CRIMINAL JUSTICE COORDINATING COUNCIL
AGENDA

Date & Time of Meeting: **Thursday, April 20, 2023, at 8:00 a.m. – 9:30 am**

Meeting Location**: Courthouse Assembly Room, (B105), Courthouse, 500 Forest Street, Wausau WI**

Council Members: Chair Suzanne O'Neill, Vice Chair Kurt Gibbs, Lance Leonhard, Matt Bootz, Michelle Van Krey Chad Billeb, Ben Bliven, Theresa Wetzsteon, Kelly Schremp, Kat Yanke, Cati Denfeld-Quiros, Gary Olsen, Christa Jensen, Jane Graham Jennings, Kenneth Grams, Yauo Yang, Daniel Tyler, Liberty Heidmann.

Marathon County Mission Statement: *Marathon County Government serves people by leading, coordinating, and providing county, regional, and statewide initiatives. It directly or in cooperation with other public and private partners provides services and creates opportunities that make Marathon County and the surrounding area a preferred place to live, work, visit, and do business. (Last updated: 12-20-05)*

Council Mission Statement: *To improve the administration of justice and promote public safety through community collaboration, planning, research, education, and systemwide coordination of criminal justice initiatives.*

1. **Call Meeting to Order**
2. **Public Comment** *(not to exceed 15 minutes)*
3. **Approval of the March 16, 2023, CJCC Meeting Minutes**
4. **Operational functions required by bylaws.**
5. **Operations Issues**
6. **Policy Issues for Discussion and Potential Council Action**
   A. Facilitated discussion regarding usage of Opioid Settlement Funds.
7. **Educational Presentations/Outcome Monitoring Report**
8. **Adjournment**

**Any person planning to attend this meeting who needs some type of special accommodation to participate should call the County Clerk's Office at 261-1500 or e-mail countyclerk@co.marathon.wi.us one business day before the meeting*

SIGNED: /s/, Judge Suzanne O'Neill
Presiding Officer or Designee

EMAILED TO: Wausau Daily Herald, City Pages, and other Media Groups
EMAILED BY: Toshia Ranallo
DATE & TIME: April 11, 2023, 2:45pm

NOTICE POSTED AT COURTHOUSE
BY: Toshia Ranallo
DATE & TIME April 11, 2023, 2:45pm

MARATHON COUNTY
CRIMINAL JUSTICE COORDINATING COUNCIL MINUTES

Thursday, March 16, 2023, at 8:00 a.m. – 9:30 am
Courthouse Assembly Room, (B105), Courthouse, 500 Forest Street, Wausau WI

Members	Present/Web-Phone	Absent
Chair Suzanne O'Neill	X	
Vice Chair Kurt Gibbs	X	
Lance Leonhard	X	
Matt Bootz	X (Craig McEwen)	
Michelle Van Krey	X	
Chad Billeb		X
Ben Bliven	X (designee Todd Baeten)	
Theresa Wetzsteon	X	
Kelly Schremp	X	
Kat Yanke	X(Kate)	
Cati Denfeld-Quiros	X	
Vicki Tylka	X	
Social Services Director	VACANT	
Jane Graham Jennings	X	
Daniel Tyler		X
Yauo Yang	X	
Liberty Heidmann	X	

Also present: Greg Grau, Amanda Ostrowski, Ruth Heinzl, Nikki Delatolas, Laura Yarie, Sandra LaDu, Shawn Yeager, Jill Seetan.

1. **Call Meeting to Order**
   The meeting was called to order Judge O'Neill at 8:00 a.m.
2. **Public Comment** *(not to exceed 15 minutes)*
   No public comment is received.
3. **Approval of the Minutes of the January 19, 2023, CJCC meeting**
   MOTION BY GIBBS, SECOND BY HEIDMANN TO APPROVE THE JANUARY 19, 2023, CJCC MEETING MINUTES. MOTION CARRIED.
4. **Policy Issues for Discussion and Potential Council Action- Review of 2022 CJCC Work – 2023 Work Plans**

Discussion:

Judge O'Neill reviewed 2022 CJCC agenda items to begin discussion on developing a work plan for 2023. Opioid Settlement Fund spending recommendations, OWI Court population transition, Defense Attorney Shortage whitepaper, Root Cause Analysis report follow up, Clerk of Courts/Restitution, Law Enforcement Deflection Program, Criminal Case Back log, Justice Programs RFP process, Traffic Initial Appearance scheduling. Truancy Court, Data Officer Position.

The group discussed priorities among the topics. Schremp informed the group restitution moving to the Clerk's office can come off the list due to the progress and having things set up for this to happen.

Judge O'Neill stated she will continue to update on case backlog as she learns new information.

Yang shared his thoughts on the CJCC giving more focus to teen prevention programs. He wondered what is available in the community for youth prevention. Yang feels the system is missing the mark by not focusing on prevention. Leonhard shared stated the County Strategic plan includes implementation of one intervention for juveniles. A presentation by Social Services may be helpful. Wetzsteon mentions much overlap in working with the same families, but lack of communication and coordination leading to gaps and wasted resources. Mention of barriers with information sharing. Wetzsteon recommends the

Truancy Court issue be revisited along with the youth presentation and also be given to the Public Safety Committee.

Wetzsteon requests the group revisit the role of the CJCC for clarity on decision making or advisory. She is concerned about getting meaningful outcomes from the groups work. Judge O'Neill advises that the CJCC is an advisory board. Leonhard states it may be beneficial to review rules and bylaws. Gibbs states that the County Board looks to the CJCC to identify issues across multiple departments and seeks ideas that can be acted on to alleviate some challenges. Tylka states that a workplan will help clarify the purpose of the CJCC and add clarification to the topics and why the group is discussing them.

O'Neill states she is taking the lead on the defense attorney whitepaper and the public defender's office stresses the importance of this. Kate Drury will send Judge O'Neill the paper from Sheboygan County. Leonhard reminds the group of the end of year deadline for the whitepaper and also shares that the State budget may help improve this issue. Wetzsteon mentions a presentation to the County Board on attorney salaries and questions whether the County Board can weigh in on the issue and offer official support.

The group determines traffic appearance date scheduling can be reviewed within the case processing group.
Wetzsteon suggested the CJCC be updated on the unhoused population and the impacts locally.

McEwen suggested the Public Safety Committee and County Board may benefit from an educational presentation on the CJCC.

Leonhard and O'Neill remind the group that the Public Safety Committee has asked for the CJCC to make recommendations regarding Opioid Settlement Funds, so this has to be the immediate focus of the group. Amanda Ostrowski discusses a process to help narrow the focus and identify what we want to accomplish. The process works to identify needs, decide on how to measure and select a strategy based on what we can have the most influence on.

Leonhard further states that Administration will focus on hiring the Data Officer, so this is not a group priority and sees the CJCC becoming more involved later in the year after the individual is on board.

Heinzl reminds the members that there is currently only one work group that is active and has an appointed chair.

Action:

Executive Committee to consider group discussion and develop a 2023 workplan. The group is asked to commit to monthly meetings to participate in the RBA Framework process.

***Follow Up*:**

Schedule monthly CJCC meetings for an Opioid Taskforce. Amanda Ostrowski, Community Health Improvement Director to assist with the process. Complete recommendations prior to September to align with County Budget. RBA Process Framework to be distributed to CJCC members. Community Health Improvement Plan to be distributed as an example.

5. Educational Presentations/Outcome Monitoring Reports

A. Update on Opioid Funds discussion by County Board Executive Committee - Gibs

Discussion:

Gibbs reports that a poll of other counties suggests the majority are still in the planning stages regarding Opioid funds. Some have allocated funding, and some have not. Other counties are working with their CJCC for recommendations. The County Board Executive Committee is looking for a deliberate process that identifies Evidence Based recommendations that have the most impact. The funds are not endless and there are restrictions by settlement as well as various reporting requirements. Settlements have varying timeframes and additional settlements will be coming.

B. Update on OWI Court

Discussion:

Leonhard thanks those who participated in our recent group discussion to gather stakeholders' feedback on the future of an additional treatment court. The outcome of that discussion was a need for continuing a treatment court that focuses on mental health and AODA needs in the criminal justice system. Yarie reports that there are many models that can be considered including splitting the court between populations and risk / need levels. Wetzsteon questions who will be leading the charge to restructure the program. Leonhard responds that further discussion will take place with the Judges assigned to the courts and administration will have to determine if changes are significant enough that they will require approval from the County Board.

C. Update of Justice Programs RFP Process – Yarie

Discussion:

Yarie reports that a small workgroup has been working on reviewing and finalizing the Justice Programs RFP for contracted services. The workgroup has determined the need to release the RFP earlier that previously done in order to give possible vendors time to propose programming and reasonable implementation timeframes. Yarie further reports that the current programs are detailed in the proposal and those interested in submitting a proposal may bid on the entire project or one or more of the three identified service umbrellas. The RFP will be published by the end of March with the intention of contracting decisions being finalized by July 1, 2023, for programming beginning January 1, 2024.

6. Adjournment

MOTION BY TYLKA, SECOND BY LEONHARD TO ADJOURN THE MEETING AT 9:20 A.M. MOTION CARRIED.

Materials	Directions
Results Based Accountability Framework 1-Pager	Review prior to meeting
Exhibit E | List of Opioid Remediation Uses	Please use to reference throughout this process
Opioid Litigation Settlement Funds Data Dashboard	Review prior to meeting
Words Matter – Terms to Use and Avoid When Talking About Addiction	Review *Terms to avoid, terms to use, and why* prior to meeting

Results-Based Accountability

Population Accountability

RESULTS

The end conditions of well-being for populations in a geographic area

The responsibility of partnerships

INDICATORS

How we measure these conditions

Baselines are what the measures show about where we've been and where we're headed

Turn the Curve is what success looks like if we do better than the baseline

From Talk to Action

For Communities, Cities, Counties, States and Nations

The step-by-step process starts with a group of partners who wish to improve the quality of life in the community.

Step 1: What are the quality of life conditions we want for the children, adults, and families who live in our community?
Step 2: What would these conditions look like if we could see or experience them?
Step 3: How can we measure these conditions?
Step 4: How are we doing on the most important measures?
Step 5: Who are the partners that have a role to play in doing better?
Step 6: What works to do better, including no-cost and low-cost ideas.
Step 7: What do we propose we do?

Repeat these steps each time you meet. The steps can be done in any order as long as you do them all.

Program Accountability

STRATEGIES

What works to improve these conditions

PERFORMANCE MEASURES

How we know if programs & agencies are working effectively

Begin with sorting the Strategy's performance measures into 3 common-sense, plain language categories:

* *How much did we do?*
* *How well did we do it?*
* *Is anyone better off?*

From Talk to Action

For Programs, Agencies, and Service Systems

The step-by-step process starts with a manager or a group of managers who care about the quality of their services.

Step 1: Who are our customers?
Step 2: How can we measure if our customers are better off?
Step 3: How can we measure if we're delivering services well?
Step 4: How are we doing on the most important measures?
Step 5: Who are the partners that have a role to play in doing better?
Step 6: What works to do better, including no-cost and low-cost ideas.
Step 7: What do we propose we do?

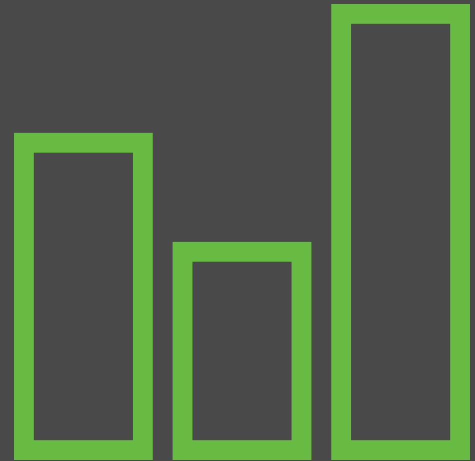
Repeat these steps each time you meet. The steps can be done in any order as long as you do them all.

Source: clear-impact.com

Results-Based Accountability

Basic Ideas

* RBA organizes the work of programs, agencies, communities, cities, counties and states around the end conditions we seek for those who live in our community and those receiving service
* Starts with ends, work backward to means:
    * *What do we want?*
    * *How will we recognize it?*
    * *What will it take to get there?*
* Use plain language, not jargon
* Use data to drive decision-making
* Use data to gauge success
* Involve a broad set of partners
* Get from talk to action as quickly as possible



"We cannot fool ourselves by taking a collection of actions that sound good and hoping for the best."

***Results Based Accountability** means that we have set out to make a change, not by chance, but by choice. And the deliberate nature of this work is different. And it requires a different way of thinking about and organizing the work. We must make the best choices possible for indicators. We must strive to get better indicators over time. We must recognize that baselines are the only real business-like way to measure change for the better or worse. We must work to understand why the baselines look the way they do so that we can target our efforts most effectively. We must bring in partners, public and private, parents and youth, to contribute their wisdom and where possible, their resources.*

We must struggle to find the things that actually work to make change at the population. This means we must search for things that have worked in other places and search deep in ourselves and our community for things we think will work here. We must not accept the easy or politically correct answers, but test everything by whether it will make a difference here. And we must get started taking action. We must take those steps that can be taken easily and inexpensively first, and gather resources to take the harder and more expensive actions as soon as we can. We must track our progress and be honest with ourselves about whether we are in fact making a difference. We must make changes and improvements to our plan over time. And if we do all this well, we must celebrate and share credit. And then we get back to doing more...

Source: clear-impact.com

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **<u>TREATMENT FOR INCARCERATED POPULATION</u>**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **<u>PREVENTION PROGRAMS</u>**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **<u>EXPANDING SYRINGE SERVICE PROGRAMS</u>**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **<u>EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE</u>**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. <u>SUPPORT PEOPLE IN TREATMENT AND RECOVERY</u>

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. <u>CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)</u>

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. <u>ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS</u>

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. <u>PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS</u>

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. <u>PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)</u>

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. <u>FIRST RESPONDERS</u>

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. <u>LEADERSHIP, PLANNING AND COORDINATION</u>

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

Determining the Use of Opioid Litigation Settlement Funds

Using the Results Based Accountability Framework

Jenna Flynn, MPH, CHES

Hannah Schommer, BS, CHES

Welcome & Introductions

Timeline

Date	Deliverable(s)
March 16, 2023	Director of Community Health Improvement for Marathon County Health Department will share the project charter, timeline, and RBA framework with members of the CJCC.
April 20, 2023	Health Educators facilitate the crafting of the Result and selecting the Indicator(s).
May 18, 2023	Health Educators facilitate the evaluation of Strategies from 'Exhibit E' document by completing the Driving Factor Matrix.
June 15, 2023	Health Educators facilitate the refining of Strategies, determining timeline and organization responsible for implementing the Strategy(ies).
July 20, 2023	TBD
August 17, 2023	TBD

MARATHON COUNTY

Operating Agreements

- Final recommendations are input, not directive
- Strive for person-first language – permission to respectfully correct each other
- The process will continue to move forward each meeting even if some people can't attend

April Meeting Purpose

- To welcome participants, ground everyone in why we are here, and move further along the Results Based Accountability Framework by crafting the Result and selecting Indicator(s).

MARATHON COUNTY

Results Based Accountability Framework

Talk → Action

What's wrong? → What do we do about it?

Decisions will be made based on data.

There is a shared set of plain language.

Result

Result Examples

- Ex. All kids in New York are physically healthy.
- Ex. Pregnant women in Marathon County have access to prenatal care.
- Ex. All working families in Marathon County have accessible, affordable childcare in their community.
- Ex. Marathon County children enter school ready to learn.

Result Options

Population + Geographical Area + Condition of Wellbeing

1. Marathon County residents are free from the physical, emotional, social, and economic impacts of opioid misuse. (16)
2. Marathon County residents of all ages and abilities will achieve well being free from opioid misuse. (1)
    1. (Defining well being: physical, emotional, social, and economic impacts)
3. Marathon County youth are educated on opiates. (0)
4. All residents have immediate rehabilitation of opiates. (1)

Final Result

Marathon County residents are free from the physical, emotional, social, and economic impacts of opioid misuse.

Selecting an Indicator

Selecting an Indicator

- Age-Adjusted Death Rate due to Opioid Overdose (This indicator shows the age-adjusted death rate per 100,000 population due to all opioid overdoses). (DHS)
- Age-Adjusted Death Rate due to Prescription Opioid Overdose (This indicator shows the age-adjusted death rate due to prescription opioid overdose per 100,000 residents). (DHS)
- Drug Overdose Deaths (MC Medical Examiner)
- Drug Charges in Marathon County (The number of felony and misdemeanor drug charges filed by the Marathon County District Attorney's Office). (MC DA Office)
- Death Rate due to Drug Poisoning (This indicator shows the death rate per 100,000 population due to drug poisoning). (comparative data, state, national) (County Health Rankings)
- Non-Fatal EMS Runs (Biospatial)

MARATHON COUNTY

Age-Adjusted Death Rate Due to Opioid Overdose (DHS)

Age-Adjusted Death Rate Due to Opioid Overdose

Year	Current Actual Value	Current Target Value	Forecast
2017	10		
2018	5		
2019	8		
2020	8		
2021		3	
2022		2	
2023		1	

Current Target Value — Current Actual Value — Labels — Forecast

ClearImpact.com

[Data Dashboard]

Age Adjusted Death Rate Due to Prescription Opioid Overdose (DHS)

Age-Adjusted Death Rate due to Prescription Opioid Overdose

4
3
2
1

3 4 3 2 1

2017 2018 2019 2020 2021 2022 2023

2017 2018 2019 2020 2021 2022

Current Target Value — Current Actual Value — Labels — Forecast

ClearImpact.com

Data Dashboard

Drug Overdose Deaths (MC Medical Examiner)

Drug Overdose Deaths

25
20
15
10

14 14 20 24 20 15 10

2019 2020 2021 2022 2023 2024 2025

2017 2018 2019 2020 2021 2022 2023 2024

Current Target Value Current Actual Value Labels Forecast

ClearImpact.com

Data Dashboard

Drug Charges in Marathon County (MC DA)

Drug Charges in Marathon County

Year	Current Actual Value	Current Target Value
2019	1,715	
2020	1,310	
2021	1,552	
2022		1,300
2023		1,200

Current Target Value — Current Actual Value — Labels — Forecast

ClearImpact.com

Data Dashboard

Death Rate Due to Drug Poisoning (County Health Rankings)

Death Rate due to Drug Poisoning

12.5
10
7.5
5
2.5

4
6
7
8
10
12
11
11
10
5
1

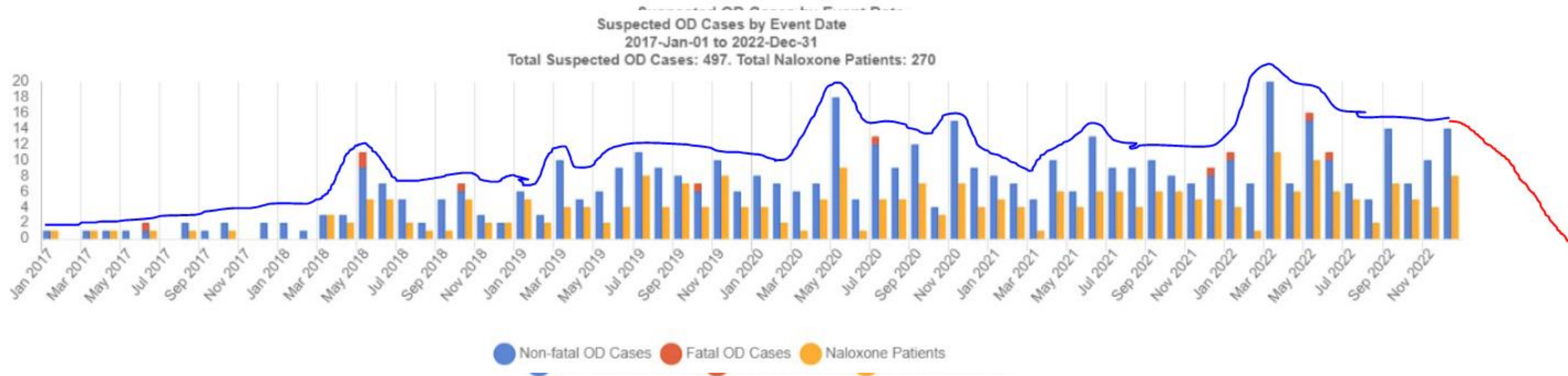
2004 2006 2008 2010 2012 2014 2016 2018 2020 2022 2024

Current Target Value — Current Actual Value — Labels — Forecast

ClearImpact.com

Data Dashboard

EMS Overdose Runs (Biospatial)



rb.gy/vdxoo

MARATHON COUNTY

Selecting an Indicator

% of incarceration due to drug misuse

drug charges

% arrest rate due to opioids

units of Narcan distributed in Marathon County (EMS, hospitals, Wausau Comprehensive Treatment, Vivent Health, Probation & Parole, Women's Community)

drug-endangered children

MARATHON COUNTY

Result: Marathon County residents are free from the physical, emotional, social, and economic impacts of opioid misuse.

Indicator	Communication Power	Proxy Power	Data Power
Drug Overdose Deaths (ME)	H	L	H
Non-fatal Overdoses (EMS)	H	M	H
# of arrests with opioid possession charges	M	M	M
# units of Narcan distributed in Marathon County	M	M	L
# drug-endangered children	H	M	M

Result: Marathon County residents are free from the physical, emotional, social, and economic impacts of opioid misuse.

Indicator	Communication Power	Proxy Power	Data Power
Drug Overdose Deaths due to Opioid (ME)	H	L	H
Non-fatal Overdoses (EMS)	H	M	H

Next Steps

- Reconvene May 18

Power Definitions

C **Communication Power:** Does the indicator communicate to a broad range of audiences? Is it simple to understand and compelling to individuals?

P **Proxy Power:** Does the indicator say something of central importance about the result? Does the indicator bring along the data herd? Pick the indicator that has the strongest ability to represent other measures.

D **Data Power:** Is quality data available on a timely basis? Is the data reliable and consistent? To what extent do we have the data at the desired levels (National, State, County, City, Community)?

Shared language

Result
The end conditions of wellbeing for populations in a geographic area

Indicator
Data used to measure the result

Strategy
What works to improve the indicators

Performance Measure
The quantity and quality of how hard we worked and whether we made a difference

Baseline
What the data shows about where we've been

Forecast
Shows where we're headed if we don't do something more or different than what we are doing now

Turn the Curve
What success looks like if we do better than the baseline