Bree Collaborative | Treatment for OUD Revision
January 16th, 2023| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUAL

Michael Sayre, MD, Medic One
Brad Finegood, King County
Everett Maroon, BMH2H
Tina Seerey, WSHA
Sue Petersohn, RN, MBA, CARN, Multicare
Mark Murphy, MD, Multicare
Libby Hein, LMHC, Molina
Ryan Caldeiro, MD, KP
Herbie Duber, MD, DOH
Bob Lutz, MD, MPH
Amanda McPeak, PharmD
Jason Fodeman, MD, LNI
Maureen Oscadal, RN, CARN, Harborview/ADAI
John Olson, MD, Sound Health
Daniel Floyd, King County BHRD

MEMBERS PRESENT IN PERSON

Tawnya Christiansen, MD, CHPW

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Ginny Weir, MPH, CEO, Foundation for Health Care Quality

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the first Bree Treatment for OUD Revision workgroup. Those present introduced themselves, their organizations, and their current experience working with people with OUD.

DISCUSS: BREE BACKGROUND AND WORKGROUP PROCESS

Beth introduced the Bree and the workgroup process. The Bree Collaborative is a program of the Foundation for Health Care Quality. The Bree was established by the state legislature in 2011 in response to health care services with high variation and utilization that do not produce better outcomes. Each year, Bree members (drawn from public and private healthcare stakeholders) choose three to four topics to develop recommendations. Revising the Treatment for OUD report is one of three topics for 2024.
The workgroup will meet monthly throughout 2024 to revise and update the Treatment for OUD report, originally published in 2017. The report will include recommendations for specific health care stakeholders and will be sent to the WA Health Care Authority. The workgroup must follow Open Public Meetings Act regulations. This includes workgroup member training and conflict of interest disclosure.
Following the presentation, Beth opened the floor for comments, but there were no questions.

PRESENT: OVERVIEW OF 2017 RECOMMENDATIONS

Beth opened the brainstorming conversation with a discussion on additional stakeholders to consider inviting to participate or speak:

- Some additional stakeholders to consider for participation include:
    - People with lived experience

    - Someone from or working with immigrant communities, and non-native English speakers
    - SUD agency providers
    - Opioid treatment programs (e.g., Evergreen)
    - Dental experts
    - Tribal health representatives

Beth asked for contact information for individuals to ask for participation or to invite to speak. Beth then provided a broad overview of the guidelines in the 2017 report. The report's original focus areas included 1) **Access to Evidence-based Treatment**: medication treatment using buprenorphine, methadone, or naltrexone (e.g., increasing geographic reach, increasing number of providers), and reduction in stigma associated with treatment; 2) **Referral Information**: providers and patients know where to access care, accessible inventory of buprenorphine and methadone prescribers, and referral infrastructure that supports patients and providers, and; 3) **Integrated Behavioral and Physical Health to Support Whole Person Care:** treatment of comorbid conditions including multiple substance use, mental illness and physical health in line with Behavioral Health Integration Report and Recommendations. Stakeholders included patients and family members, clinicians, programs and facilities, health plans, Washington State agencies, Employers, Correctional Facilities, and Health Services Academic Training Programs and Residencies. Stakeholder specific recommendations are summarized below:

- Patients and Families
    - Identify your medical or health home where you are most comfortable receiving both behavioral health and primary care.
    - Talk with your doctor and care team about treatment options. (link to SAMHSA Decisions in Recovery: Treatment for OUD)
    - Know your rights as a patient. Learn how to recognize the signs of an opioid overdose and call 911 immediately if exhibiting symptoms.
    - Learn more about preventing overdose – ask provider about carrying naloxone.
- Clinicians
    - Work with a patient to find the right type of treatment for them.
        - Provide multiple treatment options, patient decision aids may be helpful.
        - Discuss risks and benefits of all treatment options, and patient characteristics that impact selection of medication.
        - Understand risks of serious adverse events for withdrawal management and counseling without medication
    - Become waivered to prescribe buprenorphine.
    - Identify accredited OTP where you can refer any patient who fails to stabilize in the office setting
    - Work to reduce stigma when talking to patients and to other staff members. Use language that reduces stigma when talking to patients and other staff members.
        - Work to reinforce the idea of opioid use disorder as a chronic, relapsing brain disease.
    - Prescribe naloxone.
    - Coordinate physical and behavioral healthcare
- Programs and Facilities
    - Work to reduce stigma by talking to staff about opioid use disorder, reinforce idea as a chronic relapsing brain condition, provide links to short current guidelines regarding

opioid use, distribute copies of language guidelines to be used when discussing substance use disorder
    - Treat adolescents and teens in accordance with MAT best practices (full range of treatment options, involve family, treatment in specialized treatment facilities, screen for mental health, blood borne pathogens, contraceptive needs, STIs
    - Treat patients who are pregnant in accordance with MAT best practices: train pre and perinatal providers about OUD including recognizing signs of OUD, facilitate safe care, integrate prenatal care with OUD care, comanage pregnant patients with OUD with prenatal care and addiction specialist, routine verbal screening for substance use disorder, urine drug testing with informed consent, supported referral to refer patients to a setting offering methadone/buprenorphine rather than withdrawal management, initiate treatment with opioid replacement therapy as early as possible, hospitalization during initiation may be advisable
    - Prepare patient materials describing risks and benefits of available OUD treatment options, train staff on how to talk to patients about best treatment
    - Offer MAT in primary care and mental health clinics in accordance with established guidelines
    - Assess possible medication interactions, treatment of OUD should not be delayed but benzo use concurrently is dangerous
    - Identify patients with comorbidities, criteria and partners for referral, build relationshisp with OTPs, mental healthcare should be available but not required for MOUD treatment
    - Refer to appropriate levels of care; mental health professionals for patients with cooccurring mental health conditions, when OTP referral is relevant
    - Support patient involvement in other programs (peer support) but do not use attendance as criterion for receiving medication,
    - Prescribing opioids for pain: follow prescribing guidelines (Agency Medical Director's Group, CDC 2016 guidelines), require prescribers of controlled substances to sign up for and routinely use PMP, facilities with more than 5 prescribers provide PMP with information as to their employed and credentialed prescribers, develop system to monitor patients on high dose of opioids, provide naloxone, adopt policies that limit standard post-procedural 30-day supply of medication
    - Evaluate effectiveness of programs offered at facility at regular intervals,
    - Share information: assure appropriate systems and structures are in place to help share information between and across physical and behavioral health providers while respecting privacy and confidentiality.
- Chemical dependency programs
    - Follow everything under programs and policies
    - In addition, update training in conjunction with evidence based treatment
    - Do not encourage patients to stop medication treatment
    - Build capacity to provide integrated behavioral and primary care
    - Collaborate with other providers to ensure that any patient requiring inpatient stays continues medication treatment
    - Build consultation options for staff who need/want consultation
    - Write prescription for naloxone
    - Assure appropriate systems and structures are in place to share information between and across physical and behavioral health providers
- Health Plans

    - Support whole-person care: develop a reimbursement structure that actively facilitates and encourages office-based buprenorphine prescribing; consider alternative payment models that cover supportive, wrap around care
    - Support use of MAT – remove prior auth protocols for methadone, buprenorphine and naloxone for adults and pregnant patients
    - Incentivize providers or facilities in areas without access to buprenorphine to begin and maintain office-based opioid treatment services
    - Reduce copays to support appropriately timed personalized dosing
    - Support OTP reimbursement structures to cover cost of effective care including buprenorphine, naltrexone and telehealth
    - Support OTP reimbursement structures that facilitate use of buprenorphine and telehealth
    - Ensure that reimbursement programs do not prohibit patient access to med treatment
    - Reimburse provision of treatment for smoking cessation
- HCA
    - Certify patient decision aids
    - Review treatment program effectiveness – conduct and share evaluations of the effectiveness of different treatment approaches
- Department of Health
    - Offer training on medication treatment
    - Division of BH and Recovery
        - Provide treatment program information
            - Include annual substance use treatment guide whether programs offer methadone, buprenorphine-naloxone or naltrexone
            - Maintain accessible current treatment directory
- Employers
    - Eliminate insurance barriers – full range of evidence-based treatments
    - Educate employees – if EAP offered, promote understanding of BH benefits and potential opioid misuse
    - Reduce employment barriers – do not create restrictions on employment
- Correctional Facilities
    - Initiate or maintain existing medication treatment
    - Prescribe/dispense naloxone upon release
    - Build relationships with nearby OTPs to initiate treatment
- Health Services Academic Training Programs and Residencies
    - Include information on substance use disorders in the curriculum
    - Support use of medication treatment
    - Measure success of integration of evidence-based information

The recommendations were then broken out by setting (e.g., primary care) describing the current state, some intermediate steps that could be taken and the optimal care state which all settings should strive to achieve.

DISCUSSION: SCOPE AND CHARTER

Beth turned the meeting over to Karie who reviewed how the evaluation ties into the development of the report. We want to design the evaluation tools alongside the recommendations so they are

seamlessly connected. Tools for evaluation like a theory of change or logic model can support methods of goal identification, and help narrow the scope on what is realistic.
Karie then reviewed some current findings, including that health systems and small clinics had more difficulty in general implementing the guidelines, particularly around staff requirements. The organization with the lowest score was a rural/critical access hospital. The score used to evaluate this guideline was from 0-3 (0 no adoption, 1 considering adoption, 2 some or partial adoption, and 3 full adoption). Results so far:

- Staff trained on addressing stigma and bias for drug use and addiction (1.0)
- PCPs waivered to prescribe buprenorphine (1.7)
- Patients with OUD have naloxone prescription (2.0)
- Patients with current OUD diagnosis and documented visit for receiving MAT (2.0)

Beth then transitioned the conversation towards identifying our the workgroup's goals. What outcomes would we want to see from updating the report. Comments on scope included:

- Updating information to accommodate for new medications as well as medication updates
- Addressing fentanyl manufacturing
- ED initiation of MOUD
- Increase in screening and co-occurring models of care with mental health conditions
- Addressing barriers with tele-prescribing and using telehealth to address access barriers
- Polysubstance use, especially with stimulants
- Changes in criteria for ASAM
- Addressing use of trauma-informed care principles and harm reduction
- Education, training and financial considerations for implementing the recommendations
- The report is already out of date and can't keep up with the regulatory changes and the evolution of substance use trends, so the group proposed recommending a cadence for evaluation and update of the report

Beth then transitioned to reviewing the charter and updating the aim statement and purpose. The aim was updated from "decreasing opioid use and overdose" to "increase access to evidence-informed treatment for opioid use disorder and prevent opioid overdose in Washington state"
The purpose was updated to include the following:

- Reflect current regulatory and policy environment
- Identify evidence-informed strategies to screen for and address fentanyl use, co-occuring polysubstance use and/or other behavioral health diagnoses
- Promoting use of trauma-informed care and harm reduction principles across settings
- Review best practices for low barrier, increased access to MOUD (e.g., teleprescribing, EMS initiation)
- Funding mechnaisms for and barriers to high quality treatment for OUD
- Outline barriers and identify possible soluations to evidence-informed, low barrier OUD treatment (e.g., funding, regulatory environment)
- Recommending a cadence for evaluation and update of the report

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the team review comments made from the Bree member meeting on January 24th and continue the brainstorming discussion around potential focus areas for the revision and other updates. The workgroup's next meeting will be on Thursday, February 20th from 3 – 4:30PM.