Welcome

Addiction Treatment Starts Here: Primary Care Learning Collaborative
Kick-Off Webinar
March 17, 2021

While we're waiting, please:

Rename yourself

1

Click the Participants icon

2

Hover over your name & click Rename

3

Add your name, pronouns and organization's name

4

Click OK

If you connected to the audio using your phone

- Find your participant ID; it should be at the top of your Zoom window
- Once you find your participant ID, press: #number# (e.g., #24321#)
- The following message should briefly pop-up: "You are now using your audio for your meeting"

Addiction Treatment Starts Here

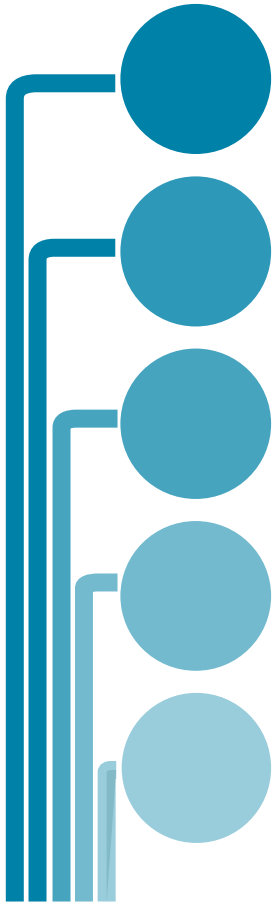
Kick-Off Webinar

March 17, 2021

CCI CENTER FOR CARE INNOVATIONS

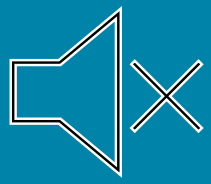
DHCS

Agenda



- Housekeeping + Introduction to CCI/ATSH
- Getting to Know One Another
- About Addiction Treatment Starts Here
- Breakouts
- Next Steps

Housekeeping Reminders



Mute

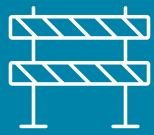
Please mute when not speaking. Please don't put put the call on hold!

Chat Box

Use the chat box to introduce yourself and questions

Slides + Recording

Slides and recoding will be posted to the ATSH Online Home



Tech Issues

Private chat Briana or Meaghan for assistance

Introductions to CCI and ATSH Teams

Center for Care Innovations

Strengthening the Health and Well-Being of Underserved Communities

Spark

New ways of working & creative problem solving

Seed

The research, testing & implementation of fresh approaches

Spread

Successful innovations, so our network rapidly adopts best practices

Addiction Treatment Starts Here

CCI Team

Meaghan Copeland
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Tammy Fisher
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Briana Harris-Mills
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Extended Team

Brian Hurley, MD
Addiction Physician and
General Psychiatrist, L.A.
County Dept. of Mental Health

Mark McGovern, PhD
Medical Director, Integrated
Behavioral Health, Stanford
University School of Medicine

Addiction Treatment Starts Here: Meet the Coaches!

Brian Hurley, MD
Addiction Physician and General Psychiatrist, L.A. County Dept. of Mental Health

Dominique McDowell, BA RLPS SUDCII
Director of Addiction & Homeless Services
Marin City Health and Wellness

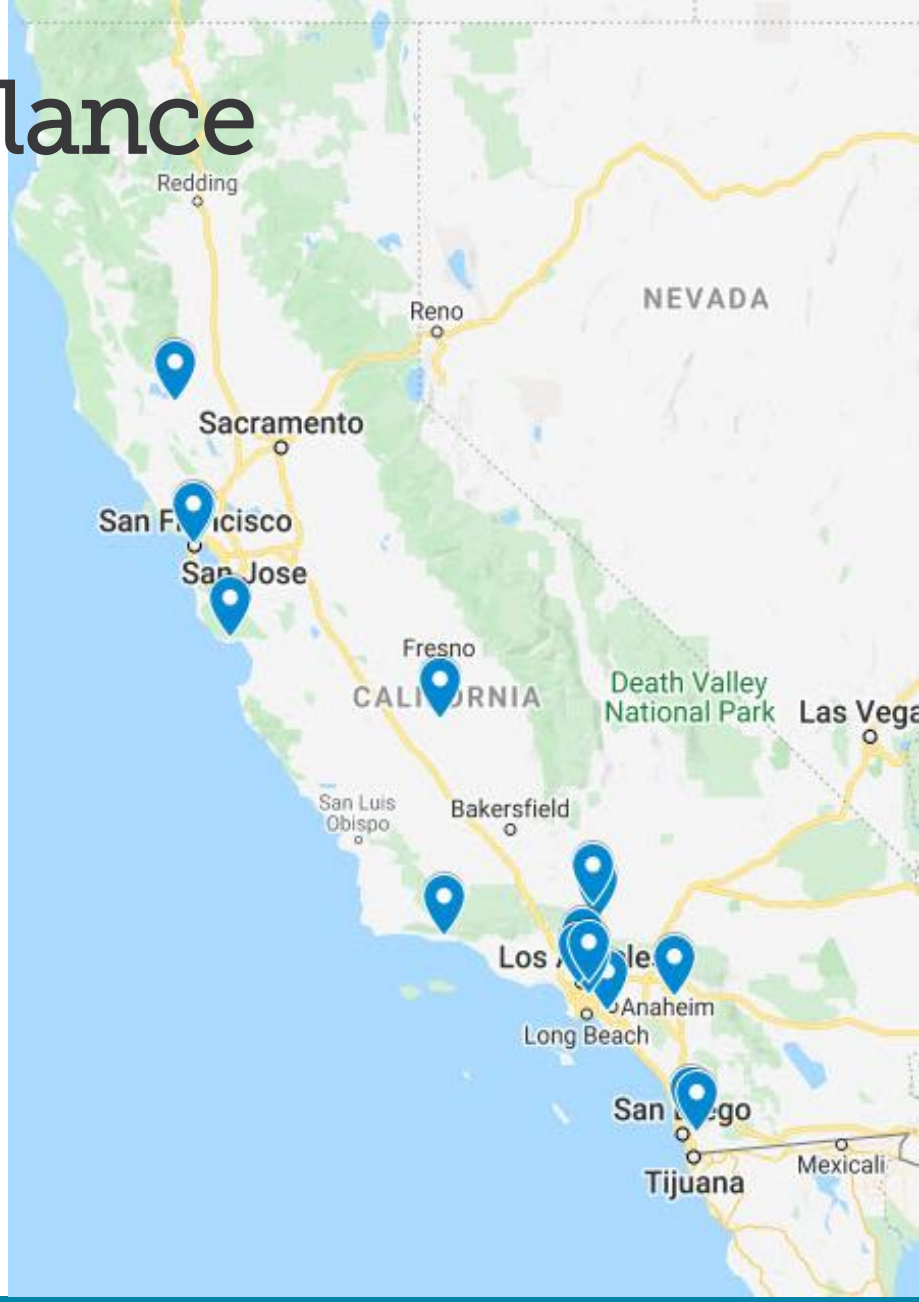
Katie Bell, MSN, RN-BC, CARN, PHN

Joe Sepulveda, MD
Assistant Medical Director
Family Health Centers of San Diego

Ginny Eck
Program Manager
JWCH Institute

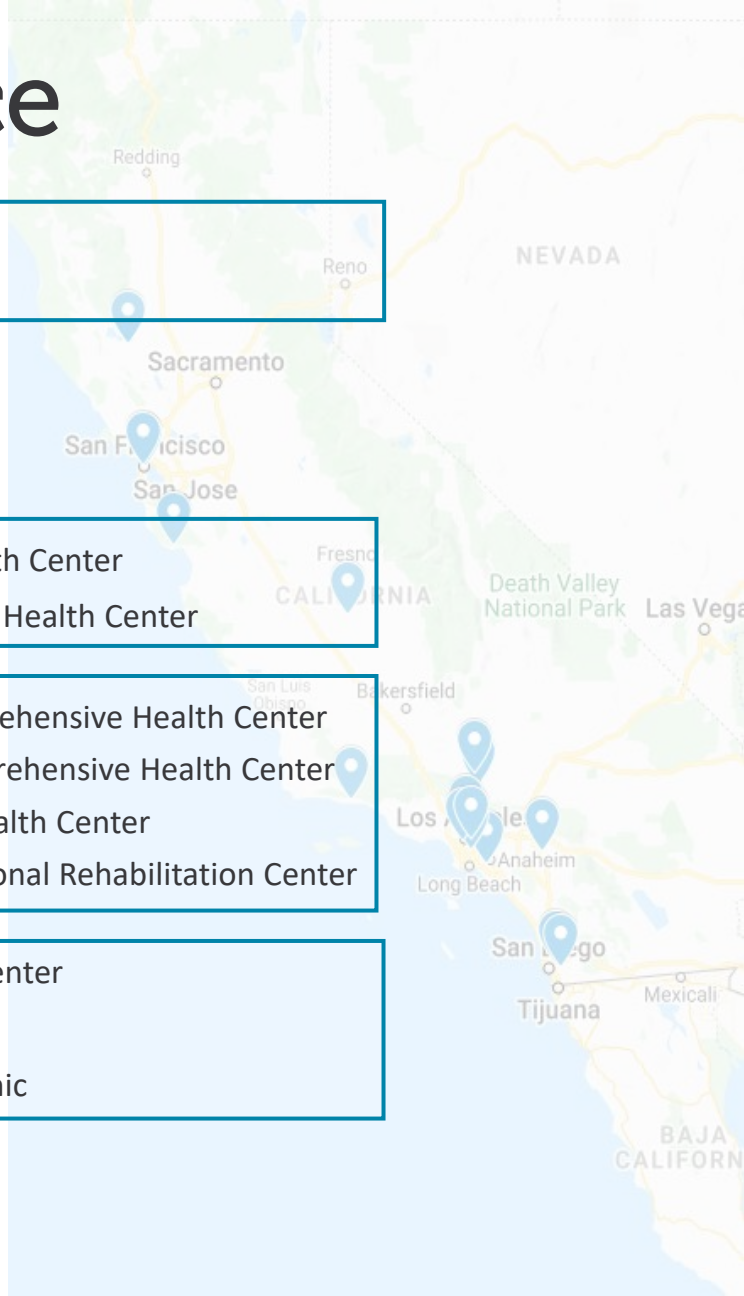
ATSH:PC Cohort At a Glance

- Program Cohort includes 18 teams, representing a total of 11 organizations
- Organization Characteristics:
  - Teams are located across 9 different counties and include urban, suburban and rural sites
  - Organizations vary in size, ranging from small to very large:
    - 2 serve <10,000 patients
    - 2 serve 10,000 – 15,000 patients
    - 9 serve 20,000 – 100,000 patients
    - 5 serve >100,000 patients



ATSH:PC Cohort At a Glance

- Adventist Health
  - Feather River
  - Lemoore
- Bartz Altadonna Community Health Center
- Comprehensive Community Health Centers, Inc.
- County of Santa Cruz Health Services Agency
- Family Health Centers of San Diego
  - City Heights Family Health Center
  - Grossmont Spring Valley Health Center
- Glendale Community Health Center
- Los Angeles Department of Health Services
  - Edward R. Roybal Comprehensive Health Center
  - H. Claude Hudson Comprehensive Health Center
  - High Desert Regional Health Center
  - Rancho Los Amigos National Rehabilitation Center
- Moreno Valley Community Health Center
- San Francisco Health Network
  - Castro Mission Health Center
  - Family Health Center
  - Richard Fine Peoples Clinic
- Santa Barbara Neighborhood Clinics
- Southland Health Center
- Via Care Community Health Center



Getting to Know One Another

Breakouts

- We will have 5 breakout sessions, each led by an ATSH coach
- Each team has been pre-assigned to the breakout led by their coach
- Each team will take a turn introducing themselves, using the slide you developed

Breakout Groups

Group A: Brian	Group B: Dominique	Group C: Ginny	Group D: Joe	Group E: Katie
• LA DHS - Rancho Los Amigos • LA DHS - High Desert • LA DHS - H. Claude Hudson • LA DHS - Edward R. Roybal	• SFHN - Family Health Center • SFHN - Richard Fine Peoples Clinic • SFHN - Castro Mission Health Center	• Comprehensive Community Health Centers • Southland Integrated Services • Via Care	• Bartz Altadonna • Santa Cruz • RUHS - Moreno Valley	• Adventist Health - Feather River • Adventist Health - Lemoore • FHCSD - City Heights • FHCSD - Grossmont • Santa Barbara Neighborhood Clinics

About Addiction Treatment Starts Here – Program Overview

ATSH: PC Goal

Increase access to addiction treatment for opioid use disorder and stimulant use disorder by working with 17 community health center sites to establish MAT programs in primary care.

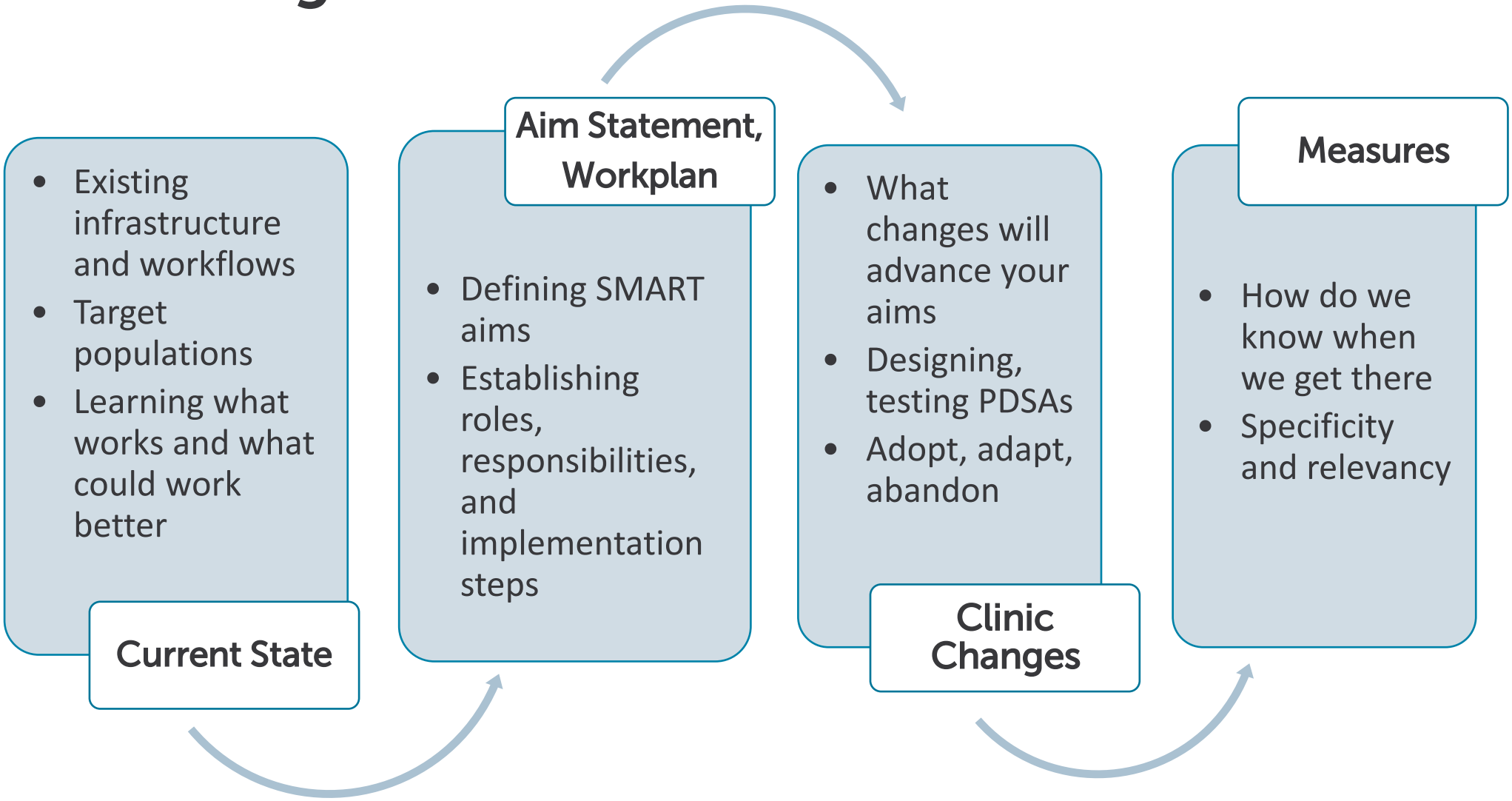
ATSH: PC Objectives

Learn from Peers	1	Create a peer group for learning, innovation and to enhance resilience
Design a Program	2	Support health center teams in designing and implementing MAT programs for OUD and stimulant use disorder in primary care
Facilitate Adoption	3	Enable participants to adopt, implement, and standardize changes critical to high quality addiction treatment, with a focus on OUD and stimulant use
Create Access	4	Spread access to MAT to more patients in primary care
Support Scope and Scale	5	Support organizations in the scale and financial sustainability of MAT programs

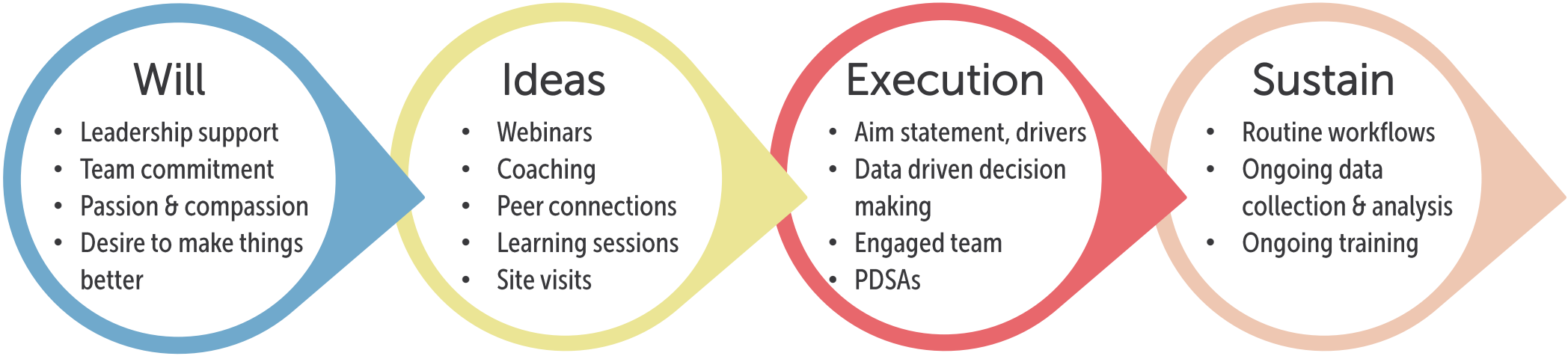
ATSH In a Nutshell

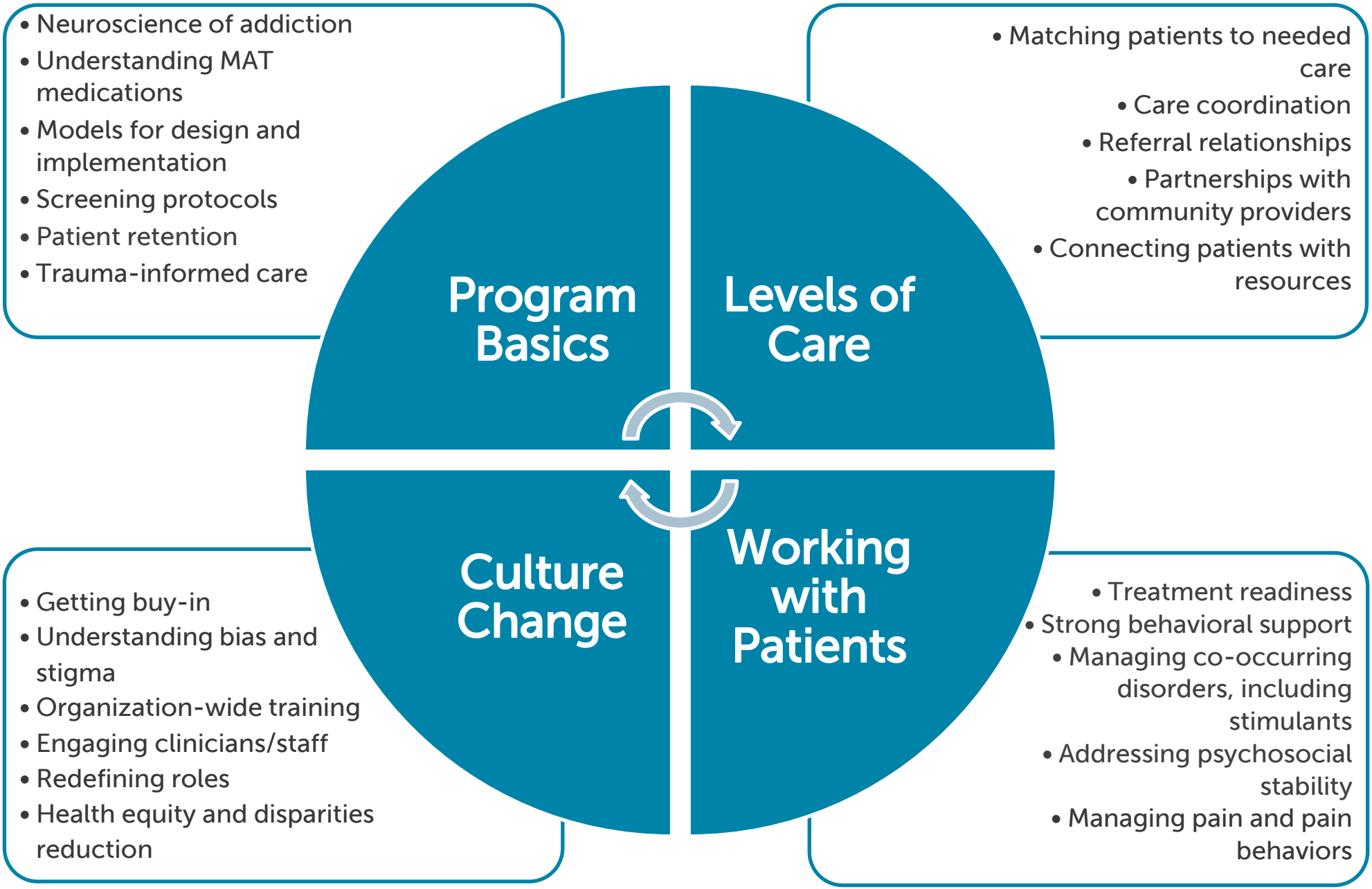
- Addiction Treatment Starts Here (ATSH) is an 18-month learning collaborative designed to support primary care clinics in designing new programs that provide medications for addiction treatment (MAT).
- The collaborative is governed by an all-teach, all-learn philosophy. We leverage expertise from experts in the field and create space for teams to learn from one another.
- During all events, we encourage participants to share their challenges and their progress. And because MAT is a team sport, we strongly encourage all members of the care team to join in the conversation!
- Progress is tracked through a measure set, a capability assessment, and periodic reports to CCI.

Foundation To Develop and Sustain Strong MAT Programs



Approach to Clinic-Level Changes




• Neuroscience of addiction
• Understanding MAT medications
• Models for design and implementation
• Screening protocols
• Patient retention
• Trauma-informed care
Program Basics
• Matching patients to needed care
• Care coordination
• Referral relationships
• Partnerships with community providers
• Connecting patients with resources
Levels of Care
• Getting buy-in
• Understanding bias and stigma
• Organization-wide training
• Engaging clinicians/staff
• Redefining roles
• Health equity and disparities reduction
Culture Change
• Treatment readiness
• Strong behavioral support
• Managing co-occurring disorders, including stimulants
• Addressing psychosocial stability
• Managing pain and pain behaviors
Working with Patients

ATSH Components

Learning Sessions	Primary goal is to enable peer sharing and best practice exchange from national and peer experts. We expect the first two convenings to be virtual and the third convening to be in-person.
Site Visits	Visit a clinic with an exemplar MAT program to see the care team and program components in action. Both virtual and in-person options will be offered.
Webinars	Foster networking and deeper knowledge on specific topics that emerge as challenges and priorities.
Coaching	Identify needs, trouble-shoot/overcome challenges, map and test workflows, support clinical and operational changes, and develop actionable plans for design and implementation.
Peer Group Forums	Virtual forum for peer groups to learn from one another. Three forums will be offered: nurses (e.g., medical assistants, LVNs, RNs), prescribers, and substance use disorder counselors.
Virtual Home	Webpage, online event registration, list serv, and repository of tools and resources to access

ATSH Activities

- In addition to the events on slide 22, you will be able to leverage:
  - A listserv to ask questions of your fellow teams or share resources
  - An Online Home where we share tools, templates, and relevant materials and policy guidance
  - Support for data-driven decision-making:
    - Onboarding support for our data portal (hosted by NICHQ)
    - Download run charts and benchmark your team's performance

Contribute

- Commitment from clinic leadership to start MAT, including senior leader participation
- Establish a core team that meets regularly and joins ATSH events
- Share your experiences and tools with others
- Complete IMAT and submit data on measure set

Receive

- TA and coaching to help design and implement MAT
- Webinars, learning sessions, forums and site visits to learn from experts and one another
- Learning community that optimizes peer sharing
- Online home
- $65,000 per site to offset costs

ATSH Events: Registration + Materials

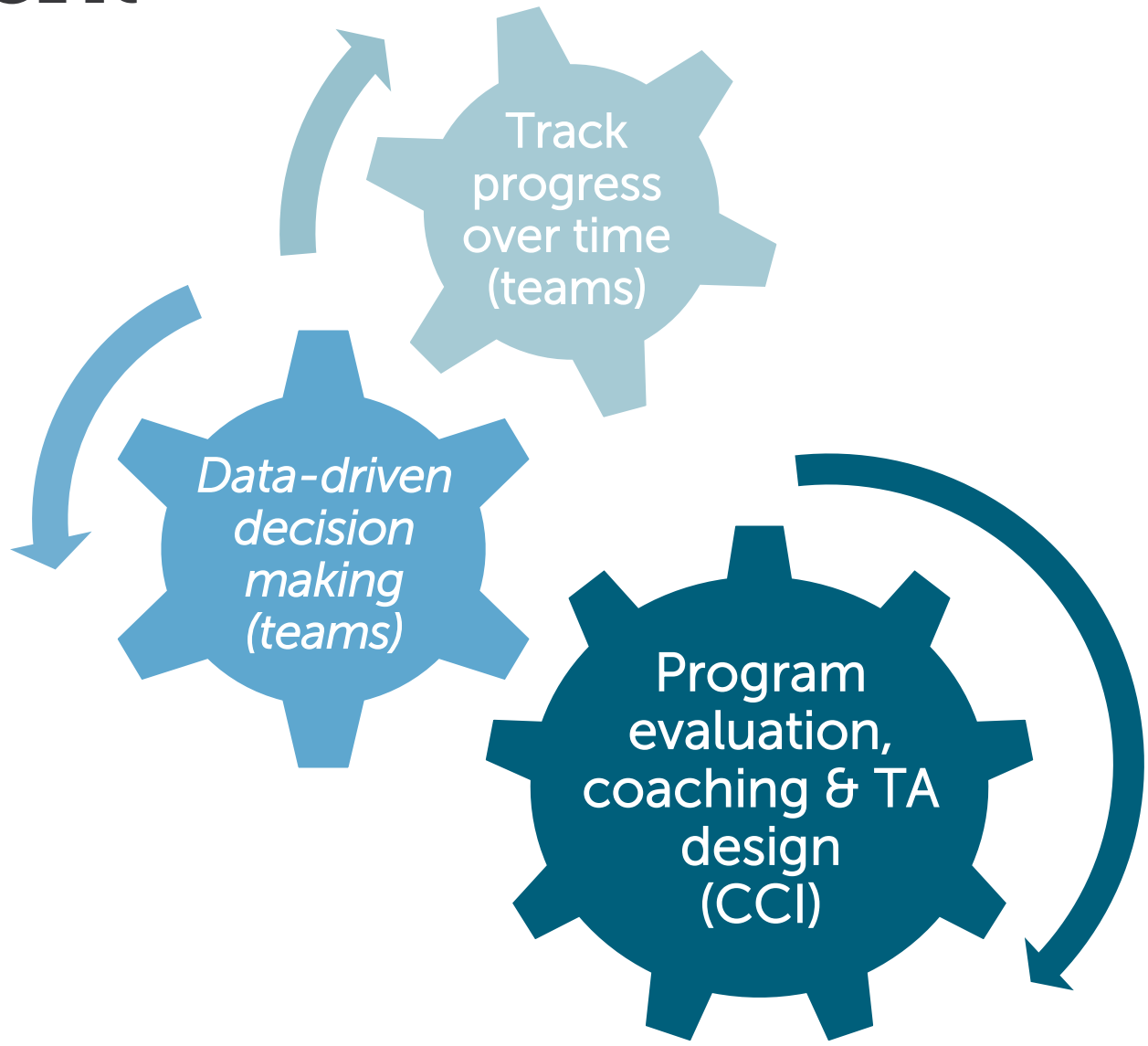
- The ATSH program offers lots of different activities and events: webinars, learning sessions, site visits, etc.
- For all webinars and learning sessions, we will ask you each person on your MAT core team to register.
- We post all materials from learning sessions and webinars to the website after the event. For virtual events, we will also post recordings to the website.
- **NOTE: We do not send calendar invites for ATSH events. For registrations that use Zoom or FormAssembly, you will download a calendar invite from the registration confirmation that you receive.**

ATSH Events

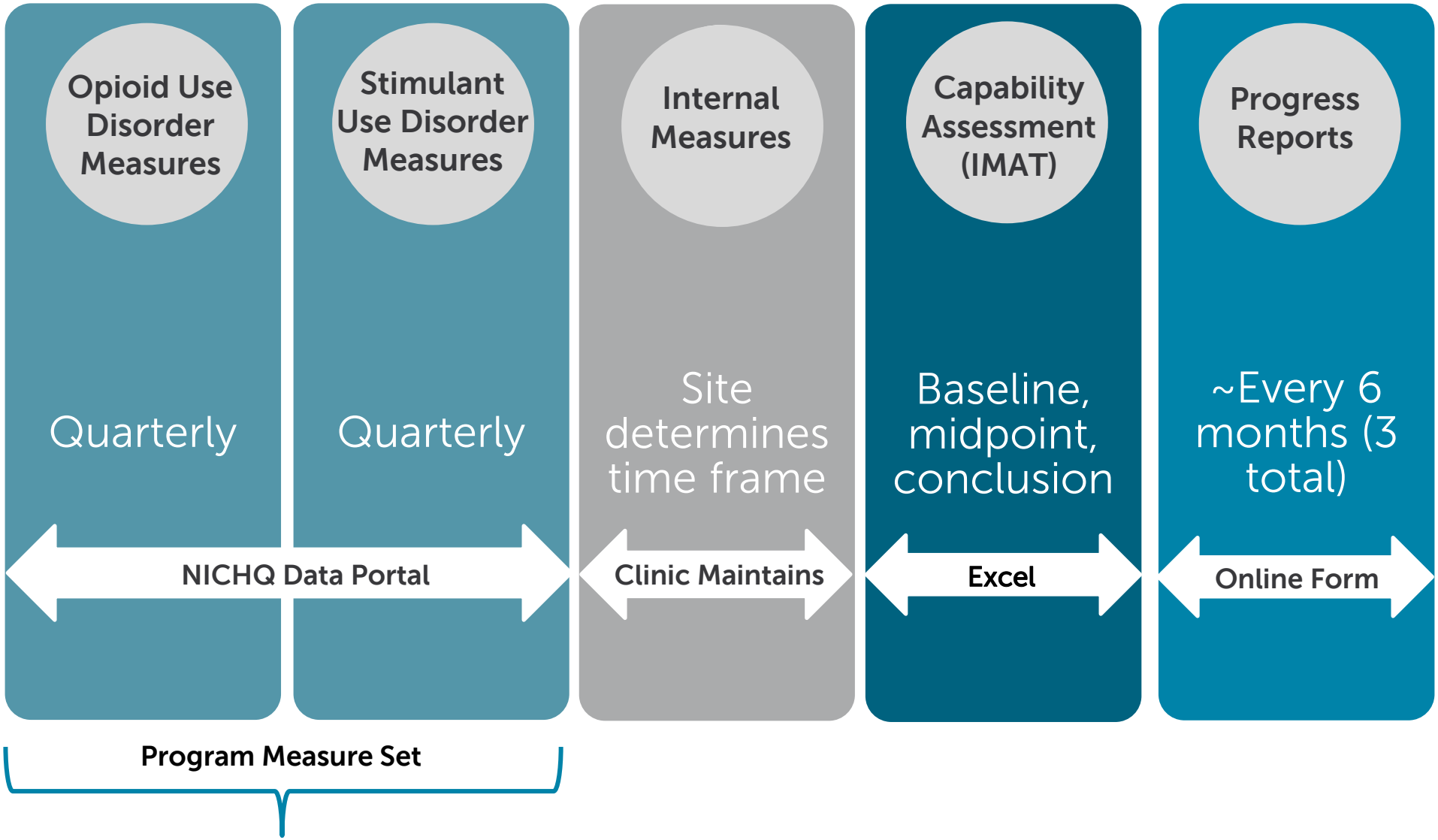
Activity & Short Description		Required	When	RSVP
Learning Sessions	There will be three learning sessions. LS 1 and LS 2 will each include two 2-hour sessions, scheduled a week apart. LS 3 will be a 1.5 day in-person session (location is tbd).	Yes	See calendar	Zoom (virtual) EventBrite (in-person)
Webinars	Throughout the 18-month program, we will host at least six 1-hour webinars, addressing MAT-related topics	Yes	See calendar	Zoom
Coaching	Each team should schedule a standing meeting with their coach, ideally once per month.	Yes	Team/ coach sets schedule	Warm hand-off from CCI
Peer Forums	Three forums will be offered: nurses (e.g., medical assistants, LVNs, RNs), prescribers, and SUD counselors. Each of the three forums will consist of a 6-session series, with the option to continue the series.	No	Rx: July SUD & RN: Sept	tbd
Site Visits	You will have the option to attend both virtual and in-person site visits. Virtual site visits will be approximately 2 hours in duration and in-person site visits are a ½ day.	No	July – Sept 2021	Site visit request form
MI Training	Virtual series to provide support to teams around motivational interviewing (MI)	No	Jan – Apr 2022	Zoom

About Addiction Treatment Starts Here – Measurement Strategy

Measurement Strategy: How Data are Used



Measurement Strategy: How and When



Measure Set: Summary

(see appendix for measure set & definitions)

OUD Measures

- **Adoption:** Two sub measures, tracking prescribers (total and active)
- **Reach:** Four sub measures, tracking new and established patients receiving medications for OUD treatment
- **Retention:** Two sub measures, addressing continuation in care of new and established patients

StUD Measures

- **Identification:** Two sub measures, tracking patients identified with stimulant use disorder (StUD) and co-occurrence with OUD
- **Treatment:** Four sub measures, tracking patients receiving treatment for StUD, including medications, contingency management, and behavioral health interventions

Internal Measures

- **Process and Outcome Measures:** Measures could address training and education, patient outreach and identification, patient experience, or other data that will inform improvement activities.

Measure Set: Collecting & Submitting OUD + StUD Data

Who is responsible? Determine who will be responsible for pulling and submitting data and submitting using the NICHQ data portal. This may be a combination of your data analysts and team lead, or other team members. Ideally the people you choose stay consistent throughout the program.

Data Periods. Data should be rolled up on a quarterly basis (starting with reporting period: January 1, 2021 – March 31, 2021, which is **DUE April 30**).

How to submit. Data is usually due 15 days after each quarter ends, except for your first reporting period where we've extended it by 15 days. Log into the NICHQ data portal and enter data for each measure set for that quarter.

Coming Up! Measurement Onboarding

Attend 1 onboarding webinar. Select one of these dates to attend:

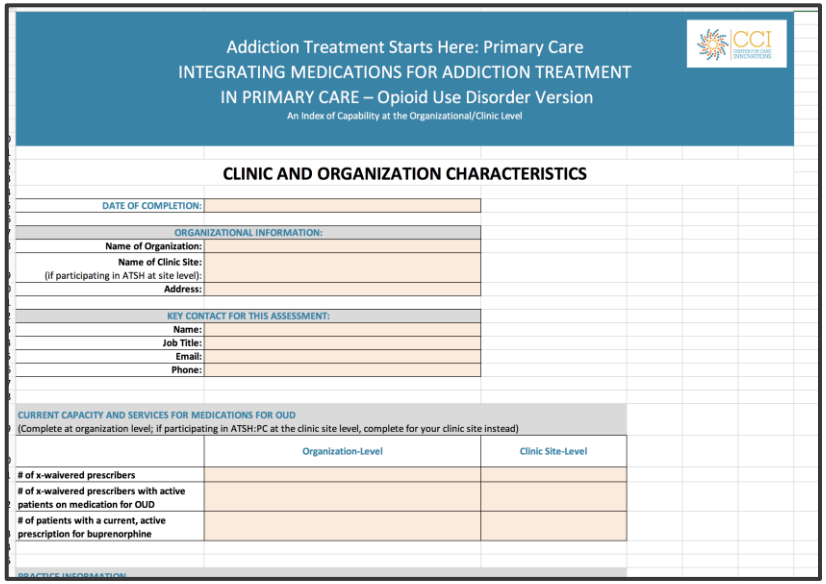
- March 31, 12-1pm – register here
- April 14, 12-1pm – register here

Who should attend? The person(s) responsible for collecting and entering data on a quarterly basis. We recommend that the team lead join in addition to any other data team member.

What will be covered? We will review the OUD and StUD measure set in detail and answer questions (e.g., how to pull accurate data). We will demonstrate how to log into the data portal and submit data. Additionally, we will answer questions about the IMAT capability assessment.

IMAT Capability Assessment: Your MAT Infrastructure

- Integrating Medications for Addiction Treatment in Primary Care (IMAT-PC) will support teams to better understand the current state, identify areas to make better, and evaluate change over time
  - The goal is to better understand MAT processes, approaches and environment – evaluating from multiple perspectives across multiple dimensions
- Development led by Mark McGovern, leveraging evidence-based processes, with support from Brian Hurley and the CCI team.
- Teams will complete the capability assessment three times:
  - Baseline, midpoint, endpoint



Addiction Treatment Starts Here: Primary Care
INTEGRATING MEDICATIONS FOR ADDICTION TREATMENT
IN PRIMARY CARE – Opioid Use Disorder Version
An Index of Capability at the Organizational/Clinic Level

CLINIC AND ORGANIZATION CHARACTERISTICS

DATE OF COMPLETION:	
ORGANIZATIONAL INFORMATION:	
Name of Organization:	
Name of Clinic Site: (if participating in ATSH at site level):	
Address:	
KEY CONTACT FOR THIS ASSESSMENT:	
Name:	
Job Title:	
Email:	
Phone:	

CURRENT CAPACITY AND SERVICES FOR MEDICATIONS FOR OUD
(Complete at organization level; if participating in ATSH:PC at the clinic site level, complete for your clinic site instead)

	Organization-Level	Clinic Site-Level
# of x-waivered prescribers		
# of x-waivered prescribers with active patients on medication for OUD		
# of patients with a current, active prescription for buprenorphine		

PRACTICE INFORMATION

Completing the IMAT

Schedule time! We suggest that you set aside 90 minutes to complete it. One completed assessment is due April 30.

Work with your team! This is an opportunity for you to learn more about your colleague's perspectives.

Rate conservatively! Select the lower of the two ratings when you're in between.

This isn't a test! Be candid and use the tool to support transformation.

Capability Assessment Benefits

"Completing the IMAT was great because we were able to identify our weaknesses. For example, the realization that not all frontline staff members received training in stigma and how this may impact vulnerable patients. We took an honest look at our capabilities and where we are lacking. The program measures were also helpful because it gave us a concrete number to strive for as far as patient MAT access and retention. It was eye-opening to see other team's data and how it compares to ours."
- ATSH participant

"Completing the IMAT has been useful in creating points for reflection. For instance, should observed urine toxicology tests be the norm? What additional trainings could we do? Some prompts caused us to think more broadly than we otherwise would have done."
- ATSH participant

"The capability measure was like a yardstick for us. Maybe more of a map of where we want to go. We plan to keep using it every 6 months from now on."
- ATSH participant

Measurement Strategy: CCI Support

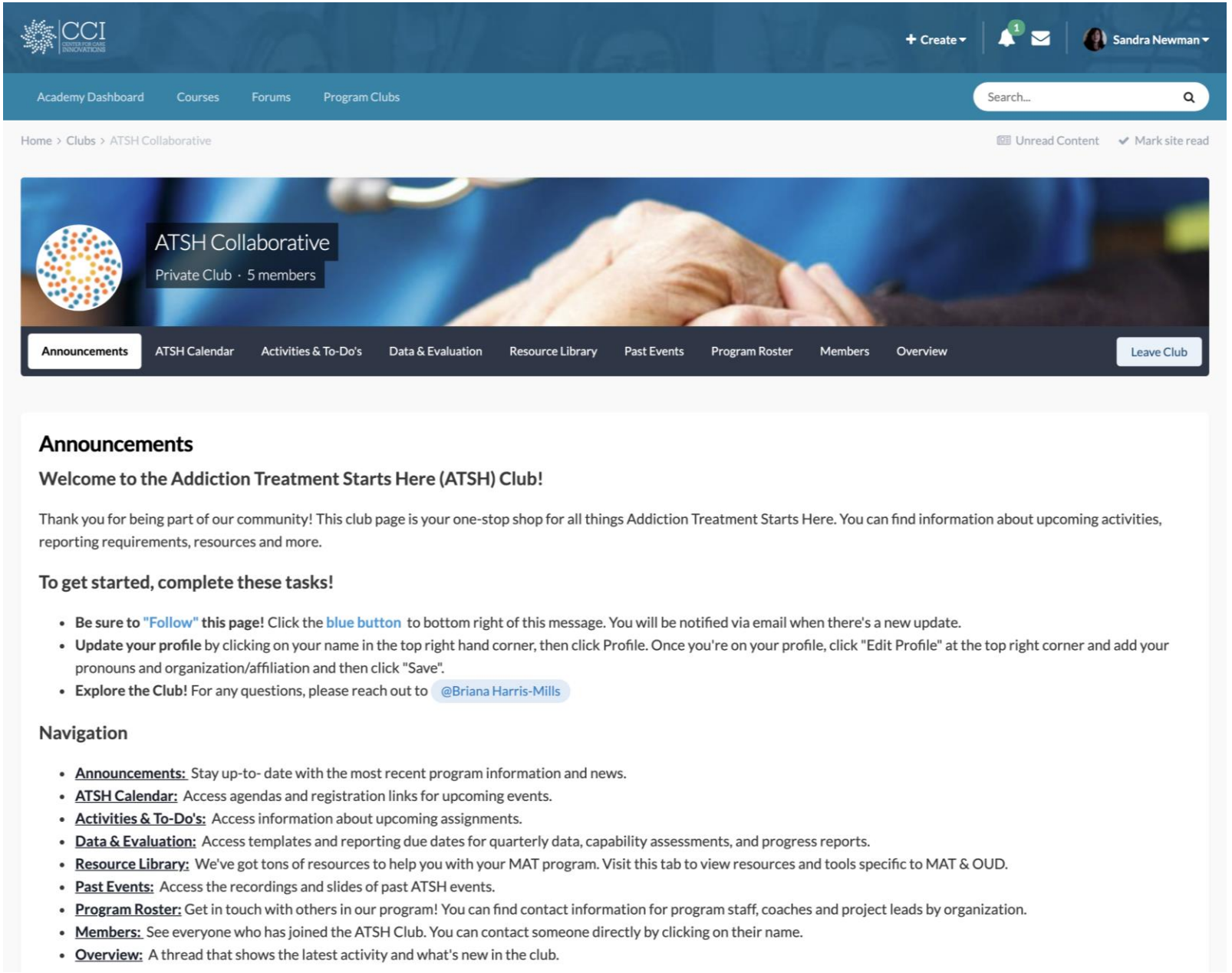
- CCI point of contact – Meaghan Copeland, Meaghan@careinnovations.org
- 1-hour onboarding webinar at beginning of program
- Technical support with data portal
- Validation of submitted data and notifications to improve data accuracy
- Run charts showing progress and comparison to peers
- Support discussions in 1:1 coaching sessions
- Feed back aggregate data via webinars and learning sessions
- Data community of practice – informal conversations with peers to discuss other internal measures for measuring success (e.g., patient experience measures)

Key Dates – Measurement Strategy

Date/Deadline	Submission
March 31 OR April 14, 2021	Measurement Onboarding Webinar (attend 1 only)
April 30, 2021	Baseline IMAT capability assessment (IMAT) Quarter 1 data (period 1/1/21 – 3/31/21)
July 15, 2021	Quarter 2 data (period 4/1/21 – 6/30/21) Progress report #1
October 15, 2021	Quarter 3 data (period 7/1/21 – 9/30/21)
December 3, 2021	Midpoint IMAT capability assessment
January 14, 2022	Q4 data (period 10/1/21 – 12/31/21) Progress report #2
April 15, 2022	Q5 data (period 1/1/22 – 3/31/22)
June 15, 2022	Endpoint IMAT capability assessment
July 15, 2022	Q6 data (period 4/1/22 – 6/30/22) Final narrative & financial report

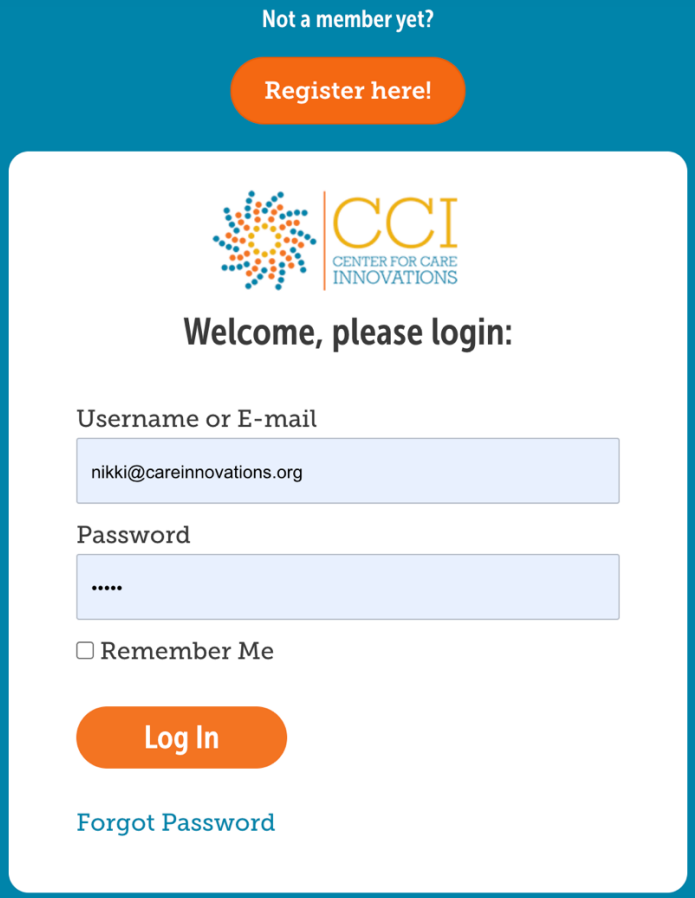
About Addiction Treatment Starts Here – Online Home

ATSH Online Home



ATSH Virtual Home on the CCI Academy

Create an account on the CCI Academy to join the ATSH Virtual Home. If you already have an account, log in.



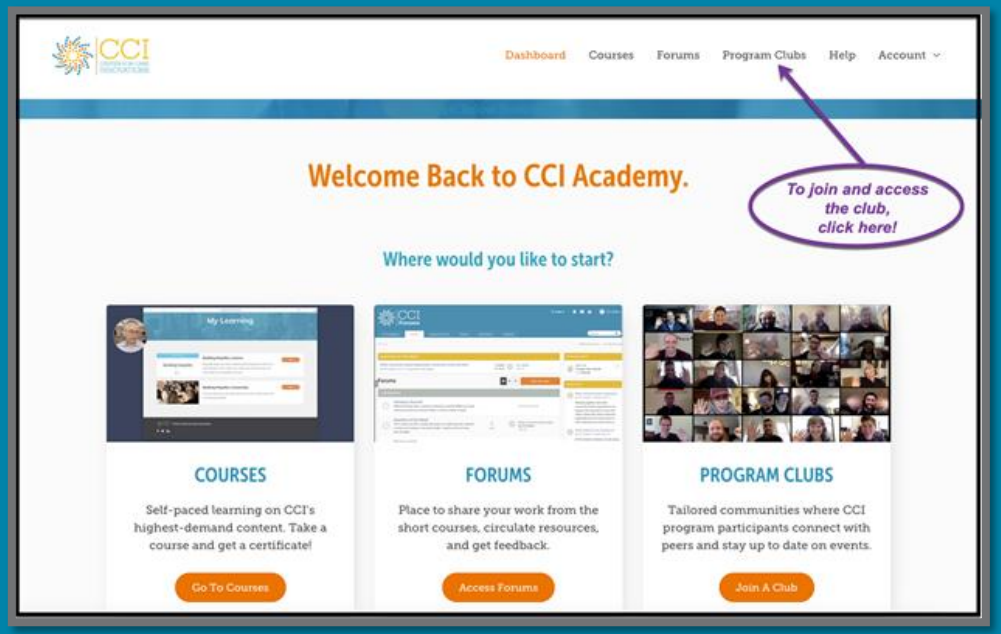
What is the ATSH Virtual Home?

This virtual home will be your one-stop shop for all things Addiction Treatment Starts Here.

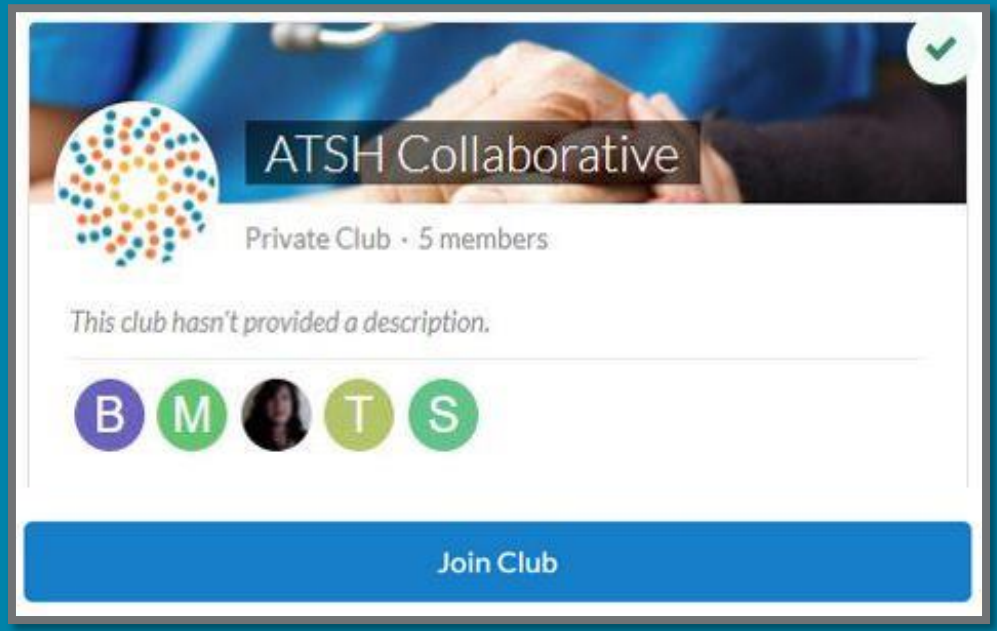
You will find information about upcoming activities, links to register for events, reporting requirements, MAT tools and resources and more!

ATSH Virtual Home Next Steps

1. Once logged in, navigate to the Program Club tab at the top of the page.



2. Find the ATSH Collaborative Page under the Featured Clubs section and click the blue "Join Club" button.



3. Once you've joined the club, bookmark the website!

Stretch Break + Transition to Breakouts

Breakout Groups

Group A: Brian

- LA DHS - Rancho Los Amigos
- LA DHS - High Desert
- LA DHS - H. Claude Hudson
- LA DHS - Edward R. Roybal

Group B: Dominique

- SFHN - Family Health Center
- SFHN - Richard Fine Peoples Clinic
- SFHN - Castro Mission Health Center

Group C: Ginny

- Comprehensive Community Health Centers
- Southland Integrated Services
- Via Care

Group D: Joe

- Bartz Altadonna
- Santa Cruz
- RUHS - Moreno Valley

Group E: Katie

- Adventist Health - Feather River
- Adventist Health - Lemoore
- CHCSD - City Heights
- FHCSD - Grossmont
- Santa Barbara Neighborhood Clinics

Group F: Mark

- Senior leaders from each team

Stretch Break

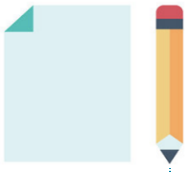
Next Steps

Poll Questions

1. On a scale of 1 – 5, please select the number that best represents your experience with today's session

5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree

2. Please select the number that best represents your response to the statement: Today's session was a valuable use of my time.



5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree

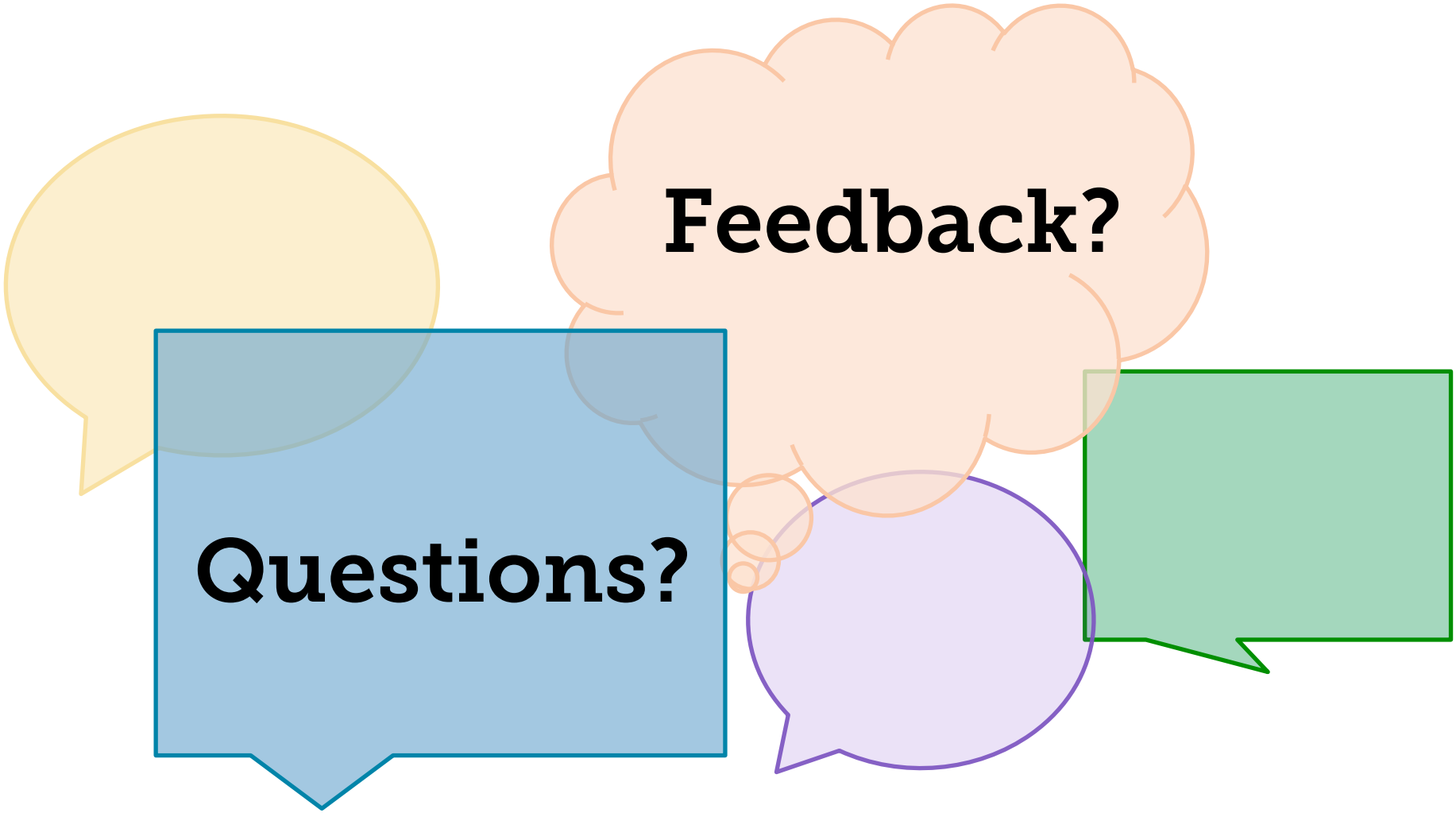
3. I can apply learnings from today's webinar to my MAT work.

5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree

Onboarding Checklist

Action Item	Date
Finalize team composition, send list with contact information to Briana Harris Mills	ASAP!
Measurement onboarding webinar	March 31, April 14
Schedule first coaching call	April 5
Complete baseline IMAT capability assessment	April 30
Submit Q1 data on program measure set	April 30

Questions + Answers


Feedback?
Questions?

Thank you!

For questions contact:

Tammy Fisher
Vice President
Center for Care Innovations
tammy@careinnovations.org

Briana Harris Mills
Senior Program Coordinator
Center for Care Innovations
briana@careinnovations.org

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CENTER FOR CARE INNOVATIONS

Appendix A: Calendar

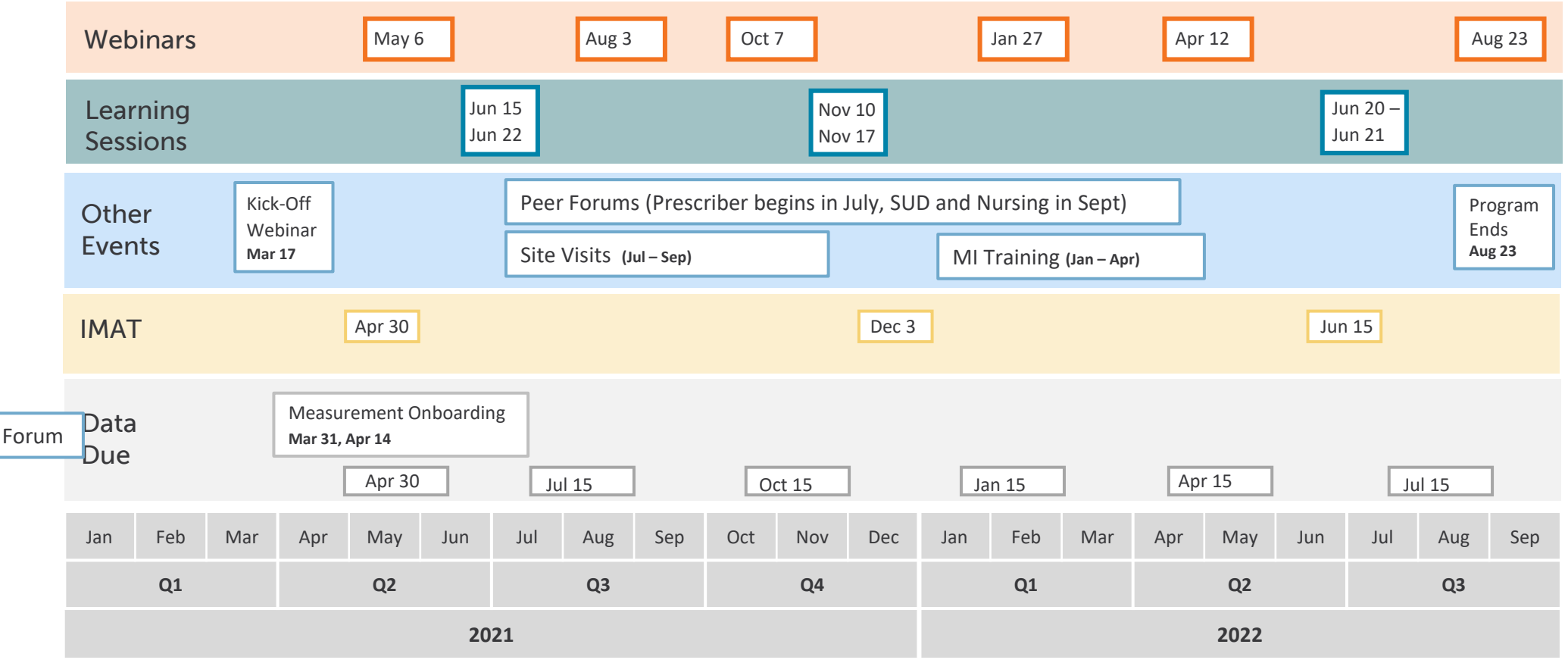
ATSH 2021 Calendar

March 17	Kick-Off Webinar (today!)	Quarterly Data Submission Due Progress Report 1 Due	July 15
March 31	Measurement Onboarding Webinar (Option A)	Topical Webinar #2	August 3
April 14	Measurement Onboarding Webinar (Option B)	Topical Webinar #3	October 7
April 30	Quarterly Data Submission Due Baseline IMAT Capability Assessment Due	Quarterly Data Submission Due	October 15
May 6	Topical Webinar #1	Learning Session 2 Reg Deadline	October 27
June 1	Learning Session 1 Reg Deadline	Learning Session 2 (Virtual Part 1)	November 10
June 15	1st Grant Installment Release	Learning Session 2 (Virtual Part 2)	November 17
June 15	Learning Session 1 (Virtual, Part 1)	2nd Grant Installment Release	November 30
June 23	Learning Session 1 (Virtual, Part 2)	Midpoint IMAT Capability Assessment Due	December 3

ATSH 2022 Calendar

January 14	Quarterly Data Submission Due Progress Report 2 Due	Endpoint IMAT Capability Assessment Due	June 15
January 27	Topical Webinar #4	Learning Session 2 (in-person)	June 20 – June 21
February 28	3rd Grant Installment Release	Quarterly Data Submission Due Progress Report 3 Due	July 15
April 12	Topical Webinar #5	Topical Webinar #6	August 23
April 15	Quarterly Data Submission Due	4th Grant Installment Release	August 31
May 30	Learning Session 3 Reg Deadline	ATSH Ends	August 31

ATSH Collaborative Calendar



Appendix B: Funding & Reports

Funding + Reports

Each team is eligible for up to $65,000 in funding across the 18-month collaborative. Disbursements are made assuming several deliverables are met

Date	Amount	Deliverables
June 15, 2021	$15,000	▪ Participation in kick-off webinar, baseline data, baseline IMAT capability assessment
November 30, 2021	$15,000	▪ Two quarters of data, aim statement, participation in learning session 1
February 28, 2022	$15,000	▪ One quarter of data, midpoint IMAT capability assessment, progress report, participation in learning session 2
August 31, 2022	$20,000	▪ Two quarters of data, endpoint IMAT capability assessment, progress report, attendance at learning session 3

Note: Disbursements are made by the Sierra Health Foundation. Processing may take up to one month.

Appendix C: Measures & Definitions

Access a PDF of the Program Measures Definitions: https://www.careinnovations.org/wp-content/uploads/Final-Program-Measures-and-Definitions_ATSH-PC-Wave-3-Learning-Collaborative_March-2021.pdf

Program Measure Set Definitions

	MEASURE	DEFINITION
A.	**Adoption - Opioid Use Disorder (OUD)**	
A1	# of x-waivered prescribers	Total number of physicians, nurse practitioners or physician assistants, onsite and with whom the clinic site has contracts, who have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder (OUD) with medications approved by the U.S. Food and Drug Administration (FDA) for this indication. This number must be current up to the end of the reporting period, meaning that only x-waivered prescribers working at the site in the last month of the reporting period should be counted. Prescribers on leave or that left the organization during the last month of the reporting period would not be counted. Planned, in process or pending waivers do not count for the current reporting period.
A2	# of prescribers actively prescribing buprenorphine	Total number of prescribers who have prescribed buprenorphine for OUD to at least 1 patient during the reporting period. This measure does not apply to prescribers of naltrexone long-acting injection. Prescribers include those with and without an x-waiver.

Program Measure Set Definitions cont.

	MEASURE	DEFINITION
B.	**Reach - Opioid Use Disorder (OUD)**	
B1	# of patients prescribed buprenorphine	The total number of unique patients in the clinic site with a current, active prescription for any formulation of buprenorphine. Included patients may be new, restarted or established. "Active" is defined as having a current prescription during the last 30 days of the reporting period only. Do not count patients who were active earlier in the reporting period, but whose prescription expired prior to the last month of the reporting period. The buprenorphine medication should be FDA approved for the indication of OUD only. Excluded patients are those prescribed buprenorphine for indications that do not include OUD, such as pain.
B2	# of patients prescribed naltrexone long-acting injection	The total number of unique patients in the clinic site who were administered naltrexone long-acting injection during the last 30 days of the reporting period only. Included patients may be new, re-started or established. Do not count patients who were administered the injection earlier in the reporting period, but who did not receive the injection in the final month of the reporting period. Excluded patients are those prescribed naltrexone for alcohol use disorders.
B3	[Auto-calculated] Total # of patients prescribed/ administered medications for OUD	**No data is entered for this measure. The measure is automatically calculated as the sum of B1 and B2 entries for the current reporting period.** This measure represents the sum of new, restarted or established patients prescribed buprenorphine and administered naltrexone long-acting injection in the final 30 days of the reporting period.
B4	Total # of new or re-started patients prescribed/administered medications for OUD	Of the total number of patients calculated for B3, calculate the subset of patients who were newly started on the medications or who re-started medications during the last 30 days of the reporting period.

Program Measure Set Definitions cont.

	MEASURE	DEFINITION
C.	**Retention - Opioid Use Disorder (OUD)**	
C1	# of all patients prescribed medications for OUD (MOUD) 6 months prior to the reporting period who adhered continuously for 6 consecutive months	This measure is calculating the retention number and rate of all patients over a 6-month period. Tip: We recommend using a registry to track patients and make this calculation easier. Indicate when patients are newly started or re-started. The retention number is calculated by the numerator. The numerator is the total number of patients prescribed either buprenorphine or naltrexone long-acting injection for OUD at 6 months prior to the reporting date (equal to B3 from two quarters prior to the current reporting period), **and** who have remained in care continuously (without interruption) for 6 months. "Continuous care" is defined as patient care where gaps do not exceed 28 days. Care includes starting the medication, being prescribed refills and attending scheduled visits (in-person or virtual). The retention rate is calculated by dividing the numerator by the denominator. The denominator is all patients from 6 months prior (the same as B3 from two quarters prior to the current reporting period). The denominator is calculated automatically. **See full measure definitions document for example calculation.**
C2	# of new start or re-started patients prescribed MOUD 6 months prior to the reporting period who adhered continuously for 6 consecutive months	This measure calculates the retention of only new start or re-started patients over a 6-month period. This is a subset of patients calculated in Measure C1. Tip: We recommend using a registry to track patients and make this calculation easier. Indicate when patients are newly started or re-started to help with this measure's calculation. The retention number is calculated by the numerator. The numerator is the total number of patients started or re-started on buprenorphine or naltrexone long-acting injection for OUD at 6 months prior to the reporting date (equal to B4 from two quarters prior), **and** who have remained in care continuously and without interruption for 6 months. "Continuous" is defined as having no gaps in care of more than 28 days. Care includes starting the medication, being prescribed refills and attending clinic visits (in-person or virtual). The retention rate is calculated by dividing the numerator by a denominator that represents all new or re-started patients from 6 months prior (the same as B4 from two quarters prior). The denominator is calculated automatically.

Program Measure Set Definitions cont.

	MEASURE	DEFINITION
D.	**Identification - Stimulant Use Disorder (StUD)**	
D1	Total # of new patients identified as having an StUD	The total number of new patients at the clinic site identified within the reporting period with current ICD10 codes of one or more cocaine related disorders and/or stimulant related disorders or DSM5 diagnosis of a stimulant use disorder. A stimulant use disorder (StUD) is characterized by the disordered use of methamphetamine, cocaine, and/or other stimulants. "Current" is defined as within any of the 90 days of the reporting period. Patients with co-occurring substance use disorders (e.g., a patient with OUD and an StUD) may be counted. Guidance for identifying patients for this measure can be found in the full measurement definitions document.
D2	Total # of newly identified patients with an StUD who also have OUD	The total number of newly identified patients at the clinic site identified with a stimulant use disorder who also have a current ICD10 or DSM5 diagnosis of opioid use disorder. Use the population of patients you identified in D1. This measure calculates how many of these patients also have co-occurring OUD.

Program Measure Definitions cont.

	MEASURE	DEFINITION
E.	**Treatment - Stimulant Use Disorder (StUD)**	
E1	Total # of newly identified patients with an StUD who received any treatment for an StUD	The total number of newly identified patients with a stimulant use disorder at the clinic site who received any documented treatment for an StUD on any date within the current reporting period. Treatment includes medications, contingency management, individual therapy, group therapy, other behavioral health interventions, or any other treatment. Use the population of patients you identified in D1. If a patient receives more than one form of treatment or received treatment multiple times during the reporting period, the patient should be counted only once for this measure.
E2	# of newly identified patients with an StUD who received medications for treatment of an StUD	The total number of newly identified patients with a stimulant use disorder at the clinic site who were administered any medication for the off-label indication of an StUD within the reporting period. Use the population of patients you identified in D1. Patients may be double counted across the different forms of treatment but not counted twice if medication was administered multiple times within the reporting period.
E3	# of newly identified patients with an StUD who received contingency management or other incentives as treatment for an StUD	The total number of newly identified patients with a stimulant use disorder at the clinic site who received contingency management or other incentives as treatment related to their StUD on any date within the current reporting period. Use the population of patients you identified in D1. Patients may be double counted across the different forms of treatment but not counted twice if they received this intervention multiple times within the reporting period.
E4	# of newly identified patients at your site with an StUD who received individual therapy, group therapy, or other behavioral health interventions as treatment for an StUD	The total number of newly identified patients with a stimulant use disorder at the clinic site who received any behavioral health intervention as treatment related to their StUD. Behavioral health interventions may include individual therapy, group therapy, or other interventions. Examples of interventions include cognitive behavioral therapy, community reinforcement approach, and motivational interviewing. Use the population of patients you identified in D1. Patients may be double counted across the different forms of treatment but not counted twice if they received this intervention multiple times within the reporting period.