final minutes

Opioid Advisory Commission (OAC) Meeting
10:00 a.m. • Thursday, September 22, 2022
Legislative Conference Room • 3rd Floor Boji Tower Building
124 W. Allegan Street • Lansing, MI

Members Present:
Ms. Kelly Ainsworth
Mr. Brad Casemore
Judge Linda Davis
Mr. Scott Masi
Mr. Mario Nanos
Mr. Patrick Patterson
Dr. Cara Anne Poland
Mr. Kyle Rambo

Members Excused:
Ms. Katharine Hude
Ms. Mona Makki
Dr. Cameron Risma
Dr. Sarah Stoddard

Ms. Hude joined virtually; therefore, was unable to be counted present for the purposes of quorum or act on voting items before the Commission per the Open Meetings Act.

I. Call to Order
The Chair called the meeting to order at 10:00 a.m.

II. Roll Call
The Chair asked the clerk to take roll. The clerk reported a quorum was present showing eight Commission members in attendance. The Chair asked for absent members to be excused.

III. Approval of the September 8, 2022 Meeting Minutes
The Chair directed attention to the proposed minutes of the September 8, 2022 meeting and asked if there were any changes. **Judge Davis moved, supported by Mr. Nanos, to approve the minutes of the September 8, 2022 meeting. There was no further discussion and the Chair asked for a role call vote. The motion prevailed and the minutes were approved.**

IV. Legislative Council Administrator Introduction
The Chair directed attention to the Legislative Council Administrator for introduction. The Chair noted outreach has been made to entities discussed in previous meetings to obtain information helpful to the Commission's work. The Legislative Council Administrator addressed questions from Commission members

V. OAC Program Coordinator Position
The Chair asked Commission members to review applicants. The Chair confirmed the interview panel will include the Commission Chair, the Legislative Council Administrator, and a representative from the Legislative Council Administrator's Human Resources. There was no further discussion.

VI. Commission ByLaws

The Chair directed attention to Mr. Casemore's suggestion to include a conflict of interest policy to the Commission ByLaws. Further discussion was had. It was unanimously decided amongst Commission members a policy was not needed in the Commission ByLaws.

VII. Commission Outreach

The Chair acknowledged Mr. Casemore and Mr. Rambo for their work in passing on information helpful to the Commission's work. The Chair directed attention to the MDHHS Opioid Settlement Prioritization Survey, Bipartisan Policy Center: Tracking Federal Funding to Combat the Opioid Crisis report, and MDHHS: Michigan Opioids Task Force Annual Report 2020 for review.

VIII. Subcommittee Updates

The Chair called on Mr. Rambo for a subcommittee update.

a. Current Funding and Programmatic Impact (Mr. Rambo)
   Mr. Rambo recommends the subcommittee meet to analyze the reports provided to develop a plan. Mr. Rambo handed out a planning process handout of the subcommittee's work.

IX. Introduction Presentation

The Chair recalled at the September 8, 2022 meeting it was discussed for members that wish to formally introduce themselves and their background for the Commission. The Chair called on members that requested to do so.

a. Mr. Patrick Patterson
b. Ms. Kelly Ainsworth
c. Dr. Cara Poland

X. Commission Member Comment

The Chair recalled the September 8, 2022 meeting to continue the informal roundtable member introduction. Mr. Nanos expressed concerns about stigma and handed out an event flyer to Commission members.

XI. Public Comment

The Chair asked if there were any comments from the public. Mr. John Klein continued his story from the previous meeting. Mr. Klein expressed concern regarding the stigma placed on him in searching for gainful employment due to his past. Mr. Klein asked the Commission to consider addressing this stigma in the Commissions work.

XII. Next Meeting Date: Thursday, October 13, 2022 at 10:00am

The Chair announced the next meeting date for Thursday, October 13, 2022 at 10:00am. The Chair reminded Commission members a majority of seven Commission members in attendance is required to conduct Commission business and instructed Commission members to let the clerk know if availability has changed.

XIII. Adjournment

There being no further business before the Commission the Chair adjourned the meeting at 12:01 p.m. with unanimous support.

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MAY 9, 2022

MDHHS
Michigan Department of Health & Human Services

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Opioid Settlement Prioritization Survey 2021–22

EXECUTIVE SUMMARY

In 2019, opioid overdoses killed 1,768 Michiganders, an average of almost five people every single day. In August 2019, Governor Gretchen Whitmer announced the creation of a task force to align and coordinate departmental efforts to fight the opioid epidemic in the state of Michigan.

The Michigan Opioids Task Force outlined five key values to guide the work, which included both prioritizing voices with lived experience and using data to inform strategy.

In line with these Task Force values, the Opioid Settlement Prioritization Survey 2021-22 sought to systematically gather data to understand priorities for settlement funding among respondents across Michigan, including individuals with lived experience, to inform strategies to address the opioid epidemic across the state.

Survey Results 2021–22

Between November 2021 and January 2022, over 1,000 respondents across Michigan completed a survey of priorities for opioid settlement funding dollars.

- Respondents represented at least 78 of 83 counties, though 23% of respondents did not identify a county of residence. All 10 of the prepaid inpatient health plan (PIHP) regions had survey representation.
- Most respondents (97%) identified an organization affiliation, while only 3% responded as an individual /unaffiliated.
- About one-third (32%) of respondents had lived experience with substance use, and about half of those with lived experience (i.e. 16% of all respondents), identified as being in recovery.
- Eleven percent (11%) of respondents identified as a racial minority, with an additional 9% of respondents choosing not to identify their race, and 80% identifying as Caucasian or white.

Key Priority Findings

The top three priorities overall among respondents surveyed in the Opioid Settlement Prioritization Survey 2021–22 align with the MDHHS 2021 Opioid Strategy (Figure 1), which includes long-term recovery support, prevention, and increased treatment capacity especially for medications to treat opioid use disorder (MOUDs).

Top three priorities overall among survey respondents

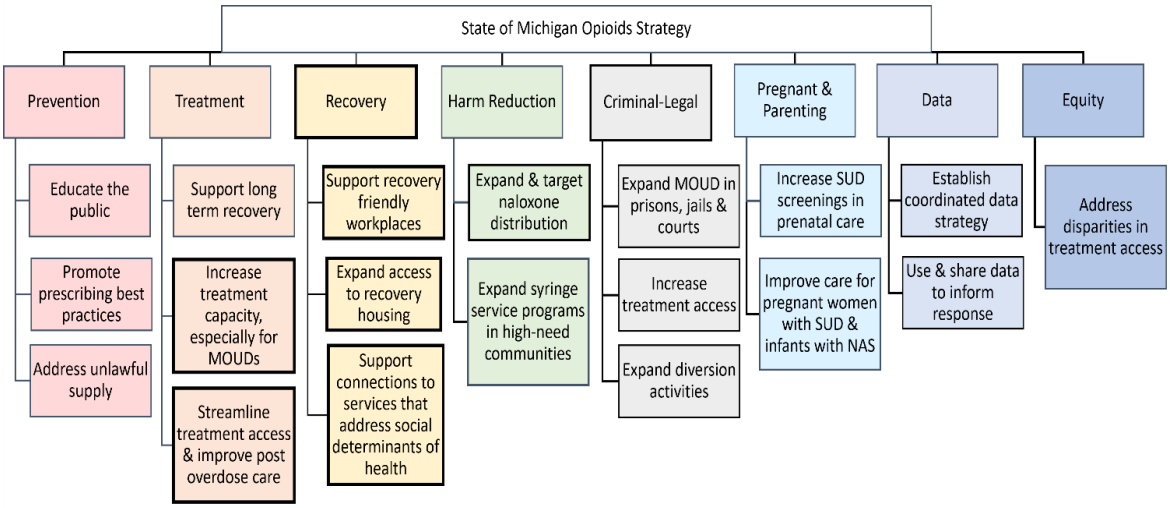
1. Recovery support services were most likely to be chosen as the overall top priority, with 36% of survey respondents identifying it as their top overall priority for settlement funding.
    - Residential treatment programming was the most commonly chosen support service with 24% of respondents including it as the top priority for treatment and recovery support services.

- Individuals with co-occurring mental health diagnoses, and/or other substance use disorders were the most frequently selected priority population/community for treatment and recovery support services, selected by 41% of respondents.

2. Prevention programming ranked second overall, selected by 19% of respondents as the overall top priority.
   - Prevention programs in K-12 schools (28%), training for first responders in programming to connect at-risk individuals with services and supports (27%), and medical provider education and outreach around opioid prescribing best practices (25%) were most commonly prioritized in the category of prevention programming.
3. Expanding access to medications to treat opioid use disorder (MOUD) and other opioid-related treatment ranked third overall, selected by 16% of respondents as the overall top priority.

Figure i

The State of Michigan Opioid Strategy strategic pillars: 1) prevention, 2) treatment, 3) recovery, 4) harm reduction, 5) criminal-legal involved populations, 6) pregnant and parenting women and new mothers, 7), data, and 8) equity.



Opioid Settlement Prioritization Survey 2021-22

Background

In 2019, Michigan and many of its municipalities filed lawsuits against numerous corporations in the opioid industry. While settlement negotiations regarding some of these lawsuits are ongoing, the State of Michigan is currently drafting legislation that would establish a fund for these resources. This opioid settlement fund would be used to support Michigan-based substance use treatment services and to address the harm created by the opioid epidemic.

In late 2021, the Michigan Department of Health and Human Services contracted with the Center for Health and Research Transformation (CHRT) to analyze results from a survey of key Michigan respondents about the best ways to use opioid settlement dollars within state and federal guidelines.

Recognizing that addressing each facet of the opioid crisis is critically important, the survey was informed by those priorities in federal settlement funding strategies Exhibit E (see appendix I) to elicit feedback as to what options respondents prioritize. The survey questions and response options were based on both the federal settlement funding strategies of Exhibit E, as well as the state's Opioid Strategy strategic pillars. Where noted, respondents were also able to write-in "other" priorities that were not included as selection options.

Methods

The Opioid Settlement Prioritization Survey 2021-22 (see appendix III for survey instrument) was fielded online between October 13, 2021, and January 17, 2022. A snowball sampling method was implemented by emailing a survey link to 45 organizations with the option to complete the survey in one of three languages (English, Spanish, or Arabic). Primary survey takers were then asked to share the survey with others. This "snowball sampling" method allowed MDHHS to access respondents that are hard to reach using conventional survey methods.

To be included in the final sample, survey respondents had to reside in the state of Michigan and must have responded to at least one of the survey's priority questions; that is, one response of substance, in order to be counted in the final sample. A total of 1,040 survey respondents were included in the final sample out of 2,009 who accessed the survey, for a response rate of fifty-two percent (52%).

Survey data were analyzed using SPSS statistical software and qualitative themes analyses. Unless otherwise noted, significant differences where the observed values differ from values expected by chance are significant at $p<.01$.

About Survey Respondents

Overall, the Opioid Settlement Prioritization Survey 2021-22 was most successful in reaching respondents affiliated with organizations (97%), and less so reaching individuals or those unaffiliated with an organization (3%). The survey was more successful reaching females (64%), which may reflect the higher proportion of women in medical and social service occupations, compared to reaching males (29%), and the survey was much more successful reaching those ages 25-64 (89%), which may also be a reflection of the high workforce/organizational representation of survey respondents. Within organizational roles, there was balance between those in leadership roles (28%) and staff roles (33%).

The survey had some success in reaching those with lived experience and in the recovery community with sixteen percent (16%) of respondents identifying as being in recovery. The survey had less success reaching Black or African American respondents[1] (7%) but did achieve input from those identifying as Native American[2] (2%) at a higher rate that the overall Michigan population. Nine percent (9%) of respondents did not disclose a race, so the actual respondent representation by race is unknown.

[1] Black or African American includes those respondents who may have also selected another race. Selections were not mutually exclusive.
[2] Native American includes those who may have selected both Native American and white.

Table 1

Respondent organizations[3]

SURVEY RESPONDENTS BY ORG TYPE	%
Substance use service provider	20%
Health care professional	17%
Mental health service provider (including PIHPs)	10%
Harm reduction and/or prevention service provider	9%
Local government (including local health department)	7%
Social service agency	7%
Judiciary/courts	6%
Academic/research institution	5%
State government or Tribal government	4%
Law enforcement/first responder	4%
Advocacy	4%
K–12 Education or early childhood	3%
Individual/self	3%
Faith-based institution	1%
OTHER (e.g. manufacturing, foundation/ philanthropic, etc)	1%

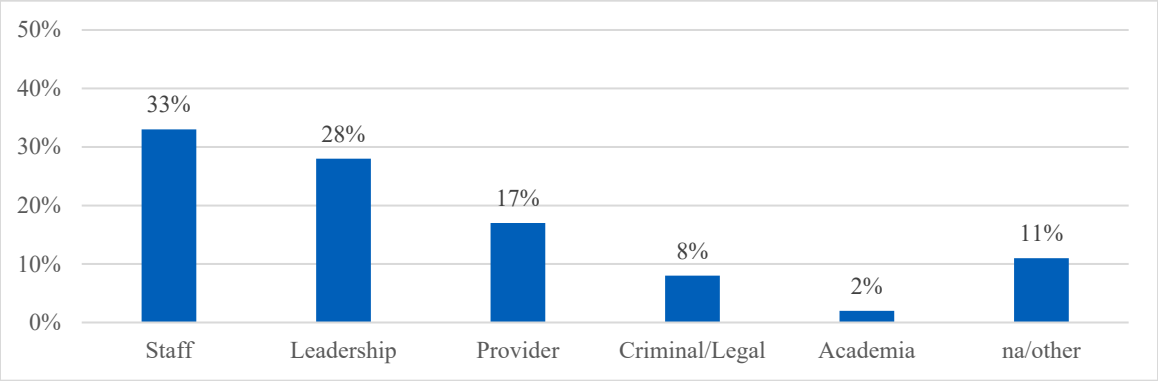
An overwhelming majority of survey respondents (97%) indicated that they were affiliated with an organization and responding in a professional capacity. Thirty percent (30%) of respondents in total indicated that they worked in either a mental health (MH) or substance use (SUD) service organization (MH/SUD organization). An additional nine percent (9%) indicated that they worked in harm reduction or prevention.

[3] Organization types were selected from a survey list. Those who selected 'other' but whose description was a clear fit for an existing category were aligned to that list category.

Roles within organizations

Figure 1

Many survey respondents were staff members, followed by leaders, then health care providers including mental health providers.

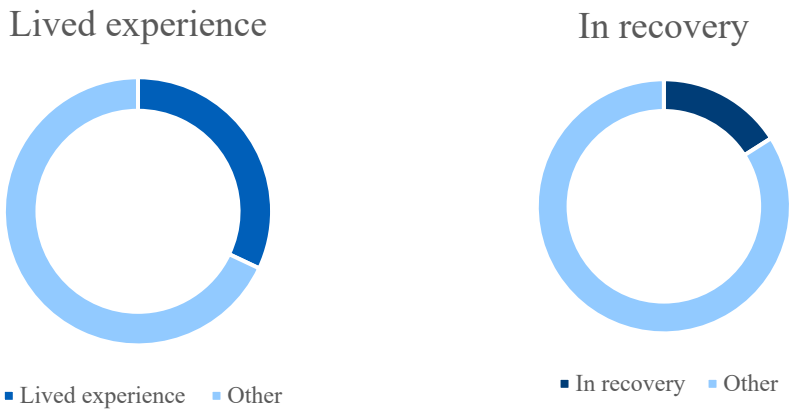


Staff roles included coordinators, specialists, managers, supervisors, administrators, etc. Leadership roles included directors, executives, etc. Provider roles included physicians, nurses, therapists, etc. Criminal/legal roles included sheriffs, first responders, jail administrators, judges, etc, Academia included professors, students, etc. N/A/other included those whose roles were indicated as 'n/a', as well as philanthropists, teachers, pastors, etc.

Experience with substance use

Figures 2 and 3

Many of the survey respondents had lived experience with substance use (32%), and about half of those with lived experience identified as being in recovery (16%).

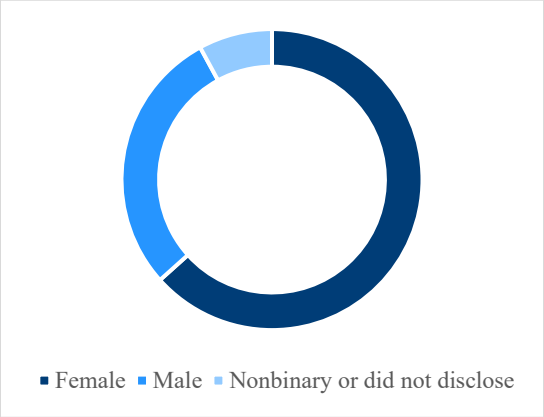


Note: Lived experience includes those who have personal experience with substance use/ in recovery, but can also include someone who counsels folks with substance use disorder, parents of those with SUD, etc. Recovery is more commonly associated with those who have had direct personal experience with substance use and/or addiction.

Gender identity

Figure 4

Two-thirds of survey respondents were female.



The proportion of females in the survey may be high because the survey was sent to many health and social service organizations, which have a higher percentage of female employees.

Race[4]

Table 2

Eighty percent of survey respondents identified as white.

Race category	%
Caucasian or white	**80%**
Black or African American	**7%**
American Indian	**2%**
Asian	**1%**
Middle Eastern or North African	**1%**
'Other'	**1%**
Prefer not to answer	**9%**

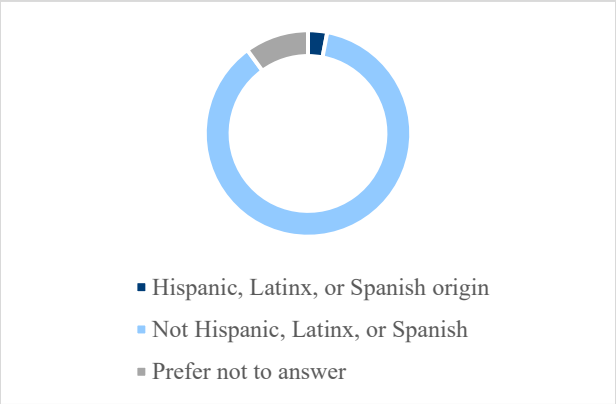
About eighty percent (80%) of the survey sample identified as white or Caucasian, which is a similar proportion to the State of Michigan; however, the survey sample also had nine percent (9%) of respondents who preferred not to answer, so the actual respondent characteristics may differ. Note that the percent total does not equal 100% due to rounding.

[4] Black or African American includes those who also indicated another race; Native American includes those who also indicated both Native American and Caucasian or white; Asian includes those who indicated Southeast Asian, East Asian, and South Asian.

Ethnicity

Figure 5

Three percent of survey respondents identified as of Latinx, Hispanic, or Spanish origin.



Three percent (3%) of survey respondents identified as of Latinx, Hispanic, or Spanish origin, including Mexican, Mexican American, or Chicano.

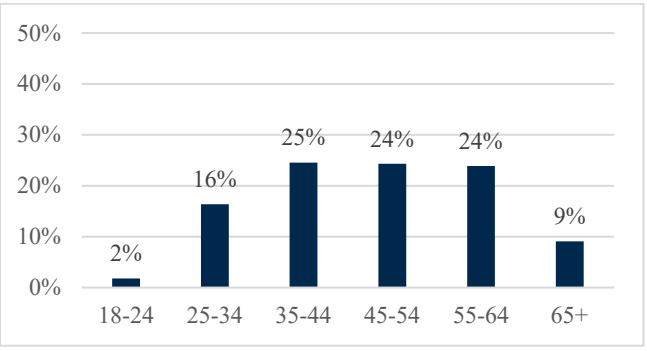
Eighty-seven percent (87%) identified as not being of Latinx, Hispanic, or Spanish origin, including Mexican, Mexican American or Chicano.

Ten percent (10%) of the sample preferred not to answer.

Age

Figure 6

Survey respondents by age.



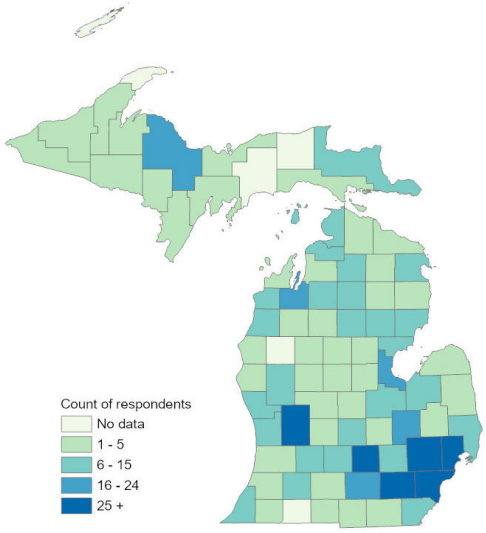
Eighty-nine percent (89%) of survey respondents reported being between the ages of 25 and 64.

This may reflect the fact that the survey was fielded predominantly among professionals.

Geography

Figure 7

Survey respondents by county

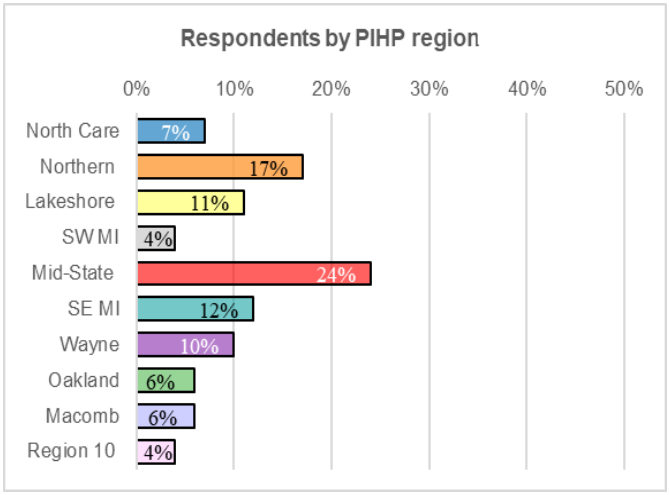


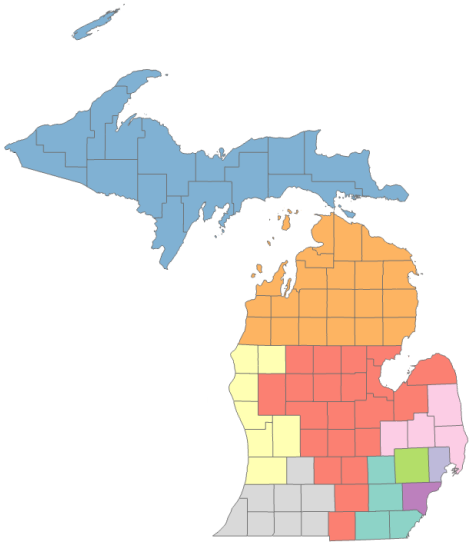
Respondents represented 78 of 83 counties across Michigan; however, about twenty-three percent (23%) of respondents did not select a county. Respondents did not indicate residence in Keweenaw, Lake, Luce, St. Joseph, or Schoolcraft counties.

Respondents who indicated a county of residence on the survey were mapped to their Michigan Prepaid Inpatient Health Plan (PIHP) Region (Figure 8)

Figure 8

Mapping respondents to PIHP regions





Survey Findings: Priority Ranking

Priority response options included in the survey were reflective of both the MDHHS Opioid Strategy (figure i), as well as options from the federal list of core strategies for opioid remediation uses (see Exhibit E in Appendix I). The order of response options appearing in the survey for each priority area was randomized to reduce order bias, i.e. the tendency to select the first or last items in a list.

Top priorities overall for opioid settlement funds

Priorities most frequently ranked as the number one priority were:

1. Recovery support services, including peer support and wrap-around services for individuals with substance use disorder and co-occurring mental health diagnoses.
2. Prevention programming.
3. Expanding access to medications used to effectively treat opioid use disorder (MOUD) and other opioid-related treatment.

Survey question 1

Which of the following priorities is most important for the investment of opioid settlement funding?

Settlement Funding (Overall)	
Priority Category	% ranked #1
Recovery support services, including peer support and wrap-around services for individuals with substance use disorder (SUD) and co-occurring mental health diagnoses	**36%**
Prevention programming	**19%**
Expanding access to medications used to treat opioid use disorder (MOUD) and other opioid-related treatment	**16%**
Support for pregnant and post-partum women affected by substance use, as well as infants with neonatal abstinence syndrome	**9%**
Naloxone distribution and training	**7%**
Treatment for incarcerated population	6%
Syringe service programs (SSP)[5]	4%
Research and evaluation of abatement strategies	3%
Total	100%

[5] People who use drugs (PWUDs) that access SSPs are 3-5 times more likely to engage in substance use disorder treatment, and to remain engaged with treatment, compared to PWUDs not accessing SSPs. This reduces the number of treatment episodes per individual, and therefore the cost burden on public and private insurance providers.

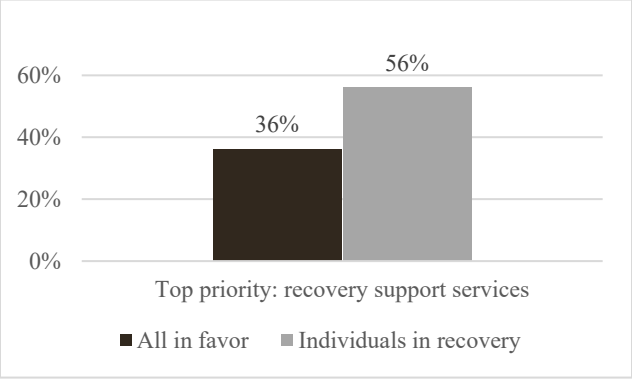
Notable differences in overall settlement funding priorities.

Respondents who identify as being in recovery were more likely to prioritize recovery support services. Interestingly, academic roles were much more likely to prioritize MOUD compared to overall. There were also differences by age, role, organization type, and PIHP region. (See Appendix II for more details).

Individuals in recovery

While 36% of all respondents were in favor of funding recovery support services, **individuals in recovery (57%)** were even more likely to favor recovery support services (Figure 9)

Figure 9

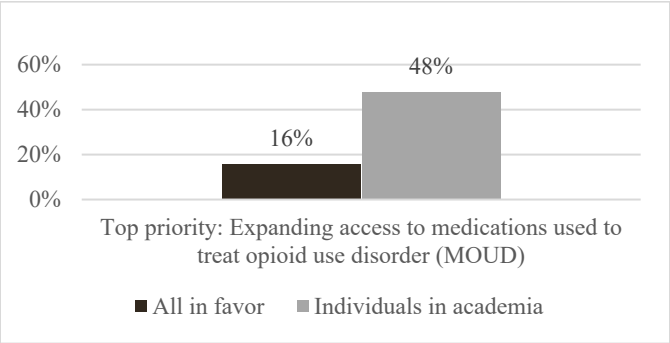


Individuals in academic roles and/or academic/research organizations

While 16% of all respondents were in favor of expanding access to MOUD, respondents in **academic roles (48%)** were more likely to be in favor (Figure 10).

Respondents who work in **academic or research organizations** were also more likely to prioritize support for pregnant and post-partum women affected by substance use, and infants with Neonatal Abstinence Syndrome (NAS) (15%) compared to respondents overall (9%).

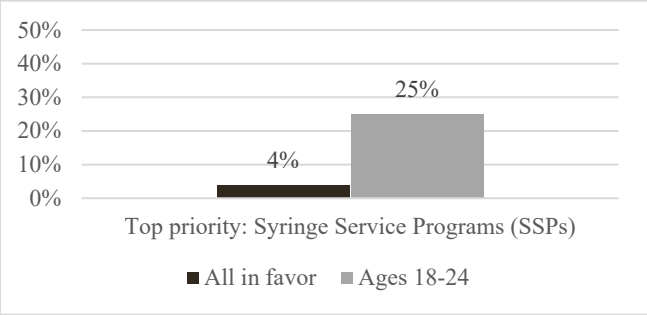
Figure 10



Respondents aged 18-24 years old

Overall, 4% of respondents ranked syringe service programs (SSPs) as their top priority, however **individuals aged 18-24 (25%)** were even more likely to support syringe service programs as a top priority (Figure 11).

Figure 11



PIHP regions

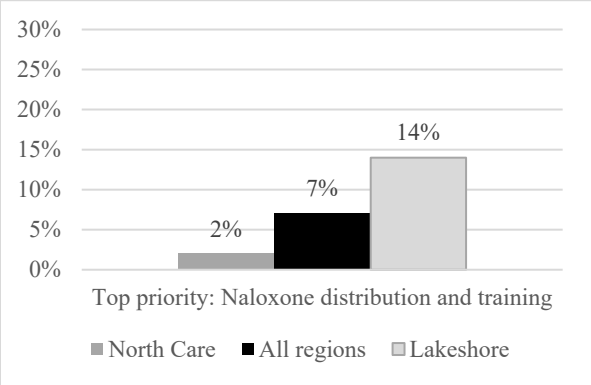
Overall, nine out of 10 PIHP regions shared the same top priority of recovery support services, with only **Oakland** ranking prevention as a higher priority. Six out of the 10 PIHPs' top three priorities included the overall top three priorities of recovery support services, prevention programing, and expanded access to MOUD.

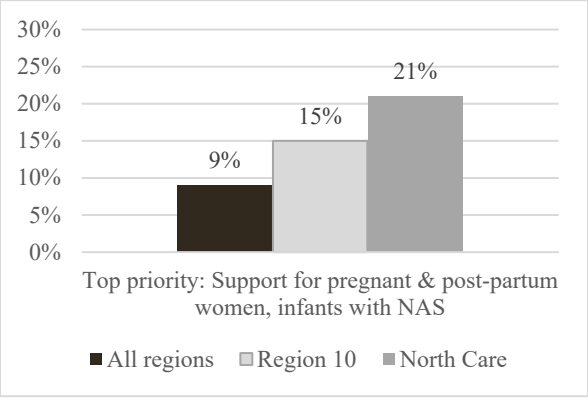
Naloxone distribution and training was the top priority for 7% of respondents, but was the top priority for 14% of those in **Lakeshore** region and only 2% of those in the **North Care** region (Figure 12). .

Syringe Service Programs (SSPs) were prioritized by 4% of respondents overall, but by 14% of those in the **Lakeshore** region.

Support for pregnant and post-partum women, infants with NAS was prioritized by 9% of respondents, but more commonly prioritized by those in the **North Care** region (21%) and the **Region 10 PIHP** (15%) (Figure 13)

Figures 12 and 13





Settlement Priorities by Priority Category

In addition to overall settlement priorities, the survey also asked about priorities within five categories: 1) prevention, 2) treatment and recovery support, 3) harm reduction, 4) population/community, and 5) data and evaluation. Notable differences in priorities are highlighted below. (See Appendix II for more details).

Prevention programming

Prevention priorities most frequently ranked as the number one priority were:

1. Evidence based prevention programs in K-12 schools.
2. Training for first responders on programming to connect at-risk individuals with services and supports.
3. Medical provider education and outreach around prescribing best practices.

Survey question 2

Which of the following prevention activities is most important to fund?

Prevention Programming Priorities	
Activity	**% ranked #1**
Evidence-based prevention programs in K–12 schools	**28%**
Training for first-responders on programming to connect at-risk individuals with services and supports	**27%**
Medical provider education and outreach around opioid prescribing best practices	**25%**
Media campaigns to prevent substance misuse	5%
Community drug disposal programs	2%
"Other"^	13%
Total	100%

^Many write-ins for "other" reinforced priorities already listed, other priority write-ins included family supports/'break the cycle', address source of the problem, and public health education including reducing stigma.

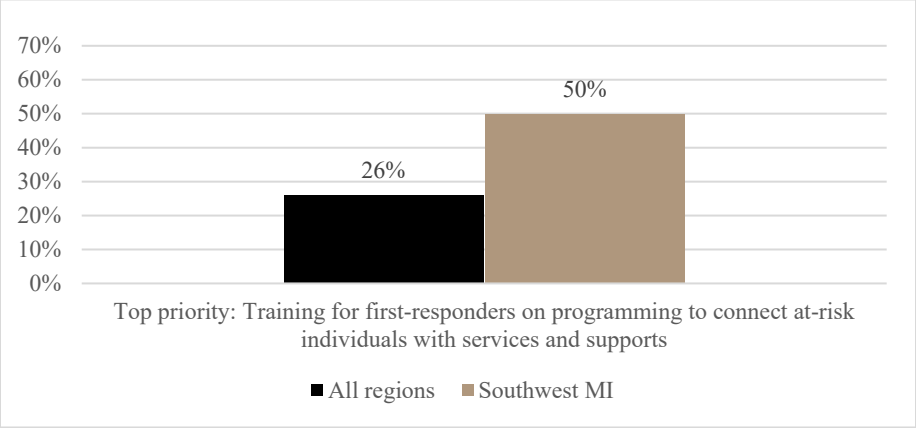
Notable differences in prevention programming priorities

Overall the top three prevention priorities were fairly consistent. The biggest differences were by PIHP regions and organization types. (See Appendix II for more details).

PIHP region

Overall, 26% of respondents ranked training for first responders on programming to connect at-risk individuals with services and supports as their top priority, however respondents in **Southwest Michigan Behavioral Health PIHP** Region were more likely to support this priority (50%) (Figure 14).

Figure 14



Treatment and recovery support services

Treatment and recovery support priorities most frequently ranked as the number one priority were:

1. Residential/inpatient programming.
2. Wrap-around service programs to address spectrum of social factors (transportation, housing, employment, etc.).
3. Access to medications used to treat opioid use disorder, including methadone, buprenorphine, and naltrexone.

Survey question 3

Which of the following treatment and recovery support services is most important to fund?

Treatment and recovery support services	
Service	% ranked #1
Residential / inpatient treatment programming	24%
Wrap-around service programs to address spectrum of social factors (transportation, housing, employment, etc.)	20%
Access to medications used to treat opioid use disorder, including methadone, buprenorphine, and naltrexone	19%
Care-coordination services to facilitate warm-handoffs into community-based services from inpatient or other institutional settings	10%
Recovery housing	8%
Outpatient treatment programming	8%
Peer support services	7%
"Other"^	5%
Total	100%

Table total varies due to rounding.
^Write-ins for 'other' included involving employers in treatment and recovery, addressing ACES, addressing social determinants of heath, and recovery community organizations (RCOs).

Notable differences in treatment and recovery support service priorities

Differences across race and ethnicity were common in treatment and recovery priorities and priorities also differed based on recovery status. Significant differences were also seen by age, role, and organization type. (See Appendix II for more details).

Individuals in recovery

Those in recovery were slightly less likely to prioritize access to MOUD (13%) compared to respondents overall (20%), and were more likely to prioritize peer supports (13%) compared to 6% of all respondents.

Native American respondents

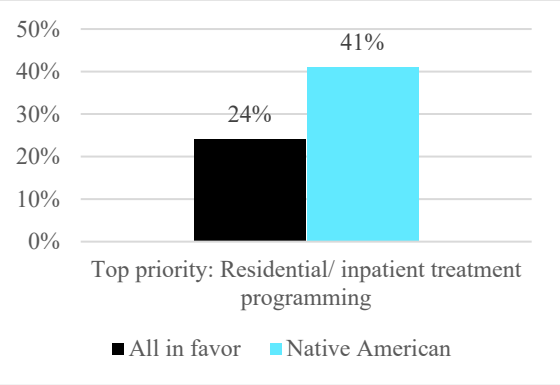
While overall support for residential / inpatient treatment programming was high at 24%, **individuals who identify as Native American** (41%) were much more likely to support residential / inpatient treatment programming. (Figure 15)

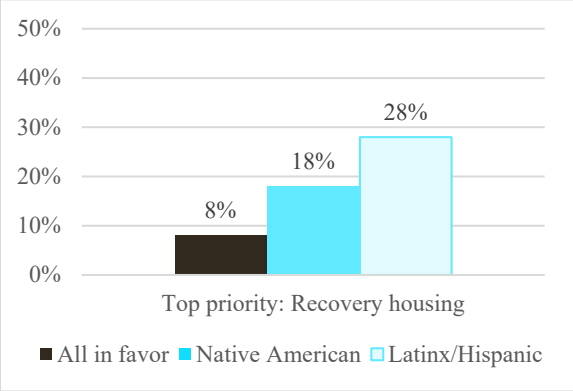
Native American respondents were also more likely to prioritize recovery housing (18%) compared to respondents overall (8%) (Figure 16)

Of Latinx, Hispanic, or Spanish origin

Overall, 8% of respondents ranked recovery housing as their top priority. Support for recovery housing was higher among and **individuals who identify as of Latinx, Hispanic, or Spanish origin** (28%) (Figure 16)

Figures 15 and 16

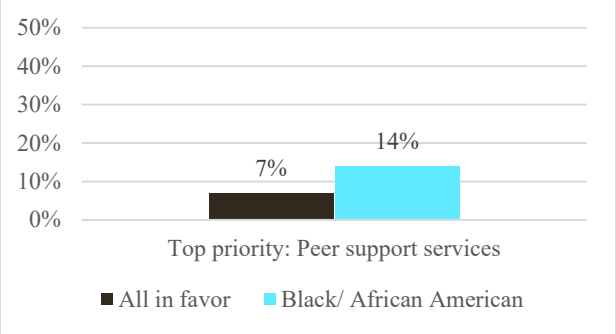




Black or African American respondents

Overall, 7% of respondents ranked support for peer support services as their top priority, however **individuals who identify as Black or African American** (14%) were more likely to favor peer support services (Figure 17).

Figure 17



Population / community priority for treatment and recovery support services

Population/ community priorities for treatment and recovery support services most frequently ranked as the number one priority were:

1. Individuals with co-occurring mental health diagnoses or other substance use disorders.
2. Pregnant and post-partum women.
3. Rural communities.

Survey question 4

Which of the following populations/communities is most important to prioritize with funding for treatment and support services?

Population/Community Priority for Treatment and Support Services	
Population/Community	% ranked #1
Individuals with co-occurring mental health diagnoses or other substance use disorders	41%
Pregnant and post-partum women	13%
Rural communities	13%
Communities where the majority of residents are racial/ethnic minorities	11%
Infants with Neonatal Abstinence Syndrome (NAS)	10%
Individuals incarcerated in jails and prisons	8%
"Other"^	5%
Total	100%

Table total varies due to rounding
^Write-in for "other" population most commonly included youth, and communities with the highest rates of SUD.

Notable differences in population /community priority for treatment and support services

Differences among PIHP regions occurred in population/community priorities. Significant differences were also apparent across role and organization type in particular around the priorities of communities where the majority of residents are racial/ethnic minorities, infants with NAS, and individuals

incarcerated in jails and prisons. There were also differences in priorities by race and ethnicity. (See Appendix II for more details).

PIHP Region

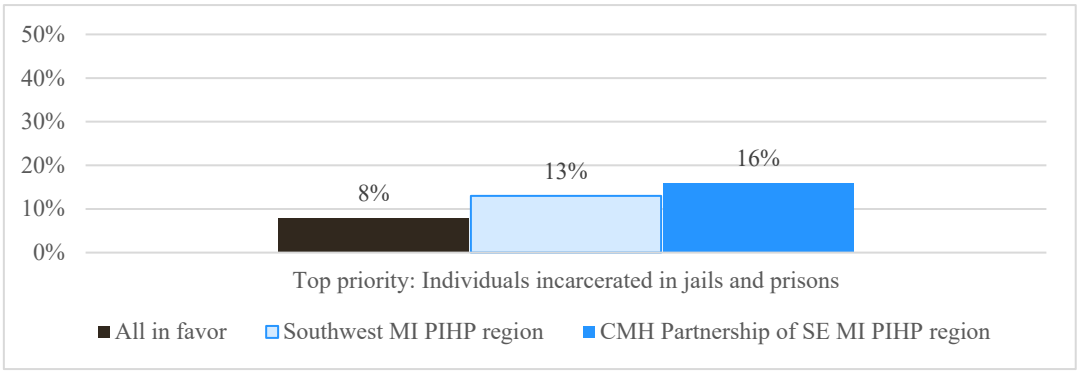
All 10 PIHPs selected individuals with co-occurring mental health diagnoses and/or other SUD most frequently as their top priority, but the frequency ranged from 53% of respondents in **Macomb**, to 29% in **Region 10**.

Respondents in the **CMH Partnership of Southeast MI PIHP region** (20%) and **Detroit-Wayne PIHP region** (21%) were more likely to prioritize communities where the majority of residents are racial/ethnic minorities compared to respondents overall (11%).

Overall, "rural communities" was a top priority for 13% of respondents, but it was a top priority for 23% of respondents from **North Care Network region**, and 26% of respondents from **Northern Michigan region**.

Overall, individuals incarcerated in jails and prisons was a top priority for 8% of respondents, but a top priority for 13% of those in **Southwest MI region** and 16% for **CMH Partnership of SE MI region** (Figure 18).

Figure 18



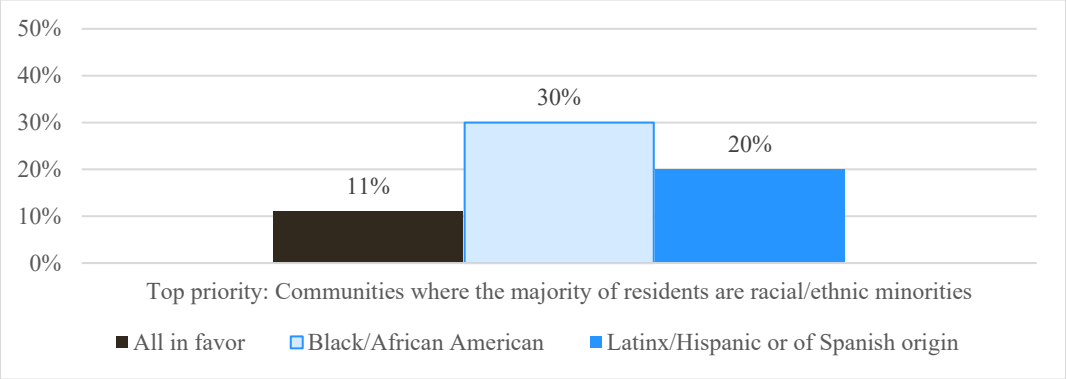
Black or African American respondents

Overall, 11% of respondents ranked communities where the majority of residents are racial/ethnic minorities as their top priority while 30% of **Black or African American respondents** supported it as a top priority (Figure 19 on next page).

Respondents who are of Latinx, Hispanic, or Spanish origin

Overall, 11% of respondents ranked communities where the majority of residents are racial/ethnic minorities as their top priority while 20% of individuals who identify as of **Latinx, Hispanic, or Spanish origin** supported it as a top priority (Figure 19 on next page).

Figure 19



Harm Reduction

Harm reduction priorities most frequently ranked as the number one priority were:

1. Expand programming to divert/deflect individuals from criminal-legal system.
2. Naloxone distribution and training.
3. Expanding capacity in existing Syringe Service Programs (SSPs) to provide more wrap-around services and linkages to treatment resources.

Survey question 5

Which of the following harm reduction activities is most important to fund?

Harm Reduction	
Activities	**% ranked #1**
Expand programming to divert/deflect individuals from criminal-legal system	40%
Naloxone distribution and training	24%
Expanding capacity in existing Syringe Service Programs (SSPs) to provide more wrap-around services and linkages to treatment resources	22%
Expanding the number of Syringe Service Programs (SSPs)	8%
"Other"^	5%
Total	100%

Table total varies due to rounding

^"Other" write-in responses most commonly included safe consumption sites, treating mental health.

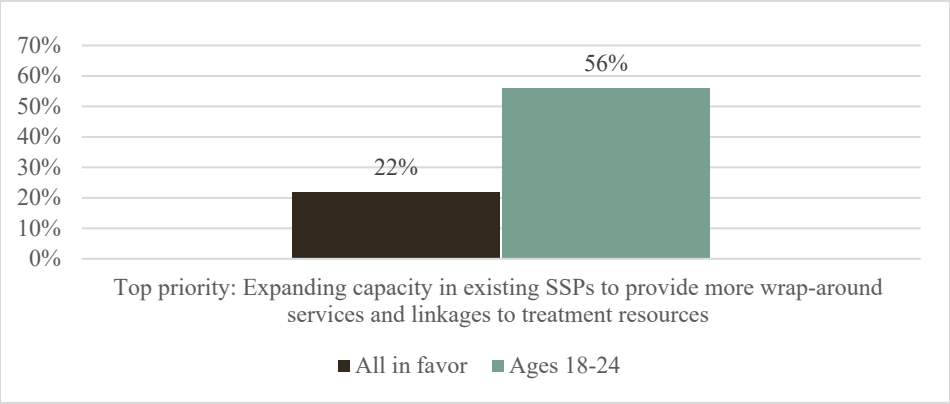
Notable differences in harm reduction priorities

There were significant differences in harm reduction priority by age group, PIHP region, race, and organization type. (See Appendix II for more details).

Ages 18-24

Respondents **ages 18–24** were much more likely to prioritize expanding capacity in existing SSPs to provide more wrap-around services and linkages to treatment resources (56%) compared to respondents overall (22%) (Figure 20).

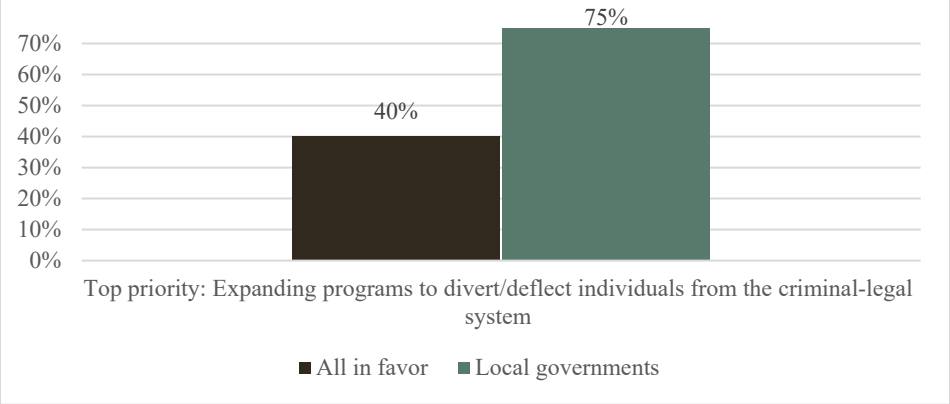
Figure 20



Local government (including local health departments)

Local government including local health departments were much more likely to prioritize expanding programs to divert/deflect individuals from the criminal-legal system (75%) compared to overall respondents (40%) (Figure 21).

Figure 21



Research and Evaluation

The research and evaluation priority most frequently ranked as the number one priority was:

1. Research on new, promising, and best practices.

Survey question 6

Which of the following data and evaluation activities is most important to fund?

Data and Evaluation Activities	% ranked #1
Research on new, promising, and best practices	**43%**
Evaluation of opioid abatement strategies	**27%**
Data collection activities	**23%**
"Other"^	**7%**

^"Other" priorities most commonly included evaluating effectiveness of current programs, and including those with lived experience.

Notable differences in research and evaluation priorities

There were no statistically significant differences across research and evaluation priorities. ($p < .01$).

Summary

The results of the Opioid Settlement Prioritization Survey 2021-22 can be used to elevate the voices of those in communities across Michigan. Although additional voices are needed to gain a more complete understanding of the priorities and needs, these results outline trends that may lead to an improved response to the issues.

Interwoven throughout these priorities were concerns about the impact of stigma on the success of amelioration efforts. Stigma was a theme that came up when respondents were asked their reason "why" they chose the priority they did.

Stigma and other themes, such as the value in treating co-occurring mental health issues along with SUD, are found in the following Qualitative Summaries of Priorities section of this report.

Note: The opinions expressed in the tables below do not necessarily reflect the views of MDHHS or of all survey respondents. Example quotes are included to add context and detail to complex survey priority topics and themes.

Qualitative Summary of Priorities

Survey respondents were asked to provide a reason why they selected the top priority they did for each of the six priority questions. Those written responses were analyzed for theme categories and frequency. The "Top 3" priorities for each question are included in the tables below, followed by a condensed table of select quotes in support of the remaining priority options for each question.

Priority most important for the investment of opioid settlement funding (overall)

Please tell us why you chose this activity as your top priority for settlement funding	
1. Recovery support services, including peer support and wrap-around services for individuals with substance use disorder (SUD) and co-occurring mental health diagnoses (n= 359)	
Common themes: • Providing care for those with a dual diagnosis/ treating mental health. • Longer term care/ services. Suggested approaches included: • Increase reimbursement from payers (for peers and other providers). • Trauma-based care/ address root causes, provide family support. • Better coordination between agencies. • Workforce development and training. Suggested target populations: • Juveniles. • Elderly. • Incarcerated individuals. • Those with a dual diagnosis. Specific Program References: CARE in Macomb County; Step Up programs; Drug Treatment Courts; Transitional Housing; Substance Use Disorder Family Support Program; Continued Connection Program.	**Select quotes (edited for clarity)**: *Access to MOUD is good, but services that build recovery capital and address social determinants of health are harder to access. Treatments of adequate quality, duration, and intensity are hard to access.* *As a provider, I see how treating the whole person and continuation of care is the most beneficial. As a small nonprofit we have attempted to start these services on our own and through the OHH program. Covid has hit us hard, and any funding would benefit the people we serve.* *Not enough people suffering from SUD are aware of how many programs are available. There are not enough programs that treat dual diagnosis for SUD and mental health disorders. Many places want to treat them separately and it results in relapse in one or both areas.*
Quotes from the recovery community: *Treatment of substance use disorder should be a multi-platform approach. More options are needed, and peer support is extremely important. It is easier to open up to a person who has been in the same position as them.* *Peer recovery coaching and other wrap-around services had proven to be effective especially with the elderly population who cannot seem to find these services within their Medicare plans.*	

Please tell us why you chose this activity as your top priority for settlement funding

2. Prevention programming (n= 187)

Common themes:

- Return on investment/cost-effectiveness of prevention.
- Education and reducing stigma.
- Addressing root causes.

Suggested approaches included:

- Education – prescriber education, age/population appropriate content in prevention education.
- Building community resilience.
- Address root causes that lead to addiction, use trauma-informed models.

Suggested target populations:

- People who have access to opioids.
- Maternal, neonatal.

Specific program references:
Communities That Care; Project ECHO; Families Against Narcotics

Select Quotes (edited for clarity):

Prevention programming is critical to prevent future addiction disorders. To clarify, it's important to think of "prevention programming" as systems work that decreases the root causes (trauma, abuse & neglect, poor academic achievement, lack of referral sources, untreated mental health issues, etc.) of youth starting to misuse substances, not just "programs." We are not going to "curriculum" our way out of addiction disorders.

Prevention education – including building resilience and strengths in communities – should be a priority because we need to stop abuse before it becomes an addiction. It's much more costly to the community after someone has become addicted. It's often easier for them to stay in drug use and abuse than to get out of it. Prevention on all levels can create open communications throughout the community and remove the stigma of needing help, putting more emphasis on strengths of being hopeful and clean.

Quotes from the recovery community:

The best time to stop a problem is before it starts.

Good prevention can stop young people from following the same destructive path.

Prevention would decrease the demand for all the other, very worthy, services.

Please tell us why you chose this activity as your top priority for settlement funding

3. Expanding access to Medications to treat Opioid Use Disorder (MOUD) and other opioid-related treatment (n= 153)

Common themes:

- Access and barriers to access.
- Eligibility, shortage of providers/staff, cost for patients, transportation, funding for implementation of programs.
- Evidence-based.
- Saves lives and allows patients to stabilize.

Suggested approaches included:

- More provider training.
- Providing access in sites where patients could benefit most.
- Primary care clinics, jails/prisons, EDs, safe consumption sites.
- Person-centered MOUD treatment.
- More choices/options for individuals, culturally competent services, equity in access.

Select Quotes (edited for clarity):

I see firsthand every single day the access barriers to MOUD treatment that our patients experience. This is my top priority for the funding because it is the first step in helping patients recover safely with evidence-based treatment and the first step that can open doors to additional treatment services.

In my clinical experience I've seen a lot of folks get better when they are first stabilized on medication because it's hard to engage in all the other services when they are actively using or in withdrawal. Folks seem to be more amenable to other forms of treatment that can help them after they are stabilized.

Quotes from the recovery community:

I put MOUD as # 1 because access is limited in our community. I work with individuals living with OUD and often assist them with trying to find treatment. I can tell you there is limited access MOUD treatment in our community.

There are not enough MOUD treatment facilities in metro areas let alone in rural areas. It is not realistic for someone to receive methadone for instance if they have to drive two hours every day to get it.

In Northern Michigan we have identified coverage and accessibility gaps. We know medications for Opiate Use Disorder can be highly effective.

"Please tell us why you chose this activity as your top priority for settlement funding" (remaining options)
4. Support for pregnant & postpartum women affected by substance use, and infants with Neonatal Abstinence Syndrome (n= 87)
There is a gap in providers who support and treat PG/PP women, or take their insurance. Many of our clients must be seen out of county creating yet another barrier. Our numbers of Sudden Unexpected Infant Deaths due to unsafe sleep primarily involve drug use in the bedroom by mom or dad. Moving upstream to treatment/assistance during the pregnancy may prevent this horrible outcome.
Changing the trajectory of a mother can impact the trajectory of the entire household/family.
I work with women with OUD and the transition from pregnancy to parenting is not being addressed. Women are seen for pregnancy and then sent to a provider that addressed their OUD but not the stress related to being a parent with an OUD.
5. Naloxone distribution and training (n= 65)
As the facilitator of a Mobile Care unit, we are witnessing the use of fentanyl in non-opioid illicit drugs, which has increased the risk of overdose and is requiring our team to be more aggressive in educating and distributing naloxone.
If people are dead none of the rest matters. I have successfully used naloxone and CPR three times. Those whom I have used it on would have died without it.
The training is VERY important, too many clinics and doctors interpret the protocols and treatment differently.
6. Treatment for incarcerated populations (n= 59)
Increased coordination for SUD Services for incarcerated individuals is vital for reducing recidivism rates.
Incarceration is an opportune time to connect with persons with SUD and provide services that help aid in stabilizing and connecting individuals to treatment, wrap around services, and programming. Community re-entry is high risk for overdose deaths and harm. If services were available, we could reduce deaths, impact recidivism, and increase the chances of recovery.
MAT treatment inside corrections settings is important for two different reasons. First, the continuation of care for those MAT involved prior to incarceration. Second, a natural reachable, teachable moment for those who are opiate involved prior to the current incarceration.
7. **Syringe Service Programs (SSP) (n=41)**
SSP programs are directly connected and interacting with the people who are most affected by the opioid epidemic. They can build relationships with people PWUD and connect them to a multitude of services. Without SSP programs we will not reach the population of PWUD.
The one thing you cannot run a syringe access program without is syringes, yet we have no sustainable funding source for this in Michigan. SSPs provide vital resources and education for individuals who use drugs, and these programs keep many people alive.
8. **Research and evaluation of abatement strategies (n= 32)**
I would like to see the money go toward public health research on best strategies. There are many clinical needs, but this is I believe is a one-time infusion and should go toward long term solutions.
Until we are able to systematically and systemically evaluate short-term and intermediate outcomes to determine the effectiveness of our programs and evaluate cost-benefit ratios to determine the efficiency of our programs, we will be wasting most of the money received from this settlement.

Priority Categories

Priority Most Important for Prevention Programming

Please tell us why you chose this activity as your top priority for prevention

1. Evidence-based prevention programs in K-12 schools (n = 268)

Common themes:

- Address root causes (i.e., focus on family, trauma) for children who have an addicted family member and at-risk youth.
- Building resilience/emotional skills development with a focus on mental health.

Suggested approaches included:

- Make prevention programming an educational requirement.
- Involve mental health professionals in the development and delivery of programming.
- Go beyond K-12 schools and start earlier (preschool).

Suggested topics included:

- Peer pressures and pitfalls of social media.
- Education on local resources and programs available to students and families.

Specific Program References:
National Harm Reduction Coalition; Drug Policy Alliance pilot program; Michigan Model for Health

Select Quotes (edited for clarity):

In the schools is where we can address the stigma and teach the impact of OUD, while also emphasizing health and wellbeing to include healthy resiliency strategies.

Finding the upstream root causes. Preventing so the other services are not needed but we need to make sure we are looking at ACES and providing support to those who have trauma.

Quotes from the recovery community:

Since most of us first start using substances in our teens, I think it's important to have effective strategies for prevention and education in K-12. Also, since many kids have parents who have substance use disorders, it's important to educate them on how it's a medical condition and how they can access support for themselves.

Drug addiction is misunderstood in society; therefore there is the need to continually educate our youth about the realities of drug addiction and alternative mental, emotional, and physical healthcare.

Please tell us why you chose this activity as your top priority for prevention

2. Training for first responders on programming to connect at-risk individuals with services and supports (n= 261)

Common themes

- Working alongside/training with other disciplines.
- Education is needed to reduce stigma around those with addiction.

Suggested approaches included:

- Ensure training is continuous/ongoing and interdisciplinary (e.g., quick response/crisis response teams, using peer supports).
- Practice diversion for calls involving substance use.

Suggested topics included:

- Harm reduction training.
- Reducing stigma, including through increased training on cultural competence.
- Mental health training.

Specific program references:
Hope Not Handcuffs (FAN); Sequential Intercept Model; ProAct Model (WSU)

Select Quotes (edited for clarity):

First responders are often the first chance for intervention. If those individuals were trained in how to easily connect individuals with services other than jail, I think it would be the most beneficial. Even though jail can be a good starting point it is not always the best starting point.

All first responders including law enforcement should be properly trained on addiction and life saving strategies including how to speak to someone suffering a mental health crisis related to SUD.

Education and training are some of the best ways to increase awareness and to allow individuals to have a safe space to exam their views, facts, beliefs about substance use and the individuals who use them.

Quotes from the recovery community:

First responders engage people in some of the worst moments of their addiction. They are also often viewed with distrust by those whom they're serving. With proper training and culture shift among first responder organizations, first responders could become a critical component of leveraging compassionate conversations with PWUD to connect them to services.

Training and education about programming to connect at-risk individuals with services is at a deficit. If law first responders were aware of the local resources at their disposal, more individuals could be connected to services.

Points of crisis can be catalysts for change. First responders are uniquely positioned to take advantage of this and connect people to appropriate services and support.

I would like to see first-responders treating OUD as an illness more than a crime. Often they are working with individuals at a critical moment where they might be willing to accept help, however they are usually sent to jail or the hospital with no follow up care, rather than getting connected with a service provider.

Please tell us why you chose this activity as your top priority for prevention

3. Medical provider education and outreach around opioid prescribing best practices (n= 244)

Common themes

- Prescription opioids are a root cause for many who develop OUD.
- Provider education is needed to reduce stigma around those with addiction.

Suggested approaches included:

- Education and prevention re: prescribing for patients naïve to opioids.
- Education and anti-stigma training for identifying and treating opioid use disorder (including with MOUD).
- Targeting those who work in jails, PCPs, dentists, and pharmacists.

Suggested topics included:

- Encourage physicians to know their own prescribing patterns, training in use of MAPS.
- Screening/training on recognizing OUD.
- MAT and harm reduction education.

Specific program references:
PreVenture Program (Canada)

Select Quotes (edited for clarity):

I believe prescribing practices contribute to opioid use disorder. Working in the field for 27 years, I have heard far too many stories where a person was prescribed opiates for an injury which was continued well beyond its intended purpose. All prescribing doctors, NPs, and PAs should be required to complete training on addictive disorders.

I still hear of medical providers not using the MAPS system and not reviewing opiate history.

Providers are afraid to prescribe buprenorphine and need better education and support. While the waiver training is substantial, there is not enough incentivization for our providers to provide this level of care to their patients.

Quotes from those with lived experience with SUD:

I believe the problem starts with medical providers. There needs to be more training before prescribing opiates to an individual. That's where the problem starts 90% of the time.

I have learned from experience that doctors have prescribed the medication without educating the patient on the potential problems/harms of taking the prescription.

We need to combat stigma in the medical field. People don't go for help when they get treated poorly.

Educating healthcare professionals on the potential dangers, as well as the proper dosing methods is essential. Especially for medicated assisted treatment. It is very misunderstood.

Please tell us why you chose this activity as your top priority for prevention
9. Media campaigns to prevent substance misuse (n = 43)
I chose this priority list because zoom/media support has helped me through first hand experience.
Social media plays an incredibly significant role in the lives of people today and holds a heavy influence. It will have the largest reach to all ages and communities to start the message that it needs to be stopped, there is help out there, and can guide those in need of how to either prevent or treat addictions.
There's still a lot of stigma around SUD. However, the media campaigns should be targeted and culturally appropriate and relevant. Peers in recovery must be involved in developing these media campaigns.
10. Community drug disposal programs (n = 22)
Often those with opioid use disorder report their first use as being from a family members medicine cabinet. Keeping drugs at home is potentially deadly and flushing them is dangerous. There should be an easy place to dispose of drugs, needles, etc. confidentially at any time.
Drug disposal programs often only run a few times a year. Better consistent access to disposal sites would be beneficial.
The training is VERY important, too many clinics and doctors interpret the protocols and treatment differently.
11. **"Other"**
Increasing mental health support: The underlying connections and causes to substance use/misuse is the most critical response. Many people will try and use drugs without addictions. Prevention begins with understanding the reasons why a person who uses drugs with end up with addictions vs someone who just uses drugs/alcohol.
Stigma education: The prevention activities listed, including media campaigns around misuse, drug disposal programs, new opioid prescribing best practices, and prevention programs in school tend to incorporate shame, stigma and harmful practices that create barriers to medication for the pain community.
Stigma training for first responders: First responders are often exposed to individuals with substance use disorder when they're at their worst. Repeated exposures to individuals when they're struggling and at their worst can cause the first responder to become desensitized. Continuing education about the disease of addiction and other mental health issues would benefit the first responder and the community.
Community-based primary prevention: We must provide concrete resources during times of need and skill-building opportunities for parents/caregivers and their children to prevent prolonged periods of stress and instability from occurring. "Primary child abuse prevention" including family/neighborhood resource centers are one important part of the solution that a portion of opioid settlement funds could support.

Priority Most Important for Treatment and Recovery Support Services

Please tell us why you chose this activity as your top priority for treatment and recovery

1. Residential/inpatient treatment programming (n = 221)

Common themes:

- Barriers to access (insurance, cost, programmatic funding, location).
- Need for immediate access for those ready to start recovery.

Suggested approaches included:

- Improve resources in existing residential/inpatient programs (in addition to funding new programs).
- Programming should promote healthy transitions to the next stage of recovery.
- Allow for longer-term care.
- Include mental health.

Suggested target populations:

- Criminal justice population.
- Juveniles.
- Low-income populations.
- Individuals on MOUD.
- Indigenous pregnant women.
- Rural communities.

Specific Program Reference:
HPRP programs; Purdue Model

Select Quotes (edited for clarity):

Access to MOUD is good, but services that build recovery capital and address social determinants of health are harder to access. Treatments of adequate quality, duration, and intensity are hard to access.

As a provider, I see how treating the whole person and continuation of care is the most beneficial. As a small nonprofit we have attempted to start these services on our own and through the OHH program. COVID has hit us hard, and any funding would benefit the people we serve.

Not enough people suffering from SUD are aware of how many programs are available. There are not enough programs that treat dual diagnosis for SUD and mental health disorders. Many places want to treat them separately and it results in relapse in one or both areas.

Quotes from the recovery community:

Every county should have an inpatient treatment facility. Some of our clients have to be transported two, three, four counties or more away from their home, their families, etc.

My order of importance is from 15 years of working with those with SUDs involved in the [criminal justice] system. Walking out of that jail door with no plan, treatment or supportive services can be deadly.

Please tell us why you chose this activity as your top priority for treatment and recovery

2. Wrap-around service programs to address spectrum of social factors (transportation, housing, employment, etc.) (n = 180)

Common themes**:**

- Providing basic needs, e.g. transportation.
- Behavioral health integration.

Suggested approaches included:

- Closed loop/ensure follow-up.
- Provide immediate access to services.
- Promote skill development/healthy transitions to the next level of care.

Specific Program References:
SOAR- certified case managers; Housing First

Select Quotes (edited for clarity):

Stability has been one of the most prominent indicators in my line of work that determines the success of a person in recovery. Their basic needs must be met for them to fully focus on recovery.

Substance abuse is not just substance abuse. Wraparound services are needed for mental health, physical health, etc.

Alpena has a large rural area where transportation is a huge problem. This becomes worse in the winter months when walking in inclement weather is common. Poor access to housing and job opportunities are very difficult for the person who is trying to be self-supporting.

Quotes from the recovery community:

Many, many people don't have their basic needs for living met. We cannot expect people to stay clean if they don't know where they will sleep at night.

Sometimes people come home and they get run through the gauntlet. The smoother the transition and more we can ease access to needed services, the more time the person has to focus on recovery and let the lessons cure.

If clients coming out of treatment had more support world wide with helping them get housing and transportation and things it would have a huge positive impact on there lives after treatment.

Transportation is the single biggest barrier to treatment right now. Many individuals with SUD do not have access to transportation to even begin to get the support they need.

Please tell us why you chose this activity as your top priority for treatment and recovery

3. Access to Medications to treat Opioid Use Disorder (MOUD), including methadone, buprenorphine, and naltrexone (n = 176)

Common themes:

- Providing MOUD alongside care coordination and wrap around services.
- Cost/affordability barriers: low cost intervention opportunity but insurance/Medicaid barrier exist.
- Lack of providers offering MOUD and need to reduce stigma around MOUD.

Suggested approaches included:

- Care coordination and wrap around services alongside MOUD including mental health and peer support.

Suggested target populations:

- ED visits.
- Patients 'barred' from MAT.

Specific Program References:
Recovery oriented system of care

Select quotes (edited for clarity):

Still not enough providers of MOUD. However, MOUD in and of itself, is not sufficient. It needs to also include support services.

MOUD + psychosocial services is the gold standard of care for individuals with OUD.

There are few providers in the Upper Peninsula and a lot of stigma around it, both in the community and among providers/professionals.

Quotes from the recovery community:

Working in the field of addiction and MH, the using community is increasing their desire to be involved in MOUD. This is the number one asked for service related to OUD that I see at this time.

Give those a chance who have OUD to stabilize their lives - not everyone needs residential treatment initially.

So many times a person cannot get into a MAT program until next week or next month. If an individual could get on a program right away, (in the ERD) then have to sign that they will be back to the hospital for follow up, could help more people.

If care coordination services are conducted properly, [support services] should be seamless.

To my knowledge MOUD often remains cost prohibitive to many OUD suffers.

If you do not have access to treatment such as MOUD, then treatment and recovery is sometimes not attainable.

Please tell us why you chose this activity as your top priority for treatment and recovery
4. Care-coordination services to facilitate warm-handoffs into community-based services from inpatient or other institutional settings (n = 90)
Integrated services (physical and medical) combined with care coordination would greatly improve care and allow for greater providers available for treatment
I was a case manager for MI REP helping those incarcerated transition back into the community successfully. I was told by those I served that they wished this service was available in the past due to helping reduce their recidivism. But now the MI REP grant ended and I believe the community will suffer due to increased use of the legal system and hospital among other resources.
We are still seeing stigma by some of our medical care facilities and first responders. Warm-handoff programs are badly needed in our ERs. They are treated for overdose and within hours released to nothing, barely being able to walk out a door. They are often treated poorly minimizing the chance of them returning if needed. I know this from personal experience.
5. Recovery housing (n = 74)
Recovery housing needs to be a Medicaid service including peer services regardless of location - it is currently not allowed in most recovery homes
One of the hardest places to be is an addict walking out of rehab. That is a very crucial and vulnerable point. We need services in place to get them out of their "old playgrounds" because they have nowhere else to go. When you take a mother and put her in a treatment, she stops using drugs and she learns a few life skills. You put her back in the same situation, the same stressors, and no support… She's going right back at it. There needs to be an in between, recovery housing and warm handoffs
6. Outpatient treatment programming (n = 71)
Quality outpatient treatment for substance use is very limited, especially for patients with Medicaid.
Many of those who need a residential level of care will not commit to it voluntarily. We need to invest in outpatient programs that utilize evidenced-based, recovery-oriented, trauma-informed service models
The level of services available on an outpatient basis in this area is minimal. I have knowledge of many adults that should be in recovery and SUD treatment, and I have never met anyone who attends IOP more than one time per week, if that. And don't get me started about the services available for juveniles. This court contracts with a private licensed substance abuse clinician because there are no services available for SUD diagnosed youth.
7. Peer support services (n = 64)
Peer support services are often difficult to bill and require staff funding grants to support the positions. Peers help agencies provide a recovery-oriented systems of care and clients often find a great deal of support through peers. Recovery Supports are often cut due to the lack of funding available through the PIHPs to fund them.
…many people who have dealt with opioid use, misuse, withdrawal, and OUD treatment are best suited to be peers, and that they have a greater credibility with those suffering acutely. Training, however, needs to be improved so that they have training on how to be great mentors, have…knowledge of all resources available to support the patients in their recovery.
8. "Other"
Employer education: 70% of the SUD population have a job-yet the employers are not educated or have policies in place to support them
Trauma informed services: The root of substance abuse is often times related to childhood trauma. If we can get to the root, help them to process the trauma and build their resiliency, they will have a better chance of sobriety.

Priority Population/ Community Most Important for Treatment and Recovery Support Services

Please tell us why you chose this population as your top priority for treatment and recovery support services

1. Individuals with co-occurring mental health diagnoses and/or other Substance Use Disorders (SUD) (n= 379)

Common themes:

- Underserved population.
- Mental health and SUD commonly co-occur.
- Untreated mental health is a barrier to SUD treatment, it is important to treat the "whole person".
- Vulnerable population with greater needs.
- Lack of coordination between MH and SUD care.
- Most difficult and complex patients to treat.

Suggested approaches included:

- Expand the capacity of treatment centers and services to provide integrated care to those with co-occurring MH & SUD.
- Expanding funding and training for dual-diagnosis providers.
- Address barriers and expand access to housing for those with co-occurring MH and SUD.

Specific Program References / Recommended Model:
Recovery Oriented Systems of Care; Recovery Cafes

Select quotes (edited for clarity):

People with co-occurring disorders are often volleyed back and forth between agencies because each org handles just 1 category of disorders. That causes many to be left without any help; or to choose 1 service over the other, but often failing to succeed in that treatment because they're weighted down by SUD or mental health issues. This a chicken & egg problem!

Co-occurring treatment centers are almost impossible to find.

There appears to be a significant lack of those trained in both mental health issues and SUD disorder co-occurring in individuals. So either one or the other is treated based on the training of the counselor.

Co-occurring treatment is the most difficult to obtain, especially for individuals that are designated severely mentally ill (SMI). There are currently very limited housing options for these individuals.

Quotes from the recovery community:

Not enough providers willing and able to treat both SUD and mental health.

This group is the least understood and have less access to comprehensive treatment and providers.

It makes it hard to treat one without options for treating the other. Many times the person using a substance is doing so to self-medicate.

Please tell us why you chose this population as your top priority for treatment and recovery support services	
2. Rural communities (n=120)	
Common themes: • Underserved population. • High concentration of individuals with SUD. • High rates of poverty and other social needs that represent barriers to recovery. Suggested approaches included: • Expand treatment access and options, including access to MOUD/MAT, harm reduction, and peer coaches. • Expand transportation supports. • Devote resources to attract and support the SUD/OUD and mental health workforce. • Support the development and expansion of Recovery Community Organizations (RCOs) and similar treatment centers. Specific program references RCOs; Hub and spoke model	**Select quotes (edited for clarity):** *I feel all of them are important, but being in a rural community, I know how little we have to help individuals and when they travel for residential treatment and come back, there is little in the way of support.* *Rural communities were disproportionately impacted by this issue, and yet are the most under-resourced.* *I chose rural communities because there are often NO options for public transportation in these areas. This creates such a hardship for people and contributes to people not accessing SUD services, and ending treatment long before they are ready.* *This is a smaller, more rural community and services are not readily available. It is difficult for CMH to attract and hire and retain quality therapists and clinicians.*
Quotes from the recovery community: *Rural communities only have access to NA and AA groups, which tend to be outdated and only promote abstinence-based recovery. Peer coaches can help connect them to resources and help them discover alternate pathways.* *Rural communities lack the basic recovery supports needed - outside of AA meetings or Celebrate Recovery - a fully equipped RCO for rural communities will align with the current HRSA Federal proposal as well.*	

Please tell us why you chose this population as your top priority for treatment and recovery support services

3. Pregnant and post-partum women (n = 118)

Common themes:

- Ripple effect of positive change within the family.
- To prevent/reduce long-term negative consequences for the children.
- High-risk population.

Suggested approaches included:

- Increase access to resources specifically for pregnant and post-partum women with SUD, including beds/transitional housing.
- Expand treatment options, including options beyond methadone, Subutex, and Suboxone.
- Provide education and resources to clinicians, policymakers, and mothers on topics such as family-centered, integrated care models, and best practices for human lactation.
- Childcare assistance.

Specific program references/ recommended models:
Integrated care models that provide medical, SUD treatment, and social and peer support services to pregnant and parenting women with SUD, a PROVEN model of care for this population; family-centered SUD treatment models that prioritize family unity and keeping parents and children together, even during residential treatment

Select Quotes (edited for clarity):

There were only a few beds for pregnant women in Substance Abuse programs - we need to make it not only available, but stigma free and inviting.

This is where the family starts, with the mom and she ultimately will be making decisions for the family. If we can help support her to help support her family everyone will benefit around her. Education and communication have been key to some of our successes that we have seen.

This is the population I work with the most. I would like to see more resources for this population other than Subutex or suboxone

Quotes from the recovery community:

In that State of MI if a woman finds herself pregnant while active in Opioid use, a doctor WILL NOT allow her to detox. She will be required to start methadone. Transitional housing that take women on methadone are non-existent. If she has other children in her care there are zero options for her. Women should have the choice on how to care for her children and her addiction.

We need to protect the unborn children and look at options outside of methadone.

Due to lack of special resources for pregnant and post partum in Muskegon. Many have to go to Kent County, which is not feasible for many. Also, stigma and women and nervous to seek help with SUD for fear of losing kids and other criminal charges if they come forward.

Please tell us why you chose this population as your top priority for treatment and recovery support services
4. Infants with NAS (n= 96)
This population is the most vulnerable of the populations.
Babies should not have to suffer because of the parents choices.
5. Communities where the majority of residents are racial/ethnic minorities (n= 92)
I have witnessed first hand … the devastation that addiction has on individuals, their families, their communities and their Tribe. At any given time, run the race reports of individual's incarcerated in the Chippewa County jail for substance related offenses and you will clearly see the disparity between race populations. This is a prime opportunity to address addiction in rural Michigan locations for people of color.
Communities where the majority of residents are racial/ethnic minorities lack resources and funding. They are also the communities that have been affected most by punitive drug laws.
Nobody did a thing for the BIPOC communities back during the "crack epidemic".[…] The racial inequity in this country is staggering, and it feels like these drug scares are simply scapegoats to avoid facing this REAL issue.
6. Individuals incarcerated in jails and prisons (n= 73)
This is a perfect opportunity to provide treatment services and explain the importance of sober support meetings when released from jail or prisons.
High problem complexity leads to high service utilization. Incarcerated people tend to have high complexity, low recovery capital, and often have high problem severity. Their contact with the criminal justice system provides a valuable opportunity to reach them.
OUD/SUD is one of the most prevalent medical/behavior condition among the incarcerated population. This population is also more likely to overdose upon reentry to their community.
7. "Other"
Teenagers and young people: If you can help a young person achieve recovery it creates the most impact across time. And young people are the most easily helped group in society. It is our duty to put young people first.
Areas where the resources are most scarce: An evaluation of current resource availability should be conducted and the funding should be directed to areas in greatest need, based on that objective evaluation.
Juveniles: Services for juveniles are drastically underfunded and overlooked.

Priority Most Important for Harm Reduction

Please tell us why you chose this activity as your top priority for harm reduction

1. Expand programming to divert/deflect individuals from the criminal-legal system (n = 358)

Common themes:

- Jail is not an effective setting for rehabilitation/recovery.
- SUD is an illness, not a crime.
- There are long-term negative outcomes of incarceration.
- Diversion/deflection is cost-effective.
- Decriminalization will help combat stigma and promote seeking treatment.

Suggested approaches included:

- Expand access to drug courts.
- Couple diversion with treatment and strengthening partnerships with mental health and community-based services.
- Incorporate recovery coaches and peer recovery counselors.

Specific Program References:
Kalamazoo Defender Program; Jail Alternatives for Drug Offenders

Select Quotes (edited for clarity):

It is a known fact that criminalizing SUD does not reduce SUD. Drug/sober court programs are effective, and funding PRCs for the teams is effective. We have effective outcomes doing this in Macomb County in many courts.

Diversion programs can be very effective if the individuals are connected to the proper treatment services. Previous priorities focused on expanding the treatment infrastructure, which would only increase the success of an expanded diversion program.

Diverting people from entering the legal system may be an effective strategy to get more people actively engaged in treatment. The legal system adds stigma to treatment services (unintentional effect).

Quotes from the recovery community:

Once an individual has a criminal record, their life and opportunities are changed forever making it more difficult to get out of the cycle of substance use and criminal activity. It has been shown repeatedly that punitive measures do not solve SUD and MH disorders and an avenue towards treatment rather than incarceration will have better results.

SUD is a huge unnecessary burden on the CJ system and diversion needs to be earlier, more accessible, and streamlined.

Criminal system diversion must be the answer for those facing criminal sanctions for medical conditions, which includes an addiction. Ineffective public defenders, probation requirements that are difficult to achieve, and paying fines are all criminal justice system consequences that negatively impact those individuals who are in poverty, underemployed, unable to afford food and safe housing, and lack privilege.

Please tell us why you chose this activity as your top priority for harm reduction	
2. Naloxone distribution and training (n= 215)	
Common themes: • Prevents imminent death. • Fewer barriers to implementing this; anyone can do it. • People afraid of stigma and criminal charges don't call for help. Suggested approaches included: • Reduce cost to access for consumer, make more accessible. • Reduce dollar cost to consumer (i.e., insurance coverage). • Make it standard practice for first responders to have training and carry naloxone. • Community-level training; have naloxone available everywhere (e.g., libraries, pharmacies, etc.).	**Select Quotes (edited for clarity):** *People are dying and some places still have EMT and police services that show up with a body bag and no naloxone.* *Easy to tackle, relatively cheap, and needed in community.* *It immediately saves lives and can provide an opportunity for entry into recovery.* *Training available for Narcan distribution as well as helping to reduce the stigma around Narcan is vital.*
Quotes from the recovery community: *Naloxone provides opportunity to continue to work with the person who has had an OD reversal. I'd love to see more work being done with media to provide information that the OD reversal provides an opportunity to access other much needed services by contacting their local RCO.* *Narcan is not free to everyone and not many people know where to find it. Every business, no matter what kind, should carry several kits and be properly trained.* *I believe we cannot make an impact in these lives unless we keep them alive first and Narcan training is what we need. The Narcan trainings not only teach people how to use Narcan but about the stigma of addiction and stigma in the recovery community.* *People are dying and some places still have EMT and police services that show up with a body bag and no naloxone.*	

Please tell us why you chose this activity as your top priority for harm reduction

3. Expanding capacity in existing Syringe Service Programs (SSPs) to provide more wrap-around services and linkages to treatment resources (n= 197)

Common themes
- Helping people help themselves.
- Captive audience – the population using SSPs knows they are at risk.
- Avoids the stigma of going to a local health department.
- Provide support and compassion.

Suggested approaches included:
- Ensure timeliness of services and linkages to treatment.
- Provide more funding for supplies, such as syringes.
- Use peer supports at SSPs and provide more funding to staff and training PRCs.

Specific program references:
Red Project; Comprehensive Care Model

Select Quotes (edited for clarity):

SSPs are often the first place my clients hear about treatment options and help protect them from disease.

SSP's build trust and connection to drug users, and they have the unique ability to assist in navigating the person toward available resources.

SSP can guide people to choose recovery plus it keeps them safe from reusing or sharing needles which is a public health matter.

There is a significant lack of SSPs, especially in rural areas and in the U.P. We need to expand so that everyone has access to these programs. This needs to happen before we can even begin to add wraparound services, which is also needed.

Quotes from the recovery community:

If the quality of existing SSPs is increased, then these organizations could become crucial front-line places of engagement for people with SUD. Greater coordination between peer support providers and SSPs seems essential. I'm looking at, in my organization, either staffing PRCs directly to SSP distribution sites or helping SSPs build capacity to receive PRC training and utilize aspects of peer support in their engagement with participants.

Helping individuals who are already helping themselves is essential.

SSPs provide incredible services to the community and are underfunded at this time. We are having to limit the supplies we give out to participants which pulls us farther away from what we set out to do, which is to provide enough supplies for a new syringe for every shot, therefore lowering the numbers of communicable disease. SSPs desperately need more funding, or we will begin to see the rates of communicable disease.

More SSPs with wraparound services to provide individuals with as many resources in ONE location.

Please tell us why you chose this activity as your top priority for harm reduction
4. Expanding the number of Syringe Service Programs (SSPs) (n= 67)
When they come to get their syringes they can be sure there is hope for them and find out what resources are available to them to get off the streets.
We do not have an SSP in our county.
You can use grant money to buy supplies for SSP's, which makes it difficult for a lot of regions to offer this service.
5. "Other"
Safe Supply: … there is a safe, regulated supply of alcohol, and now marijuana, but not one available for any other substances that could contain fentanyl! People are dying from essentially being poisoned, or not knowing what it is they are putting in their body. We need to be able to provide people with what it is they are seeking, in a regulated, and clean/quality fashion. This can be done through systems similar to a methadone.
Open a safe place for people to use drugs: People die of overdoses because they are relegated to using alone, often in unsafe environments. If they have access to somewhere they can safely use their product while being observed by medical personnel, many deaths will be prevented. These services are available in Canada and are shown to significantly reduce deaths as well as increase interest in seeking treatment along with reducing other complications of substance use disorder.
Expand access to psychiatric and behavioral health services for patients with OUD: I find this is and was the most helpful of interventions I offered to OUD patients. I believe that when we meet their behavioral health needs, we can reduce the triggers that cause them to reach for opioids.

Priority Most Important for Research and Evaluation (condensed)

Please tell us why you chose this activity as your top priority for research and evaluation
1. Research on new and best practices (n = 359)
Let's learn from what other communities are doing that is successful and not recreate the wheel.
What works is different in different communities and cultural groups. Learn! Learn! Learn!
Most studies indicate concurrent stimulant use – [we need] strategies to treat the multi substance use disorders.
2. Evaluation of opioid-abatement strategies (n = 223)
I believe there have been many programs funded. But we now need to examine, which programs work and why? This will require data collection from existing programs.
There is a lot of misinformation spread on how to reduce opioid use. Many people are given the spotlight and funding to say they are "reducing stigma" through education, however there is no data behind these approaches, nor is the data presented validated or considered reliable. The community would benefit from EBP guidance on data collection and abatement strategies funded by MDHHS to the provider network.
Data collection is only relevant if you can share and use the data, it has to be meaningful.
3. Data Collection Activities (n = 186)
Data collection/needs assessments with the affected populations allows for the community to share what their needs are rather than funders to assume what is needed. Nothing for us without us.
Connecting data across systems (overdose deaths to jail records; information about treatment with MOUD to jails/prisons) is important in understanding trajectories, as well as in providing continuity of care.
While all are important, currently it is difficult to analyze all services provided to an individual due to the varied systems used to collect data.
4. "Other"
Talk to SUD sufferers: I don't trust our current evaluation strategies. Our data is very rough, we ask the wrong questions and we are not open to including everything in the process and putting all solutions on the table.
Research on evidence-based treatment, prevention, and recovery services for historically excluded audiences: There is a lot of focus on the use of evidence-based strategies and programs for SUD and OUD. However, the evidence supporting these strategies and programs are often led by all-white teams of researchers and have majority white study populations. More research is needed to evaluate strategies and programs that can be effective with other audiences that have different lived experiences.
Community based participatory research: The communities impacted deserve to be a part of the research process and be compensated through focus groups. Also to have access and ownership of data.

Note: the opinions expressed in the tables above do not necessarily reflect the views of MDHHS or of all survey respondents. Example quotes are included to add context and detail to complex survey priority topics and themes.

Tracking Federal Funding to Combat the Opioid Crisis

March 2019

BIPARTISAN POLICY CENTER

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Glossary of Acronyms

CDC: Centers for Disease Control and Prevention

COAP: Comprehensive Opioid Abuse Site-based Program

DEA: Drug Enforcement Administration

DATA: Drug Addiction Treatment Act

DOJ: Department of Justice

FDA: Food and Drug Administration

HHS: Department of Health and Human Services

MAT: Medication-assisted treatment

NIH: National Institutes of Health

NSDUH: National Survey on Drug Use and Health

ONDCP: Office of National Drug Control Policy

OUD: Opioid use disorder

PDMP: Prescription Drug Monitoring Program

PRNS: Programs of Regional and National Significance

SABG: Substance Abuse Prevention and Treatment Block Grant

SAMHSA: Substance Abuse and Mental Health Services Administration

SOR: State Opioid Response

STR: State Targeted Response

Executive Summary

In 2017, more than 70,000 people in the United States died from a drug overdose, with almost 50,000 of these deaths involving an opioid.[1] The United States is facing a devastating opioid epidemic, and the federal government has responded by investing billions of dollars into prevention, treatment, and recovery efforts over the past two years. This includes efforts to curb the supply of both illicit opioids and unnecessary prescription opioids and to improve access to evidence-based treatment for opioid use disorder. Despite these actions, addiction policy experts believe that the end of the epidemic is not yet in sight.

Considerable attention has focused on the drivers of the opioid epidemic. However, less attention has been paid to whether the federal investments to address the issue are being effectively targeted to the communities most affected and to those with the highest overdose deaths. An effective response requires policymakers to know how resources are allocated and to use that information to minimize duplication and maximize the efficiency of limited resources. The federal government has not previously produced or made available a document that provides this information to the public or policymakers.

★ ★ ★

Thus, the Bipartisan Policy Center created this first-of-its-kind, comprehensive report that tracks federally funded opioid programs in fiscal year 2017 and FY2018, and examines how these appropriated funds are being directed to address the opioid epidemic.

Over the past six months, BPC conducted a detailed analysis of federal appropriations and identified 57 federal programs that, either entirely or significantly, fund efforts to curb the epidemic. In total, the federal government included nearly $11 billion for these programs in its FY2017 and FY2018 discretionary appropriations bills. This includes a 124 percent increase between FY2017 ($3.3 billion) and FY2018 ($7.4 billion). These programs span the continuum of care, including prevention, treatment, and recovery. In addition, funds are directed to research, criminal justice, public health surveillance, and supply reduction efforts. Between FY2017 and FY2018, funding specifically targeted to opioid use disorder treatment and recovery increased by $1.5 billion (from $599 million to $2.12 billion). Over three quarters (77 percent) of the appropriations to opioid programs are administered by the Department of Health and Human Services (HHS).

The report also examines how federal opioid investments are spent across five geographically diverse states: Arizona, Louisiana, New Hampshire, Ohio, and Tennessee. The average drug overdose death rate in the five case study states was nearly one and half times (144 percent) higher than the national average in 2017.[2] Each state case study takes an in-depth look at how these states are allocating the two largest federal opioid grants, the State Targeted Response and State Opioid Response grants. BPC's analysis also incorporates county-level maps of federal funding and drug overdose deaths from 2015 to 2017 for each of the selected states.

BPC's five state case studies revealed:

1. A statewide coordinating body, typically convened by the governor, is an essential part of developing a strategic opioid epidemic response. Each of the five states BPC studied has a coordinating body to facilitate data-sharing and communication.
2. States are increasingly focused on building out treatment networks for individuals with opioid use disorder, using funds for direct payment supports for treatment in at-risk populations, providing trainings and technical assistance, distributing naloxone, and enhancing the treatment workforce.
3. Federal funding in these states is flowing to areas with the highest number of deaths. When examining the per capita federal funding in rural and metropolitan areas, many rural counties receive relatively low levels of direct funding compared with the more populated cities. It is important to note that the recipient of funds may not necessarily correspond with the geographic service area.
4. Ongoing evaluation is needed to help track all phases of progress in the state's response to the opioid epidemic, including prevention, treatment, and recovery. Output data from these programs is only preliminary and more attention is needed to evaluate the effectiveness of this funding and its effect on longer-term outcomes.
5. Medicaid (and Medicaid expansion in four of five case-study states) has been essential to providing services to individuals with opioid use disorder.

BPC conducted interviews with various state government officials and staff and collected information from the federal and state analyses. As a result of this examination, there are three essential steps that policymakers should take to improve the federal response to the opioid epidemic:

1. HHS, other federal departments, and non-governmental organizations involved in the response should assist states in identifying sustainable sources of federal, state, and private-sector funding to address the opioid epidemic. The Substance Abuse and Mental Health Services Administration's Prevention and Treatment block grant is one example of a critical federal source of long-term funding that has been level-funded at approximately $1.8 billion for the past 10 years, representing a 31 percent decrease in funding when adjusted for inflation.[3]
2. There is substantial need for improved coordination of grant programs at the federal level, particularly with the aid of the White House Office of National Drug Control Policy. Enhanced federal coordination of opioid funding programs across federal agencies will improve program coordination at the state level. This is critical given the sheer volume of grants going to states, the need for coordination across state agencies and local governments, and the multifaceted nature of the epidemic.
3. Congress and the administration should build flexibility into federal grants to allow state agencies to adapt to quickly changing conditions on the ground. Flexibility in funding ensures that while states are responding to today's opioid epidemic, they are also prepared for other emerging drug threats, such as methamphetamine and cocaine.

Further research and evaluation is necessary to ensure that states are delivering quality, evidence-based services and that federal funds support not only service delivery but also sustainable infrastructure to prevent and treat opioid use disorder. The critical role of other sources of funding—specifically Medicaid and private insurance—to address the opioid epidemic also need to be tracked.

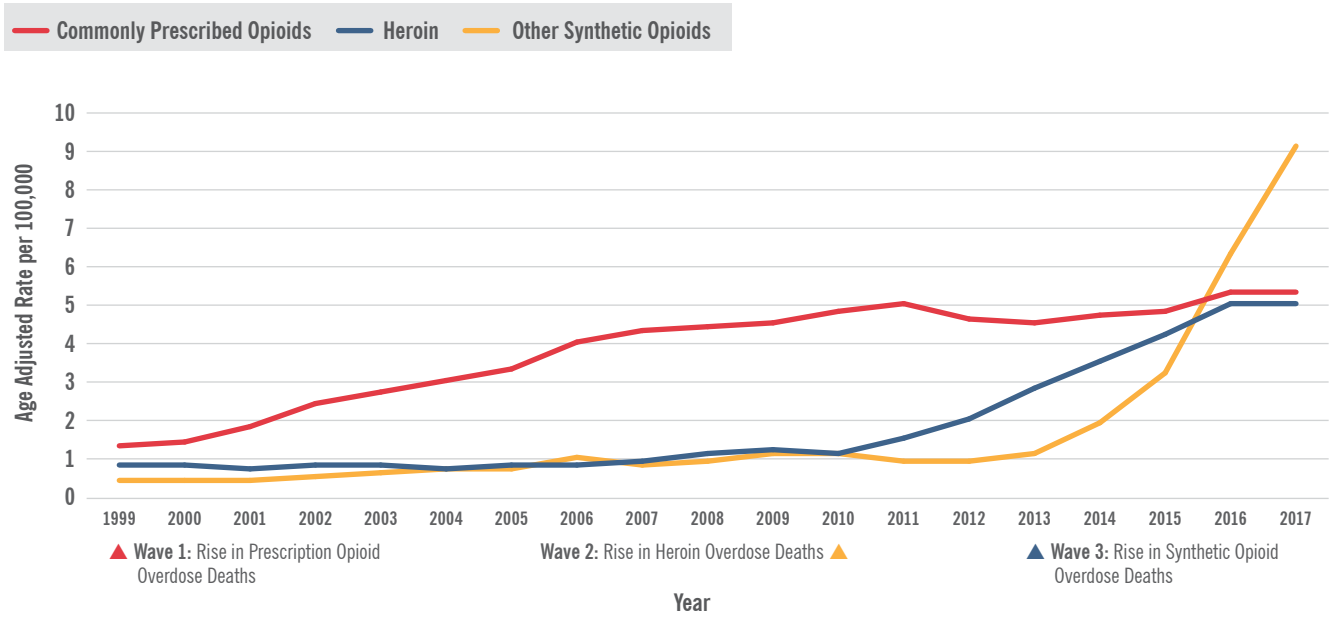
Background

As has been widely reported, more than 70,000 people in the United States died from a drug overdose in 2017, the majority of these overdoses involved an opioid.[4] 2017 also marked the third year in a row that the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics reported a decrease in life expectancy in the United States.[5] The National Center for Health Statistics linked decreased life expectancy with increasing rates of drug overdose deaths and suicide.[6]

While the majority (47,600) of overdose deaths in 2017 involved an opioid, the primary driver of opioid-involved overdose deaths is illicit fentanyl. Drug overdose deaths involving prescribed opioids have leveled off since 2016, although rates are still double what they were in 2007. Opioid prescribing rates fell from 2012 to 2017.[7] In 2017, West Virginia, Ohio, Pennsylvania, and the District of Columbia had the highest overdose death rates in the country.[8] While a few states, including Massachusetts, New Hampshire, and New Mexico experienced a decrease in overdose death rates between 2016 and 2017, and preliminary data from CDC show a slight decrease in overdose deaths in 2018—though it is too soon to tell whether this is a trend.[9]

Along with overdose mortality, there are many other consequences of the opioid epidemic. Consequences include increased risk of infectious disease among people who inject drugs, newborns with neonatal abstinence syndrome, and increasing rates of emergency department visits for opioid-involved overdoses.[10,11] In addition, after years of decline, the number of children in foster care is increasing.[12] The Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE) recently released a study exploring this increase. The ASPE report found that areas of the country with higher overdose death rates also have higher rates of children placed into foster care.[13]

Figure 1: 3 Waves of the Rise in Opioid Overdose Deaths



Source: CDC Wonder

Three Phases of the Epidemic

The CDC has identified three waves of the opioid epidemic (Figure 1), beginning with deaths involving prescription opioids, followed by increases in heroin, and finally synthetic opioids or fentanyl. The years 1999 to 2006 saw 10 percent annual increases in overdose deaths, slowing to an increase of 3 percent per year from 2006 through 2014, followed by a jump to 16 percent annually from 2014 through 2017.[14]

The first wave of the opioid epidemic was ushered in by the introduction of OxyContin onto the market in 1996. OxyContin, a long-acting opioid generically prescribed as oxycodone, was promoted as a medication capable of relieving pain for up to 12 hours and was labeled as nonaddictive.[15]

The American Pain Society sought to enhance the treatment of pain during this same time period.[16] In 2001, the Joint Commission on Healthcare Organizations (now the Joint Commission) issued new pain-management standards.[17] Opioid prescribing rates subsequently increased sharply. In 2009, primary care physicians prescribed the majority of opioids.[18]

The combination of a highly addictive drug's introduction to the market, an emphasis on addressing pain, aggressive marketing, and over prescribing—as well as a lack of evidence-based treatment availability and training in addiction—laid the groundwork for the opioid epidemic.[19]

At the same time, pain clinics with little legal or regulatory oversight sprang up in Florida and other states in the Southeast. The Drug Enforcement Administration (DEA) reported that 90 of the top 100 oxycodone prescribers in the nation were in Florida.[20] In the face of an increasing number of "pill mills" and mounting overdose deaths, beginning in 2010 Florida state legislators passed several laws intended to shut down illegally operating pain clinics. As a result of the new legislation and enhanced law enforcement activities, overdose death rates began to fall in Florida.[21]

Nationally, faced with increasing reports of overdose deaths, a new formulation of OxyContin was introduced in 2010. The product was reformulated to make it more difficult to be crushed and snorted. The new formulation, as well as an increased emphasis on proper opioid prescribing, led to the second wave of the epidemic.

The second wave was marked by increasing rates of heroin-involved overdose deaths. As prescription opioids became harder to access due to federal and state policies that encouraged the use of prescription drug monitoring programs and decreased opioid prescribing, individuals with opioid use disorders turned to a cheaper and more readily available opioid: heroin. Heroin users were increasingly residents of small urban or non-urban, predominantly white areas of the country compared to previous eras.[22] Heroin users were also likely to have begun misusing prescription opioids before using heroin.[23]

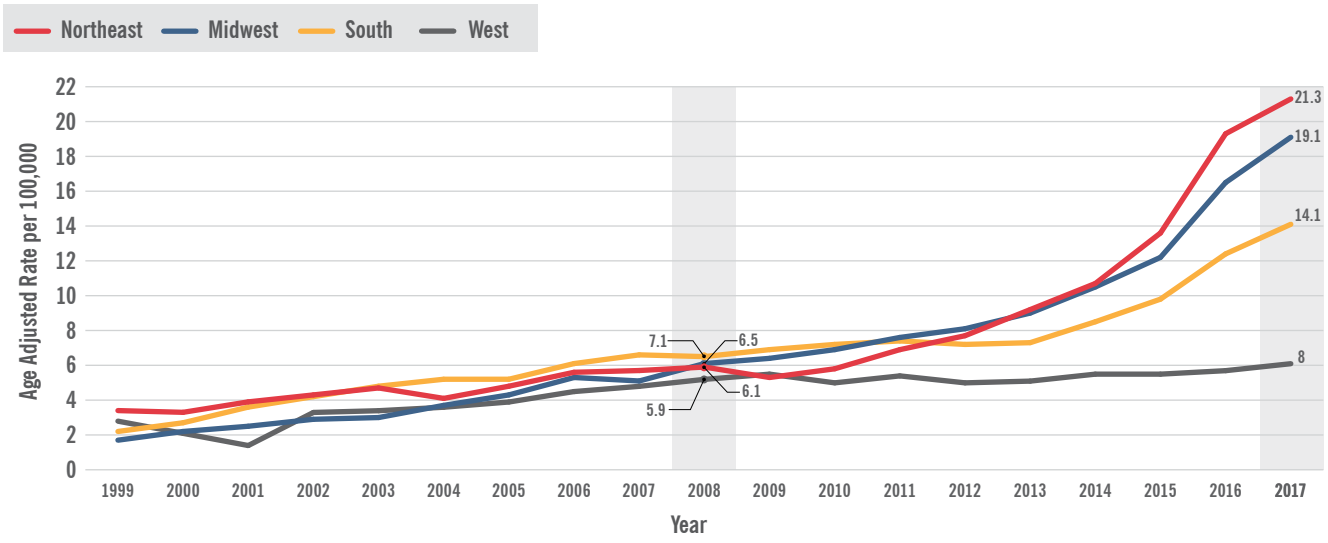
Today, the United States is in midst of the third wave of the epidemic, marked by the increasing availability of illicit fentanyl and fentanyl analogs and increasing rates of overdose deaths involving synthetic opioids. Illicit fentanyl available in the United States originates in China.[24] This product is either shipped to Mexico or the United States and is sometimes mixed with heroin, or in some cases pressed into pills. Fentanyl is cheap and powerful, and DEA seizures are more prevalent east of the Mississippi River.[25] In Washington, DC, the Office of the Chief Medical Examiner reported that 71 percent of overdose deaths in the District involved fentanyl or a fentanyl analog. West Virginia, Ohio, and New Hampshire had the highest death rates from synthetic opioids in 2017.[26] Fentanyl has contributed to skyrocketing deaths from total opioid overdoses over the last few years as depicted in Table 1. Opioid overdose deaths made up 56 percent of all drug overdose deaths in 2012, increasing to 68 percent in 2017.[27]

Table 1: U.S. Overdose Death Totals, 2015-2017[28]

	Opioids		All Drugs	
Year	Deaths	Age-Adjusted Rate Per 100,000	Deaths	Age-Adjusted Rate Per 100,000
2012	23,166	7.4	41,502	13.1
2013	25,052	7.9	43,982	13.8
2014	28,647	9.0	47,055	14.7
2015	33,091	10.4	52,404	16.3
2016	42,249	13.3	63,632	19.8
2017	47,600	14.9	70,237	21.7

While the opioid epidemic affects every state, there are regional and state-by-state differences in its impact. In 2017, the Northeast and the Midwest had opioid mortality rates (deaths per 100,000) of 21.3 and 19.1 respectively, followed by 14.1 in the South and 8 in the West.[29] Figure 2 shows the trends in opioid death rates from 1999 through 2017.

Figure 2: Opioid Death Rates by Census Region



Source: CDC Wonder

Policy Response

As the opioid epidemic has evolved, so too has the government's policy response. The CDC declared an opioid epidemic in 2011 and the Office of National Drug Control Policy (ONDCP) released a whole-of-government plan to address the epidemic that same year.[30] While the plan emphasized reducing prescription opioid misuse, successful implementation of the plan was linked to the Affordable Care Act (ACA) and Medicaid Expansion. The ACA required coverage for substance use disorder treatment and expanded access to substance use disorder treatment.[31] During this same time period, federal agencies were implementing budget sequestration measures, which limited flexibilities for policymakers to provide substantial new funding for national priorities, including addressing the opioid epidemic.

As the United States faced increasing rates of overdose deaths involving heroin and synthetic opioids such as fentanyl, the federal government readjusted its strategy. Efforts were made to expand access to treatment medications for opioid use disorder and to the opioid overdose antidote naloxone. In addition, discussions were held with China and Mexico to stop the flow of heroin and illicit fentanyl into the United States.[32] In 2015, after such discussions, China expanded its list of controlled synthetic chemicals to include six fentanyl products.[33] This process continued throughout 2018 with various commitments by China to schedule all fentanyl products.[34] However, experts note the difficulty of scheduling all fentanyl products since they can be modified easily. Domestically, the U.S. Congress passed legislation in 2017 and 2018 (the INTERDICT Act and the Stop Act, part of H.R. 6) to disrupt illicit fentanyl trafficking in the United States.[35,36]

In 2016, President Barack Obama signed into law two significant pieces of legislation to address the epidemic, the Comprehensive Addiction and Recovery Act (CARA) in 2016 and the 21st Century Cures Act (the Cures Act) also in 2016. These two laws, taken together, authorized over $1 billion in funding to curb the opioid epidemic. CARA authorized grant programs to be administered by the Department of Justice (DOJ) and HHS. The Cures Act authorized $1 billion in funding for states to be administered by HHS's Substance Abuse and Mental Health Services Administration (SAMHSA).

Also in 2016, the CDC issued a Guideline for Prescribing Opioids for Chronic Pain. The guideline provides information for prescribers on proper opioid prescribing and the potential risks associated with such prescribing.[37] The rate of opioid prescribing in the United States has decreased 9.3 percent annually from 2009 to 2016.[38] In 2017, the opioid prescribing rate fell to the lowest rate in 10 years. However, prescribing rates vary widely across the country, with some counties continuing to show exceptionally high opioid prescribing rates.[39]

With no sign of the epidemic abating, the Trump administration declared a public health emergency in October 2017.[40] The administration also formed the President's Commission on Combating Drug Addiction and the Opioid Crisis led by then-Governor Chris Christie (New Jersey) to lay out a policy blueprint to address the epidemic. The commission's report was issued on November 1, 2017, with an ambitious set of recommendations.[41] The recommendations included efforts to prevent, screen, and treat substance use disorders; to expand recovery programs; and ways to more effectively

coordinate federal drug policy. The report also included an overview of the president's fiscal year 2018 drug budget, a $27 billion funding request across various federal agencies aimed at reducing both the demand and supply of all drugs. Recommendations in the commission's report also aligned with proposals released by BPC's Governors' Council on July 12, 2017.

Since the beginning of the Trump administration, both HHS and the DOJ have announced efforts to curb the epidemic. HHS's Five Point Plan includes preventing substance use, expanding access to treatment (with an emphasis on medications for the treatment of opioid use disorder), expanding recovery supports, strengthening data collection, improving pain management, targeting overdose-reversal drugs, and conducting research.[42]

The DOJ has also taken vigorous action to curb the illegal supply of opioids through DEA enforcement actions, as well as by providing grant funding through the Bureau of Justice Assistance and other DOJ agencies, such as the Community Oriented Policing Services program.[43,44,45]

In 2018, Congress and the president enacted comprehensive authorizing legislation to address the opioid epidemic, the SUPPORT for Patients and Communities Act (the SUPPORT Act). This bipartisan law includes numerous provisions to prevent opioid misuse and increase access to treatment, as well as to control the supply of illicit drugs flowing into the country. The law seeks to expand access to treatment by authorizing a loan repayment program for professionals in areas of high need; promotes telehealth; revises the Institutions for Mental Diseases exclusion, or the "IMD exclusion," for pregnant and postpartum women; and allows for Medicare coverage of Opioid Treatment Programs. Supply-reduction provisions in the law include sections to strengthen coordination between the Food and Drug Administration (FDA) and Customs and Border Protection to improve illicit drug detection, as well as the Synthetics Trafficking and Overdose Protection Act, or "STOP" Act. The legislation also calls for enhanced safety packaging for opioids. The SUPPORT Act also directs government agencies to conduct studies on aspects of the opioid epidemic and reauthorizes various opioid-related grant programs, including the 2016 Cures Act grant program. The bill also includes provisions relating to children and their families who have been affected by the opioid epidemic.

BPC Study Purpose and Methodology

While considerable attention has focused on the drivers of the opioid epidemic, less attention has been paid to how the federal government is allocating financial resources to address the issue; what the appropriate allocation of responsibility is among federal, state, and local entities; where funding is going; and whether it is being targeted to communities most affected by the epidemic. As of the writing of this report, there is no publicly available report from the federal government that provides this information.

Key information about resource availability and allocation will allow policymakers and the American public to make informed decisions on whether sufficient resources are being spent to support an effective national response. This information will also help policymakers identify and advocate for evidence-based activities that will curb the opioid epidemic.

BPC undertook this study to determine how federal funds are allocated to states and localities and for what purpose in the government's effort to decrease opioid use disorders and overdose deaths. The study includes deep dives into spending by selected states to elucidate how states are receiving and using federal opioid funds. The information in this report will help inform federal and state policymaking, as well as identify gaps that could be filled by private-sector and philanthropic organizations.

BPC's robust analysis for this study relied on multiple research approaches:

1. **Identifying Federally Funded Opioid Programs:** BPC reviewed congressional appropriations and documentation to identify opioid-related federal grant programs. The review included scans of congressional committee and agency documents, and a review of Explanatory Statements for each of the federal appropriations bills in 2017 and 2018.[46,47] When identifying programs, BPC erred on the side of broad inclusion, including programs such as the Substance Abuse Prevention and Treatment Block Grant, the Drug-Free Communities program, and the High Intensity Drug Trafficking Areas program.[a]
2. **Validating a Catalog of Federal Appropriations and Awards:** BPC spoke with budget officials from multiple federal agencies to validate the programs included and to verify opioid program levels.
3. **Aggregating and Analyzing State Spending Data:** After determining programs to include as opioid-related federal spending, BPC obtained state-level award information from agency sources. Agency data were then cross-referenced with spending information catalogued by the U.S. Department of Treasury in USAspending.gov for quality control.
4. **Preparing Case Studies:** BPC selected five states representative of a broad cross-section of issues related to resource allocation and emphasis on addressing the opioid epidemic. Information gathered for the cases was obtained from leadership in state agencies that received the federal opioid grants to verify state-level information. BPC performed site visits for two states, Ohio and New Hampshire, to learn directly from state agency leadership about the state's use of federal funds. For case-study states, BPC also obtained state- and county-level opioid spending data for spatial analysis.

A detailed explanation of BPC's methods and considerations is included in Appendix III.

[a] These programs address all forms of substance use and drug trafficking and are not limited to opioids. BPC erred on the side of inclusion since it is impossible to separate out funding specifically targeted to opioids from spending on other substances in programs such as these. However, these programs form the basis for much of the federal government's prevention, treatment, and supply-reduction efforts.

Federal Analysis

Federal funding dedicated to the opioid epidemic is distributed to multiple agencies across the government, with the largest portion going to HHS. In FY2017, the total federal opioid funding was $3.3 billion; this increased to $7.4 billion in FY2018, an increase of 124 percent.

Federal appropriations dedicated to addressing the opioid epidemic are distributed to a wide range of programs. In turn, these federal programs provide funding to states. BPC conducted an analysis of all discretionary spending to identify and categorize opioid appropriations in FY2017 and FY2018.

The full list of 57 federal programs funded to address the opioid epidemic are included in Appendix I. Table 2 below breaks down opioid appropriations by federal department.

Table 2: Opioid Appropriations by Department

Department	FY2017	FY2018
Health and Human Services	$2,765,589,000	$5,521,368,000
Substance Abuse and Mental Health Services Administration	*$2,603,679,000*	*$3,685,479,000*
Indian Health Service	*$6,000,000*	*$6,000,000*
Centers for Disease Control and Prevention	*$112,000,000*	*$630,579,000*
Health Resources and Services Administration	*	*$480,000,000*
Administration for Children and Families	*$43,910,000*	*$125,310,000*
National Institutes of Health	*	*$500,000,000*
Food and Drug Administration	*	*$94,000,000*
Office of National Drug Control Policy	$351,000,000	$379,000,000
Department of Justice	$194,000,000	$515,839,484
Veterans Affairs	*	$704,552,000
Homeland Security	*	$261,100,000
Department of Labor	*	$21,000,000
Total Opioid Spending	**$3,310,589,000**	**$7,402,859,484**

* = No opioid-specific appropriations.

As shown in Table 2, in FY2018, Congress appropriated significant additional funds to HHS and the DOJ, and new funds to the Department of Veterans Affairs, the Department of Homeland Security, and the Department of Labor. In FY2018, appropriations provided new funding for research (National Institutes of Health), criminal justice and law enforcement (DOJ), and interdiction (Department of Homeland Security and the FDA). In 2018, the National Institutes of Health (NIH) launched HEAL (Helping End Addiction Long-Term℠) to dedicate over $500 million in FY2019 to research to improve treatments for opioid misuse and addiction and enhance pain management—including with nonaddictive treatments.[48] The increases to foundational substance use prevention and treatment programs was combined with new funding to departments that play a role in the prevention, treatment, interdiction, and workforce programs to alleviate the ongoing opioid crisis.

Further details follow below on agencies responsible for the bulk of programs that provide treatment and prevention, oversee criminal justice programs related to opioids, and provide surveillance of the opioid epidemic: SAMHSA, the DOJ, and the CDC respectively.

SAMHSA

The Substance Abuse and Mental Health Services Administration is one of the primary federal agencies charged with providing funding to address the opioid epidemic. SAMHSA administers the two main opioid grant programs: the State Targeted Response (STR) and the State Opioid Response (SOR) grants. STR was authorized in the 21st Century Cures Act and is intended to close the treatment gap between those who seek treatment and those who receive it. The grant application specifies that no less than 80 percent of the award must fund treatment services. Funds were awarded to states based on a formula and $500 million was awarded to states in FY2017 and $500 million in FY2018.[b] Supplemental STR funding of $1 million was awarded to three states in FY2018. The 10 states with the highest rate of overdose deaths were eligible to apply for this supplemental funding. STR funding made up 15 percent of total appropriations to address the opioid epidemic in FY2017.

The SOR grant program was awarded to states in FY2018. The SOR is a $1 billion grant program with a 15 percent set-aside for states with the highest rate of drug overdose deaths. The SOR program is intended to build on the STR program. The funding opportunity announcement requires that applications for funding include the entire continuum of care, prevention, treatment, and recovery. In addition, programs receiving funds under the SOR grant are required to make treatment medications—such as methadone, naltrexone, and buprenorphine—available. The STR and SOR programs combined made up 21 percent of total opioid-related appropriations in FY2018.

For purposes of this report, BPC included the Substance Abuse Prevention and Treatment Block Grant (SABG) program in its calculation. The SABG addresses all forms of substance use in states, not only opioid misuse, and is the largest discretionary program for treatment and prevention. In FY2018, the SABG made up 24 percent of total opioid funding and 54 percent in FY2017. BPC included the SABG program in this report because this program seeks to reduce all forms of substance use, including opioids, and BPC is unable to separate out the amount spent solely on opioids.

SAMHSA administers 19 additional programs that target opioid use disorder within the Programs of Regional and National Significance (PRNS). PRNS includes the Medication-Assisted Treatment for Prescription Drug and Opioid Addiction grants to states to expand their medication-assisted treatment (MAT) systems, thereby increasing access to evidence-based treatment.[49] PRNS also includes the Strategic Prevention Framework for Prescription Drugs (SPF Rx) program. SPF Rx raises awareness within the medical community about the risks of overprescribing opioids and funds prescription drug misuse prevention activities.[50] In FY2018, the total appropriations for all PRNS programs combined made up 7 percent of opioid funding; it was 12 percent in FY2017.

DOJ

The DOJ administers 11 criminal justice grant programs targeted to the opioid epidemic. The key opioid response programs administered by DOJ are the Comprehensive Opioid Abuse Site-based Program (COAP), Helping Children and Youth Impacted by Opioids, and the Paul Coverdell Forensic Science Improvement Grant Program. COAP, funded at $162 million in FY2018, supports efforts at the front lines of the opioid epidemic by funding partnerships between first responders and treatment providers responding to an overdose.[51] Further, COAP grants support:[52]

- Technology-Assisted Treatment—supports rural access to substance use treatment and recovery support services through remote monitoring;
- System-Level Diversion—supports corrections and reentry programs, and helps connect arrestees to immediate treatment;
- Statewide Planning, Coordination, and Implementation—supports initiatives jointly planned and implemented by the state criminal justice agency and the single state agency for substance use services to engage offenders who misuse opioids;
- Prescription Drug Monitoring Program Implementation and Enhancement Projects; and
- Public Safety, Behavioral Health, and Public Health Information-Sharing Partnerships— enable state agencies to leverage information from public health and safety data.

[b] The Formula was based on the number of people who meet criteria for dependence or abuse of heroin or pain relievers who have not received any treatment (NSDUH 2011-2014; 70% weight) and the number of drug poisoning deaths (CDC Surveillance System; 30% weight).

The DOJ also disbursed $46.6 million under the Helping Children and Youth Impacted by Opioids program to expand on existing programs providing services for children and youth affected by opioid-related trauma, as well as treatment and mentoring for youth affected by the opioid crisis.[53] The DOJ administers an additional $17 million under the Paul Coverdell Forensic Science Improvement Grant Program to expand the capabilities of forensic examiners and coroners in processing the backlogs of seized drugs and toxicology requests in opioid-related crimes and deaths.[54]

CDC

The CDC plays a critical role in supplying the information necessary to identify the areas of greatest need in the opioid epidemic in the United States. The CDC administers the Opioid Overdose Prevention and Surveillance (OOPS) program, funded at $476 million in FY2018 and $112 million in FY2017. The appropriation language for FY2018 mandates that OOPS expand case-level syndromic surveillance data, improve interventions that monitor prescribing and dispensing practices, support prescription drug monitoring programs, improve the timeliness and quality of morbidity and mortality data, and enhance the efforts of medical examiners' and coroners' offices.[55]

Within the OOPS program, the CDC funded 32 states' Enhanced State Opioid Overdose Surveillance (ESOOS) program to establish an early warning system, integrate data from unique medical examiner and coroner investigations, and share findings with state and national stakeholders to inform opioid response efforts. The ESOOS program enhances the ability of the CDC to report high-quality, real-time data on opioid overdoses to inform responses.[56] ESOOS was instrumental in quantifying the threat of fentanyl in 2016, documenting that more than 50 percent of overdose deaths in 10 states involved fentanyl.[57]

Opioid Appropriations by Category

Based on BPC's analysis of the FY2017 and FY2018 appropriations, new opioid funding in 2018 translated into increases across all categories. Detailed in Table 3, new funds included $500 million for research and $355 million for interdiction efforts. Figures 3 and 4 depict the overall shift in funding between FY2017 and FY2018 toward opioid use disorder treatment and recovery. The categories BPC identified are:

- **Treatment and Recovery**—Awards to improve treatment capacity and support substance use treatment services. Recovery includes grant funding for programs to sustain recovery, including community supports and recovery housing.
- **Prevention**—Primary prevention and secondary prevention activities, including funding for surveillance, screening, naloxone, and prescription drug monitoring programs.[c]
- **Mixed: Treatment/Recovery and Prevention**—Includes grant programs that are targeted to fund the continuum of care for opioid use disorders, including 80 percent of the SABG.[d]
- **Research**—Grants to fund research related to opioid use disorder, funded through the NIH.
- **Criminal Justice**—Grants directed at enhancing criminal justice responses to the opioid epidemic, including to the justice system and correctional institutions.
- **Law Enforcement**—Grants awarded to law enforcement to reduce the supply of illicit opioids and other drugs.
- **Interdiction**—Grants directed at efforts to disrupt trafficking of illicit opioids at ports of entry and through FDA opioid enforcement and surveillance activities.

[c] This category also includes 20 percent of the STR and SOR grant funding based on BPC's analysis of the STR reports and SOR budgets for the five case-study states that found approximately 20 percent of these funds were spent on prevention. As explained further below, this category also includes 20 percent of funds from the SABG.

[d] The SABG program requires 20 percent to fund primary prevention, the remaining portion includes sub-awards that fund "Prevention (other than primary prevention) and Treatment Services" that could not be separated out.

Table 3: Opioid Appropriations by Category

Category	FY2017	FY2018
Treatment and Recovery	$598,800,000	$2,115,574,000
Prevention	$789,685,800	$1,684,442,800
Mixed: Treatment/Recovery and Prevention	$1,423,103,200	$1,903,103,200
Research	*	$500,000,000
Criminal Justice	$235,000,000	$532,639,484
Law Enforcement	$264,000,000	$312,000,000
Interdiction	*	$355,100,000

* = No opioid-specific appropriations.

Figure 3: FY2017 Opioid Spending by Category

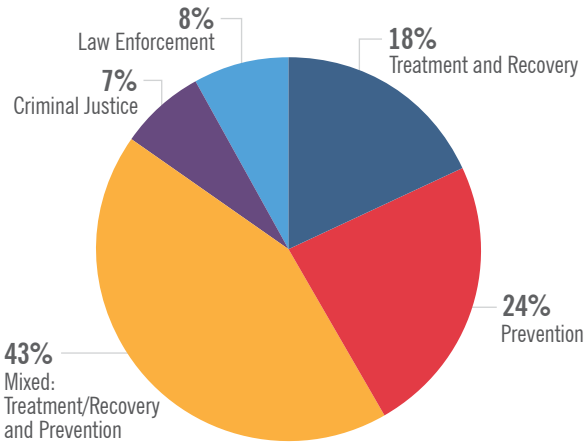
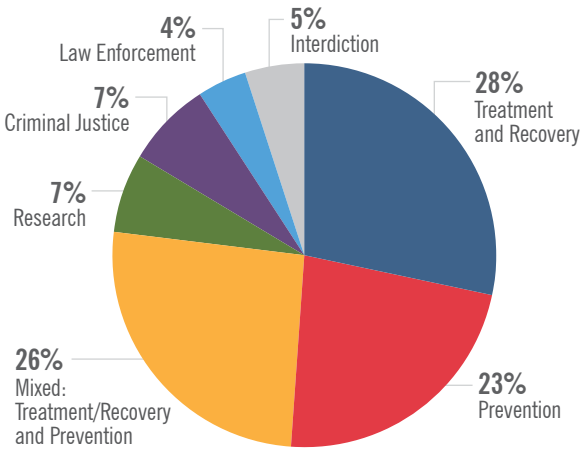


Figure 4: FY2018 Opioid Spending by Category



Federal opioid funding across the United States doubled from $10 per capita in FY2017 to $23 per capita in FY2018. Since the SOR grant from SAMHSA included a $142.5 million set-aside for the 10 states with the highest mortality rates related to drug-poisoning deaths (West Virginia, Ohio, New Hampshire, Pennsylvania, Kentucky, Maryland, Massachusetts, Delaware, Rhode Island, and the District of Columbia), 2018 funding was especially significant in states with high mortality rates.[58] Federal grants to West Virginia increased from $13 to $40 per capita. Federal grants to New Hampshire increased from $12 to $44 per capita, as shown in Figure 6 (FY2018). Figure 5 depicts the FY2017 per capita funding for every state.

Figure 5: Opioid Spending Per Capita FY2017

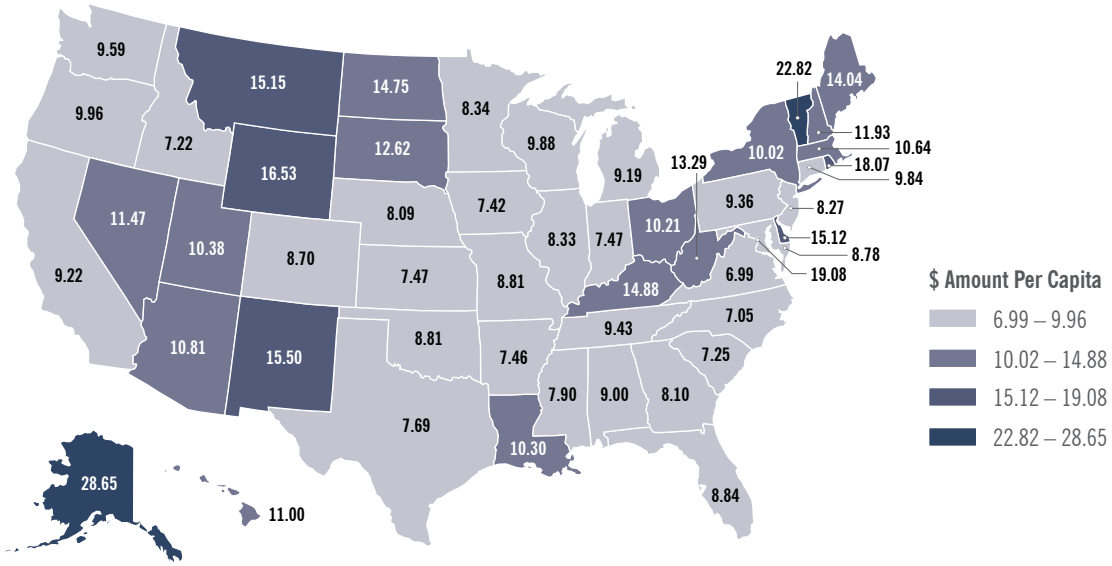
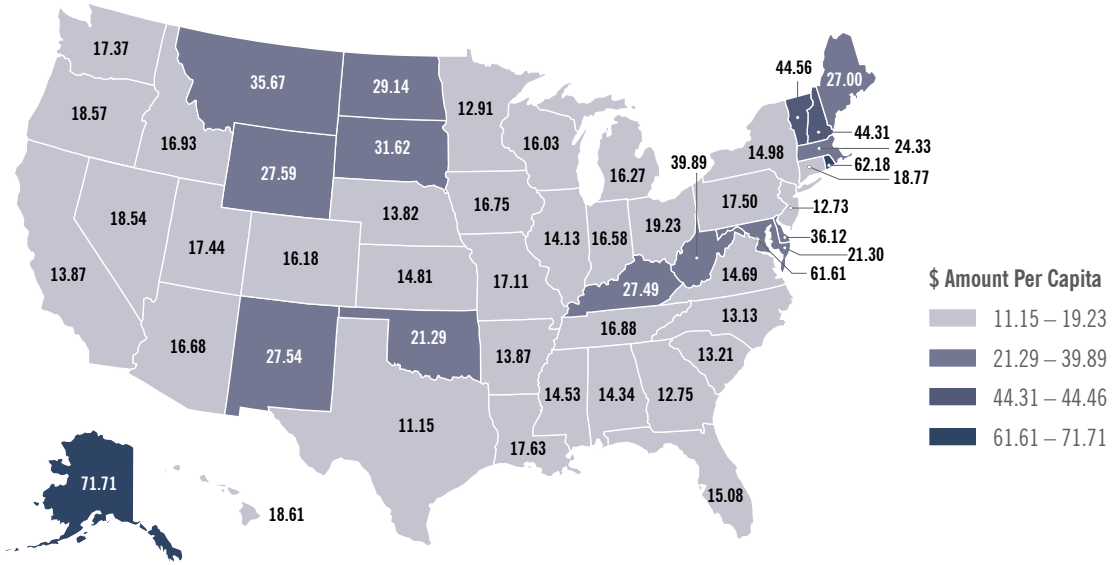
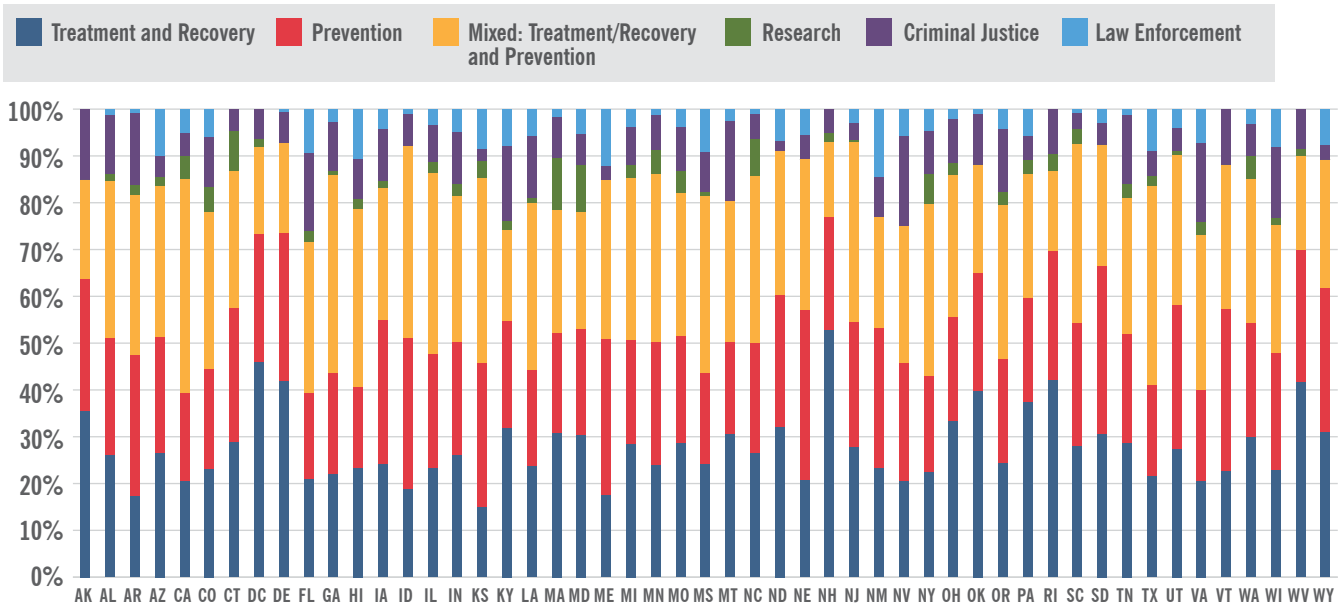


Figure 6: Opioid Spending Per Capita FY2018



BPC also analyzed the funding by category in each state, displayed in Figure 7. FY2018 spending in the category of "Treatment and Recovery" (shown in dark blue) is derived largely from the SOR grant. New Hampshire, Rhode Island, West Virginia, and the District of Columbia have a larger share of funds in this category. The block grant for Substance Abuse Prevention and Treatment, mostly categorized as "Mixed: Treatment and Prevention" (in yellow) makes up roughly a third of overall spending in each state. "Prevention" funds in red, which include 20 percent of the STR, SOR, and SABG funds, make up 25 percent of spending on average.

Figure 7: FY2018 Opioid Spending by State by Category



MEDICAID

Medicaid is a key component of the U.S. response to the opioid epidemic and provides treatment for a significant portion of the population with substance use disorders.[59] Medicaid expansion is estimated to have given new health insurance coverage to more than 17 million Americans.[60] The number of opioid-related hospitalizations in the United States increased from 672,900 in 2013 to 957,900 in 2016, yet the rate of uninsured visits decreased from 15 percent to 7 percent.[61] Medicaid was the expected payer for 37 percent of opioid-related inpatient hospital stays in 2016.[62] In emergency departments, Medicaid was the expected payer in 44 percent of emergency department visits in 2016, up from 32 percent in 2013.[63]

In addition to Medicaid coverage of inpatient treatment, Medicaid also provides coverage for outpatient MAT, reimbursing over $1.2 billion in 2018 for treatment medications, a 27 percent increase over the 2016 total shown in Table 4.[64]

Table 4: Medicaid Spending on Opioid Treatment Drugs[e] and Naloxone, 2016–2018[65]

	2016	2017	2018*
Buprenorphine	$757,111,597	$907,934,790	$917,832,749
Naltrexone	$179,597,503	$248,143,006	$272,433,926
Naloxone	$22,040,501	$18,784,465	$22,681,486
Total	**$958,749,601**	**$1,174,862,260**	**$1,212,948,161**

*2018 totals projected based on first two quarters of 2018.

[e] BPC was unable to identify Medicaid spending on methadone for opioid use disorder from 2016 to 2018 due to inconsistent data reporting on methadone spending in the State Drug Utilization Data versus spending reported from Opioid Treatment Programs, which is reimbursed under the physician payment code H0020.

State Case Studies

BPC took a deeper dive into selected states to better understand how federal dollars are being used in states to address the opioid epidemic. Each case study that follows includes information on state mortality data and other information relevant to the opioid epidemic in that state. A breakdown of funding by federal department is provided, as well as county-level funding for each state. Each case study also includes an overview of a state's goals and, where applicable, first-year outputs under the SAMHSA STR grants for FY2017 and FY2018. In addition, the plans for the FY2018 SOR grants are presented. The role of Medicaid is highlighted in each state. The latest available data on the trends in opioid use and overdose is presented.[f] Finally, the case studies include information on drug-use data and outcomes.

ARIZONA

State Opioid Overview

Arizona had the third highest rate of drug overdose deaths in the West Census Region in 2017 and the 24th highest overall in the country.[66] Relative to other states in the West region, which had the lowest national rates, Arizona had higher overdose death rates from opioids from 2015 through 2017 (see Table 5).[67] Arizona's opioid-related death rates increased by 15 percent per year during this time (see Figure 8).[68]

Arizona Governor Doug Ducey declared a public health emergency on June 5, 2017, in light of the increase in opioid deaths in the state.[69] Through the use of emergency powers, the state sought to increase surveillance of the opioid epidemic, developed new guidelines for responsible prescribing practices, and produced an Opioid Action Plan.[70] A key element of the plan was to enhance the Arizona Controlled Substance Prescription Monitoring Program.[71] The plan's recommendations were completed in June 2018.

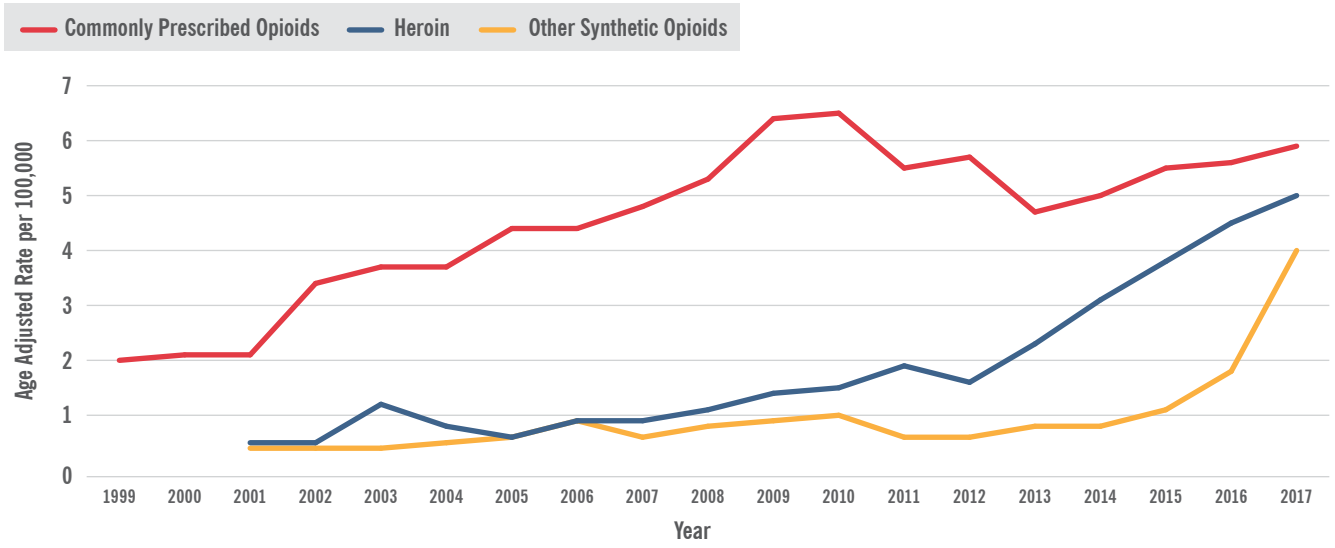
Table 5: Opioid Overdose Deaths, 2015-2017[72]

Year	Deaths	Arizona Rate*	West Region*
2015	671	10.2	7.4
2016	769	11.4	7.6
2017	928	13.5	8.0
Total	**2,368**	**12.2**	**7.6**

*Age-Adjusted Rate per 100,000.

[f] References to increases or decreases in substance use rates indicate statistically significant changes at the 0.05 level. References to rates being similar indicate a lack of statistical significance even though rates may differ.

Figure 8: Arizona Opioid Death Rates



Source: CDC Wonder

State Opioid Response Structure

Arizona's State Targeted Response (STR), State Opioid Response (SOR), and Substance Abuse Prevention and Treatment Block Grant (SABG) programs are all administered by the Arizona Health Care Cost Containment System (AHCCCS) working with the Arizona Department of Health Services and the Governor's Office of Youth, Faith, and Family (GOYFF). AHCCCS distributes the STR grant and the SABG to Regional Behavioral Health Authorities, including opioid treatment programs.

Arizona has three Regional Behavioral Health Authorities and four Tribal Regional Behavioral Health Authorities responsible for the managed care of all individuals in the public behavioral health system.[73]

The state policy response to the opioid epidemic is coordinated by GOYFF. GOYFF is responsible for the prevention activities of the STR grant and the state Prevention, Treatment and Recovery Locator.[74] GOYFF is also responsible for distributing the prevention fund portion of the SABG.

Arizona's share of federal expenditures to address the opioid epidemic increased from $75,873,531 in 2017 to $117,058,843 in 2018. The 54 percent increase translates to a per capita increase from $11 per person to $17 per person.

Federal appropriations to address the opioid epidemic are detailed in Tables 6 and 7 below. As shown, SAMHSA programs make up the majority of federal spending—79 percent in 2017 and 68 percent in 2018.

Federal Appropriations to Arizona

Table 6: Arizona Opioid Spending by Department

Department	FY2017	FY2018
Health and Human Services	$59,455,230	$99,380,264
Substance Abuse and Mental Health Services Administration	*$56,746,270*	*$82,370,933*
Centers for Disease Control and Prevention	*$2,170,408*	*$6,700,713*
Health Resources and Services Administration	*$0*	*$5,488,029*
Administration for Children and Families	*$538,552*	*$2,577,955*
National Institutes of Health	*$0*	*$2,242,634*
Office of National Drug Control Policy	$13,413,416	$13,765,542
Department of Justice	$3,004,885	$3,913,037
Department of Labor	$0	$0
Total Opioid Spending	**$75,873,531**	**$117,058,843**

Table 7: Arizona Opioid Spending by Category

Category	FY2017	FY2018
Treatment and Recovery	15%	27%
Prevention	22%	25%
Mixed: Treatment/Recovery and Prevention	42%	32%
Research	0%	2%
Criminal Justice	5%	4%
Law Enforcement	15%	10%

Figures 9 and 11 break down federal funding in Arizona on a county level for FY2017 and FY2018.[g] The majority of the funding goes to population centers. In 2017, Maricopa County comprised 61 percent of Arizona's population and received 58 percent of federal opioid funding directed to the state. Pima County was 15 percent of the population and received 24 percent of the opioid funding. The least populated county in the state, Greenlee, received 0.4 percent of all funding in Arizona and was home to 0.13 percent of the population. While receiving a small overall share of funding, the sparseness of the population accounts for Greenlee's high per capita rate. In 2018, Maricopa's percentage of the funding increased slightly to 60 percent along with Greenlee at just under 1 percent, while Pima's funding dropped to 20 percent.

Figures 10 and 12 depict the age-adjusted death rate per 100,000 people for drug overdoses in Arizona between 2015 and 2017. La Paz County and Gila County marked the highest death rate per capita over those three years at 47 and 41 respectively, although combined they received just over 2 percent of the total funding for Arizona. This level of funding is consistent with the population size for La Paz and Gila, as they constitute 1 percent of Arizona's population.

[g] Figures reflect the location of the recipient of the federal funding, which does not necessarily correspond with the service area of the funding. For the STR, SOR, and SABG funding, the sub-award locations are reflected in these figures.

Figure 9: Arizona Federal Opioid Funding 2017 by County

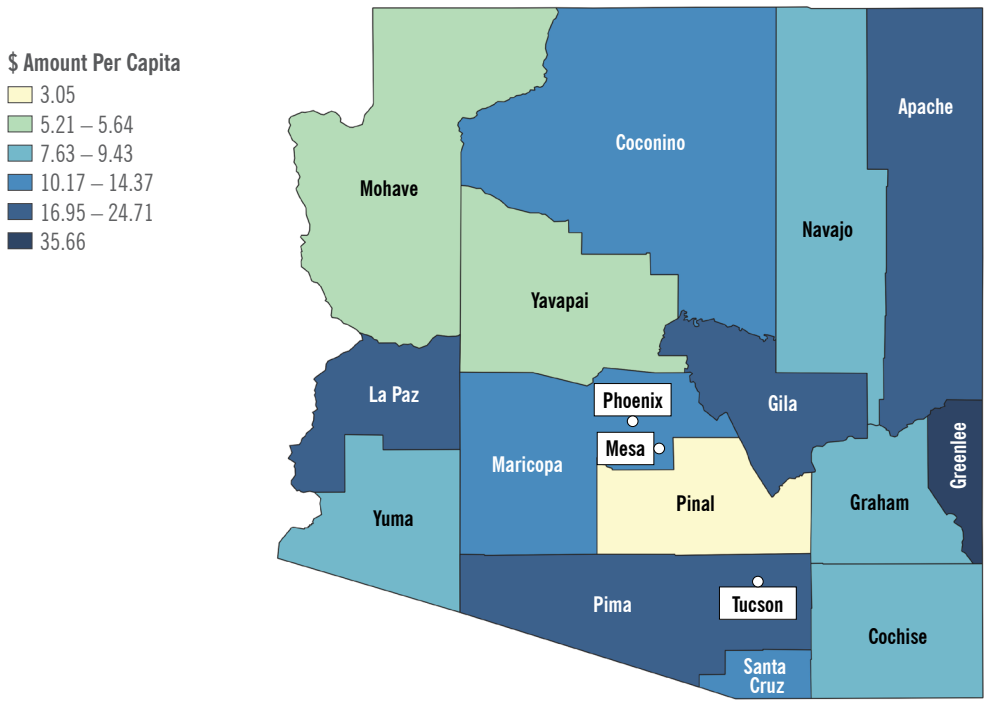
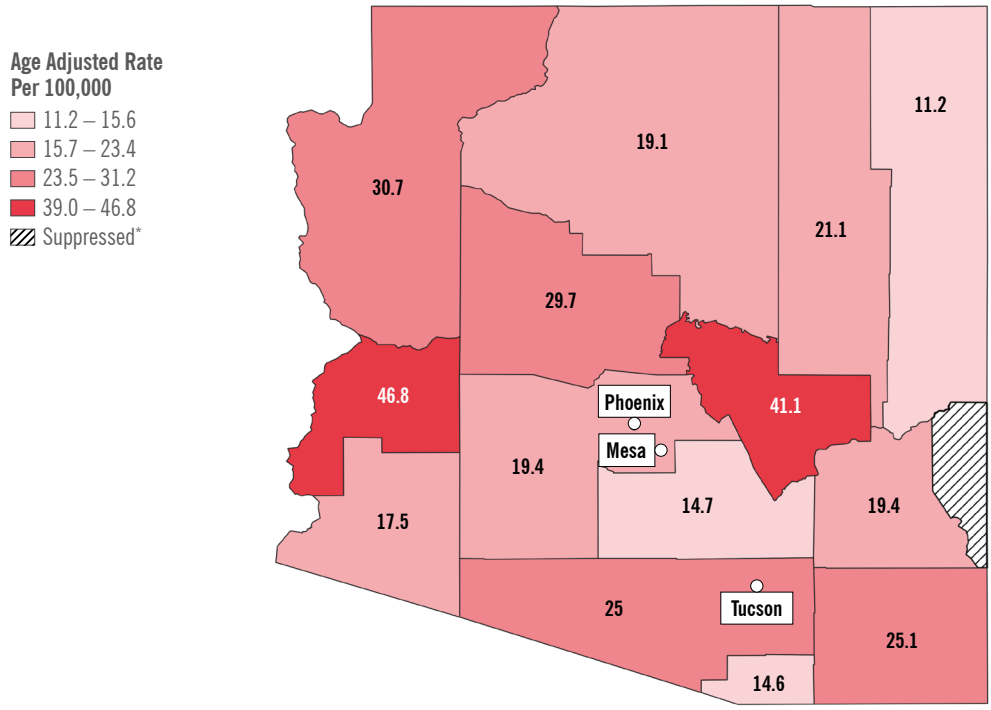


Figure 10: Arizona Drug Overdose Death Rate 2015–2017 by County



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Figure 11: Arizona Federal Opioid Funding 2018 by County

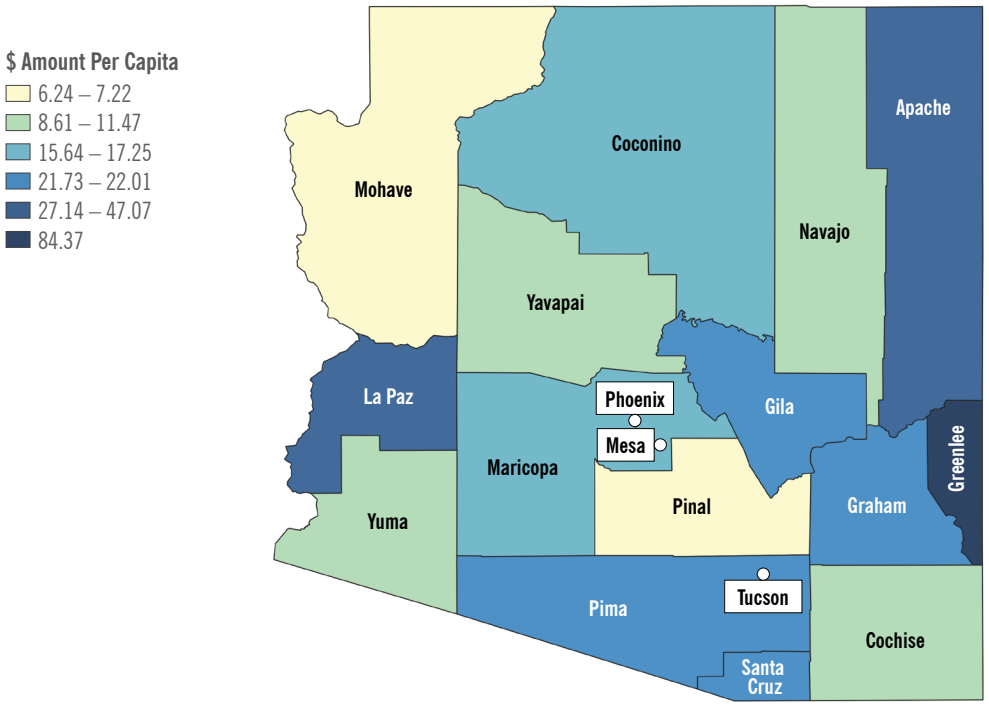
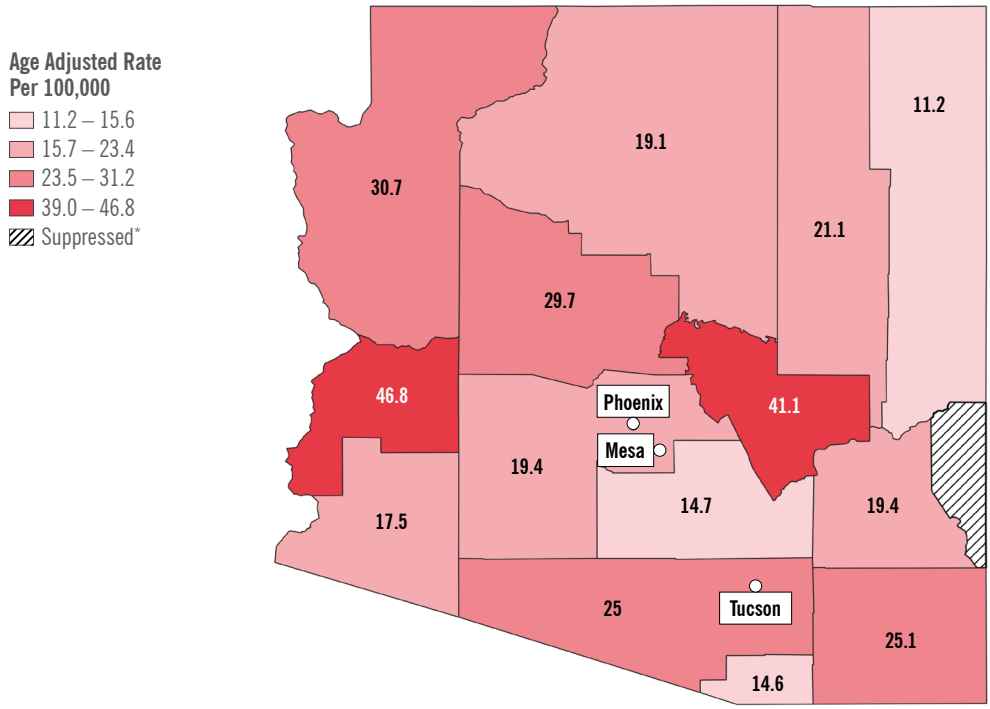


Figure 12: Arizona Drug Overdose Death Rate 2015–2017 by County



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Key Federal Grants from 2017 and 2018 Federal Appropriations

The largest FY2017 opioid-specific federal grant awarded to Arizona is the STR. In 2017, Arizona received $12 million in STR funds, equal to 16 percent of federal opioid funding in the state. In 2018, Arizona received a $41 million increase in federal funding dedicated to the opioid crisis, with $23 million (54 percent) stemming from the SOR grant program. Arizona received STR funding for Year 1 in May 2017 and for Year 2 in May 2018; the state received Year 1 SOR funding in September 2018 and is expected to receive Year 2 funding before September 30, 2019.[75] Below is a brief overview of the goals and outcomes included in Arizona's plan for STR funds, as well as information from the state's plans for the FY2018 SOR grant program.

Arizona STR Goals

With the STR funds, Arizona planned to increase use of data-driven decision-making, increase prevention activities to reduce opioid-related deaths, and improve access to comprehensive Medication-Assisted Treatment (MAT) services for opioid use disorder.[76] The state government established a multisector Opioid Monitoring Initiative to provide real-time reporting and dissemination of opioid incident reports.[77] Arizona's plan included distributing naloxone kits to law enforcement, expanding trainings to medical professionals on prescription drug misuse, and increasing awareness of the GOYFF treatment-locator resource.[78] Arizona's plan included improving treatment access and 24/7 services for evidence-based treatment using medications through regional Centers of Excellence that coordinated intake and assessment, provided treatment options and referrals to community treatment, and offered naloxone access.[79] In the STR application, Arizona planned to serve 5,069 individuals in Year 1 and 7,604 individuals in Year 2 for a total of 12,673.

Arizona STR Outcomes

Based on outcomes data from the first year of the STR, Arizona reported 4,447 people treated for opioid use disorder through the STR grant.[80] Over the same time, 3,437 people received recovery support services.[81] Arizona purchased 8,798 naloxone kits through STR funds and first responders performed 5,649 overdose reversals during the first year of the STR.[82] Finally, the STR funds were used to train 9,197 individuals in naloxone usage, opioid use disorder, MAT, prescribing guidelines, the creation of an American Indian Opioid Toolkit, and other trainings related to opioids.[83]

Arizona SOR Goals/Plan

In 2018, Arizona planned to use the additional federal funding received through the SOR grant program (85 percent more than the STR grant) to build on the programs established using the STR funds, as detailed in Table 8. Below is a list of Arizona's plans for the SOR funding. Notably, they include providing treatment and recovery support services to 16,476 individuals over two years.[84] The state is also developing a public-information campaign to reduce stigma with the goal of reaching 1 million people.[85]

Table 8: Arizona SOR Goals[86]

Goals	Objectives
1. Increase prevention activities to reduce opioid use disorder (OUD) and opioid-related deaths.	1.1. Decrease opioid-related overdose deaths by purchasing and distributing naloxone kits for law enforcement, community public health agencies, and tribal communities. 1.2. Increase local community knowledge, awareness, and preventative action on opioid misuse and abuse by implementing a suite of multi-systemic strategies from the Arizona Opioid Toolkit. 1.3. Increase the number of providers trained in and implementing Triple P and other supportive parenting programs to mitigate the number of individuals and families at high risk for opioid misuse and abuse.
2. Improve access and retention in comprehensive MAT services to treat OUD.	2.1. Increase providers, consultation, and resources for MAT providers through in-person Drug Addiction Treatment Act (DATA)-waivered trainings, practice consultation platforms, and material dissemination. 2.2. Sustain and enhance services in regional 24/7 Centers of Excellence, rural Medication Units, and extended hours in existing opioid treatment programs to ensure timely access to intake, assessment, inductions, and ongoing medication and psychosocial services for MAT. 2.3. Sustain and enhance services to conduct outreach and navigation of individuals with OUD and opioid-related events into treatment and ancillary resources.
3. Improve access to short-term and long-term recovery support services.	3.1. Increase access to recovery support services by sustaining and expanding the OUD peer-support network and providing community-based recovery support that includes family support services, work placement and employment assistance, life-skills training, and supportive programming for recovery success. 3.2. Increase access to recovery and supportive housing by standing up additional units in underserved areas and increasing options for rental assistance for individuals entering OUD treatment and for those in recovery. 3.3. Increase recovery supports for pregnant women and parents receiving OUD treatment, through nurse home-visiting programs for parents involved with the Department of Child Safety.
4. Decrease stigma related to OUD, MAT, and the recovery process.	4.1. Implement a statewide stigma-reduction campaign to educate the public on the medical model of OUD and the efficacy of MAT, and to promote recovery success.
5. Increase trauma-informed prevention, treatment, and recovery activities.	5.1. Increase knowledge, build skills, and create trauma-informed action among Arizona providers, stakeholders, and local communities by conducting trainings and disseminating trauma-informed action materials about the role of trauma, toxic stress, and adverse childhood experiences in the opioid epidemic.
6. Increase capacity to provide timely prevention, treatment, and recovery resources to the public.	6.1. Develop, disseminate, and market statewide resources, coinciding call-lines, websites, and iOS and Android applications to the public to create a "no wrong door" approach for accessing timely resources.

Medicaid

In addition to federal grant funding, another key component of Arizona's response to the opioid crisis and overall substance abuse problem is Medicaid. Overall, Medicaid expansion is estimated to have given new health insurance coverage to 426,000 people in Arizona.[87] As the number of opioid-related hospitalizations in Arizona rapidly increased from 14,850 in 2013 to 23,600 in 2017, the rate of uninsured visits decreased from 17 percent to 2 percent.[88] Medicaid was the expected payer for 41 percent of opioid-related inpatient hospital stays in Arizona in 2016, slightly above the 37 percent national average.[89]

In addition to Medicaid coverage of inpatient treatment, Medicaid also provides coverage for outpatient MAT, reimbursing over $21 million in 2018 for treatment medications, over two times greater than the total in 2016 presented in Table 9.[90]

Table 9: Arizona Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016-2018[91]

	2016	2017	2018*
Buprenorphine	$5,176,857	$8,521,264	$10,947,734
Naltrexone	$913,594	$3,400,723	$4,713,787
Methadone[92]	$3,509,854	$4,501,521	$4,088,048
Naloxone	$64,823	$561,027	$1,439,495
Total	**$9,665,128**	**$16,984,535**	**$21,189,064**

*2018 totals projected based on first two quarters of 2018.

Arizona is working to develop an evidence-based treatment infrastructure with its federal funding, as well as to prevent prescription opioid misuse. Arizona's rate of opioid prescriptions per 100 people dropped from a peak of 88.6 in 2011 to 61.2 in 2017, a 31 percent decrease.[93] It is too soon to tell from available data whether efforts made to date are reversing the overdose trend in the state. In fact, from 2016 to 2017, Arizona showed a statistically significant increase in drug overdose deaths.[94] The latest available data from the National Survey on Drug Use and Health (NSDUH) indicates that 267,000 people in Arizona reported past-year misuse of pain relievers, and 26,000 reported past-year heroin use.[95] The NSDUH prevalence data reports similar rates of pain reliever misuse from the 2015-2016 and 2016-2017 surveys, at 4.69 percent and 4.27 percent respectively.[96] For heroin, there was a decrease from 0.45 to 0.35 percent.[97] Detailed below in Table 10, heroin and prescription opioids made up nearly 25 percent of Arizona drug overdose deaths, with fentanyl making up 17 percent in 2017.[98]

Table 10: Arizona Opioid Overdose Deaths by Class, 2015-2017[99]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	19.0	10.2	4.5	1.1	3.8	1.1
2016	20.3	11.4	4.8	1.8	4.5	1.1
2017	22.2	13.5	4.9	4.0	5.0	1.2
Total	**20.5**	**12.2**	**4.7**	**2.3**	**4.4**	**1.1**

*Age-Adjusted Rate per 100,000.

LOUISIANA

State Opioid Overview

From 2015 through 2017, Louisiana had higher drug overdose death rates per year than the South Census Region average from all drugs.[100] However, as depicted in Table 11, Louisiana had a lower rate of opioid-involved overdose deaths than other states in the South.[101] As overdose deaths involving fentanyl and other synthetic opioids grew from 2015 through 2017 (see Figure 13), Louisiana's opioid-related death rates increased by 11 percent, 21 percent, and 22 percent per year.[102] In 2017, Louisiana's overall drug overdose death rate was the eighth highest in the South, and the 19th highest in the United States.[103]

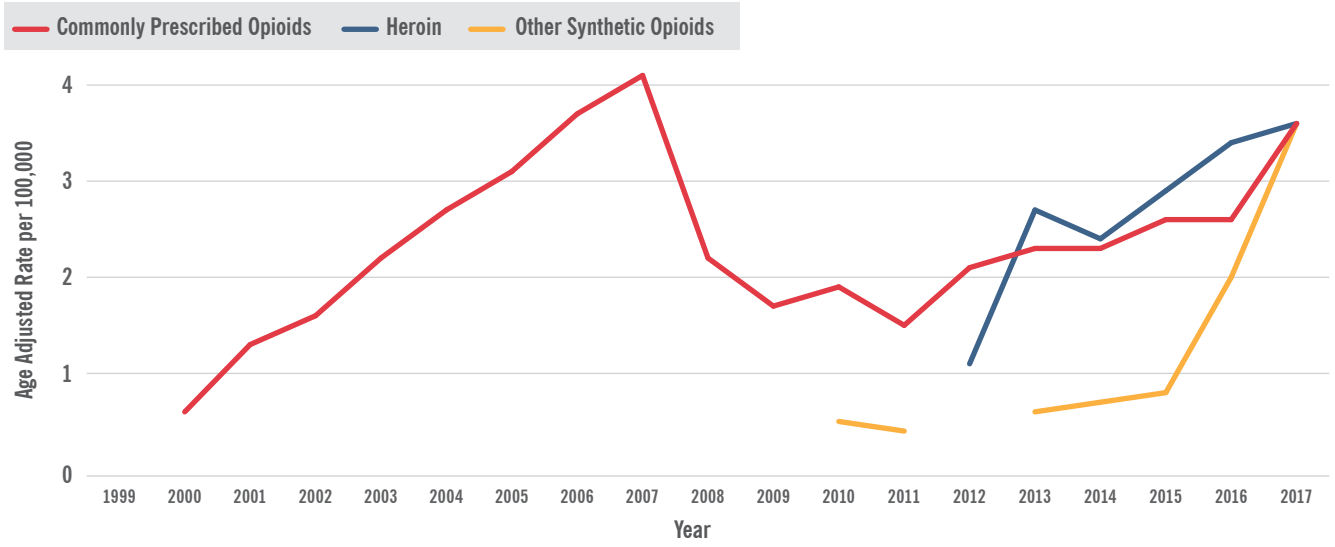
Louisiana received additional federal funds to address the opioid epidemic, from $48,259,917 in 2017 to $82,567,684 in 2018, a 71 percent increase. Per capita, appropriations increased from $10 per person to $18 per person.

Table 11: Opioid Overdose Deaths, 2015-2017[104]

Year	Deaths	Louisiana Rate*	South Region Rate*
2015	287	6.3	9.8
2016	346	7.7	12.4
2017	415	9.3	14.1
Total	**1,048**	**8.1**	**12.1**

*Age-Adjusted Rate per 100,000.

Figure 13: Louisiana Opioid Death Rates



Source: CDC Wonder

State Opioid Response Structure

The Louisiana Office of Behavioral Health within the Department of Health receives the majority of the federal opioid funds. The Office of Behavioral Health distributes the State Targeted Response (STR) grant and the Substance Abuse Prevention and Treatment Block Grant (SABG) to local governing entities and independent opioid treatment programs. Louisiana has 10 local governing entities that encompass all 64 of its parishes. In addition to the local governing entities, two department of corrections facilities receive STR grant funds, totaling $1.7 million.

Louisiana's response to the opioid epidemic is led by an advisory council on Heroin and Opioid Prevention and Education (HOPE). The council, created in 2017, is the state's central resource for surveillance. HOPE tracks all state initiatives to respond to the opioid crisis, cataloging 52 opioid-related initiatives by state agencies in 2018, and identifies gaps and opportunities to improve agency partnerships.[105] The council also developed the Interagency Heroin and Opioid Coordination Plan to guide state activities.[106] HOPE includes state legislators and senior state agency officials from the departments of the Office of Behavioral Health, Education, Children and Family Services, Public Safety and Corrections, State Police, Veterans Affairs, Office of Workers' Compensation, Insurance, and the Louisiana Supreme Court.[107] The Louisiana Opioid Data and Surveillance System collects information from Louisiana Department of Health and external organizations to analyze health data related to opioid use disorder with parish-level data.[108]

Federal appropriations to address the opioid epidemic are detailed in Tables 12 and 13 below. As shown, SAMHSA programs make up the majority of federal spending—79 percent in 2017 and 62 percent in 2018.

Federal Appropriations to Louisiana

Table 12: Louisiana Opioid Spending by Department

Department	FY2017	FY2018
Health and Human Services	$39,355,629	$66,603,880
Substance Abuse and Mental Health Services Administration	*$37,972,317*	*$50,820,229*
Centers for Disease Control and Prevention	*$997,702*	*$4,159,002*
Health Resources and Services Administration	*$0*	*$8,969,833*
Administration for Children and Families	*$385,610*	*$1,661,377*
National Institutes of Health	*$0*	*$993,439*
Office of National Drug Control Policy	$5,480,170	$5,815,883
Department of Justice	$3,424,118	$9,513,672
Department of Labor	$0	$0
Total Opioid Spending	**$48,259,917**	**$81,933,435**

Table 13: Louisiana Opioid Spending by Category

Category	FY2017	FY2018
Treatment and Recovery	19%	24%
Prevention	21%	21%
Mixed: Treatment/Recovery and Prevention	41%	36%
Research	0%	1%
Criminal Justice	9%	13%
Law Enforcement	9%	6%

Figure 14 depicts the funding per capita for opioid treatment and prevention for FY2017 in Louisiana.[h] The highest total amount of federal funds, about 20 percent, is channeled to the population center of East Baton Rouge County. In FY2018, shown in Figure 16, that rate increases to 35 percent. Given the wide range of population distribution in Louisiana, East Baton Rouge County accounts for 9 percent of the total population. In FY2017, Tangipahoa County represents the highest funding per capita at $33.78, while Bossier County has the lowest funding per capita at $0.07. Both counties are individually home to roughly 2.8 percent of the population.

Figures 15 and 17 both show the death rates for drug overdoses in Louisiana between 2015 and 2017. The county with the highest death rate in Louisiana is Washington with 57.5 drug overdoses per 100,000 residents; it accounts for 1 percent of Louisiana's population. As shown in Figure 14, Washington County received $3.04 per capita, or roughly 0.2 percent of the state's funding compared with other counties. This increased slightly to $3.35, still 0.2 percent of funding, in FY2018.

[h] Figures reflect the location of the recipient of the federal funding, which does not necessarily correspond with the service area of the funding. For the STR, SOR, and SABG funding, the sub-award locations are reflected in these figures.

Figure 14: Louisiana Federal Opioid Funding 2017 by Parish

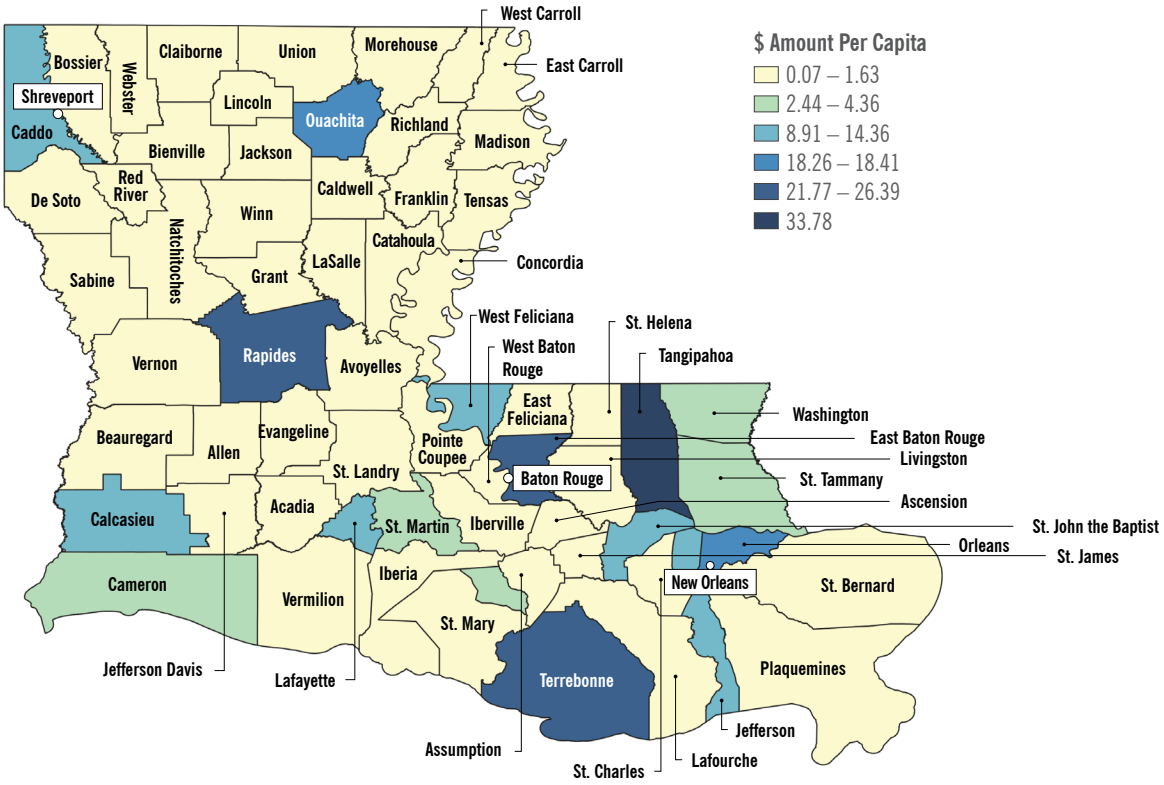
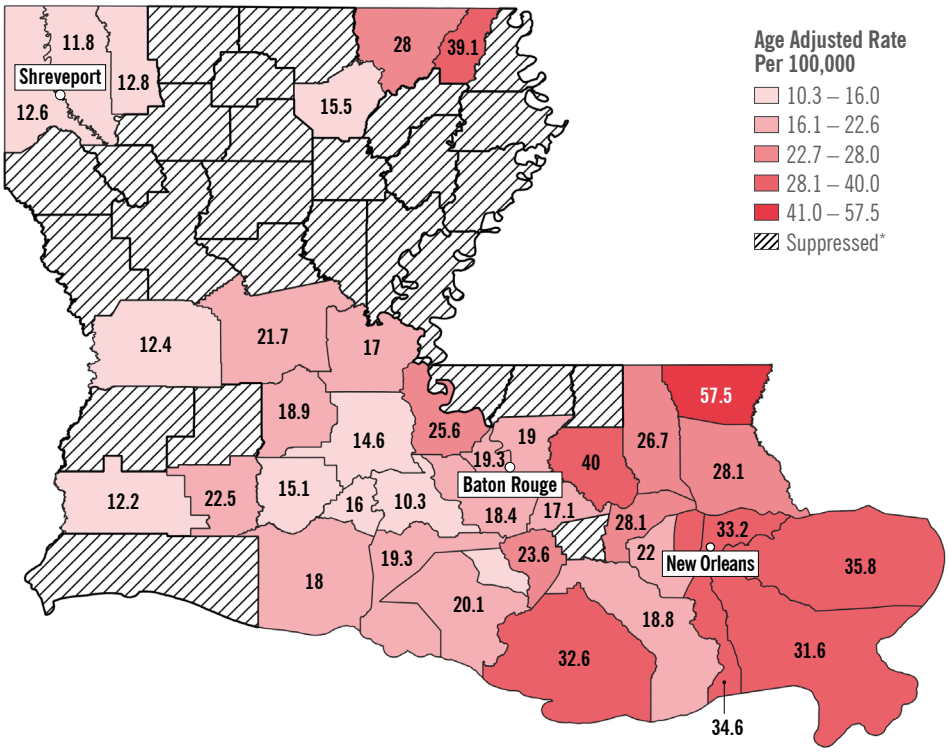


Figure 15: Louisiana Drug Overdose Death Rate 2015–2017 by Parish



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Figure 16: Louisiana Federal Opioid Funding 2018 by Parish

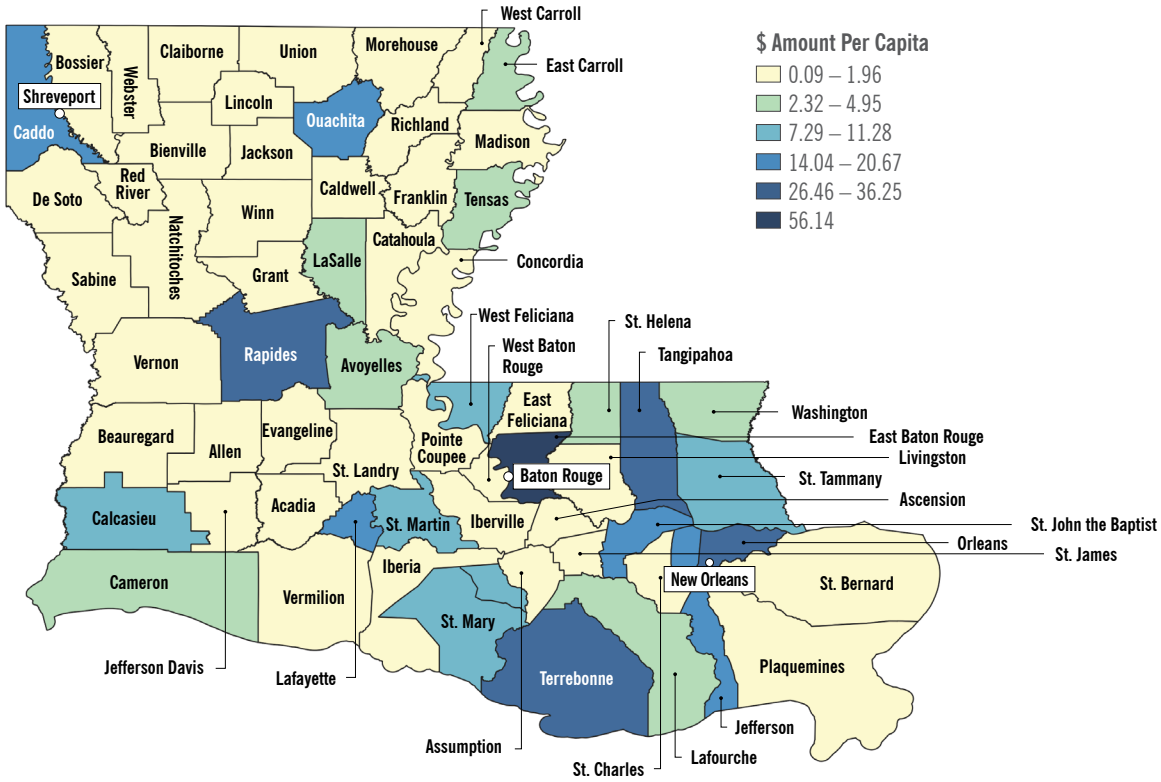
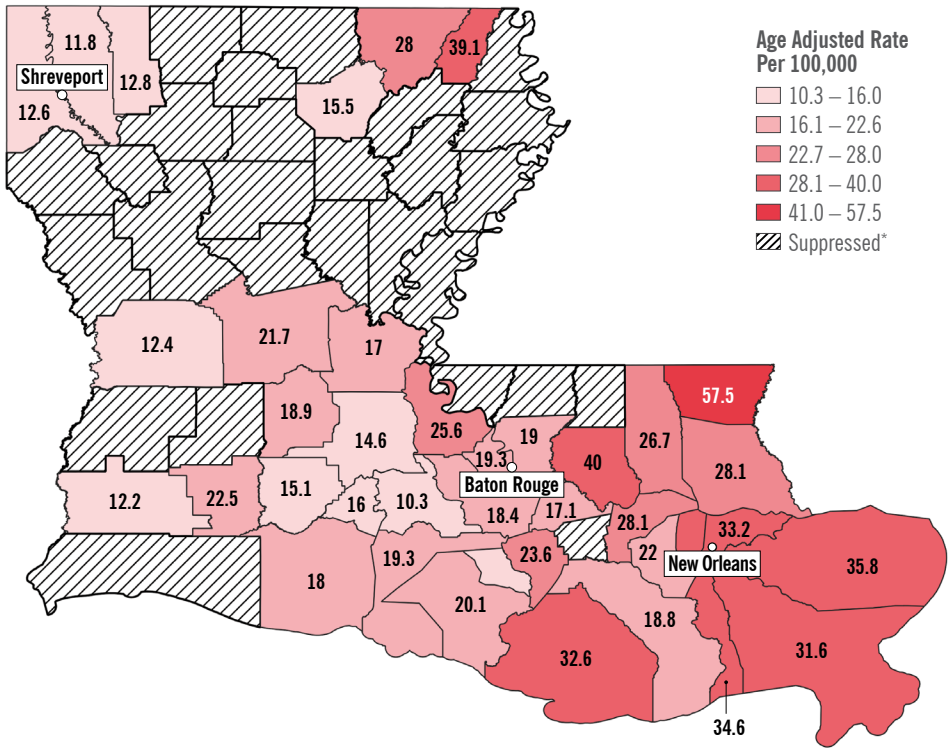


Figure 17: Louisiana Drug Overdose Death Rate 2015–2017 by Parish



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Key Federal Grants from 2017 and 2018 Federal Appropriations

The largest FY2017 opioid-specific federal grant in Louisiana is the STR grant administered by SAMHSA. In 2017, Louisiana received $8 million in STR funds, 18 percent of overall federal funding for opioids in the state. In 2018, Louisiana received $12 million in funding under the federal State Opioid Response (SOR) program, which accounted for over a third (35 percent) of the near 70 percent increase in federal opioid funding to Louisiana. The state received STR funding for Year 1 in May 2017 and for Year 2 in May 2018; Louisiana received Year 1 SOR funding in September 2018 and is expected to receive Year 2 funding before September 30, 2019.[109] In addition to resources to build on existing substance use prevention and treatment activities for the state to respond to the epidemic, the STR and SOR programs allowed Louisiana to implement a wide range of strategic goals. Below is a brief overview of the goals (Table 14) and outcomes from the first year of the STR funds as well as Louisiana's plan for the 2018 SOR grant.

Louisiana STR Goals

Table 14: Louisiana Opioid STR Initiative Goals and Objectives[110]

Goal	Objective
Prevention	
1. Increase public and professional awareness and education for prevention and treatment of opioid use, misuse, and abuse.	• Educate the public, providers, pharmacists and other health care professionals about prescription opioid use and prescribing risks naloxone, and MAT to treat OUD. • Provide training for physicians, service providers, and health care professionals on evidence-based practices for treating OUD. • Work in partnership with local communities to develop a community-based social-marketing/public-education plan. • Increase naloxone accessibility for first responders, specifically police and fire departments.
Treatment	
2. Increase number of individuals with an OUD diagnosis who are being treated with evidence-based practices.	• Provide methadone maintenance treatment by qualified professionals to underinsured or uninsured patients over two years. • Distribute naloxone kits to OUD clients and/or family members. • Provide treatment to offenders in the criminal justice population preparing for reentry.
Recovery	
3. Increase recovery support services for OUD clients.	• Provide assistance with attaining housing, benefits, vocational and educational, and other supports to OUD clients.

Louisiana planned to use the STR funds to increase the number of patients who received evidence-based treatments by 1,670 and provide recovery support services to 600 opioid use disorder clients over two years.[111] Within the underinsured and uninsured population, Louisiana identified African American men, people in correctional facilities, and Native Americans as special groups of focus for the STR grant.[112] Further, the STR plan noted that African American males were disproportionately affected by the opioid epidemic with higher rates of opioid use; they also made up 67 percent of the incarcerated population.[113] Louisiana also has four federally recognized tribes and 10 state recognized tribes, with the highest concentration of tribes located in Terrebonne Parish.[114]

Louisiana STR Outcomes

With preliminary outcomes data from the first year of the STR, which was funded from May 1, 2017, to April 30, 2018, Louisiana reported $407,925 spent on prevention activities, which included distribution of naloxone kits to 426 people and trained 2,000 people about prescription opioid use, naloxone, and MAT to treat opioid use disorder.[115] Louisiana reported spending $135,958 in STR funds on recovery services for 660 people at nine opioid treatment programs.[116]

Louisiana SOR Goals/Plan

Beginning in 2018, Louisiana used the SOR funds, 50 percent more than in the STR, to build on the STR projects. Louisiana estimates that the SOR project will provide treatment and recovery support services to 2,230 individuals and recovery services to 80 individuals.[117] Louisiana planned to enhance and expand MAT treatment capacity statewide through a hub-and-spoke model using the 10 opioid treatment programs (hubs) and 50 office-based opioid treatment providers (spokes), with five within each of Louisiana's 10 local governing entities that make up the state's behavioral health system.[118] Louisiana State University Health Sciences Center will provide oversight and surveillance of the hub-and-spoke initiative and provide incentive payments to provide MAT services and ensure continuity of services within the model.[119]

Additionally, Louisiana's SOR goals include:[120]

- Increase access to MAT for underinsured and uninsured people with an opioid use disorder diagnosis;
- Increase access to recovery support services for patients on MAT and those reentering communities from criminal justice settings;
- Increase outreach to community programs;
- Understand the needs of Louisiana tribes related to substance use disorder and connection to treatment; and
- Increase public and professional awareness, as well as education for prevention and treatment for patients with opioid use disorder.

Medicaid

Medicaid and Medicaid expansion are key components of Louisiana's response to the opioid crisis and overall substance use problem. According to Louisiana's data for July 2017 through June 2018, Medicaid payments for opioid use disorder included:[121]

- $1,858,797 for emergency department stays for 6,013 recipients;
- $39,755,833 for inpatient stays for 7,148 recipients;
- $34,153,439 for inpatient treatment for 6,286 recipients; and
- $6,212,219 for outpatient treatment for 4,622 recipients.

In addition to Medicaid coverage for hospital treatment, Medicaid also provides coverage for outpatient MAT, reimbursing nearly $28 million in 2018 for treatment medications, 2.2 times the amount reimbursed in 2016 in Louisiana, further detailed in Table 15.[122] (Medicaid expansion in Louisiana took effect mid-2016.)

Table 15: Louisiana Medicaid Spending on Opioid Treatment Drugs[i] and Naloxone, 2016-2018[123]

	2016	2017	2018*
Buprenorphine	$12,102,145	$21,568,180	$25,780,202
Naltrexone	$308,138	$1,109,879	$1,818,336
Naloxone	$193,524	$129,498	$231,894
Total	**$12,688,603**	**$22,861,767**	**$27,843,513**

*2018 totals projected based on first two quarters of 2018.

As the number of opioid-related hospitalizations in Louisiana rapidly increased from 6,850 in 2013 to 13,300 in 2016, the rate of uninsured visits decreased from 28 percent to 16 percent.[124] Overall, Medicaid expansion is estimated to have provided health insurance coverage to 324,000 people in Louisiana.[125]

Louisiana has seen increases in opioid-related overdose deaths in the last few years. Since the Louisiana Department of Health promulgated new limits on opioid prescriptions, the pills per prescription for Medicaid patients have decreased by more than 25 percent.[126] Louisiana's rate of opioid prescriptions per 100 people decreased from a peak of 113.7 in 2008 to 89.5 in 2017, a 21 percent decrease.[127]

The latest available surveys from the National Survey on Drug Use and Health (NSDUH) show similar rates of pain-reliever misuse: 4.57 percent reported in 2015-2016 and 4.12 percent in 2016-2017.[128] For heroin use, the percentage of users remained constant at 0.22.[129]

The NSDUH 2015-2016 surveys indicate that 175,000 people in Louisiana reported past-year misuse of pain relievers, and 8,000 reported past-year heroin use.[130] Finally, as depicted in Table 16, fentanyl-related deaths increased 150 percent in 2016 and 80 percent in 2017.[131]

Table 16: Louisiana Opioid Overdose Deaths by Class, 2015-2017[132]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	19.0	6.3	2.3	0.8	2.9	Unreliable
2016	21.8	7.7	2.3	2.0	3.4	Unreliable
2017	24.5	9.3	3.5	3.6	3.6	Unreliable
Total	**21.8**	**8.1**	**2.7**	**2.2**	**3.3**	**0.3**

*Age-Adjusted Rate per 100,000.

[i] Louisiana Medicaid does not cover methadone for opioid use disorder.

NEW HAMPSHIRE

State Opioid Overview

From 2014 through 2017, New Hampshire has ranked in the top five highest opioid death rates per year for any U.S. state.[133] Drug overdose deaths involving fentanyl and other synthetic opioids grew from 2014 through 2016 (see Figure 18), and New Hampshire's opioid-related death rates increased by 98 percent, 34 percent, and 14 percent per year.[134] In 2017, New Hampshire's death rate leveled off with a 5 percent decrease in opioid-related deaths.[135] New Hampshire had the highest overall drug overdose death rate in the Northeast region from 2014 to 2016, and in 2017 it had the second highest rate (see Table 17).[136]

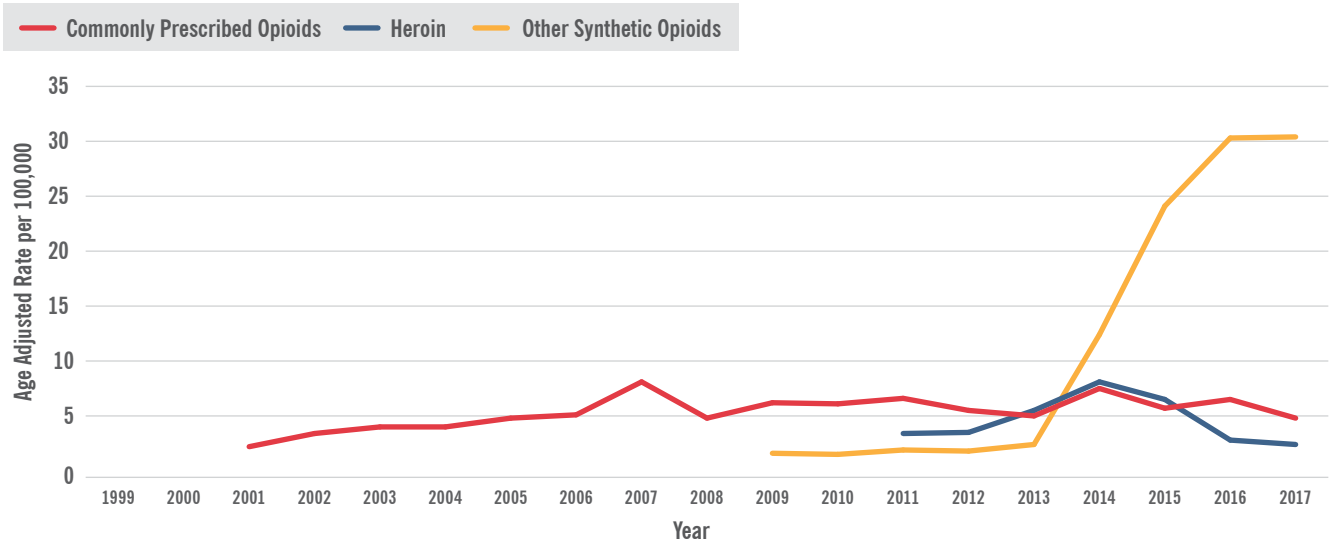
Federal opioid grants to New Hampshire to address the opioid epidemic nearly quadrupled from $16,019,880 in 2017 to $59,505,426 in 2018. Per capita, appropriations increased from $12 per person to $44 per person.

Table 17: Opioid Overdose Deaths, 2015–2017[137]

Year	Deaths	New Hampshire Rate*	Northeast Region Rate*
2015	380	31.3	13.6
2016	437	35.8	19.3
2017	424	34	21.3
Total	**1,241**	**34.2**	**18.1**

*Age-Adjusted Rate per 100,000.

Figure 18: New Hampshire Opioid Death Rates



Source: CDC Wonder

State Opioid Response Structure

The New Hampshire Bureau of Drug and Alcohol Services (BDAS) administers the majority of the federal opioid funds. BDAS distributes the State Targeted Response (STR) grant, the State Opioid Response (SOR) grant, and the Substance Abuse Prevention and Treatment Block Grant (SABG) to community-based organizations throughout the state. The BDAS service delivery system is broken out by regional public health networks. New Hampshire has 13 regional public health networks in all 10 New Hampshire counties. The treatment, prevention, and recovery services provided by organizations within these regions also receive funding from state general funds and the New Hampshire Charitable Foundation.[138]

New Hampshire has a Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery. The commission members include 17 senior state agency officials and stakeholder organizations: BDAS, Justice, Education, Safety, Insurance, and New Hampshire Medical Society.[139] Commission members also include four state representatives and seven public members. Created in 2000, the commission disburses the alcohol fund (roughly $10 million per year) and develops a statewide plan to prevent alcohol and drug misuse.[140] The commission plays a pivotal role in transparently reporting on state substance misuse resources—state agencies that are members of the commission must report state and federal expenditures. In state FY2017, the commission reported nearly $75 million in combined state and federal funds to address the opioid epidemic, an increase from $49 million in state FY2016.[141,142]

The commission also oversees an Opioid Task Force with three top priorities for 2017 through 2020:

- Support plans/guidelines and reduce stigma in order to facilitate implementation of harm-reduction strategies;
- Develop a seamless system to address substance use disorders across the justice system from pretrial to court; and
- Enhance education offered to professionals in addressing substance misuse and use disorders.[143]

Federal appropriations to address the opioid epidemic are detailed in Tables 18 and 19 below. SAMHSA programs make up the majority of federal resources—79 percent in 2017 and 68 percent in 2018.

Federal Appropriations to New Hampshire

Table 18: New Hampshire Opioid Spending by Department

Department	FY2017	FY2018
Health and Human Services	$13,067,089	$49,708,110
Substance Abuse and Mental Health Services Administration	*$12,581,241*	*$40,333,301*
Centers for Disease Control and Prevention	*$356,373*	*$4,292,327*
Health Resources and Services Administration	*$0*	*$3,262,257*
Administration for Children and Families	*$129,475*	*$635,313*
National Institutes of Health	*$0*	*$1,184,912*
Office of National Drug Control Policy	$1,500,000	$1,500,000
Department of Justice	$1,452,791	$3,297,316
Department of Labor	$0	$5,000,000
Total Opioid Spending	**$16,019,880**	**$59,505,426**

Table 19: New Hampshire Opioid Spending by Category

Category	FY2017	FY2018
Treatment and Recovery	29%	53%
Prevention	28%	24%
Mixed: Treatment/Recovery and Prevention	35%	16%
Research	0%	2%
Criminal Justice	4%	5%
Law Enforcement	4%	0%

Figures 19 and 21 depict the funding per capita for opioid treatment and prevention for FY2017 and FY2018, respectively.[j] In both years, Merrimack County, which includes the state capital of Concord, received the highest funding per capita at $31.84 in FY2017 and $158.67 in FY2018, as well as the highest total amount of funding in the state, roughly 33 percent and 42 percent, respectively. Merrimack County's death rate of 27.5, shown in Figures 20 and 22, is the fourth lowest in the state. In FY2017, Hillsborough County received roughly 31 percent of all federal opioid funds in New Hampshire, with a death rate of 46.4. Hillsborough County has the highest death rate in the state, and the percentage of total federal funds it received dropped slightly from 31 percent to 26 percent of the state total in FY2018.

[j] Figures reflect the location of the recipient of the federal funding, which does not necessarily correspond with the service area of the funding. For the STR, SOR, and SABG funding, the sub-award locations are reflected in these figures.

Figure 19: New Hampshire Federal Opioid Funding 2017 by County

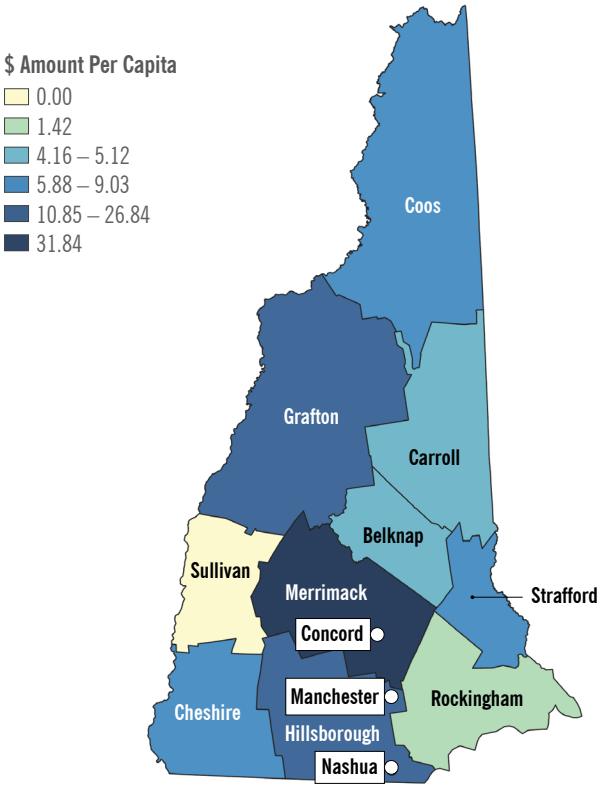


Figure 20: New Hampshire Drug Overdose Death Rate 2015–2017 by County

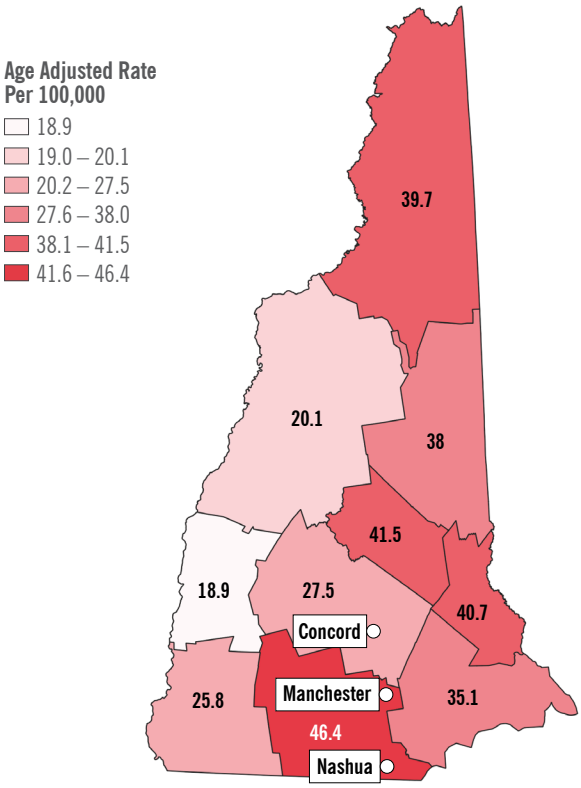


Figure 21: New Hampshire Federal Opioid Funding 2018 by County

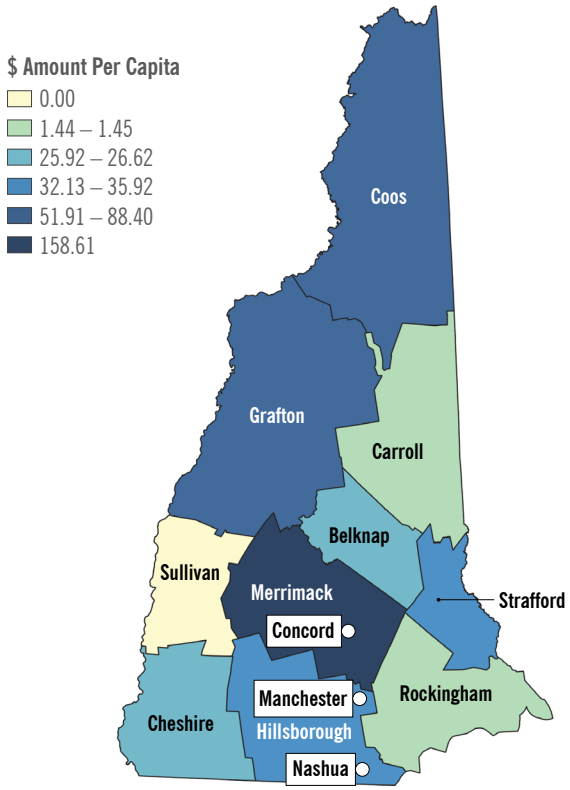
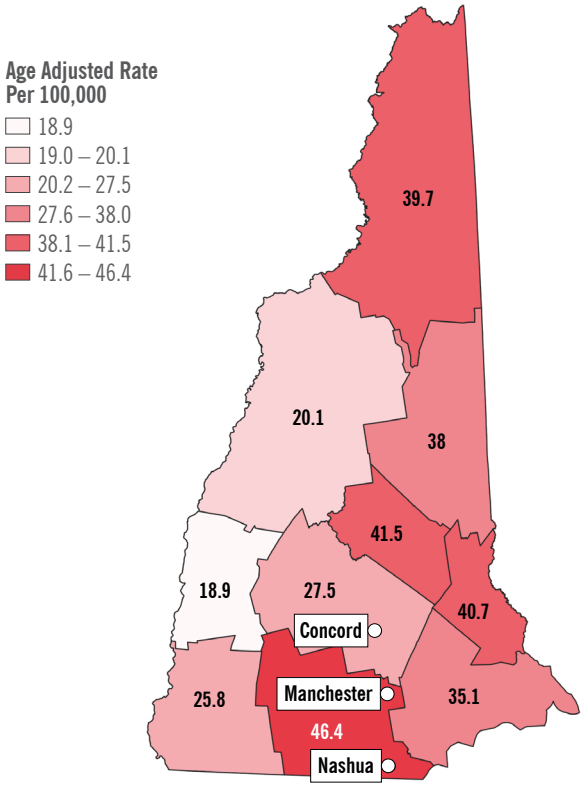


Figure 22: New Hampshire Drug Overdose Death Rate 2015–2017 by County



Key Federal Grants from 2017 and 2018 Federal Appropriations

The largest FY2017 opioid-specific federal grant program for New Hampshire is the STR grant administered by SAMHSA. In 2017, New Hampshire received $3 million in STR funds, which accounted for 20 percent of the overall federal spending on opioids in New Hampshire. In 2018, New Hampshire received $23 million from the SOR program, over half (53 percent) of the near four-fold increase in federal funding to New Hampshire dedicated to the opioid epidemic. The state received STR funding for Year 1 in May 2017 and for Year 2 in May 2018; New Hampshire received Year 1 SOR funding in September 2018 and is expected to receive Year 2 funding before September 30, 2019.[144] In addition to the resources to build on existing substance use prevention and treatment activities for the state to respond to the epidemic, the STR and SOR programs allowed New Hampshire to implement their strategic goals. Below is a brief overview of the goals and outcomes from the first year of the STR funds as well as New Hampshire's plan for the 2018 SOR grant.

New Hampshire STR Goals

New Hampshire's STR goals were to increase access to treatment, reduce unmet treatment need, and reduce opioid overdose deaths. More specifically, New Hampshire focused on expanding Medication-Assisted Treatment (MAT) in integrated-care settings for pregnant and postpartum women, establishing peer recovery support services, and providing evidence-based prevention strategies.[145] In addition, New Hampshire provided naloxone to individuals transitioning from corrections to the community and establishing a reentry care coordinator position for women with substance use disorder.[146]

New Hampshire also planned to use the STR funds to leverage the state's previously existing 15 substance use disorder treatment and recovery support service providers for outpatient, residential, and integrated MAT services that are also funded by the SABG.[147]

New Hampshire STR Outcomes

The state expected to treat 388 patients in the first year of the STR grant but reported 746 persons received treatment.[148] New Hampshire reported training nearly 25,000 individuals in the community on the use of naloxone.[149]

New Hampshire contracted the funds from the STR to the following programs (two-year totals):[150]

- MAT—$2,755,413
- Peer Recovery Support Services—$515,198
- Regional Access Point (in-person and telephone link to rapid evaluation and referrals to services)—$783,485
- Reentry Care Coordination—$300,000
- Department of Corrections Naloxone Distribution—$600,000
- Naloxone Distribution—$12,000
- Early Childhood Prevention Programming (prevention programs)—$1,190,716
- Administration (technical assistance and evaluation)—$50,000.

New Hampshire SOR Goals/Plan

Beginning in 2018, New Hampshire used the SOR funds, over seven times more than the STR funding, to build on STR projects. New Hampshire plans to use the SOR funds to implement a hub-and-spoke model for access and delivery of opioid use disorder services.[151] New Hampshire is working to establish a hub-and-spoke system for treatment of opioid use disorder by expanding services at a minimum of nine previously existing regional access points as well as creating telehealth services in rural and underserved areas.

New Hampshire's SOR project plans to provide treatment and recovery support services to 5,000 individuals and to provide overdose prevention and naloxone services to 13,000 individuals in each year of the project, for a total of 36,000 individuals over two years.[152] New Hampshire's hub-and-spoke model intends to expand services so that no one has to travel more than 60 minutes to begin the recovery process.[153] As detailed in Table 20 below, New Hampshire's SOR goals and objectives build on the STR activities of 2017 and 2018.

Table 20: New Hampshire SOR Goals[154]

Goal	Objective
Individuals seeking access to services for OUD will receive access to MAT and other clinically appropriate services.	Increase referral of individuals with OUD to MAT services, as measured by 80 percent of individuals served with the SOR funds being referred to MAT if indicated as clinically appropriate. • Increase the number of individuals with OUD accessing MAT, as measured by 50 percent of individuals with OUD served with the SOR funds receiving at least three MAT-related services. • By August 2020, the number of Drug Addiction Treatment Act (DATA)-waivered prescribers who prescribe at least 10 MAT-related medications annually will increase by 15 percent.
New Hampshire will reduce opioid overdose fatalities	By August 2020, overdose fatalities in New Hampshire will decrease by 10 to 15 percent.

Medicaid

Medicaid is a key component of New Hampshire's response to the opioid crisis and overall substance use. According to New Hampshire data, the total of 6,134 individuals receiving SUD-related services through New Hampshire Medicaid in October 2017 is more than four times as many people who received such services at the beginning of 2012.[155] Overall, Medicaid expansion is estimated to have given new health insurance coverage to 54,000 people in New Hampshire.[156]

In addition to Medicaid coverage of inpatient treatment, Medicaid also provides coverage for outpatient MAT detailed in Table 21, reimbursing nearly $13 million in 2018 for treatment medications, a 42 percent increase from 2016.[157]

Table 21: New Hampshire Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016–2018[158]

	2016	2017	2018*
Buprenorphine	$3,353,785	$4,245,552	$5,188,079
Naltrexone	$339,601	$1,089,585	$1,655,637
Methadone[159]	$5,409,303	$6,384,295	$6,103,846
Naloxone	$2,572	$4,069	$15,933
Total	**$9,105,260**	**$11,723,501**	**$12,963,495**

*2018 totals projected based on first two quarters of 2018.

Preliminary 2018 mortality data reported from New Hampshire is projecting a 10 percent decrease in overall drug overdose deaths compared with 2017.[160] In addition, prevalence data from the National Survey on Drug Use and Health (NSDUH) showed a similar rate of pain-reliever misuse in the past year in the 2015-2016 surveys and 2016-2017 surveys, 4.60 percent and 4.22, respectively.[161] For heroin, reported rates were 0.87 and 0.68.[162]

NSDUH data indicates that 53,000 people in New Hampshire reported past-year misuse of pain relievers, and 10,000 reported past-year heroin use.[163] Detailed in Table 22, less than 10 percent of the state's drug overdose deaths in 2016 and 2017 involved heroin.[164] In 2017, 80 percent of the drug overdose deaths in New Hampshire involved fentanyl and other synthetic opioids.[165]

Table 22: New Hampshire Opioid Overdose Deaths by Class, 2015-2017[166]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	34.3	31.3	4.4	24.1	6.5	1.9
2016	39.0	35.8	5.0	30.3	2.8	2.2
2017	37.0	34	3.9	30.4	2.4	Unreliable
Total	**36.8**	**34.2**	**4.7**	**28.3**	**4.4**	**1.7**

*Age-Adjusted Rate per 100,000.

OHIO

State Opioid Overview

From 2014 through 2017, Ohio has had the highest number of opioid-involved overdose deaths per year for any U.S. state.[167] Only West Virginia had a higher age-adjusted rate per 100,000 in 2017.[168] As deaths involving fentanyl and other synthetic opioids increased significantly from 2015 to 2017 (see Figure 23), Ohio's opioid-related death rates have increased by 29 percent, 33 percent, and 19 percent per year—a faster rate of increase than most Midwest states.[169] Since 2011, Ohio has had the highest drug overdose rate in the Midwest (see Table 23).[170] Ohio makes up 4 percent of the U.S. population and accounted for 9 percent of the opioid deaths from 2015 to 2017.[171]

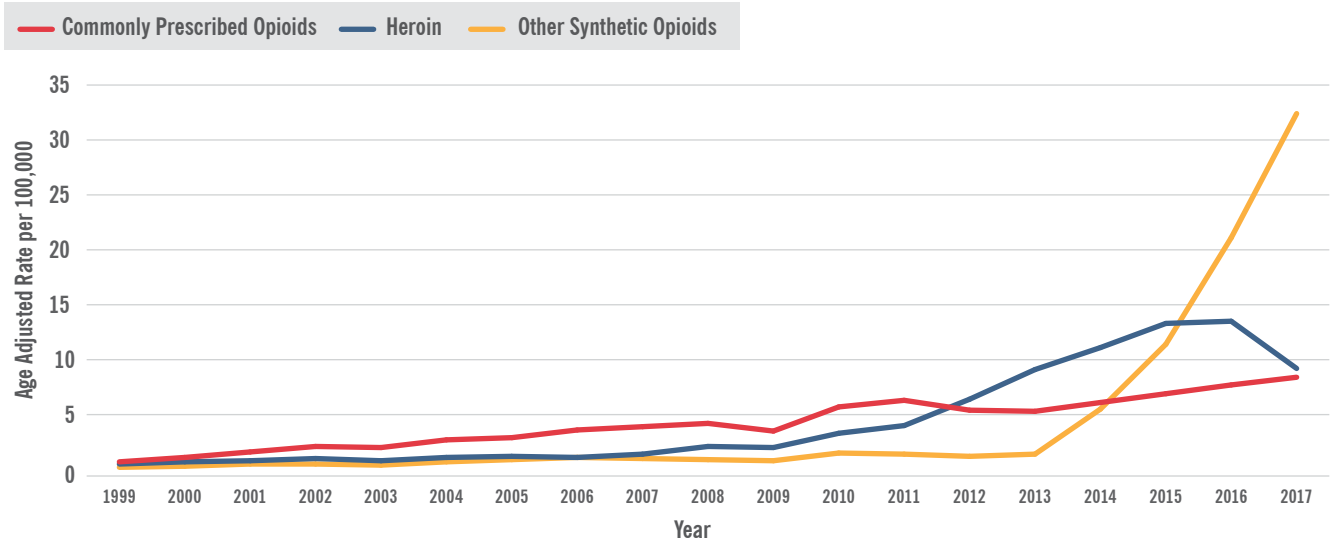
In response, federal appropriations to address the opioid epidemic nearly doubled from $119,030,865 in 2017 to $224,921,519 in 2018. Per capita, appropriations increased from $10 per person to $19 per person.

Table 23: Opioid Overdose Deaths, 2015-2017[172]

Year	Deaths	Ohio Rate*	Midwest Region Rate*
2015	2,698	24.7	12.2
2016	3,613	32.9	16.5
2017	4,293	39.2	19.1
Total	**10,604**	**32.9**	**16.0**

*Age-Adjusted Rate per 100,000.

Figure 23: Ohio Opioid Death Rates



Source: CDC Wonder

State Opioid Response Structure

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) administers the majority of federal opioid funds. OhioMHAS distributes the State Targeted Response (STR) grant and the Substance Abuse Prevention and Treatment Block Grant (SABG) to local county alcohol, drug addiction, and mental health (ADAMH) boards. Ohio has 50 ADAMH boards that encompass all 88 Ohio counties. As further detailed in the Key Federal Grants section below, ADAMH boards each have distinct opioid projects. The treatment, prevention, and recovery services provided by ADAMH boards are also funded by local property taxes.

Former Governor John Kasich established the Governor's Cabinet Opiate Action Team (GCOAT) in 2011 to "fight opiate abuse and to decrease the rate of overdose deaths."[173] During the Kasich administration, GCOAT members included 23 senior state officials from the full spectrum of state agencies: OhioMHAS, Medicaid, Public Safety, Education, Aging, Veterans Services, and more.[174] GCOAT members met in-person monthly and held weekly calls to discuss the state response to the opioid crisis epidemic, including the allocation of federal funds to fill gaps in state resources. GCOAT organized many efforts over the last eight years in Ohio including Project DAWN (Deaths Avoided with Naloxone) and led the partnership to create prescriber guidelines for management of chronic, non-terminal pain in 2013.[175] GCOAT leverages federal grants with state funding, as the state agencies on GCOAT provided $1.1 billion in total state funding in 2017.[176] This, and related cross-agency coordination continuing under the current administration of Governor Mike DeWine, is now known as RecoveryOhio.

Federal appropriations to address the opioid epidemic are broken down in Tables 24 and 25 below. As shown, SAMHSA programs make up the majority of federal spending—85 percent in 2017 and 73 percent in 2018. Ohio received grants from 34 different opioid-related federal programs, fully detailed in Appendix II.

Federal Appropriations to Ohio

Table 24: Ohio Opioid Spending by Department

Department	FY2017	FY2018
Health and Human Services	$105,682,024	$197,360,876
Substance Abuse and Mental Health Services Administration	*$101,271,017*	*$163,668,657*
Centers for Disease Control and Prevention	*$3,569,715*	*$8,667,739*
Health Resources and Services Administration	*$0*	*$15,200,899*
Administration for Children and Families	*$841,292*	*$3,920,859*
National Institutes of Health	*$0*	*$5,902,722*
Office of National Drug Control Policy	$7,348,105	$7,551,607
Department of Justice	$6,000,736	$20,009,036
Department of Labor	$0	$0
Total Opioid Spending	**$119,030,865**	**$224,921,519**

Table 25: Ohio Opioid Spending by Category

Category	FY2017	FY2018
Treatment and Recovery	21%	33%
Prevention	25%	22%
Mixed: Treatment/Recovery and Prevention	43%	30%
Research	0%	3%
Criminal Justice	7%	9%
Law Enforcement	4%	2%

Figures 24 and 26 depict the funding per capita for opioid-related grants for FY2017 and FY2018, respectively.[k] The blue counties received the highest funding, with 52 percent to Cuyahoga, Franklin, Hamilton, and Montgomery counties in FY2017. These counties made up 38 percent of deaths, shown in Figures 25 and 27. Several rural counties in southern Ohio had high death rates and low relative funding. Gallia, Highland, and Lawrence counties had death rates of 46.5, 54.6, and 51.1, respectively, and all had under $3 per capita funding in FY2017, putting each in the lowest 25 percent of funding in the state.

In FY2018, many Ohio counties received increased absolute and relative funding, as shown in Figure 26. Gallia and Highland counties received 9.7 and 8.9 per capita, respectively, above the state median (8.8). Lawrence County remained in the lowest 25 percent in the state at 5.9 per capita. Again, the highest funding went to Cuyahoga, Franklin, Hamilton, and Montgomery counties with 56 percent combined in FY2018.

[k] Figures reflect the location of the recipient of the federal funding, which does not necessarily correspond with the service area of the funding. For the STR, SOR, and SABG funding, the sub-award locations are reflected in these figures.

Figure 24: Ohio Federal Opioid Funding 2017 by County

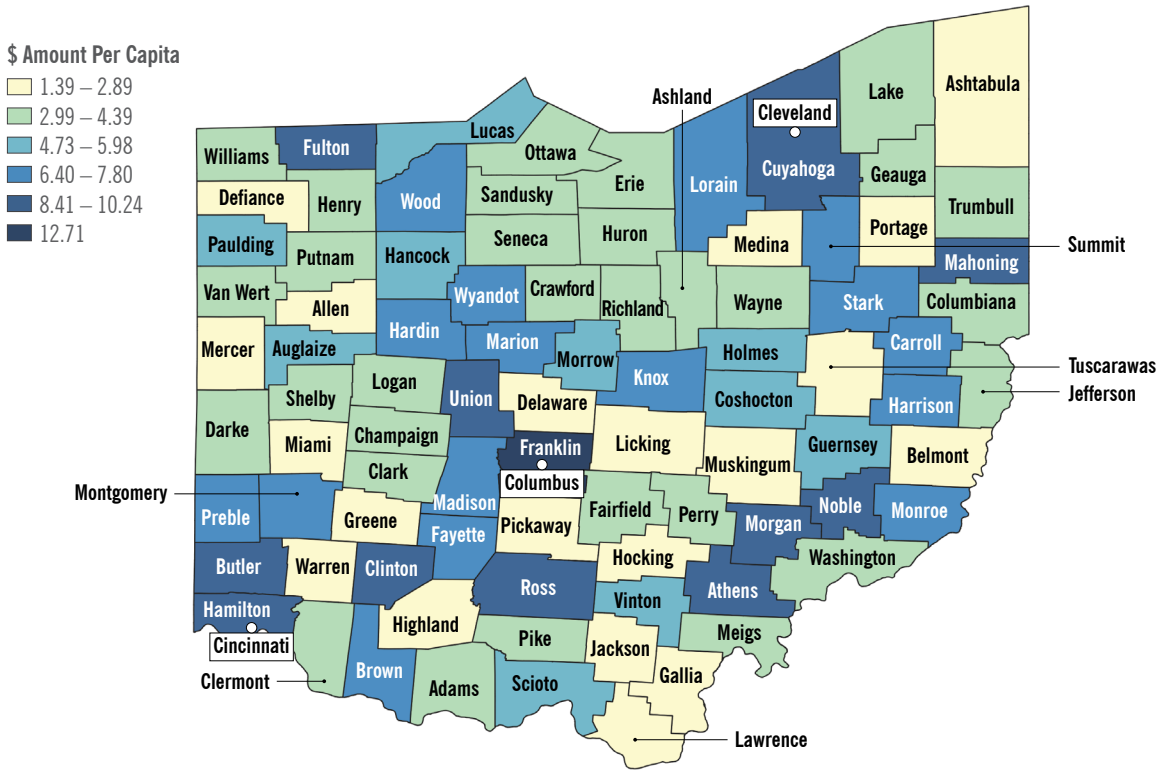
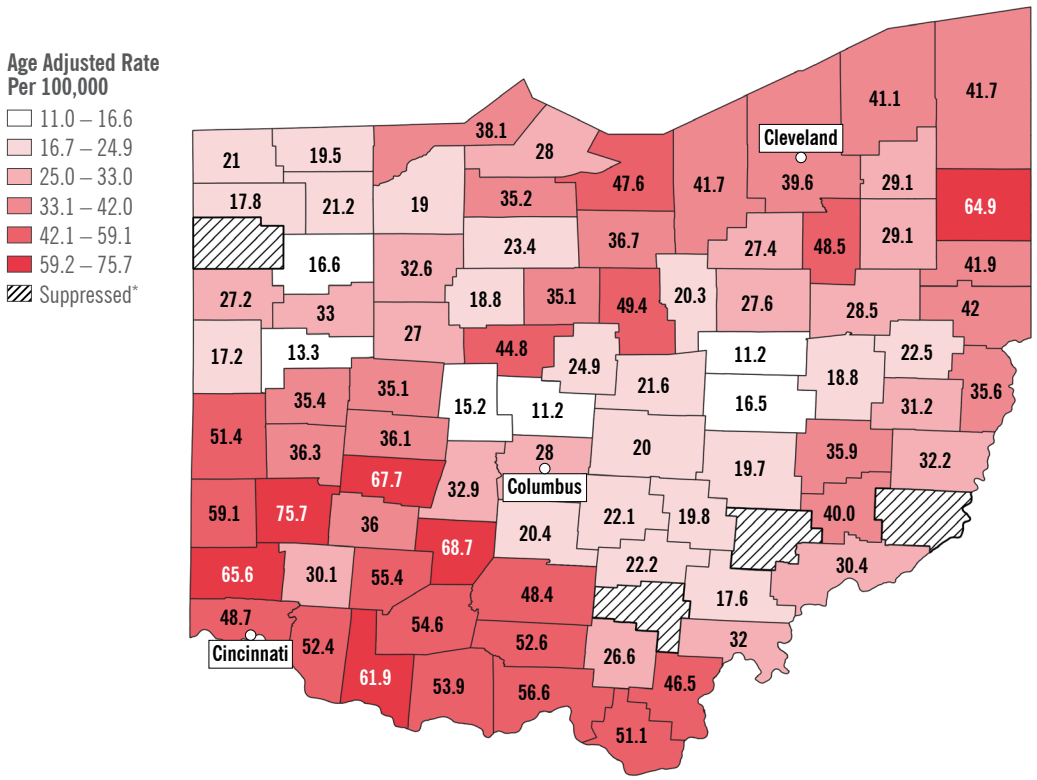


Figure 25: Ohio Drug Overdose Death Rate 2015–2017 by County



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Figure 26: Ohio Federal Opioid Funding 2018 by County

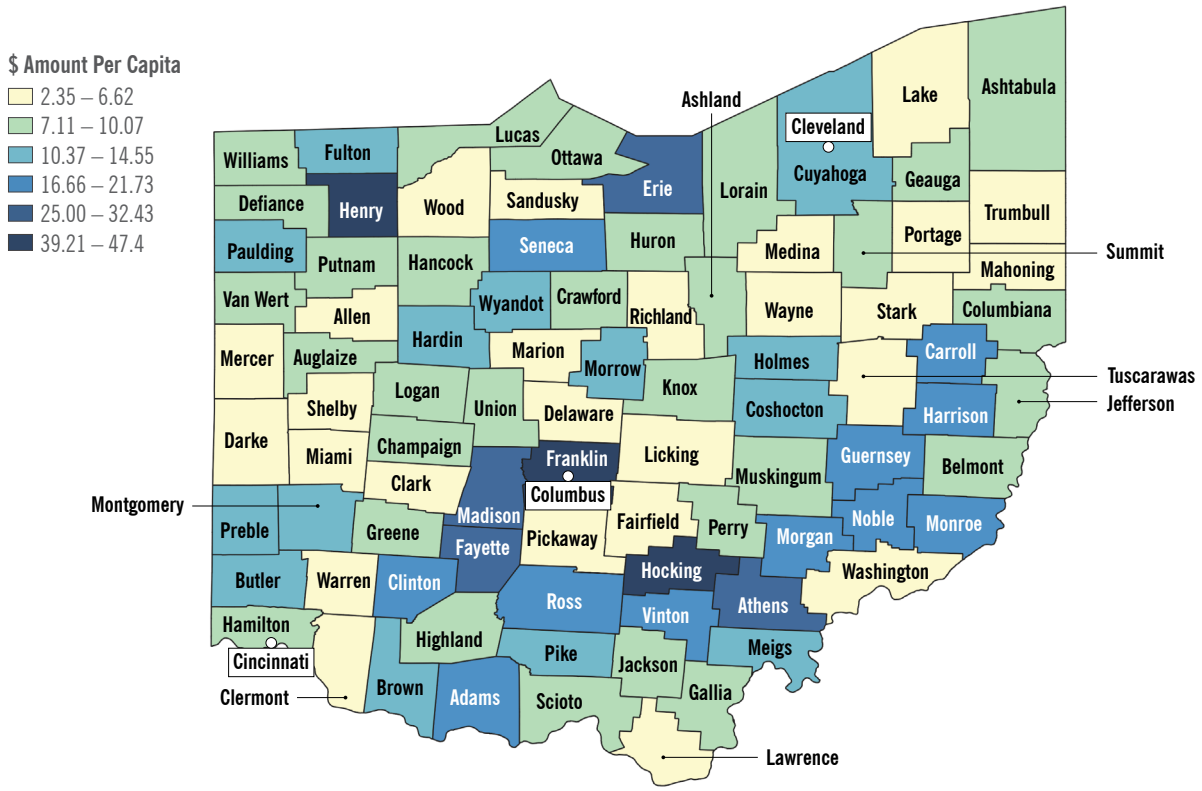
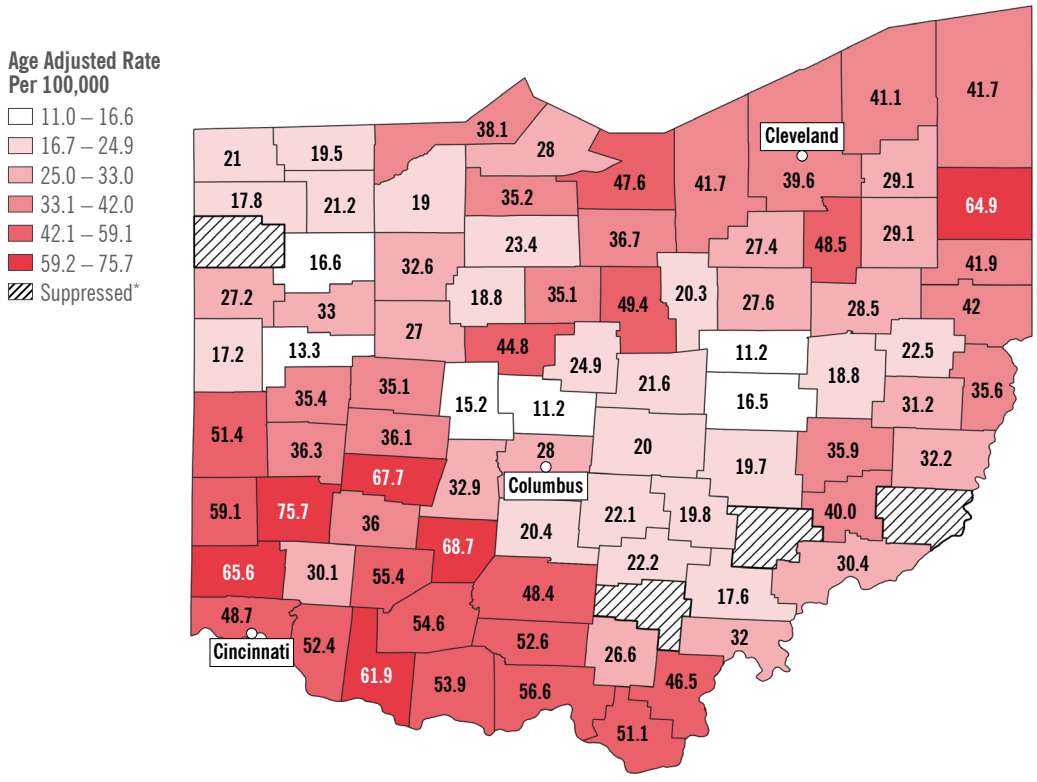


Figure 27: Ohio Drug Overdose Death Rate 2015–2017 by County



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Key Federal Grants from 2017 and 2018 Federal Appropriations

The largest FY2017 opioid-specific federal grant awarded to Ohio is the STR grant administered by SAMHSA. In 2017, this program was funded at $26 million, 22 percent of federal opioid funding in Ohio. In 2018, Ohio received $56 million in funding under the State Opioid Response (SOR) program, which made up over half (53 percent) of the new federal opioid funding awarded to Ohio. The state received STR funding for Year 1 in May 2017 and for Year 2 in May 2018; Ohio received Year 1 SOR funding in September 2018 and is expected to receive Year 2 funding before September 30, 2019.[177] In addition to the resources to build on existing substance use prevention and treatment activities for the state to respond to the epidemic, the STR and SOR programs allowed Ohio to implement a wide range of strategic goals. Below is a brief overview of the goals and outcomes from the first year of the STR funds and Ohio's plan for the 2018 SOR grant.

Ohio STR Goals

Ohio's STR goals include primary prevention, early intervention/harm reduction, workforce development, treatment, criminal justice/reentry, trauma-informed care, child welfare, and recovery supports.[178] OhioMHAS classified as "Tier 1" and "Tier 2" counties with the highest overdose death rates from 2010 to 2015, which included 61 percent of the state population.[179] OhioMHAS then prioritized funding for ADAMH boards in Tier 1 and Tier 2 counties, with Tier 3 counties that had access to statewide prevention and workforce training activities.[180] Nine boards covering 17 Tier 3 counties were subsequently awarded MAT-Prescription Drug and Opioid Addiction funds to expand the use of MAT, undertaking projects similar to those of boards in the Tier 1 and Tier 2 counties. Ohio's federal funding per capita aligned with the 2015-2017 overdose death rates as shown in Figures 25 and 27. ADAMH projects varied, but many of them funded MAT and Quick Response Teams. Quick Response Teams employ a combination of first responders, law enforcement, certified peer supporters, and clinicians who connect individuals surviving an opioid overdose to treatment.[181] Ohio's STR goals and strategies were divided into the following areas:[182]

- MAT;
- workforce development;
- immediate access;
- primary prevention;
- screening, brief intervention, and referral to treatment;
- recovery supports, including peer services; and
- addressing secondary trauma among first responders.

Ohio implemented a three-pronged approach: (1) department-directed strategies and activities focusing on counties with highest opioid overdose deaths and treatment needs; (2) department-directed strategies and activities to be deployed statewide; and (3) ADAMH-identified projects consistent with the goals and objectives of Ohio's STR project.[183]

Ohio STR Outcomes

The STR outcomes data are preliminary, but OhioMHAS has produced reports on efforts to increase workforce and capacity expansion. Through the STR program, OhioMHAS is projected to increase the number of Drug Addiction Treatment Act (DATA)-waivered physicians by 6,085. This was estimated to increase total patient capacity by at least 45,630.[184] In the first six months of STR funding, 2,120 people received opioid use disorder treatment and 533 were provided recovery support services.[185]

Ohio used an integrative care model for its approach to treatment, targeting emergency department patients and pregnant mothers with opioid use disorder.[186] In the first year of funding, 246 clients were served by the three participating hospital emergency departments.[187] The Maternal Opiate Medical Support (MOMS) program provided services to 219 women in the first year, with 71 percent of participants remaining in the program.[188] MOMS participants' use of illicit drugs decreased from 85 percent to 12 percent from May 2017 through April 2018.[189]

Ohio's STR funds supported 15 trainings to expand evidence-based treatment and recovery for opioid use disorder.[190] In the first year of funding, the STR funds were used to train more than 6,800 professionals. Trainings were in the following areas:

- American Society of Addiction Medicine Criteria—guidelines for patients with addiction and co-occurring conditions;
- Botvin Life Skills—prevention staff instructed in an evidence-based substance use and violence-prevention program;
- Extension for Community Healthcare Outcomes (ECHO)—provides prescribers support, mentorship, and education related to MAT and opioid use disorders;
- Emergency Department Case Manager Grant—funding to hire case managers to coordinate clinical care for patients with substance use disorders, including opioid use disorders; and
- PAX Good Behavior Game Training—schoolteacher training in self-regulation and behavior as a skill set.[191]

Ohio SOR Goals/Plan

In 2018, Ohio received SOR funds which were used to build on its STR projects. The Ohio SOR project is estimated to provide treatment and recovery support services to 9,000 individuals with opioid use disorder in each year of the project, totaling 18,000 individuals.[192] Ohio's SOR funds have already funded 11 trainings.[193] Table 26 shows Ohio's SOR goals and objectives.

Table 26: Ohio SOR Goals and Objectives[194]

Prevention Goals	Prevention Objectives
Increase the availability of naloxone to prevent overdose death.	Increase by 30 percent over 2018 the number of Project Dawn naloxone kits distributed.
Increase professional understanding of opioid use disorder.	70 percent of professionals who attend stigma-reduction training will report changes in practice in their respective systems.
Increase community awareness of the danger of opioids.	Social-media campaign total and unique page views will increase 25 percent above established baseline figures.
Treatment and Workforce Goals	**Treatment and Workforce Objectives**
Expand access to MAT.	Increase by 1,000 the number of prescribers who obtain the DATA waiver.
Increase the number of clinicians who provide evidence-based psychosocial treatment services to clients with an opioid use disorder.	A minimum of 750 of licensed clinicians will obtain a certificate of completion of continuing education in substance use treatment. 500 of those clinicians will demonstrate expanded client care to include OUD based on a review of service claims data.
Increase service delivery that supports family stability/unification.	Each regional community project will identify at least four agencies that add family services that make it easier for family members to seek and stay in treatment.
Recovery Services Goals	**Recovery Service Objectives**
Expand the number of certified peer supporters providing support to individuals with opioid use disorder.	Increase the number of peer supporters employed in various settings (e.g., EDs, child welfare, courts by 30 percent over 2018.
Increase the availability of recovery housing, including family recovery housing, that accepts MAT.	At least 30 recovery house owners will move to MAT acceptance in housing in 2019.
Increase number of patients who become employed.	25 percent of the unemployed client workforce will be enrolled in job-training programs in 2019.

Medicaid

Medicaid expansion is a critical component of Ohio's response to the opioid epidemic by providing treatment coverage for opioid use disorder. In total, Medicaid expansion is estimated to have given 711,000 Ohioans health insurance coverage.[195] The number of opioid-related hospitalizations in Ohio rapidly increased from 27,550 in 2013 to 47,750 in 2017, and the rate of uninsured visits decreased from 21 percent to 3 percent.[196] Medicaid was the expected payer for 57 percent of opioid-related inpatient hospital stays in Ohio in 2016, compared with 37 percent nationally.[197] In addition to Medicaid coverage of inpatient treatment, Medicaid also provides coverage for outpatient MAT, reimbursing over $100 million per year for treatment medications from 2016 to 2018 as specified in Table 27.[198]

Table 27: Ohio Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016-2018[199]

	2016	2017	2018
Buprenorphine	$85,503,743	$79,639,013	$82,094,804
Naltrexone	$41,615,608	$47,439,823	$40,095,505
Naloxone	$1,166,532	$1,409,504	$2,289,689
Methadone	†	†	†
Total	**$128,285,883**	**$128,444,341**	**$124,479,998**

†Due to the marginal cost, Ohio Medicaid includes the methadone medication cost in the administration payment therefore the cost of the methadone medication alone cannot be separately calculated at this time.

Ohio has reduced its rate of opioid prescriptions per 100 people from a peak of 102.4 in 2010 to 63.5 in 2017, a 38 percent decrease.[200] Using the STR and SOR funds, Ohio has emphasized increasing workforce capacity and access to opioid use disorder treatment.

The latest available data from the National Survey on Drug Use and Health (NSDUH) indicates that 442,000 people in Ohio reported past-year misuse of pain relievers, and 40,000 reported past-year heroin use.[201] The NSDUH prevalence data reports similar rates of pain-reliever misuse from the 2015-2016 and 2016-2017 surveys, 4.54 percent and 4.67, respectively.[202] The heroin use reported rates were also similar, 0.41 to 0.45.[203] In 2017, Ohio saw a 54 percent growth in fentanyl-related deaths in 2017, making up 69 percent of all drug overdose deaths, as shown in Table 28. Meanwhile, heroin deaths declined by a third from 2016 to 2017, making up 34 percent and 20 percent of all drug overdose deaths, respectively.[204]

Table 28: Ohio Opioid Overdose Deaths by Class, 2015–2017[205]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	29.9	24.7	6.1	11.4	13.3	1.0
2016	39.1	32.9	6.9	21.1	13.5	0.8
2017	46.3	39.2	7.6	32.4	9.2	1.0
Total	**38.5**	**32.9**	**6.9**	**21.7**	**12.0**	**0.9**

*Age-Adjusted Rate per 100,000.

TENNESSEE

State Opioid Overview

Tennessee has had one of the highest rates of opioid prescriptions per 100 people in the United States. Beginning in 2003, the state has faced increases in overdose deaths involving prescription opioids (see Figure 28).[206] From 2009 through 2017, Tennessee's age-adjusted death rate from drug overdoses has hovered at or above 20 per 100,000.[207] As deaths involving fentanyl and other synthetic opioids grew from 2015 through 2017, Tennessee's opioid-related death rates increased by 19 percent, 13 percent, and 7 percent per year (see Table 29).[208] Opioid-involved overdose deaths made up 48 percent of all drug overdose deaths in the state in 2006 and climbed to 71 percent in 2017.[209]

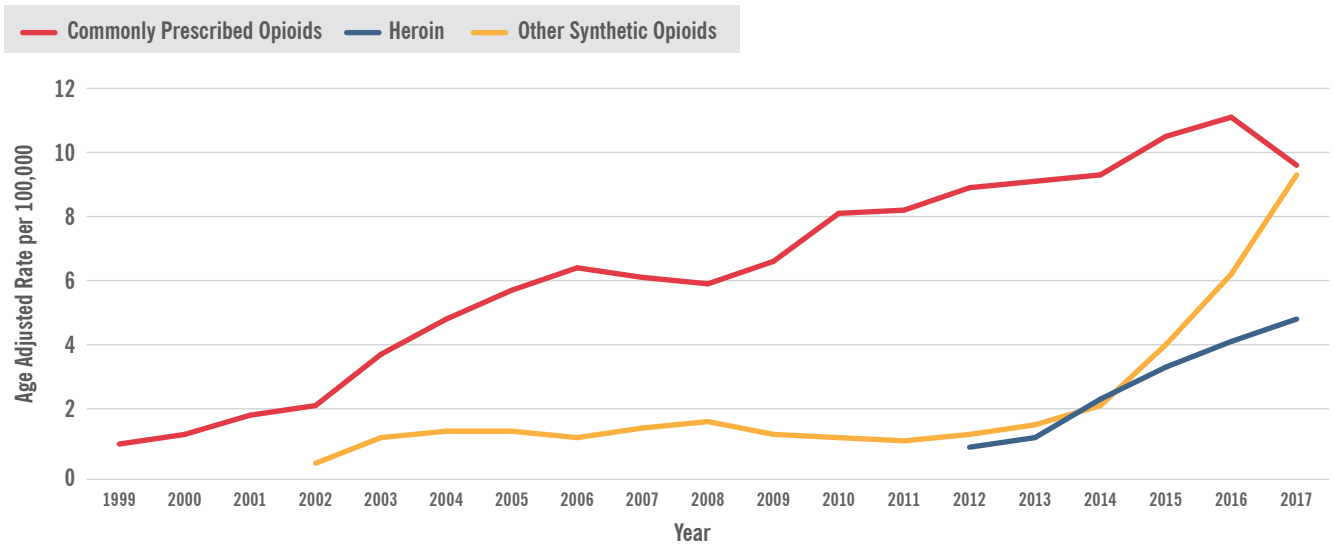
Federal grants to Tennessee to address the opioid epidemic nearly doubled from $63,358,063 in 2017 to $114,604,103 in 2018. Per capita, appropriations increased from $9 per person to $17.

Table 29: Opioid Overdose Deaths, 2015-2017[210]

Year	Deaths	Tennessee Rate*	South Region Rate*
2015	1,038	16.0	9.8
2016	1,186	18.1	12.4
2017	1,269	19.3	14.1
Total	**3,493**	**18.4**	**12.1**

*Age-Adjusted Rate per 100,000.

Figure 28: Tennessee Opioid Death Rates



Source: CDC Wonder

State Opioid Response Structure

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) administers the majority of the opioid grants the state receives from the federal government. TDMHSAS distributes the State Targeted Response (STR) grant and the Substance Abuse Prevention and Treatment Block Grant (SABG) to seven Behavioral Health Planning Regions in all 95 Tennessee counties.

Former Governor Bill Haslam oversaw the development of a strategic plan, called Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee (PFS) in 2014.[211] PFS was led by TDMHSAS in collaboration with the departments of Health, Children's Services, Safety and Homeland Security, Correction, TennCare, Tennessee Bureau of Investigation, and the Tennessee Branch of the U.S. Drug Enforcement Agency.[212] As of June 2017, PFS reported the following results in Tennessee:[213]

- Reduced doctor shopping by 63 percent from 2011 to 2016;
- Reached 6 million Tennesseans with its "Take Only as Directed" prevention ad campaign;
- State legislators passed Good Samaritan and open naloxone prescription laws;
- Decreased opioid prescriptions for pain by 805,208;
- Added nearly 200 permanent prescription drug collection boxes;
- Increased funding to 53 recovery courts—enrollees increased by 179 percent, from 1,405 in 2013 to 3,919 in 2017;
- Increased funding to Oxford Houses, 56 sober homes with 399 beds;
- Conducted 2,466 Lifeline recovery trainings, referred 1,600 people to treatment; and
- Transformed the Substance Abuse Data Taskforce into a State Epidemiological Outcomes Workgroup.

In June 2018, Haslam created TN Together, a plan to integrate prevention, treatment, and law enforcement responses to the opioid epidemic.[214] TN Together oversees $30 million in combined state and federal funds.[215] In addition to the oversight of resources, TN Together was passed along with policy reforms to respond to the crisis by limiting coverage from TennCare enrollees to an initial five-day supply; updating the schedule of controlled substances to better track, monitor, and penalize unlawful distribution of substances that mimic fentanyl; and providing incentives for offenders in correctional facilities to complete intensive substance use treatment programs.[216]

Through its grant programs, the Tennessee Department of Health also plays a critical role in supporting prescriber education and in coordinating a comprehensive and multifaceted data-driven response to the opioid epidemic. The Tennessee Department of Health has developed the Integrated Data System and Health Enterprise Warehouse, which links prescription data from the state's prescription drug monitoring program with hospital discharge data, vital statistics data, and law enforcement data to develop both descriptive and predictive analytic models. These models track outcomes such as opioid overdose and neonatal abstinence syndrome. One specific grant, the Enhanced State Opioid Overdose Surveillance program, or ESOOS, establishes an early warning system by integrating data from unique medical examiner and coroner investigations, and sharing findings with state and national stakeholders to inform opioid response efforts. Overall, the Tennessee Department of Health's efforts to share and combine data with TDMHSAS and the Tennessee Bureau of Investigation provides communities with real-time data to identify and react to inflections in the epidemic.

Federal appropriations to address the opioid epidemic are broken down in Tables 30 and 31 below. As shown, SAMHSA programs make up the majority of federal spending—86 percent in 2017 and 67 percent in 2018.

Federal Appropriations to Tennessee

Table 30: Tennessee Opioid Spending by Department

Department	FY2017	FY2018
Health and Human Services	$57,895,196	$97,218,827
Substance Abuse and Mental Health Services Administration	*$54,619,043*	*$76,847,566*
Centers for Disease Control and Prevention	*$2,775,304*	*$7,126,573*
Health Resources and Services Administration	*$0*	*$7,141,106*
Administration for Children and Families	*$500,849*	*$2,700,566*
National Institutes of Health	*$0*	*$3,403,016*
Office of National Drug Control Policy	$2,204,410	$2,232,386
Department of Justice	$3,258,457	$15,152,890
Department of Labor	$0	$0
Total Opioid Spending	**$63,358,063**	**$114,604,103**

Table 31: Tennessee Opioid Spending by Category

Category	FY2017	FY2018
Treatment/Recovery	29%	29%
Prevention	24%	23%
Mixed: Treatment/Recovery and Prevention	40%	29%
Research	0%	3%
Criminal Justice	7%	15%
Law Enforcement	0%	1%

Figure 27 depicts the per capita opioid-related funding for FY2017.[I] Davidson County, which includes Nashville, received the most funds, 38 percent of the total amount. Knox County had the 10th highest drug overdose mortality rate out of 95 counties in Tennessee, shown in Figures 28 and 30. Knox received the fourth highest funding, with 8 percent of the total. Shelby County, the most populous, had 19 percent of the state's total funds and ranked second in total deaths. Figure 29 shows the funding per capita in FY2018. Davidson County again received the most federal opioid funds, 47 percent of the state total. Knox County received 7 percent, and Shelby County received 16 percent.

[I] Figures reflect the location of the recipient of the federal funding, which does not necessarily correspond with the service area of the funding. For the STR, SOR, and SABG funding, the sub-award locations are reflected in these figures.

Figure 29: Tennessee Federal Opioid Funding 2017 by County

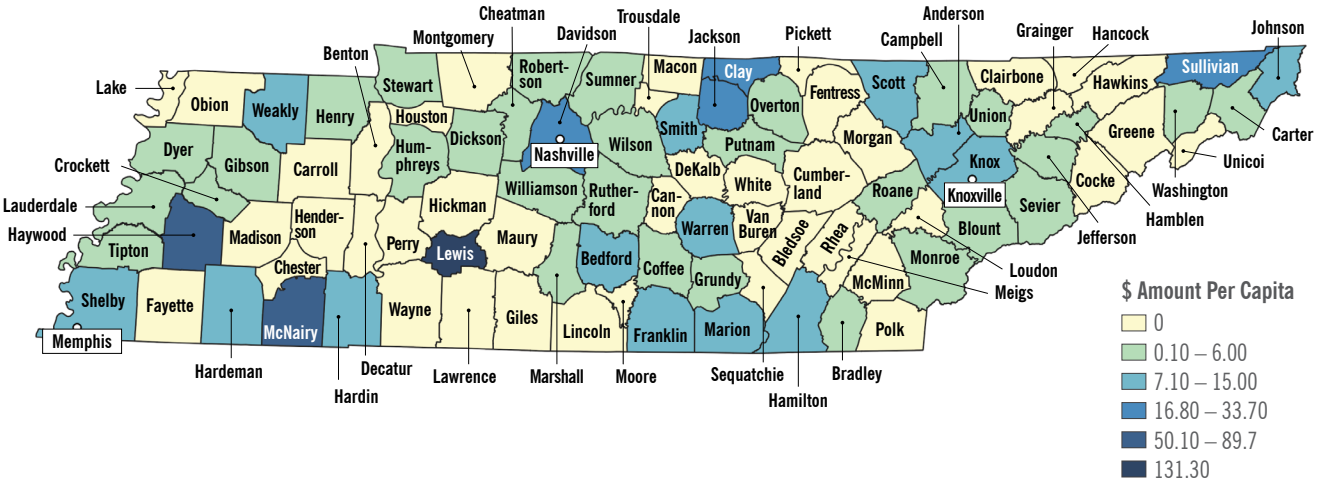
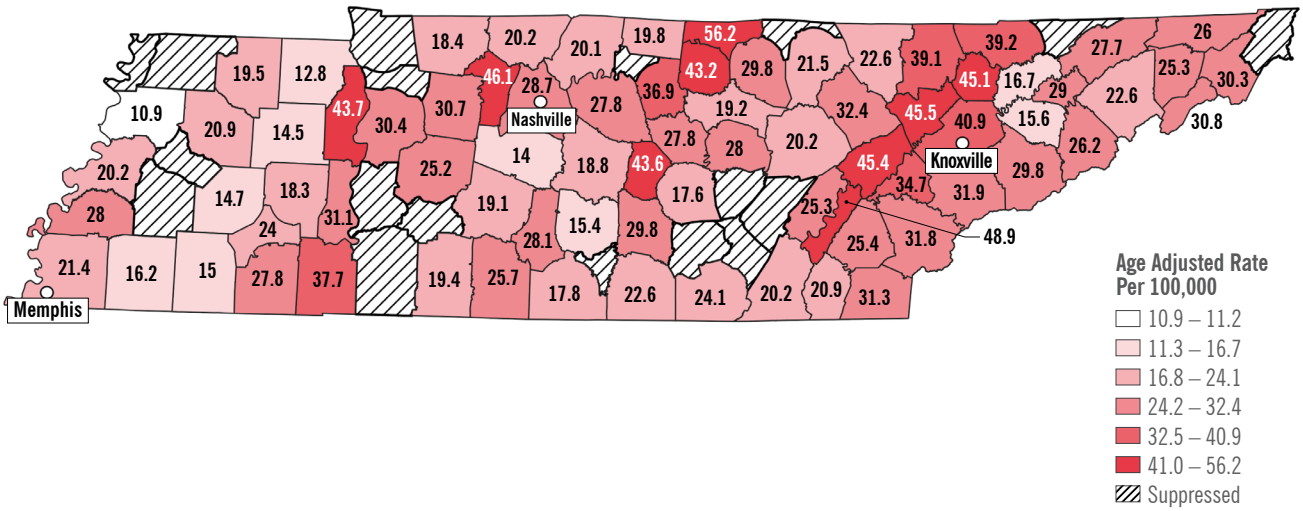


Figure 30: Tennessee Drug Overdose Death Rate 2015–2017 by County



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Figure 31: Tennessee Federal Opioid Funding 2018 by County

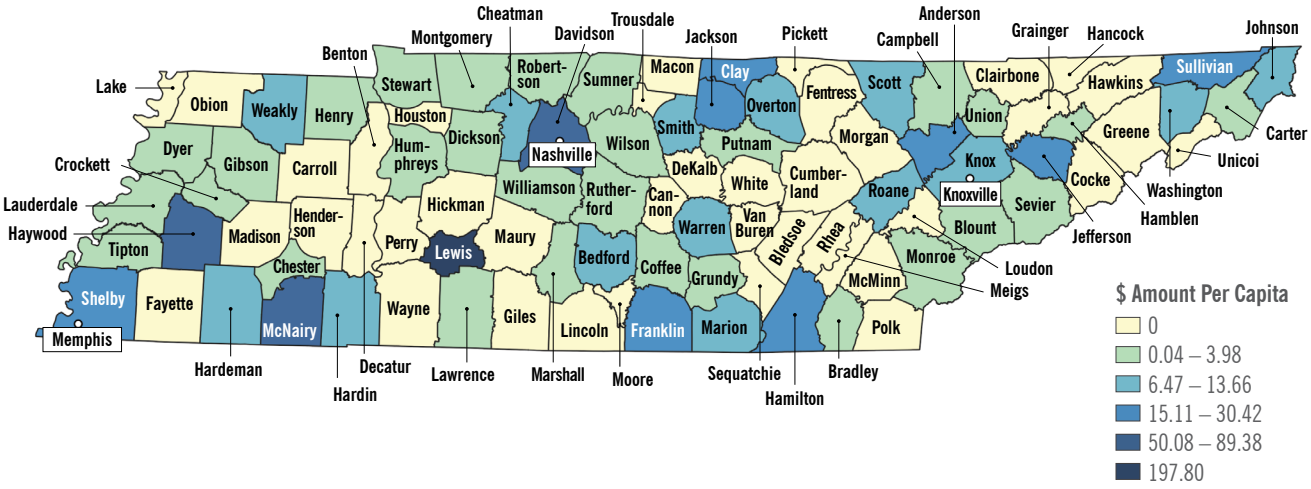
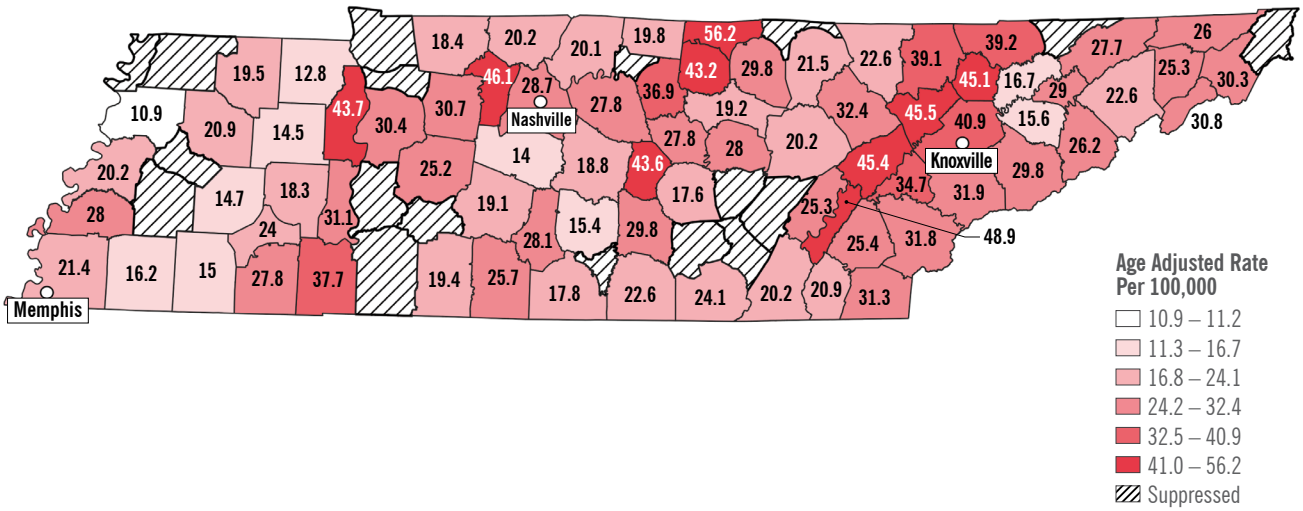


Figure 32: Tennessee Drug Overdose Death Rate 2015–2017 by County



*"Suppressed" is displayed for counties with 9 or fewer overdose deaths per CDC's policy to protect personal privacy, and to prevent revealing information that may identify specific individuals.

Key Federal Grants from 2017 and 2018 Federal Appropriations

The STR is the largest FY2017 opioid-specific grant awarded to Tennessee by the federal government. In FY2017, Tennessee received $14 million in STR funds, 22 percent of Tennessee's opioid-specific grants from the federal government. Tennessee received $19 million in federal funds through the SOR program; the STR and SOR funds combined made up 28 percent of FY2018 federal funding for the opioid epidemic in Tennessee. The state received STR funding for Year 1 in May 2017 and for Year 2 in May 2018; Tennessee received Year 1 SOR funding in September 2018 and is expected to receive Year 2 funding before September 30, 2019.[217] The STR and SOR programs allowed Tennessee to implement a wide range of strategies. Below is brief overview of the goals (Table 32) and outcomes from the first year of the STR funds as well as Tennessee's plan for the 2018 SOR grant.

Tennessee STR Goals

Table 32: Tennessee STR Treatment and Recovery Goals and Objectives[218]

Goal	Objective	Strategy
1. Increase the access to Medication Assisted Treatment in areas of the state with the greatest risk for opioid and heroin addiction.	1.a. Select additional providers to provide buprenorphine as an adjunct to clinical treatment.	1.a. Tennessee currently funds providers to provide buprenorphine treatment for those individuals with an opioid use disorder. This funding will allow for expansion of medication assisted treatment (MAT) buprenorphine services.
	1.b. Select additional providers (number to be determined) in the high need areas of the state to provide Vivitrol injections as an adjunct to clinical treatment.	1.b. The additional funding for those with opioid and heroin disorders will allow Tennessee to provide the medication assisted treatment Vivitrol at providers in the highest-need areas of the state.
2. Develop the infrastructure and capacity to increase access to outpatient treatment services in rural areas with limited services.	2.a. Expand capacity of outpatient tele-treatment in high-need areas of the state.	Tennessee currently contracts with a provider in the rural eastern area of the state to provide outpatient tele-treatment. The additional funding will allow for expansion by adding additional staff at existing county locations or by expanding to an additional county.
	2.b. Increase the number of individuals served though tele-treatment	2.b. Tennessee currently contracts with a provider in the rural eastern area of the state to provide outpatient tele-treatment. The additional funding will allow for expansion by adding additional staff at existing county locations, which will increase access to treatment.
3. Reduce the unmet needs of individuals with OUD.	3.a. Increase the availability of continuum-of-care treatment services by increasing access and availability of services.	3.a. Increase the availability of treatment services to OUD individuals.
	3.b. Increase the availability of recovery support services by expanding in areas of greatest need and adding additional services to support those with opioid and heroin use disorders in their recovery.	3.b. For those with opioid or heroin disorders, Tennessee will be able to add additional recovery services such as health/wellness and employment skills to the current array of recovery support services. The funding will also allow for expansion to other recovery support providers in the high-need areas of the state.
	3.c. To provide engagement, retention, and detox, when appropriate, from all opioids for pregnant women.	3.c. Immediate linkage to services, referral to appropriate level of clinical treatment, provide family support, and the availability of detox with the goal of tapering methadone or buprenorphine to abstinence or the lowest effective dose.

Tennessee STR Outcomes

Preliminary outcomes data from the STR program are available regarding workforce and capacity expansion in Tennessee. In the first year of the STR, TDMHSAS reports the following outcomes:[219]

- Hired 17 regional overdose prevention specialists;
- Hosted 784 training sessions on overdose prevention;
- Purchased 8,916 units of naloxone for distribution to lay people and individuals leaving treatment or deemed at high risk of overdose—through June 2018: 117 overdoses reversed;
- Media campaign: 13,713,000 television impressions through April 30, 2018;
- Implemented Opioid Overdose Rapid Response System Team; and
- More than 4,200 individuals received treatment and recovery support services.

According to the Sycamore Institute, a nonpartisan policy research group in Tennessee, the STR program contributed to reducing the number of Tennesseans with unmet opioid use disorder needs from 12,327 to 8,427.[220]

Medicaid

Medicaid plays an essential role in Tennessee's ability to respond to the opioid epidemic. Tennessee is not a Medicaid expansion state; with expansion, an estimated 163,000 more Tennesseans would have health insurance coverage.[221] Medicaid makes up a slightly lower share of hospital payments than the national average (30 percent versus 37 percent, respectively) this still translates to nearly double the stays paid by private insurance in Tennessee (17 percent).[222] The number of opioid-related hospitalizations in Tennessee increased from 15,400 in 2013 to 26,600 in 2016.[223] TennCare is developing opioid use disorder treatment networks that include both MAT and behavioral health treatment and is increasing outreach to encourage safe opioid prescribing and pain management alternatives.[224]

In addition to Medicaid coverage of inpatient treatment, Medicaid also provides coverage for outpatient MAT, reimbursing over $10 million per year for treatment medications from 2016 to 2018, as detailed in Table 33.[225] The data available for one form of opioid treatment medication, buprenorphine, demonstrates that as a non-expansion state, Medicaid covers only a small portion of treatment medications in Tennessee—only 3 percent of buprenorphine prescriptions in 2017.[226,227] In comparison, 93 percent of buprenorphine prescriptions in Ohio were covered by Medicaid.[228,229] However, the overall increases in buprenorphine prescriptions were similar in scale in Ohio and Tennessee, indicating that the states had comparable treatment medication responses. From 2010 to 2017, buprenorphine prescriptions increased by 612,000 (236 percent) in Tennessee, while they increased by 653,000 (281 percent) in Ohio over the same period.[230,231,232] In 2017, Tennessee's buprenorphine prescriptions per 1,000 people was 130, while Ohio's was 76.[233,234] Tennessee's past-year opioid use disorder rate per 1,000 people was 11.25, while Ohio's was 8.5.[235]

Table 33: Tennessee Medicaid Spending on Opioid Treatment Drugs[m] and Naloxone, 2016-2018[236]

	2016	2017	2018*
Buprenorphine	$5,706,000	$4,198,833	$4,501,202
Naltrexone	$12,930,940	$10,686,038	$11,479,343
Naloxone	$577,666	$106,638	$130,557
Total	**$19,214,606**	**$14,991,509**	**$16,111,103**

*2018 totals projected based on first two quarters of 2018.

Tennessee still has one of the top three highest rates of opioid prescribing in the United States, but it has reduced rates of opioid prescribing. Tennessee has dropped its rate of opioid prescriptions per 100 people from a peak of 140 in 2010 to 94.4 in 2017, a 33 percent decrease.[237]

The latest available data from the National Survey on Drug Use and Health (NSDUH surveys) indicate that 263,000 people in Tennessee reported past-year misuse of pain relievers, and 14,000 reported past-year heroin use.[238] The NSDUH prevalence data shows a decrease in pain-reliever misuse in the past year from 4.75 percent to 4.16 from the 2015-2016 survey to the 2016-2017 survey.[239] There was an increase in the rate of heroin use from 0.26 to 0.34.[240] Shown in Table 34 below, the NSDUH data correlate with the overdose death data. From 2016 to 2017, there was an over 50 percent annual increase in fentanyl-involved overdose deaths, but prescription opioid-involved overdose deaths decreased by 14 percent.[241] As a share of total drug overdose deaths, fentanyl increased from 24 percent to 33 percent from 2016 to 2017.[242]

Table 34: Tennessee Opioid Overdose Deaths by Class, 2015-2017[243]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	22.2	16.0	9.7	4.0	3.3	1.0
2016	24.5	18.1	10.2	6.2	4.1	1.3
2017	26.6	19.3	8.8	9.3	4.8	1.0
Total	**24.5**	**18.4**	**9.6**	**6.5**	**4.1**	**1.1**

*Age-Adjusted Rate per 100,000.

[m] Tennessee Medicaid does not cover methadone for opioid use disorder.

State Analysis

KEY TAKEAWAYS

Similarities exist across the five states BPC explored. First, in each state gubernatorial leadership in the form of an interagency-wide coordinating body guided state efforts. This reflects the high priority placed on addressing the epidemic in each state, as well as the need for a multifaceted plan to address the epidemic. Second, states used most of the federal funding received in 2017 and 2018 to increase treatment capacity. States targeted federal resources to areas with the highest number of overdose deaths. In keeping with federal grant requirements, states are required to report outcomes to the federal government, and they must use real-time data to evaluate their efforts and shift resources to areas of greatest need. Finally, the role of Medicaid was a key component of each state's response to the opioid crisis, particularly in Medicaid-expansion states.

Enhancing State Response Coordination

As noted previously, a statewide coordinating body, typically convened by the governor, is an essential part of developing a strategic opioid response. A comprehensive review of SAMHSA single-state agencies in 2015 found that 90 percent had a state task force to address prescription drug misuse.[244] The SAMHSA report emphasized that task forces provide a holistic approach to the opioid epidemic.[245] Sharing data and other communications is a core element of these statewide efforts. As the previous director of the Ohio Department of Public Safety said in a BPC interview, data is now shared continuously and publicly across state agencies and with local governments. Opioid task forces allow for various state agencies to bring their unique perspective to the issue and allow for strategy coordination.

Increasing Access to Treatment

The 124 percent increase in federal funds to states to address the opioid epidemic increased a state's potential to provide treatment access for individuals with opioid use disorder. The funds allowed direct payment supports for treatment, trainings, technical assistance, distribution of naloxone, expanding drug courts, and numerous other programs. The infusion of resources to expand treatment is especially necessary as states seek to close treatment gaps in targeted areas, such as rural populations, pregnant and parenting women, and incarcerated individuals. Three of five states studied—Louisiana, New Hampshire, and Tennessee—are using federal funding to implement a hub-and-spoke model. The hub-and-spoke model was first implemented in Vermont to expand access to treatment for opioid use disorder. Vermont's hub-and-spoke model organizes the state into nine central "hubs," providing intensive treatment for complex addictions, which are linked to more than 75 local "spokes," including primary care physicians and outpatient addiction programs. The Vermont model ensures that there is at least one licensed mental health or addictions counselor per 100 patients.[246]

Targeting Federal Resources

It is too soon to fully evaluate the effect of federal opioid funding to the states. While BPC only examined five states, based on the analysis of grants at a county level, coupled with data regarding the total number of overdose deaths per county, federal funding in these states is generally flowing to counties with the highest number of drug overdose deaths (see Appendix IV). In all of BPC's state case studies, funding is channeled to the counties with the population centers that, for the most part, correspond to the highest total overdose deaths. However, without further research delving into the availability of evidence-based treatment in specific counties of a state, it is difficult to conclude that resources are being sent to counties without access to evidence-based treatment.

For example, as shown in Table 35, Arizona's Maricopa County, which accounts for 61 percent of the population, received 61 percent of the funding in FY2018 and had 59 percent of the state's total overdose deaths. Other states with more evenly dispersed populations still track with higher total overdose deaths in their large-population counties and therefore receive significant funding.

Table 35: Opioid Funding in Highest Drug Overdose Death Counties

	County/Parish (Major city)	Number of Overdose Deaths (% of state total)	2017 Funding (millions) (% of state total)	2018 Funding (millions) (% of state total)
Arizona	Maricopa (Phoenix)	2,473 (59%)	$44 (58%)	$67 (61%)
Louisiana	Jefferson (New Orleans)	446 (16%)	$6 (13%)	$7 (10%)
New Hampshire	Hillsborough (Manchester)	546 (40%)	$4 (31%)	$15 (26%)
Ohio	Cuyahoga (Cleveland)	1,487 (12%)	$13 (16%)	$17 (12%)
Tennessee	Davidson (Nashville)	618 (13%)	$23 (38%)	$43 (47%)

However, when comparing federal funding on a per capita standard, many rural counties receive relatively low levels of funding compared with the more populated counties. A few counties in each state stood out as having both the highest quartile of drug overdose death rates and low relative federal funding (as previously stated, BPC identified the location of the funding recipient; this may not necessarily correspond with the geographic service area of the funding):

- Arizona—Mohave County 30.7 death rate and $6.24 per capita, the lowest in the state in FY2018;
- Louisiana—Washington Parish 57.5 death rate and $3.78 per capita in FY2018, below the state average;
- New Hampshire—Belknap County 41.5 death rate and $26.62 per capita in FY2018, below the state average;
- Ohio—Gallia, Highland, and Lawrence counties 46.5, 54.6, and 51.1 death rates, respectively, and all under $3 per capita funding in FY2017, the lowest 25 percent in the state;
- Tennessee—40 of 95 counties received no direct funding in FY2018, including Claiborne and Loudon counties, which have overdose mortality rates in the highest 25 percent in the state.

Several states addressed this discrepancy over the course of BPC's research. States are unable to distribute funding to rural counties because these rural areas are unlikely to have the necessary workforce capacity and treatment availability. However, rural counties require financial support to build out their treatment capacity. States are therefore seeking to address some of this capacity issue by building out hub-and-spoke programs. As stated previously, federal funds only began to reach their local recipients in late 2018, therefore it is too early to assess whether significant gaps remain. As states begin to observe the outcomes of their grants targeting vulnerable populations, it will be particularly important for states to share lessons learned and best practices.

Strengthening the Evaluation of Programs

While the increase in federal funds was a necessary first step, these programs are only just beginning and will need continued oversight, evaluation, and support to ensure programs can be sustained and that they are effective. Output data from these programs are preliminary and will require continued attention to longer-term outcomes. States will need to coordinate efforts with health surveillance data in real time to gain insights to identify the interventions that correspond with the greatest improvements in opioid-involved morbidity and mortality.

Highlighting Medicaid Benefits

Medicaid is essential to providing treatment services for individuals with opioid use disorder. Between 2011 and 2016, Medicaid spending on prescriptions to treat opioid use disorder and reverse opioid-involved overdoses increased from $394 million to $930 million, an increase of 136 percent.[247] The average annual change in spending increased during that time with later years seeing a faster growth, including 30 percent in 2016.[248] BPC's analysis of 2016-2018 Medicaid spending found that this trend continued with a 27 percent increase in Medicaid spending on treatment medications in 2018 versus 2016, for a total of over $1.2 billion reimbursed.[249] For all states, Medicaid pays for more than a third of opioid-related hospitalizations.[250] Four of the five states BPC studied were Medicaid-expansion states. As one study has shown, states with Medicaid expansion have seen improved access to opioid use disorder treatment.[251] Medicaid-expansion states can use Medicaid coverage for treatment, and other federal grant funds can be freed up for other strategies to address the opioid epidemic.

Key Insights for Policymakers

In writing this report, BPC staff spoke with federal and state government officials, including state officials from Louisiana, Tennessee, Arizona, New Hampshire, and Ohio. BPC representatives also visited New Hampshire and Ohio to meet with policymakers and staff engaged in implementing their state's opioid response. Finally, BPC staff spoke with select congressional staff representing states most affected by the opioid epidemic. Based on these engagements, as well as the review of federal opioid funding streams, BPC offers the following insights for maximizing the effectiveness of federal dollars.

State government officials appreciated federal opioid investments; however, there are concerns about the sustainability of programs funded with grants requiring annual appropriations. At the same time, greater coordination at the federal level is recommended to improve the effectiveness of federal funds distributed to states. Lastly, federal funding must be flexible enough to address all forms of substance use and to anticipate the next drug threat.

Each of these points are discussed below.

SUSTAINABILITY

As detailed in this report, since 2017, the federal government has appropriated significant funding specifically to address the opioid epidemic. BPC examined the STR and SOR funds in depth; however, there are other grant programs across the federal government that provide short-term sources of funding to address long-term issues, such as workforce capacity, law enforcement training, and treatment services in correctional institutions.

Similar to other federal grants, the SOR grant required a sustainability plan detailing how the state will continue funding programs after completion of the federal grant. Arizona's SOR application specified that their projects "would inherently live past the life of the grant" and that, among other efforts, they would seek funding under Title XIX of Medicaid.[252] Ohio's SOR application calls for an investment in the treatment workforce and education to reduce stigma.[253]

Given the considerable federal investment in opioid funding, it is unlikely that a state will be able to replace this funding without a new dedicated state funding source or continued federal funding. For example, the state of New Hampshire received $23 million in FY2018 from the SOR grant. This is 30 percent of New Hampshire's state and federal funding for all substance use disorder services in the state.[254] States will be hard pressed to find new funding streams to replace these funds.

The SOR grant also required that states conduct a gap analysis to determine the greatest needs in the cascade of care in the opioid epidemic. However, state officials had to keep in mind that any systems they created were not guaranteed long-term federal funding. This raises a question of whether states were able to maximize use of grant funds in light of the short-term nature of the funding. For example, individuals in the criminal justice system with opioid use disorder are a particularly vulnerable population. Research has shown that individuals recently released from incarceration are at a heightened risk for overdose death.[255] Further, Rhode Island successfully implemented an evidence-based treatment program in its correctional system, contributing to a 12 percent reduction in overdose deaths statewide.[256] Despite this, few states used federal funding for evidence-based treatment programs during incarceration.

HHS, other federal government departments and non-governmental organizations should assist states in identifying sustainable sources of funding for opioid-related expenditures. This is especially important for states with high rates of opioid overdose that have not expanded Medicaid. As previously stated, Medicaid expansion allows states to use Medicaid coverage for treatment while freeing up additional federal grant funds to build the infrastructure (for example, provider training, care delivery model) to address the opioid epidemic. Private insurance coverage for treatment of opioid use disorder will also help states focus on building a sustainable infrastructure with limited resources.

The federal government should also consider increased funding for all forms of substance use disorders, in recognition of the fact that drug trends change over time, but addiction is an ongoing concern. For example, the SAMHSA Prevention and Treatment block grant (SABG) has been level-funded at approximately $1.8 billion for the past 10 years, representing a 31 percent decrease when adjusted for inflation.257 Congress should consider increasing this block grant program so states have ongoing funding streams that enable them to build systems that can address all forms of substance use disorder.

Further, the federal and state governments should leverage existing funding to provide evidence-based treatment for individuals during periods of incarceration and on reentry.

FLEXIBILITY AND COORDINATION

As described in this report, many federal government agencies—such as SAMHSA, CDC, and DOJ—administer grants directed toward the opioid epidemic, either to expand treatment services, address the supply of illegal and prescribed opioids, enhance the workforce, or address other aspects of the opioid epidemic.

In some cases, these grants promote coordination between state agencies. For example, the Comprehensive Opioid Abuse Grant Program (COAP) is a program administered by DOJ's Bureau of Justice Assistance. COAP funding in FY2018 included statewide planning awards intended to enhance coordination between criminal justice agencies and the single-state agency responsible for administering substance use disorder grants. The planning grant seeks to improve a state's response to opioid use disorders in the criminal justice population. Three state case study states were among the 13 justice/substance use pilots intended to leverage resources and programs across the state.

However, overall, the sheer volume of grants going to states to address the opioid epidemic has made it difficult for state governments to track and coordinate all federal opioid funding, particularly since some grants are awarded directly to local governments. Traditionally, the single-state agency is responsible for overseeing the bulk of federal funds to address the demand for drugs, primarily through the SAMHSA block grant. In 2018, the SOR grant mandated that each state hire an opioid coordinator to facilitate coordination of all opioid funds. However, state officials interviewed said they did not always know when a fellow agency was seeking or had been awarded a specific grant. Coordination at the federal level would also help in cases where federal grants are awarded directly to local governments or nonprofit entities without state involvement. This poses a difficulty for states seeking to coordinate efforts across the whole of government and to make certain that dollars are supporting evidence-based practices. This is an issue even in states with robust opioid working groups led by governors.

In addition, a lack of coordination can make it difficult for the state or federal government to monitor the quality of treatment that is being provided. Specifically, it will be critical for the federal government and states to ensure that treatment dollars go toward evidence-based treatment for opioid use disorder, such as MAT, in both grant programs as well as state Medicaid programs.

The federal government should better coordinate opioid grant opportunities across the federal government. The President's Commission included a recommendation in its 2017 report calling on the Office of National Drug Control Policy to track all federal initiatives. Federal-level coordination will allow states to better braid funding streams and leverage different grant opportunities.

Federal government and states should coordinate efforts to ensure that treatment dollars go toward MAT for opioid use disorder. Comprehensive and barrier-free private insurance coverage of MAT will further ensure that Americans with opioid use disorder have access to evidence-based treatment.

State officials also asked for additional flexibility in federal funding. Drug-use trends and markets change over time, therefore effective approaches to addressing addiction in the United States requires the ability to anticipate changing conditions. For example, methamphetamine injection use is increasing in the United States, both independently and mixed with heroin or illicit fentanyl.[258,259,260] States must make certain that the treatment infrastructure being built out now can adapt to changing conditions and address all forms of substance use disorder.

> Policymakers and government agencies should consider building flexibility into state grants so that state agencies can adapt to changing conditions on the ground. The time from appropriation to awarding funds to states may be a year, therefore building in flexibility could enhance effectiveness.

Conclusion

In conclusion, from BPC's analysis of federal funding to address the opioid epidemic, sustainable funding is required to ensure that states can address the continuum of care for substance use disorders, as well as the consequences of addiction. To be successful at curbing today's opioid epidemic and address the broader issue of substance use disorder, the federal government should take a longer-term approach. Flexible funding and improved coordination of efforts at both the federal and state levels are necessary to curb the opioid epidemic and address the longer-term issue of addiction in the United States.

Appendix I: Full Appropriation Data 2017 and 2018

Category (Cat.): Treatment and Recovery **(T)**; Prevention **(P)**; Research **(R)**; Mixed **(T&P)**; Interdiction **(I)**; Criminal Justice **(CJ)**; Law Enforcement **(LE)**; ***Opioid-Only**

N/A: program did not exist or no opioid-specific appropriation

Cat.	Subcommittee	Agency	Account	FY2017	FY2018
T*	Labor, Health and Human Services (LHHS)	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	400,000,000	400,000,000
P*	LHHS	SAMHSA	STR	100,000,000	100,000,000
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	800,000,000
P*	LHHS	SAMHSA	SOR	N/A	200,000,000
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	*50,000,000*
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	*3,000,000*
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	1,423,103,200	1,423,103,200
P*	LHHS	SAMHSA	SABG	355,775,800	355,775,800
T*	LHHS	SAMHSA	Opioid Treatment Programs	8,724,000	8,724,000
T*	LHHS	SAMHSA	Provider's Clinical Support System—Universities	*1,999,930*	*2,393,000*
T*	LHHS	SAMHSA	Target Capacity Expansion-General	67,192,000	95,192,000
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	*56,000,000*	*84,000,000*
T	LHHS	SAMHSA	Pregnant and Postpartum Women	19,931,000	29,931,000
T	LHHS	SAMHSA	Building Communities of Recovery	3,000,000	5,000,000
T	LHHS	SAMHSA	Recovery Community Services Program	2,434,000	2,434,000
T	LHHS	SAMHSA	Children and Families	29,605,000	29,605,000
CJ	LHHS	SAMHSA	Criminal Justice Activities	78,000,000	89,000,000
CJ	LHHS	SAMHSA	Offender Reentry Program	N/A	6,800,000
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	9,046,000	9,046,000
P*	LHHS	SAMHSA	Strategic Prevention Framework Rx	10,000,000	10,000,000
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	12,000,000	12,000,000
P*	LHHS	SAMHSA	First Responder Training	12,000,000	36,000,000
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	1,000,000	1,000,000
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	5,000,000	5,000,000
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	15,000,000	15,000,000
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	49,877,000	49,877,000
T	LHHS	SAMHSA	Primary/Behavioral Health Integration TA	1,991,000	1,991,000
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	6,000,000	6,000,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018
P*	LHHS	Centers for Disease Control and Prevention (CDC)	Injury Prevention and Control—Opioid Overdose Prevention and Surveillance	112,000,000	475,579,000
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States	N/A	155,000,000
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	350,000,000
T&P*	LHHS	HRSA	Rural Health—Rural Communities Opioids Response	N/A	30,000,000
T&P*	LHHS	Office of Rural Health	Rural Health—Rural Communities Opioids Response	N/A	100,000,000
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs—Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	25,310,000	85,310,000
P	LHHS	ACF	Promoting Safe and Stable Families—Kinship Navigator Programs	N/A	20,000,000
P	LHHS	ACF	Promoting Safe and Stable Families—Regional Partnership Grants	18,600,000	20,000,000
R	LHHS	National Institutes of Health (NIH)	National Institute of Drug Abuse	N/A	250,000,000
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke	N/A	250,000,000
Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Executive Office of the President	Office of National Drug Control Policy—High Intensity Drug Trafficking Areas	254,000,000	280,000,000
P	FSGG	Executive Office of the President	ONDCP—Drug-Free Communities	97,000,000	99,000,000
Department of Justice					
CJ	Commerce Justice Science	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs—drug courts	43,000,000	75,000,000
CJ	Commerce Justice Science	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs—Veterans Treatment Courts	7,000,000	20,000,000
CJ	Commerce Justice Science	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs—Residential Substance Abuse Treatment	14,000,000	30,000,000
P*	Commerce Justice Science	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs—Prescription Drug Monitoring	14,000,000	30,000,000
CJ	Commerce Justice Science	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs—Mentally Ill Offender Act (Justice and Mental Health Collaboration)	12,000,000	30,000,000
CJ	Commerce Justice Science	State and Local Law Enforcement	Other Comprehensive Addiction and Recovery Act activities	13,000,000	145,000,000
LE*	Commerce Justice Science	Community-Oriented Policing Services	Anti-Heroin Task Forces	10,000,000	32,000,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018
CJ	Commerce Justice Science	State and Local Law Enforcement	Second Chance Act Grants	68,000,000	85,000,000
CJ*	Commerce Justice Science	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	22,000,000
CJ*	Commerce Justice Science	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	29,839,484
P	Commerce Justice Science	State and Local Law Enforcement	Paul Coverdell Forensic Science	13,000,000	17,000,000
Department of Veterans Affairs					
T	Veterans Affairs	Veterans Health Administration	Medical Care—inpatient/outpatient, pharmacy	N/A	329,953,000
T	Veterans Affairs	Veterans Health Administration	Medical Care—CARA opioid safety initiatives	N/A	55,821,000
P	Veterans Affairs	Veterans Health Administration	Medical Care—Justice Outreach and Prevention Program	N/A	48,778,000
T	Veterans Affairs	Veterans Health Administration	Medical Care—Office of Rural Health's Rural Health Initiative	N/A	270,000,000
Food and Drug Administration					
I*	Agriculture, Food and Drug Administration	Food and Drug Administration	Opioid Enforcement and Surveillance	N/A	94,000,000
Homeland Security					
I*	Homeland Security	U.S. Customs and Border Protection	Operations and Support—opioid detection equipment and labs	N/A	30,500,000
I*	Homeland Security	U.S. Customs and Border Protection	Procurement, Construction, and Improvements—opioid detection and nonintrusive inspection equipment	N/A	224,600,000
I*	Homeland Security	Science and Technology	Research, Development, and Innovation—Opioids/Fentanyl	N/A	6,000,000
Department of Labor					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	21,000,000
			TOTAL	**3,310,589,000**	**7,402,859,484**

Appendix II: Case Study States Appropriation Data, 2017 and 2018

Category (Cat.): Treatment and Recovery **(T)**; Prevention **(P)**; Research **(R)**; Mixed **(T&P)**; Interdiction **(I)**; Criminal Justice **(CJ)**; Law Enforcement **(LE)**; ***Opioid-Only**

N/A: program did not exist or no opioid-specific appropriation

ARIZONA

Cat.	Account	AZ FY2017	AZ FY2018
T*	*Substance Abuse and Mental Health Services Administration* State Targeted Response (STR)	9,737,214	9,737,214
P*	*SAMHSA* STR	2,434,304	2,434,304
T*	*SAMHSA* State Opioid Response (SOR)	N/A	16,215,442
P*	*SAMHSA* SOR	N/A	4,053,861
T*	*SAMHSA* Tribal Opioid Response	N/A	2,288,944
T*	*SAMHSA* Rural Opioids Technical Assistance	N/A	0
T&P	*SAMHSA* Substance Abuse Prevention and Treatment Block Grant (SABG)	32,150,562	32,515,446
P	*SAMHSA* SABG	8,037,641	8,128,861
T*	*SAMHSA* Opioid Treatment Programs Provider's Clinical Support System—Universities	0	0
T*	*SAMHSA* Target Capacity Expansion-General	0	0
T*	*SAMHSA* Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	950,000	1,935,296
T	*SAMHSA* Pregnant and Postpartum Women	0	0
T	*SAMHSA* Building Communities of Recovery	0	195,138
T	*SAMHSA* Recovery Community Services Program	0	0
T	*SAMHSA* Children and Families	694,899	517,928
CJ	*SAMHSA* Criminal Justice Activities	966,091	2,139,435
CJ	*SAMHSA* Offender Reentry Program	0	0
T	*SAMHSA* Addiction Technology Transfer Centers	0	0
P*	*SAMHSA* Strategic Prevention Framework Rx	0	0
P*	*SAMHSA* Grants to Prevent Prescription Drug/Opioid Overdose	0	0
P*	*SAMHSA* First Responder Training	784,790	784,791
T*	*SAMHSA* Improving Access to Overdose Treatment	0	0
P	*SAMHSA* Community-Based Coalition Enhancement Grants to Address Local Drug Crises	0	50,000

Cat.	Account	AZ FY2017	AZ FY2018
P	*SAMHSA* Tribal Behavioral Health Grants	799,783	1,204,867
T	*SAMHSA* Primary and Behavioral Health Care Integration	190,986	169,406
T	*SAMHSA* Primary/Behavioral Health Integration TA	0	0
T	*Indian Health Service* Behavioral Health Integration Initiative	0	0
P*	*Centers for Disease Control and Prevention (CDC)* Opioid Overdose Prevention and Surveillance	2,170,408	2,170,408
P*	*CDC* Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States	N/A	4,530,305
T&P	*Health Resources and Services Administration (HRSA)* Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	5,488,029
T&P*	*HRSA* Rural Health—Rural Communities Opioids Response	N/A	0
P	*Administration for Children and Families (ACF)* Children and Families Services Programs—Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	538,552	1,834,669
P	*ACF* Promoting Safe and Stable Families—Kinship Navigator Programs	N/A	743,286
P	*ACF* Promoting Safe and Stable Families—Regional Partnership Grants	N/A	0
R	*National Institutes of Health (NIH)* National Institute of Drug Abuse	N/A	2,242,634
R	*NIH* National Institute of Neurological Disorders and Stroke	N/A	0
LE	*Office of National Drug Control Policy* High Intensity Drug Trafficking Areas	11,413,416	11,817,776
P	*ONDCP* Drug-Free Communities	2,000,000	1,947,766
CJ	*Department of Justice (DOJ)* Comprehensive Addiction and Recovery Programs—Drug Courts	346,676	360,656
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Drug Courts TA and TIPS	N/A	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Veterans Treatment Courts	0	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Residential Substance Abuse Treatment	354,771	773,138
P*	*DOJ* Comprehensive Addiction and Recovery Programs—Prescription Drug Monitoring	0	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Mentally Ill Offender Act (Justice and Mental Health Collaboration)	0	747,591
CJ	*DOJ* Other Comprehensive Addiction and Recovery Act Activities	0	99,353
LE*	*DOJ* Anti-Heroin Task Forces	0	0
CJ	*DOJ* Second Chance Act Grants	2,142,995	550,000
CJ*	*DOJ* Reaching Youth Impacted by Opioids	N/A	0
CJ	*DOJ* Enhancing Community Responses to the Opioid Crisis	N/A	466,167
P	*DOJ* Paul Coverdell Forensic Science	160,443	916,132
T	*Department of Labor* National Health Emergency Dislocated Worker Demonstration Grants	N/A	0
	TOTAL	**75,873,531**	**117,058,843**

LOUISIANA

Cat.	Account	LA FY2017	LA FY2018
T*	*Substance Abuse and Mental Health Services Administration* State Targeted Response (STR)	6,534,377	6,534,377
P*	*SAMHSA* STR	1,633,594	1,633,594
T*	*SAMHSA* State Opioid Response (SOR)	N/A	9,391,923
P*	*SAMHSA* SOR	N/A	2,347,981
T*	*SAMHSA* Tribal Opioid Response	N/A	167,997
T*	*SAMHSA* Rural Opioids Technical Assistance	N/A	0
T&P	*SAMHSA* Substance Abuse Prevention and Treatment Block Grant (SABG)	20,021,379	20,235,254
P	*SAMHSA* SABG	5,005,345	5,058,813
T*	*SAMHSA* Opioid Treatment Programs Provider's Clinical Support System—Universities	0	0
T*	*SAMHSA* Target Capacity Expansion-General	0	0
T*	*SAMHSA* Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	1,000,000	1,025,000
T	*SAMHSA* Pregnant and Postpartum Women	0	0
T	*SAMHSA* Building Communities of Recovery	0	0
T	*SAMHSA* Recovery Community Services Program	0	0
T	*SAMHSA* Children and Families	552,928	0
CJ	*SAMHSA* Criminal Justice Activities	1,213,654	1,754,096
CJ	*SAMHSA* Offender Reentry Program	400,000	0
T	*SAMHSA* Addiction Technology Transfer Centers	0	0
P*	*SAMHSA* Strategic Prevention Framework Rx	371,616	371,616
P*	*SAMHSA* Grants to Prevent Prescription Drug/Opioid Overdose	0	0
P*	*SAMHSA* First Responder Training	0	0
T*	*SAMHSA* Improving Access to Overdose Treatment	1,000,000	0
P	*SAMHSA* Community-Based Coalition Enhancement Grants to Address Local Drug Crises	0	0
P	*SAMHSA* Tribal Behavioral Health Grants	0	0
T	*SAMHSA* Primary and Behavioral Health Care Integration	239,424	2,299,578
T	*SAMHSA* Primary/Behavioral Health Integration TA	0	0
T	*Indian Health Service* Behavioral Health Integration Initiative	0	0
P*	*Centers for Disease Control and Prevention (CDC)* Opioid Overdose Prevention and Surveillance	997,702	997,702
P*	*CDC* Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States	N/A	3,161,300

Cat.	Account	LA FY2017	LA FY2018
T&P	*Health Resources and Services Administration (HRSA)* Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	8,569,833
T&P*	*HRSA* Rural Health—Rural Communities Opioids Response	N/A	400,000
P	*Administration for Children and Families (ACF)* Children and Families Services Programs—Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	385,610	1,300,257
P	*ACF* Promoting Safe and Stable Families—Kinship Navigator Programs	N/A	361,120
P	*ACF* Promoting Safe and Stable Families—Regional Partnership Grants	N/A	0
R	*National Institutes of Health (NIH)* National Institute of Drug Abuse	N/A	993,439
R	*NIH* National Institute of Neurological Disorders and Stroke	N/A	0
LE	*Office of National Drug Control Policy (ONDCP)* High Intensity Drug Trafficking Areas	4,355,420	4,691,133
P	*ONDCP* Drug-Free Communities	1,124,750	1,124,750
CJ	*Department of Justice (DOJ)* Comprehensive Addiction and Recovery Programs—Drug Courts	400,000	500,000
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Drug Courts TA and TIPS	N/A	359,926
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Veterans Treatment Courts	0	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Residential Substance Abuse Treatment	302,849	663,964
P*	*DOJ* Comprehensive Addiction and Recovery Programs—Prescription Drug Monitoring	542,160	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Mentally Ill Offender Act (Justice and Mental Health Collaboration)	224,223	1,054,411
CJ	*DOJ* Other Comprehensive Addiction and Recovery Act Activities	796,277	2,999,126
LE*	*DOJ* Anti-Heroin Task Forces	0	0
CJ	*DOJ* Second Chance Act Grants	1,048,770	2,736,267
CJ*	*DOJ* Reaching Youth Impacted by Opioids	N/A	0
CJ	*DOJ* Enhancing Community Responses to the Opioid Crisis	N/A	749,124
P	*DOJ* Paul Coverdell Forensic Science	109,840	450,855
T	*Department of Labor* National Health Emergency Dislocated Worker Demonstration Grants	N/A	0
	TOTAL	**48,259,917**	**81,933,435**

NEW HAMPSHIRE

Cat.	Account	NH FY2017	NH FY2018
T*	*Substance Abuse and Mental Health Services Administration (SAMHSA)* State Targeted Response (STR)	2,502,693	2,769,093
P*	*SAMHSA* STR	625,673	692,273
T*	*SAMHSA* State Opioid Response (SOR)	N/A	18,386,086
P*	*SAMHSA* SOR	N/A	4,596,522
T*	*SAMHSA* Tribal Opioid Response	N/A	0
T*	*SAMHSA* Rural Opioids Technical Assistance	N/A	0
T&P	*SAMHSA* Substance Abuse Prevention and Treatment Block Grant (SABG)	5,574,302	6,291,709
P	*SAMHSA* SABG	1,393,576	1,572,927
T*	*SAMHSA* Opioid Treatment Programs Provider's Clinical Support System—Universities	0	150,000
T*	*SAMHSA* Target Capacity Expansion-General	0	0
T*	*SAMHSA* Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	1,000,000	1,777,726
T	*SAMHSA* Pregnant and Postpartum Women	0	0
T	*SAMHSA* Building Communities of Recovery	0	0
T	*SAMHSA* Recovery Community Services Program	0	0
T	*SAMHSA* Children and Families	760,000	785,000
CJ	*SAMHSA* Criminal Justice Activities	324,997	0
CJ	*SAMHSA* Offender Reentry Program	0	0
T	*SAMHSA* Addiction Technology Transfer Centers	0	0
P*	*SAMHSA* Strategic Prevention Framework Rx	0	0
P*	*SAMHSA* Grants to Prevent Prescription Drug/Opioid Overdose	0	0
P*	*SAMHSA* First Responder Training	0	787,551
T*	*SAMHSA* Improving Access to Overdose Treatment	0	0
P	*SAMHSA* Community-Based Coalition Enhancement Grants to Address Local Drug Crises	0	50,000
P	*SAMHSA* Tribal Behavioral Health Grants	0	0
T	*SAMHSA* Primary and Behavioral Health Care Integration	400,000	2,474,414
T	*SAMHSA* Primary/Behavioral Health Integration TA	0	0
T	*Indian Health Service* Behavioral Health Integration Initiative	0	0
P*	*Centers for Disease Control and Prevention (CDC)* Opioid Overdose Prevention and Surveillance	356,373	356,373
P*	*CDC* Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States	N/A	3,935,954

Cat.	Account	NH FY2017	NH FY2018
T&P	*Health Resources and Services Administration (HRSA)* Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	2,812,257
T&P*	*HRSA* Rural Health—Rural Communities Opioids Response	N/A	450,000
P	*Administration for Children and Families (ACF)* Children and Families Services Programs—Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	129,475	419,082
P	*ACF* Promoting Safe and Stable Families—Kinship Navigator Programs	N/A	216,231
P	*ACF* Promoting Safe and Stable Families—Regional Partnership Grants	N/A	0
R	*National Institutes of Health (NIH)* National Institute of Drug Abuse	N/A	1,184,912
R	*NIH* National Institute of Neurological Disorders and Stroke	N/A	0
LE	*Office of National Drug Control Policy (ONDCP)* High Intensity Drug Trafficking Areas	0	0
P	*ONDCP* Drug-Free Communities	1,500,000	1,500,000
CJ	*Department of Justice (DOJ)* Comprehensive Addiction and Recovery Programs—Drug Courts	0	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Drug Courts TA and TIPS	N/A	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Veterans Treatment Courts	0	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Residential Substance Abuse Treatment	56,168	142,272
P*	*DOJ* Comprehensive Addiction and Recovery Programs—Prescription Drug Monitoring	399,436	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Mentally Ill Offender Act (Justice and Mental Health Collaboration)	200,000	0
CJ	*DOJ* Other Comprehensive Addiction and Recovery Act Activities	0	1,697,079
LE*	*DOJ* Anti-Heroin Task Forces	688,856	0
CJ	*DOJ* Second Chance Act Grants	0	0
CJ*	*DOJ* Reaching Youth Impacted by Opioids	N/A	0
CJ	*DOJ* Enhancing Community Responses to the Opioid Crisis	N/A	1,186,005
P	*DOJ* Paul Coverdell Forensic Science	108,332	271,960
T	*Department of Labor* National Health Emergency Dislocated Worker Demonstration Grants	N/A	5,000,000
	TOTAL	**16,019,880**	**59,505,426**

OHIO

Cat.	Account	OH FY2017	OH FY2018
T*	*Substance Abuse and Mental Health Services Administration (SAMHSA)* State Targeted Response (STR)	20,848,402	20,848,402
P*	*SAMHSA* STR	5,212,100	5,212,100
T*	*SAMHSA* State Opioid Response (SOR)	N/A	44,632,478
P*	*SAMHSA* SOR	N/A	11,158,120
T*	*SAMHSA* Tribal Opioid Response	N/A	0
T*	*SAMHSA* Rural Opioids Technical Assistance	N/A	549,625
T&P	*SAMHSA* Substance Abuse Prevention and Treatment Block Grant (SABG)	51,629,194	53,003,741
P	*SAMHSA* SABG	12,907,298	13,250,935
T*	*SAMHSA* Opioid Treatment Programs Provider's Clinical Support System—Universities	0	285,396
T*	*SAMHSA* Target Capacity Expansion-General	0	305,000
T*	*SAMHSA* Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	2,000,000	5,172,787
T	*SAMHSA* Pregnant and Postpartum Women	377,273	0
T	*SAMHSA* Building Communities of Recovery	0	444,519
T	*SAMHSA* Recovery Community Services Program	0	25,000
T	*SAMHSA* Children and Families	800,000	1,365,463
CJ	*SAMHSA* Criminal Justice Activities	4,534,274	3,082,541
CJ	*SAMHSA* Offender Reentry Program	0	0
T	*SAMHSA* Addiction Technology Transfer Centers	0	0
P*	*SAMHSA* Strategic Prevention Framework Rx	371,616	396,616
P*	*SAMHSA* Grants to Prevent Prescription Drug/Opioid Overdose	0	0
P*	*SAMHSA* First Responder Training	1,493,080	2,607,673
T*	*SAMHSA* Improving Access to Overdose Treatment	0	0
P	*SAMHSA* Community-Based Coalition Enhancement Grants to Address Local Drug Crises	0	50,000
P	*SAMHSA* Tribal Behavioral Health Grants	0	0
T	*SAMHSA* Primary and Behavioral Health Care Integration	1,097,780	1,278,261
T	*SAMHSA* Primary/Behavioral Health Integration TA	0	0
T	*Indian Health Service* Behavioral Health Integration Initiative	0	0
P*	*Centers for Disease Control and Prevention (CDC)* Opioid Overdose Prevention and Surveillance	3,569,715	3,569,715
P*	*CDC* Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States	N/A	5,098,024

Cat.	Account	OH FY2017	OH FY2018
T&P	*Health Resources and Services Administration (HRSA)* Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	12,951,245
T&P*	*HRSA* Rural Health—Rural Communities Opioids Response	N/A	2,249,654
P	*Administration for Children and Families (ACF)* Children and Families Services Programs—Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	841,292	2,847,313
P	*ACF* Promoting Safe and Stable Families—Kinship Navigator Programs	N/A	473,607
P	*ACF* Promoting Safe and Stable Families—Regional Partnership Grants	N/A	599,939
R	*National Institutes of Health (NIH)* National Institute of Drug Abuse	N/A	5,902,722
R	*NIH* National Institute of Neurological Disorders and Stroke	N/A	0
LE	*Office of National Drug Control Policy (ONDCP)* High Intensity Drug Trafficking Areas	4,219,163	4,343,707
P	*ONDCP* Drug-Free Communities	3,128,942	3,207,900
CJ	*Department of Justice (DOJ)* Comprehensive Addiction and Recovery Programs—Drug Courts	1,411,376	1,400,000
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Drug Courts TA and TIPS	N/A	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Veterans Treatment Courts	229,526	0
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Residential Substance Abuse Treatment	423,016	928,732
P*	*DOJ* Comprehensive Addiction and Recovery Programs—Prescription Drug Monitoring	1,297,965	647,500
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Mentally Ill Offender Act (Justice and Mental Health Collaboration)	1,077,636	680,796
CJ	*DOJ* Other Comprehensive Addiction and Recovery Act Activities	799,999	11,019,932
LE*	*DOJ* Anti-Heroin Task Forces	0	742,182
CJ	*DOJ* Second Chance Act Grants	253,560	2,930,042
CJ*	*DOJ* Reaching Youth Impacted by Opioids	N/A	0
CJ	*DOJ* Enhancing Community Responses to the Opioid Crisis	N/A	750,000
P	*DOJ* Paul Coverdell Forensic Science	507,657	909,851
T	*Department of Labor* National Health Emergency Dislocated Worker Demonstration Grants	N/A	0
	TOTAL	**119,030,865**	**224,921,519**

TENNESSEE

Cat.	Account	TN FY2017	TN FY2018
T*	*Substance Abuse and Mental Health Services Administration (SAMHSA)* State Targeted Response (STR)	11,052,106	11,052,106
P*	*SAMHSA* STR	2,763,026	2,763,026
T*	*SAMHSA* State Opioid Response (SOR)	N/A	14,834,471
P*	*SAMHSA* SOR	N/A	3,708,618
T*	*SAMHSA* Tribal Opioid Response	N/A	0
T*	*SAMHSA* Rural Opioids Technical Assistance	N/A	0
T&P	*SAMHSA* Substance Abuse Prevention and Treatment Block Grant (SABG)	25,582,898	26,342,240
P	*SAMHSA* SABG	6,395,724	6,585,560
T*	*SAMHSA* Opioid Treatment Programs Provider's Clinical Support System—Universities	0	0
T*	*SAMHSA* Target Capacity Expansion-General	0	280,000
T*	*SAMHSA* Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	6,000,000	3,662,908
T	*SAMHSA* Pregnant and Postpartum Women	524,000	2,223,000
T	*SAMHSA* Building Communities of Recovery	0	0
T	*SAMHSA* Recovery Community Services Program	0	0
T	*SAMHSA* Children and Families	0	0
CJ	*SAMHSA* Criminal Justice Activities	1,227,452	3,312,449
CJ	*SAMHSA* Offender Reentry Program	0	820,675
T	*SAMHSA* Addiction Technology Transfer Centers	0	0
P*	*SAMHSA* Strategic Prevention Framework Rx	371,616	396,616
P*	*SAMHSA* Grants to Prevent Prescription Drug/Opioid Overdose	0	0
P*	*SAMHSA* First Responder Training	0	0
T*	*SAMHSA* Improving Access to Overdose Treatment	0	0
P	*SAMHSA* Community-Based Coalition Enhancement Grants to Address Local Drug Crises	0	100,000
P	*SAMHSA* Tribal Behavioral Health Grants	0	0
T	*SAMHSA* Primary and Behavioral Health Care Integration	702,221	765,897
T	*SAMHSA* Primary/Behavioral Health Integration TA	0	0
T	*Indian Health Service* Behavioral Health Integration Initiative	0	0
P*	*Centers for Disease Control and Prevention (CDC)* Opioid Overdose Prevention and Surveillance	2,775,304	2,772,696
P*	*CDC* Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States	N/A	4,353,877

Cat.	Account	TN FY2017	TN FY2018
T&P	*Health Resources and Services Administration (HRSA)* Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	6,141,106
T&P*	*HRSA* Rural Health—Rural Communities Opioids Response	N/A	1,000,000
P	*Administration for Children and Families (ACF)* Children and Families Services Programs—Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	500,849	1,700,745
P	*ACF* Promoting Safe and Stable Families—Kinship Navigator Programs	N/A	399,821
P	*ACF* Promoting Safe and Stable Families—Regional Partnership Grants	N/A	600,000
R	*National Institutes of Health (NIH)* National Institute of Drug Abuse	N/A	3,403,016
R	*NIH* National Institute of Neurological Disorders and Stroke	N/A	0
LE	*Office of National Drug Control Policy (ONDCP)* High Intensity Drug Trafficking Areas	204,410	232,386
P	*ONDCP* Drug-Free Communities	2,000,000	2,000,000
CJ	*Department of Justice (DOJ)* Comprehensive Addiction and Recovery Programs—Drug Courts	0	2,500,000
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Drug Courts TA and TIPS	N/A	360,000
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Veterans Treatment Courts	1,500,000	550,000
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Residential Substance Abuse Treatment	250,423	549,489
P*	*DOJ* Comprehensive Addiction and Recovery Programs—Prescription Drug Monitoring	0	748,556
CJ	*DOJ* Comprehensive Addiction and Recovery Programs—Mentally Ill Offender Act (Justice and Mental Health Collaboration)	41,228	75,172
CJ	*DOJ* Other Comprehensive Addiction and Recovery Act Activities	100,000	6,249,534
LE*	*DOJ* Anti-Heroin Task Forces	0	1,253,294
CJ	*DOJ* Second Chance Act Grants	1,265,032	1,491,865
CJ*	*DOJ* Reaching Youth Impacted by Opioids	N/A	1,000,999
CJ	*DOJ* Enhancing Community Responses to the Opioid Crisis	N/A	0
P	*DOJ* Paul Coverdell Forensic Science	145,804	373,981
T	*Department of Labor* National Health Emergency Dislocated Worker Demonstration Grants	N/A	0
	TOTAL	**63,402,093**	**114,604,103**

Appendix III: Detailed Methodology

1) IDENTIFYING FEDERALLY FUNDED OPIOID PROGRAMS

To identify opioid-specific federal appropriations, BPC conducted the following steps. First, BPC conducted a scan of summary documents from the U.S. House of Representatives and the U.S. Senate detailing the reported totals for opioid funding. BPC identified each opioid-related program through careful consideration and expert judgment of the program description, award announcements, and designation from federal agency sources. When including programs, BPC erred on the side of broad inclusion.

To identify the program funding levels for FY2017 and FY2018, BPC examined each of the final explanatory statements from the 2017[261] and 2018[262] Consolidated Appropriations Acts:

1. Division A-Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act
2. Division B-Commerce, Justice, Science, and Related Agencies Appropriations Act
3. Division C-Department of Defense Appropriations Act
4. Division D-Energy and Water Development and Related Agencies Appropriations Act
5. Division E-Financial Services and General Government Appropriations Act
6. Division F-Department of Homeland Security Appropriations Act
7. Division G-Department of the Interior, Environment, and Related Agencies Appropriations Act
8. Division H-Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act
9. Division I-Legislative Branch Appropriations Act
10. Division J-Military Construction, Veterans Affairs, and Related Agencies Appropriations Act
11. Division K-Department of State, Foreign Operations, and Related Programs Appropriations Act
12. Division L-Transportation, Housing and Urban Development, and Related Agencies Appropriations Act

Within the Divisions of the Explanatory Statement, BPC was able to identify opioid-specific programs and their funding levels for FY2017 and FY2018. Below is a list of the specific programs included in each division. Additionally, programs considered, but not included in BPC's analysis are listed following the included programs.

Programs Included in Opioid-Related Funding:

Division H, which includes the Department of Health and Human Services, contained most of the opioid-related programs including:

- **Substance Abuse and Mental Health Services Administration**
  - State Targeted Response
    - Opioid State Targeted Response Technical Assistance
  - State Opioid Response
    - Tribal Opioid Response
    - Rural Opioids Technical Assistance
  - Substance Abuse Prevention and Treatment Block Grant

- Opioid Treatment Programs
  - Provider's Clinical Support System
- Targeted Capacity Expansion-General
  - Medication-Assisted Treatment for Prescription Drug and Opioid Addiction
- Pregnant and Postpartum Women
- Building Communities of Recovery
- Recovery Community Services Program
- Children and Families
- Criminal Justice Activities
- Offender Reentry Program
- Addiction Technology Transfer Centers
- Strategic Prevention Framework Rx
- Grants to Prevent Prescription Drug/Opioid Overdose
- First Responder Training
- Improving Access to Overdose Treatment
- Community-Based Coalition Enhancement Grants to Address Local Drug Crises
- Tribal Behavioral Health Grants
- Primary and Behavioral Health Integration
  - Technical Assistance

- **Centers for Disease Control and Prevention**
  - Injury Prevention and Control—Opioid Overdose Prevention and Surveillance
  - Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States
- **Health Resources and Services Administration**
  - Expanding Access to Quality Substance Use Disorder and Mental Health Services
  - Rural Health—Rural Communities Opioid Response
- **Administration for Children and Families**
  - Children and Families Services Programs—Child Abuse Prevention and Treatment Act-Infant Plans of Safe Care
  - Promoting Safe and Stable Families
    - Kinship Navigator Programs
    - Regional Partnership Grants
- **National Institutes of Health**
  - National Institute of Neurological Disorders and Stroke—Opioids Research
  - National Institute on Drug Abuse—Opioids Research

Division A: Agriculture, Rural Development, Food and Drug Administration

- **Food and Drug Administration**—Opioid Enforcement and Surveillance

Division B: Commerce, Justice, Science

- **Department of Justice**
  - Comprehensive Addiction and Recovery Programs
    - Drug Courts
    - Veterans Treatment Courts
    - Residential Substance Abuse Treatment
    - Prescription Drug Monitoring
    - Mentally Ill Offender Act (Justice and Mental Health Collaboration)
    - Other Comprehensive Addiction and Recovery Act activities
  - Community Oriented Policing Services—Anti-Heroin Task Forces
  - Second Chance Act Grants
  - Reaching Youth Impacted by Opioids
  - Office for Victims of Crime—Enhancing Community Responses to the Opioid Crisis
  - Paul Coverdell Forensic Science

Division D: Energy and Water Development, this division had no opioid-related programs.

Division E: Financial Services and General Government.

- **Office of National Drug Control Policy (ONDCP)**
  - High Intensity Drug Trafficking Areas
  - Drug-Free Communities

Division F: Homeland Security

- **Department of Homeland Security**
  - U.S. Customs and Border Protection, Operations and Support—Opioid detection equipment and labs
  - U.S. Customs and Border Protection, Procurement, Construction, and Improvements—opioid detection and nonintrusive inspection equipment
  - Science and Technology—Research, Development, and Innovation—Opioids/Fentanyl

Division G: Department of the Interior, Environment, this division had no opioid-related programs.

Division I: Legislative Branch, this division had no opioid-related programs.

Division J: Military Construction, Veterans Affairs

- **Veterans Affairs**
  - Medical Care—inpatient/outpatient, pharmacy
  - Medical Care—CARA opioid safety initiatives
  - Medical Care—Justice Outreach and Prevention Program
  - Medical Care—Office of Rural Health's Rural Health Initiative

Division L: Transportation, Housing and Urban Development, this division had no opioid-related programs.

Programs Considered But Not Included in Opioid Funding:

Division C: Department of Defense. BPC considered including the Drug Interdiction and Counter-Drug Activities program but decided to exclude this program from the total opioid funding as these accounts were not grant programs, and were dedicated to international interdiction efforts.

Division E: Financial Services and General Government. BPC only included the specific programs listed above from the ONDCP, not the entire ONDCP budget as its programs to disrupt drug trafficking networks are not opioid-specific.

Division K: Department of State, Foreign Operations. BPC considered but did not include the Department of State international narcotics control and law enforcement program as these funds are dedicated to international interdiction, not granted to the states.

BPC cross-referenced information gathered from legislative documents with information provided in publicly available agency-specific sources, such as congressional justifications.

Medicaid Treatment Medication Spending

BPC found the state and federal Medicaid spending levels for drugs related to opioid use disorder and the overdose reversal medication (naloxone) for 2016 to 2018 through the Centers for Medicare and Medicaid Services State Drug Utilization Data files. BPC found the national drug codes using the FDA National Drug Code Directory. BPC excluded buprenorphine codes for buprenorphine injection, Buprenex, Butrans, and Belbuca following a previous study's methods that noted these forms are used primarily to treat pain, not for opioid use disorder.[263] BPC found the spending for naltrexone and naloxone through national drug codes.

At the national level, BPC was unable to identify Medicaid spending on methadone for opioid use disorder from 2016 to 2018 due to inconsistent data reporting on methadone used for pain spending in the State Drug Utilization Data versus spending reported from opioid treatment programs, which is reimbursed under the physician payment code H0020. To find the methadone spending in states, BPC worked the state Medicaid programs to identify the spending for H0020, which BPC reported in each of the state Medicaid tables. For Louisiana and Tennessee, these states do not cover methadone for opioid used disorder through Medicaid.

2) VALIDATING CATALOG OF FEDERAL APPROPRIATIONS AND AWARDS

Expert Interviews. To validate information gathered from document reviews, BPC cross-checked agency sources to USAspending.gov data. BPC then verified the opioid funding levels with federal agency budget officials (SAMHSA, CDC, HRSA, DOJ, and ACF) to describe the publicly available information, to further BPC's understanding of the flow of federal funds and evaluation plans to assess their effectiveness and to solicit additional detailed information and data related to identified expenditures that may be relevant but not otherwise publicly available.

3) AGGREGATING AND ANALYZING STATE SPENDING DATA

Database Queries and Text Analysis. After identifying the programs BPC decided to include as opioid-related appropriations, the next step was identifying the awards granted to each state. Through a cross-check of agency websites posted lists of awards and data from USAspending.gov—the official source for spending data for the U.S. government mandated by the Federal Funding Accountability and Transparency Act of 2006—BPC was able to match the program levels from federal appropriations to the actual awards in each state.[264]

For each program, BPC identified the Catalog of Federal Domestic Assistance (CFDA) number and then searched for the awards from this program in USAspending.gov. This entailed manually verifying the grants for each program, as the CFDA number is same for multiple programs. For example, the SAMHSA Programs of Regional and National Significance, CFDA 93.243, includes many of the opioid-related grants, but also includes many other programs not specific to opioids. To parse out the opioid awards, BPC used SAMHSA's grant archive lists to identify each of the 528 opioid-related awards from this CFDA in 2017. From FY2018, BPC located 903 opioid-related awards from the 93.243. In total, BPC identified 3,786 awards funded in FY2018 and 2,585 awards funded in 2017.

BPC also reviewed agency materials for additional verification of program levels, including the Congressional Justification documents for FY2018 and FY2019 for SAMHSA that specified the prior-year program totals.[265,266] In addition to SAMHSA's awards, DOJ public disclosures on their opioid awards helped to identify all DOJ funding to states.[267]

4) CASE STUDIES

BPC selected five states representative of a broad cross-section of issues related to resource allocation and emphasis on addressing the opioid epidemic.

Liaisons with designated state officials who oversee the receipt and administration of federal funds targeted to opioids. BPC held conference calls and corresponded with state agencies that oversaw the opioid-related grants in the state. BPC also conducted site visits for two states: Ohio and New Hampshire to further learn directly from state agency leadership about the state's use of federal funds as well as the challenges for the state in addressing the opioid crisis. This allowed BPC to gain perspectives from the diverse group of state agencies overseeing federal funds.

Mapping the data. For the awards to states, USAspending.gov provides the location of the recipient, including the county. Using this information, BPC was able to display the state-level funding. To determine the funding per capita in the states and case-study counties, the total award data for the state and county was divided by the population, using the CDC's 2017 county population figures.[268] For the case-study states, BPC also identified the sub-award-level data for the SABG and STR grants. For Arizona, Louisiana, and Ohio, sub-award recipients included regional behavioral health organizations responsible for service to multiple counties. For the purpose of this report, BPC considered these sub-awards distributed equally between the counties included in the regional organization.

The tables and charts in this report reflect BPC's analysis of this information.

5) OVERDOSE DEATH DATA

BPC included the overdose death rates from CDC's WONDER database, including outputs from 1999-2017. BPC followed CDC National Center for Health Statistics' methods to identify overdose deaths from all drugs and opioid-involved overdoses. Within CDC WONDER, drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Among deaths with drug poisoning as the underlying cause, the following multiple cause-of-death codes indicate the drug type(s) involved: any opioid, T40.0–T40.4 and T40.6; heroin, T40.1; commonly prescribed opioids/Rx opioids, T40.2; methadone, T40.3; and other synthetic opioids/fentanyl, T40.4.

Limitations

At the outset of the research planning for this project, BPC recognized one important limitation: the divergence of publicly available spending information at the unit of analysis needed. In practice, publicly available estimates of federal spending may not be the final estimates of funds available to agencies for several reasons, including the execution of budget transfers, reprogrammings for activities within budget accounts, and implementation of mandatory sequestration. Because each of these reasons for variations subsequent to an enacted appropriation is subject to further policy choices, for the purposes of this report, federal appropriations or federal "spending" reflect direct estimates reported in appropriations law. The use of these estimates reflects the most consistent and accurate baseline estimate for identifying availability of federal funds in a given fiscal year.

The state- and county-level grantee information gathered from USASpending.gov reflects information provided by agencies and grantees to the Bureau of the Fiscal Service at the U.S. Department of Treasury. Because of variation in federal appropriations subsequent to the enactment of an appropriations law in addition to the availability of resources that can be made available to grants from prior fiscal years or re-obligations from de-obligated funds, BPC chose to report "Federal Action Obligation" estimates as the most consistent and reliable estimate of "spending" at the transactional level for grantees. Thus, throughout this report, the use of the term "spending" when referring to state- or local-level data means "obligated amounts."

Appendix IV: State Map Details

Arizona Map Details, FY2017 and FY2018

County	FY2017 $ Amount	FY2018 $ Amount	Death Rate	Death Count
Apache	1,213,557	1,943,574	11.2	21
Cochise	970,659	1,431,263	25.1	88
Coconino	2,022,512	2,428,392	19.1	71
Gila	943,534	1,175,915	41.1	62
Graham	353,416	814,020	19.4	20
Greenlee	337,161	797,765	Suppressed	Suppressed
La Paz	509,129	969,733	46.8	22
Maricopa	43,818,567	67,362,460	19.4	2,473
Mohave	1,079,168	1,293,549	30.7	170
Navajo	831,594	938,975	21.1	64
Pima	18,474,004	22,507,194	25	719
Pinal	1,311,356	3,107,543	14.7	175
Santa Cruz	545,258	1,005,862	14.6	19
Yavapai	1,286,049	1,963,950	29.7	180
Yuma	1,768,175	2,228,779	17.5	98

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2015-2017.[269]

2017 Louisiana Map Details

County	FY2017 $ Amount	Death Rate	Death Count	County	FY2017 $ Amount	Death Rate	Death Count
Acadia	12,028	15.1	26	East Baton Rouge	9,713,504	19	244
Allen	16,840	Suppressed	Suppressed	East Carroll	7,017	Suppressed	Suppressed
Ascension	12,028	17.1	61	East Feliciana	12,028	Suppressed	Suppressed
Assumption	12,028	23.6	12	Evangeline	12,028	18.9	16
Avoyelles	10,525	17	19	Franklin	7,017	Suppressed	Suppressed
Beauregard	16,840	Suppressed	Suppressed	Grant	10,525	Suppressed	Suppressed
Bienville	9,355	Suppressed	Suppressed	Iberia	12,028	19.3	38
Bossier	9,355	11.8	45	Iberville	12,028	18.4	16
Caddo	2,974,740	12.6	90	Jackson	7,017	Suppressed	Suppressed
Calcasieu	2,382,495	12.2	70	Jefferson	6,304,076	34.6	446
Caldwell	7,017	Suppressed	Suppressed	Jefferson Davis	16,840	22.5	19
Cameron	16,840	Suppressed	Suppressed	Lafayette	3,054,659	16	118
Catahoula	10,525	Suppressed	Suppressed	Lafourche	12,028	18.8	53
Claiborne	9,355	Suppressed	Suppressed	Lasalle	10,525	Suppressed	Suppressed
Concordia	10,525	Suppressed	Suppressed	Lincoln	7,017	Suppressed	Suppressed
De Soto	9,355	Suppressed	Suppressed	Livingston	16,840	40	166

2017 Louisiana Map Details Continued

County	FY2017 $ Amount	Death Rate	Death Count	County	FY2017 $ Amount	Death Rate	Death Count
Madison	7,017	Suppressed	Suppressed	St. Landry	12,028	14.6	33
Morehouse	7,017	28	17	St. Martin	236,122	10.3	15
Natchitoches	9,355	Suppressed	Suppressed	St. Mary	12,028	20.1	30
Orleans	7,239,031	33.2	405	St. Tammany	1,042,477	28.1	214
Ouachita	2,846,938	15.5	72	Tangipahoa	4,475,513	26.7	101
Plaquemines	13,286	31.6	19	Tensas	7,017	Suppressed	Suppressed
Pointe Coupee	12,028	25.6	13	Terrebonne	2,958,298	32.6	108
Rapides	3,041,991	21.7	77	Union	7,017	Suppressed	Suppressed
Red River	9,355	Suppressed	Suppressed	Vermilion	12,028	18	29
Richland	7,017	Suppressed	Suppressed	Vernon	10,525	12.4	15
Sabine	9,355	Suppressed	Suppressed	Washington	141,840	57.5	76
St. Bernard	13,286	35.8	47	Webster	9,355	12.8	13
St. Charles	12,028	22	34	West Baton Rouge	12,028	19.3	12
St. Helena	16,840	Suppressed	Suppressed	West Carroll	7,017	39.1	10
St. James	12,028	Suppressed	Suppressed	West Feliciana	137,028	Suppressed	Suppressed
St. John the Baptist	522,980	28.1	32	Winn	10,525	Suppressed	Suppressed

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2015-2017.[270]

2018 Louisiana Map Details

County	FY2018 $ Amount	Death Rate	Death Count	County	FY2018 $ Amount	Death Rate	Death Count
Acadia	15,121	15.1	26	East Carroll	16,566	Suppressed	Suppressed
Allen	21,170	Suppressed	Suppressed	East Feliciana	27,257	Suppressed	Suppressed
Ascension	27,257	17.1	61	Evangeline	15,121	18.9	16
Assumption	25,977	23.6	12	Franklin	16,566	Suppressed	Suppressed
Avoyelles	126,165	17	19	Grant	13,231	Suppressed	Suppressed
Beauregard	21,170	Suppressed	Suppressed	Iberia	15,121	19.3	38
Bienville	11,761	Suppressed	Suppressed	Iberville	27,257	18.4	16
Bossier	11,761	11.8	45	Jackson	16,566	Suppressed	Suppressed
Caddo	3,461,254	12.6	90	Jefferson	7,454,855	34.6	446
Calcasieu	2,283,502	12.2	70	Jefferson Davis	21,170	22.5	19
Caldwell	16,566	Suppressed	Suppressed	Lafayette	3,609,283	16	118
Cameron	21,170	Suppressed	Suppressed	Lafourche	418,975	18.8	53
Catahoula	13,231	Suppressed	Suppressed	Lasalle	68,294	Suppressed	Suppressed
Claiborne	11,761	Suppressed	Suppressed	Lincoln	16,566	Suppressed	Suppressed
Concordia	13,231	Suppressed	Suppressed	Livingston	51,343	40	166
De Soto	11,761	Suppressed	Suppressed	Madison	16,566	Suppressed	Suppressed
East Baton Rouge	25,054,011	19	244	Morehouse	16,566	28	17

2018 Louisiana Map Details Continued

County	FY2018 $ Amount	Death Rate	Death Count	County	FY2018 $ Amount	Death Rate	Death Count
Natchitoches	11,761	Suppressed	Suppressed	St. Martin	394,678	10.3	15
Orleans	10,998,865	33.2	405	St. Mary	525,977	20.1	30
Ouachita	3,222,055	15.5	72	St. Tammany	2,073,899	28.1	214
Plaquemines	45,857	31.6	19	Tangipahoa	4,803,505	26.7	101
Pointe Coupee	27,257	25.6	13	Tensas	16,566	Suppressed	Suppressed
Rapides	3,585,693	21.7	77	Terrebonne	2,965,645	32.6	108
Red River	11,761	Suppressed	Suppressed	Union	16,566	Suppressed	Suppressed
Richland	16,566	Suppressed	Suppressed	Vermilion	15,121	18	29
Sabine	11,761	Suppressed	Suppressed	Vernon	13,231	12.4	15
St. Bernard	45,857	35.8	47	Washington	176,343	57.5	76
St. Charles	25,977	22	34	Webster	11,761	12.8	13
St. Helena	51,343	Suppressed	Suppressed	West Baton Rouge	27,257	19.3	12
St. James	25,977	Suppressed	Suppressed	West Carroll	16,566	39.1	10
St. John the Baptist	757,026	28.1	32	West Feliciana	152,257	Suppressed	Suppressed
St. Landry	15,121	14.6	33	Winn	13,231	Suppressed	Suppressed

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2015-2017.[271]

New Hampshire Map Details, FY2017 and FY2018

County	FY2017 $ Amount	FY2018 $ Amount	Death Rate	Death Count
Belknap	310,952	1,618,000	41.5	66
Carroll	200,000	69,020	38.0	48
Cheshire	685,952	1,968,611	25.8	53
Coös	201,958	1,642,211	39.7	33
Grafton	2,399,074	7,901,971	20.1	51
Hillsborough	4,443,528	14,716,679	46.4	546
Merrimack	4,750,671	23,667,233	27.5	112
Rockingham	435,952	441,164	35.1	293
Strafford	756,248	4,132,673	40.7	146
Sullivan	0	0	18.9	22

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2015-2017.[272]

2017 Ohio Map Details

County	FY2017 $ Amount	Death Rate	Death Count	County	FY2017 $ Amount	Death Rate	Death Count
Adams	118,289	53.9	41	Jackson	81,999	26.6	24
Allen	216,684	33	94	Jefferson	220,591	35.6	59
Ashland	218,240	20.3	29	Knox	396,183	21.6	38
Ashtabula	282,934	41.7	111	Lake	992,475	41.1	254
Athens	561,997	17.6	26	Lawrence	148,289	51.1	84
Auglaize	216,684	13.3	16	Licking	241,665	20	100
Belmont	97,435	32.2	61	Logan	142,095	35.1	43
Brown	293,935	61.9	75	Lorain	2,261,644	41.7	358
Butler	3,200,638	65.6	686	Lucas	2,443,073	38.1	462
Carroll	189,609	22.5	13	Madison	340,678	32.9	44
Champaign	131,095	36.1	39	Mahoning	1,939,690	41.9	269
Clark	476,558	67.7	251	Marion	502,554	44.8	82
Clermont	639,995	52.4	301	Medina	486,312	27.4	130
Clinton	380,176	55.4	64	Meigs	81,999	32	16
Columbiana	452,328	42	124	Mercer	94,634	17.2	17
Coshocton	186,052	16.5	14	Miami	198,841	36.3	101
Crawford	133,623	35.1	39	Monroe	97,435	Suppressed	Suppressed
Cuyahoga	12,674,711	39.6	1487	Montgomery	3,701,318	75.7	1114
Darke	198,841	51.4	66	Morgan	126,052	Suppressed	Suppressed
Defiance	108,858	17.8	17	Morrow	209,292	24.9	22
Delaware	334,292	11.2	63	Muskingum	196,052	19.7	45
Erie	294,815	47.6	95	Noble	126,052	40	11
Fairfield	485,357	22.1	95	Ottawa	169,815	28	29
Fayette	224,387	68.7	52	Paulding	94,634	Suppressed	Suppressed
Franklin	16,417,924	28	1102	Perry	134,063	19.8	20
Fulton	388,858	19.5	20	Pickaway	129,387	20.4	34
Gallia	81,999	46.5	39	Pike	99,387	52.6	39
Geauga	310,322	29.1	64	Portage	449,990	29.1	127
Greene	293,225	36	163	Preble	295,128	59.1	66
Guernsey	196,052	35.9	36	Putnam	130,817	16.6	13
Hamilton	7,932,634	48.7	1152	Richland	387,295	49.4	161
Hancock	383,443	32.6	69	Ross	791,446	48.4	110
Hardin	216,684	27	24	Sandusky	177,317	35.2	56
Harrison	97,435	31.2	11	Scioto	423,289	56.6	119
Henry	108,858	21.2	15	Seneca	221,865	23.4	35
Highland	99,387	54.6	61	Shelby	198,841	35.4	45
Hocking	70,797	22.2	15	Stark	2,646,412	28.5	292
Holmes	239,128	11.2	11	Summit	3,613,017	48.5	754
Huron	189,692	36.7	59	Trumbull	817,515	64.9	347

2017 Ohio Map Details Continued

County	FY2017 $ Amount	Death Rate	Death Count	County	FY2017 $ Amount	Death Rate	Death Count
Tuscarawas	249,609	18.8	47	Washington	185,353	30.4	48
Union	521,410	15.2	25	Wayne	364,128	27.6	88
Van Wert	94,634	27.2	18	Williams	138,858	21	18
Vinton	70,797	Suppressed	Suppressed	Wood	904,350	19	64
Warren	486,176	30.1	193	Wyandot	147,317	18.8	10

Death rates and counts are age-adjusted rates for all drugs, 2015-2017[273]

2018 Ohio Map Details

County	FY2018 $ Amount	Death Rate	Death Count	County	FY2018 $ Amount	Death Rate	Death Count
Adams	602,616	53.9	41	Greene	1,226,511	36	163
Allen	325,380	33	94	Guernsey	692,493	35.9	36
Ashland	510,685	20.3	29	Hamilton	8,099,308	48.7	1152
Ashtabula	796,280	41.7	111	Hancock	658,556	32.6	69
Athens	1,665,131	17.6	26	Hardin	325,380	27	24
Auglaize	325,380	13.3	16	Harrison	296,482	31.2	11
Belmont	496,482	32.2	61	Henry	1,288,803	21.2	15
Brown	496,208	61.9	75	Highland	380,787	54.6	61
Butler	4,007,739	65.6	686	Hocking	1,291,783	22.2	15
Carroll	494,696	22.5	13	Holmes	551,751	11.2	11
Champaign	383,162	36.1	39	Huron	531,088	36.7	59
Clark	686,048	67.7	251	Jackson	286,447	26.6	24
Clermont	1,307,024	52.4	301	Jefferson	480,670	35.6	59
Clinton	699,938	55.4	64	Knox	533,332	21.6	38
Columbiana	791,034	42	124	Lake	1,333,426	41.1	254
Coshocton	531,835	16.5	14	Lawrence	352,616	51.1	84
Crawford	420,290	35.1	39	Licking	408,332	20	100
Cuyahoga	17,175,828	39.6	1487	Logan	383,162	35.1	43
Darke	307,537	51.4	66	Lorain	2,615,483	41.7	358
Defiance	288,803	17.8	17	Lucas	3,352,306	38.1	462
Delaware	500,958	11.2	63	Madison	1,428,230	32.9	44
Erie	2,260,876	47.6	95	Mahoning	1,404,963	41.9	269
Fairfield	1,007,163	22.1	95	Marion	420,290	44.8	82
Fayette	755,787	68.7	52	Medina	713,585	27.4	130
Franklin	50,664,708	28	1102	Meigs	286,447	32	16
Fulton	538,803	19.5	20	Mercer	266,816	17.2	17
Gallia	286,447	46.5	39	Miami	307,537	36.3	101
Geauga	748,153	29.1	64	Monroe	296,482	Suppressed	Suppressed

2018 Ohio Map Details Continued

County	FY2018 $ Amount	Death Rate	Death Count	County	FY2018 $ Amount	Death Rate	Death Count
Montgomery	5,803,575	75.7	1114	Scioto	677,616	56.6	119
Morgan	282,181	Suppressed	Suppressed	Seneca	1,039,806	23.4	35
Morrow	375,958	24.9	22	Shelby	307,537	35.4	45
Muskingum	758,134	19.7	45	Stark	2,334,182	28.5	292
Noble	282,181	40	11	Summit	3,938,131	48.5	754
Ottawa	386,669	28	29	Trumbull	1,073,676	64.9	347
Paulding	266,816	Suppressed	Suppressed	Tuscarawas	494,696	18.8	47
Perry	282,181	19.8	20	Union	563,486	15.2	25
Pickaway	380,787	20.4	34	Van Wert	266,816	27.2	18
Pike	380,787	52.6	39	Vinton	265,131	Suppressed	Suppressed
Portage	942,837	29.1	127	Warren	1,499,938	30.1	193
Preble	477,974	59.1	66	Washington	399,917	30.4	48
Putnam	304,685	16.6	13	Wayne	676,751	27.6	88
Richland	584,568	49.4	161	Williams	288,803	21	18
Ross	1,330,457	48.4	110	Wood	778,575	19	64
Sandusky	256,013	35.2	56	Wyandot	256,013	18.8	10

Death rates and counts are age-adjusted rates for all drugs, 2015-2017[274]

2017 Tennessee Map Details

County	FY2017 $ Amount	Death Rate	Death Count	County	FY2017 $ Amount	Death Rate	Death Count
Anderson	818,947	45.5	104	Cumberland	0	20.2	28
Bedford	610,356	15.4	19	Davidson	23,328,954	28.7	618
Benton	0	43.7	17	Decatur	0	31.1	10
Bledsoe	0	Suppressed	Suppressed	DeKalb	0	27.8	14
Blount	228,862	31.9	121	Dickson	23,988	30.7	48
Bradley	252,868	20.9	66	Dyer	90,453	10.9	10
Campbell	22,000	39.1	44	Fayette	0	16.2	15
Cannon	0	43.6	15	Fentress	0	21.5	10
Carroll	0	14.5	10	Franklin	344,423	22.6	28
Carter	33,756	30.3	52	Gibson	23,400	20.9	30
Cheatham	113,333	46.1	56	Giles	0	25.7	23
Chester	0	24	10	Grainger	0	16.7	10
Claiborne	0	39.2	38	Greene	0	22.6	43
Clay	180,713	56.2	11	Grundy	32,735	Suppressed	Suppressed
Cocke	0	26.2	25	Hamblen	254,053	29	54
Coffee	212,254	29.8	46	Hamilton	5,046,304	20.2	215
Crockett	7,000	Suppressed	Suppressed	Hancock	0	Suppressed	Suppressed

2017 Tennessee Map Details Continued

County	FY2017 $ Amount	Death Rate	Death Count	County	FY2017 $ Amount	Death Rate	Death Count
Hardeman	179,905	15	10	Obion	0	Suppressed	Suppressed
Hardin	310,740	37.7	24	Overton	72,222	29.8	17
Hawkins	0	27.7	46	Perry	0	Suppressed	Suppressed
Haywood	880,017	Suppressed	Suppressed	Pickett	0	Suppressed	Suppressed
Henderson	0	18.3	13	Polk	0	31.3	13
Henry	59,206	12.8	11	Putnam	189,833	19.2	41
Hickman	0	25.2	17	Rhea	0	25.3	18
Houston	0	Suppressed	Suppressed	Roane	197,799	45.4	69
Humphreys	8,050	30.4	15	Robertson	8,430	20.2	41
Jackson	195,773	43.2	11	Rutherford	350,660	18.8	177
Jefferson	55,973	15.6	22	Scott	330,629	22.6	13
Johnson	195,098	Suppressed	Suppressed	Sequatchie	0	Suppressed	Suppressed
Knox	4,852,412	40.9	569	Sevier	181,126	29.8	85
Lake	0	Suppressed	Suppressed	Shelby	11,613,923	21.4	600
Lauderdale	60,451	20.2	14	Smith	163,369	36.9	22
Lawrence	0	19.4	25	Stewart	53,202	Suppressed	Suppressed
Lewis	1,580,439	Suppressed	Suppressed	Sullivan	3,117,283	26	120
Lincoln	0	17.8	16	Sumner	217,525	20.1	103
Loudon	0	34.7	46	Tipton	236,776	28	49
McMinn	0	25.4	39	Trousdale	0	Suppressed	Suppressed
McNairy	2,333,747	27.8	20	Unicoi	0	30.8	20
Macon	0	19.8	13	Union	46,805	45.1	26
Madison	0	14.7	39	Van Buren	0	Suppressed	Suppressed
Marion	395,988	24.1	18	Warren	325,000	17.6	21
Marshall	18,000	28.1	29	Washington	765,075	25.3	100
Maury	0	19.1	51	Wayne	0	Suppressed	Suppressed
Meigs	0	48.9	18	Weakley	315,710	19.5	15
Monroe	125,000	31.8	43	White	0	28	21
Montgomery	0	18.4	101	Williamson	57,633	14	81
Moore	0	Suppressed	Suppressed	Wilson	279,585	27.8	105
Morgan	0	32.4	19				

Death rates and counts are age-adjusted rates for all drugs, 2015-2017[275]

2018 Tennessee Map Details

County	FY2018 $ Amount	Death Rate	Death Count	County	FY2018 $ Amount	Death Rate	Death Count
Anderson	1,520,995	45.5	104	Henry	59,206	12.8	11
Bedford	585,356	15.4	19	Hickman	0	25.2	17
Benton	0	43.7	17	Houston	0	Suppressed	Suppressed
Bledsoe	0	Suppressed	Suppressed	Humphreys	8,050	30.4	15
Blount	232,462	31.9	121	Jackson	195,773	43.2	11
Bradley	252,868	20.9	66	Jefferson	1,143,049	15.6	22
Campbell	25,600	39.1	44	Johnson	195,098	Suppressed	Suppressed
Cannon	0	43.6	15	Knox	6,049,292	40.9	569
Carroll	0	14.5	10	Lake	0	Suppressed	Suppressed
Carter	36,156	30.3	52	Lauderdale	60,451	20.2	14
Cheatham	261,000	46.1	56	Lawrence	125,000	19.4	25
Chester	14,400	24	10	Lewis	2,380,489	Suppressed	Suppressed
Claiborne	0	39.2	38	Lincoln	0	17.8	16
Clay	180,713	56.2	11	Loudon	0	34.7	46
Cocke	0	26.2	25	McMinn	0	25.4	39
Coffee	212,254	29.8	46	McNairy	2,324,214	27.8	20
Crockett	7,000	Suppressed	Suppressed	Macon	0	19.8	13
Cumberland	0	20.2	28	Madison	0	14.7	39
Davidson	42,956,388	28.7	618	Marion	388,388	24.1	18
Decatur	0	31.1	10	Marshall	36,000	28.1	29
DeKalb	0	27.8	14	Maury	0	19.1	51
Dickson	23,988	30.7	48	Meigs	0	48.9	18
Dyer	95,253	10.9	10	Monroe	125,000	31.8	43
Fayette	0	16.2	15	Montgomery	9,000	18.4	101
Fentress	0	21.5	10	Moore	0	Suppressed	Suppressed
Franklin	1,267,089	22.6	28	Morgan	0	32.4	19
Gibson	27,000	20.9	30	Obion	0	Suppressed	Suppressed
Giles	0	25.7	23	Overton	250,158	29.8	17
Grainger	0	16.7	10	Perry	0	Suppressed	Suppressed
Greene	0	22.6	43	Pickett	0	Suppressed	Suppressed
Grundy	32,735	Suppressed	Suppressed	Polk	0	31.3	13
Hamblen	129,053	29	54	Putnam	182,033	19.2	41
Hamilton	5,841,750	20.2	215	Rhea	0	25.3	18
Hancock	0	Suppressed	Suppressed	Roane	522,799	45.4	69
Hardeman	179,905	15	10	Robertson	8,430	20.2	41
Hardin	315,540	37.7	24	Rutherford	384,096	18.8	177
Hawkins	0	27.7	46	Scott	205,629	22.6	13
Haywood	880,017	Suppressed	Suppressed	Sequatchie	0	Suppressed	Suppressed
Henderson	0	18.3	13	Sevier	202,726	29.8	85

2018 Tennessee Map Details Continued

County	FY2018 $ Amount	Death Rate	Death Count	County	FY2018 $ Amount	Death Rate	Death Count
Shelby	14,155,996	21.4	600	Van Buren	0	Suppressed	Suppressed
Smith	186,036	36.9	22	Warren	325,000	17.6	21
Stewart	53,202	Suppressed	Suppressed	Washington	1,453,987	25.3	100
Sullivan	2,834,950	26	120	Wayne	0	Suppressed	Suppressed
Sumner	292,697	20.1	103	Weakley	338,376	19.5	15
Tipton	236,776	28	49	White	0	28	21
Trousdale	0	Suppressed	Suppressed	Williamson	460,037	14	81
Unicoi	0	30.8	20	Wilson	281,985	27.8	105
Union	46,805	45.1	26				

Death rates and counts are age-adjusted rates for all drugs, 2015-2017[276]

Endnotes

1 Holly Hedegaard, Arialdi M. Miniño, and Margaret Warner. "Drug Overdose Deaths in the United States, 1999-2017." National Center for Health Statistics Data Brief, no. 329. November 2018. Available at: https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf.

2 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

3 National Association of State Alcohol and Drug Abuse Directors. "SAPT Block Grant Fact Sheet." 2018. Available at: http://nasadad.org/wp-content/uploads/2018/06/SAPT-Block-Grant-Fact-Sheet-5.2.2018.pdf.

4 Ibid.

5 Sherry L. Murphy, Jiaquan Xu, Kenneth D. Kochanek, and Elizabeth Arias. "Mortality in the United States, 2017." National Center for Health Statistics Data Brief, no. 328. November 2018. Available at: https://www.cdc.gov/nchs/data/databriefs/db328-h.pdf.

6 Ibid.

7 Centers for Disease Control and Prevention. "U.S. Opioid Prescribing Rate Maps." 2018. Available at: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.

8 Holly Hedegaard, Arialdi M. Miniño, and Margaret Warner. "Drug Overdose Deaths in the United States, 1999-2017." National Center for Health Statistics Data Brief, no. 329. November 2018. Available at: https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf.

9 Farida B. Ahmad, Lauren M. Rossen, Merianne R. Spencer, et al. "Provisional Drug Overdose Death Counts." National Center for Health Statistics. 2019. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

10 Centers for Disease Control and Prevention. "Addressing the Infectious Disease Consequences of the Opioid Epidemic." 2018. Available at: https://www.cdc.gov/nchhstp/budget/infographics/opioids.html.

11 Alana M. Vivolo-Kantor, Puja Seth, R. Matthew Gladden, et al. "Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses—United States, July 2016-September 2017." *Morbidity and Mortality Weekly Report*. 67 no. 9 (2018): 279-285. Available at: https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6709e1-H.pdf.

12 U.S. Department of Health, Administration for Children and Families. *Adoption and Foster Care Analysis and Reporting System (AFCARS) Report*. U.S. Department of Health and Human Services, Administration for Children and Families. September 24, 2018. Available at: https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf.

13 Robin Ghertner, Melinda Baldwin, Gilbert Crouse, et al. *The Relationship Between Substance Use Indicators and Child Welfare Caseloads*. Office of the Assistant Secretary for Planning and Evaluation. March 9, 2018. Available at: https://aspe.hhs.gov/system/files/pdf/258831/SubstanceUseCWCaseloads.pdf.

14 Centers for Disease Control and Prevention. "Understanding the Epidemic." 2018. Available at: https://www.cdc.gov/drugoverdose/epidemic/index.html.

15 In a federal court action in 2007, the manufacturer of OxyContin, Purdue Pharma, was fined $600 million for misleading marketing. Barry Meier. "In Guilty Plea, OxyContin Maker to Pay $600 Million." *The New York Times*. May 10, 2007. Available at: https://www.nytimes.com/2007/05/10/business/11drug-web.html.

16 James N. Campbell. "APS 1995 Presidential address." *Journal of Pain*. 5 no. 1 (1996): 85-88. Available at: https://www.jpain.org/article/S1082-3174(96)80076-6/abstract.

17 The Joint Commission. "The Joint Commission's Pain Standards: Origins and Evolution." May 5, 2017. Available at: https://www.jointcommission.org/assets/1/6/Pain_Std_History_Web_Version_05122017.pdf.

18 Nora D. Volkow, Thomas A. McLellan, Jessica H. Cotto, et al. "Characteristics of Opioid Prescriptions in 2009." *Journal of the American Medical Association*. 305 no. 13 (2011): 1299-1301. Available at: https://jamanetwork.com/journals/jama/fullarticle/896134.

19 Evan Wood, Jeffrey H. Samet, and Nora D. Volkow. "Physician Education in Addiction Medicine." *Journal of the American Medical Association*. 310 no. 16 (2013): 1673-1674. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4827345/.

20 Drug Enforcement Administration, Public Information Officer. "Florida Doctors No Longer Among the Top OxyCodone Purchasers in the United States." April 5, 2013. Available at: https://www.dea.gov/press-releases/2013/04/05/florida-doctors-no-longer-among-top-oxycodone-purchasers-united-states.

21 Hal Johnson, Leonard Paulozzi, Christina Porucznik, et al. "Decline in Drug Overdose Deaths after State Policy Changes—Florida, 2010-2012." *Morbidity and Mortality Weekly Report*. 63 no. 26 (2014): 569-574. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm.

22 Theodore J. Cicero, Matthew S. Ellis, Hilary L. Surratt, and Steven P. Kurtz. "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years." *JAMA Psychiatry*. 71 no. 7 (2014): 821-826. Available at: https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1874575.

[23] Wilson M. Compton, Christopher M. Jones, and Grant T. Baldwin. "Relationship Between Nonmedical Prescription-Opioid Use and Heroin Use." *The New England Journal of Medicine*. 374 no. 2 (2016):154-163. Available at: https://www.nejm.org/doi/10.1056/NEJMra1508490.

[24] U.S. Department of Justice Drug Enforcement Administration. *2017 National Drug Threat Assessment*. October 1, 2017. Available at: https://www.dea.gov/documents/2017/10/01/2017-national-drug-threat-assessment.

[25] U.S. Department of Justice Drug Enforcement Administration. "National Forensic Laboratory Information System-Drug 2017 Annual Report." 2018. Available at: https://www.nflis.deadiversion.usdoj.gov/DesktopModules/ReportDownloads/Reports/NFLIS-Drug-AR2017.pdf.

[26] Lawrence Scholl, Puja Seth, Mbabazi Kariisa, et al. "Drug and Opioid-Involved Overdose Deaths—United States, 2013-2017." *Morbidity and Mortality Weekly Report*. 67 no. 5152 (2019): 1419-1427. Available at: https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm?s_cid=mm675152e1_w.

[27] Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

[28] Ibid.

[29] Ibid.

[30] Executive Office of the President, Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis*. 2011. Available at: http://publications.iowa.gov/12965/1/NationalRxAbusePlan2011.pdf.

[31] Amanda J. Abraham, Christina M. Andrews, Colleen M. Grogan, et al. "The Affordable Care Act Transformation of Substance Use Disorder Treatment." *American Journal of Public Health*. 107 no. 1 (2017): 31-32. Available at: https://ajph.aphapublications.org/doi/10.2105/AJPH.2016.303558.

[32] Sean O'Connor. *Fentanyl Flows from China: An Update Since 2017*. U.S. China Economic and Security Review Commission. November 26, 2018. Available at: https://www.uscc.gov/sites/default/files/Research/Fentanyl%20Flows%20from%20China.pdf.

[33] China Food and Drug Administration. "Notification of the Issuance of Managing NonMedicinal Narcotics and Psychoactive Drugs." September 29, 2015. Staff translation. Available at: http://www.sfda.gov.cn/WS01/CL0056/130753.htm.

[34] Sean O'Connor. *Fentanyl Flows from China: An Update Since 2017*. U.S. China Economic and Security Review Commission. November 26, 2018. Available at: https://www.uscc.gov/sites/default/files/Research/Fentanyl%20Flows%20from%20China.pdf.

[35] Senator Edward Markey. "The INTERDICT Act." March 23, 2017. Available at: https://www.markey.senate.gov/imo/media/doc/2017-03-23-Markey-Bill-Text-INTERDICT-Act%20.pdf.

[36] SUPPORT for Patients and Communities Act. Pub. L. 115-271. 2018.

[37] Deborah Dowell, Tamara M. Haegerich, and Roger Chou. "CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016." *Morbidity and Mortality Weekly Report*. 65 no. 1 (2016):1-49. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

[38] Christine L. Mattson, Lyna Schieber, Lawrence Scholl, et al. *Annual Surveillance Report of Drug-Related Risks and Outcomes—United States, 2017*. Surveillance Special Report 1. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. August 31, 2017. Available at: https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf.

[39] Centers for Disease Control and Prevention. "U.S. Opioid Prescribing Rate Maps." 2018. Available at: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.

[40] U.S. Department of Health and Human Services. "HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis." October 26, 2017. Available at: https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html.

[41] Chris Christie, Charlie Baker, Roy Cooper, et al. *The President's Commission on Combating Drug Addiction and the Opioid Crisis*. Executive Office of the President. 2017. Available at: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

[42] U.S. Department of Health and Human Services. *Strategy to Combat Abuse, Misuse and Overdose: A Framework on the Five Point Strategy*. 2017. Available at: https://www.hhs.gov/opioids/sites/default/files/2018-09/opioid-fivepoint-strategy-20180917-508compliant.pdf.

[43] U.S. Drug Enforcement Administration. "Attorney General Sessions and Acting DEA Administrator Patterson Announce New Tools to Address Opioid Crisis." November 29, 2017. Available at: https://www.dea.gov/press-releases/2017/11/29/attorney-general-sessions-and-acting-dea-administrator-patterson-announce.

[44] U.S. Department of Justice Bureau of Justice Assistance. "Comprehensive Opioid Abuse Program (COAP)." Available at: https://www.bja.gov/ProgramDetails.aspx?Program_ID=72.

[45] U.S. Department of Justice Community Oriented Policing Services. "2018 Award Announcements." Available at: https://cops.usdoj.gov/grants.

[46] H.R. 244. Consolidated Appropriations Act, 2017. Available at: https://rules.house.gov/bill/115/hr-244-sa.

[47] H.R. 1625. Consolidated Appropriations Act, 2018. Available at: https://rules.house.gov/bill/115/hr-1625-sa.

48 U.S. National Institutes of Health. "HEAL Initiative Research Plan." January 31, 2019. Available at: https://www.nih.gov/research-training/medical-research-initiatives/heal-initiative/heal-initiative-research-plan.

49 Substance Abuse and Mental Health Services Administration. "Targeted Capacity Expansion: Medication Assisted Treatment—Prescription Drug and Opioid Addiction." May 21, 2018. Available at: https://www.samhsa.gov/grants/grant-announcements/ti-18-009.

50 Substance Abuse and Mental Health Services Administration. "SPF Rx." March 29, 2016. Available at: https://www.samhsa.gov/grants/grant-announcements/sp-16-006.

51 U.S. Department of Justice. "Justice Department is Awarding Almost $320 Million to Combat Opioid Crisis." October 1, 2018. Available at: https://www.justice.gov/opa/press-release/file/1097546/download.

52 U.S. Department of Justice. "Comprehensive Opioid Abuse Site-based Program FY 2018 Competitive Grant Announcement." June 6, 2018. Available at: https://www.justice.gov/opa/press-release/file/1097546/download.

53 U.S. Department of Justice. "Justice Department is Awarding Almost $320 Million to Combat Opioid Crisis." October 1, 2018. Available at: https://www.justice.gov/opa/press-release/file/1097546/download.

54 Ibid.

55 H.R. 1625 Consolidated Appropriations Act, 2018. "Explanatory Statement-Division H." March 21, 2018. Available at: https://docs.house.gov/billsthisweek/20180319/DIV%20H%20LABORHHS%20SOM%20FY18%20OMNI.OCR.pdf.

56 Centers for Disease Control and Prevention. "Enhanced State Opioid Overdose Surveillance (ESOOS)." October 3, 2017. Available at: https://www.cdc.gov/drugoverdose/pdf/CDC-NCIPC-ESOOSReport-508.pdf.

57 Ibid.

58 Substance Abuse and Mental Health Services Administration. "State Opioid Response Grants-Funding Opportunity Announcement No. TI-18-015." June 14, 2018. Available at: https://www.samhsa.gov/sites/default/files/grants/pdf/sorfoafinal.6.14.18.pdf.

59 Henry J. Kaiser Family Foundation. "Medicaid's Role in Addressing the Opioid Epidemic." February 27, 2018. Available at: https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/.

60 Centers for Medicare and Medicaid Services. "Total Medicaid Enrollees—VIII Group Break Out Report Reported on the CMS-64." 2018. Available at: https://data.medicaid.gov/Enrollment/2017-2Q-Medicaid-MBES-Enrollment/4sjd-9ets.

61 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP). "HCUP Fast Stats—Opioid-Related Hospital Use." October 26, 2018. Available at: https://www.hcup-us.ahrq.gov/faststats/opioid/HCUP_OpioidRelatedHospitalUse_DataExport.xls.

62 Ibid.

63 Ibid.

64 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

65 Ibid.

66 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

67 Ibid.

68 Ibid.

69 Arizona Department of Health Services. "Arizona Opioid Emergency Response: June 2017-June 2018." August 3, 2018. Available at: https://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/2017-opioid-emergency-response-report.pdf.

70 Ibid.

71 Ibid.

72 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

73 Arizona Health Care Cost Containment System. "Opioid STR Project Narrative Arizona." 2017. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/StateTargetedResponse/OpioidSTR_Project%20Narrative_Arizona.pdf.

74 Ibid.

75 National Association of State Alcohol and Drug Abuse Directors. *Timeline of Funding for the State Targeted Response (STR) and State Opioid Response (SOR) Grant Programs*. November 2018. Available at: http://nasadad.org/nasadad-fact-sheets/.

76 Arizona Health Care Cost Containment System. "Arizona Opioid STR Fact Sheet." 2017. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/StateTargetedResponse/Arizona_Opioid_STR_Fact_Sheet.pdf.

77 Arizona Health Care Cost Containment System. "Opioid STR Project Narrative Arizona." 2017. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/StateTargetedResponse/OpioidSTR_Project%20Narrative_Arizona.pdf.

78 Ibid.

79 Ibid.

80 Arizona Health Care Cost Containment System. "FY 2017 End-Year State Targeted Response to the Opioid Crisis Grants." Submitted to Substance Abuse and Mental Health Services Administration. June 27, 2018.

81 Ibid.

82 Ibid.

83 Ibid.

84 Arizona Health Care Cost Containment System. "Opioid SOR Project Narrative Arizona." 2018. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/StateTargetedResponse/OpioidSORProjectNarrativeArizona.pdf.

85 Ibid.

86 Ibid.

87 Henry J. Kaiser Family Foundation. "Medicaid in Arizona." November 2018. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-AZ.

88 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP). "HCUP Fast Stats—Opioid-Related Hospital Use." October 26, 2018. Available at: https://www.hcup-us.ahrq.gov/faststats/opioid/HCUP_OpioidRelatedHospitalUse_DataExport.xls.

89 Ibid.

90 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

91 Ibid.

92 Arizona Health Care Cost Containment System. Spending report for code H0020—methadone administration and/or service (provision of the drug by a licensed program).

93 Centers for Disease Control and Prevention. "U.S. State Prescribing Rate Maps." Available at: https://www.cdc.gov/drugoverdose/maps/rxstate2011.html.

94 Centers for Disease Control and Prevention. "Drug Overdose Deaths." 2019. Available at: https://www.cdc.gov/drugoverdose/data/statedeaths.html.

95 Substance Abuse and Mental Health Services Administration. "2016-2017 National Surveys on Drug Use and Health: Model-Based Estimated Totals." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTotal2016/NSDUHsaeTotals2016.xlsx.

96 Substance Abuse and Mental Health Services Administration. "National Survey on Drug Use and Health: Comparison of 2015-2016 and 2016-2017." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeChangeTabs2017/NSDUHsaeShortTermCHG2017.pdf.

97 Ibid.

98 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

99 Ibid.

100 Ibid.

101 Ibid.

102 Ibid.

103 Ibid.

104 Ibid.

105 Louisiana Office of Behavioral Health. "HOPE Council 2018 End-of-Year Update Report." 2018. Available at: http://ldh.la.gov/assets/docs/BehavioralHealth/HOPE/HOPEendofyear-APPROVED.pdf.

106 Ibid.

107 Ibid.

108 Ibid.

109 National Association of State Alcohol and Drug Abuse Directors. *Timeline of Funding for the State Targeted Response (STR) and State Opioid Response (SOR) Grant Programs*. November 2018. Available at: http://nasadad.org/nasadad-fact-sheets/.

110 Louisiana Office of Behavioral Health. "Louisiana STR Project Narrative." 2017.

111 Ibid.

112 Ibid.

113 Ibid.

114 Ibid.

115 Louisiana Office of Behavioral Health. "HOPE Council 2018 End-of-Year Update Report." 2018. Available at: http://ldh.la.gov/assets/docs/BehavioralHealth/HOPE/HOPEendofyear-APPROVED.pdf.

116 Ibid.

117 Louisiana Office of Behavioral Health. "Louisiana State Opioid Response Grant (LaSOR) Project Overview." 2018.

118 Ibid.

119 Ibid.

120 Louisiana Office of Behavioral Health. "Office of Behavioral Health Receives $23.1 Million State Opioid Response Grant." December 12, 2018. Available at: http://ldh.la.gov/index.cfm/newsroom/detail/5004.

121 Louisiana Office of Behavioral Health. "HOPE Council 2018 End-of-Year Update Report." 2018. Available at: http://ldh.la.gov/assets/docs/BehavioralHealth/HOPE/HOPEendofyear-APPROVED.pdf.

122 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

123 Ibid.

124 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP). "HCUP Fast Stats—Opioid-Related Hospital Use." October 26, 2018. Available at: https://www.hcup-us.ahrq.gov/faststats/opioid/HCUP_OpioidRelatedHospitalUse_DataExport.xls.

125 Henry J. Kaiser Family Foundation. "Medicaid in Louisiana." November 2018. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-LA.

126 Louisiana Office of Behavioral Health. "HOPE Council 2018 End-of-Year Update Report." 2018. Available at: http://ldh.la.gov/assets/docs/BehavioralHealth/HOPE/HOPEendofyear-APPROVED.pdf.

127 Centers for Disease Control and Prevention. "U.S. State Prescribing Rate Maps." Available at: https://www.cdc.gov/drugoverdose/maps/rxstate2008.html.

128 Substance Abuse and Mental Health Services Administration. "National Survey on Drug Use and Health: Comparison of 2015-2016 and 2016-2017." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeChangeTabs2017/NSDUHsaeShortTermCHG2017.pdf.

129 Ibid.

130 Substance Abuse and Mental Health Services Administration. "2016-2017 National Surveys on Drug Use and Health: Model-Based Estimated Totals." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTotal2016/NSDUHsaeTotals2016.xlsx.

131 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

132 Ibid.

133 Ibid.

134 Ibid.

135 Ibid.

136 Ibid.

137 Ibid.

138 New Hampshire Regional Public Health Networks. "Partners and Funders." Available at: https://nhphn.org/who-we-are/partners-and-funders/.

139 New Hampshire Department of Health and Human Services. "Commission Members." December 19, 2018. Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/members.pdf.

140 New Hampshire Department of Health and Human Services. "Governor's Commission on Alcohol and Other Drugs." Available at: https://www.dhhs.nh.gov/dcbcs/bdas/commission.htm.

141 New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. "2017 Annual Report." Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/gc-annual-report.pdf.

142 New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. "2016 Annual Report." Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/gc-final-september-2016.pdf.

143 New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. "Mid-Year Report." March 1, 2018. Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/mid-year-commmission-2018.pdf.

144 National Association of State Alcohol and Drug Abuse Directors. *Timeline of Funding for the State Targeted Response (STR) and State Opioid Response (SOR) Grant Programs*. November 2018. Available at: http://nasadad.org/nasadad-fact-sheets/.

145 New Hampshire Department of Health and Human Services. "State Targeted Response to the Opioid Crisis—New Hampshire Grant Proposal."

146 Ibid.

147 Ibid.

148 New Hampshire Department of Health and Human Services. "FY 2017 End-Year State Targeted Response to the Opioid Crisis Grants."

149 Ibid.

150 New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. "Mid-Year Report." March 1, 2018. Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/mid-year-commmission-2018.pdf.

151 New Hampshire Department of Health and Human Services. "State Opioid Response (SOR) New Hampshire Grant Proposal." Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/sor-grant-proposal.pdf.

152 Ibid.

153 Ibid.

154 Ibid.

155 New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. "Mid-Year Report." March 1, 2018. Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/mid-year-commmission-2018.pdf.

156 Henry J. Kaiser Family Foundation. "Medicaid in New Hampshire." November 2018. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-NH.

157 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

158 Ibid.

159 New Hampshire Department of Health and Human Services. "NH Medicaid FFS and MCO Reimbursement Summary by Paid Calendar Year 1/1/2016 to 6/30/2018." Medicaid Management Information System. February 20, 2019. *Note*: Excludes claims paid by Qualified Health Plans for members in NH Medicaid's Premium Assistance Program.

160 New Hampshire Department of Justice, Office of the Chief Medical Examiner. "Drug Data Update-December 2018." Available at: https://www.doj.nh.gov/medical-examiner/. *Note*: 10 percent rate calculated using the projected number of deaths for 2018, 437 versus the 2017 total of 488.

161 Substance Abuse and Mental Health Services Administration. "National Survey on Drug Use and Health: Comparison of 2015-2016 and 2016-2017." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeChangeTabs2017/NSDUHsaeShortTermCHG2017.pdf.

162 Ibid.

163 Substance Abuse and Mental Health Services Administration. "2016-2017 National Surveys on Drug Use and Health: Model-Based Estimated Totals." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTotal2016/NSDUHsaeTotals2016.xlsx.

164 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

165 Ibid.

166 Ibid.

167 Ibid.

168 Ibid.

169 Ibid.

170 Ibid.

171 Ibid.

172 Ibid.

173 Governor's Cabinet Opiate Action Team. *Combatting the Opiate Crisis in Ohio, 2011-2018*. December 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/GCOAT_Compendium.pdf.

174 Ibid.

175 Ibid.

176 Ibid.

177 National Association of State Alcohol and Drug Abuse Directors. *Timeline of Funding for the State Targeted Response (STR) and State Opioid Response (SOR) Grant Programs*. November 2018. Available at: http://nasadad.org/nasadad-fact-sheets/.

178 Ohio Mental Health and Addiction Services. "OhioMHAS Application." February 2017. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Cures-submission-Feb2017.pdf.

179 Ohio Mental Health and Addiction Services. "Fact Sheet on Ohio's Approach." March 2017. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Cures-Ohio-Fact-Sheet.pdf.

180 Ibid.

181 Ohio Mental Health and Addiction Services. "Fact Sheet on County Board Plans." October 12, 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Year-2-CURES-Opioid-STR-County-Board-Projects_10122018.pdf.

182 Ohio Mental Health and Addiction Services. "Fact Sheet on Ohio's Approach." March 2017. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Cures-Ohio-Fact-Sheet.pdf.

183 Ohio Mental Health and Addiction Services. "OhioMHAS Application." February 2017. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Cures-submission-Feb2017.pdf.

184 Ibid.

185 Ohio Mental Health and Addiction Services. "FY 2017 Mid-Year State Targeted Response to the Opioid Crisis Grants."

186 Ohio Mental Health and Addiction Services. "Fact Sheet on MAT Activities." 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Fact-Sheet-on-MAT-Activities_10092018.pdf.

187 Ohio Mental Health and Addiction Services. "CURES Year One Accomplishments." 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Cures_Year_1_Accomplishments_Fact_Sheet_2.pdf.

188 Ohio Mental Health and Addiction Services. "MOMS Year One Outcomes." 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/MOMS_PDF.pdf.

189 Ibid.

190 Ohio Mental Health and Addiction Services. "Trainings Supported by CURES and SOR Funding." 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/SOR/Trainings_CURES_SOR.pdf.

191 Ohio Mental Health and Addiction Services. "Workforce Year One Outcomes." 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/CURES/Workforce_year_one_Outcome.pdf.

192 Ohio Mental Health and Addiction Services. "Ohio SOR Application." August 13, 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/SOR/SOR_NARRATIVE_READY_FOR_SUBMISSION.docx.

193 Ohio Mental Health and Addiction Services. "Trainings Supported by CURES and SOR Funding." 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/SOR/Trainings_CURES_SOR.pdf.

194 Ohio Mental Health and Addiction Services. "Ohio SOR Application." August 13, 2018. vailable at: https://mha.ohio.gov/Portals/0/assets/Funding/SOR/SOR_NARRATIVE_READY_FOR_SUBMISSION.docx.

195 Henry J. Kaiser Family Foundation. "Medicaid in Ohio." November 2018. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-OH.

196 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP). "HCUP Fast Stats—Opioid-Related Hospital Use." October 26, 2018. Available at: https://www.hcup-us.ahrq.gov/faststats/opioid/HCUP_OpioidRelatedHospitalUse_DataExport.xls.

197 Ibid.

198 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

199 Ohio Department of Medicaid. 2019.

200 Centers for Disease Control and Prevention. "U.S. State Prescribing Rate Maps." Available at: https://www.cdc.gov/drugoverdose/maps/rxstate2010.html.

201 Substance Abuse and Mental Health Services Administration. "2016-2017 National Surveys on Drug Use and Health: Model-Based Estimated Totals." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTotal2016/NSDUHsaeTotals2016.xlsx.

202 Substance Abuse and Mental Health Services Administration. "National Survey on Drug Use and Health: Comparison of 2015-2016 and 2016-2017." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeChangeTabs2017/NSDUHsaeShortTermCHG2017.pdf.

203 Ibid.

204 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

205 Ibid.

206 Ibid.

207 Ibid.

208 Ibid.

209 Ibid.

210 Ibid.

211 Tennessee Department of Mental Health and Substance Abuse Services. "Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee-Full Report." Summer 2014. Available at: https://www.tn.gov/content/dam/tn/mentalhealth/documents/Prescription_For_Success_Full_Report.pdf.

212 Ibid.

213 Tennessee Department of Mental Health and Substance Abuse Services. "Prescription for Success Achievements." December 12, 2017. Available at: https://www.tn.gov/content/dam/tn/mentalhealth/documents/sa_data_briefs/Prescription%20for%20Success%20Achievements%2012.2017.PDF.

214 TN Together. Available at: https://www.tn.gov/content/dam/tn/opioids/documents/OpioidOnePager.pdf.

215 Ibid.

216 Ibid.

217 National Association of State Alcohol and Drug Abuse Directors. *Timeline of Funding for the State Targeted Response (STR) and State Opioid Response (SOR) Grant Programs*. November 2018. Available at: http://nasadad.org/nasadad-fact-sheets/.

218 Tennessee Department of Mental Health and Substance Abuse Services. "Tennessee STR Project Narrative." 2017.

219 Tennessee Department of Mental Health and Substance Abuse Services. "Joint Annual Report 2018." June 2018. Available at: https://www.tn.gov/content/dam/tn/mentalhealth/documents/planning/JAR%20FY%202018%20-%20FINAL.pdf.

220 The Sycamore Institute. "The Opioid Epidemic in Tennessee: 2018 Update on New Policy Actions." August 9, 2018. Available at: https://www.sycamoreinstitutetn.org/2018/08/09/opioid-epidemic-tn-policy-actions/.

221 Henry J. Kaiser Family Foundation. "Medicaid in Tennessee." November 2018. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-TN.

222 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP). "HCUP Fast Stats—Opioid-Related Hospital Use." October 26, 2018. Available at: https://www.hcup-us.ahrq.gov/faststats/opioid/HCUP_OpioidRelatedHospitalUse_DataExport.xls.

223 Ibid.

224 The Sycamore Institute. "The Opioid Epidemic in Tennessee: 2018 Update on New Policy Actions." August 9, 2018. Available at: https://www.sycamoreinstitutetn.org/2018/08/09/opioid-epidemic-tn-policy-actions/.

225 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

226 Tennessee Department of Health. "Controlled Substance Monitoring Database—2018 Report to the 110th Tennessee General Assembly." March 1, 2018. Available at: https://www.tn.gov/content/dam/tn/health/healthprofboards/csmd/2018%20Comprehensive%20CSMD%20Annual%20Report.pdf.

227 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

228 Ibid.

229 State of Ohio Board of Pharmacy. "Ohio Automated Rx Reporting System." 2019. Available at: https://www.ohiopmp.gov/State.aspx.

230 Tennessee Department of Health. "Controlled Substance Monitoring Database—2018 Report to the 110th Tennessee General Assembly." March 1, 2018. Available at: https://www.tn.gov/content/dam/tn/health/healthprofboards/csmd/2018%20Comprehensive%20CSMD%20Annual%20Report.pdf.

231 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

232 State of Ohio Board of Pharmacy. "Ohio Automated Rx Reporting System." 2019. Available at: https://www.ohiopmp.gov/State.aspx.

233 Tennessee Department of Health. "Controlled Substance Monitoring Database—2018 Report to the 110th Tennessee General Assembly." March 1, 2018. Available at: https://www.tn.gov/content/dam/tn/health/healthprofboards/csmd/2018%20Comprehensive%20CSMD%20Annual%20Report.pdf.

234 State of Ohio Board of Pharmacy. "Ohio Automated Rx Reporting System." 2019. Available at: https://www.ohiopmp.gov/State.aspx.

235 Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health. "State Level OUD and Not Receiving Treatment-Table 1.B." July 17, 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/state%20level%20OUD%20and%20not%20rec%20tx%20-%20ASC_AdHoc123_07-18-18.docx.

236 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

237 Centers for Disease Control and Prevention. "U.S. State Prescribing Rate Maps." Available at: https://www.cdc.gov/drugoverdose/maps/rxstate2010.html.

238 Substance Abuse and Mental Health Services Administration. "2016-2017 National Surveys on Drug Use and Health: Model-Based Estimated Totals." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTotal2016/NSDUHsaeTotals2016.xlsx.

239 Substance Abuse and Mental Health Services Administration. "National Survey on Drug Use and Health: Comparison of 2015-2016 and 2016-2017." 2018. Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeChangeTabs2017/NSDUHsaeShortTermCHG2017.pdf.

240 Ibid.

241 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

242 Ibid.

243 Ibid.

244 Substance Abuse and Mental Health Services Administration. "Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015." 2015. Available at: https://store.samhsa.gov/system/files/sma17-5029.pdf.

245 Ibid.

246 Vermont Blueprint for Health. "Hub and Spoke." 2019. Available at: https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke.

247 Lisa Clemans-Cope, Marni Epstein, and Genevieve M. Kenney. "Rapid Growth in Medicaid Spending on Medications to Treat Opioid Use Disorder and Overdose." Urban Institute. June 2017. Available at: https://www.urban.org/sites/default/files/publication/91521/2001386-rapid-growth-in-medicaid-spending-on-medications-to-treat-opioid-use-disorder-and-overdose_3.pdf.

248 Ibid.

249 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." Available at: https://data.medicaid.gov/.

250 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP). "HCUP Fast Stats—Opioid-Related Hospital Use." October 26, 2018. Available at: https://www.hcup-us.ahrq.gov/faststats/opioid/HCUP_OpioidRelatedHospitalUse_DataExport.xls.

251 Brendan Saloner, Jonathan Levin, Hsien-Yen Chang, et al. "Changes in Buprenorphine-Naloxone and Opioid Pain Reliever Prescriptions After the Affordable Care Act Medicaid Expansion." *JAMA Network Open*. 1 no. 4 (2018): e181588. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2696873.

252 Arizona Health Care Cost Containment System. "Opioid SOR Project Narrative Arizona." 2018. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/StateTargetedResponse/OpioidSORProjectNarrativeArizona.pdf.

253 Ohio Mental Health and Addiction Services. "OhioMHAS State Opioid Response Application." 2018. Available at: https://mha.ohio.gov/Portals/0/assets/Funding/SOR/SOR_NARRATIVE_READY_FOR_SUBMISSION.docx.

254 New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. "2017 Annual Report." Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/gc-annual-report.pdf.

255 Shabbar I. Ranapurwala, Meghan E. Shanahan , Apostolos A. Alexandridis, et al. "Opioid Overdose Mortality Among Former North Carolina Inmates: 2000-2015." *American Journal of Public Health*. 108 no. 9 (2018): 1207-1213. Available at: https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304514.

256 Traci Green, Jennifer Clarke, Lauren Brinkley-Rubinstein, et al. "Postincarceraton Fatal Overdoses after Implementing Medications for Addiction Treatment in a Statewide Correctional System." *JAMA Psychiatry*. 75 no. 4 (2018): 405-07. Available at: https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2671411.

257 National Association of State Alcohol and Drug Abuse Directors. "SAPT Block Grant Fact Sheet." 2018. Available at: http://nasadad.org/wp-content/uploads/2018/06/SAPT-Block-Grant-Fact-Sheet-5.2.2018.pdf.

258 Alia Al-Tayyib, Stephen Koester, Sig Langegger, and Lisa Raville. "Heroin and Methamphetamine Injection: An Emerging Drug Use Pattern." *Substance Use & Misuse*. 52 no. 8 (2017): 1051-1058. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5642954/pdf/nihms911090.pdf.

259 Sara Nelson Glick, Richard Burt, Kim Kummer, et al. "Increasing Methamphetamine Injection Among Non-MSM Who Inject Drugs in King County, Washington." *Drug and Alcohol Dependence*. 182 (2018): 86-92. Available at: https://doi.org/10.1016/j.drugalcdep.2017.10.011.

260 U.S. Department of Justice, Drug Enforcement Agency. *2018 National Drug Threat Assessment*. October 2018. Available at: https://www.dea.gov/sites/default/files/2018-11/DIR-032-18%202018%20NDTA%20%5Bfinal%5D%20low%20resolution11-20.pdf.

261 H.R. 244. Consolidated Appropriations Act, 2017. Available at: https://rules.house.gov/bill/115/hr-244-sa.

262 H.R. 1625. Consolidated Appropriations Act, 2018. Available at: https://rules.house.gov/bill/115/hr-1625-sa.

263 Lisa Clemans-Cope, Marni Epstein, and Genevieve M. Kenney. "Rapid Growth in Medicaid Spending on Medications to Treat Opioid Use Disorder and Overdose." Urban Institute. June 2017. Available at: https://www.urban.org/sites/default/files/publication/91521/2001386-rapid-growth-in-medicaid-spending-on-medications-to-treat-opioid-use-disorder-and-overdose_3.pdf.

264 USAspending.gov. "About USAspending." 2019. Available at: https://www.usaspending.gov/#/about.

265 Substance Abuse and Mental Health Services Administration. "Justification of Estimates for Appropriations Committees Fiscal Year 2018." May 14, 2018. Available at: https://www.samhsa.gov/sites/default/files/samhsa-fy-2018-congressional-justification.pdf.

266 Substance Abuse and Mental Health Services Administration. "Justification of Estimates for Appropriations Committees Fiscal Year 2019." November 27, 2018. Available at: https://www.samhsa.gov/sites/default/files/sites/default/files/samhsa-fy-2019-congressional-justification.pdf.

267 U.S. Department of Justice. "Fact Sheet-Justice Department is Awarding Almost $320 million to Combat Opioid Crisis." October 1, 2018. Available at: https://www.justice.gov/opa/press-release/file/1097546/download.

268 Centers for Disease Control and Prevention. "CDC WONDER Online Database." December 2018. Available at: http://wonder.cdc.gov/mcd-icd10.html.

269 Ibid.

270 Ibid.

271 Ibid.

272 Ibid.

273 Ibid.

274 Ibid.

275 Ibid.

276 Ibid.

Notes

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MDHHS
Michigan Department of Health & Human Services

Michigan Opioids Task Force Annual Report

2020

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May 17, 2021

Michigan Community,

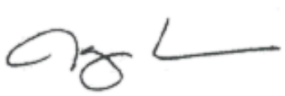
It is an honor to serve as Chair of the Michigan Opioids Task Force on behalf of Governor Whitmer and be at the forefront of such a critical issue in our state. In 2019, opioid overdoses killed 1,768 Michiganders, an average of almost five people every single day. The Task Force, Advisory Workgroup, and MDHHS are committed to continuing to understand and track how substance use disorders are impacting the lives of Michigan residents and will continue to work with communities to implement bold and robust strategies to address this epidemic. I am grateful for their willingness to serve and their collaborative approach to creating meaningful and lasting change.

This report details the actions of the Michigan Opioids Task Force to realize Governor Whitmer's goal of reducing opioid overdose deaths by 50 percent in five years. In 2020, MDHHS and the Opioids Task Force made progress on our seven-pillar statewide opioid strategic plan, covering prevention, treatment, harm reduction, criminal justice-involved populations, pregnant and parenting women populations, data, and equity initiatives. In 2020, we saw key successes in reaching people who use drugs – the Michigan naloxone portal, launched in June 2020, distributed over one hundred thousand kits across the state, we expanded emergency department-based access to medications to treat opioid use disorder programming to all corners of the state, and we launched a harm reduction campaign that put recovering voices at the forefront, all while adjusting to a pandemic. Yet, as the data shows, there is more work to be done. Strategies to address prevention, screening, and connection to treatment and interventions for opioid misuse must also be implemented understanding the opioid epidemic is encompassed in the broader substance use crisis.

In 2018 and 2019, overdose fatalities in Michigan showed promising decline, however in 2020, preliminary data shows overdose deaths likely increased in Michigan and across the country. The COVID-19 pandemic has required innovations on traditional strategies, including integrating telehealth options, allowing mail-order distribution of naloxone and harm reduction supplies, and moving town halls to a virtual platform that allowed even more participation from all parts of the mitten.

In 2021, I commit to leading a Task Force that is action-oriented, focused on evidence-based solutions, and further develops cross-agency partnerships for collaboration and innovation in order to better address increasing racial disparities, support long-term recovery, and prioritize voices with lived experience. With an understanding that the impacts of the opioid epidemic are intersectional with social determinants of health, the Michigan Opioids Task Force is unwavering in commitment to reduce the impacts of the opioid crisis.

Sincerely,



Dr. Joneigh Khaldun, MD, MPH, FACEP
Michigan Opioids Task Force Chair
Chief Medical Executive and Chief Deputy Director for Health
Michigan Department of Health and Human Services

Executive Summary

In 2019, opioid overdoses killed 1,768 Michiganders, an average of almost five people every single day. In Aug. 2019, Governor Gretchen Whitmer announced the creation of a task force to align and coordinate departmental efforts to fight the opioid epidemic in the state of Michigan. This task force builds on the work of two prior task forces: A 2015 task force that assessed the causes of the epidemic and recommended high-level response actions and a 2018 commission that made further recommendations on response.

The Michigan Opioids Task Force, chaired by Dr. Joneigh Khaldun, chief medical executive and chief deputy for health at the Michigan Health and Human Services (MDHHS), is comprised of internal state government officials and tasked with providing policy recommendations to the director of MDHHS and coordinating departmental activities. The task force convened for the first time in Oct. 2019 to finalize the high-level MDHHS opioid strategic plan and outline the proposed values to guide the task force.

Five key values were proposed to guide the work:

1. Prioritize voices with lived experience.
2. Promote evidence-based strategies backed by a strong body of research.
3. Use data to inform strategy and track outcomes.
4. Collaborate with departmental partners and external stakeholders on response actions.
5. Remain action-oriented to address an ongoing crisis.

In addition, the task force convened a Stakeholder Advisory Group that included key stakeholders from academia, insurers, health care and substance use treatment providers, local philanthropy, community organizations, court officials, law enforcement, state lawmakers and those with lived experience. Over the course of 2020, the task force met three times and the Stakeholder Advisory Group met three times. Due to constraints stemming from the COVID-19 pandemic, the task force and stakeholder group were unable meet during the second quarter of 2020.

The COVID-19 pandemic has exacerbated the impact of the opioid epidemic in Michigan; preliminary data shows overdose deaths likely increased in 2020. In response to the impact of COVID-19 on opioid use, Michigan expanded telehealth services, relaxed rules on opioid treatment program take-home policies, expanded naloxone access, increased the settings offering medications to treat opioid use disorder (MOUD), and transitioned as much of the prevention and treatment systems as possible to a virtual setting.

Michigan Opioids Task Force Opioid Town Halls

The Michigan Opioids Task Force made it a priority to hear from the public. In 2020, MDHHS and the Michigan Opioids Task Force hosted six town halls to solicit feedback on the 2020 opioids strategy.

Town halls were hosted virtually and in-person, recordings of virtual town halls can be found linked below. A summary of key findings from the town hall series can be found in the Section IV.

- Detroit (in-person), Friday, Jan. 17, 2020.
- Northern Lower Michigan (virtual link), Wednesday, Sept. 23, 2020.
- Flint and Thumb Region (virtual link) Friday, Sept. 25, 2020.
- Upper Peninsula (virtual) Thursday, Oct. 8, 2020
- West Michigan (virtual link) Friday, Nov. 6, 2020.
- Macomb and Oakland counties (virtual link) Thursday, Dec. 3, 2020

Michigan's Opioid Crisis

Background:

In 2000, 183 Michiganders died of an opioid overdose. By 2019, that number was more than nine times higher. Drug overdoses now kill more people than car crashes and are the leading cause of injury-related death in the United States. In Michigan, the epidemic touches all areas of our state. The top 10 counties (right) with the highest fatal opioid overdose rates span all regions of the state, underscoring the widespread nature of the epidemic.

In 2018 and 2019, there was a moderate decline in the number of opioid related overdoses. In 2019, total drug overdose deaths (includes opioids and unspecified substances) decreased by 9.4 percent and opioid-related deaths fell by 13.2 percent. But, in 2020, the challenges of the COVID-19 pandemic, such as increased social isolation and decreased access to treatment services, exacerbated the already deadly drug overdose epidemic. Provisional 2020 data indicates an increase in total drug overdose deaths in Michigan.

Data also shows alarming racial disparities in overdose deaths. In 2019, the age-adjusted opioid overdose mortality rate fell by 16.9 percent for White residents but rose by 0.7 percent for Black residents. In addition, American Indian populations face disproportionately high rates of mortality in the state. National data indicates the COVID-19 pandemic is disproportionately impacting Black,

Top 10 Counties* Highest fatal opioid overdose rates (2019)		
County	**Age-adjusted rate per 100,000 residents**	**Overdoses**
Wayne	35.7	640
Genesee	35.4	138
Saint Clair	31.2	44
Ingham	28.1	78
Calhoun	26.1	31
Muskegon	26.0	44
Macomb	24.7	215
Monroe	23.2	30
Livingston	20.2	34
Washtenaw	17.3	58

2019 Death Certificates, MDHSS, Division for Vital Records and Health Statistics

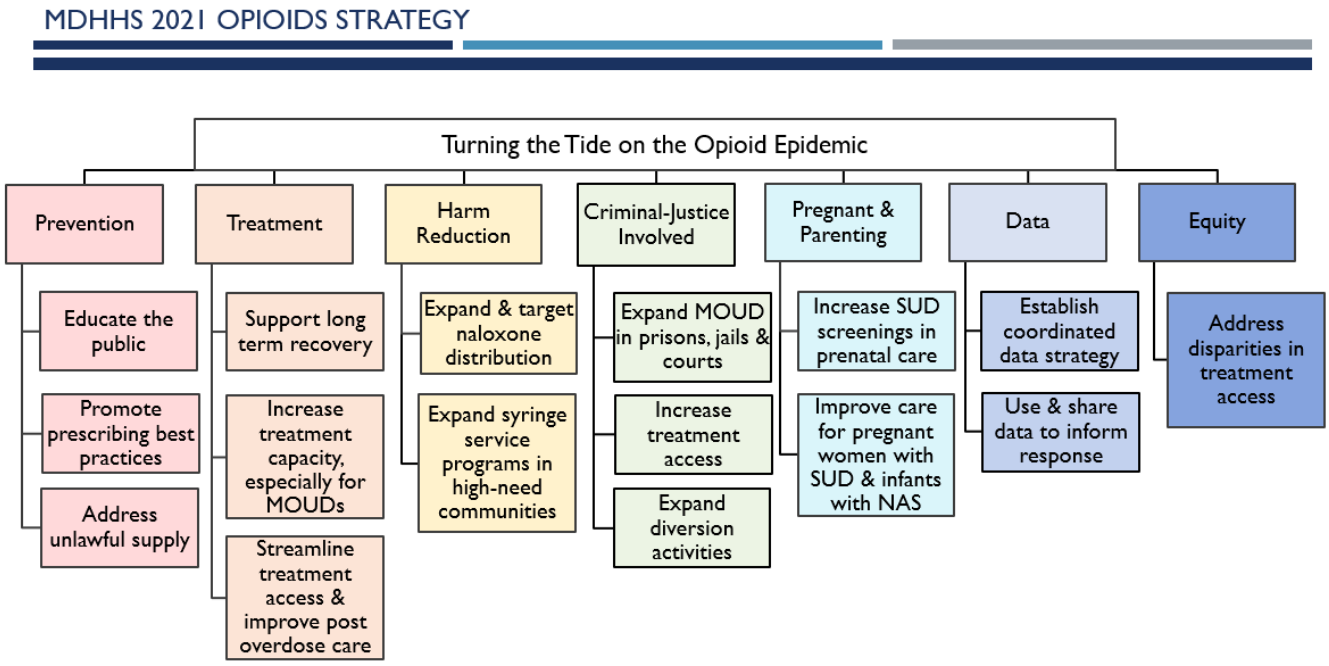
* Counties with < 20 overdoses have been suppressed due to statistical unreliability and to protect the confidentiality of individuals.

Indigenous, and other minority communities more severely than White communities, compounding with already growing racial disparities in Michigan.[1]

Michigan Department of Health and Human Services (MDHHS) Opioids Strategy:

In 2020, MDHHS developed an opioids strategic plan that was reviewed and adopted by the task force as the guiding strategy for Michigan's response to the epidemic. To catalyze action, Governor Whitmer announced a statewide goal to reduce overdose deaths by half in five years (by 2025). The opioids strategy begins with the framework of well-established public health principles: prevention, treatment and harm reduction. Within each of those categories, MDHHS and departmental partners have pursued recommended priorities likely to have the most significant impact on the epidemic, as demonstrated by available descriptive data, academic evaluations, and other states' experiences.

At the end of 2020, the Task Force reviewed and revamped to produce the 2021 Opioids Strategy (below) that maintains focus on 2020 priorities while increasing focus on reducing racial disparities. The strategy has outlined seven strategic pillars: 1) prevention, 2) expanding access to treatment, 3) harm reduction, 4) data, and 5) equity, along with efforts targeted to population at heightened risk of overdose, 6) pregnant women and new mothers and 7) criminal justice-involved populations. The task force's highest priority is to turn the tide of the opioid epidemic that took more than 2,400 Michigander's lives last year.



[1] Haley DF, Saitz R. The Opioid Epidemic During the COVID-19 Pandemic. *JAMA.* 2020;324(16):1615–1617. doi:10.1001/jama.2020.18543

Prevention

Prescription opioids account for the majority of opioid use (of 2.1 million individuals with opioid use disorder, 1.8 million reported using prescription opioids, and 650,000 reported heroin use (overlapping).[2] While illicit opioid use is the primary driver of mortality, research suggests that prescribing patterns play a substantial role in use: the greatest predictor for length of opioid use is length of prescription rather than diagnosis or similar criteria. [3] [4] MDHHS, the Michigan Department of Licensing and Regulatory Affairs (LARA), and other partners have been promoting the use of Michigan's prescription drug monitoring program, which tracks opioid prescriptions. Since 2015, total opioid prescriptions have decreased by 25 percent.

Decreasing prescriptions offers an impactful prevention measure, but directing educational outreach primarily to providers touches a significant lever of change. MDHHS is working closely with the Michigan Opioid Prescription Engagement Network (MI-OPEN) that educates medical professionals on best practices in perioperative pain management through prescribing guidelines developed with their clinical expertise.

MDHHS has provided support for local stakeholders to provide evidence-based prevention curriculum to vulnerable populations. The Prepaid Inpatient Health Plan (PIHP) regions were able to implement five youth and family focused evidence-based programs in their communities: The Strengthening Families Program, Botvin LifeSkills, Guiding Good Choices, Prime for Life, and Project Toward No Drug Abuse. Additionally, MDHHS, in partnership with Michigan State University Extension, is supporting prevention efforts for older adults (55 years and older) with high-risk behaviors that may lead to opioid use disorder. In total, these programs have reached over 2,000 Michigan youth and over 1,800 older adults.

MDHHS has also undertaken two significant public media campaigns to educate the public on opioid risks, reduce stigma, and increase awareness of harm reduction services. The latest media campaign (examples below) runs March 2021through Sept. 2021, with a primary focus on increasing awareness of harm reduction services as essential to decreasing fatal overdose.

[2] National Survey on Drug Use and Health, figure 20.
[3] CDC Injury and Prevention, Nationally, opioids were involved in 69.5% of all drug overdose deaths in 2018.
[4] Cite OPEN research.

Treatment

The opioids strategy includes a targeted focus on improving access to quality treatment for opioid use disorder (OUD). The National Academy of Sciences has found medications to treat opioid use disorder remain underutilized due to stigma, lack of provider training, and regulatory constraints.[5] A qualitative study in Michigan found similar barriers to MOUD but also identified lacking supports for social determinants of health, especially transportation, and potential implicit or explicit biases by race.[6, 7]

A key goal for MDHHS and the Michigan Opioids Task Force is to increase the number of physicians DATA 2000 waivered to prescribe buprenorphine. In partnership with MDHHS, the Michigan Opioid Collaborative (MOC) is assisting in the promotion of Blue Cross Blue Shield (BCBS) DATA 2000 waiver training and offering one-on-one physician support for treating patients with substance use disorder (SUD). In 2019, MDHHS removed prior authorization requirements for medications used to treat opioid use disorder, including buprenorphine, removing a key barrier for physicians prescribing MOUDs.

Michigan has also seen an increase in buprenorphine providers. In 2019, 16 counties did not have a buprenorphine provider, by 2020, only nine of 83 Michigan counties did not have a buprenorphine provider. In addition, the MDHHS Medical Services Administration (MSA) is reviewing Medicaid policy around payment for MOUD-related services in office-based settings through fee-for-service, with the anticipated final policy being published in spring 2021.

To address an insufficient number of addiction medicine and addiction psychiatry specialists in the state of Michigan, MDHHS partnered with the Michigan Collaborative Addiction Resources & Education System (MI CARES). MI CARES recruits, trains, and provides guidance to physicians who certify in Addiction Medicine through the American Board of Preventive Medicine (ABPM) practice pathway. To date, 43 physicians nationally have passed the exam to become certified in addiction medicine, 11 of those reside in Michigan. MDHHS is also working to build a provider network for treating patients with SUD. Over the course of 2020, the Michigan Opioid Treatment Access Loan Repayment Program provided medical education loan repayment to 20 medical providers. These providers, in turn, expanded the availability of opioid use disorder treatment in their community, increasing their net treatment numbers from 1,410 patients with OUD seen to 3,488 patients.

MDHHS is also supporting expansion of opioid-related treatment and recovery programming. Michigan's PIHP regions have expanded the use of peer support specialists in emergency departments, Federally Qualified Health Centers (FQHCs), urgent care, and other outpatient settings. PIHPs have also bolstered treatment and recovery for OUD by covering the costs of

[5] See National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. Available from: https://www.ncbi.nlm.nih.gov/books/NBK538936/ doi: 10.17226/25310
[6] Public Sector Consultants, Assessing Counseling Barriers for MAT Patients, internal study for MDHHS
[7] Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine Treatment Divide by Race/Ethnicity and Payment. JAMA Psychiatry. 2019;76(9):979–981. doi:10.1001/jamapsychiatry.2019.0876

uninsured and under-insured persons' care, providing transportation support to needed services and increasing the workforce in their respective regions. Additionally, PIHPs have increased the number of recovery homes certified by the Michigan Association of Recovery Residences (MARR), improving the infrastructure to support individuals' recovery from OUD. Mobile care units have been outfitted and implemented in communities where transportation to essential prevention and treatment services is limited or services are not available. Select PIHP regions have implemented Individualized Placement and Support (IPS) to assist individuals with co-occurring mental health disorders and OUD to secure stable employment. Finally, PIHP regions 1, 2, 4, and 9 have worked with MDHHS to implement Opioid Health Homes (OHH), which provide an intensive level of care management and coordination for qualifying individuals with an OUD and co-occurring diagnosis. PIHP regions 6, 7, and 10 are developing opioid health homes for implementation in 2021.

American Indians are especially vulnerable to OUD. MDHHS has partnered with the Inter-Tribal Council (ITC) to implement prevention, treatment, and recovery initiatives within the twelve federally recognized tribes in Michigan. These initiatives include the implementation of tribal action plans, which when enacted, require the federal government to assist tribes' efforts to address substance use in their community; the implementation of culturally tailored peer recovery support programs; tribal telehealth programs; expanded MOUD services; and enhanced evidence-based trainings to support tribal efforts, including overdose education and naloxone distribution.

The strategy also emphasizes increasing referrals to treatment or direct provision of MOUD at key intercept points for individuals with an addiction, namely emergency departments, and the criminal-legal system, which have staggering overdose risk upon release.

Hospital emergency departments (EDs) are significantly impacted by this crisis, treating an estimated 25,000 visits in Michigan for drug overdoses a year. Hospitals typically treat and release these patients, sometimes with a referral to an external substance use treatment provider. MDHHS, in partnership with the Michigan Opioid Partnership (MOP), is helping implement emergency-department based MOUD programming in hospitals across the state. In 2019, the partnership launched ED-based MOUD programs in three hospitals, by 2020, it had doubled to six ED-based MOUD programs. In 2021, MOP plans to expand to a total of 17 hospitals. Additionally, MDHHS, in partnership with the Michigan Health and Hospital Association (MHA) and MOP, is pursuing legislation to expand buprenorphine access into all emergency departments in the state.

In 2020, the Department of Insurance and Financial Services (DIFS) received federal approval to add two new benefits to treat opioid use disorder to the Essential Health Benefits Plan starting 2022 that will increase access to buprenorphine and naloxone across public and private health insurance. MDHHS is also working with partners at LARA to remove administrative barriers to MOUD provision by decreasing regulation of MOUD providers and promoting the use of telehealth through revisions to the administrative rules governing substance use treatment. These strategies have been particularly important in response to the COVID-19 pandemic restrictions on access to treatment.

Harm Reduction

The strategy also incorporates two key harm reduction initiatives – naloxone distribution and syringe service programs. Naloxone distribution decreases overdose deaths, and the strategy incorporates evidence-backed distribution tactics: targeting naloxone to high-risk individuals, areas, or social networks, addressing stigma, and offering naloxone through syringe service programs (SSPs).[8]

Research suggests that SSPs provide benefits beyond overdose reduction, including increasing the likelihood of entering treatment and decreasing communicable disease prevalence.[9,10] MDHHS has continued to expand SSPs across the state to a total of 65 SSPs in operation. As of March 2021, Michigan SSPs have distributed 31,964 naloxone kits and referred 2,036 individuals to treatment. During the COVID-19 pandemic, MDHHS has offered technical assistance to SSPs to adjust programming for the safety of clients and to reopen SSPs after temporary closures.

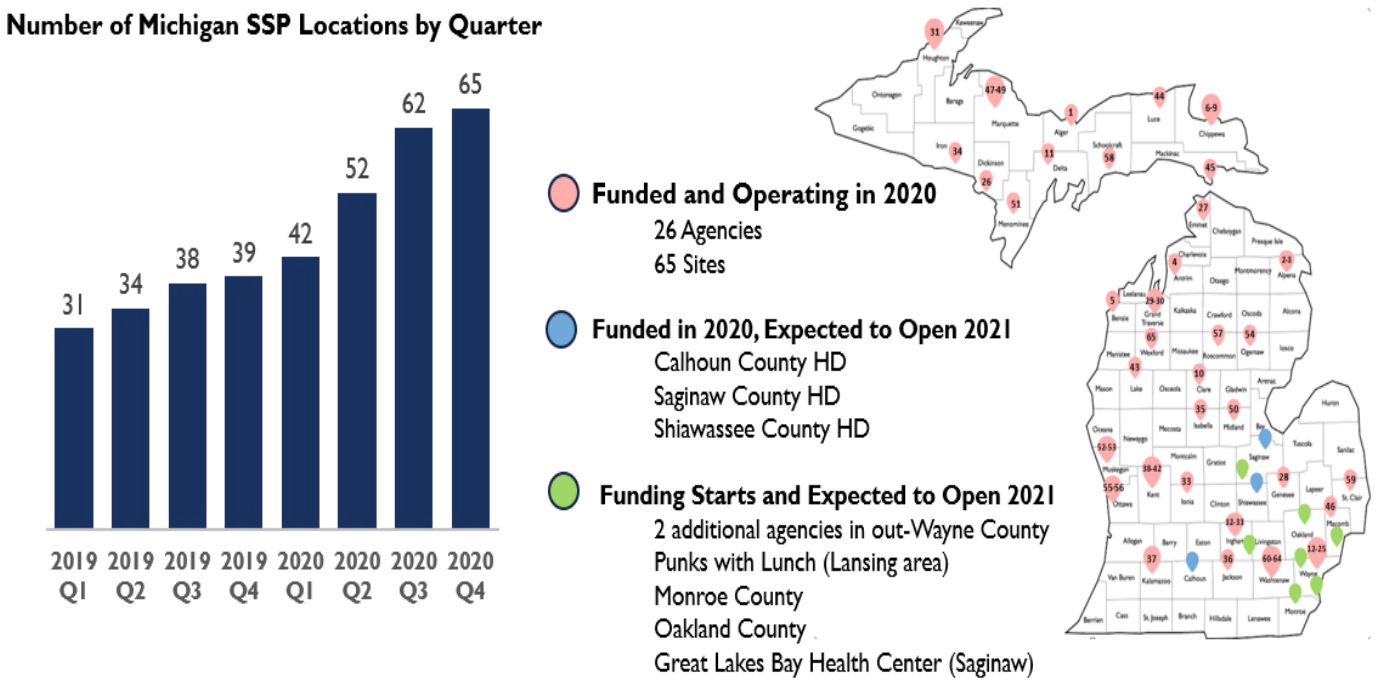
In Sept. 2019, the state of Michigan conducted one of the nation's largest single-day naloxone distribution days providing over 20,000 free naloxone kits statewide. Building on naloxone distribution day, Michigan publicly launched the Statewide Online Naloxone Portal for community-based organizations, local health departments, and PIHPs to access naloxone kits at no cost in June 2020. From Jan. 2020 through June 2020, pre-launch outreach was done to jails, SUD treatment providers, law enforcement, and Michigan Department of Corrections (MDOC) to increase naloxone distribution to individuals in active use or with a high risk of overdose, and those in closest proximity to them. Alongside the launch, MDHHS released an official statewide naloxone guidance prioritizing distribution to those actively using, ensuring individuals at highest risk have naloxone, and reducing barriers to access. MDHHS has also partnered with NEXT Naloxone to offer free mail-order naloxone to individuals. In addition, Chair Dr. Joneigh Khaldun hosted a statewide webinar with local opioid task forces encouraging adoption of the naloxone guidance. As of March 2021, the portal had distributed 88,812 kits.

During the COVID-19 pandemic, MDHHS data showed a significant increase in emergency medical services (EMS) responses for opioid overdoses, including a 33 percent increase from April to May 2020 alone. In response, MDHHS partnered with EMS providers to launch the EMS Leave Behind Naloxone Program that equips EMS providers with naloxone to leave behind with the patient, family and friends, or bystanders at the scene of a non-fatal overdose. Currently, Medical Control Authorities (MCAs) covering 20 counties in Michigan have adopted the protocol. In 2021, the task force and departmental partners will continue to do outreach to MCAs to encourage adoption of the protocol.

To compliment the ED-based MOUD programming implemented by the Michigan Opioid Partnership, MI-OPEN is supporting emergency departments in the development of naloxone distribution protocols for patients presenting to the ED with symptoms of an overdose. As of March 2021, MI-OPEN has partnered with 19 emergency departments and distributed over 1,241

[8] Id.; also https://www.fda.gov/media/121183/download
[9] SSP Quarterly Results Summary, internal MDHHS document.
[10] See CDC Evidence Summary, https://www.cdc.gov/ssp/syringe-services-programs-summary.html#linkage

naloxone kits. In 2021, MOP will work with seven local organizations to develop post overdose rapid response teams that connect with individuals in the community up to 72 hours after



2020 SSP Directory, MDHHS, Viral Hepatitis Surveillance and Prevention

experiencing an overdose. The individuals will be connected to harm reduction, treatment, or other community resources for ongoing support.

Justice Involved Populations

In carceral settings, MDHHS and the Michigan Department of Corrections (MDOC) have partnered with Medicaid, PIHPs, the Michigan Sheriff's Association, Wayne State's Center for Behavioral Health and Justice and local jails to make tremendous strides in increasing access to MOUD and streamline Medicaid re-activation for returning citizens post-release. Studies have shown higher engagement with treatment and improved outcomes for individuals receiving MOUD in those settings; for example, Rhode Island's statewide MOUD program in prisons and jails decreased mortality for returning citizens by a full 60 percent.[11] Currently, four MDOC facilities are piloting MOUD programs with the goal of expanding MOUD access to all facilities.

Individuals released from correctional facilities are 40 times more likely than the general population to die of an opioid overdose within the first two weeks following release.[12] Prior to

[11] Alexandria Macmadu, Joëlla W. Adams, S.E. Bessey, Lauren Brinkley-Rubinstein, Rosemarie A. Martin, Jennifer G. Clarke, Traci C. Green, Josiah D. Rich, Brandon D.L. Marshall, Optimizing the impact of medications for opioid use disorder at release from prison and jail settings: A microsimulation modeling study, International Journal of Drug Policy,2020,102841,ISSN 0955-3959,https://doi.org/10.1016/j.drugpo.2020.102841.

[12] Shabbar I. Ranapurwala, Meghan E. Shanahan, Apostolos A. Alexandridis, Scott K. Proescholdbell, Rebecca B. Naumann, Daniel Edwards Jr, and Stephen W. Marshall, 2018: Opioid Overdose Mortality Among Former North

launch of the naloxone state portal, targeted outreach was done to criminal-legal partners to emphasize the need for naloxone distribution from correctional settings. In addition, MDHHS is funding peer recovery coaches in MDOC probation offices to improve connections to post-release services and supporting the MISSION- Michigan Reentry Program (MI-REP) that offers pre-release services and post-release support to individuals with SUD.

The Michigan Joint Task Force on Jail and Pretrial Incarceration identified possession or use of a controlled substance as the sixth most common offense among jail inmates, recommending increased interventions to prevent individuals substance use needs from entering ("deflection") or staying in ("diversion") the justice system.[13] In response, MDHHS partnered with Vital Strategies to support the implementation of Law Enforcement Assisted Diversion (LEAD) programming in three communities – the City of Detroit, and Washtenaw and Muskegon counties – to prevent incarceration for opioid and other substance related offenses through referrals to treatment, harm reduction, and other social services. Additionally, in 2021 the State Court Administrative Office will expand supportive services for problem-solving court participants, and the Michigan Judicial Institute will provide training to judges on MOUD. PIHPs continue to work with local jails to implement and support the use of MOUD in jails. MDHHS also continues to support the Michigan State Police's (MSP) Angel Program and Families Against Narcotics' Hope Not Handcuffs, both of which leverage local and state police departments to connect individuals with treatment.

Pregnant and Parenting Women Populations

The strategy also includes a focus on pregnant and parenting women, as cases of neonatal abstinence syndrome (NAS) have sharply increased, and postpartum women face very high overdose risk. Pregnant and parenting women often face stigma from health care providers and are reluctant to pursue services as a result. To mitigate stigma and increase screenings for pregnant and parenting women, MDHHS is funding the High Touch, High Tech (HT2) project in select areas. HT2 uses a tablet-administered app to screen pregnant women for mental health and substance use disorders and offers a variety of options for follow-up. These include sharing the information with their medical provider, referral information for treatment services, and the use of a mobile application with additional resources based on their need. In 2021, HT2 will be expanding from small clinics to prenatal clinics throughout the Upper Peninsula and the Thumb region.

Infants born to women with opioid dependence often experience withdrawal symptoms in the hours and days following birth. Usually, infants with NAS are treated in a neonatal intensive care unit (NICU) using pharmacological solutions. Although, in recent years, studies have found a different approach of rooming-in with mothers after birth and providing a quiet room for skin-to-skin time, swaddling, feeding, etc. along with pharmacotherapies, if necessary, improved

Carolina Inmates: 2000–2015, American Journal of Public Health 108, 1207_1213, https://doi.org/10.2105/AJPH.2018.304514

[13] The Michigan Joint Task Force on Jail and Pretrial Incarceration Report and Recommendations

outcomes for infants with NAS.[14] In the eastern Upper Peninsula of Michigan, MDHHS in partnership with War Memorial Hospital in Sault Ste. Marie has retrofitted several rooms to serve infants with NAS and parenting women with opioid dependence. MDHHS is also working with Hurley Medical Center in Flint and Munson Medical Center in Traverse City to implement rooming-in care.

Data

The opioids strategy also includes a focus on improving data tracking. MDHHS continues to develop a data strategy to align numerous data sources to derive insights and use those insights to drive the Task Force, inform policy decisions, and share with external stakeholders to inform their decision-making as well.

Care Connect 360 (CC360), an MDHHS owned care coordination platform, is being leveraged to facilitate data sharing between health systems, community providers, Medicaid, and jails. Initiatives to provide access to CC360 in new settings are underway as well as projects to bring new data into the MDHHS data warehouse to support more informed and rapid responses to opioid related crises in patients across the state. A key project emerging in response to the COVID-19 pandemic would allow Michigan's Prepaid Inpatient Health Plans and PIHP contracted providers access to opioid Admission Discharge Transfer (ADT) notifications to perform light touch outreach (i.e., telephone calls) to overdose survivors to check their wellness and connect them with resources and services that decrease risk of future overdose mortality.

MDHHS partnered with the Bureau of Licensing and Regulatory Affairs to integrate Michigan's prescription drug monitoring program, called the Michigan Automated Prescription System (MAPS), into existing electronic medical records and pharmacy dispensation systems. In the year-long partnership, 395 health systems, hospitals, pharmacies, and physicians' offices integrated MAPS into their service protocol, and another 343 were pending integration.

MDHHS also partnered with the University of Michigan Injury Prevention Center and the Michigan High Intensity Drug Trafficking Areas to expand the System for Opioid Surveillance (SOS), which provides close to real-time mapping of fatal and naloxone administration to authorized public health and safety officials. Select local health departments have been chosen to develop statements of work and evaluation processes to enhance prevention efforts and reduce overdose injuries and fatalities.

MDHHS Overdose Data to Action (OD2A) grant team, through funding from the Centers for Disease Control and Prevention (CDC), is helping improve data collection from sources such as emergency departments, EMS responses, and medical examiner's offices, etc. Through this work, Michigan is able to better track the complex drug overdose epidemic and tailor prevention efforts.

Additionally, MDHHS is developing a dashboard to monitor progress on the state opioids strategy and its impact on fatal and non-fatal overdose across the state. The dashboard will

[14] MacMillan KDL, Rendon CP, Verma K, Riblet N, Washer DB, Volpe Holmes A. Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome: A Systematic Review and Meta-analysis. JAMA Pediatr. 2018 Apr 1;172(4):345-351. doi: 10.1001/jamapediatrics.2017.5195. PMID: 29404599; PMCID: PMC5875350.

provide data to the public and help to monitor the extent to which the opioid strategy is having its intended impact.

Equity

Finally, the opioids strategy includes a focus on racial equity to address the disparities seen in mortality data. MDHHS recognizes that racial equity is a foundational framework to the entire opioids strategy that impacts all of the work, but to address the disparities Michigan sees, specific programming focuses on reducing racial inequity.

MDHHS is funding community-based organizations to target outreach of services in majority-minority communities and conducting surveys with beneficiaries to understand how our crisis response can be more effective for these communities. The Department of Licensing and Regulatory Affairs is also releasing guidance on mandated implicit bias training for all licensed healthcare professionals to address racial bias in healthcare settings. The training is anticipated to be taken by over 400,000 healthcare providers.

Key Recommendations for Long-term Investments

In 2019, Michigan and many of its municipalities filed lawsuits against numerous corporations in the opioid industry in response to the increase in overdose deaths. Settlement negotiations regarding these lawsuits are ongoing, sparking discussions on potential avenues for long-term investment.

MDHHS recommends these key principles to guide future funding:

- Address systemic barriers to treatment – Michigan funds substance use disorder treatment through Medicaid, Healthy Michigan, and the federal Substance Abuse Prevention and Treatment Block Grant that provide services following federal rules. Michigan received additional discretionary grants to fund short-term services that provide more flexibility than existing federal funding but are slated to end in the near term. Settlement dollars should focus on critical services that are not eligible for ongoing federal funding.

- Provide equitable distribution of funding – Reducing disparities must be a focus of all programs funded with settlement funds. Funds to prevent harm should be allocated in a manner calculated to do the most good with the funds available, including by reducing harm among demographic groups that have been disproportionately impacted.

- Sustain Syringe Service Program infrastructure. SSPs offer critically needed resources, supplies, naloxone, and treatment referrals to those using injection drugs to prevent overdose and disease transmission. Michigan has expanded the number of SSPs with federal discretionary grant funding that is slated to end in 2022. Direct funds to maintain operations of existing SSPs and fund to the creation of new SSPs.

- Establish sustained funding to support the provision of Medications to treat Opioid Use Disorder in jails, prisons and juvenile justice facilities, and enhance coordination between

community and carceral settings for direct care delivery to be successful. Persons with opioid use disorder are disproportionately represented in the criminal legal system and are as much as 40 times more likely to overdose post-release. Medicaid does not fund services in carceral settings, leaving them underfunded relative to need. Michigan has used federal discretionary grants to provide funding for treatment services in jails in prisons that is slated to end in 2022.

Appendix

2020 Town Halls Key Findings and Response

In 2020, MDHHS and the Michigan Opioids Task Force hosted six town halls to solicit feedback on the 2020 opioids strategy. One stakeholder roundtable event was hosted before the Detroit Town Hall with local stakeholders to discuss how the opioid epidemic is impacting stakeholders in Wayne County. Due to the COVID-19 pandemic forcing future town halls onto a virtual platform, stakeholder roundtables were not hosted before virtual town halls.

1. **Expanding access to treatment.** Residents across the state expressed that there is not enough treatment available in their communities. Rural communities emphasized the lack of access to Methadone clinics.

In response,

- MDHHS is expanding treatment access by funding hospitals to begin emergency department-based Medication Assisted Treatment (MAT) programs.
- MDHHS through a partnership with MOP is also funding six post-overdose follow up response teams to do in-person outreach 24-72 hours after an overdose and connect individuals to services.
- MDHHS directed funding to stand up a new Methadone clinic in St. Ignace in the Upper Peninsula, previously there were no Methadone clinics in the U.P.
- MDHHS through a partnership with the Michigan Opioid Collaborative continues to fund technical assistance to providers treating individuals with opioid use disorder.

2. **Expanding harm reduction services.** Residents encouraged the state to increase access to clean injection supplies and naloxone.

In response,

- In June 2020, MDHHS launched a naloxone portal to provide free naloxone to community organizations across the state. MDHHS also partnered with NEXT Naloxone so that individual Michiganders to access mail order Naloxone.
- MDHHS has continued to expand the number of syringe service programs from 25 operating SSPs in 2018 to 64 operating SSPs in 2020.
- MDHHS is pursuing legislation to clarify state and local laws regarding the legality of SSPs.

- MDHHS Viral Hepatitis Team, alongside the National Harm Reduction Coalition (NHRC), are providing technical assistance to syringe service programs statewide.

3. **Stigma in the delivery of substance use disorder services.** Residents emphasized the impact of stigma when accessing treatment for substance use disorder, often wanting to know what concrete actions MDHHS and the Opioids Task Force plan to take to address stigma.

In response,

- In 2020, MDHHS launched a media campaign focused on stigmatizing language. In March 2021, MDHHS, with support from Vital Strategies, launched a media campaign focused on reducing stigma in majority-minority communities, particularly around harm reduction services.

4. **Rise in polysubstance use and increase in non-opioid drug use and overdose.** Residents called particular attention to the rise in cocaine and meth use in their communities.

In response,

- In response, MDHHS is now able to use federal opioid funding to treat stimulant use disorders.
- MDHHS is funding training for providers Contingency Management, a treatment practice that has been shown to be effective for individuals using stimulants.
- MDHHS Viral Hepatitis Team, alongside NHRC, are providing harm reduction technical assistance specifically for people who use stimulants.

5. **Enhanced treatment services for those with an OUD that are involved in the criminal-legal system.**

In response,

- MDHHS is funding technical assistance and programmatic support in county jails across the state to expand medication assisted treatment.
- MDHHS is implementing a grant-funded initiative to improve data sharing between jails and Medicaid and enhance care coordination using Care Connect 360, a state-owned care coordination platform.
- MDHHS has funded MDOC to provide MOUD in their facilities and to equip parole offices with peer support specialists.

6. **Supporting individuals in recovery**. Residents expressed concerns about a lack of housing, transportation, and employment for those in recovery from substance use disorder.

In response,

- MDHHS funds recovery housing and transportation through block grant and federal discretionary grants.

- MDHHS is actively exploring options and additional funding to expand these services.

7. **Impact of COVID-19**. COVID-19 caused disruptions in the delivery of services and residents wanted to know how MDHHS plans to address changes to service delivery due to the pandemic moving forward.

In response,

- MDHHS relaxed treatment rules, promoted telehealth and issued emergency policy changes to pay for telehealth services to ensure continued access to care during the pandemic.
- MDHHS is implementing an initiative to provide opioid overdose Admission, Discharge, Transfer data to regional coordinating entities to do direct outreach and create a direct path to services for high-risk individuals.

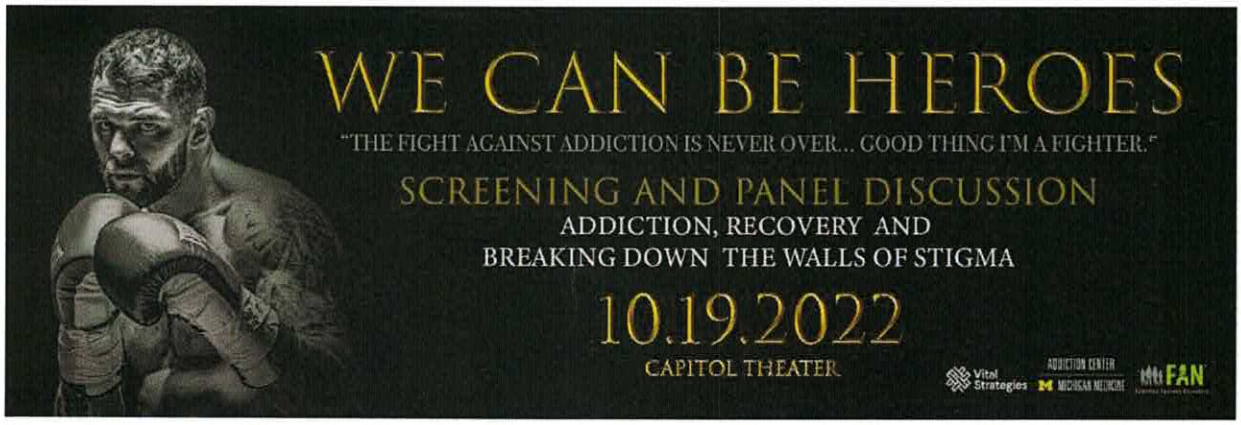
Overview of Opioid Task Force Legislation

The Michigan Department of Health and Human Services, in partnership with Michigan legislative partners from the Stakeholder Advisory Group, are pursuing three pieces of legislation to strengthen the state's response to the opioid crisis.

1. Require that hospitals have a post-overdose care protocol that includes the capability to induce patients on opioid agonist medication and connect them to community care.
2. Permit the state's Chief Medical Executive to issue a standing order for community-based organizations to directly purchase and distribute naloxone, mirroring the existing standing order that allows pharmacists to dispense naloxone to patients without an individualized prescription.
3. Strengthen existing legal protections for syringe service programs, which distribute clean syringes and other equipment to decrease the spread of communicable diseases. Under current state law, syringes distributed by public health programs are not drug paraphernalia; proposed legislation would clarify state law.

Acknowledgments

The Michigan Opioids Task Force wishes to acknowledge the countless hours of work provided to it by key staff members in the Office of the Governor and the Michigan Department of Health and Human Services. The Task Force also wishes to acknowledge the continued support from Vital Strategies, a global public health organization that has committed funding to projects of the Task Force as well as for staff to maintain the Task Force.



Wednesday October 19th, 2022 we would like to invite you to an evening of art, film and dialogue at the Beautiful Capitol Theater in Flint. This FREE event starts at 5:30 p.m. with a curated art show, featuring local artists in recovery, followed by a screening of "We Can Be Heroes," documentary film directed by Mike Ramsdell. There will be a post-film panel discussion featuring the Taylor Duerr, Mike Ramsdell, and others who have experienced the stigma of substance use disorders. This is an evening you won't want to miss.

Tickets - Tickets are free and must be reserved in advance. Visit our event webpage: *www.michmed.org/RWJ3b*

About the Film - *We Can Be Heroes* follows Detroit's own Taylor "Machine Gun" Duerr as he fights his way to a national boxing title inside the ring, while fighting the demons of his past heroin addiction out of the ring.

HEROES

FIGHT STIGMA

Event Schedule

5:30 pm - Recovery-related art show featuring local artists
7:00 pm - Documentary film screening of 'We Can Be Heroes' Directed by Mike Ramsdell
8:30 pm – Panel discussion on addiction stigma moderated by the U-M Addiction Center & Narcan training

Speakers Panel - Immediately following the film screening will be a Q&A on addiction stigma moderated by Frederic C. Blow, Ph.D., Professor and Director, University of Michigan Addiction Center, Department of Psychiatry. Panelists include:

- Kenneth Briggs -Program Relations and Business Development Administrator for Meridian Health Services, Meridian Health Services
- Taylor Duerr - Professional Boxer, Father, and Person in Recovery
- Lewei Allison Lin, M.D., M.S. - Assistant Professor, Department of Psychiatry, U-M Addiction Center, Director of the Addiction Psychiatry Fellowship Program, Practicing Addiction Clinician, VA Ann Arbor Healthcare System, Research Scientist, VA Ann Arbor Healthcare System
- Bobby Mukkamala, M.D. - Flint Resident. American Medical Association Board of Trustees, Genesee County Medical Society Immediate Past President
- Mike Ramsdell - Born and raised in Flint, MI. Director & Producer, Under The Hood Productions

Stigma Workbook - All attendees will receive a free print copy of the workbook: *I'm Still a Person: The Stigma of Substance Use & Power of Respect* to learn about and address stigma within themselves, their families, and their communities.

Art Show - The Open call for art has begun. Learn more. The art show is an opportunity for local artists who have struggled with substance use disorders, and their families and community members, to create art that reflects their experience and their hope.

The Deliberate Planning Process (Condensed version)

Establish the framework for the planning process. There are many different planning models. This example is based on the military planning process. See attached example of the Strategic Planning Flow Chart. Regardless of the size and scope of the plan or operation the planning steps remain the same. Planning steps are typically modified based on the time available to develop the plan. Crisis planning is a condensed version of the planning process when time available is extremely short. I've condensed the planning process to the following steps.

1. Receive the mission
2. Analyze the mission
3. Developing, analyzing and approving a possible course of action
4. Transition from planning to preparation

Step 1. Receive the mission

Gather information, tools and leaders to begin the planning process.

Step 2. Analyze the mission

This planning phase begins by gathering available information and resources. During this phase facts, assumptions, critical tasks, implied and specified tasks are all identified. It is also important to identify the constraints, limitations and risks during this period. Based on the evidence gathered, a planning timeline and potential outcomes of the initiative, project, or plan can begin to be seen. This phase ends with the presentation of the evidence to key stakeholders, an estimate of potential outcomes and a recommended course of action for the next phase of planning. The key stakeholders then agree on the course of action or change the course of action and provide further guidance. They agree on a planning timeline or can decide to end future planning and support efforts based on the risk assessment.

Requested planning guidance from key stakeholders at the end of this planning phase:

- Intent, critical task, and desired outcomes (Vision)
- Support relationships needed
- Timeline and resources available
- Risk assessment*

Expected Results or Decisions – Level of Engagement, initial guidance and intent, requests for information, approved timeline, and risk assessment

Step 3.

Developing a course of action or plan and building support is the next phase of the planning process. This phase begins with adopting a clear mission and vision by stakeholders. Intent, critical task and end results shape the vision statement. A clearly defined mission statement is also agreed upon. Relationships and responsibilities are clearly defined during this phase. Risk mitigation measures are in place and monitored. Also during this phase there is an approved commitment of resources. A tentative plan or course of action to assign personnel and resources over time is completed. This phase ends with an approved plan or course of action and initiation of drafting the agreed upon plan.

Guidance from Key stakeholders requested:

- Approved Mission statement and vision including critical tasks and end results.
- Approved course of action or plan to achieve critical task and achieve identified results.

Expected Results or Decision – Level of Commitment, approve the plan,

Step 4.

The final planning phase is the transition of planning to the preparation phase. This phase includes increasing awareness and support for the plan and shared vision. It also includes solidifying support systems, monitoring requirements, and reporting. This phase includes the securing of resources for long term sustainment. Evaluation criteria are developed and put in place to measure the effectiveness and efficiency of the organization in relation to advancing or supporting the mission and vision. The evaluation criteria will help determine reporting requirements and procedures for maintaining accountability of the organization. This phase ends with a completed draft plan available for review.

Guidance required:

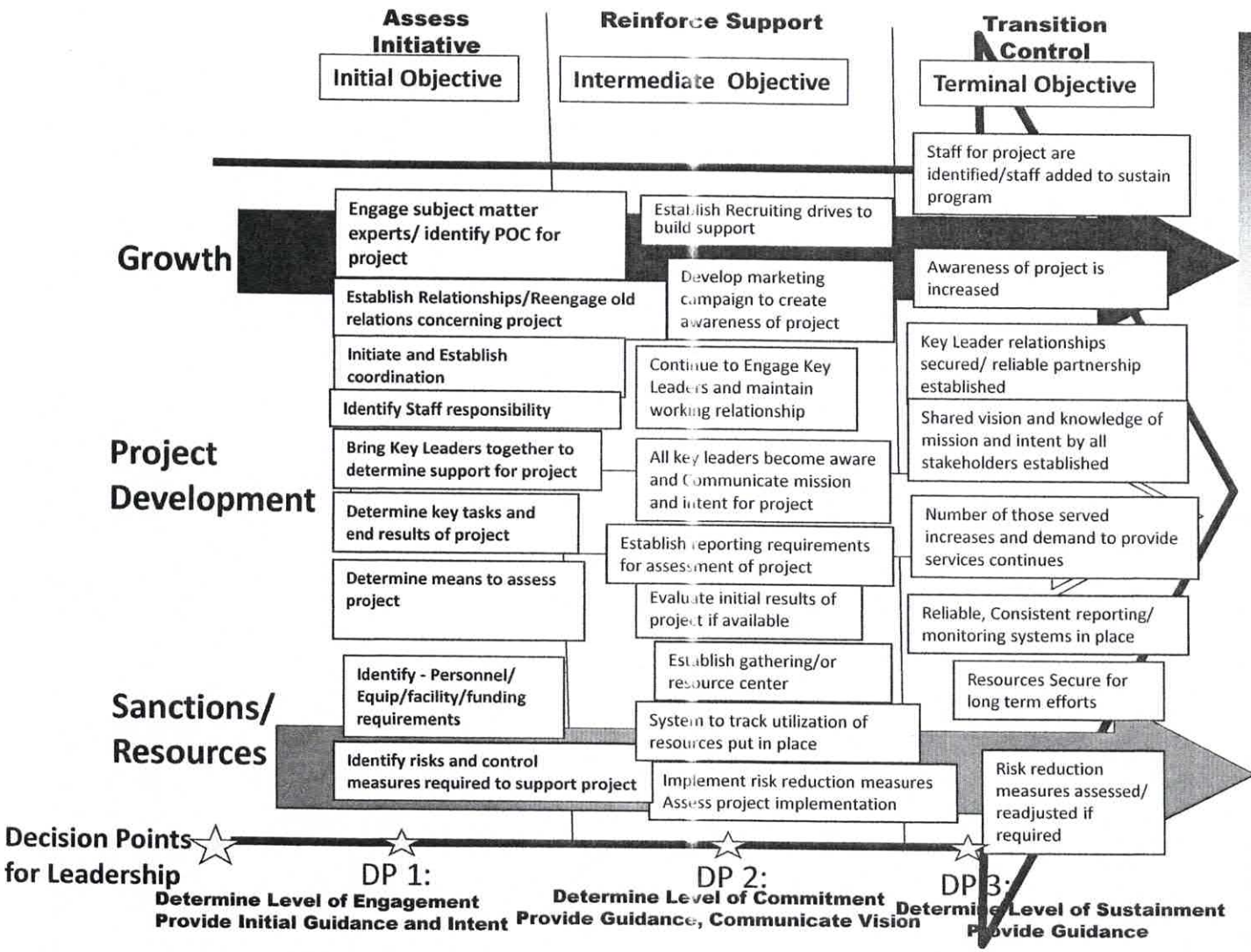
- Level of resources committed to sustain effort/program.
- Reporting requirements to assess end results.
- Evaluation criteria and accountability measures.

Results and Decisions – Level of sustainment, reporting required, evaluation criteria, draft plan for review.

*Initial risk assessment is conducted early in the planning process and updated throughout.

1. Potential hazards are identified considering probability and severity for each hazard.
2. Controls to mitigate these hazards are identified or are already present.
3. Additional controls are implemented to reduce risk to a manageable level.
4. A means to monitor and supervise the controls and assess the residual risk are in place.

The results of the planning process are reviewed periodically to clarify stakeholder intent and receive further guidance for future planning.



-End Results-

Growth

1. Staff to manage process are trained and in place.
2. Awareness of process confirmed by all users.
3. Key leadership in place and working partnerships are established.
4. Process to link service with all stakeholders is established.

Process in Place

1. Majority of the DHHS and PAFC users recognize the program as supportive and productive
2. Process is equitable and transparent throughout the BSC.
3. Awareness of all referrals has increased significantly as a result of the process.
4. Results of new process are tracked and utilized to sustain and improve future placements.
5. Benefits of process are recognized and communicated to other BSCs and PAFCs.

Sanctions/Resources

1. Staff resources in place along with systems to sustain the staff for long term operations.
2. Process is run in accordance with Director's intent and supports MI FC contract agreements.
3. Process is managed by leaders who communicate and coordinate decisions with all stakeholders.
4. Internal and external program review systems are in place to assess results of program.