Working together to improve health care quality, outcomes, and affordability in Washington State.

Opioid Use Disorder Treatment Report and Recommendations

2017

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Executive Summary

The Dr. Robert Bree Collaborative was established in 2011 to provide a forum in which public and private health care stakeholders can work together to improve quality, health outcomes, and cost-effectiveness of care in Washington State. Opioid overdose is a leading cause of death. However, access to appropriate, evidence-based treatment is not typically readily available due to lack of resources, lack of a referral infrastructure, lack of reimbursement, and other barriers. The Bree Collaborative elected to address this topic and a convened a workgroup to develop recommendations that met from December 2016 to November 2017.

The workgroup's goal is a health care system that identifies people with opioid use disorder and facilitates access to comprehensive, evidence-based treatment with the patient at the center of care. This approach works to ensure that care is available when a patient is ready. Focus areas include:

1. Access to evidence-based treatment (e.g., medication-assisted treatment, reduce stigma)
2. Referral information (e.g., inventory of medication treatment prescribers, supportive referrals and infrastructure)
3. Integrated behavioral and physical health to support whole-person care (e.g., treatment of comorbid conditions)

Strategies to meet the three focus areas outlined above are operationalized in stakeholder-specific actions on pages 10-17, including for people with opioid use disorder and family members, providers, programs and facilities, health plans, employers, and Washington State Agencies (e.g., Health Care Authority, the Department of Health, and the Department of Social and Health Services). Due to the large scope of the opioid epidemic across the state, our workgroup also includes recommendations for correctional facilities and health services academic training programs and residencies.

The workgroup endorses a "no wrong door" approach for patients wanting to access opioid use disorder treatment from a variety of settings. To support this, the workgroup developed recommendations to guide providers delivering care within a variety of settings on pages 18-22. The goal for all settings is that patients receive the care they need at the time and in the setting of their choice, reduce illicit opioid use, and have no overdose events. The remainder of this Report is meant to support the three focus areas including discussing alignment with other work within Washington State (e.g., 21st Century Cures Grant, Healthier Washington), behavioral health funding structure, and measures for opioid use disorder treatment.

Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 *"…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."* The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a pioneer in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice evidence-based approaches that build upon existing efforts and quality improvement activities aimed at decreasing variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State's largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Opioid overdose is a leading cause of death in Washington State. However, access to appropriate, evidence-based treatment is not typically readily available due to lack of resources, lack of a referral infrastructure, lack of reimbursement, and other barriers. The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from December 2016 to November 2017.

See **Appendix B** for the Opioid Use Disorder workgroup charter and a list of members.

See **Appendix C** for results of the Guideline and Systematic Review Search Results.

Glossary and Abbreviations

American Society of Addiction Medicine (ASAM). Medical specialty society representing physicians, clinicians, and associated professionals in the field of addiction medicine.

Inpatient Treatment. Care delivered in a hospital setting.

Medication-Assisted Treatment (MAT). An evidence-based treatment for opioid use disorder that combines the use of medications (e.g., buprenorphine, methadone, naltrexone) with behavioral therapy for a whole-person approach, augmenting behavioral therapy alone. Medications reduce cravings for opioids, lessen withdrawal symptoms, and/or block opioids' euphoric and sedating effects and have been shown to be more effective than traditional treatment (e.g., counseling) and medically supervised withdrawal or behavioral therapy alone.

Opioid Treatment Program (OTP). A program, certified by the federal Substance Abuse and Mental Health Services Administration that supervises assessment of opioid use disorder and treatment using methadone, buprenorphine, and/or naltrexone. An OTP offers various levels of medical and behavioral health care and is usually a stand-alone facility (e.g., outpatient setting) but can also be within a hospital setting. OTPs are often called methadone clinics.

Office-Based Opioid Treatment (OBOT). Programs in which physicians, nurse practitioners, and/or physician assistants have been waivered to treat persons with buprenorphine within a medical or behavioral health clinic.

Opioid Use Disorder (OUD). Also known as opioid addiction. Defined by the American Society of Addiction Medicine as a chronic, relapsing brain condition that results in individuals pathologically pursuing reward and/or relief by substance use or other behaviors.

Residential Treatment. Intensive drug treatment in which a client resides in a non-hospital facility.

Substance Abuse and Mental Health Service Administration (SAMHSA). The is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. More information: www.samhsa.gov

Supportive Referral. Also known as a warm hand-off or warm transfer. Actively linking a person with opioid use disorder with a facility or provider providing another or similar level of care (e.g., Opioid Treatment Program) including following-up or ensuring that the person with opioid use disorder completes the visit when referred to a new service or location. May include making the appointment and providing transportation.

Tolerance. The body's response to a drug in which higher doses are needed to achieve the same effect.

Withdrawal. Symptoms (e.g., nausea) experienced when a person stops taking a drug after they have physically become dependent.

Background

Drug overdose is the leading cause of accidental death in the United States, driven predominantly by opioid misuse.[1] Among those under 50 years of age, drug overdose is the leading cause of death, increasing 19% in 2016 to exceed 59,000 lives.[2] High schoolers who receive only one opioid prescription are 33% more likely than those who do not receive such a prescription to misuse opioids between the ages of 18-23 years.[3] Opioids have been prescribed at too high a dose, for too many days following a surgery, or for inappropriate conditions, fueling the opioid epidemic.

In 2015, Washington State Department of Health data showed a nearly 40% reduction in prescription opioid overdose deaths overall, the largest reduction in the nation.[4] As efforts to decrease the amount of opioid prescribing decreased availability, some users transitioned to heroin due to cost or decreased prescription access. Those who are addicted to prescription opioids are 40 times more likely to become addicted to heroin.[5] The 2015 National Survey on Drug Use and Health estimates that 12,462,000 Americans aged 12 or older misused pain relievers in the past year, 828,000 used heroin in the past year (with an estimated 5,099,000 lifetime users).[6]

In King County, heroin treatment admissions surpassed alcohol in 2015 for the first time.[7] These rates have initiated multiple projects aimed at reducing unnecessary opioid prescriptions and interventions in those with opioid use disorder to reduce morbidity and mortality. Many in Washington State, as in many areas across the country, are working to connect those with opioid use disorder to needed treatment resources. However, the majority of individuals with identified opioid use disorder do not receive appropriate care or treatment partially due to substance use disorders being highly stigmatized and people with opioid use disorder not being likely to receive or seek treatment themselves.[8]

Substance use disorder is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) based upon number of criteria met as mild (2-3), moderate (4-5), severe (6-11). Criteria include impact on clinical and functional impairment (e.g., health problems, failure to meet work responsibilities). Opioid use disorder is defined as "*a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:*[9]

1. *Opioids are often taken in larger amounts or over a longer period of time than intended.*
2. *There is a persistent desire or unsuccessful efforts to cut down or control opioid use.*
3. *A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.*
4. *Craving, or a strong desire to use opioids.*
5. *Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home*
6. *Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.*
7. *Important social, occupational or recreational activities are given up or reduced because of opioid use.*
8. *Recurrent opioid use in situations in which it is physically hazardous*
9. *Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids*
10. *Tolerance as defined by either of the following:*
    a. *A need for markedly increased amounts of opioids to achieve intoxication or desired effect.*
    b. *A markedly diminished effect with continued use of the same amount of an opioid.*
11. Withdrawal, as manifested by either of the following:

a. *The characteristic opioid withdrawal syndrome*
b. *Opioids (or a closely related) substance are taken to relieve or avoid withdrawal symptoms*

Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision."

The Opioid Use Disorder Treatment workgroup seeks to move the health care system from that demonstrated in Figure 1 in which people with opioid use disorder encounter gaps in care and access to that of Figure 2 in which the health care system is coordinated around individual patient need.

Figure 1: The Current Substance Use Disorder Treatment System

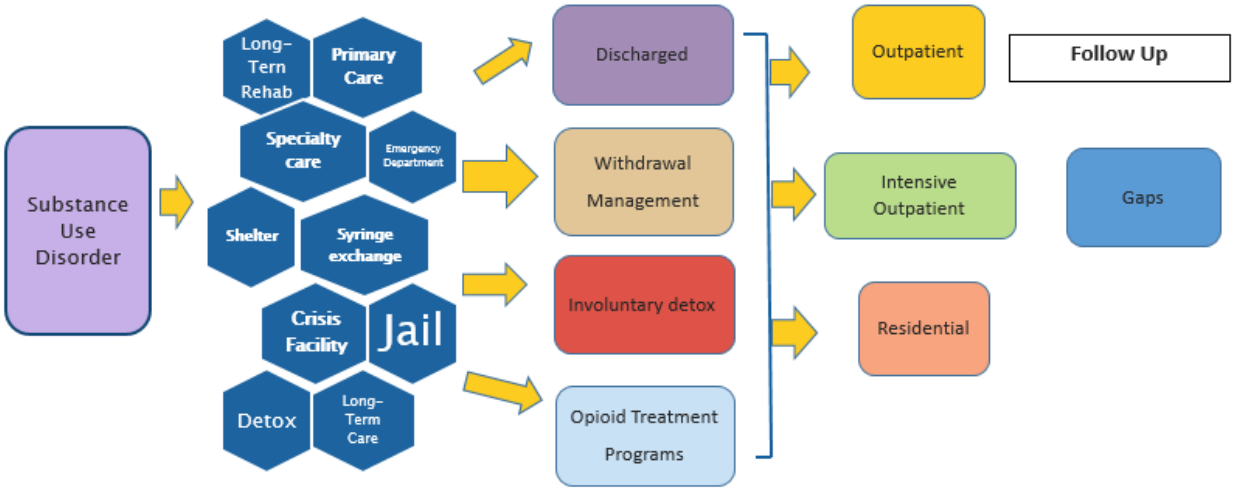
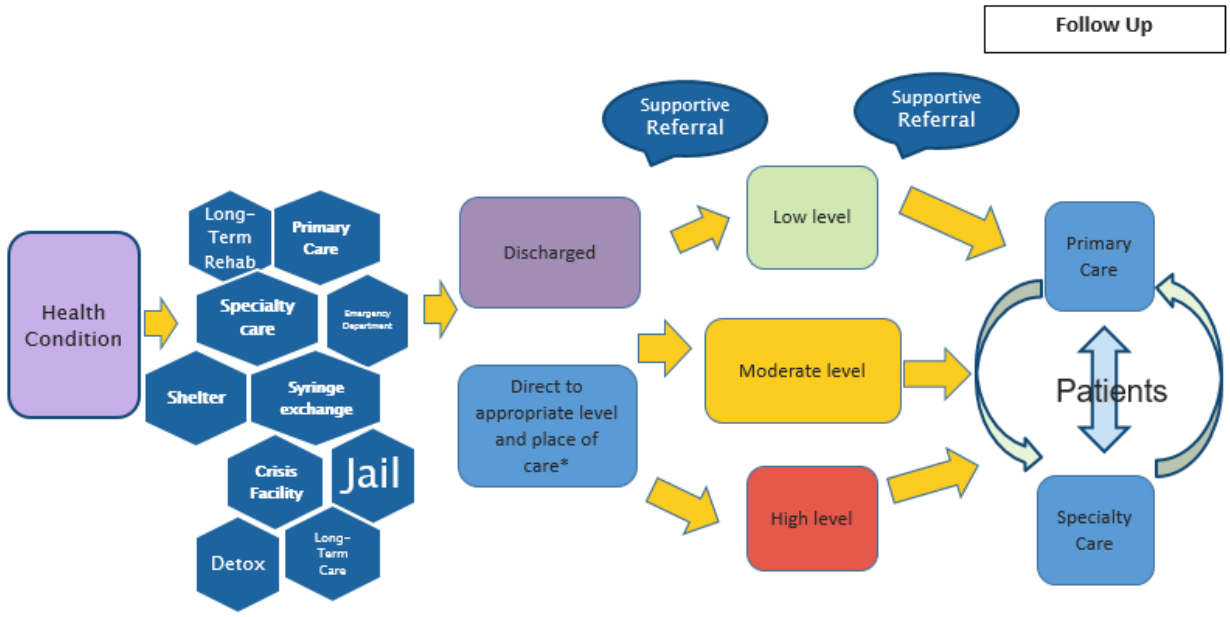


Figure 2: A Coordinated Care Health Care System



Medications for the Treatment of Opioid Use Disorder

Opioid use disorder is a chronic, relapsing brain disease. Medications to treat opioid use disorder include buprenorphine, methadone, and naltrexone, profiled below and on the following pages.[10] These medications reduce cravings for opioids, lessen withdrawal symptoms, and/or block opioids' euphoric and sedating effects.[11] Medication-assisted treatment (MAT) is an evidence-based treatment for opioid use disorder that combines the use of medications with behavioral therapy (e.g., counseling) for a whole-person approach, augmenting behavioral therapy alone.[12,13,14] Use of medications for the treatment of opioid use disorder has been shown to be more effective than behavioral therapies or medically supervised withdrawal or abstinence alone.[15,16] Research consistently shows lower rates of death from overdose and rates of illicit drug use.[17] For more information and a review of the evidence supporting medication-assisted treatment, see Medication-Assisted Treatment of Opioid Use Disorders: Overview of the Evidence or **Appendix C**.

Behavioral therapy complements medication treatment, addressing social and psychosocial factors behind opioid use and may lead to greater treatment retention.[18] Additionally, many patients have co-occurring medical or other behavioral health needs. Individual patient characteristics and preferences should help inform choice of medication as medications differ in the location from which they can be dispensed, how they can be prescribed, side effects, and how they work chemically.[19] Patient characteristics and preference should also inform type of behavioral therapy provided. This is especially true for certain populations such as adolescents and patients who are pregnant. Agonist medication therapy, methadone or buprenorphine, is recommended for patients who are pregnant. [20,21] The workgroup recommends an integrated care model (e.g., integrated behavioral and physical health care) with consideration for individualized patient needs.[22]

- **Buprenorphine**:[23]
    - Has been shown to better retain people in opioid use disorder treatment compared with placebo and to reduce the rates of overdose death by half compared to chemical dependency counseling alone.[10,19]
    - Binds to and activates receptors in the brain but to a lesser extent (partial opioid agonist) than prescription opioids or heroin. Buprenorphine can result in feelings of euphoria and has the potential to be misused but is safer than methadone due to lower risk of respiratory depression.[23]
    - In order to prescribe buprenorphine, providers have to meet certain qualifications, complete training, and be waivered by the US Drug Enforcement Administration to prescribe. Waivered providers can prescribe buprenorphine in a variety of settings. Non-waivered providers can dispense buprenorphine in Opioid Treatment Programs.[19,23]
    - Buprenorphine can be obtained at a community pharmacy.[23]

- **Methadone**:[24]
    - Systematic reviews have found methadone to be more effective than counseling and medically supervised withdrawal alone in reducing heroin use and in retaining patients

in treatment (when compared to both medically supervised withdrawal alone and to buprenorphine-naloxone).[11,15,16]

- Use results in some of the same feelings as an opioid (full opioid agonist) but eliminates opioid withdrawal. Methadone for the treatment of opioid misuse can only be dispensed, not prescribed, under supervision of a clinician at an opioid treatment program (OTP) that has been accredited by a SAMHSA-approved accrediting body and certified by SAMHSA.[24] As patients progress in treatment, take-home doses may become available over time. Methadone does have misuse potential and a higher risk of overdose than buprenorphine-naloxone.[16]
- More information on OTP certification is available here. Licensure mandates OTPs to assess drug use history and medical needs, provide counseling, conduct random drug testing through urinalysis or saliva tests, and provide vocational and educational services.

- **Naltrexone**:[25]
  - Fully blocks the euphoric and sedative effects of opioids (full opioid antagonist) with no euphoric effects. Naltrexone is FDA approved for alcohol use disorder and may be a good option for patients with both opioid and alcohol use disorders.
  - Two formulations of naltrexone are available: an oral form that is dispensed and self-administered daily, although adherence to the oral form has been shown to be difficult, and a long acting injection that is administered by a health care provider every four weeks. Long-acting naltrexone may be less cost-effective than buprenorphine and methadone.[26]
  - Naltrexone can be prescribed by any provider with prescriptive authority, a waiver is not needed, and dispensed at a pharmacy.[25] Patients must be abstinent from opioids for at least 7-10 days prior to starting naltrexone. Incarcerated or hospitalized patients may be good candidates.
  - A major risk is relapsing after stopping naltrexone (e.g., on day 31 after a 30-day injection) and reduced tolerance/increased sensitivity to opioids and subsequent overdose.

- **Naloxone**:[27]
  - Used to reverse opioid overdose by blocking opioid receptors (full opioid antagonist) in emergency overdose situations. Can be carried by users and administered by friends and family.
  - Is contained in the sublingual formulation buprenorphine-naloxone as a deterrent to misuse by injection but is not absorbed in clinically meaningful amounts when taken sublingually.
  - Administered either intranasally or parenterally.

Barriers remain for patient access to these medications.[28]

- A minority of primary care clinics offer buprenorphine or naltrexone. Except for Opioid Treatment Programs, few substance use disorder treatment centers offer medication treatment and most retain a non-medication treatment approach, neither offering medication treatment nor referring patients to a facility offering medication treatment.
- Reimbursement for substance use or mental health treatment programs is often too low to cover the costs of prescribing providers or buprenorphine, particularly when treating Medicaid patients. Low reimbursement rates effectively prohibit more patient-centered staffing models such as onsite or integrated prescribers.
- Clinics that do want to refer patients to office-based buprenorphine treatment may not have accurate information on which clinics prescribe buprenorphine in their area: there is no central accurate, up-to-date treatment locator.
- Lastly, existing services are difficult to navigate as many patients are unable to access services.

Surveys show providers list access to mental health treatment, staffing, time constraints, administrative support, access to addiction medicine expertise, and lack of experience in treating addictions as barriers to prescribing medication.[29,30,31] Expert advisory groups including the National Academy of Medicine recommend improvements in training including preservice training about opioid use disorder and treatment for both health care students and chemical dependency.[32]

Focus Areas

The Bree Collaborative Opioid Use Disorder Treatment workgroup's ultimate aim is a health care system that identifies people with opioid use disorder and facilitates access to comprehensive, evidence-based treatment with the patient at the center of care. This approach works to ensure that care is available when a patient is ready. While evidence on best treatment practices based on cultural background is lacking, providers should consider patient cultural background, language, and other factors. Patients should have an identified medical or health home from which they receive integrated physical and behavioral health care. Workgroup focus areas include:

1. Access to Evidence-Based Treatment	2. Referral Information	3. Integrated Behavioral and Physical Health to Support Whole-Person Care
•Medication treatment - buprenorphine, methadone, naltrexone (e.g., increase geographic reach, increase number of providers) •Reduction in stigma associated with treatment	•Providers and patients know where to access care •Accessible inventory of buprenorphine and methadone prescribers •Referral infrastructure that supports patients and providers	•Treatment of comorbid conditions including multiple substance use, mental illness, and physical health in line with Behavioral Health Integration Report and Recommendations

These goals must be supported by adequate training for providers and other staff and by adequate reimbursement structures. While the Bree Collaborative cannot recommend reimbursement amounts, the Opioid Use Disorder Treatment workgroup advocates for reimbursement to cover necessary and reasonable costs.

Strategies to meet the three focus areas outlined above are operationalized in the stakeholder-specific actions on the following pages (pages 10-17), including for people with opioid use disorder and family members, providers, programs and facilities, health plans, employers, and Washington State Agencies (e.g., Health Care Authority, the Department of Health, and the Department of Social and Health Services). Due to the large scope of the opioid epidemic across the state, our workgroup also includes recommendations for correctional facilities and health services academic training programs and residencies.

Our workgroup endorses a "no wrong door" approach for patients wanting to access opioid use disorder treatment from a variety of settings. To support this, the workgroup developed recommendations to guide providers delivering care within a variety of settings on pages 18-22. The goal for all settings is that patients receive the care they need at the time and in the setting of their choice, reduce illicit opioid use, and have no overdose events.

Stakeholder-Specific Recommendations

Do not use these recommendations in lieu of medical advice.

People with Opioid Use Disorder and Family Members

- **Identify your medical or health home where you are most comfortable receiving both behavioral health and primary care**. This health home can be a primary care practice, a behavioral health clinic, or an accredited opioid treatment program.
- **Talk with your health care provider and care team about treatment options.** There are many tools to help you and your provider make the right treatment decision for you. SAMHSA's website Decisions in Recovery: Treatment for Opioid Use disorder, available here: http://archive.samhsa.gov/MAT-Decisions-in-Recovery/section/whether.aspx can help assist you in making a decision.
- **Know your rights as a patient.** Available materials include SAMHSA's Rights for Individuals on Medication-Assisted Treatment. If you have concerns, talk with your provider and care team.
- **Learn how to recognize and intervene on the signs of an opioid overdose.** This is true for both opioid users and their friends and family members. From SAMHSA: "*Opioid overdose is life-threatening and requires immediate emergency attention. Recognizing the signs of opioid overdose is essential to saving lives.*
    - *Call **911 immediately** if a person exhibits any of these symptoms:*
        - *Their face is extremely pale and/or feels clammy to the touch*
        - *Their body goes limp*
        - *Their fingernails or lips have a purple or blue color*
        - *They start vomiting or making gurgling noises*
        - *They cannot be awakened or are unable to speak*
        - *Their breathing or heartbeat slows or stops.*"[33]
- **Learn more about preventing overdose.** If you are concerned, ask your provider if you should carry naloxone. This is a medication that can be administered to someone if they are showing signs of overdose to stop and reverse the overdose. Learn more here and at stopoverdose.org.
- **Make sure your care team is communicating.** If you or your family member are receiving care for an opioid use disorder or other care tell your provider so they can coordinate your care.

Providers

- **Work with patients to find the type of treatment right for them**. Discuss options that include evidence-based treatments of buprenorphine, methadone, and naltrexone when talking with patients.[10,15] This conversation may be helped with a patient decision aid.
    - Discuss the risks and benefits of all treatment options. This is legally required of programs receiving state or federal funding for opioid use disorder treatment.
    - Discuss patient characteristics that may impact selection of medication including whether the patient can do daily visits and the patient's use of other substances (e.g., alcohol, benzodiazepines).[10,15]

    - Ensure that the patient and their family, if appropriate, understand that the risks of serious adverse events including risk of relapse and overdose death for withdrawal management and counseling without medication, compared to the use of buprenorphine, methadone, and naltrexone. Many patients and families may only be familiar with abstinence-based approaches and be unaware that the success rates of medication-assisted treatment are significantly higher.
    - Address patient comorbidities including poly-drug use and any untreated mental health or physical health diagnoses.
- **Offer office-based opioid treatment in your clinic by becoming waivered to prescribe buprenorphine.** Buprenorphine can be successfully prescribed in a primary care setting and may be a good fit for many patients, if aligned with their treatment goals.
- **Identify an accredited Opioid Treatment Program where you can refer any patient who fails to stabilize in the office setting**. The opioid treatment program can help stabilize a patient through daily dispensing and more intensive support services and then refer them back to your clinic for co-management.
- **Write a prescription for naloxone for use during an overdose.**
- **Use language that reduces stigma when talking to patients and to other staff members**. Reinforce the idea of opioid use disorder as a chronic, relapsing brain condition. Use accepted current terminology used when discussing substance use disorders, such as from here.
- **Coordinate physical and behavioral healthcare.** Make sure that care delivered to patients with opioid use disorder is coordinated across physical and behavioral health providers. See **Appendix D** for information on care coordination compared to case management.

Program and Facilities

Opioid use disorder treatment can be successfully provided by variety of models on multiple levels of care (e.g. office-based opioid treatment (OBOT) in medical or mental health clinics, jail based care, opioid treatment program care). Our workgroup does not endorse a specific model but does strongly recommend adoption of evidence-based methods of treating patients that increase access for underserved populations. We also support piloting innovative and promising treatment models along with formal evaluations measuring benefits, costs, and disadvantages. Seek assistance from mentors available from comparable clinics, professional societies such as American Society of Addiction Medicine (ASAM), American Academy of Addiction Psychiatry (AAAP), and the Providers' Clinical Support System (PCSS), Telehealth programs such as UW Telepain, Project Echo, and to begin to offer office-based treatment with buprenorphine.

- **Work to reduce stigma**.
    - Talk to staff about stigma around opioid use disorder.
    - Work to reinforce the idea of opioid use disorder as a chronic, relapsing brain condition.

- Provide staff with links to current, short guidelines regarding opioid use disorder (e.g., Substance Abuse and Mental Health Services Administration, National Institute on Drug Abuse).
- Distribute copies of language guidelines to be used when discussing substance use disorder, such as from here.

- **Treat adolescents and teens in accordance with medication-assisted treatment best practices**
  - Use the full range of treatment options, including psychosocial and medication treatment.
  - Involve family and/or members of adolescent's social network, as appropriate. More information on specific treatment protocols for adolescents and teens is available here.
  - Adolescents may benefit from treatment in specialized treatment facilities that provide multidimensional services.
  - Screen for depression and suicide, educate about prevention and offer treatment for blood borne pathogens, discuss contraceptive needs and sexually transmitted infections.
  - Increase awareness about medication treatment and facilitate engagement for both parents and patients.
- **Treat patients who are pregnant in accordance with medication-assisted treatment best practices.** For more information see the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion Opioid Use and Opioid Use Disorder in Pregnancy.
  - Train pre- and perinatal care providers about opioid use disorder including how to recognize signs of opioid use disorder and how to facilitate safe and timely care.
  - Engage patients who are pregnant in prenatal care in addition to opioid use disorder treatment. Identify emergent/urgent medical conditions that require immediate referral to clinical evaluation.
  - Co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist.
  - Perform routine verbal screening for substance use including use of prescribed or illicit opioids.
  - After a positive screen for opioid use disorder, perform a medical examination and psychosocial assessment.
  - Use urine drug testing to detect or confirm suspected use with informed consent.
  - Use a supported referral to refer patients who are pregnant and physically dependent on opioids to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence. Initiate treatment with opioid replacement therapy as early as possible. Hospitalization during initiation may be advisable due to potential adverse events and/or need for close prenatal observation.
- **Prepare patient materials describing the risks and benefits of available opioid use disorder treatment options and train staf f to talk to patients about how to select the best treatment option for them.**[34]

    - Staff should discuss risk of serious adverse events including risk of relapse and overdose death for withdrawal management and counseling alone, compared to the use of buprenorphine-naloxone, methadone, and naltrexone.
    - Read more about the Health Care Authority's work to certify patient decision aids here: www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making.
    - Distribute materials containing current, accepted language regarding substance use disorder.
- **Offer medication-assisted treatment in primary care and mental health clinics in accordance with established guidelines such as from the American Society of Addiction Medicine.**
    - Waiver all primary care providers, including advanced registered nurse practitioners and physician assistants, practicing at the facility.
    - Build expectations for prescribing buprenorphine into facility culture.
- **Assess possible medication interactions, especially with benzodiazepines**. Treatment of opioid use disorder with medications should not be discouraged or delayed, but the risks of ongoing benzodiazepine use should be taken seriously and interventions guided accordingly.[35] Follow guidelines of the American Association for the Treatment of Opioid Dependence here: www.aatod.org/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-otps/
- **Identify which patient comorbidities will be treated onsite, criteria, and partners for referrals.**
    - Stabilize the patient and reduce harm as a first priority.
    - Build relationships with collaborative providers including Opioid Treatment Programs to support providers with programs for patients needing a higher level of care.
    - Assess patients for poly-drug use, physical health comorbidities, and mental health comorbidities but tailor additional care to the patient's needs and wishes. Patients with opioid use disorder may have a variety of additional medical or behavioral health comorbidities requiring specific screening, diagnosis, treatment, and referral. Some patients may benefit from mental health or psychiatric treatment by well-trained providers providing therapy and/or appropriate medications. However, having onsite mental health care should not be a prerequisite to providing or receiving treatment for opioid use disorder, especially for patients who do not want or need additional mental health care. Facilitate access to appropriate level of care or external referral as needed.
- **Referral to appropriate levels of care**
    - For patients with mental health issues, refer to treatment facilities conducting treatment by trained and licensed mental health providers, if needed and available.
    - Include Opioid Treatment Programs as part of a referral system of care. Clinics may refer to an Opioid Treatment Program when the patient requires more intensive treatment, or when a patient wants methadone or daily dosing, additional counseling support, or assessment by an addiction medicine provider, if available.
- **Support patient involvement in other programs (e.g., peer support programs**).

- Do not use attendance at peer support programs as a criterion for receiving or withholding access to medication. Some patients may wish for, and benefit from peer support groups such as Alcoholics Anonymous, Narcotics Anonymous, and other peer support programs. Evidence does not support compulsory attendance at peer and chemical dependence counseling for all patients receiving office-based medication treatment.[36,37]

- **Prescribing opioids for pain.**
  - Follow prescribing guidelines of opioids for pain in the Agency Medical Directors Group Interagency 2015 Guideline on Prescribing Opioids for Pain (available here and summary here) and the Centers for Disease Control and Prevention 2016 Guidelines.
  - Require prescribers of controlled substances to sign up for and routinely use the Prescription Monitoring Program (PMP) including prior to the start of and on an ongoing basis when prescribing opioid pain medications.
  - As it is implemented, take advantage of new legislation that will allow PMP reports to be shared with medical directors as well as individual providers. Facilities with more than five prescribers will need to provide the PMP program with information as to their employed or credentialed prescribers.
  - Develop a system to monitor patients on high doses of opioids and/or sedative hypnotics with the aim of 1) reducing variations in prescribing 2) having peer review of complex patients to encourage safe treatment of pain and 3) identifying patients with opioid use disorder.
  - Provide patients receiving opioid analgesics and patients with opioid use disorder access to naloxone and training in its use. See stopoverdose.org for patient videos and prescribing information.
  - Adopt policies and procedures that limit standard post-procedural 30-day supply of medication.
- **Evaluation.** Evaluate the effectiveness of programs offered at the facility at regular intervals (e.g., annually) or participate in external evaluations. Refer to the measurement section on page 29.
- **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

See “Programs and Facilities” above and additionally:

- Update training, policies and procedures in conjunction with evidence-based treatment.
- Support patient decision to use medication-assisted treatment for opioid use disorder.
- Allow patients legally receiving prescription medications to access all appropriate services offered by the agency.

- Be aware that the effectiveness of medication-assisted treatment increases with duration of treatment and may be lifelong. Do not encourage patients to stop medication treatment; discuss this with the prescriber and refer concerns on this topic to the prescriber.
- Build capacity to provide integrated other behavioral health and primary care.
- Collaborate with other providers to ensure that any patient on medication treatment who requires an inpatient stay continues receives/takes medication throughout that stay. Breaks in continuity of medication can put the patient at increased risk of relapse and/or overdose post-discharge.
- Build consultation options for staff who may need/want consultation around challenging or unstable patients.
- Write a prescription for naloxone and if possible dispense and physically deliver to patients.
- **Share information**. Assure appropriate systems and structures are in place to help 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. Payment, either by value-based care or fee-for-service should cover reasonable and necessary costs, including the costs of nurse or comparable care and case managers who can oversee a group of patents. Consider alternative payment models for supportive, wrap-around care for patients with opioid use disorder.
- **Support use of medication-assisted treatment as part of the treatment plan.**
    - Remove prior-authorization protocols for methadone, buprenorphine, and naloxone for adults and patients who are pregnant.
    - Incentivize providers or facilities in areas without access to buprenorphine to begin and maintain office-based opioid treatment services.
    - Reduce barriers such as co-pays to support appropriately timed (e.g., more frequent) personalized dosing.
    - Support Opioid Treatment Program reimbursement structures to cover the costs of effective care including treatment plans including buprenorphine, naltrexone, and telehealth.
    - Support Opioid Treatment Program reimbursement structures that facilitate use of both buprenorphine and telehealth.
    - Ensure that reimbursement programs do not prohibit patient access to medication treatment.
- **Reimburse provision of treatment for smoking cessation**. Individuals with opioid use disorder have very high rates of tobacco use. Patients who continue to smoke tobacco have higher all-cause mortality as well as higher opioid relapse rates.

Employers

- **Eliminate insurance barriers**.
    - Choose benefit structures that offer a full range of evidence-based treatments for substance use disorders.
    - Eliminate inadvertent barriers to behavioral health care service access. Develop benefit structures that equalize access to behavioral and physical health care.
- **Educate employees**.
    - If an employee assistance program is offered, promote employee understanding of behavioral health benefits and potential opioid misuse.
    - Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction).
- **Reduce employment barriers**. Do not create additional restrictions on employment for persons in treatment for opioid use disorder outside of those required by law.

Washington State Agencies

<u>The Health Care Authority</u>

- **Certify patient decision aids**. To help substance use providers and other providers meet regulatory requirements to conduct an informed consent on the risks and benefits of available treatments, certify patient decision aids for opioid use disorder treatment including a sample informed consent sheet that accurately describes the risks and benefits of available options for treatment.
- **Review treatment program effectiveness**.
    - Conduct and share evaluations of the effectiveness of different treatment approaches in Washington State Medicaid population.
    - Provide treatment programs with a standard methodology for evaluating patient outcomes to allow comparison of results and lessons learned between programs (e.g., retention of patients in treatment at 3, 6, and 12 months).

<u>Department of Health</u>

- **Offer training on medication treatment.** Fund preparation of sample curricula principles and an interdisciplinary lesson plan for providers.

<u>The Division of Behavioral Health and Recovery</u>

- **Provide treatment program information**.
    - Include in the annual Substance Use Treatment guide whether programs offer methadone, buprenorphine-naloxone and or naltrexone.
    - Maintain a current treatment directory accessible to public and providers that enables providers to locate different recommended treatments.

The Opioid Use Disorder Treatment workgroup also wishes to address correctional facilities and health services academic training programs and residencies. While these stakeholders are not typically within the purview of the Bree Collaborative, the scope of the epidemic necessitates their inclusion.

Correctional Facilities

- **Initiate or maintain existing medication treatment**. Offer methadone, buprenorphine, or naltrexone to inmates in programs to address opioid use disorder and reduce the risk of overdose related death upon release.
- **Prescribe and dispense naloxone upon release**. Persons released from incarceration are at high risk for fatal overdoses.
- **Build relationships with nearby Opioid Treatment Programs**. Many opioid treatment programs conduct intake/admission interviews and can start an inmate on methadone or buprenorphine and thereby be positioned to seamlessly continue care upon release.

Health Services Academic Training Programs and Residencies

- **Include information on substance use disorders, including opioid use disorder, in the curriculum**.
    - Include coursework that prepares students to screen, diagnose, and treat common addictions including alcohol and tobacco in a team and evidence-based format.
    - Encourage leadership and faculty of health service training programs to enhance and make consistent the factual basis for curricula including but not limited to medicine, chemical dependency, nursing, pharmacy, dental, mental health, and social work. This should include pain management, the Prescription Drug Monitoring Program, and the prevention, recognition, and treatment of opioid use disorder.
    - Encourage experts on opioid use disorder treatment, including opioid treatment programs, to speak to trainees.
    - Chemical dependency counselor training programs and statutes that recommend only detoxification and withdrawal should be updated. Trainees should be taught about evidence-based treatments for opioid use disorder that offer clients the highest rates of success and survival from illicit substances. Tobacco cessation should be part of chemical dependency counselor training.
    - Periodically update curricula using input from technical advisory groups without financial conflicts of interest (e.g. SAMHSA, NIDA, NIH, CDC, ASAM, AHRQ)
    - Ensure both faculty and students are using current, non-stigmatizing language.
- **Support use of medication treatment**.
    - Have residents complete a buprenorphine waiver training during residency (e.g., family practice, adolescent medicine, rehabilitation medicine, obstetrics, psychiatry, anesthesiology, internal medicine)
    - Incorporate waiver training after residents have received their DEA license for controlled substances.
    - Encourage tours of nearby opioid treatment programs as a means of educating up-and-coming professionals about this highest-level-of-care treatment option.
- **Measure success of integration of evidence-based information**. Measure success of post-service trainings by whether evidence-based prevention and treatment of opioid use disorder is institutionalized, practiced, and monitored in care settings. If possible, measure attitudes towards substance use disorders including the use of current, non-stigmatizing language related to substance use disorder.

Recommendations by Care Setting

Our workgroup endorses a "no wrong door" approach for patients wanting to access opioid use disorder treatment from a variety of settings. The following recommendations are meant to guide patients to appropriate opioid use disorder treatment. The goal for all settings is that patients receive the care they need at the time and in the setting of their choice, reduce illicit opioid use, and have no overdose events.

	Current State	Intermediate Steps	Optimal Care
Primary Care Setting	• Patients with active opioid use disorder are not detected and not treated. • If detected, providers may be uncertain as to next steps or may feel uncomfortable discussing opioid misuse.	• Primary care leadership support adding a service to treat opioid use disorder. For a summary of practice-based models see Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review. • Primary care providers are incentivized by higher reimbursement to treat opioid use disorder and co-occurring conditions. • Primary care providers are waivered to prescribe buprenorphine. • Primary care providers and staff are trained: o To diagnose opioid use disorder. o On indications for buprenorphine, naltrexone, and methadone. o On local behavioral health providers, Opioid Treatment Programs and how to provide supported referrals for patients. o To use current, non-stigmatizing language regarding substance use disorders. • The Bree Collaborative behavioral health integration framework and complementary models (e.g., AIMS Center Collaborative Care) are understood and that steps have been taken to integrate into care structures. • Primary care teams and providers are introduced to ongoing training resources such as Providers' Clinical Support System for opioid therapies	• Patients have access to behavioral health care and counseling as wanted and needed without mandatory requirements that constitute a barrier to care. • Treatment may include primary care providers treating patients with opioid use disorder with buprenorphine or naltrexone or supported referral to opioid treatment programs. • Providers have access to behavioral health specialty consultation through integrated behavioral health care.

		(PCSS) and the Telemedicine learning collaboratives.	
Pain Clinic	• Patients may have undiagnosed opioid use disorder • The Washington State Prescription Monitoring Program (PMP) may not be a routine part of prescribing practice	• Providers have been trained on: o The Agency Medical Director's Guideline on Prescribing Opioids for Pain. o How to assess opioid use disorder using DSM-5 criteria. o Referring to an addiction specialist including an opioid treatment program. o Prescribe naloxone as preventative rescue medication, if needed. o Using the PMP. o To use current, non-stigmatizing language regarding substance use disorders.	• The AMDG and CDC guidelines for prescribing opioids are followed (*e.g., Chronic Opioid Analgesic Therapy is prescribed only if there is sustained clinically meaningful improvement in function and no serious adverse outcomes or contraindications*). • Prior to any prescription, the Washington State PMP is checked. • Patients with suspected opioid use disorder are assessed using DSM-5 criteria and receive a supported referral to an opioid treatment program. • With patient's permission, the primary care provider is notified. • Patients may be prescribed naloxone as a preventative measure.
Behavioral Health Setting (including Substance Use Treatment Programs)	• Patients with opioid use disorder are not offered evidence based treatment for opioid use disorder. • Substance use treatment programs may rely on abstinence based care	• Providers are trained: o To diagnose opioid use disorder o To review and offer or refer all appropriate opioid use disorder treatment options with patients. o On local Opioid Treatment Programs and how to provide supported referrals to patients. • Behavioral health prescribers are incentivized with higher reimbursement when psychiatric disorders and opioid use disorder are both treated simultaneously. • Behavioral health and substance use disorder programs partner with primary care.	• Patients receive treatment for opioid use disorder and other co-occurring behavioral health diagnosis from available psychiatric providers. Any outside referrals include shared bi-directional communication. • Medical doctors are co-located or available remotely to prescribe medication-assisted treatment. • Providers treat opioid use disorder in a behavioral health setting with buprenorphine or naltrexone or provide supported referrals to opioid treatment programs.

		• Medical providers are available and are waivered to prescribe buprenorphine. • Providers are introduced to ongoing training resources including providers' clinical support system for opioid therapies (PCSS) and Telemedicine learning collaboratives. • Providers and staff use current, non-stigmatizing language regarding substance use disorders. • If inpatient or residential stays are medically indicated, providers support continued use of medication treatment throughout the stay.	
Opioid Treatment Programs (OTP)	• Programs may only exist in urban/suburban settings and require all patients start with daily dosing. • Treatment is typically limited to methadone with special provisions for patients who are pregnant. • Low daily reimbursement rates limit additional treatment options (e.g., primary and other behavioral health care).	• Clinics work to integrate care with local community providers and develop relationships with primary and behavioral health care settings. • Buprenorphine and naloxone are available. • Providers in all settings are reimbursed at rates that allow adequate provision of care and recruitment and retention of providers, particularly when working with the publicly funded (Medicaid) population. • Reimbursement structures support OTPs providing telehealth services.	• Patients may transfer care between primary care, behavioral health care setting, or OTP as needed. • Patients diagnosed with opioid use disorder may be treated with buprenorphine, naltrexone, or methadone. • OTPs can function as health homes.
Emergency Room (ER) *(not the ideal location to begin the recovery process – e.g., not cost-*	• Patients are treated for opioid overdoses or the complications of opioid use, but supportive referral for treatment for opioid use disorder may not occur	• Partnerships are developed with clinics that can accept patients with opioid use disorder for treatment options including medication treatment without delay. • In areas without Opioid Treatment Programs and available buprenorphine programs, hospital affiliated primary care clinics are incentivized to	• Patients are assessed for opioid use disorder using DSM-5 criteria. • Patients presenting to the emergency department for overdose are given naloxone and a supportive referral the next day or <72 hours for treatment with medication treatment.

effective, low acceptance of referrals)		start an office-based opioid treatment program to which patients, including those presenting to the ER with a possible opioid overdose can be referred. • ER providers are trained: o How to diagnose opioid use disorder. o To manage acute pain in patients on naltrexone, buprenorphine and methadone. o On 72 hour rule to administer buprenorphine in settings in which follow-up exists.	• Patients do not receive chronic pain medication from the emergency department. • Decisions on prescribing opioids to patients at risk, or suffering from opioid use disorder are done with a shared decision-making framework to maximize pain relief and prevention of relapse. • With patient's permission, the primary care provider is notified of emergency department visits. • If the patient was treated for a drug overdose, the primary care provider and any other prescribing provider(s) are notified of an overdose event. • Prior to any prescription, the Washington State PMP is checked.
Syringe Exchange Programs	• The opportunity to intervene among people using syringe exchange programs may be missed.	• Patients who wish to reduce non-medical opioid use are referred to programs which offer treatment including options for medications (buprenorphine, naltrexone, methadone). • Syringe exchange programs teach clients not to use alone, the dangers of mixing drugs, to carry naloxone, the "good Samaritan" drug law, and how to manage suspected overdoses including to call 911.	• Treatment services are co-located, if possible. • Clients of Syringe Exchange programs carry naloxone • Clients of syringe exchanges are offered information about treatment consistent with the evidence rather than just personal experience.
Jails	• Persons released from incarceration are at high risk for fatal overdoses.	*Continuation or initiation of medication treatment has been shown effective and is recommended regardless of duration of sentence.* • Opioid agonists (methadone or buprenorphine) and antagonists (naltrexone) may be considered for treatment and should	• Persons entering jails with opioid use disorder are provided with medication-assisted treatment or maintained on previous medication-assisted treatment.

		be initiated a minimum of 30 days prior to release from prison.	• Persons released from jails are prescribed and given naloxone.
Prenatal Care Providers	• Patients who are pregnant and have opioid use disorder are not routinely screened and may feel uncomfortable disclosing opioid use. • Patients are more likely to seek prenatal care late in pregnancy, miss appointments, have compromised health status, poor weight gain and prenatal complications, and exhibit signs of withdrawal and/or intoxication.	• Obstetrics providers are trained about opioid use disorder including how to recognize signs of opioid use disorder. • Treatment barriers are reduced through increased primary care services and improved coordination between prenatal and behavioral health providers. • Health care services are supported by alternative care models for substance use and mental health treatment that combine women's and parenting support services. • Supportive referral processes are developed between prenatal care and medication treatment facilities. • Co-management processes between prenatal care and addiction medicine are developed.	• Patients who are pregnant are: o Engaged in prenatal care as a first priority with emergent/urgent medical conditions that require immediate referral for clinical evaluation identified. o Screened for opioid use disorder and have access to integrated prenatal, substance use, and mental health care. o Started on opioid maintenance therapy as early as possible in pregnancy to help reduce the severity of neonatal abstinence syndrome. After a positive screen for opioid use disorder, medical examination and psychosocial assessment are performed. • Buprenorphine services for patients who are pregnant with opioid use disorder are available among primary care providers with obstetrics privileges, group buprenorphine care, case management, patient navigation and maternal support services • Women with opioid use disorder are diagnosed and supported during all phases of perinatal care including after delivery to continue recovery.

Alignment with Other Initiatives

While capacity to provide medication-assisted treatment has grown recently, supply is not sufficient to meet demand. The Comprehensive Addiction and Recovery Act, signed into law July 2016, expands buprenorphine prescribing privileges to advanced registered nurse practitioners and physician assistants.[38] The Washington State Prescription Monitoring Program reports that 19,000 patients received a buprenorphine prescription in Washington in 2016. Washington State Medicaid (Apple Health) has eliminated the need for both buprenorphine pre-authorization requirement for buprenorphine treatment and automatic limits on the duration of prescribing.[39] Additionally, Medicaid will approve buprenorphine for use for adolescents with a pre-authorization.

While the number of Opioid Treatment Programs and clinics providing medication and psychosocial treatment in Washington has grown, the number and location of active buprenorphine prescribers is not known. This makes finding providers and assessing the capacity of the treatment system difficult.

The Washington State health care community has developed many strategies and workgroups to impact prescription opioid misuse and heroin use. The Washington State Opioid State Plan, developed in January 2016, has informed many of these initiatives including Governor Jay Inslee's October 2016 Executive Order Addressing the Opioid Use Public Health Crisis and the 2017-2022 Medicaid Demonstration Project. Select initiatives are profiled below:

Washington State Opioid State Plan

Washington State Agencies developed an interagency opioid working plan in January 2016 to outline and guide goals, strategies, and actions. The four priority goals include:[40]

1. Prevent opioid misuse and abuse: Improve prescribing practices
2. Treat opioid abuse and dependence: Expand access to treatment
3. Prevent deaths from overdose: Distribute naloxone to people who use heroin
4. Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions: Optimize and expand data sources

See the Washington State Response Plan here.

21st Century Cures Grant: Hub and Spoke Model

As part of the 21st Century Cures Act to address the opioid epidemic, the Substance Abuse Mental health Services Administration (SAMHSA) has awarded the Washington State Division of Behavioral Health and Recovery a State Targeted Response Grant to develop hub and spoke projects in six areas of the state starting July 17, 2017 to April 30, 2018.[41] The hub and spoke model was pioneered in Vermont and offers a coordinated, systematic response to opioid use disorder targeted at Medicaid clients and low-income populations with a focus on medication-assisted treatment.[42] The hub and spoke model is aligned with this workgroup's goal of a "no wrong door approach" to medication treatment by funding a primary organization at a local level that will identify, collaborate, and subcontract with the spoke organization to provide integrated medication treatment. The spoke organizations in turn will provide

medication treatment, substance use disorder counseling, mental health services, case management and referral services, and staff education.

King County Heroin and Prescription Opiate Addiction Task Force

In response to the opioid epidemic in King County, leaders convened a task force co-chaired by the King County Department of Community and Human Services and Public Health – Seattle & King County from March to September 2016 to develop short and long-term strategies to prevent opioid use disorder, prevent overdose, and improve access to opioid use disorder treatment and other supportive services. Treatment-specific goals include to:

- *"Create access to buprenorphine in low-barrier modalities close to where individuals live for all people in need of services;*
- *Develop treatment on demand (on day one or day two) for all modalities of substance use disorder treatment services; and*
- *Alleviate barriers placed upon opioid treatment programs, including the number of clients served and siting of clinics."*

Like the King County recommendations, the Bree Collaborative aims to increase access to buprenorphine in office-based settings, behavioral health clinics, emergency rooms, and other settings. We advocate for a no wrong door approach to evidence-based treatment based on an integrated behavioral and physical health model outlined in our Integrated Behavioral Health Report and Recommendations. The King County model aims to use "*buprenorphine treatment induction and stabilization as the priority health intervention*" or a buprenorphine first model that is oriented toward patients who are unable to *"consistently and predictably engage in treatment and adhere to stringent treatment requirements (regular appointment attendance, urinalysis testing, etc.)*" (e.g., may be experiencing homelessness, limited social support, and complex comorbid conditions). The recommendations focus on piloting rapid (i.e., day one or day two) open access (e.g., same-day, walk-in hours) to patient-selected treatment modality and location (e.g., detoxification management, outpatient, residential, medication treatment). The third focus area works to decrease local barriers to opening and expanding Opioid Treatment Programs and is out of the scope of this workgroup.

Read the final report here.

Healthier Washington Medicaid Transformation Project

The Medicaid transformation demonstration is a five-year agreement with the Federal government allowing Washington State to test approaches to care delivery and improved patient outcomes. Similar to the broader Healthier Washington initiative, the three goals of the transformation demonstration are to (1) integrate physical and behavioral health, (2) move from fee-for-service to paying for value, and (3) establish clinical-community linkages. Specifically, the demonstration project is made of up three initiatives: transformation through the Accountable Communities of Health, long-term services and aging population support, and foundational community support.[43] The Accountable Communities of

Health Demonstration Project Toolkit includes two required projects that complement these recommendations:

- *Domain 2: Care Delivery Redesign – Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation*
    - Approaches include adherence to the Bree Collaborative's Behavioral Health Integration Report and Recommendations, outlined and discussed as a complement to these recommendations on the following pages.
- *Domain 3: Prevention and Health Promotion – Project 3A: Addressing the Opioid Use Public Health Crisis*
    - Focused on both prevention through interventions in prescribing practice and in augmenting the treatment system. Core components most aligned with the Opioid Use Disorder workgroup include Treatment (linking individuals with opioid use disorder to treatment services) and Recovery (promoting long-term stabilization and whole-person care).
    - Goals under Treatment
        - *Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify opioid use disorder (OUD), and link patients to appropriate treatment resources.*
        - *Expand access to, and utilization of, clinically-appropriate evidence-based practices for OUD treatment in communities, particularly MAT.*
        - *Expand access to, and utilization of, OUD medications in the criminal justice system.*
        - *Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing.*
        - *Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns.*
    - Goals under Recovery
        - *Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.*
        - *Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.*
        - *Support whole person health in recovery.*

    Read the Medicaid Demonstration Project Toolkit here.

Previous Bree Collaborative Recommendations

Addiction and Dependence Treatment

The Bree Collaborative elected to address addictive disorders and convened a prior workgroup to develop recommendations around increasing uptake of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol. The workgroup releasing recommendations in January 2015 the majority of which were directed at primary care and emergency room facilities. Recommendations include reducing stigma associated with alcohol and other drug screening, intervention and treatment; increasing screening; increasing capacity to provide brief-intervention and brief treatment; and decreasing barriers for facilitated referrals. However, evidence shows that SBIRT is not effective for opioid use disorder treatment or for severe alcohol use disorder.[44]

The workgroup developed recommendations specific to the opioid epidemic including:

- Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain
- Increase capacity for primary care providers to prescribe medication-assisted treatment (e.g., increase Buprenorphine, Naltrexone including extended-release injectable, treatment availability)
- Train appropriate primary care and emergency room staff to screen, engage, and facilitate both on-site opioid medication-assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment.
- Extend state and private capacity and support for medication-assisted treatment Facilitate referrals and decrease barriers to opioid addiction treatment (specialized vs on-site addiction treatment)
- Track changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings (including prenatal) for patients using opioids to evaluate change over time
- Provide opioid overdose education and offer a prescription for naloxone to all persons at risk for having or witnessing an opioid overdose, including those prescribed opioids, using heroin, and those in their social networks as allowed for by law
- Utilize the Prescription Monitoring Program to evaluate a patient's controlled substance history for potential risks

  Find out more about this workgroup here: www.breecollaborative.org/topic-areas/adt/

  Read the full Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf

Agency Medical Directors Group Opioid Prescribing Guidelines Implementation Workgroup

In response to overuse of opioid prescribing, many organizations have developed comprehensive guidelines on prescribing opioids for pain. The Washington State Agency Medical Directors released their Guideline on Prescribing Opioids for Pain in June 2015, the Centers for Disease Control and Prevention (CDC) released their Guideline for Prescribing Opioids for Chronic Pain in 2016, and the National Institutes of Health released their National Pain Strategy in 2016. Unfortunately, there remains a gap between the best practices in these guidelines and how opioids are being prescribed, as called-out in the 2015 Addiction report. Building on this previous set of recommendations, the Bree Collaborative

convened a workgroup to facilitate adoption of the 2015 AMDG Opioid Prescribing Guidelines, meeting from December 2015 to present, that has worked to develop prescribing guidelines specific to dentistry and to develop comprehensive, implementable prescribing metrics.

Find out more about the Opioid Prescribing Guideline workgroup here.
Read the 2015 AMDG Guideline on Prescribing Opioids for Pain here.

Behavioral Health Integration Workgroup

The Bree Collaborative convened a workgroup to develop a framework and supporting strategies to integrate behavioral health into primary care that met from April 2016 to April 2017. The recommendations are focused on those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate (as opposed to those accessing primary care through behavioral health clinics). The workgroup used available evidence and existing models to develop eight common elements that outline a minimum standard of integrated care. The eight elements are meant to bridge the different models used throughout Washington State and across the country and include:

1. Integrated Care Team
2. Patient Access to Behavioral Health as a Routine Part of Care
3. Accessibility and Sharing of Patient Information
4. Practice Access to Psychiatric Services
5. Operational Systems and Workflows to Support Population-Based Care
6. Evidence-Based Treatments
7. Patient Involvement in Care
8. Data for Quality Improvement

Find out more about the Behavioral Health Integration workgroup here.
Read the 2017 Behavioral Health Integration Report and Recommendations here.

This model can be adapted to the goals and focus of the Opioid Use Disorder Treatment workgroup. The team-based model of care is adapted from the Collaborative Care model among others and addresses many of the barriers to office-based buprenorphine prescribing (e.g., lack of time, lack of access to higher-levels of care, referral infrastructure). The office-based opioid treatment with buprenorphine (OBOT-B) Massachusetts Model profiled here outlines successful implementation strategies, increased admissions, and effective treatment.[45]

Behavioral Health Funding Structure

Many people with opioid use disorder also have co-morbid mental health or poly-substance use issues that may impair their ability to stop opioid use and would benefit from integrated behavioral and physical health care. Commercial insurance often does not reimburse for services to address social determinants of health, manage populations of patients, provide care management supports, or provide outreach to clients in crises. However, Medicaid offers a behavioral health benefit to support severe and chronically mentally ill individuals if in social and/or financial crisis. Below are the characteristics of both commercial insurance/Medicare and Medicaid:

Commercial Insurance/Medicare (spend down)	Medicaid
Credential Based Care (must be licensed)	Competency Based Care (delivered under agency license and supervision, contract)
Fee for Service	Capitated Rates
Prior authorization often required	Based on Access to Care guidelines, must be in a social or financial crisis
Office Based Counseling	Outreach, Care Management, Peer, Counseling, EBP, Crisis Supports, Incentive Measures
Must use ER for crisis	24 hour call access and outreach
No transitions of care	Transition of Care via discharge planning
No communication with other providers	Continuity of Care
Referral only	Care Coordination
Does not track across systems	Systems of Care

Additionally, severe and chronically mentally ill individuals with opioid use disorder being discharged from a hospital often do not have access to care coordination, case management, and outreach services after discharge. Hospitals often attempt to refer individuals to Community Mental Health Centers but may not be able to do so because of:

- Lack of access to paneled and licensed provider
- Paneled and licensed provider only able to provide office-based individual treatment
- Crisis support, case management, care coordination is not available as it is not billable

As a result, parents and social supports are coached to move the patient off of commercial plan and onto Medicaid resulting in a shift of responsibility and cost away from the existing providers and insurance to the safety net. This can lead to difficulties with safety net services including high case load, high turnover and lack of workforce capacity, limited funds, and high regulation. Patient quality, access, outcomes are in turn impacted.

Measurement

The workgroup endorses the use of the Washington State Common Measure Set and the measures to evaluate the Accountable Communities of Health as part of the Medicaid Demonstration Project.

The workgroup also encourages the Division of Behavioral Health and Recovery and other programs to evaluate and report treatments provided to patients who present with opioid use disorder. Tracking outcomes of buprenorphine, methadone or counselling will help inform best practices and emerging issues. Providers treating patients with substance use disorders should be encouraged to report outcomes at 30 or 60 days of treatment, as well as outcomes at 12 months. Medicaid could include measures such as retention in care, death, reductions in number of days of illicit drug use per last week or month, jail or recidivism, opioid drug use in last 7 or 30 days, other drug use in last 30 or 7 days, employment, participation in meaningful family or social activities and relationships, cost of medical care provided, rates of overdose and emergency department utilization, and contracting of HIV or hepatitis C.

Washington State Common Measure Set on Health Care Quality and Cost

The Healthier Washington Common Measure Set on Health Care Quality and Cost was mandated through ESHB 2572 to set a foundation for measuring performance state-wide. The most recent iteration, approved for 2017, includes:

- Substance Use Disorder Service Penetration. Measured by DSHS from claims data.
    - The percentage of members with a substance use disorder treatment need who received a substance use disorder treatment in the measurement year. Separate reporting for age groups: 6-17 years and 18-64 years.

Accountable Communities of Health

Under one of the two required projects of the Medicaid Demonstration project, Domain 3: Prevention and Health Promotion Project 3A: Addressing the Opioid Use Public Health Crisis, system-wide metrics include:

- Opioid Related Deaths (Medicaid Enrollees and Total Population) per 100,000
- Non-fatal overdose involving prescription opioids
- Substance Use Disorder Treatment Penetration (Opioid) (see Common Measure Set definition above)

Project Level Metrics include:

- New opioid users who become chronic users (in development)
- Patients on high-dose chronic opioid therapy by varying thresholds (in development)
- Patients with concurrent sedatives prescriptions (in development)
- Non-fatal overdose involving prescription opioids (in development)
- Medication Assisted Therapy (MAT) With Buprenorphine (Count and %)
- Medication Assisted Therapy (MAT) With Methadone (Count and %)

Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade MS	Deputy Director	Washington Health Alliance
John Espinola MD, MPH	Executive Vice President, Health Care Services	Premera Blue Cross
Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed MD	Chief Medical Officer	Confluence Health
Richard Goss MD	Medical Director	Harborview Medical Center – University of Washington
Jennifer Graves, RN, MS	Senior Vice President, Patient Safety	Washington State Hospital Association
Christopher Kodama MD	President, MultiCare Connected Care	MultiCare Health System
Daniel Lessler MD, MHA	Chief Medical Officer	Washington State Health Care Authority
Paula Lozano MD, MPH	Associate Medical Director, Research and Translation	Kaiser Permanente
Wm. Richard Ludwig MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O'Neill MD, MBA	Partner	Mercer
John Robinson MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers MD (Vice Chair)	Chief Executive Officer	Foundation for Health Care Quality
Jeanne Rupert DO, PhD	Medical Director, Community Health Services	Public Health – Seattle and King County
Kerry Schaefer	Strategic Planner for Employee Health	King County
Bruce Smith MD	Medical Director	Regence Blue Shield
Lani Spencer RN, MHA	Vice President, Health Care Management Services	Amerigroup
Hugh Straley MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Shawn West MD	Family Physician	Edmonds Family Medicine

Appendix B: Opioid Use Disorder Workgroup Charter and Roster

Problem Statement

Drug overdose is the leading cause of accidental health in the United States, driven predominantly by opioid addiction.[1] In King County, heroin treatment admissions surpassed alcohol in 2015 for the first time.[2] However, almost 90% of individuals with identified substance use disorders do not receive appropriate care or treatment partially due to substance use being highly stigmatized and patients not being likely to receive or seek treatment themselves.[3] Access to care and variation in treatment are also barriers to recovery.

Aim

To increase access to and align care delivery with existing evidence-based standard of care for the treatment of opioid use disorder while decreasing variation in quality of treatment across the State of Washington.

Purpose

To propose evidence-based recommendations to the full Bree Collaborative on:

- Identifying and evaluating evidence-based quality of opioid use disorder treatment.
- Increasing access to opioid use disorder treatment.
- Early identification of opioid use disorder in primary care as part of integrated behavioral health care in coordination with other Bree Collaborative workgroups and work within Washington State.
- Supportive referrals to opioid use disorder treatment.
- Treating opioid use disorder as a lifelong, chronic conditional across the age span using supported recovery.
- Measuring improvements and access to opioid use disorder treatment.
- Identifying additional areas for recommendations.

Duties & Functions

The Opioid Use Disorder Treatment workgroup will:

- Research evidence-based guidelines and best practices (emerging and established).
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

1 American Society of Addiction Medicine. Opioid Addiction 2016 Facts and Figures. Available: http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf

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3 Center for Behavioral Health Statistics and Quality. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of national findings (HHS Publication No. 14-4863, NSDUH Series H-48). Rockville MD: Substance Abuse and Mental Health Services Administration. www.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/NationalFindings/NSDUHresults2013.htm

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative or the workgroup chair.

The chair of the workgroup will be appointed by the chair of the Bree Collaborative.

The Bree Collaborative project director will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. The program director will conduct meetings along with the chair, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members to be added at the discretion of the chair.

Name	Title	Organization
Charissa Fotinos, MD (Co-Chair)	Deputy Medical Officer	Health Care Authority
Andrew Saxon, MD (Co-Chair)	Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE)	VA Puget Sound Health Care System
Jane Ballantyne, MD, FRCA	Professor, Department of Anesthesiology and Pain Medicine	University of Washington School of Medicine
Caleb Banta-Green, PhD, MPH, MSW	Senior Scientist	Alcohol and Drug Abuse Institute, University of Washington
David Beck, MD	Immediate Past President	Washington Society of Addiction Medicine
Ryan Caldeiro, MD	Chief Chemical Dependency Services and Consultative Psychiatry	Kaiser Permanente
Mary Catlin, BSN, MPH	Institutional Nurse Consultant	Department of Health
Nancy Lawton, MN, ARNP, FNP	President	ARNPs United of Washington State
Darin Neven, MD, MS	President and Founder	Consistent Care
Richard Ries, MD	Director, Addiction Psychiatry Residency Program	University of Washington
John Roll, PhD	Professor & Vice Dean for Research, Elson S. Floyd College of Medicine	Washington State University
Terry Rogers, MD	Medical Director	Lakeside Milam Recovery
Vania Rudolf, MD, MPH	Addiction Recovery Services	Swedish Medical Center
Mark Stephens	President	Change Management Consulting
Milena Stott, LICSW, CDP	Chief Of Inpatient Services	Valley Cities Counseling

Appendix C: Opioid Use Disorder Treatment Guideline and Systematic Review Search Results

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports (including USPSTF reviews)	(2016) Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings (2016) Management of Suspected Opioid Overdose with Naloxone Guidelines by Emergency Medical Services Personnel
Cochrane Collection	(2017) Use of opioid antagonists with minimal sedation to manage opioid withdrawal (2017) Supervised-dosing strategies versus take-home opioid substitution treatment for people dependent on opioid drugs (2017) Buprenorphine for managing opioid withdrawal (2016) Opioid maintenance medicines for the treatment of dependence on opioid pain medicines (2016) Clonidine, lofexidine, and similar medications for the management of opioid withdrawal (2014) Maintenance treatments for opiate-dependent adolescents (2014) Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (2013) Maintenance treatments for opiate-dependent pregnant women (2013) Methadone at tapered doses for the management of opioid withdrawal (2013) Pharmacological therapies for maintenance treatments of opium dependence
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	(2017) Committee on Obstetric Practice and American Society of Addiction Medicine Opioid Use and Opioid Use Disorder in Pregnancy (2015) American Society of Addiction Medicine National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015) Department of Defense, Department of Veterans Affairs, Veterans Health Administration Clinical practice guideline for the management of substance use disorders (2014) World Health Organization Guidelines for the identification and management of substance use and substance use disorders in pregnancy. (2014) World Health Organization Community management of opioid overdose (2014) American Pain Society, College on Programs of Drug Dependence Methadone safety: a clinical practice guideline from the American Pain Society and College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society (2012) National Institute on Drug Abuse Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)
Health Technology Assessment Program	No relevant reviews.
Center for Disease Control and Prevention	Webpage - Today's Heroin Epidemic

Institute for Clinical and Economic Review	(2017) Proven Best Choices: Treatment Options for Opioid Use Disorder (2014) Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options
BMJ Clinical Evidence Systematic Overview	(2011) Opioid dependence
Veterans Administration Evidence-based Synthesis Program	(2012) Family Involved Psychosocial Treatments for Adult Mental Health Conditions: A Review of the Evidence
Substance Abuse and Mental Health Services Administration	(2016) A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders (2016) Decisions in Recovery: Treatment for Opioid Use Disorders (2016) Advisory: Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update (2012) An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence (2012) Behavioral Health - Evidence-Based Treatment and Recovery Practices Other materials for patients in multiple languages available here

Appendix D: Care Coordination Compared to Case Management

Care coordination is a set of activities by which a system of care assures that every person served by the system has a single approved care or service plan that is coordinated, not duplicative and within prescribed parameters designed to assure cost effective and good outcomes. The goal is both managing and stretching limited resources, as well as assuring the best quality care possible to achieve the client's service goals.

- Cost effective and patient-centric in least restrictive setting.
- Can be specialized by setting/need (medical, forensic, behavioral health, housing)
- Medical home
- Transitional and intermittent
- Collaborative
- Engagement
- Referral
- Financial/Utilization management
- Resource utilization
- Support client's ease of access to resource information
- Enhance communication among providers
- Single point of entry to multiple services

Case management is a clinical service focused on those individuals who are determined to need assistance with coordination of services; daily living skills; finding and maintaining housing, jobs and friends; and in some cases, a single long-term relationship with a professional caregiver or helper. The goal of case management is the long-term recovery of the individual and increasing the ability of the individual to cope and function independently, including managing his/her own symptoms or addictions, and finding and maintaining his/her services and community living requirements.

- Work one on one with people with chronic illness(es) or disabilities.
- Liaison between insurance companies and healthcare providers
- Assessment of need
- Create and implement plans of care
- Evaluation
- Research treatment options
- Patient advocate

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