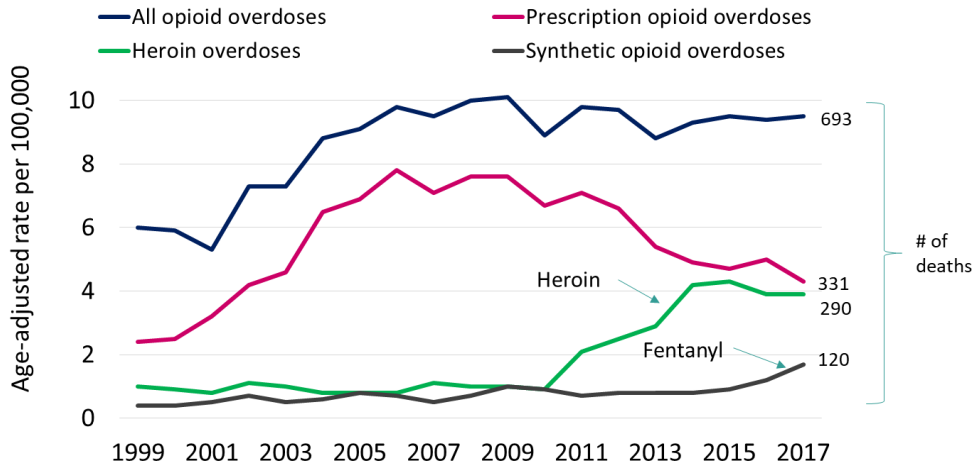
DOH 140-182 July 2018

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

GOALS, STRATEGIES AND ACTIVITIES

GOAL 1: Prevent opioid misuse and abuse

1.1	**STRATEGY 1.1: Implement strategies to prevent misuse of opioid and other substances in communities, particularly among youth.**	**Lead Party**	**Funding Source***
1.1.1	Work with Community Prevention and Wellness Initiative (CPWI) community coalitions and school districts to implement strategies to prevent misuse of opioids and other substances among youth.	HCA DBHR, OSPI	SABG and STR
1.1.2	Continue work to implement the state Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan (http://www.theathenaforum.org/sites/default/files/SPE%20Strategic%20Plan%20-%20Final%20-%20Posted%20to%20Athena%2011.29.17.pdf).	HCA DBHR, DOH	SABG
1.1.3	Provide presentations and training to school staff and administration about opioid prevention strategies.	ADAI	STR
1.1.4	Provide prevention grants to local health jurisdictions, community-based organizations, coalitions, local education partners and other partners to implement prevention strategies.	HCA DBHR	STR
1.1.5	Provide grants to federally recognized tribes for specific strategies to prevent youth opioid misuse and abuse.	HCA DBHR	SABG
1.2	**STRATEGY 2: Promote use of best opioid prescribing practices among health care providers.**	**Lead Party**	**Funding Source***
1.2.1	Implement the provisions of 2017 HB 1427 by developing opioid prescribing rules. By January 1, 2019 the boards and commissions will revise existing non-cancer pain rules created in 2011, and develop and implement rules regarding opioid prescribing in the acute, subacute, and perioperative phases of care. Issues addressed include prescribing limits, counseling on the risk of opioids, Prescription Monitoring Program use and use of alternative non-opioid pain management strategies.	DOH	GSF
1.2.2	Complete the Bree Collaborative/Agency Medical Directors' Group Supplemental Guidance on Prescribing Opioids for Postoperative Pain.	LNI, Bree, AMDG	In kind
1.2.3	Educate health care providers on the Agency Medical Directors' Group (http://www.agencymeddirectors.wa.gov/) and Center for Disease Control and Prevention (https://www.cdc.gov/drugoverdose/prescribing/guideline.html) opioid prescribing guidelines and new opioid prescribing rules to ensure appropriate opioid prescribing. Current and future focus areas include educating dental providers, surgeons, and primary care and sports medicine specialists.	L&I HCA DBHR	STR
1.2.4	Provide technical assistance and coaching to providers and clinics on best opioid prescribing practices and non-opioid alternatives to improve outcomes for patients with pain, including those diagnosed with opioid use disorder. Current efforts include: • Providing academic detailing and practice coaching to healthcare practices (e.g., Six Building Blocks model). • Sustaining funding for UW TelePain and the University of Washington Opioid Consultation Hotline.	HCA, DOH, UW	STR, HCA, CDC-PFS

	• Exploring the use of telemedicine.		
1.2.5	Enhance all healthcare higher education curricula on pain management, Prescription Monitoring Program use, and treatment of opioid use disorder (e.g., medical, nursing, physician assistant, pharmacy, and dentist curricula).	DOH, UW, WSU	CDC-PDO
1.2.6	Explore innovative methods and tools to deliver evidence-based alternatives and other promising practices to reduce overreliance on opioids for the treatment of pain while improving access to care and health outcomes. Focus areas include: • Implementing collaborative care models; • Evaluating evidence on the effectiveness of non-pharmacologic alternatives for pain and Medicaid coverage policies (not funded); • Encouraging commercial health plans to cover evidence-based non-opioid treatments for pain; and • Exploring the unique needs of those with co-existing pain and opioid use disorder.	HCA, L&I, Bree	In kind
1.2.7	Implement and/or promote policies to reduce unnecessary opioid prescribing for acute pain conditions, especially in the adolescent population. Focus areas include: • Promoting partial fills per the Comprehensive Addiction Recovery Act and Pharmacy Commission; and • Promoting the Medicaid and Public Employees Benefits opioid prescribing policy.	L&I, Bree, DOH, HCA	In kind
1.2.8	Develop guidelines to manage patients on high dose chronic opioids that might include identification of opioid use disorder, tapering strategies, use of non-opioid alternatives, and pain self-management education.	Bree	In kind
1.3	**STRATEGY 3: Increase the use of the Prescription Drug Monitoring Program to encourage safe prescribing practices.**	**Lead Party**	**Funding Source***
1.3.1	Increase the use of the Prescription Drug Monitoring Program among health care providers to help identify opioid use patterns, opioid/sedative co-prescribing, and indicators of poorly coordinated care. Focus areas include: • Promoting use of delegate accounts; • Integrating Prescription Monitoring Program access through electronic medical record systems; • Improving web-based access to the Prescription Monitoring Program; and • Considering policies to require all prescribers to use the Prescription Monitoring Program before every opioid or sedative prescription.	DOH	SABG
1.3.2	Share data with prescribers so they can understand their prescribing practices. Focus areas include: • Disseminating quarterly opioid prescribing reports to providers at health systems and medical groups so they can understand their compliance with the new Medicaid and Public Employee Benefits opioid prescribing policy for acute pain and update practice as necessary (HCA, WSHA, WSMA). • Disseminating quarterly opioid prescribing reports to individual prescribers whose prescribing practices significantly differ from other prescribers in their specialty and quarterly reports to chief medical officer who want to understand the prescribing practices of their staff (DOH).	HCA, WSMA, WSHA, DOH	SABG, GFS

	• Encouraging providers to look at their prescribing report within the Prescription Monitoring Program system. • Encouraging facilities to have providers share their prescribing reports with clinical supervisors and medical directors on at least an annual basis. • Sharing a quarterly updated Prescription Monitoring Program file to WSHA for Coordinated Quality Improvement Program use.		
1.4	**STRATEGY 4: Educate the public about the risks of opioid use, including overdose.**	**Lead Party**	**Funding Source***
1.4.1	Educate patients about best practices for managing acute pain, including the risks and benefits of opioids. Existing resources include: • Public Health--Seattle & King County materials: https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/task-forces/heroin-opiates-task-force.aspx (see document library link at the bottom) • Veteran's Administration materials (https://www.va.gov/PAINMANAGEMENT/Opioid_Safety/Patient_Education.asp).	DOH	None
1.4.2	Implement targeted and culturally appropriate public education campaigns (both print and web-based media) on the potential harms of prescription medication misuse and abuse and secure home storage of medication. Campaigns underway include: • It Starts with One (https://getthefactsrx.com/) (HCA DBHR) • One Tribal Opioid Campaign (http://www.watribalopioidsolutions.com/) (HCA DBHR) • Statewide Rx Awareness Campaign (http://doh.wa.gov/oop) (DOH).	HCA DBHR, DOH, ADAI	STR, CDC PFS
1.5	**STRATEGY 5: Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse.**	**Lead Party**	**Funding Source***
1.5.1	Educate patients and the public on the importance and ways to store and dispose of prescription medications safely (e.g. It Starts with One campaign [https://www.getthefactsrx.com/], TakeBackYourMeds.org website, Safe Storage Interagency Workgroup).	HCA DBHR, WAPC	STR
1.5.2	Implement the WA Secure Drug Take-Back Act (HB 1047) (http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/House%20Passed%20Legislature/1047-S.PL.pdf) to establish a statewide drug take back program and ensure drop boxes are accessible to communities across the state.	DOH, HCA DBHR	SABG
1.5.3	Provide funding to community-based organizations and coalitions to promote safe storage products and community use of secure medicine disposal sites.	HCA DBHR	STR
1.6	**Strategy 6: Decrease the supply of illegal opioids.**	**Lead Party**	**Funding Source***
1.6.1	Begin engaging stakeholders to discuss potential new policies to eliminate paper prescriptions.	AGO with DOH (PQAC)	

1.6.2	Develop criteria for when opioid distributors should report suspicious orders to Pharmacy Quality Assurance Commission (PQAC).	AGO with DOH (PQAC)	
1.6.3	Enabled investigators in Washington's Medicaid Fraud Unit to be appointed as limited authority peace officers for Medicaid fraud investigations.	AGO with CJOW	
1.6.4	Disrupt and dismantle organizations responsible for trafficking narcotics by restoring resources for multi-jurisdictional drug-gang task forces.	AGO with CJOW	
1.6.5	Adopt enhanced criminal penalties for trafficking of fentanyl and fentanyl analogues.	AGO with CJOW	

GOAL 2: Identify and Treat Opioid Use Disorder

2.1	**STRATEGY 1: Build capacity of health care providers to recognize signs of opioid misuse, effectively identify patients misusing opioids and other substances, and link patients to appropriate treatment resources in a non-stigmatizing way.**	**Lead Party**	**Funding Source***
2.1.1	Educate providers across all health professions about the signs of opioid misuse, screening for opioid use disorder and the harms of stigmatizing people with opioid use disorder.	HCA, DOH	CDC PFS
2.1.2	Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options.	HCA, ADAI	
2.1.3	Work to include information on substance use disorder and evidence-based treatment in all health teaching institutions, including community colleges and residency programs.	HCA, DOH, ADAI, UW & WSU	CDC PFS
2.2	**STRATEGY 2: Establish access in every region of the state to the full continuum of care for persons with opioid use disorder to include low barrier access to medication, office-based opioid treatment services, Opioid Treatment Programs (OTPs), substance use disorder treatment programs, mental health services, pain management, healthcare and recovery support services.**	**Lead Party**	**Funding Source***
2.2.1	Expand low-barrier access to medications for opioid use disorder such as providing buprenorphine in: • Syringe service programs • Emergency rooms and hospitals.	ADAI, DOH, HCA DBHR, WSHA	
2.2.2	Pilot new models of care to support primary care in accepting patients who have been induced in low-barrier settings, including syringe service programs, whose care needs are complicated by mental illness, polysubstance abuse and/or living homeless.	HCA, ADAI	

2.2.3	Support medical providers in Opioid Treatment Programs, behavioral health, and primary care settings to implement and sustain medication treatment for opioid use disorder. Focus areas include: • Expanding "hub and spoke" treatment networks; • Utilizing Care Managers to support office-based opioid treatment (OBOT) services; and • Increasing the number of providers in Washington who are waivered to prescribe buprenorphine.	HCA DBHR, ADAI, DOH	STR, GFS, CDC PFS
2.2.4	Increase the number and/or capacity of Opioid Treatment Programs and encourage Opioid Treatment Programs to offer all medications approved by the FDA for the treatment of opioid use disorder.	HCA DBHR	
2.2.5	Engage and retain people with opioid use disorder in treatment and recovery services. Focus areas include: • Expanding the use of case managers and care navigators to help patients reduce illicit drug use and improve health by accessing the appropriate level of care and ancillary services for their opioid use disorder (e.g., Opioid Treatment Program or office-based opioid treatment, substance use disorder counseling, mental health services, tobacco cessation, contraception, or medical care); • Expanding services to help those with opioid use disorder find stable housing: • Increasing services to connect people to effective treatment via the WA State Recovery Helpline including dedicated staffing, a near real time buprenorphine directory, and informational webpage; and • Expanding recovery support/coach programs, evaluating their impact, and developing financial sustainability models.	HCA DBHR, ADAI	GFS
2.2.6	Identify policy gaps and barriers that limit availability and utilization of all medications approved by the Food and Drug Administration for the treatment of opioid use disorder and develop policy solutions to expand capacity. One focus area includes: • Identifying policy gaps and barriers that limit the ability of behavioral health agencies to initiate and/or continue medications for opioid use disorder while patients are receiving residential care and work to eliminate those.	HCA DBHR, ADAI	
2.2.7	Increase workforce capacity to treat patients with opioid use disorder. Focus areas include: • Encouraging family medicine, internal medicine, obstetrics/gynecology, and psychiatry residency programs to provide wavier training for residents that includes treatment of patients with opioid use disorder. • Continuing work to increase workforce capacity for practicing primary care providers. • Identifying critical workforce gaps and developing new initiatives to attract and retain skilled professionals in the substance use disorder field. • Implementing recommendations from the Behavioral Health Workforce Assessment (http://wtb.wa.gov/behavioralhealthgroup.asp).	HCA DBHR, DOH, UW, WSU	
2.2.8	Strengthen acceptance of opioid use disorder medications in housing and residential programs serving persons with opioid use disorder. Focus areas include:	HCA DBHR, DOH, AGO	

	• Identifying policy and regulatory barriers that prevent the use of medications in housing and residential programs and work to eliminate those; • Providing technical assistance to help programs induce, refer to prescribers, or manage patients on opioid use disorder medications; • Avoiding publicly funding programs that discriminate against persons taking legally prescribed medications as directed. Work to include anti-discrimination language specific to medications for substance use disorder in WACs addressing housing and residential programs; and • Educate social workers and care managers on the need to report incidents when people who have been denied housing or other services because they are taking medications for opioid use disorder to the Human Rights Commission (and/or to the Office of the Attorney General if Medicaid funding is involved).		
2.2.9	Examine and work to implement value-based reimbursement that better covers the costs associated with medications used to treat opioid use disorder.	HCA DBHR, HCA	
2.2.10	Seek alternative funding through an 1115 waiver to allow and fund medications for individuals with opioid use disorder who are eligible for Medicaid at or during the time of incarceration.	HCA	**Not yet begun**
2.2.11	Support Accountable communities of Health in implementing their opioid-related Medicaid transformation demonstration projects.	HCA, DOH	In kind
2.2.12	Determine if barriers exist in commercial insurance plans for linking to care and treating clients with opioid use disorder. If so, implement solutions for how insurance payment mechanisms, formularies and other administrative processes can ensure appropriate availability of medications and other evidence-based services for the treatment opioid use disorder.	Office of the Insurance Commissioner	
2.2.13	Develop a state response strategy to respond to 1) spikes in fentanyl overdose deaths and 2) disruptions to opioid treatment programs during natural disasters.	HCA, DOH	In kind
2.3	**STRATEGY 3: Identify, treat and support pregnant and parenting women with opioid use disorder. Improve management of infants born with neonatal abstinence syndrome.**	**Lead Party**	**Funding Source***
2.3.1	Expand access to family planning services in syringe service programs or improve linkages between syringe service programs and family planning services.	DOH	
2.3.2	Educate maternity care providers to identify and treat (or rapidly refer) women with substance use disorder including opioid use disorder who are pregnant or parenting. • Provide Screening, Brief Intervention, Referral to Treatment training to obstetric and primary care clinicians. • Disseminate the *Substance Use during Pregnancy: Guidelines for Screening and Management* and *SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* best practice guide. • Host a SAMSHA training conference.	DOH, HCA DBHR, WSHA	

	• Build regional expertise around treating pregnant women with opioid use disorder within each Hub.		
2.3.3	Pilot and evaluate group prenatal care for women with substance use disorder.	HCA, DOH	
2.3.4	Reduce clinician biases by implementing quality improvement projects and hosting local and statewide conferences with women who are in recovery.	DOH	
2.3.5	Conduct a gap analysis on the supply and demand for treatment services for pregnant women with opioid use disorder.		
2.3.6	Link pregnant and post-partum women to appropriate services (e.g., Parent and Child Assistance Program, Maternity Support Services, Behavioral Health Organizations, Nurse Family Partnership).	HCA DBHR, HCA, DOH	
2.3.7	Expand wrap around services for pregnant and parenting women that address the social determinants of health (housing, employment, food security, etc.).		
2.3.8	Develop and implement hospital policies that support mothers rooming in with neonatal abstinence syndrome babies.	HCA, DCYF, WSHA, DOH	
2.3.9	Partner with Department of Children Youth and Families child welfare division to increase consistency in child removal practices, including working to strengthen connections between child welfare social workers and community resources at the local level.	DOH, DCYF	
2.3.10	Determine breastfeeding guidelines and best practices for mothers with substance use disorder. Educate clinicians on these guidelines and best practices.	DOH, HCA, WSHA	
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***
3.1.1	Develop and/or update information and educational materials on overdose risks, recognition and response on www.stopoverdose.org.	ADAI	SABG
3.1.2	Scale up and sustain naloxone distribution through syringe service programs.	DOH, HCA DBHR	WA-PDO STR
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
3.1.4	Provide technical assistance to professional first responders on opioid overdose education, naloxone, and post-overdose interventions.	ADAI	WA-PDO SABG
3.1.5	Provide technical assistance to substance use treatment providers and facilities on opioid overdose education and naloxone.	ADAI, DOH	WA-PDO SABG
3.1.6	Identify and address policy gaps and barriers that limit the ability of substance use treatment providers to offer naloxone.	ADAI, DOH	WA-PDO SABG
3.1.7	Educate law enforcement, prosecutors and the public about the Good Samaritan Overdose Laws.	ADAI	WA-PDO SABG
3.1.8	Identify and promote new models and best practices of post-overdose follow up to support long-term overdose prevention, particularly in emergency rooms and among first responders.	ADAI	WA-PDO SABG
3.1.9	Assist emergency departments to develop and implement protocols on providing overdose education and take-home naloxone to individuals seen for opioid overdose.	ADAI, ACEP, WSHA	WA-PDO SABG

3.2	STRATEGY 2: Make system-level improvements to increase availability and use of naloxone.	Lead Party	Funding Source*
3.2.1	Pass legislation to allow the state health officer to issue a statewide standing order to authorize professional and lay first responders to distribute and administer naloxone.	DOH	
3.2.2	Create a centralized state level naloxone procurement and distribution plan. Priority distribution partners will include SSP's, EMS, drug treatment agencies, tribes, emergency departments, jails, LHJs, social service providers, and law enforcement.	DOH lead, ADAI and HCA DBHR support	
3.2.3	Develop statewide data collection tools and processes to track the number and location of professional first responder and community-based naloxone programs, naloxone distribution volume, and overdose reversals.	DOH, ADAI	
3.3	**STRATEGY 3: Support and increase capacity of syringe services programs (SSPs) to provide infectious disease screening services and overdose education and naloxone, and engage clients in health and support services, including housing.**	**Lead Party**	**Funding Source***
3.3.1	Regularly collect survey and interview data to document current health needs of individuals who inject heroin and other opioids.	ADAI	SABG
3.3.2	Map SSP services and funding levels to determine critical gaps and unmet levels of need among people who inject drugs.	DOH, ADAI	
3.3.3	Identify and leverage diversified funding for SSPs to provide adequate levels of supplies, case management, health engagement services, infectious disease screening (especially HCV), and comprehensive overdose prevention education.	DOH, HCA DBHR, ADAI	WA-PDO, DOH
3.3.4	Provide technical assistance to local health jurisdictions and community-based organizations to organize or expand SSP and other health services for people who use drugs.	DOH, HCA DBHR, ADAI	WA-PDO, DOH
3.3.5	Expand access to family planning and sexual health services in SSPs or improve linkages between SSPs and family planning and sexual health services.	DOH	

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

4.1	STRATEGY 1: Improve Prescription Monitoring Program data quality, timeliness, completeness, access and functionality.	Lead Party	Funding Source*
4.1.1	Identify goals for improving timeliness, completeness, quality and functionality of the Prescription Monitoring Program and necessary business requirements for Prescription Monitoring Program vendor contract.	DOH	GFS
4.1.2	Improve quality and timeliness of the data submitted to the Prescription Monitoring Program from pharmacies. Focus areas include:	DOH	GFS

	• Implementing automated quality assurance / quality control protocols that identify non-reporting pharmacies, and alerts when volume of records is out of range. • Tracking Prescription Monitoring Program reporting frequency by pharmacies and ensuring compliance of reporting requirements. .		
4.1.3	Increase integration of Prescription Monitoring Program data with electronic medical records. Focus areas include: • Providing standards-based access to the Prescription Monitoring Program data for providers through electronic medical record (EHR/EMR) systems via the State's health information exchange, One Health Port • Continuing to onboard health care systems to connect to the Prescription Monitoring Program through the statewide electronic health information exchange (One Health Port). • Continuing to track barriers/facilitators with connecting Prescription Monitoring Program and electronic health records. • Exploring sharing Prescription Monitoring Program data for Medicaid clients via the clinical data repository.	DOH	GFS
4.1.4	Develop data sharing agreements with Prescription Monitoring Program in Oregon, Idaho and California.	DOH	GFS
4.1.5	Share Medicaid client Prescription Monitoring Program data linked with claims data with managed care organizations so that patients at risk for overdose can be enrolled in case management programs.	HCA	DOH - PFS
4.1.6	Automate Emergency Department Information Exchange and Prescription Monitoring Program overdose notification to providers.	DOH	GFS
4.2	**STRATEGY 2: Utilize the Prescription Monitoring Program data for public health surveillance and evaluation.**	**Lead Party**	**Funding Source***
4.2.1	Provide quarterly updates to the six Bree-based Prescription Monitoring Program metrics on the DOH Opioid Data Dashboard.	DOH	In kind
4.2.2	Refine and report Prescription Monitoring Program metrics to Community Prevention and Wellness Initiative communities and ACHs for strategic planning and monitoring of outcomes.	DOH, HCA DBHR	In kind
4.2.3	Recreate linked Prescription Monitoring Program and overdose death dataset, and analyze to determine relationships between prescribing, patient risk behavior, and overdoses.	DOH	In kind
4.2.4	Develop buprenorphine prescribing rate metric and begin reporting to DOH Opioid Data Dashboard.	DOH	CDC PFS
4.2.5	Determine the location and treatment capacity and patient load of active waivered buprenorphine prescribers and identify areas with lack of prescribers.	DOH, HCA	CDC PFS
4.2.6	Explore buprenorphine prescribing practices to assess adequacy of treatment for different models of care, develop standardized metrics, document care patterns and determine impacts of system level interventions.	ADAI, DOH, HCA	CDC PFS

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
4.3.2	Develop and disseminate a schedule for updating DOH Opioid Data Dashboard.	DOH	
4.3.3	Develop a plan to use additional data sources (e.g., EMS (WEMSIS) data, and other sources) to support public health surveillance and impact assessment.	DOH	CDC PFS, ESOOS
4.3.4	Develop the capacity for the DOH Opioid Data Dashboard to have all the measures for a county or ACH together on one dashboard.	DOH	
4.3.5	Develop materials for communities, ACHs and LHJs to understand opioid data and how the different sources fit together, so they can use the data more effectively to monitor problems, develop interventions and evaluate them.	DOH	
4.3.6	Publish Information Briefs to promote SUD evidence-based policymaking and service planning.	ADAI	
4.3.7	Improve the timeliness and classification of drug overdose deaths through collaboration between ADAI, Department of Health's Center for Health Statistics and Injury and Violence Prevention Program, and State Toxicology Laboratory. Focus areas include: • Improving the timeliness of State Toxicology Laboratory testing and reporting. • Developing collaboration between Center for Health Statistics and the State Toxicology Laboratory to support training of medical examiners/coroners on best practices for specimen collection and cause of death reporting.	DOH, ADAI, WSP	CDC PFS, ESOOS, GFS
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
4.3.11	Develop an information brief on substance use and pregnancy.	DOH, HCA	
4.3.12	Upgrade SHARE (the SSP data collection system) to better track SSPs' services, naloxone distribution, infectious disease screening, and referrals and linkages to health and social services.	DOH	

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	