Washington State Opioid Response Mid-Year Report

September 30, 2022 – September 29, 2023

Photo Credit: Greg Purnell

Prepared for

The Substance Abuse and Mental Health Services Administration

Washington State Opioid Response

Year One Annual Performance Progress Report

September 2022 – September 2023

Report on behalf of and in collaboration with the Health Care Authority Division of Behavioral Health and Recovery; funded by the Substance Use and Mental Health Services Administration grant number TI085727.

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WASHINGTON STATE IS IN THE THIRD grant cycle of the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Opioid Response grant. The Washington State program (SOR III) is administered by the Health Care Authority's Division of Behavioral Health and Recovery (HCA). Under the current grant cycle SOR III continues to support previously established prevention, treatment, and recovery support services to prevent opioid misuse and abuse; identify and treat opioid use disorder (OUD); reduce morbidity and mortality from OUD; and use available data to monitor trends related to OUD. The following is a review of selected activities of SOR III from September 30, 2022, through September 29, 2023.[1]

Program Descriptions

SOR III supports prevention, harm reduction, outreach, screening, referral services, peer coaching, and direct services such as medication for opioid use disorder (MOUD) treatment and recovery support services. Outreach, screening, referral, and treatment services are provided through the following programs:

- Hubs and Spokes (H&S): The HCA contracts with five treatment providers— "Hubs"—that subcontract and collaborate with at least five other service providers—"Spokes"—to provide integrated MOUD treatment.

- Opioid Treatment Networks (OTNs): OTNs initiate MOUD in "non-traditional" settings such as emergency departments, jails, and syringe service programs; and then refer clients to continued treatment in the community. There are 13 OTNs funded by SOR III.

- Care for Offenders with Opioid Use Disorder Releasing from Prison (COORP): COORP initiates MOUD in Department of Corrections (DOC) facilities statewide and refers clients to continued treatment upon release.

- Re-entry Post Release Treatment Decision (RPR): There are 14 jails that participate in the RPR program through DOC. These programs identify clients in DOC custody entering jail that have OUD or stimulant use disorder and discuss treatment options. Clients can select a treatment option; a care coordinator ensures a referral to treatment services at the time of release.

[1] For this annual report, SAMHSA requested details about specific activities supported by the SOR III grant. This report is not a summary of all activities supported by SOR III.

- Recovery and Support Services – Direct Client Services: The HCA contracts with seven recovery support service agencies to provide person-directed, peer-supported recovery support services. Services may include recovery coaching and planning, employment and housing support, medical co-pay assistance, or educational support.

- Peer Pathfinders: Across 13 agencies, peer support staff provide outreach and engagement services to individuals who are currently homeless or are at risk of becoming homeless and have suspected OUD or stimulant use disorder. Outreach is provided in emergency departments and homeless encampments and individuals are supported to access MOUD or other treatment services.

SOR III also supports targeted community prevention activities, statewide public service messaging, education opportunities for prevention professionals and universal, indicated, and selective family and youth prevention services.

- Community Prevention & Wellness Initiatives (CPWI): The SOR grant partially funds 22 CPWI coalitions in high-need communities with the greatest risk for youth opioid, stimulant, or other drug use. Coalitions implement evidence-based prevention programs, alternative programs, community-based processes, environmental strategies, and information dissemination to serve their communities.

- Community Based Organizations (CBO): HCA contracts with eight high-needs communities that implement direct evidence-based prevention services, information dissemination, and environmental strategies, such as drug take-back events.

- Student Assistance Prevention-Intervention Services Program (SAPISP): In partnership with the Education Service Districts (ESD), HCA provides each CPWI with a full-time student assistance professional (SAP). The SAP assists with school-based prevention and intervention services for universal prevention programming, indicated programs for the most at-risk students, and referral services.

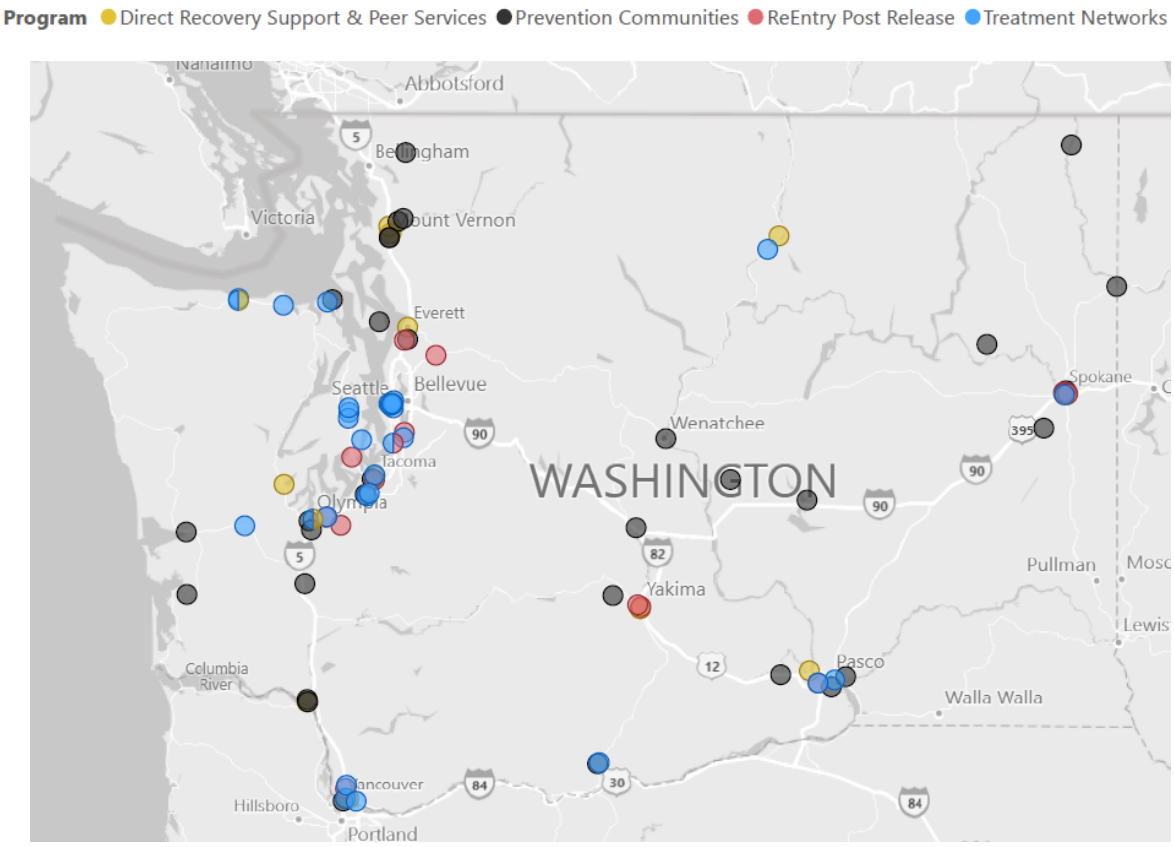
- Tribal Prevention Services (Indian Nation Agreements): Through the formal WA Tribal Consultation process, funding for prevention services was provided to address unmet needs in Tribal Communities. Prevention services include community-based processes, evidence-based programs, environmental policy, and information dissemination.

- Prescriber Education, Training, and Workforce Development Enhancements: HCA supports several conferences and other workforce development opportunities, such as the Region 10 Opioid Summit; WA State Prevention Summit; and the Spring Youth Forum.

- Fellowship Program: In partnership with Washington State University, HCA has developed a Fellowship Program. Over 10 months, fellows gain prevention system experience at the state and community level working with the CPWI coalitions.

The geographic distribution of these SOR III funded activities is illustrated in Figure 1. The following report summarizes the activities of these programs over the reporting period.

FIGURE 1.
SOR III Project Locations



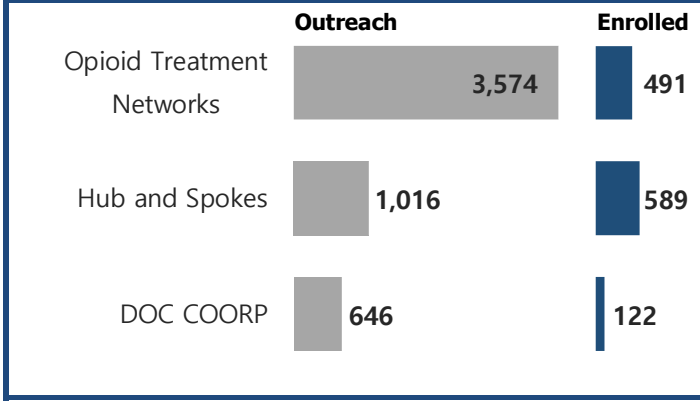
Note: The Department of Corrections COORP program is offered statewide and so is not displayed on the map. COORP clients may be served at any prison, local jail, work release, or Graduated Reentry or Community Parenting Alternative program. Direct Recovery Support & Peer Services include the Recovery Support Services – Direct Client Services and Peer Pathfinder service locations (note that Treatment Networks also provide support services). Prevention Communities include Community Prevention and Wellness Initiatives and Community Based Organizations program locations. Treatment Networks include Hub and Spokes and Opioid Treatment Networks.

Clients Reached and Served

Opioid Use Disorder Treatment

Three SOR III programs—H&S, OTNs, and COORP—conduct outreach and provide MOUD treatment. During this reporting period, September 30, 2022, through September 29, 2023, these programs provided treatment outreach to 5,236 clients identified as having OUD and offered MOUD treatment initiation (Figure 2). Of the clients receiving outreach, 1,202 agreed to enroll in SOR III and completed at least one treatment encounter after their initial induction onto to MOUD. The majority (80 percent) of enrolled clients received buprenorphine (Figure 3).

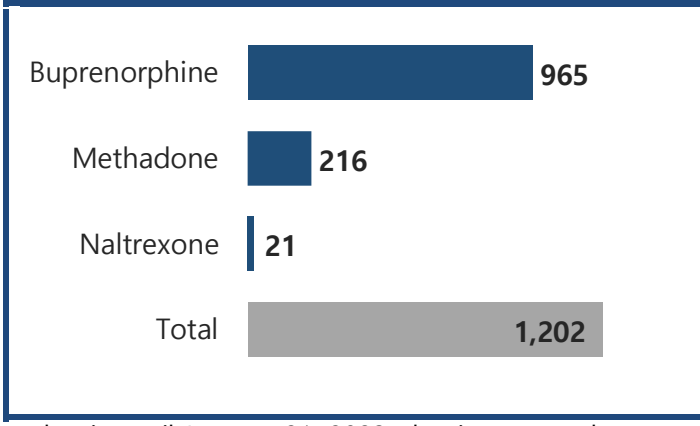
FIGURE 2.
MOUD Treatment Outreach and Enrollment
Total Clients = 5,236



While the RPR program does not provide MOUD treatment services, staff identified 610 clients entering jail that had an OUD (not shown). Among these clients, 314 opted for a referral to MOUD treatment and 149 opted for a referral to other treatment services, such as inpatient or outpatient, post release.

In addition to the 646 clients that initiated MOUD treatment in the COORP program, staff identified another 616 clients with OUD and referred them to MOUD treatment upon release from incarceration.

FIGURE 3.
Medication for Opioid Use Disorder Treatment at Enrollment
Total SOR III-Enrolled Clients = 1,202

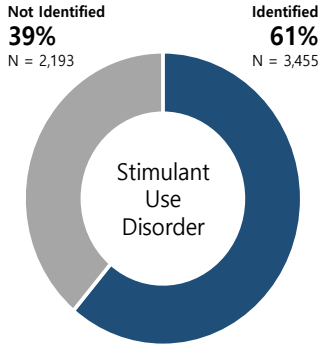


Client enrollment in SOR III services did not begin until January 21, 2023, due in part to the preparation time required to accommodate the new Government Performance and Results Act (GPRA) survey instrument and the delayed contracts with program service providers after receiving a late notice of funding award from SAMHSA.

Stimulant Use Disorder Treatment

SOR III does not directly fund stimulant use disorder treatment. Instead, clients receiving outreach services by H&S, OTNs, COORP, and RPR are screened for stimulant use disorder and referred to non-SOR-funded treatment services when appropriate. Of the 5,648 clients who received outreach by the H&S, OTNs, COORP, and RPR programs, 61 percent screened positive for stimulant use disorder (Figure 4).[2] Data on successful referrals to stimulant use disorder treatment are not collected for SOR III.

FIGURE 4.
Identified Stimulant Use Disorder
Total Clients = 5,648

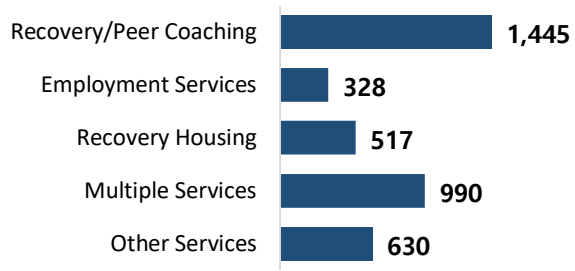


Recovery Support, Peer, and Referral Services

Four SOR III programs provide recovery support, peer, and referral services: Recovery Support Services – Direct Client Services (RSS); Peer Pathfinder (PPF); COORP, and RPR. The RSS and PPF programs offer services such as recovery or peer coaching, recovery housing, employment. Through September 2023, the RSS program conducted outreach to 568 clients and enrolled 553 clients in the SOR program (not shown). The PPF program conducted outreach to 1,166 new and returning clients. PPF clients were provided referrals for treatment and recovery support services in addition to peer coaching. Nearly all (1,445 out of 1,658) RSS and PPF clients received recovery or peer coaching and 990 received more than one service or referral (Figure 5). For PPF, outreach attempts were counted as peer coaching.

The DOC-administered COORP and RPR programs provide similar services to clients releasing from DOC facilities (e.g., 1,462 of these clients were referred to opioid or stimulant use disorder treatment). Most of the clients in DOC custody also receive naloxone and fentanyl test strips as they are released. Data on the numbers and types of additional support services provided to these clients are not systematically collected for SOR III.

FIGURE 5.
Recovery Support Services Received
Total SOR III-Enrolled Clients = 1,658



Note: Service categories are not mutually exclusive. Other services include case management; mental health or substance use peer support; community life skills; educational or housing support; and referrals to other services.

Prevention Services

SOR III prevention programs offer a wide array of services addressing youth opioid, stimulant, and other drug use. SOR III supports 22 Community Prevention and Wellness Initiative (CPWI) sites and in partnership with seven Education Service Districts (ESD), 21 schools receive the Student

[2] Totals in Figure 2 and Figure 4 differ as Figure 2 is displaying persons that received MOUD treatment services from H&S, OTN and COORP. Figure 4 includes all outreach attempts for these programs and RPR.

Assistance Prevention and Intervention Services Program (SAPISP). The latter provides school-based universal prevention programs and indicated programs for at-risk youth. Eight CBOs also serve high-need communities that offer direct evidence/research-based programs; information dissemination; and environmental strategies, such as promotion of secure and safe home storage of opioids and other drugs. Other prevention strategies offered through SOR include training and workforce development for prevention providers and a fellowship program.

Through information dissemination efforts, CBOs, CPWIs, and Tribal Programs have reached nearly 4.5 million Washingtonians (Figure 6). Between the CBOs, CPWI, SAPISP, and Tribal Programs, nearly 130,000 individuals received prevention services (Figure 7).

FIGURE 6.

Prevention Services – People Reached through Information Dissemination Efforts

Total = 4,477,318

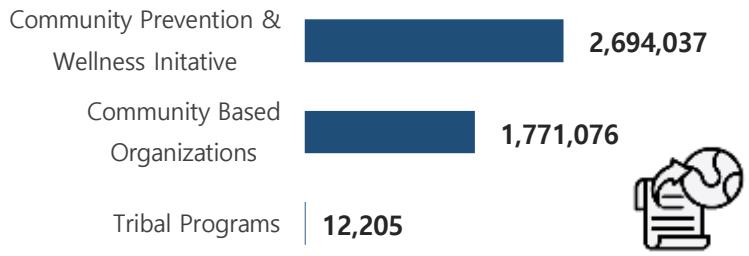


Image Credit: DPIcons from Noun Project

FIGURE 7.

Prevention Services – People Served

Total = 129,515

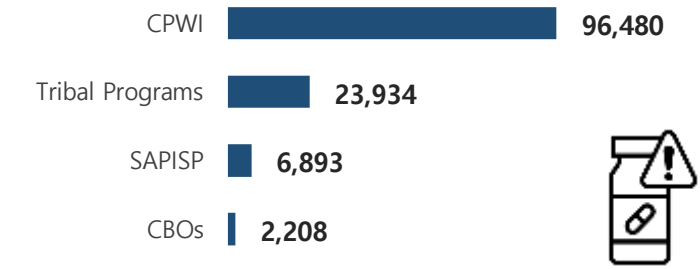


Image Credit: Sandiatresna from Noun Project

Major Annual Activities and Accomplishments

This section summarizes major accomplishments identified by project staff managing prevention, treatment, recovery support, harm reduction, and other activities under SOR III.

Prevention

Among the many activities and accomplishments for the SOR III prevention programs, the following highlights specific accomplishments of the Community Prevention and Wellness Initiative (CPWI), prescriber education and workforce development efforts, the Fellowship Program, and public education campaigns.

Community Prevention and Wellness Initiative (CPWI) and Student Assistance Prevention-Intervention Services Program (SAPISP)

In addition to serving youth, families, communities, and broad dissemination of information (Figures 6 and 7), CPWIs hosted drug take back events in October 2022 and April 2023. The SOR-funded

CPWIs, along with local law enforcement, collected nearly 4,100 pounds[3] of unused prescription medications from entering their communities. During the collection events, CPWI distributed over 630 safe storage devices for citizens to securely store medications in their home.

Prevention in Action

Starts with One – Opioid Misuse and Prevention Public Education Campaign

Credit: Division of Behavioral Health and Recovery. More information can be found at https://getthefactsrx.com/.

The Harbor Strong CPWI Coalition in Aberdeen, in collaboration with My TOWN CPWI Coalition in Hoquiam and Elevate East County Goldendale in Elma, developed and purchased a National Drug Take Back Day radio advertisement that aligns with the *Starts with One* statewide campaign. The coalitions held one of the take back events on Saturday, April 22, 2023, and had community-wide participation.

The Student Assistance Professional at Educational Services District 101, located near Spokane, Washington, sent three youth leaders to Community Anti-Drug Coalitions of America (CADCA). At this meeting, the student representatives learned about youth advocacy, best practices for substance use prevention, and presented on the *Starts with One* campaign.

Starts With One Social Media Campaign

The *Starts with One* campaign informs and educates Washingtonians at all stages of life on the dangers of prescription drug misuse and the importance of safe storage and disposal. This campaign is funded through the Washington State's Health Care Authority (HCA) and receives additional funding through the State Opioid Response grant. During year one of this campaign several accomplishments were achieved including the following:

- Nearly 4.3 million individuals reached through public education and awareness messaging.
- Over 723,000 young adults reached through media, including social platforms.
- 615 prescription lock bags distributed by community pharmacy programs.
- Pharmacists had 855 conversations with patients about locking up opioid medications.
- A pledge from 331 patients to lock up their opioid medications, following a conversation with their pharmacist.

[3] The weight of the prescription drugs mentioned in this report pertains solely to the SOR-funded CPWI sites. It's important to note that the SOR III mid-year report included combined Washington State efforts, which resulted in an overestimate of the SOR-related efforts.

Prescriber Education, Training and Workforce Development

SOR III supports several prevention-focused conferences including the Region 10 Opioid Summit; WA State Prevention Summit; and the Spring Youth Forum. Funding enhancements to increase professional development opportunities for prevention professionals and youth were added to the WA State Prevention Summit and Spring Youth Forum budgets. The 2022 WA State Prevention Summit was held November 7 – 9, 2022, and received considerable positive feedback. There were over 300 adults and 100 youth in attendance. Keynote and breakout session recordings were posted online for attendees to review. Planning for the 2023 hybrid WA State Prevention Summit began in December 2022 and included securing a venue, selecting speakers and sessions, finalizing a theme and graphics, and opening registration. This event took place in October 2023 during SOR III, Year two.

The Spring Youth Forum was held in May 2023 with 315 attendees, including 36 youth team participants. The youth teams showcased the prevention projects implemented in their communities. In addition, there were several youth development workshops on the effective use of social media and an adult workshop on the engagement of youth in prevention efforts.

The Region 10 Opioid Summit is a regional conference held in collaboration with Idaho, Alaska, and Oregon. The workshops and keynote speakers cover topics along the substance use disorder (SUD) continuum from prevention to intervention, treatment, harm reduction, and recovery. These conferences offer preventionists, SUD professionals, clinicians, and community members valuable experience to network and expand their knowledge. This year's theme was *The Road to Healthier Communities: Creating Equitable and Responsive Systems to Address the Evolving Opioid Crisis*.[4] Sessions could be attended online through a livestream or in-person. The event had 384 attendees, with 104 registration fee waivers for people that are financially disadvantaged. Overall, the conference held 19 workshops and attendees reported they would highly recommend this conference to others.

Fellowship Program

The Fellowship Program's Cohort 10 successfully completed the first two phases of the fellowship, (1) understanding the statewide prevention system; and (2) CPWI community placement to mentor under a coalition coordinator. Consistent with previous fellow cohorts, the current cohort has shown a steady trajectory of knowledge improvement over time and marked confidence in prevention work. The next cohort of four fellows will start by mid December 2023 and end in August 2024.

Treatment

Among the SOR III treatment project accomplishments, HCA program managers highlighted the accomplishments of the Tribal Treatment Program's social media campaign, as well as those of OTNs, H&S, and COORP.

Tribal Treatment Programs

Desautel Hege—a branding, advertising, and social media company located in Spokane, Washington assisting HCA with its *Starts with One* campaign—agreed to collaborate with HCA and an American Indian/Alaskan Native Workgroup to develop a Tribal Opioid Media campaign.

[4] Full program information is available at https://region10opioidsummit.org/wp-content/uploads/2023/07/713FINAL-Opioid-Summit-2023-Program.pdf.

The campaign, called *For Our Lives*, launched, and includes radio spots, a website, and video projects. The campaign also focuses on reducing stigma related to MOUD treatment. While this project is listed under the SOR III treatment activities, it incorporates the full continuum of SUD prevention, treatment and recovery. Through the end of this funding year, the campaign reached over 1.13 million individuals broadly and one million individuals through paid media, including social platforms.[5]

Opioid Treatment Networks and Hub and Spokes

Two of the SOR-funded treatment programs, OTNs and H&S, receive funds to support staff time to serve clients receiving MOUD treatment, which includes time for GPRA data collection and improvements to client outreach and communication. This year, HCA program managers conducted in-person contractor site visits for the first time since the COVID-19 public health emergency. These visits were well received and helped to build upon existing relationships with program partners.

Programs have been successful in enrolling clients and collecting the GPRA surveys in SOR III. Despite a late start due to contracting delays and the rollout of the new GPRA survey tool, the sites met their enrollment targets. Enrollment rates were 133 percent and 82 percent of target for H&S and OTNs, respectively. Additionally, sites improved their collection of 6-month follow-up surveys. The SOR III follow-up rate is 55 percent, much improved compared to the 30 percent SOR II follow-up rate. This success is due partly to better follow-up protocols, use of incentives, and clearer definitions of who qualifies as a SOR participant.

Tribal Prevention & Treatment Work in Action

Tribal Opioid Solutions – For Our Lives

Credit: Division of Behavioral Health and Recovery. More information can be found at https://fornativelives.org/.

Washington continues to see an increase in fentanyl use and overdose deaths. From 2021 to 2022, the fentanyl overdose death rate increased from 15.8 to 22.9 per 100,000 people, respectively.[6] The 13 OTNs and five H&S continue to refine their treatment programs to keep up with the changing drug use trends and best treatment practices.

To address challenges with engaging and treating persons addicted to fentanyl, treatment providers refined policies to be more person-centered. For example, many sites added walk-in availability, increased utilization of telehealth, strengthened community outreach efforts, and removed an abstinent requirement for treatment. Overall, modifying these policies has helped reduce barriers to accessing and sustaining treatment.

[5] The outreach for the Tribal Opioid Solutions – *For Our Lives* media campaign will overlap with the broader *Starts with One* campaign.

[6] Banta – Green, C. WA State Drug Trends, presented on November 29, 2023. Death data source: Washington State Department of Health death certificates, CDC Wonder.

Technical Assistance

The University of Washington Alcohol and Drug Abuse Institute (UW – ADAI) continues to offer high quality training and technical assistance for SOR treatment programs. During year one they completed a Tribal Sovereignty and the Indian Health Care System training series with 340 people in attendance. ADAI was also able to provide a technical assistance webinar series to build foundational knowledge and skills for new and current nurse care managers specializing in care for persons with OUD.

A major accomplishment for ADAI this year was hosting a Statewide in-person training titled *An Untapped Resource: Engaging Family, Friends, and Partners in MOUD Care*. This training focused on building relationships and engaging clients in MOUD care. In addition, ADAI held a webinar series called *Emerging Approaches to Treating Fentanyl Use Disorders Learning Collaborative*. Currently, ADAI is supporting technical assistance in establishing financial sustainability among SOR program sites. Trainings include information on creating alternative payment models and reviewing treatment models.

Treatment Patient Success Story

A patient first came to the clinic in August 2023 after completing inpatient treatment. They were recently diagnosed with Non-Hodgkins Lymphoma and undergoing radiation treatment after completing chemotherapy. The patient had a history of five overdoses where they were considered clinically dead. They were very determined to get healthy and sober and live the rest of their life on their own terms. The patient would like to eventually taper off buprenorphine and to assist with this, the clinic provided them with Sublocade. During their last appointment, the patient reported having a stable living situation, a vehicle, that they were actively job hunting, and had completed their cancer treatment.

Recovery Support

The following highlights the key accomplishments of the recovery support and peer services funded by SOR III.

Recovery Support Services – Direct Client Services

During the beginning of SOR III, RSS direct client services programs developed personalized GPRA data collection plans to document and improve their processes. These plans have assisted the SOR III evaluation team in providing technical assistance regarding data collection and other process improvements as needed. The plans address staff turnover concerns as new hires need to understand the data collection process and their responsibilities. RSS staff report that the plans have reduced confusion and created a smoother workflow for data collection. Despite initial contracting delays and uncertainty around the new GPRA tool, RSS programs met their annual enrollment target (100 percent). Additionally, sites successfully collected 75 percent of the six-month follow-up surveys.

The HCA established a quarterly virtual learning collaborative with the seven RSS providers. The first meeting was held in March 2023. The sessions were well received by the program providers and staff enjoyed getting to know one another. At these sessions, providers can interact, share resources, and troubleshoot ongoing implementation issues. The HCA provides updates and invites the SOR Data and Evaluation Team (SOR DET) to attend the call to answer any data collection related questions. Topics that have been covered at these meetings include Peer Supervision, process improvements to better engage and serve clients, and the recent changes to the State's peer counselor training and licensing process. A future session planned for year two will address culturally sensitive ways to engage and serve communities of color, with additional focus on tribal communities.

Peer Pathfinder

The Peer Pathfinder Homeless Outreach program performed remarkably this year. The providers far exceeded their annual statewide target for client outreach (202 percent of target). There was ample opportunity for HCA and provider staff engagement through desk reviews, in-person PPF agency site monitoring visits, and the annual meeting held in June. Additionally, the monthly peer outreach learning collaborative is well-attended and productive – reviewing topics such as health equity, vicarious trauma, and advocacy. Efforts to improve data quality have been a focus, as HCA staff have been collaborating with the SOR DET and direct service providers that input the data. One example of success has been a reduction in missing client identifiers in the data system, such as name or date of birth. Since October of 2022, the percentage of clients with missing identifiers dropped from 24 percent to 16 percent.

Harm Reduction

The SOR H&S and OTN treatment providers, as well as PPF sites, receive funds to purchase and distribute harm reduction supplies and services for their clients. Approved supplies and activities include the purchase and distribution of naloxone kits and fentanyl test strips, and overdose education. Some sites have hosted community naloxone education and overdose education events. Through this reporting period, the treatment programs purchased 114,360 fentanyl test strips and 5,910 naloxone kits (Figure 8). Systematic reporting for overdose reversals is not established, but treatment programs reported 107 overdose reversals.

FIGURE 8.
Harm Reduction – Naloxone Kits and Fentanyl Test Strip Purchases and Distribution

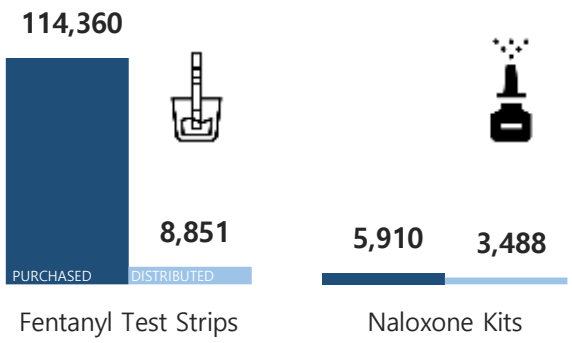


Image Credits: Iconixar and Clea Doltz from Noun Project

Limitations for collecting overdose reversal data include a lack of client reporting on overdoses, difficulty in tracking naloxone kits purchased with SOR funding versus other funding sources, and limited resources or a system to track overdose reversals.

Data Collection

The Washington State Department of Social and Health Services' Research and Data Analysis Division (RDA) is the SOR Data and Evaluation Team (SOR DET) and facilitates the data collection activities. Early in year one, the SOR DET successfully updated its data entry portal (REDCap) to accommodate the newly released and significantly changed version of the GPRA survey instrument. Completing this task required hundreds of hours of development and testing by the evaluators. Additionally, this team has successfully established a weekly batch upload protocol to SAMHSA's Performance Accountability and Reporting System (SPARS) with minimal data entry errors.

Several tools have been developed by SOR DET to assist sites in monitoring their progress and data quality. One tool was a fillable PDF version of the GPRA survey which was particularly helpful while REDCap was updated to accommodate the new GPRA tool. Additionally, REDCap reports and dashboards are available for sites to utilize that assist with real-time tracking of GPRA survey due dates, missing surveys, and reviewing key GPRA outcomes, such as past 30-day drug use.

To assist sites with locating clients that are due for follow-up surveys, SOR DET created a secondary contact form in REDCap. This optional form collects information about when the client prefers to be contacted; places they frequent; emergency contacts and the types of information that can be left with the contacts; and social media handles through which they can be contacted via private messaging. Efforts to improve the six-month follow-up survey rate for SOR III have been effective, with completion rates around 55 percent.

Finally, programs that conduct GPRA surveys must identify a back-up data coordinator. The data coordinator and back-up coordinator are designated staff that understand the data collection requirements, how they are implemented within their agency, and can train other staff at their agency to assist with data collection. The back-up coordinator has helped ameliorate issues associated with staff turnover of the data coordinator positions. All staff entering data are invited to a monthly data collection technical assistance call with SOR DET. These calls cover common data entry errors, changes to data collections protocols, process improvement strategies for data collection, and resource distribution for monitoring their performance. The calls are well attended, and program staff that collect the data are appreciative of the availability of the SOR DET.

Barriers

Overall, SOR III has met some challenges including some particularly high-impact issues such as delays in the notice of funding, contract implementation delays with sub-grantee recipients, shifting guidance on the data collection requirements, and staffing issues. The following section will highlight some of the key barriers Washington has faced with implementing SOR III, how they were addressed, and challenges that still exist.

Prevention

The prevention conferences experienced some challenges. The biggest issue for the *Spring Youth Forum* has been the rising costs of hosting a conference, especially being the one of the first in-person conferences held since the pandemic. Youth across the state are excited and eager to attend the Spring Youth Forum; however, the increased costs make it difficult to fund the conference and assist with travel expenditures for attendees.

The *Region 10 Opioid Summit* experienced technical difficulties for the livestream sessions, such as connectivity issues and inability to participate in the question-and-answer session. This impacted 94 virtual attendees. Given this experience, conference administrators will better prepare and troubleshoot these issues in the future. This will enhance attendees' access, engagement, and satisfaction with the online format.

The *Fellowship Program* is working to improve Fellow community placement. Past Fellows have voiced concern with the necessity to relocate to new communities as they move through the program. Some possible solutions include: (1) allowing hybrid work hours; (2) placements closer to the Fellow's current living residence; and (3) changing to long-term projects over the course of the Fellowship program in lieu of short-term projects. The Fellowship Program also experienced issues with recruitment for the most recent cohorts. To address this, HCA will attempt to recruit at a time that is better suited for recent college graduates.

The Pharmacy programs imbedded within the *Starts with One* media campaign, experienced implementation barriers including reduced staff and administrative and reporting burden. Due to staff shortages, pharmacists were unable to properly educate patients on safe medication storage or

obtain pledges to lock up medications. To improve the program, HCA reduced the reporting frequency from weekly to monthly; deployed new tools to engage patients (e.g., QR code and text surveys); increased training opportunities for staff; and is actively soliciting feedback from pharmacies for ongoing process improvements to increase participation and satisfaction with the program.

As stated in the mid-year report, delays in the notice of award and initiating contracts for CPWIs and CBOs stalled service delivery at the start of the grant. HCA's Contract Division worked to amend and initiate contracts as efficiently as possible once the SOR III Notice of Award was received. However, there were some lost opportunities, such as hosting a National Drug Take Back Event in October. Full-service delivery resumed once contracts were initiated.

Similar to the pharmacy program described above, staffing and recruitment issues affected CPWIs and ESD programs as well. Two key issues included high staff turnover and the inability to fill the Coalition Coordinator or Student Assistance Professionals positions. Vacancies in these positions halt service delivery and coalition work. Recruitment continues to be an issue in rural and remote communities with less available workforce.

Treatment

Sub-grantee contracts were delayed at the start of the grant due to the late Notice of Funding Award from SAMHSA. The last contracts were not signed until April 2023. Given the delay, SOR III treatment sites provided MOUD services without receipt of timely payments, which was a significant administrative barrier for the providers. To alleviate some concerns, HCA sent intent to contract letters to the providers ensuring them future funding. To expedite the contracting process in the future, HCA collaborated with its Contracts Division to prepare draft contracts that are ready once the Notice of Award is received.

Delays and uncertainty with the rollout of the new GPRA tool resulted in strain and anxiety among the SOR treatment programs. Concerns were alleviated as the new GPRA survey tool was implemented and treatment program sites realized they did not have to collect additional surveys. In general, the GPRA survey data collection remains burdensome on staff time and is not a client-centered practice. Reducing this burden on staff and clinical care as much as is possible, while meeting the grant obligations, is a priority. One of the biggest challenges is locating clients for the follow-up survey. Many clients served in these programs are experiencing homelessness; lack reliable forms of communication, such as phone or internet access; or were non-treatment seeking. For the jail programs, tracking clients that live in a county outside of where they were released or clients not on some type of supervision is challenging. Efforts to collect secondary contact information has helped some sites, as well as the use of incentives when clients are located. As mentioned before, sites have improved processes to collect the surveys and the grant follow-up rate is around 55 percent.

Staffing, workforce, and retention challenges continue to impact data collection and service delivery for SOR treatment programs. Recruitment of new staff is particularly challenging in more rural areas of the state. While this has been an ongoing challenge, most treatment sites made adaptations with existing staff to meet the staffing requirements of their SOR contracts. Additionally, sites are training multiple staff on the data collection requirements to be more prepared when a staff person leaves.

Establishing clinical practice standards for clients presenting with fentanyl addiction has been a significant challenge for treatment sites. A lack of guidelines for sufficient dosing regimens, navigating early withdrawal symptoms with clients to begin buprenorphine treatment, and client

engagement are barriers to effectively treating clients. Transportation and housing assistance, particularly in rural and frontier areas, are limited and cumbersome to access. The UW ADAI technical assistance team developed training curriculum and worked with sites to navigate these issues. Some sites have had success with transportation vouchers, but this has limitations regionally. Fentanyl is the primary self-reported substance used and providers face barriers with testing clients for fentanyl use. The Clinical Laboratory Improvement Amendments testing requirements are prohibitive. Instead, providers must rely on patient self-report, which can increase the risk for drug diversion, precipitated withdrawal, and treatment disengagement.

Finally, treatment providers still encounter issues with stigma around treating people with OUD, particularly among pharmacists and other health care providers outside of the treatment teams. Washington State has been trying to increase access to training and other initiatives to reduce stigma around SUD for medical providers and the public.

Recovery Support

Like other programs, SAMHSA's Notice of Funding delay stalled contracts with the Recovery Support Servies (RSS) providers, resulting in disruptions to client services. Providers received letters of intent to contract, however, not receiving payments for three months created administrative stress, especially for the smaller providers. Fortunately, most of the providers were still able to offer services and meet their annual targets despite the delays.

Delays and uncertainty surrounding the new GPRA data collection instrument at the start of the SOR grant stressed the providers. One challenge they experienced was holding onto a backlog of data that needed to be entered into REDCap once their contract was signed. Sites were given leniency to get their data entered to reduce this burden.

Resource limitations related to staffing and the SOR funding structure prevented many sites from engaging in community outreach. Many RSS sites only have one SOR recovery coach or peer and once they have full caseloads, are unable to take new clients or do community outreach. Further, the SOR funding structure only pays for direct services once a client is enrolled, not community outreach. To improve staffing resources, some sites reallocated funds from other programs to hire additional coaches or peers. The more remote sites are struggling to keep their caseloads up, as fewer clients are coming in for services. These sites continue to look for ways to increase their outreach efforts.

Recovery Support Client Success Story

Client came to our agency by word of mouth after first joining the Matt Talbot Recovery program. They had just been released from an inpatient treatment facility after experiencing opioid overdose three weeks prior. The client stated at the time of our first meeting that they had truly hit rock bottom. When their daughter brought her new baby to see them—their second grandchild—the client felt at that moment they could not continue down the path they were on. Right then and there they made up their mind to be in their grandchildren's lives and knew that changes were needed. Stopping their drug use was at the top of their list.

The Peer Pathfinder Homeless Outreach program struggled with staffing and funding challenges as well. High staff turnover and recruitment were problematic; funding allocation has remained stagnant; and the administrative reporting and contractual outreach targets are burdensome. A contributing factor for these issues is that the peer outreach salaries are not competitive. Site administrators are becoming proactive by documenting the issues and presenting proposals for short-term solutions. The HCA will work to improve future contracts for these programs based on recommendations from the site administrators.

Harm Reduction

Peer Pathfinder (PPF) outlined plans for harm reduction activities based on their contracts. Unfortunately, the funding allocated for harm reduction activities was inadequate to properly facilitate planning and reporting. PPF sites managed to purchase and distribute very limited supplies, and for some sites it was as few as 10 Narcan® kits. In the future, the HCA will better target these funds to high-risk regions which will reduce the administrative burden on smaller providers.

Concerns for distributing fentanyl test strips among treatment programs were high since these tests were considered drug paraphernalia. Fortunately, on July 1, 2023, Washington State passed Senate Bill 5536, which clarified that drug testing equipment, including fentanyl test strips, are no longer considered drug paraphernalia, and thus removed the potential for civil infraction for distribution.[7] This rule change allows providers to distribute this resource more confidently to clients. Sites are still working with their organization, local public health agencies, and jurisdictions to develop effective distribution processes.

Data Collection

Data collection challenges were significant at the start of SOR III. The deployment of the new GPRA survey tool was plagued by uncertainty, delays, conflicting guidance, and shifting timelines. Key challenges included:

- the absence of training on the new tool;
- changes to the go-live date for the new tool;
- insufficient or delayed supporting documentation, such as the FAQ, QxQ and codebooks;
- errors and inconsistencies in supporting documentation (e.g., the codebook);
- inability to batch upload data; and
- frequently unresponsive SPARS technical assistance.

Despite these challenges, the SOR DET was able to replicate the new GPRA survey instrument and collect grant data using REDCap. The batch upload process has been running smoothly with few errors.

Conducting six-month follow-up surveys remains a challenge. While sites are performing better than prior years, the 80 percent follow-up rate is unrealistic; this metric feels punitive to grant recipients and service providers, and it is not a true measurement of SOR program success. The SOR funded programs are serving persons with OUD—a chronic relapsing condition—that also have high prevalence of concurrent stimulant use disorder and mental health conditions, are typically homeless or unstably housed, unemployed, frequently incarcerated, and lack inconsistent means for communication. Given this population and the conditions they are experiencing, locating them six months after they receive services can be challenging. The Opioid Treatment Networks serve clients in non-treatment-seeking locations, such as jails or emergency departments, and clients are difficult to locate after they release or discharge. To address this problem, the SOR projects developed data collection plans, provided incentives, and collected secondary contact information from clients.

[7] Washington State passed Senate Bill 5536

Additionally, clients must meaningfully engage in treatment before they are enrolled in SOR services. These efforts have improved the follow-up rate, but SAMHSA should reconsider the 80 percent follow-up target considering the population and treatment modalities.

Disparity Impact

This section outlines the progress achieved in addressing the needs of diverse populations (e.g., racial/ethnic minorities, LGBTQIA+, older adults) and implementation of targeted interventions to promote behavioral health equity.

Prevention

The CPWI coalitions continue to address the needs of diverse populations in several ways. First, they ensure programs, brochures, and community information are translated into many languages. One coalition collaborated with a local partner organization to focus on offering Spanish language youth and parent prevention resources. Another coalition worked with their school district's migrant parent committee to support a family festival that was held in the spring. Coalition members attended training and conferences to increase their knowledge and understanding of diversity, equity, and inclusion (DEI) and disseminate materials on DEI to their coalitions.

Within the social media campaign project, data shows that opioid misuse disproportionately impacts Spanish-speaking, Black, American Indian/Alaska Native, and LGBTQIA+ communities. The campaign addressed this by adapting messaging to reach these communities in more culturally appropriate ways. Members of the impacted communities are invited to participate and advise on campaign messaging, videos, and materials related to prescription opioid use that effectively address cultural and communication barriers within each audience. The SOR project also helped fund the *For Our Lives* campaign, designed by and for the Native community.

Treatment

The University of Washington's Alcohol and Drug Abuse Institute (ADAI) provides training and technical assistance to the SOR III treatment and recovery support programs. Training topics include cultural change, stigma related to SUDs, harm reduction, trauma-informed care, peer navigation, tribal sovereignty and the Indian health care system, cultural considerations when working with American Indian/Alaska Native community members, historical trauma and discrimination, and special topics related to DEI.

Treatment providers submit a monthly report to HCA that must address how they are applying principles, improving processes, and building capacity around DEI. HCA reviews the DEI plans at annual site visits. In year one, sites reported that staff and leadership at their facility attended the annual training/re-training on DEI, SUD stigma, cultural sensitivity, and linguistically appropriate behaviors and attitudes. Several sites have translation services available on demand, offer transportation services, and assist clients with housing, employment, food, legal, and medical costs.

Sites set up workgroups or assigned staff to address DEI issues as it pertains to staff attitudes as well as the treatment and care provided to clients. Some sites have also received training and assistance to recruit and retain a diverse workforce, and to find staff with lived experience. Treatment providers are also developing partnerships with organizations that address homelessness; seeking housing assistance funding; and improving services for persons with co-occurring mental health conditions.

Sites are trying to offer these services in more equitable ways, accommodating clients with disabilities, treating co-morbidities and chronic illness, and continually making process improvements to provide more culturally relevant and sensitive treatment.

> **Opioid Treatment Network Administrator**
>
> *It can be challenging to motivate a patient [seeking treatment], find a treatment bed at a facility that takes Medicaid, and get them safely transported to the center in the timeframe allotted by the treatment center. Our Substance Use Disorder Providers continue to amaze me in how resourceful and caring they are when it comes to helping their patients.*

The Department of Corrections programs sent all staff to the DEI statewide training initiative required by the Governor's Executive Order 22-02 and Directive 21-0 called *A Path Toward Equity: Disrupting Structural Racism through Awareness and Belonging*. The course was developed to create a shared understanding and language around diversity, equity, and inclusion and help employees gain skills necessary for a respectful and inclusive workplace. Additionally, the RPR programs located in Yakima and Benton County are working with SUD treatment providers to find resources for undocumented clients.[8]

SOR treatment and recovery support programs do a decent job of identifying and enrolling persons in their programs that are representative of the statewide Medicaid population with OUD. Comparisons of demographic characteristics of individuals enrolled in the SOR treatment and recovery support programs are similar to those of the Medicaid population with OUD in 2022 (Appendix A) with a few exceptions. Females represent 45 percent of the Medicaid population with OUD, but only represent 34 percent of persons served by SOR. This may be due in part to funding several jail programs that predominately serve males. Efforts will be made to ensure programs are reaching more women as programs are adapted. Some communities of color are also under-represented in the SOR population, particularly American Indian/Alaska Natives (AIAN), Asians, Hispanic/Latinos, and Native Hawaiians/Pacific Islanders. The AIAN population is disproportionately impacted by the opioid epidemic. While more efforts are being made to better serve this population, activities must consider the sovereignty of tribal communities and the historical trauma they have faced due to white colonialism. The HCA is always striving to maintain respectful relationships with tribes, develop culturally appropriate programs and messaging in collaboration with the AI/AN population, and respect the autonomy of this population.

Recovery Support

Given the disproportionate impact of the opioid crisis on the AIAN community, the RSS contracts require sites to prioritize services for the AIAN population, including tribal members. All providers have updated their policies and procedures to inform staff of best practices and implementation strategies. Additionally, RSS agencies regularly hold community events to increase awareness of their services and to provide outreach to underserved communities.

The PPF contracts require agencies to provide culturally sensitive services that meet the needs of historically disadvantaged communities and populations. Agencies should initiate actions and make process improvements to increase engagement and retention in treatment and prevention services for persons of color or other historically disadvantaged communities. Further, agencies that sub-contract with the PPF sites will adhere to the same requirements. Sites are encouraged to strengthen relationships with agencies that prioritize historically disadvantaged communities.

[8] Appendix A provides a comparison of the demographics of SOR-enrolled clients compared with the Washington State adult Medicaid population with OUD.

As mentioned above, PPF outreach workers have enthusiastically delved into the issue of health equity and related topics in their peer outreach learning collaborative. HCA staff provided a presentation on diversity, equity, inclusion and belonging at the Annual Meeting. This was followed by a robust discussion on challenges that outreach workers face in overcoming individual prejudices and addressing intersectional marginalization. Initial conversations have started between HCA and PPF supervisors and outreach workers about looking for blind spots (or "equity opportunities") in program data.

Harm Reduction

Harm reduction strategies are trauma and culturally informed, low barrier activities that target specific behavior to meet individual and community needs. Clients are encouraged to ask questions and be a part of the shared decision making when creating harm reduction strategies for persons who use drugs. Agencies that offer harm reduction strategies have language interpreter services and partner with mobile health units. Further, they develop organizational and/or community level health equity committees that address SUD stigma, educate individuals about substance use, create policies to better serve clients, and organize events. Populations of focus include individuals experiencing homelessness, pregnant and parenting persons, and incarcerated individuals.

Fiscal Monitoring

Washington State was awarded $27.5 million for the first year of SOR III. Through the end of year one, SOR III spent nearly $23 million, or 83 percent of the total award. SAMHSA limits the amounts that may be spent on (1) indirect/administrative and infrastructure and (2) data collection and reporting (no more than five percent on each). Table one shows expenditures by category through year one.

Indirect/administrative and data collection and reporting expenditures stayed within the 5 percent allowance. While the total amount billed for SOR III year one is final, the expenditures by the broader prevention, treatment and recovery categories are subject to change as HCA continues to process and finalize payments.

TABLE 1.

SOR III Spending through September 29, 2023

CATEGORY	SPENT	% OF TOTAL SPENDING	% OF TOTAL AWARD
Indirect/Administrative	$803,784.81	4%	3%
Data Collection/Reporting	$1,284,949.61	6%	5%
Prevention	$2,795,017.38	12%	10%
Treatment	$13,547,347.81	59%	49%
Recovery	$4,468,895.04	20%	16%
TOTAL	**$22,899,994.65**	**100%**	**83%**

APPENDIX A | Supporting Table

Demographic Characteristics of Individuals Enrolled in SOR Direct Treatment and Recovery Support Service Programs compared to Washington State's Medicaid Clients with an Opioid Use Disorder in CY2022

	SOR POPULATION		MEDICAID POPULATION w/ OUD	
	NUMBER	PERCENT	NUMBER	PERCENT
Total	1,519	100%	61,297	100%
AGE				
Average	38.5		38.5	
Median	36.0		37.0	
18-24	80	5%	3,928	6%
25-34	542	36%	21,661	35%
35-44	545	36%	19,574	32%
45-54	205	13%	9,397	15%
55+	146	10%	6,737	11%
Missing Age	1	<1%	0	0%
GENDER				
Male	1,000	66%	33,575	55%
Female	511	34%	27,722	45%
Other Genders/Missing Gender	8	<1%	0	0%
RACE/ETHNICITY				
African American/Black	136	9%	5,630	9%
American Indian/Alaska Native	99	7%	10,003	16%
Asian	21	1%	2,221	4%
Hispanic/Latino	155	10%	7,069	12%
Native Hawaiian or Pacific Islander	16	1%	1,651	3%
White	1,223	81%	54,989	90%
White, non-Hispanic	1,108	73%	46,943	79%
Missing Race	113	7%	NA	

Note: The Medicaid population with OUD is based on adults (18+) with an opioid use disorder diagnosis in CY2022. Age for the Medicaid population was calculated as of January 1, 2022. Race categories where the Hispanic population was more than 1% of the total population are displayed in two categories: one inclusive of Hispanic people and one excluding Hispanic people (non-Hispanic). The SOR population is comprised of individuals who consented to participate in the grant among Hub and Spoke, Opioid Treatment Networks, and DOC Care for Offenders Releasing from Prison clients that initiated MOUD treatment. This includes clients that may not have completed the GPRA survey as of processing, which is why the total SOR population count in this table is higher than the count found in Figure 3. Values smaller than 11 are suppressed.

APPENDIX B | SOR III Staff

Key Personnel

Name	Position Title	Email	Tasks
Lora Weed	Acting Project Director	Lora.weed@hca.wa.gov	Oversees all major activities of the SOR grant and manages the WSU Promoting Research Initiative; Contract Manager for Dept of Correction's programs and Hub and Spokes
Kris Shera	Project Coordinator	Kris.shera@hca.wa.gov	Oversees Opioid and Overdose Response Plan and Opioid Settlement Funds
Elizabeth Speaker	Data Coordinator	Elizabeth.speaker@dshs.wa.gov	Oversees all data collection and reporting activities of the SOR grant

HCA Contract Managers

Name	Position Title	Email	Tasks
Anne Paulson	Communication Specialist	Anne.paulson@hca.wa.gov	SOR Communication Coordinator
Kiera May	Fiscal Analyst	Keira.may@hca.wa.gov	SOR Fiscal Coordinator
Kendra Wilson	Prevention System Manager	Kendra.wilson@hca.wa.gov	Athena Forum and CPWI Contract Manager; Develops e-learning prevention courses
Natalie West	Prevention System Manager	Natalie.West@hca.wa.gov	Coordinator for the Opioid Summit and Region 10 Conferences; Oversees Starts with One Campaign; CPWI Contract Manager
Kira Schneider	Recovery Support Manager	Kira.schneider@hca.wa.gov	Direct Recovery Support and Peer Services Contract Manager
Meta Hogan	Recovery Support Manager	Meta.hogan@hca.wa.gov	Peer Pathfinder Contract Manager
Megan Fowler	Treatment Manager	Megan.fowler@hca.wa.gov	Opioid Treatment Networks Contract Manager
Liz Knutter	Treatment Manager	Elizabeth.knutter@hca.wa.gov	ADAI and DSHS RDA Contract Manger; Oversees the NATIVE Project, DH Media Campaign, American Indian Health Commission and Seattle Indian Health Board SOR-funded activities, and Dept. of Health Tobacco Cessation

SOR Data & Evaluation Team (Research and Data Analysis)

Name	Position Title	Email	Tasks
Tiffany Carpenter	Operations Research Specialist	Tiffany.carpenter@dshs.wa.gov	REDCap Administrator; Data processing and reporting to SPARS
Frankie Edwards	Researcher	George.edwards@dshs.wa.gov	Assists with program evaluations and research projects; Oversees Peer Pathfinder data collection and reporting
Shilpi Gupta	Data Consultant 4	Shilpi.gupta@dshs.wa.gov	Assists with data collection quality assurances; SOR data collection training coordinator
Samuel Larsen	Data Consultant 4	Samuel.larsen2@dshs.wa.gov	Assists with data collection quality assurances; SOR data collection training coordinator

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