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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 – XX.

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

Drug overdose is the leading cause of accidental health in the United States, driven predominantly by opioid addiction.\(^1\) 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 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.

Substance use disorder is defined in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) as mild, moderate, or severe based on 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.”\(^8\)

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. need for markedly increased amounts of opioids to achieve intoxication or desired effect
    b. markedly diminished effect with continued use of the same amount of an opioid
11. Withdrawal, as manifested by either of the following:
    a. characteristic opioid withdrawal syndrome
    b. same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms”
Medication Assisted Treatment

Opioid use disorder is a chronic, relapsing disease. However, the majority of individuals with identified opioid use disorders do not receive appropriate care or treatment partially due to substance use disorders being highly stigmatized and patients not being likely to receive or seek treatment themselves. Medication-assisted treatment (MAT) is an evidence-based treatment for opioid use disorder that combines the use of medications (e.g., buprenorphine, methadone) with behavioral therapy for a whole-person approach, augmenting behavioral therapy. 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 detox alone. Behavioral therapy complements medication assisted treatment, addressing social and psychosocial factors behind opioid use and may lead to greater treatment retention. However, many patients have other medical or mental health needs, and a model of care is recommended that allows patients to access the spectrum of treatments and services they need and depending on other factors in their lives, are able to access at a particular point in time. Medications differ in the location from which they can be dispensed, how they can be prescribed, and how they work chemically. For all medications, stopping treatment results in a high risk of overdose due to decreased tolerance.

Medications include:

- **Buprenorphine**:
  - 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. Binds to and activates receptors in the brain but to a lesser extent (partial opioid agonist) than prescription opioids or heroin and can therefore result in feelings of euphoria with the potential to be misused, although with a far lower, almost negligible, risk of respiratory depression than compared to methadone. In order to prescribe buprenorphine, clinicians have to meet certain qualifications, complete training, and be waivered by the US Drug Enforcement Administration to prescribe. Waivered clinicians can offer buprenorphine in office-based primary care settings or in behavioral health clinics, Opioid Treatment Programs (waiver is not needed), or jail health programs. Buprenorphine can be obtained at a pharmacy.
- **Methadone**:
  - Systematic reviews have found methadone to be more effective than counseling and detox alone in reducing heroin use and in retaining patients in treatment. Use results in some of the same feelings as an opioid (full opioid agonist) but lessens opioid withdrawal. 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. As patients progress in treatment take-home doses may become available over time. Methadone is the standard of care for pregnant women and may be more effective than buprenorphine.
naloxone for patients dependent on high doses of heroin. Methadone does have misuse potential.

○ More information on OTP certification here. Licensure requires OTPs to mandate a comprehensive assessment of needs, and provide required counseling, and medical, regular drug testing either through urinalysis or saliva tests, vocational and educational services.

- **Naltrexone**: Fully blocks the euphoric and sedative effects of opioids (full opioid antagonist) with no euphoric or addictive effects and can also be used for alcohol use disorder (may be a good option for patients with both opioid and alcohol use disorders).
  ○ Two formulations are available: an oral form that is self-administered daily and a long acting injection that is administered every four weeks in a health care setting. Long-acting naltrexone may be less cost-effective than buprenorphine and methadone. Patients may also be more likely to discontinue the oral formulation as compared to long-acting.
  ○ Can be prescribed by any clinician with prescriptive authority, a waiver is not needed, and dispensed at a pharmacy. 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**: Used to reverse opioid overdose by blocking opioid receptors (full opioid antagonist) in acute emergency overdose situations to immediately reverse symptoms of overdose.
  ○ Is contained in the formulation buprenorphine-naloxone, the recommended formulation for medication assisted treatment in most cases (ingested sublingually). The buprenorphine component is absorbed sublingually. Very little naloxone is absorbed sublingually. Can be misused through injection. However, if this formulation is misused by injecting, the naloxone is active and partially prevents any euphoria from the buprenorphine component.
  ○ Administered either intranasally or intermuscularly by injection
Barriers remain for patient access.22

- A minority of primary care clinics offer buprenorphine and/or naltrexone. Except for Opioid Treatment Programs, few substance use disorder treatment centers offer medication assisted treatment and most retain an abstinence-only treatment approach, neither offering medication assisted treatment nor referring patients to a facility offering medication assisted treatment.

- Reimbursement for substance use or mental health treatment programs are often too low to pay for prescribing clinicians or the costs of buprenorphine, particularly when treating Medicaid patients, effectively prohibiting patient-centered staffing models (e.g., onsite or integrated prescribers).

- Clinics that do want to refer patients to office-based buprenorphine treatment, may not have accurate information on which clinics provide medication assisted treatment in their area: there is no central accurate, up-to-date treatment locator.

Surveys have shown that providers think access to mental health treatment, staffing, time constraints, administrative support, access to addiction medicine expertise, and lack of experience in treating addictions constitute barriers to prescribing.23,24,25 Expert advisory groups including the National Academy of Medicine recommend improvements in training: preservice training about opioid use disorder and treatment for both health care students and chemical dependency professionals as well.26
Recommendations

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 using a harm reduction strategy with the patient at the center of care. A harm reduction strategy was selected due to its emphasis on patient (rather than provider) readiness to change. Patients should have an identified medical or health home from which they receive integrated physical and behavioral health care. Key focus areas include:

1. Access to Evidence-Based Treatment
   - Access to medication-assisted treatment - buprenorphine and methadone (e.g., increase geographic reach, increase number of providers)
   - Reduction in stigma associated with treatment

2. Referral Information
   - Providers and patients know where to access care
   - Accessible inventory of buprenorphine prescribers
   - Referral infrastructure that supports patients and providers

3. Integrated Behavioral and Physical Health to Support Whole-Person Care
   - Treatment of comorbid conditions including multiple substance use, mental illness, and physical health in line with Behavioral Health Integration Report and Recommendations

These three goals must be supported by adequate training for clinicians 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 (e.g., to support onsite prescribers of medication-assisted treatment in those substance use disorder providers wanting, but unable to provide integrated medication-assisted treatment in their agencies, particularly for the publicly-funded (Medicaid) patient population).

Strategies to meet the three focus areas outlined above are operationalized in the stakeholder-specific actions on the following pages (pages 6-10), including for patients and family members, clinicians, 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 – particularly when many patients starting substance use disorder treatment may be by definition ambivalent to the targeted behavior change. To support this, the workgroup developed recommendations to guide providers delivering care within a variety of settings on pages 13-16. 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.

Patients 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 doctor and care team about treatment options.** There are also many tools to help you and your doctor 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](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](http://archive.samhsa.gov/MAT-Decisions-in-Recovery/section/whether.aspx). If you have concerns, talk with your doctor and care team.

- **Learn how to recognize and intervene on the signs of an opioid overdose.** This is true for both patients 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.”

- **Learn more about preventing overdose.** If you are concerned, talk with your doctor about Naloxone. This is a medication that can be delivered if someone is showing signs of overdose to stop and reverse the overdose. Learn more [here](http://archive.samhsa.gov/MAT-Decisions-in-Recovery/section/whether.aspx) 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, help assure all of your treatment providers are in communication with other to best coordinate your care.

Clinicians

- **Work with patients to find the right type of treatment for them.** Discuss options that include evidence-based treatments of buprenorphine, methadone, and naltrexone when talking with patients. 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.

  - 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, 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 that dispenses buprenorphine where you can refer any patient who fails to stabilize in the office setting.** The OTP can help stabilize a patient through daily dispensing and more intensive support services, and then refer them back to your clinic. Write a prescription for naloxone for the patient with opioid use disorder.

- **Work to reduce stigma when talking to patients and to other staff members.** Work to reinforce the idea of opioid use disorder as a chronic, relapsing brain condition. Be sure you understand the accepted current terminology used when discussing substance use disorders.

- **Coordinate care.** Make sure that care delivered to your patients with opioid use disorder is coordinated across physical and behavioral health providers

### Program and Facilities

A variety of models of care (e.g., collaborative care, nurse care manager, hub and spoke, office-based opioid treatment (OBOT), low barrier buprenorphine) have successfully been used in treating opioid use disorder. Our workgroup does not endorse a specific model but does strongly recommend adoption of evidence-based methods of treating patients and increasing access for underserved populations. We also support piloting innovative and promising treatment models that include formal evaluations measuring benefits, costs, and disadvantages. Seek assistance from comparable clinics, professional societies such as American Society of Addiction Medicine (ASAM), American Academy of Pediatrics (AAP), and PCSST-MAT as to guidance to begin 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., SAMHSA, NIDA).
  - Distribute copies of language guidelines to be used when discussing substance use disorder (see reference need above).

- **Treat adolescents in accordance with medication assisted treatment best practices**
  - Use the full range of treatment options, including psychosocial treatment and pharmacotherapy.
Adolescents may benefit from treatment in specialized treatment facilities that provide multidimensional services.

- Concurrent practices to screen for, educate about prevention and offer treatment for blood borne pathogens, unintended pregnancy and sexually transmitted infections are recommended.
- Increase awareness about medication assisted treatment and facilitate engagement for both parents and patients.

### Obstetrics
- Train obstetrics providers about opioid use disorder including how to recognize signs of opioid use disorder.
- Engage pregnant patients in prenatal care as a first priority. Identify emergent/urgent medical conditions that require immediate referral to clinical evaluation.
- 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 from the mother, realizing that there may be adverse legal or social consequences of her use.
- Use a warm handoff to refer pregnant women who are physically dependent on opioids to medication assisted treatment, methadone or buprenorphine mono product rather than withdrawal management or abstinence. Initiate treatment with opioid replacement therapy as early as possible. Hospitalization during initiation may be advisable due potential adverse events and/or need for close prenatal observation.
- Co-manage care for pregnant women with opioid use disorder with a prenatal care provider and an addiction specialist.
- Train care providers for women with opioid use disorder on facilitating safe and timely care.

### Prepare patient materials describing the risks and benefits of available opioid use treatment options and train staff to talk to patients about how to select the best treatment option for them.28
- 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](http://www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making).
- Distribute materials related to 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 ASAM.**
  - Waiver all primary care clinicians, including advanced registered nurse practitioners and physician assistants, practicing at the facility.
  - Build expectations for prescribing buprenorphine into facility culture.
  - Build relationships with collaborative providers to support clinicians with patients who are struggling to stabilize.

• **Assess possible medication assisted treatment interactions with other medications, especially 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. 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/](http://www.aatod.org/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-otps/)

• **Identify which patient comorbidities will be treated onsite and criteria and partners for referrals.**
  - Stabilize the patient and reduce harm as a first priority.
  - Assess patients for poly-drug use, physical health comorbidities, and mental health comorbidities but tailor additional care to the patient’s needs and wishes. **Pacing according to the patient’s wishes is important for overall retention in treatment.**
  - 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 others. Evidence does not support compulsory attendance at peer and chemical dependence counseling for all patients receiving office based treatment with buprenorphine or naloxone.  


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 physicians. 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 avoid use of standard post-procedural 30-day supply of medication.

Evaluation. Evaluate the effectiveness of programs offered at the facility at regular intervals (e.g., annually).

Share information. Assure appropriate systems and structures are in place to help share information between and across physical and behavioral health providers.

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 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 assisted 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 assisted treatment who requires an inpatient stay continues receives/takes their 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 to patients with opioid use disorder.
• **Share information.** Assure appropriate systems and structures are in place to help share information between and across physical and behavioral health providers.

**Correctional Facilities**

• **Offer medication assisted treatment.** Offer methadone, buprenorphine, or naltrexone to inmates in programs to reduce the risk of overdose related death 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.**
  o Include coursework that prepares students to screen, diagnose, and treat common addictions including alcohol and tobacco in a team-based format.
  o Encourage leadership and faculty of health service training programs to enhance and make consistent the factual basis for curricula including but not limited to for medicine, chemical dependency, nursing, pharmacy, osteopathic, dental, mental health, social work, and physician assistant. This should include pain management, the Prescription Drug Monitoring Program, and recognition and treatment of opioid use disorder.
  o Encourage experts on opioid use disorder treatment, including opioid treatment programs, to speak to trainees.
  o Chemical dependency counselor training programs and statutes that recommend only detoxification and withdrawal should be updated to teach about evidence-based treatments for opioid use disorder that offer clients the highest rates of success and survival from illicit substances and tobacco use as part of chemical dependency counselor training.
  o Promote methods consistent with peer reviewed literature.
  o Periodically update curricula using input from technical advisory groups without financial conflicts of interest (e.g. SAMHSA, NIDA, NIH, CDC, ASAM, AHRQ)
  o Ensure both faculty and students are using current, non-stigmatizing language related to substance use disorders.
• **Support use of medication assisted 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 when residents are preparing to apply for an individual 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.

**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 patients. Consider alternative payment models for supportive, wrap-around care for patients with opioid use disorder.

- **Support use of medication assisted treatment.**
  - Remove prior-authorization protocols for methadone, buprenorphine, and naloxone for adults and pregnant women.
  - Incentivize providers or facilities in areas without access to buprenorphine to begin and maintain OBOT services to treat opioid use disorder.
  - Reduce barriers to appropriately timed (e.g., more frequent) personalized dosing such as co-pays.
  - Ensure that reimbursement structures work for treatment providers that work with a primarily publicly-funded (e.g., Medicaid) population.
  - Support Opioid Treatment Program reimbursement structures that facilitate use of telehealth.

- **Reimburse provision of treatment for smoking cessation.** Patients who continue to smoke tobacco have higher all-cause mortality as well as higher opioid relapse rates.¹

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¹ The Centers for Disease Control and Prevention (CDC) state “tobacco causes more than 480,000 deaths annually (including deaths from secondhand smoke), “life expectancy for smokers is at least 10 years shorter” and “quitting smoking before age 40 reduces the risk of dying from a smoking-related disease by 90%.”
Employers

- **Eliminate insurance barriers.** When designing benefits, eliminate inadvertent barriers to behavioral health care services and integration of care for employees that equalize benefit structures for 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).

Washington State Agencies

The Health Care Authority

- **Certify patient decision aids.** To help substance use providers and other clinicians 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 option for treatment.
- **Review treatment program effectiveness.**
  - Conduct and share evaluation 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.

Department of Health

- **Offer training.** Fund preparation of a sample curricula principles and an interdisciplinary lesson plan.

The Division of Behavioral Health and Recovery

- **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 them to locate different recommended treatments.
  - Create a template for a comprehensive prenatal program that incorporates group prenatal care, drop in appointments, psychiatric care, buprenorphine services and a welcoming demeanor by healthcare providers.
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.

<table>
<thead>
<tr>
<th>Usual Care</th>
<th>Steps toward Goal</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Setting</strong></td>
<td>• Patients with active opioid use disorder are not detected and not treated.</td>
<td>• Patients have access to behavioral health care and counseling as wanted and needed without mandatory requirements that constitute a barrier to care.</td>
</tr>
<tr>
<td></td>
<td>• If detected, providers may be uncertain as to next steps or may feel uncomfortable discussing opioid misuse.</td>
<td>• Treatment may include primary care providers treating patients with opioid use disorder with buprenorphine or naltrexone or supported referral to opioid treatment program.</td>
</tr>
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<td></td>
<td>• Primary care leadership support adding a service to treat opioid use disorder. For a summary of practice-based models see <a href="#">Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review</a>.</td>
<td>• Clinicians have access to behavioral health specialty consultation through integrated behavioral health care.</td>
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<td>• Primary care providers are incentivized by higher reimbursement to treat opioid use disorder and co-occurring conditions.</td>
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<td>• Primary care providers are waivered to prescribe buprenorphine.</td>
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<td>• Primary care providers and staff are trained:</td>
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<td></td>
<td>o To diagnose opioid use disorder</td>
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<td></td>
<td>o On indications for buprenorphine, naltrexone, and methadone.</td>
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<td></td>
<td>o On local behavioral health providers, Opioid Treatment Programs and how to provide supported referrals to patients.</td>
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<td>o To use current, non-stigmatizing language regarding substance use disorders.</td>
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<td></td>
<td>• The Bree Collaborative behavioral health integration framework or others (e.g., AIMS Center Collaborative Care) is understood and steps have been taken to integrate into care</td>
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<td></td>
<td>• Primary care teams and providers are introduced to ongoing training resources such as Providers’ Clinical Support System for opioid therapies (PCSS) and the Telemedicine learning collaboratives.</td>
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<tr>
<td>Behavioral Health Setting (including Substance Use Treatment Programs)</td>
<td>The Washington State Prescription Monitoring Program (PMP) may not be a routine part of prescribing practice</td>
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<tr>
<td>• The Washington State Prescription Monitoring Program (PMP) may not be a routine part of prescribing practice</td>
<td>o How to assess opioid use disorder using DSM-5 criteria</td>
<td>prescribed only if there is sustained clinically meaningful improvement in function and no serious adverse outcomes or contraindications</td>
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<td></td>
<td>o Referring to addiction specialist including an opioid treatment program</td>
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<td></td>
<td>o Prescribe naloxone as preventative rescue medication, if needed</td>
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<td>o Using the PMP</td>
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<td>o To use current, non-stigmatizing language regarding substance use disorders.</td>
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<tr>
<td>Behavioral Health Setting (including Substance Use Treatment Programs)</td>
<td>Patients with opioid use disorder are not offered evidence based treatment for opioid use disorder.</td>
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<td>Substance use treatment programs may rely on abstinence based care</td>
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<td></td>
<td>Providers are trained:</td>
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<tr>
<td></td>
<td>o To diagnose opioid use disorder</td>
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<td></td>
<td>o To review and offer or refer all appropriate opioid use disorder treatment options with patients.</td>
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<tr>
<td></td>
<td>o On local opioid treatment programs and how to provide supported referrals to patients.</td>
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<tr>
<td></td>
<td>Incentivize behavioral health prescribers by providing higher reimbursement when psychiatric disorders and opioid use disorder are both treated simultaneously.</td>
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<tr>
<td></td>
<td>o Behavioral health and substance use disorder programs partner with primary care.</td>
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<tr>
<td></td>
<td>Providers are waivered to prescribe buprenorphine.</td>
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<tr>
<td></td>
<td>Providers are introduced to ongoing training resources including providers’ clinical support system for opioid therapies (PCSS) and Telemedicine learning collaboratives.</td>
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<tr>
<td></td>
<td>Providers treat opioid use disorder in a behavioral health setting with buprenorphine or naltrexone or provide supported referrals to opioid treatment programs.</td>
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<tr>
<td></td>
<td>Behavioral health prescribers receive higher reimbursement when psychiatric disorders and opioid use disorder both treated simultaneously.</td>
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</table>
- Providers and staff use current, non-stigmatizing language regarding substance use disorders.
- Providers support continued use of medication assisted treatment throughout a needed residential or inpatient stay.

**Opioid Treatment Programs (OTP)**

<table>
<thead>
<tr>
<th></th>
<th>Programs are usually located in only urban settings and require <strong>all patients start with</strong> daily dosing. Treatment is typically limited to methadone with special provisions for pregnant women. Low daily reimbursement rates limit additional treatment options (e.g., primary and other behavioral health care).</th>
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<tr>
<td></td>
<td>Dispensed buprenorphine is available as another medication within the modality. Regularly dispense naloxone to their patients. Clinics work to integrate care with local community providers and develop relationships with primary and behavioral health care settings.</td>
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<td></td>
<td>Patients may transfer care between primary care or behavioral health care setting or OTP as needed. Patients diagnosed with opioid use disorder may be treated with buprenorphine, naltrexone, or methadone. 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. OTPs can function as health homes.</td>
</tr>
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</table>

**Emergency Room**

*not the ideal location to begin the recovery process – e.g., not cost-effective, low acceptance of referrals*  

<table>
<thead>
<tr>
<th></th>
<th>Patients are treated for opioid overdoses, or the complications of opioid use, but the need or warm handoff to treatment for OUD may not occur</th>
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<tbody>
<tr>
<td></td>
<td>Partner with a clinic that can accept without delay patients with opioid use disorder for treatment options including medication assisted treatment. ER establishes a relationship with regional Opioid Treatment Program and facilitate referrals. ER clinicians are trained: o How to diagnose opioid use disorder. o To manage acute pain in patients on naltrexone, buprenorphine and methadone. o On Spokane model to use 72 hour rule to administer buprenorphine.</td>
</tr>
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<td></td>
<td>Patients are assessed for opioid use disorder using DSM-5 criteria. Patients presenting to the emergency department for overdose are given naloxone and a warm handoff the next day or &lt;72 hours for treatment with medication assisted treatment. Patients do not receive chronic pain medication from the emergency department.</td>
</tr>
</tbody>
</table>
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.

If the patient was admitted for an opioid overdose, the primary care provider and any other prescribing provider(s) are notified of overdose event.

| Syringe Exchange Programs | The opportunity to intervene among people using syringe exchange programs is missed. | Patients who wish to reduce non-medical opioid use are referred to programs which offer treatment that includes 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. | 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. |
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<tr>
<td>Jails</td>
<td>Persons released from incarceration are at high risk for fatal overdoses.</td>
<td>Continuation or initiation of medication assisted treatment has been shown effective and is recommended regardless of sentenced term</td>
<td>Opioid agonists (methadone or buprenorphine) and antagonists (naltrexone) may be considered for treatment and should be initiated a minimum of 30 days prior to release from prison (there’s insufficient evidence to recommend any one treatment as superior to another)</td>
<td>Medication assisted treatment (e.g., methadone, buprenorphine, naltrexone) to inmates in programs that reduce the risk of overdose related death upon release.</td>
</tr>
</tbody>
</table>
### Obstetrics

- Pregnant women with opioid use disorder are not routinely screened and may feel uncomfortable disclosing opioid use.
- Pregnant women with opioid use disorder 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.
- Critical gaps in care and a number of barriers, including timely access to prenatal, substance use and mental health services, overcoming the stigma of opioid use disorder and biases of healthcare providers, and accessing adequate support for intervention and treatment.

- Train obstetrics providers about opioid use disorder including how to recognize signs of opioid use disorder.
- Engage pregnant patients in prenatal care as a first priority. Identify emergent/urgent medical conditions that require immediate referral to clinical evaluation.
- 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 from the mother, realizing that there may be adverse legal or social consequences of her use.
- Use a warm handoff to refer pregnant women who are physically dependent on opioids to medication assisted treatment, methadone or buprenorphine mono product rather than withdrawal management or abstinence.
- Initiate treatment with opioid replacement therapy as early as possible. Hospitalization during initiation may be advisable due potential adverse events and/or need for close prenatal observation.
- Co-manage care for pregnant women with opioid use disorder with a prenatal care provider and an addiction specialist.
- Introduce care providers for women with opioid use disorder to education and training resources to facilitate safe and timely care.
- Refer women who are eligible to programs that assist with parenting and recovery supports.

- Pregnant women are screened for opioid use disorder and have access to integrated prenatal, substance use, and mental health care.
- Treatment barriers are reduced through increased primary care services and improved coordination between prenatal and addiction providers.
- Buprenorphine services for pregnant women with opioid use disorder are available among primary care providers with obstetrics privileges, group buprenorphine care, case management, patient navigation and maternal support services.
- Health care services are supported by alternative care models for substance use and mental health treatment that combine women's and parenting support services.
- Women with opioid use disorder are diagnosed and started on opioid maintenance therapy as early as possible in pregnancy to help reduce the severity of neonatal abstinence syndrome.
- Women are supported after delivery to continue their 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. The Washington State Prescription Monitoring Program reports that 19,000 patients received buprenorphine 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. Additionally, Medicaid will approve buprenorphine for use for adolescents with a pre-authorization.

While the number of Opioid Treatment Programs and clinics providing medication-assisted and psychosocial treatment in Washington have 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:

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. 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. The hub and spoke model is aligned with this workgroup’s goal of a “no wrong door approach” to medication-assisted treatment by funding a primary organization at a local level that will identify, collaborate, and subcontract with the spoke organization to provide integrated medication assisted treatment. The spoke organizations in turn
will provide medication assisted therapy, 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, 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, MAT). The third focus area works to decrease local barriers to opening and expanding Opioid Treatment Programs, 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. As for the broader Healthier Washington initiative, the three goals 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 up of three initiatives: transformation through the Accountable Communities of Health, long-term services and aging population support, and foundational community support. The Accountable Communities of Health demonstration project toolkit includes two required projects that complement these Opioid Use Disorder Treatment Recommendations:
• **Domain 2: Care Delivery Redesign – Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation**
  o 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**
  o 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).
  o **Goals under Treatment**
    - Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify 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.
  o **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 workgroup to develop recommendations around increasing uptake of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol. The workgroup met from April 2014 and to releasing recommendations in January 2015. The majority of the recommendations were directed to primary care and emergency room facilities and included 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 on efficacy of SBIRT for opioid use disorder is lacking. 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 onsite specialized chemical dependency treatment.
- Extend state and private capacity and support for opioid 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/

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.38
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:

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

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.

**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 six behavioral health-focused measures including:

- **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. Reported for Medicaid only. Separate reporting for age groups: 6-17 years and 18-64 years.
  - This measure is reported for Medicaid only.

**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 that 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 %)

The workgroup encourages the Division of Behavioral Health and Recovery to evaluate and report the outcomes of Medicaid patients on buprenorphine, methadone and those receiving only withdrawal management. Outcomes of interest, as from a prior evaluation would be survival, recidivism, lost to follow-up, employment, medical expenses, etc.

Substance use providers should be encouraged not just to report if clients completed 30 or 60 day treatment, but outcomes at 12 months as well. 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 ED utilization, and acquisition of HIV and hepatitis C.
Appendix C: 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. Its 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
References

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35 https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Substance%20Use/Hub_and_Spoke_LOI.pdf
37 https://www.hca.wa.gov/assets/program/10-things.pdf