final minutes

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

Members Present:
Ms. Kelly Ainsworth
Mr. Brad Casemore
Judge Linda Davis
Ms. Katharine Hude
Ms. Mona Makki
Mr. Scott Masi
Mr. Mario Nanos
Mr. Patrick Patterson
Mr. Kyle Rambo
Dr. Sarah Stoddard

Members Excused:
Dr. Cara Poland
Dr. Cameron Risma

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

Mr. Patterson, serving as Vice Chair to the Commission, presided over the Commission meeting as Chair in Dr. Poland's absence.

Ms. Dettloff serving as an Ex-officio member to the Commission was in attendance.

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

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

III. OAC Program Coordinator
The Chair welcomed and introduced Tara King in her new role as the Commission's Program Coordinator. Ms. King expressed appreciation and indicated will be reaching out to Commission members directly in assistance with the Commission's tasks.

IV. Presentations to the Commission
- Michigan Department of Attorney General Opioid Strategy
    - Assistant Attorney General Matthew Walker and Mr. Mitch Albers
- Prevention Overview
    - Dr. Sarah Stoddard, University of Michigan Injury Prevention Center

V. Commission Outreach

The Chair confirmed presentations scheduled for the December 8, 2022 meeting to include:

- Michigan Overdose Prevention Coalition
- Dr. Amy Bohnert, University of Michigan
- Dr. Claire Margerison, Michigan State University
- Dr. Sheryl Kubiak and Mr. Matthew Costello, Wayne State University

VI. Approval of the October 13, 2022 Meeting Minutes

The Chair directed attention to the proposed minutes of the October 13, 2022 meeting and asked if there were any changes. **Mr. Casemore moved, supported by Mr. Rambo, to approve the minutes of the October 13, 2022 meeting. There was no further discussion and the Chair asked for a roll call vote. The motion prevailed and the minutes were approved.**

VII. Commission Member Comment

The Chair asked if there were additional comments from Commission members.
Ms. Hude noted Director Hertel's absence from today's meeting and inquired on Director Hertel or a designee's participation at Commission meetings. Dr. Poland noted it was confirmed with Director Hertel's office that either Director Hertel or a designee will be in attendance at Commission meetings and confirmed Jared Welehodsky's from MDHHS is in attendance on today's zoom call.

Mr. Rambo inquired about reformatting the subcommittee's work to be included in a breakout session during a Commission meeting. Mr. Patterson propose to Commission members to provide feedback to Ms. King regarding additional subcommittees to include each subcommittee's framework and Commission members serving on said subcommittees. Ms. Hude inquired if the December 8, 2022 meeting time duration can be expended into an all-day meeting to begin the report drafting process. Mr. Nanos proposed in Ms. King's reaching out to Commission members that Ms. King compile a priority list for the Commission to build from. Ms. King acknowledged and confirmed will begin work on the item of a priority list to include objectives for the Commission's report.

Mr. Nanos asked Ms. Dettloff for interruption of the Legislature's expectations in the Commission's report. Ms. Dettloff confirmed the Legislature understands the time restrictions and can begin work formatting a template appendix for the Commission's report.

Mr. Patterson referenced from earlier discussion the new time duration of 10:00 a.m. to 4:00 p.m. for the December 8, 2022 meeting. **Dr. Stoddard moved, supported by Mr. Rambo, to approve the new time duration of 10:00 a.m. to 4:00 p.m. for the December 8, 2022 meeting. There was no further discussion and the Chair asked for a roll call vote. The motion prevailed.**

VIII. Public Comment

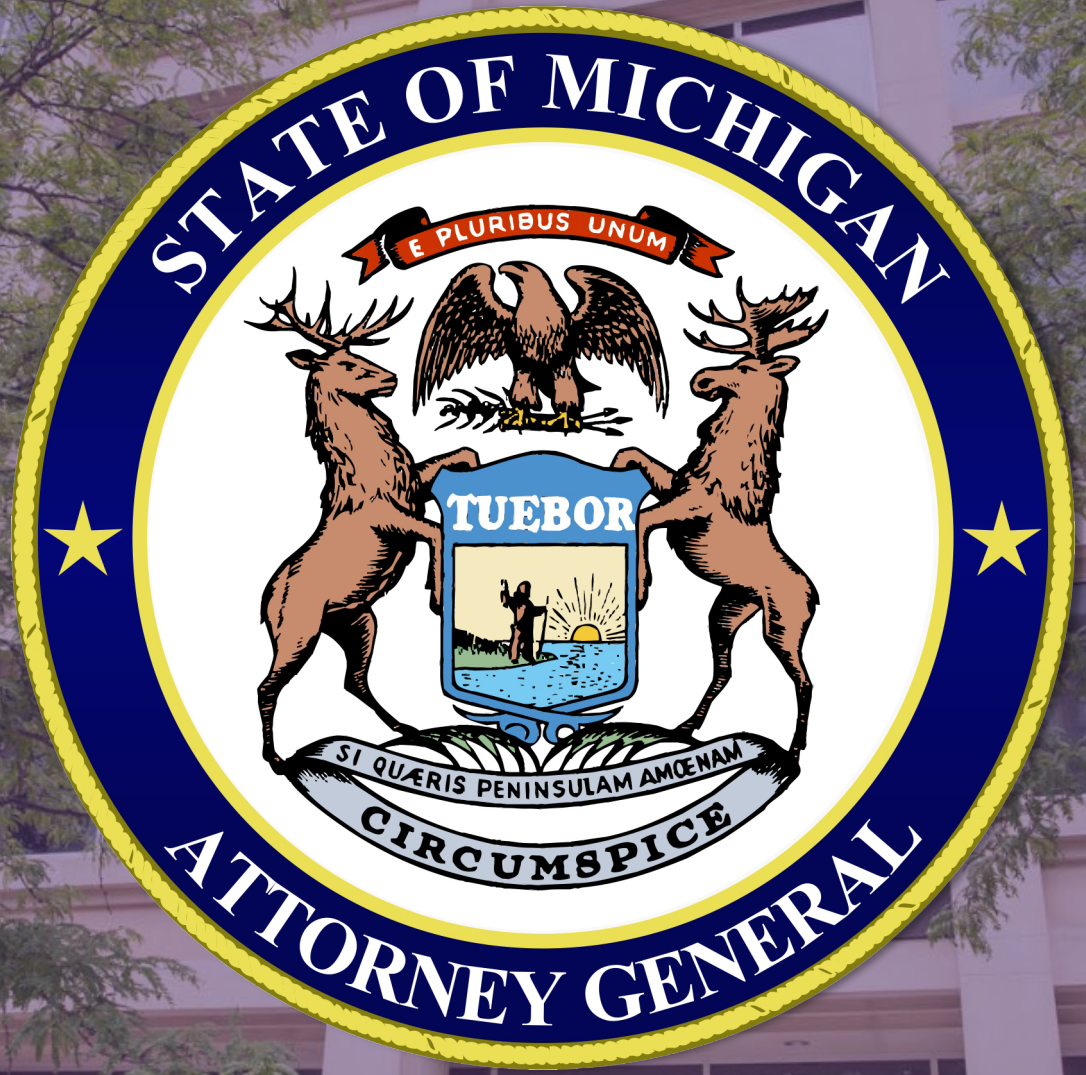
The Chair asked if there were any comments from the public. There was none.

IX. Next Meeting Date: Thursday, December 8, 2022 at 10:00 a.m.

The Chair announced the next meeting date for Thursday, December 8, 2022 at 10:00 a.m. The Chair reminded Commission members a majority of seven Commission members in attendance is required to conduct Commission business and instructed Commission members to let the clerk know if availability has changed.

X. Adjournment

There being no further business before the Commission the Chair adjourned the meeting at 12:07 p.m. with unanimous support.



Michigan Department of Attorney General

Opioid Settlements

WHOLESALE DRUG DISTRIBUTORS AND JANSSEN

Background

By 2017, over 2,000 federal lawsuits had been filed by government entities against opioid-related defendants. Among those defendants were opioid distributors and manufacturers.

In 2017, a federal judicial panel consolidated these cases into multidistrict litigation (MDL).

- The MDL was consolidated under one judge in the Northern District of Ohio.

In 2019, after receiving pressure from the MDL judge, three of the nation's largest drug distributors—McKesson, Cardinal Health, and AmerisouceBergen—agreed to settlements. Janssen, an opioid manufacturer, also agreed to settlement.

In 2021, the details of the settlement were released.

Who is settling?

Three of the Nation's largest wholesale drug distributors: McKesson, Cardinal Health, and AmerisourceBergen

- This includes several thousand subsidiaries of these companies.

Opioid manufacturer Janssen, a subsidiary of Johnson and Johnson.

What is being settled?

Many governments have agreed to release certain legal claims against these defendants, related to opioids.

In exchange for government's releasing those claims, the defendants have agreed to do certain things and pay money.

- Doing certain things is known as injunctive relief.
- Paying money is known as monetary payments.

What do the defendants have to do?

Janssen (Opioid Manufacturer), for 10 years, has agreed to:

- Stop selling and manufacturing opioids
- Stop promoting opioids
- Stop providing financial incentives to sales teams for opioid sales
- Stop lobbying for federal, state, local, and regulatory provisions that encourage or require health care providers to prescribe opioids
- Stop lobbying against federal, state, local, and regulatory provisions that
  - Support non-opioid pain relief
  - Prescribing the lowest effective dose
  - Prescribing naloxone and using urine testing for those with opioid prescriptions
  - Support evidence-based treatments (like MAT)

What do the defendants have to do?

The Distributors have agreed, for a period of 10 years, to:

- Create and implement a Controlled Substance Monitoring Program (CSMP)
  - CSMP is responsible for onboarding and approval of new controlled substance pharmacies, setting and adjusting pharmacy thresholds, setting and adjusting pharmacy thresholds, terminating or suspending pharmacies, and identifying red flags.
  - CSMP must conduct ongoing due diligence and conduct site visits, among other things
- Create and implement a National Clearinghouse to receive and analyze data received from this injunctive relief.
  - The Clearinghouse will allow Distributors to obtain comprehensive data from other Distributors , pharmacies, and other relevant sources.
  - States will have access to the data to query without limitation.

What do the defendants have to pay?

The Distributors and Janssen will pay up to $26 billion nationwide.

Michigan will receive up to 3.4%, or approximately $776 million over the course of 18 or less payments.

Payments are unlikely to be the same from year to year because of certain options in the settlement agreement.

Participation of States and eligible local governments is key

Michigan is a participating state and 269 of 278 eligible local subdivisions participated in the settlements

Tribes have a separate settlement.

DISTRIBUTORS: Base and Incentives

Base 55%
Incentives 45%
Net Abatement Amount

Incentives are earned by obtaining releases from subdivisions and limiting additional subdivisions from filing suit.

During the first two years, States that settle are treated as if receiving full base and incentive.

Illustrative only- Executed Agreements Control.

Incentive A

Incentive A provides for payment of all but Incentive D payments in exchange for near full peace.

Incentive A is earned by:

- Passing a Statute or court ruling that terminates existing and bars future claims by subdivisions (including special districts);
- Receiving releases on behalf of (i) all general purpose subdivisions above 10,000 population, (ii) larger school and hospital/health districts, and (iii) all currently litigating subdivisions; or
- A combination of these approaches that results in a complete bar of existing and future claims (e.g., legislation barring future claims combined with 100% participation by litigating subdivisions).

Incentive B

- Incentive B is not relevant if a State earns Incentive A.
- Incentive B is up to 25%.
- Incentive B is earned by obtaining releases from litigating subdivisions.

Incentive B Sliding Scale:

Participation or Case-Specific Resolution Levels	Incentive B Award
85%	30%
86-90%	40%
91-94%	50%
95-99%	60%
99-99.9%	95%
100%	100%

Not structured in time periods, as with Incentive B under the J&J Agreement.

Incentive C

- Incentive C is not relevant if a State earns Incentive A.
- Incentive C is up to 15%.
- Incentive C is earned by getting larger (population of 30,000) non-litigating and any-sized litigating counties and cities to join the deal.

Incentive C Sliding Scale:

Participation, Release, or Resolution Levels	Incentive C Award
60-69%	25%
70-74%	35%
75-79%	40%
80-84%	45%
85-89%	55%
90-92%	60%
93%	65%
94%	75%
95-97%	90%
98-99%	95%
100%	100%

There is no timing element.

Incentive D

5% share of the State's total Abatement Fund allocation (see page 20). Payable starting in year 6 through year 18.

Qualifying Criteria

- State must have had no later Litigating Subdivisions bring suit and proceed past preliminary motions.

Why Participation is Important

JOHNSON & JOHNSON: Base and Incentives

Base 45%

Incentives 55%

Global Settlement Abatement Amount

Incentives are earned by obtaining releases from subdivisions and limiting additional subdivisions from filing suit.

Illustrative only- Executed Agreements Control.

Incentive A

Incentive A provides for payment of all but Incentive D payments in exchange for near full peace.

Earning Incentive A also causes substantial payments, the first three years of payments, accelerated and paid within 90 days.

Incentive A is earned by:

- Passing a Statute or court ruling that terminates existing and bars future claims by subdivisions (including special districts);
- Receiving releases on behalf of (i) all general purpose subdivisions above 10,000 population, (ii) larger school and hospital/health districts, and (iii) all currently litigating subdivisions; or
- A combination of these approaches that results in a complete bar of existing and future claims (e.g., legislation barring future claims combined with 100% participation by litigating subdivisions).

Incentive B

- Incentive B is not relevant if a State earns Incentive A.
- Incentive B is up to 30%.
- Incentive B is earned from obtaining releases from litigating subdivisions.

Incentive B Sliding Scale:

Participation or Case-Specific Resolution Levels	Incentive B Award
75%	50%
76%	52%
77%	54%
78%	56%
79%	58%
80%	60%
85%	70%
90%	80%
95%	90%
100%	100%

Timing element
Incentive B is structured in time periods and states will receive a percentage of sliding scale payments depending on when they reach 75% of litigating subdivisions signed on: (a) 0-210 days = 100% of sliding scale; (b) 211-365 = 75% of sliding scale; and (c) 366-2 years from effective date = 50% of sliding scale.

Incentive C

- Incentive C is not relevant if a State earns Incentive A.
- Incentive C is up to 20%. It breaks Incentive C in two parts.
- Incentive C is earned by getting larger (population of 30,000) litigating and non-litigating counties and cities to join the deal. 5% is awarded for obtaining a State's ten largest general purpose subdivisions (cities and counties).

Incentive C Sliding Scale:

Participation, Release, or Resolution Levels	Incentive C(1) Award
60%	40%
70%	45%
80%	50%
85%	55%
90%	60%
91%	65%
92%	70%
93%	80%
94%	90%
95%	100%

There is no timing element.

Incentive D

5% share of the State's total Abatement Fund allocation (see page 20). Payable starting in year 6 through year 18.

Qualifying Criteria

- State must have had no later Litigating Subdivisions bring suit and proceed past preliminary motions in the 5 years following the Effective Date.

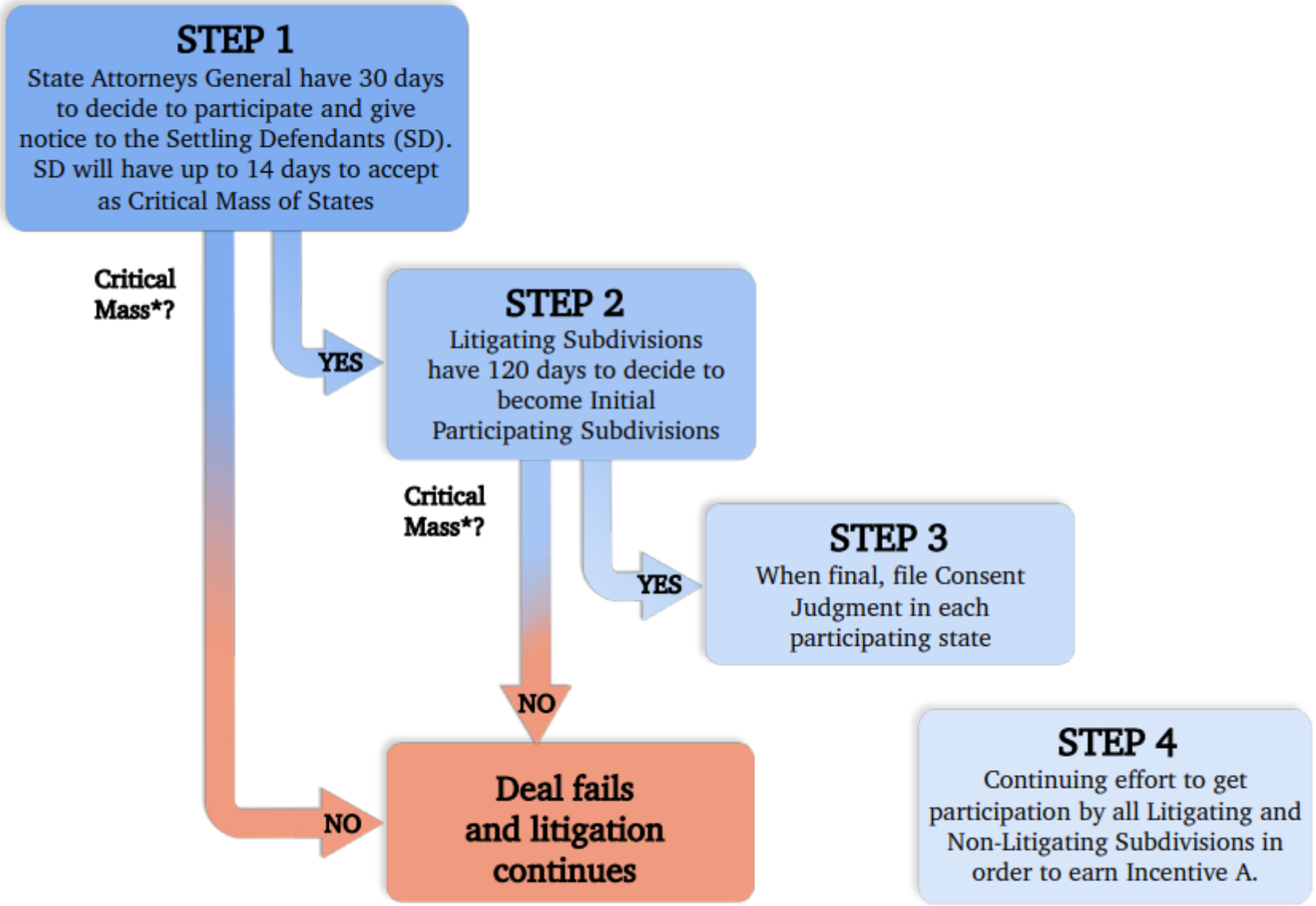
Why Participation is Important

Legislative Effort for Incentive A

Bills were passed to ensure Michigan receives Incentive A:

- SB 993 – Michigan Opioid Healing and Recovery Fund
- SB 994 – Opioid Advisory Commission
- SB 995 – Bar to new civil lawsuits against settling defendants

Implementation



*Sole discretion of Distributors & J&J

2021.07.22 Subject to Update & Correction/Executed Agreements Control

Michigan State-Subdivision Agreement

Available at Michigan.gov/agopioids

- Controls the allocation of funds to the State and Local Subdivisions, instead of what is listed in Master Settlement Agreement.
  - Allocates 50% to Local Subdivisions and 50% to the State. This is instead of 15% to Local Subdivisions, 15% to the State, and 70% to a fund.
  - Deductions for an Administrative Fund, Litigating Local Government Attorney Fee Fund, and Special Circumstance Fund.
- Allocations to individual local subdivisions are determined by a nationally used formula, modified by a litigation adjustment.
- Individual local subdivisions with an allocation percentage of less than .0023% (approx. $7,500 or less in total) will receive their complete recovery in the first payment.
- Local subdivisions may voluntarily assign all or part of their allocation to another participating subdivision.

Michigan State-Subdivision Agreement

Available at Michigan.gov/agopioids

- Attorney fees are limited to 15% of an individual Litigating Local Government's recovery and offset by a National Fee Fund.
  - For example, Subdivision A contracted with Attorney X for a 30% contingency fee. Attorney X's fee is limited to 15% of Subdivision A's recovery by the Michigan State-Subdivision Agreement and by order of the Court. The National Fee Fund pays 7% and the remainder is paid by the Litigating Local Government Attorney Fee Fund. Fees are paid over the course of 7 years.
- Special Circumstance Fund: Local subdivisions may apply for additional funding for any local impact that is not captured by a Local Government's allocation percentage.
  - The application deadline is March 30, 2022, but there is active effort to move this date back because everything is taking longer than expected.

How may settlement funds be used?

Governed by "**opioid remediation**" as defined in the Distributor and Janssen Settlements; Guided by "Exhibit E" of the **Distributor and Janssen Settlements**

- **Opioid Use Disorder** (OUD) Treatment
- Treatment and **Recovery Support**
- **Connecting People** to Help
- Address Needs of **Criminal Justice-Involved Persons**

How may settlement funds be used?

Continued

- Address Needs of **Pregnant Women**, **Infants**, and **Parents**
- **Prevention**
- First Responder **Support**
- **Leadership** Planning
- **Training**
- **Research**

When will payments begin?

Payment #1

Third or Fourth Quarter of 2022

Payment #2

Third or Fourth Quarter of 2022

Subsequent payments will be received annually in July.

Evidence-based Strategies for the Prevention of Opioid Misuse

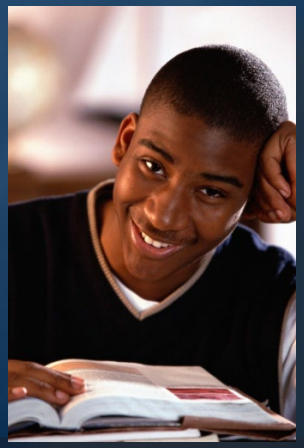
Sarah Stoddard, PhD, RN, CNP, FSAHM, FAAN

Associate Professor

Department of Systems Leadership and Effectiveness Science, School of Nursing

Department of Health Behavior and Health Education, School of Public Health

University of Michigan



November 10, 2022

Objectives

- Risk and protective factors for substance misuse during childhood and adolescence.

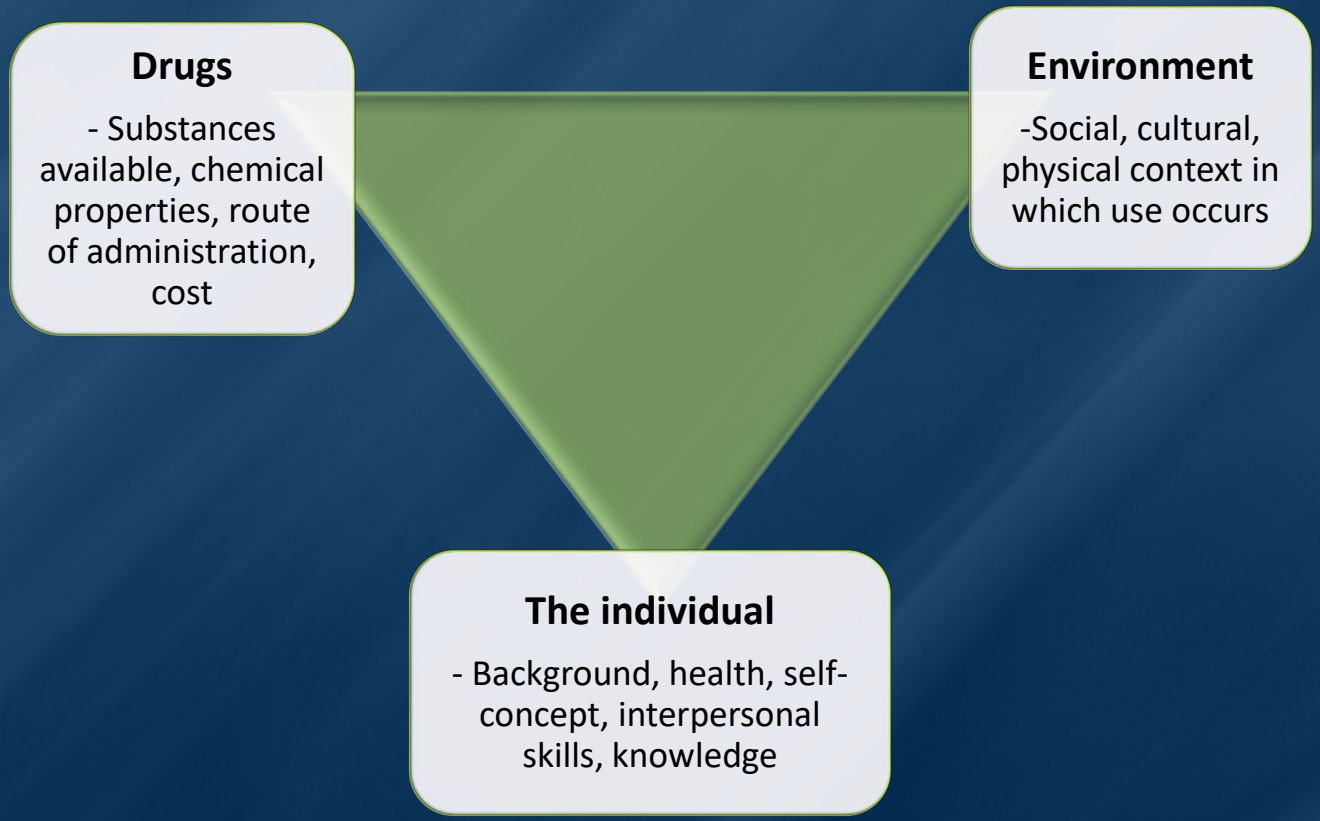
- Evidence-based individual, family, and environmental prevention strategies for substance misuse, highlighting those with evidence specific to opioid misuse/prescription drug misuse.

Surgeon General's Reports

- Evidence-based prevention interventions, carried out before the need for treatment, are critical because they can prevent initiation of substance use, delay early use, and stop the progression from use to problematic use or to a substance use disorder.
- Evidence-based prevention interventions can decrease costs related to substance use-related crime, lost work productivity, and health care.
- Policies and programs should address risk and protective factors … They should be research-tested and evidence-based.

Facing Addiction in America: Surgeon General's Report of Alcohol, Drugs, and Health, 2018; Facing Addiction in America: The Surgeon General's Spotlight on Opioids

Factors Influence Substance Misuse



Ecological Model

Bronfenbrenner, 1979; Substance Abuse and Mental Health Services Administration, 2019

Risk and protective factors

Risk Factors:

- Characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes

Protective Factors:

- Characteristics that are associated with a lower likelihood of negative outcomes
- Or that reduce a risk factors impact

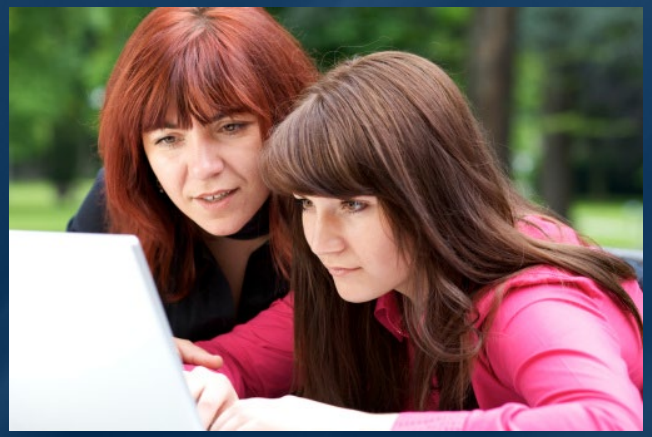
Positive Youth Development

- A strength based approach
- Youth are resources that can be developed
- Focus on mutually beneficial relationships between adolescents and the people/places they interact with in everyday life

Lerner, 2005

Promote Positive Youth Development

- Promote positive and long-term relationships between adults and youth
- Promote the development of life skills
- Promote youth participation and leadership in community programs



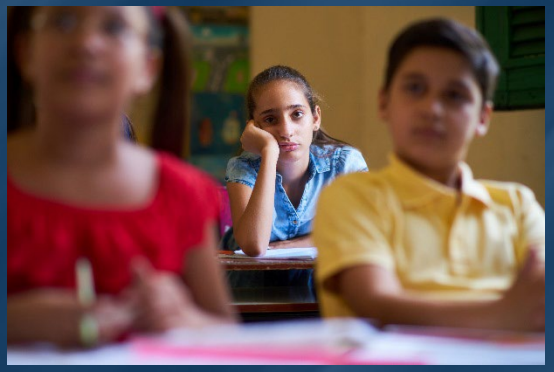
Risk Factors

Individual:

- Genetic predictors (ex. family hx. of substance abuse)
- ADD and hyperactivity, impulsivity and sensation seeking
- Early and persistent behavior problems [Externalizing behaviors, conduct disorder, antisocial behavior, delinquency]
- Rebelliousness
- Favorable attitudes toward substance use
- Peer substance use
- High levels of familial responsibility
- Experiencing many stressful situations

School-related:

- Academic failure beginning in late elementary school
- Lack of commitment to school



Marshall, 2014; Sitnick, Shaw, & Hyde, 2014; Stone, Becker, Huber, & Catalano, 2012; Telzer, Gonzales, & Fuligni, 2014

Risk Factors

Family

- Family conflict
- Family management problems (ex. lack of clear expectations, failure to monitor/supervise)
- Parent favorable attitudes towards AOD use; parent approval of AOD use
- Family history of substance misuse
- Low socioeconomic status
- **Access to opioids in the home**

Community

- Community laws and norms favorable to substance use
- High availability of substances
- Low neighborhood attachment
- Community disorganization
- High rates of community mobility
- Media portrayal of substance use

Marshall, 2014; Sitnick, Shaw, & Hyde, 2014; Stone, Becker, Huber, & Catalano, 2012; Telzer, Gonzales, & Fuligni, 2014

Promotive Factors: Infancy and Early Childhood

Individual

- Self-regulation
- Secure attachment
- Mastery of communication and language
- Ability to make friends and get along with others

Family

- Reliable support and discipline from caregivers
- Responsiveness
- Protection from harm and fear
- Opportunities to resolve conflict
- Adequate socioeconomic resources for the family

Schools, Peers, Community

- Support for learning
- Access to supplemental services (e.g., feeding, screening for hearing and vision)
- Stable secure attachment to childcare provider
- Low ratio of caregivers to children
- Regulatory systems that support high quality of care

Promotive Factors: Middle School

Individual

- Mastery of academic skills
- Following rules for behavior at home, school, and in public places
- Ability to make friends
- Good peer relationships

Family

- Consistent discipline
- Language-based rather than physical discipline
- Extended family support

Schools, Peers, Community

- Health peer groups
- School engagement
- Positive teacher expectations
- Effective classroom management
- Positive partnering between school and family
- School policies and practices to reduce bullying
- High academic standards

Promotive Factors: Adolescence

Individual:

- Emotional self-regulation
- High self-esteem
- Good coping skills and problem-solving skills
- Engagement or connections at school, with positive peers, in athletics, employment, religion, culture

Family

- Family provides structure, limits, rules, monitoring, and predictability
- Supportive relationships with family members
- Clear expectations for behavior and values

Schools, Peers, Community:

- Positive norms
- Clear expectations for behavior
- Physical and psychological safety
- Presence of mentors and support for development of skills and interests
- Opportunities for engagement within school and community

Promotive Factors: Young Adulthood

Individual

- Identity exploration in love, work, and world view
- Subjective sense of adult status
- Subjective sense of self-sufficiency, making independent decisions, becoming financially independent
- Future orientation
- Achievement motivation

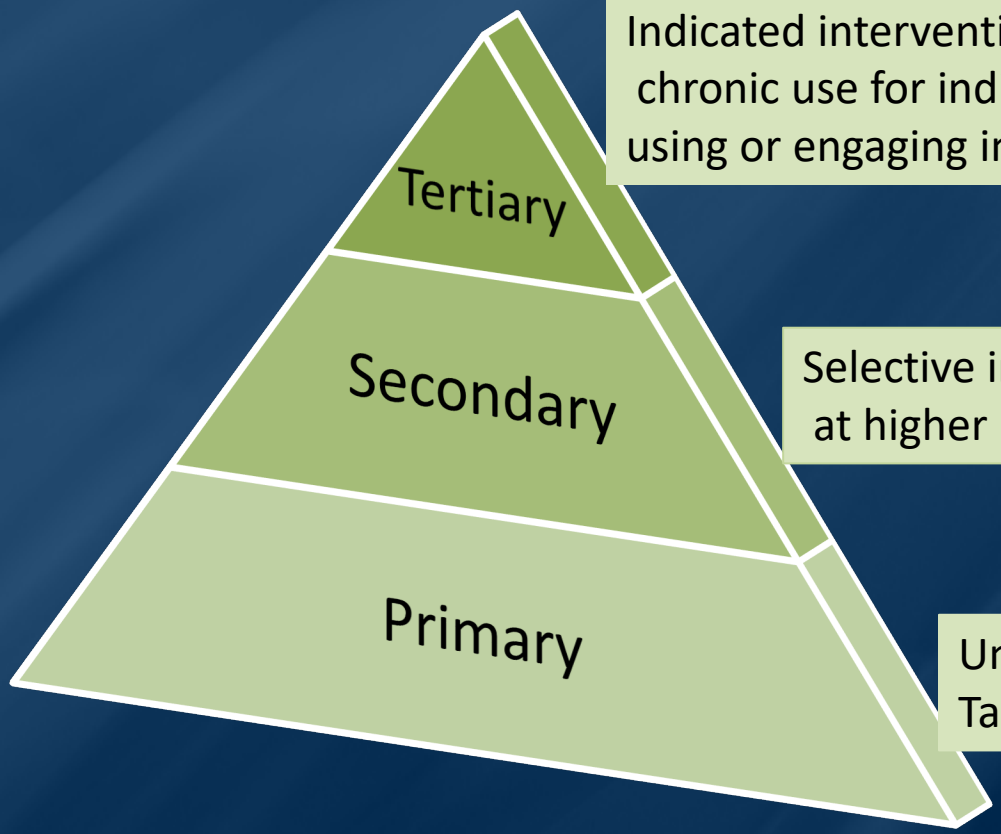
Family

- Balance of autonomy and relatedness to family
- Behavioral and emotional autonomy

Schools, Peers, Community

- Opportunities for exploration in work and school
- Connectedness to adults outside of family

Levels of Prevention



Indicated interventions - Prevent heavy or chronic use for individuals already using or engaging in other high risk behaviors

Selective interventions – Focus on groups at higher risk for substance use/misuse

Universal interventions – Target general population

Examples of Best Practice Prevention Programs and Strategies

Prevention Programs: Ages 0 - 10

Focus:

- Building healthy parent-child relationships,
- Decreasing aggressive behavior,
- Building children's social, emotional, and cognitive competence for the transition to school

Examples:

- *Nurse-Family Partnership* (selective)
- ***The Good Behavior Game*** **(universal)**
- *Fast Track Program* (selective)
- Linking the Interests of Families and Teachers (LIFT)

Prevention Programs: Ages 10 - 18

Effect either the initiation or escalation of substance use

- Building children's social, emotional, and cognitive, and substance refusal skills; Social influences/life skills
- Provide accurate information on rates and amounts of peer substance use.

Examples – Universal Programs:

- School based: **All Stars, *Life skills Training*,** *Project Toward No Drug Abuse*
- Family-based: ***Strengthening Families Program: 10-14****, Guiding Good Choices; I* ***Hear What You're Saying***
- Community/Environmental: **Bicultural Competence Skills Approach**

Examples – Selective Programs:

- Familias Unidas
- Cherokee Talking Circle

Societal: Community Coalition/Community Mobilization Prevention Models

- *Communities that Care*
- *PROSPER (Promoting School-community-university Partnerships to Enhance Resilience)*
- *Project Star (Midwestern Prevention Project)*

Summary: Prevention Program Principles

- Family-based prevention programs should enhance bonding and relationships; include parenting skills
- Prevention programs can intervene as early as preschool
- Prevention program for elementary school children should target improving academic and social-emotional learning
- Prevention programs for middle and high school students should increase academic and social competence, life skills

Preventing Drug Use among Children and Adolescence, National Institute on Drug Abuse

References

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Sussman, S. (2013). *A life span developmental-stage approach to tobacco and other drug abuse prevention.* ISRN Addiction, vol. 2013, Article ID 745783, 19 pages, 2013. https://www.hindawi.com/journals/isrn/2013/745783/

Additional Resources

Centers for Disease Control and Prevention: Preventing Opioid Overdose

https://www.cdc.gov/opioids/overdoseprevention/index.html

Centers For Disease Control and Prevention: Adolescent and School Health, High-Risk Substance Use Among Youth

https://www.cdc.gov/healthyyouth/substance-use/index.htm

Substance Abuse and Mental Health Services Administration: Evidence-Based Practices Resource Center

https://www.samhsa.gov/resource-search/ebp

Community Anti-Drug Coalitions of America

https://www.cadca.org/

Contact Information

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