POPULATION HEALTH TRUST
ADVISORY COMMITTEE

Law and Justice Meeting

Wednesday March 13th, 2019 - 8:30-9:30 am

Agenda

- Overview of the Opioid Workgroup Leadership Team – collaboration and work to date
  - Plan based on WA State Opioid Response Plan: Four goal areas plus data
  - Successes since March 7, 2017 endorsement
  - Participation by Law & Justice colleagues

- Review of State Response Plan

- Options for involvement with community-wide plan
  - Low-hanging fruit or longer-term with more substantial impact?
  - Options not part of state/county plans?

- Discuss opportunities among Council
  - What other information do you need?
  - What partners would be required?
  - What is your Return on Investment from potential ideas? What investment are you willing to make to keep from building on to justice center?

Update:

- Skagit County Public Health working on Mass Overdose Response Plan
  - Address key communication and coordination questions, policies and procedures and develop a common operating procedure with resource directory for first responder and direct service providers.
  - Four phases of planning from February – September.
  - Law enforcement and other first responder agencies incorporated during phase 3 (July-September)

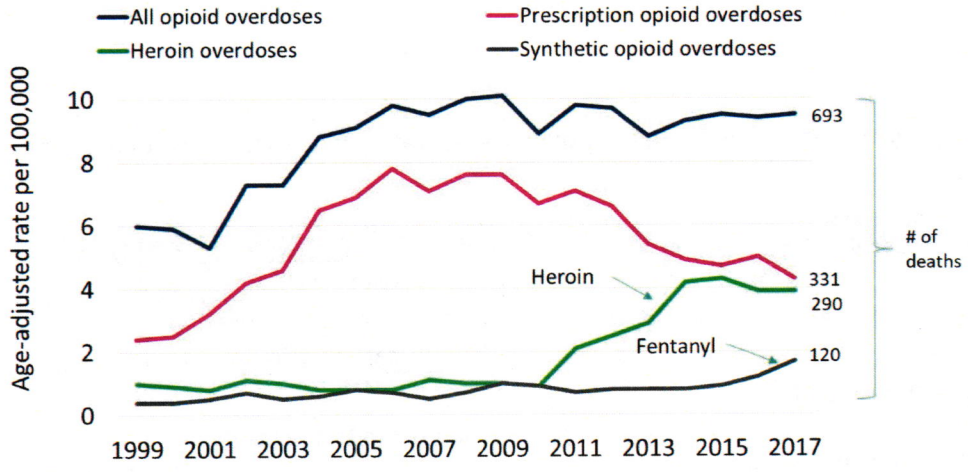
2018 Washington State Opioid Response Plan

DOH 140-182 July 2018

INTRODUCTION

Washington State is currently experiencing an opioid overdose epidemic. During 2000–2008, the rate of opioid-related overdose deaths increased dramatically due to a rapid rise in overdose deaths involving prescription opioids. Since 2008, overdose deaths related to prescription opioids have steadily fallen while overdose deaths related to heroin have increased resulting in a stable rate of overdose deaths due to any opioid. Overdose deaths related to fentanyl have increased slightly over the past few years (See figure 1).

Figure 1: Opioid-related overdose deaths by type of opioid, WA 2000–2017*



*Data for 2017 are preliminary as of 5/30/2018.
Source: DOH Death Certificates (Note: prescription opioid overdoses exclude synthetic opioid overdoses)

Opioid-related overdose deaths are one aspect of this complex public health problem. Behind these deaths are thousands of non-fatal overdose events, tens of thousands of people with opioid use disorder and hundreds of thousands of individuals who are misusing prescription opioids. The implications of this public health issue are far-reaching and include a surge in hepatitis C infections and babies born with neonatal abstinence syndrome.

In 2008, the Department of Health convened an Unintentional Poisoning Workgroup to address the alarming increase in overdose deaths involving prescription opioids. Several years later when overdose deaths related to heroin increased, the department expanded the focus of the group to include overdose deaths related to any type of opioid and changed the name of the workgroup to the Opioid Response Workgroup. In 2015, the Opioid Response Workgroup collaborated to develop a comprehensive statewide opioid response plan. On September 30, 2016, Governor Jay Inslee signed

Executive Order 16-09, *Addressing the Opioid Use Public Health Crisis*, formally directing state agencies to implement key elements of the Washington State Opioid Response Plan. The workgroup updates the plan annually to align with evolution of the problem, changing scientific evidence, new policies implemented by the legislature, and new activities supported by state and federal funding.

PLAN OVERVIEW

The **Washington State Opioid Response Plan** outlines the goals, strategies and actions that state agencies are implementing or planning to implement in the near future. The four priority goals are:

1. Prevent opioid misuse and abuse
2. Identify and treat opioid use disorder
3. Reduce morbidity and mortality from opioid use disorder
4. Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions

The plan does not include all activities underway on the local and federal level to address the opioid crisis. For more information on the status of specific activities in the plan, please see the **State Opioid Response Progress Report**.

PLAN METRICS

In order to monitor our progress with addressing the opioid issue, state agencies have developed the following 12 outcome metrics.

Overall Health Outcomes	**Data Source**	**Frequency**
Opioid overdose death rate	Department of Health/Death certificates	Quarterly
Prescription opioid overdose death rate	Department of Health/Death certificates	Quarterly
Heroin overdose death rate	Department of Health/Death certificates	Quarterly
% of 10th graders using pain killers to get high	Healthy Youth Survey	Biannually
Infants born with Neonatal Abstinence Syndrome	Department of Health/Hospital discharge data	Quarterly
Goal 1 - Prevent opioid misuse and abuse		
Patients on high-dose chronic opioid therapy > 90 mg MED	Department of Health/PDMP	Quarterly
New opioid users who become chronic users	Department of Health/PDMP	Quarterly
Chronic opioid users with concurrent sedative use	Department of Health/PDMP	Quarterly
Days of opioids supplied to new users	Department of Health/PDMP	Quarterly
Goal 2 – Identify and treat opioid use disorder		
Buprenorphine Metric TBD	Department of Health/PDMP	TBD
% Medicaid clients with an opioid use disorder receiving medication assisted treatment	Health Care Authority	Annually
Goal 3 – Reduce morbidity and mortality from opioid use disorder		
# naloxone kits distributed by syringe service programs	UW Alcohol & Drug Abuse Institute	Quarterly
# of opioid overdose reversals reported by syringe service programs	UW Alcohol & Drug Abuse Institute	Quarterly

COORDINATION AND IMPLEMENTATION

The executive sponsors for this plan are responsible for approving and overseeing the implementation of the plan. They include:

- John Wiesman and Kathy Lofy (DOH)
- Charissa Fotinos (HCA)
- Michael Langer (HCA DBHR)
- Caleb Banta-Green (UW ADAI)

The executive sponsors have established six workgroups to coordinate the action steps under each of the four goals of the plan. Workgroups meet regularly to assess progress and identify emerging issues that require new actions. The lead contacts for each workgroup are:

- **Prevention Workgroup** (Goal 1):

  Sarah Mariani, Division of Behavioral Health and Recovery *sarah.mariani@hca.wa.gov*
  Alicia Hughes, Division of Behavioral Health and Recovery *Alicia.hughes@hca.wa.gov*
  Jaymie Mai, Department of Labor & Industries *maij235@lni.wa.gov*

- **Treatment Workgroup** (Goal 2):

  Jessica Blose, Division of Behavioral Health and Recovery *jessica.blose@hca.wa.gov*
  Tom Fuchs, Division of Behavioral Health and Recovery *thomas.fuchs@hca.wa.gov*

- **Criminal Justice Opioid Workgroup (CJOW)** (Goal 2):

  Ahney King, Division of Behavioral Health and Recovery *ahney.king@hca.wa.gov*
  Earl Long, Division of Behavioral Health and Recovery *earl.long@hca.wa.gov*
  Jon Tunheim, Thurston Co. Prosecuting Attorney's Office *tunheij@co.thurston.wa.us*

- **Pregnant and Parenting Women Workgroup** (Goal 2):

  Tiffani Buck, Department of Health *tiffani.buck@doh.wa.gov*

- **Morbidity and Mortality Workgroup** (Goal 3):

  Alison Newman, UW Alcohol and Drug Abuse Institute *alison26@uw.edu*

- **Data Workgroup** (Goal 4):

  Cathy Wasserman, Department of Health *cathy.wasserman@doh.wa.gov*

Partners from all sectors on the local, state and federal levels are driving implementation of the strategies and activities in the response plan. The following partners and stakeholders have expressed a particular interest and commitment to addressing opioid misuse and overdose prevention.

Federal and tribal partners:

Center for Disease Control and Prevention (CDC)
Centers for Medicaid and Medicare (CMS)
National Institute on Drug Abuse (NIDA)
National Institutes of Health (NIH)
Northwest High Intensity Drug Trafficking Area (NWHIDTA)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Tribes
Urban tribal health centers
US Attorney General's Office (USAG)
March of Dimes

State partners:

Administrative Office of the Courts (AOC)
Agency Medical Directors' Group (AMDG)
Department of Corrections (DOC)
Department of Health (DOH), including the Dental Quality Assurance Commission (DQAC), Board of Osteopathic Medicine and Surgery (BOMS), and Podiatric Medical Board (PMB)
Medical Quality Assurance Commission (MQAC) and Nursing Care Quality Assurance Commission (NCQAC)
Department of Labor & Industries (L&I)
Department of Social and Health Services (DSHS)
Dr. Robert Bree Collaborative (Bree)
Health Care Authority (HCA) / Division of Behavioral Health and Recovery (DBHR)
Office of Superintendent of Public Instruction (OSPI)
State Prevention Enhancement (SPE) Policy Consortium
Washington State Governor's Office
Washington State Office of the Attorney General (AGO)
Washington State Patrol (WSP), including the Washington State Toxicology Lab
Washington Poison Center (WAPC)

Professional associations:

WA Association of Prosecuting Attorneys (WAPA)
WA Chapter-American College of Emergency Physicians (WA-ACEP)
NW Regional Primary Care Association
WA Society of Addiction Medicine (WSAM)
WA State Association of Police Chiefs (WASPC)
WA State Dental Association (WSDA)
WA State Hospital Association (WSHA)
WA State Medical Association (WSMA)
WA State Nurses Association (WSNA), SEIU 1199, ARNP United
WA State Pharmacy Association (WSPA)
Washington State Podiatric Medical Association

Academic institutions:

Eastern Washington Area Health Education Center (AHEC)
University of Washington, Alcohol and Drug Abuse Institute (UW ADAI)
University of Washington, Division of Pain Medicine
Washington State University, Program of Excellence in Addictions Research (PEAR)
Washington State University, Interprofessional Education Program

Local entities:

Accountable Communities of Health (ACH)
Administrative Service Organizations
Behavioral Health Organizations (BHO)
Community Prevention and Wellness Initiative (CPWI) and other prevention coalitions, including their partners such as Educational Service Districts (ESD)
Local Health Jurisdictions (LHJ)
Managed Care Organizations (MCO)
Substance use disorder treatment programs and mental health facilities
Syringe service programs (SSPs)

FUNDING

The activities in the plan are funded by a variety of local, state and federal funding sources. The abbreviations for the funding sources referenced in the plan follow:

GFS = General Fund State

SABG = Federal SAMHSA Substance Abuse Block Grant administered by the Division of Behavioral Health and Recovery

DOH PFS = Federal CDC Prescription Drug Overdose Prevention for States Grant administered by Department of Health

ESOOS = Federal Enhanced State Opioid Overdose Surveillance Grant administered by Department of Health

STR = Federal SAMHSA State Targeted Response to the Opioid Crisis Grant administered by the Division of Behavioral Health and Recovery

WA-PDO = Federal WA State Project to Prevent Prescription Drug/Opioid Overdose grant administered by the Division of Behavioral Health and Recovery

GOAL 2: Identify and treat opioid use disorders

2.4	STRATEGY 4: Expand access to and utilization of opioid use disorder medications in the juvenile and adult criminal justice system and transition those with opioid use disorder to treatment in the community upon release.	Lead Party	Funding Source*
2.4.1	Train and provide technical assistance to criminal justice professionals, including healthcare providers in jails and prisons, to endorse and promote the use of medications to treat people with opioid use disorder under criminal sanctions.	HCA DBHR, ADAI with CJOW	
2.4.2	Work with jails and prisons to initiate and/or maintain incarcerated persons on medications for opioid use disorder.	HCA DBHR, ADAI with CJOW	
2.4.3	Change systems and implement local programs to ensure a warm hand off between those released from jails and/or prisons or those living in the community under correctional supervision and treatment for opioid use disorder.	HCA DBHR, ADAI with CJOW	
2.4.4	Develop alternatives to incarceration or diversion opportunities for individuals with opioid use disorder charged with a crime. An example of such an alternative is the Sequential Intercept Model developed by the SAMHSA GAINS Center.	HCA DBHR with CJOW	
2.4.5	Address housing and transportation needs of those with opioid use disorder to support successful recovery.	HCA DBHR with CJOW	
2.4.6	Host a symposium or other round table discussion to improve collaboration around opioid use disorder in the criminal justice system.	AGO, HCA DBHR with CJOW	
2.4.7	Work with Therapeutic Courts to have licensed medical professionals offer treatment options that meet the standard of care (e.g., medications) to treat opioid use disorder.	HCA DBHR with CJOW	

GOAL 3: Reduce morbidity and mortality in those with opioid use disorder

3.1	STRATEGY 1: Provide overdose education and distribute naloxone to individuals who use opioids and those mostly likely to witness an overdose.	Lead Party	Funding Source*
3.1.3	Provide technical assistance to jails, prisons, and drug courts to implement opioid overdose education and distribute naloxone to people involved with the criminal justice system.	ADAI	WA-PDO SABG
3.1.7	Educate law enforcement, prosecutors and the public about the Good Samaritan Overdose Laws.	ADAI	WA-PDO SABG

GOAL 4: Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions

4.3	**STRATEGY 3: Enhance efforts to monitor opioid use and opioid-related morbidity and mortality.**	**Lead Party**	**Funding Source***
4.3.1	Expand DOH Opioid Data Dashboard to include additional metrics such as the Opioid Response Plan outcome measures, non-fatal hospitalizations, emergency department visits, neonatal abstinence syndrome (NAS), substance use in pregnancy, youth and adult substance use, prevention metrics, treatment metrics, and potentially Washington State Patrol data on drugs obtained during arrests. Integrate RHINO syndromic surveillance data into Opioid Data Dashboards. Explore presenting analyses stratified by gender and age.	DOH, ADAI, HCA DBHR, HCA, WSP	CDC PFS, ESOOS
4.3.8	Improve timeliness of reporting non-fatal overdose using emergency department and hospitalization data.	DOH	ESOOS
4.3.9	Explore options for passive and active overdose follow up with health care providers.	DOH	
4.3.10	Link deaths to recently released incarcerated individuals and report all-cause mortality and overdose mortality in the year after release.	DOH, UW	CDC PFS
4.3.13	Develop an information brief on the infectious disease consequences of the opioid crisis.	DOH, HCA	
4.3.14	Develop uniform data collection and data sharing with other state agencies, local justice system, prison and jails.	HCA DBHR with CJOW	
4.4	**STRATEGY 4: Monitor progress towards goals and strategies and evaluate the effectiveness of our interventions.**	**Lead Party**	**Funding Source***
4.4.1	Compile the State Opioid Response Plan metrics quarterly and review them with the Secretary of Health.	DOH	
4.4.2	Evaluate pain management rules implemented in 2011.	UW, DOH	CDC PFS
4.4.3	Evaluate HB 1427 prescribing rules with a focus this year on public understanding and acceptance of pain management.	UW, DOH	
4.4.4	Evaluate implementation and outcomes of opioid grants. Outcomes to include, but not be limited to prescribing behaviors, non-fatal overdoses and fatal overdoses related to prescription opioids.	DOH	

ESSENTIAL PRINCIPLES FOR SUCESSFUL LEAD IMPLEMENTATION

LEAD NATIONAL SUPPORT BUREAU

Law Enforcement Assisted Diversion (LEAD) *is a community-based diversion approach with the goals of improving public safety and public order, and reducing unnecessary justice system involvement of people who participate in the program. Many components of LEAD can be adapted to fit local needs and circumstances. There are, however, several core principles that are essential in order to achieve the transformative outcomes seen in Seattle.*

LEAD is not a human services program, but a public safety & order program that uses human resources tools. The goal of LEAD is to improve community health and safety by reducing criminal justice system involvement through use of specific human resources tools that are coordinated effectively with law enforcement and with community input.

LEAD is a voluntary agreement among independent decision-makers to collaborate, and therefore must work for all stakeholders. LEAD cannot work without the dedicated efforts of independent agencies and, sometimes, multiple jurisdictions. The program can only proceed as far as the key participants can achieve agreement at any given time. In addition to law enforcement, service providers, community groups, prosecutors, elected officials and others, persons with relevant lived experience (e.g. drug use, sex work, homelessness, poverty) are essential stakeholders who should be meaningfully involved partners. All stakeholders should commit to share credit and blame equally and to acknowledge the critical role of other partners.

Law enforcement officer "buy-in" is critical. LEAD only works because of the effort and insight of line officers and their sergeants. The program relies on their initiative and discretion. They must be equal partners of the program and must be involved in operational design and improvement conversations.

Command-level support is equally critical. Even when line officers are ready and willing to use LEAD, if deployment decisions, overtime approval processes, and shift scheduling do not support the program, that willingness will be squandered. Officers need to know and see that participation in this approach is valued.

Prosecutorial discretion should be utilized in LEAD participants' non-diverted cases. Regardless of whether entry into LEAD is through arrest diversion or social contact, LEAD participants typically have other cases from both before and after their referral to the program. Coordinating prosecution decisions in those filed cases with the LEAD intervention plan maximizes the success of the program in achieving behavior changes, and in reducing system utilization costs.

A dedicated project manager is critical. The project manager troubleshoots stakeholders' concerns, works to identify resources, facilitates meetings, develops information-sharing systems, and streamlines communication. Because LEAD is a consortium of politically independent actors, it is desirable for the project manager to be primarily loyal to the program itself, independent from all political and operational stakeholders.

A harm reduction/housing first framework requires a focus on individual and community wellness, rather than an exclusive focus on sobriety. The goal should be to address the participant's drug activity and any other factors driving his/her problematic behavior – even if abstinence from drug use is not achieved – and to build long-term relationships with participants without employing coercion or shame.

Intensive case management and development of an Individual Intervention Plan serve as the action blueprint. This plan may include assistance with identification, housing, treatment, education, job training, job placement, licensing assistance, small business counseling, child care, or other services. Intensive case management provides increased support and assistance in all aspects of the participant's life. By "intensive case management," we mean a type of "guerilla case management", whereby radical efforts are made to meet the individual participant where they're at.

Resources must be adequate to ensure LEAD is a diversion to a viable intervention strategy. Referral to wait lists and to an over-taxed social services infrastructure will disappoint all stakeholders and produce poor outcomes. That said, even when resources are not all that they should be, LEAD typically is more effective than system-as-usual responses that stigmatize and punish what are fundamentally health issues.

A non-displacement principle is required to ensure that the net effect of LEAD is to improve community health and safety. It is not sufficient to simply supplant existing resources and give LEAD participants preferential access to scarce resources, necessarily driving others down or off wait lists for services they need as much as LEAD participants.

Consider using peer outreach workers to enhance the program's effectiveness. In Santa Fe, most LEAD contacts are with a peer outreach worker. Decades of research demonstrate that peer-based interventions are a highly successful way to intervene with disenfranchised and stigmatized populations. These peer outreach workers stay connected to participants, provide important insight into the ongoing case management process, serve as community guides, coaches, and/or advocates, while also providing credible role models of success.

Involve community public safety leaders. Ultimately, LEAD must meet neighborhood leaders' needs for a safer, healthier community. Community members should be able to refer individuals as social contact referrals and suggest areas of focus for outreach and referral. They should also receive regular information about the program, its successes, and obstacles to effective implementation. This may best be accomplished by hiring a community liaison. Expectations should be reasonable given available resources, and program operations should be highly transparent.

Involve the business community. When appropriate, involve representatives from small business owners, franchise operations, and/or members of the Chamber of Commerce or like groups in the planning and implementation of LEAD. Shoplifting is common among individuals with problematic drug and alcohol use. Involving business owners' shows that the program is working to improve public safety for residents and business owners alike. Buy-in from this critical sector can greatly influence support from local elected officials.

Create specially-tailored interventions to address individual and community needs. Each drug activity "hot spot" and each community has its own unique character, involving different drugs and social dynamics. Rather than attempting a "one size fits all" approach, community-based interventions should be specifically designed for the population in that particular neighborhood.

Evaluation criteria and procedures should be clearly delineated, and an assessment plan identified from the outset, to ensure accountability to the public. There should be regular review of programmatic effectiveness by policymakers, including an independent evaluation of the program by outside experts. Expectations should be achievable, e.g., a small pilot project may show improvement for individual participants, but should not be expected to show gains on actual or perceived community safety until taken to scale.

Cultural competency should be built into all aspects of the program. This includes outreach, case management, and service provision. Meaningful involvement of persons with relevant lived experience in project design, implementation, and evaluation is one way to establish cultural competency.

Commit to capturing and reinvesting criminal justice savings to support rehabilitation and prevention services. Priority should be given to sustaining community diversion programs, and to improving and expanding other "upstream" human services and education efforts.

Real change takes time and patience. LEAD participants, who are usually drug-dependent and often homeless, sometimes take months or even years to make major behavior changes. When they do, they almost unanimously say they found the strength to change in part because case managers and officers refused to give up on them, and didn't rely on shaming techniques. Patience and relationship-building can eventually yield results that shorter-term strategies cannot.

Behavioral Health Navigator

The **Behavioral Health Navigator Program** gives police throughout the county access to Navigators who help connect individuals with behavioral health symptoms to services. Navigators co-respond with officers to calls involving behavioral health issues and provide outreach to individuals after police contact occurs. This program is funded by the Kitsap County Mental Health and Chemical Dependency Treatment tax.

Navigators can:

- Work with individuals to identify treatment options
- Help overcome obstacles to services
- Educate parents and caregivers about laws and resources
- Improve communication between police, attorneys, courts, and service providers

Navigators can't:

- Do assessments or involuntary commitments
- Provide therapy or other treatment services
- Share protected medical information
- Force anyone to accept help that isn't willing to accept it

The best way to contact a Navigator is through one of your police department's Crisis Intervention Officers

City of Poulsbo Police Department 360 779 3113

City of Bainbridge Island Police Department: 206 842 5211

City of Bremerton Police Department: 360 473 5220

For Program information, contact Program Manager Kim Hendrickson (360) 394 9794