

161554 - Work Plan Draft (as of 10-17-17)

2018-2022 WORK PLAN

INTRODUCTION

Drug overdoses, driven largely by overdoses related to the use of opioids, are now the leading cause of unintentional injury deaths in the United States. In order to stem the tide and reverse the 15 year trend in increasing drug overdose deaths a coordinated multi-disciplinary community participatory multi-faceted approach is needed to address this unprecedented public health crisis. This work plan serves as the City and County of Milwaukee's initial strategic plan for action.

Overview of Opioids

Opioids are a class of drugs that act on the body's opioid receptors including natural, semi-synthetic and (GA Opioid Plan) synthetic opioids. Natural opioids include drugs such as morphine, which are derived from the resin of the opium poppy, semi-synthetic opioids such as hydrocodone and oxycodone, and synthetic opioids such as fentanyl and methadone. Opioids are often used medically to relieve moderate to severe pain, but can also be used for other conditions -for example, to suppress cough, to treat diarrhea and even to treat opioid use disorder. Opioids are very effective for treating severe pain such as that associated with cancer, post-surgery, or accident-related injuries. While opioids provide pain relief, they also cause physical dependence, respiratory depression, euphoria, reduced intestinal motility and other desired and undesired effects. Since these pharmacologic effects focus on blocking pain, opioids have high potential for misuse. (GA Opioid Plan)

Opioid drugs mimic the body's natural response to pain by stimulating the body's opioid receptors, most prominently the Mu (μ) receptors. Mu receptors account for most of the effects of opioids and are primarily located in the brain, spinal cord, peripheral nervous system, and intestinal tract. By stimulating the Mu receptors, opioids reduce the perception of pain by slowing down and blocking pain signal transmission to the brain while also triggering the release of dopamine, a neurotransmitter used in the brain's pleasure or reward system. When activated, dopamine produces a pleasurable and often euphoric feeling. Use of opioids for more than a short period of time leads to tolerance and physical and psychological dependence. This means opioid users must take larger doses of opioids over time to achieve the same effect. Additionally, opioid users must not stop taking these drugs abruptly, or they will experience withdrawal symptoms such as agitation, anxiety, muscle and bone pain, insomnia, vomiting or diarrhea. Withdrawal symptoms occur when the amount of opioids used decreases or stops. (GA Opioid Plan)

According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), opioids "are a class of drugs chemically similar to alkaloids found in opium poppies." Prescription opioids include codeine (cough suppressant); fentanyl (a synthetic opioid that can be manufactured illegally as well); and morphine, hydrocodone, and oxycodone (painkillers). Per SAMHSA, "repeated use of opioids greatly increases the risk of developing an opioid use disorder [addiction]... [and that] use of illegal opiate drugs such as heroin [or other synthetic opioids] and the misuse of legally available pain relievers such as oxycodone and hydrocodone can have serious negative health effects."

Overview of Cocaine

Cocaine is a powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. Although health care providers can use it for valid medical purposes, such as local anesthesia for some surgeries, cocaine is an illegal drug. (National Institute of Drug Abuse, 2017)

Cocaine can be found in a number of forms, including white powder, paste, or solidified and rock-like (the latter commonly referred to as "crack cocaine"). Whatever the form, cocaine acts as a strong stimulant substance that can:

- Provide a rapid-onset, rewarding high.
- Speeds up various physiologic processes via its central nervous system effects.
- Influence both short- and long-term mental health.

Street dealers often mix it with things like cornstarch, talcum powder, or flour to increase profits. They may also mix it with other drugs such as the stimulant amphetamine.

Dependent on the method with which it is used—e.g., smoked, snorted or injected—cocaine can be quite rapidly acting. One of cocaine's effects in the brain is to increase dopamine release. Dopamine is a neurotransmitter that plays a role in the brain registering positive feelings, and "rewarding" the behaviors that led to those feelings to begin with. This increase of dopamine is, in part, what leads to the subjective "high" of cocaine use and its addictive power.

Cocaine's effects appear almost immediately after a single dose and disappear within a few minutes to an hour. Small amounts of cocaine usually make the user feel euphoric, energetic, talkative, mentally alert, and hypersensitive to sight, sound, and touch. The drug can also temporarily decrease the need for food and sleep. Some users find that cocaine helps them perform simple physical and intellectual tasks more quickly, although others experience the opposite effect.

The duration of cocaine's euphoric effects depend upon the route of administration. The faster the drug is absorbed, the more intense the resulting high, but also the shorter its duration. Snorting cocaine produces a relatively slow onset of the high, but it may last from 15 to 30 minutes. In contrast, the high from smoking is more immediate but may last only 5 to 10 minutes.

Short-term physiological effects of cocaine use include constricted blood vessels; dilated pupils; and increased body temperature, heart rate, and blood pressure. Large amounts of cocaine may intensify the user's high but can also lead to bizarre, erratic, and violent behavior. Some cocaine users report feelings of restlessness, irritability, anxiety, panic, and paranoia. Users may also experience tremors, vertigo, and muscle twitches.

Severe medical complications can occur with cocaine use. Some of the most frequent are cardiovascular effects, including disturbances in heart rhythm and heart attacks; neurological effects, including headaches, seizures, strokes, and coma; and gastrointestinal complications, including abdominal pain and nausea. In rare instances, sudden death can occur on the first use of cocaine or unexpectedly thereafter. Cocaine-related deaths are often a result of cardiac arrest or seizures. Many cocaine users also use alcohol, and this combination can be particularly dangerous. The two substances react to produce cocaethylene, which may potentiate the toxic effects of cocaine and alcohol on the heart.

The combination of cocaine and heroin is also very dangerous. Users combine these drugs because the stimulating effects of cocaine are offset by the sedating effects of heroin; however, this can lead to taking a high dose of heroin without initially realizing it. Because cocaine's effects wear off sooner, this can lead to a heroin overdose, in which the user's respiration dangerously slows down or stops, possibly fatally.

Over time cocaine alters the chemical pathways in the brain. Users may develop tolerances leading to higher doses and binge using. Regularly snorting cocaine can lead to loss of sense of smell, nosebleeds, problems with swallowing, hoarseness, and an overall irritation of the nasal septum leading to a chronically inflamed, runny nose. Smoking crack cocaine damages the lungs and can worsen asthma. People who inject cocaine have puncture marks called tracks, most commonly in their forearms, and they are at risk of contracting infectious diseases like HIV and hepatitis C

Risk for HIV and Hepatitis C

Drug intoxication and addiction can compromise judgment and decision-making and potentially lead to risky sexual behavior, including trading sex for drugs, and needle sharing. This increases an opioid or cocaine user's risk for contracting infectious diseases such as HIV and hepatitis C (HCV).

TALK ABOUT OPIOID HIV OUTBREAK INDIANA

Cocaine users with HIV often have advanced progression of the disease, with increased viral load and accelerated decreases in CD4+ cell counts. Infection with HIV increases risk for co-infection with HCV, a virus that affects the liver. Co-infection can lead to serious illnesses—including problems with the immune system and neurologic conditions. Liver complications are very common, with many co-infected individuals dying of chronic liver disease and cancer. Although the link between injection drug use and HIV/HCV is well established, more studies are needed to understand the molecular mechanisms underlying this increased risk of co-infection in non-injecting substance users.

The interaction of substance use, HIV, and hepatitis may accelerate disease progression. For example, HIV speeds the course of HCV infection by accelerating the progression of hepatitis-associated liver disease. Research has linked HIV/HCV co-infection with increased mortality when compared to either infection alone. Substance use and co-infection likely negatively influence HIV disease progression and the ability of the body to marshal an immune response.

<https://www.drugabuse.gov/publications/research-reports/cocaine/are-cocaine-abusers-risk-contracting-hiv-aids-hepatitis-b-c>

Talk about HEP C and HIV In Milwaukee

Scope of the Public Health Crisis

The misuse of opioids, heroin, and related synthetic analogs and cocaine (in both powder and crack form) had resulted in a significant and unmitigated risk to the public health and safety of the community. Americans comprise 4.6% of the world's population, yet consume 80% of the global prescription opioids, as well as two-thirds of the world's illegal drugs. The Centers for Disease Control and Prevention has characterized prescription opioid use as a public health epidemic in the United States. People who misuse prescription opioids may progress to use of heroin and other types of synthetic analogs. "Opioid use disorder" is now recognized as a clinically valid chronic disease diagnosis requiring medical and behavioral therapy. Opioid, heroin, and synthetic analog and cocaine use, addiction, and overdose are problems that affect an increasingly wide demographic of residents of the City of Milwaukee and Milwaukee County, including pregnant women and newborns. According to the Milwaukee County Medical Examiner's Office, heroin-related overdose deaths in Milwaukee County comprised 90 percent of the 251 drug overdose deaths in 2015.

The U.S. Drug Enforcement Agency has announced that Milwaukee will be the second of four cities in the Midwest to take part in a pilot comprehensive diversion control law enforcement and prevention “360 Degree Strategy” to help cities dealing with the opioid misuse and heroin epidemic linked to violent crime. The City of Milwaukee recognizes a need for taking a proactive and prevention-oriented approach to the assurance of public health and safety of the community. Many residents of the City and County who misuse or suffer from addiction to opioids, heroin, and synthetic derivatives, and cocaine are stigmatized from seeking treatment from medical providers. It is against this backdrop that Ald. Michael Murphy, representing the 10th District, sponsored the resolution creating this Task Force to develop and recommend meaningful evidence-based solutions to the growing problem of heroin, opioid, and cocaine misuse, addiction, and overdose.

It is now recognized by public health experts at every level of government that overdose deaths associated with heroin and prescription opioid pain relievers are epidemic in the U.S. Nearly 10 million Americans report misusing opioids. More than half of Americans (56%) say that they or someone they know has misused, been addicted to, or died from prescription pain medications.

The Centers for Disease Control and Prevention (CDC) reports that since 1999, overdose deaths involving opioids have nearly quadrupled. Every day in the U.S., 78 Americans die from opioid overdoses. Furthermore, six in ten drug overdose deaths involve opioids. In 2014, opioids were involved in 28,647 fatalities, becoming the leading cause of accidental death in the U.S.

To bring this issue closer to home, in Milwaukee County, heroin and opioid overdose deaths between 2005-14 eclipsed combined deaths associated with motor vehicle accidents and homicides during the same period of time. The average age of the overdose victim during this time frame was 43 years, with 67% of the 888 deaths being of white ethnicity/ race. By contrast, the median age in Milwaukee County in 2014 was 34 years, and 62% of the population reported being of white race/ ethnicity.

Perhaps most surprising is an April 2016 Kaiser Health Tracking Poll that found most Americans believe the federal government is not doing enough to combat recent increases in the number of people who are addicted to prescription painkillers (66%) or heroin (62%). The poll found similar public views regarding state governments and doctors who prescribe painkillers.

In short, there is compelling evidence that prescription pain relief opioids are driving the overdose epidemic. The highly addictive nature of these drugs has also fueled the subsequent explosion in heroin and other synthetic opioid use and overdose. The epidemic has touched persons from every walk of life in families, workplaces, and within community social networks.

At the urging of other Common Council members, cocaine, including crack forms, was also added to the charge of this task force. There is long-standing historical trauma related to the way in which the cocaine epidemic of the 1980s and 90s was handled, with mass incarceration and little focus on treatment. Deaths due to cocaine overdose are much fewer than those of opioids or heroin. According to data from the Milwaukee County Medical Examiner’s office, from 2011-16, there were 97 deaths due to cocaine intoxication. Despite this number appearing low, it may not be the best measure of the severity of the problem in the Milwaukee community. Many heroin and opioid overdose victims also have cocaine present in their systems at the time of death. And Impact, a Milwaukee County treatment access point, has stated that it is seeing a slight increase in the number of people seeking treatment who identify

cocaine or crack as their primary drug of choice. While cocaine and heroin differ significantly in their chemical make-up and how they affect the body, many of the interventions that focus on treatment and destigmatization of substance use disorder are likely to be beneficial to people regardless of their specific primary drug of use.

City-County Heroin, Opioid, and Cocaine Task Force

The City-County Heroin, Opioid, and Cocaine Task Force (CCHOCTF) was established by Common Council File Number 161061 on January 18, 2017, to study the problem of rising prevalence of opioid, heroin, and synthetic analogs and cocaine (in both powder and crack form) misuse and addiction in Milwaukee, and to make evidence-based recommendations to reduce fatal and nonfatal overdose within the community.

The City-County Heroin, Opioid, and Cocaine Task Force is charged with investigating and making recommendations regarding ways to ensure long-term health and safety of City and County residents by reducing fatal and nonfatal overdose from misuse of opioids, heroin, and synthetic analogs, and cocaine (in both powder and crack form) through data-driven public health prevention approaches. (City of Milwaukee Resolution 161061).

The Milwaukee City-County Opioid, Heroin, and Cocaine Task Force Work Plan outlines the goals, strategies and actions that are being implemented by a number of stakeholders across diverse professional disciplines and communities. This working plan outlines both current efforts as well as new proposed actions to scale up response and will be regularly updated as the epidemic and response evolve over time.

PLAN OVERVIEW

The Milwaukee City-County Opioid, Heroin, and Cocaine Task Force Work Plan includes six priority goals:

1. Increase naloxone availability in the community
2. Enhance community-based options for easy, safe, and environmentally friendly medication disposal.
3. Promote community understanding of pain, pain management and substance abuse disorders to achieve a reduction in opioid exposure in order to reduce risk of individuals developing abuse of other medications including heroin and cocaine
4. Assure there is adequate access to timely, affordable, and quality services for substance use disorders.
5. Maintain and enhance availability and quality of timely data about heroine, opioids, and cocaine use, its outcomes and risk factors
6. Enhance collaboration between community-based initiatives and government agencies

Collectively, the goal, strategies and specific actions span across the social-ecological framework to target:

- **Individuals:** Those who use prescription opioids and/or heroin at any level of use or dependence ranging from the population as a whole to subset of the population such as adolescents or clients of syringe exchange programs. It also includes interventions targeting professionals such

as healthcare care providers, pharmacists, first responders/law enforcement, social service providers and chemical dependency professionals.

- Neighborhood / Community such as schools, workplaces, organizations, peer support groups, and
- Society and Systems: Includes policies, financing structures, and information systems in medical, public health, criminal justice and other fields.

Proposed goals, activities and strategies under this work plan span the entire continuum of care to include:

- Prevention - Prevention, as defined by the SAMHSA Center for Substance Abuse Prevention (CSAP) is "A process that empowers individuals to meet the challenges of life by creating and reinforcing healthy behavior and lifestyles and by reducing the risks that contribute to alcohol, tobacco and other drug misuse and abuse.;
- Early Intervention - Early intervention aims to reduce the risk of harm and decrease problem behaviors that result from continued use of substances. The intent of the intervention is to take action that decreases risk factors related to substance use, abuse or dependency; enhance protective factors; and provide ongoing services, as appropriate; .
- Treatment – Treatment is intended to improve social functioning through complete abstinence from alcohol and drugs for individuals diagnosed with chemical dependency. Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from substance abuse/dependency and is designed to help that person achieve and maintain sobriety, physical and mental health and a maximum functional ability; and
- Recovery – Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential.

Prevention and early intervention measures may vary in their recommendation for application. In coordination with SAMSHA, Milwaukee utilizes a continuum of care description developed by the Institute of Medicine to describe and track interventions at different levels of risk for substance abuse and mental health disorders. This classification suggests that populations receiving prevention and early intervention services can be defined in universal, selective and indicated categories.

- Universal measures target the general public or an entire population group without regard to individual risk
- Selective measures target individuals or groups considered at risk for substance abuse through membership in a particular segment of the population. This may include children of adults addicted to alcohol, students failing academically or individuals residing in neighborhoods with a high incidence of drug abuse.
- Indicated measures are utilized to prevent the onset of substance abuse in persons who do not meet medical criteria for addiction, but are displaying early danger signs. These early signs may include some use of alcohol and/or marijuana. Prevention services may be provided in family settings, school settings or community settings.

Successful completion of this work plan would translate into the following outcomes:

- An **increase in community knowledge** about the risk of drug use, opioid use disorders, and how naloxone may be used to reverse opioid overdoses as measured by the estimated number of individuals reached through media, messaging or outreach campaigns. Specific target objectives include:
 - By 2022 educating /training xxx individuals related to the risk of opioids and cocaine
 - By 2022 training xxx individuals on the administration of naloxone
 - By 2022, 100% of youth attending high school in Milwaukee County receiving substance abuse education
 - By 2018, 100% of municipalities in Milwaukee County contributing to outreach and education regarding substance use disorders, especially heroin, opioids, and cocaine.
 - By 2022, increase the number of agencies and doses of naloxone administered.
- A **change in attitudes and beliefs around drug use, dependency, and treatment** as measured by the number of community education programs conducted to destigmatize opioid use disorder and its treatment. Additional performance targets include:
 - educational programs,
 - By 2022, community health workers, peer health educators with lived experiences educate the general public in order
- A reduction in the access to opioids as measured as
 - Increase in number of fixed site medication drop boxes.
 - Increase in distribution of drug take back envelopes
 - Increase in drug take back events
- Improved access to treatment and harm reduction
 - Increase in funding to the city and/or county to address substance use disorders, especially heroin, opioids, and cocaine. **5% increase by 2022**
 - **Reduction in recidivism to drug treatment court, where cocaine or heroin/opiates are identified as their primary drug of use.**
 - Increase in number of EDs providing a warm hand-off into treatment or detox for those with substance use disorder. **100% of Milwaukee Co. EDs by 2022**
 - **Increase in drug treatment court capacity.**
- A reduction in the number of cocaine or opioid associated deaths as measured by the number of deaths recorded by the medical examiner's office. Specific target objectives include:
 - By 2022, stabilize or reduce the number of narcotic associated overdose deaths. By 2027 reduce the number associated overdose deaths by 50%.
 - By 2022, stabilize or reduce the number of drug involved homicides. By 2027 reduce the number drug involved homicides by 50%.
 - **By 2027, decrease the need to administer naloxone. Decrease in the times naloxone is used by EMS, due to a lack of demand, not a lack of supply or availability.**
 -

Use public health and law enforcement data to monitor trends and strengthen prevention efforts.

Establish and enhance stakeholder coalitions

Consider authorizing and providing support to syringe service and other harm reduction programs

Public Safety Strategies for Reducing the Illicit Supply of and Demand for Opioids

COORDINATION AND IMPLEMENTATION

Partners from all sectors are driving forward implementation of these strategies including city, county and state-level agencies and policy makers, professional associations, law enforcement, local health departments, service providers, community coalitions and many others.

The following stakeholders have participated on the taskforce:

Representing the City of Milwaukee

- **Bevan Baker, Chair**, *Commissioner of Health*
- **Ald. Michael Murphy**, *Common Council, Tenth District*
- **Ald. Khalif Rainey**, *Common Council, Seventh District*

Representing Milwaukee County

- **Hector Colon, Vice-Chair**, *Director of Department of Health and Human Services*
- **Karen Loebel**, *Deputy District Attorney*
- **Michael Lappen**, *Administrator of Behavior Health Division*
- **Brian Peterson**, *Medical Examiner*
- **Christine Westrich**, *Director of Office of Emergency Management*

Representing Intergovernmental Cooperation Council

- **CoryAnn St. Marie-Carls**, *Mayor of St. Francis*

Representing the Medical Profession

- **E. Brooke Lerner**, *Research Director, Medical College of Wisconsin Department of Emergency Medicine*

Representing the Non-Profit Sector

- **Marisol Cervera**, *United Community Center*

Representing the Community

- **Michael Macias**, *Grand Avenue Club, Resident Advisory Council*

Individual workgroups were formed to work on each of the seven priority goals. The workgroups were facilitated by Jessica Gathirimu and Angie Hagy of the City of Milwaukee Health Department

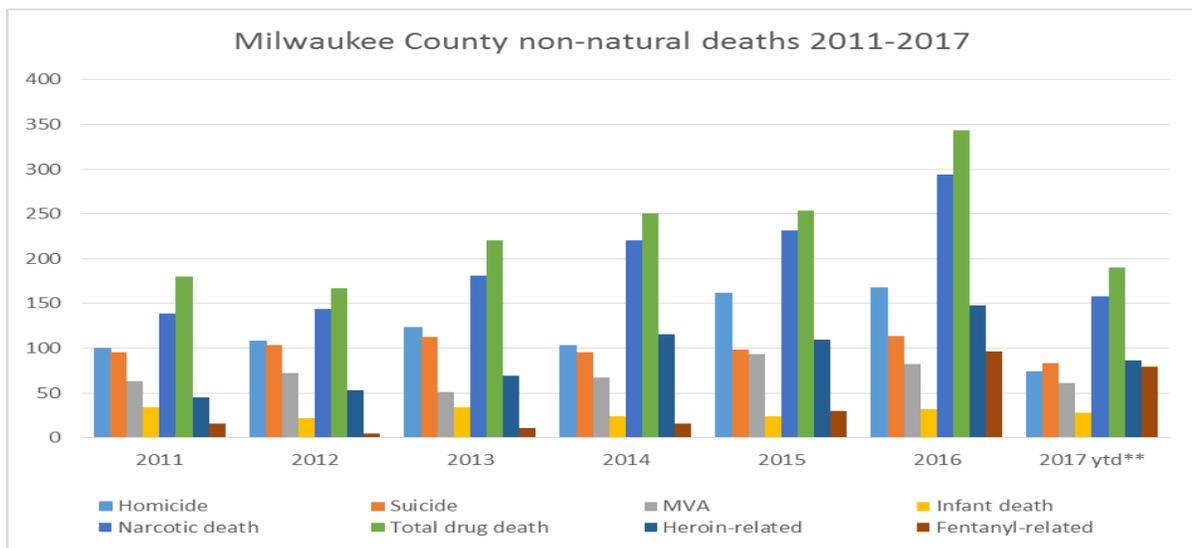
| Goal | Workgroup Members | |
|---|--------------------------------|-------------------------------|
| 1. Increase naloxone availability in the community | <i>Kyle Beyer</i> | <i>Janet Fleege</i> |
| | <i>Christine Westrich</i> | <i>Leah Redding</i> |
| | <i>E. Lerner</i> | <i>Rachel Cooper</i> |
| 2. Enhance community-based options for easy, safe, and environmentally friendly medication disposal. | <i>Jason Smith</i> | <i>Kathy Schmitz</i> |
| | <i>Jon Richards</i> | <i>Ken Darling</i> |
| | <i>Kathy Federico</i> | <i>Michael Murphy</i> |
| 3. Promote community understanding of pain, pain management and substance abuse disorders to achieve a reduction in opioid exposure in order to reduce risk of individuals developing abuse of other medications including heroin and cocaine | <i>Brett Fuller</i> | <i>Lisa Hass-Peters</i> |
| | <i>Chip Morris</i> | <i>Marisol Cervera</i> |
| | <i>James Parnau</i> | <i>Nzinga Khalid</i> |
| | <i>Khalif Rainey</i> | |
| 4. Assure there is adequate access to timely, affordable, and quality services for substance use disorders. | <i>Christine Westrich</i> | <i>Leah Redding</i> |
| | <i>Dana Thomson</i> | <i>Michael Lappen</i> |
| | <i>E. Lerner</i> | <i>P. Gutierrez</i> |
| | <i>Elizabeth Collier</i> | <i>Tracey Hooker</i> |
| | <i>Janet Fleege</i> | |
| 5. Maintain and enhance availability and quality of timely data about heroine, opioids, and cocaine use, its outcomes and risk factors | <i>Brian Peterson</i> | <i>Karen Domagalski</i> |
| | <i>Christine Westrich</i> | <i>Leah Redding</i> |
| | <i>E Lerner</i> | <i>Mallory O'Brien</i> |
| 6. Enhance collaboration between community-based initiatives and government agencies | <i>Bevan K. Baker,</i> | <i>Hector Colon</i> |
| | <i>CoryAnn St. Marie-Carls</i> | <i>Lisa Bullard-Cawthorne</i> |
| | <i>Dawn Mumaw</i> | <i>Michael Lappen</i> |
| | <i>Elizabeth Collier</i> | <i>Nzinga Khalid</i> |

Goal 1: Increase Naloxone Availability in the Community

1.1

Conduct an assessment of the availability of naloxone within the community (numbers, locations, organization, etc.)

Since 2011 the number of drug deaths in Milwaukee County has been on the rise. In 2016, 148 Milwaukee County residents died from heroin, up from 45 in 2011, the number of fentanyl related deaths (alone or in combination, has risen to 97, up from just 16 in 2011. The number of heroin and fentanyl related deaths for 2017 are predicted to match or eclipse the record set in 2016.



Many of these deaths could be avoided with the use of naloxone, an opioid antagonist medication that reverses opioid overdose without significant negative side effects. First responders, parents, and educators should have easy access to naloxone and should have training in how to administer the drug.

The current level of participation is unknown. An important first step in expanding access to naloxone is understanding where it currently is available and identifying where gaps may exist.

Action Plan / Timeline

- Recruit graduate intern(s) to complete survey and report
- Identify sampling strategy
- Develop a survey /interview tool
- Administer survey/compile interviews
- Analyze data
- Prepare report
- Present findings to workgroup

1.2

Support and expand naloxone training and distribution programs

Many myths or negative viewpoints on naloxone. Many different training providers, no standardized algorithm.

Evidence has shown that communities with higher access to naloxone and overdose training have significantly lower opioid overdose rates than those that do not. (Walley, 2013) Family and friends of opioid users have greater knowledge of opioid overdose and ability to respond appropriately after receiving training in naloxone administration than peers who learn about opioid overdose and naloxone via an information booklet. (Williams AV, 2014) Current or former opioid users who have received training in overdose response appear to identify overdose and recognize conditions when naloxone is appropriate as accurately as medical experts. (Green TC, 2008) Some studies suggest that opioid users who have participated in only a brief 5-10 minute training or learned naloxone administration through social networks can respond appropriately to an overdose. (Doe-Simkins M, 2014) (Behar E, 2014)

Training first responders such as police, firefighters, and EMTs to administer naloxone may reduce time to overdose rescue, possibly decreasing overdose-related injury and death. (Davis CS, 2014) Law enforcement officers who participate in naloxone administration and overdose training report increases in knowledge and confidence in managing opioid overdose emergencies after program completion. (Wagner KD, 2016)

Action Plan / Timeline

- Complete environmental scan of the different training being provided related to naloxone administration.
- Standardize naloxone training
- Develop and maintain a toolkit of local resources related to the administration of naloxone
- Include messaging about naloxone in a comprehensive media plan

1.3

Support legislation that mandates the availability of naloxone or naloxone in specific community settings (schools, treatment centers, prisons/jails, dorms etc.).

Providing naloxone kits to laypeople reduces overdose deaths while being safe and cost effective. (Coffin PO, 2013) (Doyon S, 2014) U.S. and international health organizations recommend providing naloxone kits to patients in substance use treatment programs, individuals leaving prison and jail and laypeople who might witness an opioid overdose. (CDC, 2015) As of 2014, the CDC reported that naloxone distributed to laypeople had resulted in more than 26,000 overdose reversals nationwide since 1996. (CDC, 2015) Since 2006, Massachusetts has implemented an overdose education and naloxone distribution program that significantly reduced overdose deaths in the 19 communities. (Walley, 2013)

As of 2015, Wisconsin allows standing order prescriptions and third-party prescriptions of naloxone, and grants prescribers and lay administrators immunity from criminal prosecution and civil liability when prescribing, dispensing, distributing, or administering naloxone (LawAtlas-Naloxone).

In 2014, 644 local opioid overdose prevention programs in 30 states and Washington, DC provided community members with naloxone kits and training in proper use (CDC MMWR-Naloxone 2015). Many states provide civil and criminal immunity for both prescribers and administrators (LawAtlas-Naloxone, Davis 2015).

In November 2015, a nasal spray method of administering naloxone was approved by the US Food and Drug Administration (FDA) along with the previously-approved injection method (US FDA-Naloxone 2015). As of January

2017, Kaléo, a pharmaceutical company, provides naloxone auto-injectors free of charge to qualifying non-profit organizations through their Product Donation Grants Program (Kaleo-Naloxone).

The Madison-Dane County Safe Community program offered overdose education and naloxone distribution trainings to the city of Madison Police Department in 2014 and has expanded training to the public (NSC-Dane County 2015). As of 2015, Wisconsin allows standing order prescriptions and third-party prescriptions of naloxone, and grants prescribers and lay administrators immunity from criminal prosecution and civil liability when prescribing, dispensing, distributing, or administering naloxone (LawAtlas-Naloxone).

Action Plan / Timeline

- Explore the current law on where naloxone can be distributed and who can administer it.
- Utilize students to create policy briefs to support mandate
- Post policy briefs on website and distribute to policymakers to advocate for policy change
- Work with elected officials / legislative reference bureau to draft proposed ordinance changes if required

1.4

Facilitate an opportunity for those who utilize naloxone to identify barriers and recommendations for improved availability.

Action Plan / Timeline

- Develop consent form, focus group guides and obtain IRB approval
- Identify and recruit persons with SUD
- Conduct focus groups
- Analyze focus group findings and write report
- Present findings to taskforce

1.5

Establish a system that makes immediate linkages to recovery services following overdose reversal to reduce the potential for repeat overdose, and increase the likelihood of sustained recovery.

Having linkages to care following inpatient hospitalization has been shown to be associated with higher rates of completion of initiated aftercare (behavior therapy or self-help programs) during the week following detoxification.

Action Plan / Timeline

- Identify baseline practice

1.6

Advocate for statewide mandate for public and private insurance coverage for naloxone.

Cost can serve as barrier to individuals obtaining their prescriptions. In 2015, 11% of Milwaukee County residents reported not taking one or more of their prescription medications due to cost. That rate rises to 14% among households in the bottom 40% of income. To remove this barrier, states such as New York have enacted laws that

have mandated insurance companies cover the costs of naloxone when prescribed to a person who is addicted to opioids and to his/her family member/s on the same insurance plan.

Action Plan / Timeline

- Identify student(s) to assist with project
- Identify insurance providers for current coverage practices including co-pay deductibles
- Review/identify insurance mandates in place in other jurisdictions
- Develop/propose revisions to ??? mandating coverage
- Develop policy brief supporting need for mandated coverage
- Outreach to policymakers / elected officials to support mandate

Goal 1 Performance Measures

| Short Term Indicators | Source | Frequency |
|--|---------------|------------------|
| <i>Number of people trained to identify and respond to opioid overdose</i> | | |
| <i>Number of agencies who carry naloxone</i> | | |
| <i>Number of points of access for naloxone</i> | | |
| <i>Number of OD prevention train the trainers</i> | | |
| | | |
| Long Term Indicators | Source | Frequency |
| <i>Number of opiate associated deaths in the community</i> | <i>MCME</i> | |
| <i>Number of narcotic associated deaths in the community</i> | <i>MCME</i> | |
| | | |

Goal 2: Enhance Community-Based Options for Easy, Safe, and Environmentally Friendly Medication Disposal.

2.1

Expand the number of fixed-site medication drop boxes to include all of Milwaukee County.

Studies found that about 80% of heroin users reported using prescription opioids for nonmedical reasons before beginning use of heroin (Jones, 2013; Muhuri et al. 2013). Overall, these studies suggest a link between nonmedical use of prescription opioids and heroin, particularly among people with frequent nonmedical use, or people with prescription opioid use disorder. However, it is important to note that only a small percentage (less than 5% of people who use prescription opioids for nonmedical reasons) begin using heroin. Nationally, this small percentage translates to several hundred thousand new heroin users per year and should not be minimized (Compton et al., 2016). Therefore, strategies should be implemented to assure the safe effective disposal of prescription medications.

Medical Society has agreed to sponsor a med drop box, other businesses have been contacted but no other commitments yet.

Action Plan / Timeline

- Immediate
 - The MHD Substance Abuse and Injury Program Manager will obtain list of all pharmacies in Milwaukee County including contact information and addresses
 - The MHD Substance Abuse and Injury Program Manager will develop and maintain a map of drop box locations which will be posted to the MHD website
- 3 to 6 months
 - The Medical Disposal Workgroup will prioritize pharmacy locations based on where overdose deaths are occurring and lack of other drop box locations nearby
 - The Medical Disposal Workgroup will conduct outreach to priority pharmacy locations to.
- 6 to 12 months
 - The Medical Disposal Workgroup will develop an “adopt a box” program for sponsorship.
 - The Medical Disposal Workgroup will identify and contact potential drop box sponsors

| Timeline | Lead Person / Organization |
|----------------|---|
| Sep – Nov 2017 | MHD will look to State Pharmacy Society, Dept of Safety and Professional Services and DOJ |
| | Med Disposal Workgroup |
| | Med Disposal Workgroup |
| | Jon will develop 1-page overview of “adopt a box” program |
| Nov 2017 | Kathy S. will call Children’s and Jon will call Froedtert |
| | Determine if/who at health department who can contact people |
| | |

2.2

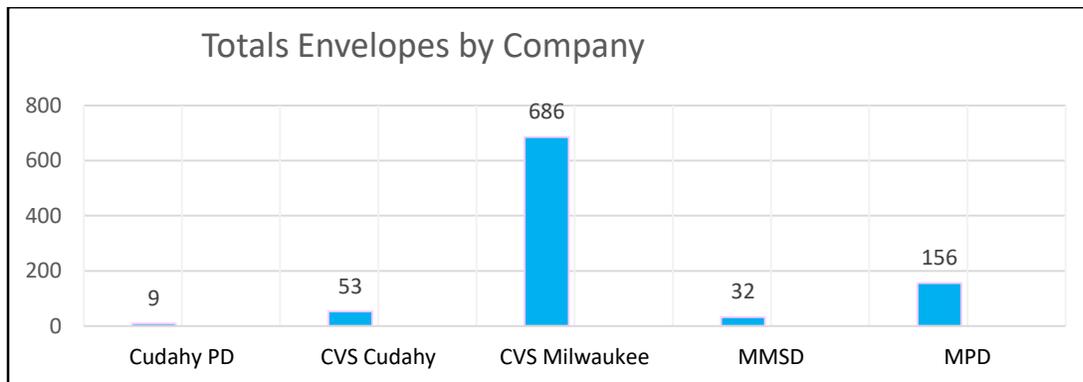
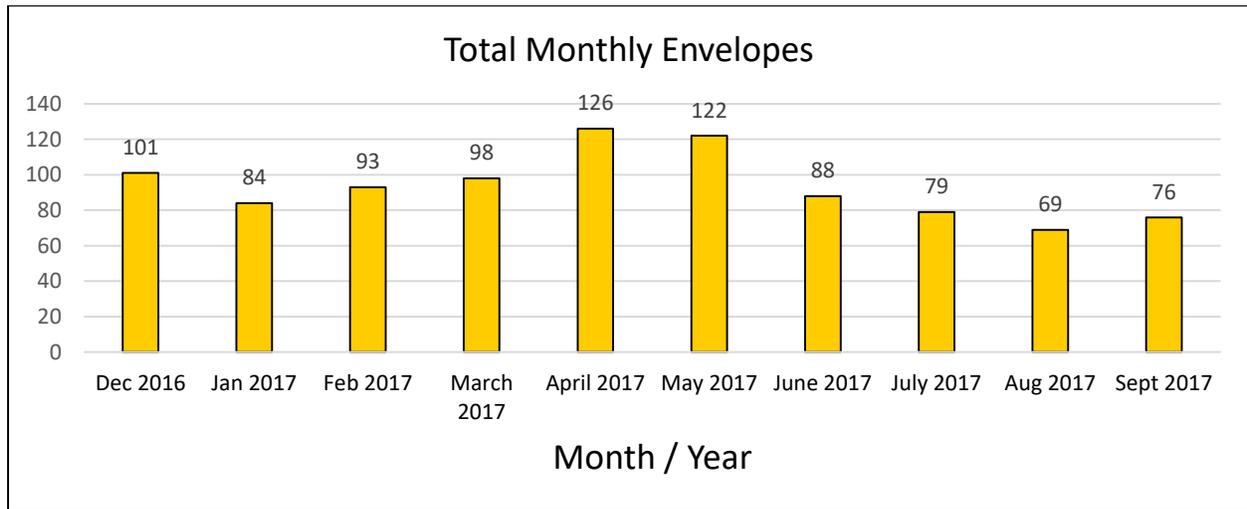
Increase the frequency of single-day drug take back events.

Action Plan / Timeline

- Facilitate discussions encouraging police departments to organize take back events
- Promote take back events to partners and included messaging regarding fixed drop box locations

2.3

Promote the use of drug mail back programs



Action Plan / Timeline

- Facilitate discussions encouraging police departments to organize take back events
- Promote take back events to partners and included messaging regarding fixed drop box locations

2.4

Develop a comprehensive health education campaign to promote the importance and availability of safe & environmentally friendly medication disposal.

Brochures from the TBMMMC and DOJ available for med disposal locations

TBMMMC has contractor to develop communications plan specific to med disposal

Action Plan / Timeline

- TBMMMC to develop communication plan , Develop social media campaign that is simple, direct, and consistent for medication disposal
- Med Disposal Workgroup to present TBMMMC plan to Task Force
- Joint statement/policy regarding preferred methods of med disposal and/or standards

Design of strategic communications plan

Design of broad public awareness and citizen engagement campaigns

Creation of timeline

Attach strategic comms plan and public engagement campaigns to timeline

Compile into document

Outline of tools and tactics needed to implement plan (included in document)

Create branding guide - voice, personality, core messaging

Submit to client for approval

Goal 2 Performance Measures

| Short Term Indicators | Source | Frequency |
|--|---------------|------------------|
| <i>Number of drop box sponsors</i> | | |
| <i>Number of businesses providing incentives for those who drop meds off</i> | | |
| | | |
| Long Term Indicators | Source | Frequency |
| <i>Number of fixed site medication drop boxes</i> | | |
| | | |

Goal 3: Promote Community Understanding of Pain, Pain Management and Substance Abuse Disorders to Achieve a Reduction in Opioid Exposure in Order to Reduce Risk of Individuals Developing Abuse of Other Medications including Heroin and Cocaine.

3.1

Immediately launch a community informed/engaged health promotion campaign focused on prevention and destigmatizing substance use disorder, and to promote seeking treatment.

Drug overdose deaths and opioid-involved deaths continue to increase in the United States. The majority of drug overdose deaths (more than six out of ten) involve an opioid.¹ Since 1999, the number of overdose deaths involving opioids (including prescription opioids and heroin) quadrupled.² From 2000 to 2015 more than half a million people died from drug overdoses. 91 Americans die every day from an opioid overdose.

We now know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. The amount of prescription opioids sold to pharmacies, hospitals, and doctors' offices nearly quadrupled from 1999 to 2010,^{3,4} yet there had not been an overall change in the amount of pain that Americans reported.^{5,6} Deaths from prescription opioids—drugs like oxycodone, hydrocodone, and methadone—have more than quadrupled since 1999.⁷

Messages communicated through the media influence how the public thinks and behaves. Communications strategies—public education, social marketing, media advocacy, and media literacy—can be used to influence community norms, increase public awareness, and attract community support for a variety of prevention issues.

XXXXXX

Misunderstandings and misperceptions regarding the causes, manifestations, and effective treatments for opioid use disorder and its co-occurring conditions result in stigma and missed opportunities for treatment.

Consider expand light and unite red campaign to be introduced in January – get materials out now, continue to refine as you go, need things, can't wait!

Action Plan / Timeline

- Immediately
 - Launch campaign using light and unite red as the framework
 - Develop/engage a community advisory panel for future campaign development (MHD partner with Milwaukee Heroin Diaries)
- Six to nine months
 - Evaluate light and unit red campaign impact
 - Identify community knowledge attitudes and beliefs (to follow up on first wave of campaign to look for refinement)
 - Identify/develop a social media plan / comprehensive media plan.
- 12 months
 - Audience testing of health promotion campaign and assure community participatory design in the health promotion campaign

- 18 months
 - Launch phase 2 of media campaign
- 24-36 months
 - Evaluate campaign materials and campaign impact, continue to refine and update plan based on feedback

3.2

Monitor and promote already existing community programs that focus on stigma reduction and peer support.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA):

“Peer support services are delivered by individuals who have common life experiences with the people they are serving. People with mental and/or substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery.”

Research has shown that peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one’s community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.”

Peer recovery support services help prevent relapse and promote sustained recovery from mental and/or substance use disorders (SUD), and examples can include: peer mentoring or coaching, peer recovery resource connecting, recovery group facilitation, and building community/social networks. Street-based reach-in programs allow peers to provide harm reduction and referral to recovery support services to others suffering from substance use disorder or opioid use disorder. Recovery support services may include medication-assisted treatment (MAT), housing resources and care coordination. Peer recovery support services are services that are designed and delivered by people who, themselves, have experienced both substance use disorder and recovery. These services can include peer counseling, career counseling, and support groups.

Action Plan / Timeline

- Immediately
 - Support and promote the inventory being done by COPE to have better awareness of community programs and efforts. Disseminate COPE in conjunction with health promotion campaign
 - Distribute the red crisis books within the community
 - Promote/support COPE as a hub of community resources, support a single point of information
 - Conduct town hall meetings to obtain community input on how a warm handoff system would work including developing a standard definition of what constitutes a warm hand off as well as explore on the utilization of technology in that process (Milwaukee Heroin Diaries)
 - Conduct town hall meetings to obtain community input on how to best utilize community health workers in substance abuse work (such as connecting individuals with care following overdose keeping individuals in care, addressing other social needs, etc.)
 - Identify marketing channels (format / location / time) for communication messaging to those with addiction.
- 9 to 12 months
 - Arrange screenings of “Chasing the Dragon” within the community, along with structured dialogue after.
- 24 to 36 months
 - Create a texting line related to initiatives

3.3

Monitor and promote school-based initiatives to reduce illicit substance use and/or recreational drug use.

Although substance misuse may occur at any age, adolescence is a particularly high-risk period. The majority of adults who have been diagnosed with a substance use disorder started use during adolescence. (Johnston, 2014) Providing evidence-based interventions, including educational activities and social supports, can delay early use and stop the progression from use to addiction. (Griffin KW, 2010)

Cost-benefit estimates show that effective school-based substance abuse prevention programs save \$18 for every \$1 spent on these programs.^{WIHer14} When dealing with the complexities of SUDs, it is clear that school-based prevention strategies are not the only effective means for delaying initiation, thereby reducing the likelihood of progression to substance abuse and addiction. In addition, prevention of heroin needs to start upstream. Initiating alcohol, nicotine and marijuana use at an early age remains a primary predictor of a later SUD. Prevention programs need to be introduced to youth early and often in order to reduce the likelihood of early substance use initiation.

The Centers for Disease Control and Prevention conducted the National School Health Policies and Practices Study in 2014, and found that 66.7 percent of middle schools and 86.9 percent of high schools require that students receive instruction on alcohol or other drug use prevention. There are multiple repositories of evidence-based prevention programs. One such repository is SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). (National Registry of Evidence-based Programs and Practices (NREPP), n.d.) According to this registry, there are 132 interventions specific to providing children and youth with substance use disorder prevention and substance use disorder treatment education. (AZ Dept. of Health Services, 2017)

Current Status

- Not sure what schools are doing county wide

Action Plan / Timeline

- 6 months
 - Conduct a survey to identify existing school based curriculums being used countywide (public and private) in order to form an inventory
- 6 to 12 months
 - Advocate that schools adopt evidence informed and evidence based curriculum for drug abuse
- 12 to 24 months
 - Engage students to create a video clips to educate their peers around drug abuse
 - Educate school staff on drug abuse and identifying the signs of drug abuse
 - Train school staff on the use of naloxone
 - Train students to be peer counselors

3.4

Conduct outreach to healthcare providers regarding evidence-based pain management and substance-use disorder treatment.

By educating physicians, nurse practitioners, physician assistants, and other health care professionals about the risks of prescription opioid painkillers and best practices for judicious prescribing — including guidelines that encourage doctors to avoid opioid painkillers except when necessary, and to use the lowest possible dose for the shortest amount of time — we can prevent future opioid overdose deaths.^{NYC}

Action Plan / Timeline

Goal 3 Performance Measures

| Short Term Indicators | Source | Frequency |
|---|--|------------------|
| <i>Number of informational contacts with members of the print, broadcast (radio and TV), and on-line media</i> | | |
| | | |
| Long Term Indicators | Source | Frequency |
| <i>Illicit Drug Use in the Past Month and Illicit Drug Use Other Than Marijuana in the Past Month among Persons Aged 12 or Older</i> | National Survey on Drug Use and Health | <i>Annually</i> |
| <i>Cocaine Use in the Past Year among Persons Aged 12 or Older</i> | National Survey on Drug Use and Health | <i>Annually</i> |
| <i>Nonmedical Use of Pain Relievers in the Past Year among Persons Aged 12 or Older</i> | National Survey on Drug Use and Health | <i>Annually</i> |
| <i>Ever used cocaine (any form of cocaine, such as, powder, crack, or freebase, one or more times during their life)</i> | Youth Behavioral Risk Factor Survey | |
| <i>Ever used heroin (also called "smack," "junk," or "China white," one or more times during their life)</i> | Youth Behavioral Risk Factor Survey | |
| <i>Ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)</i> | Youth Behavioral Risk Factor Survey | |
| <i>Number of individuals seeking treatment for opioid use disorder</i> | | |

Goal 4: Assure there is Adequate Access to Timely, Affordable, and Quality Services for Substance Use Disorders.

Effective treatment strategies for managing recovery from opioid use disorders include behavioral therapies, medication, and psychosocial supports. Evidence-based behavioral therapies may be used alone or in combination with medication management, along with other services and supports. Long-term continuing care services have been demonstrated to be the most significant factor in extended sobriety and relapse prevention.

Individuals face a range of obstacles preventing them from entering or gaining access to substance abuse treatment, including lack of knowledge regarding access to services; shame and stigma; denial of substance use disorder or substance misuse; costs and lack of insurance/Medicaid; transportation; treatment waiting lists; and prior negative treatment experiences.

4.1

Expand medically assisted treatment (MAT) capacity for those with an opioid use disorder.

Current Status:

- List of approved prescribers available at xx, and the number they can prescribe any of the methadone /suboxone because of DEA registration
- Won't be able to id # who provide vivitrol
- Vivitrol has other uses so not reliable
- Requires pre-authorization and waiting can result in relapse, not always covered, providers can be out of network
- Providers may not be aware, may not have a place to send patients for counseling that goes along with meds
- Currently being considered by the state
- Lack of information / misinformation

Action Plan / Timeline

- Determine baseline availability of MAT
- Advocate for changes in the ability to bill insurance (public and private) for MAT including an expedited approval process for coverage (remove pre-authorization)
- Educate providers MAT through the creation of a physician mentorship program
- Educate consumers/families on MAT

4.2

Expand residential treatment capacity and funding.

Short-term residential programs provide intensive but relatively brief treatment based on a modified 12-step approach. These programs were originally designed to treat alcohol problems, but during the cocaine epidemic of the mid-1980s, many began to treat other types of substance use disorders. The original residential treatment model consisted of a 3- to 6-week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as AA. Following stays in residential treatment programs, it is important for individuals to remain engaged in outpatient treatment programs and/or aftercare programs. These programs help to reduce the risk of relapse once a patient leaves the residential setting.

Many don't understand residential treatment, simply often viewed as the fix-all. Current waitlist is 150, expansion is not a solution

Medicaid won't pay if over 16 beds, state has applied for waiver, won't hear until 2019.

Need to create a bridge for people coming out of residential or people who don't need residential but need a place to stay while they get clean

Action Plan / Timeline

- Provide stakeholder and community education about residential treatment (benefits, length, who, etc.)
- Advocate for changes in Medicaid reimbursement for residential treatment (IMD)
- Advocate for policies that support housing as healthcare
- Advocate for safe and affordable housing for families, and people with substance use issues

4.3

Reduce wait-time for admission into treatment.

Current Status:

Many myths surrounding the idea of wait times.

Action Plan / Timeline

- Provide data on average wait times

4.4

Enhance care management of those identified with a substance use disorder moving from ED admission to treatment.

Action Plan / Timeline

- *Increase in number of EDs providing a warm hand-off into treatment or detox for those with substance use disorder*

4.5

Expand aftercare and relapse prevention initiatives, including sober housing.

Long-term residential treatment provides care 24 hours a day, generally in non-hospital settings. The best-known residential treatment model is the therapeutic community (TC), with planned lengths of stay of between 6 and 12 months. TCs focus on the "resocialization" of the individual and use the program's entire community—including other residents, staff, and the social context—as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility as well as socially productive lives. Treatment is highly structured and can be confrontational at times, with activities designed to help residents examine damaging beliefs, self-concepts, and destructive patterns of behavior and adopt new, more harmonious and constructive ways to interact with others. Many TCs offer comprehensive services, which can include employment training and other support services, onsite. Research shows that TCs can be modified to treat individuals with special needs, including adolescents, women, homeless individuals, people with severe mental disorders, and individuals in the criminal justice system

Many best practices throughout US to learn from.

Action Plan / Timeline

Host a sober housing symposium.

4.6

Advocate for the expansion/adequate funding of treatment alternative diversion programs ("drug courts") as a cost effective alternative to incarceration.

Drug offenders and drunk drivers accounted for 80 percent of the growth in Wisconsin prisons since 1996. Drug courts are six times more likely than prison programs to keep offenders in treatment long enough for them to get better. Individuals recently released from correctional settings are up to 130 times more likely to die of an overdose than the general population, particularly in the immediate two weeks after release.^{drugpolicy.org⁵⁹}

The Wisconsin Department of Corrections estimates that 70% of state prisoners have a substance abuse addiction. In comparison, the Wisconsin Department of Health Services estimates the rate of dependence or abuse of illicit drugs in the general population as 3%.^{HIA⁷²}

Treatment Alternative Diversion (TAD) pilot programs were established in seven Wisconsin counties in 2007, but currently get less than \$1 million a year in state funding. The pilot programs have been highly effective at reducing prison recidivism as well as treating substance abuse and mental health issues, but they barely scratch the surface of statewide need. According to the Wisconsin Department of Corrections, the average cost of putting someone behind bars for one year is about \$32,000. But a state report evaluating TAD's first four years found that even in the most expensive alternative programs, the average annual cost per participant is \$7,551. The Wisconsin Office of Justice Assistance estimates that every dollar spent on treatment alternative programs saves almost \$2 in criminal justice costs. By that yardstick alone, increased investment of \$75 million in alternatives to prison would yield an annual savings of almost \$150 million.^{HIA Report}

Increased investment by Wisconsin in problem-solving courts and other programs to keep low-risk, non-violent offenders out of prison would likely reduce crime, strengthen families and communities, improve public health and begin to correct racial inequities in the state criminal justice system, according to a wide-ranging study of the impacts of alternatives to incarceration. More funding for prison alternatives is also likely to reap significant savings on public safety, health care and social services.^{HIA Report}

Action Plan / Timeline

4.7

Advocate that prisoners be adequately treated for SUD while incarcerated, including providing MAT when appropriate.

Despite the preponderance of evidence showing that treatment reduces drug use and drug-related crime, the U.S. Office of Justice Assistance notes that only 15% of state prisoners receive treatment while incarcerated.^{HIA82}

Action Plan / Timeline

- Provide MAT in Criminal Justice Settings, Including Jails/Prisons and Drug Courts

4.8

Advocate for treatment alternatives to revocation for drug related offenses to probation violations.

Action Plan / Timeline

4.9

Evaluate the potential to implement other harm reduction interventions.

In addition to death and overdose, persons who inject opioids are at risk for infectious disease transmission including HIV and Hepatitis C. There were 84 HIV diagnoses among injection drug users (IDUs) in Wisconsin between 2007-2011. HCV, which can lead to cirrhosis and liver cancer, is primarily transmitted by injection drug use. In the United States, there is an ongoing epidemic of HCV infection among young adults who inject drugs. In Wisconsin, reports of acute HCV infection in young adults have increased. In 2013, 78% of people with new HCV infections reported injection drug use.

Syringe exchange programs are important for preventing the spread of infectious diseases such as hepatitis and HIV. Currently in Milwaukee County only 2 syringe exchange programs are

Supervised injection services (SIS) are health services that provide a safe and hygienic environment where people can inject pre-obtained drugs under the supervision of trained staff. One of the main goals of SISs is to reduce overdose deaths. There are over 90 SISs worldwide and there have been no deaths recorded at any of these services. Rather, there have been fewer overdose deaths reported following the implementation of these services. (Fischer, 2002)

No such facility currently operates in the United States, but a new cost-benefit analysis conducted by the Bloomberg School of Public Health and published in the May 2017 issue of Harm Reduction Journal, suggests that a single safe consumption space in Baltimore would annually prevent 5 percent of overdose deaths and save \$6 million in costs related to the opioid epidemic. There are campaigns underway to open supervised consumption spaces in Seattle, San Francisco, Philadelphia, New York, and Baltimore. (Rienzi, 2017)

Action Plan / Timeline

- Needle exchange?
- Safe injection sites?
- Encourage Distribution of Naloxone to Patients Receiving Opioids

Goal 4 Performance Measures

| Short Term Indicators | Source | Frequency |
|--|---------------|------------------|
| <i>Percentage of individuals entering criminal justice system screened for SUD</i> | | |
| <i>Percentage of individuals entering the criminal justice system with SUD offered treatment rather than incarceration</i> | | |
| <i>Number of individuals able to be served in TAD / drug treatment court</i> | | |
| <i>Recidivism in drug treatment court, where cocaine or heroin/opiates are identified as their primary drug of use.</i> | | |
| Long Term Indicators | Source | Frequency |
| <i># of SUD providers</i> | | |
| <i># of MAT persons who can be served (at capacity)</i> | | |
| <i>Increase in number of EDs providing a warm hand-off into treatment or detox for those with substance use disorder</i> | | |
| <i>Number of drug involved homicides</i> | | |
| <i>Number of drug involved homicides</i> | | |
| <i>Incarceration rate by race/ethnicity</i> | | |
| <i>Revocation rate</i> | | |
| <i>Property crime rate</i> | | |
| <i>Violent crime rate</i> | | |

Goal 5: Maintain and Enhance Availability and Quality of Timely Data about Heroin, Opioids, and Cocaine Use, its Outcomes and Risk Factors

Rationale

Evidence-informed decision making involves the use of research evidence along with expertise, existing public health resources, knowledge about community health issues, the local context and community, and the political climate. Quality, accessible, timely and reliable data is essential for providing evidence for decision-making as well as evaluation of intervention outcomes. Obtaining and maintaining data about the current status of heroin, opioid, and cocaine use in Milwaukee is essential to targeting interventions at those most at risk and maximizing limited resources.

Talk with BHD – what are their data needs – how do we quantify access to care issues? What about treatment issues?

Talk w/Beth Collier-regarding bed count issue

Measure of success – data is available and utilized to measure goals and evaluate outcomes

5.1

Assure children of Milwaukee routinely participate in the YBRFS

The Youth Risk Behavior Surveillance System (YRBSS) is conducted every other year and monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including—

- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

Information collected on drug use includes:

- Ever used marijuana
- Tried marijuana before age 13 years
- Currently used marijuana
- Ever used synthetic marijuana
- Ever used cocaine
- Ever used ecstasy
- Ever used heroin
- Ever used methamphetamines
- Ever took steroids without a doctor's prescription
- Ever took prescription drugs without a doctor's prescription
- Ever used inhalants
- Ever injected any illegal drug
- Were offered, sold, or given an illegal drug on school property
- Usually used marijuana by smoking it

- Ever used hallucinogenic drugs

Data can be accessed online at <https://nccd.cdc.gov/youthonline/App/Default.aspx> however data for Milwaukee and Wisconsin is not available for 2015

Wisconsin and Milwaukee specific data not provided in last YBRFS due to insufficient data collection.

Action Plan / Timeline

5.2

Support identification of funding to modernize toxicology testing equipment at MCMEO.

Action Plan / Timeline

Identify equipment and staffing expenses

5.3

Support efforts to streamline and collate data from multiple sources (OEM, BHD, MCMEO, PDMP, etc.)

In Milwaukee City/County we do not have a central repository for data related to substance use disorders.

Some measures on the COPE site either need to add/maintain COPE

Action Plan / Timeline

- Substance Abuse Manager Inventory all available data sources, including non-traditional partners.
- All taskforce participants / Substance Abuse Manager Assure data is available from partners website or it's clear how data can be requested from those partners
- Substance Abuse Manager Maintain /post inventory on a centralized website
- Substance Abuse Manager Assure relevant data included periodic assessments such as community health assessments

5.4

Increase frequency of data reporting made available to stakeholders and general public.

Some measures on the COPE site either need to add/maintain COPE

Action Plan / Timeline

Taskforce members Advocate to create open datasets wherever possible

Taskforce members Create / publish an online dashboard of key performance indicators related to achievement of this plan

5.5

Support community service providers in gathering and reporting data such as naloxone distribution, medicine collection or needle exchange

A collaborative information sharing environment that breaks down silos across agencies is essential to better understanding trends in order to target interventions and support a comprehensive local response.

Action Plan / Timeline

- Establish multidisciplinary overdose fatality review teams to conduct confidential case reviews and inform local overdose prevention
- Increase law enforcement, human services, forensic labs and public health expert collaboration and understanding of state drug data trends, patterns, implications and threats (e.g., drug monitoring initiatives, see Appendix F on page 34).
- Ensure that law enforcement data is shared with public health.

5.6 Advocate that neonatal abstinence syndrome be a reportable condition in Wisconsin.

Action Plan / Timeline

Goal 5 Performance Measures

| Short Term Indicators | Source | Frequency |
|-----------------------|--------|-----------|
| | | |
| | | |
| Long Term Indicators | Source | Frequency |
| | | |
| | | |

Goal 6: Enhance Collaboration Between Community-Based Initiatives and Government Agencies.

6.1

Support opportunities for continued shared learning of new initiatives and best practices

In the prevention field, collaboration allows for partners with different perspectives to work together towards solving a common problem. This approach leverages the expertise of multiple groups and increases the likelihood that their collective efforts will bring about change

- Light Unite Red is actively bringing together local health departments to promote each other's efforts. COPE has an ongoing inventory of local efforts.
- Need additional skill building
- Lack of coordination / communication
- Multiple venues depending upon perspective – ICC/WALHDAB

Action Plan / Timeline

- 6 months
 - Map communication channels to community members/agencies for collaboration
 -
- 12 months
 - Develop a website or location to exchange information between groups?
 - Advocate for collaboration between taskforce and groups in the county
 - Have a joint event to show collaborative effort taking on substance use disorders (wake up rooms) leveraging ICC funds and to highlight
- 12 to 24 months
 - Build capacity for community participatory design and engagement through cross discipline training opportunities
 - Increase awareness across agencies/organizations of community engagement activities

6.2

Increase leverage funding opportunities through collaboration.

Strong partnerships enable agencies to more effectively respond to the interwoven challenges that individuals and families experience when addressing substance use disorders. Through partnerships, community stakeholders can share data, align programs in new ways, create more comprehensive strategies and share resources in ways that maximize funding and save money/leverage resources and result in more competitive applications for funding.

Action Plan / Timeline

- 6 months
 - Identify baseline funding within county
- 6 to 12 months
 - Explore doing a shared service agreement for local health departments, include opioid death reviews in collaboration with the county
- 12 to 24 months
 - Implement opioid death review collaboration between local health departments and BHD
 - Create a grant writing workgroup to identify and collaboratively apply to one or more grant applications related to substance abuse.
 - If available, utilize grant writing professionals to facilitate collaboration and enhance quality of applications.
 - Investigate obtaining students to work on grant development and grant management

6.3

Provide opportunities for community input and engagement.

Engaging community members in problem-solving solutions to issues that affect them is one of the fundamental principles of public health. The most effective way to achieve public health goals, especially the elimination of disparities in health status, is to actively engage those experiencing the problems in every aspect of addressing them.

Action Plan / Timeline

- Immediate
 - Conduct community listening sessions to get input on initial draft of the work plan
- 6 to 12 months
 - Engage Community Advocates as the convener of the substance abuse coalition
 - All Task Force members and those that they partner with ensure community voice (focus groups, advisory panels, &/or peer worker, etc.) are included in every grant proposal
 - Obtain asset maps completed by local health departments as part of CHIP process
 - Advocate for inclusion of substance abuse questions in MHCP CHNA (both community survey and key informant survey)
- 12 to 24 months
 - MHD Substance Abuse and Injury will recruit graduate students to facilitate a series of key informant interviews and/or stakeholder focus group sessions to include: leaders of youth, youth, law enforcement and prevention and health care providers to gain input on goals, strategies, and actions
- 36 months
 - MHD Substance Abuse and Injury will update and revise work plan based on input provided.

6.4

Work to adopt a collective impact framework to guide substance abuse work activities county wide.

Collective Impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change. The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to abandon their own agenda in favor of a common agenda, shared measurement and alignment of effort. Unlike collaboration or partnership, Collective Impact initiatives have centralized infrastructure – known as a backbone organization – with dedicated staff whose role is to help participating organizations shift from acting alone to acting in concert. The five common elements of a collective impact partnership are:

1. All participants have a common agenda for change including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.
2. Collecting data and measuring results consistently across all the participants ensures shared measurement for alignment and accountability.
3. A plan of action that outlines and coordinates mutually reinforcing activities for each participant.
4. Open and continuous communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
5. A backbone organization(s) with staff and specific set of skills to serve the entire initiative and coordinate participating organizations and agencies.

Action Plan / Timeline

- Steps for creating collective impact?

Goal 6 Performance Measures

| Short Term Indicators | Source | Frequency |
|--|--------|-----------|
| | | |
| | | |
| Long Term Indicators | Source | Frequency |
| Increase in involvement from every municipality to contribute to outreach and education regarding substance use disorders, especially heroin, opioids, and cocaine | | |
| | | |

WHEDA should study expanding permanent supportive housing through Low Income Housing Tax Credits or other tools to provide homeless or inadequately housed individuals with substance abuse disorders the support they need to achieve and retain housing stability.

References

- AZ Dept. of Health Services. (2017). *50 State Review on Opioid Related Policy*. Phoenix, AZ: Arizona Department of Health Services.
- Behar E, S. G. (2014). Brief overdose education is sufficient for naloxone distribution to opioid users. *Drug and Alcohol Dependence*, 209-212.
- CDC. (2015). Opioid overdose prevention programs providing naloxone to laypersons—United States, 2014. *Morb Mortal Wkly*, 631-635.
- Coffin PO, S. S. (2013). Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intern Med.*, 1-9.
- Davis CS, R. S. (2014). Expanded access to naloxone among firefighters, police officers, and emergency medical technicians in Massachusetts. *American Journal of Public Health*, e7-e9.
- Doe-Simkins M, Q. E. (2014). Overdose rescues by trained and untrained participants and change in opioid use among substance-using participants in overdose education and naloxone distribution programs: A retrospective cohort study. . *BMC Public Health*, 297.
- Doyon S, A. S. (2014). Expanding access to naloxone in the United States. . *Clin Toxicol.* , 989-992.
- Fischer, B. R. (2002). Safer injection facilities (SIFs) for injection drug users (IDUs) in Canada. *Canadian Journal of Public Health*, 336-338.
- Green TC, H. R. (2008). Distinguishing signs of opioid overdose and indication for naloxone: An evaluation of six overdose training and naloxone distribution programs in the United States. *Addiction*, 979–89.
- Griffin KW, B. G. (2010). Evidence-Based Interventions for Preventing Substance Use Disorders in Adolescents. *Child & Adolescent Psychiatric Clinics of North America.*, 505-526.
- Johnston, L. O. (2014). *Monitoring the Future. National Results on Adolescent Drug Use. 2013 Overview: Key Findings on Adolescent Drug Use.* . Ann Arbor: University of Michigan Institute for Social Research.
- National Registry of Evidence-based Programs and Practices (NREPP)*. (n.d.). Retrieved from <https://www.samhsa.gov/nrepp>
- Rienzi, G. (2017, 9 27). *Supervised drug injection sites cut down on overdoses, infections, and opioid-related costs*. Retrieved from Johns Hopkins Magazine: <https://hub.jhu.edu/magazine/2017/fall/safe-effective-drug-injection-centers/>
- Wagner KD, B. L. (2016). Training law enforcement to respond to opioid overdose with naloxone: Impact on knowledge, attitudes, and interactions with community members. *Drug and Alcohol Dependence*, 22-28.
- Walley, A. X.-S.-A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. . *BMJ*, 1-12.

Williams AV, M. J. (2014). Training family members to manage heroin overdose and administer naloxone: Randomized trial of effects on knowledge and attitudes. . *Addiction*, 250-259.