**Local Opiate Overdose Prevention Plan**
**Mid-Shore Counties: Caroline, Dorchester, Kent, Queen Anne's, and Talbot**
**June 28, 2013**

## PLANNING PROCESS

The five Mid-Shore county health departments collaborated to create the April 30 and June 30, 2013 versions of the Mid-Shore Opiate Overdose Prevention Plan. Health Officers and Addictions Treatment Directors representing Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties met in early 2013 to define the approach and planning process. They determined that a regional plan would be far more effective and cost efficient (to maximize resources) and requested the ability to create and submit a document representing the collective vision of the five Mid-Shore counties. This request was approved by the Maryland Alcohol and Drug Abuse Administration (ADAA). Representatives from the five counties attended the Opiate Overdose Prevention training on March 27, 2013. From there, the Mid-Shore Local Health Department Improvement Coalition (LHIC) meeting on April 8, 2013 was devoted to preliminary planning and the LHIC meeting on June 10, 2013 was devoted to final planning for the (Local) Mid-Shore Opiate Prevention Plan.

At least sixty-five (65) different community stakeholders attended the April 8th and June 10th planning sessions including: Health Officers, Addictions Directors, law enforcement representatives, Mid-Shore Mental Health Systems, Eastern Shore Area Health Education Center, Departments of Social Services, hospital systems, Behavioral Health Crisis Team, Prevention Coordinators, Local Management Boards, Associated Black Charities, Talbot Partnerships, non-profit organizations, faith centers, and members from community alcohol and other drug coalitions.

Participants were provided with background information about the Opiate Prevention Plan including opiate overdose data, the four required plan components, existing Maryland strategies, and examples of best practices shared in the Maryland plan and at the March 27, 2013 training. A local strategic planning facilitator, who is also the evaluator for the five county alcohol and drug prevention coalitions, led the group through a brain storming session specific to each component of the plan. Participants were told that after the draft of the plan is submitted to the state by April 30, 2013, there would be at least three core group meetings to explore additional related data and polish strategies. Those meetings were held on April 18, May 13, and June 27, 2013 and primarily consisted of the Addictions Directors for each mid-shore county. The date of June 10, 2013 was set aside to present final strategies to the stakeholders for discussion and approval. At that meeting, participants recommended a deeper look into the data using extended GIS mapping (for the future) and further discussed strategy ideas, especially in light of lack of funding and existing resources that are strained.

## OVERALL GOAL

The goal of the Mid-Shore Maryland Opioid Overdose Prevention Plan is aligned with the Maryland goal and is: To reduce unintentional, life-threatening poisonings related to the ingestion of opioids, including both illicit opioid drugs (i.e. heroin) and pharmaceutical opioid analgesics. The plan encompasses efforts to reduce poisonings related to the ingestion of

opioids alone or in combination with other substances, as well as both fatal and non-fatal poisonings. The term "overdose" is used to describe poisonings that meet these criteria.

**Section 1**: **REVIEW AND ANALYSIS OF DATA**

Coalition members expressed a keen interest in seeing data representing a continuum of opiate involvement in the well-being of citizens. Data sets corresponding to arrests, treatment, Narcan administration, and intoxication deaths were gathered and examined. Where possible, the team tried to extract data more closely aligned with opiate use, but for some data sets, the details were not separated out in this way. An explanation is provided for each data set in regards to type of drugs involved. Data sets are presented next by category.

Arrests

Within the annual Uniform Crime Report, produced by the Maryland State Police, drug related arrests (adult and juvenile) are divided by the two categories of arrests for possession and arrests for sales or manufacturing. The report also separates out these arrests by type of drug to include: All Drug Arrests, Opium or Cocaine Derivatives, Marijuana, Synthetic Narcotics Which Can Cause True Addiction, and Other Dangerous Non-narcotic Drugs. For the purposes of exploring arrest data as a planning mechanism within this Mid-shore Opiate Prevention Plan, arrests stated for the drug types of "Opium or Cocaine Derivatives" are summarized across four years in the following table:

**Table 1: Mid-shore Drug-Related Arrests for Possession or Sales / Manufacturing**

| Year ➔ | 2008 | | | 2009 | | | 2010 | | | 2011 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **County⬇** | Total Arrests | Poss* | Sale & Man** | Total Arrests | Poss | Sale & Man | Total Arrests | Poss | Sale & Man | Total Arrests | Poss | Sale & Man |
| **Caroline** | 234 | 16 | 3 | 265 | 25 | 4 | 212 | 17 | 8 | 191 | 11 | 17 |
| **Dorchester** | 299 | 53 | 32 | 225 | 53 | 14 | 217 | 41 | 21 | 312 | 64 | 22 |
| **Kent** | 272 | 91 | 18 | 197 | 33 | 7 | 171 | 22 | 25 | 181 | 22 | 12 |
| **Queen Anne's** | 354 | 71 | 3 | 286 | 67 | 13 | 324 | 62 | 2 | 286 | 42 | 21 |
| **Talbot** | 342 | 55 | 47 | 327 | 47 | 18 | 258 | 42 | 20 | 250 | 48 | 19 |
| **Total Mid-Shore** | 1501 | 286 | 103 | 1300 | 225 | 56 | 1182 | 184 | 76 | 1220 | 187 | 91 |

* Poss = Possession; **Sale & Man = Sales or Manufacturing;

Source: Maryland State Police, Crime in Maryland 2009 and 2011 Uniform Crime Reports

Overall, drug arrests were highest across the mid-shore in 2008, with the exception of Dorchester County, where arrests reached a peak in 2011. Possession arrests have fluctuated over the years with Kent, Queen Anne's, and Dorchester Counties showing the greatest numbers. Arrests for sales or manufacturing were highest in Talbot County in 2008, followed by Dorchester County in the same year. For the mid-shore as a region, arrests for sales and manufacturing increased in 2011, compared to 2009 and 2010. Fluctuations in arrests may be due to a variety of variables, most of which could be connected to the ebb and flow of law enforcement funding.

Treatment

Maryland's Alcohol and Drug Abuse Administration (ADAA) collects data reflecting the home county resident of each patient in state-funded treatment. This data is not provided by primary

substance in their annual public reports, but is provided as a collective number by county (for all drug treatment patients). According to ADAA's "Outlooks and Outcomes FY 2012" report, admissions to state supported outpatient treatment programs have declined since 2009 for the region. However, Queen Anne's County admissions have increased by 18% (from 601 to 710) between FY 2011 and 2012. Again, admissions represent all drugs of choice.

**Table 2: Patient Residence for Mid-Shore County Admissions (all substances) to State Supported Alcohol and Drug Abuse Treatment Programs Reporting Data**

| County↓ Fiscal Year→ | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|---|---|
| **Caroline** | 361 | 463 | 473 | 455 | 452 |
| **Dorchester** | 572 | 593 | 654 | 720 | 680 |
| **Kent** | 420 | 395 | 354 | 365 | 297 |
| **Queen Anne's** | 594 | 680 | 791 | 601 | 710 |
| **Talbot** | 452 | 493 | 526 | 496 | 410 |
| **Total MID-SHORE Admissions** | **2399** | **2624** | **2798** | **2637** | **2549** |

Source: MD ADAA Outlook and Outcomes FY 2012

Each Addictions Director from the core planning team provided local data from the most recent three years to show the number of outpatient admissions specific to opiates as the drug of choice. For the mid-shore region there was a marked rise in admissions between FY 2010 and FY 2012. Queen Anne's and Dorchester Counties were the exception with a drop in 2011, but then an increase in opiate-related admissions in 2012.

**Table 3: Opioid Use Outpatient Treatment Data by County and by Fiscal Year FY 10 to FY 12**

| County ↓ Fiscal Year→ | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|
| **Caroline** | 35 | 48 | 50 |
| **Dorchester** | 82 | 75 | 98 |
| **Kent** | 45 | 64 | 61 |
| **Queen Anne's** | 87 | 73 | 83 |
| **Talbot** | 25 | 35 | 69 |
| **TOTAL** | **274** | **295** | **361** |

Source: County Addictions Services and ADAA SMART

The State of Maryland, in their Outlook and Outcomes FY 2012 report, provides data regarding the percentage of admissions that are opioid-related. This is divided for Oxycodone and for "Other Opioids." A review of the data reveals a clear upward trend of opioid-related admissions between FY 2008 and FY 2012. This statewide trend information is useful for comparison to local trends.

**Table 4: Percentage of Statewide Substance Opioid Problems Among Admissions from FY 08-12 to State Supported Alcohol and Drug Abuse Treatment Programs Reporting Data**

| Primary Substance Problem | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|---|---|
| **Admission # of Oxycodone** | 2096 | 2990 | 4244 | 5220 | 6075 |
| **Admission % of Oxycodone** | 5.2 | 7.2 | 9.7 | 11.6 | 13.5 |
| **Admission # of Other Opioids** | 1402 | 1786 | 2284 | 2735 | 2877 |
| **Admission % of Other Opioids** | 3.5 | 4.3 | 5.2 | 6.1 | 6.4 |

Source: MD ADAA Outlook and Outcomes FY 2012

While further in-depth study is needed to track the local trends of opioid-related admissions, compared to all admissions, and compared to the State of Maryland trends, the percentage of in-patient opiate-related admissions as a factor of all admissions was collected for the A.F. Whitsitt Center, the primary state-funding in-patient treatment center serving the mid-shore. Overall for FY 2012, opiates as the drug of choice represented 46% of all in-patient admissions at the A.F. Whitsitt Center. Talbot County had the highest percentage of opiate drug of choice patients at 63%, followed by Queen Anne's County at 47%.

**Table 5: In-Patient Resident Admissions for the Mid-Shore Counties to the A.F. Whitsitt Center in FY 2012 and Opiates as Drug of Choice**

| Admissions and Drug of Choice as Opiates | Caroline | Dorchester | Kent | Queen Anne's | Talbot | Mid-shore |
|---|---|---|---|---|---|---|
| **Total Admissions** | 34 | 27 | 39 | 74 | 48 | 222 |
| **Opiates as Drug of Choice** | 15/44% | 8/30% | 15/38% | 35/ 47% | 30/63% | 103/46% |

Source: Kent County Health Department, A.F. Whitsitt Center

Narcan Distribution

Emergency Medical Services (EMS) team members in each county are trained and authorized to administer the drug "Narcan" as a treatment in emergency situations where opioid overdose is suspected and an intoxication death could result. The Addictions Directors for each county requested information from their local EMS station asking for the number of Narcan administrations during FY 2012 or calendar year 2012. Each jurisdiction seems to have differing methods of entering the data or storing the data. As a result, the team received the data in a variety of formats as featured in the table below. For Kent and Queen Anne's County, the data extended beyond a full year, so the number column reflects the total of administrations for the time period provided (14-17 months) and the number of administrations within 12 months.

**Table 6: Narcan Administrations By County (See attached sample GIS mapping)**

| County | Number | Timeline of Data Provided by EMS |
|---|---|---|
| **Caroline** | 42 | One Year from 5/1/12 to 5/1/13 |
| **Dorchester** | 21 | Five Months from January to May 2013 |
| **Kent** | 28/19* | 14 Months from March 2012 to May 2013 |
| **Queen Anne's** | 70/49* | 17 Months from January 2012 to May 2013 |
| **Talbot** | 38 | 12 Months from June 2012 to May 2013 |
| **TOTAL** | 199 | Within 1 Year Timeframe (5 months for Dor) |

* Full time period provided/ 12 months as a portion; Source: Emergency Medical Services

The core team partnered with the GIS mapping staff at Washington College who provided a sampling of GIS mapping of Narcan administration by zip code for two counties: Queen Anne's and Talbot Counties. Both maps generally show greater occurrences of Narcan administration corresponding to areas of higher population density such as Easton (zip code area) in Talbot County and Kent Island/Grasonville in Queen Anne's County. It is the desire of the planning team to create these maps for every mid-shore county and cross reference the administrations

with intoxication deaths by zip code, as suggested by the Queen Anne's County Health Officer at the June planning session.

Intoxication Deaths

In support of the local Opiate Prevention Plan, the State of Maryland provided intoxication death data for all jurisdictions individually. It is important to point out that this data includes non-opioid related deaths, but the data was captured to show all substances revealed in the drug screening at death and often, opioids were combined with other drugs. For our region, the following tables show intoxication deaths by county and substance from 2007 to 2011, as provided by the Alcohol and Drug Abuse Administration.

**Table 7: Total Number of INTOXICATION Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| **Caroline** | 1 | 4 | 2 | 2 | 11 | 20 |
| **Dorchester** | 3 | 5 | 2 | 6 | 2 | 18 |
| **Kent** | 3 | 4 | 2 | 5 | 2 | 16 |
| **Queen Anne's** | 4 | 5 | 3 | 4 | 5 | 21 |
| **Talbot** | 5 | 4 | 3 | 3 | 1 | 16 |
| **TOTAL for Mid-Shore Region** | 16 | 22 | 12 | 20 | 21 | 91 |

**Table 8: Total Number of OPIOID-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| **Caroline** | 0 | 2 | 1 | 2 | 8 | 13 |
| **Dorchester** | 2 | 3 | 1 | 6 | 2 | 14 |
| **Kent** | 2 | 4 | 2 | 3 | 1 | 12 |
| **Queen Anne's** | 4 | 2 | 2 | 4 | 4 | 16 |
| **Talbot** | 3 | 3 | 2 | 2 | 1 | 11 |
| **TOTAL for Mid-Shore Region** | 11 | 14 | 8 | 17 | 16 | 66 |

**Table 9: Total Number of HEROIN-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| **Caroline** | 0 | 0 | 0 | 0 | 3 | 3 |
| **Dorchester** | 1 | 2 | 0 | 2 | 1 | 6 |
| **Kent** | 1 | 1 | 0 | 0 | 1 | 3 |
| **Queen Anne's** | 0 | 1 | 2 | 2 | 2 | 7 |
| **Talbot** | 1 | 2 | 0 | 0 | 1 | 4 |
| **TOTAL for Mid-Shore Region** | 3 | 6 | 2 | 4 | 8 | 23 |

**Table 10: Total Number of PRESCRIPTION OPIOID-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| **Caroline** | 0 | 2 | 1 | 2 | 5 | 10 |
| **Dorchester** | 2 | 1 | 1 | 4 | 1 | 9 |
| **Kent** | 2 | 3 | 2 | 3 | 1 | 11 |
| **Queen Anne's** | 4 | 1 | 1 | 2 | 2 | 10 |
| **Talbot** | 2 | 1 | 2 | 2 | 0 | 7 |
| **TOTAL for Mid-Shore Region** | 10 | 8 | 7 | 13 | 9 | 47 |

**Table 11: Total Number of OXYCODONE-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| Caroline | 0 | 0 | 1 | 1 | 0 | 2 |
| Dorchester | 1 | 0 | 0 | 2 | 1 | 4 |
| Kent | 0 | 0 | 1 | 2 | 0 | 3 |
| Queen Anne's | 1 | 0 | 1 | 1 | 1 | 4 |
| Talbot | 0 | 0 | 0 | 1 | 0 | 1 |
| TOTAL for Mid-Shore Region | 2 | 0 | 3 | 7 | 2 | 14 |

**Table 12: Total Number of METHADONE-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| Caroline | 0 | 0 | 0 | 1 | 1 | 2 |
| Dorchester | 1 | 1 | 0 | 0 | 0 | 2 |
| Kent | 2 | 2 | 1 | 2 | 1 | 8 |
| Queen Anne's | 2 | 1 | 1 | 1 | 1 | 6 |
| Talbot | 2 | 0 | 2 | 1 | 0 | 5 |
| TOTAL for Mid-Shore Region | 7 | 4 | 4 | 5 | 3 | 23 |

**Table 13: Total Number of FENTANYL-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| Caroline | 0 | 0 | 0 | 1 | 4 | 5 |
| Dorchester | 0 | 0 | 0 | 2 | 0 | 2 |
| Kent | 0 | 0 | 0 | 0 | 0 | 0 |
| Queen Anne's | 1 | 0 | 0 | 0 | 0 | 1 |
| Talbot | 1 | 1 | 0 | 1 | 0 | 3 |
| TOTAL for Mid-Shore Region | 2 | 1 | 0 | 4 | 4 | 11 |

**Table 14: Total Number of TRAMADOL-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| Caroline | 0 | 1 | 0 | 1 | 1 | 3 |
| Dorchester | 0 | 0 | 0 | 1 | 0 | 1 |
| Kent | 0 | 1 | 0 | 0 | 0 | 1 |
| Queen Anne's | 0 | 0 | 0 | 0 | 0 | 0 |
| Talbot | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL for Mid-Shore Region | 0 | 2 | 0 | 2 | 1 | 5 |

**Table 15: Total Number of ALCOHOL-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| Caroline | 1 | 0 | 1 | 0 | 1 | 3 |
| Dorchester | 2 | 0 | 0 | 1 | 0 | 3 |
| Kent | 0 | 0 | 0 | 1 | 0 | 1 |
| Queen Anne's | 1 | 2 | 0 | 1 | 3 | 7 |
| Talbot | 0 | 3 | 0 | 0 | 0 | 3 |
| TOTAL for Mid-Shore Region | 4 | 5 | 1 | 3 | 4 | 17 |

**Table 16: Total Number of COCAINE-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| **Caroline** | 0 | 0 | 1 | 0 | 1 | 2 |
| **Dorchester** | 0 | 1 | 0 | 1 | 1 | 3 |
| **Kent** | 1 | 2 | 0 | 1 | 0 | 4 |
| **Queen Anne's** | 3 | 0 | 1 | 0 | 1 | 5 |
| **Talbot** | 4 | 0 | 1 | 0 | 0 | 5 |
| **TOTAL for Mid-Shore Region** | 8 | 3 | 3 | 2 | 3 | 19 |

**Table 17: Total Number of BENZODIAZEPINE-RELATED Deaths By County of Occurrence, 2007-2011**

| COUNTY | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| **Caroline** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Dorchester** | 0 | 0 | 1 | 0 | 0 | 1 |
| **Kent** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Queen Anne's** | 0 | 0 | 0 | 1 | 1 | 2 |
| **Talbot** | 0 | 1 | 0 | 0 | 0 | 1 |
| **TOTAL for Mid-Shore Region** | 0 | 1 | 1 | 1 | 1 | 4 |

**Table 18: Summary - Total Number of MID SHORE OVERDOSE Deaths By SUBSTANCE TYPE, 2007-2011**

| Substance | 2007 | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|---|
| **OPIOID-RELATED** | 11 | 14 | 8 | 17 | 16 | 66 |
| **HEROIN-RELATED** | 3 | 6 | 2 | 4 | 8 | 23 |
| **PRESCRIPTION OPIOID-RELATED** | 10 | 8 | 7 | 13 | 9 | 47 |
| **OXYCODONE-RELATED** | 2 | 0 | 3 | 7 | 2 | 14 |
| **METHADONE-RELATED** | 7 | 4 | 4 | 5 | 3 | 23 |
| **FENTANYL-RELATED** | 2 | 1 | 0 | 4 | 4 | 11 |
| **TRAMADOL-RELATED** | 0 | 2 | 0 | 2 | 1 | 5 |
| **ALCOHOL-RELATED** | 4 | 5 | 1 | 3 | 4 | 17 |
| **COCAINE-RELATED** | 8 | 3 | 3 | 2 | 3 | 19 |
| **BENZODIAZEPINE-RELATED** | 0 | 1 | 1 | 1 | 1 | 4 |
| **INTOXICATION Deaths** | 16 | 22 | 12 | 20 | 21 | 91 |

Source: Tables 7-18, Maryland Alcohol and Drug Abuse Administration

Again, it is important to note that if there are multiple drugs in the toxicology screen, each drug is credited individually for cause of death. With this qualifier in mind, Tables 7-18 reveal the following key data trends:

- ✓ Generally Caroline, Dorchester, and Queen Anne's County show the highest numbers of overdose related deaths.
- ✓ Overdoses are trending upward with significant increases noted in 2010 and 2011.
- ✓ Opioid-related overdoses are the highest among all substances.

According to a Maryland DHMH Report on Overdose Deaths dated December 7, 2012, data trends for the first 6 months of 2012 compared with the first 6 months of 2011 for the nine eastern shore counties identified a decrease in overdose deaths from prescription opioids (36%) but a significant increase in overdose deaths from heroin (80%). In fact the Eastern Shore

Region had the highest percentage increase in heroin deaths during this time period compared to the Central and Southern Regions (46% and 54% respectively).

Prior to 2012, among the five mid-shore counties, the total average number of annual overdose deaths was 18. Prescription opioids accounted for 50% and heroin about 22% of these deaths. However, the first 9 months of 2012 showed overdose deaths from heroin to outnumber deaths associated with prescription drugs and therefore account for a much larger percentage. This shift from prescription opioids to heroin is believed to be related to improved enforcement and prohibitive cost of prescription drugs compared to heroin.

State-wide demographics show that overdoses occur in all age groups, but the middle-age range showed the largest occurrence rates. Also important to note is that deaths among Caucasians were higher than African Americans, but proportionally (adjusted for population) they are about the same. In terms of gender, male and female overdoses are proportionally similar. However recently on the mid-shore there seems to be a surge in intoxication deaths among males.

Additional data sets were suggested by stakeholders attending the April 8, 2013 and June 10th planning sessions. As a future step, participants would like to closely examine: the SMART data (to include routes of administration); intentional overdose data (knowing this would be found with suicide or behavioral health information); CDS arrest data specifically for juveniles; data from detention centers on detox and addiction issues; data on other drugs involved in overdoses or arrests – including alcohol; data by zip codes and resident data to better understand "hot spot" areas; hospital Emergency Department data; Emergency Medical Services data consistently across a full year for each county; medical complications as a result of opioid use; waiting lists for detox or co-occurring issues; treatment admissions for opioid use as a percentage of all outpatient treatment admissions over time, the number of child deaths related to opioid ingestion; reports from insurance carriers/Medicaid related to the issue; opioid use by income level; opioid use among veterans; and medical examiner scene data. More specifically, the Queen Anne's County Health Officer stated a desire to cross reference Narcan distribution and medical examiner data (for intoxication deaths) in GIS mapping for each county. This would support geographically-specific strategies within the counties, especially corresponding to outreach to high risk communities. Participants also expressed an interest in acquiring soft data information from "the word on the street" – perhaps conducting surveys, focus groups, or key informant interviews.

Challenges for data collection include procuring demographic specificity (by zip code, income levels, ages) for the mid-shore region desired by the planning participants. Arrest data was obtained for this report, but was not be available as a sole opioid category and is likely to be difficult to obtain by zip code or demographic information, at a time when personnel resources are strained. Emergency services and hospital data may be procured, but will be time consuming and data needs will need to be clearly articulated. Additional details for treatment data should be easily available from publically funded sources through the SMART data system, but may be more of a challenge to obtain from private treatment sources. Insurance data may

be difficult to obtain, but data applicable to opiate dependence among veterans may be more accessible. The preference to add "word on the street" data will involve soft data collection from each county in the treatment community and this will require additional planning and resources to summarize the responses. A local partner to provide GIS mapping data (see examples attached to this report for Queen Anne's and Talbot Counties) exists and has been very helpful. But collection of expanded data and transferring addresses for each data set to the GIS mapping system will require funding to generate mapping for the cross-referencing extent desired. If additional financial resources are provided to move forward, the mid-shore region is eager to produce a detailed analysis of the local crisis of overuse/misuse/use of opioids.

**Section 2: PLANNED INTERVENTIONS/ INITIATIVES**

At the April 8, 2013 LHIC planning meeting, participants chose to first take a brief inventory of existing interventions and initiatives. Members believe it is important to take stock of current strategies that might serve to help maximize resources at a later date. The following table represents a summary of the existing strategies discussed at the planning session in April.

**Table 19: Informal Inventory of Existing Strategies or Services to Address Opioid Addiction**

| Strategy ↓ County → | Caroline | Dorchester | Kent | Queen Anne's | Talbot |
|---|---|---|---|---|---|
| Addictions Prevention (public) | ✓ | ✓ | ✓ | ✓ | ✓ |
| Addictions Treatment (public) | ✓ | ✓ | ✓ | ✓ | ✓ |
| Alcohol and Drug Abuse Councils | ✓ | ✓ | ✓ | ✓ | ✓ |
| Alcohol and Drug Abuse Coalitions | ✓ | ✓ | ✓ | ✓ | ✓ |
| Public Awareness Campaigns (limited) | ✓ | ✓ | ✓ | ✓ | ✓ |
| Prescription Drug Roundup | ✓ | ✓ | ✓ | ✓ | ✓ |
| Physician Medication Treatment | ✓ | ✓ | ✓ | ✓ | ✓ |
| Prescription Drug Monitoring | Coming via the State of Maryland | | | | |
| Fatality Review Team (TBA) | Coming via the State of Maryland | | | | |
| Peer Recovery Programs | ✓ | ✓ | ✓ | ✓ | ✓ |
| Co-Occurring Crisis Beds | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mobile Crisis Teams | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medical Examiner Scene Examination | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hospital ED Screening and Response | Western | ✓ | ✓ | Northern | ✓ |
| Crisis Hotline | ✓ | ✓ | ✓ | ✓ | ✓ |
| Physician Education Booklet | | | | | ✓ (alcohol) |
| Physician Learning Community | | ✓ | Coming to other jurisdictions | | |
| 12 Step Recovery Programs | ✓ | ✓ | ✓ | ✓ | ✓ |

From this inventory, the planning participants and the core team more specifically developed local strategies that seemed feasible, depending on financial resources provided. These are described next.

**(A) EDUCATION OF THE CLINICAL COMMUNITY**

Strategies specific to educating the clinical community were generated in a brainstorming session at the April meetings, then developed more fully at the May and June meetings. It is

understood that these strategies will involve saturated, repeated, and consistent outreach to the clinical community regarding opiate overdose prevention and response.

Core team members had concerns about funding availability and decided to group the top strategies according to projected cost ranging from no cost (ease in use of in-kind resources) to moderate to high costs (clear need for outside financial support to staff positions and infrastructure). Listed below are strategy details corresponding to estimated cost. Tier 1 = no to low financial resources needed; Tier 2 = low to moderate financial resources needed; Tier 3 = moderate to high level of financial resources needed.

| **Tier 1: No to Low Cost** | **Tier 2: Low to Moderate Cost** | **Tier 3: Moderate to High Cost** |
|---|---|---|
| Generate mailing list of all direct medical providers and e-mail letter re: Prescription Drug Monitoring Program (PDMP), MD Prevention initiatives/ alerts and resources (See attached letter), MD Fatality Review Team results<br>Generate mailing list of all direct medical providers and snail mail letter re: MD Prevention initiatives and resources, alerts, and Fatality Review Team results<br>Generate a mailing list of all health care gate keepers (front desk, nurses, therapists, referral sources, navigators) and engage in information awareness campaign.<br>Create a survey or script for use by Chesapeake Helps! to collect information or inform physicians<br>Research effective practices/dialogue to help physicians counsel patients who may be getting legitimate prescriptions, but abusing them | Generate mailing list of all direct medical providers and snail mail letter re: MD Prevention initiatives and resources plus booklet (Talbot Partnership sample)<br>Conduct a special outreach to dentists and physical therapists about the plan, PDMP, and prevention strategies<br>Construct an inventory list of existing mid-shore resources and e-mail/snail mail out to medical community<br>Provide incentive resources (refreshments, mini-grants) to local Coalitions to help carry out strategies (awareness, outreach)<br>Utilize Shore Health and the Eastern Shore Area Health Education Center to educate physicians and other health care professionals about prevention and treatment options | Engage in a well-organized, highly effective (best practices) opiate prevention marketing campaign targeted for physicians and gatekeepers – utilizing professional marketing consultation and materials. Engage existing physician systems as partners such as Shore Health, Choptank Community Health Systems, and Med-Chi |

The planning team recognizes that for each strategy, research of existing evidence-based programs will need to be conducted with the programs vetted for local application.

**(B) OUTREACH TO HIGH RISK INDIVIDUALS AND COMMUNITIES**

These strategies seemed to produce the most varied ideas among the planning participants and are grouped according to the same cost tiers as mentioned in component A.

| Tier 1: No to Low Cost | Tier 2: Low to Moderate Cost | Tier 3: Moderate to High Cost |
|---|---|---|
| Step up notification regarding prescription round up programs i.e. notice on prescription bottles and other innovative (and free) methods<br>Utilize Chesapeake Helps! (information line)for raising awareness about resources<br>Incorporate educational piece into treatment programs with new information about prevention, treatment, and resources<br>Distribute existing information/ pamphlets to food pantries, shelters, detention centers, juvenile detention centers, churches<br>Provide education during custody matters<br>Provide information at worksites, in county paychecks, or other notices sent by the county out to all citizens<br>Conduct outreach to the spiritual community-sensitive to situation; Engage local nonprofit organizations-churches to disseminate materials and info; Include information in faith center bulletins<br>Provide education info to funeral directors so they can advocate to surviving family members about Rx medicine discarding<br>Investigate relationship of energy drink use to this issue and educate accordingly | Using a marketing consultant as a facilitator, develop a low cost community outreach marketing plan to effectively publicize existing resources such as crisis hotline, mobile crisis teams, treatment programs, recovery programs, prescription drop off sites; Be sure to consider disabilities as materials are developed and distributed<br>Engage in structured TOT to educate schools on what to look for and what opiates are accessible to students; Include- colleges/schools; Educate schools through facilitation by the Character Counts classroom coaches; Also educate athletic coaches in the schools and in the community leagues<br>Educate the community about the street names of drugs ex: MOLLY-combo of several drugs<br>Educate parents so they know what to look for and how to handle the problem; Raise public awareness as to comprehensive treatment available and criteria for accessing treatment<br>Educate those in the trenches-teachers, jails, etc. to know the signs/symptoms of overdose /ingestion<br>Educate professionals in any contact with drugs, drug users, and overdoses. - Include police, EMS, nurses, CAN, teachers, correctional officers, health department employees and mental health professionals<br>Conduct information distribution through treatment providers and mobile crisis teams | Engage in a well-organized, highly effective (best practices) opiate prevention marketing campaign targeted for high risk individuals and communities– utilizing professional marketing consultation and materials<br>Produce high quality, relevant video (3 min) for distribution on social media with a title such as “Drug OD on the Shore”; Utilize the video in movie theaters, cable networks and other media |

For strategies pertaining to outreach to high risk individuals and communities, the planning participants believe an important first step is a deeper analysis of the opioid use data by zip code and cross referenced using GIS mapping. This mapping will determine priority areas to ensure that resources are focused and cost-efficient, rather than diluted. Again, strategy content will need to be researched to follow best practices from other jurisdictions or states.

**(C) OTHER INTERVENTIONS/ INITIATIVES**

The top strategy suggested by the planning team members was to increase the number of physicians who are eligible to prescribe medications for treatment of opioid addiction. One such medication is Buprenorphine. The Maryland Department of Health and Mental Hygiene maintains a web-based list of physicians by zip code who have been granted waivers by the state to prescribe Buprenorphine for the treatment of opioid addiction. The following list features physicians in possession of the waiver who practice in the mid-shore region. It should be noted that some physicians on the list may not be taking new patients.

**Mid-Shore Physicians Holding a Waiver to Prescribe Buprenorphine**

| Physician Name | County | Town | Zip Code |
|---|---|---|---|
| Christian Edward Jensen, M.D. | Caroline | Denton | 21629 |
| Michael Leland Beavers, M.D. | Dorchester | East New Market | 21631 |
| Joseph Clement Boschulte, M.D. | Dorchester | East New Market | 21631 |
| Robert Schreiber, M.D. | Kent | Chestertown | 21620 |
| Eric Francis Ciganek, M.D. | Queen Anne's | Centreville | 21617 |
| Douglas Craig Holman, M.D. | Queen Anne's | Centreville | 21617 |
| Joel H. Wilkerson, M.D. | Queen Anne's | Grasonville | 21638 |
| Anthony Jack Drobnick, M.D. | Talbot | St. Michael's | 21663 |

In terms of other strategy ideas, the following list is also organized by projected tier costs.

| Tier 1: No to Low Cost | Tier 2: Low to Moderate Cost | Tier 3: Moderate to High Cost |
|---|---|---|
| Determine positions corresponding to policy and legislation and advocate from the Coalition perspective<br>Investigate and consider medical amnesty for reporting an overdose<br>Identify hot spots in counties and host neighborhood meetings within focus areas to mobilize the community<br>Ensure that prescription drug monitoring is connected to bordering states - Delaware and lower Shore Virginia and Pennsylvania; Use the Eastern Shore Delegates and Governor to get DE, PA and VA on the same computer system through joint state legislation; Support interstate collaboration with Delaware for prescription drug monitoring | Engage more physicians in providing Suboxone and other similar treatments<br>Organize a structured policy and advocacy approach to influence legislation on a national and state level.<br>Engage "brief intervention" approach in emergency departments (depending on staffing needs, this may be a moderate to high cost item) | Replicate the Peer Recovery Support Specialist and recovery center models (DRI DOCK in Dorchester) in Kent, Queen Anne's and Talbot Counties<br>Increase in-patient and crisis beds in counties with waiting lists<br>Provide more adolescent substance abuse counselors in the schools and after school<br>Increase availability of drug courts |

For all strategies, the Health Officers stressed that their budgets are currently strained and any added directives associated with the Opiate Prevention Plan will be difficult to implement, without additional resources. Some of the no cost items without a heavy reliance on in-kind support may be feasible, but each strategy would need to be carefully considered in this regard.

**Section 3: PERFORMANCE METRICS**

The performance metrics for the Mid-shore Opiate Prevention Plan is presented below and on the following page in the required format. More specificity may be added to the performance metrics with a deeper analysis (and GIS mapping) of the data.

Goal 1: Decrease overdoses and deaths related to overdose by 10% by 2016.

| **Problem Statement** | **Strategies** *(Identify each strategy you will employ to affect your goal.)* | **Activities** *( List each activity implemented to support the strategy)* | **Measurable Outcomes/ Timeline** *(how much impact by when.)* |
|---|---|---|---|
| Overdose deaths, especially for heroin, are increasing. Beyond the intoxication death data provided by the State of Maryland, there has been a recent significant rise in opiate-related deaths on the mid-shore. | 1. Improve data access and monitoring<br><br>2. Strengthen knowledge among medical professionals about opiate addiction problems, resources, and treatment options<br><br>3. Increase the base of stakeholders educated and willing to assist with awareness and educational outreach<br><br>4. Strengthen the outreach to identified high risk individuals and communities. | 1a. Identify key data needs and resources to procure data.<br>1b. Procure data with full support from partners and engage a GIS mapping source to map data.<br>1c. Share GIS mapping results with partners and determine priority high risk areas.<br><br>2a. Identify contacts within the medical community.<br>2b. Determine content of messages and best methods for information distribution.<br>2c. Distribute information and follow up with training as needed.<br><br>3a. Identify stakeholders who can assist with community outreach.<br>3b. Determine content of messages and best methods for information distribution and public engagement.<br>3c. Utilize stakeholders to distribute information to targeted areas and populations.<br><br>4a. Identify high risk individuals and communities that could benefit from awareness and educational information.<br>4b. Determine content of information based on best practices<br>4c. Utilize key stakeholders to distribute information and make authentic contact with high risk individuals/communities | High risk communities clearly identified in 5 counties by 2014<br><br>20 members of the medical community educated per year X 5 counties by 2014, 2015, and 2016<br><br>10 key stakeholders identified in each of 5 counties for assistance with education and information distribution by 2014<br><br>4 communities in each of 5 counties (approximately 5,000 individuals total) receiving saturated and repeated education information by 2015 |

Goal 2: Reduce accessibility to prescription medications within the general public and within populations at high risk by 20% by 2016.

| **Problem Statement** | **Strategies** *(Identify each strategy you will employ to affect your goal.)* | **Activities** *( List each activity implemented to support the strategy)* | **Measurable Outcomes/ Timeline** *(how much impact by when.)* |
|---|---|---|---|
| The public in general, and especially among high risk populations, may expect their physicians to prescribe opiates, even with pain that could be managed without opiates, or it is common to share prescription medications or save medications that have expired or are no longer needed. | 1. Strengthen physician participation in the MD Drug Prescription Monitoring Program.<br><br>2. Improve physician understanding and awareness of opioid addiction risks, local resources, and treatment options.<br><br>3. Increase the number of physicians who provide medication treatment for opioid (and heroin) addiction and/or who could provide training to family members to administer Naloxone (where law permits). | 1a. Identify physicians to participate in the MD DPMP program.<br>1b. Determine messages and methods for engaging physicians.<br>1c. Recruit physicians for participation.<br><br>2a. Identify contacts within the medical community.<br>2b. Determine content of messages and best methods for information distribution.<br>2c. Distribute information and follow up with training as needed.<br><br>3a. Identify physicians who may be candidates for opiate addiction and overdose treatment training and administration.<br>3b. Determine who will conduct treatment trainings and logistics.<br>3c. Conduct trainings and engage physicians as Naloxone trainers for family members of high risk individuals | 10 physicians per year per county (50 total annually) as active participants in the DPMP program (beyond prescription program requirements) by 2016<br><br>20 members of the medical community educated per year X 5 counties (100 total annually) by 2014, 2015, and 2016<br><br>4 physicians per year per county (20 total) participating in treatment training and 1 physician per year per county (5 total annually) to add the treatment and family training to their practice |

**CONTACT**

Questions and comments may be forwarded to Gary Fry, Queen Anne's County Alcohol and Drug Abuse Services Director, who is serving as the Mid-Shore regional contact for the Opiate Prevention Plan.

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