Supplemental Workbook – 3A Opioid Implementation Approach

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps.	DY 2, Q2	We did a regional survey to collect qualitative information, stake holder interviews, and working across the ACH to identify gaps. The CPAA has two facilities in two (Lewis and Thurston) of the seven counties for medicated detox for individuals with OSUD and publically funded insurance, however both accept private insurance as well. This access is potentially helpful for the areas it is available in, these resources are both very recent additions, so it is unclear how much of the need they will address. Outside of these resources the other five counties do not have access to medicated detox. The geographical distance between people needing resources and where the limited resources are available is a huge barrier to addressing the impacts of the opioid crisis. There is limited access to inpatient SUD treatment within the CPAA for those experiencing OSUD. Thurston County theoretically has increased access to MAT Methadone with the increased census cap, however the provider base does not have the space or workforce capacity to accommodate the census cap. The Suboxone waivered providers in the CPAA are concentrated in Thurston and Lewis Counties. There are a set of providers interested in training new providers in the CPAA to increase access to Suboxone through primary care. There are 3 syringe exchange programs in CPAA, they are all interested in scaling up their efforts to further increase access to the services and referrals they provide. There is a state wide shortage of chemical dependency professionals, finding ways to further support the development of that workforce within the CPAA would improve access to treatment. Mason County just received a $300,000 grant to address the opioid epidemic and they have hired an outreach worker and they are increasing access to Naloxone for overdose reversal beyond law enforcement into the IDU population in Mason County. Cowlitz County also received a grant from the SAMHSA STR funding. The CPAA opioid response work group and the larger CPAA needs to do a gap analysis for this population in order to find the places that need to be filled in to make a more connected response throughout the region. The current disconnects between Behavioral Health Organizations and the entities providing OSUD treatment in the PAA need to be identified and resolved in order to streamline and unblock access to service.
Identify how strategies for Domain I focus areas – Systems for Population Health Management/HIT, Workforce, Value-based Payment – will support project	DY 2, Q2	1) **Systems for Population Health Management**: CPAA's planning process will address data systems that a) Identify populations and partnering providers in the planning stage as the ACH develops the programs implementing the projects; Integration of care, workforce development, and connection of health information technology systems will greatly benefit the population experiencing OSUD. It could literally revolutionize SUD treatment in the CPAA. Careproviders would be able to communicate with each other in almost real time across a large geographical area that people migrate through either to access services. Currently it can take weeks to months, if ever, for information to be shared between providers.

		2) b) The opioid workgroup has identified which clients to target: incarcerated populations, injection drug users/needle exchange program users, people with Hepatitis C, people living with HIV, homeless people, pregnant and parenting women, high utilizers of the ED with conditions related to drug use, focusing on those with complex needs that cross multiple systems of care; c) generate monitoring reports to apprise partners of progress made in meeting care coordination metrics. 3) **Workforce:** CPAA will coordinate with existing work groups to identify training needs to support development of chemical dependency professional workforce, implicit bias and harm reduction training for medical, paramedicine providers and law enforcement, Suboxone waiver training for primary care providers, community health worker training for people who do outreach to injection drug users, recovery coach training. CPAA will attempt to leverage existing training resources, including those provided by HCA, DOH, Qualis and others, to develop provider training on implementing a HUB. 4) **Value-based purchasing**: Given the role of MCOs in funding medical care, CPAA is include MCO representatives in all planning activities for opioid response work group and intends to provide incentives that align well with current and emerging MCO payment approaches. Since HCA contracts with MCOs, CPAA believes that closely working with HCA in this effort will be crucial.
Finalize target population and evidence-based approach informed by regional health needs. (Consider areas with limited access to treatment for opioid disorder, and rates of opioid use, misuse and abuse.)	DY 2, Q2	The opioid workgroup has identified which clients to target: incarcerated populations, injection drug users/needle exchange program users, people with Hepatitis C, people living with HIV, homeless people, pregnant and parenting women, high utilizers of the ED with conditions related to drug use. The areas outside of Thurston County have the most access to care issues and the opioid work group recognizes that although there may not be enough population in these areas to attract a treatment facility that local providers need to be engaged in a more meaningful way to build capacity for treatments such as MAT and connected to the places that do have resources for treatment.
Identify and engage project implementation partnering provider organizations, including: -Identify established local partnerships that are addressing the opioid crisis in their communities and establish new partnerships where none exist. -Identify, recruit, and secure formal commitments for participation in project implementation including professional associations, physical, mental health and substance use disorder, (SUD) providers and teaching institutions.	DY 2, Q2	1) **Engaging providers**: CPAA has established a workgroup to address those projects meeting the needs of people with chronic conditions, including the Bidirectional Integration and has included providers who play a major role in serving Medicaid clients likely to benefit from the project. In addition, CPAA has conducted two efforts to identify partnering providers: 1) an RFQ to identify and engage partnering providers; and 2) an analysis conducted by CORE of the key providers serving 90% of Medicaid clients in the region. Since a successful Bidirectional Integration approach must include other provider types, such as housing, long-term care and children's services, during the planning year, CPAA will expand its identification of partnering providers to include these and other service categories. Continued engagement in the project will be tied to written, formal commitment to the project that specifies participant roles. 2) **Training:** During the planning year, CPAA will design a training program to assure that participating providers are

		well-versed on HUB standards. Ongoing training will serve to support and reinforce providers' efforts to adopt these practices. To the extent possible, CPAA will leverage statewide training resources, including those offered by HCA and DOH.
Develop project implementation plan, which must include, at a minimum: -Implementation timelines for each strategy -A detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health. -Identify the system supports that need to be activated to support an increase in the number of 1) providers prescribing buprenorphine; 2) patients receiving medications approved for treatment of OUD; 3) the different settings in which buprenorphine is or should be prescribed and 4) the development of shared care plans/communications between the treatment team of physical/mental health and SUD providers. -Roles and responsibilities of key organizational and physical, mental health and substance use disorder (SUD) provider participants, including community-based service organizations, along with justification on how the partners are culturally relevant and responsive to the specific population in the region. -Description of how project aligns with related initiatives and avoids duplication of efforts, including established local partnerships that are addressing the opioid crisis in their communities. -Specific strategies and actions to be implemented in alignment with the 2016 Washington State Interagency Opioid Working Plan. -Describe strategies for ensuring long-term project sustainability	DY 2, Q3	CPAA will implement a rigorous project planning and monitoring approach to implementation of each project, including Pathways Community HUB. The ACH will employ project planning software and tools to lay out required deadlines, key tasks, subordinate tasks, and milestones. The project plan will define the parties responsible for executing each task, critical paths and key dependencies. Failure to meet a critical milestone will prompt a timely management response at regular meetings that CPAA will convene with the staff and providers responsible for implementation of each project. 1) The buprenorphine waivered providers in the CPAA are concentrated in Thurston and Lewis Counties. There are a set of providers already training new providers in the CPAA to increase access to buprenorphine through primary care. 2) CPAA opioid work group is also planning for provider education with CME's to address the stigma that is often a barrier to patients seeking treatment. 3) the opioid workgroup has discussed increasing access to buprenorphine in low barrier settings. 4) The CPAA council is working to create through dimension 1, HIT systems that communicate with each other more seamlessly where possible -Syringe Exchange Programs have been identified by the CPAA opioid work group as a prime place for service co-location because of their level of engagement and connection with injection opioid users, SUD providers of MAT have relevance in that their treatment modality is the only evidence based form of treatment OUD. -The opioid workgroup is intentional about aligning existing resources to complement each other and adding services where there are none and using existing partnerships to increase capacity. Additionally, the Pathways model will work to direct people into services to address their whole health needs. -Specific strategies identified by the CPAA opioid workgroup are increasing access to Naloxone, particularly in communities not covered by the STR grant, increase usage of the PMP by primary care providers, and to increase access to MAT and to increase use of data and monitoring mechanisms by relevant providers in the CPAA. -We are working with our partners to create capacity for new work to be incorporated into existing work flows that takes resources to initiate but not to sustain once it has begun.
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation of the strategy / approach	DY 3, Q1	The workgroup tasked with designing the project implementation will identify a subgroup, supported by CPAA, to develop guidelines, policies, procedures and protocols.
Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures,	DY 3, Q2	CPAA will issue regular reports to participating providers designed to: 1) inform providers on where to target their efforts; and 2)

and targets to support the selected model / approach		advise providers on progress toward meeting required objectives. For example, if a provider is working to reduce readmissions, CPAA or a designated partner will help practices identify clients with high hospital admission rates or at high risk for readmission. Second, CPAA or designated partner will need to report to provider practices their overall progress on meeting the required metrics for each project. When a provider or a group of practices is not making adequate progress on meeting key metrics, CPAA will conduct outreach to and develop a plan of action, which would likely entail a face-to-face meeting to review the reports and an action plan to remedy identified gaps or barriers.
Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened. -Each partnership should include health care service, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions. -Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges and overall progress. -Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.	DY 3, Q2	CPAA has convened an opioid response workgroup from across the region there is participation from public health departments, behavioral health providers, law enforcement and criminal justice, medical providers, MCO's, prevention and community members. Leaders have already begun to emerge from this group and are positioning themselves in their communities to be champions for this work. As the convener CPAA has worked to develop systems of communication, and will continue to, between partners that can remain even at the end of the grant. The opioid response group will continue to meet throughout the implementation phase and into the future in order to share information and collaborate with planning around this issue.
Implement selected strategies/approaches across the core components: 1) Prevention 2) Treatment 3) Overdose Prevention 4) Recovery Supports Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan.	DY 3, Q4	1) Increased provider use of the PMP, adoption of a methodology similar to the 6 building blocks, and increased education for youth 2) Increased access to MAT in PC settings by training more providers 3) Increase naloxone access in the areas it has already begun in the CPAA. Initiate access in the areas it has not and stabilize funding sources through Medicaid. Increase standing orders. Collaborate with STR grant to initiate access in areas not yet served. 4) Collaborate through bi-directional and collaborative care models to provide recovery support services.
Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers).	DY 3, Q4	**Build local workforce of trained CHW's that have SUD experience and create a mechanism for value based payment to support recovery support services. Partner with local social service agencies to build supports in the community when at all possible.**
Stage 3: Scale & Sustain		
Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), as well as defining a path forward to deploy the partnership's expertise,	DY 4, Q4	The process to address the opioid issue in the CPAA is an active and growing piece of work. We will need to remain nimble and responsive to the needs of each area. One of the most effective ways of doing that is to pay attention to the trends that are being reported by direct service providers, i.e. syringe exchange

structures, and capabilities to address other yet-to-emerge public health challenges		programs. Opioids are the specific focus of this project, however other illicit drug use is always a concern, for example increased injection methamphetamine use. That is why it is crucial that all professionals touching these populations are well versed in harm reduction, trauma informed care, and ways to mitigate implicit bias. We will also be working across disciplines to address the other social determinants of health that often lead to SUD. i.e. ACES, prescribing practices through the 6 building blocks, and recovery support services.
Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas.	DY 4, Q4	
Convene and support platforms to facilitate shared learning and exchange of best practices and results to date.	DY 4, Q4	The CPAA will continue to provide opportunities for shared learning across disciplines.
Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches.	DY 4, Q4	The CPAA represents and is connected to a unique set of stakeholders. There are many unique perspectives that can inform this work in meaningful ways