

# Illinois Department of Healthcare and Family Services

## Medicaid Advisory Committee November 2, 2018

### MAC Members Present:

Grinter, Jason - Liberty Dental Plan  
Huggett, Thomas – Lawndale Christian Health Center  
Kanter, Arnold – Barton Healthcare  
Carmichael, Terry - Community Behavioral Healthcare Assoc. of IL (sitting in for M. Lindsey)  
Lundy, Ann – Access Community Health Network  
Peters III, Howard A. - HAP Inc. Consulting  
Rowland, Brian - A Safe Haven Foundation (sitting in for Neli Vasquez Rowland)  
Tao, Kai - Alliance Chicago

### Ex-Officio Members:

Dart, Bill - IDPH  
Moredock, Karen - DCFS

### HFS Staff Present:

Cunningham, Kelly	Kantas, Christopher
Bellock, Patricia, Director	McCullough-Starks, Kimberly
Easton, Cheryl	McGady, Shawn
Goyal, Arvind	Mendonsa, Robert
Herman, Kristine	Riperton-Lewis, Sylvia
Hursey, Teresa	Suess, Daniel
	Thomas, Lynne

### Interested Parties:

Aghi, Sameena – IPHCA	Cirrincione, Joe - Otsuka
Anderson, Kacy - ICOY	Cohen, Laurie – Civic Federation
Artola, Lindsey	Coleman, Dan - Merck
Atchison, Kevin - IPHA	Collord, Jeffrey – Haymarket Center
Auerbach, Amanda - TASC	DeLeon, Sandy – Ounce of Prevention
Bedford, Louis - ICOY	Donegan, Alicia - AgeOptions
Beebe, Jessie - AFC	Drazba, Carrie – Rush Children’s Hospital
Bell, Kenita – UIC-CHECK	Duszozake, Karelina – Illinicare Health
Bell, Maria - Avesis	Eagleson, Theresa – U of I
Bowlby, Judy – Liberty Dental Plan	Eagleton, Heather – ViiV Healthcare
Boyer, Nick - Otsuka	Feld, Kristen - Clearbrook
Burke, Kim – Lake County Health Department	Flanary, Maura – Shield Healthcare
Cahill, Ann – Harmony/Wellcare	Foster, Eric - IABH
Campbell, Paula - IPHCH	Gaines, Susan - IPHCA
Carey, Jason – Greater Elgin Family Care Center	Gelder, Michael
Carmichael, Terry	Gerges, Michael – UIC-CHECK
Carter, Meghan – Legal Council for Health Justice	Gibellina, Emily – U of I Health
Carvalho, Anna – For Choices	Godden, Kim - ISAH
Chan, Kathy – Cook County Health	Grabowski, Jessica – Coordinated Care Alliance
Chapman, Carrie - LCHJ	Gregory, Kathleen – Kathleen Gregory Consulting LLC
Chittaja, Emily - LaRabida	Haen, Chris – Lurie Children’s Hospital
	Hamell, Emily -
	Hartmann, Tina – Exact Sciences

## **Illinois Department of Healthcare and Family Services Medicaid Advisory Committee November 2, 2018**

Hellman, Talyc – Access Community Health Network  
Hernandez, Hector – Illinicare Health  
Holberg, Heather – County Care  
Honan, Kelly – Clearbrook  
Hovance, George  
Hunt, Kevin – Carle Foundation Hospital  
Hurter, David – Amita Health  
Israel, Nadeen – EverThrive IL  
Jarmuz, Martha – Choices, Inc.  
Jenkins, Daurice – Home Care Ombudsman  
Johnson, Greg – ISDS  
Jones, Laura  
Jones, Lorri – NextLevel Health  
Kaneaster, Mary – Gilead  
Kazee, Nicole – Erie Family  
King, Ken – Aunt Martha’s Health  
Koester, Brian - CBHA  
Kretschmer, Andrew – Alzheimer’s Association  
Lafond, Michael - Abbie  
Landers, Kelsie – Everthrive IL  
Martin, Norma – Pharma  
McCoy, Sarah - IHCOP  
McGowan-Tomke, Jen – NAMI Chicago  
McGuire, Patrick - MHN  
Misra, Jill – Impact Solutions Consulting  
Mobarhan, Giulia – Tahni Niazi  
Mortis, Phil - Gilead  
Muehlbauer, Carrie - ICOY  
O’Leary, James – Beacon Health Options  
O’Neill, Sheila - Thresholds  
Odeke, Moses - CBHA  
Pickens, Jessica – NextLevel Health  
Pinkwater, Jennie – American Academy of Pediatrics  
Powell, Traci - Harmony  
Ring, Ken - BMS  
Rosenlatt, Hannah – Access Community Health Network  
Ryan, Ken - ISMS  
Saberbein, Gustavo – Help At Home  
Schubert, Ralph – UIC-DSCC  
Shaffer, Katie – UIC-DSCC  
Shariff, Iqbal – Best Home Healthcare Network  
Sidell, Sharon – Elysia Healthcare  
Spivack, Felicia - Meridian  
Stumm, Tim – Health News Illinois  
Sutton, Mikal - BCBS  
Thierry, Kate - BCBS

Vinkler, David - Molina  
Vogt, Liz - IHHC  
Weber, Jamie - AVESIS  
Wildermuth, Jordan – Nurse-Family Partnership  
Winnett, Cyrus - IARF  
Yao, Kristiana

## Illinois Department of Healthcare and Family Services Medicaid Advisory Committee November 2, 2018

- I. Call to Order – The regular quarterly meeting of the Medicaid Advisory Committee was called to order on November 2, 2018, at 10:00 a.m., by Chair Howard Peters. A quorum was established.
- II. Introductions – MAC members and HFS staff were introduced in Chicago and Springfield.
- III. Current Business
  - a. Behavioral Health Transformation Update – Teresa Hursey provided an update as follows:
    - i. State Plan Amendments - Member choice will launch January 1, 2019 with auto-enrollment beginning in the spring.
    - ii. 1115 Waiver Pilots:
      - Medication Assisted Treatment in January 2017
      - Intensive in-home Services - in October 1, 2018
      - Mobile Crisis Response for adults in August 2018
      - SUD-IMD July 1, 2018 with full implementation January 1, 2019
      - Crisis Intervention (aka crisis beds) – December 1, 2018
      - Evidence Based Home Visiting for those children who were born addicted or show signs of withdrawal – January 2019
      - Peer recovery support, clinically managed withdrawal case management, and SUD case management for individuals in substance use treatment – November 1, 2018
      - Housing and employment support services to begin July 2019.
      - Respite services to begin July 2020.
    - iii. Integrated Health Homes - Member Choice will launch January 1, 2019 with auto-enrollment beginning in the spring. Members will start choosing December 1, 2018 and if members have not chosen by the middle of February they will be auto assigned and notified of their IHH beginning March 1, 2019. There will be a period where beneficiaries will have the opportunity to adjust their choice as to whether they want to be in an integrated health home and in which integrated health home they want to be. Their choice is ongoing even after the auto-assignment period begins; beneficiaries can opt to a different integrated health home in the same way they can chose a different practitioner for any of the other services received. The choice will always remain with the beneficiary as to their preferences.

There have been several concerns regarding staffing; more specifically the availability of qualified care coordinators and the numbers that this will require. The state had worked with the Center for Medicare and Medicaid Services to seek modifications in those requirements. It was indicated that 50 percent will require degrees and 50 percent will not. Our goal is to provide patient centered healthcare, and to provide access and access to quality care.

The floor was open for Q&A

## Illinois Department of Healthcare and Family Services Medicaid Advisory Committee November 2, 2018

- b. Telehealth Report Update – Kim McCullough gave an update regarding Telehealth and the Task Force report with 46 recommendations received across five areas:
1. Telemedicine Modalities
    - Synchronous – Live Video and Asynchronous-Store and Forward
  2. Place of Service
    - Originating Site
    - Distant Site
  3. Provider Eligibility
  4. Service Eligibility
  5. Reimbursement Rates

The Telehealth Taskforce has concluded its work. The recommendations can be found at

<https://www.illinois.gov/hfs/SiteCollectionDocuments/TelemedicineTaskforceRecommendations102918.pdf>.

The floor was open for Q&A

#### IV. New Business

- a. Opioid subcommittee – The Medicaid Advisory Committee will start the formation of the Opioid subcommittee and asked that interested parties to submit their names for consideration to serve on the opioid committee. Kathy Chan has agreed to chair this subcommittee.

Dr. Maria Bruni, Acting Assistant Secretary for the Illinois Department of Human Services, spoke by phone about the state's action plan and the implementation plan regarding the opioid epidemic crisis.

<https://www.illinois.gov/hfs/About/BoardsandCommissions/MAC/Pages/MeetingMinutes.aspx>.

- Opioid overdose epidemic on the west side of Chicago is 8 times that of the state in general. It is really affecting communities on the west side and impacting many Medicaid participants.
- We need not only access to care but also access to quality care.

#### V. Old Business

- a. HealthChoice Illinois Enrollment – Robert Mendonsa gave an update on HealthChoice Illinois.

Most clients are grouped into one or two large enrollment groups.

January 1<sup>st</sup> – 1.2 million clients joined via open enrollment

April 1<sup>st</sup> - 400,000 clients joined via open enrollment.

As of this day we have mailed out 7,000 open enrollment letters for the January 1<sup>st</sup> date.

- Due to their improvement and the responsive actions on our demands, we have returned Blue Cross Blue Shield for patients who make that choice effective the last part of October. We will continue to monitor the progress; it is hoped that we will also be able to bring it back in to auto assignment at some point in the near future.

## Illinois Department of Healthcare and Family Services Medicaid Advisory Committee November 2, 2018

- Purchase of Meridian by Wellcare was briefly discussed.

The floor was open for Q&A

- b. Legislative Update - NA
- c. Long Term Service Support - NA
- d. Provider Complaint Portal – Compared to 2018 and 2017, complaints are up by 16 percent, from 23,000 this time last year to about 27,000 this year. Seeing that we have increased enrollment by 400,000 this year, this is not unexpected. There has been a big jump in complaints, specifically around the second quarter. The top five provider types who have filed complaints are admissions, long term care facilities, hospitals, home and community based providers and durable medical equipment providers.

We are developing Health Choice Illinois portal complaint reports by plans, which will be available in the first quarter (2019).

We actively monitor the MCOs turnaround time; and we also monitor the denials. The plans are committed to developing a set of billing guidelines so, that payments are made on time and appropriately. We look at denials broken down by behavioral health, non-behavioral health and a variety of other circumstances.

With HealthChoice Illinois, all plans have the same populations. Effective January 1, 2019, there will be four state-wide plans and two in Cook County.

The floor was open for Q&A

- e. IES Eligibility/ IES Phase II / Redetermination – Update given by Lynne Thomas.
  - IES Phase II has been live for over a year; during that time there have been some issues with the roll-out of our new eligibility system. There were slowness and other performance issues in the first few months of 2018. Those issues have been resolved.
  - Improvements are being done through monthly releases that will continue for a while.
  - Since Phase II implementation, we have processed over 630,000 applications.
  - Over 450,000 Manage My Case accounts have been linked.
  - Over 136,000 medical renewals through Manage My Case have been processed.
  - Over 52,000 SNAP – Mid-point reports have been submitted.
  - Nearly 94,000 changes have been submitted through Manage My Case.
  - 48,000 Member Program application requests have been received.

Renewals as of August:

- We have processed over 950,000 renewals; of those 213,000 were renewed through the ex-parte process (when a person is able to file information electronically) and confirm that they would continue to be eligible. Those individuals did not have to return the form and their eligibility will be renewed. However, if we see something on the form that is in error, they must return the form.
- Over 270,000 individuals were required to return the form

## Illinois Department of Healthcare and Family Services Medicaid Advisory Committee November 2, 2018

- Over 382,000 were cancelled for not responding; prior to IES we were not sending out the full redeterminations that were due each month and the percentage of people that were cancelled at renewal is about the same as it is now.
- There are currently over 3 million active SNAP, cash and medical cases in IES
- Currently there are under 65,000 cases that we haven't yet entered due to detailed information that is needed after the conversion.

The floor was open for Q&A

### VI. Subcommittee Reports

- a. Public Education Subcommittee Report – Kathy Chan gave a brief update from the October 2018 meeting. All future minutes will be available online at <https://www.illinois.gov/hfs/About/BoardsandCommissions/MAC/Pages/MeetingMinutes.aspx>. The next Public Education Subcommittee meeting TBA.

The floor was open for Q&A

- b. Quality Care Subcommittee – Ann Lundy gave a brief update from the October 9, 2018 meeting. All future minutes will be available online at <https://www.illinois.gov/hfs/About/BoardsandCommissions/MAC/Pages/MeetingMinutes.aspx>. The next Quality Care Subcommittee meeting will be held on January 8, 2019.

The floor was open for Q&A

### VII. Approval of November 2, 2018 meeting minutes –

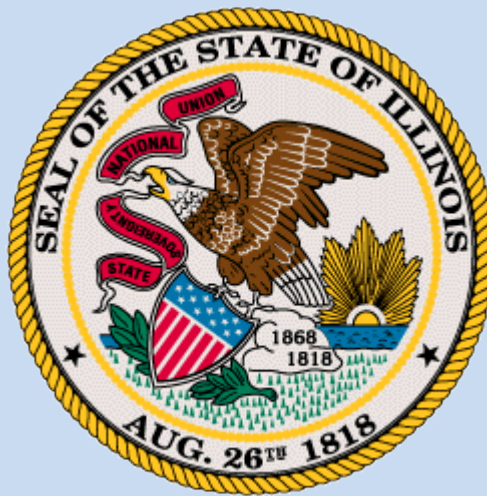
### VIII. Adjournment – The meeting was adjourned at 11: 50 a.m.

Next Medicaid Advisory Committee will be held February 1, 2019 at the JRTC, Room 2-025 from 10:00 a.m. – 12:00 p.m.

***A Note from Chair Peters – If you have items that you believe should be considered for the agenda for next Medicaid Advisory Committee meeting, please submit them a month in advance of the next committee meeting to Cheryl Easton at [Cheryl.Easton@Illinois.gov](mailto:Cheryl.Easton@Illinois.gov).***

***Items for the Opioid Subcommittee should be directed to either Cheryl Easton at [Cheryl.Easton@Illinois.gov](mailto:Cheryl.Easton@Illinois.gov) or Jodi Carr at [Jodi.Carr@Illinois.gov](mailto:Jodi.Carr@Illinois.gov).***

# State of Illinois Opioid Action Plan Implementation Report



May 31, 2018

## Table of Contents

Introduction .....	3
I. Prevention .....	6
A) Safer Prescribing and Dispensing .....	6
Strategy 1: Increase Prescription Monitoring Program Use by Providers.....	6
Strategy 2: Reduce High-Risk Opioid Prescribing Through Provider Education and Guidelines .....	8
B) Education and Stigma Reduction .....	10
Strategy 3: Increase Accessibility of Information and Resources.....	10
Strategy 4: Increase the Impact of Prevention Programming in Communities and Schools .....	14
C) Monitoring and Communication.....	15
Strategy 5: Strengthen Data Collection, Sharing, and Analysis to Better Identify Opportunities for Intervention .....	15
II. Treatment and Recovery.....	18
D) Access to Care .....	18
Strategy 6: Increase Access to Care for Individuals with Opioid Use Disorder .....	18
E) Supporting Justice-Involved Populations.....	25
Strategy 7: Increase the Capacity of Deflection and Diversion Programs Statewide .....	25
III. Response.....	28
F) Rescue .....	28
Strategy 8: Increase the Number of First Responders and Community Members Who Are Trained and Have Access to Naloxone .....	28
G) Supporting Justice-Involved Populations.....	30
Strategy 9: Decrease the Number of Overdose Deaths After an At-Risk Individual’s Immediate Release From A Correctional Facility .....	30



# Introduction

On September 6, 2017, Illinois released its State Opioid Action Plan (SOAP)<sup>1</sup>, along with Executive Order (EO) 2017-05, establishing the Governor's Opioid Prevention and Intervention Task Force (Task Force). The SOAP forms the strategic framework for addressing the opioid epidemic in Illinois, setting a **statewide goal of reducing opioid-related deaths by one-third in three years** and formulating a set of evidence-based strategies to achieve this goal. The SOAP focuses on efforts falling into **three pillars**:

- 1) **Prevention**: preventing people from using opioids
- 2) **Treatment and Recovery**: providing evidence-based treatment and recovery services to Illinois citizens with opioid use disorder (OUD)
- 3) **Response**: avoiding death after overdose

The three pillars encompass **six main priorities**, which are addressed through **nine evidence-based strategies**.

The EO directed the Task Force to collaborate with the Illinois Opioid Crisis Response Advisory Council (Advisory Council), the statewide opioid stakeholder group, to formulate a detailed implementation plan with specific activities and metrics for the execution of the strategies set forth in the SOAP. In October 2017, the Task Force charged the Advisory Council with developing recommendations for each of the nine strategies in the SOAP. The Advisory Council recommendations were released<sup>2</sup> and reviewed by the Task Force earlier this year, and form the basis of the State's implementation plan.

The State of Illinois Opioid Action Plan is a three-year plan, and implementation will occur in multiple phases over the next few years. This report details accomplishments since the release of the SOAP last year, as well as the **first phase** of implementation. This report is intended to be dynamic and continually updated as the State and its partners roll out further activities, recommendations, and planned initiatives.

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<sup>1</sup> <http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf>

<sup>2</sup> <http://www.dhs.state.il.us/OneNetLibrary/27896/documents/CommitteeRecommendationsGoalandMetricsJanuary122018.pdf>

# OVERALL GOAL

Reduce Opioid-Related Deaths by 33%  
Against Estimated Deaths in Three Years

## PREVENTION

### **A** Safer Prescribing and Dispensing

- 1 Increase PMP use by providers
- 2 Reduce high-risk opioid prescribing through provider education and guidelines

### **B** Education and Stigma Reduction

- 3 Increase accessibility of information and resources
- 4 Increase impact of prevention programming in communities and schools

### **C** Monitoring and Communication

- 5 Strengthen data collection, sharing, and analysis to better identify opportunities for intervention

## TREATMENT AND RECOVERY

### **D** Access to Care

- 6 Increase access to care for individuals with opioid use disorder

### **E** Supporting Justice-Involved Populations

- 7 Increase the capacity of deflection and diversion programs statewide

## RESPONSE

### **F** Rescue

- 8 Increase the number of first responders as well as community members who are trained and have access to naloxone

### **G** Supporting Justice-Involved Populations

- 9 Decrease the number of overdose deaths after an at-risk individual's immediate release from a correctional or other institutional facility

Stakeholder Collaboration

# Summary of Initiatives

## Prevention

**A**

**Initiative 1.1**  
Integrate PMP into all EHRs by 2021

**Initiative 1.2**  
Expand PMP access to delegates & other professionals

**Initiative 2.1**  
Identify & evaluate high-prescribers

**Initiative 2.2**  
Require PMP registration & opioid CE for CS licensing

**B**

**Initiative 3.1**  
Tailor messaging on opioids & OUD

**Initiative 3.2**  
Develop comprehensive state opioids website

**Initiative 3.3**  
Expand IL Helpline capacity

**Initiative 4.1**  
Understand how opioids impact schools, students & families

**C**

**Initiative 5.1**  
Increase opioid-related public data reporting

**Initiative 5.2**  
Grow opioid data collection & interagency collaboration

**Initiative 5.3**  
Track & map opioid ODs in real time

## Treatment & Recovery

**D**

**Initiative 6.1**  
Implement "Hub & Spoke" treatment model

**Initiative 6.2**  
Increase & support MAT prescribers

**Initiative 6.3**  
Expand OMT & recovery home services

**Initiative 6.4**  
Update DCFS opioids training & policies

**Initiative 6.5**  
Mental health & SUD treatment parity

**Initiative 6.6**  
Address impact of opioids on pregnant women & newborns

**E**

**Initiative 7.1**  
Educate on diversion & deflection frameworks

**Initiative 7.2**  
Linkage & bridge services for individuals with OUD

**Initiative 7.3**  
Promote opioids & diversion trainings for legal professionals

## Response

**F**

**Initiative 8.1**  
Expand naloxone training and access

**Initiative 8.2**  
Educate public about naloxone

**G**

**Initiative 9.1**  
Expand naloxone distribution to justice-involved individuals & supporters

**Initiative 9.2**  
Expand MAT availability at correctional facilities

**Initiative 9.3**  
Post-release linkage services for justice-involved individuals

## I. Prevention

### A) Safer Prescribing and Dispensing

On December 13, 2017, Governor Rauner signed Senate Bill 772 (Public Act 100-0564) into law. The bill was aimed directly at promoting safer opioid prescribing and dispensing by strengthening the Illinois Prescription Monitoring Program (PMP) and increasing PMP use by providers. Key mandates include:

- Requiring all prescribers with an Illinois controlled substances license to register with the PMP;
- Requiring prescribers or their designees to document an attempt to access the PMP when providing an initial prescription for Schedule II narcotics, including opioids;
- Requiring the Illinois Department of Human Services (DHS) to adopt rules requiring all electronic health records (EHR) systems to integrate with the PMP by 2021; and
- Requiring DHS to adopt rules allowing prescribers and pharmacists registered with the PMP to authorize designees to check PMP records on their behalf, as well as requiring hospitals to facilitate the designation process.

Implementation initiatives and activities under the priority of Safer Prescribing and Dispensing were developed in collaboration with the Advisory Council, with a focus on reflecting the requirements of PA 100-0564.

#### **Strategy 1: Increase Prescription Monitoring Program Use by Providers**

***Initiative 1.1: Fully integrate the Illinois Prescription Monitoring Program into all electronic health records systems by 2021, prioritizing hospital systems in areas of high need for initial integration***

#### **Implementation Activities and Progress**

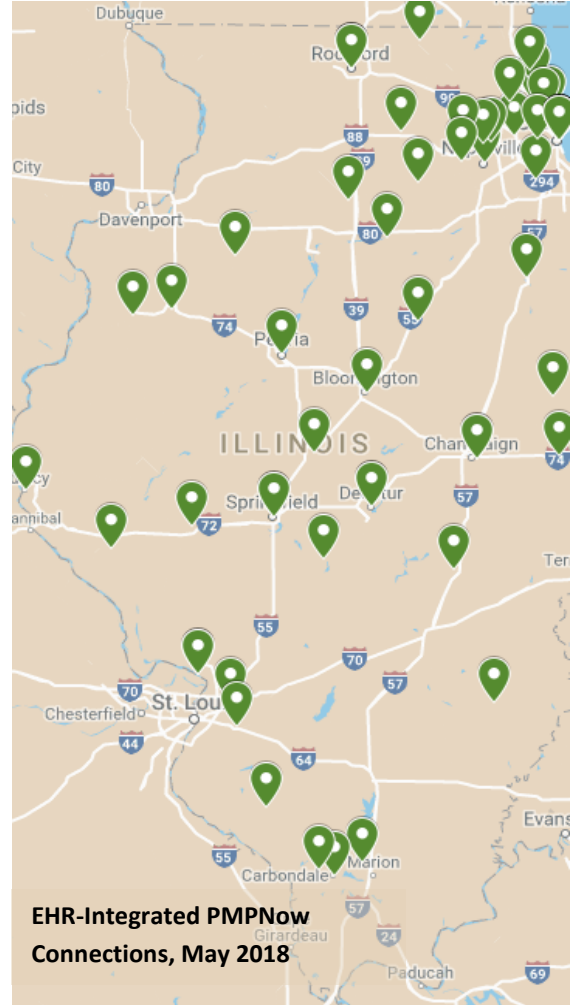
- PMP has been actively integrating EHRs with the PMP statewide over the past year, allowing prescribers in these systems to make PMP queries via an automated EHR connection (PMPNow). PMP will continue implementing PMPNow in more health system EHRs statewide in the upcoming months and years, prioritizing and targeting areas of high need in Illinois. As of May 2018, 35

health systems across Illinois have had their EHRs integrated with the PMP, with an additional 51 systems in process (see map below).

- There have been more than 14 million automated PMPNow queries in the first four months of 2018, 40% more than PMPNow queries in all of 2017. Non-automated PMP checks via the PMP website have also increased significantly, with 32% more checks in April 2018 (315,862) as compared to December 2017 (239,193).

### Metrics

- Number of EHR systems integrated with the PMP
- Number of automated PMPNow queries via EHR-integrated systems
- Number/proportion of EHR systems in high-need areas identified and integrated



***Initiative 1.2: Give licensed delegates (e.g., registered nurses, physician assistants, certified nurse practitioners) and other non-licensed professionals access to the Illinois Prescription Monitoring Program***

### Implementation Activities and Progress

- PMP is in the process of implementing the technical infrastructure to enroll and give access to licensed delegates. This process is expected to be completed and live by the end of fiscal year 2018.

- PMP is currently revising administrative rules to expand PMP access to non-licensed professionals (e.g., medical assistants, veterinarians, coroners/medical examiners). These rule changes are expected to be completed by the end of calendar year 2018.

### Metrics

- Rule adoption for registered prescribers or pharmacists to authorize a designee
- Number of designees authorized to use in the PMP
- Number of hospitals facilitating designees' access to the PMP
- Number of hospital designees registered with the PMP
- Proportion of designees registered with the PMP who are utilizing the PMP

## Strategy 2: Reduce High-Risk Opioid Prescribing Through Provider Education and Guidelines

*Initiative 2.1: Identify providers statewide who are prescribing opioids at levels higher than recommended guidelines and evaluate their practice.*

### Implementation Activities and Progress

- PMP is identifying practitioners statewide who are prescribing outside of CDC guidelines (>90 MMEs/day) and sending letters informing them of how their practice compares to other providers in the state within the same area of practice. These letters are in addition to unsolicited letters that PMP is sending providers of patients with a prescription history suggesting “doctor shopping” behavior.
- PMP plans to use identified prescribers as the focus for dissemination of information about risk mitigation tools, prescribing guidelines, continuing medical education programs, and academic detailing. PMP also plans to evaluate activity before and after such interventions to determine the most effective methods to impact opioid prescribing practices.
- The Illinois Department of Insurance (DOI) has held meetings with six of the largest insurers in the state to address OUD and mental health parity. These discussions incorporated plans for addressing the highest prescribers of opioids, including incentives and penalties as appropriate. DOI plans to hold an Insurer Summit in 2018 to review additional action items.

## Metrics

- Number of outlier prescribers identified
- Number of practice evaluation letters sent
- List of DOI OUD action items

***Initiative 2.2: As part of controlled substance licensing, require (a) that prescribers be registered with the PMP, and (b) that prescribers receive continuing education regarding opioid prescribing***

## Implementation Activities and Progress

- Per PA 100-0564, controlled substance (CS) licensed prescribers are now mandated to register with the PMP. There have been significant increases in new PMP registrations from prescribers since PA 100-0564 was passed, with 28,418 new enrollments since December 2017, raising the total number of PMP registered users to 65,630.
- The Illinois Department of Financial and Professional Regulation (DFPR) introduced a bill (SB 2777) requiring all health care professionals holding a CS license to take three of the mandated continuing education hours on proper opioid prescribing. SB 2777 was passed by the Illinois General Assembly on May 30, 2018. DFPR will adopt rules for the administration of the new continuing education requirement.
- DFPR has proposed rulemaking that would adopt the Federation of State Medical Boards' Guidelines for the Chronic Use of Opioid Analgesics into the Medical Practice Act's Administrative Rules which would govern all licensed physicians in Illinois. These proposed rule changes are currently scheduled for review by the Illinois Joint Committee on Administrative Rules in June 2018.

## Metrics

- Status of SB 2777 and administrative rules
- Number of CS-licensed prescribers registered with the PMP
- Proportion of PMP-registered licensed prescribers utilizing the PMP

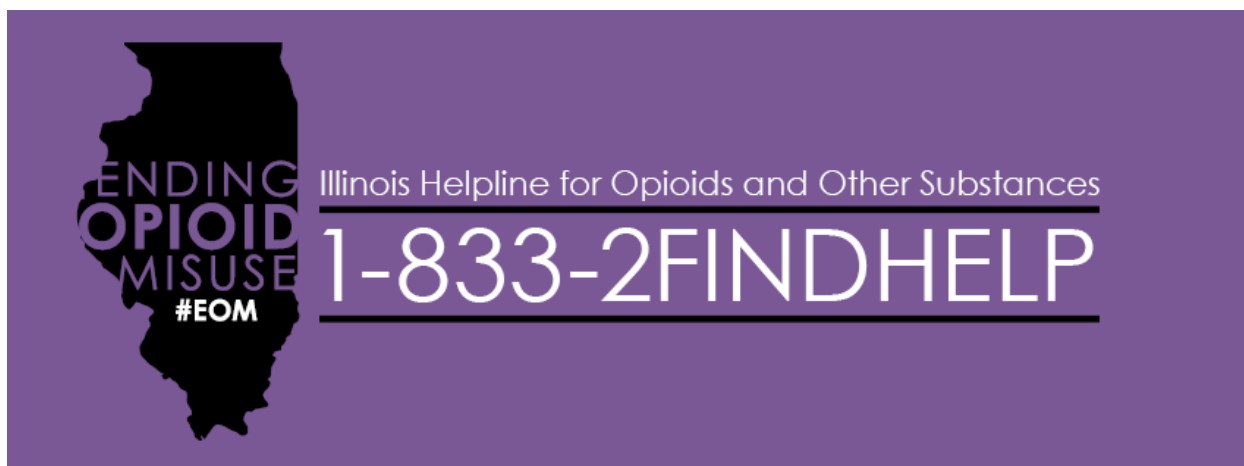
## B) Education and Stigma Reduction

### Strategy 3: Increase Accessibility of Information and Resources

*Initiative 3.1: Tailor the content and delivery of messaging about opioids and OUD to different audiences, including messaging about the Illinois Helpline for Opioids and Other Substances, using research-based, non-stigmatizing, and effective strategies*

#### Implementation Activities and Progress

- In December 2017, DHS-SUPR launched the Illinois Helpline for Opioids and Other Substances (Helpline), a 24-hour helpline providing treatment referral and informational support services for individuals in Illinois suffering from OUD and SUD as well as their supporters. As of May 2018, there have been more than 3,000 calls to the Helpline.



- DHS recently launched #EOM: *Ending Opioid Misuse in Illinois*, a statewide media campaign. #EOM targets individuals who are misusing opioids as well as their friends, families, and communities, using non-stigmatizing messaging in both English and Spanish to encourage them to call the Illinois Helpline for Opioids and Other Substances (Helpline). #EOM is also being promoted for incorporation in all social media messaging regarding opioid misuse. As of May 2018, over 18,000 #EOM: *Ending Opioid Misuse* posters are being displayed on the CTA as well as at gas stations and convenience stores, with an estimated 58 million views by members of the public per month.



- The Outdoor Advertising Association of Illinois has donated approximately 100 billboards to help promote the Helpline. In developing the billboards, over 700 people were surveyed to test billboard messaging for effectiveness and non-stigmatizing language.
- DHS also launched *Guard and Discard*, a statewide media campaign that focuses on raising public awareness of the importance of safe use, storage, and disposal of prescription pain medications. As of May 2018, over 200,000 *Guard and Discard* posters, postcards, and magnets, in both English and Spanish, are being displayed or circulated.
- The Illinois Department of Public Health (DPH) has been working with the Illinois Broadcaster's Association to conduct a series of public service announcement (PSA) campaigns on radio and television regarding opioid use disorder, Illinois' Good Samaritan Law, and stigma reduction. DPH's radio-based PSA regarding opioid overdose and Illinois' Good Samaritan Law began airing in south-central Illinois in March 2018. DPH's television and radio-based PSA raising awareness of OUD began airing in February 2018. A third television-based PSA focused on stigma reduction and OUD awareness has completed production and is expected to begin airing in late May 2018.
- DPH has been awarded a grant from the Association of State and Territorial Health Officials (ASTHO) to develop and disseminate patient-centered and research-based educational materials statewide regarding opioids, OUD, Neonatal Abstinence Syndrome (NAS), and breastfeeding. DPH is collaborating closely with perinatal administrators across the state as well as the Illinois Perinatal Quality Collaborative (ILPQC) Mothers and Newborns affected by Opioids (MNO) Initiative in this effort. One set of educational materials will provide information on prevention and opioid prescriptions to all pregnant women. The second set of materials will provide education to mothers with OUD on the importance of breastfeeding, providing skin-to-skin contact, and rooming in with their baby. In developing these educational materials, DPH compiled existing materials on these topics, utilizing feedback from several focus groups comprising women and recent mothers to review and update the content. DPH will distribute the newly developed educational materials to hospitals, who will then work with their outpatient providers and clinics to distribute and discuss these materials with women in prenatal care through their quality improvement work on the ILPQC MNO initiative.

- DOI has developed and disseminated educational materials, including an informational video, FAQ, and Fact Sheet regarding mental health, substance use disorders (SUDs), and opioids on its website.<sup>3</sup> Updates and revisions to the Consumer Toolkit are currently underway, as are plans to publish a Provider Toolkit.

## Metrics

- Messaging, communication strategies, media campaigns, and educational materials developed, implemented, and disseminated
- Estimated number of informational contacts by members of the public across various media sources
- Number of calls to the Illinois Helpline for Opioids and Other Substances

***Initiative 3.2: Develop a dedicated, comprehensive opioids website specific to Illinois and target a range of audiences by using various platforms and technology***

## Implementation Activities and Progress

- A comprehensive single state opioids website is currently being developed and is expected to launch in late 2018. Once developed, partners will use a variety of social media platforms and technologies to promote the website. In the meantime, both DPH and DHS' Division of Substance Use Prevention and Recovery (DHS-SUPR) have recently overhauled their respective opioids websites<sup>4</sup> to include updated and additional information specific to Illinois with respect to prevention, treatment, overdose response, naloxone, relevant statutes and regulations, and data.
- DOI is developing a landing page on its website dedicated to mental health, SUDs, and opioids to provide consumers with easier access to relevant insurance-related resources and educational materials. These resources will also be made available on the comprehensive single state opioids website.

<sup>3</sup> <http://multimedia.illinois.gov/ins/ins-parity.html>  
<http://insurance.illinois.gov/HealthInsurance/MentalHealthFAQs.pdf>  
<http://insurance.illinois.gov/healthInsurance/MentalHealthConsumerFactSheet.pdf>

<sup>4</sup> [www.dph.illinois.gov/opioids](http://www.dph.illinois.gov/opioids)  
<http://www.dhs.state.il.us/page.aspx?item=93882>

## Metrics

- Single state opioids website developed and launched
- Number of website hits, webpage hits, website materials downloaded
- Number/proportion of users linked to website by link medium (e.g., social media, smartphone apps)

***Initiative 3.3: Expand the capacity of the Illinois Helpline for Opioids and Other Substances to include texting, social media, and/or other non-verbal forms of communication***

## Implementation Activities and Progress

- Social media, texting, and other non-verbal forms of communication are included in the marketing plan for the Helpline. During the launch of the Helpline, business cards, posters, and a social media #EOM campaign were included in initial marketing. The Helpline website was recently launched,<sup>5</sup> with a Spanish-language version to be released in summer 2018. More robust social media presence and activities are currently in development. The goal of social media promotion will be to increase engagement with the Helpline by providing multiple marketing platforms to reach various audiences. In recognition that texting is often a primary form of communication for youth and young adults, the Helpline is currently in the process of exploring options for individuals to access help via text messaging.

## Metrics

- Helpline expanded to include texting, social media, and other non-verbal forms of communication
- Number of texts/social media posts made or sent to the Helpline

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<sup>5</sup> <https://helplineil.org/>

## **Strategy 4: Increase the Impact of Prevention Programming in Communities and Schools**

*Initiative 4.1: Strengthen understanding of how schools, students, and families are affected by the opioid epidemic; identify existing school-based prevention programming with respect to opioids and support existing training activities for school nurses regarding opioids and naloxone access*

### **Implementation Activities and Progress**

- The Advisory Council is currently reviewing the Illinois Youth Survey (IYS) to assess existing opioid-related questions and provide recommendations on modifications to understand how schools, students and families are affected by the opioid epidemic in Illinois. Once these recommendations are released, the Task Force will coordinate to incorporate new opioid-related questions as appropriate and to promote IYS use by more school districts and communities.
- In Fall 2017, DPH's School Health Program provided trainings incorporating information about the opioid epidemic in Illinois as well as naloxone to approximately 1,000 school nurses at four locations statewide. Discussions are in progress between the Illinois State Board of Education, DPH, and DHS-SUPR to improve coordination of school naloxone access, training, and procedures, as well as to perform an inventory of school-based prevention programming statewide.

### **Metrics**

- IYS questions assessing impact of opioids on students and families developed and added
- Number of schools administering the IYS version with opioids-related questions
- Opioid-related trainings for school nurses conducted
- Existing school-based prevention programming inventoried

## C) Monitoring and Communication

### Strategy 5: Strengthen Data Collection, Sharing, and Analysis to Better Identify Opportunities for Intervention

*Initiative 5.1: Strengthen reporting of opioid-related data to the public so that stakeholders and other interested individuals can be better informed on how the opioid epidemic affects their communities.*

#### Implementation Activities and Progress

- DPH—in collaboration with other state agencies—has been actively working on more robust public reporting of opioid-related data, including the development of a dynamic, searchable, public-facing Opioid Data Dashboard. In March 2018, DPH released the Opioid Data Dashboard,<sup>6</sup> which presents non-fatal and fatal opioid overdose data by county and ZIP code, trends by demographics and cause of overdose, prescribing trends, a more detailed breakdown of the type of opioid involved in fatal overdoses, and an interactive map of all pharmacies and other entities in Illinois that provide naloxone without a prescription. DPH is in the process of developing additional capabilities on the dashboard. These include interactive maps of prescription drug disposal sites as well as OUD treatment services locations, which are expected to be added to the Dashboard by summer 2018.
- DPH released the State of Illinois Comprehensive Opioid Data Report<sup>7</sup> in December 2017.
- DPH produces an Opioid Overdose Semiannual Report in June and December. Additionally, DPH reports fatal drug overdoses, including opioid overdose, by county and demographics, in its Drug Overdose Deaths report which is updated monthly. These reports, along with the DPH Opioid Data Dashboard and the State of Illinois Comprehensive Opioid Data Report, are viewable under the Publications list on DPH's Opioids Data webpage.<sup>8</sup>

<sup>6</sup> <https://idph.illinois.gov/OpioidDataDashboard/>

<sup>7</sup> <http://dph.illinois.gov/sites/default/files/publications/publicationsdoil-opioid-data-report.pdf>

<sup>8</sup> <http://dph.illinois.gov/opioids/idphdata>

## Metrics

- Data reports, dashboards, and other reporting mechanisms developed and released
- Number of website hits to DPH's Opioid Data Dashboard

***Initiative 5.2: Strengthen opioid-related data surveillance; enhance sharing, linkage, and cross-analysis of opioid-related datasets housed across different agencies.***

## Implementation Activities and Progress

- DPH has received approximately \$1.2 million in federal funding to enhance statewide monitoring and surveillance of opioid-related mortality and morbidity as well as facilitating collaboration and data sharing between criminal justice, public health, and SUD treatment communities.
- DPH has received federal funding from the Maternal and Child Health (Title V) Block Grant program to support data analysis specifically identifying how opioids are affecting Illinois women of reproductive age (15-44 years old), including analysis of opioid-related mortality and morbidity in pregnant and post-partum women and newborns. DPH has recently published a data snapshot<sup>9</sup> reporting on and summarizing these analyses.
- DPH and PMP have signed a data-sharing agreement and are in the process of performing various data analyses cross-linking PMP prescription opioid and DPH opioid mortality/morbidity data.
- DPH and the Illinois Criminal Justice Information Authority (ICJIA) will be collaborating to study opioid-related mortality, morbidity, and hospital utilization of individuals recently released from correctional facilities.
- DPH is collaborating with the Chicago High Intensity Drug Trafficking Area program (Chicago-HIDTA) and the University of Chicago Urban Labs to cross-analyze law enforcement data with DPH opioids data.
- DPH is collaborating with the University of Chicago and Southern Illinois University under a federal grant from the National Institute on Drug Abuse to

<sup>9</sup> [http://dph.illinois.gov/sites/default/files/publications/publicationsowhdrug-poisoning-and-opioid-deaths-among-women\\_0.pdf](http://dph.illinois.gov/sites/default/files/publications/publicationsowhdrug-poisoning-and-opioid-deaths-among-women_0.pdf)

perform predictive/epidemiological modeling on HIV, Hepatitis C, opioid overdose, and related comorbidities in rural communities in southern Illinois affected by opioid injection drug use.

### Metrics

- Number of data sharing agreements signed; data analysis collaborations implemented
- Reports, studies, and evaluations resulting from data collaborations

***Initiative 5.3: Implement platforms for tracking and mapping opioid overdoses in real time in order to identify geographical hot spots for targeted interventions and alert public health and safety authorities.***

### Implementation Activities and Progress

- The Illinois State Police (ISP) is implementing the Overdose Detection Mapping Application Program (ODMAP), a real-time opioid overdose reporting and tracking platform offered through HIDTA, for state troopers to report overdoses and naloxone administrations.
- DPH has implemented the BioSpatial platform to track and analyze opioid overdose reports from emergency medical services (EMS) in real-time. DPH is also implementing ODMAP for use by law enforcement agencies in rural Illinois receiving naloxone under DPH's First Responders – Comprehensive Addiction Recovery Act (FR-CARA) Rural Opioid Overdose Prevention Program funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).
- DPH maintains a syndromic surveillance system that captures the reason for visit for every emergency department visit in Illinois in near real-time. Data is accessible in the web-based BioSense Platform for state and local health departments to track all drug-related morbidity on a daily and continuous basis, including opioid overdoses.

### Metrics

- Real-time overdose tracking platforms implemented
- Number of agencies utilizing ODMAP to report overdoses in real-time
- Number of hospitals satisfying their mandatory opioid overdose reporting requirement through syndromic surveillance submission

## II. Treatment and Recovery

### D) Access to Care

In May 2018, federal CMS approved Illinois' 1115 Medicaid waiver, enabling the state to implement a series of 10 pilot programs. These pilot programs are focused on better integrating behavioral health treatment with physical health treatment for the approximately three million Medicaid recipients in Illinois, with a strong focus on improving access to OUD and other SUD treatment statewide. The approved programs include:

- A pilot lifting the “IMD exclusion” that normally excludes OUD/SUD treatment services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Disease (IMD), which will allow for expansion of inpatient treatment beds available statewide;
- A pilot covering clinically managed withdrawal management services;
- An SUD case management services pilot for justice-involved individuals;
- A peer recovery pilot supporting services delivered by individuals in SUD recovery (*i.e.*, a peer recovery coach) to provide counseling support, promote recovery, and help prevent relapse;
- An evidence-based home visiting services pilot to support mothers with babies born with substance withdrawal symptoms, including neonatal abstinence syndrome;

In addition to the above OUD/SUD specific pilots, the 1115 waiver covers several pilots covering home and community-based services – including community integration, housing support, employment support, and respite care services – as well as crisis intervention and in-home behavioral health services. Illinois will implement these pilot programs over the next five years. More information on the 1115 waiver can be found on the DHFS website<sup>10</sup>.

### **Strategy 6: Increase Access to Care for Individuals with Opioid Use Disorder**

***Initiative 6.1: Build capacity in Illinois to implement the “Hub and Spoke” model of opioid use disorder treatment.***

<sup>10</sup> <https://www.illinois.gov/hfs/SiteCollectionDocuments/BetterCareIllinoisFAQs.pdf>



## Implementation Activities and Progress

- In the “Hub and Spoke” model of OUD treatment, individuals with complex needs receive care through specialty treatment “hubs” responsible for coordinating care across health and SUD treatment systems, while individuals with less complex needs receive care through “spokes” comprising MAT-prescribing physicians and collaborating professionals who provide supportive services. DHS-SUPR will use federal State Targeted Response (STR) funds to pilot two Hub and Spoke projects in geographic areas of Illinois without access to Medication Assisted Treatment (MAT). The pilot projects will incorporate an evaluation component to document project process and outcomes measures. Pilot project results and “lessons learned” will be used to inform training and replicate the Hub and Spoke model in future phases of implementation. DHS-SUPR released a Notice of Funding Opportunity for these pilot projects on April 30, 2018. Program funding available under this opportunity will total \$1 million, split between two projects. Grantees are expected to be selected in July 2018 and project implementation is expected to begin by September 2018.

### Metrics

- Notice of Funding opportunity for pilot projects released
- Pilot projects selected and implemented
- Evaluation component implemented
- Pilot project data on process and outcomes collected
- Programmatic, administrative, and financial metrics developed

***Initiative 6.2: Increase the number of Medication Assisted Treatment (MAT) prescribers in Illinois and support current MAT prescribers by providing technical assistance and targeted training***

## Implementation Activities and Progress

- DHS-SUPR is supporting Southern Illinois Healthcare, located in the Illinois Delta region, to sponsor and coordinate meetings discussing opportunities and resources related to MAT. These meetings will provide a training venue in which experienced MAT providers share successes and barriers in providing MAT and address questions from new/prospective providers on how MAT programs can work in their practices.

- DHS-SUPR is currently using federal STR funds to support a multi-disciplinary program at the Rush University Hospital network on the west side of Chicago (Rush STR Program). This program includes peer-to-peer support for MAT prescribers via substance use intervention consult teams, training programs regarding MAT for clinical staff, as well as the establishment of an addiction medicine fellowship for physicians and nurse practitioners.
- DHS-SUPR is surveying active MAT providers to identify those currently accepting new patients and Medicaid. DPH is working on a qualitative study of active and inactive MAT providers to identify facilitators and barriers to office-based MAT to inform further training, technical assistance, and policy activities in future phases of implementation.
- The Advisory Council is in the process of identifying, reviewing, and compiling recommendations with respect to existing training materials for MAT prescribers. These recommendations will form the basis of targeted training activities in future phases of implementation.
- DHS-SUPR and DPH conducted a naloxone webinar for MAT providers on May 3, 2018. DHS-SUPR will develop more training materials for MAT providers regarding the importance of providing naloxone to MAT patients at both initial treatment induction and discharge.

## Metrics

- Number of providers receiving training and technical assistance
- Number of new providers becoming MAT prescribers

***Initiative 6.3: Expand existing outpatient methadone services and recovery home services.***

## Implementation Activities and Progress

- DHS-SUPR has contracted with 12 community-based licensed provider organizations to provide expanded OMT services through the STR grant. As of May 2018, nearly 2000 clients have been admitted to these expanded OMT services.
- DHS-SUPR has contracted with three organizations through the STR grant to provide expanded recovery home services for individuals with OUD who have unstable living arrangements and are active in some form of MAT. As of May 2018, nearly 40 clients have been admitted to these services.

## Metrics

- Number of organizations contracted to provide expanded services
- Number of clients served by expanded services

***Initiative 6.4: Review and update opioid-related policies, procedures, and trainings at the Illinois Department of Children and Family Services (DCFS) to ensure that they reflect the most current understanding of best practices for short and long-term child and family well-being and safety***

## Implementation Activities and Progress

- DCFS will create new general training as well as review and update policies and procedures regarding opioids, OUD, and related topics for all DCFS staff in the upcoming year.
- DCFS will disseminate updated procedures regarding opioids and OUD to its delegate agencies and hospitals via existing communications processes.

## Metrics

- Training/procedures regarding OUD and related topics developed and updated
- Number of DCFS trainings
- Number of delegate agencies and hospitals receiving communications plan

***Initiative 6.5: Promote the equal treatment and coverage of mental health and substance use disorders, including OUD, and ensure that insurers comply with mental health parity laws.***

## Implementation Activities and Progress

- DOI has been conducting internal training of staff for researching and identifying mental health parity violations. These trainings will continue as new materials are developed and made available.

- DOI has held meetings with six of the largest insurers in the state to review action items with respect to OUD and mental health parity. DOI plans to hold an Insurer Summit in 2018 to review additional action items.
- DOI is conducting several examinations of health companies operating in Illinois to review their practices related to mental health and substance use disorders for compliance with state and federal laws and regulations with respect to mental health parity. Reports on the results of these examinations will be released once examinations are concluded.
- DOI has developed a “palm card, quick use guide” to educate consumers and non-clinical professionals on mental health parity rights and resources available through DOI. These materials will be distributed throughout Illinois, including during DOI’s Statewide Engagement Tour in 2018.
- DOI has developed and posted a video<sup>11</sup> on its website to aid consumers in understanding and protecting their health care rights regarding mental health and substance use disorders. The video provides valuable resources to support consumers who feel their rights have been violated.

## Metrics

- Mental health parity internal trainings developed and conducted
- DOI mental health parity action items reviewed and implemented
- Mental health parity market conduct examinations conducted and reports released
- Educational materials regarding mental health parity developed and distributed

***Initiative 6.6: Strengthen activities and develop resources aimed specifically at addressing the impact of opioid misuse on pregnant women and newborns.***

<sup>11</sup> <http://multimedia.illinois.gov/ins/ins-parity.html>

## Implementation Activities and Progress

- DPH's Office of Women's Health and Family Services has developed a directory listing OUD treatment resources for pregnant women on Medicaid. The directory is available on DPH's opioids website<sup>12</sup> and will be provided to the Helpline so that pregnant women in Illinois can be appropriately directed to treatment resources in their communities.
- The Illinois Neonatal Abstinence Syndrome (NAS) Advisory Committee, formed by DPH in 2015, has been charged with developing processes, protocols, guidelines, and programs to better identify and treat NAS as well as improve pregnancy outcomes. Since its inception, the NAS Advisory Committee has developed an appropriate standard clinical definition of NAS, developed a uniform process of identifying NAS, and made recommendations on evidence-based guidelines and programs to improve the outcomes of pregnancies with respect to NAS. The NAS Advisory Committee has released three annual reports on their progress,<sup>13</sup> and will continue to develop recommendations for DPH to implement going forward.
- DPH has funded the Illinois Perinatal Quality Collaborative (ILPQC) to implement the Mothers and Newborns affected by Opioid (MNO) initiative for obstetric and neonatal teams across all Illinois birthing/newborn hospitals. The goals of the MNO initiative are to (1) prevent OUD through a systems-based approach emphasizing reduced opioid prescribing for routine deliveries, increased PMP use, and OUD prevention/stigma reduction education; (2) increase screening and MAT linkage for mothers with OUD through implementation of validated screening tools, systematic local resource mapping, and development of protocols to manage women who screen positive for opioids; and (3) optimize care for mothers and newborns affected by opioids through the development of prenatal, intrapartum, and postpartum checklists and protocols. The initiative will work closely with the Alliance for Innovation on Maternal Health and leaders in obstetrics, neonatology/pediatrics, and addiction medicine to provide hospital teams with obstetric and newborn toolkits. The MNO initiative began in January 2018 with approximately 30 Wave 1 hospitals and was expanded to all participating Illinois hospitals in April 2018 with a launch webinar. In May 2018, a kick-off collaborative face-to-face meeting was held with monthly collaborative webinars for all hospital teams to follow.

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<sup>12</sup> [http://dph.illinois.gov/sites/default/files/publications/publicationsowhopioid-use-treatment-resource-manual-ab\\_0.pdf](http://dph.illinois.gov/sites/default/files/publications/publicationsowhopioid-use-treatment-resource-manual-ab_0.pdf)

<sup>13</sup> <http://dph.illinois.gov/topics-services/prevention-wellness/prescription-opioids-and-heroin/neonatal-abstinence-syndrome>

- As described earlier in this report, DPH has been performing data analysis on how opioid misuse affects women of reproductive age in Illinois as well as developing and disseminating educational materials for pregnant women and new mothers regarding opioids, OUD, NAS, and breastfeeding.
- As described earlier, a pilot project to support home visiting services for mother with babies born with substance withdrawal symptoms, including NAS, was approved in Illinois' 1115 Medicaid waiver.

## Metrics

- Resources for pregnant women and new mothers developed and disseminated
- Recommendations from the NAS Advisory Committee developed and implemented
- Number of hospital teams participating in MNO initiative

## E) Supporting Justice-Involved Populations

### Strategy 7: Increase the Capacity of Deflection and Diversion Programs Statewide

***Initiative 7.1: Educate jurisdictions about and support their implementation of diversion and deflection frameworks, as well as diversion efforts that occur at the court level***

#### Implementation Activities and Progress

- As part of the FR-CARA Rural Opioid Prevention Initiative funded by SAMHSA, DPH will develop a training for law enforcement agency leadership participating in diversion/deflection programs and the importance of linking opioid overdose survivors to treatment and recovery supports.
- ICJIA has been conducting trainings, performing evaluations, publishing reports, and administering/identifying funding opportunities related to diversion/deflection programs, and plans to continue with these efforts.
- ICJIA has conducted multiple trainings on diversion/deflection programs. Most recently, ICJIA has hosted a conference on criminal justice responses to the opioid crisis, a summit with UChicago Labs, and conducted trainings at the Illinois Association of Chiefs of Police Annual Conference and Illinois Problem-Oriented Policing Conference.
- ICJIA has completed a process evaluation of the Safe Passage deflection program and is currently conducting an outcome evaluation of Safe Passage to inform future implementation efforts for diversion/deflection programs.
- ICJIA has administered a number of deflection/diversion grants. These include diversion/deflection programs in Lee County and Naperville (Justice Assistance Grant program), and eight drug court programs serving 23 counties (Adult Redeploy Illinois).

## Metrics

- Number of jurisdictions trained on diversion/deflection programs
- Process and outcome evaluations of diversion/deflection programs conducted
- Number of grants identified, issued, or obtained
- Number of new diversion/deflection programs implemented

***Initiative 7.2: Identify linkage gaps for justice-involved individuals with OUD; implement critical bridge services at the point of law enforcement and/or emergency department/hospital contact so that opioid overdose survivors can stay safe, stable, and alive while they wait to enter formal OUD treatment***

## Implementation Activities and Progress

- DHS-SUPR, DPH, and ICJIA will perform an environmental scan to survey current services and linkage gaps as well as existing resources and funding mechanisms for justice-involved individuals with OUD.
- DHS-SUPR is supporting a number of linkage, referral, and “warm hand-off” pilot projects for individuals with OUD using federal STR funds. DHS-SUPR will continue supporting these programs and begin working on ways to scale these pilot projects out more broadly.
- DHS-SUPR has contracted with four organizations to provide screening and “warm hand-off” services for individuals with OUD in targeted Illinois hospitals. Services have thus far been initiated at nine hospitals and multiple Cook County Health and Hospitals System locations, with 1,287 patients having been served as of May 2018. Of these patients, 80.2% (1,032) were admitted to formal OUD treatment by the community-based treatment providers to which they were referred following discharge.
- DHS-SUPR has entered into a contract to provide community-based outreach, referral, and linkage services for individuals with OUD in high-need areas across Illinois. As of April 2018, 2,908 individuals received outreach services, of whom 1,231 screened positive for opioid use and expressed interest in treatment, 772 completed a meeting with a linkage manager, and 590 appeared for treatment intake.



- During the first five months of operation, the Rush STR Program provided SBIRT (Screening, Brief Intervention, and Referral to Treatment) services to 2,516 of their inpatients, of whom 708 screened positive for any SUD and 227 screened positive for OUD. Buprenorphine services were initiated for 94 of these patients and 62 were referred to external SUD providers
- DPH's FR-CARA Rural Opioid Prevention Initiative will, among other things, provide care coordination services for opioid overdose survivors in 18 rural counties in south-central Illinois. Care coordinators under this program will develop referral relationships with hospital emergency departments as well as law enforcement to follow up on overdose survivors and refer them to appropriate long-term treatment and recovery supports.

### Metrics

- Environmental scan conducted; current client/service flow and linkage gaps and existing resources/funding mechanisms for justice-involved individuals with OUD inventoried
- Number of clients served by DHS-SUPR STR-funded linkage, referral, and "warm hand-off" programs

***Initiative 7.3: Promote training for prosecutors, judges, and other attorneys regarding opioids, OUD, MAT, and the diversion of people with OUD to evidence-based treatment programs***

### Implementation Activities and Progress

- New rules regarding continuing legal education (CLE) in Illinois require that all attorneys participate in at least one hour of CLE covering mental health/substance abuse topics. The Task Force will engage with the Illinois Attorney Registration and Disciplinary Commission and the Minimum Continuing Legal Education Board of the Supreme Court of Illinois in the upcoming year to promote CLE credits for training regarding opioids/OUD/diversion programs.

### Metrics

- CLE regarding opioids/OUD/diversion programs made available

## III. Response

### F) Rescue

#### **Strategy 8: Increase the Number of First Responders and Community Members Who Are Trained and Have Access to Naloxone**

***Initiative 8.1: Facilitate naloxone access statewide; expand naloxone purchase, training, and distribution services throughout Illinois***

#### **Implementation Activities and Progress**

- DHS-SUPR is supporting (and will continue to support) expanded naloxone purchase, training, and/or distribution services in Illinois through its Drug Overdose Prevention Program (DOPP), including funding through the SAMHSA STR and Prescription Drug/Opioid Overdose (PDO) projects. As of April 2018, 113,187 individuals have been trained in naloxone administration and 1,828 opioid overdose reversals have been reported to the DOPP. In addition, 17,356 naloxone kits have been distributed in fiscal year 2018 under STR and PDO-funded services.
- DPH's FR-CARA Rural Opioid Overdose Prevention Program will, among other things, provide free naloxone and naloxone administration training for municipal and county law enforcement agencies in 18 rural counties in south-central Illinois.
- In October 2017, DPH released a statewide standing order for naloxone. As of May 2018, 166 pharmacies and organizations have downloaded the standing order.
- DPH and partners have conducted two webinars for new pharmacists regarding the statewide naloxone standing order.

#### **Metrics**

- Number of individuals trained in naloxone administration
- Number of naloxone kits purchased/distributed
- Number of opioid overdose reversal reported

***Initiative 8.2: Educate the general public regarding what naloxone is, how it saves lives, and how to access it***

### **Implementation Activities and Progress**

- DPH will develop, compile, and disseminate educational materials regarding naloxone for the general public, including materials for people with low literacy. These materials will be made available on DPH's own opioids website as well as on the single state opioids website currently in development.
- DPH's Opioid Data Dashboard has a module mapping out every pharmacy and naloxone distribution program in Illinois that provides naloxone without a prescription. The map is interactive, searchable by city, and provides directions/contact information for each pharmacy/program listed.
- DHS-SUPR will expand the current *#EOM* communication campaign efforts targeting the general public to include naloxone education.
- Helpline operators have been trained on naloxone and are currently offering information regarding naloxone and naloxone training to callers.

### **Metrics**

- Educational materials regarding naloxone developed and disseminated
- Interactive standing order pharmacy map released on Opioid Data Dashboard

## G) Supporting Justice-Involved Populations

### Strategy 9: Decrease the Number of Overdose Deaths After an At-Risk Individual's Immediate Release From A Correctional Facility

*Initiative 9.1: Expand the number of counties and correctional facilities that distribute naloxone and provide training to at-risk justice-involved individuals and their supporters*

#### Implementation Activities and Progress

- A number of Illinois counties have already begun naloxone programs for justice-involved individuals or are working on forming partnerships with local law enforcement to establish naloxone programs for released individuals. In particular, DHS-SUPR is currently using federal funds to offer naloxone to individuals released from Lake County Jail and Cook County Jail. Additionally, the Chicago Recovery Alliance is collaborating with the Cook County Sheriff's Department to provide naloxone to individuals on electronic monitoring. Will County is also distributing naloxone to residents at a halfway house. The Task Force will actively encourage and promote expansion of these programs to more counties.
- ICJIA has convened a working group on OUD in Illinois correctional facilities, with involvement from the Illinois Department of Corrections (DOC), DPH, DHS-SUPR, as well as local stakeholders. Take-home naloxone as well as MAT in IDOC facilities are both active topics of discussions. ICJIA is administering a survey of Illinois sheriffs on naloxone use and MAT, the results of which will be shared in a future report.

#### Metrics

- Number of take-home naloxone programs implemented statewide
- Number of participants in programs

***Initiative 9.2: Expand the availability of MAT in correctional facilities, in particular following the model currently being piloted at DOC's Sheridan and Southwestern Illinois (SWICC) Correctional Centers***

### Implementation Activities and Progress

- The ICJIA-led working group on OUD in Illinois correctional facilities is actively discussing MAT availability, as is the working group led by DHS-SUPR, DOC, and Treatment Alternatives for Safe Communities (TASC), which is directing the Sheridan Correctional Center (Sheridan) and Southwestern Illinois Correctional Center (SWICC) Vivitrol pilots. Currently there are 31 clients in Sheridan and seven clients at SWICC being prescribed Vivitrol under the pilot project.
- DOC is reviewing plans to expand its SUD treatment and dual diagnosis programs at the Logan Correctional Center for women. Discussions are also underway regarding the expansion of the Sheridan/SWICC MAT pilot projects into Logan Correctional Center, in addition to a potential pilot project of other MAT medications, pending evaluation of funding streams.

### Metrics

- Number of correctional facilities providing MAT services
- Number/proportion of incarcerated individuals with SUD who receive treatment, including MAT, in correctional facilities

***Initiative 9.3: Ensure that linkage services, case management, timely access to treatment, and other resources to support recovery are available to individuals leaving jails and prisons.***

### Implementation Activities and Progress

- DHS-SUPR has entered into contracts with six organizations to provide long-acting naltrexone-based MAT for individuals with OUD in Illinois county jails. These services consist of screening, assessment, initial long-acting naltrexone injections, and post-release treatment referrals while incarcerated. As of May 15, 2018, nine county jails implemented services and served 299 clients. Of these 299 clients, 91.6% (275) were admitted for formal OUD treatment by the community-based providers to which they were referred.

- DOC is reviewing plans to expand the number of correctional facilities educating clients about MAT and providing linkages to treatment. Currently there are seven DOC facilities providing MAT education for all clients, with TASC assisting with getting clients onto Medicaid and making active linkages to treatment.
- The Helpline currently provides assistance with accessing SUD treatment services and/or other treatment and linkage resources for individuals leaving jails or prisons.
- A pilot project to focus on case management for SUD for justice-involved individuals, was recently approved in Illinois' 1115 Medicaid Waiver.

### Metrics

- Number of jails/prisons that have discharge/release programs for individuals with SUD
- Number of individuals inducted into, and maintained on, MAT from jails/prisons with release programs for individuals with SUD

## List of Abbreviations

#EOM: Ending Opioid Misuse in Illinois

Advisory Council: Illinois Opioid Crisis Response Advisory Council

ASTHO: Association of State and Territorial Health Officials

CDC: Center for Disease Control and Prevention

Chicago-HIDTA: Chicago High Intensity Drug Trafficking Area

CLE: Continuing Legal Education

CS: Controlled Substance

DCFS: Illinois Department of Children and Family Services

DFPR: Illinois Department of Financial and Professional Regulation

DHS: Illinois Department of Human Services

DHS-SUPR: Illinois Department of Human Services, Division of Substance Use Prevention and Recovery

DOC: Illinois Department of Corrections

DOI: Illinois Department of Insurance

DOPP: Drug Overdose Prevention Program

DPH: Illinois Department of Public Health

EO: Executive Order

FR-CARA: First Responders – Comprehensive Addiction Recovery Act

Helpline: Illinois Helpline for Opioids and Other Substances

HER: Electronic Health Record

ICJIA: Illinois Criminal Justice Information Authority

ILPQC MNO: Illinois Perinatal Quality Collaborative, Mothers and Newborns Affected by Opioids

ISP: Illinois State Police

IYS: Illinois Youth Survey

MAT: Medication-Assisted Treatment

MME: Morphine Milligram Equivalent

NAS: Neonatal Abstinence Syndrome

ODMAP: Overdose Detection Mapping Application Program

OUD: Opioid Use Disorder(s)

PDO: Prescription Drug/Opioid Overdose

PMP: Illinois Prescription Monitoring Program

PSA: Public Service Announcement

SAMHSA: Substance Abuse and Mental Health Services Administration

SBIRT: Screening, Brief Intervention, and Referral to Treatment

Sheridan: Sheridan Correction Center

SOAP: State of Illinois Opioid Action Plan

STR: State Targeted Response

SUD: Substance Use Disorder(s)

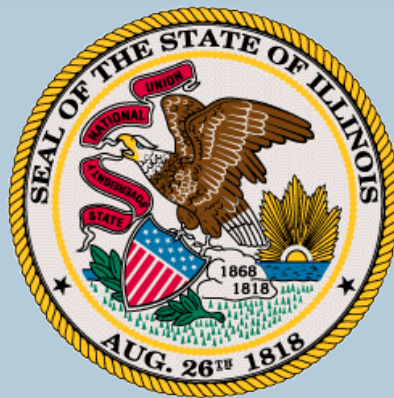
SWICC: Southwestern Illinois Correctional Center

TASC: Treatment Alternatives for Safe Communities

Task Force: Governor's Opioid Prevention and Intervention Task Force



# State of Illinois Opioid Action Plan



September 2017

Bruce Rauner, Governor

# Table of Contents

<b>Executive Summary</b> .....	<b>3</b>
<b>Addressing Illinois’ Opioid Epidemic: A Statewide Strategic Action Plan</b> .....	<b>5</b>
Understanding the Epidemic .....	6
Finding Solutions to the Epidemic: Illinois’ Response .....	8
<b>Achieving the Overall Goal: Priorities and Strategies</b> .....	<b>9</b>
<b>A) Safer Prescribing and Dispensing</b> .....	<b>11</b>
Strategy #1: Increase Prescription Monitoring Program Use by Providers .....	11
Strategy #2: Reduce High-Risk Opioid Prescribing Through Provider Education and Prescribing Guidelines .....	13
<b>B) Education and Stigma Reduction</b> .....	<b>15</b>
Strategy #3: Increase Accessibility of Information and Resources .....	15
Strategy #4: Increase the Impact of Prevention Programming in Communities and Schools .....	17
<b>C) Monitoring and Communication</b> .....	<b>19</b>
Strategy #5: Strengthen Data Collection, Analysis, and Sharing to Better Identify Opportunities for Intervention .....	19
<b>D) Access to Care</b> .....	<b>21</b>
Strategy #6: Increase Access to Care for Individuals with Opioid Use Disorder .....	21
<b>E) Supporting Justice-Involved Populations</b> .....	<b>25</b>
Strategy #7: Increase the Capacity of Deflection and Diversion Programs Statewide .....	25
<b>F) Rescue</b> .....	<b>27</b>
Strategy #8: Increase the Number of First Responders and Community Members Who Have Access to and Are Trained to Administer Naloxone .....	27
<b>G) Supporting Justice-Involved Populations</b> .....	<b>29</b>
Strategy #9: Decrease the Number of Overdose Deaths After an At-Risk Individual’s Immediate Release from a Correctional or Other Institutional Facility .....	29
<b>Next Steps</b> .....	<b>32</b>
<b>Appendix 1: Further Information, Data, and Statistics</b> .....	<b>33</b>
<b>Appendix 2: Illinois Opioid Crisis Response Advisory Council Members</b> .....	<b>38</b>
<b>List of Abbreviations</b> .....	<b>43</b>
<b>Endnotes</b> .....	<b>46</b>

# Executive Summary

**The United States is in the middle of the deadliest drug crisis in our history.** In Illinois and across the country, opioids are claiming more and more lives by the day. Fueled by the growing opioid epidemic, drug overdoses have now become the leading cause of death nationwide for people under the age of 50. **In Illinois, opioid overdoses have killed nearly 11,000 people since 2008.** Just last year, nearly 1,900 people died of overdoses—almost twice the number of fatal car accidents. Beyond these deaths are thousands of emergency department visits, hospital stays, as well as the pain suffered by individuals, families, and communities. The opioid epidemic is the most significant public health *and* public safety crisis facing Illinois.

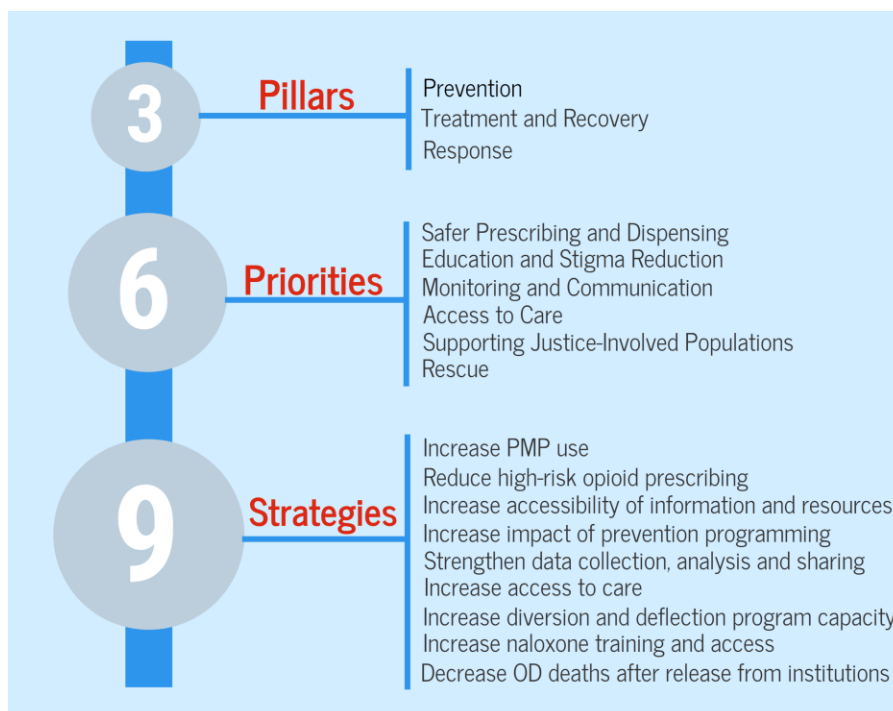
**The Illinois Opioid Action Plan presents the State of Illinois’ collective call to action.** The opioid crisis affects everyone in the state in some way. Its victims are of all ages, races, and walks of life. The causes of the epidemic are complex, and state government must work with everyone—health care providers, local agencies, law enforcement, community groups, individual citizens, and national partners—toward a solution.

**The focus of our efforts is to save lives.** At the current rate, the opioid epidemic will claim the lives of more than 2,700 Illinoisans in 2020. We must take action to halt this explosive growth. Our goal is to reduce the number of projected deaths in 2020 by a third.

## Overall Goal: Reduce Opioid Deaths by 33% in Three Years

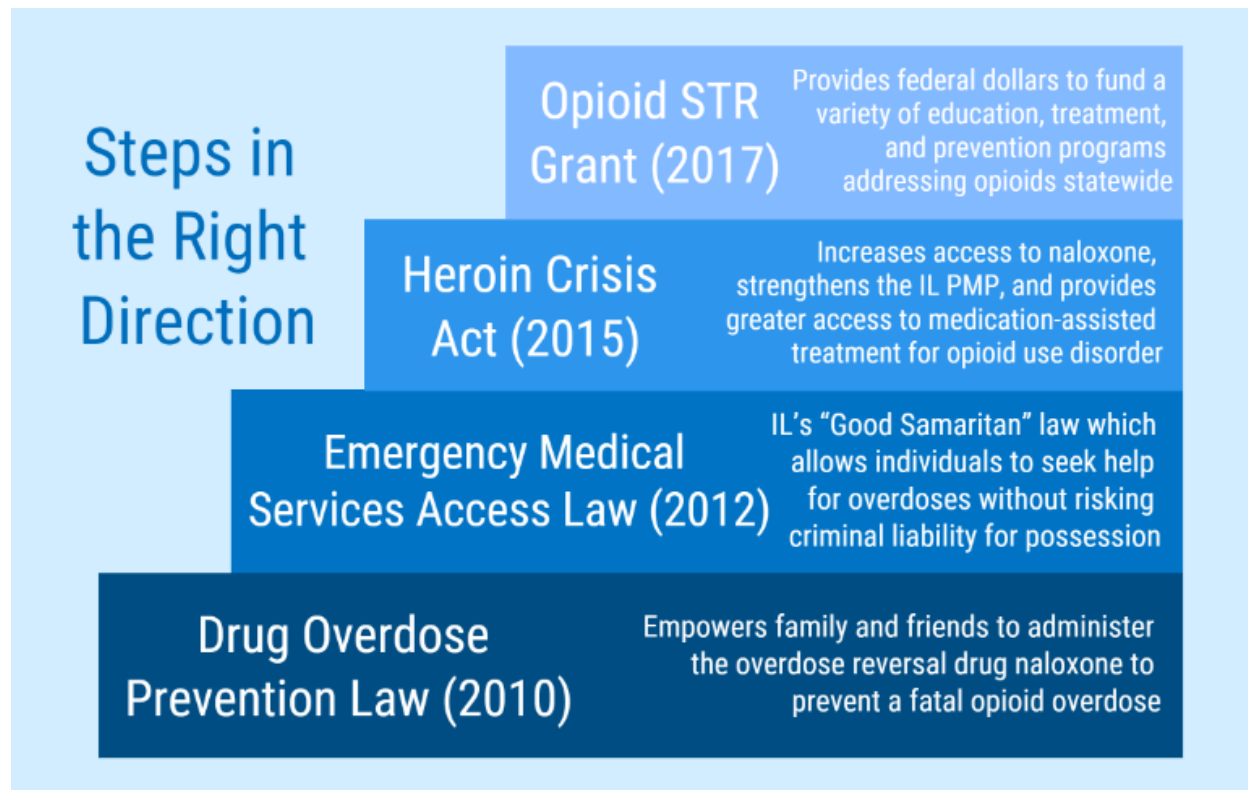
This Plan focuses on efforts falling into **three pillars, six main priorities, and nine** evidence-based strategies. The pillars are:

- (1) **Prevention:** preventing the further spread of the opioid crisis
- (2) **Treatment and Recovery:** providing evidence-based treatment and recovery services to Illinois residents with opioid use disorder (OUD), and
- (3) **Response:** averting overdose deaths.



Unfortunately, the crisis will get worse before it gets better. Dangerous synthetic opioids, such as fentanyl, are responsible for an increasing number of deaths. These substances can be thousands of times more poisonous than heroin, adding fuel to the fire.

A great deal of work to combat the epidemic is already underway and many stakeholders across the state have established strong policies and programs. Although we face an uphill climb, Illinois has been moving in the right direction.



This document is among the first steps in moving toward our goal. It is the strategic framework for the work ahead of us and outlines *what* we need to do to address the crisis and *why* we need to do it. The next steps will involve building the “how”—the specific tactics needed to implement our strategies and achieve our goal. That more detailed implementation plan, which will be developed over the next several months, will require active collaboration among all levels of government, health care providers, community organizations, interested citizens, and other stakeholders.

The opioid epidemic is a crisis we must overcome. Although we have much work ahead of us, convening all the stakeholders to provide a comprehensive strategy is the first step in our path forward. Opioid use disorder is a treatable disease and recovery is within reach. With the combined and united efforts of all Illinoisans, we can and will achieve our goal.

# Addressing Illinois' Opioid Epidemic: A Statewide Strategic Action Plan

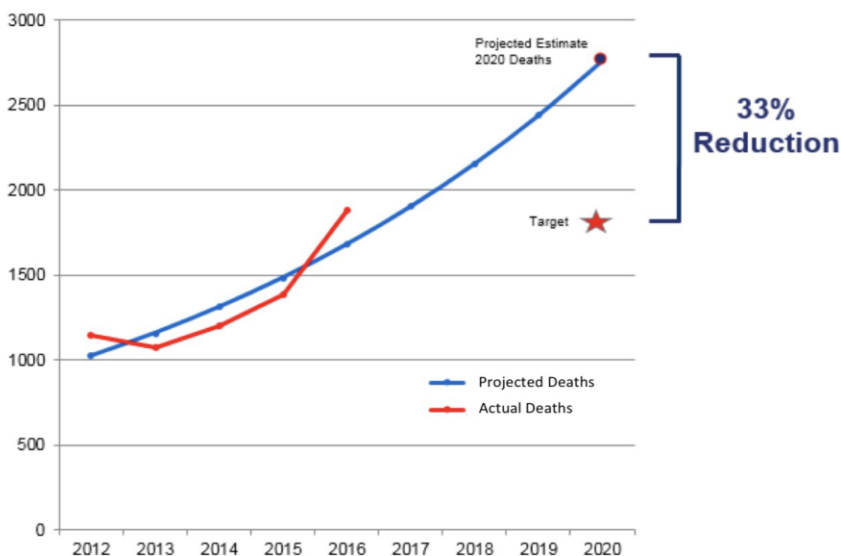
Illinois is in the midst of an unprecedented opioid epidemic. Across the state, opioid overdoses have tragically taken the lives of thousands of our residents. Opioid misuse continues unabated, destroying families and futures. In 2016, opioid overdoses killed 1,889 people in Illinois—more than one and a half times the number of homicides and nearly twice the number of fatal motor vehicle accidents. Since 2013, the number of heroin deaths has nearly doubled, the number of opioid analgesic deaths has almost quadrupled, and the number of synthetic opioid deaths has increased more than tenfold. The death toll continues to rise exponentially, and if the current rate of increase continues unchecked, opioid overdoses will kill more than 2,700 people in 2020 (see figure below). In short, the opioid epidemic is the most significant public health and public safety crisis facing Illinois. It is also a human crisis—even a single death is one death too many, and we must take action to turn the tide.

A coalition of state agencies met in early 2017 to develop a statewide approach to the epidemic. This group recognized that any response should be comprehensive, cross-disciplinary, and concerted. After extensive discussion and analysis, the State set an **overall goal of reducing opioid-related deaths by 33% in three years**. Through policy development, targeted interventions, health promotion, and stigma reduction, this ambitious goal can and must be realized to protect the health and lives of Illinois residents.

To achieve this goal, there is an urgent need for a statewide action plan that brings together systems and stakeholders to prevent the further spread of the opioid crisis and address the needs of those who are currently suffering from opioid use disorder (OUD). The key priorities and strategies of this Action Plan, which are further detailed in the next section, will be rooted in the three pillars of:

- **Prevention:** preventing the further spread of the opioid crisis,
- **Treatment and Recovery:** providing evidence-based treatment and recovery services to Illinois residents with OUD, and
- **Response:** averting overdose deaths.

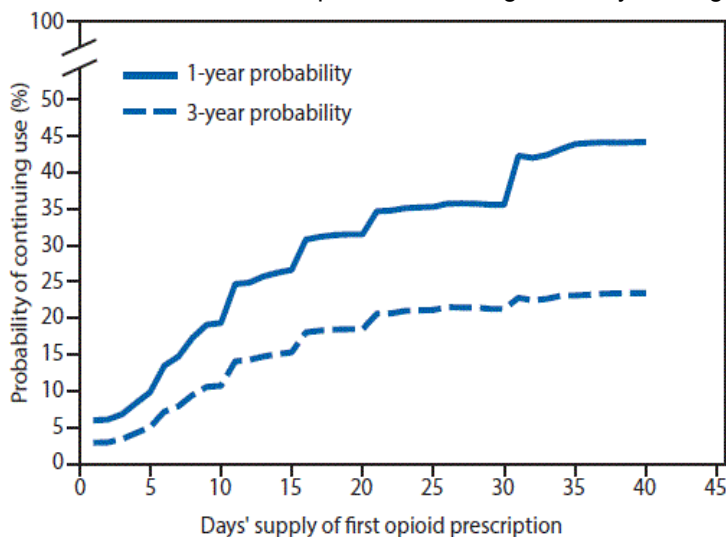
Unfortunately, the crisis will get worse before it gets better. Dangerous synthetic opioids—such as fentanyl, carfentanil, and even more toxic formulations—are responsible for an increasing number of deaths. These substances can be hundreds to thousands of times more poisonous than heroin and are driving the growth of the epidemic.



**This Action Plan is only the first step toward achieving our goal.** It is intended to be a strategic document that focuses on what the State of Illinois ought to do and why we ought to do it. The next steps will require collaborating and coordinating with various stakeholders to develop an evidence-based implementation plan. This forthcoming “tactical” plan will identify the specific activities that need to be put in place at both state and local levels to bring each strategy to fruition. Stakeholder input and involvement in the implementation plan will be essential to ensuring that we achieve our goal. Although the opioid epidemic in Illinois affects individuals of all races, ages, and walks of life, its effects have been disproportionately felt by minority populations, particularly by African American and Hispanic communities. Thus, in developing the implementation plan, it will be essential to involve and engage stakeholders representing these minority communities.

## UNDERSTANDING THE EPIDEMIC

Opioids are a class of drugs that includes heroin as well as prescription pain relievers such as oxycodone, hydrocodone, morphine, and fentanyl—medications more commonly known as Vicodin®, Percocet®, Oxycontin®, or Actiq®.<sup>1</sup> Prescription opioids are important pain medications that can provide relief for acute or chronic pain. These drugs work by binding to the body’s opioid receptors in the reward



center of the brain, diminishing pain as well as producing feelings of relaxation and euphoria.<sup>2</sup>

**Opioids are addictive.** Taking opioids at high doses for extended periods of time increases the risk of developing OUD (colloquially referred to as “addiction”), a chronic disease that can develop with repeated opioid use. Characteristics of OUD include developing physical tolerance (*i.e.*, a need for increasingly higher doses accompanied by a marked decrease in effect), being unable to consistently stop using opioids, and experiencing painful physical withdrawal

symptoms when abruptly stopping use. **Physical tolerance to opioids can begin to develop as early as two to three days following the continuous use of opioids**, which is a large factor that contributes to their addictive potential. For first-time users of prescription opioids, the probability of using opioids long-term is directly correlated to the length of their first prescription (see figure above), and with a 10-day initial supply of prescription opioids, one patient in five will become a long-term user.<sup>3</sup>

Like other chronic diseases, OUD is cyclical, with people experiencing periods of remission and relapse.<sup>4</sup> Years of data show that treatment works and recovery from OUD is possible. But without treatment, OUD can have devastating effects on people’s lives—those with an OUD are at a greater risk of dropping out of school, losing their jobs, becoming homeless, losing custody of their children, and/or getting arrested.<sup>5,6</sup> The Centers for Disease Control and Prevention (CDC) estimates that for every unintentional opioid overdose death, there are 161 individuals who report drug misuse or dependence.<sup>7</sup> Applying this to Illinois, we estimate that there may be more than 300,000 people in Illinois who misuse or are dependent on opioids.

**Opioids are deadly.** Because opioids affect respiratory regulation in the brain, high doses can cause people to stop breathing and die. Combining opioids with other substances, particularly benzodiazepines

(e.g., Valium<sup>®</sup> and Xanax<sup>®</sup>) greatly increases the risk of fatal overdose.<sup>8</sup> Overall, drug overdose deaths have significantly increased in Illinois, and the majority of this increase is attributable to opioids. Nationally, the number of deaths involving opioids, including prescription opioids and heroin, has quadrupled since 1999.<sup>9</sup>

**What is causing the opioid epidemic?** The increase in OUD and opioid overdose deaths is largely due to the dramatic rise in the rate and amount of opioids prescribed for pain over the past decades.<sup>10</sup> Since 1999, the amount of prescription opioids sold in the U.S. has nearly quadrupled.<sup>11</sup> This increase has been attributed to regulatory pressures and pharmaceutical company campaigns that minimized the risks of opioid misuse and encouraged health care providers to prescribe more opioids to treat their patients’

### *Synthetic Opioids and the “Third Wave” of the Opioid Epidemic*

The U.S. is now entering the “third wave” of the opioid epidemic and the largest increases in overdose deaths in recent years have been attributable to synthetic opioids such as fentanyl. According to the CDC, the death rate from synthetic opioids nationwide increased 72.2% from 2014 to 2015. In Illinois, that percentage increase was 120%.

Fentanyl is a powerful synthetic opioid usually used for surgical anesthesia as well as to manage post-operative and severe chronic pain. It is similar to morphine, but 80 times more potent. Fentanyl is also fast acting, meaning that overdoses can occur in seconds to minutes (rather than the longer periods associated with heroin and other opioid overdoses). Overdoses with fentanyl and other synthetics can be more difficult to reverse than with other types of opioids and often require multiple doses of the opioid reversal medication naloxone to treat. Heroin and/or cocaine sold on the street is frequently mixed with illicitly manufactured fentanyl to increase the drug’s effects, which can be a lethal combination. Because of its potency and quick onset of action, an individual who is unaware that the drugs they’ve been sold have been mixed with fentanyl can easily overdose and die on what they mistakenly believe is a “regular” dose of heroin. Even more recently, carfentanil, a fentanyl analogue 100 times more potent than fentanyl and 10,000 times more potent than morphine, has been increasingly making its way into street drugs over the past year and has been implicated in a number of overdose deaths in Illinois and nationwide.

As we move forward with our overall goal of reducing opioid overdose deaths, we will need to take the increasing impact of synthetic opioids into account and be responsive to future shifts and trends that emerge from the epidemic.

pain.<sup>12,13</sup> In response, providers began prescribing opioids at greater rates and doses: in 2013, providers wrote nearly a quarter billion prescriptions for opioids—enough for every adult in the U.S. to have their own bottle of pills.<sup>14</sup>

The risks of OUD, overdose, and death all increase with high-risk opioid prescribing.<sup>15,16</sup> In 2015, an estimated 12.5 million people in the U.S. used prescription opioids for non-medical use.<sup>17</sup> Many people who use heroin often begin with prescription opioids but later switch to heroin, frequently because heroin is cheaper and more readily available. In fact, people who misuse prescription opioids are 40 times more likely to become addicted to heroin, and 80% of heroin users report prior misuse of prescription opioids.<sup>18,19,20</sup> With powerful and dangerous synthetic opioids such as fentanyl and carfentanil increasingly making their way into street heroin and other drugs (see inset), the risks of opioid misuse have never been higher.

Although it would seem that an easy solution to the epidemic would be to reduce the availability of prescription opioids, these medications are often necessary for patients who suffer from acute and chronic pain. In the absence of alternative treatments, reducing the supply of prescription opioids too abruptly may drive more people to switch to using illicit drugs (including heroin), thus increasing the risk of overdose. At the other end of the issue, we know that providing evidence-based treatment to people with OUD, such as medications like methadone or buprenorphine in combination with counseling and recovery support services, reduces opioid overdose and risk of

relapse.<sup>21,22,23</sup> However, treatment capacity in Illinois is not adequate to serve all those in need.

## FINDING SOLUTIONS TO THE EPIDEMIC: ILLINOIS' RESPONSE

Illinois has been actively addressing the opioid epidemic through legislation and state agency initiatives since 2010, including the following:

- During the 2016 State of the State address, Governor Rauner announced a **Health and Human Services Transformation** that focuses on behavioral health (mental health and substance use), specifically the integration of behavioral and physical health service delivery. Transformation efforts emphasize (1) prevention and public health, (2) making evidence-based decisions, and (3) moving individuals from institutions to community care to keep them more closely connected with their families and communities.
- The **Medicaid 1115 Demonstration Waiver** proposes enhancements to Illinois' current system of care that will build on transformation efforts, creating a truly integrated physical and behavioral health system that is centered on individuals with behavioral health disorders, their families, and their communities. Proposed pilot projects to improve care available to people with OUD include a medication-assisted treatment (MAT) program for individuals prior to their release from the Illinois Department of Corrections (IDOC); restructuring intake, pre-discharge, and discharge processes in Illinois correctional facilities to ensure that all eligible individuals are enrolled in Medicaid upon release; facilitating linkages to care; and a recovery coaching pilot for individuals with an OUD who have begun the recovery process.
- The Illinois Department of Public Health's (IDPH) most recent **State Health Improvement Plan (SHIP)** was released in 2016 in collaboration with a team of public, private, and voluntary sector stakeholders statewide. Based on stakeholder input, the SHIP identified behavioral health as one of the three most important public health priorities for the state. The SHIP behavioral health priority includes goals to reduce opioid-related deaths and improve opioid-related data collection, utilization, and sharing. A multi-sector group of stakeholders has been appointed to the implementation council and SHIP implementation is currently underway.
- The **Drug Overdose Prevention Law (PA-096-0361)**, enacted in 2010, made it legal in Illinois for non-medical persons to administer the opioid overdose reversal medication naloxone to another individual to prevent a fatal opioid overdose. It also allowed the Illinois Department of Human Services/Division of Alcoholism and Substance Abuse (IDHS/DASA) to create its Drug Overdose Prevention Program (DOPP), which establishes and authorizes community naloxone distribution programs statewide.
- The **Emergency Medical Services Access Law (PA-97-0678)**, sometimes referred to as Illinois' "Good Samaritan Law," was enacted in 2012 and ensures that individuals experiencing an overdose or seeking emergency medical assistance for someone experiencing an overdose are not charged or prosecuted for felony possession (within specific limitations).
- The **Heroin Crisis Act (PA-99-0480)** was adopted in 2015, amending nearly 25 existing state laws to facilitate coordinated activity to strengthen statewide capacity for the prevention and management of opioid overdoses. Among other things, the Heroin Crisis Act expands access to naloxone statewide; supports education and training initiatives for law enforcement, schools, emergency responders, and others regarding naloxone; strengthens the Illinois Prescription Monitoring Program (ILPMP); and provides greater access to all U.S. Food and Drug Administration (FDA)-approved medication-assisted treatment (MAT) for Medicaid-eligible patients in Illinois.



- Federal dollars awarded to the Illinois Department of Human Services/Division of Alcoholism and Substance Abuse (IDHS/DASA) for **Illinois' State Targeted Response to the Opioid Crisis Grant** (Opioid STR) have been earmarked to fund prevention, treatment, and recovery programs across the state.

We recognize that many regional and local coalitions have been working together to combat this public health and safety crisis within their own communities. The Illinois Opioid Crisis Response Advisory Council (the Council), a statewide stakeholder group whose members represent provider organizations, county health departments, local coalitions, and professional/trade organizations, is currently assessing statewide initiatives and identifying evidence-based practices that might be used across Illinois to address the epidemic. In keeping with its statewide focus, the Council will work with the State of Illinois going forward to develop a strategic implementation plan that includes the specific practices and policies we must put in place to achieve our overall goal.

Participating State Agencies	
Governor's Office	Lieutenant Governor's Office
Criminal Justice Information Authority	Department of Corrections
Department of Financial and Professional Regulation	Department of Healthcare and Family Services
Department of Human Services	Department of Insurance
Department of Juvenile Justice	Law Enforcement and Training Standards Board
Department of Public Health	State Police

## Achieving the Overall Goal: Priorities and Strategies

Although statewide efforts have begun moving in the right direction, many challenges remain. Solutions to these challenges—and the opioid crisis itself—will require a comprehensive and coordinated approach that builds on these efforts. The opioid crisis is a community crisis that affects people from all walks of life where they live, learn, work, and play. Active collaboration and engagement—with national, state, and local governments, elected officials, the medical community, providers, insurers, educators, law enforcement, patient advocacy organizations, and the public—will be critical to our success.

To achieve our overall goal, the State developed **nine key strategies** that address **six main priorities**, which fall under the **three pillars** of Prevention, Treatment and Recovery, and Response, as illustrated in the figure on the next page and detailed in following sections.

# OVERALL GOAL

Reduce Opioid-Related Deaths by 33%  
Against Estimated Deaths in Three Years

## PREVENTION

### A Safer Prescribing and Dispensing

- 1 Increase PMP use by providers
- 2 Reduce high-risk opioid prescribing through provider education and guidelines

### B Education and Stigma Reduction

- 3 Increase accessibility of information and resources
- 4 Increase impact of prevention programming in communities and schools

### C Monitoring and Communication

- 5 Strengthen data collection, sharing, and analysis to better identify opportunities for intervention

## TREATMENT AND RECOVERY

### D Access to Care

- 6 Increase access to care for individuals with opioid use disorder

### E Supporting Justice-Involved Populations

- 7 Increase the capacity of deflection and diversion programs statewide

## RESPONSE

### F Rescue

- 8 Increase the number of first responders as well as community members who are trained and have access to naloxone

### G Supporting Justice-Involved Populations

- 9 Decrease the number of overdose deaths after an at-risk individual's immediate release from a correctional or other institutional facility

Stakeholder Collaboration

## A) Safer Prescribing and Dispensing

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Opioids are the most commonly misused type of prescription medication in the U.S. Across the nation, prescription opioid misuse and opioid-related mortality have risen in direct proportion to the significant increase in the volume of opioids being prescribed.<sup>24,25</sup> In particular, unsafe prescribing and dispensing practices, such as combining opioids and benzodiazepines, greatly increase the risk of opioid use disorder and fatal overdose. Promoting safer prescribing and dispensing practices is an important priority and will be crucial to achieving our long-term goal.

There are two key strategies to help address this priority:

- Increase the percentage of prescribers using the Illinois Prescription Monitoring Program (ILPMP)
- Reduce the volume of inappropriate and high-risk opioid prescribing through improved prescriber education and the use of safe prescribing guidelines

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### STRATEGY #1: INCREASE PRESCRIPTION MONITORING PROGRAM USE BY PROVIDERS

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#### Rationale

Prescription monitoring programs (PMPs) are state-run electronic databases that collect and distribute data about the prescription and dispensation of controlled substances. They are intended to reduce the rates of prescription drug misuse, diversion, and overdose by curtailing doctor and pharmacy “shopping” by patients. Patients who pursue multiple opioid prescriptions are a small percentage of the opioid-prescribed population, but they are a particularly high-risk group, obtaining on average 32 prescriptions in a 10-month period from an average of 10 prescribers.<sup>26</sup> Use of PMP data by providers informs clinical decision-making and can help providers identify patients who are at risk of developing an OUD or who may benefit from treatment intervention. Studies of states where PMP use is mandated for providers have shown decreases in the number of patients seeking prescriptions for the same drugs from multiple providers, overall reductions in opioid prescribing, as well as reductions in overdose death rates.<sup>27,28,29</sup>

The usefulness of a PMP is limited by the number of providers who actively use it. In the busy setting of clinical encounters, adding an extra step of checking a PMP can be burdensome for providers who are already time constrained, particularly if accessing the database is unwieldy and not easily integrated into provider routines. Efforts to promote increased PMP use by providers should address the issue of integration with health information technology (IT) and electronic health record (EHR) systems.

The IDHS Office of Clinical, Administrative, and Program Support (OCAPS)—Bureau of Pharmacy and Clinical Support Services (BPCSS) oversees the ILPMP. The ILPMP receives controlled substance prescription data from retail pharmacies and allows prescribers and dispensers to view historical data for current and prospective patients. Current estimates indicate that only 18.4% of all potential users in Illinois are actively using the ILPMP. ***Given the influence of PMP use on safer prescribing practices and its potential to reduce opioid misuse and overdoses, there would be great value from increasing the rate of active ILPMP use.***

## Current PMP Activities in Illinois

- There are currently several major initiatives underway at the ILPMP, in part supported by the CDC's Prescription Drug Overdose Prevention for States grant awarded to the ILPMP in 2015. These include the following:
  - Collaborating with and providing technical support to health systems wishing to automate ILPMP inquiries. To date, 14 large hospital and clinic systems in Illinois have successfully integrated the ILPMP with their EHR systems
  - Collaborating with major commercial EHR systems to develop add-on software modules and protocols designed to facilitate the implementation of ILPMP integration. To date, the ILPMP is connected to the Epic, Allscripts, Cerner, Meditech, NextGen, Touchworks, and GE Centricity EHR systems
  - Developing training and education materials for providers, dispensers, and patients, as well as educating prescribers on using the ILPMP as standard practice
  - Working with local health departments to increase ILPMP awareness and disseminate regional statistics with a focus on "high-burden" areas, including the 16 lower Illinois Delta Region counties and Cook County
- With the passage of the Heroin Crisis Act, registration with the ILPMP is now required when prescribers renew their controlled substance licenses with the Illinois Department of Financial and Professional Regulation (IDFPR). Use of the ILPMP is still voluntary.

## Future Areas of Activity and Exploration

In addition to building on current efforts to increase the use of the ILPMP, it will be important to explore opportunities to develop its capacity further to promote safer prescribing and dispensing and achieve our overall goal of reducing opioid-related mortality.

- Recently, there has been a growing trend of the combined use of opioids with benzodiazepines and other medications that depress the central nervous system.<sup>30</sup> These combinations are particularly unsafe and are associated with a much higher risk of fatal overdose. One potential way to address this issue would be to develop a "flagging" system within the ILPMP that would alert prescribers when a patient's prescription includes these combinations.
- Another possible future step is to facilitate increased sharing of ILPMP data with relevant stakeholders, including researchers, to allow for better-informed policymaking, program evaluations, and other data-driven activities at all levels.

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## STRATEGY #2: REDUCE HIGH-RISK OPIOID PRESCRIBING THROUGH PROVIDER EDUCATION AND PRESCRIBING GUIDELINES

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### Rationale

Providers often lack training in appropriate prescribing of opioid medications. They may write opioid prescriptions for people who have or are at risk for OUD without adequate medical justification or oversight, contributing to opioid misuse. They may also prescribe high-risk combinations of opioids with other medications, such as benzodiazepines. Opioid prescribing guidelines from the CDC, American Pain Society, Federation of State Medical Boards, the U.S. Department of Veterans Affairs, the American Academy of Pain Medicine, and others are based on current research on the safe and effective use of opioids for acute and chronic pain conditions.<sup>31</sup> Adherence to prescribing guidelines is associated with reduced opioid overdose deaths and misuse.<sup>32</sup> ***Educating prescribers about opioids and prescribing guidelines can save lives.***

### Current Opioid Prescribing Education Activities in Illinois

Illinois is currently managing the following efforts related to prescriber education:

- The Illinois Department of Healthcare and Family Services' (IDHFS) Pain Management Program is designed to decrease the inappropriate prescribing of narcotic analgesics for chronic, non-cancer pain. It was developed using evidence-based literature including national guidelines and developed in conjunction with IDHFS' medical advisors in April 2013.
- The Illinois Department of Public Health (IDPH) and the Illinois Office of the Attorney General, in partnership with the University of Chicago, have recently developed a video training module that provides guidance for new prescribers to screen for opioid misuse, monitor patients, and use the ILPMP. This free training is offered to residents and fellows in medicine and dentistry and is also appropriate for medical students and faculty. The training is designed to be incorporated into new prescriber orientation and residency onboarding and has been pushed out to training programs across the state. In conjunction with the development of the training, IDPH has created free pocket cards that provide a snapshot of the guidelines and a link to the ILPMP.

### Future Areas of Activity and Exploration

- The Federation of State Medical Boards (FSMB) adopted updated opioid prescribing guidelines in April 2017. These guidelines are based on various state and federal policies, including the guidelines published by the CDC in March 2016, as well as input from relevant medical and policy stakeholders. In Illinois, there are several localized initiatives for prescribing guidelines already underway by various hospitals and health systems, as well as the Illinois Health and Hospital Association (IHHA). Developing and adopting statewide prescribing guidelines in keeping with the updated FSMB guidelines, as well as in consultation with the IHHA and other stakeholders, would be a logical next step to promote safer prescribing statewide. As these efforts progress, the development of context-specific prescribing guidelines, tailored to clinical settings (*e.g.*, emergency rooms vs. hospital inpatient wards vs. clinics vs. long-term care) would also be beneficial.
- IDFP is considering continuing education efforts to ensure that controlled substance prescribers are appropriately trained and educated on best practices for opioid prescribing.

- Co-prescribing the opioid reversal medication naloxone to patients taking prescription opioids can significantly reduce opioid-related adverse events. One study showed that co-prescription of naloxone to chronic pain patients reduced opioid-related emergency department visits by 63%.<sup>33</sup> California has recently released opioid stewardship guidance for primary care providers recommending the co-prescription of naloxone to all patients receiving opioid medications to treat chronic pain. Developing and promoting similar recommendations for providers in Illinois should be strongly considered.
- Possible future educational measures might include letters to prescribers from IDPH on safer prescribing, the dangers of benzodiazepine/opioid co-prescription, and/or reporting on individual prescribers' levels of opioid prescribing in comparison to peers. Utilizing ILPMP data to identify and target high-risk opioid prescribers could also be beneficial.

## B) Education and Stigma Reduction

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Successful prevention efforts in public health require broad public awareness, engagement, and participation. Although the increasingly visible impact of the opioid epidemic has brought the issue to the public eye in recent years, we will need to work toward a greater public understanding of its causes, consequences, and scope. Doing so will help us reduce the number of people who begin misusing opioids, connect those with OUD to treatment, and prevent overdose-related deaths. Promoting greater public education regarding opioids and reducing the stigma associated with OUD is an important priority that will be critical to our prevention efforts.

There are two key strategies to help address this priority:

- Increase the accessibility of information and resources
  - Increase the impact of prevention programming in schools and communities
- 

### STRATEGY #3: INCREASE ACCESSIBILITY OF INFORMATION AND RESOURCES

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#### Rationale

People with OUD often experience a great deal of stigma, and feelings of shame and embarrassment may prevent them from seeking treatment. Public misperception and misunderstanding about the opioid epidemic, OUD, and treatment contribute to this stigma. Educating the general public about the causes of the opioid crisis and OUD—as well as spreading the message that OUD is a chronic disease, that the opioid crisis and OUD are health issues, that treatment works, and that recovery is possible—can help decrease this stigma. Increasing access to evidence-based and non-stigmatizing information and resources can encourage people with OUD to seek help, as well as empower families and friends to connect loved ones who may be misusing opioids to treatment. Making information and resources on specific topics—such as Illinois’ “Good Samaritan Law” with respect to overdoses or Drug Enforcement Agency (DEA) drug take-back events—more publicly available can also enhance community involvement in local prevention and intervention initiatives.

Although a great deal of information and resources regarding the opioid epidemic and OUD exist, much of it is scattered, “siloed,” and thus functionally inaccessible to many, even at a government or organization level. For example, regional and local agencies, community organizations, and other stakeholders may be unaware of state-level information and activities (and vice versa), potentially leading to duplicative and uncoordinated efforts. **Increasing the accessibility of information and resources for all levels of government, interested stakeholders, as well as members of the general public will be vital to achieving our overall goal.**

#### Current Public Education Efforts in Illinois

- IDPH shares information on DEA-sponsored drug take-back events. On April 29, 2017, a total of 43,408 pounds of unused prescription drugs—including unused prescription opioids—were collected in Illinois.<sup>34</sup>
- IDHS/DASA established the Drug Overdose Prevention Program (DOPP) as a result of PA-096-0361 (the Drug Overdose Prevention Law). The DOPP educates and trains first responders—including families and friends of people with OUD—on methods to reduce overdose fatalities,

including the administration of naloxone. To date, DOPP has trained more than 90,000 individuals statewide and 11,646 lives have been saved via naloxone administration.

- The Illinois Department of Insurance (IDOI) published a *Consumer Toolkit for Navigating Behavioral Health with Substance Use Disorders* (SUDs) that consumers can use to ensure their health plan pays for appropriate care. IDOI also launched a Statewide Consumer Education Campaign on Parity in the spring of 2016 to educate Illinois residents on parity coverage issues.
- Various coalitions, task forces, advisory groups, and organizations at the state, regional, and local levels have been very active in coming together over the past few years to share information and resources about the opioid crisis with each other and with the public.
  - Over the past year, the West Side Heroin Task Force has convened town hall meetings with elected officials, state agencies, local organizations, and community members to discuss and answer questions about the opioid epidemic. The last meeting was in April 2017.
  - A coalition of providers and local health departments in Illinois' 33 most southern counties has been convening regularly since 2016 and holding public education summits on the opioid crisis.
  - The Lake County Underage Drinking and Drug Prevention Task Force has created one of the largest prescription drug take-back programs in the U.S. This task force has placed safe disposal boxes in nearly every police department in Lake County. In 2016, the task force collected 10,928 pounds of medications. The DEA is using this program as a national model.

#### Future Areas of Activity and Exploration

- The State, in consultation with the Illinois Opioid Crisis Response Advisory Council, plans to create a comprehensive website that includes educational materials on opioids, OUD, and treatment; resource lists of how and where to seek treatment; information about existing initiatives addressing the crisis; information about funding opportunities; and other informational materials. The website is intended to be the “go-to” place for Illinois residents—as well as government agencies at all levels, community organizations, and other interested stakeholders—to find accurate, up-to-date information on opioids. The website would also include a feedback mechanism for agencies and organizations to share information, make suggestions, and keep the State apprised of local initiatives. In addition to establishing a website, social media messaging would be a valuable way to reach the general public with educational materials and links to resources.
- As part of the federal Opioid STR award, IDHS/DASA will develop public awareness communication campaigns to address stigma and educate the public regarding the safe disposal and storage of opioids, harmful consequences of opioid misuse (including both prescription opioids and heroin), signs and symptoms of OUD, and availability of OUD treatment.
- The Emergency Medical Services Access Law (EMSA), sometimes referred to as Illinois' “Good Samaritan Law,” ensures that individuals who seek emergency medical assistance for someone who is experiencing an overdose will not be charged or prosecuted for felony possession (within certain limitations).<sup>35</sup> However, lack of awareness and misinformation regarding legal liability cause many people to be wary and less inclined to call 911 during an overdose event.<sup>36</sup> Although naloxone training is being conducted for all new recruits at the academy level and is made available for experienced officers either through in-house departmental trainings or regional mobile training units,<sup>37</sup> some law enforcement officers may be unaware of the drug immunity component of the law, hampering its intended effect and further contributing to misinformation. Educational efforts to increase overall awareness of the Emergency Medical Services Access Law will be critical for getting more individuals to seek help when confronted with an overdose.<sup>38</sup>



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## STRATEGY #4: INCREASE THE IMPACT OF PREVENTION PROGRAMMING IN COMMUNITIES AND SCHOOLS

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### Rationale

88,000 Illinois adolescents per year in 2013-2014 reported using illicit drugs (including heroin) in the past year and 40,000 teens per year reported non-medical use of prescription opioids.<sup>39</sup> Parents and other family members sometimes share their unused prescription opioids, unaware of the dangers of non-medical opioid use. Studies suggest that most teens who misuse prescription opioids were given them for free by a friend or relative.<sup>40,41</sup>

Adolescents are still in the process of physical, social, and emotional development, and they are more likely to take risks, be influenced by their peers, and experiment with illicit substances.<sup>42</sup> Teen substance use can have a devastating impact on young people's lives, putting them at an increased risk of being arrested, suspended, or expelled from school and for developing physical and mental health problems. Teen substance use also increases the risk of adult substance use,<sup>43</sup> and research shows that most adults with substance use disorders began using in their teens.<sup>44</sup>

***Preventing adolescent opioid use is critical to resolving the opioid crisis.*** Prevention efforts should be directed at all age groups; however, priority must be given to efforts that affect youth at or shortly before the times they are most likely to begin to use drugs and alcohol. This crucial time is during the pre-adolescent and adolescent years, ages 10–17. Educating youth about the dangers of opioids *before* they are confronted with decisions about whether to use opioids is ideal. Prevention programs that increase awareness of high-risk situations for substance use and abuse, provide information to change teens' inaccurate beliefs about opioids (e.g., you won't get addicted to heroin if you just snort it), and teach teens resilience skills to resist pressure to use opioids can reduce teen opioid misuse.<sup>45</sup>

***Preventing adolescent opioid use is a community effort.*** Prevention efforts should engage with families, schools, and communities such that the environments in which adolescents live and learn are ones that support growth rather than substance use. Prevention program development should be driven by local data and take into account a community's unique needs and assets to best address the particular factors affecting its rates of opioid use. Community buy-in is critical for sustained support and, ideally, *all* sectors of a community should be involved in building prevention efforts in order to best achieve a meaningful and long-term reduction in opioid misuse.

### Current Community-Based Prevention Programming Activities in Illinois

- The Illinois Critical Health Problems and Comprehensive Health Education Act requires classroom instruction on substance misuse for students in grades 5 through 12.<sup>46</sup> The Illinois State Board of Education (ISBE) makes instructional materials and guidelines available to all Illinois school districts.
- Local coalitions have partnered with school districts to encourage school prevention activities. For example, a community coalition in southern Illinois has created a Youth Advisory Council at Massac County High School.
- IDHS/DASA provides funding to community-based providers to deliver an array of substance misuse prevention services. This statewide program serves Chicago community areas, suburbs, and counties throughout Illinois and is meant to target adolescents, parents, and communities. Required services under this program include prevention programming, communications campaigns, and

other awareness-raising activities that educate communities about prescription drug misuse (including opioid misuse) as well as the safe storage and disposal of prescription drugs.

- IDHS has funded the administration of the Illinois Youth Survey (IYS) biennially since 1993. The IYS is a self-reported survey completed by 8<sup>th</sup>-, 10<sup>th</sup>- and 12<sup>th</sup>-grade students that collects information on youth substance misuse and attitudes toward substance misuse. During survey years, it is freely available to all public and private schools in the state and each participating school can receive a report specific to their own students' responses. These local reports can provide critical information to school administrators, prevention professionals, and community members as they work to address substance use in their communities. In 2014, 892 schools (representing 214,249 youth) took advantage of the opportunity to gather local IYS data.

#### **Future Areas of Activity and Exploration**

- The Opioid STR award will help support the Illinois High School Association (IHSA) to provide education and awareness services for high school coaches, athletic directors, and parents about the use of prescription opioids in youth. The IHSA will produce a variety of messages aimed at identifying and combatting opioid misuse among student athletes.
- There are several existing education materials that could be used in school prevention programming:
  - The DEA and Discovery Education have created resources for K-12 students on the effects of prescription opioid and heroin use, toolkits for parents on recognizing the warning signs of and preventing opioid misuse, and a video challenge that encourages youth to create and share their own messages with peers about preventing opioid misuse.
  - The National Institute on Drug Abuse (NIDA) provides a range of free materials tailored to different age groups that educate youth about physiological responses to drugs, the dangers and consequences of drug use, and prevention strategies. These materials also address frequently asked questions from students and present “myth-busting” facts.

## C) Monitoring and Communication

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One of the most fundamental tools for disease prevention and control in public health is the active monitoring and surveillance of epidemiological data, as well as the communication and sharing of that data. The opioid epidemic is just that—an *epidemic* of a preventable and controllable disease, and optimizing the capacity of our public health surveillance system to inform our prevention efforts will be vital to achieving our goals.

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### STRATEGY #5: STRENGTHEN DATA COLLECTION, ANALYSIS, AND SHARING TO BETTER IDENTIFY OPPORTUNITIES FOR INTERVENTION

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#### Rationale

A great deal of data around opioid misuse and overdose are already being collected in Illinois in the form of overdose reports, public health surveillance data, PMP data, and public safety data. Building upon and analyzing these data sources, as well as identifying any data gaps, would help us better identify opportunities for intervention. The ability to utilize these data to map out “hot spots” of increased opioid-related activity in real time, for instance, would allow for quicker alerting and allocation of critical resources to communities that are most in need. Additionally, routine sharing of opioid-related data in meaningful ways would support coordination among public health and public safety agencies at all levels. For example, sharing public safety data on particularly poisonous (e.g., fentanyl-laced or otherwise adulterated) illicit drugs being sold in a community can help public health officials to quickly respond via public safety announcements, as well as through alerts to emergency departments and community providers. ***Strengthening the State’s capacity to collect, analyze, and share opioid-related data will allow for more timely and targeted interventions and reduce fatalities.***

#### Current Monitoring Activities in Illinois and Future Areas for Exploration

- IDPH currently tracks opioid overdose reports as well as all opioid (and other drug-related) hospitalizations and emergency room (ER) visits at the county level. This information is publicly accessible on the IDPH website. Additionally, as part of the state’s syndromic surveillance system, local public health agencies have access to an online dashboard that generates reports on a wide variety of epidemiological markers and measures. The purpose of this dashboard (and syndromic surveillance generally) is for the early detection of increasing trends in illness and continuous awareness of public health situations so that officials can respond quickly before a problem grows larger. IDPH has recently added the ability to track opioid overdoses and opioid-related ER visits to this online dashboard so that local public health agencies can check whether there has been any activity in their area that would indicate an increase in opioid-related activity warranting a further public health response.

## Future Areas of Activity and Exploration

- One future step building on current IDPH opioid monitoring activities is to utilize the automated ER reporting infrastructure of the syndromic surveillance system to routinely track different markers of opioid misuse in real time to inform direct responses (e.g., the need for more naloxone access, case management or referrals of treatment services, needle exchange, and disease testing services). Another use would be to assist local health departments with utilizing the alerting feature within the syndromic surveillance system to receive automated notifications of unusual spikes in opioid-related activity in their areas of service.
- Going forward, another potential strategy would be to take overdose data, integrate it with ILPMP data (as well as clinical, administrative, Medicaid, and other relevant data collected by other agencies), and apply predictive analytics to identify measures of possible opioid misuse. Doing so would allow the state to anticipate potential areas of increased opioid misuse and overdose. Several other states (including Michigan, Massachusetts, and Pennsylvania) have recently begun piloting this type of “big data” predictive approach to the opioid epidemic as well.
- As the State of Illinois progresses with its efforts to address the opioid epidemic, it will be important to collect data that tracks our impact. Evaluating outcomes will ensure that the activities undertaken to implement this Plan continue to be evidence based, data driven, and responsive to emerging trends in the epidemic as well as best practices.

### *Neonatal Abstinence Syndrome*

Neonatal Abstinence Syndrome (NAS) refers to the collection of signs and symptoms that occur when a newborn prenatally exposed to opioids experiences withdrawal. The syndrome is primarily characterized by irritability, tremors, feeding problems, vomiting, diarrhea, sweating, and, in some cases, seizures. Infants born with NAS have longer hospital stays and higher hospital charges than infants without NAS. Although the long-term consequences of NAS are not yet well-established, recent research has revealed evidence of adverse outcomes throughout childhood, including mental health and behavioral problems, as well as visual disorders.

Reflective of increasing maternal opioid use, the incidence of NAS has increased sharply over the last decade. The CDC reports a nationwide increase of 400% between 2000 and 2012. More recent Illinois data show that the NAS rate increased by 52% between 2011 and 2016, with a reported (and likely underestimated) 391 newborns in Illinois affected by NAS in 2016. The NAS rate in Illinois is highest among non-Hispanic white infants, infants on Medicaid, and infants residing in urban counties outside Chicago and rural counties.

Recognizing the growing need to address NAS in Illinois, IDPH formed the NAS Advisory Committee in 2015. The Committee is charged with assisting IDPH with developing appropriate and uniform definitions, identification processes, hospital training protocols, and reporting options with respect to NAS, as well as to make recommendations on evidence-based guidelines and programs to improve pregnancy outcomes. Since its creation, the NAS Advisory Committee has met six times and provided two annual reports on its progress.

## D) Access to Care

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It is well established that treatment for OUD is effective and that individuals can recover and return to full lives in their communities. Ensuring that people with OUD have access to and receive appropriate evidence-based treatment to help them reduce their opioid use as well as handle the emotional and social issues associated with OUD is critical to solving the opioid crisis.

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### STRATEGY #6: INCREASE ACCESS TO CARE FOR INDIVIDUALS WITH OPIOID USE DISORDER

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#### Rationale

Medication-assisted treatment (MAT) is the use of medications in combination with counseling, behavioral therapies, and other recovery support services for the treatment of SUDs. The most common FDA-approved medications used in the treatment of OUD are methadone and buprenorphine. Taking these medications is analogous to taking medication for diabetes or asthma—they help people manage their disorder so they can maintain their recovery. Using these medications for treatment of OUD is not the same as substituting one addictive drug for another. Once stabilized, patients can live a normal life and do not experience the compulsive thoughts and behaviors that define a substance use disorder. The World Health Organization (WHO), CDC, National Institutes of Health (NIH), and other experts all agree that MAT is essential to treating those with OUD and helping them recover.

**MAT saves lives.** MAT with methadone and/or buprenorphine\* decreases opioid-related deaths and reduces opioid use.<sup>47,48,49</sup> It also improves birth outcomes for pregnant women with OUD.<sup>50</sup> Individuals with OUD who receive MAT:

- Are more likely to stay in OUD treatment,<sup>51,52</sup>
- Are less likely to relapse,<sup>53,54</sup>
- Have decreased criminal activity,<sup>55</sup>
- Are more likely to find work and keep their jobs,<sup>56</sup>
- Have a decrease in risky behaviors that are associated with HIV or hepatitis C transmission,<sup>57</sup> and
- Have better social functioning and improved relationships with families and friends.<sup>58</sup>

Recovery support services (e.g., behavioral therapy, peer recovery coaches, 12-step groups, psychiatric consultations) help people with OUD understand and modify their addictive behaviors and treat the mental health symptoms that often accompany OUD and/or relapse triggers. Providing these services in conjunction with medications such as methadone and buprenorphine helps people stay engaged in treatment and cope with social problems related to their opioid misuse.<sup>59</sup>

Virtually no state in the U.S. has sufficient treatment capacity to provide MAT to all the people with OUD who need it. Between 2010 and 2014, Illinois' annual average of treatment provision to individuals 12

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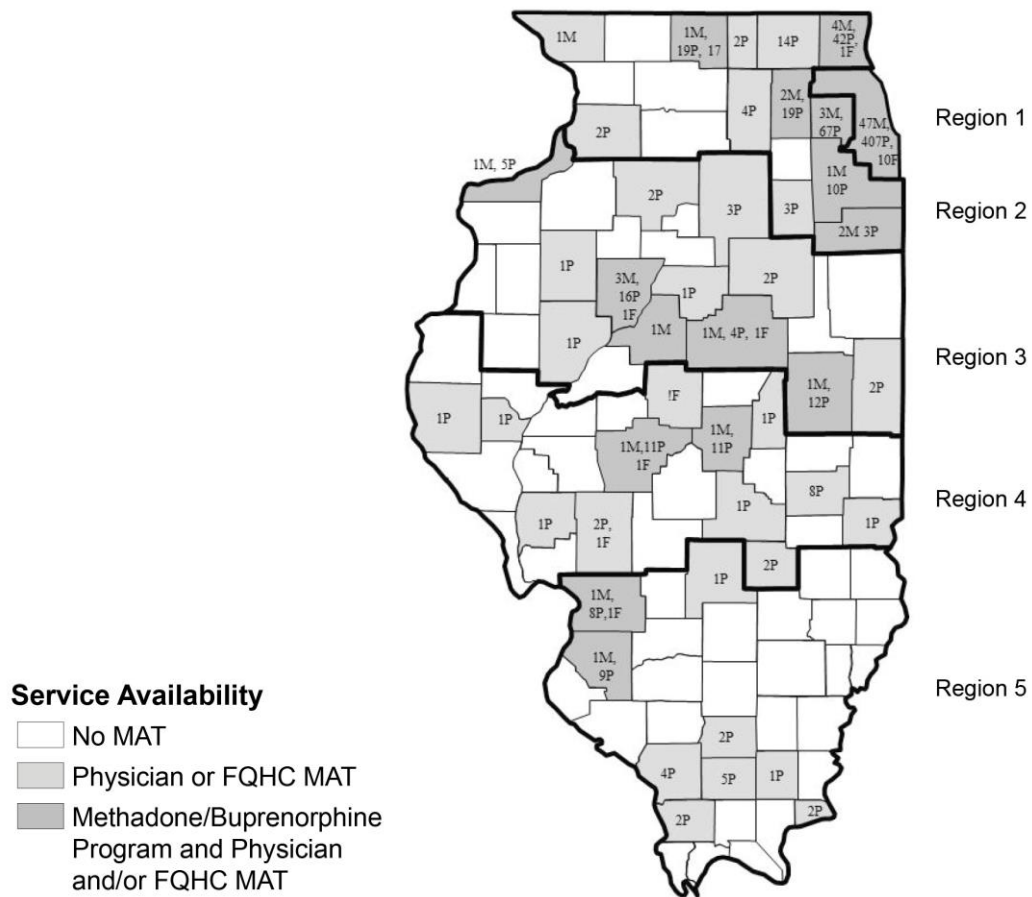
\* Another medication used to treat OUD is naltrexone, in particular, extended-release injectable naltrexone (Vivitrol®), which was approved by the FDA to treat OUD in 2010. The ability of Vivitrol to improve outcomes is still being evaluated. Further information about the differences between methadone, buprenorphine, and naltrexone is available in Appendix A.

years and older who misused or were dependent on illicit drugs (including opioids) was 11.7%.<sup>60</sup> This means that during that period of time, approximately 248,000 Illinois residents per year needed but did not receive treatment for illicit drug use.

MAT, particularly outpatient methadone treatment (OMT), has the potential to save significantly more money than other forms of treatment. The cost savings attributable to MAT arise from a wide range of improvements in the poor health commonly experienced by people with OUD. This includes reduced rates of drug use, increased access to health care and other recovery support services, improved interpersonal relationships and living conditions, and decreased involvement in high-risk behaviors such as injection drug use.

***Increasing access to MAT, behavioral therapy, and recovery services across the state will reduce opioid misuse, overdoses, and deaths, as well as give people with OUD the evidence-based treatment they need to regain their quality of life.***

**Current MAT Availability in Illinois**



■ The map above shows the availability of MAT services in Illinois. The text in counties shows the number OMT programs (M), physician prescribers of buprenorphine (P), and federally qualified health centers (FQHCs) (F) that provide MAT. Areas in white are counties that have no MAT. As the map illustrates, there are large areas of Illinois where residents have little or no access to MAT.

- The majority of OMT sites are in Cook County. There are only three OMT sites in IDHS Region 3 and only two in each of Regions 4 and 5.

- Only four FQHCs that provide MAT are in Regions 4 and 5.
- Buprenorphine can only be provided by prescribers who have completed the required training in accordance with the Drug Addiction Treatment Act of 2000 (DATA). Of the 715 physicians in Illinois authorized under DATA to provide buprenorphine (*i.e.*, “DATA-waivered” physicians), 400 are in Cook County, 50 are in Region 4, and 34 are in Region 5 (17 of whom are in two counties—Madison and St. Clair).
- IDHS/DASA licenses 71 OMT providers; 31 of these providers are publicly funded and 40 are privately funded.
- Seventeen FQHCs in Illinois received funding in 2016 from the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) to expand MAT services for people with OUD.
- Medicaid expansion under the Affordable Care Act has extended treatment for substance use disorders, including OUD, to many patients who would otherwise not be covered, and Medicaid is an essential component of the access-to-care landscape. In Illinois, MAT is available for Medicaid-eligible individuals with OUD without prior authorization mandates or lifetime limits.
- IDHS/DASA is the recipient of a Targeted Capacity Expansion—MAT-Prescription Drug and Opioid Addiction (PDOA) awarded by the SAMHSA Center for Substance Abuse Treatment (CSAT). This project supports the expansion and enhancement of OMT for people with OUD in Cook and Sangamon counties, as well as the Vivitrol<sup>®</sup> Re-entry Program described in Strategy #9.
- In addition to OMT, IDHS/DASA licenses 452 SUD treatment providers and funds a total of 127 providers. The state’s system of care includes case management, recovery support services, detoxification, residential rehabilitation, halfway houses, and recovery homes.

#### Future Areas of Activity and Exploration

- In October 2016, IDHFS submitted a Medicaid State Plan Amendment (SPA) to allow Illinois to implement the requirement of the Heroin Crisis Act (PA-99-0480) to fully allow reimbursement for outpatient methadone treatment through Medicaid fee-for-service and Medicaid Managed Care Organizations for Medicaid-eligible patients. The SPA was approved on June 30, 2017, and will increase MAT capacity throughout Illinois.
- Vermont has recently implemented a “hub and spoke” model that uses health homes to provide MAT treatment to people with OUD. In this model, individuals with complex needs receive care through a specialty treatment “hub” responsible for coordinating care across the health and substance-abuse-treatment systems of care. Individuals with less complex needs receive care through a “spoke” comprising an MAT-prescribing physician as well as collaborating professionals who provide assistance obtaining a medical home, monitor treatment adherence, and coordinate access to psychosocial supports. This unique care coordination model helps ensure that people with OUD receive MAT along with the behavioral health services they need to support their recovery, and that these services are tailored to their individual needs. Implementing a similar model in Illinois is a potential future strategy to be considered.
- Emergency departments (EDs) offer an excellent opportunity to screen people for OUD and connect them with MAT. People who receive MAT in the ED are more than twice as likely to stay engaged in treatment than people who are referred elsewhere for treatment.<sup>61</sup> Several states (Rhode Island, Connecticut, Massachusetts, New Jersey, and New Hampshire) have implemented programs that send recovery coaches to EDs to meet overdose survivors and offer them support. Promoting the development of OUD screening, MAT referral, and other recovery support programs in EDs is a

possible future step. The Opioid STR award will explore this via a project that will support teams of recovery coaches and counselors in seven Illinois hospitals who will work with patients who present in EDs with symptoms of opioid misuse. These teams will assess patients, create continuing-care plans, and coordinate treatment referrals upon patients' release from the hospital.

### ***Recovery: One Illinoisan's Story***

*"I grew up on a farm in central Illinois. For more than 20 years, I was an extremely successful businessman. I moved to New Orleans; Hurricane Katrina destroyed everything I had, and FEMA moved me and my family to Jacksonville, IL. I struggled to find work and my wife and I divorced. Alone and hopeless, I started to spiral into hell.*

*I pulled my back working at a local business. I went to a pain doctor who wrote me a prescription for 90 hydrocodone—three pills a day, every day. I discovered that not only did these pills alleviate my back pain, it also removed my mental pain. I kept going back for more, but when he went out of business a year later, I was out of drugs and out of sources. I started getting sick that day. I threw up, my muscles ached, I was very weak. A friend said it could be fixed and came back with a needle full of liquid. I shot it into me and I felt amazing within seconds. It was heroin. Heroin! The one drug I always said I would never do. I was hooked and there was no way out.*

*On March 2, 2012, I woke up with my usual morning opioids ready and a pint of vodka to chase it with. I looked at my reflection in the bathroom mirror and I could barely recognize myself. I had hit rock bottom. I picked up the phone and called the Wells Center, but I was told that there were no open beds and I would have to wait a few days. I hung up and locked myself in my bedroom to detox for the next 36 hours. I am told that heroin detox cannot kill you, but I would have paid someone to kill me then. A few days later, I got the call that a bed was available and I rushed over to check myself into treatment. When I got out a month later, I no longer had a home, the bank had repossessed my car, and I had been fired from my job. I lived at a homeless shelter for a week and a half before I realized that Lincoln Land Community College was just down the street. I didn't know what else to do, so at 45 years old, I walked in and asked for help to go back to college. I graduated from Lincoln Land and went on to graduate from the University of Illinois with my Bachelors in Psychology. I am currently working on my Masters in Human Development Counseling at UIS to gain my Professional Counselor License in order to help others who suffer from addiction. I credit AA and mental health counseling for my recovery and for keeping me sober. If I had had access to Suboxone (buprenorphine) when I went into treatment, it would have made detox easier, but it was too expensive and not covered by Medicaid at that time.*

*We need to make MAT affordable, available, and accessible for everyone. We need to get drugs out of the hands of people who are using. We need more treatment beds, especially for people on Medicaid. We need more drug courts to divert people to treatment, not jail. And we need to realize that recovery takes time: on average, it takes seven attempts for someone to get off heroin and succeed in treatment.*

*I have had the opportunity to stare addiction in the face and walk away without it taking my life. My story is not unique or different but painfully like many of those who I share this disease with. I just hope someday to be able to share my hope with someone and that it helps them turn the other way."*

*—Andrew Dewey*



## E) Supporting Justice-Involved Populations

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People with OUD are at an increased risk of being arrested and incarcerated. Once they become involved in the criminal justice system, their options and opportunities for treatment decrease drastically.

Recognizing that punishment is not the solution to the opioid epidemic, public safety and public health officials have started to address the needs of individuals whose opioid use is an underlying factor for their criminal behavior. Supporting the needs of this particularly at-risk population will be an important part of achieving our overall goal.

There are two key strategies that address this priority (the second of which is detailed later in this document under Strategy #9):

- Increase the capacity of deflection and diversion programs statewide
- Decrease the number of opioid overdose deaths immediately following release from institutional (and particularly correctional) facilities

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### STRATEGY #7: INCREASE THE CAPACITY OF DEFLECTION AND DIVERSION PROGRAMS STATEWIDE

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#### Rationale

**Treatment for OUD should be more accessible for justice-involved individuals.** The opioid crisis is both a public health and a criminal justice issue. Recognizing that increasing arrests of those with OUD will not improve individual and community outcomes, police have become a point of contact for those seeking help by facilitating immediate access to treatment. These deflection and diversion initiatives can help with barriers (e.g., lack of knowledge of available services, shame and stigma, cost and lack of insurance/Medicaid, lack of transportation, long treatment waiting lists) that prevent individuals from receiving treatment.<sup>62</sup>

**Deflection is a promising practice.** In deflection models (i.e., pre-arrest diversion models), citizens voluntarily contact police or are contacted via outreach efforts. After contact, individuals are offered treatment without the threat of arrest and are provided with transportation to treatment facilities.<sup>63,64</sup>

**These deflection strategies can reduce overdose deaths, improve lives, and improve police–community relations—all while decreasing the burden on the criminal justice system.** As of late 2016, 153 other police departments in 28 states have adopted some form of a deflection model.<sup>65</sup> The Police Assisted Addiction and Recovery Initiative (PAARI), a nonprofit organization, was developed to support police departments and communities in these efforts.<sup>66</sup>

**Post-arrest diversion is an effective practice.** Post-arrest diversion initiatives introduce individuals to SUD treatment after arrest, with police officers serving as resources for treatment referrals. Studies show that people who participate in post-arrest diversion programs are less likely to be re-arrested, spend fewer days in jail, and are more likely to stay in treatment.<sup>67,68,69</sup>

#### Current Deflection and Diversion Efforts in Illinois

- As of May 2017, there are programs using deflection models in the following Illinois counties: DuPage, Lake, Lee, Livingston, Whiteside, and Will. The Illinois Criminal Justice Information Authority (ICJIA) is evaluating the Safe Passage Initiative operating in Dixon, IL, as well as

Livingston and Whiteside counties. Rosalind Franklin University is evaluating the program A Way Out, which operates in Lake County.

- The Westside Narcotics Diversion and Treatment Initiative (WNDTI), a collaboration between the Chicago Police Department (CPD), the Chicago High-Intensity Drug Trafficking Areas (C-HIDTA) Program, the University of Chicago Health and Crime Labs, and three local service providers—Haymarket Center, Thresholds, and Heartland Health Outreach—began in April 2016. WNDTI is a pilot pre-arrest diversion program in selected Chicago police districts that deflects not only drug users but also nonviolent addicted drug *sellers* into treatment prior to arrest. In the pilot's first year, more than 80 individuals were connected with treatment, and resources have been committed to expanding the initiative.
- For nearly 20 years, drug courts in Illinois have been diverting non-violent defendants with SUDs into highly structured and closely monitored drug treatment programs. There are currently 116 adult drug courts and seven juvenile drug courts in Illinois. Drug court participants commit to treatment and counseling, agree to abide by the rules of the drug court program, undergo random drug testing, and have regular court hearings. Drug courts are supported by Illinois statute (730 ILCS 166 and 705 ILCS 410).

#### Future Areas of Activity and Exploration

- The Opioid STR grant will support the Cook County Hospital and Health Care System's (CCHHS) Triage Center on Chicago's West Side. The Triage Center will provide specialized screening, linkage care management, and recovery support services for people with OUD, diverting them from jail to treatment. CCHHS runs a similar triage center in Chicago's Roseland neighborhood.
- There have been a number of successful deflection and diversion programs implemented in other states that could potentially serve as models for future activities in Illinois. These include the following:
  - The Law Enforcement-Assisted Diversion (LEAD) program in King County, Washington, is a voluntary post-arrest/pre-booking police diversion program for those facing possible drug or prostitution charges. In the LEAD program, police officers refer individuals to case workers who conduct in-house assessments and connect them with the appropriate services. LEAD participants were less likely to be arrested and incarcerated than a comparison group.<sup>70</sup>
  - The Stop, Triage, Engage, Educate, and Rehabilitate (STEER) program in Montgomery County, Maryland, refers individuals to an on-call community-based case manager for full clinical assessment and referral to SUD treatment.<sup>71</sup> Early results show that more than one-third of STEER participants are successfully engaged in treatment.<sup>72</sup>
  - The Conversations for Change program in Dayton, Ohio, is a deflection outreach model that invites individuals identified by police as having an SUD or after an overdose to community meetings addressing SUD, treatment options, and other support services.<sup>73</sup>
  - The Angel Program is a deflection model started by the Gloucester, Massachusetts, Police Department in 2015. The majority of participants in the Angel Program completed treatment and follow-up services, and fewer than half returned to substance use.<sup>74,75</sup>

## F) Rescue

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The opioid epidemic is as much a public safety issue as a public health issue. The principal means to reverse an overdose is through the rapid administration of a drug called naloxone. Naloxone is an opioid antagonist medication that can quickly restore breathing, brain function, and save the life of a person experiencing an overdose. Across the country, naloxone is widely used by emergency medical personnel, and studies show that communities with naloxone programs have significantly reduced their number of opioid overdose deaths.<sup>76</sup> Increasing naloxone availability and training is critical to achieving our overall goal of fewer opioid-related deaths.

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### **STRATEGY #8: INCREASE THE NUMBER OF FIRST RESPONDERS AND COMMUNITY MEMBERS WHO HAVE ACCESS TO AND ARE TRAINED TO ADMINISTER NALOXONE**

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#### **Rationale**

***Having more first responders, public safety officers, and community members able to administer naloxone in the event of an opioid overdose will result in more lives saved.*** In particular, public safety officers are often the first to arrive on the scene of an overdose, and increasing their access to naloxone as well as training them to administer it when necessary is a critical strategy in reducing opioid overdose deaths. In 2015, more than 220 law enforcement agencies in 24 states carried naloxone, with more than 10,000 administered overdose reversals.<sup>77</sup> In Illinois, although the majority of paramedics and firefighters carry naloxone, comparatively fewer law enforcement officers are trained to administer and carry this life-saving drug.<sup>78</sup>

#### **Current Public Safety Naloxone Efforts in Illinois**

- Illinois' Drug Overdose Prevention Law (PA 96-0361) empowered non-medical persons to administer naloxone to individuals experiencing an opioid overdose without risking criminal or civil liability. This law also enabled IDHS/DASA to establish and authorize community programs to distribute naloxone and provide training in its use under its Drug Overdose Prevention Program (DOPP). To date, IDHS/DASA has enrolled 717 program sites in 33 counties into its DOPP and trained more than 90,000 individuals to administer naloxone, resulting in more than 11,000 overdose reversals.<sup>79</sup>
- The Heroin Crisis Act requires all Illinois government agencies employing law enforcement officers and other first responders to stock naloxone, provide their employees with access to it, and establish training programs for its administration.<sup>80</sup> Additionally, all emergency medical vehicles in the state must carry naloxone. Since passage of the Act, the Illinois Law Enforcement Training and Standards Board has conducted naloxone training for all new recruits and made training available for other officers through departmental or regional mobile unit trainings.<sup>81</sup> Although many police officers currently have access to naloxone per the Act's requirements, they may not carry it.

#### **Future Areas of Activity and Exploration**

- After an overdose intervention, some police departments are incorporating a follow-up component that includes law enforcement and/or public health or community service professionals connecting the individual with OUD treatment.<sup>82</sup> Linking individuals who have overdosed to OUD treatment is key to combatting the opioid crisis, especially since individuals who have previously overdosed are at higher risk of future overdoses.<sup>83,84</sup> One example of law enforcement linking people who overdose

with treatment is the Camden County Police Department's Operation Save a Life program, which offers those treated for an overdose immediate participation in a 30-day substance use treatment program.<sup>85</sup>

- The Opioid STR award will expand naloxone training for law enforcement agencies in Illinois counties in high need.
- The Heroin Crisis Act expanded access to naloxone under state law, allowing trained pharmacists to dispense naloxone to individuals at risk of overdose, bystanders (e.g., family members and friends of those at risk), and first responders without the need for a prescription. However, because naloxone is still categorized as a prescription medication under federal law—and because reimbursement under some prescription benefit plans, including Medicaid, is denied without a prescription—the intended expansion in access to naloxone has been limited in practice in some areas. Illinois is currently pursuing plans to issue a statewide standing order for naloxone, which would expand naloxone access to individuals and smaller organizations.
- In addition to first responders, community members can play a key role in reversing opioid overdoses. Research has shown that community naloxone distribution programs can reach large populations of high-risk individuals and facilitate large numbers of overdose reversals. In particular, active drug users and individuals who have previously witnessed an overdose are the most likely community members to use naloxone for overdose reversal as well as refill naloxone prescriptions.<sup>86</sup> Increasing access to (and training regarding) naloxone for community members, including bystanders and active opioid users, will be an important future step in achieving our overall goal.
- Individuals who have been rescued from an opioid overdose remain at risk of future overdose. Unfortunately, many return to using opioids as soon as they leave the hospital. EDs are important access points for reaching individuals with OUD. As described above in Strategy 6, the Opioid STR award will fund teams in seven hospitals to directly connect patients in EDs who have been rescued with community treatment. Additionally, research has shown that the vast majority of patients in EDs at risk of opioid overdose accept take-home naloxone when it is offered.<sup>87</sup> In addition to developing OUD screening and MAT/recovery support referrals in EDs, implementing take-home naloxone for at-risk patients in EDs may be a future strategy to consider.

### *Harm Reduction*

Harm reduction is a set of pragmatic strategies aimed at reducing the negative consequences of substance use. The goal of harm reduction is to meet substance users “where they are at,” and try to address the conditions of substance use to minimize their harmful effects. In addition to expanding naloxone access and use, harm reduction interventions aimed at opioid misuse might include such activities as opioid overdose education, educating users on safer injection practices (e.g., syringe hygiene, “tester shots” to determine potency and dosage), and needle exchange programs. Research indicates that harm reduction strategies reduce the spread of HIV and hepatitis B and C, minimize other drug-related adverse health effects, are cost-effective, and save lives. Achieving our overall goal of reducing opioid-related deaths will require strengthening overall harm reduction efforts throughout the state.

## G) Supporting Justice-Involved Populations

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### STRATEGY #9: DECREASE THE NUMBER OF OVERDOSE DEATHS AFTER AN AT-RISK INDIVIDUAL'S IMMEDIATE RELEASE FROM A CORRECTIONAL OR OTHER INSTITUTIONAL FACILITY

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#### Rationale

Individuals with OUD who undergo detoxification and a period of abstinence in institutional facilities (e.g., prison, hospitals, residential rehabilitation) are at an increased risk of fatal opioid overdose in the period immediately after leaving these facilities, particularly after release from correctional facilities.<sup>88,89,90</sup> In the U.S., 65% of individuals in prison meet medical criteria for a substance use disorder, but only 11% receive any type of treatment during their incarceration and fewer still receive evidence-based care.<sup>91</sup> The first month after release from a correctional facility is a period during which individuals are at a greatly increased risk of fatal overdose. This increased risk may be attributable to incarcerated individuals' lowered physical tolerance to drugs as a result of enforced reduction of drug use in prison, as well as their return to negative support systems following release. Formerly incarcerated individuals' return to such milieus can trigger relapse to drug use, putting them at an increased risk of overdose.<sup>92,93</sup>

***There is a need for additional treatment for SUD in the justice-involved population.*** Prison-based treatment followed by aftercare in the community can reduce recidivism and save money over time.<sup>94</sup> In Illinois, half of all individuals entering IDOC were identified as in need of substance abuse treatment; however, less than a third of those needing treatment received any in prison.<sup>95</sup> Despite evidence for its efficacy, limited community resources and a lack of coordination among agencies involved in prison-to-community transition services means that post-release treatment is infrequently provided or not provided at all. Lack of valid state identification and difficulties obtaining health insurance are often significant obstacles to treatment for formerly incarcerated individuals. Additionally, when these individuals are forced to wait for a significant period to access treatment, they become less likely to begin treatment at all.<sup>96</sup>

***There is a need for additional MAT in the justice-involved population.*** Although research has shown that MAT is effective and evidence based, it has not been widely adopted in correctional facilities. Of state prison systems nationwide, only 45% provide inmates with referrals to methadone clinics and only 29% provide inmates with referrals to buprenorphine-therapy clinics upon release.<sup>97</sup> ***Ensuring that MAT is available after release from jail or prison will improve continuity of care in the community; reduce recidivism, relapse, and overdose; increase the quality of life for the justice-involved population; and build the foundation for improving system-wide outcomes.***

#### Current Efforts in Illinois to Reduce Overdose Deaths Upon Release

- IDOC operates 25 adult state correctional centers (CCs) and provides services to inmates with medical and behavioral health treatment. Currently, IDOC operates 11 facilities where SUD treatment is provided.<sup>98</sup>
- In Illinois, a DASA-funded MAT Vivitrol Re-entry Program (administering extended-release injectable naltrexone only) operates at one facility—Sheridan CC. This program involves prison-based treatment at Sheridan CC through the WestCare Foundation (Illinois) and case management after

release through Treatment Alternatives for Safe Communities (TASC). DASA also supports the Vivitrol Re-entry Program in Cook County Jail through Cermak Health Services.

- Within the Illinois Department of Juvenile Justice (IDJJ), all youth are assessed for substance misuse treatment needs at the time of admission. IDJJ offers SUD treatment in all five of its youth correction facilities (Illinois Youth Centers or IYCs) using the Evidence-Based Forward Thinking curriculum. IDJJ offers an inpatient-like therapeutic community setting at IYC St. Charles, IYC Harrisburg, and IYC Chicago, as well as an outpatient-like treatment setting at IYC Warrenville and IYC Pere Marquette. Additionally, IDJJ provides targeted relapse prevention services to individual youth based on treatment needs as well as follow-up referrals and support for youth as they transition back into the community upon release. For particularly high-risk youth, IDJJ also provides more intensive community supervision and support upon re-entry.<sup>99</sup>
- The Medicaid 1115 Demonstration Waiver seeks to ensure that justice-involved individuals are linked with and have relationships with community treatment providers *before* they are released from Illinois correctional facilities. Initiatives under the waiver will restructure intake, pre-release, and release procedures for individuals from IDOC and Cook County Jail to ensure that all Medicaid-eligible individuals are enrolled upon release and auto-assigned/enrolled to a managed care organization at the earliest possible point. These measures will ensure that individuals are linked with and have immediate access to needed OUD treatment upon release.

### ***Law Enforcement: Addressing the Supply of Opioids***

The supply of illicit opioids is a significant driver of the opioid crisis, particularly given the increasing prevalence of fentanyl and other synthetic opioids in illegal markets. Opioid trafficking contributes to violent crime and increases the availability of opioids, subsequently leading to increased negative outcomes and deaths. Law enforcement plays a critical role in addressing opioid trafficking and impacting the supply of illicit opioids.

Law enforcement combats trafficking by investigating and prosecuting illicit opioid distribution networks and making drug seizures. Multi-jurisdictional drug task forces, comprising law enforcement officers from state, county, and local police departments can pool resources and combat drug distribution networks more efficiently and effectively. These task forces work closely with federal agents (*e.g.*, DEA, FBI, ATF, ICE, USFIS) in investigating distribution networks, including the tracing of drug sources to other states and countries. There are currently 22 narcotics teams working throughout Illinois (nine metropolitan enforcement groups and 13 task forces), 19 of which received federal funding administered by ICJIA in federal fiscal year 2016.

Chicago is a High Intensity Drug Trafficking Area (C-HIDTA) that facilitates cooperation among federal, state, and local agencies to share information and implement coordinated enforcement activities. C-HIDTA provides resources, funding, and analytical support to an array of initiatives in Chicago aimed at the opioid crisis. Among these is the Fentanyl Response Initiative (FRI), which was started in 2016 as a collaboration between C-HIDTA, the Chicago Police Department, the Illinois State Police, and the DEA. The FRI uses several sources to track and map locations in Chicago where fentanyl is being distributed. Enforcement activities are then directed to these locations to interdict drug trafficking organizations, reduce the flow of fentanyl, and reduce fatal overdoses.

As the State of Illinois progresses toward the goal of reducing opioid deaths, it will be critical to support and work in parallel with existing law enforcement efforts directed at reducing the supply of illicit opioids.

### Future Areas of Activity and Exploration

- The Opioid STR grant will support four IDHS/DASA-licensed treatment providers to provide pre-release case management services, Vivitrol, and post-release linkage services to persons with OUD who are incarcerated in Illinois county jails in areas of high need.
- The National Commission on Correctional Health Care (NCCHC) supports increased access to and use of naloxone in correctional facilities.<sup>100</sup> NCCHC recommends that correctional and medical staff undergo training that includes education regarding opioid overdose and its signs; correct technique for the administration of naloxone; and essential related procedures, including the performance of cardiopulmonary resuscitation and emergency transfer of the inmate to a facility equipped to treat overdose. Adopting some of these recommendations in Illinois correctional facilities could be a potential future strategy to consider.
- New York has piloted a program in which incarcerated individuals are given training in overdose recognition and response as well as provided with naloxone upon release. Implementing similar naloxone training and take-home naloxone programs in Illinois correctional facilities is a potential future strategy that would reduce overdose deaths of at-risk individuals upon community re-entry.

## Next Steps

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The strategies proposed in this Plan represent the shared consensus and commitment of the State of Illinois to reduce opioid-related deaths by 33% in three years. This Action Plan has set out what Illinois needs to do and why we need to do it. Over the coming months, the State will actively collaborate with other key stakeholders, including the Opioid Crisis Response Advisory Council as well as stakeholders representing minority communities of high need, to build on this framework. We anticipate announcing a more detailed implementation plan thereafter.

Although the State has chosen to focus our overall goal on reducing opioid-related deaths, we recognize that the suffering caused by the epidemic extends beyond just the number of fatalities. Preventing opioid misuse and OUD in the long term will require not only increased awareness of the dangers of opioid misuse in particular, but also persistent efforts to reduce stigma and achieve a broader cultural shift in how we converse about substance misuse in general. Addressing the needs of individuals with OUD will also require sustained investment. The process of beginning and maintaining recovery from OUD requires access to quality care and ongoing services, similar to that of other chronic diseases such as hypertension and diabetes. Like these other chronic conditions, individuals with OUD must have adequate support throughout their lifetime to help them through potential threats to their recovery. To fully address the epidemic, we must continue to strengthen our treatment systems to ensure that people with OUD have access to the services and supports they need to not only attain but also maintain recovery.

Implementing the strategies in this Plan and reducing the number of opioid-related deaths will not mean that the crisis will have been solved. The opioid epidemic developed out of many complex and interacting factors over several decades, and it will require a great deal of sustained collaborative effort to turn the tide. As we move forward with this effort, we will need to pay attention to what the data tell us, be responsive to emerging trends in the environment and changes in best practices, and continue to set ambitious goals to advance the health and well-being of the people of Illinois.

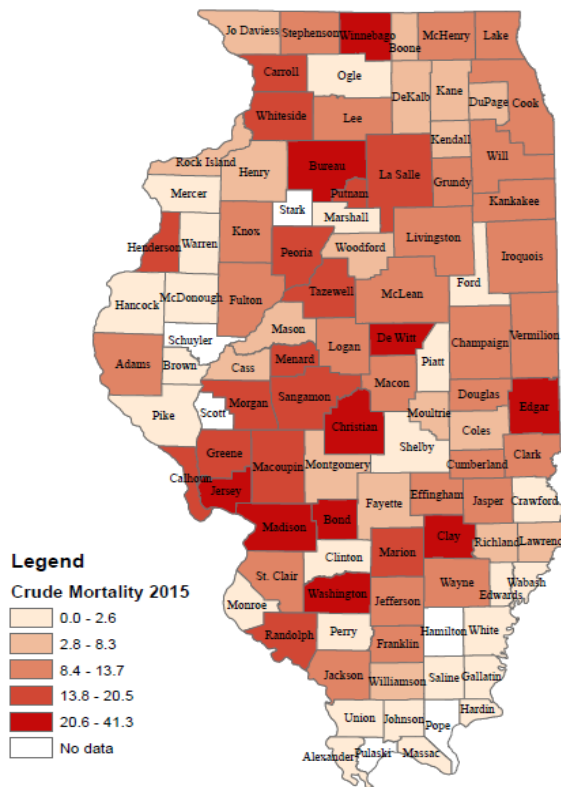


# Appendix 1: Further Information, Data, and Statistics

## THE OPIOID EPIDEMIC

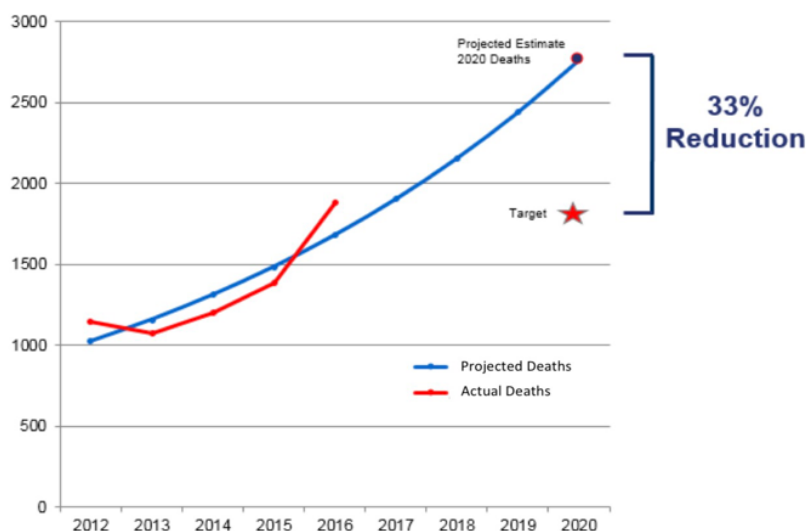
- August 2017 provisional data from IDPH show a 48.8% increase in all drug overdose deaths and a 76.2% increase in opioid overdose deaths from 2013 to 2016. Opioids were a contributing factor in 68% of drug overdose deaths in 2013 and in 80% of drug overdose deaths in 2016. The number of heroin deaths has nearly doubled since 2013: There were 583 heroin-related deaths in 2013 and 1,008 deaths in 2016. The number of opioid analgesic deaths has almost quadrupled: There were 344 opioid analgesic deaths in 2013 and 1,233 deaths in 2016. Opioid analgesics encompass prescription opioids and include natural and semi-synthetic opioid analgesics (e.g., morphine, codeine, oxycodone, hydrocodone, hydromorphone, oxymorphone).
- As the 2015 map below illustrates, the opioid crisis is not a problem confined to metropolitan Chicago—it is an issue that affects communities and individuals throughout Illinois.

Opioid Overdose Related Crude Mortality Rate  
(per 100,000 population) 2015, Illinois



## OPIOID OVERDOSE DEATHS IN ILLINOIS: THE DATA AND THE GOAL

Year	Actual Deaths	Projected Deaths
2012	1149	1021
2013	1072	1157
2014	1203	1310
2015	1382	1484
2016	1889	1680
2017		1903
2018		2155
2019		2441
2020		2765



Projected overdose deaths were estimated using overdose data from prior years and applying a best fit model. As can be seen, overdose deaths are increasing exponentially, and in 2016, actual overdose deaths exceeded projections by more than 200.

### ADOLESCENT OPIOID USE AND MISUSE

- In 2015, 276,000 adolescents in the U.S. were current non-medical users of opioids, with 122,000 reporting an addiction to prescription opioids.<sup>101</sup> An estimated 21,000 adolescents had used heroin in the past year and an estimated 5,000 were current heroin users.<sup>102</sup> Approximately 88,000 Illinois adolescents per year in 2013-2014 reported using illicit drugs (including heroin) in the past year and 40,000 teens per year reported non-medical use of prescription opioids.<sup>103</sup>
- Studies suggest that involvement with substance use early in life increases the risk of use and abuse later in life.<sup>104</sup> The majority of substance use treatment admissions among individuals aged 18-30 report beginning substance misuse in their adolescent years, highlighting the importance of interventions targeted toward youth and their families to promote prevention.<sup>105</sup> Easy access to prescription opioids in the household has also been shown to be a risk factor for developing an SUD.

### PRESCRIPTION MONITORING PROGRAMS

#### ■ Research

Analysis of aggregate Medicaid utilization data in 20 states using PMPs found reductions of 9%–10% in Schedule II opioid prescriptions among states that included a mandate.<sup>106</sup> Individual states have also documented positive outcomes. In a one-year period, New York state had a 75% drop in patients seeking prescriptions for the same drugs from multiple providers. In Florida, the combination of PMP requirements and a regulation that prohibited dispensing opioids from health care offices saw a 52% decrease in oxycodone overdose deaths over a two-year period.<sup>107</sup> A study of Ohio emergency departments using PMP data found that 41% of providers changed their opioid prescribing practices after reviewing data, with 61% prescribing fewer or no opioids than initially planned.<sup>108</sup>

### ■ **PMP Use in Illinois: The Numbers**

As of April 2017, 34,000 users (24,000 of which were prescribers) were enrolled in the ILPMP out of an estimated 114,000 potential users. Of these users, only 21,000—18.4% of all potential users in the state—were actively using the ILPMP.

## **NALOXONE**

### ■ **Research**

A study of 2,912 opioid users at risk of overdose and 19 communities over seven years found that communities with naloxone programs had significantly reduced opioid overdose fatalities. A meta-analysis of 21 studies found that naloxone training and education programming led to higher survival rates when implemented in communities.<sup>109</sup>

### ■ **Naloxone Access in Illinois: The Numbers**

- The Drug Overdose Prevention Law (PA 096-0361), passed in January 2010, made it legal in Illinois for non-medical persons to administer naloxone to another individual to prevent an opioid overdose fatality. This Act also allowed IDHS/DASA to establish and authorize programs to distribute naloxone. IDHS/DASA has since developed processes and guidelines to assist programs with operating as “enrolled programs” under its Drug Overdose Prevention Program (DOPP). To date, IDHS/DASA has enrolled 717 program sites in 33 counties. In addition, more than 90,000 individuals have been trained to administer naloxone, which has resulted in more than 11,000 overdose reversals.<sup>110</sup>
- A 2016 survey of Illinois police chiefs and sheriffs found 34% of responding law enforcement agencies reported they had no officers trained to administer naloxone. By contrast, of the responding agencies, 92% reported paramedics and 63% reported firefighters in their respective jurisdictions carried naloxone. In the same study, of law enforcement agencies who reported heroin or prescription drugs to be very problematic in their area, 38% reported that none of their officers carried naloxone and 25% reported that their officers were not trained in administering naloxone.<sup>111</sup>

## **TREATMENT AND RECOVERY: ADDITIONAL INFORMATION ABOUT MEDICATION-ASSISTED TREATMENT**

- **Methadone vs. buprenorphine:** Both methadone and buprenorphine are opioid agonist medications that are used as long-term maintenance therapy to assist with treatment of OUD (methadone is a full agonist and buprenorphine a partial agonist). The efficacy of methadone/buprenorphine-assisted treatment in treating OUD has been well established. Both of these medications have been shown to similarly improve outcomes, but most studies suggest that methadone-based treatment is associated with higher rates of patient retention. Methadone is also less expensive than buprenorphine. On the other hand, buprenorphine has been shown to be somewhat safer than methadone during the initiation of treatment and is associated with less sedation and respiratory depression. Buprenorphine is also theoretically more accessible than methadone, as trained physicians that are “waivered” under the Drug Treatment Act of 2000 (DATA) are authorized to provide it in-office (by contrast, methadone is more tightly regulated and can only be provided in a licensed methadone clinic).<sup>112</sup>
- **Naltrexone** is an opioid antagonist that blocks the effects of opioids.<sup>113</sup> A patient must be detoxed and opioid-free for 7 to 10 days prior to the initiation of naltrexone. While naltrexone has been approved for the treatment of OUD since the 1980s, in the form of oral daily pills, adherence is generally poor and oral naltrexone for treating OUD has been found to not be any superior to placebo or no medication at all.<sup>114</sup> Extended-release injectable naltrexone (Vivitrol) was approved by

the FDA for OUD treatment in 2010 and has been shown to be more effective at preventing relapse than placebo,<sup>115</sup> but there have been no studies directly comparing its efficacy as compared to methadone or buprenorphine. In the justice-involved population, Vivitrol has been shown to possibly decrease the rate of relapse and increase the median time to relapse.<sup>116</sup> The inhibition of any physical response to opioids by naltrexone means that an opioid “high” is practically impossible to achieve while naltrexone is active in the body and overdose risk is significantly reduced. However, extended periods of abstinence from opioids, whether pharmaceutically induced by Vivitrol or otherwise, decreases physical tolerance to opioids, which greatly increases an individual’s risk of fatal overdose in the event of a relapse (*i.e.*, if an individual relapses when there is no active naltrexone in their body).<sup>117</sup> Additionally, the blockade of opioid receptors by naltrexone is not insurmountable. Patients who take large amounts of opioids in an attempt to overcome the opioid blockade could possibly face fatal overdose.

## TREATMENT AND RECOVERY: ACCESS TO CARE IN ILLINOIS

- In Illinois during state fiscal year (SFY) 2015, 14,282 primary opioid admissions (accounted for by 9,942 individual patients) were to levels of care other than detoxification.
- In SFY 2015, there were 66,427 total admissions to IDHS/DASA-funded treatment services. A total of 19,289 (29%) of these admissions were for individuals who indicated opioids as their primary substance of abuse. Only 14.9% of these primary opioid admissions to IDHS/DASA were accounted for by admissions to OMT.
- IDHS/DASA currently funds 5,631 OMT slots throughout Illinois. During SFY 2015, 2,125 people with OUD were admitted to OMT through these state-supported slots. The differential between the number of slots and the number of annual admissions is attributable to the length of time that most OMT clients remain in treatment. A total of 7,530 unduplicated clients were served through state-supported OMT in SFY 2015.

## OPIOID OVERDOSE DEATHS FOLLOWING RELEASE FROM A CORRECTIONAL FACILITY

- **Research**
  - There is an increased risk of drug-related death immediately after release from prison, particularly in the first two weeks after release and extending into the second two weeks. In a meta-analysis of six studies, there was a three- to eightfold increased risk of drug-related death in the first two weeks after release from prison compared with the subsequent 10 weeks.<sup>118</sup>
  - Incarcerated individuals frequently return to environments that strongly trigger relapse to drug use and put them at risk of an overdose. In a qualitative study of formerly incarcerated individuals, researchers found the social isolation from friends and family members who were still actively using was particularly difficult after release.<sup>119</sup> Interventions to prevent overdose after release from prison may benefit, such as structured treatment with gradual transition to the community, enhanced protective factors, and reductions of environmental triggers to use drugs.
- **Substance Use Disorder and Justice-Involved Individuals in Illinois: The Numbers**
  - In Illinois in 2016, 52% of persons entering IDOC were identified as needing substance use treatment. However, only approximately 30% received treatment in prison.<sup>120</sup> Between 2016 and 2017, out of 928 youths assessed in IDJJ facilities, 755 had a substance use disorder, and 57 had OUD.<sup>121</sup>
  - A 2011 Illinois study found inmates who successfully completed or were still enrolled in post-release aftercare had a 44% lower likelihood of recidivism than a comparison group.<sup>122</sup>

## DIVERSION PROGRAMS: EARLY SUCCESSES

- In the first year of operation of the Gloucester Angel Program in Massachusetts, 376 individuals presented to the Gloucester Police Department for assistance. In 94.5% of these cases, police were able to offer direct treatment placement. And of those offered placements, 95% entered their assigned program.<sup>123, 124</sup>
- Four evaluations of the Law Enforcement-Assisted Diversion (LEAD) program in Washington have shown positive initial results. Research found statistically significant differences in recidivism between LEAD participants and a comparison group. LEAD participants had 60% lower likelihood of arrest at six months than a comparison group. After four years, LEAD participants were 58% less likely to be arrested compared to the control group. On average, LEAD participants had 1.4 fewer jail bookings per year, spent 39 fewer days in jail per year, and had 87% lower odds of at least one period of incarceration after entry into LEAD.<sup>125, 126</sup>
- Another example of a pre-arrest diversion model featuring police outreach is the Arlington Opioid Outreach Initiative in which behavioral health practitioners proactively contact individuals identified by police as having an SUD or having experienced an overdose. Researchers from the Boston University School of Social Work are evaluating the program.<sup>127</sup>

## Appendix 2: Illinois Opioid Crisis Response Advisory Council Members<sup>†</sup>

Illinois Opioid Crisis Response Advisory Council Members	
<b>ADAPT Pharma</b>	Jonathon Bloomfield, Senior Director of Government Affairs
<b>Administrative Office of the Illinois Courts</b>	Kelly Gallivan-Ilarraza, Problem Solving Court Coordinator Richard Adkins, Assistant Director
<b>Alkermes</b>	Adam Rondeau, Director, Policy & Government Relations
<b>AMITA Alexian Brothers Neurosciences Institute</b>	Ankur Dave, MD, Interventional Pain Management Specialist
<b>Bartonville Police Department</b>	Brian Fengel, Police Chief
<b>Catholic Charities of the Archdiocese of Chicago</b>	Debbie Shepard, Program Director
<b>Center for the Application of Prevention Technologies</b>	Chuck Klevgaard, Regional Coordinator Erin Ficker, Associate Coordinator Central Region
<b>Champaign County Coroner</b>	Duane Northrup, Coroner
<b>Chestnut Health Systems</b>	Russ Hagen, CEO Alan Markwood, Corporate Director of Prevention Services Donna Nahlik, Director Joan Hartman, Vice President of Behavioral Health Chris Scott, Director, Lighthouse Institute
<b>Chicago High Intensity Drug Trafficking Area</b>	Nicholas Roti, Executive Director Nicole Fox, Counterdrug Intelligence Analyst
<b>Chicago Recovery Alliance</b>	Dan Bigg, Director
<b>Chicago Urban League</b>	Kathie Kane-Willis, Director of Policy
<b>Chicago Department of Public Health</b>	Elizabeth Salisbury-Afshar, MD, MPH, FAAFP, FASAM, Medical Director
<b>Cook County Health and Hospital Systems</b>	Stephen Aks, DO, Toxicology Director, Department of Emergency Services Juliegh Nowinski-Konchak, MD, Physician Lead Kathy Chan, Director of Policy Leticia Reyes-Nash, Director of Programmatic Services and Innovation
<b>Cook County Medical Examiner's Office</b>	Ponni Arunkumar, Cook County Medical Examiner
<b>Community Behavioral Healthcare Association of Illinois</b>	Marvin Lindsey, Chief Executive Officer Blanca Campos, Public Policy Associate
<b>DePaul University &amp; Chicago Recovery Alliance</b>	Suzanne Carlberg-Racich, Assistant Professor Outreach & Research
<b>Dixon Police Department</b>	Danny Langloss, Chief

<sup>†</sup> The Council is the statewide group that will work with the State to develop the implementation plan—the next step in our state response to the opioid epidemic. Membership list as of June 2017, collected via Council meeting attendance logs. Membership in the Council is open to **all** interested stakeholders.

<b>Illinois Opioid Crisis Response Advisory Council Members</b>	
<b>DuPage County Coroner</b>	Richard Jorgensen, Coroner
<b>DuPage County Health Department</b>	Karen Ayala, Executive Director Chris Hoff, Assistant Director of Community Health Resources Mila Tsagalis, Director of Community Initiatives
<b>Drug Enforcement Agency, Chicago Field Division</b>	Daniel J. Gillen, Diversion Program Manager Dennis Wichern, Special Agent in Charge
<b>Helen Wheeler Center for Community Mental Health</b>	Jackie Haas, President/CEO
<b>Heritage Behavioral Health, Inc.</b>	Bruce Angleman, Association Representative
<b>Illinois Academy of Family Physicians</b>	Vincent D. Keenan, Executive Vice President
<b>Illinois Advisory Council on Alcoholism and Other Drug Dependency</b>	Ron Vlasaty, Chairperson
<b>Illinois Association of Behavioral Health</b>	Sara Howe, CEO Eric F. Foster, Vice President, Substance Abuse Policy and COO
<b>Illinois Association of Chiefs of Police</b>	Ed Wojcicki, Executive Director
<b>Illinois Association of Rehabilitation Facilities</b>	Emily Miller, Director of Policy for Behavioral Health
<b>Illinois Board of Higher Education</b>	Cindy Deitsch, Secretary to the Board
<b>Illinois Board of Nursing</b>	Jerry Miller, Board Liaison
<b>Illinois Coroners and Medical Examiners Association</b>	Amy Winas, President
<b>Illinois Criminal Justice Information Authority</b>	John Maki, Executive Director Jessica Reichert, Research Manager
<b>Illinois Department of Child and Family Services</b>	George Sheldon, Director Sam Gillespie, AOD Administrator
<b>Illinois Department of Corrections</b>	John N. Nunley, Manager Addiction Recovery Services Tracey B. Williams, Assistant to the Director
<b>Illinois Department of Financial and Professional Regulation</b>	Bryan Schneider, Secretary Jessica Baer, Acting Director Alex Cooper, Associate General Counsel Brian S. Zachariah, Chief Medical Coordinator
<b>Illinois Department of Healthcare and Family Services</b>	Felicia Norwood, Director Arvind Goyal, Medical Director Kristine Herman, Bureau Chief, Behavioral Health Mark Huston
<b>Illinois Department of Human Services</b>	James Dimas, Secretary Fred Flather, Chief of Staff

## Illinois Opioid Crisis Response Advisory Council Members

<b>Illinois Department of Human Services, Division of Alcoholism and Substance Abuse</b>	Maria Bruni, Acting Assistant Secretary of Programs, Acting Director Division of Alcoholism and Substance Abuse Danielle Kirby, Deputy Director Richard Sherman, Opioid STR Project Director Richard Weisskopf, Program Manager Rosie Gianforte, Prevention Program Coordinator Kimberly Fornero, Bureau Chief, Prevention and Program Services Seth Eisenberg, Medical Director
<b>Illinois Department of Human Services, Division of Developmental Disability Services</b>	Greg Fenton, Director
<b>Illinois Department of Human Services, Division of Family and Community Services</b>	Diane Grigsby Jackson, Director Karrie Rueter, Associate Director, Office of Community and Positive Youth Development
<b>Illinois Department of Human Services, Division of Mental Health</b>	Diana Knaebe, Director
<b>Illinois Department of Human Services, Illinois Prescription Monitoring Program</b>	Meta Jo Floyd, PMP Director Craig Berberet, PMP Manager Sarah Pointer, Clinical Manager Edward Dowllar, Clinical Database Coordinator Michael Patton, OCAPS Director Stan Murzynski, IT Director
<b>Illinois Department of Human Services, Office of Innovation, Strategy, and Performance</b>	Bruce Bendix, Director Matt Coyne, Lead Analyst
<b>Illinois Department of Human Services, Office of Legislation</b>	Jennifer Aring, Director of Legislative Affairs JB Meier, Deputy Director of Legislative Affairs Gloria Simmons, Legislative Affairs Liaison
<b>Illinois Department of Insurance</b>	Matt Ryan, Chief of Staff Carol West, Regional Outreach Coordinator
<b>Illinois Department of Juvenile Justice</b>	Heidi Mueller, Director Debi Rauch, Regional Director Wells Center
<b>Illinois Department of Public Health (IDPH)</b>	Nirav D. Shah, MD, JD, Director Donald G. Kauerauf, Assistant Director Jennifer Layden, MD, Chief Medical Officer Mai Pho, MD, MPH, Medical Advisor for Health Research and Policy Amanda Kim, JD, Head of Strategic Health Initiatives Allison Hasler, Health Officer
<b>Illinois General Assembly</b>	Lou Lang, Representative 16 <sup>th</sup> District, Assistant Majority Leader Mattie Hunter, Senator 3 <sup>rd</sup> District
<b>Illinois Health and Hospital Association</b>	Michael Wahl, Medical Director
<b>Illinois Law Enforcement Alarm System</b>	Dave Fellows, Regional Planning Coordinator
<b>Illinois Mental Health Collaborative</b>	Trenda Hedges, Recovery Team Manager
<b>Illinois Nurses Association</b>	Alice Johnson, Executive Director Julia Bartmes, Staff Specialist Atty
<b>Illinois Pharmacist Association</b>	Garth Reynolds, Executive Director Tim Oyer, Student Pharmacist



<b>Illinois Opioid Crisis Response Advisory Council Members</b>	
<b>Illinois Primary Health Care Association</b>	Rajesh Parikh, MD, Vice President, Clinical Services and Workforce Development
<b>Illinois Psychiatric Society</b>	Meryl Sosa, Executive Director
<b>Illinois Sheriffs Association</b>	Michael McCoy, President
<b>Illinois Society for Advanced Practice Nursing</b>	Susan Swart, Executive Director
<b>Illinois State Board of Education</b>	Tony Smith, PhD, State Superintendent Jessica Gerdes, Principal Consultant
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<b>Illinois State Medical Society</b>	David Porter, VP Health Policy
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<b>Live4Lali</b>	Chelsea Laliberte, Executive Director
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<b>Office of Lieutenant Governor Evelyn Sanguinetti</b>	Susan Bence, Springfield Director & Legislative Liaison
<b>Office of the State Fire Marshal</b>	Greg Hay, Fire Service Outreach Coordinator
<b>Perfectly Flawed Foundation</b>	Luke Tomsha
<b>Popovits Law Group</b>	Renee Popovits, Principal Attorney
<b>Positive Sobriety Institute</b>	Fran Langdon, MD, Medical Consulting Physician
<b>Prevent Child Abuse Illinois</b>	Ron Harley, Director
<b>Prevention First</b>	Karel Homrig, Executive Director
<b>Rock Island County Coroner</b>	Brian Gustafson, Coroner
<b>Substance Abuse and Mental Health Services Administration</b>	Jeffrey A. Coady, Regional Administrator

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<b>Treatment Alternatives for Safe Communities, Inc.</b>	Sherie Arriazola, Director of Payer and Healthcare Strategy
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<b>Will County Executive</b>	Nick Palmer, Chief of Staff Kathleen Burke, Project Coordinator
	Maya Doe-Simkins, Consultant (no organizational affiliation)

# List of Abbreviations

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BPCSS: Bureau of Pharmacy and Clinical Support Services

CC: Correctional Center

CCHHS: Cook County Hospital and Health Care System

CDC: Centers for Disease Control and Prevention

C-HIDTA: Chicago High-Intensity Drug Trafficking Area

CPD: Chicago Police Department

CSAT: Center for Substance Abuse Treatment

DASA: Division of Alcoholism and Substance Abuse

DATA: Drug Addiction Treatment Act

DEA: Drug Enforcement Agency

DOPP: Drug Overdose Prevention Program

ED: Emergency Department

EHR: Electronic Health Record

ER: Emergency Room

FDA: U.S. Food and Drug Administration

FQHC: Federally Qualified Health Center

FSMB: Federation of State Medical Boards

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

HRSA: Health Resources and Services Administration

ICJIA: Illinois Criminal Justice Information Authority

IDFPR: Illinois Department of Financial and Professional Regulation

IDHFS: Illinois Department of Healthcare and Family Services

IDHS: Illinois Department of Human Services

IDJJ: Illinois Department of Juvenile Justice

IDPH: Illinois Department of Public Health

IDOC: Illinois Department of Corrections

IDOI: Illinois Department of Insurance

IHHA: Illinois Health and Hospital Association

IHSA: Illinois High School Association

ILPMP: Illinois Prescription Monitoring Program

ISBE: Illinois State Board of Education

IT: Information Technology

IYC: Illinois Youth Center

IYS: Illinois Youth Survey

LEAD: Law Enforcement-Assisted Diversion

MAT: Medication-Assisted Treatment

NAS: Neonatal Abstinence Syndrome

NCCHC: National Commission on Correctional Health Care

NIDA: National Institute on Drug Abuse

NIH: National Institutes of Health

NSDUH: National Survey on Drug Use and Health

OCAPS: Office of Clinical, Administrative, and Program Support

OMT: Outpatient Methadone Treatment

Opioid STR: Illinois' State Targeted Response to the Opioid Crisis Grant

OUD: Opioid Use Disorder(s)

PAARI: Police Assisted Addiction and Recovery Initiative

PDOA: Prescription Drug and Opioid Addiction

PMP: Prescription Monitoring Program

SAMHSA: Substance Abuse and Mental Health Services Administration

SFY: State Fiscal Year

SHIP: State Health Improvement Plan

SPA: State Plan Amendment

STEER: Stop, Triage, Engage, Educate, and Rehabilitate

SUD: Substance Use Disorder(s)

TASC: Treatment Alternatives for Safe Communities

WHO: World Health Organization

WNDTI: Westside Narcotics Diversion and Treatment Initiative

# Endnotes

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