless, setting systemic performance goals and measuring progress across multiple systems is too important to allow these limitations to prevent a beginning.

- Patching the leaks in the Cascade may require new interventions and new partnerships and/or the re-conceptualization of how services are integrated and linked with other services. It may also involve changing how services are evaluated.

ALTERNATIVE PAYMENT SYSTEMS TO IMPROVE QUALITY OF CARE

- The goal of value-based payment for SUD/OUD is to improve access to care and, in treatment, to improve the quality of care patients receive leading to more positive outcomes
- Encouraging plans to implement pay for reporting and pay for performance and to identify contract language focused on SUD/OUD can improve provider use of measures and ultimately to improve treatment and recovery
- Some examples:
  - Integrated primary care
  - Bundled services and costs to improve quality and accountability
  - Health homes for opioid dependency with incentive payments
  - Pay for reporting and performance

ALTERNATIVE PAYMENT SYSTEMS: SOME EXAMPLES

- **Bundling Services for MAT**

  - Increasing access to medications for treatment of addictions rests heavily on our ability to support physicians and patients throughout care
  - Administrative and clinical services and supports are built into bundled services arrangements from assessment through induction to maintenance in all settings
  - Bundled arrangements include linking patients to the services they need to adhere to medications and to maintain clinical and medical routines

ALTERNATIVE PAYMENT SYSTEMS

- **Health Homes for Individuals with Opioid Use Disorders Using Incentive Payments**
  - For individuals who are have opioid use disorders AND are at risk or have at least one other chronic medical condition
  - Clinical settings including comprehensive treatment settings and Opioid Treatment Programs (OTPs) are incentivized to provide assessment and intensive treatment servicies including induction, administration and monitoring of medications, counseling, clinical management , and monitor treatment progress on a continuing basis
  - Incentives are provided to assist patients to become engaged with primary care physicians to receive treatment of other chronic and health conditions on an ongoing basis

ALTERNATIVE PAYMENT SYSTEMS

- **Pay for Reporting and Pay for Performance-Tying Payments to Quality**
  - Step One - incentive payments are provided to improve use of measures and reporting and using measures to better understand and design interventions to improve access and linkage to treatment; without measurement we cannot design systems interventions to improve early intervention and treatment
  - Step Two – incentive payments and contract language are used to require implementation of evidence-based practices, including use of medications in treatment, medication adherence, and support for transitions in care
  - Step Two - prospective, population-based payments are used to provide comprehensive care and create integrated systems in primary care

ACCOUNTABILITY STRUCTURES

- Accountability for measurement and reporting at the population and patient level is currently fragmented despite best efforts

- We currently have little ability to enforce the use of measures and reporting; to require quality improvement planning at the provider level or to design systems improvement strategies at the health plan level whether public or commercial

- We need to create accountability structures, including public reporting in order to make progress

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BrightView
[Patient-focused, evidence-based, addiction treatment]
Shawn A. Ryan, MD, MBA
President & Chief Medical Officer
Chair of Payer Relations, ASAM

Agenda

- The Issue

- PCOAT (Patient Centered Opioid Addiction Treatment)
  - ASAM/AMA Alternative Payment Model

- Focusing on Patient Access to Evidence-Based Treatment

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THE ISSUE

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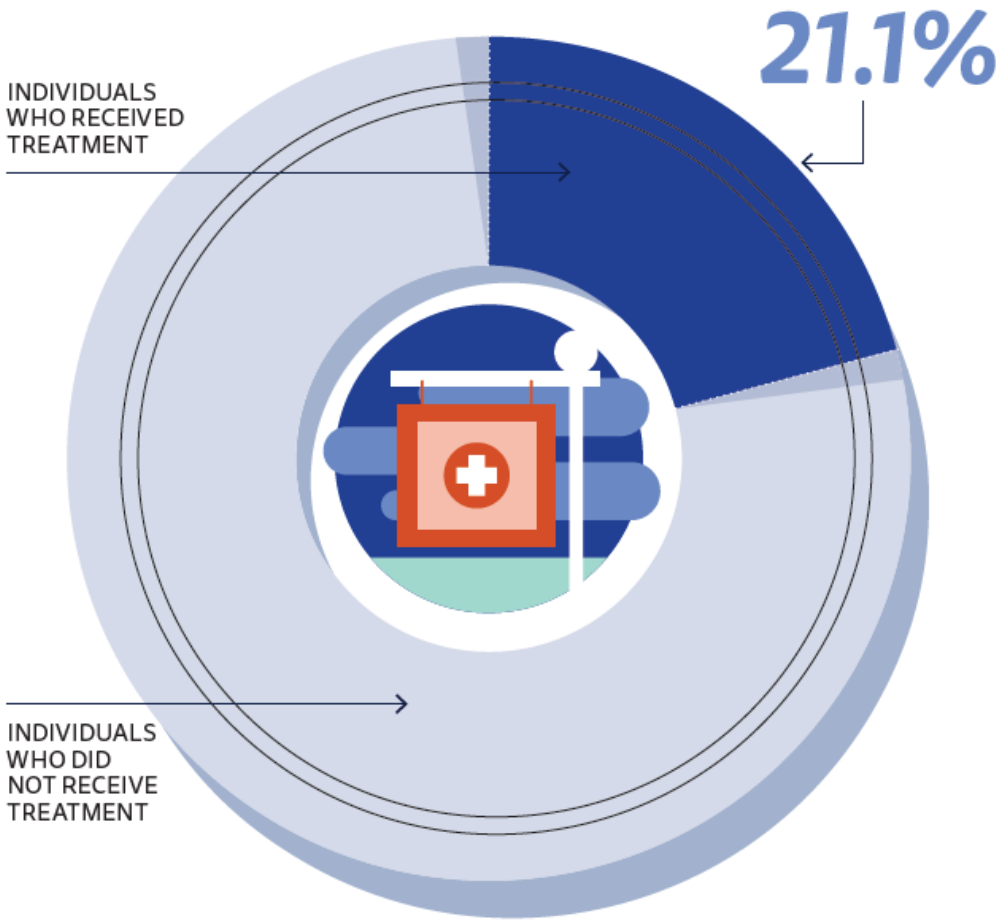
THE ISSUE

2.1 Million with OUD



Only 1 in 5 individuals with an opioid use disorder (OUD) received speciality treatment for illicit drug use

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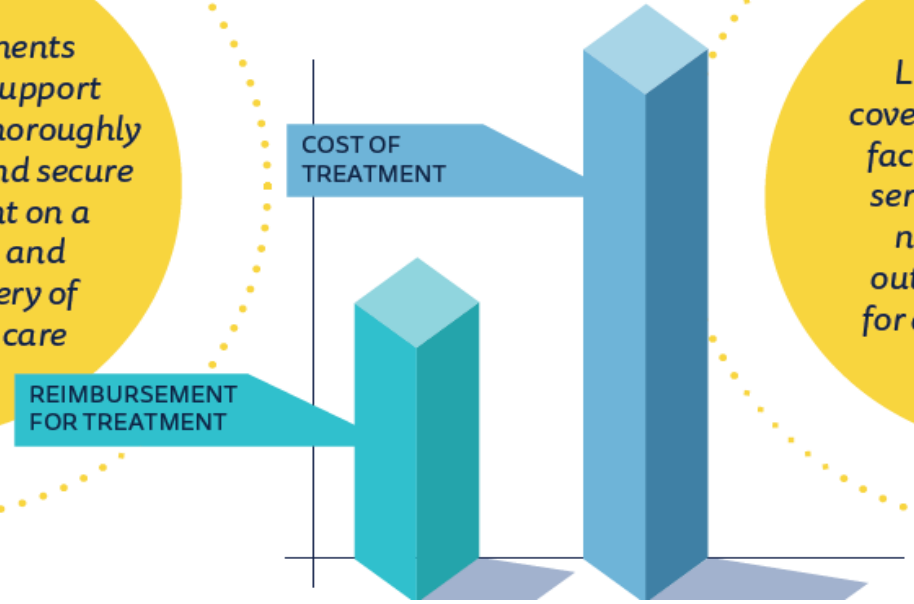
EXISTING HEALTHCARE PAYMENT SYSTEM BARRIERS TO HIGH-QUALITY CARE

One of the biggest barriers to the successful treatment of patients with OUD and contributors to the underutilization of medication in combination with medical services, and psychosocial supports is the existing healthcare financing system for outpatient treatment for addiction involving opioid use.

Some of these systemic problems include:

Unnecessarily complex and ever-changing billing for face-to-face services in a piecemeal way under the existing payment infrastructure

Insufficient payments for office visits to support the time it takes to thoroughly diagnose, develop and secure patient agreement on a treatment plan, and coordinate delivery of evidence-based care



Limited insurance coverage of non-face-to-face and non-medical services that patients need to succeed in outpatient treatment for addiction involving opioid use

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PCOAT: ASAM/AMA APM

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PCOAT: ASAM/AMA APM

- Focused on delivery of the Evidence-Based Biopsychosocial Model including the following components
  - Medical care (including MAT for OUD)
  - Psychological therapies when indicated
  - Social interventions as necessary

- Other key areas of focus include
  - Improved reimbursement for complex patient care, especially when delivered by an appropriately constructed multi-disciplinary team
  - Reduction in administrative burden including paperwork and prior authorizations; also reduction in co-pays for patients

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THE MODEL

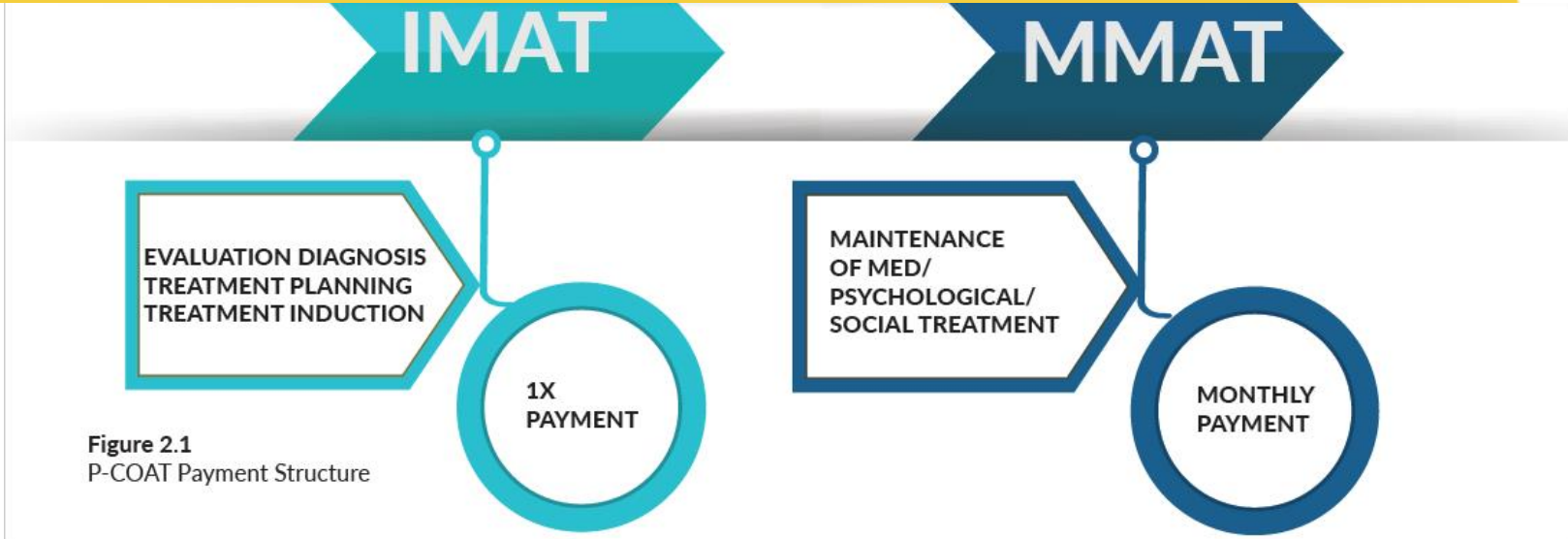

Figure 2.1
P-COAT Payment Structure

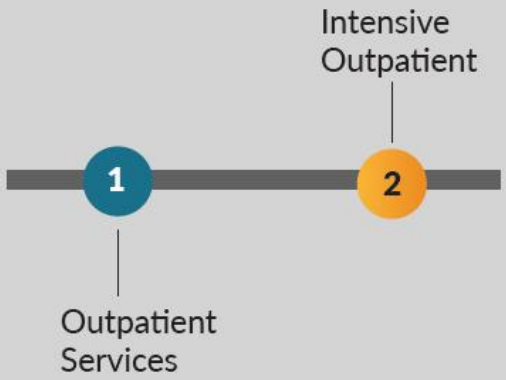

Figure 3.1
ASAM Levels of Care
Addressed by P-COAT

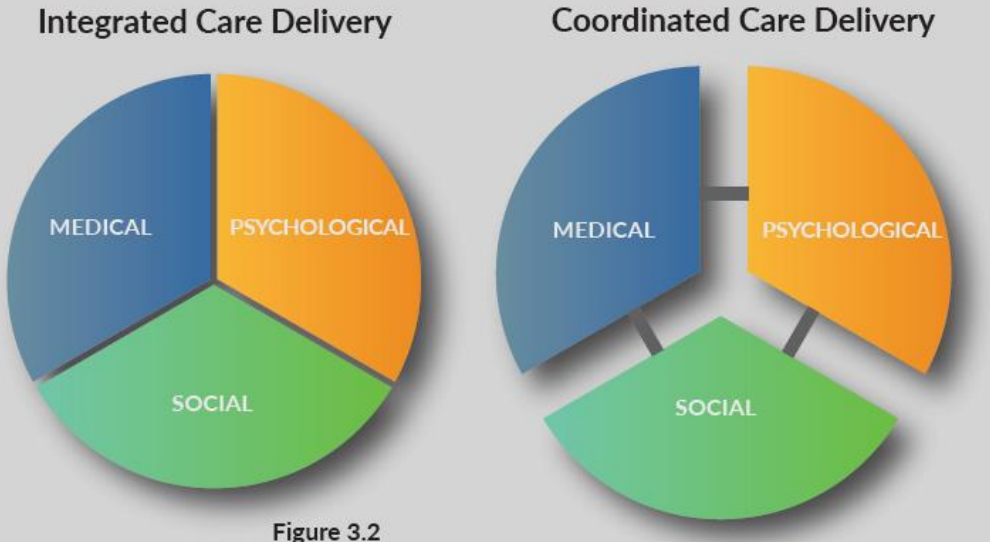

Figure 3.2
Treatment Delivery Structures

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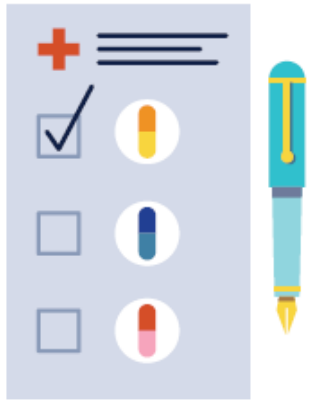
Measurements of Quality

Treatment Measure #1:

% of patients who filled and used prescribed medications throughout the month (except for patients who terminated treatment through a supervised process)



Treatment Measure #2:

% of patients who demonstrated compliance by only taking medications that are part of the written treatment plan at the end of the month (as seen in testing and testing claims data)

Utilization of Services Measure #1:

% of patients whose opioid and other drug-related laboratory testing during initiation of treatment is consistent with evidence-based widely used documents, such the ASAM Appropriate Use of Drug Testing Document

Utilization of Services Measure #2:

Risk-adjusted average number of opioid-related emergency department visits per patient

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Pay for Performance

The performance of treatment teams is assessed and payments are adjusted based on performance.

PAYMENT STRUCTURE	RISK ADJUSTMENT
IMAT & MMAT	Good performance = Avg. performance on a measure within 2 standard deviations

IMAT & MMAT RISK ADJUSTMENT	PERFORMANCE ON TREATMENT MEASURES		
Performance on Utilization of Services	Poor	Good	Excellent
Poor on Either	-4%	-2%	0%
Good on Both	-2%	0%	+2%
Excellent on 1, good on other	0%	+2%	+4%

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PATIENT ACCESS

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PATIENT ACCESS

- Back to the most important focus – PATIENT ACCESS TO EVIDENCE-BASED TREATMENT FOR OPIOID USE DISORDER

- There currently are not nearly enough trained professionals who can provide biopsychosocial treatment including MAT
- Payment models must be improved to support the coordinated care of complex patients

IMPROVED REIMBURSEMENT AND LOWER ADMINISTRATIVE BURDEN WILL RESULT IN THE DEVELOPMENT OF TREATMENT ACCESS

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