Attendees: Annie Failoni, OPHS; Anna McEnery, JCPH (for Vicki Fitzpatrick); Ford Kessler, Safe Harbor; Gabbie Caudill, Believe in Recovery; Jim Walkowski, EJFR; Joe Nole, County Sheriff; Matt Ready, JHC; Jim Novelli, DBH; Patrick Johnson, NAMI; John Nowak, Lori Fleming, and Bernadette Smyth, Grant Team.

Dial In: Brian Richardson, Recovery Café/Dove House; Lisa Grundl, Health Facilities Planning & Development; Lisa Rey Thomas, Regional Representative; Jud Haynes, Navigator.

Apologies: Jenn Wharton, JHC

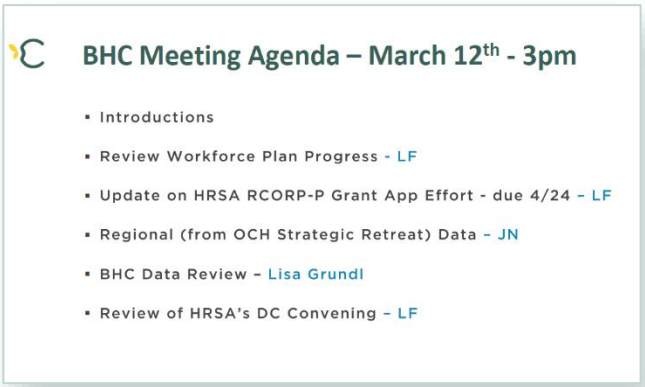
BHC Voting Members Absent: James Kennedy, County Prosecutor's office

Access Meeting Documents: here

Notes

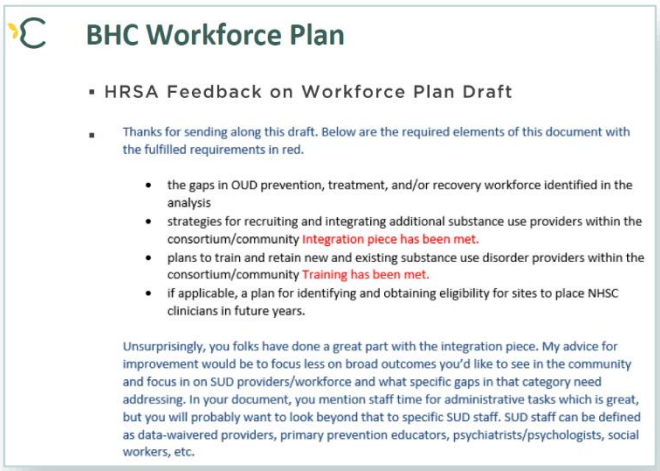
Consortium and ad hoc members introduced themselves and were welcomed. Lisa Grundl, Lisa Rey Thomas and Brian Richardson called in to the meeting by conference phone.

Lori outlined the Agenda for the meeting, including updates on Workforce Plan and HRSA Grant Application progress; regional data updates; and update on HRSA Convening in DC in March.



Workforce Plan Update

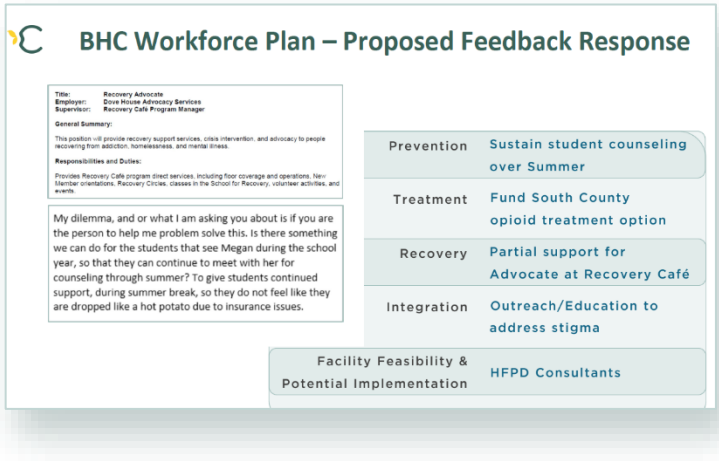
The draft workforce plan has been submitted to HRSA and the team has received feedback on it. They agreed that the integration and training sections of the draft meet the requirements of the grant, but that full time equivalents (FTEs) for staff will need to be added. Currently, much of the FTE work around navigators and case managers is being done by the Mental Health Field Response (MHFR) team. We still have to visit a non-profit facility, but because of the Coronavirus pandemic, that will have to be put on hold, though we may be able to set up a conference call to obtain needed numbers. We may have to develop "guesstimates" on some of this information.



Sheriff Joe Nole asked how we hope to deal with co-occurring disorders—substance abuse and mental health. John Nowak pointed out that one of the things learned on the tour of the for-profit facility is that dual certification is actually a more complicated certification to obtain, and difficult to find folks with it, and that this often drives service providers to focus either on substance use disorder or mental health. Jim Novelli pointed out that it's not desirable to expect people with co-occurring disorders to go from one provider to another, so that anything we can do to facilitate training and co-occurring disorder counselling would be great.

Workforce Plan Content:

- The first suggestion to include, under Prevention, is a FTE (or partial FTE) to sustain counseling for students over the summer who have been getting it throughout the school year. (UPDATE 3/20/2020: the grant team has pivoted from this to focus funding support of the Benji Project with the goal to solidify their stress management and resiliency training curriculum (an evidenced-based program from UC San Diego's Center for Mindfulness) being offered and engaged with in all Jefferson County school districts 6th, 9th and 12th grades by the end of the RCORP-I grant's term (August 30, 2023).
- Under Treatment, we hope to fund a South County treatment option, maybe building on the current nurse practitioner in the Quilcene clinic—perhaps enhance the needle exchange program or some other wraparound service we could provide.
- Under Recovery, we plan to offer support to the Advocate/Manager at the Recovery Café.



- At the intersection of all these, Integration, is outreach and education to address stigma. We would like to contract a consultant to help the BHC to create that master communications plan that could be executed over the term of the next grant.
- Finally, we plan to include funding for Lisa Grundl and Jody Carona of HFPD to continue moving the BHC through feasibility and into the possible planning and implementation of a CSC/E&T facility.

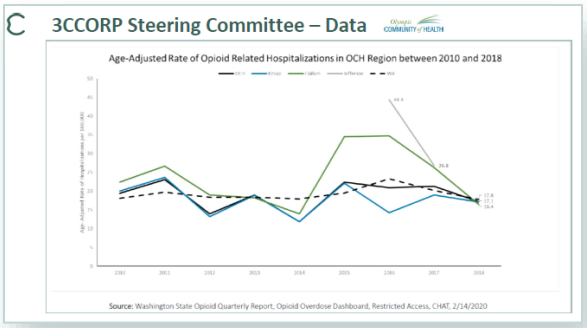
HRSA/RCORP Grant Application Update

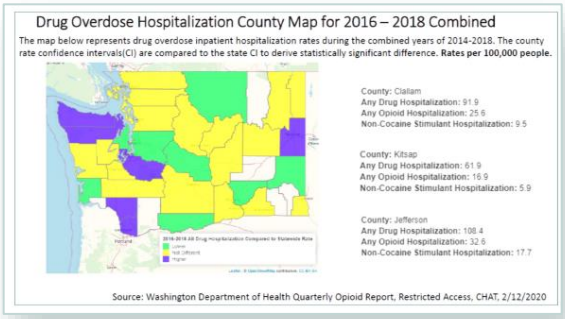
This is a HRSA/RCORP grant for $1 million over three years, beginning September 2020, that would be used to implement the Strategic Plan that's been developed by the Consortium. The grant application is due 4/24/2020 and covers three main areas: Prevention (address stigma, increase access to naloxone, implement year-round drug take-back programs, increase school and community based prevention programs, and identify and screen individuals at risk for USD/OUD); Treatment (address infectious complications in those with SUD/OUD, create interdisciplinary teams willing to provide MAT etc., increase

number of providers, reduce barriers to treatment, strengthen collaboration with first responders, ensure financial sustainability of service through proper coding and billing, and enable individuals to access SUD/OUD treatments); and Recovery (enhance discharge coordination for those who require linkages to home and community based services, expanded peer workforce, and support development of recovery communities). The application will include what we have going on in our community, what we put in our Strategic Plan, and so on. We will need data from Consortium members on the number of individuals screened for STD over the past six months. We have received some of this information (OPHS, Believe in Recovery) but still have to get numbers from others (Jail, Hospital, DBH). We will also need Consortium members to sign a commitment letter that will identify organizations' roles and responsibilities on the project, the activities that will be undertaken, and a commitment to share aggregate performance data. We will be asking those signing to commit to all three years of the implementation project.

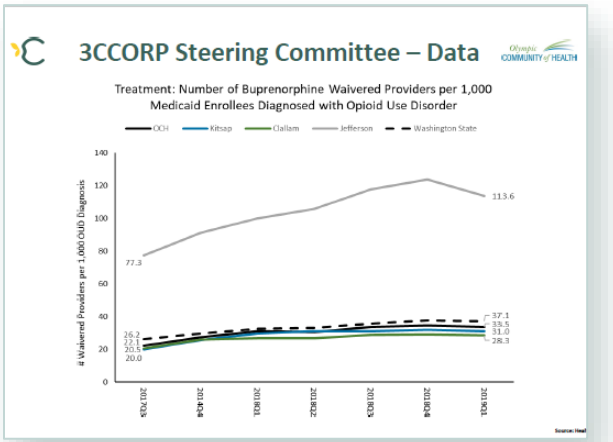
Data Update – Regional and County

Olympic Community of Health have a 3CCORP effort around opioid treatment in the three-county region (Clallam, Jefferson, Kitsap), and part of their work is to look at data about opioid use in our community, which has produced some pretty interesting and sometimes surprising data.





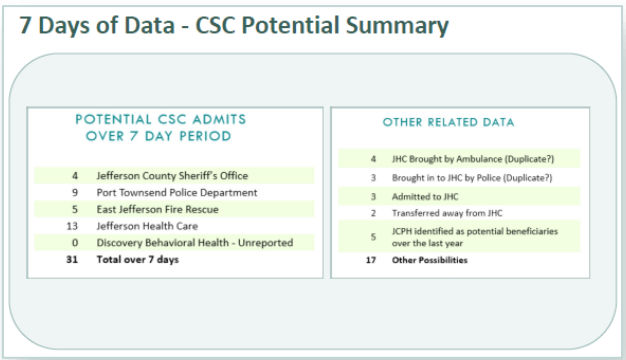
For example, while common belief is that Clallam County has significantly higher opioid rates than Jefferson County, this data indicates that Jefferson is at least as bad as Clallam, and that in relation to hospitalization rates, we are significantly higher than either Clallam or Kitsap—and higher than the state average.



This slide shows the number of providers in our community that are waivered for Buprenorphrine administration, Suboxone. Jefferson County is way above other counties, and part of the reason for this is that we received some funding to have several primary care providers trained. Even though our hospitalization and provider rates are high, our rate of people receiving treatment is low, so more waivered people and hospitalizations isn't translating into more patients receiving treatment. The issue is, how are people accessing providers? Of note is these are statistics from 2018, and things have changed so much in the last year, so it may be that more people are accessing providers now. John will contact Healthier Washington to see if there is more recent data available, and bring it to the next meeting if more recent data exists.

On Syringe Exchange, there was an almost doubling of the syringe exchange in Jefferson County from 2016 to 2017. The numbers stayed about the same in 2018, and dropped a little bit in 2019.

Data Update – BHC Specific



HFPD requested seven-days worth of data from members to form a snapshot of the need for a CSC facility and the bed number capacity Jefferson County would support. Analysis of earlier data indicated an ADC of around one, but the seven-day data suggested an ADC of five to ten. Lisa pointed out that, while individual organization numbers might be low, when added together they represented a patient population that could support a small CSC facility of 10-15 beds. Lisa added that she would like to do this exercise every week for a few weeks, as it's revelatory, but all agreed with the current COVID-19 landscape, we'd not try to do that this month.

Lisa asked those in the room to comment on whether the figures in the seven-day data reflected what they normally see in their organization.

Joe Nole said that the Sheriff's Office data was lower than he thought it would be, and wondered if an average across a few weeks might give a more accurate picture. Joe added that the exercise made him think about whether having a place to take somebody would change the kind of triage they are currently

doing; he also said he realized that he didn't really know what the criteria would be for sending someone to a facility, and that could change who they would take for help.

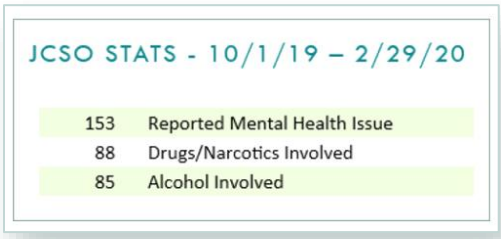
Jim Walkowski of EJFR agreed. He thought his numbers were lower than he anticipated. He also said that it would be great if there were a kind of algorithm (here's the client; here's the definition of what x looks like; here are their options) they could use. Right now, the choices are hospital, jail, or leave them where they are.

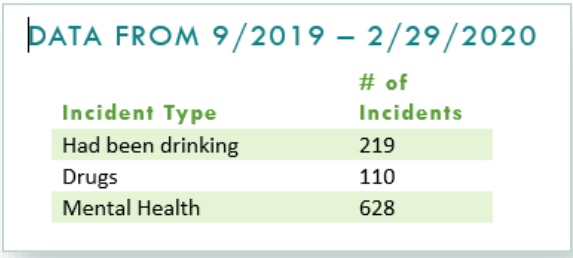
Jim Novelli of DBH said the numbers have been fluctuating greatly since Volunteers of America started taking crisis calls for DBH. In January 2020, DBH had 11 ITAs—more than for the whole of 2019. Jim posited that, when DBH used to get two calls a week, they could de-escalate the situation differently, and they have been in discussion with Volunteers of America to address this. Meanwhile, even though ITAs have increased, the number of calls DBH gets to do a crisis de-escalation has dropped. Jim agreed that what people need is criteria around what services to provide individual clients.

Lisa said that how the potential facility is funded will help determine criteria for use: who would qualify, who would not. Most of the patients are likely to be covered by Medicaid, although there is potential for insurance and private coverage, too—much would depend on how the facility is licensed and what the different categories of care would be within the facility. We would need to talk to nonprofit clinics about their mix of funding and eligibility requirements. Lisa acknowledged that, in the field, it can be difficult to assess, but if unsure, the individual could be brought to the facility to be assessed and then referred to the relevant services.

Lisa also said that we need to keep talking about how SUD plays into this. For example, the data from Jefferson Healthcare and the Jail(?) would indicate a higher substance use interaction than mental health. We need to be aware that there's both drug and alcohol issues, and mental health issues in the community. In the site visit to the for-profit facility in Shelton, it was interesting that most of their mental health patients had substance use issues, and so we'll want to consider how we'll deal with patients going through withdrawal.

Joe Nole said that JSCO collects information on mental health/drug incidents, but when they pull up this data, it is separate—thus, co-occurring data is not gathered, and it would be nice to see that. Lori noted it might be worth exploring how the coding is happening with the Sheriff's team and see if that reveals why the marked difference in the PTPD and JSCO stats on the Mental Health front.





Lori was excited about the statistics being gathered by the Jail. Anna McEnery commented that she was surprised by the huge number of people (28) who self-reported TBI (traumatic brain injury) at booking in the first couple of months of 2020. This was particularly of concern as we don't have any TBI resources in our community. Joe Nole and others in the group agreed and commented that it's not unusual for TBI to be mistaken for mental health issues. Jim Novelli added that TBIs are a black hole for service throughout the county, and that TBI patients are not admittable to a psychiatric unit, as it's not a psychiatric issue.

JAIL – 2020 STATS

6	Evaluated by DCR
88	Booked on drug and alcohol charges
42	Interested in MAT (AT BOOKING)
3	Reported Suicidal Ideation (AT BOOKING)
27	Reported Prior Suicide Attempts (AT BOOKING)
50	Reported Behavior health Problem (AT BOOKING)
9	Reported Developmental Disability (AT BOOKING)
127	Reported Drug or Alcohol Use in last week (AT BOOKING)
65	Reported Drug Problem (AT BOOKING)
13	Reported Alcohol Problem (AT BOOKING)
19	Reported Both Drug and Alcohol Problem (AT BOOKING)- 19
68	Currently Under the influence of Drugs or Alcohol – UA or Admission (AT BOOKING)
31	Opiates or Suboxone
37	None or none opiates
28	Reported TBI (AT BOOKING) – 28
15	Reported having Hepatitis (AT BOOKING)
16	MAT Inductions
246	**Total bookings YTD**

Jim Walkowski said that EJFR moved over to a new, very robust, records management system on March 1st. In this report, numbers were included for 2017, 2018, and 2019. Ironically, the last quarter of 2019 slowed down quite a bit, although 2020 started off strong (2020 figures only go through February 5th), with an uptick in the number of opioid overdoses they have dealt with. Because of the new records management system, he anticipates that they will get even better at reporting this data.

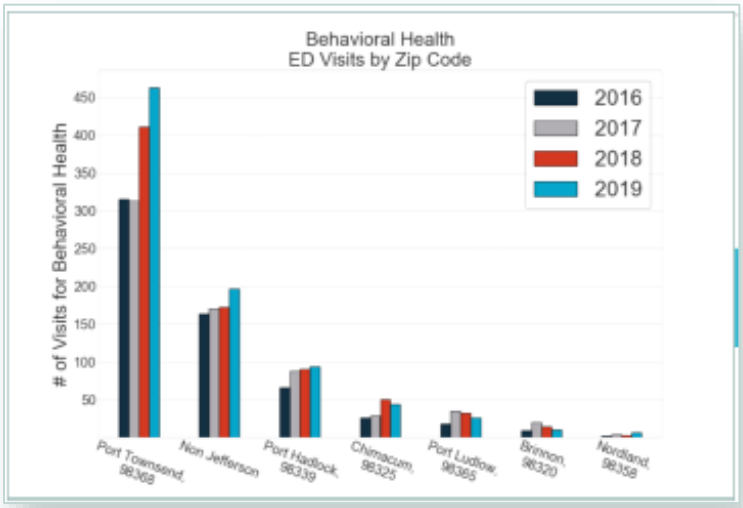
EJFR – OPIOID & BEHAVIORAL HEALTH OCCURENCES

Date	Zip Code	Incident Type	# Narcan Administered	Patient Outcome
1/2/2019	98368	Unknown, Oxycodone	2 doses narcan from friend	Tx to JGH
2/1/2019	98368	Heroin	Family gave x3 Narcan, State Patrol - 2 nasal Narcan	Tx to Harrison
3/14/2019	98339	Heroin	Nasal Narcan by family	Airlift to HMC
6/12/2019	98368	Heroin/Benzo	.4m narcan by law... Medics - .4 IV Narcan	Tx to JGH
6/12/2019	98368	Heroin	.4mg, .8mg IV Narcan	Tx to JGH
7/4/2019	98368	Heroin	.4mg nasal Narcan by friend	Tx to JGH
7/8/2019	98365	Codeine		JGH-Virginia Mason
7/26/2019	98368	Unknown Benzo's		Tx to JGH
8/6/2019	98368	Heroin		Tx to JGH
8/8/2019	98368	Oxycodone	CPR, intubated	Airlift to HMC
9/14/2019	98339	Possible Meth		Tx to JGH
11/24/2019	98368	Heroin		Tx to JGH
12/10/2019	98369	Heroin	JCSO .4mg narcan	Tx to JGH
1/8/2020	98368	Heroin	Law 4mg nasal narcan, EMS .4mg iv narvan	Tx to JGH
1/25/20	98368	Heroin & Meth	.4 Naloxone	
2/5/20	98368	Unknown	.8mg narcan	Tx to Harrison
3/1/2020	98368	Heroin	.4 Narcan by JCSO / .4 Narcan by EMS	Tx to JGH

EJFR – BEHAVIORAL HEALTH RESPONSES

Year	Responses
2017	151
2018	153
2019	144
2020 (Through 2/5/2020)	8

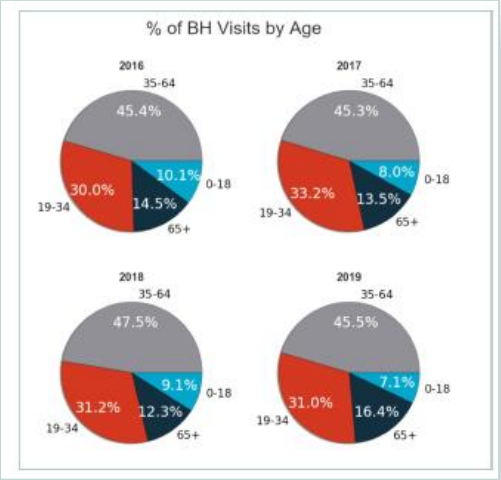
There was nobody present at the meeting to comment on the PT Police Department data. Chief Mike Evans has retired and moved out of county, and Sergeant Troy Surber will be filling in until such time as a new PTPD chief is hired. In the meantime, Lori will try to get more complete data from the department. Joe Nole pointed out that the Police Department use the same tracking system as the Sheriff's Office. He also added, in response to a question from the group, that officers using their best judgement and experience, but they are not mental health professionals, so their data is not perfect. However, officers deal with people and situations every day, and that does increase their experience and their ability to judge a situation.

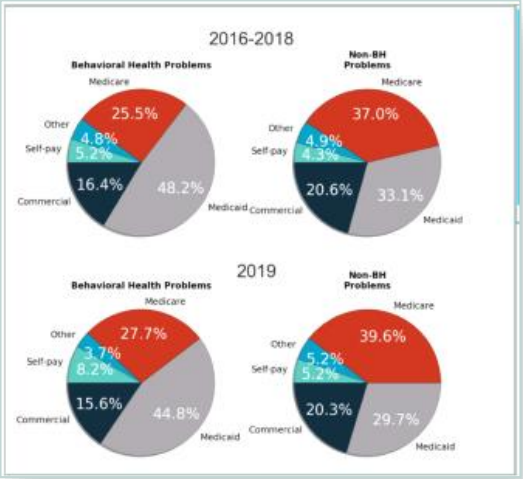


John Nowak reported on the Jefferson Healthcare data, which he said were mostly ED visits by zip code. The data also gives a snapshot of the total number of visits, and whether the trend is up or down—it is pretty clearly up. A high percentage of behavioral health clients are from Port Townsend, with the rest distributed around the County. A member commented that the 98368 zip code goes beyond Port Townsend, and John said the data could be geo-coded by address to figure out who is actually from the city of Port Townsend.

The next slide gives some idea of age breakdown. The largest group of people accessing care for behavioral health issues is the 35-64 age range, mostly covered by Medicaid. This was surprising because of the large percentage of elderly in our County.

All data is combined mental health and substance use disorder. It will also be easy to this data by gender





This slide gives information on payor mix, showing a large proportion being covered by Medicaid.

HRSA Convening – Washington DC

Lori reported on the HRSA meeting in DC, where there were about 250 projects in attendance, doing all kinds of interesting work. There were also some great working sessions around creating quality improvement and metrics. It was a good education all around, and made her look forward to possibly having the same coach if we get the implementation grant. Coach Andrew would like to come and carry out a site visit, but travel restrictions around Covid-19 may not make that feasible.

Future Meetings

Our next meeting is scheduled for April 9th at 3:00 pm at the Chimacum Fire Station. While the group agreed it may be prudent to have the meeting via Zoom or Skype, it was felt there was a lot of important work that needed to be done before the grant application was due. So the decision was to meet as planned, and to monitor the situation and let everyone know exactly how the meeting will be conducted.

Next Meeting: Thursday, April 9th, 2020. 3:00pm-4:00pm
Chimacum EJFR Firehouse Training Room, 9193 Rhody Drive, Chimacum