# The Opioid Crisis in Illinois: Data and the State's Response

**Overview.** Although the COVID-19 pandemic has receded as an emergent public health crisis, the opioid epidemic in Illinois continues more or less unabated. However, there is potential good news as most indicators examined for this report show a plateau or even downturn in 2021/2022 compared to 2020. Despite these promising statistics, opioid misuse and associated issues present an ongoing, serious public health concern for the state with continuing high fatality levels driven by the continued use of fentanyl in drugs sold on the street and the increasing presence of Xylazine in street drug supplies.

According to the most recent data available from the Illinois Department of Public Health dashboard (https://idph.illinois.gov/OpioidDataDashboard/) there were 3,013 fatal overdoses due to heroin or other opioids in 2021. Opioid fatalities accounted for 81% of all drug-overdose related fatalities (N = 3,717) in the state. This represents a **2.3% increase** in fatal overdoses relative to 2020 when there were 2,944 recorded fatalities. Provisional data for the first two quarters of 2022 indicate a 3.3% increase over the number of fatalities for the same time period in 2021 with total monthly fatalities ranging between 231 and 285 per month in the first two quarters of 2022, the most recent period for which data are available.[1] Consistent with national data, the bulk of the increased number of fatalities has been among men and specifically among Black/African American men.[2] However, the 16,804 non-fatal overdoses in 2021 represent an **8.7% decrease** compared with the number of non-fatal overdoses (18,282) in 2020. Thus, while fatalities are still increasing, albeit at a slower rate of increase than in previous years, fewer persons experienced opioid-related overdoses suggesting a higher proportion of reported overdoses are fatal.

The highly potent synthetic opioid fentanyl, which has long supplanted or been added to heroin and other drugs, remains a main cause of both fatal and non-fatal overdoses. The near market saturation of fentanyl in street drugs purported to contain heroin (or in some instances non-opioid street drugs such as cocaine) could underly the pattern of a higher number of fatalities and a decreasing number of non-fatal overdoses. It is not uncommon in Illinois (and elsewhere) for street drugs sold as heroin to contain no heroin at all but to instead consist entirely of fentanyl or a mixture of fentanyl and an ever-growing, ever-evolving list of other constituent drugs intended to either enhance the drug mixture's psychoactive effects or to serve as cheaper substitutes for heroin or fentanyl. Though not as commonly included in non-opioid street drugs, fentanyl has been identified in drugs sold as cocaine or pressed into illegally manufactured pills sold as prescription drugs such as OxyContin®, Percocet®, and Xanax®.[3]

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[1] Illinois Department of Public Health (February 2023). *Statewide semiannual opioid report*. Available at: https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/opioids/idphdata/idph-statewide-semiannual-opioid-report-02-2023.pdf

[2] Butelman,E. R., Huang, Y., Epstein, D. H. et al. (2023). Overdose mortality rates for opioids and stimulant drugs are substantially higher in men than in women: state-level analysis. *Neuropsychopharmacology*. Epub. doi: 10.1038/s41386-023-01601-8

[3] United States Drug Enforcement Administration (undated). *Laboratory testing reveals that 6 out of 10 fentanyl-laced fake prescription pills now contain a potentially lethal dose of fentanyl*. Retrieved from: https://www.dea.gov/alert/dea-laboratory-testing-reveals-6-out-10-fentanyl-laced-fake-prescription-pills-now-contain

An unfortunate recent development has been the increasing presence of the drug xylazine in illegally manufactured opioids. Known by the street name "tranq" or "tranq dope", xylazine's only medically approved use is as a large-animal veterinary tranquilizer. First identified as a factor in drug-related overdoses in Puerto Rico in the early 2000's, xylazine use in street drugs spread first along the east coast, eventually spreading across the U.S. including Illinois.[4] This trend is concerning as xylazine is not an opioid and does not respond to naloxone, the most commonly used drug to reverse opioid-related overdoses. A recent study suggests that xylazine might potentiate and prolong lower brain oxygen levels seen with fentanyl and heroin, thereby reducing the brain's ability to rebound from opioid-induced hypoxia.[5] This effect could underly an increase in overdose-related fatalities owing to respiratory suppression when xylazine is added to street opioids. Additionally, if injected, xylazine causes skin necrosis and ulcerations over time which, in the most severe instances, require amputation following an infection.

Xylazine's main use in street drugs is to increase the relatively short psychoactive duration of fentanyl.[6] For this reason, toxicology surveillance reports have typically found xylazine and fentanyl mixed together in tested samples. A recent Cook County report based on an analysis of substance-related deaths between January 2017 and October 2021 found an increasing presence of xylazine over that time, peaking at 12.1% of fentanyl-related deaths in Cook County in October 2021.[7] Other counties throughout Illinois such as Kane, Lake, Sangamon, St. Clair, and Winnebago have all reported drug overdose deaths involving xylazine as of June 2022.[8]

Owing to these trends, harm reduction advocates have called for increased distribution of xylazine test strips along with fentanyl test strips to provide drug users with the means of detecting these drug's presence in their street drugs. Efforts to distribute xylazine test strips have already begun in Illinois, focused initially in the Chicago area. However, keeping up with which drugs are being sold on the street as opioids or in combination with opioids remains a significant challenge owing to the volatility of the drug supply and markets. For instance, designer benzodiazepines such as bromazolam and meclonazepam have been recently found in drug samples obtained in Maryland and Florida.[9] We expect the profile of drugs involved in opioid-related fatalities and overdoses to continually shift as new designer drugs are manufactured or existing drugs such as xylazine are repurposed and combined into highly potent and shrewdly marketed/branded opioids sold on the street.

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[4] Drug Enforcement Administration (October 2022). *The growing threat of xylazine and its mixture with illicit drugs. DEA Joint Intelligence Report.* Available at: https://www.dea.gov/sites/default/files/2022-12/The%20Growing%20Threat%20of%20Xylazine%20and%20its%20Mixture%20with%20Illicit%20Drugs.pdf

[5] Choi, S., Irwin, M. R., & Kiyatkin, E. A. (2023). Xylazine effects on opioid-induced brain hypoxia. *Psychopharmacology, 240:* 1561-1571. doi: 10.1007/soo123-023-06390-y.

[6] Friedman, J., Montero, F., Bourgois, P. et al. (2022). Xylazine spreads across the US: A growing component of the increasingly synthetic and polysubstance overdose crisis. *Drug and Alcohol Dependence, epub. doi:* 10.1016/j.drugalcdep.2022.109380.

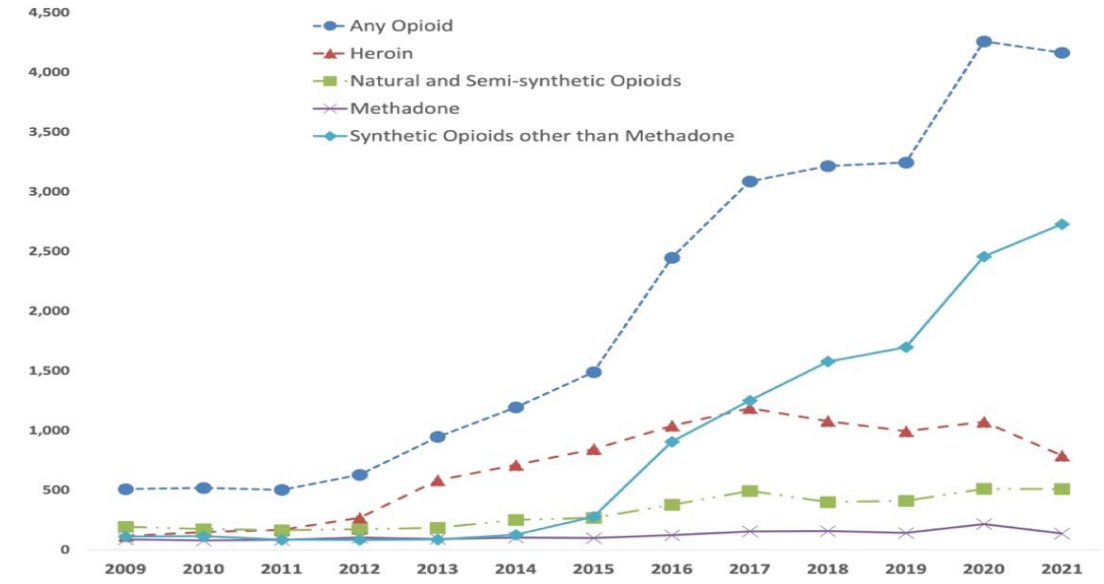
[7] Chhabra, N., Mir, M., Hua, M. J. et al. (April 1, 2022). Notes from the field: Xylazine-related deaths – Cook County, Illinois 2017-2021. *Morbidity and Mortality Weekly Report*, CDC. Available at: https://www.cdc.gov/mmwr/volumes/71/wr/mm7113a3.htm#contribAff

[8] Mason, M. (April 2023). *Fact sheet: Xylazine involvement in fatal drug overdoses data from Illinois Statewide Unintentional Drug Overdose Reporting System* (SUDORS).

[9] Ovalle, D. (April 30, 2023). Artist's death spotlights peril posed by xylazine-fentanyl mix. The Washington Post. Available at: https://www.washingtonpost.com/health/2023/04/30/xylazine-fentanyl-overdose-deaths/

**Opioid Overdoses and Overdose-Related Fatalities.** The majority of overdose-related fatalities in Illinois (and nationally) remain attributable to opioid analgesics, a broad class of drugs that includes natural, semi-synthetic opioids, methadone, and synthetic opioids other than methadone (Figure 1). Concurrently, heroin accounts for an increasingly smaller number of these fatalities. Heroin-related overdose deaths have declined or remained flat as have deaths attributable to natural and semi-synthetic opioids such as morphine and hydrocodone and methadone, while overdose-related deaths owing to synthetic opioids other than methadone – primarily illicitly manufactured fentanyl – have increased sharply between 2019 and 2020 before leveling off in 2021. Factors related to the COVID-19 epidemic in 2020 such as increased isolation and difficulty accessing treatment almost certainly account for some of the increase in fatalities in 2020.

**Figure 1. Number of Overdose-Related Fatalities by Year and Opioid Type: 2009 – 2021**

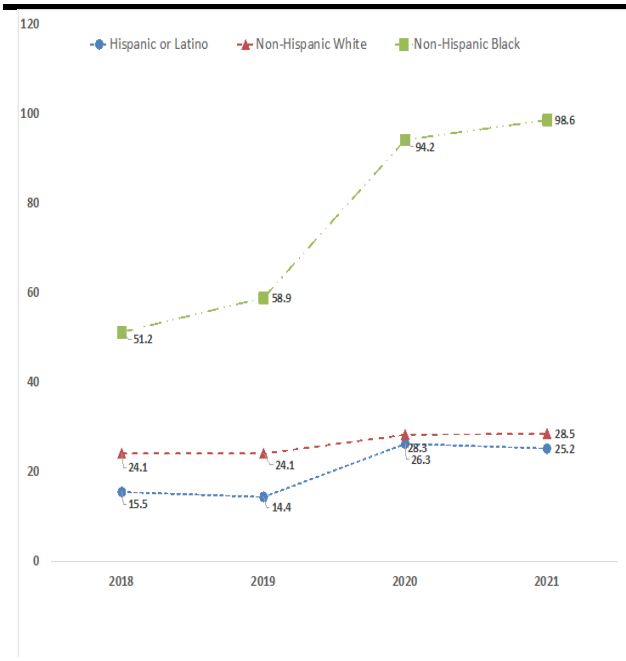



**Note.** Opioid-related fatality data were obtained May 2023 from the CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER). Records with underlying causes of death due to drug-poisoning were selected using ICD-10 codes: X40-X44, X60-X64, X85, and Y10-Y14. Multiple cause of death codes were used to identify a specific drug or drug classes: T40.0-T40.4 and T40.6 (any opioid); T40.1 (heroin); and opioid analgesics composed of T40.2 (natural and semi-synthetic opioids), T40.3 (methadone), and (T40.4) synthetic opioids other than methadone. Natural and semi-synthetic opioids include morphine, oxycodone, codeine, and hydrocodone. Synthetic opioids other than methadone include fentanyl and analog drugs as well as tramadol. Trend lines shown reflect the annual number of opioid overdose-related fatalities.

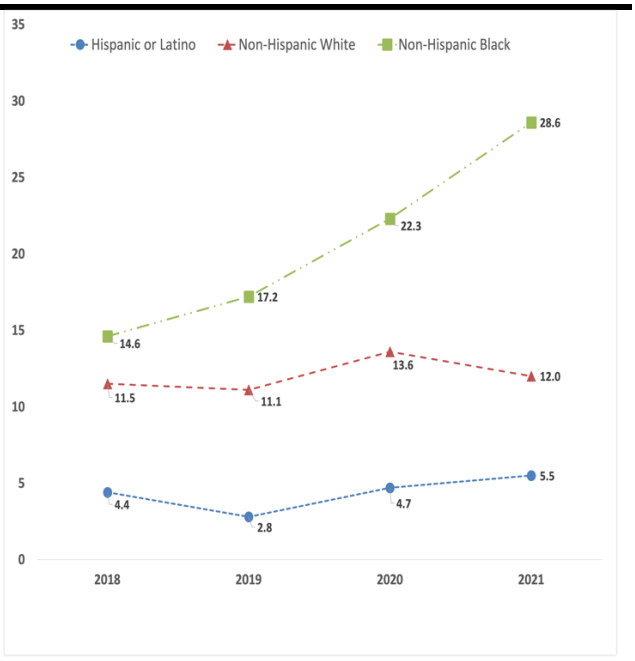
As shown in Figure 2, the increase in opioid overdose-related fatalities between 2018 and 2021 has not been born equally by race-ethnicity or gender. Non-Hispanic Black men and, to a lesser extent, non-Hispanic Black women had, by far, the largest increases in the age-adjusted rates of opioid overdose-related fatalities. The age-adjusted opioid-related fatality rate per 100,000 population increased from

**Figure 2. Age Adjusted Rates of Opioid Overdose-Related Fatalities by Gender, Race-Ethnicity and Year: 2018 – 2021**

**Males**




**Females**




**Note.** Opioid-related fatality data were obtained May 2023 from the CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER) data system. Records with underlying causes of death due to drug-poisoning were selected using ICD-10 codes: X40-X44, X60-X64, X85, and Y10-Y14. Multiple cause of death codes were used to identify a specific drug or drug classes: T40.0-T40.4 and T40.6 (any opioid); T40.1 (heroin); and opioid analgesics composed of T40.2 (natural and semi-synthetic opioids), T40.3 (methadone), and (T40.4) synthetic opioids other than methadone. Natural and semi-synthetic opioids include morphine, oxycodone, codeine, and hydrocodone. Synthetic opioids other than methadone include fentanyl and analog drugs as well as tramadol. Figures shown are age-adjusted rates per 100,000 population.

58.9 per 100,000 in 2018 to 94.2 in 2019 for non-Hispanic Black men and from 17.2 per 100,000 to 22.3 per 100,000 for non-Hispanic Black women. In contrast, there were only slight increases for Hispanic or Latino and White men and women over this same time period. The age-adjusted fatality rates for non-Hispanic Black men and women have remained elevated through 2021 with the rate for non-Hispanic Black women showing a substantial increase from 22.3 to 28.6 per 100,000 population.

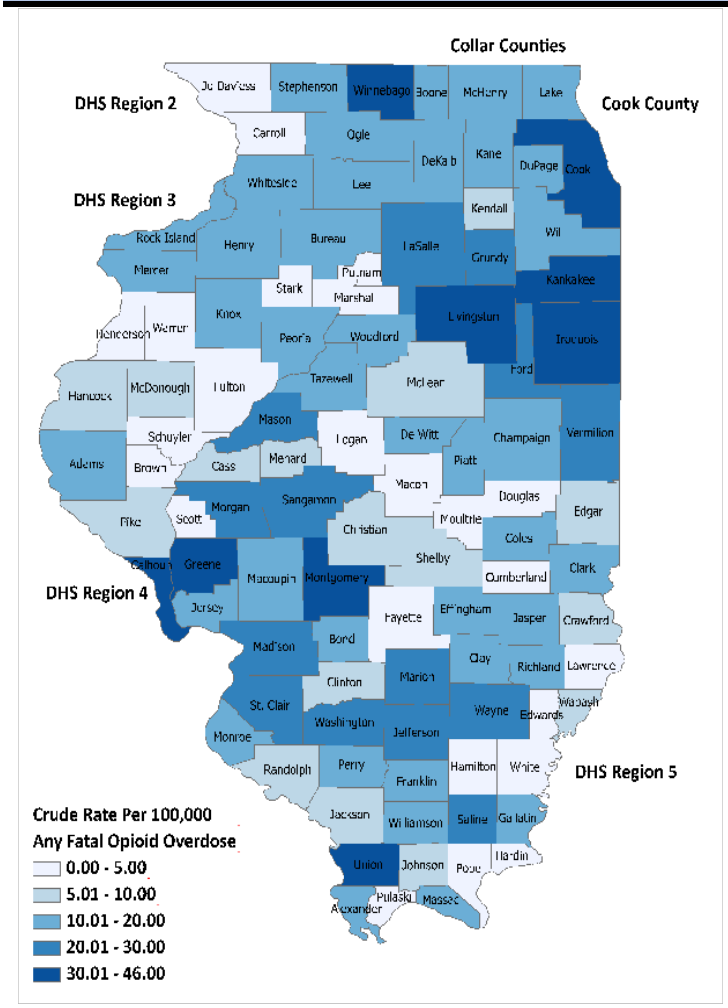
**Table 1. Illinois Counties with the Highest Overdose-Related Fatality Rates in 2021 by Population Size and Opioid Type**

| | | |
|---|---|---|
| **Population >= 100,000** | | |
| **Any Opioid** | **Heroin** | **Synthetic Opioids** |
| Winnebago (42.7) | Cook (9.9) | Winnebago (39.6) |
| Cook (31.7) | LaSalle (9.1) | Kankakee (31.5) |
| Kankakee (31.4) | Rock Island (5.5) | Cook (28.7) |
| Madison (28.9) | Kankakee (4.6) | Madison (27.4) |
| LaSalle (27.3) | McHenry (4.2) | St. Clair (25.9) |
| **Population >= 50,000 < 100,000** | | |
| **Any Opioid** | **Heroin** | **Synthetic Opioids** |
| Vermillion (25.3) | Grundy (9.5) | Vermillion (21.3) |
| Grundy (21.0) | Vermillion (5.3) | Grundy (19.1) |
| Knox (15.9) | Knox (4.0) | Knox (13.9) |
| Ogle (13.5) | Williamson (1.5) | Boone (11.2) |
| Williamson (3.4) | | Ogle (9.7) |
| **Population < 50,000** | | |
| **Any Opioid** | **Heroin** | **Synthetic Opioids** |
| Calhoun (44.1) | Mason (15.1) | Calhoun (44.1) |
| Green (41.0) | Livingston (8.4) | Montgomery (31.6) |
| Livingston (36.2) | Greene (8.2) | Iroquois (29.2) |
| Union (34.8) | Ford (7.4) | Livingston (25.1) |
| Iroquois (32.9). | Clark (6.4) | Greene (24.6) |

**Note.** Opioid-related fatality data were obtained May 2023 from the CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER). Records with underlying causes of death due to drug-poisoning were selected using ICD-10 codes: X40-X44, X60-X64, X85, and Y10-Y14. Multiple cause of death codes were used to identify a specific drug or drug classes: T40.0-T40.4 and T40.6 (any opioid); T40.1 (heroin); and (T40.4) synthetic opioids other than methadone. Synthetic opioids other than methadone include fentanyl and analog drugs as well as tramadol. Figures shown are crude rates per 100,000 population.

The Illinois opioid epidemic continues to affect communities and individuals throughout the state. However, whereas heroin fatalities are more concentrated in the northern part of Illinois, especially prevalent in Cook and several surrounding collar counties, fatalities owing to synthetic opioids have a wider dispersion across many counties and affect the southern and more rural parts of the state as well as the more populous central and northern counties. The five sets of counties with the highest 2021 fatality rates for any opioid, heroin, and synthetic opioids are shown in Table 1. Counties are separated by population size into 3 groups: counties with greater than 100,000 residents; counties with 50,000 to 100,000 residents; and counties with less than 50,000 residents. Figures 3 and 4 show the 2021 opioid overdose fatality rates per 100,000 population 18 or older for all 102 Illinois counties for any opioid, for heroin, and for synthetic opioids, chiefly fentanyl.

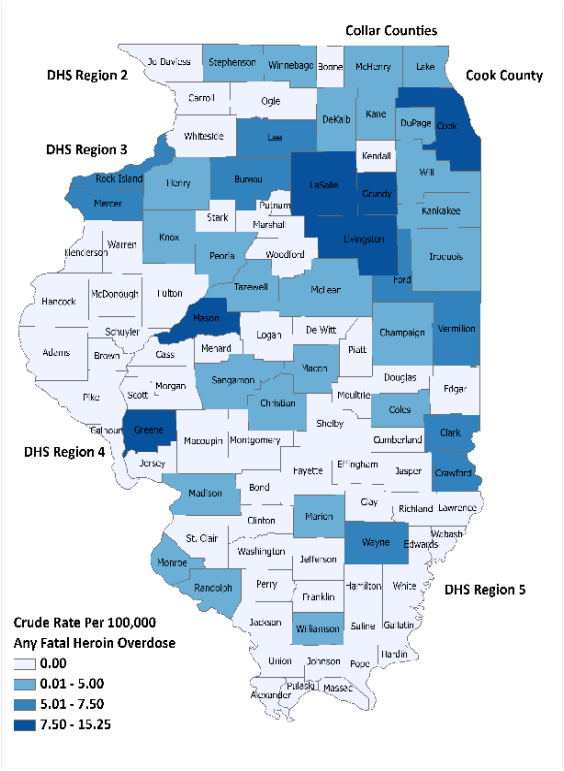
**Figure 3. Rates of Overdose-Related Fatalities in 2021 by County: Any Opioid**



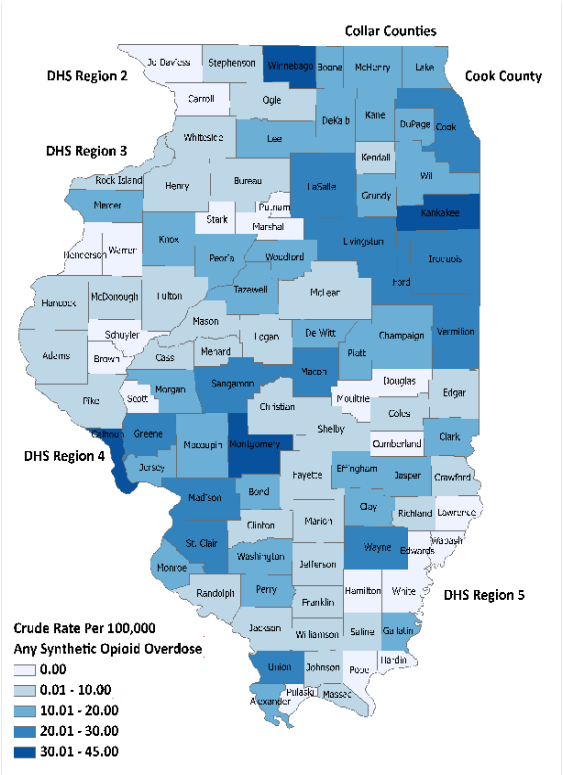

**Note.** Opioid overdose-related fatality data provided by the IDPH Division of Health Data and Policy and reflect fatalities related to use of any opioid including prescription analgesics, heroin, or synthetic opioids, chiefly fentanyl.

**Figure 4. Rates of Overdose-Related Fatalities in 2021 by County: Heroin and Synthetic Opioids**

Heroin Overdose-Related Fatalities




Synthetic Opioid Overdose-Related Fatalities




**Note.** Opioid overdose-related fatality data provided by the IDPH Division of Health Data and Policy and reflect fatalities related to use of heroin, or synthetic opioids, chiefly fentanyl. Fatality rates per 100,000 are based on the number of opioid overdose-related fatalities within a given county, divided by that county's adult population 18 years of age or older per 2021 American Community Survey estimates. Category thresholds vary by drug owing to different fatality rates. Accordingly, comparisons across drug classes are only intended to show where overdose fatalities for a given opioid are more or less common.

**Opioid Use and Misuse.** Use of heroin, more often than not mixed with or completely substituted for by fentanyl and other substances such as xylazine as noted in the overview section, remained relatively stable per the most recent data (2021) available from the National Survey on Drug Use and Health. However, this stability means that large numbers of Illinoisan's continue to report heroin use/misuse or prescription pain reliever use/misuse. In 2021, an estimated 61,000 (95% CI = 25,000 – 144,000) Illinois residents 18 years of age or older reported any heroin use during the past year. A much larger number of Illinois residents (304,000, 95%CI = 227,000 – 406,000) reported misusing (i.e., using without a prescription or using more than prescribed) prescription pain relievers in the past year. Beyond use or misuse, 210,000 (95% CI = 147,00 – 298,000) met DSM-5 criteria for an opioid use disorder (OUD), inclusive of heroin and/or pain relievers.[10]

[10] *Substance Abuse and Mental Health Services Administration (March 2023). 2021 National Survey on Drug Use and Health: Model-based estimated totals (in thousands) (50 states and the District of Columbia.* Available at:

**Naloxone Distribution and Administrations.** In response to the then increasing problem of opioid overdose-related fatalities among state residents, Illinois Public Act 096-0361 took effect in 2010. This act made it legal in Illinois for non-medical persons to administer the drug overdose reversal medication naloxone to another individual to prevent an opioid/heroin overdose from becoming fatal. In 2012, the Illinois Public Act 097-0687 *Good Samaritan Law* ensured that the individual providing emergency medical assistance and the person experiencing the overdose are not charged or prosecuted for felony possession (within specified limitations).

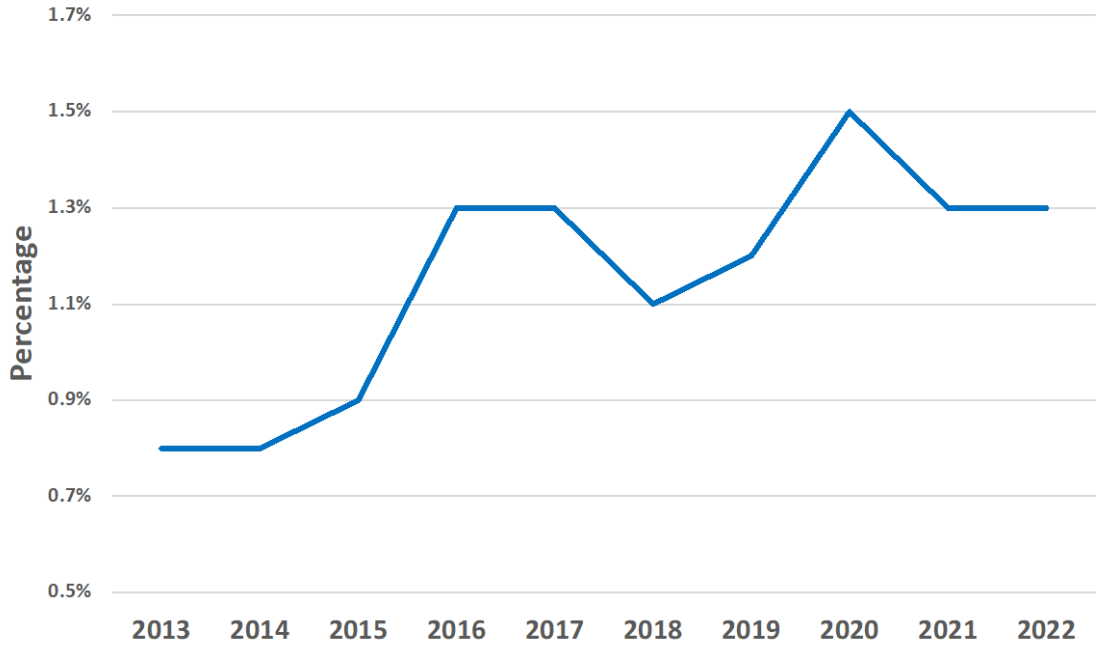
As a result of this law, IDHS/SUPR established its **Drug Overdose Prevention Program (DOPP)**. Through this program, IDHS/SUPR provides: 1) training for 'Enrolled Programs' that then train multiple sites within their communities to administer naloxone and 2) assistance with access to naloxone, including actual distribution of the medicine, but also training regarding additional paths to access naloxone. In 2021, IDHS/SUPR launched its Access Narcan project. Enrollment in the division's DOPP automatically registers organizations into the Access Narcan project. Through the Access Narcan project, organizations enrolled in DOPP can order Narcan directly funded by the state . Organizations enroll in DOPP on the SUPR website at https://www.dhs.state.il.us/page.aspx?item=58142. As of June 2022, 314 organizations, hospitals and clinics have enrolled in the program. 131, 508 Narcan 2 dose boxes have been successfully distributed to heroin and other opioid users, their families, and friends, and first responders including law enforcement, non-profit agencies, hospitals, treatment facilities, and public health departments in Illinois

Local governments and organizations voluntarily provide information regarding naloxone training and education activities, naloxone administrations, and overdose reversals back to DOPP. In state fiscal year (SFY) 2022, IDHS/SUPR programs. trained 32,452 individuals throughout the state. As a result of these efforts, 3,212 opioid overdoses were reversed. In addition, since SFY14, a total of 64,799 first responders have been trained and 9,030 overdose reversals have been reported to DHS.

IDPH collects data on naloxone administrations provided as part of emergency medical service (EMS) runs or "events" by fire department, private, governmental non-fire or hospital-based ambulance services. Following a peak in 2020, when 1.5% of all EMS runs involved naloxone administration to reduce an opioid-related overdose, 2021 and 2022 saw a reduction to 1.3% of EMS where naloxone was administered (Figure 5).

https://www.samhsa.gov/data/sites/default/files/reports/rpt39466/2021NSDUHsaeTotals121522/2021NSDUHsaeTotals121522.pdf

**Figure 5. Percentage of EMS Runs Involving Naloxone Administration by Year**




**Note.** Estimates of the percentages of EMS events involving naloxone administration are based on the EMS data set maintained by the IDPH Division of EMS and Highway Safety. Data provided May, 2023.

As in past reports, we examined the amount of naloxone administered to reverse an overdose per EMS run. The trend since 2013 has been for higher dosages of naloxone administered, attributable to the increased presence and high potency of fentanyl.[11,12] Table 2 shows that the trend towards providing higher dosages of naloxone to reverse an overdose leveled off in 2021 and 2022. Comparable to 2020,

[11] Moss, R. B., & Decarlo, D. J. (2019). Higher doses of naloxone are needed in the synthetic opioid era. *Substance Abuse Treatment, Prevention, and Policy. 14*(1), epub. doi: 10.1186/s13011-019-0195-4

[12] Whether or not greater amounts of naloxone are necessary to reverse the overdose effects of the higher potency synthetic opioids is not firmly established. There are some contradictory reports suggesting no better outcomes with higher naloxone dosages in the presence of a fentanyl-related overdose (e.g., Bell, A. et al. (2019). Amount of naloxone used to reverse opioid overdoses outside of medical practice in a city with increasing illicitly manufactured fentanyl in illicit drug supply, *Substance Abuse, 40*(1), 52-55.) However, it certainly seems to be the case in Illinois and elsewhere that EMS techs as well as other first responders and bystanders are using multiple dosages of naloxone on average, to reverse opioid-related overdoses, a trend coincident with the increasing presence of fentanyl and other synthetic opioids (c.f., Abdelal, R., Banerjee, A. R., Carlberg-Racich, S., Darwaza, N., Ito, D., & Epstein, J. (2022). The need for multiple naloxone administrations for opioid overdose reversals: A review of the literature. *Subst Abus*, *43*(1), 774-784.)

about 5.0% of all EMS runs where naloxone was administered required a dosage in the range of 4.1 – 6.0 mg, with about 3.0% requiring administration of more than 6.0 mg to achieve a reversal.

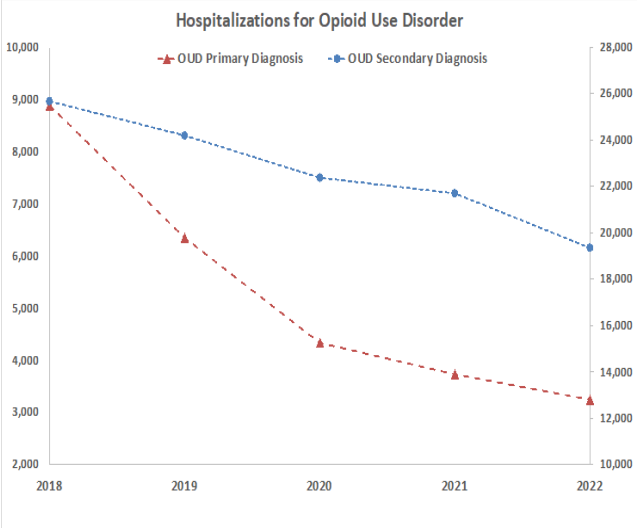
**Table 2. Number of Naloxone Dosages per EMS Event where Naloxone was Administered: 2013-2022**

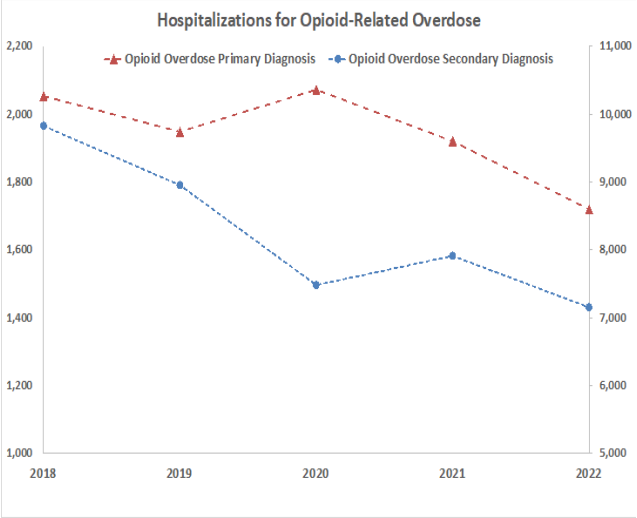
| | Dosage Administered (in milligrams) | | | |
|---|---|---|---|---|
| **Year** | **0.2 – 2.0** | **2.1 – 4.0** | **4.1 – 6.0** | **> 6.0** |
| **2013** | 88.6% | 9.9% | 1.3% | 0.2% |
| **2014** | 87.3% | 10.9% | 1.4% | 0.4% |
| **2015** | 85.5% | 12.2% | 1.9% | 0.4% |
| **2016** | 80.1% | 16.3% | 2.8% | 0.7% |
| **2017** | 76.1% | 19.0% | 3.6% | 1.3% |
| **2018** | 74.3% | 19.6% | 4.2% | 1.9% |
| **2019** | 70.9% | 21.5% | 5.0% | 2.6% |
| **2020** | 71.0% | 21.3% | 5.0% | 2.8% |
| **2021** | 69.8% | 21.7% | 5.1% | 3.3% |
| **2022** | 70.9% | 21.2% | 4.9% | 2.9% |
| **Percent Change 2013-2022** | -20.0% | 114.1% | 276.9% | 1350.0% |
| **Percent Change 2021-2022** | 1.6% | -2.3% | -3.9% | -12.1% |

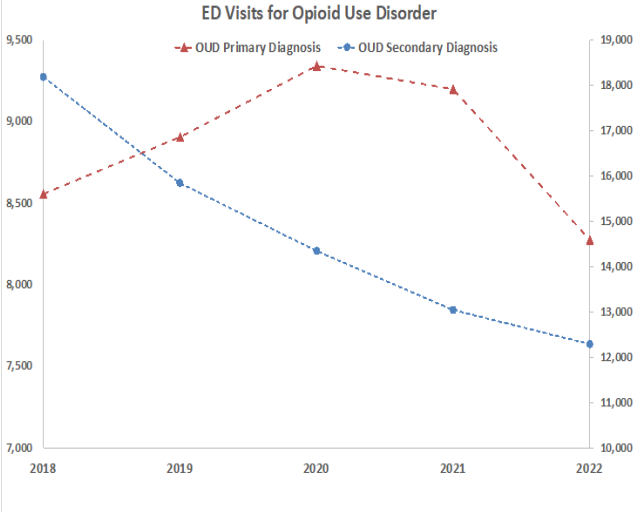
**Note.** Estimates of the percentage of EMS events involving naloxone administration as well as naloxone dosages per reported EMS event are based on the EMS data set maintained by the IDPH Division of EMS and Highway Safety and were obtained May 2023.

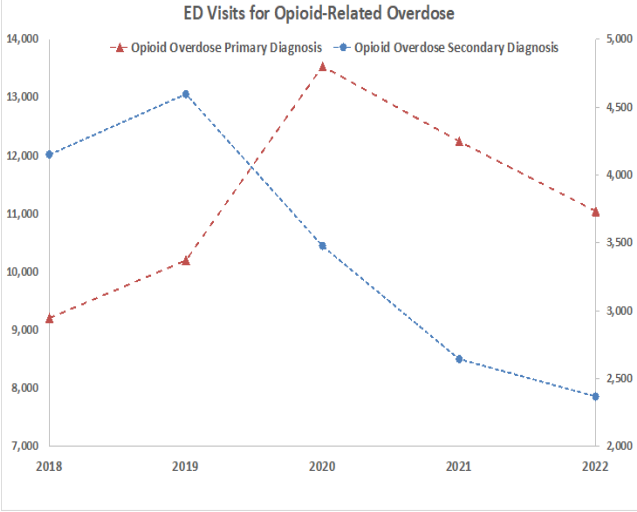
**Opioid-Related Hospital Admissions and Emergency Department (ED) Visits.** Data reported in this section are based on analyses of Illinois hospitalizations and ED visits related to opioid use/misuse or an opioid-related overdose between 2018 and 2022. Hospitalization and ED discharge data were provided by the Illinois Department of Public Health,

**Figure 6. Hospitalizations and ED Visits for an Opioid Use Disorder or Opioid-Related Overdose by Year: 2018 – 2022**



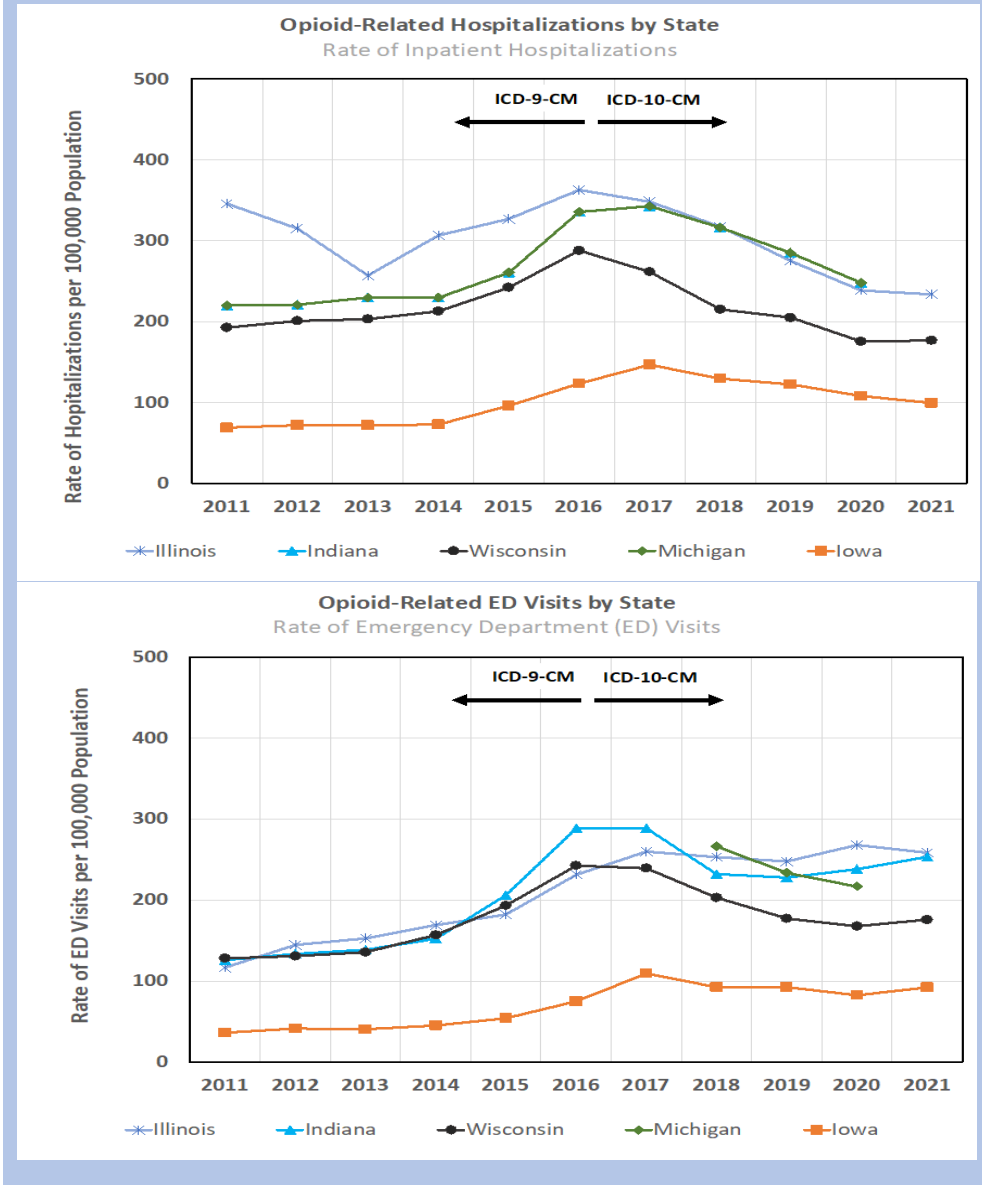

**Note.** Opioid-related hospitalizations and ED visits were obtained May 2023 from the Illinois Department of Public Health, Division of Patient Safety and Quality. Opioid use disorders and overdoses were determined from the admitting diagnosis for the hospitalization data and the reason for admission diagnosis for the ED data. Diagnosis codes for opioid use disorder included ICD-10 "F11" codes for opioid abuse or dependence. Visits or admissions due to drug-poisoning (i.e., an overdose) were selected using ICD-10 codes: T40.0-T40.4 and T40.6 (any opioid); T40.1 (heroin); and opioid analgesics composed of T40.2 (natural and semi-synthetic opioids), T40.3 (methadone), and (T40.4) synthetic opioids other than methadone. Figures shown represent number of visits or admissions and could reflect duplicate patients.

Division of Patient Safety and Quality. We also used Illinois data obtained from the state inpatient database maintained by the Agency for Healthcare Research and Quality (AHRQ) as part of their Healthcare Cost and Utilization Project (HCUP). The HCUP data allowed examination of trends over a

longer timeline (2011 to 2021) disaggregated for ED “treat-and-release” visits and opioid-related hospital inpatient stays. We examined the HCUP data for trends in ED visits and hospitalizations by sex, age-group, community-level income, and location category based on population size.

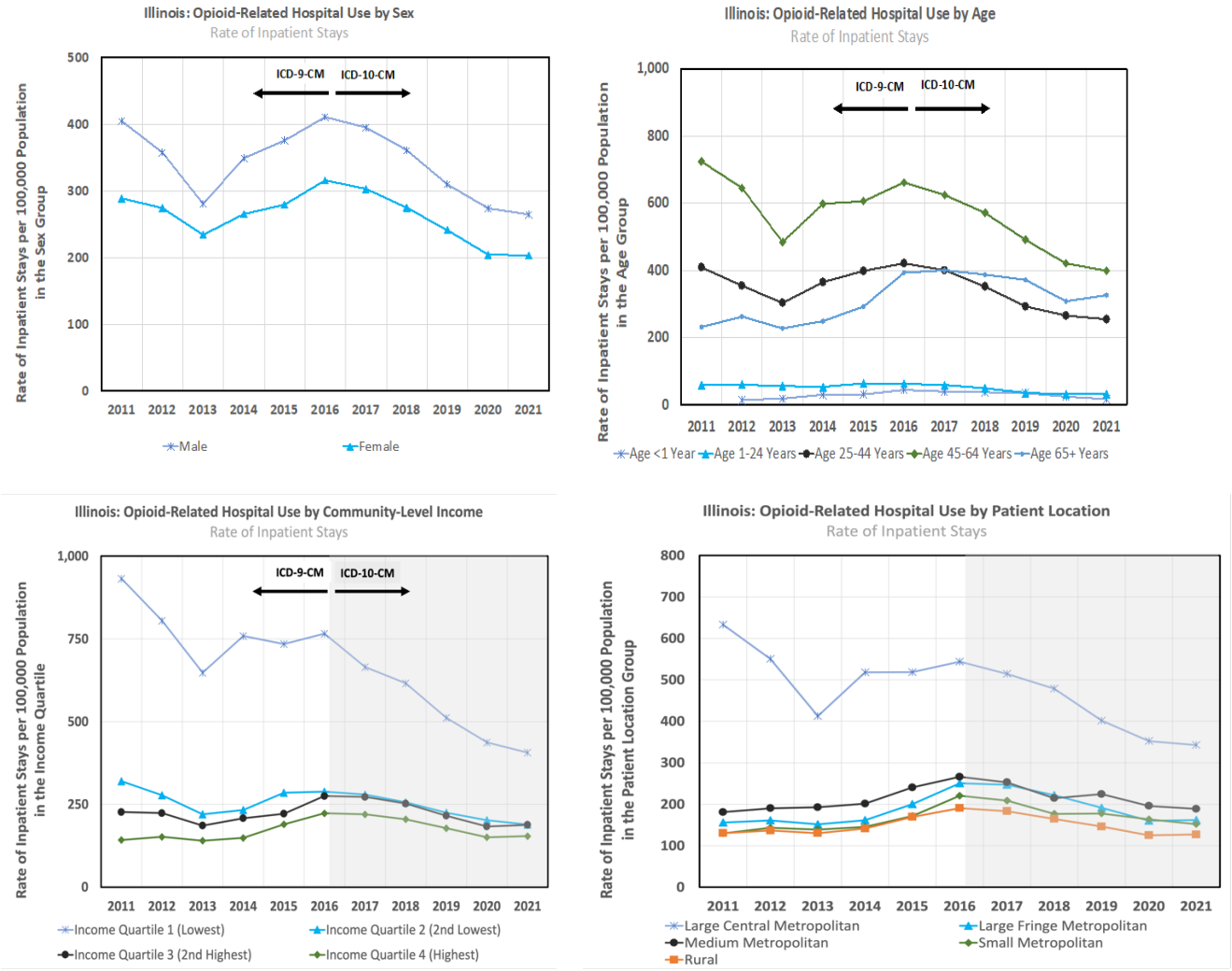
Figure 6 shows that for hospitalizations, when whether an OUD was the primary or secondary admitting diagnosis, admissions peaked in 2020, the first year of the COVID pandemic, ad have been showing a decreasing trend over the past few years. We see a relatively similar though more erratic downward trend in ED visits over the same time period. Comparisons of opioid-related hospitalizations and ED visits for either an OUD or an opioid-related overdose for Illinois and contiguous surrounding Midwest states – Indiana, Michigan, Wisconsin, and Iowa – shows that Illinois has tended to have higher admission and visit rates for each from 2011 through 2021 even with the decrease in hospitalization rates over that time span.

**Figure 7. Comparison of Opioid-Related Hospitalization and ED Visit Rates for Illinois and Contiguous Midwest States**



`**Note.** Data for emergency department (ED) visits and hospital stays were obtained from the national state inpatient databases maintained by the Agency for Healthcare Research and Quality (AHRQ) as part of their Healthcare Costs and Utilization Project (HCUP). Emergency department visits are defined as ED encounters that do not result in hospital admission to the same hospital (i.e., "treat and release").

**Figure 8. Opioid-Related Hospitalizations by Sex, Age Group, Community-Level Income, and Location**



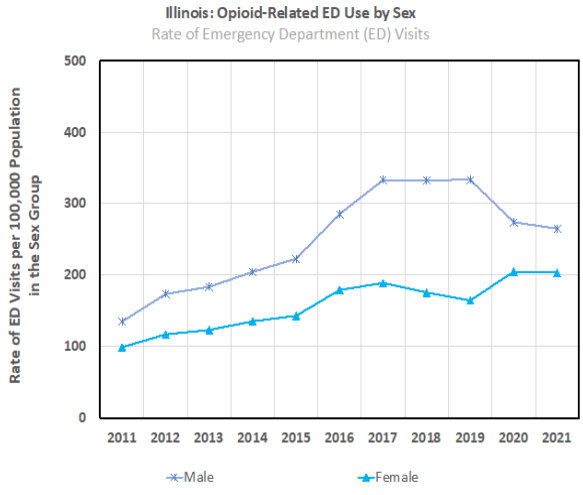

**Note.** Data for hospital stays were obtained from the national state inpatient databases maintained by the Agency for Healthcare Research and Quality (AHRQ) as part of their Healthcare Costs and Utilization Project (HCUP). Hospital stays are based on diagnostic data provided at discharge. More specifics on the ICD

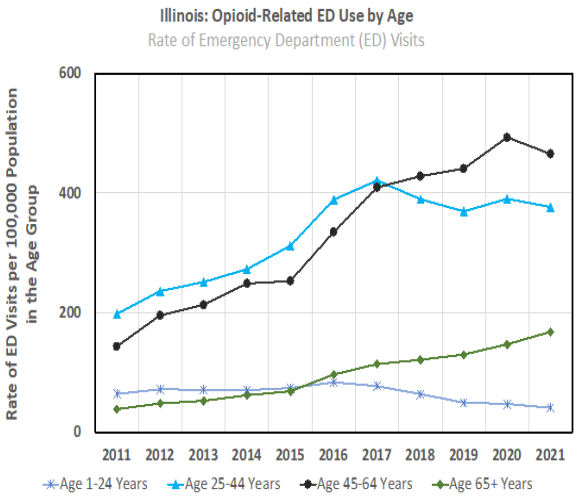
diagnostic codes used and other methodological details such as definitions of locations and income quartiles are available on the HCUP web site: www.hcup-us.ahrq.gov/sidoverview.jsp.

The next two sets of graphs (Figures 8 and 9) show trends for ED "treat-and-release" visits and hospitalization rates respectively by selected socio-demographic factors available in the HCUP data set.[13] While reflecting the downward trends seen for hospitalizations overall as just reported, disaggregation by demographics shows that the persons most likely to be hospitalized remain consistent with those previously reported on: males, persons 45-64, those in the lowest income quartile, and those living in large central metropolitan area had the highest rates of admissions.

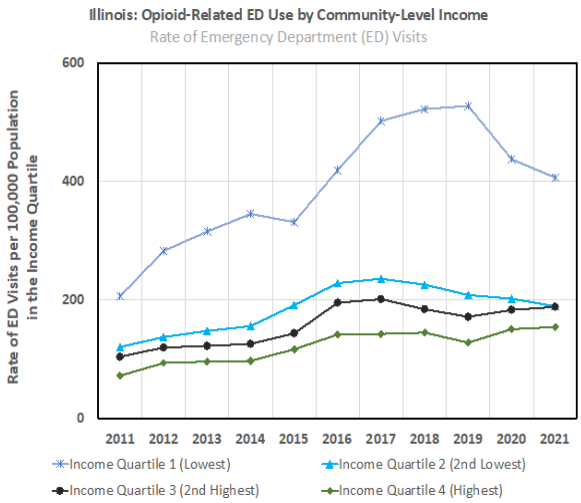
The ED visit data are consistent with the hospitalization data in that they also show males, persons with the lowest income levels, and those living in the largest metropolitan areas of the state are most likely to be admitted to a hospital for treatment related to opioid use. However, there are several important divergences worth noting: First, the rate of hospital inpatient stays appears to have trended down since 2015 and not up as with the ED treat-and-release rates though the increase in ED rates appears to have flattened and remained steady in 2021 compared with 2020.

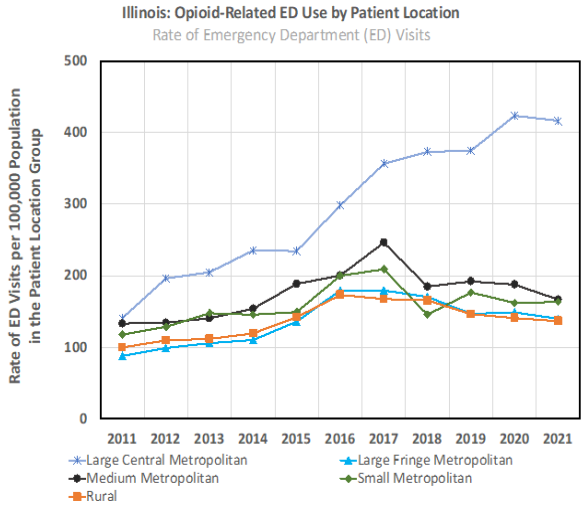
**Figure 9. Opioid-Related ED Visits by Sex, Age Group, Community-Level Income, and Location**




[13] Treat and release is a term used in association with the HCUP ED data and indicates a person was treating for some condition or conditions but was not subsequently hospitalized.




**Note.** Data for emergency department (ED) visits were obtained from the national state inpatient databases maintained by the Agency for Healthcare Research and Quality (AHRQ) as part of their Healthcare Costs and Utilization Project (HCUP). Emergency department visits are defined as ED encounters that do not result in hospital admission to the same hospital (i.e., "treat and release"). More specifics on the ICD diagnostic codes used and other methodological details such as definitions of locations and income quartiles are available on the HCUP web site: www.hcup-us.ahrq.gov/sidoverview.jsp.

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We again note that the data suggest that while more persons are admitted to the ED for opioid misuse, fewer are being admitted for an inpatient stay. And second, while persons 45 to 64 years old have the highest inpatient admission rate as they do for ED admissions, persons 25 to 44 years old are not admitted to the hospital at a comparable rate while those 65 and older are admitted at a rate comparable to 25 to 44 years old but still less than those in the 45- to 64-year-old age group. Factors driving these differences in hospital inpatient and ED admission trends and age group differences require further analysis and study but the consistencies outweigh these differences and suggest a target demographic for state efforts to reduce the consequences of the ongoing opioid epidemic.

**Neonatal Abstinence Syndrome**. Neonatal Abstinence Syndrome (NAS) refers to a constellation of symptoms present in newborns whose mother's used drugs during pregnancy. The drugs most associated with NAS are alcohol, tobacco, cannabis, stimulants, and opioids.[14] Opioid use during pregnancy is not uncommon. In 2020, approximately 6% of pregnant women reporting prescription opioid use, of whom about 20% reported opioid misuse.[15] Neonatal opioid withdrawal syndrome (NOWS) is a subset of NAS and refers specifically to the symptoms that occur within the first 28 days of life in infants exposed to opioids *in utero.* Symptoms include: tremors, irritability, sleep disturbances, hyperactive reflexes, seizers, yawning, sneezing, vomiting, and increased sweating. Health consequences

[14] Barry, J. M., Birnbaum, A. K., Jasin, L. R., & Sherwin, C. M. (2021). Maternal exposure and neonatal effects of drugs of abuse. *The Journal of Clinical Pharmacology, 6*(52), I42-I55. 10.1002/jcph.1928

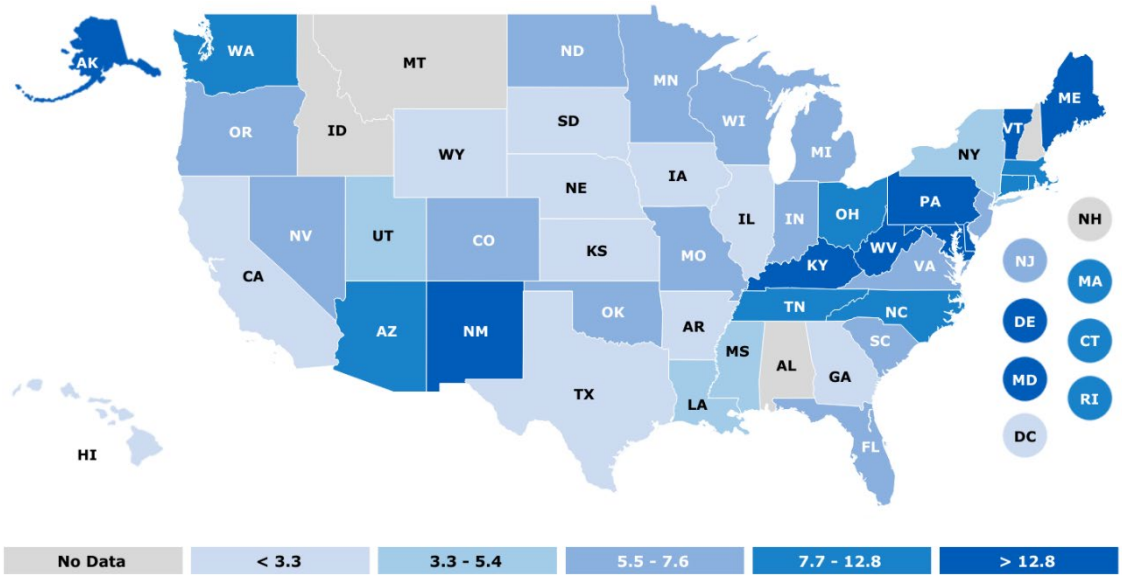
[15] Centers for Disease Control and Prevention. About opioid use during pregnancy. https://www.cdc.gov/pregnancy/opioids/basics.html. Published 2020. Accessed December 1, 2021.

can include preterm birth, poor fetal growth, birth defects, and rehospitalization or longer hospital stays. Longer term effects such as developmental delays or speech/language impairment are suspected but a clear causal relationship has not been established.

As shown in the national map below, Illinois has fortunately continued to have one of the lowest rates of NAS compared with other states. The 2020 rate of NAS – inclusive of all births affected by maternal substance use of a range of drugs not just opioids – was 2.3 cases per 1,000 newborn hospitalizations whereas the national average was 6.3 per 1,000 newborn hospitalizations.

**Figure 10. Rate of NAS per 1,000 Newborn Hospitalizations in 2020**

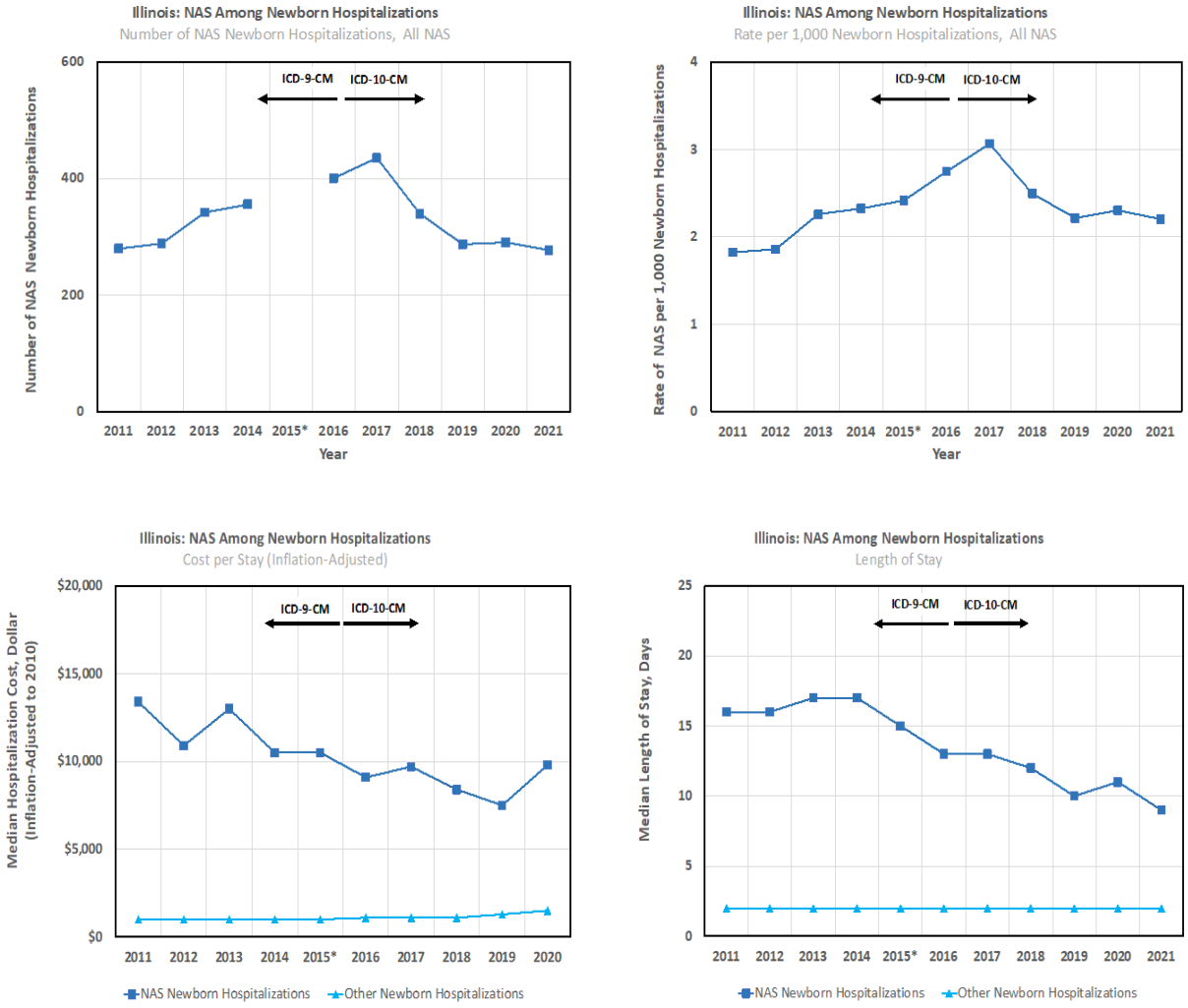
**National Rate: 6.3 - Illinois Rate: 2.3**




**Note.** Map obtained online from https://datatools.ahrq.gov/hcup-fast-stats. Retrieved May 19, 2023.

The next set of charts shown in Figure 11 provide more detailed NAS trend data for Illinois between 2011 and 2021. NAS numbers and rates in Illinois showed the largest declines from a peak year of 2017 through 2019 and have remained stable in 2020 and 2021. The lower set of charts compare the average costs and length of stay in days per NAS newborn hospitalizations. Length-of-stay continues to move gradually downward whereas the costs of hospitalization increased from 2020 to 2021. Both the costs and length-of-stay associated with NAS hospitalizations remain substantially higher than when NAS is not present at birth.

**Figure 11. Neonatal Abstinence Syndrome Among Newborn Hospitalizations: Count, Rate, Inflation-Adjusted Costs, Length-of-Stay**




**Note.** Data for newborn hospitalizations were obtained from the national state inpatient databases maintained by the Agency for Healthcare Research and Quality (AHRQ) as part of their Healthcare Costs and Utilization Project (HCUP). The median cost per stay is inflation adjusted using price indexes for the Gross Domestic Product (GDP) from the U.S. Department of Commerce Bureau of Economic Analysis (BEA). More specifics on the ICD diagnostic codes used and other methodological details are available on the HCUP web site: www.hcup-us.ahrq.gov/sidoverview.jsp.

**Opioid Use Treatment.** According to the most recently available Treatment Episode Data Set (TEDS), there were 36,199 admissions to DHS-funded substance use disorder treatment in 2020. Of these, 11,024 admissions (30.4%) were for an opioid use disorder (OUD). A large majority of persons admitted

for an OUD, 9,553 (86.6%), reported heroin as their primary drug with 1,441 (13.3%) reporting “other opioids” as their primary drug class. Persons admitted to publicly funded treatment for opioid misuse were significantly older with a higher proportion (29.3%) 50 years of age or older compared with persons admitted for other types of substance use disorders (17.7%). Persons admitted for opioid misuse were also more likely to be female (36.7% vs 31.6%), to indicate they inhaled (48.4% vs. 5.4%) or injected (30.5% vs. 4.2%) their primary drug, and to report daily use (66.8% vs. 35.0%). Persons admitted for an OUD were also more likely (60.5% vs. 37.7%) to be self-referred to treatment whereas those admitted for another SUD were more likely (45.6% vs. 20.5%) to have been referred by the courts or the criminal justice system. Among those admitted for an OUD, 1,304 (10.0%) were admitted to ASAM level I, outpatient methadone treatment (OMT).

We also examined Illinois Medicaid data for adults ages 18 to 64 insured under a Medicaid managed care plan during 2018, as part of a project to assess the prevalence of OUD and misuse of prescription opioid analgesics among Illinois Medicaid beneficiaries. We obtained estimates for OUD prevalence from Medicaid claims data and other sources such as the National Survey on Drug Use and Health that ranged from 1.9% to 3.0%. Table 3 shows the data sources and estimated OUD prevalence for each.

The obtained percentages translate to 23,323 to 33,515 Illinois Medicaid managed care beneficiaries, 18 to 64 years of age, having an OUD per ICD-10 or DSM-5 diagnostic criteria. At the low end of the estimated prevalence rate (1.9%), the proportion of persons with an OUD insured through Medicaid is about 4 times higher than the state’s general population rate, which the NSDUH restricted data set places at 0.5%, and 6 times higher at the upper estimate (3.0%).

**Table 3. Estimated OUD Prevalence Rates for Illinois Adult Medicaid Managed Care Beneficiaries by Data Source**

| Data Source | Prevalence Estimate | Notes |
|---|---|---|
| Medicaid Claims Data—National<br><br>SUPPORT Annual Report to Congress algorithm | 2.1% (N = 23,323) Illinois 2018 Medicaid claims data, TAF files. Algorithm | 2.1% (N = 23,323) Illinois 2018 Medicaid claims data, TAF files. Algorithm |
| Medicaid Claims Data—Medicaid<br><br>Outcomes Distributed Research Network (MODRN) simplified algorithm | 3.0% (N = 33,515) | Illinois 2018 Medicaid claims data, TAF files. Algorithm derived from MODRN analysis of data from 11 states; OUD determined by ICD-10 diagnosis in inpatient or other services records. |
| Medicaid Claims Data including those likely to have an OUD | 2.3% (N = 25,373) | Based on logistic regression modeling of the predicted probability of an OUD > .50 among those undetected/untreated for an OUD per claims data. |
| NSDUH Restricted Data Set—OUD only | 1.9% (N = 31,000) | Illinois subsample from the 2019–2020 national<br><br>survey; sample includes all participants ages 12+, potentially biasing the estimate downwards; the<br><br>data also include fee-for-service as well as managed care Medicaid beneficiaries. |

**Note.** These analyses were originally conducted for the Illinois Department of Healthcare and Family Services with funding through a grant from the Centers for Medicare and Medicaid Services to IDHFS. Details on methods and other project findings are available in the full report: Swartz, J. A., Franceschini, D., Scamperle, K., Waples, J., & Kim, Y. (October 2022). *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) enrolled in Illinois Medicaid managed care - final project report.*

Illinois Medicaid managed care beneficiaries with and without an OUD were compared on demographics and co-occurring substance use and mental health disorders, as well as any type of substance use disorder treatment received in the past year, including medication assisted recover (MAR). These results are presented in Table 4. Compared to Illinois Medicaid beneficiaries not identified as having an OUD, those with an OUD were more likely to be male, non-Hispanic White or non-Hispanic Black, and older—with a mean age of 44 compared to 39 years of age. Among the more striking findings were the rates of co-occurring substance use and mental health disorders among beneficiaries with an OUD. Over half had at least one co- occurring substance use disorder, with alcohol use disorder being most common (excluding tobacco use disorder). Over half had a co-occurring mental health disorder, with anxiety and depression being the most common classes of disorders. Those with an OUD were also more likely to have elevated symptoms of severe psychological distress indicative of a serious mental illness. The rate of serious mental illness with at least moderate functional impairment was 6 to 10 times higher for beneficiaries with an OUD compared with the Illinois general population rate, and 4 times higher compared with beneficiaries not detected as having an OUD.

**Table 4. Co-occurring Substance Use and Mental Health Disorders by Opioid Use Disorder (OUD) Status for Adult Illinois Medicaid Managed Care Beneficiaries**

| | No OUD (N = 1,079,156) | OUD (N = 23,323) | Total (N = 1,102,479) | Sig | Cramer's V |
|---|---|---|---|---|---|
| **Substance Use Disorders** | | | | | |
| Alcohol | 1.9 %/(sd) | 18.7 %/(sd) | 2.3 %/(sd) | *** | 0.16 |
| Cannabis | 1.3 | 11.7 | 1.5 | *** | 0.12 |
| Cocaine | 0.5 | 15.7 | 0.8 | *** | 0.24 |
| Other Stimulants | 0.2 | 3.7 | 0.3 | *** | 0.09 |
| Sedatives | 0.1 | 4.0 | 0.2 | *** | 0.14 |
| Tobacco | 5.6 | 40.4 | 6.4 | *** | 0.20 |
| Hallucinorgens | 0.1 | 0.9 | 0.1 | *** | 0.05 |
| Inhalants | 0.0 | 0.1 | 0.0 | *** | 0.01 |
| Other | 0.5 | 16.0 | 0.8 | *** | 0.25 |
| Number of Co-occurring SUDs (mean/sd) | 0.1 (0.4) | 1.1 (1.4) | 0.1 (0.5) | *** | |
| **Mental Health Disorders** | | | | | |
| Anxiety | 8.6 | 34.3 | 9.1 | *** | 0.13 |
| Depression | 7.1 | 32.8 | 7.7 | *** | 0.14 |
| Bipolar | 3.3 | 19.0 | 3.6 | *** | 0.12 |
| Schizophrenia/Psychotic Disorder | 2.6 | 11.2 | 2.8 | *** | 0.08 |
| Post-traumatic Stress Disorder | 1.1 | 6.1 | 1.2 | *** | 0.07 |
| Personality Disorder | 0.7 | 3.7 | 0.7 | *** | 0.05 |
| ADHD | 0.6 | 2.7 | 0.7 | *** | 0.04 |
| Autism | 0.2 | 0.2 | 0.2 | NS | |
| Intellectual Disability | 0.5 | 0.4 | 0.5 | NS | |
| Number of Co-occurring MHDs (mean/sd) | 0.2 (0.7) | 1.1 (1.4) | 0.3 (0.7) | *** | |

Note. Results based on all adult Illinois residents ages 18 to 64 years of age who were enrolled in a Medicaid/CHIP managed care program in calendar year 2018 with no less than a 45-day gap in coverage. Exclusion criteria included: dually eligible for Medicaid and Medicare, receiving limited benefits, and not having a residential zip code located within Illinois. Persons with an OUD were identified through analysis of Medicaid claims data indicating receipt of treatment services for an OUD during the year. All figures are percentages unless otherwise indicated. Significance levels for all categorical variables are based on the Pearson Chi-square statistic while effect size is based on Cramer's V. Significance for the comparison of the mean numbers of SUDs and MHDs are based on the t-statistic. Mean number of SUDs excludes OUD.

Because not all persons with an OUD receive treatment, these estimates are likely lower-bound — only those persons with a more severe OUD are likely to end up in treatment, experience an overdose requiring an emergency department (ED) visit or hospitalization, etc. To get a sense of persons who might have an OUD but who did not receive OUD-related treatment services, we examined Medicaid pharmacy claims data to estimate the prevalence of prescription opioid misuse (e.g., obtaining multiple, concurrent, or overlapping prescriptions from multiple providers and pharmacies) were not included in the estimates of OUD. Those misusing prescribed opioid analgesics are at elevated risk for or have already developed an as-yet-untreated OUD. These analyses identified an additional 2.5% to 4% of the Illinois adult Medicaid managed care population as having either probable (N = 36,795) or possible (N = 4,644) opioid misuse. Combining these estimates with those for OUD prevalence means that between

60,000 and 70,000 Medicaid beneficiaries have an OUD or are likely misusing prescription opioid analgesics and are thereby at elevated risk for developing an OUD.

**Medication Assisted Recovery.** Within the substance use disorder treatment continuum of care, medication-assisted recovery (MAR) involves the use of a medication to treat a substance use disorder, primarily but not exclusively opioid use disorders (OUD). According to the CDC, expanding access to MAR is essential to an effective response to the dramatic increase in opioid-related problems.[16] Research indicates that MAR for clients with an OUD, particularly those in outpatient methadone treatment (OMT), has the potential to save significantly more lives and money than other forms of treatment.[17]

The cost-saving impacts of MAR are attributable not only to reductions in use and overdoses but also to a wide range of improvements in the health conditions commonly experienced by clients with an OUD. These improvements include increased access to health care and other recovery support services, improved interpersonal relationships and living conditions, and decreased rates of behaviors such as injection drug use that increase risk for infectious diseases such as hepatitis C and HIV/AIDS. The longer-term involvement of opioid users in MAR, as opposed to shorter term use of MAR for detoxification, plays a significant role in overall harm reduction practices. There is additional evidence of harm reduction benefits among both primary opioid clients who continue to use opioids while in MAR and those who prematurely discontinue treatment.

MAR for an OUD includes one of three medication options, often but not always delivered in tandem with counseling and social supports. FDA-approved OUD medications include methadone, injectable extended-release naltrexone (e.g., Vivitrol®), and buprenorphine in a variety of formulations such as tablets (e.g., Subutex®), a long-acting injectable (e.g., Sublocade®,) a sublingual film (Belbuca®), subdermal implant (e.g., Probuphine®), and in tablet form in combination with naloxone (e.g., Suboxone®).[18,19]Each medication class works differently and is subject to different regulations regarding where, how and by whom they might be prescribed and dispensed. Naltrexone, an opioid antagonist, blocks the effects of opioids, making the person unable to get high from using them but has no effect on cravings or withdrawal symptoms. It has no diversion risk or "street value" because it does not cause the psychoactive effects of an opioid, is not itself an opioid, and is not classified as a narcotic. Because it is not an opioid and not a controlled substance, naltrexone may be prescribed by any health care professional licensed to prescribe medications. Methadone, an opioid agonist, and buprenorphine, a partial agonist, do reduce cravings and withdrawal symptoms without making the person feel high. Methadone is the most restricted of the three drugs for treating an OUD and must be provided by a federal and state approved clinic through a controlled dispensary procedure. Figure 11 shows the

[16] https://www.cdc.gov/vitalsigns/heroin/

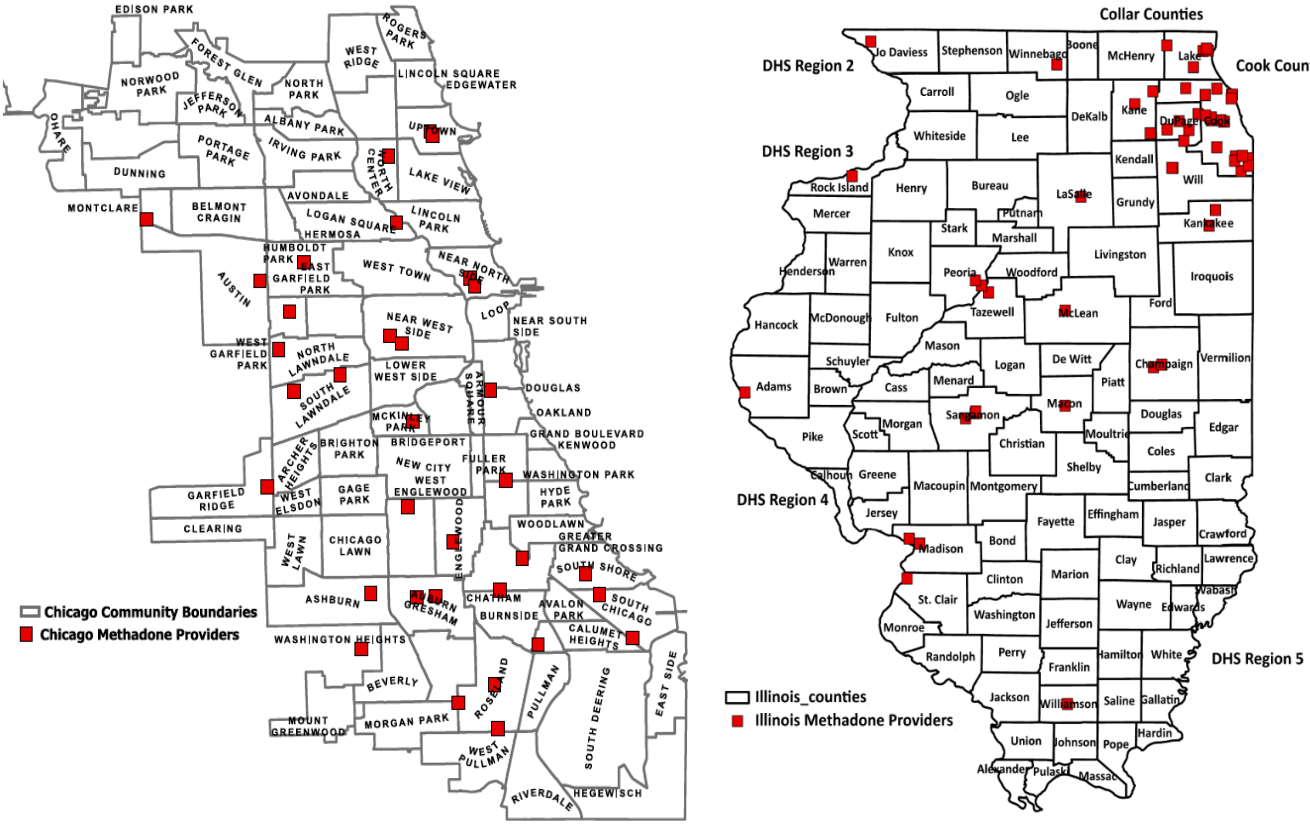
[17] Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2014). Medication assisted therapies – Tackling the opioid-overdose epidemic. *The New England Journal of Medicine, 370*, 2063-2066.

[18] Modesto-Lowe, V., Swiezbin, K., Chaplin, M., & Hoefer, G. (2017). Use and misuse of opioid agonists in opioid addiction. *Cleveland Clinic Journal of Medicine, 84*(5), 377-384.

[19] Volkow, N. D., & Blanco, C. (2023). Fentanyl and other opioid use disorders: Treatment and research needs. *American Journal of Psychiatry, 180*(6), 410-417.

distribution of presently licensed methadone clinics in Illinois for Chicago and the state. It can be seen that large parts of the state such as in counties in the mid and southeastern areas still do not have available methadone services, which tend to be clustered in Chicago and surrounding counties.

**Figure 11. Licensed Methadone Treatment Providers by Chicago Community Area and Illinois County**




**Note.** Data obtained from SAMHSA's Treatment Provider Locator, retrieved May 25, 2023.

Buprenorphine may be prescribed by a physician, physician assistant or nurse practitioner whose license allows them to prescribe DEA Schedule III medications. Until this past year, providers were required to obtain a DATA or x-waiver through SAMHSA and the Drug Enforcement Administration (DEA) in order to prescribe buprenorphine to treat an OUD. The waivers limited the total number of patients to 20, 100, or 275 for whom a provider could prescribe buprenorphine for treating an OUD depending on the provider's request access, experience, and practice credentials. The requirements also included mandatory training before a waiver would be granted. This waiver requirement was removed in the past year with passage of the Consolidated Appropriations Act, 2023. At present, any provider with a DEA

registration and Schedule III authority may prescribe buprenorphine for treating an OUD, potentially expanding the availability of this MAR treatment.

In the last report, we noted there were 2,409 Illinois providers with an x-waiver, although analyses of Illinois PMP data indicated many (~30%) were not actively prescribing in the past year. This is consistent with other study findings based on national as well as data collected from individual states.[20,21,22,23] That number of providers represents both those who make their information available on the Substance Abuse and Mental Health Association's provider registry, which allows potential patients to locate a nearby provider, as well as those who choose not to make their information publicly available. SAMHSA no longer shares the information of providers who opt to not be included in the registry. There are currently, 1,504 Illinois providers listed in the public registry of which about 70% are MD's or DO's and 23% nurse practitioners. We do not know how many Illinois practitioners prescribing or intending to prescribe buprenorphine have chosen to not have their contact information listed in SAMHSA's provider public registry.

To assess the availability and distribution of buprenorphine as treatment for an OUD in Illinois, we analyzed data available from the Illinois Prescription Monitoring Program's buprenorphine dashboard.[24] These results are shown in Figure 12, which shows there is continuing unevenness across the state in terms of both buprenorphine providers per capita as well as prescriptions written per capita.

[20] Duncan, A., Anderman, J., Deseran, T., Reynolds, I., & Stein, B. D. (2020). Monthly Patient Volumes of Buprenorphine-Waivered Clinicians in the US. *JAMA Netw Open*, *3*(8), e2014045. https://doi.org/10.1001/jamanetworkopen.2020.14045

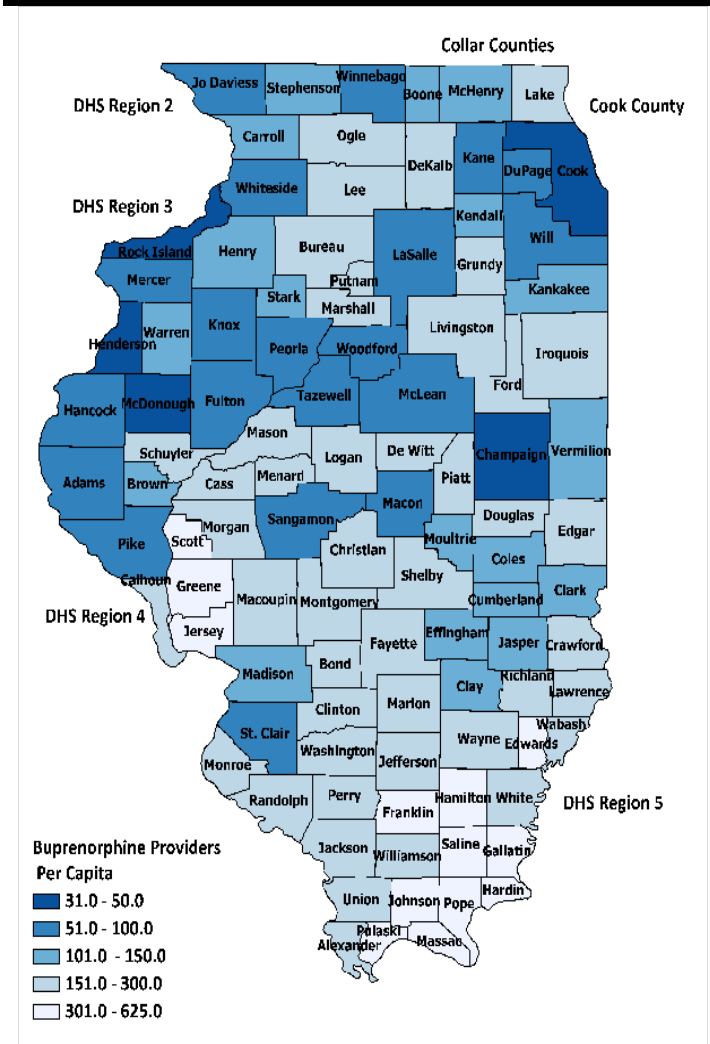
[21] Huhn, A. S., & Dunn, K. E. (2017). Why aren't physicians prescribing more buprenorphine? *J Subst Abuse Treat*, *78*, 1-7. https://doi.org/10.1016/j.jsat.2017.04.005

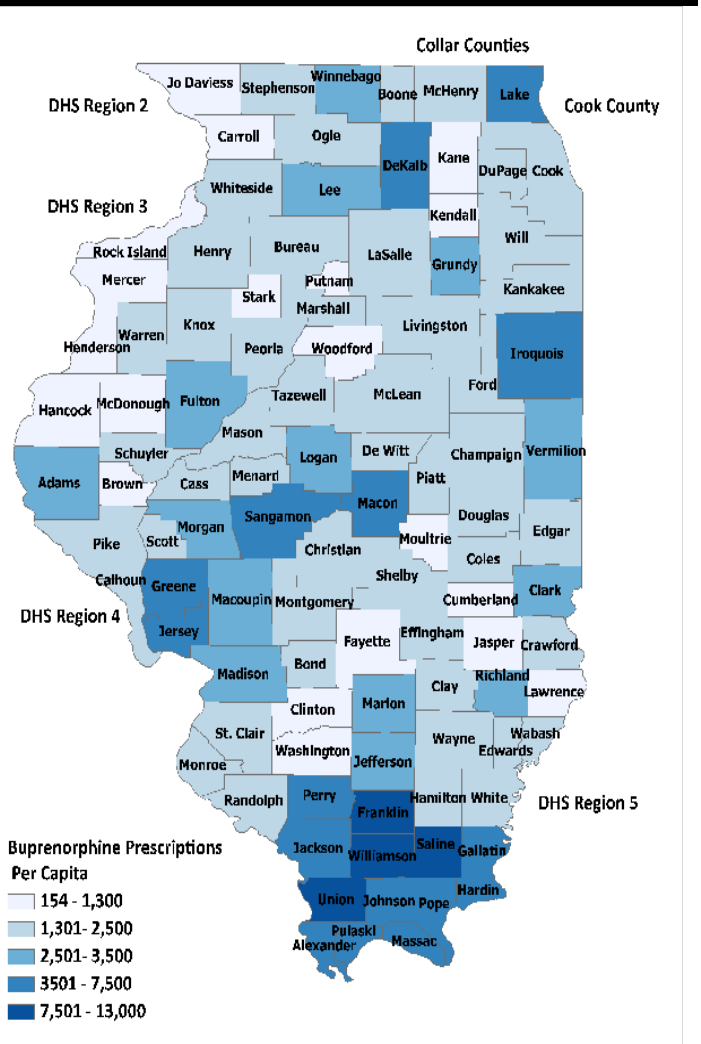
[22] Rhee, T. G., & Rosenheck, R. A. (2019). Buprenorphine prescribing for opioid use disorder in medical practices: can office-based out-patient care address the opiate crisis in the United States? *Addiction*, *114*(11), 1992-1999. https://doi.org/10.1111/add.14733

[23] Thomas, C. P., Doyle, E., Kreiner, P. W., Jones, C. M., Dubenitz, J., Horan, A., & Stein, B. D. (2017). Prescribing patterns of buprenorphine waivered physicians. Drug Alcohol Depend, 181, 213-218. https://doi.org/10.1016/j.drugalcdep.2017.10.002

[24] https://www.ilpmp.org/CDC/buprenorphineDashboard.php

**Figure 12. Illinois Buprenorphine Providers and Prescriptions Per Capita by County**




**Note. Data were obtained from the Illinois Prescription Monitoring Program**

# FY 22 State Efforts to Address the Opioid Crisis

The State Overdose Action Plan[25] (SOAP) forms the strategic framework for addressing the opioid epidemic in Illinois, setting a statewide goal of reducing projected opioid- related deaths by one-third in three years[26] and formulating a set of evidence-based strategies to achieve this goal. The SOAP focuses on efforts in five categories:

- 1) Social Equity
- 2) Prevention
- 3) Treatment and Recovery
- 4) Harm Reduction
- 5) Justice-Involved Populations and Public Safety

Each priority includes a set of metrics that will be used to document our progress. The programs supported through these grants are designed to address the range of serious overdose-related problems and issues that are being experienced among residents across Illinois. These programs primarily aim to address the overdose crisis by expanding the availability of medication assisted treatment (MAR), improving the quality of the MAR provided, enhancing access to treatment, reducing overdose related deaths, increasing public awareness of overdose-related problems and expanding access to the resources that are available to address these problems.

**OFFICE OF THE CHIEF BEHAVIORAL HEALTH OFFICER**

In June of 2022, Governor Pritzker announced the creation of the Illinois' Chief Behavioral Health Officer (CBHO). As part of the goal to transform how Illinois supports behavioral health wellness, the CBHO will provide overarching leadership to facilitate collaboration among the state agencies that deliver and support behavioral health services. The CBHO also will solicit stakeholder feedback; lead HHS Strategic Plan implementation; coordinate with the Director of the Children's Behavioral Health Transformation Initiative; develop an infrastructure blueprint; allocate resources; amend policies, rules, regulations; and create an interconnected interagency system and an efficient and effective state infrastructure. The CBHO will partner with the Office of Medicaid Innovation for research and administrative leadership and support.

During year one, the CBHO will oversee an interim action phase to 1) establish and accomplish short-term goals to improve the behavioral health system; and 2) develop a blueprint outlining proposed funding and administrative structure for the longer term. Desired outcomes include improved interagency collaboration; increased capacity and/or increased service provision; expanded pathways to increase access to behavioral health treatment, services and supports; processes and constructs

[25] http://www.dph.illinois.gov/opioids/ilplan
[26] From the SOAP: “Our goal is to reduce the number of projected deaths in 2020 by a third.”

connecting behavioral health treatment with social determinants of health; and improved emotional, mental, and overall behavioral health wellness for Illinoisans.

**Illinois Opioid Settlement Funds**

In 2019, the Illinois Attorney General filed two different lawsuits against various opioid manufacturers and the three largest pharmaceutical distributors. Settlements with Johnson & Johnson and Distributors were announced in July 2021; these entities will pay $21.5B nationally over the next 18 years. Additional national settlements are ongoing. For more information go to: National Opioid Settlement.

The Illinois Opioid Allocation Agreement (Illinois-Opioid-Allocation-Agreement-Fully-Executed.pdf (nationalopioidsettlement.com) governs how funds from the national opioid settlements are allocated in Illinois. Twenty percent is allocated for the State, 25% will support local subdivisions and 55% will support the Illinois Remediation Fund. To date, 94 counties and 78 eligible municipalities have joined the agreement.

It is estimated that the Illinois Remediation Fund will receive approximately $437M over 18 years. Funds disbursed from the Remediation Fund will support uses included in the list of approved abatement programs. In addition, funds from the Remediation Fund require equitable allocation within seven regions of the state and considering population and other factors relevant to opioid abatement. The IORAB will develop and review recommendations for allocating Remediation Funds, ensuring that recommendations align with the core abatement strategies and geographic disbursement requirements outlined in the Illinois Opioid Agreement.

Settlement funding must support treatment of opioid use disorder (OUD) and co-occurring disorders (CODs) and mental health conditions through evidence-based and evidence-informed programs and/or strategies

**Illinois Department Of Healthcare And Family Services (IDHFS)**

Federal funding from the Centers for Medicare and Medicaid Services (CMS) for Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Providers and Communities (SUPPORT) Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity supported a collaboration between the Illinois Department of Healthcare and Family Services (HFS), UIC Jane Addams School of Social Work, Cook County Health (CCH) and SIH that assessed state infrastructure and provider capacity to deliver SUD treatment and recovery support services to Illinois Medicaid members.

A quantitative study conducted by UIC examined reasons why non-public DATA-waivered prescribers did not want to be listed on SAMHSA's online public registry of waivered providers. Preliminary analyses suggest that providers did not want to be listed for the following reasons: 1) providers do not practice in a clinical setting in which they see people seeking MAR, such as an ED or inpatient unit; 2) limited capacity to take on new clients; and 3) lack of organizational resources and infrastructure support to put systems in place to allow providers to prescribe buprenorphine.

A qualitative study conducted by HFS, CCH and SIH explored providers' challenges to prescribing buprenorphine. Challenges identified by providers include low reimbursement rates for provider/prescriber visits, inability to bill for additional support services such as case management, and concerns that complex patient require additional provider time.

These study results will be used to develop and implement strategies to encourage prescribers to join SAMHSA's online registry.

**Illinois Department of Public Health (IDPH)**

IDPH's Office of Women's Health and Family Services currently oversees and coordinates two maternal mortality review committees. One committee reviews deaths due to drug-related causes and creates recommendations based on the preventable factors within these deaths. This work is an ongoing needs assessment of the families that are most in need of OUD/SUD treatment, recovery supports, child, youth and family-centered services, the community-based organizations that provide these services, and barriers to accessing these services. Identified factors result in recommendations and initiatives to prevent morbidity and mortality among PPW. A new list of recommendations from this needs assessment are being developed and will be released in 2023.

IDPH funded the ILPQC from 2018-2020 to implement the Mothers and Newborns affected by Opioids (MNO) initiative. MNO worked with 101 birthing hospitals to train maternal health clinicians on OUD/SUD and MAR, increase standardized screening for PPW, and improve access to and initiation of MAR among PPW with OUD/SUD. Between 2017 and 2020, the proportion of women with OUD connected to MAR prenatally or by delivery discharge increased from 2% to 45% and 39% to 72%, respectively. For more information go to: Mothers and Newborns affected by Opioids – OB initiative – Illinois Perinatal Quality Collaborative.

IDPH convened its second annual virtual Harm Reduction Summit August 23-24, 2022. A total of 365 people attended the Summit. The Summit's web platform had 11,296 views.

Participants shared that the Summit increased their understanding that harm reduction is part of recovery, helped them recognize the importance of meeting their clients "where they are at", encouraged them to educate others about harm reduction and implement harm reduction strategies in their organizations.

Representatives from 24 and national and state organizations helped organize and/or presented at the Summit.

**Illinois Criminal Justice Information Authority (ICJIA)**

The mission of the Authority is to improve the administration of justice, ensuring its efficiency and efficacy. To do this, the Authority collaborates with key justice system leaders and the public to help identify current issues regarding the criminal justice system in Illinois. The Authority does this through grants administration, research and analysis, policy and planning, and information systems and technology.

ICJIA's commitment to countering the opioid overdose epidemic is threefold:

1) through the administration of grants to support ongoing efforts to combat and mitigate opioid misuse;

2) through research and evaluation of programs and policies related to the opioid epidemic from prevention through incarceration and reentry; and

3) through participation on state, county, and local commissions and councils looking to counter the opioid epidemic.

The Illinois Criminal Justice Information Authority (ICJIA) has submitted a grant application with RAND Corporation to the National Institute of Justice to conduct a national survey of deflection and diversion programs. If the grant is funded, ICJIA and RAND Corporation's survey will assess the number and types of diversion programs statewide, the number and types of licensed treatment program and community partnerships that have agreements to provide OUD/SUD treatment as part of a formal deflection strategy, the number of individuals deflected to treatment and/or services in lieu of formal charging actions, the number of peer recovery programs that help deflect people into treatment, and the number of people transported by deflection and diversion programs to a licensed treatment provider or other program partner location. Funding decisions will be made in late fall 2022.

ICJIA will issue the NOFO for deflection and diversion programs in 2023. Grantees will be awarded funding for three years.

IDHS/SUPR is partnering with the Illinois State Police (ISP), ICJIA and Treatment Alternatives for Safe Communities (TASC) Center for Health and Justice to expand a deflection initiative to assist people with OUD/SUD encountered by law enforcement with access to a network of services and providers, diverting these individuals away from criminal justice involvemefeaThe overdpnt and into community-based SUD and mental health treatment, recovery support, housing and social services. The first deflection initiative, known as the ISP Public Enforcement Safety Group (PSEG), was launched in East St. Louis in January 2022. Two additional initiatives are underway in southern Illinois in Jackson, Union, and Williamson Counties, and in southwestern Illinois in Madison, St. Clair, Monroe, Bond, Calhoun, Greene, Jersey, Macoupin and Montgomery Counties. A fourth initiative will be implemented in 2023 in southern Illinois in Randolph, Washington, Jefferson, Hardin, Massac, Pulaski and Alexander Counties.

**Illinois Department of Human Services - IDHS**

There are two areas within IDHS charged with responding to the opioid crisis. The Office of Clinical, Administrative and Program Support (OCAPS) Bureau of Pharmacy and Clinical Support Services (BPCSS) maintains the Illinois Prescription Monitoring Program (ILPMP). The Division of Substance Use Prevention and Recover (SUPR) manages grants funded through the federal Substance Abuse and Mental Health Services Administration (SAMHSA.)

**Prescription Monitoring Program (PMP)**

The Illinois Prescription Monitoring Program (PMP) receives Controlled Substance prescription data from retail pharmacies which enables prescribers and dispensers to view the historical data for current and prospective patients. Prescribers are required to review the PMP when considering opioids for individual patients, but this manual process is burdensome for medical practitioners in a busy practice. IDHS/SUPR is supporting a portion of the PMP's PMPnow campaign, an effort to support improved opioid prescriber reporting in commonly used EHR systems among Illinois medical provider systems. These "automated connections" make it more convenient for prescribers to check the PMP through their EHR, rather than logging into an external system. Senate Bill 722 (SB722), which took effect on January 1, 2018, mandates that all prescribers possessing an Illinois Control Substance license must register with the PMP. The PMP attributes the new law, along with the increase in automated

connections, to a massive influx of PMP registrations. As of June 30, 2022, there were 1,304 PMP/EHR connectivity implementations (PMPnow), and 79,633 registered PMP users. Additionally, 55,459,195 searches were conducted through PMP now requests.

**Division of Substance Use Prevention and Recovery (SUPR)**

The Illinois Department of Human Services Division of Substance Use Prevention and Recovery (IDHS/SUPR) is receiving federal funding to address the opioid crisis, awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services (HHS). The programs supported through these Opioid Crisis Response Grants are designed to address the range of serious opioid-related problems and issues that are being experienced among residents across Illinois.

**Increasing Access to MAR**

**MAR NOW**

IDHS/SUPR and the Chicago Department of Public Health (CDPH) launched MAR NOW in May 2022. MAR NOW connects Helpline callers to immediate treatment for OUD, include telephonic prescription and home induction on buprenorphine or same-day clinic appointments for methadone, buprenorphine, or naltrexone. MAR NOW can also connect patients to withdrawal management and residential treatment. After induction on MAR, patients with MAR NOW are referred to community-based care for ongoing treatment. The Helpline has made 198 MAR NOW referrals as of September 30, 2022.

MAR NOW was featured on the CDPH Medical Director's September 20, 2022 Facebook Live show. This live stream event had 400 views on Facebook and 2,370 views on Twitter, 6,064 social media impressions, 125 social media engagements and 35 link clicks.

**Mobile MAR**

Family Guidance Center's (FGC) mobile MAR unit provides access to all three FDA-approved medications for the treatment of OUD (methadone, buprenorphine, and naltrexone). A Recovery Support Specialist works with clients to develop an initial recovery support service plans and assists with referrals to other services. As of October 2022, the FGC mobile MAR unit has served 320 PWUD on Chicago's West Side.

The Community Outreach Intervention Project (COIP) mobile unit dispenses buprenorphine and other forms of MAR. It also provides medical care, including comprehensive HIV and Hepatitis-C care. In the first quarter of FY23, the COIP mobile unit served 385 PWUD on Chicago's West Side

Carle Foundation Hospital's mobile unit provide behavioral health, obstetric, primary care and pediatric health care to people in central Illinois. As of September 30, 2022, the mobile unit provided behavioral health services, including MAR to 84 people.

**Street Outreach**

Street outreach teams operated by the West Side Heroin/Opioid Task Force (WSHOTF), Chicago Recovery Alliance (CRA), The Night Ministry and Thresholds distribute naloxone to PWUD on Chicago's West Side and link them to MAR and other recovery support services. From January-September 2022, the WSHOTF's street outreach team provided services to 3,558 PWUD; and Thresholds' street outreach team provided services to 57 PWUD.

**State Opioid Response (SOR) Grant**

SOR II- IDHS/SUPR received an award from SAMHSA for SOR-II funding of $36.7 million. The project period is 9/30/2020 through 9/29/2022, for a total of $73.5 million over two years. SUPR continues to fund the work of programs in this report and has initiated some new projects as well. The grants include initiatives that align with the SOAP and include MAR Integration for Justice-Involved Populations; Leadership Centers; and Access Narcan. Additionally, this grant expands the pool of those who can be served to now include persons with stimulant use disorder. From 9/2020 through March 2023, 6,771persons were served through the outreach, treatment, and recovery support services supported through the SOR grant

Illinois Opioid Crisis Helpline SOR funds support a statewide 24-hour, 7-day/week, 365 day/year helpline for persons with OUD-related issues. https://helplineil.org The Helpline was launched on December 5, 2017 and received 73,934 calls as of June 30, 2022. Of these calls, 49,099 ended in a referral, with 7,266 of those being a warm transfer. The Helpline's website was launched in March 2018 and has received 444,685 visits by 348,712 unique individuals. During 2020, texting was added to the Helpline telephone technology, and a chat function was added to the Helpline website, opening more opportunities for people to seek and receive help. As of June 30, 2022 2,632 chat interactions resulted in 445 referrals and 901 text interactions resulted in 303 referrals. New marketing campaigns were implemented statewide, including television ads in the Chicago market to focus on the West Side heroin epidemic. The Recovery Housing registry is now managed by the Helpline. Additionally, Helpline partnered with the Illinois Department of Public Health (IDPH) to design a harm reduction campaign, leading people to resources for syringe services, fentanyl test strips, and other harm reduction supports.

OUD Public Awareness Activities - Public awareness approaches are underway to deliver messaging and education to various audiences regarding the impacts of the opioid crisis in Illinois and the availability of programs and activities that have been developed in response. Primary campaigns that ran their course include Guard and Discard and Ending Opioid Misuse in Illinois. In June 2019, IDSH/SUPR added an important component to the overall statewide public awareness campaign by launching the A Dose of Truth campaign. The A Dose of Truth campaign started with a focus on creating a baseline of knowledge in the general population about what are opioids, specifically those found in medicine cabinets, and has evolved overtime to focus on the current drivers of overdose and overdose death in Illinois. This includes the need to address the ever-increasing crisis of opioid overdose and racial disparities. The initial Dose of Truth campaign included social media Facebook posts reaching an estimated 18,049,187 individuals, engaged (likes, comments, and shares and more) 75,849 individuals, and had 3,008,400 video views (video played for at least 3 seconds and excludes replaying the video during a single instance). In June 2019, IDHS/SUPR added another public awareness campaign, Naloxone Now. The Naloxone Now campaign addressed issues of stigma and acceptance of this life-saving medication within the general population, equating it to other life-saving medications and devices. The Naloxone Now campaign ended June 2020 and components were integrated into the current ADOT campaign. As of October 31, 2020, messaging for the Naloxone Now campaign through interior rail and bus cards displayed on Chicago's trains and buses, achieved an estimated 543.2 million impressions. An additional 12.75 million impressions were achieved through PACE interior bus cards and bus shelters. Final numbers for displays through gas stations and convenience stores statewide include an estimated 131.4 million views and 37,675,400 million views for bar restrooms signage.

An increasing need was identified to demystify Medication Assisted Recovery (MAR) and encourage both prescribers and patients to discuss its effectiveness in treating OUDs, what using medications to treat a SUD signifies in the context of recovery, and ultimately its effectiveness in decreasing overdose deaths. This led to the development and implementation of the Rethink Recovery campaign. Rethink Recovery is a statewide public awareness campaign that seeks to increase an openness and interest in MAR) among those at high risk of overdose. This campaign provides education and resources directly to those in-need and their support systems including medical providers and loved ones, to facilitate the first steps towards recovery.

New reach numbers are being reported to reflect the change in the ADOT campaign. As of June 30, 2022, the ADOT campaign has 14,282,598 Social Media Impressions (Social Media Impressions are the number of times that paid or unpaid content was displayed/seen by someone), 4,074,624 Social Media Engagements (Social Media Engagements are the number of actions a person took on campaign content, including post likes/reactions, photo views, link clicks, post saves, video/gif completions, shares/retweets, comments/replies, and page likes/follows), and 67,882 Website Sessions (Website Sessions are a single visit to a campaign website. As of June 30, 2022, for the Rethink Recovery campaign, there have been 32,691 Website Sessions, 5,008,668 Social Media Impressions, 729,677 Social Media Engagements, and 178 pdf downloads.

Student Athlete OUD Primary Prevention Services IDHS/SUPR supports a regional program that focuses on the risk of increased access to opioid pain medications for student-athletes. The Student Athlete Opioid Use Prevention Project conducts educational and awareness activities that target high school coaches, athletic directors, parents, and student-athletes regarding the misuse and risk of misuse of prescribed opiate pain medications by youth athletes. These activities include training on the Rx Playbook and dissemination of awareness promoting key messages, partnering with key organizations who focus on High School athletes, collaborating with existing prevention resources to promote key messages, promoting the Rx Playbook to targeted High Schools, and establishing social media connections with targeted schools and athletes attending those schools. As of June 30, 2022, the Rx Playbook has been shared at 42 county, statewide, and national events and conferences, reaching 3,394 school staff, parents, and/or community members. Comprehensive opioid education and awareness materials have been distributed to over 203 prevention providers and grantees (CSUPS, CDC-DFC, SUPS). Social media activities include a total of 131,653 reaches on Twitter, 347,752 reaches on Facebook, and 71,404 engagements on Instagram page. The project website received in total over 49,972 page views with 5,426 visits to the Rx Playbook pages.

The ilhpp.org website has a membership of 259 individuals. In addition, the project has launched 4 self-paced online training courses, The Athletic Trainer's Role in Opioid Education, Adolescent's and Opioids, Opioids 101, and Be Your Own Best Advocate.

Other accomplishments include the addition of two new courses Stimulants 101: Introduction to Stimulants and Stimulants 102: Types of Stimulants.

**Treatment and Recovery Initiatives**

**Access to Medication Assisted Recovery (A-MAR) Networks.** One of IDHS/SUPR's approaches to increase access to MAR is via the AMAR Project. The AMAR Project utilizes a "Hub and Spoke" model, the goal of which is to have a substantial population center working with the surrounding areas with low

access to MAR. Illinois has implemented five AMAR Networks, across Illinois. All five networks were identified via the NOFO process. As of June 30, 2022, 1,357 clients have been admitted to MAR through these service networks.

**Residential Stabilization Centers for Patients with Opioid Use Disorder -** These resources are targeted to the current gap in the service continuum for persons with OUD who lack housing and other supports to effectively engage in MAR during the early stage of their recovery process. Residential/inpatient care is expensive and unnecessarily restrictive for many persons with MAR, but many individuals still need safe, stable, temporary housing and supports like clothing, meals, and access to mental health services and primary health care. As of June 30, 2022, 810 clients have been admitted to the Residential Stabilization Centers.

**Recovery Homes-** Recovery Homes are alcohol and drug free homes whose rules, peer-led groups, staff activities and/or other structured operations are meant to help with maintaining sobriety. ORF grants have allowed IDHS/SUPR to expand Recovery Home services for persons with OUD who have unstable living arrangements and are active in some form of MAR. As of June 30, 2022, 1,012 clients have been admitted to a recovery home.

**Correctional Facility-Based MAR Services** Injectable naltrexone is the form of medication assistance for OUD that is most often preferred by correctional facility administrators because it has no risk of diversion. Federal ORF grant funds support six organizations providing injectable Naltrexone services for persons with OUD in county jails and at the Sheridan Correctional Center, one of Illinois' prisons.

These services consist of screening, assessment, initial injections, and post-release treatment referrals before discharge. Through June 30, 2022, 426 persons have been served. About 95% of these offenders were admitted by the community-based treatment providers to which they were referred.

**Learning Collaborative to Support MAR Implementation for the Justice-Involved Population in Illinois Counties** This program offers expert technical assistance (TA) for county teams starting or expanding medication assisted recovery (MAR) programs in their jail with continued recovery support in the community post-release. It expands upon the injectable naltrexone project by moving counties towards offering all three forms of federally approved medications for opioid use disorder. As of 2022, fifteen jails (Kane, Kendall, Grundy, Will, Lake, DuPage, Iroquois, LaSalle, Boone, Kankakee, Lee, Ford, Sangamon, Richland, Bureau) are participating in the program with their county team that includes custody officers, SUD and BH healthcare providers, probation, health departments, and others.

**Leadership Centers** Five organizations were chosen to support the development of a comprehensive statewide network to assess and move persons with SUD through treatment and recovery, helping to bring together the numerous programs created in IL in response to the overdose crisis. Centers plan, develop and manage relationships and connections between traditional SUD services and the medical system, integrating prevention, treatment, and recovery. Each Center has an area of expertise that helps SUPR meet the goals of the SOR program. Centers expand the use of recovery support services through their provider networks, including interventions for co-occurring medical/mental illness.

**Co-Located Hospital Warm Hand-off Services** Patients who arrive at a hospital emergency department (ED) after an overdose reversal are at high risk of subsequent overdose. Additionally, patients in other hospital departments June have undiagnosed OUD. Hospitals don't typically screen for substance use

disorders routinely, so patients with OUD are not often discharged with a referral to address their opioid use. Hospital Warm Hand-off Services involve robust, evidence-based screening and referral to treatment. Peer recovery support specialists "warm up" the referral to MAR services by going beyond providing a written referral or scheduling an appointment. It involves establishing a collaborative relationship with the patient, providing practical, personalized support for entering and adhering to treatment, and, in coordination with treatment providers, delivering ongoing recovery support services based upon patient needs. The Co- located Hospital Warm Hand-off Services have been initiated at 15 hospitals and multiple Cook County Health (CCH) locations, with 9,110 patients served through June 30, 2022. Over 70% of these patients were admitted by the community- based treatment providers to which they were referred following discharge.

**Hospital Screening and Warm Handoff Services** This is an expansion of the Co-Located Hospital Warm Hand-off Services, whereby hospitals provide grant-supported services directly rather than through sub agreements with external organizations. These services build upon the co-located hospital warm hand-off ORF grant awards in that services will be available throughout the hospital, and at more extended period time. Service delivery is consistent with the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) model that has been the focus of multiple SAMHSA-funded cooperative agreements and discretionary grants. The number of patients screened positive for OUD and referred to treatment post discharge is 4,305 through June 30, 2022

**Rush University Hospital Multi-Disciplinary Programs** IDHS/SUPR funds support multiple programs within Rush University Hospital, which is located on the west side of Chicago. As of July 2022, Rush provided Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to 25,813 patients, of whom 6,149 screened positive for any SUD, with 2,600 of these patients screening positive for OUD. Buprenorphine services were initiated for 559 patients, 345 patients were referred to other MAR services, and 661 non-OUD patients were referred to external SUD providers.

**Community-based Outreach/Linkage/Referral Services** Specialized and specific community-based outreach, referral, and linkage services are offered for persons with OUD in high-need areas. As a means of identifying individuals who are currently using heroin or other illicit opioids, peer outreach workers canvass multiple locations that are frequented by high-risk individuals, such as parks, street corners, public transportation stations, mini-marts, and liquor stores. Through the end of June 2022: 8,294 persons were provided outreach services; 5,503 of these persons screened positive for opioid and other illegal substance use and expressed an interest in treatment; 3,253 of these completed a meeting with a linkage manager; and 2,572 presented for the treatment intake.

**Service Enhancement for Pregnant and Postpartum Women with OUD** Enhanced services are made available to pregnant and postpartum women with OUD by staff who are certified in the following evidenced-based practices: Community Reinforcement and Family Training (CRAFT), Motivational Interviewing, Seeking Safety, Real Life Parenting, Individual Placement and Support (IPS) Employment. The staffing pattern for the supported enhancement will include Doula Certified Recovery Coaches. A Doula Certified Recovery Coach is a person in active recovery who obtains dual certification as both a birth and a postpartum doula to assist the recovering mother through prenatal and postpartum phases, and with recovery from her addiction. Services have been initiated by the five providers which were selected through the NOFO process.  As of June 30, 2022, 1,258 women have been admitted to these enhanced services.

**Opioid Use Disorder (OUD) MAR in Federally Qualified Health Centers (FQHC)** The intent of this initiative is to increase the number of persons who are receiving MAR at FQHCs in Illinois. FQHCs can bill Medicaid for the medications and supportive services that make up MAR, so this grant will support services for patients that are not Medicaid-eligible, and services that are not Medicaid-billable. Such services include case management and recovery support services. Through the NOFO process five providers were identified and services began in November 2019. As of June 30, 2022, 203 clients have been admitted to these services.

**Digital Toolkit Recovery Support Services** In order to retain patients in MAR and offer additional supports, Illinois Recovery Community Organizations (RCOs) and SUPR-licensed providers have been awarded funds and technical assistance to develop digital recovery support toolkits including secure messaging, web resources, and recovery support mobile applications (apps) for persons with OUD who are active in some form of MAR. Through the NOFO process five providers were identified and began services in December 2019. As of June 30, 2022, 596 clients have been admitted to these services.

**Technical Assistance for MAR Providers** Rush Fellowship has developed a comprehensive weekend program for training and supporting medical staff to prescribe and treat individuals with the medication buprenorphine. Patients with OUD can be medically complex and sometimes medical staff are hesitant to treat these patients. The purpose of the program is to provide technical assistance to office-based buprenorphine prescribers in Illinois, especially within counties with limited or no current access to MAR. Physicians who have successfully begun prescribing buprenorphine share their challenges, successes and words of wisdom to assist their colleagues in breaking down the challenges to providing MAR. There have been six cohorts participate in an immersion weekend, held by Rush, since November 2018. A total of 62 providers participated. Training of a 7th Cohort began in January 2022. A total of 38 prescribers are participating. Ongoing technical assistance, including coaching and additional training, is being provided to these cohorts. Several rural counties are represented by prescribers who have thus far enrolled, and senior fellows who have been through the training are now assisting to gain experience for mentoring in their own communities.

**Response Initiatives**

**Expanded Naloxone Purchase/Training/Distribution Services** Naloxone is a medication that reverses an overdose by blocking opioids, including prescription opioids, heroin, and fentanyl. Federal funds are used for naloxone purchase, training, and distribution to traditional first responders like law enforcement officers and fire departments as well as non-traditional first responders like people who use drugs, friends and family members of people who use drugs, and other bystanders or community members who may witness an opioid overdose. As June 30, 2022, there have been 91,792 naloxone kits distributed and 114,806 people trained in overdose recognition and response. SUPR has recently initiated a program "Access Narcan" for organizations that enroll in our Drug Overdose Prevention Program. Information on Access Narcan can be found here: IDHS: IDHS/SUPR Drug Overdose Prevention Program (state.il.us)

**Community Reinforcement Approach (CRA)**

CRA is an evidence-based treatment for substance use disorders and has been shown to be effective for both stimulant and opioid use disorders, especially in combination with contingency management. CRA training is for clinicians and clinical supervisors. SUPR funds this training for any of our treatment providers where appropriate. As of the end of 2021, 115 SOR and SUPR-funded staff persons have been trained in CRA; 20 have earned CRA certification, and many are currently enrolled in the ongoing trainings. For more information about the CRA model, training, and certification, visit https://www.chestnut.org/ebtx

**Data and Outcomes**

IDHS/SUPR has taken multiple steps to comply with SAMHSA expectations regarding administration of the CSAT GPRA tool to each person who participates in the treatment and recovery services supported by this grant. The Illinois SOR grant has a two-year cumulative target of 4,500 unduplicated clients for the 10 service programs that contribute to this target.

For the SOR-II project, for the period September 2020 through March, 2022, Illinois SOR-II has recruited and provided 3,419 clients with SOR-funded services. Among the clients with both a baseline and 6-month follow up:

- There were statistically significant reductions from the month before intake to the month before follow up in 15+ days using heroin/opioids (41% to 11%), as well as decreases in 15+ days use of other substances including cocaine/crack/methamphetamines (29% to 5%).
- Participants also experienced significant decreases in mental health symptoms, including reductions in 15+ days of anxiety (33% to 25%), and in physical health problems (51% to 39% reporting poor/fair health).
- Conversely, there were significant increases in 15+ times utilizing substance use treatment including MAT (25% to 38%).

Improvements in these domains were generally seen within each SOR-II service type. There was some variability in outcomes across service types, reflecting the differences in baseline levels of severity among participants in the different service types.

**Additional MAR**

There are 112 recovery residences listed in the Helpline's database. Of these, 10 provide MAR and 28 accept MAR clients. There are 143 OTPs listed in the Helpline's data. All 143 OTPs provide MAR. IDHS/SUPR provided training on MAR, harm reduction and recovery to 233 of its licensed providers, including OTPs and Recovery Homes. Financing mechanisms for all forms of MAR that allow OTPs to fully utilize all medications in an equitable manner are being developed. Currently, OTPs can bill for physicians' time.

**NEXT STEPS**

This report demonstrates the progress the State has made – and is making- in response to the Illinois opioid crisis. As noted earlier, in 2018, the number of opioid overdose-related fatalities in Illinois leveled off. Building on the pillars of the State Overdose Action Plan, the integrated, multi-agency activities and

projects described in this report continue to address the crisis. Through coordinated efforts in prevention, treatment and recovery, and response, the state continues to work towards the goal of decreasing opioid-related deaths in Illinois.

In order to better coordinate the state's response to the opioid crisis, in January 2017 a statewide council was formed that now includes over 200 members representing State agencies, members of the General Assembly, statewide provider organizations, professional/trade organizations, community-based providers, county health departments, county coroners, hospitals, and local coalitions. Membership is open to all and continues to grow, with new people participating in Council meetings. This next year, the Council will continue to serve as a way to gather stakeholder feedback as we implement programs and policies that will help us better address continued opioid misuse, racial disparities and the changing nature of the opioid crisis by:

- Coordinating with the Council's soon-to-be created Opioid Social Equity Committee to make policy recommendations regarding how to address social and racial disparities.
- Establishing local recovery-oriented systems of care councils in communities that have been disproportionately impacted by the crisis in order to reach out to and engage individuals in all stages of recovery.
- Evaluating harm reduction programs that encourage safer use of opioids and recommending new harm reduction strategies that should be included in a new SOAP.
- Collaborating with law enforcement to curtail illegal drug trafficking activities that are increasing fatal and non-fatal overdose risks (e.g., fentanyl).
- Adding age-appropriate platforms, appeals and public communication tools to the Helpline to expand access to youth and young adults seeking opioid use disorder (OUD) treatment.

**Additional Information**

There are many ways to stay informed about the state's progress on the opioid crisis. Here are some of the state's websites that give information on the opioid crisis and regular progress updates:

Drug Overdose Prevention Program: https://www.dhs.state.il.us/page.aspx?item=58142

IDPH Opioid Data Dashboard: https://idph.illinois.gov/OpioidDataDashboard/

IDPH Semi Annual Report https://dph.illinois.gov/topics-services/opioids/idph-data-dashboard/statewide-semiannual-opioid-report-may-2022.html

Illinois Helpline for Opioids and Other Substances: https://helplineil.org/

Illinois Opioid Response Advisory Council: http://www.dhs.state.il.us/page.aspx?item=97186

Illinois Opioid Remediation Advisory Board https://www.dhs.state.il.us/page.aspx?item=146327

Drug Overdose Prevention Program: https://www.dhs.state.il.us/page.aspx?item=58142

Statewide Opioid Action Plan 2022
https://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/SUPR/State-of-Illinois-Overdose-Action-Plan-March-2022.pdf

SUPR Newsletters https://www.dhs.state.il.us/page.aspx?item=42567

SUPR Opioid Resources: http://www.dhs.state.il.us/page.aspx?item=93882D

SUPR Quarterly Overdose Response Dashboards: http://www.dhs.state.il.us/page.aspx?item=105980