Bree Collaborative | Treatment for OUD Revision
March 19th 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, CHAS
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 March meeting. Beth invited Everett to share something with the group this morning

- Everett: Take a minute to reflect on a client in low-barrier buprenorphine program, still supporting with suboxone on opioid treatment program. She overdosed and passed the previous weekend. She had long history of mental health and substance use issues, she won our hearts over and worked very hard to stabilize for a long time. We are all very sad that she will no longer have the opportunity to do that. Request that we take a moment of silence. Thank you.
- Charissa thanked Everett for bringing that to the group's attention. The opioid epidemic is around us everywhere. We are committed to ease the suffering it brings, those working through recovery, those still using. Charissa was part of the report from 2017, and have been in tons of conversations on this topic with a variety of audiences. Hope to use this report to bring together efforts across the state to bring things forward.

Beth then transitioned the group to reviewing the February minutes.
Action: Unanimously approved February meeting minutes

Comments from Charissa:

- Updating guidelines in a very different world
- Heroin and oxy were predominant opioids in use, and polysubstance use was not as common. In age of fentanyl everything has turned on its head.

- There's a difference in commercial plans stepping up to manage their clients with OUD versus Medicaid plans, Medicaid has robust payment for things. Can we leverage this setting as a call to action for commercial plans? states attorneys general have started to reach out to facilities in nursing homes not allowing people with buprenorphine and methadone, as that's a violation of nondiscrimination.
- Do we want to recognize the degrees of severity of use and with that continuum the various challenges with people on the high use of continuum, how do we call those out and what are the recommendations for that.
    - **Everett**: month 1 is pretty challenging for people transitioning, would love to see more innovative thinking about combining the therapeutics that are out there and longer stays for people that do need inpatient (1& ½ or 2 months would be ideal for coverage, since that is when we see a lot of relapse)
    - **Charissa**: one of the challenges with these groups is that traditionally the Bree has focused on hospitals, commercial plans, etc. Some on the call focus on high need continuum, that subset of folks present different challenges and therapeutic interventions and needs than people regularly seeking care in Multicare or KP setting. Is the work of this group to say what people should be doing in usual settings?
    - **John**: wants to echo what Charissa says, works with people with homelessness whose lives are very out of control. Getting them to a point where they are getting more functional, so when they transition to KP or Multicare, and that typical PCP cannot handle their needs. Fentanyl tends to make people more critical.
    - **Karie**: for some of these populations that are more at risk (people experiencing homelessness, prison) might be more difficult to get data
        - **Charissa**: measurement piece – anything covered through Medicaid funding, federal block grants, etc, there are measures that are out there, the Bree may not have access but there is information out there on uptake especially. What we don't know is what happens to people commercially insured. Lots of data for folks on Medicaid, no insight on folks that are commercially insured.
    - **Tom**: part of the workgroup might be to define the scope in the spectrum of what is traditional to more cutting edge and innovative (e.g., mobile medical units, Seattle EMS is providing buprenorphine doses to people after Narcan, SAMHSA hotline/Washington state line people are connected directly to doctor to get prescription over the phone) so something as seemingly simple as referrals – there's so much cutting edge and experimental so does it belong in the scope of a group making recommendations or is it that we promote innovative models.
    - **Charissa**: HCA just got funded for a variety of new provisos that expand beyond the ones Tom listed, changes with each funding session, we could certainly list examples and emphasize the innovative work needs to continue. The traditional model and most people are actively using are not going to show up in a clinic. There's also work on updating ASAM criteria of what kind of care to expect in what settings.

REVIEW AND DISCUSSION: 2017 OUD REPORT AND RECOMMENDATIONS

Beth transitioned the group to reviewing the 2017 OUD guidelines in more detail, beginning with the program/facilities 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.

- Add 24/7 line for providers to the section under programs and facilities.

Under work to reduce stigma recommendation:

- Karie: stigma and bias training mentioned in many guidelines, not a lot of uptake across the different reports.
    - John: agree call for something specific for stigma and bias training. Valuable to personalize the treatment.
    - Liz: sometimes coming from stigma or anti-bias perspective is not always meeting people where they're at. Sometimes applying harm reduction lens is more helpful – is your goal to follow best practices and recommendations? How can I meet your goals?
    - Charissa: intervention going to vary by book of business that the agency has, stigma is not going to be reduced quickly. It's important to mention it, but we're not going to come up with successful ways to do it.
        - Shatterproof addiction index: attitudes of providers still pretty poor. Until people see how folks can get better, they don't know its possible.
        - Don't want to spend a lot of time there, we are not going to make it better.
        - John:"Develop training and forums for communication that reduce stigma and l owers barrier to care entry"
- Remove statement "work to reinforce the idea of opioid use disorder as a chronic, relapsing brain condition."
    - Language of "relapsing brain condition" can be stigmatizing.

Treat adolescents and teens in accordance with medication assisted treatment best practices.

- Kelly: many people treat adolescents with OUD in primary care pediatric settings.
    - John: reluctance to treat adolescents in programs that only treat adults because there's this notion that there's treatment somewhere. That's not true. Change language to encourage effectiveness for adolescents, providers should be prepared to provide treatment (MOUD)
    - Charissa: what do we mean by treatment? Want to emphasize medications first, everything that follows after that.
    - Evidence for long term residential treatment is not necessarily there. Lots of different setting are looking at different ways to incorporate this treatment. Want to make sure settings can see themselves in our recommendations.
    - Kelly: starting to hear lots of success stories with Sublocade with adolescents.
        - Charissa: also seeing Brixadi success with adolescents.
    - Libby: Washington age of consent is 13 and up, want to respect that with this treatment.
    - Emily N: ADAI has shared decision making resource for picking meds for OUD
    - Charissa: HCA is using UW shared decision making tools, process of being certified now. More patient centered. Would want to highlight shared decision making tools if not the specific one from the ADAI.

Treat patients who are pregnant in accordance with medication assisted treatment best practices.

- Charissa: thrilled to see more OBGYNs and perinatal providers stepping into the area. There are pros and cons to doing urine drug testing, some parts of the state it is done without consent.
- Standard of care is split dosing for people on methadone and pregnant, there are a number of updates in this space – fentanyl.
- Not a requirement to comanage pregnant person with addiction medicine, but most OBGYNs are not ready to treat someone with substance use disorders. The majority of people who pass are with substance use disorders and they had horrible care.

- Bob: strong emphasis on appropriate testing for STIs given high rates of infection in pregnant people. Screening can be controversial for people, want to think about how we are scaring people away.
- Charissa: Eat sleep console model is appropriate for those not actively in withdrawal. It is not the model for people actively using or not stable on MOUD at time of delivery. Swedish hospital and SAMHSA working on compassion model of care, potentially looking at longer postpartum stays at time of delivery.
    - Perinatal Psych line is great, but only open 8-5PM. No great line for adolescents, no one willing to provide that so far, but wherever we can list report.
- Mark: can go down rabbit hole on urine screening document, probably best served if we use a good resource (ASAM, SAMHSA) if we attempt to say too much it will take us places we shouldn't go.
    - Charissa: people will tell you if they are using if you ask them in a way that is compassionate and empathetic. The difference is that if they say the wrong answer they get sent to jail. So many people are not going to clinics for care because they feel stigmatized, don't want to focus too much on urine drug screening.
- Everett: pregnant individuals – there's only one maternity ward in Walla Walla. If people are alienated from available providers because they are using, it can be very stigmatizing and they don't receive care. Confidentiality is a huge issue for rural communities.
    - Karie: is entry into prenatal care an important thing for this guideline? Are there different things that would happen if someone came in during first or third trimester?
        - Everett: what's more important is any prenatal care, early is great but any is really where I'm at with some heavy substance users. Health Engagement hub is going to try to deliver own prenatal care.
    - Charissa: The earlier identifying syphilis the better their outcome, in that instance it's better, but most of these folks are not seeking any care because they got kids taken away, they were treated horribly, etc. How do we make it easier to access care?
    - Charissa: the legislature did fund doulas, substance use disorder doulas do a much better job for pregnant folks of color, advocates for people who are pregnant in accessing care. Another potential support for folks using substances.
    - Nikki: good to discuss potential positive outcomes data for people who are pregnant and receiving treatment. Want to add it into the background to highlight people can get better and reduce stigma.
    - Emily N: **Bree Perinatal Behavioral Health** report focuses on substance use disorder, may want to build off that report instead of repeating information.

Prepare patient materials describing the risks and benefits of available opioid use disorder treatment options and train ~~staff~~ providers/clinicians to talk to patients about how to select the best treatment option for them.

- Mark: want to highlight that providers/clinicians should be the one to educate patient on MOUD treatment
    - Kelly: would you include nurse care managers in that definition? Many have CARN certification.
    - Mark: if their training includes these medications, should those be included?

Offer MOUD in primary care and mental health clinics in accordance with established guidance such as from the American Society of Addiction Medicine

- Charissa: when heroin was the opioid out there, pcp's could do this easily. Is the recommendation that everyone with a DEA license be able to start someone on MOUD. Folks who are early in recovery, with bunches of medical/behavioral health conditions, they might be better served by a specialist who does this every day.
    - Ryan: need to set expectation that everyone needs to be involved in the care. If they're treating someone stable on buprenorphine, and they are involved in the bulk of psychotropic prescribing, they could take that one. Problem is we can't repatriate them from specialty care to primary care, and they defer primary care because they have specialty care.
    - Mark: lean towards PCP, but not all of them don't want to get into the fray. They don't know enough about the treatment or space. So helping them get comfortable is important.
    - Everett: for highest acuity most complex folks, OTP start induction, goal from ADAI/UW was to stabilize them and hand them off to PCP, barrier was the primary care setting was not ready for them. These patients take a lot longer to see. On the one hand anyone can prescribe buprenorphine, on the other hand, we need a low barrier way to help complex people and primary care settings may not be it.
        - Every physician out there should have screening conversation ant stigmatizing the fact that they might be reliant on misusing opioids, or using fentanyl, but if they are using fentanyl you will know because their life will be a wreck.
    - Tawnya: don't see suboxone as super different than antidepressants, but need availability of consultation to support.
    - Charissa: if a PCP is doing something once or twice a month, they won't do it as well as every day. Wonder if there is information out there or ways to acknowledge there is a subset of people with severe opioid use disorder, they will not respond to the usual initiation protocol and have tried these medications before, they require massive doses of meds. Can we identify that group of people, if they show up and primary care and we can't help them, they won't go back.
        - Kelly: One of the things we're seeing is people are trying bupe in the field saying its not working, for fentanyl need to go high and go fast, cross the bridge as fast as you can. That is the training we are working on for people.
        - Charissa: most PCPs are not going to keep someone around for 3-4 hours to stabilize them on a dose, going fast and high requires a setting where you can monitor people, most PCPs are not going to want to touch that.
- Nikki: when you say mental health clinic, are we referencing behavioral health agency?
    - Charissa: no, we are not speaking only to community health centers we also want to include private practice.
    - Action: revisit language later on
- Mark: PCPs will get burned with too complex patients, the nurse care manager model is good to identify patients that need more support and identify patients appropriate for primary care

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/

- Charissa: do people feel the call out to benzodiazepines is still as important?

- Tom and John agree to leave it in. Tom mentioned the 2017 letter from FDA to say don't not start people on Buprenorphine who are on benzodiazepines
- Tom also highlighted that with the 72 hour rule to authorize methadone in outpatient settings, we don't want providers to shy away from that since the mechanism of action is different.

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the team will continue reviewing the Treatment for OUD guidelines from 2017 to inform the revision's focus areas. The workgroup's next meeting will be on Tuesday, April 16th 2024.