Advisory Board
Pre-Meeting Training

November 5, 2019

12:10 – 12:50

Cammy Hart-Anderson

Jennifer Alderman

Snohomish County

Carnegie Resource Center

And

Diversion Center

Empowering individuals and families to improve their health and well-being

SNOHOMISH COUNTY

Snohomish County Human Services' Behavioral Health Projects

Cammy Hart-Anderson, Division Manager
Jennifer Alderman, Behavioral Health Supervisor
Behavioral Health & Veteran Services

- Snohomish County Diversion Center
  - Opened July 2018
  - Operated by Pioneer Human Services
  - 585 Participants; January – September 2019
  - Referrals from Law Enforcement – Social Worker Teams
  - 44 beds for males and females
  - DSHS Research Study

- Snohomish County Carnegie Resource Center
  - Opened January 2019
  - Operated by Pioneer Human Services
  - 1,521Served; January – September 2019
  - Multitude of Social Services
  - Amazon holding monthly hiring events – 35 hired on the spot last month

- Medication Assisted Treatment in County Jail
  - Beginning in October, all inmates have access to MAT
  - Partnering with Ideal Options
  - Opioid addicted inmates do not need to detox
  - Inmates have access to MAT from booking to release
  - Focus on linking inmates to MAT upon release
  - 133 inmates on MAT as of 10/24th

- Behavioral Health Crisis Services
  - 24/7 Immediate Response
  - 1-800-584-3578
  - Voluntary and Involuntary Services
  - Mental Health and Substance Use Disorders
  - Responses in the community; homes, schools & provider sites
  - Next Day Appointments
  - Direct Access Pilot – Everett Police Dept. & Sheriff's Office

- North Sound Substance Use Inpatient Treatment Services
  - Two 16-Bed Inpatient Facilities for Adults
    - One treatment program with Opioid Addiction Focus
    - One treatment program for Substance Use Disorders with Mental Health Needs
  - Repurposing Vacant Space at Denney Juvenile Justice Center
  - State, BHO and Local Capital Funding Sources
  - Groundbreaking April 2020
  - Occupancy 2nd Quarter of 2021

- What's Next For Division of Behavioral Health Services?
  - Continued Exploration of Creative Housing Options
  - Participate in the Creation of a Misdemeanor Community Court

Contact Information

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Snohomish Cty Veterans Homelessness Committee

9th Annual

National Homeless Memorial Day Candlelight Vigil

including a Tribute to Veterans

December 20, 2019 – 5:15pm

3000 Rockefeller Avenue, Everett (Courthouse Amphitheater)

If you know of anyone who has lost their life while homeless or if you have any other questions, please contact:

Stacy LaFlam: stacy.laflam@snoco.org

Don Wischmann: vfwpost2100@yahoo.com

Please join us in honoring all of our citizens who have died on the streets of Snohomish County in 2019

North Sound Behavioral Health Advisory Board

Agenda

October 1, 2019

1:00 p.m. – 3:00 p.m.

Call to Order and Introductions

Revisions to the Agenda

Approval of September Minutes.....TAB 1

Announcements

Brief Comments or Questions from the Public

Executive/Finance Committee Report

- **Approval of September Expenditures .....TAB 2**
- **Review Proposed 2020 Advisory Board Operating Budget .....TAB 3**

Executive Director's Report .....TAB 4

Early Warning Signs Workgroup Update .....TAB 5

Future Goals of the North Sound BH ASO.....TAB 6

Executive Director's Action Items .....TAB 7

Old Business

- **2020 Youth Opioid Video Challenge Contest Update .....TAB 8**

New Business

- **Advisory Board Resignations**
- **2020 Chair and Vice-Chair Nominations .....TAB 9**
- **North Sound BH ASO Guiding Principles.....TAB 10**
- **Advisory Board Webpage**
- **Advisory Board Bylaws.....TAB 11**
- **2020 Legislative Advocacy Priorities .....TAB 12**
- **2020 Advisory Board Advocacy Priorities .....TAB 13**
- **Reminder of the Annual Holiday Potluck**

Report from Advisory Board Members

Reminder of Next Meeting

Adjourn

North Sound Behavioral Health Advisory Board

October 1, 2019

1:00 – 3:00

Meeting Minutes

Empowering individuals and families to improve their health and well-being

Members Present:

- **Island County: Christy Korrow**
- **San Juan:**
- **Skagit County: Duncan West, Ron Coakley**
- **Snohomish County: Marie Jubie, Fred Plappert, Pat O'Maley-Lanphear, Joan Bethel, Carolann Sullivan, Jennifer Yuen**
- **Whatcom County: Mark McDonald, Kara Mitchell**

Members Excused:

- **Island County: Candy Trautman, Chris Garden**
- **San Juan County: Theresa Chemnick**
- **Skagit County: Joan Lubbe**
- **Snohomish County: Jack Eckrem**
- **Whatcom County: Michael Massanari**

Members Absent:

- **Island County:**
- **San Juan County:**
- **Skagit County: Joan Lubbe**
- **Snohomish County: Ashely Kilgore**
- **Whatcom County: Arlene Feld**

North Sound BH-ASO Staff: Joe Valentine, Joanie Williams (Recording)

Managed Care Organization Representation:

- **United Healthcare:**
- **Coordinated Care: Naomi Herrera**
- **Molina Healthcare:**
- **Community Health Plan of Washington [CHPW]: Marci Bloomquist**

Guests: Boone Sureepisarn North Sound Region Ombuds, Katelyn Morgan; North Sound Region Ombuds, Kala Buchanon; North Sound Regional Ombuds, Patti Banister, Amy Paxton, Linda Santini, Britta Johnson; Lake Whatcom Residential & Treatment Center

Call to order and Introductions

The chair called the meeting to order and initiated introductions.

Revisions to the Agenda

The chair asked if there were any revisions to the October 1st, 2019 Agenda, there were none.

Approval of September Minutes

Ron Coakley moved a motion for the approval of the September 2019 Meeting Minutes; Marie Jubie seconded the motion, all were in favor, motion carried.

Announcements

There chair asked if there were any announcements, there were none.

Brief Comments from the Public

The chair asked if there were any comments from the public, there were none.

There were two individuals who attended the meeting today who said they are possibly interested in being board members. They said they were just observing today. They said if they were interested in what the Advisory Board does, they may request membership.

Executive Directors Report

Joe Valentine gave the Executive Director's Report and covered the following topics:

- Integrated Managed Care Planning Update
  a. Interlocal Leadership Structure
  b. Joint Operating Committee
  c. Early Warning Workgroup
  d. Provider Meetings
  e. BH-ASO Budget
- Supplemental Behavioral Health Data
- State Auditor
- North Sound Federal "Medicaid Assisted Treatment-Prescription Drug and Opioid Addiction: Grant (Mat-PDOA)
- Opioid Reduction Planning
- Smokey Point Behavioral Health Hospital (SPBH) Update
- Behavioral Health Facilities Updates

Early Warning Signs Workgroup Update

Joe Valentine gave an update on the Early Warning Signs Workgroup.

Executive Director's Action Items

Joe Valentine presented the Action Items that will be presented to the Board of Directors.
Marie Jubie moved a motion to approve the Action Items get forwarded to the Board of Directors, Joan Bethel seconded, all in favor, motion carried.

Marie Jubie moved a motion to approve the North Sound BH-ASO Strategic Goals to be forwarded to the Board of Directors; Carolann Sullivan seconded the motion, all in favor, motion carried. It was noted that the Action Items will be approved to forward to the Board of Directors once Joe meets with Margaret for the language revision on the SABG Brigid Collins Motion.

Future goals of the North Sound BH ASO

Joe Valentine gave an update on the Strategic Goals of the North Sound ASO for Fiscal Year 2019-2020. Joe noted the Advisory Board will be approving the Strategic Goals during the November Meeting.

Executive/Finance Committee Report

The September Expenditures were reviewed and discussed. The chair noted that the Executive Committee moved the motion for approval, Fred Plappert seconded the motion, all in favor, motion carried.

Review Proposed 2020 Advisory Board Operating Budget

Individuals were asked to discuss allocation of the 2020 Advisory Board Operating Budget funds. Marie suggested more money to be allocated to the Legislative Session. Christy Korrow appreciated the fact that there was an allocation for the Youth Opioid Awareness Video Challenge Contest.

Old Business

2020 Youth Opioid Video Challenge Contest Update

The chair gave an update on the Video Challenge Contest.
Discussion followed. It was mentioned that there was previous AB art and poetry that could be utilized for calendars to be disbursed at the state level.
Maria will email the video challenge information out to the members. One member pointed out spelling errors that need corrected.
Members were persuaded to ask for award money from private funders.

New Business

2020 Chair and Vice-Chair Nominations

Chair and Vice-Chair Nominations were discussed. Christy Korrow said she is interested in being part of the Nominating Committee.

Members will get Maria/Joanie their nominations for 2020 Chair and Vice Chair. The ballets will be presented during the November meeting and will be voted on during the December meeting.

Advisory Board Resignations

The chair noted that two board members have resigned. She gave the update on the total number of current open seats on the Advisory Board.

The open Advisory Board Seats will be added to the next County Coordinators Meeting Agenda.

North Sound BH ASO Guiding Principles

The Chair pointed out the new verbiage on the Guiding Principles. There were minimal revisions, which were reviewed.

Advisory Board Webpage

Members were encouraged to review the North Sound BH-ASO web page and offer comment. The chair asked if each member would create a short paragraph about their individual investment and/or passion toward being a member on the Advisory Board and/or the reason why they choose to sit on the board. Blurbs should be sent to Maria prior to the next meeting.

Advisory Board Bylaws

The revisions to the bylaws were reviewed and discussed:

- Section 4 line 2: it was pointed out that the parentheses need to be removed, as they are not needed.
- The "LGBTQ" acronym needs corrected. (The acronym is correct that is in quotes).
- Change "Advocate for a …." versus the word champion; Section 10, article 2
- Article 2, #5 "to visit" "to create" …. be consistent. Change Article 2, #9 "to encourage members to" ……

Fred Plappert moved a motion to accept the revisions to the Bylaws, Ron Coakley seconded, all in favor, motion carried.

2020 Legislative Advocacy Priorities

Suggested priorities discussed included

- Housing
- Operating support for North Sound region's new behavioral health facilities
- ITA Hearing court costs
- Residential treatment "Transition" services

Joe will draft a Legislative Priority document. This will be brought back to the Board in November

2020 Advisory Board Advocacy Priorities

The budget and the Advisory Board's legislative advocacy priorities were discussed. Below are topics that members would like to ensure are included in the list priorities:

- Ron: Housing Support(s); he noted they are a hot legislative hot topic right now. (This should be on the top of the list he added).
- Marie: Abusive Management Companies
- Christy: (re-affirmed housing is a concern)
- Joan: Transition Services (Western State Hospital [WSH] to jail and other transitions)
- Ron: Transition Services (Community Responsibility Program)
- Ron: Operating Funds; for specifically non-Medicaid individuals (all 5 counties)
- Joe: Involuntary Treatment Act (ITA) Court Costs
  - Legislation to set clear guidelines and realistically project costs

Joe will work with Maria (and the counties) on the wording for the priority statements.

It was noted the that legislation session is shorter this upcoming year.
North Sound BH-ASO AB Calendars will be handed out to the Legislators. Maria will present them to the board soon. Marie Jubie is taking the lead on Legislative Session trip and will research the best time to attend.
Joe and Ron are interesting in joining the legislative session with Marie. The MCOs stated they will check with their staff regarding any MCO concerns that they think should be added to the priority list.

Reminder of the Annual Holiday Potluck

The ASO will be providing the main holiday potluck food and the AB will bring side dishes, appetizers and desserts. Maria will send out an email asking that folks let her know what they are bringing so there is variation in food items.
County Coordinators and MCOs will be invited the Annual Holiday Potluck as well.

Report from Advisory Board Members

Fred reported that 3315 Broadway is receiving the finishing touches. At the corner of 33rd and Lombard, signs have gone up for proposed land use for the new supportive housing for Compass Health. He went on to say they are building a new apartment complex on 32nd and Broadway.

Christy reported on a new committee called Interfaith Health Committee in San Juan. Representatives of Island County Health are on this committee. A new NAMI chapter is formed in Whidbey Island. Christy went on to say an event held for LGBTQ in Everett will be held. Christy gave a poster of this event to the ASO.

Reminder of Next Meeting

Tuesday, November 5, 2019 in Conference Room Snohomish

Adjourn

Chair O'Maley-Lanphear adjourned the meeting at 3:00 p.m.

North Sound BH ASO Executive Director's Report

Advisory Board, November 5, 2019

1. INTEGRATED MANAGED CARE PLANNING UPDATE

a) HCA ASO Audits

- The Health Care Authority [HCA] will be conducting their formal post go-live review of the North Sound BH ASO on January 28. On December 9, we will be given the list of materials we have to submit ahead of time by January 10, so we'll only have a short time left to pull everything together
- In September, we're then scheduled for our formal annual review.

b) Interlocal Leadership Structure

- On October 11, the Interlocal Leadership Structure meeting included representatives from the expanded list of stakeholders, including: hospitals, law enforcement, Behavioral Health Agencies, and Tribal Authorities.
- The extended stakeholder meetings will be held once a quarter, and the current smaller group of MCOs, Counties, ASO and Tribal representatives will continue to meet monthly in the intervening months. However, all ILS meetings are open to the public.
- The "Capacity Building Workgroup" has been folded into the ILS and development of recommendations related to joint grant applications and new capacity building initiatives will become a standing item on ILS agendas.

c) Joint Operating Committee

- The JOC is continuing to work on a crisis services "care coordination protocol" outlining how ASO and Crisis Services staff will work with the assigned MCO care coordinator in coordinating follow up services to persons at risk.

d) Early Warning Workgroup

- The 3d HCA "Early Warning Report" was presented at an Early Warning webinar on October 24.
- Crisis Services for response to calls and DCR dispatches continue to meet the established targets. [see TAB 4].
- There continue to be problems with high rates of claim rejection and/or denial with some MCOs as well as notable difference in both measures between the 5 MCOs.
- Data on changes in Emergency Department utilization that are to be included in the Early Warning reports are still not available.

e) Crisis Services

- We continue to track on a weekly basis our ability to leverage both Medicaid and federal block grant dollars. The ability to report Medicaid eligible continues to improve as agencies resolve some of the technical challenges related to identifying and reporting on the Medicaid status of persons receiving Crisis Services.

- We have developed the draft 2020 Operating Budget for the BH-ASO. This will be posted on the BH-ASO website following the October 10 Board of Directors meeting. We will review it at the November Advisory Board, County Coordinator, and Board of Director meetings.

2. BH-ASO LEGISLATIVE PRIORITIES

- The county administered BHOs and BH ASOs have developed proposed budget priorities and a policy paper targeting the most critical areas of funding need for ASO administered services. [see YELLOW TAB] These include:
  1) A separate appropriation for ITA Court Hearings and related expenses: this would include clear criteria for what the courts could charge for these services and reimbursements to courts would be limited to the level of the legislative appropriation;
  2) Funding to expand Crisis Services beyond ITA investigation services, including crisis stabilization services in Triage facilities and withdrawal management services.
  3) Operational funding for county owned behavioral health facilities.
  4) Allowing BH-ASOs additional administrative support to cover fixed expenses such as data support which will rise with the new federally mandated requirement to collect and report Supplemental Behavioral Health data.

3. NORTH SOUND FEDERAL "MEDICATION ASSISTED TREATMENT-PRESCRIPTION DRUG AND OPIOID ADDICTION" GRANT [MAT-PDOA]

- Following the October 10 Board of Directors, in which we reported on the difficulties with the contractor serving Island County, SeaMar, meeting the necessary performance targets, we were able to successfully negotiate with the other contractor under this grant, Life Line Connections, to pick up the Island County portion of the contract.
- We are working with Island County Human Services Staff to assist Lifeline Connections in establishing referral connections and to look for a suitable location for their staff.

4. OPIOID REDUCTION PLANNING

- At the October 25 meeting of the "Harm Reduction Coalition" which the North Sound BH ASO has supported as part of our continuing work on the regional Opioid Reduction Plan, a presentation on the rise of Methamphetamine use both in conjunction with Opioid use and by itself was given by Susan Kingston from the University of Washington "Alcohol & Drug Abuse Institute".
- I have attached her slide presentation illustrating this rise in Meth addiction. Clearly, in our future efforts in focusing on Opioid addiction we also need to take into account the corresponding increase in poly substance abuse. [PowerPoint slides attached BLUE TAB]

County/Local Crisis & Diversion System

Each Rregional Sservice Aarea (RSA) shall have one contracted Behavioral Health Administrative Services Organization (BHASO) to provide crisis services and Involuntary Treatment Act evaluations for the Medicaid and Non-Medicaid population. The BHASOs are also responsible for ~~diversion services~~ non-crisis behavioral health services, including diversion services, for the Nnon-Medicaid population. The BHASO's may be operated by a single county, a group of counties or a Managed Care Organization (Beacon Health Options). Currently, 7 of 10 regional service areas will be served by county managed BHASOs.

Funding for the crisis continuum has traditionally come from a combination~~mingling~~ of Medicaid, ~~state~~ general state funds (GFS), local funds for counties which have them and dedicated funding for these services, and federal funds. This "braiding" of funding streams has allowed for a robust and extensive crisis and diversion continuum to be developed and operated in most regions. However, as the State transitions to fully integrated managed care (FIMC), all Medicaid funds as well as 30% of the state general funds have been allocated to the Managed Care Organizations to serve the Medicaid populations in their contracted regions. This shifting of funds has resulted in funding gaps for the crisis and diversion system.

In order to ensure that regions can maintain current service levels, additional general state ~~general~~ funds are required.

Projected Service Reductions

North Sound:

Elimination of separate mobile crisis outreach teams for non-ITA related crisis services.

Elimination of funding for crisis stabilization in Triage facilities, withdrawal management facilities, other diversion services, and outpatient treatment and residential mental health treatment for low income non-Medicaid persons.

Please list your regions anticipated or realized service reductions as well as the over-all fiscal shortfall.

2020 BHASO Priorities

- Involuntary Treatment Act (ITA) Court Funding: Under RCW 71.05 and 71.34, Washington State's Involuntary Treatment Act (ITA) allows for individuals (13 and older) to be committed by a court order to a free-standing behavioral health Evaluation and Treatment facility (E&T) or psychiatric hospital against their will for a limited period. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a mental or substance use disorder who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to 72 hours, but can be extended for additional periods of 14, 90, and 180 days, as necessary. The BHASOs continue to fully fund ITA Courts and related services although it continues to represent an increasing percentage of our overall GFS Nnon-Medicaid funding, which ~~and therefore~~ takes funding away from critical behavioral health treatment services.

  The BHASOs request that ITA county funding be separated out in the budget as a separate funding line while ensuring any change to GFS non-Medicaid funding be based on the most recent ITA Court data, including total volume and cost per case, and results in the long-term preservation of funding for community-based services as well as adequate revenue to support necessary ITA Court processes. The most recent comprehensive, statewide data on Washington State ITA Court systems is the 2012 JLARC Report, for which actual ITA expenditure data was not available. Additionally, it is requested that the state adopt a fee

Commented [JV1]: Brad-did you want each of us to list our service reductions? It's hard to attach a dollar amount to a 'fiscal shortfall" because we had to reduce services to stay within the allocated budget. The "shortfall" is relative to which services woudl be resotored.

schedule that ITA Courts may use in establishing their rates, this will ensure more consistency in court fees state-wide as well aid in annual budget development both at the state and BHASO level. Finally, there is no methodology to project the required costs for non-Medicaid services such as ITA investigations, court costs, and inpatient and outpatient services for low-income non-Medicaid persons. ASO's would like to work with the State to develop a methodology for projecting actual costs.

- Non- ITA/Non-Crisis Inpatient Behavioral Health Services for Eligible Non-Medicaid Individuals' (at or below the 220% Federal Poverty Level): There is a need for additional ~~state~~ general state fund~~s~~ing for ~~inpatient~~ crisis stabilization and withdrawal management ~~behavioral health~~ services for Non-ITA/Non-Crisis Eligible Non-Medicaid Individuals, including crisis stabilization facilities, withdrawal management facilities, and evaluation & treatment facilities (which, under the current HCA/ASO contract may be funded "within available resources"~~)~~ of which there is currently little to no available resources.

- Direct Service~~s~~ Support Rate: Historically, Behavioral Health Organizations were allowed to report the costs for services that support direct services, e.g., the Crisis Line, Ombuds services, Data Support, and Utilization M~~m~~anagement which includes the Behavioral Health Medical Director and licensed mental health and substance use disorder professional staff with clinical expertise, as a separate category outside of their direct administrative costs. ~~-~~These were capped at an additional 5% in the Health Care Authority BHASO contract. However, when a 5% cap is applied to a significantly smaller funding base, i.e., N~~n~~on-Medicaid funding only, not enough revenue is provided to cover the fixed costs for these services.~~(PLEASE INSERT TEXT)~~ A cap of at least 10% for direct services support ~~would be~~is needed to cover the minimum costs to meet the state's contractually required responsibilities for BH-ASOs. The federally mandated requirement to collect and report Supplemental Behavioral Health data effective January 1 is an example of a fixed data support cost that could not be absorbed within the 5% cap.

- County Owned Behavioral Health Facilities: Adequate funding to support the ongoing operations of the County owned crisis facilities, which are essential behavioral health system infrastructure. Currently, MCOs see their responsibility as to only negotiating rates with the behavioral health agencies operating these facilities. The counties who own these facilities are not addressed as stakeholders with a financial stake in the outcome of these negotiations. Without adequate funding,Counties will need to decide as to whether they will be able to continue to cover the maintenance costs associated with owning these facilities.

Commented [JV2]: Crisis Stabilization and withdrawal management, as well as E&T services, are not considred "inpatient" services which normally refer to psychiatric hospitalization or residential treatment facilities.

Washington State Health Care Authority

EWS Indicator: Provider Payment

Summary of Claims/Payment – September 2019

United HealthCare:
0.1% of All "Received" Claims/Encounters were Rejected
22.9% of All "Finalized" Claims/Encounters were Denied

Molina:
0.43% of All "Received" Claims/Encounters were Rejected
4.00% of All "Finalized" Claims/Encounters were Denied

CHPW:
1.00% of All "Received" Claims/Encounters were Rejected
1.91% of All "Finalized" Claims/Encounters were Denied

Amerigroup:
5.91% of All "Received" Claims/Encounters were Rejected
37.14% of All "Finalized" Claims/Encounters were Denied

CCW:
0.52% of All "Received" Claims/Encounters were Rejected
12.44% of All "Finalized" Claims/Encounters were Denied

Source: MCOs

MCO/ASO Responses to BH Provider Payment Survey - Amerigroup

- Prior authorizations provided to AMG not communicated to correct departments within MCO. Services not paid at correct rate. MUE denials inappropriately, policy changes not consistent denials due to MHC showing another primary insurance; provider does not see this in Provider One (P1) when doing monthly eligibilities. Significant time delay of getting issues resolved.
  AMG spoke with provider to obtain clarification on these issues & inquired if these are issues for AMG, or Molina based on comment including MHC. Provider clarified that it does apply to all MCOs. AMG is regularly meeting with the provider to discuss outstanding issues & is actively working on claims being processed incorrectly due to open configuration projects. Once the configuration projects are complete, AMG will submit to have claims reprocessed.

- Contract asked for HCFA 1500 so programmed for that; now only accepting UB. Provider has to reprogram residential and detox FFS at additional cost in order to send claims in UB format. AMG owes the provider a large amount and can't pay because of this.
  AMG advised provider per CMS guidelines, IP stays must be billed on UB form. AMG advised possible contract amendment & is currently reviewing verbiage. Checking in with the provider on their status of updating their system to submit UB form. AMG and the provider are working to figure out specific requirements to update the provider's system and how much it would cost.

- All of provider's claims have been paid at a fraction of the contracted rates.
  AMG advised Provider of agreement issue, not all providers were updated with contract agreement. In addition, provider is not billing with modifier as shown on the fee schedule. AMG reached out to Provider Data team to review why the agreement is not showing per contract, discovered the roster was not fully completed due to missing information. AMG reached out to provider on 10/14 to obtain missing information.

Source: BH Providers/MCOs

MCO/ASO Responses to BH Provider Payment Survey – CHPW

- Can't process electronic claims. CHPW has paid no claims and asked us to submit manual Excel spreadsheet. Head of Operations said she prefers electronic claims but don't seem to have the capacity yet. CHPW represents about 20% of our overall services and we need electronic billing ability with them.
  Provider and CHPW met on 10/11. Actively working with the provider to be able to bill electronically vs. the excel spreadsheet. Provider will submit claims on 10/16 in hopes to have payments later this week, early next week. CHPW has been working diligently with the provider to make sure they receive payments ASAP.

- Billing address incorrect, this was not communicated to us prior to rejections. Time consuming to create excel invoice and submit 837P claims. It is a challenge for the provider to post payments when they are not receiving electronic remits (the provider submits manual invoices).
  Email from provider indicates no issues with CHPW. They have also signed a new contract amendment, which allows them to submit claims versus invoicing for services.

- No Preauth, Incorrect Modifier, Dispute Authorization. Slow pay is affecting cash flow.
  CHPW has been working with this group and has regularly scheduled phone calls/meetings. Provider admitted multiple CHPW members into their inpatient/residential programs since 1/1/19 without obtaining prior authorization from CHPW. The claims that were denied for no notification have been approved to pay as an exception once records are reviewed establishing medical necessity. CHPW is working with the provider get additional records, once those records are received and claims cleared for medical necessity CHPW will process those claims. The denied claims also used the incorrect CPT Codes/Modifiers, CHPW staff have discussed this with provider.

Source: BH Providers/MCOs

MCO/ASO Responses to BH Provider Payment Survey - CCW

- Provider is experiencing issues with payments for E&T bed days. Multiple unit issue still happening, and occasional issues with claims where Coordinated Care is secondary to commercial insurance. Cash flow is improving for proportional pre pay, but slow for claim payments.
  CCW met with provider on 10/8 to review claim issues/examples and has scheduled biweekly meetings with the provider.

- H0020 claims are denied when units are reported per SERI. H0020 is a major service, so this is affecting the provider's cash flow.
  CCW has a project in process to update their system to pay correct number of units for H0020. Target system production date is 10/28/19 at which point impacted claims will be reprocessed. CCW is meeting with the provider weekly until all issues are resolved.

- Provider is experiencing issues regarding no preauthorization, incorrect modifier, & dispute authorization. Slow pay is affecting cash flow.
  CCW is completing roster updates to address the root cause of underpayments. Claims project will be completed once updates are complete.

Source: BH Providers/MCOs

MCO/ASO Responses to BH Provider Payment Survey - Molina

- Denials due to Molina showing another primary insurance; provider does not see this in P1 when doing monthly eligibilities. Capitated Encounters reporting - No report/EOB to distinguish if a claim was denied. Because the provider is not notified of denials, this is an unknown. Provider saw a report a few months ago showing some services had been submitted to the wrong payor (Molina) but if the provider is not notified, they can't bill the correct payor to recoup that loss.
  Molina connected with the provider and will begin monthly reporting of encounters to better support provider in understanding what needs to be resubmitted. Will work to determine if provider may be able to submit all encounters to their claims environment in order to receive responses on the same 835 file.

- Issues with timeliness on bed day/auth approvals and payments for E&T and residential bed days, multiple unit issue still happening, & occasional issues with claims where Molina is secondary. Cash flow is improving for proportional pre pay, but slow for claim payments. 21% of claims have been denied; Molina claim edit fixes are underway.
  Molina continues to have bi-weekly meetings with this group to provide updates and work through all claim processing concerns. Due to a system edit error, all claims are being corrected and an open claims adjustment project is in process for all claims.

- Claim/service not covered by this payer, though P1 shows Molina. H0020 denials due to units reporting misunderstanding. H0020 is a major service, so this is affecting provider's cash flow.
  Molina has weekly check in calls with this group. H0020 had previously been an issue when billing with 2 units. Molina's system has been updated to allow and all affected claims were reprocessed for payment on 9/30/19. We have confirmed that our system is not denying newly received claims.

Source: BH Providers/MCOs

MCO/ASO Responses to BH Provider Payment Survey – United Healthcare

- Provider hasn't been able to get past the authorization process. Auths for out of County Inpatient is near impossible, haven't been able to admit any United Clients to bill.
  United has been in contact with the provider. Provider submitted appeal that is currently under review. Additional support will be provided to ensure provider's UM staff is trained on the online portal to submit auth requests and concurrent reviews.

- United says they will pay w/o auths; then deny claims. When provider gets auths, all denials on payments. Provider has received payments in Outpt but has large amount in outstanding claims. State director said they would pay denials but no one knows HOW to do that. Provider did get a United point person to work with on auths and that is going smoother, but no improvement on billing. Provider is frustrated by inability to resolve claims issues.
  Provider Advocate has a conference call with biller every Monday. United says they have paid the majority of the total amount billed by the provider. United has identified outpatient three codes that need to be added to the contract, contract amendment has been sent to provider and is awaiting signature. Additionally, provider is billing R&B H2036, which is currently not a code on the Facility contract. Communication has been made that this code is currently being denied. UHC has inquired it this code needs to be added to the facility agreement and waiting a response from the provider.

- No Preauth, Incorrect Modifier, Dispute Authorization. United has not paid any claims.
  Provider & United had a meeting on 10/9. United will be working with the provider on submitting online auths once they have portal access. Provider has been billing with NPI of Fac for OP codes and with individual clinician NPI for IP services and applying incorrect modifiers. Provider has been educated on correct billing and how to submit corrective claims for payment.

Source: BH Providers/MCOs

Washington State Health Care Authority
EWS Indicator: Provider Payment

MCO/ASO Responses to BH Provider Payment Survey – North Sound BH-ASO

- Too little money to cover all State clients that fall between cracks if not in the Federal priority list (IVDU, PG etc.)
  North Sound BH-ASO reached out to the provider to clarify the comment and offered to meet to see if there was any confusion around how to get individuals, who may be eligible for North Sound BH-ASO funding, an authorization.

- Provider didn't get their claims paid.
  North Sound BH-ASO reached out to the provider to clarify the comment, has not yet received a response.

Source: BH Providers/MCOs

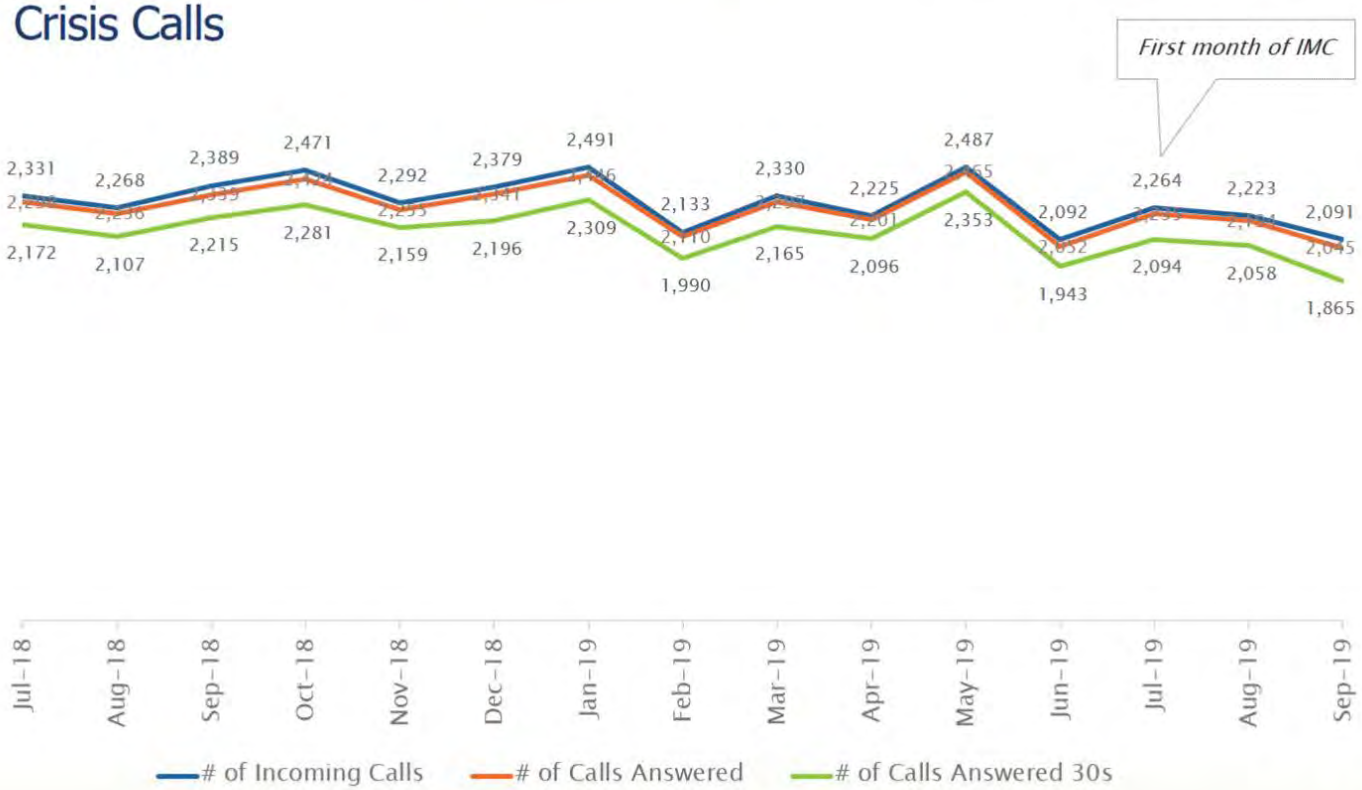
Washington State Health Care Authority

Crisis System

Washington State Health Care Authority

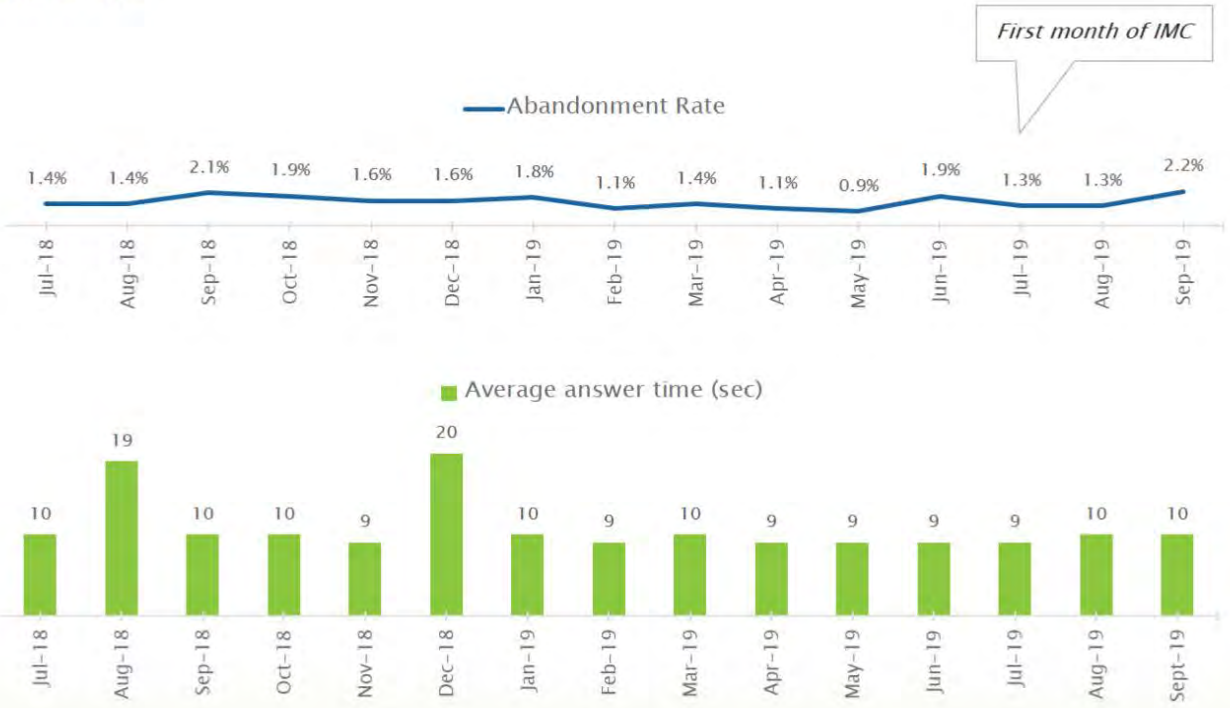
EWS Indicator: Crisis System

Crisis Calls



Source: North Sound BH-ASO

Crisis Calls



Source: North Sound BH-ASO

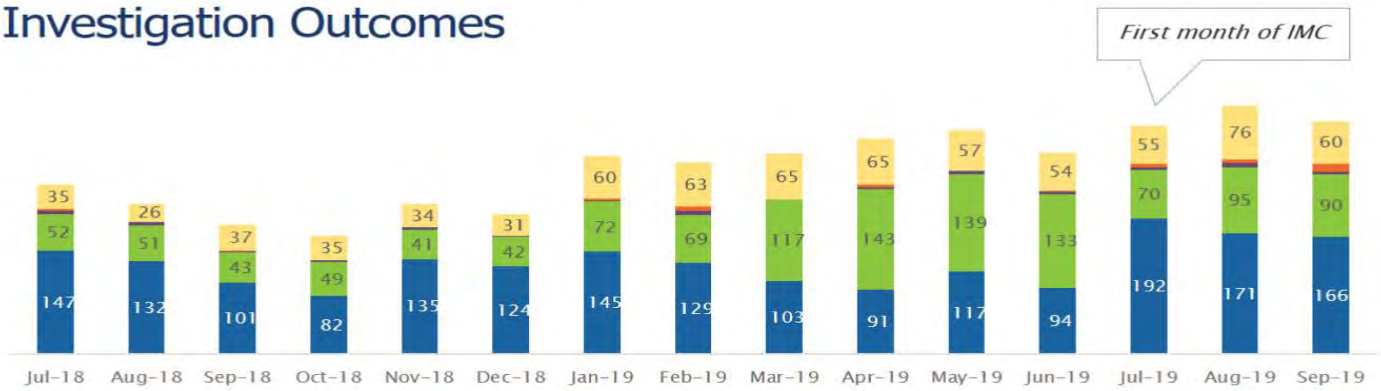
ITA Investigations

Source: North Sound BH-ASO

Investigation Reasons

Source: North Sound BH-ASO

Investigation Outcomes



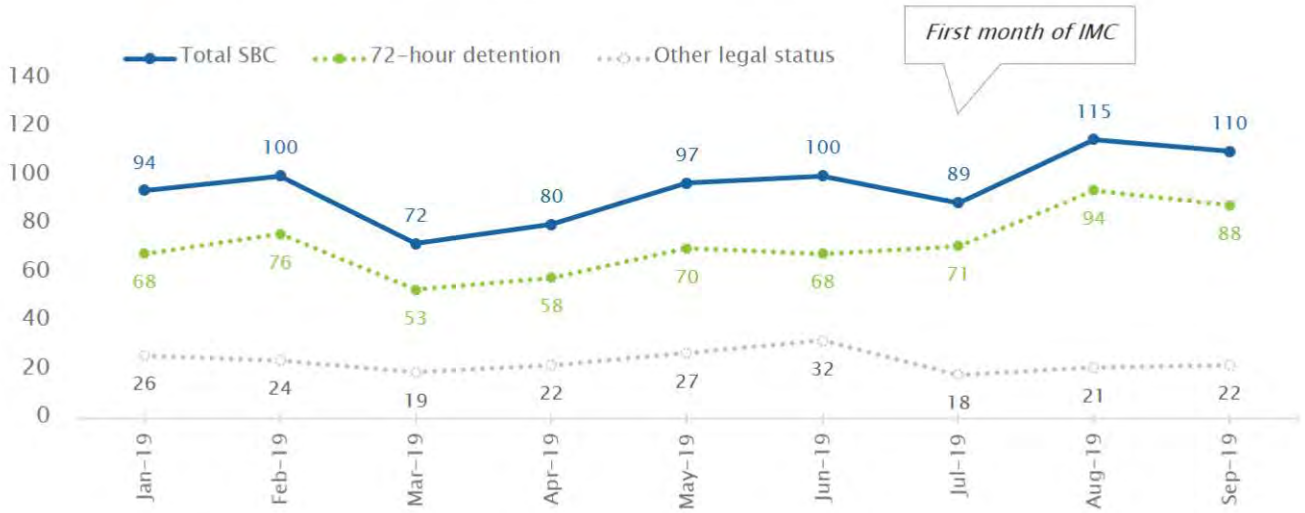
State Group	Investigation Outcome
Detentions and Commitments	Detention (72 hours as identified under RCW 71.05), Detention to Secure Detox facility (72 hours as identified under 71.05), Returned to inpatient facility/filed revocation petition.
Voluntary MH Treatment	Referred to crisis triage, Referred to voluntary inpatient mental health services, Referred to voluntary outpatient mental health services.
Less Restrictive Options MH	Filed petition – recommending LRA extension.
No Detention Due to Issues	No detention – E&T provisional acceptance did not occur within statutory timeframes No detention – Secure Detox provisional acceptance did not occur within statutory timeframes No detention – Unresolved medical issues
Other	Referred to non-mental health community resources. Other

Source: North Sound BH-ASO

Washington State Health Care Authority

EWS Indicator: Crisis System

Single Bed Certifications



A single bed certification permits a person to be detained under the mental health Involuntary Treatment Act (ITA) and temporarily receive involuntary inpatient mental health services from a licensed facility that is not currently certified to treat involuntary clients under WAC 388-865-0500.

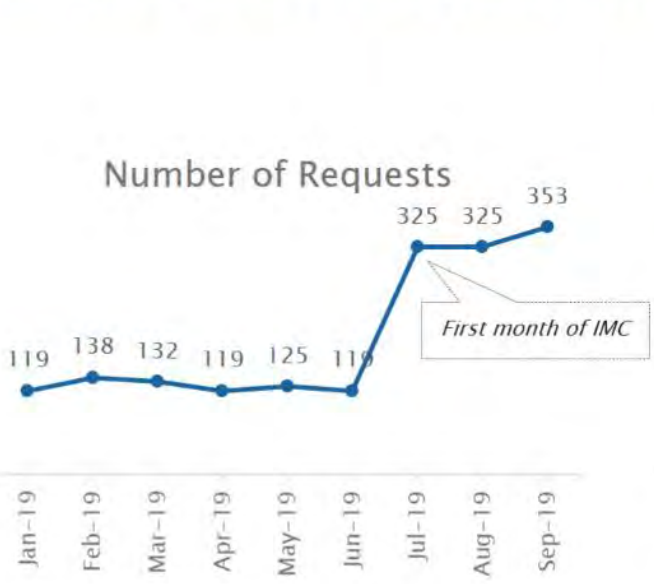
Other legal status includes: 14 Day Commitment, 180 Day Commitment, 180 Day LRA Revocation Order, 365 Day LRA Revocation Order, 90 Day Commitment, 90 Day LRA Revocation Order, LRA Revocation Detention, and unknown

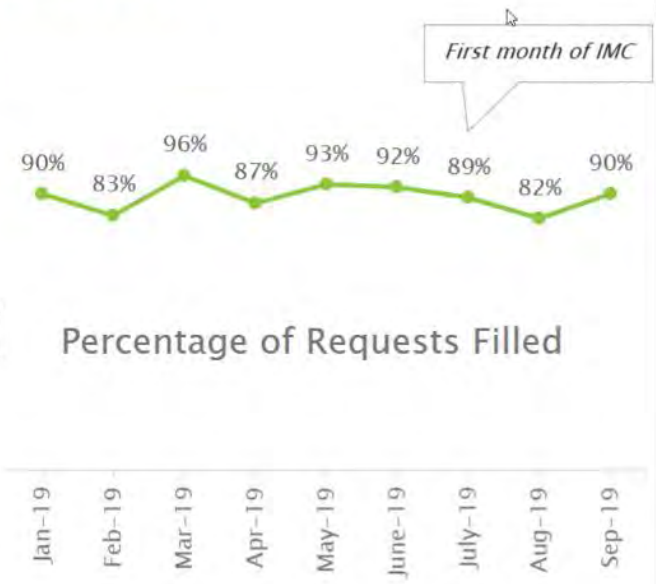
Source: Research and Data Analysis (RDA) - WA State Department of Social and Health Services (DSHS)

Washington State Health Care Authority

EWS Indicator: Interpreter Services

Interpreter Services Requests – BH Providers



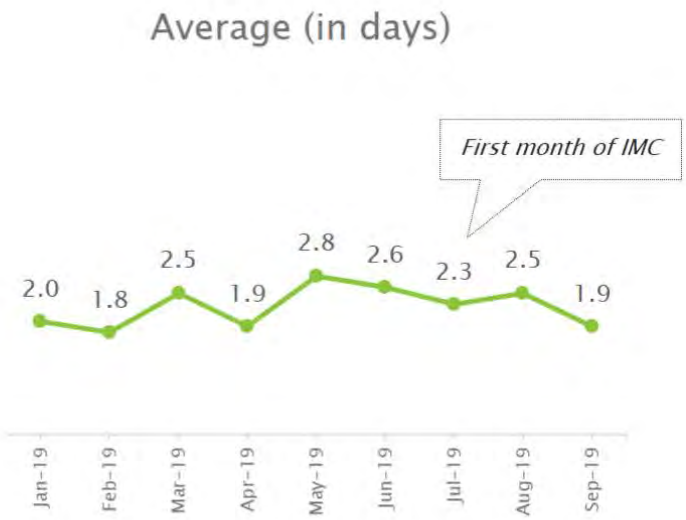


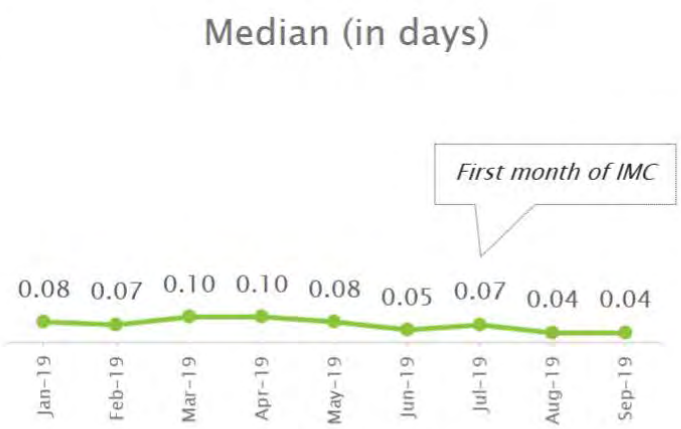
Source: Interpreter Services Division - Health Care Authority

Washington State Health Care Authority

EWS Indicator: Interpreter Services

Speed of Filling BH Interpreter Services Requests





Washington State Health Care Authority

EWS Indicator: State Hospitals

State Hospital Data – Civil Census/Occupancy*

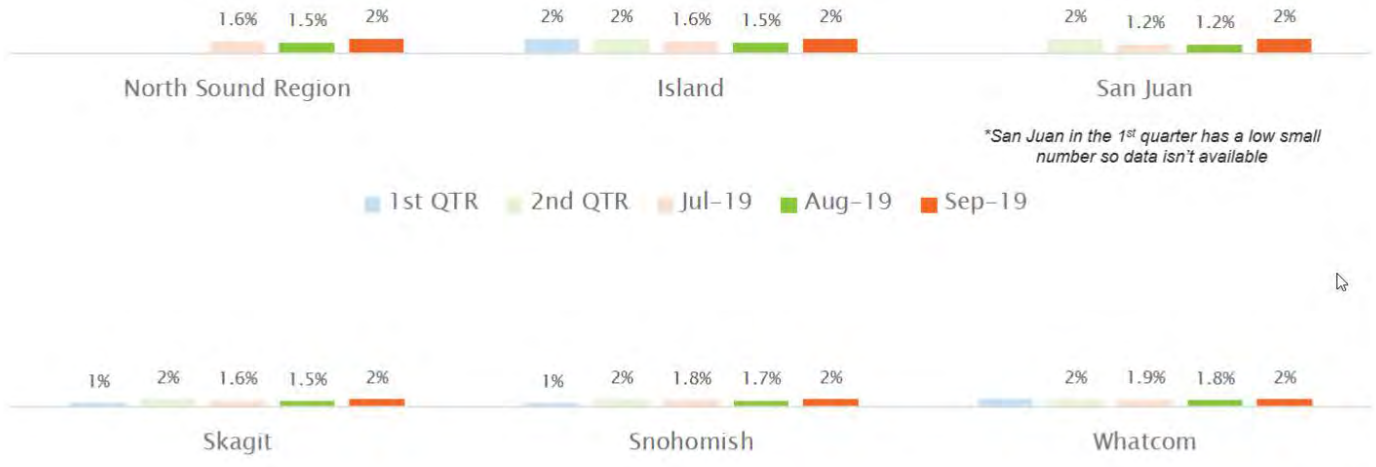
*Occupancy - Numbers represent patients in residence with a civil legal authority (LA) status located in designated civil wards on last Monday of the month. (Civil patients in forensic wards or patients with a forensic LA in civil wards are excluded.)

For WSH, region is based on county of commitment from the ad-hoc data extract;
For ESH, numbers are based on BHO/MCO of responsibility from the Daily Census Report

Monthly Forensic Flips and Discharge data is suppressed due to HCA's small number standards

Source: Research and Data Analysis (RDA) - WA State Department of Social and Health Services (DSHS)

Health Plan Client Churn – Average Churn Rates



Source: Health Care Authority

Questions?

Please send your questions and feedback to the Early Warning System Team, WA State Health Care Authority

hcaews@hca.wa.gov

North Sound Behavioral Health Adminstrative Services Organization
Advisory Board Budget
October 2019

	Total	All Conferences	Board Development	Advisory Board Expenses	Stakeholder Transportation	Legislative Session
		Project # 1	Project # 2	Project # 3	Project # 4	Project # 5
Budget	$ 22,000.00	$ 10,200.00	$ 575.00	$ 10,200.00	$ 75.00	$ 950.00
Expense	(15,442.99)	(5,257.29)	(1,750.00)	(7,286.02)		(1,149.68)
Under / (Over) Budget	**$ 6,557.01**	$ 4,942.71	$ (1,175.00)	$ 2,913.98	$ 75.00	$ (199.68)

BHC , NAMI, COD, OTHER	BOARDS SUMMIT (RETREAT)	Costs for Board Members (meals mileage, misc.)	Non- Advisory Board Members, to attend meetings and special events	Shuttle, meals, hotel, travel

North Sound Behavioral Health Administrative Services Organization
Warrants Paid
October 2019

	Type	Date	Name	Memo	Amount
			Supplies		
	Bill	10/16/2019	Shutterstock	Batch # 130199	31.53
	Bill	10/16/2019	Farmhouse Inn	Batch # 130199	399.43
Total Supplies					**430.96**
			Travel		
	Bill	10/08/2019	AA Dispatch	Batch # 130087	84.50
	Bill	10/08/2019	AA Dispatch	Batch # 130087	121.25
	Bill	10/08/2019	AA Dispatch	Batch # 130087	87.50
Total Travel					**293.25**
TOTAL					**724.21**

North Sound Behavioral Health Administrative Services Organization
Advisory Board Budget
2020

	Total	All Conferences	Board Development	Advisory Board Expenses	Stakeholder Transportation	Legislative Session	Video Contest	Contest Support
		Project # 1	Project # 2	Project # 3	Project # 4	Project # 5	Project # 6	Project # 7
Budget	**$ 19,998.00**	$ 4,500.00	$ 1,000.00	$ 10,200.00		$ 1,200.00	$ 3,098.00	
Expense	0.00							
Under / (Over) Budget	$ 19,998.00	$ 4,500.00	$ 1,000.00	$ 10,200.00	$ -	$ 1,200.00	$ 3,098.00	$ -
		All expenses to attend Conferences	Advisory Board Retreat/Summit	Costs for Board Members (meals mileage, misc.)	Non- Advisory Board Members, to attend meetings and special events	Shuttle, meals, hotel, travel	All Expenses for Video Contest	Any Funding Received for the Video Contest

North Sound Early Warning Report

Crisis Calls and Investigations

Behavioral Health System Indicators generated by North Sound BH ASO

Prepared By Dennis Regan 10/09/2019

NORTH SOUND BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES ORGANIZATION

301 Valley Mall Way, Suite 110, Mt. Vernon, WA 98273

360.416.7013|800.864.3555|F: 360.416.7017

www.nsbhaso.org

Table of Contents

Executive Summary

The North Sound Interlocal Leadership Structure developed the Early Warning System Workgroup to bring local and state stakeholders together to develop a system of metrics that will provide early warning about significant changes associated with the change to intergrated care. This report contains the data North Sound BH ASO provides to the state monthly to be incorporated into the state's monthly report on the larger set of Early Warning Metrics.

Early Warning Metric Dashboards

North Sound Crisis Calls

Period From Sep-18 To Sep-19

	crisis calls	Calls Answered	Calls LT 30 sec	Average answer time (sec)	Calls Abandoned
Average	2,315	2,280	2,155	0:00:10	35
Min	2,092	2,052	1,943	0:00:09	22
Max	2,491	2,465	2,353	0:00:20	50
St dev	128	125	120	0:00:03	9
Sep-19	2,091	2,045	1,865	0:00:10	46
Current Month	✓	✓	✗	✓	✓

North Sound Investigations

Period From Sep-18 To Sep-19

	invest.	detentions	MH invest.	SUD invest.	MH and SUD invest.	Referred from Law Enforcement	avg dispatch response time
Average	266	112	148	11	108	27	1.4
Min	168	74	108	5	52	13	1.0
Max	353	175	245	15	167	50	2.0
Standard dev.	58	30	44	3	43	13	0.3
Sep-19	331	160	242	5	84	29	1.4
Current Month	✓	✓	✗	✓	✓	✓	✓

	Detentions and Commitments	Less Restrictive Options MH	No Detention Due to Issues	Voluntary MH Treatment	Other
Average	124	3	2	84	53
Min	82	0	0	41	31
Max	192	6	6	143	76
Standard dev.	32	2	2	38	14
Sep-19	166	3	12	90	60
Current Month	✓	✓	✗	✓	✓

✓ Inside 2 stdev

! at 2 stdev

✗ outside 2 stdev

Areas outside limits

Crisis Calls metrics outside limits

Calls answered in less than 30 seconds - are lower than the 2 standard deviation lower bound, corresponding with this, the percent of call abandonded is up to 2.2%, exceeding th previous 12 month's maximum.

Investigation metrics outside limits

No Detention due to issues – September having 12 of these detention outcomes is well outside of 2 standard deviations from the average. A review of the detailed outcomes shows that 3 were for E&T provisional acceptance outside of stautory limits and 9 for unresolved medical issues. 6 were from Snohomish and 3 for Skagit, 2 for Whatcom and 1 for Island counties.

MH Invest. - Incorrect coding of the referral source in 4 counties has been fixed for Jul'19 forward – baseline data was invalid - only recording "MH and SUD" as reason for investigation for those counties.

Detailed Data Discussion

North Sound Crisis Call Metrics

North Sound Crisis call data is captured by Volunteers of America (VOA) and submitted to North Sound ASO.

Current Crisis Call Data Used

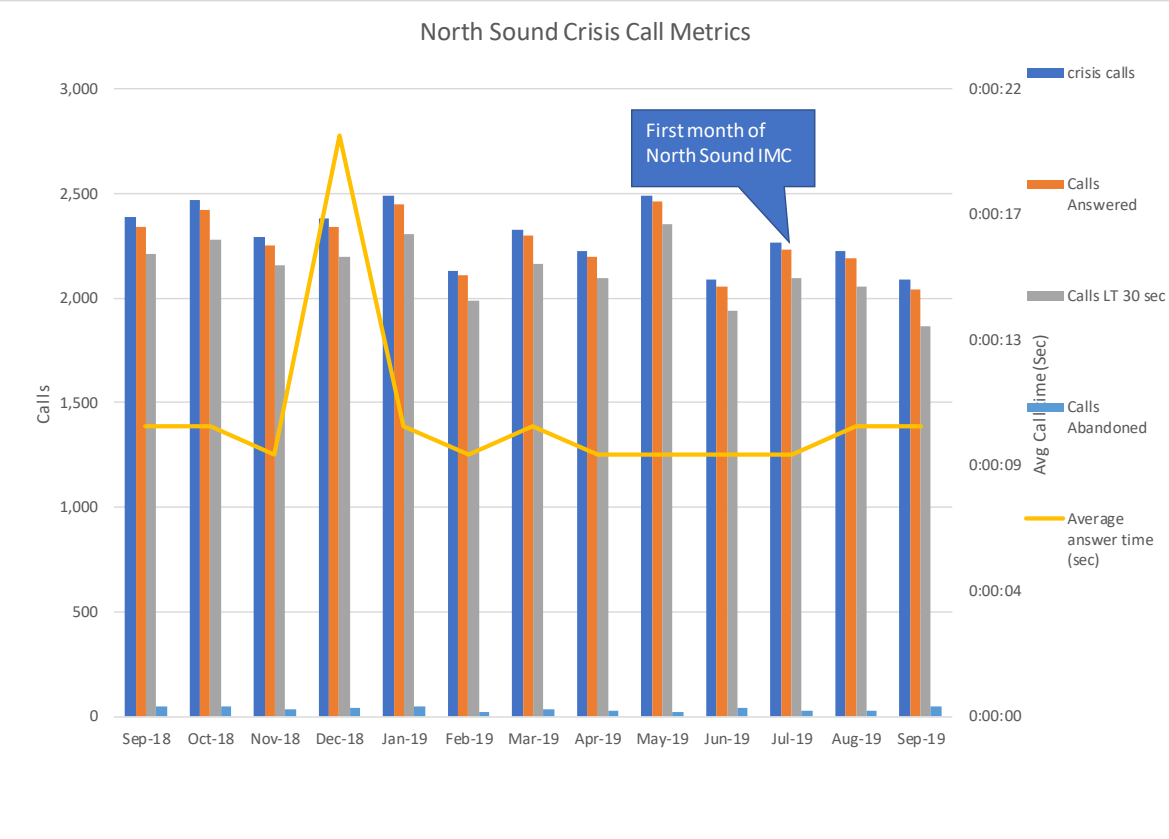
The current data used for the dashboard is below:

Month	crisis calls	Calls Answered	Calls LT 30 sec	Average answer time (sec)	Calls Abandoned	Abandoned percent
Sep-18	2,389	2,339	2,215	0:00:10	50	2.1%
Oct-18	2,471	2,424	2,281	0:00:10	47	1.9%
Nov-18	2,292	2,255	2,159	0:00:09	37	1.6%
Dec-18	2,379	2,341	2,196	0:00:20	38	1.6%
Jan-19	2,491	2,446	2,309	0:00:10	45	1.8%
Feb-19	2,133	2,110	1,990	0:00:09	23	1.1%
Mar-19	2,330	2,297	2,165	0:00:10	33	1.4%
Apr-19	2,225	2,201	2,096	0:00:09	24	1.1%
May-19	2,487	2,465	2,353	0:00:09	22	0.9%
Jun-19	2,092	2,052	1,943	0:00:09	40	1.9%
Jul-19	2,264	2,235	2,094	0:00:09	29	1.3%
Aug-19	2,223	2,194	2,058	0:00:10	29	1.3%
Sep-19	2,091	2,045	1,865	0:00:10	46	2.2%
average	2,315	2,280	2,155	0:00:10	35	1.5%
min	2,092	2,052	1,943	0:00:09	22	0.9%
max	2,491	2,465	2,353	0:00:20	50	2.1%

Current monthly data is highlighted for further review if it is outside 2 standard deviations of the 1 year period prior to the month. Currently, calls answered in less than 30 seconds meets this criteria.

North Sound Call Center Metrics over time Graph

North Sound Crisis call metrics are presented next with answer time plotted as a line on top



Long term Call Center model

The graph below models the previous 6 months of data with a regression based on the 12 months to model the predicted total of calls. This is presented to allow for controlling some variability in the particular month and is not included in the more basic dashboard values. High and Low values are at the 95-percentile range. The adjust R-squared of the model used was .77 and all monthly variable had a p value far smaller than .05.

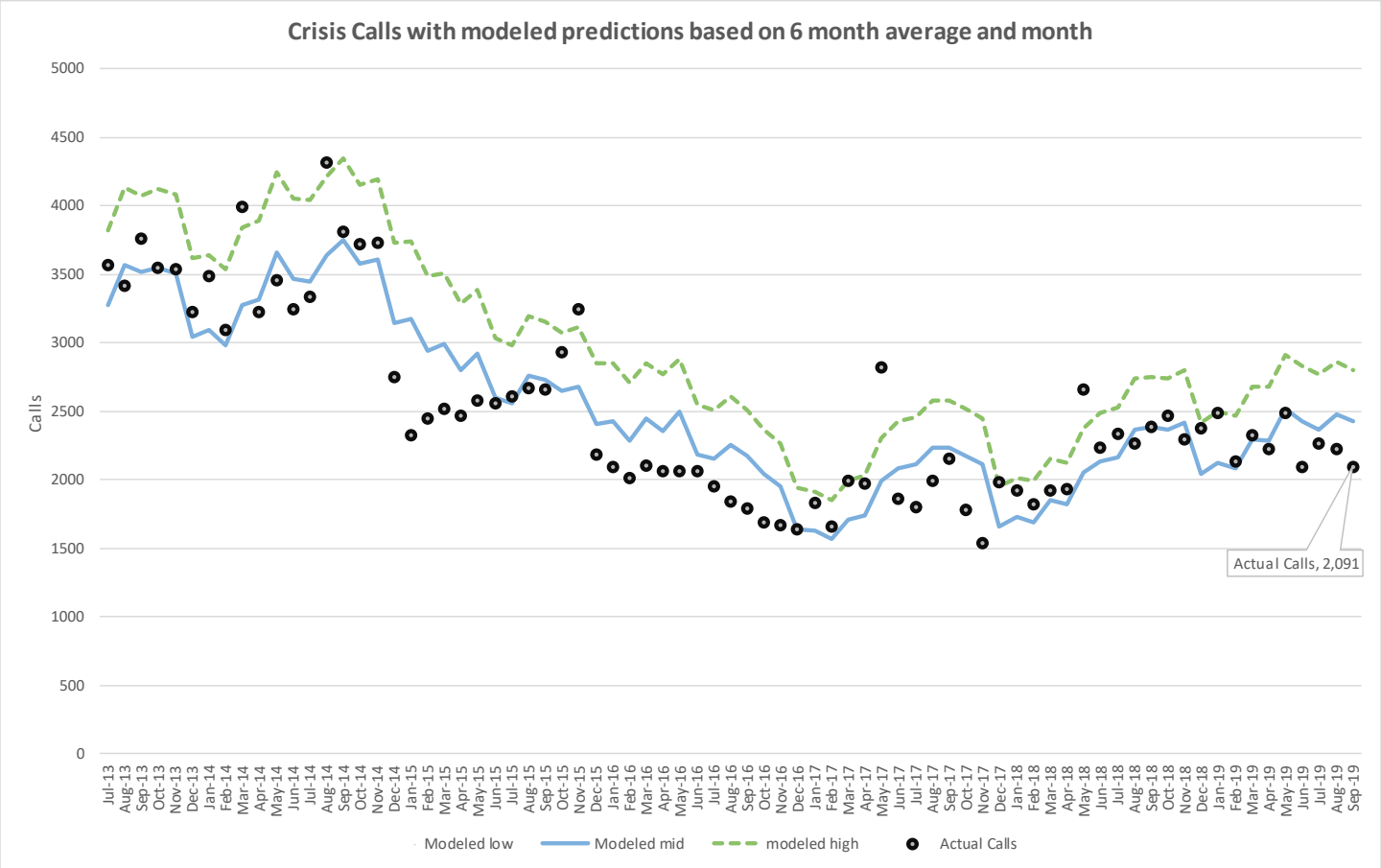
SUMMARY OUTPUT

Regression Statistics	
Multiple R	0.882476441
R Square	0.778764669
Adjusted R Square	0.735944927
Standard Error	356.9969644
Observations	75

ANOVA

	df	*SS*	*MS*	*F*	*ignificance F*
Regression	12	27814579	2317882	18.18705	5.54E-16
Residual	62	7901704	127446.8		
Total	74	35716283			

	Coefficients	*andard Err*	*t Stat*	*P-value*	*Lower 95%*	*Upper 95%*
Intercept	162.5109422	175.0512	0.928362	0.35682	-187.411	512.4333
X Variable 1	0.833670174	0.077884	10.70395	1.01E-15	0.677982	0.989359
X Variable 2	0.807583011	0.079085	10.21163	6.6E-15	0.649495	0.965671
X Variable 3	0.904219852	0.081431	11.10409	2.23E-16	0.741441	1.066999
X Variable 4	0.90457982	0.083888	10.78323	7.47E-16	0.736891	1.072269
X Variable 5	1.020314029	0.085977	11.86729	1.33E-17	0.848448	1.19218
X Variable 6	0.967657273	0.08668	11.16353	1.79E-16	0.794386	1.140929
X Variable 7	0.962987621	0.086001	11.19746	1.58E-16	0.791075	1.1349
X Variable 8	1.02618902	0.085152	12.05132	6.79E-18	0.855973	1.196405
X Variable 9	0.99776255	0.082737	12.05939	6.6E-18	0.832373	1.163152
X Variable 10	0.958410516	0.081445	11.76762	1.91E-17	0.795605	1.121216
X Variable 11	0.9436368	0.080305	11.75072	2.03E-17	0.78311	1.104163
X Variable 12	0.806632062	0.080172	10.06127	1.18E-14	0.646371	0.966894


Crisis Calls with modeled predictions based on 6 month average and month
Calls
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Actual Calls, 2,091
Modeled low
Modeled mid
modeled high
Actual Calls

North Sound Investigation Metrics

The North Sound Investigation data is captured in the North Sound ASO data system through the ICRS contact sheet data submitted by Designated Crisis Responders.

Current Investigation Data Used

Total Investigations/detentions/response and LE referral

month	invest.	detentions	avg dispatch response time	Referred from Law Enforcement	detention percent
Sep-18	184	90	2	13	49%
Oct-18	168	74	2	13	44%
Nov-18	214	116	2	15	54%
Dec-18	199	111	1	15	56%
Jan-19	281	134	2	19	48%
Feb-19	273	123	1	21	45%
Mar-19	285	94	1	43	33%
Apr-19	306	81	1	35	26%
May-19	318	101	1	25	32%
Jun-19	285	85	1	29	30%
Jul-19	325	175	1	45	54%
Aug-19	353	161	1	50	46%
Sep-19	331	160	1	29	48%
average	271	116	1	27	43%
min	168	74	1	13	26%
max	353	175	2	50	56%

Investigation Reasons

month	MH invest.	SUD invest.	MH and SUD invest.	Percent SUD related
Sep-18	108	15	61	41%
Oct-18	109	7	52	35%
Nov-18	143	8	63	33%
Dec-18	124	11	64	38%
Jan-19	156	13	112	44%
Feb-19	129	7	137	53%
Mar-19	118	10	157	59%
Apr-19	129	10	167	58%
May-19	159	13	146	50%
Jun-19	118	5	162	59%
Jul-19	245	12	68	25%

month	MH invest.	SUD invest.	MH and SUD invest.	Percent SUD related
Aug-19	232	15	106	34%
Sep-19	242	5	84	27%
average	155	10	106	43%
min	108	5	52	25%
max	245	15	167	59%

Investigation Reason's baseline data is invalid. Reporting in 4 of the 5 counties was defaulting to investigation reason '3' (MH and SUD) for the entire baseline period. This problem was corrected for the July and August periods – making it appear that there is a large spike in investigation due to MH reasons. Corrections to the data in the baseline period data are underway but not completed at the time of this report.

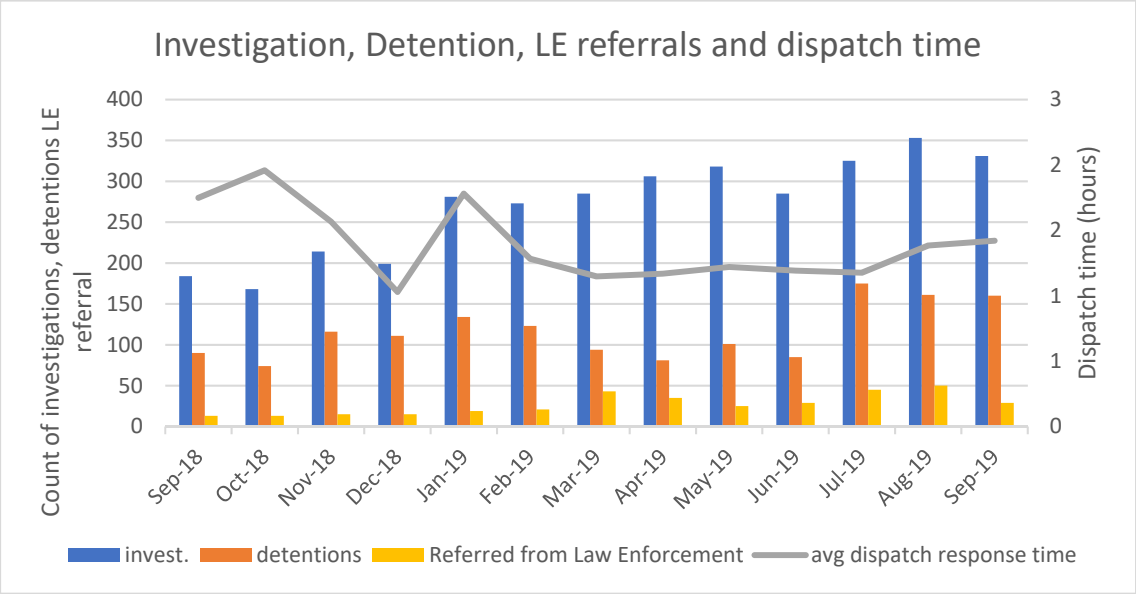
The total investigations are valid, the total number of investigations is down from the previous month's high of 367 and well under the average of 263 but higher than September 2018's total of 184.

Investigation Outcomes

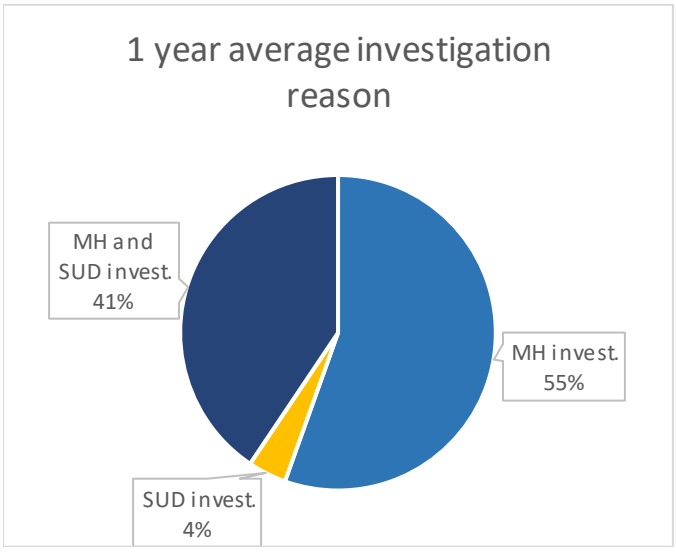
month	Detentions and Commitments	Voluntary MH Treatment	Less Restrictive Options MH	No Detention Due to Issues	Other
Sep-18	101	43	1	2	37
Oct-18	82	49	2	0	35
Nov-18	135	41	4	0	34
Dec-18	124	42	2	0	31
Jan-19	145	72	2	2	60
Feb-19	129	69	6	6	63
Mar-19	103	117	0	0	65
Apr-19	91	143	3	4	65
May-19	117	139	4	1	57
Jun-19	94	133	4	1	53
Jul-19	192	70	4	4	55
Aug-19	171	95	6	5	76
Sep-19	166	90	3	12	60
average	127	85	3	3	53
min	82	41	0	0	31
max	192	143	6	12	76

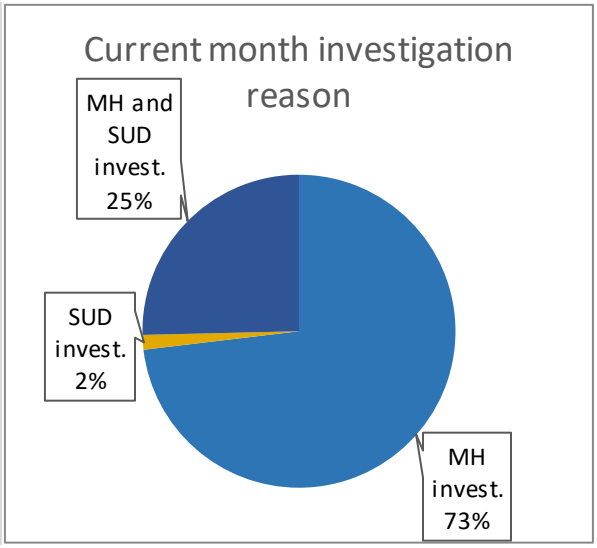
Current monthly data is highlighted for review if it is outside 2 standard deviations of the data in the period 1 year prior.

North Sound Investigation Metrics over Time graph

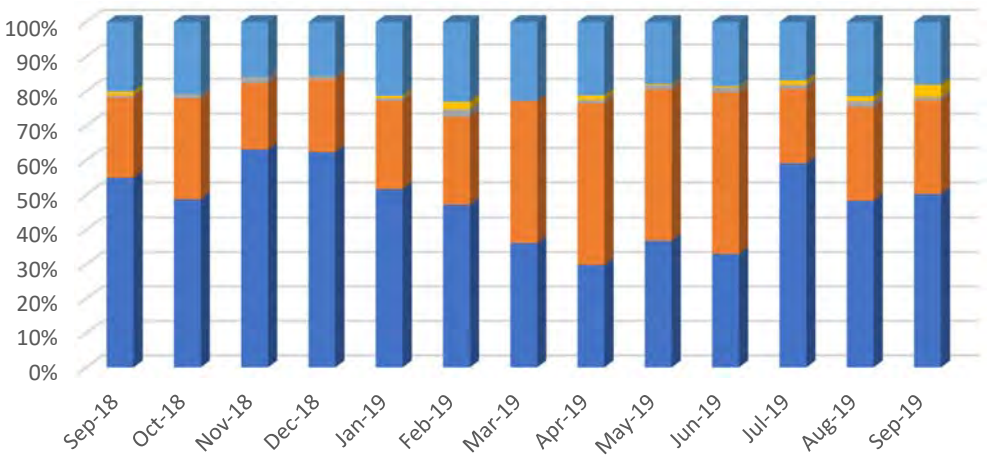


Investigation Reason Percentages Pie Charts





Investigation Outcomes over time percent of total chart



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Other	37	35	34	31	60	63	65	65	57	53	55	76	60
No Detention Due to Issues	2	0	0	0	2	6	0	4	1	1	4	5	12
Less Restrictive Options MH	1	2	4	2	2	6	0	3	4	4	4	6	3
Voluntary MH Treatment	43	49	41	42	72	69	117	143	139	133	70	95	90
Detentions and Commitments	101	82	135	124	145	129	103	91	117	94	192	171	166

Investigation Outcome Grouping

Investigation outcomes are grouped to duplicate the investigation outcomes published by the state.

State Group	Investigation Outcome	all invest. in period
Detentions and Commitments	Detention (72 hours as identified under RCW 71.05).	1,495
Detentions and Commitments	Detention to Secure Detox facility (72 hours as identified under 71.05)	8
Detentions and Commitments	Returned to inpatient facility/filed revocation petition.	147
Less Restrictive Options MH	Filed petition - recommending LRA extension.	41
No Detention Due to Issues	No detention - E&T provisional acceptance did not occur within statutory timeframes	9
No Detention Due to Issues	No detention – Secure Detox provisional acceptance did not occur within statutory timeframes	1
No Detention Due to Issues	No detention - Unresolved medical issues	27
Voluntary MH Treatment	Referred to crisis triage	55

State Group	Investigation Outcome	all invest. in period
Voluntary MH Treatment	Referred to voluntary inpatient mental health services.	121
Voluntary MH Treatment	Referred to voluntary outpatient mental health services.	927
Other	Referred to non-mental health community resources.	38
Other	Other	653
Grand Total		3,522

NORTH SOUND BEHAVIORAL HEALTH ADVISORY BOARD
2020 LEGISLATIVE PRIORITIES

1. HOUSING

- Provide legislative recognition of the fact that safe, affordable housing and housing support services are an essential part of the behavioral health treatment system.
- Provide flexible funding to support persons ready for discharge from the state hospitals or psychiatric inpatient facilities to pay for essential community-based services that would support their successful transition back to the community. These services would include additional supports for Adult Family Homes or Residential Treatment facilities, PACT or other intensive outpatient services, and transitional "step-down" facilities.[1]
- This should include funding for both Medicaid enrollees and low-income non-Medicaid persons.
- Continue to support and expand "HARPS" housing vouchers and housing support services for low-income non-Medicaid persons and link these to new affordable housing projects providing behavioral health supportive services.

2. OPERATING SUPPORT FOR NORTH SOUND REGION'S NEW BEHAVIORAL HEALTH FACILITIES

- Ensure there is sufficient operating support for the new Crisis Stabilization and Substance Use Disorder [SUD] treatment facilities which the North Sound counties have invested local dollars in and secured additional Department of Commerce administered state capital fund dollars for.
- The North Sound counties initiated the development of new behavioral health facilities based on a detailed needs assessment and multi-year plan that addressed the significant shortages in crisis stabilization and SUD treatment beds in the North Sound region.
- Counties are now at financial risk if there is insufficient ongoing operating support for services in these facilities. Sufficient operating support includes both sustainable Medicaid reimbursement rates from the Managed Care Organizations and adequate state general fund appropriations for serving low-income, non-Medicaid persons.
- In 2019, the Legislature allocated $500,00 annually to the Whatcom County crisis stabilization center to provide both sub-acute withdrawal management services and mental health crisis stabilization services to person who are not eligible for Medicaid.
- A similar level of support for the other new facilities that Island, Skagit and Snohomish counties are bringing online would meet this need.

[1] This is similar to the recommendation being made by the Health Care Authority in response to the directive of ESSSB 5432, Section 1003 (3)

3. ITA HEARING COURT COSTS

- Provide a separate legislative appropriation for Involuntary Treatment Act [ITA] Court Hearing costs and related expenses: this would include clear criteria for what the courts could charge for these services. Reimbursements to courts would be limited to the level of the legislative appropriation.
- Behavioral Health Administrative Services Organizations [BH-ASOs] are required to reimburse counties for all costs associated with Involuntary Treatment Act [ITA] court hearings.
- This funding comes from the same state general fund appropriation that is used to pay for crisis services, Evaluation and Treatment services, inpatient hospitalization and other treatment services for low-income non-Medicaid persons. As the costs to courts, and the ASOs, for ITA court hearings have increased there has been proportionately less money to pay for treatment services.

4. RESIDENTIAL TREATMENT "TRANSITION" SERVICES

- Expand the availability of short-term "step-down" residential treatment services to facilitate the discharge of persons from the state hospitals or psychiatric inpatient facilities for both Medicaid and low-income non-Medicaid persons.
- Persons who are ready for discharge from psychiatric inpatient facilities often need a temporary placement back on the community while longer term placement options are being explored.

North Sound Behavioral Health Advisory Board

2020 Advocacy Priorities

1) Supportive Housing
2) Transition Services
    a) Western State Hospital transition to the community
    b) Jail transition to the community (Community Responsibility Program)
3) ITA
    a) Separate line funding for associated treatment
    b) Actual court costs
    c) Set clear guidelines and realistically project costs
4) Funding for Coordination of Services
    a) Service planning for the 5 county low income individuals
    b) Non-Medicaid individuals
5) Crisis Services
    a) Crisis planning and follow up for high utilizers
        i) Patterns from fragmented care

2020 North Sound BH ASO Operating Budget Overview

Presented by:

Joe Valentine, Executive Director

Agenda

- Budget Highlights
- Accomplishments
- Challenges
- Revenue
- Expenditures
- Staffing

Budget Highlights

North Sound BHO transitioned to a Behavioral Health Administrative Services Organization [BH-ASO]on July 1

2019 Budget included both 6 months as a “BHO” and 6 months “closing out the remaining bills” for BHO authorized services

2020 Budget reflects the first full year of operations as a BH-ASO

BH ASO operating budget includes a significant reduction in administrative infrastructure

Total direct and indirect administrative expenses are capped at the allowed limit of 15%

Budget Highlights

BH ASO Revenue Sources:

- State General Fund [GF-S]
- GF-S “Provisos” e.g., Jail Transition Services
- GF-S “Behavioral Health Enhancement Services”
- Federal Block Grant – Mental Health and Substance Abuse
- Medicaid reimbursement from MCOs for crisis services

Accomplishments

- Passed HCA “Readiness Review” to become a BH-ASO
- Coordinated regional efforts to procure capital funding for new behavioral health facilities
- Re-designed Crisis Services and developed financing plan to maintain existing level of Crisis Line and “DCR” services
- Provided significant staff support to integrated managed care planning activities, e.g., Interlocal Leadership Structure, Joint Operating Committee, Early Warning Workgroup, Provider Forums

Accomplishments

- Provided technical assistance and procured financial assistance from the North Sound Accountable Community of Health [NSACH] supporting provider agency capacity development to meet new data and billing requirements
- Continued to support the Regional Opioid Reduction plan and worked with the NSACH to develop new funding and planning structure
- Developed new Tribal Crisis Services Coordination Agreements
- Provided staff support for the 2019 Tribal Behavioral Health Conference

Challenges/Goals

- Fully operationalize all the HCA BH-ASO contract requirements
- Support Crisis Services agencies in fully leveraging all available Medicaid reimbursement and Federal Block Grant dollars
- Work with Counties and Crisis Services Agencies to maintain a continuous process of quality improvement for crisis services
- Work with MCOs and Crisis Services Agencies to develop effective crisis services “care coordination” protocols

Challenges/Goals

- Support the development of a regional “capacity building” plan to encourage MCO investments and collaboration in securing adequate funding to implement the plan, including operating funds for the new behavioral health facilities
- Identify gaps in services for low-income non-Medicaid persons and support advocacy efforts to address these funding gaps
- Work with the NCACH to implement a new planning and funding structure for regional Opioid Prevention and Reduction strategies
- Implement the new Tribal Crisis Services coordination agreements including training for Crisis Services staff

Revenue and Expenditure Summary

	Revenues	Expenditures
2019 Budget	$138,927,456	$138,927,456
2019 Projected	$110,014,989	$124,708,503
2020 Budget	$23,723,286	$23,723,456

Revenue Forecast

REVENUE SOURCE	AMOUNT
Federal Block Grant Mental Health	$1,535,920
Federal Block Grant SABG	$3,89,438
SAMHSA Grant – MAT PDOA	$524,670
MCO Medicaid Subcontracts	$3,455,876
State GF-S: MH, SUD, Provisos	$13,274,924

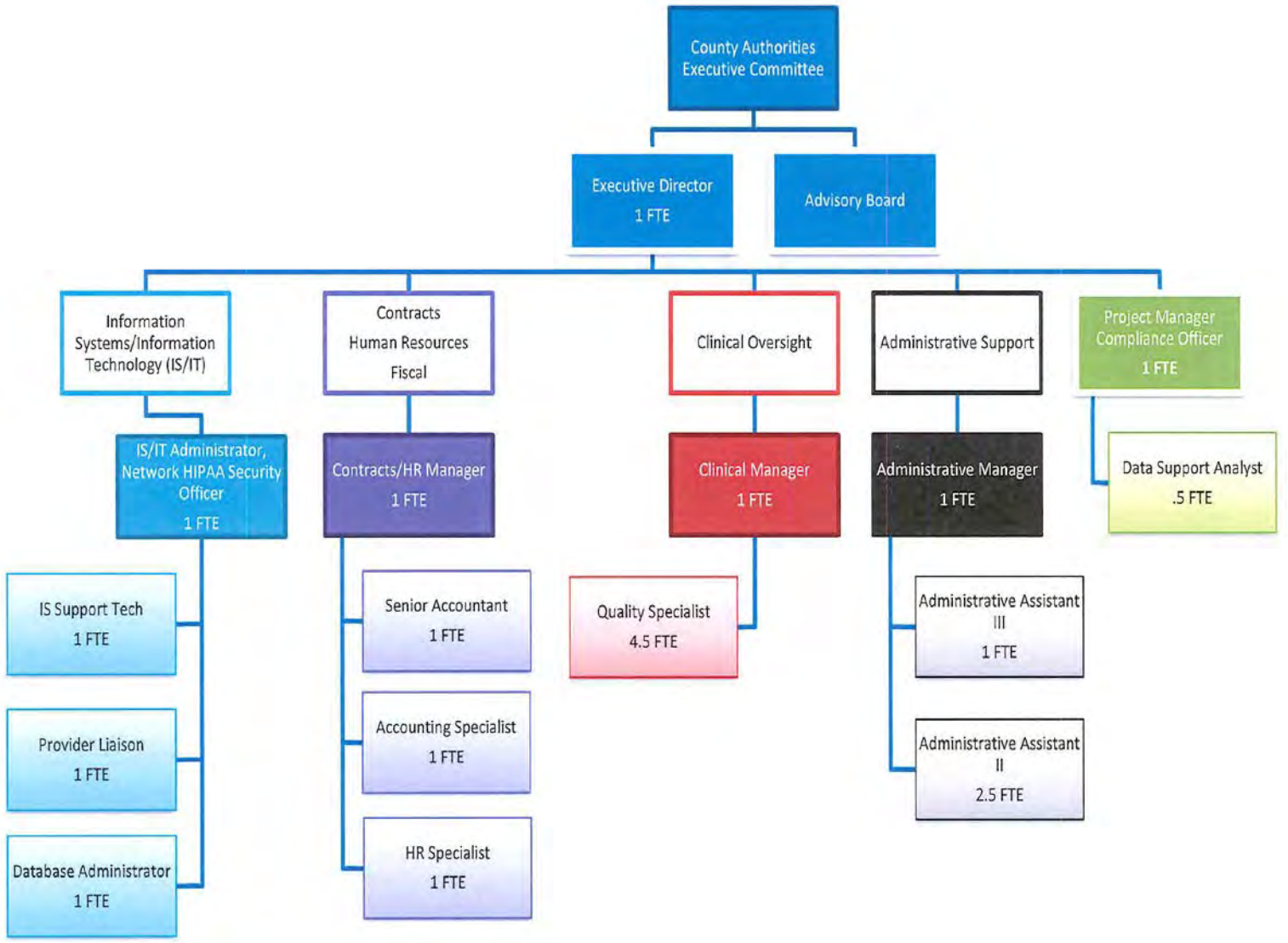
Revenue Forecast

REVENUE SOURCE	AMOUNT
GF-S Behavioral Health Enhancement	$992,088
HARPS [Housing Vouchers]	$326,000
FYSPRT	$75,000
Whatcom Triage/Detox	$250,000
Total	$23,723,916
15% for Administrative Expenses	$3,228,493

Expenditure Details

Category	Amount
Salaries & Benefits [20.5 FTEs]	$2,645,989
Operating Expenses	$892,504
Sub-Total ASO Operations Budget	$3,538,493
Advisory Board	$20,000
Behavioral Health Services	$19,258,417
Inpatient Hospital Costs	$906,376
TOTAL NORTH SOUND BH ASO BUDGET	$23,723,286

Staffing


County Authorities Executive Committee
Executive Director 1 FTE
Advisory Board
Information Systems/Information Technology (IS/IT)
Contracts Human Resources Fiscal
Clinical Oversight
Administrative Support
Project Manager Compliance Officer 1 FTE
IS/IT Administrator, Network HIPAA Security Officer 1 FTE
Contracts/HR Manager 1 FTE
Clinical Manager 1 FTE
Administrative Manager 1 FTE
Data Support Analyst .5 FTE
IS Support Tech 1 FTE
Provider Liaison 1 FTE
Database Administrator 1 FTE
Senior Accountant 1 FTE
Accounting Specialist 1 FTE
HR Specialist 1 FTE
Quality Specialist 4.5 FTE
Administrative Assistant III 1 FTE
Administrative Assistant II 2.5 FTE

North Sound Behavioral Health Administrative Services Organization, LLC

2020 Proposed Operating Budget
October 10, 2019

NORTH SOUND BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES ORGANIZATION, LLC

2020 PROPOSED OPERATING BUDGET

TABLE OF CONTENTS

I. 2020 ADOPTED OPERATING BUDGET NARRATIVE

A. BUDGET HIGHLIGHTS

On July 1, 2019, the North Sound Behavioral Health Organization [BHO] transitioned to the North Sound Behavioral Health Administrative Services Organization [BH-ASO]. This was the result of the state implementing Integrated Managed Care in the North Sound region.

Under the Integrated Managed Care model, Medicaid funding for behavioral health services are integrated into the health care contracts with Apple Health Managed Care Organizations [MCOs]. The North Sound region is served by all 5 Apple Health MCOs. The Health Care Authority [HCA] contracts with BH-ASOs to administer state general fund dollars, federal block grant dollars, and other non-Medicaid funds to support behavioral health services that are not covered by Medicaid. A core responsibility of BH-ASOs is to fund and oversee behavioral health Crisis Services, specifically; a 24-hour toll-free crisis line, Involuntary Treatment Act investigation services, and Mobile Crisis Outreach Teams.

The Apple Health MCOs also contract with the BH-ASO to cover the cost of Crisis Services to their Medicaid members. They do this by providing an estimated portion of their PerMember/PerMonth payments from HCA. At the end of 6 months, the MCOs will conduct a "reconciliation" process with the BH-ASO to determine if the cost value of crisis services provided to Medicaid members equaled the value of the payments the MCOs provided to the BH-ASO.

The overall funding base for Crisis Services, as well as the funding for the BH-ASOs administrative infrastructure, are significantly reduced from the funding levels that were available to the BHO. The proposed 2020 BH-ASO Operating Budget will allocate all available non-Medicaid funds, including state-general funds, state "Behavioral Health Enhancement Funds", and a portion of federal block grant funds to maintain the existing staffing levels for the Crisis Line and DCRs. It also provides some additional funds to provide Mobile Crisis Outreach services other than ITA investigation services. The former "voluntary" mobile Crisis Outreach teams [Community Prevention Intervention Teams] and the DCRs have been integrated into single teams in each county. The remaining non-dedicated state General Fund dollars, i.e., funding not associated with a specific budget "proviso", have been allocated to cover other mandatory costs such as ITA hearing costs and involuntary psychiatric hospitalization services for low-income non-Medicaid persons.

Addressing the gaps in funding for services to low-income non-Medicaid persons will continue to be a challenge for the region.

<u>2019 Accomplishments Included</u>:

- Passed the HCA "Readiness Review" that qualified us to receive the new BH-ASO contract.
- Provided the primary staff support to a comprehensive planning structure guiding the transition to Integrated Managed Care. This included supporting the Interlocal Leadership Structure and various

- workgroups, such as; Joint Operating Committee, Early Warning Workgroup, Model of Care Workgroup, and a Technical Workgroup.
- Helped coordinate and provide staff support to integrated managed care "Provider Forums".
- Coordinated regional efforts to procure state capital funding for new behavioral health facilities. As a result, counties were awarded funding to complete: the Whatcom County Crisis Stabilization Facility, the Island County Stabilization Center, the Snohomish County SUD Treatment Facilities to be located in the re-purposed Denny Juvenile Justice Center, and the new Skagit County Evaluation and Treatment facility to be located on the Skagit County Crisis Stabilization Campus.
- In collaboration with the North Sound's Crisis Services agencies, re-designed the crisis services system to integrate the mobile crisis outreach teams and maximize the ability to leverage other funds sources.
- Arranged to provide both technical and financial assistance to the regions Behavioral Health Agencies [BHAs] to assist them in getting ready to transmit billing and service data to the MCOs. This included procuring over $6 million in funding form the North Sound Accountable Community of Health that was passed onto the BHAs and contracting with a Technology Consulting firm to provide individualized technical assistance to each agency.
- Supported the development of a Regional Opioid Addiction Reduction and Prevention Plan that outlined specific goals and activities to implement a comprehensive array of strategies.
- Planned, coordinated, and sponsored an Opioid Youth Services summit aimed at improving early detection and prevention of addiction among youth.
- Developed a new Tribal Coordination Plan for Crisis Services and began to negotiate agreements with each Tribe.
- Planned, coordinated, and co-sponsored the annual North Sound Tribal Behavioral Health Conference.
- Successfully expanded contracted WISe treatment slots to achieve the mandated targeted number for the region.
- Totally redesigned and launched a more public friendly website for the North Sound BH-ASO.

<u>2020 Challenges and Goals</u>

- Fully operationalize all state contract requirements for the North Sound BH-ASO so that we can successfully pass the 6-month post go-live review by HCA.
- Maintain the core level of crisis services by fully leveraging MCO Medicaid reimbursements and earning of federal block grant funds.
- In partnership with the contracted Crisis Services agencies engage in a process of continuous process improvement.
- Develop care coordination protocols to improve coordination between the BH-ASO, Crisis Services, and the Medicaid Integrated Care network.

- Resume joint work with the North Sound Accountable Community of Health on a regional Opioid reduction plan.
- Continue to Support system planning activities: Interlocal Leadership Structure [ILS], Joint Operating Committee [JOC], Early Warning Workgroup, Provider Forums.
- Support the development of a regional "Capacity Building Plan" by the Interlocal Leadership Structure, including providing operating support for the new behavioral health facilities the counties are creating.
- Strengthen oversight of and evaluate the effectiveness of non-Medicaid funded programs, such as: HARPS, DMA, Jail Transition Services, Opioid Outreach, Opioid Treatment, etc.
- Join with Counties and Other BHOs/ASOs in identifying critical gaps in services for low-income non-Medicaid persons and advocating for funding to address these gaps
- Develop new strategies to support the discharge of non-Medicaid persons from WSH.
- Continue to act as the joint voice for the North Sound Counties regarding the behavioral health service needs of their citizens
- Support the Advisory in their advocacy work.

B. SUMMARY OF 2020 VERSUS 2019 REVENUES AND EXPENDITURES

	REVENUES	EXPENDITURES
2019 Budget	$138,927,456	$138,927,456
2019 Projected	$110,014,989	$124,708,503
2020 Budget	$23,723,286	$23,723,286

C. REVENUE AND EXPENDITURE APPROVAL PROCESS

1. Preliminary review Governance and Operations Committee 10/10/19
2. Introduction to the Executive Committee 10/10/19
3. Distribution to:
   a. Advisory Board 10/11/19
   b. Interested Public and Stakeholders 10/11/19
   c. Available on North Sound BHO Website 10/11/19
4. Review and recommendation of the Advisory Board 11/5/2019
5. Review at the Board meeting 11/14/19
6. Review and approval by Advisory Board 12/3/19
7. Review and recommendation of all stakeholders Up to 12/12/19
8. Recommended budget presented for Board adoption 12/12/19

D. OPERATING BUDGET SPECIFICS

Budget Area	2019	2020	Difference	Percent	Notes
Salaries	3,704,467	1,707,194	-1,997,273	-53.92%	1) Termination of BHO on June 30. 2) Reduction of 3.5 ASO FTE including Fiscal Manager
Benefits	1,666,207	938,795	-727,412	-43.66%	1) Reduction in FTEs, 2) COLA at 1.7%
Office Operating Supplies	96,000	43,200	-52,800	-55.00%	1) Reduction in FTEs 2) Advance purchase of supplies in 2019
Small Tools	86,000	20,000	-66,000	-76.74%	1) Reduction in FTEs 2) Advance purchase of supplies in 2019
Professional Services	494,000	184,250	-309,750	-62.70%	1) Reduction in Legal Services, Translators, Medical Director Services, HR consulting, other consulting services, ISIT in house training. 2) Reduction in discretionary consulting services from $100,000 to $5,000
Communications	87,629	49,821	-37,808	-43.15%	1) Reduction in FTEs
Travel	113,510	13,300	-100,210	-88.28%	1) Reduction in FTEs 2) Reduction in travel for trainings and conferences
Advertising	8,000	450	-7,550	-94.38%	1) Advertising only for RFPs, Board meetings, and vacant positions
Operating Rentals	344,000	308,900	-35,100	-10.20%	1) Facility lease cost of $290,000 was prepaid in 2019 for 2020 but shown in budget as an expense to maintain administrative operating baseline for 2021
Insurance	50,000	45,000	-5,000	-10.00%	1) Reduction in FTEs
Utilities	35,108	30,000	-5,108	-14.55%	1) Fewer offices being used

Budget Area	2019	2020	Difference	Percent	Notes
Repair and Maintenance	89,000	53,280	-35,720	-40.13%	1) Fewer copy machines being maintained 2) Reduction in maintenance contracts and repairs 3) Reduction in days per week for janitorial services
Miscellaneous	113,700	23,100	-90,600	-79.68%	1) Reductions in all line items 2) Significant reductions in training
Reserve		121,203			
Total Operating Budget	7,027,621	3,538,493	-3,489,128	-49.65%	1) Transition to full year as ASO 2) Other reductions as noted above 3) Includes SAMHSA grant funds 4) Minus $20,000 for Ombuds 5) Under the 15% Administrative cap
Tribal Conference	35,000	0	-35,000	-100.00%	Funding will be provided by HCA and MCOs
Advisory Board	22,000	20,000	-2,000	-9.09%	Full year at ASO funding level-dedicated funding from HCA
Provider Training	250,000	0	-250,000	-100.00%	
Behavioral Health Services	116,092,835	19,258,417	-96,834,418	-83.41%	Medicaid Outpatient and Inpatient services transferred to MCOs
Medicaid Inpatient	12,000,000	0	-12,000,000	-100.00%	Adjusted Estimate
IMD	1,500,000	0	-1,500,000	-100.00%	Adjusted Estimate
State Only Inpatient	2,000,000	906,376	-1,093,624	-54.68%	Adjusted Estimate
TOTAL BUDGET	138,927,456	23,723,286	-115,204,170	-82.92%	

E. CONCLUDING REMARKS

The 2020 Operating Budget represents the estimated revenues and expenditures for the first full year of the North Sound operating as a BH-ASO. It describes how we will meet all the requirements in the state's contract with the North Sound BH-ASO while at the same time working with our community stakeholders to continue to identify gaps in behavioral health services and opportunities for improvement. Developing dynamic and collaborative partnerships with the 5 Apple Health Managed Care Organizations will be key to this effort. Maintaining an adequate level of funding for Crisis Services and addressing gaps in services to low-income non-Medicaid persons will remain key challenges for the coming year.

II. Revenue Forecast

REVENUE DETAIL
NORTH SOUND BEHAVIORAL HEALTH ORGANIZATION
Estimated
2020 ANNUAL BUDGET

SOURCE	DESCRIPTION	Amount	2020 BH-ASO Operating Budget 15%
30800	*USE of FUND BALANCE*	$ -	
	TOTAL CHARGES FOR SERVICE	**$ -**	
	GRANT REVENUE		
331000	Direct Federal Block Grant PDOA	$ 524,670	
331000	Federal Block Grant Mental Health	1,535,920	
331000	Federal Block Grant SABG	3,289,438	
	TOTAL GRANT REVENUE	**$ 5,350,028**	$ 5,350,028
	CHARGES FOR SERVICE		
34640	Medicaid Crisis Subcontracting	3,455,876	
34640	State Funds Mental Health & Substance Use Disorder	13,274,294	
34640	State 6032	992,088	
34640	HARPS Vouchers	326,000	
34640	FYSPRT	75,000	
34640	Whatcom Triage/Detox	250,000	
34640	Accountable Community of Health		
	TOTAL CHARGES FOR SERVICE	**$ 18,373,258**	18,373,258
	MISCELLANEOUS REVENUES		23,723,286
36110	Investment Interest		15%
36990	Charges for Conference	-	
	*** MISCELLANEOUS REVENUES**	-	3,558,493
	TOTAL REVENUE	**$ 23,723,286**	

III. 2020 NORTH SOUND OPERATING BUDGET

A. Summary Budget

EXPENDITURES	Total
Regular Salaries	$ 1,707,194
Personnel Benefits	938,795
Office, Operating Supplies	43,200
Small Tools	20,000
Professional Services	184,250
Communications	49,821
Travel	13,300
Advertising	450
Operating Rentals & Leases	308,900
Insurance	45,000
Utilities	30,000
Repairs & Maintenance	53,280
Miscellaneous	23,100
Machinery & Equipment	-
Reserve	121,203
Subtotal - North Sound Operations Budget	$ 3,538,493
Advisory Board	20,000
Agency County and Other Services	19,258,417
Inpatient Hospital Costs	906,376
Total North Sound ASO Budget	$ 23,723,286

2016 ACTUAL	2017 ACTUAL	2018 BUDGET	2018 ACTUAL	2019 BUDGET	2020 ASO	2020 NORTH SOUND OPERATING BUDGET DETAILS
2,689,406	3,520,409	3,573,328		3,596,570	1,675,407	**REGULAR SALARIES**
					0	OVERTIME
		107,200		107,897	28,482	COLA SALARY CONTINGENCY Cost of living adjustment budgeted 1.7%. (If the COLA not approved, this amount becomes zero)
2,689,406	**3,520,409**	**3,680,528**	**0**	**3,704,467**	**1,703,889**	**REGULAR SALARIES**
1,749,369	2,209,455					**PERSONNEL BENEFITS**
		1,206,533		898,349	383,794	HEALTH, LIFE, DENTAL, VISION Government Entity Pool WCIF
					205,000	HRA
		453,812		432,195	196,393	PERS RETIREMENT Based on 2019 rate of 12.86% for Public Employee Retirement Systems.
		273,359		275,138	128,417	SOCIAL SECURITY The rate remains at 7.65% of FTE salaries.
		11,805		10,782	7,968	UNEMPLOYMENT COMPENSATION The 2019 rate is .49% of FTE salaries, capped at $47,300 per employee.
		32,926		27,378	11,423	WORKERS COMPENSATION The 2019 rate is $.2679 multiplied by the FTE annual hours.
		21,816		22,365	5,800	COLA BENEFIT CONTINGENCY Cost of living adjustment budgeted 1.7%.
1,749,369	**2,209,455**	**2,000,251**	**0**	**1,666,207**	**938,795**	**PERSONNEL BENEFITS**
282,749	135,476					**OFFICE, OPERATING SUPPLIES** For office supplies such as software, books, paper, pens, food.
		60,000		60,000	27,000	Leadership
		35,000		35,000	15,750	ISIT (software)
		2,000		1,000	450	Clinical Oversight
282,749	**135,476**	**97,000**	**0**	**96,000**	**43,200**	**OFFICE, OPERATING SUPPLIES**
191,027	195,249					**SMALL TOOLS & MINOR EQUIPMENT** For operating equipment including desks, chairs, file cabinets, computers.
		25,000		25,000	20,000	Leadership
		70,000		60,000	0	IS/IT (hardware)
		2,000		1,000	0	Clinical Oversight
191,027	**195,249**	**97,000**	**0**	**86,000**	**20,000**	**SMALL TOOLS & MINOR EQUIPMENT**
						PROFESSIONAL SERVICES
398,987	603,125	339,000		120,000	45,000	LEGAL SERVICES
		4,000		5,000	2,250	Translators - Leadership
		42,000		42,000	42,000	TREASURER & ACCOUNTING SERVICES $3,500 a month for charges of processing voucher and payroll, issuing warrants by Skagit County and investing, accounting and budget services.
		60,000				MEDICAL SERVICES System Operations DR Lipman and peer review, second opinions, etc.
		60,000		110,000	45,000	Clinical Oversight
		35,000		35,000	35,000	AUDIT SERVICES For annual NSBH-ASO financial audit by WA State Examiner. Leadership
		30,000		17,000	5,000	HUMAN RESOURCES SERVICES Contracts HR
		25,000		35,000	5,000	TEMPORARY HELP Admin. Services Administrative Support
		100,000		100,000	5,000	BH-ASO Consulting - Leadership
		50,000		30,000	0	ISIT In house training
398,987	**603,125**	**745,000**	**0**	**494,000**	**184,250**	**PROFESSIONAL SERVICE**

III B. Operating Budget Details

2016 ACTUAL	2017 ACTUAL	2018 BUDGET	2018 ACTUAL	2019 BUDGET	2020 ASO	2020 NORTH SOUND OPERATING BUDGET DETAILS
51,693	78,596					**COMMUNICATIONS**
						POSTAGE
		19,000		20,000	9,000	Leadership
						TELEPHONE
						Monthly telephone and internet
		20,000		20,000	9,000	Leadership
		20,000		20,000	20,000	T1 & DSL Connection IS/IT
						CELLULAR PHONES
		1,345		1,345	1,345	Leadership
		1,742		1,742	1,742	Contracts HR
		1,742				System Operations
		871		1,742	1,742	Administrative Support
		23,197		20,584	3,905	Clinical Oversight
		2,216		2,216	2,216	IS/IT
					871	Project Management
51,693	**78,596**	**90,113**	**0**	**87,629**	**49,821**	**COMMUNICATIONS**
89,908	110,271					**TRAVEL & LODGING**
						MILEAGE, FARES, MEALS
						Reimbursement for NSBH-ASO employees to use personal vehicles to attend meetings or perform work on behalf of the NSBH-ASO.
						For meals while attending meetings on behalf of the NSBH-ASO.
		13,000		13,000	5,800	Leadership
		10,000		10,000	1,500	Contracts HR
		17,510				System Operations
		10,000		10,000	1,000	Administrative Support
		65,646		65,700	3,500	Clinical Oversight
				3,500	400	Project Management
		4,000		3,000	400	Fiscal
		8,310		8,310	700	IS/IT
89,908	**110,271**	**128,466**	**0**	**113,510**	**13,300**	**TRAVEL**
6,172	5,512					**ADVERTISING**
						Advertising of vacant positions, RFQ's, RFP'S, Board meetings, etc..
		1,000		1,000	450	Leadership
		7,000		7,000	0	Contracts HR
6,172	**5,512**	**8,000**	**0**	**8,000**	**450**	**ADVERTISING**
302,463	264,738					**OPERATING RENTALS**
						RENTALS
						For renting rooms, training, short term equipment rentals, etc.
						SPACE RENTAL OFFICE
						The 2020 estimated lease
		260,000		290,000	290,000	Leadership, 2020 estimated lease amount less reimbursments
						COPY LEASE
		32,000		33,000	6,400	Leadership, Lease of two copy machines
						POSTAGE METER LEASE
		8,500		11,000	8,000	Leadership
						Contracts & Admin. Services
		10,000		10,000	4,500	IS/IT
302,463	**264,738**	**310,500**	**0**	**344,000**	**308,900**	**OPERATING RENTALS**
52,717	59,113					**INSURANCE**
						Endures formerly WGEP (Washington Gov't Entity Pool) membership fee.
		63,500		50,000	45,000	Leadership
52,717	**59,113**	**63,500**	**0**	**50,000**	**45,000**	**INSURANCE**
23,842	27,325					**UTILITIES**
		30,000		35,108	30,000	Leadership
23,842	**27,325**	**30,000**	**0**	**35,108**	**30,000**	**UTILITIES**
164,863	146,231					**REPAIR & MAINTENANCE**
						For repair of office equipment and maintenance of phone system.
		5,000		5,000	2,250	Leadership-maintenance on two copy machines
		10,000		14,000	6,300	Maintenance contracts and repairs IS/IT
		66,000		70,000	44,730	Janitorial Services - Leadership
164,863	**146,231**	**81,000**	**0**	**89,000**	**53,280**	**REPAIR & MAINTENANCE**

III B. Operating Budget Details

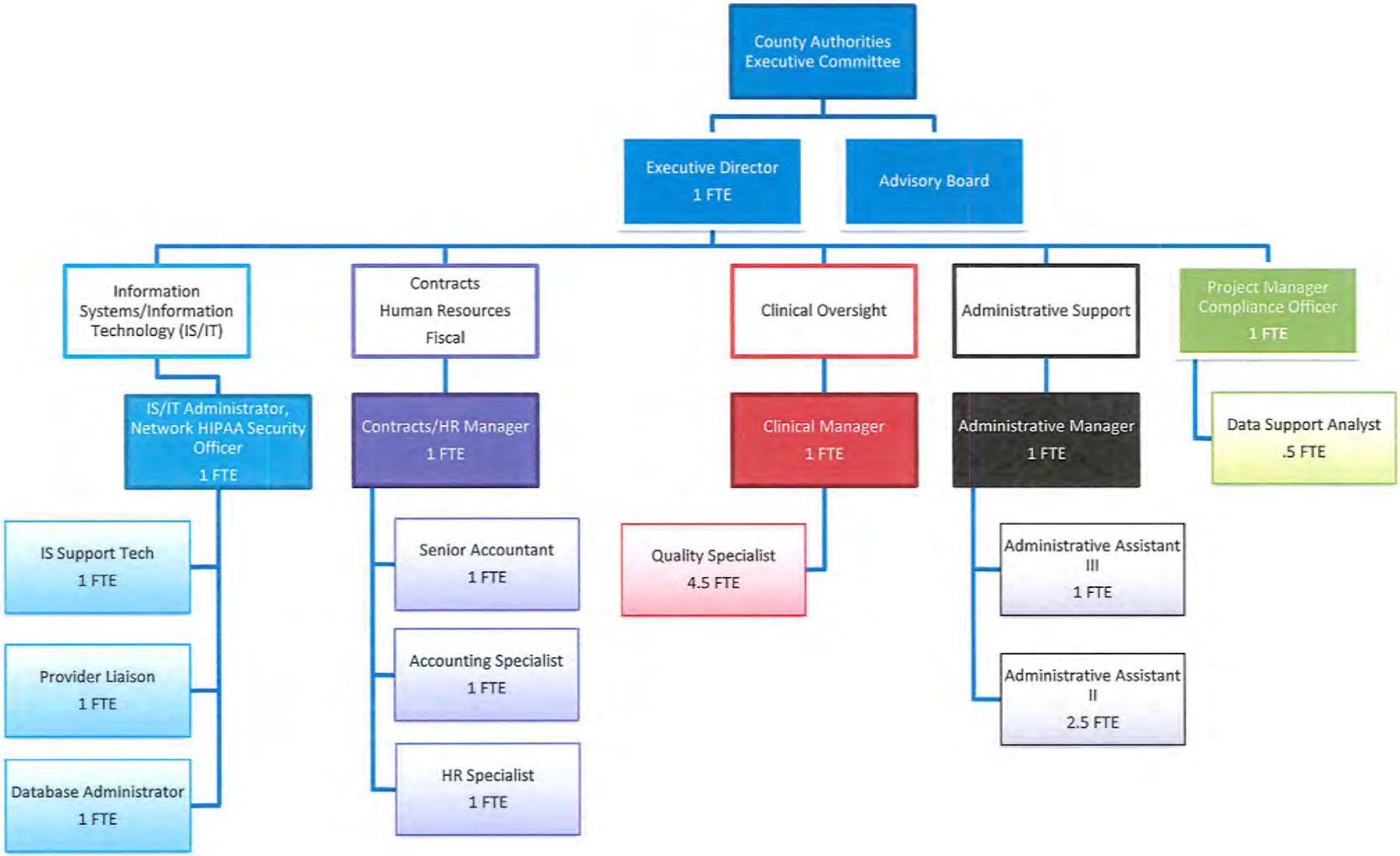
2016 ACTUAL	2017 ACTUAL	2018 BUDGET	2018 ACTUAL	2019 BUDGET	2020 ASO	2020 NORTH SOUND OPERATING BUDGET DETAILS
44,290	102,369					**MISCELLANEOUS**
						PRINTING & BINDING
						For printing of forms, reports, brochure, letterhead stationary, envelopes, business cards etc.
		3,000		3,000	1,200	Leadership
		4,000		4,000	1,500	NSBHO-ASO Brochures - Leadership
						DUES AND SUBSCRIPTIONS
						For cost of periodical and other professional journals, hosting web page.
		3,000		3,000	1,000	Leadership
		12,000		12,000	5,400	IS/IT
		2,100				System Operations
		1,000		1,000	500	Contracts HR
				1,500	500	Project Management
						REGISTRATION AND FEES
						To provide off site work related training
		20,000		20,000	5,000	WSAC dues - Leadership
		800		800	400	Leadership
		21,400		2,400	800	Contracts HR
		10,350				System Operations
		9,200		7,200	2,000	Administrative Support
				1,600	400	Project Management
		24,000		17,600	1,600	Clinical Oversight
		3,200		3,200	800	Fiscal Training
		69,600		6,400	2,000	IS/IT
		30,000		30,000	0	Leadership Training Contingency
44,290	**102,369**	**213,650**	**0**	**113,700**	**23,100**	**MISCELLANEOUS**
293,239						Redemption of Long-Term Debt
6,512						Interest on Debt Service
299,751	**0**	**0**	**0**	**0**	**0**	**REDEMPTION OF LONG TERM DEBT**
137,067	158,823	40,000		40,000	0	MACHINERY & EQUIPMENT IS/IT To purchase new Computers, software & equipment over $7,500. Contracts & Admin. Services Leadership
137,067	**158,823**	**40,000**	**0**	**40,000**	**0**	**MACHINERY & EQUIPMENT**
				100,000	124,508	**ADMINISTRATION RESERVE** This is a reserve set aside to plan for budget cuts and reduced revenue in 2019. Leadership
	0	**0**	**0**	**100,000**	**124,508**	**ADMINISTRATION RESERVE**
6,484,304	**7,616,692**	**7,585,008**	**0**	**7,027,621**	**3,538,493**	**NSBH-ASO BUDGET** Budget Limit Calculation: (*see revenue detail for explanation*) ASO budget $3,398,613 PDOA Grant budget $139,880 Total ASO Budget & PDOA Grant less $20,000 Ombuds budget $3,538,493
6,484,304	**7,616,692**	**7,585,008**	**0**	**7,027,621**	**3,538,493**	**TOTAL NSBH-ASO OPERATING BUDGET**
38,101	0	35,000		35,000		Tribal Conference Budget.
38,101	**0**	**35,000**	**0**	**35,000**	**0**	**Total Tribal Conference**
37,923	35,314	42,000		22,000	20,000	Advisory Board expenses; travel, training, conferences, supplies, etc.
37,923	**35,314**	**42,000**	**0**	**22,000**	**20,000**	**Total Advisory Board Expenditures**
15,436	0	0		0		Peer Support Network
15,436		**0**	**0**	**0**	**0**	**Total Peer Support Network**
247,726	322,640	450,000	450,001	250,000	0	Provider Training - Relias learning system, WISe and CANS, WRAP motivational interviewing, mental health first aid, peer counselor development, CD/Mental Health cross training, Illness Management Recovery training
247,726	**322,640**	**450,000**	**450,001**	**250,000**	**0**	**Total Provider Training Budget**
129,404,195	**145,956,640**	**148,663,288**	**148,663,289**	**116,092,835**	**19,258,417**	**Behavioral Health Services**
136,212,249	**153,931,286**	**156,775,296**	**149,113,290**	**123,427,456**	**22,816,910**	**Total NSBH-ASO Budget without Inpatient Expense**
13,623,795	**15,071,521**	**15,000,000**	**15,000,000**	**12,000,000**	**0**	Medicaid Inpatient Funding
	298,111	**2,500,000**	**2,500,000**	**1,500,000**	**0**	IMD Costs n/a medicaid
1,332,779	**1,170,931**	**1,500,000**	**1,500,000**	**2,000,000**	**906,376**	State Only Inpatient Funding
151,168,823	**170,471,849**	**175,775,296**	**168,113,290**	**138,927,456**	**23,723,286**	**TOTAL NSBH-AHO Budget**

C. NSBHO SALARY & BENEFITS WORKSHEET

2020 ANNUAL BUDGET

POSITION	initials	TEAM	FTE	RANGE	STEP	MONTHLY SALARY No. of Mths	Amount	Months x Amount	ANNUAL SALARY	BENEFITS Health, Life etc. Fixed Amount	PERS Retirement Salary x .1286	Social Security Salary x .0765	Unemployment Compensation $47300x .0049	Workers Compensation Hours x $.2679	TOTAL BENEFITS	TOTAL SALARY AND BENEFITS
Executive Director	JV	LT	1.00		N/A	12	$12,624.71	$151,496.52	$151,496.52	18,476.04	do not contribute	11,589.48	231.77	557.23	**30,854.53**	**182,351.05**
Quality Specialist # 1	VJ	CL	1.00	35	E	12	$6,643.78	$79,725.36	$79,725.36	18,476.04	10,252.68	6,098.99	231.77	557.23	**35,616.71**	**115,342.07**
Quality Specialist # 2	AFP	CL	1.00	35	E	12	$6,643.78	$79,725.36	$79,725.36	18,476.04	10,252.68	6,098.99	231.77	557.23	**35,616.71**	**115,342.07**
Quality Specialist # 3	JD	CL	1.00	35	C	4	$6,026.11	$24,104.44								
					D	8	$6,327.41	$50,619.28	$74,723.72	16,189.67	9,609.47	5,716.36	231.77	557.23	**32,304.50**	**107,028.22**
Quality Specialist # 4 Grant	LC	CL	0.80	35	D	5	$5,061.93	$25,309.64								
					E	7	$5,315.02	$37,205.17	$62,514.81		8,039.40	4,782.38	231.77	445.79	**13,499.34**	**76,014.15**
Quality Specialist # 4 ASO	LC	CL	0.20	35	D	5	$1,265.48	$6,327.41								
					E	7	$1,328.76	$9,301.29	$15,628.70	16,189.67	2,009.85	1,195.60		111.45	**19,506.56**	**35,135.26**
Quality Specialist Manager - WSH	SM	CL	0.50	37	E	12	$3,910.51	$46,926.12	$46,926.12	16,189.67	6,034.70	3,589.85	229.94	278.62	**26,322.77**	**73,248.89**
Quality Manager	MM	CL	1.00	37	A	6	$6,430.55	$38,583.30								
					B	6	$6,591.31	$39,547.86	$78,131.16	16,189.67	10,047.67	5,977.03	231.77	557.23	**33,003.37**	**111,134.53**
Contracts Manager	MR	HR/C	1.00	38	E	12	$8,524.84	$102,298.08	$102,298.08	16,189.67	13,155.53	7,825.80	231.77	557.23	**37,960.01**	**140,258.09**
HR Specialist	MI	HR/C	1.00	33	E	12	$5,695.89	$68,350.68	$68,350.68	16,189.67	8,789.90	5,228.83	231.77	557.23	**30,997.39**	**99,348.07**
Administrative Manager	JW	Admin	1.00	34	E	12	$6,151.57	$73,818.84	$73,818.84	16,189.67	9,493.10	5,647.14	231.77	557.23	**32,118.91**	**105,937.75**
Administrative Assistant III	LH	Admin	1.00	32	E	12	$5,273.94	$63,287.28	$63,287.28	16,189.67	8,138.74	4,841.48	231.77	557.23	**29,958.89**	**93,246.17**
Administrative Assistant II	MA	Admin	1.00	31	D	11	$4,650.76	$51,158.36		16,189.67						
				31	E	1	$4,883.30	$4,883.30	$56,041.66	16,189.67	7,206.96	4,287.19	231.77	557.23	**28,472.81**	**84,514.47**
Administrative Assistant II	DM	Admin	1.00	31	B	8	$4,555.83	$36,446.64								
				31	C	4	$4,783.62	$19,134.48	$55,581.12	16,189.67	7,147.73	4,251.96	231.77	557.23	**28,378.36**	**83,959.48**
Admimistrative Assistant II	CR	Admin	0.50	31	D	8	$2,325.38	$18,603.04								
					E	4	$2,441.65	$9,766.60	$28,369.64	16,189.67	3,648.34	2,170.28	139.01	278.62	**22,425.91**	**50,795.55**
Project Management/Compliance	CD	PM	1.00	37	E	12	$7,821.02	$93,852.24	$93,852.24	16,189.67	12,069.40	7,179.70	231.77	557.23	**36,227.76**	**130,080.00**
Data Support Analyst	DR	PM	0.50	35	E	12	$3,321.89	$39,862.68	$39,862.68	16,189.67	5,126.34	3,049.50	195.33	278.62	**24,839.45**	**64,702.13**
IS Administrator /Network Security	DM	IS/IT	1.00	38	B	3	$7,364.08	$22,092.24								
					C	9	$7,732.28	$69,590.52	$91,682.76	16,189.67	11,790.40	7,013.73	231.77	557.23	**35,782.80**	**127,465.56**
IS Support Technician #2	PH	IS/IT	1.00	35	D	6	$6,327.41	$37,964.46								
					E	6	$6,643.78	$39,862.68	$77,827.14	16,189.67	10,008.57	5,953.78	231.77	557.23	**32,941.02**	**110,768.16**
Programmer/Developer Analyst	TS	IS/IT	0.00	37	E	0					0.00	0.00	0.00		**0.00**	**0.00**
Database Administrator	EW	IS/IT	1.00	37	E	12	$7,821.02	$93,852.24	$93,852.24	18,476.04	12,069.40	7,179.70	231.77	557.23	**38,514.14**	**132,366.38**
Provider Support IT	JW	IS/IT	1.00	35	E	12	$6,643.78	$79,725.36	$79,725.36	16,189.67	10,252.68	6,098.99	231.77	557.23	**33,330.34**	**113,055.70**
Accounting Specialist	SD	Fiscal	1.00	33	E	12	$5,695.89	$68,350.68	$68,350.68	18,476.04	8,789.90	5,228.83	231.77	557.23	**33,283.77**	**101,634.45**
Fiscal Officer	DH	Fiscal	1.00	37	D	3	$7,748.59	$23,245.77								
				37	E	9	$7,821.02	$70,389.18	$93,634.95	16,189.67	12,041.45	7,163.07	231.77	557.23	**36,183.20**	**129,818.15**
HRA Deductables										205,000.00					**205,000.00**	**205,000.00**
									$1,675,407.10	$383,794.22	$195,974.90	$128,168.64	$4,967.91	$11,423.26	$708,139.26	$2,383,546.36
								COLA	$28,481.92		$3,331.57	$2,178.87	$84.45	$194.20	**34,271.01**	$34,271.01
TOTAL			20.50					**$ 1,675,407**	**$1,703,889.02**	**$588,794.22**	**$199,306.47**	**$130,347.51**	**$5,052.36**	**$11,617.45**	**$742,410.27**	**$2,622,817.37**

North Sound Behavioral Health Administrative Services Organization Org Chart



Revised: October 2019

2019 Pre-Meetings, Site Visits, Conferences and Legislative Visits

Date	Pre-Meeting Topics	Note
January	HCA - Accountability Standards	Alice Lind & Jessica Diaz
February	Cancelled	
March	ACH - Accountability Standards	Liz Baxter
April	Washington State Mental Health System Reform	Joe Valentine
May	Skagit Jail Transition Team	Carol Totten
June	Early Warning Signs	Joe Valentine & Dennis Regean
July	*Retreat/No Pre-Meeting*	
August	Opioid Outreach Program - Island County Human Serv. Sheriff's Office and Public Health	
September	BH ASO Crisis System Update	Michael McAuley
October	Skagit County Opioid Outreach Program/CANCELLED	Patti Banister
November	Carnegie Resource Center	Jennifer and Cammy
December	Holiday Potluck - No Pre Meeting	
	HARPS	
	Dedicated Marijuana Account	
	PPW - Evergreen Recovery	
	Opioid Outreach Programs - Skagit, Whatcom, Snohomish, San Juan	

Date	Site Visits	Note
April 16, 2019	Iron Gate - Bellingham	Completed
March 19 and 26	Diversion Program - Snohomish County	Completed

Date	Advocacy	Note
Jan. 31 - Feb. 1st.	5 scheduled completed appointments	

Date	Conferences	Location
June13-14	Behavioral Health Conference	Vancouver
October 4-5	NAMI Conference - The Road to Recovery: Mental Health Matters	Yakima
April 3 - 4	Tribal Conference	Tulalip Conference Center
October 7-8	Co-Occurring Disorders Conference	Yakima

INSIDE

Trends since February, 2019

Facts about our clients

Community Action of Skagit County

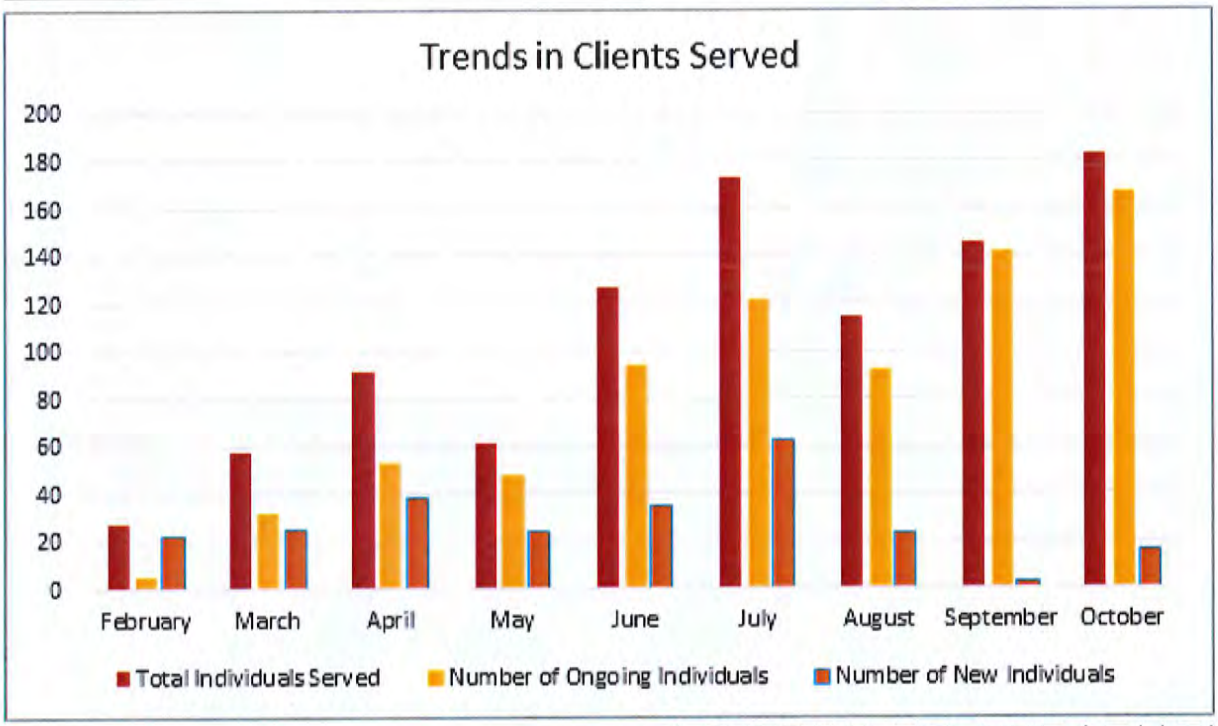
NOVEMBER 2019

OPIOID STREET OUTREACH

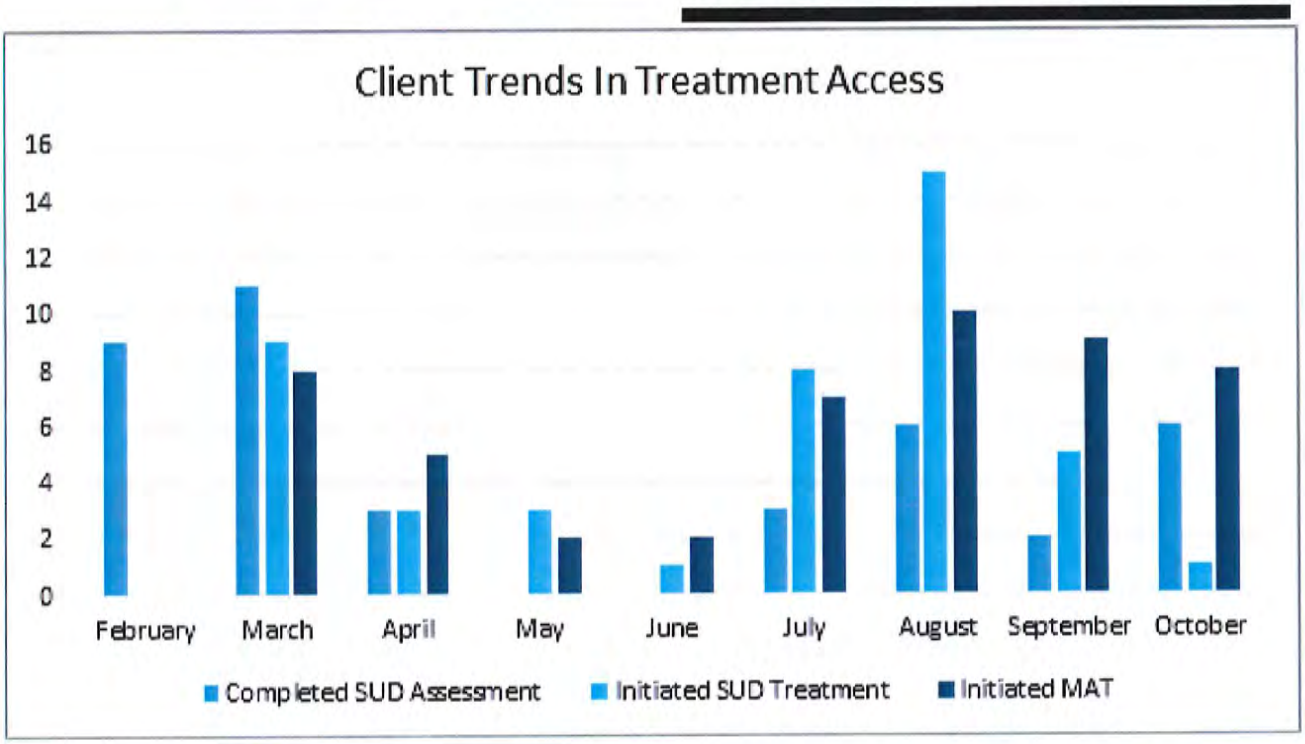
PREPARED BY: PATTI BANNISTER

TRENDS SINCE FEBRUARY 2019

CLIENTS SERVED THROUGH TOUCHES



ACCESS TO TREATMENT



FACTS ABOUT SKAGIT COUNTY'S HOMELESS POPULATION WITH OUD

Among the clients that we have encountered, trust is the thing that is most valued within their community and their interactions with the street outreach team. This program is run on the Recovery Coach Model, ensuring that the volunteers meet the clients where they are at in their recovery journey.

Most of the clients we serve are between the ages of **18 and 67 years old** and have been living on the streets for an average of **three** years. **Over half** of these individuals have suffered an overdose.

ADDITIONAL FACTS (HEALTH, ACCESSIBILITY, ETC.)

- **100%** use drugs intravenously
- **94%** have developed abscess as a result of IV use
- Access a shower about **every two weeks**
- Only **1%** have Identification
- **2%** own a working phone
- **None** have proper cold weather gear
- Infected teeth are common at about **98%**
- **All would like to quit with some additional support**
- **98%** of individuals have lost contact with their families
- When admitted to the hospital, **only 3%** of OUD Homeless Individuals stay the duration of their treatment

Methamphetamine Trends in WA State and the North Sound Region

Susan Kingston
University of WA
Alcohol and Drug Abuse Institute

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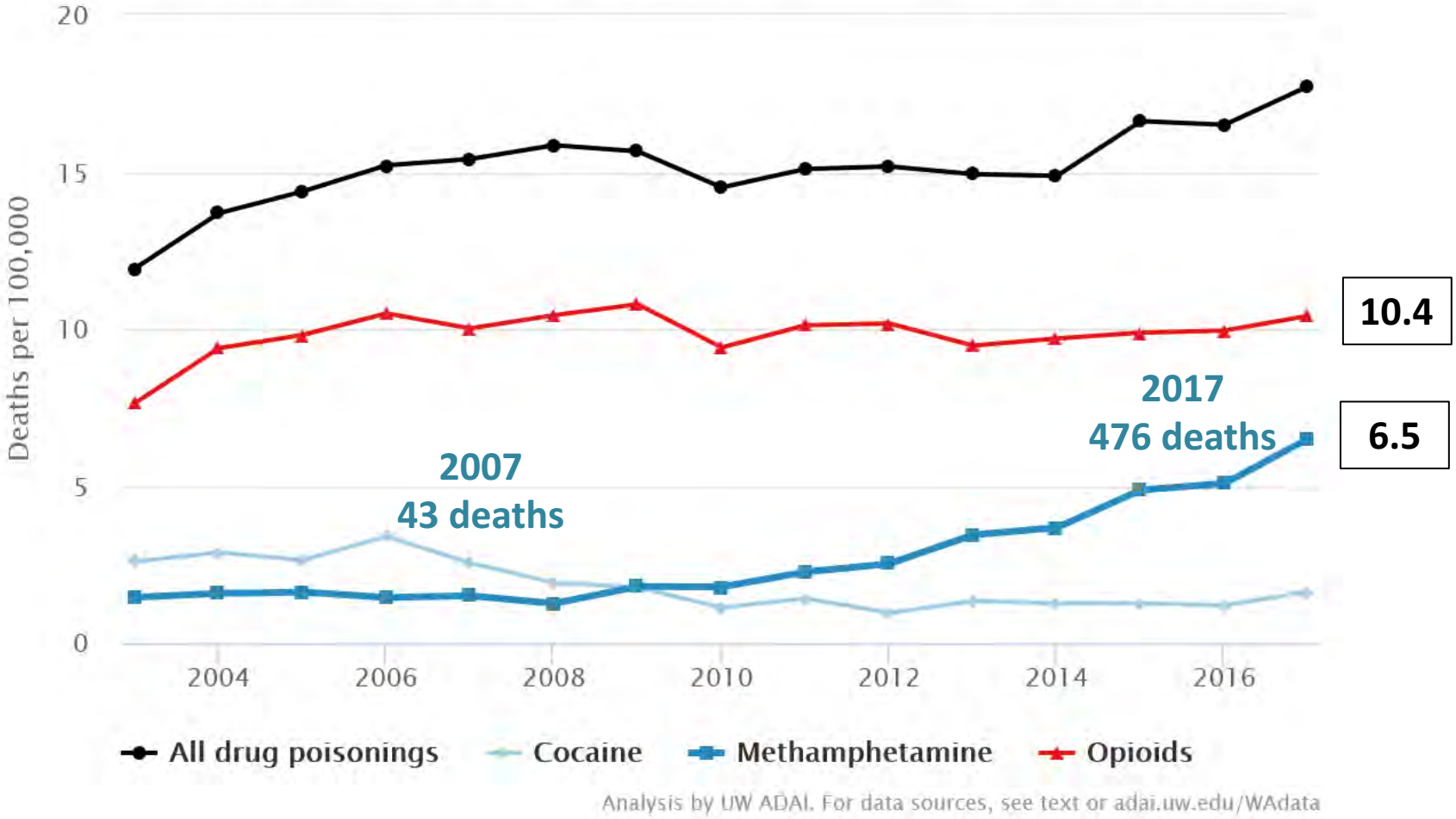
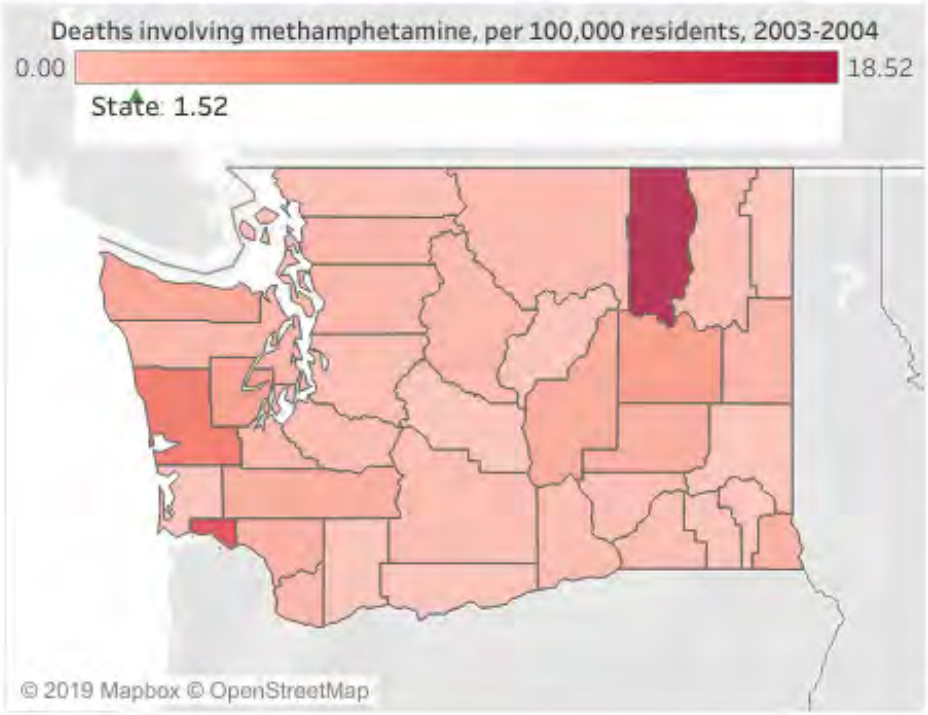
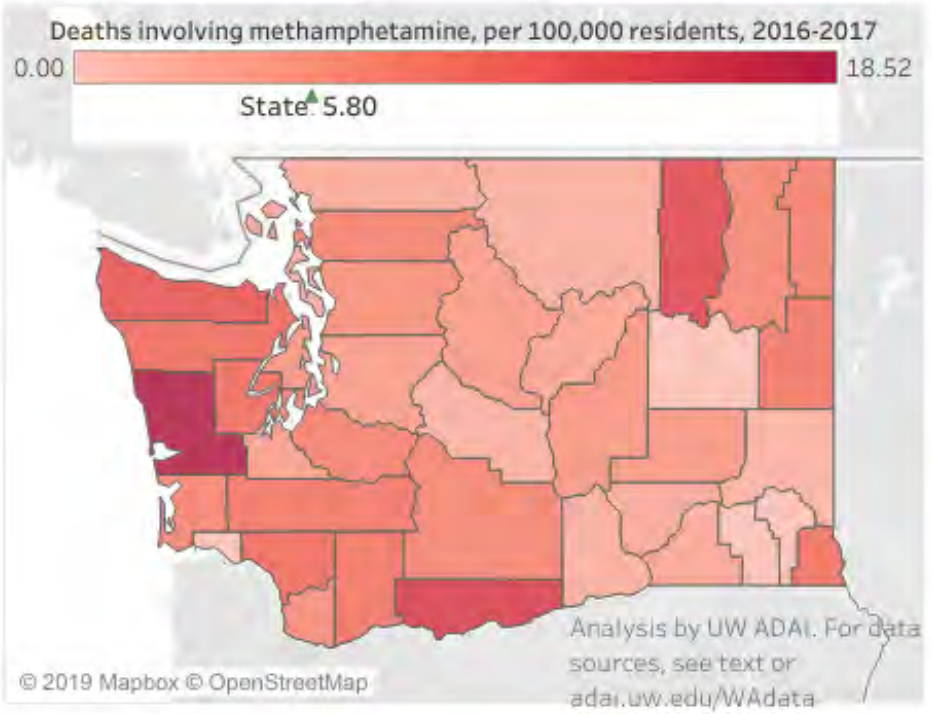
Drug-caused death rates/100,000 residents, WA State



Meth death rates/100,000 residents, WA State

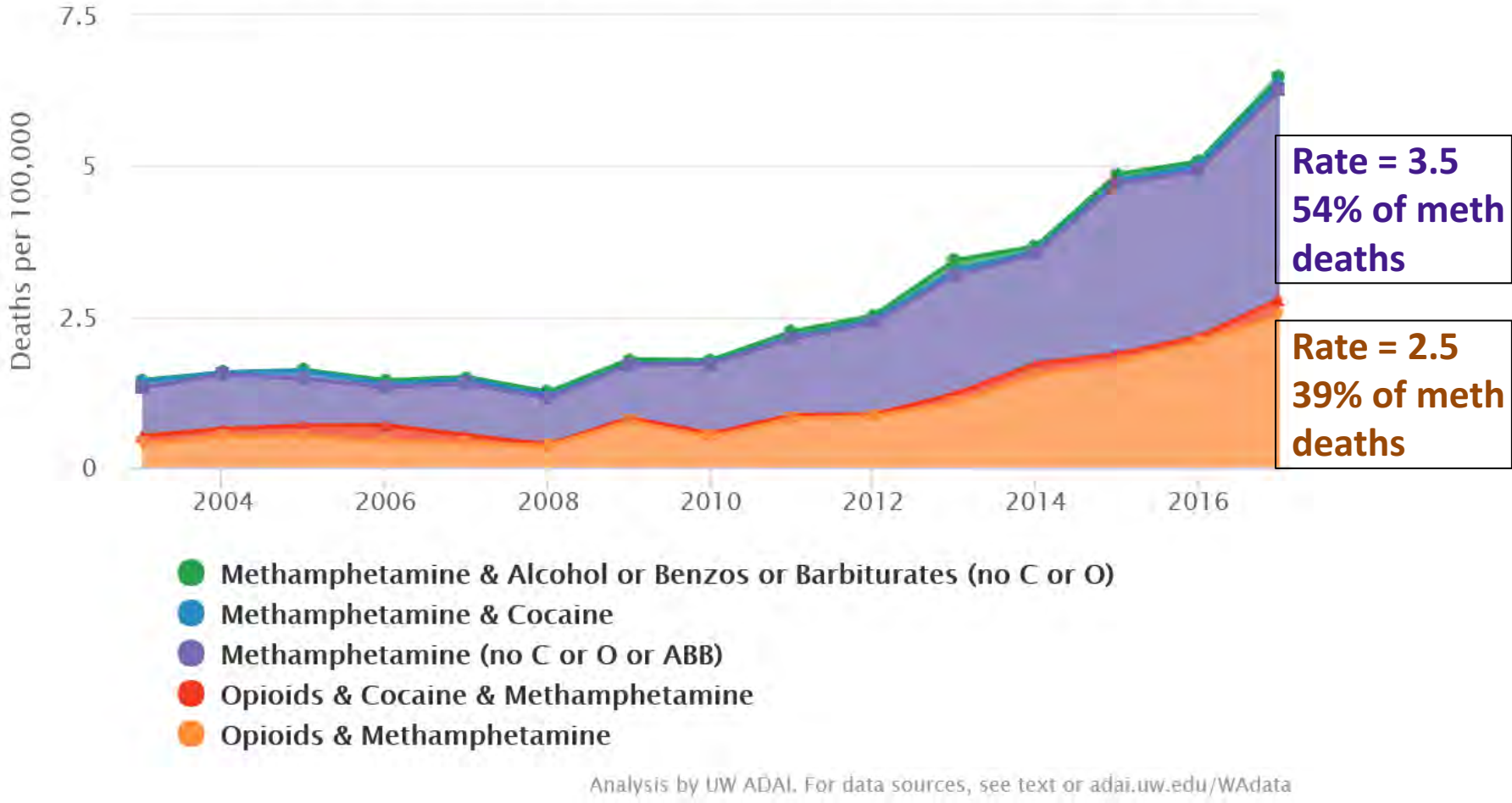


2003 - 2004



2016 - 2017

Death rates from meth+other drugs, WA State



Meth death rate, North Sound ACH

NR* = Not Reliable due to RSE.>25. For definitions of the drug type, please see the Technical Notes on the landing page: https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidDashboards

Red = North Sound **Gray** = WA State

Preliminary data from the 2019 WA State Syringe Exchange Health Survey

Whatcom, Island, Skagit, Snohomish
n=161 surveys

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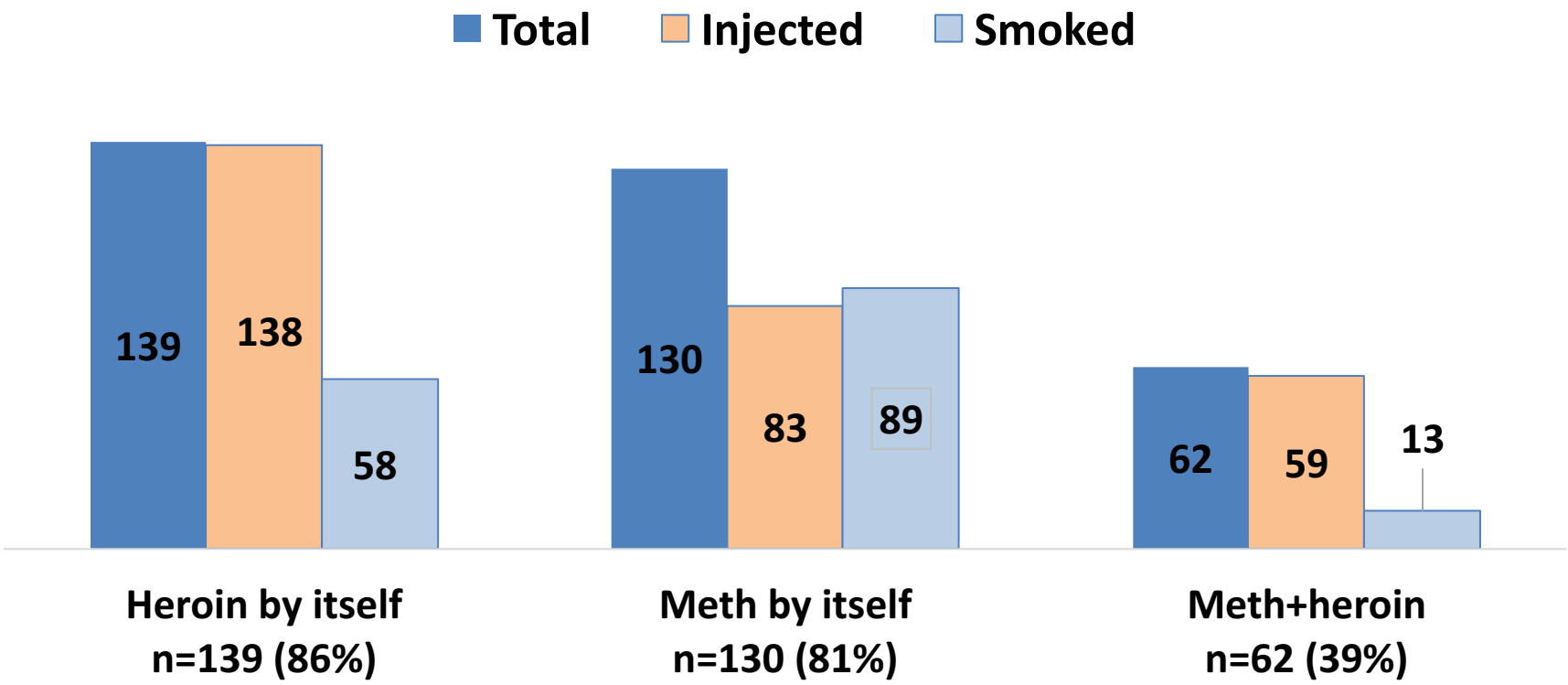
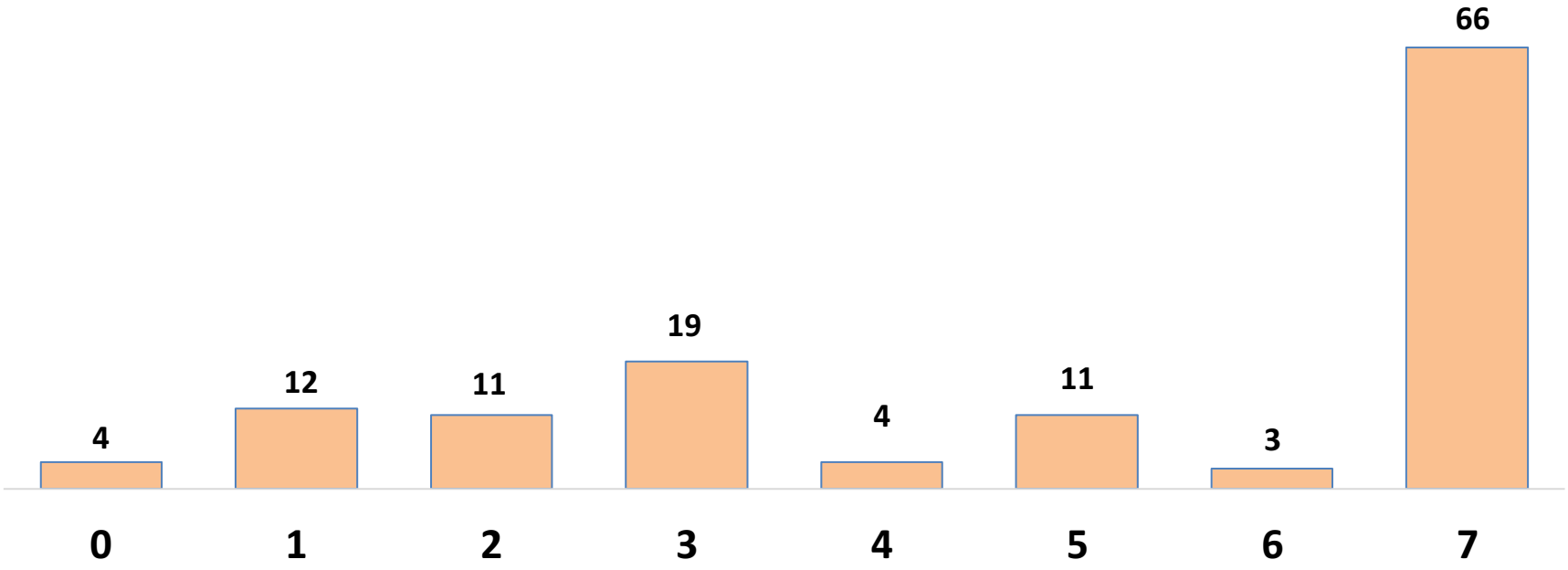
Drug use last 3 months and route of administration, North Sound

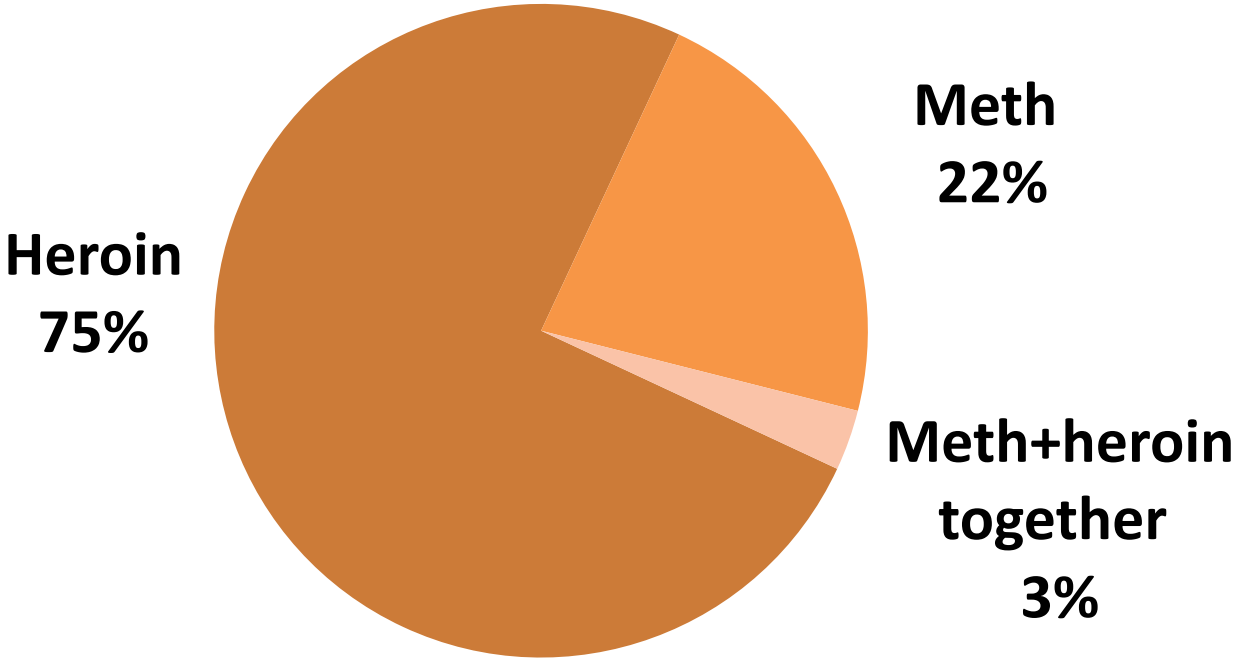


Meth use, last 7 days, North Sound

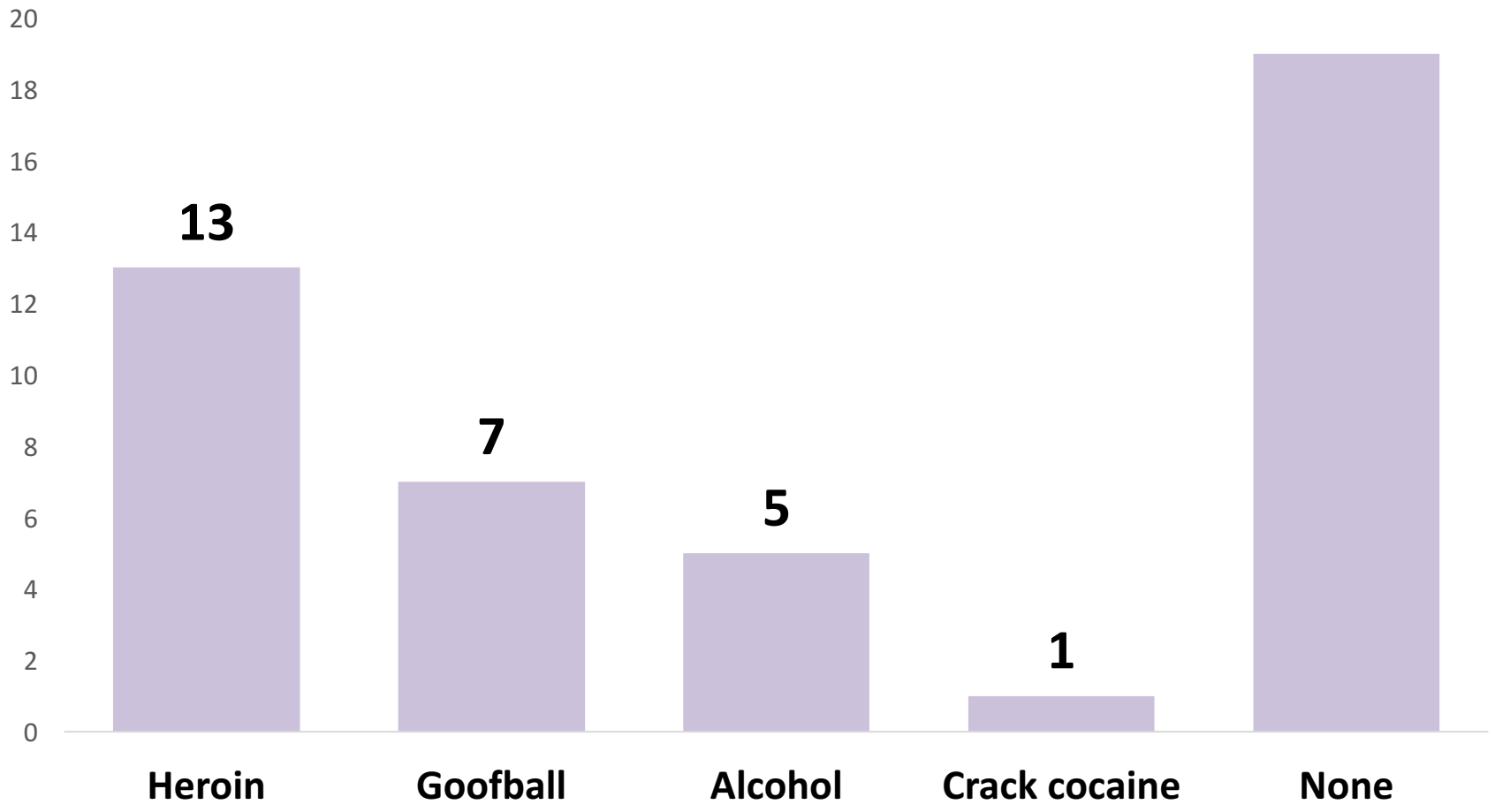


days used meth by itself in the last 7 days

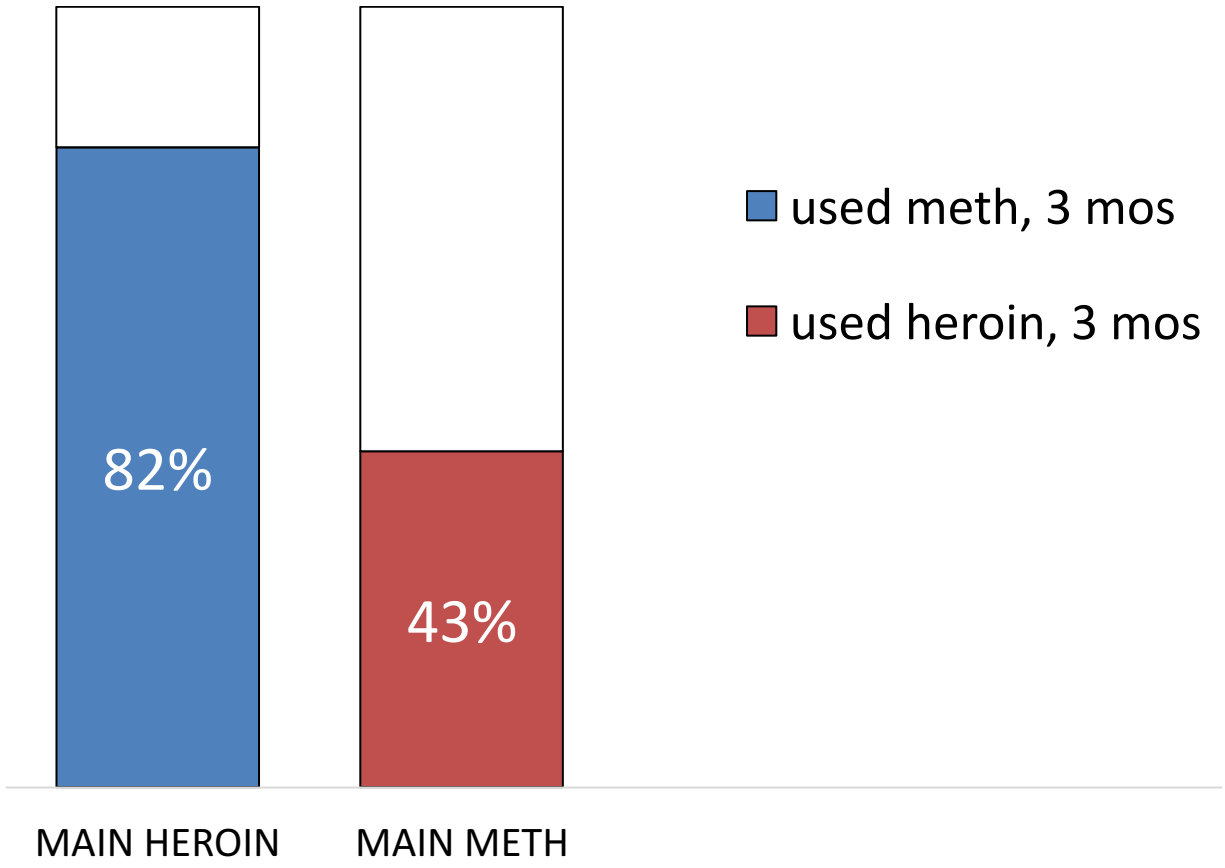
Primary drug



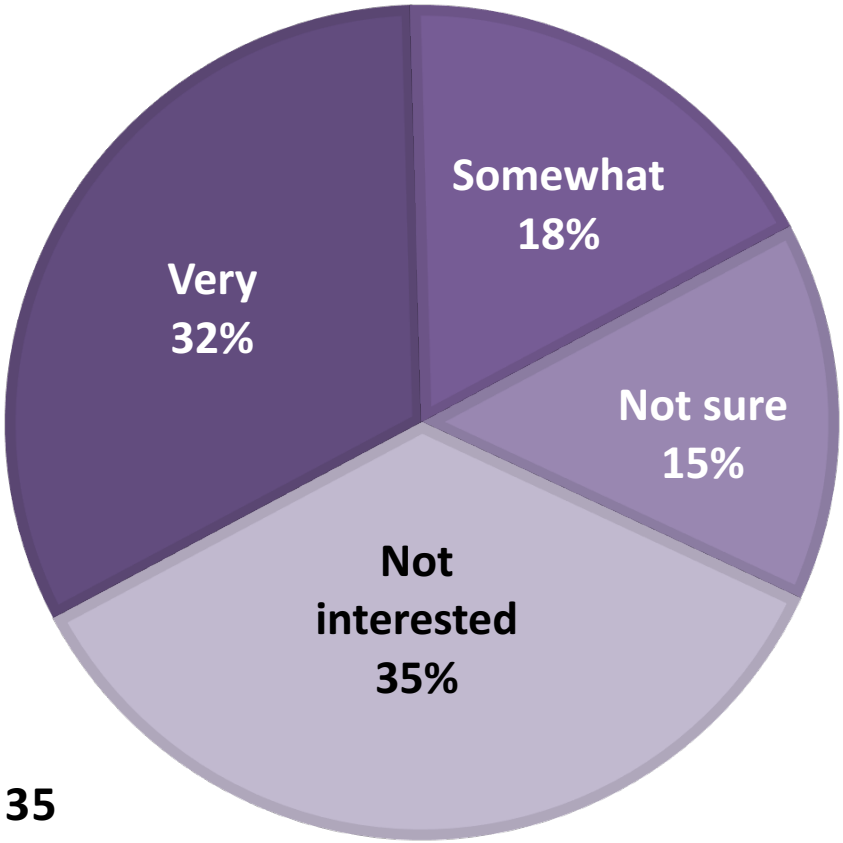
Meth is main drug, other substances used in last 3 months, n=35



Comparing meth and heroin use



Meth is main drug, interest in reducing or stopping stimulant use



N= 35

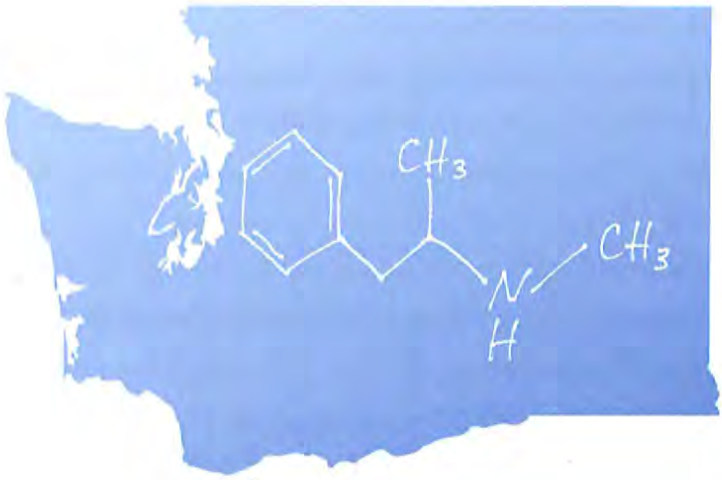
Type of help wanted, n=22	
1-1 counseling	7
Medication that may reduce stimulant use	7
Mental health medication	6
Someone to help navigate services	5
Outpatient treatment	3
Inpatient treatment	2
Detox	2
Don’t want help	2

Discussion

Methamphetamine in Washington

Report to the Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services

June 2018



Susan A. Stoner, PhD, Jason R. Williams, PhD, Alison Newman, MPH, Nancy Sutherland, MLS, Caleb Banta-Green, MSW, MPH, PhD

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Appendices

1. Key Findings

- Methamphetamine-involved deaths increased in Washington State from 2008 to 2016; in that time span, deaths quadrupled from 1.3 per 100,000 residents to 5.1 per 100,000.
- Death rates vary across Washington counties, and by race/ethnicity, with Whites making up the majority of deaths.
- Native Americans are over-represented among methamphetamine-related deaths and treatment admissions.
- People who use methamphetamine often have social, cultural, and functional reasons for their use, and interventions to reduce use should address these factors.
- There is no clearly effective medication to treat methamphetamine use disorders.
- Evidence-based treatments for methamphetamine use disorder include contingency management, the Matrix Model, other forms of cognitive behavioral therapy, motivational interviewing, mindfulness-based approaches, and exercise.
- Harm reduction strategies present important alternatives to those uninterested in abstinence.

Citation: Stoner SA, Williams JR, Newman A, Sutherland NL, Banta-Green CJ. Methamphetamine in Washington: Report to the Division of Behavioral Health and Recovery. Seattle: Alcohol & Drug Abuse Institute, University of Washington, June 2018.
URL: http://adai.uw.edu/pubs/pdf/2018MethamphetamineInWashington.pdf

This report was produced with support from the Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services.

2. Introduction to the Report

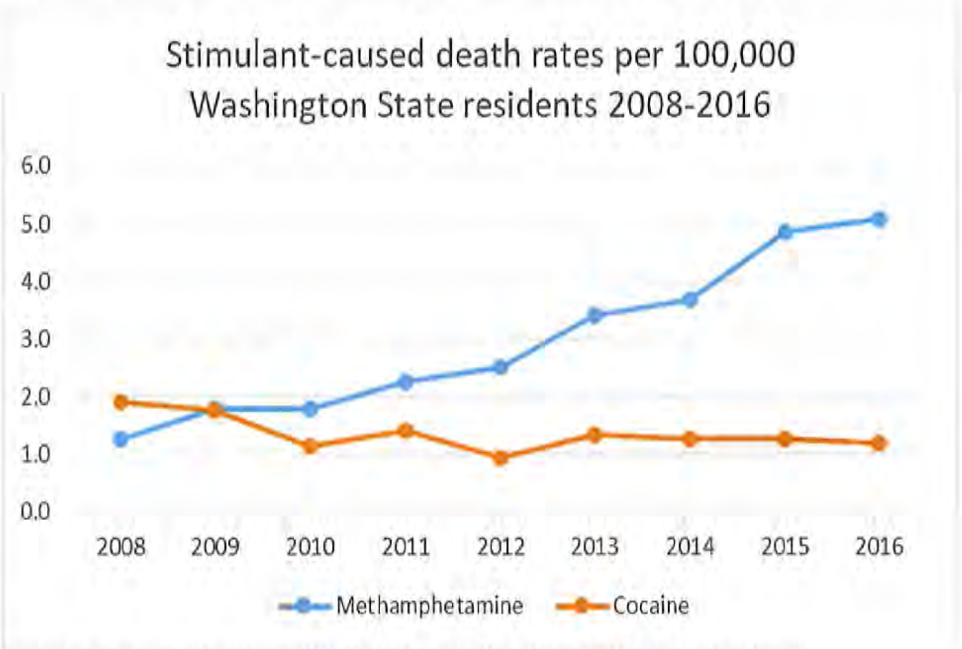
Methamphetamine use is a significant and increasing problem in Washington State. This report presents the scope of methamphetamine use; reviews harms associated with use; describes characteristics of users, their treatment utilization and needs; and reviews current approaches for treating methamphetamine use disorder. Finally, we note key issues to consider when developing strategies aimed at reducing the use of and harms associated with methamphetamine use in Washington.

The authors would like to acknowledge the contributions of the Treatment Research Subcommittee, which met on March 15, 2018 to discuss issues around methamphetamine use. Their insights helped to inform the development of this report and are presented in the Appendices.

3. Scope of Methamphetamine Use in Washington

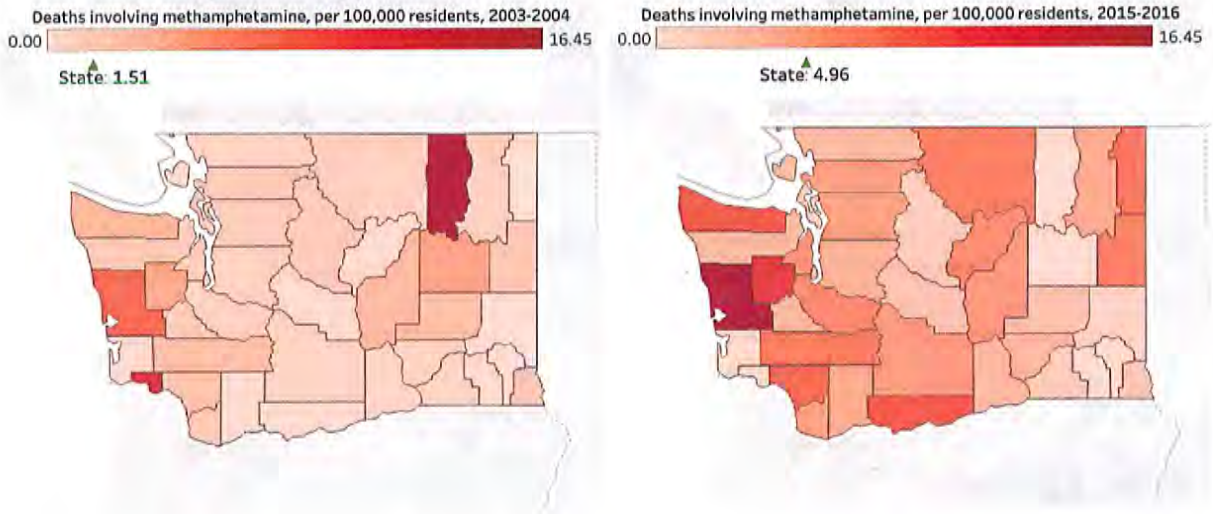
Methamphetamine Related Deaths

In Washington, deaths associated with methamphetamine increased over the last decade; from 2008 to 2016, the number of deaths per year attributed to methamphetamine poisoning increased from 83 to 364 (1.3 to 5.1 per 100,000). During the same time frame, rates of deaths attributed to cocaine poisoning remained relatively stable, and the gap between deaths due to cocaine vs. methamphetamine poisoning increased since 2009.



Sources: Washington State Department of Health (deaths), state Office of Financial Management (population)

The maps below show the rate of methamphetamine involved overdose deaths for each county in Washington State (see interactive maps at http://adai.washington.edu/WAdata. The data indicate both highly variable rates between counties as well as different rates of change of methamphetamine overdose deaths over time. For example, Spokane County has twice the rate of methamphetamine-involved overdose deaths as King County. In Spokane County methamphetamine deaths greatly exceed heroin deaths, while the inverse is true in King County.



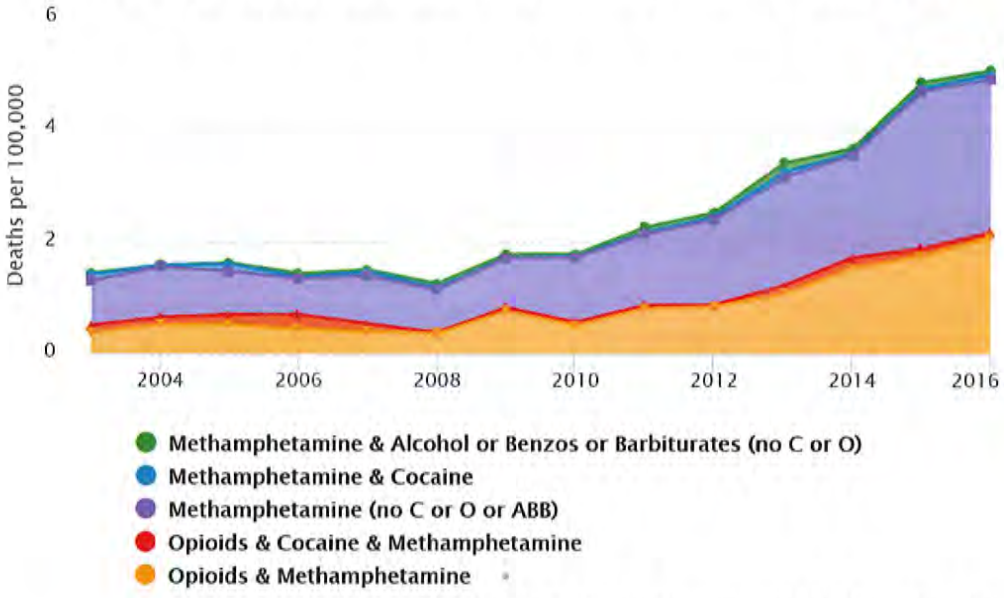
Race and Ethnicity of Individuals Who Died from Methamphetamine

The large majority of methamphetamine deaths were among white people, although the number of non-white individuals dying from methamphetamine increased between 2003 and 2016. The average age ranged from 39.5-46 years old, and the percent of deaths among women made up 25.8%-34.9% of deaths. Native Americans were over-represented among methamphetamine deaths; they make up 1.9% of the population of Washington State but were between 3.6%-7.2% of deaths from 2003-2016. More detailed demographics can be found at http://adai.uw.edu/wadata/methamphetamine.htm.

Other Drugs Co-ingested with Methamphetamine in Overdose Deaths

The presence of co-ingestants in methamphetamine-involved overdose deaths is detailed below. The graph indicates that even as the rate of methamphetamine involved overdose deaths increased dramatically from 2003 to 2016, the pattern of co-ingestants did not change. Specifically, a slight majority of deaths involving methamphetamine do not include other major drugs such as alcohol, cocaine, heroin, benzodiazepines or barbiturates. A consistent substantial minority of deaths involve methamphetamine and an opioid.

Death rates per 100,000 state residents, methamphetamine deaths detail

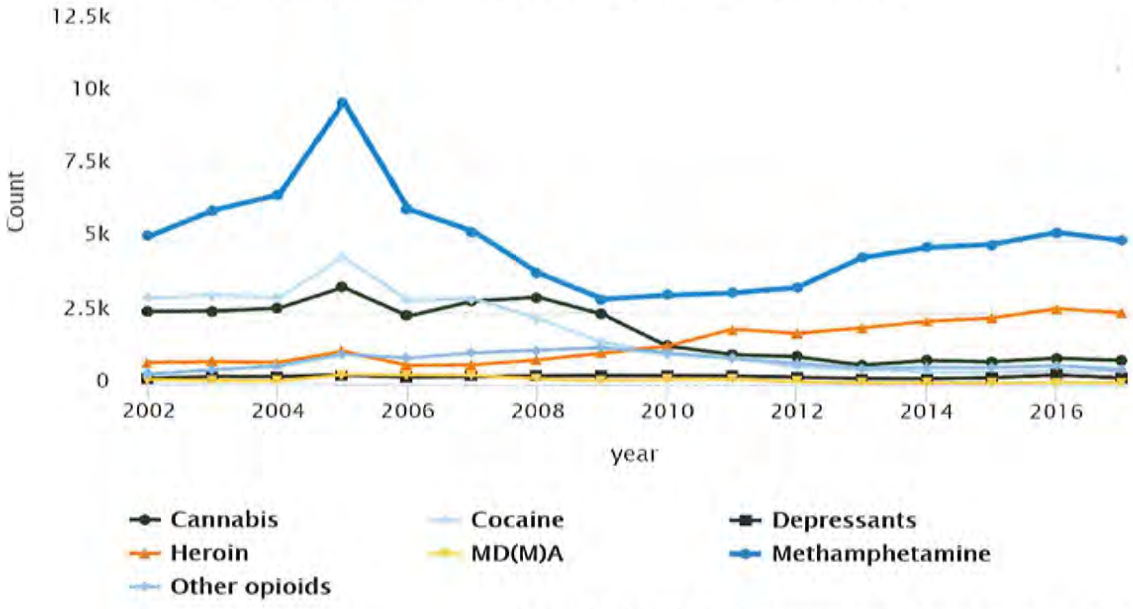


Analysis by UW ADAI. For data sources, see text or adai.uw.edu/WAdata

Crime Lab Cases

Methamphetamine in police evidence testing peaked in 2005 with 9,677 cases, declined for several years, and in 2017 totaled 4,964. Throughout the entire period of observation, methamphetamine was consistently the most common drug detected in police evidence.

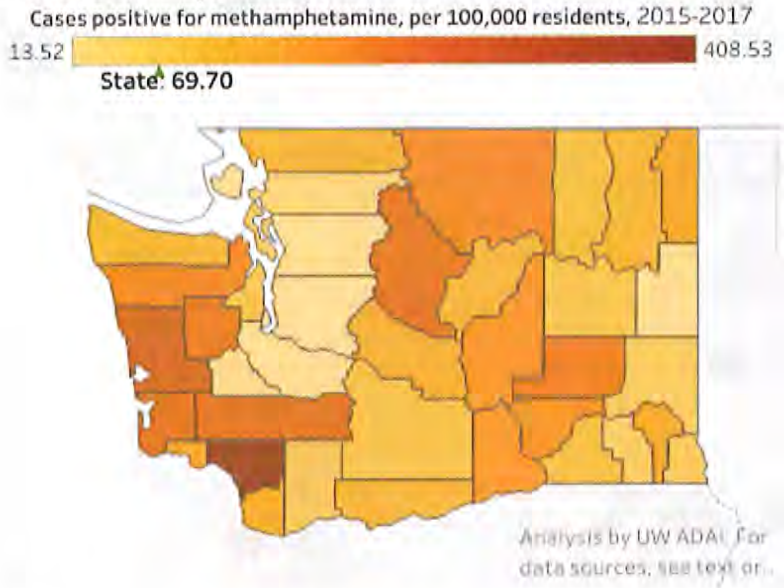
Counts of crime lab cases by drug result, statewide



Analysis by UW ADAI. For data sources, see text or adai.uw.edu/WAdata

In Washington, crime lab cases positive for methamphetamine varied across counties, with rural parts of the state seeing more positive cases. Cowlitz County had the highest rate of positive crime lab cases with 408.5 per 100,000 residents, compared with the statewide average of 69.7, rates are impacted.

Crime lab cases positive for methamphetamine by county, 2015-2017



Law Enforcement Perception of Drug "Threats" – Data from the DEA

As shown in Table 1, results of a 2017 survey of law enforcement agencies in the DEA Seattle Field Division[1], indicated that methamphetamine was perceived as highly available by 79% of respondents. It was identified as the greatest drug threat by 40%, the drug that most contributes to property crime by 54%, and the drug that takes up most law enforcement resources by 49%.

Table 1. Percentage of 2017 National Drug Threat Survey Respondents in the Seattle Field Division* Identifying Particular Concerns, by Drug.

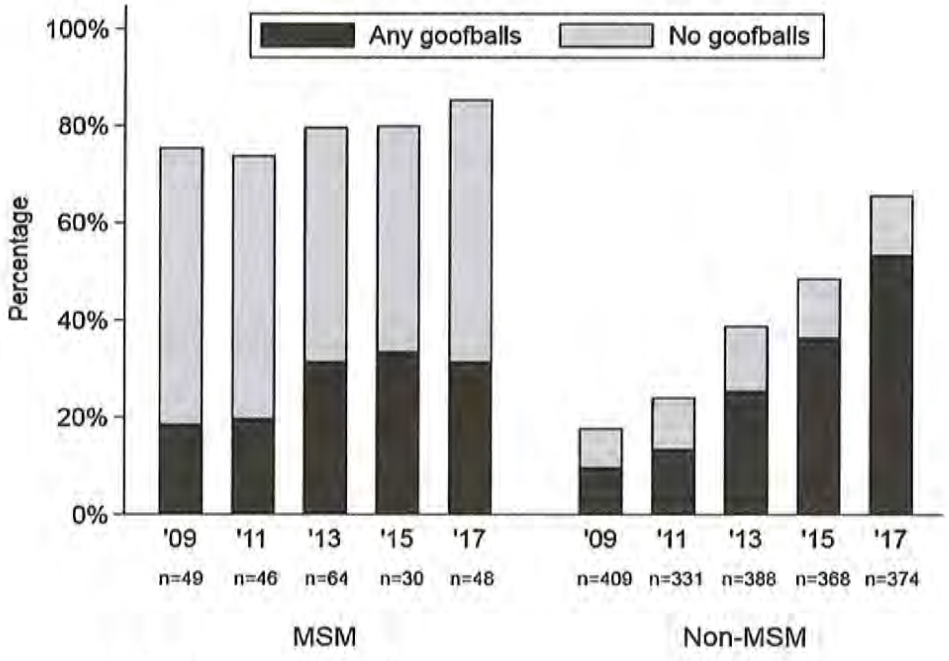
	Heroin	MA	CPDs	Fentanyl	MJ	Cocaine	NPS
High availability	68%	79%	47%	5%	90%	9%	6%
Greatest drug threat	46%	40%	4%	3%	6%	1%	0%
Most contributes to property crime	35%	54%	4%	5%	0%	1%	0%
Most contributes to violent crime	71%	14%	2%	5%	1%	1%	1%
Takes up most law enforcement resources	37%	49%	7%	5%	1%	1%	0%

*Seattle Field Division covers the states of Washington, Oregon, and Idaho.
MA, methamphetamine; CPDs, controlled prescription drugs; MJ, marijuana; NPS, new psychoactive substances.

Methamphetamine Use and Transmission of HIV in MSM and non-MSM

Glick et al.[2] examined methamphetamine injection rates and behaviors among men who have sex with men (MSM) and non-MSM using data from two serial cross-sectional surveys of people who inject drugs (PWID), including five biannual surveys of Public Health–Seattle and King County Needle and Syringe Exchange Program (NSEP) clients and three National HIV Behavioral Surveillance IDU (NHBS-IDU) surveys.

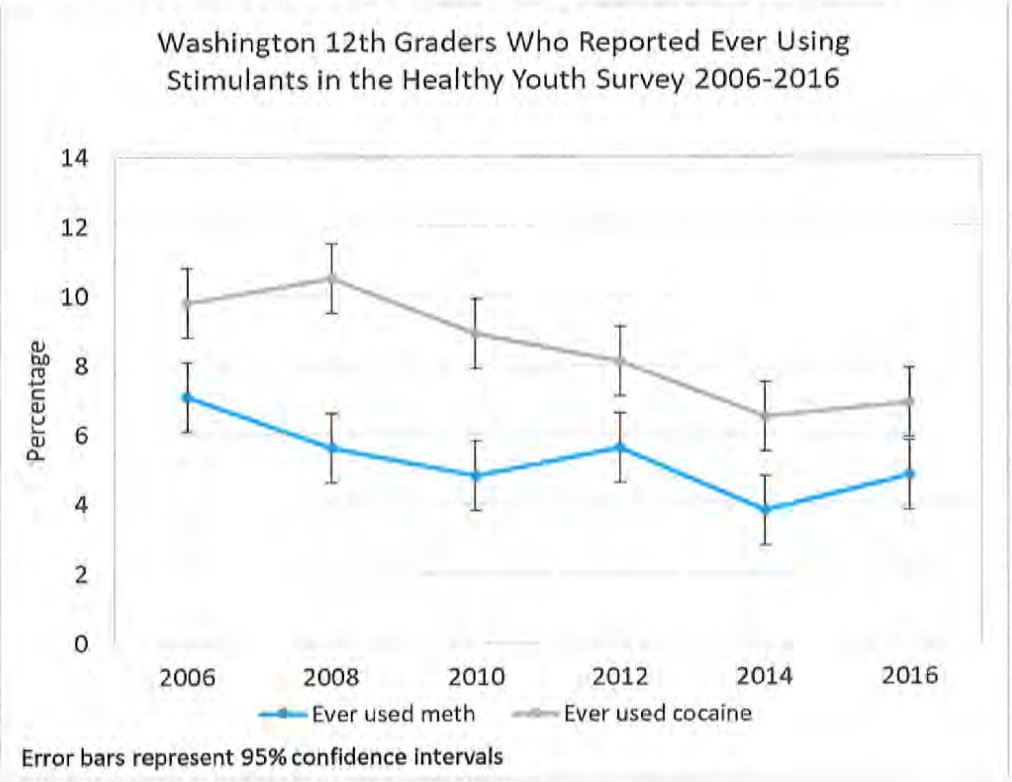
Approximately 16% of all men reported sex with a man in the past year. Homelessness and unstable housing were very common in both samples (49-59%). More than two thirds (68-74%) of participants reported injecting drugs at least once a day. Among those who reported any opioid use, 16-19% reported an overdose in the past year. Methamphetamine injection was consistently higher among MSM than among non-MSM with 85-88% of MSM reporting methamphetamine injection in the most recent surveys. Neither the NSEP nor the NHBS-IDU showed evidence of a significant increase in methamphetamine injection among MSM PWID since 2009. However, the proportion of non-MSM PWID who reported recent (past 3 months) methamphetamine injection increased substantially between 2009 and 2017 from 18-23% to 62-66%. Data from the NSEP suggested that most of the increase was attributable to an increase in injecting a combination of methamphetamine and heroin, known as a "goofball." While sharing syringes was less common (27-39%), sharing any injection equipment was relatively common (53-69%).



Source: NSEP data reported in Glick et al., 2018.

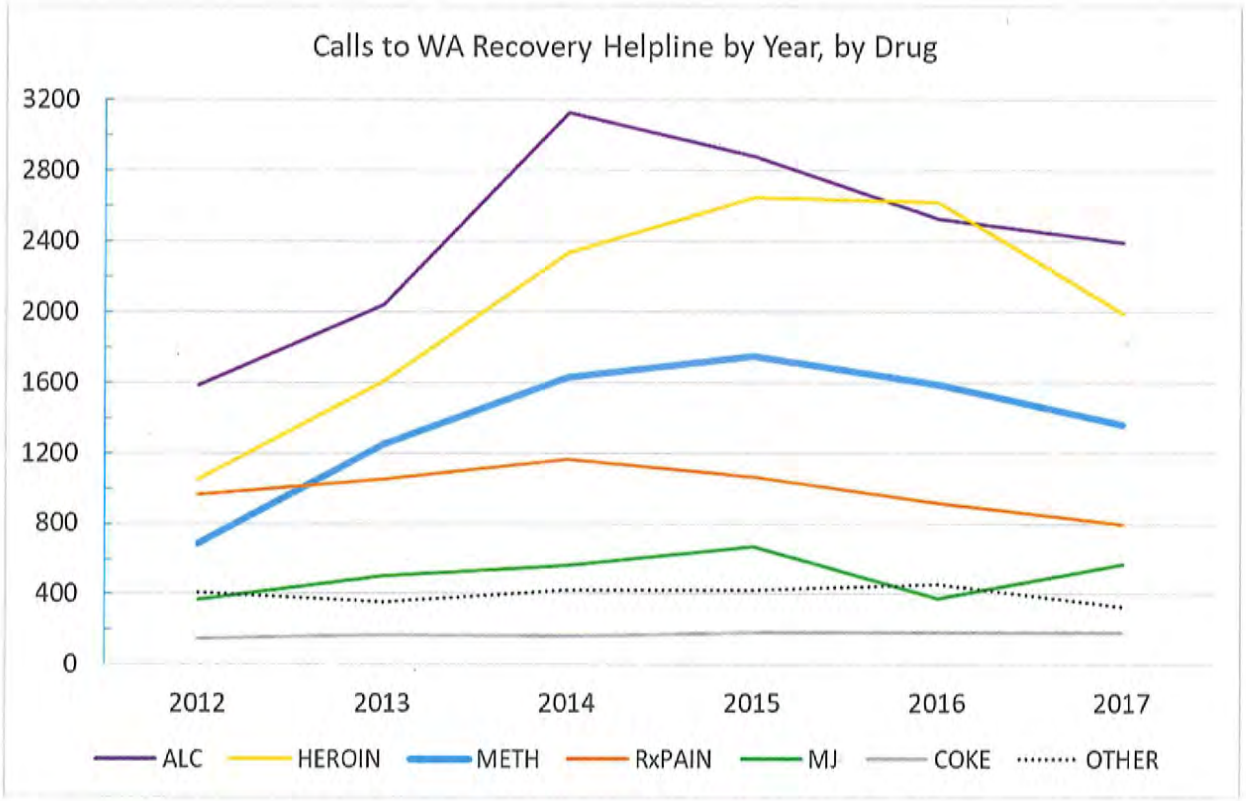
Healthy Youth Survey

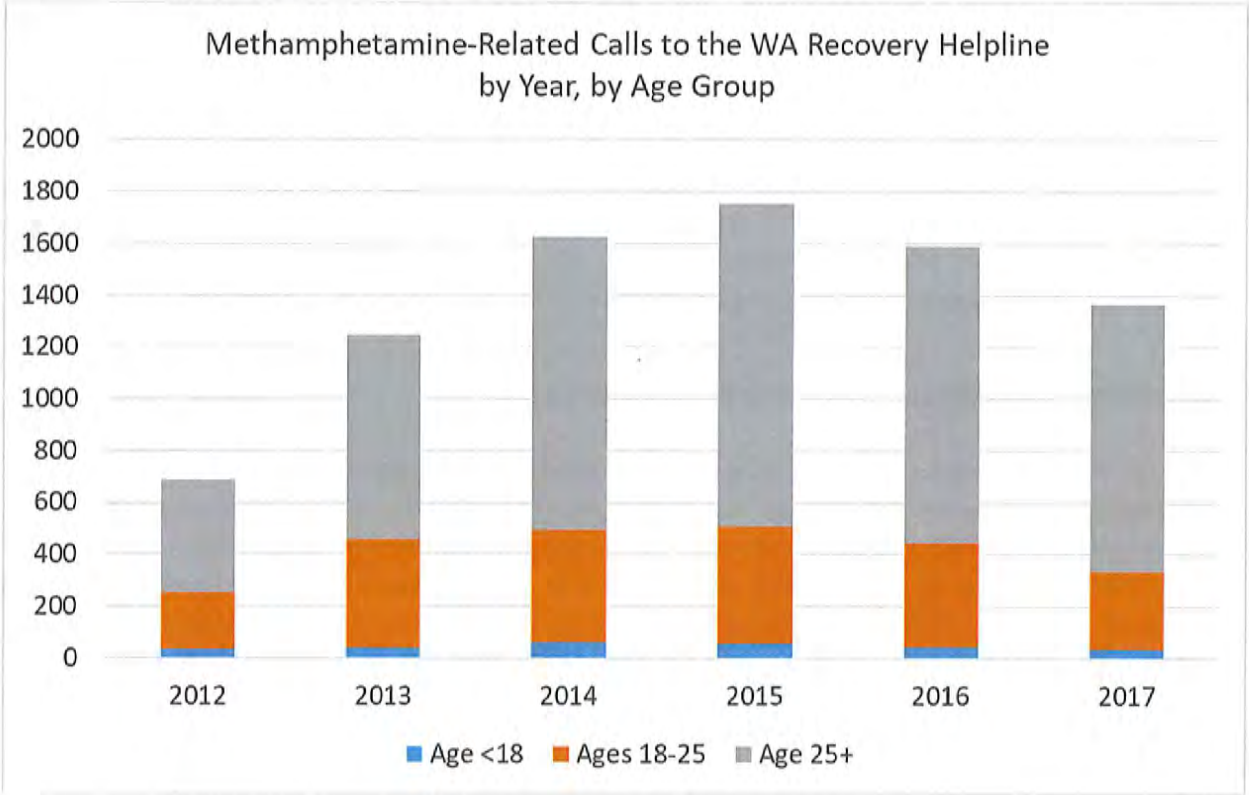
The Healthy Youth Survey is a statewide survey of Washington students in grades 6, 8, 10, and 12, conducted every two years since 2002. In the fall of 2016, over 230,000 students in over 1,000 schools in 236 school districts in all 39 counties took part.[4] Results of the survey from 2006-2016 suggest that lifetime rates of stimulant use among 12th graders have declined. Of those who reported any stimulant use in the 2006-2016 surveys, more 12th graders had "ever used" cocaine than had "ever used" methamphetamine. Approximately 4.8% of 12th graders reported ever using methamphetamine in 2016, down from 7.1 a decade earlier.



Washington State Recovery Helpline Calls

Calls to the Washington State Recovery Helpline provide an indication of the relative level of care-seeking for specific substances, however trends over time are difficult to interpret due to changes in overall call volume year to year. Data are presented by age group for the primary drug mentioned during calls for each year. In 2017, methamphetamine was the third most common substance identified by those under age 18, less common than alcohol and marijuana, similar to prior years. Among young adults 18-25, a different pattern is evident, with methamphetamine consistently the second most common drug mentioned following heroin and/or pharmaceutical opioids. For those 25 and older, methamphetamine is consistently the third most common substance following alcohol and heroin/pharmaceutical opioids. These data indicate methamphetamine is a persistent problem over time and across age groups.


Calls to WA Recovery Helpline by Year, by Drug
3200
2800
2400
2000
1600
1200
800
400
0
2012
2013
2014
2015
2016
2017
ALC
HEROIN
METH
RxPAIN
MJ
COKE
OTHER


Methamphetamine-Related Calls to the WA Recovery Helpline
by Year, by Age Group
2000
1800
1600
1400
1200
1000
800
600
400
200
0
2012
2013
2014
2015
2016
2017
Age <18
Ages 18-25
Age 25+

4. Harms Associated with Methamphetamine Use

Potential harms from the use of methamphetamine come from acute and long-term effects of the drug, consequences of route of administration, drug-involved sexual activity, drug use during pregnancy, and drug production.[35]

Harm from Acute and Long-term Effects of Methamphetamine

Harms may arise from negative acute effects of methamphetamine intoxication. These include increased heart rate, elevated body temperature, increased respiratory rate, shaking, teeth grinding, dry mouth, appetite suppression, abdominal cramps, anxiety, aggressiveness, insomnia, and hallucinations, including formication (a crawling sensation under the skin).[36, 37]

Drug effects may be harmful during intoxication, or harms may accrue over time. Users may develop skin lesions, sores, and scabs. Methamphetamine use alters inflammatory responses within the immune system, degrading physical and chemical protective barriers which results in delayed healing.[36] Long-term use may increase the likelihood of arrhythmia, tachycardia, abnormally elevated blood pressure, and ischemic stroke.[36]

Teeth grinding and dry mouth are implicated in the development of mouth sores and "meth mouth," or methamphetamine-related tooth decay that often results in tooth loss. Lifestyle factors associated with methamphetamine use have also been associated with tooth decay, including inadequate oral hygiene and preference for sugary foods and beverages.[36]

Psychiatric symptoms commonly associated with methamphetamine dependence include anxiety, depression, insomnia, and psychosis, and acute intoxication observed in emergency departments is associated with agitation, aggression, and suicidality.[37]

Methamphetamine users who do not want to stop using the drug completely may reduce the harms they experience from the drug by addressing hydration, nutrition and hygiene; moderating patterns of use; and attending to physical and mental health.[35]

Harm from Route of Administration

There is a widely accepted hierarchy of risk with regard to routes of administration for illicit drugs that holds true for methamphetamine. Generally speaking injecting is riskier and potentially more harmful than smoking, snorting, and ingesting, which are less risky and harmful, roughly in that order. Injecting and smoking methamphetamine confer higher risk of acute toxicity due to rapid drug uptake and development of addiction because the intensity of the effects provide a powerful motivator for re-administration.[37] Thus, one approach to harm reduction is to encourage meth users to switch from a riskier or more harmful route of administration to a less risky/harmful approach.[35]

When injected intravenously, methamphetamine reaches cerebral circulation in 10-15 seconds.[37] In addition to addiction and acute toxicity, risks and harms from injecting methamphetamine are largely due to sharing and/or using non-sterile injection equipment and include overdose, blood-borne viruses (HIV, hepatitis), endocarditis, abscesses, sepsis, and collapsed, veins. Syringe exchange services are available to injection drug users regardless of their drug of choice and, as demonstrated in the Washington State Syringe Exchange survey described above, are attended by methamphetamine users. Syringe exchange services typically provide not only sterile syringes but also other safe injection equipment and often provide wound care and testing for blood-borne viruses in addition to health education.[38]

When smoked, methamphetamine reaches the brain in 6-8 seconds, making this route of administration comparable to injection in terms of achieved blood levels and subjective effects.[37] In addition to addiction and acute toxicity, risks and harms from smoking methamphetamine are largely due to sharing pipes and/or using unsafe smoking materials or methods and include blood-borne viruses contracted through cracked lips, burns, and inhalation of toxic fumes. Some syringe exchange services have sought to address these risks and harms by distributing glass pipes.

Snorting methamphetamine produces euphoria in 3-5 minutes.[37] Risks and harms from snorting methamphetamine come primarily from sharing straws or razor blades. Again these include blood-borne viruses contracted through irritated nasal passages.[35] Harm reduction organizations address these issues by distributing straws and other sterile snorting supplies in addition to health education materials.

"Snorting Party Kit" distributed by the People's Harm Reducation Alliance and Stay Safe Seattle. Source: http://www.peoplesharmreductionalliance.org

Absorption of ingested methamphetamine occurs through the intestines, with peak plasma levels occurring 180 minutes after ingestion. Clinical reports describe methamphetamine dependence occurring with levels of use ranging from 50 to 1000 mg daily.[37] In addition to addiction or dependence, risks and harms from ingesting methamphetamine include gastric ulcers from long-term use, nausea, and vomiting.[35]

Other changes in methods of routes of administration may help methamphetamine users be safer, such as changing from smoking with a pipe to smoking with foil and a tube to decrease the intensity of the high.[35] Many harm reduction advocates, such as the People's Harm Reduction Alliance, emphasize that it is important that active and former drug users with lived drug use experience be involved in–and ideally lead–harm reduction efforts.[39]

Harm from Methamphetamine-involved Sexual Activity

Methamphetamine use is associated with increased risky sexual behavior, including unprotected sex and sex with multiple partners, which increases the risk of sexually transmitted infections.[40] Disinhibiting effects of methamphetamine facilitate sex, including high-risk sex, and resultant impulsivity often means methamphetamine users are less likely to use condoms.[35] Methamphetamine smokers associate the drug with better, longer and more adventurous sex, and some reported sex could be rougher and potentially more damaging.[41] Among men who have sex with men (MSM), methamphetamine users and injection drug users are at higher risk of HIV infection.[41] MSM have reported that sharing pipes is integral to methamphetamine use in sexual transactions in which methamphetamine is shared in exchange for sex.[42] Strategies to reduce harm from sexual activity include discussing sexual risk and risk perception, providing condoms and lubricant and promoting their use, providing information about HIV and other STIs and low threshold STI/HIV testing, encouraging condom use, discussing sexual violence, addressing barriers to safer sex.[35]

Harm from Methamphetamine Use during Pregnancy

Although prenatal exposure to methamphetamine does not appear to cause birth defects, it has been associated with low birth weight, premature birth, increased emotional reactivity and anxiety in preschool-age children, and subtle deficits in inhibitory control during early school years.[35] Potential harms to mothers from methamphetamine use during pregnancy include postpartum hemorrhage and retained placenta.[35] Because harms may be due to the drug itself or to correlates of drug use, such as poor nutrition, poor sleep, or inattention to prenatal care,[35] strategies to reduce harm would include reducing drug use, improving maternal health in general, and improving access to prenatal care.

Harm from Methamphetamine Production

Production of methamphetamine in illicit settings (e.g., in a home "meth lab"), can be extremely dangerous. Chemical processes require and produce flammable, carcinogenic, poisonous and caustic substances that can cause explosions, particularly with novice producers or those impaired by drug use.[35] Risks of harm exist not only for those making the drug, but also for their neighbors and other members of the community, as chemicals can spread into surrounding areas, contaminating soil and water and necessitating dangerous, expensive, and time-consuming cleanup.[43] To reduce the harms from illicit methamphetamine production, in 2010 the Washington Legislature passed legislation to restrict the sale and purchase of

methamphetamine precursors, i.e., nonprescription products containing ephedrine, pseudoephedrine, and phenylpropanolamine or their salts or isomers, or salts of isomers.[43] Precursor legislation appears to have been partially successful in reducing harm from production. According to the 2017 National Drug Threat Assessment, domestic production has been occurring at much lower levels and seizures of domestic methamphetamine laboratories have declined since 2010; however, there has been little effect on drug availability as production has largely shifted to Mexico.

5. Characteristics of Methamphetamine Users, their Treatment Utilization, and Needs

Motivations for and Harms Due to Methamphetamine Use

Research investigating motivations for and harms resulting from methamphetamine use provide important insights into why people use, and types of care that may support them in stopping their use. Two relevant papers are summarized. (see also Section 4 re: meth-related harms.)

A 2014 paper from Texas surveyed methamphetamine users in residential treatment.[5] In considering the comparability of the findings, Texas gets its methamphetamine and other drugs such as heroin via Mexico, the same source as Washington State, though Texas has different demographics with a larger Latino and smaller Native American population. Major findings are that a majority of those surveyed reported both smoking and injecting methamphetamine and that most had gone on a "binge", defined as being high on methamphetamine for at least 48 hours. Mental health and dental problems were reported by a majority of respondents. The most common benefits of methamphetamine were "the high", having fun, enhanced sexual experience, increased energy, and weight loss, with many other benefits also cited. Women were significantly more likely to report they used methamphetamine for the following reasons: "do more housework/care of kids", "increased confidence", "weight loss", and "to not be depressed". Men were significantly more likely to report using for "enhanced sexual experience" and "the high". The most common risks of methamphetamine use reported were addiction/dependence, paranoia, depression, anxiety/panic, legal/police problems, and damage to brain function. Women were more likely to report problems with child welfare and men were somewhat more likely to report lack of motivation. Other major issues included 56% having been arrested in the prior year and 63% having been homeless at some point.

Interviews conducted with men who have sex with men and inject methamphetamine in the Seattle area in the mid-1990s found some similar motivations and consequences of use including increased energy and enhancing sex.[6] as well as mental health problems associated with use and withdrawal: "Methamphetamine withdrawal is a lot more psychological... more devastating than heroin. That's what usually kept me out there [using methamphetamine]...". This population is at very high risk for HIV infection, even relative to other MSM. Unique findings for this population include that methamphetamine use was closely intertwined with sexual behaviors, some reported only having sex while on methamphetamine, and also closely identified with gay culture and identity. These findings suggest that services to support reducing

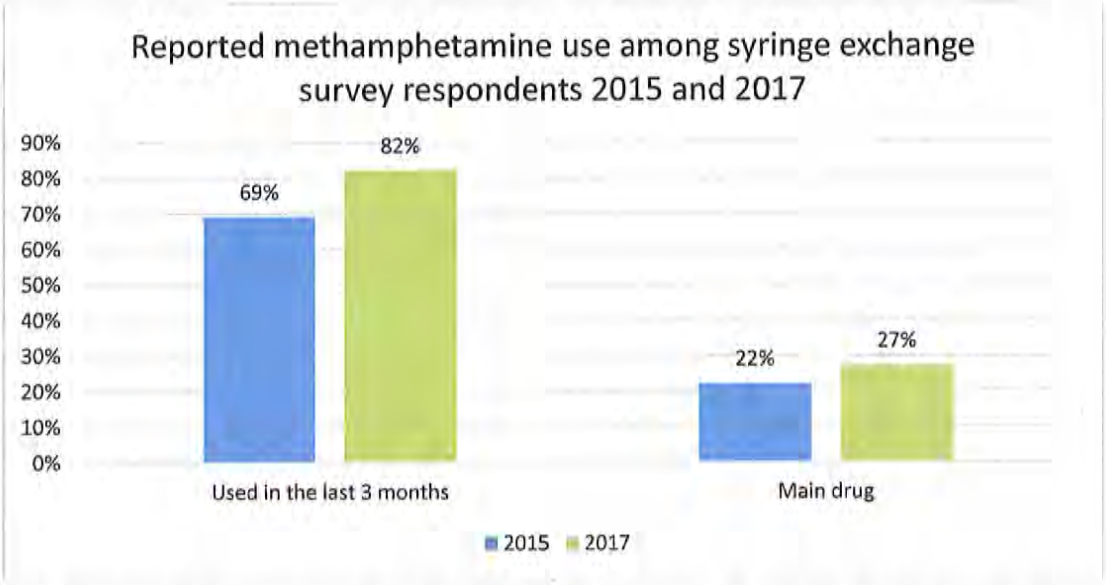
or stopping methamphetamine use need to address these cultural and identity issues associated with the drug, not just the biological effects of methamphetamine. Though these data are two decades old, similar associations between sexual behaviors, identity, and methamphetamine use continue in the Seattle area.

Data from the 2017 Syringe Exchange Survey

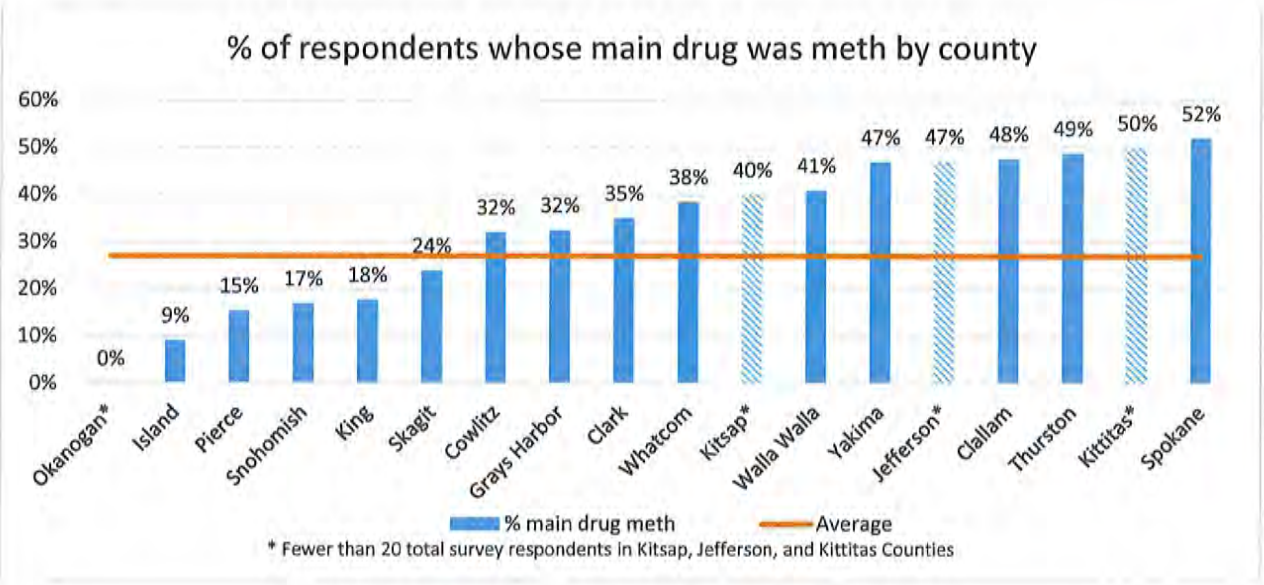
The Washington State Syringe Exchange survey was conducted by the University of Washington Alcohol and Drug Abuse Institute (ADAI) in 2015 and 2017.[3] Syringe exchange clients were surveyed about drug use, health, and interest in reducing or stopping their drug use. Data presented here are for people whose main drug was methamphetamine, referred to hereafter as primary methamphetamine users.

Syringe exchange programs in Washington are operated by non-profit organizations or public health departments. Exchange programs vary in how many hours a week they operate, from a few hours a week to up to 40 hours per week, as well as whether or not they have a fixed or mobile site for exchange. They provide a range of services including exchanging used syringes for sterile one, HIV/HCV testing, providing other safe injection supplies, and referring people to drug treatment or other services.

Among the 1,079 respondents to the 2017 survey, 82% (n=885) reported they had used methamphetamine in the last three months, and 27% (n=292) reported that it was their main drug. This was an increase from the 2015 survey where 69% of respondents reported past three month use of methamphetamine, and 22% reported it was their main drug.



The percent of respondents who used methamphetamine in the last three months ranged from 75%-95% across Washington counties. There was a much larger variation between the percent of respondents who were primary methamphetamine users, from 0%-52%.



Primary methamphetamine users by county from the 2017 Syringe Exchange Survey							
County	**Primary meth users**	**Total surveys**	**% Primary meth users**	**County**	**Primary meth users**	**Total surveys**	**% Primary meth users**
Okanogan*	0	5	0%	**Whatcom**	10	26	38%
Island	2	22	9%	**Kitsap***	8	20	40%
Pierce	10	65	15%	**Walla Walla**	9	22	41%
Snohomish	12	71	17%	**Yakima**	15	32	47%
King	75	424	18%	**Jefferson***	8	17	47%
Skagit	16	67	24%	**Clallam**	30	63	48%
Cowlitz	8	25	32%	**Thurston**	20	41	49%
Grays Harbor	25	77	32%	**Kittitas***	5	10	50%
Clark	14	40	35%	**Spokane**	25	48	52%
				Total	292	1075	27%

Demographics of Primary Methamphetamine Users

Almost two-thirds of primary methamphetamine users were men (65%), and the majority were white (85%). About a quarter of primary methamphetamine users were under 30. Only 28% had permanent housing, and 32% had been in jail or prison in the last twelve months. Legal income was very low, with a mean of $454 a month. Overall, 20% (n=37) of men reported having sex with other men in the last 12 months. However, of these the majority (67%, n=25) were located in King County.

Gender	n	%	**What race are you?**	n	%
Male	189	65%	White	249	85%
Female	100	34%	American Indian/Alaska Native	28	10%

Transgender	1	<1%	Latino/Hispanic	14	5%
Other	1	<1%	Black/African American	9	3%
Age			Asian/South Asian	3	1%
18-21	8	3%	Hawaiian/Pacific Islander	2	1%
22-25	20	7%	Other	10	3%
26-29	38	13%	**Housing Status**		
30-39	96	33%	Homeless	93	32%
40-49	63	22%	Temporary	117	40%
50-59	54	19%	Permanent	82	28%
60+	12	4%	**In jail or prison in the last 12 months?**	93	32%
			Legal monthly income*	Mean =$454	

*No King County data

Drug Use Patterns and Consequences

About half (48%) of primary methamphetamine users were also polysubstance users, with 36% reporting having used heroin in the last three months. This is in contrast to primary heroin users, who were much more likely to report having used another substance (89%). Neither alcohol nor cannabis use were documented in the survey.

	Primary HEROIN n=664	**Primary METH** n=291
Used another drug in last 3 months	89%	48%
Other Drugs Used		
Heroin by itself	100%	36%
Methamphetamine	78%	100%
Heroin mixed with methamphetamine (goofball)	52%	24%
Powder cocaine by itself	16%	12%
Crack cocaine by itself	16%	8%
Cocaine mixed with heroin (speedball)	13%	5%
Prescription opioids	37%	20%
Benzodiazepines/downers	34%	16%
Fentanyl	13%	4%

Route of Administration

Among primary methamphetamine users, 92% (n=266) reported injecting and 61% (n=177) reported smoking methamphetamine in the last three months.

Overdose and "Overamping" Among Primary Methamphetamine Users

Twenty percent of primary methamphetamine users had experienced "overamping" (stimulant overdose) and 33% had witnessed someone overamp. Of these who witnessed a stimulant overdose, 23% called 911. Seven percent of primary methamphetamine users had experienced an opioid overdose, while 40% had witnessed one, showing that they may be good candidates to carry naloxone. Of those who witnessed an opioid overdose, about half (47%) called 911, compared with 23% who called 911 the last time they witnessed a stimulant overdose.

Overdose and overamping among primary methamphetamine users (n=292)		
Had an opioid overdose	20	7%
Witnessed an opioid overdose	117	40%
Called 911 for an opioid overdose	39	47%
Had a naloxone kit	105	36%
Had a stimulant overdose	59	20%
Witnessed a stimulant overdose	95	33%
Called 911 for a stimulant overdose	14	23%

Health Concerns and Healthcare Access

The large majority of primary methamphetamine users had health insurance (89%), mainly Medicaid (77% of all primary methamphetamine users). However, respondents reported other barriers to accessing healthcare, and 53% of respondents reported there was a time in the last 12 months when they should have seen a health care provider, but did not go. Distrust of doctors and stigma related to drug use were top reasons for not seeking medical care.

Healthcare access among primary methamphetamine users		
Had health insurance	n=260	89%
Had Medicaid	226	77%
In the last 12 months, was there a time when you thought you should see a healthcare provider for a medical/physical issue, but you did not go?*	114	53%
What were the main reasons you did not go?		
Don't trust/like doctors	29	25%
Other**	24	21%
Other bigger priorities (e.g. homeless)	17	15%
Drug use gets in the way	16	14%
Don't want to be lectured/judged for my drug use	15	13%
No money or health insurance	11	10%
No transportation	8	7%
Too long to get seen	6	5%
Don't know where/no place to go	5	4%
Symptoms went away/not bad enough	5	4%
Won't help/not worth it	3	3%

Fear of results	1	1%
Other **	24	21%
*Not asked by King County **Other reasons included warrants or other legal issues, mental health challenges		

Where Primary Methamphetamine Users Receive Health Care

The emergency room was the most common place where primary methamphetamine users received medical care in the last 12 months, with 47% reporting having gone to an E.R. Other places primary methamphetamine users received care were other clinic or hospital settings (32%), and jail or prison (13%). Twenty-two percent of primary methamphetamine users reported they did not receive medical care in the last year.

Serious Health Conditions Reported by Primary Care Users

In the last 12 months have you:		
Had an abscess	n=69	24%
Had a skin or tissue infection	60	21%
Had endocarditis	2	1%
Had an STI (not asked by King County)	18	8%
Pregnancy (among women only)	8	8%

Biggest Health Concerns

When asked about their biggest health concern, 27% of primary methamphetamine users reported that the had none, while others reported that mental health and respiratory issues were major concerns.

What is your biggest concern about your health?*		
None	n=57	27%
Miscellaneous	25	12%
Mental health	24	11%
Respiratory issue	20	9%
Drug use/addiction	14	7%
Pain	13	6%
Cardiac/circulatory issue	13	6%
Nutrition/weight	9	4%
Dental	8	4%
Complications from injecting	5	2%
Hepatitis C	5	2%
Sexual/reproductive health	5	2%
Aging	4	2%
Cancer/tumors	4	2%
Homelessness	3	1%

Other chronic condition	2	1%
Health system issues	2	1%
Overdosing	1	0%
HIV	1	0%
Total	215	100%
*Not asked by King County		

Mental Health Concerns

Although mental health was a primary concern for only 11% of respondents, over half (55%) of *primary* methamphetamine users reported that they were somewhat or very *concerned* about their anxiety, depression, or other mental health issues. Forty-five percent said they were not at all concerned. [This question was not asked by King County].

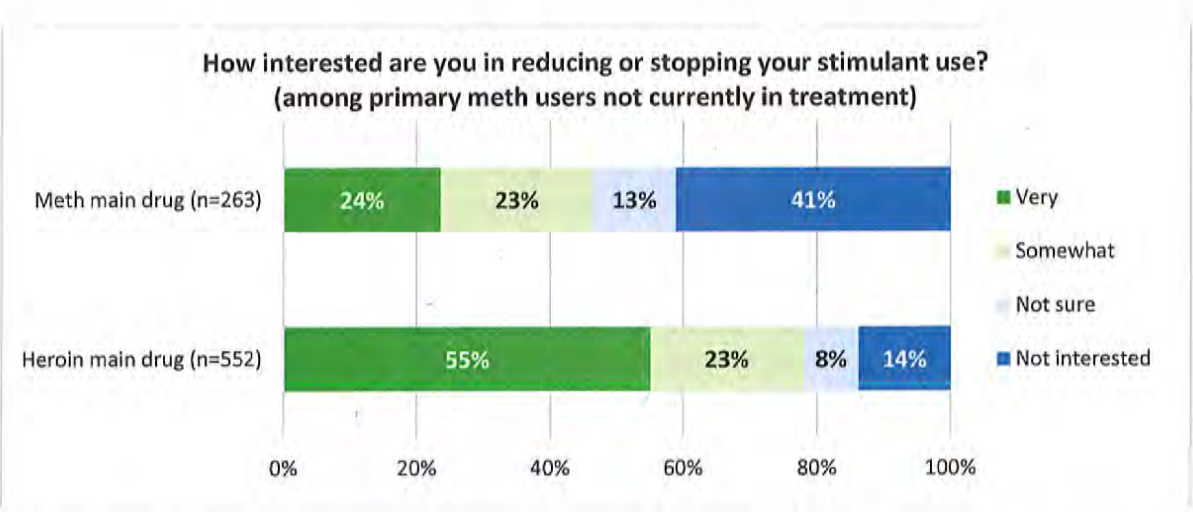
Treatment for Drug Use

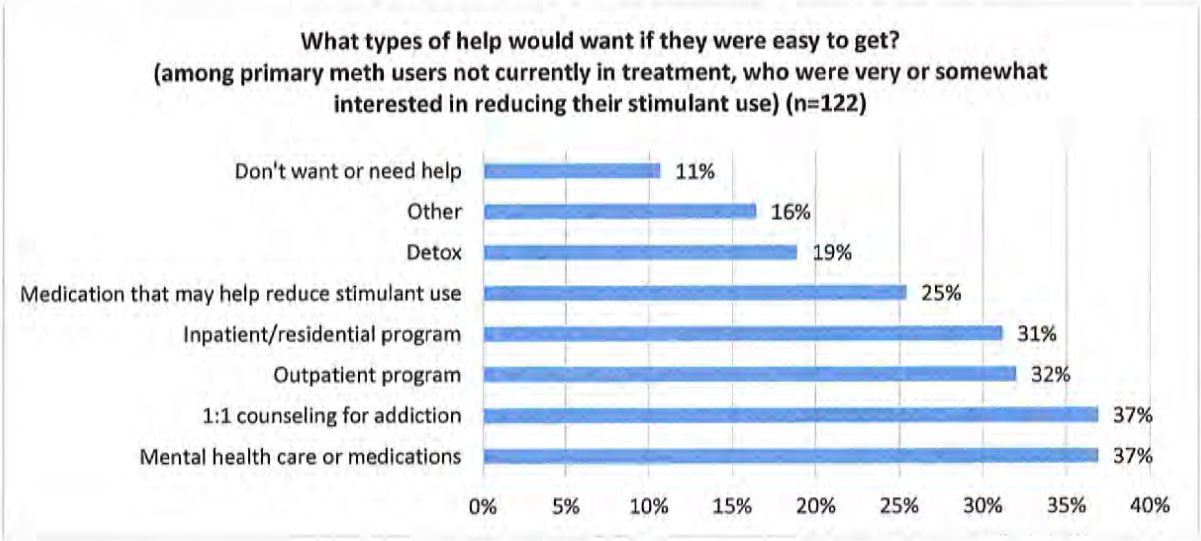
Ten percent of primary methamphetamine users surveyed were currently receiving treatment for their drug use, and 28% had received some form of treatment in the last year. Support groups, inpatient and outpatient programs were the most frequent forms of treatment.

Currently receiving treatment for drug use	**n=28**	**10%**
Any treatment in the last 12 months	**81**	**28%**
12-step/support groups	34	12%
Inpatient	32	11%
Outpatient	26	9%
Detox	14	5%
Buprenorphine	12	4%
Methadone	8	3%
Other	1	0%
Naltrexone	0	0%

Interest in Reducing or Stopping Methamphetamine Use

Almost half (47%) of primary methamphetamine users were very or somewhat interested in reducing or stopping their stimulant use. Among those who were very or somewhat interested there was no clear preference for types of help. Respondents were interested in mental health care or medications, one on one counseling, inpatient and outpatient programs, medication to reduce stimulant use, and detox.





Among primary methamphetamine users who were not sure or not interested in reducing or stopping their use, 71% said it was because they "did not want to quit." Other reasons for being not sure or not interested included:

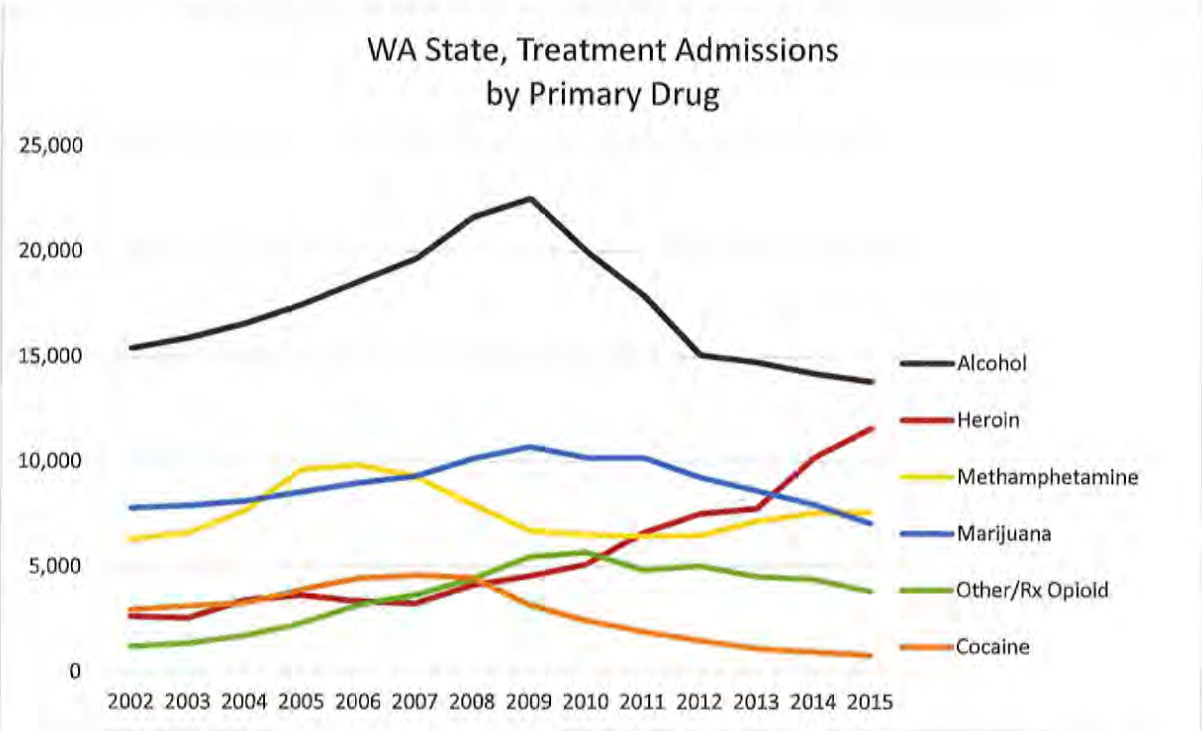
"I'm dying of cancer."
"Not sure how my anxiety would feel-meth calms me down."
"Only thing keeping me going right now."
"Not sure how my body would handle without meth."
"I like it. Feel normal."

Limitations of the Syringe Exchange Survey Data

Because the survey was conducted at syringe exchanges, it represents the views and experiences of injectors. It does not capture primary methamphetamine users who only smoke, and do not inject. Some questions were not included in the survey conducted in King County.

Treatment Admissions

Treatment admission data from 2015 are presented here, as that is the last year with comparable data collected statewide. Data are presented for those who received any public funding for their treatment and for which data were entered into the Washington State Department of Behavioral Health and Recovery (DBHR) TARGET data system. Data are reported as the number of treatment admissions, not the number of unique people, that is, the data are duplicated for people with multiple admissions per year to the same or different treatment modalities. Data are presented by the primary drug identified at the time of admission, comparing methamphetamine with treatment admissions for all drugs and alcohol, including methamphetamine.



A higher proportion of primary methamphetamine users are female compared to everyone entering treatment. The largest proportion of methamphetamine users were ages 30-39. Methamphetamine users were more likely to be white, less likely to be African American, and a substantial proportion, relative to population size, were American Indian/Alaskan Native.

	Methamphetamine		**All drugs / alcohol**	
Gender	**#**	**%**	**#**	**%**
Female	4,351	48%	23,275	41%
Male	4,729	52%	33,713	59%
Other/Unknown	-	0%	4	0%
Age				
<18	547	6%	5,801	10%

18-25	1,790	20%	10,203	18%
26-29	1,516	17%	8,751	15%
30-39	3,115	34%	15,403	27%
40-49	1,473	16%	9,223	16%
50-59	597	7%	6,243	11%
60+	42	0%	1,365	2%
Race				
White	7,004	77%	38,886	68%
African American	384	4%	4,321	8%
American Indian/Alaskan Native	830	9%	7,054	12%
Asian	85	1%	609	1%
Pacific Islander	110	1%	642	1%
Multiple race	97	1%	698	1%
Other/unknown	570	6%	4,782	8%
Total	**9,080**		**56,992**	

Most, 62%, reported smoking methamphetamine, with 31% injecting. This is important context for interpreting the syringe exchange data, knowing that among the relatively severe group or users entering treatment, a minority are injecting. (Route of ingestion is not reported for all substances as it is not interpretable across different types of substances.)

	Methamphetamine		**All drugs/alcohol**	
Route of ingestion (primary)	**#**	**%**	**#**	**%**
Inhalation	93	1%	-	-
Injection	2,793	31%	-	-
Oral	143	2%	-	-
Smoking	5,598	62%	-	-
Other	453	5%	-	-
Unknown	-	0%	-	-
Secondary substance				
Heroin	1,486	16%	2,929	5%
Other opioids	452	5%	3,826	7%
Alcohol	2,060	23%	9,091	16%
Methamphetamine	-	0%	9,350	16%
Marijuana/hashish	3,100	34%	12,724	22%
Cocaine/Crack	388	4%	2,475	4%
Other Amphetamines	75	1%	1,036	2%
Benzodiazepine	35	0%	702	1%
Other drugs	154	2%	949	2%
None	1,330	15%	13,910	24%
Total	**9,080**		**56,992**	

Most methamphetamine-primary users, 85%, reported a secondary drug with almost all of them being sedating substances i.e. marijuana, alcohol and opioids. This is a common pattern where

people use different types of substances to address the biological and psychological effects of methamphetamine. Among those reporting primary drugs other than methamphetamine, many reported methamphetamine as a secondary drug used. The number of people reporting methamphetamine as a secondary drug (9,350) was similar to the number reporting it as a primary drug (9,080), indicating that methamphetamine is very commonly used among those entering drug treatment. These data indicate that in ss2015, more than 18,000 treatment admissions in Washington State involved methamphetamine as a primary or secondary drug.

Insights from the Treatment Research Subcommittee

In March 2018, a meeting of the Treatment Research Subcommittee brought together researchers, clinicians, and other professionals who work on substance use disorders and methamphetamine. The meeting included presentations and discussion about the epidemiology of methamphetamine use, lessons learned from working with people who use methamphetamine, and treatments to help reduce methamphetamine use. A few key themes emerged:

- Patterns of methamphetamine use are different than those for opioids or alcohol
- Methamphetamine has some functional purposes for the people who use it
- Traditional substance use disorder treatment may not be appropriate or adequate for some people who use methamphetamine
- Methamphetamine use continues to be highly stigmatized.

During this meeting Susan Kingston, now at UW-ADAI, presented on her experience working as a counselor with methamphetamine users in the 1990s. Johnny Ohta, a counselor who works with street youth, also shared his experiences working with this population.

Both Kingston and Ohta expressed that patterns of use are very different for methamphetamine than for opioids, and desire for treatment may wax and wane depending on how someone is feeling about their use in the moment.

"The other thing about the motivation for change is the binge use pattern of methamphetamine. People go hard, and then they get some sleep and do some stuff, and turn back up, everything's fine. So if you talk to them at that point, it's not a big problem," –Johnny Ohta

People may use methamphetamine for functional reasons such as helping them cope with being homeless.

"And then when we talk about homeless people who are homeless and pretty much driven to use every day and can't sleep very much, then we have that whole other group of people that we're talking about, that's really separate, I think, from probably the majority of methamphetamine users in Washington state who are using and not homeless." –Johnny Ohta

Traditional forms of treatment and services may not be a good fit for methamphetamine users because of the patterns, motivations for, and functions that its use serves. Methamphetamine

users may need services that are available more readily so they can access them during the brief windows when they want those services. They also need services and treatment that can help address the functional role that methamphetamine may provide.

"Traditional drug treatment failed to realize the utility that methamphetamine offered people in their lives. What I heard regularly...is that the model of drug treatment doesn't at all fit them and their experience. They couldn't handle the boredom, to be honest, of regular treatment... None of the discussions were relevant to methamphetamine use that talked about cravings. Nothing was at all reflective of what their experience was." –Susan Kingston

Speakers felt that people who use methamphetamine face even greater stigma than people who other drugs such as opioids.

"What everybody said is that, "Nobody else gets us," that the experience of using methamphetamine is so different and so unique, and the stigma at that time was so severe, that at that time the most disgusting person you could be was somebody who used methamphetamine. You remember the pictures, remember the posters. We all remember that." –Susan Kingston

One meeting attendee spoke about the importance of empathy for all people who have substance use disorders, including those who use methamphetamine, and that people may use substances as a way to cope with emotional trauma.

"Empathy is really. really important because... we in the field watched the shift of attitude [with the opioid epidemic], when all of a sudden, it wasn't "those people" anymore, it was your daughter ... it wasn't "those" people anymore. Hopefully there has been some awareness about substance use disorder that has come along with this epidemic. But I also think that there's an opportunity in helping folks understand about substance use disorder and the tie to childhood trauma and understanding that there is such a connection there. That both really are just trying to use drugs to feel normal." –TRSC meeting attendee

The full transcript of the TRSC meeting is included as Appendix C to this report.

6. Current Treatment Approaches for Methamphetamine Use Disorders

Pharmacotherapeutic Treatments

A wide range of pharmacotherapeutic approaches have been tried in the treatment of methamphetamine use disorders, including antidepressants, antipsychotics, and substitution/replacement therapies.[8] There are currently no approved medications for the treatment of methamphetamine dependence, nor are there any medications on the horizon with scientific literature sufficient to demonstrate a robust treatment effect.

Pharmacotherapeutic agents that have shown the most, albeit modest, promise include the atypical antidepressants mirtazapine and bupropion, that attention deficit drug methylphenidate-SR, and the anticonvulsant topiramate.[8]

Substitution therapies for methamphetamine dependence deserve particular mention due to existence of FDA-approved substitution therapies for opioid and nicotine dependence. Studies of substitution therapies for methamphetamine dependence have provided mixed results.[8] A 2013 Cochrane review of the efficacy of stimulant drugs for amphetamine abuse or dependence by Pérez-Mañá et al.[9] identified 11 randomized clinical trials with 791 participants investigating four drugs with psychostimulant effects. The review concluded that neither psychostimulants as a group nor any single drug was found to reduce amphetamine use (as evidenced by urinalysis), attain sustained amphetamine abstinence, or improve treatment retention. Pérez-Mañá et al.[9] concluded that the available data did not support substitution therapy for amphetamine dependence.

Frontiers of pharmacotherapeutic treatment development for methamphetamine use disorders include novel functionally-selective serotonin 5HT2 drugs (phenylaminotetralin analogs), drugs selectively binding synaptic glycoprotein 2C (which plays an important role in dopamine neurotransmission) or the trace amine-associated receptor 1 (TAAR1), nonpeptide small molecule compounds for the neurotensin receptor system (NTR1 and NTR2), drugs targeting the cannabinergic and oxytocinergic systems, and immunotherapies.**Error! Bookmark not defined.**

Behavioral/Psychosocial Treatments

Behavioral and psychosocial interventions are the primary form of treatment for methamphetamine use disorders. Interventions vary in terms of the extent to which they are delivered to individuals, families, or groups of unrelated individuals, and they may differ substantially in terms of frequency and duration. Reviews of behavioral/psychosocial treatments for methamphetamine have not found that any particular treatment is clearly superior to others.[11,12]

The behavioral and psychosocial treatments with the most research support, those supported by Substance Abuse and Mental Health Services Administration (SAMHSA) as effective for methamphetamine use disorders, include the Matrix Model, other forms of cognitive-behavioral therapy (CBT), contingency management (CM), motivational interviewing (MI), mindfulness-based approaches, and exercise.

Matrix Model

One of the most commonly used psychosocial treatments for stimulant use disorders in general and methamphetamine use disorders in particular is the Matrix Model.[13] Developed in response to the cocaine epidemic of the 1980s by the Matrix Institute in Los Angeles, Matrix sought to incorporate empirically-supported treatment elements into a manualized, non-confrontational, structured program that is considered to be primarily cognitive-behavioral in nature. Standard Matrix Model treatment generally spans 16 weeks and consists of group cognitive behavioral therapy (36 sessions), individual counseling (4 sessions), family education groups (12 sessions),

group social support (4 sessions) and urine and weekly breath alcohol testing. Weekly (at least) attendance at 12-step meetings such as Crystal Meth Anonymous is also encouraged.

Other Forms of Cognitive Behavioral Therapy

CBT encompasses a range of interventions that may be quite different in application and focus.[14] In general, the term is applied to approaches that derive from principles of learning and classical conditioning and emphasize the role of thoughts in behavior change. CBT seeks to provide and strengthen skills to reduce or stop drug use and sustain abstinence (relapse prevention). In 2008, Lee and Rawson[14] reviewed the literature on CBT for methamphetamine dependence and noted that relapse prevention and coping skills therapy are the most widely known and commonly practiced approaches. They concluded that while there was only a small number of studies examining interventions for methamphetamine users, those that have been conducted with CBT (with and without MI) have shown some evidence of efficacy. They noted that studies are difficult to compare because many of the studies had only a brief description of the intervention that was conducted, despite having fidelity checks built in to their methods.[14]

Motivational Interviewing

Engaging the disengaged is a key aim of MI. A number of studies have examined different forms of MI for methamphetamine use disorders, with favorable effects found for one-[15], two-[16], three-[17], and nine-session[18] adaptations of the intervention. In the nine-session adaptation, session one focused on problem identification and feedback. Session two focused on ambivalence, reasons for using, and desires for change. The third session focused on developing a change plan and identifying possible obstacles. Patterned after the "booster sessions" in the Project MATCH motivational enhancement therapy manual, sessions four through eight reviewed events of the past week, relapses, and other concerns raised by the client, focused on progress made on the change plan, ambivalence towards the change plan, revision of goals, and desired changes in strategies for achieving goals.[19]

Contingency Management

Contingency Management (CM) is a behavioral technique that seeks to encourage positive behavior change (e.g., abstinence) by providing positive reinforcement (i.e., desirable consequences) when clients meet treatment goals and by withholding reinforcement or providing punishment when patients engage in an undesired behavior (e.g., drug use). For example, consequences for abstinence may include positive reinforcement in the form of vouchers exchangeable for money or prizes while consequences for drug use may include non-reinforcement by withholding vouchers or punishment by making an unfavorable report to a parole officer. Reinforcing or punishing consequences may be contingent on objective evidence of drug use (e.g., urine screens) or on another important behavior, such as compliance with a medication regimen or regular clinic attendance. CM procedures are frequently implemented with written contracts that detail the desired behavior change, duration of intervention, frequency of monitoring, and potential consequences of the person's success or failure in making the agreed upon behavior changes.[20]

CM is the most studied and considered the most promising psychosocial approach to be added to treatment as usual.[12] However, studies suggest that the efficacy of CM programs tends to be greatest during the treatment period when contingent rewards are provided and deteriorates

after rewards are withdrawn.[21] Cost effectiveness and sustainability of this resource-intensive intervention remain in question.

Mindfulness-based Approaches

Mindfulness-based approaches, such as acceptance and commitment therapy (ACT) and mindfulness-based relapse prevention (MBRP) are considered among the "third wave" of cognitive and behavioral therapies, where behavior therapy and traditional CBT represent the first and second waves. Unlike traditional CBT, mindfulness-based approaches do not seek to directly engage with and change thoughts but rather encourages its adherents simply to notice thoughts without engaging with or judging them and striving to be present fully in the moment.[22]

ACT for substance use disorders emphasizes observation of the thinking process rather than disputation and modification of thought content, reducing experiential avoidance through increasing distress tolerance and acceptance skills, and values clarification to direct alternative activities to substance use.[23] With a somewhat different focus, MBRP typically seeks to increase awareness of relapse triggers, interrupt automatic behavior sequences to promote mindful responses to triggers and cravings, and practice nonjudgmental awareness of one's moment-to-moment experience.[24,25] MBRP sessions commonly begin with a guided meditation followed by homework review, and participants may be given meditation exercise CDs for between-session practice and logs to record time spent practicing.

Exercise

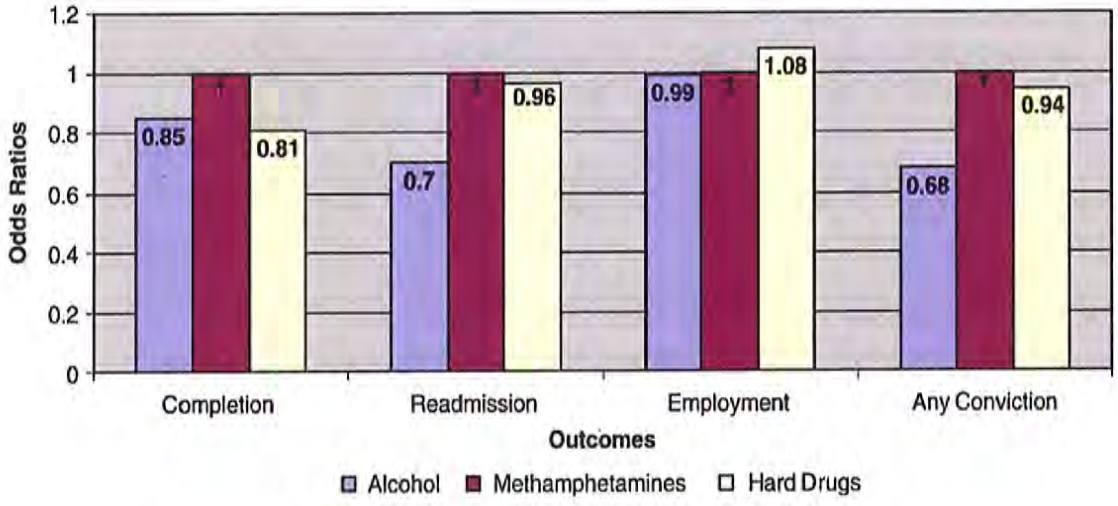
Exercise has been proposed as a potential treatment for methamphetamine dependence because it has been shown to ameliorate negative mood states and improve cognition. Methamphetamine dependence is associated with comorbid depression and anxiety, and cessation of methamphetamine use produces an abstinence syndrome characterized by anhedonia, dysphoria, irritability, poor concentration, hypersomnia, low energy, and possible suicidality coupled with drug cravings.[26] Morais et al.[27] reviewed the literature on exercise and methamphetamine dependence and concluded that methamphetamine users who engaged in a physical exercise program showed less depression and anxiety symptoms, lower relapse rates, and sustained abstinence when compared to non-exercised individuals. Relatively few studies have examined methamphetamine use outcomes, but the most favorable outcomes have generally been observed among those who were most adherent to the exercise intervention.[28]

Outcomes of Treatment for Methamphetamine Use Disorders

Psychosocial treatment provided for methamphetamine abuse and dependence provided in both inpatient and outpatient treatment settings frequently emphasizes abstinence, especially in residential inpatient settings. In outpatient settings aims of drug use reduction and harm minimization are also commonly pursued. Beyond these primary aims common goals of psychosocial interventions are to engage and retain dependent methamphetamine users in the treatment process, to promote treatment compliance, and to help them avoid relapse into harmful methamphetamine use.[11]

Because methamphetamine users tend to present for treatment with greater medical and psychiatric disorders compared to cocaine users, researchers have questioned whether there is a differential treatment effect for methamphetamine and cocaine users and whether methamphetamine use disorders should have a specialized treatment. A 2007 study in Washington by Luchansky et al.[29] examined whether treatment outcomes of methamphetamine users were different than those of users of other substances. Using data from administrative systems in Washington State, for both adults (n = 12,726) and youth (n = 2,715), results indicated that one-year post-treatment outcomes for methamphetamine users were similar to those for users of other hard drugs but not as positive as outcomes for users of marijuana or alcohol. As shown in the figure, in the adult sample, methamphetamine users were actually more likely to complete treatment than alcohol or other hard drug users.

Odds ratios on four outcomes comparing primary drugs of abuse



Source: Luchansky et al., 2007.

Vocci and Montoya[30] examined the research literature in 2009 to compare outcomes for methamphetamine and cocaine users and concluded that, despite the worse medical and psychiatric condition of methamphetamine users, there was no evidence for a differential treatment effect of any psychosocial treatment. The researchers asserted that the efficacy of psychological and behavioral treatments may be improved by providing treatments for a longer time and developing efficacious relapse prevention strategies, consistent with a chronic disease approach. Furthermore, they argued that while abstinence from methamphetamine use may be the ultimate goal of treatment, interventions aimed at reducing drug use and minimizing harm from drug use should be investigated.

A recent Australian study[31] found that treatment success, defined as abstinence from or a reliable reduction in frequency of use of the primary drug of choice in the month prior to follow-up, was actually greatest when the primary drug of choice was methamphetamine / amphetamine. The researchers asserted the outcomes following engagement in treatment are at least as good among those with methamphetamine use disorders as they are among those with heroin or alcohol-related problems and that this is a critical message for professionals and the

public alike. They argue that future priorities should include stronger communication to the general population of the potential for positive outcomes for methamphetamine users following treatment as well as increased promotion of strategies to encourage treatment-seeking and facilitate access to diverse evidence-based treatment options.[32]

Harm Reduction Approaches

For methamphetamine users who are not interested in stopping their use, recommended strategies can help to minimize harm that might result from ongoing drug use, improve users' quality of life, and contribute to overall public health. Harm reduction is a conceptual framework that provides for individuals willing to be engaged in services without immediately seeking abstinence.[3] MacMaster3[3] articulated five assumptions common to discussions of harm reduction to frame the development of interventions to reduce drug-related harm without insisting on abstinence as the only solution:

1. *Substance use has and will be part of our world; accepting this reality leads to focus on reducing drug related harm rather than reducing drug use.*
2. *Abstinence from substances is clearly effective at reducing substance related harm, but is only one of many possible objectives of services to substance users.*
3. *Substance use inherently causes harm; however, many of the most harmful consequences of substance use (HIV/AIDS, Hepatitis C, overdoses, etc.) can be eliminated without complete abstinence,*
4. *Services to substance users must be relevant and user friendly if they are to be effective in helping people minimize their substance-related harm.*
5. *Substance use must be understood from a broad perspective and not solely as an individual act; accepting this idea moves interventions from coercion and criminal justice to a public health or counseling perspective.*

The Interior Health Authority of British Columbia has developed and published on the web a *Guide to Harm Reduction* for frontline staff who deliver harm reduction services. Covering principles and history of harm reduction, trauma informed practices, service delivery and engagement strategies, special populations, peer engagement, working with personal values, attitudes and misconceptions, stigma and discrimination, best practices for supply distribution, best practices for needles syringe distribution, disposal and handling of drug use equipment, disposing of needles safely, commonly used drugs and their effects, and common infections related to substance use, the guide is an excellent example of a comprehensive resource for harm reduction service providers.[34]

7. Discussion and Recommendations

Discussion

Methamphetamine use as measured by youth surveys and Helpline calls is moderate, with declines in lifetime use reported by youth over the prior decade. Methamphetamine remains the most common drug detected in police evidence and is up in recent years, though well below the peak in 2005. Police across Washington State indicate that methamphetamine is a major drug of abuse and is associated with substantial levels of property crime and takes up substantial law enforcement resources. Recent treatment data indicate that most entering treatment with methamphetamine as their primary drug report smoking as their primary route of administration. Drug treatment data show an uptick in methamphetamine primary admissions from 2012 through 2015 (the most recent data) though below the level seen a decade earlier. Most syringe exchange clients report using methamphetamine, though a minority report it as their primary drug. Mortality data are up four-fold from 2010 to 2016 when there were 364 methamphetamine involved deaths in the state. While methamphetamine use and consequences occur across Washington State, rates vary substantially by region.

Methamphetamine users identify many positive consequences of use including relieving depression, increasing energy, and weight loss. However, negative consequences are also common and severe, including mental health, dental problems, and consequences of injecting. Among methamphetamine primary injectors surveyed in Washington in 2017, 72% were homeless or impermanently housed, and 32% had been incarcerated in the previous year. Despite negative consequences, slightly less than half of methamphetamine users indicate they are interested in stopping or reducing their use, a much smaller proportion than heroin users. There are a range of services that people would be interested in accessing to help stop or reduce their use, including mental health care and medications, counseling, drug treatment and "medication that may help reduce stimulant use".

Experienced clinicians have identified many challenges in working with heroin users and the limitations of existing services, perhaps best summed up by:

"Traditional drug treatment failed to realize the utility that methamphetamine offered people in their lives." –Susan Kingston

Treatment research indicates modest and inconsistent findings for the impact of anti-depressants on decreasing methamphetamine use and no positive findings for maintenance on stimulant medications. Some behavioral treatments have been found to have modest impact on methamphetamine use, with contingency management having perhaps the strongest effects while it is maintained.

Recommendations

High and increasing mortality rates must be addressed.

Almost half of methamphetamine overdose deaths involve an opioid, so treatment of opioid use disorder and use of the opioid antidote naloxone may help decrease some methamphetamine involved overdoses.

People who have an overdose involving methamphetamine without other major drugs often have signs of chronic cardiovascular disease likely due to their methamphetamine use so decreasing or ceasing methamphetamine use and obtaining health care are necessary.

All meaningful interventions, even those with modest benefits, should be considered given the severity of consequences due to methamphetamine use. Many people who use methamphetamine do want to stop their use and are interested in mental health care; some express interest in treatment medications. Despite their modest and inconsistent effects, clinicians may wish to consider psychiatric medications knowing that some patients will be open to their use and there may be some benefit, with likely modest side effects compared to the serious side effects of methamphetamine use.

Homelessness is high among methamphetamine users and often cited as exacerbating use due to the appetite suppressant and stimulant effects of methamphetamine. Homeless people often feel vulnerable to violence at night, with methamphetamine perceived as protective by keeping them awake. Addressing homelessness may help reduce methamphetamine use indirectly by decreasing some of the factors that reinforce use.

Given the serious consequences of methamphetamine use on those who use, their social networks, law enforcement and the broader community, it is important to consider multiple approaches to intervening directly on methamphetamine use as well as social factors that exacerbate use. And, we must continue researching interventions that may have direct and indirect effects on reducing methamphetamine use and the severe consequences of use.

Growing out of discussions with the Division of Behavioral Health and Recovery and the Treatment Research Subcommittee, the UW Alcohol and Drug Abuse Institute is planning a conference in 2019 that will focus on methamphetamine. This event will be an opportunity to enhance our understanding of methamphetamine use in Washington and the needs of individuals, families, and communities affected by methamphetamine use.

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