

WASHINGTON STATE NALOXONE DISTRIBUTION PLAN
State Fiscal Year 2021

Introduction

This plan for the statewide distribution of naloxone has been developed at the request of the Executive Leadership Group of the *Washington State Opioid and Overdose Response Plan*.¹ The following individuals contributed to the development of this plan:

- Kathy Lofy, Washington Department of Health (DOH)
- Charissa Fotinos, Washington Health Care Authority (HCA)
- Emalie Hurliaux, DOH
- Sean Hemmerle, DOH
- Susan Kingston, University of Washington, Alcohol and Drug Abuse Institute (ADAI)
- Caleb Banta-Green, ADAI
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- Steve Gustaveson, King County Department of Community and Human Services (DCHS)
- Erin James, (DCHS)
- Sue Green, Washington Health Care Authority, Division of Behavioral Health and Recovery (DBHR)

The purpose of this plan is to outline state priorities and strategies to:

- Continue to distribute naloxone across the state beginning July 1, 2020 through June 30, 2021 with the use of federal grants targeted for naloxone.
- Build infrastructure capacity at the state level to support sustainability of naloxone access.

Priority Populations and Settings

This plan focuses specifically on distribution of naloxone to populations and settings prioritized in the *Washington State Opioid and Overdose Response Plan*:

- Primary population: People who use opioids and other drugs.
Secondary populations: Friends and family members who may witness/respond in an overdose.
Professionals who may witness/respond in an overdose.

The *Washington State Opioid and Overdose Response Plan* targets distribution of publicly funded naloxone through the following settings and entities:

- Syringe services programs (SSPs)
- Local health jurisdictions
- Emergency medical personnel
- Organizations providing substance use disorder treatment
- Federally recognized tribes
- Jails and other entities that work with those involved in the criminal judicial system
- Housing and social service providers, outreach workers, and peer organizations serving people experiencing homelessness
- EMS “leave behind” programs
- Law enforcement officers

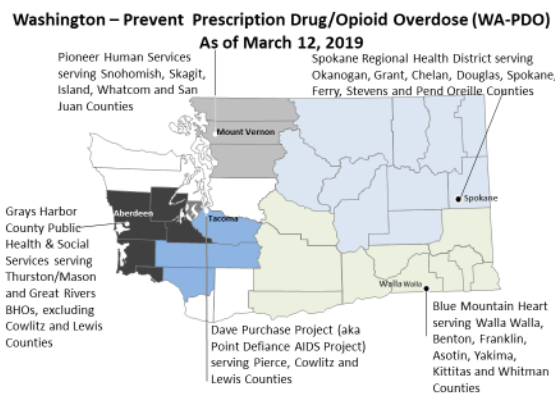
Note: Through the statewide standing order other entities with the potential to distribute naloxone to the primary populations includes other local governments.

¹ The Executive Leadership Group also serves as the Advisory Group for the Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) grant. Recommendations contained in this plan may affect the scope of activities of the WA-PDO grant.

Allocation of Resources

Certain funds for naloxone are already committed to particular geographic areas and/or populations, such as the Washington State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) grant that prioritizes naloxone distribution through SSPs and law enforcement in five high-need areas of the state (Figure 1). Funds that are not already committed to certain uses will be allocated across counties or regions based on a formula representing estimated level of current need while ensuring a basic floor of geographic coverage across the state.

Figure 1.



In order to determine the range of naloxone need across counties, the Department of Social and Human Services’ Research and Data Analysis (RDA) developed an allocation model based on the incidence of opioid use disorder treatment among Medicaid recipients in each county (more detail is available in the Appendix A).

The results of this model to estimate level of opioid risk are shown in Table 1 and appear to align with the proportion formula currently used by DBHR to allocate Substance Abuse Block Grant (SABG) monies across the ten Integrated Managed Care (IMC) Organizations shown in Appendix B.

Distribution Strategy for July 1, 2020 through June 30, 2021

This plan proposes a dual-strategy approach to the statewide distribution of naloxone using the three primary funds sources available for distribution between July 1, 2020 and June 30, 2021:

Table 1. Washington State Opioid Risk by County

County	Fiscal year 2019	
	Total Estimated # of People	Percent
King	20,687	21.7%
Pierce	12,190	12.8%
Snohomish	11,373	11.9%
Spokane	9,578	10.1%
Clark	4,718	5.0%
Thurston	3,524	3.7%
Whatcom	3,442	3.6%
Kitsap	3,258	3.4%
Yakima	3,074	3.2%
Cowlitz	2,469	2.6%
Benton	2,405	2.5%
Grays Harbor	2,257	2.4%
Skagit	2,238	2.4%
Clallam	1,816	1.9%
Lewis	1,318	1.4%
Mason	1,183	1.2%
Grant	1,019	1.1%
Chelan	1,004	1.1%
Walla Walla	813	0.9%
Stevens	811	0.9%
Franklin	779	0.8%
Island	668	0.7%
Okanogan	648	0.7%
Asotin	607	0.6%
Douglas	544	0.6%
Jefferson	421	0.4%
Kittitas	415	0.4%
Pacific	381	0.4%
Pend Oreille	250	0.3%
Klickitat	230	0.2%
Whitman	230	0.2%
Ferry	160	0.2%
Skamania	148	0.2%
San Juan	138	0.1%
Lincoln	101	0.1%
Adams	96	0.1%
Columbia	72	0.1%
Wahkiakum	58	0.1%
Garfield	28	<0.1%
Unknown	56	0.1%
State Total	95,207	100%

• WA State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO)	\$861,562
• State Opioid Response (SOR) (DOH FTE)	\$142,863
• Substance Abuse Block Grant (SABG)	<u>\$864,000</u>
Total	\$1,868,425

Strategy 1: Maintain distribution to SSPs and law enforcement through the WA-PDO grant

The first strategy is to continue the distribution of naloxone through the existing contract arrangement between DBHR and the University of Washington’s Alcohol and Drug Abuse Institute (ADAI) under the WA-PDO grant to distribute naloxone through SSPs in five high-need areas (HNA) in the state (Figure 1). WA-PDO coordinators in the HNAs also distribute naloxone throughout their regions to law enforcement partners who need naloxone as seen in Table 2.

Table 2. Naloxone Distribution Coverage via WA-PDO, July 2020 to June 2021

Priority Distribution Channel	# receiving naloxone or technical assistance (TA)	# counties	# naloxone kits distributed
Syringe services programs (SSP)	23	23	12,000
Law enforcement units	40	21	1,032

ADAI will continue to track the purchase and distribution of naloxone through monthly reports to DBHR. Distribution will be paired with data collection. Organizations will be responsible for collecting anonymous data about who receives naloxone kits and the number of kits used in overdose reversals.

Strategy 2: Distribute naloxone through other high-priority channels through the Department of Health

The second strategy is to use SABG and SOR funding to cover gaps in regions and/or priority populations not reached by the WA-PDO (e.g., drug treatment agencies, jails, and local health jurisdictions in counties without any SSPs, and SSPs not covered by WA-PDO). In order to do so, resources from the SABG and SOR grants have been identified to address this infrastructure gap.

The Washington State Department of Health has a staff person to manage the Overdose Education and Naloxone Distribution program which established an agreement for the purchase of naloxone and began distribution and training in April 2019. DOH continues to work in conjunction with ADAI and WA-PDO coordinators to identify local partners to distribute naloxone and provide education/training/technical assistance to geographic areas, population and settings not covered by WA-PDO partners, as seen in Table 3 below.

Table 3. Naloxone Distribution Coverage via DOH, July 2020 – June 2021

Priority Distribution Channel	# receiving naloxone or technical assistance (TA)	# counties	# naloxone kits distributed
Drug treatment agencies	50	20	5,000
Federally recognized tribes	5	5	1,000
Local health jurisdictions, healthcare providers and Accountable Communities of Health	20	10	2,000
Housing/social service providers and outreach, peer organizations	20	15	2,500
Jails	15	15	2,000

DOH will continue to track the purchase and distribution of naloxone through monthly reports to DBHR. Distribution will be paired with data collection. Organizations will be responsible for collecting monthly data about the number of naloxone kits distributed, the number of people they trained on overdose response and naloxone administration, and the number of kits provided by each agency that were reported to be used to successfully reverse an opioid overdose.

Strategy after June 30, 2021

DOH, ADAI and DBHR will establish a plan and timeline for the transfer of naloxone purchasing in all areas of Washington State from ADAI to DOH by the end of the WA-PDO grant (August 2021). Additional resources will also need to be identified to meet the demand for naloxone and ensure no decrease in naloxone distribution after WA-PDO funding ends, as well as to meet the demand for overdose education and naloxone distribution staffing both at DOH and at SSPs currently supported by WA-PDO.

Maximizing naloxone distribution through the Medicaid benefit is an additional strategy. Medicaid currently covers naloxone prescriptions, however barriers exist for some patients to fill their naloxone prescriptions at the pharmacy, following medical visits. Patients often leave medical care with a written naloxone prescription, rather than naloxone “in hand.” This may be due to burdensome steps required to fill the prescription (time, place, and convenience). Technical assistance may be helpful to address disparities and increase access to naloxone for underserved patient populations. Moreover, prescribers who provide patients with an opioid prescription, including medication for opioid use disorder (MOUD), should consider whether a naloxone prescription is also appropriate, in conjunction with Federal Drug Administration (FDA) recommendations (<https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-health-care-professionals-discuss-naloxone-all-patients-when-prescribing-opioid-pain>).

Agencies should understand cost differences of intramuscular (IM) and nasal spray formulations where they exist. Partners may consider leveraging limited resources to distribute additional doses of naloxone via lower cost formulations, as appropriate for the primary population. Training for secondary populations may increase their comfort with IM naloxone administration, however, equitable access to nasal spray naloxone should continue to be available.

WA-PDO will produce a comprehensive report by September 2021 on the results of its 5-year naloxone distribution program, including cost analysis and overdose reversal outcomes. Results and recommendations will be used to inform distribution priorities in the WA State Opioid Response Plan and resource allocation.

The Executive Leadership Group of the *Washington State Opioid and Overdose Response Plan* will monitor the implementation of the Naloxone Distribution Plan and develop a revised strategy for distribution starting July 1, 2021 if needed. This possible revision would be completed following the end of the 2021 legislative session. This would allow for the incorporation of any relevant legislation enacted during the 2021 session and/or revisions to the current *Washington State Opioid and Overdose Response Plan*.

The Department of Health will take over the administration of the Naloxone Distribution Plan beginning with the fiscal year 2022 plan (July 1, 2021), and DOH will have full responsibility for naloxone purchasing, distribution, training and technical assistance, as outlined in the sustainability plan.

Implementation Issues

Several issues will need to be addressed to ensure successful implementation of this plan:

- This plan may require the following modifications to approved WA-PDO grant activities:
 - Eventual transfer of naloxone procurement from ADAI to DOH. Currently DBHR is anticipating ADAI to continue with the grant to its end date on August 31, 2021. The main reason for this is data consistency – it is important to have data that is consistent with previous years.
 - Possible sub-contracting responsibilities with SSPs from ADAI to DOH after August 2021.
 - DOH, ADAI and DBHR will establish a plan and timeline for the transfer of naloxone purchasing in all areas of Washington State from ADAI to DOH by the end of the WA-PDO grant (August 2021).
- Additional resources may also need to be identified to meet the demand for naloxone and ensure no decrease in naloxone distribution after WA-PDO funding ends, as well as to meet the demand for overdose education and naloxone distribution staffing both at DOH and at SSPs currently supported by WA-PDO. In 2020, DOH had planned to develop a Decision Package to compensate for the end of WA-PDO to create a financial transition plan that includes ongoing SABG funding allocated to DBHR (and provided to DOH via Interagency Agreement). Due to COVID-19 and the inevitable lack of state resources to support a Decision Package for the 2021 Legislative session, DOH is planning to submit a Decision Package at a later date.
- Data collection remains an essential tool for obtaining future funding as well as demonstrating the effectiveness of the distribution models used by ADAI and DOH. Before the transition of all naloxone distribution to DOH in August 2021, DOH, ADAI and DBHR will examine past and current methods of data collection by their respective programs. DOH and DBHR will develop and continue data collection that meets the needs of the funding source and resources of participating agencies. This data collection must be sensitive to the time and resource constraints of the diverse agencies distributing naloxone. We will also examine any new deliverables that might come along with funding sources. DOH will work within the parameters set forth by both the funding sources and their partnership with DBHR.

Appendix A

Naloxone Resource Distribution, Washington State FY 2020 Research and Data Analysis, DSHS

Naloxone Resource Allocation Table

Washington State continues to allocate more resources to the distribution of naloxone to combat the opioid crisis. To distribute these resources across the State according to need, we propose an allocation model based on the incidence of opioid use treatment need among Medicaid recipients in each county presented as the estimated number of people who would benefit from having a naloxone kit based on their own opioid use. Resource allocations will be based on the following:

Measure: Opioid Use Disorder Treatment Need Indicator

- The *opioid treatment need indicator* for the Washington Medicaid population is based on claims, encounters, or assessment diagnoses in Provider One, CARE and behavioral health data sources (Table 2).
- The indicator is positive for any occurrence (over a specified period of time) of a health service event associated with opioid use disorder (OUD) diagnosis, complications attributed to opioid use, or accidental or intentional poisoning by opioids. Examples of health service events included are fatal overdose events, non-fatal overdose events resulting in hospitalizations, or diagnosis of opioid abuse or dependence.

Method

- Identify all Medicaid eligible individuals in FY 2019.
- Flag Medicaid clients with any OUD treatment need indicator in FY 2019 or the two preceding years (FY 2017 or 2018). Any individual with an indicator for OUD treatment need during the time frame described is counted as having OUD treatment need in FY 2019.
- Individuals with OUD treatment need are assigned to their county of residence as of June 30, 2019 (according to the DSHS Integrated Client Database).
- Individuals are only counted once, no matter how many indicators for OUD treatment need they had in the period and are only assigned to one county.

Limitations

- Based on the Medicaid population only.
- Individuals that do not access medical services are not included in this measure.
- This measure does not include receipt of opioid prescriptions or opioid related crimes.

Washington State Opioid Risk and Need by County	FISCAL YEAR 2019	
	TOTAL Estimated # of People	PERCENT
King	20,687	21.7%
Pierce	12,190	12.8%
Snohomish	11,373	11.9%
Spokane	9,578	10.1%
Clark	4,718	5.0%
Thurston	3,524	3.7%
Whatcom	3,442	3.6%
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Okanogan	648	0.7%
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Douglas	544	0.6%
Jefferson	421	0.4%
Kittitas	415	0.4%
Pacific	381	0.4%
Pend Oreille	250	0.3%
Klickitat	230	0.2%
Whitman	230	0.2%
Ferry	160	0.2%
Skamania	148	0.2%
San Juan	138	0.1%
Lincoln	101	0.1%
Adams	96	0.1%
Columbia	72	0.1%
Wahkiakum	58	0.1%
Garfield	28	0.0%
Unknown	56	0.1%
State Total	95,207	100%

ICD-10 Codes Used to Create the Opioid Use Disorder Treatment Need Indicator

ICD-10 Code	Description
F1110	Opioid abuse, uncomplicated
F11120	Opioid abuse with intoxication, uncomplicated
F11121	Opioid abuse with intoxication delirium
F11122	Opioid abuse with intoxication with perceptual disturbance
F11129	Opioid abuse with intoxication, unspecified
F1114	Opioid abuse with opioid-induced mood disorder
F11150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11181	Opioid abuse with opioid-induced sexual dysfunction
F11182	Opioid abuse with opioid-induced sleep disorder
F11188	Opioid abuse with other opioid-induced disorder
F1119	Opioid abuse with unspecified opioid-induced disorder
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11921	Opioid use, unspecified with intoxication delirium
F11922	Opioid use, unspecified with intoxication with perceptual disturbance
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1194	Opioid use, unspecified with opioid-induced mood disorder
F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11982	Opioid use, unspecified with opioid-induced sleep disorder
F11988	Opioid use, unspecified with other opioid-induced disorder
F1199	Opioid use, unspecified with unspecified opioid-induced disorder
T400X1A	Poisoning by opium, accidental (unintentional), initial encounter
T400X1D	Poisoning by opium, accidental (unintentional), subsequent encounter
T400X1S	Poisoning by opium, accidental (unintentional), sequela
T400X2A	Poisoning by opium, intentional self-harm, initial encounter
T400X2D	Poisoning by opium, intentional self-harm, subsequent encounter
T400X2S	Poisoning by opium, intentional self-harm, sequela

T401X1A	Poisoning by heroin, accidental (unintentional), initial encounter
T401X1D	Poisoning by heroin, accidental (unintentional), subsequent encounter
T401X1S	Poisoning by heroin, accidental (unintentional), sequela
T401X2A	Poisoning by heroin, intentional self-harm, initial encounter
T401X2D	Poisoning by heroin, intentional self-harm, subsequent encounter
T401X2S	Poisoning by heroin, intentional self-harm, sequela
T402X1A	Poisoning by other opioids, accidental (unintentional), initial encounter
T402X1D	Poisoning by other opioids, accidental (unintentional), subsequent encounter
T402X1S	Poisoning by other opioids, accidental (unintentional), sequela
T402X2A	Poisoning by other opioids, intentional self-harm, initial encounter
T402X2D	Poisoning by other opioids, intentional self-harm, subsequent encounter
T402X2S	Poisoning by other opioids, intentional self-harm, sequela
T403X1A	Poisoning by methadone, accidental (unintentional), initial encounter
T403X1D	Poisoning by methadone, accidental (unintentional), subsequent encounter
T403X1S	Poisoning by methadone, accidental (unintentional), sequela
T403X2A	Poisoning by methadone, intentional self-harm, initial encounter
T403X2D	Poisoning by methadone, intentional self-harm, subsequent encounter
T403X2S	Poisoning by methadone, intentional self-harm, sequela
T404X1A	Poisoning by other synthetic narcotics, accidental (unintentional), initial encounter
T404X1D	Poisoning by other synthetic narcotics, accidental (unintentional), subsequent encounter
T404X1S	Poisoning by other synthetic narcotics, accidental (unintentional), sequela
T404X2A	Poisoning by other synthetic narcotics, intentional self-harm, initial encounter
T404X2D	Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter
T404X2S	Poisoning by other synthetic narcotics, intentional self-harm, sequela
T40601A	Poisoning by unspecified narcotics, accidental (unintentional), initial encounter
T40601D	Poisoning by unspecified narcotics, accidental (unintentional), subsequent encounter
T40601S	Poisoning by unspecified narcotics, accidental (unintentional), sequela
T40602A	Poisoning by unspecified narcotics, intentional self-harm, initial encounter
T40602D	Poisoning by unspecified narcotics, intentional self-harm, subsequent encounter
T40602S	Poisoning by unspecified narcotics, intentional self-harm, sequela
T40691A	Poisoning by other narcotics, accidental (unintentional), initial encounter
T40691D	Poisoning by other narcotics, accidental (unintentional), subsequent encounter
T40691S	Poisoning by other narcotics, accidental (unintentional), sequela
T40692A	Poisoning by other narcotics, intentional self-harm, initial encounter
T40692D	Poisoning by other narcotics, intentional self-harm, subsequent encounter
T40692S	Poisoning by other narcotics, intentional self-harm, sequela
T411X2A	Poisoning by intravenous anesthetics, intentional self-harm, initial encounter
T411X2D	Poisoning by intravenous anesthetics, intentional self-harm, subsequent encounter
T411X2S	Poisoning by intravenous anesthetics, intentional self-harm, sequela
T507X1A	Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), initial encounter
T507X1D	Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), subsequent encounter
T507X1S	Poisoning by analeptics and opioid receptor antagonists, accidental (unintentional), sequela
T507X2A	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, initial encounter
T507X2D	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, subsequent encounter
T507X2S	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, sequela

Appendix B

Chart 1: Comparison of RDA Washington State Opioid Risk and Need by County Tables to Behavioral Health Organizations/Integrated Managed Care (IMCs) Organizations.

Level of RDA's Opioid Risk by County (sort into IMC areas)										
IMC	County	Fiscal Year 2019		IMC Percent		IMC	County	Fiscal year 2019		IMC Percent
		#	%					#	%	
Greater Columbia	Benton	2,405	2.5%			North Sound	Snohomish	11,373	11.9%	
Greater Columbia	Yakima	3,074	3.2%			North Sound	Whatcom	3,442	3.6%	
Greater Columbia	Franklin	779	0.8%			North Sound	Skagit	2,238	2.4%	
Greater Columbia	Walla Walla	813	0.9%			North Sound	Island	668	0.7%	
Greater Columbia	Asotin	607	0.6%			North Sound	San Juan	138	0.1%	
Greater Columbia	Kittitas	415	0.4%							18.8%
Greater Columbia	Whitman	230	0.2%							
Greater Columbia	Columbia	72	0.1%			Salish	Kitsap	3,258	3.4%	
Greater Columbia	Garfield	28	0.0%			Salish	Clallam	1,816	1.9%	
				8.8%		Salish	Jefferson	421	0.4%	
										5.8%
Great Rivers	Cowlitz	2,469	2.6%							
Great Rivers	Grays Harbor	2,257	2.4%			Spokane	Spokane	9,578	10.1%	
Great Rivers	Lewis	1,318	1.4%			Spokane	Stevens	811	0.9%	
Great Rivers	Pacific	381	0.4%			Spokane	Pend Oreille	250	0.3%	
Great Rivers	Wahkiakum	58	0.1%			Spokane	Ferry	160	0.2%	
				6.8%		Spokane	Lincoln	101	0.1%	
						Spokane	Adams	96	0.1%	
King	King	20,687	21.7%	21.7%						11.5%
North Central (IMC)	Grant	1,019	1.1%			Southwest	Clark	4,718	5.0%	
North Central (IMC)	Chelan	1,004	1.1%				Skamania	148	0.2%	
North Central (IMC)	Douglas	544	0.6%				Klickitat	230	0.2%	
North Central (IMC)	Okanogan	648	0.7%							5.4%
				3.4%						
						Thurston Mason	Thurston	3,524	3.7%	
Pierce	Pierce	12,190	12.8%	12.8%			Mason	1,183	1.2%	
										4.9%
Unknown	Unknown	56	0.1%							
							State Total	95,207	100%	100%

Chart 2: Comparison of Opioid Risk sorted into IMC areas (FY 2019) to DBHR's distribution of Substance Abuse Block Grant (SABG) Federal Block Grant Funds (FY 2021)

IMC Region	RDA Opioid Risk Percent	Federal SABG Distribution Percent	Difference
Great Rivers	6.8%	5.0%	1.8%
Greater Columbia	8.8%	9.7%	-0.9%
King	21.7%	20.8%	0.9%
North Central	3.4%	2.6%	0.8%
North Sound	18.8%	18.9%	-0.1%
Pierce	12.8%	11.4%	1.4%
Salish	5.8%	7.0%	-1.2%
Southwest	5.4%	6.7%	-1.3%
Spokane	11.5%	12.4%	-0.9%
Thurston Mason	4.9%	5.4%	-0.5%
Total	100%	100%	