

Academic Learning Collaborative Symposium

Friday, October 3, 2025

9 a.m. – 12:30 p.m.

Welcome!



- Thank you for joining the first Academic Learning Collaborative (ALC) Symposium
- The ALC aims to bring together organizations involved in evidence-based health care, cultivating a statewide research community

Agenda

Agenda Items	Time	Presenter
Welcome & Introduction	9:00 – 9:10	Christopher Chen, Melanie Golob, Health Care Authority
Panel 1: Presentation 1	9:10 – 9:20	George Gonzalez, University of Washington
Panel 1: Presentation 2	9:20 – 9:30	Jason Kilmer, University of Washington
Panel 1: Presentation 3	9:30 – 9:40	Jaymie Bockelman, Health Care Authority; Gitanjali Shrestha, Washington State University
Panel 1: Presentation 4	9:40 – 9:50	Teresa Winstead, Addictions, Drug and Alcohol Institute, University of Washington
Panel 1: Q&A	9:50 – 10:05	<i>Behavioral/Mental Health & SUD Panel</i>
Break 1	10:05 – 10:10	
Panel 2: Presentation 1	10:10 – 10:20	Ashok Reddy, Jonathan Staloff, Edwin Wong, University of Washington
Panel 2: Presentation 2	10:20 – 10:30	Amy Edmonds, Oregon Health and Science University
Panel 2: Presentation 3	10:30 – 10:40	Veena Shankaran, Hutchinson Institute for Cancer Outcomes Research (HICOR), Fred Hutchinson Cancer Center
Panel 2: Q&A	10:40 – 10:55	<i>Medical Panel</i>
Break 2	10:55 – 11:00	
Poster Session	11:00 – 11:20	
Panel 3: Presentation 1	11:20 – 11:30	Alastair Matheson, Jennifer Liu, Susan Hernandez, Public Health Seattle King County
Panel 3: Presentation 2	11:30 – 11:40	Karen Yao, Health Care Authority
Panel 3: Q&A	11:40 – 11:55	<i>Public Agency Panel</i>
Break 3	11:55 – 12:00	
HCA update/research priorities/Q&A	12:00 – 12:25	Charissa Fotinos, Judy Zerzan-Thul, Health Care Authority
Wrap Up	12:25 – 12:30	Christopher Chen, Melanie Golob



CBT+ Learning Collaborative

Implementing Evidence-Based Practice and Building Organizational Capacity

October 3, 2025

George Gonzalez, MSW, LICSW

goko@uw.edu

Assistant Director, Harborview Abuse & Trauma Center

What is the CBT+ Learning Collaborative?

A learning collaborative model for CBT evidence-based treatments. Our primary purpose is to support capacity building in community mental health agencies

Training components include:

- Asynchronous Training
- Web-Based Live Training
- Clinical Consultation Calls

Post Training Support

- Clinical Support for Supervisors
- Advanced Training Colloquium
- Resource Tool Kit

Why a collaborative for community mental health?

- High demand for effective evidence-based practices for children experiencing traumatic stress
- Community Mental Health has historically been underfunded and challenged with implementing EBP for children
- Constant staff turnover

Implementation Science

Exploration-Preparation-Active Implementation- Sustainability

- Implementation
 - > Phase One:
 - > Build a model that trains clinicians across WA State
 - > Phase Two: Refine Capacity Building
 - > Build a model that trains agencies so they can train their own staff

Embedded Clinical Coaching-In House Model

Train the Trainer

- Components
 - > Asynchronous Learning
 - > In-House Clinical Consultation
 - > Remain part of the larger collaborative
 - > Resources
 - > Support for Supervisors
 - > Ongoing Training

Traditional vs Embedded Clinical Coaching

Traditional CBT+ Model

- Over 35 Community Mental Health Agencies Trained
- Train 200-250 practitioners a year
- Consistent high satisfaction with training and consultation calls

Over 6 years

UNIVERSITY *of* WASHINGTON

Embedded Clinical Coaching

- 7 Community Mental Health Agencies Trained
- 74 people completed the training
- Awaiting satisfaction survey results
- All agencies will complete consultation by December
- Most agencies are choosing to continue

1st year pilot

What does the future hold?

- Evaluating In-House CBT/Embedded Clinical Coaching
- Make needed adjustments
- Identify new sites
- Support pilot sites

Washington's Young Adult Health Survey: Highlights from 11 Years of Data Collection

**Jason R. Kilmer, Mary E. Larimer, Isaac C. Rhew,
Joseph Lambuth, & Rose Lyles-Riebli**

**Center for the Study of Health & Risk Behaviors,
University of Washington, Psychiatry & Behavioral Sciences**

October 3, 2025



Before we get started...

- **Special thank you to Sarah Mariani, Kasey Kates, Megan Stowe, and Rachel Oliver**
- **Thank you to Melanie Golob for all she did to make today happen!**

Washington Young Adult Health Survey (YAHS)

- Funded by Division of Behavioral Health & Recovery (DBHR):
 - Sarah Mariani
 - Kasey Kates
 - Rachel Oliver
 - Megan Stowe
- Young Adult Health Survey Team:
 - Jason Kilmer
 - Mary Larimer
 - Rose Lyles-Riebli
 - Joseph Lambuth
 - Isaac Rhew

Washington State Health Care Authority (Division of Behavioral Health and Recovery) (PI: Kilmer).

Young Adult Health Survey Recruitment...

A Reminder of the Main Steps

- Participants recruited using a combination of direct mail advertising to a random sample from DOL, as well as online advertising (Facebook, Craigslist, Instagram, study web site, etc.)
- Assessed demographics on ongoing basis and modified strategies to recruit under-represented groups
- Convenience sample, not a random sample

Post-stratification weighting and analyses

- To improve generalizability, used post-stratification weights based on sex, race, and geographic region
- Weighted results are consistently very similar to non-weighted

Young Adult Health Survey

- Each year we collect data from a new cohort of 18-25 year olds

Sample sizes over time

• Cohort 1 (2014):	2,101
• Cohort 2 (2015):	1,675
• Cohort 3 (2016):	2,493
• Cohort 4 (2017):	2,342
• Cohort 5 (2018):	2,412
• Cohort 6 (2019):	1,942
• Cohort 7 (2020)	1,643
• Cohort 8 (2021):	1,756
• Cohort 9 (2022):	1,110
• Cohort 10 (2023):	1,237
• <u>Cohort 11 (2024):</u>	<u>1,751</u>
• TOTAL:	20,462

Young Adult Health Survey

- In 2024, we also followed up with each of the previous 10 cohorts (participants in Cohort 1, 18-25 in 2014, were largely 28-35 when we collected data from them in 2024)

Select findings (for today's time frame)
with eleven years of data

Any past year "recreational"/non-medical/personal use: Cohorts 4-8 higher than Cohort 1

	Cohort 1 (2014)	Cohort 2 (2015)	Cohort 3 (2016)	Cohort 4 (2017)	Cohort 5 (2018)	Cohort 6 (2019)	Cohort 7 (2020)	Cohort 8 (2021)	Cohort 9 (2022)	Cohort 10 (2023)	Cohort 11 (2024)	Total across 11 years
18-20	43.27%	44.82%	40.94%	43.41%	44.42%	43.68%	40.39%	44.89%	39.11%	36.57%	39.00%	42.18%
21-25	43.67%	47.09%	46.55%	49.75%	50.87%	49.61%	52.29%	55.21%	53.60%	51.90%	52.00%	49.76%
TOTAL	43.51%	46.29%	44.76%	47.43%	48.49%	47.24%	47.94%	51.19%	47.26%	46.24%	46.44%	46.91%

Cohort 1 vs. Cohorts 2-11:

Compared to Cohort 1, significantly higher prevalence for

- Cohort 4 (t=2.29, p<.05; odds ratio = 1.171; Cohort 4 has 17% higher odds of non-medical cannabis use than Cohort 1)
- Cohort 5 (t=2.96, p<.01; odds ratio = 1.222; Cohort 5 has 22% higher odds of non-medical cannabis use than Cohort 1)
- Cohort 6 (t=2.11, p<.05; odds ratio = 1.163; Cohort 6 has 16% higher odds of non-medical cannabis use than Cohort 1)
- Cohort 7 (t=2.41, p<.05; odds ratio = 1.196; Cohort 7 has 20% higher odds of non-medical cannabis use than Cohort 1)
- Cohort 8 (t=4.19, p<.001; odds ratio = 1.362; Cohort 8 has 36% higher odds of non-medical cannabis use than Cohort 1)

Source: Young Adult Health Survey, Preliminary Data Report to DBHR, March 2025, Kilmer (PI)

Any past year "recreational"/non-medical/personal use: Significant increasing linear trend for 18-25-year-olds

	Cohort 1 (2014)	Cohort 2 (2015)	Cohort 3 (2016)	Cohort 4 (2017)	Cohort 5 (2018)	Cohort 6 (2019)	Cohort 7 (2020)	Cohort 8 (2021)	Cohort 9 (2022)	Cohort 10 (2023)	Cohort 11 (2024)	Total across 11 years
18-20	43.27%	44.82%	40.94%	43.41%	44.42%	43.68%	40.39%	44.89%	39.11%	36.57%	39.00%	42.18%
21-25	43.67%	47.09%	46.55%	49.75%	50.87%	49.61%	52.29%	55.21%	53.60%	51.90%	52.00%	49.76%
TOTAL	43.51%	46.29%	44.76%	47.43%	48.49%	47.24%	47.94%	51.19%	47.26%	46.24%	46.44%	46.91%

Linear trend from Cohort 1 to Cohort 11:

Significant ($t=2.41$, $p<.05$; odds ratio = 1.0127; odds of non-medical cannabis use are 1.3% higher with each successive year/cohort)

Age by cohort interaction:

- Significant, reflecting the differences in the linear trend seen in the stratified models below ($t=4.38$, $p<.001$)

Source: Young Adult Health Survey, Preliminary Data Report to DBHR, March 2025, Kilmer (PI)

Any past year "recreational"/non-medical/personal use: Significant decreasing trend for 18-20, increasing trend for 21-25

	Cohort 1 (2014)	Cohort 2 (2015)	Cohort 3 (2016)	Cohort 4 (2017)	Cohort 5 (2018)	Cohort 6 (2019)	Cohort 7 (2020)	Cohort 8 (2021)	Cohort 9 (2022)	Cohort 10 (2023)	Cohort 11 (2024)	Total across 11 years
18-20	43.27%	44.82%	40.94%	43.41%	44.42%	43.68%	40.39%	44.89%	39.11%	36.57%	39.00%	42.18%
21-25	43.67%	47.09%	46.55%	49.75%	50.87%	49.61%	52.29%	55.21%	53.60%	51.90%	52.00%	49.76%
TOTAL	43.51%	46.29%	44.76%	47.43%	48.49%	47.24%	47.94%	51.19%	47.26%	46.24%	46.44%	46.91%

Model split by over/under 21

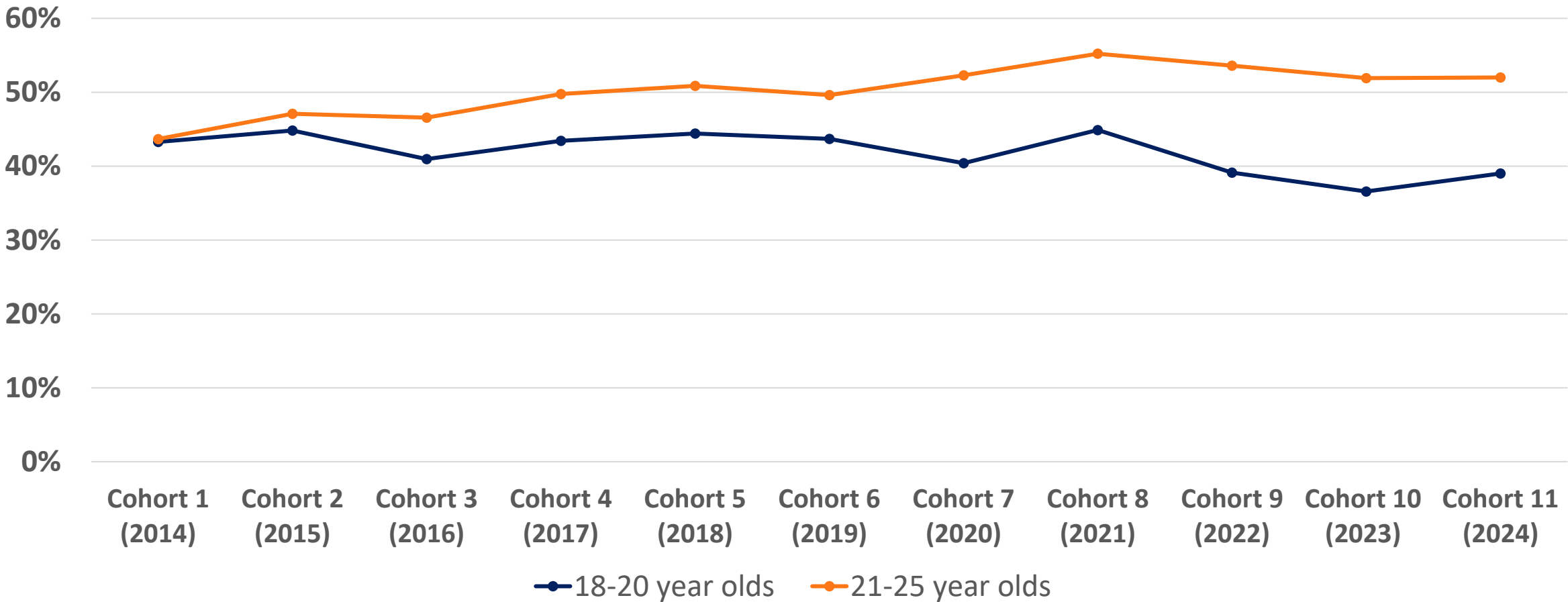
18-20: Newly significant decreasing trend ($t = -2.31, p < .05$)

21-25: Significant increasing trend over time ($t=5.36, p < .001$)

Source: Young Adult Health Survey, Preliminary Data Report to DBHR, March 2025, Kilmer (PI)

Non-medical (or “recreational”) use in the past year by age group

Past year prevalence of non-medical use



Other time frames for non-medical use

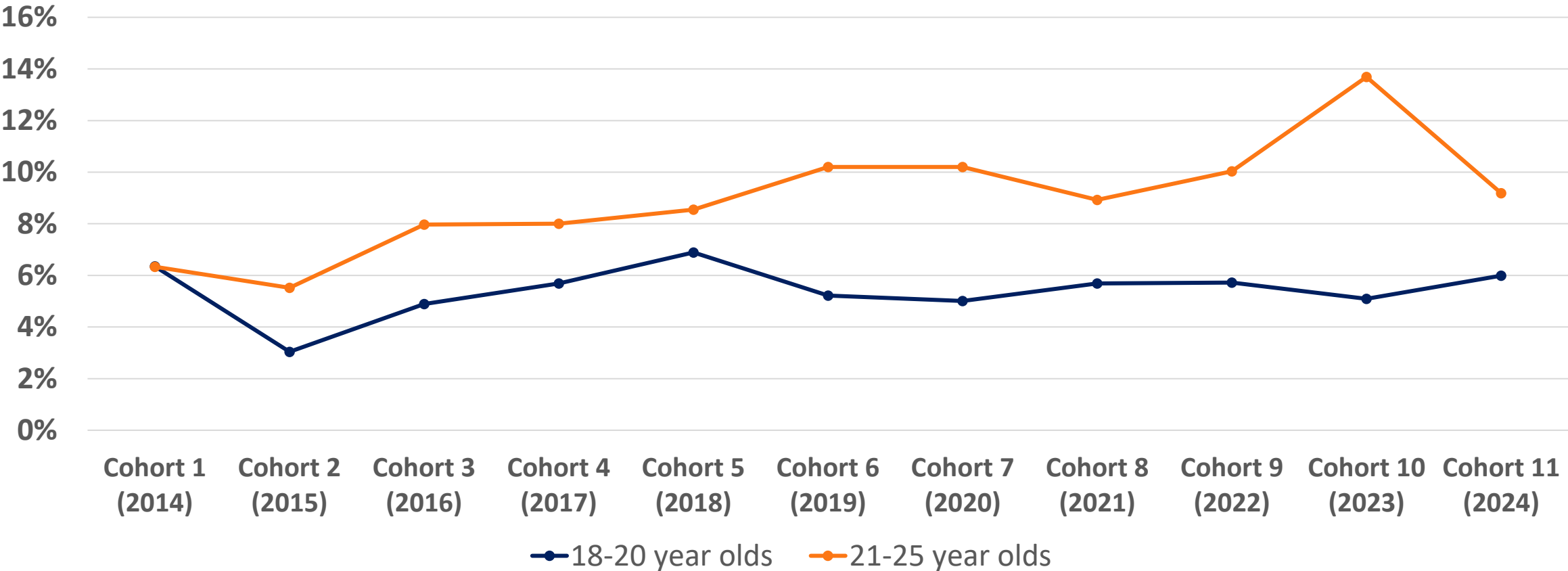
- At least monthly...
 - Cohorts 5-9 and 11 higher than Cohort 1
 - Significant increasing trend for 18-25-year-olds
 - When model is split by age group, overall trend driven by the increase among 21-25 year olds
- At least weekly...
 - Cohorts 7, 8, and 10 higher than Cohort 1
 - Significant increasing trend for 18-25-year-olds
 - When model is split by age group, overall trend driven by the increase among 21-25 year olds

Source: Young Adult Health Survey, Preliminary
Data Report to DBHR, March 2025, Kilmer (PI)

Source: Young Adult Health Survey, Preliminary Data Report to DBHR, March 2025, Kilmer (PI)

Daily non-medical (or “recreational”) use by age group

Daily prevalence of non-medical use



Decreasing trend significant
Increasing trend significant

Source: Young Adult Health Survey, Preliminary
Data Report to DBHR, March 2025, Kilmer (PI)

WHERE DO PEOPLE GET CANNABIS, 18–20-year-olds

	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Cohort 7	Cohort 8	Cohort 9	Cohort 10	Cohort 11
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
From friends	72.86%	76.24%	69.68%	77.40%	63.75%	60.74%	66.87%	65.62%	59.68%	58.06%	63.88%
Gave money to someone	23.29%	26.47%	34.72%	41.45%	39.29%	43.17%	40.55%	39.80%	37.62%	33.36%	35.45%
Got it from someone w/ medical card	17.60%	14.12%	4.30%	5.24%	2.79%	2.82%	4.27%	4.58%	4.10%	1.62%	5.02%
Got it from a medical dispensary	13.65%	18.99%	5.58%	4.72%	6.50%	8.28%	8.41%	12.03%	3.40%	7.53%	6.96%
	newly significant trend from last year's report										
Got it at a party	22.99%	22.14%	23.08%	24.92%	20.12%	22.91%	8.82%	24.67%	16.43%	10.98%	13.56%
Got it from family	5.65%	5.18%	11.75%	9.75%	11.24%	10.92%	13.49%	7.09%	11.36%	9.67%	9.52%
Got it some other way	11.64%	4.12%	6.12%	9.02%	7.30%	6.21%	5.04%	6.24%	3.62%	4.28%	2.20%
Bought from retail store	0.99%	4.58%	1.73%	1.92%	2.03%	3.55%	1.58%	1.03%	3.08%	1.53%	1.71%
Got it from parents w/ permission	5.75%	6.02%	12.33%	10.44%	11.69%	12.91%	13.08%	13.91%	12.38%	15.77%	14.00%
	Note: ** Parents with permission remains the third most mentioned source by 18–20-year-olds **										
Grew it themselves	1.91%	1.15%	1.65%	0.23%	1.47%	2.78%	1.64%	0.42%	0.59%	0.56%	1.85%
Stole it from store/ dispensary	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.16%	2.40%	0.00%	0.57%	0.36%

Decreasing trend significant
Increasing trend significant

Source: Young Adult Health Survey, Preliminary
Data Report to DBHR, March 2025, Kilmer (PI)

WHERE DO PEOPLE GET CANNABIS, 21–25-year-olds

	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Cohort 7	Cohort 8	Cohort 9	Cohort 10	Cohort 11
	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>
From friends	67.50%	54.89%	42.78%	36.51%	33.80%	25.72%	20.26%	26.44%	26.04%	21.17%	26.70%
Gave money to someone	19.87%	10.72%	8.10%	5.64%	4.97%	3.63%	5.08%	4.61%	7.75%	4.46%	1.27%
Got it from someone w/ medical card	18.85%	9.41%	2.53%	2.02%	0.17%	0.65%	0.27%	0.62%	1.16%	1.03%	0.21%
Got it from a med. dispensary	20.65%	13.03%	12.60%	9.96%	10.15%	14.23%	14.71%	15.62%	16.02%	16.90%	9.85%
Got it at a party	11.81%	10.76%	10.93%	8.06%	6.54%	5.76%	1.57%	7.12%	10.93%	3.87%	6.94%
Got it from family	11.48%	8.26%	4.08%	7.04%	5.76%	4.37%	4.02%	5.52%	4.56%	4.04%	5.74%
Got it some other way	5.13%	6.68%	3.29%	3.41%	3.71%	3.71%	1.24%	2.13%	1.85%	1.97%	1.29%
Bought from retail store	8.80%	51.86%	72.60%	76.31%	80.06%	78.03%	77.27%	74.42%	70.93%	72.28%	78.09%
Got it from parents w/ permission	4.56%	3.50%	2.02%	4.28%	4.47%	3.15%	2.75%	4.75%	4.41%	5.79%	1.97%
Grew it themselves	1.51%	3.01%	1.49%	1.82%	1.81%	0.71%	1.11%	1.74%	0.79%	1.16%	0.86%
Stole it from store/ dispensary	2.84%	0.17%	0.60%	0.29%	0.17%	0.11%	0.97%	0.43%	0.69%	0.78%	0.46%

DRIVING AFTER CANNABIS USE

Source: Young Adult Health Survey, Preliminary
Data Report to DBHR, March 2025, Kilmer (PI)

Driving after cannabis use

“During the past 30 days, how many times did you drive a car or other vehicle within three hours after using cannabis (e.g., marijuana, hashish, edibles)?”

	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Cohort 7	Cohort 8	Cohort 9	Cohort 10	Cohort 11
	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>
Never	50.59%	55.29%	58.19%	58.56%	58.73%	61.80%	65.00%	66.38%	64.64%	68.69%	68.10%
1 time	14.13%	13.13%	12.50%	12.85%	12.11%	8.32%	9.56%	10.25%	10.27%	7.70%	10.15%
2-3 times	13.28%	12.34%	11.97%	11.98%	10.59%	11.66%	11.24%	10.51%	11.50%	9.83%	10.09%
4-5 times	6.43%	4.35%	3.48%	4.48%	6.04%	4.00%	4.51%	4.39%	2.53%	3.40%	2.65%
6 or more times	15.57%	14.88%	13.85%	12.12%	12.52%	14.21%	9.69%	8.47%	11.05%	10.38%	9.02%

***There are declines in driving after cannabis use between cohorts 3-11 and cohort 1 (cohort 3, $p<.05$; cohort 4, $p<.01$; cohort 5, $p<.05$; cohort 6, $p<.01$; cohort 7, $p<.001$; cohort 8, $p<.001$; cohort 9, $p<.001$; cohort 10, $p<.001$; cohort 11, $p<.001$), as well as a significant linear trend ($p<.001$). ***

Medical cannabis in past year

Newly significant decreasing trend over time

	Cohort 1 (2014)	Cohort 2 (2015)	Cohort 3 (2016)	Cohort 4 (2017)	Cohort 5 (2018)	Cohort 6 (2019)	Cohort 7 (2020)	Cohort 8 (2021)	Cohort 9 (2022)	Cohort 10 (2023)	Cohort 11 (2024)	Total across 11 years
18-20	14.02%	12.73%	8.33%	12.02%	12.90%	11.75%	11.43%	11.04%	10.20%	9.11%	7.92%	11.16%
21-25	15.20%	15.53%	14.77%	16.83%	16.80%	18.05%	15.04%	15.18%	13.37%	14.21%	10.25%	15.26%
TOTAL	14.74%	14.54%	12.68%	15.04%	15.42%	15.53%	13.71%	13.54%	11.96%	12.22%	9.25%	13.71%

Regression models:

Cohort 1 vs. Cohorts 2-11:

Linear trend from Cohort 1 to 11:

Age by cohort interaction:

Cohort 9 ($t=-1.97$, $p<.05$) and Cohort 11 ($t=-4.55$, $p<.001$) significantly lower than Cohort 1

Newly significant decreasing trend over time ($t = -4.30$, $p<.001$)

Non-significant

Medical cannabis in past year

Newly significant decreasing trend over time

	Cohort 1 (2014)	Cohort 2 (2015)	Cohort 3 (2016)	Cohort 4 (2017)	Cohort 5 (2018)	Cohort 6 (2019)	Cohort 7 (2020)	Cohort 8 (2021)	Cohort 9 (2022)	Cohort 10 (2023)	Cohort 11 (2024)	Total across 11 years
18-20	14.02%	12.73%	8.33%	12.02%	12.90%	11.75%	11.43%	11.04%	10.20%	9.11%	7.92%	11.16%
21-25	15.20%	15.53%	14.77%	16.83%	16.80%	18.05%	15.04%	15.18%	13.37%	14.21%	10.25%	15.26%
TOTAL	14.74%	14.54%	12.68%	15.04%	15.42%	15.53%	13.71%	13.54%	11.96%	12.22%	9.25%	13.71%

Model split by over/under 21

18-20:

- Newly significant decreasing trend over time ($t = -2.94$, $p < .01$)

21-25:

- Newly significant decreasing trend over time ($t = -2.79$, $p < .01$)

Source: Young Adult Health Survey, Preliminary Data Report to DBHR, March 2025, Kilmer (PI)

Perceived norms

- Perceptions of non-medical use continue to increase significantly (both a linear trend, and past 8 cohorts higher than cohort 1)
- Perceptions of medical use continue to increase significantly (both a linear trend, and past 8 cohorts higher than cohort 1)

Source: Young Adult Health Survey, Preliminary
Data Report to DBHR, March 2025, Kilmer (PI)

Other substances

- Significant decreasing trend in:
 - Alcohol, at least once in past year
 - Alcohol, at least monthly
 - Cigarettes, at least once in the past year
 - Pain relievers to get high, at least once in the past year (down to 1.94%...lowest in the 11 years of the study)
 - Heroin use, at least once in the past year (down to 0.07%, second lowest only to 0.00% in 2022))

Source: Young Adult Health Survey, Preliminary
Data Report to DBHR, March 2025, Kilmer (PI)

Perceived risk

- **Cannabis**

- Physical risk of occasional cannabis use ** newly non-significant **
- Psychological/emotional/cognitive risk of occasional cannabis use ** newly non-significant **
- Physical risk of regular cannabis use ** newly significant **
- Psychological/emotional/cognitive risk of regular cannabis use ** newly significant **

- **Alcohol**

- Physical risk of 2 drinks every day
- Psychological risk of 2 drinks every day
- Physical risk of 5+ drinks every weekend ** newly significant **
- Psychological risk of 5+ drinks every weekend

** newly non-significant **

** significant increasing linear trend **

Our activities in 2025

- We invited collaborators/partners to provide input on new items
- We are currently collecting data in our 12th year of data collection

jkilmer@uw.edu

Thank you!

- DBHR:
 - Sarah Mariani
 - Kasey Kates
 - Rachel Oliver
 - Megan Stowe

This research was supported by a contract with the Washington State Health Care Authority (Division of Behavioral Health and Recovery) (PI: Kilmer)

Reducing youth substance use and related risks in Washington State:

A success story of the Community Prevention and Wellness Initiative

October 2025

Jaymie Bockelman, PhD, MS

Prevention Research & Evaluation Manager
WA State Health Care Authority

Evaluation team:



WASHINGTON STATE
UNIVERSITY



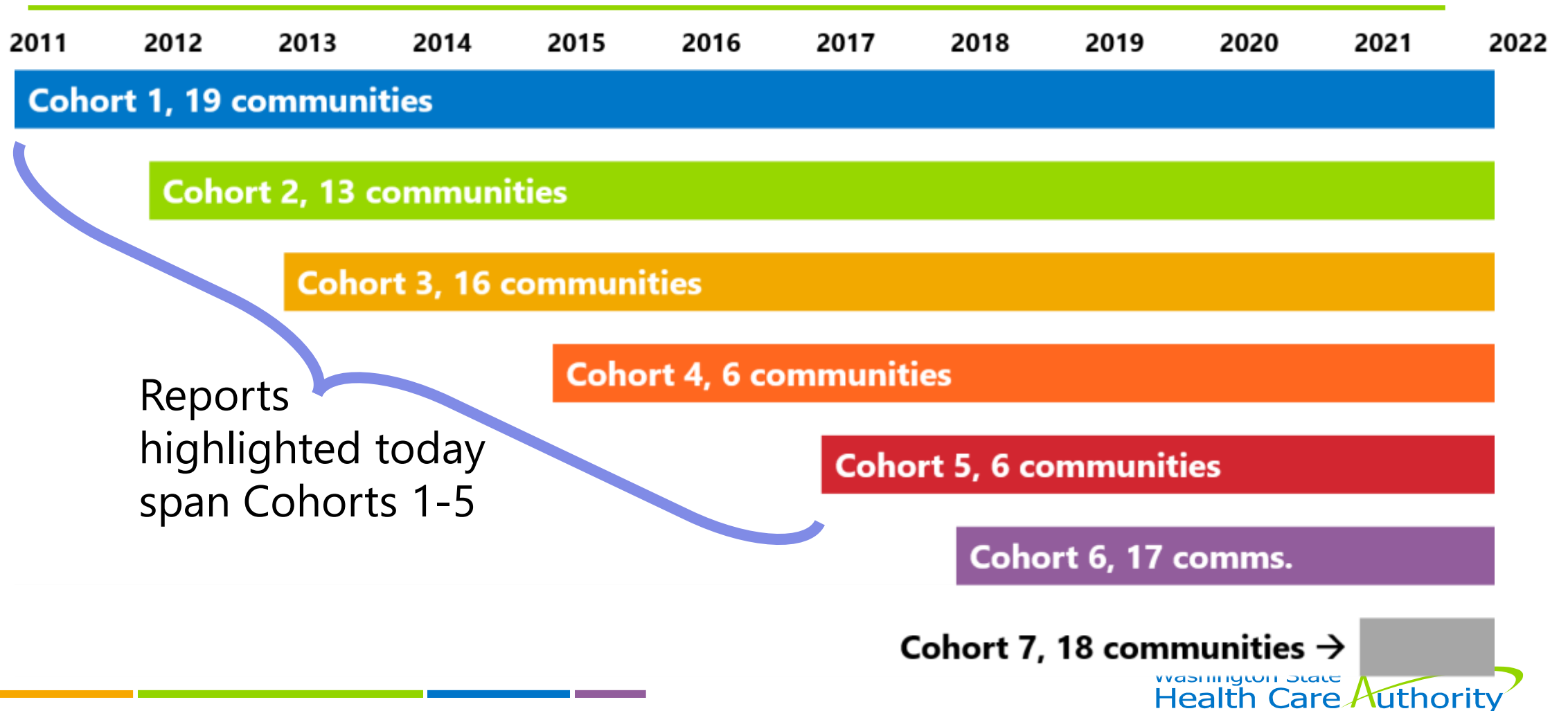
Washington State
Health Care Authority

The CPWI Model



CPWI: local solutions to promote community health and well-being.

CPWI Timeline: 95 Communities



Risk Scoring and Propensity Score Weighting

Substance use¹

- Any alcohol use in past 30 days
- Frequency of alcohol use in past 30 days
- Any cigarette smoking in past 30 days
- Frequency of cigarette smoking in past 30 days
- Any marijuana use in past 30 days
- Frequency of marijuana use in past 30 days

School performance¹

- Self reported truancy

Youth delinquency¹

- Self-reported fighting
- Carrying a weapon in school
- Gang membership
- Driving under influence

Mental health¹

- Depression
- Considering suicide
- Suicide attempts

Economic indicators

- Median household income²
- TANF, child recipients³
- Food stamps recipients³
- Levies due to school district⁴

Demographics

- Total population²
- Population density⁵
- Eastern vs. Western WA⁶

CPWI = Community Prevention and Wellness Initiative; TANF = Temporary Assistance for Needy Families

¹Washington State Healthy Youth Survey, ² American Community Survey, ³ Washington State Department of Social and Health Services, Division of Research and Data Analysis, ⁴ Washington State Department of Revenue, ⁵ Washington State Office of Financial Management, Forecasting and Research Division, ⁶Coded by evaluation team with input from HCA

	Impact Over Time	Developmental Trend
Research question(s)	Did the CPWI model reduce the gap in substance use and related risk factors between higher-need CPWI communities and lower-need non-CPWI communities?	1. Did developmentally expected changes in substance use and related risk factors differ significantly in higher-need CPWI communities compared to lower-need non-CPWI communities? 2. How likely is it that positive outcomes for CPWI are due to chance?
Analytic approach	Propensity score weighted MLM	
Data sources for propensity score weighting¹	HYS, American Community Survey, state archival and administrative data, codes for Eastern and Western regions of Washington state	
Data source for outcomes²	HYS data (10 th grade): 2008, 2010, 2012, 2014, 2018	HYS data (6 th , 8 th , 10 th , 12 th grade): 2008, 2010, 2012, 2014, 2018
CPWI = Community Prevention and Wellness Initiative; MLM = multilevel modeling, a type of hierarchical regression analysis; HYS = Washington State Healthy Youth Survey		

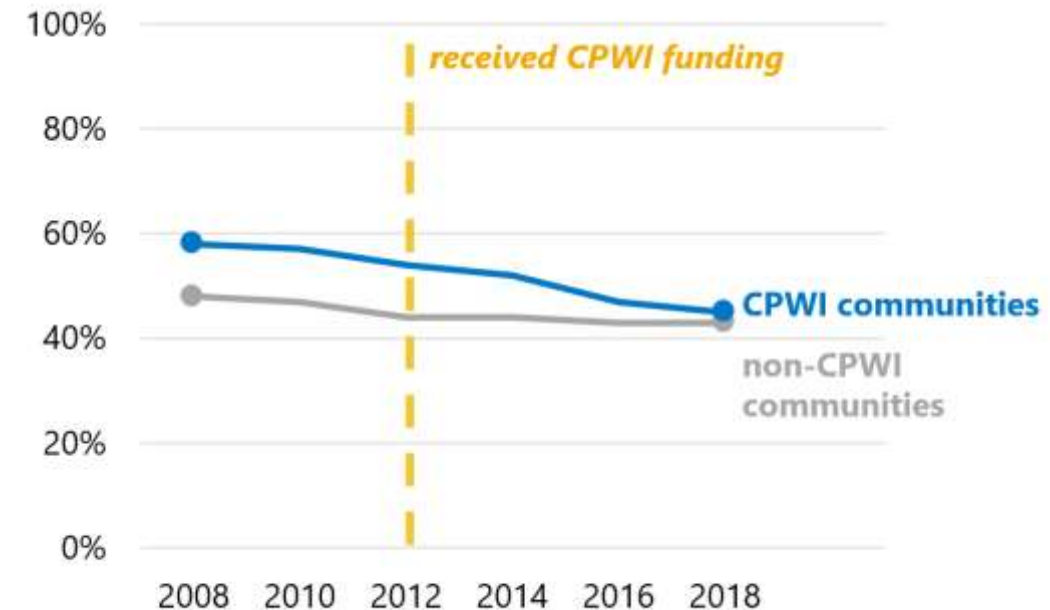
Impact Over Time: Question and Approach

▶ Question

- ▶ Did CPWI communities **close the gap** with non-CPWI communities in substance use and related risk factors from pre- to post-test?

▶ Approach

- ▶ WA Healthy Youth Survey data
- ▶ Propensity score analysis
- ▶ Multilevel Modeling



Baseline (T1) and post-intervention time points for the cohorts are as follows:

	Cohort 1 (Funding start 2011)		Cohort 2 (Funding start 2012)		Cohort 3 (Funding start 2013)		Cohort 4 (Funding start 2015)		Cohort 5 (Funding start 2017)	
	T1	T2	T1	T2	T1	T2	T1	T2	T1	T2
HYS	2008	2018	2010	2018	2010	2018	2014	2018	2016	2018

Overview of Results



Closed Gap



Did Not
Close Gap



No Initial
Gap

Alcohol Use	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5
Lifetime use					
Past-month use					
Frequency of past-month use					
Binge drinking, past two weeks					

Cigarette Use	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5
Lifetime use					
Past-month use					
Frequency of past-month use					

Marijuana Use	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5
Lifetime use					
Past-month use					
Frequency of past-month use					

Shrestha, G., Cooper, B. R., & Hill, L. G. (2019, June). Community Prevention and Wellness Initiative: Impact over time analysis report. *Washington State Department of Social and Health Services*.

Developmental Trend: Questions and Approach



#1. Did developmentally expected change in substance use and related risk factors differ significantly in CPWI communities compared to non-CPWI communities?

Propensity score weighted regression modeling



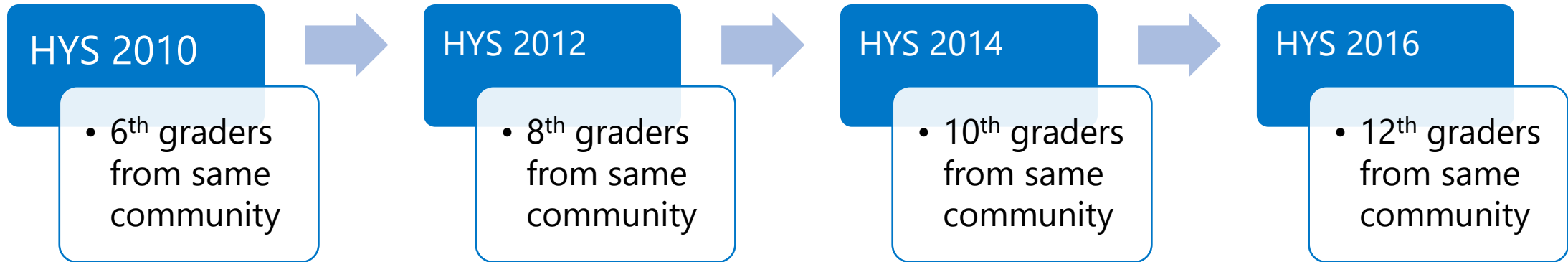
#2. What is the probability that the positive outcomes for CPWI are due to chance?

Binomial probability calculation

Developmental Trend Approach

Who is included in the analysis?

Linked grade cohorts of students who filled out the Healthy Youth Survey from 2010 to 2018.



Developmental Trend: Question 1 Results



#1. Did expected changes over time in substance use and related risk factors differ significantly in CPWI communities compared to non-CPWI communities?

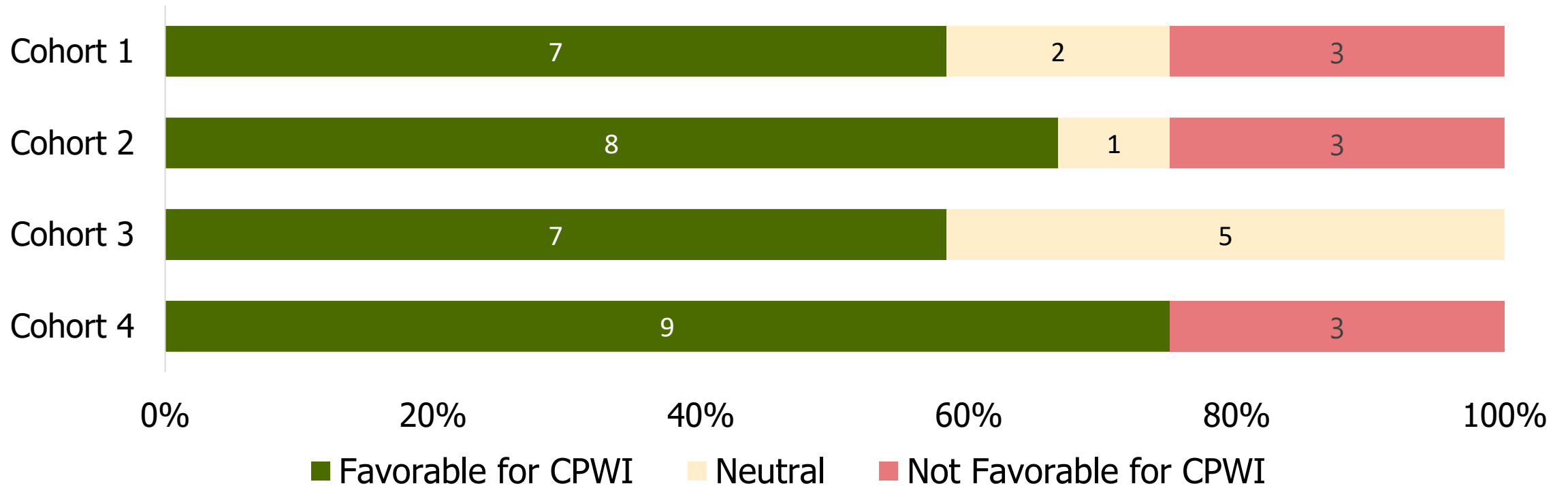
Propensity score weighted regression modeling

Substance use increased in both CPWI and non-CPWI communities.

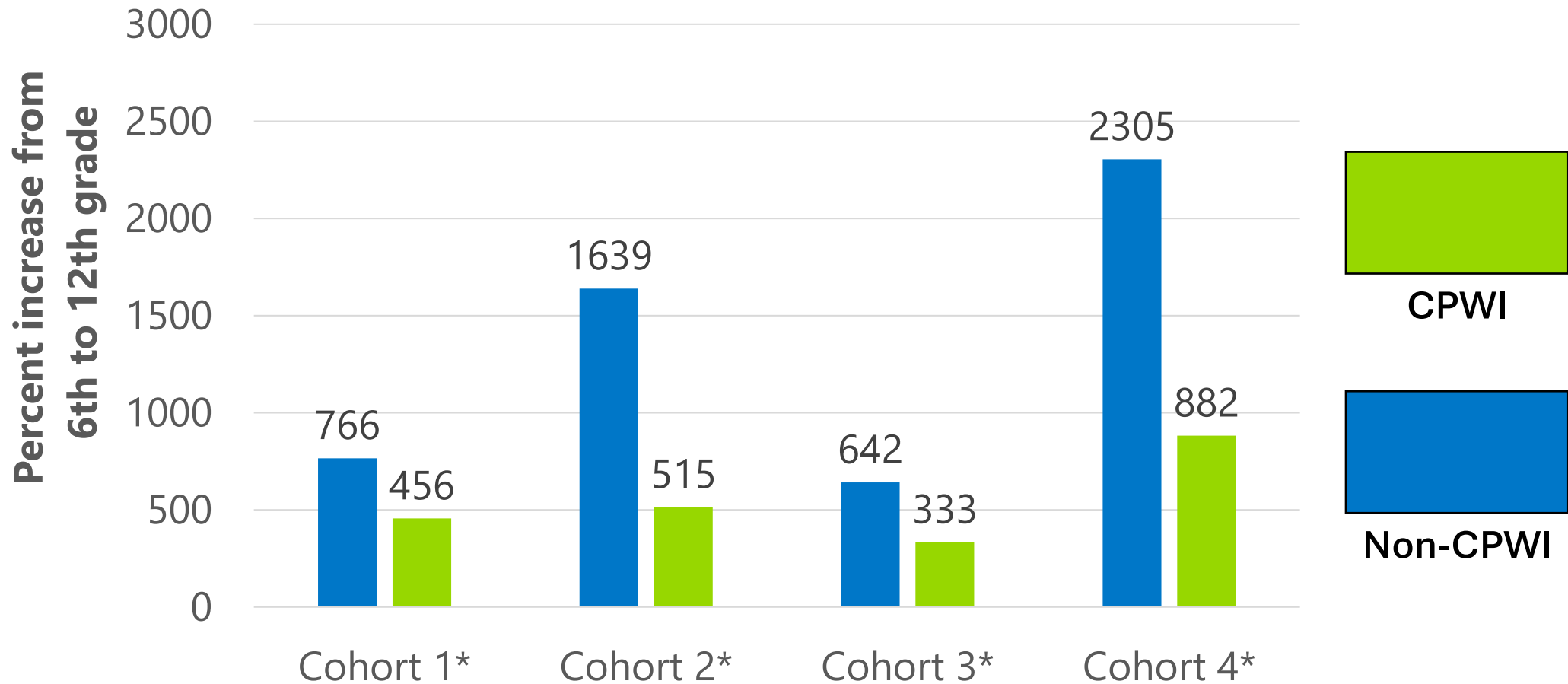
BUT, the increase in most substance use outcomes was **significantly less steep in CPWI communities** compared to non-CPWI communities.

Developmental Trend: Substance Use Outcomes

Most results for substance use outcomes were favorable for CPWI.



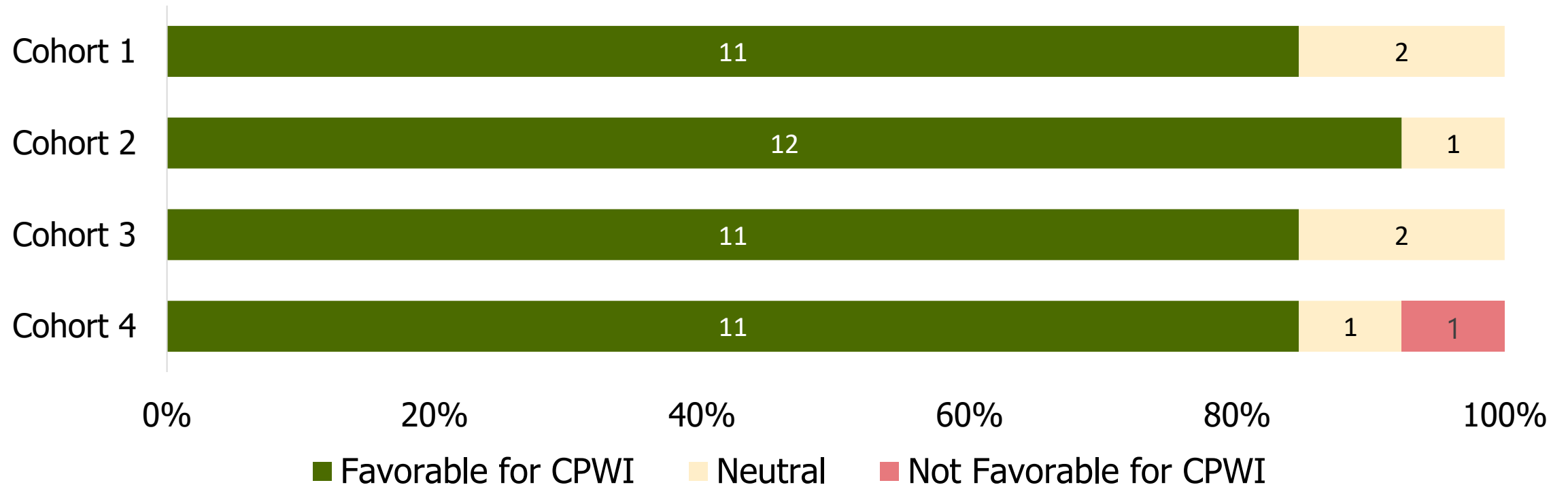
Example: 30-day alcohol use



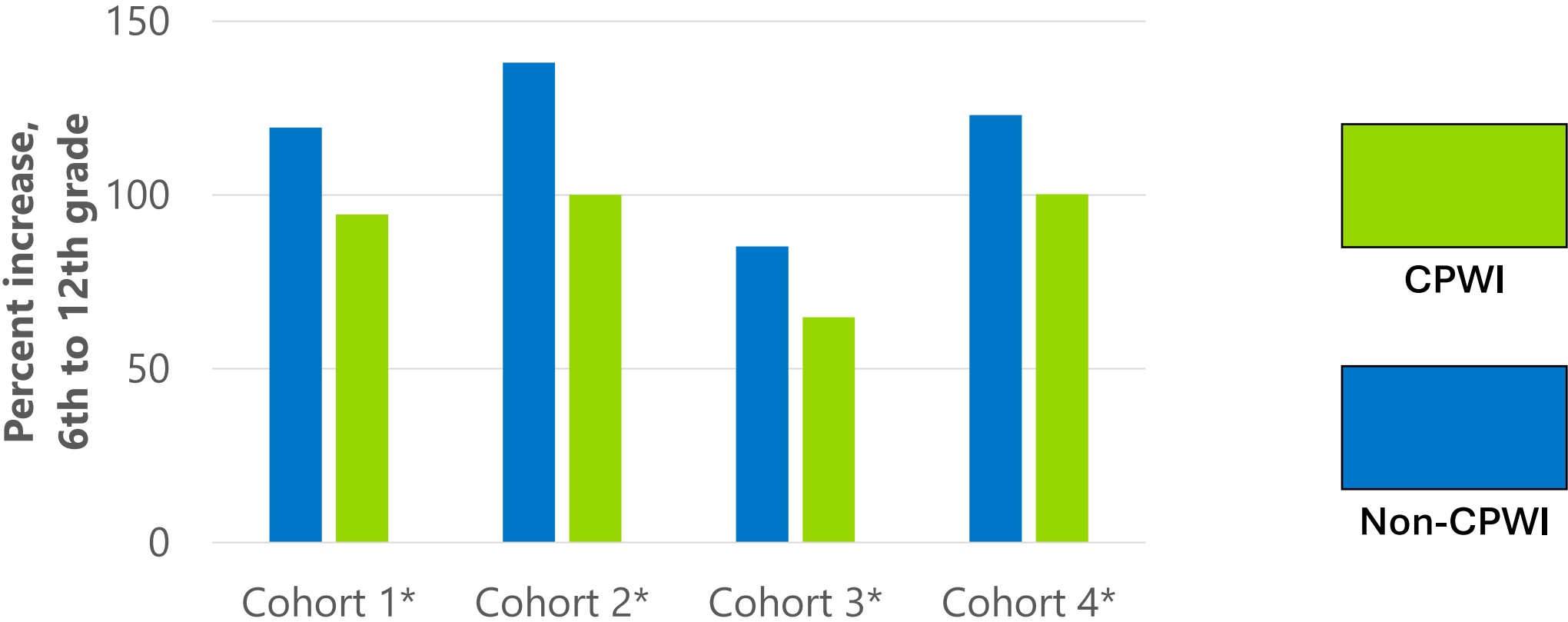
* $p < .05$

Developmental Trend: Risk Factor Outcomes

Most results for risk factors were favorable for CPWI.



Example: Favorable Attitudes Towards Drug Use



*p<.05

Evaluation Question #2



#2. What is the probability that the positive outcomes for CPWI are due to chance?

Binomial probability calculation

The probability that the pattern of positive results is due to chance is extremely low.

- Cohorts 1 and 4 = 0.2%
- Cohorts 2 and 3 = 0.1%



LOW

HIGH

Take Home Messages

Impact Over Time

- ▶ CPWI is showing **positive impact**, especially in the **alcohol** domain
- ▶ CPWI communities are "**catching up**" with lower-need communities
- ▶ Non-CPWI services may have contributed to these results
 - ▶ Subsequent Longitudinal MLM analyses suggest **CPWI and length in CPWI** are drivers

Developmental Trend

- ▶ CPWI is **slowing the trajectory of increase** in adolescent **substance use** and related **risk factors**
- ▶ CPWI communities are "**catching up**" with lower-need communities
- ▶ Non-CPWI services may have contributed to these results
 - ▶ Subsequent Longitudinal MLM analyses suggest **CPWI and length in CPWI** are drivers

Questions?

- ▶ Dr. Jaymie Bockelman, Prevention Research & Evaluation Manager, HCA DBHR
 - ▶ Jaymie.bockelman@hca.wa.gov
- ▶ Dr. Gitanjali Shrestha, WSU IMPACT lab
 - ▶ gshrestha@wsu.edu



Center for Community-Engaged Drug Epidemiology, Education, and Research (CEDEER)

Teresa Winstead, PhD, MA (she/her)

Senior Research Scientist | Addictions Drug & Alcohol Institute

UW School of Medicine

Affiliate Associate Professor | Health Systems and Population Health

UW School of Public Health



UNIVERSITY of
WASHINGTON



Outline

1

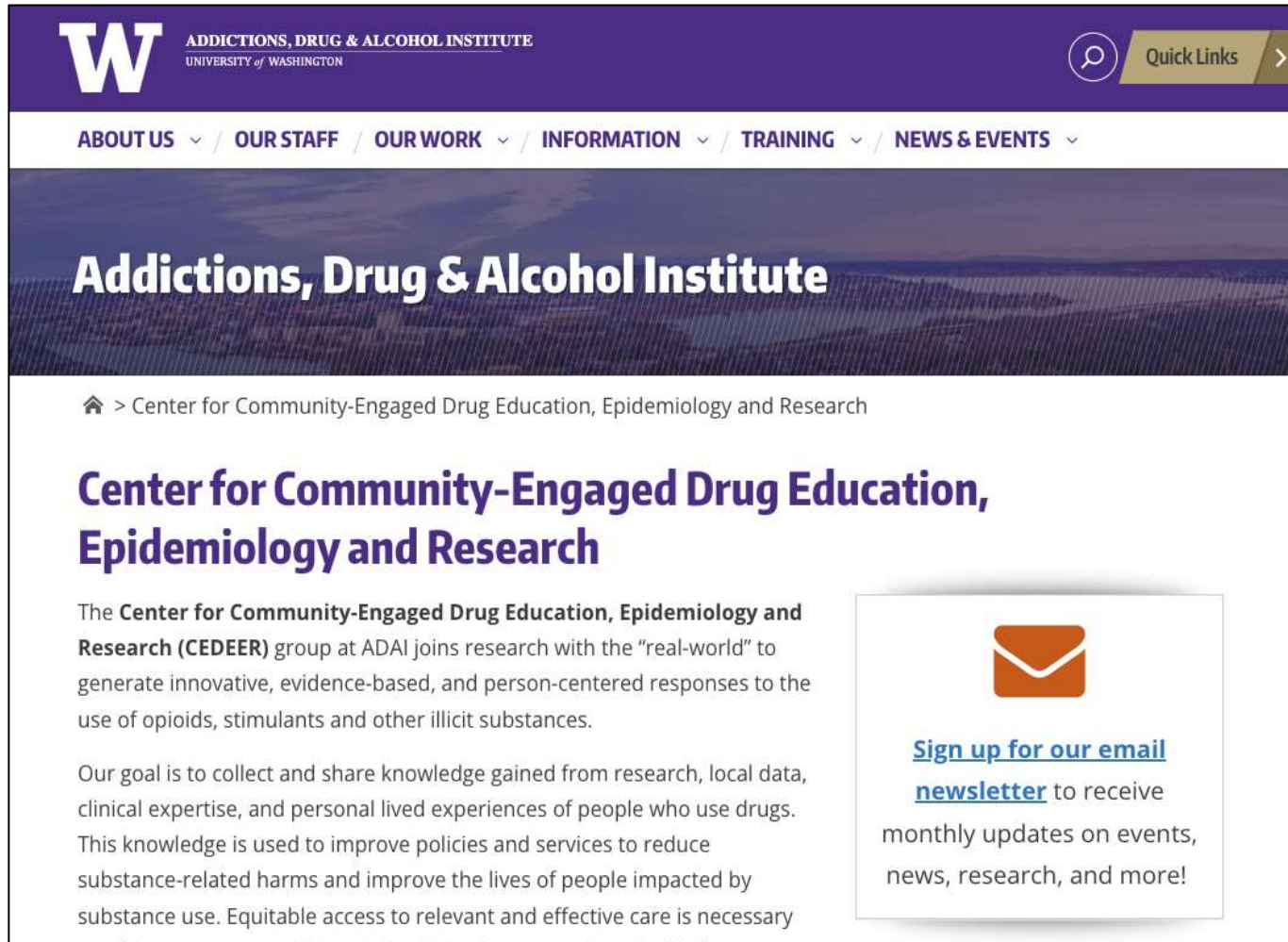
Introduce
ADAI/CEDEER!
Team & Partners

2

Our approach

3

A few examples
of ongoing work



The screenshot shows the website for the Addictions, Drug & Alcohol Institute (ADAI) at the University of Washington. The header features the ADAI logo and navigation links: ABOUT US, OUR STAFF, OUR WORK, INFORMATION, TRAINING, and NEWS & EVENTS. A search icon and 'Quick Links' are also present. The main banner reads 'Addictions, Drug & Alcohol Institute'. Below this, a breadcrumb trail indicates the location: Home > Center for Community-Engaged Drug Education, Epidemiology and Research. The page title is 'Center for Community-Engaged Drug Education, Epidemiology and Research'. The text describes the CEDEER group's mission to generate innovative, evidence-based, and person-centered responses to the use of opioids, stimulants, and other illicit substances. It states the goal is to collect and share knowledge from research, local data, clinical expertise, and personal lived experiences to improve policies and services, reduce substance-related harms, and improve the lives of people impacted by substance use. A call to action box on the right encourages signing up for the email newsletter to receive monthly updates on events, news, research, and more.

W ADDICTIONS, DRUG & ALCOHOL INSTITUTE
UNIVERSITY of WASHINGTON

ABOUT US / OUR STAFF / OUR WORK / INFORMATION / TRAINING / NEWS & EVENTS

Quick Links

Addictions, Drug & Alcohol Institute

Home > Center for Community-Engaged Drug Education, Epidemiology and Research

Center for Community-Engaged Drug Education, Epidemiology and Research

The **Center for Community-Engaged Drug Education, Epidemiology and Research (CEDEER)** group at ADAI joins research with the “real-world” to generate innovative, evidence-based, and person-centered responses to the use of opioids, stimulants and other illicit substances.

Our goal is to collect and share knowledge gained from research, local data, clinical expertise, and personal lived experiences of people who use drugs. This knowledge is used to improve policies and services to reduce substance-related harms and improve the lives of people impacted by substance use. Equitable access to relevant and effective care is necessary


[Sign up for our email newsletter](#) to receive monthly updates on events, news, research, and more!

<https://adai.uw.edu/cedeer/>

ADAI Centers



CEDEER Team & Partners

Our Team

- [Caleb Banta-Green, PhD, MPH, MSW](#)
- [Ben Biamont](#)
- [LeiLani Dawn, CPC, MA-P](#)
- [Anthony Floyd, PhD](#)
- [Leif Layman, MPH](#)
- [Amy Lee](#)
- [Rieanna McPhie](#)
- [Alison Newman, MPH](#)
- [Maureen Oscadal, MPH, BSN, RN-CARN](#)
- [Mandy Owens, PhD](#)
- [Mandy Sladky, MSN, RN, CARN](#)
- [Jason Williams, PhD](#)
- [Teresa Winstead, PhD, MA](#)
- [Kelly Youngberg, MHA](#)

Graduate students

- [Julia Fox, MA, doctoral student](#)
- [Samyukta Singh, MPH, doctoral student](#)

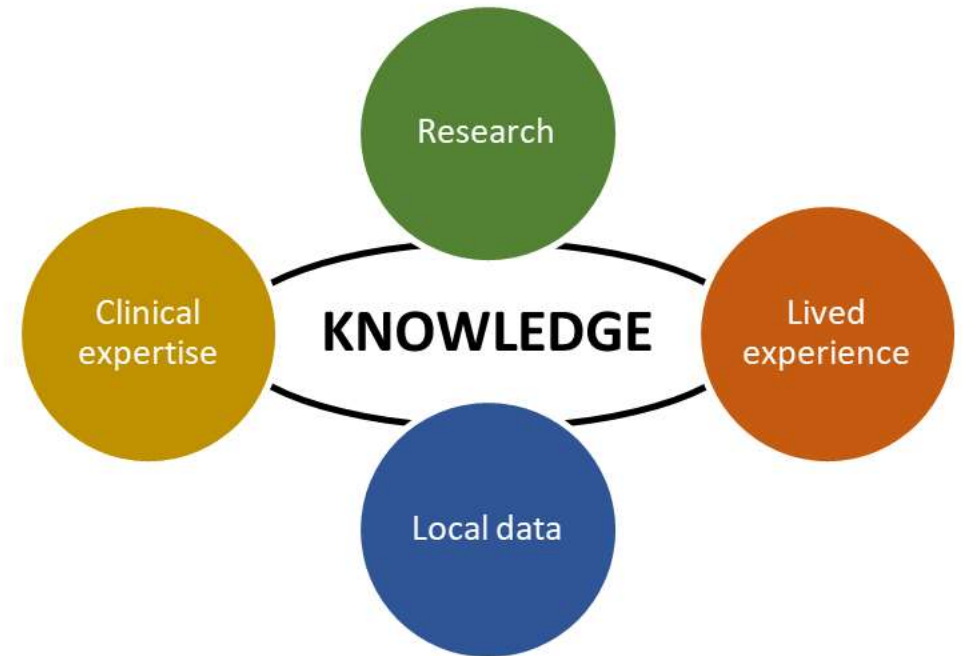


Our approach

What do PWUD need to improve their health?

What's happening right now in drug supply and OD mortality?

How can we reduce barriers to care and improve health outcomes?



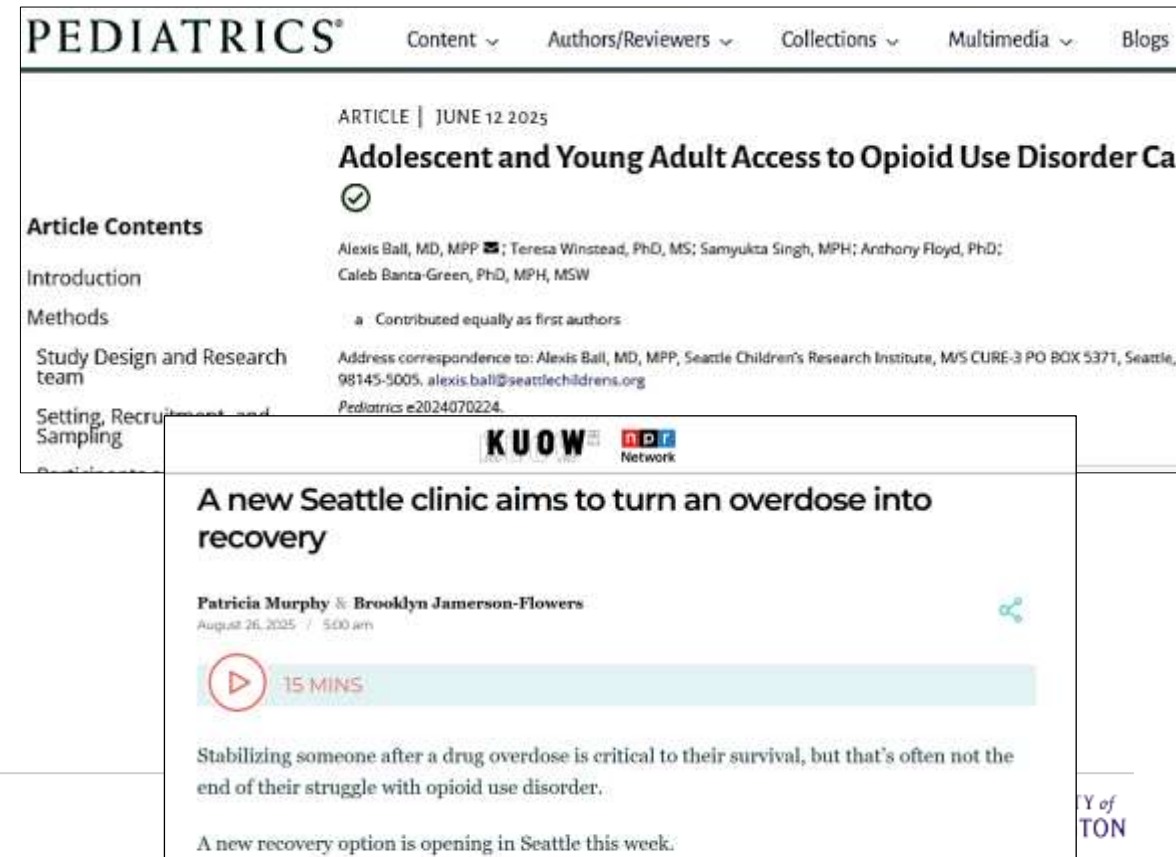
Our approach

- We **partner with and incorporate the perspectives of people who use drugs** and alcohol, their family and friends, and communities impacted in all our work.
- We are engaged in **secondary data analyses** and **epidemiological studies, clinical trials, implementation research** and— both qualitative and quantitative in design.
- We value real world impact, bringing *research results*, to **implementation support, community education, media interviews**, and other kinds of policy work.



We Heard from You, Here's What We Learned!
Results from 2022 Interviews about Fentanyl

WHO	WHY	WHEN
We talked to 30 people who regularly used fentanyl, at syringe services programs in WA.	To learn why people use fentanyl, and what services and supports people want.	Surveys were conducted in the Fall of 2022.
Why people use fentanyl: • Lessen physical pain • Numb emotions		<i>Well, it's just that it just numbs my body, my mind and my body. It makes me feel really, really good. It just shuts you off from the rest of the world.</i>



PEDIATRICS® Content ▾ Authors/Reviewers ▾ Collections ▾ Multimedia ▾ Blogs

ARTICLE | JUNE 12 2025

Adolescent and Young Adult Access to Opioid Use Disorder Ca

✓

Alexis Ball, MD, MPP; Teresa Winstead, PhD, MS; Samyukta Singh, MPH; Anthony Floyd, PhD; Caleb Banta-Green, PhD, MPH, MSW

a Contributed equally as first authors

Address correspondence to: Alexis Ball, MD, MPP, Seattle Children's Research Institute, M/S CURE-3 PO BOX 5371, Seattle, 98145-5005. alexis.ball@seattlechildrens.org

Pediatrics e2024070224.

KUOW   Network

A new Seattle clinic aims to turn an overdose into recovery

Patricia Murphy & Brooklyn Jamerson-Flowers
August 26, 2025 / 5:00 am

15 MINS

Stabilizing someone after a drug overdose is critical to their survival, but that's often not the end of their struggle with opioid use disorder.

A new recovery option is opening in Seattle this week.

Y of TON

Our approach & 6 examples

What do PWUD need to improve their health?

SSP Data collection cycle

What's happening right now in drug supply and OD mortality?

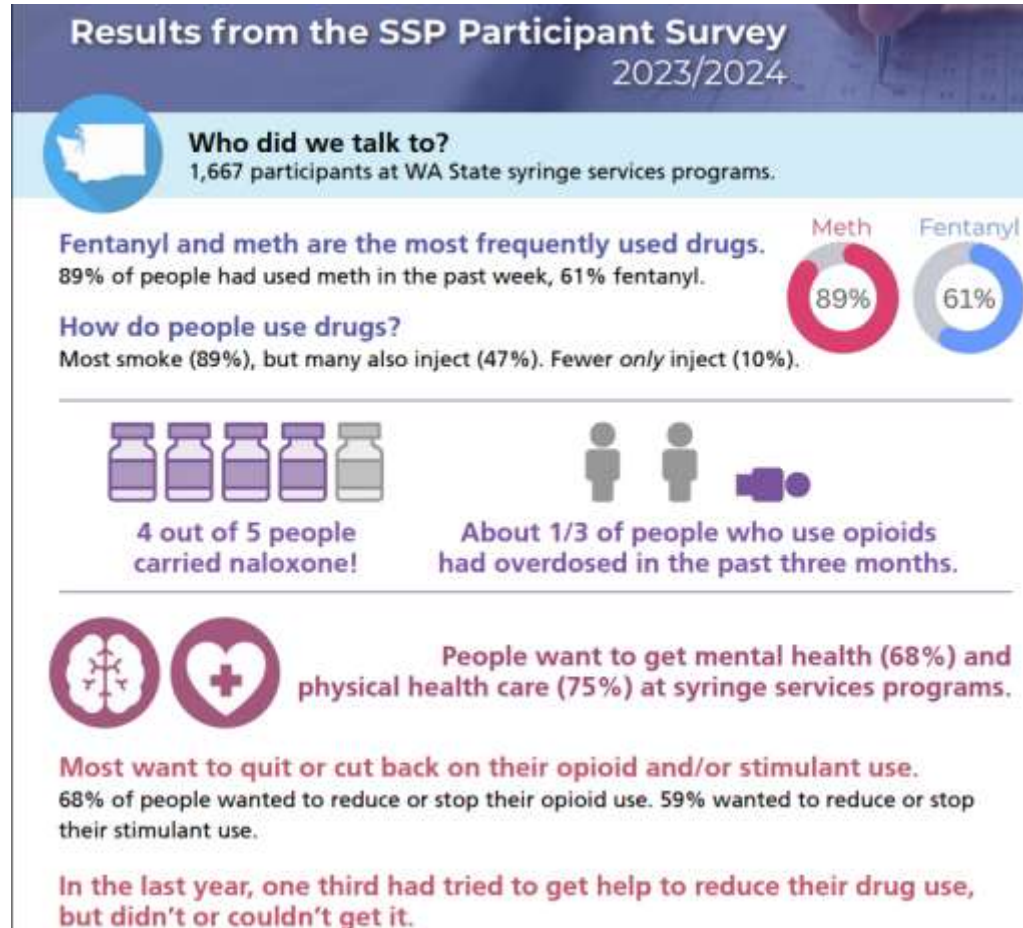
Drug checking data
Drug poisoning data

How can we reduce barriers to care and improve health outcomes?

Learn about treatment/SOR
SB6228 Proviso
CLEARs Project/ORCA

WA State SSP Data Collection Cycle

Bi-annual SSP **survey**



This work is supported by WA DOH & Health Care Authority, Division of Behavioral Health and Recovery.

Bi-annual **Qualitative** Interviews



Data Dashboards

Washington State Opioid/Major Drug Interactive Data

This site offers a series of interactive data charts and maps featuring Washington state data related to overdose deaths, treatment admissions, statewide opioid sales, and police evidence testing data for opioids and other drugs.

Find data by:



Geography



Drug Type



Indicator/Source



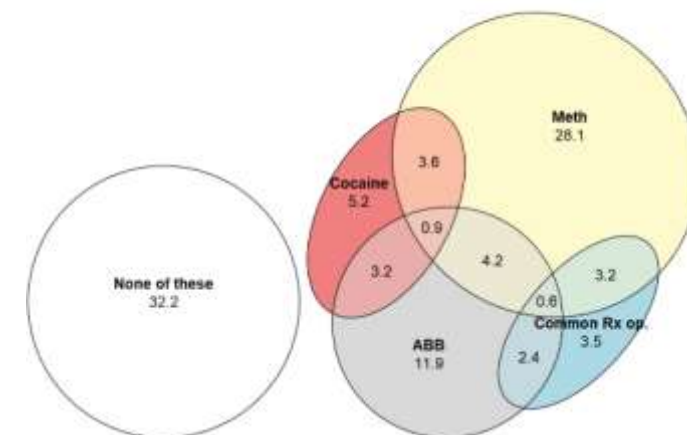
Acknowledgments

Funding from the Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery. Marijuana indicators analysis was provided with support from the Washington State Dedicated Marijuana Fund for research at the University of Washington. All analysis and interpretation by ADAI.

We thank the following for data access:

- King County Medical Examiner
- Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery
- Center for Health Statistics, Washington State Department of Health
- Washington State Patrol Forensic Laboratory Services Bureau
- US Drug Enforcement Agency [ARCOS database](#)
- Washington State Office of Financial Management
- Washington State Department of Health Prescription Monitoring Program
- American Community Survey, US Census Bureau
- [Looking Glass Analytics](#)
- Washington State Liquor and Cannabis Board

Drugs present along with other synthetic opioids, no heroin
% of n = 2746 deaths in Washington, 2021-2022



<https://adai.washington.edu/WAdata/index.htm>

<https://adai.uw.edu/cedeer/>

Data Dashboards



Percent of drug poisonings involving given drug pairs 2023-24





Drug Checking

- The **WA State Community Drug Checking Network** is a partnership of organizations around WA State that provide community-level drug checking and related harm reduction services.
- ADAI provides technical assistance, training, and ongoing operational support to the network, in collaboration with Public Health – Seattle & King County.

Drug checking

WA Community Drug Checking Network (CDCN) Site Sheet

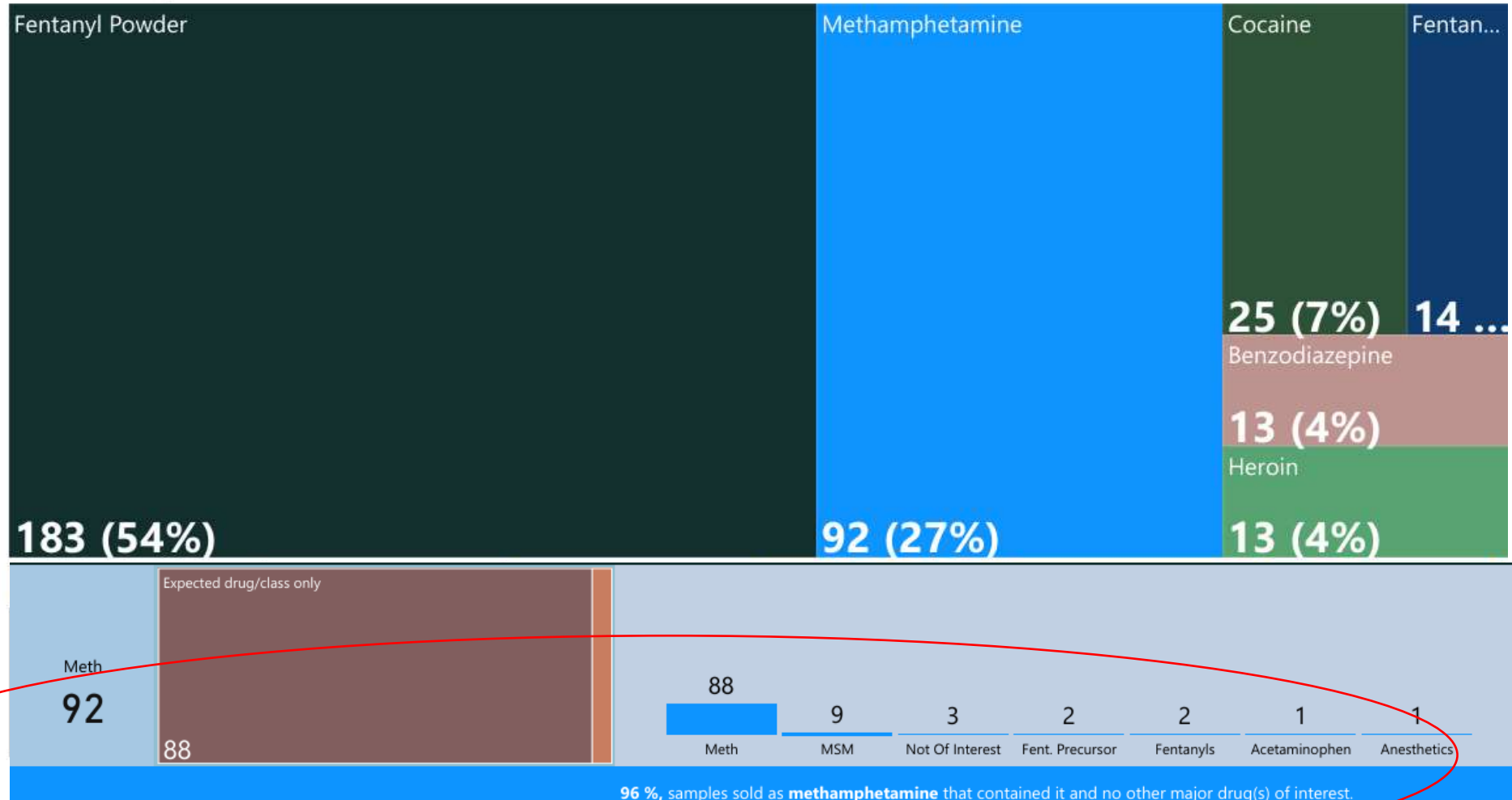
Samples from:
All CDCN Sites

Samples Collected Between

6/1/2025

8/31/2025

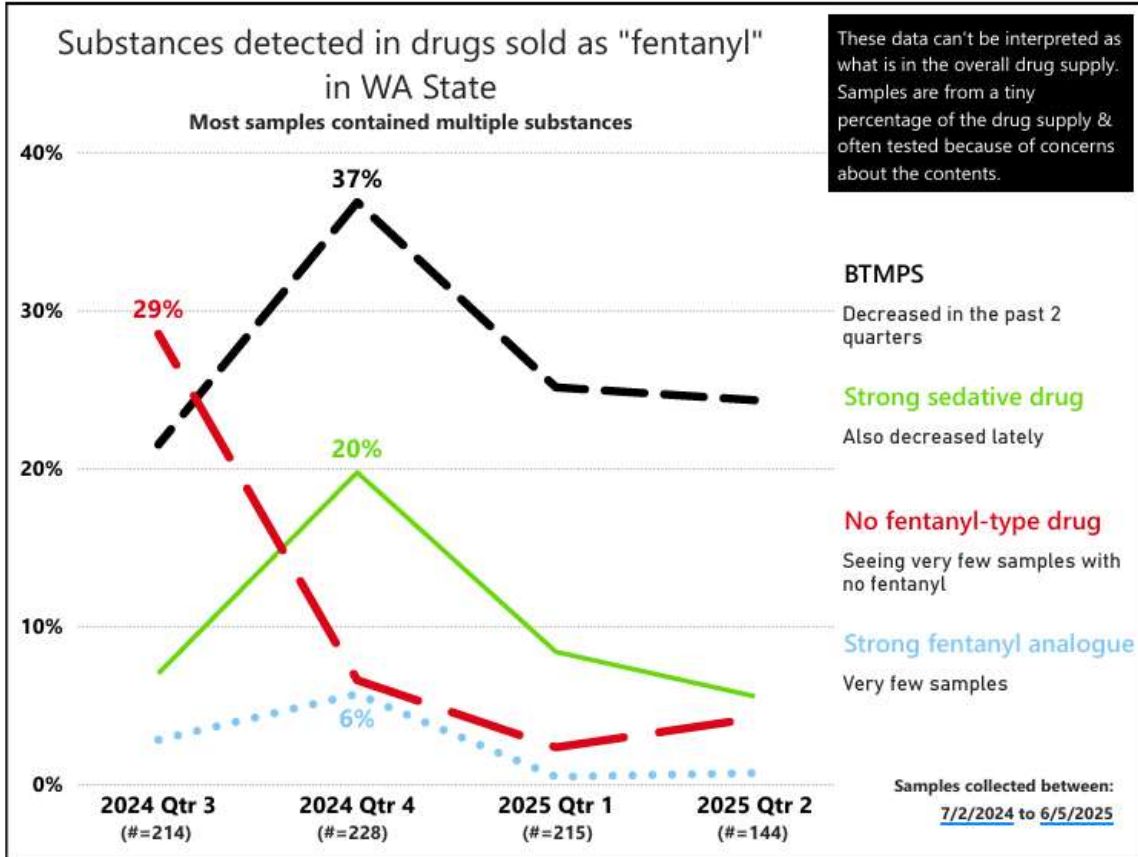
What samples have been sold as...



Drug Checking

What's in the "fentanyl" in Washington State?

Results from detailed chemical analysis of drug samples that were sold as "fentanyl" suggest rapid changes of what's in the "fentanyl." Samples were collected at community drug checking network sites across Washington State. **Now more than ever it's likely you don't know what you're getting.**



What can I do to protect myself? Stay vigilant!

- Shifts in fentanyl supply can affect tolerance and make dosing more difficult, both can increase chances of overdose.
- Get the latest info from your local harm reduction program. Get your drugs checked.
- Always carry naloxone.
- Take care of your overall health. See a medical provider if you are having health problems.

- **The drug supply is highly unpredictable** with many different and ever-changing substances. The strength of the drugs varies and is unknown.
- We have seen an increase in **Carfentanil** which is an incredibly strong opioid used medically in large animals that is 100 times stronger than fentanyl and 10,000 times stronger than morphine. (9/26/2025)

<https://adai.uw.edu/carfentanil-in-wa-state/>



Access to care & Training

Diverse audiences:

- General public
 - **Learn about treatment** website, treatment resources
- People who use drugs
 - Treatment access – Low barrier care, shared decision-making tools
- Health care, treatment, first responder professionals
 - Eg: **Statewide Opioid Response** work, SB 6228

Materials:

- Basic education
- Advanced education
- Interactive tools
- Printable resources (also available t/ ADAI clearinghouse)

Access to Care & Training

LEARN ABOUT TREATMENT

Learn About Treatment > For Professionals > Low-Barrier Buprenorphine

Goal: The goal of low-barrier buprenorphine, a new and growing model of care for opioid use disorder (OUD), is to reduce opioid overdose deaths and improve health and quality of life for *all* people with OUD.

Strategy: Increase access to buprenorphine for people with OUD by creating patient-centered programs that are easy to access, offer a high quality of care, and eliminate hurdles to access or stay in care for OUD.

Rationale: Medications are the front-line treatment for opioid use disorder and are underutilized.

In Washington State, data that helped motivate this model of care included:

- No significant impact of an **overdose prevention intervention** on people at high risk for overdose (most with opioid use disorder and homeless/unstably housed).
- Syringe service client **data** that indicate:
 - Most people (78%) who use opioids want to stop or reduce their use,
 - The number one intervention of interest is treatment medication (69%),
 - The majority of respondents (59%) needed medical care and didn't get it, often because of being treated poorly by health care providers.



Find more resources related to opioid use disorder, treatment, and recovery by clicking to expand each topic below:

- + Opioids and Opioid Use Disorder
- + Medications for Opioid Use Disorder in Washington State
- + Overdose and Naloxone
- + Crisis Intervention
- + Drug and Alcohol Treatment and Support
- + Services for People Who Use Drugs
- + Resources for Professionals

New Guide: Supporting the Health of Youth Who Use Fentanyl/Opioids: Information for Family & Friends

04/11/2025



The [ADAI Center for Community-Engaged Drug Education, Epidemiology & Research \(CEDEER\)](#) is happy to announce the release of the new guide [Supporting the Health of Youth Who Use Fentanyl/Opioids: Information for Family and Friends](#).

This guide is [available online](#) and as a [printable 12-page pamphlet](#) from CEDEER's website [LearnAboutTreatment.org](#).

It focuses on two key ideas, **staying connected & health and safety**, and provides **accurate and practical information for friends and family** about how to support their youth as they navigate fentanyl/opioid use, treatment medications, and/or recovery.



<https://www.learnabouttreatment.org/for-professionals/low-barrier-buprenorphine/>

<https://adai.uw.edu/new-guide-supporting-youth/>

SB 6228 Proviso

- ADAI/ CEDEER tasked with developing a shared decision-making tool for:
 - Alcohol Use Disorder
 - Opioid Use Disorder
- Support implementation of the tools in Behavioral Health Agencies across the state
- Conduct regular evaluations of the tools and update the tools as necessary

CERTIFICATION OF ENROLLMENT
SECOND SUBSTITUTE SENATE BILL 6228
68th Legislature
2024 Regular Session

Passed by the Senate March 5, 2024
Yeas 49 Nays 0

the Senate

CERTIFICATE
I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is the SECOND SUBSTITUTE SENATE BILL 6228 as amended and that the Senate Representatives on file set forth.

APR 29, 2024

CLEARs Project

Investigators

[Mandy Owens, PhD](#) Principal Investigator

[Jenna van Draanen, PhD](#) Co-Investigator

Project Staff

[Rieanna McPhie, BA](#) Project Coordinator

[Dana Pearlman](#) Lead Facilitator

[Amy Naylor](#) Lead Facilitator

[Jeff Myers](#) Law Enforcement Consultant

[Allyn Hershey](#) Drug use and Health Consultant

[Malika Lamont, MPA](#) Consultant

Partners with:
Research Expert Advisors on Drug Use (READU)

- The **Community-Law Enforcement Aligning in Response to Substance Use** (CLEARs) Project is legislatively funded to develop regional solutions to improve law enforcement response to drug use.



<https://adai.uw.edu/clears-project/>

Questions & Opportunities

*Questions about our work?
Opportunities to partner?*

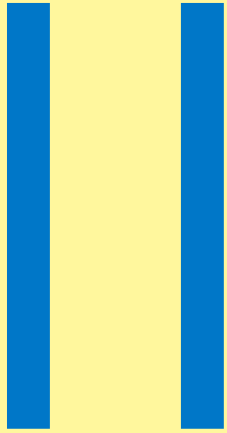


Please reach out!
Teresa Winstead – twinstea@uw.edu

Thank you!

Behavioral/Mental Health & SUD Panel

▶ Q&A



Break



Primary Care Follow-up After Behavioral Health– Related ED Visits in WA Medicaid

WA Academic Learning Collaborative Symposium

Jonathan Staloff, MD, MSc

Edwin Wong, PhD

Ashok Reddy, MD, MSc



Background

- Medicaid beneficiaries – particularly those with mental health conditions (MH), substance use disorders (SUD) and alcohol use disorder (AUD) – frequently utilize Emergency Departments (EDs)

Background

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- Timely primary care follow-up can reduce 30-day ED revisit rates for these conditions and ensure continuity

Background

- Medicaid beneficiaries – particularly those with mental health conditions (MH), substance use disorders (SUD) and alcohol use disorder (AUD) – frequently utilize Emergency Departments (EDs)
- Timely primary care follow-up can reduce 30-day ED revisit rates for these conditions and ensure continuity
- Primary care follow-up after MH, SUD, and AUD-related ED visits is understudied

References

1. Lin MP, Parrish C, Burke LG, et al. Ambulatory Follow-Up Visits After Emergency Department Discharge Among Medicaid Beneficiaries. *JAMA Netw Open*. 2024;7(10):e2441182. doi:10.1001/jamanetworkopen.2024.41182
2. Castner J, Wu YWB, Mehrok N, et al. Frequent emergency department utilization and behavioral health diagnoses. *Nurs Res*. 2015;64(1):3-12. doi:10.1097/NNR.0000000000000065
- Theriault KM, Rosenheck RA, Rhee TG. Increasing Emergency Department Visits for Mental Health Conditions in the United States. *J Clin Psychiatry*. 2020;81(5). doi:10.4088/JCP.20m13241
3. Serrano N, Prince R, Fondow M, et al. Does the Primary Care Behavioral Health Model Reduce Emergency Department Visits? *Health Serv Res*. 2018;53(6):4529-4542. doi:10.1111/1475-6773.12862

Objective

To assess 30-day condition-concordant primary care follow-up after MH, SUD, and AUD-related ED visits and identify factors linked to follow-up

Methods

Design: Retrospective Cohort Study

Methods

Design: Retrospective Cohort Study

Data Source: 2022 WA Medicaid claims data

Methods

Design: Retrospective Cohort Study

Data Source: 2022 WA Medicaid claims data

Population: Adults enrolled in Medicaid for at least 11+ months who had an ED visit

Methods

Design: Retrospective Cohort Study

Data Source: 2022 WA Medicaid claims data

Population: Adults enrolled in Medicaid for at least 11+ months who had an ED visit

Exposure: ED visits for MH conditions, SUDs, and AUD

Methods

Design: Retrospective Cohort Study

Data Source: 2022 WA Medicaid claims data

Population: Adults enrolled in Medicaid for at least 11+ months who had an ED visit

Exposure: ED visits for MH conditions, SUDs, and AUD

Outcomes: Primary care follow-up for MH, SUD, or AUD within 30 days following an ED visit for those diagnoses (**condition-concordant primary care follow-up**)

Diagnosis Code Criteria

- **Statistical Analysis:** Multivariable logistic regression with marginal effects
 - Approach to quantify factors predictive of binary outcomes

Diagnosis Code Criteria

- **Statistical Analysis:** Multivariable logistic regression with marginal effects
 - Approach to quantify factors predictive of binary outcomes
- **Covariates:**
 - **Patient Level:** Age, Sex, Race, Ethnicity, Homelessness, Spoken Language, Charlson Comorbidity Index
 - **Area level:** Residence (e.g., rural vs urban), poverty level

Diagnosis Code Criteria

Diagnosis Inclusion: Substance Use, Alcohol Use, and Mental Health (ICD-10 codes)

- Substance Use Includes:
 - Alcohol-related disorders
 - Opioid-related disorders
 - Cannabis disorders
 - Sedative disorders
 - Stimulant disorders
 - Hallucinogen disorders
 - Inhalant disorders
 - Other specified substance-related disorders

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Diagnosis Code Criteria

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- Cannabis disorders
- Sedative disorders
- Stimulant disorders
- Hallucinogen disorders
- Inhalant disorders
- Other specified substance-related disorders

- **Alcohol Use Includes:**

- Alcohol-related disorders

- **Mental Health Includes:**

- Schizophrenia, schizotypal, delusional, other
- Mood (affective) disorders
- Anxiety, dissociative, stress-related, somatoform, other nonpsychotic mental disorders
- Behavioral syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behavior
- Intellectual disabilities
- Pervasive and specific developmental disorders
- Behavioral, emotional disorders, unspecified disorders

Results: Condition Concordant Primary Care Follow-up

	ED Visit Claims	Condition Concordant Primary Care Follow-Up Claims, N (%)
Mental Health	131,704	18,722 (14.2%)
Substance Use Disorders	101,684	11,353 (11.2%)
Alcohol Use Disorder	33,196	3,675 (11.1%)

Marginal Effects, Example

- Reference Group Follow-Up Rate: 10%

Marginal Effects, Example

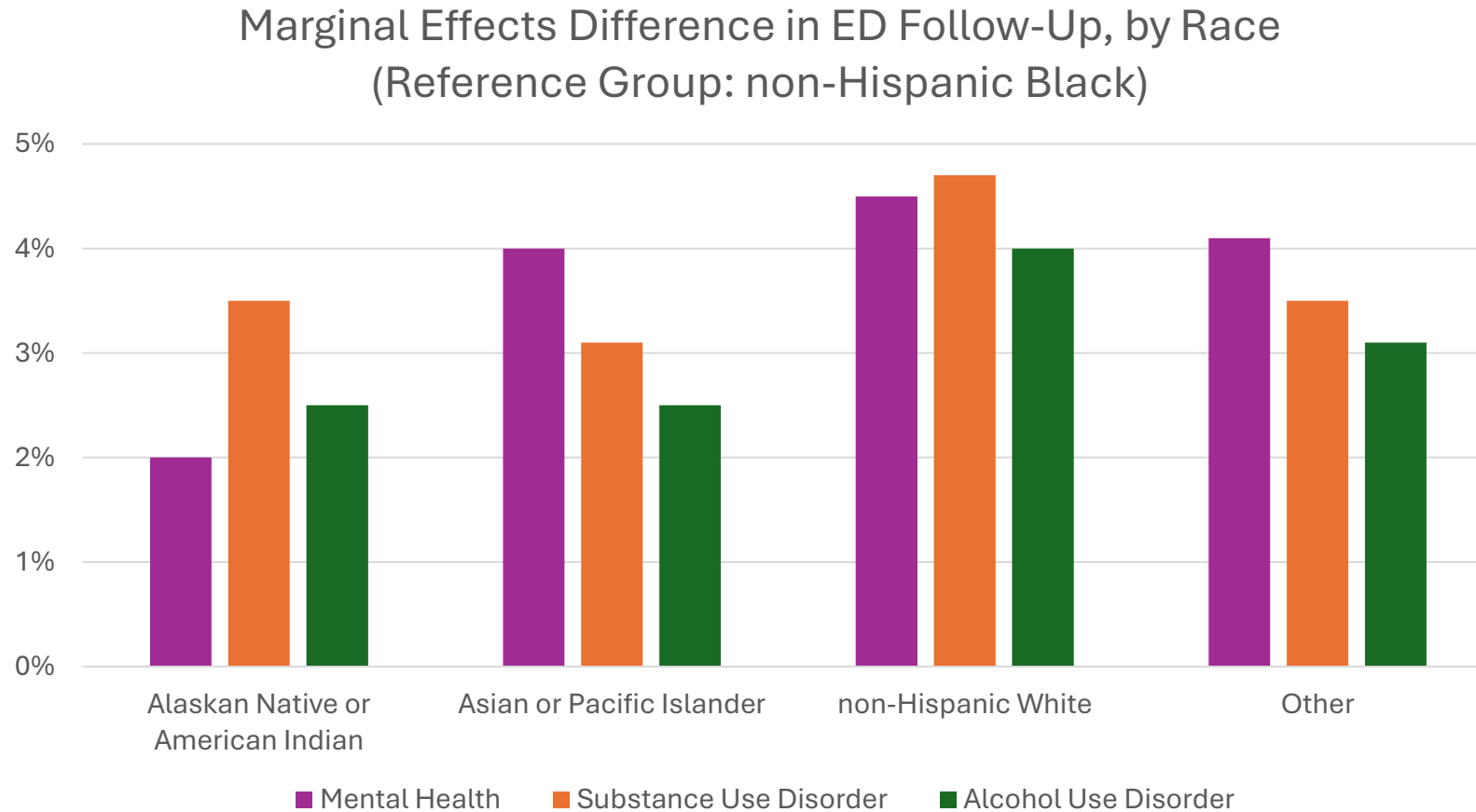
- Reference Group Follow-Up Rate: 10%
- Marginal Effect Estimate, Rurality: -3%

Marginal Effects, Example

- Reference Group Follow-Up Rate: 10%
- Marginal Effect Estimate, Rurality: -3%
- **Explanation:** All other variables equal to reference group, rural residing individual has follow-up rate of 7%

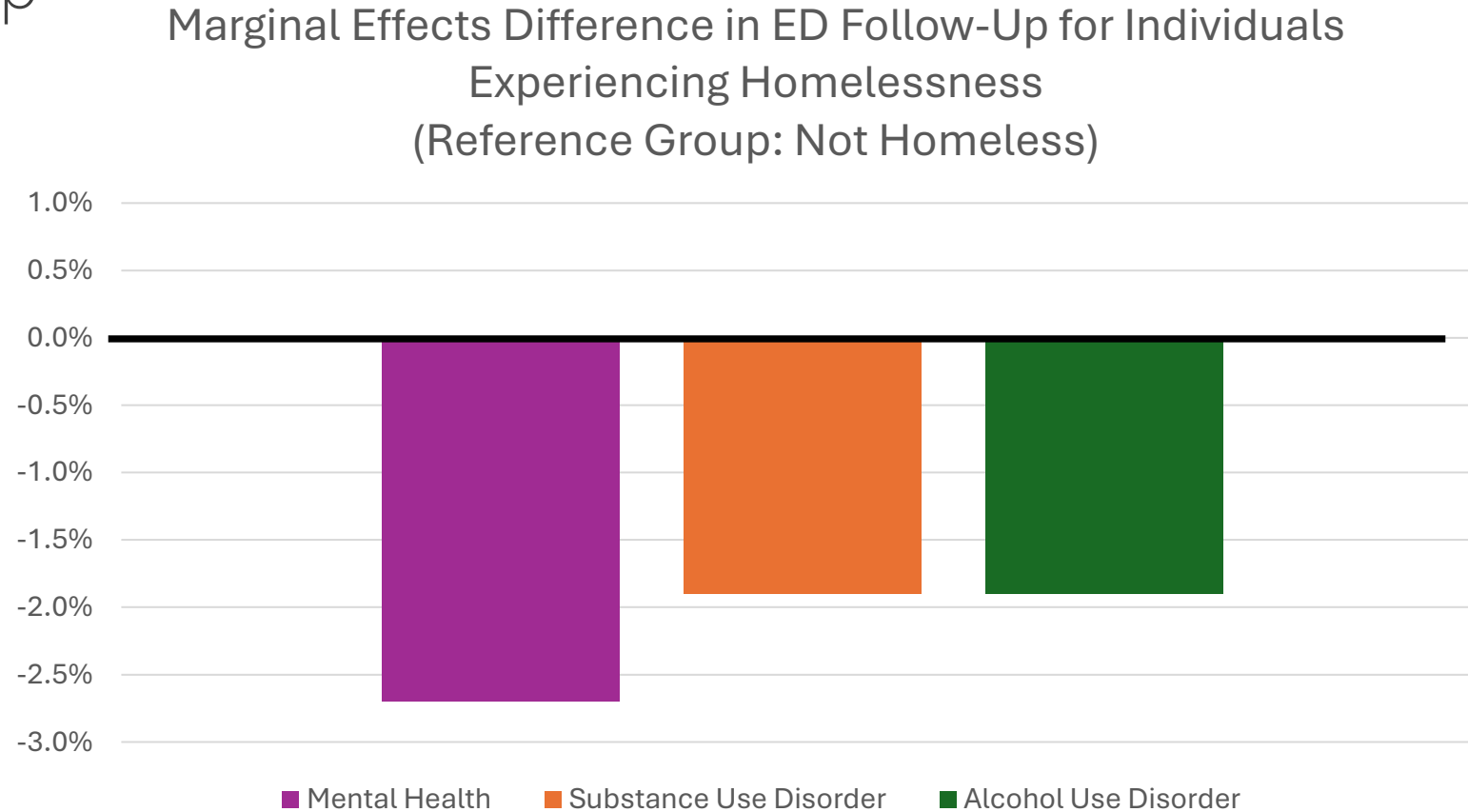
Results

Non-Hispanic Black Individuals Consistently Have Lowest ED Follow-up Rates



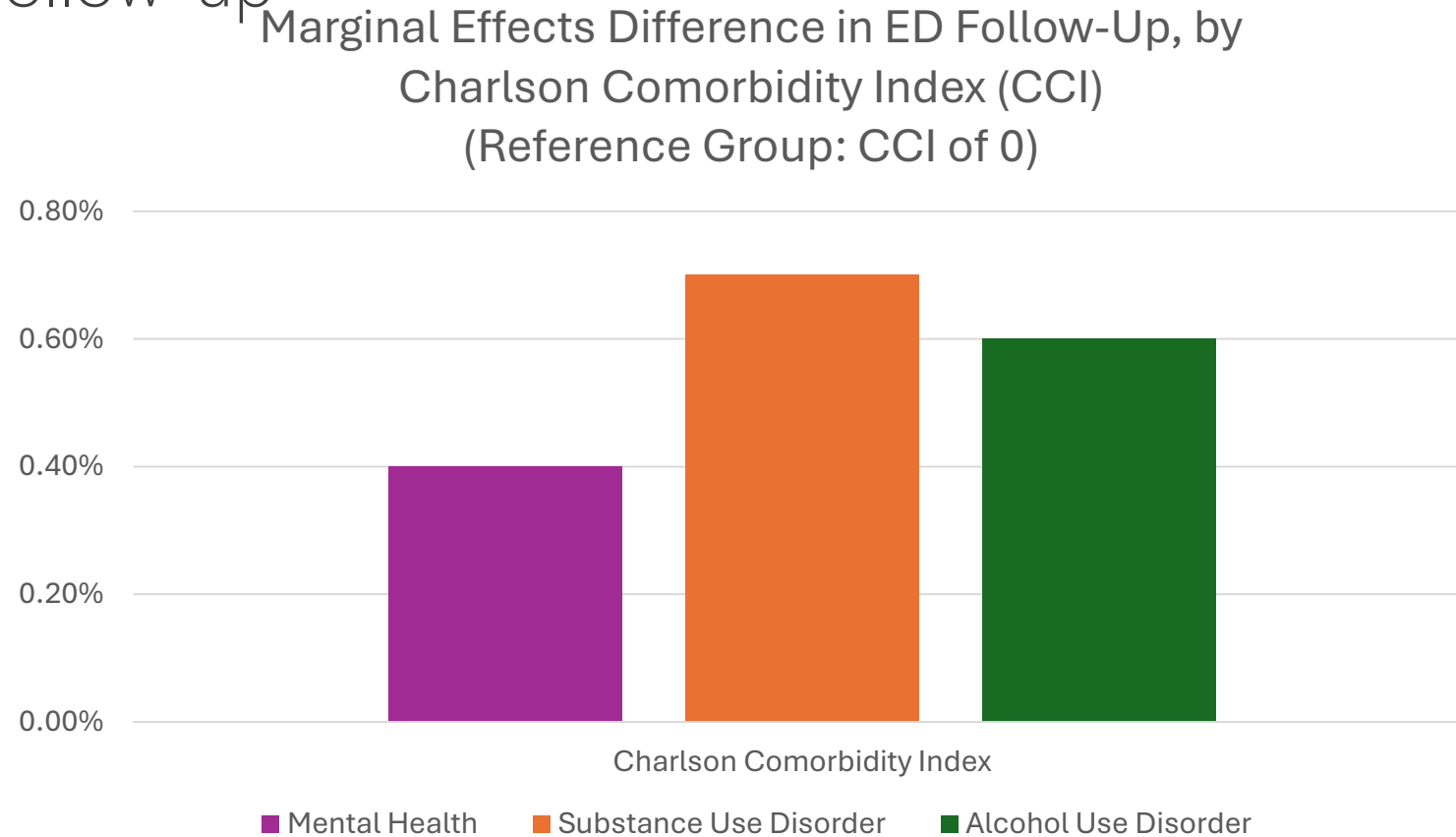
Results

Individuals Experiencing Homelessness Consistently Have Lower Rates of ED Follow-up



Results

Individuals with Higher Physical Comorbidity Consistently Have Higher Rates of ED Follow-up



Conclusions

- WA Medicaid beneficiaries infrequently receive condition-concordant primary care follow-up for MH, SUDs, and AUD (<15% across all conditions)

Conclusions

- WA Medicaid beneficiaries infrequently receive condition-concordant primary care follow-up for MH, SUDs, and AUD (<15% across all conditions)
- Non-Hispanic Black individuals and those experiencing homelessness consistently have lowest probability of condition concordant primary care follow-up

Conclusions

- WA Medicaid beneficiaries infrequently receive condition-concordant primary care follow-up for MH, SUDs, and AUD (<15% across all conditions)
- Non-Hispanic Black individuals and those experiencing homelessness consistently have lowest probability of condition concordant primary care follow-up
- Individuals with more chronic medical conditions had higher rates of condition concordant primary care follow-up

Implications

- Tailored care coordination and outreach strategies may be needed to improve access to primary care services among populations experiencing MH, SUDs, and AUD

Implications

- Tailored care coordination and outreach strategies may be needed to improve access to primary care services among populations experiencing MH, SUDs, and AUD
- Broader primary care access issues may contribute to low ED follow-up

Implications

- Tailored care coordination and outreach strategies may be needed to improve access to primary care services among populations experiencing MH, SUDs, and AUD
- Broader primary care access issues may contribute to low ED follow-up
- Demonstrates need for investment to bolster primary care infrastructure and access in general

Team

- Lingmei Zhou
- Chaylin Couzens
- Joseph Joo
- Joshua Liao
- Christopher Chen
- Judy Zerzan

Appendix: Additional Results

Mixed Findings Across Conditions

- Female patients have higher condition concordant ED follow-up for mental health (2.5%) and AUD (1.0%) than males, but not for SUD
- Older individuals have higher ED follow-up for SUD (0.05%) and AUD (0.04%), but lower follow-up rates for mental health (-0.10%)
- Rural residing individuals have higher ED follow-up for mental health (4.7%), but lower follow-up for AUD (-2.9%)

Appendix: Demographic Characteristics Associated with ED Visits

	Mental Health Condition Related ED Visits (N=131,704 claims)	Substance Use Disorder Related ED Visits (N=101,684 claims)	Alcohol Use Disorder Related ED Visits (N=33,196 claims)
Age (SD)	40.7 (14.6)	40.7 (13.0)	43.6 (13.3)
Female (%)	57.2	39.8	36.2
Race/Non-Hispanic Black (%)	9.7	10.2	8.2
Race/Non-Hispanic White (%)	63.9	61.6	60.9
Rural Residence Area (%)	2.2	2.5	2.9
Individual Federal Poverty Level %, mean (SD)	25.5 (46.97)	19 (41.22)	23.2 (45.39)
Homeless (%)	15.5	24.7	18.6



Hutchinson Institute for
Cancer Outcomes Research

Access to Cancer Care in Washington State

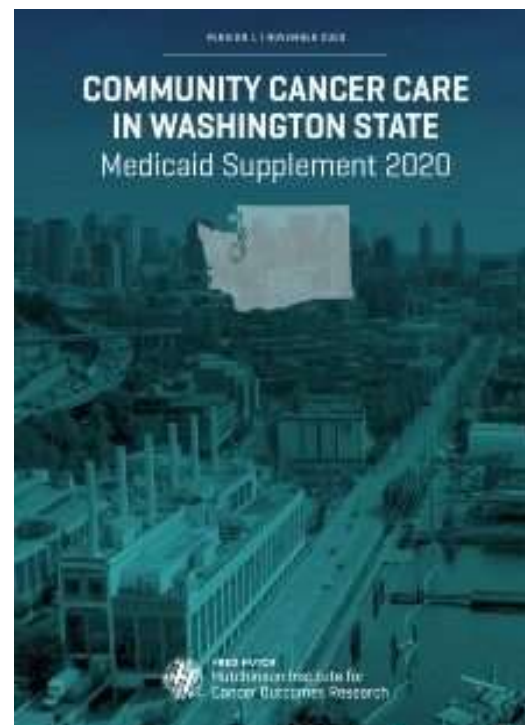
Hutchinson Institute for Cancer Outcomes Research (HICOR)

HICOR Vision

We believe that
every cancer patient
should get quality
care that meets their
goals at a
reasonable cost,
wherever they live.



Community Cancer Care Reports (2018 – 2025)

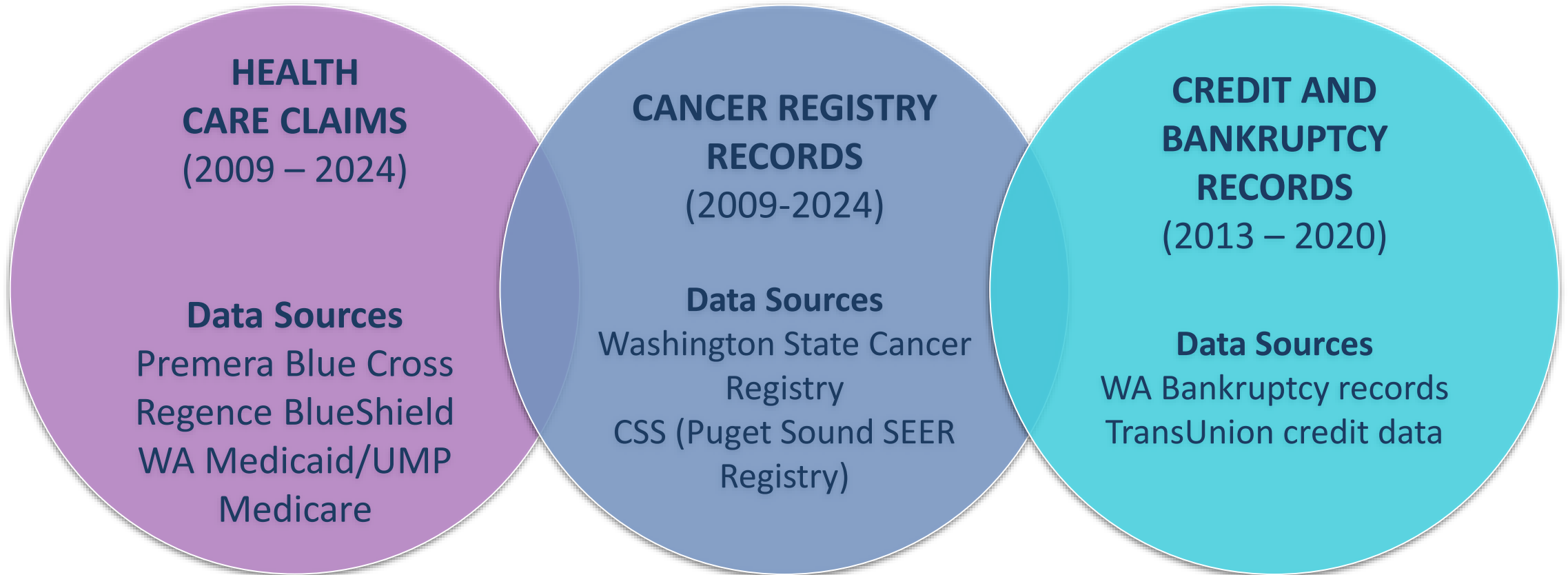


Washington State Oncology Clinics

- | | |
|----------------------------------|---------------------------------|
| 1 Cancer Care Northwest | 15 Partner Oncology |
| 2 CHI Franciscan Health | 16 PeaceHealth |
| 3 Compass Oncology | 17 The Polyclinic |
| 4 Confluence Health | 18 Providence Health & Services |
| 5 The Everett Clinic | 19 Rockwood Clinic |
| 6 EvergreenHealth | 20 Seattle Cancer Care Alliance |
| 7 Jefferson Healthcare | 21 Skagit Regional Health |
| 8 Kadlec | 22 Southlake Clinic |
| 9 MultiCare Health System | 23 Summit Cancer Centers |
| 10 Northwest Medical Specialties | 24 Swedish |
| 11 Olympic Medical Center | 25 Trios Health |
| 12 Overlake Medical Center | 26 Vancouver Clinic |
| 13 Pacific Gynecology | 27 Virginia Mason |
| 14 Pacific Medical Centers | 28 Vista Oncology |



HICOR Data Repository



Currently includes 466,865 patients; Represents 70% of insured WA cancer patients

Community Cancer Care Report (CCCR) Current Metrics

HICORs quality metrics are based on national guidelines for quality cancer care and reported at the clinic-level.

- **Measure 1:** Recommended Cancer Treatment
- **Measure 2:** Hospitalization During Chemotherapy
- **Measure 3:** Breast Cancer Tumor Marker Testing Following Treatment
- **Measure 4:** End of Life Care

Metric #1: Recommended Cancer Treatment

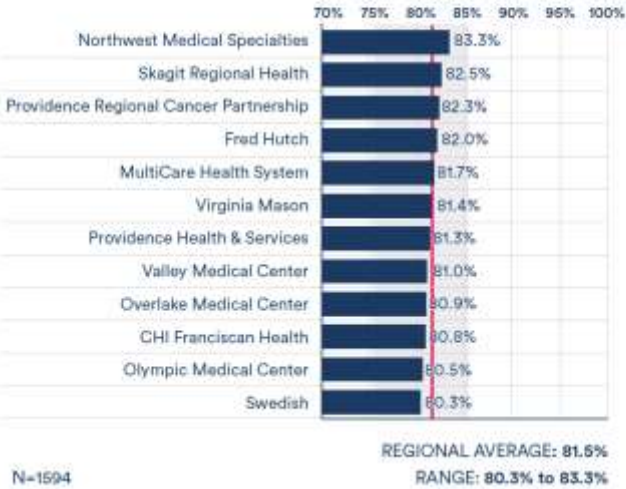
1A: RECOMMENDED TREATMENT FOR BREAST, COLORECTAL AND LUNG CANCER



Figure 1A.1: Recommended therapy based on cancer type

Risk-Standardized Rate | Higher rate = higher quality

■ ≥ 5% above average ■ ≥ 5% below average



RESULTS: 1A.1

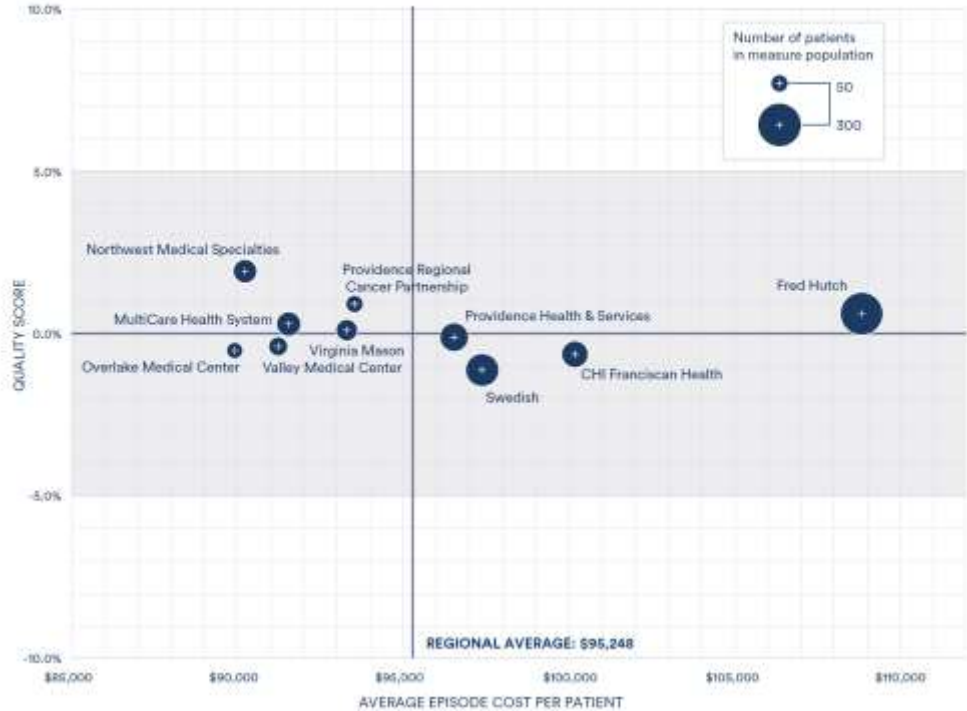
The Recommended therapy metric (1A.1) includes 1,594 patients.

On average, 81.5 percent of patients received recommended therapy based on cancer type. There is a 3.0 percentage point difference between the highest and the lowest clinic rate. In general, patients are receiving appropriate therapy based on their cancer type.

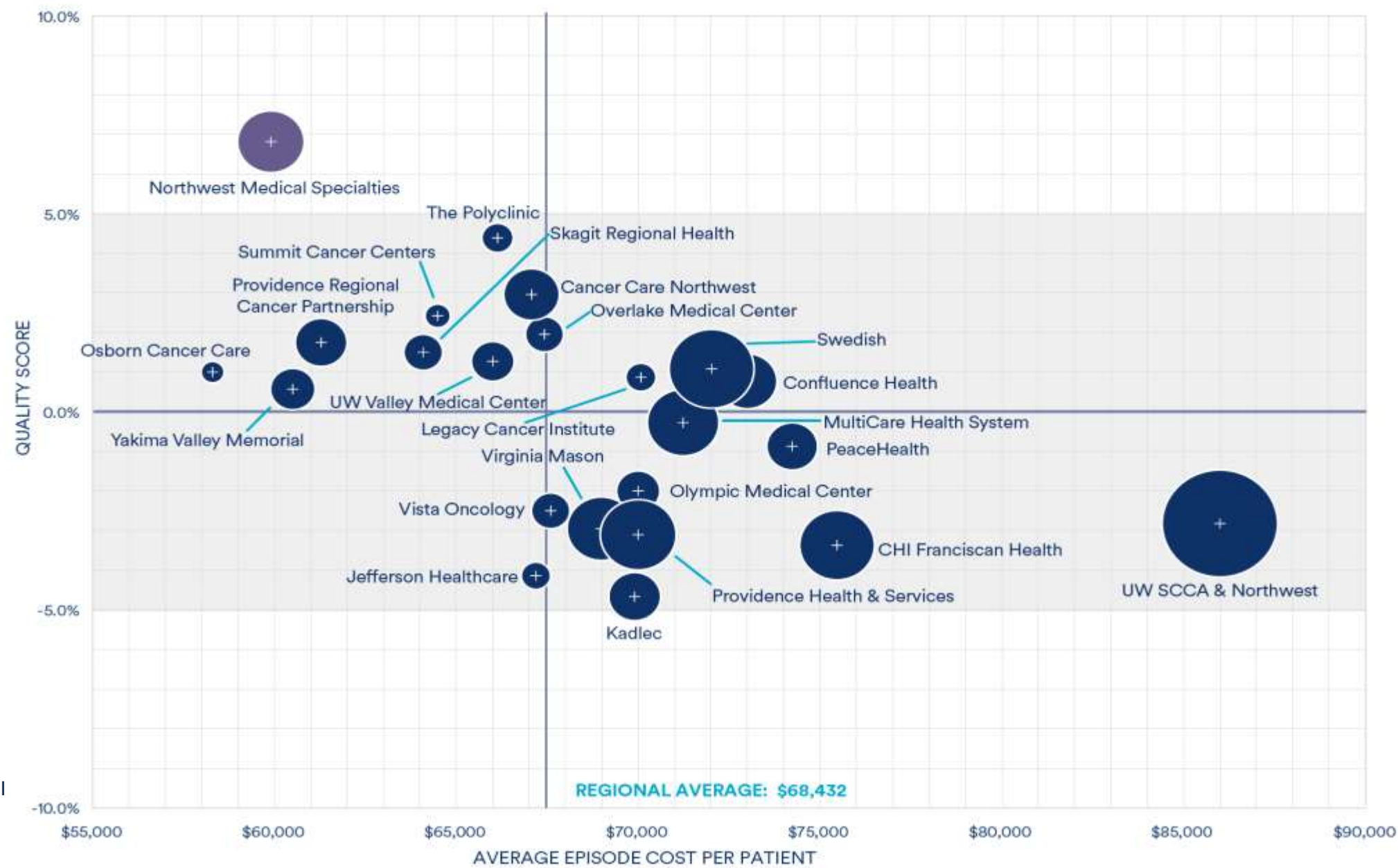


Figure 1A.3: Recommended treatment for breast, colorectal and lung cancer
Summary quality score and cost

■ ≥ 5% above average ■ ≥ 5% below average



Metric #2: Hospitalizations During Chemo



Metric #3: Breast Cancer Tumor Marker Testing



Figure 3.1: Breast cancer tumor marker testing following treatment

Risk-Standardized Rate | Lower rate = higher quality

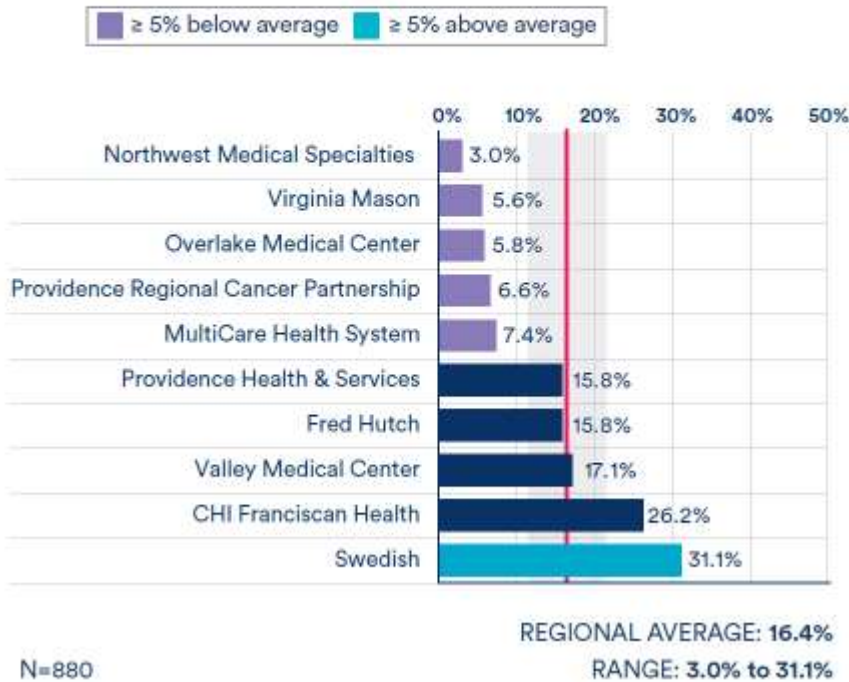


Figure 3.3: Breast cancer tumor marker testing following treatment

Summary quality score and cost

Purple circle: $\geq 5\%$ above average
Teal circle: $\geq 5\%$ below average

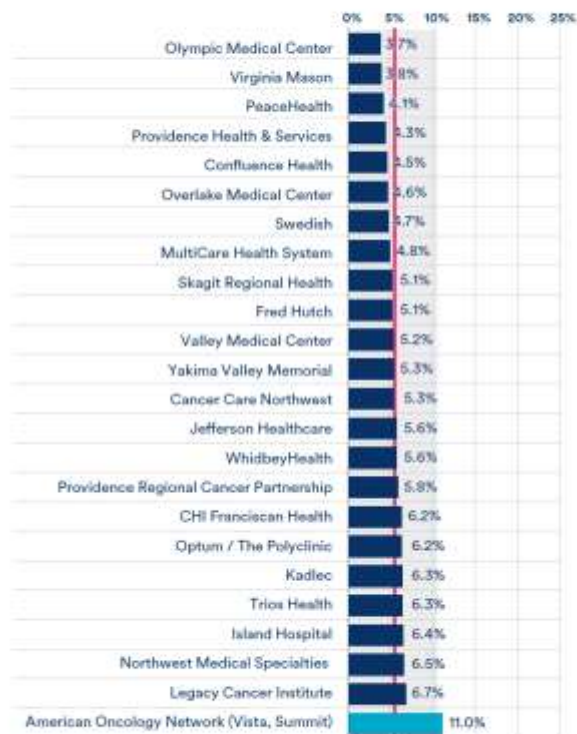


Metric #4: End of Life Care

Figure 4.1: Chemotherapy in the last 14 days of life

Risk-Standardized Rate | Lower rate = higher quality

■ ≥ 5% below average ■ ≥ 5% above average



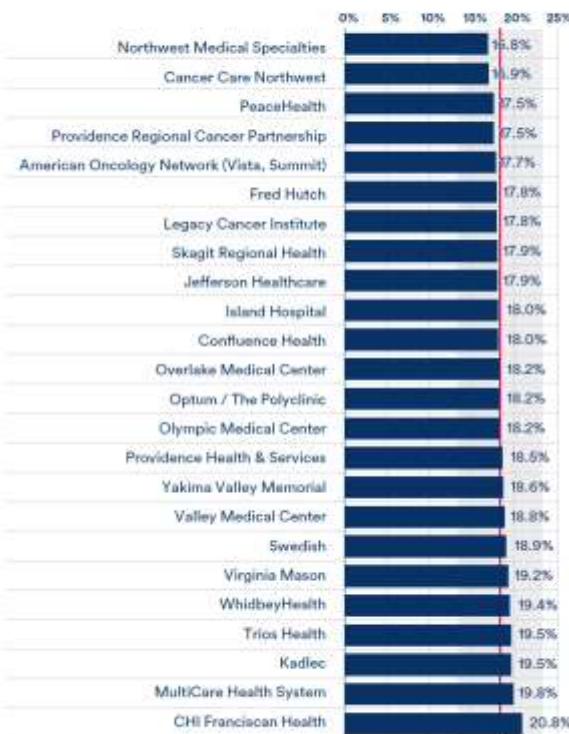
REGIONAL AVERAGE: 5.5%
RANGE: 3.7% to 11.0%

N=9314

Figure 4.2: Multiple emergency department (ED) visits in the last 30 days of life

Risk-Standardized Rate | Lower rate = higher quality

■ ≥ 5% below average ■ ≥ 5% above average



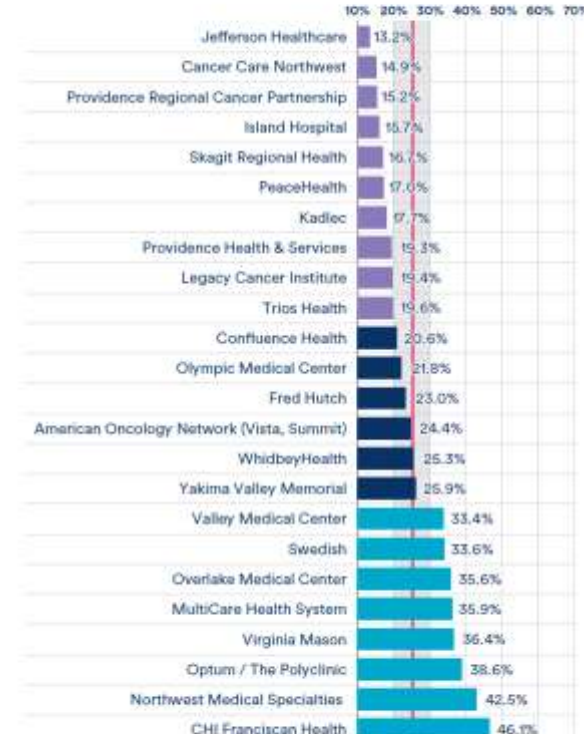
REGIONAL AVERAGE: 18.4%
RANGE: 16.8% to 20.8%

N=9314

Figure 4.3: Intensive care unit (ICU) stay in the last 30 days of life

Risk-Standardized Rate | Lower rate = higher quality

■ ≥ 5% below average ■ ≥ 5% above average



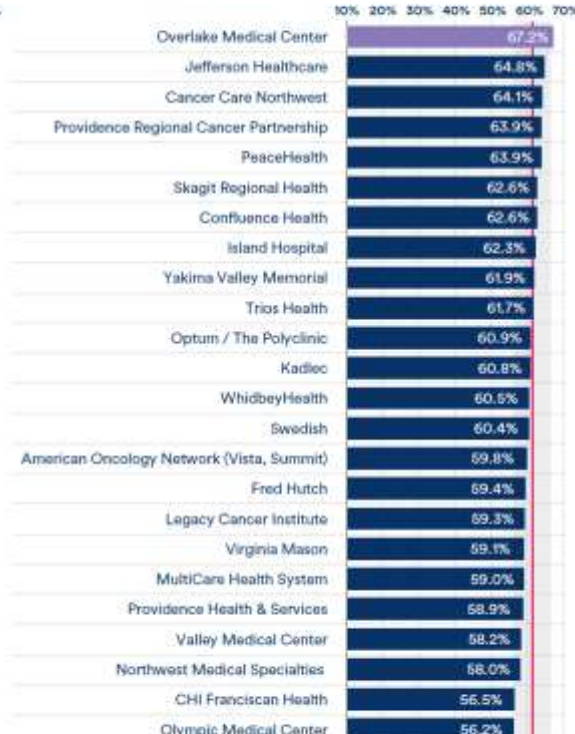
REGIONAL AVERAGE: 25.3%
RANGE: 13.2% to 46.1%

N=9314

Figure 4.4: Hospice care 3 or more days prior to death

Risk-Standardized Rate | Higher rate = higher quality

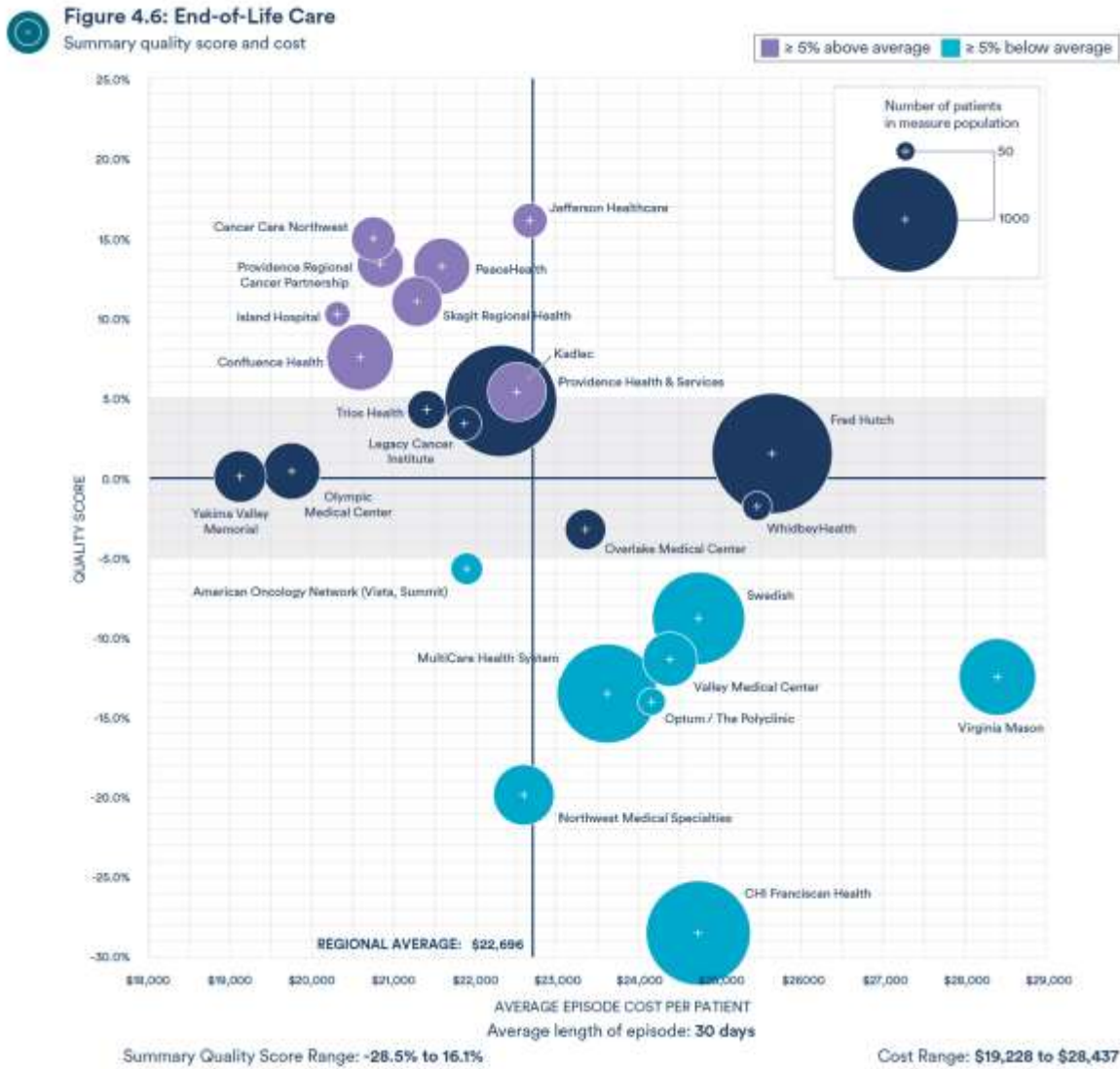
■ ≥ 5% above average ■ ≥ 5% below average



REGIONAL AVERAGE: 61.2%
RANGE: 56.2% to 67.2%

N=9314

Metric #4: End of Life Care



Metrics: Medicaid versus Commercial



MEASURE 1: RECOMMENDED TREATMENT

Measure	Tumor Site	Commercial	Medicaid	p-value
Recommended cancer treatment	Breast, lung, colorectal	85.5%	74.8%	<0.01
Recommended treatment for breast cancer	Breast	84.7%	69.8%	<0.01
Somatic mutation testing based on cancer type	Lung, colorectal	97.6%	90.6%	0.01

RESULTS: Commercially insured patients with breast, lung and colorectal cancer have higher levels of receipt of recommended treatment and testing than Medicaid-insured patients with these cancers.



MEASURE 2: HOSPITALIZATION DURING CHEMOTHERAPY

Measure	Tumor Site	Commercial	Medicaid	p-value
Emergency department visits during chemotherapy	All except leukemia	22.9%	35.9%	<0.01
Inpatient stays during chemotherapy	All except leukemia	25.8%	34.0%	

RESULTS: Medicaid-insured patients undergoing chemotherapy have a significantly and substantially higher rate of emergency department visits and inpatient stays than similar patients enrolled in commercial health plans.



Metrics: Medicaid versus Commercial

MEDICAID-INSURED MEASURE RESULTS



MEASURE 3: BREAST CANCER TUMOR MARKER TESTING FOLLOWING TREATMENT

Measure	Tumor Site	Commercial	Medicaid	p-value
Tumor marking testing after treatment	Breast	18.7%	11.2%	

RESULTS: Adherence to tumor marker testing following treatment among Medicaid-insured patients with stage I to IIIA breast cancer were better than for commercially insured patients (for this metric, lower rates are better).



MEASURE 4: END-OF-LIFE CARE

Measure	Tumor Site	Commercial	Medicaid	p-value
End of Life (EoL): Chemotherapy	Solid	9.7%	5.5%	<0.01
EoL: 2+ ED visits	Solid	20.4%	22.8%	
EoL: ICU stay	Solid	26.0%	21.3%	<0.01
EoL: Hospice	Solid	35.3%	41.3%	<0.01

RESULTS: Overall adherence to measures of quality in end-of-life care was higher for Medicaid-insured patients compared to their commercially insured counterparts. ICU stays were significantly lower and enrollment in hospice care was significantly higher for the Medicaid enrollees than commercially insured patients.



Barriers to Cancer Care



- **Affording / Accessing Care**
- **Receipt of biomarker and germline testing**
- **Participation in cancer research studies.**

Financial fragility is more common in younger patients and Medicaid enrollees

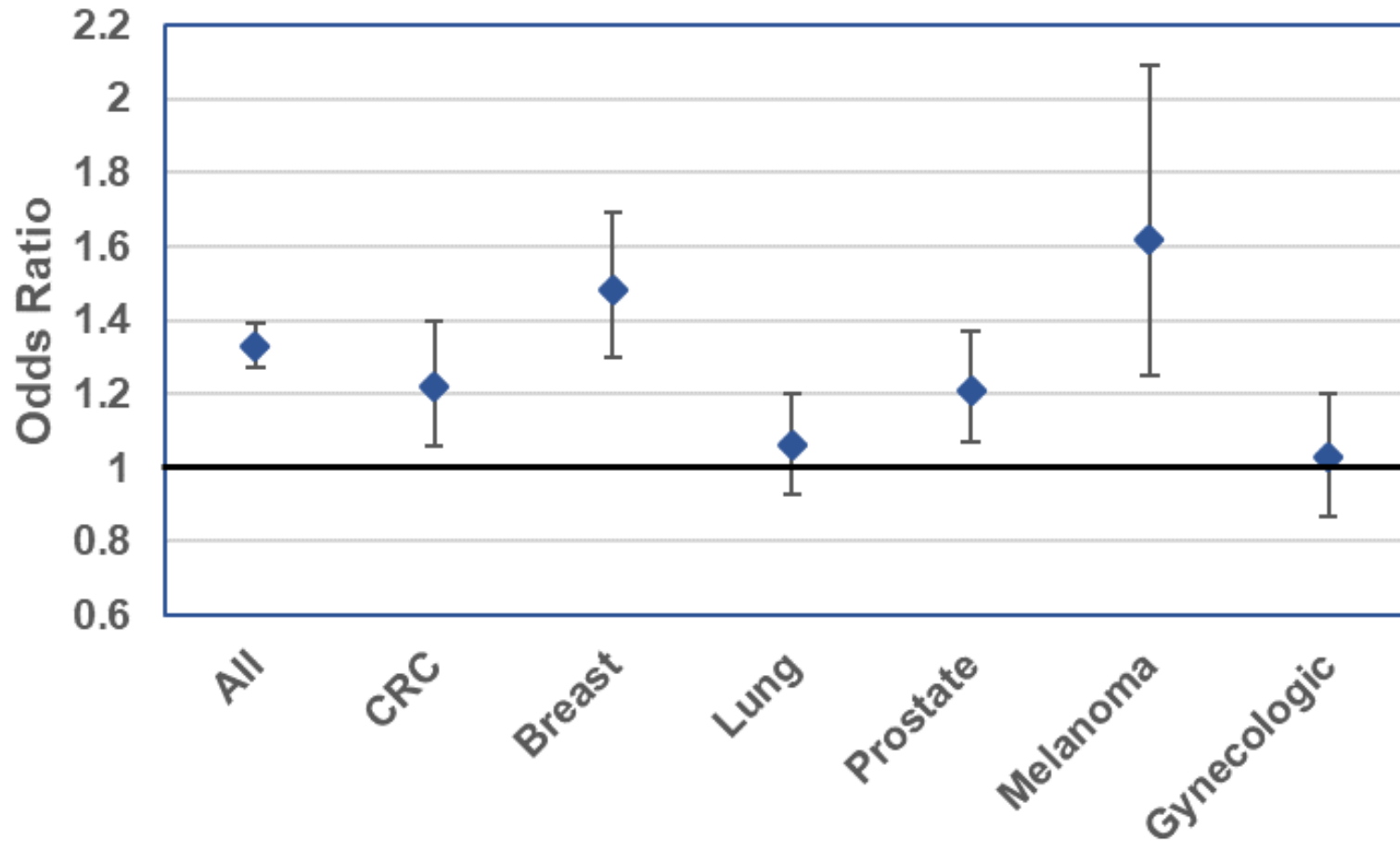
Measured using credit reports 3 months prior to diagnosis, Puget Sound region

AFE = collections, delinquencies, liens, foreclosures, bankruptcies

Payer Type	% with AFE
Commercial	17%
Medicaid	55%
Medicare	16%
Multiple	11%

Age	% with AFE
<40	39%
40-49	37%
50-64	28%
65+	13%

Financially fragility is associated with later stage diagnosis



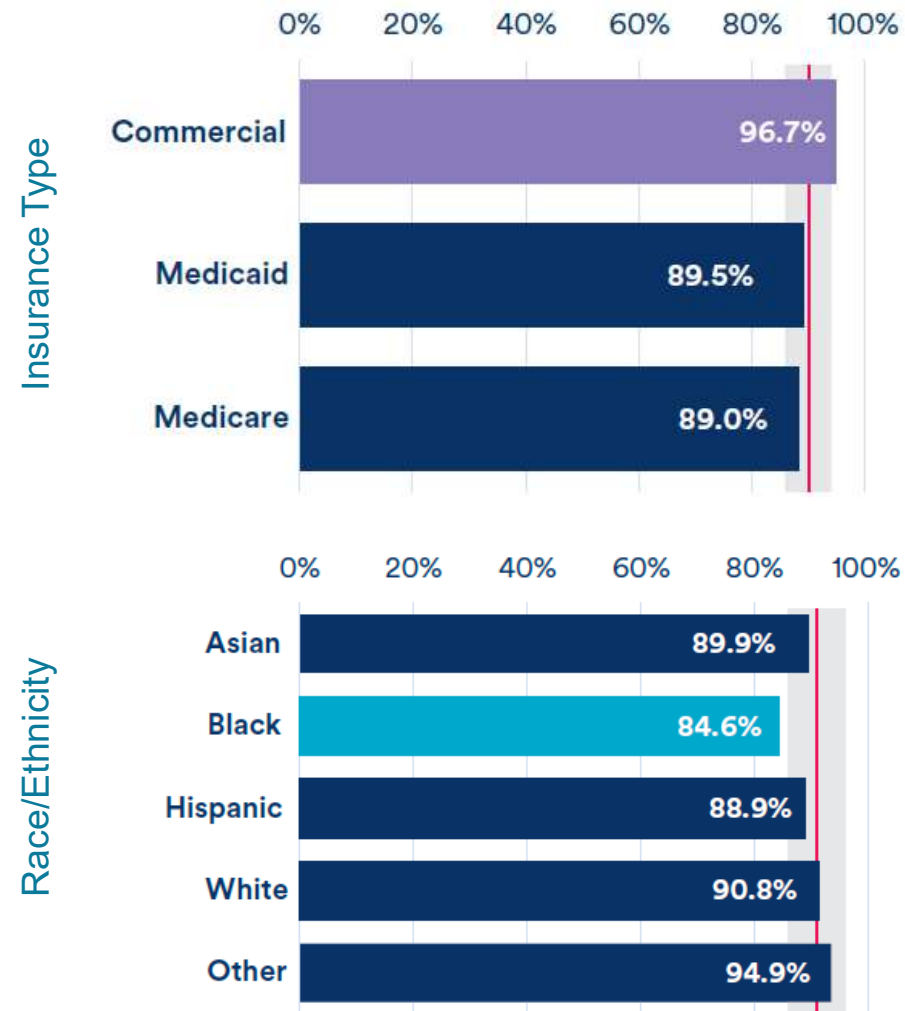
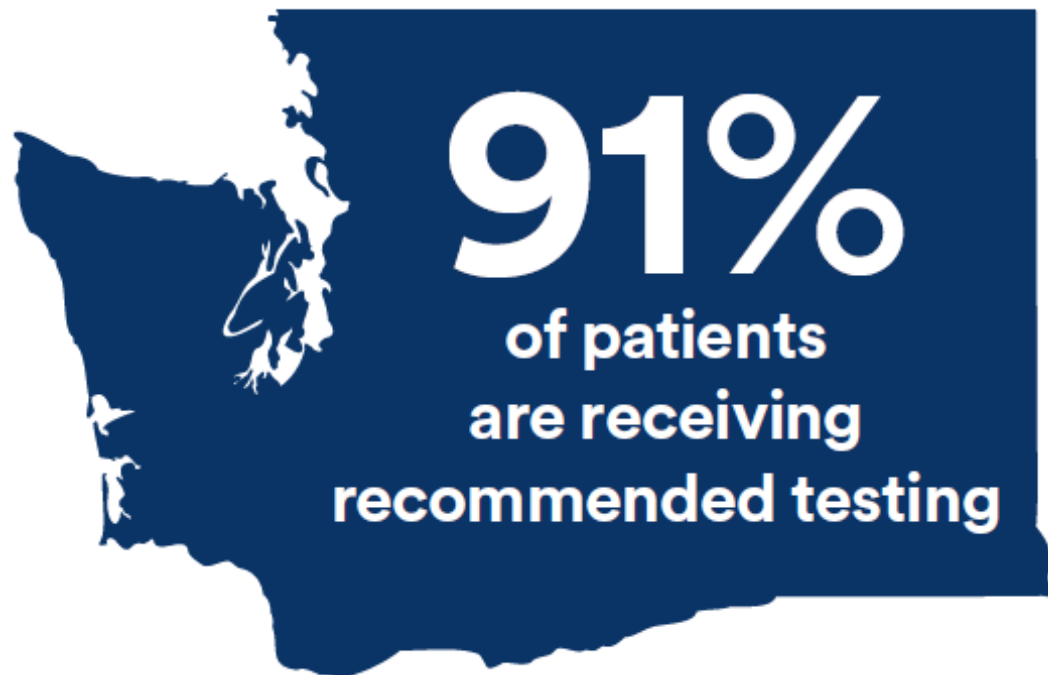
Exposure = AFE within 2 years prior to diagnosis

Outcome = later stage (III/IV) cancer diagnosis (vs. early stage I/II)

Adjusted for = age, race, sex, marital status, year of dx, insurance type, area deprivation, rurality

Biomarker Testing at Diagnosis for Metastatic NSCLC

2018-2020, WA State, testing in first four months of diagnosis
Tests included: EGFR, ALK, ROS1, NGS



Biomarker Testing at Diagnosis for Metastatic Colorectal Cancer

2017-2022, Puget Sound region

Testing in first six months of diagnosis

Any Test: **90.0 %**

Tests included:

MSI, MMR IHC, KRAS, NRAS, BRAF, NGS

Payer Type	% with Testing
Commercial	97%
Medicaid	86%
Medicare	88%
Multiple	88%

Community Cancer Care Report: Germline Testing



Breast Cancer
Ovarian Cancer
Pancreatic Cancer
Prostate Cancer

Population



Patients who meet guidelines for
germline testing

Diagnosed 2018-2020

Testing Period



2 months prior through 24
months following diagnosis

Tests



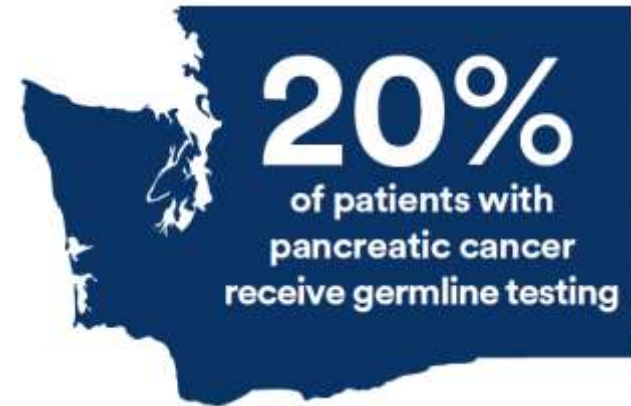
Breast: BRCA1/2
Other: Any germline test

Community Cancer Care Report: Germline Testing

Breast



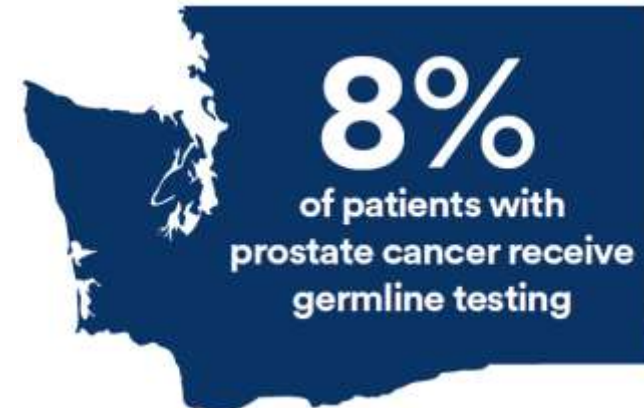
Pancreatic



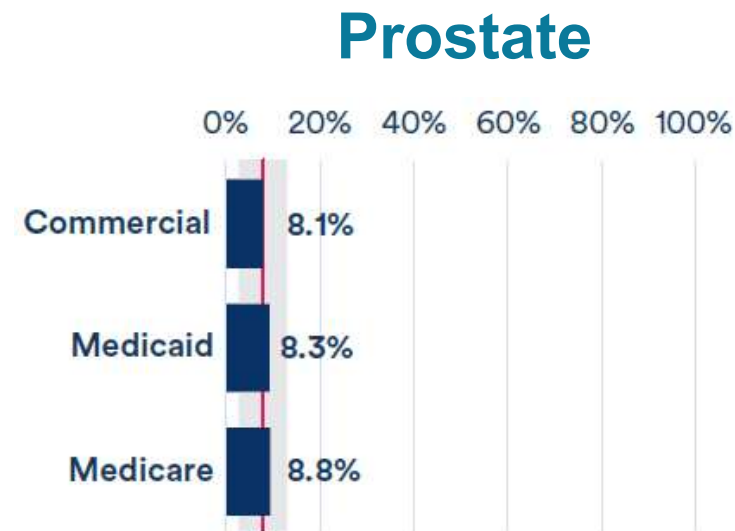
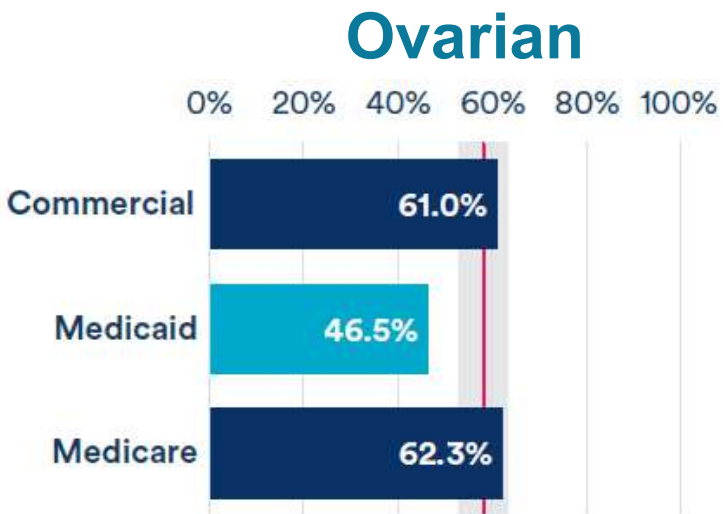
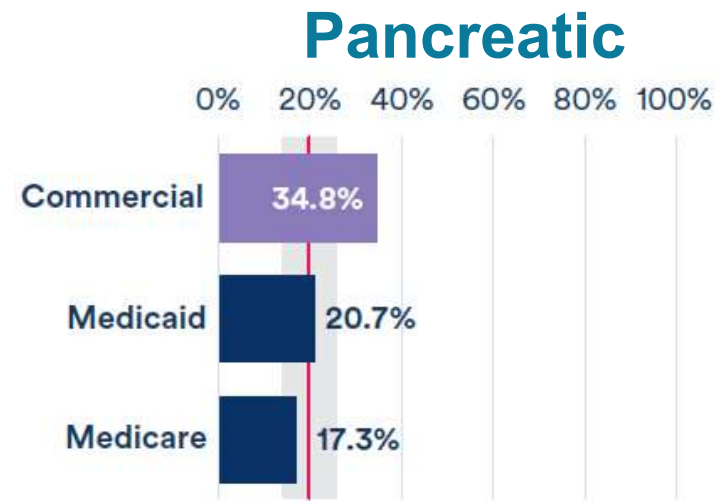
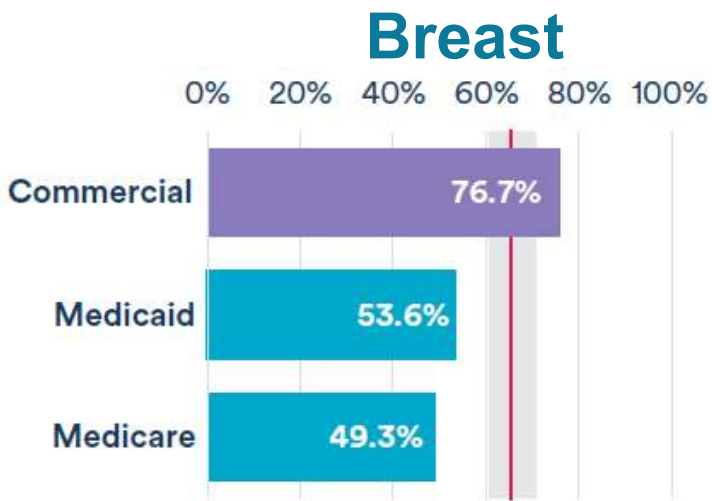
Ovarian



Prostate



Germline Testing – Disparities by Insurance Type





Fred Hutch Initiative: Expanding Access to Cancer Research in Washington State

Expanding Access to Cancer Research

VISION

By 2030, 1 in 5 Washington State cancer patients will be enrolled in a research study.

Finding a Better Way: A New Cancer Research Paradigm for our Community

CHALLENGES



For Patients

- Time and financial burden
- Uncertainties about the experience
- Not offered by provider



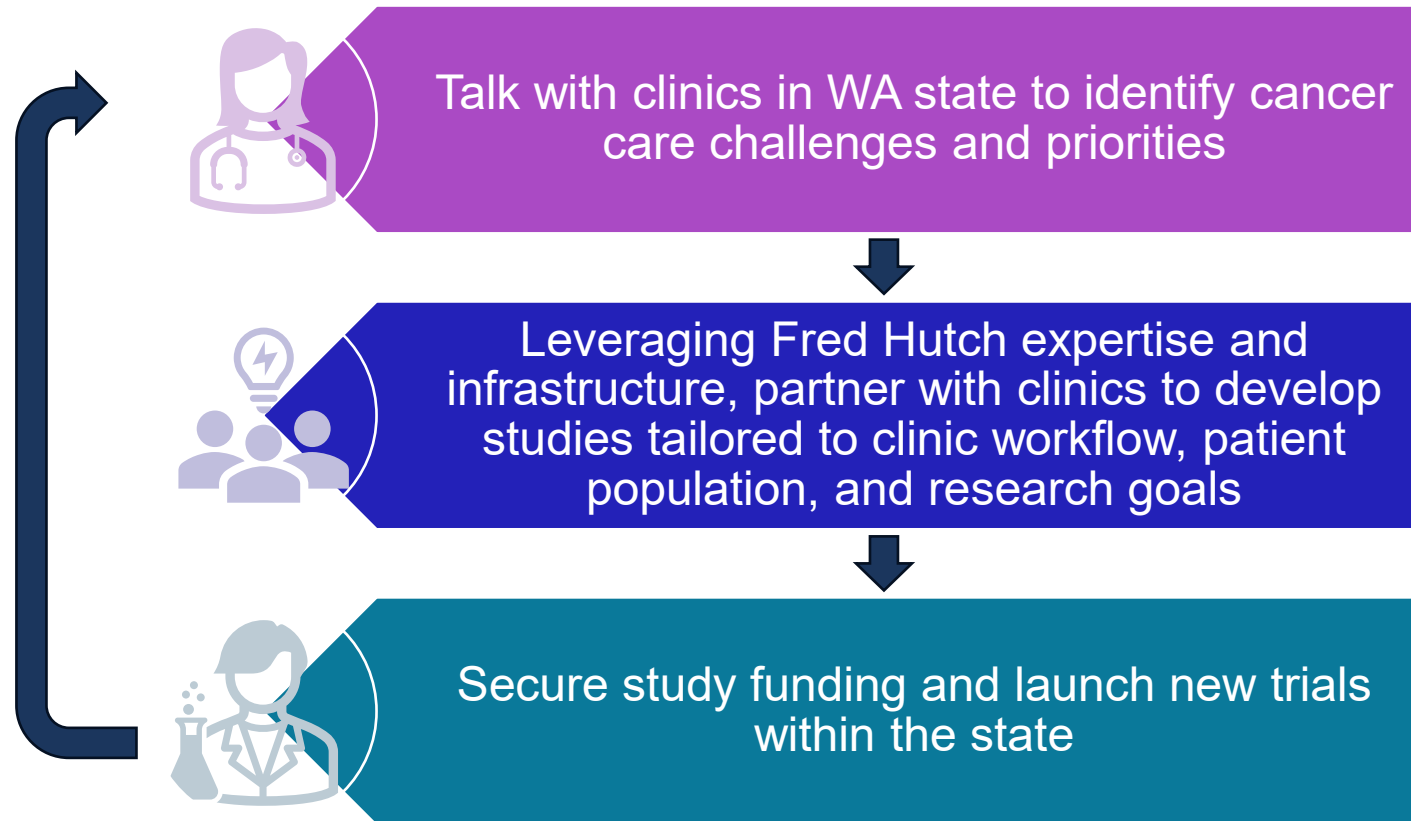
For Oncology Clinics

- Administrative burden
- Financial burden
- Applicability to the patients or practice

SOLUTIONS/PROGRAM GOALS

- Partner with community cancer care providers in WA to conduct cancer care delivery trials.
- Build a research program focused on improving care and the care experience to address clinic challenges and ease the treatment journey for patients.
- Make it easier to conduct and participate in cancer trials for both clinics and for patients.

Our Community Collaboration Process



Funded Trials Expansion Studies

Title	PI	Overview	Target Enrollment	Partnering Clinic(s)
 DISCOVER*	Scott Ramsey	Assess the relationship between insurance status, health-related social needs, and symptoms during chemotherapy.	60	 Spokane and Puget Sound
 PAYMENT*	Veena Shankaran	Test a randomized intervention of unrestricted payments to cancer patients following diagnosis to improve outcomes.	20	 Bellingham, Longview, and Vancouver
 PRO-ACTIVE	Erin Gillespie	Assess if virtual fitness program reduces cancer-related fatigue in patients undergoing radiation for breast cancer.	60	 Spokane and Puget Sound
 Talking About Cancer	Megan Shen	Assess if a remote training intervention helps patients with advanced cancer and their informal caregivers with advanced care planning.	40	 Mount Vernon  Providence Everett
 REGENT	Hiba Khan	Assess feasibility, uptake, and patient/provider satisfaction of a remote, comprehensive germline genetic testing program.	50	 Everett
 FLoC	Allison Cole	Assess the impact of a social prescribing intervention on cancer survivor loneliness, quality of life, and receipt of guideline-concordant survivorship care.	20	 Mount Vernon  Ketchikan, AK

Medical Panel

▶ Q&A

Break & Poster Session

Poster presenters, please stand by
your posters for attendees to ask
questions



Beyond Claims Reimbursement: Novel Uses of Medicaid Data at Public Health Seattle & King County

Susan Hernandez, Nithia Chowattukunnel, Eli Kern, Jennifer Liu, Alastair Matheson

Agenda



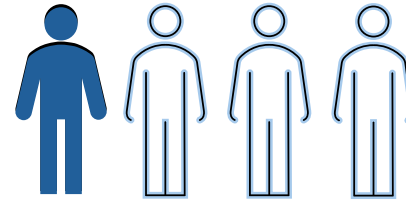
- Background
- Public health surveillance
- Research applications
- What's next?

Why is a public health agency interested in Medicaid data?

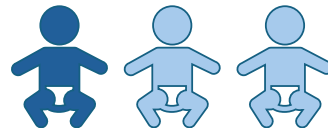
Medicaid in King County covers:



2 out of 5 (42%) King County children & youth ages 0-18, approximately 207,000 in 2024



1 out of 4 King County residents (26%), representing approximately 571,000 people in 2024

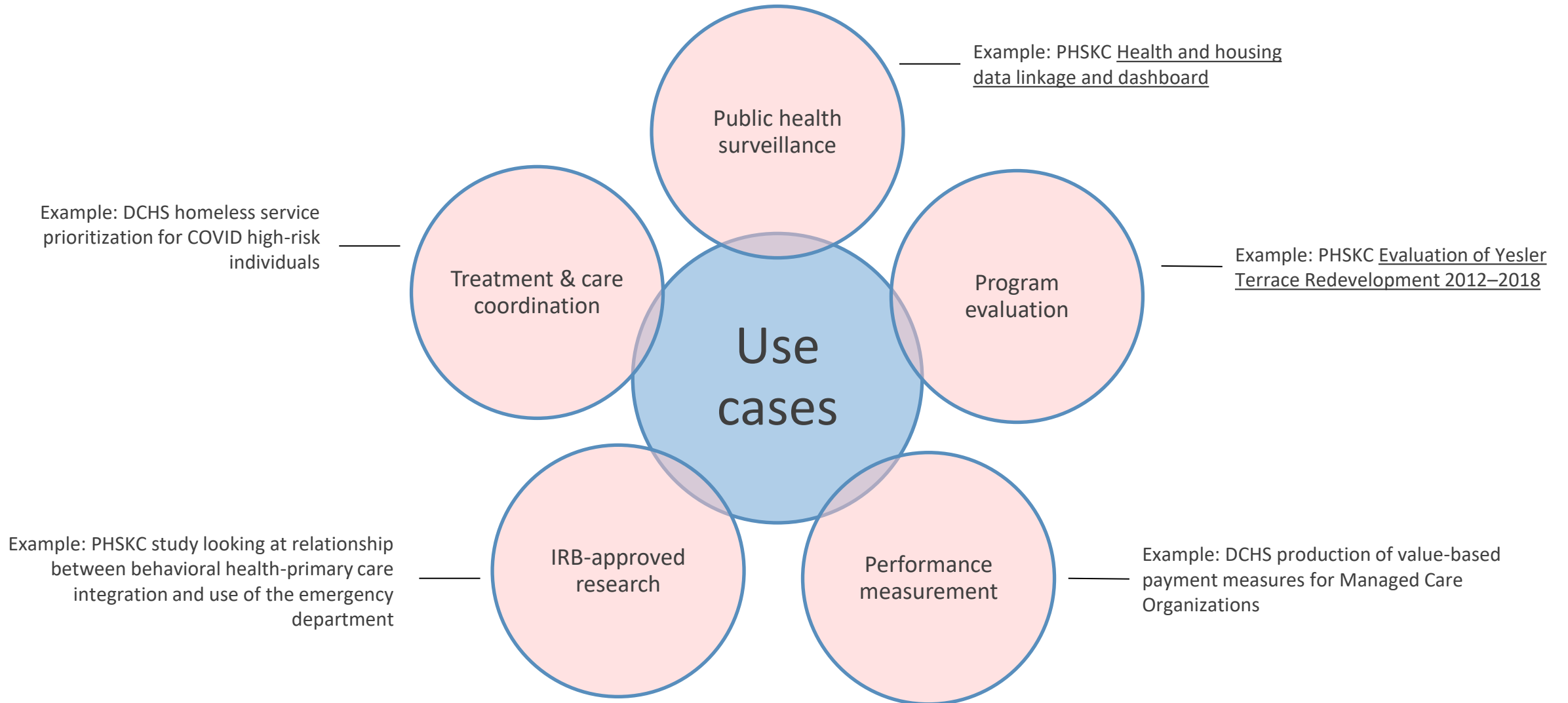


1 out of 3 (37%) births, representing 8,173 in 2023

Priority Areas



King County uses health insurance claims data to support community health and well-being



Selected King County uses of ProviderOne data

- Public health surveillance
- Research applications
 - Research Enhanced Identification of Tobacco Use Among Adult Medicaid Members — King County, Washington, 2016–2023
 - Medications for Opioid Use Disorder Receipt among Medicaid Beneficiaries in King County, 2017-2024
 - Latent Class Analysis of Suicide Deaths Among Medicaid & Medicare Enrollees (King County, 2015–2023)

Surveillance applications

Housing dashboard overview



Medicaid dashboard overview

The dashboard now features:

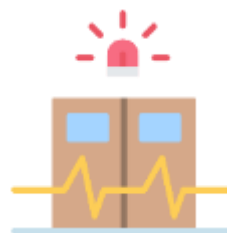
- Monthly, quarterly, and annual data
- Enrollment data by demographic characteristics and geography with a one-month lag time
- Healthcare use data by demographic characteristics with a five-month lag time
- Standardized format and header for navigation
- Easy addition of new concepts



Primary care



Inpatient stays



ED visits



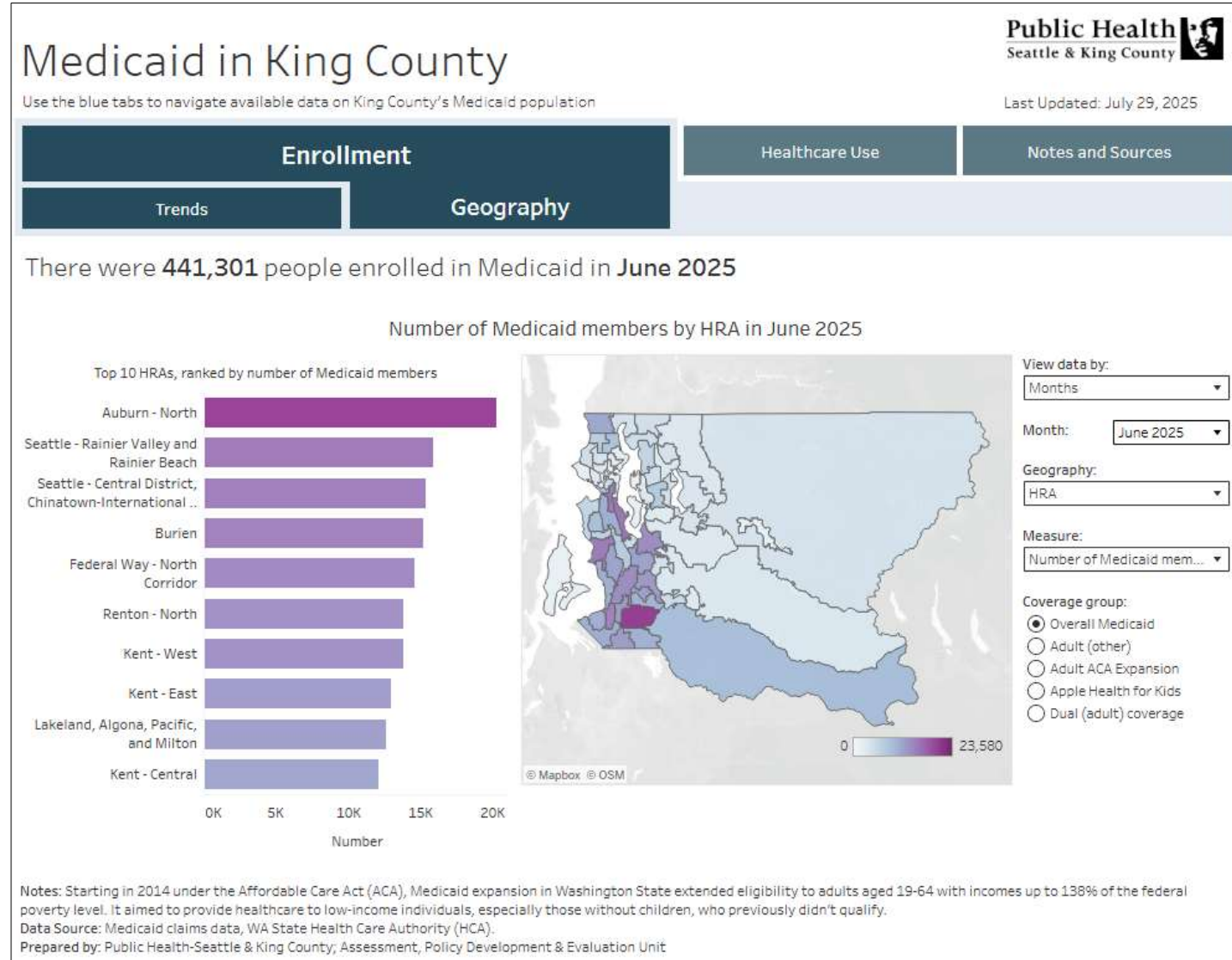
Telehealth



Next up: Urgent care

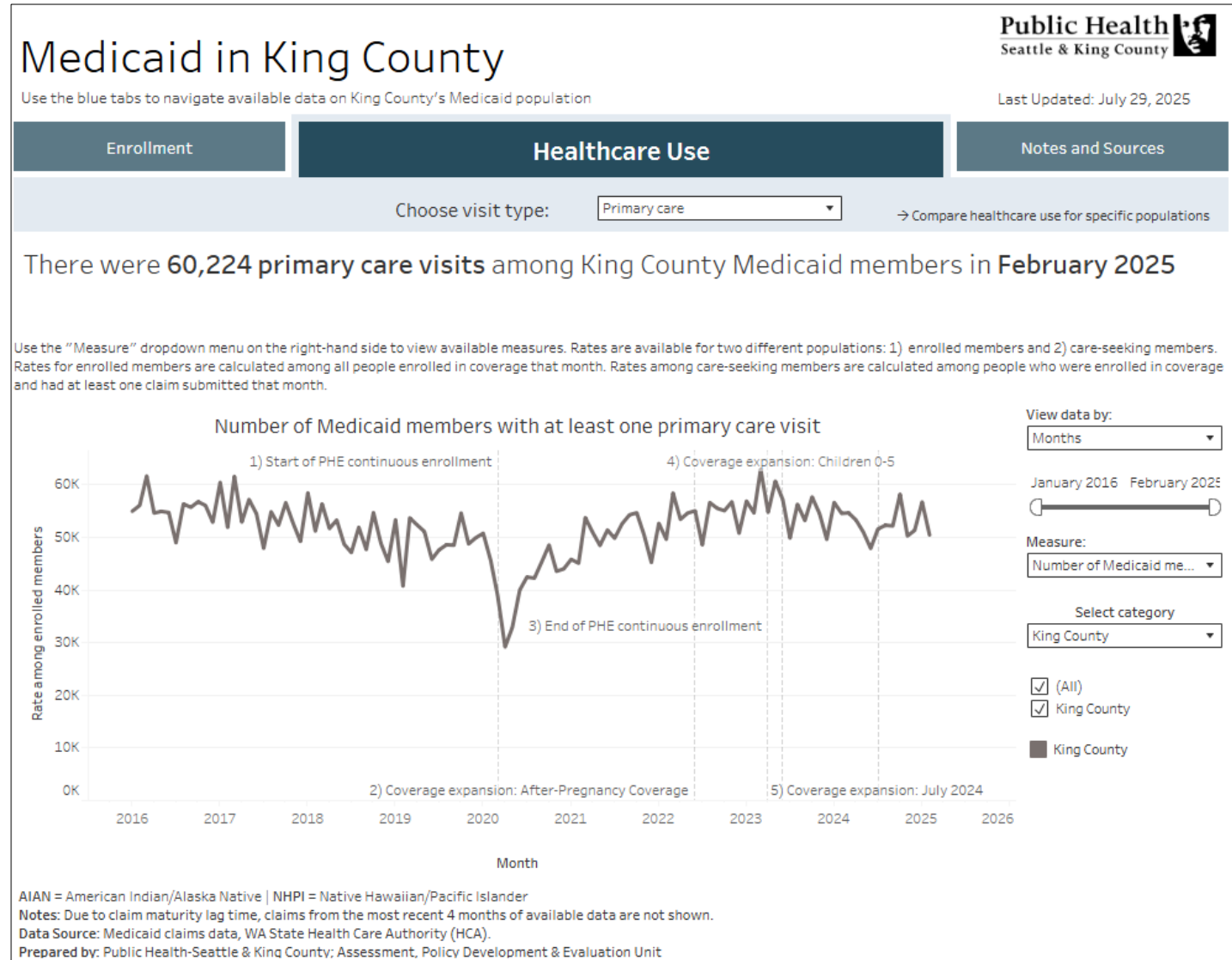
Medicaid dashboard overview

Enrollment by geography



Medicaid dashboard overview

Healthcare use



Research applications

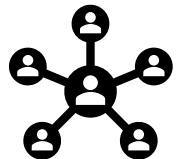
Enhanced identification of tobacco use among adult Medicaid members — King County, Washington, 2016–2023



- Tobacco use is the leading cause of preventable disease and death in the United States
- The percentage of adults with Medicaid who use tobacco (28.1%) is almost twice that of adults with private insurance (16.2%)



- Nationally, annual Medicaid spending on smoking-related diseases is approximately \$68 billion



- Methods: Linked self-reported tobacco use from Washington Medicaid enrollment from the WA Health Benefit Exchange the with 2016–2023 claims data

Morbidity and Mortality Weekly Report

Notes From the Field

Enhanced Identification of Tobacco Use Among Adult Medicaid Members — King County, Washington, 2016–2023

Waller E, Silberman M, Bhatti A, Zeng L, Davis M, et al. *MMWR*. 2024;73(10):250–254. DOI: <https://doi.org/10.15585/mmwr.mm7310a1>

In 2021, tobacco use prevalence among Medicaid members nationwide was 28.1%, compared with 16.2% among those with private insurance (1). Medicaid members experience a higher prevalence of tobacco-related disease as well as gaps in receiving effective tobacco cessation therapies (2,3), which increase the likelihood of approximately half of adults who smoke on smoking-related diseases (4). Identifying Medicaid members who use tobacco and providing tobacco cessation care can improve health and reduce health care costs.

Investigation and Outcomes

Washington is one of the states that collect tobacco use data on Medicaid eligibility forms. To maximize health outcomes data with tobacco use and smoking cessation, data can help improve identification of Medicaid members who use tobacco, self-reported tobacco data not reflected through the Washington Health Information Exchange (HIE).¹ An initial investigation for health insurance, non-qualified and non-beneficiary status data to identify a cohort of King County Washington Medicaid members aged 18–64 years who use tobacco. These members during 2016–2023 with claims related to tobacco use during 2016–2023 were included in the study. An 18-month adequate time for diagnosis of cardiovascular, Medicaid members were required to be enrolled ≥ 7 months before given.

The primary outcome was the accumulation of target data on tobacco products among Medicaid members. Adult respondents affirmatively on the questionnaire form to using tobacco products including cigarettes and vapor products more than four times weekly during the preceding 12 months.

¹ <https://www.hie.wa.gov/>

The Washington HIE is a public-private partnership made up of the operators of Washington's healthplan information system to facilitate the exchange of health information between providers and payers. The HIE is used by all Medicaid and Medicare beneficiaries across the state, and is used by all Washington state health plans. The HIE is used by all Washington state health plans. The HIE is used by all Washington state health plans.

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

2024.11.14

2024.11.14

Introduction

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Enhanced Identification of Tobacco Use Among Adult Medicaid Members — King County, Washington, 2016–2023

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Introduction

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Results

Results

Results

Results

Results

Results

Results

Results

Results

You need both data sources. In 31.3% of cases, both HIE and Medicaid data were needed to identify tobacco use. You could miss 14.5% of people who smoke if you only use one data source.

Figure 1. Number of Medicaid members who use tobacco by data source.

Figure 2. Number of Medicaid members who use tobacco by data source.

Figure 3. Number of Medicaid members who use tobacco by data source.

Figure 4. Number of Medicaid members who use tobacco by data source.

Figure 5. Number of Medicaid members who use tobacco by data source.

Figure 6. Number of Medicaid members who use tobacco by data source.

Figure 7. Number of Medicaid members who use tobacco by data source.

Conclusion

The research demonstrates the power of using multiple data sources to identify tobacco use among Medicaid members. The study found that using both HIE and Medicaid data was necessary to identify tobacco use in 31.3% of cases. This finding highlights the importance of using multiple data sources to identify tobacco use among Medicaid members.

The study also found that using both HIE and Medicaid data was necessary to identify tobacco use in 14.5% of cases. This finding highlights the importance of using multiple data sources to identify tobacco use among Medicaid members.

The study also found that using both HIE and Medicaid data was necessary to identify tobacco use in 14.5% of cases. This finding highlights the importance of using multiple data sources to identify tobacco use among Medicaid members.

Acknowledgments

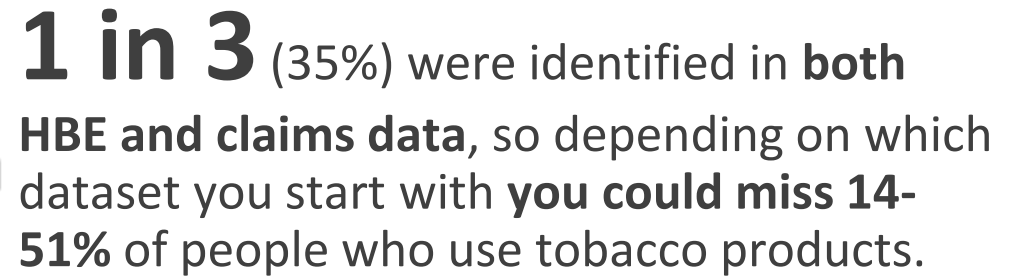
We thank the staff of the King County Department of Public Health for their assistance in data collection and analysis.

DOI: <https://doi.org/10.15585/mmwr.mm7310a1>

MMWR 2024.11.14

astha

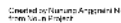
cdc



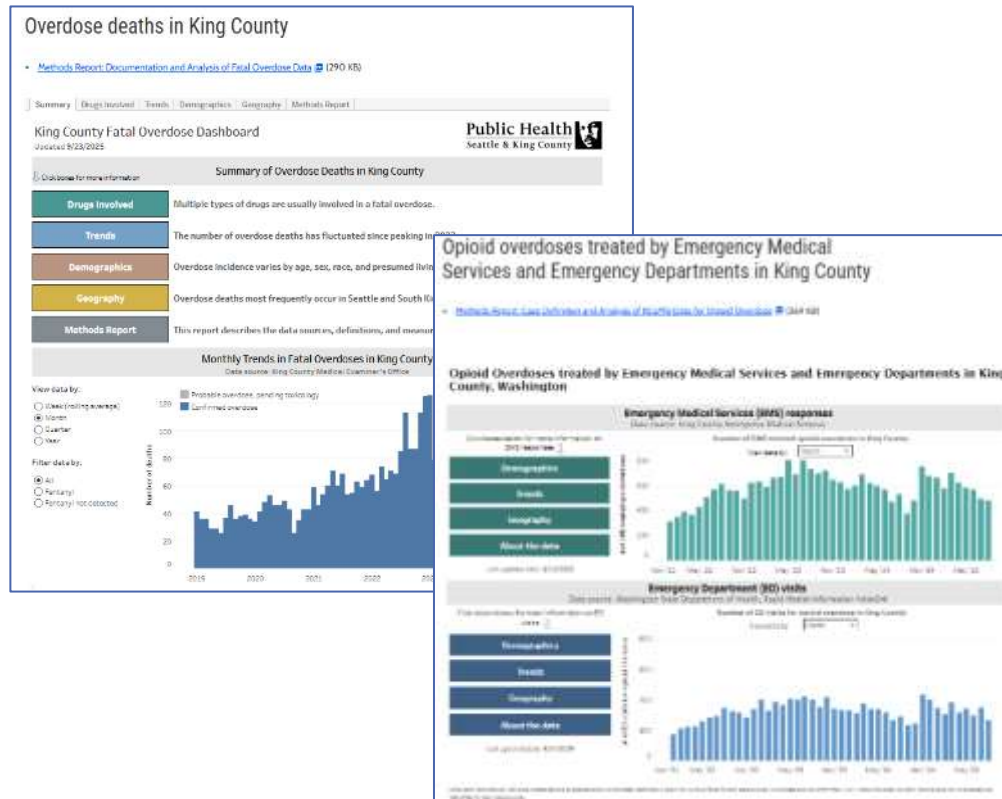
Claims and enrollment data capture distinct tobacco-using populations, aiding tailored surveillance and intervention.



Data modernization includes building partnerships and breaking down information silos.

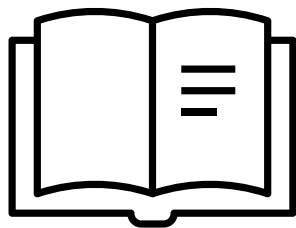


Medications for opioid use disorder (MOUD) receipt among Medicaid beneficiaries in King County, 2017–2024



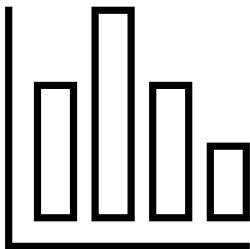
- Medications for opioid use disorder (MOUD) are associated with lower risks of opioid overdose and death
- King County currently has public-facing dashboards showing fatal and non-fatal overdose data, but none currently exist for MOUD trends
- Methods: Used Medicaid claims data to assess MOUD receipt among Medicaid beneficiaries

Medicaid can be used to assess MOUD trends

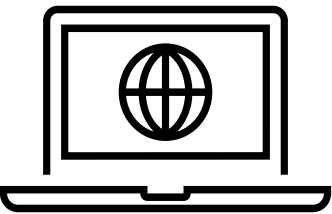


Defined different concepts related to OUD and MOUD in the Medicaid data:

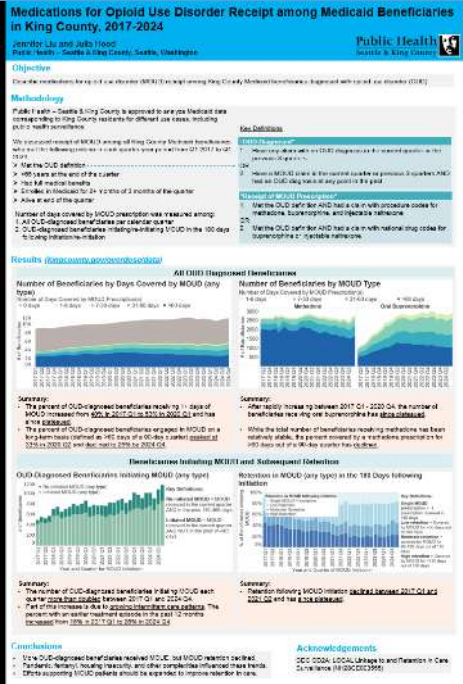
- OUD-diagnosed
- Receipt of MOUD prescription
- MOUD initiation/re-initiation
- MOUD retention



More OUD-diagnosed beneficiaries received MOUD, but MOUD retention declined



Can now regularly monitor MOUD trends through dashboard (will be published to King County's website soon)



Latent class analysis of suicide deaths among Medicaid & Medicare enrollees (King County, 2015–2023)



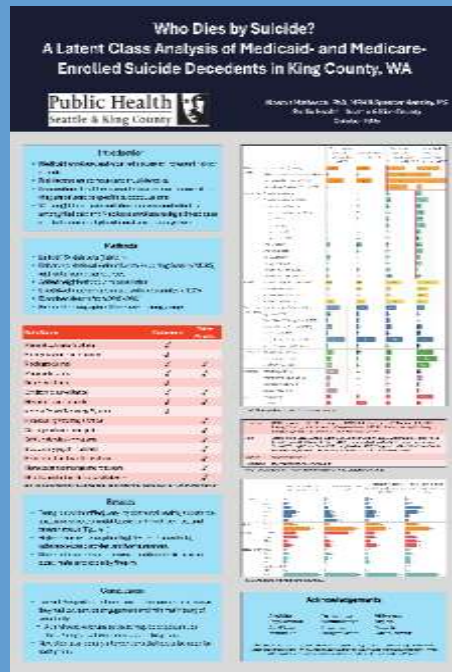
- The death rate for suicide among King County residents was **12 per 100,000**, totaling 298 death
- Medicaid enrollees and older adults are at increased risk for suicide
- Risk factors are complex and multi-factorial



Methods:

- Linked 15+ datasets, including neighborhood characteristics
- Enhanced National Violent Death Reporting System (VDRS) with data from other sources
- Used 64 characteristics in a latent class analysis (LCA)

Four groups Identified

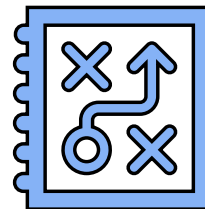


Four groups identified:

- Disruptive life events with substance use
- Low public service use
- Mental health needs & suicidality w/o service use
- Mental health needs & suicidality with service use



Largest group of decedents may be the hardest to reach as they had low service engagement and minimal history of suicidality



Next step is to identify interventions that could be used for each group

Conclusion and next steps

Conclusion

- Medicaid (and Medicare) claims data is a crucial source of information for public health
- Linking data across sectors improves our ability to understand priority populations
- Public health is always looking to partner with healthcare payors, providers to improve health and wellbeing
- View by our posters to learn more about specific examples
- Next steps:
 - Wrapping up research activities and beginning new projects
 - Enhancing and updating surveillance activities
 - Incorporating the Clinical Data Repository in our analyses

Acknowledgements

APDE Healthcare Data Team

- Nithia Chowattukunnel
- Eli Kern
- Susan Hernandez
- Jennifer Liu

Medicaid ETL and Data Modernization Team

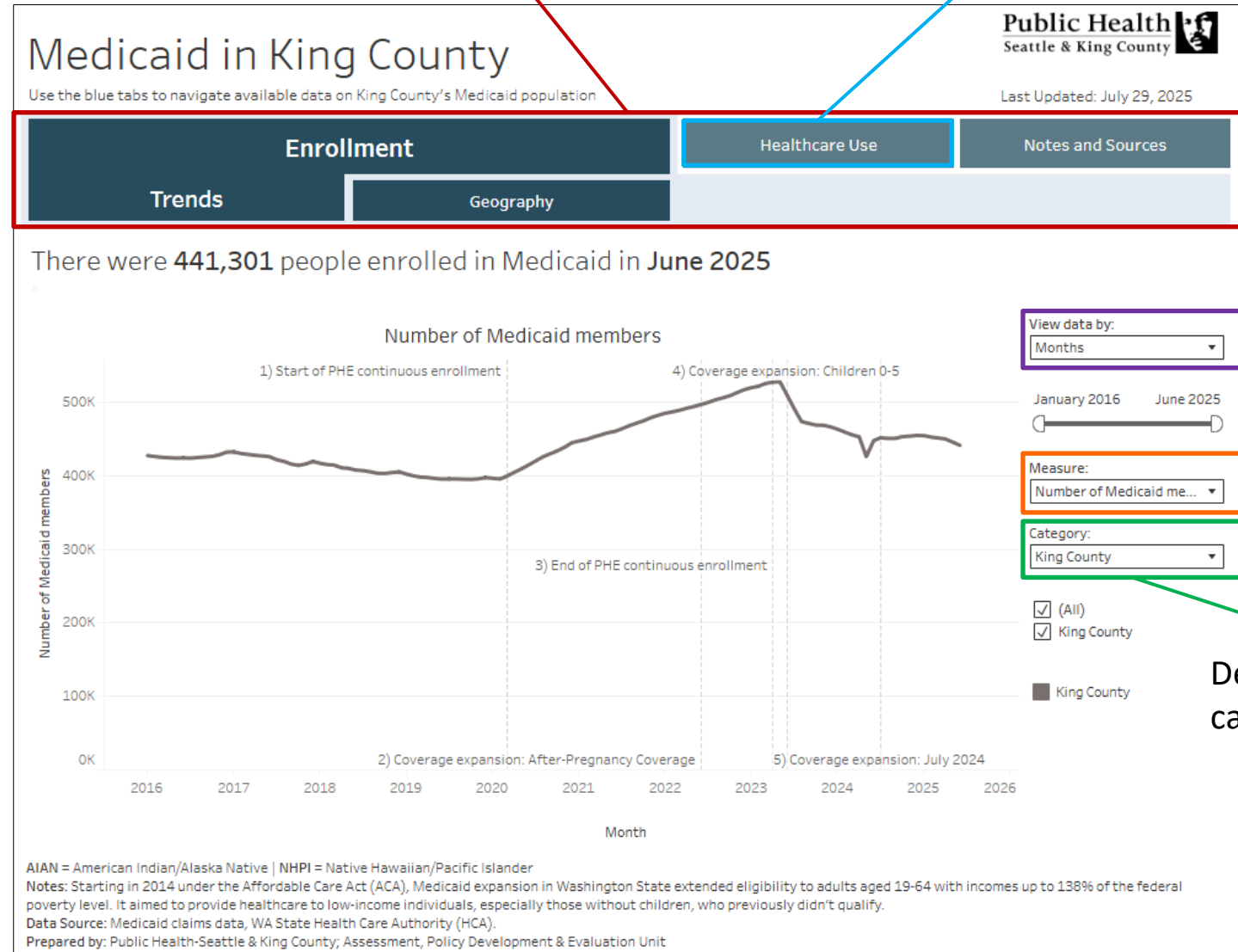
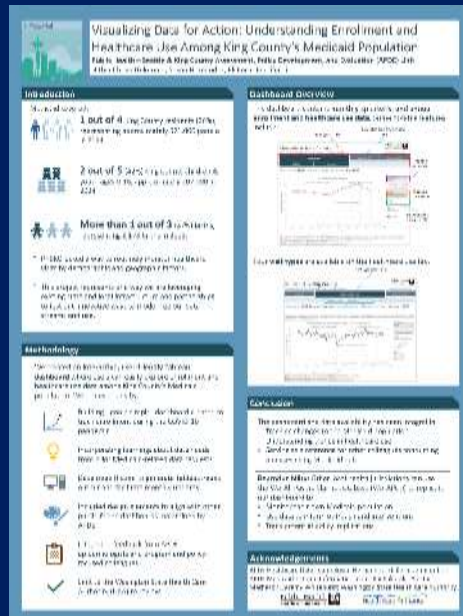
- Kai Fukutaki
- Alastair Matheson
- Jeremy Whitehurst



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Additional slides

Enrollment Dashboard Overview



Time unit parameter

Measure parameter

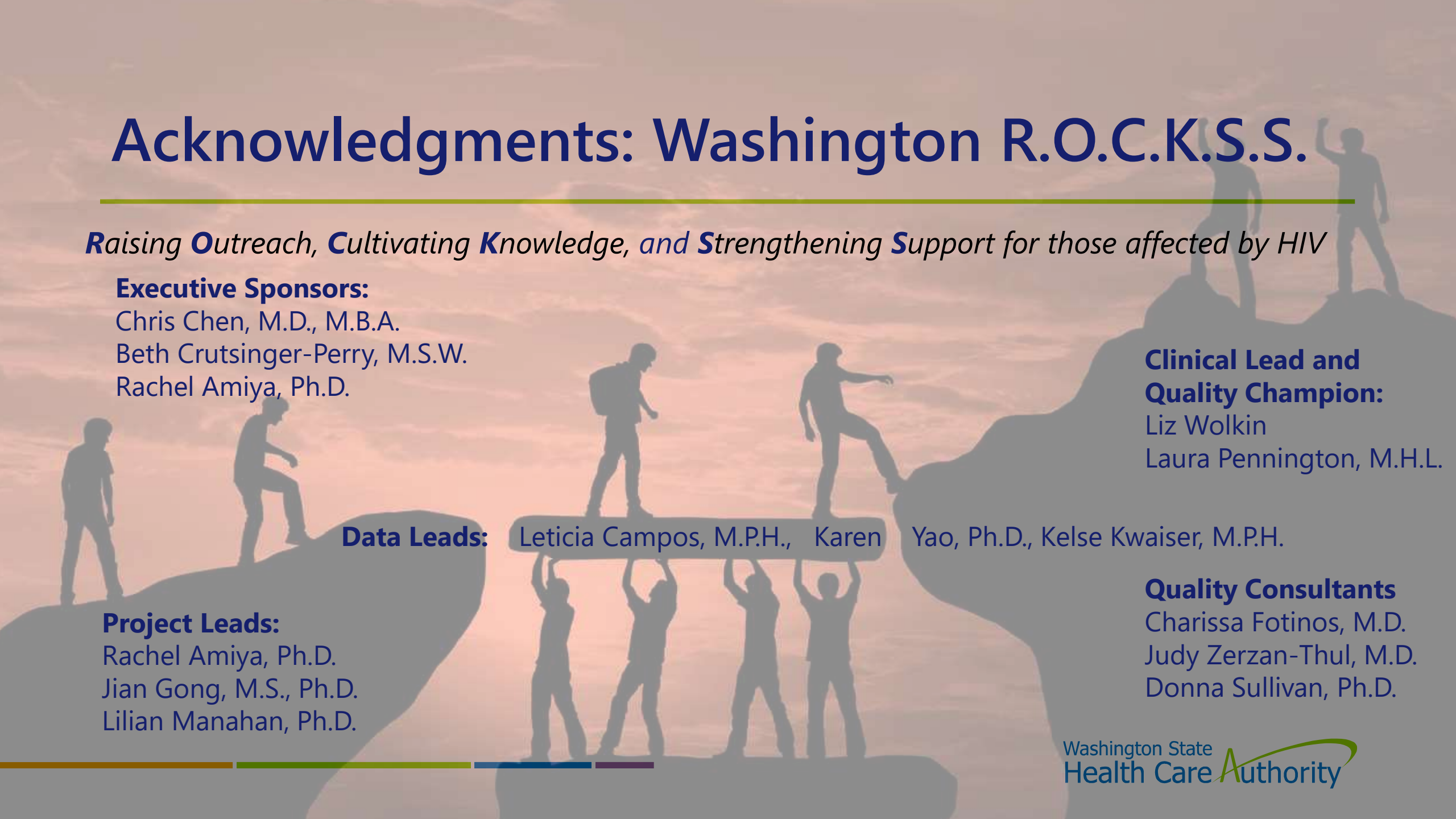
Demographic category filter

Harnessing HIV Viral Load Data to Understand Policy Impact on HIV Care in Washington State

Washington Health Care Authority, Department of
Health and University of Washington Medicine

Presenter: Karen Yao, Ph.D.

Acknowledgments: Washington R.O.C.K.S.S.



*Raising **O**utreach, **C**ultivating **K**nowledge, and **S**trengthening **S**upport for those affected by HIV*

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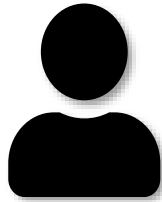
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The Challenge: HIV Treatment is Costly

Medicaid is a major healthcare payer, covering over 5000 clients, ~40% of the HIV population in WA State.



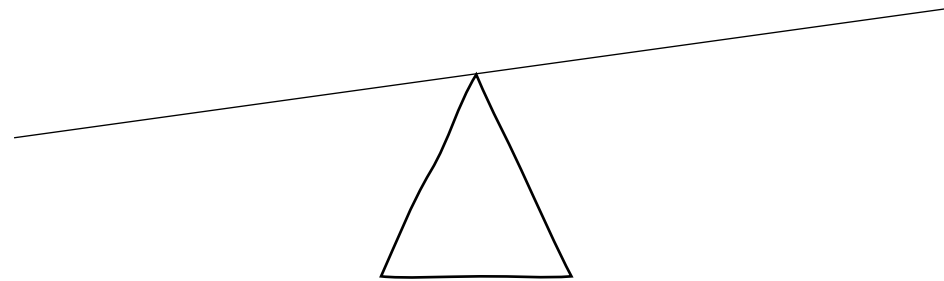
Access delays =
Health impact?



Cost Control?

State Medicaid use Prior Authorization to encourage less expensive drugs and lower treatment cost

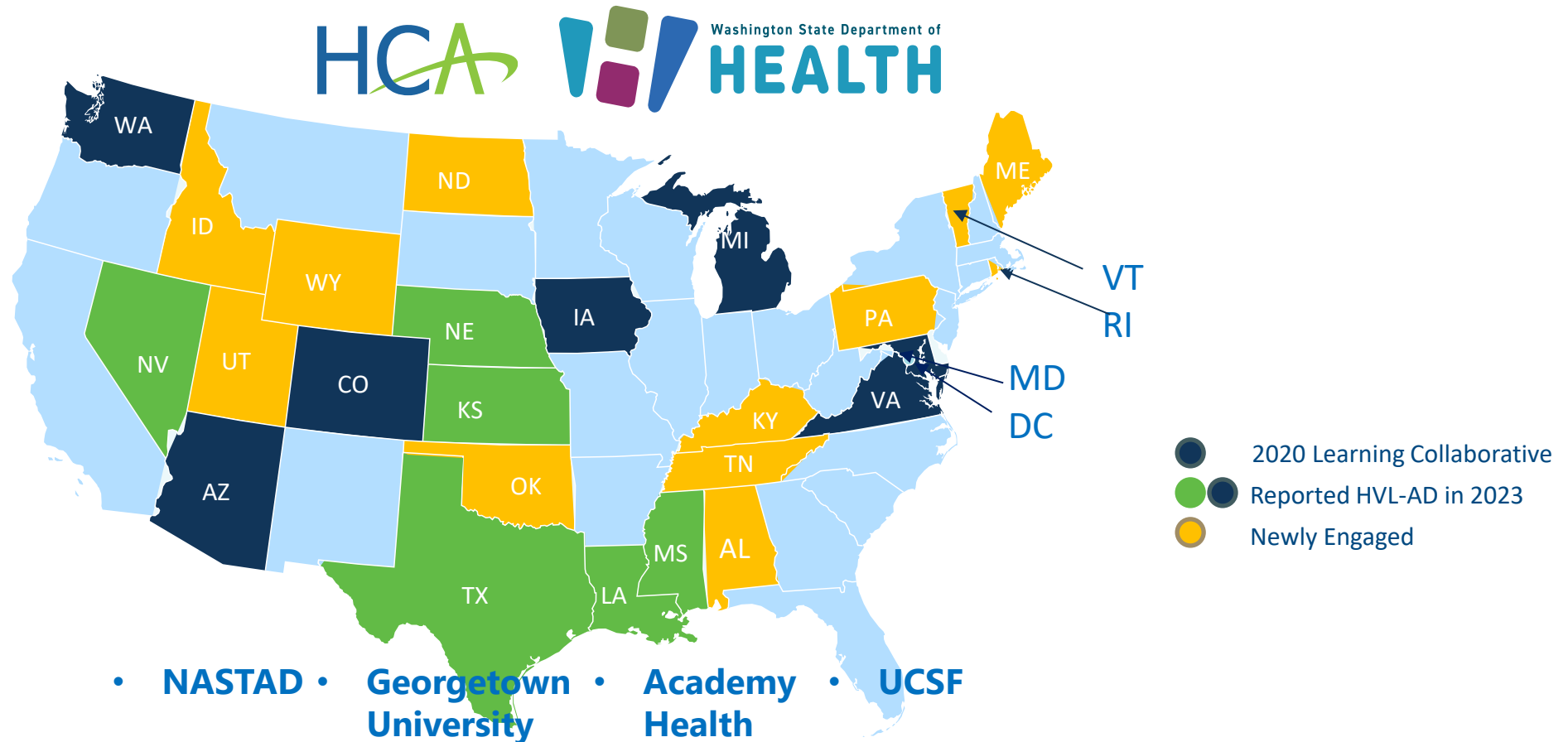
WA Medicaid removed PA for ARVs in 2023, this change was projected to increase in spending between \$84-\$114 million over 5 years (Golden MR. et al, *Sex. Transm Dis.*, 2023)



Prior authorization policy

How can we measure the real-world impact of policy change on health outcomes in this population?

Building Capacity to Improve HIV Suppression Data in Medicaid: a Multi-State Collaborative



HVL-AD (HIV Suppression) CMS Quality Metric

* The percentage of people with diagnosed HIV who have less than 200 copies of HIV per milliliter of blood.

Criteria		Specifics
	Member Age	≥18 years by the last day of the measure year
	Diagnosis	Prior to the start or the first 90 days of the measure year
	Medical Visit	≥1 medical visit in the first 240 days of the measure year

Methodology Overview

▶ Why a DSA was Needed

- ▶ Medicaid and Department of Health are under separate agencies in Washington State.
- ▶ A Data Sharing Agreement (DSA) was required to securely exchange the data and confirm client HIV status, access viral load data.

▶ Data Linkage Process

- ▶ Tool Used: *LINKPlus* (CDC)
- ▶ Probabilistic matching of Medicaid client lists with eHARS (enhanced HIV/AIDS Reporting System).

▶ Viral Suppression rate monitoring period

- ▶ 2020, 2021, 2022, 2023
- ▶ Prior authorization to access HIV ARV removal began on **January 1 ,2023 (SB5551)**

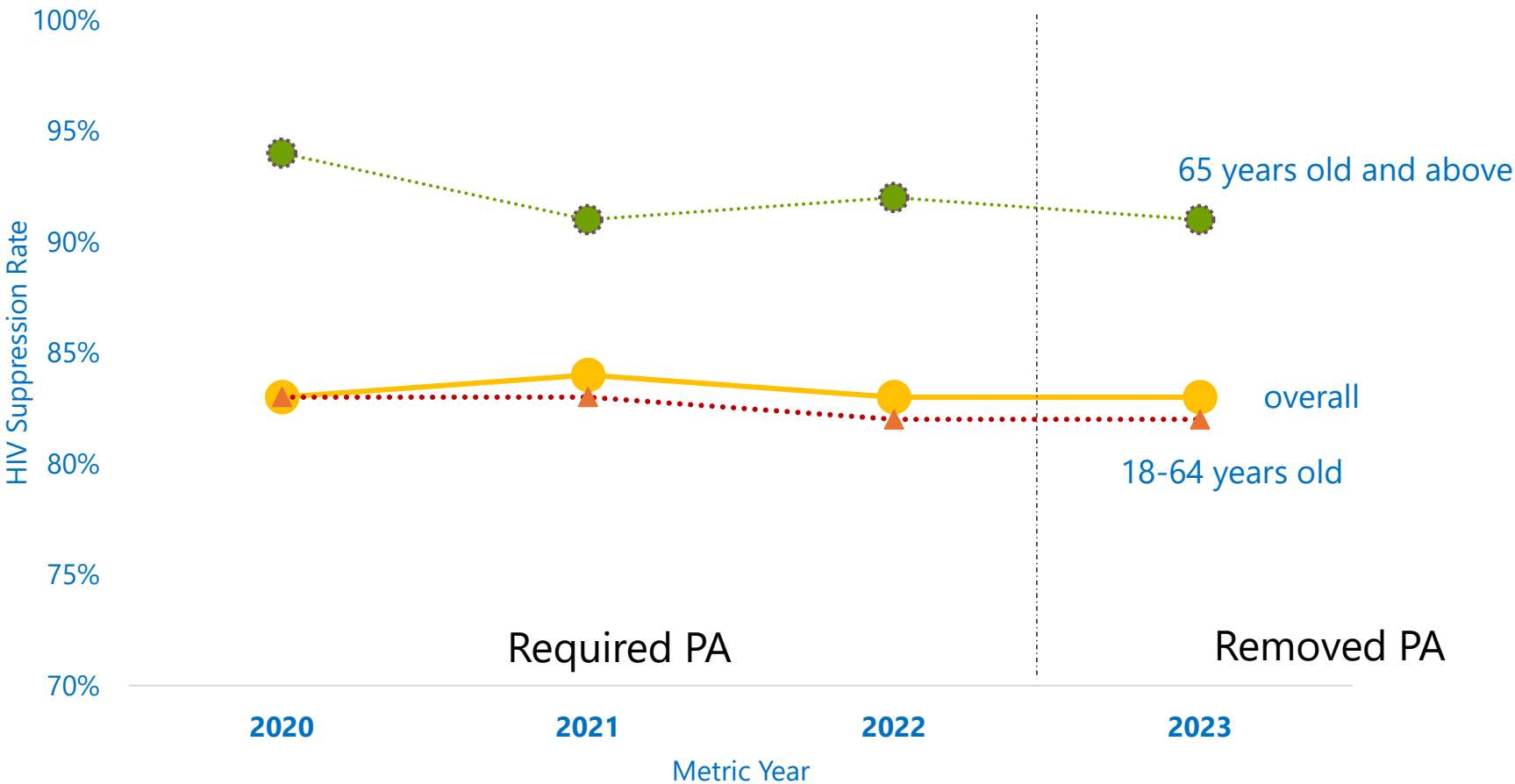
Impact of Prior Authorization Policy Change

- ▶ Will there be a shift from Multi-Tablet to Single Tablet Regimens?
- ▶ Did suppression dip or improve?
- ▶ Were disparities exacerbated or mitigated?

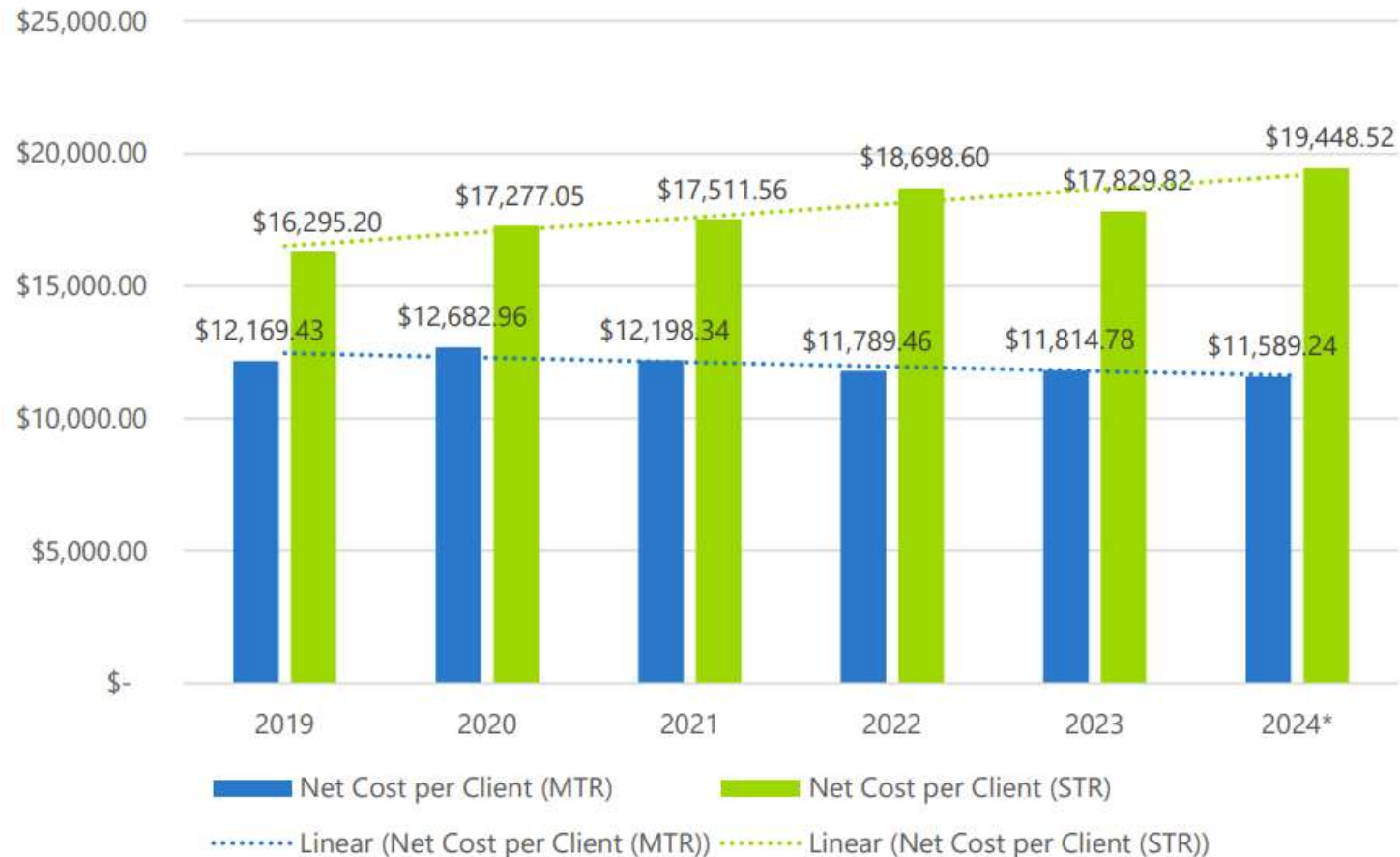
Longitudinal Characteristics of HIV Medicaid Cohorts

Year	N	Avg Age	Gender Ratio (M:F)	% with viral load measurement	% Rx filled(* _{RW} not included)
2020	3947	47	3.6	94 %	75 %
2021	4107	49	3.5	92 %	76 %
2022	4306	49	3.7	92 %	76 %
2023	4369	49	3.4	92 %	78 %

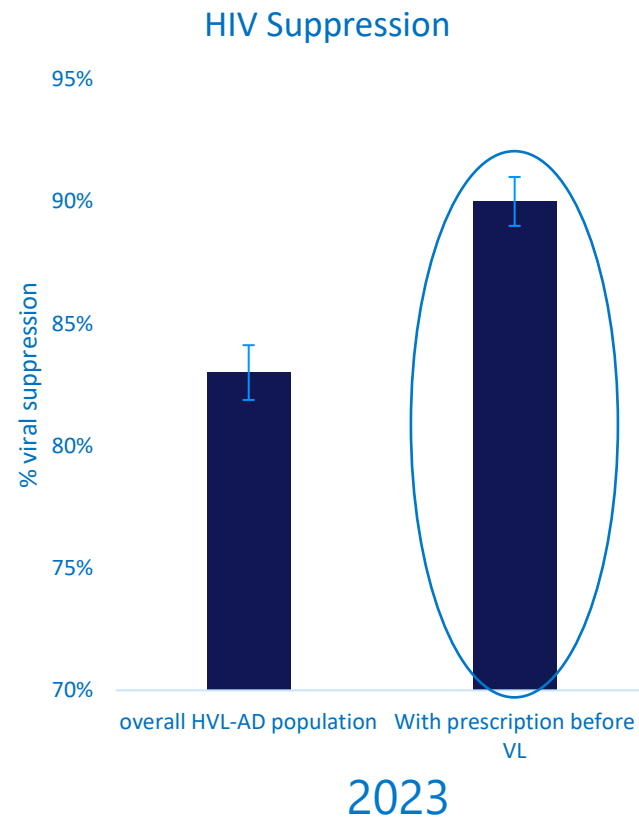
Viral Suppression in Washington's Medicaid Population (2020 -2023)



Net cost per client per year by HIV treatment regimen, 2019–2024



Did Expanded Access to Single-Tablet Regimens Led to Better Viral Suppression?



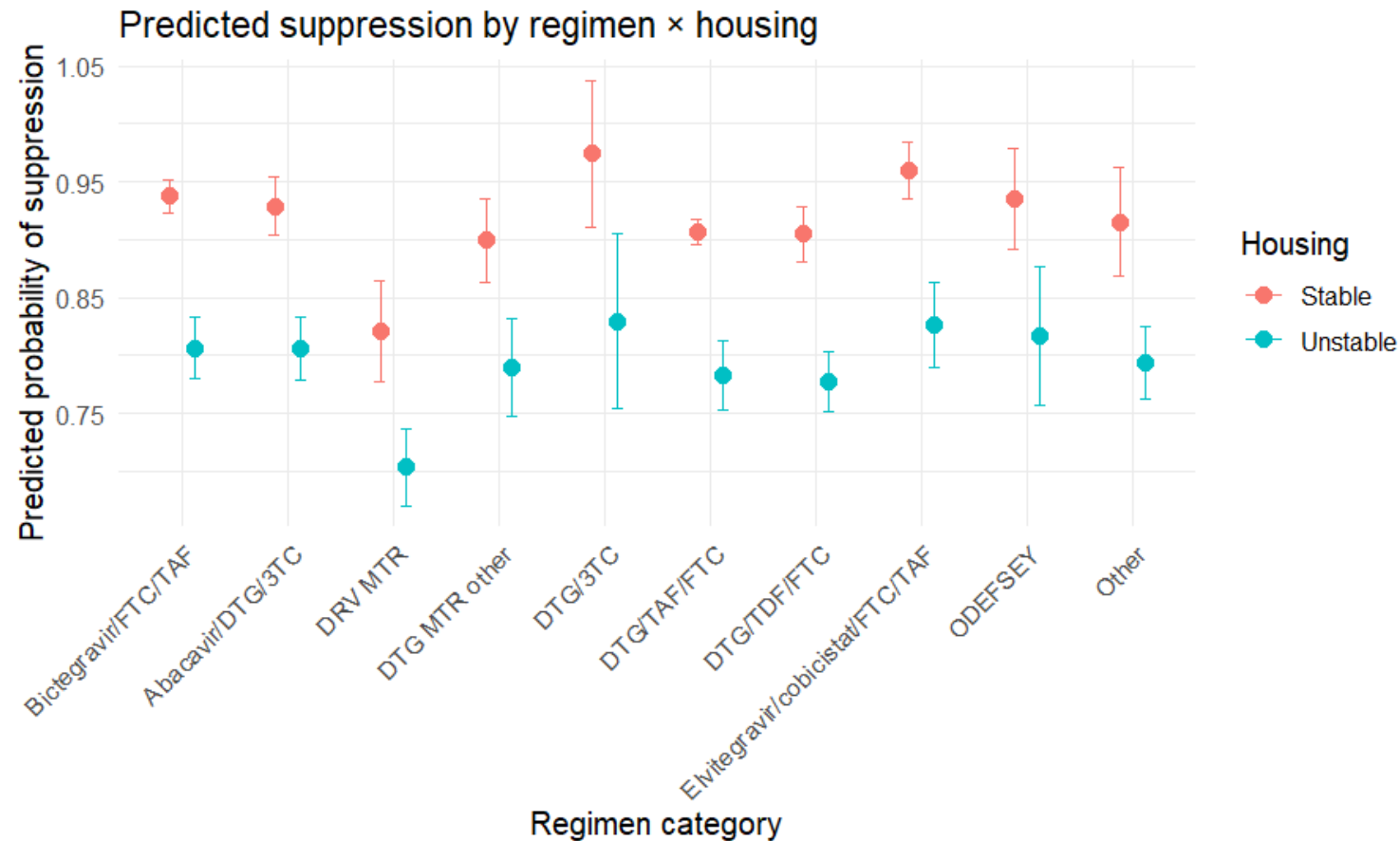
Multi-variable Association of ART Regimen with Viral Suppression

	Single Tablet Regimen	First Line Multi-Tablet Regimen	Other Multi-Tablet Regimen
N	1536	737	326
Suppression	92.2%	88.7%	86.5%
Relative Risk	Reference	0.98	0.94

NS between categories

** Lower levels of viral suppression associated with female sex at birth, younger age, unstably housed, and darunavir containing regimens*

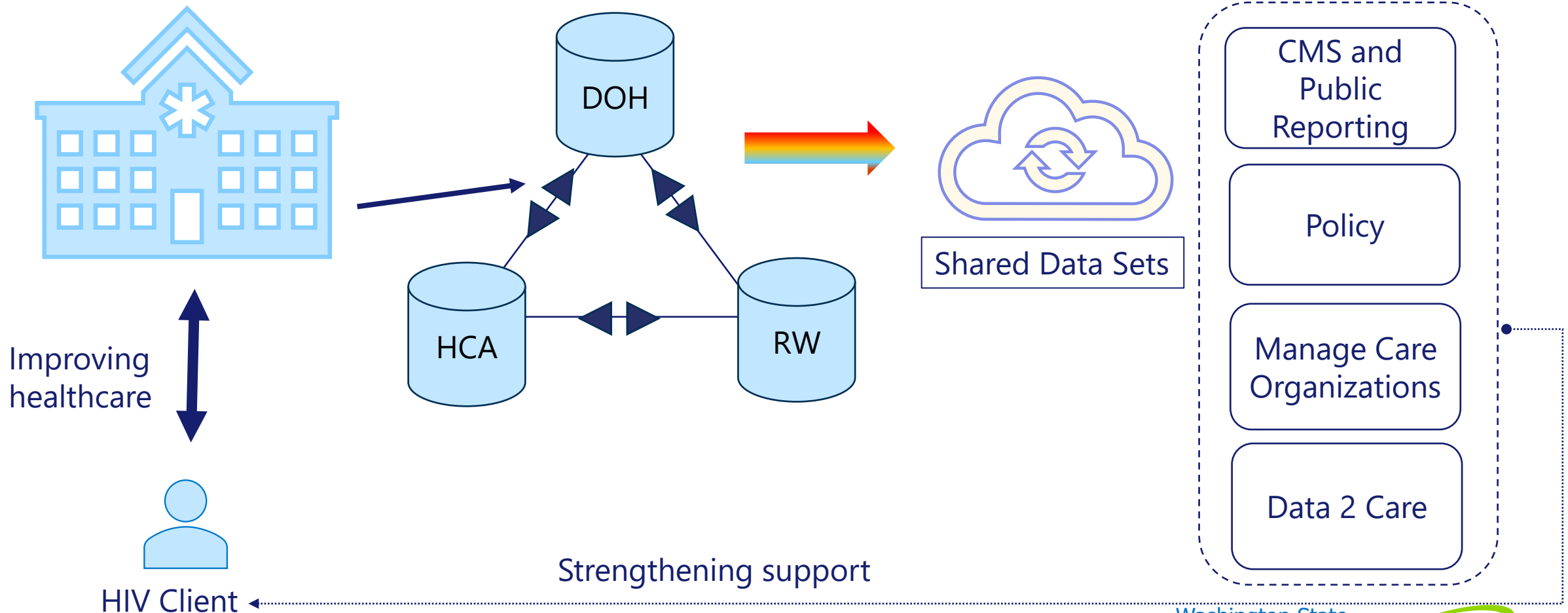
Housing Instability Tied to Suppression Gap



Summary

- ▶ The HVL-AD quality metric, in addition to serving as a population health indicator, also enables policy evaluation.
- ▶ Policy implications: While lifting PA increased Medicaid net cost spending on ART of ~**\$7 millions from 2022 to 2023**, was NOT associated with significant change in viral suppression at the population level.
- ▶ Could the money be better used to address underlying issues such as housing instability?

Leveraging Data Sharing Infrastructure for Continuous Improvement in HIV Care



With Gratitude to Our Academic Collaborators



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NASTAD



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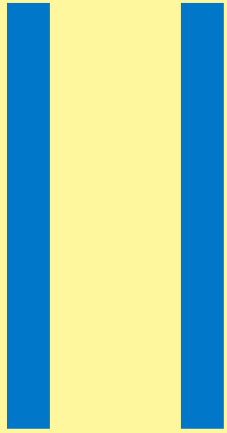


Matthew Golden,
M.D., M.P.H.
UW Medicine and
Seattle King County
Public Health
Department

Thank you!

Public Agency Panel

▶ Q&A



Break

HCA Update, Research Priorities, Q&A

Charissa Fotinos & Judy Zerzan-Thul, Health Care Authority

Wrap Up

Christopher Chen & Melanie Golob, Health Care Authority



Thank you

Questions? Want to get involved in the ALC?

Contact melanie.golob@hca.wa.gov