OPIOID ADVISORY COMMISSION

2024 **Annual Report**

Community-centered frameworks
for health, healing, and justice

MICHIGAN
OPIOID
ADVISORY
COMMISSION

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LETTER FROM THE CHAIR

As we reflect on the second year of the Opioid Advisory Commission (OAC), we embrace the understanding that Michigan's communities hold real solutions—and that a continued focus on community engagement, collaboration, health equity, cultural humility, and transparency remain essential in supporting positive change. The recommendations outlined in this year's report stem from a thoughtful review of publicly available data, insights gleaned from community surveys, invaluable input from Michigan's communities, thoughtful contributions from members of our advisory workgroup, and meaningful engagement with partners at all levels.

I am honored to announce that our membership now includes leadership from the Sovereign Nations, with recent appointee Jamie Stuck, Tribal Council Chairperson for the Nottawaseppi Huron Band of the Potawatomi and President of the United Tribes of Michigan. The OAC is privileged to support meaningful collaboration with Tribal partners, enriched by Chairperson Stuck's involvement in this space. This marks the beginning of what we hope will be a longstanding, fruitful partnership between the twelve (12) Sovereign Nations, Tribal partners, and the OAC.

Our community engagement efforts have been a central focus of the work over the last year. The OAC hopes to foster collaborations with key sectors, including Recovery Community Organizations (RCOs) and those uniquely positioned for direct engagement with individuals and families directly impacted.

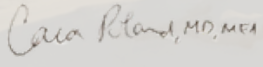
We aim to engage with communities, especially those disproportionately impacted, by practicing humility, cultivating partnership, and possessing an honest desire to listen and learn. Through this process, the unique needs and strengths of communities, and the solutions proposed by community members, can be better understood, and elevated to help inform state leaders and decision-makers, at all levels.

The OAC remains steadfast in its call for public transparency in state planning, decision-making, and use of opioid settlement dollars—this is the minimum standard our state should ensure. We endeavor to support meaningful collaboration at all levels—across Michigan's legislative, executive, and judicial branches, localities, communities, and the Sovereign Nations.

Guided by the Bloomberg-Hopkins Principles, with an emphasis on utilizing resources to save lives, the Commission is dedicated to honoring the memory of those who have succumbed to addiction and trying to support those grappling with the diseases of addiction and mental illness. The Commission also recognizes the tireless efforts of our colleagues who are on the front lines, saving lives every day by providing necessary care. Gratitude, honor, and respect for our communities (and the individuals within them) are the principles that frame all activities of the OAC—and it is a privilege for our membership to do such meaningful work.

I am deeply grateful for the opportunity to serve the Legislature and the citizens of the State of Michigan. Thank you for entrusting me with this honor.

With utmost respect,



Cara Poland, MD, MEd, FACP, DFASAM

A STATEMENT ON HEALTH EQUITY AND JUSTICE

The Opioid Advisory Commission (OAC) presents the 2024 Annual Report with cultural humility and acknowledgement that historical harms, racism, discrimination, and the criminalization of drug use have contributed to inequitable health outcomes for different communities, especially BIPOC (Black, Indigenous, People of Color) and Tribal communities. The OAC acknowledges that social drivers [determinants] of health (SDOH) can influence an individual's "health, wellbeing, and overall quality of life". [1] The OAC recognizes that economic stability and access to education, transportation, housing, health care, as well as community connectedness, are factors that may impact an individual's health—and that different groups are impacted, differently. Poverty remains a significant contributing factor to health disparities. The OAC recognizes that communities of color as well as individuals experiencing poverty, have been disproportionately impacted by the addiction and mental health crisis and continue to experience disparities in access to necessary, life-saving resources. The OAC supports meaningful inclusion of and collaboration with communities, especially those most profoundly impacted, to inform cultural learning and partnership, reduce health disparities, and support positive health outcomes for all.

Structural Racism as a Root Cause of Health Disparities

The National Institute on Minority Health and Health Disparities (NIMHD) [2] defines structural racism and discrimination (SRD) as "macro-level conditions (e.g. residential segregation and institutional policies) that limit the opportunities, resources, power, and well-being of individuals and populations based on race/ethnicity and other statuses…" including but not limited to sexual orientation and gender identity.[3] Structural racism may also be considered the "normalization and legitimization of an array of dynamics (historical, cultural, institutional and interpersonal) that routinely advantage White people while producing cumulative and chronic adverse outcomes for people of color"– this is the notion put forth by the American Heart Association, that also declares structural racism a "fundamental driver of health inequity" [4][5]–and the NIMHD supports that "achieving health equity for all in the U.S. will require dismantling this country's historical legacy of structural racism."[6]

The OAC acknowledges that structural and systemic racism are among the complex root causes of health disparities experienced by BIPOC and Tribal communities, and that continued attention and intentional efforts to address and eliminate structural racism, may help support positive health outcomes for all individuals and communities in Michigan.

Commitment to Equity in Data

The OAC adopts the following data equity commitment from the Public Health Institute at Denver Health [7] as it aligns with the Commission's understanding and vision for use and interpretation of data:

The OAC "aspires to present data humbly, recognizing numbers never tell the whole story. It strives to work with individuals and communities to learn and share their stories to improve collective understanding. Knowing that people across life circumstances have inequitable opportunities to achieve optimal health, the OAC commits to pair numbers and stories to inform policy and systems change to improve health for all". [8]

The OAC supports the following data equity principles presented by the Public Health Institute at Denver Health [9]:

1. We recognize that systemic, social and economic factors – racism being the largest – impact health.
2. We understand that health inequities are worse for communities who experience injustice.
3. When we talk about people, we use a strengths based approach; when we talk about inequities we use a systems level approach. We do this to avoid judgment, blame, or marginalization of individuals or communities.
4. We strive to include the lived experience and traditional knowledge of community members into population health analysis, because the community health experience is complex.
5. We proactively engage communities to identify inequities, interpret findings, shape our work, and take action toward improving health.

Acknowledgement: Title and formatting adopted from the 2021-2022 Washington State Opioid Overdose Response Plan.

EXECUTIVE SUMMARY

Michigan's opioid epidemic is an addiction and mental health crisis. While polysubstance use and the presence of illicit fentanyl [10][11] remain significant contributing factors, the issues facing Michiganders are complex and exceed a singular cause, effect, or solution.

BIPOC (Black, Indigenous, People of Color) communities are disproportionately impacted by overdose, with Black and Indigenous populations experiencing the highest rates of overdose death in Michigan. [12]

In general, there has only been a marginal reduction [13] in overdose fatalities, with provisional estimates of 98 fewer deaths in 2022 as compared to 2021. Unfortunately, predicted estimates from the Centers for Disease Control and Prevention (CDC) present a grimmer reality—that overdose deaths may actually be rising in Michigan. [14] Meaning we remain stagnant in our efforts to significantly reduce overdose fatalities.

While Michigan remains below the national average, both in reported and predicted provisional overdose fatalities, [15] the prediction of increasing rates, especially when compared to the State's robust Naloxone distribution efforts, [16][17] begs the question: Is this only about opioids?

The answer of course, is "no". For those who have lived it personally, for those who have lived with it, familially, and for those who are closest to the issues, professionally, the factors contributing to overdose are myriad and complex. In fact, the disproportionate rates of overdose observed among BIPOC communities echo other health disparities, especially those among Black and Indigenous populations, including rates of chronic health disease, access to health care and health insurance, and economic and housing factors. [18]

With an understanding that the "opioid crisis" of today is not limited to opioid use, rather polysubstance use, co-occurring substance use and mental health disorders, inequities in social drivers of health, and barriers to accessing necessary, life-saving resources, Michigan is approaching a critical point that could determine the course and impact of all interventions to come—a point requiring real decisions, that have real implications now, and for generations.

In its second year, the Opioid Advisory Commission (OAC) will take an honest approach to evaluating the strengths and limitations of opioid response measures in Michigan.

Meaningful work continues to take place at the state level, much of which is outlined in the 2023 Michigan Department of Health and Human Services (MDHHS) Opioid Annual Report, [19] however the OAC hopes to identify areas for improvement, so considerations about the use of funds, can be fully informed.

In assessing areas for improvement, the OAC acknowledges that thoughtful evaluation is not always convenient—but is vital in helping identify impactful solutions to address Michigan's addiction and mental health crisis, and in developing practical, purposeful recommendations that can offer guidance for how to enhance the work.

Solutions are best informed by evidence, expertise, and the cultural and experiential knowledge found in our communities—especially from community members who have been directly and disproportionately impacted—and from professionals in key sectors—who know the issues deeply and understand service needs, best practices, and practical intervention points. Solutions are also best achieved through partnership—through authentic and meaningful engagement and collaboration with our communities, where voices are heard, respected, and valued in decision-making around what to do and how best to do it.

The OAC is taking steps to partner, listen, and learn from communities throughout the state so that recommendations put forth for consideration by state leaders are representative of Michigan's communities—including Tribal communities from the twelve (12) Sovereign Nations.

As the OAC has begun this process, the following truths have emerged:

1. Communities hold solutions.
2. Collaboration, at all levels, is essential.
3. Inclusion and representation of leaders from communities most impacted, is needed.
4. To support real solutions, real commitment is needed—and must be demonstrated through collaboration, funding, and policy.
5. [Most] state opioid settlement funds should be directed back to communities.
6. Public transparency and improvements in the communication, dissemination, and accessibility of information, are essential—especially to communities most impacted.
7. Leadership is needed—to develop a plan, align and optimize existing efforts, and devise a framework for long-term response measures.
8. There are real inequities in Michigan—health disparities are (at least in part) a result of these inequities.
9. Medicaid-covered and uninsured individuals are disproportionately impacted by Michigan's addiction and mental health crisis—so are their family members.
10. Intergenerational trauma has real health and behavioral health impacts—especially for BIPOC and Tribal communities.

What follows are recommendations for action, accompanied by assessment and supporting evidence, not only from national and state level-data, but from the experiential and cultural knowledge acquired through OAC listening sessions, public survey, and ongoing engagement with state, regional, local, Tribal, and community partners throughout Michigan.

Recommendations for **action**

7

Goals to support community inclusion, public transparency, and the just use of state opioid settlement funds.

OPIOID ADVISORY COMMISSION **2024 RECOMMENDATIONS**

Listen to communities

Commit to community inclusion as a necessity for all settlement work. Provide regular opportunities for community voices to be heard…and utilized, in state decision-making.

Invest in communities

Ensure that the majority of state settlement dollars are directed back to Michigan's communities.

Prioritize communities most impacted

Direct dollars to Tribal Nations and communities most profoundly impacted by the addiction and mental health crisis.

Develop a plan

Leverage state settlement funds around the development of a multi-year, comprehensive state strategic plan.

Optimize existing efforts

Ensure meaningful collaboration to eliminate silos and synergize state response efforts.

Invest for impact and sustainability

Invest with intention and foresight. Develop and define measurable goals for all state funding initiatives and position investments for growth and sustainability.

Build trust through transparency (and engagement)

Commit to reporting 100% of settlement expenditures to the public. Share planning and decision-making processes openly and through easily accessible means. Increase meaningful communication and engagement with communities—especially those most profoundly impacted.

1. Listen to communities

Value the experiential knowledge and unique expertise of communities in developing real solutions. Commit to community inclusion as a necessity for state settlement work. Provide regular opportunities for community voices to be heard and utilized in decision-making. Elevate voices with lived experience and create funding priorities that are inclusive of community input.

Michiganders have been harmed. The opioid settlements are intended to mitigate harms. The nature of the opioid settlements require a level of ethical responsibility; "to be intentional and conscientious of how opioid settlement funds are planned for, used, and managed and…to be inclusive of the community, representative of communities disproportionately impacted, and informed, by the experiences of individuals and families throughout this state, who have been directly and deeply, impacted". [20] Listening to Michigan's communities is a way to honor the individuals and families who have been impacted.

Communities hold solutions.

To meaningfully address Michigan's addiction and mental health crisis, we should first listen to communities—to individuals and families who have been directly impacted, and to professionals who are closest to the issues. Experiential knowledge is an asset in state planning and implementation efforts. Settlement investments should be informed by an understanding of what has worked, what hasn't, and what holds potential for improving health outcomes.

1.1 Ensure that initiatives funded by settlement dollars are representative of community input. Elevate voices with lived experience and create regular opportunities for communities to be included in planning and implementation efforts. Prioritize inclusion of individuals and families, directly impacted, and from communities most profoundly impacted.

Create investments that align with the identified needs and proposed solutions offered by Michigan's communities. Utilize community input from OAC listening sessions, survey results, [21] and community needs assessments. Publicly report on settlement investments, including how investments are representative of community input.

Create intentional and ongoing pathways for community voices to be applied to funding decisions, by way of statewide community listening sessions, roundtables, planning sessions, and workgroups organized for the purpose of developing and enhancing state response efforts.

Given historic harms and institutional mistrust—especially among BIPOC and disproportionately impacted communities—inauthentic efforts run the risk of compromising trust, damaging relationships, and perpetuating harm. The expertise of advisory bodies, like the Racial Equity Workgroup (Opioids Task Force), [22][23] Community Engagement and Planning Collaborative (Opioid Advisory Commission), and direct input from community and Tribal partners, can help frame considerations of equity and ethics.

1.2 Support an annual allocation of state settlement funds for outreach and engagement activities with disproportionately impacted communities.

Michigan will be receiving settlement funds for the next 18+ years. Allocating funds for outreach and engagement promotes partnership with Michigan's communities and prioritizes ongoing state-local collaboration to best address community needs. The expertise of divisions like the Office of Equity and Minority Health (OEMH), [24] advisory workgroups like the Racial Equity Workgroup (Opioids Task Force), [25] Community Engagement and Planning Collaborative (Opioid Advisory Commission), [26] community leaders, Tribal partners, and data from existing sources like the Michigan Overdose Data to Action (MODA) Dashboard, [27] should help outreach and engagement activities.

2. Invest in communities

Ensure that settlement dollars are directed back to communities. Create low-barrier funding opportunities to increase access and decrease burden in communities that have been most impacted. Explore opportunities for endowing funds to support sustainability planning.

Opioid settlement funds present a unique opportunity for community investments. Low-barrier funding opportunities increase accessibility and reduce administrative burden. Funding for evidence-based or culturally responsive prevention, harm reduction, treatment, and recovery supports, can help community-based organizations expand services to help more Michiganders, especially in communities that have been most profoundly impacted.

2.1 Support the Governor's recommendation for appropriation of opioid settlement funds to the Department of Health and Human Services. [28] Support an increase of $6 million for an FY 2025 "Community Investments" set-aside. Ensure that these dollars are used to create low-barrier community funding opportunities, administered by the Department of Health and Human Services.

Creating community investments through low-barrier pathways is representative of community input, [29] national guidance, [30] and the intent of the opioid settlements. Legislators can ensure that funds are directed back to communities by working with the Department of Health and Human Services to create a "Community Investments" set-aside within boilerplate language [31] of the FY 2025 state budget bill. State leaders can improve access to low-barrier funding opportunities by supporting frequent and consistent (quarterly) Requests for Proposals ($1.5 million/fiscal quarter; $6 million/fiscal year) and eliminating administrative burden with a simple application process and minimal reporting requirements.

2.2 Ensure that communities, especially those most profoundly impacted, have awareness of potential funding opportunities, knowledge of application pathways, and adequate support to access potential funding.

State leaders can help improve information equity by ensuring that communities have awareness of settlement funding opportunities and adequate support to access them. While ongoing engagement is needed, strategic outreach to disproportionately impacted communities by way of trusted organizations and community leaders, can help increase communication, enhance information-sharing, and improve access to funding.

Direct outreach and technical assistance for navigating state settlement resources, should be prioritized.

Leaders should consider culture and how information is disseminated and received in different communities—including those that rely on print media. Leaders should explore options to improve effective communication of state opioid settlement work so that the impact of settlement investments can be maximized for Michigan's communities—especially those disproportionately impacted by the addiction and mental health crisis.

2.3 Explore opportunities for endowing a portion of state settlement funds for future opioid remediation.

The Legislature should work with the Department of Attorney General, Department of Treasury, House and Senate Fiscal Agencies, Opioid Advisory Commission, Opioids Task Force, and the Governor's Office of Foundation Liaison (OFL) to explore potential endowment opportunities that support conservation of state settlement funds for future opioid remediation.

Endowment can help ensure service sustainability [32] and responsible management of funds through fiscal longevity, but endowment must adhere with the requirements of the opioid settlement agreements and Public Act 83 of 2022 (MCL 12.253). [33] Collaboration from key offices is needed to initiate these discussions and begin exploring potential opportunities.

3. Prioritize communities most impacted

Direct dollars to Tribal Nations and communities most profoundly impacted by the addiction and mental health crisis.

State opioid settlement funds should be used to help address the needs of communities most profoundly impacted. Tribal Nations should remain a priority for the duration of Michigan's opioid settlements. Other communities should be identified by objective methods, including assessment of vulnerability to adverse substance use outcomes (MI-SUVI) [34], rates of overdose death and nonfatal overdose, rates of suicide, landscape analysis or community resource mapping, and/or local assessment of social drivers of health.

3.1 Prioritize Tribal communities by ensuring an appropriation from the Michigan Opioid Healing and Recovery Fund to Tribal Nations for FY 2025. Consult with the United Tribes of Michigan (UTM) and all twelve (12) individual Sovereign Nations to determine appropriate funding mechanisms and distribution methods. Support data sovereignty and ensure low-barrier pathways for direct appropriation of state settlement dollars to Tribal Nations. Explore opportunities for traditional healing practices and culturally responsive care, through recurring funding to Tribal communities.

In Michigan, Indigenous populations (American Indian or Alaska Native) experience the highest rate of suicide [35] and second highest rate of overdose death [36] among all racial and ethnic groups. While state data indicates a reduction in overdose fatalities among Indigenous populations, [37] current rates remain disproportionately high [38] and may be grossly underestimated. [39] Nationally, "non-Hispanic American Indian or Alaska Native (AI/AN) people had the highest drug overdose death rates in both 2020 and 2021" [40] and age-adjusted suicide rates continue to be "highest among non-Hispanic AI/AN people (28.1 per 100,000)". [41]

"Resources from statewide initiatives are not used to their maximum benefit in Tribal communities, when Tribal governments are not involved". [42] Tribes know best how to support their members' health, healing, and wellness. State opioid settlement funds should be used to empower Tribal Nations to address the behavioral health needs in their communities.

Beyond health disparities, there are cultural considerations for health and behavioral health response measures in Tribal communities. "Conventional behavioral health programs have not yielded the same outcomes within American Indian communities, as they have for other communities. However, traditional healing, a multi-generational, multidisciplinary approach to mental health and substance use disorder treatment, has been very successful". [43] In Michigan, traditional healing practices are not covered by Medicaid. This presents

significant gaps within the public substance use disorder (SUD) and mental health systems for Tribal members who are seeking cultural and traditional healing supports for wellness and recovery.

Observing similar health disparities and service gaps, other Great Lakes states have prioritized Tribal communities, including Wisconsin and Minnesota. Noting that Michigan, Wisconsin, and Minnesota fall within the same regional catchments for federal services, including the Bemidji Area (Indian Health Services; U.S. Department of Health and Human Services) and the Midwest Region (Bureau of Indian Affairs). Wisconsin and Minnesota are also estimated to receive significantly less settlement funding [44] than Michigan, however, both states have prioritized Tribal communities in the following ways:

Wisconsin

- Development of a $6 million opioid settlement-funded initiative to support "Tribal Nation Needs: This funding is for prevention, harm reduction, treatment, and recovery services for tribal members with the specific services [funded], determined by local needs". [45] Each of the eleven (11) Sovereign Nations in Wisconsin received funding from this appropriation.

Minnesota

- Development of a $2 million annual (recurring) initiative to support traditional healing practices. The direction of funds for this purpose is codified by Minnesota statute for establishment of and appropriations from the Opioid Epidemic Response Fund (OERF)(256.043). [46][47] Noting funds used for this purpose are are non-settlement funds.

- Direct representation of Tribal citizens on the Opioid Epidemic Response Advisory Council (OERAC), a 23-member joint council with legislative, executive, community, and Tribal inclusion. Built into OERAC's enabling statutory language is the following requirement for Tribal representation/membership: "…two members representing Indian tribes, one representing the Ojibwe tribes and one representing the Dakota tribes". [48] Additional representation from "an urban American Indian community" is codified within council membership of the statute. [49]

- Statutory requirements for the Opioid Epidemic Response Advisory Council (OERAC) to conduct annual meetings with all eleven (11) Sovereign Nations for the purposes of collaboration and communication on shared issues and priorities. [50]

A review of Michigan's settlement investments (FY 2024) [51] and estimated spending (FY 2023 settlement expenditures) [52] reveal no priorities explicitly addressing the needs of Tribal communities. The 2023 Michigan Opioid Healing and Recovery Fund Annual Financial Report (November 2023) [53] contains no Tribal "Grantees", nor are there any prioritized initiatives containing the phrases "Tribal", "Indigenous", "American Indian", and/or "Traditional Healing" within FY 2024 state opioid settlement investments. [54]

While a $2.5 million "Equity" allocation (estimate) is indicated to address "…racial disparities in treatment access and delivery", proposed activities do not appear to address the needs of Tribal communities:

"Activities include piloting a faith-based learning collaborative with faith-based leaders and expanding Neighborhood Wellness sites services for training and naloxone distribution. Additional work focusing on equitable internal processes and evaluation measures will be implemented". [55]

With acknowledgment of historical harms, intergenerational trauma, ongoing health disparities, and the need for access to cultural and traditional healing practices, the absence of Tribal prioritization among settlement-funded initiatives in Michigan, is acutely noted. Michigan should prioritize Tribal communities through direct funding initiatives and direct representation in state advisory spaces. [56]

See Appendix D: State Practices in Tribal Prioritization

3.2 Create intentional funding opportunities for communities most profoundly impacted by the addiction and mental health crisis. Use objective measures to define and determine community vulnerability. Ensure that most settlement funds are directed for use in Michigan's most impacted communities.

State leaders should prioritize funding for communities most profoundly impacted by Michigan's addiction and mental health crisis; objective measures for determining "vulnerability" and prioritizing the direction of state settlement dollars, should be used.

It is unknown to what extent this occurred with FY 2023 allocations or is presently occurring with FY 2024 opioid settlement investments. [57][58] Information on the determination and prioritization of settlement funding should be transparent and easily accessible to the public. The State of Michigan has developed valuable tools like the Overdose Data to Action (MODA) Dashboard [59]—there is also meaningful work taking place through advisory groups like the Michigan Suicide Prevention Commission [60] and workgroups like the Community Engagement and Planning Collaborative (Opioid Advisory Commission) and Racial Equity Workgroup (Opioids Task Force) [61]—all can be used to understand community vulnerability.

See Appendices E and F: High SUVI Counties and High SUVI ZIP Codes

3.3 Ensure that dollars are directed to support health equity. Prioritize the needs of BIPOC and rural communities in settlement-funded initiatives. Ensure that low-barrier funding opportunities are easily accessible to these communities.

Intentional and explicit efforts should be made to prioritize funding opportunities for BIPOC and rural communities. Settlement funds can improve community vulnerability to adverse substance use outcomes while also addressing health disparities in communities impacted by historic harms and discriminatory policies, like the War on Drugs. [62] There are racial (and health) disparities found in the overrepresentation of BIPOC groups in carceral settings, and disproportionate rates of overdose and suicide, especially among Black and American Indian/Alaska Native populations; "…these disparities have contributed to ongoing discrimination as well as racial gaps in socioeconomic status, educational attainment, and employment." [63]

"Equity" is emphasized as part of Michigan's Opioid Response Framework (2023), [64] but it is unclear how BIPOC and rural communities have been prioritized in FY 2022-2024 settlement investments. Focus is needed in this area to avoid "continuing cycles of inequity". [65]

Substance use vulnerability is also expressed by urbanicity; 17 of 21 Michigan counties with the highest substance use vulnerability, are rural. [66] Suicide rates by geographic distribution follow similar trends, with the highest suicide rates observed in rural communities of the Upper Peninsula, Northern Michigan (Lower Peninsula), and Southwest Michigan. [67]

3.4 Ensure representation from disproportionately impacted communities in state advisory spaces. Support the OAC in amending Public Act 84 of 2022 (MCL 4.1851) to reflect Commission membership that is representative of the geographic, racial, ethnic, and cultural diversity of Michigan.

State leaders should develop advisory groups that are inclusive and representative of the geographic, racial, ethnic, and cultural diversity of Michigan. Beyond professional expertise, cultural and experiential knowledge is vital in identifying impactful solutions.

While members of the OAC are subject matter experts (many also have personal or familial lived experience), there is full acknowledgment of the lack of racial and ethnic diversity among its current membership—especially from disproportionately impacted communities. To address this, the OAC recommends statutory changes to Public Act 84 of 2022 (MCL 4.1851), including but not limited to amendments addressing membership requirements.

4. Develop a plan

Leverage state settlement dollars to develop a publicly accessible, comprehensive state plan for the use of opioid settlement funds.

A long-term plan to address Michigan's addiction and mental health crisis is needed—but a multi-year, strategic plan for the use of state settlement funds, can help. Without a broader plan, investment potential is impaired. Currently, the use of state settlement dollars is only understood in the context of an "Opioid Response Framework", [68] "Opioids Strategy", [69] and/or short-term investments—leaving much to interpretation.

"When state spending is attuned to state budgets…[settlement] disbursements require a longer planning approach." [70]

A multi-year, publicly accessible state plan for the use of settlement funds, will provide organization and guidance for work occurring at all levels—including local and regional response measures, that are often developed downstream of state initiatives.

A comprehensive and publicly accessible state plan can provide the reasoning, accountability, and necessary guidance around priority areas, goals and objectives, intended outcomes, and target dates for implementation.

While existing planning documents [71] provide a rationale for prior investments, there is no publicly accessible state plan that lends guidance to current or future efforts. Michigan's planning documents represent an improvement from the information landscape of early 2023, however they fall short of being a multi-year, publicly accessible, strategic plan.

To improve public transparency and strategic planning efforts, the Legislature can act as an accountability partner by leveraging the appropriation of settlement dollars around the development of a multi-year strategic plan for the use of state opioid settlement funds.

4.1 Act as an accountability partner for the Department of Health and Human Services (MDHHS) to ensure the development of a clear, transparent, and publicly accessible state plan for the use of opioid settlement funds.

Legislative and Executive branches should support MDHHS and OAC collaboration to develop a multi-year plan. While the requirement of a plan may entail statutory changes, legislative appropriation could be contingent on such plan being developed, with variations requiring joint approval by MDHHS and the OAC.

It is necessary to remember the reason behind the opioid settlement. Real harm has been caused to the residents of this state. State leaders should consider how the absence of common-sense measures for the use of state settlement dollars, may be perceived by the public—and how the lack of accountability, ensuring responsible use of state settlement funds, is perceived by residents who have been directly, and deeply, impacted.

5. Optimize existing efforts

Promote meaningful collaboration to eliminate silos and synergize state response efforts.

Meaningful work is taking place, but it is siloed within executive departments and different specialty divisions. "The opioid settlements and the existence of lateral advisory groups like the OAC (legislative) and Opioids Task Force (executive) provide an ideal, if not unprecedented, opportunity for collaboration and alignment at all levels". [72] If the work is not easily understood, it can't be supported or enhanced.

5.1 Model collaboration and leadership by partnering with the Executive Office of the Governor (EOG) to establish an intergovernmental workgroup for information-sharing and coordination of state opioid settlement work.

State leaders can model the very practices being recommended in the state opioid settlement space: collaboration and partnership. Legislative leaders should partner with the Governor's office to establish an intergovernmental workgroup for the purpose of information-sharing, coordination, and alignment of state opioid settlement work.

A joint effort by the Legislature and Governor's office to convene key partners and align state advisory groups [73] can send a powerful message to Michigan's communities about the importance of settlement work and the necessity of working together to develop solutions for the addiction and mental health crisis.

5.2 Ensure inclusion of the Opioid Advisory Commission, Opioids Task Force, local, regional, legislative, executive, judicial, and Tribal partners in the formation of a settlement workgroup.

State leaders should convene an opioid settlement workgroup with representation from all key agencies, offices, and governments.

Representation from the Legislature [74], Judiciary, State Court Administrative Office (SCAO), Michigan Judicial Council, Michigan State Police, and key executive offices, including but not limited to the Department of Health and Human Services, Department of Attorney General, Department of Treasury, Department of Civil Rights, Department of Corrections, and the Michigan State Housing Development Authority, should be included.

Representation from regional entities, [75] local government, local health/mental health departments, Tribal governments and/or Tribal health offices, and key state advisory groups including the Opioid Advisory Commission, Opioids Task Force, Mental Health Diversion Council, and Michigan Suicide Prevention Commission, should be ensured.

5.3 Utilize the convening power of the Governor's office and support facilitation of the settlement workgroup. Prioritize facilitator expertise in health policy, behavior health policy, equity, and/or community engagement.

The Governor's office is best positioned to convene key partners for a state opioid settlement workgroup. Facilitation by EOG staff provides the necessary leadership required to get key partners to the table.

"Governors can use their unique ability to convene the correct groups of stakeholders and community participants to ensure that a diversity of voices are at the table". [76] They play an essential role in "ensuring that opioid settlement funds are used to their fullest potential while not supplanting existing resources." There is a "need for coordination and communication within and among all levels of implementation – Governors, state officials, localities, communities, community groups, and people with opioid use disorder or who have lost loved ones to an overdose. A Governor's power of convening is a strong tool, but this engagement must be ongoing to ensure that programs and funds are operating efficiently as the needs evolve. Parties also need to be transparent with each other…cooperation among groups is [was] best achieved when Governors' offices incentivized parties to act together". [77]

Consideration 5.3.1
Develop and adopt a resolution that calls for intergovernmental collaboration and the formation of an opioid settlement workgroup. A resolution can represent the Legislature's commitment to (and advocacy for) cross-branch collaboration and strategic alignment of state opioid settlement work.

Consideration 5.3.2
Develop a Memorandum of Understanding (MOU) between all participating parties of the workgroup, outlining (a) the purpose of the workgroup; (b) scope of the group's work; (c) member roles and responsibilities; (d) communication, coordination, and collaboration expectations; and (e) mutual commitment to improving, aligning, and enhancing state response efforts.

Consideration 5.3.3
Encourage key tasks of the intergovernmental workgroup, specifically (a) conducting an evidence-based, statewide needs assessment including but not limited to a regional landscape analysis and/or asset map; (b) determining frequency of assessment or analysis; and (c) releasing all findings in a public-facing report. To support the workgroup in accomplishing this task, appropriate funds, not to exceed $500,000, [78] for the purpose of conducting a comprehensive statewide needs assessment.

5.4 Appropriate a minimum of $250,000 in non-settlement funds for the creation of an OAC budget under the Legislative Council (General Government). Support the OAC in carrying out its statutory obligations, as required by Public Act 84 of 2022 (MCL 4.1851).

The OAC has no formal budget, nor was it allocated any funds in FY 2024 to execute key tasks, including community outreach and engagement activities, data collection, and data analysis. Funding is required for the OAC to fulfill its statutory obligations, including but not limited to performing a "statewide evidence-based needs assessment" [79] and developing "goals and recommendations, including the rationale behind 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". [80]

The OAC is also required to perform 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". [81]

The OAC has demonstrated meaningful work in the state opioid settlement space. It has established and maintained partnerships with state, local, and community stakeholders, conducted ongoing community engagement and emerging Tribal partnership efforts, established and facilitated an advisory workgroup, maintained collaboration with local representative agencies, [82] and developed the "Community Voices" [83] initiative involving facilitation of statewide, community listening sessions, and development/deployment of a public survey.

While community organizations have expressed gratitude for the work of the OAC, the Commission cannot fulfill its statutory obligations without appropriate funding. Ultimately, the OAC needs the support of the Legislature, the body it was created to advise, to support fulfilment of its statutory requirements.

See Appendix G: Michigan Opioid Settlement Funds: Community Impact Survey—Data Snapshot November 2023

6. Invest for impact and sustainability

Invest with intention and foresight. Develop and define measurable goals for all state funding initiatives and position investments for growth and sustainability.

Settlement funds should be approached with thoughtful consideration of impact and sustainability. The State can be a supportive partner by helping community grantees plan for growth and sustainability, and by developing pathways to support long-term sustainability of key initiatives.

6.1 Conduct asset mapping of funds.

Opioid settlement funds offer an opportunity to perform state-level asset mapping. To maximize the impact of state settlement dollars, a thorough and transparent account of the current funding landscape, is needed. As a first step, this should include an understanding of exactly which initiatives are being funded, where they are being delivered, who they are being delivered by, and why they were prioritized for funding. As appropriations have been made primarily to MDHHS, this work should be led by MDHHS in collaboration with entities of the [proposed] intergovernmental settlement workgroup. [84]

"Determining where funds should go relies upon knowing where funds are already being spent. It is also important that the mapping assess smaller population units to understand the needs of specific localities. For instance, in a number of states, there is an inequitable distribution of funds to rural areas. While opioid litigation proceeds may seem like a considerable sum, at current levels over an 18-year period, it breaks down into an amount that pales in comparison to annual Medicaid funding for opioid use disorder and is also less than current annual funding from the U.S. Department of Health and Human Services. Gauging where these assets are being used will allow states to use the settlement funds to identify and fill gaps or supplement ongoing program needs without supplanting existing funding". [85]

6.2 Leverage settlement funds around the development of sustainability plans for all settlement-funded initiatives that are not considered "community investments" (low-barrier funding opportunities).

Several valued state-funded initiatives have faced recent funding cuts, the threat of service disruption, and in some cases, full and abrupt discontinuation. The harms of discontinuing a service with proven value, especially those delivered to disproportionately impacted communities and groups, can be profound.

It is the responsibility of the State to work with community partners around growth and sustainability so services that have demonstrable value can be both expanded and maintained. Sustainability considerations should be at the forefront of any state investments that (a) have proven efficacy; (b) have cultural value; or (c) are addressing an enduring community need. It is primarily the responsibility of the State to be wise with investments, which means taking proactive steps to be a supportive partner in helping community grantees plan for sustainability.

To promote the responsible use of settlement dollars, the legislature should enhance budgetary (boilerplate) reporting requirements for the Department of Health and Human Services to include developing sustainability plans for any settlement-funded initiatives that are not considered "Community Investments". [86] Further consideration should be made to ensure that the administrative burden for sustainability planning is not placed solely on community grantees; the process should be initiated by MDHHS, and undertaken in collaboration between the Department and community grantees once a sustainability pathway(s) has been determined.

7. Build trust through transparency (and engagement)

Commit to reporting 100% of state settlement expenditures to the public. Share planning and decision-making processes transparently and through easily accessible means. Increase communication and engagement with the public, especially with communities most impacted by Michigan's addiction and mental health crisis.

These dollars are different. Michiganders were harmed—the funds received from the opioid settlements are intended to mitigate those harms. "While no amount of money can change the loss that Michigan's communities have experienced, what can be done is to honor, respect, and understand the reason behind these dollars" [87] and to be intentional with all efforts around planning and implementation. Community partnerships are vital to creating real solutions, but they require trust.

Opioid settlement funds present an opportunity to improve and enhance trust-building with Michigan's communities—especially those disproportionately impacted by the addiction and mental health crisis. Transparency and authentic engagement are initial steps to building trust, and valuing community voices in action, not only in statement.

7.1 Commit to reporting 100% of state settlement expenditures to the public.

State leaders should commit to reporting 100% of state settlement expenditures to the public, as 16 other states have committed. [88] As elected representatives of the people of Michigan, the legislature is important in promoting public transparency and providing clear, consistent, and timely communication about how state settlement funds are used, to their constituents.

7.2 Increase strategic outreach, engagement, and information-sharing to communities—especially disproportionately impacted communities.

There are significant information gaps around Michigan's planning and use of opioid settlement funds. While the State has taken meaningful strides to increase information to the public through the MDHHS opioid settlement website [89], most residents still do not know (a) how the state is making decisions on where to spend funds; (b) how the state is spending opioid settlement funds; (c) the ways the state can improve racial and health equity; and (d) how communities are being included in opioid settlement conversations. [90] These information gaps are more pronounced with disproportionately impacted groups.

Intentional and ongoing efforts by the State to improve and increase communication, information-sharing, outreach to, and authentic engagement with, all communities—especially those experiencing the greatest impacts—can begin to bridge gaps and create pathways for delivery of information, trust-building, and partnership.

The Impact of the Addiction and Mental Health Crisis

The following section presents statistics involving non-fatal overdose, overdose death, and suicide. While the impact of the addiction and mental health crisis is significantly more complex than is captured by the data landscape, the OAC presents mortality information of overdose death alongside suicide death, to emphasize the prevalence and co-occurrence of substance use, substance use disorders (SUD), and mental health conditions.

Data Equity

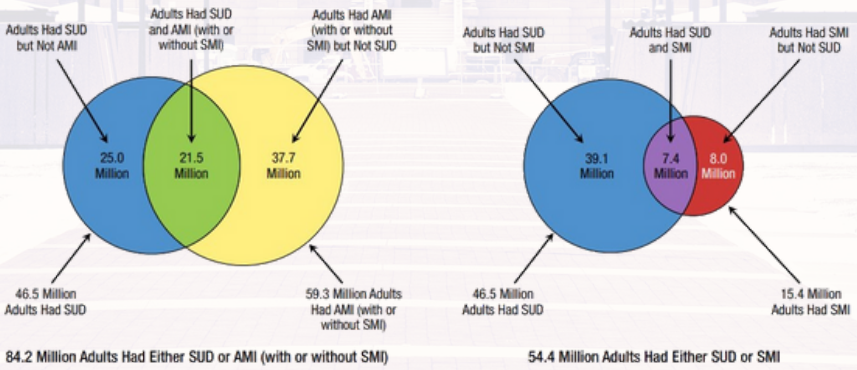
While data can be used to help illustrate the scope and impact of any issue, the OAC acknowledges the limitations of available (especially government-sourced) data, as viewed from a health equity lens. Structural racism, [91] collection limitations including "racial misclassification and misrepresentation", [92] and historic misuses of data to marginalize various groups, particularly BIPOC and Tribal communities, provide cause for full and thoughtful consideration of any data use. The OAC supports principles of data equity [93] and data sovereignty [94] and acknowledges potential limitations in the information contained, herein. The following data is sourced from state and federal agencies and may only present a partial understanding of impact and scope, with potential statistical underrepresentation of data concerning race and ethnicity, especially that specific to Indigenous, Tribal, and/or "American Indian/Alaska Native" communities.

Co-Occurring Disorders

The "coexistence of both a mental health condition and substance use disorder is known as a co-occurring disorder" [95]. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "people with substance use disorders [96] are at particular risk for developing one or more primary conditions or chronic diseases", including mental health conditions, and "people with mental illness are more likely to experience a substance use disorder than those not affected by a mental illness." [97]

SAMHSA's 2022 National Survey on Drug Use and Health (NSDUH) [98] estimates that **1 in 12 adults (8.4%) in the U.S. aged 18 or older, experienced a mental health condition and substance use disorder (SUD) in the past year,** with over one third of adults (21.5 million), experiencing both an SUD and mental health condition. **BIPOC and Multiracial individuals were found to experience SUD and mental health conditions at disproportionate rates**, with American Indian/Alaska Native individuals aged 12 or older experiencing the highest percentage (24%) of SUD within the past year; Multiracial adults, aged 18 or older (35.2%) were more likely to have had any mental illness (AMI) in the past year compared with White (24.6%), Hispanic (21.4%), Black (19.7%), American Indian or Alaska Native (19.6%), or Asian adults (16.8%)". [99]

Figure 45. Any Mental Illness (AMI), Serious Mental Illness (SMI), or Substance Use Disorder (SUD) in the Past Year: Among Adults Aged 18 or Older; 2022



Source: "Key Substance Use and Mental Health Indicators in the United States"; Results from the 2022 National Survey on Drug Use and Health (November 2023). Substance Abuse and Mental Health Services Administration (SAMHSA).

Michigan's Data Landscape
Overdose Death

3096

Overdose Deaths 2021
Michigan Overdose Data to Action (MODA)
Provisional Overdose Deaths 2021

2998

Overdose Deaths 2022
(-3.2%)
Michigan Overdose Data to Action (MODA)
Provisional Overdose Deaths 2022

2953

Reported Overdose Deaths 2022
CDC: National Vital Statistics System (NVSS)
Provisional Overdose Death Counts (Aug 2022-2023)

2877

Reported Overdose Deaths 2023
(-2.57%)
CDC: National Vital Statistics System (NVSS)
Provisional Overdose Death Counts (Aug 2022-2023)

3002

Predicted Overdose Deaths 2022
CDC: National Vital Statistics System (NVSS)
Provisional Overdose Death Counts (Aug 2022-2023)

3062

Predicted Overdose Deaths 2023
(2.00%)
CDC: National Vital Statistics System (NVSS)
Provisional Overdose Death Counts (Aug 2022-2023)

American Indian/Alaska Native

23.7

Overdose Death Rate by Race
Provisional overdose deaths per 100,000
July 2022 - June 2023
Michigan Overdose Data to Action (MODA)

Nationally, **"Non-Hispanic American Indian or Alaska Native (AI/AN) people had the highest drug overdose death rates in both 2020 and 2021".** (Source: CDC National Center of Health Statistics Data Brief 457; 2022). **In 2021, "1,358 non-Hispanic AI/AN people died by overdose, which was the highest rate of any racial or ethnic group."** See CDC Opioid Overdose Prevention in Tribal Communities.

Black or African American

57.3

Overdose Death Rate by Race
Provisional overdose deaths per 100,000
July 2022 - June 2023
Michigan Overdose Data to Action (MODA)

Nationally, Non-Hispanic Black people had the second highest drug overdose death rates in both 2020 and 2021. (Source: CDC National Center of Health Statistics Data Brief 457; 2022).

White

22.3

Overdose Death Rate by Race
Provisional overdose deaths per 100,000
July 2022 - June 2023
Michigan Overdose Data to Action (MODA)

Michigan's Data Landscape
Suicide Death

1482

Suicide Deaths in 2021
Michigan Suicide Prevention Commission
2023 Annual Report

1200

Men died by suicide in 2021
Michigan Suicide Prevention Commission
2023 Annual Report

80%

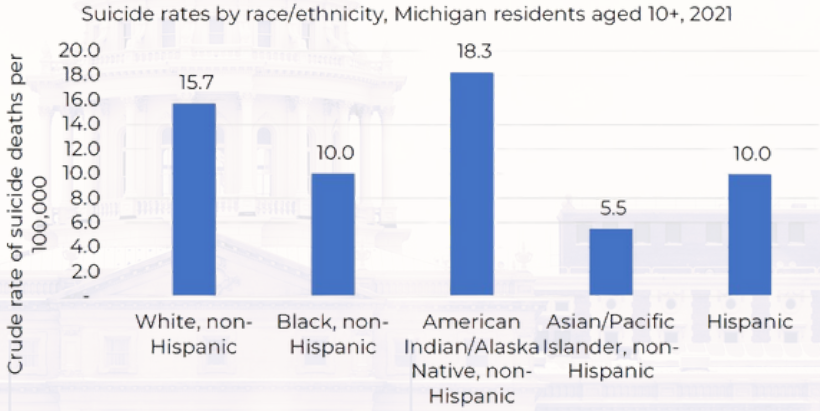
of suicide deaths were men (2021)
Michigan Suicide Prevention Commission
2023 Annual Report

18.3

American Indian/Alaska Native
Suicide rates by race/ethnicity, Michigan residents aged 10+ (2021) Crude Rate of Suicide Deaths per 100, 000

Nationally, "age-adjusted suicide rates are highest among non-Hispanic American Indian and Alaska Native (AI/AN) people (28.1 per 100,000)".
The "suicide rate among non-Hispanic AI/AN males ages 15–34 is 82.1 per 100,000, and suicide is the 9th leading cause of death among all AI/AN people. (Source: CDC National Center for Injury Prevention and Control; 2023. See Facts About Suicide: "Disparities in Suicide")

Figure 5: Suicide rates by race/ethnicity, Michigan residents aged 10+, 2021



Source: Michigan Suicide Prevention Commission Annual Report 2023.

14.4

Michigan Suicide Rate 2021
Crude Rate of Suicide Deaths per 100,000

Suicide Rate by Local Health Department (LHD)

Three (3) highest suicide rates among LHDs (high SUVI counties/LHD, underlined)

32.7

District Health Department Region 4
Alpena, Cheboygan, Montmorency, and Presque Isle
Suicide Rate by LHD 2021
Crude Rate of Suicide Deaths per 100,000

32.0

District Health Department Region 2
Alcona, Iosco, Ogemaw, and Oscoda
Suicide Rate by LHD 2021
Crude Rate of Suicide Deaths per 100,000

27.4

Luce, Mackinac, Alger, Schoolcraft
District Health Department
Suicide Rate by LHD 2021
Crude Rate of Suicide Deaths per 100,000

55%

of suicide deaths involved a firearm
Michigan Suicide Prevention Commission
2023 Annual Report

39%

increase in suicide death (2011-2021) among Black Michigan residents aged 10 and older
Michigan Suicide Prevention Commission
2023 Annual Report

Learn more about special populations and higher risk groups for suicide, including LGBTQIA+ youth and Veterans.

Acknowledgement: Figures and formatting for "Michigan's Data Landscape: Suicide Death" taken from the Michigan Suicide Prevention Commission 2023 Annual Report.

Michigan's Data Landscape
Non-Fatal Overdose

30,946

Total Emergency Department Overdose Visits 2021
Q1 2021 - Q4 2021
Michigan Overdose Data to Action (MODA)

28,158

Total Emergency Department Overdose Visits 2022 (-9.0%)
Q1 2022 - Q4 2022
Michigan Overdose Data to Action (MODA)

13,346

EMS Response to Probable Opioid Overdose 2022
Q1 2022 - Q4 2022
Michigan Overdose Data to Action (MODA)

12,194

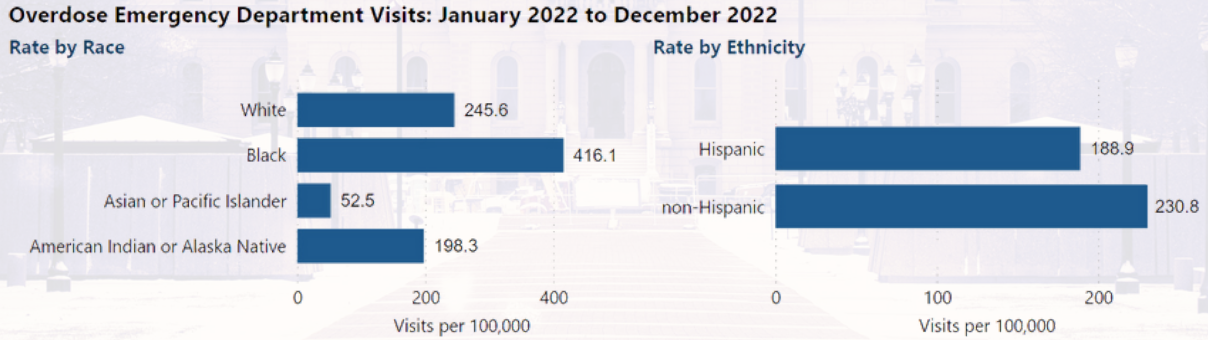
EMS Response to Probable Opioid Overdose 2023 (-8.6%)
Q1 2023 - Q4 2023
Michigan Overdose Data to Action (MODA)

3174

EMS Response to Probable Opioid Overdose Q4 2022
Count by Quarter (Q4 2022)
Michigan Overdose Data to Action (MODA)

2675

EMS Response to Probable Opioid Overdose Q4 2023
Count by Quarter (Q4 2023)
Michigan Overdose Data to Action (MODA)



ED data for Washtenaw county are not available due to missing data. Estimates for regions/selections including Washtenaw are under-counts. Data are suppressed where counts are between 1 and 5 to protect confidentiality and preserve statistical stability.

Source: Michigan Overdose Data to Action (MODA) Dashboard. Michigan Department of Health and Human Services (MDHHS). Accessed February 25, 2024. https://www.michigan.gov/opioids/category-data

MICHIGAN'S **REPORT CARD**

for the planning, use, and management of
state opioid settlement funds
2023-2024

Principle 1: Spend money to save lives

Strategies for Improvement

Commit to 100% public reporting of state opioid settlement expenditures. Provide information on prior funding sources for multi-year projects that receive settlement dollars; ensure adherence with Public Act 83 of 2022 (MCL 12.253). [100]

B

Principle 2: Use evidence to guide spending

Strategies for Improvement

Increase community outreach and engagement to enhance culturally responsive data collection [101] and program development efforts. Utilize cultural, traditional, and experiential knowledge as evidence to help guide the use of settlement dollars.

C

Principle 3: Invest in youth prevention

Strategies for Improvement

Increase public reporting on youth prevention initiatives. Include communities in the development process. Prioritize disproportionately impacted communities and ensure that prevention strategies are culturally responsive, trauma-informed, and data-supported.

B

Principle 4: Focus on racial equity

Strategies for Improvement

Prioritize racial equity through commitment to policy and authentic engagement practices. Improve meaningful inclusion of and outreach to BIPOC communities, including Tribal communities; maintain outreach and engagement efforts as an ongoing process of learning and collaboration. Prioritize communities impacted by historic harms and discriminatory policies. Utilize and align the expertise of the Racial Equity Workgroup (Opioids Task Force), Community Engagement and Planning Collaborative (OAC), experts in racial equity, and community leaders, to move recommendations to action.

C-

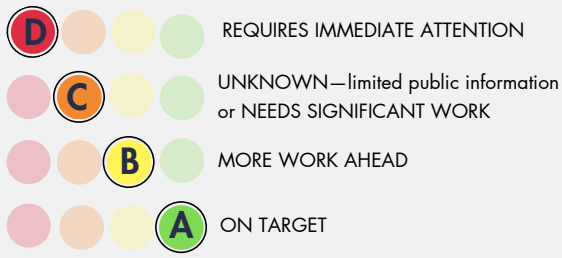
Principle 5: Develop a fair and transparent process for deciding where to spend the funding

Strategies for Improvement

Increase public transparency around how decisions are being made for the direction and prioritization of settlement-funded initiatives. Ensure that communities are meaningfully included in decision-making processes; ensure that these processes are fair, transparent, and in alignment with community needs.

C

UNDERSTANDING **THE REPORT CARD**



The OAC used the Bloomberg-Hopkins Principles [102] as a framework to assess Michigan's practices in planning, use, and management of State opioid settlement funds. Only publicly available information was used, so information gaps could be more easily identified. The report card provides a snapshot of current practices and a comparison point for annual reassessment.
See "Adopting the Bloomberg-Hopkins Principles"

Grading: A final letter grade was assigned to each of the five (5) Principles, with, consideration of the fifteen (15) "Principle" strategies. Final grades represent the OAC's assessment, which has been supported by publicly available information. **Assigned grades are an interpretation of State practices, based on public information available at the time of assessment. Grades may not be reflective of actual practices, rather what can be understood from available (easily accessible) information, as assessed by the OAC.**

PRINCIPLE 1: Spend money to save lives

Michigan has taken meaningful steps to increase information available to the public—especially on the State's use of opioid settlement funds. The information landscape of today is notably improved from that of early 2023. Resources like the Michigan Department of Health and Human Services state settlement website [103] have helped, but there is still more work ahead. An explicit commitment to 100% public reporting, including reporting on prior funding sources, can help model transparency for all jurisdictions and ensure adherence to state law for the spending of dollars from the Michigan Opioid Healing and Recovery Fund (MCL 12.253). [104]

PRINCIPLE 2: Use evidence to guide spending

The cultural and experiential knowledge offered by communities can serve as guidance for how to approach data equity and build evidence-based [105] programs from an equity lens. While evidence-based practices (EBPs) may be preferred, there are meaningful interventions, such as cultural and traditional healing practices, that may not be EBPs, but hold equally important value for health, healing, and wellness. A deeper look at how programs and initiatives can be tailored to support culture and community-specific needs, is necessary. Cultural and experiential knowledge obtained through meaningful engagement can serve as evidence for planning and development of settlement-funded initiatives.

PRINCIPLE 3: Invest in youth prevention

Youth prevention initiatives can be enhanced by meaningful inclusion of communities in planning, development, and implementation processes. Evidence-based practices can be adjusted to support community and culturally-specific needs. Increasing public reporting on youth prevention efforts, including the development process, can help model culturally-responsive practices for all jurisdictions.

PRINCIPLE 4: Focus on racial equity

To avoid perpetuating harm, State efforts addressing racial equity must be intentional, authentic, and guided by the expertise of individuals who understand racial equity deeply—this includes community members and leaders who can offer cultural and experiential knowledge. Racial equity work requires an understanding that social and economic inequities, historic harms, and discriminatory practices are real—and have had real impacts on BIPOC and Tribal communities. Equity has often been used as a politicized term—efforts to support racial equity work must transcend politics and demonstrate a commitment to the work, through action. [106]

PRINCIPLE 5: Develop a fair and transparent process for deciding where to spend the funding

Understanding how decisions are made can help model responsible decision-making practices while offering transparency and clarity to community members. The direction of state settlement dollars should be fair—transparency around how and why decisions are being made can provide accountability for responsible decision-making. Communities, especially those most impacted, should be included at every level of planning, development, and implementation.

KEY TAKEAWAYS **2023-2024**

Core needs and improvements of the state opioid settlement space

The OAC previously identified "key takeaways" from its inaugural report (March 2023). These were used as a way to frame the broader needs of Michigan's opioid settlement landscape. "Takeaways" were identified in relation to state-level gaps and national guidance, supporting the necessity of public transparency, community inclusion, collaboration, and accountability. These areas are core to responsible (and ethical) practices that support Michigan's planning, use, and management of opioid settlement dollars. [107] [108]

Public transparency

Efforts involving the planning, use, and management of state [share] opioid settlement funds should be communicated transparently and made easily accessible to the public. Transparency is essential in building trust and empowering communities to identify funding opportunities and maximize the use of settlement dollars.

Improvements 2023-2024

- Increased reporting from OAC (October 2023).
- Development/launch of the MDHHS Opioid Settlement Website (October 2023).
- Release of key planning and spending documents (MDHHS; November 2023).
- Release of the Opioid Settlement Payment Estimator (AG; November 2023).

Needs 2023-2024

- Explicit commitment by state leaders to providing 100% public reporting on settlement spending, prior funding sources, planning processes, and anticipated investments.
- Development of a comprehensive (public) strategic plan to frame current/future settlement efforts.

Community and Tribal engagement and inclusion

All planning and implementation efforts should include unique perspectives and experiential knowledge from Michigan communities and the twelve (12) Sovereign Nations. Authentic engagement and inclusion are essential to this process.

Improvements 2023-2024

- OAC "Community Voices" initiative: community engagement activities, listening sessions, public survey (November 2023; ongoing).
- Monthly OAC/Tribal partnership calls. (December 2023; ongoing)
- Racial Equity Workgroup (Opioids Task Force) recommendations.

Needs 2023-2024

- Demonstrable commitment to community engagement and inclusion as a foundational component of all state opioid settlement work.

Meaningful collaboration

Intergovernmental partnership and government-community collaboration must be present to support alignment of resources, strategies, and response measures for Michigan's addiction and mental health crisis. Opioid settlement funds are not used to their maximum benefit if state efforts aren't synergized.

Improvements 2023-2024

- Ongoing collaboration with community partners, (regional and local) on "Community Voices" activities.
- Ongoing collaboration between the OAC and local representative agencies (MAC, MML, MTA) on "Local Spotlights".
- Emerging collaboration between the OAC and Tribal partners.

Needs 2023-2024

- Demonstrable commitment by state leaders to supporting intergovernmental, interdepartmental, collaboration and alignment of state settlement work.

Legislative oversight

Oversight by the Legislature can support state alignment with best practices and national guidance for opioid settlement work. The Legislature can act as an accountability partner for any executive [state] departments that have been appropriated settlement dollars; this helps ensure that investment efforts align with statutory requirements (Public Act 83 of 2022. MCL 12.253) and are representative of impacted communities and constituents.

Improvements 2023-2024

- The FY 2024 State Budget Bill (Public Act 119 of 2023) requires semiannual reporting from the Department of Health and Human Services, on revenues, expenditures, encumbrances, and planned revenues and expenditures, as related to the Michigan Opioid Healing and Recovery Fund.

Needs 2023-2024

- Statutory assurance for public transparency of all reports required by Sec. 917 of PA 119 of 2023.

A year in review

In its second year, the Opioid Advisory Commission (OAC) established an advisory workgroup (CEPC) to enhance community engagement and health equity, [109] developed and launched the Community Impact Survey, [110] collaborated with representative agencies to spotlight localities with promising practices, [111] and went to Michigan's communities—to partner, listen, and learn.

As a statutorily established advisory body, the OAC is accountable to the Legislature, the Governor, the Attorney General, [112] and most importantly, to the people of Michigan.

Recommendations produced by the OAC are intended to represent the voices and needs of the people. The opioid settlements are an opportunity to reach out—to learn about the unique strengths and challenges facing our communities, especially those most profoundly impacted by the addiction and mental health crisis. The best way to learn about the unique needs of Michigan's communities is through direct outreach and meaningful engagement—through connection and trust.

The OAC believes that to advise effectively, there must be awareness and understanding of what is occurring; the cultural, experiential, and practical knowledge offered by our community members (especially those who have been directly impacted), helps provides this—and an honest assessment of the state settlement landscape, both in its strengths and limitations, can help enhance this.

The following links connect to information on OAC activities from 2023-2024—all done in an effort to partner and serve—none of which would be possible without collaboration and the invaluable support of local, regional, Tribal, State, and community partners.

Community Voices

- Michigan Opioid Settlement Funds: Community Impact Survey
- Community Listening Sessions
- Virtual Listening and Informational Sessions

Community Engagement & Planning Collaborative (CEPC)

Local Spotlights

In partnership with the Michigan Association of Counties (MAC), Michigan Municipal League (MML), and Michigan Townships Association (MTA).

Opioid Advisory Commission: Decision Making

STATE OF MICHIGAN

Opioid **Healing and Recovery Fund**

Establishment

"Senate Bill 993 amended the Michigan Trust Fund Act to create the 'Michigan Opioid Healing and Recovery Fund' within the Department of Treasury and to require the State Treasurer to deposit into the Fund all proceeds received by the State as a result of a judgment or settlement pertaining to violations, or alleged violations, of law pertaining to the manufacture, marketing, and distribution of opioids" (Senate Fiscal Agency analysis). [113]

Supplement, Not Supplant

"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" (PA 83 of 2022; MCL 12.253). [114]

Unspent Funds

"Money in the Michigan Opioid Healing and Recovery Fund at the close of the fiscal year must remain in the Michigan opioid healing and recovery fund and must not lapse to the general fund" (PA 83 of 2022; MCL 12.253). [115]

Funds from the Michigan Opioid Healing and Recovery Fund are considered restricted revenues.

$123.2 million

Estimated total State share, non-regional, and regional opioid settlement funds, received as of December 31, 2023

$104.1 million

Estimated Balance of the Michigan Opioid Healing and Recovery Fund, as of December 31, 2023

$3.7 million

Estimated interest accrued through "Common Cash" [116] investments, as of September 30, 2023

Total Appropriations

MDHHS: $62.4 million (FYs 22-24)
AG: $11.285 million (FY 22-23)

MDHHS Work Projects

$15.98 million
"Opioid Settlement Funds"
FY 21-22 Work Project/Carryforward

$10 million
"Opioid Response Activities"
FY 22-23 New Work Project

$26 million (66%) of FY 21-23 DHHS appropriations ($39.2 million) **estimated in work projects**

$12 million (31%) of FY 21-23 DHHS appropriations ($39.2 million) **estimated in spending**

Estimates only. Please contact MDHHS for further information.

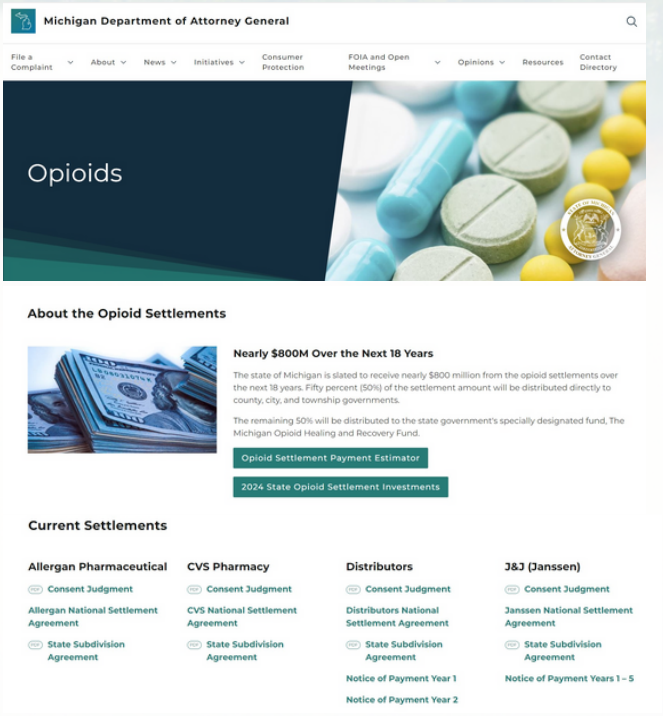
DEPARTMENT OF ATTORNEY GENERAL

Opioid **Settlement Website & Payment Estimator**

In November 2023, the Michigan Department of Attorney General (AG) released the "Opioid Settlement Payment Estimator". [117] The "Payment Estimator" is publicly available through the **AG's opioid settlement website** [118] and includes several worksheets covering information on estimated settlement payments by jurisdiction (state and local government), year, company, and estimated payment totals. "The worksheets...provide estimates of opioid settlement funding. These numbers are intended to provide guidance to Michigan governments for opioid settlement payments...Payment information is provided for both local governments and the State of Michigan". [119]

DEPARTMENT OF ATTORNEY GENERAL
Opioid Settlement Website
Information on:

- Current opioid settlements (Michigan) including settlement agreements, state subdivision agreements, and allocation notices.
- State and local resources, including links to county dashboards.
- News and updates related the opioid settlements.



Source: www.michigan.gov/ag/initiatives/opioids (Department of Attorney General; February 2024)

$16.2M
Estimated State Share Payments
2021

$836K
Estimated State Share Payments
2022

$102.9M
Estimated State Share Payments
2023

$109.2M
Estimated State Share Payments
2024

$52.1M
Estimated State Share Payments
2025

$53.9M
Estimated State Share Payments
2026

$841M 2021-2040
Estimated Total State Share Payments

$338.5M
Estimated State Share Payments
2021-2026

Source: www.michigan.gov/ag/initiatives/opioids (Department of Attorney General; Opioid Settlement Payment Estimator; February 2024)

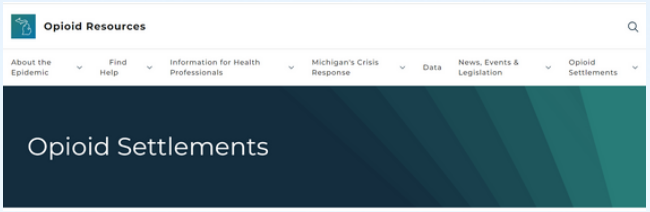
DEPARTMENT OF HEALTH AND HUMAN SERVICES

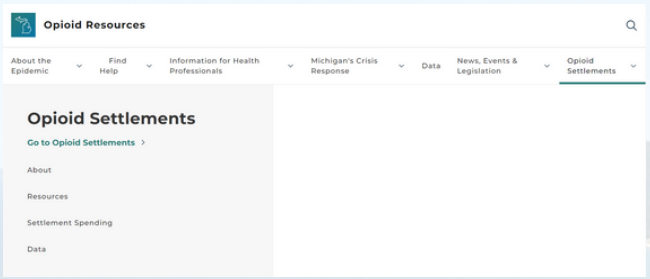
Opioid **Settlement Website**

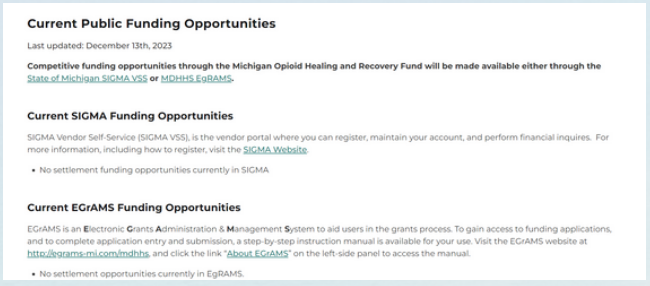
In October 2023, the Michigan Department of Health and Human Services (MDHHS) launched the "Opioid Settlement" website. [120]

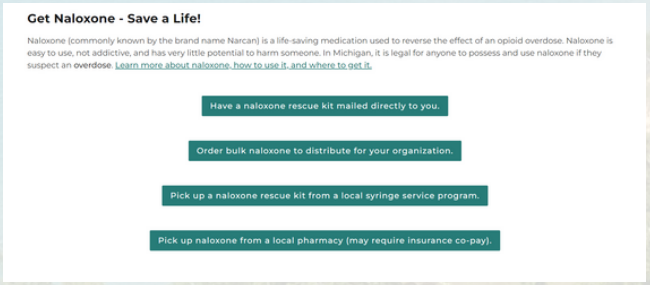
The website is a valuable resource, especially for information related to MDHHS spending and planned investments of settlement dollars. The website contains information including but not limited to, the following areas:

- Departmental spending (opioid settlement funds)
- Planned settlement investments
- Public funding opportunities
- Technical assistance resources
- Naloxone access/linkage (Naloxone Portal)
- Information on opioids, state settlements, and national opioid litigation
- State and local data; overview and links to the Michigan Overdose Data to Action (MODA) Dashboard

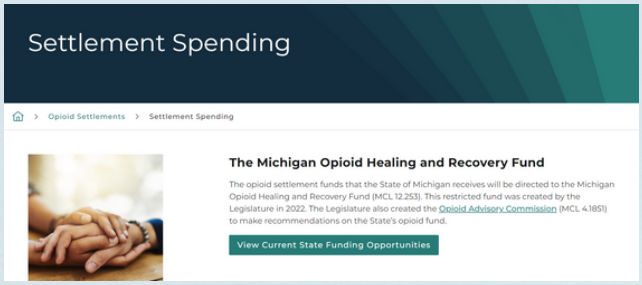


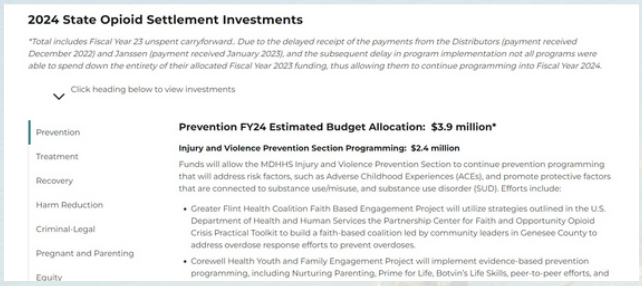


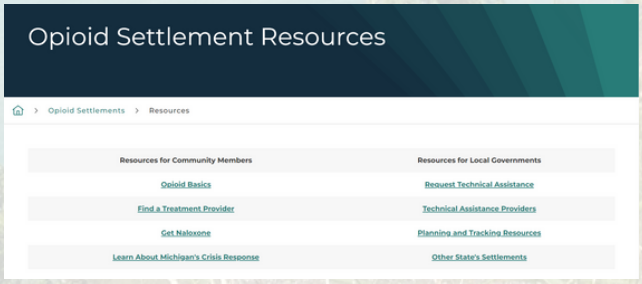


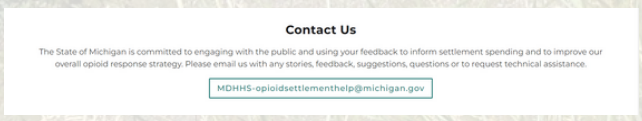


Source: www.michigan.gov/opioids/opioidsettlements (Department of Health and Human Services; January 2024)









Source: www.michigan.gov/opioids/opioidsettlements (Department of Health and Human Services; January 2024)

MDHHS **Settlement Website Links**

Settlement Home
About the Settlements
Resources
Data
Settlement Spending
Opioids Task Force
Racial Equity

THE OPIOID SETTLEMENT LANDSCAPE

RESOURCE LIST

Michigan Opioid Settlement Resources

Opioid Advisory Commission (OAC) [Website]
What is the Opioid Advisory Commission? [Document]
OAC Quarterly Bulletin (October 2023) [Report]
OAC 2023 Annual Report: A Planning Guide for State Policy Makers [Report]

Michigan Opioid Settlement Funds Part I: Key Agencies and Settlements [Document]
Michigan Opioid Settlement Funds Part II: Frequently Asked Questions [Document]
Michigan Association of Counties (MAC): Opioid Resource Center and Settlement Resource Library [Website]
Guide for Community Advocates on the Opioid Settlement: Michigan (Vital Strategies) [Document]

Michigan Department of Attorney General: Opioid Settlements [Website]
Michigan Department of Health and Human Services: Opioid Settlements [Website]
Michigan Department of Health and Human Services 2023 Opioid Report [Report]
2023 Michigan Opioid Healing and Recovery Fund Annual Financial Report (MDHHS) [Report]
Michigan's Opioids Settlement – MDHHS FY23 Spend Plan Programming Planning Overview [Document]
Opioid Strategy and Implementation of Opioid Settlements (MDHHS) [Document]

Michigan Opioids Task Force (OTF) [Website]
OTF Meeting Announcements [Website]
Racial Equity Workgroup (REWG) [Website]
REWG Draft Recommendations [Document]

Tools

Michigan Overdose Data to Action Dashboard (MODA)—MDHHS [Website]
Michigan Substance Use Disorder Data Repository (MI-SUDDR) [Website]
Opioid Abatement Needs and Investment Tool (OANI)—Duke - Margolis Center for Health Policy [Website]
Recovery Ecosystem Index Map—(NORC/University of Chicago; East Tennessee State University) [Website]

National Opioid Settlement Resources

Johns Hopkins Bloomberg School of Public Health (JHSPH): Principles for the Use of Funds from Opioid Litigation [Website]
JHSPH "Principles" [Website]
Center for Indigenous Health: Tribal Principles [Website]
National Academy for State Health Policy (NASHP): How are States Using Opioid Settlement Funds [Website]
National Association of Counties (NACo.): Opioid Solutions Center [Website]
Equity Considerations for Local Health Departments on Opioid Settlement Funds (NACCHO) [Report]
Opioid Settlement Tracker [.com] [Website]
National Opioids Settlements [Website]
National Opioid Abatement Trust II (NOAT) [Website]
National Governors Association Center for Best Practices Opioid Litigation Settlement Funds Summit [Document]
Vital Strategies: Opioid Settlement Funds State Level Guides [Website]
VOCAL-New York A Roadmap for Opioid Settlement Funds: Supporting Communities & Ending the Overdose Crisis [Report]
RAND: Strategies for effectively allocating opioid settlement funds [Report]
O'Neill Institute for National and Global Health Law at Georgetown Law: Conflicts of Interest and Opioid Litigation Proceeds: Ensuring Fairness and Transparency [Document]

Acknowledgements

OPIOID ADVISORY COMMISSION—MEMBERS

Dr. Cara Anne Poland, **Chair**
Patrick Patterson, **Vice Chair**
Sheriff Daniel Abbott
Bradley Casemore
Hon. Linda Davis (Ret.)
Katharine Hude
Mona Makki
Scott Masi
Mario Nanos
Kyle Rambo
Dr. Sarah Stoddard
Hon. Jamie Stuck

Jennifer Dettloff, Legislative Council Administrator (Ex-Officio Member)
Elizabeth Hertel, Director, Department of Health and Human Services (Ex-Officio Member)

Tara King, Program Coordinator

KEY PARTNERSHIPS

Governor Gretchen Whitmer
Attorney General Dana Nessel
Senate Majority Leader Winnie Brinks
Speaker of the House Joe Tate
Senate Minority Leader Aric Nesbitt
House Republican Leader Matt Hall
Senator Sarah Anthony, Chair,
Senate Appropriations Committee
Representative Angela Witwer, Chair,
House Appropriations Committee
Michigan Legislative Council
House Fiscal Agency
Senate Fiscal Agency
Department of Attorney General
Department of Civil Rights
Department of Corrections
Department of Health and Human Services
Department of Treasury
State Court Administrative Office
Michigan Association of Counties
Michigan Municipal League
Michigan Townships Association
Bay Mills Indian Community
Grand Traverse Band of Ottawa and Chippewa Indians
Hannahville Indian Community
Keweenaw Bay Indian Community
Lac Vieux Desert Band of Lake Superior Chippewa Indians
Little River Band of Ottawa Indians
Little Traverse Bay Band of Odawa Indians
Match-e-be-nash-she-wish Band of Pottawatomi Indians (Gun Lake Tribe)
Nottawaseppi Huron Band of the Potawatomi
Pokagon Band of Potawatomi Indians
Saginaw Chippewa Indian Tribe
Sault Ste. Marie Tribe of Chippewa Indians
United Tribes of Michigan

A special thanks to the members of the Opioid Advisory Commission Community Engagement and Planning Collaborative (CEPC) for their time, expertise, and commitment to advancing the Commission's work and supporting positive health outcomes for all.

APPENDICES

Appendix A Public Act 84 of 2022 (MCL 4.1851)

Appendix B Public Act 83 of 2022 (MCL 12.253)

Appendix C "Exhibit E" (Distributors Settlement)

Appendix D The National Opioid Settlement Landscape: State Practices in Tribal Prioritization

Appendix E High SUVI Counties

Appendix F High SUVI ZIP Codes

Appendix G Opioid Advisory Commission Deliverables

Appendix H Opioid Advisory Commission Michigan Opioid Settlement Funds: Community Impact Survey Data Snapshot

APPENDIX A

Public Act 84 of 2022 (MCL 4.1851)

Act No. 84
Public Acts of 2022
Approved by the Governor
May 19, 2022
Filed with the Secretary of State
May 19, 2022
EFFECTIVE DATE: May 19, 2022

STATE OF MICHIGAN
101ST LEGISLATURE
REGULAR SESSION OF 2022

Introduced by Senator Huizenga

ENROLLED SENATE BILL No. 994

AN ACT to amend 1986 PA 268, entitled "An act to create the legislative council; to prescribe its membership, powers, and duties; to create a legislative service bureau to provide staff services to the legislature and the council; to provide for operation of legislative parking facilities; to create funds; to provide for the expenditure of appropriated funds by legislative council agencies; to provide for the designation and authentication of certain electronic legal records as official; to authorize the sale of access to certain computerized data bases; to establish fees; to create the Michigan commission on uniform state laws; to create a law revision commission; to create a senate fiscal agency and a house fiscal agency; to create a commission on intergovernmental relations; to prescribe the powers and duties of certain state agencies and departments; to repeal certain acts and parts of acts; and to repeal certain parts of this act on specific dates," (MCL 4.1101 to 4.1901) by amending the title, as amended by 2018 PA 638, and by adding chapter 8A.

The People of the State of Michigan enact:

TITLE

An act to create the legislative council; to prescribe its membership, powers, and duties; to create a legislative service bureau to provide staff services to the legislature and the council; to provide for operation of legislative parking facilities; to create funds; to provide for the expenditure of appropriated funds by legislative council agencies; to provide for the designation and authentication of certain electronic legal records as official; to authorize the sale of access to certain computerized data bases; to establish fees; to create the Michigan commission on uniform state laws; to create a law revision commission; to create a senate fiscal agency and a house fiscal agency; to create a commission on intergovernmental relations; to create the opioid advisory commission and prescribe its powers and duties; to prescribe the powers and duties of certain state agencies and departments; to repeal certain acts and parts of acts; and to repeal certain parts of this act on specific dates.

CHAPTER 8A

OPIOID ADVISORY COMMISSION

Sec. 850. As used in this chapter:

(a) "Michigan opioid healing and recovery fund" means the Michigan opioid healing and recovery fund created in section 3 of the Michigan trust fund act, 2000 PA 489, MCL 12.253.

(b) "Opioid advisory commission" means the opioid advisory commission created in section 851.

Sec. 851. (1) The opioid advisory commission is created in the council.

(2) The opioid advisory commission must consist of the following members:

(a) Twelve voting members that have experience in substance abuse prevention, health care, mental health, law enforcement, local government, first responder work, or similar fields appointed as follows:

(*i*) Four members appointed by the senate majority leader.

(*ii*) Four members appointed by the speaker of the house of representatives.

(*iii*) One member appointed by the senate minority leader.

(*iv*) One member appointed by the minority leader of the house of representatives.

(*v*) One member appointed by the senate majority leader and the speaker of the house of representatives and selected from a list of 3 individuals provided by the governor.

(*vi*) One member appointed by the senate majority leader and the speaker of the house of representatives and selected from a list of 3 individuals provided by the attorney general.

(b) The director of the department of health and human services, or his or her designee, who shall serve as an ex officio member without vote.

(c) The council administrator, or his or her designee, who shall serve as an ex officio member without vote.

(3) In appointing members or providing a list from which members will be selected under subsection (2)(a), the governor, the senate majority leader, the speaker of the house of representatives, the senate minority leader, the minority leader of the house of representatives, and the attorney general shall ensure that the members of the opioid advisory commission, to the extent possible, reflect the geographic diversity of this state.

(4) All initial opioid advisory commission members must be appointed within 60 days after the effective date of the amendatory act that added this section.

(5) Of the first voting members appointed, 4 shall be appointed to 1-year terms, 4 shall be appointed to 2-year terms, and 4 shall be appointed to 3-year terms, as determined by the senate majority leader and the speaker of the house of representatives. After the first appointments, the term of a voting member of the opioid advisory commission is 3 years or until a successor is appointed under subsection (2), whichever is later.

(6) If a vacancy occurs on the opioid advisory commission, an individual must be appointed in the same manner as the original appointment to fill the vacancy for the balance of the term.

(7) The senate majority leader and the speaker of the house of representatives may concur to remove a member of the opioid advisory commission for incompetence, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

(8) The council administrator, or his or her designee, shall call the first meeting of the opioid advisory commission. At the first meeting, the opioid advisory commission shall elect a member as a chairperson and, except as otherwise provided in this subsection, may elect other officers that it considers necessary or appropriate. The council administrator, or his or her designee, shall serve as secretary. The opioid advisory commission shall meet at least quarterly. The opioid advisory commission may meet more frequently at the call of the chairperson or at the request of at least 7 members.

(9) Seven voting members of the opioid advisory commission constitute a quorum for transacting business. A majority vote of the voting members appointed and serving is required for any action of the opioid advisory commission.

(10) The opioid advisory commission shall conduct its business in compliance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

(11) A writing that is prepared, owned, used, possessed, or retained by the opioid advisory commission in performing an official function is subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(12) A member of the opioid advisory commission is not entitled to compensation for service on the opioid advisory commission, but the opioid advisory commission may reimburse a member for actual and necessary expenses incurred in serving.

(13) The opioid advisory commission shall do all of the following:

(a) Adopt policies and procedures for the administration of the opioid advisory commission as allowed by law.

(b) Review 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 establish priorities to address substance use disorders and co-occurring mental health conditions, for the purpose of recommending funding initiatives to the legislature.

(c) By March 30 of each year, provide a written report to the governor, the attorney general, the senate majority

leader, the speaker of the house of representatives, and the chairs of the senate and house of representatives appropriations committees that includes all of the following:

(*i*) A statewide evidence-based needs assessment that includes at least all of the following:

(A) A summary of current local, state, and federal funding used to address substance use disorders and co-occurring mental health conditions.

(B) A discussion about how to prevent overdoses, address disparities in access to health care, and prevent youth substance use.

(C) An analysis, based on quantitative and qualitative data, of the effects on this state of substance use disorders and co-occurring mental health conditions.

(D) A description of the most common risk factors associated with substance use disorders and co-occurring mental health conditions.

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

(A) Substance use disorder and co-occurring mental health conditions prevention, treatment, recovery, and harm reduction efforts.

(B) Reducing disparities in access to prevention, treatment, recovery, and harm reduction programs, services, supports, and resources.

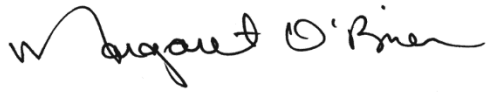
(*iii*) An evidence-based assessment of the prior use of money appropriated from the Michigan opioid healing and recovery fund, including the extent to which such expenditures abated the opioid crisis in this state.

(*iv*) Recommended funding for tasks, activities, projects, and initiatives that would support the objectives of the commission.

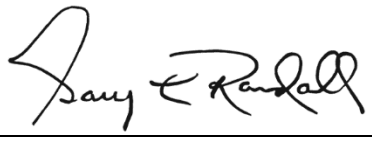
(*v*) If applicable, recommended additional legislation needed to accomplish the objectives of the commission.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 993 of the 101st Legislature is enacted into law.

This act is ordered to take immediate effect.



Secretary of the Senate



Clerk of the House of Representatives

Approved_____

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Governor

APPENDIX B

Public Act 83 of 2022 (MCL 12.253)

Act No. 83
Public Acts of 2022
Approved by the Governor
May 19, 2022
Filed with the Secretary of State
May 19, 2022
EFFECTIVE DATE: May 19, 2022

STATE OF MICHIGAN
101ST LEGISLATURE
REGULAR SESSION OF 2022

Introduced by Senator MacDonald

ENROLLED SENATE BILL No. 993

AN ACT to amend 2000 PA 489, entitled "An act to create certain funds; to provide for the allocation of certain revenues among certain funds and for the operation, investment, and expenditure of certain funds; and to impose certain duties and requirements on certain state officials," by amending section 2 (MCL 12.252), as amended by 2021 PA 137, and by adding section 3.

The People of the State of Michigan enact:

Sec. 2. As used in this act:

(a) "Community district education trust fund" means the community district education trust fund created in section 12.

(b) "Flint settlement trust fund" means the Flint settlement trust fund created in section 11.

(c) "Medicaid benefits trust fund" means the Michigan Medicaid benefits trust fund established in section 5.

(d) "Medicaid program" means a program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-6.

(e) "Medicaid special financing payments" means the Medicaid special adjustor payments each year authorized in the department of health and human services appropriations act.

(f) "Michigan merit award trust fund" means the Michigan merit award trust fund established in section 9.

(g) "Michigan opioid healing and recovery fund" means the Michigan opioid healing and recovery fund created in section 3.

(h) "Strategic outreach and attraction reserve fund" means the strategic outreach and attraction reserve fund created in section 4.

(i) "Tobacco settlement revenue" means money received by this state that is attributable to the master settlement agreement incorporated into a consent decree and final judgment entered into on December 7, 1998 in *Kelly Ex Rel. Michigan v Philip Morris Incorporated, et al.*, Ingham County Circuit Court, docket no. 96-84281CZ, including any rights to receive money attributable to the master settlement agreement that has been sold by this state.

(j) "21st century jobs trust fund" means the 21st century jobs trust fund established in section 7.

Sec. 3. (1) The Michigan opioid healing and recovery fund is created in the department of treasury.

(2) The state treasurer shall deposit all proceeds received by this state as a result of any judgment, settlement, or compromise of claims pertaining to violations, or alleged violations, of law related to the manufacture,

marketing, distribution, dispensing, or sale of opioids into the Michigan opioid healing and recovery fund, except for proceeds received under the Medicaid false claim act. The state treasurer may deposit money or other assets from any other source into the Michigan opioid healing and recovery fund as provided by law.

(3) The state treasurer shall direct the investment of the Michigan opioid healing and recovery fund consistent with 1855 PA 105, MCL 21.141 to 21.147, and shall credit interest and earnings from the investments to the Michigan opioid healing and recovery fund.

(4) Money in the Michigan opioid healing and recovery fund at the close of the fiscal year must remain in the Michigan opioid healing and recovery fund and must not lapse to the general fund.

(5) The department of treasury is the administrator of the Michigan opioid healing and recovery fund for audits of the fund.

(6) Subject to subsection (7), the department of treasury 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.

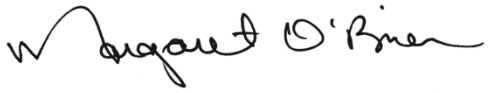
(7) Money in the Michigan opioid healing and recovery fund must be used to create or supplement programs or services. The money must not be used to replace any other governmental funds that would otherwise have been appropriated or expended for any other program or service.

(8) Subject to subsection (9), the department of the attorney general may expend money from the Michigan opioid healing and recovery fund, on appropriation, to pay for costs and reasonable attorney fees incurred in the pursuit of an opioid judgment, settlement, or compromise of claims, except for a pursuit under the Medicaid false claim act.

(9) If possible, the department of the attorney general shall attempt to have costs and attorney fees described in subsection (8) paid by a defendant or source other than the Michigan opioid healing and recovery fund.

(10) As used in this section, "Medicaid false claim act" means the medicaid false claim act, 1977 PA 72, MCL 400.601 to 400.615.

This act is ordered to take immediate effect.



Secretary of the Senate

Clerk of the House of Representatives

Approved_____

_____

Governor

APPENDIX C

"Exhibit E" (Distributors Settlement)

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

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

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. 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.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, 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; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. 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; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. 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);

4. Funding for community drug disposal programs; and

5. 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.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. 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.

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

Schedule B
Approved Uses

Support 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 that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support 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 that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

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

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

APPENDIX D

The National Opioid Settlement Landscape: State Practices in Tribal Prioritization

THE NATIONAL OPIOID SETTLEMENT LANDSCAPE

STATE PRACTICES IN TRIBAL PRIORITIZATION

DISCLAIMER: The following information is subject to change. This document was created using information available at the time of its development and may be updated at any time to reflect necessary and/or suggested changes. Information used for this document was obtained from multiple sources including but not limited to web-based publicly available information/materials and direct contact with members of state teams. This document is intended to support informational and advisory functions of the Opioid Advisory Commission and may be modified, accordingly. Sourcing for information contained herein, can be found within "References"(endnotes) of the Opioid Advisory Commission 2024 Annual Report.

THE NATIONAL OPIOID SETTLEMENT LANDSCAPE

STATE PRACTICES IN TRIBAL PRIORITIZATION

STATE	STATE APPROPRIATIONS	SETTLEMENT STRUCTURE & ESTIMATED TOTALS	TRIBAL INCLUSION IN STATE PLANNING*	TRIBAL REPRESENTATION ON STATE ADVISORY COUNCIL(S)
 MICHIGAN 12 Sovereign Nations (BIA Midwest Region)	A review of Michigan's settlement investments (FY 2024) and estimated spending (FY 2023 settlement expenditures) reveals **no funding priorities explicitly addressing the needs of Tribal communities.** The Opioid Advisory Commission (OAC) is recommending the appropriation of state opioid settlement funds to Sovereign Nations (2024 Annual Report).	**50% State / 50 % Local** **$1.5 billion** 2023 Michigan Opioid Healing and Recovery Fund Annual Financial Report Michigan Department of Health and Human Services (MDHHS) Opioid Settlement Website	**MDHHS:** Per report, consultative process for settlement spend plan development. **OAC:** Initiation of monthly Tribal Partnership Calls (2023). Goal: collaboration with Tribal partners to support mutual learning and recommendation-development.	**OAC: Current representation**, however no statutory requirement (MCL 4.1851) codifying membership of Tribal representative(s). Additional language in the OAC's Community Engagement & Planning Collaborative (advisory workgroup) supporting Tribal membership, as designated by Tribal Leadership (see CEPC group charter).
 MINNESOTA 11 Sovereign Nations (BIA Midwest Region)	**$9.375 million** (since 2020) directed to Sovereign Nations through a combination of monies from the **Opioid Epidemic Response Fund (OERF)**, including **$2 million annual, recurring appropriation** for Traditional Healing practices and capacity-building; **remaining percentage of OERF to support additional allocation to Tribal Social Service agencies** for CPS initiatives.	**25% State / 75% Local** **$570 million** Opioid Epidemic Response Spending Dashboard 2023 Minnesota Statutes: Opioid Epidemic Response Fund (OERF)	Consultative process with **additional "statutory requirements** for the Opioid Epidemic Response Advisory Council (OERAC) to conduct annual meetings with all eleven (11) Sovereign Nations for the purposes of collaboration and communication on shared issues and priorities."	**Direct representation on the Opioid Epidemic Response Advisory Council (OERAC)**, a 23-member joint council with legislative, executive, community, and Tribal inclusion. **Statutory requirements** for Tribal representation/membership: "…two members representing Indian tribes, one representing the Ojibwe tribes and one representing the Dakota tribes"; representation from "an urban American Indian community" is also included within the statute.
 WISCONSIN 11 Sovereign Nations (BIA Midwest Region)	**$6 million** (2023;19% of total state settlement spending for FY 2023) authorized for "Tribal Nation Needs". The appropriation supported "prevention, harm reduction, treatment, and recovery services for tribal members…each of the 11 federally recognized tribal nations…received comparable funding."	**30% State / 70% Local** **$754.9 million** Wisconsin Opioid Settlement Website Wisconsin: FY 2024, Q1 Opioid Settlement Summary	Consultative process including **listening sessions** held with Tribal partners.	**Unknown;** noting further exploration with the Wisconsin Department of Health Services and the Wisconsin Office of Tribal Affairs.
 WASHINGTON 29 Sovereign Nations (BIA Northwest Region)	**$15.45 million** in state settlement funds (2023) "to pass through to tribes and urban Indian health programs for opioid and overdose response activities. The funding must be used for prevention, outreach, treatment, recovery support services, and other strategies to address and mitigate the effects of the misuse and abuse of opioid related products."	**50% State / 50 % Local** **$1.1 billion** Washington AG: 2023 Opioid Abatement Account Settlement Report (2023 Legislative Session) WA Opioid Settlement Website	Consultative process with additional monthly "**learning community**" meetings (2024) that seek "to bring together state government leaders, Tribes, academic researchers, health care providers, individuals with lived experience, members of the community…".	**Unknown.** An American Indian/Alaskan Native (AI/AN) Workgroup is listed in association with the Washington Opioid and Overdose Response Plan (2021-2022); "to coordinate the action steps under each of the five goals of the plan". It is presumed that the eight workgroups (including the AI/AN workgroup) have transitioned into the "learning community". Formal Tribal representation on advisory and/or decision-making councils, is unknown.
 OREGON 9 Sovereign Nations (BIA Northwest Region)	**Potential $44 million (estimated) by 2040** to the nine (9) Sovereign Nations. The Opioid Settlement Prevention, Treatment and Recovery (OSPTR) Board recently voted (January 2024) to "**allocate 30% of the state's share of the settlement money to the nine tribal governments**".	**45% State / 55 % Local** **$748 million** OSPTR Board Website OSPTR for Tribal allocation Oregon Opioid Settlement Website	**Unknown;** noting further exploration of OSPTR and Oregon Health Authority practices.	**Statutory language for membership consideration of the OSPTR:** **(3)(a)(A)** "At least 75 percent of the members appointed by the Governor must be representatives of the following public health and health care stakeholder groups: …(ii) Indian tribes…" (ORS 430.221).

February 2024

THE NATIONAL OPIOID SETTLEMENT LANDSCAPE

STATE PRACTICES IN TRIBAL PRIORITIZATION

COLORADO—State Appropriations to Sovereign Nations

2 Sovereign Nations (BIA Southwest Region)

Appropriation of over $2 million in state opioid settlement funds (September 2023): Per the Office of the Colorado Attorney General "…the Southern Ute and Ute Mountain Ute Tribes will receive one-time distributions from the state opioid settlement funds for drug treatment, recovery, prevention and education programs.The Southern Utes will receive $1,274,536 and the Ute Mountain Utes will receive $747,178 from the State Share. The State Share represents 10% of all opioid settlement funds and is managed by the Colorado Department of Law. The amounts distributed to the tribes are based on the impact of the opioid crisis in their communities using public health data and are comparable to nearby communities."

ALASKA—Tribal Representation on State Advisory Council(s)

228 Sovereign Nations (BIA Alaska Region)

Representation of entities built into Alaska's existing opioid advisory, planning and response infrastructure:

"**Alaska Native Health Board The Alaska Native Health Board (ANHB)**, established in 1968, is recognized as the statewide voice on Alaska Native health issues. The mission of the ANHB is to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is a 28-member board entity, consisting of one representative of the Board of Directors or health committees from each of Alaska's Tribes/Tribal Health Organizations (T/THOs) and independent tribal public Law 93-638 compactors/contractors.11 ANHB's ongoing mission centers on fostering constructive communication with government agencies, elected officials, and industry stakeholders to raise awareness of Tribal health issues and to promote meaningful dialogue and effective policy change at the state and federal levels."

Alaska Opioid Policy Task Force, Opioid Work Group: Representation on the Alaska Opioid Policy Task Force created to "address the rising incidence of heroin and opioid misuse in Alaska, in 2016, ABADA, the Division of Public Health, and the Trust co-facilitated an Alaska Opioid Policy Task Force (AOPTF). 13 The goal of this taskforce was to provide recommendations to the Governor and Legislature.14 This group continues meeting monthly as the "Opioid Work Group" with the intent of coordinating and leveraging efforts across State of Alaska Departments."

SOUTH DAKOTA—Tribal Representation on State Advisory Council(s)

9 Sovereign Nations (BIA Great Plains Region)

South Dakota Prescription Opioid Abuse Advisory Committee: Current (direct) representation from the (1) Great Plains Tribal Leaders Health Board, (2) Great Plains Indian Health Services, and (3) Sisseton-Wahpeton Oyate of the Lake Traverse Reservation. "South Dakota's Prescription Opioid Abuse Advisory Committee will make recommendations to the Department of Social Services (DSS) on uses of the state's 70% of funds, which the legislature ultimately appropriates through its normal budget process and assigns to DSS for implementation" (see South Dakota's Guide for Community Advocates on the Opioid Settlement).

STATES TO WATCH: WASHINGTON & OREGON

WASHINGTON—Recent Legislation Introduced for Annual Appropriation of State Opioid Settlement Funds to Sovereign Nations

Recent legislation introduced (**SB 6099**; **bill summary**; **legislative status**) could support annual appropriation of state opioid settlement funds to Sovereign Nations. See recent Associated Press article: "As opioids devastate tribes in Washington state, tribal leaders push for added funding" (January 15, 2024); "the proposed measure would guarantee $7.75 million or 20% of the funds deposited into an opioid settlement account during the previous fiscal year — whichever is greater — go to tribes annually to respond to the opioid crisis. The account includes money from the state's $518M settlement in 2022 with the nation's three largest opioid distributors."

OREGON—Recent Decision by the Opioid Settlement Prevention, Treatment, and Recovery (OSPTR) Board to Allocate 30% of State Opioid Settlement Funds to Sovereign Nations

See recent Oregonian article "Oregon will devote 30% of its share of opioid settlement funds to tribes" (January 18, 2024), "a state board has decided to allocate 30% of the state's share of opioid settlement money – amounting to possibly $44 million – to the nine federally recognized tribes in Oregon." The Opioid Settlement Prevention, Treatment, and Recovery (OSPTR) Board, holds open meetings on a monthly basis with virtual accessibility; a meeting schedule and virtual access information can be found on the OSPTR's website.

APPENDIX E

High SUVI Counties
(75th - 100th percentile)

APPENDIX E High SUVI Counties (75th-100th percentile)

The following information has been extracted from "Michigan Substance Use Vulnerability Index Documentation – June 2022" (MDHHS) and presented within Appendix E to support reader awareness. The OAC encourages that the aforementioned document accompany any use of Substance Use Vulnerability Index (SUVI) data, and that appropriate consultation be had with the MDHHS Michigan Overdose Data to Action (MODA) and/or Opioid and Emerging Drugs Unit to support further understanding of data, methodology, strengths, and limitations, as related to the Michigan Substance Use Vulnerability Index (MI-SUVI).

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Michigan Substance Use Vulnerability Index Documentation
June 2022

Executive Summary and Public Health Implications
"Overdose and substance use disorder (SUD) are significant and complex public health problems in Michigan. Historically, overdose death data alone have often been used for SUD policy/program planning. The Michigan Department of Health and Human Services (MDHHS) recognizes that many factors influence a community's vulnerability to adverse outcomes associated with substance use and should be considered in policy and program planning.

With this in mind, MDHHS developed the Michigan Substance Use Vulnerability Index (MI-SUVI) as a tool to help guide equitable SUD program and policy decision-making. The MI-SUVI is a single, standardized score that considers multiple factors that influence a community's vulnerability related to substance use, including indicators related to substance use burden, resources, and social vulnerability. The MISUVI score is standardized and available at the county and ZIP Code Tabulation Area (ZCTA) levels. Counties/ZCTAs can be assessed by how far above or below the county/ZCTA average they fall in the total MI-SUVI score, as well as in their substance use burden, substance use resources, and social vulnerability scores.

All communities in Michigan are impacted by substance use. The MI-SUVI does not describe "communities" or "bad" communities with regards to substance use, but rather indicates the extent to which a county has been impacted in comparison to others. The MI-SUVI should not be used alone in decision-making but can be used as a strategic starting point for conversation and to highlight the extent to which certain communities may require further outreach or assessment. **Additional information, such as local knowledge and additional, relevant data indicators should be included in any SUD related decision-making.**

The MI-SUVI is available at: michigan.gov/OpioidsData. Questions regarding the MI-SUVI may be addressed to the MDHHS Opioid and Emerging Drugs Unit: **MDHHS-MODASurveillance@michigan.gov**."

APPENDIX E HIGH SUVI COUNTIES—NOTES
The information contained in Appendix E "High SUVI Counties" represents data sourced from the Michigan Overdose Data to Action Dashboard. Public Use Datasets, "County Substance Use Vulnerability Index Results". The OAC has presented this information in a simplified form to support accessibility to the reader, incorporating "County Ranks" and "Percentile Ranks" of counties determined to fall within the 75th-100th percentile for substance use vulnerability (2020). Data has been sorted to present counties in descending order of MI-SUVI score (2020), beginning with those assessed at highest "vulnerability" by percentile and county rank.

County	MI-SUVI Score (2020)	MI-SUVI Score (2020)
	Percentile Rank	*County Rank*
Oscoda	98.8	1
Wayne	97.6	2
Clare	96.4	3
Schoolcraft	95.2	4
Oceana	94.0	5
Luce	92.9	6
Lake	91.7	7
Montmorency	90.5	8
Genesee	89.3	9
Branch	88.1	10
Van Buren	86.9	11
Crawford	85.7	12
Mackinac	84.5	13
Calhoun	83.3	14
Roscommon	82.1	15
Alger	81.0	16
Berrien	79.8	17
Osceola	78.6	18
St. Joseph	77.4	19
Baraga	76.2	20
Iosco	75.0	21
**Counties listed below fall within the 70th-74th percentile rank*		
Saginaw	73.8	22
Kalkaska	72.6	23
Iron	71.4	24
Sanilac	70.2	25

Source: "County Substance Use Vulnerability Index Results".
See "Public Datasets"; Michigan Overdose Data to Action (MODA) website: https://www.michigan.gov/opioids/category-data
Accessed February 19, 2024.

APPENDIX F

High SUVI ZIP Codes (75th-100th percentile)

APPENDIX F High SUVI ZIP Codes (75th-100th percentile)

The following information has been extracted from "Michigan Substance Use Vulnerability Index Documentation – June 2022" (MDHHS) and presented within Appendix F to support reader awareness. The OAC encourages that the aforementioned document accompany any use of Substance Use Vulnerability Index (SUVI) data, and that appropriate consultation be had with the MDHHS Michigan Overdose Data to Action (MODA) and/or Opioid and Emerging Drugs Unit to support further understanding of data, methodology, strengths, and limitations, as related to the Michigan Substance Use Vulnerability Index (MI-SUVI).

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Michigan Substance Use Vulnerability Index Documentation
June 2022

Executive Summary and Public Health Implications
"Overdose and substance use disorder (SUD) are significant and complex public health problems in Michigan. Historically, overdose death data alone have often been used for SUD policy/program planning. The Michigan Department of Health and Human Services (MDHHS) recognizes that many factors influence a community's vulnerability to adverse outcomes associated with substance use and should be considered in policy and program planning.

With this in mind, MDHHS developed the Michigan Substance Use Vulnerability Index (MI-SUVI) as a tool to help guide equitable SUD program and policy decision-making. The MI-SUVI is a single, standardized score that considers multiple factors that influence a community's vulnerability related to substance use, including indicators related to substance use burden, resources, and social vulnerability. The MISUVI score is standardized and available at the county and ZIP Code Tabulation Area (ZCTA) levels. Counties/ZCTAs can be assessed by how far above or below the county/ZCTA average they fall in the total MI-SUVI score, as well as in their substance use burden, substance use resources, and social vulnerability scores.

All communities in Michigan are impacted by substance use. The MI-SUVI does not describe "communities" or "bad" communities with regards to substance use, but rather indicates the extent to which a county has been impacted in comparison to others. The MI-SUVI should not be used alone in decision-making but can be used as a strategic starting point for conversation and to highlight the extent to which certain communities may require further outreach or assessment. **Additional information, such as local knowledge and additional, relevant data indicators should be included in any SUD related decision-making.**

The MI-SUVI is available at: Michigan.gov/OpioidsData. Questions regarding the MI-SUVI may be addressed to the MDHHS Opioid and Emerging Drugs Unit: **MDHHS-MODASurveillance@michigan.gov."**

APPENDIX F HIGH SUVI ZIP CODES—NOTES
The information contained in Appendix F "High SUVI ZIP Codes" represents data sourced from the Michigan Overdose Data to Action Dashboard. Public Use Datasets, "County Substance Use Vulnerability Index Results". The OAC has presented this information in a simplified form to support accessibility to the reader, incorporating "ZCTA Ranks" and "Percentile Ranks" of ZIP Codes determined to fall within the 75th-100th percentile for substance use vulnerability (2020). Data has been sorted to present counties in descending order of MI-SUVI score (2020), beginning with those assessed at highest "vulnerability" by percentile and ZCTA rank.

ZCTA	Associated Counties	Associated County Subdivisions	MI-SUVI Score (2020)	MI-SUVI Score (2020)
			Percentile Rank	*ZCTA Rank*
49320	Mecosta	Chippewa township	99.9	1
49450	Allegan	Casco township, Cheshire township, Clyde township, Lee township, Valley township	99.8	2
48743	Iosco	Plainfield township	99.7	3
48933	Ingham	Lansing city	99.6	4
49903	Iron	Bates township, Crystal Falls township, Hematite township	99.5	5
49757	Mackinac	Mackinac Island city	99.4	6
48201	Wayne	Detroit city	99.3	7
48342	Oakland	Pontiac city	99.2	8
49440	Muskegon	Muskegon city	99.1	9
49458	Mason	Branch township	99.0	10
48502	Genesee	Flint city	98.9	11
49007	Kalamazoo	Kalamazoo charter township, Kalamazoo city	98.8	12
48229	Wayne	Ecorse city, Lincoln Park city	98.7	13
49793	Chippewa, Mackinac	Chippewa township, Hendricks township, Hudson township, Trout Lake township	98.6	14
48208	Wayne	Detroit city	98.5	15
48203	Wayne	Detroit city, Highland Park city	98.4	16
48109	Washtenaw	Ann Arbor charter township, Ann Arbor city	98.3	17
48210	Wayne	Detroit city	98.1	18
48630	Roscommon	Roscommon township	98.0	19
48218	Wayne	Ecorse city, River Rouge city	97.9	20
48209	Wayne	Detroit city, River Rouge city	97.8	21
48211	Wayne	Detroit city, Hamtramck city	97.7	22
49877	Dickinson	Felch township, West Branch township	97.6	23
48607	Saginaw	Saginaw city	97.5	24
49834	Dickinson	Breen township, Waucedah	97.4	25
48505	Genesee	Flint city, Genesee charter township, Mount Morris	97.3	26
49043	Van Buren	Bangor township, County subdivisions not defined, Covert	97.2	27
48852	Montcalm	Day township	97.1	28
49883	Alger, Schoolcraft	Burt township, Doyle township, Germfask township, Manistique township, Seney township	97.0	29

48601	Saginaw	Albee township, Blumfield township, Bridgeport charter township, Buena Vista charter township, Frankenmuth township, Saginaw city,	96.9	30
48212	Wayne	Detroit city, Hamtramck city	96.8	31
48213	Wayne	Detroit city	96.7	32
48238	Wayne	Detroit city	96.6	33
48204	Wayne	Detroit city	96.5	34
48228	Wayne	Detroit city	96.4	35
49459	Newaygo, Oceana	Beaver township, Colfax township, Crystal township, Elbridge township, Leavitt	96.3	36
49255	Branch, Hillsdale	California township, Camden township, Kinderhook township, Reading township	96.2	37
49743	Presque Isle	Belknap township, Bismarck township, Case township, Metz township, Pulawski township	96.1	38
48234	Wayne	Detroit city	96.0	39
48340	Oakland	Pontiac city	95.9	40
48633	Clare	Lincoln township	95.8	41
48206	Wayne	Detroit city	95.7	42
48647	Alcona, Oscoda	Big Creek township, Comins township, Elmer township, Mentor township, Mitchell	95.6	43
49022	Berrien, Van Buren	Bainbridge township, Benton Harbor city, Benton charter township, County subdivisions not defined, Hagar township, Keeler township, Sodus	95.5	44
49863	Menominee	Nadeau township	95.4	45
49312	Newaygo	Merrill township, Monroe	95.3	46
48141	Wayne	Inkster city	95.2	47
48207	Wayne	Detroit city	95.1	48
49827	Mackinac	Garfield township, Newton township, Portage township	95.0	49
48043	Macomb	Clinton charter township, Mount Clemens city	94.9	50
48503	Genesee	Flint city	94.8	51
48214	Wayne	Detroit city	94.7	52
48215	Wayne	Detroit city	94.5	53
49074	Kalamazoo	Kalamazoo city	94.4	54
49261	Jackson	Napoleon township	94.3	55
48227	Wayne	Detroit city	94.2	56
49788	Chippewa	Kinross charter township, Pickford township	94.1	57

49902	Iron	Mastodon township	94.0	58
48705	Alcona	Hawes township, Millen township, Mitchell township	93.9	59
49056	Allegan, Van Buren	Arlington township, Bloomingdale township, Casco township, Cheshire township, Columbia township, Geneva	93.8	60
48202	Wayne	Detroit city	93.7	61
49961	Houghton	Duncan township	93.6	62
49967	Houghton, Iron, Ontonagon	Duncan township, Haight township, Interior township, Iron River township, Laird township, Stambaugh township,	93.5	63
49057	Van Buren	Bangor township, Hartford city, Hartford township, Keeler township, Lawrence township	93.4	64
48122	Wayne	Melvindale city	93.3	65
48217	Wayne	Detroit city	93.2	66
48224	Wayne	Detroit city	93.1	67
48341	Oakland	Pontiac city, Sylvan Lake city, Waterford charter township	93.0	68
48737	Alcona, Iosco	Curtis township, Mikado township, Millen township, Mitchell township, Oscoda charter township, Plainfield	92.9	69
48120	Wayne	Dearborn city, Melvindale city	92.8	70
48504	Genesee	Flint charter township, Flint city, Mount Morris township	92.7	71
48434	Sanilac	Delaware township	92.6	72
49825	Alger	Onota township, Rock River	92.5	73
48766	Arenac	Arenac township, Au Gres township, Clayton township, Mason township, Turner	92.4	74
49013	Van Buren	Arlington township, Bangor city, Bangor township, Columbia township, Geneva township,	92.3	75
49725	Chippewa	Detour township, Raber	92.2	76
48761	Alcona, Iosco, Ogemaw, Oscoda	Curtis township, Goodar township, Mentor township, Mitchell township, Plainfield	92.1	77
49507	Kent	Grand Rapids city, Wyoming city	92.0	78
49642	Lake	Cherry Valley township, Pleasant Plains township, Yates	91.9	79
48216	Wayne	Detroit city	91.8	80
48627	Roscommon	Lyon township	91.7	81

49705	Cheboygan	Ellis township, Koehler township, Nunda township, Walker township, Waverly	91.6	82
49864	Delta	Nahma township	91.5	83
49868	Luce	Columbus township, County subdivisions not defined, Lakefield township, McMillan township, Pentland township	91.4	84
49667	Missaukee	Aetna township, Butterfield township, Enterprise township, Norwich township, West Branch	91.3	85
48235	Wayne	Detroit city	91.2	86
49709	Montmorency	Albert township, Avery township, Briley township, Hillman township, Loud township, Montmorency township, Rust township,	91.0	87
48205	Wayne	Detroit city	90.9	88
49037	Calhoun	Battle Creek city, Bedford charter township, Springfield	90.8	89
49748	Chippewa, Luce	Hulbert township, McMillan township, Whitefish township	90.7	90
48529	Genesee	Burton city, Flint city	90.6	91
48506	Genesee	Flint city, Genesee charter township, Richfield township	90.5	92
48507	Genesee	Flint charter township, Flint city, Grand Blanc charter township, Mundy township	90.4	93
48219	Wayne	Detroit city	90.3	94
49736	Chippewa	Detour township, Pickford township, Raber township	90.2	95
49775	Mackinac	Bois Blanc township	90.1	96
49891	Alger	Limestone township, Mathias township, Rock River township	90.0	97
49879	Iron, Marquette	Crystal Falls township, Humboldt township, Mansfield township, Republic township	89.9	98
48602	Saginaw	Carrollton township, Saginaw charter township, Saginaw city	89.8	99
49836	Mackinac, Schoolcraft	Germfask township, Mueller township, Portage township	89.7	100
49919	Baraga	Baraga township, Covington township, L'Anse township, Spurr township	89.6	101
49839	Alger	Burt township, Munising	89.5	102
49679	Mecosta, Osceola	Evart township, Fork township, Orient township, Sylvan	89.4	103

49745	Mackinac	Clark township, Marquette township, St. Ignace township	89.3	104
49309	Lake, Newaygo	Beaver township, Home township, Lilley township, Merrill township, Monroe township, Troy township, Yates	89.2	105
49718	Cheboygan, Emmet	Bliss township, Carp Lake township, County subdivisions not defined, Hebron township, Mackinaw township, Wawatam	89.1	106
49768	Chippewa	Whitefish township	89.0	107
48126	Wayne	Dearborn city, Detroit city	88.9	108
49619	Manistee	Bear Lake township, Brown township, Dickson township	88.8	109
49838	Mackinac	County subdivisions not defined, Newton township, Portage	88.7	110
48091	Macomb	Warren city	88.6	111
49795	Charlevoix, Cheboygan, Otsego	Charlton township, Corwith township, Dover township, Hudson township, Livingston township, Nunda township,	88.5	112
49665	Clare, Missaukee, Osceola	Clam Union township, Freeman township, Hartwick township, Highland township, Marion township, Middle Branch township, Redding township, Richland township, Riverside township, Summerfield township, Sylvan township,	88.4	113
49854	Delta, Schoolcraft	County subdivisions not defined, Doyle township, Garden township, Hiawatha township, Inwood township, Manistique city, Manistique township,	88.3	114
49410	Mason	Branch township, Free Soil township, Sheridan township, Sherman township	88.2	115
49965	Houghton, Ontonagon	Adams township, Bohemia township, County subdivisions not defined, Elm River township, Laird township, Stanton	88.1	116
49884	Alger, Schoolcraft	Burt township, Hiawatha township, Manistique township, Munising township	88.0	117
49232	Hillsdale	Amboy township, Camden township, Woodbridge	87.9	118

49960	Ontonagon	Rockland township, Stannard township	87.8	119
49920	Iron	Bates township, Crystal Falls city, Crystal Falls township, Hematite township, Mansfield township, Mastodon township, Stambaugh township	87.7	120
49336	Mecosta, Montcalm, Newaygo	Aetna township, Big Prairie township, Deerfield township, Hinton township, Reynolds township, Winfield township	87.6	121
49819	Marquette	Wells Township	87.4	122
49929	Ontonagon	Greenland township	87.3	123
49689	Manistee, Wexford	Brown township, Dickson township, Norman township, South Branch township,	87.2	124
49840	Schoolcraft	County subdivisions not defined, Doyle township, Germfask township, Hiawatha township, Manistique township, Mueller township, Seney township	87.1	125
49895	Alger, Delta, Schoolcraft	Au Train township, Garden township, Hiawatha township, Inwood township, Masonville township, Mathias township, Munising township, Nahma	87.0	126
49925	Ontonagon	Haight township, Matchwood township, McMillan township, Rockland township	86.9	127
49969	Gogebic	Marenisco township, Watersmeet township	86.8	128
49915	Iron	Caspian city	86.7	129
48749	Arenac	Arenac township, Au Gres township, Clayton township, Deep River township, Mason	86.6	130
48458	Genesee	Forest township, Genesee charter township, Mount Morris city, Mount Morris township, Richfield township, Thetford township, Vienna charter	86.5	131
48426	Sanilac	Evergreen township, Lamotte township	86.4	132
49935	Iron	Bates township, Caspian city, Crystal Falls township, Iron River city, Iron River township,	86.3	133

49421	Newaygo, Oceana	Beaver township, Dayton township, Denver township, Elbridge township, Ferry township, Greenwood township, Leavitt township, Merrill township, Newfield township,	86.2	134
48146	Wayne	Lincoln Park city	86.1	135
49820	Mackinac	Newton township, Portage	86.0	136
49632	Missaukee	Aetna township, Butterfield township, Clam Union township, Holland township, Reeder township, Riverside township	85.9	137
49874	Menominee	Harris township, Spalding	85.8	138
48654	Ogemaw, Oscoda	Big Creek township, Cumming township, Foster township, Klacking township, Mentor township, Rose City city, Rose	85.7	139
49645	Manistee	Bear Lake township, Brown township, Dickson township, Maple Grove township, Marilla township, Springdale township	85.6	140
49947	Gogebic, Ontonagon	Bergland township, Bessemer township, Marenisco township, Wakefield township	85.5	141
48437	Genesee	Genesee charter township	85.4	142
49817	Delta, Schoolcraft	Garden township, Inwood	85.3	143
48089	Macomb	Warren city	85.2	144
49455	Oceana	Benona township, County subdivisions not defined, Ferry township, Golden township, Hart township, Shelby township	85.1	145
49304	Lake	Cherry Valley township, Lake township, Newkirk township, Peacock township, Pleasant Plains township, Sweetwater township, Webber township	85.0	146
48915	Ingham	Lansing city	84.9	147
48756	Arenac, Ogemaw	Churchill township, Clayton township, Logan township, Mills township, Richland township	84.8	148
48765	Arenac, Iosco	Au Gres township, Burleigh township, Sherman township, Turner township, Whitney	84.7	149
49918	Keweenaw	Grant township	84.6	150

49765	Cheboygan, Presque Isle	Allis township, Bearinger township, Case township, Forest township, Grant township, North Allis township, Nunda township, Onaway city, Walker	84.5	151
49746	Alpena, Montmorency	Avery township, Green township, Hillman township, Montmorency township, Ossineke township, Rust	84.4	152
49310	Isabella, Mecosta, Montcalm	Broomfield township, Fremont township, Hinton township, Home township, Millbrook township, Rolland township, Wheatland township	84.3	153
49948	Houghton, Ontonagon	Bohemia township, Greenland township, Laird township, Rockland township, Stannard	84.2	154
48770	Iosco, Ogemaw	Burleigh township, Grant township, Reno township, Richland township, Sherman	84.1	155
49812	Menominee	Cedarville township, Faithorn township, Gourley township, Nadeau township, Spalding	84.0	156
49872	Delta	Baldwin township	83.8	157
49634	Manistee	Filer charter township	83.7	158
49835	Delta	Fairbanks township, Garden	83.6	159
48632	Clare, Isabella, Mecosta, Osceola	Coldwater township, Fork township, Freeman township, Garfield township, Gilmore township, Lincoln township, Orient township, Sherman	83.5	160
49953	Ontonagon	Bohemia township, Carp Lake township, Greenland township, Matchwood township, Ontonagon township, Rockland	83.4	161
49420	Oceana	Crystal township, Elbridge township, Ferry township, Golden township, Hart city, Hart township, Leavitt township,	83.3	162
48625	Clare	Arthur township, Franklin township, Freeman township, Frost township, Greenwood township, Hamilton township, Harrison city, Hatton township, Hayes township, Lincoln township, Redding township, Summerfield township,	83.2	163

49861	Baraga, Marquette	Covington township, L'Anse township, Michigamme township, Republic township,	83.1	164
48440	Lapeer	Hadley township	83.0	165
48048	Macomb	Lenox township	82.9	166
49644	Lake, Manistee, Mason	Eden township, Elk township, Meade township, Newkirk township, Norman township, Peacock township, Sauble	82.8	167
49726	Chippewa	Drummond township	82.7	168
49442	Muskegon	Egelston township, Muskegon charter township, Muskegon	82.6	169
49952	Houghton, Ontonagon	Bohemia township, Duncan township, Laird township	82.5	170
49638	Manistee, Wexford	Boon township, Dickson township, Henderson township, Norman township, Slagle township, South Branch	82.4	171
48223	Wayne	Detroit city, Redford charter	82.3	172
48745	Alcona, Iosco	Greenbush township, Gustin township, Harrisville township, Mikado township, Millen township, Oscoda charter	82.2	173
49815	Dickinson	Felch township, Sagola township, West Branch	82.1	174
49668	Manistee, Wexford	Antioch township, Colfax township, Hanover township, Marilla township, Slagle township, Springville township,	82.0	175
49655	Lake, Osceola	Burdell township, Cedar township, Ellsworth township, Hartwick township, Le Roy township, Lincoln township, Rose Lake township, Sherman	81.9	176
48912	Ingham	East Lansing city, Lansing charter township, Lansing city	81.8	177
48613	Bay, Gladwin	Gibson township, Grim township, Mount Forest	81.7	178
49853	Luce, Mackinac	Columbus township, Lakefield township, Portage township	81.6	179
49962	Baraga	Arvon township, County subdivisions not defined, L'Anse	81.5	180
49847	Menominee	Faithorn township, Meyer township, Spalding township	81.4	181
48190	Washtenaw	Augusta charter township	81.3	182

49878	Alger, Delta	Baldwin township, Bay de Noc township, Brampton township, County subdivisions not defined, Ensign township, Garden township, Limestone township, Maple Ridge township, Masonville township, Mathias	81.2	183
48621	Oscoda	Clinton township, Comins township, Mentor township	81.1	184
49779	Presque Isle	Belknap township, Bismarck township, County subdivisions not defined, Krakow township, Moltke township, Ocqueoc township, Pulawski township, Rogers City city, Rogers	81.0	185
49631	Mecosta, Osceola	Cedar township, Chippewa township, Evart city, Evart township, Hartwick township, Hersey township, Middle Branch township, Orient township,	80.9	186
49733	Crawford, Otsego	Chester township, Frederic township, Grayling charter township, Lovells township, Maple Forest township, Otsego	80.8	187
49938	Gogebic	Bessemer township, County subdivisions not defined, Erwin township, Ironwood charter township, Ironwood city	80.7	188
49656	Lake	Cherry Valley township, Dover township, Eden township, Ellsworth township, Newkirk township, Peacock township,	80.6	189
49887	Menominee	Cedarville township, County subdivisions not defined, Daggett township, Holmes township, Ingallston township, Lake township, Mellen township, Stephenson city,	80.5	190
49762	Mackinac	County subdivisions not defined, Garfield township, Hendricks township, Hudson township, Moran township	80.3	191
49908	Baraga	Baraga township, Covington township, L'Anse township	80.2	192

49444	Muskegon	Fruitport charter township, Muskegon Heights city, Muskegon charter township, Muskegon city, Norton Shores	80.1	193
48811	Gratiot, Montcalm	Bloomer township, Carson City city, Crystal township, New Haven township, North Shade	80.0	194
48739	Iosco, Ogemaw	Goodar township, Hill township, Logan township, Plainfield township, Reno township	79.9	195
49452	Oceana	Grant township, Otto township, Shelby township	79.8	196
48748	Iosco	Grant township, Plainfield township, Sherman township, Tawas township, Wilber	79.7	197
49728	Chippewa	Bay Mills township, Chippewa township, Kinross charter township, Superior township, Trout Lake township, Whitefish	79.6	198
49760	Chippewa, Mackinac	Brevort township, Moran township, St. Ignace township, Trout Lake township	79.5	199
48028	St. Clair	Clay township	79.4	200
49436	Oceana	Benona township, County subdivisions not defined, Golden township, Pentwater township	79.3	201
48911	Eaton, Ingham	Delhi charter township, Delta charter township, Lansing city, Lansing city, Windsor charter	79.2	202
49912	Ontonagon	Haight township, Interior township, Rockland township, Stannard township	79.1	203
49756	Crawford, Montmorency, Oscoda, Otsego	Albert township, Big Creek township, Charlton township, Elmer township, Greenwood township, Loud township,	79.0	204
49651	Missaukee	Aetna township, Bloomfield township, Caldwell township, Enterprise township, Forest township, Lake City city, Lake township, Norwich township, Pioneer township, Reeder	78.9	205
49405	Mason	Branch township, Custer township, Eden township, Logan township, Sheridan township, Sherman township	78.8	206

49349	Newaygo	Big Prairie township, Brooks township, Denver township, Everett township, Goodwell township, Lincoln township, Merrill township, Monroe township, Norwich township, Sherman township, White Cloud	78.7	207
49871	Marquette	Richmond township	78.6	208
49808	Marquette	Champion township, County subdivisions not defined, Ishpeming township, Michigamme township, Powell	78.5	209
49715	Chippewa	Bay Mills township, Chippewa township, Dafter township, Kinross charter township, Soo township, Superior township	78.4	210
49224	Calhoun, Jackson	Albion city, Albion township, Clarence township, Concord township, Eckford township, Lee township, Marengo township, Parma township, Sheridan	78.3	211
49782	Charlevoix	Peaine township, St. James	78.2	212
49503	Kent	Grand Rapids charter township, Grand Rapids city, Wyoming city	78.1	213
49759	Presque Isle	Bearinger township, Bismarck township, Case township, County subdivisions not defined, Moltke township, Ocqueoc	78.0	214
49633	Grand Traverse, Kalkaska, Missaukee, Wexford	Bear Lake township, Bloomfield township, Boardman township, Fife Lake township, Garfield township, Greenwood township, Liberty township, Oliver township, Orange township, Springfield township, Union	77.9	215
48225	Wayne	Detroit city, Harper Woods city	77.8	216
48617	Clare, Isabella	Arthur township, Clare city, Clare city, Denver township, Grant township, Hatton township, Sheridan township,	77.7	217
49910	Ontonagon	Bergland township, Carp Lake township, Matchwood township	77.6	218
49968	Gogebic	Bessemer township, Ironwood charter township, Marenisco township, Wakefield city, Wakefield township	77.5	219

49680	Kalkaska	Boardman township, Garfield township, Kalkaska township, Orange township, Springfield	77.4	220
48614	Gratiot, Saginaw	Brant township, Chapin township, Hamilton township,	77.3	221
48060	St. Clair	Port Huron charter township, Port Huron city	77.2	222
49064	Van Buren	Arlington township, Bangor township, Hamilton township, Hartford township, Lawrence township, Paw Paw township,	77.1	223
48532	Genesee	Clayton charter township, Flint charter township, Flint city	77.0	224
49646	Kalkaska	Bear Lake township, Blue Lake township, Boardman township, Coldsprings township, Excelsior township, Kalkaska township, Oliver township, Orange township, Rapid River township	76.9	225
48619	Montmorency, Oscoda	Clinton township, Comins township, Loud township, Rust	76.7	226
48651	Roscommon	Backus township, Denton township, Higgins township, Nester township, Roscommon	76.6	227
49340	Isabella, Mecosta	Broomfield township, Deerfield township, Fremont township, Martiny township, Millbrook township, Sheridan township, Sherman township, Wheatland	76.5	228
48656	Roscommon	Au Sable township, Backus township, Higgins township, Nester township, Richfield	76.4	229
49710	Chippewa	Bruce township, Soo township	76.3	230
48453	Lapeer, Sanilac, Tuscola	Burlington township, Burnside township, Elmer township, Flynn township, Koylton township, Lamotte township, Marlette city, Marlette township	76.2	231
49040	Branch, St. Joseph	Colon township, Leonidas township, Matteson township, Sherwood township	76.1	232
48708	Bay, Saginaw	Bay City city, Buena Vista charter township, Hampton charter township, Merritt township, Portsmouth charter	76.0	233

49946	Baraga	Arvon township, Baraga township, County subdivisions not defined, Covington township, L'Anse township,	75.9	234
49252	Branch, Calhoun, Hillsdale, Jackson	Butler township, Homer township, Litchfield city, Litchfield township, Pulaski	75.8	235
48750	Alcona, Iosco	Au Sable charter township, County subdivisions not defined, Greenbush township, Mikado township, Oscoda charter township, Plainfield township,	75.7	236
49950	Keweenaw	Allouez township, County subdivisions not defined, Eagle Harbor township, Grant township, Houghton township, Sherman township	75.6	237
48629	Missaukee, Roscommon	Denton township, Enterprise township, Lake township, Markey township, Roscommon	75.5	238
49245	Branch, Calhoun, Jackson	Albion township, Butler township, Clarendon township, Eckford township, Homer township, Pulaski township	75.4	239
48465	Sanilac	County subdivisions not defined, Delaware township, Forester township, Marion township, Minden township, Wheatland	75.3	240
49098	Berrien, Van Buren	Bainbridge township, Coloma charter township, Covert township, Hartford township, Keeler township, Watervliet city,	75.2	241
49873	Menominee	Harris township, Meyer township, Spalding township	75.1	242
49663	Missaukee, Wexford	Bloomfield township, Caldwell township, Cedar Creek township, Colfax township, Greenwood township, Hanover township, Liberty township, Manton city, Pioneer township	75.0	243

Source: "County Substance Use Vulnerability Index Results".
See "Public Datasets"; Michigan Overdose Data to Action (MODA)
website: https://www.michigan.gov/opioids/category-data
Accessed February 19, 2024.

APPENDIX G

Opioid Advisory Commission Deliverables (2023-2024)

MICHIGAN OPIOID ADVISORY COMMISSION

OPIOID ADVISORY COMMISSION
DELIVERABLES 2023-2024

2023 ANNUAL REPORT MAR 2023

Release of the Opioid Advisory Commission
2023 Annual Report: A Planning Guide for State Policy Makers
See supplemental documents for:
Community Stakeholders
Tribal Partners

QUARTERLY BULLETIN OCT 2023

Release of the Opioid Advisory Commission
October 2023 Bulletin

COMMUNITY LISTENING SESSIONS NOV 2023

Initiation of community listening sessions as part of the OAC's "Community Voices" initiative; ongoing. As of February 28, 2024, 17 sessions held in PIHP regions 5, 6, and 10.
View the **Community Voices Announcement**

DATA SNAPSHOT FEB 2024

Release of the November 2023 Data Snapshot (summary of findings; Michigan Opioid Settlement Funds: Community Impact Survey).
View the **Data Snapshot**

WORKGROUP JAN 2023

Participation in/facilitation of the State-Local Opioid Settlement Workgroup (Jan 2023-Oct 2023; currently inactive)
See collaboratively developed information guides for Michigan:
Part I: Key Agencies & Settlements
Part II: Frequently Asked Questions

ADVISORY WORKGROUP SEP 2023

Establishment of the Community Engagement and Planning Collaborative (CEPC); advisory workgroup to support the OAC's statutory tasks. Specific focus on health equity and community engagement.
See the **Group Charter**

COMMUNITY IMPACT SURVEY OCT 2023

Development and release of the Michigan Opioid Settlement Funds: Community Impact Survey (active)
View the survey
Take the survey

TRIBAL PARTNERSHIP CALLS DEC 2023

Initiation of monthly Tribal partnership calls to support shared learning and explore further opportunities for collaboration.

2024 ANNUAL REPORT MAR 2024

Release of the Opioid Advisory Commission 2024 Annual Report, including information on the **Local Spotlights** project. 2024 Annual Report available on the **OAC's website**

APPENDIX H

Opioid Advisory Commission
Michigan Opioid Settlement Funds:
Community Impact Survey
Data Snapshot (November 2023)

MICHIGAN OPIOID ADVISORY COMMISSION

OPIOID ADVISORY COMMISSION

Michigan Opioid Settlement Funds: Community Impact Survey

Data Snapshot: November 2023

DISCLAIMER: The following information is subject to change. This document was created using information available at the time of its development and may be updated at any time to reflect necessary and/or suggested changes. The data used in this report was based on a convenience sample. The Opioid Advisory Commission (OAC) recommends caution when using this data, as it is not fully representative of the geographic, racial, social, economic, and ethnic diversity of the state of Michigan. The OAC and Michigan Legislative Council are not responsible for any interpretation or re-use of data contained herein and encourage a full and thoughtful review of any findings and limitations, noted.

Background

The "Community Voices" initiative was developed in 2023 to help support the Opioid Advisory Commission (OAC) in carrying out its statutory tasks, including recommending funding initiatives to the state legislature and developing goals and recommendations to reduce disparities in service access.

The aim of the "Community Voices" initiative is to:

1. Engage and include voices of individuals and families who have been directly impacted by Michigan's addiction and mental health crisis, by way of:
   - Lived experience with substance use disorders (SUD), mental health conditions, and/or co-occurring disorders (COD);
   - Lived experience with the criminal-legal system;
   - Lived experience losing a family member to overdose, substance-related death, and/or suicide;
   - Lived experience with active (current) use of drugs/substances.

2. Engage and include voices of professionals who are closest to the issue(s); those that provide direct or indirect services around health, prevention, treatment, recovery, and/or harm reduction, as well as professionals representing key sectors serving individuals who are directly impacted (e.g., criminal-legal system, hospitals/emergency departments, recovery networks, public SUD/mental health treatment providers, emergency/supportive housing providers, faith-based communities, overdose fatality review teams, community task forces).

3. Engage and include voices of the public.

As part of the initiative, the OAC launched the Michigan Opioid Settlement Funds: Community Impact Survey[1], in late October 2023. The survey is ongoing and remains publicly accessible through the OAC's website[2].

The following represents a "snapshot" of survey data collected between October 24, 2023, and November 30, 2023. Initial findings are presented below. Additional analysis of the data is planned and will be reported in upcoming annual and/or quarterly reports of the OAC.

Commitment to Equity in Data

The OAC has adopted the following data equity commitment from the Public Health Institute at Denver Health (PHIDH)[3], as it aligns with the Commission's understanding and vision for use and interpretation of data.

The OAC "aspires to present data humbly, recognizing numbers never tell the whole story. We strive to work with individuals and communities to learn and share their stories to improve collective understanding. Knowing that people across life circumstances have inequitable opportunities to achieve optimal health, we commit to pair numbers and stories to inform policy and systems change to improve health for all".[4]

[1] https://council.legislature.mi.gov/Council/OAC
[2] OAC Website: https://council.legislature.mi.gov/Council/OAC
[3] https://www.phidenverhealth.org/
[4] https://www.phidenverhealth.org/about-us/health-racial-equity/data-commitment-and-principles

Important limitations to note: "BIPOC" (Black, Indigenous, People of Color)[5] and "Medicaid-covered" [6] individuals are underrepresented in the survey results. To increase the visibility of input provided by individuals from these underrepresented groups, the OAC presents the data from "BIPOC" and "Medicaid/Uninsured" respondents alongside data from "All respondents".

Given these limitations, the OAC also intends to utilize additional data sources for any/all considerations involving public input.

Additional data sources may include but are not be limited to the following:

- OAC community listening sessions and roundtables;
- OAC virtual listening sessions;
- Community (non-OAC) listening sessions and roundtables; local/regional;
- Community needs assessments;
- Findings of and recommendations from lateral advisory bodies, including but not limited to the Opioids Task Force Racial Equity Workgroup (REWG) and the OAC's Community Engagement and Planning Collaborative (CEPC).

A full description of limitations can be found later in this document[7] accompanied by suggested strategies to address identified limitations.

Data Collection

The primary aim of the OAC's Community Impact Survey is to solicit input from the public, especially individuals and families who have been directly impacted[8] to (1) identify priorities for the use of state opioid settlement dollars and (2) identify potential information/service gaps.

The survey is web-based and publicly available through the OAC's website[9]. A preview (printable) version of the survey was also available through the OAC's website[10], providing an opportunity for interested parties to view/print content, prior to taking the survey.

Email announcements containing a description of the "Community Voices" initiative, including electronic link to the survey, were sent on October 30, 2023, to members of the OAC, OAC advisory workgroup(s), legislative offices, state partners (executive departments and judicial offices), local representative agencies, regional

[5] The "BIPOC respondents" subgroup was identified by response to survey question (Q5). *Please select all options that best describe your race/ethnicity*; responses containing one or more of the following selections were used/aggregated: American Indian or Alaskan Native; Asian or Asian American; Black or African American; Hispanic or Latino/a; Middle Eastern or North African; Native Hawaiian or Pacific Islander; Other. Response to Q5. was not mutually exclusive, with flexibility for respondents to select more than one race or ethnicity.

[6] The "Medicaid-covered respondents" or "Medicaid respondents" subgroup was identified by response to survey question (Q15.) *I have _____ health care coverage;* responses containing one of the following selections were used/aggregated: Medicaid; Medicaid and Medicare; I'm unsure; I have no coverage.

[7] See pages 16 -18 for "Limitations" and "Strategies to Address Limitations".

[8] The term "directly impacted" is intended to include personal and/or familial experience of substance use, substance use disorders (SUD), mental health conditions, involvement with the criminal legal system, and/or the loss of a family member due to overdose, substance-related death, or suicide.

[9] https://council.legislature.mi.gov/Council/OAC

[10] https://council.legislature.mi.gov/Council/OAC

collaborators, and Tribal partners. While no requests were made to distribute announcements, recipients were free to do so and the OAC encouraged distribution in by informal means; from this, what may be loosely considered snowball sampling, was utilized.

Respondents

There were 747 respondents between October 24, 2023, and November 30, 2023. Most (55.8%) reported personal "lived experience"[11], including lived experience with substance use disorders (34.1%), mental health conditions (39.8%), and current (active) use of substances (3.7%). Overdose was experienced by 8.4% of respondents, with 3.4% reporting experiences of multiple overdose. Lived experience around involvement in the criminal-legal system was reported by 16% of respondents, with prior experience in carceral settings (county or state correctional facilities) reported by nearly 11% of respondents.

Familial lived experience was reported by most (83.8%)[12], including substance use disorders (72.7%), mental health conditions (65%), and current (active) use of substances (28.4%). The experience of familial overdose was reported by 23% of respondents, with 13.3% reporting familial experience with multiple overdoses. Familial lived experience concerning involvement in the criminal-legal system was reported by 37.6% of respondents, with over 30% reporting a family member's experience in a carceral setting(s).

Most respondents (57.34%)[13] reported professional affiliation with at least one of eighteen (18) key sectors included in the survey. Of those, professionals providing substance use disorder treatment (29.9%), mental health services (24.1%), co-occurring disorder services (22.2%), specialized supports for justice-impacted populations (20.9%), peer support services (19.2%), recovery support services (18.1%), and harm reduction services (16.6%), were represented.

Total respondents: 747 (n=747)
A 79% completion rate was noted. [14]

Demographics

Age (Q3. 695 answered; 52 skipped)
The majority of respondents were older than 35, with 73% (n=508) between the ages of 35 and 64. Only 13% (n=91) of respondents were between the ages of 25 and 34, with only 1% of respondents between the ages of 18 and 24. No respondents were under the age of 18.

Race/Ethnicity* (Q5. 689 answered; 58 skipped)

[11] "Lived experience" as defined by selected responses to *Q8. "I have lived experience with…".* Total percentage (55.8%) determined from Q8. respondents (654 answered; 93 skipped). Noting 41.7% of Q8. respondents selected "None of the above" with 2.5% selecting "Prefer not to answer".
[12] "Familial lived experience" as defined by selected responses to *Q9. "My family member(s) has lived experience with…".* Total percentage (83.8%) determined from Q9. respondents (662 answered; 85 skipped). Noting 14.95% of Q9. respondents selected "None of the above" with 1.21% selecting "Prefer not to answer".
[13] "Professional affiliation" as defined by selected responses to *Q12. "I am a professional that provides…".* Total percentage (57.34%) determined from Q12. respondents (609 answered; 138 skipped). Noting 33.33% of Q12. respondents selected "None of the above" with 0.82% selecting "Prefer not to answer"; 8.54% of Q12. respondents selected "Other".
[14] "Completion rate" refers to "the number of surveys filled out and submitted, divided by the number of surveys started by respondents". https://www.surveymonkey.com/mp/what-is-the-difference-between-a-response-rate-and-a-completion-rate/

BIPOC (Black, Indigenous, People of Color)**: 14% (n=102) of respondents selected one (or multiple) of the following categories to describe their race or ethnicity:

- *American Indian or Alaska Native*
- *Asian or Asian American*
- *Black or African American*
- *Hispanic or Latino/a*
- *Middle Eastern or North African*
- *Native Hawaiian or Pacific Islander*
- *Other*

White or European: 84% (n=579) of respondents selected "White or European".

Other: 1% (n=9) of respondents selected "Other: My race/ethnicity is best described as…"
4% (n=30) of respondents preferred not to answer about their race or ethnicity.

**Noting that race/ethnicity was not mutually exclusive, with ability for respondents to select more than one race/ethnicity.*
***Noting that aggregation of responses from Q5. "Race/Ethnicity" into the "BIPOC Respondents" category was made due to small sample size.*

Gender Identity (Q6. 687 answered; 60 skipped; Q7. 687 answered; 60 skipped)
Most respondents (72%; n=492) identified as women, with 24% (n=164) identifying as men; less than 3% (n=13) identifying as transgender, nonbinary, gender nonconforming, gender queer, or questioning/unsure.

Veteran Status (Q4. 692 answered; 55 skipped)
Less than 3% (n=17) of respondents reported service in the armed forces.

Health Care Coverage (Q17. 617 answered; 130 skipped)

Medicaid-Covered and Uninsured
Only 8% (n=63) of respondents selected one of the following categories to describe their current healthcare coverage:

- *Medicaid (n=41)*
- *Medicaid and Medicare (n=4)*
- *I have no coverage (n=17)*
- *I'm unsure (n=1)*

Private Coverage
Most respondents (75%; n=461) reported private health care coverage.

Findings

The following represents a summary of findings, with limited analysis.

1. Most respondents believe their voice should be heard by state government officials; less than 40% believe that it will be.

Over 92% of respondents believe their voice should be heard by state government officials, while only 39% believe that their voice will be heard by state government officials; 56% of respondents believe that their voice will be heard by the Opioid Advisory Commission (OAC). Noting that BIPOC and Medicaid respondents endorsed slightly higher confidence that "my voice will be heard by state government officials" and by the OAC, as compared to all respondents.

Figure 1a. **All Respondents** (n=747; 588 answered; 159 skipped)

Q19. I believe that…					
	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
My voice should be heard by state government officials	73.25% 430	19.08% 112	6.13% 36	0.51% 3	1.02% 6
My voice will be heard by state government officials	21.03% 122	18.10% 105	27.41% 159	22.07% 128	11.38% 66
My voices will be heard by the OAC	27.74% 162	29.28% 171	28.77% 168	9.59% 56	4.62% 27

Figure 1b. **BIPOC Respondents** (n=102; 85 answered; 17 skipped)

Q19. I believe that…					
	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
My voice should be heard by state government officials	78.82% 67	16.47% 14	2.35% 2	0.00% 0	2.35% 2
My voice will be heard by state government officials	38.27% 31	18.52% 15	19.75% 16	11.11% 9	12.35% 10
My voices will be heard by the OAC	37.35% 31	28.92% 24	20.48% 17	4.82% 4	8.43% 7

Figure 1c. **Medicaid/ Uninsured Respondents** (n=63; 63 answered; 0 skipped)

Q19. I believe that…					
	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
My voice should be heard by state government officials	77.78% 49	17.46% 11	4.76% 3	0.00% 0	0.00% 0
My voice will be heard by state government officials	27.87% 17	16.39% 10	26.23% 16	18.03% 11	11.48% 7
My voices will be heard by the OAC	32.26% 20	24.19% 15	27.42% 17	9.68% 6	6.45% 4

2a. Most respondents believe that state opioid settlement funds should be directed back to communities.

540 respondents provided comment to Q16. "How do you think state opioid settlement funds should be used?" Of those responses, a central theme was identified in funding services and supports at the community level. While broader needs, including state-level anti-stigma campaigns and the development/expansion of inpatient treatment facilities (both for SUD and acute psychiatric needs), were also referenced, most comments seemed to involve the need for funding directed to core services, at the community level.

2b. Most respondents believe that state opioid settlement funds should be used in the following ways[15]:

Housing

- Funding to increase supports across the entire housing continuum including emergency housing, recovery housing, sober living, Housing First, transitional housing, and long-term supports. Funding to increase housing access for justice-impacted individuals.

Treatment

- Funding for the development/expansion of inpatient treatment facilities (both SUD and psychiatric), particularly in rural regions (e.g., Michigan's Upper Peninsula); extended care for long-term residential treatment and withdrawal management.

Supports for mental health and/or co-occurring disorders

- Funding to provide and expand necessary supports for co-occurring needs; integrated care in SUD and mental health treatment settings; funding to support mental health treatment, particularly in rural communities.

Prevention—with an emphasis on youth prevention, early intervention, and education

- Funding to support expansion of prevention efforts, especially youth prevention and early intervention response measures in the K-12 system.

[15] Listed items are non-exhaustive and only include the top ten (10) themes that appeared among respondent comments (n=540) to Q16. *"How do you think state opioid settlement funds should be used?"*

Recovery supports

- Funding to support local Recovery Community Organizations (RCOs), expansion of the peer professional workforce, and development/expansion of community-based youth recovery supports.

Harm reduction and overdose prevention

- Funding to support the continuation, expansion, and enhancement of local harm reduction services and safer-use practices (syringe service programs/providers).

Transportation

- Funding to support transportation services, especially those available in rural communities and for transportation to support SUD treatment, MOUD services, and immediate access to care.

Services to support justice-impacted individuals

- Funding to address the unique needs of justice-impacted individuals including those in carceral and community (supervised) settings. Funding to support diversion programming, service/treatment access, and linkage with specialized housing supports.

Increasing access to care

- Funding to improve immediate access to care, particularly in rural communities.

Wraparound services, transitional support, assertive outreach, and case management

- Funding for transitional and comprehensive support at the community level including wraparound services, outreach, engagement, and resource-linkages delivered at critical times (e.g., hospital discharge; discharge from residential SUD treatment facility; community re-entry from carceral settings), and case management services to support systems navigation.

3. Recovery supports are identified as a priority with the greatest funding need; housing and transportation are consistently identified priorities.

Among all respondents and respondent subgroups, "Recovery Supports" was identified as an area in most need of funds.

"Housing and Transportation Supports" and "Prevention and Anti-Stigma Efforts" were also prioritized by all respondents and respondent subgroups, with 21% of all respondents and 25% of Medicaid respondents selecting "Housing and Transportation" as the area in most need of funds; 16% of all respondents and 19% of BIPOC respondents selected "Prevention and Anti-Stigma Efforts" as the area in most need of funds.

Q7. What area is in most need of funding?

All Respondents (n=747; 580 answered; 167 skipped)

Prevention and Anti-Stigma Efforts	**16.38%** (95)
Supports for Co-Occurring Disorders	**12.07%** (70)
Recovery Supports	**21.21%** (123)
Supports for Harm Reduction and Overdose Prevention	**11.03%** (64)
Housing and Transportation Supports	**20.52%** (119)

Supports for Justice-Impacted Individuals	**7.59%** (44)
Supports for Pregnant and Parenting Persons	**2.24%** (13)
Supports for Impacted Families	**5.00%** (29)
Culturally and Community Specific Supports	**3.97%** (23)

BIPOC Respondents (n=102; 84 answered; 18 skipped)

Prevention and Anti-Stigma Efforts	**19.05%** (16)
Supports for Co-Occurring Disorders	**16.67%** (14)
Recovery Supports	**17.86%** (15)
Supports for Harm Reduction and Overdose Prevention	**15.48%** (13)
Housing and Transportation Supports	**11.90%** (10)
Supports for Justice-Impacted Individuals	**7.14%** (6)
Supports for Pregnant and Parenting Persons	**2.38%** (2)
Supports for Impacted Families	**1.19%** (1)
Culturally and Community Specific Supports	**8.33%** (7)

Medicaid/Uninsured Respondents (n=63; 62 answered; 1 skipped)

Prevention and Anti-Stigma Efforts	**14.29%** (9)
Supports for Co-Occurring Disorders	**7.94%** (5)
Recovery Supports	**19.05%** (12)
Supports for Harm Reduction and Overdose Prevention	**15.87%** (10)
Housing and Transportation Supports	**25.40%** (16)
Supports for Justice-Impacted Individuals	**7.94%** (5)
Supports for Pregnant and Parenting Persons	**0.00%** (0)
Supports for Impacted Families	**3.17%** (2)
Culturally and Community Specific Supports	**6.35%** (4)

4. Medicaid/Uninsured respondents (and their family members) are profoundly impacted by experiences of overdose, substance use disorders, mental health conditions, and involvement in the criminal-legal system.

Medicaid and uninsured respondents were found to be disproportionately impacted in all identified areas, as compared to non-Medicaid respondents[16]; Medicaid/Uninsured respondents experienced the highest rates of multiple overdose (19%), substance use disorders (76%), mental health conditions (59%), involvement in the criminal-legal system (41%) and incarceration (30%).

Family members of Medicaid/Uninsured respondents were also found to be disproportionately impacted in all identified areas, as compared to family members of non-Medicaid respondents. Medicaid respondents reported familial experiences of substance use disorders (90%), mental health conditions (73%), active/current use of substances (43%), multiple overdoses (29%), involvement in the criminal-legal system (52%) and incarceration (48%).

[16] The "Non-Medicaid respondent" subgroup was identified by response to survey question (Q15.) *I have _____ health care coverage;* responses containing one of the following selections were used/aggregated: Private (e.g., employer-sponsored); Medicare; Prefer not to answer; Other.

Medicaid/Uninsured respondents were also overrepresented in the loss of a friend or family member to overdose, substance-related death, and/or suicide; 43% of respondents reported the loss of a family member(s) due to overdose or substance related death, 25% experienced the loss of a family member to suicide, 67% experienced the loss of a friend to overdose, with 56% experienced the loss of more than one friend to overdose; 38% experienced the death of a friend to suicide, with 33% experiencing the death of more than one friend, to suicide.

Figure 4a.

Q8. I have lived experience with…	**All Respondents** (n=747; 617 answered; 130 skipped)	**Non-Medicaid Respondents** (n=554; 546 answered; 8 skipped)	**Medicaid / Uninsured Respondents** (n=63; 63 answered; 0 skipped)
None of the above	**41.74%** (273)	**44.32%** (242)	**14.29%** (9)
Substance Use Disorder(s)	**34.10%** (223)	**29.30%** (160)	**76.19%** (48)
Mental Health Condition(s)	**39.76%** (260)	**38.46%** (210)	**58.73%** (37)
Active (current) use of substances	**3.67%** (24)	**3.48%** (19)	**6.35%** (4)
Overdose	**8.41%** (55)	**6.23%** (34)	**25.40%** (16)
Multiple overdoses	**3.36%** (22)	**1.47%** (8)	**19.05%** (12)
Using Naloxone (Narcan) on someone	**10.40%** (68)	**8.97%** (49)	**22.22%** (14)
Having Naloxone (Narcan) used on me	**2.14%** (14)	**0.73%** (4)	**14.29%** (9)
Previous or current involvement in the criminal-legal system	**16.06%** (105)	**13.55%** (74)	**41.27%** (26)
Previous or current involvement in a county or state correctional facility (jail or prison)	**10.86%** (71)	**8.97%** (49)	**30.16%** (19)
Previous or current involvement on community supervision (probation or parole)	**15.29%** (100)	**12.64%** (69)	**41.27%** (26)
Prefer not to answer	**2.45%** (16)	**2.56%** (14)	**1.59%** (1)

Figure 4b.

Q9. My family member(s) have lived experience with...	**All Respondents** (n=747; 654 answered; 93 skipped)	**Non-Medicaid Respondents** (n=554; 553 answered; 1 skipped)	**Medicaid / Uninsured Respondents** (n=63; 63 answered; 0 skipped)
None of the above	**41.74%** (273)	**44.32%** (242)	**7.94%** (5)
Substance Use Disorder(s)	**34.10%** (223)	**29.30%** (160)	**90.48%** (57)
Mental Health Condition(s)	**39.76%** (260)	**38.46%** (210)	**73.02%** (46)
Active (current) use of substances	**3.67%** (24)	**3.48%** (19)	**42.86%** (27)
Overdose	**8.41%** (55)	**6.23%** (34)	**39.68%** (25)
Multiple overdoses	**3.36%** (22)	**1.47%** (8)	**28.57%** (18)
Using Naloxone (Narcan) on someone	**10.40%** (68)	**8.97%** (49)	**19.05%** (12)
Having Naloxone (Narcan) used on me	**2.14%** (14)	**0.73%** (4)	**30.16%** (19)
Previous or current involvement in the criminal-legal system	**16.06%** (105)	**13.55%** (74)	**52.38%** (33)
Previous or current involvement in a county or state correctional facility (jail or prison)	**10.86%** (71)	**8.97%** (49)	**47.62%** (30)
Previous or current involvement on community supervision (probation or parole)	**15.29%** (100)	**12.64%** (69)	**38.10%** (24)
Prefer not to answer	**2.45%** (16)	**2.56%** (14)	**0.00%** (0)

Figure 4c.

Q10. I have had...	**All Respondents** (n=747; 654 answered; 93 skipped)	**Non-Medicaid Respondents** (n=554; 546 answered; 8 skipped)	**Medicaid / Uninsured Respondents** (n=63; 63 answered; 0 skipped)
None of the above	27.52% 180	28.21% 154	11.11% 7
A family member die by overdose or substance-related death	26.15% 171	24.73% 135	42.86% 27
More than one family member die by overdose or substance-related death	9.17% 60	8.42% 46	17.46% 11
A family member die by suicide	21.87% 143	21.98% 120	25.40% 16
More than one family member die by suicide	5.20% 34	5.86% 32	3.17% 2
A friend die by overdose or substance-related death	36.09% 236	33.52% 183	66.67% 42

More than one friend die by overdose or substance-related death	25.08% 164	21.98% 120	55.56% 35
A friend die by suicide	31.04% 203	31.50% 172	38.10% 24
More than one friend die by suicide	14.22% 93	12.27% 67	33.33% 21
Prefer not to answer	1.22% 8	1.10% 6	0.00%

5. Substance use disorder (SUD) treatment, mental health services, supports for co-occurring disorders (COD), housing, and transportation supports are believed to have the greatest barriers to access.
Most respondents* identified the following services and supports as most difficult to access in their communities:

- Mental health services (74.9%)
- Substance use disorder (SUD) services (71.2%)
- Housing support services (64.0%)
- Transportation support services (60.4%)
- Services or supports for co-occurring disorders (COD) (55.9%)

**Noting that most respondents (57%) identified as professionals from key sectors, offering a unique understanding of potential service needs and gaps, given their professional affiliation. Of the respondents that identified as professionals from key sectors, with most represented the following services and supports:*

- Mental health services (24%)
- Substance use disorder (SUD) services (30%)
- Services or supports for co-occurring disorders (COD) (22%)
- Peer support services (19%)
- Services for individuals involved in the criminal-legal system (21%)

Figure 5a.

Q14. I believe others in my community may have difficulty accessing…	**All Respondents** (n=747; 614 answered; 133 skipped)	**BIPOC Respondents** (n=102; 89 answered; 13 skipped)	**Medicaid / Uninsured Respondents** (n=63; 63 answered; 0 skipped)
None of the above	3.91% 24	6.74% 6	4.76% 3
Mental health services	74.92% 460	67.42% 60	65.08% 41
Substance use disorder (SUD) treatment services	71.17% 437	67.42% 60	71.43% 45
Services or supports for co-occurring disorders (COD)	55.86% 343	52.81% 47	52.38% 33
Traditional or Indigenous healing practices	24.76% 152	25.84% 23	39.68% 25

Trauma-specific services	47.23% 290	50.56% 45	52.38% 33
Medication for Opioid Use Disorder	48.70% 299	53.93% 48	52.38% 33
Medications for a mental health condition(s)	49.19% 302	49.44% 44	47.62% 30
Recovery support services	49.67% 305	57.30% 51	55.56% 35
Peer support services	40.07% 246	44.94% 40	49.21% 31
Wraparound and/or intensive case management services	41.37% 254	48.31% 43	42.86% 27
General case management services	35.83% 220	37.08% 33	47.62% 30
Harm reduction/health promotion services	42.02% 258	47.19% 42	49.21% 31
Housing support services	64.01% 393	61.80% 55	71.43% 45
Transportation support services	60.42% 371	56.18% 50	65.08% 41
Justice-Involved: Services for individuals involved in the criminal-legal system	36.48% 224	47.19% 42	47.62% 30
Justice-Involved: Medication for Opioid Use Disorder (MOUD), Medication Assisted Treatment (MAT), Medication Assisted Recovery (MAR) services, provided in jail or prison	37.13% 228	47.19% 42	46.03% 29
Pregnant & Parenting: Services for pregnant and postpartum persons	31.92% 196	41.57% 37	34.92% 22
Pregnant & Parenting: Medication for Opioid Use Disorder (MOUD), Medication Assisted Treatment (MAT), Medication Assisted Recovery (MAR) services, provided during pregnancy	31.11% 191	37.08% 33	38.10% 24

Figure 5b.

Q12. I am a professional that provides…	**All respondents** (n=747; 609 answered; 138 skipped)
None of the above	33.33% (203)
Mental health services	24.14% (147)
Substance use disorder (SUD) treatment services	29.89% (182)

Services or supports for co-occurring disorders (COD)	22.17% (135)
Traditional or Indigenous healing practices	1.48% (9)
Trauma-specific services	12.64% (77)
Medication for Opioid Use Disorder	9.36% (57)
Medications for a mental health condition(s)	7.72% (47)
Recovery support services	18.06% (110)
Peer support services	19.21% (117)
Wraparound and/or intensive case management services	7.88% (48)
General case management services	17.90% (109)
Harm reduction/health promotion services	16.58% (101)
Housing support services	11.82% (72)
Transportation support services	9.20% (56)
Justice-Involved: Services for individuals involved in the criminal-legal system	20.85% (127)
Justice-Involved: Medication for Opioid Use Disorder (MOUD), Medication Assisted Treatment (MAT), Medication Assisted Recovery (MAR) services, provided in jail or prison	4.76% (29)
Pregnant & Parenting: Services for pregnant and postpartum persons	4.27% (26)
Pregnant & Parenting: Medication for Opioid Use Disorder (MOUD), Medication Assisted Treatment (MAT), Medication Assisted Recovery (MAR) services, provided during pregnancy	3.12% (19)

6. High SUVI (rural) counties are not represented

Limited representation from high-vulnerability rural communities, was observed. 17 of the 21 counties with the highest substance use vulnerability, had less than 1% in total survey respondents; 8 of these counties had no respondents. All of these counties are rural.[17]

Figure 6.

County of residence ("High SUVI" counties) [18]	**All respondents** (n=747; 604 answered; 143 skipped)
Oscoda	**0%** (0)
Wayne	**8.28%** (50)
Clare	**0.5%** (3)
Schoolcraft	**0%** (0)

[17] https://mcrh.msu.edu/aboutus/whoweserve

[18] Counties are listed in order of substance use vulnerability, as indicated by the Michigan Overdose Data to Action (MODA) Dashboard, Substance Use Vulnerability Index (MI-SUVI); counties reflected in the list represent counties in the 75th-100th percentile. https://www.michigan.gov/opioids/category-data

Oceana	**0%** (0)
Luce	**0%** (0)
Lake	**0.17%** (1)
Montmorency	**0%** (0)
Genesee	**1.82%** (11)
Branch	**0.33%** (2)
Van Buren	**0.5%** (3)
Crawford	**0.5%** (3)
Mackinac	**0.33%** (2)
Calhoun	**15.23%** (92)
Roscommon	**0%** (0)
Alger	**0.5%** (3)
Berrien	**1.66%** (10)
Osceola*	**0.17%** (1)
St. Joseph*	**0.5%** (4)
Baraga	**0%** (0)
Iosco	**0%** (0)
***Responses determined from comments in "Other"*	

7. Most respondents don't know or are unsure about where to find important information related to the state opioid settlement space.

Most respondents identified the following areas of uncertainty around where to find information related to the following:[19]

- How the state is actually spending opioid settlement funds (79%)
- How the state is making decisions on where to spend funds (78%)
- How communities are being included in opioid settlement conversations (76%)
- Ways the state can improve racial and health equity (73%)
- Agencies involved in the state opioid settlement space (71%)
- The national opioid settlements (66%)
- The Opioid Advisory Commission (55%)

[19] Responses from question (Q20.) *I know where to find information on…* were used; responses of "No" and "Unsure" were aggregated to determine all percentages/levels, reflected; topics are listed in descending order, by percentage/level (of uncertainty).

Figure 7.

Q20. I know where to find information on…	All Respondents (n=747; 585 answered; 162 skipped)		BIPOC Respondents (n=102; 84 answered; 18 skipped)		Medicaid / Uninsured Respondents (n=63; 63 answered; 0 skipped)	
	No	**Unsure**	**No**	**Unsure**	**No**	**Unsure**
Health and behavioral health services in my community	5.31% 31	9.25% 54	7.14% 6	8.33% 7	6.35% 4	11.11% 7
My local legislator(s)	18.79% 109	11.55% 67	30.49% 25	8.54% 7	25.81% 16	19.35% 1
The Opioid Advisory Commission (OAC)	36.90% 214	18.28% 106	44.58% 37	18.07% 15	35.48% 22	22.58% 14
The national opioid settlements	44.58% 259	20.48% 119	50.60% 42	22.89% 19	50.00% 31	20.97% 13
Agencies involved in the state opioid settlement space	49.57% 288	20.65% 120	48.78% 40	24.39% 20	43.55% 27	25.81% 16
How the state is making decisions on where to spend funds	55.92% 326	21.61% 126	56.63% 47	26.51% 22	53.23% 33	22.58% 14
How the state is actually spending opioid settlement funds	58.66% 342	20.41% 119	60.24% 50	24.10% 20	53.23% 33	22.58% 14
Ways the state can improve racial and health equity	49.05% 285	23.75% 138	53.01% 44	24.10% 20	51.61% 32	27.42% 17
How communities are being included in opioid settlement conversations	53.26% 310	22.68% 132	59.04% 49	22.89% 19	54.84% 34	22.58% 14

Limitations

Limited language options (English only)
Currently, the Michigan Opioid Settlement Funds: Community Impact Survey is only offered in English. This presents significant barriers for Michigan's non-English speakers that may be interested in taking the survey, but unable to do so due to language barriers.

Underrepresentation of BIPOC respondents
Only 14% (n=102) of respondents selected one (or multiple) of the following categories to describe their race or ethnicity:

- *American Indian or Alaskan Native*
- *Asian or Asian American*
- *Black or African American*
- *Hispanic or Latino/a*
- *Middle Eastern or North African*
- *Native Hawaiian or Pacific Islander*
- *Other*

Underrepresentation of Medicaid-covered/uninsured respondents
Only 8% (n=63) of respondents selected one of the following categories to describe their current healthcare coverage:

- *Medicaid*
- *Medicaid and Medicare*
- *I'm unsure*
- *I have no coverage*

Underrepresentation of respondents from high SUVI[20] (rural) communities
Responses from 17 of the 21 counties with the highest substance use vulnerability were either (1) not represented (n=0) or (2) accounted for less than 1% of total responses.

Small sample size (n=747)
Only 747 responses were received within the date range of October 24, 2023, to November 30, 2023. A 79% completion rate[21] was noted.

[20] "High SUVI" refers to communities (counties) assessed with a Substance Use Vulnerability Index (SUVI) score in the 75th to 100th percentile, as represented on the Michigan Overdose to Data Action (MODA) Dashboard of the Michigan Department of Health and Human Services; https://www.michigan.gov/opioids/category-data

[21] "Completion rate" refers to "the number of surveys filled out and submitted, divided by the number of surveys started by respondents". https://www.surveymonkey.com/mp/what-is-the-difference-between-a-response-rate-and-a-completion-rate/

Strategies to Address Limitations

1. Utilize multiple data sources for all OAC considerations/work involving community/public input. Additional data sources may include but are not be limited to the following:

- OAC community listening sessions and roundtables;
- OAC virtual listening sessions;
- Community (non-OAC) listening sessions and roundtables; local/regional;
- Community needs assessments;
- Findings of and recommendations from lateral advisory bodies, including but not limited to the Opioids Task Force Racial Equity Workgroup (REWG) and the OAC's Community Engagement and Planning Collaborative (CEPC).

2. Implement ongoing, direct outreach and engagement efforts with underrepresented groups.

3. Explore translation services to increase access and utilization of any/all surveys administered by the OAC; at a minimum, support translation of the Community Impact Survey into Spanish and Arabic.

4. Identify and develop key (strategic) partnerships in communities with the highest substance use vulnerability; develop relationships with organizations/entities serving underrepresented groups.

5. Develop specific strategies to increase penetration rates to Michigan's rural and frontier communities; especially those with greatest vulnerability to adverse substance use outcomes.

6. Partner with state, regional, local, and Tribal entities to (a) support resource-sharing, (b) improve data collection efforts, including strategies to support culturally responsive data collection, data equity, and data sovereignty, and (c) enhance engagement efforts with underrepresented groups.

7. Maintain ongoing communication and collaboration with key (community) partners, to support:
   - Relationship and trust-building;
   - Community awareness of the Opioid Advisory Commission (OAC) and its charge; the work of the OAC, including the Community Voices initiative and Community Impact Survey;
   - OAC awareness of community needs and barriers;
   - Community feedback on the Community Impact Survey and potential strategies for improvement;
   - Exchange of information related to the state opioid settlement space, opioid settlement resources, general resources.

Considerations for Capacity and Implementation

The OAC is presently a group of twelve (12) community members, and one (1) assigned staff person of the Legislative Council.[22] Members are legislatively appointed and serve in a voluntary capacity.

The OAC has no formal budget, nor has it been allocated any funds for the execution of key tasks including but not limited to community outreach and engagement, data collection, and/or analysis.

[22] https://council.legislature.mi.gov/Council/Index

By statute, the OAC is required to perform a "statewide evidence-based needs assessment" and develop "goals and recommendations, including the rationale behind goals and recommendations, sustainability plans, and performance indicators relating to all 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."[23]

The OAC has one (1) assigned staff member presently carrying out activities related to design, distribution, data collection, assessment, and analysis of the Community Impact Survey, as well as the broader activities of the Community Voices initiative.[24]

[23] Public Act 84 of 2022 (MCL 4.1851) https://legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0084.pdf

[24] https://council.legislature.mi.gov/Content/Files/OAC/OAC%20Community%20Voices%20Announcement.pdf

References

A Statement on Health Equity and Justice

Notes: Formatting and heading "A Statement on Health Equity and Justice" adopted from the Washington State "2021-2022 Opioid Overdose Response Plan". Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/WashingtonStateOpioidandOverdoseResponsePlan-final-2021.pdf

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3. "Other statuses" referenced by the NIMHD include but are not limited to the following: gender; sexual orientation; gender identity; disability status; social class or socioeconomic status; religion
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Executive Summary

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Recommendations for Action

Recommendation 1. Listen to communities

20. Michigan House of Representatives Health and Human Services Appropriations Subcommittee; hearing on the state opioid settlements; testimony offered by Dr. Cara Poland, Chair, Opioid Advisory Commission (October 25, 2023). https://www.house.mi.gov/hfa/PDF/HealthandHumanServices/DHHS_Subcmte_OAC%20Testimony_10-25-23.pdf
21. Suggested surveys include the Opioid Advisory Commission's "Michigan Opioid Settlement Funds: Community Impact Survey" (2023), and the Michigan Department of Health and Human Services/Center for Health and Research Transformation's (CHRT) "Opioid Settlement Prioritization Survey 2021-2022", noting limitations for each.
22. Michigan Opioids Task Force: Racial Equity Workgroup (REWG). https://www.michigan.gov/opioids/crisis-response/racial-equity

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26. Opioid Advisory Commission: Community Engagement and Planning Collaborative (CEPC). https://council.legislature.mi.gov/Council/OAC
27. Michigan Overdose Data to Action (MODA) Dashboard. Michigan Department of Health and Human Services. https://www.michigan.gov/opioids/category-data

Recommendation 2. Invest in communities

28. "Proposed settlement appropriations" involves the suggested appropriation from the Michigan Opioid Healing and Recovery Fund to the Department of Health and Human Services, as outlined in Governor's FY 2025 Recommended Budget; "FY 2025-2026 Executive Recommendation General Omnibus Budget Bill". https://www.michigan.gov/budget/-/media/Project/Websites/budget/Fiscal/Executive-Budget/Current-Exec-Rec/FY25-General-Omnibus.pdf?rev=e6b543270a844fcaa1f0ede891d0c963&hash=5883C11789E992C0FC5AB677CB09906D
29. "Community input" as provided through community listening sessions, the Community Impact Survey, and engagement activities of the Opioid Advisory Commission.
30. "A Roadmap for Opioid Settlement Funds: Supporting Communities & Ending the Overdose Crisis" (2023). Vocal—New York. https://www.vocal-ny.org/wp-content/uploads/2023/08/A-Roadmap-for-Opioid-Settlement-Funds-Final-Updated.pdf
31. "Language" refers to boilerplate language/legislative requirements accompanying appropriations within the State budget bill.
32. "Service" includes projects, initiatives, and services funded by appropriations from the Michigan Opioid Healing and Recovery Fund.
33. Public Act 83 of 2022 (MCL 12.253) https://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0083.pdf

Recommendation 3. Prioritize communities most impacted

34. "Michigan Substance Use Vulnerability Index"; Michigan Overdose Data to Action (MODA) Dashboard. Michigan Department of Health and Human Services. https://www.michigan.gov/opioids/category-data
35. "Suicide rates by race/ethnicity, Michigan residents aged 10+, 2021"; Michigan Suicide Prevention Commission 2023 Annual Report (2023). https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Boards-and-Commissions/MSPC/2023-Meeting-Packets/Suicide-Commission-Annual-Report-2023-v3.pdf?rev=2d0b7e2013814ed596bdce4f2a8180b4&hash=FD04844D6AF2F9A07B64E5ADF84BF5C1
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39. Figure 3. Age-adjusted rate of drug overdose deaths, by race and Hispanic origin: United States, 2020 and 2021 "NOTES: Misclassification of race and Hispanic origin on death certificates results in the underestimation of death rates by as much as 34% for American Indian or Alaska Native people…"
"Drug Overdose Deaths in the United States 2001-2021". National Center for Health Statistics (NCHS) Data Brief No. 457 (December 2022). https://www.cdc.gov/nchs/data/databriefs/db457.pdf
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49. Minnesota Statutes 2023: Opioid Epidemic Response Advisory Council (Minnesota State Section 256.042) https://www.revisor.mn.gov/statutes/cite/256.042/pdf
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Recommendation 4. Develop a plan

68. 2023 MDHHS Opioids Annual Report (2023). Michigan Department of Health and Human Services. https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/documents/2023_Opioids_Report_10302023.pdf?rev=c06a7c649d59426494dd2a5d0b211a52&hash=08ABD924279B8A6776BEF783D3AF7FD8
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Recommendation 5. Optimize existing efforts

72. Michigan House of Representatives Health and Human Services Appropriations Subcommittee; hearing on the state opioid settlements; testimony offered by Dr. Cara Poland, Chair, Opioid Advisory Commission (October 25, 2023). https://www.house.mi.gov/hfa/PDF/HealthandHumanServices/DHHS_Subcmte_OAC%20Testimony_10-25-23.pdf

73. "Advisory groups" includes but is not limited to the Opioid Advisory Commission (legislative) and Opioids Task Force (executive).
74. Specific considerations are made for representation from the House and Senate Health and Human Services Appropriations Subcommittees and/or legislative leadership teams.
75. Community Mental Health Entities (CMHE); Prepaid Inpatient Health Plans (PIHP).
76. "NGA Litigation Opioid Settlement Funds Summit" (2023). National Governors Association Center for Best Practices. https://www.nga.org/wp-content/uploads/2023/10/2023_Opioid_Post_Meeting_Issue_Brief_Oct2023.pdf
77. "NGA Litigation Opioid Settlement Funds Summit" (2023). National Governors Association Center for Best Practices. https://www.nga.org/wp-content/uploads/2023/10/2023_Opioid_Post_Meeting_Issue_Brief_Oct2023.pdf
78. The figure of $500K was used based on prior funding recommendations for a statewide needs assessment, found in the OAC's 2023 Annual Report: https://council.legislature.mi.gov/Content/Files/OAC/OAC%202023%20Annual%20Report%20A%20Planning%20Guide%20for%20State%20Policy%20Makers.pdf
79. Public Act 84 of 2022 (MCL 4.1851). https://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0084.pdf
80. Public Act 84 of 2022 (MCL 4.1851). https://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0084.pdf
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82. "Local Spotlights" released December 2023; offered by the Opioid Advisory Commission in partnership with the Michigan Association of Counties, Michigan Municipal League, and Michigan Townships Association.
83. https://council.legislature.mi.gov/Content/Files/OAC/OAC%20Community%20Voices%20Announcement.pdf

Recommendation 6. Invest for Impact and sustainability

84. Group involvement, contingent on the formation of an intergovernmental settlement workgroup, as outlined in Recommendation 5.1. State-level asset mapping can be optimized through collaborative involvement.
85. "NGA Litigation Opioid Settlement Funds Summit" (2023). National Governors Association Center for Best Practices. https://www.nga.org/wp-content/uploads/2023/10/2023_Opioid_Post_Meeting_Issue_Brief_Oct2023.pdf
86. "Community Investments" are previously described in Recommendation 2.1 and include "low barrier" community funding opportunities.

Recommendation 7. Build trust through transparency (and engagement)

87. Michigan House of Representatives Health and Human Services Appropriations Subcommittee; hearing on the state opioid settlements; testimony offered by Dr. Cara Poland, Chair, Opioid Advisory Commission (October 25, 2023). https://www.house.mi.gov/hfa/PDF/HealthandHumanServices/DHHS_Subcmte_OAC%20Testimony_10-25-23.pdf
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89. https://www.michigan.gov/opioids/opioidsettlements (2023)
90. "Data Snapshot: November 2023", Michigan Opioid Settlement Funds: Community Impact Survey. Opioid Advisory Commission (February 20, 2024). https://council.legislature.mi.gov/Content/Files/OAC/Data%20Snapshot%20November%202023_UPDATED%20FINAL_2.2024.pdf

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Volume 142, Issue 24, 15 December 2020; Pages e454-e468
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https://www.ahajournals.org/journal/circ
92. https://www.uihi.org/projects/decolonizing-data-toolkit/
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94. https://www.nnlm.gov/guides/data-glossary/data-sovereignty#:~:text=Definition,storage%2C%20and%20interpretation%20of%20data.
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Michigan's Data Landscape—Overdose Death

Notes: Primary sourcing for all data represented in "Michigan's Data Landscape—Overdose Death" attributed to the following:

Michigan Overdose Data to Action (MODA) Dashboard (Accessed January-February 2024). Michigan Department of Health and Human Services. https://www.michigan.gov/opioids/category-data

National Vital Statistics System (NVSS).
Provisional Drug Overdose Death Counts; August 2022 – August 2023. (Accessed January 2024).

Centers for Disease Control and Prevention (CDC): National Center for Health Statistics (NCHS).
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Michigan's Data Landscape—Suicide Death

Notes: Primary sourcing for all data represented in "Michigan's Data Landscape—Suicide Death" attributed to the Michigan Suicide Prevention Commission Annual Report (2023).
https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Boards-and-Commissions/MSPC/2023-Meeting-Packets/Suicide-Commission-Annual-Report-2023-v3.pdf?rev=2d0b7e2013814ed596bdce4f2a8180b4&hash=FD04844D6AF2F9A07B64E5ADF84BF5C1

Additional sources include the following:
The Trevor Project
"Facts About Suicide Among LGBTQ+ Young People"
https://www.thetrevorproject.org/resources/article/facts-about-lgbtq-youth-suicide/

U.S. Department of Veteran Affairs
"Veterans Suicide Data and Reporting"
https://www.mentalhealth.va.gov/suicide_prevention/data.asp

Michigan's Data Landscape—Non-Fatal Overdose

Notes: Primary sourcing for all data represented in "Michigan's Data Landscape—Overdose Death" attributed to the following:

Michigan Overdose Data to Action (MODA) Dashboard (Accessed January-February 2024). Michigan Department of Health and Human Services.
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https://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0084.pdf
101. Race and Ethnicity Data Collection Standards; Office of Equity and Minority Health (Michigan Department of Health and Human Services; 2022).
https://www.michigan.gov/mdhhs/keep-mi-healthy/multihealth/race-and-ethnicity-data-collection-standards
102. "Principles for the Use of Funds from Opioid Litigation". (2021). Johns Hopkins Bloomberg School of Public Health (coalition). https://opioidprinciples.jhsph.edu/wp-content/uploads/2022/02/Opioid-Principles-Doc.pdf
103.
https://www.michigan.gov/opioids/opioidsettlements/settlement-spending
104. Public Act 83 of 2022 (MCL 12.253)
http://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0083.pdf
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"Evidence-Based and Culturally Relevant Behavioral Health Interventions in Practice: Strategies and Lessons Learned from NNED Learn (2011-2020)". Substance Abuse and Mental Health Services Administration (SAMHSA).
https://store.samhsa.gov/sites/default/files/pep21-05-02-001.pdf
106. "Racial Equity Toolkit: A Road Map for Government, Organizations, and Communities". (2021). Michigan Department of Civil Rights and the Gerald R. Ford School of Public Policy at the University of Michigan.
https://www.michigan.gov/-/media/Project/Websites/mdcr/racial-equity/racial-equity-toolkit-revised-february-2021.pdf?rev=10a307255d1b41b7a1c449d8624aab95

Key Takeaways 2023-2024

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https://council.legislature.mi.gov/Content/Files/OAC/OAC%20Stakeholder%20One-Pager_4.18.2023.pdf
108. "OAC 2023 Tribal Partners One-Pager" (2023). Opioid Advisory Commission.
https://council.legislature.mi.gov/Content/Files/OAC/OAC_Tribal%20Partners_One-Pager_4.26.2023.pdf

A Year in Review

109. "Michigan Opioid Settlement Funds: Community Impact Survey"(2023);
https://council.legislature.mi.gov/Content/Files/OAC/OAC%20Community%20Impact%20Survey%20Announcement.pdf
110. "Local Spotlights" project, conducted in partnership with the Michigan Association of Counties, Michigan Municipal League, and Michigan Townships Association.
111. Statutory requirements of the OAC direct annual reporting to the Senate Majority Leader, Speaker of the House, the Chairs of House and Senate Appropriations Committees, the Governor, and the Attorney General.
112. "Statutory tasks" as set forth in Public Act 84 of 2022 (MCL 4.1851)

Michigan Opioid Healing and Recovery Fund

Source(s): Information on the Michigan Opioid Healing and Recovery Fund, including but not limited to estimates on account balance, earned interest, departmental expenditures, work projects and/or carryforward work projects (estimates only), has been provided and/or confirmed by the House Fiscal Agency (HFA) and/or Department of Treasury. Noting that all figures related to Michigan Department of Health and Human Services (MDHHS) expenditures/spending and work projects should be confirmed with MDHHS for accuracy.

Estimated total state share, region, and non-regional payments ("$123.2 million as of December 31, 2023) provided, courtesy of the Department of Attorney General.

Noting the term "work project" to align with that found in the "Glossary of Terms", as provided by the State Budget Office (SBO): https://www.michigan.gov/budget/glossary-of-terms "Work Project. A one-time, nonrecurring undertaking for the purpose of accomplishing a specific objective, the appropriation for which remains available until the work is completed. This does not include Work Orders. Page | 4 A work project shall meet all of the following criteria: (a) The work project shall be for a specific purpose. (b) The work project shall contain a specific plan to accomplish its objective. (c) The work project shall have an estimated completion cost. (d) The work project shall have an estimated completion date."

113. http://www.legislature.mi.gov/documents/2021-2022/billanalysis/Senate/pdf/2021-SFA-0993-N.pdf
114. Public Act 83 of 2022; MCL 12.253; https://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0083.pdf
115. Public Act 83 of 2022; MCL 12.253; https://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0083.pdf
116. Bureau of State and Authority Finance, State Cash Management: "Staff assists the State Treasurer with the management of the Common Cash Fund. The Common Cash Fund pools the combined cash balance of State funds until paid out as provided by law, including the General and School Aid Funds, but not certain trust funds and funds covering the operations of State Authorities, colleges, and universities. Staff performs cash flow analysis and forecasting which enables the State Treasurer to make investment, payment, and borrowing decisions". https://www.michigan.gov/treasury/finance/state-finance-division-/state-cash-management#:~:text=The%20Common%20Cash%20Fund%20pools,Authorities%2C%20colleges%2C%20and%20universities

Additional Sourcing

a. FY 2022-2023 General Omnibus http://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0166.pdf
b. FY 2023-2024 General Omnibus http://www.legislature.mi.gov/documents/2023-2024/publicact/pdf/2023-PA-0119.pdf
c. FY 2022 Carryforward (Work Projects) https://www.michigan.gov/budget/-/media/Project/Websites/budget/Fiscal/Spending-and-Revenue-Reports/Work-Projects-Assets/2023-Work-Project-Letter-Prior-Year-Projects-10-2-23.pdf?rev=6271f44657294d20a76791de66e35ee8&hash=3F1BB08F34C28866A509C567A5A03CA1
d. FY 2023 Work Projects https://www.michigan.gov/budget/-/media/Project/Websites/budget/Fiscal/Spending-and-Revenue-Reports/Work-Projects-Assets/2023-Work-Project-Letter-New-Projects-10-2-23.pdf?rev=bad66bfd41af4575b14622925226cb3a&hash=5B94328BAA2C5769F9458D8A6FD7B286
e. Contact information used in hyperlink for the Michigan Department of Health and Human Services: MDHHS-opioidsettlementhelp@michigan.gov

Department of Attorney General: Opioid Settlement Payment Estimator & Website

Source(s): Information on the Opioid Settlement Payment Estimator, including but not limited to estimated figures and descriptions has been provided and/or confirmed by the Department of Attorney General, with additional sourcing through the Department of Attorney General "Opioid Settlement Payment Estimator" (February 23, 2024).

117. "Opioid Settlement Payment Estimator" (Last revised February 23, 2024). Department of Attorney General. https://www.michigan.gov/ag/initiatives/opioids
118. https://www.michigan.gov/ag/initiatives/opioids
119. "Opioid Settlement Payment Estimator" (Last revised February 23, 2024). Department of Attorney General. https://www.michigan.gov/ag/initiatives/opioids

Department of Health and Human Services: Opioid Settlement Website

120. https://www.michigan.gov/opioids/opioidsettlements

Additional Sourcing

a. https://www.michigan.gov/opioids/opioidsettlements
b. https://www.michigan.gov/opioids/opioidsettlements/about
c. https://www.michigan.gov/opioids/opioidsettlements/resources
d. https://www.michigan.gov/opioids/opioidsettlements/settlement-data
e. https://www.michigan.gov/opioids/opioidsettlements/settlement-spending
f. https://www.michigan.gov/opioids/crisis-response
g. https://www.michigan.gov/opioids/crisis-response/racial-equity

The Opioid Settlement Landscape—Resource List

State Opioid Settlement Resources

a. Opioid Advisory Commission Website: https://council.legislature.mi.gov/Council/OAC
b. "What is the Opioid Advisory Commission?" https://council.legislature.mi.gov/Content/Files/OAC/What%20is%20the%20Opioid%20Advisory%20Commission_Jan%202024.pdf
c. OAC October 2023 Bulletin https://council.legislature.mi.gov/Content/Files/OAC/Opioid

%20Advisory%20Commission%20(OAC)%20October%202023%20Bulletin.pdf
d. OAC 2023 Annual Report: A Planning Guide for State Policy Makers
https://council.legislature.mi.gov/Content/Files/OAC/OAC%202023%20Annual%20Report%20A%20Planning%20Guide%20for%20State%20Policy%20Makers.pdf
e. Michigan Opioid Settlement Funds: Key Agencies & Settlements
https://council.legislature.mi.gov/Content/Files/OAC/Michigan%20Opioid%20Settlement%20Funds%20Part%20I_Key%20Agencies%20and%20Settlements.pdf
Document created in collaboration between the Opioid Advisory Commission, Michigan Department of Attorney General, Michigan Department of Civil Rights, Michigan Department of Corrections, Michigan Department of Treasury, Michigan Association of Counties, Michigan Municipal League, and Michigan Townships Association (08.28.2023).
Noting some information contained within the document may be outdated, given date of release (August 2023) and ongoing developments with participation and/or receipt of funds from various opioid settlements.
f. Michigan Opioid Settlement Funds: Frequently Asked Questions
https://council.legislature.mi.gov/Content/Files/OAC/Michigan%20Opioid%20Settlement%20Funds%20Part%20II_Frequently%20Asked%20Questions.pdf
Document created in collaboration between the Opioid Advisory Commission, Michigan Department of Attorney General, Michigan Department of Civil Rights, Michigan Department of Corrections, Michigan Department of Treasury, Michigan Association of Counties, Michigan Municipal League, and Michigan Townships Association (09.05.2023).
Noting some information contained within the document may be outdated, given date of release (August 2023) and ongoing developments with participation and/or receipt of funds from various opioid settlements.
g. Michigan Association of Counties: Opioid Resource Center
https://micounties.org/opioid-settlement-resource-center/
h. "A Guide for Community Advocates on the Opioid Settlement"
http://www.vitalstrategies.org/wp-content/uploads/Michigan-Opioid-Settlement-Fact-Sheet-V2.pdf
i. Michigan Department of Attorney General: Opioid Settlement Website
https://www.michigan.gov/ag/initiatives/opioids
j. Michigan Department of Health and Human Services: Opioid Settlement Website
https://www.michigan.gov/opioids/opioidsettlements
k. Michigan Department of Health and Human Services 2023 Opioid Report
https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/documents/2023_Opioids_Report_10302023.pdf?rev=c06a7c649d59426494dd2a5d0b211a52&hash=08ABD924279B8A6776BEF783D3AF7FD8
l. 2023 Michigan Opioid Healing and Recovery Fund Annual Financial Report (November 2023)
https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/documents/Opioid-Settlement-Docs/2023-110-57467-Fund-1584-91823.pdf?rev=5dcfa39a0e3240719592ff6875b48687&hash=0CD66E27867CF6D9CC06CB724B3DB800
m. MDHHS FY 2023 Spend Plan Programming and Planning Overview
https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/documents/Opioid-Settlement-Docs/2023_Opioids_Settlement_Planning_Template.pdf?rev=779bbd370a3d467c876c0be64738ac37&hash=43B030DDBFB7C25AAB75AEFAE0B5BEE0
n. MDHHS Opioid Strategy and Implementation of Opioid Settlements
https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/documents/Opioid-Settlement-Docs/Opioid-Strategy-and-Implementation-of-Opioid-Settlements.pdf?rev=c2d9f28a3d37469e8a18282ef17ff5ac&hash=BC9E08BE80C23234769122B526888AB1
o. Michigan Opioids Task Force Website
https://www.michigan.gov/opioids/crisis-response
p. OTF Meeting Announcements
https://www.michigan.gov/opioids/nel
q. Racial Equity Workgroup (REWG)
https://www.michigan.gov/opioids/crisis-response/racial-equity
r. REWG Draft Recommendations
https://www.bridgedetroit.com/wp-content/uploads/2024/01/opioid-draft-report.pdf
Source: "Michigan disbands racial equity group as tension mounts over opioid money"; January 16, 2024. Robin Erb. and Ron French. Bridge Michigan.
https://www.bridgemi.com/michigan-health-watch/michigan-disbands-racial-equity-group-tension-mounts-over-opioid-money

Tools

a. Michigan Overdose Data to Action (MODA) Dashboard (MDHHS).
https://www.michigan.gov/opioids/category-data
b. Michigan Substance Use Disorder Data Repositor (MI-SUDDR)
https://mi-suddr.com/
c. Opioid Abatement Needs and Investments Tool (OANI)— Duke-Margolis Center for Health Policy
https://duke.ths-data.community/
d. Recovery Ecosystem Index Map— NORC/University of Chicago; East Tennessee State University
https://rsconnect.norc.org/recovery_ecosystem_index/

National Opioid Settlement Resources

a. "Principles for the Use of Funds from Opioid Litigation" Johns Hopkins Bloomberg School of Public Health
https://opioidprinciples.jhsph.edu/wp-content/uploads/2022/02/Opioid-Principles-Doc.pdf
b. The "Principles" website
https://opioidprinciples.jhsph.edu/the-principles/
c. Center for Indigenous Health: Tribal Principles

https://www.tribalprinciples.cih.jhu.edu/
d. National Academy for State Health Policy (NASHP)
https://nashp.org/how-are-states-using-opioid-settlements/
e. National Association of Counties (NACo.) Opioid Solutions Center
https://www.naco.org/program/opioid-solutions-center
f. Equity Considerations of Local Health Department on Use of Opioid Settlement Funds
https://www.naccho.org/uploads/card-images/custom/Equity-Considerations-for-LDH-Opioid-Settlement-Funds_pdf-1.pdf
g. Opioid Settlement Tracker [.com]
https://www.opioidsettlementtracker.com/
h. National Opioid Settlements (BrownGreer)
https://nationalopioidsettlement.com/
i. National Opioid Abatement Trust II (NOAT)
https://www.nationalopioidabatementtrust.com/
k. NGA Center Opioid Litigation Settlement Funds Summit—Issue Brief
https://www.nga.org/wp-content/uploads/2023/10/2023_Opioid_Post_Meeting_Issue_Brief_Oct2023.pdf
l. Vital Strategies: Opioid Settlement Funds State Level Guides
https://www.vitalstrategies.org/resources/opioid-settlement-funds-state-level-guides-for-community-advocates/
m. Vocal NY: A Roadmap for Opioid Settlement Funds
https://www.vocal-ny.org/wp-content/uploads/2023/08/A-Roadmap-for-Opioid-Settlement-Funds-Final-Updated.pdf
n. RAND: Strategies for effectively allocating opioid settlement funds
https://www.rand.org/health-care/centers/optic/tools/fund-allocation.html
o. O'Neill Institute for National and Global Health Law at Georgetown Law: Conflicts of Interest and Opioid Litigation Proceeds: Ensuring Fairness and Transparency
https://oneill.law.georgetown.edu/wp-content/uploads/2023/10/ONL_QT_Opioid_Conflict_Interest_P6-FINAL.pdf

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Build-Out Sections of the Opioid Advisory Commission 2024 Annual Report: Community-centered frameworks for health, healing, and justice

References

Adopting the Bloomberg-Hopkins Principles

Notes: Content and formatting for "Adopting the Bloomberg-Hopkins Principles" taken from the "2023 Annual Report: A Planning Guide for State Policy Makers" (Opioid Advisory Commission; 2023).
https://council.legislature.mi.gov/Content/Files/OAC/OAC%202023%20Annual%20Report%20A%20Planning%20Guide%20for%20State%20Policy%20Makers.pdf

a. "Coalition Releases Principles to Guide State and Local Spending of Forthcoming Opioid Litigation Settlement Funds". Johns Hopkins Bloomberg School of Public Health; January 27, 2021.
https://publichealth.jhu.edu/2021/coalition-releases-principles-to-guide-state-and-local-spending-of-forthcoming-opioid-litigation-settlement-funds

b. "Principles Endorsements as of July 1, 2023". Johns Hopkins Bloomberg School of Public Health.
https://opioidprinciples.jhsph.edu/wp-content/uploads/2023/07/Opioid-Principles-Endorsing-Organizations.pdf

Community Voices

120. "High SUVI" refers to communities (county or ZIP) assessed in the 75th-100th percentile, according to the Michigan Overdose Data to Action (MOD) Substance Use Vulnerability Index (MI-SUVI; 2020);
https://www.michigan.gov/opioids/category-data

Additional Sourcing

a. While the OAC initiated virtual (weekly) sessions intended for the purpose of soliciting/gathering community input, recent utilization of the virtual space indicates a greater need for information-sharing and resource-linkages. To be responsive to these identified needs, the OAC has modified the virtual meetings to accommodate an informational and educational focus. The OAC is currently exploring collaboration with State and local partners to help increase access to key agencies of Michigan's opioid settlement space.
b. "High SUVI" refers to geographic communities (by county or ZIP) assessed in the 75th-100th percentile, according to the Michigan Overdose Data to Action (MOD) Substance Use Vulnerability Index (MI-SUVI; 2020);
https://www.michigan.gov/opioids/category-data
c. "Teams that service high SUVI communities" includes Overdose Fatality Review (OFR) teams and/or Michigan Department of Corrections RAPS teams.
d. The Michigan Association of Recovery Community Organizations (MARCO) and its participating membership remain collaborators for public regional/community listening sessions of the OAC. To date, sessions have been held with Blue Water Recovery & Outreach Center (BWROC), Jackson Area Recovery Community (JARC), Lifeboat Addiction Recovery Services (Lifeboat), Serenity House Communities (SHC; Flint and Lapeer), Recovery Advocacy Warriors (RAW), and Recovery Advocates in Livingston (RAIL; noting RAIL and additional community partners).
e. The Michigan Public Health Institute (MPHI) and participating OFRs remain collaborators for non-public, tailored listening sessions of the OAC.
f. Community Mental Health Entities (CMHEs) remain a primary sector, with representation from PIHP Region 10, St. Clair County Community Mental Health.

g. To date, collaborating PIHPs include Mid-State Health Network, Region 10, and the Community Mental Health Partnership of Southeast Michigan.
h. Grief Recovery After a Substance Passing (GRASP) Mid-Michigan Chapter; https://grasphelp.org/mid-michigan-chapter/
i. Identified goal to increase listening sessions held with/in disproportionately impacted communities from 50% to 75% of all regional sessions. Noting "disproportionately impacted communities" including but not limited to high SUVI communities (by county and/or ZIP); BIPOC communities; justice-impacted individuals; individuals and families impacted by housing instability, including those unhoused.
j. The term "people who use drugs" (PWUD) is intended to capture individuals who are in current (active) use.
k. "Post incident response" may also be referred to as "Quick Response" teams (QRT).

Community Engagement & Planning Collaborative (CEPC)

a. All information contained in this section has been taken from the Community Engagement & Planning Collaborative Charter (October 12, 2023); the charter is anticipated to be publicly available by March 2024.
b. Kindig D, Stoddart G. What is population health? Am J Public Health. 2003 Mar;93(3):380-3. doi: 10.2105/ajph.93.3.380. PMID: 12604476; PMCID: PMC1447747. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/pdf/0930380.pdf
c. "Opioid abatement" may be defined as the condition(s) in which impacts from the state's opioid epidemic are mitigated and/or lessened in severity. "Opioid abatement and remediation" include "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." 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.

Local Spotlights

121. https://micounties.org/opioid-settlement-resource-center/
122. https://mml.org/
123. https://michigantownships.org/
124. "National guidance" references the Johns Hopkins Bloomberg School of Public Health "Principles" (for use of funds from opioid litigation); https://opioidprinciples.jhsph.edu/
125. "National guidance" references the Johns Hopkins Bloomberg School of Public Health "Principles" (for use of funds from opioid litigation); https://opioidprinciples.jhsph.edu/

Additional Sourcing

a. https://council.legislature.mi.gov/Council/OAC
b. https://micounties.org/opioid-settlement-resource-center/

Appendices of the Opioid Advisory Commission 2024 Annual Report:
Community-centered frameworks for health, healing, and justice

References

Appendix A: Public Act 84 of 2022 (MCL 4.1851)

http://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0084.pdf

Appendix B: Public Act 83 of 2022 (MCL 12. 253)

http://www.legislature.mi.gov/documents/2021-2022/publicact/pdf/2022-PA-0083.pdf

Appendix C: "Exhibit E" (Distributors Settlement)

https://www.michigan.gov/-/media/Project/Websites/AG/opioids/Pages_from_Final_Distributor_Settlement_Agreement_003_1.pdf?rev=2c0828e4bbe8496cbd337c8230280c68

Appendix D: The National Opioid Settlement Landscape—State Practices in Tribal Prioritization

Minnesota

1. https://www.bia.gov/regional-offices/midwest-region
2. https://mn.gov/mmb/impact-evaluation/projects/opioid-epidemic-response/spending-dashboard/
3. https://www.revisor.mn.gov/statutes/cite/256.043
4. https://www.opioidsettlementtracker.com/globalsettlementtracker
5. https://mn.gov/mmb/impact-evaluation/projects/opioid-epidemic-response/spending-dashboard/
6. https://www.revisor.mn.gov/statutes/cite/256.043
7. *Information represented in "Tribal Inclusion in State Planning" section, obtained through state team presentation(s) in national learning networks, direct/independent meetings between Opioid Advisory Commission Coordinator and state team members

(Minnesota and Wisconsin), and/or web-based, publicly available sources.
8. https://www.revisor.mn.gov/statutes/cite/256.042/pdf
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Wisconsin

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11. https://www.dhs.wisconsin.gov/opioids/settlement-funds.htm
12. https://www.opioidsettlementtracker.com/globalsettlementtracker
13. https://www.dhs.wisconsin.gov/opioids/settlement-funds.htm
14. https://www.dhs.wisconsin.gov/opioids/fy24-q1-opioid-settlement-summary.pdf
15. *Information represented in "Tribal Inclusion in State Planning" section, obtained through state team presentation(s) in national learning networks, direct/independent meetings between Opioid Advisory Commission Coordinator and state team members (Minnesota and Wisconsin), and/or web-based, publicly available sources.
16. https://nashp.org/strategies-to-support-state-local-collaboration-on-opioid-settlement-spending/
17. https://www.dhs.wisconsin.gov/tribal-affairs/index.htm

Washington

18. https://www.bia.gov/regional-offices/northwest/tribes-served
19. https://agportal-s3bucket.s3.amazonaws.com/uploadedfiles/Another/News/Press_Releases/2023-Opioids-Account.pdf
20. https://www.opioidsettlementtracker.com/globalsettlementtracker
21. https://agportal-s3bucket.s3.amazonaws.com/uploadedfiles/Another/News/Press_Releases/2023-Opioids-Account.pdf
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States to Watch: Washington & Oregon

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Appendix E: Michigan Department of Health and Human Services—Michigan Overdose Data to Action (MODA) High SUVI Counties

Notes: Content within Appendix E (overview) was extracted from "Michigan Substance Use Vulnerability Index Documentation—June 2022" offered by the Michigan Department of Health and Human Services (MDHHS). The OAC encourages that the aforementioned document accompany any use of Substance Use Vulnerability Index (SUVI) data, and that appropriate consultation be had with the MDHHS Michigan Overdose Data to Action (MODA) and/or Opioid and Emerging Drugs Unit to support further understanding of data, methodology, strengths, and limitations, as related to the Michigan Substance Use Vulnerability Index (MI-SUVI).

"Michigan Substance Use Vulnerability Index Documentation—June 2022" (MDHHS): available at https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/documents/4651dMichigan-SUVI-Documentation.pdf?rev=1f2b16d662bf4c17ad8c73bc35ed28b8

Information used in "Appendix E" sourced from "County Substance Use Vulnerability Index Results"; Public Use Datasets. (Accessed February 19, 2024). Michigan Department of Health and Human Services—Michigan Overdose Data to Action (MODA) Dashboard https://www.michigan.gov/opioids/category-data

Appendix F: Michigan Department of Health and Human Services—Michigan Overdose Data to Action (MODA) High SUVI ZIP Codes

Notes: Content within Appendix F (overview) was extracted from "Michigan Substance Use Vulnerability Index Documentation—June 2022" offered by the Michigan Department of Health and Human Services (MDHHS). The OAC encourages that the aforementioned document accompany any use of Substance Use Vulnerability Index (SUVI) data, and that appropriate consultation be had with the MDHHS Michigan Overdose Data to Action (MODA) and/or Opioid and Emerging Drugs Unit to support further understanding of data, methodology, strengths, and limitations, as related to the Michigan Substance Use Vulnerability Index (MI-SUVI).

"Michigan Substance Use Vulnerability Index Documentation—June 2022" (MDHHS): available at https://www.michigan.gov/opioids/-/media/Project/Websites/opioids/documents/4651dMichigan-SUVI-Documentation.pdf?rev=1f2b16d662bf4c17ad8c73bc35ed28b8

Information used in "Appendix F" sourced from "ZCTA (ZIP Code) Substance Use Vulnerability Index Results"; Public Use Datasets. (Accessed February 19, 2024). Michigan Department of Health and Human Services—Michigan Overdose Data to Action (MODA) Dashboard https://www.michigan.gov/opioids/category-data

Appendix G: Opioid Advisory Commission Deliverables 2023-2024

a. "Michigan Opioid Settlement Funds Part I: Key Agencies and Settlements" (August 2023). Document created in collaboration between the Opioid Advisory Commission, Michigan Department of Attorney General, Michigan Department of Civil Rights, Michigan Department of Corrections, Michigan Department of Treasury, Michigan Association of Counties, Michigan Municipal League, and Michigan Townships Association (08.28.2023). https://council.legislature.mi.gov/Content/Files/OAC/Michigan%20Opioid%20Settlement%20Funds%20Part%20I_Key%20Agencies%20and%20Settlements.pdf

b. "Michigan Opioid Settlement Funds Part II: Frequently Asked Questions" (September 2023). Document created in collaboration between the Opioid Advisory Commission, Michigan Department of Attorney General, Michigan Department of Civil Rights, Michigan Department of Corrections, Michigan Department of Treasury, Michigan Association of Counties, Michigan Municipal League, and Michigan Townships Association (09.05.2023). https://council.legislature.mi.gov/Content/Files/OAC/Michigan%20Opioid%20Settlement%20Funds%20Part%20II_Frequently%20Asked%20Questions.pdf

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Appendix H: Opioid Advisory Commission Michigan Opioid Settlement Funds: Community Impact Survey—Data Snapshot: November 2023

https://council.legislature.mi.gov/Content/Files/OAC/Data%20Snapshot%20November%202023_UPDATED%20FINAL_2.2024.pdf

The Opioid Advisory Commission is a commission of the Michigan Legislative Council. Recommendations contained within the 2024 Annual Report are represented to support advisory functions only, and do not reflect the opinions or beliefs of the Legislative Council or its members.