Opioid Response Work Group Meeting

Meeting Summary, 9/27/2017

Support and Backbone Staff: Megan Moore – *CHOICE*, Jennifer Brackeen – *CHOICE*, Shannon Linkous – *CHOICE*, Liz Argen – *HMA*, David Hanig – *HMA*, Malika Lamont – *CHOICE*
In Attendance: Doug Spingelt -- *SeaMar*, Jeanie Knight, Katie Strozyk – *Lewis County*, Roseanne McPhail – *Pacific County*, Robyn Smith – *Crisis Clinic*, Mike McIntosh – *Grays Harbor*, Gena James – *Cowlitz County*, Ramona Leber, Christi Salin, Tim Candela – *DSHS*, Jen Houk – *Providence*, Rachel Wood – *Thurston County Health and Social Services*, Dr. Phyllis Cavens, Laura Johnson – *UHC*, David Windom – *Mason County*, Cindy Grande – *Pioneer Family Practice*, Laura Akhavan – *BHR*

I. Welcome and Introductions

Malika Lamont started the meeting and facilitated introductions. She reviewed the agenda and work plan for the meeting, which consisted of review of target populations from the previous meeting, providers and Domain 1 investments, and a review of what would happen at the next meeting.

II. Target Population and RFQ Submission Review

David Hanig reviewed target populations that were established from the August work group meeting. He let the group know CPAA and HMA would be working with Providence Core to hone in on specific geographic regions to develop more specific target populations. He assured these additions would be integrated into the November 16 Project Application. Additionally, during the October meeting on the 25, a draft of the project application will be provided to this work group for review to allow for comments, updates, or changes.

Jennifer Brackeen reviewed the RFQ Response Summary document which broke down the organizations that had submitted RFQs and what they were about. Overall themes were pulled from these RFQ submissions and shared with the group. The themes for Opioid Response were to enhance/expand syringe exchange and enhance/expand clinical and referral capacity within the populations of Medicaid lives, ED patients and SEP clients. Jennifer then transitioned into a discussion about RFQ submission. SeaMar said they had submitted one and Cowlitz County said they would be submitting one.

Robyn Smith described her submission and said she was working with Kayla Green at ADAI to update database expansion via a recovery help line to make real time information readily available. CPAA's role in this would be to partner and collaborate with people in the region that haven't been partnered with lately, so CPAA could provide support and outreach throughout the region. Robyn explained that it would be great for providers to have access to this type of information not only to update patient info, but to access patient info, as well, perhaps using an "access code" or "login" for the database. This database is meant to find providers for opioid addition more than providers who could help with co-morbidities.

Jennifer Houk described Providence's RFQ proposal, which designed a three hour program to link providers in providence medical group who have the ability to prescribe ongoing therapy.

The program is also meant to provide help to people who are being discharged so readmission will be made easier. Ongoing support after discharge would need to be addressed within this structure.

Thurston County Health and Social Services representative, Rachel Wood, described an RFQ for syringe exchange to re-expand the mobile exchange through fixed sites in Thurston County. This work is already under way in the southern and northwest parts of the county. Thurston wants to expand to having stationary SEP sites in these areas. They do not have it at this time.

III. Gaps in Medicaid Providers and RFQ Submissions

Jennifer reviewed the Major Medical Providers document. The existing caveats in the data derive from billing addresses being included in only one county when some providers operate in several counties. The data is not perfect and is based on 2016 data. There was also a reminder that this data is based on *major* Medicaid providers only. Some missing providers on this list were some behavioral health agencies in Cowlitz County and some BHO providers in Great Rivers, which can be cross referenced on the Great Rivers BHO website, searched for by county.

Jennifer warned the group that we may not hit all four areas we were hoping to hit with RFQs that have been submitted thus far. Most submissions fit into the treatment and recovery buckets, and areas that need looked at are overdose reduction, and prevention. When asked who needs to be included in outreach to fill these gaps, the group said the following:

- Law enforcement
- ESD's and whoever carries P.I. contracts
- Schools
- Dental as an area for prevention – Arcora is a good contact
- CPWIs (Community Prevention and wellness intervention) - for prevention
- Corrections in regards to law enforcement is providing treatment (naloxone) upon release. It would be great to expand this to other counties. It was recommended that the medical clinic hand out kits at release or people are referred to a MAT provider to get one.
- Mike McIntosh said he would send Grays Harbor initiative in regards to prevention. It can be accessed here.
- Drug takeback? Not very cost effective because it's no longer covered by the DEA.
- Pacific County does drug take back – partnered with pharmacies to get permanent drop boxes for drug drop off/return
- Mason County is currently sending drugs taken back to Spokane
- Some counties are partnering with mortuaries to administer drug take back

Potential outreach needs to happen to get other people engaged in RFQs. Perhaps, by identifying areas where prevention would be effective, it could generate more ideas and would make the subject less broad. The focus should be on what kinds of prevention would be the best evidence-based moving forward for the 2018 implementation year. Liz mentioned that

none of the metrics actually relate to opioid reduction and prevention, so that could be why no one is focusing RFQs on this subject area.
Malika challenged the group to look at this from a different scope. Prevention doesn't have to focus directly on opioid prevention. For example, prevention of child abuse could reduce drug use because those are generally connected. Focusing on the other social determinants of health could interrelate to opioid reduction. Thinking outside the box could be what makes this prevention work in the community. For example, creation of an app? Relationships with people like store owners who know all of the opioid addicts? It was agreed amongst the group that naloxone distribution should be built into home visiting programs since these providers are exposed to a high amount of people who are at risk of overdose. Additionally, wraparound services that include a counselor who would provide crisis intervention when needed, among other needed services. If housing and transportation could be addressed, this work would be easier to make successful.

IV. Addressing Domain 1 Investments

Liz opened up the Domain 1 discussion. The three domain 1 focuses are financial sustainability through VBP, workforce, and systems for population health management. The overarching goal for VBP is that 90% of state payments need to be tied to value by 2021. The idea of value based payment is to pay for outcomes rather than volume. The role of the ACH is to inform providers, connect providers to training and technical assistance, support an initial survey to figure out where gaps are and what's already in place and identify strategies to be implemented in region. The overarching goal for workforce is to promote a health workforce that supports comprehensive, coordinated and timely access to care. The role of the ACH is to consider implications and develop workforce strategies to address gaps and training needs. The overarching goal of population health management is to leverage and expand interoperable HIT and HIE infrastructure and tools to capture, analyze and share relevant data. The role of the ACH is to respond to the needs and gaps identified in the current infrastructure to ensure the regional providers' needs are met and all is ready for Domain 2 and 3 implementation strategies. Liz told the group this discussion is still high level because we are still in first stage of planning, but it will get more specific in the implementation phase and later stages.

David addressed the Domain 1 matrix. The results are in the chart below:

#	**Project** & Interventions	**Domain 1**		
		Value-Based Purchasing	**Workforce**	**Health Info Tech**
3A	**Addressing the Opioid Use** • Prevent Opioid use/misuse • Link to OUD with treatment	• **Assets:** • BHOs changing payment structure – moving towards King county tier based structure, BHO QE level • BHO contracts fund % of all services for vulnerable community	• **Assets:** • Training for waivers on physicians who can distribute Suboxone • Training for trauma informed care	• **Challenges:** • HIT should become more mobile to eliminate need for desktop entrance • Privacy and sharing rules are a barrier – policy, privacy, etc.

#	**Project** & Interventions	Domain 1		
		Value-Based Purchasing	**Workforce**	**Health Info Tech**
	• Overdose prevention • Recover: LT stabilization & whole person care	• **Challenges:** • Gap in funding unless large funds are available – how to bridge gap and transition from fee for service to VBP • Equate value to provider for providing continued outreach • Make sure VBP doesn't penalize providers for engaging challenging clients • Providence re-did their system to compensate physicians – from fee for service to VBP • Flexible funds to engage clients where they are • King county - Mobile Crisis Team & Crisis Solution Center • Community Paramedicine can engage clients on the street • No on-demand place to refer clients • Payment streams for VBP come from BHOs & MCOs • 1/10th dollars will not convert to VBP but will fund metrics that are met in this project • Incarcerated do not qualify for Medicaid- is there a funding source? • Criminal Justice Treatment Account	• Crisis intervention training for law enforcement and paramedicine • BHO hosted training • Mental health first aid • **Challenges:** • Need harm reduction training for providers • Increase of providers – primary care, behavioral health, co-providers • Cultural Competency/Stigma of drug use training & continued education • BHO filling open positions/retention	• Data sharing is costly and inefficient • EHR & data sharing reformation – agreements should be established • Public Health Plan needs access to certain data via client registry and connections & registry of client diagnosis for proper assessment • Jail/Law enforcement data sharing with providers that could be beneficial • Induction of telehealth with patients incarcerated, no transportation, rural communities, etc. • Law enforcement mobile device could provide real time BH consultants to address client needs • First Responders

V. Next Steps & Closing

- ❖ HMA and CPAA staff working on Project Drafts, which workgroups will review at next meeting
- ❖ Finance Committee will be meeting to discuss principles and will use information from project work groups to identify potential areas for investment
- ❖ Project Drafts and Finance Committee recommendations to council and board for approval
- ❖ Next meeting: Wednesday, October 25, 2017 from 1 – 3pm
  - New Location: Valley View Health Center in Administration Board Conference Room
  - 2690 Northeast Kresky Avenue, Chehalis, WA 98532