CHANGING Maryland *for the Better*

Nationally Recognized Best/Promising Practices Overview and Data Profile Project

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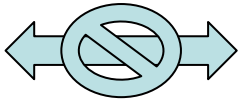
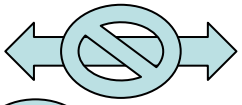
Why Focus on Practice *Integration?*

- Services for high-risk population fragmented across multiple provider systems:
  - Somatic/hospital  BH treatment
  - Public health programs  clinical services
  - BH Tx: medication  psychosocial
  - Social supports  clinical services
- High-risk population difficult to engage & retain
- Limited resources requires maximizing existing opportunities, staff, expertise, funding….
- Consolidate *local level* care system that supports individuals in their own community

What Practices are Being Highlighted?

- Medication-Assisted Treatment (MAT): expanding capacity & improving access & quality of care
- Overdose Education & Naloxone Distribution (OEND): empowering at-risk people & their close associates to save lives
- Peer Recovery Support: linking across clinical, social service & recovery settings

Why Highlight These Practices?

- Individuals with serious opioid use disorder are at highest risk for overdose
- Public health strategy must target high-risk individuals to reduce fatal/nonfatal overdose
- Services for high-risk individuals with strongest evidence base must be prioritized
- Integration of evidenced-based services most likely to be effective

Medication-Assisted Treatment

Decades of research, strong evidence that MAT:

- Improves retention in treatment
- Reduces illicit opioid use
- Reduces criminal activity associated with drug addiction
- Reduces HIV-risk behaviors, incl. injection & needle sharing
- Reduces mortality risk from overdose

Fullerton, C.A., et. al. “Medication-Assisted Treatment with Methadone: Assessing the Evidence” *Psychiatric Services* Vol. 65 No. 2, Feb. 2014
Thomas, C.P., et. al. “Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence” *Psychiatric Services* Vol. 65 No. 2, Feb. 2014
Friedmann, P.D. & Schwartz, R.P. “Just call it ‘treatment’” *Addiction Science & Clinical Practice,* 7:10, 2012.

Overdose Education & Naloxone Distribution

OEND is feasible in many settings.	• Walley et al. JSAT 2013; 44:241-7 • Bennett et al. J Urban Health. 2011: 88; 1020-30 • Enteen et al. J Urban Health 2010:87: 931-41 • Doe-Simkins et al. Am J Public Health 2009: 99: 788-791 • Piper et al. Subst Use Misuse 2008: 43; 858-70
Participants demonstrate knowledge and skills after training.	• Wagner et al. Int J Drug Policy 2010: 21: 186-93 • Tobin et al. Int J Drug Policy 2009: 20; 131-6 • Green et al. Addiction 2008: 103;979-89
Naloxone does not lead to an increase in risky use, but does lead to an increase in drug treatment.	• Seal et al. J Urban Health 2005:82:303-11 • Wagner et al. Int J Drug Policy 2010: 21: 186-93 • Galea et al. Add Beh 2006: 31: 907-912
OEND contributes to reduction in overdose in communities.	• Maxwell et al. J Addict Dis 2006:25; 89-96 • Evans et al. Am J Epidemiol 2012; 174: 302-8 • Walley et al. BMJ 2013; 346: f174

Peer Support Services

- SAMHSA: peer support and consumer operated services are evidence based practices
- CMS: “Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. http://www.cms.hhs.gov/SMDL/downloads/SMD081507A.pdf
- Institute of Medicine: importance of peer services in landmark report “Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series”. http://www.iom.edu/Reports/2005/Improving-the-Quality-ofHealth-Care-for-Mental-and-Substance-Use-Conditions-Quality-ChasmSeries.aspx
- Annapolis Coalition on the Behavioral Healthcare Workforce: peer services as one of its areas of emphasis to transform the behavioral health workforce and prepare for anticipated workforce shortages in the face of healthcare modernization. http://www.annapoliscoalition.org/pages/
- Peer specialists may increase wellness and decrease costs: *Cost Effectiveness of Using Peers as Providers,* Sue Bergeson, VP, Consumer Affairs, OptumHealth

Overdose Data Profile Project

Goals:

- Improve quantity, quality, timeliness & regularity of data analysis to inform surveillance, planning & evaluation
- Increase data sharing b/t state, academic partners, jurisdictions & other stakeholders
- Inform primary, secondary & tertiary prevention efforts
- Institutionalize iterative process for development of data products

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Overdose Data Profile Project

Objectives:

- Expand State Epidemiological Outcomes Workgroup (SEOW) to include OD prevention focus & serve as OD epi hub
- Include multiple DHMH, university, LHD data analysts working on addiction & OD projects
- Develop statewide & jurisdictional opioid addiction/OD epi profiles, update frequently
- Establish regular SEOW mtg/web-conference to discuss findings & provide technical assistance on data analysis, methodology, interpretation, etc.
- Leverage partner resources to conduct & distribute ad hoc analyses of PDMP, HSCRC, BH treatment & other data

State Epidemiological Outcomes Workgroup

- SAMHSA framework for epi support for prevention planning
- Convened under state authority, includes state & local health program staff, academic researchers, data custodians
- Collate and make available existing data and analysis products; coordinate new data projects
- Required to develop epi profiles describing drug/alcohol use prevalence & consequences
- Identify risk & protective factors & align strategies to impact factors

Maryland's SEOW

- Overseen jointly by BHA Offices of Prevention & Wellness and Overdose Prevention
- Coordinated by UMB School of Pharmacy, PI Linda Simoni-Wastila, BSPharm, MSPH, PhD
- Website: https://pharmacy.umaryland.edu/programs/seow/
- SUBSTANCE USE AND OUTCOMES: 2015 MARYLAND STATE EPIDEMIOLOGICAL PROFILE
  https://pharmacy.umaryland.edu/media/SOP/wwwpharmacyumarylandedu/programs/seow/PDF2016/substance-use-and-outcomes-2015-epi-profile.pdf

Datasets Available/Analyzed

- Prescription Drug Monitoring Program (PDMP)
- Health Services Cost Review Commission (HSCRC)
- National Survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS)
- IMS National Prescription Audit
- Maryland Automated Accident Reporting System (MAARS)
- National Vital Statistics System (NVSS)
- State of Maryland Automated Record Tracking (SMART) System
- Treatment Episode Data Set (TEDS)
- Youth Risk Behavior Survey (YRBS)

Next Steps

- LHD review of DRAFT jurisdictional epi profile
- BHA survey of LHDs for feedback on profile and preferred SEOW structure/process
- Profile revisions based on feedback
- SEOW invitations
- Schedule first SEOW meeting to review recommendations and begin data strategy development

Opioid & Other Drug Use and Consequences:
'X' County

Maryland State Epidemiological Outcomes Workgroup (SEOW)

This report highlights recent information on the use and consequences of opioids and other drugs in 'X' County, Maryland.

SUMMARY

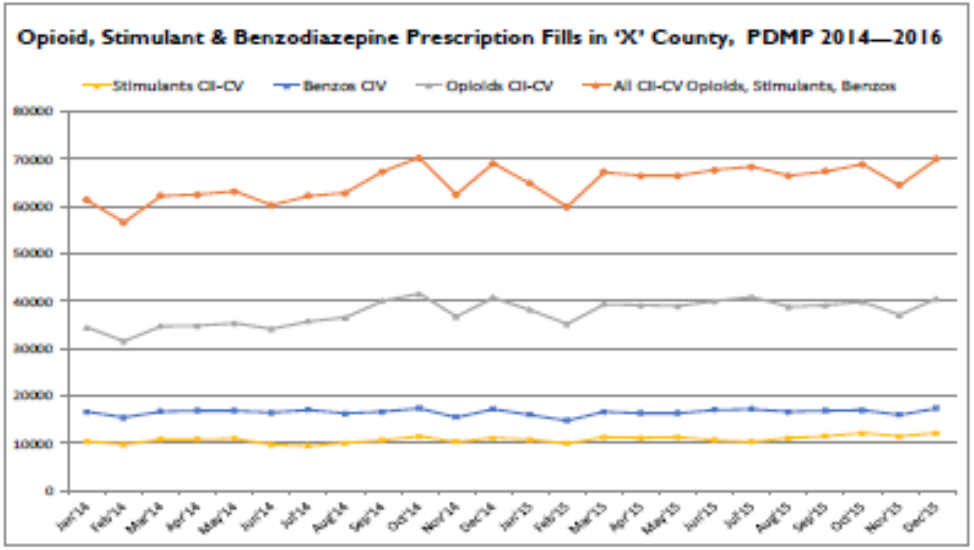
- In 2014-2015, 'X' County accounted for 11% of all statewide prescription opioid, benzodiazepine, and stimulant fills while making up only 9% of the state population
- Significant differences in total prescription fills and prescriptions per person were found between zip codes across the county
- Annual hospital events involving prescription opioids and heroin increased from 2011 to 2014
- Prescription opioids alone and in combination with other prescription and illicit drugs made up a significant proportion of drug-related hospital events

County Demographics
(2014 U.S. Census Estimates)

- **Population:** 550,269
- **Racial mix:** 15.7% black, 74.8% white, 3.5% Asian, 6.7% other
- **Below poverty level:** 5.9%
- **Unemployed:** 4.5%
- **Median household income:** $89,031
- **High school graduation rate:** 91.1%

Opioid, Benzodiazepine, and Stimulant Use

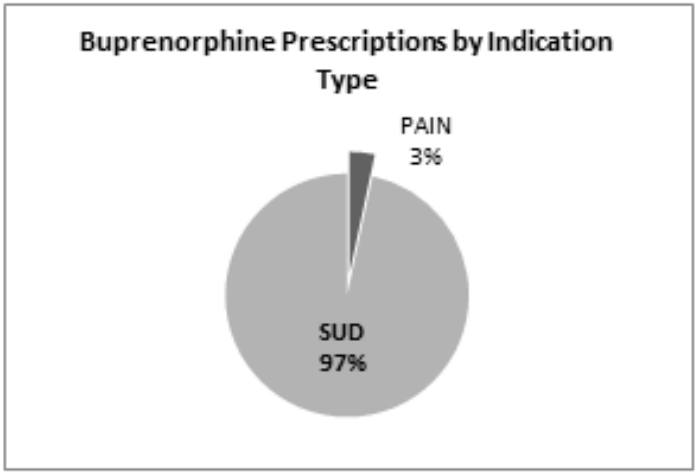
- 'X' County accounts for 11% of all statewide prescription opioid, benzodiazepine, and stimulant fills
- Prescription opioid fills have steadily increased, regardless of minor fluctuations during 2014-2015
- Benzodiazepine and stimulant prescription fills remained stable throughout 2014-2015



Buprenorphine Prescribing Patterns in Maryland: January 1 to October 15, 2016

Total Prescriptions of Buprenorphine Containing Drugs Captured in PDMP, Statewide

Drug Name/Formulation	Total Prescriptions	% Total
Indicated for Pain:	7388	3.35
BELBUCA/FILM	482	0.22
BUPRENEX/VIAL	7	0.00
BUPRENORPHINE/VIAL	14	0.01
BUPRENORPHINE/POWDER	318	0.14
BUTRANS/PATCH	6567	2.98
Indicated for Opioid Use Disorder(OUD) Treatment:	213298	96.65
BUNAVAIL/FILM	245	0.11
BUPRENORPHINE-NALOXONE/FILM	24221	10.98
BUPRENORPHINE/TABLET	19320	8.75
PROBUPHINE/IMPLANT	1	0.00
SUBOXONE/FILM	140664	63.74
SUBOXONE /TABLET	6	0.00
ZUBSOLV/TABLET	28841	13.07
Total	**220686**	**100.00**



Prescription Counts of Buprenorphine- Containing Drugs by Patient County of Residence

COUNTY	Total Prescriptions	Pain Prescriptions (% County Total)	Pain Prescriptions % State Total	OUD Treatment Prescriptions (% County Total)	OUD Prescriptions % State Total	COUNTY	Total Prescriptions	Pain Prescriptions (% County Total)	Pain Prescriptions % State Total	OUD Treatment Prescriptions (% County Total)	OUD Prescriptions % State Total
Allegany	4971	169 (3.4%)	2.29	4802 (96.6%)	2.25	Harford	11407	436 (3.82%)	5.90	10971 (96.18%)	5.14
Anne Arundel	24857	1016 (4.09%)	13.75	23821 (95.91%)	11.17	Howard	5460	405 (7.59%)	5.48	5075 (92.61%)	2.38
Baltimore	35296	1098 (3.11%)	14.86	34198 (96.89%)	16.03	Kent	1868	39 (2.09%)	0.53	1829 (97.91%)	0.86
Baltimore City	52514	352 (0.67%)	4.76	51962 (99.33%)	24.36	Montgomery	12555	979 (7.92%)	13.25	11576 (92.08%)	5.33
Calvert	6555	90 (1.38%)	1.22	6445 (98.62%)	3.02	Prince George's	5329	488 (9.16%)	6.61	4841 (90.84%)	2.27
Caroline	1900	75 (3.95%)	1.02	1825 (96.05%)	0.86	Queen Anne's	5251	111 (5.41%)	1.50	5140 (96.59%)	1.47
Carroll	7892	334 (4.23%)	4.52	7558 (95.77%)	3.54	Somerset	2125	59 (2.78%)	0.80	2066 (97.22%)	0.97
Cecil	11227	76 (0.68%)	1.03	11151 (99.32%)	5.23	St. Mary's	5407	141 (4.14%)	1.91	5266 (95.86%)	1.55
Charles	4279	249 (5.82%)	3.37	4030 (94.18%)	1.89	Talbot	1192	99 (8.31%)	1.34	1093 (91.69%)	0.51
Dorchester	1660	258 (15.54%)	3.49	1402 (84.46%)	0.66	Washington	6712	241 (3.59%)	3.26	6471 (96.41%)	3.03

Questions?