Data-Informed Risk Mitigation (DORM) Report:
An Overview of Demographic and Behavioral Health Outcomes for Opioid Decedents in the Public Behavioral Health System

Presentation to the Commission to Study Mental and Behavioral Health in Maryland

July 13, 2021
Presentation Overview

➢ Purpose:
  ○ Review DORM report results pertaining to opioid decedents with prior service engagement in the Public Behavioral Health System (PBHS)
    ■ Explore client characteristics, service use and outcomes for PBHS decedents who were recipients of both MH and SUD services prior to their death
    ■ Highlight BHA prevention and treatment strategies to target and engage dually diagnosed individuals and opportunities for service improvement
Methods and Analysis

Data Source(s):
- OCME VSA Unintentional Intoxication Death Data: 2016 to 2019
- Public Behavioral Health Service Claims Data: 2016 to 2019
- Outcome Measurement System (OMS) Data: 2019

Methods:
- OCME VSA Unintentional Intoxication Death data was linked to the PBHS Service Claims and OMS data based using a matching algorithm
PBHS SUD and MOUD Service Utilization Trends
Trends in SUD and MOUD Service Use Among PBHS Service Recipients: 2016 to 2019

Data Source: PBHS Service Claims Data FY 2016 to FY 2019, based on claims paid through December 31, 2019
Trends in MOUD and SUD Service Use Among PBHS Service Recipients By Age Group: 2016 to 2019

Data Source: PBHS Service Claims Data FY 2016 to FY 2019, based on claims paid through December 31, 2019
Trends in MOUD and SUD Service Use Among PBHS Service Recipients By Race: 2016 to 2019

Data Source: PBHS Service Claims Data FY 2016 to FY 2019, based on claims paid through December 31, 2019
Intoxication Deaths Among PBHS Service Recipients
Trend in Intoxication Related Deaths Statewide and Among PBHS Service Recipients: 2016 to 2019

Data Source: PBHS Service Claims Data FY 2016 to FY 2019; VSA-OCME Intoxication death data, 2016 to 2019 linked file
Trend in Intoxication Deaths Among PBHS Service Recipients By Type of Service Engagement: 2016 to 2019

Data Source: PBHS Service Claims Data 2016 to 2019/VSA-OCME Intoxication death data, 2016 to 2019 linked data file
Comparison of Intoxication Related Deaths Among PBHS Service Recipients By Type of Service Engagement, 2019

<table>
<thead>
<tr>
<th>Service Type</th>
<th>All Persons Active in PBHS</th>
<th>All Decedents Active in</th>
<th>Rate of Death Per 1,000 Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Only</td>
<td>175,840</td>
<td>116</td>
<td>0.66</td>
</tr>
<tr>
<td>SUD Only</td>
<td>66,867</td>
<td>394</td>
<td>5.89</td>
</tr>
<tr>
<td>Both</td>
<td>50,751</td>
<td>839</td>
<td>16.53</td>
</tr>
<tr>
<td>Total</td>
<td>293,458</td>
<td>1,349</td>
<td>4.60</td>
</tr>
</tbody>
</table>

Data Source: PBHS Service Claims Data/VSA-OCME Intoxication death data, 2016 to 2019 linked data file
Time Between Last PBHS Service Contact and Death By Service Type, 2019

Data Source: PBHS Service Claims Data//VSA-OCME Intoxication death data, 2016 to 2019 linked data file
Trend in Time Lapse between Last PBHS Service Contact and Time of Death Among Decedents Engaged in Both MH and SUD Service, 2016 to 2019

Data Source: PBHS Service Claims Data/VSA-OCME Intoxication death data, 2016 to 2019 linked data file
Demographic Comparison of PBHS Decedents and All PBHS Service Recipients Engaged in MH and SUD Services, 2019

<table>
<thead>
<tr>
<th></th>
<th>MH/SUD Decedents (568)</th>
<th>MH/SUD All PBHS (71,500)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>38.4%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Male</td>
<td>61.6%</td>
<td>48.0%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>35.4%</td>
<td>41.3%</td>
</tr>
<tr>
<td>White</td>
<td>62.0%</td>
<td>54.0%</td>
</tr>
<tr>
<td>Other Race</td>
<td>2.6%</td>
<td>4.7%</td>
</tr>
<tr>
<td><strong>Age Category</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20 Years</td>
<td>0.2%</td>
<td>6.8%</td>
</tr>
<tr>
<td>20 to 29</td>
<td>16.5%</td>
<td>19.9%</td>
</tr>
<tr>
<td>30 to 39</td>
<td>33.1%</td>
<td>27.3%</td>
</tr>
<tr>
<td>40 to 49</td>
<td>19.5%</td>
<td>18.8%</td>
</tr>
<tr>
<td>50 to 59</td>
<td>26.2%</td>
<td>21.1%</td>
</tr>
<tr>
<td>60 years +</td>
<td>4.4%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Data Source: PBHS Service Claims Data/VSA-OCME Intoxication death data, CY 2019 - based on individuals active in PBHS system between July 2018 and December 2019.
Comparison of PBHS Service Use Among Decedents Engaged in Both Mental Health and SUD Services and All MH-SUD Engaged Service Recipients, 2019

All PBHS MH/SUD = 71,500
MH/SUD PBHS Decedents = 568

Data Source: PBHS Service Claims Data//VSA-OCME Intoxication death data, CY 2019- individuals active in PBHS July 2018 to December 2019
Outcomes Between All PBHS Outpatient Service Recipients and Overdose Decedents Engaged in Both MH and SUD Services, 2019
Comparison of OMS Outcomes Between All PBHS Outpatient Service Recipients and Opioid Decedents Engaged in Both MH and SUD Services, 2019

Data Source: PBHS Outcome Management System; PBHS Service Claims and VSA-OCME Intoxication death data, 2019 linked file
Comparison of OMS Outcomes Between All PBHS Outpatient Recipients and Intoxication Decedents Engaged in Both MH and SUD Services, 2019

Data Source: PBHS Outcome Management System; PBHS Service Claims and VSA-OCME Intoxication death data, 2019 linked file
BHA Current Strategies to Engage and Reduce Risk of Overdose Death Among Public Behavioral Health Service Recipients
Current BHA Strategies: Training

➢ BHA’s Office of Workforce Development and Technology Transfer:
  ○ Medications for Treatment of Opiate Addiction and Other Substance Use Disorders Training
  ○ Medication Assisted Treatment Training of Trainers Training.
  ○ Ongoing Ethics and Boundaries training, offered statewide to all clinicians
  ○ “Co-Occurring Disorders” webinar series, which provides training and supervisory supports to improve outcomes for individuals with dual diagnosis

➢ Opioid Workforce Innovation Fund
Current BHA Strategies: Programs

- OTP Peer Expansion Project
- The Peer Certification Expansion
- MCI-W (Maryland Correctional Institute for Women) CPRS Initiative
- State Opioid Response Grant Prevention, Treatment and Recovery Services for Individuals with OUD
- Recovery Housing for Women and Children
- Recovery Support Coordinators during Pregnancy
- State Care Coordination
Recovery Support for Individuals who are Homeless

➢ Critical time intervention pilot, an evidence-based practice that provides short-time interventions to engage and connect individuals to resources in the community.
➢ MDRN services that provides funding for recovery housing, medical, dental, transportation, birth certificates and identification.
➢ Continuum of Care funding from the Department of Housing and Urban Development - supports individuals who have co-occurring mental illness and substance use disorders with accessing permanent housing.
➢ SSI/SSDI, Outreach, Access and Recovery (SOAR) that provides outreach, assistance with applying for social security disability programs.
➢ Housing First Initiative in Baltimore City, Montgomery and Prince George’s County that provides permanent housing, supportive services, and representative payee services if needed.
➢ Homeless Identification Program that pays for birth certificates and state identification often needed to access benefits and other services.
➢ Projects for Assistance in Transition from Homelessness (PATH) that provides screening, outreach, case management, linkages to housing and services, training, and SOAR services.
Current BHA Strategies: Programs

➢ Maryland Addictions Consultation Service (MACS)
➢ Opioid Use Disorder Medical Patient Engagement, Enrollment in treatment and Transitional Support Program (OUD MEETS)
➢ Hub and Spoke Pilot
➢ MOUD and Peer Support in Four Detention Centers (HB 116)
➢ Medication Assisted Treatment-prescription Drug Opioid Addiction (MAT/PDOA) Grant targeting Pregnant Women and Women with Children
Areas of Increased Need/Opportunities

• Creating system-level coordination of care
• Assessing appropriateness of services used
• Improving billing for dual-diagnosis services on-site (collaborative/co-located care)
• Targeting interventions at the individual level (high risk utilizers)
• Utilizing predictive analytics to identify high-risk utilizers
• Reimbursement for harm-reduction type of approach
Questions
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