Medication-Assisted Treatment (MAT) in Serving the Rural Community and Improving the Systems of Care for Opioid Use Disorder

Safina Koreishi MD MPH
Medical Director, Columbia Pacific CCO
The opioid epidemic

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

Opioid Overdose Data

**Columbia:**
- 7.7 deaths per 1000
- 11 deaths total

**Tillamook:**
- 14.1 deaths per 1000
- 18 deaths total

**Clatsop:**
- 5.8 deaths per 1000
- 11 deaths total

**Statewide:**
- 6.8 deaths per 1000
- 22.49 hospitalizations per 1000
- 1,356 deaths
- 4,542 hospitalizations

**Columbia, Clatsop & Tillamook (combined):**
- OHA Q4 Data: 255 Rxs per 1000
- CPCCO Q4 Data: 178 Rxs per 1000

Source: OHA Data Dashboard
Time-Frame: 2013-2017
A Journey towards Addressing the Opioid Epidemic

2013:
- Community meetings with providers to opioid prescribing
  - "If we had an alternative place to refer, we could do it."
- CPCCO promoted best practice guidelines, <120 MED

2014:
- CPCCO started the North Coast Pain Clinic in Astoria, OR
  - Behavioral-based pain clinic, 10-week group classes

2015:
- Pain Clinics expanded to Tillamook & Columbia Counties
- Multidisciplinary community meetings in each county to discuss shared vision & how to move forward collectively
- Benefit expansion: acupuncture for chronic pain & increase PT
- End of 2015: Pulled data... ➔ no improvement

2016:
- Clinical Advisory Panel task force and regional goal development
- First regional opioid summit ➔ collective community action
- Steering committee formation

2017
- Organizational trainings and dashboard sharing
- Summit-MAT
- Increased focus on building OUD treatment services
- Needle exchange program

2018
- Expanding access to OUD treatment
- Summit-SUD/MAT/TIC/Law enforcement
- Continued data sharing, more targeted

2019
- Acute prescribing
- High risk strategy
- Overdose taskforce
- Summit
Addressing the opioid epidemic through multifactorial system of care

Regional Opioid Model of Care

Non-pharmaceutical Treatments
- Behavior-based pain clinics
- Acupuncture coverage
- CBT / Behavioral health
- PT benefit
- Yoga resources

Pharmacy
- Taper plan education
- Drug take backs
- Naloxone
- Data / Opioid risk score

Addictions Treatment
- Detox Center
- Naloxone
- Medication Assistance Treatment

Health Care Providers
- Prescribing guidelines
- Opioid dashboard
- Community of practice
- ED / Surgeons / Dentists
- Coiling dose and tiered goal
- Changing paradigm of chronic pain
- Clinical up-skilling

Community
- Social Marketing
- Community events
- Awareness of risks
- Community action

Public Health
- Needle exchange programs
- Naloxone
- Social marketing
- OPDMP grant

Behavioral Health
- Integrated behaviorist
- Increasing access to specialty mental health
- Crisis respite
- Community Action
Systems Approach

• **Provider level:**
  • Provider training and pledge, clinical support for tapering and difficult conversations, updated opioid prescribing guidelines, clinical wellness, academic detailing

• **Organization level:**
  • Technical assistance re: clinic work flows, team based care, integrated BH, risk stratification, opioid dashboards and data

• **Community level:**
  • Regional steering committee, county-level work groups, local non-profit organizations, public health efforts

• **Benefit level:**
  • Funded behavior-based pain clinic; acupuncture benefit, expanded PT and chiropractor benefit, prior authorizations, benefit restrictions

• **State level:**
  • Restrictions on coverage for non-indicated conditions (low back pain), and expanded coverage for non-pharmaceutical treatments, PDMP, Acute prescribing
Strategy to Achieve Goal-
Collective Community Impact

• North Coast Opioid Summit: April 2016, 2017 and 2018
  • Over 250 people gathered to collectively discuss this issue
• North Coast Regional SUD Steering Committee
  • Improved Clinical Prescribing
  • Expanding Access to Treatment for Opioid Use Disorders
  • Naloxone
  • Better Disposal of Pills
• Community Education Campaign
• 2018- transfer to local public health
Improving Prescribing Practices

• Early 2016: CPCCO Clinical Advisory Panel (CAP) review of:
  • Population-level and clinic-level data
  • Current evidence on harms and benefits of opioids
• CAP developed evidence-based regional goals
• CAP advised strategy to achieve goals
Strategy to Achieve Goal: Clinical Data and Prescribing

• Training and support for prescribing clinics/organizations:
  • Primary care, ED, urgent care, surgeons, specialists, dentists
  • Commitments to meet MED goals and pledge
  • Updated CPCCO guidelines
  • Registration and training for OPDMP
  • Regional quarterly Community of Practice meetings

• Highlight & spread knowledge of non-pharmacologic options/evidence-based treatments:
  • BH-based pain clinics
  • BH integration
  • Acupuncture, chiropractor, PT

• Assist organizations with polices and procedures
• Dashboards and data
Sharing data: Organization Level
Getting more targeted: Provider level

Step 1. Sharing prescriber info

Step 2. Tracking provider patterns

Step 3. Top Prescriber Letters And Audit
Getting more targeted: Patient Level

Step 1. Claims analysis to detect potential misuse, risk stratification by dose and concomitant medications

Step 2. Individualized patient plans (Audit)

Step 3. Work with community and clinic teams to execute plan
### OPIOID THERAPY AUDIT

Return completed form with chart documentation to opioidaudit@careoregon.org

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Prescriber Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID #:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Patient DOB:</td>
<td>Clinic Name:</td>
</tr>
<tr>
<td>Prescriber Contact Person:</td>
<td>Prescriber Office Phone:</td>
</tr>
</tbody>
</table>

#### Current Opioid Medication Regimen (including strength and directions)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Acute Use or Chronic?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute with specified duration (define):</td>
</tr>
<tr>
<td></td>
<td>Chronic (no planned end date)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Taper?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes (state taper plan goal and timeline):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tapering more difficult than planned? Explain</th>
</tr>
</thead>
</table>

#### Past Pain Therapy Trials?

| Has the member actively participated in non-pharmacological interventions? |
|-------------------------------|------------------|
| Examples: Physical activity/exercise, acupuncture, yoga, group support classes |
| Risk of abuse (DOT, CAGE-AD, SOPH-R, COMM, DIB, CRE, and AUDIT) |
| Risk of respiratory adverse events |
| Mental Health/Depression Screening (PHQ-9, GAD-7, PC-PTSD or mental health evaluation) |
| Urine drug screen |
| POMR Reviewed |

| Has the member demonstrated functional improvement while on opioids? |
|-------------------------|------------------|
| Examples include PEG, PFO, and PDI questionnaires. Alternatively: documentation of changes from baseline functional status. |

#### Co-prescribing naloxone: Evidence has shown a significant reduction in overdose events when high-risk opioids are co-prescribed with naloxone. Please document if any of the following high-risk scenarios apply if naloxone has been co-prescribed.

<table>
<thead>
<tr>
<th>High risk scenarios for opioid overdose (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid dose ≥ 50 MED</td>
</tr>
<tr>
<td>Comorbid respiratory condition (such as sleep apnea, COPD)</td>
</tr>
<tr>
<td>Concurrent benzodiazepines, sedatives, or alcohol use</td>
</tr>
<tr>
<td>Active tapering chronic opioids</td>
</tr>
<tr>
<td>History of Overdose</td>
</tr>
<tr>
<td>Recent release from institution requiring abstinence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Naloxone (Nasal, Nasal or injectable naloxone) Prescribed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

Prescriber Signature: Date:

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return FAX) immediately and arrange for the return or destruction of these documents.
Chronic Opioid Progress

• Outcome: 60% reduction in number of patients using chronic opioids with dose >50 MED/day
  • Goal for 2018 was a 30% reduction, we saw a 29.2% reduction
  • Interventions:
    • Opioid Prescribing Training
    • Wellness Centers
    • Summit
    • Prescribing Guidelines
    • Dashboards and Patient Lists
  • 2019 Tapering Taskforce
Chronic Users by MED Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Q1 2017</th>
<th>Q2 2017</th>
<th>Q3 2017</th>
<th>Q4 2017</th>
<th>Q1 2018</th>
<th>Q2 2018</th>
<th>Q3 2018</th>
<th>Q4 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic ≥ 50 MED</td>
<td>16.8%</td>
<td>17.3%</td>
<td>15.8%</td>
<td>16.7%</td>
<td>13.2%</td>
<td>13.5%</td>
<td>13.0%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Chronic ≥ 90 MED</td>
<td>10.8%</td>
<td>12.3%</td>
<td>10.2%</td>
<td>10.3%</td>
<td>9.5%</td>
<td>8.0%</td>
<td>8.4%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Chronic ≥ 120 MED</td>
<td>34.1%</td>
<td>35.4%</td>
<td>33.9%</td>
<td>34.1%</td>
<td>32.5%</td>
<td>29.6%</td>
<td>28.5%</td>
<td>27.8%</td>
</tr>
</tbody>
</table>

Q1 2017 to Q4 2018
Chronic & Acute Opioid Users

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Chronic Users</th>
<th>Acute Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2017</td>
<td>659</td>
<td>1497</td>
</tr>
<tr>
<td>Q2 2017</td>
<td>619</td>
<td>1470</td>
</tr>
<tr>
<td>Q3 2017</td>
<td>607</td>
<td>1339</td>
</tr>
<tr>
<td>Q4 2017</td>
<td>592</td>
<td>1273</td>
</tr>
<tr>
<td>Q1 2018</td>
<td>569</td>
<td>1298</td>
</tr>
<tr>
<td>Q2 2018</td>
<td>547</td>
<td>1217</td>
</tr>
<tr>
<td>Q3 2018</td>
<td>523</td>
<td>1129</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>510</td>
<td>1146</td>
</tr>
</tbody>
</table>
Oregon Acute Opioid Prescribing Guidelines

• **Background:**
  • Longer duration of initial prescription associated with higher likelihood long-term opioid use and addiction

• **Goals:**
  • Improve patient safety while focusing on effective and compassionate treatment of acute pain
  • Remove opioids as first line for mild to moderate pain in opioid naïve patients
Whether your patient is 13 or 30, opioids make a strong first impression.

Age matters. Our patients age 10 to 19 are most likely to get their first opioid prescription from our profession.²

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentists</td>
<td>32%</td>
</tr>
<tr>
<td>GP/FM/DO</td>
<td>13%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>12%</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>8%</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>6%</td>
</tr>
</tbody>
</table>

We can reduce the risk.

- One in eight high schoolers report using opioids recreationally.⁷
- Adolescents who are exposed to opioids have a 33 percent higher risk of abusing them later in life.³

We can reduce the supply.

- 41 percent of us expect our patients to have left-over opioid medication.⁴
- Nationally, an estimated 100 million opioid doses go unused for wisdom tooth extractions alone.⁵
Community Education

GOT PAIN?
Get your life back.

staysafeoregon.com

colpachealth.org

Columbia Pacific CCO

Is there a killer in your cabinet?
Pain killers, sedatives, and narcotics. Dangerous when taken as prescribed. They can also be deadly.

Keep your family safe. Store safely. Dispose safely.
Community Education and Clinical Trainings

• Opioid Education 2.0
  • How to identify and diagnose OUD
  • Pain management with buprenorphine
  • Reducing risk in long-term opioid patients
  • Available Q3-ish

• Drug education for adolescents
  • Jr High and High School
  • Risks of substances, practical limits, how to maintain healthy relationships with substances, clear advice on drugs to never try

• 2019 North Coast Opioid and Substance Abuse Summit
  • October 14th, 2019 Seaside Convention Center
Driver Diagram for Opioid Prescribing

Reduce Opioid-Related Harms and Death

- Reduce inappropriate opioid prescribing
  - Chronic Opioid Strategy (2017-2018 focus)
  - Acute Prescribing Strategy (2019 focus)
- Raise awareness of opioid risks
  - Community Education and Clinical Training
- Identify and Intervene on High Risk Cohort
  - High Risk Cohort Strategy

Treat Opioid Use Disorder and Dependence

- ED, Urgent Care, and Surgeon Engagement
  - Adoption of State Acute Guidelines
  - Education Pamphlet for Providers
  - Dental Coordination
  - Data and Report Cards on Metric
- Opioid Training 2.0
  - Teaching adolescents about drugs
  - Buprenorphine for Pain
  - Reducing Risk in legacy patients
  - Behavioral treatment of pain
- High dose, co-ingestants, ED or IP for opioid-related issue, adolescents with chronic use
  - Using RCT, audit process, and PCPs for intervention
High Risk Cohort Strategy

- Opioid Therapy Audit
- New Dashboard build
- Patient lists

High Dose (>90 MED)

- Review of all ED visits related to opioids
- Mandatory audit
- Overdose taskforce

ED or IP related to Opioid Use

- Identify in data
- Review and refer to PCP for follow-up

Adolescents with Multiple Prescriptions

- PA on dose 3 of naloxone, workflow for notification
- Audit selection
- PDMP

Multiple Naloxone Fills, Prescribers, or Pharmacies

- Adding data to dashboard
- Gathering state benzo data for review and trending

Dangerous Co-Ingestants

- Premanage flags
- RCT

Diagnosed SUD with Opioid Use
Naloxone

• Co-prescribing for chronic users at risk
  • Recommend for > 50 mg/d or high risk
  • Nasal spray easiest for patients, IM least expensive
  • “Risky drugs, not risky people”
  • Educate patient and a loved one/household member
  • Pharmacists can now also prescribe

• Overdose risk factors
• First responder trainings
• Pharmacist trainings
• Primary care trainings
Overdose Data and Heroin Impact

OVERDOSES IN COLUMBIA PACIFIC 2015-2018

- 40% Heroin
- 35% Prescription
- 25% Unclear

Overdose Response:
- Overdose Event: 48
- Heroin: 19
- Still receiving Rx opioids: 18
- Naloxone fill post overdose: 5
- Receiving Buprenorphine: 3
Heroin, Overdose, and Mandatory Audits?

• How do we want to approach Overdose Response and FU?
• Mandatory Audit following Overdose?
  • Naloxone
  • Risk Reduction
  • OUD Assessment
  • What leverage do we have for prescribers?

• What other ways can we reduce impacts from heroin in our communities?
• What can medical directors do to influence change in their clinics?
Heroin, Overdose, and Mandatory Audits?

- Creating a High Risk and Opioid Overdose Taskforce
- Goal is to develop real-time action plan for overdose events
The disease of addiction

• Behavior that is driven by biological reward systems that have become permanently altered.
• “Compulsive Use Despite Harm,” Dr. Nora Volkow, NIDA Director
• Treatable chronic disease state, just like diabetes.
• Best practices call for individualized treatment that includes, medication, behavioral and physical healthcare, and community support.
  • Goal is a continuum of care which is consistent with the treatment of a chronic disease

Adapted from slide by Dr. Andy Mendenhall
RE. Clark et. Al, JSAT 2015

• 52,000+ Massachusetts Medicaid Members
• Evaluated UDS, Treatment continuation and all-cost of care for this large population.

• Goals were to understand clinical efficacy characterized by opioid relapse rates.
  • Behavioral Health (Traditional) Treatment
  • Buprenorphine + BH Treatment
  • Methadone + BH Treatment

Patients Maintained with OAT Demonstrate VASTLY Less Relapse with Opioids. (OAT = Opioid Agonist Treatment)

What are the costs of caring for patients? (OAT = Opioid Agonist Treatment)

Rate of Past Year Opioid Abuse or Dependence* and Rate of Medication-Assisted Treatment Capacity with Methadone or Buprenorphine

Rate per 1,000 persons aged 12 years and older

Rate of dependence
- 3.4 - 6.4
- 6.5 - 9.2
- 9.4 - 10.3
- 10.8 - 12.9

Treatment capacity
- 0.7 - 3.0
- 3.2 - 4.3
- 4.4 - 7.2
- 7.3 - 16.5

*Opioid abuse or dependence includes prescription opioids and/or heroin

State-by-State Access Regression Analysis

FIGURE 2—Comparison of state rates of past-year opioid abuse or dependence and capacity for opioid agonist medication-assisted treatment: United States, 2012

Note: O-MAT = opioid agonist medication-assisted treatment.
Regional SUD Vision Statement

Develop a local trauma informed network for all substance use disorders that ensures timely equitable access, reduces stigmas and promotes extensive cross organizational coordination and a long-term recovery support system.
2016: CPCCO MAT Services
2019: CPCCO MAT Services

- CBH/CMH
- CODA- OTP
- Rinehart
- TCCHC (Tillamook)
- Bridges Detox
- OHSU Scappoose
- Legacy St. Helens
Lessons learned

• Overcoming barriers: cultural, organizational, provide
• Technical assistance
• Is it SOOO much more than just the x waiver
• The role of the organization
• Community readiness
• Community tipping point
Our Driver: Reduce Harms

• The WAY that you deliver care matters almost as much as the care that you deliver

• Harm Reduction principles are very similar to Trauma-Informed Practice principles
### Harm Reduction Principles

<table>
<thead>
<tr>
<th>Principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.</td>
</tr>
<tr>
<td>Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.</td>
</tr>
<tr>
<td>Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.</td>
</tr>
<tr>
<td>Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.</td>
</tr>
</tbody>
</table>
Harm Reduction Principles

- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.

- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.
Coordinate Care for Addictions

• MAT Collaborative, Q3 2019
  • Bringing ECHO Curriculum to Collaborative
  • Opportunity to develop referral pathways, share workflows, discuss cases, community of practice

• County-level PDSAs for referrals

• Community Paramedic and Regional Care Teams
  • Leverage spaces in between, referral “gaps”
The Missing Piece: Data for Action for OUD

- Epidemiologic
- Geographic: State and county
- Organization
- Provider
- Patient
Identification: Opioid Use Disorder on one or more claim 705 members

Gap: no treatment 197 members (28%)

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

SUD Treatment without MAT 140 members (20%)

Received MAT 368 members (52%)

MAT Drop/ Low Engagement 111 members (30.2%) MPR <0.5

MAT Moderate Engagement 42 members (11.4%) MPR 0.5 – 0.74

MAT High Engagement 215 members (58.4%) MPR > 0.75
CPCCO MAT Engagement

Assigned Primary Care Provider Name

- OHSU FAMILY HEALTH CENTER AT SCAFFOISE
  - No Treatment: 26
  - SUD Only: 26
  - Early/Low/Drop: 30
  - Moderate: 28
  - High: 17

- PROVIDENCE NORTH COAST CLINIC
  - No Treatment: 35
  - SUD Only: 8
  - Early/Low/Drop: 17
  - Moderate: 15
  - High: 7

- COASTAL FAMILY HEALTH CENTER
  - No Treatment: 25
  - SUD Only: 2
  - Early/Low/Drop: 3
  - Moderate: 15
  - High: 11

- CMH PRIMARY CARE CLINIC
  - No Treatment: 32
  - SUD Only: 2
  - Early/Low/Drop: 6
  - Moderate: 10
  - High: 11

- RINEHART CLINIC
  - No Treatment: 10
  - SUD Only: 5
  - Early/Low/Drop: 4
  - Moderate: 6
  - High: 5

- LEGACY CLINIC ST HELENS INTERNAL MEDICINE
  - No Treatment: 12
  - SUD Only: 5
  - Early/Low/Drop: 4
  - Moderate: 6
  - High: 5

- TILLAMOOK COUNTY COMMUNITY HEALTH CENTERS
  - No Treatment: 5
  - SUD Only: 3
  - Early/Low/Drop: 3
  - Moderate: 3
  - High: 1

- ADVENTIST TILLAMOOK MEDICAL PLAZA
  - No Treatment: 2
  - SUD Only: 2
  - Early/Low/Drop: 1
  - Moderate: 1
  - High: 1

- COMMUNITY HEALTH CENTER OF CLATSKANIE
  - No Treatment: 8
  - SUD Only: 2
  - Early/Low/Drop: 2
  - Moderate: 2
  - High: 1

- ADVENTIST HEALTH TILLAMOOK MED GRP WOMENS & FAMILY HEALTH
  - No Treatment: 7
  - SUD Only: 3
  - Early/Low/Drop: 3
  - Moderate: 2
  - High: 1

- ADVENTIST HEALTH BAYSHORE MEDICAL PACIFIC CITY
  - No Treatment: 3
  - SUD Only: 3
  - Early/Low/Drop: 3
  - Moderate: 3
  - High: 1

- LOWER COLUMBIA CLINIC
  - No Treatment: 3
  - SUD Only: 3
  - Early/Low/Drop: 3
  - Moderate: 3
  - High: 1

- RAINIER HEALTH CENTER
  - No Treatment: 3
  - SUD Only: 3
  - Early/Low/Drop: 3
  - Moderate: 3
  - High: 1

- THE MIDDLE WAY HEALTH CARE
  - No Treatment: 1
  - SUD Only: 1
  - Early/Low/Drop: 1
  - Moderate: 1
  - High: 1

- VANDERWAAL, STEVEN C
  - No Treatment: 1
  - SUD Only: 1
  - Early/Low/Drop: 1
  - Moderate: 1
  - High: 1

- SAINT HELENS INTERNAL MEDICINE
  - No Treatment: 7
  - SUD Only: 3
  - Early/Low/Drop: 3
  - Moderate: 2
  - High: 1

- COLUMBIA PACIFIC MEDICAL SERVICES
  - No Treatment: 1
  - SUD Only: 1
  - Early/Low/Drop: 1
  - Moderate: 1
  - High: 1
Driver Diagram for Opioid Use Disorder Treatment

Reduce Opioid-Related Harms
- Reduce inappropriate opioid prescribing
- Reduce Overdose Deaths

Treat Opioid Use Disorder and Dependence

Build a System of Care for Opioid Use Disorder
- Detox
- Residential
- MAT in Primary Care
- MAT in CMHPs
- Opioid Treatment Program (CODA)

Coordinate Care Among System Components
- System Mapping
- Risk Share Leveraging
- PDSAs for intersections
- RCT/Community Paramedic for coordination

Community Education and Clinical Training
- MAT Fundamentals: trainings for clinics
- How to assess for and diagnose OUD
- Stigma Busting
- Summit

Data-Informed Strategy
- Data Report for OUD in second phase
- Proactive outreach
- Coordinated tracking

Develop Payment Mechanism to Support MAT Services
- APM Workgroup for MAT
- Define how to incentivize coordinated care

Identify and Develop Community Partnerships to Provide Non-Clinical Services
- Housing
- Harm Reduction
- Public Health
- Law Enforcement
- Recovery Community
Community Partnerships

- Harm Reduction
  - More than 250,000 syringes exchanged in Clatsop county
  - Tillamook and Columbia county both working towards harm reduction services
  - Naloxone distribution, over 45 saves in Clatsop

- Law Enforcement
  - Naloxone support
Prevention and ACE’s

ACEs are not Destiny

ACES are Risk Factors
Health Behavior
Health Outcomes

High (>=4) vs Low (0)
Alcoholism 6X
SUD 10 X

https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean