
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 E** 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-November 2024.

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

## Background

Opioid-related deaths continue to be alarmingly high despite the availability of effective medication treatment. 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. [i] From 1999 to 2021, opioid-related deaths increased six times and in 2022, over 75% of total overdose deaths involved an opioid. [ii] 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. People of color, especially Black and American Indian/Alaska Native peoples, experience a disproportionately higher rate of opioid overdose deaths than non-Hispanic White individuals. [iii] [iv]

Opioid use disorder is a chronic condition and must be managed as such. Medications for opioid use disorder (MOUD), including buprenorphine, methadone, and naltrexone, are the most appropriate, evidence-based treatment in addition to harm reduction. [v] MOUD reduces 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. Research consistently shows MOUD lowers rates of death from overdose and rates of illicit drug use. [vi]

This report focuses on the treatment of OUD with first-line medications (partial opioid agonists and full opioid agonists). MOUD is an aspect of whole-person care for people who use drugs. MOUD is the most effective treatment for OUD for reducing the risk of overdose, however some people may not be ready to initiate MOUD when they interact with the healthcare system or may decide not to have MOUD as part of their treatment goals. The workgroup promotes an approach to care that is trauma-informed, person-centered, nonjudgmental, and reduces harm as a first priority to help meet the person's physical, behavioral and social needs. The workgroup recognizes that the healthcare system has systematically disenfranchised diverse communities in Washington state, especially people of color, LGBTQIA+ communities, people living with disabilities, neurodiverse, people with low income, people experiencing homelessness, immigrant communities, and others. All individuals should receive care tailored to meet their individualized goals. [vii]

Highly potent synthetic opioids (HPSO), most commonly fentanyl, are now the majority of the drug supply. 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. [viii] Fentanyl and its analogues are more potent than heroin or prescription opioids and can rapidly induce tolerance and dependence. Fentanyl byproducts are stored in fat cells, slowing elimination from the body and prolonging and complicating withdrawal. Those who use fentanyl, or opioids contaminated with fentanyl, require higher doses of buprenorphine or methadone to control their symptoms and reduce cravings.

However, most individuals with identified opioid use disorder do not receive appropriate care or treatment. In 2022, only 0.5% of adolescents with a substance use disorder sought treatment. [ix] 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 and due to inherent gaps in the American health care system.

This guideline outlines a multisector approach to coordinate low-barrier MOUD around individual patient need across a variety of care settings. Non-traditional access points for MOUD are essential for the most underserved. Recovery support services, including care coordination, peer support, and if a site

is unable to offer MOUD, warm handoffs during transitions of care are vital to quality care for people who use opioids. The following focus areas are used to structure and guide necessary changes.

| Focus Area | Objectives |
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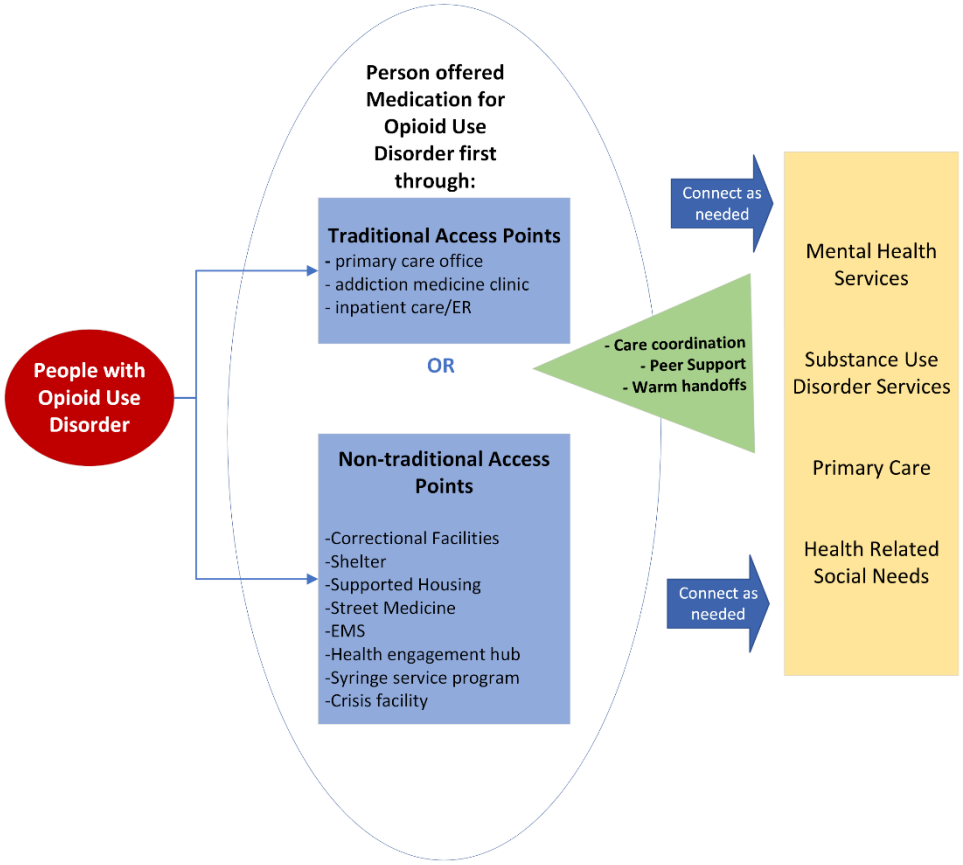
| **Education** | Close gaps in understanding about feasibility of offering and receiving MOUD.<br>Increase alignment of policies and protocols with low-barrier MOUD. |
| **Access** | Reduce structural and financial barriers to MOUD and adjunctive interventions.<br>Increase number of care sites providing MOUD. |
| **Screening and Diagnosis** | Increase sites that provide screening and diagnosis.<br>Increase identification and diagnosis of OUD. |
| **Treatment** | Increase sites providing onsite MOUD treatment.<br>Increase reimbursement for MOUD.<br>Reduce barriers for patients to receive personal doses.<br>Integration with harm reduction and other physical, behavioral, and social care and needs. |
| **Recovery Support & Coordination** | Increase treatment retention for people with OUD including care coordinators and peers. |

Figure A. below outlines the ideal, low-barrier state to facilitate MOUD for people who use opioids.

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



## Guidelines

### Washington State Health Care Authority

- **Conduct and share evaluations of 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.
- **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 specific populations (e.g., perinatal people, adolescents)

### Washington State Department of Health

- **Evaluate retention in care** stratified by social drivers of care and other variables to identify disparities using available data sets (e.g., PMP)
- **Facilitate offering low barrier MOUD treatment access,** including supporting a statewide telehealth buprenorphine line.
- **Mount a public awareness campaign that medications for substance use disorders can be prescribed by your primary care provider.** Many people do not know that their primary care provider can prescribe buprenorphine and other medications for substance use. [x] Consider targeting messaging to those likely to be impacted by substance use and to not know about evidence-based treatment options.

### Washington State Division of Behavioral Health and Recovery

- **Maintain a singular repository** of substance use disorder treatment programs that offer methadone and buprenorphine, including routes offered (e.g., sublingual versus long-acting injectables) that is updated continuously.

## Health Plans

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| **Education** | |
| **Member Education** | • **Educate members** on services provided to them and evidence-based treatment options for opioid use disorder using destigmatizing language. |
| **Access** | |
| **General** | • **Make low-barrier access to MOUD as a strategic priority.** |
| **Payment Models** | • **Actively facilitate access to MOUD across all available care settings within network**. Payment should cover reasonable and necessary costs, including the costs of nursing or comparable care and case managers who can oversee a group of patents.<br>• **Consider alternative payment models** for supportive, wrap-around care for patients with opioid use disorder.<br>• **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. (resource: billing and coding guidance)<br>• **Remove prior-authorization requirements** for methadone, buprenorphine, and naloxone for all patients, including daily dose-based (e.g., 32mg of buprenorphine) and quantity-based prior authorizations. |
| **Cost of Care** | • **Minimize the total cost of care** to allow for appropriately timed (e.g., more frequent) and personalized dosing of MOUD. |
| **Network Adequacy** | • **Reimburse for certified peer support specialists,** whether under alternative payment models or, through direct billing (after July 2025).<br>  ○ Plan to meet network adequacy standards once determined by Washington Office of the Insurance Commissioner.<br>• **In areas where network adequacy standards are sufficient, investigate and provide education or incentives** for providers and facilities that refuse to offer or continue buprenorphine or methadone treatment for OUD.<br>  ○ If still refusing, consider not contracting with them.<br>• **In areas where network adequacy is insufficient, investigate and provide education or incentives** for providers and |

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| | facilities to provide MOUD.<br>• **Incentivize long term care facilities** to screen for and manage opioid use disorder.<br>• **Reimburse for Opioid Treatment Programs** to provide full range of MOUD also through telehealth. For OTPs that wish to provide services additional to those required by Federal statute, allow them to do so through contract amendments.<br>• **Support non-traditional models of care**.<br>  o Reimburse for services provided outside of buildings.<br>  o Explore partnerships with community organizations to reimburse for outreach models (e.g., street medicine, mobile services, harm reduction services).<br>  o Explore inclusion of nontraditional models in network adequacy standards and quality measures where appropriate for substance use disorder |
| **Evaluate** | • **At least annually analyze claims data** to identify gaps in MOUD coverage for members with diagnosed OUD. Stratify by race, ethnicity, language, disability status, housing status and other relevant variables to identify and address disparities. See **Bree Collaborative Evaluation Framework** for more details. |

## Providers

| Education | |
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| Provider Education | • **Become familiar with the latest evidence-based guidelines** to reinforce the understanding that OUD is a chronic condition. See **Appendix B** for a list of updated guidelines.<br>• **Build skills and confidence to discuss substance use** with patients in a nonjudgmental way without using stigmatizing language (e.g., motivational interviewing) and around prescribing MOUD.<br>• **Understand the legal limitations** for accessing different formulations of MOUD in order to provide informed options counseling on the logistics and care environments.<br>• **Understand the local epidemic** in your community and be aware of populations most impacted by opioid use disorder and overdose.<br>• **Participate in continuing education** on the above topics as needed.<br>• **Advocate for clinic process changes that improve timely access to MOUD,** such as same-day medication prescribing, rapid referral to behavioral healthcare, and educating support staff about stigma and the chronic disease model of substance use disorders. |
| **Screening & Diagnosis** | |
| Screening | • **Universally screen people in primary care at least annually for unhealthy substance use using a validated instrument** (see NIDA Screening and Assessment Tools)<br>  ○ Screening may be done by another care team member, clinic staff, or online/on paper prior to appointments.<br>  ○ Screening should be done in a straightforward, nonjudgmental manner while asking about other health behaviors.<br>  ○ Pediatric providers who have high clinical suspicion for substance use should screen for substance use; MOUD is recommended for adolescents with opioid use disorder.<br>  ○ Screen aging adults (e.g., 65+) for unhealthy substance use using age-friendly print sizes.<br>• **Providers not in primary care settings should also consider routinely screening for substance use disorders using validated instruments.** |
| Diagnosis | • **If a patient screens positive, or independently brings up concerns about their opioid use,** ask about frequency, amount, and route of opioid use, perform assessment to determine diagnosis of OUD (following DSM-5 criteria)<br>• **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%. [xi]<br>  ○ **Do not delay medication** until a comprehensive assessment can be performed.<br>  ○ **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:<br>  ▪ **Risks and benefits** of available medications. |

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| | ▪ **How treatment setting can impact medication choice** (e.g., whether the patient can do daily visits) as well as the patient's use of other substances (e.g., alcohol, benzodiazepines)<br>▪ **Ensure that the patient and members of their support system 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.<br>▪ **How to reduce harm** regardless of choice to use MOUD.<br>○ **Assess and address patient comorbidities**, including poly-substance use and any untreated mental health or physical health conditions.<br>▪ Screen and treat for common co-occurring concerns, including but not limited to:<br>• Stimulant use (see ASAM Clinical Practice Guideline for Stimulant Use Disorder.)<br>• Hepatitis C virus (HCV – see Bree Collaborative's Hepatitis C Virus report and guidelines here)<br>• sexually transmitted infections (STIs). |
| **Treatment** | |
| MOUD | • **Offer medications for opioid use disorder treatment, including in primary care.**<br>○ Follow evidence-based guidelines for assessment of opioid withdrawal and MOUD initiation. (ASAM, PCSS).<br>○ If a patient does not choose to use MOUD, **continue to offer medications at follow-up visits.**<br>○ If unable to offer MOUD within your clinic, find someone in your system or external to your system that can prescribe MOUD. (MOUD Locator)<br>○ **Prescribe dosages of MOUD and adjunct therapies that adequately address symptoms.** 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.<br>• **Prescribe MOUD for duration adequate to treat OUD as a chronic condition** (e.g., 30 days instead of 2 weeks). There is no limit on how long an individual may use any MOUD.<br>• **Assess possible medication interactions, especially with benzodiazepines, according to evidence based guidelines (ASAM, American Association for the Treatment of Opioid Dependence)**. 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. [xii] |
| Harm Reduction | • **Write a prescription for and/or provide naloxone for use during an overdose.** For in-person visits, ideally, the patient should leave the appointment with naloxone in their possession. |

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| | ○ Council patients that anyone in Washington state can get naloxone through the statewide standing order.<br>○ Offer education on overdose prevention and harm reduction including printed materials. Naloxone can be ordered/found for free – see Implementation Guide for resources. |
| Management | • **In primary care, coordinate care across physical and behavioral health providers.** Optimal treatment for SUD in primary care involves the integration of physical and behavioral healthcare.<br>• Consider referring to an Opioid Treatment Program for patients with complex needs, including those that may require intense support/case management services.<br>• **Continue to follow up** with patients identified with opioid use disorder **with or without MOUD.**<br>• **Use telehealth (audio-visual and/or audio-only) in care for patients with OUD, including for providing MOUD.**<br>• Refer patients to local community organizations that support people with substance use.<br>○ 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 a 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, and other available resources (SEE OUR IMPLEMENTATION GUIDE). Whenever able, offer medications for opioid use disorder and harm reduction services.*

***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****.*[xiii] *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.***

- Read and follow guidelines for your setting under Appendix A**. Progression Towards Optimal Care** in addition to the following guidelines.

| **Education** | |
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| Staff Education | • **Establish expectations that clinicians and care teams provide trauma-informed care** according to most updated evidence-based guidelines (i.e., ASAM, PCSS)<br>  ○ Provide staff with access to current, short guidelines regarding opioid use disorder (e.g., Substance Abuse and Mental Health Services Administration, National Institute on Drug Abuse).<br>• **Staff should understand how to have shared decision-making** conversations with patients to present evidence-based choices for treatment.<br>  ○ 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 or |

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| | methadone.<br>○ Utilize a patient decision aid to guide discussion. (some are certified by Washington State HCA).<br>○ Draw from available provider facing resources for education, such as learnabouttreatment.org.<br>• **Distribute copies of language guidelines** to be used when discussing substance use disorder such as from here.<br>• **Staff should understand regulations around prescribing of MOUD** (e.g., 72-hour rule) |
| **Access** | |
| Low-Barrier Treatment | • **Change practice workflows to align with principles of low-barrier treatment**.<br>○ Minimize delays to MOUD initiation (start patients on medications for opioid use disorder on the same day if possible).<br>○ Do not discharge patients from treatment for initial or ongoing polysubstance use or for ongoing substance use.<br>○ Do not delay or discontinue care due to sporadic engagement.<br>○ Counseling and other adjunct therapies offered but not mandated for treatment.<br>○ Engage patient in creating an individualized follow up plan after visits.<br>• **Outpatient facilities and programs should expand to include drop-in visits**, and/or weekend/night hours without appointment requirements. |
| Multidisciplinary Team | • **When possible, utilize a multidisciplinary team approach to support comprehensive care for patients with opioid use disorder (OUD),** including but not limited to nurses, pharmacists, substance use disorder professionals, a professional responsible for care coordination, and others, to collaboratively address medical, behavioral and social aspects of whole-person care.<br>○ **Employ staff with dedicated time** to facilitate access to the appropriate level of care or external referral as needed. |
| **Treatment** | |
| Offer MOUD | • **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. |

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| | • **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)<br>  ○ **Provide a range of MOUD options,** including long-acting injectable versions of buprenorphine.<br>• **Be familiar with and provide alternative resources** for access to medications for opioid use disorder in case patient cannot reach usual providers. See **Implementation guide** for resources. |
| Comorbidities | • **Assess patients for poly-substance use, physical health comorbidities, and mental health comorbidities** and tailor additional care to the patient's needs and wishes. 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.<br>  ▪ **Screen and treat** for STIs, hepatitis C virus (see Bree Collaborative Hepatitis C Report), and mental health concerns |
| Evaluation | • Evaluate the effectiveness of programs offered at the facility at regular intervals (e.g., annually) and/or participate in external evaluations. See the **Bree Collaborative's Evaluation Framework** for more details. |
| Share Information | • Assure that appropriate systems and structures are in place to share information between and across physical and behavioral health providers, while respecting privacy and confidentiality |
| **Recovery Support** | |
| Harm Reduction | • **Stabilize the patient and reduce harm, death from overdose, as a first priority.** Refer to harm reduction services for patients not ready to cease substance use (e.g., syringe service programs) |
| Integrated Care & Referrals | • **Build capacity to provide a range of medical, harm reduction, treatment, and social services on site to minimize the need for transitions of care.** |

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| | • **Incorporate peer support services into the care team whenever possible.** 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.<br>• **Identify which patient comorbidities will be treated onsite, criteria, and partners for referrals.**<br>• **Build referral capacity with an accredited Opioid Treatment Programs where you can refer patients when appropriate.** Opioid Treatment Programs can help stabilize a patient through additional MOUD options including methadone or more intensive support services, such as counseling. OTPs should be seen as specialty care services.<br>  ○ **Care for people referred to OTPs should be shared with patient permission between the program and referring PCP,** unless the program also provides primary care services.<br>• **Refer to outside programs and providers, including harm reduction programs, to meet other care needs as necessary using warm handoffs.** |
| **Special Populations** | |
| Adolescents | • **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.<br>  ○ **Primary care settings should be prepared to identify adolescents with OUD and start them with MOUD per clinical guidelines**.<br>  ○ **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.<br>  ○ **Consider specialized treatment facilities** providing multidimensional services when appropriate.<br>  ○ **Screen, educate about prevention and offer treatment to adolescents for common physical and behavioral health comorbidities**, including but not limited to blood borne pathogens such as hepatitis C virus, sexually transmitted infections, depression and suicide. Discuss contraceptive needs with adolescents.<br>  ○ **Increase awareness about medications for opioid use** |

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| | **disorder for adolescents** and facilitate engagement for both caregivers and patients.<br>○ **Consider attending continuing education opportunities (see Implementation Guide)**<br>• |
| Pregnant and Postpartum | • **Treat patients who are pregnant or postpartum in accordance with evidence-based best practices.** (e.g., Bree Collaborative's Perinatal Behavioral Health 2023 Guidelines, SAMHSA's Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants, and ACOG/ASAM's Opioid Use and Opioid Use Disorder in Pregnancy., and ASAM 4th Edition Treatment for OUD Guidelines) Additional or specific steps have been identified below:<br>○ **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.<br>○ **Universally screen for substance use** using validated instruments. (e.g., 4Ps, NIDA Quick Screen, CRAFFT<br>○ After a positive screen for opioid use disorder, **perform a medical examination and psychosocial assessment.**<br>○ **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.<br>▪ Screen for sexually transmitted infections.<br>▪ Engage in or connect to harm reduction services.<br>○ **Provide MOUD as early as possible**. Hospitalization during initiation may be advisable due to potential adverse events and/or need for close observation.<br>○ **Do not unnecessarily switch formularies of MOUD**.[xiv]<br>○ Perinatal/primary care providers should co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and addiction specialist when necessary.<br>○ **If unable to provide MOUD, use a warm handoff to refer pregnant patients to a setting offering methadone or buprenorphine** rather than withdrawal management or abstinence.<br>○ **Facilities should embed easy-to-access consultation** |

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| | **resources** for providers – see our Implementation Guide for resources.<br>○ **Incorporate substance use disorder doulas** as a part of the care team as available. |
| Older Adults | • **Treat aging adults in accordance with evidence-based best practices.** Follow these tips from SAMHSA on Treating Substance Use in Older Adults<br>○ Available data show opioid agonist therapy and partial agonist therapy is effective in aging adults – age should not be a barrier to treatment.<br>○ Monitor closely for adverse effects associated with opioids in aging adults.<br>○ Consider aspects of aging that may impact meeting diagnostic criteria for opioid use disorder, such as age-related changes in tolerance of substances, cognitive functioning and social isolation.<br>○ Assess aging adults for exposure to chronic opioids, a risk factor for opioid use disorder. |

## 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:

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| **Access** | |
| MOUD | • **Do not encourage patients to stop medication treatment**.<br>• **Use MOUD as a first line treatment for OUD.** Be aware that the effectiveness of medications for opioid use disorder increases with duration of treatment and may be lifelong. Refer to prescribers for concerns with medication treatment.<br>• **Do not bar access to all appropriate services offered by the agency based on any substance and/or medication use.**<br>• **Ensure any patient requiring an inpatient stay is able to continue MOUD throughout that stay** by collaborating with other providers including opioid treatment programs. Breaks in continuity of medication can put the patient at an increased risk of recurrence of substance use and/or overdose post-discharge.<br>• **Write a prescription for naloxone**, dispense and physically deliver to patients. |
| **Treatment** | |
| Management | • **Collaborate with harm reduction programs to offer harm reduction services.**<br>• **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's Consult Lines. See Implementation Guide for resources.<br>• **As able, integrate primary care and other behavioral health services**. |
| **Recovery Support** | |
| Share information with patient permission. | • **Review your organization's policies** to ensure you can exchange information with everyone involved in patients' care with patients' consent.<br>• Assure appropriate systems and structures are in place to help share information between and across physical and behavioral health providers |

## Employer Purchasers

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| **Education** | |
| Employee education | • **Encourage participation in employee assistance programs.**<br>• **Universally promote employee understanding of behavioral health benefits and potential substance misuse**. Universal communication around services offered can reduce stigma and increase utilization of services. |
| **Access** | |
| OUD services | • **Choose benefit structures that offer a full range of evidence-based treatments** for substance use disorders, including MOUD, screening and treatment for comorbidities (physical and behavioral), screening and addressing social needs, peer support services and harm reduction programs. Ensure benefit structure follows Health Plan guidelines.<br>• Eliminate inadvertent barriers to behavioral health care service access, including MOUD (e.g., counseling requirements, prior authorizations, etc.). |
| Employment Barriers | • **Reduce employment barriers**. Do not create additional restrictions on employment for people in treatment for opioid use disorder outside of those required by law.<br>• **Offer and honor paid sick leave** to allow employees to attend to their medical and behavioral health care needs. |

*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.*

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| **Education** | |
| Staff training | • **Train correctional health care and custody staff in:**<br>○ Science and treatment of OUD as a chronic illness,<br>○ Universal screening for withdrawal and substance use<br>○ Appropriate monitoring during MOUD administration,<br>○ Overdose reversal and naloxone administration. |
| **Access** | |
| MOUD | • **Ensure MOUD treatment continuity upon entry and discharge and offer buprenorphine long** acting **injectables** before known release date to protect people who use opioids from overdose after discharge.<br>• |
| **Screening & Diagnosis** | |
| Screening | • **Universally screen people** entering facilities for withdrawal and substance use disorders.<br>• **Provide appropriate evidence-based counseling** about treatment options for OUD. |
| **Treatment** | |
| MOUD | • **Offer treatment with buprenorphine and methadone**. Methadone and buprenorphine decrease the risk of overdose upon release by half and continued treatment with buprenorphine or methadone can save lives.[xv] |

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| | • **Prescribe and dispense naloxone upon release**. Teach how to use naloxone prior to release. People released from incarceration are at high risk for fatal overdoses following a period of abstinence due to decreased tolerance. |
| **Recovery Support** | |
| Integrated Care & Referrals | • **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.<br>• **People being released should receive appointments with community providers, an adequate supply of MOUD upon release and back-up plans** if appointments are cancelled or delayed. |

## Health Services Academic Training Programs and Residencies

| **Education** | |
|---|---|
| Student Education | • **Incorporate evidence-based information on substance use disorders, including opioid use disorder,** into the curriculum for all licensed clinicians at a minimum according to educational agencies (e.g., AACGME). |

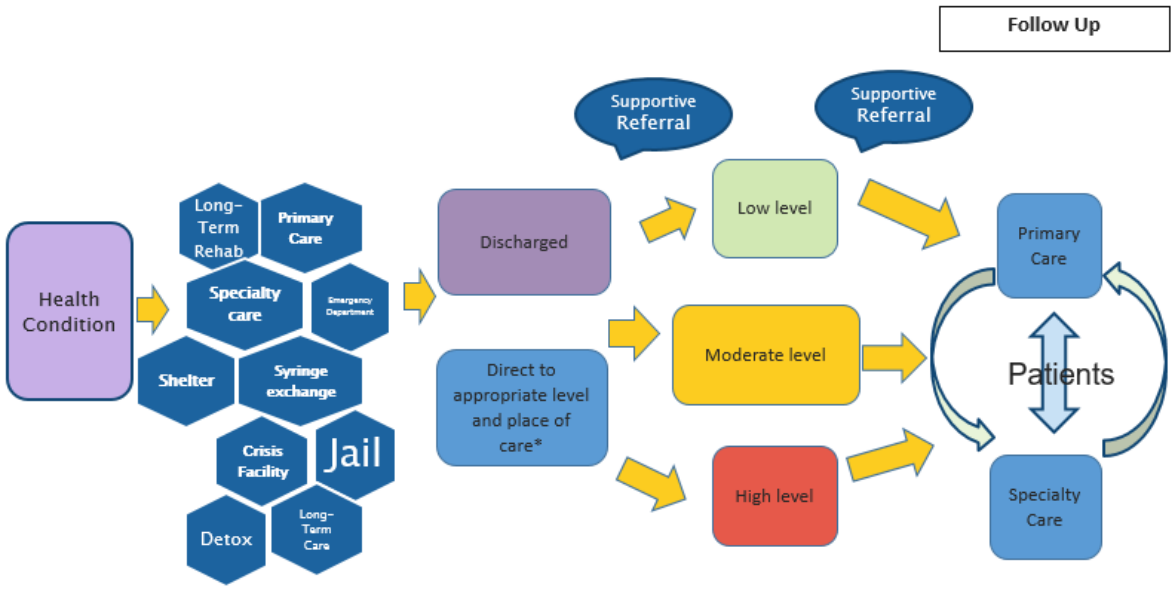
## Context

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).[xvi] 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).[xvii] Older adults are less likely to be screened for unhealthy substance use than younger individuals, but overdose rates in older adults are increasing.[xviii xix]

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.[xx] 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.

Transitioning people using HPSO is 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.

**Figure 2. A Coordinated Health Care System (2017)**



## 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, in conjunction with harm reduction services. 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 supports 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. Sublingual formulations come with and without naloxone.
- 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. [xxx] [xxxi]
- 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]
- Buprenorphine 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: Buprenorphine 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]
- Buprenorphine 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 An HHS Final Rule in 2024 significantly increased the amount of take-home medication available in early treatment,

including up to a week of medication at a time during the first 14 days of treatment, two weeks of medication later in the first month, and one month of medication after the first month of treatment, subject to progress in recovery and absence of significant risk factors for diversion or misuse. More information is available in the Final Rule.

- 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

- **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**. Patients should be informed of this increased risk if they return to illicit opioid use. [xxxviii]
- Opioid antagonist that fully blocks the effects of opioids (full opioid antagonist). Naltrexone is FDA approved for alcohol use disorders 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 [xxxix] [xl], 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. [xli]
- 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.

## Medications for Overdose Reversal

### Naloxone

- Used to reverse opioid overdose by blocking opioid receptors (full opioid antagonist) to restore respiration in emergency overdose situations. Should be carried by anyone in the community, including people who use drugs, and can be administered by bystanders.
- **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 people experiencing an opioid-related overdose. Read more at the DOH here.

## Dosing in Fentanyl Era

In Washington state, deaths due to fentanyl have risen over 750% between 2018 – 2022, and in 2022 accounted for almost 90% of all opioid-involved deaths.[xlii] The increase in fentanyl involvement in overdose and deaths has led to 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,[xliii] although recent studies have suggested higher doses of buprenorphine may be necessary.[xliv] 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.[xlv] 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 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.[xlvi] 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.[xlvii] 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.[xlviii] Off-label hydromorphone, both injectable and tablet, is currently being offered in several Canadian sites.[xlix] 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*."[l]

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.[li][lii] SROM has demonstrated some improvement over methadone in reducing cravings,[liii] mental health symptoms,[liv] and treatment satisfaction.[lv] 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."*[lvi] 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.

## Best Practices

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 substances 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)"* [lvii] 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 co-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 no-wrong-door model for all-in-one location where people who use drugs can access a range of primary care, behavioral health, case management, harm reduction, outreach and social services with no appointment necessary 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. Five geographically diverse sites are currently testing this model; two sites are legacy syringe service programs, two sites are Tribal health providers, and one site is a federally qualified health center. All sites work closely with OTPs to provide same or next-day access to the methadone. 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 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, [lviii] and retain in treatment. [lix] 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 is critical to supporting all people who use opioids in Washington State

## 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. As research evolves, further longitudinal metrics should be considered related to treatment retention.

**Evaluation Framework**

The workgroup's subcommittee have developed specific measures and metrics that would apply to the evaluation of care for people with OUD. Specific metrics include The workgroup endorses the use of specific metrics where applicable, for identification, treatment initiation and treatment retention to track involvement in the cascade of care for OUD. Beyond these specific metrics, the workgroup endorses specific measures related to increased access to OUD treatment, increased number of individuals with naloxone, and the use of impact measures defined on the Washington State Department of Health Opioid Dashboard (e.g., reduction in opioid related deaths, reduction in nonfatal overdose ED visits, and reduction in EMS overdose response)

Whenever possible, programs should include in their evaluations measures that address patient satisfaction and quality of life beyond retention in treatment, such as patient-reported outcomes.

See the **Bree Collaborative Treatment for OUD Evaluation Framework** for more information.

**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 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.)

## Appendix A. Progression Towards Optimal Care

Our workgroup endorses a "no wrong door" approach for patients wanting to access opioid use disorder treatment from a variety of settings. The following recommendations are meant to guide patients to appropriate opioid use disorder treatment. The goal for all settings is that patients receive the care they need at the time and in the setting of their choice, reduce harm and have no overdose events.

| | Current State | Intermediate Steps | Optimal Care |
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| **Primary Care Setting** *Offering MOUD treatment must be the standard of practice. More information here.* | • Patients with opioid use disorder are not identified and offered treatment.<br>• If identified, providers may be uncertain as to next steps or may feel uncomfortable discussing opioid use.<br>• Providers are uncomfortable prescribing buprenorphine and do not refer people to providers who are. | • Primary care leadership supports adding a service to treat opioid use disorder. See an example manual for office-based opioid treatment here.<br>• Primary care providers are incentivized by higher reimbursement to treat opioid use disorder and co-occurring conditions.<br>• Primary care providers and staff are trained:<br>  ○ To diagnose opioid use disorder.<br>  ○ On indications for MOUD<br>  ○ On local behavioral health providers, Opioid Treatment Programs and how to provide supported referrals for patients.<br>  ○ To use current, non-stigmatizing language regarding substance use disorders.<br>• 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.<br>• 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.<br>• Clinics restructure workflows and facility operations to reduce barriers to accessing treatment, including providing drop-in hours or extended hours for same-day MOUD. | • Patients have access to all available treatments for OUD and behavioral health care and counseling as wanted and needed without mandatory requirements that constitute a barrier to care. Patient care is not interrupted or terminated due to ongoing and recurring opioid use and polysubstance use.<br>• Treatment may include primary care providers treating patients with opioid use disorder with buprenorphine or naltrexone or supported referral to opioid treatment programs. Referrals are provided through warm handoffs to support patients during transitions.<br>• Behavioral and physical healthcare is co-located and integrated with access to harm reduction services in a non-stigmatizing setting.<br>• 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.<br>• Care navigation to assess needs for other services (e.g., housing, employment, |

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| | | • Consider following some example of models here. | legal, recovery supports, harm reduction programs) and to help clients connect and stay engaged with these services.<br>• Provide drop-in hours for patients with OUD |
| **Behavioral Health Setting (including Substance Use Treatment Programs)** | • Patients with opioid use disorder are not offered evidence-based treatment for opioid use disorder.<br>• Substance use treatment programs may rely on abstinence-based care | • Providers are trained:<br>  ○ To diagnose opioid use disorder<br>  ○ To review and offer or refer to all appropriate opioid use disorder treatment options with patients.<br>  ○ On local Opioid Treatment Programs and how to provide supported referrals to patients.<br>  ○ Harm reduction and stigma/bias towards people who use drugs.<br>• Behavioral health prescribers are incentivized with higher reimbursement when psychiatric disorders and opioid use disorders are both treated simultaneously.<br>• Medical providers are available and able to prescribe medications for opioid use disorder.<br>• Providers are introduced to ongoing training resources including providers' clinical support system for opioid therapies (PCSS) and Telemedicine learning collaboratives.<br>• Providers and staff use current, non-stigmatizing language regarding substance use disorders.<br>• If inpatient or residential stays are medically indicated, providers support continued use of medication treatment throughout the stay.<br>• Behavioral health and substance use disorder programs partner with primary care. | • Patients receive treatment for opioid use disorder and other co-occurring behavioral health diagnosis from available psychiatric or other licensed behavioral health providers. Any outside referrals include shared bi-directional communication and care coordination.<br>• 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.<br>• Providers treat opioid use disorder in a behavioral health setting or provide supported referrals to opioid treatment programs depending on patient-specific treatment goals.<br>• Behavioral and physical healthcare is co-located and integrated with access to harm reduction services in a non-stigmatizing setting through a trauma-informed approach to care.<br>• Refer to or collaborate with harm reduction programs. |

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| **Opioid Treatment Programs (OTP)** | • Programs may only exist in urban/suburban settings.<br>• Generally, offer all three forms of MOUD (methadone, buprenorphine products, and long-acting naltrexone)<br>• 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.<br>• Buprenorphine and naloxone are available.<br>• 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.<br>• 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.<br>• Patients diagnosed with opioid use disorder are offered MOUD based on their individualized treatment goals.<br>• OTPs can function as health homes (providing comprehensive coordinated medical and behavioral healthcare, such as through the Health Engagement Hub model)<br>• As able, partner with primary care providers to offer or coordinate follow up for primary care services.<br>• Provide services over telemedicine in addition to in person |
| **Perinatal Care Providers** | • Patients who are pregnant and have opioid use disorder are not routinely screened and may feel uncomfortable disclosing opioid use.<br>• Many patients have been poorly treated by the healthcare system and are concerned about referral to child protective services. | • Obstetrics providers are trained in opioid use disorder including how to screen for and recognize signs of opioid use disorder.<br>• Treatment barriers are reduced through increased primary care services and improved coordination between prenatal and behavioral health providers.<br>• Health care services are supported by alternative care models for substance use and mental health treatment that combine patient's and parenting support services.<br>• Supportive referral processes are developed between prenatal care and medication treatment facilities. | • Patients who are pregnant are:<br>○ Engaged in prenatal care as a first priority with emergent/urgent medical conditions that require immediate referral for clinical evaluation identified.<br>○ Screened for opioid use disorder and have access to integrated prenatal, substance use, and mental health care.<br>○ Started on medications for opioid use disorder.<br>○ After a positive screen for opioid use disorder, medical |

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| | • 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.<br>• Many pregnant people with OUD have experienced significant trauma in their past. | • Co-management processes between prenatal care and addiction medicine are developed.<br>• Buprenorphine and methadone are offered to patients for treatment of OUD.<br>• Trauma informed approaches are used in clinical settings.<br>• Do not automatically refer to child protective services.<br>• Consistently practice eat-sleep-console model in hospitals for birthing parent with SUD and infant [lx] | examination and psychosocial assessment are performed.<br>○ Screened for STIs according to ACOG guidelines.<br>• 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<br>• Pregnant or postpartum individuals with opioid use disorder are diagnosed and supported during all phases of perinatal care including after delivery to continue recovery.<br>• Patients have access to promotoras, peers, doulas or community health workers to support them in pregnancy if they choose.<br>• Refer to and collaborate with harm reduction programs.<br>• Practice trauma-informed model of extended stay in hospital for birthing people with SUD and their support system (e.g., COMPASSION model) [lxi] |
| **Emergency Department** *(not the ideal location to begin recovery process – e.g.,* | • Patients are treated for opioid overdoses or the complications of opioid use, but initiation of MOUD and supportive referral for | • 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 | • Patients are assessed for opioid use disorder using DSM-5 criteria.<br>• Patients presenting to the emergency department for overdose are given naloxone and a supportive referral the next day or <72 hours for treatment |

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| *not cost-effective, low acceptance of referrals)* | treatment for opioid use disorder may not occur | MOUD.<br>• 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.<br>• ED providers are trained in:<br>○ How to diagnose opioid use disorder and determine severity.<br>○ How to initiate patients with opioid use disorder on MOUD utilizing a certified shared decision-making tool.<br>○ To manage acute pain in patients on naltrexone, buprenorphine and methadone.<br>• 72-hour rule for methadone dispensing to continue access to MOUD until patient can make follow-up appointments or establish care at an OTP.<br>• Patients are given the option to start MOUD in the ED.<br>• Refer to ScalaNW protocols for initiation or most updated guidance for EDs. | with MOUD.<br>• Patients do not regularly initiate on chronic pain medication from the emergency department.<br>• 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.<br>• 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.<br>• 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.<br>• With patient's permission, the primary care provider is notified of emergency department visits.<br>• 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.<br>• Prior to any prescription for controlled substances, the Washington State PMP is checked.<br>• Peer recovery support and support for health-related social needs are integrated on site. |

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| | | | • Ensure EHRs can share care plan information with other providers.<br>• Patients are provided naloxone upon discharge.<br>• Refer to or collaborate with harm reduction programs |
| **Inpatient Care Settings.** *(Inpatient care teams have an opportunity to identify patients experiencing OUD and offer engagement in treatment, even if not admitted for an OUD-related condition or overdose. Initiation of MOUD in inpatient settings is successful and can improve* | • 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.<br>• 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.<br>• Hospitals may decline to hire peer support staff due to stigma or for fear of recurring substance use.<br>• Hospital providers are not well trained in how to manage pain in people maintained on MOUD.<br>• Patient-directed | • Patients with OUD are offered and provided MOUD during their inpatient stay<br>• 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<br>• Partnerships are developed with clinics that can accept patients with opioid use disorder for treatment options including MOUD treatment without delay.<br>• Build pathways for specialty addiction medicine consults for patients with severe OUD and/or co-occurring conditions.<br>• 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.<br>• Inpatient providers regardless of specialty are trained:<br>  • How to diagnose opioid use disorder and determine severity<br>  • How to initiate patients with opioid use disorder on MOUD.<br>  • To manage acute pain in patients on MOUD | • Patient with OUD are identified and assessed for severity based on DSM-5-TR criteria<br>• 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.<br>• 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<br>• With patient's permission, the primary care provider is notified of hospitalization and discharge.<br>• 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.<br>• Address other health needs related to SUD, such as HCV treatment<br>• Prior to any prescription for a controlled substance, the |

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| *outcomes such as ER utilization, hospital readmission and retention in MOUD treatment.)* | discharges (patients discharging "AMA") occur due to untreated OUD symptoms during hospitalization. | • To manage pain and/or withdrawal symptoms in patients who do not want to initiate MOUD.<br>• Can utilize DEA-72-hour rule to dispense take-home methadone doses at discharge for up to three days while arrangements are made for follow-up or intake at an OTP.<br>• Hospitals hire peer support specialists and other staff to support patients with SUDs.<br>• Providers are trained in how to manage pain in people maintained on MOUD. Pain and withdrawal symptoms are managed regardless of the patient's decision to start MOUD. | Washington State PMP is checked.<br>• Prescribe bridge doses of MOUD at discharge.<br>• Care management teams support the 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<br>• Patients who are not yet in withdrawal or decline MOUD are offered a prescription at discharge.<br>• Peer support specialists are available on site.<br>• Patients maintained on MOUD have their pain adequately managed. Offer palliative goals-of-care counseling.<br>• Patients are provided naloxone upon discharge.<br>• Refer to or collaborate with harm reduction programs |
| **Syringe Service Programs** | • The opportunity to offer MOUD to syringe service program participants may be missed.<br>• Syringe services programs teach | • Participants who wish to reduce opioid use are linked to (including offering transportation) programs which offer treatment including options for medications (buprenorphine, naltrexone, methadone), or MOUD is offered on-site.<br>• Participants have access to new drug use | • MOUD treatment is co-located, if possible.<br>• Additional services are available on-site: wound care, HCV screening and treatment, STI screening and treatment, referrals to community resources, sexual and reproductive |

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| | participants on the risk of overdose death if they use alone, the dangers of mixing drugs, to carry naloxone, the "good Samaritan" drug law, and how to manage suspected overdoses including to call 9-1-1.<br>• Naloxone is freely available, both in intramuscular and nasal versions.<br>• Participants of syringe service programs carry naloxone | supplies, including injection and smoking supplies | health services, basic primary care services, basic mental health services, peer navigation and support, and linkage to more robust primary care and mental health services that is non-judgmental and sensitive to the needs of people who use drugs. See Health Engagement Programs here.<br>• Services offered over telehealth |
| **Correctional Facilities** | • Persons released from facilities are at high risk for fatal overdoses.<br>• Patients denied or not offered evidence-based treatment for OUD while in facilities | *Continuation or initiation of medication treatment has been shown effective and is recommended regardless of duration of sentence.*<br>• Screen for withdrawal and substance use disorders.<br>• MOUD (methadone, buprenorphine, and naltrexone) is considered for treatment and should be initiated a minimum of 30 days prior to release from facility. | • Persons entering correctional facilities with opioid use disorder are provided with medications for opioid use disorder and adjunct therapies or maintained on previous treatment on entry.<br>• Persons released from facilities are prescribed, trained on how to use and given naloxone.<br>• Persons transitioning out of correctional facilities are provided MOUD at discharge and coordinated connection to community-based provider that will continue medication |

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| **Long-term Care Facilities** | • Patients with opioid use disorder are denied acceptance into skilled nursing facilities [lxii]<br>• 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.<br>• Establish partnerships with Opioid Treatment Programs and community providers to offer and continue MOUD.<br>• 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.<br>• Develop services like counseling and peer support to support patients with SUDs.<br>• Establish protocols for the safe prescribing, dispensing, and monitoring of opioids. Utilize prescription drug monitoring programs (PDMPs) to track patient prescriptions.<br>• Prescribe and manage buprenorphine like all other controlled medications. | • Patients with OUD are admitted into high quality long-term care facilities and transition smoothly from acute settings to post-acute settings.<br>• Patients with OUD receive evidence-based treatment in long-term care facilities, including continuation of MOUD and adequate management of symptoms with adjunctive treatments.<br>• Staff approach care for patients with OUD through a harm reduction lens<br>• Patients with OUD have reliable access to supportive services like counseling and peer support.<br>• 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. |
| **Pain Clinic** | • Patients may have undiagnosed opioid use disorder.<br>• The Washington State Prescription Monitoring Program (PMP) may not be a routine part of | • Providers have been trained on:<br>○ The Agency Medical Director's Guideline on Prescribing Opioids for Pain.<br>○ How to screen and diagnose opioid use disorder using DSM- 5-TR criteria.<br>○ Offer buprenorphine as an alternative to full-agonist opioid pain medications.<br>○ Referring to an addiction specialist as | • The most updated 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*). |

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| | prescribing practice | appropriate, including an opioid treatment program.<br>○ Prescribe naloxone as preventative rescue medication, if needed.<br>○ Using the PMP.<br>• Providers learn about available resources in the community for patients with OUD.<br>• 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.<br>• To use current, non-stigmatizing language regarding substance use disorders. | • The initial evaluation should include a comprehensive assessment that evaluates for important comorbidities including OUD and SUD and evaluates past and current use of all pain medicine and substances.<br>• Prior to any prescription, the Washington State PMP is checked.<br>• Patients with suspected opioid use disorder are assessed using DSM-5-TR criteria and receive a supported referral to a specialist to treat OUD as appropriate. If referrals are necessary, referrals are coordinated to support patients during transitions. Ideally, patients could have MOUD managed by pain clinic providers.<br>• With the patient's permission, the primary care provider is notified.<br>• Patients are prescribed, taught how to use, and leave with naloxone in hand as a preventative measure. |

## Appendix B. Opioid Use Disorder Treatment Guidelines

| Source | Guidelines or Systematic Reviews |
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| USPSTF | (2020) Screening for Unhealthy Drug Use in Primary Care in Adolescents and Adults, Including Pregnant Persons: Updated Systematic Review for the U.S. Preventive Services Task Force<br>(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<br>(2024) Patient perceptions of and experiences with stigma using telehealth for opioid use disorder treatment: a qualitative analysis<br>(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<br>(2022) Opioid agonist treatment for people who are dependent on pharmaceutical opioids<br>(2017) Buprenorphine for managing opioid withdrawal<br>(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<br>(2020) National Practice Guideline for the Treatment of Opioid Use Disorder<br>(2021) Department of Defense, Department of Veterans Affairs, Veterans Health Administration Management of Substance Use Disorder<br>(2020) World Health Organization International Standards for the Treatment of Drug Use Disorders<br>(2018) American Pain Society, College on Programs of Drug Dependence Treatment Programs for Opioid Use Disorders: A Review of Guidelines<br>(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<br>(2018) Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants<br>(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<br>(2020) Systematic Review of Opioid Use Disorder Treatment Training for Medical Students and Residents<br>(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 |

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| | (2022) Inclusion of Patient-Reported Outcomes to Inform Treatment Effectiveness Measures in Opioid Use Disorder: A Systematic Review<br>(2022) Digital Interventions for Opioid Use Disorder Treatment: A Systematic Review of Randomized Controlled Trials<br>(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: 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*

## Appendix D. 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 support, 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 |
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| 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 providers
- Paneled and licensed providers are only able to provide office-based individual treatment.
- Crisis support, case management, and 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 E. 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 |
| **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 F. 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., tele prescribing, 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 |

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| 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 | | Asotin County Health Department |
| 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, MPH | 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 Clinics |
| 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 |

## Appendix G. Treatment for OUD Evaluation Subcommittee Members

| Name | Title | Organization |
|---|---|---|
| Kelly Youngberg, MHA | Assistant Director for Health Care Implementation and Strategy | Addictions, Drug and Alcohol Institute |
| Everett Maroon, MPH | Executive Director | Blue Mountain Heart 2 Heart |
| Brook Evans, PhD, LICSW, CSAC | Senior Research Associate | Comagine Health |
| Colin Fields, MD, AAHIVA | Medical Director of Government Relations and Public Policy; Quality Program Medical Director HIV & PrEP Program | Kaiser Permanente Washington |
| Tina Seery, RN, MHA, CPHQ, CPPS, CLSSBB | Senior Director, Quality and Rural Programs | Washington State Hospital Association |
| Herbie Duber, MD | Regional Medical Officer – Northwest WA | Department of Health |
| Sara Halvik, BA, MPH | Vice President, Data Solutions | Comagine Health |
| Donya Karimi, PhD | Leader, Analytics, Research and Measurement Team | Health Care Authority |
| Petra Eichelsdorfer | Pharmacist Account ManagerKi | United Health Care |
| Amanda Alavos | | Health Care Authority |
| Susanne Quistgaard, MD | Medical Director, Provider Customer Engagement | Premera Blue Cross |
| Nicole Saint Claire, MD< FACOG | Executive Medical Director | Regence |
| LuAnn Chen, MD, MHA, FAAFP | Senior Medical Director | Community Health Plan of Washington |

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