`Bree Collaborative | Treatment for OUD Revision
August 20th, 2024| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUAL

Charissa Fotinos, MD, WA HCA
Tawnya Christiansen, MD, CHPW
Mark Murphy, MD, Multicare
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
Everett Maroon, Blue Mountain Heart to Heart
Herbie Duber, DOH
Dan Floyd, King County
Michael Sayre, MD, Seattle Fire Medic One
Ryan Caldeiro, MD, KP

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Tim Candela, DOH
Mo Bailey, HCA
Shelly Shor, HCA
Jon Ehrenfeld, Mobile Integrated Care Program, Seattle Fire
Hillary Norris, WSMA
Fan Xiong, DOH

WELCOME

Beth Bojkov, Bree Collaborative Staff welcomed the group to the August meeting and reviewed the agenda for the day.

Action: Unanimously approved July meeting minutes.

PRESENT & DISCUSS: SEATTLE MEDIC ONE BUPRENORPHINE PROGRAM

Jon Ehrenfeld, Program Manager, Mobile Integrated Health Program Manager joined to discuss this low barrier buprenorphine access program. Jon Ehrenfeld Is the Program Manager for Mobile Integrated Health program with Seattle Fire. The Health One program has been up and running since 2019, and are a collaborative between Seattle Fire and Health and human services department to pair specially trained Seattle firefighter EMTs with case managers from Human Services. Purview is the City of Seattle, and mayor's office mandated that the fire department as part of Seattle's fentanyl and synthetic opioid strategy would stand up an overdose response unit. The program was largely modeled after San Francisco's Fire Department and Public Health San Francisco, with two arms.
Arm 1: response arm where people go out immediately to overdoses in the field as they're dispatched
Arm 2: follow-up arm, typically within 24-72 hours if possible
Jon then introduced Dr. Michael Sayre the medical director for Seattle Fire Department

1. Noticing a significant decline in the number of incidents with drug use that we're responding to, peak was spring 2023, across all responses close to 700 calls in 31 day period

2. Now, down to 405 in July 2024
    a. Seeing the same thing looking at the whole county, the overdose rates are flattening
3. Review of Seattle Medic One Buprenorphine Cases
    a. 36 patients treated Feb 21-July 18 2024
    b. Paramedics volunteered to get trained to use buprenorphine
    c. Most patients are male, around mid 30s, most have opioids in toxicology and most also have methamphetamine
    d. Started health 99 program in Seattle Fire, group of people that do this on a regular basis and identify people that would be ideal for field initiation of buprenorphine
    e. Most of the time, treating someone in withdrawal after they received naloxone
        i. There's a narrow window of opportunity to start someone in buprenorphine, many patients no longer in withdrawal once they get to the ED so the window is closed
        ii. Many people who get transferred to the ED stay a long time, but others are out the door in a few hours
    f. Steps of the process (ED Cascade)
        i. Step 1: EMS identifies bupe candidate
        ii. Step 2: EMS administers bupe to patient
        iii. Step 3: Transport to care setting
        iv. Step 4: ED eval
        v. Step 5: Outpatient RX
        vi. Step 6: Outpatient linkage plan
    g. Steps in the process (Inpatient Cascade)
        i. Step 1: EMS identifies bupe candidate
        ii. Step 2: EMS administers bupe to patient
        iii. Step 3: Transport to care setting
        iv. Step 4: inpatient Eval
        v. Step 5: Outpatient RX
        vi. Step 6: Outpatient linkage plan

One thing that will help, is when there is a place to take them that is dedicated to overdose response. If we're able to take some subset of patients that is able to care for their specific needs, we'll have a higher success rate.

Questions

i. Charissa: did you say meds being delivered by the team or is the team taking the to pick them up, in the absence of sublocade how is that happening?
    a. Initial induction through paramedics, clinic based treatment is the only option for sublocade, but mostly we try to make contact with them to get them to their appointments or to the pharmacy
    b. Charissa: how many days are your paramedics providing?
        i. Michael: they are not allowed to dispense medicine. That is too unlikely due to regulatory reasons. We're very open to exploring all of this in some research setting if possible. Could we have people getting injectables in the field? Could imagine paramedics embracing this if they had enough handholding to do it.

ii. Charissa: How are you managing if the treatment facility isn't willing to take a person with withdrawal? Are there prescribers willing to give additional buprenorphine for breakthrough symptoms or additional opioids because we know that unless folks are in withdrawal the risk of precipitated withdrawal is there?

a. Michael: learning is ongoing, providers at Hobson clinic at HMC have been providing people with buprenorphine sublingual that thye can use as bridge, other colleagues are taking phone calls from people who are wanting prescriptions. People are learning to prescribe more, like 2 week supply, because the patient might not make it to their appointment next week.
b. Michael: getting some push back with nerves, is the DEA going to come after us? I haven't done it this way since I was trained back in 2018, so not used to this – uncovering a lot of barriers

iii. Charissa: UW ADAI is evaluating this, there remain a ton of barriers to treatment, not least of which is experiencing withdrawal. We have people turned away from treatment who have been in withdrawal management programs and happened to use in the two weeks between the time they're discharged from the program and they show up ands still have signs in their toxicology screen, so treatment is not necessarily the next best step for people. Are the folks you're referring seeking treatment, or are they seeking a place to get away from their current environment? Trying to tease out at the state level do we need more residential treatment or is a safe place for folks, with a broader array of supports?
a. Jon: of the broader cohort of individuals we are seeing for overdose, huge range of interest in treatment options. People who are willing to accept that first initiation, that's pretty strong predictive of a future desire to keep engaging. Significant number of people wanting residential treatment and there are no beds. Then there are people who want home-based recovery, and suboxone is the way to go for that. We need to continue to do follow up analysis.

iv. Everett in Chat: We have found that offering as many services as possible while also helping identify barriers so that we can address them with the client helps people stay engaged. The collaboration with the co-responder program includes things like Fire/EMS starting an induction and us continuing at the clinic. They can supply a SL bupe with us continuing with that or sublocade. We also are looking to get EMS support if they encounter a client with their community paramedic program, and if that person is a mutual client, having us authorize some other kind of medication support, like tx for syphilis, for example. This then helps high-acuity patients recognize a community wide care team. Such a team includes SUDPs, mental health clinicians, case managers, and nurses who can all talk to each other using multi-party ROIs to offer care no matter where that individual is encountered.
a. Charissa: is the supply that the fire EMS team gives, it is prescription or are they administering SL buprenorphine in the field?
b. Everett: administer in the field.
c. Michael: where we are today is we give an induction dose of buprenorphine and then they go somewhere else to continue, have talked with others about potential for clinical trial like using the long acting injectable in conjunction with this to see if that would enhance people's engagement with care later. Link to article about LAI in ED: depending on results of that, that might provide foundation to extend into the prehospital setting.
d. Michael: one challenge is that before we get there, they get many doses of Narcan, and their overdose is very reversed. Right now teams don't have anything to offer them, so having some buprenorphine to treat withdrawal help them in the moment, and then have Health 99 program follow up with them to see if they would be interested in getting a shot. Getting someone to come to the patient and meet them literally where they are would be likely to have some success.

i. Jon: looking on our dispatch board, we dispatched to McDonalds 3rd and Pike, in all likelihood because this person is going to receive 4-16 mg of Narcan and push them into precipitated withdrawal.
ii. Where the specialization comes in is for people who are in regular withdrawal and not precipitated, or they received less Narcan, and would be interested in starting on MOUD. Big proponent of the co-responder model where medical personnel partnered with civilian personnel or social work. Seattle will open overdose center next year, so we'll be able to take them there next year.
iii. Charissa: will crisis connection centers be additional opportunities?
iv. Jon: potentially some capacity, but they will not be providing exactly the same things
v. Kelly: working closely with Dr. Goldman to make sure that there is some replication of DESC center into the crisis centers

e. Michael: question in the chat about using nalmefene – majority of patients don't get any naloxone from EMS now, we've lost control of dosing strategy for reversal drugs. Before Spring 2022, we were microdosing naloxone and getting them to ER to get them induced, that is such and infrequent event now. Not sure where nalmefene would fit into that.
i. Mark: if you're considering initiating LAI bupe in the 4-12 hour window post-overdose it's less complicated if they are not continuing to deal with the withdrawal
ii. Michael: fair enough, where we are is learning the sales pitch – what are the objections that clients have? How do you overcome that? Providers can use these scripts, just working to get first dose on board and what that optimal first dose might be. Then figuring out where to go next.
iii. Charissa: heard from our public health colleagues, it's great that there is so much naloxone out there. There's a misunderstanding of what reversing an overdose looks like, it's not getting them up and walking and talking its getting them breathing again. Then once they are put into significant withdrawal, there is nowhere for them to go. From the state perspective there's no significant benefit for nalmefene.
iv. Michael: the FDA has not done us any favors with the 4mg naloxone dose, the Europeans have 1.8mg dose intranasally and that seems to be much better.

f. Beth: any final thoughts for what the Bree could do to support your work or address some of these barriers?
i. Michael: we need more places to take patients, would love to explore ways that paramedics could dispense buprenorphine on weekends. Think our teams could safely dispense buprenorphine for people.
ii. Jon: we are primarily working with HMC because that is where our clinical connections are, we are using that as a test case for what we can do on the ED front. Highlight the ScalaNW program protocols, see ED encounters as missed opportunities for intervention. There are lots of opportunities for brief and structured interventions around this, discharging people home with 3-7 doses of buprenorphine.

PRESENT & DISCUSS: PEER SUPPORT SPECIALISTS

Beth then invited Shelly Shor and Mo Bailey from the Healthcare Authority discussed the peer support program, including the process to become a certified peer counselor, the expansion of peer support services, and the new credentialing process for certified peer specialists. They highlighted the importance of peer support in the recovery process.

i. Peer support is the process of giving and receiving nonclinical assistance to achieve long-term recovery from severe psychiatric traumatic or substance use challenges. This support is provided by peer supporters – people who have "lived experience" and have been trained to assist others in initiating and maintaining long-term recovery and enhancing the quality of life for individuals and their families.
ii. Started certified peer counselors trainings in 2005, one of first 11 states to deliver peer services using Medicaid funding. In 2019, SUD peer support services were added as a Medicaid benefit.
iii. 2023 a bill was passed with the intent to expanding access to peer support services, eliminating financial barriers to professional licensing, honor the contributions of peer specialists. Moving forward the certified peer specialist will be a standalone credential, which would open up peer services to more folks with the intent of billing private insurance.
iv. Beginning July 1, 2025 certified peer specialists and certified peer specialist trainees they are established as a new health profession that may engage in practice of peer support services
    a. The title is not voluntary unless that person or employer bills a health carrier or medical assistance for those services, certificate is not required to practice peer support services but is required to use the title of certified peer specialist or trainee.
    b. HCA is planning on contracting for a program to link eligible persons in recovery from behavioral health challenges who are seeking employment as peers with potential employers – create a statewide database accessible to eligible persons and employers.
v. Certified peer specialist tracks
    a. Certificated peer specialist has a requirement of 1000 supervised hours, trainees are those working toward certification.
    b. Approved supervisors are a behavioral health provider with at least 2 years of experience working on BH practice that employs peer specialist as part of treatment teams, OR certified peer specialist who has completed at least 1500 hours of work with at least 500 hours attached through join supervision of peers in conjunction with another supervisor and has taken the training developed by HCA for supervisors
vi. Operationalizing Peer Support training
    a. Operationalizing peer support program assists agencies and organizations who want to add peer services to their book of business or for organizations who already use peer support services and need technical assistance
vii. There are no disqualifying convictions to obtain any DOH credential – each application is reviewed independently on a case by case basis, individuals often have a criminal history based on life experiences
viii. Ethics of peer support: ethics have been a concern around peer support, and the DOH is creating an ethics of peer support guidelines. They are not enforceable laws but rather a guide to maintaining proper boundaries and avoiding conflicts with clients. Guidelines are based on national organizations such as SAMHSA. The rules are not finalized and there are ways to get involved in that decision making.

Questions

i. Relationship between SUDPs and certified peer counselors – there has been a rub historically between the two roles. What we can do to mitigate that is educate about peer support. There's a lot of concern about the rate of pay, compared to SUDPs. When it comes down to roles, the Operationalizing peer support training really helps.

ii. Mark: how should services of CPS be allocated to individuals and treatment residential and ambulatory offered to all those who express interest?
    a. Mo: we did have a prior program with Pioneer Human Services to do a bridger program where they were connecting with individuals and residential treatment and building relationships, help them transition to community after inpatient treatment
iii. Beth: are there any organizations that you're seeing lots of friction
    a. Mo: historically it was substance use disorder treatment, changing a lot with harm reduction and understanding the role of peer support versus role of SUDP
iv. Beth: where do we stand with commercial insurance billing for peer support
    a. Mo: currently we don't have commercial insurance reimbursing for peer support
v. Mark: how does your community regard people who do not have lived experience with SUDs?
    a. Mo: we all come with a bit of lived experience, and we can all relate to walking through certain struggles, and peer supporters build on that. Everyone has a role.
    b. Shelly: peer supporters don't think there is such a thing, we all have lived experience, so we are open to everyone.

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup, The workgroup's next meeting will be on **September 17th, 2024, 3-4:30PM**.