Transcript:

Overdose Disparities Series: Rural and Urban Overdose Prevention Strategies

Presenters: Chuck Klevgaard, Brandon Hool, & James Kowalsky
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PRESENTER: Good morning, everyone. We will get started in just about a minute. So everyone can get in and get settled.

All right, I think we're going to get started. Because we have a lot of amazing content to go through today. Welcome, everyone, to our webinar, Overdose Disparity Series. This one is Rural and Urban Overdose Prevention Strategies in Illinois and Michigan. This webinar today is brought to you by SAMHSA and the Great Lakes PTTC. And the Great Lakes ATTC, MHTTC, and PTTC are all funded under the following cooperative agreements from SAMHSA.

This presentation was prepared for the Great Lakes PTTC under that cooperative agreement, and the opinions expressed in this webinar are the views of the speakers and do not necessarily reflect the official position of DHHS or SAMHSA. The Great Lakes PTTC believes that words matter, and we use affirming language that inspires hope.

And just a quick couple of housekeeping details. If you're having technical issues today, please individually message Stephanie Behlman in the chat section at the bottom of your screen, and she'll be happy to assist you. Due to the high number of participants today, we ask that your cameras be off and your microphones being muted. If you have any questions during the presentations, please put them in the chat section, and we will have the speakers answer them at the end of the session.

At the-- will be sent a link after this webinar to a very short survey. And we would really appreciate it if you could fill it out. It's how we report back to SAMHSA. And certificates of attendance will be sent to all who attend the full session. They will be sent to you via email, and it will take about two weeks. If you would like to see what any of the Great Lakes ATTC, MHTTC, or PTTC are doing, please follow us on social media.

Our presenters today are Chuck Klevgaard, the Prevention Manager for the Great Lakes PTTC, Brandon Hool, and James Kowalsky. Chuck will do a more in-depth presentation with them, and I'm going to just turn this over to Chuck.

CHUCK KLEVGAARD: All right. Thank you, Ann. As we get started, let me say first, welcome you want to talk to of this Disparities in Overdose in Region 5 series on looking at overdose disparities in particular here in the Midwest, in region 5. We spent the first installment on the series looking at issues around defining some of the disparities, looking at issues in particular around race, for example, socioeconomic kinds of determinants, and how they play a part in some of the disparities that are happening here in the region.

We wanted to take a specific time to look at some of the challenges around disparities in particular with urban and rural kinds of issues here in the region, as they present very differently. And so we're going to-- we have the joy of having two states who are working in those respective ways in particular, have an understanding about some of what the challenges look like in an urban area, like Chicago. James will talk with us about that, as well as some folks who focus on urban areas in Michigan. So you'll hear from Brandon.

In a moment I'll introduce them But I want to, again, give you some quick background about what we covered last time. So fast review, we spent some time [AUDIO OUT] overdose special populations, and we looked at that in the context of the region. We looked in the country first. But then we look more directly here in region 5.

The second definition here is from the World Health Organization. This is more about differences that are not only unnecessary and avoidable, but in addition are considered unfair and unjust. We spent a fair amount of time looking at issues with regard to some of what we know, disparities have happened in terms of some good news trends that were happening with regard to overdose rates in some places here in the region, leveling off, but not fairly across all populations. We felt like this is a really important time to spend this time having this discussion about which populations are not moving in the right direction, and in fact, in some cases, actually increasing with regard to overdose rates.

We spent a little bit of time talking about some issues about disparities and strategies for prevention. So I invite you all to share right now by participating in this poll. Which of the following strategies that we covered last-- and I'll say them real quickly-- are issues that are important to you where you live? So are you working to address disparities by implementing comprehensive holistic approaches? Are you working to try to better engage community and develop multisectorial, diverse partnerships? Are you working at culturally relevant public awareness? Or are you trying to work on specific culturally specific engagement strategies? Or do you really have a commitment to working on a more relevant and diverse workforce?

I made-- all right. As we watch the issues coming in, I see folks interested in all five of these strategies, again, with a slight lead, with regard to looking at community, multisectorial, diverse community partnerships.

As we move into this next section-- and you can go ahead end the poll. Thank you all for taking that moment with us to engage. We want to frame a little bit about what we know with regard to urban and rural disparities, and then move right into our first presenter.

So the graph that you're looking at makes the case that from 1999 through 2017, is when this particular study was done, looking at rates of overdose. They increased in both urban and rural. Now you can see some of what was going on in the early 2000s was that urban issues were greater. And you saw somewhere around 2006, that urban population slightly overtook things, and continue to increase. Again, you see lots of fluctuations there, but both increasing across that 10 year span of time.

So it's really important for us to, again, make the case. While rates were leveling off with regard to overall populations, in addition, we looked at last at race [AUDIO OUT]. For urban and rural populations, we have similar concerns, that something drives those situations differently. So a little bit of some of the bigger points that you may hear presenters talk about, or you'll definitely hear that we know a little bit more about-- overdose rates are higher with regard to urban counties.

We know that there are specific gender differences. Women, in many places here in the region, are more likely to have an experience, overdose, death, and in particular, fatal overdose deaths in rural parts of our region. In particular, males are more likely in this case to be at greater risk in urban areas. So again, there's some, I think, some nuances there that we need to better understand. But we know that there are gender differences that we should pay attention to when we look at urban and rural issues.

We know that rates are higher with regard to urban counties looking at heroin, synthetic opioids, methadone, cocaine, other than methadone and cocaine. And then looking at rural issues, semi-synthetics, in terms of oxycodone type of stimulants, all issues that present differently in rural areas.

Here's a quick graph to kind of show you how distinct or significant some of these are. Again, the green line, in this case, is now looking at the issues of urban. So again, you can see that in some cases, there the differences are slight. In other cases, they're much more significant, with regard to synthetic opioids in urban areas. You see that again, a more significant difference with cocaine, and then again.

So pay attention to that as you listen to presenters today, to know that these are some of what we think of as drivers. We also spent a little bit of time last time talking about challenges to prevention. So we know negative representations and stigma, of course, present challenges across the continuum, from prevention to early intervention to treatment and recovery.

But I think that some of what we talked about last time-- a negative representation, stereotypes, and racial issues-- all compound challenges with regard to overdose. Fear of legal consequences certainly gets under way of overdose prevention. Intergenerational use really compounds the issue of successful intervention, with regard to the overdose rates. Misperceptions about addiction and opioids, something that we talked a lot about last time in particular, and including misperceptions about the role of treatment or medication assisted treatment, or even sort of lack of acceptance or understanding around opioid specific treatments.

Lack of culturally responsive, respectful care-- and that goes back to that work force issue that you all just selected.

Separate or unequal prevention and treatment, also an issue, in that sense. These were the basic issues. Now let's take a quick look at some of the rural issues where you are, and then we'll move right into our first presentation. So again, let's bring a quick poll.

So this time, which of these issues, the following issues, are challenges to rural populations where you live? So again, is it the distance to travel, and it's the transportation that presents challenges to care and overdose prevention? Is it access? To technology itself that may present challenges to using tele-behavioral health, for example? Or is it-- in some parts of the region, we've heard folks talk about overdose deaths occurring in homes in rural areas, where rescue efforts may fail, because relatives, family members may have limited knowledge about using antidotes, or even less access to naloxone itself.

So which of these are issues where you live for rural populations?

Awesome. Lots of you chiming in. So thank you for, again, taking time to help guide us, in terms of where we should spend some point talking today. Let's go ahead and close the poll. I know some of you are still chiming in. Again, we have a winner in this case. Distance to travel, access to transportation-- so the geography itself, as well as the culture of rural populations, I think, in that same respect, are related to that issue of travel and transportation and challenges to here.

Overwhelmingly, again, we've mentioned the issue of socioeconomic drivers, sort of root causes. And I think some of that relates to when we talk about rural issues as well. So thanks for participating in that poll. We want to start with our first presenter today.

Brandon is going to talk with us. Brandon Hool is a Harm Reduction Analyst. He works for the Michigan Department of Health and Human Services. He actually works in the viral hepatitis unit. In his role with harm reduction, his worked to deal with programs such as syringe exchange programs. He's worked at expanding the overdose approaches, using the six pillars of

Michigan's opioid response strategy, which you'll hear him talk a little bit more about. So without further ado, we'll start with Brandon as our first presenter. Turning it over to Brandon.

BRANDON HOOL: All right. Thanks for the introduction, Chuck. And thank you for attending, and your interest in this subject, everybody. I'm going to share my screen now.

There we go. Again, thanks for attending. Thanks for your interest. Yeah, my name is Brandon Hool. I'm with the Viral Hepatitis Unit of Michigan Department of Health and Human Services. I'm going to talk a little bit about some of the disparities between rural and urban overdose that we're, seeing some other disparities, and strategies we're using to address these.

So first, I'm going to start out by talking about the unique geography we have here in Michigan. And you can see this map on the right. Michigan Upper peninsula, which has got one bridge there between the two. And most of the state of Michigan is pretty rural. A lot of our population is concentrated in the Southeast portion of Michigan, the Detroit area, and then a little bit more over here in the Southern lower peninsula, the west side of that peninsula.

And as you get North in the lower peninsula, it gets a little bit more rural. As you get into the upper peninsula, it gets very, very rural in some areas. So historically, we've seen high rates of overdose in our more urban areas-- so in the Southeast part and the western part of the lower peninsula. But as most of the country has seen, we've seen in Michigan here, overdoses rise dramatically in the last couple of decades.

And in recent years, leading up to 2018 when this final overdose data is from, what we started to see is rising rates of overdose in our more rural areas-- so the northern part of the lower peninsula, parts of the upper peninsula, the southern center part of the lower peninsula. And even though-- a note here-- even though a lot of these counties are in white, the data is suppressed. Doesn't mean that they have low rates of overdose. the population can be pretty sparse in some of these counties. And so a lot of the northern lower peninsula sees pretty high overdose rates.

Now as we're going into 2018, we've pretty much, for six years, we saw a consistent rise in overdose deaths. And then from 2017 to 2018, we were really relieved to finally see overdose deaths drop off. And in most cases, that would be cause for celebration. But what this drop in overdose deaths really highlighted was some really concerning disparities.

And so in Michigan, the majority of the population is White. So overdose trends among the White population really drive overdose trends in the overall population. But what we saw in 2017, when those overall rates started to drop, is an increasing disparity between our Black population in Michigan and

our White population. Because overdose deaths continue to increase in our Black population.

And then we've continued to see again increases in overdose fatality overall. [AUDIO OUT]

Issues among Michigan residents-- Governor Whitmer created a task force by executive order. And this task force, one of the things they were tasked with is creating a comprehensive strategy for addressing opioid use in Michigan. And then they came up with a comprehensive, six pillar strategy. And I mean, I could-- this is a little too much to go into today. So I'm just going to focus on a little bit of it here.

But one of the things that could be-- one of the most immediate actions that could be taken from this strategy was to increase harm reduction services, because of the historic-- the evidence of historic success of these programs across the country, across the world, and more recent data showing the success of these programs in the state of Michigan.

So obviously, first off was to expand access to naloxone and syringes for all people in Michigan. And the most immediate concern was the people who were at highest risk for overdose-- so targeting our response to people who injected drugs, people who are leaving abstinence based treatment or incarceration, and the survivors of non-fatal overdoses.

So a lot of our initial efforts were increasing harm reduction services. But also, a lot of this strategy is focused on a harm reduction philosophy-- making all services more accessible, lower barriers, low threshold. And so these initial efforts were based on the data we were seeing leading up to these disparities we were seeing in 2018. And as we're seeing the rise in rates of overdose in rural areas, a lot of our initial strategy was based on getting services into those rural areas.

Now prior to 2018, there were actually four syringe service programs in the state of Michigan. These programs were in our urban areas-- So one in Grand Rapids, in Kent County, one in Detroit, one in Ann Arbor, and one in Flint. So because of the success we'd seen from these programs in our urban areas, we wanted to expand the service to our rural areas, with these emerging health concerns.

So like I said, prior to 2018, we had these four syringe service programs in the state of Michigan. [AUDIO OUT]

One program up here in Houghton. This health department up here actually covers all these counties that don't have dots in them. So there's syringe services available in every county in the upper peninsula, through much of the northern lower peninsula, and some of those areas that I highlighted in the previous map-- so the central, southern part of the lower peninsula.

So we were able to expand these programs, and we had a lot of evidence of their effectiveness across the state of Michigan. And now with the disparities we started to see in 2018, or that were really highlighted in 2018, our 2021 efforts are going to be in strengthening these services in our urban areas.

And so all of these syringe service programs in Michigan distribute naloxone. All of them are building relationships with their clients. People are reporting overdoses is being reversed. We're seeing an increasing amount of community utilization of these programs, more people visiting, distributing more syringes, and engaging more with the programs. And like I said, a lot of this effort was driven on success we'd seen previously in the state. In 2018, we-- well, 2016, 2017, we were looking at our overdose numbers for our 10 most densely populated counties. And at that time, the largest naloxone distribution, the largest harm reduction based naloxone distribution program in the state, was the Grand Rapids Red Project. And they operate out of Grand Rapids, which is in Kent County.

And they actually had the lowest overdose rate out of the 10 most populated counties in the state. And they've been distributing naloxone at a pretty high rate since 2008. And if we look at the population, and look at what's expected as an overdose rate in Kent County, we would actually expect to see 100 to 200 more people dying each year. So it's definitely-- something was happening in Kent County that was reducing overdose fatality. And a lot of our efforts are focused on replicating that for all Michigan residents.

And as far as this Red Project and expanding their effort to [AUDIO OUT]

Across the states. You get their Naloxone. In 2021, they'll also be incorporating SSP into these services. So they'll also be doing mail-order arm reduction, supplies, syringes, that type of thing.

Another initiative, another part of the opioid strategy in Michigan to increase naloxone access, is the naloxone portal. The portal was launched in 2020. And the value of this is that naloxone access in Michigan, the legislation regulating it is complicated. Anybody in the state of Michigan can walk into a pharmacy, and under the standing order, can receive-- or they can purchase a naloxone rescue kit, which can be a barrier.

So one of the ways to overcome this barrier is grant funded, government funded, donation funded, organizations purchasing naloxone kits in bulk and distributing them at no cost to the community. However, the standing order doesn't cover an agency that wants to practice this distribution method. So the naloxone portal allows access to the jails, substance use disorder treatment providers, the Michigan State Police, the Michigan Department of Corrections, other community based organizations.

They can register for this portal. And basically, they just plug-in a number of Narcan rescue kits that they need, and they get shipped to them. They can

distribute them to the community. So overcomes that barrier of an individual having to walk into a pharmacy and purchase a kit, and the barrier that an organization that wants to distribute kits has in getting the prescription and being able to distribute them.

And as of November 30, so just-- I mean, really just five months after the portal launched, it had already distributed 62,268 kits. These kits are getting out to these community organizations, going out to the communities.

Another way to get naloxone out to the community, another [AUDIO OUT]

Then they can leave behind a rescue kit. If that person is to overdose again, they can be rescued, either before EMS gets there, or if EMS is not called. And then 10 additional EMS agencies are already in talks to adopt the same protocol. In 2021, there's-- we're going to be pursuing a number of legislative changes. One to change the legislation, to allow for community organizations to actually purchase naloxone, require all levels of EMS to carry naloxone, require a substance use disorder treatment providers to offer kits to clients that are discharging, and continue to persuade jails to offer naloxone to people being released.

Another initiative in the state of Michigan to increase MOUD being prescribed to people using opioids is emergency department based at MIT, MAT initiation. So MDHHS, we're already funding this through the Michigan opioid partnership to 12 hospitals. So somebody comes in for an opioid related injury, possibly an overdose, they can be initiated on MOUD while in the emergency department.

We're already working with 9 plus hospitals, hospital EDs, to increase naloxone kit distributions, to increase naloxone kit distribution to individuals post overdose. Piloting-- we're piloting six post overdose rapid response teams to provide in-person outreach within 24 to 72 hours post overdose. So these teams will respond after somebody's overdosed, basically knock on their door, offer them resources, offer them take home naloxone. And since the creation of this show, one of these teams is already in the works of implementing syringe service programming through the rapid response team.

Now, we'll be expanding health benefits for opioid use disorder and 21 priority-- 2021 priority through legislation is to require hospital emergency departments to have the capability to initiate MOUD following an overdose. So in 21, in 2021, we're expecting the total number of EDs to be offering MAT in 29 emergency departments across the state.

We've also focused on the criminal justice populations-- obviously, the population with a higher risk of overdose. So we've committed over $6 million.

Michigan would offer MOUD by 2023. And it's currently being piloted in three facilities. And then we're also funding initiatives to connect people to care after leaving these facilities.

And then in 2021, another priority we have is to pilot lead diversion programs. So lead program is a law enforcement assisted diversion program. This would be a program where if somebody committed a low level offense, typically a substance use related offense, instead of entering the criminal justice system, they'd be diverted to community resources, without entering the justice system.

So those programs would be piloted in Washtenaw County and in Muskegon County. And so Washtenaw is kind of the Southeast portion of the lower peninsula. Muskegon is the West Coast of the lower peninsula.

And always happy to talk more about this stuff. You can visit our website to learn more. Really appreciate having the chance to talk to anybody today. And with that, I'm going to go ahead and pass it back to Chuck.

CHUCK KLEVGAARD: Well, thank you so much, Brandon, for a great overview. We are going to do a Q&A at the end. Before we leave Brandon however, there was a question specifically about the map, in terms of the orange dots. So the Q&A, we'll meet more broadly about to either speaker, about questions. But given that was kind of visual, and it relates to a slide, I wonder if you would take a moment and back up and answer that question?

So let me take a look. So the question was on harm reduction, SST side-- what do are the numbers inside the orange circles on the map mean?

BRANDON HOOL: OK, sure. Yeah, so those are-- this is actually from our directory, which you can find on our website, Michigan.gov/SSP. The numbers in there correspond to the sites. And then the site information is given in the directory.

So for instance, up here in Marquette, we've got 47 through 49. So there's three sites up there in Marquette County.

CHUCK KLEVGAARD: Perfect. All right. Thank you so much. Again, remember, everybody else, we are going to do a Q&A. We are tracking your questions as you paste them into the chat. Please continue to do that.

We're going to kind of move the conversation now, and take it to do another quick poll with you all, to take a look at urban issues. So we've just spent the last 20 minutes looking more directly in depth at Michigan [AUDIO OUT]

Bigger urban issues around fighting poverty or social inequities that further complicate overdose prevention in urban neighborhoods where you live.

And seeing lots of folks chiming in to give us an idea of what some of the leading drivers are of overdosing in urban areas where you all live here in the region 5. Let's go ahead and close. It looks like we've got two close. We definitely got one that seems to present us as the biggest concern for lots of folks on the call today, that issue of crime and poverty and social inequities. Absolutely, we've spent some time in the last webinar about that, in the series. We're talking about that today, and that will become a theme in the next several, to look at those issues, and to figure out, how do we really take the time to look at some of those bigger roots that are social and economic determinants in that same way? So thank you for participating in the poll.

We're going to move into Illinois, and hear a bit from James Kowalsky. James is a Project Director with the Illinois Department of Human Services. He works in the Division of Substance Use Prevention and Recovery. James works with the drug overdose program coordinator, and he works with overdose education and naloxone distribution. And he is going to tell us a little bit about what's going on here in Illinois, where I live.

So turning it now over to James Kowalsky.

JAMES KOWALSKY: Thanks, Chuck. I'm just going to pull up my slides real quick. And hopefully, you can see these now. So as Chuck mentioned, I work for the Illinois Department of Human Services, Division of Substance Use, Prevention, and Recovery, in addition to licensing our treatment programs in the state. IDHS/SUPR is the acronym you'll hear. But IDHS/SUPR is responsible also for funding a lot of the overdose education and naloxone distribution work that happens in the state.

And so that's where my role comes in is I do a lot of technical assistance for the OEND. That's another acronym you'll hear a lot. But I do a lot of the technical assistance for the OEND providers throughout the state of Illinois.

I do want to just say, quickly, good morning, and thank you for attending today. Obviously, there's a lot of people on the call today, and I think that's just a really good indication of how urgent the issue of the overdose crisis is, and how eager all of us are to find ways to fix it and address it.

So my presentation today, I'm going to focus a little bit on giving you an overview of what the statistics related to overdose in Illinois, and specifically in Cook County look like, because Cook County is our most populated county in Illinois, and obviously an urban county. And then I'm also going to talk a little bit about what [AUDIO OUT]

It also includes medication assisted recovery, or medications for opioid use disorder, like Brandon was talking about. And then there-- and so I think the real question is, how do we implement these strategies in the most effective way possible, and how do we make sure those resources are reaching the people who need them the most?

So with that, here's a quick view of the trend in opioid overdose deaths in Illinois, starting from January 2018 through June of 2020. That top line there is the darker line. Shows you the number of overdose deaths in 2020 so far. I'll just add a quick caveat to this data. The data from 2019 and 2020 should be considered provisional, meaning it could change. But more likely than anything, that means these numbers would go up over time, as more overdose deaths are counted.

So this is just looking at opioid overdose deaths in Illinois. And the reason that we focus on opioid overdose deaths is around 80% of all drug overdose deaths that occur each year involve opioids. So opioids really are the main driver of drug overdose deaths in our state. So that's part of the focus here.

And broadly speaking, which you can see is those two lines kind of going back and forth on the lower end, are 2018 to 2019. And overall, the number of overdose deaths were pretty comparable in those two years. There was a slight increase from 2018 to 2019. But what we're seeing in 2020 so far is a very significant increase. So when you compare the first six months of 2020-- so January to June-- to 2018 and 2019, there's been over a 50% increase from 2020 to 2019 in the number of overdose deaths, and that if things continue at this pace, we would anticipate around 3,000 opioid overdose deaths for the year 2020.

That would be the worst year on record for us. And when you look specifically at the last 12 months, that there have been over 2,600 opioid overdose deaths already from July 2019 to June 2020-- so last 12 months that we have data for, I should say.

I guess the other thing I'll just note right here very quickly is, while there has been this very significant increase that you see in March, April, and May of 2020, the death increase most significantly during that period. But the deaths did start increasing earlier. So August 2019 is where we start to see [AUDIO OUT]

Disparity numbers in Illinois from 2019. The key takeaway from this side is that non-Hispanic Black people are more than twice as likely to die from a drug overdose than non-Hispanic Whites. And so Black people in the state of Illinois have the highest rate of overdose deaths of any group, or of any race or ethnicity. The one-- and that's true. So each of these bars is sort of showing you in different drug categories. So overall, Black people have the highest rate. And then within all these subcategories of different types of opioids, Black people also have the highest rates there.

I think the other caveat I wanted to add to this data is in general, we see Hispanic overdose rates being lower when compared to Black and White overdose rates. But a recent study actually came out and showed that within the Hispanic population, if you look just at Puerto Rican heritage individuals, that their rates of overdose are actually more comparable to non-Hispanic

Whites, and in some years actually even higher than non-Hispanic Whites. So I think that's an important thing to take into consideration when we're talking about disparities, is not everyone who fits into that broad relative of Hispanic is going to have the same characteristics or the same overdose rates.

Here, shifting gears to focus specifically on Cook County-- so my piece is talking a little bit more about the urban side of things. If you're not familiar, Cook County is the most populated county in Illinois, and home to Chicago. And about 40% of the state's population lives in Cook County. What this graph is showing you is the proportion of deaths from each month since January 2018, where overdose deaths occurred either in Cook County-- so that's the bottom half, the darker blue-- or the top half, all other counties in Illinois.

So this red line here shows you about 40% of the population, which indicates roughly where the proportion of people who live in Cook County. So in general, the number of overdose deaths that come out of Cook County are disproportionately high, relative to the number of people in the county. But what has happened here, again in 2020, is that rise has been even more significant. The number of opioid overdose deaths has been even more significant when you look at Cook County.

So here, you see from 20, when you look at the first six months of 2019 to 2020, an 82% increase in overdose, in opioid overdose deaths over that time. And then what you can also see is when you compare 2018 to 2019, that the overall proportion is actually increasing over that time. So you see here, 46.7%, 51.7%, 58.3% of opioid overdose deaths occurring in Cook County so far in 2020 that we have data for. And again, just past 12 months here. [AUDIO OUT]

Related to opioid overdose. And you see that even though-- so Black people obviously have the highest rate of overdose deaths, when compared to Whites and Hispanics. Even though Black people are roughly around 20% to 25% of the population in Cook County, they account for 45% of the opioid overdose deaths in 2019. So significant racial disparities at the county level also, in terms of the disproportionate impact on Black people.

The lower table here indicates some information about the route of administration in opioid overdose deaths when that information was available. And this data mirrors information that shows black people are less likely to inject drugs in general. And I think what's interesting here-- So. You'll see, injection drugs were-- injection of opioids was it was the case 26% of the time for non-Hispanic Whites, only 4.8% of the time for Black people.

And so what's significant here is that we know that injecting heroin, or injecting drugs, actually increases your risk of overdose. So the fact that Black people are less likely to use this route of administration points to the impact of other risk factors as contributing to the disparities in overdose rates-- so

things like health care coverage, and health care service access, the presence-- the disproportionate impact of certain health conditions, higher incarceration rates. All these kind of racist outcomes have, I think, are things that we can see are sort of contributing, or can interpret or contributing to the disproportionate impact of overdose in the Black community in Illinois and in Cook County. I think this also gives us some indication of how we can try to tailor our intervention to better reach Black people.

I will also just show here-- and I think this sort of echoes some of what Chuck was talking about as well. These cables give information about the drugs that are involved in opioid overdose deaths in Cook County. These are the substances that people tested positive for. So you can see overall, fentanyl is the most common drug involved in opioid overdose deaths, outpacing heroin. And so that speaks to the contamination of our drug supply.

I'll just note here, it's the highest for all groups. But it is the highest overall for Black people. So again, even though fentanyl is most common for everyone, there's sort of a disproportionate impact of how common fentanyl is for Black people. And I think that, again, gives us some indications of what we're dealing with.

In general, in Cook County, meth use is in combination with opioids is relatively rare. So meth is not a contributing factor in a lot of these opioid overdose deaths for any of the groups. But what we do see is, cocaine is pretty common across all groups. So Chuck also mentioned the idea of poly substance use, and [AUDIO OUT]

Substance use of cocaine and opioids together is a pretty significant issue. I also just noted here, benzodiazepines, combined with opioids, increases people's risk of overdose significantly. But when you look at Black people, the number of benzodiazepines involved overdose is a lot lower. This lower table here specifically shows prescription versus illicit opioid-- prescription versus illicit opioid use. And you can see that prescription only opioid overdoses are relatively rare. What's most common is illicit only opioid overdose deaths.

And so I highlight this specifically to just say that if we really want to address the overdose crisis, it will be insignificant if our strategies are only looking at prescription opioids. It will fall far short of actually addressing the most significant contributors to the overdose crisis.

So narrowing in a little bit, about half of Cook County's population is located in Chicago. And so here is a slide that looks specifically at opioid overdose data for Chicago from January to June of 2019 and January to June of 2020. And you'll see a lot of the same trends that were sort of highlighted before. There's been a significant increase in 2020, when you compare it to 2019. There's a high prevalence of fentanyl involvement in opiate overdose deaths. And then there's an elevated rate of overdose death for Black non-Hispanic people.

And while overall, opioid overdose deaths numbers increased, they increased more significantly for Black people. And over 59%, when you look at January to June of 2020, you can see that here, and then kind of here, in the table. Over 59% of the opioid overdose deaths in Chicago were among Black people. And again, very disproportionately impacting Black people. Black people in Chicago are about 30% of the population, but account for nearly 60% of the opioid overdose deaths. So again, I think that really challenges some of the dominant narratives that are out there about who is impacted by opioid overdose deaths.

So I mentioned OEND services, or overdose education and naloxone distribution are, is one of our most effective tools for reducing overdose deaths. And these best practices that are listed on this side are really focused on who do you distribute naloxone to, and how do you distribute to them? This language comes from the Illinois law 2019 Overdose Prevention Harm Reduction Act. So you see the link there at the bottom.

What I'll just highlight here is essentially, the most effective way to deliver OEND services is by directly giving naloxone to people who use drugs, and then using street and community outreach to reach them. And ideally, that would include the incorporation of peers into the outreach and distribution efforts. [AUDIO OUT]

Brandon talked a lot about SSPs, and how important they are. With all of these different. With all of these different settings, you can sort of see, these are all places where people who use drugs will be. And so we need to make sure we're getting the naloxone on to them from these locations-- so programs that are doing street outreach, programs that offer substance use disorders treatment and including medication assisted recovery, like methadone and buprenorphine, or medications for opioid use disorder, as well as peer support and recovery groups, social service and health care organizations, hospitals and emergency departments.

So Brandon talked a little bit about getting naloxone out through emergency departments, as well as buprenorphine induction. That's something that we're trying to promote here in Illinois as well. Making sure that people who are being discharged from jails and prisons have access to naloxone, because they come out with a lower tolerance and a significantly higher risk of overdose.

And then when working with traditional first responders, making sure that people are using a leave behind approach. And so Brandon talked a little bit about this with EMS. In addition to EMS, we also have law enforcement agencies and fire departments in Illinois that offer the leave behind approach.

So here are some enhancements to our naloxone distribution efforts that I think are tailored to the urban setting, and designed to hopefully help better reach the people who are most impacted. So in general, outreach gives us a

way to bring services to the communities most impacted by overdose. And harm reduction and social service providers engage in outreach by a number of ways, but setting up in regular locations, as they're using mobile vans, or by just literally setting tables up on the side of the sidewalk in certain neighborhoods, as well as just walking around in high need community areas. So we have different groups that do that in different ways.

The block by block training specifically refers to-- there's one community group that brings together a lot of organizations on the West side of Chicago, where overdose rates are highest. And their goal was basically to train at least one person on each block where the highest rates of overdose were, on overdose response and naloxone administration.

In general, the community outreach providers have really emphasized the need to offer a variety of services to engage people-- so not just walking around and saying, hey, we have naloxone, but in recent months distributing resources like PPE-- so protective equipment, because of COVID, but also offering things like linkage to housing, health care, substance use treatment-- including-- and this is also because of COVID. Now we have outreach teams that are offering telehealth appointments on the spot to link people to buprenorphine. So that's been something else that outreach providers offer as a way to engage people, and then also supply naloxone.

The community distribution events-- similarly, picking a corner [AUDIO OUT]

Part of the way that we get information about naloxone into the Black community is through what are called trusted messengers. So in my case in particular, in Chicago, I'm thinking of faith leaders that's been one strategy for doing this. So pastors or reverends have sort of taken it on to present the information to their churches, but also to other faith communities in their area. And the value of trusted messengers is that they're community insiders. They're people who know their communities, have a history of engaging in health promotion activities, and they can be trusted when they're presenting this kind of information. So I think it helps get that information out into populations that aren't otherwise being reached.

The safer substance use supply-- so I notice, I noted before, the distinction, in terms of the number of-- or in terms of the amount of injection drug use in the Black community. So part of what organizations have done is implemented safer snorting and smoking kits. So in addition to offering sterile syringes, which has been kind of the historic approach to safer substance use supplies, offering snorting and smoking kits as a way to engage people, to engage different people into harm reduction services.

So essentially, these snorting and smoking kits, if you're not familiar with them, include things like clean glass pipes, rubber stoppers so you don't burn your lips, cut up straws, plastic cards so you can chop up drugs into smaller pieces. Those are the types of things that are going to be safer snorting and

smoking kits. And the goal of offering these services is to better engage people who snort and smoke their drugs, which are disproportionately going to be Black people.

And so I think part of what we've seen is that because injection drug use is less common among Black people, that seems like a contributing factor in some of the data that we've seen, which shows that Black people are less likely to access certain service programs, and then thereby by less likely to have access to naloxone. So providing these snorting and smoking kits basically brings new people into services, and then makes sure that they get access to naloxone as well.

Naloxone rescue stations is the idea of putting up naloxone kits in specific areas-- so like low income hotels. Our rapid deployment teams, for us, that means we've specifically funded people to use data to target disparities in their community, and then especially to employ people, peers and people with lived experience. So targeting disparities, and then when spikes in overdose occur, to try to go to the specific community areas where those spikes happened.

And then lastly, we've been doing more work to promote the availability of harm reduction services. So this is the Illinois helpline, which was [AUDIO OUT]

But in addition to offering information about treatment and recovery services, the website also includes information about harm reduction services as well. And so I'm going to show a quick advertisement that we use here in Illinois, from the need the provider series, which is designed to help raise awareness about our harm reduction services on the Illinois helpline.

FEMALE: Every day, when I go home, I still feel like if I save one person from not getting HIV, from not contacting hepatitis C, from not overdosing, I feel like I did a good thing. I saved somebody's life.

JAMES KOWALSKY: So this advertisement was part of-- it is part of a larger harm reduction campaign, aimed at reducing stigma and promoting awareness of the available harm reduction services in our state. And this was actually the first. This was part of a series of-- if you want to see the other videos-- showing people who work in harm reduction programs, talking about the work. And be aired on TV in Chicago. And it was actually the first time since the helpline was established, that we paid the extra money to air TV advertisements in Chicago. And that was really in response to the concentration of heroin overdoses on the west side of the city.

So the thing I'll just point out specifically is that if you're going to do public health awareness campaigns, we believe that it's important that the people we're trying to reach see themselves represented in these campaigns. And so this is a good example, Cheryl being, obviously, a Black woman, talking about

harm reduction services and reducing overdose deaths, and hopefully engaging those people that way.

You don't need to watch it a second time. So, I'll just finish up here. I realize I'm out of time. Hopefully, we can still have a few minutes for questions. Some challenges, lessons, and takeaways-- I think one of the big challenges is how do we better track to make sure naloxone is reaching people who are Black or African-American, in general in Illinois, but in particular in Cook in Chicago, where we see these high disparities of opioid overdose.

And then some successes-- since implementing these rapid deployment funding, earlier in, I guess in mid-2020, we have seen a lot more peers being offered employment. And they-- and then we've sort of heard anecdotally about their ability to reach into networks that are not otherwise accessing services. When you have peers going out into the community, you get naloxone into the hands of people who might not otherwise receive it. And then an additional thing is since implementing the safer smoking and starting kits, one of the programs that we fund here in Cook County [AUDIO OUT]

So I also include some resources here. I think we're going to send out the slides afterwards. So you'll be able to see any of the resources that are used for this presentation. And so with that, I'm going to go ahead and pass it back to Chuck, as soon as I can figure out how to stop sharing.

CHUCK KLEVGAARD: Thank you so much, James. Amazing. Lots of stuff. And transition back. We're going to a Q&A. Some of you may-- we are at the top of the hour. If you need to jump, off your feet to do that, of course. Know that we're going to stay on. Because there's a fair amount of really, I think, thoughtful questions in the Q&A in the chat.

So we're going to stay on with you all. All of you that want to stay and get the answers to your questions, we're going to spend some more time with you right now. We're also going to have the opportunity to answer some questions by mail. I don't know that we'll get to all of them today. So know we'll get as far as we can in this Q&A session.

I also want to take a moment to acknowledge those of you who've been typing resources in the chat. Amazing. We'll send that out to you folks as well, if there are critical links or suggestions for resources and websites. And amazing stuff coming in. We feel like the entire series is about opening the dialogue about what we're doing here in the region 5, and how it relates to us in the Midwest, and to the people who are doing this amazing work, being able to connect with each other in amazing ways.

So without further ado, Ann has some of the questions that have been in the chat and that we've been sitting on for the last hour.

PRESENTER: Thank you, Chuck. Again, as Chuck said, if we're not able to get to these, we'll have them answered in writing and put them up on the website when we post the recording and the slides. So the first question is, the rapid response team-- who are they, and how do they get around HIPAA laws, in order to show up at someone's house? That's for anyone.

BRANDON HOOL: Yeah, so this is Brandon. I haven't been that involved with that project. So I'm not sure exactly how that works. But I can get the answer to that.

PRESENTER: Great, thank you. Someone asked, she said, I have seen the term age adjusted on a few of the slides. Can you tell me what that means?

And I think they were on your slides, Brandon.

BRANDON HOOL: Sure. Yeah, so sometimes, we see age as a confounder in our data. So for instance, with overdose, we see higher concentrations of overdose in the like 25 to 35 age range. So if you go to some area that has a very small, 25 to 35-year-old population and say a lot larger older population, over 35, it's going to look like there's a really low overdose rate. Because there's just not that many of that age range that are in that area.

So basically, that's misleading. Because in that age range of people, the overdose rate could still be pretty high. But it looks low, because there's a larger population of older people in the county. So basically, what-- when they adjust, they adjust the numbers as if all the counties had the same number of people in each age range.

That way, that the overdose rates make more sense.

PRESENTER: OK. What about the old stats showing in the early days, rural areas were identified as places or locations for manufacturing drugs, and urban areas, places identified as distribution? It says, the affordability of designer drugs, as opposed to inner cities in urban-- the good stuff was actually cut to make more for distribution sales? Is there any-- have you noticed any differences in those stats?

BRANDON HOOL: We don't really compile that data, that I've seen, in Michigan. We do have a lot of methamphetamine manufacture in rural areas. But we are starting to see more is these multi-drug overdoses that involve something like methamphetamine or cocaine, along with synthetic opioid. Then we see different rates of overdose with different drugs mentioned in different counties. Different things are happening.

But what really changed all that was the availability of these prescription opioids, where typically, the drug of choice in a more rural area would be something more accessible, like a manufactured drug. In an urban area, which it's really more profitable for a drug distributor to distribute a shipment,

something that's coming from out of the country, like heroin or cocaine, you can see that in an urban area, because there's not much profit margin to ship that stuff out to a rural region, because of the risks involved.

So we still see drugs manufactured in rural areas. We still see them distributed in rural areas. The type of drug [AUDIO OUT]

JAMES KOWALSKY: I think the difference in the contents of drugs, it's not so distinct from one area to another that I think it radically changes our public health messaging. So I think that whenever you're talking to people who are using illicit drugs, yes, I think in wealthier or more suburban areas, or in certain areas, I think people are more likely to find higher quality of substance. But at the end of the day, anybody who is using illicit drugs, especially illicit heroin, at this point, should assume that there is fentanyl in there and the drugs that they're using.

And so that should be part of our messaging to everyone is, be prepared. Here's some of the things that fentanyl does, increasing your risk of overdose. It's still responsive to naloxone, but you might need more naloxone. But I think that messaging about the contamination of the drug supply should be part of any overdose education efforts, regardless of whether you're in an urban or rural setting or a suburban setting.

BRANDON HOOL: Yeah, I agree with James on that. We've seen the same thing for us SSPs that distribute fentanyl test strips. And people are testing different types of drugs. So unofficially, our data says that there is-- yeah, with any substance somebody is using, suspect that fentanyl is present in the mix. That's what we're seeing with our fentanyl test strips among people who are using drugs, in all parts of the state.

JAMES KOWALSKY: Brandon, since you brought up the fentanyl test strips, I saw that somebody had commented that incorporating fentanyl test strips into outreach is also a way to engage people. And I think-- I just wanted to highlight that. That is a good point, and we've heard that from several of our providers, that fentanyl sentinel test strips kind of brings people into these programs. And then you can give naloxone when they get there.

One of the limitations here is that SAMHSA currently will not fund or pay for or reimburse people for fentanyl testing strips. Because they don't feel like there's enough evidence behind that strategy right now to allocate resources towards it. So programs have had to kind of come up with alternative routes of paying for fentanyl testing strips, different grants and funding sources. But that is something that I've heard from providers, is that they feel like it is a good way to get people's foot in the door, as part of their harm reduction services.

PRESENTER: All right. Thank you. We have time for one more question. Again, if you submitted a question and we were not able to get to it, we will get the answers in writing. And we'll have a Q&A document on our website.

But the last question is, any tips on getting buy-in on harm reduction strategies? My grant administrator doesn't necessarily support HR, but would like-- I'd like to get them on board.

BRANDON HOOL: Resistance to harm reduction, especially in our rural conservative areas. And the key really seems to be a lot of data, which is good to have as a backup. But a lot of times, when somebody is that resistant to an evidence based strategy, it takes a very emotional argument. And this is just what I found.

Find people who have benefited from harm reduction, and give them the venue to tell their story, and explain why this is important, and why this works. I mean, that's really the overall strategy we've used, is that people have their moralistic views. And those can often contradict scientific evidence. And harm reduction is a very moralistic issue, unfortunately, despite the scientific evidence.

So that's my overall advice, is work on making an emotional argument.

JAMES KOWALSKY: I agree with Brandon on both those points. I mean, it really depends on the person, in some cases. And I do know of people who have sort of come around to harm reduction interventions, because they saw the evidence and the data. And they said Oh well then that makes sense, and let's go with that. And then there are people who need the more emotional appeal.

I just put into the chat the link to another public health campaign that we funded called Naloxone Now campaign. And one-- to Brandon's point about telling the story about people who have benefited from harm reduction, one of the phases of that campaign was called Naloxone Saves Lives. And the public health advertisements include pictures of real people who have been saved by naloxone, and gives them details about their life, like I was saved by naloxone three times. Now I'm a mother. Now I'm a business owner. Now I'm living my life.

And so I think just making the point that we need to give people the opportunity to stay alive and stay as healthy as possible, in order for them to be able to pursue recovery. It is a difficult argument to make. But I think as much as possible, when we're talking about these harm reduction interventions, we know that the evidence is there. We know that these are the right strategies to be pursuing.

And the resistance to them, I think it comes from a well-intentioned place. People are maybe worried about encouraging drug use. But at the end of the day, what we know is, these strategies reduce harm and save lives. And that's-- I think that's really the common ground. And I think starting from that common ground of saying, there are people out here in our community, or in our county [AUDIO OUT]

Every Avenue that we can to save people's lives. These are people's parents, and siblings, and children. And they are community members. And we need to do everything possible in our range of strategies to help them out. And so I think-- I guess that to me going with more of an emotional appeal overall. But yeah I would really just try to drive home, you and I have-- when you're talking to somebody who is resistant or concerned about harm reduction, to start from the place of I care about people who use drugs.

I want them to not die. I want them to not get diseases. And I know that's what you want, too, right? And so starting from that common ground, I think, can maybe be a good place to sort of open up some doors to conversations about what harm reduction strategies an organization or program might be willing to pursue.

PRESENTER: And on that, I would like to thank everyone-- all of our speakers, all of our attendees-- for their time and their attention. And again, the recording, the slides, the Q&A, and any other additional resources or materials, will be posted on our website. It usually takes us a week to 10 days to get everything up.

But again, thank you all. This was a phenomenal presentation. And we hope to see you again.

CHUCK KLEVGAARD: Also want to say thank you to Brandon and James. Incredible job, knowing that this, again, has been sort of two pronged goal of increasing the dialogue here in region 5, but also beginning to share best practices and lessons learned more broadly. Watch for the next installment in our series for region 5 on dealing with disparities in February. And then we'll also have a specific emphasis on looking at culturally specific approaches and responses in March.

So looking forward to you all back with us again. Thanks Brandon and James.

BRANDON HOOL: Thank you, and thank you again, everyone who attended.