Background

Opioid-related deaths continue to rise at alarming rates. From 1999 to 2021, opioid-related deaths increased six times and in 2022, over 75% of total overdose deaths involved an opioid. [i] Among those under 50 years of age, drug overdose is the second leading cause of death, increasing 12% in 2024 to exceed 71,000 lives. High schoolers who receive only one opioid prescription are 28% more likely than those who did not receive a prescription to misuse opioids between 18-23 years of age. In Washington, the rate of overdose deaths from per 100,000 population for any opioids doubled between 2019 – 2022 (10.59 per 100,000 versus 25.74 per 100,000) while overdose deaths from prescription opioids have maintained relatively constant (3.28 per 100,000 versus 3.59 per 100,000).[ii] The 2022 National Survey on Drug Use and Health estimated that 8.9 million Americans 12 years or older misused opioids (heroin or prescription pain relievers) in the past year, and almost 1 million Americans 12 years or older misused prescription or illegally made fentanyl (IMF).[iii]

The past 20 years have seen several separate waves of increase in substance use disorders linked to the availability and use of different substances. The first wave in the 1990s followed increases in prescription opioids. The second began in 2010 following the introduction and increase of heroin use, and the third wave began in 2013 brought a significant increase in deaths involving synthetic opioids, particularly fentanyl. In recent years, stimulant use has also increased dramatically; nationally, psychostimulant deaths increased 27% between 2019 to 2020.[iv] With the overwhelming use of fentanyl, alone and in combination with stimulants, the response from the healthcare system must change to prevent overdose related harm and deaths.

Highly potent synthetic opioids (HPSO), most commonly fentanyl, have become more and more present in the United States drug supplies. Washington state death rates due to fentanyl have risen over 750% between 2018-2022, and in 2022 were almost 90% of all opioid-involved deaths.[v] One of the challenges of treating opioid use disorder in the fentanyl era is that fentanyl and its analogues are much more potent than heroin or prescription opioids and can rapidly induce tolerance and dependence. People using HPSO experience persistently higher serum opioid levels and develop higher levels of tolerance. This coupled with the fact that the breakdown products of fentanyl are stored in fat cells, makes elimination from the body slow, prolonging and complicating withdrawal. In practice this means that people who use fentanyl, or opioids contaminated with fentanyl, require higher doses of buprenorphine or methadone to control their symptoms and reduce their cravings. These facts make transitioning people using HPSO more challenging than when prescription or lower potency heroin were the predominant opioids. With few rigorous research studies on how best to transition people off of fentanyl and on to medications for opioid use disorder, standards of care that minimize the risk of withdrawal and rapidly transition people off fentanyl have been slow to develop ; however, buprenorphine and methadone are still efficacious treatment options, reducing mortality by over 50%, and should be offered to any individual interested.

Despite the lifesaving effectiveness of medications for opioid use disorder, MOUD, most individuals with identified opioid use disorder do not receive appropriate care or treatment. This is partially due to substance use disorders being highly stigmatized and people with opioid use disorder not being likely to receive or seek treatment themselves. In 2022, only 0.5% of adolescents with a substance use disorder sought treatment. [vi]

Opioid Use Disorder Diagnostic Criteria

Opioid use disorder is defined as "*a problematic pattern of opioid use leading to problems or distress, with at least two of the following criteria occurring within a 12-month period:*[9]

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. *A need for markedly increased amounts of opioids to achieve intoxication or desired effect.*
    b. *A markedly diminished effect with continued use of the same amount of an opioid.*
    a. *Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision."*
11. *Withdrawal, as manifested by either of the following:*
    a. *The characteristic opioid withdrawal syndrome (i.e., dysphoric mood, nausea or vomiting, muscle aches, lacrimation or rhinorrhea, pupillary dilation, piloerection, sweating, diarrhea, yawning, fever or insomnia)*
    b. *Opioids (or a closely related) substance are taken to relieve or avoid withdrawal symptoms*
    c. *Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision*

The Opioid Use Disorder Revision workgroup seeks to move the health care system from that demonstrated Figure 1 in which people with Opioid Use Disorder encounter gaps in care and access to that of Figure 2 in which the health care system is coordinated around individual patient need. Figure 2 differs from the original 2017 report document in the language used to describe access points (e.g., removing stigmatizing language) and recognizing the addition and necessary inclusion of nontraditional models of care and access points for people with opioid use disorder.

Figures

Focus Areas and Goals

Component	Objectives	Goals
Education	Increase alignment of policies and protocols with evidence-based guidelines Increase evidence-based educational materials	To improve the content and reach of education for OUD treatment
Access	Reduce financial barriers to access for MOUD and adjunctive interventions Increase number of primary care sites providing MOUD Increase	Reduce financial barriers to care, proximity barriers to care and increase access points for appropriate care
Screening and Diagnosis	Increase incentives; increase sites that can provide screening and diagnosis; increase providers that can provide screening and diagnosis	To increase number of patients with OUD that are identified and appropriately diagnosed
Referral and/to Treatment	Increase reimbursements for MOUD and increase number of sites that provide referral and/or treatment	Maximum number of patients with OUD who want MOUD receive it; All patients with OUD receive referral to appropriate care.
Prescribing	Reduce barriers for patients to receive personal doses	All patients with OUD receive prescriptions that adequately address their symptoms in accordance with evidence-based guidelines
Ongoing Care/Recovery Support	Increase warm handoffs, supports for people with OUD including care coordinators and peers	Increase treatment retention for medications

Guidelines

Primary care providers should be educated on the latest evidence-based guidelines for diagnosing, treating, and managing opioid use disorder, including the use of medications such as buprenorphine and methadone, as well as the importance of a multidisciplinary approach to care. *Medication for opioid use disorder treatment must be the standard of practice for primary care.*

Providers

- **Become educated on the latest evidence-based guidelines** for diagnosing, treating and managing opioid use disorder, including use of medications such as methadone and buprenorphine and the importance of approaching opioid use disorder as a chronic condition.
- **Universally screen at least annually for substance use disorders including opioid use disorder using a validated instrument** (see NIDA Screening and Assessment Tools) **following the United States Preventative Task Force recommendations.** Screening may be done by another care team member, clinic staff, or online/on paper prior to appointments.
- **If patient screens positive or brings up concerns about their opioid use, ask about frequency, amount, and route of opioid use; perform comprehensive assessment; and discuss medications for opioid use disorder including buprenorphine, methadone, and naltrexone..** Many people may only be familiar with abstinence-based approaches and unaware that using medications reduce risk of overdose by about 50%[vii]. Do not delay medication until a comprehensive assessment can be performed.
  Use an evidence-based patient decision aid to support the conversation (some are certified by the Washington HCA, see more here). The conversation should include:
  - Risks and benefits of available medications.
  - How lifestyle can impact which medication might best meet their need (e.g., whether the patient can do daily visits) as well as the patient's use of other substances (e.g., alcohol, benzodiazepines)
  - Ensure that the patient and their family or support system, if appropriate, understand risks of serious adverse events including of relapse and overdose death for withdrawal management and counseling without medication, compared to the use of buprenorphine, methadone, and naltrexone.
  - Assess and address patient comorbidities including poly-substance use and any untreated mental health or physical health diagnoses.
- **In primary care, offer office-based medications for opioid treatment.** 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. Offering access to medications for opioid use disorder is considered standard of care for patients with opioid use disorder. Follow evidence-based guidelines for assessment of opioid withdrawal and MOUD induction. (ASAM, PCSS).
- **Prescribe dosages of MOUD and adjunct therapies that adequately addressing symptoms.** With the use of more potent substances like fentanyl, required doses needed to curb symptoms of withdrawal can be much higher. Adjunct medications may be helpful to address symptoms of opioid withdrawal (e.g., autonomic arousal, anxiety/restlessness, insomnia, musculoskeletal pain, and gastrointestinal distress).
- **Write a prescription for and/or provide naloxone for use during an overdose.** For in-person visits, the ideal scenario is for patients to leave the appointment with naloxone in their

possession. Providers can use the statewide standing order to dispense naloxone, and naloxone is free to request by mail in Washington state. Order free naloxone through Washington Department of Health.
    - Teach patients and families how and when to use naloxone. Washington State Department of Health's video tutorial on how to respond to an opioid overdose and administer naloxone linked here.
- **In primary care, coordinate physical and behavioral healthcare.** Coordinate care across physical and behavioral health providers. See **Appendix D** for information on care coordination compared to case management.
- **Regularly follow up with patients with opioid use disorder, whether they decide to pursue medication or not.**

Health Care Facilities

Opioid use disorder treatment can be successfully provided by variety of models on multiple levels of care (e.g. office-based opioid treatment (OBOT) in medical or mental health clinics, jail-based care, opioid treatment program care, mobile care, telehealth, ER, inpatient, EMS-initiated). Our workgroup does not endorse a specific model but does strongly recommend adoption of evidence-based methods of treating patients that increase access for underserved populations and that address the treatment of opioid use disorder as care for a complex medical condition. We also support piloting innovative and promising treatment models along with formal evaluations measuring benefits, costs, and challenges. Providers in all systems should seek assistance from mentors available from comparable clinics, professional societies such as American Society of Addiction Medicine (ASAM), American Academy of Addiction Psychiatry (AAAP), and the Providers' Clinical Support System (PCSS), Telehealth programs such as UW Telepain, Project Echo, Integrated Care Training Program, Use the UW Psyhiatric Consultation Line (877-927-7294), and whenever able, offer office-based treatment with buprenorphine.

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

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

    - **Change practice workflows to align with principles of low-barrier treatment**.
        - Short time until medication start (start patients on medications for opioid use disorder on the same day if possible).
        - Do not discharge patient from treatment for initial or ongoing polysubstance use.
        - Counseling and other adjunct therapies offered but not mandated for treatment.
        - Engage patient in creating an individualized follow up plan after visits
    - **Outpatient facilities and programs should expand hours to include drop-in visits**, and/or weekend/night hours without appointment requirements. Patients with OUD may have sporadic engagement but that should not delay or discontinue care.
- **Prepare or use available evidence-based patient materials describing the risks and benefits of available opioid use disorder treatment options using current, accepted language regarding substance use disorders** including evidence-based patient decision aids (some are certified by Washington State HCA). Train staff to talk to patients about how to select the best treatment option for them.
    - **Staff should discuss risk of serious adverse events** including risk of relapse and overdose death for withdrawal management and counseling alone, compared to the use of buprenorphine-naloxone, methadone, and naltrexone.
    - **Utilize a patient decision aid to guide discussion**. Read more about the Health Care Authority's work to certify patient decision aids here: www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making.
- **Be aware of and provide community resources** for access to medications for opioid use disorder in case patient cannot reach usual providers (King County Tele-buprenorphine Hotline – call 206-289-00287)
- **Offer MOUD** in primary care, behavioral health clinics/programs, mental health clinics, hospitals, (inpatient and emergency departments), and nontraditional care settings (e.g., mobile vans, street medicine teams, syringe service programs, etc.) in accordance with established guidelines (e.g., ASAM, PCSS)
    - **Prescribe dosages of MOUD and adjunct therapies that adequately addressing symptoms.** With the use of more potent substances like fentanyl, the required doses needed to curb symptoms of withdrawal can be much higher. Adjunct medications may be helpful to address symptoms of opioid withdrawal (e.g., autonomic arousal, anxiety/restlessness, insomnia, Musculo-skeletal pain, and gastrointestinal distress)
- **When possible, utilize an interdisciplinary team approach to support comprehensive care for patients with opioid use disorder (OUD).** Such teams can integrate diverse expertise to address the multifaceted needs of these patients. Nurses play a crucial role in monitoring patient health, administering medications, providing education on OUD, and offering emotional support. Pharmacists may contribute by managing and dispensing medications for OUD, ensuring adherence to treatment protocols, and advising on drug interactions and side effects.. This collaborative effort helps optimize patient outcomes through coordinated, holistic care that addresses both medical and psychosocial aspects.

- **Incorporate peer support services into the care team whenever possible.** Peer support workers can bridge gaps in care by assisting patients in navigating health care systems, connecting them to community resources, and offering continuous emotional and social support. Bringing their own lived experience to their interactions with patients, peers are able to establish trusting relationships that better support people trying to navigate an often-stigmatizing healthcare system.
- **Assess possible medication interactions, especially with 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
- **Identify which patient comorbidities will be treated onsite, criteria, and partners for referrals.**
    - **Stabilize the patient and reduce harm, death from overdose, as a first priority.**
    - **Assess patients for poly-substance use, physical health comorbidities, and mental health comorbidities** and tailor additional care to the patient's needs and wishes. Patients with opioid use disorder may have 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.
    - **Clinicians should engage patients in shared decision-making around their goals and transfers of care.** Patients who are not meeting their treatment goals in their current setting should be offered available options and resources to either adjust treatment plans or smoothly transition to another setting that may be able to provide more intensive levels of service and wrap around support.
- **Build capacity to provide for a range of medical, harm reduction, treatment, and social services**. Patients can be lost to follow up if there are many transitions of care or access points for different services.
- **Build referral capacity with an accredited Opioid Treatment Program where you can refer patients when appropriate.** Opioid Treatment Program can help stabilize a patient through additional MOUD options including methadone and more or more intensive support services, such as counseling. OTPs should be seen as specialty care services and unless the program also provides primary care services, care for persons referred to OTPS should be shared between the program and the referring PCP. With patient permission, care plans can be readily shared between the programs.
- **Referral to appropriate levels of care**
    - **Employ staff** (e.g., care coordinators, case management and peer support) with dedicated time to facilitate access to appropriate level of care or external referral as needed. Use a warm handoff when possible.

    - For patients with mental health issues, refer to treatment facilities conducting treatment by trained and licensed mental health providers, if needed and available.
    - For patients with co-occurring stimulant use disorder, offer and refer to a program offering evidence-based care, such as contingency management.
- **Support patient involvement in other programs (e.g., peer programs,** employee assistance programs)
    - **Do not use attendance at peer support programs as a criterion for receiving or withholding access to medication**. Some patients may wish for, and benefit from, peer support groups such as Alcoholics Anonymous, Narcotics Anonymous, and other peer support programs. Evidence does not support compulsory attendance at peer and chemical dependence counseling for all patients receiving office-based medication treatment.
- **Prescribing opioids for pain**
    - Follow prescribing guidelines of opioids for pain in the Agency Medical Directors Group ~~inte~~agency 2015 Guideline on Prescribing Opioids for Pain (available here and summary here) and the Centers for Disease Control and Prevention 2022 Guidelines. Or most updated guidelines.
- **Evaluation.** Evaluate the effectiveness of programs offered at the facility at regular intervals (e.g., annually) or participate in external evaluations. Refer to the measurement section at the end of this report.
- **Share information.** Assure appropriate systems and structures are in place to help share information between and across physical and behavioral health providers while respecting privacy and confidentiality.
- **Treat adolescents and teens in accordance with evidence-based best practices.** Ensure providers are aware of the age of consent for treatment (in 2024, age of consent is 13 years old). See Seattle Children's resource for substance use in adolescence and this UW Addictions, Drug and Alcohol Institute brief.
    - MOUD is a first line treatment for adolescents. Primary care settings should be prepared to identify adolescents with OUD and start them on MOUD per clinical guidelines.
    - Encourage involvement of caregivers and/or members of adolescent's social network, as appropriate, but do not turn away receiving treatment adolescents at age of consent. More information on specific treatment protocols for adolescents and teens is available here.
    - Adolescents can receive quality care in primary care settings and every patient requires a shared care plan with patient and involved care team that is individualized to meet their needs. Consider specialized treatment facilities providing multidimensional services when appropriate.
    - Screen for depression and suicide, educate about prevention, and offer treatment

for blood borne pathogens, discuss contraceptive needs and sexually transmitted infections.
    - Increase awareness about medications for opioid use disorder and facilitate engagement for both caregivers and patients.
- **Treat patients who are pregnant in accordance with evidence-based best practices.** For more information see the Bree Collaborative's Perinatal Behavioral Health 2023 Guidelines in addition to the Substance Use and Mental Health Services Administration's Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants and the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion Opioid Use and Opioid Use Disorder in Pregnancy. Additional or specific steps have been identified below:
    - Train pre- and perinatal care providers about opioid use disorder including how to recognize signs of opioid use disorder, how to facilitate safe and timely care and manage patients with opioid use disorder.
    - Routine universal screening should use validated instruments (e.g., 4Ps, NIDA Quick Screen, CRAFFT)
    - Engage patients who are pregnant in prenatal care in addition to opioid use disorder treatment. Identify emergent/urgent medical conditions that require immediate referral to clinical evaluation.
        - Provide screening for sexually transmitted infections according to the most updated clinical guidelines (e.g., AAFP guidelines). Newborn syphilis cases have increased 10-fold from 2012 to 2022.
    - Opioid agonist pharmacotherapy is the recommended therapy and preferable to medically supervised withdrawal. Initiate treatment with opioid replacement therapy as early as possible. Hospitalization during initiation may be advisable due to potential adverse events and/or need for close observation.
    - Perinatal patients can be safely managed in the perinatal or primary care setting. Work to provide opportunities for perinatal providers to co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist.
    - Use a supported referral to refer patients who are pregnant and physically dependent on opioids to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence.
    - After a positive screen for opioid use disorder, perform a medical examination and psychosocial assessment.
    - Embed resources for providers such as the Perinatal Psychiatry Consult into clinic resources that are easy to access for providers.
    - Incorporate substance use disorder doulas as a part of the care team as available.

Chemical Dependency Programs

Chemical dependency programs are specialized services that help people who have substance use disorders. They offer a range of interventions, such as counseling, medication-assisted treatment, and peer support. By providing evidence-based care for people who have opioid use disorder, chemical dependency programs can reduce the risk of overdose, improve quality of life, and promote recovery.

See “Programs and Facilities” above and additionally:

- Support patient decision to use medication for opioid use disorder. Be aware that the effectiveness of medications for opioid use disorder increases with duration of treatment and may be lifelong. **Do not encourage patients to stop medication treatment**; refer to prescriber for concerns with medication treatment.
- Collaborate with other providers, including opioid treatment programs, to ensure that any patient on medication treatment who requires an inpatient stay continues receives/takes medication throughout that stay. **Breaks in continuity of medication can put the patient at increased risk of recurrence of substance use and/or overdose post-discharge.**
- **Build consultation options** for staff who may need/want consultation around patients with complex or multiple needs or conditions. Consider available resources such as the University of Washington Psychiatry Access Line
- **Do not bar access to all appropriate services** offered by the agency based on any substance and/or medication use.
- Build capacity to provide integrated other behavioral health and primary care.
- Write a prescription for naloxone, dispense and physically deliver to patients.
- **Share information**. Assure appropriate systems and structures are in place to help share information between and across physical and behavioral health providers.

Health Plans

- **Support whole-person care**. Develop a reimbursement structure that actively facilitates and encourages access to MOUD across all available settings. 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 patents. Consider alternative payment models for supportive, wrap-around care for patients with opioid use disorder
    - If engaged in fee-for-service payment plans, include prospective payments to cover non-billable services including but not limited to care coordination, warm handoffs, and wrap-around services. Consider pathways to reimburse for peer support workers.
    - Continue to move towards value-based purchasing based on patient outcomes such as overdose rates, retention in treatment, , and patient satisfaction to drive quality improvement.
- **Do not contract with facilities that refuse to offer first-line treatment for patients with opioid use disorder or continue MOUD once admitted. Ensure continued access to MOUD is required in any contracting negotiations.** This includes long-term care facilities.
- **Prioritize prescription of MOUD and remove barriers to access. Support use of MOUD as part of the treatment plan.**
    - Remove prior-authorization protocols for methadone, buprenorphine, and naloxone for all patients, including those pregnant or under the age of 18. Remove prior authorization for higher doses of buprenorphine treatments in accordance with evidence-based guidelines, as higher doses demonstrate effectiveness for patients using high potency synthetic opioids like fentanyl.
    - Remove co-pays for screening and assessment for substance use disorder
    - Incentivize providers or facilities in areas without access to buprenorphine to begin and maintain office-based opioid treatment services.
        - Consider developing rural specific higher reimbursement rates or other incentives to encourage rural access to care
    - Cover buprenorphine induction and continuation via telehealth (audio only and audio visual) in alignment with federal regulations
    - Reduce barriers such as co-pays to support appropriately timed (e.g., more frequent) and personalized dosing.
    - Support Opioid Treatment Program reimbursement structures that cover the costs of effective care including treatment plans including buprenorphine, naltrexone, and telehealth. Facilitate use of both buprenorphine and telehealth in OTPs. For OTPs that wish to provide services additional to those required by Federal statute, allow them to do so through contract amendments.

    - Ensure that reimbursement programs do not prohibit patient initiation and ongoing access to medication treatment.
- **Support nontraditional models of care**.
    - Remove barriers to billing for services not provided in clinic buildings.
    - Provide adequate reimbursement for street medicine or mobile services using prospective payments to cover non-billable items like outreach, referral and care coordination.
    - Include nontraditional models in network adequacy standards and quality measures where appropriate for substance use disorder
    - Facilitate data sharing and communication between nontraditional models and other providers through integrated mobile electronic health systems and information exchange services.
- **Reimburse provision of treatment for smoking cessation**. Individuals with opioid use disorder have very high rates of tobacco use. Patients who continue to smoke tobacco have higher all- cause mortality as well as higher opioid relapse rates.
- **Educate members on services provided to them and evidence-based treatment options for opioid use disorder.** Ensure education materials follow guidelines on destigmatizing language.

Employer Purchasers

- **Eliminate insurance barriers**.
    - Choose benefit structures that offer a full range of evidence-based treatments for substance use disorders and remove barriers to accessing medications for opioid use disorder (e.g., counseling requirements, prior authorizations, etc)
    - Eliminate inadvertent barriers to behavioral health care service access. Develop benefit structures that equalize access to behavioral and physical health care.
- **Educate employees. Encourage participation in employee assistance programs.**
    - If an employee assistance program is offered, universally promote employee understanding of behavioral health benefits and potential opioid misuse. Universal communication around services offered can reduce stigma and increase utilization of services.
    - Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction).
- **Reduce employment barriers**. Do not create additional restrictions on employment for persons in treatment for opioid use disorder outside of those required by law.

Washington State Agencies

Health Care Authority

- **Certify patient decision aids.** To help 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 options for treatment.
    - Consider patient decision aids for targeted populations (pregnant people, adolescents)
- **Review treatment program effectiveness**.
    - Conduct and share evaluations 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 (e.g., retention of patients in treatment at 3, 6, and 12 months).
- **Advocate for national reduction in cost of medications for opioid use disorder**
- **Support community pharmacies** seeking Risk Evaluation and Mitigation Strategy (REMS) certification for long-acting injectable buprenorphine.

Department of Health

- **Offer training on medication first MOUD.** Fund preparation of sample curricula principles and an interdisciplinary lesson plan for providers.
- **Mount a public awareness campaign that medications for substance use disorders can be prescribed by your primary care provider.** Many people do not know their primary care provider can prescribe buprenorphine and other medications for substance use. Consider targeting messaging to those most likely to be impacted by substance use and those most likely to not know (e.g., non-Hispanic Black individuals, pregnant individuals, adolescents and teens).[xi]

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 providers to locate different recommended treatments.

The Opioid Use Disorder Treatment workgroup also wishes to address correctional facilities and health services academic training programs and residencies. While these stakeholders are not typically within the purview of the Bree Collaborative, the scope of the epidemic necessitates their inclusion.

Correctional Facilities

These guidelines have been adapted from the National Commission on Correctional Health Care's Opioid Use Disorder Treatment in Correctional Settings Position Statement. Starting July 2025, Washington Health Care Authority will offer limited Medicaid coverage to youth and adults in correctional facilities up to 90 days before they are released; minimum coverage includes care management, medication for opioid use disorder, including a 30-day supply of prescribed medications for post-release.

- Establish MOUD programs that involve universal screening of OUD for people entering facilities, offering treatment with MOUD and ensuring MOUD treatment continuity upon entry and discharge. Methadone and buprenorphine decrease the risk of overdose upon release by half.[xii] These processes should include appropriate counseling about OUD, patient management and recovery groups, risks associated with stopping medication and how continued treatment with buprenorphine or methadone can save lives.
- Train correctional health care and custody staff in science and treatment of OUD as a chronic illness, appropriate monitoring during MOUD administration and provision of intranasal naloxone.
- Prescribe and dispense naloxone upon release. Teach how to use naloxone prior to release. Persons released from incarceration are at high risk for fatal overdoses.
- Establish partnerships with nearby Opioid Treatment Programs and community treatment providers to assist in people continuing to receive treatment while in custody, establish pathways for MOUD initiation during incarceration and seamless transition after discharge to community treatment.
- People being discharged should receive appointments with community providers, adequate supply of MOUD upon release and back-up plans if appointments are cancelled or delayed.

Health Services Academic Training Programs and Residencies

- **Incorporate evidence-based information on substance use disorders, including opioid use disorder, into the curriculum for all licensed clinicians.**
    - Include coursework that prepares students to screen, diagnose, and treat common substance use disorders including alcohol and tobacco in a team and evidence-based format.
    - When able, consider including rotations with opportunities to gain experience

in evidence-based treatment practices for patients with OUD.
    - Encourage leadership and faculty of health service training programs to enhance and make consistent the factual basis for curricula including but not limited to medicine, chemical dependency, nursing, pharmacy, dental, mental health, and social work. This should include pain management, the Prescription Drug Monitoring Program, and the prevention, recognition, and treatment of opioid use disorder.
    - Encourage experts on opioid use disorder treatment, including opioid treatment programs, to speak to trainees.
    - **Chemical dependency counselor training programs and statutes that recommend only abstinence-based treatment should be updated to prioritize medication first access.** Trainees should be taught about evidence-based treatments for opioid use disorder that offer clients the highest rates of success and survival from illicit substances. Tobacco cessation should be part of chemical dependency counselor training.
    - Periodically update curricula using input from technical advisory groups without financial conflicts of interest (e.g. SAMHSA, NIDA, NIH, CDC, ASAM, AHRQ)
    - Ensure both faculty and students are using current, non-stigmatizing language.
- **Support use of MOUD.**
    - Have residents complete training on prevention, recognition and evidence-based treatment for opioid use disorder (e.g., family practice, adolescent medicine, rehabilitation medicine, obstetrics, psychiatry, anesthesiology, internal medicine, emergency medicine, pediatrics)
    - Encourage tours of nearby opioid treatment programs as a means of educating up-and- coming professionals about this treatment option and how to co-manage patients with opioid treatment programs.
- **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.

Medications for Opioid Use Disorder

Opioid use disorder is a chronic condition and must be managed as such. The workgroup recognizes medications for opioid use disorder (MOUD) as the most appropriate, evidence-based treatment. Medications to treat opioid use disorder include buprenorphine, methadone, and naltrexone, profiled below and on the following pages.[xiii] MOUD medications reduce cravings and withdrawal symptoms, block the effects of opioids, and/or block opioids' euphoric and sedating effects, and reduce the risk of having an overdose. While whole-person approaches that include behavioral therapy still provide benefit for some patients, medications should not be withheld based on lack of engagement with other more traditional methods of treatment, (e.g. outpatient, intensive outpatient, residential or 12 step based programs) as medications for the treatment of opioid use disorder has been shown to be more effective than behavioral therapies, medically supervised withdrawal or abstinence alone. Therefore, medications should be available and offered at any point where a person interacts with the healthcare system. Research consistently shows MOUD lowers rates of death from overdose and rates of illicit drug use. [xiv] For more information and a review of the evidence supporting medication-assisted treatment, see Medication Treatment of Opioid Use Disorder - Biological Psychiatry (biologicalpsychiatryjournal.com) or **Appendix C.**

Co-occurring use of stimulants is common among people who use opioids. Nationally and in Washington state, more individuals are using both stimulants and opioids together resulting in increases overdoses and deaths [xvxvi] Stimulants offer increases in energy, attention, respiration, heart rate, appetite suppression and enhanced mood. People use opioids and stimulants together for many reasons, including increased positive feelings, coping with emotional pain, balancing effects of each substance and their availability on the drug market. People who use stimulants and opioid tend to have lower treatment retention, more physical and mental health conditions, riskier drug use patterns and consequences, and higher rates of houselessness and unemployment.[xvii] There are no specific treatments for co-occurring stimulant and opioid use disorder, but buprenorphine use for opioid use has been found to reduce the use of the stimulant methamphetamines in some people.[xviii] Evidence-based psychosocial treatments targeting stimulant use include Contingency Management, Motivational Interviewing, Cognitive Behavioral Therapy and the Community Reinforcement Approach. Read more about evidence-based treatment for stimulant use disorders through SAMHSA here.

Behavioral therapy when delivered alone has limited efficacy in addressing the symptoms and physical aspects of opioid use disorder,[xix] but has been shown to complement medication treatment, address social and psychosocial factors behind opioid use, and may lead to greater treatment retention.[xx] Additionally, many people have co-occurring medical or other behavioral health needs. Individual characteristics and preferences should help inform choice of medication as medications differ in the location from which they can be dispensed, how they can be prescribed, side effects, and how they work chemically. Providers should always engage in shared decision-making to create individualized goals that may or may not include behavioral therapy. This is especially true for certain populations such as adolescents and patients who are pregnant. **Agonist medication therapy, methadone or buprenorphine, is recommended for patients who are pregnant and adolescents and should be offered without contingent behavioral therapy**.[xxi] The workgroup recommends an integrated care model (e.g., integrated behavioral and physical health care) with consideration for individualized patient needs.

- **Buprenorphine:**

- Can come in formulations of sublingual (under the tongue), oral, patch or injectable.
- 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.[xxii][xxiii]
- Binds to and activates receptors in the brain but to a lesser extent (partial opioid agonist) than prescription opioids, heroin or fentanyl. Buprenorphine can result in feelings of euphoria and has the potential to be misused but is safer than methadone due to lower risk of respiratory depression. Buprenorphine-naloxone formulations reduce diversion to injected misuse.[xxiv]
- Buprenorhpine can now be prescribed by any licensed provider (MD, DO, PA, NP) in the state of Washington without requiring a waiver from the DEA.
- Buprenorphine can be obtained at a community pharmacy.
- **Emerging strategies for buprenorphine induction are being explored in the case that standard induction is not preferred or not possible (rapid high-dose buprenorphine and low-dose buprenorphine with opioid continuation**).[xxv] The American Society of Addiction Medicine published Clinical Considerations: Buprenorhpine Treatment of Opioid Use Disorder for Individuals Using High-Potency Synthetic Opioids which provides a brief summary of evidence for these emerging induction strategies.
- **Extended-release buprenorphine compared with sublingual buprenorphine has shows significant reductions in opioid use and durable opioid blockade, and can be started after only 1 dose of sublingual buprenorphine**. It may be useful for patients who have struggled to stabilize on sublingual buprenorphine including those with a history of extensive HPSO exposure, unsafe living environments and/or multiple opioid overdoses.[xxvi]
- Buprenorhpine use, while not indicated for stimulant misuse or disorder, has been associated with eventual reduction in methamphetamine use among some people.[xxvii]

- **Methadone**
  - Systematic reviews have found methadone to be more effective than counseling, medically supervised withdrawal alone, or no treatment in reducing illicit opioid use and in retaining patients in treatment (when compared to both medically supervised withdrawal alone and to buprenorphine-naloxone) [xxviii]
  - Longitudinal studies have also found methadone maintenance associated with reduced risk of overdose related deaths, reduced risk of HIB and hepatitis C infection, lower rates of cellulitis, and lower rates of HIV risk behavior.[xxix]
  - Use results in some of the same feelings as an opioid (full opioid agonist) but eliminates opioid withdrawal. Methadone for the treatment of opioid misuse 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. **In 2024, SAMHSA updated regulations for OTPs allowing them to dispense up to 28 days of "take home" methadone for stable patients and up to 14 doses for less stable patients. The final rule also allows initiation of methadone or buprenorphine over telehealth.** See SAMHSA website for further

details.
    - This updated rule also allows for up to 72 hours of methadone to be dispensed to a person upon release from a hospital or emergency department to facilitate transition to an opioid treatment program.
    - More information on OTP certification is available here. Licensure mandates OTPs to assess drug use history and medical needs, provide counseling, conduct random drug testing through urinalysis or saliva tests, and provide vocational and educational services.

- **Naltrexone**
    - Opioid antagonist that fully blocks the euphoric and sedative effects of opioids (full opioid antagonist) with no euphoric effects. Naltrexone is FDA approved for alcohol use disorder and may be a good option for patients with both opioid and alcohol use disorders.
    - Two formulations of naltrexone are available – oral and injectable: oral naltrexone is not recommended except under limited circumstances and has not been shown to be superior to placebo or to no medication in clinical trials[xxxxxxi], and a long-acting injection that is administered by a health care provider every four weeks. In studies comparing extended-release naltrexone to sublingual buprenorphine, some found reduction in relapse when using naltrexone versus buprenorphine due to challenging initiating and maintaining the medication.[xxxii]
    - Patients must be abstinent from opioids for at least 7-10 days prior to starting naltrexone. Incarcerated or hospitalized patients may be good candidates.
    - **Naltrexone carries major risk of relapsing after stopping naltrexone (e.g., on day 31 after a 30-day injection) and reduced tolerance/increased sensitivity to opioids and subsequent overdose**. Patient should be informed of this increased risk if they return to illicit opioid use.[xxxiii]

Medications for Overdose Reversal

- Naloxone
    - Used to reverse opioid overdose by blocking opioid receptors (full opioid antagonist) in emergency overdose situations. Should be carried by anyone in the community, including people who use drugs, and administered by friends and family.
    - Use **lowest dose necessary** to provide adequate respiratory drive and hemodynamic stability. This is to avoid putting someone into full blown withdrawal.
    - Is contained in the sublingual formulation buprenorphine-naloxone as a deterrent to misuse by injection but is not absorbed in clinically meaningful amounts when taken sublingually.
    - Administered either intranasally or parenterally. At the time of this revision, intranasal naloxone is available over the counter and covered by most insurances.
    - **Washington state introduced a standing order for naloxone** that allows pharmacies or other entities to dispense and deliver naloxone products to eligible persons and entities including those at risk of experiencing opioid related overdose or persons/entities in a

position to aid persons experiencing an opioid-related overdose. Read more at the DOH here.

Dosing in Fentanyl Era

In King County, the number of opioid nonfatal overdoses treated by EMS rose by 200% and confirmed fentanyl-involved deaths rose over 600% from 2021 to 2023. In 2023, over 60% of poisoning deaths in King County were attributed to a combination of opioids and stimulants.[xxxiv] These rates have initiated multiple projects aimed at reducing opioid use and connect people with opioid use disorder to services to that can prevent increased morbidity and mortality.

There is no fixed dose of buprenorphine or methadone that works for everyone, and each person's needs may vary depending on their level of exposure to fentanyl, their metabolism, their pain level, and other factors. Therefore, it is important to monitor and adjust the dose of buprenorphine or methadone based on the patient's response, using clinical assessment of withdrawal symptoms, and self-report as indicators. The goal is to find the optimal dose that prevents withdrawal, reduces cravings, blocks the effects of illicit opioids, and minimizes side effects and risks of overdose.

See Providers Clinical Support System's report Practice-based Guidelines: Buprenorphine in the Age of Fentanyl for more information

Slow-Release Oral Morphine & Safe Supply

While treatment medications for OUD in the US are limited to methadone, buprenorphine and naltrexone, other countries have taken a broader approach. Another medication option for opioid use disorder treatment is slow-release oral morphine (SROM), which can provide a more stable and individualized dosing regimen for patients who do not respond well to buprenorphine or methadone or for whom buprenorphine or methadone use is not in their treatment goals. SROM has been shown to be effective and safe in reducing substance use, retaining in treatment, and improving quality of life among patients with opioid use disorder.[xxxv][xxxvi] SROM has demonstrated some improvement over methadone in reducing cravings,[xxxvii] mental health symptoms,[xxxviii] and treatment satisfaction.[xxxix] SROM is used in Canada and some European countries; in the Canadian Medical Association Guideline on Management of opioid use disorders, they give a strong recommendation for SROM as an alternative specialist-led approach, stating, "*in patients whom first- and second-line treatment options are ineffective or contraindicated, opioid agonist treatment with slow-release oral morphine (initially prescribed as once-daily witnessed doses) can be considered.*"[xl] SROM it is not currently approved by the FDA in the United States.

While buprenorphine and methadone are efficacious treatment options for patients with opioid use disorder, there are other effective treatment options that are not available in the United States. Internationally, alternatives such as injectable hydromorphone, have been tested and are even recommended as treatment options for certain populations.[xli] Hydromorphone injection may be appropriate for those whom other opioid agonist therapy is not in their treatment goals. Providing safe injectable opioids through prescription has shown to reduce overdose risk, improve overall health and reduce drug-related harms. In the Study to Assess Longer-term Opioid Medication Effectiveness in

Vancouver, British Colombia injectable hydromorphone demonstrated effectiveness against the active ingredient in heroin for in reducing illicit heroin use after 6 months.[xlii] A cost-effectiveness study showed similar outcomes for diacetylmorphine and hydromorphone, but reduced costs and QALYs compared to methadone over a lifetime.[xliii] Off-label hydromorphone, both injectable and tablet, is currently being offered in several Canadian sites.[xliv] The British Colombia Centre on Substance Use's Guideline for the Clinical Management of Opioid Use Disorder includes weak recommendations for, "*injectable OAT with diacetylmorphine or hydromorphone for adults with severe OUD and ongoing unregulated injection opioid use who have not benefitted from or declined oral options for OAT*."[xlv]

The workgroup advocates for the removal of regulatory barriers to treatment options that are effective at reducing a person's risk of overdose, death and improve quality of life for people who use opioids.

Standards of Care

Providers and other clinicians have a critical role in preventing, identifying and treating OUD among their patients. Standard of care should include universally screening patients for opioid use disorder using a validated screening tool, offering medication for opioid use disorder if OUD is suspected regardless of if a comprehensive assessment can be done at point of care, providing naloxone in hand accompanied by education on how to recognize and response to overdose, and referring patients to appropriate levels of care and follow-up services, including primary care, specialty care, mental health care if wanted and needed, harm reductions services and/or recovery support groups. Care teams should use warm handoff and coordinate care carefully during transitions as many patients are lost to follow up.

Health delivery systems should facilitate and hold clinicians accountable for universally applying screening for OUD, offering MOUD and using shared decision-making with patients in developing plans of care, removing barriers to access for MOUD, and hire and sustain dedicated support staff such as peer support workers, social workers and care managers, to provide supportive services to patients using substances. Primary care sites should ensure universal screening for OUD, offer office-base medications for opioid use disorder (OBOT) and providing in-hand naloxone with education on overdose response. Hospitals and emergency departments should be prepared to offer and continue MOUD for patients with OUD, prioritize warm handoffs to continued treatment and support services once discharged, and coordinate referrals to appropriate follow up care. Specialty clinics should incorporate OUD screening and referral for MOUD as part of their routine practice, recognizing the intersection between substance use and other chronic conditions. Behavioral health programs must adopt a patient-centered, trauma-informed approach to and provide culturally responsive care. All healthcare settings must foster a compassionate, collaborative culture, reduce stigma, and provide continuous training in evidence-based practices for OUD treatment.

Several barriers remain to patients accessing these medications:

- A minority of primary care clinics offer buprenorphine or naltrexone, and few substance use disorder treatment centers offer medication treatment. Most retain a non-medication treatment approach, neither offering medication treatment nor referring patients to a facility offering medication treatment.
- Reimbursement for substance use or mental health treatment programs is often too low to cover the costs of prescribing providers or buprenorphine, particularly when treating Medicaid patients. Low reimbursement rates effectively prohibit more patient-centered staffing models such as

onsite or integrated prescribers.

- Expensive efficacious therapies, such as extended-release buprenorphine, are not covered or covered with significant copays by some health plans, limiting this treatment option for patients that might be most impacted. Pharmacies are required to be REMS certified to dispense extended-release buprenorphine, which as of this report only 19 out of over 1,000 pharmacies in Washington are certified.

Progression Towards Optimal Care

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 harm and have no overdose events.

	Current State	Intermediate Steps	Optimal Care

Primary Care Setting	• Patients with active opioid use disorder are not detected and not treated.
	• If detected, providers may be uncertain as to next steps or may feel uncomfortable discussing opioid misuse.
	• Providers are uncomfortable prescribing buprenorphine and do not refer people to providers who are.
		• Primary care leadership support adding a service to treat opioid use disorder. See an example manual for office-based opioid treatment here.
		• Primary care providers are incentivized by higher reimbursement to treat opioid use disorder and co-occurring conditions.
		• Primary care providers and staff are trained:
		  ○ To diagnose opioid use disorder.
		  ○ On indications for MOUD
		  ○ On local behavioral health providers, Opioid Treatment Programs and how to provide supported referrals for patients.
		  ○ To use current, non-stigmatizing language regarding substance use disorders.
		• The Bree Collaborative behavioral health integration framework and complementary models (e.g., AIMS Center Collaborative Care) are understood and that steps have been taken to integrate into care structures.
		• 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.
		• Clinics restructure workflows and facility operations to reduce barriers to accessing treatment, including providing drop-in hours or extended hours for same-day MOUD.
			• Patients have access to all available treatments for OUD and behavioral health care and counseling as wanted and needed without mandatory requirements that constitute a barrier to care. Ongoing and recurring illicit opioid use is expected due to the remitting relapsing nature of OUD. Patient care is not interrupted or terminated due to use.
			• Treatment may include primary care providers treating patients with opioid use disorder with buprenorphine or naltrexone or supported referral to opioid treatment programs. If referrals are necessary, referrals are coordinated to support patient during transitions.
			• Behavioral and physical healthcare is co-located and integrated with access to harm reduction services in a non-stigmatizing setting.
			• Consider incorporating or partnering with providers in nontraditional settings such as mobile vans or street medicine teams to expand access to care based on community needs.

			• Care navigation to assess needs for other services (e.g., housing, employment, legal, recovery supports) and to help clients connect and stay engaged with these services.
Pain Clinic	• Patients may have undiagnosed opioid use disorder • The Washington State Prescription Monitoring Program (PMP) may not be a routine part of prescribing practice	• Providers have been trained on: ○ The Agency Medical Director's Guideline on Prescribing Opioids for Pain. ○ How to assess opioid use disorder using DSM-5 criteria. ○ Referring to an addiction specialist including an opioid treatment program. ○ Prescribe naloxone as preventative rescue medication, if needed. ○ Using the PMP. • Providers have access to and use the University of Washington Pain & Opioid Provider Hotline where providers can present individual complex patient cases or call for consultation with a pain specialist or pharmacist about medication management. • To use current, non-stigmatizing language regarding substance use disorders.	• The AMDG and CDC guidelines for prescribing opioids are followed (*e.g., Chronic Opioid Analgesic Therapy is prescribed only if there is sustained clinically meaningful improvement in function and no serious adverse outcomes or contraindications*). • Prior to any prescription, the Washington State PMP is checked. • Patients with suspected opioid use disorder are assessed using DSM-5 criteria and receive a supported referral to an opioid treatment program. If referrals are necessary, referrals are coordinated to support patient during transitions. • With patient's permission, the primary care provider is notified. • Patients are prescribed, taught how to use, and leave with naloxone in hand as a preventative measure.
Behavioral Health Setting (including Substance Use Treatment	• Patients with opioid use disorder are not offered evidence-based treatment for opioid use disorder. • Substance use treatment programs	• Providers are trained: ○ To diagnose opioid use disorder ○ To review and offer or refer all appropriate opioid use disorder treatment options with patients. ○ On local Opioid Treatment Programs and how to provide supported referrals to	• Patients receive treatment for opioid use disorder and other co-occurring behavioral health diagnosis from available psychiatric or other licensed behavioral health providers. Any outside referrals include shared bi- directional communication and

Programs)	may rely on abstinence-based care	patients. • Behavioral health prescribers are incentivized with higher reimbursement when psychiatric disorders and opioid use disorders are both treated simultaneously. • Medical providers are available and able to prescribe medications for opioid use disorder. • Providers are introduced to ongoing training resources including providers' clinical support system for opioid therapies (PCSS) and Telemedicine learning collaboratives. • Providers and staff use current, non-stigmatizing language regarding substance use disorders. • If inpatient or residential stays are medically indicated, providers support continued use of medication treatment throughout the stay. • Behavioral health and substance use disorder programs partner with primary care.	care coordination. • Clinicians with ability to prescribe are co-located or available remotely to prescribe medications for opioid use disorder at all times a clinic is open. • Providers treat opioid use disorder in a behavioral health setting or provide supported referrals to opioid treatment programs depending on patient-specific treatment goals. • Behavioral and physical healthcare is co-located and integrated with access to harm reduction services in a non-stigmatizing setting.
Opioid Treatment Programs (OTP)	• Programs may only exist in urban/suburban settings • MOUD treatment is typically limited to methadone with special provisions for patients who are pregnant. • Low daily reimbursement rates limit additional treatment options (e.g., primary and other behavioral health care).	• Clinics work to integrate care with local community providers and develop relationships with primary and behavioral health care settings. • Buprenorphine and naloxone are available. • 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.	• Patients may transfer care between primary care, behavioral health care setting, or OTP, but minimize as able. When transitions are necessary, ensure care coordination support to maintain contact. • Patients diagnosed with opioid use disorder are offered MOUD based on their individualized treatment goals • OTPs can function as health homes (providing comprehensive coordinated medical and behavioral healthcare, such as through the Health Engagement Hub model) • As able, partner with primary care

			providers to offer or coordinate follow up for primary care services.
Perinatal Care Providers	• Patients who are pregnant and have opioid use disorder are not routinely screened and may feel uncomfortable disclosing opioid use. • Many patients have been poorly treated by the healthcare system and are concerned about referral to child protective services. • As a result, some 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. • Many pregnant people with OUD have experienced significant trauma in their past.	• Obstetrics providers are trained about opioid use disorder including how to screen for and recognize signs of opioid use disorder • Treatment barriers are reduced through increased primary care services and improved coordination between prenatal and behavioral health providers. • Health care services are supported by alternative care models for substance use and mental health treatment that combine women's and parenting support services. • Supportive referral processes are developed between prenatal care and medication treatment facilities. • Co-management processes between prenatal care and addiction medicine are developed. • Trauma informed approaches are used in clinical settings.	• Patients who are pregnant are: ○ Engaged in prenatal care as a first priority with emergent/urgent medical conditions that require immediate referral for clinical evaluation identified. ○ Screened for opioid use disorder and have access to integrated prenatal, substance use, and mental health care. ○ Started on medications for opioid use disorder as early as possible in pregnancy to help reduce the severity of neonatal abstinence syndrome. After a positive screen for opioid use disorder, medical examination and psychosocial assessment are performed. • Buprenorphine services for patients who are pregnant with opioid use disorder are available among primary care providers with obstetrics privileges, group buprenorphine care, case management, patient navigation and maternal support services • Women with opioid use disorder are diagnosed and supported during all phases of perinatal care including after delivery to continue recovery. • Women have access to promontoras, peers, doulas or community health workers to

			support them in pregnancy if they choose.
Emergency Department *(not the ideal location to begin recovery process – e.g., not cost-effective, low acceptance of referrals)*	• Patients are treated for opioid overdoses or the complications of opioid use, but initiation of MOUD and supportive referral for treatment for opioid use disorder may not occur	• Partnerships are developed with clinics that can accept patients with opioid use disorder for treatment options including medication treatment without delay. • In areas without Opioid Treatment Programs and available buprenorphine programs, hospital affiliated primary care clinics are incentivized to start an office-based opioid treatment program to which patients, including those presenting to the ER with a possible opioid overdose can be referred. • ER teams have access to specialty addiction medicine support to assist in assessment, diagnosis and treatment planning of patients with OUD and co-occurring conditions • ER providers are trained in: ○ How to diagnose opioid use disorder and determine severity ○ How to initiate patients with opioid use disorder on MOUD utilizing a certified shared decision-making tool. ○ To manage acute pain in patients on naltrexone, buprenorphine and methadone. • On 72 hour rule for methadone dispensing to continue access to MOUD until patient can make follow-up appointments.	• Patients are assessed for opioid use disorder using DSM-5 criteria. • Patients presenting to the emergency department for overdose are given naloxone and a supportive referral the next day or <72 hours for treatment with MOUD • Patients do not regularly initiated on chronic pain medication from the emergency department. • Decisions on prescribing opioids to patients at risk, or suffering from opioid use disorder are done with a shared decision-making tool to maximize pain relief and prevention of relapse. • Decisions on prescribing MOUD to patients with OUD are made jointly between provider and patient with assistance from a shared decision-making tool to identify the best treatment option • With patient's permission, the primary care provider is notified of emergency department visits. • If the patient was treated for a drug overdose, the primary care provider and any other prescribing provider(s) are notified of an overdose event. • Prior to any prescription for controlled substances, the Washington State PMP is checked. • Peer recovery support and

			support for health-related social needs are integrated on site
Syringe Service Programs	• The opportunity to intervene among people using syringe exchange programs may be missed.	• Patients who wish to reduce non-medical opioid use are referred to programs which offer treatment including 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.	• Treatment services are co-located, if possible. • 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.
Jails	• Persons released from incarceration are at high risk for fatal overdoses.	*Continuation or initiation of medication treatment has been shown effective and is recommended regardless of duration of sentence.* • 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.	• Persons entering jails with opioid use disorder are provided with medications for opioid use disorder and adjunct therapies or maintained on previous treatment • Persons released from jails are prescribed, trained on how to use and given naloxone. • Persons transitioning out of correctional facilities are provided MOUD at discharge and coordinated connection to community-based provider that will continue medication
Mobile Van/Street Medicine	Nontraditional models like mobile vans or street medicine teams may not exist	• Clinics and providers consider developing nontraditional models based on community need	• Mobile vans/street medicine teams are available in communities with difficulty with patient engagement and identified community needs

			• Nontraditional models can offer, prescribe and maintain patients on medication for opioid use disorder and offer coordinated referrals for other relevant health or social needs • Providers engage in shared decision-making with patients and educate them on their options to engage in treatment for OUD.

Inpatient Care Settings. *(Inpatient care teams have an opportunity to identify patients experiencing OUD and offer engagement in treatment, even if not admitted for an OUD-related condition or overdose. Initiation of MOUD in inpatient*	• Patients are treated for opioid overdoses or complications of opioid use, but initiation of MOUD and supportive referral for treatment for opioid use disorder is rare.
	• Patients admitted under a different primary condition may not be assessed for opioid use disorder and its severity and may not be offered treatment while inpatient.
	• Hospitals may decline to hire peer support staff for fear of recurring substance use
	• Hospital providers are not well trained on
		• Partnerships are developed with clinics that can accept patients with opioid use disorder for treatment options including MOUD treatment without delay.
		• Build pathways for specialty addiction medicine consults for patients with severe OUD and/or co-occurring conditions.
		• In areas without Opioid Treatment Programs and available buprenorphine programs, hospital affiliated primary care clinics are incentivized to start an office-based opioid treatment program with flexible treatment options including telehealth to which patients discharging from the hospital with a diagnosis of opioid use disorder can be referred.
		• Inpatient providers regardless of specialty are trained:
		  • How to diagnose opioid use disorder and determine severity
		  • How to initiate patients with opioid use disorder on MOUD.
		  • To manage acute pain in patients on MOUD
		  • To manage pain and/or withdrawal
			• Patient with OUD are identified and assessed for severity based on DSM-5 criteria
			• If not done before admission, screen patients for OUD and possibility of withdrawal or unmanaged pain - initiate MOUD and/or withdrawal and pain management alongside admission and other inpatient care.
			• 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.
			• Decisions on prescribing MOUD to patients with OUD are made jointly between provider and patient with assistance from a shared decision-making tool to identify the best treatment option
			• With patient's permission, the primary care provider is notified of

settings is successful and can improve outcomes such as ER utilization, hospital readmission and retention in MOUD treatment.)	how to manage pain in people maintained on MOUD.	symptoms in patients who do not want to initiate MOUD • On 72-hour rule for methadone dispensing, or a bridge prescription of buprenorphine, to continue access to MOUD until patient can make follow-up appointments • Hospitals hire peer support workers and other support staff to support patients with SUDs • Providers are trained in how to manage pain in people maintained on MOUD.	hospitalization and discharge. • If the patient was treated for a drug overdose, the primary care provider and any other prescribing provider(s) are notified of an overdose event. • Prior to any prescription for a controlled substance, the Washington State PMP is checked. • Prescribe bridge doses of MOUD at discharge • Care management teams support transition to community-based care by scheduling follow up appointments with appropriate level of care for OUD severity, and connecting patients with other services to address health related social needs • Pain and withdrawal symptoms are managed regardless of patient's decision to start MOUD. • Patients who are not yet in withdrawal or decline MOUD are offered a prescription for home induction. • Peer support workers are available on site to support patients with SUDs • Patients maintained on MOUD have their pain adequately

			managed.
Long-term Care Facilities	• Patients with opioid use disorder are denied acceptance into skilled nursing facilities[xlvi] • Patients with opioid use disorder who are admitted to long-term care facilities may not continue their medication treatment	• Change admittance practices to accommodate the needs of patients with OUD • Establish partnerships with Opioid Treatment Programs and community providers to offer and continue MOUD • Train staff members in recognizing and managing OUD through a harm reduction lens and using evidence-based practices. Train to recognize signs of overdose and administer intranasal naloxone. • Develop services like counseling and peer support to support patients with SUDs • Establish protocols for the safe prescribing, dispensing, and monitoring of opioids. Utilize prescription drug monitoring programs (PDMPs) to track patient prescriptions.	• Patients with OUD are admitted into high quality long-term care facilities and transition smoothly from acute settings to post-acute settings • Patients with OUD receive evidence-based treatment in long-term care facilities, including continuation of MOUD and adequate management of symptoms with adjunctive treatments. • Staff approach care for patients with OUD through a harm reduction lens • Patients with OUD have reliable access to supportive services like counseling and peer support

Other Initiatives

Washington State Opioid Overdose Response (SOOR) Plan

The Washington State Opioid Overdose Response Plan is a comprehensive strategy designed to address the complex challenges posed by the opioid crisis. By ensuring that patients with OUD have reliable access to supportive services such as counseling and peer support, the plan aims to provide holistic care that is patient-centered and compassionate. A key element of the plan includes training staff to adopt a harm reduction approach, ensuring that care is empathetic and effective. Patients in long-term care facilities benefit from evidence-based treatments, including the continuation of MOUD and the management of symptoms with adjunctive treatments. Moreover, the plan emphasizes the establishment of safe prescribing, dispensing, and monitoring protocols for opioids, utilizing prescription drug monitoring programs (PDMPs) to track patient prescriptions and prevent misuse. The seamless transition of patients from acute to post-acute settings and the formation of partnerships with Opioid Treatment Programs and community providers further underscore the state's commitment to quality care and recovery for those affected by opioid addiction.

EMS Providing Buprenorphine – Health 99 Team in Seattle

The Seattle Medic One Program serves as a crucial part of the State Opioid Overdose Response Plan. This program aims to provide low-barrier access to Medication for Opioid Use Disorder (MOUD). It focuses on offering rapid, often on-site, MOUD to individuals experiencing opioid overdoses or those identified as at risk, thereby reducing the barriers to treatment access. The program aligns with broader efforts to combat opioid-related morbidity and mortality by integrating emergency medical services with addiction treatment pathways.

Health Engagement Programs

Health engagement programs refer to a range of models *"providing low-barrier substance use treatment, harm reduction, and basic medical services for people who use drugs (primarily opioids and stimulants)"*[xlvii] These models provide coordinated services in single point of access that can support building trust and engagement that can meet the unique needs of patients with substance use disorders. The workgroup endorses col-locating services when possible in settings that provide a comprehensive range of services for people who use drugs.

The University of Washington Addiction Drugs and Alcohol Institute recently published and implementation toolkit to support community organizations in implementing health engagement programs for people who use drugs.

See more here: Health Engagement Programs | Addictions, Drug & Alcohol Institute (uw.edu)

Previous Bree Collaborative Recommendations

Addiction and Dependence Treatment

The Bree Collaborative elected to address addictive disorders and convened a prior workgroup to develop recommendations around increasing uptake of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol. The workgroup releasing recommendations in January 2015 the majority of which were directed at primary care and emergency room facilities. Recommendations include 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 shows that SBIRT is not effective for opioid use disorder treatment or for severe alcohol use disorder.44

- 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 , now MOUD (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 offsite specialized chemical dependency treatment.
- Extend state and private capacity and support for 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/

Read the full Report and Recommendations here: www.breecollaborative.org/wp- content/uploads/ADT-Final-Report.pdf

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.

Measurement

The workgroup endorses the use of the Washington State Common Measure Set and several specific measures to evaluate impact of this report and guidelines.

The workgroup also encourages the Division of Behavioral Health and Recovery and other programs to evaluate and report treatments provided to patients who present with opioid use disorder. Tracking outcomes of medications for opioid use disorder will help inform best practices and emerging issues. Providers treating patients with substance use disorders should be encouraged to report outcomes at 30 or 60 days of treatment, as well as outcomes at 12 months. 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 emergency department utilization, and contracting of HIV or hepatitis C.

Specific Metrics or Measures

The workgroup endorses the use of these specific metrics to track improvement in the cascade of care for OUD and improvement in the Bree Collaborative identified goals.

- **Initiation of OUD Treatment;** (**2a**. Use of pharmacotherapy for OUD (cascade measure) Percentage of individuals with an OUD diagnosis who filled a prescription for or were administered or dispensed an MOUD, overall and by type of MOUD (methadone, buprenorphine, naltrexone). **2b**. OUD provider availability (supporting measure) Number of providers who can prescribe buprenorphine, number of providers who do prescribe

buprenorphine, number of opioid treatment programs that dispense methadone and/or buprenorphine.)

- **OUD Identification/diagnosis** (**1a**. OUD diagnosis (cascade measure) Percentage of individuals who had documented OUD diagnosis (e.g.,on an insurance claim). **1b**. Assessed for SUD using a standardized screening tool (supporting measure) Percentage of individuals who were screened/assessed for SUD using a standardized screening tool.)
- **Retention in Treatment** (**3a**. Continuity of pharmacotherapy for OUD (cascade measure) Percentage of individuals who filled a prescription or were dispensed an MOUD who received the MOUD for at least six months, overall and by type of MOUD (methadone, buprenorphine, naltrexone).**3b**. Initiation of OUD treatment and engagement in OUD treatment (supporting measure) Percentage of individuals who initiate SUD treatment within 14 days of an OUD diagnosis. Percentage of individuals who had two or more additional SUD services within 30 days of the initiation SUD treatment encounter. **3c**. Follow-up after an emergency department visit for substance use (supporting measure) Percentage of emergency department visits for individuals with a principal SUD or overdose diagnosis who had a follow-up visit for SUD within seven days of the visit and within 30 days of the visit)

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 2024, includes:

- Substance Use Disorder Treatment Rate. Measured by DSHS Claims data. The percentage of members with a substance use disorder treatment need who received a substance use disorder treatment in the measurement year. Separate reporting for two age groups: 12 – 17 years and 18 years and older. Reported for Medicaid only.
- Timely Receipt of Substance Use Disorder Treatment for Medicaid Beneficiaries Released from a Correctional Facility. Measured by DSHS claims data. The percentage of members aged 18-64 receiving SUD treatment within a specified time period following release from a correctional facility or local jail, among enrollees with an identify SUD treatment need indicated between the day of release through 90-days post-release. There are four reportable rates for this measure
    - Rate 1a: Receipt of SUD treatment within 7 Days of Release from a Department of Corrections Correctional Facility
    - Rate 1b: Receipt of SUD treatment within 30 Days of Release from a Department of Corrections Correctional Facility
    - Rate 2a: Receipt of SUD treatment within 7 Days of Release from a Local Jail Facility while Under Department of Corrections Custody
    - Rate 2b: Receipt of SUD treatment within 30 Days of Release from a Local Jail Facility while Under Department of Corrections Custody
- Follow Up After ED Visit for Substance Use (FUA). Measured by NCQA HEDIS. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose, for which there

was follow up within 30 days of the ED visit. (NCQA requires an additional reporting rate of follow-up within 7 days of the ED visit. For public reporting of the Washington State Common Measure Set, report only the 30-day rate.)

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