Bree Collaborative | Treatment for OUD Revision
February 20th, 2024| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUAL

Everett Maroon, BMH2H
Tina Seerey, WSHA
Sue Petersohn, Multicare
Mark Murphy, Multicare
Libby Hein, Molina
Ryan Caldeiro, KP
Herbie Duber, DOH
Bob Lutz, DOH
Amanda McPeak, Harborview/Kelley-Ross
Jason Fodeman, LNI
Maureen Oscadal, Harborview/ADAI
John Olson, Sound Health
Daniel Floyd, King County BHRD
Tawnya Christiansen, CHPW
Tom Hutch, We Care Daily
Nikki Jones, UHC
Kelly Youngberg, ADAI
Cris DuVall, Compass Health, Island Drug
Liz Wolkin, Washington HCA

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Michelle Tran, WSPA (Washington State Pharmacy Association)
Boris Zhang, WSPA
Hillary Norris, WSMA
Natalie Dziadosz

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the Bree Treatment for OUD Revision workgroup February meeting. Beth invited those new to the workgroup to introduce themselves. Beth then went over the process for approving the minutes and got the meeting minutes from January approved.

Action: Unanimously approved January meeting minutes

PRESENT: EVALUATION DATA AND SUBCOMMITTEE

Beth turned it over to Karie to review the Treatment for OUD report evaluation results. Karie states that we have had difficulty understanding if organizations adopt our guidelines, and so we conducted an evaluation. We asked different organizations to identify how much these guidelines were adopted. The information presented are preliminary results from the evaluation of the Treatment for OUD guidelines, displayed in the table below:

The scale used in the evaluation was: 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; 3 -Full adoption

Report	Overall Score	Audience	Score
OUD Treatment	2.1	Health Systems	2.0
		Health Plans	2.9
		Small clinics/FQHCs	2.0
		Critical Access Hospitals	1.0
	Item Description	**Item ID**	**Score**
	Reimbursement office-based buprenorphine prescribing	Hp1, hp3	3.0
	Remove prior authorization	hp2	3.0
	Copays, patient costs	Hp4, hp5	2.5
	Reimbursement supports MAT and telehealth	Hp6, hp7	3.0
	Provider Stigma and Bias Training	Med 1	1.6
	Patients with OUD diagnosis receiving MAT	Med 4	2.0
	Providers are waivered	Med 2	1.8
	Patients with diagnosis have prescription	Med 3	2.0

Karie elaborated that:

- Metrics seem to be more difficult to adopt in general, and tend to score low
- Stigma and bias and are patients receiving MAT are particularly low
- Hopeful that these scores will inform the evaluation strategy for this update

Questions

- Stigma and bias training score seems low relative to others, are there any qualitative data on what barriers orgs experienced in training?
    - We asked generally about barriers and enablers and asked them to comment on certain things, not sure if we have specific qualitative information at this point. Will be adding to the report if we have it. Will circle back as Karie takes a closer look at the qualitative data.

Karie then transitioned to the subcommittee, detailing that we are starting a subcommittee and looking for a few members from the workgroup. The meetings will occur April – September, developing a dashboard structure to put up on our website and look in real-time to see what is going on.

- We'll come up with evaluation items (self-attestation for organizations)
- Identifying existing metrics if metrics exist to measure progress towards a goal.
    - E.g., getting more people into treatment, identify metrics that reflect that goal.
- Might have 2-3 UW students working on this a little bit April – June doing legwork
- Volunteers:
    - Everett Maroon
    - Tina Seerey
    - Herbie Duber
    - Kelly Youngberg

Action: Karie to follow up with subcommittee volunteers after workgroup meeting

PRESENT & DISCUSS: EXISTING GUIDELINES

Beth then turned the discussion toward reviewing preliminary existing guidelines for the report. Resources reviewed included:

- ASAM National Practice Guideline for the Treatment of OUD (2020)
- ASAM: Clinical Practice Guideline on Management of Stimulant Use Disorder
    - Question: what is StUD? – Stimulant Use Disorder
- PCSS: Practice Based Guidelines – Buprenorphine in the Age of Fentanyl (2023)
- SAMHSA: Treating from Concurrent Substance Use Among Adults (2021)
- AHRQ: The Role of Low-Threshold treatment for Patients with OUD in Primary Care
- AHRQ: The Role of Primary Care and Integrated Behavioral Health in Polysubstance Use
- USPSTF: Unhealthy Drug Use – Screening (2020): recommends screening by asking questions about unhealthy drug use in adults age 18 or older
- USPSTF: Illicit Drug Use in Children, Adolescents and Young Adults: Primary Care-Based Interventions (2020)
- AHRQ: Primary Care Relevant Interventions to Prevent OUD: Current Research and Evidence Gaps (2021)
- CDC: Opioid Use Disorder Prevention and Treatment Website
- ADAI: Unmet Needs, Complex Motivations and Ideal Care for People Using Fentanyl in Washington State – Qualitative Study (2023)
    - Kelly: 2024 survey released soon
    - Everett: this study was good for gathering information from people in what has gotten in their way in getting to treatment
- ADAI: Treatment medications for fentanyl use disorder: Prescriber practices and support needs in WA state (2023)

REVIEW AND DISCUSSION: 2017 OUD GUIDELINES

Beth transitioned the group to reviewing the 2017 OUD guidelines in more detail, beginning with the stakeholder specific recommendations. Beth invited feedback on language, themes in the guidelines or anything else we might need to address as part of the update.

- People with OUD and Family Members
    - Chat Comment: settings for care have expanded since this was written. Started off listening to some of the low barrier programs that are out there, they take place in a variety of settings like FQHCs or community-based organization, and new health engagement hub pilot program looking at primary care in nontraditional settings. In the ADAI interviews, the question on what ideal care looks like to you did not reach saturation as there were so many different answers.
- Programs and Facilities:
    - Comment: There are programs in the state that do direct outreach to people, people are receiving care and treatment where they are living so will be important to capture that. (mobile settings, community-based organizations, home-based care)
    - Comment: make sure to include telehealth providers, many people are benefitting from telehealth options
        - Is Telehealth option for MOUD going to become permanent?
            - Not able to predict, but seeing an increase in use of telehealth providers, so good to recognize that it's really working for some people
            - Everett – JAMA had article recently about telehealth connection to OUD care

    Action: find JAMA article on effectiveness of telehealth connections for OUD

- Providers
    - Comment: do we want to call out long-acting injectables specifically? LAI buprenorphine has a very different process in terms of administration, settings and regulations. Long-acting formulations are new since the 2017 report.
    - Comment: language change MAT -> MOUD
    - Comment: Consider changing language of x waiver to ask consider replacing pharmacies and clinics becoming LAI REM certified. For LAIs, it requires specialty approval to start them, so if the group is interested in pursuing LAI evidence review we could encourage them to get certified instead.
    - Comment: Not sure if transitioning to OTPs is universally practiced. Finding that transition somewhere elsewhere if they haven't stabilized often results in losing people. Practice has changed to doing more shared decision making with patients and doing more support in clinic compared to transitioning to an OTP. An emphasis on keeping individuals in the setting in which they engaged is important, troubleshooting as much as possible before transitioning.
        - Reply: Intensify care management in patients preferred locale of treatment
        - Reply: Don't discontinue treatment when transitioning to different care setting
        - Focus on transition between care settings when its necessary, like necessitating a warm handoff
        - Reply: definition of stabilizing isn't clear as well, in practice its someone not being able to take their medications which is where sublicade is helpful; however, if someone not taking medications anymore is what we're saying stabilization is, that is something we'd want to tease out.
    - Comment: use change in vocabulary – when patients aren't meeting their treatment goals, providers are aware of resources in the community and the referrals for changing that patients level of care, intensifying level of care, whether its formal ASAM level of care intensification or wanting to try a different care setting
        - Agree that transitions whether someone is leaving jail, a hospital, etc, are often points at which people have higher risk of being lost to follow-up, but shouldn't change the options available, and that providers should be well informed about resources available and places they can go.
    - Question: is there any relevance or guidance for patients receiving episodic care in the ED/Hospital environment?
        - Value looking into evidence for ED/Hospital environments for the recommendations
        - ADAI working on improving ED treatment, Molina looking into partnership with WI to create pathways and workflows for patients in ER, not the preferred place for patients to get care, but that's where they are getting care.
        - Comment: incidence is high being seen in the ED, also want to capture individuals in hospital settings that are admitted for other things and how they can be cared for in those settings.

      Action: look into BRIDGE program transitioning people out of ED

      Action: look into overdose center in King County, divert people from ED and have them bring them directly to appropriate facility that can treat them in a more harm reduction way
    - Comment: Would options such as Vivitrol (naltrexone) be good to mention during transitions of care? For people transitioning from jail, or other long-term facilities, that

have already gone through detoxification but have yet to see primary care provider to prevent overdose by preventing going back to illicit use with a decreased tolerance.
        - Reply: Things have changed in the use of Vivitrol, it's not used as much anymore because of updated evidence so would like to have discussion with the group on whether or not we should include in this report and how
        - Reply: evidence-base is limited for naltrexone, think we should discuss further if we want it to be in the recommendations
    - Question: what about creating a subgroup for evidence review?
        - Last time we did subgroups we ended up missing pieces of evidence review at the end, so it would likely be in the group's best interest to steer clear of subgroups for the time being
- Settings
    - Comment: strong recommendation to include Inpatient Care to the list of care settings, can be a spot where people get access
        - Reply: Harborview's Addiction Medicine Specialists are a newer team but get lots of patients started on MOUD that then transition to the primary care setting
        - Reply: Inpatient treatment has changed significantly since 2017, more hospitals are getting people started on bupe when they can, OTPs have started remotely admitting patients when they can to ease transitions from hospital settings,
        - Harborview and two Swedish campuses can now discharge patients on MOUD including methadone with up to three days of medications avoiding the rush of getting to an OTP the day after they discharge.
        - Question: Have we discussed recommendations around the 3-day methadone prescribing changes yet?
            - Not yet
- Question: do we have a shared folder for resources/regulations/literature?
    - Not yet, but will set one up! Google Drive will work best

Action: Beth to set up folder for shared resources

DISCUSSION: FOCUS AREAS

Beth transitioned the group to discussing the group's focus areas. Beth described that evaluation of previous reports has shown that more concise, scoped reports tend to be implemented easier. We hope to identify 1-2 narrow goals that if achieved would have the greatest impact for people.

- Karie provided an example: most recent Diabetes report was very good, had three large areas looking at prediabetes, primary care empanelment and gaps in care for people with diabetes currently, and the feedback we are getting is that it could have been about one of those things
- Pointing out what has the biggest gap or what needs the most attention, might be best to identify those and any low-hanging fruit since that tends to be received the best.
- Boris: UW School of Pharmacy and WSPA is working on integrating community pharmacies as a point of access for MOUD, so reading the documents earlier wanted to see if this fits in with BHI across various settings. Doing a study right now interviewing pharmacy staff and providers about what a model of care would look like if integrated in this setting.
- Comment: expanding access to LAI buprenorphine relates to cost, coverage and availability, Medicaid and Medicare covers it but commercial doesn't, so when patients transition insurance coverage they lose their access to Sublocade

    - Reply: would be interesting to do a survey of commercial PBMs to see what variance there is, some request of LAIs are being rejected on the basis of what they consider failing on oral formulations, maybe this report could promote some unanimity around this, we recently set this up in our own organization for this.
    - **Action**: follow up with Bree members from commercial plans to see who might have this information
- Comment: the REMS certification is a barrier, but Sublocade is a great option for rural patients, those who can't get into offices – think it should be offered widely
- Comment: what we're working on at BMH2H clinic sites:
    - Improved and expanded wrap-around care
    - Single point of care for primary care at harm reduction CBO settings
    - Improved transitions to concurrent mental health care
    - Flexibility of starting on methadone transitioning to buprenorphine
    - Greater number of referral partners (pharmacies, EMS, in hospital)
- Comment: payment models seem to be the biggest barrier, don't seem to have the payment models to do what is effective (care management, navigators, OBOT, harm reduction services, etc)
- Comment: sublingual failure requirement and buprenorphine rejections

Beth then reviewed the contents drafted under the potential new focus areas

- Comment: switch from sublingual to long acting buprenorphine could be considered a transition of care which can be challenging (what it's covered under, insurance piece, educating patients, etc)

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. There was a public comment that there was not much emphasis on rural areas in the previous report or focus areas. Beth stated there is definitely room to highlight rural challenges as the recommendations apply statewide. At the next workgroup meeting, the team will continue reviewing the Treatment for OUD guidelines from 2017 to inform the revision's finalized focus areas. The workgroup's next meeting will be on Tuesday, March 19th 3-4:30PM.