3A: Addressing the Opioid Use Public Health Crisis Supplemental Workbook

Project Stage Milestones	Completion Deadline (Demonstration Year, Quarter)	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	Building on past regional capacity assessments, CPAA will conduct an online survey of key clinical and social service providers in the region to gauge the current state of capacity for effective opioid response services delivery by the end of DY2, Q1. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key clinical and social service partners as well as technical assistance partners (e.g., Qualis Health and DOH) to identify missing resources and assets. We also plan to utilize the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub. The Opioid Response Work Group will review data and provide input into the final landscape analysis by DY2 Q2. To date, the following service providers in the CPAA region have been identified as potential partners as part of the current regional assets to effectively impact the current opioid crisis: 1. Eleven hospitals (Capital Medical Center, Grays Harbor, Legacy Salmon Creek, Mason General, Morton General, Ocean Beach, Peace Health St. Johns Medical Center, Providence Centralia, Providence St. Peter, Summit Pacific, and Willapa Harbor) 2. Four short or long-term inpatient chemical dependency programs (Harbor Crest, NW Indian Treatment Center, and Providence Centralia, Cowlitz Family health Center) 3. One licensed Opioid Treatment Program (OTP) (Evergreen Treatment Services) 4. Numerous outpatient chemical dependency treatment programs 5. Six multi-site behavioral health care organizations (Behavioral Health Resources, Great Rivers BHO, SeaMar, Thurston-Mason BHO, and Valley View, Cowlitz Family Health Centers) 6. Three syringe exchange programs in Thurston, Cowlitz and Grays Harbor counties.

		7. Public Health Departments throughout the region are expanding their service provision around the opioid issue; Mason and Cowlitz counties have received State Targeted Response grants. A further review of all the available interventions by the Opioid Response Work Group will determine which additional strategies will best meet the local needs of the CPAA region, with emphasis on addressing the following identified gaps to providing an integrated program to address the opioid crisis: 1. Large geographical distance between people needing resources and the physical location of service providers, due in part to the rural nature of much of the region 2. Stigma, which is identified as a primary barrier after geography 3. Limited availability of MAT due to a) only one Opioid Treatment Program, which has insufficient space and workforce capacity to accommodate its census cap; and b) a shortage of medical providers trained and willing to prescribe buprenorphine, particularly outside Lewis and Thurston counties 4. A shortage of chemical dependency professionals, particularly those educated about MAT 5. Lack of communication, coordination, and digital information exchange among service providers 6. Limited access to inpatient treatment for SUD 7. Lack of education among the general population, professionals (medical, chemical dependency, and law enforcement), and families and individuals living with OUD on topics including the stigma of OUD, MAT as the established evidence-based treatment for OUD, social contributors to OUD (e.g. ACEs), trauma-informed care, and harm reduction 8. Homelessness or a transitory living situation among many individuals with OUD

Identify how strategies for Domain I focus areas – Systems for Population Health Management/HIT, Workforce, Value-based Payment – will support project	DY 2, Q2	By the end of DY2, Q2, CPAA will have finalized the specific Domain 1 strategies that will support the project. 1)Systems for Population Health Management: Population health data analysis will continue to be used to refine target populations, including identifying sub-groups and sub-regions. Additionally, we will develop an inventory of our partnering providers' electronic health record (EHR) systems to develop strategies for information sharing, to facilitate coordination of care in real-time among medical and behavioral health care providers, social service providers, and law enforcement. This will include push and pull notifications based on the level of system interoperability. CPAA will also explore opportunities for expanding the use of EPIC among partnering providers, given that approximately 40% of our region is already using this technology platform. The care coordination improvement plan developed by our region over the last few years includes specific strategies to leverage EPIC, including with providers who do not have routine access to EPIC. Additionally, CPAA will facilitate continued shared learning about risk screening tools used by our region's hospitals to identify patients with an elevated risk of rehospitalization to ensure systematic risk screening occurs. Importantly, our investments in Systems of Population Health Management will be coordinated across all project areas so that they become mutually reinforcing. We will be working with all partners to encourage enrollment and usage of the Prescription Monitoring Program. 2) Workforce: CPAA has solicited feedback from the Opioid Work Group to identify training needs to support the development of provider workforce capacity. The Opioid Workgroup has identified the shortage of Chemical Dependency Professionals, low number of active and trained MAT providers, community health worker training for people who do outreach to injection drug users, recovery coach training as areas of focus (please see above for more information). CPAA will continue this assessment of provider workforce needs during implementation planning through an online survey of providers. Survey results will be discussed by the Opioid Response Work Group to interpret the results and ensure completeness. This includes

		providing targeted training of our partnering providers' personnel on evidence-based opioid response strategies. CPAA will leverage existing training resources and models with the help of technical assistance partners, including, but not limited to, HCA, DOH, Qualis Health, and the AIMS Center. Workforce training will include prescribing buprenorphine, cultural competency, trauma-informed care, and ways to mitigate implicit bias. In addition, CPAA will continue to explore provider workforce recruitment and retention support strategies that benefit all project areas, such as offering loan forgiveness and conditional scholarships. Additional workforce mitigation strategies CPAA will explore include shared workforce strategies, such as expanding access to telehealth, changing overly burdensome licensing requirements for certain practitioners, developing internships for college students, and establishing a learning collaborative of partnering providers. As with investments in Systems of Population Health Management, our investments in Workforce training, recruitment, and retention will be coordinated across all project areas in order to develop synergies. 3) Value-based Purchasing: Given the importance of MCOs in funding clinical care for Medicaid beneficiaries, CPAA has included MCO representatives in all stages of project selection and planning, including the Opioid Response Work Group. This ensures that our project design and implementation aligns well with current and emerging VBP approaches. Since HCA contracts with MCOs, working closely with HCA will be crucial. CPAA will work with the statewide VBP Task Force to assess how VBP contracts can support successful opioid response and share insights gained on evolving VBP opportunities with partnering providers. This will allow partnering providers to assess VBP options and prepare their organizations for value-based care delivery. Again, CPAA's efforts to support provider movement to value-based care will not be specific to opioid response, but support all project areas, including opioid response.

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	By the end of DY2, Q2, CPAA will refine the selection of target populations. 1)Target Population(s): CPAA determined that it would target efforts in areas where the region underperformed compared to the state average and focus on areas where there was the greatest need for improvement. As a result of the analysis, we identified target populations and project areas that would address gaps and have the deepest impact for populations that most needed an intervention. As a proxy to identify areas where there are significant health disparities, CPAA looked at Medicaid claims data and mortality rates in counties by census tracts to identify specific target populations and sub-regions for our projects. Examples of such groups include: • Incarcerated populations • Injection drug users/individuals who utilize needle exchange programs • Individuals with Hepatitis C • Individuals with HIV/AIDS • Homeless populations • Pregnant and parenting women with OUD • Individuals with inadequate control of SUD and behavioral health issues (e.g., multiple ED visits and hospital readmissions related to drug use) • Individuals living in rural areas with limited access to OUD treatment In addition to these populations, there are specific geographic areas in our region that require special focus due to oversaturation of opioid prescriptions, lack of services, and high ED utilization. We believe by addressing health disparities, health equity will improve in our community. Going forward, we will review the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas. CPAA will perform a similar cross-analysis of sub-populations and sub-regions. Aligning our target populations and sub-regions across project areas to the greatest extent possible will generate maximum synergies and impact. In support of this analysis, we will continue to work with CORE to refine our data tools. As we progressively narrow down our target population(s) through these efforts, our Opioid Response Work Group and partnering providers

		will be able to make a final determination about the project's target population(s). 2) Evidence-based Approach: CPAA will employ all of the evidence-based approaches included in the Medicaid Transformation Toolkit in this project area; no one strategy will be sufficient to achieve the level of impact required. In addition to employing MAT and Harm-Reduction, CPAA will work with the Opioid Response Work Group to identify additional strategies that may need to be included in order to reach the desired outcomes. With the support of CORE, the work group will vet these strategies as to likely impact and feasibility (cost, provider readiness, etc.) before a final determination about chosen evidence-based approaches will be made.
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	CPAA has already identified key clinical partnering providers for this project using (1) the well-established network of partnerships with a broad range of clinical providers through CHOICE Regional Health Network's health improvement projects; (2) responses to a Request for Qualifications (RFQ) that was issued this summer; and (3) an analysis of the main Medicaid providers in the CPAA region by our strategic data analytics partner, CORE. In the coming weeks, we will be systematically reaching out to those main Medicaid providers that have not yet engaged in project planning to introduce the project and encourage participation in project design and implementation planning. Concurrently, we will reach out to social service providers in our region whose participation is vital for successful opioid response. We are using our extensive stakeholder list from work that CHOICE has led to improve substance use disorders in the region over the last several years as a starting point. We will augment this list of potential partnering providers with information gleaned from our regional asset mapping (see above) to ensure a comprehensive approach. The recruitment of specific partnering providers - both clinical and community-based - will be guided by our final decision about the target population(s) and sub-regions for this project. In order to secure formal commitments for participation from implementation partners, CPAA will need to resolve a number of specific issues first. These include, but are not limited to:

		the specific scope of work for each partnering provider (what and where will investments be made); reporting requirements of partnering providers (what measures and how frequently will reports be made); payment of partnering providers (how much and when payment occurs). Partnering providers will only commit to participating in the Transformation if they are clear on expectations and can assess the risks and rewards of their participation. CPAA will work with its Finance Committee and TA partners (e.g., Health Management Associates, Manatt, etc.) to establish the necessary payment framework. CPAA will work with its Opioid Response Work Group to clarify the scope of work of prospective partnering providers. CPAA will utilize its Support Team to assess partnering providers' scope of work across project areas. CPAA looks at the Transformation projects as an integrated project portfolio; hence, our partnering providers will be asked to engage in integrated project initiatives, rather than discreet, stand-alone projects. We anticipate that partnering providers will be able to make a firm commitment to participating in the Transformation once they have a full understanding of their implementation role across the entire project portfolio. These commitments will be memorialized in written agreements/contracts by DY 2 Q2.