

WASHINGTON STATE NALOXONE DISTRIBUTION PLAN
State Fiscal Year 2022

Introduction

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

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- Charissa Fotinos, MD, Washington Health Care Authority (HCA)
- Emalie Hurliaux, DOH
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- Caleb Banta-Green, PhD, MPH, ADAI
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- Sue Green, HCA, Division of Behavioral Health and Recovery (DBHR)

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

- Continue to distribute naloxone across the state beginning September 30, 2021 through September 30, 2022 with the use of federal grants targeted for naloxone.
- Build infrastructure capacity at the state level to support sustainability and expansion of naloxone access.

Priority Populations and Settings

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

Primary population: People who use opioids (including fentanyl) and other drugs.

Secondary populations: Friends and family members who may witness/respond in an overdose.
Professionals who may witness/respond in an overdose.

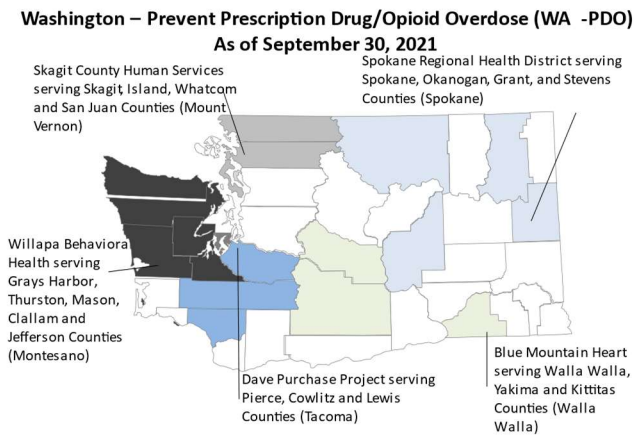
The *Washington State Opioid and Overdose Response Plan* targets distribution of publicly funded naloxone through the following settings and entities:

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

Allocation of Resources

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

Figure 1.



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

The results of this model to estimate level of opioid risk are shown in Table 1 and appear to align with the proportion formula currently used by DBHR to allocate Substance Abuse Block Grant (SABG) monies across the ten Behavioral Health Administrative Services Organizations (BH-ASO) shown in Appendix B.

This model has some limitations since it does not capture recreational or occasional users and individuals who use opioids but may not have an opioid use disorder, for example younger individuals who buy counterfeit pills online.

Table 1. Washington State Opioid Risk by County

County	Fiscal year 2020	
	Total Estimated # of People	Percent
King	20,146	20.4%
Pierce	12,813	13.0%
Snohomish	11,305	11.4%
Spokane	10,528	10.6%
Clark	4,916	5.0%
Whatcom	3,561	3.6%
Kitsap	3,533	3.6%
Yakima	3,525	3.6%
Thurston	3,375	3.4%
Benton	2,715	2.7%
Cowlitz	2,630	2.7%
Grays Harbor	2,384	2.4%
Skagit	2,338	2.4%
Clallam	2,022	2.0%
Lewis	1,483	1.5%
Mason	1,339	1.4%
Grant	1,121	1.1%
Chelan	1,002	1.0%
Walla Walla	921	0.9%
Stevens	892	0.9%
Franklin	862	0.9%
Island	727	0.7%
Okanogan	692	0.7%
Asotin	661	0.7%
Douglas	544	0.6%
Jefferson	466	0.5%
Kittitas	434	0.4%
Pacific	419	0.4%
Pend Oreille	266	0.3%
Whitman	241	0.2%
Klickitat	220	0.2%
Skamania	170	0.2%
Ferry	145	0.2%
San Juan	132	0.1%
Adams	115	0.1%
Lincoln	114	0.1%
Columbia	75	0.1%
Wahkiakum	55	0.1%
Garfield	29	<0.1%
Unknown	8	<0.1%
State Total	98,924	100%

Distribution Strategy for September 30, 2021 through September 30, 2022

This plan proposes a dual-strategy approach to the statewide distribution of naloxone using the two primary funds sources available for distribution between September 30, 2021 and September 30, 2022:

• WA State Project to Prevent Prescription Drug/Opioid Overdose (WA-PDO) FFY 2021 (includes a supplemental award) (9/30/2021 to 8/30/2022)	\$702,512
• Substance Abuse Block Grant (SABG) FFY 2022 (10/1/2021 to 9/30/2022)	\$864,000
Total	\$1,566,512

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

The first strategy is to continue the distribution of naloxone through a new contract arrangement between DBHR and the Washington State Department of Health (DOH) under the WA-PDO grant to distribute naloxone through SSPs in five high-need areas (HNA) in the state (Figure 1). WA-PDO coordinators in the HNAs also distribute naloxone throughout their regions to law enforcement and other relevant partners who need naloxone as seen in Table 2. HCA received a new round of grant funding that will provide this naloxone distribution through August 30, 2026, however the grant amount was \$150,000 less per year than the previous five year grant (\$850,000 vs \$1,000,000 per year)

Table 2. Estimated Naloxone Distribution Coverage via WA-PDO, September 30, 2021 to August 30, 2022

Priority Distribution Channel	# receiving naloxone or technical assistance (TA)	# counties	# naloxone kits distributed
Syringe services programs (SSP)	18	18 (See Figure 1)	8,943
Other entities via SSP	40	21	1,891

DOH will track the purchase and distribution of naloxone through monthly reports to DBHR. Distribution will be paired with data collection. Organizations will be responsible for collecting anonymous data about who receives naloxone kits, the number of kits provided by DOH used in successful overdose reversals, other data related to where naloxone administrations took place, how many doses were used in the overdose reversal and the number of individuals trained on overdose response and naloxone administration, as required by the grant.

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

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

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

Table 3. Estimated Naloxone Distribution Coverage via DOH, October 1, 2021 – September 30, 2022

Priority Distribution Channel	# receiving naloxone or technical assistance (TA)	# counties	# naloxone kits distributed
Syringe Services Programs (non WA-PDO)	11	5 (King, Snohomish, Thurston, Kitsap and Clark)	10,000 [9,100 intramuscular (IM) and 900 intranasal (IN)]
Substance Use Disorder treatment agencies until SB 5195 is implemented	50	20	2,000 IN
Federally recognized tribes	5	5	1,000 IN
Local health jurisdictions, healthcare providers and Accountable Communities of Health	20	10	2,000 IN
Housing/social service providers and outreach, peer organizations	20	15	2,000 IN
Emergency Departments until SB 5195 is implemented	2	2	100 IN
Jails	15	15	1,000 IN

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

Current and Potential Strategies Going Forward

Maximizing naloxone distribution through the Medicaid benefit is an additional strategy for emergency departments and all licensed or certified behavioral health agencies. The passage of Senate Bill 5195 (2021) will be instrumental in implementing policies and procedures to achieve this strategy. Medicaid currently covers naloxone prescriptions, however barriers exist for some patients to fill their naloxone prescriptions at the pharmacy, following medical or emergency department visits. Patients often leave medical care with a written naloxone prescription, rather than naloxone “in hand.” This may be due to burdensome steps required to fill the prescription (time, place, and convenience). Technical assistance may be helpful to address disparities and increase access to naloxone for underserved patient populations. Moreover, prescribers who provide patients with an opioid prescription, including medication for opioid use disorder (MOUD), should consider whether a naloxone prescription is also appropriate, in conjunction with Federal Drug Administration (FDA) recommendations (<https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-health-care-professionals-discuss-naloxone-all-patients-when-prescribing-opioid-pain>).

We seek to innovate regarding access points for naloxone. We know that people access counterfeit pills (pressed blue pills often containing fentanyl, usually labeled “M30”) via the Internet and other informal sources. We also know that some people prefer a private and low-barrier access point for naloxone that does not require walking into a pharmacy or clinic, where issues related to respectful treatment and stigma may come to the fore. While naloxone access is very good at syringe service programs (SSPs), we

know that there is a population of people who use drugs who do not inject and, thus, does not access SSPs. We would like to pursue developing an online portal for individuals in Washington State to access mail-order naloxone [similar to what King County Department of Community and Human Services (DCHS) is doing through their “Laced & Lethal” fentanyl overdose prevention campaign]. This mail-order program could be promoted at various venues, including partner pharmacies, clinics, and programs that serve people who use drugs. We would also seek to promote the mail-order portal through social media that reaches priority populations (e.g., SnapChat to reach adolescents and young adults).

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

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

The Executive Leadership Group of the *Washington State Opioid and Overdose Response Plan* will monitor the implementation of the Naloxone Distribution Plan and develop a revised strategy for distribution starting July 1, 2022, if needed. This possible revision would be completed following the end of the 2022 legislative session. This would allow for the incorporation of any relevant legislation enacted during the 2022 session and/or revisions to the current *Washington State Opioid and Overdose Response Plan*.

The Department of Health will take over the administration of the Naloxone Distribution Plan beginning with the fiscal year 2023 plan (July 1, 2022), and DOH will have full responsibility for naloxone purchasing, distribution, training and technical assistance that is outside of the requirements of [SB 5195](#), “concerning prescribing opioid overdose reversal medication,” which passed in legislative session 2021.

In response to the increased misuse of fentanyl and the possibility of any additional resources, funding could be used for future naloxone distribution statewide as described in the following chart. Teens and younger adults, who are experimenting with drugs that may contain fentanyl, who are not necessarily diagnosed with a substance use disorder and may not be able to access naloxone in the current and typical locations, this allows other options for access to naloxone. This chart also includes the current WA-PDO and SABG funds for reference.

Current Access for Naloxone Distribution (per year)					
Current Funds Sources	Amount for Naloxone	Number of Kits	Access Point	Reporting Requirements?	Anonymous Access?
WA-PDO (DOH) \$702,512 minus DOH admin/indirect and SSP HNA subcontractors 09-30-2021 to 8-30-2022	\$296,188 (includes funds allocated to 2 of the HNA that are able to purchase their own IM naloxone at a reduced rate)	8,943 Intramuscular 1,891 Intranasal (Based on projected allocations for FFY 2021)	Syringe Services Programs (SSP) (law enforcement is able to access naloxone through the SSP)	YES	YES

Current Funds Sources	Amount for Naloxone	Number of Kits	Access Point	Reporting Requirements?	Anonymous Access?
SABG (DOH) \$864,000 minus 1.4% DOH medical purchase indirect and \$15,000 for promotional items for approved events 10-01-2021 to 09-30-2022	\$832,066	18,100 Combination of Intramuscular and Intranasal (Based on FFY 2021 data)	SSP; jails; housing programs; FHQC; LHJ; Tribes While SB 5195 is being implemented, SABG funding from this contract will continue to provide naloxone to entities addressed by the bill.	YES	YES
Potential Access Options for Naloxone Distribution if Additional Funds Allocated (per year)					
Amount of Funds Needed for Access Point Allocated to Naloxone (Includes administrative costs for FTE at DOH /other to staff the expansion)	Number of Intranasal Kits	Access Point	Do we want Reporting Requirements?	Do we want this to be Anonymous Access?	
\$1,633,330 total cost Includes; 6,600 naloxone kits @ \$75 per kit = \$495,000; DOH shipping of naloxone costs \$20,000; \$1,000,000 for expansion of "Laced and Lethal" campaign and social media buys to promote mail order naloxone; DOH indirect cost @ \$21,400; DOH medication contractual indirect @ 1.4% = \$6,930; FTE at community-based organization to provide staffing to do shipping and shipping expenses @ \$90,000	6,600 (550 intranasal kits per month @ \$75 per kit) = \$495,000	Online/Mail Order	NO	YES	
\$3,117,000 total cost Includes DOH FTE @ \$75,000, 40,000 naloxone kits @ \$75 per kit = \$3,000,000; and DOH medication contractual indirect @ 1.4% = \$42,000	40,000 intranasal kits per year @ \$75 per kit = \$3,000,000	DOH expand distribution efforts like the DOH SABG (see above)	NO	YES	

Amount of Funds Needed for Access Point Allocated to Naloxone (Includes administrative costs for FTE at DOH to staff the expansion)	Number of Intranasal Kits	Access Point	Do we want Reporting Requirements?	Do we want this to be Anonymous Access?
<p>\$3,367,200 total cost</p> <p>Includes 20 climate-controlled vending machines @ \$10,760 per machine = \$215,200; 40,000 naloxone kits @ \$75 per kit = \$3,000,000; 2.0 FTE @ \$20 per hour to maintain and restock machines = \$110,000; 2,000 kits per machine @ \$75 per kit; and DOH medication contractual indirect @ 1.4% = \$42,000</p> <p><i>This quote is based on 20 machines statewide.</i></p> <p>This option would take time to implement.</p> <p>Could be scaled up or down: 1 machine is \$10,760; maintenance and restocking 1 machine is 0.1 FTE; 2,000 kits per machine per year; and 1.4% medication contract indirect. One machine would be approximately \$168,360.</p>	<p>40,000 kits per year @ \$75 per intranasal kit = \$3,000,000</p>	<p>Vending Machines (could be at entities such as food banks, shelters, bars, restaurants)</p>	<p>NO</p>	<p>YES</p>
Other Items per year				
\$5,000	Promotional materials to promote access points			
\$5,000	Promotional materials for using vending machines			

Implementation Issues

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

- Transfer of naloxone procurement and distribution from ADAI to DOH August 31, 2021. This transfer was completed as of August 31, 2021, and DOH has full responsibility for naloxone procurement and distribution outside of the requirements of [SB 5195](#), “concerning prescribing opioid overdose reversal medication,” which passed in legislative session 2021.
- Additional resources may also need to be identified to meet the demand for naloxone statewide. This could be through a request to the Governor’s Office, a formal Decision Package, or possible funding that is provided to the state through other sources.

- Data collection remains an essential tool for the federal grants, however for obtaining future funding the past research already shows that naloxone distribution is effective and data collection should not be a requirement for non-federal grant funding. Data collection is an administrative burden on the entity receiving and distributing the naloxone, as well as on the individual receiving naloxone.

Before the transition of all naloxone distribution to DOH in August 2021, DOH, ADAI and DBHR examined past and current methods of data collection by their respective programs. DOH and DBHR will continue data collection that meets the needs of the federal funding source and resources of participating agencies. DOH will work within the parameters set forth by the funding sources and their partnership with DBHR for the WA-PDO and SABG federal grants. Data collection must be sensitive to the time and resource constraints of the diverse agencies distributing naloxone.

- If we choose to provide naloxone through online and mail orders access, it will be important to use funding for advertising and education through social media and other options to get the word out to those that are most likely to need to access naloxone.

Appendix A

Naloxone Resource Distribution, Washington State FY 2022 Research and Data Analysis, DSHS

Naloxone Resource Allocation Table

Washington State continues to allocate more resources to the distribution of naloxone to combat the opioid crisis. To distribute these resources across the State according to need, we propose an allocation model based on the incidence of opioid use treatment need among Medicaid recipients in each county presented as the estimated number of people who would benefit from having a naloxone kit based on their own opioid use. In the future, data regarding overdose deaths and hospitalization may need to be added to this allocation calculation as youth fentanyl overdoses related to pills continues to increase. Current resource allocations will be based on the following:

Measure: Opioid Use Disorder Treatment Need Indicator

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

Method

- Identify all Medicaid eligible individuals in FY 2020.
- Flag Medicaid clients with any OUD treatment need indicator in FY 2020 or the two preceding years (FY 2018 or 2019). Any individual with an indicator for OUD treatment need during the time frame described is counted as having OUD treatment need in FY 2020.
- Individuals with OUD treatment need are assigned to their county of residence as of June 30, 2020 (according the DSHS Integrated Client Database).
- Individuals are only counted once, no matter how many indicators for OUD treatment need they had in the period and are only assigned to one county.

Limitations

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

Table 1. Washington State Opioid Risk by County

County	Fiscal year 2020	
	Total Estimated # of People	Percent
King	20,146	20.4%
Pierce	12,813	13.0%
Snohomish	11,305	11.4%
Spokane	10,528	10.6%
Clark	4,916	5.0%
Whatcom	3,561	3.6%
Kitsap	3,533	3.6%
Yakima	3,525	3.6%
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Grays Harbor	2,384	2.4%
Skagit	2,338	2.4%
Clallam	2,022	2.0%
Lewis	1,483	1.5%
Mason	1,339	1.4%
Grant	1,121	1.1%
Chelan	1,002	1.0%
Walla Walla	921	0.9%
Stevens	892	0.9%
Franklin	862	0.9%
Island	727	0.7%
Okanogan	692	0.7%
Asotin	661	0.7%
Douglas	544	0.6%
Jefferson	466	0.5%
Kittitas	434	0.4%
Pacific	419	0.4%
Pend Oreille	266	0.3%
Whitman	241	0.2%
Klickitat	220	0.2%
Skamania	170	0.2%
Ferry	145	0.2%
San Juan	132	0.1%
Adams	115	0.1%
Lincoln	114	0.1%
Columbia	75	0.1%
Wahkiakum	55	0.1%
Garfield	29	<0.1%
Unknown	8	<0.1%
State Total	98,924	100%

Table 2: ICD-10 Codes Used to Create the Opioid Use Disorder Treatment Need Indicator

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

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

Chart 2: Comparison of Opioid Risk sorted into Behavioral Health Administrative Services Organizations (BH-ASO) (FY 2020) to DBHR's distribution of Substance Abuse Block Grant (SABG) Federal Block Grant Funds (FY 2022)

Behavioral Health Administrative Services Organizations (BH-ASO)	RDA Opioid Risk Percent	Federal SABG Distribution Percent	Difference
Great Rivers	7.0%	5.0%	2.0%
Greater Columbia	9.6%	9.7%	-0.1%
King	20.4%	20.8%	-0.4%
North Central	3.4%	2.6%	0.8%
North Sound	18.3%	18.9%	-0.6%
Pierce	13.0%	11.4%	1.6%
Salish	6.1%	7.0%	-0.9%
Southwest	5.4%	6.7%	-1.3%
Spokane	12.2%	12.4%	-0.2%
Thurston Mason	4.8%	5.4%	-0.6%
Total	100%	100%	