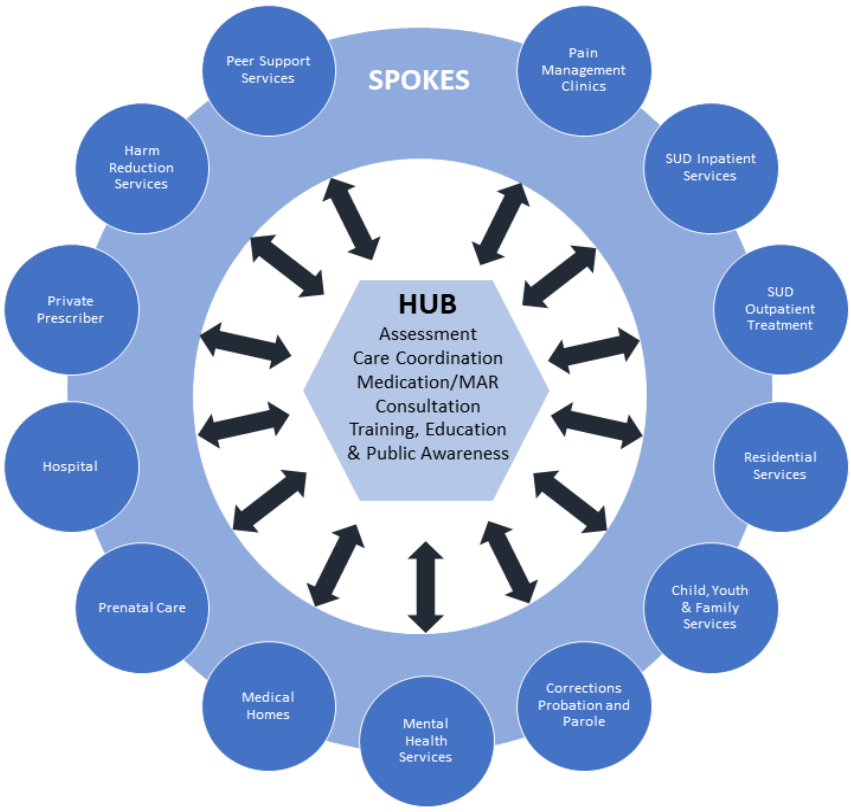
Illinois Opioid Crisis Response Advisory Council Committee Recommendations for the 2020 State Opioid Action Plan (SOAP)

In August and September 2020, each of the six Illinois Opioid Crisis Response Advisory Council (Council) Committees developed a set of recommendations for the 2020 SOAP. These recommendations address the specific focus of each committee as well as issues that cut across the committees, such as the need to address racial, social, and geographic inequities in opioid use disorder (OUD) treatment, and exploring new strategies to increase access to medication assisted recovery (MAR).

The six Committee Chairs met in early September to discuss their respective committee's recommendations. During this meeting, the Chairs suggested that the Steering Committee consider using a modified Hub and Spoke model, depicted below, as a potential framework for the next SOAP. This model assumes a "no wrong door" policy for people to access services. In the traditional Hub and Spoke model, initial assessment and care coordination occur within one organization (the Hub) and linkages are made to services and service settings (Spokes) based on individual needs. In our modified model, a referral to assessment and care coordination might take place in a Spoke. For example, a pregnant woman with OUD might be referred to a Hub for assessment for MAR during a prenatal care visit. Our modified model also recognizes the wide range of services that people with OUD may need, including harm reduction and family support services, as well as the settings in which services may occur, such as corrections.



While not depicted here, this model also assumes that racial, social, and geographic inequities, as well as social determinants of health involved in substance use and inequities in access to and receipt of services, are addressed in all Hub and Spoke services and settings.

Please note that this is a draft model. We welcome Steering Committee and Council feedback and suggestions for additional modifications to the model.

Each Committee's recommendations are grouped by focus area. Recommendations include new initiatives and/or issues that are not addressed in the 2017 SOAP as well as suggestions to continue ongoing efforts to "finish our work".

Children and Families Committee Recommendations

The Children and Families Committee identifies the unique treatment and recovery needs of children and family members whose lives have been impacted by OUD. This Committee therefore focuses on a broad range of issues and needs across the lifespan.

Recommendation: Reduce rates of maternal mortality and morbidity

1. Establish voluntary universal prenatal connection/visit that offers anyone who is pregnant with a comprehensive assessment, referral and connection to all services needed, including health and community services that address social determinants of health.
2. Extend the postpartum period of health coverage and supports for all Illinois birthing parents for the full 12 months after birth, including those who are undocumented.
3. Establish a statewide taskforce to gather data from pregnant and birthing individuals on their experiences in the health care delivery system. Develop recommendations for actions to improve the quality of care given during the perinatal period.
4. Expand funding for and access to community-based doulas, including those who can offer peer-based support. Ensure coverage of community-based perinatal services through Medicaid, Managed Care Organizations and private insurance.
5. Increase funding for community-based perinatal support, including perinatal health workers, educators, advocates, and home visitors, with intentional focus on grants to Black-led community-based organizations that can be most responsive to the needs of Black families, who are disproportionately impacted by maternal and infant mortality and morbidity.
6. Prohibit medication assisted recovery (MAR) providers to involuntarily detoxify or discharge people during the full 12 months after birth.
7. Increase behavioral health integration in reproductive and perinatal healthcare settings, including the availability of office-based opioid treatment (OBOT), behavioral health services, and peer-based support.
8. Alcohol or drug screening or testing of a pregnant or perinatal person by any service provider is only allowed with the individual's informed written consent and within the scope of the medical care of that person (the only exception is in the case of a medical emergency).
9. Support targeted harm reduction services for pregnant and parenting individuals.
10. Build capacity of medical and community-based providers who work with pregnant and postpartum people to increase their knowledge of SUD during pregnancy, conduct respectful and sensitive screening, provide appropriate referrals to recovery services, and distribute naloxone.
11. Provide naloxone training and distribute naloxone to pregnant and postpartum people and their families.
12. Convene a cross-systems working group to identify best practices and make recommendations for regulatory changes, training, and model policies for increasing access to recovery services for pregnant people and improving prenatal and postpartum health for women with SUD in general. The working group should especially consider potential improvements to mandated reporting policies and related training.
13. Incorporate recommendations emerging from the Maternal Mortality Review Committee on Violent Deaths (MMRC-V) related to SUD into the State Opioid Action Plan.

Recommendation: Promote positive health, development, and well-being of young children and their families impacted by OUD

14. Expand voluntary universal newborn nurse home visits for all newborns that offers a comprehensive assessment, referral and connection to all services needed, including health and community services that address social determinants of health.
15. Expand access to the Early Intervention (EI) system for infants and toddlers who have been exposed to opioids or who have a parent/caregiver with OUD. This should include potential changes to eligibility for EI and additional training for EI providers and developing processes for hospitals, pediatricians, and perinatal health providers to make referrals.
16. Expand access to Infant and Early Childhood Home Visiting Programs for infants and toddlers who have been exposed to opioids. This should include developing processes for hospitals, pediatricians, and perinatal health providers to make referrals.
17. The IDHS Bureau of Subsidy Management should collaborate with the Division of Substance Use Prevention and Recovery to identify and implement strategies to expand access to child care for parents participating in substance use recovery services, including but not limited to expanding access to the Child Care Assistance Program, co-locating child care with recovery services, and providing relevant training to child care and SUD recovery service staff on how to support the unique needs of this population.
18. Launch an initiative to recruit and train perinatal services and early care and learning professionals as Certified Peer Recovery Specialists.

Recommendation: Increase access to family-centered recovery services

19. Expand funding and access to peer-based recovery support services for pregnant and parenting people with OUD, and their families.

Recommendation: Improve outcomes for youth in care who use substances and who are dually involved with the Illinois Department of Juvenile Justice (IDJJ)

20. Create a workgroup to examine the needs and outcomes of youth in care who are dually involved with IDJJ with the goal of establishing evidence-informed and youth-centered recommendations.

Recommendation: Promote positive parenting and pregnancy when a caregiver has a substance use disorder or uses substances

21. Convene a short-term task force to identify harm reduction strategies to support parents/caregivers who are impacted by substance use.
22. Differentiate child welfare involvement due to substance use alone separate from findings of abuse/neglect that involve the use of substances in data collection. This will facilitate an analysis of unique barriers and outcomes that can inform needed services and resources.

Recommendation: Support adolescent and young adult recovery

23. Implement evidence-based models that help adolescents and young adults initiate and maintain their recovery, including recovery high schools, alternative peer groups, collegiate recovery groups, and recovery dorms. These models provide a continuum of recovery support for youth that prevent relapse and increase their ability to complete high school and college.

Recommendation: Support communities in establishing/growing systems for supporting families impacted by SUD and connecting them to all relevant services

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

Recommendation: Elevate child and family voice

25. Ensure that the Steering Committee includes representation from individuals most proximate to the experiences of children and families who are impacted by OUD/SUD, including state agency staff who administer child/family service programs and services and children, youth, and families with lived experience.

Recommendation: Increase alignment and collaboration across family-serving 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 to collaboratively serve families

26. Create an inventory of all relevant state plans, policies, initiatives, etc. that relate to SUD and take steps to ensure alignment and improved coordination. Priority focus should be on:
    - Title V
    - MIECHV
    - IL Maternal Health Strategic Plan (I-PROMOTE)
    - Family First Prevention Services Act/Title IV-E
    - Illinois Prenatal to Three Coalition
    - Preschool Development Grant

Criminal Justice Populations Committee Recommendations

The Criminal Justice Populations Committee addresses the intersection of the opioid epidemic and justice-involved populations.

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

The Committee recognizes that there is a continued need for deflection/pre-arrest and diversion programs statewide (2017 SOAP Strategy #7: Increase the capacity of deflection and diversion program statewide). To meet this need, we need to address program implementation barriers. The Committee recommends that:

27. The State should examine the role Medicaid can play to increase access to treatment. This includes funding work to engage justice-involved individuals with OUD, such as street outreach and early intervention. The State should consider funding models such as standard Medicaid benefits and blanket reimbursable services to ensure that there is "no wrong door", i.e., that people are able to access treatment regardless of where they enter the justice system.
28. Community-level connections to deflection and diversion programs should be explored. Due to COVID-19 and increased incidences of police-involved shootings, people with OUD are less likely to go to police departments for help accessing treatment. We need creative, community-level strategies—and funding to support those strategies—to deflect and divert justice-involved individuals with OUD to treatment. These include the five pathways authorized in SB3023 that support investment in knowledge-dissemination and technical assistance for communities and police departments to implement deflection and diversion models, and incentivizing law enforcement to deflect people into treatment. This also

includes diversion efforts that could take place in emergency departments (EDs). The Committee therefore supports the recommendation made by the Prescribing Practices and Medication Assisted Recovery (MAR) Committees to increase the number of DATA waivered prescribers in EDs.

Recommendation: In collaboration with the MAR Committee, increase linkages and access to MAR and other recovery support services for people with OUD by making telehealth policies established during COVID-19 permanent.

29. The Committee supports the MAR Committee's recommendation that the State make telehealth policies established during COVID-19 permanent. Telehealth can increase linkages and access to MAR and other recovery support services for justice-involved individuals with OUD at several criminal justice system intercept points, including diversion and community re-entry.
30. Telehealth barriers, such as the lack of Internet access/connectivity and smartphones and other devices should also be explored and addressed. The Committee supports the MAR Committee's recommendation to continue to support investment in telehealth and improve providers' capacity to deliver telehealth services.

The Committee recognizes that Strategy #9 initiatives are still needed in order to decrease overdose deaths after an at-risk individual's immediate release from a correctional facility. To that end, the Committee makes the following recommendations.

Recommendation: Ensure that justice-involved people and their loved ones receive naloxone and naloxone training.

31. The Committee recommends that all people leaving prisons and jails, and their loved ones, receive naloxone training and be given take-home naloxone. This should be standard release practice from both county jails and state prisons in Illinois.
32. The Committee recognizes that some individuals may not accept naloxone if it is given to them by law enforcement or correctional officers. The Committee recommends that the State explore and consider replicating successful distribution strategies, such as those used at the Winnebago County Jail. In this program, naloxone is placed in the individual's personal belongings; program staff report that individuals have been more receptive to taking home naloxone this way rather than having it given to them by corrections.

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

33. The Committee recommends that access to all forms of MAR be made available to individuals with an OUD as a standard part of correctional-based treatment. Along with this, the Committee recommends that:
34. The State explore and implement funding mechanisms that support provision of MAR in correctional facilities.
35. The State ensure that people with OUD who are mandated to treatment are referred to programs that provide evidence-based care, including systematic education and access to all three forms of medications for those who have opioid use disorder. The Committee suggests that the Helpline might be leveraged to help identify these programs.

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

36. The Committee continues to recommend that linkage services, case management, wraparound services, timely access to treatment and other resources to support recovery be

available to individuals leaving jails and prisons as a standard part of the re-entry process regardless of the facility they are being released from. (This is SOAP Initiative 9.3).

37. The Committee recognizes the impact of Medicaid on this recommendation and further recognizes that not everyone being released leaves with active Medicaid coverage. To address this, the Committee recommends that:
38. The State support pending federal legislation that would either eliminate the inmate exclusion in the Social Security Act or modify it to allow for Medicaid to cover services provided to incarcerated individuals 30 days prior to release.
39. The State automates the Medicaid enrollment process using a data-interchange solution that uses data between Illinois Department of Healthcare and Family Services (HFS) and the Illinois Department of Corrections (IDOC) systems to verify identify, income, and activate enrollment similar to the initiative implemented by the state of Pennsylvania using a mix of federal and state funds.[1] We further recommend that individuals be allowed to pick a plan at the time of Medicaid enrollment, so that they can gain access to managed care organizations (MCO) care coordination immediately upon release.
40. The State implement health homes for all Medicaid Fee for Services (FFS) justice-involved individuals to provide and ensure continuity of care upon release. For the individuals released from prison with active Medicaid benefits, they start out in Medicaid FFS and not in Managed Care. Yet the state's health home model is predicated on managed care enrollment and previous claims histories (which would be non-existent for those most who have been incarcerated for years and whose care has been provided outside the Medicaid system[2]. This population is in high need of the type of care coordination provided by health homes. Multiple studies demonstrate that this population is at high risk for fatal overdose and hospitalizations in the weeks following release. The care navigation and coordination provided by health homes is critical to ensuring that this population receives life-saving care. To make such services available to one subset of the Medicaid population and not the other would be inequitable. Until managed care enrollment can begin on day 1 of Medicaid approval, the state's health home strategy should be adjusted to reflect this reality or a similar benefit be put in place to afford Medicaid beneficiaries the same services when they need it most.
41. Further, the Committee supports OSE Committee recommendations that address social determinants of health and recommends that the State explore ways to ensure that justice-involved individuals basic needs at re-entry are met. This includes exploring ways to incentivize organizations to house and employ justice-involved individuals with substance use disorders as a standard component of treatment for this population. One example is the expansion of the Illinois Housing Development Authority (IHDA) and the IDOC re-entry housing pilot program.

[1] https://www.media.pa.gov/pages/corrections_details.aspx?newsid=331

[2] With the exception of off-site hospitalizations.

Medication Assisted Recovery (MAR) Committee Recommendations

The MAR Committee focuses on reducing barriers to treatment and increasing access to MAR and recovery support services.

Recommendation: Increase access to MAR and other recovery support services for people with OUD by making telehealth policies established during COVID-19 permanent

42. Make telehealth policies established during COVID-19 permanent. Telehealth can reach people with OUD in rural and MAR desert areas of the state. It can also reduce stigma and transportation barriers and allows people to receive treatment in the privacy of their own homes. Telehealth also is vehicle for provider training, education, and support through programs such as Project Extension for Community Healthcare Outcomes (ECHO).
    - Accommodations may be needed for people who prefer video rather than phone visits, but who do not have video capability on their phones and/or limited video/Internet connectivity.
    - Reimbursement rates for telehealth are lower than for in-person visits.
    - Not all individuals benefit from telehealth – we need to assess patient preference and identify those that do benefit from telehealth and those who need and/or prefer face-to-face visits.

Recommendation: Increase access to MAR in residential treatment settings

43. Increase access to MAR in residential treatment settings by 1) providing buprenorphine initiation in these settings and 2) establishing linkages to federally qualified health centers (FQHCs) and other health centers to ensure that people are able to stay on buprenorphine after completing residential treatment.
    - Some residential treatment programs say that they can't offer buprenorphine induction because there are no prescribers available to offer/continue buprenorphine after an individual completes residential treatment. Linkages to FQHCs and health centers can address this issue, as well as prescribers' concerns about how to connect patients to services.
    - Telemedicine can be utilized as a linkage to care, specifically to a buprenorphine prescriber during and following residential treatment or an acute care visit.

Recommendation: In collaboration with the Criminal Justice Populations Committee, ensure access to all forms of MAR in correctional settings

44. Many mandates to treatment for justice-involved individuals are to settings that do not offer medication. We need to ensure that justice-involved individuals with OUD who are mandated to treatment sent to settings that provide medication/access to MAR. The Committee also supports the Criminal Justice Populations Committee recommendation that MAR should be offered within correctional settings.
45. Individuals who are already maintained on medications/MAR should not have this treatment interrupted following arrest or incarceration.
46. Linkages to continuing care/medication that is initiated during incarceration must be arranged before release.

Recommendation: In collaboration with the Prescribing Practices Committee, increase initiation to buprenorphine in emergency departments

47. Increase initiation to buprenorphine in emergency departments (EDs) for people who present in EDs with opioid overdoses and/or in acute opioid withdrawal. (This is a cross-committee recommendation with the Prescribing Practices Committee).

- EDs are the best place to reach people who are most at risk for fatal and non-fatal opioid overdoses.
- Medicaid is exploring how to best incentivize and support hospitals to do buprenorphine initiations.
- Massachusetts passed legislation in 2018 mandating that all EDs in the state be capable of initiating buprenorphine; we could use this legislation as a guide.
- The Illinois Department of Human Services/Division of Substance Use Prevention and Recovery (IDHS/SUPR)'s IL State Opioid Response (SOR)-funded Hospital Warm Handoff project supports hospital linkages to care (warm handoff) so there is a precedent for ED-based services for people with OUD here in IL.

Recommendation: Establish alternative financing structures for MAR reimbursement

48. In order to facilitate increased MAR initiation in residential facilities, hospital EDs, and elsewhere, the Committee recommends that the State establish alternative financing structures for MAR reimbursement. The State should consider:
49. Increased Medicaid reimbursement rates for MAR initiation that is comparable to current rates for withdrawal management. Providers should be reimbursed at least as much for helping individuals start MAR as they are for monitoring a managed withdrawal from opioids, an often clinically unhelpful and dangerous intervention.
50. A bundled Medicaid reimbursement benefit for buprenorphine initiation, treatment, and maintenance. The current reimbursement structure only reimburses for the provider visit but other supports provided by nurses, counselors, and/or peer specialists are often needed to assess and stabilize someone on buprenorphine. All these services could be reimbursed through one episodic payment that encompasses all needed buprenorphine and other medication/MAR initiation services.

Recommendation: In collaboration with the Prescribing Practices Committee, promote and support DATA waiver training and waiver-trained prescribers

51. Continue to promote DATA waiver-training and provide training and technical assistance) to waivered-providers. (This 2017 SOAP Initiative 6.2). We need waivered providers in all EDs (see above)
52. Encourage medical residents to become waiver-trained so they can prescribe in their chosen practice/setting.
53. Encourage hospitals and other facilities to actively support their waivered prescribers.

Recommendation: Facilitate access to recovery support resources through evidence-based digital tools

54. IDHS/SUPR currently supports an IL SOR-funded digital recovery support toolkit project to develop web-based and mobile application recovery support resources for people with OUD. The Committee recommends that the State continue to support digital tools, such as digital toolkits and evidence-based mobile applications such as Prescription Digital Therapeutics (PDTs), that provide 24/7 access to recovery supports and resources.
    - Patients can access digital tools anytime, anywhere. No appointments are required.
    - Similar to telehealth, digital tools may not be viable options for people who lack Internet access/connectivity.

Opioid Social Equity (OSE) Committee Recommendations

The OSE Committee developed the social equity statement that guides its work and the work of the Council and makes policy recommendations regarding how to begin to address how the opioid crisis has affected different communities in different ways. The OSE Committee will review SOAP recommendations, and the SOAP itself, to ensure that racial, social, geographic and other inequities are addressed.

Recommendation: Review client demographic data to help identify and address disparities in access and receipt of MAR, harm reduction and recovery support services.

The Committee recognizes that there are major disparities in access and receipt of MAR, harm reduction and recovery support services Black and Latinx individuals are less likely to be referred to and receive harm reduction, MAR, and recovery support services. Data on State funding for OUD services, the 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 treatment in these communities. The Committee also recognizes that it is difficult to collect the data needed to accurately assess these disparities. Given these constraints, the Committee recommends that:

55. The State identify data sources that could be used to identify the demographic characteristics—particularly race and ethnicity—of individuals who seek and receive treatment for OUD. Suggested data sources include the Helpline, PMP, and GPRA data collected for services funded by SAMHSA SOR 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 characteristics of people receiving these services.
56. The State regularly monitor and analyze these to data to help identify potential treatment disparities and direct resources to address these disparities.
57. Organizations that provide MAR and recovery support services to people with OUD 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.

Recommendation: Address structural racism through ongoing dialogues with people who use drugs and people from racially and geographically diverse communities on the root causes of treatment inequities

The Committee recognizes that the causes for racial inequities in overdose mortality, overdose incidence, and different types of service provision are not fully understood. Structural racism as manifested by inequities in criminal justice enforcement and involvement, socioeconomic opportunity, access to quality housing, educational opportunity, and health care access are root causes. Similarly, the specific interventions that can address the inequities in overdose incidence and treatment access are also not well understood. The State should endeavor to address structural racism and root causes, but more must be done in the near term as well. The Committee recommends that:

58. The State engage in dialogues with racially and geographically diverse communities to better understand the causes for inequity and the potential interventions that could advance a more equitable response.
59. The State specifically engage in dialogues with people who use drugs or are in recent recovery who represent racially and/or geographically diverse communities. We must learn whether the current structure of the treatment and recovery system serves them well enough and what the State can do from their perspective to improve accessibility.

60. The State regularly collate the qualitative information received by engaging diverse communities and use this information in service provision and funding decisions.

Recommendation: Incorporate holistic strategies across and within state agencies to address the social determinants of health that contribute to substance use

61. The Committee acknowledges that the disparities in the opioid epidemic occur alongside other inequities impacting racial and ethnic minority communities, including violence, homelessness, incarceration, economic development, suicides, unemployment, and poverty. The Committee recommends the State use a holistic approach that addresses not only substance use, but the other facets of people's lives and society that contribute to substance use. This includes but is not limited to housing, employment, education, and justice involvement. The Committee recommends that the State incorporate strategies to address these issues, specifically housing and employment, as a part of its holistic and equitable approach to the opioid epidemic. Strategies should identify relevant state agencies (e.g. IHDA, Illinois Department of Commerce and Economic Opportunity) in addition to Illinois Department of Human Services (IDHS) that can work together to address these inequities.

Recommendation: Identify strategies to address racial disparities in the treatment of chronic pain

62. The Committee recognizes that disparities in chronic pain treatment for people of color exist: they are less likely to receive needed medication for their pain or be offered alternatives to opioids. The Committee recommends that the State identify strategies to address these disparities, such as academic detailing for prescribers.

Recommendation: Promote equitable organizational practices

63. The Committee recommends that the State promote equitable organizational practices, including hiring and paying a livable wage to peers, people with lived experience, and people who live in the communities being served.
64. The Committee recommends that state-funded services be required to demonstrate culturally-competent and trauma-informed care through ongoing training and consultation for staff.
65. The Committee recommends that the State address social determinants of health by incentivizing organizations to hire and house people in recovery, including people who take medications to support their recovery. This includes providing financial incentives/credits to employers who hire people who are in recovery. This is a cross-committee recommendation with the Criminal Justice Populations Committee.
66. The Committee also recommends that the State offer training and technical assistance to employers to support recovery-friendly workplaces and cultures and ensure equitable work environments for people in recovery.

Recommendation: In collaboration with the Prescribing Practices Committee, increase access to MAR in rural and racial and ethnic minority communities by providing technical assistance to newly DATA-waivered prescribers

67. The Committee recommends that the State address geographic, social and racial disparities by continuing to provide technical assistance and other supports to newly DATA-waivered prescribers and other providers to encourage and ensure that MAR, harm reduction, and recovery support services are provided in rural and racial/ethnic minority communities. This is a cross-committee recommendation with the Prescribing Practices Committee.

Prescribing Practices Committee Recommendations

The Prescribing Practices Committee focuses on promoting safer prescribing and dispensing practices to reduce opioid misuse and overdoses, including provider education and increased use of the IL Prescription Monitoring Program (PMP).

Recommendation: Provide DATA waiver training and ongoing technical assistance to increase the number of DATA waivered (buprenorphine) prescribers statewide

The Committee recognizes the need to continue to increase the number of DATA waivered practitioners in Illinois as well as continue technical assistance activities to support waivered prescribers (2017 SOAP Initiative 6.2). Recommendations include:

68. Target primary care and ED physicians for waiver training and technical assistance. (This is a cross-committee recommendation with the MAR and Criminal Justice Populations Committees).
69. Provide stipends to incentivize practitioners to take DATA waiver training.
70. Encourage state leadership to join federal efforts to abolish the x-waiver (the separate DEA waiver for buprenorphine prescribing) and patient prescribing limits by supporting HR 2482, Mainstreaming Addiction Treatment Act.
71. Make buprenorphine prescribing financially sustainable for practitioners: 1) integrate DATA waivered providers 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. This is a cross-committee recommendation with the MAR Committee.

Recommendation: Provide education on naloxone prescribing

72. Only 1 in 5 people who receive a prescription for naloxone fill that prescription. The Committee recommends increased education on naloxone prescribing for providers. Additional related recommendations include:
73. Targeted naloxone education and distribution efforts are needs in primary care and in the ED. Resources to fund and/or supply for take-home naloxone—naloxone that patients can be given in the ED to take home with them—as well as “bedside” naloxone that a nurse or other practitioner can give a patient in the hospital or clinic should be explored and made available. Regulation and reimbursement issues related to funding take-home naloxone also should be explored and address. This is cross-committee recommendation with the Criminal Justice Populations Committee.
74. Insurance co-pays can be a barrier to patients filling a naloxone prescription. The Committee recommends that the State discuss lowering naloxone co-pay amounts with insurance companies.
75. Stigma is another barrier to patients filling a naloxone prescription. Some patients are not filling prescriptions because they may be denied life insurance coverage. The Committee recommends that the State address this issue with life insurance companies.

Recommendation: Provide education to prescribers on addiction, patient-centered care, and alternative treatments for pain management

76. The Committee recommends exploring opportunities to support training for providers and prescribers on addiction and patient-centered care.
77. The Committee recommends that providers receive education on alternatives to opioids for pain management, including what alternative treatments are covered by insurance.

78. All alternative treatment for pain management should be covered by low, out-of-pocket insurance co-pays. The State may need to discuss this with insurance companies to ensure that these costs are covered.

Recommendation: Address high-risk prescribing through peer-to-peer academic detailing

79. The Committee recommends that peer-to-peer academic detailing and/or technical assistance be provided to high-risk prescribers identified by the PMP.

Recommendation: Reduce diversion of controlled substances prescribing

80. The Committee recommends that diagnosis be included on all prescriptions for controlled substances.
81. The Committee recommends that all controlled substances (schedule II) should be E-prescribed in systems with electronic health record (EHR) integration. This will minimize the chance of diversion of controlled substances (i.e., a person can't steal a paper prescription pad, copy a DEA number, etc).
    - Prescriptions for schedule III, IV, and V substances would still to be called in to a pharmacy, but schedule II substances (e.g., hydrocodone, codeine, hydromorphone, oxycodone) would be more tightly controlled.

Public Education and Awareness Committee Recommendations

The Public Education and Awareness Committee addresses public misperception and misunderstanding about the opioid crisis and works to spread the message that OUD is a chronic disease, that treatment works, and recovery is possible.

Recommendation: Promote use of evidence-based messaging guidelines in public awareness and communications campaigns

82. The Committee recommends that any public awareness or communications campaigns that are developed use the following evidence-based messaging guidelines:
    - Define the objective or what behavior needs to be changed
    - Define the target audience. Clearly, not *everyone* needs to change a behavior. Who needs to change and why?
    - Segment on psychographics (e.g. values) to divide audience…only not demographics.
    - Tailor messages to fit the specific subgroup so that they know that is directed to them.

Recommendation: Create a web-based "toolbox" for sharing evidence-based messaging resources

83. The Committee recommends that the State create a web-based "toolbox" where organizations can share resources for creating and distributing evidence-based messaging. The toolbox would contain "buckets" of resources on messaging for specific audiences that others could use to create their own messaging campaigns for similar audiences.

Recommendation: Coordinate stigma education campaigns

84. Stigma related to OUD prevents people from seeking and receiving treatment and recovery support services. We continue to need public awareness and education campaigns to reduce stigma. Numerous campaigns have occurred throughout the past three years, many simultaneously in the same geographic regions of the state. The Committee recommends that the State coordinate stigma reduction campaigns to avoid duplication of effort.

Recommendation: In collaboration with the OSE Committee, include people with lived experience of OUD from diverse communities in creating messaging campaigns

85. The Committee acknowledges that stigma related to OUD is not well-defined, hindering effective messaging efforts. The Committee recommends that in order to better define stigma related to OUD and create effective messaging campaigns, research with people who have experienced stigma, i.e., people with lived experience of OUD, should be conducted. A diverse group of people—those who have been incarcerated, people of color, those who live in rural areas—need to be involved in this research in order to address racial and geographic disparities. This research could include focus groups, surveys, individual interviews, etc. (This is a cross-committee recommendation with the OSE Committee).