MID-SHORE LOCAL HEALTH IMPROVEMENT COALITION MEETING
April 8, 2013

Present:	Tressa Ball	Nora Becker	Carolyn Brooks	Scott Burleson
	Joseph Ciatola	Mike Clark	Ruth Colbourne	Susan Collins
	Jim Culp	Mark Curry	Tracy Curry	Gloria Dill
	Ashyrra Dotson	Tim Dove	Sharon Dundon	Cornelius Edwards
	Nancy Fauntleroy	Kathy Foster	Jake Frego	Gary Fry
	Janet Fountain	Roger Harrell	Margaret Ellen Kalmanowicz	
	Audrey Lazarus	Becky Lepter	Paula Lowry	Carol Masden
	C.V. Mench	Kathleen McGrath	Cathy McKelvy	Roger McKnight
	Chris Mitchell	Michelle Morrissette	Dale Oberender	Sharon Pahlman
	Laura Patrick	Gary Pearce	Chris Pettit	Rebecca Rice
	Sara Rich	Karen Russum	John Ryan	April Sharp
	Leland Spencer	Sharon Stagg	Kelly Tarr	Rebecca Taylor
	Ina Upshur	Mary Ann Thompson	Mary Walker	Linda Walls
	Linda Webb	Denise Whiteley	Linda Wilson	John Winslow

I. WELCOME:

Dr. Spencer welcomed everyone to the meeting and shared information about the LHIC's mission and vision. A round of self-introductions was deferred; however, representatives from each of the 5 Mid-Shore counties were confirmed present by a show of hands.

II. MEETING OBJECTIVE FOCUS:

Strategic planning to develop a Regional Opioid Prevention Plan.

III. DR. SPENCER'S INTRODUCTION AND ANNOUNCEMENTS:

- Between January-September 20 11-2012 heroin overdoses increased by 40% on the Eastern Shore. During the same time period, prescription drug overdoses declined. The change has been brought about because policing for prescription drug use has increased, and heroin is relatively cheap and easy to come by, causing the dramatic shift in trends.
- The numbers do not include people who committed suicide or substance related deaths such as with a motor vehicle accident. These numbers are reflected in different data sets.
- When you look at the Eastern Shore based on percentage, we have the highest increase in heroin deaths (80%). The numbers are small when you include the whole Eastern Shore, but the percentage numbers are telling.
- The average yearly basis is 18 deaths per year which is about same across all counties. The majority are opioid deaths- methadone and Oxycontin. These numbers more accurately reflect doctors prescribing methadone, not methadone received at clinics. If there are multiple drugs in the toxicology screen, each drug gets credited individually for cause of death.

- Data from 2007 on are readily available, including name, age, race, ethnicity and other demographics.
- Toxicology findings are available.
- Public Health planning is underway to find ways to gather information on the following types of data sets (there is a proposal in the works to access this data): history of domestic abuse, ER visits, dates of previous overdose(s), criminal justice system involvement.
    - The only way to get this kind of data would be through a local overdose fatality review team which would have access to confidential information.
    - It would have to be an organized group with an MOU with DHMH/ADA, etc.
- For every overdose that we see (in the ER/through EMS), there are 10 that didn't succeed. This type of data tends to be a few years behind.
- State wide demographics show that overdoses occur in all age groups, but the mid-age range showed the largest occurrence rates.
    - Caucasians were higher than African Americans but proportionally they are about the same.
    - This is also true for gender- Male/Female overdoses are proportionally the same.

IV. STRATEGIC PLANNING-OPIOID PREVENTION PLAN

Dr. Spencer gave a warm welcome to Linda Walls, and turned the meeting over to her.

Linda Walls:

- We are working on an Opioid Prevention Plan. The data just came out and there was a training last Wednesday where approximately ¼ of those at this meeting went. We have until April 30th to submit the rough draft plan; the final plan is due June 30th. We will have time during June's meeting to work on this some more.
- This is the first time we have had all 5 counties at one meeting to discuss this and to work on a collective plan for the 5 counties. Many regions are doing the same. We will be focusing on no cost/low cost strategies as of right now because we don't know what, if any, funding will be available.
- The goal is to reduce the number of unintentional overdoses. We will be working together to look at the available data. There is no reason we can't supplement the data we have, but you may know something we don't yet. Is there other data available to include in the plan?
- The required plan components are:
    - The review and analysis of data.
    - Plan for education of the clinical community
    - Outreach to high risk individuals and communities.
    - At least 5 performance metrics to assess the effectiveness of adopted actions.
- Jake Frego asked, "Who is 'they'?" Linda responded, DHMH.
- Dr. Spencer and Gary Fry will be heading up the effort.

EXISTING STRATEGIES:

- The state of Maryland/DHMH is very involved in training- shared strategies for Maryland- and other states.
    - DHMH is working on epidemiology of opioids- will keep looking at data for enhanced epidemiology
    - Getting people into treatment
    - Co-occurring mental health and substance use.
- Public Health will be sending out mailings/information to counties every month about overdose rates in each county. It will be up to the Health Departments to get that information out to vested agencies.
- Prescription monitoring program. In a couple months this program will be underway and will provide a central clearing house for when people are prescribed opioids to track recipients and issues related to the use of these substances. It will work with both clinicians and pharmacies.
- Controlled Integration Unit- data sharing on use of opioids
- Establishing policy on data disclosure
- Medical Assistance and fraud detection
- Emergency response plan
- Naloxone- (Narcan)- having more available
    - When the number of prescriptions decrease, many people will be in withdrawal and many will turn to Heroin as a substitute.

WHITE CARDS- Today's date
Challenges Strengths

GREEN CARDS- Ideas/data ideas

BLUE CARDS- Strategies/Priorities/Help

DATA NOT IN THE CHART BUT IMPORTANT TO INCLUDE

- Routes of administration- SMART data
- Intentional versus unintentional overdose-
    - The data is based on unintentional overdose, i.e. self-medicating or experimenting
    - Intentional overdose data is kept under another data set.
- Statistics on arrests-We have Law Enforcement Officers here- the data is always a year or so behind- Washington College has a program to collect data- GIS mapping
- Seasonal data- there is a large population of migratory people to the area.
    - Maybe looking at the data by zip codes?
    - Currently, the address of the individual is used, so therefore may not be indicative of what is happening in the mid-shore region
- Data from juvenile services
- Data from the Governor's Office of Crime Control and Prevention (GOCCP).
- What other drugs are being involved in the incident- to track trends- include alcohol
- Hospital data- does tend to be a few years behind
    - ER data

    - Medical complication as result of taking drugs
- Anecdotal data- "the word on the street"-what are they talking about on the street?
- Johnstown PA- national drug information center.
- EMS data/info
- Waiting lists for crisis beds/detox beds
- Reporting at treatment admission
    - Addiction directors say yes this can be done- anyone using public money including Medicaid
- The number of child deaths
    - Possibly from a child fatality team?

Final thoughts from Linda Walls: "We will get what we can."

EXISTING STRATEGIES:

- A Fatality Review Team is being formed at the state level- alerts will be coming from them.
- All 5 counties are funded by alcohol and drug prevention and treatment
- Available suboxone - expand to include methadone- we can refer out as needed for these services, i.e. naltrexone treatment.
    - A question was asked, "Is this payment based or universal?" First come first served as available while funds exist.
- Public awareness campaigns in place already- at Wednesday's training- spoke about effectiveness of coalitions in communities.
- Prescription drug roundup days/services- sheriff's office/drop boxes.
    - Kent is doing it right now
    - Law enforcement has to take the prescriptions- call ahead before you go.
- Dorchester/Talbot- peer recovery and support-folks in recovery assist those coming into recovery
    - All counties have some form of this to varying degrees.
- Co-occurring crisis beds for treatment- all 5 counties have these
- Mobile crisis teams- Carol Masden
- Scene examination- The Medical Examiner does this.
- Shore Wellness- reduce readmissions to hospital- discharge planning- Patient education at discharge
- Crisis hotline
- Physician education programs- (Talbot-Talbot Partnership) booklet sent to all family physicians.
- Learning community- in its infancy- working with direct care physicians- Dorchester, Mid-Shore Mental Health Systems
- Chester River Hospital Center ER looks out for drug seeking behavior in ER- behavioral health assessments done in ER
- Recovery centers- Dorchester and Talbot that public can go to for support and information
- Narcotics Anonymous/Alanon/Alateen/AA, etc.

NEW STRATEGIES:

- Educating schools on what to look for and what is out there- colleges/schools
- Get pharmaceutical companies who make synthetic drugs to help develop strategies
- Increase physicians prescribing meds for treatment.
- National Association of Drug Diversion Education
- Educating the community about the names of drugs on the street-street names ex: MOLLY-combo of several drugs
- Prescription Monitoring Program- tapping into data for resources (PDMP)
- Increased use of SBIRT- screening intervention
- Educating schools- Character Counts- incorporating it in through the coaches
- Adolescent substance abuse counselors in schools
- Educating those in the trenches-teachers, jails, etc. to know the signs/symptoms of overdose /ingestion
- Shortages of detox beds/outpatient treatment- patients can wind up in the ER
- Area Health Education Center- education and outreach -pamphlets/brochures- work with medical students- University of Maryland School of Medicine for curriculum
- Chesapeake Helps!- Mid-Shore soft line of information
    - conduct a survey
    - Call with scripts to educate doctors
- Identifying hot spots in counties and having neighborhood meetings-focus areas to mobilize the community
- Educational piece placed into the treatment programs
- Limiting prescription pads for doctors- better tracking-harder to steal scripts
    - each provider has NPI number and DEA number
- Medical amnesty for reporting an overdose.

STRATEGIES FOR OUTREACH TO HIGH RISK COMMUNITIES/INDIVIDUALS:

- Information out to food pantries/shelters/detention centers/juvenile detention centers.
- Real estate should have them in packets to give out.
- Information placed in tax assessments
- First Responders-to give out information
- Cover education during custody matters
- Worksites- especially with younger employees
- Pamphlets with lists of recovery meeting dates, places and times
- Information on what to do if someone needs help for the community
- Peer recovery/pain management centers/dental practices/urgent cares/ Wellmobile- education/fliers/brochures, etc.
- Outreach to the spiritual community-sensitive to situation
- Developmental and disabled individuals
- Education on Naloxone treatment- narcotic antagonist
- Who are high risk individuals?
    - Previous overdoses
    - Senior centers
    - Mental Health/behavioral health patients
    - Students
    - **ALL GROUPS/ALL AGES**

FINAL THOUGHTS/ CLOSING REMARKS- LINDA WALLS:

- On blue cards- write PRIORITY and write what you think is/are the most important strategies.
- If interested in helping with the plan- write HELP, your name and phone number, and we will be in touch.
- Addictions directors- please stay after the meeting to schedule a follow-up meeting or conference call.

WHITE CARDS-CHALLENGES

- Denial that there's a problem
- Resources already thin
- This may have been something for more front line folks in a larger venue, i.e. Chesapeake College
- Drug courts are voluntary
- Opioid prevention vs. opioid "overdose" prevention
- With a large group like today, may have been better to break into smaller groups to collect more information
- Will the minutes be in the next newsletter?
- How long will it take to turn the curve?
- Next time provide delicious yellow layered cake with very light and good chocolate icing :o)
- Need to regionalize efforts of ALL health departments in one regional plan-forget about county boundaries.
- Need to coordinate all mental health providers, public and private, in data collection efforts
- Unintentional Overdose data only. Is it really that important without suicide data included?
- No "tourist or visitor" data included due to county of origin.
- Physician Community Outreach
- Somewhat hard to hear/was sitting in back of room
- Funds
- Medical Assistance not in every county. Long drive to get weekly/daily dose. Cash only.

WHITE CARDS-STRENGTHS

- Collaborative. Regional.
- Very Organized. Great turnout.
- Great topic to get a hold of to prevent and educate
- Well organized. Allowed for brainstorming.
- The people in the room
- Taking a regional approach to a regional problem
- Educate parents + Law enforcement officers.
- Help parents know what is happening now in the communities-where these drugs come from, how easy they are to get.
- Help parents know impact of misuse of energy drinks.
- Give public info on what signs to look for in behaviors associated with drug misuse.
- Good group of participants
- Well organized presentations
- Interesting topic

- Good facilitator
- Large group with broad scope of professionals
- All counties represented
- Linda always does a great job
- Lunch
- Productive discussion
- Great job!! Thanks for staying on time.
- That we are discussing it.
- QA has strong partnerships between agencies.

GREEN CARDS: DATA IDEAS

- Work with insurance carriers
- Community based organizations that work with substance users.
- Verify if the person who overdosed had verifiable insurance at time of death and differentiate between employer groups and medical assistance.
- Medicaid readmittance data-PAC
- Prescription drug abuse by income level
- Other drug use by income level
- I have looked at hospital ER incidence (with Nora Becker) of drug and alcohol abuse*-it is not reliable by <u>type</u> of drug. (* for years)
- VA data regarding veterans seeking treatment and veterans identified with addictions issues.
- Drugs that caused source of fatal overdoses.
- "Scene" report by medical examiner.
- Case specific-custody
- Detention Centers
- FIMUR data (fetal infant mortality data-each health department has one)
- Number of ER visits with overdose prior to overdose deaths.
- Number of rehab visits on these drug overdoses
- Treatments/prevention on drug users and their overdoses.
- Available detox beds

BLUE CARDS: STRATEGIES

- Use local nonprofit organizations-churches to disseminate materials and info
- Drug/problem solving courts
- Public education regarding prescription drop boxes
- Federally qualified health centers
- Chase Brexton can help with substance abuse treatment for its patients. Site located in Easton.
- Work specifically with gatekeepers, i.e. office managers, practice administrators that work alongside PCPs and primary care.
- Providers want to help but don't always have time to attend meeting, etc. Community is key-could alerts be emailed to let providers know what is happening?
- What education/responsibilities do pharmacies have when filling a prescription for a CDS?
- Educate parents so they know what to look for and how to handle the problem.
- Public awareness as to comprehensive treatment available and criteria for accessing treatment.

- Chesapeake Helps!- they could be available to make phone calls to Dr. offices in order to share information or do surveys. Someone could have to provide scripts.
- Prescription drug monitoring- will it cover Delaware and lower Shore Virginia (and Pennsylvania for that matter)? I suggest we use the Eastern Shore Delegates and Governor to get DE, PA and VA on the same computer system through joint state legislation.
- Gary Fry should do all of the work
- For physician education- Offer CMEs for Physician training
- Use Shore Health-physician education program housed at Memorial Hospital
- Marketing campaign- List drop box information on prescription bottles
- Physician education on dangers of over-prescribing-via county medical societies.
- Interstate collaboration with Delaware for prescription drug monitoring
- Energy drinks were not discussed today, however, with misuse can lead to deaths. How will they or could they be included in the overall need?
- Community awareness event on May 11th in St. Michaels (Talbot) called Open Doors- organized by Talbot Partnerships and Royal Oak Community UMC
- Give lesson plans to Character Counts Coaches in the schools
- Produce high quality, relevant video (3 min) for distribution on social media, "Drug OD on the Shore."
- Do not forget about outreach to Dentists. Also, Physical Therapists.
- Peer support and recovery programming specialists (I know they are available in Dorchester and Talbot)
- Increase the number of specialists
- Provide education info to funeral directors so they can advocate surviving family members about Rx med discarding
- Veteran outreach-individual veterans, outpatient clinic, VA hospital treating folks from our region.
- Naloxone
- Existing now-Kent- Adolescent Substance Abuse Counselor in school can see in-school or at clinic during out of school hours if needed. Includes Alcohol education, online education program-evidence-based.
- Increase PSAs- Radio/TV interviews
- Increase articles-Free magazines- Caroline Review
- Education to all professionals in any contact with drugs, drug users, and overdoses. Example: police, EMS, nurses, CAN, teachers, and health department employees. Also, education on mental health to all.
- More rehab/treatment centers on the shore.
- Info at retirement homes, assisted living and group homes.
- Brief interventions being done in ERs-unclear current practice
- Information distribution through treatment providers and mobile crisis teams.
- Outreach to doctors/physicians-educating them and strategize with them to address their patients who are getting legitimate prescriptions and abusing them.

PRIORITIES

- Connection between marijuana use (recent actions by MD legislation) to opioid use
- Community education-Physicians
- SBEKT
- Naltrexone? Harm reduction

- Public awareness/coalition
- Emphasis on buyback programs
- SBIRT in providers offices, ED, etc.
- Dentist/physician education
- Increase detox beds and Suboxone programs.
- Community Outreach
- Physician outreach-increase number prescribing
- Education
- Prevention
- Education in Community
- Education of Health Care Professionals
- Increase substance abuse treatment funds
- In-home treatment/management/care coordination Rx drug treatment strategies
- Education of medical providers
- Increase the number of detox beds for uninsured
- Education to local stakeholders, detention centers, courts, mental health providers, day programs in developmentally disabled, senior centers.
- Education in treatment centers
- Juvenile substance abuse counselors in schools, Chesapeake College, Washington College, Sojourner Douglas
- Strategy to empower children of addicted parents to enable kids to help mom/dad etc., to get help.
- Medical amnesty for EMS response
- Education for signs of opioid intoxication
- Educate parents, clergy, law enforcement and youth
- Outreach to communities- have key community leaders “buy-in” to plan
- Schools involvement through classroom instruction whether Character Counts, DARE. Guidance on regular instruction in classroom.
- Schools, clergy, physicians and others need to be aware of signs of drug use and what to do if you come across an overdose patient.
- Suboxone and methadone treatment are, in my opinion, crime control tools, and have nothing to do with recovery. That being said, since we have to deal with present policy, these drugs are not easily obtained in Kent County. I know several people who have to travel to Cecil County to get methadone. Addicts are not people who have a lot of support to travel distances.
- Physician and Pharmacy coalition including education and the PDMP.
- Any strategies to reduce “Dr. shopping”
- Prescription computer program
- Send info in tax assessments, real estate offices, dental, medical offices, etc.
- Education, re, what to look for and what to do
- Brochures, re available treatment (in-patient, outpatient, recovery)
- Need to better identify the extent of the problem; do we have enough information to select a strategy?
- Outreaching to shelters, food pantries, etc.
- Medical amnesty

PEOPLE WHO INDICATED THEY WOULD LIKE TO HELP

Tracy Curry [redacted]
Mike Clark
Scott Burleson
Nora Becker
Laura Patrick [redacted]
Gary Pearce
Ina Upshur

V. MEMBER UPDATES AND ANNOUNCEMENTS:

Dr. Spencer:

- The next meeting is May 13th. Representatives from DHMH- Chronic Disease Prevention will be coming to talk and will bring self-management modules to discuss.
- For June- please leave the date open for working on the prevention plan
  - The preliminary plan is due at the end of April.
  - We will bring the group back together to go through the plan so everyone will be on board.
  - We can discuss changes and amendments that need to be made before submitting the final draft at end of June.
- July- and August we take off for summer break
- September and October we will revisit Behavioral Health and substance use and overutilization of the ER.
- Last month we discussed the paramedic home visiting program
  - Caroline County is discussing a pilot project for this with the hospital and John Barto.

Jake Frego:

- Programs and classes are available.
- Brochures are available with the information. Please take one home with you.

Ashyrra Dotson:

- Dorchester-Caroline Partnership- May 2nd -HEZ kickoff with a visit from Lt. Governor- registration will be soon

Collaborative Community Project called **Open Doors** is a family-friendly community event focused on preventing and overcoming addictions.

- The event is scheduled for 11 a.m. to 2 p.m. Saturday, May 11 at the St. Michael's Community Center and Union United Methodist Church in historic downtown St. Michaels.
- This event is for all ages and will feature speakers, free food, a live DJ, a rock-climbing wall, games and prizes.
- A prayer group will be on site and available to listen and pray for individuals in need of spiritual healing.
- Open Doors will feature a wide variety of local and state agencies, recovery groups, healthcare providers and community organizations specializing in helping people overcome addictions.
- Several break-out sessions are scheduled throughout the day, addressing a variety of addiction-related topics.

- Individuals seeking freedom from addiction will find resources available for the mind, body and spirit.
- Help will also be available for individuals indirectly affected by a loved one's dependency.
- The event will conclude with a prayer and healing service at Union UM Church.
- Open Doors is being financially supported by Royal Oak Community UMC, Talbot Partnership and grants from the United Methodists Conference Council on Youth Ministries and CRS, the Cigarette Restitution Fund of the Talbot County Health Department.

VI. NEXT COALITION MEETING:

The next coalition meeting will take place on Monday, 13 May 2013 at 12:30pm, at the Queen Anne's County Health Department. Lunch will be provided, beginning at noon.

VII. ADJOURNMENT

The meeting adjourned at 2:00 pm.