

The Heroin Response Strategy

2017 ANNUAL REPORT



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Executive Summary

The Heroin Response Strategy (HRS) is an unprecedented public health-public safety partnership between the High Intensity Drug Trafficking Area (HIDTA) program and the U.S. Centers for Disease Control and Prevention (CDC), with the mission of reducing rates of fatal and non-fatal opioid overdose.

The cross-disciplinary HRS initiative supports collaboration between public safety and public health agencies at the federal, state and local levels. The HRS adopts a four-pronged approach for addressing overdose: law enforcement; response; treatment and recovery; and prevention. This report briefly describes the current state of the opioid epidemic and outlines the strategies employed by the HRS in 2017 to combat this epidemic.

In 2017, the HRS expanded its partnerships for the third consecutive year. The initiative now includes ten HIDTA programs spanning twenty-two states. Each of these states receives funding for a team of two dedicated professionals: a Drug Intelligence Officer (DIO) and a Public Health Analyst (PHA). These DIOs and PHAs work with state and local agencies to improve the sharing of essential data describing local opioid use and overdose epidemics as well as criminal intelligence and arrest information. They also support the development and implementation of new, innovative projects that support the HRS strategic directions.

During the second half of 2017, the PHAs, DIOs, and a team overseen by experts at the CDC worked together to conduct the “9-1-1 Good Samaritan Law” Cornerstone Project. This project was designed to assess the effects of 9-1-1 Good Samaritan Laws on policing practice, describe officers’ recent experience responding to overdose, and identify professional training opportunities to enhance officers’ understanding of overdose response policies. This project consisted of interviews with more than one hundred law enforcement leaders and surveys collected from nearly three thousand patrol officers.

In 2017, CDC provided \$2 million in funding to ONDCP to support a number of public health-public safety interventions at the local level, with the goal of enhancing the portfolio of evidence-based approaches that could be used in the HRS. The HRS provided technical and scientific expertise to the recipient of the award—the University of Baltimore. Thirteen pilot projects were selected for subawards, including 11 from within the HRS states and two (Texas and Arizona) outside the current HRS footprint.

Much of the work of the HRS is conducted at the local level, and the details of that work vary widely from jurisdiction to jurisdiction. This report is not an exhaustive catalog of every HRS effort or success, but instead illustrates through selected examples the scope of the work undertaken by the HRS.

The Opioid Overdose Epidemic

The United States has experienced an alarming rise in the rate of drug overdose deaths since the 1990s. In 2015, alone, more than 52,000 people nationwide died of a drug overdose. In 2016, this number increased to nearly 64,000ⁱ. The majority of these deaths are attributed to opioids, a category of substances that includes prescription analgesics, organic opiates like heroin, and synthetic opioids like fentanyl. In 2016, approximately 115 people in the U.S. died each day from an opioid overdoseⁱⁱ. This increase in opioid overdose fatalities contributed to American life expectancy falling in both 2015 and 2016ⁱⁱⁱ.

The U.S. opioid epidemic has historically been fueled by two primary structural drivers. The first driver was the broad acceptance among health care providers that pain should be considered a fifth vital sign^{iv}, which, in turn, led to increased prescribing of opioid analgesics in the 1990s and 2000s. During this time, well-intentioned health care providers were taught that pain patients could not become “addicted” to their pain medication^v and thus began to prescribe opioids in ways that we now understand put most patients at higher risk for opioid use disorder, such as prescribing high doses of opioids for extended periods of time^{vi}.

The second driver was and continues to be poor health system and health care provider capacity to identify individuals with opioid use disorder and engage them in (or refer them to) high-quality, evidence-based treatment for opioid use disorder, including the full spectrum of medications for addiction treatment (MAT)^{vii}. The majority of people with opioid use disorder in the U.S. do not receive treatment, and, among those who do, many do not receive evidence-based care^{viii}.

Fentanyl: Amplifying the Problem

The third wave of opioid overdose fatalities, which appeared in 2015, is attributed to the introduction of illicitly manufactured fentanyl and fentanyl analogs into the heroin market^{ix}. These synthetic opioids are much more powerful and potent than other opioids. Fentanyl is between 50 and 100 times more potent than morphine^x. Numerous fentanyl analogs have also been identified in illicit drug markets, including carfentanil, which is estimated to be

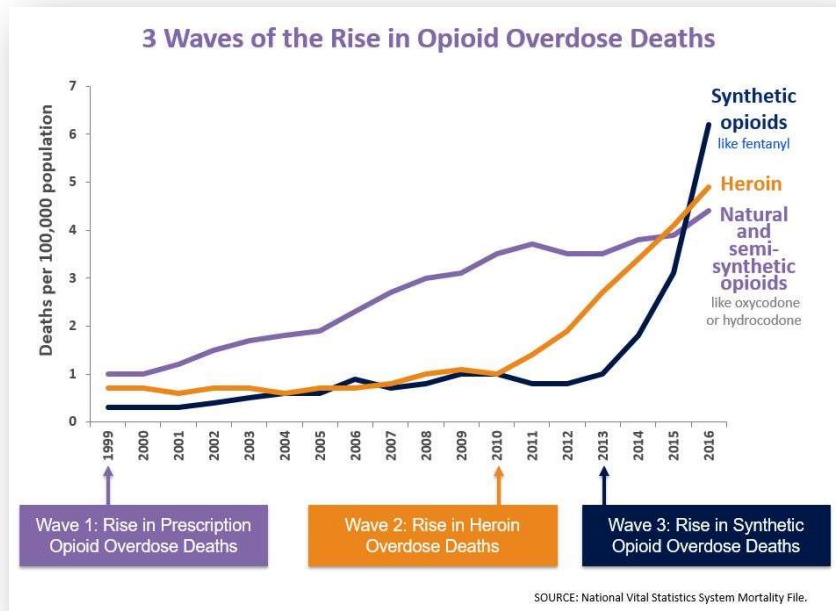


FIGURE 1: OPIOID OVERDOSE DEATHS 1999 TO 2016, CDC

10,000 times more potent than morphine^{xi}. Estimates of relative potency have some uncertainty because illicit fentanyl analog potency has not been evaluated in humans^{xii}.

Over half of the people in 10 states who died of opioid overdoses during the second half of 2016 tested positive for fentanyl, according to a study released by CDC in 2017^{xiii}. The report found that out of a total of 5,152 opioid overdose deaths, almost 3,000 tested positive for fentanyl, and over 700 tested positive for fentanyl analogs, including carfentanil. Northeastern states (Maine, Massachusetts, New Hampshire, and Rhode Island) and Missouri reported the highest percentages of opioid overdose deaths involving fentanyl (approximately 60%-90%), followed by Midwestern and Southern states (Ohio, West Virginia, and Wisconsin), where approximately 30%-55% of decedents tested positive for fentanyl. Similarly, 2016-2017 data from the Drug Enforcement Administration's (DEA) National Forensic Laboratory Information System (NFLIS), which collects drug chemistry analysis results from drugs seized during law enforcement operations, indicates that the Northeast is experiencing the heaviest concentration of fentanyl in its local drug markets. The largest number of fentanyl exhibits submitted to NFLIS in 2016 came from Ohio (7,971), Massachusetts (3,911), and Pennsylvania (2,355)^{xiv}.

Among the 10 states reporting opioid overdose death data, CDC also found that other illicit drugs co-occurred in 57% and 51% of deaths involving fentanyl and fentanyl analogs, respectively, with cocaine and confirmed or suspected heroin detected in a substantial percentage of deaths^{xv}. This supports findings from other reports indicating that fentanyl and fentanyl analogs are commonly used with or mixed with heroin or cocaine. Nearly half of overdose deaths involving fentanyl and fentanyl analogs, however, did not test positive for other illicit opioids, suggesting that fentanyl and its analogs might be emerging as unique illicit products.

The Federal Response to the Opioid Epidemic

Given the enormity of this national crisis, collaboration across agencies is essential. Each sector of government has a role to play—whether implementing prevention activities, providing treatment to individuals with opioid use disorder, identifying and disrupting the flow of illicit opioids into and across the country, or advancing research to increase our knowledge on promising practices.

In March 2017, President Trump established the President's Commission on Combating Drug Addiction and the Opioid Crisis charged with the mission "to study the scope and effectiveness of the Federal response to drug addiction and the opioid crisis and to make recommendations to the President for improving that response^{xvi}."

The Commission's final draft report was released in November 2017. The report^{xvii} listed 56 distinct recommendations, including: providing block grant federal funding for opioid-related and substance use disorder-related activities to states; expanding federal drug courts; devising new law enforcement strategies to reduce the illicit opioid supply; expanding prescription drug monitoring programs to include a data-sharing hub with the Department of Justice; providing more resources to hospital and recovery organizations to expand the use

of recovery coaches, especially in hard-hit areas; and improving coordination between all federal programs and agencies that target the opioid crisis.

An Overview of the Heroin Response Strategy (HRS)

The HRS is, at its core, an example of this cross-agency, interdisciplinary collaboration. Since Congress established the High Intensity Drug Trafficking Area (HIDTA) Program in 1988, it has continued to develop and support criminal intelligence sharing and interagency collaboration. In 2015, in response to the increase in heroin use and overdose across the country, five HIDTAs came together to create the HRS. The HRS believes that an effective response to the opioid epidemic requires public health and public safety to work collaboratively towards a common goal: reducing the number of Americans dying from opioid-related overdoses.

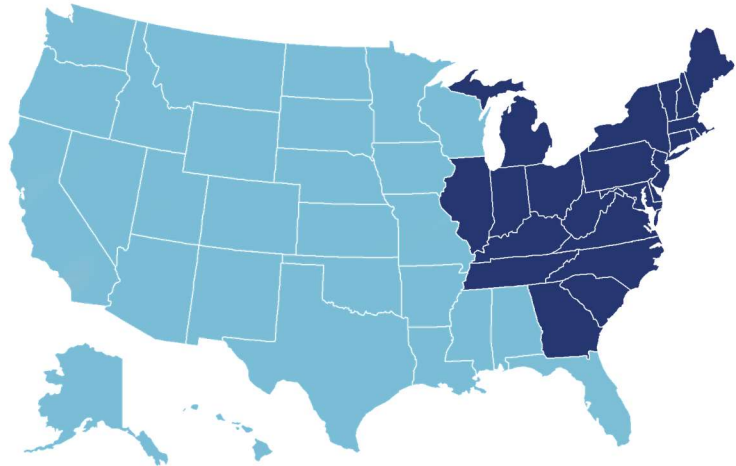


FIGURE 2: THE HEROIN RESPONSE STRATEGY, 2017

The HRS now encompasses ten HIDTAs covering twenty-two states and the District of Columbia, and includes a partnership with the CDC. In 2017, the HRS spanned the New England, New York/New Jersey, Liberty Mid-Atlantic, Ohio, Michigan, Appalachia, Washington/Baltimore, and Atlanta/Carolinas HIDTAs. During the second half of 2017, the Indiana and Chicago HIDTAs received funding to join the initiative. At the end of the year, the HRS encompassed Connecticut, Delaware, the District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and West Virginia.

The mission of the HRS is to reduce fatal and non-fatal opioid overdose incidents by, first, developing and sharing information about heroin and other opioids across agencies, and, second, by supporting evidence-based strategies across participating states. The HRS has adopted four strategic directions that shape the boundaries of HRS work and provide a “roadmap” for achieving the HRS mission of reducing overdose rates. These strategic directions are: (1) law enforcement; (2) response; (3) treatment and recovery; and (4) prevention.

Prevention

Prevention refers to the primary prevention of opioid misuse. Prevention efforts should target the major risk factors for the initiation of opioid use, including the excess availability of prescription opioids; these risk factors may be addressed through enhancing the use of prescription drug monitoring programs (PDMP), improving pain management, and supporting CDC guideline-concordant care to reduce unnecessary exposure to prescription opioids. Educating health professionals through academic detailing is another

example of an evidenced-based prevention effort. Academic detailing consists of structured visits by trained personnel to health care professionals to provide tailored training and technical assistance, helping health care providers use best practices^{xviii}. Academic detailing has been used to assist physicians in reducing potentially risky opioid prescribing practices, and to prepare pharmacists to effectively distribute naloxone to the public.

In addition to educating health professionals, primary prevention also involves educating the public about the risks of opioid misuse. Education campaigns and programs should take an evidence-based approach. Universal school-based programs that have shown effectiveness in reducing youth risk taking behaviors, such as the evidence-based positive youth development programs promoted by [Blueprints](#) and programs found in SAMHSA's National Registry of Evidence-based Program and Practices ([NREPP](#)) are examples of evidence-based primary prevention education programs. As another example, in 2017, CDC launched Rx Awareness, its first prescription opioid overdose prevention campaign. The Rx Awareness campaign is evidence-driven and tells the stories of real people whose lives were affected by opioid misuse. The campaign empowers consumers to talk to their health care providers about safe prescribing and alternatives to prescription opioids.

Law Enforcement

Law Enforcement refers to federal, state, local and tribal agencies tasked with the surveillance of illegal drug markets and the policing of the drug trade. Law enforcement agencies play a pivotal role in stopping the flow of illicit drugs into and across the U.S. The entrance of powerful synthetic opioids into U.S. drug markets requires targeted enforcement and disruption of particularly potent drug supplies. A central goal of the HIDTA program is to disrupt and dismantle drug trafficking organizations. Law enforcement officers, in their capacity as first responders and public safety officers, have strong and immediate impact on community perceptions of substance use and overdose. Additionally, many of the most at-risk members of our communities have contact with the criminal justice system before, during, and after an overdose^{xix}. It is vitally important to implement law enforcement responses to opioid misuse and the disease of opioid use disorder through officer training, alternatives to incarceration, and other innovations that leverage the criminal justice system, as these are often touch point for people who use opioids.



FIGURE 3: HEROIN RESPONSE STRATEGY
STRATEGIC DIRECTIONS, 2017

Treatment and Recovery

The third strategic direction—Treatment and Recovery—refers to a variety of social, clinical and institutional tools that aid individuals in altering their relationship with and/or regaining control over their consumption of opioid products. Treatment may include traditional social-behavioral interventions such as addiction counseling and psychological therapy, social support groups, or MAT provided by a licensed physician within an in-patient or out-patient setting. There are currently three FDA approved medications available for the treatment of opioid use disorder: methadone, buprenorphine, and naltrexone. All three medications have proven highly effective for treating opioid use disorders^{xx}. Only 20%-40% of individuals diagnosed with an opioid use disorder are estimated to receive care in any given year^{xxi}. Potential interventions to link individuals to care and treatment are essential. Examples of these linkage to care programs include “warm hand offs” following diagnosis or admittance to an ER, post-overdose outreach by a team consisting of a police officer, clinician or social worker, and outreach to justice-involved populations upon release from incarceration to link them to care.

Response

Response refers to emergency responses to prevent fatalities from unintentional overdose and other harms related to opioid misuse. Effective, evidence-based strategies for response include post-overdose protocols in emergency departments, checklists and protocols to alert partners to overdose spikes in a particular jurisdiction, increasing the availability of naloxone for community members and first responders, and working with risk reduction partners to help vulnerable populations reduce their chance of fatal and nonfatal overdose and infectious disease transmission.

HRS State Teams

HRS State Teams are comprised of one Drug Intelligence Officer (DIO) and one Public Health Analyst (PHA). These teams form the foundation of the HRS and operate in each HRS state. In this capacity, DIOs and PHAs are responsible for helping to increase communication, data flow, and intelligence sharing between public safety and public health sectors within and across HRS states.

Public Health Analysts (PHAs)

Public Health Analysts (PHAs) work with numerous key agencies to increase interagency data sharing. PHAs often split their time between multiple state and local agencies, including state health departments, fusion centers, medical examiners’ offices, and prosecutor’s offices. This interagency framework uniquely positions PHAs to serve as liaisons between the public health and public safety sectors.

PHAs’ responsibilities and tasks vary from state to state as determined by the nature of the opioid epidemic in their particular area of responsibility; however, in 2017, PHA efforts across the HRS were largely focused on the following four areas:

1. Enhancing opioid overdose reporting and public health surveillance systems
2. Developing and disseminating reports on trends in substance use and overdose
3. Integrating public health and public safety data

4. Developing opioid overdose response protocols

As many state and federal agencies continue to prioritize drug overdose data collection and analysis, PHAs have filled a critical role in enhancing state-wide overdose reporting and surveillance systems. HRS PHAs support local agencies by improving the reporting, coding and counting of opioid overdose data in their state. The accuracy and availability of this data is crucial to understanding and addressing a rapidly evolving opioid epidemic.

Many PHAs are also responsible for developing monthly or quarterly reports that highlight trends in substance use and fatal or non-fatal overdoses in their jurisdiction. These reports help state and regional partners better understand the threats in their area and respond promptly to changes in that environment.

From January 1st to December 31st, 2017, the HRS PHAs developed and disseminated **461 reports containing drug use and overdose trends** to public health and public safety partners.

Since most PHAs are well-connected with law enforcement and public health agencies within their state, they can often integrate independent datasets from these otherwise unconnected agencies, thus creating a more complete picture of substance use-related trends within their state. Through the establishment Memorandums of Understanding (MOUs) or data sharing agreements with various public health and public safety entities, PHAs are also able to contribute to the sustainable infrastructure necessary for trend analyses that overlap law enforcement and public health data, such as trafficking patterns and overdose deaths.

PHAs also play an important role in developing and implementing response protocols within their state. Through collaboration with first responders, prosecutors, treatment providers, and other key agencies, PHAs support projects that seek to create more efficient and effective systems for responding to overdose incidents and connecting overdose victims to care.

Drug Intelligence Officers (DIOs)

DIOs are retired law enforcement officers with extensive experience investigating drug trafficking organizations (DTOs) in their assigned state. DIOs serve to fill a critical gap in intelligence sharing by reporting cross-jurisdictional links, communicating interstate intelligence, relaying case referrals between agencies, and developing timely intelligence reports for law enforcement audiences. Each DIO is assigned to the HIDTA Investigative Support Center or to a fusion center in their state, and many DIOs spend a significant amount of time meeting with local law enforcement agencies in order to build relationships and increase awareness of the resources that HIDTAs and the HRS can offer.

Because drug trafficking organizations operate across regions without regard for jurisdictional boundaries, dismantling them requires the collaboration of partners spanning various states. The HRS brings an innovative approach to current law enforcement models, one that is designed to yield smarter responses to expansive and increasingly sophisticated drug trafficking and distribution threats. The DIO serves as a communication point within the state for reporting cross-jurisdictional drug trafficking links, disseminating interstate drug intelligence, making case referrals, and enhancing drug investigations. The DIO Network relies

heavily on each DIO's extensive law enforcement experience and contacts throughout their state.

Essential to the DIOs' intelligence sharing work is the transmission of Felony Arrest Notifications (FANs). DIOs track and relay drug-related felony arrests of out-of-state and out-of-area residents and report this information to the individual's home law enforcement agency. DIOs receive information about felony drug arrests from multiple sources, including a central state repository, law enforcement agencies throughout the state, and open source information (e.g., news articles). This information is used to connect the arresting agency to the appropriate out-of-state and in-state entities to expedite intelligence sharing that otherwise would not happen, and to facilitate law enforcement responses.

These transmitted FANs transmitted by DIOs can have a significant impact on case investigations. By connecting agencies that may have disparate information about an individual or group, individual arrests can lead to larger drug trafficking and criminal cases.

From January 1st to December 31st, 2017, the HRS DIOs transmitted **19,607 notifications** to police departments that an individual who lives in their jurisdiction was arrested elsewhere on felony drug charges.

In addition to felony arrest notifications and targeting DTOs, DIOs offer critical support to a range of criminal investigations. Across law enforcement networks, DIOs are able to share information and intelligence gathered from investigative tools such as license plate readers, facial recognition programs, phone record databases, and Division of Motor Vehicle photo programs. DIOs often find that their information can help enhance law enforcement efforts to investigate and prosecute larger cases. DIOs provided case assistance over 1,500 times in 2017.

Innovation at the Local Level

While the opioid epidemic is of national scope and importance, local agencies and organizations are at the forefront of the fight to prevent and control its consequences. Due to the ways in which emergency services, health care, policing, and treatment services for opioid use disorder are often "siloeed" off from one another, building partnerships between public health and public safety also requires localized problem-solving.

Combating Opioid Overdose Through Community-level Intervention Initiatives (COOCLI) Funding Awards

As opioid overdose surveillance data improves, the most pressing question in many HRS states is now: *How should we act on this information?* To assist state and local law enforcement and health agencies with answering this question, CDC, as a result of the HRS partnership, provided \$2 million to ONDCP to create a number of public health/public safety interventions at the local level. These Combating Opioid Overdose Through Community-level Intervention Initiatives (COOCLI) are now funding 13 pilot projects to implement innovative, evidence-based, community-level interventions with the goal of creating replicable solutions to the opioid epidemic in rural, suburban, and urban areas. These pilot projects are taking place in high need areas, with funding provided in support of personnel, services, technology and/or equipment needs.

Each project application was eligible to receive up to \$150,000 to fund efforts carried out between December 2017 and November 2018. Each COOCLI applicant was required to receive a letter of support from their local HIDTA Director. COOCLI award recipients were selected by a board which included leaders from ONDCP, CDC, HRS HIDTA Directors, as well as public health and public safety experts. Eleven of the 13 COOCLI grants were awarded to applicants from HRS states. Two recipients were from states outside the current HRS footprint (Texas and Arizona), demonstrating the reach and benefit of the HRS beyond the designated HRS HIDTAs.

Examples of COOCLI projects funded in 2017 include:

- Emergency department-initiated referrals to MAT in Philadelphia, PA
- Post-arrest diversion to treatment for opioid use disorder in Kingsman, AZ
- On-call recovery coaches and referral to treatment for opioid use disorder in Fire Departments in Providence, RI
- Corrections-based MAT in Boston, MA
- Early prevention model to decrease opioid use by reducing adverse childhood experiences in Martinsburg, WV

HRS Pilot Projects

In addition to the COOCLI grants, the HRS is also focused on implementing pilot projects in high-need areas within the HRS states. The HRS received funding in 2017 to support these pilot projects, with the goal of building the evidence-base for innovative solutions to combatting the opioid epidemic. In some cases, HIDTAs chose to use the funding to bolster the COOCLI grant taking place in their state, and in other cases HIDTAs used the funds to implement novel pilot projects. Examples of these pilot projects are described below.

Massachusetts:

HRS is partnering with Plymouth County Outreach (PCO), a strong coalition of law enforcement agencies, treatment providers, and peer recovery coaches, to build the capacity of this organization to monitor and evaluate the efficacy of their outreach efforts through broader collaboration in the Plymouth County area.

Currently, numerous police departments in and around the Plymouth County area maintain an internal database (kept separate and distinct from investigative data) of individuals who have experienced a suspected non-fatal overdose in their jurisdictions. Once an overdose victim is transported to a local ED, staff at the ED has the option to contact the PCO organization and indicate that further outreach with the individual is, for a non-disclosed social or clinical reason, merited. When fulfilling these outreach requests, PCO volunteers visit residents and their families or loved ones with a few goals in mind: to de-escalate any tension stemming from the overdose through empathy and compassion; to increase residents' awareness of treatment options and other resources available to them in the Plymouth County area; and, if possible, to facilitate a warm hand-off to treatment or other services should the non-fatal overdose victim agree to seek care and consent.

HRS is working with the PCO organization and with the primary provider of varied treatment options for opioid use disorder in Plymouth County, High Point, to develop a protocol that

allows this coalition of local partners to better understand how interaction with PCO outreach teams is affecting treatment seeking in the days and months following outreach efforts. Kelley Research Associates, a professional consulting and evaluation firm, has assisted the PCO organization with building and maintaining a database of PCO activities, tracking information like: the basic demographics of individuals targeted for outreach (per request from a local ED); the date and time of the outreach event; the composition of the outreach team; the individuals engaged during outreach (the victim, friends, family, loved ones, etc.); and the initial outcome of that visit. PCO and High Point are currently discussing ways to provide PCO with limited, fully de-identified data from High Point's intake records, so as to allow PCO to better understand what proportion of their outreach efforts are resulting in treatment seeking and identify aspects of their outreach efforts, which appear to be associated with a higher likelihood of successful linkage to care.

While this monitoring and evaluation system being developed will not be able to track individual residents of Plymouth County through different points along the continuum of care for opioid use disorder, it will allow for a greater understanding of how individuals at risk of overdose flow between different points on the upstream end of that continuum. This is a novel approach for the development of successful community coalitions responding to the opioid crisis, and could serve as a model for other communities where the efficiency of post-overdose response and linkage to care efforts often truly are a matter of life and death.

Ohio:

In collaboration with local partners, HRS is undertaking efforts to better understand the relationships between criminal justice system involvement and overdose risk in Ohio. Early investigations undertaken by the HRS PHA in Ohio indicate that as much as a majority of fatal overdose victims in the state may have been incarcerated within 6 months of their fatal overdose incident. These early numbers have inspired action among local leadership coalitions in Cuyahoga county, where efforts to initiate evidence based overdose prevention interventions—including buprenorphine induction in local Emergency Departments and MAT diversion in local drug courts—have been picking up pace in the wake of these revelations.

Given the enormous response to these preliminary findings, the Ohio HIDTA is dedicating its pilot funds to an interagency effort to more systematically and effectively assess the links between criminal justice involvement and overdose risk in Ohio. Specifically, these funds will be used to support local County Sheriff's offices as they dedicate additional staff time or staff overtime for producing reports on bookings and charges in local jails. This would involve not only extracting this data, going back many years, from existing criminal justice databases, but also re-coding that data into a uniform variable list (to allow comparison across counties) and transmitting that data to HRS partners in a safe, legal, and ethically sound manner.

To date, the Ohio HIDTA has already begun planning discussions with Cuyahoga, Franklin, and Hamilton counties, with the intention of expanding even further, as funds and program design efforts allow. To our knowledge, this would be the first statewide effort to describe overdose mortality among jailed and incarcerated populations over a period of time beyond 1-2 months post release. This project has the potential to change how the opioid crisis in Ohio is understood as well as the public health and public safety efforts implemented in response. Such systematic evaluation of the relationship between criminal justice

involvement and overdose risk could impact other states in similar ways, positioning Ohio's pilot effort as a model for others to follow.

West Virginia:

HRS is actively supporting novel initiatives for the primary and secondary prevention of opioid-use related harms in Berkeley County, West Virginia. One of these initiatives is being led by partners from the School of Nursing at the University of West Virginia and seeks to tackle one of the most persistent, unanswered questions of the opioid crisis: how prevention, treatment, and other essential services can be successfully accessed and delivered to high risk populations who live in thinly populated rural areas.

This effort, which has been colloquially referred to as the "Bridging Project" was designed to complement the Martinsburg Initiative, which is working to prevent the initiation of drug use in Martinsburg, Berkeley County's largest urban area, through early, community-based responses to adverse childhood events that are known to lie upstream from problematic drug use later in life. The "Bridging Project" is specifically targeting individuals in the Berkeley County area who are already "upstream" and living across the county area. HRS was instrumental in getting this program off of the ground, identifying local talent who could carry out this initiative and providing technical assistance in project design, coalition building, and the identification of adequate funding for fulfilling the project's agenda.

The ultimate goal of this project is to more successfully and efficiently connect individuals at risk of overdose with evidence-based overdose prevention tools, information, and services. The "Bridging Project" is, in these early stages, focused on conducting a thorough assessment of overdose trends and need for services, to inform outreach efforts and priorities. Simultaneous with these population-level assessments, the Bridging project is carrying out ethnographic research among individuals at risk of overdose in Berkeley County in order to discover and understand barriers and facilitators of access to care in rural areas and is using its current social capital to help build a network of trained peer recovery coaches who are prepared to take the lead in outreach efforts in rural parts of Berkeley County and implement the services and programs designed according to the findings of the epidemiological and ethnographic assessments currently underway. This project is poised not only to reduce the risk of fatal overdose across Berkeley County, West Virginia, but also to provide the first major roadmap for implementing effective prevention programs in rural areas within and beyond Appalachia.

HRS-wide Efforts to Understand the Epidemic

While the implementation of overdose prevention interventions often happens at the local level, sharing innovative ideas across jurisdictions and highlighting regional trends is a useful strategy to better understand the scope of the epidemic as a whole. In keeping with this philosophy, the HRS undertook several activities in 2017 to enhance our understanding of the opioid epidemic and strategies for combating it across the entire HRS region.

The "9-1-1 Good Samaritan Law" Cornerstone Project

The public health and public safety collaboration between DIOs and PHAs is foundational to the work they do every day. Accordingly, the HRS provides purposeful opportunities to leverage the power of this collaboration through annual Cornerstone Projects. These projects mobilize

the entire HRS to answer common questions or address shared informational needs that affect the HRS region as a whole. The projects focus on a different priority topic each year, selected by HIDTA Directors and the CDC, and build upon evidence-based practices to reduce overdose.

In 2017 PHAs and DIOs implemented the “9-1-1 Good Samaritan Law” Cornerstone Project that examined the impact of legislation, currently enacted in many states, that affords individuals limited immunity from minor charges of drug possession when calling 9-1-1 to report a suspected opioid overdose. The “9-1-1 Good Samaritan Law” Cornerstone Project was designed to assess the effects of 9-1-1 Good Samaritan Laws on policing practice; describe officers’ recent experience responding to overdose; and identify professional training opportunities to enhance officers’ understanding of overdose response policies.

In September and October 2017, HRS state teams conducted interviews with law enforcement leaders and, upon the conclusion of that interview, asked to distribute a survey to the patrol officers in that department. Surveys were distributed electronically, and potential participants were given a common URL for accessing the survey instrument. Survey data was collected online and maintained anonymously behind standard Law Enforcement Sensitive protections at the National HIDTA Assistance Center. The collected data was analyzed regionally and on a state-by-state basis. The survey instrument was designed to capture officer knowledge of their state’s 9-1-1 Good Samaritan Law, recent experience responding to overdose, and their perceptions of the law and other overdose response policies gained through their experience on the job.

In total, 2,869 patrol officers from 20 states participated in the survey. This Cornerstone was launched before the addition of Indiana and Illinois to the HRS. HRS partners at the CDC developed individual, state-level reports outlining key findings and—with the assistance of law enforcement experts—offered recommendations for responding to these findings. Recommendations focused on enhancing officer knowledge of the Good Samaritan Law through trainings, addressing officer safety and liability concerns around opioid exposure in the field, and exploring the feasibility of implementing police-assisted recovery initiatives and/or pre-arrest diversion programs within state jurisdictions.

Heroin Response Strategy Symposium

The HRS Symposium is another initiative-wide effort that brings together all HRS personnel along with key experts in the public health and public safety fields. This high-profile, annual event provides an opportunity for public health and public safety officials to gain familiarity with ongoing efforts “across the aisle” as the work and outcomes of law enforcement and public health agencies are not seen by each other. The Symposium provides a platform for

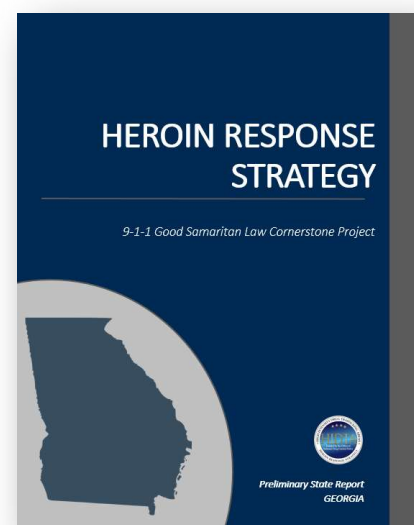


FIGURE 4: GEORGIA GOOD SAMARITAN REPORT COVER

presentations by experts on best practices in overdose prevention and response and encourages others to develop similar interventions and surveillance methods in their own jurisdictions. By calling attention to areas in need of improvement and highlighting projects that have been particularly effective, the HRS Symposium increases collaboration and spreads innovation throughout the country.

The 2017 HRS Symposium, which took place November 8th and 9th in Atlanta, Georgia, focused on actionable strategies or interventions, with information about how innovative projects can be replicated or expanded elsewhere. The Symposium featured elected officials, physicians, medical examiners, epidemiologists, front-line staff, police, prosecutors, emergency responders, software developers and data analysts, all focused on sharing innovative strategies to reduce fatal and nonfatal opioid overdose.

Nearly 300 attendees from 23 states took part in the event. Panels included such topics as:

- Overdose Prevention within Criminal Justice Settings
- Community-Led Initiatives and Front-Line Partnerships
- Overdose Public Health Surveillance Strategies
- Public Health and Public Safety Collaboration in New York City

Capacity Building Through Training and Technical Assistance

Through its partnership with the Institute for Research, Education and Training in the Addictions (IRETA), the HRS provided online trainings throughout 2017 to PHAs and DIOs. These trainings utilized subject matter experts at IRETA, CDC and DEA to provide high-quality, relevant and timely trainings to enhance PHAs' and DIOs' understanding of the opioid epidemic and further strengthen technical skills essential to their work. IRETA conducted a training needs assessment with PHAs and DIOs to determine their current level of knowledge and skills in a variety of areas, and then used the results from the needs assessment to develop and tailor trainings that would address those needs. In 2017, these trainings consisted of: an overview of HIDTA and CDC, Microsoft Excel training, a briefing on the role of "the Dark Web" in drug trafficking, and a primer on opioid use disorders and medication assisted treatment (MAT).

The Role of the HRS in Combatting the Opioid Epidemic

The work of the HRS builds upon existing public health and public safety infrastructures to create strong, lasting information sharing systems, response initiatives, and other innovations to combat the opioid epidemic.

In 2017, the HRS demonstrated its value by:

1. Enhancing overdose reporting and surveillance systems
2. Identifying drug trafficking organizations (DTOs) through intelligence sharing
3. Increasing collaboration between agencies and states
4. Supporting linkage to treatment for opioid use disorder

Enhancing Overdose Reporting and Surveillance Systems

The HRS engaged in a variety of activities in 2017 to increase opioid overdose surveillance. These efforts varied from local county-level demonstration projects to opioid overdose surveillance on a national scale. Below are several examples of these types of activities.

Improving the Accuracy of Overdose Surveillance

The Michigan Public Health Analyst (PHA) played a central role in developing and piloting Michigan's System for Opioid Overdose Surveillance (SOS). SOS is a real-time surveillance platform that combines data from emergency departments, medical examiners, and EMS to increase the timeliness and quality of overdose reporting with the goal of developing regional strategies to reduce fatal and non-fatal overdoses.

When Michigan joined the HRS in 2017, several surveillance challenges existed, including decentralized medical examiner and emergency department data. In response, the Michigan PHA worked with the University of Michigan Injury Center to develop SOS in order to capture timely and accurate data and inform prevention and intervention efforts. With HRS support, pilot implementation of the proposed SOS was completed in one county in 2017. The SOS interface combines previously disparate datasets (i.e., EMS, emergency department, and medical examiner data) and presents that data through a visual interface which allows for more accurate measurements of opioid overdose incidence. Through the SOS system, county-level data are available to the public, and census tract-level data are available to key stakeholders. With HRS support, the Michigan SOS will continue to expand, with the ultimate goal of a statewide surveillance system.

Efforts to improve the accuracy of fatal overdose data were also carried out in New York State (NYS), which saw an alarming increase in drug overdose deaths involving synthetic opioids (excluding methadone)-the highest in the nation-from 2014-2015^{xxii}. State officials became increasingly concerned over the role that fentanyl played in these fatalities. While the National Center for Health Statistics (NCHS) assigns a unique ICD-10 code for heroin overdose (T40.1) that makes it relatively easy to analyze changes in these overdose rates over time, fentanyl has not been assigned its own ICD-10 code. Since fentanyl-related overdoses are coded as part of a broad category of synthetic opioids excluding methadone (T40.4), confirmation of the number of fentanyl-related overdose deaths with existing data was challenging. The New York Public Health Analyst examined death certificate data for NYS (excluding New York City)

from 2015 and 2016 to see how many fentanyl-related overdoses were assigned the broad synthetic opioid ICD-10 code, and what proportion of the cases assigned the T40.4 code was fentanyl-related, based on literal texts from the death certificate data. Using the data provided by the NYS Department of Health's Bureau of Vital Records, some fentanyl-related deaths that were not assigned the T40.4 code were identified. It was determined that the expected codes in the majority of these cases were missing due to variations in how the data was recorded on the death certificate. The NYS Department of Health team consulted with NCHS and compiled a list of terms that were frequently used by coroners and medical examiners to describe drug overdose deaths that were not otherwise coded as a synthetic opioid overdose. The NYS DOH made an enhancement to the NYS Electronic Death Reporting System so that those words will trigger prompts in to help ensure that fentanyl and other drug overdoses are recorded accurately. This will enable the proper ICD-10 code(s) to be assigned by NCHS and is expected to improve the accuracy of official overdose statistics.

In 2017, New Jersey's PHA worked with the Department of Health, Rutgers University, and other New York/New Jersey HIDTA staff to host a symposium titled "The Opioid Crisis: A Medical Examiner and Public Health Perspective" with the goal of enhancing medical examiners' understanding of best practices and providing up-to-date CDC and American College of Medical Toxicology guidelines. The PHA developed an assessment in conjunction with the symposium to analyze current protocols used by medical examiners in county and regional offices across the state. The pre-symposium assessment helped define specific barriers medical examiners faced in accurately documenting overdose deaths across the state and provided medical examiners with new tools and perspectives to improve overdose death reporting.

Enhancing Overdose Reporting

The PHA in North Carolina develops a monthly surveillance report highlighting opioid overdose emergency department visits across the state. Rates of opioid-related emergency department visits are reported by county to identify those with the largest opioid burden. To increase the relevance of the surveillance information for public safety partners, the PHA developed heat maps to highlight opioid diagnosis-related emergency department visits as well as overdose-related emergency department visits.

The PHA in South Carolina develops a monthly report detailing EMS naloxone administrations and opioid overdose reversals across the state. The reports allow public health and public safety partners to monitor trends in non-fatal overdoses using syndromic data.

Additionally, many PHAs and DIOs have been very involved in supporting the Overdose Detection Mapping Application Program (ODMAP) that was developed by the Washington/Baltimore HIDTA in response to a lack of consistent methods to track fatal and non-fatal overdoses in real time across jurisdictions. ODMAP is a system where first responders enter basic fatal and non-fatal overdose information, and document whether

naloxone was administered at the scene. ODMAP data is both timely and mobile, providing information locally as well as across county and state lines.

The most innovative feature of ODMAP is the overdose spike alert, an email sent to stakeholders when an overdose spike occurs, defined by the submission of a locally-specified number of overdoses in a 24-hour period. The purpose of the alert is to give public health and public safety partners real time information with which to mobilize a response (such as increased naloxone or public health alerts). By the end of 2017, over 250 agencies in 27 states across the country had joined the ODMAP network. ODMAP ventures beyond the usual county and even state-level activities, with hopes of national coverage.

Integrating Public Health and Public Safety Data to Improve Reporting

HRS state teams find novel ways to integrate and combine public health and public safety data to enhance the picture of the opioid epidemic in their state. Several states have implemented Drug Monitoring Initiatives (DMIs) to serve as a repository of drug data and to distribute actionable drug intelligence to key stakeholders. Throughout 2017 the PHAs assigned to New Hampshire and New Jersey were instrumental in ensuring these DMIs contained relevant public health data, including naloxone administration data, treatment data, and overdose death data. These additions provided a more robust, 360-degree view of the epidemic and facilitated collaboration among key partners.

In many cases, improved surveillance occurs through ongoing collaboration between public health and public safety sectors. In 2017 West Virginia's PHA successfully forged new relationships with the Office of the Chief Medical Examiner, securing access to monthly overdose death data through the Health Statistics Center. The PHA also received a bulletin by the El Paso Intelligence Center (EPIC) that included a list of states in which new fentanyl analogues were identified and, though West Virginia was not listed in the bulletin, identified one of the analogues in West Virginia overdose data. This information was relayed to the West Virginia HIDTA and then communicated to DEA for continued surveillance.

Similarly, the PHA in North Carolina used ArcGIS to map opioid-related drug seizures, deaths, and emergency department visits to analyze connections between public safety efforts and public health outcomes. High rates of opioid-related deaths and emergency department visits occurred in some rural counties without a major highway, in areas that were not HIDTA-funded and had no known drug seizures. The PHA's analysis helped identify counties that may be potential drug trafficking destinations that are not currently part of the Atlanta-Carolinas HIDTA's disruption efforts. Public health/public safety collaboration, a hallmark of the HRS, creates opportunities for this kind of cross-agency communication, resulting in improved information and enhanced surveillance.



FIGURE 5: ODMAP LEVEL 1 INTERFACE

Identifying Drug Trafficking Organizations (DTOs) through Intelligence Sharing

In 2017, DIOs routinely provided partner agencies with intelligence, which supported federal cases against large-scale, multi-state drug trafficking organizations (DTOs). While reviewing FANs, the Michigan DIO obtained information on two subjects: one from a Michigan State Police Domestic Highway Enforcement (DHE) trafficking arrest, and the other from an Ohio State Highway Patrol trafficking arrest. The Michigan DIO used this information to notify his fellow DIOs of the connection and discovered that there was a DEA Analysis and Response Tracking System (DARTS) match on the suspects from DEA and that both subjects were members of a large DTO in a DEA West Virginia case. He turned the information over to the DEA case agent in West Virginia, who reported back that the information would significantly aid in the pending indictments.

In another instance, the DIO assigned to Michigan gave information gathered by the Ohio DIO regarding an individual arrested for a large number of Oxycodone tablets to DEA. The individual stated that she was traveling from Michigan to Pennsylvania, but through the Michigan DIO's communication with the DEA, it was discovered that the woman was actually from Detroit and part of a large DTO in Charleston, West Virginia. Once again, this information significantly contributed to the DEA's investigation of the Drug Trafficking Organization.

In the Washington/Baltimore HIDTA, the DIOs regularly work with the Investigative Support Center (ISC) to provide case support to ongoing DTO investigations. For example, in 2017 one Washington/Baltimore DIO assisted the Virginia State Police in their efforts to locate and arrest a federally indicted leader of a major DTO operating in the Richmond, Virginia area. The DIO discovered that the target was temporarily residing in Baltimore City and notified the Baltimore Police Department. Within 24 hours of notification, the target was located and arrested by officers from the Baltimore Police Department and the Virginia State Police.

Identifying Fentanyl and Fentanyl Analog Trends

DIOs' extensive network of law enforcement partnerships has become particularly significant as fentanyl and its analogs continue to spread through local drug markets. In March 2017, intelligence regarding a specific stamp brand connected to fentanyl-contaminated heroin made its way from Selbyville Police Department in Delaware to multiple Maryland police departments via the DIO network. In return, Maryland law enforcement provided information on two more stamps they were aware of that were associated with fentanyl-contaminated heroin.

Similarly, the Delaware DIO helped bring together the Millsboro Police Department with the Delaware Intelligence & Analysis Center and the Delaware State Police Department's Governor's Task Force to collaborate on an investigation into a particular stamp brand, which was often seen at the scene of opioid-related fatalities. In both of the above instances, the DIOs made a previously unseen connection across jurisdictions, expanding multiple law enforcement agencies' knowledge of fentanyl-associated stamps and encouraging collaboration in the context of a rapidly changing drug environment.

In September 2017, the South Carolina DIO responded to a request from DEA Atlanta regarding the presence of 4-Fluoroisobutyryl fentanyl in South Carolina. Although this DEA

office had identified eight instances of the substance nationwide, this was a novel substance for Atlanta DEA, specifically. The South Carolina DIO succeeded in bridging a long-standing information gap between federal and local entities, using his extensive network of contacts to gather information that revealed several seizures of 4-Fluoroisobutyl fentanyl in South Carolina, including photographic evidence of the substance.

Connecting the Dots on Violent Crimes

Drug trafficking activities are frequently connected to other serious crimes, and DIOs' swift transmission of drug trafficking information helps advance investigations into these serious, often violent crimes. One such example emerged in March 2017 when the Vermont and Connecticut DIOs brought together officers from the Vermont State Police and the Hartford Connecticut Police Department following the arrest of suspects from the Hartford area in Vermont on charges related to heroin importation. Information from the Hartford Police Department revealed that the suspect in Vermont had provided false identification, while information obtained from the Hartford Police Department helped identify the suspect as wanted in connection to a homicide.

In January 2017, the Kentucky DIO provided the Ohio DIO with a FAN for an Ohio resident arrested in Kentucky for possession of heroin. Numerous credit cards, checkbooks, passports, and mail from several Ohio residents were found in the arrestee's vehicle. When the Ohio DIO passed the information received from his counterpart in Kentucky to the Champaign (Ohio) County Sheriff's Office, it was revealed that the Sheriff's Office was already working a "multi-subject theft ring" that involved this particular individual. The Champaign County Sheriff's Office further reported that the information from the DIOs and the Fort Wright Kentucky Police Department helped them solve numerous theft, forgery, and aggravated burglary cases in the Champaign County area.

Helping Law Enforcement Agencies Build and Strengthen Cases

DIOs utilize information and intelligence gathered from investigative tools such as license plate readers, facial recognition programs, phone record databases, and Division of Motor Vehicle photo programs. In 2017, the Maine DIO used these investigative resources to help Maine DEA identify multiple vehicles through license plate readers. This is important as suspicious vehicles crossing state lines are often associated with drug trafficking. One notable incident involved a vehicle from New York City engaged in the transportation of illicit substances from out-of-state.

In yet another example, a West Virginia Detective intercepted a parcel containing seven driver's licenses from seven states—all with the same person's photograph, but under different names. Each name likewise had a corresponding VISA money card. The parcel was being mailed to Brooklyn, so the West Virginia DIO sent a photo of the suspect to a New York DIO. The New York DIO ran the photo through facial recognition, identified the individual, and gathered a wealth of intelligence on this suspect. The suspect and two co-conspirators arrived the next day to collect the parcel and were apprehended. Because of the connection with the New York DIO, the detectives on the case had additional information from the onset, including the suspects' real identities. The three subjects were arrested and charged with several

felonies in State Court as Homeland Security Investigations and Secret Service continued the investigation.

Increasing Collaboration between Agencies and States

The unique position occupied by state PHA/DIO teams allows the HRS to provide support that may be outside of any single agency's purview or scope of work.

For example, in Rutland, Vermont, the Rutland Police Department and Rutland Regional Medical Center has been working with Project VISION, a local coalition dedicated to addressing drug related challenges in their community, to develop a post-overdose outreach intervention. The Vermont PHA supported this effort by researching different programming strategies and training models used by recovery coach and peer navigator programs elsewhere in the U.S. The PHA was able to interface with several such programs in Massachusetts, gaining vital information that aided in program implementation and facilitated collaboration between the medical center and the police department in Vermont.

HRS-supported Combating Opioid Overdose Through Community-level Intervention Initiatives (COOCLI) grants have also made collaboration across agencies possible, providing needed resources and capacity for innovative new positions and solutions. In Delaware, the New Castle County Police Department used COOCLI funding to hire a coordinator to serve as a liaison between law enforcement, treatment providers, hospitals, peer counselors, and people with opioid use disorders. This liaison identifies services that are responsive to the needs of each participant in the Heroin Overdose Prevention and Education Program, and provides training to police officers on these service options.

Facilitating Collaboration through Analytic Support

Throughout 2017, the state Office of the Chief Medical Examiner in Connecticut provided overdose data to the PHA at the Connecticut Intelligence Center. The PHA tracked trends by town and, based on the PHA's analyses, the medical examiner then reached out to the towns that experienced the highest rate of overdoses to provide training on handling overdose deaths and preserving evidence on the scene of an overdose death. Connecticut now serves as a model for other states looking to implement similar trainings.

In November 2017, the Ohio PHA provided a Cuyahoga County Common Pleas Court judge with a statewide map illustrating the availability of prescription buprenorphine/naloxone for the treatment of opioid use disorder using DEA Automation of Reports and Consolidated Orders System (ARCOS) data. The judge used this map during a television interview to demonstrate the low availability of this evidence-based treatment in Cuyahoga County. News coverage of this topic stimulated policy discussions between the judge, the Metro-Health System, and local government on the need for additional agonist medications in Cuyahoga County. By assisting the judge in procuring and analyzing important information about treatment availability, the PHA supported an effort by multiple entities to address a significant lack of resources in the region.

The Tennessee PHA played a pivotal role in a multi-agency collaborative effort to address rising drug-related deaths in Knox County, Tennessee. The PHA merged data from the medical

examiner's office and data from the District Attorney's Office to analyze the relationship between 2016 fatal overdose victims and their contact with the criminal justice system. The resulting report details the connections fatal overdose victims had to the criminal justice system in the five years prior to their death, and identifies possible opportunities for intervention. The PHA's analysis served as a linkage for interagency collaboration and data sharing, and provided a clear deliverable for many agencies in Knox County to use to address the higher risk of overdose following release from incarceration.

As another example from the Appalachia HIDTA, the PHA in West Virginia monitors overdose data from emergency departments across the state and relays information about potential overdose spikes or clusters to the DIO, who then shares the information with the appropriate drug task force. West Virginia utilizes ESSENCE, a cloud-based software tool used to collect emergency department data and analyze public health indicators that is housed within CDC's National Syndromic Surveillance Program (NSSP). ESSENCE requires that 95% of patient data be entered within 24 hours of the patient's arrival to the emergency department. The PHA queries this system by ICD code or free text search looking for individual facilities and zip codes where a spike may be occurring. Patient and facility confidentiality is maintained; only frequency of visits and zip code data are shared with the drug task forces. The drug task force uses the information to help determine whether interdiction in a particular area might be appropriate.

Dynamic Assistance and Support

One of the unique aspects of the DIO network is its ability to quickly connect various law enforcement agencies to potentially life-saving information. In particular, DIOs are able to leverage their extensive investigative experience to quickly identify important information and share it with the right people. When the Ohio DIO received information regarding a Methamphetamine arrest from the West Virginia DIO, he immediately relayed the information to the Washington County, Ohio Sheriff's Office. The Washington County Sheriff's Office reported back that they had an active warrant for this individual and had been looking for the suspect. If they had not received this notification, the Washington County Sheriff's Office would have continued to devote time and resources to finding this individual, but this information saved them unnecessary work and potential officer risk, as they now knew where the individual was and could connect with the arresting agency directly.

When the Rhode Island DIO received a fatal overdose report from the Providence Police Department involving counterfeit pills and a potential suspect from Connecticut, he immediately reached out to the Connecticut DIO. The State lab expedited analysis on the pills and confirmed that they were counterfeit and contained furanyl-fentanyl. As a result of the Rhode Island and Connecticut DIOs' connection, the lab contacted both the Providence Police Department and Connecticut officials directly with this information.

In 2017, the Vermont DIO discovered information in a Midwest HIDTA Domestic Highway Enforcement report regarding a Canadian national arrested in Louisiana in connection with a major cocaine seizure. Although the information did not have a direct link to Vermont, the DIO relayed this information to the Vermont-Canadian Port of Entry Customs and Border Patrol (CBP) office, suspecting this individual may have used these ports of entries to transport drugs

from Canada to the U.S. The Vermont DIOs' suspicions were quickly confirmed when CBP informed him that this information aided an active investigation conducted by CBP, Canadian law enforcement, and the DEA.

Supporting Linkage to Treatment for Opioid Use Disorder

In 2017, through the work of the State PHA/DIO Teams and COOCLI grants, the HRS promoted innovative ways to improve access and linkage to treatment for opioid use disorder. With the improved ability to link more individuals to the services available in their communities, local agencies and community organization gain the ability to strategically target at-risk populations and significantly reduce the rates of overdose and overdose-related fatality.

For example, in conjunction with a new mandatory police officer training entitled "Understanding Addiction," the PHA and DIO in Maine collaborated with the Maine Center for Disease Control to produce a resource card raising awareness about Maine's statewide 2-1-1 program. This program provides free assistance to individuals seeking resources related substance use disorders and mental health care by connecting them to local organizations that meet their needs. These cards are designed for distribution through first responders, emergency rooms, education centers and other local entities. The initial printing of 25,000 cards was funded by the New England HIDTA.

In Kentucky, the PHA helped implement a survey to evaluate certain aspects of a syringe services program in Fayette County. Survey results indicated that most program participants wanted more information regarding treatment and other resources to be displayed on the syringe disposal containers. The PHA, in cooperation with the local research team, made significant changes to the containers' labels to include this information. A follow-up survey is planned to assess the outcomes of the change.



FIGURE 6: MAINE RESOURCE CARD

Developing Overdose Response Protocols

The HRS has supported the development and implementation of targeted outreach and linkage to care intervention after non-fatal overdose incidences in a number of communities. As one of the greatest predictors of fatal overdose is a prior non-fatal overdose, reaching this high-risk population is a significant public health priority. Through the implementation of appropriate, evidence-based efforts, which specifically targeting community members who have experienced a non-fatal overdose, public health and public safety organizations may be able to drastically reduce the rate of overdose fatalities in their communities.

In Pennsylvania, COOCLI funding was awarded to Prevention Point Philadelphia to increase their capacity to rapidly link members of their community with medication-assisted treatment (MAT) after a non-fatal overdose. This warm handoff initiative includes multiple modes of treatment referral, including referral from an emergency department and referral from first

responders in the event that individuals refuse to be transported to the emergency department. By focusing on the initiation of MAT with buprenorphine/naloxone in the emergency department, and access to case management and care coordination for patients receiving MAT, Prevention Point will help ensure linkage to and retention in treatment along the continuum of care.

In West Virginia, Morgantown Sober Living, Inc. received a COOCLI award to hire and train Certified Peer Recovery Coaches to link overdose survivors to local treatment resources and human services. This funding expands the support that the CDC already provides the organization to deploy Certified Peer Recovery Coaches to conduct home visits when overdose survivors refuse transport to the hospital. The Morgantown Sober Living, Inc. developed these intertwined efforts to address the needs of those most at risk of a fatal overdose in the community.

Responding to Geographic Spikes in Overdose

In addition to building capacity for individual follow-up after non-fatal overdoses, the HRS is supporting the development of other interventions that rely on timely non-fatal overdose data. Due to inconsistencies in the potency of illicit opioids, many communities have seen short time periods with irregularly high rates of non-fatal and fatal overdoses that appear to accompany a particularly powerful batch of illicitly produced drugs. As “spikes” in overdoses occur across the country, many communities are interested in developing protocols for mitigating the impact of these events.

To this end, the CDC and the Washington/Baltimore HIDTA submitted an application to and were selected for the Department of Health and Human Services (HHS) Ignite program to create an overdose response protocol for ODMAP. The resulting product was an Overdose Spike Response Framework developed by the PHAs from the Washington/Baltimore HIDTA. The framework provides recommendations for coordinated responses to overdose spikes identified by ODMAP, with a focus on processes that are adaptable and scalable. The framework serves as a guide for stakeholders to develop a response protocol specific to the needs in their particular jurisdiction. In developing this response framework, the PHAs engaged stakeholders including state health departments, local health departments, law enforcement leadership, first responders, forensic laboratories, medical examiners, treatment providers, parole and probation offices, correctional facilities, and peer recovery specialists.

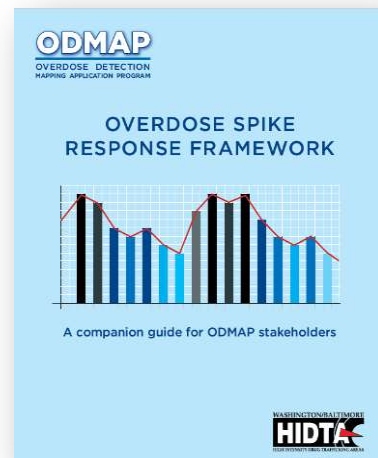


FIGURE 7: ODMAP SPIKE RESPONSE FRAMEWORK

The PHA and DIO in Rhode Island both serve as integral members of the state’s Surveillance, Response, and Intervention team, which analyzes 48-hour overdose data and sends notifications to local law enforcement, EMS, and hospitals when overdoses surpass pre-determined thresholds in any area of the state. If there is an extended series of overdose

events over a number of weeks, the PHA, along with other Surveillance, Response, and Intervention team members, participates in a Community Overdose Engagement (CODE) meeting with affected stakeholders to help explain the overdose spike and provide recommendations on how to best respond.

Looking Ahead: Improving Communication and Clarifying Evaluation Metrics in 2018

In 2017, the HRS built upon its work of the previous two years by: improving overdose reporting and public health surveillance systems; identifying DTOs through intelligence sharing; increasing collaboration at the local, state, and federal levels; implementing protocols that connect at-risk individuals to treatment; and creating systems for responding to sudden “spikes” in overdose at the community level.

In 2018, HRS is prioritizing two efforts: 1) improving communication through building a sustainable information-sharing infrastructure across its 22-state network, and 2) refining the HRS’s performance measures to include outcome-oriented measures that better demonstrate the program’s success and value. HRS will also apply for funding to add North Central HIDTA, which includes Wisconsin and Minnesota, to the initiative.

Focus on improving the initiative’s communication infrastructure and evaluation capacity will create new stability and sustainability within the HRS as the initiative continues to expand its scope and footprint. This work will ensure continued innovation and support a stronger, data-driven focus on the goal of reducing overdoses in our communities.

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