## Health Care 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, correctional facility-based care, opioid treatment program care, mobile care, telehealth, ER, inpatient, EMS-initiated). 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 and that address the treatment of opioid use disorder as care for a complex medical condition. We also support piloting innovative and promising treatment models along with formal evaluations measuring benefits, costs, and challenges. Providers in all systems should 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,* [*Integrated Care Training Program*](https://ictp.uw.edu/programs/uw-pacc)*, Use the* [*UW Psyhiatric Consultation Line*](https://psychiatry.uw.edu/clinical-care-consultation/provider-consultation/) *(877-927-7294), and whenever able, offer medications for opioid use disorder.*

***Many individuals with opioid use disorder are protected by the Americans with Disability act as OUD is considered a disability which substantially limits major life activities****.[[1]](#endnote-2) It is essential to note that denying someone medications for opioid use disorder (MOUD) can have serious legal repercussions. Healthcare providers or facilities that refuse to admit a patient because they take MOUD is a discriminatory practice* ***and may be subject to legal action.***

* **Establish expectations that clinicians and care teams provide care for patients with OUD according to most updated evidence-based guidelines (i.e., ASAM, PCSS), including timely access to MOUD if the patient determines that is their preferred treatment.**
	+ **Ensure each facility or program has a provider available** and trained to initiate and/or continue MOUD, OR the ability to provide referral for same-day access to MOUD.
	+ **Draw from available provider facing resources for education,** such as [learnabouttreatment.org.](https://www.learnabouttreatment.org/)
	+ Provide staff with links to current, short guidelines regarding opioid use disorder (e.g.,  [Substance Abuse and Mental Health Services Administration,](https://www.samhsa.gov/) [National Institute on Drug Abuse](https://www.drugabuse.gov/)).
	+ Distribute copies of language guidelines to be used when discussing substance use disorder such as from [here](https://www.recoveryanswers.org/addiction-ary/#gateway-hypothesis).
* **Reduce structural barriers to treatment for OUD by following principles of the** [**Low barrier Treatment**](https://www.learnabouttreatment.org/for-professionals/low-barrier-buprenorphine/) **for treatment of opioid use disorder.** Low-barrier treatment has shown promise in engaging patients in care and reducing harms and deaths related to OUD in Washington state.[[2]](#endnote-3)

* + **Change practice workflows to align with principles of low-barrier treatment**.
		- Short time until medication start (start patients on medications for opioid use disorder on the same day if possible).
		- Do not discharge patient from treatment for initial or ongoing polysubstance use or for ongoing substance use.
		- Counseling and other adjunct therapies offered but not mandated for treatment.
		- Engage patient in creating an individualized follow up plan after visits
	+ **Outpatient facilities and programs** **should expand to include drop-in visits**, and/or weekend/night hours without appointment requirements. Patients with OUD may have sporadic engagement but that should not delay or discontinue care.
* **Prepare or use available evidence-based patient materials describing the risks and benefits of available opioid use disorder treatment options using current, accepted language regarding substance use disorders** including evidence-based patient decision aids (some are certified by Washington State HCA). Train staff to talk to patients about how to select the best treatment option for them.
	+ **Staff should discuss risk of serious adverse events** including risk of recurrent substance use and overdose death with withdrawal management and counseling alone, compared to treatment with buprenorphine-naloxone and methadone.
	+ **Utilize a patient decision aid to guide discussion**. 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.](http://www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making)
* **Be familiar with and provide alternative resources** for access to medications for opioid use disorder in case patient cannot reach usual providers such as the [King County Tele-buprenorphine Hotline](https://em.uw.edu/sections/population-health/telebup-program) – call 206-289-00287 and the Washington MOUD Locator line: <https://search.warecoveryhelpline.org/>
* **Offer MOUD** in all care settings including but not limited to primary care, behavioral health clinics/programs, mental health clinics, hospitals, (inpatient and emergency departments), and nontraditional care settings (e.g., mobile vans, street medicine teams, syringe service programs, etc.) in accordance with established guidelines (e.g., ASAM, PCSS)
	+ **Provide MOUD options, including sublingual and long-acting injectable versions of buprenorphine and long-acting injectable naltrexone**
	+ **Prescribe dosages of MOUD and adjunct therapies that adequately addressing symptoms.** With the use of more potent substances like fentanyl, the required doses needed to curb symptoms of withdrawal can be much higher. Adjunct medications may be helpful to address symptoms of opioid withdrawal during medication initiation (e.g., autonomic arousal, anxiety/restlessness, insomnia, Musculo-skeletal pain, and gastrointestinal distress)
	+ **Prescribe MOUD for adequate duration.** There is no limit on how long an individual may use any MOUD, and shorter prescription lengths (e.g., 1-2 weeks) may introduce unnecessary barriers to MOUD access.
* **When possible, utilize an interdisciplinary team approach to support comprehensive care for patients with opioid use disorder (OUD).** Such teams can integrate diverse expertise to address the multifaceted needs of these patients. Nurses play a crucial role in monitoring patient health, medication management and monitoring, providing education on OUD, and offering emotional support. Pharmacists may contribute by ensuring adherence to treatment protocols and advising on drug interactions and side effects. Collaborative efforts help optimize patient outcomes through coordinated, holistic care that addresses both medical and psychosocial aspects.
* **Incorporate peer support services into the care team whenever possible.** Peer support workers can bridge gaps in care by assisting patients in navigating health care systems, connecting them to community resources, and offering continuous emotional and social support. Bringing their own lived experience to their interactions with patients, peers are able to establish trusting relationships that better support people trying to navigate an often-stigmatizing healthcare system.
* **Identify which patient comorbidities will be treated onsite, criteria, and partners for referrals.**
	+ **Stabilize the patient and reduce harm, death from overdose, as a first priority.**
	+ **Assess patients for poly-substance use, physical health comorbidities, and mental health comorbidities** and tailor additional care to the patient’s needs and wishes. Patients with opioid use disorder may have 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.
	+ **For patients with cooccurring stimulant use disorders, follow** **ASAM Clinical Practice Guideline for Stimulant Use Disorder.**
	+ **Some common cooccurring health related concerns include sexually transmitted diseases (STDs), hepatitis C virus (HCV), mental health concerns like depression and self-harm or suicidal ideation.** Screen for these conditions concurrently and offer or refer for treatment.
	+ **Clinicians should engage patients in shared decision-making around their goals and transfers of care.** Patients who are not meeting their treatment goals in their current setting should be offered available options and resources to either adjust treatment plans or smoothly transition to another setting that may be able to provide more intensive levels of service and wrap around support
* **Build capacity to provide for a range of medical, harm reduction, treatment, and social services**. Patients who use opioids are at higher risk of loss to follow up if there are many transitions of care or access points for different services.
* **Build referral capacity with an accredited Opioid Treatment Program where you can refer patients when appropriate.** Opioid Treatment Program can help stabilize a patient through additional MOUD options including methadone and more or more intensive support services, such as counseling. OTPs should be seen as specialty care services and unless the program also provides primary care services, care for persons referred to OTPS should be shared between the program and the referring PCP. With patient permission, care plans can be readily shared between the programs.
* **Referral to appropriate levels of care**
	+ **Employ staff** (e.g., care coordinators, case management and peer support) with dedicated time to facilitate access to appropriate level of care or external referral as needed. Use a warm handoff when possible.
	+ For patients with mental health issues, refer to treatment facilities conducting treatment by trained and licensed mental health providers, if needed and available.
	+ For patients with co-occurring stimulant use disorder, offer and refer to a program offering evidence-based care, such as contingency management.
* **Support patient involvement in other programs (e.g., peer programs,** [employee assistance programs](https://www.samhsa.gov/workplace/employer-resources/provide-support))
	+ **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 substance use disorder counseling for all patients receiving office-based medication treatment.
* **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](https://www.qualityhealth.org/bree/our-guidelines/long-term-opioid-prescribing/) and summary [here](http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf)) and the [Centers for Disease Control and Prevention 2022 Guidelines](https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm) or most updated guidelines.
	+ Follow ASAM Clinical Guidelines for pain management patients with opioid use disorder
* **Program 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 at the end of this report.
* **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.
* **Treat adolescents and teens in accordance** **with evidence-based best practices.** Ensure providers are aware of the age of consent for treatment (in 2024, age of consent is 13 years old). See Seattle Children’s [resource](https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/wa/wa-substance-use-care-guide.pdf) for substance use in adolescence and this UW Addictions, Drug and Alcohol Institute [brief](https://adai.uw.edu/pubs/pdf/2021AdolescentsOUD.pdf).
	+ MOUD is a first line treatment for adolescents. Primary care settings should be prepared to identify adolescents with OUD and start them on MOUD per clinical guidelines.
	+ Encourage involvement of caregivers and/or members of adolescent’s social network, as appropriate, but do not turn away receiving treatment adolescents at age of consent. More information on treatment for adolescents and teens is available [here.](https://adai.uw.edu/pubs/pdf/2021AdolescentsOUD.pdf)
	+ Adolescents can receive quality MOUD care in primary care settings and every patient requires a shared care plan with patient and involved care team that is individualized to meet their needs. Consider specialized treatment facilities providing multidimensional services when appropriate.
	+ 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 medications for opioid use disorder and facilitate engagement for both caregivers and patients.
* **Treat patients who are pregnant or postpartum in accordance with evidence-based best practices.** For more information see the [Bree Collaborative’s Perinatal Behavioral Health 2023 Guidelines](https://www.qualityhealth.org/bree/perinatal-behavioral-health/) in addition to the Substance Use and Mental Health Services Administration’s [Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants](https://store.samhsa.gov/sites/default/files/sma18-5054.pdf) and the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion [Opioid Use and Opioid Use Disorder in Pregnancy](https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy). Additional or specific steps have been identified below:
	+ Train perinatal care providers about opioid use disorder including how to recognize signs of opioid use disorder, how to facilitate safe and timely care and manage patients with opioid use disorder.
	+ Routine universal screening should use validated instruments (e.g., 4Ps, NIDA Quick Screen, CRAFFT)
	+ 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.
		- Provide screening for sexually transmitted infections according to the most updated clinical guidelines (e.g., [AAFP guidelines](https://www.aafp.org/pubs/afp/issues/2022/0500/p553.html#:~:text=During%20pregnancy%2C%20universal%20screening%20for%20HIV%2C%20syphilis%2C%20and,facilities%20and%)). Newborn syphilis cases have increased 10-fold from 2012 to 2022.[[3]](#endnote-4)
	+ Opioid agonist or partial agonist pharmacotherapy is the recommended therapy and preferable to medically supervised withdrawal. Initiate treatment with methadone or buprenorphine as early as possible. Hospitalization during initiation may be advisable due to potential adverse events and/or need for close observation. Do not unnecessarily switch formularies of MOUD.[[4]](#endnote-5)
	+ Perinatal patients can be safely managed primarily in the perinatal or primary care setting. Facilities should also work to provide opportunities for perinatal providers to co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist when necessary.
	+ Use a warm handoff to refer patients who are pregnant and have opioid use disorder to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence when necessary
	+ After a positive screen for opioid use disorder, perform a medical examination and psychosocial assessment.
	+ Embed resources for providers such as the [Perinatal Psychiatry Consult](https://www.bing.com/search?q=perinatal+psychiatry+consult+line+uw&qs=n&form=QBRE&sp=-1&ghc=1&lq=0&pq=perinatal+psychiatry+consult+line+u&sc=6-35&sk=&cvid=1174490B9A9846259DF6A52B4B3177D1&ghsh=0&ghacc=0&ghpl=) into clinic resources that are easy to access for providers.
	+ Incorporate substance use disorder doulas as a part of the care team as available.
* **Treat older adults in accordance with evidence-based best practices.** Follow these tips from SAMHSA on [Treating Substance Use in Older Adults](https://store.samhsa.gov/sites/default/files/tip-26-pep20-02-01-011.pdf)
	+ While more high-quality trials are needed for opioid agonist and partial agonist therapy in older adults, available data suggest that opioid agonist and partial agonist therapy is effective in older adults and age should not be a barrier to treatment.[[5]](#endnote-6)
	+ Several physiological changes with age, such as decreasing renal clearance, changes in metabolism and total body water, and changes in neurotransmitter levels increase the likelihood of adverse effects associated with opioids in older adults.
	+ Some older adults may not meet DSM-5 diagnostic criteria for opioid use disorder due to age-related changes in tolerance to substances, cognitive functioning and social isolation.[[6]](#endnote-7) Consider aspects of aging that may impact diagnosis when assessing for opioid use disorder.
	+ Older adults are more likely to experience chronic pain, and experience exposure to chronic opioids which is a risk factor for opioid use disorder.[[7]](#endnote-8)

## Checklists for Health Care Facilities

Overview:

The checklist translates the Bree guidelines into action steps for that sector (i.e., clinician, health delivery site, public health, etc.). The action items have been arranged into levels 1, 2, and 3 to correspond to the difficulty level of implementing the action into the sectors’ setting. Bree staff co-created the checklists with report workgroup members and topic experts.

Level 1

* **Build referral capacity with an accredited Opioid Treatment Program where you can refer patients when appropriate.** Opioid Treatment Program can help stabilize a patient through additional MOUD options including methadone and more or more intensive support services, such as counseling. OTPs should be seen as specialty care services and unless the program also provides primary care services, care for persons referred to OTPS should be shared between the program and the referring PCP. With patient permission, care plans can be readily shared between the programs.
* **Establish expectations that clinicians and care teams provide care for patients with OUD according to most updated evidence-based guidelines (i.e., ASAM, PCSS), including timely access to MOUD if the patient determines that is their preferred treatment.**
	+ **Ensure each facility or program has a provider available** and trained to initiate and/or continue MOUD, OR the ability to provide referral for same-day access to MOUD.
	+ **Draw from available provider facing resources for education,** such as [learnabouttreatment.org.](https://www.learnabouttreatment.org/)
	+ Provide staff with links to current, short guidelines regarding opioid use disorder (e.g.,  [Substance Abuse and Mental Health Services Administration,](https://www.samhsa.gov/) [National Institute on Drug Abuse](https://www.drugabuse.gov/)).
	+ Distribute copies of language guidelines to be used when discussing substance use disorder such as from [here](https://www.recoveryanswers.org/addiction-ary/#gateway-hypothesis).
* **Prepare or use available evidence-based patient materials describing the risks and benefits of available opioid use disorder treatment options using current, accepted language regarding substance use disorders** including evidence-based patient decision aids (some are certified by Washington State HCA). Train staff to talk to patients about how to select the best treatment option for them.
	+ **Staff should discuss risk of serious adverse events** including risk of recurrent substance use and overdose death with withdrawal management and counseling alone, compared to treatment with buprenorphine-naloxone and methadone.
	+ **Utilize a patient decision aid to guide discussion**. 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.](http://www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making)
* **Be familiar with and provide alternative resources** for access to medications for opioid use disorder in case patient cannot reach usual providers such as the [King County Tele-buprenorphine Hotline](https://em.uw.edu/sections/population-health/telebup-program) – call 206-289-00287 and the Washington MOUD Locator line: <https://search.warecoveryhelpline.org/>
* **Identify which patient comorbidities will be treated onsite, criteria, and partners for referrals.**
	+ **Stabilize the patient and reduce harm, death from overdose, as a first priority.**
	+ **Assess patients for poly-substance use, physical health comorbidities, and mental health comorbidities** and tailor additional care to the patient’s needs and wishes. Patients with opioid use disorder may have 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.
	+ **For patients with cooccurring stimulant use disorders, follow** **ASAM Clinical Practice Guideline for Stimulant Use Disorder.**
	+ **Some common cooccurring health related concerns include sexually transmitted diseases (STDs), hepatitis C virus (HCV), mental health concerns like depression and self-harm or suicidal ideation.** Screen for these conditions concurrently and offer or refer for treatment.
	+ **Clinicians should engage patients in shared decision-making around their goals and transfers of care.** Patients who are not meeting their treatment goals in their current setting should be offered available options and resources to either adjust treatment plans or smoothly transition to another setting that may be able to provide more intensive levels of service and wrap around support
* **Referral to appropriate levels of care**
	+ **Employ staff** (e.g., care coordinators, case management and peer support) with dedicated time to facilitate access to appropriate level of care or external referral as needed. Use a warm handoff when possible.
	+ For patients with mental health issues, refer to treatment facilities conducting treatment by trained and licensed mental health providers, if needed and available.
	+ For patients with co-occurring stimulant use disorder, offer and refer to a program offering evidence-based care, such as contingency management.
* **Support patient involvement in other programs (e.g., peer programs,** [employee assistance programs](https://www.samhsa.gov/workplace/employer-resources/provide-support))
	+ **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 substance use disorder counseling for all patients receiving office-based medication treatment
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	+ MOUD is a first line treatment for adolescents. Primary care settings should be prepared to identify adolescents with OUD and start them on MOUD per clinical guidelines.
	+ Encourage involvement of caregivers and/or members of adolescent’s social network, as appropriate, but do not turn away receiving treatment adolescents at age of consent. More information on treatment for adolescents and teens is available [here.](https://adai.uw.edu/pubs/pdf/2021AdolescentsOUD.pdf)
	+ Adolescents can receive quality MOUD care in primary care settings and every patient requires a shared care plan with patient and involved care team that is individualized to meet their needs. Consider specialized treatment facilities providing multidimensional services when appropriate.
	+ 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 medications for opioid use disorder and facilitate engagement for both caregivers and patients.
* **Treat patients who are pregnant or postpartum in accordance with evidence-based best practices.** For more information see the [Bree Collaborative’s Perinatal Behavioral Health 2023 Guidelines](https://www.qualityhealth.org/bree/perinatal-behavioral-health/) in addition to the Substance Use and Mental Health Services Administration’s [Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants](https://store.samhsa.gov/sites/default/files/sma18-5054.pdf) and the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion [Opioid Use and Opioid Use Disorder in Pregnancy](https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy). Additional or specific steps have been identified below:
	+ Train perinatal care providers about opioid use disorder including how to recognize signs of opioid use disorder, how to facilitate safe and timely care and manage patients with opioid use disorder.
	+ Routine universal screening should use validated instruments (e.g., 4Ps, NIDA Quick Screen, CRAFFT)
	+ 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.
		- Provide screening for sexually transmitted infections according to the most updated clinical guidelines (e.g., [AAFP guidelines](https://www.aafp.org/pubs/afp/issues/2022/0500/p553.html#:~:text=During%20pregnancy%2C%20universal%20screening%20for%20HIV%2C%20syphilis%2C%20and,facilities%20and%)). Newborn syphilis cases have increased 10-fold from 2012 to 2022.[[8]](#endnote-9)
	+ Opioid agonist or partial agonist pharmacotherapy is the recommended therapy and preferable to medically supervised withdrawal. Initiate treatment with methadone or buprenorphine as early as possible. Hospitalization during initiation may be advisable due to potential adverse events and/or need for close observation. Do not unnecessarily switch formularies of MOUD.[[9]](#endnote-10)
	+ Perinatal patients can be safely managed primarily in the perinatal or primary care setting. Facilities should also work to provide opportunities for perinatal providers to co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist when necessary.
	+ Use a warm handoff to refer patients who are pregnant and have opioid use disorder to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence when necessary
	+ After a positive screen for opioid use disorder, perform a medical examination and psychosocial assessment.
	+ Embed resources for providers such as the [Perinatal Psychiatry Consult](https://www.bing.com/search?q=perinatal+psychiatry+consult+line+uw&qs=n&form=QBRE&sp=-1&ghc=1&lq=0&pq=perinatal+psychiatry+consult+line+u&sc=6-35&sk=&cvid=1174490B9A9846259DF6A52B4B3177D1&ghsh=0&ghacc=0&ghpl=) into clinic resources that are easy to access for providers.
	+ Incorporate substance use disorder doulas as a part of the care team as available.
* **Treat older adults in accordance with evidence-based best practices.** Follow these tips from SAMHSA on [Treating Substance Use in Older Adults](https://store.samhsa.gov/sites/default/files/tip-26-pep20-02-01-011.pdf)
	+ While more high-quality trials are needed for opioid agonist and partial agonist therapy in older adults, available data suggest that opioid agonist and partial agonist therapy is effective in older adults and age should not be a barrier to treatment.[[10]](#endnote-11)
	+ Several physiological changes with age, such as decreasing renal clearance, changes in metabolism and total body water, and changes in neurotransmitter levels increase the likelihood of adverse effects associated with opioids in older adults.
	+ Some older adults may not meet DSM-5 diagnostic criteria for opioid use disorder due to age-related changes in tolerance to substances, cognitive functioning and social isolation.[[11]](#endnote-12) Consider aspects of aging that may impact diagnosis when assessing for opioid use disorder.
	+ Older adults are more likely to experience chronic pain, and experience exposure to chronic opioids which is a risk factor for opioid use disorder.[[12]](#endnote-13)

Level 2

* **Offer MOUD** in all care settings including but not limited to primary care, behavioral health clinics/programs, mental health clinics, hospitals, (inpatient and emergency departments), and nontraditional care settings (e.g., mobile vans, street medicine teams, syringe service programs, etc.) in accordance with established guidelines (e.g., ASAM, PCSS)
	+ **Provide MOUD options, including sublingual and long-acting injectable versions of buprenorphine and long-acting injectable naltrexone**
	+ **Prescribe dosages of MOUD and adjunct therapies that adequately addressing symptoms.** With the use of more potent substances like fentanyl, the required doses needed to curb symptoms of withdrawal can be much higher. Adjunct medications may be helpful to address symptoms of opioid withdrawal during medication initiation (e.g., autonomic arousal, anxiety/restlessness, insomnia, Musculo-skeletal pain, and gastrointestinal distress)
	+ **Prescribe MOUD for adequate duration.** There is no limit on how long an individual may use any MOUD, and shorter prescription lengths (e.g., 1-2 weeks) may introduce unnecessary barriers to MOUD access.
* **When possible, utilize an interdisciplinary team approach to support comprehensive care for patients with opioid use disorder (OUD).** Such teams can integrate diverse expertise to address the multifaceted needs of these patients. Nurses play a crucial role in monitoring patient health, medication management and monitoring, providing education on OUD, and offering emotional support. Pharmacists may contribute by ensuring adherence to treatment protocols and advising on drug interactions and side effects. Collaborative efforts help optimize patient outcomes through coordinated, holistic care that addresses both medical and psychosocial aspects.
* **Program 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 at the end of this report.
* **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.

Level 3

* **Reduce structural barriers to treatment for OUD by following principles of the** [**Low barrier Treatment**](https://www.learnabouttreatment.org/for-professionals/low-barrier-buprenorphine/) **for treatment of opioid use disorder.** Low-barrier treatment has shown promise in engaging patients in care and reducing harms and deaths related to OUD in Washington state.
	+ **Change practice workflows to align with principles of low-barrier treatment**.
		- Short time until medication start (start patients on medications for opioid use disorder on the same day if possible).
		- Do not discharge patient from treatment for initial or ongoing polysubstance use or for ongoing substance use.
		- Counseling and other adjunct therapies offered but not mandated for treatment.
		- Engage patient in creating an individualized follow up plan after visits
	+ **Outpatient facilities and programs** **should expand to include drop-in visits**, and/or weekend/night hours without appointment requirements. Patients with OUD may have sporadic engagement but that should not delay or discontinue care.
* **Incorporate peer support services into the care team whenever possible.** Peer support workers can bridge gaps in care by assisting patients in navigating health care systems, connecting them to community resources, and offering continuous emotional and social support. Bringing their own lived experience to their interactions with patients, peers are able to establish trusting relationships that better support people trying to navigate an often-stigmatizing healthcare system.
* **Build capacity to provide for a range of medical, harm reduction, treatment, and social services**. Patients who use opioids are at higher risk of loss to follow up if there are many transitions of care or access points for different services.
1. U.S. Department of Justice. (n.d.). Opioid use disorder. Retrieved September 16, 2024, from <https://www.ada.gov/topics/opioid-use-disorder/#:~:text=Opioid%20Use%20Disorder.%20The%20Americans%20with> [↑](#endnote-ref-2)
2. The Community-Based Medication-First program for opioid use disorder: A hybrid implementation study protocol of a rapid access to buprenorphine program in Washington State. Banta-Green CJ, et al. Addiction Science & Clinical Practice 2022;17:34. [↑](#endnote-ref-3)
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