Responding to a request for information from its members, in mid-February ASTHO queried the Directors of Public Health Preparedness peer group regarding their jurisdictions’ activities around the opioid epidemic in the context of using an Incident Management Structure to support the response. As of March 17, 2017, 43 jurisdictions, including two territories and two directly-funded cities, responded to ASTHO’s request with information on the current status in responding to the opioid epidemic. A summary of their responses, including additional comments and source documents, are listed/provided below.

**Responses**

*Question 1: Has your jurisdiction issued any executive or administrative orders or declarations that provides emergency powers needed for response to the opioid epidemic?*

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(n=43)</strong></td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td><strong>(7)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(36)</strong></td>
<td>16%</td>
<td>84%</td>
</tr>
</tbody>
</table>

**Additional comments:**

- **Alaska:** Disaster Declaration to provide a statewide medical standing order to allow entities with non-medical direction to distribute and administer naloxone. Administrative Order establishing statewide multi-agency ICS system
- **Arizona**: Administrative orders relating to prescribing authority and one with regards to Department of Corrections

- **Colorado**: In response to a high level of heroin overdoses SB 15-053 was passed which allowed the Department Executive Director, Dr. Wolk, to issue standing orders for pharmacies and other detox/recovery and reduction organizations to make Naloxone (Narcan) available to those who may benefit from access to it. This initiative has also resulted in law enforcement carrying Naloxone and having EMT-Bs administer it as well. Although this initiative was for the heroin issue, this may have had an indirect impact on an increase in other opioid abuse.

- **Florida**: In 2016, Florida enacted the “Emergency Treatment and Recovery Act” which authorizes health care practitioners to prescribe and dispense opioid antagonists to patients, caregivers and first responders for the emergency treatment of known or suspected opioid overdoses occurring when a health care practitioner is not available. Pharmacists are authorized to dispense an appropriately labeled opioid antagonist based on a prescription that has been issued in the name of a patient or caregiver. The statute defines caregiver and authorizes patients or caregivers to store and possess a dispensed opioid antagonist for later administration. Additionally, it authorizes emergency responders, including but not limited to, law enforcement officers, paramedics and emergency medical technicians, to possess, store and administer emergency opioid antagonists as clinically indicated. Immunity from civil liability is provided under s. 768.13, F.S., the Good Samaritan Act, to any person, including health care practitioners and emergency responders, who possess, administer or store an approved opioid antagonist in accordance with the Act. A health care practitioner acting in good faith and exercising reasonable care is not subject to discipline under the applicable professional licensure statute and is also immune from civil or criminal liability for prescribing or dispensing an opioid antagonist in accordance with the Act.

- **Georgia**: There is a proposed legislative bill moving through legislature at this time for emergency powers.

- **Louisiana**: The State of Louisiana has issued a standing order for naloxone. This allows for participating pharmacists to dispense naloxone to laypeople including caregivers, family and friends of an opioid user. This standing order also includes directions on how to administer naloxone to someone who has overdosed. Opioid abuse is a concern as 80 percent of heroin users reported starting out misusing prescription opioids. By mid-year 2016, in both East Baton Rouge and Orleans Parishes, narcotic overdose deaths surpassed homicide deaths. This standing order is one step LA is taking to help reduce the number of unnecessary deaths. The standing order is the result of legislation that made it legal for medical professionals to prescribe naloxone. Now, anyone can get naloxone from a participating pharmacy in case they need to assist someone who is overdosing. Those who receive naloxone will be provided education about how to recognize an overdose, how to store and administer the medication, and given information about emergency follow-up procedures. Please see link below for full standing order:
**Maryland**: Attached Executive Order from 2015 that established statewide advisory councils charged with making recommendations. Attached Exec. Order from 2017 that established the OPIOID Crisis Response Structure designed to implement those recommendations as well as other recommendations.

- Maryland Executive Order (2015)
  - MD_EXEC for OPIOD Advisory Counsils 01012015.pdf
- Maryland Executive Order (2017)
  - MD_Executive Order_OOCC_01.01.2017.01pdf (2).pdf
- Press Release signed March 1, 2017 on Maryland’s state of emergency and funding: [Link](http://governor.maryland.gov/2017/03/01/hogan-rutherford-administration-declares-state-of-emergency-announces-major-funding-to-combat-heroin-and-opiod-crisis-in-maryland/)

**New Hampshire**: Several laws were rapidly enacted to specifically allow for broader dispensing of naloxone. A summary of the NH response is available here:


**Utah**: [Our] Executive Director issued a standing order that will allow any Utah pharmacy to dispense a naloxone kit to anyone requesting it, at their expense.

**Virginia** provided the following documents:

- Virginia Declaration of Public Health Emergency
  - VA_SKM_C454e1701 2615020.pdf
- Virginia Standing Order
  - VA_Naloxone Standing Order with NPI and Med License.pdf
Question 2: What is your jurisdiction’s current stance on using an Incident Command Structure as an escalated platform to help organize and coordinate your response? (Check one below)

What is your jurisdiction’s current stance on using an Incident Command Structure as an escalated platform to help organize and coordinate your response? (n=43)

Additional comments:

- **Alaska**: Date of ICS Implementation: February 16, 2017

- **California**: We did work with our emergency preparedness staff for several weeks when California was experiencing issues with Fentanyl related ER visits. We asked hospitals to voluntarily report these incidents.

- **Colorado**: This is because ICS is the standard management process used by prehospital, hospitals, LPHAs and emergency management organizations.

- **District of Columbia**: Our ICS footprint would essentially mimic our standard activation posture for incident management. The DC Department of Health’s Health Emergency Preparedness and Response Administration (DOH HEPRA) has incorporated a 24/7 Watch Officer program that is able to effectively initiate coordinated response action of micro or macro incidents in near real-time, which supports an immediate response to any surveilled and reported epidemiologic urgent matter. Should such an urgent event occur, our Health Emergency Command Center will be activated in collaboration with the DC Department of Health’s Health and Medical Coalition (HMC). Communication and messaging would ensue with Emergency Departments and with a request for relevant information marked by opioid incidents. Monitoring this information supports the collaborative efforts between DOH HEPRA and the DC Homeland Security Emergency Management Agency’s Office of Unified Communications for EMS dispatching. The
ICS system lends itself to modularity, which allows us to incorporate subject matter experts (SMEs) in overdose, treatment, detox, residential/outpatient rehab and therapies, for example. Our Task Force supports our Public Health Emergency Preparedness efforts with situational awareness.

- **Hawaii**: While this hasn’t been specifically considered, our practice here is that should a response escalate to require multiple resources and a number of staff (e.g., large-scale outbreak), ICS would be utilized.

- **Kentucky**: Date of ICS Implementation: Labor Day weekend 2016

- **Maryland**: We have established the "virtual response center" using ICS principles. OP&R was tasked with assisting in setting up the structure that integrates response actions across all state agencies.

- **Minnesota**: Leadership is open to and embraces using ICS at the Minnesota Department of Health.

- **New Hampshire**: This was considered early on but a formal ICS structure was not activated. The response was managed through a regular team meeting that had some structure but did not operate under the principles of ICS.

- **Rhode Island**: In 2015, we discussed briefly the potential for issuing a public health emergency, which would ultimately then include an ICS activation. However, similar to the multi-agency Zika Virus Task Force we previously activated (RIDOH’s EOP includes a section for informal activation, which is usually the activation of a Task Force to help coordinate a cross-Department effort), the [RI Governor’s Overdose Prevention and Intervention Task Force](#), the RIDOH Internal Overdose Task Force, and the weekly state leadership OD calls allow for an acceptable one step down from statewide ICS activation for now.

- **Virginia** provided the following document:
  - Virginia IMT

- **West Virginia**: WVDHHR is currently exploring ICS command options to assist with information sharing, coordination, and response activities.
Question 3: Has your jurisdiction/agency officially activated its Emergency Operations Center for the Opioid Crisis?

Has your jurisdiction/agency officially activated its Emergency Operations Center for the Opioid Crisis? (n=42)

- Yes: 5% (2)
- No: 95% (40)

Additional comments:

- **Colorado**: There has been little noticeable impact of an Opioid crisis. This is handled at the local clinic, prehospital and hospital level.

- **Kentucky**: In the days leading up to Labor Day weekend, the State Health Officer convened several branches in the department to discuss ways to tackle the overdoses in state. Preparedness organized an ICS response to help support the public information messages, statewide call with hundreds of stakeholders from medical community, and surveillance we did over the weekend to collect information from hospitals, EMS and the Poison Control on the number of overdoses. An Operations Center Manager was assigned for each 24 hour shift during the holiday weekend. Following Labor Day weekend events, [the] Preparedness [Unit] has been working with our partners in HIV, local health departments and the Kentucky Pharmacists Association to exercise our plans for the mobile pharmacy and distribute Narcan free to the community. To date, we have visited 3 communities and a few more exercises are scheduled in other communities in the next few months. As part of this effort, LHDs are offering HIV/HCV testing, syringe exchange (where programs already exist) and treatment referrals through collaboration with community behavioral health partners. We did organize an operational structure to support the various aspects including logistics and a central point of contact to coordinate all pieces of the operation.
Opioid Epidemic Information Scan

- **Maryland**: Maryland established the “virtual response center” (VirtOPs Center). The Core Group includes DHMH/OPR; Maryland Emergency Management Agency; DHMH/ Behavioral Health Administration; Governor’s Office, and more.

- **Virginia**: VDH Emergency Coordination Center (ECC) is on standby for potential surge. VDH Incident Management Team (IMT) is activated. Coordination at executive level co-chaired by Secretaries of Health / Human Resources and Public Safety / Homeland Security.

*Question 4: Please feel free to share any other information that you feel is relevant and helpful to others.*

Additional comments:

- **Arkansas**: In 2013, a prescription drug monitoring program known as the Arkansas Prescription Monitoring Program (AR PMP) was implemented by the Arkansas Department of Health in an effort to combat prescription drug abuse. Enrollees (health care professionals with authority to prescribe or dispense controlled substance prescriptions in their scope of practice) of the program were invited to participate in the AR PMP. Since implementation, PMP data show quantities of opioids prescribed by Arkansas prescribers has decreased. Data also indicates that medication assisted treatment with buprenorphine has increased. If interested, please see the mortality report posted on the website: [http://www.arkansaspmp.com](http://www.arkansaspmp.com). Click on reports to the left.

- **California**: Although we have not needed an ICS structure for the response to the opioid crisis, we have established a statewide workgroup across departments and Agencies including external stakeholders to ensure that we are working in alignment. We have worked with law enforcement, our Medicaid program, our Office of Statewide Health Planning and Development, foundations, the consumer board, and others to share our work and determine next steps. We have also created a data dashboard that allows local jurisdictions to drill down and see a cross section of data specific to their communities. A summary of California’s Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup and prescription drug overdose prevention accomplishments can be found below:
  - [CDPH Prescription Drug Overdose Prevention Initiative_March2017.docx](http://www.astho.org)

- **Colorado**: The state of Colorado has not experienced this Opioid crisis that has been seen in other parts of the US. Any slight increase may have been mitigated by the impacts of SB 15-053. There are anecdotal discussions that this may have been reduced due to the legalization of marijuana and its accessibility.

- **District of Columbia**: The DC Department of Health’s Director, Dr. LaQuandra S. Nesbitt, convened The Heroin Task Force in 2015. The Task Force is represented by state and federal government agencies including, but not limited to, the DC Department of Behavioral Health...
In collaboration with the Department of Health’s Health Regulation and Licensing Administration (HRLA) - Prescription Drug Monitoring Program (PDMP), the Center for Policy, Planning and Evaluation (CPPE), and the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), the TF began to address heroin use/overdoses and other drug related issues like K2 and synthetic cannabinoids. Syndromic surveillance (ESSENCE) is used to view findings consistent with an overdose. Additionally, geo-mapping based on Fire and EMS, MPD and Fusion data provides potential area hotspots and overall distribution of heroin and other trends, e.g. Carfentanyl.

- **Florida**: It is important to note that the lead agency on substance abuse and mental health, in Florida, is the Department of Children and Families. They are taking the lead on this issue.

- **Hawaii**: We’re aware of the concerns around the opioid epidemic; however, the conditions here do not warrant emergency operations or even the need for specific response at this time. Our health director, however, has convened a multi-disciplinary work group within the Department to review and discuss potential issues and identify areas we need to address and possible preventive or future response actions. Our “Opioid Work Group” continues to meet monthly and includes members from across our department and multiple subject areas, reflecting the cross-sectional nature of the concerns and issues. Additionally, in 2016 our legislature passed and our Governor signed into law, Act 068, which “takes steps to reduce opioid-related drug related overdoses in the State by encouraging the use of opioid antagonists (i.e., naloxone) to assist individuals experiencing or at risk of experiencing an opioid related drug overdose.” Basically, it provides immunity for physicians and pharmacists to prescribe and dispense, respectively, naloxone, and for first responders and others to administer naloxone to those who need it. It also requires Medicaid coverage for such treatment.

- **Kentucky**: We are seeking alternative funding to create a free-standing program that would be called the Harm Reduction Mobile Program. This program would build upon the work done by Preparedness and HIV but would be supported by dedicated staff and would use preparedness plans, resources and partnerships already established (like the mobile pharmacy and network of pharmacy volunteers) to support. If funded, it would offer a variety of services and include response component for surge in overdoses or spread of disease from IV drug use. Another key component would be a “fusion center” of sorts that would involve collaboration with partners that collect and have access to data and information related to opioid use and would have a response plan to outline the roles of various partners to respond to surges.

- **Louisiana**: Louisiana Department of Health/Office of Public Health and the Bureau of Community Preparedness (LDH/OPH/BCP) has a strong partnership with the Louisiana State Analytical & Fusion Exchange (LA-SAFE) which is a section within the Louisiana State Police (LSP) which promotes collaboration in an all-crimes/all-hazards environment, supporting federal, state, local and private sectors by working together to provide timely information for use in promoting public safety and national security against terrorist and other criminal threats. LA-SAFE supports the state during major disasters and emergencies by gathering, analyzing and
disseminating information to assist relevant agencies in their decision making processes, which permit resource maximization in the protection of citizens of the state of Louisiana. Both entities are responsible for information exchange and dissemination of relevant information pertaining to ESF-8 which affects the public health or possesses the potential to affect the public health of the citizens of Louisiana. Both parties have been conferring regularly regarding the opioid epidemic. BCP partnered with LA-SAFE in assisting The Gulf Coast High Intensity Drug Trafficking Area (GC HIDGTA) in coordinating its annual drug threat assessment by completing a survey to produce this year’s drug survey.

- **Michigan**: We are engaging in a large number of activities related to the opioid crisis involving enhanced syndromic surveillance, outreach to forensic pathologists, EMS data monitoring, PCC, behavioral health, risk communications, etc. [The]Preparedness [Unit] is in the middle of the activities but the SEOC is still actively working on Flint. We also have an Opioid Taskforce that is assisting.

- **Minnesota**: MDH is working across the department on this crisis. At this time the injury prevention staff as well as the executive office have been engaged. The PHEP program is open to assisting as needed with ICS structures as requested. There is Governor executive orders related to the opioid crisis. I know that we do have the SOOP (State Opioid Overdose Prevention) group, which is convened under executive authority. There has also been a lot of activity on this by the Attorney General’s Office.

- **Missouri**: Missouri has been working closely with locals agencies to characterize the opioid crisis in Missouri and identify strategies to combat the issue. DHSS has been accessing a variety of health data information systems to identify high risk areas within the state. In addition, in 2014 a law was passed to allow first responders to carry and administer Narcan (Naloxone) and in 2016 a law was passed allowing pharmacists to dispense Narcan while also legalizing possession of Narcan without a prescription.

- **Mississippi**: The MS Legislature is in session and working to pass Legislation that makes Narcan available to first responders (fire, police, etc.) to use for overdose calls. EMTs of all levels are already approved.

- **North Carolina**: We enacted a standing order from our State Health Director to allow naloxone by first responders.

- **Nebraska**: While this hasn’t been a declared or “activated” emergency in the state, there are a number of opioid abuse projects going on at the state level in our Public Health, Behavioral Health, Medicaid, AG’s Office, universities, and law enforcement systems.

- **New Hampshire**: NH has moved beyond the point of needing an IMT response at this point, rather we need to maintain capacity and organization to address the lasting effects of this drug epidemic. Our response has been multifaceted and has been led not by our public health agency, but by the governor’s office and the DHHS bureau of drug and alcohol services, which is not part of the state public health agency. Public health has been at the table though, just not in
a lead role. Of particular relevance to PHEP, we used Strategic National Stockpile inventory and dispensing strategies for dispensing naloxone to communities to prevent opioid-related deaths.

- **New Mexico**: NM has had the highest rate of drug overdose death among states for most years since 1992 and this has been a crisis in this state since at least 1999. New Mexico was one of five states recognized by the National Safety Council in 2016 as having the best policy approach to the epidemic.

- **New York City**: We have considered using our medical reserve corps to support dissemination of educational messages around opioids; we have used our mental health service corps to expand naloxone distribution over a 2-week period.

- **Pennsylvania**: The response to the opioid epidemic has been led by the Governor’s office, and coordinated through the Departments of Health, Human Services, and Drug and Alcohol programs working as a multi-agency task force.

- **Puerto Rico**: Currently there are no steps taken regarding a possible response to an opioid crisis. The jurisdiction has not officially declare, either administrative or by any other mean, that there is an epidemic... however it is important to point out that at the moment the jurisdiction does not have a steady count of the amount of possible cases seen due to Opioid OD, therefore there is no data that could contribute to support a declaration of a crisis or epidemic in PR.

- **Tennessee** provided the following document and news articles:
  - Tennessee Letter of Support for CDC “Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality” FOA
  - Four State Agency Leaders Call For Increased Awareness About Fentanyl August 29, 2016: [https://www.tn.gov/news/45112](https://www.tn.gov/news/45112)
Opioid Epidemic Information Scan

- **Texas**: This is a very complex and challenging response issue. Texas is somewhat fortunate to be among the states with a relatively lower prevalence of abuse and has not needed to activate a formal response structure.

- **Virginia**: CONOPS DRAFT is in review. Health Regional Champions / Cells are identified using State Police Regions to coordinate with counterparts. Coalitions are being engaged. Commissioner Standing Order for Naloxone published (see attached). Commissioner letters to Clinicians and Pharmacists published. In addition to the Virginia Department of Health activity on this issue, we have a multi-agency collaboration between our Secretariats of Health and Human Resources and Public Safety. Attached is the diagram as well as some descriptions of the structure. We are using heavily the ASTHO pyramid, which I have also attached.
  - Virginia Frameworks for Addiction Crisis pyramid
  - Virginia multi-agency collaborative leadership organization chart
  - Virginia overview of Governor’s Executive Leadership Team on Opioid Abuse & Addiction

- **Washington**: We are implementing a heightened level of project management across our agency to coordinate planning, information, and communications associated with the Opioid crisis. This is not the same as ICS, yet is aimed at achieving similar results. However, we are concerned about sudden and unexpected changes in the current situation, such as a large number of overdose deaths occurring in a very short time frame, as has occurred in Vancouver, B.C. Such consequences could force our hand toward an ICS response, albeit of short duration.

- **West Virginia**: Rahul Gupta, MD, MPH, FACP, Commissioner and State Health Officer, briefed the new Governor and the DHHR Cabinet Secretary on the opioid health crisis in January. As a result, the Bureau for Public Health was asked to help craft legislation to comprehensively address the opioid crisis. The Bureau assisted in developing the Governor’s omnibus bill (Senate Bill 418) which would establish the Comprehensive Substance Use Reduction Act and create the Office of Drug Control Policy under the direction of the Secretary of DHHR and the supervision of the State Health Officer. The bill incorporates the West Virginia Poison Center as a division of the Office. A companion bill, House Bill 3028, was introduced today [March 15, 2017].

Both bills are comprehensive in their focus on substance use and treatment and highlights of the bills are below:
The omnibus bill authorizes the Office of Drug Control Policy to establish clean syringe exchange programs to be operated by local boards of health and to set standards, practices and operational requirements. The Commissioner is authorized through the Secretary to propose legislative rules for the approval and certification of harm reduction programs.

The Office of Drug Control Policy will coordinate with other bureaus in DHHR and other state agencies in matters related to research, execution of drug control policy and for the management of state and federal grants.

The State Health Officer is directed to conduct a study of prescribing and treatment history of persons who suffered a fatal or nonfatal opiate overdose in calendar years 2013-2015.

The State Health Officer in conjunction with the Office is authorized to develop guidelines for prescribing opioids for acute pain.

The bill authorizes the Secretary of DHHR, through grants contracted with community based agencies, to plan, establish and administer pilot projects to develop effective and efficient prevention and treatment services for low-income, pregnant substance abusers.

The DHHR Secretary is directed to establish an unused prescription drug disposal program.

The bill directs the Department of Education and the Bureau for Public Health to develop comprehensive health education curriculum for students in grades kindergarten through twelve.

A liaison is created to coordinate employment services for persons seeking substance use disorder treatment. This position would facilitate coordination between Workforce West Virginia and the DHHR, Bureau for Behavioral Health and Health Facilities, and drug treatment providers to coordinate employment services, and

The bill transfers responsibility of the Controlled Substance Monitoring Program from the Board of Pharmacy to the Office of Drug Control Policy.

Additionally, the Bureau for Public Health is in the process of finalizing a report analyzing trend data regarding overdoses deaths. The data for 2016 thus far show an 11-12% increase in overdose deaths as compared to 2015. Toxicology testing and data analysis is not complete for 2016, so the percent increase will likely be greater. The Bureau completed a study of an opioid-related overdose incident that occurred in Huntington, West Virginia on August 15, 2016. The results of the report were presented to partners in February 2017.
The Bureau for Public Health has completed development of guidelines for syringe exchange programs, a voluntary certification program and set state-level standards for community project and the WVDHHR is exploring options for standing up a multi-agency command center and working to identify and engage partners.

- **Wisconsin**: Wisconsin is engaging in many activities to monitor the opioid epidemic including the release of a Wisconsin Opioid Overdose Morbidity and Mortality Report and enhanced monitoring of our statewide syndromic surveillance system, fatal overdoses, and EMS data system. This information has been shared with local agencies and other partners throughout the state for response and planning purposes. Wisconsin is utilizing a new tool called the Prescription Drug Monitoring Program (PDMP) to characterize and combat prescription opioid abuse. Wisconsin has also established an opioid coordination workgroup across the Division of Public Health to provide situational awareness and coordination of activities and actions related to opioid harm reduction. The Governor of Wisconsin created the Governor’s Task Force on Opioid Abuse to address and combat the opioid epidemic. Additionally, a standing order for Naloxone was enacted, allowing Wisconsin pharmacists to dispense Naloxone without a prescription to individuals at risk for opioid overdose or who may witness an overdose.

- **Wyoming**: WY is mostly focused on the wider availability of naloxone right now. There is a bill working its way through the legislature that would allow more access.