

# Preventing Overdoses in Barry-Eaton Counties: A Collaborative, Data-Driven Approach

Overdose Data to Action (OD2A)



Barry-Eaton District  
Health Department

Be Active • Be Safe • Be Healthy

# Introduction

## **Milea Burgstahler, MPH**

Planning and Promotion Director  
OD2A: Principal Investigator

## **Aurelia Hocquard, MPH**

Epidemiologist  
OD2A: Surveillance & Needs Assessment

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Community Health Promotion Specialist  
OD2A: Harm Reduction

## **Objectives**

- Increase awareness among audience members of the key findings from the needs assessment that informed the development of the overdose response infrastructure.
- Equip participants with knowledge of the methodologies used for strategic placement of harm reduction resources and the strategies employed to improve linkage-to-care for individuals with SUD.

# Use person-first language, which focuses on the person—not their illness.

Use...	Instead of...
<ul style="list-style-type: none"> <li>• Substance use disorder (SUD)</li> <li>• Opioid use disorder (OUD)</li> </ul>	<ul style="list-style-type: none"> <li>• Addict</li> <li>• User</li> <li>• Substance or drug abuser</li> </ul>
<ul style="list-style-type: none"> <li>• In recovery or long-term recovery/previously used drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Former addict</li> <li>• Reformed addict</li> </ul>
<ul style="list-style-type: none"> <li>• Use (for illicit drugs)</li> <li>• Misuse (for prescription medications used other than prescribed)</li> </ul>	<ul style="list-style-type: none"> <li>• Abuse</li> </ul>
<ul style="list-style-type: none"> <li>• Medications for opioid use disorder (MOUD)</li> <li>• Medication treatment for OUD</li> <li>• Opioid antagonist therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Medication-assisted treatment (MAT)</li> <li>• Replacement therapy</li> <li>• Opioid substitution</li> </ul>
<ul style="list-style-type: none"> <li>• Being in remission or recovery</li> <li>• Abstinent from drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Clean</li> </ul>

# MENTIMETER



<https://www.menti.com/ale4k394y4mb>



## OD2A: Local Overview

**OD2A: LOCAL** will support city or county local health departments in using data to drive actions that reduce overdose morbidity and mortality in communities, with a primary focus on opioids and/or stimulants.

**BEDHD applied for and was awarded Component A: Core Prevention and Surveillance Strategies (required)**

- ~800K annual for 5 years
  - Awarded in September 2023
- Intent to increase the capacity of the community

## Over the 5-year grant period, recipients will:

- Decrease nonfatal and fatal drug overdoses
  - Especially among disproportionately affected and underserved populations
- Reduce health inequities related to overdose by closing gaps in access to care and services
- Integrate harm reduction strategies and principles
- Improve linkage to and re-engagement and retention in services, care, treatment, and recovery, focused on opioid use disorder (OUD) and stimulant use disorder (StUD)
- Build overdose surveillance infrastructure
- Track linkage to and retention in care

# Required Activities

## Prevention Strategies

- Linkage to and retention in care and recovery
- Harm reduction
- Clinician and health system best practices

**Prevention strategies must be implemented in the following settings:**

- Community
- Public Safety
- Health Care Settings

## Surveillance

- Overdose surveillance infrastructure
  - Data to Action Framework
- Substance Use Needs Assessment within the first 10 months of grant award

# Required Prevention Activities

## Linkage to and Retention in Care in All Settings

Use of navigators to link to evidence-based treatment of SUD

Use of navigators to link to harm reduction services

## Harm Reduction in All Settings

Support naloxone distribution to people who use drugs and/or people at risk of overdose

Overdose prevention education and naloxone distribution

## Clinical and Health System Best Practices

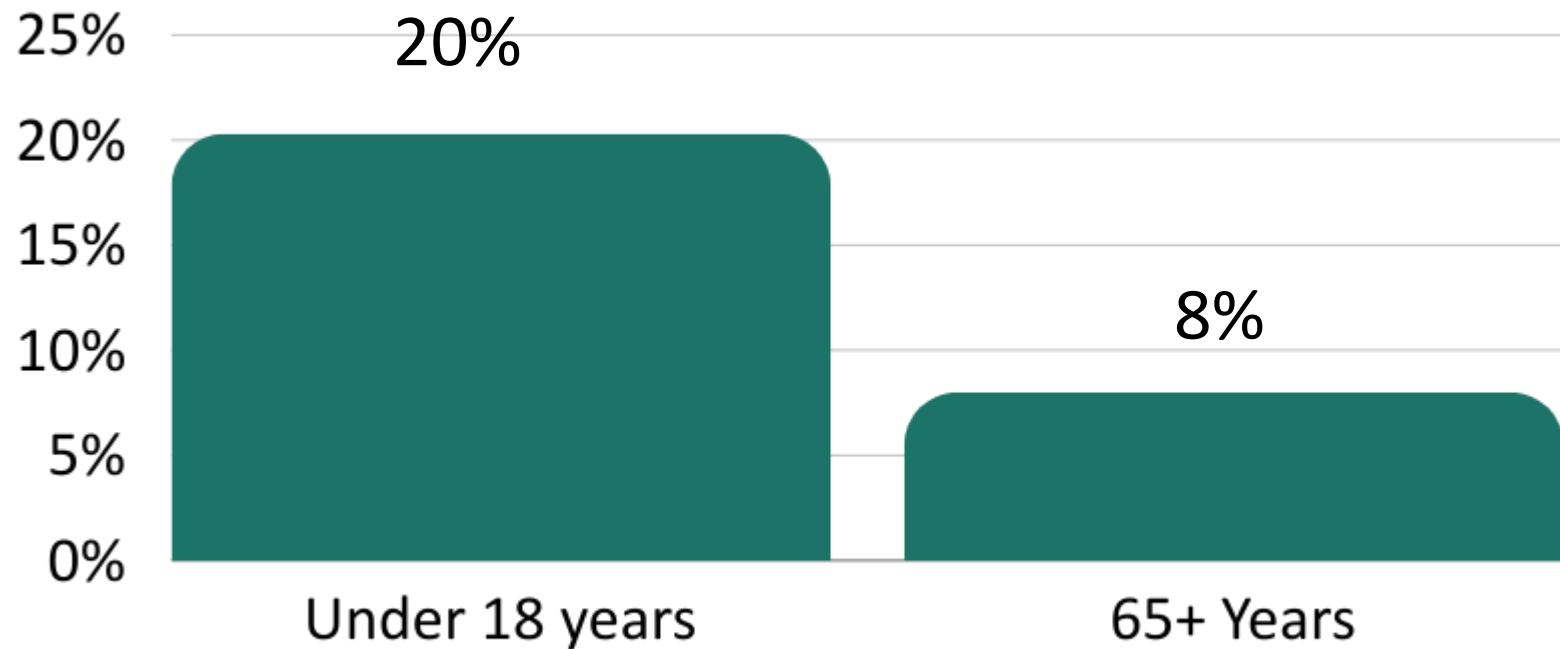
Support Implementation of *Clinical Care Concordant with the CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022*



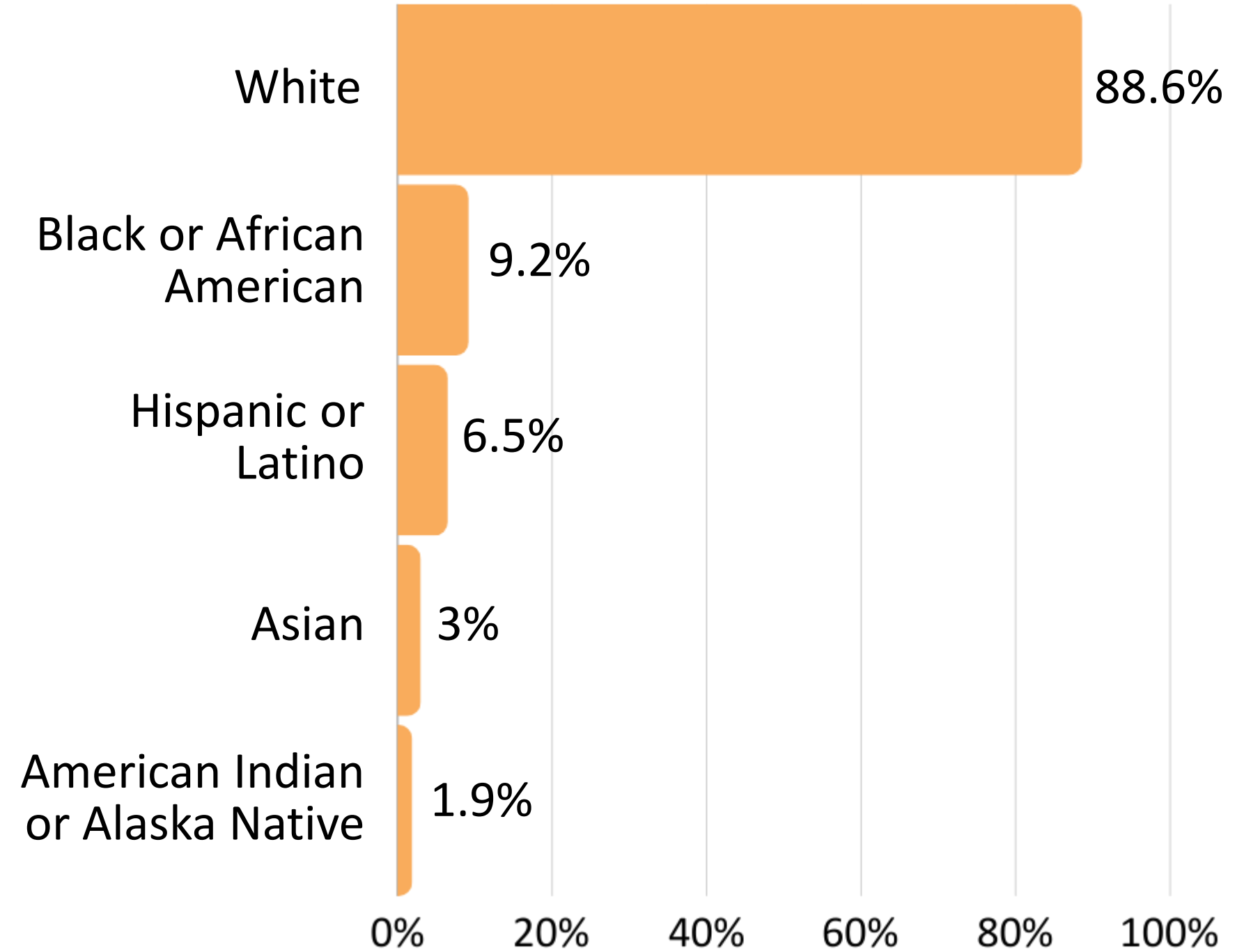
# Eaton County Demographics

Population: 108,820

## Age



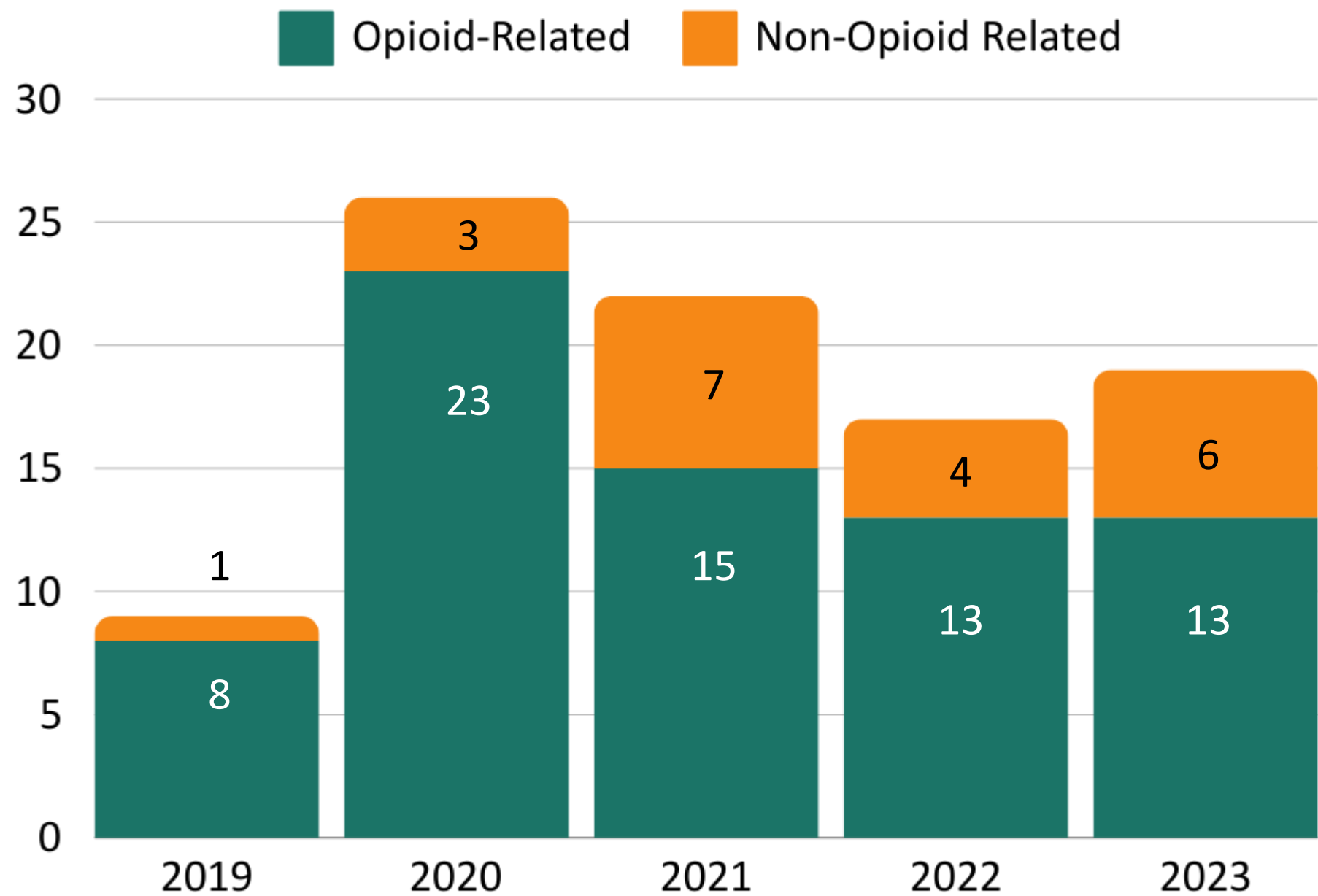
## Race/Ethnicity



# Quick Glimpse of Overdoses in Eaton County

In 2023, fentanyl was present in 85% of Opioid-Related Deaths

## Drug Overdose Deaths - Eaton County, 2019-2023

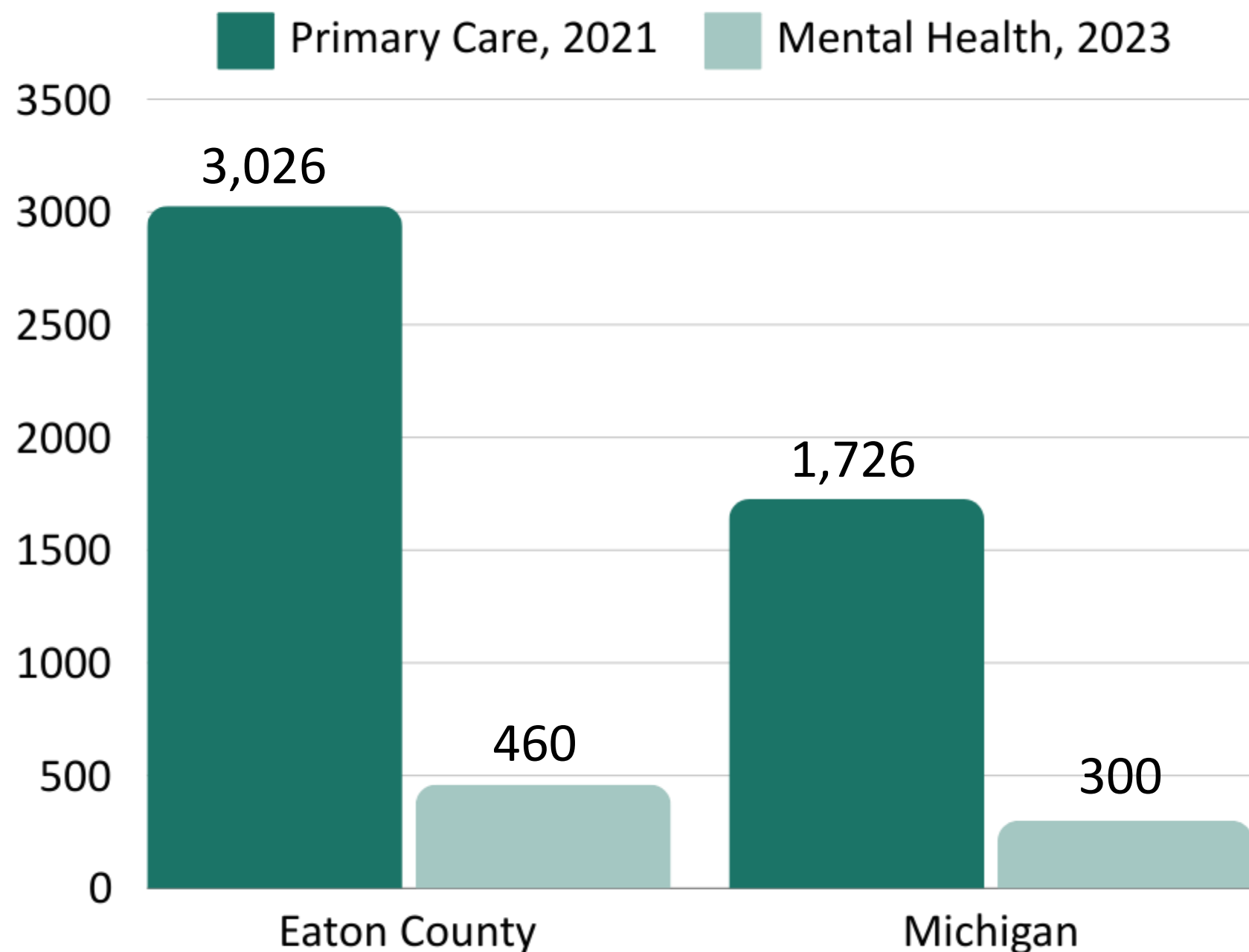


SUVI Score Measurements	All MI County Average	Eaton County
5-Year Average Fatal Overdose Rate per 100,000 (2018-2022)	19.1	22.1
3-Year Average Nonfatal Overdose Emergency Healthcare Visit Rate per 100,000 (2020-2022)	271.5	311.7
Opioid Prescription Unit Rate per 1,000 (2022)	42,175.3	43,006.7
Buprenorphine Prescription Unit Rate per 1,000 (2022)	3207.8	1507.3

Cells highlighted in orange indicate that the measurement for that county is worse than the all Michigan county average.

# Eaton County SUD Treatment Landscape

## Ratio of Population to Care Provider



## Drive Time to SUD Resources



Percent of Population within a 30-minute drive to SUD Treatment Center (2022): **100%**

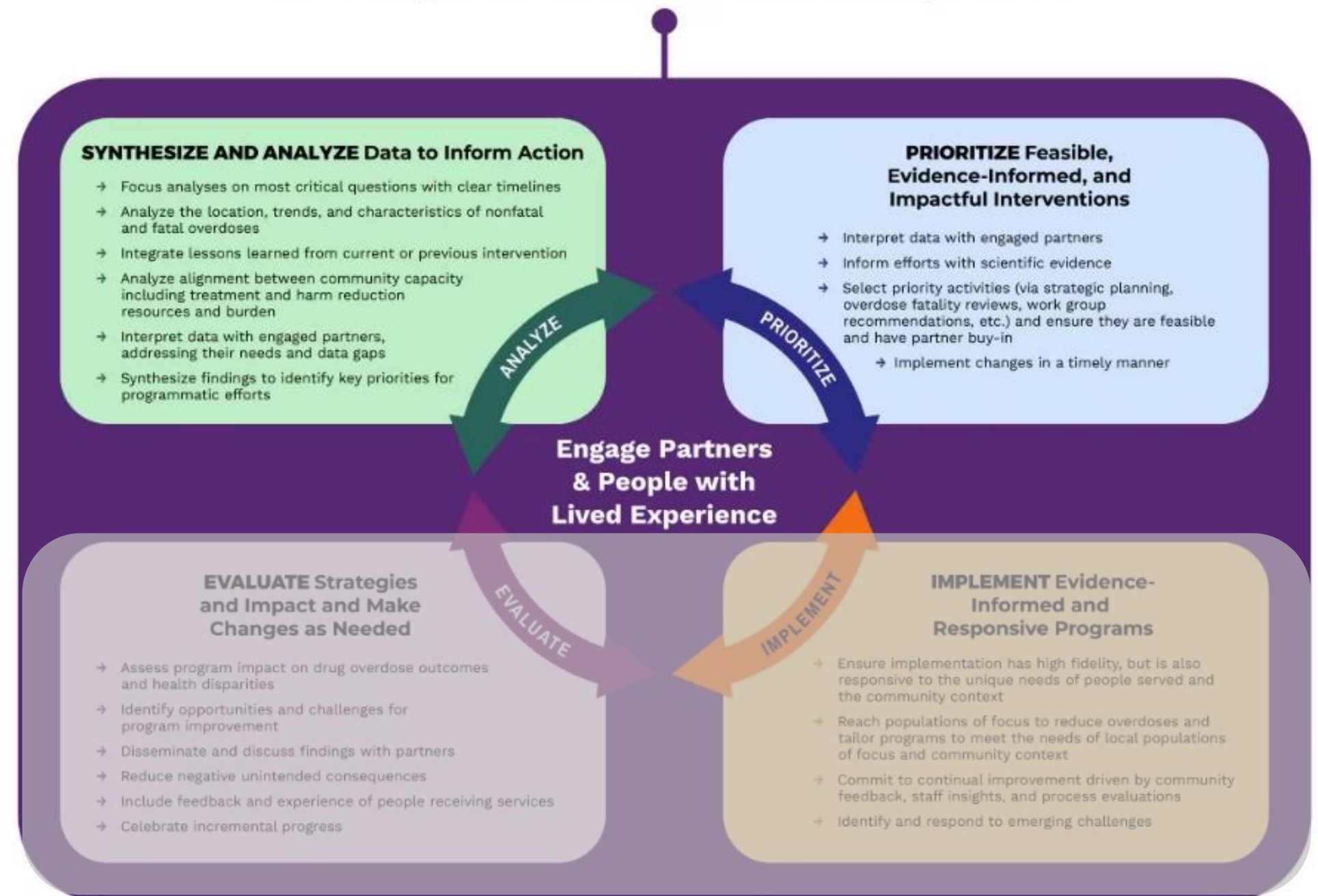
Percent of Population within 15-minute drive of syringe service program (2022): **39.5%**



# Eaton County Substance Use Needs Assessment

- What is a Community Needs Assessment (CNA)?
- Goal of OD2A: Local CNA
- Overdose Data to Action Framework

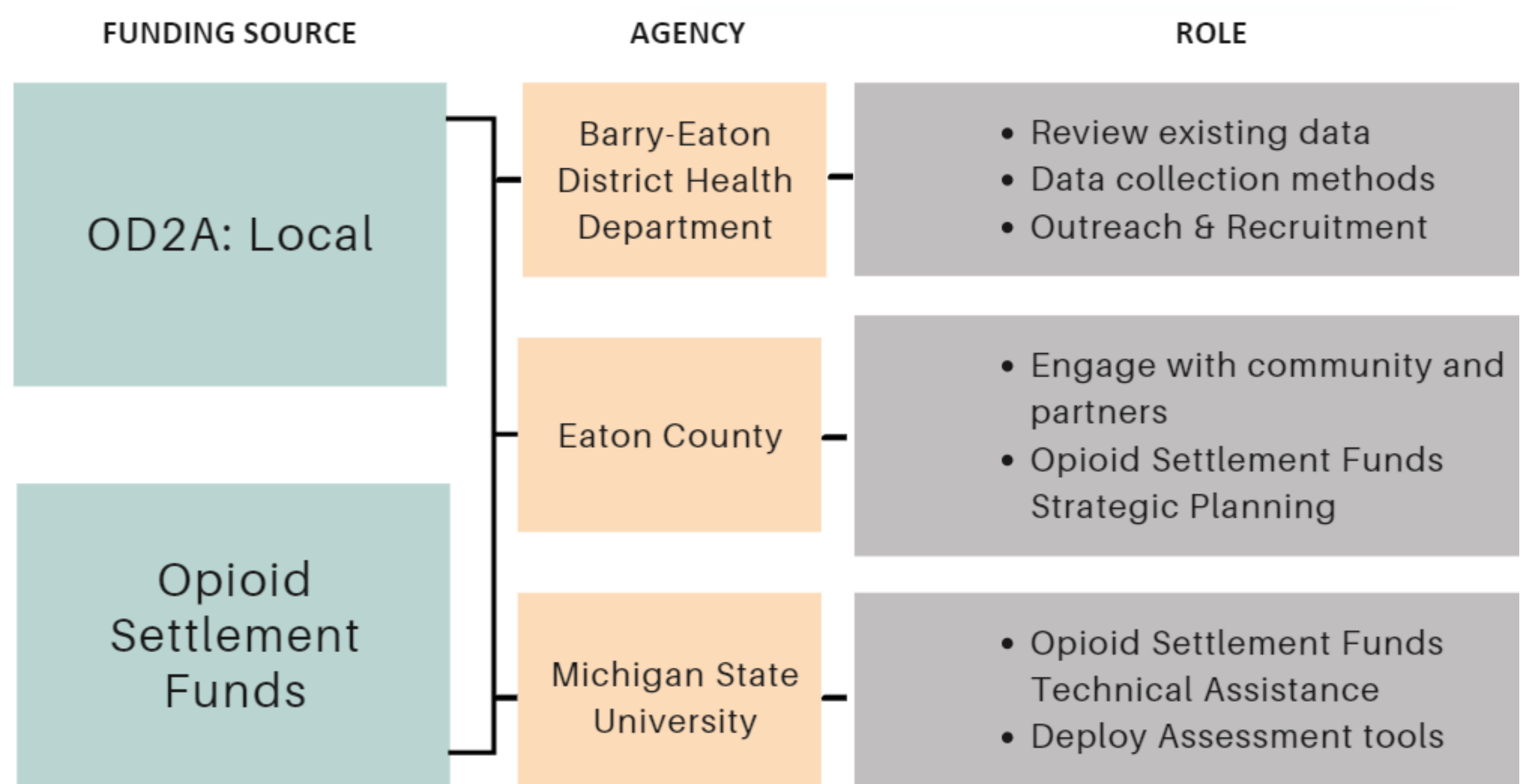
## OD2A Data to Action Framework: Reducing Overdoses and Health Disparities



# Project Planning

## Identify Key Partners:

- Eaton County: Strategic Planning for Opioid Settlement Funds
- Michigan State University: Opioid Settlement Technical Assistance Group
  - Combine resources to conduct one Needs Assessment for Eaton County



# Eaton County Needs Assessment



## Information Gathering

# What information do we have?

- Review available data:
  - ME, EMS, TEDS, MSP, MiPHY, Syndromic Surveillance, Overdose Fatality Review Team, SUVI
- Environmental scan, asset mapping, research, priority populations

## What do we want to know? & What data do we still need?

- Review of data findings
- Priority populations: PWLE, Loved Ones, Emergency Services, Community Based Organizations, General Community
- *What needs of the priority populations are being met and how well they are being met?*
- *What areas need more focus to decrease risk of overdose for the priority populations?*

# Methods

## Survey

- Incentives
- MSU Involvement



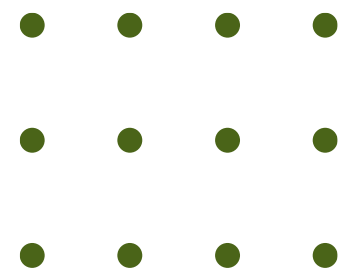
## Focus Group/1:1 Interviews

- Incentives & Recruitment
- PWLE Participation
- MSU Involvement
- 1:1 Interviews





# Key Findings: Linkage to Care



# Finding Help and Resources

1/3

Residents felt it was easy or somewhat easy to access services when they were ready

PWLE highlighted two key factors for successful engagement and retention in SUD care:

- **Peer Support:** The value of having a peer recovery coach with lived experience to guide individuals through the care process and navigate available resources.
- **Social Support:** The importance of a strong support network and social connections in maintaining recovery.

49.4%

PWLE attempted to access peer support \*



36%

Successfully accessed peer support\*

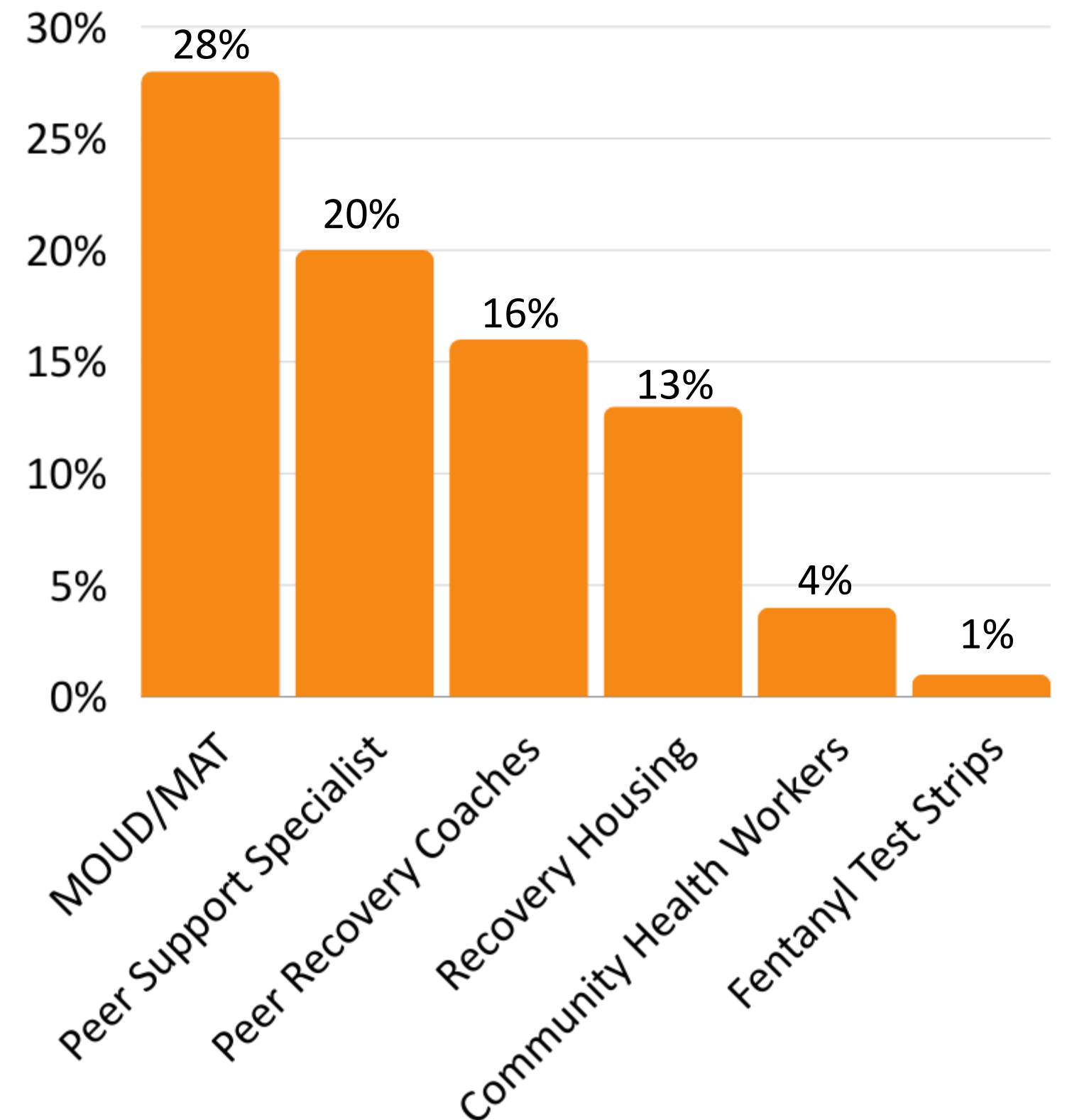
\* Peer Support includes Peer Support Specialists or Peer Recovery Coaches

# Success Rate for PWLE Accessing Services

The least successfully accessed services by PWLE:

- Fentanyl test strips
- Jail-based services
- Community Health Workers

## Success Rate for PWLE Accessing Services

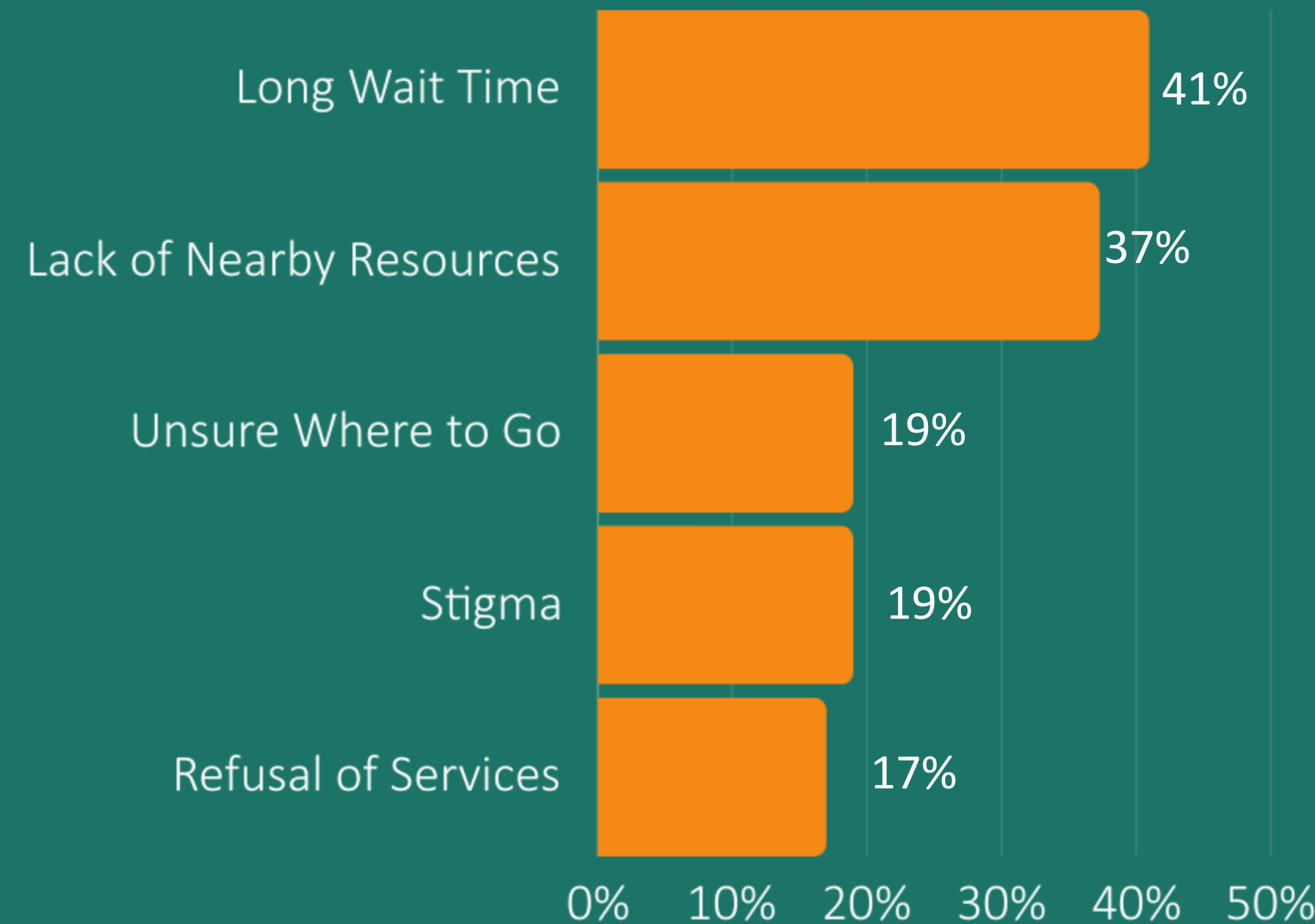


# Barriers to Accessing Substance Use Resources

**41% of PWLE said long wait times affected their recovery journey**

“Everyone I've talked to so far has said, well, there's (person's name) and then there's the peer recovery coach through Community Mental Health, one peer recovery through Community Mental Health, and that's all people know of are those two peer recovery coaches for all of Eaton County.”

## Key Barriers to Accessing Substance Use Resources for PWLE



# Health Care Providers

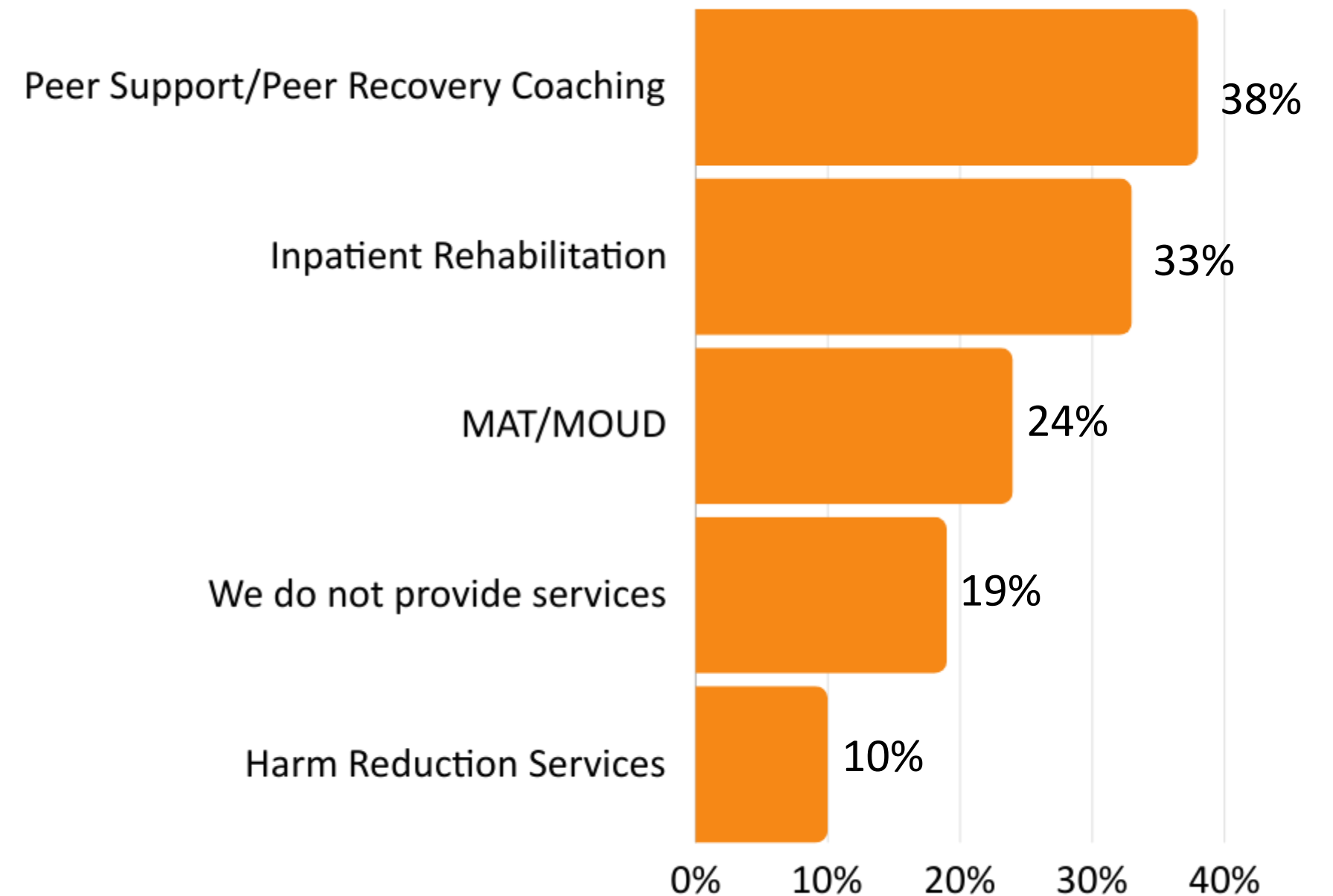
Of the providers surveyed:

- 24% offered MAT/MOUD
- 10% offer harm reduction services
- 19% do not offer any programs or supports

When providing referrals:

- 55% of providers are providing contact information for resources
- 14% are making appointments for resources

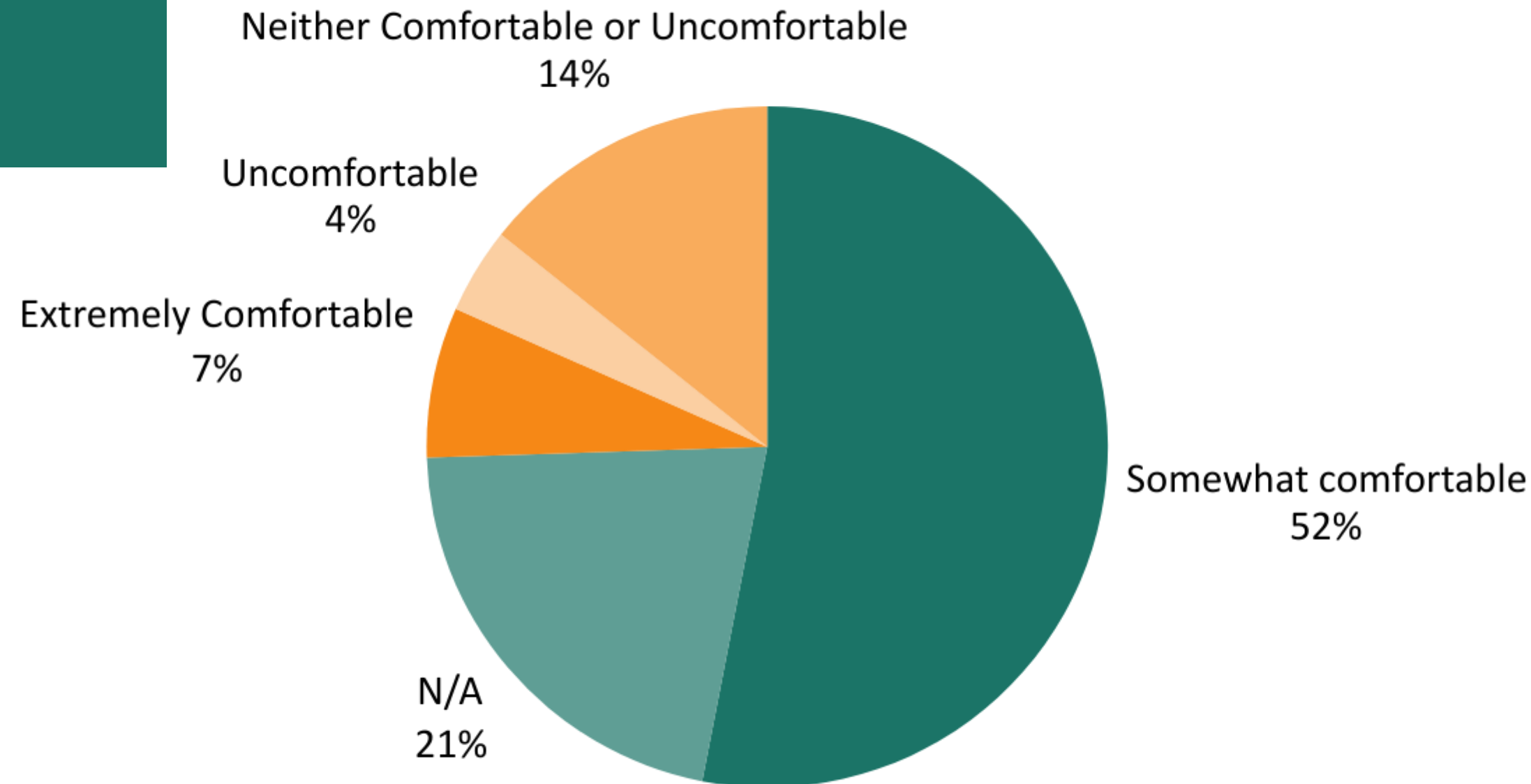
## What programs or supports do you provide for Opioid Use Disorder and co-occurring Opioid Use Disorder and/or Mental Health Disorders?



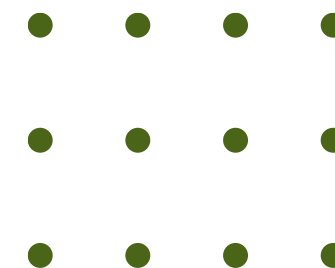
## Providers' comfort level with making referrals to SUD Services

### How comfortable are you and your staff with making referrals to substance use disorder services?

- 52% of providers report being somewhat comfortable with making referrals to substance use disorder services
- 43% of providers acknowledged additional training for staff would improve referral processes

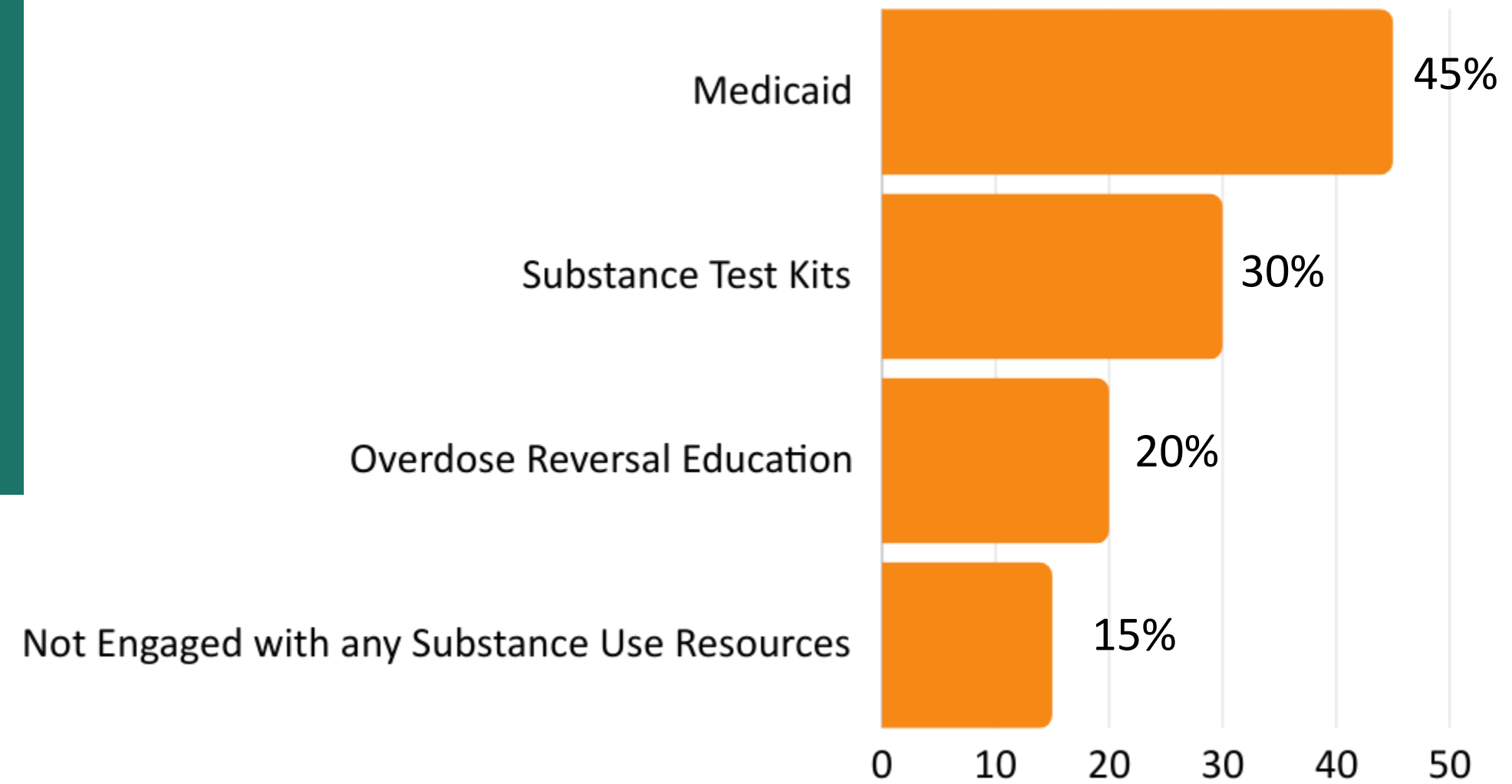


# Key Findings: Harm Reduction



# Loved Ones of PWLE

## Programs or Supports Accessed by Loved Ones of PWLE



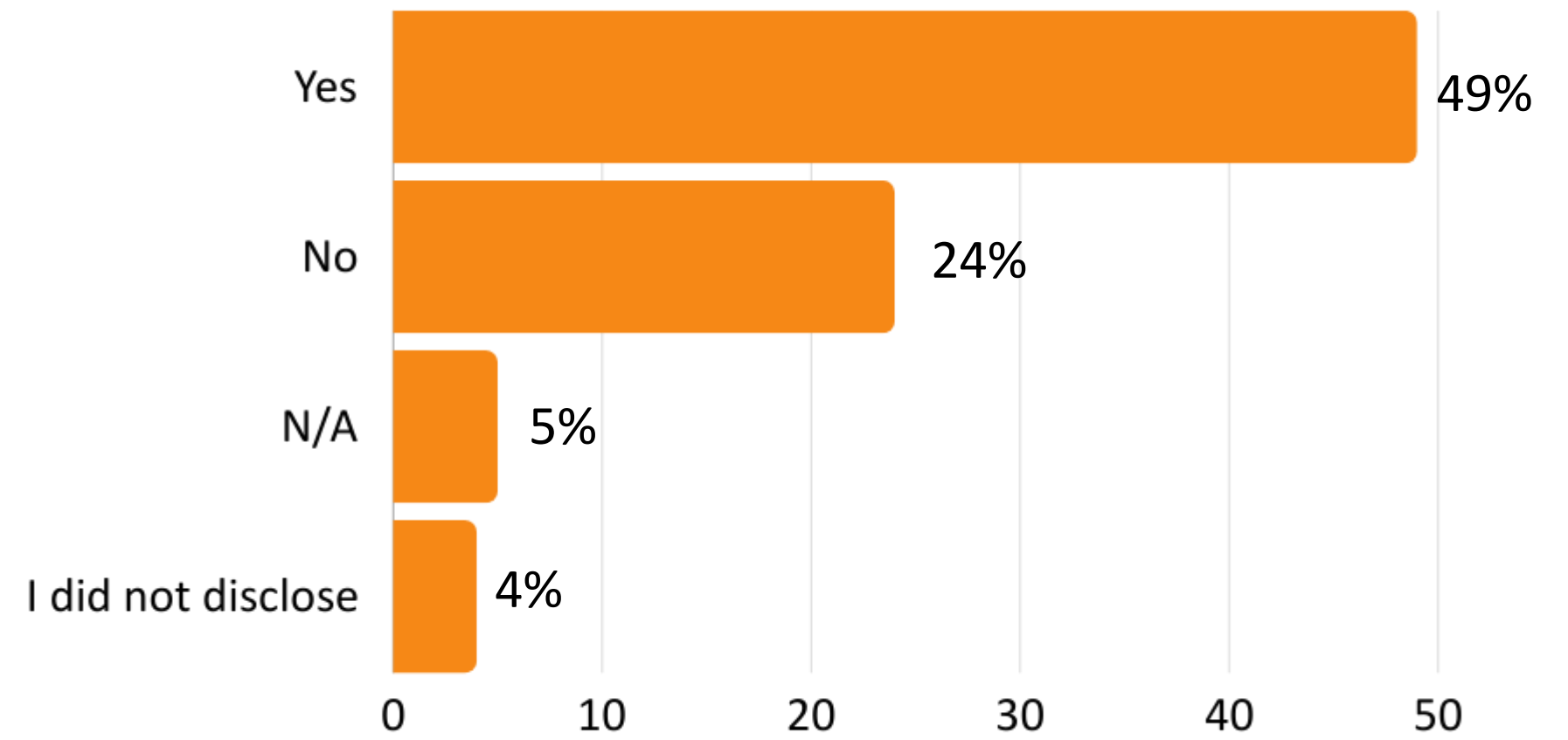
**What programs or support do you think are most valuable for family and friends of those in active substance use or recovery to have?**

- 45%** noted overdose reversal supplies, education and training (Narcan/naloxone)
- 40%** noted education and supplies to treat withdrawal symptoms
- 25%** noted fentanyl test strips- substance testing supplies for overdose prevention



# PWLE

## Have you been offered support related to substance use disorder in your place of work?



**What programs or support do you think are most valuable for family and friends of those in active substance use or recovery to have?**

**52%** noted family Support Group/Mutual Aid Societies- Safe space to share

**37%** noted fentanyl test strips- substance testing supplies for overdose prevention

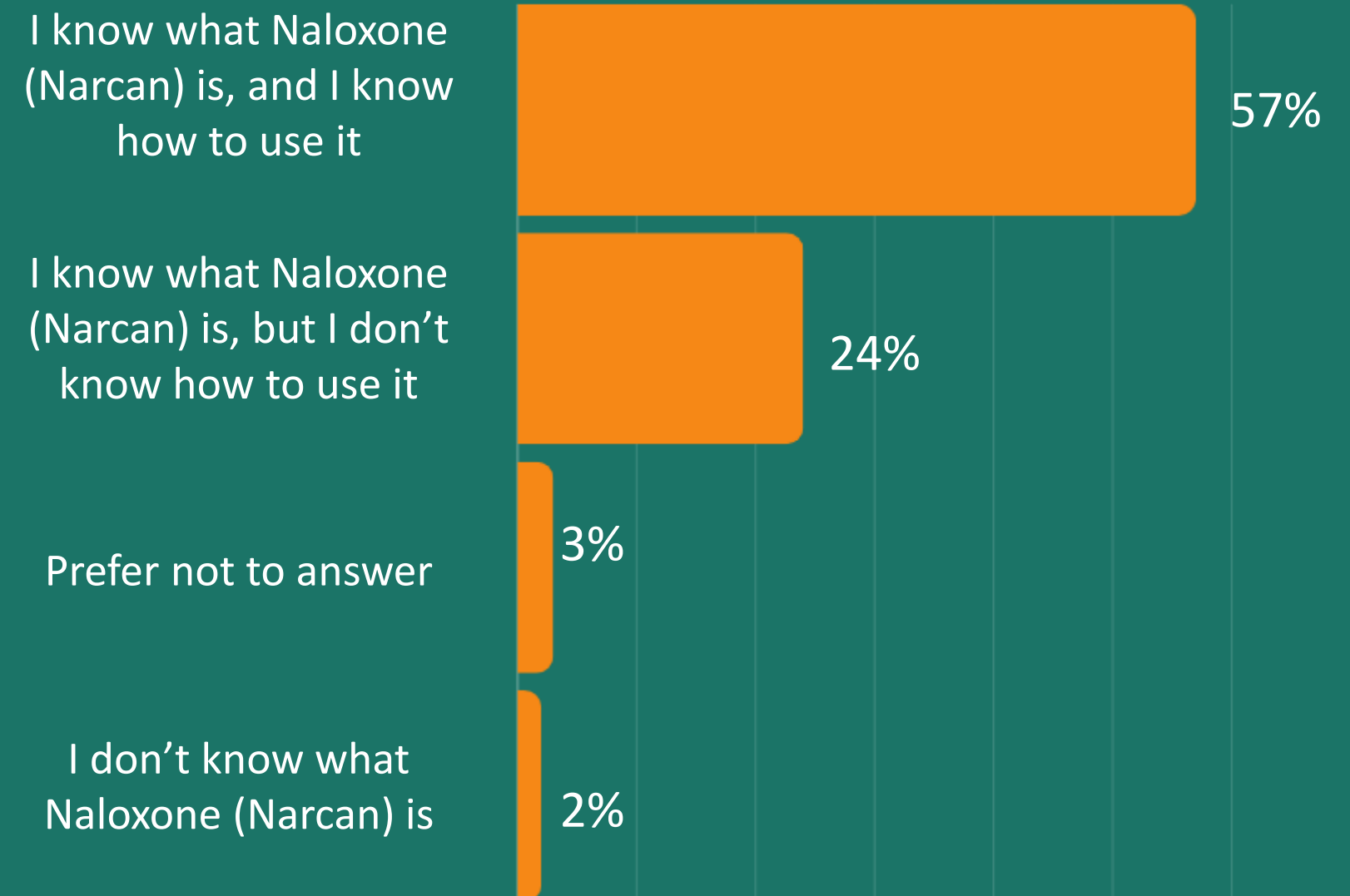
**21%** noted overdose reversal supplies, education and training (Narcan/naloxone)

# Knowledge & Perceptions

**Nearly half (49%) of general Community respondents expressed a desire for more information about identifying substance use disorder.**

“No, because they're all reactive. So no. Narcan will help keep them alive to the next one. It's a stopgap. It saves a life at the time. It doesn't fix the problem. So it just prolongs it. It desensitizes them a little bit because they're like, 'Ah, I got a narcan. So if I OD, they'll just give me narcan. I'll be all right.’”

## General Community: Which of these statements about overdose reversal drugs best applies to you?



# Accessing Services

Public fentanyl test strip access sites in Eaton County: **6**

Public naloxone access sites in Eaton County: **6**

- There is no syringe service program (SSP) in Eaton County
- Percent of Population within 15-minute drive of syringe service program (2022): **39.5%**
- Average Distance to nearest SSP for residents: **20.2 miles**

# 37%

of PWLE noted Lack of Nearby Resources was a barrier encountered when attempting to engage with substance use resources

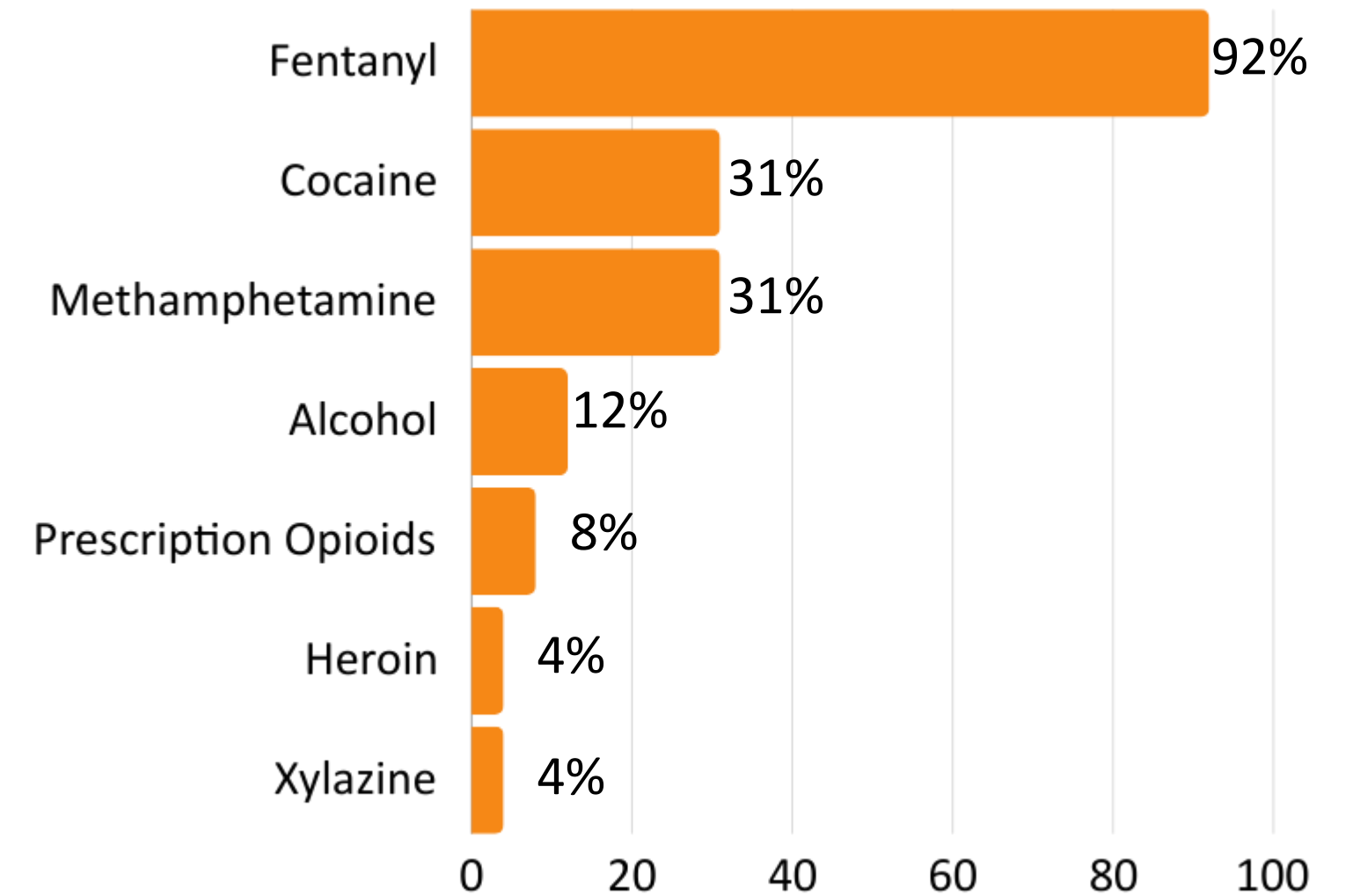
# Poly-Substance Use

**Between 2022 and 2023, there were 26 opioid-related deaths in Eaton County.**

- 73% of these deaths involved the use of multiple substances
- Fentanyl was found to be in 92% of the opioid-related fatal overdoses
- Fentanyl was present in all methamphetamine overdoses

## Substances Involved in Opioid-Related Deaths

Eaton County, January 2022 - December 2023



# Lessons Learned

## Lessons

- Partnerships and importance of formal agreement
- Communication with all partners is key to success
- Trust-building with community prior to conducting needs assessment
- Time constraints
- Bots and incentives
- Flexibility

## Learnings

- Gaps in Care
- Opportunities for partnerships
- Inform Opioid settlement spending
- Define key issues in the community
- Defining priority populations
- Understand Data Gaps

# Year 2 Linkage to Care

## Outreach and Linkage to Care

- Expansion of Community Health Workers (with lived experience)
  - Transportation assistance
  - Warm Handoffs
  - Expand access to navigators for people leaving incarceration
- Continuation of supporting additional PRC through community mental health
- Expand Project Assert to additional hospital system



## Improved Referral Systems

- Referral agreements
- Education to local providers
- Strengthen partnerships to streamline referrals

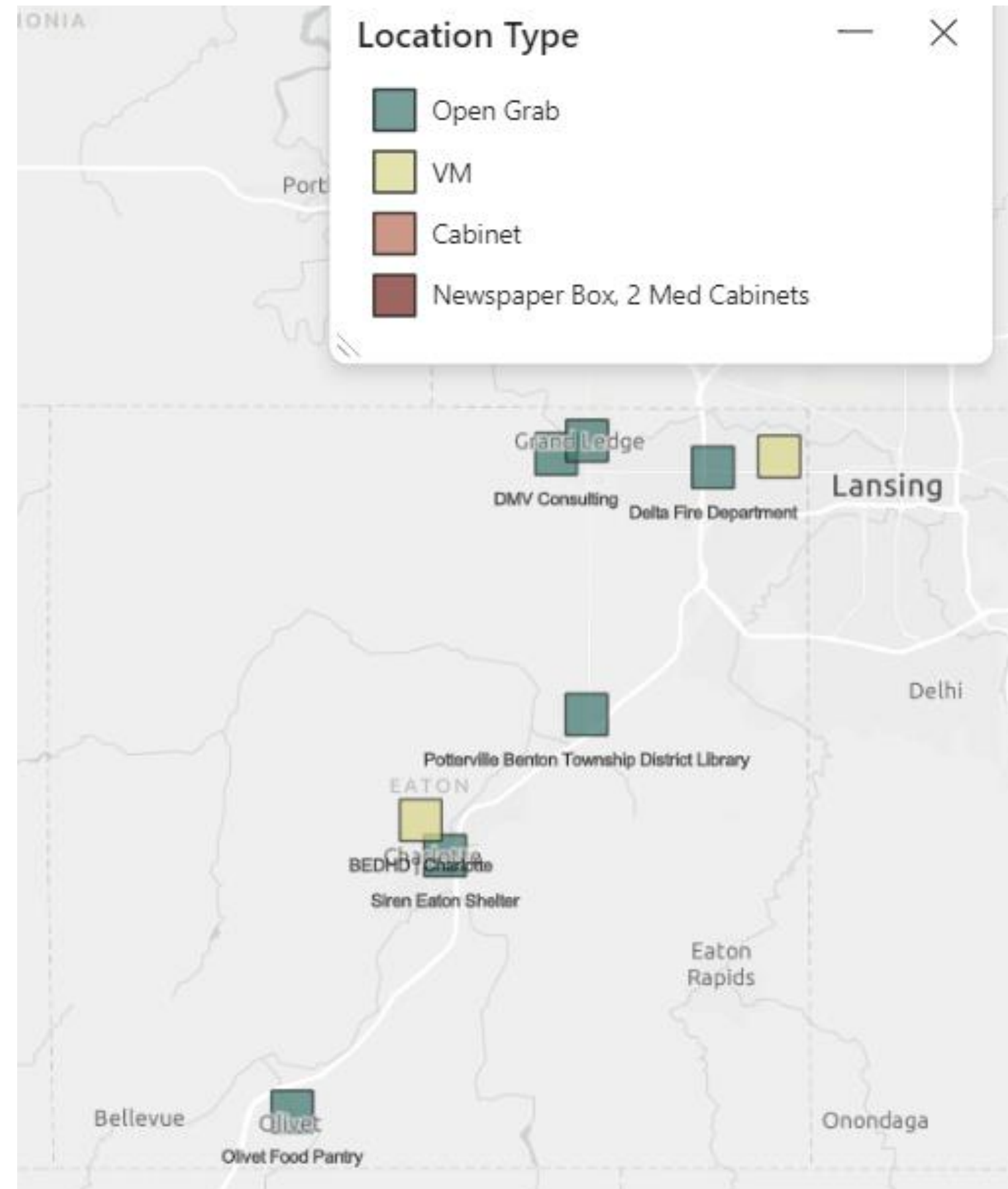
## Data Monitoring

- Monitoring referral sources
  - Follow-up with providers to review referral

# Harm Reduction Access through Partnerships

## Access Points & Community Partners

- Barry-Eaton District Health Department
- Delta Township District Library
- Eaton County Sheriff Lobby (24hr)
- Olivet Food Pantry
- Delta Fire Department – Station 1
- Potterville Benton Township District Library
- Grand Ledge Police Department
- SIREN Eaton Shelter
- DMV Consulting



# Harm Reduction Access through Partnerships

Vending Machine



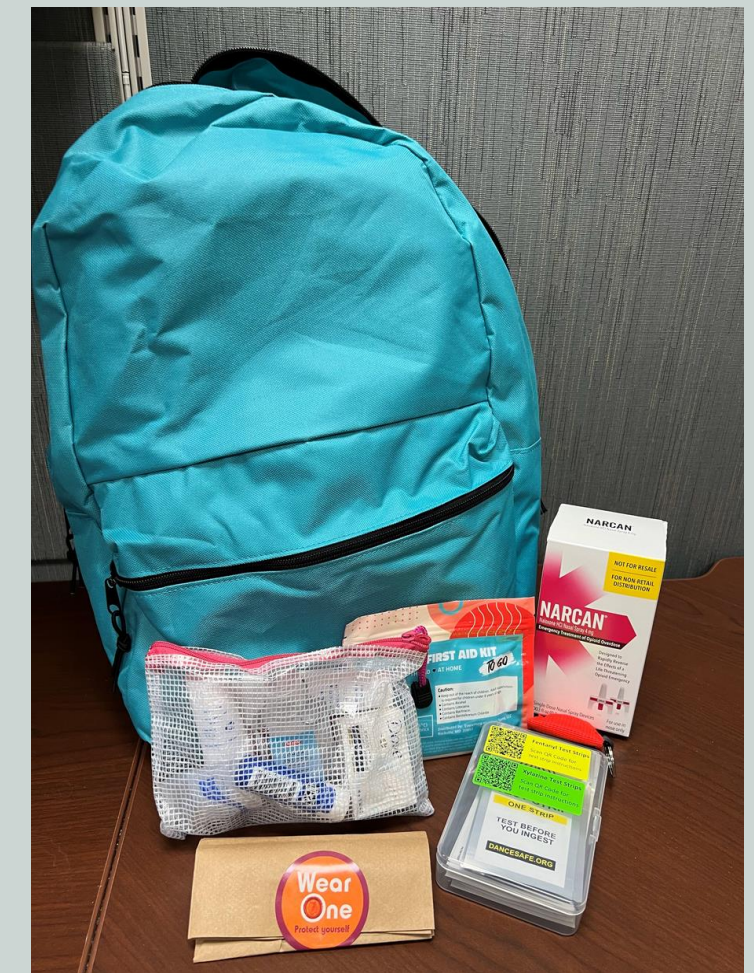
3-Compartment Stand



Newspaper Stand



Backpack





# Harm Reduction Access through Partnerships



	Total Distribution <i>(as of 10/2/2024)</i>
Nasal Narcan / Naloxone ( <i>doses</i> )	1152
Fentanyl Test Strips	1705
Xylazine Test Strips	1085

DELTA TWP - GRAND LEDGE

**A public health vending machine at the Delta Township District Library aims to help neighbors**

The vending machine contains items focused on harm reduction

LOCAL NEWS

**Barry-Eaton District Health Dept. to add Health Resources Vending Machine**

Posted About One Year Ago by WBCH - BEDHD

In partnership with Mid State Health Network, Barry Eaton District Health Dept. (BEDHD) has installed a new Health Resource Vending Machine in the lobby of the Health Dept. office in Charlotte. The purpose of the machine is to provide FREE health resources, like Naloxone, to the community in a private and easily accessible way. BEDHD is looking into avenues to install a similar Health Resource Vending Machine in Barry County.

# Harm Reduction Access through Partnerships

## Future Partners & Utilization of the Substance Use Vulnerability Index (SUVI)

- Identify regions with a high burden of opioid use and low saturation of naloxone supplies. By focusing on these areas, we can effectively allocate resources where they're needed most, ensuring that individuals at risk have better access

## Programmatic Expansions

- Leave Behind Program –
  - Provides Narcan kits to individuals at risk of opioid overdose, especially in settings like emergency departments and among first responders. After a medical encounter, healthcare professionals can leave behind a Narcan kit to increase access among at risk-populations.
- Backpack Programming –
  - Preassembled backpacks are distributed to community partners who engage regularly with individuals at risk of substance use or those currently using drugs. Key recipients include mental health organizations, correctional facilities, and emergency departments, ensuring essential support reaches those who need it most.
- SSP Mobile Unit Potential –
  - To increase access to safer consumption supplies, conversations with neighboring syringe service programs (Punks with Lunch & Red Project) we will continue our conversations to determine process and logistics.

# Naloxone Utilization Awareness / Training

## Narcan Training Settings

- 45-60 Minute Trainings
  - Substance Use Education
  - Resource Awareness
  - Narcan Demonstration Opportunity
- Offered to Organizations:
  - Substance Use Action Teams (SUAT)
  - Homeless Shelters
  - Residential Cleaning & Restoration Agencies

	Total Individuals	Total Narcan Distributed
Training #1 (SUAT)	24	24
Training #2 (SUAT)	54	49
Training #3 (SERV PRO)	32	28*
Training #4 (SIREN)	10	10*
<b>TOTAL</b>	<b>120</b>	<b>111</b>
* Kits were developed and distributed rather than just the box of Narcan being provided		

## Expansion of Training Settings

- Aim to host trainings open to community members through active engagement in community events.
  - Health Fairs, Community Festivals, School Workshops, Public Safety Events, Church or Faith-Based Gatherings

# Overdose Awareness Community Engagement

## **Overdose Fatality Review Team (OFR)**

- Virtual Group
- Various Career Perspectives
- Hosted Quarterly for Eaton County
  - Data Overview by BEDHD Epidemiologist
  - Case Presentation by Medical Examiner
  - Group Discussion using anonymous platform

## **OUTCOMES**

### **OFR Recommendations**

- Community & Provider Education
- Education & Supporting the OFR Team
- Coordination of Care & Wraparound Services
- Harm Reduction
- Treatment & Healthcare

### **Development of Action Team**

- Meet on the off months of the OFR

# Overdose Awareness Community Engagement

## Substance Use Action Team (SUAT)

- Data Overview
- Action Plan Development
  - OFR Recommendations are utilized to build activities and identify lead organizations/individuals.
    - Each meeting has a roundtable to communicate progress/updates

Recommendation	Action Steps	Who	Timeline	Outcome	Status
Include mental health diagnoses in OFR timeline	Implement OFR email request for providers,	ME Office/ BEDHD Epidemiologist	August OFR Meeting	Medical History of decedent	In progress
	Request information from OFR members/contacts	OFR Team/SUAT Members	August OFR Meeting		In progress

# MENTIMETER



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