City of Milwaukee

200 E. Wells Street
Milwaukee, Wisconsin
53202

Meeting Minutes

CITY-COUNTY HEROIN, OPIOID, AND COCAINE TASK FORCE

BEVAN BAKER, CHAIR
Michael Lappen, Vice-Chair
Karen Loebel, James Mathy, Ald. Michael Murphy, Ald. Khalif Rainey, Mayor CoryAnn St. Marie-Carls, Brian Peterson, Christine Westrich, E. Brooke Lerner, Marisol Cervera, and Michael Macias

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Friday, August 18, 2017 | **9:00 AM** | **Room 301-B, Third Floor, City Hall**

Meeting convened at 9:10 a.m.

1. Roll call.

Present 10 - Murphy, Baker, Rainey, Loebel, Marie-Carls, Lappen, Lerner, Cervera, Macias and Mathy

Excused 2 - Westrich and Peterson

2. Review and approval of the previous meeting minutes from July 21, 2017.

Ald. Murphy moved approval, seconded by Director Mathy, of the meeting minutes from July 21, 2017. There were no objections from those members present.

3. City-County efforts, programs, initiatives, grants or activities.

a. Litigation towards pharmaceutical companies

Dr. Michael McNett appeared and introduced himself as the Medical Director of Chronic Pain, a member of the Wisconsin Society Opioid Task Force, and the principal author of "MEB Opioid Prescribing Guidelines".

Dr. McNett proceeded with a PowerPoint presentation.

Precedent for litigation comes from tobacco litigation. Tobacco companies settled in 1998 with 46 states and 6 other jurisdictions by providing large annual payments indefinitely for public health programs to counter the impact of tobacco on health. The basis of the settlement was to have the tobacco companies be responsible for the costs associated with tobacco use and be granted immunity from future litigation. Consumers were using tobacco products as directed and were the target of tobacco ad campaigns.

Basis for suits against drug companies may include their drugs being responsible for enormous costs to state and local jurisdictions due to addiction/overdose, false advertising that indicate drugs are safer and more effective than they are, and knowledge of drugs being funneled to the black market while doing nothing to stop it.

Opioid costs are in fact responsible for enormous costs to state and local jurisdictions relative to EMTs/fireman called to sites of overdoses, police called to sites of illegal activity, crime associated with drug addiction, Medicaid/Medicare costs due to addressing drug addiction, public funding for drug control programs, and incarceration and drug-court costs.

Dr. McNett added that during his employment in a methadone program in Peoria, Illinois, in 1981, there were $315,000 in costs to the county per year due to heroin use, a 95 percent recidivism rate, and a $12.1 million in crime cost savings to the county from use of the program. This data was measured through looking at the amount and price of heroin use back then. Heroin has become cheaper since then. A low level addiction would cost a user $30 a day now compared to $200 back in the 1980s. There are now ways of providing cheaper care, such as with outpatient buprenorphine programs. Past numbers may not associate to today, but the amount of crime associated is still large. Estimates on current numbers can be done and forwarded to the task force.

Dr. McNett continued the presentation.

There is strong basis for opioid false advertising. Purdue Pharma had claimed that Oxycontin was less "less prone to abuse" due to long-acting effect and had quoted a low, weak evidence observation study "Porter & Jick". The company also claimed Oxycontin had a 12-hour effect when it knew the effect was shorter, thus allegedly promoting abuse. Several companies are also under investigation for promoting their opioids for uses not approved by the FDA. Fentanyl lozenges and sprays were being promoted for non-cancer uses despite being approved by the FDA to only treat cancer. One company, Insys, had set up a "reimbursement unit" allegedly defrauding insurers by saying its sublingual fentanyl sprays were for cancer when it was not.

There is difficulty proving that opioid drugs are being funneled to the black market. In some cases a highly disproportionate number of pills are going to low-population areas, such as in western West Virginia, southeastern Ohio, and southeastern Pennsylvania. There is extreme difficulty to make a case for companies to be responsible to police their drugs.

There are problems with suing drug companies and distributors. Patients may be abusing drugs rather than taking them as recommended. Courts tend to consider patients to be responsible for their own addiction, which is suspect due to addiction being an illness that people may not have control over. Advertising was directed at doctors and not the patients.

There is a lot of blame to go around. The scientific community accepted opioids as "safe" and "effective" based on very dubious evidence and overlooked growing evidence to the contrary. JCAHO and CMS adopted "5th Vital Sign", required caregivers to aggressively treat pain with severe certification punishment for not doing so, started with inpatient care, and expanded to outpatient care. CMS is recently using pain satisfaction scores and penalizing doctors in the bottom quartile by reducing reimbursement. Pharmacies and distributors failed to report suspicious prescriptions

and orders. There is a mandate from the DEA that pharmacies must ensure that prescriptions are appropriate. The FDA continued to allow additional opioids to come out despite little evidence of long-term benefit, particularly long acting opioids. Some doctors, though most following what was taught by the scientific community, continued to prescribe despite little evidence of benefit and often failed to screen for developing evidence of addiction.

Drug companies have defense stance arguments. Drugs were approved by the FDA. Drugs were not taken as prescribed. Doctors are responsible for the amount used. Pharmacists are responsible for determining the appropriateness of prescriptions. Drug companies have worked with the FDA in developing Risk Evaluation and Mitigation Strategy training for prescribers in safe use.

Several companies have been sued with lawsuits concerning a variety of their opioid drugs. Purdue Pharma was sued and settled for misleading advertising from 1995 to 2001. Purdue Pharma settled $10 million with West Virginia for creating a "public nuisance" with marketing in 2001, $19.5 million to 26 states and the District of Columbia for encouraging overprescribing in 2007, $600 million in fines and payments to federal and state agencies for misleading advertising in 2007, and $130 million to resolve civil lawsuits.

In 2015 lawsuits were halted in Orange and Santa Clara counties in California to allow the FDA to finish studies on long-term effectiveness, Kentucky settled with Purdue Pharma for misleading the public about addictiveness of OxyContin, and Oregon settled with Subsys for off-label promotion.

In 2016 a judge allowed a lawsuit in Illinois similar to the lawsuits in California to proceed, Illinois sued Insys for promoting Subsys for non-cancer pain, Suffolk County in New York sued 11 drug companies for misleading the public and doctors about opioid addictiveness, and St. Clair County in Illinois sued Abbot and Purdue Pharma companies for OxyContin marketing.

In 2017 New Hampshire settled with Insys for $2.9 million for off-label marketing; shareholders sued Insys for violating securities laws; Everett in Washington sued Purdue Pharma for allowing OxyContin to be funneled into the black market; the Cherokee Nation sued distributors and pharmacies in tribal court over the opioid epidemic; Ohio sued Purdue Pharma, Teva, and Johnson & Johnson for misleading risks and benefits of opioids; Mississippi sued opioid makers for misrepresenting dangers of opioids; Missouri sued Endo, Purdue Pharma, and Janssen for lying about the risks of opioids; and Bates Carey LLP, a national insurance coverage law firm, opened "Opioid Coverage Task Force" to monitor opioid litigation risk.

Commissioner Baker questioned litigation stemming at the city or county level as opposed to the state level and attorney generals, a preemptive global settlement move by Purdue Pharma similar to the tobacco industry, and American Society of Addiction Medicine (ASAM) and other agencies formally commenting on desired federal action to be taken.

Commissioner Baker added that a global settlement piece would be important to create an endowment for future medicine and pain relief for those suffering and in recovery.

Dr. McNett replied. Lawsuits have come from multiple levels. St. Claire County,

Illinois and one from the state of Washington are from a local level. He is unaware of a global settlement and commenting on federal action from various entities. Purdue Pharma should adopt an approach to make narcan and buprenorphine cheaper as costs to provide these needs to the community are enormous. One shot of Vivitrol shot costs $1200.

Ald. Murphy commented. The City and County may want to collaboratively consider filing a lawsuit at some point and establish factual record for a basis. There have been costs and misrepresentation from pharmaceutical companies, who should have responsibility to address the problems that they have created. The City has engaged in the expensive proposition of properly disposing of opioid prescription medicine with mail-back envelopes and drop box sites at CVS and Walgreens locations. There is a track record established to punish civil negligence. The District Attorney in New York did prosecute two individuals from Purdue Pharma criminally a few years ago.

Member Macias questioned the source of fentanyl.

Dr. McNett added comments. Since 911 a hundred times as many people have died from opioid use than those that died from 911. Efforts to address terrorism due to 911 have not been the same to address the opioid epidemic. Fentanyl is being produced in China and sold to Mexican cartels. China has indicated to crack down on its companies that are producing fentanyl. Carfentanyl is scarier than fentanyl.

b. Local physicians' response

Kathleen Schmitz, Medical Society of Milwaukee County Executive Director, and Dr. George Morris, Wisconsin Medical Society Task Force on Opioids Chair, appeared. Director Schmitz gave a PowerPoint presentation.

The Medical Society of Milwaukee County (MSMC) was established in 1846 in the State as a chapter of the Wisconsin Medical Society, is the largest county chapter in the State, and has 3500 physicians and medical students. A new brand was launched (Powered by Physicians. Compelled by the Community) in 2013 to view local physicians as medical experts and thought leaders to provide leadership through active engagement on critical health issues, including opioid use, important to the health of the community. The founder of MSMC was General/Surgeon Dr. Erastus B. Wolcott, and there is a statue of him in Lake Park.

In 2013 MSMC Board of Directors identified prescription drug safety as the lead health initiative for MSMC regarding the opioid crisis. The goals are to help reduce deaths by changing the culture, building education and awareness among physicians and the public, and start the difficult conversation. MSMC has been partnering with key local and state officials, communities, businesses, and civic leaders.

MSMC has engaged in various efforts. Physician leadership and staff have served or been advisors to the National Governor's Association Prescription Drug Task Force, Attorney General Dose of Reality Campaign, Local Physician Continuing Medical Education by WMS, and DEA 360 Key Influencers Summit and media editorial board meetings. MSMC have participated in media interviews, news conferences, and phone banks. MSMC is the lead sponsor of the Take Back Your Meds Milwaukee Coalition with the goal to install a drop box at every pharmacy. MSMC is a member of the WMS Opioid Task Force where Dr. George Morris, Michael McNett, and Tim Westlake are working with Rep. Nygren and the Medical Examining Board to bring up the PDMP and

change policy and legislation. MSMC hosted Rep. Patrick Kennedy in Milwaukee last September regarding his experience with prescriptions and alcohol.

Dr. Morris commented from a physician perspective.

The opioid overdose crisis is only starting to really be addressed despite being known for about a decade. A decade ago physicians had started to work with the County District Attorney's Office to identify what was happening regionally with drug diversion and inappropriate use of medications. That has expanded since then to a statewide task force, which has been a major effort. The opioid crisis is a medical problem. Physicians understand the aspects and use of narcan and the concept of treating chronic pain. There is no place for opioids in chronic pain management, but opioids inherently find their way there and outside to people who they were not meant for. Diversion of opioids has been a major source to the development of addiction, the number of overdoses that have occurred, and the aftermarket (heroin and fentanyl). Opioids create the demand. 70 percent of children that get opioids get them from a friend or family member (diversion) and not from prescriptions.

The management of pain is a complex issue involving consideration of satisfying patient needs while protecting them. Patient input has an effect on physicians and the prescribing community, which is something that has been difficult to address. The time and communication in the exam room regarding pain needs to be more elaborate and culturally engrained to produce reasonable or other approaches to avoid drugs with serious complications.

The task force would benefit from a physician perspective with live patient experience and interaction. Physicians do have a strong voice and understanding of the opioid crisis. Addiction would not result if true public health in the exam room would work. Addiction is tied to genetics and would not occur if people are not exposed to opioids. $700 million in DHS funds to address the opioid crisis for hundreds of thousands of opioid addicts pale in comparison to $100 billion that were applied to the zika virus with 2300 cases in the country. There is advocacy for smaller, fewer, or no prescriptions as well as expansion of medicine take-backs. MSMC is lobbying to assist the task force and will use PDMP to find those who would be in violation. Everyone needs to be aware of the appropriate way to approach pain, deal with medications, and support ending diversion.

Director Schmitz added remarks. The issue comes full circle starting with prescriptions. Doctors are taking the crisis seriously on many levels and doing their part. Anecdotally, doctors are stopping the spigot. Patients are expressing to their physicians of their refusal of opioid drugs. Calls to her at the MSMC have tripled regarding patients reporting that doctors are not giving them their prescriptions. People are turning to the streets.

Dr. Morris showed a video regarding Milwaukee County District Attorney's Office in helping to identify at-risk individuals and reduce overdose fatalities. The video can be found at https://www.youtube.com/watch?v=9NkTHOA3hlY&t=31s.

Mayor St. Marie-Carls questioned the dental community in prescribing opioids and participating in the Take Back program. She added that the dental community is a major source of opioid prescriptions and that anti-inflammatory drugs works just as well or better.

Member Macias added that his dental oral surgeon recently offered OxyContin prescription with ease to him for pain management for which he did not fill but rather took Aleeve (anti-inflammatory) for his pain instead.

Dr. Morris replied. The licensing board deals with all practitioners. The awareness of the dental community is on the rise, although not at a desired level. MSMC is actively educating with 12 CME courses for about 1600 physicians. MSMC has reached out to the Wisconsin Dental Association. National data suggest the dental community contribute 10 percent to the Take Back program. MSMC does have the understanding that nonsteroidals are just as effective.

Administrator Lappen concurred that folks who are strongly motivated for drugs can present significant challenges for doctors. At a previous experience where he helped run a mental health outpatient clinic in another county, stimulants and benzodiazepines clients were coming to the clinic with adamant demand for those drugs. The clinic doctors were conservative in granting those drugs, which resulted in patients filing formal complaints on a daily basis. There needs to be a safety valve or appeal process within the governance of scoring systems for doctors who are being ethnical prescribers.

Dr. Lerner inquired about dentists and physicians being required to take education regarding prescribing opioids. She also questioned a recommendation beyond the 2-hour physician course.

Dr. Morris replied. Rather than pain management satisfaction surveys being a simple yes or no, there needs to be a more elaborate line of questioning with regards to pain management satisfaction. The education requirement is for all parties, except nurse practitioners, who own a DEA certification that licenses them to prescribe. It is the only mandatory CME requirement in the State concerning the issue. The cultural thinking by all that pain can completely be taken care of needs to be addressed. Additional requirements can occur beyond the 2-hour physician course but would best happen after giving some time for the current education requirement and other initiatives, such as the PDMP, to play out.

c. Other

Member Macias, who was present for the first time representing those in recovery with lived experience, made a brief introduction at Commissioner Baker's request. He was a former heroin addict with 1.5 years in sobriety, was homeless, recovered through the Housing First program and other County programs, and is serving on a number of different councils or other bodies.

Commissioner Baker said that the Medical Examiner Office (ME) accreditation is at risk due to the immense number of cases before it. Of importance is advocating to increase ME capacity (staffing and facilities) due to its high volume and backlog of cases.

4. Discussion on the opioid crisis as a declaration of national emergency.

Danielle Decker, Intergovernmental Relations (IRD), and Sarah Zarate, Milwaukee Health Department Public Health Planning and Policy Director, appeared and gave an update.

President Trump had signed on March 29th an executive order establishing the President's commission, chaired by New Jersey Governor Chris Christie, on combating the drug addiction and opioid crisis. The commission released its preliminary report on June 16th outlining some national recommendations. President Trump declared a national emergency on August 10th surrounding the opioid crisis as a first step, but has not enacted any act. The declaration is a symbolic gesture until further action is taken, such as enacting the Stafford Act or Public Health Service Act.

There can be two different types of declarations under the Stafford Act: emergency declaration or disaster declaration. An emergency declaration would only really apply in this case, based on IRD preliminary analysis. A governor would be responsible for requesting an emergency declaration in response and must furnish information and coordination with city-county partners. It is recommended for the task force to continue to discuss the matter to prepare for possible activity. Within the emergency declaration allowance, a governor can declare a pre-disaster emergency declaration to preempt an imminent disaster that can be caused by the opioid crisis. This declaration can be more flexible than an emergency declaration and does not require a disaster to have already occurred.

A declaration under the Public Health Service Act would be made by the U.S. Health and Human Services Secretary Tom Price, which has more commonly taken place to address communicable diseases and bioterrorism. This act was most recently used to combat the zika virus in Puerto Rico.

IRD will actively engage the congressional delegation to determine how further action would affect the local levels and will engage FEMA for preparation of further action. There are many different scopes and types of resources under the different federal acts.

Director Lappen remarked. Under an emergency declaration the Institute for Mental Disease restriction on Medicaid providers could be relaxed. For instance, there can be Medicaid reimbursement for residential providers of substance abuse disorder services that have more than 15 beds. Most of BHD treatment providers have more than 15 beds and are eligible for Medicaid reimbursement. IMD exclusion was asked to be relaxed by 36 senators specifically for substance abuse treatment facilities, and there seems to be strong national support. The guard against institutionalizing has inappropriately come to apply to treatment facilities where people need treatment the most.

Commissioner Baker commented. The 15 bed threshold was set for decades to guard against institutionalizing individuals but should be revisited and modified accordingly. At a minimum there should be advocacy from state delegates for quick access to, purchase of, and free distribution of the national stockpile of drugs (narcan, buprenorphine, vivtrol, etc.) to alleviate the cost prohibitive nature of expanding downstream solutions to the crisis.

Member Macias said that there should be advocacy for continued access to vivitrol, which costs an expensive $1200 a shot, if Medicaid is severely damaged by the possible passage of President Trump's healthcare plan.

Ms. Decker responded. IRD can work with the Milwaukee Health Department to look further into Medicaid reimbursement for treatment providers that have more than 15 beds and pursue advocating for access to the national stockpile. A declaration may

involve FEMA analyzing both statewide and local level impact to determine the possible public assistance program, which is based on per capita impact. It would be advantageous to be ready with respect to both statewide and local level impact. IRD will work with delegates and the federal government for the City and County to be in the best possible position. She may investigate further as she is unsure how the stalled American Healthcare Act would affect Medicaid coverage for vivitrol as well as whether the Stafford Act or Public Health Service Act would pick up where Medicaid coverage stops.

Dr. Lerner added that the disaster with current levels of fatalities may help the ME office in finding additional resources and capacity.

Ms. Zarate commented. She can provide to the task force a few articles that break down national level activities. Access to the national drug stockpile would fall under the Public Health Service Act where Secretary Price would be able to buy drugs at discounted prices through the strategic national stockpile and provide them free to states. Secretary Price would also be able to reasonably negotiate the lowering of drug costs.

Commissioner Baker added comments. The types of declaration discussed is all about expediency where more severe conditions would yield a quicker response from the federal government. The opioid crisis is a slow moving, cumulative disaster that is reaching a crescendo. The fear is that FEMA and other federal agencies will not look at the previous ten years when looking at a threshold regarding the crisis. IRD input is welcomed on the matter, and the task force should assist in any way. There is public and congressional sentiment that the pricing of drugs is wrongfully becoming out of control, which should be pursued and addressed.

Ald. Murphy left the committee at 10:31 a.m.

5. Work groups update.

Mayor St. Marie-Carls gave an update on the collaboration work group. There have been a few conference calls. Recruiting of a substance abuse manager in the Milwaukee Health Department would assist the work group. The work group is working on gathering data and funding resources, looking at a starting point to set up and maintain a database, looking at possibly partnering with a PHD student to find and write for grants, and wanting to be more productive by more face-to-face meetings as opposed to teleconferences. One goal is to get 100 percent participation from all 12 health departments from 19 municipalities.

Dana Thompson, Clean Slate, appeared and gave an update on the continuum of care work group. Task force goal D has been revised to "ensure there is adequate access to timely, affordable, and quality services for substance abuse disorders." Some strategies and tactics have been narrowed down, including expanding medically assisted treatment (MAT) capacity for those with opioid use disorder. The work group has looked at those using their x-waivers, advocating changes in the ability to bill insurance, expediting the approval process for coverage (pre-authorization for prescriptions and access to MAT), educating providers through creation of a physician mentorship program, expediting residential treatment capacity and funding, advocating changes for Medicaid reimbursement, adding a 16th bed, advocating policies that support housing as healthcare, supporting sober housing, reducing the wait time for admission to treatment, and enhancing care management for those identified with a

substance use disorder moving from emergency department admissions to treatment.

Dr. Morris appeared and gave an update on the community understanding work group.

Task force goal C has been modified to read "promote community understanding of pain, pain management, and substance abuse disorder to achieve a reduction in opioid exposure in order to reduce the risk of individuals developing abuse of medications including heroin and cocaine." A tactic is to develop a community engaged and informed health promotion campaign focused on prevention, destigmatizating substance abuse disorder, and promoting treatment. A community advisory panel is to be engaged and sought for campaign development. Work group recommendations include identifying community knowledge, beliefs, and attitudes about substance abuse; developing and identifying a social media plan; doing audience testing of health promotion campaigns in a community participatory design, and evaluating campaign materials and impact.

Another tactic is to monitor and promote all existing community programs focused on stigma reduction and peer support through support of COPE and all of its different features concerning community awareness via a health promotion campaign and its hub for people to receive and identify resources. Other tactics are to monitor and promote school-based initiatives to reduce illicit substance use or recreational drug use; identifying existing school-base curricula; and ensuring all schools have access to the curricula.

Member Macias said that current thought processes must change to look at things as more asset based than needs based and to give addicts opportunities rather than telling them what to do. Addicts hate being told what to do and must choose to get clean despite services being available. Those who want to change will get clean.

6. Work plan update.

Commissioner Baker commented. The most recent work plan, updated 8/14/17, was distributed to members. The work plan continues to be an organic, living document.

There were no other comments made.

7. Public comments.

Michael Vaan, Wisconsin Resource Center (WRC), appeared and testified. He is a clinical substance abuse counselor, a clinical supervisor, a former heroin addict, and has been clean for 40 years. Opioids and heroin are in the prisons and jails. Many who get out of local jails and WRC are overdosing. There are former addicts who do become sober and function well afterwards. A concerted effort, as represented by the task force composition, is needed to address the heroin and opioid crisis. Persons with lived experience are experts, too, should have a voice in meetings, and can offer many things. Politics of addiction should be taken into consideration, and funds should be distributed equally to all communities of color. The brown community had heroin, opioid and cocaine problems in the past, but the issue was not seen back then. People were sent to prison instead. Current efforts and initiatives are due to the issue crossing over into the white, middle-class community and youth populations. There are many initiatives taking place throughout the state that does not include Milwaukee County and its large brown community. Milwaukee does not have a heroin court, but there is one in Green Bay.

Administrator Lappen said that he was familiar with Mr. Vann's substance abuse work in Ozaukee and that Mr. Vann, considered an expert, can serve the task force in any capacity.

Commissioner Baker acknowledged the disparity, importance of addressing reentry from incarceration, and the valuable testimonies of lived persons with experience. He added that Mr. Vann may perhaps be involved with the work groups.

Paul Mozina, appeared and testified. People have never granted the government to have authority to control the right of possessing and consuming drugs. The drug war is illegitimate in its foundation and is rather a war against the people. The drug war is a failure. Drugs are in prisons. The task force needs to consider the City-County costs of the drug war relative to its crime, violence, incarceration, and programs fighting drugs. Members should read Lysander Spooner's "Vices are Not Crimes". There would not be any street drugs, such as fentanyl, if there was no prohibition. As long as there is prohibition there will be demand that will be met, violence, and crime. Corrosive prohibition needs to be taken out of the equation.

8. Meeting frequency, dates, times and location.

a. Next regular meeting (Friday, September 15, 2017)

There was no discussion.

b. Community meetings.

Commissioner Baker commented. The goal is to have two meetings in the community at large, one on the north side and the other on the south side of the City, during nontraditional work hours either during the early evenings or a Saturday. Setting of the community meetings and securing venues, preferably County pavilions, should be managed subsequently through e-correspondence in early September.

Commissioner Baker questioned cancelling the October regular task force meeting due to holding community meetings.

Member Macias said that the task force should keep its October regular meeting.

9. Agenda items for the next meeting.

Director Mathy inquired about Intergovernmental Cooperation Council (ICC) consideration and data to leverage different pots of money and existing County CDBG block grant funds that go to municipalities.

Mayor St. Marie-Carls replied. There has not been any new County CDBG funds coming in, applications for the funds are very specific with regards to what the funds can be used for, and the application deadline is August 21st. ICC can possibly discuss leveraging CDBG funds. The next ICC meeting is September 12th where District Attorney John Chisholm will be appearing to discuss some initiatives and addressing cases not being charged from his office. ICC had already inquired about the opioid crisis prior to this task force being formed. There are certain funds that mayors and village presidents have that can be collaboratively contributed toward an initiative, such as for public awareness. A recent example was a contribution to a

transit initiative.

Commissioner Baker made ending remarks. By the next task force meeting there may be the likelihood of legislative movement at the federal or state level that the ICC and other County entities may have to respond to. The engagement and role of ICC can be an agenda item going forward.

10. Adjournment.

Meeting adjourned at 11:04 a.m.

Chris Lee, Staff Assistant
Council Records Section
City Clerk's Office

This meeting can be viewed in its entirety through the City's Legislative Research Center at http://milwaukee.legistar.com/calendar.

Matters to be considered for this meeting and materials related to activities of the task force can be found within the file:

161554 Communication relating to the activities of the City-County Heroin, Opioid and Cocaine Task Force.

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