Collaborative Care for MAT: Evidence-Based Support and New Reimbursement Strategies

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Disclosure Information

Lori Raney, MD – APPI Publication Royalties
Mark Duncan, MD – No Disclosures
Virna Little, LCSW – No Disclosures

To Prescribe MAT or Not to Prescribe: That is the Question

- Think of at least one reason data waived providers might not want to prescribe MAT even though they went to the effort to obtain waiver
- Any reasons you have personally hesitated?
- Share your thoughts with your neighbor

Results from Studies

- 92 with data waiver interviewed – only 28% prescribing
- Reasons why not prescribing
  - Lack of mental health and psychosocial support #1 reported barrier
  - Lack of institutional support
  - More likely to prescribe if had a waived partner in the practice
  - Funding barriers

Hutchinson, E., et al. (2014). "Barriers to primary care physicians prescribing buprenorphine." Ann Fam Med 12(2): 128-133

Hannah K. Knudsen, Ph.D , Amanda J. Abraham, Ph.D, and Carrie B. Oser, Ph.D

Barriers to the implementation of medication-assisted treatment r substance use disorders: The importance of funding policies and medical infrastructure. Eval Program Plann. 2011 November ; 34(4): 375–381. doi:10.1016/j.evalprogplan.2011.02.004

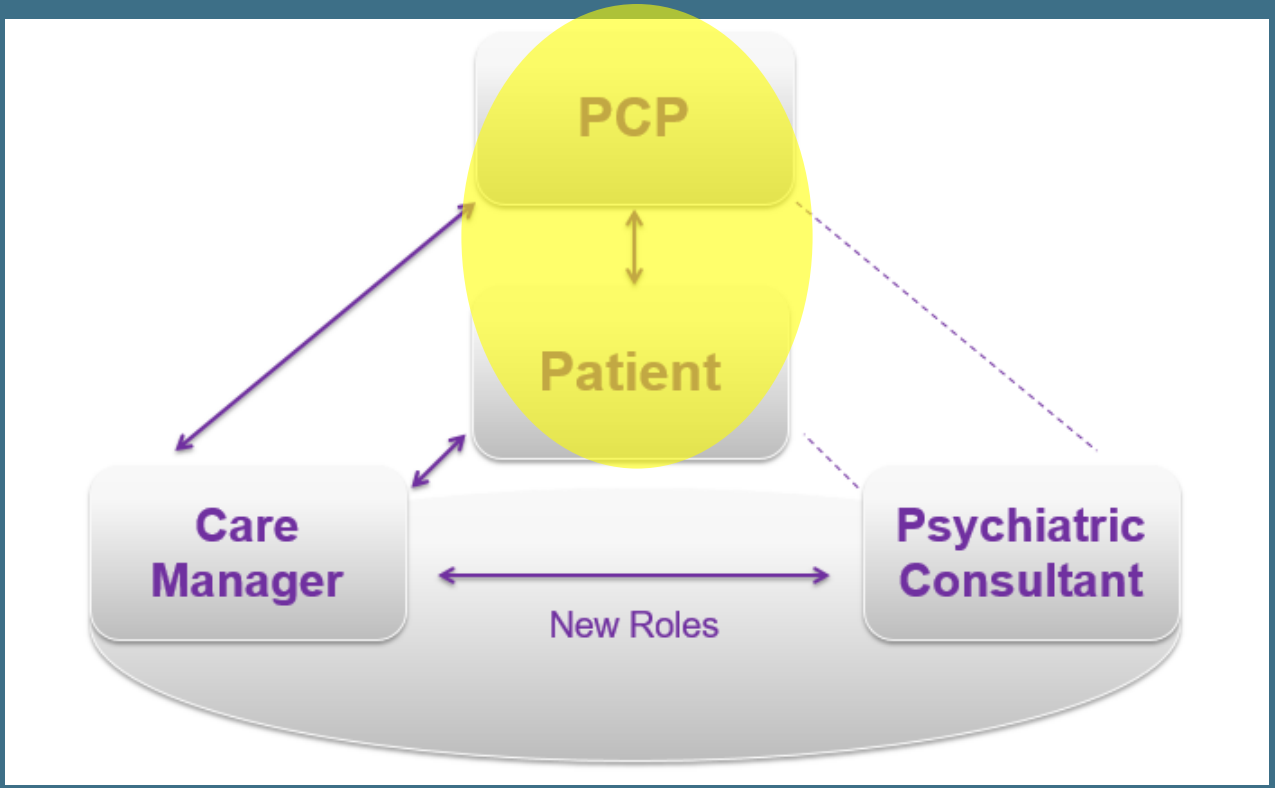
Other Setting Challenges

- Administrative support
- Stigma of staff and providers
  - Don’t want “difficult” patients
- Provider lack of confidence in treatment
- PCPs limited time
- Need willing and waivered PCPs

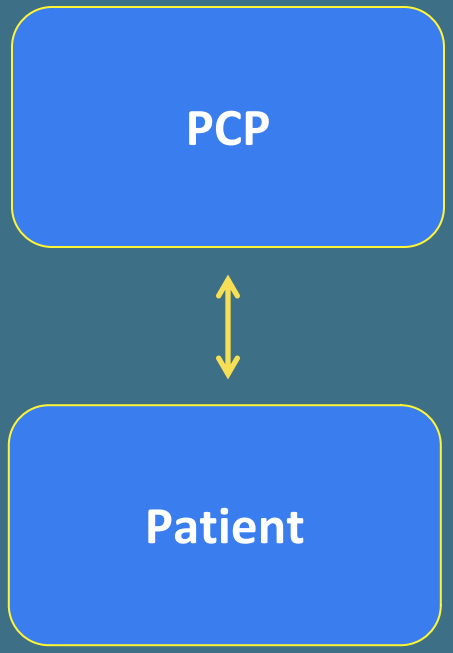
Why Collaborative Care Model for SUDs?

1. Most studied and effective evidence-based model of primary care integration of mental health disorder
2. Widely disseminated
3. Addresses key barrier for additional support
4. Principles of CC lend themselves to the treatment of chronic relapsing conditions and are good practice
5. Widely disseminated already
6. Financial support is established and growing

Collaborative Care Team

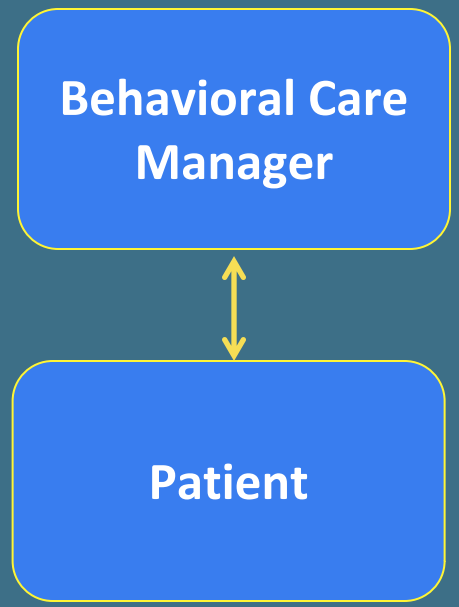


Team Roles: PCP



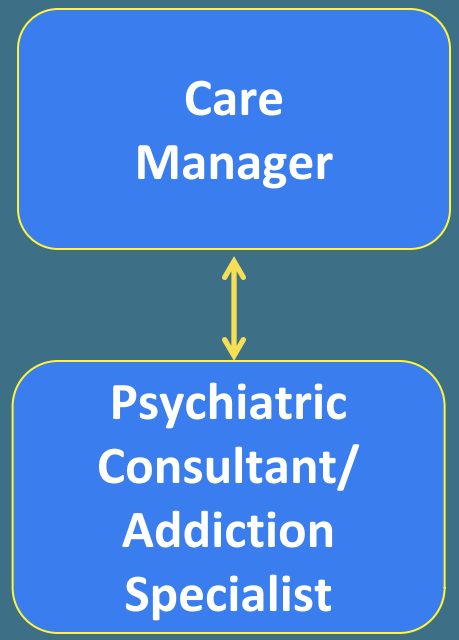
- Assess and Diagnose
- Induction on Buprenorphine-Naloxone
- Prescribe and manage medications
- Introduce CC model
- Refers to Behavioral Care Manager

Team Roles: BH Care Manager



- Further screening for co-occurring disorders
- Regular contact
- Check on med adherence
- Psychosocial support
- Mutual help group support
- Problem solving
- Use Monitoring
- Maintains/monitors registry

Team Roles: Psychiatric & Addiction Consultant



- Weekly review of caseload
- Discuss therapy issues
- Discuss medication issues
- Review need for additional psychiatric services
- Provide practical written recommendations
- Does not prescribe medications
- Expertise in mental health and addiction needed

Caseload Review

- Weekly
- Use Registry to review progress of individual patients and population
- Identify unstable patients
- CC and Consultant develop plan to address instability

Registry

Registry Requirements			
Tracks progress at individual level and at caseload level	Tracks population-based care	Facilitates efficient systematic case review	Prompts treatment to target

Possible Registry Headers

Name	Treatment Status				Urine Drug Screens		Brief Addiction Monitor						MAT	Last PMP accessed	Addiction Consult
	Initial Assessment	Most Recent	#Session	Weeks in Tx	First	Last	First			Last			Med and dose		
							Use	Risk	Protection	Use	Risk	Protection			

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Measurement Based Care

Important for Substance Use Disorders!

Retention: The fundamental measure for treating Substance Use Disorders

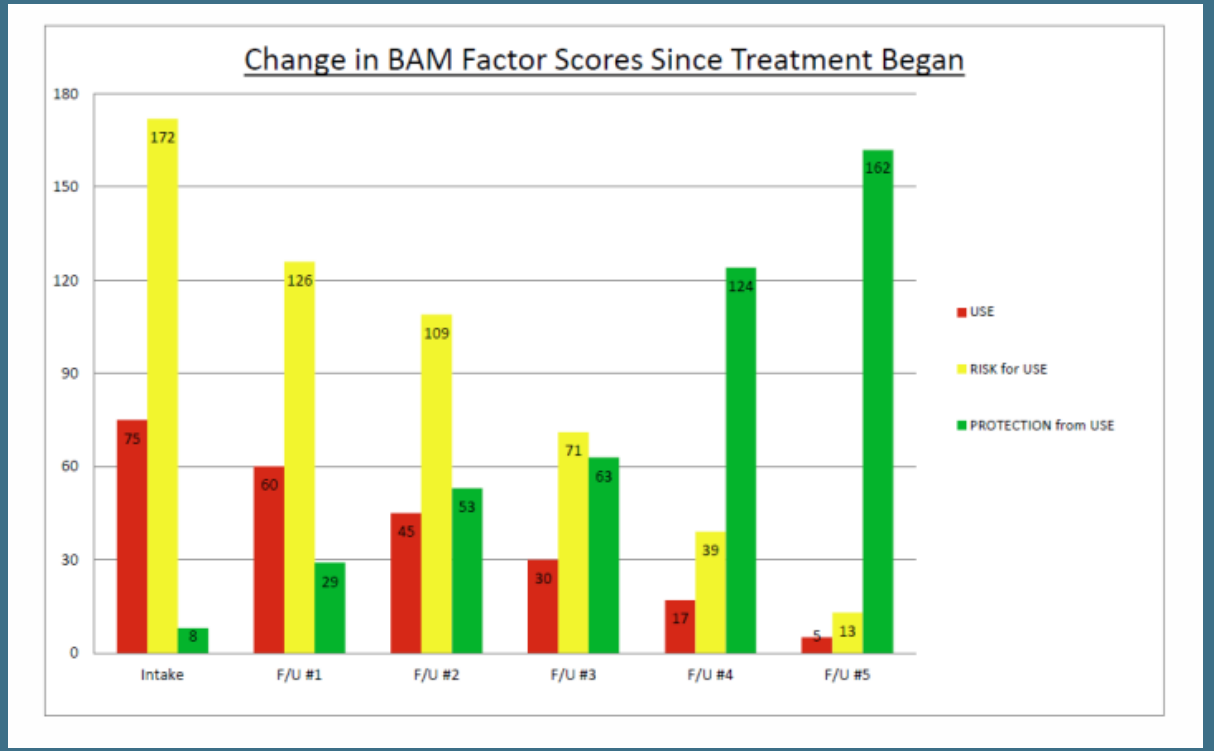
- Individual Goal
- Population Goal

Other Useful Metrics

- Illicit Substance Use
  - Urine, saliva drug and alcohol screens
- Dose of Buprenorphine (as indicated)
  - On average, individual and population dose should be ≥ 8mg of Buprenorphine daily (typical dose is 12-16mg a day)

Brief Addiction Monitor

- 17 item measure (5 min)
- Clinician or Self administered
- Can track past 7 or 30 days
- Use for all substances
- Assesses



Substance Use

- Any alcohol use
- Heavy alcohol use
- Drug use

Risk Factors

- Craving
- Sleep prob
- Poor mood
- Risky situations
- Family/social problems
- Physical health

Protective Factors

- Self-efficacy
- Self-help
- Spirituality
- Work/school
- Income
- Social supports

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Measurement Based Care

There is no PHQ9 for Substance Use Disorders

Closest Equivalent is the: **Brief Addiction Monitor**

https://www.mentalhealth.va.gov/communityproviders/docs/BAM_Overview_01_28_2014.pdf

https://www.mentalhealth.va.gov/communityproviders/docs/bam_continuous_3-10-14.pdf

BAM study results

- all 3 parts were sensitive to change
- excellent test/restest reliability
- Recovery protection and substance use and risk had predictive validity

Others

- Short-Inventory of Problems for alcohol and Drugs
- DSM-5 criteria

The SUMMIT Trial

Collaborative Care (CC) for Opioid & Alcohol Use Disorders

Collaborative Care for AUD/OUD vs. Usual Care (facilitated self-referral)

- CA FQHC patients with A/OUDs, 49% unhoused, 6 months

Elements

- CM
- Therapists
- Clinicians (12/28 waivered)
- Weekly Caseload Reviews
- Registry
- Measurement based care

Main Outcomes:

- Any Evidence-based Treatment
- Self-reported 30 day abstinence

		Treatment Arm	
		Collab. Care (n=187)	Usual Care (n=190)
Intervention Characteristics	Intervention	Enrolled, proactively followed in PC by CC team	Pt given info for in-clinic & external specialty SUDs tx
	Contact Intensity	Goal: 6-sesson psychotherapy +/- MAT	Variable
	Psycho-therapy	MET/CBT	Variable
	MAT	XR-NXT (AUD), bup-nalox. (OUD)	Variable, per clinic or provider

Watkins et al. (2017)

The SUMMIT Trial

Collaborative Care (CC) for Opioid & Alcohol Use Disorders

Engagement:

- Collaborative Care:
  - 93% met Care Coord. ≥ 1 time
  - 45% had ≥ 1 therapy appnt
  - 22% had ≥2 therapy appnts
- Usual Care:
  - Unknown?!

Results:

- Receipt of any EBT CC > Usual Care:
  - Beh Th CC > UC (36% vs 11%)
    P Value < .001
  - MAT CC = UC (13% vs 13%)?
- 30-day Abstinence (self-report)
  - CC > Usual Care (33% vs. 22%)
    [β=0.12, 95 % CI=(0.01, 0.23)]

Conclusions:

- CC-based AOUD treatment can be more effective than usual care***…though a ↑ effect size would be nice, yes?***

Summary

- Collaborative Care is the most robust evidence-based model for the integration of mental health in primary care and widely disseminated.

- Collaborative care and/or principles of collaborative care can/should be expaneded to support substance use disorder treatment.

Typcial Role of the Behavioral Care Manager

- Further screening for co-occurring disorders – depression and anxiety, etc, PHQ9 , GAD -7, trauma (PCL-5)
- Regular, frequent contact (in person or by phone)
- Check on med adherence
- Psychosocial support
- Mutual help group support
- Problem solving therapy, behavioral activation, motivational interviewing
- Maintains/monitors registry
- Meets weekly with psychiatric consultant/addiction specialist to review the registry

Modify the Role?

- Training issues
- Pre-induction, during induction, post-induction roles
- Working with the Addiction Specialist
- Weekly meeting and caseload review with addiction specialist
- Measuring outcomes and Registry management
- Care Agreements, UDS discussions
- Overall support for the MAT prescriber

Admission

- Review psychosocial & pre screening
  - Strengths / Barriers
  - Treatment history
- Does patient meet program requirements?
- Does patient require higher level of care?

Team Meetings: Treatment Recommendation

- In office or home induction
- Outpatient or in office counseling
- Obtain additional information

Team Meetings: Documentation

- Documenting Case Conference
  - Justification for determination
  - Treatment Recommendations
- Updating your MAT Registry
  - Disposition
  - Care team

Example documentation

Referred by: _____ on Date: _____
Pre-screening Score: _____ Date: _____
Psychosocial Completed Date: _____
Current Care Team _____
Services: _____

Inclusion Criteria Met: Eligible for care at the treatment site

Meets criterial for Opioid Use Disorder

Motivated for Office Based MAT

Age > 18 years or emancipated minor

Able to comply with MAT program policies

Documentation continued

Is Patient Pregnant : _____

Transitioning from higher level of care (Jail, Residential, Detox): ___

Is patient returning to MAT Care at this center: _____

Summary:

Suboxone team met to discuss patient's current appropriateness to begin office based MAT at this center. Patient has been determined to meet eligibility, and not identified to meet exclusion criteria at this time. Patient has been scheduled for a medical clearance appointment to further discuss MAT Treatment, induction and treatment recommendations.

Case Conference

- Resumed substance use
- Change in mental health or physical health
- Medication Diversion
- Aberrant behaviors

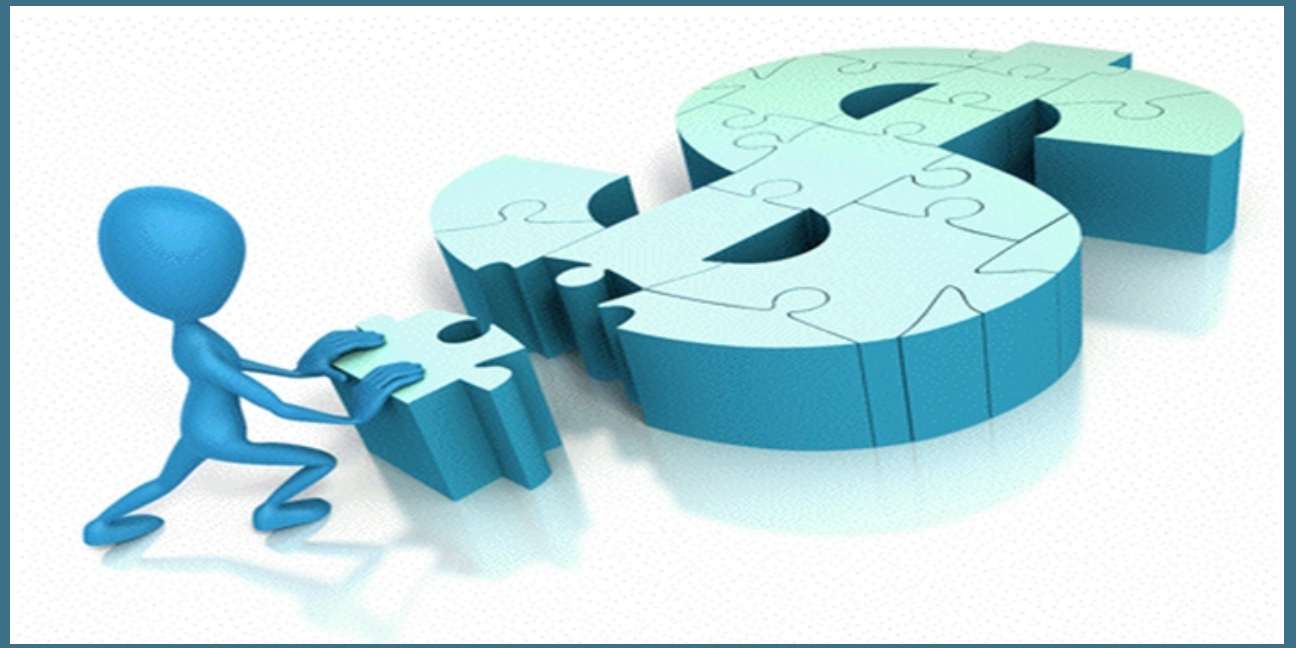
Case Conference: Planned discharge

- Discussed with patient and provider over time
- Increased supports added
- Discuss increased risks of overdose
- Agreement on how to handle slips
- Planned taper (28 days)

Traditional Payment for MAT

- Outpatient New Patient (99202/3/4/5, 99215)
- Outpatient Medication Management (99211-15)
- Outpatient Psychotherapy (90834, 90837)
- Outpatient Group Psychotherapy (90853)
- UDS
- Prolonged service codes

Collaborative Care Codes for MAT



CoCM Coding Summary non FQHC

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
CoCM First Month CPT 99492)	First 70 minutes per calendar month	• Initial Assessment • Outreach/engagement • Entering patients in registry • Psychiatric consultation • Brief intervention
CoCM Subsequent Months (CPT 99493)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning
Add-on CoCM (Any month) (CPT 99494)	Each additional 30 minutes per calendar month	• Same as Above
General BHI (CPT 99484)	At least 20 minutes per calendar month	• Assessment + Follow-up • Treatment/care planning • Facilitating and coordinating treatment • Continuity of care

CoCM Coding Summary FQHC

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
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CoCM Subsequent Months (GO511)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning

Time Based Inclusions

- Psychiatric/addiction specialist consultation
- Discussions, case reviews with primary care
- Registry management
- Telephonic work
- Discussions with collaterals
- In person visits
- If its not documented its not done !
- Case management/concrete services carved out
- 90% attached to billable event (10% capacity)
- 90% of events billable (may mean not including items)

Questions?

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