Vision
To influence the improvement of health and well-being for all Ohioans.

Mission
To provide the independent and nonpartisan analysis needed to create evidence-informed state health policy.
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Share your thoughts on twitter throughout the presentation
@HealthPolicyOH
Today

• Data and context
• Purpose and process
• Key findings
• What you can do
Unintentional Drug Overdose Deaths Involving Selected Drugs, by Year, Ohio, 2000-2017

*Prescription opioids reflect ICD-10 codes T40.2-T40.4, T40.6. Deaths are captured in this category only if there is no mention of fentanyl and related drugs (reflected in T40.4 and T40.6) on the death certificate, even if the death involved natural & semi-synthetic opioids (T40.2) or methadone (T40.3).


Multiple drugs are usually involved in overdose deaths. Individual deaths may be reported in more than one category.

Source: Ohio Department of Health, Bureau of Vital Statistics
Number of unintentional drug overdose deaths, Ohio, Jan. 2013 – Sept. 2018

Note: 2018 data is provisional
Source: Ohio Public Health Data Warehouse, data accessed April 25, 2019
Drug overdose deaths
Drug overdose deaths

- Homelessness
- Job loss and reduced worker productivity
- Paranoia, delusions and anxiety
- Liver disease (fibrosis, cirrhosis, liver cancer)
- Neonatal Abstinence Syndrome
- Hepatitis C
- Nonfatal overdose
- HIV/AIDS
- Child maltreatment and loss of custody
- Stroke
- Endocarditis
- Motor vehicle crash injuries and death
- Lung cancer
- Tooth decay and gum disease
- Alcohol poisoning
- Crime and incarceration
- Liver disease (fibrosis, cirrhosis, liver cancer)
- Drug overdose deaths
New hepatitis C cases* in Ohio, by number of cases, 2014-2017

*Includes all hepatitis C cases, both “acute” and “past or present” for 2013-2015 and both “acute” and “chronic” for 2016 and 2017.

New diagnoses of HIV infection in Ohio, 2013-2017

*Exposure categories for people who use injection drugs include injection drug use only; male-to-male sex and injection drug use; injection drug use and heterosexual contact; and male-to-male sex, injection drug use and heterosexual contact.


*6% of new HIV diagnoses were among people who use injection drugs.*

*13% of new HIV diagnoses were among people who use injection drugs.*
Ohio hospital encounters for patients with endocarditis, by age group, 2008 and 2017

- **0-17**: 35 (2008) vs. 43 (2017)
- **40-64**: 1,231 (2008) vs. 1,523 (2017)
- **65+**: 43 (2008) vs. 1,829 (2017)

624% increase

Source: Ohio Hospital Association
harm reduction
Role of harm reduction in a comprehensive approach to addiction

**Prevention**
- Opioid prescribing limits
- School-based prevention
- Local prevention coalitions

**Connections between prevention and treatment**
Example: 
- Screening, Brief Intervention and Referral to Treatment (SBIRT)

**Treatment and recovery**
Examples:
- Medication-assisted treatment
- Recovery housing
- Peer support and 12-step programs

**Connecting between treatment and harm reduction**
Examples:
- Quick Response Teams (QRT)
- Referrals to treatment from syringe services programs

**Harms related to substance use disorder**
Examples:
- Naloxone distribution
- Syringe services programs
- Ignition interlocks for impaired drivers
Harm reduction strategies with strong evidence of effectiveness

- Overdose reversal
- Syringe services programs (SSPs)
- Strategies to reduce motor vehicle crashes from drunk driving
- Housing First
**Evidence resource pages**
Hubs for:
- Clinical standards and guidelines
- Expert consensus statements and recommendations
- Model policies
- Evidence registries

**Policy inventories**
Lists of Ohio:
- Legislation
- Rules and regulations
- New or expanded state agency initiatives and programs

**Policy scorecards**
Analysis of:
- Strengths
- Gaps
- Opportunities for improvement
Key elements of a comprehensive policy response to addiction

Source: Health Policy Institute of Ohio adapted from Addiction Policy Forum (2017)

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Inventory

Number of addiction-related policy changes in Ohio, by topic, January 2013 to May 2018*

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Treatment</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>75</td>
<td>24</td>
</tr>
<tr>
<td>34% of total**</td>
<td>36% of total**</td>
<td>19% of total**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overdose reversal</th>
<th>Other harm reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>5</td>
</tr>
<tr>
<td>19% of total**</td>
<td>2% of total**</td>
</tr>
</tbody>
</table>

* Overdose reversal and other harm reduction policies were identified through May 2018, while prevention, treatment and recovery policies were identified through December 2017.

** Percents exceed 100 percent because some policies were counted in more than one category.

Source: HPIO review of Ohio legislation, regulations, Governor’s Cabinet Opiate Action Team timeline and other policy summaries.
# Summary scorecard rating

Extent to which Ohio policies and programs align with research evidence and reach Ohioans in need

<table>
<thead>
<tr>
<th>Subtopic</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naloxone distribution, access and awareness</td>
<td>Moderate</td>
</tr>
<tr>
<td>Immunity for naloxone prescribing and dispensing and Good Samaritan law</td>
<td>Moderate</td>
</tr>
<tr>
<td>Syringe services programs</td>
<td>Weak</td>
</tr>
<tr>
<td>Hepatitis C and HIV screening and treatment</td>
<td>Moderate</td>
</tr>
<tr>
<td>Other harm reduction strategies (drunk driving prevention and Housing First)</td>
<td>Strong</td>
</tr>
</tbody>
</table>

*Note: Rating based on evidence alignment and implementation reach. See Part 6 of the full report for details.*
What can state policymakers do to reduce harm?

- Expand overdose reversal
- Reduce spread of bloodborne infections
- Increase access to hepatitis C treatment
Expand overdose reversal
Overdose reversal

**Strengths**

• Strong policy focus at state level
• Legal protections for professionals

**Gaps**

• Some Ohioans still lack access
• Community organizations and lay people face barriers
Overdose death rate, by county, 2012-2017 and Project DAWN sites

Note: Includes Ohio residents who died due to unintentional drug poisoning (underlying cause of death ICD-10 codes X40-X44). Rate suppressed if less than 10 total deaths for 2012-2017.


Bystander present and naloxone administered by a lay person during overdose death, Ohio, 2016

Source: Enhanced State Opioid Overdose Surveillance (ESOOS) data, provided by the Ohio Department of Health, Oct. 11, 2018
Percent change in number of drug overdose deaths, 12-month period ending in June 2015 to 12-month period ending in June 2016

Source: National Center for Health Statistics, Vital Statistics Rapid Release, Provisional Drug Overdose Counts, as of Feb. 6, 2019

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Percent change in number of drug overdose deaths, 12-month period ending in June 2016 to 12-month period ending in June 2017

Source: National Center for Health Statistics, Vital Statistics Rapid Release, Provisional Drug Overdose Counts, as of Feb. 6, 2019
Percent change in number of drug overdose deaths, 12-month period ending in June 2017 to 12-month period ending in June 2018

Note: 2018 data is based on provisional counts, which may not include all deaths that occurred during a given time period. Numbers are subject to change.
Source: National Center for Health Statistics, Vital Statistics Rapid Release, Provisional Drug Overdose Counts, as of Feb. 6, 2019

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Percentage of unintentional drug overdose deaths involving selected drugs, Ohio, 2010-2017

*Prescription opioids reflect ICD-10 codes T40.2-T40.4, T40.6. Deaths are captured in this category only if there is no mention of fentanyl and related drugs (reflected in T40.4 and T40.5) on the death certificate, even if the death involved natural & semi-synthetic opioids (T40.2) or methadone (T40.3).

Source: Ohio Department of Health, Bureau of Vital Statistics, analysis conducted by ODH Violence and Injury Prevention Program
Opportunities for improvement

Overdose reversal

1. **Access.** Increase number of community sites and partners that can distribute naloxone

2. **Immunity.** Improve Ohio’s Good Samaritan law

3. **Awareness.** Expand current media campaign to raise awareness of naloxone access and Good Samaritan law

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Reduce spread of bloodborne infections
**Bloodborne infections**

**Strengths**
- Initial steps to curb infectious disease associated with injection drug use
- Increase in number of counties with syringe services programs (SSPs)

**Gaps**
- Minimal prevention response to surge in hepatitis C
- 80% of Ohio counties lack an SSP, including some high-risk counties

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County-level hepatitis C case rate per 100,000 population, 2016 and location of Syringe Services Programs

SSP Source: 18 and counting: Another Ohio county starts syringe exchange, Harm Reduction Ohio; Syringe Exchanges in Ohio, Harm Reduction Ohio

Hepatitis C sources: Vulnerable Counties and Jurisdictions Experiencing or At-Risk of Outbreaks, Centers for Disease Control and Prevention; Ohio Department of Health, Hepatitis Surveillance Program, data reported as of June 17, 2017.
Cost of hepatitis C prevention and treatment for people who use injection drugs

Injection drug users at risk for hepatitis C infection
- People who inject drugs are at increased risk of hepatitis C infection
- Approximately half of people who inject drugs are estimated to be infected with hepatitis C\(^6\)
- Hepatitis C is transmitted through used needles, blood and contaminated surfaces

Acute hepatitis C infection
- Initial onset of hepatitis C is referred to as “acute”
- Acute hepatitis has mild or no symptoms, so many people do not realize they are infected

Chronic hepatitis C infection
- Hepatitis C infection is considered chronic if it persists for 6 months or longer
- Hepatitis C becomes chronic in approximately 75% to 85% of cases\(^9\)
- Chronic hepatitis C eventually develops into liver disease by progressing slowly without any signs or symptoms for several decades

Liver disease
- Scarring of the liver (fibrosis) leads to cirrhosis, which is permanent liver scarring that impairs function
- Cirrhosis is a precursor to advanced liver disease and/or liver cancer
- If liver disease is life-threatening, liver transplant is needed
- If untreated, patients can die from liver disease, a leading cause of premature death in Ohio\(^11\)
Opportunities for improvement

Infection prevention

1. **Prioritize and plan.** Create integrated state plan to reduce hepatitis C transmission and reinfection

2. **Spread SSPs.** Increase number of SSPs, particularly in high-risk counties

3. **Sustain and support SSPs.** Identify sustained funding sources and establish statewide coordination hub for SSPs
Increase access to hepatitis C treatment
Hepatitis C treatment

**Strengths**

Jan. 2019 Ohio Department of Medicaid policy change will increase access

**Gaps**

Many barriers to evidence-based treatment remain (specialist access, sobriety requirement)
Number of Ohio Medicaid enrollees diagnosed with and receiving treatment for hepatitis C and HIV, 2015-2017*

* Calendar year

Note: Data includes fee-for-service and managed care enrollees of all ages

Source: Ohio Department of Medicaid, 2018

<table>
<thead>
<tr>
<th>Year</th>
<th>Hepatitis C</th>
<th>HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>43,169</td>
<td>8,565</td>
</tr>
<tr>
<td>2016</td>
<td>47,463</td>
<td>9,459</td>
</tr>
<tr>
<td>2017</td>
<td>50,730</td>
<td>10,001</td>
</tr>
</tbody>
</table>
Opportunities for improvement

Hepatitis C treatment

1. **Access.** Remove or reduce restrictions related to sobriety timeframes and specialist providers

2. **Primary care.** Engage primary care providers (including FQHCs) in screening and treatment

3. **Financing.** Implement strategies from National Governor’s Association report to ensure fiscal sustainability within Medicaid
Ohio’s harm reduction “deserts”

Counties with insufficient access to overdose reversal or other harm reduction strategies.

Population size source: U.S. Census Bureau, 2016
Harm reduction desert source: Health Policy Institute of Ohio, “Ohio addiction policy inventory and scorecard 2: Overdose reversal and other forms of harm reduction.”
The alternative to safe drug use is unsafe drug use. 
The alternative to supervised drug use is unsupervised drug use. 
The alternative to unused needles is sharing needles. 
The alternative to being revived with naloxone is death.

Being alive is the only prerequisite for recovery.
Key takeaways

1. Cautious optimism and continued action on overdose deaths. More can be done to save lives.

2. Hepatitis C presents major challenges for policymakers. Evidence-based prevention and treatment can be better deployed.

3. Evidence-based harm reduction is an underutilized tool and an important component of a comprehensive, person-centered response to the addiction crisis.
What can you do?

• **Disseminate.** Share the scorecard report with your contacts.

• **Educate.** Select one or two opportunities for improvement from the report and educate policymakers about them.

• **Partner.** Build bridges between prevention, treatment, recovery and harm reduction.
Ohio addiction policy inventory and scorecard

Overdose reversal and other forms of harm reduction

HPIO Addiction Evidence Project

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Addiction Evidence Project

There is evidence for what works to prevent, treat and recover from addiction. Progress is being made across the country and throughout Ohio, but more can be done to identify and implement effective strategies in a widespread and coordinated way. Click here for a description of the HPIO Addiction Evidence Project scope and purpose.

The HPIO Addiction Evidence Project will provide state policymakers and other stakeholders with tools to:

- Quickly find existing information about what works
- Review addiction policy changes enacted in Ohio in recent years
- Assess the extent to which new policies align with existing standards and evidence
- Identify areas where Ohio policy can be better aligned with standards and evidence, including potential gaps in Ohio’s response to the opiate crisis

HPIO has released the following products from the first phases of the Addiction Evidence Project:

- Evidence resource page: Prevention, treatment and recovery

HPIO has released the following products from the first phases of the Addiction Evidence Project:
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Educate policymakers

Opportunities for Improvement

- Educate policymakers on the need for policy changes that support the implementation of LHW services.
- Increase awareness among policymakers about the benefits of LHW services.
- Encourage policymakers to allocate funds for LHW services.
- Advocate for the inclusion of LHW services in national development plans.
- Facilitate the training of policymakers on the technical aspects of LHW services.
- Collaborate with policymakers to develop monitoring and evaluation frameworks for LHW services.

Key takeaway:

- Policymakers need to be educated about the importance of LHW services for public health.
- LHW services can contribute to achieving the global health goals.
- Policymakers can play a crucial role in supporting the implementation of LHW services.
Optimal health
Prevention
Examples:
- Opioid prescribing limits
- School-based prevention
- Local prevention coalitions

Connections between prevention and treatment
Example:
- Screening, Brief Intervention and Referral to Treatment (SBIRT)

Substance use disorder
Treatment and recovery
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Harm reduction
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Questions?

Download all materials from the Addiction Evidence Project at:
www.hpio.net/tools/addiction-evidence-project/
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