`Bree Collaborative | Treatment for OUD Revision
July 16th, 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
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
Jason Fodeman, MD, L&I
Liz Wolkin, MSN, RN, NPD-BC, CEN, Washington HCA
Maureen Oscadal, RN, CARN, Harborview Medical Center, ADAI
Everett Maroon, Blue Mountain Heart to Heart
Herbie Duber, DOH
Bob Lutz, MD, MPH, CHAS Health

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Fan Xiong, DOH

WELCOME

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

Action: Unanimously approved July meeting minutes.

PRESENT & DISCUSS: CORE INTERVENTION COMPONENTS

Beth Bojkov discussed the key areas of impact identified by the subcommittee, including clinic treatment pathways, care coordination, proximity to treatment, low barrier access, and dedicated support staff. The workgroup members provided feedback on the identified areas and suggested consolidating some of the categories.

- Be specific about the settings where you would expect providers to have oral medications on hand, because most won't
- Add nursing and pharmacist role to team-based care – can fill role of when it would normally take months to see a provider, someone can see a nurse that follows their case – move toward interdisciplinary team
- Add adequate dosing of medications based on symptoms, and ability to provide higher dose of buprenorphine when needed
- Payment models for each of these providers, might be a good point to hone in on the different clinician types
- Updating language to reflect expanding settings for MOUD delivery/access (EMS), Access to prescriptions in places where providers are not readily available, facilitating access to the medication

Comments

- Methadone should not create financial burden, there are some logistical burdens and legal concerns from hospitals about how to provide methadone to folks in hospital but its not a cost issue – don't want this to just be an outpatient access issue

PRESENT & DISCUSS: DRAFT GUIDELINES

Beth then transitioned the group to review the draft revision of the guidelines. The in person Bree staff experienced some technical difficulties and transitioned to ask Karie Nicholas to guide the workgroup through reviewing and revising the draft guidelines.

- Worry about peoples concerns about diversion, whether they think patients are ready for treatment or not – don't think this is the group to say the state should set up technical assistance for any clinician who wants to prescribe but is nervous about something or has a specific question,
- Frustrated with more responsibility being put on the state – state doesn't train people how to use insulin. Maybe we can just call out the training that does exist, DBHR does training and multiple models on SAMHSA website and in person courses – we need people to understand that this is not a choice, being uninformed has significant consequences
- Instead of saying something like providers should offer medication for opioid use disorder, something like not offering medication for opioid use disorder is considered substandard level of care
    - Seen lots of documents saying you should do this but nothing saying this is substandard care if you are not doing this
    - People listen to that language "substandard care"
    - Some concern that there are legal issues with using the statement standard of care
        - Basic things like offering medications for opioid use disorder is standard of care, but offering things like screening it gets tricky
        - "if someone in your practice or where the person in engaged in care has self identified or you identify as having opioid use disorder, medication treatment for their opioid use disorder is the standard of care" not about screening or reading people's minds
        - Also ensure people are not taken off their medications for opioid use disorder, if you have a patient on MOUD please continue them – we were talking about all the access points at EMS and all specialty care, and once people get stabilized if they come to a pcp just don't take them off meds
- Because we have the second iteration of the report, thousands of people have passed in the interim, and tired of begging people to just do this – DOJ is starting to prosecute people that aren't doing this
- We want whole system to recognize this a collective responsibility, and can't afford to employ people not willing to do this, from delivery systems to insurers
    - Direct messaging that this is what you do for a chronic condition, we should all help to get everybody there
- Higher doses of naloxone that are now being marketed; it can cause more harm. We want people to use the doses of naloxone that will keep them breathing. It's a complicated space because people will also not take it to avoid withdrawal.
    - One of the major concerns with using higher doses of naloxone is that it can lead to people not calling 911, and that's become a concern in the harm reduction community.
    - Reframe to consider lowest dose necessary to maintain appropriate respiratory drive and hemodynamics

- Does a decision aid need to be certified by the HCA? If it's reviewed and certified it adds some protection, that's the only reason but you can use whatever decision aid you want – could be replaced by evidence-based decision aid and add something like protection isn't available to clinicians when not using something certified by HCA
- OTPs: explanation of when it's appropriate to involve an OTP, statements about what we have to offer the community and how patients and other providers think about the opiate treatment programs. New regulations in 2024, lots of patients don't have to come in for daily dosing, even those in first week of treatment. Wording could be something like: "stabilize the patient through additional MUD options, including methadone and more intensive support services" – that shifts the focus to actual care and services people are offered rather than just frequency with which people sometimes come in
    - Could also say refer back to clinic for co management if that's preferred by the patient and their treatment plan
    - Dosing levels have increased significantly from years ago, and now seeing 10x the dose that we used to – sometimes buprenorphine wont do the trick for people – why OTPs can be a useful resource
        - Some are not being offered adequate buprenorphine, and think that's another thin that can be offered when we're talking about supporting patients in their treatment goals and where do they want to be and what's going to work best
- Restructure statement in the report about when patients are not meeting treatment goals in their current setting - if they are not meeting their goals considerations will be provided or transitions to other settings smoothly
    - Transfers of care and transitions of care conversations need to be done in partnership with patients and we need to be thinking about low barrier care as well, if we have someone coming in to see for treatment, they don't necessarily want to go to an OTP for treatment for different medications, what does that look like in conversation
- Some people have the perception that methadone is a worse medication, but calling out that it's not might be helpful
- Think we should include the risks that healthcare systems are putting themselves under in terms of parity laws if they choose to not provide care, because people with a substance use disorder are considered to have a disability defined federally – will link resources

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 hear from our colleagues at Medic One about King County's bupe program, and from the HCA's Department of Behavioral Health and Recovery Peer Support Programs
The workgroup's next meeting will be on **August 20th, 2024, 3-4:30PM**.