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	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.
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.	DY 2, Q3	By the end of DY2, Q2, the project implementation plan which will address project-specific strategies and supports (detailed later under Implantation) will be developed by CPAA staff in close collaboration with the Opioid Response Work Group and in consultation with the Support Team to ensure the project implementation plan integrates well with and supports the other Transformation projects pursued by CPAA. This includes alignment with Projects 2A and 2B through the comprehensive review and coordination of target populations across different project areas detailed above (see Finalization of target population and evidence-based approaches). Additionally, our two advisory committees, the Clinical Provider and Consumer Advisory Committee, will review the project implementation plan to assess feasibility and impact from their respective perspectives and provide guidance on the final implementation plan. This will ensure that the implementation plan employs evidence-based approaches, is responsive to the needs of the region, and impacts high-need target populations. CPAA will work with partnering providers to establish timelines that meet the needs of our providers, first by focusing on large Medicaid providers and community-based social service providers, and then gradually building out to include smaller clinical and community-based providers. In finalizing commitment letters from partnering providers, CPAA will include final evidence-based approaches each provider will implement and ensure all implementation requirements are met. CPAA will ensure that alignment across project areas is prioritized to serve specific target populations that cross the entire health care system. An assessment of current state capacities will be conducted to avoid duplicating efforts and instead build upon existing assets and resources to

-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		the greatest extent possible. Again, this current state assessment will be reviewed across different project areas to develop maximum leverage and avoid duplication. The Opioid Response Program Manager will ensure roles and responsibilities of implementing partners are clearly articulated in both the project implementation plan and our contracts with partnering providers. This includes the description of the service delivery mode. The Program Manager will monitor adherence to the implementation plan by all partners on an ongoing basis. CPAA will work closely with all partnering organizations, including MCOs and BHOs, to ensure that Domain 1 investments are leveraged to support the long-term sustainability of the project (see Domain 1 project support above for details). Additionally, CPAA anticipates working with other ACHs to maximize investments in Domain 1 activities through coordinated investments across the state, or at least those regions that are interested in developing shared capacity, especially around Systems of Population Health Management and workforce development.
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation of the strategy / approach	DY 3, Q1	BY the end of DY3, Q1, CPAA will establish project-specific guidelines, policies, procedures, and protocols necessary to ensure consistent implementation of selected evidence-based strategies and models. In developing these documents, we will build to the greatest extent possible on already existing guidelines, policies, procedures and protocols that the proponents of the selected evidence-based strategies and models have already develop. For instance, there is a readily available set of guidelines and procedures for MAT that are consistent with a Harm Reduction approach. With guidance from the Clinical Director, the Opioid Response Program Manager will take the lead on developing any additional guidelines, policies, procedures, and protocols necessary to customize the evidence-based strategies and models to our specific regional context, if appropriate. The Opioid Response Work Group will review the proposed project-specific guidelines, policies, procedures, and protocols and make changes as necessary. We will consult with our Clinical Provider Advisory Committee as necessary, as well as with other technical assistance providers that have detailed knowledge of the chosen evidence-based strategies and models. The program manager will ensure all partnering organizations have access to and understand the guidelines that will be implemented. The program manager is also responsible for monitoring adherence to these guidelines, policies and procedures and protocols through provider spot checks.
Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach	DY 3, Q2	By the end of DY3, Q2, CPAA will establish a progressive implementation and performance monitoring system. This will include regular meetings with partnering providers to assess implementation progress and challenges. These meetings will be augmented by regular provider and regional performance reports

		that demonstrate movement toward critical milestones and achievement of key outcome goals. If performance problems are identified, the Opioid Response Program Manager will take the lead on developing a QIP in consultation with the partnering provider who is underperforming. In developing the QIP, the program manager will be supported by the Clinical Director and senior agency leadership, as well as the Opioid Response Work Group and both the Clinical Provider Advisory Committee and the Consumer Advisory Committee. Whenever possible, the QIP will identify technical assistance resources that help the partnering provider to get back on track. CPAA will establish a common format for QIPs detailing strategies, measures, and targets along with timelines for required improvement to ensure accountability.
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 already has a well-established network of partnerships with a broad range of clinical providers and an extensive stakeholder list from work CHOICE Regional Health Network has led in health improvement projects, including 11 hospitals in the region, numerous primary care offices and clinics, inpatient chemical dependency programs, a licensed Opioid Treatment Program, numerous outpatient chemical dependency treatment programs, numerous small behavioral heave care provider groups, 6 multi-site behavioral health care organizations, 3 syringe exchange programs, professional associations, community service programs, non-profit organizations, 7 county and 6 Tribal health departments, and first responders. From this, CPAA has convened an Opioid Response Work Group. There is participation across the region from public health departments, behavioral health providers, law enforcement, 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, and will continue to work, to develop sustainable systems of communication between partners. The Opioid Response Work Group will continue to meet throughout the implementation phase to share information, collaborate, and problem-solve.
Implement selected strategies/approaches across the core components (numbers indicate which strategy is associated with the 4 areas of the plan: 1) Prevention 7 2) Treatment 1,2,3,4,5 3) Overdose Prevention5,7 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	In implementing the project, we will follow the project implementation plan (see above), which details timelines, action steps and the specific roles and responsibilities of our partnering providers in their implementation of the selected evidence-based strategies. It will be the responsibility of the program manager to be in regular contact with our partnering providers to monitor adherence to the implementation plan and to ensure project-specific guidelines, policies, and procedures and protocols are followed, so that implementation addresses the core components of the selected evidence-based strategies and models. Specifically, CPAA will develop a plan to implement by DY 2 Q 4: 1) A consortium of physician professional organizations (local chapters of WAFP and WSMA, Providence Medical

		Group, and Physicians of SW Washington) will be chartered by CPAA to build the buprenorphine prescribing capacity in the region. Projects to be undertaken by this group include: a. Buprenorphine waiver training program to increase the number of local medical providers (MDs, NPs, and PAs) with waivers to prescribe buprenorphine. This will build on the waiver training of 40 new prescribers in May 2017 sponsored by this group, which used curriculum and resources from the American Academy of Addiction Psychiatry. The consortium will conduct periodic trainings to engage primary care clinics in the CPAA region. Other targeted providers will include jail medical personnel, hospital emergency department providers, hospitalists, and specialists in psychiatry, infectious disease, and obstetrics, all of whom frequently encounter CPAA's target populations. b. Peer support network to increase the number of waivered providers actively prescribing buprenorphine. The consortium will assign to each newly trained prescriber an experienced prescriber as a coach. Each multi-provider setting (e.g. clinic, hospital, jail) will be asked to designate a champion to identify barriers to implantations and to problem-solve with administrative management. Coaches and clinic champions will meet periodically to identify opportunities to better support waivered providers and increase their prescribing. 2) Nurse care managers for buprenorphine to increase the number of patients per buprenorphine prescriber. Each provider's prescribing authority can be dramatically leveraged by collaborative care with a nurse care manager. This care model was established at Boston Medical Center and is currently implemented at Harborview Medical Center in Seattle. CPAA will perform outreach to the behavioral health organizations (BHR, Great Rivers, SeaMar, Valley View), and the inpatient and outpatient chemical dependency treatment programs. CPAA will ask each to identify a nurse experienced in the care of patients with opioid addiction and to contract with an experienced physician recruited from the consortium to provide prescriptions and oversight. The nurses will be trained to maintain a standard of clinical practice that satisfies federal buprenorphine regulations. The nurses' clinical responsibilities will include assessing appropriateness of office-based opioid treatment (OBOT), educating patients, obtaining informed consent, developing treatment plans, overseeing medication management, referrals, monitoring for treatment adherence, and communication with prescribing physicians, addiction counselors, and pharmacists. Collaboration with

		pharmacists reduces OBOT physician burden by allowing buprenorphine prescriptions with multiple refills while allowing for cancelation of the refills if the patient is non-adherent. 3) Low-barrier buprenorphine clinic to increase MAT access for the large number of opioid-addicted individuals who have severe mental health or behavioral issues. This clinic is intended for patients who are unable to meet the reliable attendance requirements of an OTP or OBOT program. Similar to the Integrated Buprenorphine Intervention Services (IBIS) Centers in San Francisco, and the recently established and highly successful buprenorphine Pathways program at the 4th Avenue Seattle/King County Public Health Center in Seattle, the clinic can provide a buprenorphine prescription pre-authorized by a waivered provider for 4-7 days to individuals who request it on a drop-in basis. The clinic will be co-located with behavioral health services, either at a medical clinic, chemical dependency treatment program, OTP, or behavioral health center, providing an entry point to comprehensive services for individuals seeking help. A collective agreement will be established with a local pharmacy or a small on-site pharmacy. 4) Information exchange network to facilitate functioning of a Hub and Spokes network with referrals and sharing of care plans among hospitals, clinics, behavioral health organizations, chemical dependency programs, social services, community service programs, jails, and law enforcement. This will be implemented using a CPAA data system shared with other projects. An important limitation to data sharing is a federal regulation (CFR 42 Part 2) requiring a higher level of protection of information about substance use disorder compared to other medical conditions. 5) Hospital initiation of buprenorphine in ED and for inpatients. CPAA will perform outreach to hospital leadership to educate them on the community benefits of initiating MAT for inpatients and ED visitors with an OUD prior to discharge. Waiver training of the ED providers and hospitalists will be encouraged. Several hospitalists at Providence St. Peter were recently trained in buprenorphine prescribing but have not yet started prescribing. The main barrier has been a shortage of community prescribers to take over prescribing after hospital discharge. The planned buprenorphine provider training, peer support network, nurse care managers, and low-barrier buprenorphine clinic will ultimately remove this barrier. 6) MAT for the incarcerated. This is a high priority target population because of the high rate of opioid use disorder and the serious consequences of leaving the disease untreated, including an extremely high risk of overdose death immediately following release. The nurse care manager model will be used to establish collaboration between experienced buprenorphine prescribers from the consortium who will provide

		oversight and jail personnel who will administer medications according to a protocol. Coordination with the Hub and Spokes network will improve treatment during transitions of care between the community and periods of incarceration. 7) Other implementation strategies include: a) Syringe exchange enhancement, meaning colocation of services. NONE of these funds will be used to pay for syringes. b) Training professionals (medical, behavioral, and chemical dependency) and the general public on topics including stigma of OUD, MAT, social contributors to OUD, trauma-informed care, and principles of harm reduction c) Increasing use of PMP by primary care providers d) Supplying first responders with naloxone and training them to use it. This process has been initiated in the region with the Lacey police. Mason County recently received a $300,000 grant to address the opioid epidemic, and they have hired an outreach worker; they are interested in increasing access to naloxone for overdose reversal beyond law enforcement into the IDU population. Cowlitz County also received a grant from the SAMHSA STR funding As detailed below, the program manager will utilize regular reports from providers and periodic meetings with partnering providers to monitor partnering provider performance. The program manager is also responsible for ascertaining partnering providers' training and technical assistance needs, which are expected to surface through provider reports and regular meetings with providers, and to arrange for necessary trainings and technical assistance. Special emphasis will be placed on making sure care team members have access to shared care plans. We anticipate establishing effective bi-directional communication strategies and systems will be a major emphasis of this project. This includes establishing functioning care plan exchange capabilities with community-based social service agencies that play a key role in effective. In monitoring the performance of partnering providers, we will use a combination of quantitative information provided by partnering providers through monthly reports (provider specific project metrics and milestones will be negotiated and contractually agreed upon) and qualitative data gathered through regular check-ins with partnering providers by the project manager as well as quarterly provider peer learning meetings. With the help of the CPAA finance committee a performance-based compensation system will be developed and implemented for all projects by the end of DY3, Q4.
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	By DY3, Q4, a further review of all the available interventions by the Opioid Response Work Group will determine which additional strategies to date will best meet the local needs of the CPAA region, with emphasis on addressing the identified gaps to providing an integrated program to address the opioid crisis, which include:

		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) 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 3) A shortage of chemical dependency professionals, particularly those educated about MAT 4) Lack of communication, coordination, and digital information exchange among service providers 5) 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 6) Homelessness or a transitory living situation among many individuals with OUD Addressing these gaps will require developing an improved communication, coordination, and digital information exchange among providers; training medical professionals in buprenorphine prescribing, cultural competency, harm reduction, and trauma-informed care; establishing a peer support network; utilizing nurse care managers and all professionals working at the top of their clinical licensing; establishing low-barrier buprenorphine clinic(s) to increase MAT access, hospital initiation of buprenorphine in ED and for inpatients, and MAT for incarcerated populations; and syringe exchange program enhancement. .
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, structures, and capabilities to address other yet-to-emerge public health challenges	DY 4, Q4	By the end of DY4, in keeping with our overall project approach, we will initially focus our interventions by working with implementation partners that serve large numbers of Medicaid beneficiaries in our region for the specified target population(s) and sub-region. As these core partners experience implementation success, CPAA will be able to build out the project to include progressively more partners, including partners that serve smaller numbers of Medicaid beneficiaries and additional community-based organizations that can augment the reach and scale of the project. In determining these additional implementation partners, CPAA will use its current state analysis with appropriate updates as well as the data provided by CORE assessing the relative attribution of potential implementation partners. Implementation information from our initial set of partnering providers (documented through performance reports and our peer learning collaborative) will be made available to new implementation partners to leverage existing implementation experience and guide new partners in project planning and implementation. Emphasis will be placed first on

		expanding OUD improvements to prioritized target populations from sub-regions to the entire region and then to serving additional high-risk populations. CPAA will work across disciplines to address social determinants of health that often lead to illicit SUD (i.e. ACEs), prescribing practices through the 6 Building Blocks, working with MAT prescribers, and SUD providers to create a Hub and Spoke model throughout the region, and with social service providers to create a network of recovery support services. The Opioid Response Work Group will have a key role in guiding the increase in scope and scale of the project. .
Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas.	DY 4, Q4	At the end of DY4, working with HCA, Qualis Health, and self-reported data, CPAA will review data collected from Y1-4. CPAA will track trends reported by direct service providers, i.e. syringe exchange programs, and develop standardized approaches for collecting this data in order to incorporate critical information into the data landscape, tracking trends in a consistent way that can intersect with the larger EHR systems already in place. Building on what we've discovered, the Opioid Response Program Manager and Work Group will identify gaps in opioid response reach and respond in a meaningful way. The Work Group, in collaboration with providing partners, the Clinical Advisory Group, and the Consumer Advisory Committee, will discuss strategies for more targeted outreach, increased capacity, and improved approaches for dealing with OUD throughout the region as outlined above.
Convene and support platforms to facilitate shared learning and exchange of best practices and results to date.	DY 4, Q4	Throughout the Transformation, CPAA will continue to provide opportunities for shared learning across disciplines. We will design and implement training that incorporates trauma informed care, ACEs prevention and mitigation, bias recognition, and how to transform care delivery systems so that they are meeting people where they are and moving them along the continuum towards better health outcomes. These shared learnings will be available for all CPAA providing partners, work groups, council, and board.
Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches.	DY 4, Q4	By DY4, CPPAA will have identified ongoing support and training essential to achieving continuation and expansion of the Opioid Response project. CPAA will use quarterly gatherings of its implementation partners (peer learning collaborative) to determine specific ongoing support needs as well as feedback from individual implementation partners. We anticipate that ongoing support needs will change in later years of the Transformation Project, emphasizing sustainability and shared learning. Thus, working even more closely with our MCO partners to establish new payment mechanisms that will fund opioid response improvements for the long term and providing opportunities for our implementation partners to learn with and from each other, as our region scales up the Transformation Project's scope and reach, will be essential. In providing these supports, CPAA will work with other ACHs' Opioid Response to the greatest extent possible in order to increase the spread of the project and maximize resource efficiencies through economies of

		scale (e.g., through shared training costs or technical assistance, partnering with the State and other ACH's).