

SECTION II: PROJECT-LEVEL: Addressing the Opioid Use Public Health Crisis

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Project Selection & Expected Outcomes

Abstract

The Cascade Pacific Action Alliance (CPAA) region has not been spared from the opioid epidemic plaguing America. An increased number of legal opioid prescriptions combined with illegal drug use is overwhelming the region’s health care, social services, and law enforcement systems. This project builds on our successes and creates new opportunities to improve the lives of people experiencing Opioid Use Disorder (OUD) and the communities in which they live. Through this project, we will decrease the number of opioid overdose deaths by increasing access to naloxone, and improve the systems of care for people experiencing OUD, so that they can stabilize their physical health and address the underlying causes of their drug use. This will be achieved by increasing access to evidence-based therapies delivered in a cohesive system by providers that understand the role of trauma in Substance Use Disorder (SUD). Training will reduce stigma and judgement with the goal of “meeting the patients where they are” in the cycle of behavior change. The project will create pathways to engage people with OUD with supports, to help them maintain their recovery, and to improve their lives and the communities in which they live.

Project Description and Justification

Justification for Selecting Project and How It Addresses Regional Priorities

The CPAA region is significantly affected by the opioid epidemic and the resulting health and social impacts. Approximately 11% of all Medicaid opioid users in the state live within the region, higher than the region’s 9% share of statewide Medicaid beneficiaries. Six of the seven counties in our region have an opioid prescription rate higher than the statewide average, and many of the opioid prescription rates in the region’s rural counties are significantly higher than those in the most urban county in the state¹. For example, Wahkiakum County has 906.2 opioid prescriptions documented per 1,000 residents compared to King County’s 636 opioid prescriptions per 1,000 residents. The high number of prescription opioids does not account for the number of illicit opioids in the CPAA region. According to law enforcement evidence reports, the number of illicit opioids has significantly increased over the last

¹ DOH, W. S. (2017). *Prescription Monitoring Program County Profiles CY 2014*. Tumwater, WA: Washington State Department of Health.

ten years². Another indicator of the large scale of the opioid epidemic in the region is the number of overdoses and the number of overdose deaths due to opioids. In 2016, there were 694 opioid related deaths in Washington; 435 from prescription opioids, 287 from heroin, and 87 from synthetic opioid overdose³. Cowlitz county has the highest death rate, with a rate of 13.6 per 100,000, exceeding the Washington state average³. These high rates of access to, use of, and impacts of OUD are compounded by low treatment rates reflected in regional data: only approximately 7% of CPAA's Medicaid members with a diagnosis history of opioid abuse or dependence received medication assisted treatment with buprenorphine, and approximately 17% with methadone.

The opioid epidemic has strained social services and contributed to workforce reduction. OUD throughout CPAA has the greatest impact on people under the age 39,^{4,5} which coincides with the more productive, working years of a person's life. The progression of this crisis over the last ten years has severely impacted the workforce due to reduction in engagement with education and work programs. An anecdotal example that demonstrates larger economic issues and the cascading detrimental effects of OUD throughout our region is the port in Cowlitz County having difficulty hiring employees who can pass a mandatory drug test.

Addressing the opioid crisis, and the urgent need of a more effective regional opioid response, was identified as a regional need when CPAA conducted its regional health needs assessment. The regional health needs assessment led to the establishment of five priority shared regional health needs: improving healthcare access (provider capacity), improving care coordination and integration, mitigating adverse childhood experiences, preventing and managing chronic disease, and enhancing educational and economic opportunities. While there is overlap between these five priorities and the Opioid Response project, there are three notable key areas for alignment:

1. **Improving Healthcare Access:** Increase the co-location of services directly engaged with drug users (i.e. syringe exchange) with healthcare and other services currently not well connected with opiate users. Primary Care Providers (PCP) can increase harm reduction approaches with prevention and treatment of communicable diseases and address other health issues that disproportionately impact injection drug users (i.e. skin infections and communicable disease exposure).
2. **Improving Care Coordination and Integration:** Opioid users are generally difficult to treat within the current fragmented care system. The Transformation is a unique opportunity to address these challenges and relieve the costly burden of ineffective, uncoordinated health care while improving health outcomes for individuals and communities.
3. **Mitigating Adverse Childhood Experiences (ACEs):** Addressing the opioid crisis will prevent ACEs from impacting future generations. Parents experiencing OUD can potentially expose their children to a wide variety of trauma, including overdose and death. Educating providers to focus on prescribing practices post-partum, naloxone distribution to reverse opioid overdoses, increased access to syringe exchange to prevent the spread of communicable disease, and increased access to Medication Assisted Treatment (MAT) are specific areas of opportunity to reduce ACEs and have a positive impact on Maternal and Child Health.

² WSP, F. L. (2017, October 24). Emerging Drug Trends. Olympia, WA, USA.

³ Washington Department of Health (2017). Opioid-related Overdose Deaths. Accessed:

<https://www.doh.wa.gov/Portals/1/Documents/Pubs/346-083-SummaryOpioidOverdoseData.pdf>

⁴ Green-Banta, C., & Kingston, S. (2016). *Results from the 2015 Washington State Drug Injector Health Survey*. Seattle: University of Washington.

⁵ Lamont, M. (2016, April 27). Harm Reduction and Syringe Exchange in Our Region. Olympia, WA, USA: Thurston County Syringe Exchange Program.

How the Project Will Support Sustainable Health Systems Transformation for the Target Population

The Opioid Response Medicaid Transformation Project will support sustainable health system transformation for the chosen target population/s by assisting providers to adopt a whole-person approach to care that is patient-centered and focused on providing accountable care. This will require changes in partnering providers' workflow, business practices, and staffing patterns to support team-based care, treatment to target, and population-based care. Investments in this project will be supported by the other projects that CPAA is implementing, including Bi-Directional Care Integration, Community Care Coordination (Pathways HUB), and Maternal and Child Health. The project metrics and populations targeted by these other initiatives overlap those served under this project, and many of their strategies will support success in this initiative as well. CPAA anticipates interventions and resources developed in this project, i.e. regionally organized prevention efforts and increasing access to care, also will be shared across other projects, therefore benefiting target populations in multiple project areas. Once these investments have been made, they will become permanent, as the care systems have become permanently reoriented to these new norms and standard processes and procedures.

CPAA and its administrative partner, CHOICE Regional Health Network, have a proven track record transitioning pilot projects to ongoing programs in the region. CHOICE has accomplished this by demonstrating effectiveness and cost-effectiveness to participating funders, who then have maintained funding for these efforts on a continuing basis. CPAA will apply this approach to assure sustainability of the opioid response project post Transformation.

How CPAA Will Ensure Project Coordinates With and Does Not Duplicate Existing Efforts

CPAA and CHOICE have worked closely with the community for over 20 years and are thus familiar with both health care needs, and existing services provided in the region. CPAA's governance and advisory structure bring to the table a wide-range of service providers, stakeholders, and organizational leaders in the CPAA region, including the two Behavioral Health Organizations and all five Managed Care Organizations that serve Medicaid beneficiaries. This broad range of partner representation already in place throughout the CPAA structure enables us to hear real-time concerns about health issues, including implementation of opioid response.

Improving opioid response vitally depends on establishing a coordinated approach across currently fragmented care systems. CPAA is taking great care to build upon our region's collective work to ensure the Opioid Response project does not duplicate existing efforts and capacity. One way we are accomplishing this is through the establishment and support of the Opioid Response Work Group, composed of individuals experienced working with the region's population most affected by the opioid crisis. The work group has helped to develop this application. Furthermore, one of the first implementation steps in this project area will be a thorough assessment of our partnering providers' existing care systems and capabilities relating to care coordination and opioid response services. Aggregating CHOICE's healthcare improvement work over the last two decades, we can build on inventories performed over the past few years and our deep knowledge of existing care capabilities in our region. With a broad range of partner relationships across the region solidly in place, we anticipate we will be able to complete this analysis quickly.

CPAA began taking stock of project areas in which partnering providers are planning to implement

interventions by opening a Request for Qualifications (RFQ) process that prompted providers to describe new project ideas, how new projects will avoid duplicating efforts, and which partners are working in collaboration. It has been well-communicated through project work groups and correspondence with partners that Transformation funding can only be used for new projects and/or enhancing current projects. To date, we have received 38 RFQ responses of which nine relate to the Opioid Response Project. (see Appendix XXX).

Additionally, CPAA conducted a landscape analysis of major Medicaid providers and payers, as well as public health departments in the region (see Appendix XXX). For providers, this includes dental, primary care, FQHCs, hospitals, and major health systems. The purpose of this assessment is to better understand who the major stakeholders are in the CPAA region, who is already engaged in Transformation projects, and who CPAA still needs to engage in the Transformation work. During a review of this tool by the CPAA Council and Opioid Response Work Group, a number of key providers were identified that needed to be added to the list. To populate this tool, we used Provider data supplied by the HCA and included providers who collectively served approximately 90% of Medicaid beneficiaries in 2016. By analyzing the provider landscape, CPAA is able to facilitate new partnerships between providers, keep track of individual provider initiatives, and create new tools to monitor existing project efforts. CPAA is well positioned to develop oversight, monitoring, and continuous quality improvement (CQI) mechanisms to assure timely implementation of project interventions, and promote fidelity to evidence-based practices that do not duplicate efforts.

Anticipated Project Scope

Anticipated Target Population

The Medicaid Transformation Toolkit identifies the following target population for opioid response: Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.

Based on our analysis of the relevant date for our region and the work to date of the Opioid Response project work group (which includes providers with extensive experience in the field), CPAA has identified the following (unranked) list of potential target populations in this project area:

- 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

We will refine the specific target population(s) for this project during implementation planning. This will include an assessment of target populations identified in *other* project areas in an effort to align project interventions across our entire project portfolio to the greatest extent possible and achieve maximum synergies and impact. This will also include an analysis of sub-populations and sub-regions across project areas.

As we narrow our target population(s), the following additional information will be considered:

Intravenous Drug User (IDU) efforts will be targeted in the counties with syringe exchange programs: Cowlitz, Grays Harbor, and Thurston counties. Co-location of services is already occurring in Cowlitz County; the syringe exchange program is now located in the Federally Qualified Health Center (FQHC). This type of co-location, in a place where people already feel comfortable engaging in services, has proven a successful model in other parts of the country for addressing health needs and engagement in behavioral health resources. We anticipate the model will be pursued at the other syringe exchanges in our region as well. Jail populations may be targeted for MAT, communicable disease testing, and linkage to treatment.

To determine the estimated reach of the project, the following table with diagnosis rate in the region is helpful.

Table 3A-11 CPAA Diagnosis 2016 Rates

Diagnosis	CPAA Medicaid #	CPAA Medicaid Percentage
SUD only	5,484	3.65%
SUD + 1 chronic condition	4,763	3.17%
SUD + more than 1 chronic condition	10,585	7.04
All SUD (total)	20,832	13.86%
MH only	12,598	8.38%
MH + 1 chronic condition	10,731	7.14%
MH + more than 1 chronic condition	19,187	12.76%
All MH (total)	42,516	28.28%
SUD + MH only	2,179	1.45%
SUD + MH + 1 chronic condition	2,510	1.67%
SUD + MH + more than 1 chronic condition	7,422	4.94%
All SUD + MH (total)	12,111	8.06%

Health Care Authority Category 1 Behavioral Health and Chronic Conditions, 2016

The table above suggests the maximum target population reach for evidence-based treatment is 5,484 Medicaid beneficiaries based on those currently diagnosed with a Substance Use Disorder. This population will need to be further refined to determine specific diagnosis and the patient’s motivation for treatment. Effective prevention and identification programs will identify additional individuals who have not yet been diagnosed.

For opioid users, we believe that PRISM, or a similar tool, will enable CPAA to identify individuals with profiles indicating risk for opioid usage, i.e., Medicaid beneficiaries with local incarcerations and multiple ED visits for wound care or exposure to Hepatitis C. This will help focus our resources more effectively in such a broad geographical area, pinpointing where to target resources to engage people and efficiently coordinate their care. The outcomes we hope to achieve are increased engagement in health care, testing and treatment for any communicable diseases, referral into treatment for those who are ready, and decreased usage of the ED.

Involvement of Partnering Providers

CPAA has established a work group comprised of key providers and other stakeholders from throughout the region to plan and develop the Opioid Response project. For a list of work group members see [xxx]. The work group came together in recognition of the fact they are all invested in improving the region’s opioid response and they play a critical role in contributing to evidenced-based approaches.

In addition, CPAA has conducted two efforts to identify potential partnering providers: 1) a Request for

Qualifications (RFQ) was issued in August 2017 to identify and engage partnering providers; and 2) an analysis was conducted by CORE to identify the key providers serving collectively 90% of Medicaid clients in the region in 2016.

The analysis of main Medicaid providers in the CPAA region is now being used to systematically approach and engage key Medicaid providers that serve large numbers of Medicaid beneficiaries but have not yet responded to the RFQ. As CPAA finalizes the selection of specific target populations, we will further refine this analytical tool to identify those key Medicaid providers that serve our prioritized project target populations, especially those in prioritized sub-regions.

CPAA is keenly aware that we need to engage the right providers in order to meet our region's transformation goals. Clearly, this includes the main Medicaid providers in our region; however, this also includes key social services providers such as public health, homeless outreach, and housing services that are essential for successful opioid response improvements. While our initial analyses and outreach focused on medical and behavioral health providers, we are now reaching out to business associations such as the Olympia Downtown Association, criminal justice partners, and training programs to include Economic Support Group of YWCA and Washington State Peer Counselor Programs. The opioid epidemic is many faceted and impacts people from all walks of life. Involving these diverse partners will help standardize the care people are given in settings outside of hospitals and create systems of support for people early on in their recovery. During the project planning phase, CPAA will expand this outreach to partnering providers to include these and other service agencies, and we will make explicit connections to other Transformation project areas, such as community-based care coordination, bi-directional care integration, and maternal and child health.

CPAA will continue to meet with providers, both one-on-one and during work group meetings, to develop their project ideas and align them with the project fundamentals. Nine organizations proposed projects, with many of the projects covering more than one project area. Note that while the proposals represent preliminary ideas for consideration during the planning year, CPAA has made no commitments to support any particular proposal at this time.

Level of Impact

Opioid response needs improvement across the CPAA's seven-county region. Thus, the level of impact of this project is necessarily regional. This region-wide impact is supported by the fact that the project is part of a synergistic project portfolio that CPAA is developing to achieve transformative health systems change across the entire seven-county area.

Additionally, our analysis of available data points to certain geographic sub-regions requiring heightened attention. The region has a particular area devastated by OUD, located in the southwest corner of Thurston County and the Northwest corner of Lewis County. This geographic area has especially poor health outcomes, due in part to high numbers of OUD and other social determinants of health. Pacific and Wahkiakum counties, both rural areas highly saturated with opioid prescriptions and limited access to services, also stand out as geographic sub-regions requiring focused efforts. Thus, we anticipate that special emphasis will be placed on targeting our interventions at these geographic areas, while ensuring the project is implemented across the region.

Similarly, our ongoing analysis of potential target populations for this project leads us to specific communities within our region where members of the prioritized target population reside in larger

numbers. According to the Washington State Department of Health’s CHARS reporting system, in 2016,⁶ the region covered by CPAA paid nearly \$17 million dollars for hospitalizations for poisoning and toxic effects of drugs, and three of our area’s hospitals handled 90% of those cases: Providence St Peters (Thurston County), Peace Health St. John (Cowlitz County), and Providence Centralia (Lewis County). An analysis of the demographic make-up of these patients may lead to the identification of additional sub-populations and sub-areas in the region. We are waiting for data from the University of Washington identifying where injection drug users are living in the CPAA region. As this additional information becomes available, we will be able to narrow our target population(s) accordingly.

How CPAA Will Ensure Health Equity is Addressed in the Project Design

As per the discussion above, our data analysis points us toward certain target populations and geographic focus areas in the opioid response project. After reviewing the data, our work group explicitly considered health equity as a guiding principle, in keeping with the CPAA’s broader values. Specifically, the identification of potential target groups in this project area was guided by an analysis of mortality data by census tracts as a proxy measure for health disparities.⁷ The Opioid Response Work Group carefully considered this information by overlaying mortality data with other health statistics, which led to the identification of the preliminary target populations mentioned above.

A key aspect of an equity approach with this project is addressing the role of stigma as one of the greatest barriers when addressing SUD or the health and social issues associated with opioid use in order to achieve recovery.^{8,9} CPAA seeks to transform how intervention, treatment, and support is provided to patients by introducing training opportunities such as *Intercultural Foundations*, an ongoing program to help transform the way practitioners interact with the people seeking services. It focuses on bias training, so practitioners can recognize how their bias impacts the care they are giving.

CPAA is engaging consumers in our region to help with the identification and selection of the correct target population/s for this and other project areas. In late October, the CPAA began to vet the work of the Opioid Response Work Group through a conversation with consumers from throughout the seven-county region coming together within the CPAA Consumer Advisory Committee. This will continue in the coming weeks and months as we work with this committee more closely and seek to engage consumers in the project implementation planning through surveys and community meetings.

We are also consulting with our Tribal partners, some of whom have been involved in our work groups, to ensure that health equity is thoroughly considered in our project planning and implementation. For instance, we recently met with the health director of the Nisqually Indian Tribe to learn about the Tribe’s greatest health needs. As a result of these ongoing consultations, the list of priority target populations and interventions may change, reflecting more fully health equity considerations.

Finally, in keeping with CPAA’s commitment to adopt a health equity lens in our planning and implementation of our project portfolio, we are equipping our project partners with information and practical tools to ensure health equity considerations are at the forefront of our regional health improvement. For instance, we have used a monthly shared learning session at CPAA Council meetings to conduct health equity trainings, and we are developing a decision-making aid that our council, board,

⁶ (DOH W. , 2017)

⁷ In our view, elevated mortality is to be interpreted as the ultimate result of a host of health disparities experienced by sub-populations in a given geographic area.

⁸ Harnish, S. (2015). *Is There an Unmet need for Wound Care for people Who Inject Drugs in Thurston County?* Olympia: Evergreen State College (unpublished).

⁹ Green-Banta, C., & Kingston, S. (2016). *Results from the 2015 Washington State Drug Injector Health Survey*. Seattle: University of Washington.

and work groups will use to formally integrate health equity consideration into their decision-making.

Project's Lasting Impacts and Benefits to the Region's Overall Medicaid Population

The investments in this project area will generate lasting impacts in many ways:

1. **Reducing Stigma:** Expanding Medically Assisted Treatment and Harm Reduction Programs will have lasting practice transformation effects, which may help reduce stigma.
2. **Workforce:** We anticipate making targeted investments in the workforce of our region as part of this project. This will include training partnering provider personnel in evidence-based strategies, such as Medical Assisted Treatment, integration of services, and harm reduction. Once partnering providers are trained, the expertise gained, and the capacity built through these trainings will be available indefinitely as a resource to our partnering providers and region.
3. **Changes at the Practice Level:** Similarly, we anticipate our partnering providers will make structural changes in their business practices, staffing configurations, and workflows to conform to the evidence-based models and strategies associated with the chosen interventions. Once these changes have been made, they will be “hard-coded” into the service delivery infrastructure (processes and procedures) and provide lasting benefits beyond the Transformation project period. For instance, through this project, we anticipate educating providers on standard prescribing practices and alternative pain control will reduce opioid prescription rates that can later lead to abuse or dependence.
4. **Health System Infrastructure:** This project includes targeted investments in the ability of our partnering providers to communicate with each other and exchange relevant patient information. The exact nature of these investments will be determined during implementation planning and will, in part, depend on investments the state is going to make in Health Information Exchange systems. Regardless, once these infrastructure investments have been made, they will provide benefits into perpetuity for our region to improve transitions of care specifically and care coordination in general.
5. **Partnerships:** Through this project, partnering providers will learn what community resources and services are available in the region to which they can turn and refer patients in need of social supports and other wrap-around services. Once awareness about available community resources has been raised and interagency relationships have been established, these essential community-clinical linkages will be permanent and provide lasting benefits.
6. **Standardizing care:** Through this project, providers will be trained on prescribing approaches with the adoption of a set of standards throughout the region and encouraged to enroll into the Prescription Monitoring Program (PMP). Implementing the PMP will help reduce the number of prescribed opioids, and improved screening in PCP settings and co-location of services will engage people who use opioids and encourage them to begin treatment. This will lead to improved quality of life by interrupting unhealthy use of opioids and injection drug use behaviors which also carry added health risk, i.e. blood clots, communicable diseases, and soft tissue infections. Naloxone distribution saves lives and healthcare dollars by reducing hospital admissions and preventing complications. Monitoring data to track trends will enable services to be responsive to the needs of each community.
7. **VBP:** In part, the permanence of the transformation of partnering providers' infrastructures, systems, and behaviors depends on sustainable payment mechanisms that carry this change into the future beyond the Medicaid Transformation Project. The state's commitment to changing its healthcare purchasing from fee-for-service to value-base care will be a major supporting strategy for sustaining CPAA's investments in a transformed healthcare delivery system through the investment

areas outlined above.

In sum, a number of mutually reinforcing mechanisms will ensure the benefits of our investments in improved opioid response will not be limited to the five-year Medicaid Transformation performance period.

While our investments in this project area will be targeted at specific target populations as a subset of Medicaid beneficiaries, the workforce trained, the workflows established, the infrastructure built, the partner relations established, the financing mechanisms put into place, and the overall synergies harnessed are not exclusive to these prioritized populations. Rather, they will benefit all populations, including the entire Medicaid population.

Implementation Approach and Timing (Supplemental Workbook Tabs)

See 3A Implementation Approach tab in ACH Project Plan Supplemental Data Workbook for a brief description of how CPAA will accomplish each set of project milestones in State 1, Stage 2, and Stage 3.

Partnering Providers (500 words + Supplemental Workbook Tabs)

[How CPAA Has Included Partnering Providers That Collectively Serve a Significant Portion of the Medicaid Population](#)

CPAA is well positioned to bring major partnering providers in the region together to create collective impact. A principal asset in this engagement process is the well-established provider relationships CHOICE has cultivated over the last two decades; many key Medicaid providers are members of CHOICE, including two of the region's three Federally Qualified Health Centers (Valley View Health Center and Sea Mar) and all of the region's hospitals in five of the seven counties covered by CPAA, including our largest tertiary hospital, Providence St. Peter Hospital. From the beginning, CPAA has included a broad range of providers in its work across our seven-county region, including providers that collectively serve a significant portion of the Medicaid population.

With the help of CORE, we have identified key providers serving collectively 90% of Medicaid clients and partners in the CPAA region. The following key Medicaid providers in our region have participated consistently in the planning for the Opioid Response project: Behavioral Health Resources, Child and Family Health Center in Cowlitz County, Evergreen Treatment Resources, Great Rivers BHO, Providence St. Peter's Family Practice and Chemical Dependency Treatment Center, Public Health, Sea Mar, and Thurston-Mason BHO.

Additionally, the following key Medicaid providers in our region have responded to date with a project proposal in response to the CPAA's Request for Qualifications (RFQ) that was issued over the summer: Arcora, Child and Adolescent Clinic, Cowlitz Family Health Clinic, and the Crisis Clinic (Appendix XXX).

[Process for Ensuring Partnering Providers Commit to Serving the Medicaid Population](#)

As previously mentioned, CPAA began taking stock of project areas in which partnering providers are planning to implement interventions by opening a Request for Qualifications (RFQ) process that prompted providers to describe the target population and estimated number of Medicaid lives served. Partnering providers for this project have a track record of serving Medicaid beneficiaries in the region.

Although the opioid crisis impacts all income levels, low-income communities are especially affected, and Medicaid beneficiaries will be the focus of this project. We will secure formal commitments from our partnering providers to implement the evidence-based approaches outlined in the project toolkit that include a commitment to serve specific Medicaid populations. These commitments will be made in the form of contracts with partnering providers that specify the specific scope of work for each implementation partner, reporting requirements, and payment arrangements. CPAA will monitor these commitments by tracking progress on project implementation and outcomes for performance metrics per agreed upon contracts with partnering providers.

We are confident this systematic, personalized, and multi-pronged approach will build on well-established partnerships in our region and result in the successful engagement of key Medicaid providers in our region as well as a broad range of social service agencies that are essential for successful opioid response.

Process for Engaging Partnering Providers That are Critical to the Project's Success, and Ensuring a Broad Spectrum of Care and Related Social Services are Represented

CPAA engages key partnering providers in the Transformation in various ways. A number of key implementation partners serve on our project work groups. Work groups consist of individuals from partnering organizations, including large and small, urban and rural clinical providers that encompass behavioral health and primary care, social services, community-based organizations, MCOs, and public health departments.

We are now systematically reaching out to key Medicaid providers who have neither participated in the project planning so far, nor responded to the RFQ to ensure that they are aware of this project and engage in the project planning and implementation going forward. In instances where engagement from missing key Medicaid providers should prove challenging, we will ask our Provider Champions, clinicians who have agreed to assume a leadership role in liaising with our provider community, to reach out to their peers at these key Medicaid provider organizations to begin the engagement process. We will follow up with in-person visits to explain the project and answer any questions the targeted key providers may have.

Concurrently, we are conducting an analysis of missing prevention and treatment organizations that are essential to successful project planning and implementation. To date, the following agencies have participated in project planning: Behavioral Health Resources, Child and Family Health Center in Cowlitz County, Evergreen Treatment Resources, Great Rivers BHO, Providence St. Peter's Family Practice and Chemical Dependency Treatment Center, Public Health, Sea Mar, and Thurston-Mason BHO.

In our outreach to missing social service providers, we can again draw on the CHOICE membership network, which includes five of the seven local health jurisdictions in the CPAA region (public health and social/human services departments at the county level). Given the well-established relationships we have been able to forge with these critical partners in the opioid response improvement process, CPAA is highly confident that we will be able to engage any missing social service partners successfully.

How CPAA is Leveraging MCO's Expertise in Project Implementation, and Ensuring There is No Duplication

MCOs have been active participants in the all work groups, the Clinical Advisory Committee, and the CPAA Council and Board of Directors. MCO representatives have contributed to the identification of

regional health priorities, have provided input into the project planning process, and will continue to be key partners throughout Transformation implementation. CPAA encourages MCO representatives to share developments in their organizations regarding VBP strategies, moving to fully integrated managed care, and any additional guidance for working with providers at the clinical level on integrated care.

MCOs are critical to the success of this project, as we need to ensure payment mechanisms are aligned with and support our project interventions. In the case of opioid care, multiple MCOs are engaged in the CPAA's project planning to date, most actively CHPW and Molina Healthcare. However, all five MCOs that serve our region have participated in the CHOICE-led regional health improvement work over the years and, moving forward, we anticipate that the MCOs will play an active role in the Medicaid Transformation project planning and implementation. This will ensure there is good coordination between payers, their expertise is leveraged, and duplication will be avoided.

Appendix TK lists MCO representatives and the organizations they represent.

Regional Assets, Anticipated Challenges and Proposed Solutions (1,000 words)

[Assets the CPAA and Regional Partnering Providers Will Bring to the Project](#)

One of the principal assets CPAA brings to this project is CHOICE's broad and well-established network of positive, collegial relationships with clinical providers, community-based organizations, and health plans developed over more than two decades of community-led health improvement and collective action. In its project planning and implementation, CPAA can readily build on this strong, trusting foundation.

Regarding opioid response, our region can leverage other assets, too, thanks to CPAA's collaborative work. The following assets have been identified by the Opioid Response Work Group to date in the form of existing service providers in the CPAA region:

- 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)
- Numerous primary care offices and clinics
- Four short or long-term inpatient chemical dependency programs (Harbor Crest, NW Indian Treatment Center, Cowlitz Family Health Center, and Providence Centralia)
- One licensed Opioid Treatment Program (OTP) (Evergreen Treatment Services)
- Numerous outpatient chemical dependency treatment programs
- Six multi-site behavioral health care organizations (Behavioral Health Resources, Great Rivers BHO, SeaMar, Thurston-Mason BHO, Cowlitz Family Health Center, and Valley View)
- Numerous small behavioral health care provider groups and skilled professionals (psychologists, psychiatrists, counselors, mental health workers, and social workers)
- Three syringe exchange programs in Thurston, Cowlitz and Grays Harbor counties.
- 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.
- Professional associations (Physicians of Southwest Washington and local chapters of Washington Academy of Family Physicians, Washington State Medical Association, and Washington Association of Nurse Practitioners)
- Community service programs (Housing Opportunities of SW WA, Lower Columbia Community

Action Program, Youth and Family Link, the Family Support Center, Crisis Clinic, Thurston County Together, Community Youth Services)

- Non-profit organizations (e.g. churches, Catholic Community Services, homeless shelters, food banks, Sidewalk Homeless Services, Union Gospel Mission, Salvation Army, Safe Place, EGYHOP).
- Government agencies which currently or potentially could provide relevant services include:
- The seven County and 6 Tribal Health Departments (Skokomish, Squaxin Island, Nisqually, Chehalis, Shoalwater Bay, Cowlitz),
- First responders (police and fire departments),
- Schools
- County jails

We plan to augment this list of existing assets in the region with an online survey of key clinical and social service providers early during implementation planning.

Challenges to Improving Outcomes and Lowering Costs for Target Population and Strategy to Mitigate Risks and Overcome Barriers

There are many challenges and barriers to overcome in order to achieve the intended project outcomes. Broadly speaking, these fall into two categories: (1) general challenges and barriers, and (2) project-specific challenges and barriers.

General Challenges and Barriers

All Transformation projects require:

- **Data:** CCAA must have access to timely, accurate data to:
 - Identify/refine target populations, partnering providers, and interventions, and
 - Monitor the performance of our partnering providers under the Transformation to determine partner compensation, course correct if milestones and performance metrics are not being achieved, and conduct continuous quality improvement efforts.
- **Health Information Systems:** Our partnering providers must have the ability to exchange information about patients and care plans in order to avoid care gaps and duplication of services. Currently, there is no consistent standard and/or IT system for information sharing in our region, especially between providers that serve patients with multiple chronic illnesses and behavioral health conditions.
- **Workforce:** Our partnering providers must have access to the right workforce to implement the evidence-based interventions in the chosen project areas. This includes personnel with the right general professional qualifications, expertise and experience in the project area, and training in the specific methods and approaches of the chosen interventions. Ensuring ready access to this workforce is a major concern, especially in rural, under-resourced areas.
- **Finances:** Our partners need to be clear on:
 - Fund flows, i.e., they need to understand when, how and how much they will be paid to inform their decision-making about investments in the Transformation.
 - Financial sustainability, i.e., they need to understand what payment mechanisms are being developed to sustain their investments beyond the Transformation. The principal barrier in this arena is the fact that the vast majority of purchasing activities occur in other venues and are controlled by other parties. Most medical purchasing is conducted by MCOs, while behavioral health services are currently purchased under the rubric of

BHOs.

Project-Specific Challenges and Barriers

In addition to these general challenges and barriers, there are a number of project-specific challenges and barriers to overcome related to OUD behavior and stigma, resulting in a higher rate of morbidity and mortality at large and in the CPAA region. The following is a list of selected key challenges and barriers specific to opioid response:

- **Geography:** The 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.
- **Stigma:** This represents a primary barrier after geography. A survey conducted at Thurston County Syringe Exchange found the most common reason people waited to seek medical attention was they thought they would face discrimination from a practitioner. The same study also surveyed practitioners and found bias in their reported feelings about treating PWID with soft tissue infections¹⁰
- **Lack of Provider Capacity:**
 - Limited availability of MAT due to (a) only one Opioid Treatment Program in the region, 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 Thurston and Lewis Counties.
 - A shortage of chemical dependency professionals, particularly those educated about MAT and willing to encourage clients to use it.
 - Limited access to inpatient treatment for substance use disorder (SUD).
- **Lack of Communication,** coordination and digital information exchange among service providers.
- **Lack of Education** among the general population, professionals (medical, chemical dependency, and law enforcement), and families and individuals living with OUD, on the following topics: profound stigma about OUD, medication-assisted treatment (MAT) as the established evidence-based treatment for OUD, social contributors to OUD including socioeconomic disadvantage, physical, psychological and sexual trauma, adverse childhood experiences (ACE), trauma-informed care, and principles of harm reduction
- **Homelessness** or a transitory living situation among many individuals with OUD.

CPAA Strategy for Mitigating the Identified Risks and Overcoming Barriers

The following lists various mitigation strategies to address the identified challenges and barriers.

Barrier	Potential Solutions
Data	<ul style="list-style-type: none"> • Partner with CORE, state and providers to identify/refine target populations, partnering providers, and interventions (underway) • Partner with providers and MCOs to obtain close to real-time provider performance information; explore contracting with a third-party data aggregator with data analytics capabilities (underway).

¹⁰ Harnish, S. (2015). *Is There an Unmet need for Wound Care for people Who Inject Drugs in Thurston County?* Olympia: Evergreen State College (unpublished).

Barrier	Potential Solutions
Health Information Systems	<ul style="list-style-type: none"> Partner with state, MCOs, providers, and other ACHs in developing interoperability between health information systems; expedite planning for and implementation of clinical integration of behavioral health.
Workforce, Stigma, Lack of Education	<ul style="list-style-type: none"> Invest in training of partnering providers in evidence-based methods/models Train providers in harm reduction, trauma informed care, and implicit bias to reduce stigma. Increase number of PCP trained with MAT waivers and the use of telemedicine in primary care settings to create a hub and spoke model in more remote areas of the region Create mentorship program for newly waived buprenorphine providers to help them build their experience level working with this population. Student loan forgiveness or tuition reimbursement to address the shortage of chemical dependency professionals, particularly those educated about MAT Explore shared workforce options, e.g., through telehealth
Finances	<ul style="list-style-type: none"> Funds Flows: Work with CPAA Finance Committee to clarify funds flows (underway) Financial Sustainability: Work with payers (health plans and state) to support transition to value-based purchasing; state needs to adjust contracting w/ MCO who in turn modify provider payment approaches accordingly
Lack of Communication	<ul style="list-style-type: none"> See <i>Health Information Systems</i> above Encourage all providers in the CPAA to register in and use the PMP
Lack of Provider Capacity	<ul style="list-style-type: none"> Co-location of services with syringe exchanges. Most syringe exchange programs are trusted points of contact and access to care. Cohort of physicians who are willing to train providers on Buprenorphine waivers Partner with the Chemical Dependency Professional Program at Centralia College to implement classes on MAT and other evidence-based approaches Continue to identify referral sources for both in-patient and out-patient services

Monitoring and Continuous Improvement

Plan for Monitoring Project Implementation Progress, Including Addressing Delays in Implementation

To ensure oversight of partnering provider participation and performance, CPAA is using a rigorous project monitoring approach. The same approach will be employed across the entire portfolio of projects. This includes entering into contracts that clearly spell out partnering providers' responsibilities, including reporting requirements, and supports CPAA can offer as well as employing project planning software and tools to lay out required deadlines, key tasks, subordinate tasks, and milestones. Each project implementation plan will define critical paths

and key dependencies. Key indicators will be determined for each project area that will serve as an early warning system to detect when implementation challenges are encountered. A monthly performance dashboard report will compare actual performance of key indicators against targets within and across all project areas. This will allow the project managers as well as the CPAA Support Team, which includes the chairs of each project work group, to identify both implementation problems and early wins.

CPAA has hired dedicated support staff for each project area (program managers). It is the responsibility of the program managers to stay in close contact with all partnering providers in their respective project area. Specifically, the project managers are responsible for:

- Identifying support needs of partnering providers throughout the duration of the Transformation;
- Serving as subject matter experts for partnering providers or, if additional expertise is required, identify and facilitate external subject matter experts providing enhanced technical assistance to partnering providers; and
- Monitoring overall partnering provider performance toward milestones and performance metrics (see below for details).

Project implementation monitoring is closely tied to performance monitoring of partnering providers. The next section of the project plan discusses in detail how CPAA will monitor the performance of individual partnering providers. The data reporting and analytics tools used to hold individual partnering providers accountable to agreed upon deliverables will provide CPAA also with a clear sense about the project's overall implementation progress, as individual provider performance data rolls up into a region-wide performance summary. See next section for details.

[Plan for Monitoring Continuous Improvement, Supporting Partnering Providers and Determining Whether or Not the CPAA is on Track to Meet Expected Outcomes](#)

CPAA will set up a progressive implementation and performance monitoring structure with tiered interventions up to termination of partnering provider contracts. This will include regular meetings with our partnering providers to assess implementation progress and challenges. If project implementation progress becomes questionable or is delayed, the Opioid Response Program Manager will inform her immediate supervisor, the Clinical Director, of the concern. The senior project management team will assess the severity of the situation. When possible, we will seek to mitigate the risk or delay by providing technical assistance to help the partnering provider/s get back on track. This will include seeking advice from clinical experts, including Provider Champions serving on the CPAA Clinical Provider Advisory Committee. The partnering provider and CPAA will agree on an action plan (Performance Improvement Plan) to resolve the issue or renegotiate the contract deliverables, if necessary. In severe cases or if the technical assistance does not correct the problem, we will escalate the issue to our Clinical Provider Advisory Committee for a more comprehensive review. The committee may identify additional problem solution strategies, ask our Provider Champions to intervene, help access additional external technical assistance resources, or engage other key stakeholders in addition to affected providers to remedy the cause of delays. If the problem cannot be resolved, is of a major magnitude or involves key partners that serve large numbers of Medicaid beneficiaries, the CPAA Council and Board will be informed. The board will make the final decision about modifying or terminating contracts with partnering providers.

Access to timely and relevant data will be critical to our ability to monitor project implementation and

support continuous improvement. Measurement is an integral part of quality improvement. We will enter into a contract with each partnering provider that will detail the provider's responsibilities, including the nature and scope of investments to be made; implementation of the key components of each selected approach; adherence to project guidelines, policies, procedures, and protocols; the target population(s) and any geographic sub-regions on which the interventions will be focused; reporting requirements (milestones and outcome metrics as well as frequency of reports); participation in peer learning collaboratives and payment modalities.

Partnering providers will be required to submit performance information monthly. We are exploring utilizing the Washington Hospital Association's (WSHA) updated QBS business intelligence system to capture and analyze provider data that is not already reported through other systems. Our goal is to place minimal reporting burdens on our partnering providers while providing CPAA with an effective performance monitoring tool that provides us with timely performance data, so we can actively monitor and track partnering provider performance. QBS is easy to populate by our partners (including automated data uploads) and easy for us to analyze (inbuilt reporting tools, including comparison of actual achievement against goals, trend information over time, and comparative performance evaluation across providers). We plan to augment this information system through less frequent region-wide data reports on key regional performance measures, including claims-based data. The latter may require us to contract with a third-party data aggregator with sufficient data analytics capability to validate and augment the performance information reported by our providers through the QBS system.

CPAA will be using data from the above sources and analytical tools to issue regular reports to participating providers. These reports will serve two purposes: 1) inform providers on where to target their efforts; and 2) advise providers on progress toward meeting required objectives. First, for example, if a provider is working to reduce readmissions, CPAA will need to advise practices on clients with high hospital admission rates and clients with conditions that put them at high risk for readmission. This will enable provider practices to proactively engage these clients and provide care and patient education interventions to reduce the incidence of readmissions. Second, CPAA will need to report to provider practices their overall progress on meeting the required metrics for each project. For example, CPAA will need to monitor hospital utilization to determine readmission rates and will need to correctly associate individual clients with responsible practices. CPAA or its designated partner will provide regular reports (e.g., quarterly) to providers for this purpose.

As detailed above, when a provider or a group of practices is not making adequate progress on meeting key milestones and metrics, CPAA will reach out to the provider in question and develop a plan of action with the provider to remedy identified gaps or barriers. For example, CPAA and the provider might agree to additional workforce training to assure best practices are fully employed in working with the target population.

Additionally, CPAA will convene all partnering providers once per quarter to participate in a *peer learning collaborative*. Partnering providers will have the opportunity to share successes as well as to raise implementation challenges that the partners can then jointly resolve. Likely, these meetings will result in the identification of additional technical assistance needs of partnering providers, which CPAA will follow up accordingly. This learning collaborative will provide an important peer support function to our partnering providers and prove essential for the continuous improvement of our project.

Plan for Addressing Strategies That are Not Working or Not Achieving Outcomes

A similar approach will be used to assess overall progress of project initiatives and the efficacy of strategies within those initiatives. CPAA will use its quarterly performance reports, along with semi-annual reports provided by the state with key metrics, to determine whether the project initiative is on track and/or whether specific strategies within project areas are working as intended.

If the reports indicate that one or more strategies within the project area are not working, CPAA will convene key stakeholders to assess the reasons for the lack in effectiveness. This will include partnering providers, Provider Champions (Clinical Provider Advisory Committee), consumers (Consumer Advisory Committee), and subject matter experts (e.g., technical assistance providers). Based on this analysis, a recommendation will be made whether to continue the strategy in question with a revised approach, or whether to discontinue the strategy in favor of a different one. The decision to change the approach or pursue a different strategy altogether rests with the CPAA Board, based on discussion and recommendation by the CPAA Council. However, given their key implementation role, any decision to change elements of a strategy or switch out an entire strategy will require the consent of our partnering providers. It may also require the approval of the state. If the CPAA Board authorizes a different approach or strategy, the project implementation plan will be revised accordingly and CPAA will enter into a new or revised contract with partnering providers as the case may be.

Similarly, if the reports indicate an entire project initiative is not achieving desired outcomes, CPAA will convene partnering providers, Provider Champions (Clinical Provider Advisory Committee), consumers (Consumer Advisory Committee), and subject matter experts (e.g., technical assistance providers) to analyze why the initiative is not effective. Every effort will be made to explore whether adjusting program elements or switching out certain strategies may lead to goal accomplishment. This may include consulting with other ACHs that work in a similar project area and are achieving success.

If the group believes changes to the project initiative will rectify the performance problem, a corresponding recommendation will be made to the CPAA Council, which will then discuss the matter and make a recommendation to the CPAA Board. Final decision-making rests with the board. As with switching out a specific strategy or changing a project approach within a project area, any such change requires the consent of our partnering providers that will need to implement the revised set of strategies. State approval may also need to be obtained. Assuming everyone approves the revised strategies, a detailed revised implementation will be developed with clear milestones, performance metrics, etc.

If, however, the group of key stakeholders concludes that the project initiative is irreparably compromised and no change in strategies will likely lead to success, a recommendation to discontinue the work in the project area altogether will be made to the CPAA Council. The Council will discuss the matter and make a recommendation to the CPAA Board, which will make the final decision.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

Yes	No
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

Yes	No
X	

Project Sustainability (500 words)

CPAA’s Strategy for Long-Term Project Sustainability and Impact on Washington’s Health System Transformation Beyond the Demonstration Period

There are a number of factors that support the long-term sustainability of this project.

There is great interest in this project in our region, state, and country, and key stakeholders have already made substantial investments that will be leveraged to reduce the opioid epidemic. Given the importance of this project to the core mission of many of CPAA’s health partners and the high visibility that this issue is attracting nationwide, it is highly likely that our key partners will continue their investments in this project area beyond the duration of the Medicaid Transformation.

As detailed in the *Lasting Impacts and Overall Benefits* section, during project implementation, important investments into our region’s health system transformation will be made that provide lasting benefits. The improvements to key health information systems; the expertise gained, and skills built by training our partnering providers’ workforce; the deep changes made to the workflows and business practices of our partners during this project; and the partnerships built and strengthened through the collaborative planning and implementation of this project all combine to ensure that the improvements resulting from project initiative will be ongoing and sustained by our partners.

Addressing the opioid crisis effectively will require a cultural shift and reducing stigma. Opioid Response

aligns with Bi-directional Care Integration, Maternal and Child Health, Transitional Care, and Care Coordination. The work in these other project areas will have a synergistic effect, especially as we will align target populations and interventions to the greatest extent possible. Together, these projects will bring more resources and create important connections that will support a system for whole-person care. We anticipate that the connective work from syringe exchange programs with embedded services will demonstrate the value of funding positions to engage in collaborative care. These mechanisms occurring in tandem in collaborative care settings are expected to help fund the social service and recovery support service work with this population. If the region adopts the Six Building Blocks framework, increased utilization of the PMP can be sustained within the workflow with minimum impact on cost once initiated.

The development of value-based payment contracts is critical to the long-term sustainability of this and other Transformation projects. Reliable funding streams to support opioid response tied to value-based care will be central to the long-term sustainability of our region's investments in this project area. We are hopeful that the increased value resulting from the project will be reflected in reimbursement rates and/or provider payments. CPAA will consider advocating for improved methods of funding in the Medicaid program to support efforts that demonstrate success.