MICHIGAN **OPIOID ADVISORY COMMISSION**

2023 ANNUAL REPORT

A PLANNING GUIDE FOR **STATE POLICY MAKERS**

MICHIGAN LEGISLATIVE COUNCIL

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LETTER FROM THE CHAIR

To our communities,

As I've had the privilege of working alongside my fellow commissioners over the last seven months in steering the Opioid Advisory Commission, I've often looked around the room in amazement over how so many great minds are together advocating for safe, appropriate, careful, and thoughtful use of the funding. Centered around deeply personal and professional desires to improve the lives of Michiganders, we came together as volunteers to serve.

Our goals have remained consistent: to support Michigan with informed, intentional, and collaborative solutions for the use of funds from opioid litigation; solutions that are deliberate, transparent, and carefully planned because that's what the residents of this state deserve. Our commission includes members with lived experience who have been personally impacted by Michigan's opioid epidemic; members whose families have been deeply impacted by the opioid epidemic. The issue is personal to our commission—as it is for many individuals and families throughout this state who have also been impacted by harms from opioids.

Given the scope and impact of the issue, we are determined to do more as a commission. While our role is advisory, we aim to take an honest, ethical, and objective look at current practices to understand better where opportunities for improvement lie.

Michigan's opioid epidemic, including issues of health equity, access to care, and meaningful support for residents and families experiencing substance use disorders and mental health conditions, is not defined by politics—it is not restricted to one governmental branch, one departmental entity. It requires collaboration in action and not merely in statement. We need meaningful partnership across systems, communities, jurisdictions, and branches, to find impactful (and innovative) solutions that can do what they are intended to do: improve the lives of all Michiganders by addressing root causes of substance use and mental health conditions, and the harms caused by opioids.

As a commission, we are committed to doing more—engaging Michigan's communities actively and authentically; learning about the unique needs and priorities of communities, especially those which have been historically left out of conversations around what the problem is, as seen from their perspective. We aim to develop collaborative solutions. As a commission of community representatives from throughout the state, we encourage Michigan residents to engage, ask questions, and hold us, as the Opioid Advisory Commission, accountable. Open and honest dialogue about the opioid epidemic, how it has impacted each community uniquely, and how we as a state, can do more to help support Michigan's communities affected by opioid harms, is the only path forward.

What follows is the Opioid Advisory Commission's plan to encourage and increase collaboration and transparency so we may do our statutorily defined job to the utmost of our abilities. As an addiction doctor, I want more. As a mother, I demand more. As a sister whose brother died of substance use related causes, I will fight for more.

Respectfully,

Cara Poland, MD, MEd

Cara Poland, MD, MEd, FACP, DFASAM

2023 EXECUTIVE SUMMARY

Understanding the Facts

Michigan's Opioid Epidemic and the National Opioid Settlements

In Michigan, over eight people die every day from overdose.[1] There were nearly 3,100 fatal overdoses in 2021 and while preliminary state data for 2022 shows a slight reduction in total overdose deaths, fatal overdose rates remain largely unchanged. Individuals of color continue to be disproportionately impacted by overdose. In Michigan, Black individuals are dying at over twice the rate of their White counterparts[2] and remain overrepresented in rates of emergency department visits for non-fatal overdose.

Michigan's opioid epidemic is complex. Understanding it requires acknowledging it is not merely about "opioids"—rather multiple intricate and interconnected factors that have produced health inequities and made entire communities susceptible to adverse health outcomes. These impacts have been exacerbated by the availability of prescription opioids and the false messaging around their minimal health risks. This is ultimately the basis for national opioid litigation: **pharmaceutical opioids caused harm to the public and the companies that manufactured, distributed, marketed, and dispensed them, should be held responsible for those harms.**

As a result of the national and tribal opioid settlements, companies are required to direct funds to states, local subdivisions and tribes. The Opioid Advisory Commission (OAC) was created to satisfy requirements of the national opioid settlements as the designated state entity to advise the Michigan legislature on appropriate use of opioid settlement funds.

The Opioid Advisory Commision: Role and Activities

In May 2022, Public Act 84 (MCL 4.1851)[3] was enacted, establishing twelve (12) voting members, legislatively appointed in June 2022; Dr. Cara Anne Poland, M.D., M.Ed. was elected Chair at the OAC's initial meeting, August 31, 2022. Current membership includes community leaders and subject matter experts in the fields of behavioral health, addiction medicine, recovery, maternal/fetal health, youth prevention, diversion and specialty courts, community health and community advocacy; the Director of the Michigan Department of Health and Human Services (MDHHS) and the Administrator of the Legislative Council serve as ex-officio members on the commission.

In its inaugural year, the OAC strived to promote cross-system collaboration and encourage information sharing to support collective, data-driven solutions for opioid settlement planning. Since December 2022, the OAC has held nearly seventy (70) engagement meetings with key state offices and community partners; it aims to increase community engagement efforts for fiscal year 2024. It convened a cross-branch settlement workgroup with representation from both state and local partners, which remains active. The OAC also participates in national learning networks on the opioid settlements, including workgroups facilitated by the National Academy for State Health Policy (NASHP)[4] and the Colorado Attorney General's office.

Despite its best efforts, the OAC encountered numerous challenges in accessing information that may have otherwise supported completion of critical, statutory tasks. Barriers were noted in meaningful information flow around current and proposed planning efforts of the state, specific to opioid settlement funds and broader opioid response activities.

As a result, the OAC relied almost exclusively on publicly available information, which ultimately served to highlight broader information gaps, specifically (1) the lack of sufficient reporting mechanisms required for use of opioid settlement funds, (2) limited public transparency around settlement planning and implementation efforts and (3) minimally publicly accessible information. Significant structural gaps were also noted in the lack of accountability and oversight measures for state use of opioid settlement funds.

Promoting Better Practices with National Guidance

Through ongoing participation in various national workgroups, the OAC gained an informed understanding of nationally recognized standards (guidance) for the use of opioid settlement funds: the Bloomberg/Hopkins Principles.[5] Similarly, it gained recognition of other state practices that Michigan has not adopted: Michigan is in the minority, lacking defined reporting requirements and is one of seventeen (17) states that do not appear to have language outlining reporting protocols for use of State opioid settlement funds. [6]

While there are no statutory requirements for entities to report to the public on the use of opioid settlement funds, ethical considerations for transparency are noted, given the nature of the national opioid settlements; dollars are being directed to the state because harm has been caused to Michigan's residents, the most serious of which has been death, from pharmaceutical opioids. National guidance also supports public reporting on use of opioid settlement funds.

As information gaps and limitations in statutory requirements have challenged fulfillment of the OAC's critical tasks, this document has been developed as a planning guide to assist state policy makers with a baseline understanding of the subject matter and an assessment of the opioid settlement landscape in Michigan, including current practices, strengths and limitations.

Recommendations for FY 2023 -2024

The OAC aims to support the legislature, the state and all Michigan residents with considerations for responsible planning, use and management of State opioid settlement funds, thus the following recommendations are strongly encouraged by the OAC and are being offered for legislative consideration:

(1) Increase awareness of the Bloomberg/Hopkins Principles for Use of Funds From Opioid Litigation; support practices that help Michigan adopt the "Principles" in all settlement planning and implementation efforts (see Section 4: Strategies for Adopting the Bloomberg/Hopkins Principles, pages 29-38)

(2) Support the OAC's FY 2023-2025 strategic plan, including adoption of all funding and policy recommendations (see Section 5: Findings and Recommendations, pages 40-46)

(3) Encourage public transparency and governmental accountability for use of opioid settlement funds by increasing oversight capabilities of the legislature through increased reporting requirements (see Section 5: Findings and Recommendations, pages 40-44)

(4) Improve current monitoring and authorization protocols for "State Share" opioid settlement funds, including requiring detailed spending plans and the creation of sub-funds within the Opioid Healing and Recovery Fund (see Section 5: Findings and Recommendations, pages 40-44)

(5) Promote cross-branch partnership, information-sharing and collaborative strategic planning to support informed decision-making on use of opioid settlements funds and data-driven recommendations, by the OAC (see Section 5: Findings and Recommendations, pages 40-44)

OAC 2023 ANNUAL REPORT

SECTION 1

GOALS AND BACKGROUND

2023 Annual Report: A Planning Guide for State Policy Makers
Background: Michigan's Opioid Epidemic

2023 ANNUAL REPORT

A PLANNING GUIDE FOR STATE POLICY MAKERS

Goals of the Planning Guide

This document is the inaugural report for the Opioid Advisory Commission and has been written as a planning guide to support state policy makers in the following ways:

- **Building competency of national opioid litigation:** increasing awareness of the national opioid settlements, key components, and settlement payment structures for Michigan
- **Building familiarity with nationally recognized guidance on the use of opioid settlement funds:** providing information on the Bloomberg/Hopkins Principles and recommended practices for planning, use and management of opioid settlement funds
- **Increasing awareness of gaps** that may hinder efforts in planning, monitoring, and administration of State opioid settlement funds
- **Providing strategies to address all policy, service, process, and structural gaps**
- **Promoting practices that improve integration of the Bloomberg/Hopkins Principles** for planning and implementation related to State opioid settlement funds
- **Providing transparency on strategic planning efforts of the OAC**, including rationale behind recommended strategies and initiatives
- **Enhancing cultural competency for planning and implementation efforts**
- **Improving competency of substance use disorders (SUD), mental health conditions and co-occurring disorders (COD)**
- **Offering guidance on how best to plan, use, monitor and manage State opioid settlement funds**

Considerations for State Policy and Funding

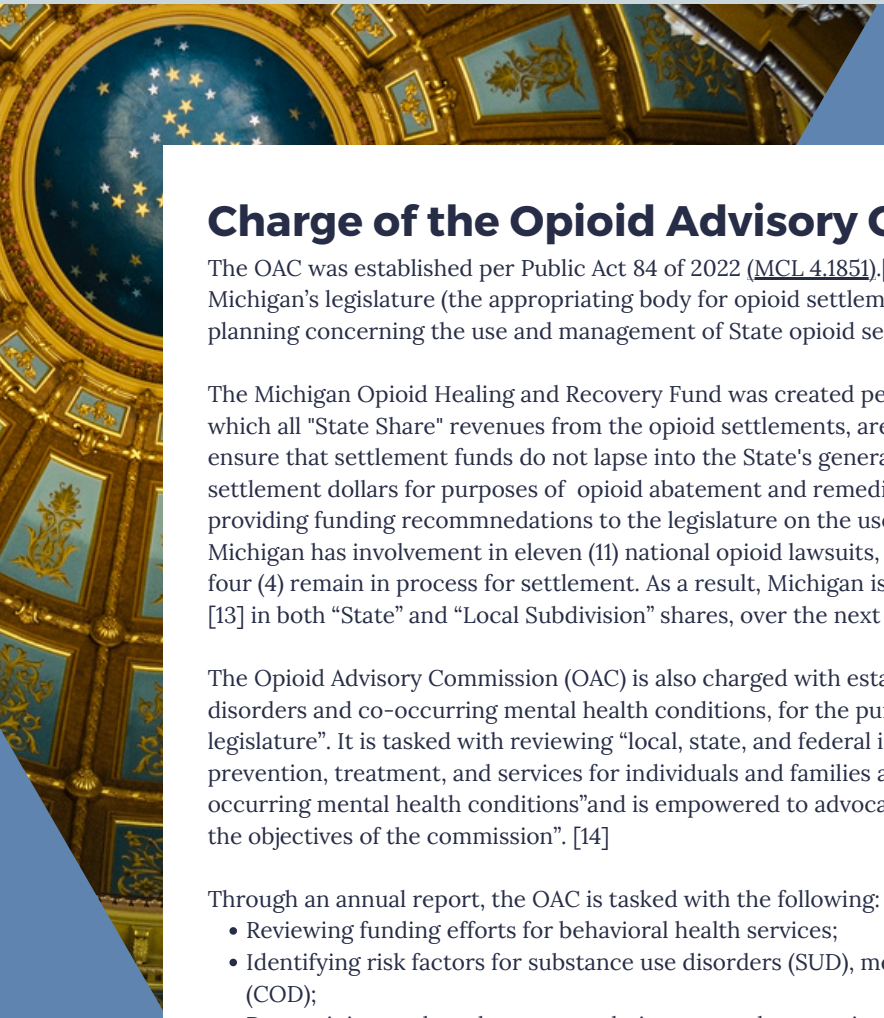
As both a planning guide and a foundational document, the 2023 report is intended to frame broader considerations for State policy and funding related to (1) substance use disorders (SUD), mental health conditions and co-occurring disorders (COD), (2) the behavioral health care continuum (prevention, treatment, recovery, and harm reduction services) and integrated care efforts (SUD treatment, mental health services, recovery supports, medical care and access to social services) and (3) the use of State opioid settlement funds for abatement and remediation of Michigan's opioid crisis.

"Opioid abatement and remediation" are what drive all activities related to State opioid settlement funds. This captures all "programs, strategies, expenditures, and other actions designed to prevent and address the misuse and abuse of opioid products and treat or mitigate opioid use or related disorders or other effects of the opioid epidemic."[7]

Overview of the Planning Guide

The following pages provide a brief overview of Michigan's opioid epidemic. Outlined, are the OAC's key findings as they relate to state structures, supports and strategies for future planning efforts. The Johns Hopkins Bloomberg School of Public Health "Principles for the Use of Funds from Opioid Litigation" [8] are heavily emphasized throughout, to support reader awareness of emerging national standards (guidance) for the use of opioid settlement funds.

The OAC has provided a multi-year strategy which includes recommendations for seminal projects that will fulfill statutory requirements and help guide future collaborative planning efforts for the state. All recommendations contained herein have been developed with consideration for Michigan's communities, current state policy, behavioral health treatment and recovery ecosystems, the Bloomberg/Hopkins Principles and the OAC's strategic priorities and guiding principles.



Charge of the Opioid Advisory Commission

The OAC was established per Public Act 84 of 2022 (MCL 4.1851).[9] and is the state-designated entity to advise Michigan's legislature (the appropriating body for opioid settlement funds) on funding, policy, and strategic planning concerning the use and management of State opioid settlement funds.[10]

The Michigan Opioid Healing and Recovery Fund was created per PA 83 of 2022 (MCL 12.253) [11], as the fund to which all "State Share" revenues from the opioid settlements, are directed. The fund is structured in such a way to ensure that settlement funds do not lapse into the State's general fund, helping support restricted use of settlement dollars for purposes of opioid abatement and remediation. The OAC is statutorily charged with providing funding recommnedations to the legislature on the use of State opioid settlement funds.[12] Presently, Michigan has involvement in eleven (11) national opioid lawsuits, three (3) of which, have resulted in settlement; four (4) remain in process for settlement. As a result, Michigan is anticipated to receive an estimated $1.45 billion, [13] in both "State" and "Local Subdivision" shares, over the next eighteen years.

The Opioid Advisory Commission (OAC) is also charged with establishing "priorities to address substance use disorders and co-occurring mental health conditions, for the purpose of recommending funding initiatives to the legislature". It is tasked with reviewing "local, state, and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families affected by substance use disorders and co-occurring mental health conditions"and is empowered to advocate for "additional legislation needed to accomplish the objectives of the commission". [14]

Through an annual report, the OAC is tasked with the following: [15]

- Reviewing funding efforts for behavioral health services;
- Identifying risk factors for substance use disorders (SUD), mental health conditions and co-occurring disorders (COD);
- Determining goals and recommendations around prevention, treatment, recovery and harm reduction efforts;
- Determining strategies to reduce disparities in access to health care and behavioral health services; and
- Reviewing state use of opioid settlement funds and assessing settlement-funded programming for effectiveness, as measured by the abatement of Michigan's opioid crisis.

Guiding Documents, Principles and Strategic Priorities

In its inaugural year, the following items were used (and developed) to help guide the work of the OAC:

Guiding Documents

- Public Act 83 of 2022 (MCL 12.253)
- Public Act 84 of 2022 (MCL 4.1851)
- Exhibit E of the National Opioid Settlements
- 2022 MDHHS Opioids Strategy
- Johns Hopkins Bloomberg School of Public Health: Principles for the Use of Funds From Opioid Litigation

Guiding Principles

- Advancing **Health Equity**
- Effecting **Stigma Change**
- Enhancing **Whole Person Care**
- Expanding **Cross-System Collaboration**
- Promoting **Service Innovation**

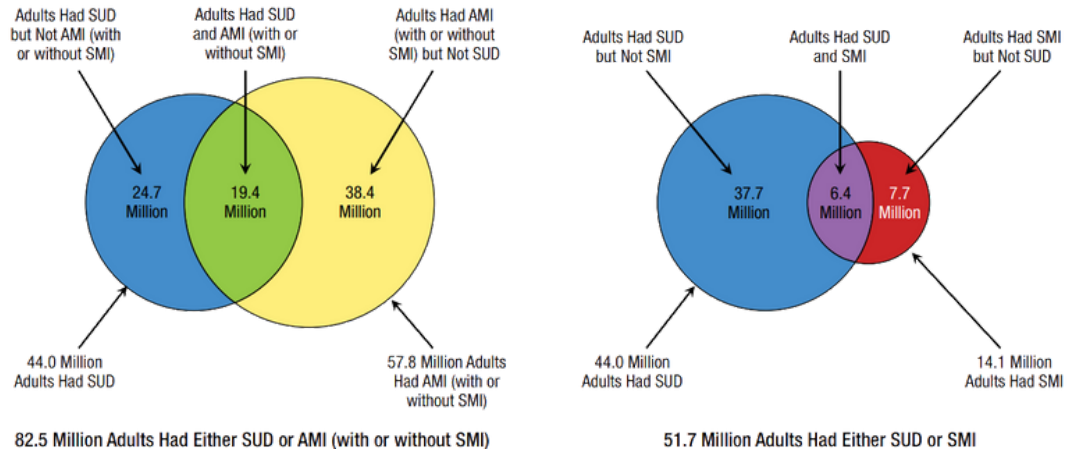
Background **Michigan's Opioid Epidemic and Considerations for Complex Needs**

In 2017, 75% of all overdose deaths in Michigan were related to opioids.[16] While dated, this data provides a baseline understanding that harms from opioids are not only real, but that they were, and continue to be, a major health crisis for the state.

The opioid epidemic is not unique to Michigan. Nationally, **synthetic opioid overdose deaths** reached over 70,000 in 2021,[17] with total overdose deaths involving **any opioid**, surpassing 80,000 for 2021.[18] National data also supports **steadily increasing rates of overdose death from "stimulants"**[19] **(53,495 in 2021), with the majority of overdose deaths involving stimulants, also involving the presence of synthetic opioids** (2021).[20]

Factors of the opioid epidemic, both causal and contributive, are complex. Equitable access to care, social determinants of health (the conditions where people live, work, and play), systemic racism and discriminatory practices, medical comorbidity (multiple medical condition[s] occurring alongside a substance use disorder), **co-occurrence of SUD and mental health conditions (mental health conditions occurring at the same time as a substance use disorder), experiences of trauma, and growing data that supports polysubstance use (active use of more than one substance),** are vital considerations for planning and implementation of any state strategy. Co-occurring SUD and mental health needs remain of considerable interest to the OAC, given national data on prevalence among adults. The following represents findings from the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2021 National Survey on Drug Use and Health [21] capturing "Key Substance Use and Mental Health Indicators in the United States":

Figure 45. Past Year Substance Use Disorder (SUD), Any Mental Illness (AMI), and Serious Mental Illness (SMI): Among Adults Aged 18 or Older; 2021



Source: SAMHSA 2021 National Survey of Drug Use and Health

Michigan's SUD and mental health treatment systems are serving populations with increasingly complex and severe needs. This necessitates whole-person care, cross-system collaboration, active community engagement, service innovation, ongoing data collection and evaluation, and considerations of health equity, to support the needs of Michiganders experiencing SUD, mental health or co-occurring disorders (COD); and offer pathways to enhance prevention, treatment, recovery and harm reduction efforts.

Publicly available resources like the Michigan Data to Action Dashboard (MODA)[22], the Substance Use Vulnerability Index (MI-SUVI) and the Substance Use Disorder Data Repository (MI-SUDDR)[23] help support awareness of population risk and need, as it relates to substance use, substance overdose, suicide rates, health inequities and community vulnerability to adverse outcomes from substance use.

Unmet Need for SUD and Mental Health Care

In Michigan there are gaps in "unmet need" for behavioral health services; populations estimated to have been untreated, when a clinical need for services, existed. While overall access to behavioral health treatment has improved since 2016, there remain disparities in unmet treatment need for SUD and mental health services, especially among Michigan's most vulnerable populations. Collectively, Michigan's Medicaid enrollees and uninsured residents are shown to have the highest prevalence of mental health and SUD conditions; they also present with substantial rates of individuals, untreated. Available data from the 2019 Behavioral Health Access Study [24] conducted by the Michigan Health Endowment Fund (MHEF) and Altarum, supports findings of "unmet need" in mental health care that range from 44% (Medicaid enrollees) to 69% (Uninsured individuals) and 46% (Medicaid enrollees) to 79% (Uninsured Individuals) for SUD treatment. This means that 44% of Michigan's Medicaid enrollees and 69% of uninsured residents, who are estimated to have a need for mental health services, did not receive care. For SUD treatment, that an estimated 46% of Medicaid enrollees and 69% of uninsured individuals, did not receive treatment.[25]

Michigan Overdose Data to Action (MODA) Dashboard

Per MDHHS, the "MODA Team is funded by the Centers for Disease Control and Prevention (CDC) Overdose Data to Action Grant [26] to bring surveillance and prevention efforts together decrease rates of drug misuse, substance use disorder, fatal and non-fatal overdoses and drug-use related health risks"[27]. Per the CDC "Overdose Data to Action (OD2A) supports jurisdictions in collecting high quality, comprehensive, and timely data on nonfatal and fatal overdoses and in using those data to inform prevention and response efforts. OD2A focuses on understanding and tracking the complex and changing nature of the drug overdose epidemic and highlights the need for seamless integration of data into prevention strategies".[28]

State Data Needs and **Planning Considerations**

- **Aggregated data on state prevalence of co-occurring disorders is needed** *While project parameters may limit data collection efforts on MODA, collection and public access to data on Michigan's co-occurring prevalence (within publicly funded SUD and mental health treatment systems) would help support planning, implementation and policy.*
- **State data on Naloxone administration by race/ethnicity, is needed** *Presently, no public, aggregated data exists on Naloxone administration by race/ethnicity, however data from state funded Syringe Service Programs (SSP) and "Quick Response"/Post-Incident Response teams may help fill informational gaps to kick-start data collection efforts. Given disproportionate overdose rates among individuals of color, data on Naloxone administration by racial and ethnic demographics, is needed.*
- **Michigan residents are experiencing longer waits to access public SUD services** *As of Q4, 2022, the average time from an individual's request for SUD services to SUD treatment intake was 7.4 days; this is the highest average recorded in available data, tied with rates from Q2, 2022. Indigenous populations and rural communities experience the longest wait for care, at over 10 days, respectively.*[30]
- **Updated state data on county suicide deaths may help enhance assessment of community vulnerability (MI-SUDDR)** *Five (5) of the twenty (20) counties with the highest SUVI scores (75th-100th percentile; 2020) also appear among Michigan's top ten counties/municipalities with the highest number of suicides (2018). Oscoda County appears with both the highest "Substance Use Vulnerability" (2020) and highest "Crude Suicide Rate" (2018). [31]*
- **Residential SUD services amount to 49% of all publicly funded SUD treatment** *State-level data on residential providers that permit the use of Medications for Opioid Use Disorder (MOUD), is needed. Residential services are utilized at comparable rates to outpatient services, however there is no available aggregated data around provider "MOUD allowances" (MOUD allowances, including types of medications, permitted); this is a critical consideration for coordination of care. [29]*

OAC 2023 ANNUAL REPORT

SECTION 2

THE NATIONAL LANDSCAPE: OPIOID SETTLEMENTS AND STATE SPENDING

Opioid Settlements Overview
National Academy for State Health Policy (NASHP)
MDHHS Intended Uses of Settlement Funds
Core Strategies and Approved Uses of Funds

OPIOID SETTLEMENTS OVERVIEW

National litigation involving companies that manufactured, distributed, marketed, and dispensed pharmaceutical opioids, has resulted in multiple, national settlements, generally termed the "opioid settlements". Presently, Michigan is involved in eleven (11) national lawsuits that are at various stages of litigation and settlement.

For lawsuits that have resulted in settlement, each settlement contains specific terms, distinct to the "agreement" which has been entered into by the Defendant (company), the state and local subdivisions (if applicable). Local subdivisions may include counties, municipalities or townships.

Each entity (State and Local subdivisions) receives funding, independent from the other, resulting in the distinction of a "State Share" and "Local Share" of the total settlement payout. Each settlement agreement outlines unique terms and conditions, including payout structure, core strategies and approved uses of settlement funds.

$99.3M

Total State Shares Received, as of Q2, FY 2023 [34]

$1.45B

Total State and Local Shares, Anticipated by 2040 [35]

Settlements in Active Payout as of Q2, FY 2023 [32]

Settlement/Company	Estimated Total State Share	Estimated State Share (Received)	Payment Schedule	
McKinsey & Co.	$19,557,215.93	$17,046,956.00 (87% total)	5Y	April Payment
Janssen (J&J)	$72,541,608.50	$54,638,181.13 (75% total)	9Y	June Payment
Distributors	$315,605,905.88	$27,627,046.64 (8.7% total)	18Y	July Payment

Pending: Teva, Allergan, CVS, Walmart
Trial Pending (Michigan): Walgreens
Bankruptcy: Endo, Mallinckrodt, Purdue

NATIONAL OPIOID SETTLEMENTS EXECUTIVE SUMMARY

In 2021, nationwide settlements were reached to resolve all opioids litigation brought by states and local political subdivisions against the three largest pharmaceutical distributors—McKesson, Cardinal Health, and AmerisourceBergen ("Distributors")—and against manufacturer Janssen Pharmaceuticals, Inc. and its parent company Johnson & Johnson (collectively, "J&J"). These "2021 National Settlements" have been finalized, and payments have already begun. In all, the Distributors will pay up to $21 billion over 18 years, and J&J will pay up to an additional $5 billion over no more than nine years.

In late 2022, agreements were announced with three pharmacy chains—CVS, Walgreens, and Walmart—and two additional manufacturers—Allergan and Teva. In January 2023, each of those pharmacy chains and manufacturers confirmed that a sufficient number of states had agreed to the settlements to move forward. As with the 2021 National Settlements, states and local governments that want to participate in the 2022 National Settlements now will have the opportunity to "opt in." The greater the level of subdivision participation, the more funds will ultimately be paid out for abatement. Assuming maximum participation, the 2022 National Settlements require:

- Teva to pay up to $3.34 billion over 13 years and to provide either $1.2 billion of its generic version of the drug Narcan over 10 years or $240 million of cash in lieu of product, as each state may elect;
- Allergan to pay up to $2.02 billion over 7 years;
- CVS to pay up to $4.90 billion over 10 years;
- Walgreens to pay up to $5.52 billion over 15 years; and
- Walmart to pay up to $2.74 billion in 2023, and all payments to be made within 6 years.

Under both the 2021 and 2022 National Settlements, at least 85% of the funds going directly to participating states and subdivisions must be used for abatement of the opioid epidemic, with the overwhelming bulk of the proceeds restricted to funding future abatement efforts by state and local governments.[33]

NATIONAL OPIOID LITIGATION
UNDERSTANDING THE LANDSCAPE

OPIOID SETTLEMENT AGREEMENTS: **THE KEY COMPONENTS (NASHP)**

In its December 2022 Issue Brief, "Understanding Opioid Settlement Spending Plans Across States: Key Components and Approaches"[36], the National Academy for State Health Policy (NASHP) offered a look at key components of the national opioid settlements including the role of advisory councils (such as the OAC), statewide Abatement Accounts, and differences between "State" and "Local" Shares, as defined within the opioid settlement agreements. The following reflects selected portions of the NASHP document; subheadings (bolded) have been added by the OAC to consolidate themes; trailers (bolded) have been included to capture information specific to Michigan.

Allowable uses of funding

At least 70% of funding awarded to states and localities must be spent on "opioid remediation efforts" defined in the settlement agreement as "Care, treatment, and other programs and expenditures (including reimbursement for past such programs or expenditures except where this Agreement restricts the use of funds solely to future Opioid Remediation) designed to (1) address the misuse and abuse of opioid products, (2) treat or mitigate opioid use or related disorders, or (3) mitigate other alleged effects of, including on those injured as a result of, the opioid epidemic."[37]

Janssen (J&J) and Distributor settlements stipulate 85% of funds must be used for opioid remediation with 70% for future opioid remediation. [38] As Michigan's FY 2023 expenditures have not yet been released by MDHHS, it is unknown to what extent settlement spending is occurring in alignment with "opioid remediation efforts".

Advisory Committees

Each state is required to establish an Opioid Settlement Remediation Advisory Committee to provide input and recommendations for remediation spending from the state's Abatement Accounts Fund.

The Opioid Advisory Commission (OAC) is Michigan's statutorily designated entity for advising the State legislature on the use of State opioid settlement funds.

Required reporting of settlement spending

Participants [39] are required to report to the Settlement Fund Administrator (BrownGreer) any spending that does not directly address opioid spending, such as attorneys' fees, investigation costs, litigation costs, or administrative costs. Other reporting structures are allowable through the settlement.

As expenditures have not been made public by MDHHS, spending that does not directly address opioid remediation is unknown at this time. Beyond disclosure of non-opioid remediation expenditures, there are no current reporting requirements of the settlement agreements.

Considerations for **Public Transparency and Accountability**

To support improved transparency of opioid settlement spending, twenty-nine states have reporting requirements in their memoranda of agreements. Some states, like New Hampshire, will require narrative reports from recipients of state opioid settlement funds. Other states will require key performance indicators from recipients of state and local opioid settlement funds. North Carolina is promoting transparency of settlement spending by requiring that participating local governments report their settlement spending annually through an online portal created by the state, and those reports will be shared on public-facing dashboards.[40]

Presently, Michigan has no monitoring requirements, key performance indicators, annual reporting requirements, or public-facing opioid settlement dashboard at the state level.

The “State Share"

Settlement funding awarded directly to the state, with final spending authority residing with legislative appropriation, attorneys general, the Department of Health, or the state agencies responsible for substance use services.

Michigan’s State spending authority is the State Legislature. The OAC is the designated entity to advise the legislature on spending of “State Share” opioid settlement funds.

The “Local Share"

Settlement funding allocated directly to participating political subdivisions, including participating cities and counties. Local entities may be required to report spending but retain authority for spending decisions.

Michigan’s subdivisions include local governments from counties, municipalities, and townships. The OAC and the State legislature have no direct influence over spending practices of Michigan’s subdivisions.

Michigan Opioid Healing and Recovery Fund

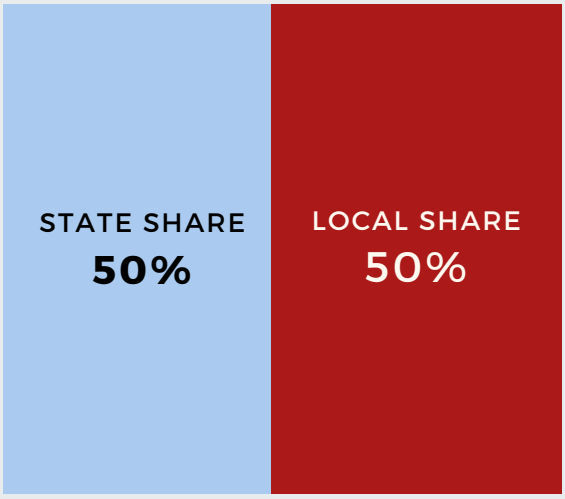
All "State Shares" of the opioid settlements are directed to the Michigan Opioid Healing and Recovery Fund. Settlement funds are considered "restricted revenues" and must remain in the Opioid Healing and Recovery Fund unless expended. This structure ensures that settlement dollars are used for their "restricted" (intended) purpose.

The Michigan Opioid Healing and Recovery Fund is structured as a restricted fund to ensure that “State Share” dollars do not lapse into the state general fund

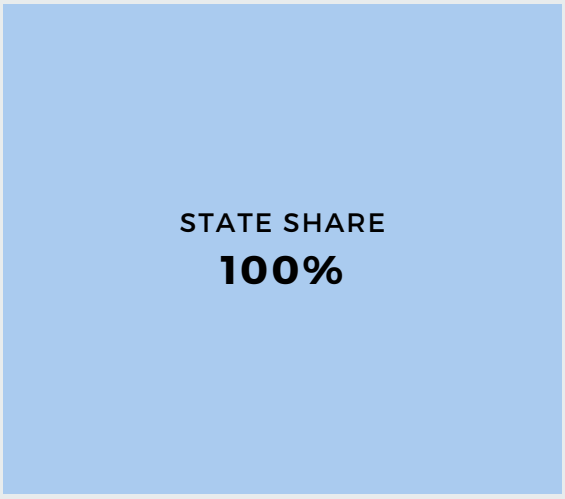
SETTLEMENTS IN ACTIVE PAYOUT (MICHIGAN)[41]

PAYMENT STRUCTURES

Janssen (Johnson & Johnson)
Distributors (McKesson, Cardinal Health, AmerisourceBergen)



McKinsey and Co.



OPIOID SETTLEMENTS

MDHHS INTENDED USES OF FUNDS[42]

The following is a synthesis of information provided to the OAC by MDHHS, including key projects supported by opioid settlement funds for FY 2023 and FY 2024. Information provided by MDHHS has been used to create charts capturing "intended uses" of opioid settlement funds. The OAC was not involved in any planning or development of the MDHHS FY 2023 Settlement Spend Plan [43], key projects (reflected below) or proposals for FY 2024:

$39.2M

Total legislative appropriations of opioid settlement funds to MDHHS as of FY 2023

$23.2M

Opioid settlement funds currently appearing in the FY 2024 Executive Budget (MDHHS)

Prevention $6.1 million

PHA Injury Prevention Initiatives: $2.4 million
Children's Services Administration Initiatives: $2.1 million
BPHASA Areas on Aging Initiatives $1.6 million

Treatment $8.56 million

Transportation: $2.5 million
Contingency Management and Technical Assistance: $3.06 million
Infrastructure Grants: $2 million
Loan Repayment and Staff Incentives: $1 million

Recovery $6.5 million

RCO Grants: $525K
MSHDA Recovery Housing Expansion: $4 million
Additional Recovery Supports: $2 million

Harm Reduction $8.5 million

Naloxone Portal: $4.5 million
Syringe Service Programs (SSP): $4 million

Criminal-Legal $4 million

MOUD in Carceral Settings (Local Jails): $1.5 million
MOUD in Carceral Settings (MDOC): $2.5 million

Pregnant & Parenting $800K

High Touch, High Tech Expansion: $400K
Rooming-In Expansion: $400K

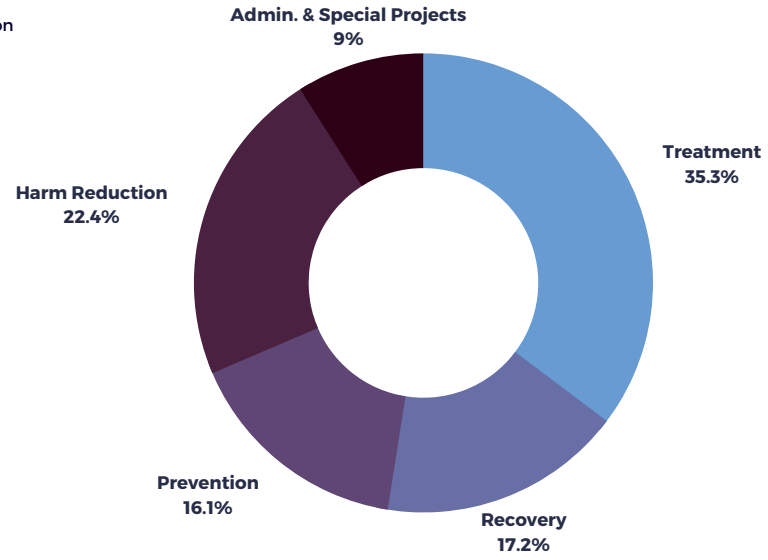
Data $750K

Updates to Michigan's Medical Examiner System: $750K

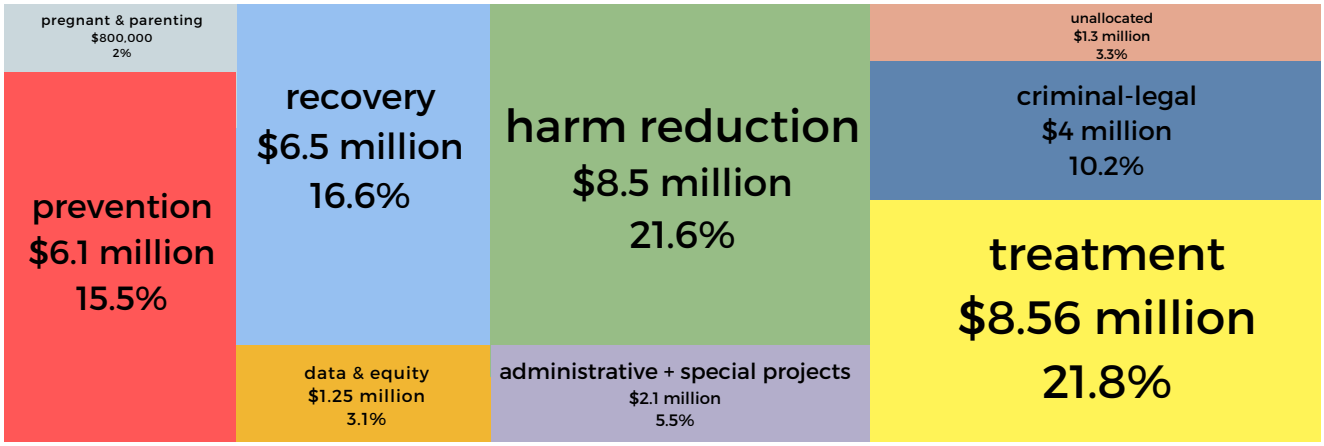
Equity $500K

Racial Equity Workgroup Recommendations: $500K

FY 2023 MDHHS INTENDED USES
ESTIMATES BY PRIORITY AREA



OPIOID SETTLEMENT FUNDS ESTIMATED USE BY "PILLAR"



CORE STRATEGIES AND APPROVED USES

AS OUTLINED IN "EXHIBIT E" OF THE NATIONAL OPIOID SETTLEMENTS

This section is intended to increase reader awareness of the "Core Strategies" and "Approved Uses" for spending of opioid settlement funds. Reference is frequently made to "**Exhibit E: List of Opioid Remediation Uses**", an exhibit document appearing in seven (7) of the national opioid settlements. For context, the document is popularly referred to as "Exhibit E" among national, state, and local entities doing work in opioid settlement planning and implementation. It is **the primary guiding document for allowable uses and spending strategies for opioid settlement funds** and while it is not universal to all opioid settlements, it is applicable to the following national settlements:

- **Janssen** (Johnson & Johnson)[44]
- **Distributors** (McKesson, Cardinal Health, AmerisourceBergen)[45]
- **Teva**[46]
- **Allergan**[47]
- **CVS**[48]
- **Walmart**[49]
- **Walgreens***[50]

**Michigan in active litigation; no current settlement agreement*

"Exhibit E" outlines various abatement strategies to address the harms caused by opioids. States and local subdivisions have discretionary spending based on approved uses (general abatement strategies), with guidance for prioritization of core abatement strategies ("Core Strategies"), in the use of opioid settlement funds.[51]

The following items are listed as they appear in the exemplar "Exhibit E" document (Teva agreement), however "Approved Uses" only reflects subheadings from "Part One: Treatment", "Part Two: Prevention" and "Part Three: Other Strategies". A list of specific (suggested) strategies can be found under **Schedule B of Exhibit E**.[52]

CORE STRATEGIES

AS OUTLINED IN "EXHIBIT E" OF THE NATIONAL OPIOID SETTLEMENTS

EXHIBIT E: LIST OF OPIOID REMEDIATION USES

CORE STRATEGIES

NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES

- Expand training for first responders, schools, community support groups and families
- Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service

MEDICATION-ASSISTED TREATMENT ("MAT") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT

- Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service
- Provide education to school-based and youth-focused programs that discourage or prevent misuse
- Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders
- Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services

PREGNANT & POSTPARTUM WOMEN

- Expand Screening, Brief Intervention, and Referral to Treatment ("SBIRT") services to non-Medicaid eligible or uninsured pregnant women
- Expand comprehensive evidence-based treatment and recovery services, including MAT/MOUD, for women with co-occurring Opioid Use Disorder ("OUD") and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum
- Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare

EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("NAS")

- Expand comprehensive evidence-based and recovery support for NAS babies
- Expand services for better continuum of care with infant need dyad
- Expand long-term treatment and services for medical monitoring of NAS babies and their families

CORE STRATEGIES

AS OUTLINED IN "EXHIBIT E" OF THE NATIONAL OPIOID SETTLEMENTS

LIST OF OPIOID REMEDIATION USES

CORE STRATEGIES—CONTINUED

EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES

- Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments; expand warm hand-off services to transition to recovery services
- Broaden scope of recovery services to include co-occurring SUD or mental health conditions
- Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare
- Hire additional social workers or other behavioral health workers to facilitate expansions above

TREATMENT FOR INCARCERATED POPULATION

- Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system
- Increase funding for jails to provide treatment to inmates with OUD

PREVENTION PROGRAMS

- Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco)
- Funding for evidence-based prevention programs in schools
- Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing)
- Funding for community drug disposal programs
- Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports

EXPANDING SYRINGE SERVICE PROGRAMS

- Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases

EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE

APPROVED USES

AS OUTLINED IN "EXHIBIT E" OF THE NATIONAL OPIOID SETTLEMENTS

EXHIBIT E: LIST OF OPIOID REMEDIATION USES

APPROVED USES

Support treatment of Opioid Use Disorder (OUD) and any other co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed program or strategies that may include but are not limited to the following:

TREATMENT

- Treat Opioid Use Disorder (OUD)
- Support people in treatment and recovery
- Connect people who need help to the help they need (Connections to Care)
- Address the needs of criminal-justice involved persons
- Address the needs of pregnant or parenting women and their families, including babies with Neonatal Abstinence Syndrome

PREVENTION

- Prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids
- Prevent misuse of opioids
- Prevent overdose deaths and other harms (Harm Reduction)

OTHER STRATEGIES

- Wellness and support services for first responders; education regarding appropriate practices and precautions when dealing with fentanyl or other drugs
- Leadership, Planning and Coordination
- Training
- Research

OAC 2023 ANNUAL REPORT

SECTION 3

BEHAVIORAL HEALTH SPENDING AND COUNTY VULNERABILITY

Using Tools and Boilerplate Reports for Planning and Policy
Michigan's Substance Use Vulnerability Index (MI-SUVI)
Michigan's Prepaid Inpatient Health Plans (PIHP)
SUD Spending
Mental Health Spending
Considerations for Boilerplate Reports: Section 904

Using tools and boilerplate reports for **planning, implementation, and policy**

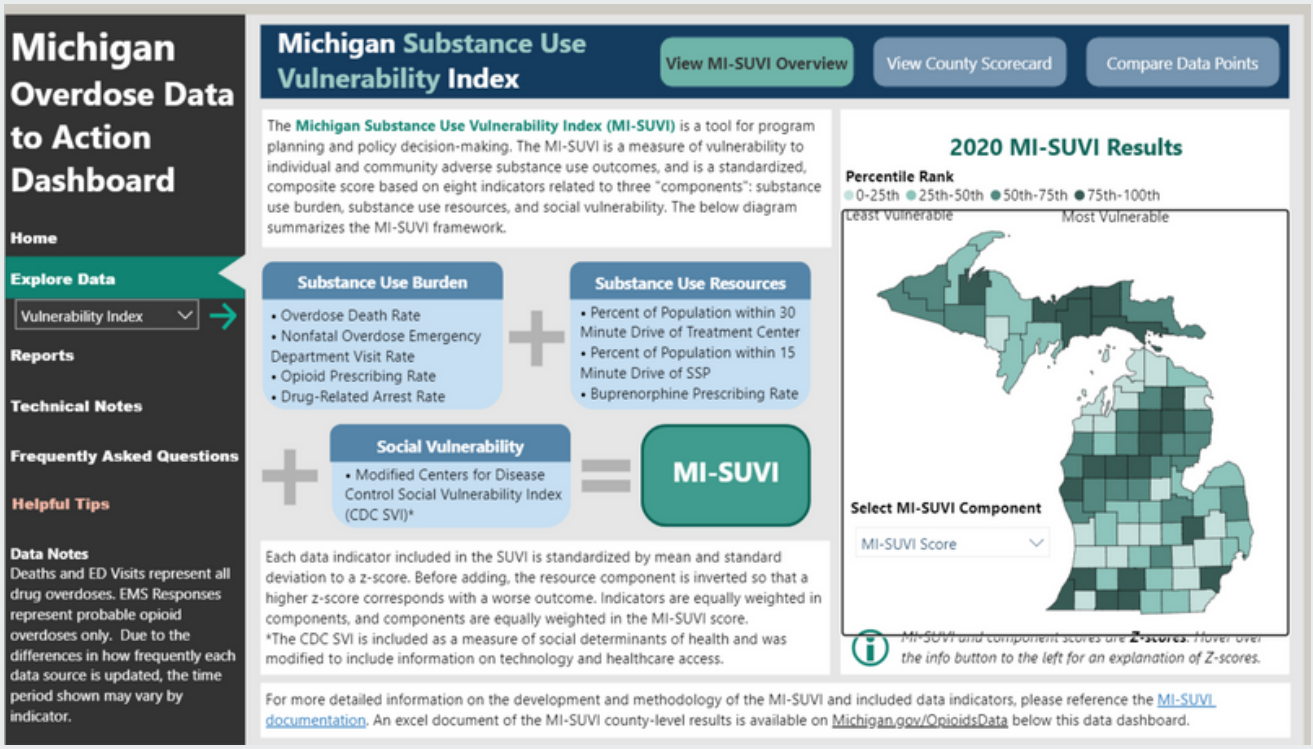
Beyond direct engagement with Michigan's communities, policy makers interested in local, regional and state trends in health/behavioral health can use existing tools and boilerplate reports to help inform their understanding of community needs. The following items are provided as key resources and were used in the development of all graphical charts that reflect Michigan's **public spending** on behavioral health services (Section 3: Behavioral Health Spending and Community Vulnerability):

- **Michigan Overdose Data to Action Dashboard (MODA)** [53]
- **Boilerplate Report Section 904: Report on CMHSPs, PIHPs and Regional Entities** [54]

The OAC recognizes that Michigan's communities have unique needs that will change over time. In an effort to support data-driven solutions for opioid abatement and remediation and broader health policy decisions, the OAC encourages familiarity with the MODA Dashboard and the Section 904 Report on CMHSPs, PIHPs and Regional Entities (MDHHS).[55] Additional resources include the **CDC/Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index (SVI)** [55] and the **Recovery Ecosystem Index**. [56]

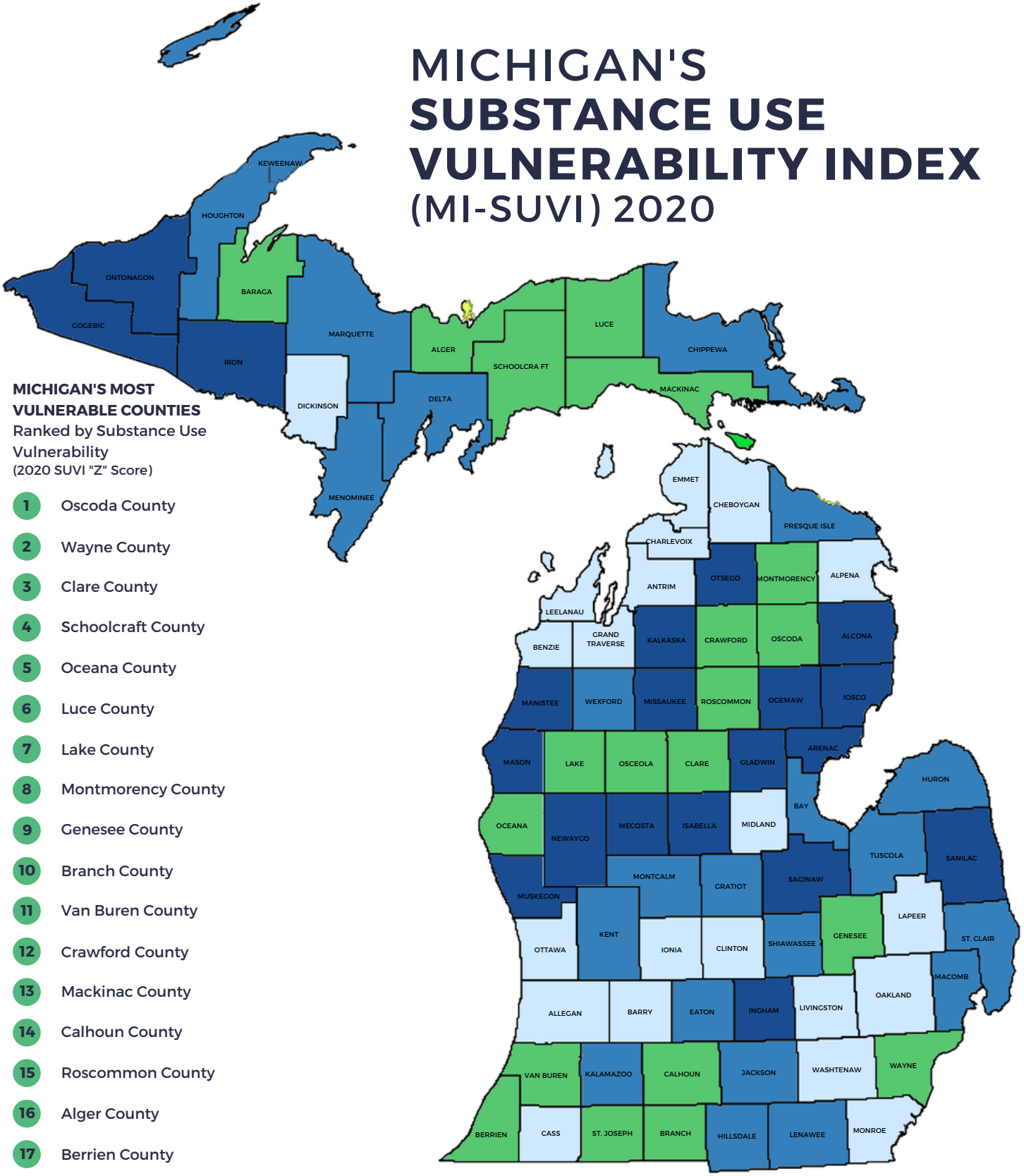
Michigan Overdose Data to Action (MODA) Dashboard

Among the many valuable tools included on the MODA dashboard is the Michigan **Substance Use Vulnerability Index (MI-SUVI).** [57] The MI-SUVI is "**a tool for program planning and policy-decision-making**. The MI-SUVI is a measure of vulnerability to individual and community adverse substance use outcomes, and is standardized, composite score based on eight (8) indicators related to three (3) "components": substance use burden, substance use resources and social vulnerability" [58].



Source: MDHHS Michigan Overdose Data to Action Dashboard; "Vulnerability Index"

MICHIGAN'S **SUBSTANCE USE VULNERABILITY INDEX** (MI-SUVI) 2020



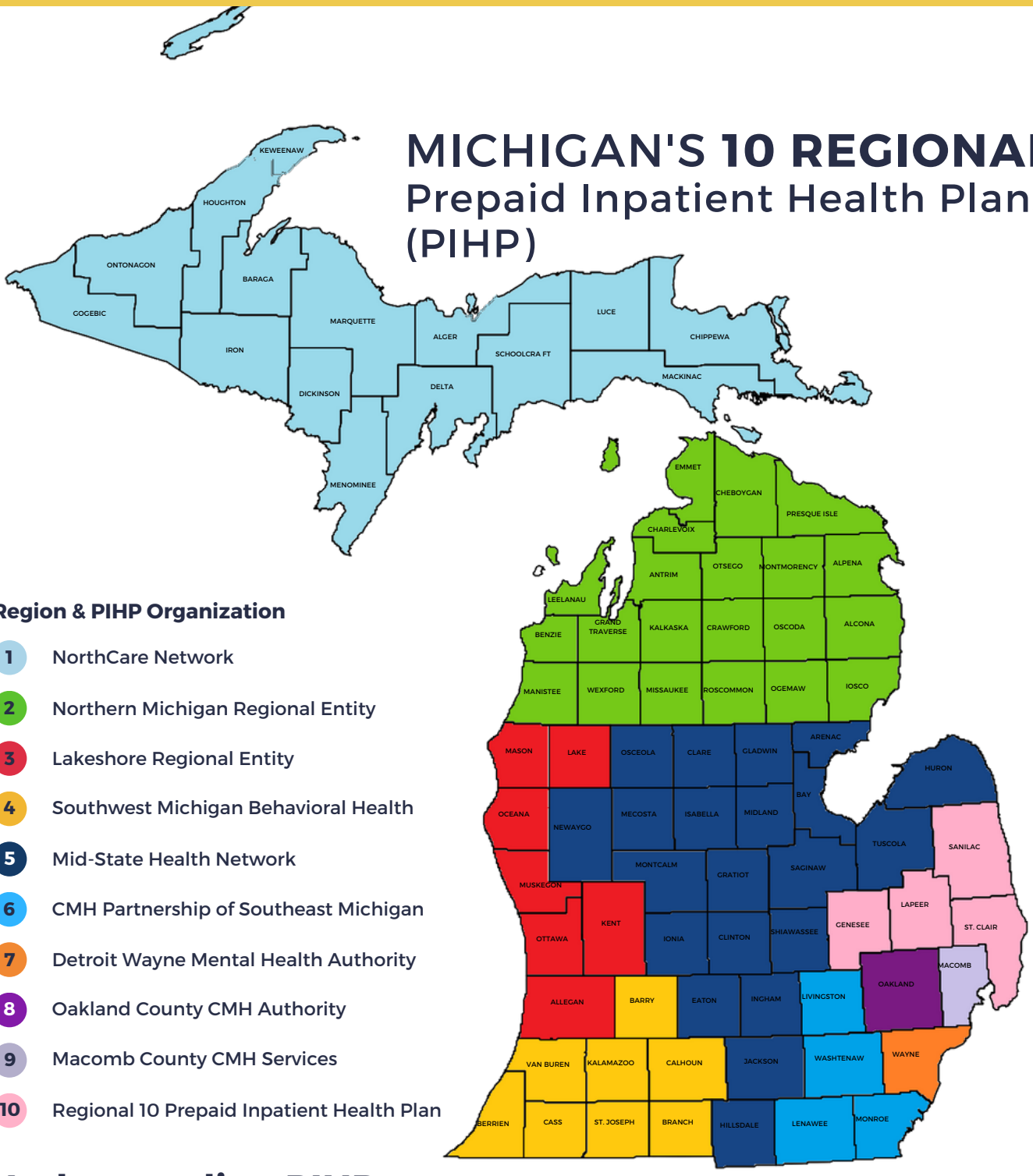
MICHIGAN'S MOST VULNERABLE COUNTIES
Ranked by Substance Use Vulnerability
(2020 SUVI "Z" Score)

1. Oscoda County
2. Wayne County
3. Clare County
4. Schoolcraft County
5. Oceana County
6. Luce County
7. Lake County
8. Montmorency County
9. Genesee County
10. Branch County
11. Van Buren County
12. Crawford County
13. Mackinac County
14. Calhoun County
15. Roscommon County
16. Alger County
17. Berrien County
18. Oscelola County
19. St. Joseph County
20. Baraga County

0-25th *percentile*	25th-50th *percentile*	50th-75th *percentile*	75th-100th *percentile*

Source: MDHHS 2020 MI-SUVI RESULTS [59]
Noting that data from the Michigan Overdose Data to Action Dashboard was used in the creation of the above graphics; https://www.michigan.gov/opioids/category-data

MICHIGAN'S **10 REGIONAL**
Prepaid Inpatient Health Plans (PIHP)



Region & PIHP Organization

1. NorthCare Network
2. Northern Michigan Regional Entity
3. Lakeshore Regional Entity
4. Southwest Michigan Behavioral Health
5. Mid-State Health Network
6. CMH Partnership of Southeast Michigan
7. Detroit Wayne Mental Health Authority
8. Oakland County CMH Authority
9. Macomb County CMH Services
10. Regional 10 Prepaid Inpatient Health Plan

Understanding PIHPs

PIHP is an acronym for Prepaid Inpatient Health Plan, a term contained in federal regulations from the Centers for Medicare & Medicaid Services. PIHPs are entities that:

- Provide medical services to enrollees under contract with the state Medicaid agency on the basis of prepaid capitation payments
- Include responsibility for arranging inpatient hospital care
- Do not have a comprehensive risk contract

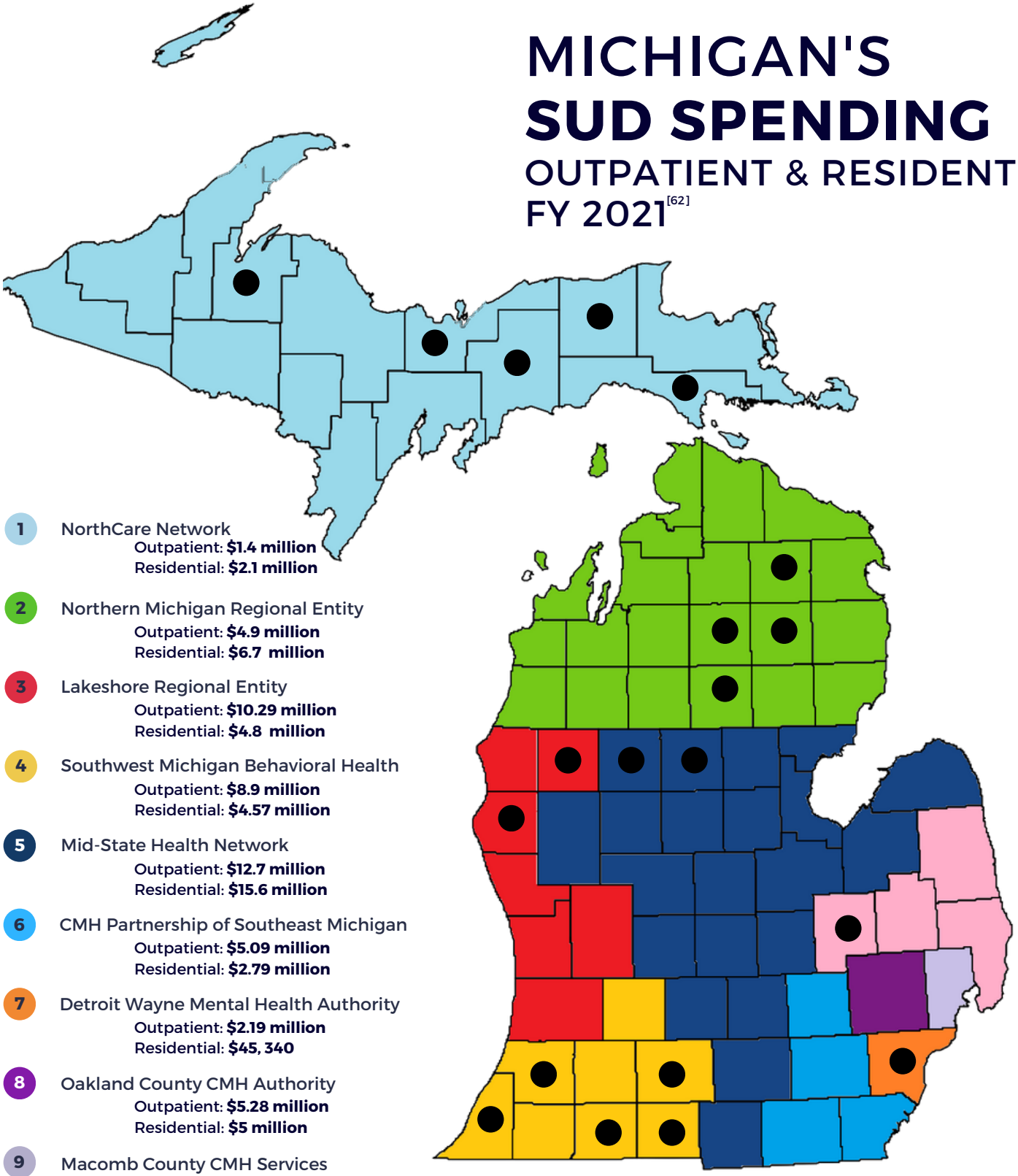
Source: Community Mental Health Association of Michigan [60]. Items have been represented, verbatim, to support reader awareness.

Michigan operates several types of managed care programs to provide health services to Medicaid beneficiaries including ten (10) regional PIHPs to manage specialty mental health and substance use disorder treatment benefits

Source: Mid-State Health Network [61] Items have been represented, verbatim, to support reader awareness.

MICHIGAN'S **SUD SPENDING**

OUTPATIENT & RESIDENTIAL FY 2021[62]



1. NorthCare Network
   Outpatient: **$1.4 million**
   Residential: **$2.1 million**
2. Northern Michigan Regional Entity
   Outpatient: **$4.9 million**
   Residential: **$6.7 million**
3. Lakeshore Regional Entity
   Outpatient: **$10.29 million**
   Residential: **$4.8 million**
4. Southwest Michigan Behavioral Health
   Outpatient: **$8.9 million**
   Residential: **$4.57 million**
5. Mid-State Health Network
   Outpatient: **$12.7 million**
   Residential: **$15.6 million**
6. CMH Partnership of Southeast Michigan
   Outpatient: **$5.09 million**
   Residential: **$2.79 million**
7. Detroit Wayne Mental Health Authority
   Outpatient: **$2.19 million**
   Residential: **$45, 340**
8. Oakland County CMH Authority
   Outpatient: **$5.28 million**
   Residential: **$5 million**
9. Macomb County CMH Services
   Outpatient: **$1.6 million**
   Residential: **$2.3 million**
10. Regional 10 Prepaid Inpatient Health Plan
    Outpatient: **$4.05 million**
    Residential: **$5.49 million**

Salvation Army Harbor Light
Outpatient: **$983,769**
Residential: **$2.4 million**

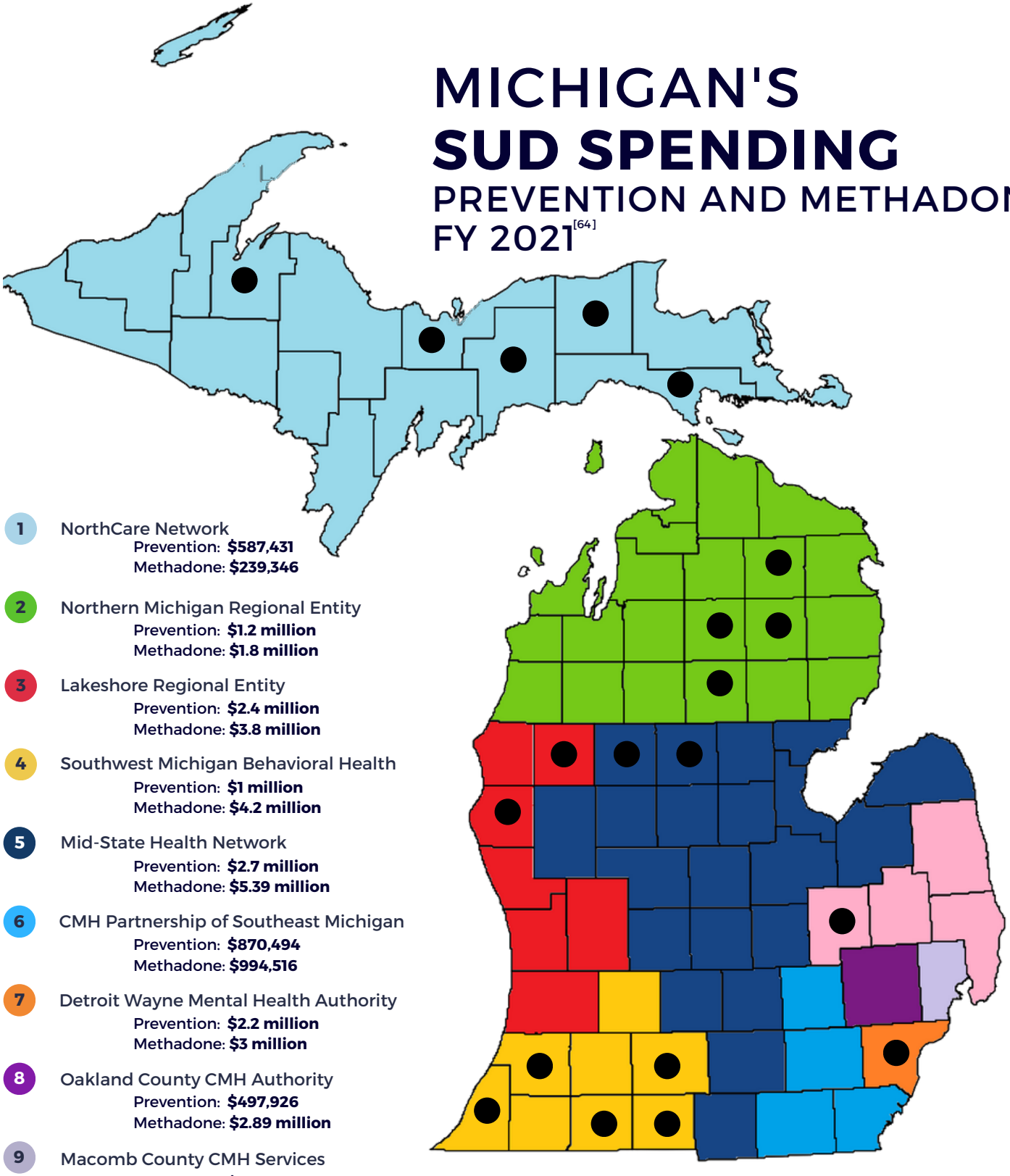
● **Most vulnerable counties**
75th-100th percentile (SUVI "Z" Score)

Racial Equity Considerations

Monroe and Washtenaw ranked among Michigan's top 20 counties for "best outcomes" (as measured by 2020 SUVI "Z" Score), however both have some of the highest rates of overdose fatalities observed in Michigan, with disproportionate deaths among individuals of color. Black individuals had substantially higher overdose rates in Monroe County (2021-2022) as compared to their White counterparts. The OAC encourages further community engagement and data collection efforts to better understand causes for county disparities in "substance use outcomes" and "overdose rates" [63].

MICHIGAN'S **SUD SPENDING**

PREVENTION AND METHADONE FY 2021[64]



1. NorthCare Network
   Prevention: **$587,431**
   Methadone: **$239,346**
2. Northern Michigan Regional Entity
   Prevention: **$1.2 million**
   Methadone: **$1.8 million**
3. Lakeshore Regional Entity
   Prevention: **$2.4 million**
   Methadone: **$3.8 million**
4. Southwest Michigan Behavioral Health
   Prevention: **$1 million**
   Methadone: **$4.2 million**
5. Mid-State Health Network
   Prevention: **$2.7 million**
   Methadone: **$5.39 million**
6. CMH Partnership of Southeast Michigan
   Prevention: **$870,494**
   Methadone: **$994,516**
7. Detroit Wayne Mental Health Authority
   Prevention: **$2.2 million**
   Methadone: **$3 million**
8. Oakland County CMH Authority
   Prevention: **$497,926**
   Methadone: **$2.89 million**
9. Macomb County CMH Services
   Prevention: **$675,741**
   Methadone: **$4 million**
10. Regional 10 Prepaid Inpatient Health Plan
    Prevention: **$639,776**
    Methadone: **$2.2 million**

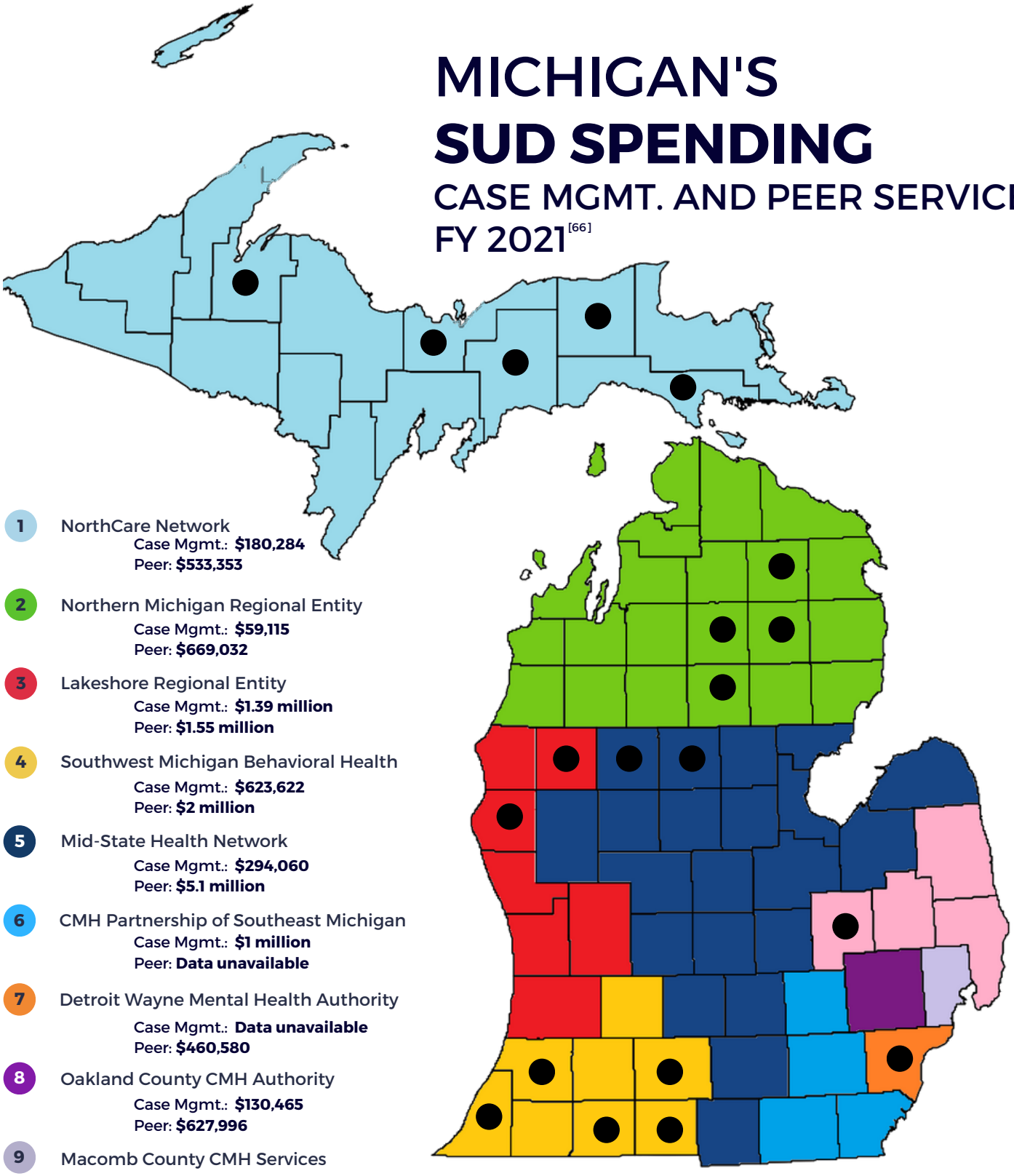
● **Most vulnerable counties**
75th-100th percentile (SUVI "Z" Score)

Community Mental Health Entities (CMHE's)

Michigan has ten (10) state-designated CMHE's according to the Michigan Mental Health Code sections 330.1210, 330.1269, 330.1274 and 330.1287. [65] CMHE's "coordinate the provision of substance use disorder services in its region..." through direct services and contracted services. They are responsible for developing "comprehensive plans for SUD treatment, rehabilitation, and prevention." Further they must "evaluate and assess substance use disorder services" annually. Notably, there are additional carve out services provided through Medicaid Fee for Service.

MICHIGAN'S **SUD SPENDING**

CASE MGMT. AND PEER SERVICES FY 2021[66]



1. NorthCare Network
   Case Mgmt.: **$180,284**
   Peer: **$533,353**
2. Northern Michigan Regional Entity
   Case Mgmt.: **$59,115**
   Peer: **$669,032**
3. Lakeshore Regional Entity
   Case Mgmt.: **$1.39 million**
   Peer: **$1.55 million**
4. Southwest Michigan Behavioral Health
   Case Mgmt.: **$623,622**
   Peer: **$2 million**
5. Mid-State Health Network
   Case Mgmt.: **$294,060**
   Peer: **$5.1 million**
6. CMH Partnership of Southeast Michigan
   Case Mgmt.: **$1 million**
   Peer: **Data unavailable**
7. Detroit Wayne Mental Health Authority
   Case Mgmt.: **Data unavailable**
   Peer: **$460,580**
8. Oakland County CMH Authority
   Case Mgmt.: **$130,465**
   Peer: **$627,996**
9. Macomb County CMH Services
   Case Mgmt.: **$93,153**
   Peer: **$1.8 million**
10. Regional 10 Prepaid Inpatient Health Plan
    Case Mgmt.: **$17,961**
    Peer: **$5 million**

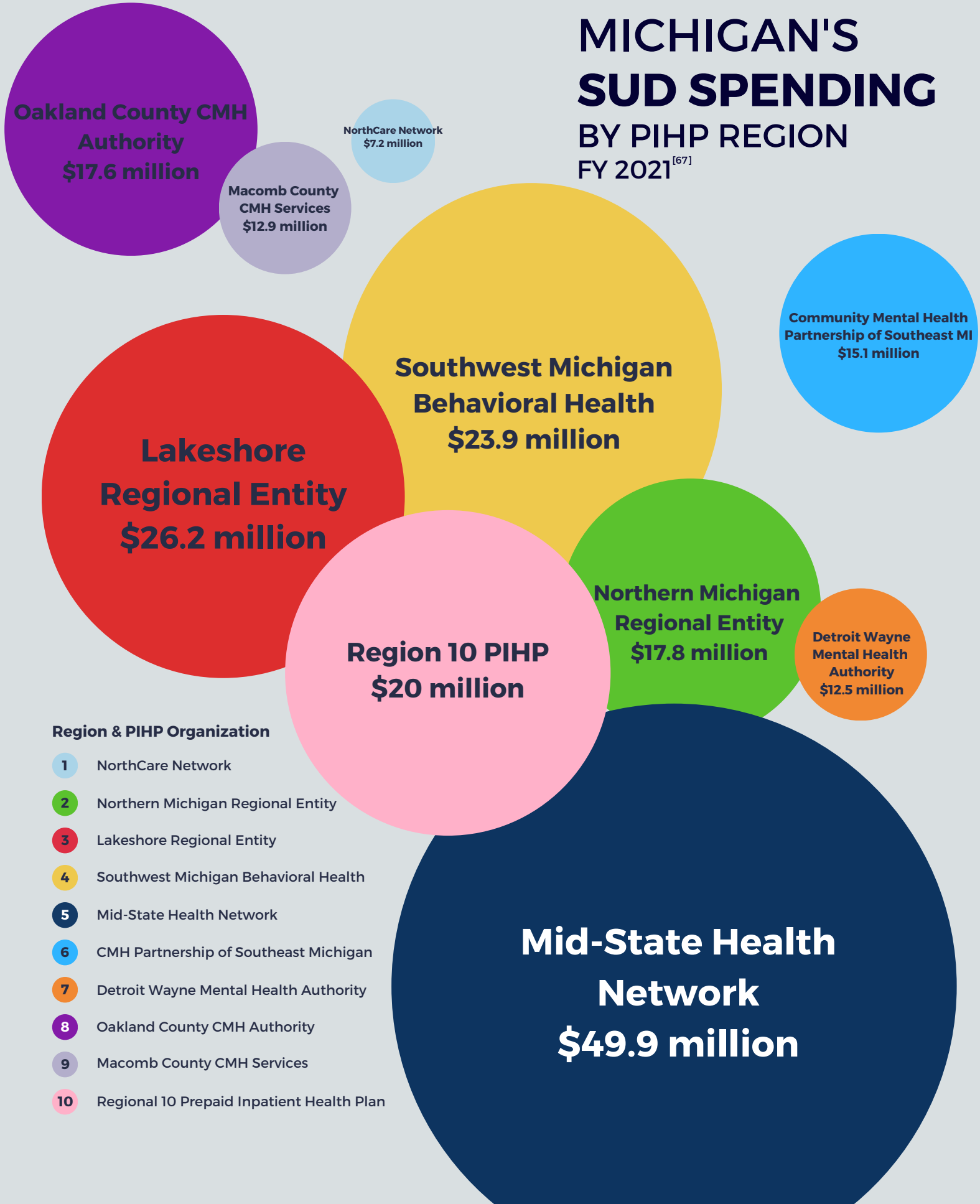
● **Most vulnerable counties**
75th-100th percentile (SUVI "Z" Score)

CMHE's and Recovery Oriented Systems of Care

CMHEs have almost a decade of substance use disorder planning, prevention, service use and performance data. Regarding local connectiveness, oversight and engagement CMHEs have a Substance Use Disorder Oversight Policy Board with members appointed by County Commissions. Each CMHE engages with local Recovery-Oriented Systems of Care Committees to assure stakeholder involvement and guidance.

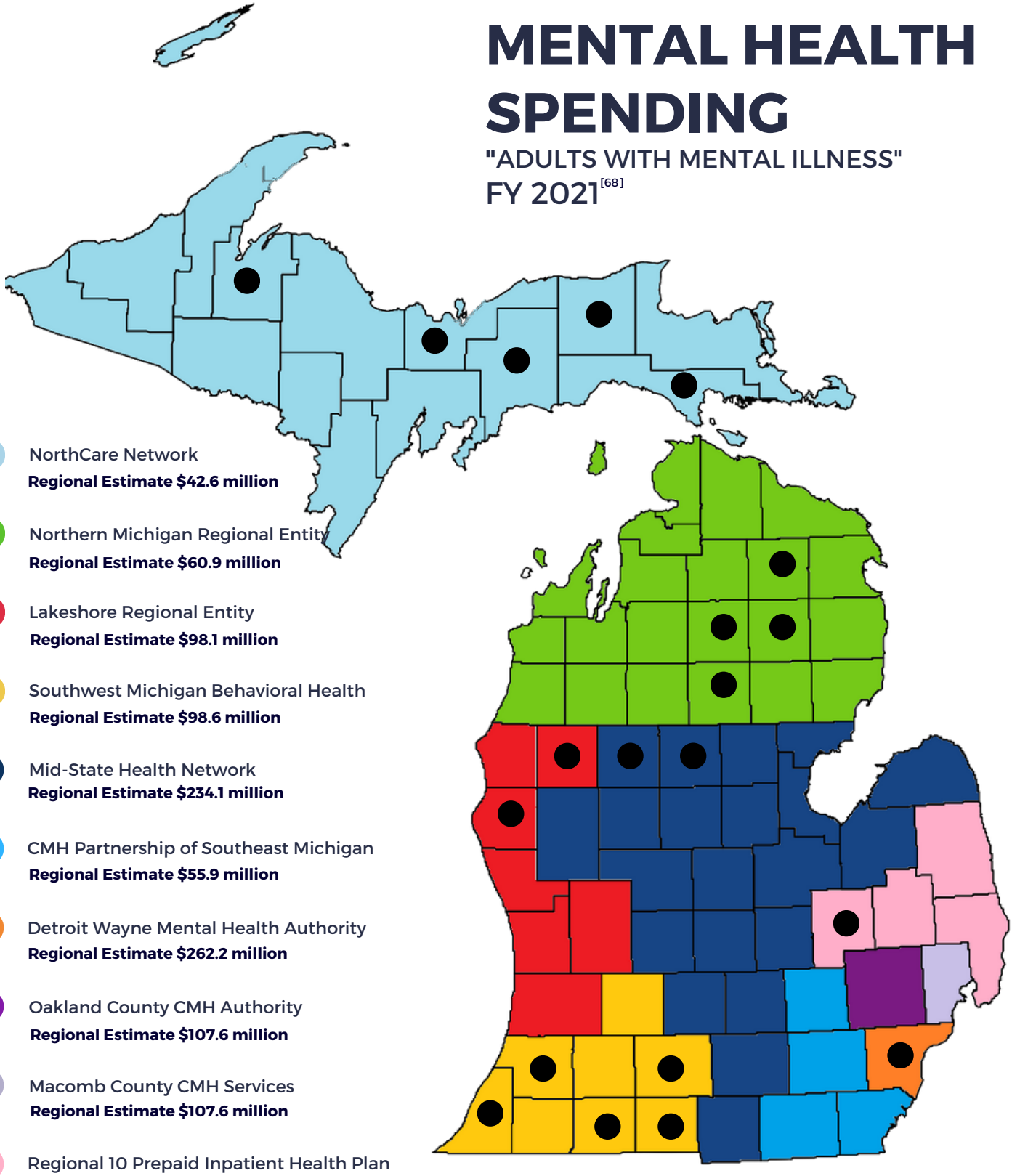
MICHIGAN'S **SUD SPENDING** BY PIHP REGION

FY 2021[67]



MICHIGAN'S **MENTAL HEALTH SPENDING**

"ADULTS WITH MENTAL ILLNESS" FY 2021[68]



1. NorthCare Network
   Regional Estimate $42.6 million
2. Northern Michigan Regional Entity
   Regional Estimate $60.9 million
3. Lakeshore Regional Entity
   Regional Estimate $98.1 million
4. Southwest Michigan Behavioral Health
   Regional Estimate $98.6 million
5. Mid-State Health Network
   Regional Estimate $234.1 million
6. CMH Partnership of Southeast Michigan
   Regional Estimate $55.9 million
7. Detroit Wayne Mental Health Authority
   Regional Estimate $262.2 million
8. Oakland County CMH Authority
   Regional Estimate $107.6 million
9. Macomb County CMH Services
   Regional Estimate $107.6 million
10. Regional 10 Prepaid Inpatient Health Plan
    Regional Estimate $96.69 million

● **Most vulnerable counties**
75th-100th percentile (SUVI "Z" Score)

INFORMATION NEEDS
BEHAVIORAL HEALTH SPENDING FY 2021

Considerations for review of future Section 904 Boilerplate Reports

"Sec. 904. (1) By May 31 of the current fiscal year, the department shall provide a report on the CMHSPs, PIHPs, and designated regional entities for substance use disorder prevention and treatment to the members of the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, and the state budget director that includes the information required by this section." [69]

SUD BENEFIT

LIMITED REPORTING ON RECOVERY SERVICES
While SUD spending on Medicaid-billable "Peer Services" is indicated in the 904, there is no specific reporting on any non-billable recovery supports funded by public dollars; data concerning recovery housing programs/recovery residences and recovery community organizations (RCO's) can help inform the assessment and expansion of the recovery ecosystem.

HARM REDUCTION SPENDING IS NOT CLEARLY IDENTIFIED
While it is assumed that expenditures in "harm reduction" services are occurring with public funds, they are not explicitly reported in the 904; this includes spending for Naloxone and Syringe Service Programs (SSP).

FURTHER INFORMATION IS NEEDED ON "INTEGRATED TREATMENT"
Additional information is needed on "Integrated Treatment" expenditures, including service descriptions and scope of implementation. While reference is made that "Integrated treatment occurs within all treatment settings" there is no definition for "Integrated Treatment" (of the SUD Benefit) clearly indicated within the 904.

76% ESTIMATED SPENDING ON **SUD TREATMENT**

8.5% ESTIMATED SPENDING ON **RECOVERY**

7.8% ESTIMATED SPENDING ON **PREVENTION AND EARLY INTERVENTION**

$32.6M ESTIMATED SPENDING ON **"INTEGRATED TREATMENT"**

MENTAL HEALTH BENEFIT

0.002% **ESTIMATED SPENDING ON SUD SERVICES** DELIVERED BY CMHSPS [71]

0.007% ESTIMATED ANNUAL SPENDING ON **INTEGRATED CARE FOR CO-OCCURRING DISORDERS** ADULT SERVICES [72]

LIMITED SPENDING ON EVIDENCE-BASED PRACTICES FOR CO-OCCURRING DISORDERS
Estimated annual spending on evidence-based practices for co-occurring disorders (IDDT) is $7.3 million or 0.007% of total spending for Adult Mental Health Services. This total was determined from a review of billable Current Procedural Terminology (CPT) codes [70] for Integrated Dual Diagnosis Treatment (IDDT), the evidence-based treatment modality for co-occurring disorders. Noting that "integrated care" efforts for co-occurring disorders are being delivered throughout the state by the CMHSPs, however the scope and prevalence of service delivery (and fidelity with evidence-based models) is unknown due to lack of publicly available data; State data collection efforts around this topic are currently unknown.

CLARIFICATION IS NEEDED ON "PERSONS WITH SUBSTANCE USE DISORDER"
$2.5 million in SUD spending only captures expenditures for SUD services provided by CMHSPs to "Persons with Substance Use Disorder".
The subgroup "Persons with Substance Use Disorder" only includes individuals with an SUD-only diagnosis (4%) served by the CMHSPs— not **individuals with both an SUD diagnosis and/or mental health diagnosis (co-occurring disorders) which is estimated to be substantially greater than the reported subgroup.**

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SECTION 4

STRATEGIES FOR ADOPTING THE BLOOMBERG/HOPKINS PRINCIPLES

Michigan's Scorecard
Michigan's Scorecard—Expanded Strategies for Improvement
Adopting the Bloomberg/Hopkins Principles

MICHIGAN'S SCORECARD

FOR STATE PLANNING, USE, AND MANAGEMENT OF **OPIOID SETTLEMENT FUNDS**

Principle 1: Spend Money to Save Lives — 1.5 / 4.0

Strategies for Improvement

Increase public transparency and independent oversight of State opioid settlement funds

Principle 2: Use Evidence to Guide Spending — 2.6 / 4.0

Strategies for Improvement

Increase community engagement to support data collection and assessment; increase reporting on strategic planning efforts to address community needs and service gaps

Principle 3: Invest in Youth Prevention — 3.0 / 4.0

Strategies for Improvement

Increase data collection and public reporting on youth prevention initiatives. Ensure that strategies are data-supported, trauma-informed and culturally competent

Principle 4: Focus on Racial Equity — 2.5 / 4.0

Strategies for Improvement

Increase community outreach and engagement efforts; implement culturally competent assessments and assessment strategies; integrate community input into program planning and implementation

Principle 5: Develop a Fair and Transparent Process for Deciding Where to Spend Funding — 2.0 / 4.0

Strategies for Improvement

Increase public transparency around processes, planning efforts and decisions concerning allocation of opioid settlement funds

UNDERSTANDING THE SCORCARD

1 REQUIRES IMMEDIATE ATTENTION

2 UNKNOWN—LIMITED PUBLIC INFORMATION

3 MORE WORK AHEAD

4 ON TARGET

The OAC used the Bloomberg/Hopkins Principles and their associated strategies, as a framework to assess Michigan's practices in planning, spending, and management of State opioid settlement funds. Only publicly available information was used so information gaps could be more easily identified. The scorecard aims to provide an understanding of State gaps in planning, use, and management of State opioid settlement funds, to establish a baseline for comparative re-assessment. It is a guide to help determine areas for improvement in the structures, processes, planning and implementation efforts related to opioid settlement funds. **Scoring:** A score was assigned to each of the fifteen "Principle" strategies based on the OAC's assessment of State strengths and limitations (see "Adopting the Bloomberg/Hopkins Principles"). Final scores represent averages from the fifteen strategies, as they relate to each of the five (5) principles. Color and numeric point values align with the OAC's scoring chart (left).

MICHIGAN'S SCORECARD
EXPANDED STRATEGIES FOR IMPROVEMENT

Principle 1: Spend Money to Save Lives

- Establish sub-funds within the Michigan Opioid Healing and Recovery Fund; at a minimum for non "Exhibit E" settlements
- Establish defined and independent tracking mechanisms for State opioid settlement funds
- Increase public reporting on intended and actual uses of State opioid settlement funds
- Develop an authorization process for State departments requesting appropriation of opioid settlement funds
- Require reporting on initiatives supported by State opioid settlement funds
- Ensure supplemental use of settlement funds for development, expansion, and service enhancements
- Integrate sustainability measures in State spend plans
- Establish reasonable limits on annual legislative appropriations of opioid settlement funds

Principle 2: Use Evidence to Guide Spending

- Increase reporting on strategic planning efforts and program rationales
- Support lateral service expansion for treatment, recovery and ancillary supports that relate to core initiatives
- Increase data collection capacity in Michigan's marginalized communities
- Increase community engagement efforts to support data collection, strategic planning and program implementation
- Routinely assess existing service data to determine trends and gaps (i.e. accurate identification of individuals with co-occurring disorders served by CMHPs; co-occurring programming currently offered CMHPs; service engagement and utilization trends for priority populations); publicly report findings

Principle 3: Invest in Youth Prevention

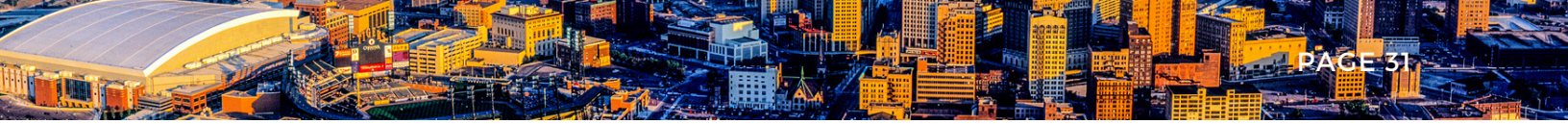
- Support prevention strategies that are trauma-informed, evidence-based, data-supported, flexible in application, representative of equity and community considerations, and in alignment with general prevention principles.
- Increase community engagement efforts to expand settings for delivery of youth prevention programming, based on cultural considerations
- Enhance prevention programming based on community/population need; increase secondary prevention efforts with justice-involved youths and at-risk populations
- Increase local efforts to identify youth risk behaviors and indicators of trauma (i.e. Adverse Childhood Experiences Questionnaire)

Principle 4: Focus on Racial Equity

- Encourage the work of equity-focused workgroups, including the State's Centering Equity (Racial Disparities) workgroup and the Opioid Task Force Racial Equity workgroup; support standing workgroups that focus on racial equity in health and behavioral health
- Increase direct engagement efforts with communities of color and indigenous communities; solicit and integrate community input for planning initiatives
- Increase data collection and reporting on root causes of health disparities, including social determinants of health
- Improve culturally competent practices in assessment and engagement to improve identification of and intervention for SUD mental health conditions or co-occurring disorders among individuals of color and indigenous communities
- Increase continuity of care efforts for justice-involved populations. Support lateral service expansion along the behavioral health care continuum and SIM
- Increase comprehensive, wraparound supports for justice-involved individuals
- Increase community engagement efforts to enhance anti-stigma campaigns for individuals of color and indigenous communities

Principle 5: Develop a Fair and Transparent Process to Decide Where to Spend the Funding

- Ensure public transparency around State opioid settlement planning and spending
- Build data collection capacity to support accurate identification of needs/gaps
- Increase engagement with community leaders, health and behavioral health experts, service providers in prevention, treatment, recovery and harm reduction, law enforcement and first-responders, social service providers and faith-based organizations, housing providers, individuals and families with lived experience in SUD, mental health conditions and co-occurring disorders, as well as the general public, as a means to informing planning efforts
- Partner with representatives, leaders, and residents of communities of color, indigenous and tribal communities, rural areas and low-income communities
- Include Michigan's communities in decision-making for opioid settlement planning and program implementation
- Ensure that all funding initiatives include equity considerations built in; ensure that RFPs provide equitable opportunities for providers from marginalized communities (MI-SUVI)



ADOPTING THE BLOOMBERG/HOPKINS PRINCIPLES

The Bloomberg/Hopkins Principles [73] **are "nationally recognized guidance for states" and local jurisdictions receiving funds from opioid litigation**[74]**. This section is intended to provide an overview of the Bloomberg/Hopkins Principles and recommended strategies for how Michigan can best adopt "The Principles" to support responsible planning, use and management of opioid settlement funds.** The OAC has used the guiding strategies ("how can jurisdictions adopt this principle?") as a framework for assessing current planning and implementation practices at the State level. Gaps have been identified based on the Bloomberg/Hopkins Principles, MDHHS 2022 Opioids Strategy, the OAC's Guiding Principles and the subject matter expertise of the OAC's members.

Background

In 2021 "a coalition of 31 professional and advocacy organizations,"[75] coordinated by faculty at the Johns Hopkins Bloomberg School of Public Health, released a set of five (5) principles to help guide local, tribal and State decision-making on the use of opioid settlement funds. The "Bloomberg/Hopkins Principles" have now become nationally recognized guidance for planning and implementation efforts around the use of opioid settlement funds.[76]

Principle 1. Spend money to save lives

How can jurisdictions adopt this principle?

1.1 Establish a dedicated fund

1.2 Supplement rather than supplant existing funding

1.3 Don't spend all the money at once

1.4 Report to the public on where the money is going

Principle 2. Use evidence to guide spending

How can jurisdictions adopt this principle?

2.1 Direct funds to programs supported by evidence

2.2 Remove policies that may block adoption of programs that work

2.3 Build data collection capacity

Principle 3. Invest in youth prevention

How can jurisdictions adopt this principle?

3.1 Direct funds to evidence-based interventions

Principle 4. Focus on racial equity

How can jurisdictions adopt this principle?

4.1 Invest in communities affected by discriminatory policies

4.2 Support diversion from arrest and incarceration

4.3 Fund anti-stigma campaigns

4.4 Involve community members in solutions

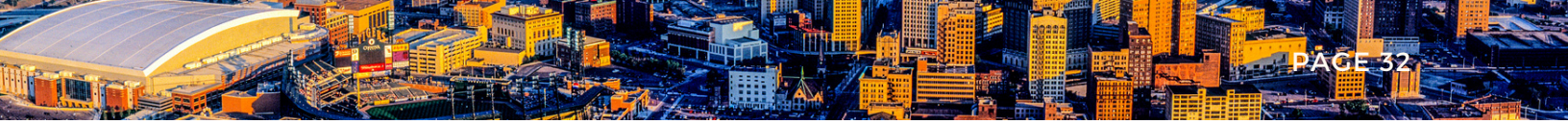
Principle 5. Develop a fair and transparent process for deciding where to spend the funding

How can jurisdictions adopt this principle?

5.1 Determine areas of need

5.2 Receive input from groups that touch different parts of the epidemic to develop the plan

5.3 Ensure that there is representation that reflects the diversity of affected communities when allocating funds



Principle 1. Spend money to save lives

Given the economic downturn, many states and localities will be tempted to use the dollars to fill holes in their budgets rather than expand needed programs. Jurisdictions should use the funds to supplement rather than replace existing spending.

1.1 Establish a dedicated fund

The Michigan Opioid Healing and Recovery Fund was created per **Public Act 83 of 2022**[77] to fulfill settlement requirements for a state Abatement Accounts Fund.[78] It is the fund to which all "State Share" settlement payments are directed, and the account from which all state-level settlement spending is drawn. The Department of Treasury is the designated "administrator of the Michigan opioid healing and recovery fund for audits" and "shall expend money from the Michigan opioid healing and recovery fund, on appropriation, in a manner and for purposes consistent with the opioid judgment, settlement, or compromise of claims from which the money was received".[79] The fund is considered "restricted" based on its statutorily defined use and any revenues from the account do not lapse into the state's General Fund if they remain unspent.

MICHIGAN'S **GAPS**

Absence of sub-funds

Presently, the Michigan Opioid Healing and Recovery Fund does not include sub-funds. While opioid settlement revenues are considered "restricted", the absence of any sub-funds presents a barrier to effectively tracking unique settlement monies (earmarked, appropriated and/or expended) and monitoring the use of funds for adherence to the settlement agreements.

Absence of oversight measures for State opioid settlement funds

While the Department of Treasury is statutorily identified as the administrator of the Michigan Opioid Healing and Recovery Fund, the scope of its administration remains limited to reception, expenditure, and audit of account funds.[80] This does not include specific tracking and reporting of settlement dollars earmarked (budgeted, pending legislative appropriation), appropriated (legislatively authorized for spending), or in process of expenditure. Both the Senate and House Fiscal Agencies are charged with the analysis of State budget bills and general monitoring of legislative appropriations, however there are no independent entities explicitly charged with oversight of opioid settlement funds. There are also no defined processes requiring consistent reporting on the State's use of opioid settlement funds. The OAC supports measures that increase general oversight of State opioid settlement funds, including but not limited to the following:

1. **Establish defined and independent tracking mechanisms for State opioid settlement funds**
2. **Increase public reporting on intended and actual uses of State opioid settlement funds**
3. **Develop an authorization process for State budget requests involving opioid settlement funds**
4. **Require reasonable, consistent reporting on initiatives supported by State opioid settlement funds**

REQUIRES IMMEDIATE ATTENTION

1.2 Supplement rather than supplant existing funding

MICHIGAN'S **GAPS**

Limited information on program planning and spending

There is limited information available on FY 2023 spending practices and FY 2024 planning efforts, specific to use of State opioid settlement funds. Information gaps limit the ability to review departmental spending in relation to broader strategic planning efforts that are currently underway. While $39.2 million in settlement funds have already been authorized for expenditure by MDHHS [81], "money in the Michigan opioid healing and recovery fund must be used to create or supplement programs or services. The money must not be used to replace any other governmental funds that would otherwise have been appropriated or expended for any other program or service".[82] The OAC supports supplemental use of settlement funds for program development, expansion and service enhancement, in alignment with the statutory requirements of PA 83 of 2022.

UNKNOWN—LIMITED PUBLIC INFORMATION

1.3 Don't spend all the money at once

Michigan has received approximately $99.3 million in "State Share" payments.[83] Of that, $39.2 million was appropriated to MDHHS as of FY 2023, with an additional $23.2 million appearing in the MDHHS/Executive Budget for FY 2024. [84] While additional settlement payments are anticipated between April – August 2023 , authorized and earmarked (anticipated) appropriations amount to nearly **63% of all "State Share" dollars received** as of Q2, FY 2023.
Noting that some of the national opioid settlements include "acceleration clauses" which front-load funds at the beginning of the payment schedule. This structure accelerates payments that would otherwise span multiple years, yielding a substantially larger initial lump sum as compared to subsequent annual payments.

MICHIGAN'S **GAPS**

Absence of longitudinal spend plans

Publicly available information on State spend plans remains limited . MDHHS spending priorities for FY 2023 align with the MDHHS 2022 Opioids Strategy,[85] reflecting initiatives under each of the eight (8) pillars: Prevention, Treatment, Harm Reduction, Recovery, Criminal-Legal, Pregnant and Parenting, Data, and Equity. However, programmatic details, gaps being filled, and specific funding allocations are not accounted for in publicly available information. At the time of this report, MDHHS has not shared additional information with the OAC regarding current settlement planning efforts or prioritization methods for FY 2024. Publicly available information around strategic priorities and implementation efforts that extend beyond FY 2023, is nonexistent. With an understanding that project spending may be adapted to the changing needs of Michigan's communities over time, the OAC supports multi-year strategic planning to promote fiscal longevity and responsible management of State settlement funds. The OAC encourages conservation of opioid settlement funds through integration of sustainability measures in State spend plans. The OAC also supports reasonable limits on annual legislative appropriations.

UNKNOWN—LIMITED PUBLIC INFORMATION

1.4 Report to the public on where the money is going

With FY 2023 well underway, information available to the public on State use of opioid settlement dollars remains limited. Funding priorities include behavioral health workforce development and support for maintenance/expansion evidence-based programming in areas of prevention, treatment, recovery and harm reduction.[86] "MDHHS has developed a proposed Opioid Settlement Spend Plan for the State of Michigan's Fiscal Year (FY) 2023 funding that has been driven by data, including the Opioid Settlement Prioritization Survey 2021–2022 [87], as well as ongoing programming needs and gaps due to federal funding restrictions."[88]

MICHIGAN'S **GAPS**

Limited reporting on settlement spending

While the MDHHS FY23 Settlement Spend Plan has been made publicly available, it lacks sufficient detail on actual spending efforts related to Michigan's use of opioid settlement funds. It reflects "proposed efforts", while FY 2023 expenditures are already underway. With knowledge that State opioid settlement funds are currently being expended, the OAC supports increased transparency through regular and timely public reporting on how opioid settlement funds are being spent, including outcomes data.

REQUIRES IMMEDIATE ATTENTION

Principle 2. Use evidence to guide spending

At this point in the overdose epidemic, researchers and clinicians have built a substantial body of evidence demonstrating what works and what does not. States and localities should use this information to make funding decisions.

2.1 Direct funds to programs supported by evidence

For FY 2023, Michigan seems to prioritize settlement spending on evidence-based programming, emphasizing appropriate data-driven solutions to the opioid epidemic and expanding initiatives that are supported by evidence. "DHHS will use the funding to continue to support evidence-based programming, including for treatment providers, recovery supports, harm-reduction strategies, prevention programming and other organizations that support individuals with substance use disorders". [89]

MICHIGAN'S **GAPS**

Limited reporting on settlement planning

There is limited current and publicly available information on State opioid settlement planning, which presents barriers to fully understanding spending decisions that direct settlement funds to specific programs, projects, or initiatives. While the language in the MDHHS Opioids Settlement: FY 2023 Spend Plan[90] indicates funding for evidence-based programming, the OAC supports detailed reporting on gaps filled, programs funded, outcome goals, and subsequent spending tracking, inclusive of outcomes data to inform future settlement planning. Furthermore, the OAC encourages public, private, and other stakeholder engagement in settlement planning with transparency on who, how, and what processes were developed and followed for settlement planning.

MORE WORK AHEAD

2.2 Remove policies that may block adoption of programs that work

State initiatives (fiscal years 2023 and 2024) to expand MOUD services in carceral settings,[91] help remove policies that have historically prevented linkages to evidence-based treatment for opioid use disorder. However, these initiatives require consideration for lateral expansion across community treatment and recovery ecosystems, where incentivizing allowances for MOUD may help remove prohibitive policies that ultimately place undue burden on the individual. As both State and Federal [92] initiatives expand availability and access to MOUD, considerations should be made for how to expand options for MOUD in state-funded withdrawal management ("detox"), residential SUD services, and state-contracted recovery housing.

MICHIGAN'S **GAPS**

Limited aggregated data around community provider policies

Provider policies that prohibit MOUD medications like buprenorphine (Suboxone and Zubsolv) and methadone, present conflicts between State-driven initiatives for MOUD expansion and State-funded services for treatment and/or recovery housing. It is unknown to what extent State efforts are being made to expand, promote, or incentivize allowances for MOUD across addiction treatment and recovery continuums. Further information is needed to fully assess statewide need, however with an increasing number of individuals linked with MOUD services, the OAC encourages information-sharing and further data collection efforts to assess for gaps that may be supported by opioid settlement funding. The OAC supports the consideration of lateral service expansion and funding incentives for expansion of treatment and recovery programs that include medications as part of their services to adequately support a growing number of Michigan residents who benefit from MOUD and other forms of pharmacological mental health support.

MORE WORK AHEAD

2.3 Build data collection capacity

MICHIGAN'S **GAPS**

Limited information available on data collection needs/efforts

Without a full understanding of State data collection efforts currently underway, it is unknown to what extent data gathering needs, exist. Despite limited information, the OAC recognizes the general need for increasing data collection efforts throughout the state and the necessity for building data collection capacity in Michigan's marginalized communities including but not limited to low-income communities, communities of color, and Michigan's tribal communities. The OAC supports increasing cross-organization and cross-department information sharing to assist in identifying current data collection efforts to consider utilization of opioid settlement dollars to close data gaps.

UNKNOWN—LIMITED PUBLIC INFORMATION

Principle 3. Invest in youth prevention

States and localities should support children, youth and families by making long-term investment in effective programs and strategies for community change.

3.1 Direct funds to evidence-based interventions

For FY 2023, Michigan is directing settlement funds to injury and violence prevention programming in multiple ways:

- Integration of content from the Adverse Childhood Experiences (ACEs) questionnaire into MDHHS school health curriculum
- Delivery of Health and Opioid Prevention Education (HOPE) curriculum for communities
- Implementation of Strengthening Families, an "evidence-based family skills training program for high-risk and general population families".[93]

MDHHS is also spending approximately $2.1 million in opioid settlement funding on in-home family support programs [94], including the Substance Use Disorder Family Support Program (SUDFSP) and Oregon Peer Recovery Coach Model (Morrison Peer Mentor Program).[95]

MICHIGAN'S **GAPS**

Clinical and cultural considerations for youth prevention programming

According to the CDC's 2019 Youth Risk Behavior Surveillance (YRBS), rates of substance use, suicidality and experiences of violence were higher for Michigan's racial and sexual minority youth[96] with substance use, suicidality, and experiences of violence most prevalent among Michigan's LGBTQIA youth. An informed understanding of youth risk behaviors, including awareness of mental health needs, trauma and experiences of physical and sexual violence, may help provide clinically and culturally competent prevention strategies. Differences observed among minority youth present cultural considerations for enhancement of existing prevention services, tailored to equity, community, and population needs. The OAC supports prevention strategies that are trauma-informed, evidence-based, data-supported, flexible in application, representative of equity and community considerations, and in alignment with general prevention principles.

Youth prevention services for priority populations

Due to lack of information, the strategic delivery of youth prevention services to priority populations remains a service gap. While family-based interventions are addressed in the MDHHS Opioids Settlement: FY 2023 Spend Plan, it is unknown if additional youth prevention programming (primary, secondary, or tertiary interventions), is being considered for other priority populations of the State's 2022 Opioids Strategy: justice-involved youths (Criminal-Legal), communities of color and/or indigenous populations (Equity). Executive priorities for FY 2024 include $32 million in juvenile justice programming, "providing reimbursement through the Michigan Child Care Fund for evidence-based community programing"[97] as well as $58 million for implementation of recommendations of the Racial Disparities Task Force, including $18.5 million for implementation of neighborhood health grant programs[98].
These may be opportune access points for delivery and expansion of youth prevention services; providing prevention programming alongside other priority interventions. The OAC supports collaborative planning across State branches, departments and teams to enhance strategic delivery of prevention services to priority populations.

Assessment of youth prevention needs: secondary and tertiary strategies

Absent in the MDHHS Opioids Settlement: FY 2023 Spend Plan is an assessment specific to secondary and tertiary youth prevention programming. The 2019 YRBS supports further consideration of secondary and/or tertiary (harm reduction) strategies for Michigan youth, particularly with racial and sexual minority youth. Overall, 13% of Michigan high school students reported misuse of prescription opioids, with 15% of lesbian and gay youth indicating misuse of heroin and 11.2% reporting lifetime history of injectable use of substances.[99] Data from the 2022 and 2020 MiPHY also reflects rates of injectable drug use (lifetime history) and "painkiller" use in the last 30 days that were disproportionately high.[100]
It is unknown to what extent publicly-funded secondary and tertiary prevention/harm reduction strategies are currently utilized or may be needed with Michigan's youth populations. The OAC supports further assessment to help enhance the youth prevention service array.

Principle 4. Focus on racial equity

States and localities should direct significant funds to communities affected by years of discriminatory policies and now experiencing substantial increases in overdoses.

4.1 Invest in communities affected by discriminatory policies

Michigan is implementing strategies to advance health equity for all state residents. The Michigan Overdose Data to Action Dashboard (MODA) and Substance Use Vulnerability Index (MI-SUVI),[101] Racial Disparities Task Force,[102] Opioids Task Force Racial Equity workgroup,[103] and 2022-2024 Social Determinants of Health (SDOH) Strategy[104] are among the State's efforts to address racial/ethnic, cultural, and socio-economic disparities in health care and root causes of health disparities in low-income communities, communities of color and Michigan's indigenous populations.

MICHIGAN'S **GAPS**

Limited information available on community implementation

While health equity strategies converge across multiple State teams, there is limited available information about how opioid settlement funds are being invested in communities affected by discriminatory policies. Without available information on community implementation of settlement-funded programs, it remains unknown to what extent State opioid settlement dollars are being invested in marginalized communities. Future recommendations of the Racial Equity workgroup and utilization of the MI-SUVI hold promise for strategic planning efforts around racial and socio-economic equity. The OAC supports both the work of the Racial Equity workgroup and use of MI-SUVI as resources to help guide meaningful community investment of opioid settlement funds. The OAC also encourages regular and ongoing engagement with Michigan's community members (e.g., "listening sessions")[105] to help inform decision-making on settlement spending. Finally, the OAC supports transparency regarding how these measures are used to determine appropriate allocations for settlement spending to reflect the diversity and equity gaps identified and filled utilizing settlement dollars.

UNKNOWN—LIMITED PUBLIC INFORMATION

4.2 Support diversion from arrest and incarceration

The MDHHS Opioids Settlement: FY 2023 Spend Plan includes MOUD linkages for carceral populations ($4M), continuation of syringe service programming ($4M), maintenance of the State Naloxone portal ($4.5M) and investment in "quick response" (post-incident) programming.[106]

Additional diversion efforts (FY 2024) supported by non-settlement funds include $15.6 million for expansion of MOUD services in correctional facilities, $3.85 million to "implement jail diversion pilot programs"[107], $32 million in local reimbursements through the Michigan Child Care Fund for "evidence-based community programing for juvenile justice", and $5 million for development of Job Courts to "divert offenders from criminal justice system".[108]

MICHIGAN'S **GAPS**

Lateral service expansion along the behavioral health care continuum

While initiatives in harm reduction and carceral MOUD help support general diversion efforts, as stand-alone programs, they present an incomplete service array along both the behavioral health care continuum and Sequential Intercept Model (SIM).[109] MDHHS identifies "Criminal-Legal" as one of the eight pillars in the State's Opioids Strategy; this includes increasing treatment access for justice-involved populations and expanding diversion efforts.[110] While it is unclear to what extent diversion programming is being coordinated across State teams, the OAC supports lateral expansion of services that promote continuity of care beyond carceral settings and offer programming along the behavioral health care continuum. Services should include wraparound and case management supports that are comprehensive, flexible and tailored to the unique needs of justice-involved individuals with SUD, mental health conditions or co-occurring disorders. The OAC also supports expansion of prevention, treatment, recovery and harm reduction interventions along the SIM.

MORE WORK AHEAD

4.3 Fund anti-stigma campaigns

A settlement-funded anti-stigma initiative exists under the Behavioral and Physical Health and Aging Services Administration (BPHASA); this includes partnerships with local Area Agencies on Aging for programming aimed to increase "awareness, education and health literacy among staff and older adults to improve safe and appropriate use of opioids".[111] In the 2020 MDHHS Opioids Task Force Town Halls, "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."[112] Prior State efforts around anti-stigma initiatives have included digital media campaigns in 2021, undertaken in partnership with Vital Strategies[113] and aimed at providing education around "opioid risks, reducing stigma, and increasing awareness of harm reduction services",[114] and the "African American Community Outreach" initiative involving MDHHS, Michigan Public Health Institute (MPHI) and Wellness Services, Inc., aimed to "extend harm reduction and prevention overdose messaging and outreach to reduce the number of overdose deaths in the African American community in Genesee County".[115]

MICHIGAN'S **GAPS**

Limited spending on anti-stigma campaigns

For FY 2023, $1.6 million of opioid settlement funding has been allocated for (what is inferred to be) an education and anti-stigma campaign spanning three years (BPHASA).[116] Adjusted for project duration, this amounts to little over 1% of annual State opioid settlement spending on anti-stigma initiatives. Due to limited information, it is unknown to what extent identifying, addressing and reducing stigma has been prioritized among other prevention efforts.
Cultural considerations around stigmatization of SUD, mental health conditions and COD, present opportunities for further implementation of prevention programming, particularly in communities of color. To best inform future efforts, routine and continuous data gathering around "attitudes, beliefs and behaviors targeted by stigma reduction initiatives" can help produce anti-stigma campaigns that are based in evidence.[117] The OAC supports expansion of data-driven, culturally competent anti-stigma campaigns, directed to, and developed in partnership with Michigan's communities. It is also unknown what identified gap in the current campaign this allocation is specifically addressing.

MORE WORK AHEAD

4.4 Involve community members in solutions

MICHIGAN'S **GAPS**

Limited Information available on planning processes

With limited information available on current settlement planning processes, it is difficult to assess the extent to which Michigan's communities have been involved in helping drive solutions. Beyond the valuable work underway with multiple MDHHS workgroups, further information about community engagement efforts for opioid settlement planning, is absent. The OAC supports ongoing, active and strategic engagement with Michigan's communities to help determine areas of need, service and funding gaps and viable strategies for opioid settlement spending.

UNKNOWN—LIMITED PUBLIC INFORMATION

Principle 5: Develop a fair and transparent process for deciding where to spend the money

This process should be guided by public health leaders with the active engagement of people and families with lived experience, as well as other key groups.

5.1 Determine areas of need

MICHIGAN'S **GAPS**

Limited information available on community and State needs

The 2021-2022 Opioid Prioritization Survey[118] provides initial data about how core strategies and approved uses of opioid settlement funds are prioritized by a limited subset of residents throughout the state. However, limitations exist in the survey's sample size, sampling method, organizational affiliation of respondents (with only 3% of respondents unaffiliated with a local organization), and general underrepresentation of individuals of color. With limited information on the processes, methods and assessments informing current settlement planning, it is unknown how areas of need are determined. The OAC encourages transparency around opioid settlement planning and supports building data collection capacity to fulfill its statutory obligation of an evidence-based, statewide needs assessment.[119]

UNKNOWN—LIMITED PUBLIC INFORMATION

5.2 Receive input from groups that touch different parts of the epidemic to develop the plan

MDHHS has previously engaged community groups in State planning efforts. In 2020, a series of community town halls were held to "solicit feedback on the 2020 opioids strategy".[120] Key findings (considerations) included the following:

- Expanding access to treatment
- Stigma in the delivery of substance use disorder services
- Rise in polysubstance use and increase in non-opioid drug use and overdose
- Enhanced treatment services for those with an OUD that are involved in the criminal-legal system
- Expanding access to harm reduction services
- Supporting individuals in recovery
- Impact of COVID-19

MICHIGAN'S **GAPS**

Limited information on efforts made to solicit input

Without available information on State opioid settlement planning, the extent to which various groups are being included in current planning efforts remains unknown. To help inform opioid settlement planning, the OAC supports ongoing efforts to solicit input from groups impacted by Michigan's opioid epidemic. The OAC encourages engagement with community leaders, health and behavioral health experts, service providers in prevention, treatment, recovery and harm reduction, law enforcement and first-responders, social service providers and faith-based organizations, housing providers, individuals and families with lived experience in SUD, mental health conditions and co-occurring disorders, as well as the general public, as a means to both informing and enhancing planning efforts.

MORE WORK AHEAD

5.3 Ensure that there is representation that reflects the diversity of affected communities when allocating funds

In 2020, MDHHS provided the following recommendation to help guide settlement funding efforts:
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.[121]

MICHIGAN'S **GAPS**

Limited information on community engagement efforts

It remains unclear to what extent community representatives have been engaged in recent State planning efforts. The OAC encourages partnership with representatives, leaders and residents of all disproportionately affected communities, with special attention to communities of color, indigenous populations and tribal communities, rural areas and low-income communities. The OAC supports active inclusion of Michigan's communities in decision-making for opioid settlement planning and implementation.

UNKNOWN—LIMITED PUBLIC INFORMATION

OAC 2023 ANNUAL REPORT

SECTION 5

FINDINGS AND RECOMMENDATIONS

Findings and Recommendations on Legislative Action
OAC Strategic Plan Fiscal Years 2023 - 2025
Planning Considerations
Next Steps

OPIOID ADVISORY COMMISSION

FINDINGS AND RECOMMENDED LEGISLATIVE ACTION

Key Finding 1. **Michigan's advisory structure presents strengths for balanced and effective oversight, but statutory changes and appropriations oversight are needed to compel cross-branch collaboration and ensure public transparency and responsible management of the Opioid Healing and Recovery Fund.**

Opioid settlement funds are being granted because pharmaceutical opioids and the companies that manufactured, marketed, distributed, and dispensed them, caused pervasive and ongoing harm to the public. Harms that devastated individuals, families and entire communities, with intergenerational impacts that are yet to be fully realized. Given the nature of the opioid settlements, the ubiquity of Michigan's opioid crisis and the level of harm caused by pharmaceutical opioids, at a minimum, there is an ethical responsibility for timely and transparent reporting to the legislature and the public on the use of opioid settlement funds.

Of the thirty-three (33) states with established opioid advisory commissions, Michigan has uniquely positioned its settlement advisory body (OAC) under the legislative branch. This structure supports logistical efforts for coordination between the OAC and the spending authority for State opioid settlement funds, the State Legislature. This also complements our democratic system of checks and balances, as the Legislature holds the responsibility for ensuring the executive branch serves the best interests of the people in administering the programs and funds entrusted to it.

Despite its strengths, statutory limitations are noted in the lack of language compelling effective information-sharing across branches. While the statute infers interdepartmental collaboration it overestimated the willingness of agencies to provide meaningful information flow across departments and the extent to which cross-branch data-sharing would be available to support informed decision-making for settlement planning and spending.

As of FY 2023, the Department of Health and Human Services received $39.2 million in Opioid Settlement Funds. The appropriation lacked detailed reporting requirements that would allow the public, OAC, and the legislature to effectively monitor if the expenditures were consistent with state's larger planned response to the opioid epidemic or whether funding shifts would be advised based on the efficacy of the expenditures. At a minimum, future appropriations to state departments administering grant programs using Opioid Settlement Funds, with the exception of approved uses for litigation by the Attorney General should include a requirements as follows:

Recommendation 1.1: **Implement detailed reporting requirements for state departments managing the expenditure of Opioid Settlement Funds.**

While in FY 2023, the Department of Health and Human Services received $23.2 million ($39.2 million total) in Opioid Settlement Funds to distribute to community providers, the appropriation lacked detailed reporting requirements that would allow the public, OAC, and the legislature to effectively monitor if the expenditures were consistent with state's larger planned response to the opioid epidemic or whether funding shifts would be advised based on the efficacy of the expenditures. At a minimum, future appropriations to state departments administering grant programs using Opioid Settlement Funds, with the exception of approved uses for litigation by the Attorney General should include requirements as follows:

Recommendation 1.1 Continued: **Implement detailed reporting requirements for state departments managing the expenditure of Opioid Settlement Funds.**

1. Submission of an annual, public "Opioid Settlement Funds Spend Plan" to the Opioid Advisory Commission and chairs of the legislative appropriations committee, no later than October 31. The Spend Plan should include, at a minimum, rationale(s) for proposed spending; descriptions of processes for determining grantees and/or contracted vendors including scorecard metrics for evaluation, expected performance on identified abatement measures, and compliance monitoring; and a description of equity considerations for planning, use, and administration of funds. Changes to a previously submitted Opioid Settlement Funds Spend Plan should be resubmitted to the Opioid Advisory Commission and the chairs of the legislative appropriations committees.
2. All "Opioid Settlement Funds Spend Plans" and any applicable amendments, shall be released to the public, no later than December 1, annually; language modifications may be made for purposes of confidentiality
3. Quarterly reporting on department use of opioid settlement funds, including details of specific grant recipients' encumbered and issued payments as well as performance on the department's compliance metrics. Reports shall be submitted to the Opioid Advisory Commission within 30 days of the end of each fiscal quarter.
4. Submission of an annual report to the Opioid Advisory Commission by January 31, summarizing departmental use of opioid settlement funds; comparison of actual to intended uses; description of settlement-funded projects and contracted providers; description of data collection, analysis and evaluation methods; description of key indicators for measuring remediation/abatement; description of equity considerations in planning, use and implementation of funded projects.

Recommendation 1.2: **The Opioid Advisory Commission and the Department of Health and Human Services should be compelled to execute a data sharing agreement for all data relevant to the state's role in responding to substance use disorders and co-occurring mental health conditions.**

Public Act 84 of 2022 requires the OAC to analyze, among other things, an assessment of prior use of money appropriated from the Michigan Opioid Health and Recovery fund, including the extent to which such expenditures abated the opioid crisis in the state. OAC was unable to acquire meaningful data and information from the Department of Health and Human Services in the timeframe covered by this report and relied on the limited, publicly available information to conduct its assessment.

In addition to expenditure reporting requirements, the state's data on the opioid crisis and co-occurring mental health conditions would be not only valuable to the work of this commission, but the creation of meaningful subsequent reports, as required by statute, will be impossible to complete without it.

Recommendation 1.3: **The Department of Treasury should be compelled to create sub-funds in the Opioid Healing and Recovery Fund.**

National guidance encourages consideration for responsible management of opioid settlement funds; the creation of sub-funds within the Michigan Opioid Healing and Recovery fund for distinct settlement revenues that are restricted to "Exhibit E" uses, supports this. The Attorney General should be consulted regarding the necessity of additional funds to monitor compliance with settlement agreements.

Recommendation 1.4: **The Department of Treasury should provide a quarterly, publicly available report regarding the use of the opioid settlement funds.**

Public transparency recalibrates systemic power structures based in access, ultimately promoting equity by increasing access to information on State opioid settlement practices. Communities should have this information freely and easily accessible to help them navigate the complex settlement landscape; this helps empower the public to appropriately engage in local and State settlement planning efforts.
To ensure that expenditures reported by grant administering agencies and entities, the Department of Treasury should provide a quarterly report, to be made publicly available, that includes the following:

1. Account balance, at time of report
2. Confirmation of all legislative appropriations from the Michigan Opioid Healing and Recovery Fund
3. Confirmation of any “earmarked” funds (appearing in the Executive Budget/General Omnibus), prior to legislative appropriations
4. Confirmation of any quarterly expenditures from the Michigan Opioid Healing and Recovery Fund
5. Confirmation of any “encumbrances” (funds awaiting expenditure) to the Michigan Opioid Healing and Recovery Fund
6. Description of State department expenditures, as they relate to approved used of opioid settlement funds; coordination with legislative fiscal agencies and/or State departments may be needed to support this task
7. Confirmation of any revenues to the account and general description
8. Confirmation of any settlement revenues to the account, including vendor information (originating source/payer)
9. Indication of any structural changes to the Michigan Opioid Healing and Recovery Funds
10. Treasury recommendations for changes to investment/securitization of State opioid settlement funds, based on legislative direction

Recommendation 1.5: **Establish reasonable statutory limits on annual legislative appropriations of monies from the Opioid Healing and Recovery Fund.**

While using settlement funds for immediate responses to Michigan's opioid crisis has been critical in our communities, understanding substance abuse disorders requires a complex analysis of numerous systemic and individual factors. A true holistic response that remediates the opioid crisis will take years of action, evaluation, and planning. Ensuring that funding is available to support Michigan's long term, planned response can best be guaranteed by limiting annual appropriations amounts, for example total appropriations for the fund not to exceed 40% of the annual state share opioid settlement revenues.

Program sustainability (for settlement-funded initiatives) and the financial health of the Opioid Healing and Recovery Fund should also be considerations when evaluating annual spending plans and recommendations.

Recommendation 1.6: **Ensure creation of a consolidated public dashboard (website) for spending plans and expenditures of Opioid Healing and Recovery Fund monies that includes all required public reports.**

The public should have one easily accessible location to understand the state's opioid crisis response and use of settlement funds. All reports required under recommendations 1.1 and 1.4 should be made available, along with education information about substance use disorders (SUD), co-occurring disorders (COD) community resources and resources made available by use of opioid settlement funds.

Key Finding 2. **The state must make deliberate efforts to facilitate community engagement and collaborative strategic planning to identify gaps in our state's opioid response and avoid redundancies in programming.**

At all levels, engagement with community stakeholders best supports planning, implementation, and evaluation efforts. As Michigan's needs change, stakeholder partnerships can help innovate abatement programming and offer collaborative response strategies for opioid remediation. In its inaugural year, the OAC strived to promote active collaboration across all branches of government, State departments, and localities. It held nearly seventy (70) engagement meetings since December, 2022 and continues facilitating a biweekly opioid settlement workgroup with representation from both State and local partners.
Without a statewide planning collaborative, data collection, analysis, and spending plans will continue to be disconnected from the realities faced in our communities. Increased information flow and cooperative decision-making about our state's opioid crisis response are vital to ensuring not only an accurate understanding of the current prevention, treatment, and recovery landscape but will create a structure that supports long term systemic healing in our communities.

Recommendation 2.1: **Dedicate appropriations not to exceed $5 million for FY 2024 for a county level data project, to be administered by the Department of Treasury and supported by a state level Opioid Planning Collaborative.**

This planning collaborative project would increase data (quantitative and qualitative) collection efforts needed for a statewide needs assessment. The goals of the project would be to identify community needs, gaps and priorities; actively engage communities in discussion around local and State opioid settlement planning; and encourage community involvement in State and local decision-making on settlement planning and spending. The OAC should act as a neutral convener of the Opioid Planning Collaborative, which should include, at a minimum partners from (a) state government, (b) local government and/or representative agencies, (c) Tribes and/or tribal representative agencies, (d) community mental health and public SUD providers, (e) non-profit community foundations, (f) community health organizations, (g) recovery community organizations, (h) criminal justice system and/or organizations serving justice-involved persons (i) emergency/transitional/recovery housing organizations (j) health equity and (k) community engagement fields. Considerations for equity should be made in terms of representation on the Opioid Planning Collaborative, with prioritization for representatives from Michigan's "vulnerable communities" as measured by substance use vulnerability index (MI-SUVI) or other comparable measure. Membership shall not exceed fifteen (15) total members.

The OAC and engaged partners anticipate the development of a community stakeholder portal that would be used by counties and tribal partners to provide and access data and information needed to conduct a statewide needs assessment. The Opioid Planning Collaborative should identify portal and data requirements so the Department of Treasury can initiate an RFP to identify a vendor that would be able to facilitate the development of the portal as well as data collection, management, and long term availability to community partners, governmental entities, and if appropriate, the public.

Recommendation 2.1 Continued: **Dedicate appropriations not to exceed $5 million for FY 2024 for a county level data project, to be administered by the Department of Treasury and supported by a statewide Opioid Planning Collaborative.**

The OAC is proposing a direct appropriation of $25,000 to each (voluntarily participating) county and each of the 12 (voluntarily participating) federally recognized tribes, to aid in their local data collection and participation efforts for an anticipated total cost of $2,375,000, payable directly to the county or tribal partner in adherence with Opioid Planning Collaborative guidelines and upon successful registration and initial response to the data portal requirements. All data and information collected should be made available via the portal to the OAC, Department of Health and Human Services, and Opioid Planning Collaborative members by December 31, 2024.

Recommendation 2.2: **Dedicate appropriations for FY 2024 not to exceed $500,000 for a statewide needs assessment, using data collected by the Opioid Planning Collaborative and county level data project, to be administered by the Department of Treasury and supported by a statewide Opioid Planning Collaborative**

Once initial data is collected, it must be analyzed, evaluated, and summarized into a statewide needs assessment. The Opioid Planning Collaborative should identify desired report requirements and timeline so the Department of Treasury can initiate an RFP to identify a vendor that would be able to accurately analyze and summarize the data collected in the community data portal; funds may also support development and maintenance of the community data portal.

Key Finding 3: **Existing sources of data are not being adequately leveraged to understand whether vulnerable populations are receiving continuity of care for co-occurring mental health conditions and substance use disorders.**

The prevalence of co-occurring SUD and mental health conditions, especially among individuals served by Michigan's public behavioral health systems, remains a central focus of the OAC. Nationally, co-occurring needs affect an estimated 17 million adults, with over 6 million adults experiencing both an SUD diagnosis and a serious mental health condition ("Serious mental illness"). Given the estimated need and the absence of state level public-facing reports on the prevalence of co-occurring disorders in both public SUD and mental health (CMHSP) treatment systems, significant information gaps exist for adequate assessment of co-occurring needs. The gaps identified have significant and broad implications especially when national data indicates that substantial populations served by public behavioral health treatment systems present with co-occurring needs.

Recommendation 3.1: **The Department of Health and Human Services must be compelled to collect information on co-occurring mental health conditions and substance abuse disorders.**

Integrated Treatment for Co-Occurring Disorders (formerly Integrated Dual Diagnosis Treatment; IDDT) [122] is an evidence-based intervention for co-occurring mental health and substance use disorders. At the time of this report, only twelve (12) certified IDDT programs exist in Michigan for an estimated 244,442 individuals served annually by the CMHSPs. As of FY 2021, spending for IDDT [123] programs was only 0.007% of total expenditures for adult mental health services. [124]

The Department of Health and Human Services should focus on collecting data on the current state of (a) certified IDDT programs, (b) integrated care efforts addressing co-occurring needs and (c) the prevalence of co-occurring SUD and mental health diagnoses among populations served by CMHSPs and PIHP SUD providers in Michigan; the Department of Health and Human Services must be compelled to provide that data to OAC so that information can inform future spending plans and efficacy analysis.

OAC OPIOID SETTLEMENT FUNDS STRATEGY FISCAL YEARS 2023-2025

PHASE I: **ASSESSMENT & PLANNING**

IDENTIFY STRUCTURAL GAPS AND INTEGRATE STRATEGIES FOR RESPONSIBLE PLANNING, USE AND MANAGEMENT OF OPIOID SETTLEMENT FUNDS

FY 2023

- Assess statutory strengths and limitations (PA 83 of 2022; PA 84 of 2022)
- Assess structures related to State opioid settlement funds; identify process gaps
- Review monitoring and reporting measures for use of opioid settlement funds; identify gaps
- Initiate outreach and engagement efforts with stakeholders; solicit input on needs and priorities
- Develop preliminary strategy for settlement planning and implementation FY 2023 – FY 2025
- Identify initial funding priorities for FY 2024
- Report to Legislative leadership, House and Senate Appropriations Committee Chairs, the Governor, Attorney General and the public on findings and recommendations
- Expand outreach and engagement efforts to Michigan's communities, including tribal communities
- Participate in national learning networks and opioid settlement workgroups to enhance settlement planning efforts
- Expand cross-branch and state-local partnership through Opioid Settlement Collaborative (OSC) workgroup

If funding recommendations are adopted by the State legislature

1 **Develop initial work plan including budget proposal, project timeline, list of community partners and preliminary implementation strategies for the following recommended initiative(s):**
Target Date: June 1, 2023 (Q3, FY 2023)

(a) **Establish an "Opioid Planning Collaborative" (Steering Committee) for planning/development of (i) a statewide needs assessment, (ii) structured community outreach/engagement activities, (iii) options for future community endowment fund(s), and (iv) public-facing "settlement dashboard", if applicable. The OAC shall assume responsibility as the neutral convener of the "Opioid Planning Collaborative"**
Target Date: June 1, 2023 (Q3, FY 2023)

(b) **Develop grant process(es) for vendors (data collection, analysis and evaluation services; development of dashboard/website). Treasury to facilitate all grants/ Request for Proposal (RFP) processes.**
Target Date: August 1, 2023 (Q4, FY 2023)

(c) **Develop "registration portal" or similar mechanism for county and tribal partners. Initiate community outreach/engagement efforts**
Target Date: August 1, 2023 (Q4, FY 2023)

(d) **Activate "registration portal" for county and tribal partners**
Target Date: October 1, 2023 (Q1, FY 2024)

(e) **Initiate statewide community needs assessment and community outreach/engagement activities**
Target Date: November 1, 2023 (Q1, FY 2024)

(f) Legislature **Directly appropriate "planning incentive" to participating counties and Tribes**
Target Date: January 1, 2024 (Q2, FY 2024)
"Planning incentive" intended to (i) encourage participation in reporting/statewide needs assessment, (ii) promote community inclusion in settlement funding discussions, (iii) increase community involvement in state/local planning efforts, (iv) promote public transparency in identification of community needs, gaps and priorities (v) increase public awareness of state/local opioid settlement practices, (vi) increase utilization of state/local resources to support strategic planning efforts, and (vii) increase awareness of national guidance around planning and use of opioid settlement funds. Specific requirements to be outlined by the " Opioid Planning Collaborative".

2 Neutral Convener (OAC) **Provide quarterly, public reports (status updates) on project planning and implementation efforts. Reporting schedule effective October 1, 2023 (project summary). Following initial summary, all reports due by end of fiscal quarter.**

OAC OPIOID SETTLEMENT FUNDS STRATEGY FISCAL YEARS 2023-2025

PHASE II: **COMMUNITY ENGAGEMENT & COLLABORATION**

DETERMINE STATEWIDE NEEDS, INCREASE COMMUNITY ENGAGEMENT EFFORTS AND DEVELOP INVESTMENT GOALS

FY 2024

- Develop and expand strategic partnerships to support collaborative planning efforts
- Opioid Planning Collaborative (Steering Committee): Initiate community outreach, education and engagement efforts with key stakeholders, community partners, local governments, and the public
- Establish and maintain quarterly reporting (public) on updates from OAC-involved initiatives
- Opioid Planning Collaborative (Steering Committee): Conduct (i) statewide needs assessment and (ii) consistent community engagement activities; ongoing
- Maintain cross-branch and state-local collaboration through Opioid Settlement Collaborative (OSC) workgroup
- Enhance cross-branch partnerships with State departments, including MDHHS. Develop data agreements to support information sharing
- Advocate for policy change to MCL 4.1851 (PA 84 of 2022) and/or MCL 12.253 (PA 83 of 2022) to support recommended statutory changes
- Collaborate with State department councils including but not limited to the Governor's Opioids Task Force and Racial Equity Workgroup, Governor's Health Equity/Racial Disparities Task Force, Social Determinants of Health workgroup, Mental Health Diversion Council and Michigan Department of Corrections workgroups
- Maintain involvement in national workgroups and learning networks including but not limited to NASHP SOS Learning Network and Colorado AG's Office Opioid Settlement Workgroup
- Evaluate qualitative and quantitative data from (i) statewide needs assessment and (ii) community engagement activities
- Develop long-term investment goals, based on initial data
- Opioid Planning Collaborative (Steering Committee): Determine outreach, assessment and evaluation frequency; identify areas for improvement; determine evaluation methods
- Determine "key indicators" for measuring effectiveness of opioid abatement strategies
- Compose OAC 2024 Annual Report, including funding enhanced recommendations for use of State opioid settlement funds

PHASE III: **IMPLEMENTATION & EVALUATION**

IMPLEMENT STRATEGIC FUNDING EFFORTS, ANALYZE SPENDING TRENDS AND EVALUATE ABATEMENT STRATEGIES

FY 2025

- Maintain cross-branch, state-local and community-based partnerships to support collaborative strategic-planning
- Maintain involvement in national workgroups and learning networks
- Planning Collaborative (Steering Committee): Maintain outreach, assessment, and evaluation frequency, as previously recommended (FY 2024)
- Maintain community outreach and engagement efforts to support public transparency, identification of local needs and community collaboration
- Maintain quarterly reporting (public) on updates from OAC-involved initiatives
- Develop an OAC subcommittee(s) to enhance advisory functions for the following: reducing disparities in access to prevention, treatment, recovery and harm reduction; improving racial, cultural and socioeconomic equity in behavioral health settings; addressing co-occurring SUD and mental health needs; addressing polysubstance use; supporting trauma-informed care
- Support ongoing data collection around State opioid settlement-funded programming/projects
- Planning Collaborative (Steering Committee): Conduct evaluation of State opioid settlement-funded programing/projects; assess for effectiveness, as measured by "key indicators" (FY 2024)
- Report to the public on effectiveness of opioid abatement strategies
- Adhere to long-term investment goals, if advised; report on changes to long-term investment goals, if needed
- Compose OAC 2025 Annual Report, including enhanced recommendations for use of State opioid settlement funds

PLANNING CONSIDERATIONS

The OAC's FY 2023-2025 Strategic Plan outlines objectives and activities that promote responsible planning, use, monitoring, and management of State opioid settlement funds. All activities of the Strategic Plan are intended to support fulfillment of critical tasks of the OAC as framed by Public Act 84 of 2022 [124]. Critical tasks include but are not limited to:

(1) **Conducting a statewide needs assessment**

- Needs assessment to include summary of funding used to address substance use disorders and co-occurring mental health conditions.
- Discussion of how to prevent overdoses, address disparities in access to health care and prevent youth substance use.
- An analysis based on quantitative (statewide needs assessment) and qualitative (community outreach/engagement sessions) data, of the effects on this state of substance use disorders and co-occurring mental health conditions.
- Description of the most common risk factors associated with substance use disorders and co-occurring mental health conditions.

(2) **Developing goals and recommendations, including the rationale behind the goals and recommendations, sustainability plans and performance indicators relating to all of the following:**

- Substance use disorder and co-occurring mental health conditions prevention, treatment, recovery and harm reduction efforts.
- Reducing disparities in access to prevention, treatment, recovery and harm reduction programs, services, supports and resources.
- An evidence-based assessment of the prior use of money appropriated from the Michigan Opioid Healing and Recovery Fund, including the extent to which such expenditures abated the opioid crisis in this state.

To support transparency in planning, the following pages outline the OAC's Guiding Principles, Strategic Priorities and broader planning considerations. While these items are preliminary, they were considered in all strategies and recommendations of this document and are expected to play a central role in the OAC's FY 2024 Annual Report. **They are included to offer insight into the OAC's strategy, objectives, recommendations and future planning goals.**

OAC OPIOID SETTLEMENT FUNDS STRATEGY **PRIORITIES, PRINCIPLES AND ANCHORS**

Address co-occurring needs
in prevention, treatment, recovery and harm reduction planning

Reduce disparities in access
to prevention, treatment, recovery and harm reduction services

Enhance support services
across health, SUD and mental health care continuums

Assess program effectiveness
in abating Michigan's opioid epidemic

Plan for sustainability
to ensure continuation of programs that work

OAC PLANNING CONSIDERATIONS

GUIDING **PRINCIPLES**

Adopted in tandem with the Bloomberg/Hopkins Principles, the OAC has developed the following guiding principles to help drive strategic planning, policy and funding recommendations

advance
health equity

Ensure that everyone has a fair and just opportunity to be as healthy as possible
Robert Wood Johnson Foundation

effect
stigma change

Promote strategies to eliminate stigma associated with substance use disorders, mental health conditions and co-occurring disorders, by way of education, outreach, advocacy, engagement, training, collaboration and inclusion of voices with lived experience

expand
cross-system collaboration

Develop and maintain community partnerships across systems and sectors that enhance integrated care, advance health equity and reduce disparities in service access and delivery

enhance
whole person care

Consider the whole person, including regard for the individual, their biology, life experiences, circumstances, and connections, to better understand adverse health impacts, better support individual health needs and better promote positive health outcomes

promote
service innovation

Support creative, novel and promising approaches that advance health equity and meaningfully address substance use disorders, mental health conditions and co-occurring disorders

Authentic Community Engagement as principles to action

With legislative recommendations that include expanding community engagement activities for FY 2024, the OAC regards "authentic community engagement" [126] as principles to action. The following represents "Principles of Authentic Community Engagement" [127] as envisioned by the Minnesota Department of Health and as supported by the OAC. It has been included in this document as a planning consideration for projects anticipated FY 2024-2025 and as a way to emphasize the value the OAC places on community engagement as a means to informing settlement planning and implementation efforts for the state.

Foster trust

1. Immerse yourself in the community
2. Listen deeply
3. Recognize different kinds of groups
4. Understand the historical context of previous attempts of engagement
5. Notice assets
6. See different experiences

Support community-led solutions

Ensure the population impacted by the problem is involved in co-creating solutions.

7. Work with communities
8. Agree on the process
9. Understand each partner's individual and community interests
10. **Allocate resources for community members to be active participants, so that community engagement is valued for its contribution to the process**
11. Balance Power
12. Share power
13. Create positive experiences of contribution
14. Recognize the contributions of the community

Public health improvement requires social change

15. Leave the community stronger
16. Stay in it for the long term
17. Address racism
18. Remember that self-determination is a right
19. Expect tension
20. Address challenges
21. Welcome new accountabilities and opportunities to transform practice
22. Strengthen relationships among participating

Items (above) have been adapted from the Minnesota Department of Health "Principles for Authentic Community Engagement" [128]. The OAC also values national guidance from the CDC/ATSDR /NIH/DHHS/CTSA Principles of Community Engagement (2015) [129]

OAC PLANNING CONSIDERATIONS

STRATEGIC PRIORITIES

To develop meaningful recommendations for abatement of Michigan's opioid crisis, the OAC has identified the following strategic priorities: Prevention, Treatment, Recovery and Harm Reduction.

These priorities align with statutory language that guides the OAC (PA 84 of 2022) and broadly cover a landscape of all services, supports, strategies and interventions aimed to address substance use disorders (SUD), mental health conditions (MHC) and co-occurring disorders (COD).

The priorities are intended to provide a foundation for all recommendations of the Commission, present and future. While the OAC recommends annual re-assessment of strategic priorities to best reflect the unique and changing needs of Michigan's communities, the hope is that any focus areas recommended by future commissions, find relevance to the foundational priorities, contained herein.

SUBSTANCE USE, MENTAL HEALTH AND CO-OCCURRING DISORDERS

prevention

Any strategy which helps educate, identify and prevent negative health or social outcomes from substance misuse, substance use disorders, mental health conditions or co-occurring disorders

treatment

Any intervention intended to treat symptoms, improve functioning, and support positive health and social outcomes for individuals with substance use disorders, mental health conditions or co-occurring disorders

recovery

Any non-clinical support which helps promote positive change and sustainable life outcomes for individuals with substance use disorders, mental health conditions or co-occurring disorders

harm reduction

Any effort intended to help reduce the negative health impacts and social harms associated with substance use and substance overdose (overdose prevention)

EQUITY

Significant disparities exist in health outcomes, access to health services and rates of service-engagement, among individuals of color, ethnic minorities and populations with basic needs insecurity.

Systemic racism, discriminatory policies and practices, and inequities in social determinants of health, have served to marginalize certain populations, creating barriers to equitable and just care.

The OAC acknowledges that not all Michigan residents have access to the same opportunities; that limitations in social and economic opportunity as well as limited access to essential resources, have real and adverse impacts on health and wellbeing. The OAC understands that individuals of color and those experiencing economic insecurity, are unfairly and disproportionately impacted.

For these reasons, equity, with emphasis on racial and socioeconomic equity, exists as an anchor for all priorities, principles and recommendations of the OAC.

DATA & POLICY

Data and policy are integral to all priorities, principles and recommendations of the OAC.

When data is complete, accurate, timely and accessible, it enables sound analyses, driving wise public policy, program, and procedural decisions.

Data and resultant information serve to:

- Identify needs and service gaps
- Inform public policy
- Assess interventions and program efficacy
- Identify best practices and promising strategies
- Evaluate the worth and value of demonstrations, pilots, and creative new approaches

Fair and just care for all Michigan residents remains a key strategy for abating the harms of the opioid epidemic. The OAC will use data and policy with purpose, in the pursuit of addressing service gaps, achieving equitable healthcare, and offering sustainable solutions to improve outcomes for all people of Michigan.

OAC PLANNING CONSIDERATIONS

Prioritizing **equity, data, and policy** in opioid abatement and remediation

The OAC regards equity, data, and policy as three legs of a conceptual model that should frame all settlement planning and implementation efforts. Equity represents both a key value and primary goal of the OAC; data and policy represent tools to help advance equity. The World Health Organization defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups." This can only be achieved through creating the opportunities, conditions, and resources for all Michigan residents to live their healthiest lives.

In the U.S., certain populations—particularly people of color—are dying at disparate rates across the life spectrum, from infant mortality[130] and maternal mortality[131] to end of life expectancy.[132] In Michigan, Black residents experience fatal overdose at over twice the incidence of their White counterparts[133]. Black individuals also experience the highest rate of non-fatal overdoses in the state.[134]

This data points to the importance of upstream consideration for root causes of health inequities, including the impacts of social determinants of health (the conditions where people live, work, and play), systemic racism and discriminatory practices that have historically and disproportionately impacted communities of color (e.g., the "War on Drugs" under which nearly 80% of people in federal prison and almost 60% of people in state prison for drug offenses were Black or Latino).[135] With a charge to reduce "disparities in access to prevention, treatment, recovery and harm reduction"[136] services, language found in the MDHHS Opioids Strategy and the national standards laid out in the Bloomberg/Hopkins Principles, consideration for equity, data and policy is supported by both State and national guidance.[137]

Understanding **Equity**
in health and behavioral health care

The CDC describes **health equity** [138] as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to:

- **Address historical and contemporary injustices;**
- **Overcome economic, social, and other obstacles to health and health care; and**
- **Eliminate preventable health disparities.**

To achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to racial and ethnic health disparities

All information (above) can be found on the CDC's Health Equity website: cdc.gov/healthequity [139] It has been expressed verbatim to support reader awareness.

Source: Robert Wood Johnson Foundation (2017)

OAC PLANNING CONSIDERATIONS

Focusing on **social determinants of health, community engagement and cross-system partnerships** in opioid abatement and remediation

Social **Determinants of Health**

Source: U.S. Department of Health and Human Services

Social determinants of health (SDOH) [140] are **the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.**

SDOH can be grouped into 5 domains:

- **Economic Stability**
- **Education Access and Quality**
- **Health Care Access and Quality**
- **Neighborhood and Built Environment**
- **Social and Community Context**

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- **Safe housing, transportation, and neighborhoods**
- **Racism, discrimination, and violence**
- **Education, job opportunities, and income**
- **Access to nutritious foods and physical activity opportunities**
- **Polluted air and water**
- **Language and literacy skills**

All information (above) can be found on health.gov/healthypeople a microsite through the Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. [141] It has been expressed verbatim to support reader awareness.

Michigan Department of Health and Human Services **Social Determinants of Health Strategy**

Health in All Policies (HiAP)[142] is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. It seeks to ensure all policies have neutral or beneficial impacts on the determinants of health and introduces improved health for all and the closing of health gaps as shared goals.

Multisector partnerships are critical to improve health outcomes and reduce disparities. The **Health in All Policies** approach makes it possible to respond to complex issues impacting health and wellbeing. It supports the development of innovative solutions, utilizing limited resources, to address increasingly challenging problems. Collaboration across sectors breaks down the more traditional silos of government to reduce duplicative efforts, more efficiently uses resources (often decreasing costs), and improves health outcomes.

All information (above) can be found in the MDHHS "2022-2024 Michigan's Roadmap to Healthy Communities, Phase II: Holistic Phase". It has been been expressed verbatim, to support reader awareness [143]

Figure 6. Achieving Population Health Together

Source: MDHHS SDOH Strategy

OAC PLANNING CONSIDERATIONS

Elevating **voices with lived experience and recognizing the critical role of recovery supports** in opioid abatement and remediation

What are peer recovery services? [144]

Per the Substance Use and Mental Health Services Administration (SAMHSA): *Peer recovery support services*,1 delivered by *peer recovery coaches*, are one form of peer support. They involve the process of giving and receiving non-clinical assistance to support long-term recovery from substance use disorders. A peer recovery coach brings the lived experience of recovery, combined with training and supervision, to assist others in initiating and maintaining recovery, helping to enhance the quality of personal and family life in long-term recovery (White, 2009). Peer recovery support services can support or be an alternative to clinical treatment for substance use disorders.

Peer-based recovery supports are part of an emerging transformation of systems and services addressing substance use disorders. They are essential ingredients in developing a recovery-oriented system in which clinical treatment plays an important, but singular, role. Acute care substance use treatment without other recovery supports has often not been sufficient in helping individuals to maintain long-term recovery. Substance use disorders are currently understood to be chronic conditions that require long-term management, like diabetes. Peer-based recovery support provides a range of person-centered and strength-based supports for long-term recovery management. These supports help people in recovery build recovery capital—the internal and external resources necessary to begin and maintain recovery (Best & Laudet, 2010; Cloud & Granfield, 2008).

What do peer recovery coaches do? [145]

Per SAMHSA[1]: Peer recovery coaches walk side by side with individuals seeking recovery from substance use disorders. They help people to create their own recovery plans, and develop their own recovery pathways. Recovery coaches provide many different types of support, including:

- **Emotional** (empathy and concern)
- **Informational** (connections to information and referrals to community resources that support health and wellness)
- **Instrumental** (concrete supports such as housing or employment)
- **Affiliational support** (connections to recovery community supports, activities, and events)

All information (above) can be found on SAMHSA's "Peers Supporting Recovery From Substance Use Disorder" infographic (2017). [146] It has been expressed verbatim to support reader awareness.

Recovery Support Settings

The following represent only some of the many settings where peer recovery services are delivered:

- Recovery Community Organizations (RCOs)
- SUD and Community Mental Health Providers
- Courts, Carceral Settings and Community Supervision Depts.
- Emergency Departments, EMS and Post-Overdose Response Teams
- Community Outreach, Harm Reduction, and Safe Syringe Programs

OAC PLANNING CONSIDERATIONS

Enhancing treatment and recovery ecosystems to support **intervention at critical access points**, as a strategy for opioid abatement and remediation

National efforts are underway to expand supports for individuals with SUD and mental health needs in emergency, health, carceral and community settings. Initiatives that support post-incident response programs[147] Recovery Community Organizations (RCO's)[148] and provider "co-location" [149], offer opportunities to increase engagement efforts and linkages to necessary supports and services at critical access points.

Model legislation supporting service expansion in emergency settings, was recently introduced (March 2023) [150]. In collaboration with the O'Neill Institute for National and Global Health Law at Georgetown University, the Legislative Analysis and Public Policy Association (LAPPA) has developed the "**Model Substance Use Disorder Treatment In Emergency Setting Act**" [151] that "establishes and aligns mechanisms for maximizing emergency medical settings as intervention points for people who experience a substance use-related emergency, people with substance use disorders, and their families". The Act "intends to do so by addressing the barriers to implementing protocols in emergency medical settings that would **ensure evidence-based treatment of patients with substance use-related emergencies**. The Act also intends to **address barriers to expedited connection to the appropriate level of care following discharge**, and **incorporates best practices and promising innovations from interdisciplinary research analyzing protocols for emergency medical care delivery for the people most at risk of dying after emergency room discharge**" [152]

Critical Access Points for intervention

Supporting engagement and linkage to necessary services and supports

Emergency Medical and Mental Health Systems

- Emergency Departments
- Psychiatric Emergency Departments
- Labor and Delivery Departments

Crisis Response Settings

- EMS Departments (Post-Incident Response)
- Law Enforcement Departments (Crisis Intervention/ Diversion)
- Crisis Centers
- Emergency Housing Programs
- Inpatient SUD Programs
- Partial Hospitalization Programs
- Urgent Care Facilities

Court and Carceral Settings

- Treatment and Recovery (problem-solving) Courts
- Criminal Courts
- Family Courts
- Local Jails
- State and Federal Correctional Facilities
- Community Supervision Settings (Probation and Parole Departments)

Community Hubs

- Recovery Community Organizations (RCO's)
- Community/"Street" Outreach and Harm Reduction Programs
- Community Health Departments
- Community SUD and Mental Health Settings
- Community Engagement/ Resource Centers
- Local Churches/Faith-Based Organizations

OPIOID ADVISORY COMMISSION

NEXT STEPS
FY 2023

1 **Continue onging engagement efforts** with community stakeholders and key state offices; distribute and discuss inaugural report; prepare for Opioid Planning Collaborative (Steering Committee)

2 **Consult with community leaders and equity experts** on considerations for the Opioid Planning Collaborative; ensure equitable organizational and community representation

3 **Expand outreach to community and tribal leaders** for collaborative planning on statewide needs assessment and community engagement activities

4 **Determine parameters and identify community partners** for Opioid Planning Collaborative; outline group expectations, goals and objectives for further review

Acknowledgements

OPIOID ADVISORY COMMISSION—MEMBERS

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Senate Fiscal Agency
Department of Attorney General
Department of Corrections
Department of Health and Human Services
Department of Treasury
State Court Administrative Office
Michigan Association of Counties
Michigan Municipal League

COMMUNITY PARTNERS

The OAC promotes engagement with organizations and service providers, community leaders, subject matter experts and the public, as a means to helping inform its membership about the needs, gaps and priorities of Michigan's communities. The OAC would like to thank the many community partners who took time to speak with program staff—they provided invaluable insight into the work being done throughout this great state—and constructive suggestions on where more can be done.
The OAC would also like to thank the following contributors, without whose expertise the 2023 Annual Report could not have been completed:

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Key Terms and Definitions

Any Mental Illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness) [1]

Approved Uses is meant to describe the "approved uses" of opioid remediation (settlement) funds as outlined in "Schedule B" of "Exhibit E" of the national opioid settlements; approved uses include support for treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies, as detailed in "Exhibit E" [2]

BIPOC is an acronym that stands for Black, Indigenous, and people of color .[3]

Buprenorphine is a medication approved by the Food and Drug Administration (FDA) to treat Opioid Use Disorder (OUD). The following buprenorphine products are FDA approved for the treatment of OUD: [4]

- Generic Buprenorphine/naloxone sublingual tablets
- Buprenorphine sublingual tablets (Subutex)
- Buprenorphine/naloxone sublingual films (Suboxone)
- Buprenorphine/naloxone) sublingual tablets (Zubsolv)
- Buprenorphine/naloxone buccal film (Bunavail)
- Buprenorphine implants (Probuphine)
- Buprenorphine extended-release injection (Sublocade)

Collaborative Strategic Planning is meant to capture cross-branch, interdepartmental, state-local and community-state efforts to support information-sharing and promote strategies for high level planning regarding projects, processes and implementation efforts related to the recommended use of Michigan's opioid settlement funds

Community Engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices [5]

Community Mental Health Service Programs (CMHSPs) are governmental entities established by Michigan Mental Health Code. community mental health services programs (CMHSPs) and the organizations with which they contract provide a comprehensive range of services and supports to children, adolescents and adults with mental illnesses, developmental disabilities and substance use disorders in all 83 Michigan counties. The CMH network provides 24 hour emergency/crisis response services, screens admissions to state facilities, acts as the single point of entry into the public mental health system, and manages mental health benefits for persons enrolled in the Medicaid, MIChild and Adult Benefit Waiver programs. [6]

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[1] https://www.nimh.nih.gov/health/statistics/mental-illness
[2] https://nationalopioidsettlement.com/wp-content/uploads/2023/02/TEVA-Exhibit-E.pdf
[3] https://www.samhsa.gov/dtac/disaster-planners/diversity-equity-inclusion/key-dei-terms
[4] https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine
[5] https://www.atsdr.cdc.gov/communityengagement/pce_what.html
[6] https://cmham.org/membership/cmhsp-directory/

Continuum of Care is an integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.[7]

Co-occurring Disorders is meant to include any combination of two or more substance use disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR). No specific combinations of mental and substance use disorders are defined uniquely as co-occurring disorders. Some of the most common mental disorders seen in SUD treatment include: [8]

- Anxiety and mood disorders
- Schizophrenia
- Bipolar disorder
- Major depressive disorder
- Conduct disorders
- Post-traumatic stress disorder
- Attention deficit hyperactivity disorder

Core Strategies includes the "core strategies" for opioid abatement, as outlined in "Schedule A" of the "Exhibit E" of the national opioid settlements [9]

Cross-branch collaboration is the deliberate effort to create or deepen formal partnerships between executive and legislative branch representatives, is one strategy that states should consider when working to sustain evidence-based policymaking through administration changes, staff transitions, or setting of new priorities among state leadership. [10]

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures. To produce positive change, practitioners must understand the cultural context of the community that they serve, and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working with knowledgeable people from the community to plan, implement, and evaluate recovery activities. [11]

Cultural competency is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services. [12]

Equity means that resources are distributed based on the tailored needs of a specific audience. Equity recognizes that some communities will need more—or different—access compared to other communities. [13]

Ethnicity is a set of cultural and linguistic traits that individuals belonging to a particular social group share.

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[7] https://www.ncbi.nlm.nih.gov/books/NBK424856/
[8] https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders
[9] https://nationalopioidsettlement.com/wp-content/uploads/2023/02/TEVA-Exhibit-E.pdf
[10] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/03/how-cross-branch-collaboration-helps-states-strengthen-evidence-based-policymaking#:~:text=Cross%2Dbranch%20collaboration%2C%20the%20deliberate,transitions%2C%20or%20setting%20of%20new
[11] https://www.samhsa.gov/find-help/recovery
[12] https://www.samhsa.gov/dtac/disaster-planners/diversity-equity-inclusion/key-dei-terms

Fentanyl is a synthetic opioid, approved for treating severe pain, typically advanced cancer pain. It is 50 to 100 times more potent than morphine. However, illegally made fentanyl is sold through illicit drug markets for its heroin-like effect, and it is often mixed with heroin or other drugs, such as cocaine, or pressed into counterfeit prescription pills. [13]

FY Fiscal year (FY) is the annual period established for government accounting purposes. A fiscal year begins on October 1 and ends on September 30 of the following year. For example: FY2023 started on October 1, 2022 and ended on September 30, 2023. [14]

Harm Reduction is meant to include any effort intended to help reduce the negative health impacts and social harms associated with substance use and substance overdose (overdose prevention)

Implementation is a specified set of activities designed to put policies and programs into practice. [15]

LGBTQIA is an abbreviation that stands for lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual and/or ally. [16]

Lived Experience means "lived experience" of recovery from a mental health condition, substance use disorder, or both. [17]

Medication-assisted treatment (MAT) – Treatment for opioid use disorder combining the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies; [18] used interchangeably with the updated terminology "Medication for Opioid Use Disorders" (MOUD)

Medications for Opioid Use Disorder (MOUD) is all FDA-approved medications for the treatment of opioid use disorder. Buprenorphine, methadone, and naltrexone are the most common medications used to treat OUD. These medications operate to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative and euphoric effects of the substance used. [19]

Formerly referred to as "Medication-assisted treatment" (MAT)

Methadone is a synthetic opioid that can be prescribed for pain reduction or for use in MAT for opioid use disorder (OUD). For MAT, methadone is used under direct supervision of a healthcare provider [20]

Methamphetamine – A highly addictive central nervous system stimulant that is also categorized as a psychostimulant. Methamphetamine use has been linked to mental disorders, problems with physical health, violent behavior, and overdose deaths. Methamphetamine is commonly referred to as meth, ice, speed, and crystal, among many other terms. [21]

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[13] https://www.cdc.gov/opioids/basics/terms.html
[14] https://www.samhsa.gov/grants/grants-glossary
[15] https://www.ncbi.nlm.nih.gov/books/NBK424856/
[16] https://www.samhsa.gov/dtac/disaster-planners/diversity-equity-inclusion/key-dei-terms
[17] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peer-support-2017.pdfcommun
[18] https://www.cdc.gov/opioids/basics/terms.html
[19] https://www.samhsa.gov/medications-substance-use-disorders
[20] https://www.cdc.gov/opioids/basics/terms.html
[21] https://www.cdc.gov/opioids/basics/terms.html

Michigan Overdose Data to Action (MODA) Dashboard: [22]Michigan's surveillance tool funded by the CDC's Overdose Data to Action (OD2A) grant; [23] the initiative supports jurisdictions (Michigan) in collecting high quality, comprehensive, and timely data on nonfatal and fatal overdoses and in using those data to inform prevention and response efforts. OD2A focuses on understanding and tracking the complex and changing nature of the drug overdose epidemic and highlights the need for seamless integration of data into prevention strategies.

Naloxone is a medication approved by the Food and Drug Administration (FDA) designed to rapidly reverse opioid overdose. "Narcan" is common brand name for naloxone. [24]

Naltrexone is a medication approved by the Food and Drug Administration (FDA) to treat both alcohol use disorder (AUD) and opioid use disorder (OUD). Intramuscular extended release Naltrexone is a medication approved by the Food and Drug Administration (FDA) to treat both Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD). Naltrexone can be prescribed and administered by any practitioner licensed to prescribe medications, and is available in a pill form for Alcohol Use disorder or as an extended-release intramuscular injectable for AUD and OUD. [25]

Neutral Convener is a term used to illustrate the OAC's role as a nonpartisan, legislative entity, that would actively engage and "convene" community leaders and organizations for the purposes of forming and facilitating the Opioid Planning Collaborative (OPC) Steering Committee.

Opioid is the term that includes compounds that are extracted from the poppy seed as well as semisynthetic and synthetic compounds with similar properties that can interact with opioid receptors in the brain. Opioids have analgesic and sedative effects, and are commonly used for the management of pain. Opioid medicines such as methadone and buprenorphine are used for maintenance treatment of opioid dependence. After intake, opioids can cause euphoria, which is one of the main reasons why they are taken for non-medical reasons. Opioids include heroin, morphine, codeine, fentanyl, methadone, tramadol, and other similar substances. Due to their pharmacological effects, they can cause difficulties with breathing, and opioid overdose can lead to death. [26]

- Opioid analgesics – Commonly referred to as prescription opioids, medications that have been used to treat moderate to severe pain in some patients. Categories of opioids for mortality data include:

1. Natural opioid analgesics, including morphine and codeine;
2. Semi-synthetic opioid analgesics, including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
3. Synthetic opioid analgesics other than methadone, including drugs such as tramadol and fentanyl.

Overdose is injury to the body (poisoning) that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal. [27]

- **Fatal Overdose:** substance overdose resulting in death
- **Non-Fatal Overdose:** substance overdose not resulting in death

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[22] https://www.michigan.gov/opioids/category-data
[23] https://www.cdc.gov/drugoverdose/od2a/about.html
[24] https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naloxone#:~:text=Naloxone%20is%20a%20medication%20approved,heroin%2C%20morphine%2C%20and%20oxycodone.
[25] https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone
[26] https://www.who.int/news-room/fact-sheets/detail/opioid-overdose
[27] https://www.cdc.gov/opioids/basics/terms.html

Opioid Remediation per the national settlements means "care, treatment, and other programs and expenditures (including reimbursement for past such programs or expenditures except where this Agreement restricts the use of funds solely to future Opioid Remediation) designed to (1) address the misuse and abuse of opioid products, (2) treat or mitigate opioid use or related disorders, or (3) mitigate other alleged effects of the opioid abuse crisis, including on those injured as a result of the opioid abuse crisis. Exhibit E provides a non-exhaustive list of expenditures that qualify as being paid for Opioid Remediation. Qualifying expenditures may include reasonable related administrative expenses". [28]

Opioid use disorder (OUD) is defined by the CDC as a problematic pattern of opioid use that causes significant impairment or distress. A diagnosis is based on specific criteria (from the Diagnostic and Statistical Manual Fifth Edition; DSM-V) such as unsuccessful efforts to cut down or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria. Opioid use disorder is preferred over other terms with similar definitions, “opioid abuse or dependence” or “opioid addiction.” [29]

Outpatient is treatment that may be offered in a variety of settings, but often takes place in an office-type setting. Can include group and/or individual therapy services. [30]

Peer Services encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both [31]

Peer Support Worker (PSW) is someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. They provide support to others experiencing similar challenges. They provide non-clinical, strengths-based support and are “experientially credentialed” by their own recovery journey (Davidson, et al., 1999).. Peer support workers include Peer Recover Coaches (PRC) and Peer Support Specialists (PSS) [32]

People of color (POC) is used primarily in the United States to describe individuals who are not White. [33]

Polysubstance Use is the use of more than one drug. This includes when two or more are taken together or within a short time period, either intentionally or unintentionally. [34]

- Intentional polysubstance use occurs when a person takes a drug to increase or decrease the effects of a different drug or wants to experience the effects of the combination.
- Unintentional polysubstance use occurs when a person takes drugs that have been mixed or cut with other substances, like fentanyl, without their knowledge.

Prepaid Inpatient Health Plans (PIHP) is a term contained in federal regulations from the Centers for Medicare & Medicaid Services. It means an entity that 1) provides medical services to enrollees under contract with the state Medicaid agency on the basis of prepaid capitation payments, 2) includes responsibility for arranging inpatient hospital care, and 3) does not have a comprehensive risk contract. [35]

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[28] https://nationalopioidsettlement.com/wp-content/uploads/2023/01/Janssen-agreement-03302022-FINAL2-Exhibit-G-as-of-1.9.23.pdf
[29] https://www.cdc.gov/opioids/basics/terms.html
[30]https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder79/Folder2/Folder179/Folder1/Folder279/Outpatient_Continuum_of_Services.pdf?rev=316ba865b80844c9acff0ce1a59191ec
[31] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peer-support-2017.pdf
[32] https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
[33] https://www.samhsa.gov/dtac/disaster-planners/diversity-equity-inclusion/key-dei-terms
[34] https://www.cdc.gov/stopoverdose/polysubstance-use/index.html
[35] https://cmham.org/membership/pihp/

Prevention is meant to include any strategy which helps educate, identify and prevent negative health or social outcomes from substance misuse, substance use disorders, mental health conditions or co-occurring disorders..

Public-Facing Dashboard is a website to help governmental entities communicate with the public; a publicly available website for information, resources, and updates on a certain topic (e.g. opioid settlement funds and Michigan's opioid epidemic)

Public Transparency is the capacity of the public to obtain valid and timely information about the activities of government; specifically used in context to Michigan's opioid litigation and opioid settlement funds. [36]

"Quick Response" Teams (QRT)/Post-Incident Response Programs: Quick Response Teams, or QRTs, are pre-arrest diversion (deflection) programs that involve interdisciplinary overdose follow-up and engagement with survivors to link individuals to treatment during the critical period following overdose. [37]

Racial Equity is the societal condition in which the distribution of resources and opportunities is neither determined nor predicted by race, and in which structures and practices in society provide true fairness. [38]

Recovery is meant to include any non-clinical support which helps promote positive change and sustainable life outcomes for individuals with substance use disorders, mental health conditions or co-occurring disorders

Recovery Community Organizations (RCO's) are independent, grassroots, non-profit organization led and governed by representatives of local communities of recovery. These organizations are made up of lived experience and are not treatment providers, rather they work in, around and sometime in lieu of treatment. The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Public education, policy advocacy and peer-based recovery support services are the strategies through which this mission is achieved

These organizations:

- Organize recovery-focused policy advocacy activities;
- Carry out recovery-focused community education and outreach programs; and
- Provide peer-based recovery support services.

Recovery Ecosystem is a complex linkage of multiple sectors, including but not limited to recovery communities, peer support, health, human services, faith communities, criminal justice, public safety, housing, transportation, education, and employers. The goal of the recovery ecosystem is to help individuals in recovery access the support services and training they need to maintain recovery and successfully obtain sustainable employment. [39]

Recovery Housing is an intervention that is specifically designed to address the recovering person's need for a safe and healthy living environment while supplying the requisite recovery and peer supports [40]

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[36] https://www.britannica.com/topic/transparency-government
[37] https://www.centerforhealthandjustice.org/chjweb/tertiary_page.aspx?id=109&title=Quick-Response-Teams:-Interdisciplinary-Overdose-Response-and-Prevention
[38] https://www.samhsa.gov/dtac/disaster-planners/diversity-equity-inclusion/key-dei-terms
[39] https://www.arc.gov/sud/
[40] https://www.samhsa.gov/sites/default/files/housing-best-practices-100819.pdf

Residential Treatment is intensive, 24-hour a day services delivered in settings other than a hospital. [41]

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI. [42]

Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. [43]

SDOH can be grouped into five (5) domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Spend Plan is meant to capture a "plan" that outlines proposed "spending" (allocations) developed by State departments, specific to "planned" (intended) use of opioid settlement funds; details regarding key projects, project budgets, proposed vendor rationale for projects/initiatives and sustainability considerations may be captured within a spend plan

State Opioids Strategy: 2022 Michigan Department of Health and Human Services Opioids Strategy eight (8) pillar strategy for "fighting the opioid epidemic". The MDHHS Opioids Strategy includes the following pillars: Prevention, Treatment, Harm Reduction, Recovery, Criminal-Legal, Pregnant and Parenting, Data, and Equity [44]

Stigma (of mental health disorders and/or SUD) is when someone views another individual or group in a negative way because they have a distinguishing characteristic or personal trait that's thought to be, or actually is, a disadvantage (a negative stereotype). Unfortunately, negative attitudes and beliefs toward people who have SUD and/or a mental health condition are common. Stigma can lead to discrimination. [45]

Some of the harmful effects of stigma can include:

- Reluctance to seek help or treatment
- Lack of understanding by family, friends, co-workers or others
- Fewer opportunities for work, school or social activities or trouble finding housing
- Bullying, physical violence or harassment
- Health insurance that doesn't adequately cover your mental illness treatment
- The belief that you'll never succeed at certain challenges or that you can't improve your situation

Substance Use is the use—even one time—of any substance. [46]

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[41] https://www.ncbi.nlm.nih.gov/books/NBK424856/
[42] https://www.nimh.nih.gov/health/statistics/mental-illness
[43] https://health.gov/healthypeople/priority-areas/social-determinants-health
[44] https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/MI_Opioids_Strategy.pdf?rev=4ff15ed2512b4744800cb60b69913f64&hash=203BF21F93406ABDA1D80CE1CAF74F74
[45] https://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477
[46] https://www.ncbi.nlm.nih.gov/books/NBK424856/

Substance Use Disorders (SUD) are medical illnesses caused by repeated misuse of a substance or substances. According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), substance use disorders are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. Substance use disorders range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Note: Severe substance use disorders are commonly called addictions. [47]

Substance Use Disorder Treatment represents a service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability. [48]

Syringe Service Programs (SSPs) are community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases. [49] SSP's are considered a harm reduction support service.

Trauma is considered the lasting emotional response that often results from living through a distressing event. [50]

SAMHSA [51] describes individual trauma as an event or circumstance resulting in:

- physical harm
- emotional harm and/or
- life-threatening harm

The event or circumstance has lasting adverse effects on the individual's:

- mental health
- physical health
- emotional health
- social well-being
- and/or spiritual well-being

Treatment is meant to include any intervention intended to treat symptoms, improve functioning, and support positive health and social outcomes for individuals with substance use disorders, mental health conditions or co-occurring disorders

Withdrawal Management is monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance; a common service with SUD "detox" services [52]

Wraparound Services are non-clinical services that facilitate patient engagement and retention in treatment as well as their ongoing recovery. This can include services to address patient needs related to transportation, employment, childcare, housing, legal and financial problems, among others. Noting that elements of "wraparound' services may be considered clinical interventions (e.g. case management)

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[47] https://www.ncbi.nlm.nih.gov/books/NBK424856/
[48] https://www.ncbi.nlm.nih.gov/books/NBK424856/
[49] https://www.cdc.gov/ssp/index.html
[50] https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/trauma
[51] https://www.samhsa.gov/trauma-violence
[52] https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder100/Residential_TX_Policy_10.pdf?rev=4f1cd3a3a2864e728985853c8ab72c91
[53] https://www.ncbi.nlm.nih.gov/books/NBK424856/

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1. “Average daily overdose deaths” calculated from annual overdose deaths for 2021 https://www.michigan.gov/opioids/category-data
2. “Provisional Overdose Deaths: October 2021 – September 2022”; https://www.michigan.gov/opioids/category-data
3. MCL § 4.1851
4. https://nashp.org/
5. “Principles for the Use of Funds from Opioid Litigation” Johns Hopkins Bloomberg School of Public Health (2021) https://opioidprinciples.jhsph.edu/
6. Mermin, S., Falkner, R., Greene, K., “Understanding Opioid Settlement Spending Plans Across States: Key Components and Approaches” (2022) https://nashp.org/understanding-opioid-settlement-spending-plans-across-states-key-components-and-approaches/ Noting inference in statement "one of seventeen (17) states"; available information indicates that 29 (of 46) states have language in the their Memoranda of Understanding outlining reporting requirements
7. A general definition for “opioid abatement and remediation purposes” is found in Tennessee’s statutory language of Public Charter 491. The definition encompasses multiple references from both national settlement language and State guidance. For the purpose of identifying a single definition where one did not exist for Michigan, Tennessee’s statutory language has been used; https://www.tn.gov/content/dam/tn/attorneygeneral/documents/foi/opioids-settlements/tn-publichapter-0491.pdf
8. “Principles for the Use of Funds from Opioid Litigation” Johns Hopkins Bloomberg School of Public Health (2021) https://opioidprinciples.jhsph.edu/
9. MCL § 4.1851
10. MCL § 4.1851
11. MCL § 12.253
12. MCL § 4.1851
13. Michigan Office of the Attorney General. “Michigan’s 81 Million Dollar Settlement Set to Begin” (2023) https://www.michigan.gov/ag/news/press-releases/2023/01/13/michigan-81-million-opioid-settlement-distribution-set-to-begin
14. MCL § 4.1851
15. MCL § 4.1851
16. https://mi-suddr.com/opioids/
17. CDC WONDER via https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
18. CDC WONDER via https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
19. “Stimulants” is used to encompass cocaine and psychostimulants, such as methamphetamines https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
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47. Allergan Settlement Agreement (2022) https://nationalopioidsettlement.com/wp-content/uploads/2022/12/Final-Allergan-Global-Agreement-and-Exhibits_12-20-22.pdf
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124. Data for "Information Needs Behavioral Health Spending FY 2021, Considerations for Review of Future Section 904 Boilerplate Reports: Mental Health Benefit” was taken from the FY 2021 Section 904 Report to the legislature; only data from the CMHSP/Mental Health Benefit was used. Methodology: CPT codes and applicable modifiers used for determination of the “estimated total spending” on Integrated Dual Diagnosis Treatment/Integrated Care for Co-Occurring Disorders are the following: H2019; H2019TT; H2019GT; H2019TTGT. Only billable service codes were reviewed for the “Adults with Mental Illness” population. “Estimated total spending for IDDT” ($7,379,761) was divided by total spending for “Adults with Mental Illness” ($1,119,007,056) to determine percentage (%) of spending of billable IDDT services delivered by the CMHSPs for FY 2021. Figures should be regarded as estimates only; consult Michigan Department of Health and Human Services for final confiramtion
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