Addressing the Opioid Crisis – An ACH Collaboration

The purpose of this document is to offer a set of strategies that can help hospitals, health systems, and independent/group practices and Accountable Communities of Health (ACH) address the opioid crisis. These six strategies offer promising interventions that can be implemented as part of the Medicaid demonstration opioid project – Project 3A.

We urge hospitals and health systems to engage with their ACHs on efforts to address the opioid crisis and support appropriate prescribing. Hospitals, health systems and providers should be in discussion with their ACHs about priorities and what system supports or resources they need to address the goals outlined in the Medicaid demonstration. We encourage stakeholders to review the six strategies to determine the ones that may be important and appropriate in your community.

Six Strategies for Hospitals, Health Systems, and Independent/Group practices:

1. **Overdose Prevention** – Implementing protocols and policies in the ED and primary care setting for overdose education and take home naloxone for at-risk individuals;
2. **Expanding Access to Treatment** – Initiating medication assisted treatment (MAT) in emergency departments and coordinating outpatient treatment for at-risk individuals;
3. **Integrating PMP Data into Clinical Workflows** – Furthering utilization of the Prescription Monitoring Program (PMP) and integration of PMP data into EMR;
4. **Expanding Access to Treatment** – Developing and implementing a tool kit to support providers in increasing the number of patients treated with MAT;
5. **Improving Opioid Prescribing Practices** – Leveraging data and guidelines to support appropriate opioid prescribing practices; and
6. **Develop Low-Barrier Methadone and Buprenorphine Access** – *under development.

ACHs are being asked to submit applications by November outlining their transformation strategies. To assist the ACHs and their providers, the Washington State Hospital Association (WSHA) and the Washington State Medical Association (WSMA) convened subject matter experts to identify promising strategies for hospitals, health systems, and independent/group practices to address the opioid crisis. We hope that hospitals, health systems and providers will discuss these strategies with their ACHs and that ACHs will implement many of these approaches. We believe the impact will be stronger by having work aligned across regions.

While each strategy can stand on its own, we envision that hospitals, health systems and ACHs will want to couple individual strategies and supporting data to form a comprehensive opioid strategy focused on prevention, appropriate prescribing and access to treatment.

As with other components of the ACH work, we fully expect these strategies to evolve and become more tightly calibrated over time. We recognize that much of the work on applications is starting now and we wanted to offer our suggestions in a timely manner for consideration as ACHs begin their drafting. We welcome your feedback on how these strategies can be improved.

If you have further questions or wish to partner with WSHA or WSMA on any of these strategies please contact Ian Corbridge, ianc@wsha.org or Jeb Shepard, jeb@wsma.org

DRAFT ACH Opioid Project Template

PROJECT 3A – Addressing the opioid crisis; an ACH collaboration

Overview

This proposal represents the culmination of work between subject matter experts across the state to align interventions to address the opioid crisis. While this proposal focuses on a particular aspect of care, we encourage Accountable Communities of Health (ACHs) to couple this project with other interventions (e.g., promoting appropriate prescribing patterns and expanding access to treatment) and supporting data to form a comprehensive opioid strategy for each ACH region.

The sections of this proposal align with the subject headings in the ACH Project Plan Template. ACH may use this proposal to complete the Project Plan Template as appropriate.

Project Selection & Expected Outcomes

Proposal title

Overdose Prevention – Implementing protocols and policies in the ED and primary care setting for overdose education and take home naloxone for at-risk individuals.

Statement of need

Overdose deaths involving a prescription opioid or heroin kill on average 600 individuals in Washington every year. In 2015, the Department of Health (DOH) estimates that the overdose death rate per 100,000 residents for counties in our ACH ranged from xxx to xxx *(refer to DOH county overdose death data)*. These deaths are taking a toll on our communities and health care resources.

Naloxone is a prescription drug that can reverse the effects of a prescription opioid and heroin overdose, and can be life-saving if administered in time. Implementing take-home naloxone policies and protocols and opioid overdose education to at-risk patients in the ED coupled with co-prescribing policies and protocols in the ambulatory care settings has the potential to reduce overdoses and save lives.

Ensuring at risk individuals receive take home naloxone and supporting education address the ACH goal of *Overdose Prevention: Intervene in opioid overdoses to prevent death.* It also supports our community and ACH's priority to reduce opioid overdose deaths and support healthier communities. This project will further support health system transformation by embedding evidence-based practices into patient care procedures and clinical work flow.

Hospitals/health systems and the provider community have made individual efforts to expand access to naloxone. We are not aware of any system-wide approach in our

region to ensure all at-risk individuals receive naloxone. This project will be the first of its kind in our region.

Anticipated scope
This project will target individuals who are at risk for opioid abuse or who have a history of opioid related overdoses. The number of individuals we anticipate reaching through this project remains unclear. However, in the planning portion of the project we anticipate using facility level data and new opioid data from DOH to quantify the impact of this project.

Expected outcomes (goal)
Reduce opioid overdose deaths by providing at-risk individuals with take home naloxone and supporting education.

Project outcomes by stages:

- **Stage 1: Planning** – The ACH and partnering organizations will perform a gap analysis to assess facilities' policies and procedures for prescribing naloxone in the ED and primary care settings. Facilities will also assess patient education on the use of naloxone. Partners will look to existing guidelines (detailed below) and best practices when developing protocol and procedures.
- **Stage 2: Implementation** – Partnering organizations will implement standard protocols and procedures for prescribing take home naloxone in the ED and co-prescribing in the primary care setting. Facilities will also establish supporting education for at-risk individuals.
- **Stage 3: Scale and Sustain** – Once this project is adopted and part of a facility's practice we envision that it will be easy to sustain as it will be part of the facility's normal practice of care.

Implementation Approach and Timing

Stage 1 – Supporting overdose prevention is one component of our ACH's comprehensive strategy to address the opioid crisis. The milestones for our overdose prevention strategy is as follows:

Stage 1: Planning – *[ACH to insert general information required for stage 1 of the Supplemental Data Workbook]*
The ACH will work with partners to develop a comprehensive project plan. The plan to address overdose prevention will at minimum consist of:

1. Gap analysis and assessment of resources *[insert year, quarter];*
2. Identification of best practices and guidelines and formulation of policies and procedures for prescribing naloxone to at-risk individuals *[insert year, quarter]*
3. Implementation of best practices and procedures *[insert year, quarter];* and
4. Transition to sustainability *[insert year, quarter].*

The ACH will work with partners to identify current practices, assess resources, perform a gap analysis and identify existing guidelines and best practices for prescribing take home naloxone.

Stage 2: Implementation

The ACH will leverage existing guidelines and resources to assist in developing protocol and procedures around prescribing naloxone in the ED and primary care setting. Resources that will be considered are:

1. Washington Agency Medical Directors' Group – Opioid Prescribing Guidelines
   Clinical recommendations on when to prescribe take-home naloxone for at-risk patients.

2. CDC – Guideline for Prescribing Opioids for Chronic Pain, 2016
   Clinical Recommendations on when to prescribe take home naloxone for at risk patients.

3. Kelly-Ross Pharmacy Group: www.kelley-ross.com/naloxone-program/
   Toolkit on naloxone for providers and patients.

4. UW Alcohol & Drug Abuse Institute: www.stopoverdose.org
   Resources on naloxone and overdose education.

The ACH will use a mix of both process and outcome metrics to track short-term progress and long-term project goals. Metrics to track progress and outcomes that will be considered under this project may include, but are not limited to:

- Hospitals/clinics have performed a gap analysis and assessment of resources for prescribing naloxone.
- Hospitals/clinics have registered for facility level access to the state Prescription Drug Monitoring Program (PMP).
- Hospitals/clinics have policies and procedures for prescribing naloxone in place.
- Number of health care providers, by type, trained on the Agency Medical Director's Group (AMDG) opioid prescribing guidelines.
- Number of retail pharmacies who have a collaborative drug therapy agreement (CDTA) for dispensing naloxone.
- Patients on high-dose opioid therapy who were also prescribed naloxone.
- Patients who present to the ED with an opioid use disorder (OUD) or overdose event who were prescribed naloxone.
- Opioid overdose deaths.

Incentive payments will be adjusted based on the level of performance against agreed upon metrics.

Required Health System and Community Capacity (Domain I) Focus Areas for all ACHs

Value-based Payment Strategies

This project supports the migration to value-based payment in two key ways:

1. Use data to predict individuals at risk for opioid abuse and potential overdose and provide appropriate clinical services to reduce overdose deaths. While initial costs may be higher, our aim is to improve health and reduce long-term health care costs from repeated overdose events; and
2. Use standards and guidelines to promote consistent and appropriate care services throughout our ACH. Many value-based payment arrangements are based on standards and guidelines. Moving our providers to using standards and guidelines in a consistent fashion will promote future migration to new and innovative payment arrangements.

Workforce

This project will leverage the existing workforce (MDs, NPs, PAs, RNs, etc.) in our ACH region. Providers are aware of naloxone; however, we anticipate a gap in provider's knowledge around when to prescribe naloxone or to co-prescribe naloxone. To address this knowledge gap, we will identify regional champions to support training and coaching, disseminate best practices and work with respective associations and professional groups to support provider training.

We aim to support providers in delivering comprehensive, coordinated and timely access to care by:

1. Leveraging existing provider champions in our community to support and facilitate change; and
2. Intentionally change facility protocols and procedures around naloxone access so that it becomes easier for providers to prescribe naloxone.

Population Health Management Systems

This project will leverage two state population health management systems:

1. State PMP – the PMP will allow providers and their delegates to identify at-risk individuals and prescribe naloxone according to agreed upon policies and procedures. The PMP is an important component in helping providers understand a patient's full prescriptive history and support appropriate treatment.
2. Emergency Department Information Exchange (EDIE) – EDIE will allow ED providers and their delegates to quickly identify at-risk individuals when they register at a hospital ED and prescribe naloxone according to agreed upon policies and procedures. The EDIE system is an important tool for ED providers that queries the state PMP and packages patient's clinical and prescriptive history in a consistent format. The EDIE system is active in all Washington State hospital EDs.

One gap in our existing population health management systems is the inability to see if a patient has experienced an overdose event. Information pertaining to a patient's overdose event history would support providers in better prescribing take home naloxone to at-risk individuals. We anticipate working with state partners to explore options to address this gap by leverage existing management systems like EDIE.

Partnering Organizations

To cover a significant portion of the Medicaid population we have engaged and gained commitment for this project from [*insert*]. These partners represent the primary service providers for Medicaid clients in our community and are essential for addressing opioid overdose deaths.

To ensure commitment of partnering providers and the goals of the project we will be working with key clinical leaders at hospitals, health systems and individual practices to gain organizational support and provider trust. By having providers involved and leading this work from the beginning we anticipate easier adoption and sustained commitment to serving the Medicaid population.

Using the Partnering Organizations tab of the ACH Project Plan Supplemental Data workbook, list partnering providers. Refer to ACH project plan template.

(If you wish to partner with the Washington State Hospital or Medical Associations please contact Ian Corbridge, ianc@wsha.org or Jeb Shepard, jeb@wsma.org)

Regional Assets, Anticipated Challenges and Proposed Solutions

Our ACHs biggest regional asset for this project are the *[insert number]* hospitals, health systems and individual provider offices in our community. These partners are at the front lines of the opioid crisis. We also intend to leverage the power of state-wide collaboratives like the WSHA/WSMA Safe Table Forum to advance provider trainings and best practices.

While guidelines for co-prescribing are established, moving all partners to standard policies and procedures for prescribing take home naloxone and co-prescribing in the primary care area has challenges. We anticipate using the initial planning year to further address barriers and work with partners to identify and implement strategies to overcome challenges.

Monitoring and Continuous Improvement

[ACH to insert general information required for this section]

Project Sustainability

[ACH to insert general information required for this section]

Project Metrics and Reporting Requirements

[ACH to insert and attest to general information required for this section]

Relationship with Other Initiatives

[ACH to insert and attest to general information required for this section]

DRAFT ACH Opioid Project Template

PROJECT 3A – Addressing the opioid crisis; an ACH collaboration

Overview

This proposal represents the culmination of work between subject matter experts across the state to align interventions to address the opioid crisis. While this proposal focuses on a particular aspect of care, we encourage Accountable Communities of Health (ACHs) to couple this project with other interventions (e.g., promoting appropriate prescribing patterns and expanding access to treatment) and supporting data to form a comprehensive opioid strategy for each ACH region.

The sections of this proposal align with the subject headings in the ACH Project Plan Template. ACH may use this proposal to complete the Project Plan Template as appropriate.

Project Selection & Expected Outcomes

Proposal title

Expanding Access to Treatment – Initiating medication assisted treatment (MAT) in emergency departments and coordinating outpatient treatment for at-risk individuals.

Statement of need

Over 2 million people in the U.S. are addicted to prescription opioids. While clinical treatment is available, access to medication assisted treatment (MAT) remains difficult, especially in rural communities.

To expand access to MAT, our ACH needs to consider new ways of initiating treatment, building treatment capacity and supporting care coordination. Emergency departments (EDs) are a prime place to initiate treatment given that opioid related ED visits increased 99 percent between 2000 and 2014. Initiating MAT in the ED has the potential to improve patient outcomes, reduce opioid use disorder and decrease opioid overdose deaths.

Ensuring at-risk individuals receive initial MAT in the ED and are connected with community providers at the time of discharge address the ACH goal of *Treatment: Link individuals with opioid use disorders to treatment services.* This project will further support health system transformation by embedding evidence-based practices into patient care procedures and clinical work flow.

Some hospitals and health systems are starting to explore the concept of initiating MAT in the ED, however there is no system-wide approach in our region and support for care coordination once patients are discharged from the ED.

Anticipated scope
This project will target individuals who present to hospital EDs who have an opioid use disorder (OUD). The number of individuals we anticipate reaching through this project remains unclear. However, in the planning phase of the project we anticipate using facility level data and data from the state to quantify the impact of this project.

Expected outcomes (goal)
Increase the number of patients who are receiving MAT by initiating treatment in hospital EDs and connecting patients with community providers at the time of discharge.

Project outcomes by stages:

Stage 1: Planning – The ACH and partnering organizations will perform a gap analysis to assess facilities' policies and procedures and infrastructure for initiating MAT in the ED, and supporting systems, financing and capacity to transition patients to community providers at the time of ED discharge. Partners will look to existing best practices and promising work in Washington State when developing this project.

Stage 2: Implementation – Partnering hospitals will implement standard protocols and procedures for initiating MAT in the ED and discharging patients with a supply of medication. Partnering organizations will develop the infrastructure and systems to support appropriate care coordination as patients transition from the initial point of treatment in the ED to a community provider.

Stage 3: Scale and Sustain – Partnering organizations will need to work with community providers to expand access to MAT in the community and with payers to ensure reimbursement supports the initiation of treatment, care coordination and ongoing community treatment.

Implementation Approach and Timing

Stage 1 – Initiating MAT in the ED is one component of our ACH's comprehensive strategy to address the opioid crisis. The milestones for our treatment strategy are as follows:

Stage 1: Planning – *[ACH to insert general information required for stage 1 of the Supplemental Data Workbook]*

The ACH will work with partners to develop a comprehensive project plan. The plan to expand access to initial treatment in the ED will at minimum consist of:

1. Gap analysis and assessment of resources within the hospital ED setting, community MAT providers and with existing structural supports for care coordination. *[insert year, quarter];*
2. Identification of best practices and guidelines for initiating MAT in the ED for individuals with an OUD *[insert year, quarter]*
3. Formulation of policies and procedures for initiating MAT in the ED for individuals with an OUD *[insert year, quarter]*
4. Implementation of policies and procedures *[insert year, quarter];* and

5. Transition to sustainability *[insert year, quarter].*

The ACH will work with partners to identify current practices, assess resources, perform a gap analysis and identify existing guidelines and best practices for initiating MAT in the ED for individuals with an OUD.

Stage 2: Implementation
The ACH will leverage existing guidelines and resources to assist in developing protocol and procedures around initiating MAT in the ED for individuals with an OUD. Resources that will be considered are:

1. Washington Agency Medical Directors' Group – Opioid Prescribing Guidelines
   Clinical recommendations on when to initiating MAT in the ED for individuals with an OUD.

2. CDC – Guideline for Prescribing Opioids for Chronic Pain, 2016
   Clinical recommendations on when to initiating MAT in the ED for individuals with an OUD.

The ACH will use a mix of both process and outcome metrics to track short-term progress and long-term project goals. Metrics to track progress and outcomes that will be considered under this project may include, but are not limited to:

- Number of hospitals/clinics who have policies and procedures for initiating MAT in the ED for individuals with an OUD.
- Number of ED providers trained on the AMDG's/CDC opioid prescribing guidelines.
- Contract between hospital and community MAT provider in place.
- Patients with an OUD diagnosis seen in the ED who received MAT and supporting education.
- Patients who are initiated on MAT in the ED who receive follow-up care from a community provider.
- Number and locations of MDs, ARNPs and PAs who are approved to prescribe buprenorphine.
- Number of patients receiving MAT in the community.
- Opioid overdose deaths.

Required Health System and Community Capacity (Domain I) Focus Areas for all ACHs

Value-based Payment Strategies
This project uses standards and guidelines to promote consistent and appropriate care services throughout our ACH. Many value-based payment arrangements are based on standards and guidelines. Moving our providers to using standards and guidelines in a consistent fashion will promote future migration to new and innovative payment arrangements.

Workforce

This project will largely leverage the existing ED workforce (MDs, NPs, PAs, RNs and pharmacists) in our ACH region. Providers are aware of MAT; however, we anticipate a gap in provider's knowledge around how and when to prescribe MAT in the ED. We also anticipate that hospital pharmacies and pharmacists will have to consider new ways of supplying MAT in the ED and supporting care providers in the ED. To address this knowledge gap and questions, we will identify regional champions to support trainings and coaching, disseminate best practices and work with respective associations and professional groups to support provider trainings.

Population Health Management Systems

This project will leverage two state population health management systems:

1. State PMP – the PMP will allow providers and their delegates to identify individuals who may have an OUD. The PMP is an important component in helping providers understand a patient's full prescriptive history and support appropriate treatment.
2. Emergency Department Information Exchange (EDIE) – EDIE allows ED providers and their delegates to quickly identify individuals who may be at risk for an OUD when they register at a hospital ED. MAT would then be initiated per agreed upon policies and procedures. The EDIE system is an important tool for ED providers that queries the state PMP and packages patient's clinical and prescriptive history in a consistent format. The EDIE system is active in all Washington State hospital EDs.

Further consideration is needed to identify a population health management system that will support care coordination and monitoring as the patient transitions between the hospital ED to a community MAT provider. Specific management systems will be considered during the planning stage of the project.

Partnering Organizations

To cover a significant portion of the Medicaid population we have engaged and gained commitment for this project from [*insert*]. These partners represent the hospitals and current MAT providers in our ACH region.

To ensure commitment of partnering hospitals and providers, and the goals of the project we will be working with key clinical leaders at hospitals, health systems and individual practices to gain organizational support and provider trust. By having providers involved and leading this work from the beginning we anticipate easier adoption and sustained commitment to serving the Medicaid population.

[Using the Partnering Organizations tab of the ACH Project Plan Supplemental Data workbook, list partnering providers. Refer to ACH project plan template]

(If you wish to partner with the Washington State Hospital or Medical Associations please contact Ian Corbridge, ianc@wsha.org or Jeb Shepard, jeb@wsma.org)

Regional Assets, Anticipated Challenges and Proposed Solutions

Our ACHs biggest regional asset for this project are the *[insert number]* hospitals, health systems and individual MAT prescribers in our community who have agreed to participate in this project. These partners are at the front lines of the opioid crisis. Hospital EDs are also key components of the health system where individuals with an OUD may seek care and are uniquely positioned to initiate MAT. We also intend to leverage the power of state-wide collaboratives like the WSHA/WSMA Safe Table Forum to advance provider trainings and best practices.

We anticipate a dearth of guidelines or best practices for initiating MAT in the ED for individuals with an OUD. We intend to work with and learn from a select set of state hospitals who have piloted MAT initiation in the ED to address challenges and enhance our project.

Monitoring and Continuous Improvement

[ACH to insert general information required for this section]

Project Sustainability

[ACH to insert general information required for this section]

Project Metrics and Reporting Requirements

[ACH to insert and attest to general information required for this section]

Relationship with Other Initiatives

[ACH to insert and attest to general information required for this section]

DRAFT ACH Opioid Project Template

Addressing the opioid crisis; an ACH collaboration

Overview

This proposal represents the culmination of work between subject matter experts across the state to align interventions to address the opioid crisis. While this proposal focuses on a particular aspect of care, we encourage Accountable Communities of Health (ACHs) to couple this project with other interventions (e.g., promoting appropriate prescribing patterns and expanding access to treatment) and supporting data to form a comprehensive opioid strategy for each ACH region.

The sections of this proposal align with the subject headings in the ACH Project Plan Template. ACHs may use this proposal to complete the Project Plan Template as appropriate.

Project Selection & Expected Outcomes

Proposal title

Integrating PMP Data into Clinical Workflows

Statement of need

- Washington's PMP contains all records for Schedule II, III, IV and V drugs, and can be queried before or during a patient visit where controlled substance prescriptions are likely to be discussed.
- This query allows prescribers to make better decisions about patient care by identifying high utilizers or multi-drug class patients; integrating practice and facility EHRs with the PMP allows this information to be pushed to a physician at the point of care.
- PMP programs are associated with sustained reductions in opioid prescribing by physicians.
- There are two ways to check the PMP before prescribing, via integration with a practice or facility EHR, or manual reviews.
- Integrating PMP data into facility's EHRs makes it part of the clinical record and thus easier and more readily available for members of the health care team to access.
- This project is needed as there are numerous barriers that exist to integrating PMP information into clinical workflows, chiefly associated with potential costs around staffing and/or technical integration.

Anticipated scope

This project will target providers, groups of providers, and facilities that write prescriptions for controlled substances. The project seeks to incentivize provider practices and facilities to further utilize PMP data by offsetting costs associated with integrating PMP data into an EHR or offsetting the costs associated with manual checks. To make sure practices and facilities already doing the right thing are not frozen out from the benefits of this program, and to

encourage entities already working on this process from delaying until the project is live so that they are eligible for funds, the project will consider retroactively offsetting costs for practices and facilities that already check the PMP.

Expected outcomes (goal)
Reduce inappropriate opioid prescribing, prescriptions for high utilizers, or multi-drug class prescriptions, and associated harms (misuse, abuse and overdose) by incentivizing all providers regardless of setting, to use PMP data before prescribing controlled substances.

Implementation Approach and Timing

- **Stage 1: Planning** *[insert year, quarter].*
    - Conduct analysis to understand costs and other barriers associated with integrating PMP data into clinical workflows
        - Manual approach (practice staff)
            - Identify best practices for integrating PMP information into clinical workflows utilizing a manual approach
                - These best practices will be collated and shared among providers in the ACH.
            - How much weekly FTE time is required to manually check the PMP?
            - A manual approach requires the provider, or officially delegated staff member, to check a patient record in the PMP before or during an encounter where treatment of pain, or prescriptions for controlled substances, will be discussed. That information is used to inform the prescriber's care decisions.
        - PMP/EHR integration
            - Understand barriers and best practices to integrating the PMP with practice EHRs
            - Understand vendor and provider readiness
                - Which vendors offer this functionality?
                - How many providers have a certified EHR?
                - Barriers to HIE connection
        - Formulate metrics to gauge PMP utilization progress (both manually and through PMP/EHR integration) and payment mechanisms to incentivize this behavior from both practices and facilities that do not yet check the PMP, and those that already do check the PMP as part of clinical workflows.
- **Stage 2: Implementation** *[insert year, quarter].*
    - Practices, facilities, and other partnering organizations will be made eligible for payments to offset costs by indicating their intention to participate in this program by signing an "Integrating PMP Data into Clinical Workflows notice of intent" and registering with the state PMP. This notice of intent would require participants to indicate if their practice will be checking the PMP:

        - Through integration with EHR
        - Manually
        - Already checks the PMP (manually or via integration)
    - This agreement would cover the cost of initial integration between the practice or facility EHR with the PMP (vendor charges and HIE connection costs) **OR** help to offset the costs of hiring additional staff to conduct manual checks.
    - Once practices and facilities begin querying the PMP, additional resources will be considered to help scale and sustain.
- **Stage 3: Scale and sustain** *[insert year, quarter].*
    - Once initial barriers are overcome by practices and facilities that have adopted this project, we envision that it will be sustainable as it becomes part of the entity's work flows, practice of care, and strategic mission. Additional resources may need to be drawn down to help sustain this program in the community.

The ACH will use a mix of both process and outcome metrics to track short-term progress and long-term project goals. Metrics to track progress and outcomes that will be considered under this project may include, but are not limited to:

- Number of practices and facilities within ACH boundaries that prescribe controlled substances
- Number of practices and facilities that do not check the PMP before prescribing controlled substances at onset of project
- Number of practices and facilities that currently check the PMP before prescribing controlled substances at onset of project
- Number of practices and facilities who have taken advantage of HB 2730 and provide single point registration for the PMP.
- Number of queries to the PMP before project implementation
- Number of queries to the PMP during and after project implementation
- Number of facilities with EHRs which link to the PMP

Required Health System and Community Capacity (Domain I) Focus Areas for all ACHs

Value-based Payment Strategies

This project supports the migration to value-based payment in two key ways:

1. Uses data to predict individuals at risk for opioid overdose to mitigate risk and decrease opioid overdose deaths before they happen;
2. Promotes the use of state and federal guidelines around when to check the PMP

Workforce

This project will largely leverage the existing workforce (MDs, NPs, PAs, RNs, practice staff, etc.) in our ACH region. Providers are aware of the PMP; however, we anticipate a gap in provider's knowledge around how to best integrate PMP data into clinician workflows. To address this knowledge gap, we will identify regional champions to support trainings and coaching,

disseminate best practices and work with respective associations and professional groups to support provider trainings.

We aim to support providers in delivering comprehensive, coordinated and timely access to care by:

1. Leveraging existing projects in our state and community; and
2. Intentionally changing facility protocols and procedures around checking the PMP before prescribing controlled substances so that it becomes part of provider's standard clinical care and workflow.

Population Health Management Systems

This project seeks to proliferate the use of a current population health management system, the state PMP.

Data needs

- The cost to various sized practices for integrating EHR with PMP
- The cost to various sized practices for manually checking the PMP before prescribing controlled substances

Resource needs and system supports

- Funding to facilitate integration with workflows
    - HIE connection/EHR functionality
    - FTE for manual checking

Alignment with other ACH projects

- Care Delivery Redesign:
    - Community-based care coordination
    - Transitional care
    - Diversion interventions
- Health System & Community Capacity Building
    - Systems for population health management

Key work or projects already underway to leverage

- Meaningful Use – most practices now have an EHR, making widespread integration a possibility (investigate what parts of a health system already have connectivity to the HIE)
- Clinical Data Repository (CDR) – HCA is looking to provide PMP data via the CDR
- Leveraging existing EHR functionalities from an affiliated health system
- EDIE/CMT – already integrated; lessons learned?
- HB 2730 – group/facility registration with PMP
- HB 1427 – annual DOH report to legislature on integration

DRAFT ACH Opioid Project Template

PROJECT 3A – Addressing the opioid crisis; an ACH collaboration

Overview

This proposal represents the culmination of work between subject matter experts across the state to align interventions to address the opioid crisis. While this proposal focuses on a particular aspect of care, we encourage Accountable Communities of Health (ACHs) to couple this project with other interventions (e.g., promoting appropriate prescribing patterns and expanding access to treatment) and supporting data to form a comprehensive opioid strategy for each ACH region.

The sections of this proposal align with the subject headings in the ACH Project Plan Template. ACHs may use this proposal to complete the Project Plan Template as appropriate.

Project Selection & Expected Outcomes

Proposal title

Expanding Access to Treatment – Develop and implement a tool kit to support providers in increasing the number of patients treated with MAT

Statement of need

Overdose deaths involving a prescription opioid or heroin kill on average 600 individuals in Washington every year. In 2015, the Department of Health (DOH) estimates that the overdose death rate per 100,000 residents for counties in our ACH ranged from xxx to xxx *(refer to DOH county overdose death data)*. These deaths are taking a toll on our communities and health care resources.

Medication assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to treat substance use disorder. MAT has been established as the gold standard in treating opioid use disorders, yet many patients suffering from opioid use disorder do not have access to life saving treatments.

Barriers to MAT are well documented and include (but are not limited to):

- Low numbers of waivered providers
- Low numbers of waivered providers providing MAT services
- Treatment accessibility, long waiting lists, inflexible admission criteria
- Limited availability and access through primary care
- Cost of treatment
- Lack of individualization of treatment design
- Social determinants of health (transportation to services)

Hospitals, health systems and individual providers have made individual efforts to expand access to MAT, but a more coordinated approach is required. Packaging information about MAT into a toolkit, including how to get waivered, how to best provide the service in the ED, primary care setting and/or resources available in the community to refer; with a focus on emerging and innovative hub and spoke, and nurse care manager models.

Ensuring that individuals suffering from opioid use disorder have access to MAT addresses the ACH goal of *Treatment: Link individuals with opioid use disorders to treatment services.* This project will further support health system transformation by embedding evidence based practices into patient care procedures and clinical work flow.

Anticipated scope
This project will target providers in the community who may be positioned to provide MAT services in their practice setting, or need information about where their patients can best access these services in their community.

Expected outcomes (goal)
Connect individuals with OUD to treatment pathways by making providers aware of MAT options and expanding access to MAT.

Implementation Approach and Timing

- Stage 1 *[insert year, quarter]*: Planning – The ACH and partnering organizations will perform an analysis to assess best practices, policies and procedures for providing MAT in the community, including information on existing guidelines and best practices when developing protocols for providing MAT, and resources in the community for referral. The ACH and partnering organizations will also assess approaches to increasing the number of providers who are wavered and proscribing MAT to patients.
- Stage 2 *[insert year, quarter]*: Implementation – The ACH will work with all DEA-waivered providers and facilities to implement the MAT toolkit and set up structures to increase the number of waivered providers and the number of patients they see.
- Stage 3 *[insert year, quarter]*: Scale and Sustain – Once this project is adopted and part of a facilities practice, we envision that it will be easy to sustain as it will be part of the facilities normal practice of care.

The ACH will use a mix of both process and outcome metrics to track short-term progress and long-term project goals. Metrics to track progress and outcomes that will be considered under this project may include, but are not limited to:

- Number of providers with DEA number and provide patient care
- Number of providers with a DEA number that provide patient care waivered to provide MAT services (before, during and after project)

- Number of waivered providers providing MAT services (before, during and after project)
- Number of referrals to MAT treatment (before, during and after project)
- Number of MAT toolkits distributed

Workforce
This project will largely leverage the existing workforce (MDs, NPs, PAs, RNs, etc.) in our ACH region. Providers are aware of MAT; however, we anticipate that most do no provide the service, or are unaware of resources in their community to refer patients suffering from OUD. To address this knowledge gap, we will identify regional champions to support trainings and coaching, disseminate best practices and work with respective associations and professional groups to support provider trainings.

We aim to support providers in delivering comprehensive, coordinated and timely access to care by:

1. Leveraging existing providers in our community; and
2. Intentionally changing facility protocols and procedures around MAT access so that it becomes part of provider's standard clinical care and workflow.

Partnering Organizations

To cover a significant portion of the Medicaid population we have engaged and gained commitment for this project from [*insert*]. These partners represent the primary service provides for Medicaid clients in our community and are essential for addressing opioid overdose deaths.

To ensure commitment of partnering providers and the goals of the project we will be working with key clinical leaders at hospitals, health systems and individual practices to gain organizational support and provider trust. By having providers involved and leading this work from the beginning we anticipate easier adoption and sustained commitment to serving the Medicaid population.

(If you wish to partner with the Washington State Hospital or Medical Associations please contact Ian Corbridge, ianc@wsha.org or Jeb Shepard, jeb@wsma.org)

Regional Assets, Anticipated Challenges and Proposed Solutions

Our ACHs biggest regional asset for this project are the *[insert number]* hospitals, health systems and individual provider offices in our community. These partners are at the front lines of the opioid crisis. We also intend to leverage the power of state-wide collaboratives like the WSHA/WSMA Safe Table Forum to advance provider trainings and best practices.

While guidelines for prescribing MAT are established, moving all partners to standard policies and procedures for prescribing MAT or understanding resources in the community has

challenges. We anticipate using the initial planning year to further address barriers and work with partners to identify and implement strategies to overcome challenges.

Monitoring and Continuous Improvement

[ACH to insert general information required for this section]

Project Sustainability

[ACH to insert general information required for this section]

Project Metrics and Reporting Requirements

[ACH to insert and attest to general information required for this section]

Relationship with Other Initiatives

[ACH to insert and attest to general information required for this section]

This project relates to and supports other ACH initiatives to support:

- Bi-direction integration of care
- Community-based care coordination

Further consideration will be given as the ACH assesses how funding from one project area may be leveraged to support other project areas that are closely aligned or have similar goals.

DRAFT ACH Opioid Project Template

PROJECT 3A – Addressing the opioid crisis; an ACH collaboration

Overview

This proposal represents the culmination of work between subject matter experts across the state to align interventions to address the opioid crisis. While this proposal focuses on a particular aspect of care, we encourage Accountable Communities of Health (ACHs) to couple this project with other interventions (e.g., promoting appropriate prescribing patterns and expanding access to treatment) and supporting data to form a comprehensive opioid strategy for each ACH region.

The sections of this proposal align with the subject headings in the ACH Project Plan Template. ACH may use this proposal to complete the Project Plan Template as appropriate.

Project Selection & Expected Outcomes

Proposal title

Improving Opioid Prescribing Practices – Leveraging data and guidelines to improve appropriated opioid prescribing practices.

Statement of need

Over 2 million people in the U.S. are addicted to prescription opioids. One contributing factor to this high rate of addiction is the variation in prescribing practices between providers and geographic regions.

To address the opioid crisis, our ACH needs to ensure providers are aware of and adhering to state or federal opioid prescribing guidelines and using prescribing data to illuminate areas where further quality improvement is needed. Opioid prescribing variance reports are a low cost and high yield program to address issues of overprescribing or variations in prescribing. Previous efforts in Washington State which used opioid prescribing variance reports in hospital emergency departments yielded a dramatic double digit reduction in prescribing practices and adherence to guidelines.

Ensuring providers adhere to opioid prescribing guidelines and leveraging data to improve prescribing practices address the ACH goal of *Prevention: Prevent opioid misuse and abuse.* This project will further support health system transformation by embedding guidelines and evidence based practices into patient care procedures and quality improvement efforts.

Some hospitals, health systems and individual providers have integrated opioid prescribing guidelines and quality improvement efforts focused on prescribing practices into their practice, however there is no system-wide approach in our region that supports a uniform approach.

Anticipated scope
This project will target prescribers in our ACH who prescribe controlled substances. The number of providers we anticipate reaching through this project is not yet determined. However, in the planning phase of the project we anticipate using facility and local data to assess the number of eligible providers.

Expected outcomes (goal)
Improve opioid prescribing practices by ensuring consistent adherence to opioid prescribing guidelines and initiating a regional quality improvement program focused on reducing opioid prescribing variation.

Project outcomes by stages:

Stage 1: Planning – The ACH and partnering organizations will perform a gap analysis to assess facilities and individual provider's policies and procedures around opioid prescribing guidelines and the penetration of and adherence to prescribing guidelines. Partners will look to existing guidelines: Washington Agency Medical Directors' Group – Opioid Prescribing Guidelines and CDC – Guideline for Prescribing Opioids for Chronic Pain, 2016 when assessing current guideline compliance.

The ACH and partnering organizations will also identify an infrastructure and process to support training on prescribing guidelines and opioid variance reports. This infrastructure and process may include working with the Washington State Hospital and Medical Associations (WSHA and WSMA) who have an existing structure in place via their Coordinated Quality Improvement Program to review data from the state Prescription Monitoring Program, support provider trainings and, provide opioid variance reports and advance quality improvement initiatives.

Stage 2: Implementation – Partnering hospitals, health systems and providers will implement prescribing guidelines within their institution and will participate in structured quality improvement initiatives to address variation in opioid prescribing. Partnering organizations will also implement a structure to receive and respond to opioid variance reports.

Stage 3: Scale and Sustain – Partnering organizations will need to identify a process for sustained provider training on opioid guidelines as guidelines change or as new employees are hired.

Implementation Approach and Timing

Stage 1 – Improving opioid prescribing practices is one component of our ACH's comprehensive strategy to address the opioid crisis. The milestones for our treatment strategy are as follows:

Stage 1: Planning – *[ACH to insert general information required for stage 1 of the Supplemental Data Workbook]*

The ACH will work with partners to develop a comprehensive project plan. The plan to improve opioid prescribing practices will at minimum consist of:

1. Gap analysis and assessment of current adoption of opioid prescribing guidelines and use of variance reports. Initial metrics will focus on process steps (MOU signed to receive opioid variance reports, establish process for quality improvement committee to review and follow up on reports, etc.) *[insert year, quarter];*
2. Implementation and adoption of opioid prescribing guidelines and opioid variance reports. Metrics will focus on establishing a baseline, facilities requesting/receiving variance reports and quality improvement committee or Chief Medical Officer meeting with providers or if the Chief Medical Officer is participating in WSMA/WSHA opioid quality improvement effort. *[insert year, quarter];* and
3. Transition to sustainability. Maintenance period where peak performance should be achieved. Transition to local control and maintenance of the program. *[insert year, quarter].*

The ACH will work with partners to identify current practices, assess resources, perform a gap analysis and identify existing guidelines and best practices for initiating improving opioid prescribing practices.

Stage 2: Implementation

The ACH will leverage existing opioid prescribing guidelines. Resources that will be considered are:

1. Washington Agency Medical Directors' Group – Opioid Prescribing Guidelines
   Clinical recommendations on when to initiate MAT in the ED for individuals with an OUD.

2. CDC – Guideline for Prescribing Opioids for Chronic Pain, 2016
   Clinical recommendations on when to initiate MAT in the ED for individuals with an OUD.

The ACH will use a mix of both process and outcome metrics to track short-term progress and long-term project goals. Metrics to track progress and outcomes that will be considered under this project may include, but are not limited to:

- Number of hospitals/clinics who have policies and procedures regarding opioid prescribing guidelines.
- Number of health care providers, by type, trained on the AMDG's/CDC opioid prescribing guidelines.
- Number of hospitals/clinics who have policies and procedures in place to receive opioid variance reports.
- Number of variance reports received.
- Patients on high-dose chronic opioid therapy by varying thresholds

- Patients with concurrent sedative prescriptions
- Opioid overdose deaths.

Required Health System and Community Capacity (Domain I) Focus Areas for all ACHs

Value-based Payment Strategies
This project uses standards and guidelines to promote consistent and appropriate care services throughout our ACH. Many value-based payment arrangements are based on standards and guidelines. Moving our providers to using standards and guidelines in a consistent fashion will promote future migration to new and innovative payment arrangements.

Workforce
This project will largely leverage the existing workforce (MDs, NPs, PAs, RNs and pharmacists) in our ACH region. Providers are largely aware of the guidelines; however, we anticipate a gap in provider's knowledge around specifics aspects of the guidelines. To address this knowledge gap, we will identify regional champions to support trainings and coaching, disseminate best practices and work with respective associations and professional groups to support provider trainings.

We also anticipate that most providers believe they are prescribing appropriately or in accordance with the guidelines. This said, we expect that the variance reports will illuminate new opportunities for quality improvement that were not previously known.

Population Health Management Systems
This project will leverage the state PMP to provide WSHA and WSMA data on opioid prescriptions to support prescribing variance reports that will inform quality improvement initiatives or targeted discussion with providers who are not prescribing in accordance with guidelines.

Partnering Organizations

To cover a significant portion of the Medicaid population we have engaged and gained commitment for this project from [*insert*]. These partners represent the hospitals, health systems and providers in our ACH region.

We anticipate partnering with WSHA and WSMA to develop and provide trainings and/or the variance reports and a platform to have structured quality improvement conversations under their coordinated quality improvement program.

Chief Medical Officers of hospitals and health systems, clinical leads and local public health will be key participants in structured trainings on guidelines and discussions on variance reports. We understand that WSHA and WSMA will also work with other specialty societies or individual provider clinics in the state to implement guidelines and improve prescribing.

To ensure commitment of partnering hospitals, health systems and providers, the goals of the project we will be working with key clinical leaders at hospitals, health systems and individual practices to gain organizational support and provider trust. By having providers involved and leading this work from the beginning we anticipate easier adoption and sustained commitment to serving the Medicaid population.

[Using the Partnering Organizations tab of the ACH Project Plan Supplemental Data workbook, list partnering providers. Refer to ACH project plan template]

(If you wish to partner with the Washington State Hospital or Medical Associations please contact Ian Corbridge, ianc@wsha.org or Jeb Shepard, jeb@wsma.org)

Regional Assets, Anticipated Challenges and Proposed Solutions

Our ACH's biggest regional asset for this project are the *[insert number]* hospitals, health systems and individual prescribers in our community who have agreed to participate in this project. These partners are at the front lines of the opioid crisis.

This project is an expansion of the Washington ER is for Emergencies work that has been ongoing in the state for the past six years. This program showed a 25% reduction in narcotic prescribing in the first year it was administered. Furthermore, in the DOH data for 2015 for pediatrics, emergency medicine was the lowest prescribing specialty by pill count and MEDs. Leveraging the existing structure and lessons learned from the ER is for Emergencies work will be a substantial regional asset to our ACH.

While we expect this project to be lean and efficient, provider trainings, data analytics, and developing variance reports have a cost. We will continue to work with partnering organizations to better understand these costs and develop a strategy and financing structure to support the work.

Monitoring and Continuous Improvement

[ACH to insert general information required for this section]

Project Sustainability

[ACH to insert general information required for this section]

Project Metrics and Reporting Requirements

[ACH to insert and attest to general information required for this section]

Relationship with Other Initiatives

[ACH to insert and attest to general information required for this section]