



Opioid Response Work Group Meeting

Meeting Summary, 10/25/2017

Support and Backbone Staff: Jennifer Brackeen – *CHOICE*, Megan Moore – *CHOICE*, Shannon Linkous – *CHOICE*, Liz Arjun – *HMA*, Malika Lamont – *CHOICE*, Christina Mitchell – *CHOICE*

In Attendance: Doug Spingelt – *SeaMar*, Mike McIntosh – *Grays Harbor*, Vicky Brown – *Mason General*, Jeanie Knight, Robyn Smith, Jim Coffee – *Cowlitz Family Health Center*, John Lanning – *Providence*, Tim Candela – *DSHS*, Christina Garcia – *Molina*, Jeanne Snow – *Cowlitz County*, Gena James – *Cowlitz County*, Kelly Golob – *Tumwater Chiropractic*, Adam Marquis, Laura Dawson, Ramona Leber, Cindy Grande, Appalachia Martine, Laura Akhavan – *BHR*, Dave Windom – *Mason County*, Katie Strozyk – *Lewis County*

I. Welcome and Introductions

Malika Lamont welcomed everyone and facilitated introductions. She reviewed the objectives in the agenda, which were to discuss and review the draft project application, the draft work plan and project alignment.

II. Review Work Plan and Gaps in the Project Application

Liz provided context about all other work going on within the demonstration. This whole project application consists of a larger scale with several other work groups (i.e. care transitions, chronic disease, care coordination, bi-directional integration of care, oral health, and maternal child health). At the October council and board meetings, the decision was made to move forward with six projects rather than eight for the project application. The two projects that were removed were oral health and diversions. The decision was based on the overlap the six selected projects have in line with the metrics that need to be met. Oral health and diversions could be plugged into selected projects, including opioid response, so they are still tied into the project application.

Liz reviewed what CPAA work groups did in August and September, which was:

- Identify target populations
- Discuss engaged providers via RFQ and high-volume Medicaid providers
- Identify Domain 1 assets and challenges (for Section I)
- Develop proposals- HMA and CPAA

The focus of the October meeting was on gaps in the project application. The opioid response group needs to touch on the four realms of treatment, prevention, overdose prevention and recovery. CPAA and HMA took the RFQs received and placed them in the four buckets accordingly. HMA made a visual display of the information received from providers and placed them in the “Core Component Addressed” column you see below.



Org	Intervention	Target Pop.	Project Description	Core Component Addressed
Arcora	Integrated Care	People at high risk for oral disease, maternal/child health, chronic disease (estimated #)	Integrate aspects of oral health into most MTD projects where appropriate	Treatment
Child & Adolescent Clinic	Collaborative Care Pathways	Children birth to 20 (estimated #)	Add Behavioral Health Specialist to integrated care team and continue collaboration with other community partners	Treatment and Recovery
Cowlitz Family Health Center	Syringe Exchange Collaborative Care	Syringe exchange clients (estimated #)	Wrap-around services (define) in SEP setting	Prevention and Treatment
Crisis Clinic	Collaborative Care MAT	People seeking MAT (estimated)	Recovery Help Line - provide accurate information about available MAT services and link to care	Prevention and Treatment
Mason General Hospital	Collaborative Care Model Bree Collaborative	Chronic pain patients	Develop a Wellness Clinic that offers whole person care to patients with SUD	Treatment and Recovery
Providence Health and Services	Medicated Assisted Therapy (Buprenorphine)	Estimated #	Establish a regular, centralized clinic to provide initial induction for MAT	Prevention and Treatment
Sea Mar Community Health Centers	Collaborative Care Model Pathways, MAT	Sea Mar patients (estimated #)	Provide integrated care and implement the Pathways care coordination model	Treatment and Recovery
Thurston County Health and Social Services	Syringe Exchange	South and NW areas of county (estimated #)	Expand geographic reach and hours of operation for SEP (need to be clear about what is happening here-expanding primary care and treating those engaged)?	Prevention and Treatment



The following is a list of things the community could do to address gaps in overdose prevention:

- Get creative with the clinic setting of standing orders within all counties (i.e. find a physician who is willing to write prescriptions for naloxone to different pharmacies).
- Provide education around naloxone use needs to both providers and others who may witness an overdose.
- Have naloxone available at homeless events to touch on that population (with a standing order from a physician in the area to coordinate the possibility).
- Make it a goal to work with county leadership to get standing orders adopted in more counties to allow for naloxone distribution.
 - Several counties have had this conversation, so they are aware, but many do not want to go this direction right now because there are collaborative drug therapy agreements established by medical officers already, which is another way to mitigate the overdose issue.
- Be creative with access points and delivery of naloxone via home health programs, needle exchange programs, homeless health programs, free clinics, missions and eat free cafes, faith communities engaged with sheltering the homeless and sexual minority out and proud coalitions to reach the underserved populations, etc.
- Convene stakeholder groups like small store owners who may have knowledge about the community and make easier connections with the people who need help while also providing a venue for this work to happen.
- Target drug users and families of them.
- Target homeless, but also people who don't fit stereotypes of drug users because many of them are members of society who work and have families.
 - It's important for all walks of life to feel safe and secure in where they get free naloxone from.
- Over-prescription needs to be addressed - opioids are mainly prescribed in emergency rooms and dental offices. Specialty doctors also overprescribe opioids.
 - Dental providers are moving away from this issue by limiting prescriptions.
- Kelly Golob mentioned the importance of alternative medicine over traditional medicine because it produces better outcomes for patients.
 - The barrier to this is that Medicaid doesn't cover many alternative medicine procedures and therefore makes it unaffordable and essentially inaccessible. Hopefully this can be addressed in the future and reform the Medicaid demonstration.
- Encourage and promote PMPs to spend more time on and with patients, specifically SUD patients, while also promoting alternative medicine to limit need for opioids.
- Provide access to health coaches and physical activity.
- Educate patients about the risk of the medications being taken.



- Co-prescribe naloxone with opioid prescriptions and provide the education that goes along with it.
 - CPAA could encourage and incentivize this to later lead to a requirement.
 - Important to remember that if CPAA buckles down on prescribing guidelines, people will just go somewhere else until they get the opioid prescription they're looking for.
- Present barrier – Pain management organizations are disappearing quickly and those that do treatment outside of opioid prescribing are full and won't accept new patients.
- CPAA works with MCO's to coordinate alternative medicine as best practice and advocate to the state that this is something that needs to be covered by Medicaid.
 - A caveat to this type of treatment is that there can already be patients who are addicted to opioids and then start receiving alternative medicine treatment, which can cause patients to turn to heroin use and another addiction.
- Establish best practice guideline within the community for ways to prescribe alternative pain management treatment.
- Present barrier – Many alternative medicine providers (like chiropractors, massage therapists, acupuncturists) are not allowed to enroll under Medicaid to accept patients, which limits patients to the one county within a region that is able to enroll providers.
 - CPAA could advocate for using providers through a VBP contract rather than having to go through a policy route or advocacy board and use evidence-based data with contracts that are in place.

III. Overdose Prevention Challenges and Suggested Mitigation Strategies

1. Increase providers prescribing suboxone
 - Make naloxone/suboxone prescribers available and provide them with some resources to make providers comfortable.
 - Providers also need community support to feel this is a normalized practice.
2. Training for trauma-informed care
 - Make sure people providing care for SUD patients or addicts know how to provide for patients who have experienced trauma.
 - Providers need more ACEs training.
3. Sharing info across systems
 - Data share agreements are tumultuous when dealing with SUD and CFR.
 - Partnering providers need to be able to access care across providers.
4. Harm reduction training for providers and training to address stigma of drug use
 - Transform the way we care for people by attaching CME's and support, which would address the need for training centered on harm reduction, reducing stigma and trauma-informed care.
5. Crisis intervention training for law enforcement and paramedics
 - Partner with BHOs to address this need.



- Put out RFPs for entities who already have the needed training, then address the population who does not have the training so trained providers know who needs it and when is the best time to do it.

IV. Work Plan Review and Discussion

Liz reviewed the work plan at a high level by referring to the project supplemental workbook approach. Malika went over some specifics within the work plan. Following the meeting, the project application draft was sent out to opioid response work group participants to get subject matter expert reviews and edits. During edits, keep in mind if you can think of something that needs to or can happen sooner, that's what the state wants to know since it would bring about a more immediate impact on the problem. Malika requested that people let her know if any opioid task forces or informational meetings happen within their respective areas so she can take in knowledge to maximize the project application and overall work plan.

V. Provider Capacity for Successful Projects

Liz reviewed visual displays that address how the projects align within the entire project demonstration. The first visual displayed the overall vision of the Medicaid Demonstration. The second visual was a demo logic model, which will be updated based on the Domain 2 discussion that happened October 17. To view the visuals, click [here](#).

Liz asked the group to recognize the connections that are present with the other projects:

- MCH project
 - Pregnant mothers who are affected with SUD need to be able to obtain treatment. Substance abuse issues are also related with pain medication prescription after giving birth.
 - Naloxone prescription is a way to reduce ACEs so mom doesn't die OR mom doesn't use.
- Transitions of care
 - Skin infections through use of injection or other infections from substance use.
 - Make sure people coming out of detox have a warm handoff to people providing care which will reduce death in a short amount of time.
 - Target high utilizers in jail systems when transitioning out.

VI. Next Steps & Closing

- ❖ The next meeting is November 29, 2017 from 1pm – 3pm
 - Providence Centralia Mother Joseph Conference Room
 - 914 S. Scheuber Rd., Centralia, WA 98531
- ❖ Review and edit work plan Malika sent out (by Wednesday Nov. 1 at 12pm)
- ❖ Provide any additional feedback for success in project application and work plan