`Bree Collaborative | Treatment for OUD Revision

June 18th, 2024| 3-4:30PM

Hybrid

MEMBERS PRESENT VIRTUAL

Charissa Fotinos, MD, WA HCA
Tawnya Christiansen, MD, CHPW
Kelly Youngberg, MHA, UW ADAI
Sue Petersohn, RN, CARN, Multicare,
Tom Hutch, MD, We Care Daily
Cris DuVall, PharmD, SUDP, Compass Health, Island Drug
Tina Seery, RN, MHA, CPHQ, CPPS, CLSSBB, WSHA
Nikki Jones, LICSW, SUDP, CMHS, DDMHS, GMGS, United Health Community
Amanda McPeak, PharmD, Kelley-Ross Pharmacy Group
Nicole Rodin, PharmD, MCA, WSU
Daniel Floyd, King County DSHS
David Sapienza, MD, PHSKC
Jason Fodeman, MD, L&I
John Olson, MD, MHA Sound Opiate Use Recovery Center (SOURCE) at Sound
Nikki Jones, SUDP, LICSW, UnitedHealthcare.
Liz Wolkin, MSN, RN, NPD-BC, CEN, Washington HCA
Maureen Oscadal, RN, CARN, Harborview Medical Center, ADAI

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Ginny Weir, MPH, CEO Foundation for Health Care Quality
Sarah Deutsch, HCA
Hillary Norris, Washington State Medical Association (WSMA)-policy analyst
Fan Xiong, DOH

WELCOME

Beth Bojkov, Bree Collaborative Staff welcomed the group to the June meeting and reviewed the agenda for the day. Once quorum was reached Beth transitioned the group to approve the May meeting minutes.

Action: Unanimously approved May meeting minutes.

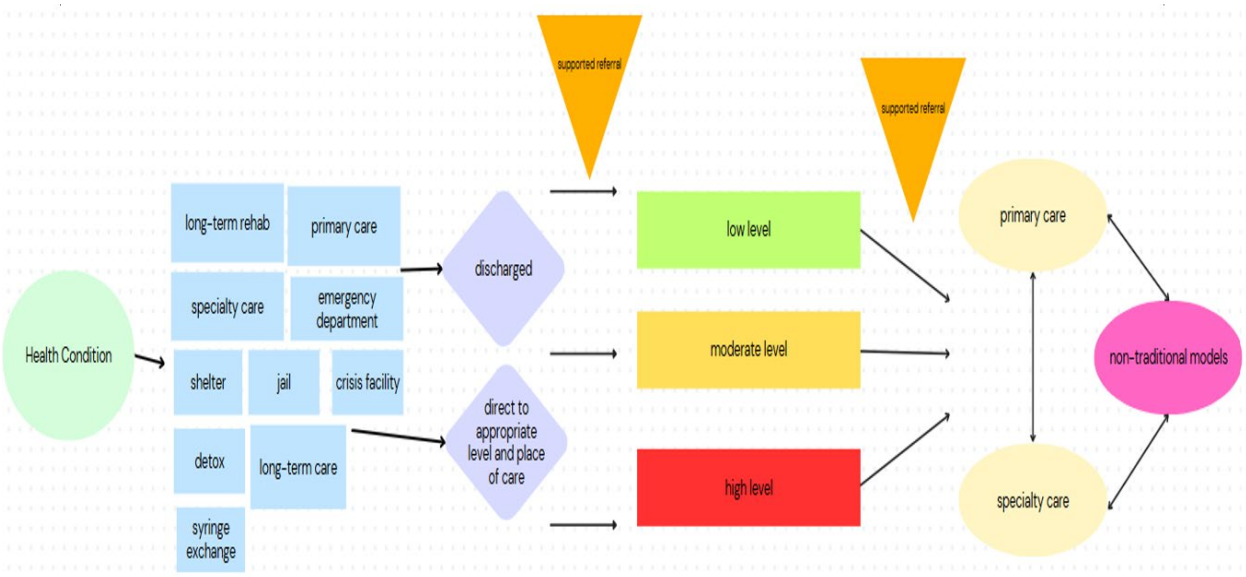
DISCUSS: COORDINATED CARE SYSTEM DIAGRAM

Beth transitioned the group to reviewing and discussing the Coordinated Care System Diagram.

- **Charissa:** This diagram got adapted from another project, but the idea being that folks show up in different ways and get filtered to different treatment settings. Some may be just sent to a clinic, get MOUD and they're fine, some have co-occurring mental health conditions where they need management or primary care with collaborative models, and there are folks with serious mental illness and substance use disorder who are probably most often and best managed in the community setting. Proposing this new model, over time the medical profession has not done an excellent job at taking care of people who are marginalized. That's shown because they don't want anything to do it. We've adapted to better meet people where they are, going to shelters, low barrier clinics, etc. Are we going to say yes we recognize that a subset of folks will

not seek care through traditional pathways and we have to be mindful and make recommendations for nontraditional access points too?

- Senator Cantwell has proposed a federal bill for a demonstration project for health engagement hubs.
- Any suggestions that the group has on the demonstration model that's in the press release calls for prospective payment model recognizing this can't be done in fee for service
- **Tawnya**: biggest barriers are providers willingness to be flexible and step into nontraditional models, but think they are necessary to meet people's needs
- **John**: right now, it's keeping the door open for when people can make appointments and that's where we're successful, we don't want people to continue in street medicine forever, but its critical to make sure people have access to their medications.
- **Charissa:** does this group support the notion that people get care wherever they are comfortable receiving it?
    - **Several members voiced support, no members opposed**
- **Charissa:** Health engagement hubs are meant to be comprehensive primary care, and that includes a lot of things like suturing, IUDs, etc, which is unreasonable to do in a van setting.
- **Sarah:** the pilot sites were funded out of a recommendation from the SURAC committee plan, came out of the Blake decision, but the goal was to establish these sites for comprehensive primary care across the state for people who use drugs. Funding for three more sites was allocated this year, to be awarded later this summer. Eventually the hope is that they would be self-sustaining with a payment model figured out. HCA is working on value-based payment models to reimburse for these programs.
- **Charissa:** Every part of the state has different resources, so should this group say anything about a minimum level of services that should be offered in this type of setting recognizing that some places will have a prescriber alone that does this on their off time, some will have more staff and they are able to do more? If not that's fine, but what other recommendations would the group like to make about payment for these models?
    - John: don't think its practical to have co-located mental health services, but need to be prepared to help people access robust mental health services. Also, financially, prospective payments or grant funding to support nontraditional models – there's no way to make it work for you with FFS, and the current payment system.
    - Tom: FFS doesn't work with so much of our patient population, people struggle logistically to make appointments and get to appointments. Hope that the prospective payment recommendations should be robust enough to support walk ins and no-shows because it is expensive. Nate also mentioned the value structure and what exactly they're measuring – including primary care visits, mental health screening and referrals, pregnancy outcomes, engagement in general, some other harder to measure aspects. This group could help guide what we hope to be measured in the future, if the health engagement hub model becomes larger.
    - Tom: What is the minimum that maybe should be offered at a health engagement hub, there's quite a few things we hope engagement hubs do, but offering access to start MOUD is one we could list, also brief intervention and screening. Having someone that can diagnose and prescribe. But there is a spectrum of how complicated and time consuming those minimum requirements would be.



NONTRADITIONAL SETTINGS AND HEALTH ENGAGEMENT HUB MODELS

Beth then transitioned the group to review the health engagement hub model worksheet with draft guidelines for minimum services offered at nontraditional settings.

- Fan: Is there a requirement for why someone would qualify for low barrier model of care versus primary care?
- Maureen: Working in primary care with OBOT, we have patients with established primary care who still struggle to engage and think that at times thye would benefit engaging in a low barrier setting
- Kelly: the engagement hubs are modeled after meds first programs, so the intention is for anyone who can't get traditional access to care and really lower those barriers we can get those hard to treat populations in our doors and there's plenty of people to treat. These sort of services offered but not limited to is key because some of these sites making these services a minimum might be a barrier to entry for syringe services programs.
- Kelly: Think there is new guidance from HCA on street medicine, so would have to follow up about that and get back to you.
- David: if there are minimum services, it should be very minimum. I don't think there should be many restrictions, because think the more things you say people have to do the more programs who maybe have least resources will not be able to access funding.
- Ginny: would you argue for removing some services offered but not limited to and maybe have minimum less comprehensive list and what an ideal state could look like?
    - David: yes
    - Kelly: would you consider that these are two separate structures and therefore two separate sets of recommendations?
    - David: yes, ideally they are integrated (hub with street medicine team) but think hard requirements should be minimized
    - Tawnya: I agree, we want to be careful about limiting access to care by imposing specific reuquirements. Maybe at the health engagement hub level, perhaps some amount of standardization would be helpful. Would want to see some flexibility for other nontraditional entry points.

- John: Would feel better if we changed managing medications for mental health concerns to bridging for common mental health conditions while coordinating referral.
    - Tawnya: I think that aligns with the state's bidirectional goal of integration, and honestly if you look at their integrated care assessment tool, increasing bridging is a piece of it.
    - Kelly: I afree that bridging, with Everett Maroon was here, but normally in our work with ADAI it is common that once these patients are finally engaged, they don't want to go anywhere else to get care. Most referrals fail.
        - John: That's my experience too.
        - David: Me too. I would want to clarify, for something called a hub, probably there should be minimum standards. For general nontraditional care locations like Charissa was talking about in the beginning, finding ways to support a diverse range of nontraditional care that is not reimbursed through FFS is important to not put restrictions on that. But if we're calling something a hub for people that use drugs, there should be some minimum standards for that specifically. There need to be other options in decentralized places.
        - Tom: The engagement hub like David was saying, that's where my heart goes first – lets not have too many requirements because this whole model is based on there being enough of these places to engage patients – would hate for a place to be pretty well-suited and staffed and not able to get funding if they don't have a wound care nurse.
        - Tom: Historically, OTPs treat people for OUD with three forms of MOUD, but I'm a family doc and enjoy doing contraception and Hep C treatment, so we do that here too. One thing we don't do is a wound care nurse, and that's just because we're not staffed to do it. So just want to ensure we're not putting something too prohibitive on here, and think it's important to consider that the referral acceptance rate is super low. People trust their counselor and provider but have had terrible stigma elsewhere in the community,
    - Beth: since we are talking about the engagement hubs, want to share that there's minimum services offered but also minimum staffing: partial or full time APP licensed in WA, partial or full time RN that provides medication management, medical case management, wound care, vaccine administration, and community based outreach, partial or full time behavioral health staff qualified to assess and provide counseling and treatment for substance use and mental health diagnoses, partial or full time outreach and engagement staff, and a prescriber for psychiatric and co-occurring disorders with experience prescribing MOUD
        - John: the question is are we being asked to make recommendations about what is the minimum, and do we think wound care nurse is appropriate as a minimum service? I like this slide about staffingmodel minimums because it's less about menu of services you're saying these are the people involved and it come down to their skill set.
        - Maureen: chiming in as a nurse, any nurse can do wound care. Not all nurses who do this work are certified wound care nurses.
        - Kelly: the RN role at Harborview also runs training programs for RN's across the state in OBOT, doing comprehensive amount of services so

providing medication management, meeting weekly, meeting regularly with patients, care coordination, wound care, all of that.
    - Beth: is it RNs usually, not LPNs?
    - Kelly: yes, most places RNs. There's reasons around licensure and who can do medication management, some places combine social workers with pharmacists instead but it's a bit more expensive.
- Jason: is the expectation that the prescriber be a primary care provider with background in addiction medicine or a psychiatry provider or potentially both?
    - Sarah: As long as the provider could provide the minimum set of services its sufficient, but I do think that if you wanted to get more specific you could, because we're relying on the specific list of services that would be required within an engagement hub to help organization identify who they are looking for
    - Kelly: the way this is put together with the prescriber being open is helpful, because we've seen pediatricians in this role. NPs as well, also psych NPs cant do wound care or put in orders, it's nice to leave it up to the sites but the main thing is the person needs to be able to prescribe for all those things on the list of services, most of the time filled by someone in primary care.
- Beth: Is there anyone on the list of services for engagement hubs that is missing?
    - David: I'm not interested in really changing the engagement hub model since thye put funding out for it already, but want to make sure we are endorsing or supporting those nontraditional models of care not just the hub. I'm a little unclear where that fits right now.
- Beth: what kind of payment models would facilitate these types of nontraditional models?
    - Kelly: think listing the certain types of services would be better, because it's about the services provided not about the people there. That allows flexibility to design the model the way they want.
    - David: when talking about prospective payment flexibility similar to FQHCs where it's not based on encounter rate but decided these are the minimum services and based on UM reimbursement so they don't have to do all those things but a subset to allow for continued offering of services.
    - Kelly: that's a great idea, and whether or not its per member per month or caseload rate, there's different ways to do it but incentivizing providing these services not tied to monthly rate of visits is important.
    - Beth: Maybe we change to bridging of mental health medications for nontraditional models?
    - Kelly: is screening for HIV/Hep C more comprehensive than what street medicine teams do? Thinking of what Seattle Fire is doing right now providing MOUD
    - David: for public health street medicine teams, that is definitely within their scope. They do all things like screening, but right the paramedics don't do all those things, it depends on what types of street medicine. Public Health street medicine teams could do most of the same things

as health engagement hubs, but some vaccinations they wouldn't be able to provide in the field.

- Liz: should we consider outlining reasons or policies for temporary discharge from services?
    - Liz: There could be value in saying if services are being considered low barrier, then someone couldn't be excluded from or required to discharge from or leave the program for these programs. It might be good to understand why someone might not be able to continue accessing services or continuing its program. Should we think about why someone might not be able to continue accessing services or continuing in the program? For example, there are policies in place around staff safety. What level of intoxication can you have or not have to consent a particular person, things like that.
    - Kelly: it would be curious to hear from Everett who runs a super low barrier program, so he might have some realistic ideas around that criteria.
    - John: the scenario that comes to mind is someone who is severely decompensated mental illness, engagement with a low barrier program might be getting in the way of accessing more appropriate treatment but in that situation you still want to use low barrier model to engage them because chances are if you turn them out you're not making more appropriate treatment available to them.
    - Tawnya: As a psychiatrist, I can say decisional capacity and ability to consent to medical things is separate, so support engaging people who want to be engaged regardless.

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup, we'll review identified intervention components the subcommittee has determined this workgroup could have an impact on and continue our review of nontraditional model recommendations. The workgroup's next meeting will be on **July 16th, 2024, 3-4:30PM**.