Decreasing Drug Overdose Deaths in Maine:
What Will It Take?

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Drug Overdose Deaths: What Do We Know?

• Overdose (OD) deaths have **tripled** in US between 1999 & 2016
• 116 people die every day in U.S. (1 every 12’!)
• Fentanyl contributing greatly to rise in deaths
• Some populations even higher risk:
  o Homeless: 9X higher
  o Post-incarceration: 12X higher
• Current strategies are proving insufficient!
3 Waves of the Rise in Opioid Overdose Deaths

- **Wave 1:** Rise in Prescription Opioid Overdose Deaths
- **Wave 2:** Rise in Heroin Overdose Deaths
- **Wave 3:** Rise in Synthetic Opioids like fentanyl

**SOURCE:** National Vital Statistics System Mortality File.
Drug deaths in Maine

The number of overdose deaths hit a record 418 in 2017. Opioids, both illicit and prescription, were responsible for the vast majority of fatal overdoses. In many cases, more than one drug was listed as a cause of death or significant contributing factor.
2017 Overdose Deaths by County

2017 Drug Deaths Report
– ME Attny Genl’s Office
QC Moving Forward: Taking C4ME to the Next Level

Objective:

➢ Reduce drug OD deaths by 1/3\textsuperscript{rd} in 3 yrs
➢ Prevent 125 Maine people from dying of drug OD by 2020 (decrease 418 to 293)
Addressing Opioid Epidemic: Successes

• Significant drop in opioid prescribing
• Many community forums
• More public awareness of opioid issues
• Many more provider grps offering MAT svcs
• Some EDs initiating buprenorphine
• New naloxone law/rules in place
• Recovery community voice increasing
Changes in Opioid Prescribing ME: 2013-2017

Total # Opioid Rxs

The Challenge: Cont’d Rise in OD Deaths, Even As Opioid Prescribing Decreases

Deaths Due to Overdose in Maine, 2000-2017

- All Overdose Deaths
- Opioid Overdose Deaths

Source: ME Office of Chief Medical Examiner and US Centers for Disease Control and Prevention—repr’d with permission from Toho Soma, UNE
Community-Based Efforts

Several community efforts to address opioid epidemic – e.g.

• Bangor Community Health Leadership Board
• Downeast & Washington County Substance Tx Networks
• Portland OD Taskforce, Greater Portland Addn Collab
• Waldo County
• Lakes Region Substance Abuse Coalition
• Lewiston-Auburn opioid collaborative
• York Recovery Center
• Others..
Continued Challenges & Gaps

• Few cross-sector community efforts focused on decreasing OD deaths
• Lack of rapid/immediate access to treatment in most communities
• Many barriers to accessing existing MAT programs (often unrecognized!)
• Lack of consistent approach for offering treatment to most high-risk populations- e.g.
  ▪ Recently released from prisons/jails
  ▪ Homeless
  ▪ Prior OD
• Limited efforts to make naloxone widely available
Learning From Other States

• US CDC 2016 data showed 14 states reporting decrease in drug OD deaths from previous year

• States with decrease incl’d MA, RI, WA, CA

• Other focused community efforts have shown decreases in OD deaths
What Will It Take to Reduce OD Deaths?

➢ Connected communities, working together on...

1. Data, with particular attn to most high-risk pops
2. Rapid, low-barrier access to MAT/MAR services, especially for those at highest OD risk – e.g.
   - Hubs, bridge clinics
   - Emergency Depts, other models?
   - MAT offered in prisons, with plan for tx post-release
3. Provide wide access to naloxone rescue meds
4. Promote recovery & harm-reduction strategies
What Could ME Communities Do?

✓ Convene leadership of area community grps, major health care organizations, SUD tx & BH org’s, recovery community - with renewed, sharpened focus on preventing OD deaths!
  
  o Review current OD deaths, local “hotspots”
  o Set goals for tracking & reducing drug OD deaths
  o Review capacity for rapid, low-barrier access to care
  o Coordinate response strategies
  o Engage the public
Project Lazarus

Overview

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<tr>
<th>The Situation</th>
<th>Target Health Outcome</th>
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<td>Wilkes County, NC had the third highest county-level mortality rate in the nation from overdoses of narcotics and hallucinogens in 2005.</td>
<td>This program seeks to reduce the number of deaths from prescription opioid drug misuse and abuse.</td>
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- Bottom-up (community based) & top-down (medically-based) public health approaches

- Key Components
  - Public Awareness
  - Coalition Action
  - Prescriber Education
  - Policy Change


https://www.projectlazarus.org/
Project Lazarus Model

Goal: Engage and empower local communities

- Primary care providers
- Local law enforcement agencies
- Local hospitals
- Faith communities
- Local school systems
- Mental health and substance abuse providers
- Emergency Medical Services
- Housing providers
- Care management agencies


https://www.projectlazarus.org/
Results

Within 3 years of implementing risk-reduction strategies, accidental deaths from opioid overdoses decreased by 72%, from 46.0 to 14.4 deaths per 100,000 residents in Wilkes County per year.


Data: What Could ME Communities Do?

✓ Assess local systems for real-time tracking of drug OD deaths
  ▪ Could EDs, police, rescue report OD deaths?
  ▪ Ways to share timely OD data with using & recovery community, clinicians, EMS, police?
  o Consider use of OD-MAP free software for policy, EMS from HIDTA (www.hidta.org/odmap)
Rapid Tx: What Could ME Communities Do?

✓ Assess, understand, map current community MAT/MAR capacity, resources, & gaps
  o Availability & accessibility of rapid, low-barrier tx?
  o Number of MAT prescribers? Number accepting pts?
  o Barriers to treatment, particularly for those at highest risk of OD?

✓ Assess access to immediate treatment for those at greatest risk
  ▪ Presence of any low-barrier, rapid-access MAT centers?
  ▪ Availability of methadone for most severe SUD?
  ▪ Availability of buprenorphine in EDs?
Sample SUD/OUD Tx Snapshot - Maine

- Methadone clinic (0-3)
- Specialty addiction services (or not)
- Private SUD practices offering MAT (0 – many)
- Primary care MAT svcs (genl’ly limited to practice pts)
- Pregnancy / peri-natal SUD care (or not)
- MAT for homeless (or not)
- Inpatient detox (very few)
- Buprenorphine initiation in ED (MidCoast, Mercy)
- County Drug Courts
- Rapid, low-barrier access to comprehensive assessment & treatment for any patient - ???
A Siloed Landscape of Care

- Health Care
- Mental Health Care
- SUD Treatment
- Recovery Supports?
- Alcohol ("Abstinence")
- Opioids (+/-MAT)
Learning From Other States: Mass Genl “Bridge Clinic” Model

• Provides on-demand, low-barrier access to MAT/MAR services for SUD ED, inpatients
• Open ~12hrs/day, 7-days/wk
• When not open, ED initiates buprenorphine (all ED docs X-waivered)
• ED patients walked over for “warm handoff” to Bridge Clinic
• Offer ongoing treatment for ~3-6 months before handing off to community clinicians
• Since opening in 2016, have provided 4039 visits for 459 vulnerable patients
Learning From Other States: RI “Levels of Care” for EDs

• Sets expectation that all hospital EDs have protocol to routinely dispense naloxone to pts at risk for OD

• Level 1 EDs offer buprenorphine

• Requires hospitals EDs to routinely refer OD patients for urgent treatment

• Requires hospitals, EDs to report ODs within 48hrs using online system
Levels of Care for RI Hospitals & EDs Treating Patients with OUD

**LEVEL 1**
Meets criteria of Level 3 and Level 2 and also:
1. Maintains a Center of Excellence or comparable arrangement for initiating, stabilizing, and re-stabilizing patients on medication assisted treatment
   - Ensures transitioning to/from community care to facilitate recovery
   - Evaluates and manages medication assisted treatment

**LEVEL 2**
Meets all criteria of Level 3 and:
1. Conducts comprehensive, standardized substance use assessment
2. Maintains capacity for evaluation and treatment of opioid use disorder using support from addiction specialty services

**LEVEL 3**
1. Follows discharge planning per law
2. Administers standardized substance use disorder screening for all patients
3. Educates all patients who are prescribed opioids on safe storage and disposal
4. Dispenses naloxone to patients at risk, according to clear protocol
5. Offers peer recovery support services
6. Provides active referral to appropriate community provider(s)
7. Complies with 48-hour reporting of overdose to RIDOH
8. Performs laboratory drug screening that includes fentanyl on patients who overdose

[http://health.ri.gov/publications/guides/Less.ofCareForTreatingOverdoseAndOpioidUseDisorder.pdf](http://health.ri.gov/publications/guides/Less.ofCareForTreatingOverdoseAndOpioidUseDisorder.pdf)
Learning From Other Communities: MidCoast Hospital & Addn Resource Cntr

- MidCoast ARC provides rapid access to comprehensive assessment & MAT services – gently within 48hrs (no wait list)
- Has links with community, maintenance MAT providers (MidCoast Med Grp) for “hand-off”
- Working with MidCoast ED/Bluewater Emergency Medicine to provide buprenorphine in ED
- NO overdose deaths in community for past 1-2yrs
High Risk Populations: What Could ME Communities Do?

✓ Strengthen focus, provide more support for most high-risk populations – e.g.
  o Homeless
  o Incarcerated and/or rec’ly released from prisons, jails

✓ Offer low-barrier access to treatment for these pop’s (e.g. daily observed dosing for homeless)

✓ Further expand County Drug Tx Court system

✓ Routinely provide, promote naloxone/rescue strategies for high-risk populations
Learning From Other States: RI Pilot – MAT in Jails & Prisons

- Since 2016, RI offering MAT to indiv’s with SUD in all correctional facilities
- 61% drop in drug OD deaths in 12 mos post-incarceration period
- Decreased deaths in post-incarceration population contributed to overall 12% reduction in RI OD deaths last year
- NNT = Treat 11 inmates to prevent 1 death
Naloxone: What ME Communities Do?

✓ Assess current practice re: naloxone/rescue meds
- Do area EDs have systems in place to routinely prescribe, offer naloxone post-OD to pts & families?
- Are opioid-prescribing clinicians also prescribing naloxone?
- Adherence to CDC Opioid Prescribing rec’s? i.e. “Consider prescribing naloxone when factors that increase OD risk”:
  - OD history
  - History of SUD
  - Prescription for opioid dosages ≥50 MME/day
  - Concurrent opioid & benzodiazepine use
Learning From Other States: Expanding Naloxone Availability

• NH: uses federal funds, STR grants to purchase & widely distribute naloxone to community & clinical sites, recovery community, jails & prisons

• RI: requires EDs to dispense naloxone to high-risk pts, according to protocol

• RI: introduced “NaloxBox” concept (ala AEDs!)
Recovery Support: What Could ME Communities Do?

✓ Strengthen & promote recovery support svc’s
  o Increase clinician awareness of recovery support services
  o Build stronger linkages between clinical sites and recovery support services
  o Increase support for community recovery centers
  o Increase availability of Recovery Peer Support Specialists for patients seeking tx, particularly for those at highest risk of OD (e.g. ED)
Learning From Other States: RI ED Peer Recovery Coaches

• Connects ED OD patients with trained peer recovery coach
• Recovery coaches “on call”, accessed by hospital ED staff calling AnchorED hotline
• Recovery coaches encourage, help pts navigate to rapid treatment
• Funded by state
Harm Reduction: What Could ME Communities Do?

✓ Promote harm-reduction strategies – e.g.
  • Expand, support for syringe exchange programs
  • Consider developing medically monitored post-injecting sites
  • Consider building support for safe use sites
Learning From Other States: BHCHP “SPOT” Program

• SPOT = “Supportive Place for Observation & Tx”
• Offers engagement, support, medical monitoring for individuals post-injection
• Serves as entryway to tx on demand for individuals over-sedated from use of substances and otherwise unable to get care
• Have treated >200 individuals in 800 encounters in first 4 months
• Strategy for offering supportive care while working on widespread resistance to safe use sites
Convening Communities to Decrease ODs

- Police
- EMS, first responders
- SUD treatment providers
- Primary care MAT providers
- Emergency Dept
- Pre-trial diversion programs
- Jails & prisons
- Peer Recovery Support Specialists / Coaches
- Community recovery centers
- Recovery housing