Working together to improve health care quality, outcomes, and affordability in Washington State.

Treatment for Opioid Use Disorder Report and Guidelines 2024

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Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 "…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous health care quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying health care services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State's largest health care purchasers, Medicaid, and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Bree Collaborative members identified diabetes care as a priority improvement area and convened a workgroup to develop evidence-informed standards. The workgroup met from January 2022 to January 2023.

See **Appendix B** for the workgroup charter and a list of members.

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]

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 1. A Coordinated Health Care System (2017)

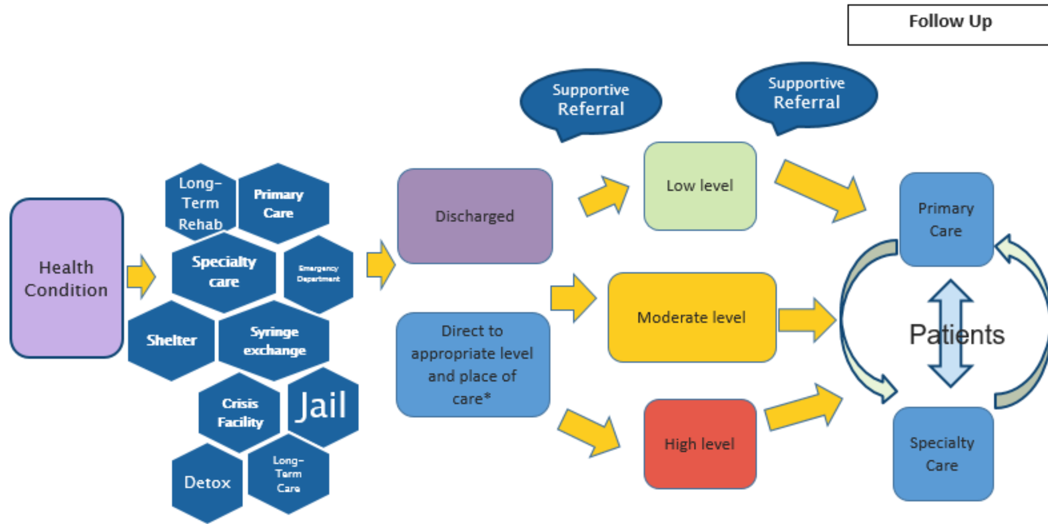
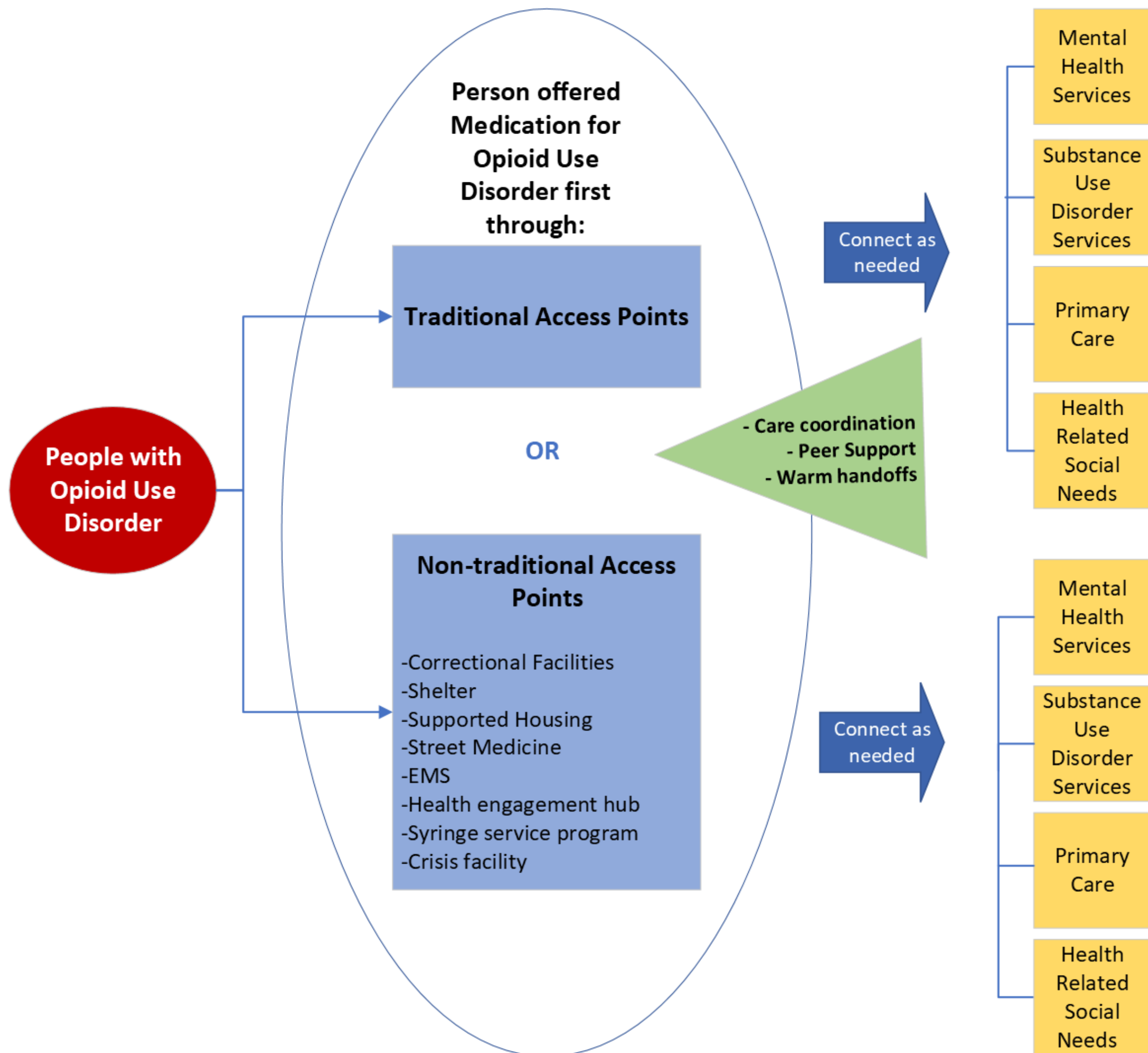


Figure 2. Prioritizing Medication Access and Person-Centered Care for People Who Use Opioids



The workgroup endorses low barrier access to medications for opioid use disorder (MOUD) across a variety of settings where people with opioid use disorder might seek care. Care coordination, peer support and warm handoffs during transitions of care when necessary are vital to quality care for people who use drugs; while other services should be offered and co-located whenever possible, medication access should never be dependent on engagement with other services. Non-traditional access points for MOUD are essential for people who are most underserved.

Focus Areas and Goals

Component	Objectives	Goals
Education	Increase alignment of policies and protocols with evidence-based guidelines Increase evidence-based educational material	Improve the content and reach of education for OUD treatment
Access	Reduce structural and financial barriers to access for MOUD and adjunctive interventions Increase number of care sites providing MOUD	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	Maximize the 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 medication that adequately address their symptoms
Ongoing Care/Recovery Support	Increase warm handoffs, supports for people with OUD including care coordinators and peers	Increase treatment retention

Guidelines

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.

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. See **Appendices** for list of updated guidelines.
- **Universally screen in primary care 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. Providers not in primary care settings should also routinely screen for substance use disorders using validated instruments.** Screening may be done by another care team member, clinic staff, or online/on paper prior to appointments. Screening should be done in a straightforward, nonjudgmental manner while asking about other health behaviors.
    - While current USPSTF recommendations do not endorse screening for adolescents, Washington overdose related deaths have increased especially in youth. Providers caring for pediatric patients should consider routinely screening for and have high clinical suspicion for substance use, and MOUD is recommended for adolescents with opioid use disorder.
    - **Ensure older adults are screened for unhealthy substance use.** Older adults are less likely to be screened for unhealthy substance use than younger individuals, but overdose rates in older adults are increasing.[vii] If screening on paper, ensure print on screening is large enough for older adults to read easily.[viii]
- **If a patient screens positive, or independently 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.** Many people may only be familiar with abstinence-based approaches and unaware that using buprenorphine or methadone may reduce risk of overdose by about 50%.[ix] **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 treatment setting 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 members of their support system (e.g., family, partners, etc.) understand the risk of adverse events, including recurrent substance use and fatal overdose, are increased when treatment does not include the use of buprenorphine or methadone.
    - Assess and address patient comorbidities including poly-substance use and any untreated mental health or physical health conditions. Include screening and treatment

for common co-occurring concerns including hepatitis C virus (HCV) and sexually-transmitted diseases (STDs) including syphilis.

- **Offer medications for opioid use disorder 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 initiation. (ASAM, PCSS).
    - See more resources on starting a program in primary care here.
- **Prescribe dosages of MOUD and adjunct therapies that adequately address symptoms.** With the use of more potent substances like fentanyl, required doses needed to manage symptoms of withdrawal and cravings can be higher. Adjunct medications may be helpful to address symptoms of opioid withdrawal (e.g., autonomic arousal, anxiety/restlessness, insomnia, musculoskeletal pain, and gastrointestinal distress) during the MOUD stabilization period.
- **Prescribe MOUD for adequate duration.** There is no limit on how long an individual may use any MOUD, and shorter prescription lengths (e.g., 1-2 weeks) may introduce unnecessary barriers to MOUD access.
- **Assess possible medication interactions, especially with benzodiazepines**. Treatment of opioid use disorder with medications should not be discouraged or delayed, but the combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks.[x] Follow ASAM National Practice Guidelines for Treatment for Opioid Use Disorder and guidelines of the American Association for the Treatment of Opioid Dependence
- **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 **Appendices** for information on care coordination compared to case management.
    - Consider referring to an Opioid Treatment Program for specialized care.
- **Regularly follow up with patients with opioid use disorder.** Document instances of recurrent substance use, reemergence of cravings or withdrawal symptoms and ongoing behavioral or physical health needs. Patients with opioid use disorder need care coordination of care as they are at increased risk of loss to follow up.
- **Use telehealth in care for patients with OUD.** MOUD can be safely provided over audio-visual and audio-only telehealth.
- **Understand the local epidemic in your community and be aware of populations most impacted by opioid use disorder and overdose.** With the rapid evolution of the opioid epidemic, providers should stay engaged with local community organizations that support people with substance use

and stay up to date on local demographic trends and populations most impacted by opioid use, overdoses and deaths in their community and at the state level.

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, correctional facility-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 medications for opioid use disorder.

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.*[xi] 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.
    - **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 Low barrier Treatment 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.[xii]

- **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 or for ongoing substance 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 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 recurrent substance use and overdose death with withdrawal management and counseling alone, compared to treatment with buprenorphine-naloxone and methadone.
    - **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 familiar with and provide alternative resources** for access to medications for opioid use disorder in case patient cannot reach usual providers such as the King County Tele-buprenorphine Hotline – call 206-289-00287 and the Washington MOUD Locator line: https://search.warecoveryhelpline.org/
- **Offer MOUD** in all care settings including but not limited to 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)
    - **Provide MOUD options, including sublingual and long-acting injectable versions of buprenorphine and long-acting injectable naltrexone**
    - **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 during medication initiation (e.g., autonomic arousal, anxiety/restlessness, insomnia, Musculo-skeletal pain, and gastrointestinal distress)
    - **Prescribe MOUD for adequate duration.** There is no limit on how long an individual may use any MOUD, and shorter prescription lengths (e.g., 1-2 weeks) may introduce unnecessary barriers to MOUD access.

- **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, medication management and monitoring, providing education on OUD, and offering emotional support. Pharmacists may contribute by ensuring adherence to treatment protocols and advising on drug interactions and side effects. Collaborative efforts help 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.
- **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 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.
    - **For patients with cooccurring stimulant use disorders, follow ASAM Clinical Practice Guideline for Stimulant Use Disorder.**
    - **Some common cooccurring health related concerns include sexually transmitted diseases (STDs), hepatitis C virus (HCV), mental health concerns like depression and self-harm or suicidal ideation.** Screen for these conditions concurrently and offer or refer for treatment.
    - **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 who use opioids are at higher risk of loss 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 substance use disorder 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 Interagency 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.
  - Follow ASAM Clinical Guidelines for pain management patients with opioid use disorder
- **Program 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 treatment for adolescents and teens is available here.
  - Adolescents can receive quality MOUD 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 or postpartum 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 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.[xiii]
  - Opioid agonist or partial agonist pharmacotherapy is the recommended therapy and preferable to medically supervised withdrawal. Initiate treatment with methadone or buprenorphine as early as possible. Hospitalization during initiation may be advisable due to potential adverse events and/or need for close observation. Do not unnecessarily switch formularies of MOUD.[xiv]
  - Perinatal patients can be safely managed primarily in the perinatal or primary care setting. Facilities should also 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 when necessary.
    - Use a warm handoff to refer patients who are pregnant and have opioid use disorder to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence when necessary
    - 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.
- **Treat older adults in accordance with evidence-based best practices.** Follow these tips from SAMHSA on Treating Substance Use in Older Adults
    - While more high-quality trials are needed for opioid agonist and partial agonist therapy in older adults, available data suggest that opioid agonist and partial agonist therapy is effective in older adults and age should not be a barrier to treatment.[xv]
    - Several physiological changes with age, such as decreasing renal clearance, changes in metabolism and total body water, and changes in neurotransmitter levels increase the likelihood of adverse effects associated with opioids in older adults.
    - Some older adults may not meet DSM-5 diagnostic criteria for opioid use disorder due to age-related changes in tolerance to substances, cognitive functioning and social isolation.[xvi] Consider aspects of aging that may impact diagnosis when assessing for opioid use disorder.
    - Older adults are more likely to experience chronic pain, and experience exposure to chronic opioids which is a risk factor for opioid use disorder.[xvii]

Substance Use Disorder Programs

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

See "Health Care Facilities" above and additionally:

- **Do not encourage patients to stop medication treatment**. **Encourage and support use of MOUD and do not bar access to all appropriate services offered by the agency based on any substance and/or medication use.** Be aware that the effectiveness of medications for opioid use disorder increases with duration of treatment and may be lifelong. 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
- Build capacity to provide integrated other behavioral health and primary care.
- Write a prescription for naloxone, dispense and physically deliver to patients.
- **Share information with patient permission**. 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 nursing 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.
  - Reimburse for peer support specialists
  - 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.
  - Evaluate programs for equitable access to MOUD for patients with diagnosed with OUD focusing on populations most impacted by overdose.
- **Do not contract with facilities or providers that refuse to offer buprenorphine and methadone treatment for patients with opioid use disorder or continue these medications once admitted. Do not contract with facilities that attempt to switch patient medications (e.g., methadone to buprenorphine) once admitted without consideration to the patient's individualized treatment goals**. Ensure continued access to buprenorphine and methadone is required in any contracting negotiations.
  - **Encourage and incentivize long term care facilities to screen for and manage opioid use disorder.** Members with opioid use disorder should not be denied admission on the grounds of taking MOUD.
- **Support use of MOUD as part of the treatment plan and remove barriers to access.**
  - Remove all prior-authorization requirements for methadone, buprenorphine, and naloxone for all patients, including those pregnant/postpartum or under the age of 18, including dose-based (e.g., 32mg of buprenorphine) and quantity-based prior authorizations as higher doses have been shown to be more effective.
  - Remove co-pays for screening and assessment for substance use disorder
  - Incentivize providers or facilities in areas without access to MOUD to implement and maintain office-based opioid treatment services that include buprenorphine
  - Cover buprenorphine initiation 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 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 rates of recurrent opioid use.
- **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.
  - Ensure benefit structure follows above Health Plan guidelines.
- **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.
  - **Offer and honor paid sick leave** to allow employees to attend to their medical and mental health care needs.

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 and healthcare facilities seeking Risk Evaluation and Mitigation Strategy (REMS) certification** for long-acting injectable buprenorphine.

Department of Health

- **Offer training on low barrier MOUD treatment.** 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.[xviii] Consider targeting messaging to those most likely to be impacted by substance use and those most likely to not know.

Division of Behavioral Health and Recovery

- **Provide treatment program information.**
  - Include in the annual Substance Use Treatment guide whether programs offer methadone, buprenorphine, buprenorphine-naloxone and/or naltrexone. Include routes offered (e.g., sublingual versus long-acting injectables)
  - 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.[xix] 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.
- **Consider offering and providing buprenorphine long-acting injectables** before known release date to protect people who use opioids from overdose after discharge.
- **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 release to community treatment.
- **People being released 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

    substance use disorders including stimulant use and opioid use 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 SUD.
  - 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, substance use disorder programs, 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.
  - **Substance use disorder counselor training programs and statutes that recommend only abstinence-based treatment should be updated to prioritize low barrier medication access.** Trainees should be taught about evidence-based treatments for opioid use disorder that offer clients the highest rates of success and reduce overdose risk. Tobacco cessation should be part of substance use disorder professional 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 medical residents complete training on prevention, recognition and evidence-based treatment for opioid use disorder (e.g., including but not limited to 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.

Progression Towards Optimal Care

<table>
<tr><td colspan="4">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.</td></tr>
<tr><th></th><th>Current State</th><th>Intermediate Steps</th><th>Optimal Care</th></tr>
<tr><td>Primary Care Setting
Medication for opioid use disorder treatment must be the standard of practice for .</td><td>• Patients with 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 use.
• Providers are uncomfortable prescribing buprenorphine and do not refer people to providers who are.</td><td>• 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.
• Consider following some example of models</td><td>• 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 opioid use and polysubstance 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 syringe service programs, mobile vans or street medicine teams to expand access to care based on community needs.</td></tr>
</table>

		here.	• 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-TR criteria. ○ Offer buprenorphine as an alternative to full-agonist opioid pain medications ○ Referring to an addiction specialist as appropriate, 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-TR criteria and receive a supported referral to an opioid treatment program. If referrals are necessary, referrals are coordinated to support patients during transitions. Ideally, patients could have MOUD managed by pain clinic providers. • With the 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	• Patients with opioid use disorder are not offered evidence-based treatment for opioid use disorder.	• Providers are trained: ○ To diagnose opioid use disorder ○ To review and offer or refer all appropriate opioid use disorder treatment options with patients.	• Patients receive treatment for opioid use disorder and other co-occurring behavioral health diagnosis from available psychiatric or other licensed behavioral health providers.

Use Treatment Programs)	• Substance use treatment programs may rely on abstinence-based care	○ On local Opioid Treatment Programs and how to provide supported referrals to 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.	Any outside referrals include shared bi- directional communication and 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. • 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.
		• Buprenorphine and methadone are offered to patients for treatment of OUD.
		• 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, perinatal providers, primary care providers with obstetrics privileges, group buprenorphine care, case management, patient navigation and maternal support services
			• Pregnant or postpartum individuals 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. Join the ScalaNW network in Washington to support implementation of emergency department MOUD. • 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 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 or establish care at an OTP. • Patients are given the option to start MOUD in the ED. • Refer to ScalaNW protocols for initiation or most updated guidance for EDs	• 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. • 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 • 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 recurrent opioid use. • 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
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*	• 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 due to stigma or for fear of recurring substance use	• Patients with OUD are offered and provided MOUD during their inpatient stay • 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 • 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. • 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:	• Patient with OUD are identified and assessed for severity based on DSM-5-TR criteria • 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 recurrent opioid use. • 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 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

MOUD in inpatient settings is successful and can improve outcomes such as ER utilization, hospital readmission and retention in MOUD treatment.)	• Hospital providers are not well trained on how to manage pain in people maintained on MOUD. • Patient-directed discharges (patients discharging "AMA") occur due to untreated OUD symptoms during hospitalization •	• 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 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 specialists and other staff to support patients with SUDs • Providers are trained in how to manage pain in people maintained on MOUD. Pain and withdrawal symptoms are managed regardless of patient's decision to start MOUD.	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 • Patients who are not yet in withdrawal or decline MOUD are offered a prescription at discharge. • Peer support specialists are available on site to support patients with SUDs • Patients maintained on MOUD have their pain adequately managed.
Syringe Service Programs	• The opportunity to offer MOUD to syringe exchange program clients may be missed. • Syringe exchange programs teach clients not to use alone, the dangers of mixing	• Clients who wish to reduce opioid use are referred to programs which offer treatment including options for medications (buprenorphine, naltrexone, methadone), or MOUD is offered on-site. • Clients have access to new drug use supplies, including injection and smoking supplies	• MOUD treatment is 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

	drugs, to carry naloxone, the "good Samaritan" drug law, and how to manage suspected overdoses including to call 9-1-1.	• Naloxone is freely available, both in intramuscular and nasal versions	experience. • Additional services are available on-site: wound care, HCV screening, referrals to community resources, peer navigation and support. See Health Engagement Programs here.
Correctional Facilities	• 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.* • MOUD (methadone, buprenorphine, and 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 on entry. • 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
Long-term Care Facilities	• Patients with opioid use disorder are denied acceptance into skilled nursing facilities[xx] • 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.	• 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.

		• 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. • Prescribe and manage buprenorphine like all other controlled medications.	• 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 • LTCs work with discharging hospitals and OTPs to facilitate intakes and ongoing care at OTPs, including utilizing the 3-day rule and chain of custody for methadone dispensing to smooth the transition to OTP care for methadone treatment.

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.*
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*

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.[xxi] 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. [xxii]

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 [xxiii][xxiv] 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.[xxv] 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.[xxvi] 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,[xxvii] but has been shown to complement medication treatment, address social and psychosocial factors behind opioid use, and may lead to greater treatment retention.[xxviii] 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**.[xxix] 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), patch or injectable. The patch is only approved for the treatment of chronic pain, not as a medication for opioid use disorder.
  - 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 counseling alone.[xxxxxxi]
  - 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.[xxxii]
  - 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 initiating buprenorphine 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**).[xxxiii] 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 strategies.
  - **Extended-release injectable buprenorphine compared with sublingual buprenorphine has shown 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 start or stabilize on sublingual buprenorphine including those with a history of extensive HPSO exposure, unsafe living environments and/or multiple opioid overdoses.[xxxiv]
  - Buprenorhpine use, while not indicated for stimulant misuse or disorder, has been associated with eventual reduction in methamphetamine use among some people.[xxxv]

- **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) [xxxvi]
  - Longitudinal studies have also found methadone maintenance associated with reduced risk of overdose related deaths, reduced risk of Haemophilus influenzae type b (Hib) and hepatitis C infection, lower rates of cellulitis, and lower rates of HIV risk behavior.[xxxvii]
  - Methadone is a full opioid agonist, and at effective doses, manages opioid cravings and withdrawal; because it is long-acting, many may only need to take it once a day.
  - 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 and non-OTP settings to dispense up to 3 days of methadone doses. Settings like clinics, emergency rooms, jails, skilled nursing facilities and more can dispense methadone for OUD for up to 3 days to bridge someone to starting at an OTP.** 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, conduct random drug testing through urinalysis or saliva tests, and provide vocational and educational services.

- **Naltrexone**
  - Opioid antagonist that fully blocks the effects of opioids (full opioid antagonist). 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[xxxviii][xxxix], 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, naltrexone reported being more challenging to initiate and maintain then sublingual buprenorphine.[xl]

  - Patients must be abstinent from opioids for at least 7-10 days prior to starting naltrexone. Incarcerated or hospitalized patients who have not received any opioids while inpatient may be good candidates.
  - **Naltrexone carries major risk of recurrent substance use 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.[xli]

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 can be administered by friends and family.
  - **Use the lowest dose necessary** to provide adequate respiratory drive and hemodynamic stability and minimize withdrawal symptoms.
  - Is contained in the sublingual formulation buprenorphine-naloxone as a deterrent to misuse by injection but is not absorbed in clinically meaningful amounts when buprenorphine-naloxone is 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.[xlii] In Washington state, deaths due to fentanyl have risen over 750% between 2018 – 2022, and in 20222 accounted for almost 90% of all opioid-involved deaths.[xliii] 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. Prescribers in Washington report various strategies to begin a patient on either sublingual buprenorphine, long-acting injectable or extended-release buprenorphine, or methadone,[xliv] although recent studies have suggested higher doses of buprenorphine may be necessary.[xlv] Long-acting injectables can be particularly helpful for their potential to stabilize people who use fentanyl quickly – however, stricter regulatory barriers and higher cost restrict access.[xlvi] 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 should be 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 or Treatment medications for fentanyl use disorder brief from the Addiction Drugs and Alcohol Institute

Slow-Release Oral Morphine & Safe Supply

While buprenorphine and methadone are efficacious treatment options for patients with opioid use disorder, 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.[xlvii] 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 heroin use after 6 months.[xlviii] A cost-effectiveness study showed similar outcomes for diacetylmorphine and hydromorphone, but reduced costs and quality-adjusted life-years (QALYs) compared to methadone over a lifetime.[xlix] Off-label hydromorphone, both injectable and tablet, is currently being offered in several Canadian sites.[l] 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*."[li]

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.[lii][liii] SROM has demonstrated some improvement over methadone in reducing cravings,[liv] mental health symptoms,[lv] and treatment satisfaction.[lvi] 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.*"[lvii] SROM it is not currently approved by the FDA in the United States.

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

Healthcare providers and other clinicians have a critical role in preventing, identifying and treating OUD among their patients. Standards 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 the warm handoff approach and carefully coordinate care carefully during transitions as these are points at which patients are at risk for loss 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 hiring and sustaining dedicated support staff such as peer support workers, social workers and nurse care managers, to provide supportive services to patients who use substances.**

- *Primary care sites* should ensure universal screening for OUD, offer office-based medications for opioid use disorder (OBOT) and provide 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 patients insured through Medicaid. 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 often not covered by insurance or come with significant copays, limiting this treatment option for patients that might be most impacted. Pharmacies are required to be REMS certified to dispense extended-release buprenorphine; as of this report only 19 out of over 1,000 pharmacies in Washington are certified.

Other Initiatives

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)"*[lviii] 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.

Washington Health Care Authority is testing the functionality and operability of a model for all-in-one location where people who use drugs can access a range of medical, harm reduction and social services called **Health Engagement Hubs.** These Hubs will incorporate a model of low-barrier care and access to MOUD with wrap around supports and are meant to meet the needs of people who use drugs. Two sites are currently testing this model; one site is a syringe service program, and one site is a federally qualified health center with a partnership with an OTP to provide low barrier access to methadone and other services. In 2024, additional funding was appropriated to expand the Health Engagement Hub program to include 3 additional sites in the following fiscal year. See more here.

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)

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.

Emergency Medical Services and Buprenorphine

Emergency medical services offer another access point for people who use drugs to initiate buprenorphine. EMS personnel often see individuals after they experience an overdose and a bystander calls 911. Traditionally, EMS personnel have offered naloxone, medications to manage symptoms of withdrawal and offer to transport to the emergency department. Now, many of the public carry naloxone and know how to reverse an overdose, so EMS personnel may be arriving on scene after the a person has already been given naloxone. Being able to administer buprenorphine on site and offer follow up to

connect to ongoing medication and care is a critical access point for people who use opioids who may not have other contact with the healthcare system. Studies have shown people who take buprenorphine from EMS after an overdose can experience a decrease in their opioid withdrawal symptoms, improvement in outpatient follow up,[lix] and retain in treatment.[lx] Several cities in the state are beginning to offer MOUD access through specially trained EMS personnel and support patients with connection to care after they experience an overdose, including Seattle and Spokane.

Continual funding to sustain and iteratively improve upon these innovative access models are critical to supporting all people who use opioids in Washington State.

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 substance use 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](http://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.

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. Below are the metrics, the measures that make up that particular metrics, the metric type, audiences that are applicable to that metrics

Metric	Measure	Measure type	Audiences	Benchmark	Use
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).	Process	HCA,		Value-based Purchasing, Quality Improvement
	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	Process	HCA,		Value-based Purchasing, Quality Improvement

	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 OUD 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).	Process	HCA		Value-based Purchasing, Quality Improvement
	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.)

Appendices

Appendix A. Care Coordination Compared to Case Management

Care coordination is a set of activities by which a system of care assures that every person served by the system has a single approved care or service plan that is coordinated, not duplicative and within prescribed parameters designed to assure cost effective and good outcomes. The goal is both managing and stretching limited resources, as well as assuring the best quality care possible to achieve the client's service goals.

- Cost effective and patient-centric in least restrictive setting.
- Can be specialized by setting/need (medical, forensic, behavioral health, housing)
- Medical home
- Transitional and intermittent
- Collaborative
- Engagement
- Referral
- Financial/Utilization management
- Resource utilization
- Support client's ease of access to resource information
- Enhance communication among providers
- Single point of entry to multiple services

Case management is a clinical service focused on those individuals who are determined to need assistance with coordination of services; daily living skills; finding and maintaining housing, jobs and friends; and in some cases, a single long-term relationship with a professional caregiver or helper. The goal of case management is the long-term recovery of the individual and increasing the ability of the individual to cope and function independently, including managing his/her own symptoms or addictions, and finding and maintaining his/her services and community living requirements.

- Work one on one with people with chronic illness(es) or disabilities.
- Liaison between insurance companies and healthcare providers
- Assessment of need
- Create and implement plans of care
- Evaluation
- Research treatment options
- Patient advocate

Appendix B Behavioral Health Funding Structure

Many people with opioid use disorder also have co-morbid mental health or poly-substance use issues that may impair their ability to stop opioid use and would benefit from integrated behavioral and physical health care. Commercial insurance often does not reimburse for services to address social determinants of health, manage populations of patients, provide care management supports, or provide outreach to clients in crises. However, Medicaid offers a behavioral health benefit to support severe and chronically mentally ill individuals if in social and/or financial crisis. Below are the characteristics of both commercial insurance/Medicare and Medicaid:

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

Additionally, severe and chronically mentally ill individuals with opioid use disorder being discharged from a hospital often do not have access to care coordination, case management, and outreach services after discharge. Hospitals often attempt to refer individuals to Community Mental Health Centers but may not be able to do so because of:

- Lack of access to paneled and licensed provider
- Paneled and licensed provider only able to provide office-based individual treatment
- Crisis support, case management, care coordination is not available as it is not billable

As a result, parents and social supports are coached to move the patient off of commercial plan and onto Medicaid resulting in a shift of responsibility and cost away from the existing providers and insurance to the safety net. This can lead to difficulties with safety net services including high case load, high turnover and lack of workforce capacity, limited funds, and high regulation. Patient quality, access, outcomes are in turn impacted.

Appendix C. Opioid Use Disorder Treatment Guidelines

Source	Guidelines or Systematic Reviews
USPSTF	(2020) Screening for Unhealthy Drug Use in Primary Care in Adolescents and Adults, Including Pregnant Persons: Updated Systematic Review for the U.S. Preventative Services Task Force (2020) Interventions for Unhealthy Drug Use – Supplemental Report: A Systematic Review for the U.S. Preventative Task Force
AHRQ: Research Findings and Reports (including USPSTF reviews)	(2024) The Lived Experiences of Pregnant and Parenting Women in Recovery Toward Medication Treatment for Opioid Use Disorder (2024) Patient perceptions of and experiences with stigma using telehealth for opioid use disorder treatment: a qualitative analysis (2022) Management of opioid use disorder, opioid withdrawal and opioid overdose prevention in hospitalized adults: a systematic review of existing guidelines
Cochrane Review	(2020) Maintenance agonist treatments for opiate-dependent pregnant women (2022) Opioid agonist treatment for people who are dependent on pharmaceutical opioids (2017) Buprenorphine for managing opioid withdrawal (2017) Opioid antagonists with minimal sedation for opioid withdrawal
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	(2017, reaffirmed 2021) Committee on Obstetric Practice and American Society of Addiction Medicine Opioid Use and Opioid Use Disorder in Pregnancy (2020) National Practice Guideline for the Treatment of Opioid Use Disorder (2021) Department of Defense, Department of Veterans Affairs, Veterans Health Administration Management of Substance Use Disorder (2020) World Health Organization International Standards for the Treatment of Drug Use Disorders (2018) American Pain Society, College on Programs of Drug Dependence Treatment Programs for Opioid Use Disorders: A Review of Guidelines (2012) National Institute on Drug Abuse Medication Treatment for Opioid Use Disorder
Center for Disease Control and Prevention	Webpage – Treatment for Opioid Use Disorder
Substance Abuse and Mental Health Services Administration	(2023) Practice-Based Guidelines: Buprenorphine in the Age of Fentanyl (2018) Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants (2024) Advisory: Evidence-based, Whole Person Care of Pregnant People Who Have Opioid Use Disorder
PubMed	(2020) Optimal Dose of Buprenorphine in Opioid Use Disorder Treatment: A Review of Pharmacodynamic and Efficacy Data (2020) Systematic Review of Opioid Use Disorder Treatment Training for Medical Students and Residents (2022) Systematic review and meta-analysis of retention in treatment using medications for opioid use disorder by medication, race/ethnicity, and gender in the United States

	(2022) Inclusion of Patient-Reported Outcomes to Inform Treatment Effectiveness Measures in Opioid Use Disorder: A Systematic Review (2022) Digital Interventions for Opioid Use Disorder Treatment: A Systematic Review of Randomized Controlled Trials (2022) Buprenorphine initiation strategies for opioid use disorder and pain management: a systematic review
Institute for Clinical and Economic Review (ICER)	(2021) The Effectiveness and Value of Digital Health Technologies as an Adjunct to Medication-Assisted Therapy for Opioid Use Disorder
Canadian Family Medicine	(2019) Managing opioid use disorder in primary care

Appendix C. Bree Collaborative Members

Member	Title	Organization
June Altaras, MN, NEA-BC, RN	Executive Vice President, Chief Quality, Safety and Nursing Officer	MultiCare Health System
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Colin Fields, MD, AAHIVS	Medical Director, Government Relations & Public Policy	Kaiser Permanente
Dary Jaffe, MN, ARNP, NE-BC, FACHE	Senior Vice President Safety and Quality	Washington State Hospital Association
Sharon Eloranta, MD	Medical Director, Performance Measurement and Care Transformation	Washington Health Alliance
Norifumi Kamo, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
Kristina Petsas, MD, MBS, MLS	Market Chief Medical Officer – WA, OR, MT, AK, and HI	UnitedHealthcare, Employer & Individual
Greg Marchand	Director, Benefits, Policy and Strategy	The Boeing Company
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Nicole Saint Clair, MD	Executive Medical Director	Regence BlueShield
Mary Kay O'Neill, MD, MBA	Partner	Mercer
Kevin Pieper, MD	Chief Medical Officer	Kadlac Medical Center
Susanne Quistgaard, MD	Medical Director, Provider Strategies	Premera Blue Cross
Colleen Daly, PhD	Director, Occupational Health, Safety and Research	Microsoft
Emily Transue, MD (Chair)	Chief Clinical Officer	Comagine Health
Judy Zerzan-Thul, MD	Medical Director	Washington State Health Care Authority
Jake Berman, MD, MPH	Medical Director for Population Health Integration	UW Medicine and UWM Primary Care and Population Health

Appendix D. Treatment for OUD Revision Workgroup Charter and Roster

Problem Statement

Opioid use disorder continues to be prevalent in Washington State, with a 10% increase from 2018 to 2019 and 35% for both 2020 and 2021 over the prior year. The Bree Collaborative developed guidelines in 2017, outlining full or partial opioid agonists for treatment (as opposed to treatment without medication). As the number of opioid overdose death rate has continued to climb, the Bree Collaborative members decided to revisit the previous guidelines and report. In the time since the last report, the X waiver requirement has been removed, and the increase in fentanyl in Washington's drug supply has complicated opioid overdose response. A significant number of methamphetamine overdoses involve opioids, and most people who use drugs use multiple substances. According to the Washington DOH, the stimulant-related overdose death rate has increased 388%. As a result, the response to opioid use and overdose should address strategies that are associated with many drugs not just opioids. Fentanyl and analogues carry a higher overdose risk than other opioids; in 2022, a survey by the UW's Addiction, Drug & Alcohol Institute (ADAI) found that 18% of respondents had used fentanyl within the past 3 months. There is a need for guidance for providers to improve confidence and competence and for payors on successful and safe initiation, stabilization, and titration of individuals on medication for opioid use disorder in the age of fentanyl and with a focus on populations that are or have been underserved.

Aim

To increase access to evidence-informed treatment for opioid use disorder and prevent opioid overdose in Washington state.

Purpose

To propose evidence-informed recommendations to the full Bree Collaborative around access to evidence-based treatment for opioid use disorder and prevent opioid overdose in Washington state, including:

- Defining topic area and scope
- Review current Treatment for OUD Guidelines and report evaluation to inform updates of guidance
- Reflect current regulatory and policy environment
- Identify evidence-informed strategies to screen for and address fentanyl use, co-occurring polysubstance use and/or other behavioral health diagnoses
- Promoting use of trauma-informed care and harm reduction principles across care settings
- Review best practices for low barrier, increased access to MOUD (e.g., teleprescribing, EMS initiation)
- Review evidence for safe consumption facilities and safe opioid agonist supply
- Funding mechanisms for and barriers to high quality treatment for OUD
- Outline barriers and identify possible solutions to evidence-informed, low barrier OUD treatment (e.g., funding, regulatory environment)
- Recommending a cadence for evaluation and update of the report

Duties & Functions

The workgroup will:

- Review current Treatment for OUD Report for necessary updates
- Research evidence-informed and expert-opinion informed guidelines and best practices (emerging and established).
- Identify current barriers and future opportunities for implementing interventions.
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies including metrics or a process for measurement.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.
- Identifying measures and metrics that are meaningful to understand the effectiveness of guidelines
- Identifying implementation strategies for guidelines

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative. The Bree Collaborative director and program coordinator will staff and provide management and support services for the workgroup.
Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. Bree Collaborative staff will conduct meetings, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the Bree Collaborative director.

Workgroup Members

Name	Title	Organization
Charissa Fotinos, MD (Chair)	Deputy Chief Medical Officer	Washington HealthCare Authority

Nikki Jones, LCISW, SUDP, CMHS, DDMHS, GMGS	Behavioral Health Addictions Administrator	United Health Community
Michael Sayre, MD	Medical Director	Medic One
Brad Finegood, MA, LMHC	Strategic Advisor Opioids and Health	King County
Everett Maroon, MPH	Executive Director	Blue Mountain Heart 2 Heart
Tina Seery, RN, MHA, CPHQ, CPPS, CLSSBB	Senior Director, Quality and Rural Programs	Washington State Hospital Association
Tawnya Christiansen, MD	Behavioral Health Medical Director	Community Health Plan of Washington
Sue Petersohn, EN, MBA, CARN	Program Manager, Multicare SUD Task Force	MultiCare
Mark Murphy, MD	Medical Director Addiction Services	MultiCare
Libby Hein, LMHC	Director of Behavioral Health	Molina Healthcare
Ryan Caldeiro, MD	Chief Chemical Dependency Services and Consultative Psychiatry	Kaiser Permanente
Herbie Duber, MD	Regional Medical Officer – Northwest WA	Department of Health
Bob Lutz, MD, MPH		CHAS Health
Amanda McPeak, PharmD	Pharmacist and Director of Long-term Care	Kelley-Ross/Harborview
Jason Fodeman, MD	Associate Medical Director of Innovation and Outreach	L&I
Maureen Oscadal, RN, CARN	Registered Nurse	Harborview Medical Center/Addiction Drugs and Alcohol Institute
John Olson, MD, MHA	Addiction Medicine Physician	Sound Health
Daniel Floyd	Care Coordination and Recovery Section Manager	King County Behavioral Health and Recovery Division
Kelly Youngberg, MHA	Assistant Director for Health Care Implementation and Strategy	Addictions, Drug and Alcohol Institute
Cris DuVall, PharmD, SUDP, WSPA	Clinical Pharmacist Counselor	Compass Health, Island Drug
Tom Hutch, MD, FASAM	Medical Director	We Care Daily Clinic
Liz Wolkin, MSN, RN, NPD-BC CEN	Emergency Department Support Program Administrator	Washington HealthCare Authority
David Sapienza, MD	Lead Physician	Pathways, Public Health Seattle & King County – Community Health Services Division

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