



Ohio addiction policy scorecard

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Prevention,
treatment
and
recovery

HPIO
Addiction
Evidence
Project

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Acknowledgements

Authors

Amy Bush Stevens, MSW, MPH
Hailey Akah, JD, MA

Graphic design and layout

Nick Wiselogel, MA

Contributors

Dan Purkepile, MPA, HPIO intern
Amy Rohling McGee, MSW
Reem Aly, JD, MHA
Zach Reet, MPA
Grace Dolan, HPIO intern
Bridget Cook, HPIO intern

Other stakeholders

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This report is part of HPIO's [Addiction Evidence Project](#). In December 2017, HPIO released two other products as part of this project:

- [Addiction Overview and Project Description](#) (12-page policy brief)
- [Evidence Resource Page: Prevention, Treatment and Recovery](#) (hub for expert consensus statements and guidelines, evidence registries and model policies)

In 2016, 4,050 Ohioans died because of unintentional drug overdoses¹, and preliminary 2017 data indicates that the number of deaths has continued to rise.² The [overview and project description](#) for HPIO's Addiction Evidence Project provides additional information about drug trends and the factors driving this epidemic.

The 2017 Ohio Health Issues Poll found that 27 percent of Ohio adults had a family member or friend who had problems as a result of using prescription pain drugs and 23 percent knew someone who had problems with heroin.³

The consequences of addiction are widespread. For example, the number of babies born with neonatal abstinence syndrome (NAS) increased 500 percent in the past ten years⁴ and thousands of children living in families struggling with addiction experience trauma.⁵ Employers report difficulty hiring drug-free workers, and researchers estimate that the opioid crisis cost Ohio \$3,385 per capita in healthcare and criminal justice spending and reduced worker productivity in 2015.⁶

Public and private stakeholders have worked hard to understand and address the crisis. Policy changes advanced by the executive and legislative branches have led to implementation of many evidence-based programs in Ohio, reduced the amount of opioid prescriptions dispensed and increased health insurance coverage and treatment access for thousands of Ohioans through expanded Medicaid eligibility.

In order to provide policymakers and other stakeholders with the information needed to take stock of the policy response, this report reviews state-level policy changes related to addiction prevention, treatment and recovery enacted in Ohio from 2013-2017. It includes:

- **An inventory** of policy changes (legislation, rules, regulations and state agency initiatives, programs and systems changes) (see figure ES 1)
- **A scorecard** that indicates the extent to which Ohio is implementing strategies that are proven effective by research evidence (see figure ES 2)
- **Opportunities for improvement** in both the public and private sectors

3 key findings for policymakers

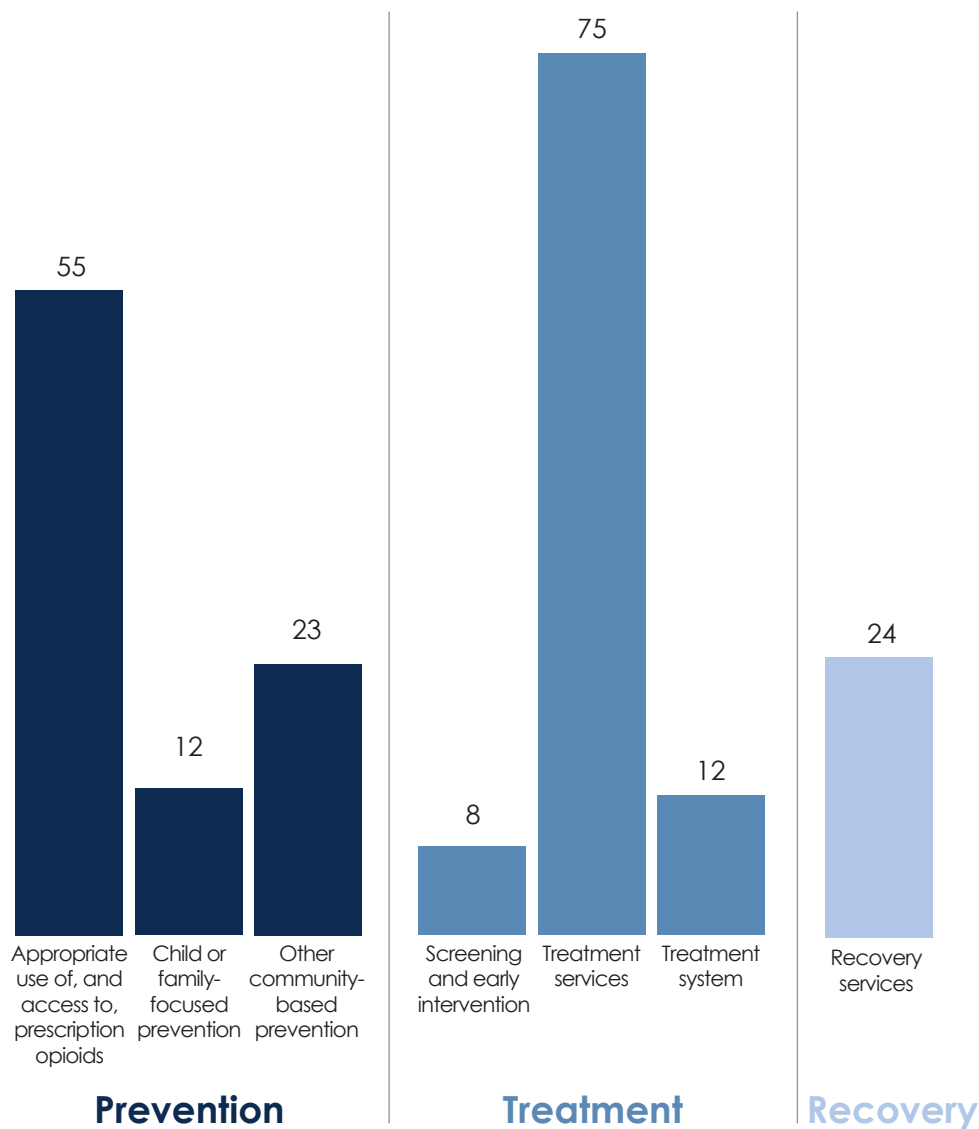
- **Progress to build on.** Policy changes advanced by the governor, state agencies and the General Assembly have led to implementation of many evidence-based programs, reduced the number of opioid prescriptions dispensed, and increased health insurance coverage and treatment access for thousands of Ohioans through expanded Medicaid eligibility.
- **Gaps that need more action.** Going forward, policymakers and others must address the underlying drivers of demand for drugs, expand the reach of effective programs that currently serve small numbers of Ohioans, strengthen the behavioral health treatment system and support long-term wellbeing for the thousands of Ohioans who are in recovery.
- **Data to drive improvement.** Policymakers need better information to evaluate the effectiveness and cost of strategies, while understanding that some will not yield immediate results.

What are the strengths of Ohio's policy response?

The Ohio General Assembly, Governor's Cabinet Opiate Action Team (GCOAT) and the Ohio Attorney General's Office are leading a wide range of activities to address the opiate crisis. The following strengths stand out:

- **Leadership and priorities.** Overdose deaths and behavioral health prioritized in state budgets and mid-biennium review bills
- **Cross-sector partnerships.** Strengthened partnerships between behavioral health, health care, public health, law enforcement and other sectors
- **Decreased opioid prescribing.** Policies that have successfully decreased opioid prescribing, including the Ohio Automated Rx Reporting System (OARRS), Ohio's Prescription Drug Monitoring Program (PDMP) and a series of prescribing guidelines for providers

Figure ES 1. **Number of addiction-related policy changes in Ohio, 2013-2017**



Note: See Appendix B for further description of these categories.

Source: HPIO review of Ohio legislation, regulations, Governor’s Cabinet Opiate Action Team timeline and other policy summaries

- **Medication-Assisted Treatment (MAT).** Evidence-aligned approach to MAT and strong efforts to increase MAT capacity
- **Medicaid eligibility.** Increased number of Ohioans with health insurance coverage, an important source of payment for addiction treatment, primarily through expanded Medicaid eligibility

What are the gaps in Ohio’s policy response?

Despite these strengths, Ohio continues to struggle with rising drug overdose death rates and the many challenges that result from addiction. Urgent action is needed to save lives. The following gaps remain:

- **Too few Ohioans reached.** Evidence-aligned programs and services are often limited to a small number of counties or participants

- **Poor pain management.** Limited patient and provider use of, and insurance coverage for, evidence-based non-opioid pain management therapies
- **Patchwork approach to prevention.** Lack of a sustained, long-term approach to child, family and community-based prevention resulting in a patchwork of uncoordinated programs that fail to reach many Ohioans
- **Inadequate treatment capacity.** Need for more providers of MAT, psychosocial treatment and recovery services, as well as more useful and comprehensive data on behavioral health treatment system capacity and workforce
- **Limited outcome measurement.** Difficulty assessing the effectiveness of programs and policies due to limited use of program evaluation and lack of measurable policy goals specified in legislation

In addition, there has been minimal policy focus on:

- Tobacco and nicotine, even though tobacco-related diseases continue to kill far more Ohioans every year than opioids
- Recovery, even though addiction is a chronic, relapsing disease and requires ongoing chronic disease management
- Health disparities and social determinants of health, even though low educational attainment and difficult economic conditions are risk factors for overdose death

Opportunities for improvement

The public and private sectors in Ohio can work together to:

1. Build upon the strong framework for appropriate opioid prescribing to continue to drive down opioid use rates

- a) Sustain and continually improve OARRS, including increased provider integration with electronic health records and ongoing enforcement of OARRS requirements
- b) Enforce, monitor and evaluate the impact of recently implemented prescribing limits and, based on evaluation results, consider tightening limits to three to five days as some other states have done
- c) Offer education, technical assistance and other support to providers to operationalize and implement prescribing limits and guidelines

2. Increase use of non-opioid pain management therapies, such as acupuncture, physical therapy and chiropractic care, through:

- a) Patient and provider education
- b) Improved insurance coverage for these services
- c) Partnerships across sectors (healthy aging,

chronic disease prevention, behavioral health, etc.) to promote widespread availability of non-pharmacologic approaches, such as tai chi, yoga and stress reduction

3. Strengthen the effectiveness and reach of addiction prevention activities

- a) Increase sustained sources of funding for evidence-based prevention strategies for children, families and communities
- b) Explore development of an addiction prevention wellness trust funded by future potential legal settlement proceeds
- c) Support a comprehensive approach to prevention of all forms of substance use disorder (including opioids, methamphetamines, alcohol, tobacco, etc.) across the life span, including adults over age 18
- d) Improve coordination, monitoring and evaluation of school-based prevention activities
- e) Increase coordination between state agencies so that local communities receive consistent and coordinated support from the state regarding community and school-based prevention

4. Ensure that evidence-based addiction treatment and recovery services are available for all Ohioans in need

- a) Actively promote awareness of state and federal parity laws and strengthen monitoring and enforcement
- b) Evaluate the impact of Behavioral Health Redesign on addiction treatment system capacity and treatment outcomes and make continuous improvements based on the results
- c) Collect quantitative data regarding treatment gaps and publicly report the

Figure ES 2. **Summary scorecard rating**

Topic	Subtopic	Rating
Prevention	Appropriate use of, and access to, prescription opioids: Prescribing and dispensing	Strong
	Appropriate use of, and access to, prescription opioids: Non-opioid pain management	Weak
	Child and family-focused prevention	Moderate
	Other community-based prevention	Weak
Treatment	Screening and early intervention	Weak
	Treatment services	Moderate
	Treatment system access and coverage	Strong
	Treatment system capacity and workforce	Weak
Recovery	Recovery services	Moderate

Note: Rating based on evidence alignment and implementation reach

number of patients receiving evidence-based treatment (including MAT) in state-certified facilities and through county ADAMH board funding

- c) Strengthen the behavioral health workforce through increased reimbursement rates, enhancing the Behavioral Health Workforce Initiative and continuing to build integration with physical health care

5. Reduce health disparities and address the social determinants of health

- a) Ensure that resources and strategies are more aggressively directed toward populations at greatest risk of overdose deaths and incarceration
- b) Improve social and economic conditions in struggling Ohio communities

6. Increase use of data and evaluation to drive improvement

- a) Include measurable policy goals in legislation and integrate tools to track implementation and outcomes into the policymaking process
- b) Increase the transparency and usefulness of evaluation findings, such as by posting all evaluation results on state agency websites

In addition, the following steps would boost the effectiveness of Ohio's response to current and future addiction challenges:

- 7. Strengthen clinical-community linkages and connections between sectors. For example, ensure that hospital emergency departments, law enforcement and community behavioral health providers work together to make sure that people in need of treatment do not fall through the cracks
- 8. Develop a coordinated, long-term approach to serve the needs of children exposed to Adverse Childhood Experiences (ACEs) as a result of the addiction crisis, including sustained investments in early childhood home visiting and education, parenting education, trauma-informed care and education, the child welfare system and other evidence-based interventions
- 9. Develop a comprehensive plan for addressing potential positive and negative consequences of medical marijuana legalization, including impact on pain management, employers, adolescents and motor vehicle safety

About the HPIO Addiction Evidence Project

This report is part of HPIO's **Addiction Evidence Project**, which provides policymakers and other stakeholders with information needed to address substance use disorders in a comprehensive, effective and efficient way. This inventory and scorecard addresses three topics: prevention, treatment and recovery. Future reports will address the other topics listed below, including overdose reversal (naloxone).

Prevention	Treatment	Recovery	— This report — Future reports
Harm reduction	Overdose reversal	Data and evaluation	
Children, youth and families	Law enforcement	Criminal justice	

Part 1. Purpose and process

The purpose of this inventory and scorecard is to provide policymakers and other stakeholders with information needed to take stock of Ohio's policy response to the opiate crisis, including how well this response aligns with evidence, and to identify next steps to reduce addiction and improve the overall health of Ohioans. More specifically, this report:

- Reviews addiction policy changes relevant to prevention, treatment or recovery enacted in Ohio from 2013 to 2017
- Assesses the extent to which policy changes align with evidence on what works
- Evaluates the extent to which policies and programs are reaching Ohioans in need
- Identifies Ohio's policy strengths, challenges and opportunities for improvement

This report focuses on the first three elements of a comprehensive policy response to addiction, highlighted in red in figure 1: prevention, treatment and recovery. HPIO plans to develop similar inventories and scorecards for the other key elements of figure 1 in 2018 and 2019.

Although this report has a strong focus on prescription opioids and other opiates, the detailed inventory and scorecard also review policy changes related to several other substances (alcohol, tobacco, methamphetamine, cocaine, etc.).

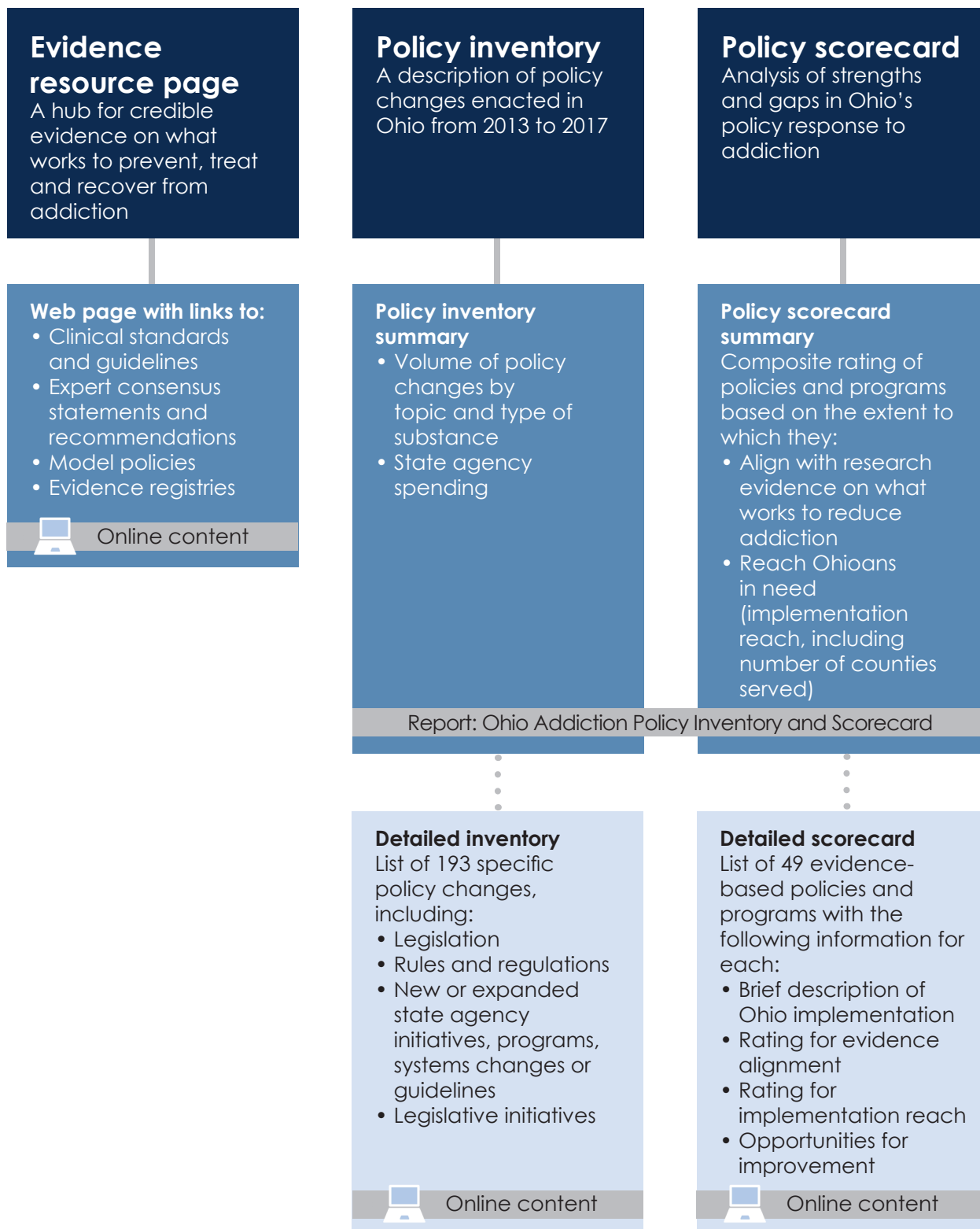
Figure 2 provides an overview of the contents and purpose of this report, as well as supplemental materials posted on the HPIO website which provide additional detail.

Figure 1. Key elements of a comprehensive policy response to addiction



Source: Health Policy Institute of Ohio adapted from Addiction Policy Forum (2017)

Figure 2. HPIO Addiction Evidence Project: Prevention, treatment and recovery



Part 2. Key findings

Overview

This section identifies 9 opportunities for improvement based on key findings regarding the following questions:

- What are the strengths of Ohio's policy response?
- What are the gaps in Ohio's policy response?
- Why does the overdose death rate continue to climb, despite all of the policy changes enacted in Ohio over the past five years?

In addition, this section highlights:

- Potential threats and changes on the horizon
- Information policymakers need, but do not currently have
- The role of evidence-based policymaking to reduce addiction in Ohio

What are the strengths of Ohio's policy response?

The General Assembly, Governor's Cabinet Opiate Action Team (GCOAT) and the Attorney General's Office have led a wide range of policy changes and other actions to address the opiate crisis. The following strengths stand out:

- **Leadership and priorities.** Overdose deaths and behavioral health have been prioritized in state budgets and mid-biennium review bills.
- **Cross-sector partnerships.** The crisis has mobilized local communities and strengthened partnerships between behavioral health, health care, public health, law enforcement and other sectors.
- **Focus on Medication-Assisted Treatment (MAT).** Evidence-aligned policies have been put in place to increase the number of Ohioans who receive MAT, a highly effective form of addiction treatment.

In addition, significant reductions in the number of opioid prescriptions dispensed and an increase in the number of Ohioans with health insurance coverage are major accomplishments that set a firm foundation for future prevention and treatment system improvements. The following policy changes directly contributed these outcomes:

Policies to decrease opioid prescribing. Ohio policymakers have implemented a series of policies and programs to decrease opioid prescribing, including:

- Robust Prescription Drug Monitoring Program (PDMP), the Ohio Automated Rx Reporting System (OARRS)
- Prescribing limits for acute pain

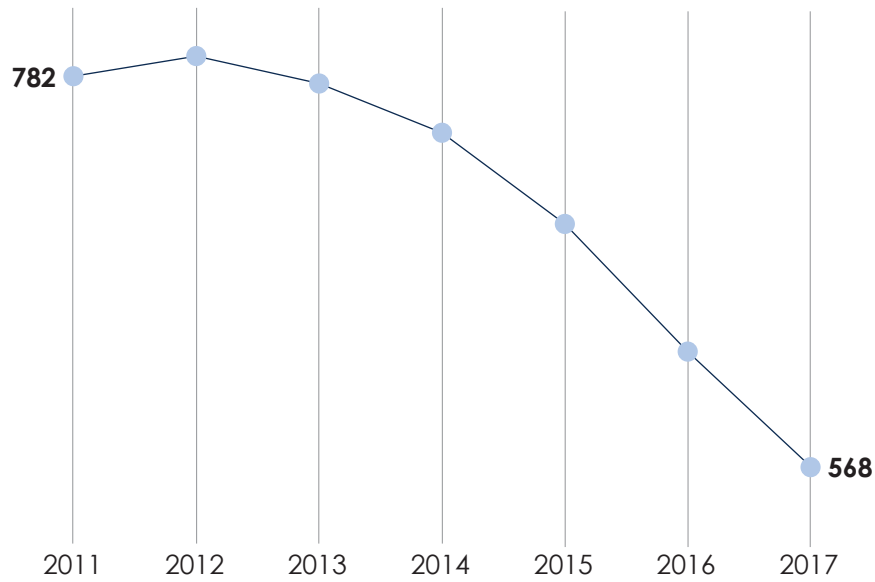
- Series of prescribing guidelines for acute and chronic pain

As shown in figure 3, the result has been a downward trend in the total number of prescription opioid doses dispensed from 2011 to 2017. It is important to note, however, that Ohio continues to have a high rate of prescription opioid use compared to many other states (see figure 4).

Expanded Medicaid eligibility levels. Health insurance, including Medicaid, is a critical source of payment for addiction treatment. In Ohio in 2016, for example, Medicaid covered 49.5 percent of buprenorphine, a medication used in MAT.⁷ In 2014, Ohio extended Medicaid eligibility to all adults with incomes at or below 138 percent of the federal poverty level (FPL). By 2016, Ohio's uninsured rate for adults ages 18-64 had fallen to 4.7 percent, well below the U.S. rate of 9.7 percent.⁸

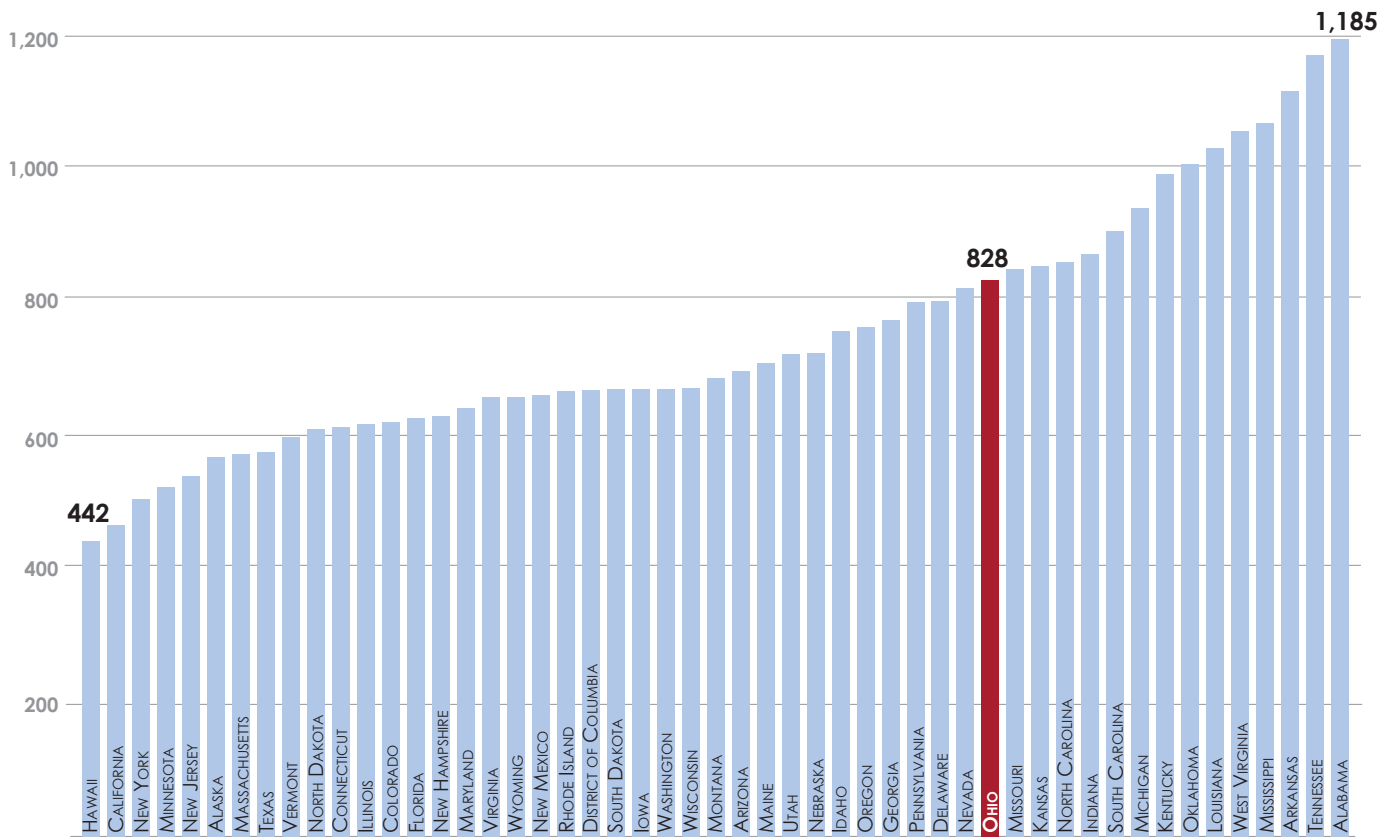
Evidence alignment. Overall, the policies and programs implemented in Ohio over the past five years have been largely consistent with recommendations from national experts and researchers on what works to reduce addiction. Ohio's comprehensive approach has been recognized by national organizations. A recent report from the National Safety Council, for example, identified Ohio, along with twelve other states, as leaders in implementing six key actions to address the opioid crisis (including opioid prescribing guidelines and Medicaid coverage for MAT).⁹ Other national organizations recognize OARRS as a strong PDMP.¹⁰

Figure 3. Number of opioid solid doses dispensed (in millions) to Ohio patients, 2011-2017



Source: State of Ohio Board of Pharmacy, Ohio Automated Rx Reporting System 2017 Annual Report

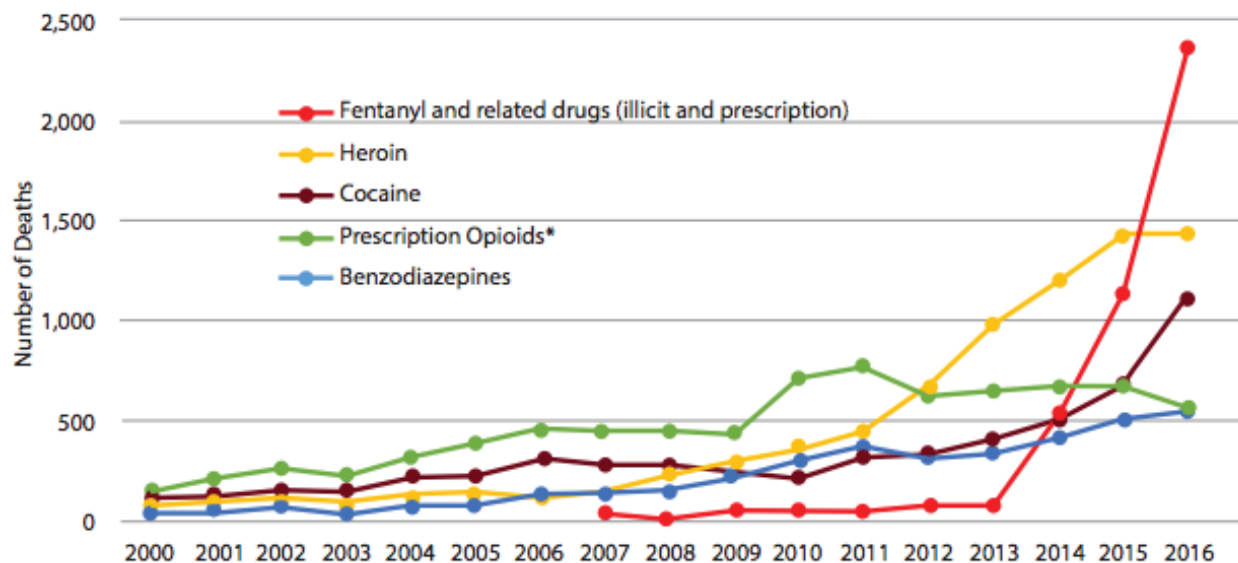
Figure 4. Prescription opioids dispensed per 1,000 population, by state, 2016



Note: Data year is the 12 months ending June 30, 2016

Source: IMS PayerTrak, IMS National Prescription Audit, June 2016; Centers for Disease Control and Prevention, as reported in "Use of Opioid Recovery Medications," IMS Institute for Healthcare Informatics

Figure 5. **Overdose deaths in Ohio, by drug type, 2000 to 2016**



*Excludes deaths involving fentanyl and related drugs

Source: 2016 Ohio drug overdose data: General findings, Ohio Department of Health

What are the gaps in Ohio's policy response?

Despite these strengths, Ohio continues to struggle with rising drug overdose death rates and the many challenges that result from addiction. Ohio continues to have a high rate of prescription opioid use compared to many other states (see figure 4). And, as shown in figure 5, Ohio's overdose death rate climbed steadily from 2000 to 2016, led by increases in deaths from heroin and fentanyl.

The following gaps remain as critical areas where Ohio could do more to reverse these trends:

- **Too few Ohioans reached.** Evidence-aligned policies and programs are often limited to a small number of counties or participants.
- **Poor pain management.** There is limited health insurance coverage for, and patient and provider use of, evidence-based non-opioid pain management therapies.
- **Limited outcome measurement.** It is difficult to assess the effectiveness of programs and policies due to limited program evaluation and lack of measurable policy goals.

Although prevention and treatment have received considerable policy attention, the following gaps remain and will require significant attention and funding going forward:

Patchwork approach to prevention. The lack of a sustained, long-term approach to child, family and community-based prevention has resulted in a patchwork of un-coordinated programs.

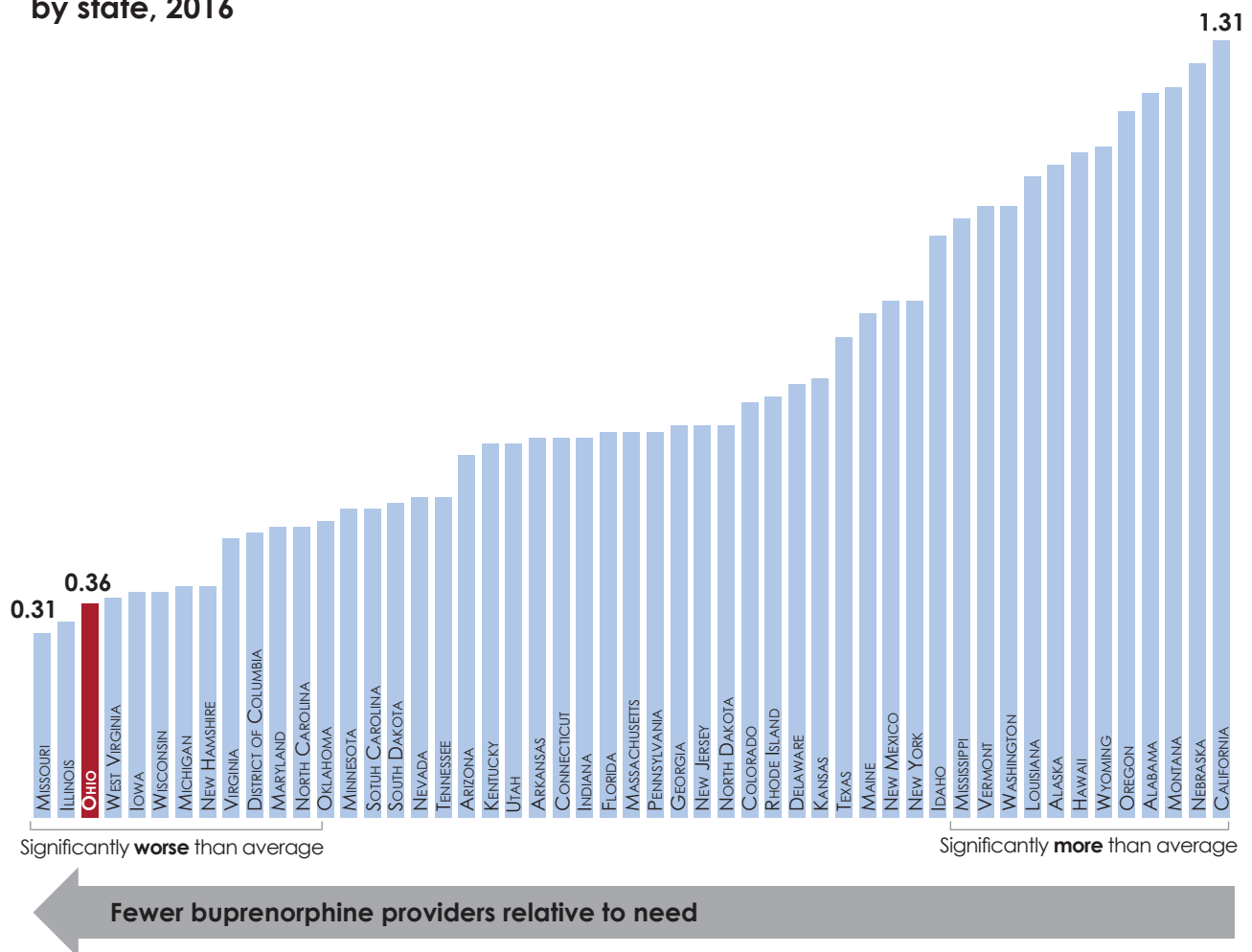
Potential threats and changes on the horizon

The following trends and potential changes in the environment pose a potential threat to Ohio's efforts to reduce addiction:

- Changes in substances being abused (e.g. shift from heroin to fentanyl and fentanyl analogues; resurgence of methamphetamine and cocaine, etc.)
- Disruption caused by the upcoming change in administration (possible lack of continuity caused by change in Governor and agency leadership)
- Decreased federal and/or state funding for prevention, treatment, recovery and social determinants of addiction
- Increased uninsured rate (a possible consequence of policy changes at the state and/or federal level)
- Increased number of children exposed to Adverse Childhood Experiences, which increases risk for future addiction
- Increased number of older adults due to Ohio's aging population, including many seniors at risk for pain and the negative side effects of opioid and benzodiazepine use (falls, cognitive impairment, overdose)

Prevention strategies fail to reach many Ohioans because they are largely funded by short-term grants (often from federal sources). Coordination between state agencies involved in prevention also could be strengthened.

Figure 6. **Ratio of certified buprenorphine providers to opioid overdose deaths, by state, 2016**



Sources: Avalere analysis of SAMHSA Opioid Treatment Program Directory and Centers for Disease Control and Prevention (CDC) WONDER, 2016

Inadequate treatment capacity. Many stakeholders report a need for additional behavioral health system capacity, including more providers of MAT, evidence-based psychosocial treatment and recovery services. For example, Ohio's ratio of buprenorphine providers to overdose deaths is the third lowest in the nation (see figure 6), indicating less behavioral health system capacity relative to demand. (Buprenorphine is one form of MAT. See page 22.)

The behavioral health workforce must be increased to meet current and future needs, although data on the adequacy of the addiction treatment workforce is limited. Increasing the capacity of mental health services for young people is particularly important given that untreated emotional and behavioral problems are risk factors for addiction.

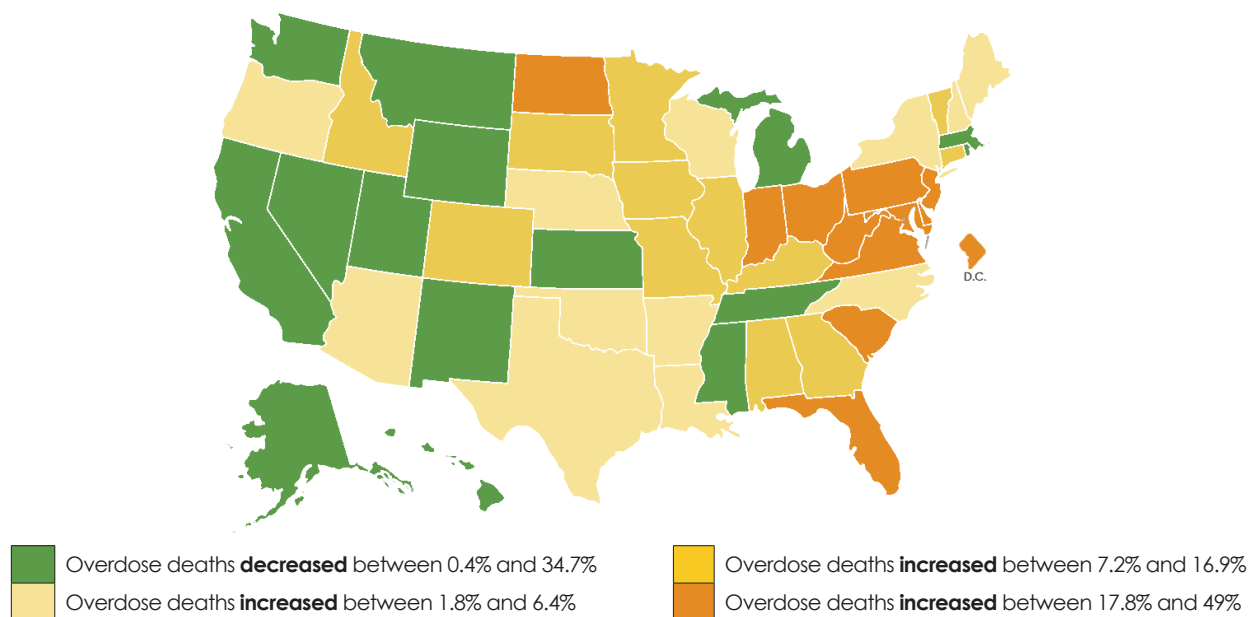
In addition, the following topics have received less policymaking attention and public funding:

Recovery services and supports. There has been minimal policy focus on recovery, compared to prevention and treatment, and Ohio lacks adequate long-term supports for ongoing recovery. Addiction is a chronic, relapsing disease and requires ongoing chronic disease management.

Alcohol, nicotine/tobacco and other non-opiate drugs. Tobacco-related diseases kill far more Ohioans every year than do opioids (estimated 20,180 annual smoking attributable deaths vs. 3,497 opioid overdose deaths in 2016).¹¹ However, fewer than 10 percent of the policies in this inventory specifically addressed alcohol or nicotine/tobacco, and there has been very little focus on non-opiate illicit drugs, such as cocaine and methamphetamine.

Existing tobacco cessation resources, such as Medicaid cessation coverage and the Ohio Tobacco QuitLine, suffer from low utilization.

Figure 7. **Percent change in number of drug overdose deaths, 12-month period ending in August 2016 to 12-month period ending in August 2017**



Note: Based on provisional counts, which may not include all deaths that occurred during a given time period. Numbers are subject to change.
Source: National Center for Health Statistics, Vital Statistics Rapid Release, Provisional Drug Overdose Death Counts, as of March 4, 2018

Much more can be done to streamline access to cessation services and encourage smokers to quit, and to prevent youth from ever starting to use nicotine.

Health disparities. Health disparities are differences in health outcomes across groups of people.¹² Ohio's policy response over the past five years has acknowledged geographic variations in outcomes, such as disparities in overdose death rates by county. In some cases, these differences have guided resource allocation, such as when high-risk counties were prioritized for the 21st Century Cures Act State Targeted Response (Cures STR) grant funds.

Other disparities, such as differences by education level or race and ethnicity, have received less attention from policymakers. Overdose death rates are much higher among Ohioans with lower levels of education¹³, and are rising rapidly among African Americans.¹⁴ For these reasons, it will be important to monitor substance abuse trend data by education and income level, race and ethnicity, and other demographic characteristics to ensure that resources and strategies are more aggressively directed toward communities with the highest levels of need.

Social determinants of health. The social determinants of health refer to factors beyond medical care that affect health, such as income, educational attainment and social connectedness. Research estimates that conditions in the social, economic and physical environment account for a larger share of the modifiable factors that impact health than clinical care.¹⁵

There is growing recognition that social and economic factors have contributed to the opiate epidemic. A 2017 Ohio State University study, for example, found that Ohio counties with higher unemployment and poverty rates, and lower labor force participation rates, had higher drug overdose death rates.¹⁶ Recent commentary in the American Journal of Public Health implored policymakers to address the root causes of demand for opioids and to acknowledge "the role of opioids as a refuge from physical and psychological trauma, concentrated disadvantage, isolation, and hopelessness."¹⁷

Ohio's policy response has been heavily focused on activities within the healthcare system (e.g. opioid prescribing and MAT) and there has been less explicit focus on social determinants.

Why does the overdose death rate continue to climb, despite all of the policy changes enacted in Ohio over the past five years?

The policy inventory and scorecard demonstrate that Ohio has implemented many evidence-aligned policies and programs over the past five years. However, the annual number of drug overdose deaths has continued to climb, increasing from 3,857 in the 12-month period ending August 2016 to 5,234 by August 2017, based on provisional data released by the CDC in March 2018.¹⁸ During that 12-month time period, Ohio had the third highest increase in overdose deaths in the U.S. (see figure 7).¹⁹

There are several potential reasons why negative outcomes have escalated, despite significant efforts from state and local leaders. The most obvious reason for the increase in overdose deaths is the widespread proliferation of fentanyl and other fentanyl-related drugs into the illicit drug supply. While policy efforts focused on prescription opioids have succeeded in reducing prescription opioid consumption and deaths, the epidemic has shifted to use of these extremely powerful substances that carry a higher risk of death. In addition, according to the Ohio Substance Abuse Monitoring (OSAM) Network, cocaine and methamphetamine are highly available across the state, and methamphetamine use is on the rise.²⁰

Second, it is not reasonable to expect that all policies and programs will have an immediate impact. In many cases, particularly for youth-focused prevention programs, it can take many years to yield positive behavioral health outcomes. Evidence-based approaches such as home visiting and PAX Good Behavior Game, for example, build protective factors and resilience for children ages 0-12 and may not demonstrate reductions in drug use until five to 20 years later.

Third, despite laudable efforts to increase treatment capacity and access to care, available data indicates that there are still not nearly enough behavioral health providers to meet the need for treatment and recovery services. Therefore, many Ohioans suffering from addiction may fall through the cracks because they wait too long to get help once they are ready to seek treatment.

Information policymakers need, but do not currently have

Future research by universities, state agencies and other public and private partners should be designed to answer the following questions in order to inform the policy response to the addiction crisis in 2018 and beyond:

- To what extent are Ohio's acute and chronic pain guidelines being followed by providers?
- How many Ohio children are participating in evidence-based prevention programs?
- What is the current capacity of Ohio's publicly-funded behavioral health system?
 - What services are least available to those in need? (MAT, psychosocial, inpatient vs. outpatient, recovery supports, etc.)
 - How many additional providers are needed to meet current and future demand?
 - How will we know if Behavioral Health Redesign is successful?
- To what extent are federal and state behavioral health parity laws and guidance being implemented?
- Which policies, programs and services are most cost effective?
- How much will state and local governments need to spend on addiction-related services and consequences in coming years?
- How many children have been affected by the addiction crisis? How many have had a parent die or have been placed in out-of-home care due to addiction or related neglect?

Finally, rather than devoting so many resources to reducing the supply of specific drugs, Ohio needs a stronger focus on the underlying drivers of demand for drugs. Alcohol, crack cocaine, methamphetamine, prescription opioids and heroin have devastated many families over the past four decades. Regardless of the next drugs on the horizon, Ohio families and communities need to be equipped with the knowledge, skills, resilience, economic resources and social capital needed to prevent addiction and sustain long-term wellbeing for the thousands of Ohioans who are in recovery.

Opportunities for improvement

The public and private sectors in Ohio can work together to:

1. Build upon the strong framework for appropriate opioid prescribing to continue to drive down opioid use rates

- a) Sustain and continually improve OARRS, including increased provider integration with electronic health records and ongoing enforcement of OARRS requirements
- b) Enforce, monitor and evaluate the impact of recently implemented prescribing limits and, based on evaluation results, consider tightening limits to three to five days as some other states have done
- c) Offer education, technical assistance and other support to providers to operationalize and implement prescribing limits and guidelines

2. Increase use of non-opioid pain management therapies, such as acupuncture, physical therapy and chiropractic care, through:

- a) Patient and provider education
- b) Improved insurance coverage for these services
- c) Partnerships across sectors (healthy aging, chronic disease prevention, behavioral health, etc.) to promote widespread availability of non-pharmacologic approaches, such as tai chi, yoga and stress reduction

3. Strengthen the effectiveness and reach of addiction prevention activities

- a) Increase sustained sources of funding for evidence-based prevention strategies for children, families and communities
- b) Explore development of an addiction prevention wellness trust funded by future potential legal settlement proceeds
- c) Support a comprehensive approach to prevention of all forms of substance use disorder (including opioids, methamphetamines, alcohol, tobacco, etc.) across the life span, including adults over age 18
- d) Improve coordination, monitoring and evaluation of school-based prevention activities
- e) Increase coordination between state agencies so that local communities receive consistent and coordinated support from the state regarding community and school-based prevention

4. Ensure that evidence-based addiction treatment and recovery services are available for all Ohioans in need

- a) Actively promote awareness of state and federal parity laws and strengthen monitoring and enforcement

- b) Evaluate the impact of Behavioral Health Redesign on addiction treatment system capacity and treatment outcomes and make continuous improvements based on the results

- c) Collect quantitative data regarding treatment gaps and publicly report the number of patients receiving evidence-based treatment (including MAT) in state-certified facilities and through county ADAMH board funding
- c) Strengthen the behavioral health workforce through increased reimbursement rates, enhancing the Behavioral Health Workforce Initiative and continuing to build integration with physical health care

5. Reduce health disparities and address the social determinants of health

- a) Ensure that resources and strategies are more aggressively directed toward populations at greatest risk of overdose deaths and incarceration
- b) Improve social and economic conditions in struggling Ohio communities

6. Increase use of data and evaluation to drive improvement

- a) Include measurable policy goals in legislation and integrate tools to track implementation and outcomes into the policymaking process
- b) Increase the transparency and usefulness of evaluation findings, such as by posting all evaluation results on state agency websites

In addition, the following steps would boost the effectiveness of Ohio's response to current and future addiction challenges:

7. Strengthen clinical-community linkages and connections between sectors. For example, ensure that hospital emergency departments, law enforcement and community behavioral health providers work together to make sure that people in need of treatment do not fall through the cracks
8. Develop a coordinated, long-term approach to serve the needs of children exposed to Adverse Childhood Experiences (ACEs) as a result of the addiction crisis, including sustained investments in early childhood home visiting and education, parenting education, trauma-informed care and education, the child welfare system and other evidence-based interventions
9. Develop a comprehensive plan for addressing potential positive and negative consequences of medical marijuana legalization, including impact on pain management, employers, adolescents and motor vehicle safety

A path forward: The role of evidence-based policymaking to reduce addiction in Ohio

Evidence-based policymaking is the “systematic use of findings from program evaluations and outcome analyses to guide government policy and funding decisions.”²¹ The purpose of this approach is to²²:

- Reduce wasteful spending
- Expand innovative programs that prove to be effective
- Strengthen accountability

As Ohio struggles to overcome the opiate epidemic, evidence-based policymaking provides a roadmap to ensure that the state is investing in the right approaches. The [Pew-MacArthur Results First Initiative](#) identifies five key components of evidence-based policymaking²³:

- **Program assessment:** Systematically review available evidence on the effectiveness of public programs
- **Budget development:** Incorporate evidence of program effectiveness into budget and policy decisions, giving funding priority to those that deliver a high return on investment of public funds
- **Implementation oversight:** Ensure that programs are effectively delivered and are faithful to their intended design
- **Outcome monitoring:** Routinely measure and report outcome data to determine whether programs are achieving desired results
- **Targeted evaluation:** Conduct rigorous evaluations of new and untested programs to ensure that they warrant continued funding

While state agencies are conducting outcome monitoring and targeted evaluation for some programs (see part 5), more could be done to incorporate evidence of program effectiveness into the state budget process. Furthermore, legislation in Ohio rarely requires an evaluation study or outcome tracking, and there are no mechanisms built into the legislative process that specify measurable outcomes for legislation. It is therefore difficult to assess whether legislation has achieved desired outcomes and if resources are being allocated toward the most effective approaches.

Other states have done more to incorporate evidence into the policymaking process, including steps to strengthen drug prevention and the behavioral health system. Examples include:

- **Washington:** The state legislature created the [Washington State Institute for Public Policy \(WSIPP\)](#) in 1983. WSIPP works with legislators and state agency staff to conduct non-partisan research on the effectiveness of policies and programs, including [benefit-cost analyses](#) on a wide variety of substance use prevention and treatment interventions. The WSIPP approach is being replicated in several other states through the [Pew-MacArthur Results First Initiative](#).
- **Minnesota:** The Department of Management and Budget is using the Results First framework to inventory currently-funded services, review which ones have evidence of effectiveness and conduct benefit-cost analyses. Findings on substance use disorder prevention, treatment and recovery services are [posted on the agency website](#).
- **Utah:** The Department of Human Services' Division of Substance Abuse and Mental Health is required to develop and publish a [statewide registry](#) of evidence-based prevention programs, and then use the registry to guide its contracting decisions. The division has established an [evidence-based workgroup](#) of prevention and evaluation experts that identify evidence-based programs and continually refine the criteria for effectiveness.
- **Massachusetts:** A [2016 law](#) established a Special Commission on Behavioral Health Promotion and Upstream Prevention. The purpose of this commission is to investigate evidence-based practices, allocate funding toward what works and set achievable goals for reducing behavioral health disorders.

Going forward, Ohio can do more to embed evidence considerations into the policymaking process to ensure that measurable objectives are met and resources are targeted to the most effective approaches in a more coordinated way.

For additional information about evidence-based policymaking, visit HPIO's [Guide to Improving Health Value](#).

Part 3. Policy inventory summary

Overview

This section highlights key findings from the policy inventory, including:

- Volume of policy changes, by topic
- Volume of policy changes, by substance type
- State agency spending

A complete list of specific policies, programs and services, including descriptions and links for more information, is available in the [detailed policy inventory](#).

Inventory process and methodology

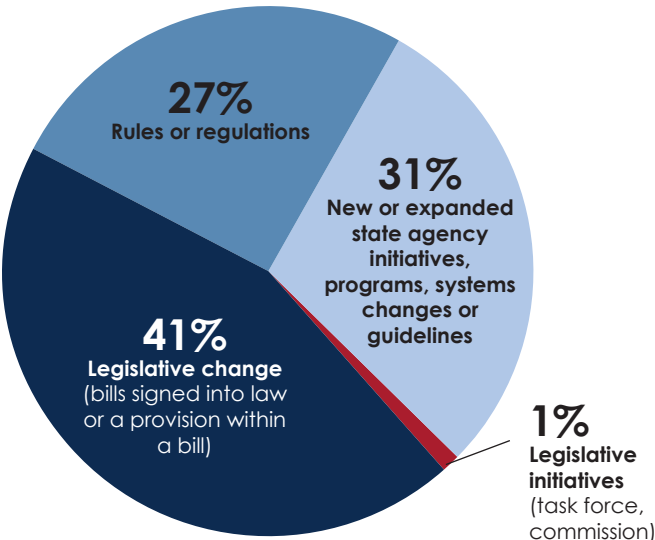
To develop the policy inventory, HPIO conducted a structured review of policy changes that occurred at the state level from 2013-2017 (130th and 131st General Assembly and first half of the 132nd General Assembly²⁴ as of December 2017). See Appendix A for a list of the search terms used.

Of the policy changes identified, 41 percent were legislative changes, 27 percent were rules or regulations and 31 percent were new or expanded state agency initiatives, programs, systems changes or guidelines (see figure 8).

Volume of policy changes, by topic

Figure 9 displays the number of policy changes enacted between 2013 and 2017 for addiction-related topics. Overall, treatment services and appropriate use of/access to prescription opioids received the largest amount of policy attention, while child and family-focused prevention and screening and early intervention received less attention. There

Figure 8. **Addiction-related policy changes in Ohio, by type of policy change, 2013-2017** (n=193)



Source: HPIO review of Ohio legislation, regulations, Governor's Cabinet Opiate Action Team timeline and other policy summaries

was also less policymaking activity regarding the treatment system—which includes capacity, workforce and access to care—and recovery services and supports.

Prevention

Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.²⁵ Preventing the onset of substance use disorder in the first place is critical for reversing the overdose epidemic. Addiction prevention policies and programs are designed to:

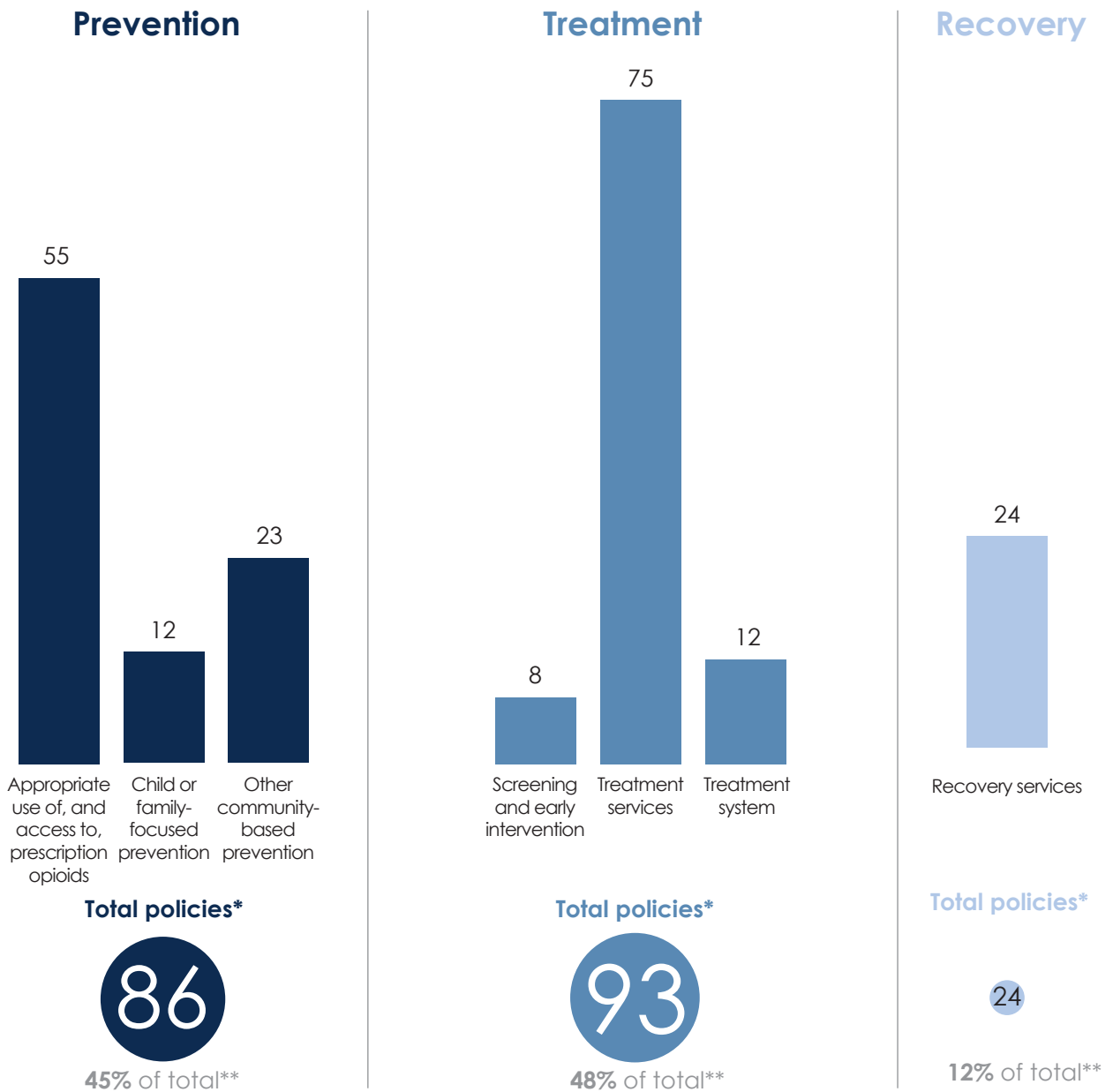
- Reduce the supply of or access to drugs (such as by reducing opioid prescribing, increasing the price of tobacco products or narcotics interdiction by law enforcement), or
- Reduce the demand for drugs by strengthening protective factors (such as positive youth social skills) and reducing risk factors (such as social norms that promote drug use)

Treatment and recovery

Treatment includes a wide range of services provided in an outpatient or inpatient setting, such as assessment, behavioral counseling, withdrawal management with follow-up care and MAT. Recovery services, such as recovery housing, peer support and 12-step programs, are designed to enable individuals to improve their health and wellness over the long-term.

This policy inventory and scorecard includes specific treatment and recovery services, as well as information about the overall capacity of the behavioral health system and access to care.

Figure 9. Number of addiction-related policy changes in Ohio, by topic, 2013-2017



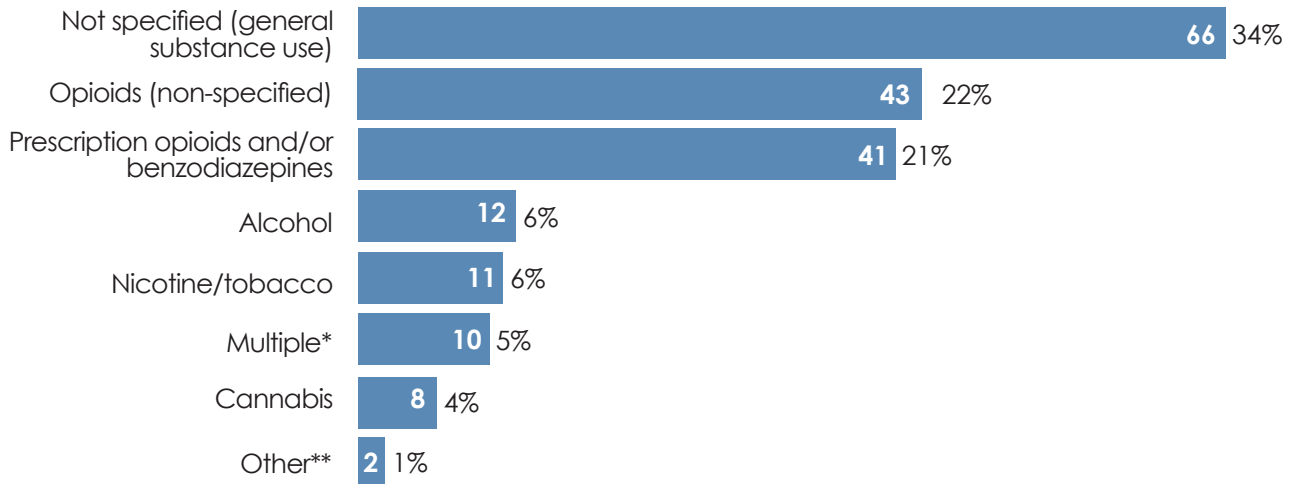
* Policies in the subcategories exceed the number of total policies because some policies were counted in more than one subcategory.

** Percents exceed 100 percent because some policies were counted in more than one category.

Note: See Appendix B for further description of these categories.

Source: HPIO review of Ohio legislation, regulations, Governor's Cabinet Opiate Action Team timeline and other policy summaries

Figure 10. **Number of addiction-related policy changes in Ohio, by substance type, 2013-2017** (n=193)



Note: There were no policies, programs or services newly enacted from 2013-2017 that focused specifically on methamphetamines or cocaine.

* "Multiple" includes policies that address more than one specific drug

** "Other" includes policies that address other drugs not specifically listed here (i.e., gabapentin, anorexiant)

Source: HPIO review of Ohio legislation, regulations, Governor's Cabinet Opiate Action Team timeline and other policy summaries

Volume of policy changes, by substance type

Overall, 43 percent of addiction-related policy changes addressed opioids (see figure 10). More specifically, 21 percent addressed prescription opioids and/or benzodiazepines, such as updates to OARRS, and 22 percent addressed either non-prescription opioids (including heroin and fentanyl), or opioids in general, such as access to MAT.

About one-third of addiction policy changes addressed "controlled substances" or "dangerous drugs" generally without naming specific drugs, or addressed addiction generally (such as early childhood prevention, drug taskforces and behavioral health workforce capacity).

Between 2013 and 2017, there were a smaller number of policy changes related to cannabis, alcohol and tobacco. Notably, most of the alcohol-related policies increase access to alcohol.

State agency spending

Figure 11 displays addiction-related spending in state fiscal year 2017 by state agencies with significant roles in prevention, treatment and recovery: Ohio Department of Mental Health and Addiction Services (OMHAS), Ohio Department of Health (ODH), Ohio Attorney General's Office (AG) and the Ohio Board of Pharmacy (BOP). (Criminal justice, law enforcement and child welfare spending will be included in a future report.)

Figure 11. **State spending, by agency*, State Fiscal Year 2017**

	Prevention		Treatment and Recovery	
	Federal	Non-federal	Federal	Non-federal
Ohio Department of Mental Health and Addiction Services	\$21,149,613	\$5,278,517	\$62,603,444	\$40,147,974
Ohio Department of Health	\$2,603,543	\$6,493,187	\$743,417	\$1,846,260
Board of Pharmacy	\$291,993	\$663,318	NA	NA
Attorney General	\$0	**\$2,742,649	***NA	***NA
Total for above agencies	\$24,045,149	\$15,177,671	\$63,346,861	\$41,994,234

*Only includes agencies primarily responsible for leading addiction prevention, treatment and recovery activities, other than ODM

** 2017-2018 school year

*** Treatment and recovery spending by the Attorney General will be captured in a future phase of the Addiction Evidence Project that focuses on children, youth and families, law enforcement and criminal justice.

The Ohio Department of Medicaid (ODM) has had the largest share of addiction-related state spending, focused on treatment services. In SFY 2016, ODM spent \$650,200,000 to provide healthcare services for Ohioans with drug addiction/behavioral health issues. Medicaid spending will increase to \$762,948,490 in SFY 2017. This amount includes spending on addiction treatment, community mental health services, community psychiatric supportive treatment, behavioral health counseling/therapy, mental health assessment services, crisis intervention, pharmacologic management services and emergency services/coverage of naloxone.²⁶

Medicaid is funded by a mix of state and federal dollars; the federal share, referred to as the Federal Medical Assistance Percentage (FMAP) is 62.3 percent for most Medicaid recipients in Ohio, but some eligibility groups, including the newly eligible Group VIII category, are reimbursed at higher rates.

Overall, state agency spending has been concentrated on treatment services, with less funding allocated to prevention. Notably, more than half of all funding for addiction prevention, treatment and recovery has come from federal sources.

Total spending

Local governments and private entities (consumers, employers, etc.) have also spent considerable amounts of money on addiction treatment and the consequences of the opioid epidemic. A recent working paper from the American Enterprise Institute estimates that the total cost of the opioid crisis to Ohio was \$3,385 per capita in 2015, including health care, worker productivity and criminal justice costs.²⁷

A similar analysis of total costs by Ohio State University researchers estimated that opioid abuse, dependency and overdose deaths resulted in \$6.6 to \$8.8 billion in healthcare and criminal justice costs and lost productivity in Ohio in 2015.²⁸

Cost-effectiveness of prevention and treatment spending

Studies have found that effective prevention and treatment programs can save taxpayer dollars. For example, WSIPP estimates that the Good Behavior Game, a prevention approach used in many Ohio schools, saves Washington State taxpayers \$2,760 per student (compared to \$163 program cost) due to education, criminal justice and other savings.²⁹ Similarly, a California study of substance use disorder treatment concluded that every \$1 spent on treatment saves \$7 due to reduced crime and increased earnings.³⁰

Medication-Assisted Treatment (MAT) Basics

MAT combines behavioral therapy and medications to treat substance use disorders. This report focuses primarily on MAT for opioid use disorder, although MAT can also be used to treat alcohol or nicotine addiction.³¹

There is strong evidence that MAT is an effective treatment for substance use disorder.³²

The three medications listed below are used to treat opioid addiction. Each medication has advantages and disadvantages, and providers work with patients to identify the appropriate medication for their needs. The American Society of Addiction Medicine (ASAM) recommends that medication be accompanied by a psychosocial needs assessment, supportive counseling, links to existing family members and referrals to community services.³³

Cost effectiveness

Several studies have found that methadone and buprenorphine are highly cost effective because

they reduce future healthcare and criminal justice costs. For example:

- The New England Comparative Effectiveness Public Advisory Council concluded that for every dollar spent on MAT with methadone or buprenorphine, \$1.80 in savings are realized due to reduced healthcare and social costs (law enforcement, crime victimization and productivity loss). New England states could save \$1.3 billion by expanding treatment of opioid-dependent persons by 25 percent.³⁴
- WSIPP found that for every \$1 spent on methadone maintenance, there was a \$2.19 benefit based on increased earnings and reduced healthcare costs.³⁵

Although naltrexone is also effective in achieving positive health outcomes, the comparatively high price for this drug reduces its cost effectiveness.³⁶

Federal Drug Administration-approved medications to treat opioid use disorder³⁷

Medication (brand name examples)	How it is used	Prescriber regulations
Methadone	<ul style="list-style-type: none"> • Liquid • Patient must go to a certified treatment facility frequently to receive medication at beginning of treatment 	<ul style="list-style-type: none"> • Highly regulated (Drug Enforcement Agency [DEA] schedule II drug) • Can only be dispensed by a Substance Abuse and Mental Health Services Administration (SAMHSA)-certified Opioid Treatment Program (OTP)
Buprenorphine-naloxone and buprenorphine hydrochloride (Suboxone, Subutex)	<ul style="list-style-type: none"> • Tablet, film or implant • Used daily, but patient does not have to go to provider every day 	<ul style="list-style-type: none"> • Highly regulated (DEA schedule III drug) • Can only be prescribed by physicians (and some other providers³⁸) who are registered with the DEA and have obtained a waiver from SAMHSA (DATA 2000 waiver) • Prescribers are limited in the number of patients they can treat (30 in first year of waiver; 100 after first year; up to 275 after second year)
Naltrexone (Vivitrol, Revia, Depade)	<ul style="list-style-type: none"> • Extended-release injection or tablet • Monthly injection from healthcare provider 	<ul style="list-style-type: none"> • Not a scheduled drug • Can be prescribed by any physician, nurse practitioner or physician assistant with prescribing authority

For additional information, see the [SAMHSA MAT Pocket Guide](#).

Part 4. Policy scorecard summary

Overview

The policy scorecard summary tables in this section rate Ohio's prevention, treatment and recovery policies and programs on a three-point scale (see key below) based on the extent to which they:

- Align with research evidence on what works to reduce addiction, and
- Reach Ohioans in need

In addition, the scorecard summary tables in this section highlight key strengths and gaps related to evidence alignment and implementation reach or utilization of evidence-based services. High-priority opportunities for improvement are listed in the right-hand column and additional opportunities are described in the [detailed policy inventory](#).

Scorecard process

To develop the list of evidence-based policies and programs in the scorecard, HPIO consulted rigorous reviews of available research literature, including:

- **Expert consensus statements and recommendations** from independent expert panels convened by organizations such as the National Academies of Sciences, Engineering and Medicine; U.S. Surgeon General; and the Centers for Disease Control and Prevention
- **Clinical guidelines** from medical associations such as the American College of Physicians and ASAM
- **Evidence registries and clearinghouses**, such as What Works for Health and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide

HPIO then reviewed the inventory to identify policies and programs implemented in Ohio that were relevant to the specific evidence-based approaches and assessed the extent to which Ohio's efforts align with the evidence and are being implemented in a widespread

way. Although guided by specific criteria (see Appendix A), this assessment was largely qualitative.

HPIO sought and received input from state agencies and other stakeholders to ensure that the description of policy implementation in Ohio was accurate. Information about the number of Ohioans reached or fidelity to evidence-based models was often not available. See Appendix A for further description of limitations.

Key

Strong	Most policies, programs and services in this category are consistent with evidence on what works and some are being implemented in a widespread way.	Moderate	Many policies, programs and services in this category are consistent with evidence on what works, but overall implementation reach may be limited.	Weak	For many of the policies, programs and services in this category, alignment with evidence and/or implementation reach is weak, mixed or unknown.
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*See Appendix A for scoring methodology. See [detailed policy scorecard](#) for list of specific policies, programs and services reviewed.

Figure 12. **Prevention scorecard summary**

		Strengths	Gaps	Opportunities for improvement
Strong	Appropriate use of and access to prescription opioids: Prescribing and dispensing	<ul style="list-style-type: none"> • Robust PDMP (OARRS), an evidence-based approach to reducing opioid use • Evidence-aligned opioid prescribing limits and guidelines in place 	Extent to which prescribing guidelines are being implemented is unknown	<ul style="list-style-type: none"> • Enforce, monitor and evaluate 2017 prescribing limits • Based on evaluation results, consider strengthening limits to 3-5 days • Offer education and technical assistance to help providers to operationalize and implement prescribing limits and guidelines • Sustain and continually improve OARRS
Weak	Appropriate use of and access to prescription opioids: Non-opioid pain management	<ul style="list-style-type: none"> • Ohio Medicaid covers several evidence-based, nonpharmacologic pain management therapies, including acupuncture, chiropractic and physical therapy • ODH and other state agencies launched the Take Charge Ohio campaign in 2017 to promote safe pain management and medication use, consistent with evidence-based guidelines 	<ul style="list-style-type: none"> • Ohio Medicaid does not cover some evidence-based, non-pharmacologic pain management therapies, such as tai chi, yoga, progressive relaxation, biofeedback, etc. • Ohio healthcare providers are not required to be trained in addiction or appropriate pain management, which may limit utilization of non-opioid therapies, including nonpharmacologic methods 	<ul style="list-style-type: none"> • Increase utilization of evidence-based, non-opioid pain management therapies through patient and provider education and improved insurance coverage • Require all providers who prescribe controlled substances to complete mandatory Continuing Medical Education credits on addiction, appropriate pain management and other relevant topics
Moderate	Child and family-focused prevention	<ul style="list-style-type: none"> • Ohio is implementing many evidence-based programs that support healthy child development, such as Nurse Family Partnership home visiting and Incredible Years parenting education • Ohio is implementing evidence-based prevention programs in K-12 schools, such as PAX Good Behavior Game, Botvin Life Skills and Keepin' It REAL 	<ul style="list-style-type: none"> • Implementation reach of many evidence-based programs is very limited • Data on the total number of K-12 students participating in evidence-based prevention programs is not currently available • Legislation requires K-12 schools to focus on opioid education, although a more comprehensive, skill-based, evidence-aligned approach is needed to prevent all forms of substance abuse 	<ul style="list-style-type: none"> • Sustain funding for evidence-based prevention programs, supporting a comprehensive approach to prevention of all forms of substance misuse • Improve coordination, monitoring and evaluation of school-based prevention activities, including increased coordination between ODH, OMHAS, ODE and AG • Establish health education standards for the state of Ohio
Weak	Other community-based prevention	<ul style="list-style-type: none"> • Many local communities have formed prevention coalitions to increase the reach of drug prevention activities through multi-sector collaboration • Ohio has a strong, evidence-aligned smoke-free workplace policy 	<ul style="list-style-type: none"> • There is minimal implementation of prevention activities for adults ages 18+ • Ohio has some alcohol and tobacco policies that are not aligned with evidence, such as relatively low taxes on alcohol and tobacco products and low investments in tobacco prevention and cessation 	<ul style="list-style-type: none"> • Expand community-based prevention efforts to reach adults ages 25-64—the group with the highest rates of overdose deaths • Given that overdose death rates are much higher among Ohioans with lower levels of education, focus on community-based prevention activities for adults who are not enrolled in college • Reduce consumption of alcohol and tobacco by increasing the unit price (excise taxes or minimum pricing)

Figure 13. Treatment and recovery scorecard summary

		Strengths	Gaps	Opportunities for improvement
Weak	Screening and early intervention	<ul style="list-style-type: none"> • OMHAS and ODH have implemented initiatives to increase use of SBIRT, an evidence-based screening method for alcohol/drugs • SBIRT is being implemented in a variety of settings, including primary care hospital emergency departments 	<ul style="list-style-type: none"> • Stakeholders report that SBIRT implementation in Ohio has focused primarily on screening, while referral to treatment may be lacking • Although quality metrics for tobacco use screening, an evidence-based service, are now being tracked, ODM is not currently undertaking any initiatives to increase utilization of tobacco screening and cessation 	<ul style="list-style-type: none"> • Strengthen implementation and monitoring of “referral to treatment” component of SBIRT • Collect data regarding treatment gaps from SBIRT providers • Increase effective screening for tobacco use, particularly among Medicaid enrollees, and ensure provision of, or referral to, effective cessation services
Moderate	Treatment services (MAT, psychosocial services, outpatient, residential, etc.)	<ul style="list-style-type: none"> • Several policies have supported implementation of MAT, an evidence-based practice, such as Medicaid coverage (started in 2011), rules consistent with ASAM National Practice Guidelines and use of MAT in drug courts • Several programs have been implemented to extend the implementation reach of treatment services to priority populations, including pregnant women, infants with NAS and justice-involved adults 	<ul style="list-style-type: none"> • Despite recent improvements, the implementation reach of MAT is still limited in many parts of the state; Only 13 counties have at least 1 provider for all 3 types of MAT (see figure 14) • A 2017 OSU study estimated that Ohio’s current MAT capacity can serve only 10% to 40% of those in need • A recent national analysis determined that Ohio’s ratio of certified buprenorphine providers to opioid overdose deaths was significantly worse than most other states (see figure 6), indicating significant unmet need for MAT 	<ul style="list-style-type: none"> • Increase the number of counties that have all 3 types of MAT, including better access to methadone and buprenorphine in rural counties • Ensure that certified buprenorphine prescribers are maximizing their ability to fill capacity gaps, while adhering to ASAM guidelines and state and federal regulations • Assess the extent to which MAT is being paired with effective psychosocial approaches and improve integration as needed • Provide adequate treatment for people who use multiple substances, including methamphetamine and cocaine, which cannot be treated with MAT

Figure 13. **Treatment and recovery scorecard summary** (cont.)

		Strengths	Gaps	Opportunities for improvement
Strong	Treatment system access and coverage	<ul style="list-style-type: none"> Increased insurance coverage is an effective way to improve access to care; Policy changes in Ohio reduced the uninsured rate for adults ages 18-64 to 4.7% in 2016, compared to 7.4% in the U.S. Enactment of requirements for ODI and OMHAS to provide education on state and federal parity laws; create and promote a consumer hotline; and provide a report on outreach, trends and barriers to access and coverage 	Insurance coverage does not always lead to adequate access to care due to lack of providers, prior authorization requirements and other barriers to care	<ul style="list-style-type: none"> Continue policies that have contributed to Ohio's historically low uninsured rate, including maintenance of current Medicaid eligibility levels Actively promote awareness of federal and state parity laws and strengthen monitoring and enforcement of federal behavioral health parity laws and guidance
Weak	Treatment system capacity and workforce	<ul style="list-style-type: none"> Behavioral Health Redesign, an initiative to improve community behavioral health system capacity, started in 2015, with full implementation to begin in 2018 Behavioral health primary care integration, an evidence-based approach, is a key component of Behavioral Health Redesign 	<ul style="list-style-type: none"> Provider workforce gaps are likely limiting the implementation reach of effective treatment services Other than the MAT provider information described above, there is limited data available to assess the capacity of Ohio's addiction treatment system relative to need 	<ul style="list-style-type: none"> Continue to implement Behavioral Health Redesign and assess impact on addiction treatment system capacity and outcomes Strengthen the behavioral health workforce through increased reimbursement rates, enhancing the Behavioral Health Workforce Initiative and continuing to build integration with physical health care
Moderate	Recovery services	<ul style="list-style-type: none"> ADAMH board continuum of care requirements include evidence-based services, such as recovery housing and peer support Several policies have been implemented to increase access to certified recovery housing and peer support, including increased funding for housing and formal certification of Peer Recovery Supporters 	<ul style="list-style-type: none"> Ohio Recovery Housing-certified housing is only available in 32 counties Implementation reach of peer support is also limited in many counties Ohio's policies and funding for supported employment services focus on people with severe and persistent mental illness, creating a gap for people recovering from addiction 	<ul style="list-style-type: none"> Increase the number of certified recovery houses throughout the state Extend Medicaid coverage of peer support to include people in recovery from substance use disorder Increase supported employment programs for people recovering from addiction

Acronyms in figure 12

AG: Ohio Office of the Attorney General
 OARRS: Ohio Automated Rx Reporting System
 ODE: Ohio Department of Education
 ODH: Ohio Department of Health
 OMHAS: Ohio Department of Mental Health and Addiction Services

Acronyms in figure 13

ADAMH: Alcohol Drug and Mental Health Boards
 ASAM: American Society of Addiction Medicine
 NAS: Neonatal Abstinence Syndrome
 ODH: Ohio Department of Health
 ODI: Ohio Department of Insurance
 ODM: Ohio Department of Medicaid
 OMHAS: Ohio Department of Mental Health and Addiction Services
 OSU: The Ohio State University
 SBIRT: Screening, Brief Intervention and Referral to Treatment

Figure 14. **Providers of Medication-Assisted Treatment (MAT), by Ohio county, as of January 2018**

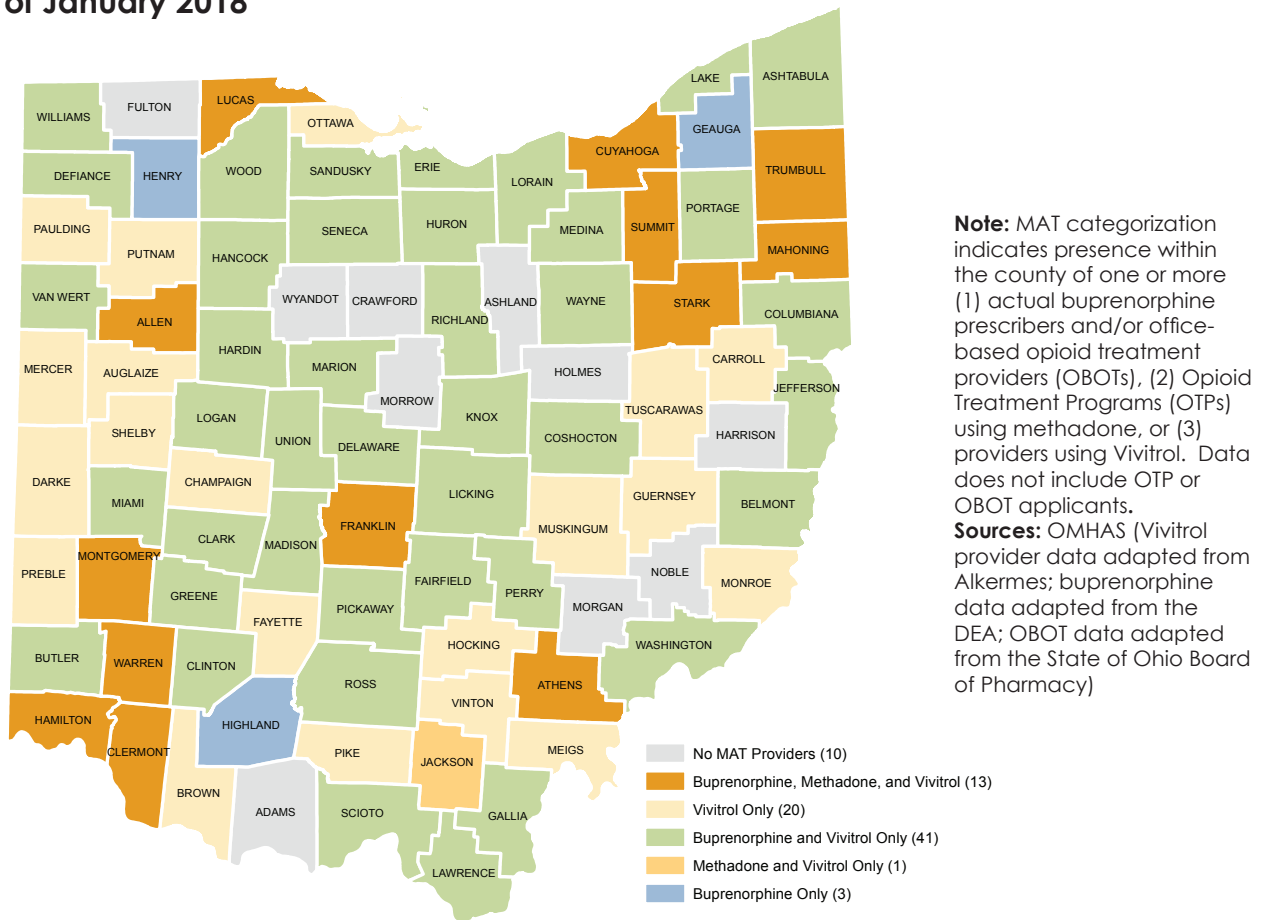


Figure 14 illustrates the implementation reach of MAT. Only 13 counties have at least one provider for all three types of MAT and 10 counties have no MAT providers.

Ohio policies for which there is a lack of evidence of effectiveness

The [detailed policy inventory](#) includes many specific policy changes implemented in Ohio for which there is not currently research evidence available. In some cases, this is because the policy changes are related to administrative or systems changes (such as ADAMH board contracting requirements or chemical dependency counselor licensure provisions) that have not been evaluated. In other cases, the research base is simply too new to provide definitive evidence of effectiveness. Although the research literature includes decades of studies on what works to prevent and treat nicotine and alcohol

addiction, the evidence base on opiate addiction prevention, treatment and recovery is still developing.

Given the severity of the overdose epidemic, policymakers must act—sometimes without rigorous research evidence. In these cases, it is important for policymakers to implement strategies that are evidence-informed—meaning that they are built upon accurate information about the nature of the problem and contributing factors.

The Start Talking! campaign, launched by OMHAS in 2014, is one example of an evidence-informed approach that lacks rigorous outcome evaluation. Start Talking! provides parents with information about how to talk with their children about drugs. This is an evidence-informed approach because it aims to increase important protective factors that research finds deter adolescent substance

use: positive parent-child communication and parents expressing a negative attitude about drug use. However, the overall Start Talking! initiative has not been evaluated in a rigorous or comprehensive way so it is not possible to determine whether it has been effective in increasing these protective factors in Ohio. The K-12 Health and Opioid Abuse Prevention Education (HOPE) Curriculum, a new component of Start Talking!, is currently being evaluated by Wright State University researchers, although results are not yet available.

Ohio policies for which there is evidence of ineffectiveness or harm

The research literature includes few examples of prevention, treatment or recovery policies that have specifically been found to be ineffective or harmful. Below are examples of public policies or programs that have been implemented in Ohio that are not aligned with evidence:

- **Mandatory random drug testing in schools:** The OJJDP Model Programs Guide rates mandatory random drug testing in schools as an intervention with no effects³⁹ and the American Academy of Pediatrics opposes widespread drug testing in schools due to the lack of evidence of effectiveness.⁴⁰ Some schools in Ohio test their students for drug use (including 27 schools participating in Drug Free Clubs of America⁴¹), although the total number is unknown.
- **Traditional DARE:** The traditional DARE program (as evaluated from 1983-2009) was found to be ineffective in reducing youth substance use.⁴² In response to negative evaluation findings, DARE has adopted an evidence-based curriculum called Keepin' it REAL, which is now used by most DARE officers in Ohio.
- **Alcohol access and price:** Increased access to alcohol is a risk factor for excessive alcohol use and addiction⁴³ and experts recommend increasing alcohol taxes to reduce harmful alcohol use.⁴⁴ Ohio's alcohol tax rates were rated as weak by the CDC⁴⁵ and Ohio implemented 10 policy changes during the past five years that increased access to alcohol.⁴⁶

- **Opioids for chronic, non-cancer pain:** There is a growing body of research that finds that opioids are as effective or less effective than other pain management methods, and carry much higher risks.⁴⁷ Despite many policy changes to reduce opioid dispensing, Ohioans still consume more prescription opioids per person than people in most other states (see figure 4).⁴⁸ This means that, through Medicaid and health insurance coverage for state employees, the state of Ohio continues to pay for large quantities of drugs for which there is evidence of ineffectiveness and harm. Furthermore, prescription opioids for pain remain less highly regulated than methadone and buprenorphine (two forms of MAT).

Part 5. Evaluating the impact of Ohio’s policies and programs

Evaluation research assesses how a policy or program was implemented and whether or not it was effective in achieving desired outcomes.

Of the 193 prevention, treatment and recovery policies reviewed in this inventory, only 25 (13 percent) included a clear reference to an evaluation requirement or some other provision related to implementation or outcome monitoring or data tracking.

While state legislation rarely requires documentation of outcomes, federal grants typically include an evaluation component. Most evaluation activity over the past five years, therefore, has been for federally-funded programs. The federal Cures STR grant, for

example, is being evaluated at the national level in a large cross-site evaluation by an external evaluator, with additional evaluation activities being conducted by OMHAS.

Some state-funded pilot programs have also been evaluated, such as the Addiction Treatment Project, which provides MAT to drug court participants.

Transparency of evaluation results

Of the 25 policies with an evaluation or data monitoring component identified, about half (11) had evaluation results or other data posted online. Figure 15 provides links to this publicly-available information.

Figure 15. **Publicly-available evaluation results or other data used to evaluate addiction prevention, treatment and recovery policies implemented in 2013-2017**

Policy or program	Evaluation results or other data posted online
Multiple policies to reduce opioid prescribing and dispensing, such as prescribing guidelines and improvements to OARRS	Annual OARRS reports and county data with information about number of opioid doses dispensed are posted on the Ohio Board of Pharmacy website .
Addiction Treatment Project (pilot program to provide MAT in drug courts)	A December 2015 evaluation report from the Begun Center for Violence Prevention, Research and Education at Case Western Reserve University is posted on the OMHAS website .
Addiction Treatment Project (expanded program to provide MAT in drug courts)	A June 2017 evaluation report from the Treatment Research Institute is posted on the OMHAS website .
ORC 5119.362 requires that all community addiction services providers maintain a waiting list for opioid and co-occurring drug addiction services and recovery supports. The waiting list data is due to OMHAS on a monthly basis. (Note that behavioral health stakeholders report limitations to the usefulness of this data.)	The waiting list data is reported in aggregate, by county, on the OMHAS website .
Baby and Me Tobacco Free (tobacco cessation program for pregnant women)	A December 2017 evaluation report from Strategic Research Group is posted on the ODH website .

In addition, ODH posts [drug overdose death reports](#) and OMHAS posts [Ohio Substance Abuse Monitoring \(OSAM\) Network](#) qualitative and quantitative drug trend data and State Epidemiological Outcome Workgroup (SEOW) data via a [Network of Care website](#). This data can be used to assess the overall impact of Ohio's addiction policy changes.

Academic researchers are conducting evaluation studies and data analytics that can also help to identify effective approaches to reducing addiction. The Ohio Colleges of Medicine Government Resource Center (GRC), for example, is currently working with academic partners and ODM on several relevant research projects, including the [Ohio Opioid Analytics Project](#) and Behavioral Health Redesign monitoring.

Additional information about evaluation and data sources will be included in a future HPIO addiction policy inventory and scorecard, to be released later in 2018, which will address data and evaluation.

Links to data on addiction and the behavioral health system

- [Ohio Automated Rx Reporting System \(OARRS\) reports](#), Ohio Board of Pharmacy
- [Ohio Substance Abuse Monitoring Network \(OSAM\)](#), OMHAS
- [Ohio Public Health Data Warehouse \(mortality data\)](#), ODH
- [State Epidemiological Outcomes Workgroup \(SEOW\)](#), OMHAS
- [2016 State Health Assessment](#), ODH
- [Behavioral Health Barometer](#), SAMHSA
- [National Survey of Substance Abuse Treatment Services \(N-SSATS\)](#), SAMHSA
- [Overdose Data Dashboard](#), Ohio Hospital Association

Appendix A. Methodology

Inventory process

In order to compile the detailed policy inventory, HPIO researchers searched the Ohio Revised Code (ORC), Ohio Administrative Code (OAC), the Governor’s Cabinet Opiate Action Team (GCOAT) timeline ([Combating the Opiate Crisis in Ohio](#)), state agency websites and policy summaries from other organizations. See figure 16 for examples of the types of policy changes reviewed.

HPIO researchers used the following search terms when reviewing the ORC and OAC:

- Addiction
- Alcohol
- Beer
- Buprenorphine
- Cigarette (including e-cigarettes)
- Cigars
- Cocaine
- Detox/detoxification
- Heroin
- Liquor
- Medication-Assisted Treatment
- Methamphetamine
- Naltrexone
- Neonatal Abstinence Syndrome
- Nicotine
- OARRS
- Opiate
- Opioid
- Pain
- Prevention
- Recovery
- Spirits
- Substance abuse
- Tobacco
- Vapor
- Wine

Figure 16. Types of policy changes reviewed

Type of policy change	Examples	Sources searched or consulted
Legislative change (bills signed into law or a provision within a bill)	<ul style="list-style-type: none"> • Provision of 2018-19 state budget (HB 49) requiring teacher preparation programs to include instruction on opioid and other substance abuse prevention • HB 367 requires school districts to provide education about prescription medication and opiate abuse 	<ul style="list-style-type: none"> • State main operating budget documents⁴⁹ • General Assembly archives⁵⁰
Rules or regulations	<ul style="list-style-type: none"> • OAC 4731-11-12 specifies uniform standards for treating patients with opiate addiction using buprenorphine 	<ul style="list-style-type: none"> • OAC • Relevant state agency websites
State agency initiatives, programs, systems changes or guidelines	<ul style="list-style-type: none"> • Improvements to OARRS, such as integration with Electronic Health Records • Department of Mental Health and Addiction Services receives federal grant to expand SBIRT 	<ul style="list-style-type: none"> • GCOAT timeline (Combating the Opiate Crisis in Ohio) • State agency websites • General Assembly archives (legislation)
Legislative initiatives (task force, commission)	<ul style="list-style-type: none"> • Ohio House HOPES Task Force 	<ul style="list-style-type: none"> • Media reports and policy summaries prepared by associations and other stakeholder organizations • General Assembly website

Major marijuana policy changes are included in the inventory, although HPIO did not conduct a comprehensive search for all policy changes related to marijuana or cannabis. There is some evidence that medical marijuana may provide effective pain management for certain conditions.⁵¹ Conversely, there is also evidence that cannabis use is likely to increase the risk for developing dependence on other substances.⁵² For these reasons, the overall impact of Ohio's new Medical Marijuana Control Program on the opiate crisis and the prevalence of substance use disorders is difficult to estimate. For additional detail on medical marijuana in Ohio, visit HPIO's [Medical Marijuana in Ohio](#) resource page.

The terms “naloxone” and “overdose” will be included for the next phase of the project (policy inventory and scorecard for Harm Reduction, Overdose Reversal and Data and

Evaluation). Overdose reversal (naloxone) is not categorized as prevention because it occurs after an overdose has begun, and typically after substance use disorder has progressed.

Scorecard process

Step 1: Rating for specific policies and programs in detailed scorecard. HPIO researchers rated the specific policies, programs and services in the [detailed policy scorecard](#) based on five rating levels: strong, moderate, mixed, weak or unknown/more information needed. Each policy was given two ratings, one for alignment with evidence and another for extent of implementation reach. Figure 17 defines each of these ratings, as well as the score assigned to each rating.

Step 2. Summary score for subtopics. In order to summarize the scorecard findings for this report, the scores for each policy and program in the

Figure 17. Definition of detailed scorecard rating levels

Rating and score	Ohio alignment with evidence	Extent of implementation reach in Ohio
Strong (4)	Services, programs and policies being implemented in Ohio are highly consistent with the most rigorously-evaluated and effective evidence-based approaches in this category.	Services and programs are being implemented throughout the entire state (statewide or > 80 counties), are reaching a majority of intended groups of Ohioans and are funded at the level needed to implement widespread, effective programming with fidelity to the evidence-based model. Policies are being monitored, implemented and enforced as intended.
Moderate (3)	Services, programs and policies being implemented in Ohio are mostly consistent with recommended evidence-based approaches in this category.	Services and programs are being implemented in at least 40-80 counties, are reaching large numbers of intended groups of Ohioans and/or are funded adequately to meet current capacity and demand. Policies are likely being implemented and enforced as intended, although rigorous monitoring information may not be available.
Mixed (2)	Ohio is implementing some services, programs or policies with “strong” or “moderate” alignment with evidence, but is also implementing significant number of services, programs or policies with “weak” alignment.	Within this category, Ohio is implementing some services or programs with “strong” or “moderate” implementation reach, but is also implementing a significant number of services or programs with “weak” implementation reach. Some policies are being implemented as intended and enforced, while others are not.
Weak (1)	Ohio is implementing services, programs and policies that are not consistent with recommended evidence-based approaches within this category.	Services and programs are being implemented in fewer than 40 counties, are only reaching a small proportion of intended groups of Ohioans, and/or funding is inadequate to meet demand. Policies are not being implemented as intended and/or are not being enforced.
Unknown/ More information needed (1)	Adequate information to determine evidence alignment is not currently available.*	Adequate information to determine implementation reach is not currently available.*

*Note that this information may be available within specific counties, but is not available for an overall statewide basis.

Figure 18. **Final summary score and rating for prevention, treatment and recovery subtopics**

Subtopic	Alignment with evidence*	Extent of implementation, reach and funding*	Total summary Score	Summary rating
Appropriate use of and access to prescription opioids: Prescribing and dispensing	3.6	2.6	6.2	Strong
Appropriate use of and access to prescription opioids: Non-opioid pain management	3.0	1.4	4.4	Weak
Child and family-focused prevention	3.3	1.8	5.1	Moderate
Other community-based prevention	2.1	2.2	4.3	Weak
Screening and early intervention	3.7	1.0	4.7	Weak
Treatment services	3.9	1.6	5.5	Moderate
Treatment system access and coverage	3.5	2.5	6.0	Strong
Treatment system capacity and workforce	2.7	1.0	3.7	Weak
Recovery services	3.3	2.0	5.3	Moderate

*Average score across specific policies/programs within subtopic

Note: Subtopics with a score of 6.0 or higher received a strong rating, subtopics with a score between 5.0 and 5.9 received a moderate rating and subtopics with a score below 5.0 received a weak rating.

detailed policy scorecard were averaged across sub-topics. For example, policies on opioid prescribing limits, opioid prescribing guidelines and OARRS were averaged to calculate scores for the prevention subtopic: “Appropriate use and access to prescription opioids: *Prescribing and dispensing*.” This method was replicated for each subtopic (see figure 18). The total score for a subtopic is a composite score of alignment with evidence and extent of implementation and reach. If the subtopic total score was 6.0 or higher, it received a strong rating. Subtopics with a score between 5.0 and 5.9 received a moderate rating and subtopics with a score below 5.0 received a weak rating.

Sources of evidence

In order to identify the evidence-based policies, programs and practices listed in the scorecard, HPIO relied upon the most credible sources of information available. Rather than citing individual studies, HPIO turned to expert consensus statements, clinical guidelines and evidence registries whenever possible; these sources involve rigorous review of available research evidence by a group of experts who synthesize the information and make a recommendation or statement about what approaches are most effective. The types

of sources used to develop the scorecard are listed below, in order of preference. For some topics, gray literature reports were used if expert consensus statements or clinical guidelines were not available:

- 1. Expert consensus statements or recommendations from independent expert panels** convened by organizations such as the National Academies of Sciences, Engineering and Medicine (NAEM) or a federal agency. These reports are based on rigorous, systematic reviews of research evidence and typically rate the strength of recommendations based on quality of the evidence base. Examples: NAEM consensus study report, Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use, and U.S. Preventive Services Task Force (USPSTF) recommendations on alcohol and tobacco use screening
- 2. Clinical guidelines from professional/medical associations**, typically published in peer-reviewed journals. Example: ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opiate Use
- 3. Evidence registries and clearinghouses.** Searchable databases or other user-friendly compilations of evidence-based

policies and programs. These registries use specific screening criteria to identify effective strategies and/or rate strategies on the strength of their available evidence of effectiveness. Examples: What Works for Health (University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation), and OJJDP Model Programs Guide. (Note: Only programs with high ratings of evidence of effectiveness were included.)

4. Gray literature reports from private sector organizations with recommendations based on review of evidence (although typically not a systematic review). Example: Pew Charitable Trusts, Prescription Drug Monitoring Programs: Evidence-based Practices to Optimize Prescriber Use

For a complete list of credible sources of evidence on effective addiction prevention, treatment and recovery, visit the HPIO Addiction Evidence Project [evidence resource page](#).

Limitations

The inventory begins in 2013, and therefore does not include policies that were implemented earlier in the opiate crisis, such as the closing of the “pill mills” in 2011. (Major policies implemented prior to 2013 are however mentioned in the detailed scorecard when relevant to evidence alignment. Visit the [GCOAT timeline](#) for policies implemented in 2011-2012.)

Although this inventory is the most comprehensive review of addiction prevention, treatment and recovery policy changes in Ohio completed to date, it is likely that some policies may have been missed, such as:

- Legislation or rules/regulations that did not include any of the search terms used by HPIO researchers (listed above) when reviewing legislation and the OAC
- Rules/regulations that were revised between 2013 and 2017 but have prior effective dates outside of that date range. Due to the way rules are recorded, HPIO researchers were unable to discern which language was newly added and which language existed prior to 2013.

There were several challenges to rating the extent of implementation reach for the scorecard. First, information about the number of Ohioans or number of counties reached by a program or service was not always available. Second, information about the extent to which policies were being implemented as intended was not always available. Finally, service penetration rates and per-capita spending information from other states would provide useful context for assessing the adequacy of Ohio's efforts, but this information is rarely available.

Advisory Group

HPIO convenes an Addiction Evidence Project Advisory Group made up of over 20 representatives from state and local, public and private organizations with expertise in addiction prevention, behavioral health treatment and recovery, child welfare and criminal justice (listed below). This group provides guidance to HPIO on Addiction Evidence Project products, including this report.

First Name	Last Name	Organization
Carol	Baden	Ohio Attorney General
Andrea	Boxill	Ohio Department of Mental Health and Addiction Services; The Governor's Cabinet Opiate Action Team
Tara	Britton	Center for Community Solutions
Lori	Criss	Ohio Council of Behavioral Health & Family Service Providers
Jolene	Defiore-Hyrmer	Ohio Department of Health
Joan	Englund	Mental Health Advocacy Coalition
Fawn	Gadel	Public Children Services Association of Ohio
Paul	Hicks	Ohio Hospital Association
Shancie	Jenkins	Ohio Department of Health
Lesli	Johnson	Ohio University
Teresa	Long	Columbus Public Health (retired)
Jaime	Love	Interact for Health
Brie	Lusheck	Center for Community Solutions
Dustin	Mets	CompDrug
Alisha	Nelson	Ohio Attorney General
Amy	O'Grady	City of Columbus
G. Dante	Roulette	Summa Health
Jim	Ryan	Alcohol and Drug Abuse Prevention Association of Ohio
Shawn	Ryan	BrightView
Stephen	Snyder-Hill	Columbus Public Health
Ann	Spicer	Ohio Academy of Family Physicians
Molly	Stone	Ohio Department of Mental Health and Addiction Services
Cheri	Walter	Ohio Association of County Behavioral Health Authorities
Kathy	Yokum	Ohio Department of Mental Health and Addiction Services

Appendix B. Additional policy inventory tables

Trends

Figure 19. Number of addiction-related policy changes in Ohio, by year, 2013-2017

General Assembly session	Year legislation was passed, rule enacted or other policy change was made	Prevention	Treatment	Recovery	Total
130	2013 (includes SFY 2014-2015 budget)	2	4	1	7 (4%)
	2014 (includes 2014 Mid-Biennium review)	20	10	4	34 (17%)
131	2015 (includes SFY 2016-17 budget)	13	13	1	27 (14%)
	2016 (includes 2016 Mid-Biennium Review)	20	22	6	48 (24%)
132	2017 (includes SFY 2018-19 budget)	29	43	11	83 (42%)

Prevention policy changes

Figure 20. Number of prevention policy changes in Ohio, 2013-2017

Prevention subtopic	Number of policy changes
Appropriate use of, and access to, prescription opioids	55
Prescribing (authority, requirements, guidelines and education for prescribers of opioids or other controlled substances/dangerous drugs)	36
Pharmaceutical dispensing and other (anything pertaining to the dispensing, coverage/insurance/prior authorization, selling, purchasing, tracking, production or distribution of controlled substances/dangerous drugs and/or any provisions related to OARRS ["drug database"]. Includes requirements for pharmacies/pharmacists/pharmacy technicians.)	29
Non-opioid pain management (including coverage and formulary changes)	6
Prescription drug disposal programs (including public education on safe storage and disposal, drop boxes, take backs, etc.)	3
Child and family-focused prevention	12
Early childhood programs and prevention interventions for young children	2
School-based prevention interventions for K-12 school-aged youth	9
Policies to reduce excessive drinking by reducing access to or supply of alcohol for children specifically (access, availability, under age enforcement, etc.)	0
Policies to reduce tobacco use by reducing access to or supply of tobacco (access, availability, under age enforcement, etc.)	1
Other community-based prevention	23
Local community prevention coalitions	4
Local community opiate task forces (led by law enforcement)	3

Figure 21. **Number of prevention policy changes in Ohio, 2013-2017** cont.

Prevention subtopic	Number of policy changes
Other community-based prevention (cont.)	
Media campaigns and public education	3
Prevention interventions for age 18-25	0
Prevention interventions for age 26-64	0
Prevention interventions for age 65+	1
Family and economic opportunity policies and programs	0
Policies to reduce excessive drinking by reducing access to or supply of alcohol (pricing/taxes, access, availability, etc.)	3
Policies to reduce tobacco use by reducing access to or supply of tobacco (pricing/taxes, access, availability, etc.)	1
Prevention provider contract rules and licensing	1
ADAMH board requirements specific to prevention	2
Tobacco prevention- general/other	3
Prevention — other	4

Treatment policy changes

Figure 22. **Number of treatment policy changes in Ohio, 2013-2017**

Treatment subtopic	Number of policy changes
Screening and early intervention	8
SBIRT	4
Tobacco use screening	4
Treatment services	75
Transition from overdose reversal to treatment	1
Withdrawal management, detox and ambulatory detox	2
MAT (including protocols, treatment standards and coverage)	27
General treatment services (including treatment program regulations and treatment provider contract rules; assessment; behavioral therapies and psychosocial approaches; outreach and engagement activities; assessment services; care coordination; inpatient and residential treatment and partial hospitalization; outpatient treatment)	17
Medicaid provider regulations or coverage provisions	7
Treatment services for criminal justice-involved clients (treatment in context of drug court, diversion or treatment in lieu of conviction, treatment in jail/prison, treatment at re-entry, etc.)	16
NAS treatment and treatment for pregnant, post-partum and parenting women	3
Tobacco cessation	6
Treatment — other	5

Figure 23. **Number of treatment policy changes in Ohio, 2013-2017** cont.

Treatment subtopic	Number of policy changes
Treatment system	12
Behavioral health system access and integration (includes Behavioral Health Redesign, workforce, parity, capacity, parity)	11
ADAMH board requirements specific to treatment	3
Media campaigns and other efforts to reduce stigma associated with addiction	1
Treatment/BH system- other	1

Recovery policy changes

Figure 24. **Number of recovery policy changes in Ohio, 2013-2017**

Recovery subtopic	Number of policy changes
Recovery services	24
Mutual aid groups and 12-step programs	1
Peer support	4
Recovery housing	4
Recovery employment services	0
Recovery education and vocational training services	0
Recovery program regulations and recovery provider contract rules	1
ADAMH board requirements specific to recovery	1
Recovery- other or general recovery unspecified	10

Other addiction-related policy changes

The policy inventory included a total of 193 policy changes. Of these, 19 addressed mood-altering substances but did not directly contribute to prevention, treatment or recovery. All of these 17 policy changes increase access to substances in some way (see figure 21d).

Figure 25. **Number of policy changes that increase access to substances in Ohio, by substance type, 2013-2017**

Substance	Number of policy changes
Alcohol (policies eliminating the maximum permitted alcohol content of beer, exemptions to open container laws, permitting the manufacturing of alcohol ice cream, etc.)	19
Alcohol (policies eliminating the maximum permitted alcohol content of beer, exemptions to open container laws, permitting the manufacturing of alcohol ice cream, etc.)	10
Cannabis (legislation and regulation establishing the Medical Marijuana Control Program)	7
Prescription opioids (policies eliminating the requirement for optometrists to check OARRS before prescribing opioids and permitting emergency medical providers to treat minor patients with opioids without obtaining written parental consent)	2

For additional detail and links to more information about each policy, see [detailed policy inventory](#).

Notes

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