State of Illinois Overdose Action Plan

MARCH 2022

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Introduction

On September 6, 2017, in the midst of an unprecedented opioid epidemic that had tragically taken the lives of thousands of our residents, Illinois released its first State Opioid Action Plan (SOAP).[1] Based on three pillars of prevention (preventing the further spread of the opioid epidemic), treatment and recovery (providing evidence-based treatment and recovery services), and response (averting overdose deaths), the 2017 SOAP brought together systems and stakeholders to prevent the further spread of the crisis and to address the needs of people with opioid use disorder (OUD). The SOAP formed the strategic framework for addressing the opioid epidemic in Illinois, setting a statewide goal of reducing the number of projected deaths in 2020 by one-third and formulating a set of nine evidence-based strategies to achieve this goal.

Implementation of SOAP strategies began in late 2017 with the expectation that efforts would be ongoing through 2020, and beyond. The Illinois Opioid Crisis Response Advisory Council (Council) developed recommended initiatives for each SOAP strategy. Implementation Reports released in 2018[2] and 2020[3,4] describe our accomplishments and progress carrying out these initiatives. As described in detail in the Implementation Reports, these accomplishments include:

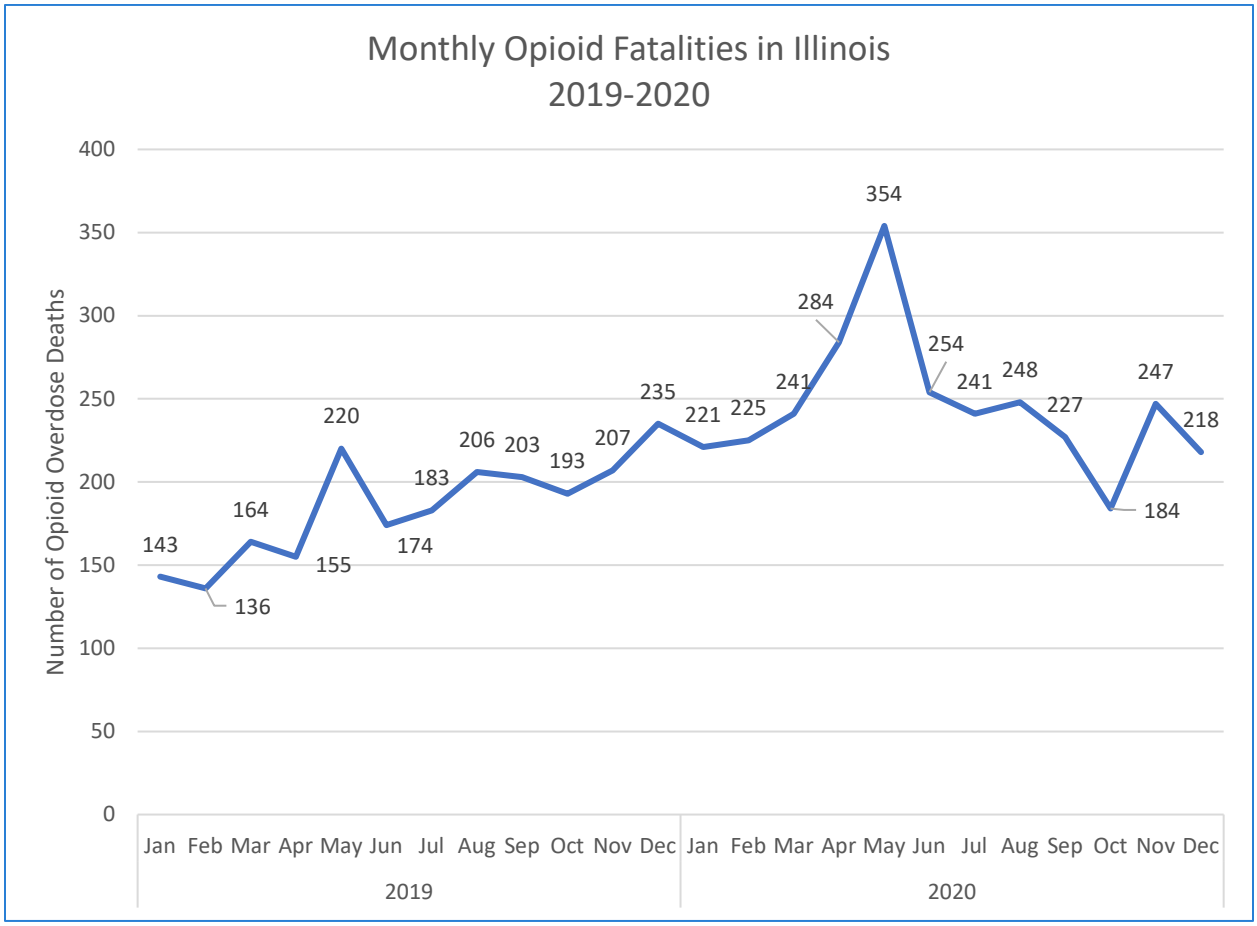
- Reducing high-risk opioid prescribing and dispensing.
- Creating public databases, such as the Illinois Department of Public Health (IDPH)'s Opioid Data Dashboard[5] that provides opioid overdose-related data, including treatment provider and naloxone distribution locations at the county and zip code levels.
- Providing treatment referral and support services for people with OUD and substance use disorder (SUD) via the Illinois Helpline for Opioids and Other Substances (Helpline),[6] a statewide multi-lingual helpline. To date, the Helpline has received over 40,000 calls and more than 200,000 visits to its website.[7]
- Educating people across Illinois about opioids, opioid misuse, and overdose prevention as well as that treatment works, and that people recover through numerous statewide messaging campaigns.
- Providing prevention, treatment, and recovery services to nearly 30,000 people with OUD/SUD through programs supported by the federal Overdose Response Funding (ORF) grants that the Illinois Department of Human Services/Division of Substance Use Prevention and Recovery (IDHS/SUPR) has received from the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Training more than 110,000 people how to administer naloxone to reverse an opioid overdose and save lives.[4]

We also saw the initial success of our early efforts when 2018 data from IDPH showed a 1.6% decrease from 2017 to 2018 in opioid deaths statewide,[8] the first decrease in deaths in five years. These 2018 data also show a 21.6% reduction from the 2020 projected number of fatal opioid overdoses.[9] However, non-fatal opioid overdoses did not decrease, and we began to see new challenges, such as the growing disparities of the opioid crisis in certain communities. In Executive Order (EO) 2020-02, "Strengthening the State's Commitment to Ending the Opioid

Epidemic",[9] Governor Pritzker put strategies into place that build on our progress and emphasize new areas that were not addressed in the 2017 SOAP, such as social equity and harm reduction.

Despite our efforts, overdose deaths began increasing in 2019 and continued into 2020. There was a 3% increase in fatal opioid overdoses from 2018-2019.[10] Statewide, the number of opioid overdose deaths in 2020 increased 33% compared to 2019.

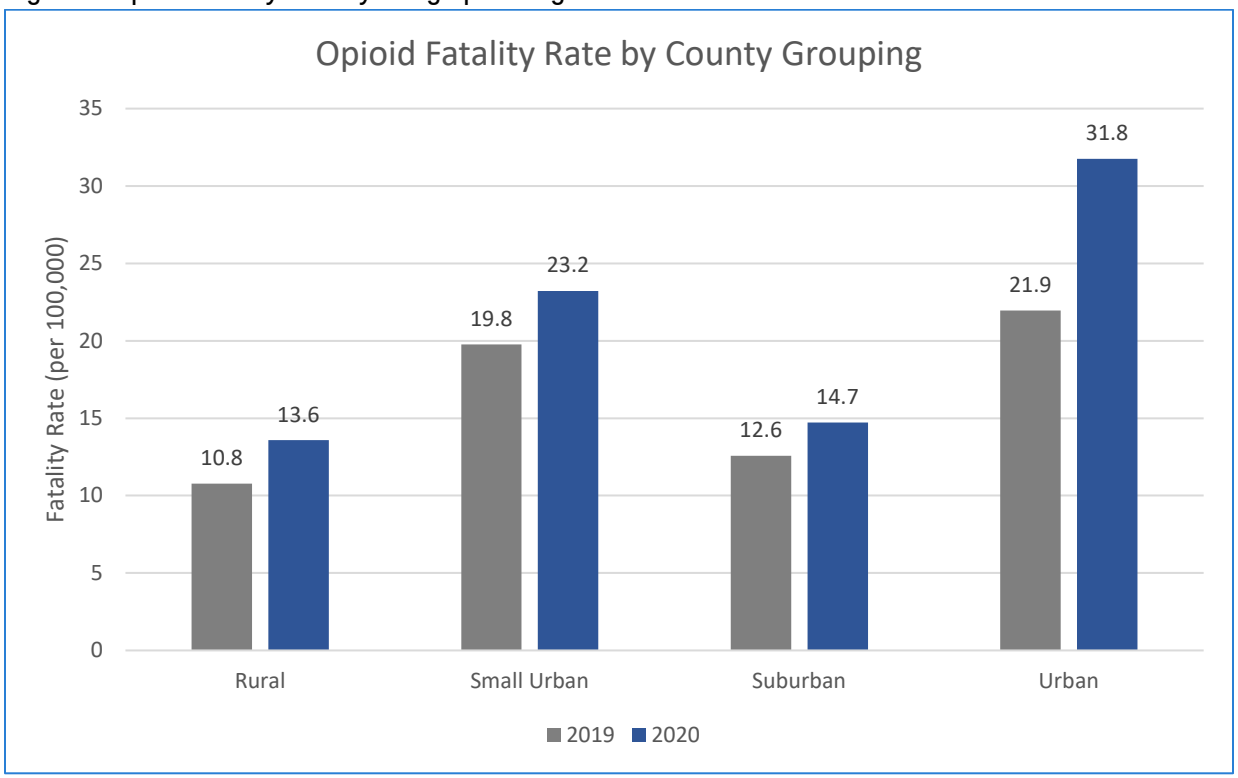
Figure 1. Monthly Opioid Overdose Deaths for 2019 and 2020



Source: Illinois Vital Records System.

Figure 2 depicts regional changes in overdose fatalities. The number of overdose deaths statewide in 2020 increased 45% in urban areas, 26% in rural areas and 17% in small urban and suburban areas compared to 2019.[11]

Figure 2. Opioid Fatality Rate by Geographic Region



Source: Illinois Vital Records System.

This dramatic increase in fatal overdose deaths that prevented us from reaching our 2017 goal to reduce overdose deaths by one-third is happening not just in Illinois but across the United States. Provisional data from the Centers for Disease Control and Prevention (CDC) show that drug overdose deaths nationwide increased 29.4% from 2019 to 2020. There was an estimated 93,000 deaths in 2020, the highest number of overdose fatalities ever recorded in a 12-month period.[12,13] Overdose deaths from synthetic opioids increased by nearly 55% during this same period. This increase in deaths began **before** the COVID-19 pandemic,[14] but accelerated throughout 2020.

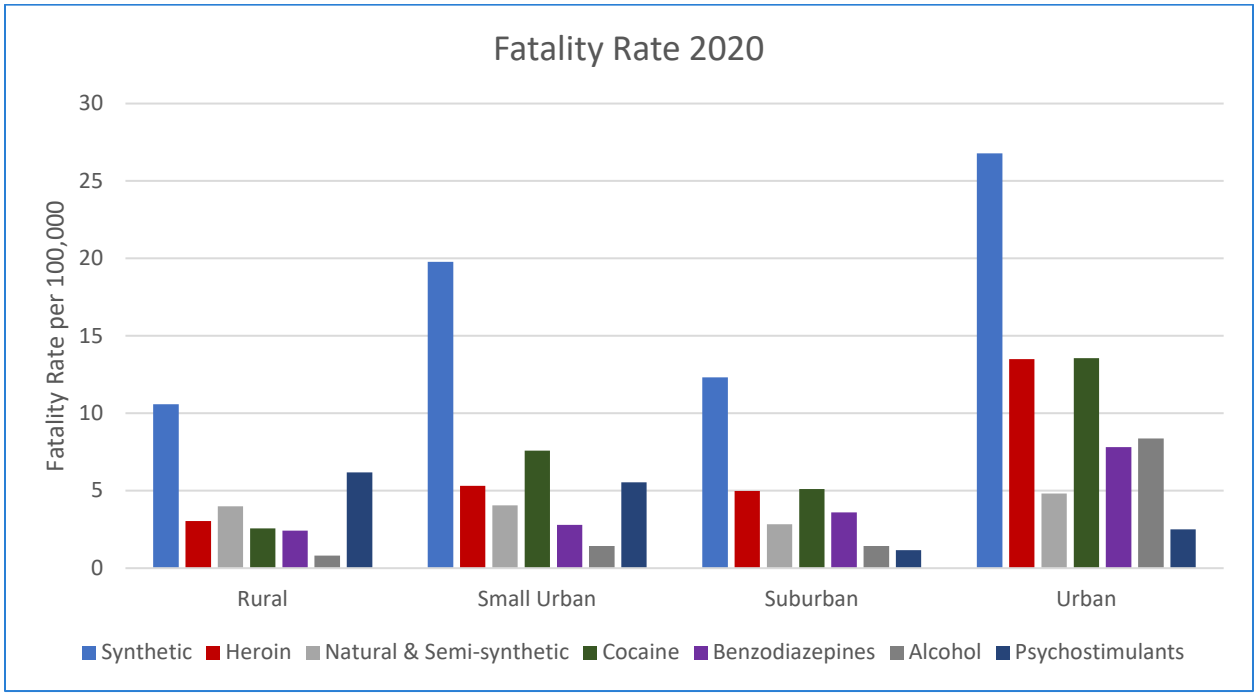
What is driving this increase in overdose deaths? According to the CDC, the influx of fentanyl in the drug supply[13] and increased methamphetamine and polysubstance use[15] are the primary drivers of this increase in overdose deaths. Increases in mortality are likely due to people unknowingly using heroin and/or synthetic opioids that are laced with fentanyl as well as people using stimulants—cocaine and methamphetamine—in combination with opioids. We have seen a significant increase in people with OUD using stimulant drugs since 2018.[16] Polysubstance use increases overdose risks, and the combined use of opioids and stimulants is particularly deadly. Unfortunately, the COVID-19 pandemic and its associated stresses, especially social

isolation, job loss, and the disruption of in-person OUD/SUD treatment and recovery support services also play a role in increased overdose deaths.[12]

The opioid epidemic has never been constant. It has and continues to change over time, and we continue to put new initiatives in place to address new challenges. But what we have right now is an **overdose** epidemic. As Figure 3 illustrates, while synthetic opioids are the main cause of overdose fatalities statewide, heroin and cocaine are also involved in a large number of overdose deaths, especially in small urban, suburban, and urban areas of the state, and psychostimulants are involved in the majority of overdose deaths in rural areas. To save lives, we need to reach out to and engage individuals who are at risk for both fatal and non-fatal overdose due to multiple drugs: synthetic opioids, heroin, cocaine, methamphetamine, and other substances. We don't just need a statewide opioid action plan: we need a statewide **overdose** action plan that includes new efforts to address the changing nature of the overdose crisis and builds on our prior progress in stopping overdoses and saving lives.

It's not just an opioid epidemic, it's an OVERDOSE epidemic!

Figure 3. Overdose Fatalities by Geographic Region and Substances Involved

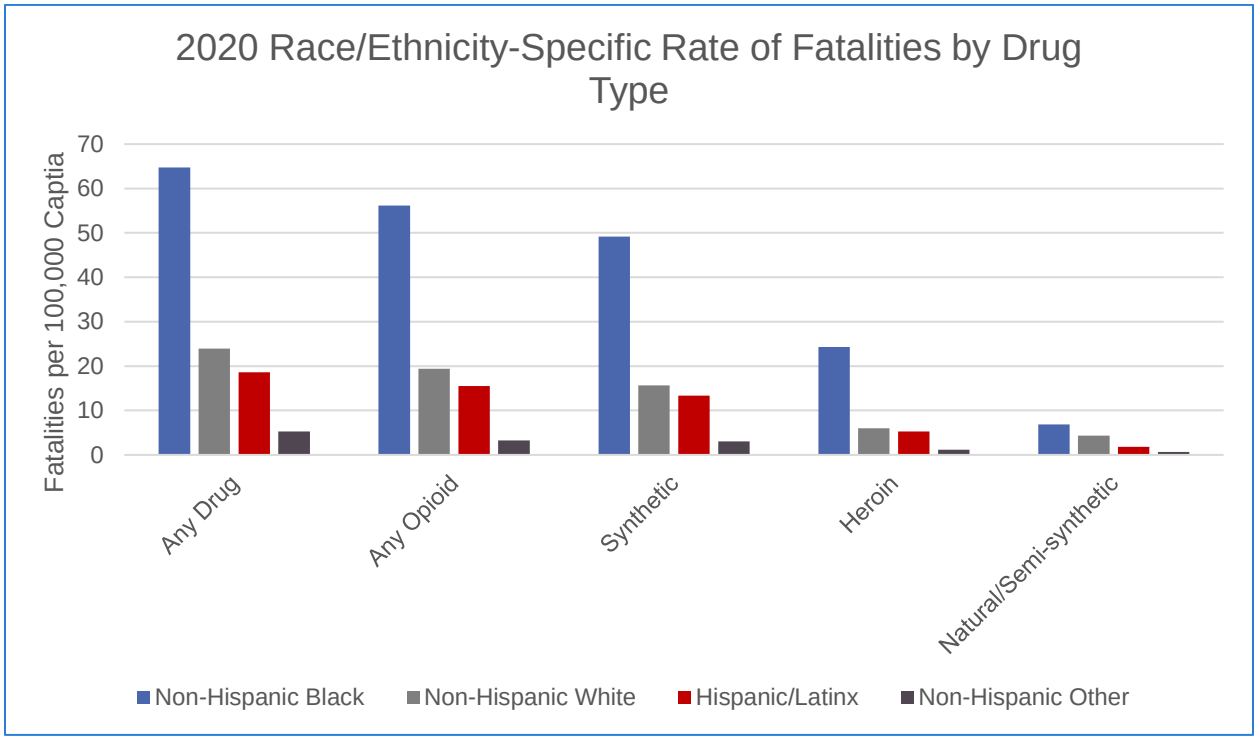


Source: Illinois Vital Records System.

Addressing Racial and Social Disparities in the Overdose Crisis

There has been, and continues to be, significant racial and social disparities in the overdose crisis. The EO recognizes that certain communities in Illinois—primarily racial and ethnic minority communities—have been disproportionately impacted by the overdose crisis and face greater difficulties than White communities accessing OUD/SUD treatment and recovery support services.[9] In 2018, IDPH data showed that, while opioid overdose deaths among non-Hispanic White residents in Illinois decreased 6.5%, deaths among non-Hispanic Black residents increased by 9.1%. In 2020, as shown below in Figure 4, non-Hispanic Blacks were more than twice as likely to die from any drug overdose than non-Hispanic Whites.

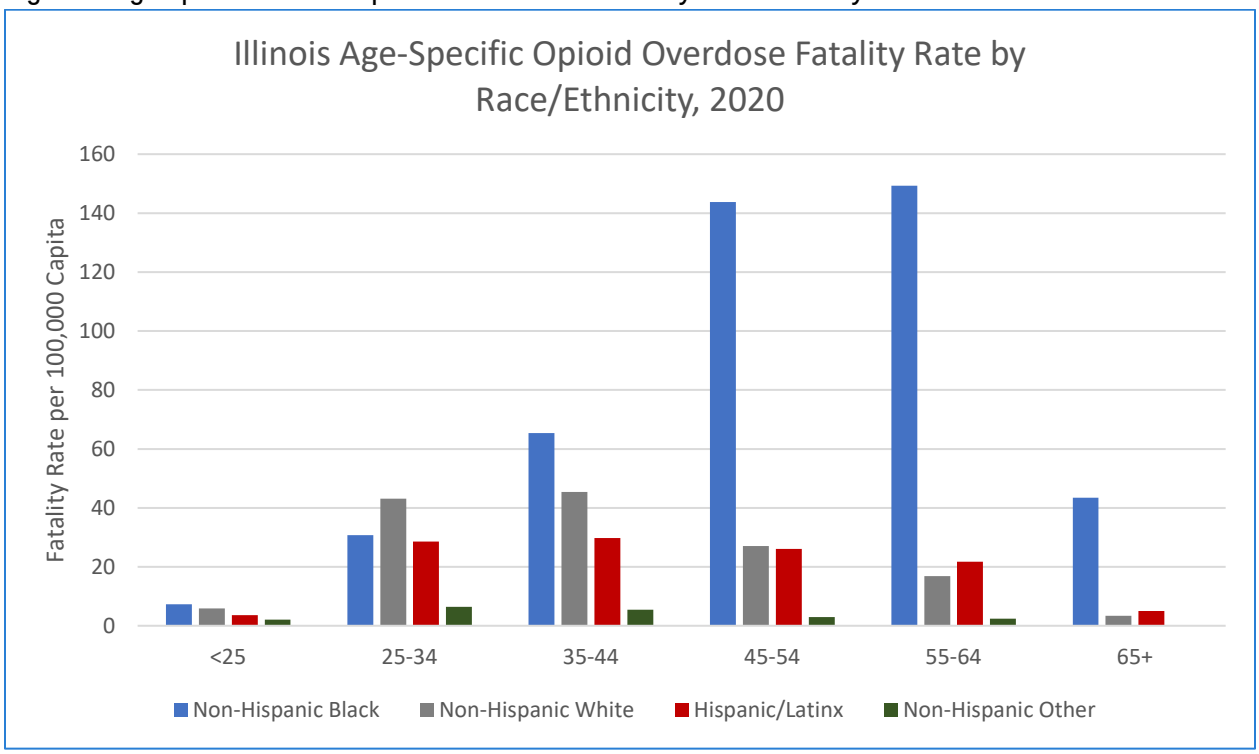
Figure 4. Fatal Overdose Cases by Race/Ethnicity 2020



Source: Illinois Vital Records System.

The racial disparities in overdose deaths continue to exist. As Figure 5 shows, in 2020, the highest opioid overdose fatality rate across all age groups occurred among non-Hispanic Blacks, with the exception of the 25-34 age group, where non-Hispanic Whites had the highest fatality rate.[11]

Figure 5. Age-Specific Rate of Opioid Overdose Fatalities by Race/Ethnicity in 2020



Source: Illinois Vital Records System.

To save lives, we **must** address the social inequities that underlie the racial disparities in overdose deaths. While social equity is one of the five categories that form the basis of the 2022 SOAP, it is also the lens through which we implement initiatives and assess our progress. This includes acknowledging the role of structural racism and social determinants of health and ensuring that **every** priority and recommended initiative takes these factors into consideration. It also includes actively involving people of color in developing and implementing recommended initiatives, as emphasized in the working social equity statement developed by the Council's Opioid Social Equity (OSE) Committee:

*We recognize that communities have experienced structural racism, stigma and other systems of oppression and built strong, social, human, and cultural capital to manage racism and inequity. This capital must be the foundation of our efforts to redress health and social inequities. This means meeting people where they are, asking, listening to and using **their** definitions of justice and fairness, and ensuring that people who are impacted by a problem are involved in the decision-making and are part of the solution. Everyone should have a fair opportunity to attain their full health potential, and no one should be disadvantaged from achieving this potential. This includes addressing social, geographical, and structural determinants of health; focusing on humanistic, person-centered care; and developing just policies.*

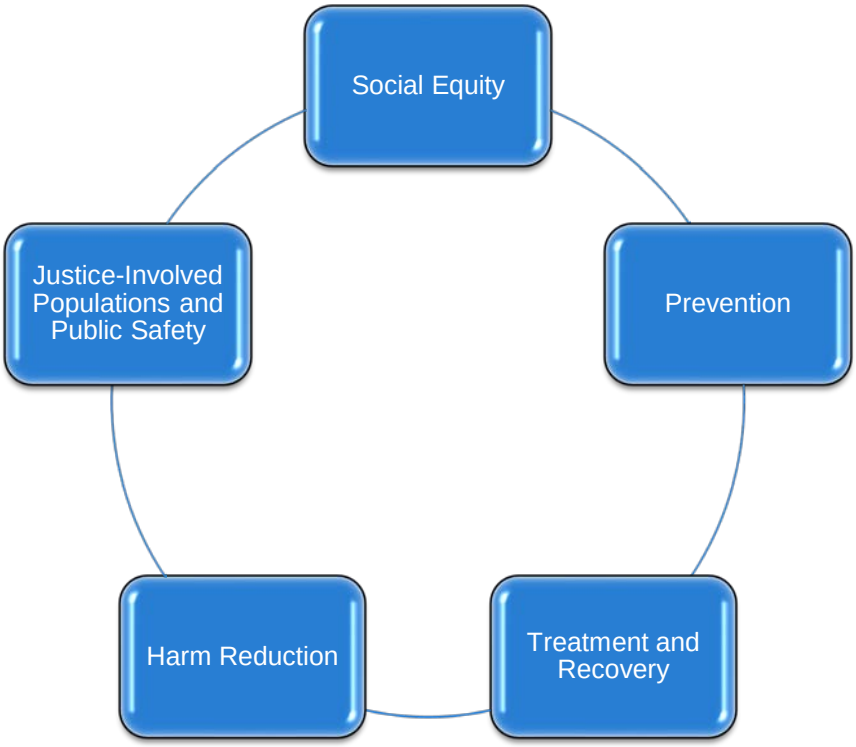
2022 SOAP Recommendation Development and Prioritization

In the Fall of 2020, the Council submitted 85 recommendations for the 2022 SOAP. A small group from IDHS/SUPR and IDPH reviewed each recommendation and assigned recommendations to the State agency (or agencies) that can best address it based on the agency's focus and function. State agency workgroups, as well as a workgroup comprised of members of the Governor's Opioid Overdose Prevention and Recovery Steering Committee (Steering Committee), reviewed, and prioritized their assigned recommendations. Prioritization criteria factors included determining:

- What recommendations are most important and will have the greatest impact on reducing overdoses?
- What recommendations can be implemented now or in the future?
- What recommendations align with current State and/or agency strategic goals?

Led by Lt. Governor Stratton, IDHS Secretary Hou and IDPH Director Ezike, the Steering Committee includes Directors of several State agencies as well as a Council representative and person with lived experience of OUD. The Steering Committee is charged with working with State agencies and other stakeholders through the Council to establish policies and programs that address the changing nature of the opioid crisis.

The workgroups identified 25 high priority recommendations. These priorities have been compiled into five categories that form the basis of the 2022 SOAP.

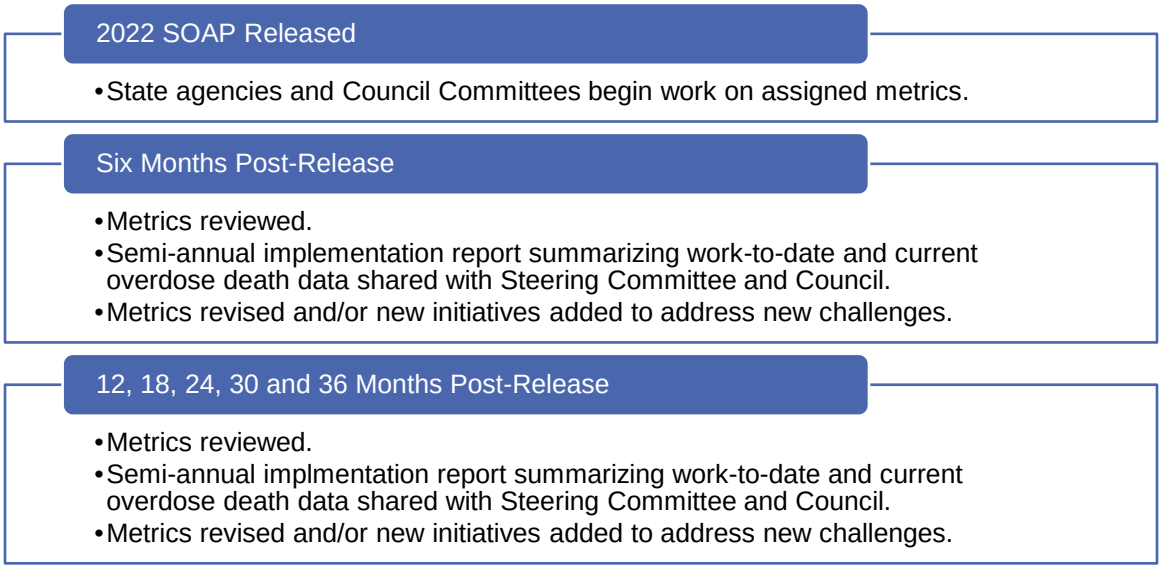


SOAP Implementation

This SOAP is a living document. To that end, **our one broad goal is to reduce the number of overdose deaths in Illinois.** We—State agencies, Council committees and stakeholders—will work together to achieve this goal by implementing the recommended initiatives (i.e., priority initiatives) that were developed by the Council and that address the ever-evolving overdose crisis that is shaped not only by opioids but by polysubstance use, the shifting use of different substances, racial and ethnic disparities, and criminal justice involvement.[1]

Each priority includes a set of metrics that will be used to document our progress in achieving recommended initiatives. Similar to the recommendation prioritization process, metrics will be assigned to the State agency (or agencies), Council committee(s) or other group(s) that can best implement a specific activity. Metrics will be reviewed semi-annually (i.e., twice a year). The semi-annual implementation report that will be a part of this review will summarize each metric's work-to-date. The semi-annual implementation report will include overdose fatality data so that we can examine the impact of SOAP initiatives on reducing overdose deaths. The report will be shared with and reviewed by the Steering Committee and the Council.

Our semi-annual review process will ensure ongoing evaluation of our priority initiatives and will allow us to assess whether and how we are accomplishing our goal to reduce the number of overdose deaths statewide. It will help us determine what metrics need to be revised, as well as identify the initiatives listed in the Additional Recommendations section that need to be implemented to address new challenges.



[1] During the review and prioritization process, we learned that several Council recommendations are being addressed by various State agencies and/or coalitions. To avoid duplication of effort, we chose not to list those recommendations as high priority initiatives. Instead, as appropriate, they are included in the Additional Recommendations section.

Social Equity

National data show a surge in opioid-related overdose deaths in Black and Latinx communities.[17–20] In some areas of the country, rates of fatal opioid overdoses in Black and Latinx communities now outpace overdoses in White populations.[21,22] In Illinois, as Figures 3 and 4 above illustrate, the highest opioid overdose fatality rates have consistently occurred in non-Hispanic Black populations since 2018. Structural racism, and social and health inequities are underlying causes of these racial disparities in fatal and non-fatal overdoses. As discussed above, we need to actively involve people of color in developing and implementing initiatives and interventions to address these inequities. We also need to review data that can help us better identify and address where and how disparities in access to and receipt of treatment and recovery support services exist and to develop policies to mitigate those disparities.

Priority 1: Address structural racism through community engagement activities and other meaningful representation of people with lived experience (PLE), including people who use drugs (PWUD) and people from racially and geographically diverse communities on the root causes of treatment inequities and by increased representation in State workforces and systems changes.

Black and Latinx communities have historically faced structural and institutional barriers that contribute to high opioid overdose rates, including limited access to treatment options,[23–25] physician bias,[25,26] and the failure to address the needs of people of color in government-funded opioid initiatives.[25–27] Decades of research on the War on Drugs, which imposed harsh criminal sentences for low-level drug offenses, show a disproportionate impact on Black and Latinx communities,[18,28] including higher rates of arrest and incarceration and long-term negative effects on education, employment, housing, public safety and access to many essential services.[29]

Structural racism manifested by inequities in criminal justice enforcement and involvement, socioeconomic opportunity, access to quality housing, educational opportunity, and health care access are root causes that need to be addressed. This includes exploring efforts that decriminalize drug possession. For example, the Drug Policy Reform Act (DPRA) of 2021, which was introduced in the House of Representatives in June 2021, will remove criminal penalties for drug possession at the federal level, shift the regulatory authority of drugs from the Attorney General to the Secretary of Health and Human Services (HHS), expunge records and provide re-sentencing, and invest in alternative health-centered approaches towards drug use and misuse. The bill will also eliminate many of the life-long consequences associated with drug arrests and convictions, including the denial of employment and public benefits.[30]

Recommended Initiatives

- Convene summits in racially and geographically diverse communities that include PWUD, pregnant and postpartum women (PPW) with OUD/SUD, people in recent recovery, faith leaders, local Recovery Oriented Systems of Care (ROSC) councils, and Regional Leadership Centers (RLCs) to identify the causes of inequity and the potential interventions that can address those inequities.
- Conduct focus groups, surveys, and peer-led key informant interviews with PWUD, people in recent recovery and PPW with OUD/SUD in racially and geographically diverse communities to learn how the current structure of the treatment and recovery system serves them, and what the State can do from their perspective to improve accessibility.
- Conduct focus groups with faith leaders in racially and geographically diverse communities to learn how the current structure of the treatment and recovery system serves their communities, and what the State can do from their perspective to improve accessibility.
- Submit a report summarizing summit discussions and focus groups, surveys, and peer-led key informant interview results. The report should highlight strategies identified by summit, focus group, survey, and key informant interview participants to address treatment and recovery system inequities and increase the active involvement of stakeholders (PWUD, people in recent recovery and community members) in the State's prioritization, implementation, and funding of these strategies.
- Conduct a brief survey with summit, focus group, survey and peer-led key informant participants six months after the report is released to assess their satisfaction with the State's implementation and funding of their recommended strategies.
- Monitor the Illinois state legislature and U.S. Congress for bills that arise related to SOAP social equity principles, including the DPRA of 2021 and other drug decriminalization efforts. This will help us pursue systemic change by determining which bills should be supported, and uplift efforts from our legislative partners.

Metrics

- Summits on the causes of inequity and potential interventions to address those inequities convened in racially and geographically diverse communities.
- Number of summit participants who are PWUD, people in recent recovery, faith leaders, ROSC Council members and RLC members.
- Focus groups, surveys, and peer-led key informant interviews that collect data from PWUD and people in recent recovery in racially and geographically diverse communities on treatment and recovery system services conducted.
- Focus groups with faith leaders in racially and geographically diverse communities on treatment and recovery system services conducted.
- The report summarizing summit discussions, focus group, survey and peer-led key informant interview results that identifies strategies to address treatment and recovery system inequities and active involvement of stakeholders submitted to the Steering Committee and the Governor's Office.

- Brief survey assessing summit, focus group, survey and peer-led key informant participants' satisfaction with the State's implementation and funding of their recommended strategies conducted.
- State and federal legislatures monitored by the Council's Opioid Social Equity (OSE) Committee for bills related to drug decriminalization and other social equity-related issues.
- Reports on these bills shared with the Steering Committee and Council to inform decisions on which bills and efforts from our legislative partners should be supported.

Priority 2: Promote equitable organizational practices by hiring and paying a living wage to PWUD, people in recovery, and people who have criminal justice records.

PWUD and people in recovery often have criminal records, and 60% of people with criminal records commonly struggle with an OUD/SUD.[31] Having a criminal record makes it difficult to find and keep a job and build a career.[32] Stable employment after returning from the criminal justice system reduces the risk for relapse, overdose, and recidivism.[33] There is a need to incentivize equitable hiring and payment practices to provide needed opportunities for PWUD, people in recovery and those with criminal justice backgrounds to earn a living wage and build employment histories that can improve their overall quality of life. At the same time, we need to provide training and technical assistance to potential employers to ensure that workplaces support people in recovery. IDHS/SUPR provides training on culturally-competent and trauma-informed care to organizations that it licenses that could serve as a model for these trainings.

Recommended Initiatives

- The State should offer training and technical assistance to employers to support recovery-friendly workplaces and cultures and ensure equitable work environments for people in recovery.
- State-funded services should provide ongoing staff training on culturally-competent and trauma-informed care.
- Rate structure development for state-funded services should incorporate living wages, particularly for PWUD, people in recovery and people who have criminal justice records.

Metrics

- Training and technical assistance materials on recovery-friendly workplaces and cultures developed.
- Training and technical assistance materials on recovery-friendly workplaces and cultures posted on IDHS/SUPR's website.
- Number of training and technical assistance materials disseminated to organizations that provide State-funded services, the Illinois Chamber of Commerce and local community chambers of commerce.
- Number of training and technical assistance materials on recovery-friendly workplaces and cultures downloaded from IDHS/SUPR's website.

- Number of visits to training and technical assistance materials on recovery-friendly workplaces and cultures webpage.
- Number of culturally-competent and trauma-informed care staff trainings delivered at organizations that provide State-funded services.
- Number of people who participate in culturally-competent and trauma-informed care staff trainings delivered at organizations that provide State-funded services.
- Rate structure development for State-funded services incorporates living wages, including for PWUD, people in recovery and people who have criminal justice records.

Priority 3: Review client demographic data to help identify and address disparities in access to and receipt of medication assisted recovery (MAR), harm reduction and recovery support services.

Black and Latinx individuals are less likely to be referred to and receive MAR, harm reduction, and recovery support services. Data on State funding for OUD/SUD services, demographic characteristics of individuals who access and receive treatment, and wait times could potentially help identify where and how disparities are occurring and help direct resources to racial and ethnic minority communities and/or organizations that provide OUD/SUD treatment in these communities. However, the data needed to accurately assess these disparities are difficult to collect. Targeted efforts are needed to identify appropriate data sources and encourage timely data collection.

Recommended Initiatives

- The State should identify data sources that could be used to identify the demographic characteristics—particularly age, race, ethnicity, and language spoken—of individuals who seek and receive treatment for OUD/SUD. Suggested data sources include the Helpline and Government Performance and Results Act (GPRA) data collected for services funded by SAMHSA ORF dollars. If these data are not available and/or reliable, the State should consider using zip code data on the racial/ethnic makeup of the municipalities, and/or counties served by State-funded providers as a proxy for the racial and ethnic characteristics of people receiving these services.
- The State should regularly monitor and analyze these data to help identify potential treatment disparities and direct resources to address these disparities.
- Organizations that provide MAR, harm reduction and recovery support services to people with OUD/SUD should be encouraged to collect and report client demographic data to 1) identify their own service inequities and 2) improve service delivery to people of color.

Metrics

- Appropriate data sources for demographic characteristics of people who receive State-funded treatment for OUD/SUD identified.
- Analyses identifying treatment disparities conducted annually. Reports summarizing results of disparity analyses shared with the Steering Committee and State agency directors.
- Client demographic data collection, analysis and reporting guidelines developed and shared with organizations that provide MAR, harm reduction and recovery support services to people with OUD/SUD.

Priority 4: Support communities in establishing and growing systems for supporting all families impacted by OUD/SUD and connect them to relevant services.

Substance misuse impacts not just individuals but their families and communities. Opioid misuse among women of reproductive age affects their own health as well as the health of their children. Children who have a parent with an OUD/SUD are at an increased risk for physical, developmental, and behavioral health problems—including substance misuse—that can last into adulthood.[34] The grandparents, aunts and uncles, and adolescent siblings who step in to care for children whose parents have an OUD/SUD also experience their own increased physical and behavioral health problems.[35] This "ripple effect" of OUD/SUD impacting family members across generations also is felt by communities and the various systems that provide services and supports to parents with OUD/SUD, their children, and kinship caregivers.

In Illinois, opioid use during pregnancy has increased significantly in the last ten years. Fatal opioid overdoses among pregnant women increased 10-fold from 2008-2017, and nearly doubled from 2016 to 2017.[36] There was a 52% increase between 2011-2016 in the neonatal abstinence syndrome (NAS) rate of infants born in Illinois.[37] Additionally, data show that 45% of overdose deaths occur among people ages 25-44, prime parenting years.

There is a critical need in Illinois for a collaborative continuum of care that is committed to supporting families impacted by OUD/SUD. This collaborative continuum of care must include services and supports across systems, including maternal and child health, substance use and mental health treatment, primary and hospital care, child welfare, public benefits and entitlements, prevention, early childhood development, and education. Partnerships across these systems are needed to create and sustain integrated, family-based treatment services that can meet the needs of parents with OUD/SUD, their children, and kinship caregivers. Several initiatives are underway, including the Governor's Office of Early Childhood Development's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program for at-risk pregnant women and parents. IDHS/SUPR has federally-funded projects that use doulas and certified peer recovery specialists (CPRS) to provide family-centered treatment to pregnant and postpartum women (PPW) with OUD/SUD. IDHS/Division of Family and Community Services' (DFCS) Office of Family Wellness reaches vulnerable families through its family case management program as well as through its oversight of the federal Women, Infants and

Children (WIC) nutrition program. The Opioid Use Disorder, Maternal Outcomes and Neonatal Abstinence Syndrome Initiative (OMNI), is a cross-systems workgroup that works collaboratively to develop a state workplan to address treatment barriers, reduce stigma, and create standardized systems of support and continuing maintenance/treatment for PPW with OUD/SUD and their families. OMNI members include IDPH, the Illinois Department of Healthcare and Family Services (HFS), IDHS/SUPR, the Illinois Department of Children and Family Services (DCFS) and the Illinois Perinatal Quality Collaborative (ILPQC).

Recommended Initiatives

- Establish a state-wide system for collaboration that includes a lead entity and collaborations that serve all areas of the state to: 1) implement community-driven planning for 0-5 services and accessing funding opportunities; 2) support full enrollment and staffing in all programs; 3) engage families who most need services; and 4) implement a “no wrong door” approach for all families seeking services and supports.

Metrics

- Convene leadership from ongoing initiatives to identify common goals and a lead entity to oversee collaboration on planned activities to support families impacted by OUD/SUD.
- Conduct a needs assessment on parental OUD/SUD that identifies families most in need of OUD/SUD treatment, recovery supports, child and youth and family-centered services, the community-based organizations that provide these services, and barriers to accessing these services.
- Use the needs assessment data to develop recommendations for increasing families’ access to and engagement in OUD/SUD treatment, recovery supports, child and youth and family-centered services, including “no wrong door” approaches that help families gain access to this continuum of care at any point across and within service systems.
- Identify funding opportunities to increase community-based organizations’ capacity to serve families impacted by OUD/SUD.

Prevention

According to the CDC, some of the best ways to prevent overdose deaths are to improve opioid prescribing, reduce exposure to opioids and other substances, and prevent misuse.[38] Opioids continue to be one of the most misused prescription medications in the U.S. In 2019, over 70% of drug overdose deaths involved opioids.[39] While there have been some recent declines in opioid prescribing rates, the amount of opioids prescribed per person is still three times higher than it was in 1999.[40] Education on safe opioid prescribing and OUD/SUD can help address providers’ prescribing practices. The Controlled Substances Act (720 ILCS 570/315.5) requires every prescriber who is licensed in Illinois to prescribe controlled substances to complete three hours of continuing education on safe opioid prescribing practices during the pre-renewal period. Advanced Practice Registered Nurses are required to have 20 continuing education hours in pharmacotherapeutics including 10 hours of opioid prescribing or substance use

education for licensure renewal (225 ILCS 65/65-60). Promoting safer prescribing and dispensing practices continues to be a critical priority for reducing non-fatal and fatal overdoses.[1]

Successful prevention efforts also include broad public awareness, engagement, and participation. Although the very visible impact of the opioid epidemic, including the recent impact of the COVID-19 pandemic, fentanyl, and polysubstance use on the dramatic increase in opioid-related overdose deaths, has brought this issue to the public eye, we continue to need to work toward a greater public understanding of its causes, consequences, and scope. Reducing the stigma associated with OUD/SUD will help us reduce the number of people who begin misusing opioids and other substances, connect people to treatment and prevent overdose deaths.

While primary prevention efforts should be directed at all age groups, priority must be given to efforts that affect youth at or shortly before the times they are most likely to begin to use opioids and other substances. Primary prevention efforts can help curb or delay initiation of substance use, staving off future increases in OUD/SUD. The return on investment for youth prevention services are future-oriented and measured in the number of emerging adults who do not start misusing opioids and other substances and those who reduce their substance misuse. The education and skills provided to youth through these prevention efforts can have a significant impact on decreasing fatal overdoses.

Priority 5: Reduce diversion of controlled substances prescribing.

Unsafe prescribing and dispensing practices, such as combining opioids and benzodiazepines, greatly increase overdose risks. Prescription monitoring programs (PMPs) are state-run electronic databases that collect and distribute data about the prescription and dispensation of controlled substances. PMPs are intended to reduce the rates of prescription drug misuse, diversion, and overdose. Prescribers are able to view the historical data for current and prospective patients and are required to review the PMP when considering opioids for individual patients. Public Act 100-0564, which was signed into law on December 13, 2017, promotes safer opioid prescribing and dispensing by strengthening the Illinois PMP and increasing PMP use by providers. Since the enactment of Public Act 100-0564, the number of registered PMP users has more than doubled, more than 800 healthcare organizations across the state have integrated their electronic health records (EHR) systems with the PMP through the automated EHR connection service known as PMPnow, and there has been a 45% increase in PMP queries. The PMP also has implemented MyPMP, an analytical tool that helps prescribers better evaluate their own prescribing activity. MyPMP also sends alerts to prescribers about their patients who meet criteria for high overdose risk.

Additional data can further strengthen the PMP's capability to identify at-risk patients. These include patient diagnosis on all prescriptions for controlled substances to determine whether the drugs prescribed are clinically appropriate or warranted and notifying prescribers of a patient's accidental injury or opioid overdose. As mandated in the EO, the PMP has created an Injury and

Accident Notification System (IANS) that will allow the PMP to collect injury, accident and overdose data from healthcare facilities and display that information directly on the PMP. IANS will create proactive notifications to all known prescribers for a patient when an injury or overdose occurs. The PMP is currently piloting IANS with a small number of hospitals statewide.

Recommended Initiatives

- Explore whether patient diagnosis should be included in all prescriptions for controlled substances.
- The Illinois PMP should collect additional data to help identify at-risk patients, such as those with an accidental injury or opioid overdose, and proactively notify prescribers of the associated risk through the implementation of IANS within current PMPnow connections.

Metrics

- Workgroup convened to explore whether patient diagnosis should be included in all prescriptions for controlled substances. Workgroup members include the PMP and the Illinois Department of Financial and Professional Regulations (IDFPR), the Council's Prescribing Practices Committee, people with OUD/SUD and people living with chronic pain.
- Complete connection for initial IANS pilot test sites.
- Notification system that alerts prescribers when a patient has potentially experienced an overdose created by the PMP.
- Implement IANS within PMPnow.

Priority 6: Address high-risk prescribing and dispensing through peer-to-peer academic detailing.

Chronic pain management education provided in health professional schools and postgraduate training is limited. As a result, providers often lack training in appropriate prescribing and dispensing of opioid medications. They may write opioid prescriptions for people who have or are at risk of OUD/SUD without adequate medical justification or oversight, contributing to opioid misuse. They may also prescribe high-risk combinations of opioids with other medications, such as benzodiazepines. Targeted education outreach approaches, such as academic detailing (AD), are supported as an approach to supplement providers' knowledge in lieu of limited chronic pain management education to improve opioid prescribing and dispensing behaviors. AD is a method of educational outreach intended to modify and improve medical decision-making. The PMP worked in conjunction with the University of Illinois at Chicago (UIC) to study the effectiveness of AD as a prescriber and dispenser intervention across the state. Preliminary results show that the number of high dose opioid prescriptions decreased by 25% and the number of patients who were dispensed at least one opioid prescription decreased by 30%.[4] There are several AD efforts taking place statewide. For example, UIC currently provides AD to Medicaid prescribers on OUD and opioid prescribing. Peer-to-peer (i.e., physician-to-physician), AD and technical assistance on opioid prescribing may further reduce high-risk prescribing and dispensing.

Recommended Initiatives

- Provide peer-to-peer academic detailing and/or technical assistance to prescribers and dispensers, including racial and ethnic minority medical providers and associations, to supplement their knowledge of chronic pain management, OUD/SUD and opioid prescribing.
- PMP will work with project partners to develop a process for identifying high-risk prescribers and dispensers for education opportunities.

Metrics

- Roster of peer educators identified by the Council's Prescribing Practices Committee.
- Peer educators work with PMP and UIC to develop AD materials and guidelines for delivering AD.
- Peer educators provide AD to prescribers, dispensers, racial and ethnic minority medical providers, and associations.
- Number of peer education sessions provided to prescribers, dispensers, racial and ethnic minority medical providers, and associations.
- Number of prescribers, dispensers, racial and ethnic minority medical providers and associations who participate in peer education sessions.
- Process for identifying high-risk prescribers and dispensers developed by PMP and project partners.

Priority 7: Continue to conduct and coordinate anti-stigma education campaigns.

Stigma related to OUD/SUD, overdose and polysubstance use prevents people from seeking and receiving treatment and recovery support services.[41] Public misperception and misunderstanding about the overdose epidemic, OUD/SUD, and substance use and treatment contribute to this stigma. Educating the public about the causes of substance misuse—as well as spreading the message that OUD/SUD is a chronic disease, that the overdose crisis and OUD/SUD are health issues, that treatment works, and that recovery is possible—can help decrease this stigma. Increasing access to evidence-based and non-stigmatizing information and resources can encourage people with OUD/SUD to seek help, as well as empower families and friends to connect loved ones who may be misusing opioids and other substances to treatment. The Helpline, our statewide multi-lingual 24-hour, 7-day/week, 365 day/year helpline provides treatment referral and information support services for people with OUD/SUD, their family members, and other supporters. To date, the Helpline has received more than 40,000 phone calls and over 200,000 visits to its website. IDHS/SUPR, IDPH and other organizations have conducted several successful stigma reduction campaigns in the past three years that have reached thousands of Illinois citizens. These include *Ending Opioid Misuse in Illinois, Guard and Discard, A Dose of Truth, Naloxone Now* and a series of Illinois Broadcasters Association public service announcements. Given the recent increase in overdose deaths, we need to continue to deliver targeted public education campaigns to reduce stigma and connect people to treatment and recovery support resources. We also need to ensure that this messaging reaches and is relevant to communities that have been hardest hit by the overdose

crisis. At the same time, we need to coordinate stigma reduction campaigns statewide to avoid duplication of effort. For example, rather than conduct two separate messaging campaigns about harm reduction, IDPH and IDHS/SUPR signed an Intergovernmental Agreement (IGA) to support a harm reduction and stigma reduction campaign that IDPH will conduct in partnership with the Helpline. IDPH, IDHS/SUPR and the Helpline also are partnering on an anti-stigma awareness campaign that promotes the availability of treatment programs in Illinois for PPW with OUD/SUD.

Recommended Initiatives

- Over the past three years, numerous stigma reduction campaigns occurred simultaneously in the same geographic regions of the state. The State should coordinate stigma reduction campaigns to identify gaps in target populations, pool resources, strengthen messaging and avoid duplication of effort.
- To better define stigma related to OUD/SUD, overdose and polysubstance use and create effective messaging campaigns, research with people who have experienced stigma (i.e., people with lived experience of OUD/SUD), should be conducted. A diverse group of people—those who have been incarcerated, people of color, and those who live in rural areas—need to be involved in this research to better address racial and geographic disparities.
- Conduct a broad, coordinated campaign on the benefits and availability of MAR via targeted messaging in racial and ethnic minority communities, and rural communities. This campaign also should include anti-stigma messaging directed at providers. This messaging should be shared with local social service and advocacy organizations, as well as substance use treatment and healthcare providers, that serve identified and targeted communities.

Metrics

- Information about planned stigma reduction campaigns listed on the single state website and shared with the Steering Committee and the Council's Public Awareness & Education Committee to increase awareness of stigma reduction campaigns across State agencies and decrease duplication of effort.
- Focus groups on stigma convened with people with lived experience of OUD/SUD, including those who have been incarcerated, live in rural areas and are people of color.
- Focus group results used to develop stigma reduction campaigns targeting racial and ethnic minority communities, and rural communities.
- Broad, coordinated campaign conducted on the benefits and availability of MAR via targeted messaging in racial and ethnic minority communities, and rural communities that includes anti-stigma messaging for providers.

Priority 8: Increase the impact of prevention programming in schools, communities, and other settings where comprehensive evidence-based practices, programs and strategies that reduce risk factors and promote protective factors can reach all Illinois young people.

Adolescents are still in the process of physical, social and emotional development, and they are more likely to take risks, be influenced by their peers and experiment with illicit substances.[42] Substance misuse can have a devastating impact on young people's lives. Youth who engage in non-medical use of prescription opioids and heroin use have poor school adjustment, worsened mental health and high rates of polysubstance use.[43–45] Young people who misuse opioids also are more likely to experience violence and victimization.[46] A recent study of 26,233 Illinois high school students ages 18 and older found that youth who reported using opioids in the past year were more likely to report lower grades, polysubstance use, depressed mood, suicidal ideation and bullying victimization than youth who did not report prior year opioid use.[47]

While there are several school-based prevention efforts taking place across the state, we need to ensure that prevention programming reaches **all** Illinois young people. Youth who misuse opioids and other substances have high rates of truancy;[48] thus, they are less likely to receive school-based prevention programs. We also need to ensure that prevention programming includes comprehensive evidence-based strategies that reduce substance misuse risk factors and promote protective factors. These include community-based programs that engage families and community members in prevention efforts; address the role of adverse childhood experiences (witnessing and/or experiencing violence, abuse and/or neglect), especially among young people of color;[49] reach out to youth who do and do not attend school; and take into account the social and health inequities that racial and ethnic minority communities experience.[50,51]

Increased collaboration between state agencies that impact the lives of youth, such as the Illinois State Board of Education (ISBE), IDHS/SUPR, IDHS/DFCS, IDPH and DCFS, can help strengthen the substance use prevention system in Illinois. The current relationship between IDHS/SUPR and ISBE specific to section 22-81 of the Illinois School Code (105 ILCS 5/22-81) has begun to expand. We must continue this relationship, as well as establish collaborations with other youth-serving state partners and organizations to reach young people and reduce their substance misuse and overdose risks.

Recommended Initiatives

- Expand opportunities for collaborations across youth-serving state agencies and organizations specific to substance use prevention.
- Explore the use of evidence-based programs and practices across the prevention continuum from universal to selected strategies that address young people's substance use.
- Expand the reach of the current ISBE and IDHS/SUPR relationship driven by the Illinois School Code.

Metrics

- Workgroup of state agencies and organizations that provide or support services to young people convened to explore opportunities to integrate youth substance use prevention efforts into existing programs and projects.
- Workgroup identifies and promotes evidence-based programs and practices across the prevention continuum from universal to selected strategies that address young people's substance use and develops guidelines for program implementation.
- ISBE and IDHS/SUPR comply with all aspects of the Illinois School Code Section 22-81.

Treatment and Recovery

It is well established that treatment for OUD/SUD is effective and that individuals can and do recover. Yet nationwide, in 2019, among people aged 12 or older who had an OUD/SUD, only 10.3% received any treatment.[52] Another recent study found that that only 16.6% of patients received follow-up treatment after a non-fatal opioid overdose.[53] While nearly 30,000 people with OUD/SUD in Illinois have received outreach, treatment, and support services since 2016 through programs funded by ORF dollars, we need to continue to address barriers to treatment, especially those experienced by people of color, those who live in rural areas, and people involved in the criminal justice system. Ensuring that **all** people with OUD/SUD have access to and receive evidence-based treatment and recovery support services in every community statewide is critical to reducing overdoses and saving lives.

Priority 9: Increase access to MAR.

MAR is the use of evidence-based Food and Drug Administration (FDA)-approved medication (i.e., methadone, buprenorphine, naltrexone) by individuals with an OUD/SUD to support their recovery. IDHS/SUPR recognizes that individuals who identify as in recovery and take medications to manage their OUD/SUD *are* in recovery. MAR decreases opioid-related deaths and reduces opioid misuse.[54] People who use MAR to manage their OUD/SUD are more likely to find work and keep their jobs,[55] have better social functioning and improved relationships with their families and friends,[56] and are less likely to engage in criminal activity[57] or risky behaviors that are associated with infectious diseases.[58] They also are more likely to stay in treatment and less likely to experience relapse.[59] MAR also improves birth outcomes for pregnant women with OUD/SUD.[60]

We have made significant progress in increasing access to MAR statewide. In 2017, 57 counties were MAR "deserts": counties that have no documented access to any of these three medications. PMP data now show that residents in **all** Illinois counties have access to buprenorphine. Despite this progress, many people with OUD/SUD still face barriers to accessing MAR. Justice-involved individuals with OUD/SUD, for example, often experience challenges with re-initiating their public and/or private health insurance when they leave correctional facilities, and may have more difficulty accessing MAR. They also may return to communities that have few MAR and recovery support resources and may rely on residential

treatment programs and recovery homes for housing. As noted in the EO, not all recovery residences provide access to MAR; this may increase the risk of fatal overdoses. We need new, innovative strategies to connect people in areas of high need to MAR.

Recommended Initiatives

- Increase access to low/no barrier 24/7 MAR via mobile MAR units—vans or other forms of mobile transportation—that provide MAR induction, prescribing and dispensing as well as recovery and peer support services in targeted geographic areas of high-risk/high-need.
- Fund street outreach teams to initiate MAR and link people to MAR and other recovery support services. Build capacity for increased naloxone distribution by street outreach teams, especially in communities experiencing high rates of overdose.
- Increase access to MAR in recovery residences by 1) providing buprenorphine initiation in these settings and 2) establishing linkages to federally qualified health centers (FQHCs) and other prescribers to ensure that people are able to stay on buprenorphine while living in recovery homes or after completing residential treatment.
- Increase Opioid Treatment Programs' (OTPs) access to all three forms of MAR. Strategies include: training and technical assistance on buprenorphine and buprenorphine prescribing; developing sustainable funding for all three forms of MAR; and working with pharmacies to increase access and availability to all three forms of MAR.
- Create best practice guidelines for OTPs and American Society of Addiction Medicine (ASAM) Level 3.5 residential treatment programs that work with people who are prescribed methadone.
- Leverage the Helpline to identify recovery residences and OTPs that provide access to MAR.
- Explore best practice guidelines and standards of care for hospitals and healthcare systems to treat patients with OUD/SUD at every ASAM level of care.

Metrics

- Number of mobile MAR units that provide MAR induction, prescribing and dispensing and recovery support services in targeted geographic areas of high-risk/high-need.
- Number of people with OUD/SUD who receive mobile MAR services.
- Number of street outreach teams that 1) initiate MAR and link people to MAR and other recovery support services and 2) distribute naloxone in communities experiencing high rates of overdose.
- Number of people with OUD/SUD who receive street outreach team services.
- Number of MAR trainings and technical assistance provided to recovery residences and residential treatment providers.
- Number of recovery residences that participate in MAR training and technical assistance.
- Review and finalize the Council's MAR Committee's recommendations for guidelines on ensuring access to MAR for people living in IDHS/SUPR licensed recovery residences.
- Number of trainings and technical assistance on buprenorphine and buprenorphine prescribing provided to OTPs.

- Number of people who participate in OTP training and technical assistance on buprenorphine and buprenorphine prescribing.
- Develop financing mechanisms for all forms of MAR that allow OTPs to fully utilize all medications in an equitable manner.
- Best practices guidelines for OTPs and ASAM Level 3.5 residential programs developed.
- Number of recovery residences and OTPs identified by the Helpline that provide MAR.
- Workgroup convened to explore best practice guidelines and standards of care for hospitals and healthcare systems to treat patients with OUD/SUD at every ASAM level of care. Workgroup members include the Council's MAR Committee and Prescribing Practices Committee, IDHS/SUPR, IDPH, HFS and the Illinois Hospital Association.

Priority 10: Increase initiation to buprenorphine in emergency departments for people who present with opioid overdoses and/or in acute withdrawal.

Emergency departments (EDs) are one of the best places to reach people who are most at risk for fatal and non-fatal opioid overdoses. Studies show that administering buprenorphine in EDs results in much greater treatment retention after inpatient care and helps effectively manage cravings and withdrawal symptoms.[61,62] Massachusetts passed legislation in 2018 mandating that all EDs in the state either be capable of initiating buprenorphine or establish a partnership with a nearby community organization that can administer burprenorphine.[63] California and New York have implemented pilot programs to test the impact of this practice in a small number of EDs,[64,65] and there is a growing consensus among federal officials that such approaches hold promise.[66] In Illinois, the Chicago Department of Public Health (CDPH) and the Illinois Public Health Institute recently launched the Chicago Linkage to Assisted Recovery and Treatment program that will work with hospitals to build internal capacity for MAR initiation within their EDs. Rush University Medical Center plans to launch an effort to initiate buprenorphine treatment in their EDs as part of an ongoing project that uses peer recovery support specialists to connect people in EDs to MAR.

Recommended Initiatives

- Develop and implement ED buprenorphine initiation pilot program.
- Establish a learning collaborative for hospitals; topics should include "lessons learned" from existing ED buprenorphine initiation programs and address barriers to ED buprenorphine initiation such as the lack of ED clinicians who can prescribe buprenorphine and linkages to buprenorphine prescribers post-ED discharge.
- Use pilot program and learning collaborative results to 1) create best practice guidelines for ED buprenorphine initiation and 2) evaluate next steps in formalizing the practice in hospitals statewide.

Metrics

- ED buprenorphine initiation pilot program implemented.
- Learning collaborative on buprenorphine initiation in EDs established and offered to hospitals statewide.
- Number of hospitals that participate in ED buprenorphine initiation collaborative.
- ED buprenorphine best practice guidelines developed.
- ED buprenorphine pilot program and learning collaborative results used to evaluate next steps in formalizing the practice in hospitals statewide.

Priority 11: Increase the number of DATA-waivered prescribers.

In order to prescribe buprenorphine, qualified prescribers—physicians, nurse practitioners and physician's assistants—must obtain a Drug Addiction Treatment Act of 2020 (DATA) waiver. The training and practice standards, patient prescribing limits and a designation known as an X-waiver from the DEA often are barriers to clinicians obtaining a DATA waiver and prescribing buprenorphine.[67] Multiple policy efforts, including the Mainstreaming Addiction Treatment Act (H.R. 2482), would abolish the X-waiver and remove many of these barriers to buprenorphine prescribing. The bill was re-introduced to Congress in February of 2021 with bipartisan support.[68] The U.S. Department of Health and Human Services (HHS) published updated buprenorphine practice guidelines in the April 28, 2021 Federal Register.[69] These guidelines allow qualified clinicians to prescribe buprenorphine to treat up to 30 patients at any one time for OUD **without** obtaining the certification requirements related to training, counseling, and other ancillary services. Providers are still required to submit an application designated as a "Notice of Intent" (NOI) in order to prescribe buprenorphine for treatment of OUD, however, they will not have to certify as to their capacity to provide counseling/ancillary services or provide certification of training. The NOI must be submitted to SAMHSA before initial dispensing or prescribing of OUD treatment medication. However, training is still required if a practitioner wishes to treat more than 30 patients. Additionally, time spent practicing under this exemption will not qualify the practitioner for higher patient limit.

Removing these two requirements will decrease barriers to prescribing buprenorphine for OUD, especially for ED clinicians. However, it will not address the potential lack of comfort or knowledge of incorporating addiction care as part of a prescriber's clinical practice. IDHS/SUPR has implemented several initiatives to increase the number, knowledge, and comfort level of DATA-waivered prescribers in Illinois. These include providing funding for a rural opioid training program, supporting Rush University Medical Center's comprehensive weekend training program that provides initial training on buprenorphine, peer-to-peer support, and ongoing technical assistance, and funding the Southern Illinois University (SIU) School of Medicine's program that gives stipends to eligible clinicians to complete DATA waiver training and actively prescribe buprenorphine. IDPH funded programs to increase the number of DATA-waivered obstetric clinicians and DATA waiver training and support for rural prescribers.[4] Efforts to incentivize clinicians to become DATA-waivered and technical assistance to encourage and

support these clinicians to actively prescribe buprenorphine need to continue. These training and technical assistance efforts also need to be expanded to increase the number of buprenorphine prescribers in racial and ethnic minority communities, rural communities, EDs, and FQHCs.

Recommended Initiatives

- Promote existing DATA waiver training (as applicable) and provision of training and technical assistance (i.e., mentoring and coaching) to newly waivered prescribers in racial and ethnic minority communities, and rural communities.
- Continue to provide stipends to incentivize clinicians to begin prescribing.
- Conduct a study exploring the reasons why non-public DATA-waivered prescribers do not want to be listed on SAMHSA's online public registry of waivered providers. Study results should be used to develop and implement strategies that address these prescribers' concerns and encourage them to join the registry.
- Target primary care, ED clinicians and medical students for MAR and technical assistance, and DATA waiver training as applicable. Encourage hospitals and other facilities to actively support their buprenorphine prescribers.
- Make buprenorphine prescribing financially sustainable for practitioners: 1) integrate buprenorphine prescribers into Hub & Spoke networks and FQHCs and 2) consider requiring health systems to have linkages in place for people with OUD. Integration of buprenorphine prescribers into existing systems can improve care coordination for people with OUD as well as support prescribers (i.e., they have network partners where they can refer patients and connect them to services).

Metrics

- Number of existing trainings and technical assistance (i.e., mentoring and coaching) provided to new buprenorphine prescribers in racial and ethnic minority communities and rural communities.
- Number of new buprenorphine prescribers in racial and ethnic minority communities and rural communities who participate in training and technical assistance programs.
- Number of stipends provided.
- Study exploring the reasons why non-public DATA-waivered prescribers do not want to be listed on SAMHSA's online public registry of DATA-waivered prescribers conducted.
- Study results used to develop and implement strategies to encourage prescribers to join SAMHSA's online public registry.
- Work with the Illinois Hospital Association, Illinois Primary Care Association, Illinois Medical Society, medical schools, and the Council's Prescribing Practices Committee to widely advertise buprenorphine prescribing technical assistance, DATA waiver trainings and stipends to primary care and ED clinicians and medical students.
- Number of primary care and ED clinicians and medical students who prescribe buprenorphine.

- Work with RLCs to develop guidelines for hospitals and primary care on how to support their buprenorphine prescribers.
- Number of clinicians prescribing buprenorphine.
- Number of patients clinicians treat with buprenorphine.
- Number of clinicians who prescribe buprenorphine who are linked to existing Hub & Spoke networks.
- Number of health systems that have linkage agreements with clinicians who prescribe buprenorphine.
- Payment mechanism that incentivizes clinicians who prescribe buprenorphine to increase their practices in their geographic location/area of the state developed.

Priority 12: Increase access to MAR for PPW with OUD/SUD.

MAR is the gold standard of treatment for PPW with OUD/SUD.[70,71] MAR reduces opioid use, improves treatment retention and decreases pregnancy complications.[72] Data from the National Survey of Drug Use and Health suggest that in 2017-2018, more than 10,000 pregnant women in Illinois reported substance misuse, yet less than a third of these women reported receiving any treatment.[73] In their April 2021 *Maternal Morbidity and Mortality Report 2016-2017*,[74] IDPH's Maternal Mortality Review Committee (MMRC) lists several barriers PPW experience when trying to access MAR including: lack of knowledge regarding where and how to seek treatment, lack of transportation to and from treatment centers, and being denied treatment due to insurance or pregnancy status. The MMRC also found that some women who tested positive for drugs at the time of delivery were discharged with no follow-up or referrals to MAR or other recovery support services. Some PPW who were started on MAR did not receive follow-up care to monitor their treatment.

To ensure that PPW with OUD/SUD receive life-saving MAR, we need to educate maternal health and other non-medical providers, including early childhood and other family support services, on PPW substance misuse, screening for substance misuse and MAR. Medical providers may be uncomfortable or may not know how to discuss substance misuse with their PPW patients. Along with this, while screening for OUD/SUD is an important first step in helping PPW with OUD/SUD access treatment, few maternal health providers conduct universal screening of PPW for substance use or other healthcare issues. Two initiatives are underway that address provider education on PPW with OUD/SUD, screening, and MAR. ILPQC's Mothers and Newborns Affected by Opioids (MNO) initiative educates maternal health providers at birthing/newborn hospitals statewide on OUD/SUD, substance use screening, and clinical guidance for opioid prescribing. Since PPW with OUD/SUD and their families also need education on substance misuse risks during pregnancy and the postpartum period, the MNO initiative also includes patient education components on NAS and the benefits of MAR. HFS's Illinois DocAssist program makes available to Medicaid providers caring for PPW free training sessions in MAR and continuing support and consultation services for managing the psychiatric and substance use treatment needs of their patients, upon request. These DocAssist services are delivered by clinicians experienced in managing perinatal OUD/SUD.

The fear that DCFS will take away their children prevents many PPW from seeking MAR. Maternal health providers may be reluctant to screen women for substance use out of concern that if women test positive, providers will be required to report them to DCFS. Provider and public beliefs that PPW with OUD/SUD cannot parent their children and should automatically lose custody of their children is another barrier to women seeking MAR. DCFS will always accept a report to their hotline involving information that a baby is born exposed to a controlled substance. However, DCFS child protection specialists will never bring a child into care unless their assessment of the total environment of the child demonstrates that the child is at urgent and immediate risk of harm in that setting. DCFS provides (and DCFS child protection specialists refer these families to) Intact Family services which have specialized units to address recovery, including MAR. It is DCFS' commitment to support the safety, permanency and well-being of the children and families where addiction is present, keeping families intact whenever safely possible. Messaging to PPW, providers, the court system and the public that clarifies this policy and demystifies DCFS involvement is needed to encourage PPW with OUD/SUD to seek treatment, persuade providers to screen for OUD/SUD and connect PPW to MAR. DCFS case workers and DCFS/purchase of service (POS) child welfare agencies also need this messaging, as well as education on OUD/SUD, including information on relapse and recovery.

Recommended Initiatives

- Encourage mobile MAR units to include maternal health clinicians either in-person or via telehealth.
- Leverage the Helpline to identify programs that provide MAR to PPW and share information about these programs to maternal health clinicians and community-based programs that serve PPW and their families.
- Build capacity of medical and community-based providers who work with PPW to increase their (providers') knowledge of substance misuse during pregnancy, conduct respectful and sensitive screening and provide appropriate referrals to MAR and recovery support services.
- Target maternal health clinicians for training and technical assistance on MAR, and DATA waiver training as applicable. Encourage birthing hospitals and other maternal healthcare facilities to actively support their buprenorphine prescribers.
- Develop and distribute messaging on DCFS policies related to PPW substance misuse to PPW and their families, providers, the general public, judges and family court staff, DCFS case workers, and DCFS/POS child welfare agencies.
- Educate DCFS case workers and DCFS/POS child welfare agencies on OUD/SUD and MAR.

Metrics

- Number of mobile MAR teams that include maternal health clinicians.
- Number of programs that provide MAR to PPW identified by the Helpline.
- Number of birthing hospitals and community-based maternal health providers trained on OUD/SUD in pregnancy, standardized screening tools such as the Screening, Brief

Intervention, and Referral to Treatment (SBIRT) and 5Ps Prenatal Substance Abuse Screen for Alcohol and Drugs (5Ps), MAR, and recovery support services for PPW with OUD/SUD.

- Number of birthing hospitals and community-based maternal health providers using the SBIRT and 5Ps to screen for and assess PPW substance use and recovery support service needs.
- Number of PPW screened for OUD/SUD.
- Number of maternal health clinicians receiving Illinois DocAssist consultations.
- Number of maternal health clinicians who prescribe buprenorphine.
- Number of PPW with OUD/SUD maternal health clinicians treat with buprenorphine.
- Workgroup convened to 1) develop and distribute messaging on DCFS policies related to PPW substance misuse and 2) identify educational materials on OUD/SUD and MAR for DCFS case workers. Workgroup members include DCFS, IDHS/SUPR, IDPH, ILPQC and the Council's Children & Families Committee.
- Messaging on DCFS policies related to PPW substance misuse developed for PPW and their families, providers, the general public, the court system, DCFS case workers and DCFS/POS agencies.
- Number of messaging materials distributed to PPW and their families.
- Number of messaging materials distributed to providers.
- Number of messaging materials distributed to the general public.
- Number of messaging materials distributed to judges and family court staff.
- Number of messaging materials distributed to DCFS case workers and DCFS/POS child welfare agencies.
- Educational materials on OUD/SUD and MAR for DCFS case workers and DCFS/POS child welfare agencies identified and shared with DCFS leadership.
- Number of DCFS case workers and DCFS/POS child welfare agencies that receive educational materials on OUD/SUD and MAR.

Priority 13: Establish alternative financing structures for MAR reimbursement.

Currently, MAR can be accessed through two types of settings: 1) a buprenorphine prescription through a clinician (physician, advanced practice nurse or physician's assistant) whether that be in a primary care, outpatient, hospital, or non-traditional setting, or 2) through an IDHS/SUPR licensed OTP. In the buprenorphine prescription from a clinician setting, services necessary to assess and stabilize someone on buprenorphine are covered under the existing fee structure; laboratory and counseling services are separately reimbursable. All of these services could be reimbursed through one episodic payment that encompasses all needed buprenorphine and other medication/MAR initiation services. One potential option is a bundled Medicaid reimbursement for MAR stabilization including buprenorphine initiation, treatment, and maintenance. In the OTP setting, while there is a Medicaid rate for dispensing methadone, there currently is not a Medicaid rate for the administration of buprenorphine, or the supports provided by ancillary staff. Beyond an OTP there is not currently a Medicaid rate structure that supports inclusion of MAR in an IDHS/SUPR licensed OUD/SUD residential or outpatient setting. HFS

remains open to considering a bundled Medicaid reimbursement benefit for buprenorphine initiation, treatment, and maintenance, if the services included in the bundle are currently qualified for reimbursement on an itemized basis, and if such new bundled services are allowable and approved by federal Center for Medicaid and Medicare Services (CMS). However, it must be noted that increased Medicaid reimbursement rates are subject to budgetary and managed care considerations. Furthermore, implementation of a bundled rate requires more in-depth discussion with attention to budget neutrality and managed care provisions. This priority aligns with HFS's OUD Withdrawal Management Subcommittee's July 2019 Content of Care/Reimbursement Recommendations to revise Illinois Medicaid reimbursement policies to create payment models that encourage OUD treatment providers to use the most current and accepted evidence-based OUD treatment approaches and that ensure that a broad range of Medicaid-covered services, including case management, peer recovery supports and medication administration and monitoring are available to persons with OUD in a variety of settings.

Recommended Initiatives

- Appropriate reimbursement for Medicaid providers caring for OUD/SUD populations in accordance with best practice guidelines, which includes FDA-approved MAR if available and counseling, subject to budgetary and managed care considerations. Additional payment tied to pre-defined quality and outcome metrics might be available.
- IDHS/SUPR should consider structuring their payments for people with no insurance using payment structures that drive positive patient outcomes.
- Survey providers, OTPs, and people with OUD/SUD to assess capacity for MAR, patient and provider-level barriers to MAR services, and patient outcomes. Use survey results to help inform MAR investment and infrastructure needs.
- Explore implementation of a bundled rate for withdrawal management that includes the use of MAR or other medications.

Metrics

- Options for bundled Medicaid reimbursement rates that acknowledge budgetary and managed care considerations reviewed.
- Survey of providers, OTPs and people with OUD/SUD assessing capacity for MAR, patient and provider-level barriers to MAR services and patient outcomes conducted.
- Survey results used to help inform MAR investment and infrastructure needs.
- Quality metrics to inform fee for performance rates identified.

Priority 14: Evaluate telehealth policies on services related to OUD/SUD established during the COVID-19 Public Health Emergency (PHE).

Very early in the COVID-19 pandemic, telehealth was encouraged for use as an effective tool to maintain access to services for people with OUD/SUD while "stay at home" advisories were in effect. With strong backing from Governor Pritzker, as well as the federal CMS, HFS, which administers Medicaid, the Children's Health Insurance Program (CHIP), and several State funded programs in Illinois, expanded all telehealth services, including care delivered via video and via audio (phone only). The PHE allowed several accommodations, such as waiver from compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations, patients' ability to connect from home, and not requiring a licensed healthcare professional to be present. Further, providers were paid for telehealth services at the same rate as in-person visits. Many other insurers adopted similar flexibilities.

The quality and outcomes of care delivered via telehealth during the PHE will require additional information to explicitly determine effectiveness. Some anecdotal reports point to benefits, especially for conditions where participating in the therapeutic process was a mainstay of treatment. Others have observed negative consequences of telehealth, such as missed or delayed diagnoses and treatment, inability to do comprehensive physical examinations and point-of-care testing, and inability to deliver treatment such as immunizations, wound care, implants, etc.

Continuation of telehealth post-pandemic will require, at a minimum, collection, and analysis of quality, short- and long-term outcomes, utilization, cost and benefits of each payer, provider and customer/patient experience and preference. Additionally, for the Medicaid program, flexibilities made available by the federal CMS in regard to HIPAA and other regulatory considerations, and digital equity (availability of Wi-Fi) will be important considerations.

Recommended Initiatives

- Request HFS and commercial payers doing business in Illinois for the recommendations for telehealth services, post-pandemic, based on their analysis of available elements of telehealth data identified above.
- Survey providers, people with OUD/SUD and other stakeholders to assess telehealth service delivery, patient and provider-level barriers to telehealth services, and patient outcomes. Use survey results to help inform telehealth investment and infrastructure needs.
- Request that HFS, IDHS and IDPH work together to conduct a literature review on COVID-19 telehealth provider and patient outcomes. Use the literature review to inform and develop telehealth best practice guidelines for Illinois.

Metrics

- Telehealth survey conducted.
- Telehealth best practice guidelines for OUD/SUD developed.

- Best practice guidelines shared with State policymakers.
- Quality metrics to determine incentives for improved performance implemented, if available.

Priority 15: Ensure insurance coverage for MAR and recovery support telehealth services.

Medicaid and health insurance coverage are critical to the long-term sustainability of MAR and recovery support telehealth services. On March 19, 2020, Governor Pritzker issued Executive Order 2020-09, "Executive Order to Expand Telehealth Services and Protect Health Care Providers in Response to COVID-19".[75] This EO expanded access to telehealth during the pandemic and prohibits commercial health insurers from setting requirements for telehealth services that are more restrictive or less favorable towards providers and insureds than those established for Medicaid. Also in the spring of 2020, HFS swiftly implemented telehealth services across Fee-For-Service (FFS) and Medicaid Managed Care Organization (MCO) populations. Payment parity with in-person visits was assured by the federal CMS and HFS. While HFS hopes to continue to reimburse telehealth services in the future, it is not guaranteed given the State's current budgetary climate. Additionally, continuation of telehealth reimbursement post-pandemic will be dictated by data providing evidence of quality outcomes, equity, cost-effectiveness, and federal guidance. This priority recommendation, however, aligns with HFS' OUD Withdrawal Management Subcommittee's July 2019 Content of Care/Reimbursement Recommendation to revise Illinois Medicaid reimbursement policies to create payment models that encourage providers who treat OUD to use the most current and accepted evidence-based OUD treatment approaches, including connection to community-based MAR and/or other treatment.

Recommended Initiatives

- Share literature review on COVID-19 telehealth provider and patient outcomes with HFS to help inform consideration of the continuation of Illinois Medicaid telehealth reimbursement policies.

Metrics

- Literature review shared with HFS.
- Current Illinois Medicaid telehealth reimbursement rates established during the COVID-19 pandemic continued, if supported by access, quality, and cost data, as well as provider and consumer surveys, and if determined to be budgetarily feasible.
- Quality metrics to inform fee for performance rates for telehealth identified.

Harm Reduction

We recognize that OUD/SUD is a chronic disease, that relapse is expected, and that recovery is possible. To save lives, we need to ensure that efforts are made to reach out and engage individuals in **all** stages of recovery who experience a relapse and who are at risk for both fatal and non-fatal overdoses. Harm reduction is a public health strategy aimed at reducing the negative consequences associated with substance use. Harm reduction incorporates a range of programs and policies that meet people who are actively using drugs "where they're at" and addresses conditions of substance use along with the use itself. Harm reduction strategies reflect individual and community needs, from safer use to managed use to abstinence. By meeting people where they are, harm reduction strategies decrease stigma and personal feelings of shame and embarrassment that keep many PWUD from seeking and engaging in treatment. Harm reduction increases access to OUD/SUD treatment by accepting people "for who they are, where they are at, and what they want."

Nationally and internationally, treatment programs are moving away from abstinence-only models to those that accept that relapse is part of recovery and that provide services to people even if they are actively using drugs. Treatment programs, advocacy organizations, law enforcement and other community stakeholders are actively partnering together on several harm reduction strategies including targeted overdose education, naloxone distribution, bystander intervention trainings, overdose prevention sites, and syringe exchange programs.[76–80] Harm reduction strategies have been shown to decrease drug overdose deaths, promote safer use of opioids and other substances, and increase access to MAR and recovery support services.

Several harm reduction initiatives are underway in Illinois. IDPH, CDPH and the Chicago Recovery Alliance (CRA) are collaborating on a CDC-funded grant that provides mobile drug testing stations where PWUD can have their drugs tested for fentanyl and potential contaminants. IDHS/SUPR supports Overdose Education and Naloxone Distribution (OEND) programs throughout the state. To date, more than 110,000 people have been trained on how to administer naloxone to reverse an opioid overdose and over 97,000 naloxone kits have been distributed. Since the onset of the COVID-19 pandemic, IDHS/SUPR has created Rapid Deployment (RD) outreach teams that use data to target areas where disparities exist, and overdose spikes occur. Local RD teams focus on direct naloxone distribution through street outreach, secondary distribution, hiring of peer specialists and collaboration with harm reduction organizations. Legislation supporting syringe service programs (SSPs) has been enacted.

Harm reduction saves lives. As mandated in the EO, we need to continue to support existing initiatives and implement new, innovative strategies that can encourage safer use of opioids and other substances and reduce overdose deaths, especially in communities disproportionately impacted by the overdose crisis.[9]

Priority 16: Continue to share information, listen to and support communities experiencing high rates of overdoses in their exploration of overdose prevention sites (OPS).

The West Side Heroin/Opioid Task Force's OPS Community Engagement Project has been engaging Chicago's West Side community members in discussions about OPS and how an OPS might benefit the West Side, a community that has one of the highest fatal and non-fatal overdose rates in the state.[81] Overdose prevention sites have been launched in other countries and are legally sanctioned health service facilities that allow people to use pre-obtained drugs under the supervision of trained staff. OPS give people a safe, clean place to use their drugs and staff who can step in immediately and administer naloxone if an overdose occurs.[4] OPS also provide opportunities to educate people about OUD/SUD and recovery as well as connect them to treatment and other services they may need, such as medical care and housing.[81] Studies show that OPS reduce fatal and non-fatal overdoses, improve public safety, decrease the workload of emergency medical services (EMS) responders, and reduce the risk of infectious diseases such as HIV and Hepatitis C.[82–84] OPS do not encourage drug use; on the contrary, use of detoxification and substance use treatment services increases among people who use OPS.[85,86] Additionally, numerous analyses of local crime statistics have consistently shown no increases in crime or drug trafficking in the vicinity of OPS.[87–89] Rather, studies show positive public safety outcomes, including reduced public drug use, loitering and aggressive behaviors, and fewer dirty needles in parks, streets, and other public places.[85,88,90]

For OPS to be successful, community members need to be involved and provide input on where the OPS should be located and how it should be operated. Led by the West Side Heroin/Opioid Task Force, the OPS Community Engagement Project activities focus on reaching out to West Side residents, business owners, faith leaders, law enforcement, healthcare and social service providers, elected officials, and PWUD, and educating these stakeholders about OPS, obtaining their input on concerns related to OPS, and promoting community buy-in. Survey and focus group data show that the majority of West Side community members believe that an OPS would be beneficial for the West Side and would reduce overdose deaths. However, community members are concerned about safety and security, and long-term OPS sustainability. The project continues to actively engage community members in discussions and educational events to listen to and address these concerns.

Recommended Initiatives

- Learn from and support community stakeholders—residents, business owners, faith leaders, social service providers, harm reduction and health care providers, people who use drugs, law enforcement and local officials—as they explore OPS for their communities. Attend community meetings and other activities to collect information on stakeholders' concerns about OPS. Use data on OPS implementation in other countries to understand benefits and concerns and share with community stakeholders.

Metrics

- OPS community engagement activities expanded beyond the West Side to other communities statewide that are experiencing high rates of fatal and non-fatal overdoses.
- Number of OPS community engagement and education activities convened.
- Number of community stakeholders who participate in OPS community engagement and education activities.
- Community stakeholder survey and focus group data on OPS benefits and concerns collected and analyzed. Reports summarizing survey and focus group data submitted to State agencies.

Priority 17: Improve equitable access to harm reduction and syringe service programs to decrease overdoses, transmission of infectious diseases, and bacterial and fungal infections.

In August 2019, Governor Pritzker signed Senate Bill 1828, the Needle and Hypodermic Syringe Access Program Act, into law, legalizing syringe exchange programs statewide. Syringe exchange programs—also known as syringe service programs or SSPs—are community-based programs that provide access to sterile injection materials and facilitate safe disposal. According to the CDC, people who use SSPs are more likely to enter substance use treatment and less likely to be exposed to HIV, Hepatitis C, and other bloodborne diseases.[91,92] All Illinois SSPs are registered with IDPH through the Service Program Registry.[93] To date, there are 14 registered SSPs.

In addition to SSPs, we need to maintain a network of harm reduction services for people who use opioids and other substances, but who may not yet be ready to enter treatment. Through funding from the CDC, IDPH is working with several community-based harm reduction organizations to expand their client base and develop more comprehensive linkages to harm reduction services for individuals with OUD, encompassing prescription opioids, as well as illicit drugs such as heroin. Harm reduction services include naloxone training and distribution, needle and syringe services, peer support, HIV and Hepatitis C testing, and safer smoking and snorting. These services may include post-overdose outreach programs: community-based programs that use teams comprised of law enforcement, peers and providers to check in with people who recently survived an overdose and help connect them to naloxone, MAR and/or treatment services.[94] Cook County has a post-overdose outreach program; several programs are in development across the state.

Recommended Initiatives

- Provide capacity building and technical assistance to registered SSPs.
- Partner with state and local law enforcement to launch a SSP awareness campaign designed to improve officers' knowledge and understanding of the Needle and Hypodermic Syringe Access Program Act, which legalizes syringe exchange programs statewide.

- Conduct pre/post-SSP awareness campaign knowledge tests to assess changes in law enforcement officers' knowledge and understanding of the Needle and Hypodermic Syringe Access Program Act.
- Use the jurisdictional vulnerability assessment of HIV and Hepatitis C outbreak risk related to injection drug use at a zip code level to inform state level prevention activities.
- Increase availability of harm reduction services across the state.
- Organize an annual statewide Harm Reduction Summit to provide individuals and organizations the opportunity to network, learn about best practices and evidenced-based strategies, and to hear from different harm reduction initiatives across the state. Harm reduction educational videos should be produced as part of the Summit and made publicly available.
- As a follow-up to the annual statewide Harm Reduction Summit, IDHS/SUPR and IDPH should collaborate on a white paper that positions harm reduction within the context of Illinois. This white paper should define harm reduction, present data on the evidence behind the interventions, provide guidance on national best practices, and give examples of programs in Illinois. The white paper should be published on the single state website and disseminated throughout the state.
- Continue the current harm reduction communications campaign.
- Conduct a survey to identify post-overdose outreach programs statewide. Use survey results to inform best practice guidelines for post-overdose outreach programs.
- Identify funding opportunities for culturally specific harm reduction services and organizations in communities where people of color are disproportionately impacted by overdose.

Metrics

- Number of SSP registrations submitted.
- SSP awareness campaign for law enforcement launched.
- Pre/post-SSP awareness campaign knowledge tests conducted with state and local law enforcement officers.
- Jurisdictional vulnerability assessment of HIV and Hepatitis C outbreak risk related to injection drug use analyzed and used to inform state level prevention activities.
- Number of harm reduction services provided statewide.
- Number of people with OUD/SUD who receive harm reduction services.
- Harm Reduction Summit held.
- Number of organizations participating in the Harm Reduction Summit.
- Harm reduction white paper written and disseminated.
- Harm reduction education videos created and posted on the single state website.
- Harm reduction communications campaign launched.
- Survey to identify post-overdose programs statewide conducted.
- Survey results used to develop post-outreach program best practice guidelines.

- Funding opportunities for culturally specific harm reduction services and organizations in communities where people of color are disproportionately impacted by overdose identified.

Priority 18: Increase public access to naloxone.

Naloxone saves lives by restoring breathing and brain function to a person experiencing an opioid overdose. While numerous efforts have increased naloxone training and distribution statewide, stigma and misinformation often stymie efforts to make naloxone more widely available to PWUD and public bystanders.[95] Discomfort with syringes may make many people reluctant to use injectable naloxone kits. While intranasal naloxone, or Narcan, is easier to administer, and is the preferred method for both people at high risk for an overdose and bystanders to use,[96] the high cost of Narcan prohibits its widespread distribution and use. IDHS/SUPR is addressing this via a new initiative where the agency will purchase Narcan for community organizations, hospitals and clinics that enroll in IDHS/SUPR's Drug Overdose Prevention Program (DOPP) to provide OEND services.

Another promising approach to increasing public access to naloxone is take-home or leave-behind naloxone: people who have recently experienced an overdose, those who are at high risk of overdose, and their families and friends are given a supply of naloxone by EMS, law enforcement, hospital ED staff or other providers. Other innovative strategies that have been found to increase public access to naloxone include vending machines, and wall-mounted boxes ("rescue stations").[97,98] In Illinois, law enforcement and EMS in several counties have implemented leave-behind naloxone programs. Will County partnered with low-income hotels in the Spring of 2020 to install four naloxone rescue stations in hotels where individuals experiencing homelessness were housed during the COVID-19 pandemic. To save lives, we need to implement innovative strategies to make naloxone more widely and publicly available to PWUD, their families and friends, and bystanders.

Recommended Initiatives

- Conduct a survey to identify the number and type of naloxone take-home and leave-behind programs statewide. Use survey results to inform best-practice guidelines for take-home/leave-behind programs.
- Leverage IDHS/SUPR's Narcan purchasing initiative to increase Narcan distribution and use.
- Explore strategies to increase implementation of naloxone vending machines and rescue stations statewide.

Metrics

- Survey to identify the number and type of naloxone take-home and leave-behind programs statewide conducted.
- Survey results used to develop best-practice guidelines for take-home/leave-behind programs.
- Number of DOPP enrollees that order Narcan.
- Number of Narcan doses ordered by DOPP enrollees.

- Number of Narcan doses distributed by DOPP enrollees to PWUD, their families and friends, and bystanders.
- Workgroup convened to explore strategies to increase implementation of naloxone vending machines and rescue stations statewide. Workgroup members include IDHS/SUPR, IDPH and harm reduction organizations.

Priority 19: Provide education on naloxone insurance coverage.

Insurance co-pays and stigma may prevent people who are at high-risk for an opioid overdose from filling naloxone prescriptions. Some individuals may not fill naloxone prescriptions because they fear that they may be denied life insurance coverage. Naloxone is mandated to be covered in individual or group policies of accident and health insurance under 215 ILCS 5/356z.23. Insurance companies must provide for at least one opioid antagonist. The coverage must also include refills for expired or utilized opioid antagonists. Education about naloxone insurance coverage mandates may help address co-pay cost and stigma barriers to filling naloxone prescriptions.

Recommended Initiatives

- The Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness—a working group mandated by The Heroin Crisis Act (PA 099-0480) that includes the Illinois Department of Insurance (IDOI), IDHS/SUPR, HFS, and health insurance carriers, mental health advocacy groups, substance use patient advocacy groups, and mental health physician groups—should explore naloxone insurance coverage education for consumers and develop and disseminate education materials to consumer groups.
- Develop naloxone insurance coverage education materials for consumer groups.
- Disseminate naloxone insurance coverage education materials to consumer groups.

Metrics

- Naloxone insurance coverage education added to the Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness meeting agenda.
- Naloxone insurance coverage education materials for consumer groups developed.
- Number of consumer groups that receive naloxone insurance coverage education materials.

Priority 20: Implement system-level policies and interventions to reduce rates of maternal morbidity and mortality among PPW with OUD/SUD.

The pregnancy and the postpartum periods can be times of increased stressors that may exacerbate women's underlying OUD/SUD. IDPH's MMRC[74] found that opioids were the most common substance involved in pregnancy-associated drug overdose deaths, with 91% of drug overdose deaths involving at least one type of opioid. A combination of multiple types of drugs

accounted for 49% of overdose deaths. The most common multi-drug combination among the pregnancy-associated overdose deaths was opioids and benzodiazepines. The report further stresses that 98% of drug overdose deaths were potentially preventable and 41% of these deaths had a good chance of being averted. Thus, there is a critical need for collaborative efforts, such as HFS' successful initiative that expanded Medicaid coverage for PPW to 12 months postpartum, to identify and implement harm reduction strategies and services targeting PPW with OUD/SUD.

Recommended Initiatives

- Identify harm reduction strategies that address the needs of PPW with OUD/SUD and their families.
- Provide naloxone training and distribute naloxone to PPW with OUD/SUD, their partners and their families.
- Build capacity of medical and community-based providers who work with PPW to distribute naloxone.
- Explore how MMRC recommendations related to OUD/SUD can be incorporated into other SOAP harm reduction initiatives.

Metrics

- Workgroup convened to identify harm reduction strategies that address the needs of PPW with OUD/SUD and their families. Workgroup members include the Council's Children & Families Committee, IDPH, IDHS/SUPR and community-based harm reduction organizations.
- Number of naloxone trainings provided to PPW with OUD/SUD.
- Number of naloxone trainings provided to partners and family members of PPW with OUD/SUD.
- Number of PPW with OUD/SUD who receive naloxone training.
- Number of partners and family members of PPW with OUD/SUD who receive naloxone training.
- Number of PPW with OUD/SUD who receive naloxone.
- Number of partners and family members of PPW with OUD/SUD who receive naloxone.
- Number of birthing hospitals and community-based maternal health providers that receive naloxone training.
- Workgroup convened to explore how MMRC recommendations related to OUD/SUD can be incorporated into other SOAP harm reduction initiatives. Workgroup members include IDPH, IDHS/SUPR and the Council's Children & Families Committee.

Priority 21: Increase fentanyl testing.

Fentanyl is more potent—and deadly—than heroin and prescription opioids. The influx of illicitly manufactured fentanyl and fentanyl analogs in the drug supply is one of the primary drivers of the recent increase in overdose deaths.[13] Fentanyl test strips can help PWUD test for and avoid using substances laced with fentanyl. These affordable, easy-to-use strips can detect the

presence of fentanyl and fentanyl analogs in 30 seconds.[99] Distributing fentanyl testing strips and providing a brief training on how to use the strips has been found to reduce fentanyl use.[100] Studies suggest that PWUD who are at high risk of overdose are willing to use fentanyl test strips, learn to use them quickly, and plan to continue to use fentanyl test strips after initial training. [100,101]

SAMHSA announced in April 2021 that its grantees can use federal funds to purchase fentanyl test strips.[102] Research shows that fentanyl testing can be easily integrated into existing OUD treatment and harm reduction services. Trainings that teach providers how to educate and encourage PWUD to use fentanyl testing strips are readily available from the National Harm Reduction Coalition and other harm reduction organizations.[103] IDHS/SUPR and other state agencies are working with community providers to promote the use of fentanyl test strips and implement fentanyl testing programs.

IDPH, CDPH and CRA are partnering together on a CDC-funded grant that provides mobile drug testing stations where PWUD can have their drugs tested for fentanyl and other potential contaminants. These mobile units use mass spectroscopy to quickly test and determine whether drugs have been adulterated. To date, 568 samples have been tested.

Recommended Initiatives

- Develop and distribute best practice guidelines on fentanyl test strips and fentanyl testing programs.
- Encourage IDHS/SUPR's SAMHSA-funded ORF grantees to purchase fentanyl test strips and implement fentanyl testing programs.
- Increase access to mobile drug testing technologies.

Metrics

- Best practice guidelines on fentanyl test strips and fentanyl testing programs implemented.
- Number of ORF grantees that purchase fentanyl test strips and implement fentanyl testing programs.
- Number of fentanyl test strips distributed to PWUD.
- Number of PWUD who receive fentanyl test strips.
- Number of PWUD who receive training on fentanyl test strips.
- Number of mobile drug testing units.
- Number of drug samples tested via mobile drug testing technologies.

Justice-Involved Populations and Public Safety

People with OUD/SUD are at high risk of being arrested and incarcerated. Criminal justice involvement and its limited treatment options may exacerbate OUD/SUD and overdose risks. Recognizing that punishment is **not** the solution to the overdose crisis, public safety and public health officials are working together to address the needs of individuals whose OUD/SUD is an underlying factor for their involvement in the criminal justice system. Supporting the needs of this at-risk population is critical to reducing overdose deaths.

Priority 22: Address deflection/pre-arrest diversion program implementation barriers in order to increase capacity of these programs statewide.

We cannot arrest our way out of the overdose crisis. Law enforcement and other first responders have become a point of contact to offer, and facilitate rapid access to, OUD/SUD treatment for individuals in their communities. In deflection or pre-arrest programs, law enforcement or other first responders offer a warm handoff to OUD/SUD treatment and other services. Typically, individuals are assessed to determine their best treatment options, offered referrals to that treatment, and provided with transportation to treatment without the threat of arrest or prosecution.[104] Diversion programs, which focus on linking individuals to treatment instead of further involvement in the criminal justice system, have shown promise for increasing access to care, reducing recidivism, and improving psychosocial outcomes.[105] Research on deflection and diversion programs also suggests that people who participate in deflection and diversion programs are less likely to be re-arrested, spend fewer days in jail, and are more likely to stay in treatment.[104,106]

In Illinois, the Community Law Enforcement and Other First Responder Partnership for Deflection and Addiction Treatment Act (Public Act 101-0652) (the Act) allows a law enforcement agency to facilitate contact between a person and a licensed substance use treatment provider for assessment and coordination of treatment.[107] The Illinois Criminal Justice Information Authority (ICJIA) has administered grants to deflection programs through the Act. The Act designated funds for law enforcement and first responders to develop and implement deflection programs that offer referrals to OUD/SUD treatment.

ICJIA's evaluation of a self-referral deflection program found that, overall, stakeholders, law enforcement officers, treatment providers, and clients offered positive feedback. Recommendations for future programs included providing enhanced officer training on OUD/SUD, engaging the community to increase awareness of the self-referral deflection program, and addressing local treatment capacity to ensure that services are available when officers are attempting to connect people to OUD/SUD treatment.[108]

Due to the COVID-19 pandemic and increased calls for police reform, people with OUD/SUD may be less likely to seek help from police to get help accessing treatment.[109] We need creative, community-level strategies—and funding to support those strategies—to deflect and divert justice-involved individuals with OUD/SUD to treatment and to expand the capacity of these programs statewide. These strategies include the five pathways authorized in the Act that support investment in knowledge-dissemination and technical assistance for communities, police departments and other first responders (e.g., fire departments) to implement deflection and diversion models, and incentivizing law enforcement to deflect people into treatment.

Recommended Initiatives

- Explore community-level connections to deflection and diversion programs, including the broad range of treatment services outlined in the Act. Strategies to consider include investment in knowledge-dissemination and technical assistance for communities, police departments and other first responders to implement deflection and diversion models using peer support recovery approaches and incentivizing law enforcement to deflect people into treatment.
- Conduct a survey to identify the number and type of law enforcement and other first responder deflection and diversion programs statewide.

Metrics

- Survey to identify the number and type of law enforcement and other first responder deflection and diversion programs statewide conducted.
- Number and types of deflection and diversion programs.
- Notice of Funding Opportunity (NOFO) for deflection and diversion programs released.
- Number of new deflection and diversion programs funded through the NOFO.
- Number of licensed treatment program and community member or organization partnership teams with agreements to provide OUD/SUD treatment as a part of a formal deflection strategy.
- Number of individuals deflected to treatment and/or services in lieu of formal charging actions.
- Number of peer recovery or recovery support programs helping to deflect people into treatment.
- Number of people transported by deflection and diversion programs to a licensed treatment provider or other program partner location.

Priority 23: Ensure access to all forms of medications/MAR in correctional facilities.

Approximately 60% of individuals in the criminal justice system have an OUD/SUD,[31] but only 5% of these individuals receive MAR.[110,111] Providing MAR in correctional settings reduces recidivism, overdose risk following release, and improves treatment retention.[106,111] The framework that is emerging as the most effective for those in the criminal justice system is to

provide a continuum of care that screens for OUD/SUD and overdose risks, provides continuous access to MAR, and takes preventative steps to reduce overdose risk after release (e.g., naloxone provision and education).[112] However, barriers such as a lack of knowledge about the potential benefits of MAR, and negative attitudes about medication among community corrections officers hinder efforts to help people access MAR in the criminal justice system.[1,113]

Initiatives in states such as Vermont, Massachusetts, California, Pennsylvania, and Rhode Island have paved the way in providing increased access to MAR in prisons and jails. For example, a Vermont law (Act No.176) enacted in 2018 requires correctional facilities to immediately initiate or continue MAR for patients who meet the criteria for medical necessity on buprenorphine, methadone, or naltrexone. This law further established several mechanisms by which those previously on MAR continue to receive treatment during incarceration, and which requires any discontinuation of MAR to come from a licensed practitioner who must provide explicit rationale for the decision.[114,115] The Rhode Island Department of Corrections offers a choice between the three FDA-approved MAR medications to any individuals in correctional facilities who screened positive for OUD/SUD and found a 61% year-over-year reduction in overdose deaths upon release. Massachusetts is testing a program called Medication Assisted Treatment and Directed Opioid Recovery (MATADOR), that screens and provides rapid access to MAR upon entry and provides naloxone 48-hours prior to release. Initial findings from the project suggest considerable reductions in overdose deaths following release and reduced recidivism.[116] California gives criminal justice system employees a MAR toolkit to help reduce stigma and educate staff on the importance of MAR.[117] These state-led initiatives demonstrate how increasing access to MAR in prisons and jails reduces overdose risks and recidivism, improves treatment for OUD, and potentially saves financial costs in the long-run.[1,111]

In Illinois, initial efforts by the Illinois Department of Juvenile Justices (IDJJ) are underway to provide bridge medication for youth and to link them with continuing care in the community while they are in IDJJ facilities or aftercare facilities. An ORF-funded project led by Health Management Associates (HMA) will bring together criminal justice health care and custodial staff, drug court staff, county SUD and behavioral health programs, and county administrators to form an integrated learning collaborative and to prioritize the use of at least two forms of MAR in jail and drug court settings.[118]

Recommended Initiatives

- Access to all forms of MAR should be made available to individuals with OUD/SUD as a standard part of correctional-based treatment. Individuals who are already maintained on medications/MAR should not have this treatment interrupted following arrest or incarceration.
- The State should explore and implement funding mechanisms that support the provision of MAR in correctional facilities.
- Explore strategies to ensure that linkages to continuing care/medication that are initiated during incarceration are arranged before release.

- Leverage the Helpline to identify programs that provide evidence-based care, including systematic education and access to all forms of medication/MAR and share information about these programs with drug courts and correctional facilities to help ensure that people with OUD/SUD who are referred to community-based treatment are referred to programs that provide evidence-based care.
- Provide targeted education and training on medications/MAR and OUD/SUD to probation and parole officers.

Metrics

- Number of county teams participating in the HMA learning collaborative to prioritize at least two forms of MAR in jail and drug court settings.
- Number of county teams that implement MAR in jails and drug courts.
- Number of county teams that implement MAR in jails and drug courts that serve PPW.
- Strategies to ensure that linkages to continuing care/medication are arranged prior to release identified and shared with correctional facilities.
- Develop funding mechanisms that support the provision of MAR in correctional facilities.
- Number of community-based treatment programs that provide evidence-based care identified by the Helpline.
- Information on community-based treatment programs that provide evidence-based care shared with drug courts and correctional facilities.
- Number of trainings on medications/MAR and OUD/SUD provided to probation and parole officers.
- Number of probation and parole officers who participate in medications/MAR and OUD/SUD trainings.

Priority 24: Ensure linkages to services, case management, timely access to treatment and other resources to support recovery are available to individuals leaving jails and prisons.

Justice-involved individuals with OUD/SUD are at the highest risk for fatal overdose in the first two weeks after leaving jail or prison.[119] Ensuring that these individuals are linked to and have access to OUD/SUD treatment, case management and other recovery support services at re-entry is essential to reducing overdose risks.[1] The care coordination provided by Medicaid managed care health homes can provide continuity of care upon release. However, individuals who are released from prison are in Medicaid FFS and not managed care. Allowing justice-involved individuals to pick a plan at the time of Medicaid enrollment can help them gain access to this care coordination immediately upon release. HFS has had ongoing discussions with the Illinois Department of Corrections (IDOC) on how to better coordinate processes to ensure continuity of care. At the federal level, the Medicaid Re-Entry Act (H.R. 1329) that was introduced in early 2019 could eliminate the inmate exclusion in Social Security or modify it to

allow for Medicaid to cover services provided to incarcerated individuals 30 days prior to release.[111,112,120]

Recommended Initiatives

- Explore strategies to ensure that linkage services, case management, wraparound services, timely access to treatment and other recovery support resources are available to individuals leaving jails and prisons as a standard part of the re-entry process.
- Continue HFS and IDOC discussions on the options for individuals to choose a plan at the time of Medicaid enrollment, so that they can gain access to MCO care coordination immediately upon release.

Metrics

- Strategies to ensure that linkage to services and recovery support resources are a standard part of the re-entry process identified.
- HFS and IDOC discussions on Medicaid enrollment options held.

Priority 25: Ensure that people who are involved in the criminal justice system and their loved ones receive naloxone and naloxone training.

With 60% of individuals in the criminal justice system diagnosed with a SUD,[31] only 5% receiving MAR,[110] and the high risk of fatal overdose in the first two weeks after returning to the community from prison,[119] it is critical to provide naloxone and naloxone training to people who are involved in the criminal justice system and their loved ones.[81,121] In Pennsylvania, all facilities in the corrections system have trained at least 20 Certified Peer Specialists (CPS) who help distribute naloxone to those leaving criminal justice facilities.[122] Riker's Island OEND program has trained hundreds of those released into the community and 44% of patients refilled their naloxone prescriptions, demonstrating the feasibility and effectiveness of this approach.[121] In Illinois, Winnebago County Jail staff place naloxone in individuals' personal belongings prior to release. IDJJ is working with IDHS/SUPR to train youth on naloxone and distribute it to them at community re-entry. IDPH and IDOC are partnering on an overdose prevention pilot project inside selected Illinois prisons. The pilot project will include overdose prevention education provided by peer educators and the provision of two doses of Narcan at release.

Recommended Initiatives

- All people leaving state prisons, and their loved ones, should receive naloxone training and be given take-home naloxone. This should be standard release practice from Illinois state prisons.
- All people leaving county jails, and their loved ones, should receive naloxone training and be given take-home naloxone.

- Some individuals may not accept naloxone if it is given to them by law enforcement or correctional officers. The State should explore and consider replicating successful distribution strategies, such as those used in Pennsylvania and at the Winnebago County Jail.

Metrics

- Cross-sector workgroup on naloxone training and distribution in state prisons and county jails convened. Workgroup members include IDOC, IDHS/SUPR, IDPH, Illinois Sheriff's Association and community-based organizations that serve justice-involved individuals.
- Workgroup tasks include identifying barriers to naloxone training and distribution, reviewing current models and strategies used to distribute naloxone in prisons and jails, and developing recommendations for implementing naloxone training and distribution in state prisons and county jails.
- A white paper summarizing workgroup activities, including identified barriers to naloxone training and distribution, and recommendations for implementing naloxone training and distribution in state prisons and county jails submitted to the Steering Committee.
- Number of inmates who receive overdose prevention education provided by the IDPH and IDOC pilot project.
- Number of inmates who receive Narcan provided by the IDPH and IDOC pilot project.

Additional Recommendations

The recommendations listed below are those that the Steering Committee and State agency workgroups ranked as lower priority during their respective recommendation review and prioritization process. During our semi-annual metrics assessment, these recommendations will be re-reviewed to determine whether and how they can be implemented to address new challenges that arise in the ever-evolving overdose crisis. Additionally, the Steering Committee will ask the Council and its Committees to further refine recommendations, as needed, to better define how recommended initiatives can reduce overdose deaths.

Social Equity: Additional Recommendations

- Incorporate holistic strategies across and within State agencies to address the social determinants of health that contribute to substance use.
- Partner with state universities to develop strategies to promote workforce development, recruiting and training in racially and geographically diverse communities.
- Reduce rates of Black maternal and infant mortality and morbidity due to OUD/SUD through targeted funding and interventions in Black communities.
- Elevate child and family voices by ensuring that the Steering Committee includes representation from individuals most proximate to the experiences of children and families who are impacted by OUD/SUD.
- Increase alignment and collaborations across family-service systems/state agencies, including early care and education, child welfare, health, and mental health systems, to

establish systematic referral pathways, procedures to share information, and approaches to collaboratively serve families impacted by OUD/SUD.
- Promote positive health, development and well-being of young children and their families impacted by OUD/SUD.
- Increase participation of people from racial and geographically diverse communities, PLE and PWUD on the Council.

Prevention: Additional Recommendations

- Expand prevention services across the lifespan.
- Create a web-based “toolbox” for sharing evidence-based messaging.
- Promote the use of evidence-based messaging guidelines in public awareness and communications campaigns.

Treatment and Recovery: Additional Recommendations

- Facilitate access to recovery support resources through evidence-based digital tools.
- Reduce rates of maternal morbidity and mortality among PPW with OUD/SUD by prohibiting involuntary discharge during the postpartum period.
- Support adolescent and young adult recovery by implementing evidence-based models that help adolescents and young adults with OUD/SUD initiate and maintain their recovery.
- Increase access to family-centered recovery services.
- Expand inpatient OUD/SUD treatment for adolescents, focusing on the needs of child welfare, juvenile justice, and other at-risk populations.
- Explore initiation of buprenorphine by EMS in cases where patients refuse transport to the hospital.

Harm Reduction: Additional Recommendations

- Provide education on naloxone prescribing and distribution to primary care and ED practitioners.
- Provide education to prescribers on naloxone, addiction, patient-centered care, and alternative treatments for pain management.
- Monitor the SSP policies of states bordering Illinois for potential impact on Illinois SSPs.
- Explore harm reduction education and training for PPW.
- Explore strategies to increase overdose, addiction and harm reduction education provided in Illinois law enforcement academies and in paramedic schooling to ensure that new officers and EMTs (Emergency Medical Technicians) are equipped to provide harm reduction services to PWUD.
- Explore strategies to enhance drug seizure data sharing between public health and public safety to help alert communities about changes in the drug supply (i.e., increased presence of fentanyl and/or other drugs) and overdose spikes.

Justice-Involved Populations and Public Safety: Additional Recommendations

- Improve outcomes for youth in care who use substances and who are dually involved with IDJJ.
- Promote strategies to link youth to community-based OUD/SUD services upon immediate release from IDJJ.

List of Acronyms

List of Acronyms	
5Ps	5Ps Prenatal Substance Abuse Screen for Alcohol and Drugs
AD	Academic Detailing
ASAM	American Society for Addiction Medicine
CDC	Centers for Disease Control and Prevention
CDPH	Chicago Department of Public Health
CHIP	Children's Health Insurance Program
CMS	Center for Medicaid and Medicare Services
CPRS	Certified Peer Recovery Specialists
CPS	Certified Peer Specialists
CRA	Chicago Recovery Alliance
DATA	Drug Addiction Treatment Act of 2020
DCFS	Illinois Department of Children and Family Services
DEA	Drug Enforcement Agency
DOPP	Drug Overdose Prevention Program
DPRA	Drug Policy Reform Act
ED	Emergency Department
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EHR	Electronic Health Record
EO	Executive Order
FDA	Food and Drug Administration
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
HB	House Bill
Helpline	Illinois Helpline for Opioids and Other Substances
HFS	Illinois Department of Healthcare and Family Services
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMA	Health Management Associates
IANS	Injury and Accident Notification System
ICJIA	Illinois Criminal Justice Information Authority
IDFPR	Illinois Department of Financial and Professional Regulations
IDHS/DFCS	Illinois Department of Human Services / Division of Family and Community Services

List of Acronyms	
IDHS/SUPR	Illinois Department of Human Services / Division of Substance Use Prevention and Recovery
IDJJ	Illinois Department of Juvenile Justice
IDOC	Illinois Department of Corrections
IDOI	Illinois Department of Insurance
IDPH	Illinois Department of Public Health
IGA	Intergovernmental Agency
ILCS	Illinois Compiled Statutes
ILPQC	Illinois Perinatal Quality Collaborative
ISBE	Illinois State Board of Education
GPRA	Government Performance and Results Act
MAR	Medication Assisted Recovery
MCO	Managed Care Organization
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MMRC	Maternal Mortality Review Committee
MNO	Mothers and Newborns Affected by Opioids
NAS	Neonatal Abstinence Syndrome
NOFO	Notice of Funding Opportunity
NOI	Notice of Intent
OEND	Overdose Education and Naloxone Distribution
OMNI	Maternal Outcomes and Neonatal Abstinence Syndrome Initiative
OPS	Overdose Prevention Site
ORF	Overdose Response Funding
OSE	Opioid Social Equity Committee
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PHE	Public Health Emergency
PLE	People with Lived Experience
PMP	Prescription Monitoring Program
POS	Purchase of Service
PPW	Pregnant and Postpartum Women
PWUD	People Who Use Drugs
RD	Rapid Deployment
RLC	Regional Leadership Center
ROSC	Recovery Oriented Systems of Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SIU	Southern Illinois University
SOAP	State Overdose Action Plan
SSP	Syringe Service Program
SUD	Substance Use Disorder
UIC	University of Illinois at Chicago
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

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