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The Massachusetts Opioid Abuse Prevention Collaborative – A Multi-Site Cluster Prevention Model

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Topics

- Background and brief description of the MOAPC initiative.
- MOAPC requirements and activities.
- Evaluation design for the MOAPC.
- Preliminary findings.

The Strategic Prevention Framework State Incentive Initiative (SPF-SIG)

- Left it to states to select the substance abuse consumption or consequence problem(s) on which to focus.
- Selection process to be informed by epidemiological data and other factors, e.g., political will, current allocation of resources, feasibility.

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Massachusetts SPF SIG (MassCALL2) Selected Prevention of Fatal and Non-Fatal Opioid Overdoses

- In 2005, leading cause of injury death in MA, surpassing deaths from motor vehicle injuries (#1 out of 4 other states).
- Proportion of poisoning deaths associated with opioid-related poisoning increased from 28% in 1990 to 68% in 2005.
- For every 1 opioid-related fatal overdose in 2007, there were 47 nonfatal incidents treated at MA acute care hospitals.
- Non-fatal opioid overdose emergency department visits increased by 19% from 2002-2005.
- Inpatient hospitalizations for non-fatal opioid overdoses increased by 63% from 1999-2005.

Massachusetts SPF-SIG (MassCALL2) Selected Prevention of Fatal and Non-Fatal Opioid Overdoses

- Other state and federal resources were already funding use/consumption prevention programming.
- Other state resources already devoted to alcohol and tobacco prevention programs.
- Issue was “on the radar”/ evidence of favorable political will.

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As MassCALL2 Ends, MOAPC Emerges

- Opioid overdoses and interest in preventing them continued.
- New PFS-II federal funding (2012) was not an ideal fit for opioid overdose work.
- Solution was to allocate state's Substance Abuse Prevention and Treatment Block Grant funds to prevent both opioid use and overdoses.

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Goals of MOAPC

- To prevent the misuse/abuse of opioids.
- To prevent/reduce unintentional fatal and non-fatal opioid overdoses.
- To increase the number and capacity of municipalities addressing these issues (Cluster Model).

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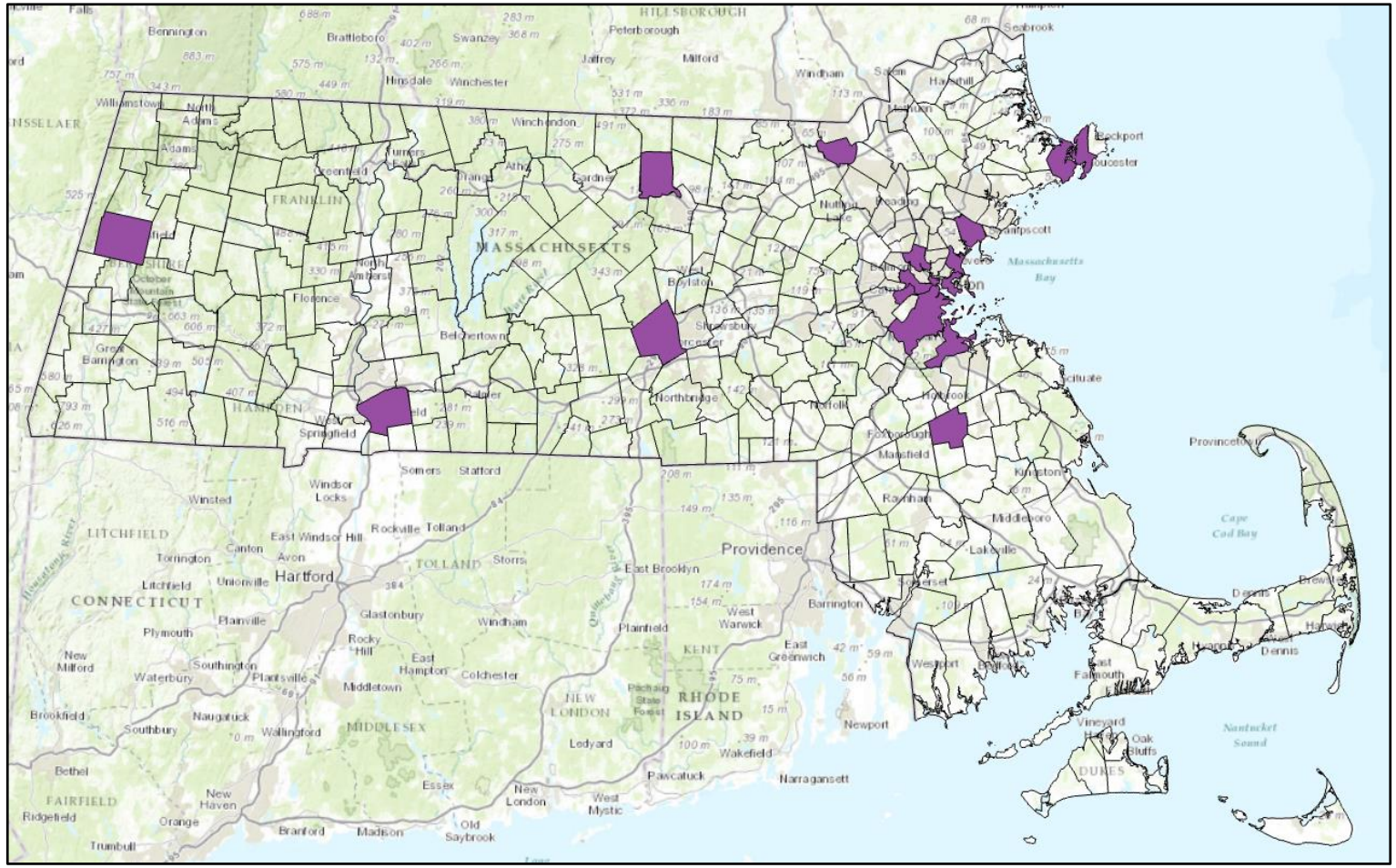
Key Features of MOAPC

- 3-year contracts with 4 one-year renewal options of about $100K/yr. awarded July 2013.
- Used a cluster model. Funded 13 lead municipalities with experience working in this area (mentors). Each to work with 2-4 adjacent partner communities (mentees).
- Communities given a year to generate a final strategic prevention plan, but initiated limited program implementation during year 1.

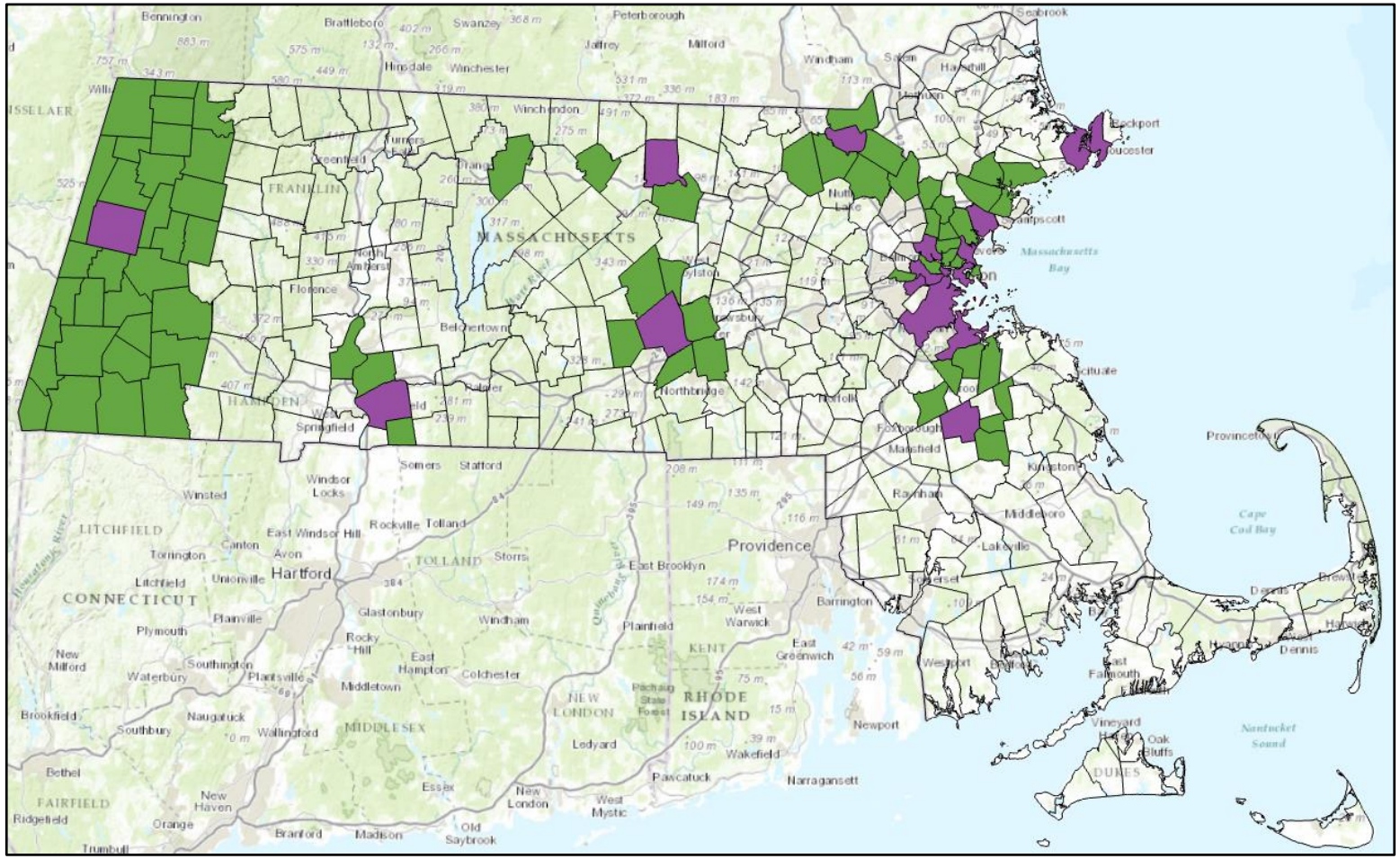
MOAPC Lead Municipalities (n=13)

- 12 Municipalities and 1 PH District
- Average 30+ fatal and non-fatal OD cases 2008-2010 **or** prior SPF-SIG.
- 10 of the 13 were MassCALL2 sites.



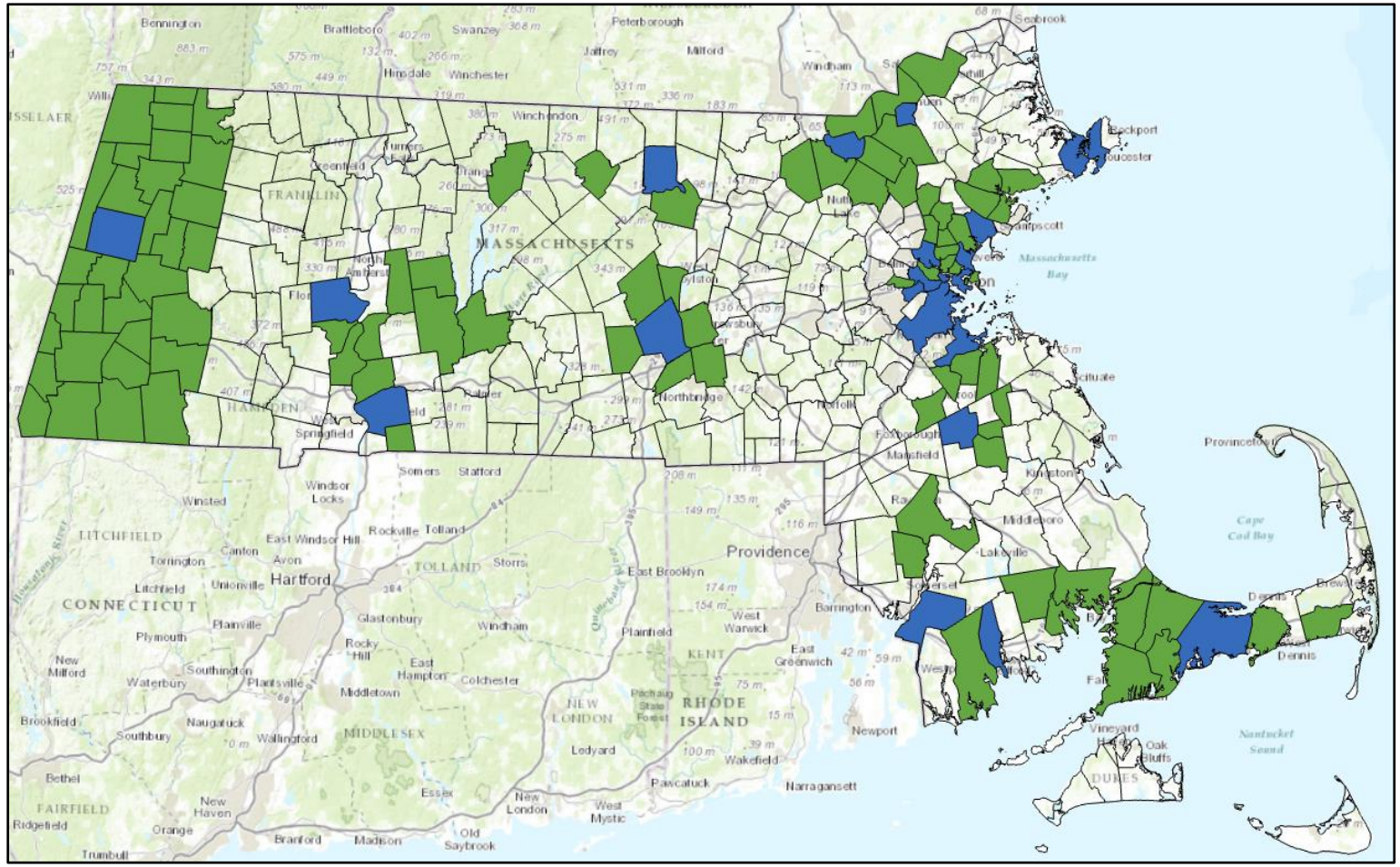
MOAPC Lead and Cluster Municipalities (n=84)

- 71 Partners
- 84 Total Municipalities
- 24% of the 351 municipalities.
- 45% of the state population.



MOAPC Cohort 1 and 2 Municipalities (n=110)

- 5 more leads and 21 partners added in Jan 2015.
- Total of 110 Municipalities.
- 31% of the 351 municipalities.
- 58% of the state population.



MOAPC Year One Timeline (7/1/13 – 6/30/14)

Assessment: Needs and resource assessment for region.

Capacity: Coalition building and develop regional structure.

Planning: Two-part strategic plan (December 30 and April 30 deliverables).

Implementation: Primary prevention **pilot** in lead and OD prevention strategy in at least one partner community (January 1 – June 30). **50%-50% rule.**

Evaluation: Quarterly MIS data and discrete evaluation of pilot strategies.

Sustainability/Cultural Competence: Both were core components of the plan.

Strategic Plan Supports

- MassTAPP
- Guidance Document
- TA Specialists
- State Contract Managers
- Statewide Evaluation Team
- CAPT Products/Resources

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MOAPC Strategic Plan Part I

Due 12/30/13 in Month 6

Assessment: *Process* for collecting data on opioid consumption, consequences, and intervening variables. Data currently available. Gaps. Challenges. TA needs. Plan for collecting new/archival data. How intend to prioritize IVs.

Capacity: Description of region; understanding of populations being disproportionately impacted; key stakeholders; core planning committee; cluster structure; decision-making; team functioning; education and training; TA needs.

Planning: *Process* for developing full strategic plan; how sustainability and cultural competence are built-in to the Assessment and Capacity steps.

- Do **NOT** select any IVs or propose any strategies at this point.

MOAPC Strategic Plan Part I (Review Process)

- Due date was extended from 12/30/13 to 1/8/14 for holidays.
- 11 of 13 submitted on or prior to due date. All plans received by 1/13/14.
- Average plan length was 15 pages (range: 10 to 29 pages).
- Each plan was reviewed by BSAS Contract Manager and State Evaluation Team. Detailed written feedback provided to each site along with TA recommendations.
- Review process averaged 11 days (range: 5 to 14 days).
- All sites received approval to proceed to Part II by 1/20/14.
- **Lesson Learned**: The timeline and review process worked.

MOAPC Strategic Plan Part II

45-Page Limit – Due 4/30/14 in Month 10

- Overview/Abstract
- Assessment of opioid consumption, consequences, and IVs.
- Capacity Building needs and capacity building action plan.
- Strategic Plan process and components
  - Final set of IVs with prioritization criteria
  - Target Population(s)
  - Strategies – description, evidence, rationale, culture, sustainability
  - Logic Model
- Implementation Plan for first 12 months (7/1/14 – 6/30/15)
- Evaluation Plan

MOAPC Strategic Plan Part II (Review Process)

- Plans due 4/30/14 to MassTAPP for pre-review. Plans due to BSAS on 5/12/14.
- 12 of 13 submitted on or prior to due date. All plans received by 5/14/14.
- Average plan length was 36 pages (range: 25 to 45 pages) + LM/Appendices.
- Same review process. Very detailed feedback.
- 6 Approved; 4 Approved with Conditions; 3 Not Approved.
- 11 sites implementing by 7/9/14. 12 sites by 8/20/14. All sites by 9/25/14.
- **Lesson Learned**: Part I was essential for quality plans at Phase II. Pre-review by MassTAPP helped shorten senior review time. Guidance document worked. Almost all sites (11 of 13) met our original timeline.

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MOAPC Strategic Plan Pitfalls – Lessons Learned

Being overambitious. Proposing more than is feasible from a financial or a time stand point.

Conducting an inadequate assessment. Data sources may be inaccurate. Significant subpopulations may not be included in some data sources.

Unclear rationale for an activity. Activities are identified within the plan but it isn't clear what their intended outcomes were, and therefore why they are being selected.

Wrong target population. Sometimes the target population for an intervention was much too broad, and didn't correspond to what the data said about who should be targeted.

Wrong size target. Sometimes the number of people being reached by an intervention was clearly inadequate to have any effect (e.g., reaching 10% of parents at a health fair).

Lack of knowledge about the scope of what is being proposed. Proposing to implement a school based curriculum that needs to be modified may take more than a year to accomplish.

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Pilot Strategies – What and Why?

January 1, 2014 to June 30, 2014 – Months 6-12 in Year One During Strategic Planning

Goal: Promoting collaboration, learning to work together, project visibility. Not based on SPF process. Selection guided by capacity, feasibility, fit, and the wisdom of practice.

Lead Community Requirements: Pilot one new primary prevention strategy

- (1) Rx take back events, (2) enrolling prescribers in the PMP, (3) working with pharmacists to reduce access, and (4) strategies promoting proper storage and disposal of Rx drugs.
- The 10 former MassCALL2 sites could continue OD prevention strategy if they desired.

Partner Community Requirements: Pilot one OD prevention strategy

- (1) improve the response of first responders, (2) dissemination of OD prevention materials, (3) share information about the Good Samaritan Law, (4) connecting/collaborating with a Learn to Cope group, or (5) promote connections to the Narcan Pilot Program.

Evaluation and Monitoring (Data Sources)

State-Level Cross-Site Evaluation

- Strategic Plans and Logic Models
- Online quarterly narrative reports – based on SPF Steps – **PRE-POPULATED**
- MIS reports on service delivery hours, numbers served, demographics.
- Technical Assistance Database from State TA Provider (MassTAPP).
- Annual Assessment Survey of TA services.
- Hospital ED data and Death Certificate Data.
- Limited Local Evaluation (discrete consultants) and TA on evaluation.

Quarterly Report Components

- Updated Contact Information and Cluster Composition.
- Strategies List and Current Status.
- Separate sections for: (1) Assessment, (2) Partnerships and Grant Management, (3) Strategic Planning and Logic Model, (4) Strategy Implementation, (5) Sustainability, (6) Cultural Competence.
  - Focus on Capacity, Success, Challenges, and Lessons Learned.
- Technical Assistance and Events/Trainings.
- Contextual Factors; TA Needs; Attachments.

Online Quarterly Report System

PARTNERSHIPS

Save and continue survey later

MOAPC Quarterly Report FY16 - Quarter 1

Partnership and Grant Management

The following questions are about the Capacity Building step of SAMHSA's Strategic Prevention Framework (SPF). Please answer these questions with only your MOAPC grant in mind and only for the previous state fiscal quarter.

PARTNERSHIP. The next questions ask about the average level of involvement of various sectors across your cluster. Please use the following definitions to help guide your selections.

- ***Not Represented*** - this sector is not currently represented in your cluster.
- ***Very Low Involvement*** - general awareness of each others' work; loosely defined roles; little communication; all decisions are made independently.
- ***Low Involvement*** - provide information to each other; somewhat defined roles; formal communication; all decisions are made independently.
- ***Medium Involvement*** - share information and resources; defined roles; frequent communication; some shared decision making.
- ***High Involvement*** - share ideas; share resources; frequent and prioritized communication; all members have a vote in decision making.
- ***Very High Involvement*** - active membership; frequent communication is characterized by mutual trust; consensus is reached on all decisions.

7. Please rate the average level of involvement of representatives in each of the following sectors across your cluster during the last quarter as it relates to the planning and operation of your MOAPC grant.

	Not Represented	Very Low Involvement	Low Involvement	Medium Involvement	High Involvement	Very High Involvement
Business Community	○	○	○	○	○	○
Civic or Volunteer Organizations	○	○	○	○	○	○
Clergy/Faith-based Organizations	○	○	○	○	○	○
Law Enforcement Agencies	○	○	○	○	○	○

IMPLEMENTATION

Save and continue survey later

MOAPC Quarterly Report FY16 - Quarter 1

Implementation: Opioid Consumption Strategies

The following questions are about the opioid consumption primary prevention strategies that your cluster proposed to implement in its strategic plan. Please report on the status of each strategy for the previous state fiscal quarter.

CONSUMPTION STRATEGY STATUS.

15. For each of the opioid consumption strategies listed below, indicate whether the strategy was dropped, whether there was no action associated with the strategy last quarter, whether you engaged in planning activities only, or whether you engaged in implementation.

	This strategy has been dropped	We didn't work on this strategy last quarter but plan to in the future	Planning work only during last quarter	Implementation during last quarter
Consumption Strategy #1: Education on PMP for prescribers and dispensers	⊙	○	○	○
Consumption Strategy #2: Education and social marketing on proper disposal and storage of Rx medication for parents, grandparents, and the greater community	○	○	○	○
Consumption Strategy #3: Identify and integrate age-appropriate evidence-based curriculum for school-aged youth in selected communities/schools	○	○	○	○

ADDITIONS OR MODIFICATIONS. The following questions ask you to report on any additions or modifications that you made to your opioid consumption strategies during the last quarter.

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Consumption (Primary Prevention) Strategies

45 Consumption Strategies Across 13 clusters (roughly 3 per cluster)

- Prescriber/Dispenser Education (9)
- Community Awareness/Knowledge/ Norms (7)
- Safe Storage and Disposal (7)
- Parent Information (5)
- Prescription Recipient Information (4)
- School Athlete Awareness/Knowledge/ Norms (4)
- School-Based Health Curriculum (3)
- Youth Awareness/Knowledge/Norms (3)
- Linkages to Treatment (1)
- Parent Curriculum (1)
- SBIRT in Schools (1)

Source: MOAPC Online Quarterly Reporting System.

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Consequence (OD Prevention) Strategies

52 Consequence Strategies Across 13 clusters (roughly 4 per cluster)

- **Overdose RRR Training (19)**
  - PWUO, family, bystanders (10)
  - Systems, providers, first responders, businesses, agencies (6)
  - Incarcerates, TX, detox (3)
- **Increase Access to Naloxone (10)**
  - PWUO, family, bystanders (5)
  - Systems, providers, first responders, businesses, agencies (5)
- **Overdose RRR Information (9)**
  - Media, pharmacies, providers (5)
  - OD Scenes, TX, detox, incarcerates (4)
- Awareness of Good Samaritan Law/Reducing Fear of Calling 911 (6)
- Promote Linkages to TX in ED post-OD (4)
- Outreach/Recovery Coach (2)
- SBIRT in Medical Practices (1)
- Stigma Reduction for First Responders (1)

Source: MOAPC Online Quarterly Reporting System.

Consequence (OD Prevention) Strategies

Fitchburg Man Saves Life Just Days After Learning How To Use Narcan

November 10, 2015 8:43 PM **By Ken MacLeod**

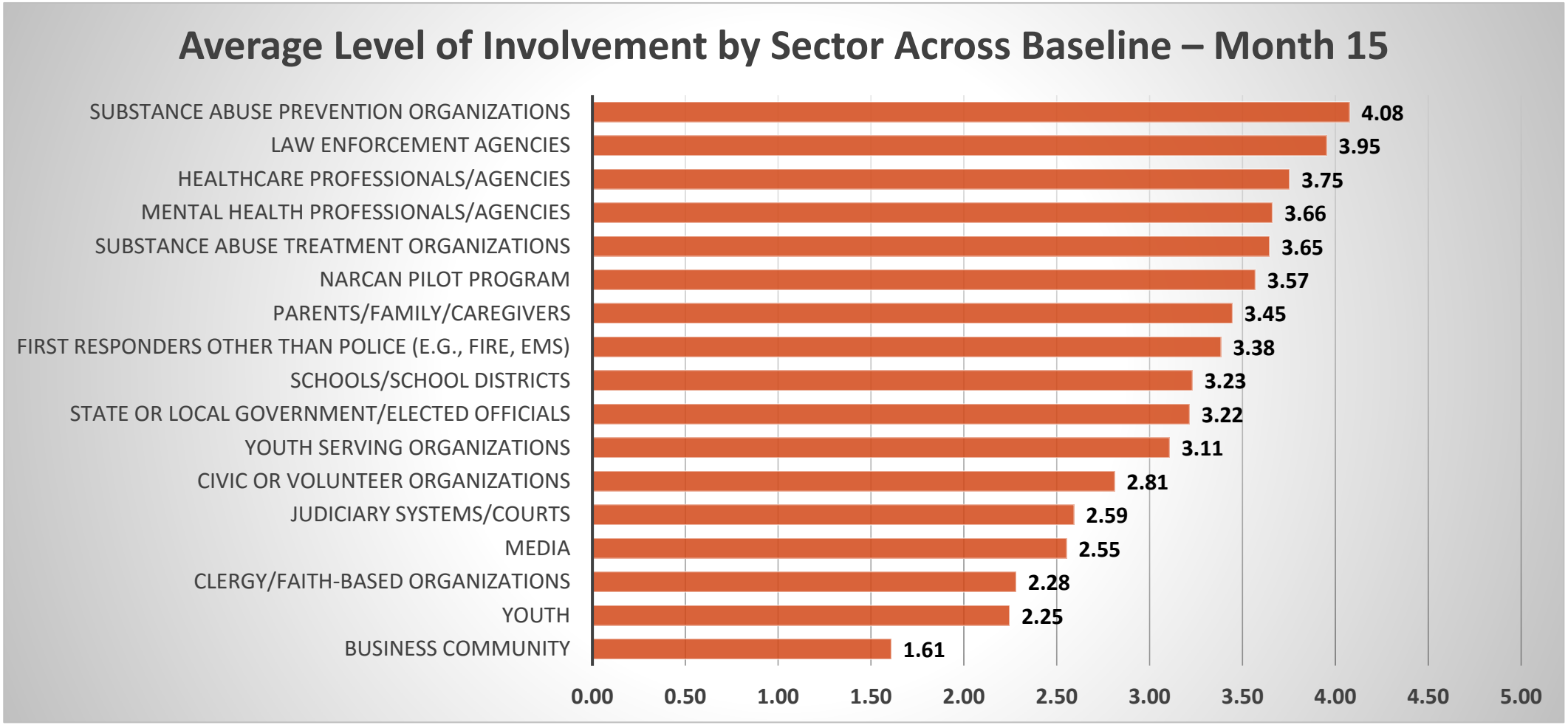
Filed Under: Alfred Rivera, Fitchburg, Heroin, Ken MacLeod, Narcan

FITCHBURG (CBS) – A Fitchburg man saved a woman's life just days after learning how to use Narcan.

As the Fitchburg Public Library's maintenance man, Alfred Rivera knew it was only a matter of time until a heroin overdose came to his

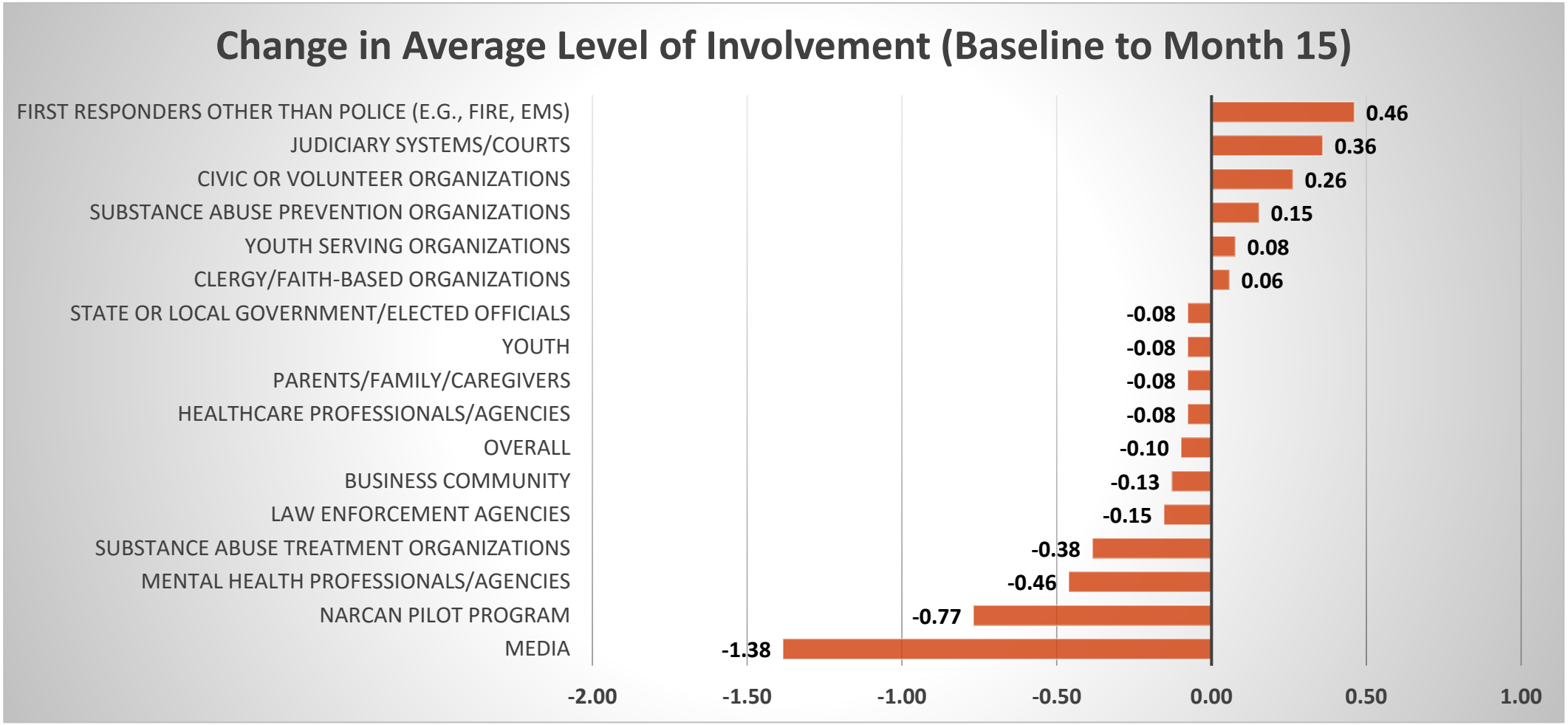
Source: http://boston.cbslocal.com/2015/11/10/fitchburg-overdose-rescue-narcan/.

Partnerships and Collaborations



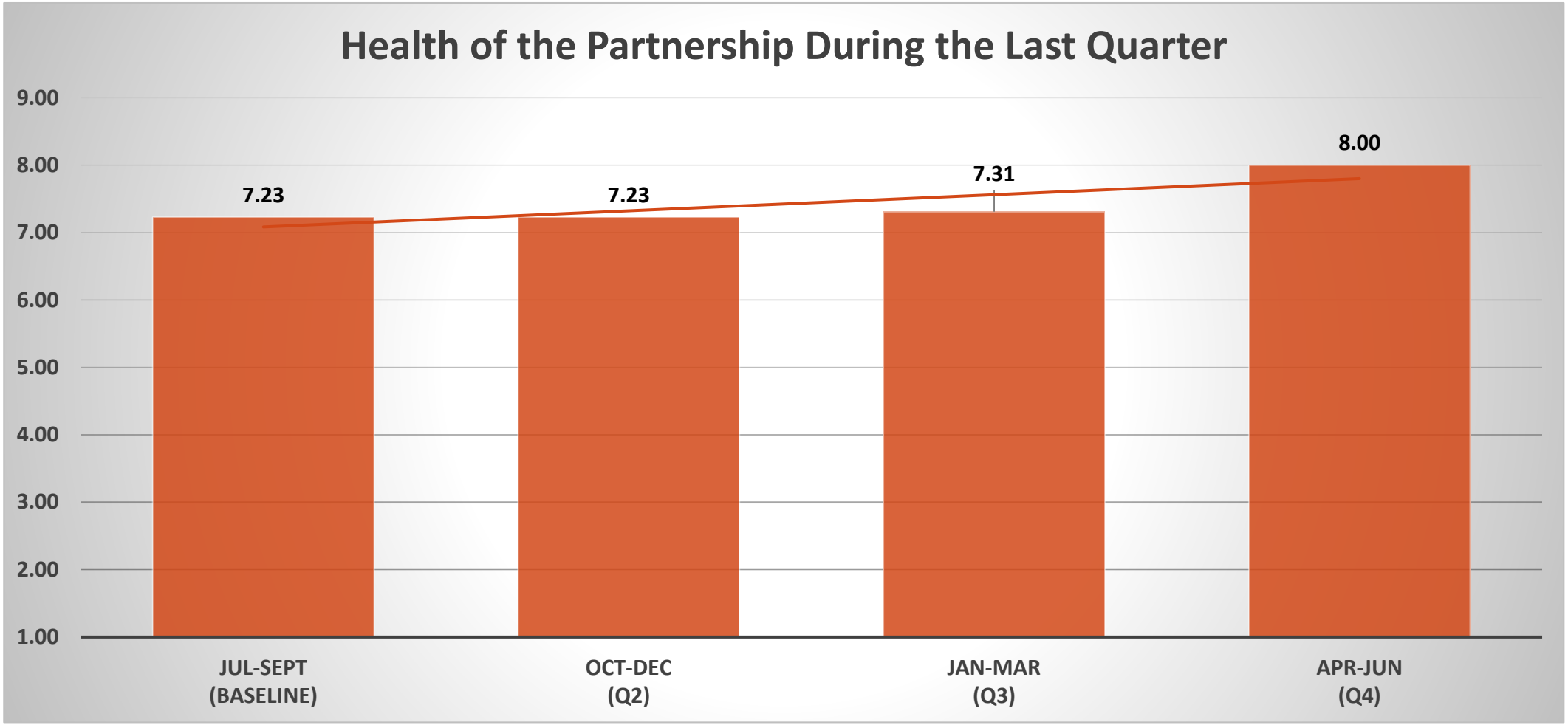
Source: MOAPC Online Reporting System: 0=Not Represented; 1=Very Low Involvement; 2=Low Involvement; 3=Medium Involvement; 4=High Involvement; 5=Very High Involvement.
Frey, B.B., Lohmeier, J.H., Lee., S.W., & Tollefson, N. (2006). Measuring Collaboration Among Grant Partners. *American Journal of Evaluation*, (27): 383-392.

Partnerships and Collaborations



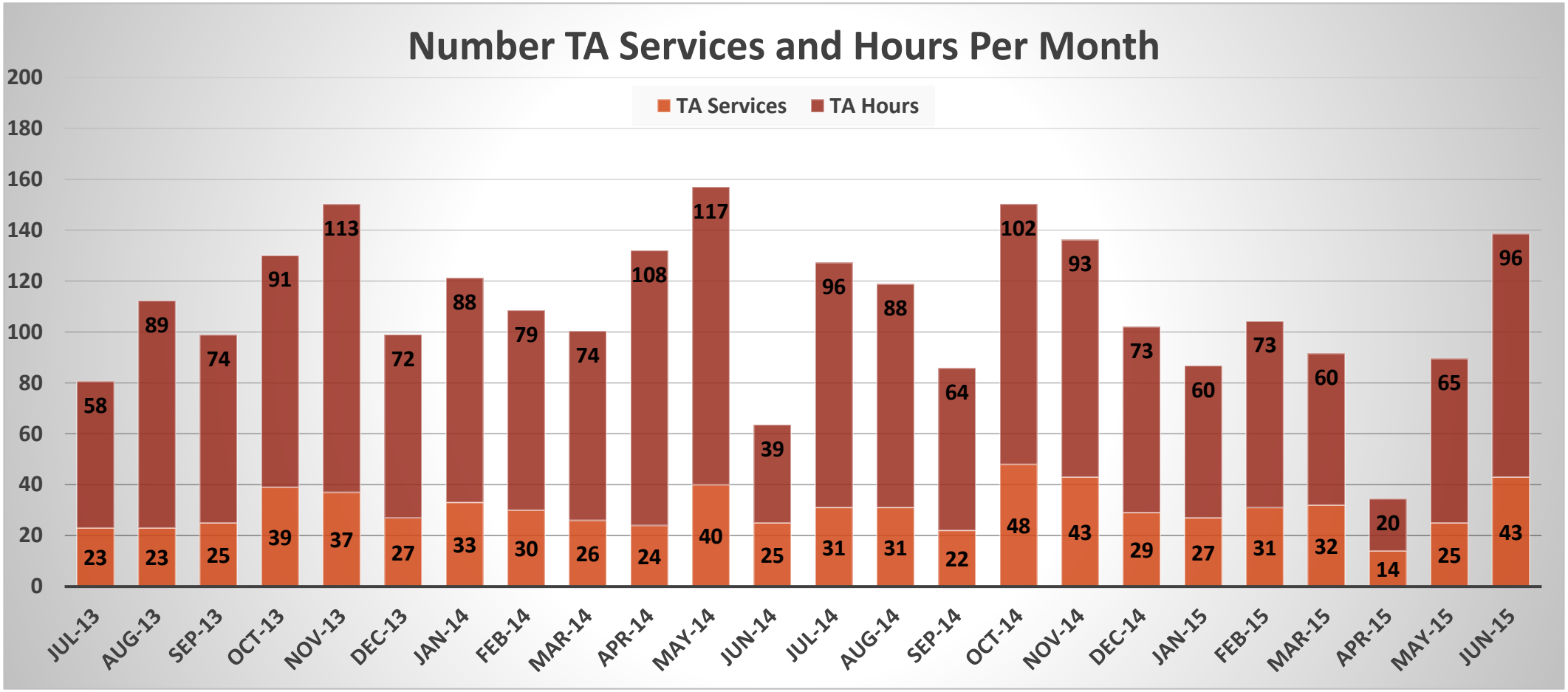
Source: MOAPC Online Quarterly Reporting System.

Partnership Health



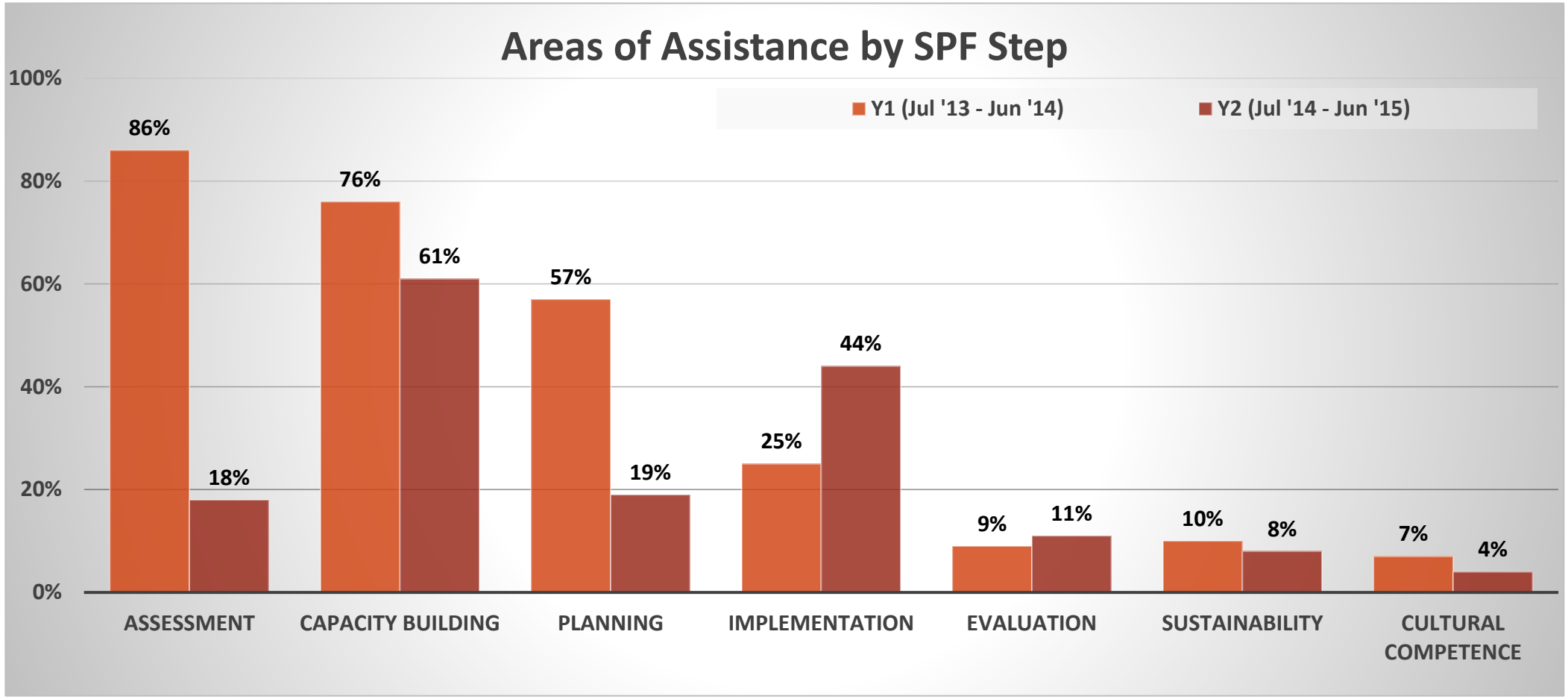
Source: MOAPC Online Reporting System – Scale from 1-9 where 1-3 = Very Poor; 4-6 = Average; 7-9 = Excellent.

Technical Assistance



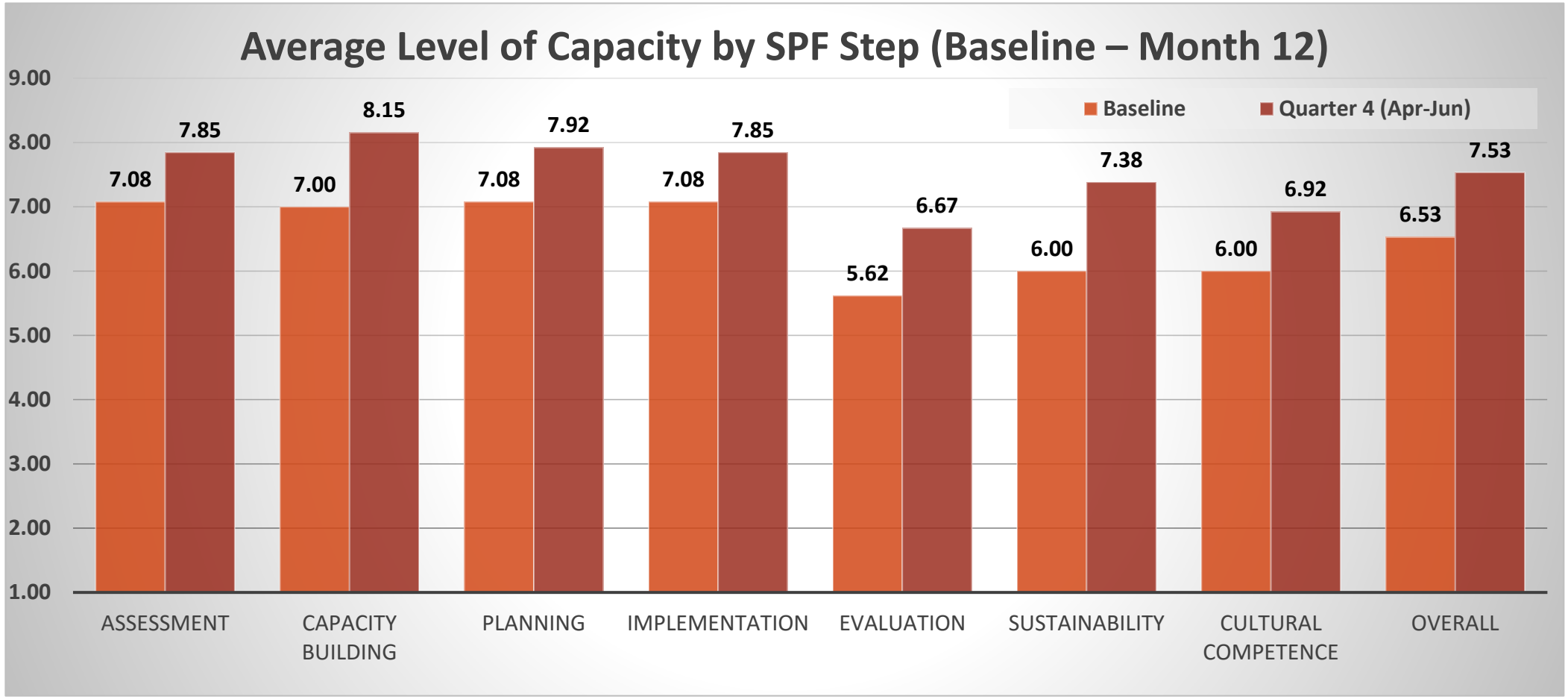
Source: Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) Technical Assistance Database.

Technical Assistance



Source: Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) Technical Assistance Database.

Prevention Capacity



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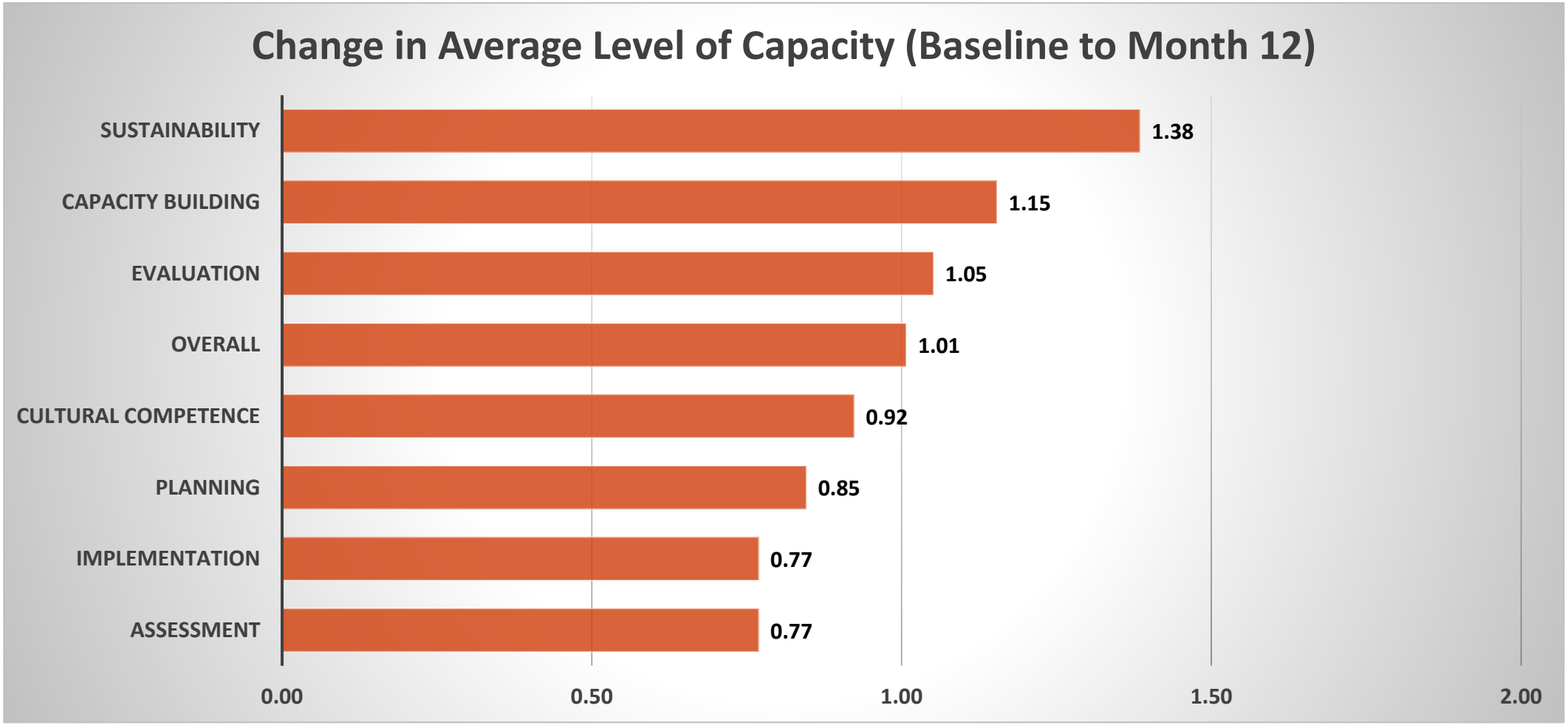

State-Level Lessons/Considerations

- Importance of 12-month strategic planning process.
- Pilot strategies helped build early collaboration.
- Strategic plan reviews were very time-intensive; but critical.
- Guidance document was essential.
- Thin literature base – better at describing *WHAT* vs. *HOW*.
- Local evaluators were a casualty of going to scale.

State-Level Lessons/Considerations

- Political climate and public health state of emergency led to early focus on answering the question, "*WHAT are you doing?*"
- Value of real-time report summaries at local and state agency levels.
- Challenge of outcome data lag and rigorous evaluation models given all that is going on.
- Benefits of a centralized TA provider.
- Intensive TA has been essential.
- Annual monitoring site visits have been key.

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Local-Level Lessons/Considerations

- Need to involve people who use opiates, people in recovery, and other non-traditional “experts” when doing this work.
- Obtaining and warehousing data from multiple sources (e.g., police, fire, EMS, death certificates) is challenging.
- Not all cluster communities have access to the same types of data.
- Different levels of capacity and different issues across communities in each cluster.
- Partnership structure differs widely from cluster to cluster.

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Local-Level Lessons/Considerations

- Strategy-specific workgroups help balance all of the moving parts of these projects.
- Difficult to maintain momentum and engagement among partners not specifically identified as part of the interventions in the plan.
- Balancing local need vs. regional need and long-term solutions vs. quick fixes has been challenging with this issue.
- The cluster model is very time consuming to implement well.
- Many philosophical debates surrounding harm reduction and primary vs. tertiary prevention.

Thank You!

- Questions?
- Visit **http://masstapp.edc.org/** for more information on MOAPC, resources, and a copy of the guidance document.
- Program Contact: José Morales (jose.morales@state.ma.us; 617-624-5141)
- Evaluation Contact: Scott Formica (sformica@ssre.org; 781-334-8055)