Wright, Kevin (Finance)

From: jen@recoveryworksnw.com
Sent: Monday, February 12, 2018 11:30 AM
To: opioids,
Subject: Hatch-Wyden Opioid

Recovery Works Northwest is a medical assisted treatment facility that provides affordable, sustainable addiction treatment for opioid-addicted patients. Our providers have 35 years of combined experience in drug addiction treatment, our effective, unique model develops personalized plans to treat opioid addiction. We serve 800 patients between our two clinics and 350 of those are the medicaid population.
As experts in the field we would like to respond to your opioid questionnaire.
1. How Can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD/SUD.
a. Incentives for opening suboxone and/or methadone clinics in rural areas, offering higher fee for service in those areas as motivation for suboxone waivered/addiction medicine doctors to treat patients on an outpatient basis.
b. Outcomes watch recurrent chronic disease patients who have multiple and return visits to ERs, and incentives in place not to have chronic disease patients keep showing up at the ER i.e. congestive heart failure, or heart disease, diabetes, and this has reduced return visits as primary care is incentivised to treat and monitor these diseases closely. The same should be for addiction, ERs are still trying to treat it as an acute problem when it is a chronic problem, incentives to connect patients with evidenced based practice, i.e. peers and MAT clinics should be incentivised.
c. Retention rates should have incentives for MAT clinics.
2. What barriers to non-pharmaceutical therapies for chronic pain currently exist? WAY too many pre-authorizations and hoops to jump through with the CCO's in order to get patients massage or acupuncture treatment, or even a health club membership.
3. How can Medicare/Medicaid payment incentives be used to remove barriers or create incentives to ensure patients receive evidence based prevention, screening, assessment and tx of OUD/SUD to improve outcomes?
a. incentives for having peer and/or counselors working at primary care locations or collaboration within clinics. Incentives for SUD clinics to have peer mentors.
4. Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD/SUD while promoting efficient access to appropriate prescriptions.
a. Prescription monitoring systems are imperative in this effort.
b. Coordination of care between all providers.
c. Appropriate trauma-informed training prior to putting patients on an opioid, those with past trauma or mental health history are more likely to abuse opioids.
5. How can Medicare/Medicaid better prevent, identify and educate health professional who have high prescribing patterns of opioids?
a. REQUIRE them to get their suboxone waiver for educational purposes and good practice.
b. More training in medical schools about addiction, currently they only get 4 hours!!! We have an epidemic in our country and our future physicians are only getting 4 hours of training!
6. Data sharing.
a. Require prescription monitoring in all states, and allow states to access each others, one database on Federal level would be helpful.
7. best practices...enhanced.
a. Don't just hand out money to the states to "fix" the drug problem, there should be accountability and instead of giving it straight to the state to deal with, which often gets mishandled or certain non-profits are in bed with CCOs and get all the money that trickles down. Instead it should be available to ALL clinics who are the ones working in the trenches with these high risk folks and actually making an impact on the opioid crisis.
8. what human services efforts appear to be effective in preventing or mitigating adverse impacts?
A. Housing, housing....housing!!!!! Homeless are vulnerable and higher risk to drug abuse.
B. Case Managers and Peer Mentors to connect beneficiaries to resources.
As a side note, we do not take Medicare because the fee for service is not sustainable because of what we have to pay our suboxone waivered physicians, the pay for behavioral health services is awful. Also the hoops you have to jump through to be a Medicare provider is also difficult for our clinic. Our docs are board certified as internal medicine, family medicine, etc,. but we do specialty not primary care, so none of the measuring components for Medicare apply to us so we just don't take Medicare which I find is ALOT of SUD providers, finding someone who will accept medicare in our community is a huge problem.
Thanks for your time.

Jen Robbins, CADCII, QMHP
Executive Director
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