PRESCRIPTION DRUG AND OPIOID ABUSE COMMISSION
MAY 24, 2018 MEETING

APPROVED MINUTES

In accordance with the Open Meetings Act, 1976 PA 267, as amended, the Prescription Drug and Opioid Abuse Commission met on May 24, 2018, at the Ottawa Building, Conference Room 3, 611 West Ottawa Street, Lansing, Michigan 48933.

CALL TO ORDER

Judge Linda Davis, Chairperson, called the meeting to order at 2:05 p.m.

ROLL CALL

Members Present:
Judge Linda Davis, Chairperson, Ex-Officio for LARA
Vincent Benivegna
Rebecca Cunningham
Richard Dettloff (teleconference)
Lisa Gigliotti
Timothy Hurtt (departed at 4:06p.m.)
Stephen Lazar
Michael Paletta (teleconference)
Gretchen Schumacher
Judge Patrick Shannon
Larry Wagenknecht (teleconference)
Laurie Wesolowicz (teleconference)

Members Absent:
Stephen Bell
Paul Lauria
Paula Nelson
Melissa Owings
Roy Soto
Adam Wilson

Ex-Officio Members:
Michelle Brya, Assistant Attorney General
Dr. Debra Pinals, Department of Health and Human Services
Col. W. Thomas Sands, Michigan State Police

Staff:
Cheryl Pezon, Bureau Director, BPL

Kimmy Catlin, Board Support, Boards and Committees Section
Andria Ditschman, Analyst, Boards and Committees Section
Weston MacIntosh, Analyst, Boards and Committees Section

APPROVAL OF AGENDA

MOTION by Gigliotti, seconded by Benivegna, to approve the agenda as

presented.

A voice vote followed.

MOTION PREVAILED

APPROVAL OF MINUTES

MOTION by Gigliotti, seconded by Benivegna, to approve the minutes from April 12, 2018 as written.

A voice vote followed.

MOTION PREVAILED

Federal Response and the President's New Opioid Initiative

Doug O'Brien, HHS Region V Director, introduced himself to the Commission and presented a PowerPoint entitled "Combating the Opioids Crisis". (Please see addendum #1).

Discussion was held.

Collaboration Between State Departments Update

Elizabeth Gorz, Senior Policy Advisor, introduced herself to the Commission and informed the members of the efforts that have been taken to create a unified approach to the epidemic.

Discussion was held.

Michigan Association of Health Plans Presentation

Christine Shearer and Karen Jonas introduced themselves to the Commission and presented a PowerPoint entitled "Health Plan Approach to Managing the Opioid Epidemic". (Please see addendum #2).

Discussion was held.

System for Opioid Overdose Surveillance (SOS)

Dr. Abir and Craig Summers, MI HIDTA Executive Director, introduced themselves to the Commission and presented a PowerPoint entitled “Michigan HIDTA”. (Please see addendum #3).

Discussion was held

Exploration of Offices of Drug Policy in Various States in the U.S. – CMU Public Health Code

Toyin Olumolade and Sam Tacconelli introduced themselves to the Commission and presented a document entitled “Exploration of Offices of Drug Policy in Various States in the U.S.” (Please see addendum #4).

Discussion was held.

DHHS Update

None

Legislative Update

Pezon discussed the recently introduced bills that address opioid abuse.

OLD BUSINESS

Recommendations to Department of Education for the Instruction of Pupils on Prescription Opioid Drug Abuse

Gigliotti presented the recommendations.

SUBCOMMITTEE REPORTS

Treatment

The Commission reviewed the subcommittee report.

Regulation and Enforcement

None

Policy and Outcomes

The Commission reviewed the subcommittee report.

Prevention

The Commission reviewed the subcommittee report.

Benivegna informed the Board of an upcoming presentation regarding infectious diseases.

Discussion was held.

Action Items – Subcommittee Motions

These items were not discussed due to loss of quorum.

CHAIR REPORT

Judge Davis thanked the Commission for all their work and informed the Commission that there is a lack of funding for the mobile bus for opioid abuse/addiction.

DEPARTMENT UPDATE

Pezon shared an email that was received from a nursing school responding to a letter the Commission sent regarding education on addiction.

Discussion was held.

PUBLIC COMMENT

None

ANNOUNCEMENTS

The next regularly scheduled meeting will be held June 26, 2018 at 2:00 p.m. in the Ottawa Building, 611 W. Ottawa Street, Conference Room 3, Upper Level Conference Center, Lansing, Michigan.

ADJOURNMENT

The meeting concluded at 4:34 p.m.

Minutes approved by the Commission on: June 26, 2018.

Prepared by:
Kimmy Catlin, Board Support June 5, 2018
Bureau of Professional Licensing

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

COMBATING THE OPIOIDS CRISIS

HHS.GOV/OPIOIDS

The opioid epidemic by the numbers

4.4%

of the population, or 11.5 million – have Opioid Misuse Disorder.

170

people die from drug overdoses a day – 116 are opioid-related.

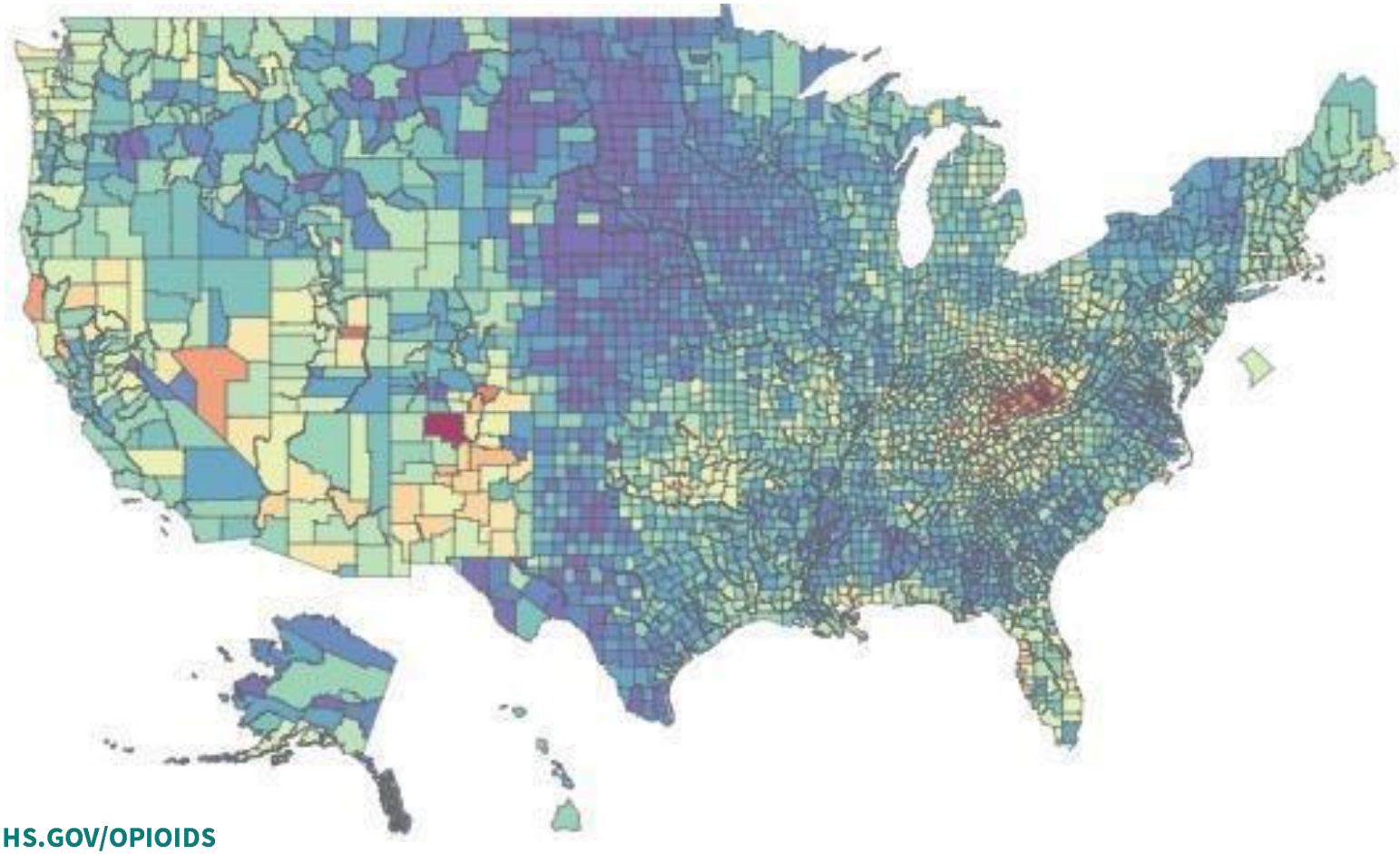
13%

Increase in overdose deaths 2016-2017

HHS.GOV/OPIOIDS

Deaths in 2006

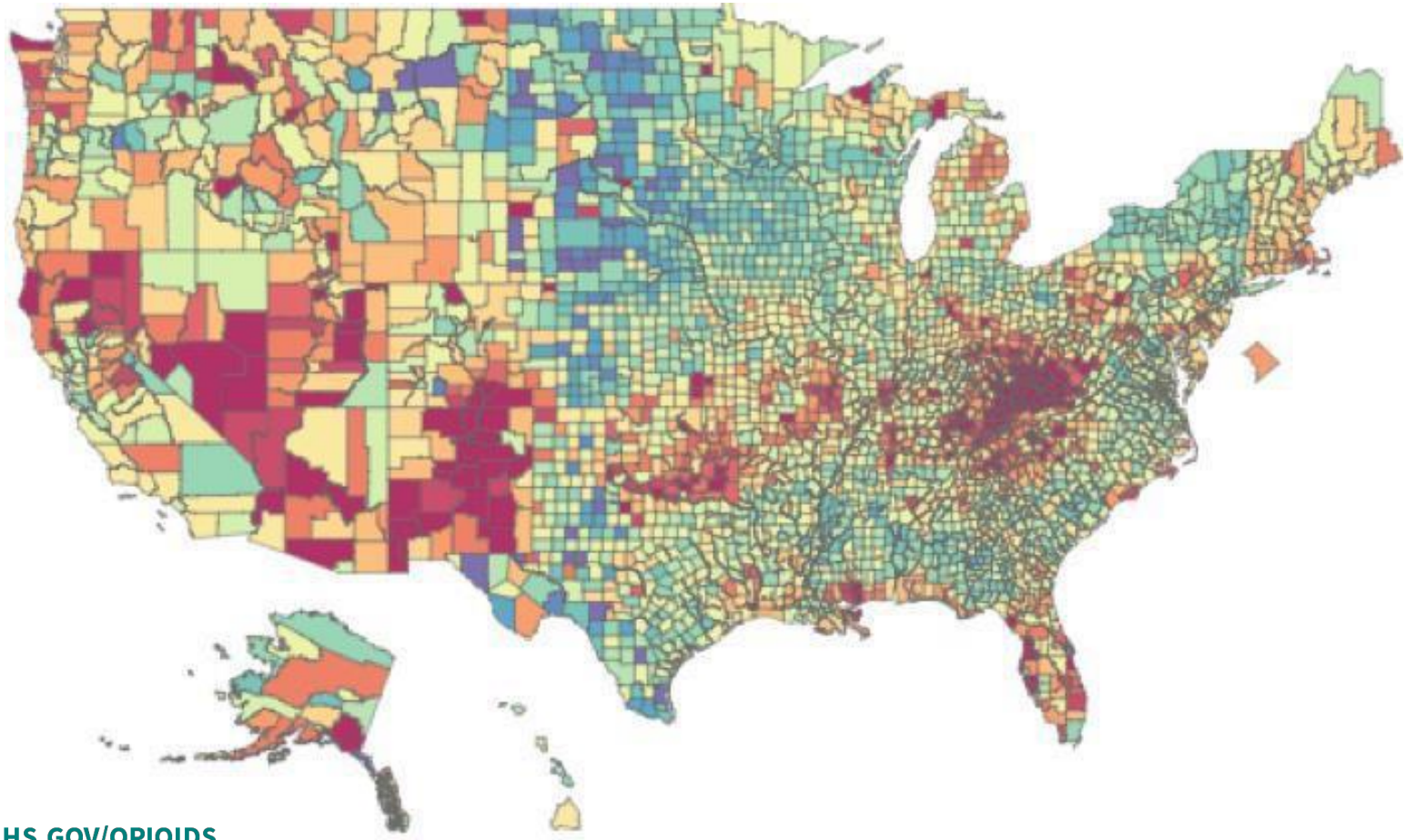
Estimated age-adjusted
death rates for drug poisoning



HHS.GOV/OPIOIDS

Deaths in 2016

Estimated age-adjusted
death rates for drug poisoning



HHS.GOV/OPIOIDS

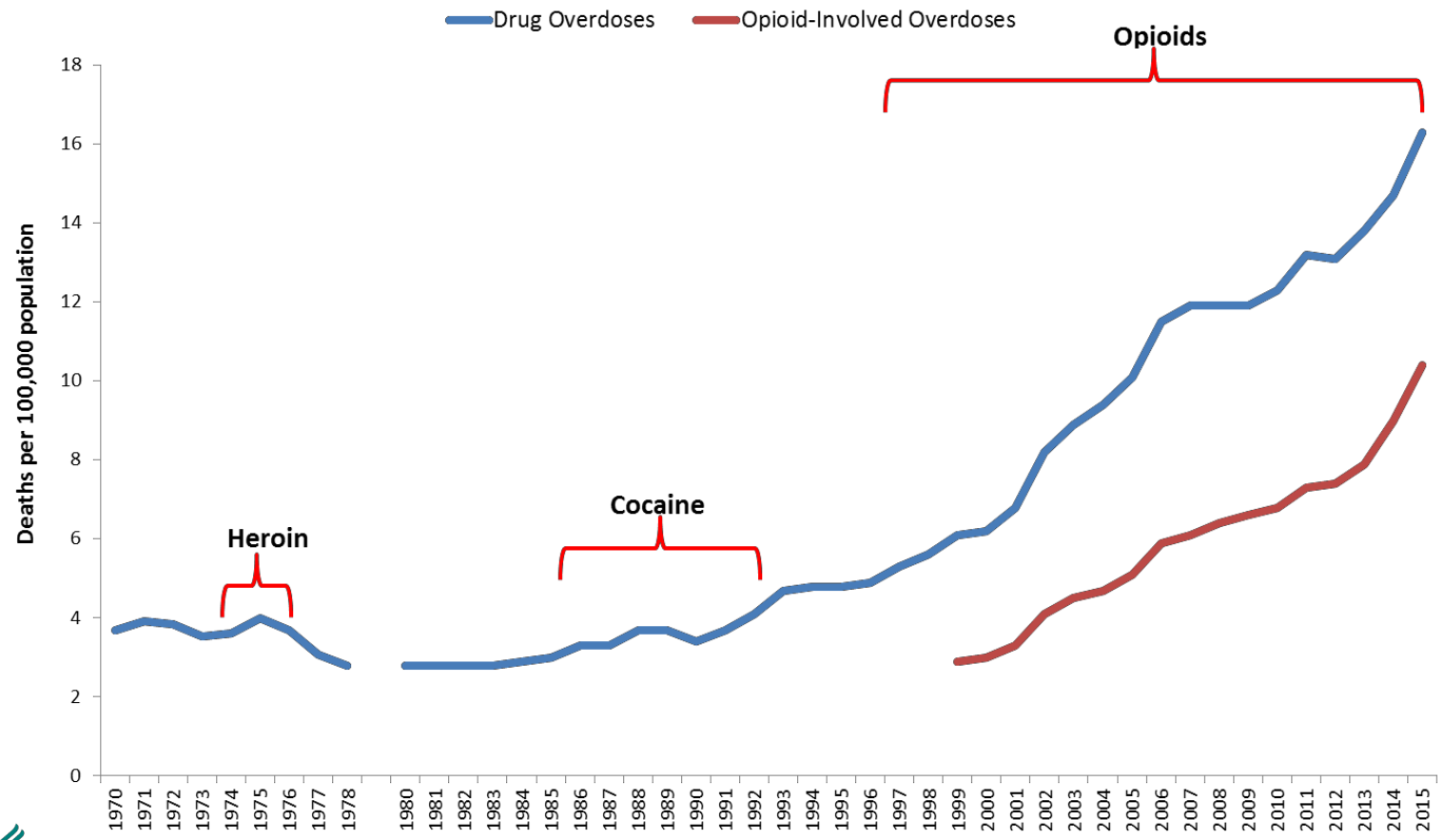
Drug overdose deaths

2016 OPIOID DEATHS

Florida	4,728
California	4,654
Pennsylvania	4,627
Ohio	**4,329**
New York	3,638
Texas	2,831
Illinois	**2,411**
Michigan	**2,347**
Massachusetts	2,227
New Jersey	2,056
Indiana	**1,526**
Wisconsin	**1,074**
Minnesota	**672**

The crisis in context

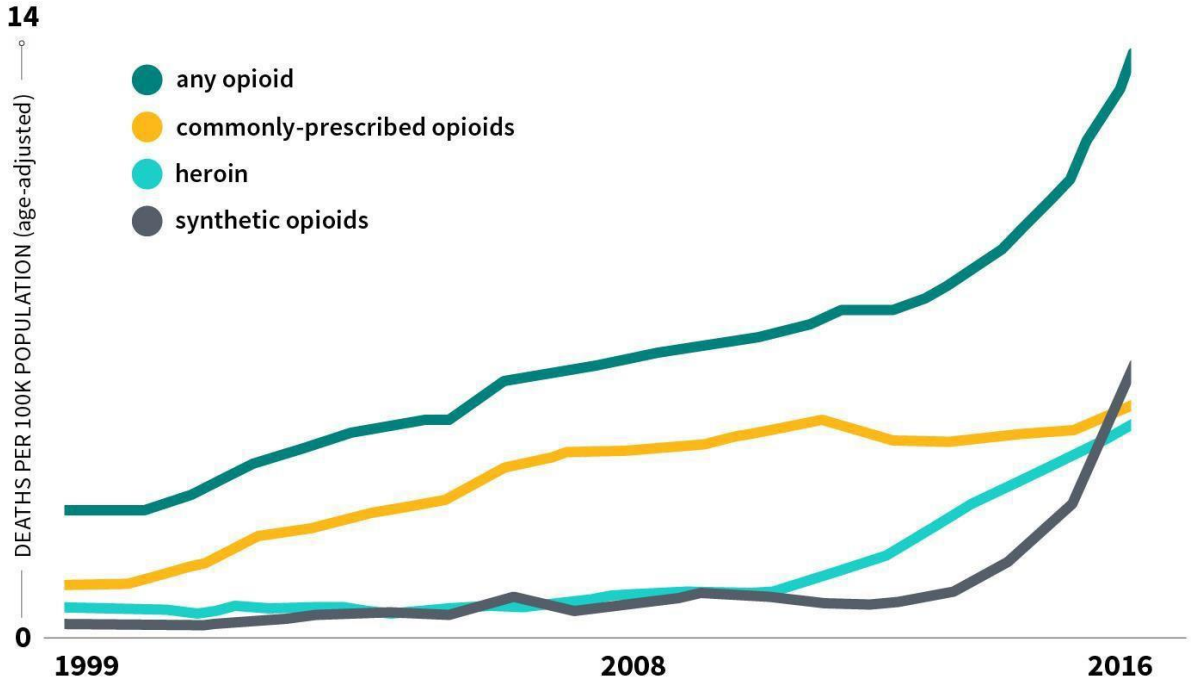
Drug overdose deaths from 1970–2015



HHS.GOV/OPIOIDS

The crisis in context

Opioid overdose deaths at historically high levels



HHS.GOV/OPIOIDS

Treacherous potency

Lethal doses of heroin, fentanyl, and carfentanyl

[LEFT TO RIGHT]

HHS.GOV/OPIOIDS

HHS mission

Enhance and protect the health and well-being of all Americans

Complete strategy

HHS Five-point strategy
to combat the opioids crisis

1

Better addiction prevention, treatment, and recovery services

2

Better data

3

Better pain management

4

Better targeting of overdose reversing drugs

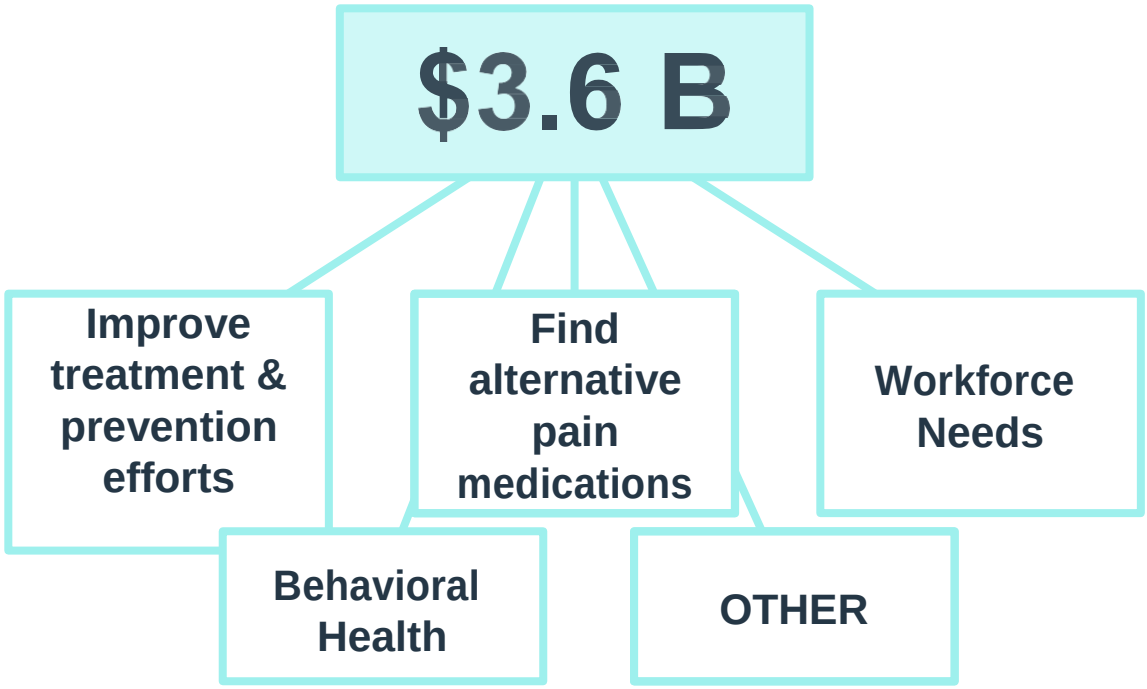
5

Better research

HHS.GOV/OPIOIDS

FY2018

Estimated HHS opioid-related funding for 2018 & beyond

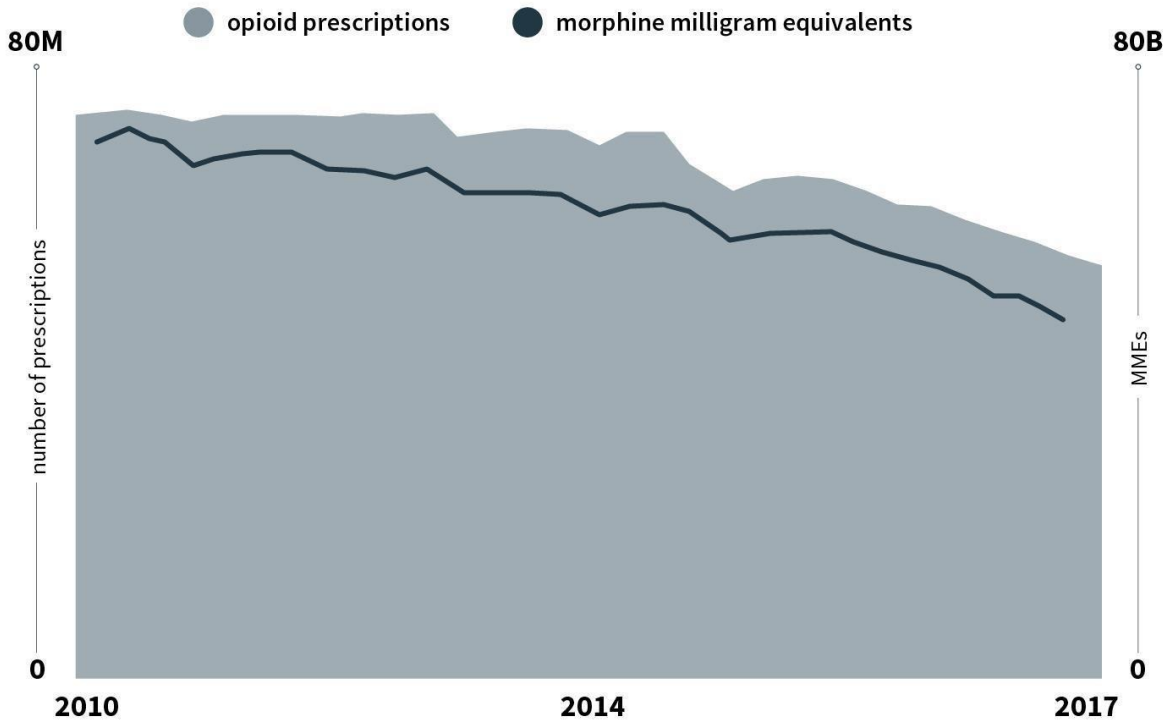


Key actions

- **SAMHSA** – STR Grants, Provides $44.7 million to equip first responders with naloxone
- **OCR HIPPA Guidance** – Doctor's can now tell family of loved ones about life threatening addiction.
- **Surgeon General** expands access to overdose reversing drugs.
- **CMS** – Restricts Medicare opioid prescriptions for acute pain to 7 days.
- **CMS** – Creates Substance Use Disorder Waivers
- **FDA**: Expands treatment formulations; Ramps up investigations to intercept fentanyl coming into the country; Gets the opioid Opana ER out of the marketplace
- **NIH** - Doubles investment in opioid research, to $1.1 billion.
- **CDC** - Speeding up release of preliminary overdose death data.

Progress

Decreasing opioid prescribing 2010-2017



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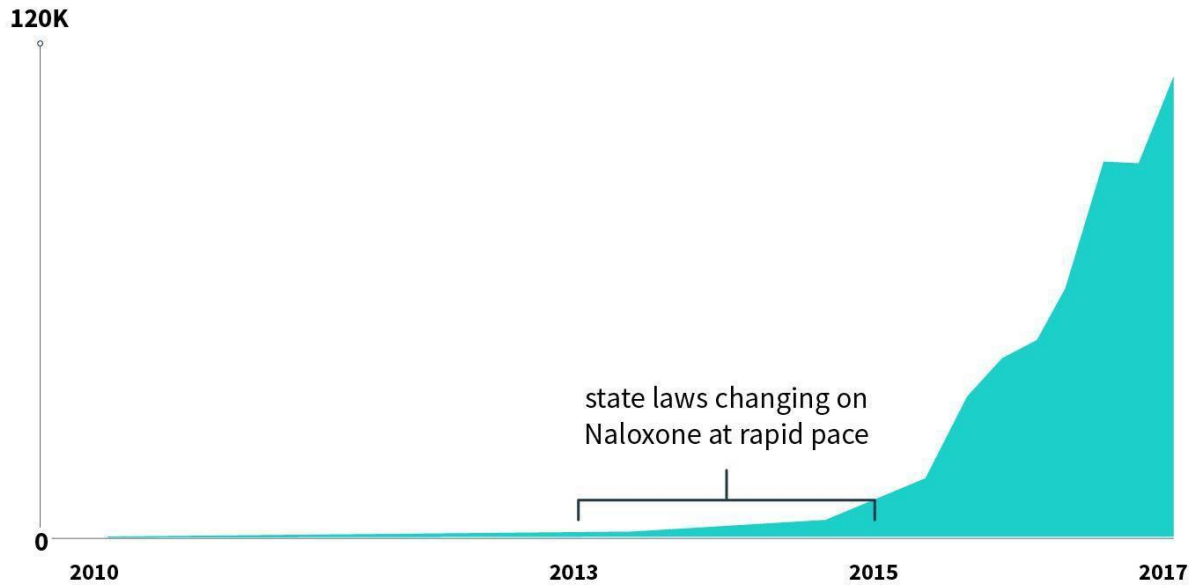
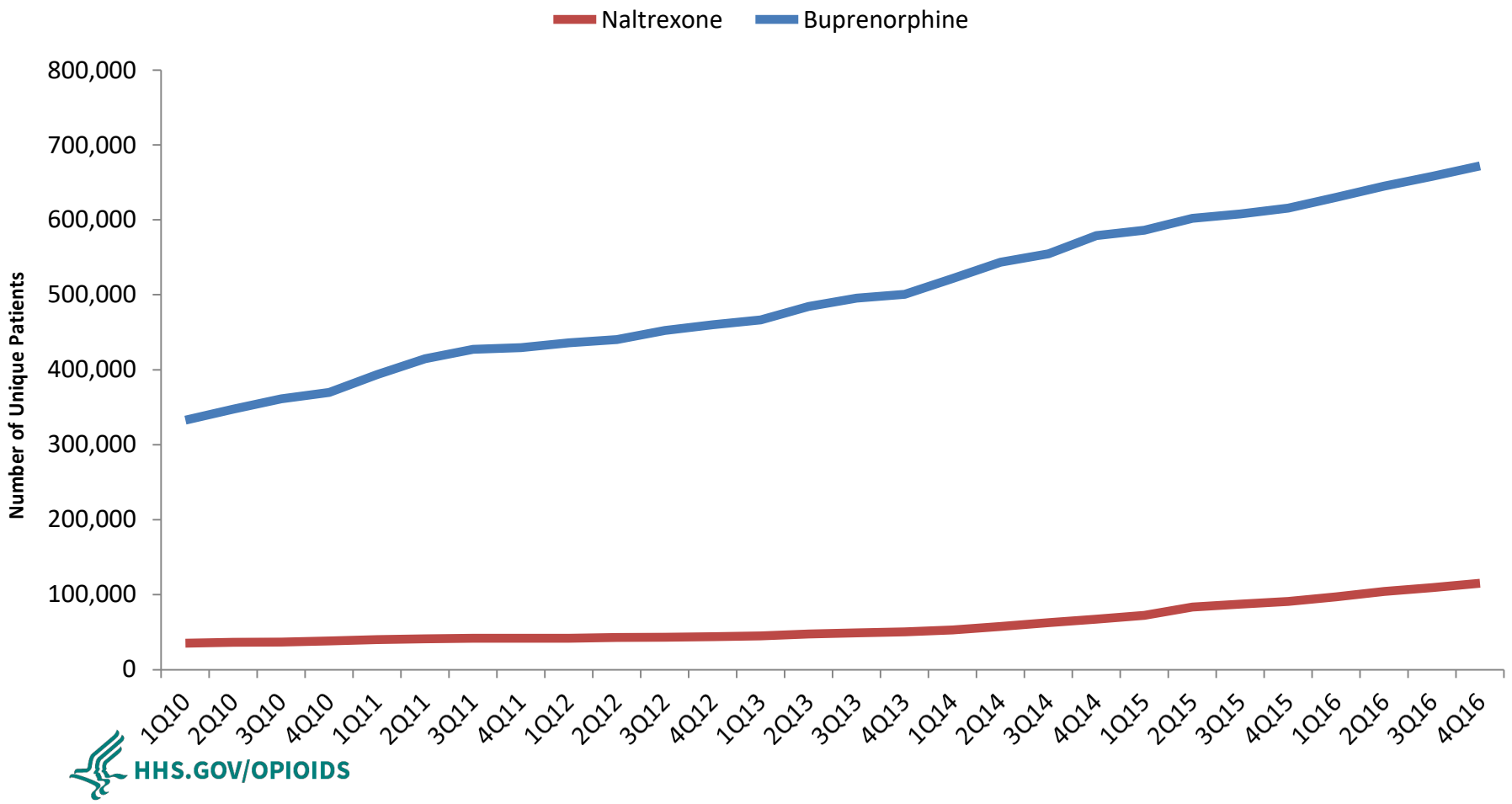
Progress

Increasing naloxone dispensing 2010-2017



Progress

Increasing receipt of MAT
2004-2015



HHS.GOV/OPIOIDS

Signs of Progress

- Youth prescription opioid misuse declining over past decade; heroin use stable among youth
- Prescription opioid misuse initiation declining
- Plateauing of overdose deaths involving commonly prescribed opioids
- Some states seeing a leveling off of overdose deaths

Recent and Upcoming

- March 2018 – President Trump announces concrete goals for fight on opioids
- Funding for Opioid Fight (doubles, triples, etc.)
- NIH – almost doubling research on addiction and pain alternatives
- CARA 2.1 being developed by Congress
- National Drug Take-Back Day: April 28, 2018 – *Region V collected 83 pounds!*
- SAMHSA STR Grants Announced April, 2018 - $485 million nationally; $83 million in Region V
- September: SAMHSA will release $1 billion grant funding for states, territories, and tribes hardest hit by the crisis.

Thank you

NATIONAL HELPLINE

800-662-HELP (4357)

HHS.GOV/OPIOIDS

Stay **Connected**

Regional Director Doug O'Brien –
douglas.obrien@hhs.gov

Region V Phone number: (312) 353 - 5160

HHS.GOV/OPIOIDS

Health Plan Approach to Managing the Opioid Epidemic

MAHP: Who We Are

- The Michigan Association of Health Plans is a nonprofit corporation established to promote the interests of member health plans.
- MAHP's mission is "to provide leadership for the promotion and advocacy of high quality, accessible health care for the citizens of Michigan."
- Represents 13 health plans covering all of Michigan and more than 45 related business and affiliated organizations. Our member health plans employ about 8,000 persons throughout the state.
- Member health plans provide coverage for more than 4 million Michigan citizens – nearly one in every three Michiganders.
- Member health plans collect and use health care data, support the use of "evidence based medicine", and facilitate disease management and care coordination in order to provide high quality cost-effective care.

mahp
Michigan Association of Health Plans

Our members

Aetna Better Health of Michigan [1,2,3]

Michigan Complete Health [3]

Harbor Health Plan [2]

Health Alliance Plan [1,2,3]

Molina Healthcare of Michigan [1,2,3]

Physicians Health Plan [1]

Total Health Care Plan [1,2,3]

McLaren Health Plan [1,2,3]

Meridian Health Plan [1,2,3]

Paramount Care of Michigan [1]

Priority Health [1,2,3]

Upper Peninsula Health Plan [2,3]

United Healthcare Community Plan [1,2,3]

Key: 1 = Commercial Health Plan **2 = Medicaid Health Plan** **3 = Medicare Advantage or MedicareSpecial Needs Plan**

mahp Michigan Association of Health Plans

Estimated MI Population Using Opioid Prescriptions by Payer Level in 2016

1/6 of the Population Took an Opioid

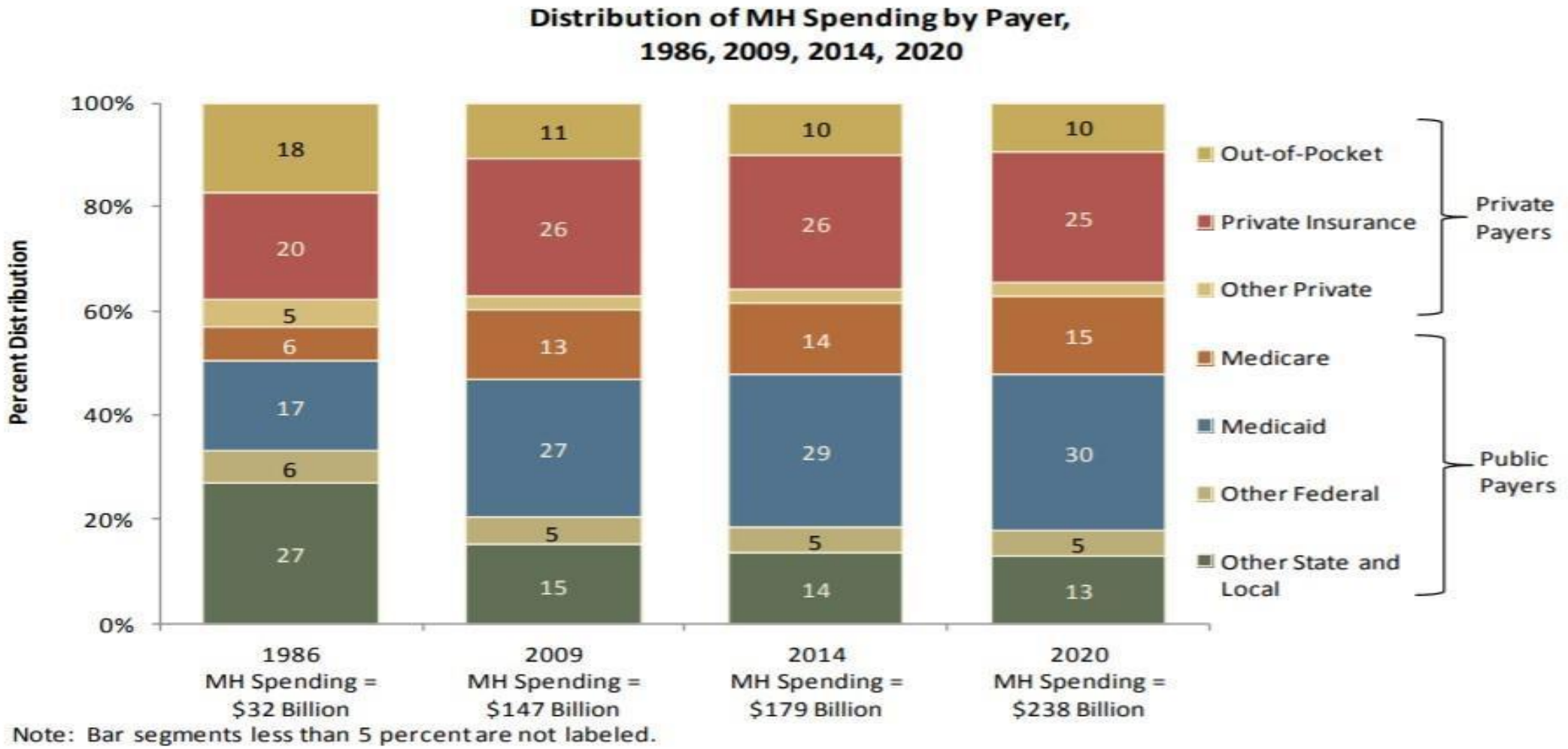
Prescriptions	Medicaid (Actual)	Commercial and No-Insurance (Estimated)	Total (Estimated)
30 Days	402,154	1,206,462	1,608,616
90 Days	115,841	347,523	463,364
365 Days	21,847	65,541	87,388
1000 Days	234	702	936

Source: MDHHS

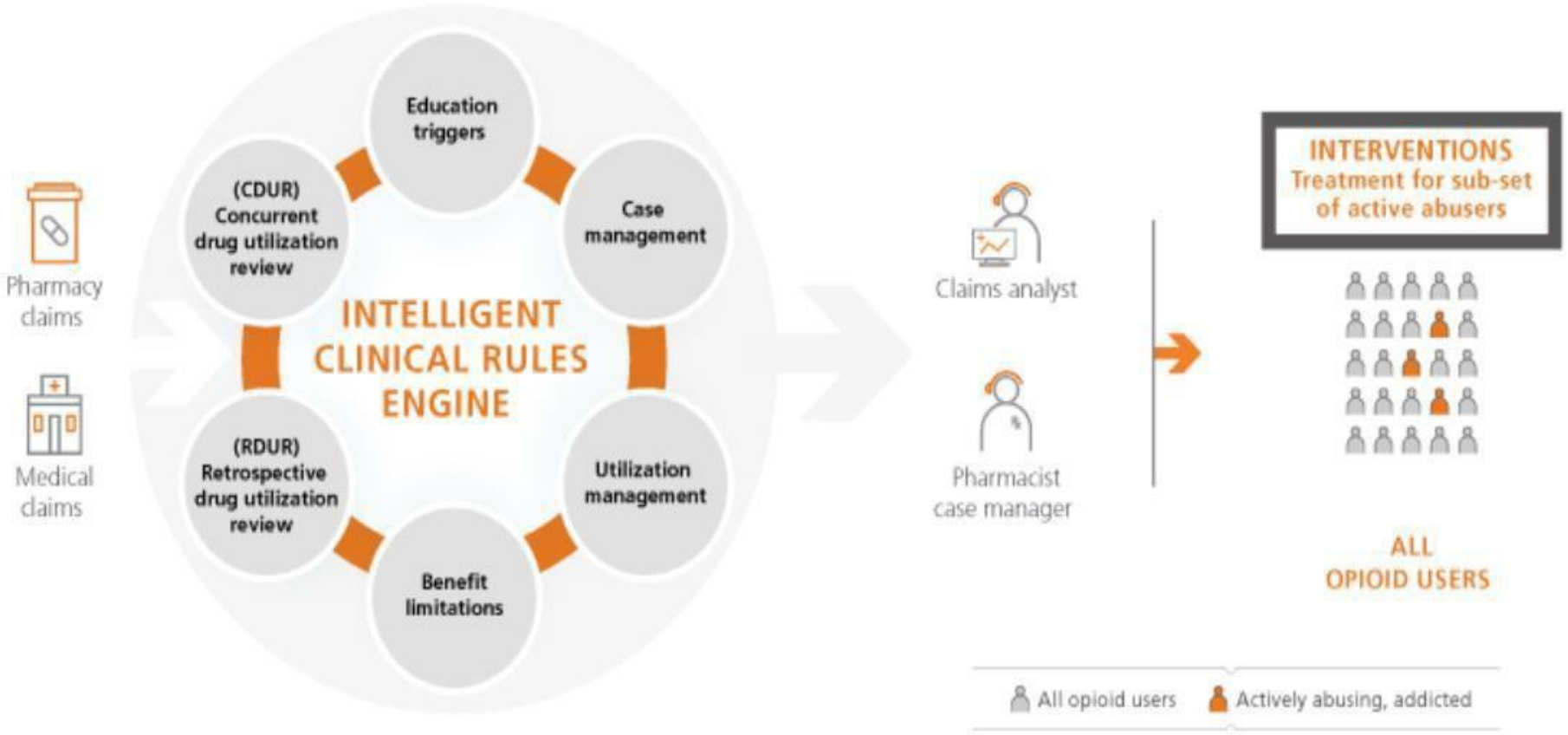
Opioid Epidemic at the Payer Level

- Insurers saw a 3,200% increase in the number of claims for opioid dependence diagnosis between 2007 and 2014
- Cost of treatment for opioid use disorder increased 1,000% between 2011-2014; from $32 million to $446 million
- Current treatment approximately $20,000 per patient
- This represents a 563% increased costs to the $3,435 in average claims paid for all patients
- Insurer's use a multipronged approach to create well-designed insurance plans to counter the steep cost of opioid misuse

Opioid Epidemic at the Payer Level



Health Plan Approach to Opioid Crisis: Multipronged Management



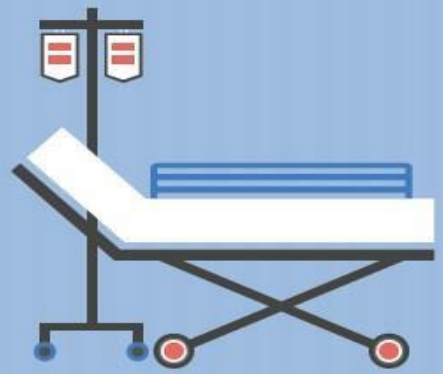
Health Plan Approach to Opioid Crisis

Reducing supply and demand

- Educating physicians when they are prescribing more than others.
- Collaborating with providers to develop protocols for drug dose and quantities for acute pain management
- Reducing excessive opioid prescriptions
- Supporting drug take back programs for safe opioid disposal

Patient intervention

- Reviewing health records of patients taking opioids to ensure appropriate treatment and minimize adverse medication effects and negative health outcomes
- Recommending counseling for those showing early signs of addiction and overdose
- Outreach to those with high opioid use.



Improved access to treatment

- Allowing physicians certified to handle detox programs to bill for services
- Working with regional mental health groups to increase outreach and treatment programs

CMS/Health Plan Initiatives to Reduce Opioid Misuse

- Ensure providers who prescribe opioids and other controlled substances are enrolled in Medicaid and Medicare
- Evaluation of prescribing and dispensing practices to minimize fraud, waste and abuse
  - Quarterly pharmacy risk assessment, which categorizes pharmacies and high, medium or low risk
  - Prescriber risk assessment, which provides a peer comparison of prescribing practices
  - Assessing “Trio Prescribing”, monitoring for prescribers that prescribe the dangerous combination of opioid, benzodiazepine, and the muscle relaxant carisoprodol
  - Identify for improper payments for drugs inappropriately prescribed

Health Plan Data Analytics and Retrospective Drug Reviews to Prevent Future Opioid Dependence

- Assessment of prescribers of opioid prescriptions
  - Evaluate doses exceeding CDC recommended guidelines of 90 morphine milligram equivalents per day
  - Exceeding 7-days of treatment
  - Written for extended release/long-acting opioids
- Evaluate percentage of beneficiaries with opioid prescription without other supportive therapies or treatments
- Evaluate beneficiaries who are “doctor shopping” or “pharmacy shopping” through review of MAPS and claims data
- Provide additional case management support for incidences in which naloxone is administered

Challenges in Treatment for Opioid Use Disorder

- Limited availability of treatment facilities and limited physiciannetwork certified in addiction medicine
- Lack of adherence to substance-use disordertherapies
- Insufficient post treatment social support system for patients resultingin high return to use
- Underfunded appropriations for government programs – Medicareand Medicaid
- Conflicting health plan accreditation quality metrics (NationalCommittee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set (HEDIS) with opioid related quality metrics and pay-for-performance metrics
- Bifurcated health model in MI Medicaid – behavioral health and physical health separation and “carve-out” model provides significant coverage challenges for payers, providers and patients

Medicaid Behavioral Health "Carve-out" Coverage in MI

- MI Managed Care Health Plans responsible for coverage of physical health services
- Behavioral health services and substance use services are "carved-out" from the managed care health plans
  - Covered under fee-for-service (FFS) or under the 10 regional mental health authorities or Pre-paid inpatient health plans (PIHP)
- Substance use disorder prescription drugs are also "carved-out" of the managed care health plans and covered under FFS
- Confusion exists on where to bill for services often creating challenges for the provider and the patient

Table 2: Selected States' Coverage of Behavioral Health Benefits for Newly Eligible Medicaid Enrollees in 2014

State	Delivery systems			
	Physical health services	Mental heath services	Substance use services	Behavioral health prescription drugs
Connecticut	Fee-for-service (FFS)	FFS; contracted separately from physical services	FFS; contracted separately from physical services	FFS; contracted separately from physical and behavioral health services
Kentucky	Managed care (MC)	MC[a]		
Maryland	MC	Carved out; FFS		Carved out FFS
Michigan	MC	Carved out; limited benefit plan	Carved out; limited benefit plan	Carved out FFS
Nevada[d]	FFS and MC[e]	FFS and MC[e]	FFS and MC[e]	FFS and MC[e]
West Virginia[f]	FFS	FFS	FFS	FFS; contracted separately from physical and behavioral health services

Source: GAO analysis of information from state Medicaid programs. | GAO-15-239

Medicaid Behavioral Health Coverage - PIHP

Michigan Pre-Paid Inpatient Health Plan (PIHP) Contact Information:

CMH Partnership of Southwest Michigan	(734) 344-6079
Detroit Wayne Mental Health Authority	(313) 833-2500
Lakeshore Regional Entity	(231) 769-2050
Macomb County Mental Health Services	(586) 469-6210
Mid-State Health Network	(517) 253-7525
NorthCare Network	(906) 225-7254
Northern Michigan Regional Entity	(231) 487-9144
Oakland County CMH Authority	(248) 858-1210
Region 10	(810) 966-7803
Southwest Michigan Behavioral Health	(269) 202-8398

Michigan Medicaid Health Plan Contact Information:

Aetna Better Health	(866) 316-3784
Blue Cross Complete of Michigan	(800) 228-8554
HAP Midwest Health Plan	(888) 654-2200
Harbor Health Plan	(844) 427-2671
McLaren Health Plan	(888) 327-0671
Meridian Health Plan	(888) 437-0606
Molina Healthcare of Michigan	(888) 898-7969
Priority Health Choice	(888) 975-8102
Total Health Care	(800) 826-2862
UnitedHealthcare Community Plan	(800) 903-5253
Upper Peninsula Health Plan	(800) 835-2556

Health Plans Working to Assist Provider Shortage and Coverage Gaps

- Plans are working to increase detoxification program access for existing high opioid users by developing processes to allow primary care physicians certified to prescribe opioid detoxification drugs to bill for these services
  - This will help address the insufficient SUD provider shortage
- Plans are working in their communities to assure community resources, physician organizations and other outreach programs are included in their opioid crisis management programs
- Plans are working with provider networks to increase the number of members in substance abuse treatment and assisting providers with plan coverage guidelines to increase access to treatment

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(517) 371-3181

Michigan HIDTA

High Intensity Drug Trafficking Areas

PURPOSE, MISSION, SERV ICES

Craig Summers, Michigan HIDTA Executive Director

Office of National Drug Control Policy

WHAT'S A HIDTA?

Michigan HIDTA

A COALITION OF FEDERAL, STATE, LOCAL AND TRIBAL LE AGENCIES

- From a specific geographic area
- That have joined together to receive federal grant funds
- To facilitate specific drug control issues

A program of the federal government – not an agency – no law enforcement authority

HIDTA MISSION

TO ASSIST LAW ENFORCEMENT **DISRUPT** and **DISMANTLE** DTOs and MLOs

DISRUPT: The normal and effective operation of the organization is impeded, as indicated by changes in leadership, methods, financing, transportation or distribution.

DISMANTLE: An organization's leadership, financial base and supply network are destroyed and incapable of operating and/or reconstituting itself.

TO IMPROVE the EFFICIENCY and EFFECTIVENESS of LE INVESTIGATIONS

- REDUCE duplication of law enforcement effort
- LEVERAGE existing resources
- INCREASE prosecutions and seizures

EXECUTIVE BOARD COMPOSITION

Michigan HIDTA

FEDERAL	STATE and LOCAL	EX-OFFICIO
U.S. Attorney	Michigan State Police	MI National Guard
FBI	Detroit Police Department	U.S. Secret Service
DEA	Prosecutor's Representative	U.S. Coast Guard
HSI	Eastern Sheriff's Representative – 2	U.S. Postal Inspector
U.S. Marshal	Western Sheriff's Representative	Dept. of Emergency Medicine – U of M
U.S. Customs and Border Protection	Eastern Chief's Representative	WC Prosecutor's Office
IRS	Western Chief's Representative	
ATF		

DTOs and MLOs

Drugs Trafficked

HIDTA TASK FORCES INVESTIGATED 218 DTOS IN 2017

- 111 DTOs (50%)were classified as **poly-drug organizations**
- 95 DTOs (43%) of the total under investigation trafficked **marijuana**
- 102 DTOs (47%) trafficked **heroin**
- 87 DTOs (40%) trafficked **cocaine**
- 41 DTOs (18%) trafficked **prescription drugs**
- 21 DTOs (9%) trafficked **crack cocaine**
- 14DTOs (6%) trafficked **methamphetamine**

DTOs/MLOs may be included in totals more than once due to their status as poly-drug traffickers

Heroin

Michigan's Greatest Drug Threat?

Readily available and its abuse in Michigan continues to increase. 47% of DTOs investigated by MI HIDTA task forces traffic heroin. Heroin demand has surpassed cocaine

In 2017, 22,082 residents (31% of all public drug treatment admissions) were admitted for treatment for heroin.

In 2017, heroin accounted for the largest percentage of drug treatment admissions in Macomb, Monroe, St. Clair, Washtenaw and Wayne counties, as well as the City of Detroit.

MDHHS Records and Health Statistics Section, reports 242 heroin only and 277 heroin with opioids deaths in 2016

HIDTA initiatives seized more than 32.9 kilos(72.4 pounds) of heroin in 2017, with a wholesale value of over $1.9 million.

Price of heroin per kilogram is $60,000 - $100,000. Street gram prices range $100 - $300.

2018 Michigan HIDTA Threat Assessment ranks heroin as a serious **drug threat in the state.** Presence of heron laced with fentanyl is significantly raising statewide concerns.

Fatal Comparison Amounts

Michigan HIDTA

Lethal overdose of fentanyl compared to a penny

Fentanyl and Carfentanil in the Mix

"More deadly than heroin already is"

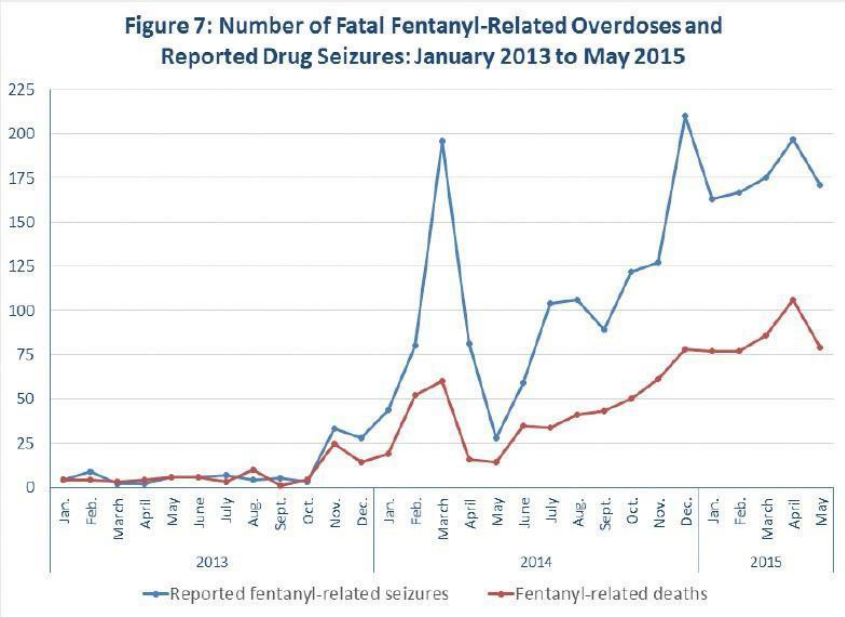
Michigan HIDTA

Carfentanil is 10,000 times more potent than morphine.

In 2017, Michigan HIDTA Task Forces seized 29 kilos of fentanyl (100 times more potent than morphine) up from 1 kilo in 2016.

MDHHS reports 823 confirmed opioid related deaths in 2016 that did not include heroin.

MDHHS reports 8,629 publicly funded treatment admissions for opioids other than heroin in 2017.



2017 Drugs Seized by Michigan HIDTA Initiatives

Statewide

- **Heroin = 32.9 kilograms (72.6 pounds)**
- **Fentanyl = 28.7 kilograms (63.14 pounds)**
- **Cocaine = 204.7 kilograms (450.3 pounds)**
- **Prescription Drugs = 46.9 kilograms (103.1 pounds)**
- **Methamphetamine/ICE = 36.6 kilograms (80.5 lbs)**
- **Marijuana = 10,442 kilograms (22,972.6 pounds)**

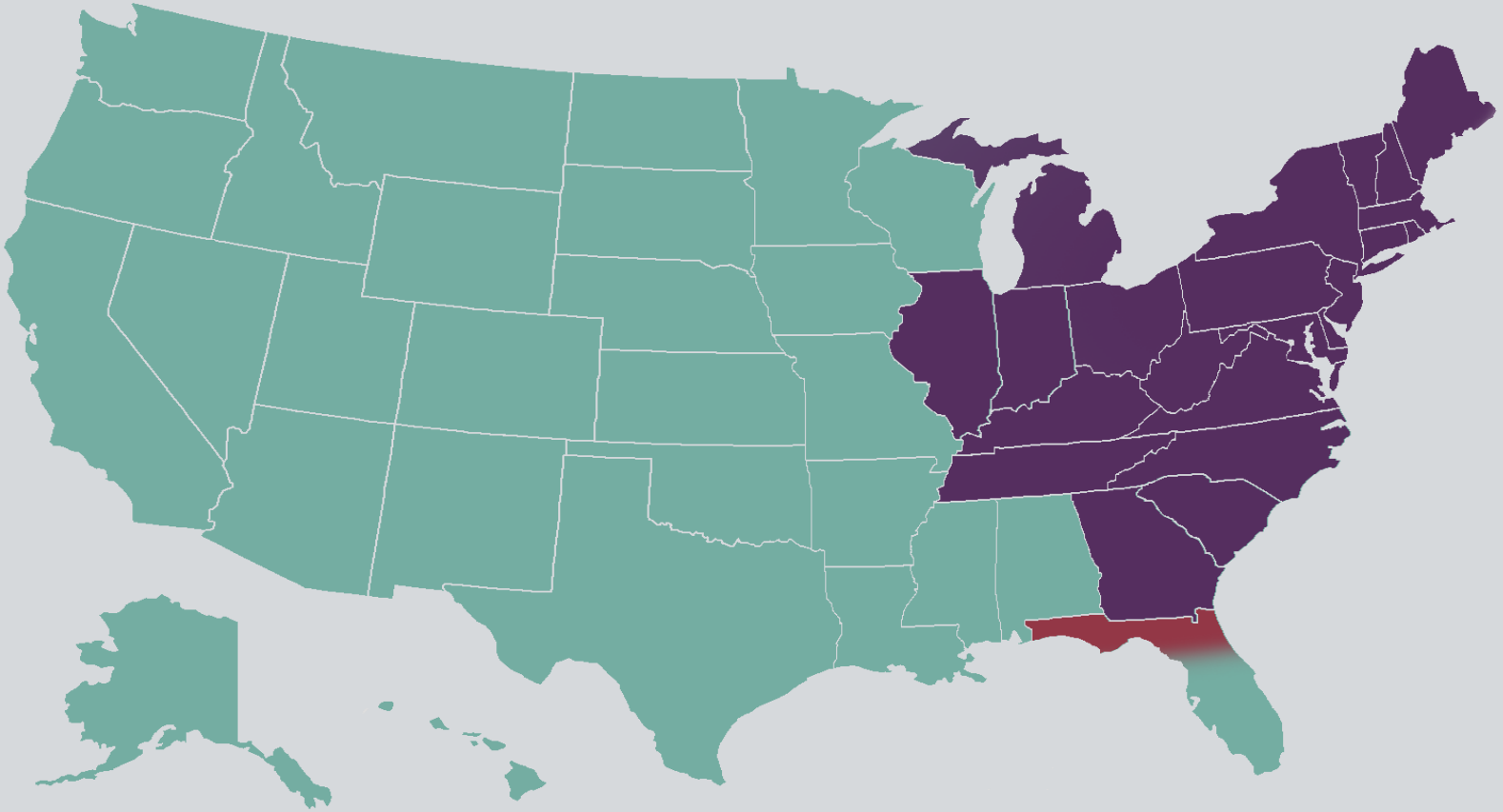
Heroin Response Strategy

Vision: The Heroin Response Strategy (HRS) is committed to creating overdose-free communities

Mission: The mission of the HRS is to reduce fatal and non-fatal opioid overdoses by developing and sharing information about heroin and other opioids across agencies and by offering evidence-based intervention strategies

HIDTA HRS 22 Participating States

Michigan HIDTA



HRS Goals

➢Reduce heroin/fentanyl/opioid-related overdose deaths by identifyingand arresting drug traffickers and primary distribution networks before they can distribute more of these drugs

➢HIDTA will serve as a central repository for the collection, analysis, and sharing of heroin, fentanyl, and opioid data and intelligence

➢Educate families & young people about the risks of heroin/opioid abuse and available treatmentresources

➢Establish lasting public health-public safety partnerships beginning with the Drug Intelligence Officer (DIO) and the Public Health Analyst (PHA)

ACUTE CARE RESEARCH UNIT
UNIVERSITY OF MICHIGAN

HIDTA
HIGH INTENSITY DRUG TRAFFICKING AREA
Executive Office of the President
Washington, D.C.
Office of National Drug Control Policy
MICHIGAN

INJURY CENTER
UNIVERSITY OF MICHIGAN

System for Opioid Overdose Surveillance (S.O.S.)

Mahshid Abir, MD, MSc

May 24, 2018

State of Opioid Overdose Surveillance in the United States

- Surveillance based on:
  - Individual counties and/or Health Departments
  - Outdated and/or manually collected data
  - Naloxone administration
  - Syndromic surveillance

State of Opioid Overdose Surveillance in the United States

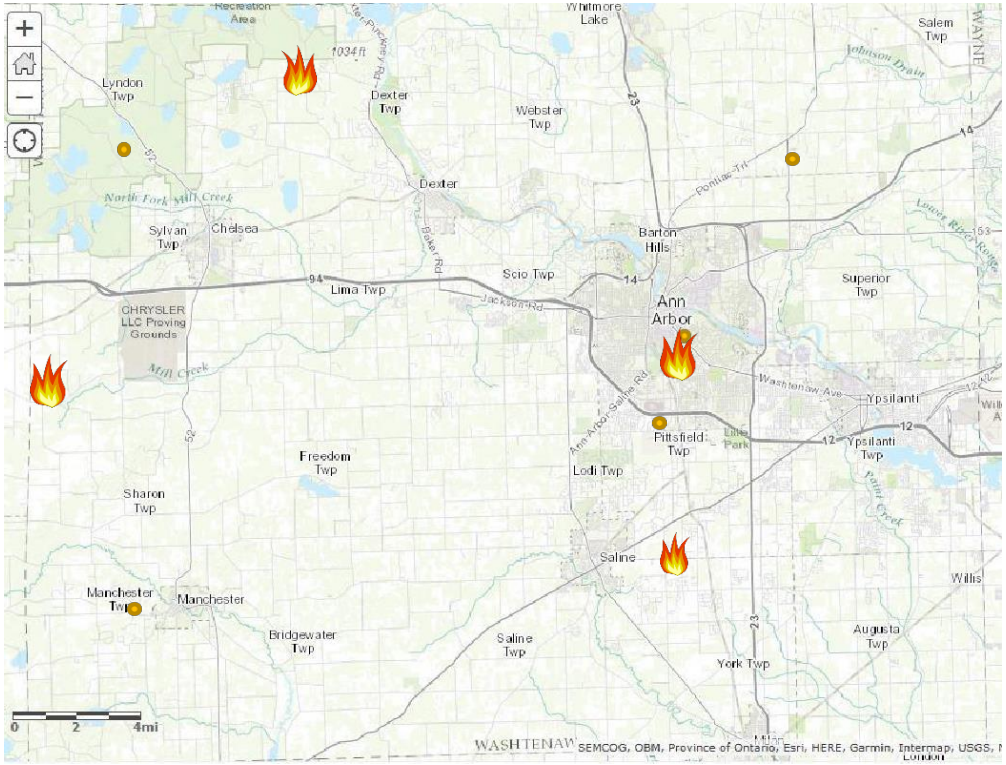
- Surveillance based on:
  - Individual counties and/or Health Departments—*Not streamlined, not scalable, notsustainable*
  - Outdated and/or manually collected data—*May notrepresent on-the-ground reality, may misinform interventionefforts*
  - Naloxone administration—*Naloxone used for any unresponsive patient, can lead to over-counting overdoses*
  - Syndromic surveillance—*Not as valid as ICD-10 codes,may lead to over- or under-counting overdoses*

State of Opioid Overdose Surveillance
Michigan

- Medical examiner (ME) data is not centralized
  - Current fatal overdose data lags 18 months statewide
- Emergency department (ED) data is not centralized
  - No system currently tracks ED overdoses statewide
- Emergency medical services (EMS) naloxone deployments can be tracked through the Michigan EMS Information System

System for Opioid Overdose Surveillance (S.O.S.)

- ***Scalable***—By using the minimum number of datasets to obtain the most relevant data
- ***Maximizes limited resources***—By identifying "hotspots" of fatal and non-fatal overdose
- ***Timely and accurate***—By providing overdose data that is not over- or under-counted



Note: Example of geo-coding hot spots. This is **NOT** real data.

Designing the System for Opioid Overdose Surveillance (S.O.S)

Federal/State/Local Government	Academia
Law Enforcement	Public Health

INJURY CENTER
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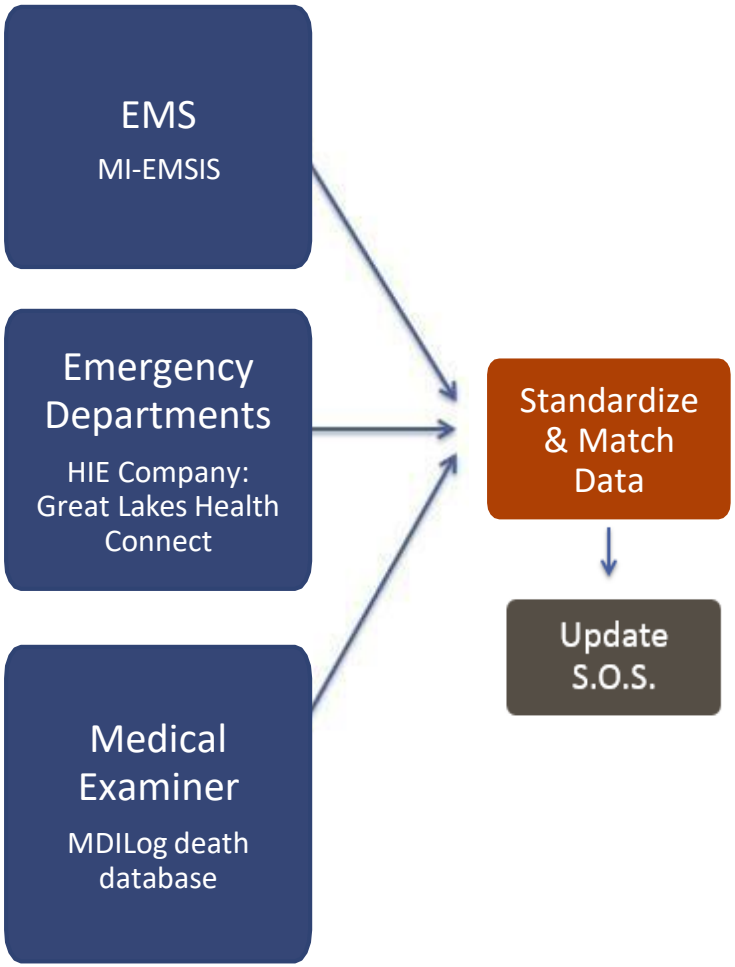
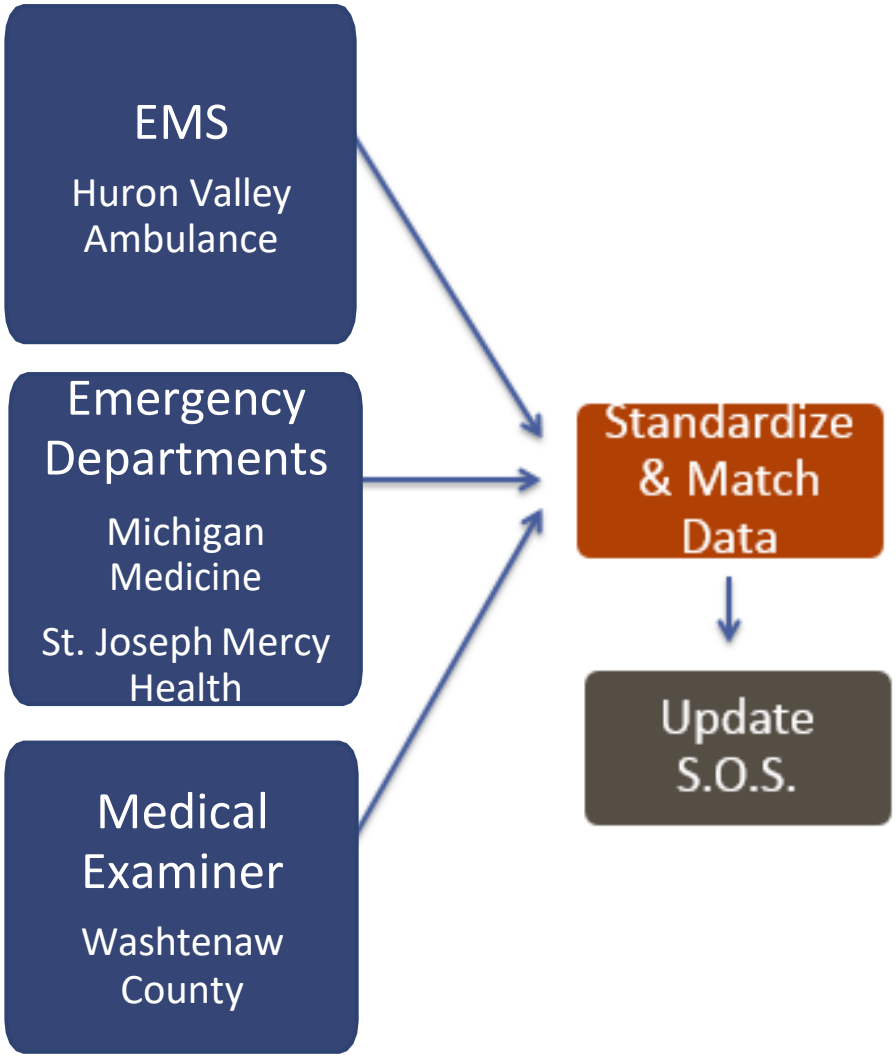
System for Opioid Overdose Surveillance (S.O.S.)

S.O.S. will cover 3-5 HIDTA counties by October 2018

- Partnership with **MDILog** to obtain real-time ME overdose data
  - Used in 42 of 83 (50%) Michigan counties
- Partnership with **Great Lakes Health Connect (GLHC)** to obtain real-time ED overdose data from the lower peninsula
- Obtain EMS data through **MI-EMSIS** database
- Further develop the S.O.S. interface



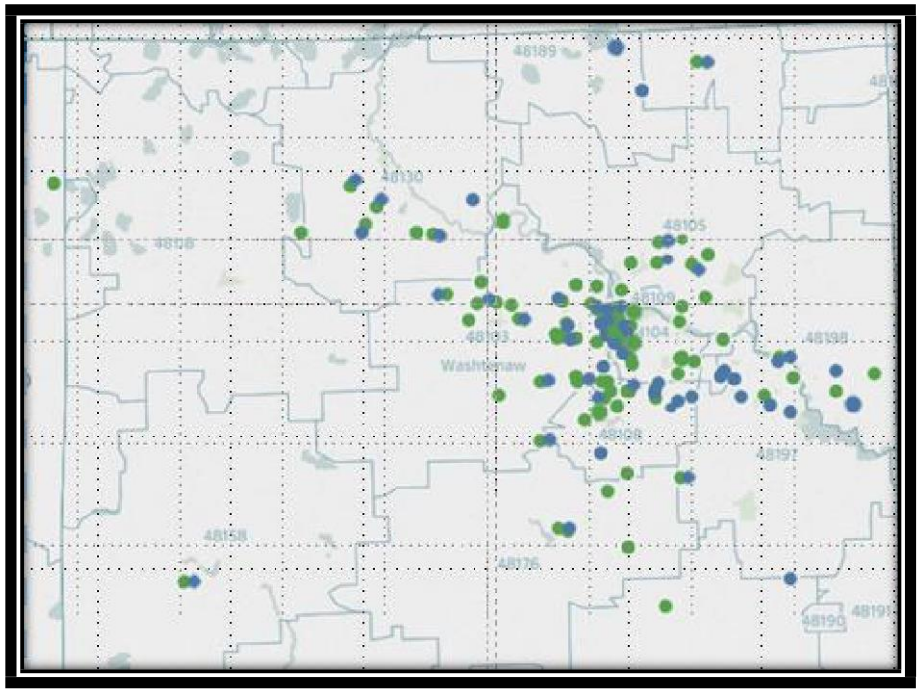
Washtenaw County Pilot



EMS Data: Naloxone Deployments Transported to Michigan Medicine

January 1, 2017- December 31, 2017

HVA Naloxone Deployments Transported to Michigan Medicine		
January 1, 2017 - December 31, 2017		
Characteristic	**Frequency**	**Percent (%)**
Gender		
Female	48	33.80
Male	94	66.20
Race		
White	77	54.23
Black	11	7.75
Asian	1	0.70
Hispanic	1	0.70
Unknown	51	35.92
Other	1	0.70
Missing	0	0.00
Age group		
0-18	4	2.82
19-24	15	10.56
25-34	58	40.85
35-44	20	14.08
45-54	21	14.79
55-64	10	7.04
65+	13	9.15
Missing	1	0.70



Green= incident location, blue= residence location

Hot spots found in: 48103, 48104, 48109

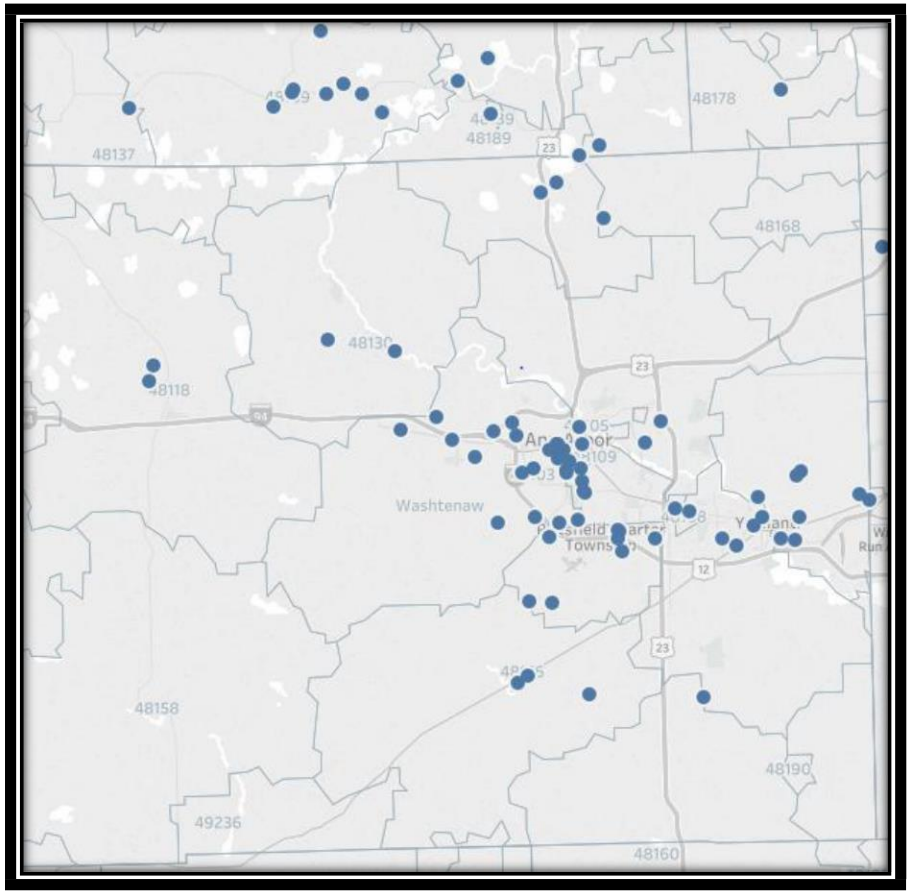
44% of naloxone administrations were at residence address

Note: Naloxone is frequently used as a “catch-all” for unresponsive EMS patients. These may not all be true overdoses.

Emergency Department Data: Michigan Medicine Opioid Overdoses

January 1, 2017- December 31, 2017

Michigan Medicine Emergency Department Opioid Overdoses *January 1, 2017- December 31, 2017*		
Characteristic	**Frequency**	**Percent (%)**
Gender		
Female	53	35.81
Male	95	64.19
Race		
White	123	83.11
Black	12	8.11
Asian	1	0.68
Hispanic	6	4.05
Other	2	1.35
Missing	4	2.70
Age group		
0-18	10	6.76
19-24	22	14.86
25-34	61	41.22
35-44	20	13.51
44-54	20	13.51
55-64	8	5.41
65+	7	4.73
Outcome		
Fatal	3	2.03
Non-fatal	145	97.97



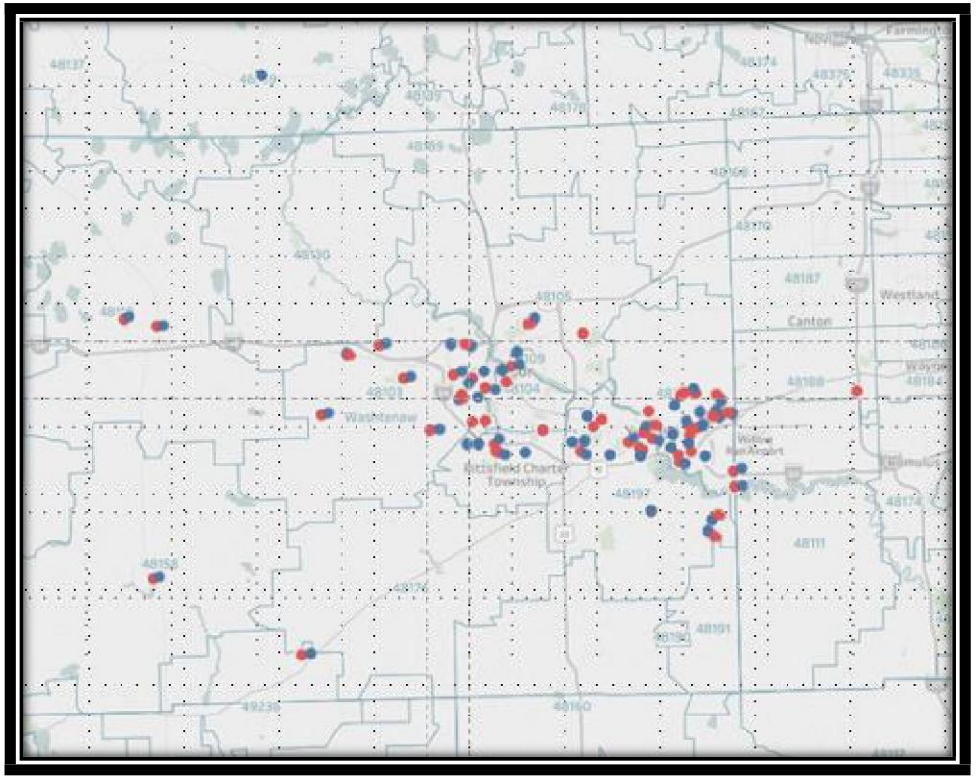
*Mapping based on residence address

Hot Spots found in zip codes: 48103, 48104, 48109

Medical Examiner Data: Washtenaw County Opiate Related Deaths

January 1, 2017-December 31, 2017

Washtenaw County Opiate Overdose Related Deaths *January 1, 2017 -December 31, 2017*		
Characteristic	**Frequency**	**Percent (%)**
Gender		
Female	19	24.36
Male	59	75.64
Race		
White	67	85.90
Black	9	11.54
Asian	0	0.00
Hispanic	0	0.00
Unknown	1	1.28
Other	1	1.28
Missing	0	0.00
Age group		
0-18	3	3.85
19-24	6	7.69
25-34	17	21.79
35-44	12	15.38
45-54	24	30.77
55-64	14	17.95
65+	2	2.56



Red= Death Location

Blue= Residence Location

Hot spots found in: 48103, 48104, 48108, 48197, 48198

55% of cases had same death and residence location

S.O.S. Capabilities

- Fatal Overdoses (ODs)
  - Update suspected ODs every 24 hours
  - Confirm ODs after toxicology results are obtained ~90 days later
- Non-fatal Overdoses
  - ED: Update every 24 hours
  - EMS: Update 3 times a week
- **Linkage** of 3 datasets- eliminates over counting of EMSand fatal ED visits
- Presents both **rates** and raw **numbers** of events
- Provides both **location** of home and location of death for fatal overdoses and non-fatal EMS: allows for tracking of movement
- County level data available to the **public**
- Census tract data password protected for key **stakeholder** access

S.O.S. Interface

- http://acru.med.umich.edu/SOS/sos.html

S.O.S. Interface
About page

About S.O.S.™ System for Opioid Overdose Surveillance

In 2015, a record number of Americans died of an opioid-involved overdose, bringing devastation to families and communities in urban and rural communities alike. Now more people in America die from drug overdoses than car accidents. In response to this alarming public health crisis, the Office of National Drug Control Policy (ONDCP) is supporting the development of opioid overdose monitoring systems in High Intensity Drug Trafficking Areas (HIDTA). In collaboration, the University of Michigan Injury Center, the Acute Care Research Unit (ACRU), and the University of Michigan Transportation Research Institute (UMTRI) are developing and piloting a real-time System for Opioid Overdose Surveillance (S.O.S.) in Washtenaw County, a Michigan HIDTA county. Through connecting overdose and mortality data from Emergency Departments (EDs), Medical Examiners, and Emergency Medical Services (EMS) agencies, the S.O.S. project aims to increase the timeliness and quality of overdose reporting so that regional strategies to reduce fatal and non-fatal overdoses may be developed.

The S.O.S project plans to expand to the additional 10 Michigan HIDTA counties in partnerships with the electronic death database Medicolegal Death Investigation Log (MDILog), who will provide medical examiner data and the Health Information Exchange (HIE) company Great Lakes Health Connect (GLHC), who will provide emergency department data.

Partners

M | ACUTE CARE RESEARCH UNIT UNIVERSITY OF MICHIGAN

M | INJURY CENTER UNIVERSITY OF MICHIGAN

HIDTA MICHIGAN

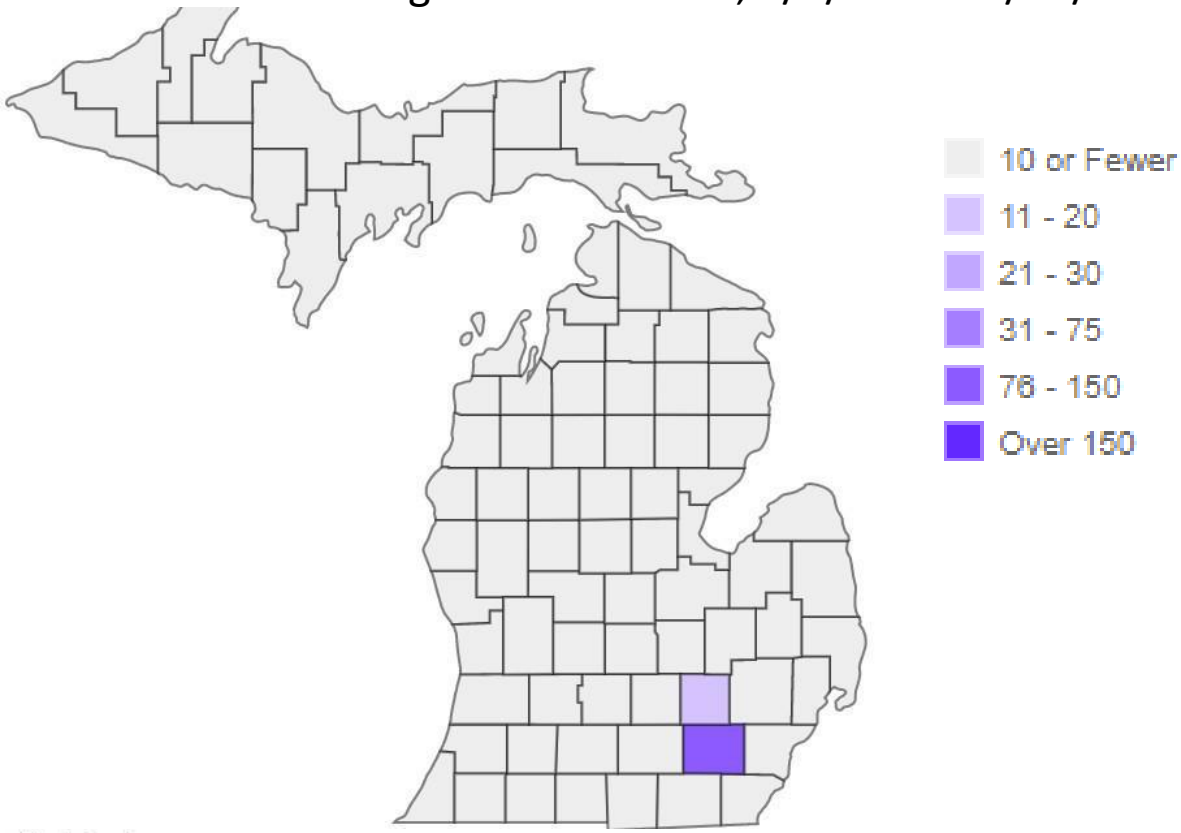
GLHC GREAT LAKES HEALTH CONNECT

M | UMTRI TRANSPORTATION RESEARCH INSTITUTE UNIVERSITY OF MICHIGAN

MDI Log Medicolegal Death Investigation

S.O.S. Interface
Emergency Department

Opioid Overdose Emergency Department visits by County
Michigan Medicine ED, 1/1/2017-10/25/2017



Disclaimer: Data are subject to change.

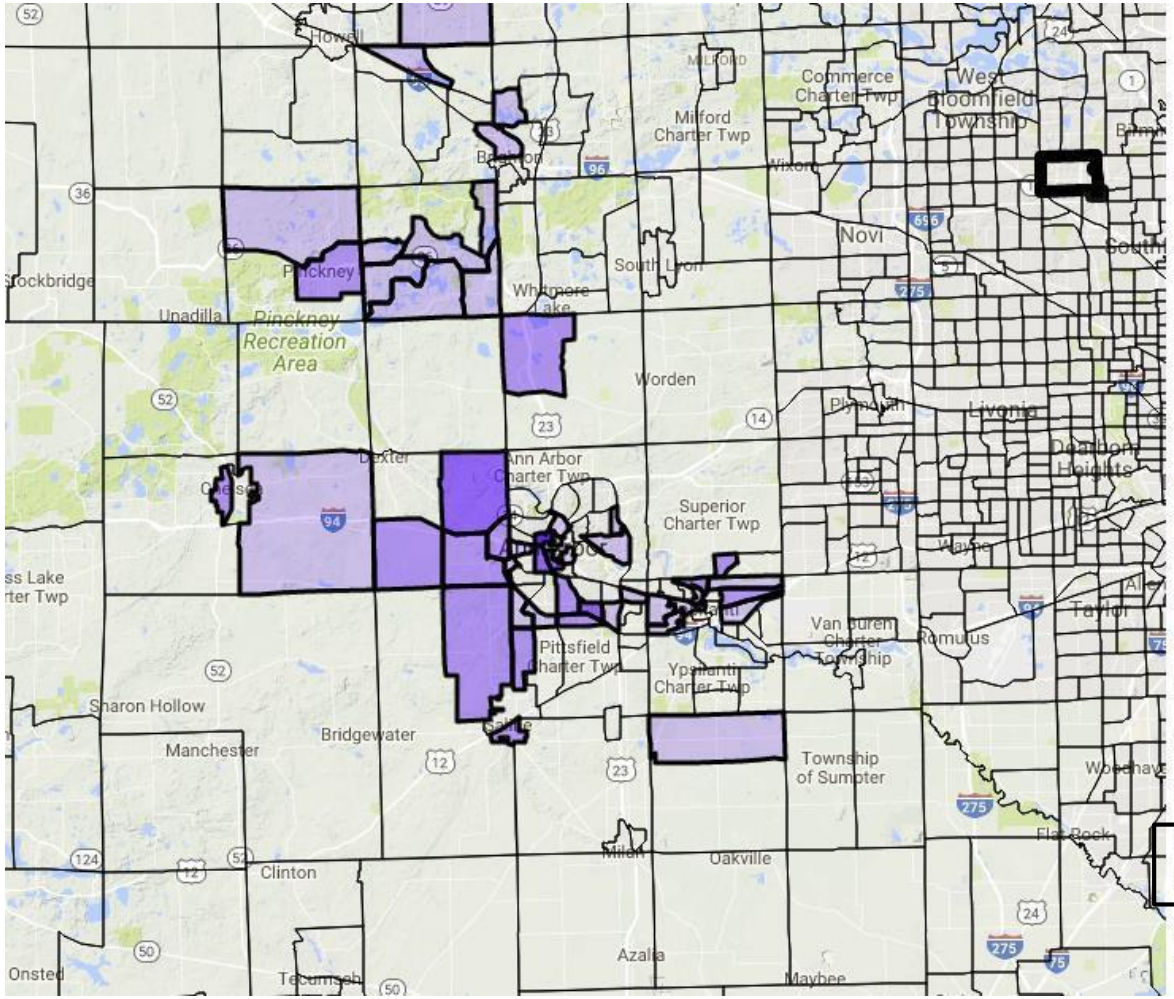
Cases are defined using the International Classification of Disease (ICD-10) codes for opioid overdose and include both intentional and unintentional overdoses.

Locations represent the recorded home address of the patient and are only shown for counties with 10 or more recorded cases.

S.O.S. Interface

Detail Map: ED Home Locations

EMS, Emergency Department, and Medical Examiner
1/1/2017-10/25/2017



Medical Examiner: Event Locations

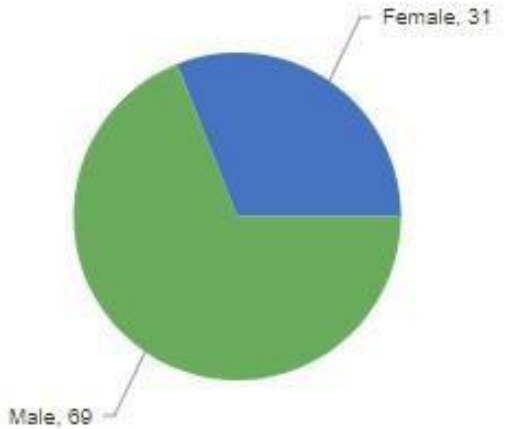
- ☐ Overdose Locations
- ☐ Home Locations
- ☐ Death Heatmap
- ☐ Home Heatmap

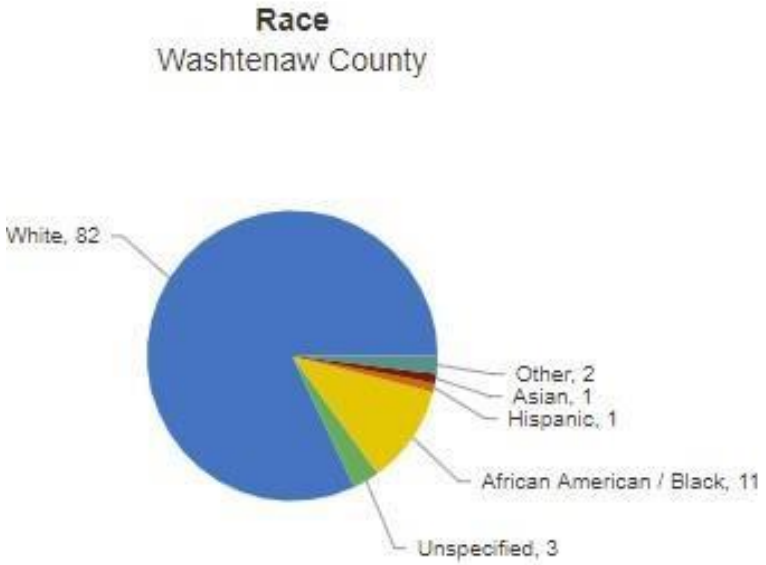
Base maps

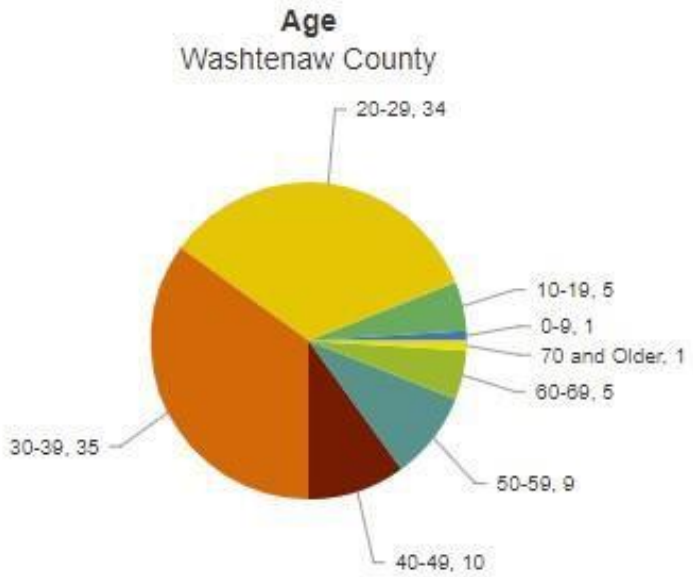
- ○ No Base Map
- ○ Census Tract Base Map, Medical Examiner Overdose Locations
- ○ Census Tract Base Map, Medical Examiner Home Locations
- ○ Census Tract Base Map, EMT Incident Locations
- ○ Census Tract Base Map, EMT Home Locations
- ◉ Census Tract Base Map, Emergency Department Home Locations

Location Details:
Tract ID: 7408

S.O.S. Interface
Emergency Department



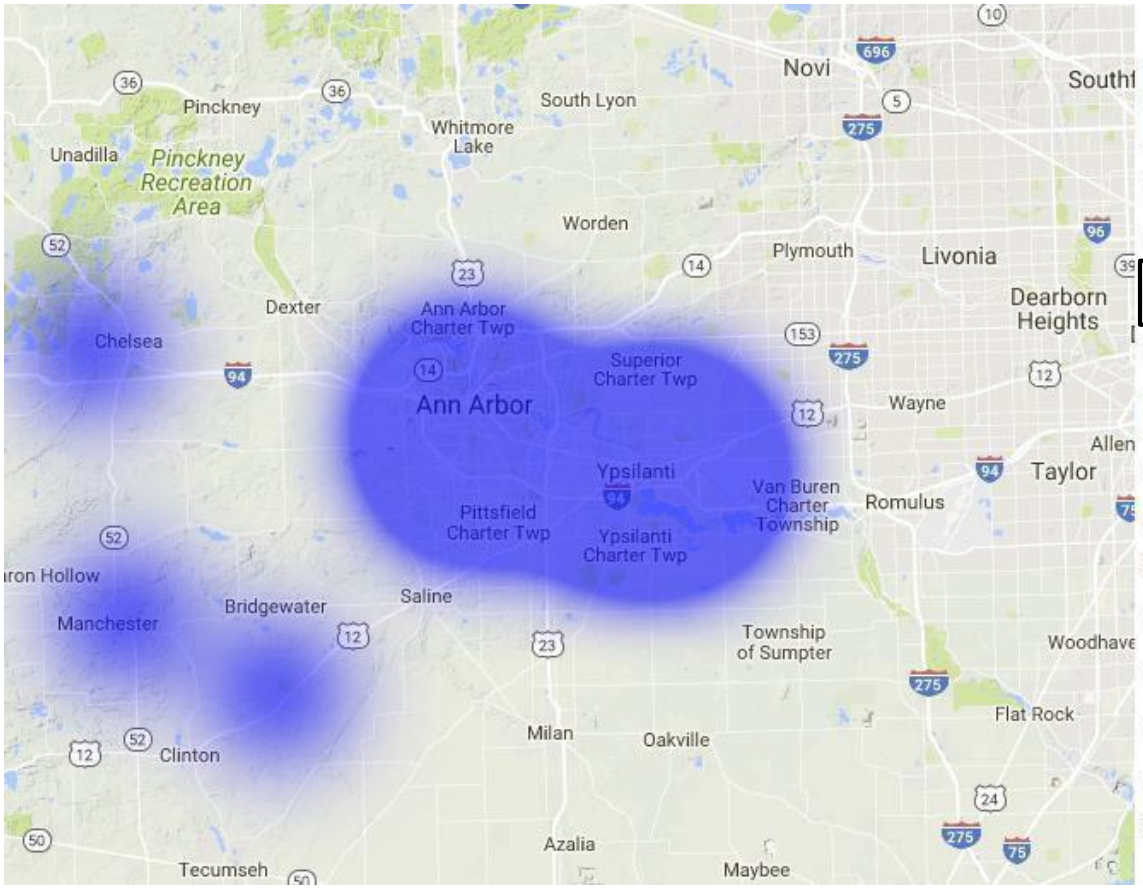


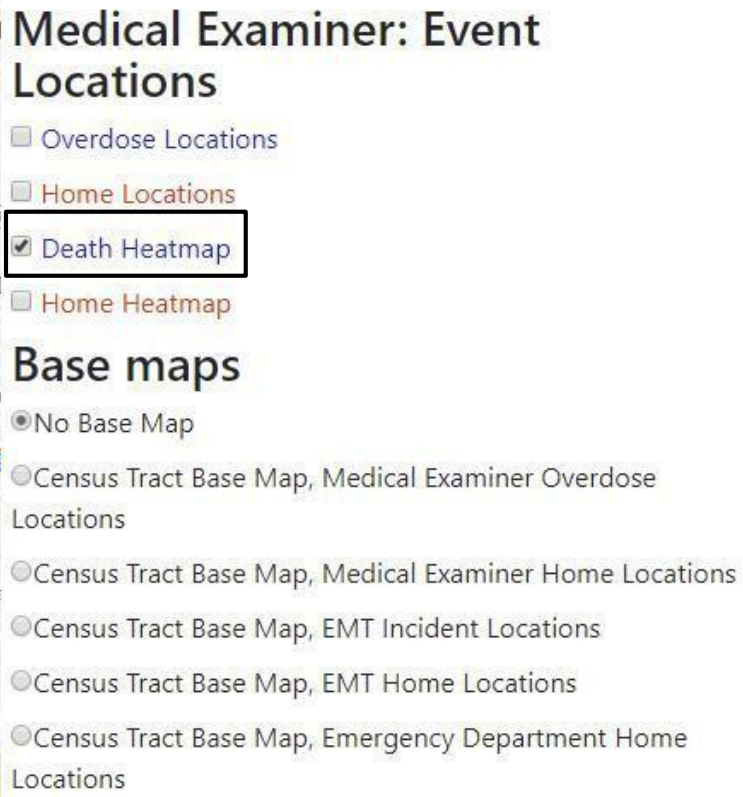


S.O.S. Interface

Detail Map: Fatal Heatmap

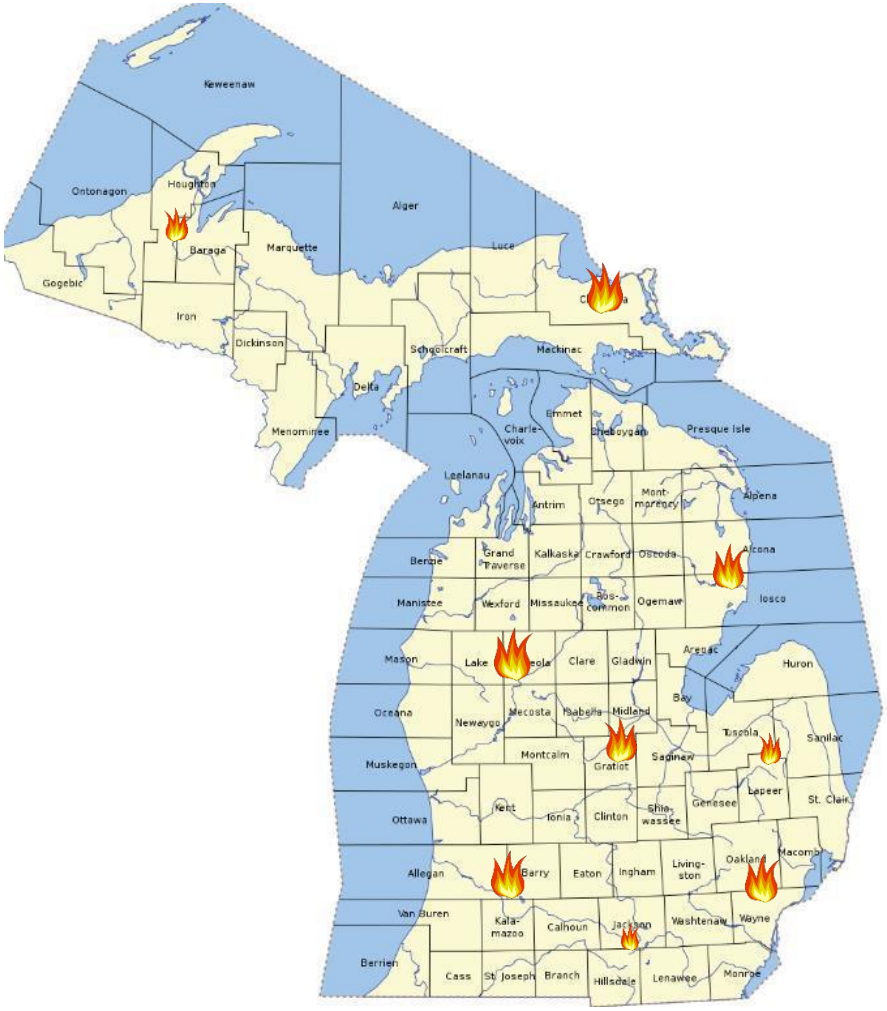
EMS, Emergency Department, and Medical Examiner
1/1/2017-10/25/2017





Next Steps

- Continue expanding surveillance to the **12 HIDTA counties**
- Ultimate goal of **statewide surveillance** in the next 3 years



Implications

- S.O.S. allows both public health and law enforcement to:

  1) Continuously follow the size, spread, and trends of non-fatal and fatal overdoses

  2) Implement interventions in communities where they are most needed

  3) Inform allocation of resources

Future Use
Research

- Modeling to predict likelihood of fatal overdose through preceding non-fatal overdose encounters with the health care system
- Implementing interventions for repeat overdose victims

Michigan: A Leader in Opioid Overdose Surveillance?

Designing the System for Opioid Overdose Surveillance (S.O.S)

HIDTA

State Government

U-M

Law Enforcement

Community Stakeholders

Public Health

INJURY CENTER
UNIVERSITY OF MICHIGAN

HIDTA
MICHIGAN

ACUTE CARE RESEARCH UNIT
UNIVERSITY OF MICHIGAN

Looking for Synergy and Opportunities for Collaboration

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05/11/18

Exploration of Offices of Drug Policy in various states in the U.S.

Investigators: Toyin Olumolade[1 2], Sam Tacconelli[1 2], Jessica Black[3]
[1]Masters of Public Health Student. [2]Central Michigan University. [3] Bachelor of Social Work Student.

Introduction

The objective of this summary is to present information concerning state Offices of Drug Policy and similar entities in the United States. This report will include the history and location (in government) of the office/agency, along with its authority/responsibilities and successes. Data collection included speaking with agency staff and searching the Internet. Attempts were made to contact 14 such agencies (Table1).

Table 1. Summary table of states with an Office of Drug Control Policy.

State	Location in Government	Year Created	Authority/Responsibilities	Success
Massachusetts	Governor's Office	2015	In charge of making recommendations to the governor on what legislation to propose that will address the opioid epidemic in the Commonwealth.	-Generated millions of dollars in grant funding to increase access to resources for opioid recovery. Legislation Passed: -HB 4056- STEP Act- First State in the nation to pass legislation that was relative to substance use, treatment, education, and prevention. Established 7-day limit on 1st time opioid prescriptions, etc.
California	Part of California Department of Public Health	Spring 2014	The workgroup, and its supporting task forces, provide a platform for both state and local entities addressing opioid overdoses and addiction to improve coordination and expand joint efforts. The Statewide Opioid Safety Workgroup then created the Prescription Drug Overdose Prevention Initiative to focus on 3 areas of intervention.	-Their multi-sector efforts has resulted in the state receiving an abundance of grant funding that supports the states' efforts to address the opioid epidemic. Legislation Passed: -SB 809; Chapter 400: Controlled Substances Reporting. Allocates $1,500,000 General Fund dollars that will be ongoing annually for the Prescription Drug Management Program CURES. The system is housed and managed by the Department of Justice. -SB 833; Chapter 708 (2016). Passed to mandate all prescribers of controlled substances to register with and consult CURES 2.0 prior to prescribing schedule II-IV drugs to individuals for the first time and at least every few months.

				-SB 833; Chapter 30. Established a one-time naloxone grant program and allocated $3,000,000 in General Funds for the period of 2017 to 2019 for statewide distribution of naloxone to local health jurisdictions for distribution throughout their respective communities.
Alaska	Alaska DHHS- Division of Public Health	November 30, 2016	The Alaska Opioid Policy Task Force partnership was created as a one-year-in-duration working group to represent the public systems that are being affected by the issues surrounding the opioid crisis while simultaneously representing the diversity of the Alaska community. The task force's primary responsibility was to create evidence-based recommendations that would serve as a guide to policymakers for addressing Alaska's opioid crisis at all levels.	-Created/implemented statewide Mobilizing for Action through Planning and Partnership (MAPP) campaign. -Created Your Voice, Your Community conference. -Passing Legislation --Administrative Order 283- mandating state departments to apply for funding for Prevention/treatment etc.
West Virginia	West Virginia DHHS	2017	In charge of prevention, treatment and reduction of substance abuse. Makes recommendation for legislation. Control funding for all programs related to substance abuse and establish the programs purpose.	Developed an Opioid Response Plan. Passing Legislation – SB 272-imporved reporting of substance abuse and required the carrying of opioid antagonists – SB 273-Limits the dispensing of prescription opioids
Louisiana	Executive Office of the Governor	1990	Identifies challenges and provides solutions to address substance abuse and to make recommendations to the governor and state agencies regarding programs, policies and practices that support and sustain prevention, treatment and enforcement efforts	Developed a substance abuse prevention system and state infrastructure that supports communities addressing substance abuse locally
Ohio	In process of creation	In process of creation	In process of creation	In process of creation
Florida	Executive Office of the Governor	1999-2011	No Response	No Response

Florida	Florida DOH	2011	Make recommendations to the governor based on surveillance and research. Ensures a coordinated, integrated, and multidisciplinary response to the substance abuse problem in the state. Assist communities and families in pooling their knowledge and experiences with respect to the problem of substance abuse.	Passing Legislation – Tracking of pseudoephedrine and ephedrine – Increased response to pill mills – Enhanced the penalty of selling alcohol to minors – Improved access to suicide prevention for schools – Decreased the selling of smoking paraphernalia
Kentucky	Justice and Public Safety Cabinet	2004	Governor's representative to the General Assembly. Administrative spokesperson on substance abuse issues. Works with other agencies. Allocates money from grants and tobacco settlements to the various efforts and departments for drug prevention. Creates reports and manages social media	Passing Legislation - Pseudoephedrine (2006) - Bill about chronic pain medication prescriptions (2012) - Limit use of opioid prescription to 3 days (2017) 1st Southern state to establish needle sharing exchange
Minnesota	Part of Department of Human Services	1973 (Current division created in 1987)	Single State Authority for Prevention and Treatment of Alcohol and Drugs. Determines the allocation of state and federal funds. Conducts research related to substance use. Coordinates and reviews all state department activities and programs related to substance use. Establish the state's goals and priorities for a complete continuum of care for substance use and substance misuse disorder	Passing Legislation - The creation of Minnesota Statutes 254A - The creation of Minnesota Statutes 254B Naloxone distribution
Arkansas	Governor's Cabinet	1990s (State Drug Director position – no current office)	Single state authority - serves on the Executive Board of the Department of Human Services as an advisor chairperson. Collaborate with the DHS to resolve issues related to substance abuse since the issue affects many of the DHS responsibility. Looking into developing an Office of Drug Policy.	Passing Legislation - Prescription drug monitoring Expansion of the Arkansas Drug Take Back Day
Iowa	Governor's Office	1987 (Name	Coordinate and monitor all programs related to drug	Passing Legislation

		changed in 2000)	enforcement and substance abuse. Propose new laws and bills for legislative consideration. Coordinates and collaborates with other agencies. Fund drug task forces.	- Pseudoephedrine Control (2005) - Electronic tracking of pseudoephedrine (2010)
Maryland	Governor's Office (Subcabinet)	2015	Provides guidance and direction to agencies. Allocates funding. Develops processes to improve sharing of data.	Creation of OOCC Declaration of State of Emergency Creation of programs for residents with substance abuse issues Expansion of Good Samaritan Law

Kentucky

Name: Office of Drug Policy, https://odcp.ky.gov.

Contact: Van Ingram – Executive Director. Email Van.Ingram@ky.gov. Phone (502) 564-8291.

Location in Government: Justice and Public Safety Cabinet

Respondent: Van Ingram – Executive Director

History: The Office was created in 2004 by Executive Order. Prior to its creation, the Statewide Drug Control Assessment Summit conducted a 20-week assessment of substance abuse in Kentucky ("Justice & Public Safety Cabinet Office of Drug Control Policy," 2018). The assessment included evaluating the effectiveness of substance abuse programs, collecting input from residents regarding related issues in their communities, and developing recommendations to improve the effectiveness of statewide drug control efforts. Based in part on these findings, the creation of the office was recommended by a 51-member coalition consisting of state, federal, and local officials experienced in substance abuse prevention-education, treatment and enforcement.

Authority/Responsibilities: The Office is run by committee. One of the primary roles of the Office is to act as the governor's lobbyist to the General Assembly. The Office allocates funds from grants and tobacco settlements towards drug treatment and prevention efforts. The Office acts as the administrative spokesperson for issues regarding substance use and works with other agencies including the Kentucky Department for Public Health, the Division of Behavioral Health, the Office of the Inspector General, Medicaid and the Department of Education and Labor. These various agencies work to prevent duplication of efforts and maximize efficiency. The Office is responsible for coordinating efforts towards prevention and treatment of substance abuse disorders.

Success: Kentucky was the first state to implement a syringe exchange program. The Office of Drug Policy has also been successful in getting legislation passed. This includes laws restricting the sale pseudoephedrine products in 2005 and further restrictions in 2012, as well as bills regulating the owning and operating of pain management facilities and the dispensing of controlled substances in 2012 ("Drug Control Policy Cold-Allergy Medication Restrictions," 2018). In 2017 HB 333 was passed which limited prescriptions of Schedule II drugs to three days ("17RS - Legislative Record Online," 2017).

Minnesota

Name: Minnesota Alcohol and Drug Abuse Division www.dhs.state.mn.us/adad

Contact information: Richard Moldenhauer - State Opioid Treatment Authority Representative. Phone (651) 431-2460. Email Richard.moldenhauer@state.mn.us

Location in the government: Minnesota Department of Human Services

Respondent: Richard Moldenhauer - Human Services Representative 2/State Opioid Treatment Authority Representative

History: In 1973, the Department of Public Welfare was created to address and provide rehabilitative and social services to residents who are dependent on alcohol and other drugs ("Public Health; Alcohol and other Drug Abuse; Public Policy.," 1973). The legislature and the Commissioner of the Department of Human Services created the first version in order to accept Federal Block Grant money. The current version, the Alcohol and Drug Abuse Division were created in 1987.

Authority/Responsibilities: The Alcohol and Drug Abuse Division (ADAD) is the Single State Authority for the prevention and treatment of alcohol and drugs. The ADAD works with partners and providers to ensure the availability of detoxification and treatment centers throughout the state. Allocation of state and federal funds is determined by the ADAD. This division also conducts research related to substance use and substance misuse disorder, and coordinates and reviews all state department activities and programs related to substance use ("254A.03 - 2017 Minnesota Statutes," 2017). Other responsibilities of the ADAD include developing, demonstrating and disseminating new methods and techniques related to the prevention, early intervention, treatment and recovery support, as well as informing and educating the public. The ADAD establishes the State's goals and priorities for a complete continuum of care for substance use and substance misuse disorder.

Success: The successes of the ADAD include the creation of Minnesota Statute 254A which authorized legislation for the chemical dependency division and provides a comprehensive range of rehabilitation services for residents with substance dependency ("254A.03 - 2017 Minnesota Statutes," 2017). The ADAD is also responsible for Minnesota Statute 254B which authorized legislation for the Consolidated Chemical Dependency Treatment Fund which pays for drug treatment for qualifying residents ("254B - 2017 Minnesota Statutes," 2017). The ADAD was responsible for writing statutes and testifying before legislature. One current project of the ADAD is using funds from the State Targeted Response to the Opioid Crisis Grants for naloxone distribution throughout the state ("Programs & Initiatives in Communities – Expanding Nalaxone Access for Opioid Overdose - Minnesota Department of Health," 2016).

Iowa

Name: Governor's Office of Drug Control Policy (OCDP), https://odcp.iowa.gov/

Contact information: Dale Woolery – Interim Director. Email dale.woolery@iowa.gov. Phone (515) 725-0310.

Location: Executive branch agency under the direction of the Governor's Office.

Respondent: Susie Sher – Budget Analyst

History: In 1987 a predecessor the OCDP, the Governor's Alliance on Substance Abuse was created as part of the Iowa Department of Public Health ("History | Governor's Office of Drug Control Policy," n.d.). The Alliance was given independent status in 1990 when it was moved from the Department of Public Health to the office of the Drug Enforcement and Abuse Prevention Coordinator in 1990. The name was changed in 2000 to the Governor's Office of Drug Control Policy. The Drug Policy Advisory Council was also created ("Drug Policy Advisory Council | Governor's Office of Drug Control Policy," 2017). It is staffed by the OCDP and other agencies.

Authority/Responsibilities: The OCDP has a central mandate to coordinate and monitor all programs related to drug enforcement and substance abuse ("History | Governor's Office of Drug Control Policy," n.d.). One of its responsibilities is to propose new laws and bills for legislative consideration. The OCDP also coordinates and collaborates with other agencies involved in substance abuse and drug trafficking. These agencies include Corrections, Public Health, Human Services, Education, Juvenile Justice Planning, the Iowa National Guard, the Iowa Attorney General's Office, as well as other state agencies and non-governmental organizations. Agencies and organizations that have developed or are interested in

developing programs specific to substance abuse and drug enforcement can work with the OCDP. Funding related to these problems is allocated through this office. Drug task forces throughout the state are funded through the OCDP. Another responsibility is to develop a comprehensive drug policy and strategy for the state. The Drug Policy Advisory Council develops and evaluates state policy and evaluates programs. The OCDP works in collaboration with other stakeholders to develop the states Drug Control Strategy.

Success: The OCDP was instrumental in the creation of the Iowa Pseudoephedrine Control Law in 2005 where the drug became a Schedule V controlled substance (*Iowa Pseudoephedrine Control Law (Senate File 169)*, 2005). Electronic tracking of pseudoephedrine was implemented in 2010 ("Pseudoephedrine Tracking | Governor's Office of Drug Control Policy," n.d.). The Office submitted legislation for both these laws.

Arkansas

Name: State Drug Director (no office currently exists)

Contact information: Kirk Lane – Drug Director. Email kirk.lane@asp.arkansas.gov. Phone. (501) 683-0380.

Location: Governor's Cabinet.

Respondent: Kirk Lane.

History: As a way to fulfill obligations of state government to review state asset forfeitures and other drug related policy issues the Drug Director position was created in 1989.

Authority/Responsibilities: The State Drug Director is a single state authority who serves on the Executive Board of the Department of Human Services (DHS) as an advisor chairperson. Responsibilities include working in collaboration with the DHS to resolve issues related to substance abuse since the issue affects many of the DHS's responsibilities. The drug director is the chairperson of the Alcohol and Drug Coordinating Council was created around the same time. This council oversees the staff responsible for grant allocation. The council also funds and oversees the 19 drug task forces throughout the state. Other responsibilities include bringing previously separated efforts towards the substance use and drug enforcement in harmony to eliminate duplication and maximize effectiveness. The Director also looks into implementing good practices. Arkansas is looking into developing an Office of Drug Policy.

Success: The State Drug Director has been successful in the passing of prescription drug monitoring laws in 2011 ("Arkansas Prescription Monitoring Program," 2017). The Director has also been successful in the expansion of the Arkansas Drug Take Back Day, which began in 2009 ("Arkansas Take Back | History," 2017).

Maryland

Name: Governor's Inter-Agency Heroin and Opioid Coordinating Council
https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Pages/interagency-heroin-council.aspx

Contact information: Smita Sarkar – Inter-Agency Council Liaison. Email smita.sarkar@maryland.gov. Phone (410) 767-2206.

Location: Subcabinet of the Governor.

Respondent: Smita Sarkar – Inter-Agency Council Liaison

History: To address the severity of Maryland's opioid crisis, the Heroin and Opioid Emergency Task Force was created by executive order in February 2015 (*Inter-Agency Heroin and Opioid Coordination Plan*, 2018). This task force consisted of 11 members with experience in addiction, prevention, law enforcement, and/or education. The purpose of the task force was to assist the Governor in creating a statewide, multi-jurisdictional effort to address the consequences of heroin and opioid abuse. The results of this task force included 33 recommendations relating to treatment, enhancing quality of care, increasing overdose prevention efforts, law enforcement, alternatives of incarceration, promoting education in the community, and state support services. Twenty-eight of the 33 recommendations were implemented in 2016.

Another result of the emergency task force was the creation of the Inter-Agency and Opioid Coordinating Council (IAC). The purpose of the IAC was to enable coordination among State agencies towards the statewide effort to prevent, treat, and significantly reduce heroin and opioid abuse. ("Heroin & Opioid Coordinating Council, Maryland Governor's Inter-Agency," 2018). The IAC is a subcabinet of the Governor. Members of the council come from different state and executive branch agencies. Some of the agencies included in the IAC are the Maryland Department of Health (Chair), State Police, Department of Public Safety and Correctional Services, and the Department of Juvenile Services. This is not an exhaustive list of the agencies involved.

Authority/Responsibilities: The IAC acts as the Senior Policy Group and provides guidance and direction to its member agencies. The council meets quarterly and oversees funding allocation for the treatment and prevention strategies towards the heroin and opioid crisis ("Heroin & Opioid Coordinating Council, Maryland Governor's Inter-Agency," 2018). The IAC is also responsible for the developing processes to improve the sharing of relevant data among the various state agencies and the Governor. Another responsibility is documenting the progress on the implementation of the Task Force's 33 recommendations. The IAC meets quarterly in an effort to increase inter-agency collaboration among other tasks. They also evaluate the practices of local responders.

Success: A major success if the creation of the Opioid Operational Command Center (OOCC) In January 2017 by executive order. This center was created within the council to increase coordination efforts and improve sharing of information. Initial findings from the OOCC led to Maryland's Governor declaring a State of Emergency. This allowed for the rapid coordination between state and local authorities as well as $50 million in funding over five years to support Maryland's efforts regarding heroin and opioid abuse.

Some responsibilities of the OOCC is to:

- Continue to implement the 33 recommendations from the Heroin and Opioid Task Force by developing operational strategies.
- Collect, analyze and disseminate relevant epidemiological data across thatstate.
- Develop a memorandum among state and local agencies that provides for the sharing and collection of related health and public safety information anddata.
- Assist local agencies with the creation of OITs that will share saiddata
- Coordinate the training and provide resources for state and local agencies to address theimpact of this crisis on public health, security and the economic well-being of the State ofMaryland.
- Instituting public information and awarenessprograms
- Authorizing the procurement of supplies and equipment necessary to control and eliminate the crisis.

Another success of the IAC is the creation of Opioid Intervention Teams (OITs). These are local jurisdiction multi-agency coordination bodies responsible for addressing the issue at a local level. Programs and initiative are tailored to the characteristics of the local community. These OITs have been successful in decreasing gaps in programming and increasing programs' abilities to address the opioidepidemic.

Some successful programs include Anne Arundel's Safe Station initiative which offers helps to county residents with substance abuse issues receive access to care and treatment. This is done in collaboration with Anne Arundel County and Annapolis City Fire Departments and the County State's Attorney's Office. Since August 2017 159 people have been assisted. Almost 60% have accepted treatment. Another program was implemented in Wicomico County. The Community Outreach Addiction Team (COAT)

program provides county residents with substance abuse disorders with the appropriate resources. Partners in COAT include the State Attorney's Office, Peninsula Regional Medical Center and the Sheriff's Department.

The IAC has also been instrumental in passing legislature related to the opioid epidemic. Effective March 2016, the Maryland Good Samaritan Law was expanded ("Maryland Code and Court Rules," 2018). People who provide assistance during an overdose are protected from arrest and prosecution for drug-related crimes. Starting July 2018 another successful piece of legislature will require prescribers of controlled dangerous substances to review patients who are prescribed opioids every 90 days (House Bill 437, 2016).

West Virginia

Name: Office of Drug Control Policy

Contact Information: Susie Mullens, Interim Director of Office of Drug Control Policy. Email: susie.l.mullens@wv.gov Phone: 304-590-5605

Location: West Virginia Department of Health and Human Resources

History: In 2017 under the general direction of the Cabinet Secretary and supervision of the State Health Officer, the West Virginia Drug Control Policy Act created the Office of Drug Control Policy (ODCP) within the Department of Health and Human Resources. The West Virginia Office of Drug Control Policy is relatively new and has had issues with staff turnover. They've had 2 acting directors one serving a 5-month term and the second director serving only 6 weeks. This has presented challenges for the office and the meeting of their goals.

Authority/Responsibility: The ODCP is designed to be in charge of prevention, treatment and reduction of substance abuse (Gupta, 2018). This includes making recommendations on policy and legislation based on the offices surveillance and research. The OCDP is responsible for controlling funding for all programs related to substance abuse and to establish the programs' objective. The office also works to establish a reporting system that will enhance the responsibility and information required to be reported by specific entities (Gupta, 2018).

Success: Due to challenges in maintaining long term leadership in the ODCP, success has been limited. However, the ODCP has been able to create an Opioid Response Plan which has laid out a strategy to combat the opioid epidemic in West Virginia. They have worked to pass legislation SB 272 and 273 to accomplish this. SB 272 works to improve the reporting of drug overdoses or instances, establish a

program for community response, and require that first responders carry an opioid antagonist ("SB 272 Text," 2018). SB 273 works to limit the dispensing of prescription opioids by setting rules on limiting initial prescriptions, ensuring the proper education of the patient, improved reporting, and improved ability to investigate abnormal prescribing ("SB 273 Text," 2018). They are currently working on obtaining a strategic planner from the West Virginia Army National Guard to start collaborating with their state military partners.

Louisiana

Name: Drug Policy Board

Contact Information: Dr. Chaunda Allen Mitchell, Director Email: chaunda.mitchell@la.gov Phone:(225)342-0424

Location: Executive Office of the Governor

History: The Drug Policy Board was created in 1990 through legislation to address substance abuse prevention, treatment and enforcement. The board supports prevention efforts, specifically the Louisiana Partnerships for Success. The State Epidemiology Workgroup and the Prevention Systems Committee were formed as subcommittees of the Drug Policy Board using the Strategic Prevention Framework-State Incentive Grant (Office of the Governor of Louisiana, 2018).

Authority/Responsibility: Identifies challenges and provides solutions to address substance abuse; to make recommendations to the governor and state agencies regarding programs, policies and practices that support and sustain prevention, treatment, and enforcement efforts (Office of the Governor of Louisiana, 2018).

Success: The Louisiana Drug Policy Board has developed a substance abuse prevention system and state infrastructure that supports communities addressing substance abuse locally. The state infrastructure developed will support the local efforts of high-need communities to address underage drinking and prescription drug misuse and abuse (Office of the Governor of Louisiana, 2018).

Ohio

In process of Creation

Florida

Name: Office of Drug Control Policy

Contact Information: N/A

Location: Executive Office of the Governor

History: Founded in 1999 and led the charge against substance abuse in Florida until the office was disbanded in 2011 to form the Drug Policy Advisory Council (Florida Department of Health, 2018).

Authority/Responsibility: N/A

Success: N/A

Florida

Name: Drug Policy Advisory Council

Contact Information: Rebecca R. Poston, BPharm, MHL**,** Staff Director, Statewide Drug Policy Advisory Council, Department of Health

Email:Rebecca.Poston@flhealth.gov

Phone:(850) 558-9950

Location: Florida Department of Health

History: Formed in 1999 with the Office of Drug Control. After the repeal of the Office, the Drug Policy Advisory Council (DPAC) took over as the lead in the fight against substance abuse in Florida. The membership of the DPAC includes nine high-level state officials and seven members of the public appointed by the Governor. Historically, the DPAC has been an active advisory group to the Governor (Florida Department of Health, 2018).

Authority/Responsibility: Make recommendations to the governor based on surveillance and research. Ensure that there is a coordinated, integrated, and multidisciplinary response to the substance abuse problem in the State. Assist communities and families in pooling their knowledge and experiences with respect to the problem of substance abuse (Florida Department of Health, 2018).

Success: The DPAC has worked to pass legislation such as SB 1050, which required the tracking of pseudoephedrine and ephedrine sales to reduce the production of illicit methamphetamines (Florida Department of Health, 2018). SB 2272 provides legal authority for the Department of Health to shut down pain clinics in violation of the law. Prohibits the dispensing of more than 72 hours of controlled substances to cash paying customers, restricts disciplined physicians and felons from owning pain clinics, and strengthens the Prescription Drug Monitoring Program by providing information to law enforcement

regarding potential “doctor shoppers” and medical professionals possibly colluding with patients to violate prescription drug laws (Florida Department of Health, 2018). SB 1068 enhanced the penalty of selling alcohol to minors (Florida Department of Health, 2018). SB 434 provides access to suicide prevention and educational resources for school personnel as part of their in-service training requirements. SB 366 makes it a first-degree misdemeanor for any person to sell smoking devices unless they have a retail tobacco products dealer permit, they derive at least 75 percent of their annual gross revenues from the retail sale of cigarettes, cigars, and other tobacco products or they derive no more than 25 percent of their annual gross revenues from the retail sale of items listed as “smoking pipes and smoking devices” (Florida Department of Health, 2018).

Alaska

Name: Alaska Opioid Policy Task Force (AOPTF)

Contact information: N/A

Location in the government: Department of Health and Social Services-Division of Public Health

History: The Alaska Opioid Policy Task Force was a group created on November 30, 2016 as a partnership between the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Trust Authority. These agencies co-facilitated this task force that would meet for one year to address the rising issue of heroin and opioid use in order to provide recommendations to the governor and legislatures. When creating the recommendations for the governor and legislatures, the group collected data through the National Survey on Drug Use and Health (NSDUH), the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), and the Central Peninsula Community Behavioral Needs Assessment. The group also hosted open town hall meetings across the State to hear from residents about their personal experiences (Alaska Opioid Task Force, “Heroin & Opioid Abuse Data”,2016).

Authority/Responsibilities: The Alaska Opioid Policy Task Force partnership was created as a one-year-in-duration working group to represent the public systems that are being affected by the issues surrounding the opioid crisis while simultaneously representing the diversity of the Alaska community. The task force’s primary responsibility was to create evidence-based recommendations that would serve as a guide for policymakers to address Alaska’s opioid crisis on all levels. Through assistance from federal and state agencies, the legislature, community organizations, and individuals, these partnerships and recommendations have helped to increase public awareness and understandings well as reduce the stigma associated with opioid dependence and overdose. In addition, these partnerships encourage

individuals and families to seek treatment and support, comfort those who have lost someone to an opioid overdose, increase access to naloxone, increase access to opioid use disorder treatment (including withdrawal management and medicated assisted treatment), and reinforce that recovery is possible (Butler, Ebbesson, & Jesse, 2016, p.1).

Success: The successes of the task force include the Mobilizing for Action through Planning and Partnership (MAPP), a statewide campaign that includes cultural considerations for addiction/recovery and how to address them through television and radio public service announcements and digital ads. The task force also succeeded in creating the Your Voice, Your Community Conference which facilitated discussion between small groups of Alaskan residents and the task force. Topics discussed included knowledge and perceptions of the epidemic, unique contributing factors to opioid misuse and addictions, concerns about the epidemic, and existing efforts to halt the epidemic in their communities. In addition, the Alaska Opioid Task Force was able to have several pieces of legislation passed in 2017 based on their recommendations. On February 16, 2017 Governor Walker issued Administrative Order 283, directing state departments to prioritize resources to combat the opioid epidemic and apply for federal grants to fund prevention, treatment and enforcement. On March 6, Governor Walker filed HB159/SB 79 to change how opioids are prescribed and monitored and was signed into law on July 25, 2017. On April 17, Governor Walker signed SB 91, life-saving naloxone bill, into law (Press Release: 17-118, 2017).

Massachusetts

Name: Massachusetts Governor's Opioid Addiction Working Group

Contact information: www.mass.gov/lists/governors-opioid-addiction-working-group

Location in the government: Governor's Office

History: The Massachusetts Governor's Opioid Addiction Working Group was appointed in 2015 to build upon and accelerate existing prevention, intervention, treatment, and recovery support strategies across the state. This working group was appointed to utilize bold new strategies to compose recommendations after the Opioid Task Force and Massachusetts Department of Public Health released their recommendations in 2014. (Massachusetts Governor's Opioid Working Group, 2015, p.1) In order to create the 65 actionable recommendations, the group hosted four listening sessions across the state and held 11 in-person meetings. The working group also received and examined documents and recommendations from more than 150 organizations and heard from more than 1,100 individuals. Most importantly, the group reviewed academic research, government reports, and reports of previous task

forces and commissions to create their final recommendations (Massachusetts Governor's Opioid Working Group, 2015, p.2).

Authority/Responsibilities: The Massachusetts Governor's Opioid Addiction Working Group's objective is to report findings and make recommendations to the governor on what legislation to propose that will address the opioid epidemic in the Commonwealth. The group holds many responsibilities such as the task of making recommendations that would create new pathways to treatment, increase access to medicated assisted treatment (MAT)for making recommendations that acknowledge addiction as a chronic medical condition, reduce the stigma of substance use disorders, and support substance use prevention education in schools. The group's additional responsibilities when making these recommendations included: requiring all practitioners to receive training about addiction/safe prescribing practices, improve the prescription monitoring program, require manufacturers and pharmacies to disposed of unused prescription medication, increase distribution of naloxone to prevent overdose deaths, and to eliminate insurance barriers to treatment (Massachusetts Governor's Opioid Working Group, 2015, p.6-7).

Success: The successes of the Massachusetts Working Group on Opioids posted their most recent updates on their successes as of November 14, 2017. Since their appointment in 2015, the Massachusetts Working Group on Opioids has certified 162 sober homes, totaling 2,168 beds and added 680 substance abuse disorder and psychiatric treatment beds (GWGO, "Governor's Working Group on Opioids Update-Action Items", 2017, p. 1). In 2016, Governor Charlie Baker signed the first bill in the country, HB 4056, better known as the STEP Act that was relative to substance use, treatment, education, and prevention. This bill established a 7-day limit on first-time opioid prescriptions that required practitioners to check the prescription monitoring program before prescribing opioids, as well as increased prescriber education requirements at Universities across the state. The HB 4056 also required student prevention education training during concussion safety training for athletes, expanded Good Samaritan protections by shielding individuals administering naloxone to a person during opiate overdose from civil liability, and required that a substance use disorder evaluation be conducted for individuals presenting in the emergency room due to an apparent opioid overdose (GWGO, "Governor's Working Group on Opioids Update-Action Items", 2017, p. 23).

The Massachusetts Working Group on Opioids has also helped generate billions of dollars in grant funding to increase access to resources for opioid recovery. In the fiscal year 2018 budget the state of Massachusetts appropriated $185.3 million for substance use treatment, prevention, intervention, and

recovery efforts (GWGO, "Governor's Working Group on Opioids Update-Action Items", 2017, p. 23). Through the MassHealth 1115 Demonstration Waiver, over $150 million will be invested in expanding the substance use treatment system over the next 5 years. The state will receive up to $21 million per year over a 5-year period for the expansion of residential treatment capacity that will create 500 new beds. The state will also receive up to $14 million per year over a 5-year period that will expand access to medication assisted treatment and $8 million per year over a 5-year period for coverage of additional recovery support services. There will also be $4 million per year over a 5-year period that will go towards the implementation of standardizing the American Society of Addiction Medicine care-planning tool with substance use disorder providers (GWGO, "Governor's Working Group on Opioids Update-Action Items", 2017, p. 3). In August 2017 the state was granted $500,000 in Medicated Assisted Treatment Re-entry Initiative (MATRI) funding that would increase access to MAT as well as provide case management services to facilitate successful transition for individuals from a correctional services environment back into their communities (GWGO, "Governor's Working Group on Opioids Update-Action Items", 2017, p. 19).

California

Name: Statewide Opioid Safety Workgroup (SOS Workgroup)

Contact information: Steve Wirtz—steve.wirtz@cdph.ca.gov

Location in the government: California Department of Public Health

History: The state of California found that heroin related overdoses had increased 57% from 2012 to in 2016. The CDPH recognized that the opioid epidemic is a complex issue that cannot be solved by the actions of a single organization, industry, institution, or group. It was also acknowledged that today's patients with chronic, non-cancerous pain, are increasingly being treatment with prescription opioids despite the serious risks and lack of evidence about the long-term effectiveness of opioids for chronic pain. The state of California decided to utilize a multi-sector, strategic collaboration at both state and local levels to address the epidemic by appointing the Statewide Opioid Safety Workgroup in Spring 2014 (CDPH, "Statewide Opioid Safety Workgroup", 2017). The workgroup, and its supporting taskforces, provide a platform for both state and local entities addressing opioid overdoses and addiction to improve coordination and expand joint efforts. The State Health Officer/Director of the CDPH, in partnership with over 40 state-level and non-government stakeholders launched the SOS Workgroup (CDPH & Safe and Active Communities, 2018, p. 2).

Authority/Responsibilities: In 2015, the CDC granted the California Department of Public Health (CDPH) with a four-year grant to implement a comprehensive program to address opioid misuse and abuse. Thus, the SOS and CDPH birthed the Prescription Drug Overdose Prevention Initiative that was created to focus on 3 areas of intervention. Firstly, the promotion and increased use of the Controlled Utilization Review and Evaluation System (CURES), which tracks and monitors all opioid prescriptions within the state of California. Secondly, the engagements of health insurance plans and healthcare systems to implement safe prescribing policies, expand MAT, promote increased use of naloxone, and conduct physician and pharmacist educational outreach. And thirdly, increasing local health departments and community coalition capacity building through the distribution of local prescribing and health consequences data, increasing outreach and education, and other community-based interventions (CDPH, "Statewide Opioid Safety Workgroup", 2017).

Successes: Since the creation of the SOS Workgroup in 2014, the CDPH has funded 25 local opioid safety coalitions statewide as well as increased access to naloxone and drug-take-back services (CDPH & Safe and Active Communities, 2018, p. 2). On the legislative level, there have been 3 bills that have been passed. Senate bill 809; Chapter 400: Controlled Substances Reporting was passed allocating $1,500,000 General Fund dollars that will be ongoing annually for the Prescription Drug Management Program CURES. The system is housed and managed by the Department of Justice and supports prescription tracking to identify patients that may be at risk for overdosing. Senate bill 833; Chapter 708 (2016) was also passed to mandate all prescribers of controlled substances to register with and consult CURES 2.0 prior to prescribing schedule II-IV drugs to individuals for the first time and at least every few months. Senate bill 833; Chapter 30 was passed and established a one-time naloxone grant program and allocated $3,000,000 in General Funds for the period of 2017 to 2019 for statewide distribution of naloxone to local health jurisdictions for distribution throughout their respective communities (CDPH & Safe and Active Communities, 2018, p. 4).

In addition, through these multi-sector efforts it has resulted not only in legislation being passed but the state has received an abundance of grant funding that supports the states' efforts to address the opioid epidemic. Through the Center for Disease Control (CDC), the state has received a prescription drug opioid prevention initiative grant of $8,084,091 for the time period of 2017-2019. The state also received an enhanced drug overdose surveillance grant from the CDC of $1,570,648 for the time period of 2017-2019. The Department of Justice awarded the state with the Harold Rogers Grant that granted the state $750,000 from the period of October 1, 2015 to September 30, 2018 to upgrade CURES. The Substance

Abuse and Mental Health Services Administration (SAMHSA) awarded the state with the strategic prevention framework partnership for success grant which will give the state $1.2 million per year over a 5-year period to support 6 local counties through education, outreach, and prevention activities targeting youth. In addition, SAMHSA also awarded the state with the state targeted response to opioid crisis grant which will give the state $44,749,771 per year for a 2-year period to establish a California Hub and Spoke System for better access to MAT (CDPH & Safe and Active Communities, 2018, p. 4).

Conclusion

State Drug Control Policy Offices are generally responsible for the development of drug policy for their state. Some offices have been in existence for over 30 years while other were developed as late at 2017. Many of the agencies were developed as the Single State Authority on substance use issues and work to directly address the populations affected by the opioid epidemic. The location of the office/position in the government varies by state. It is common for these offices to allocate or supervise the allocation of grants and other funding to the various efforts in drug prevention. Many of these offices are also responsible for proposing new laws and bills for legislative consideration and lobbying. Surveillance is another responsibility of many of these offices/agencies and includes monitoring arrests, deaths, hospitalizations, etc. related to substance abuse. Some of the offices/agencies are currently working to bring the different factions involved in drug prevention together to minimize duplication of efforts and resources and maximize effectiveness. Many of these offices also law enforcement. Overall, most of the success has come from the ability of the offices to form strategic plans and to then pass legislation to support the plan.

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