final minutes

Opioid Advisory Commission (OAC) Meeting
10:00 a.m. • January 11, 2024
Legislative Conference Room • 3rd Floor Boji Tower Building
124 W. Allegan Street • Lansing, MI

Members Present:	**Members Excused:**
Sheriff Daniel Abbott	**Brad Casemore**
Judge Linda Davis	**Scott Masi**
Katharine Hude	**Dr. Cara Poland**
Mona Makki	**Dr. Sarah Stoddard**
Mario Nanos	
Patrick Patterson	
Kyle Rambo	

Mr. Patrick Patterson served as Chair in Dr. Poland's absence.

Ms. Tara King serving as Program Coordinator to the Commission was in attendance.

Ms. Jennifer Dettloff serving as ex-officio to the Commission was in attendance.

I. Call to Order

The Chair called the meeting to order at 10:01 a.m.

II. Roll Call

The Chair asked the clerk to take roll. The clerk reported a quorum was present. The Chair asked for absent members to be excused.

III. Approval of the November 16, 2023 Meeting Minutes

The Chair directed attention to the proposed minutes of the November 16, 2023, meeting and asked if there were any changes. **The Chair asked for a motion to approve a proposed change in the November 16, 2023 meeting minutes to reflect change to add "OAC efforts" at the end of Mr. Gladstone's workgroup update. Judge Davis moved, supported by Ms. Hude.** No other changes were discussed. **Judge Davis moved to approve the November 16, 2023 amended meeting minutes, supported by Ms. Hude to approve the minutes of the November 16, 2023, meeting to include a change to add "OAC efforts" at the end of Mr. Gladstone's workgroup update. There was no further discussion and the Chair asked for a roll call vote. The motion failed and the meeting minutes were not approved.**

IV. Approval of the December 14, 2023 Meeting Minutes

The Chair directed attention to the proposed minutes of the December 14, 2023, meeting and asked if there were any changes. **Judge Davis moved, supported by Ms. Hude to approve the minutes of the December 14, 2023 meeting minutes. There was no further discussion and the Chair asked for a roll call vote. The motion prevailed and the minutes were approved.**

V. Public Comment

The Chair asked if there were any comments from the public.

Ms. Hude introduced Leah Doemer, a student from Michigan State University participating in the Michigan Government Semester Program Intern. The Commission welcomed Ms. Doemer.

Ashley Shukait representing the Michigan Drug Users Health Alliance referenced materials submitted to the Commission.

Yashica Ellis representing Wellness Services expressed support and advocated for findings from the Michigan Drug Users Health Alliance referenced materials.

Cornelius Williams representing Curebase Safety and a member of the Racial Equity Workgroup an advisory group to the Opioids Taskforce expressed support and advocated for findings from the Michigan Drug Users Health Alliance referenced materials.

Judge Davis expressed appreciation and support for the Michigan Drug Users Health Alliance referenced materials.

VI. Community Engagement and Planning Collaborative (CEPC) Updates

The Chair directed attention to Ms. King to open discussion around CEPC updates.

Ms. King directed attention to Mr. Dominick Gladstone for an update of the Community Engagement & Planning Committee.

Mr. Gladstone reported the CEPC is awaiting the Commission's Annual Report expressing the group would like to be able to share input in reference to the Commission's Annual Report.

Ms. King directed attention to Ms. Amy Dolinky for an update of the Health Equity Subcommittee

Ms. Dolinky's reported the subcommittee continues to develop a workplan and continuing its research on what data and resources are available.

VII. Key Activities of the Opioid Advisory Commission (OAC)

The Chair directed attention to Ms. King to open discussion around key items and activities.

- General Updates
- 2024 Annual Report – Planning and Development
    - *Full Review*
    - *Action Steps*
    - *Target Dates*
- Community Voices
    - November 2023 Data Snapshot
    - Regional Updates

The Commission recessed for break at 11:35 a.m.

The Chair called the meeting to order at 11:44 a.m. The Chair asked the clerk to take roll. The clerk reported a quorum was present. The Chair asked for absent members to be excused.

Members Present:	**Members Excused:**
Sheriff Daniel Abbott	**Brad Casemore**
Judge Linda Davis	**Scott Masi**
Katharine Hude	**Dr. Cara Poland**
Mona Makki	**Dr. Sarah Stoddard**
Mario Nanos	
Patrick Patterson	
Kyle Rambo	

The Chair directed attention to Ms. King to continue discussion.

VIII. Workgroup Member Comment

The Chair asked if there were any comments from members of the Community Engagement & Planning Collaborative.

Mr. Gladstone expressed a need for cohesiveness with the Commission, the workgroup and fitting into the state calendar to stay proactive on all activities to include the state budget process and the survey process.

IX. Commission Member Comment

The Chair asked if there were any comments from members of the Commission.

There was none.

X. Next Meeting Date: Thursday, February 8, 2024

The Chair announced the next meeting date for February 8, 2024 at 10:00 a.m.

The Chair reminded Commission members a majority of seven (7) Commission members in attendance is required to conduct Commission business and instructed Commission members to let the clerk know if availability has changed.

XI. Adjournment

There being no further business before the Commission the Chair adjourned the meeting at 11:49 a.m. with unanimous support.

MICHIGAN COMMUNITY OVERDOSE SURVEY RESULTS

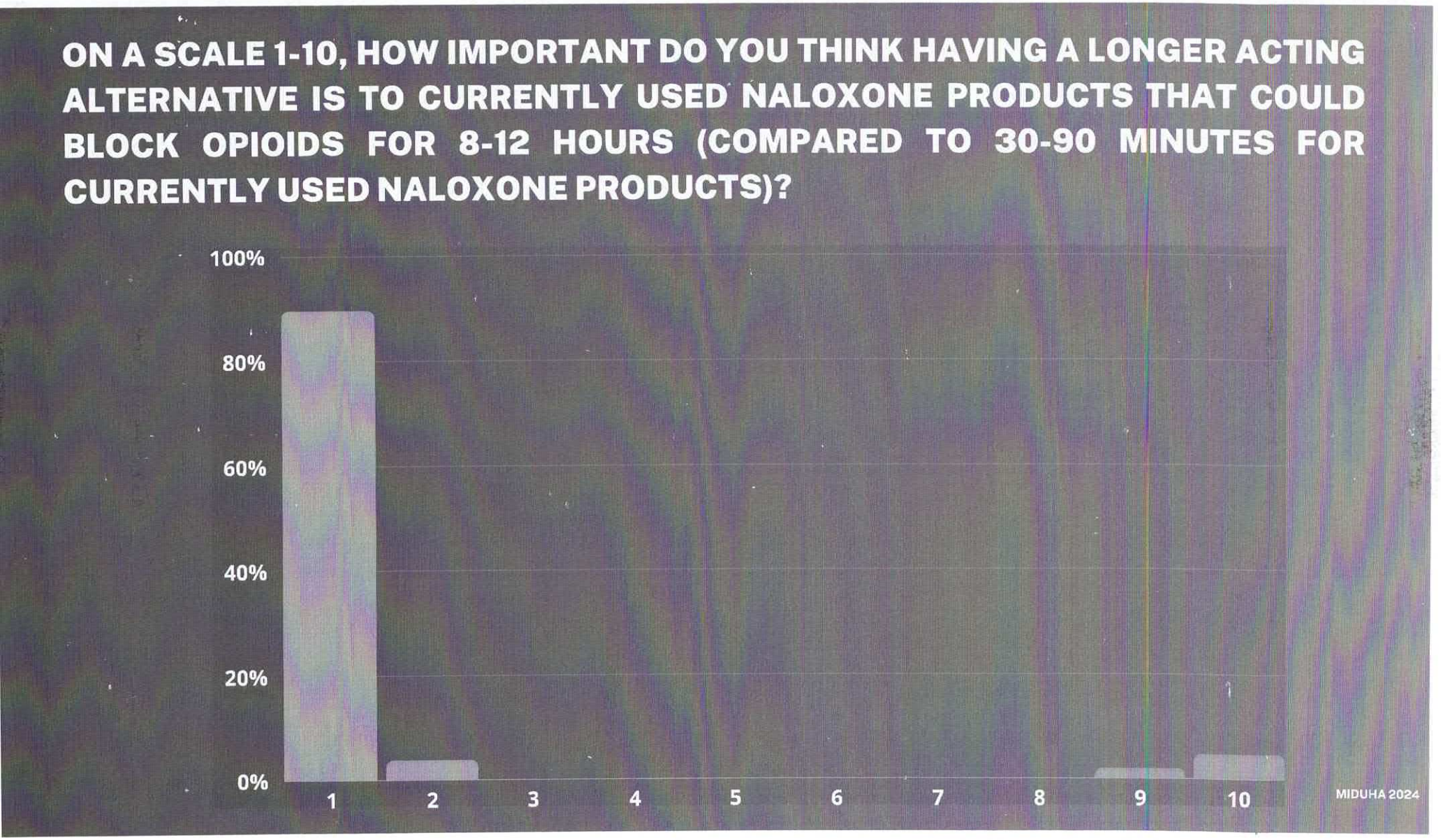
1/8/2024

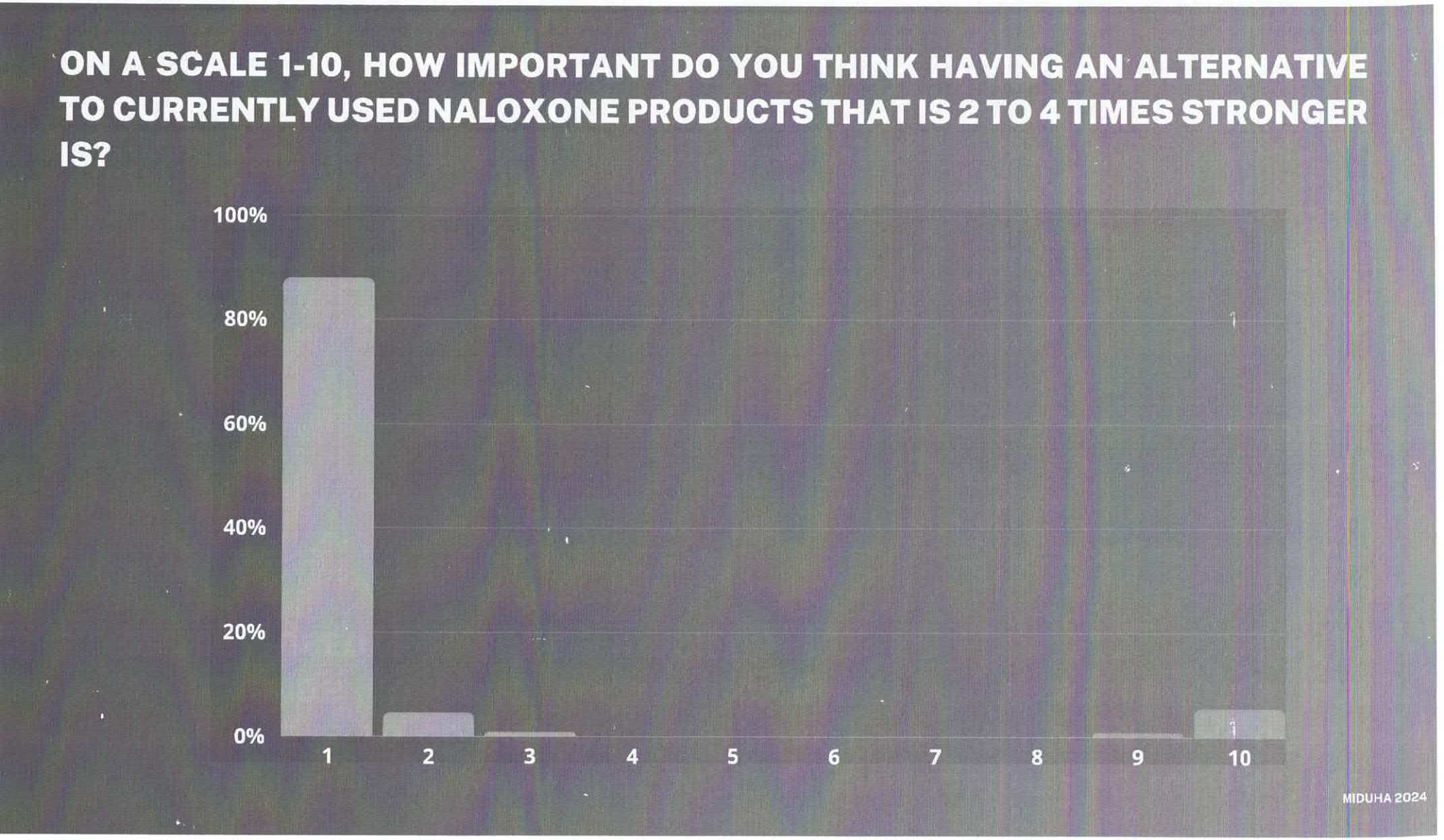
OVERVIEW

SSPs across Michigan wanted to ensure people who use drugs (PWUD) and those reversing overdoses have their voices centered.

- Surveys distributed online and in person over three weeks
- Anonymous and confidential
- The background gave information on naloxone and nalmefene
- 108 people took the survey

MIDUHA 2024

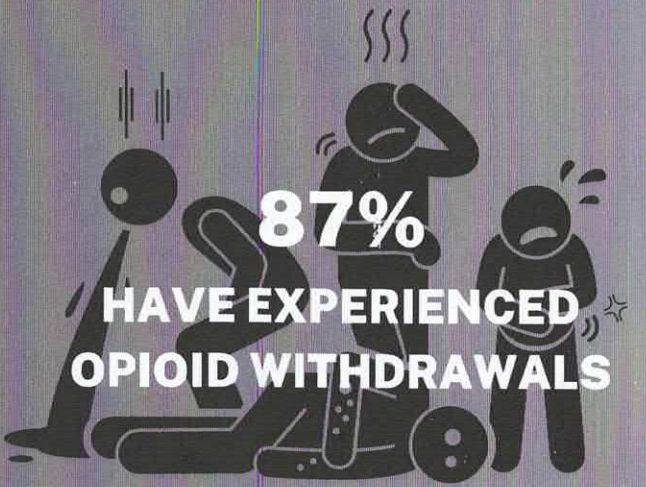

ON A SCALE 1-10, HOW IMPORTANT DO YOU THINK HAVING A LONGER ACTING ALTERNATIVE IS TO CURRENTLY USED NALOXONE PRODUCTS THAT COULD BLOCK OPIOIDS FOR 8-12 HOURS (COMPARED TO 30-90 MINUTES FOR CURRENTLY USED NALOXONE PRODUCTS)?
100%
80%
60%
40%
20%
0%
1
2
3
4
5
6
7
8
9
10
MIDUHA 2024


ON A SCALE 1-10, HOW IMPORTANT DO YOU THINK HAVING AN ALTERNATIVE TO CURRENTLY USED NALOXONE PRODUCTS THAT IS 2 TO 4 TIMES STRONGER IS?
100%
80%
60%
40%
20%
0%
1
2
3
4
5
6
7
8
9
10
MIDUHA 2024

SURVEY PARTIPANTS LIVING & LIVED EXPERIENCE WITH OVERDOSES INCLUDE:

90.7%
REVERSED A SUSPECTED OPIOID OVERDOSE USING NALOXONE

88%
HAVE PERSONALLY SURVIVED AN OPIOID OVERDOSE



87%
HAVE EXPERIENCED OPIOID WITHDRAWALS

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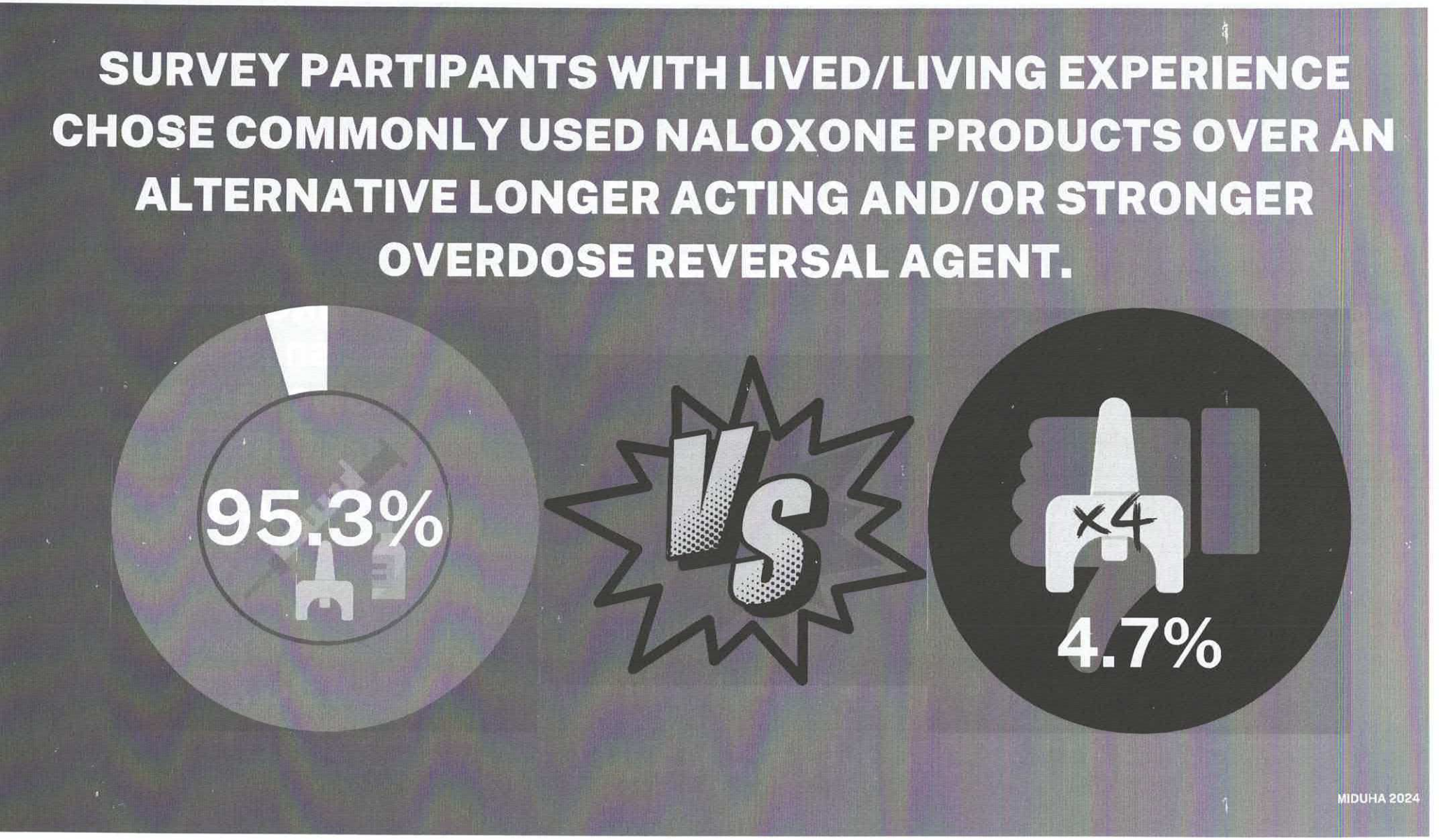
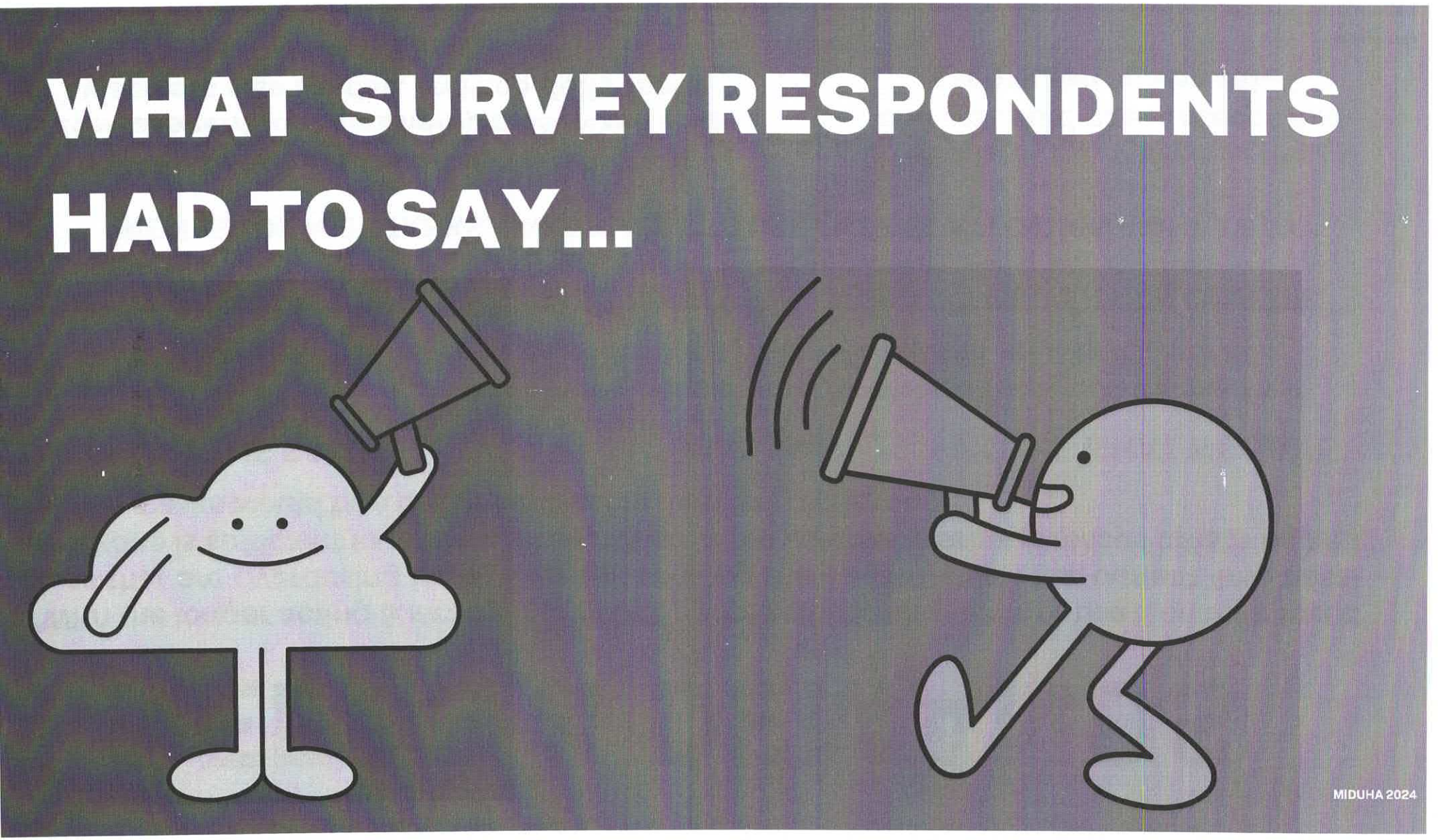

SURVEY PARTIPANTS WITH LIVED/LIVING EXPERIENCE CHOSE COMMONLY USED NALOXONE PRODUCTS OVER AN ALTERNATIVE LONGER ACTING AND/OR STRONGER OVERDOSE REVERSAL AGENT.
95.3%
Vs
x4
4.7%
MIDUHA 2024


WHAT SURVEY RESPONDENTS HAD TO SAY...
MIDUHA 2024

NEEDS & DEMANDS

"With the longer acting & stronger product, people will be less likely to use it on their loved ones that are overdosing because it will prolong their withdrawal. The current 4mg nasal Naloxone is sufficient to reverse an overdose. More education around rescue breathing and rescue masks would be a better alternative than 8mg Naloxone."

"KEEP IT THE SAME"

"LIKE WHAT WE HAVE"

"We need oxygen that we can carry around when reversing ODs. We need supervised consumption sites so people get taken care of immediately and not found hours later."

"NALOXONE WORKS- WE NEED A SAFE SUPPLY AND OVERDOSE PREVENTION CENTERS."

"WE NEED OXYGEN TANKS, SAFE PLACES TO USE AND GET ATTENTION RIGHT AWAY."

"This is greatly appreciated and needed, but a reversal agent for Xylazine/opiates mixed w 🏚 Xylazine is also needed, and hopefully there will be one in the near future."

"How about not make use illegal and we could use in places and get oxygen and be safe"

MIDUHA 2024

TORTURE

"Stop torturing users, keep cops out of overdose responses."

"I'D RATHER DIE THAN GO THROUGH WITHDRAWALS FOR THAT LONG."

"I think it's dangerous to throw people with OUD into an 8-10 hour precipitated withdrawal. I think Opvee is dangerous, unnecessary, and will quite literally lead to suicides and more overdoses."

"PEOPLE ARE REOVERDOSING BECAUSE THEY ARE TRYING TO STOP WITHDRAWALS FROM REGULAR NARCAN, DO THEY NOT SEE PEOPLE USING MORE TO STOP THESE WITHDRAWALS?"

"PEOPLE ARE GOING TO HAVE HEART ATTACKS, COMMIT SUICIDE, OR USE SO MUCH THEY OVERDOSE AND DIE."

"THEY ENJOY HURTING US"

"I got edema in my lungs from narcanned too much by police-how is this ok?"

"just because you kept us alive doesnt mean torture is okay"

MIDUHA 2024

CRUELITY

"Between my partner and I, we've probably reversed upwards of 100 overdoses. If you're doing rescue breaths (as you should), you shouldn't need more than a single dose of naloxone to revive someone. Neither of us have personally seen someone re-overdose after the naloxone has worn off—though I believe it's possible I think the risk is exaggerated. I've personally been in precipitated withdrawal and I can't imagine having to be in that hell for 10+ hours. I honestly believe we'll see people unalive themselves by suicide if forced into PW for that long—or they'll be so desperate to stop the PW that they'll do enough dope to override the antagonist and die by overdose despite the long acting antagonist in their system."

"What if I have a heart attack and it's their fault for giving medicine that isn't needed?"

"why do they hate us so much?"

"WHY BE SO CRUEL?"

MIDUHA 2024

PUNISHMENT

"I have been reversed so many times and each time the cops have given me narcan they slammed it up my nose to bust it, gave me a ton and would laugh as i vomit and shit myself saying it would teach me a lesson. this has been in so many areas throughout the state it wasnt just 1 bad actor. They will use higher dose to make it a game and kill us."

"we dont need something else making our hearts race more from the girl even if fent is in it"

"I get that naloxone wears off quicker than fentanyl, but I don't think it makes sense to put a ton of resources into a much stronger and longer lasting alternative because the dope sick that comes from it is much worse. The benefit is good, the harm is not great. It would be cool if it was easy to access but naloxone is very effective already so I don't see that much of a need."

"NOONE WILL EVER CALL 911 AGAIN ONCE THEY GET HIT WITH A DOSE NARCAN OR SOMETHING ELSE TO MAKE THEM NOT BE WITHOUT PAIN FOR THAT LONG."

MIDUHA 2024

ACCOUNTABILITY

"Why did the government of Michigan allow Oakland county to make us guinea pigs for Opvee? Why do the cops get to play doctors?"

"None of these people promoting this have overdosed themselves and been opioid dependent and it shows."

"Michigan doesn't listen to us who use drugs they'd rather us suffer so they feel good bout themselves"

"YOU KNOW IT'S A PROBLEM WHEN POLICE ARE PUSHING FOR IT AND YET YOU DON'T SEE DOCTORS PUSHING FOR IT AT HOSPITALS"

"Who let these clowns decide what is best for us without talking to us first to see what we neeed?"

MIDUHA 2024

FRUSTRATION

"All I hear when a cop is giving Opvee is them bust a nut because they get off making us sick."

"Fuck Oakland County Police and Opvee."

"Just like pharma, sell more products that we didn't ask for."

"BIG PHARMA PLAYING ON PEOPLE'S FEARS - DIDN'T MICHIGAN SUE THIS COMPANY BECAUSE OF THEIR MARKETING?"

"if these orgs are giving out this, they need to have their asses lit publicly how they don't listen to what we have to say."

MIDUHA 2024

DISAPPROVAL

"Hard no. This shouldn't be allowed"

"Ban this now!"

"Longer acting products is a terrible idea"

"Wtf"

"NO!!"

"This should be illegal I thought it was a joke."

"Don't do it please"

"This new idea is stupid and it's gonna harm and kill us"

"NEW NARCAN IS STUPID"

"I personally have been apart of hundreds of reversals as boots on the ground. And it is bad enough. If I need to hit somebody 3 times, It is a bad bad bad od."

MIDUHA 2024


MIDUHA
EST
2023
MICHIGAN DRUG USERS HEALTH ALLIANCE
THANKS FOR WATCHING
NO FINANCIAL DISCLOSURES, NO FUNDS PAID FOR THIS SURVEY!
For more details, check out MIDHUA's under construction website!

OAC Final Meeting Minutes
January 11, 2024

BLOG / 01-09-24

Engaging with People with Lived Experience in Opioid Settlement Decision-Making

by Rebekah Falkner (https://nashp.org/author/rfalkner/)

As states administer opioid settlement funds, they are seeking ways to engage people who have been affected by the opioid epidemic in decision-making, policy development, and program implementation. In many states, legislation or memoranda of agreement creating administrative structures for distributing settlement funds require representation of people with lived experience* on advisory boards and other decision-making bodies.

As of June 2023, 17 states require representation (https://kffhealthnews.org/news/article/opioid-settlement-funds-state-council-members-database/#methodology) of people with lived experience in their opioid settlement decision-making and/or advisory groups. According to analysis by the Kaiser Family Foundation, Shatterproof, and Johns Hopkins University, approximately 7 percent of state advisory council membership (https://kffhealthnews.org/news/article/opioid-settlement-funds-state-council-members-database/) for opioid settlements is currently filled by people citing their lived experience.

Effective collaboration with people with lived experience, particularly from racial and ethnic groups that have borne disproportionate harms from the opioid epidemic, can lead to the development of services that more closely meet the needs of those impacted. State officials working in behavioral health have a long history of engaging people with lived experience — particularly groups that have experienced stigma in prior interactions with policymakers or the health care system — and lessons can be taken from those experiences.

Despite examples of successful approaches to engaging people with lived experience, stigma and other systemic barriers can often complicate efforts to engage these individuals in the policy process. Based on interviews with experts and state officials, this resource summarizes strategies that states have adopted for engaging with people with lived experience in opioid settlement decision-making, as well as some lessons learned and pitfalls to avoid.

Empower Leaders with Lived Experience

Establishing state requirements to ensure people with lived experience are included in decision-making bodies or appointing people with lived experience into leadership positions can effectively elevate the voices of people with lived experience.

Through its Governor's Overdose Prevention and Intervention Task Force (https://preventoverdoseri.org/the-task-force/), Rhode Island ensures that people affected by the task force's work have an active voice in decision-making. In November 2022, Governor Dan McKee signed an Executive Order, "Expansion of the Governor's Overdose Task Force (https://governor.ri.gov/executive-orders/executive-order-22-35)," adding a community co-chair to join the state agency leadership team and hiring a task force director, who is a person with lived experience. The co-chairs and director are responsible for ensuring strategic alignment, community engagement, and providing recommendations to the Opioid Settlement Advisory Committee through community engagement by including people with lived experience in overdose prevention and intervention decision-making.

The task force and community members have developed a community engagement process that provides recommendations to the Opioid Settlement Advisory Committee. Moreover, state leadership remains committed to including the expertise of people with lived experience by uplifting community voices in its decision-making processes, particularly by employing and appointing people with lived experience in its overdose prevention work.

In North Dakota, First Lady Kathryn Burgum is a powerful advocate for recovery, often taking opportunities to weave narratives of her long-term recovery into press conferences and larger conversations with the public. By candidly speaking about her experience, and offering others the space to do the same, she uses her platform to help confront stigma and normalize conversations around addiction. Through her role as Advisory Council chair, Bergum helps to elevate the work of the state's Office of Recovery Reinvented (https://recoveryreinvented.com/), which aims to end the shame and stigma surrounding the disease of addiction in North Dakota.

Engage People with Lived Experience at All Levels of the Process

A key strategy emphasized by state leaders is the need to engage individuals at every point in the policy process, from ideation to implementation and evaluation. Input and engagement processes perceived as a one-time endeavor without further feedback or policy action can result in degradation of trust.

To help foster ongoing dialogue, officials can institute processes for bi-directional feedback and transparency throughout the policy process, including evaluation of outcomes. Continuing to invest and build long-term relationships with organizations that represent or serve people with lived experience can also help shape and refine approaches that better meet the unique needs of communities. For example, in establishing Maryland's Center for Harm Reduction Services, Maryland took a "bottom up" approach, first engaging the perspectives of local health departments delivering harm-reducing services and allowing local communities to apply for syringe service programs based on identified community needs.

Two syringe exchange programs funded across the state provide a foundation for ongoing communication, with grant funding processes and a quarterly advisory meeting providing an ongoing opportunity to hear about emerging challenges and to gather feedback on program implementation and challenges. Responsiveness to community concerns creates a "virtuous cycle," whereby people affected by policy decisions are more likely to see engagement as genuine and to participate in the process.

Address Barriers to Participation by Paying Participants for Their Time and Efforts

Many advisory committees currently rely on volunteers, which can pose barriers to participation from many people with lived experience. Time away from jobs or family care, for example, is not financially feasible for many. Paying individuals for their time, travel, and work allows for engagement with a broader segment of the population. States have pursued several different funding strategies for providing compensation for participation in policy-making bodies. For example, in 2022 the Washington Legislature passed legislation allowing for compensation to be paid to individuals with lived experience, which includes stipends, child and adult care reimbursement, and lodging and travel expenses. In Rhode Island, members of the community who sit on the Governor's Overdose Prevention and Intervention Task Force receive stipends of $4,090 annually, administered through the organizations who they represent.

Listen First

Cultural humility (https://www.cdc.gov/globalhealth/equity/guide/cultural-humility.html) is a key element in successful engagement with people with lived experience. In North Dakota, officials prioritize listening to people with lived experience before embarking on decision-making processes, and the state cannot make allocation decisions prior to listening sessions. These listening sessions have been targeted, focusing on mothers who have lost children and other specific populations, such as people who are currently incarcerated or in treatment centers.

Washington's state officials are also thoughtful in how they engage people with lived experience, acknowledging that government has a history of engaging individuals with lived experience, particularly in historically marginalized communities. They note that avoiding perceptions of tokenism — the practice of making only a perfunctory or symbolic effort to be inclusive to members of minority groups — has been a historical challenge they are actively working to address. They are doing so by prioritizing meaningful engagement with community-based organizations and incorporating input into recommendations and policies.

Pitfalls to Avoid

State officials and people with lived experience both expressed a desire to avoid "checking the box" when including those who have been affected by the opioid epidemic in decision-making. State officials with experience in engaging people with lived experience in policymaking, or who have lived experience themselves, share their insights on common pitfalls and challenges:

lived experience" is not monolith, so input from people with lived experience may be rejected because they present issues that officials previously deemed out of scope or because they lack professional certifications. Consider that people's encounters with services and issues, level of professional experience, and perspectives may differ from state officials' expectations and consider strategies for training internal staff on principals and strategies for culturally informed engagement.

- Consider if your organization is ready to have people with lived experience in decision-making positions. This readiness requires intentional planning, and if organizational culture is not ready to act on input from people with lived experience, conflicts and further deterioration of relationships may occur.
- Superficial engagement, such as "including youth in youth decision-making" by inviting an adolescent to meetings but not soliciting their input, can be viewed as tokenizing. To mitigate situations like this, require the inclusion of people with lived experience in legislation or consider other options to promote sustainability of engagement efforts. Be conscious to include people with "living" experience and the voices of anyone who has been touched by addiction.
- Pay attention to power dynamics and framing. Government entities inherently have more power than individual citizens, so consider procedures, meeting formats, and other methods to foster inclusivity and an environment where participants both feel comfortable providing input and that their input will have an effect on the outcomes. Engaging people in their own communities, rather than expecting them to come to you, can be an important gesture that mitigates some of these power dynamics.

Resources for Working with People with Lived Experience

Several organizations have in-depth resources and frameworks for working with people with lived experience. In general, these resources offer pathways to better adapt internal processes, communication practices, and meeting facilitation strategies to meet the needs of all participants.

The Office of the Assistant Secretary for Planning and Evaluation's (ASPE) Engaging People with Lived Experience to Improve Federal Research, Policy, and Practice (https://aspe.hhs.gov/lived-experience#:~:text=In%20the%20context%20of%20ASPE's,policies%2C%20practices%2C%20and%20pr resource includes materials ASPE has prepared as it leads work on how federal agencies and programs can meaningfully and effectively engage people with lived experience, which can offer state officials guidelines for tailoring their own efforts.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Participation Guidelines for Individuals with Lived Experience and Family (https://www.samhsa.gov/grants/how-to-apply/forms-and-resources/guidelines-lived-experience)

SAMHSA provides these guidelines to encourage organizations to involve individuals with lived experience of mental and/or substance use disorders and families in grant proposal development, implementation, and review, which offers a framework for state officials to build into their own processes, from mission to evaluation.

The World Health Organization's resource, Meaningful engagement of people with lived experience of noncommunicable diseases and mental health and neurological conditions (https://www.who.int/groups/gcm/meaningful-engagement-of-people-with-lived-experience)

This resource offers an array of considerations for including people with lived experience, such as financing strategies, power dynamics, eliminating stigma, and capacity-building.

* The term "people with lived experience" is a broad term used to refer to people who are directly affected by the opioid crisis or strategies that aim to address it and may encompass a broad range of life paths or views. People with lived experience may include individuals who use opioids or other drugs, those who are receiving services for opioid use disorder, those who are in recovery from opioid use disorder, or others directly impacted by opioid or drug use.

Acknowledgements

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(https://nashp.org/author/rfalkner/)

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Policy Areas: (https://nashp.org/engaging-with-people-with-lived-experience-in-opioid-settlement-decision-making/) Behavioral Health (https://nashp.org/policys/behavioral-health/)

Topic: (https://nashp.org/engaging-with-people-with-lived-experience-in-opioid-settlement-decision-making/) Opioid Use Disorder (https://nashp.org/topics/opioid-use-disorder/)

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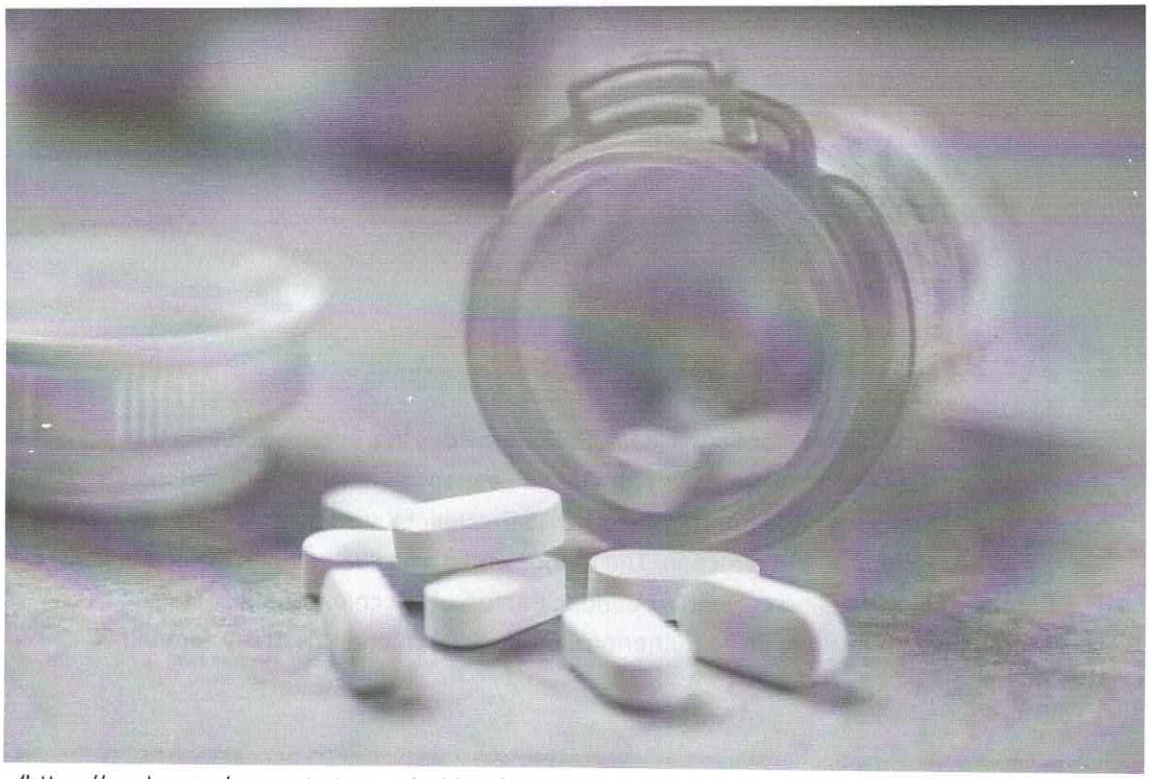

(https://nashp.org/current-state-priorities-for-opioid-settlements-and-beyond-emerging-themes-from-the-nashpconf23-opioid-preconference/)

BLOG / 10-20-23

Current State Priorities for Opioid Settlements and Beyond: Emerging Themes from the #NASHPCONF23 Opioid Preconference (https://nashp.org/current-state-priorities-for-opioid-settlements-and-beyond-emerging-themes-from-the-nashpconf23-opioid-preconference/)

Good afternoon.

My name is Tiffany Morelli and I'm an ER Nurse at Corewell East Beaumont Troy's Emergency Center. I've been here almost twelve years. Three years ago, I started a program here, along with Royal Oak Beaumont, through a grant we received through Community Foundations of Southeast Michigan. We have been successfully identifying, treating, and connecting patients with community resources. We even follow patients after discharge in the ER, which isn't common practice for an emergency center. The benefits to having the program in an ER is it is also open 24/7. We work with numerous community organizations, depending on what the patient, and/or their family, may need.

At Troy our team consists of two full-time RN's, one emergency physician, and one physician assistant. We utilize the social workers in the emergency department as well. As we near the end of our funding, we are looking for a way to sustain our program for the next couple years as we work to make our program self-sustaining itself. We provide free take home Narcan Kits at the bedside, as well as all of our ER physicians are waivered and provide MAT treatment. We work with pediatrics as well as adults. We also cover other substances along with opioids. We make sure to utilize the community resources for Peer Recovery Coaches, Family Recovery Coaches, MAT, inpatient and outpatient treatment.

We have been able to collect our data over the last three years on all our patients that came in suffering from OUD/SUD. During the formation of our program, I was on many different committees and organizations with other hospital systems, under the guidance from CFSEM. We had the privilege of working with Dr. King and Dr. Rademacher during the process. It was such a privilege to work with these individuals and they listened to me and took advice from me, which meant so a lot. The number of people and families we have been able to help and impact through our efforts is substantial and inspiring. We are truly making a difference! I will forever be grateful for their guidance.

I lost my only sibling, my brother Damion, to an overdose, December 8, 2018. Growing up in a very supportive, solid, middle-class home, we are proof that addiction truly doesn't discriminate, and it can happen to anyone. His daughter, along with my three boys, learned at an early age as well, the dangers of drugs. My husband and I also took in two children after their mother overdosed in the ER where I work. They already lost their father to an overdose. I will tell you, the hurdles we went through just to help these kids out while their mom was able to get treatment, was exhausting but worth every minute. We were not foster parents, so we received no help whatsoever for

almost a year. I wouldn't take it back for anything. Being able to help their mom and provide a safe home was worth every tear.

In 2020, I was awarded Crain's Detroit Healthcare Heroes Award. That was a huge accomplishment for me. Following that I also worked with CFSEM and MHA, to create a commercial on opioid/overdose awareness. I also teach Narcan Classes for Families Against Narcotics, locally and virtually. I recently had the pleasure to speak at the ED MOUD Symposium, along with CFSEM, MHA, MDHHS, BCBS, MHEF, and MOC. What an honor to meet and speak after Director Hertel, Sarah Scranton and Sarah Wedepohl. I'm just a nurse, and that was a huge honor for me and my family. I was tasked by Corewell Health/Beaumont, to set up all ten of our emergency centers OUD programs, which was also a great learning experience for me.

So here I am, running a very successful program in the ER with a great team just as compassionate as me. We along with our other sites are doing what we love, being able to help those suffering from addiction, and helping those when they unfortunately lose a family member to addiction. I am super proud of one of my relatives, Patrick Patterson, who also sits on the Opioid Advisory Commission, and is changing lives every day by the great work he does! This experience has motivated me to return to school to further my education and find ways to help more.

It hurts my heart to know that our funding will come to a close early 2024, and there is a chance that the hospital may not be able to fund it 100%. We were funded the first two years through CFSEM, then our Foundation has covered us this this and will until mid 2024. They have been amazing and supportive thus far, I must add. Our expenses aren't excessive as we use outside resources to the best of our ability. So, I am reaching out to whomever I can, to see if there are any options available for us to continue our mission. Any guidance would be greatly appreciated. Thank you for taking the time to read this letter. Have a blessed week!

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