HPIO Addiction Evidence Project

Detailed policy scorecard

updated June 13, 2018

Prevention, treatment and recovery

Purpose and overview

This detailed policy scorecard provides information about addiction-related policy changes enacted in Ohio from 2013-2017. The scorecard:

- Describes the current status of evidence-based policies, programs and practices in Ohio
- Rates the extent to which these policies and programs align with evidence on what works
- Rates the extent to which these policies and program are reaching Ohioans in need
- Identifies opportunities for improvement

For a summary of the scorecard's key findings and a description of the scorecard methodology, see the **full report**.

This document contains the following sections:

- Definitions of the detailed scorecard rating levels and a list of acronyms
- Tables that describe Ohio's implementation of evidence-based policies, programs and practices
- Tables that list the sources of evidence used to develop this scorecard

Definition of scorecard levels

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

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

Acronyms

General terms

Cognitive behavioral therapy (CBT)
Continuing Medical Education (CMEs)
Drug Abuse Resistance Education (DARE)
General Assembly (GA)
House bill (HB)
Medication-Assisted Treatment (MAT)
Mid-biennium review (MBR)
Morphine Equivalent Dose (MED)
Ohio Administrative Code (OAC)
Ohio Automated Rx Reporting System (OARRS)
Prescription Drug Monitoring Program (PDMP)
Positive Behavior Interventions and Supports (PBIS)
Screening Brief Intervention and Referral to Treatment (SBIRT)
Senate bill (SB)
Washington State Institute for Public Policy (WSIPP)

Government agencies

State/local

Alcohol, Drug and Mental Health Board (ADAMH)
Governor's Cabinet Opiate Action Team (GCOAT)
Governor's Office of Health Transformation (OHT)
Ohio Department of Administrative Services (DAS)
Ohio Department of Health (ODH)
Ohio Department of Medicaid (ODM)
Ohio Department of Mental Health and Addiction Services (OMHAS)
Ohio Department of Public Safety (DPS)
Ohio Department of Rehabilitation and Corrections (DRC)
Ohio Public Employees Retirement System (OPERS)

Federal

Centers for Disease Control and Prevention (CDC)
Drug Enforcement Agency (DEA)
Office of Juvenile Justice and Delinquency Prevention (OJJDP)
National Academies of Science, Engineering and Medicine (NASEM)
U.S. Department of Health and Human Services (HHS)
U.S. Department of Health and Human Services, Office of the Surgeon General (shortened to Surgeon General's Office)
U.S. Department of Veterans Affairs (VA)
U.S. Preventive Services Task Force (USPSTF)

Prevention

Table 1. **Appropriate use of, and access to, prescription opioids: Prescribing and dispensing**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Opioid prescribing limits for acute pain	**Moderate evidence alignment** / **Strong implementation reach** • As regulated by the Dental, Nursing and Medical Boards starting in 2017, prescribers in Ohio can prescribe no more than 7 days of opioids for adults and 5 days of opioids for minors (with parental consent).[1] • These limits do not apply to opioids prescribed for cancer, palliative care, hospice care or MAT. • Adherence to the limits is tracked through OARRS.	• Monitor and evaluate the 2017 prescribing limits • Based on evaluation results, consider revising prescribing limits to meet the CDC recommendation (3 days[2]) or the VA recommendation (3-5 days) ***Note:*** Other states have prescribing limits of 3-5 days, such as Kentucky, Minnesota and New Jersey. • Increase enforcement of prescribing limits • Offer education and technical assistance to help providers operationalize and implement prescribing limits
Other opioid prescribing guidelines for acute pain	**Strong evidence alignment** / **Unknown implementation reach** • In 2016, GCOAT released guidelines for the management of acute pain outside of emergency departments.[3] • This guidance aligns with the evidence by advising prescribers to use non-pharmacological therapies (such as exercise, massage and acupuncture), followed by non-opioid pharmacological treatment if non-pharmacological therapy is insufficient alone. • In the case of severe injuries, surgery or when non-opioid options are ineffective, the guidance states that opioids may be prescribed for acute pain. • Because the GCOAT prescribing guideline for acute pain is guidance rather than a requirement, it is difficult to know the extent to which it is being implemented across the state.	Offer education and technical assistance to help providers operationalize and implement prescribing guidelines
Opioid prescribing guidelines for chronic pain (non-cancer, non-terminal pain)	**Strong evidence alignment** / **Unknown implementation reach** • In 2013, GCOAT released guidelines for the treatment of chronic, non-terminal pain.[4] • The GCOAT guideline advises prescribers to use non-pharmacologic and non-opioid therapies, discuss the risks and realistic benefits of opioid therapy with the patient, avoid extended-release formulations of opioids and reassess compliance every 12 weeks. • The guideline also suggests that prescribers reevaluate the treatment plan when the patient's daily opioid intake reaches 80 mg MED. • Because the GCOAT prescribing guideline for chronic pain is guidance rather than a requirement, it is difficult to know the extent to which it is being implemented across the state.	• Revise the opioid prescribing guidelines for chronic pain so that the trigger point for treatment reevaluation is 50 mg MED, as recommended by the CDC[5] • Offer education and technical assistance to help providers to operationalize and implement prescribing guidelines

Table 1. **Appropriate use of, and access to, prescription opioids: Prescribing and dispensing** (cont.)

Evidence-based policy, program or practice*	**Ohio status** (brief description of Ohio implementation)**	Opportunities for improvement
Prescription Drug Monitoring Program (PDMP)	**Strong evidence alignment** | **Moderate implementation reach** **Components and requirements** • The Ohio Board of Pharmacy launched OARRS, Ohio's PDMP, in 2006 and has made several system enhancements in recent years, such as mandated reporting for prescribers of opioids and benzodiazepines; data system integration with electronic health records and overdose death data; NARX report cards for patients; and education for providers, patients and law enforcement. • Prescribers are required to check a patient's prescription history in OARRS before they prescribe or personally furnish an opioid or a benzodiazepine (with some exceptions), and pharmacists must report every controlled substance dispensed to an outpatient to OARRS. **Utilization and impact** • In March 2017, 87% of prescribers who prescribed a controlled substance in the past month had checked OARRS.[6] • The number of retail-filled opioid prescriptions in Ohio decreased by 19.6% from 2013 to 2016, faster than the 14.6% decline for the U.S. in the same time period.[7] **Evidence alignment relative to other states** • A 2016 review of state PDMPs reported that Ohio has adopted 6 of the 8 evidence-based practices to optimize prescriber use of PDMPs.[8] • CDC Prevention Status Reports rate Ohio highly for implementing two key evidence-based PDMP policies (prescriber mandate and timely submission requirements).[9]	• Continue to adopt additional evidence-based practices to increase OARRS utilization, including greater use of unsolicited reports to flag potentially harmful drug use or prescribing activity • Increase integration with electronic health records, including with the VA system • Increase enforcement of PDMP requirements and regulations • Using the TTAC Best Practice Checklist, identify additional steps Ohio can take to improve OARRS performance and outcomes[10]
E-prescribing of controlled substances (EPCS)[11]	**Moderate evidence alignment** | **Strong implementation reach** • EPCS became legal in Ohio in 2011 (OAC 4729-5-21 and 4729-5-30). • According to federal regulation (21 CFR part 1311), EPCS is only permitted if the provider or pharmacy's e-prescribing software has been audited or certified by an approved third-party. • As of October 2017, 95% of Ohio pharmacies had certified e-prescribing software, while only 13% of prescribers use software that is EPCS certified.[12] • Research indicates that EPCS reduces medication errors and adverse drug events, improves patient safety and increases adherence to clinical guidelines.	Create e-prescribing requirements for controlled substances, similar to New York's EPCS requirement

*As identified in the HPIO **Evidence Resource Page: Prevention, Treatment and Recovery**
**As of December 2017, as identified in the Ohio policy inventory and information from state agencies. Note that the inventory includes policy changes enacted in 2013 to 2017. Some policies prior to 2013 are included in this detailed scorecard when highly relevant.

Table 2. **Appropriate use of, and access to, prescription opioids: Non-opioid pain management**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Provider and patient education on non-opioid pain management	**Strong evidence alignment** / **Weak implementation reach** • In 2017, ODH and other state agencies launched the Take Charge Ohio campaign to promote safe pain management and medication use, consistent with evidence-based guidelines. • Although physican owner/operators of pain management clinics must complete 20 hours of CME in pain medicine every 2 years[13], other Ohio healthcare providers are not required to be trained in addiction or pain management.	Require providers with DEA registration to prescribe controlled substances to complete mandatory CME credits on addiction, opioid and benzodiazepine prescribing, appropriate pain management and other relevant topics
Insurance coverage for non-opioid pain management-Complementary and integrative therapies (acupuncture, massage, chiropractic/ spinal manipulation) (through public payers)	**Strong evidence alignment** / **Unknown implementation reach** **Medicaid** In 2017, Ohio Medicaid added acupuncture as a covered service for non-opioid pain management (for lower back pain and migraines), and added acupuncturists as certified providers in 2018. • 27 counties have at least one acupuncture provider eligible to receive Medicaid reimbursement. • Ohio Medicaid covers chiropractor services (15 visits every 12 months for adults age 21+). • Ohio Medicaid covers therapeutic massage if provided by a physician, physical therapist or other certified provider. **Retired state employees** • OPERS does not cover acupuncture or massage. • OPERS covers up to 10 chiropractic visits within the benefit period. *Note: DAS declined to provide information to HPIO on coverage of non-opioid pain management therapies. Current state employees are therefore not included in this section of the scorecard.*	**Medicaid** • Increase awareness of Medicaid coverage of acupuncture, massage and chiropractic care among enrollees and providers • Monitor utilization and effectiveness of acupuncture, consider expanding coverage for additional conditions, and extend acupuncture access to counties that do not currently have it **Retired state employees** Explore coverage of acupuncture and massage for pain management for retired state employees
Insurance coverage for non-opioid pain management-Rehabilitative therapies (physical therapy, occupational therapy, multi-disciplinary) (through public payers)	**Strong evidence alignment** / **Strong implementation reach** **Medicaid** • Ohio Medicaid covers 30 visits for physical and occupational therapy combined every 12 months. • Physical therapy and occupational therapy are available in all regions of the state. **Retired state employees** • OPERS covers physical and occupational therapy, with some limits and subject to deductible and coinsurance	**Medicaid** • Increase awareness of the role of physical and occupational therapy for pain management among Medicaid patients and providers • Improve Medicaid Non-Emergency Medical Transportation in order to increase access to physical and occupational therapy appointments **Retired state employees** • Increase awareness of the role of physical and occupational therapy for pain management among OPERS-covered patients and providers

Table 2. **Appropriate use of, and access to, prescription opioids: Non-opioid pain management** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Insurance coverage for non-opioid pain management-Exercise and movement (tai chi, yoga and other exercise) (through public payers)	**Weak evidence alignment**	**Weak implementation reach**	**Medicaid and retired state employees** • Increase utilization of tai chi, yoga and other exercise-related evidence-based pain management among physical and occupational therapists • Explore reimbursement for these activities through Medicaid and state employee coverage • Build upon the Ohio Injury Prevention Partnership's efforts to expand availability of Tai Chi in Ohio (for older adult fall prevention) • Increase awareness among Medicaid enrollees, state employees and providers about these activities as pain management strategies
	Medicaid Ohio Medicaid does not cover tai chi, yoga or other exercise/movement services (although some physical and occupational therapists may incorporate these approaches into their care). **Retired state employees** OPERS does not cover tai chi, yoga or other exercise.		
Insurance coverage for non-opioid pain management-Psychological (CBT, progressive relaxation, mindfulness-based stress reduction, operant therapy) (through public payers)	**Mixed evidence alignment**	**Unknown implementation reach**	**Medicaid and retired state employees** Increase use of CBT, progressive relaxation and other stress reduction therapies for pain management among physical and behavioral health providers Increase awareness among Medicaid enrollees, state employees and providers about these activities as pain management strategies
	Medicaid • Ohio Medicaid covers mental health counseling, which may include CBT, although the extent to which CBT is being used for pain management is not known. • Ohio Medicaid does not specifically cover progressive relaxation or mindfulness-based stress reduction. **Retired state employees** These services may be covered by OPERS through psychotherapy.		
Insurance coverage for other non-pharmacologic, non-opioid pain management (e.g. biofeedback, laser therapy) (through public payers)	**Weak evidence alignment**	**Weak implementation reach**	**Medicaid** Explore Medicaid reimbursement for biofeedback and laser therapy for pain management
	Medicaid Ohio Medicaid does not cover biofeedback. **Retired state employees** OPERS covers biofeedback, subject to deductible and coinsurance.		

Table 2. **Appropriate use of, and access to, prescription opioids: Non-opioid pain management** (cont.)

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Insurance coverage for non-opioid pain management-Pharmacologic (NSAIDs, muscle relaxants, topicals) (through public payers)	**Strong evidence alignment** / **Unknown implementation reach** • Ohio Medicaid and OPERS cover these medications if prescribed by a provider. • The extent to which these medications are used for pain management is unknown.	• Assess the extent to which these medications are being used for pain management • Increase provider use of these medications as an alternative to opioids
Prescription drug disposal and take-back programs	**Strong evidence alignment** / **Weak implementation reach** • In 2014, the Board of Pharmacy adopted rules authorizing pharmacies to accept unused or expired prescription controlled substances from the public.[14] • Additional rules passed in 2015 specified other provisions related to drug collection and destruction.[15] • Many Ohio communities have DEA-certified collection sites, although the regulations can be a burden to adoption. DEA provides **a list** of of Controlled Substance Public Disposal Locations, searchable by zip code or city (not county).	Increase the number of pharmacies participating in drug disposal and take-back programs

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Table 3. **Child and family-focused prevention**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Early childhood interventions (ages 0-5): Nurse-Family Partnership home visiting program Included in SHIP	**Strong evidence alignment** / **Weak implementation reach** • Nurse-Family Partnership is one of the home visiting models administered by ODH as part of the Help Me Grow program, supported in part by federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding. • In SFY 2016, Nurse-Family Partnership was implemented in 3 counties and served 350 families (state/federally-funded).[16]	• Expand Nurse-Family Partnership to reach more low-income families • Implement Nurse-Family Partnership in more counties, prioritizing counties with high rates of drug overdose deaths
Early childhood interventions (ages 0-5): Other evidence-based home visiting programs Included in SHIP	**Strong evidence alignment** / **Moderate implementation reach** • SB 332 (2017) requires that all home visiting programs be evidence-based or "innovative, promising home visiting models recommended by the Ohio Home Visiting Consortium." • Through ODH's Help Me Grow program, evidence-based home visiting is being implemented in 86 counties, primarily serving low-income families. • At most, 4.7 percent of Ohio children under age 6 living below 100 percent FPL received home visiting services from a state and/or federally-funded program in SFY 2016.[17]	Expand Help Me Grow to reach more low-income Ohio families
Early childhood interventions (ages 0-5): Parenting education (such as Incredible Years and similar programs with substance use reduction outcomes)	**Strong evidence alignment** / **Unknown implementation reach** • The Ohio Children's Trust Fund (OCTF) provides funding to local communities to implement the Incredible Years and other evidence-based parenting programs. • Information about the number of families participating in Incredible Years was not available.	Expand Incredible Years and other evidence-based parenting education programs to reach more families
School-based universal prevention programs: PAX Good Behavior Game and Botvin Life Skills Included in SHIP	**Strong evidence alignment** / **Unknown implementation reach** • As result of funding from 2014 MBR (HB483), OMHAS funded 13 counties to implement PAX GBG and the Life Skills program for 1 year and many have continued the programs with support from local ADAMH Boards and other community partners. • With funds from the federal Cures STR 2-year grant, OMHAS is providing training and technical assistance on these programs in 2017-2018. Over 50 counties and 800 teachers have participated in PAX GBG training in 2017 (goal is to train at least 1000 teachers by 2018) and 122 participants in 25 counties have participated in Life Skills training (middle and high school). • The total number of counties, schools and students reached by these programs is currently unknown, although OMHAS is in the process of collecting this information.	• Increase funding to schools and community partners to support training, ongoing technical support and implementation of these programs • Improve monitoring and evaluation of school-based prevention programs

Table 3. **Child and family-focused prevention** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
School-based universal prevention programs: DARE and Keepin' it REAL	**Moderate evidence alignment**	**Moderate implementation reach**	Ensure that all DARE officers are implementing Keepin' It REAL, or some other evidence-based curriculum
	• Although the traditional DARE program (1983-2009) was not found to be effective in reducing youth substance use[18], a newer DARE curriculum, Keepin' it REAL, has been evaluated and found to be effective.[19] • The AG's office provides prevention grants to local law enforcement agencies. Grantees can select an evidence-based curriculum to implement and most select Keepin' It REAL. • In 2014-2015, the AG provided approximately $3 million to 157 local agencies to implement DARE with almost 362,000 students.[20] • In 2017-2018, the AG provided approximately $3 million to 130 agencies, representing 58 counties.[21]		

Table 3. **Child and family-focused prevention** (cont.)

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Other school-based prevention programs for children ages 5-17 (universal or selective prevention)	**Mixed evidence alignment** **Unknown implementation reach** **K-12 drug prevention education requirements** • HB 367 (2014) required the Board of Education for each local school district to select a health curriculum that includes instruction on the dangers of prescription opioids. • ODE guidance to districts on HB 367 includes grade-band-appropriate information specific to prescription opioids, but does not include information about more comprehensive, evidence-based programs or about the K-12 Health and Opioid Abuse Prevention Education (HOPE) curriculum. • HB 49 (2018-19 state operating budget) required teacher preparation programs to include instruction on opioid and other substance abuse prevention. Guidance on this provision refers back to the HB 367 materials mentioned above, as well as Start Talking! and Generation Rx. • Ohio is the only state that does not have comprehensive health education standards. **State agency activities** • In 2017, OMHAS released the HOPE curriculum to help schools meet HB 367 requirements. Teacher training on the curriculum is to begin in 2018. • OMHAS has implemented several educational campaigns with school-based components, including: 5 Minutes for Life campaign, Start Talking!, Know! Tips and TEACHable Moments. • Since 2013, OMHAS has awarded approximately $2 million per year to local communities through SAMHSA Safe Schools Healthy Students grant funds, and in partnership with ODH, worked with communities to develop infrastructure and capacity for preventing and reducing risk factors associated with behavioral health and including alcohol, tobacco and other drugs (ATOD).[22] • The AG's 2017 Joint Study Committee on Drug Use Prevention Education report made 15 recommendations to improve drug prevention, including school-based programs. **Implementation reach** • School districts around the state are implementing various drug prevention curricula. A comprehensive inventory of the number of schools or students receiving evidence-based programming is not currently available. • OMHAS has hired an external evaluator to survey schools and other partners in order to gather this information. Results should be available in 2018.	• Add information about evidence-based universal prevention programs and the HOPE curriculum to the Opioid Abuse Prevention Requirements for Schools (HB 367) website (e.g., links to evidence registries such as the OJJDP Model Programs Database or WSIPP) and better support districts to implement them • Ensure that school-based drug prevention includes all substances (marijuana, alcohol, tobacco, methamphetamine, etc.), in addition to opioids • Improve monitoring and evaluation of school-based prevention programs, including assessment of the extent to which evidence-based programs are reaching Ohio students of all ages • Implement other recommendations from the AG's 2017 Joint Study Committee • Monitor implementation of the HOPE curriculum and evaluate impact on outcomes • Establish health education standards for the state of Ohio • Evaluate professional development received by licensed teachers to plan and conduct health education • Support efforts to improve school climate, build social-emotional skills and fully implement PBIS • Expand school-based behavioral health services

Table 3. **Child and family-focused prevention** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Community or family-based prevention programs for children ages 5-17, including mentoring (universal or selective prevention)	**Unknown evidence alignment**	**Unknown implementation reach**	Assess the extent to which ADAMH boards are investing in evidence-based prevention activities
	• Mentoring programs, such as Big Brothers Big Sisters, are an evidence-based approach being implemented in many Ohio communities. A comprehensive, statewide inventory of these programs is not currently available. • All ADAMH boards receive funding allocations for prevention services, including youth-led prevention. Rigorous research evidence on the effectiveness of youth-led prevention is not currently available. • OMHAS funds the Prevention Action Alliance (PAA) to oversee the Ohio Youth Led Prevention Network (OYLPN) and the Ohio Youth Council (OYC). Fifty counties have at least one OYLPN affiliate.		
Community mobilization to reduce youth access to tobacco Included in **SHIP**	**Strong evidence alignment**	**Mixed implementation reach**	Increase the number of local communities participating in evidence-based approaches to reducing youth access to tobacco, including advocacy for Tobacco 21
	• In 2014, HB144 prohibited children from using or purchasing alternative nicotine products. • ODH funds 20 counties to engage youth in tobacco prevention activities, including collection of tobacco marketing data, compliance checks with sales to minors laws and marketing to counter the marketing of tobacco. • 9 local communities have passed "Tobacco 21" laws raising the minimum age to purchase tobacco products		
Enhanced enforcement of laws prohibiting sales of alcohol to minors	**Strong evidence alignment**	**Unknown implementation reach**	Ensure continuation of compliance checks and appropriate follow-up action
	OMHAS funds programs to assess retailer compliance on refusing to sell alcohol and tobacco to minors.		

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SHIP: 2017-2019 State Health Improvement Plan

Table 4. **Other community-based prevention**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Prevention programs for ages 18+ (including college and workplace programs)	**Weak evidence alignment** | **Weak implementation reach** • OMHAS provides small grants to 6 colleges/universities and the Prevention Action Alliance College initiative, focused on 52 colleges and universities, with minimal requirements for evidence alignment. • ODH promotes adoption of tobacco-free college campus policies. • There is no specific state funding allocated for community-based prevention aimed at adults not enrolled in college/university (other than the Take Charge Ohio campaign described above).	• Expand community-based prevention efforts to reach adults ages 25-64—the group with the highest rates of overdose deaths • Given that overdose death rates are much higher among Ohioans with lower levels of education, community-based prevention activities for adults who are not enrolled in college should be explored. Workplace programs, particularly in lower-wage industries, may be an effective way to reach this population.
Local community prevention coalitions using evidence-based models, such as Communities that Care and PROSPER	**Unknown evidence alignment** | **Unknown implementation reach** • In 2015 and 2017, GCOAT released a toolkit which includes guidance for local coalitions. • ODH, OMHAS and DPS have all received federal funds for grants to local communities to support prevention coalitions or drug task forces. These grants typically cover a small number of counties. In addition, Ohio has 10 Strategic Prevention Framework/ Partnerships for Success coalitions and 26 Drug Free Communities coalitions (some federally funded, others state funded). • OMHAS funds the Statewide Prevention Coalition Association, which provides training and technical assistance to local prevention coalitions. • HB 49 (2018-19 state budget) included the County Hub program which requires ADAMH boards to administer the hubs and report to OMHAS on their progress. • Some local coalitions are using the Communities that Care model or other evidence-informed approaches, but the extent to which all local coalitions in Ohio are implementing evidence-based strategies is unknown. The number of counties with an active prevention coalition is unknown.	• Conduct an environmental scan to identify all of the community addiction prevention coalitions in the state supported by OMHAS, ODH, the AG or other state or local entities • Use the results to improve coordination, information-sharing and implementation of evidence-based approaches
Smoke-free policies Included in **SHIP**	**Strong evidence alignment** | **Strong implementation reach** (workplace) • Ohio has comprehensive smoke-free workplace law that is monitored and enforced. • In addition, ODH currently funds 26 counties to pursue promotion of tobacco-free or smoke free environments including smoke-free multi-unit housing, tobacco free schools and college campuses and tobacco-free outdoor spaces.	• Maintain and enforce Ohio's smoke-free workplace law, including prompt collection of fines for violations • Support implementation and enforcement of HUD smoke-free multi-unit housing rule

Table 4. **Other community-based prevention** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Increase unit price for tobacco products Included in SHIP	**Moderate evidence alignment**[23]	**Strong implementation reach**	• Increase excise taxes on cigarettes/ other tobacco products and/or allow local municipalities to do so. Impacts on tobacco use are proportional to the size of the price increase • Revise Ohio's minimum price law to prohibit the use of price discounting tactics
	Excise tax rate on traditional cigarettes: Ohio's cigarette tax was increased by $0.35 in 2015 and is now $1.60 per pack, similar to the national average of $1.61 per pack. **Excise tax rates for other tobacco products and e-cigarettes:** • Little cigars: 37 percent of wholesale price • Other tobacco products: 17 percent of wholesale price (unchanged since 1993) • Electronic smoking devices and nicotine liquid: None • ODH manages mass media campaigns delivered via TV, radio, social media, etc. • The Centers for Disease Control and Prevention (CDC) funds and implements the national "Tips for Former Smokers" campaign in Ohio. • Ohio spent approximately $1.9 million on media campaigns in SFY 2016; the CDC-recommended level of investment for Ohio is $14.4 million.		
Media campaigns for tobacco prevention Included in SHIP	**Strong evidence alignment**	**Weak implementation reach**	Increase investment in mass media campaigns aimed at youth and adults
	• ODH manages mass media campaigns delivered via TV, radio, social media, etc. • The Centers for Disease Control and Prevention (CDC) funds and implements the national "Tips for Former Smokers" campaign in Ohio. • Ohio spent approximately $1.9 million on media campaigns in SFY 2016; the CDC-recommended level of investment for Ohio is $14.4 million.		
State funding for tobacco prevention and control	**Weak evidence alignment**[24]	**Weak implementation reach**	Increase funding for tobacco prevention and control to better align with the CDC's minimum recommended amount of $92 million per year
	In SFY 2017, Ohio's investment in tobacco prevention and control was 11.8% of the amount recommended by CDC.		
Increase alcohol taxes	**Weak evidence alignment**[25]	**Weak implementation reach**	Increase excise taxes for beer, wine and other alcohol products
	• Ohio's excise tax per gallon of beer is $0.18. • Ohio's excise tax per gallon of wine is $0.32.		

Table 4. **Other community-based prevention** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Regulate alcohol outlet density	**Weak evidence alignment**	**Weak implementation reach**	Reduce alcohol outlet density by increasing existing liquor licensing restrictions
	• The Ohio Department of Commerce Division of Liquor Control is responsible for controlling the manufacture, distribution, licensing, regulation, and merchandising of beer, wine, mixed beverages and spirituous liquor. • There are no state-level efforts underway to reduce alcohol outlet density in Ohio from current levels.		
Dram shop (commercial host) liability and other alcohol sales restrictions	**Moderate evidence alignment**	**Moderate implementation reach**	Strengthen the commercial host liability law, and/or strengthen enforcement of current law
	• Ohio has a commercial host liability law, with some limitations.[26] • SB 7 (2015) prohibits the sale of powdered alcohol.		

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SHIP: 2017-2019 State Health Improvement Plan

Treatment

Table 5. **Screening and early intervention**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Screening, Brief Intervention and Referral to Treatment (SBIRT) for adults and screening practices consistent with the USPSTF screening recommendation for primary care providers (adult alcohol misuse) Included in **SHIP**	**Strong evidence alignment** **Unknown implementation reach** • In 2013, SBIRT became a Medicaid billable service. • OMHAS has received federal funding to support SBIRT training and implementation in 18 counties ($10 million SAMHSA grant in 2013, plus Cures STR grant funds). • SBIRT is provided to caregivers participating in Help Me Grow home visiting. • Stakeholders report that SBIRT implementation in Ohio has focused primarily on screening, while referral to treatment may be lacking. • The total number of patients who are receiving SBIRT or number of providers who are implementing SBIRT in Ohio is unknown.	Strengthen implementation and monitoring of "referral to treatment" component of SBIRT
SBIRT for adolescents and screening consistent with American Academy of Pediatrics Policy statement on alcohol use by youth	**Strong evidence alignment** **Unknown implementation reach** • OMHAS is not currently funding SBIRT for adolescents. Private foundations and some school districts are supporting SBIRT in some communities. • ODH provided in-person SBIRT training to 100 school nurses and has made online SBIRT study available through the OhioTrain online training website.	Integrate SBIRT into school-based health services

Table 5. **Screening and early intervention** (cont.)

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Tobacco use screening Included in **SHIP**	**Moderate evidence alignment** / **Unknown implementation reach** **OHT and ODM** • Ohio's Comprehensive Primary Care Program (CPC) clinical quality metrics include a tobacco screening and cessation metric.[27] • Starting in 2017, ODM added the same quality metric as a contract requirement for managed care plans. • Performance on this metric for CPC and managed care plans has not yet been reported. State-level data on the percent of patients appropriately screened for tobacco use is therefore not currently available. • ODM is not currently undertaking any initiatives to increase enrollee use of cessation services. **ODH** • ODH funds 5 community cessation projects in 12 counties to develop capacity to address adult tobacco dependence, including training on tobacco use screening and referral for healthcare providers. • ODH also funds 3 Disparity Demonstration Projects designed to decrease tobacco use among high-risk groups (people with mental illness, people with disabilities, low-income Ohioans). • ODH does not currently fund any programs to support screening or cessation for youth tobacco use.	• Review performance data on tobacco screening and cessation, set targets and identify specific strategies to increase effective tobacco use screening and cessation services among providers who participate in CPC and/or Medicaid • Increase provider awareness of effective screening methods, cessation referral sources and Medicaid cessation coverage • Increase patient awareness of Medicaid cessation coverage

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Table 6. **Treatment services**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Medication-Assisted Treatment for opioid use disorder Included in SHIP	**Strong evidence alignment**	**Weak implementation reach** (with efforts under way to increase to moderate)	• Increase the number of counties that have all 3 types of MAT, including better access to methadone and buprenorphine in rural counties • Increase percent of substance abuse treatment facilities and primary care providers that offer MAT • Assess the extent to which providers with waivers to prescribe buprenorphine are actually providing this service • Ensure that certified buprenorphine prescribers are maximizing their ability to fill capacity gaps, while adhering to ASAM guidelines and state and federal regulations • Assess the extent to which MAT medications are being paired with effective psycho-social approaches and improve integration as needed • Integrate MAT into primary care and specialty (e.g., OB/GYN) medical practices • Increase collaboration between state and federal regulatory bodies responsible for MAT (Medical Board, Pharmacy Board, DEA)
	Coverage and requirements • Ohio Medicaid began covering MAT in 2011. • MAT is included in continuum of care requirements for ADAMH boards. • The State Medical Board has developed draft rules to establish standards for physicians and physician assistants for MAT consistent with ASAM National Practice Guidelines. These rules are currently under review.[28] **Efforts to increase utilization** • Ohio has implemented several programs to increase access to MAT for justice-involved adults, including partnerships with drug courts, jails, prisons and re-entry programs. • In 2017, the Board of Pharmacy developed rules permitting pharmacists to administer long-acting, non-narcotic MAT at pharmacies. • Ohio's federal Cures STR 2-year grant includes several strategies to increase access to MAT, including training for physicians to obtain waivers that allow them to prescribe buprenorphine. **Implementation reach and provider capacity** • 13 counties have at least 1 provider for all 3 types of MAT (Methadone, Buprenorphine, Naltrexone/Vivitrol).[29] • 65 counties have at least 1 provider for 2 types of MAT.[30] • 10 counties have 0 MAT providers.[31] • 32.8% of outpatient substance abuse treatment facilities in Ohio offer MAT, compared to 21.4% in the U.S. overall.[32] • A 2017 OSU study estimated that Ohio's current MAT capacity can serve only 10 to 40% of those in need of opioid abuse treatment.[33] • Analysis by Avalere determined that Ohio's ratio of certified buprenorphine providers to opioid overdose deaths was significantly worse than most other states (see Figure 6).[34]		
Medication-Assisted Treatment for alcohol use disorder	**Strong evidence alignment**	**Unknown implementation reach**	Medicaid Managed Care organizations and other payers can cover Vivitrol and other FDA-approved MAT utilization for alcohol use disorder
	SB 319 (2016) specified that MAT in the ADAMH board continuum of care must include MAT for the treatment of alcoholism (in addition to opioid use disorder).		
Behavioral therapies/ Psychosocial treatment for substance use disorder	**Strong evidence alignment**	**Weak implementation reach** (with efforts under way to increase to moderate)	• Increase education of addiction treatment providers on evidence based practices • Track and evaluate the extent to which MAT is accompanied by evidence-based psychosocial counseling across the state
	• OMHAS certification rules require addiction treatment providers to use ASAM guidelines which recommend psychosocial treatment in conjunction with MAT. • Ohio's federal Cures STR grant includes an initiative to train counselors, case managers and other care providers in evidence-based behavioral/psychosocial therapies.		

Table 6. **Treatment services** (cont.)

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Treatment for infants with Neonatal Abstinence Syndrome (NAS)	**Strong evidence alignment** / **Moderate implementation reach** • The Ohio Perinatal Quality Collaborative, in partnership with the Ohio Children's Hospital Association, has established a protocol for the treatment of NAS, which was updated in 2017. • The protocol aligns with evidence by emphasizing non-pharmacological treatment for all infants with NAS, complimented by pharmacological treatment (either methadone or morphine). Adjunct therapies, phenobarbital or clonidine, are to be used only when necessary. • The protocol is part of a NAS Project with 54 participating sites, including NICUs, special care nurseries and newborn nurseries.	• Evaluate the NAS project and assess whether adjustments should be made • If the evaluation results are favorable, expand the reach of the project; consider strategies to implement the protocol statewide • Increase adoption of the NAS protocol as a standard form of practice in all Level 1 and Level II NICUs
Treatment for pregnant women with substance use disorder, including appropriate use of MAT	**Strong evidence alignment** / **Weak implementation reach** • The MOMS program provides pregnant women with access to care coordination to help manage various appointments (prenatal, behavioral health, MAT) and to ensure that women have access to housing, food, child care and other resources. • MOMS providers prescribe methadone or buprenorphine, which is consistent with the evidence. • The initial MOMS project was started by OMHAS in 2013 and was completed in 2016. • With support from the 21st Century Cures STR grant, MOMS 2.0 was launched in January 2018 with sites covering 8 counties. OMHAS plans to add three additional sites in 2018-2019, and anticipates serving at least 600 women.	• Evaluate MOMS 2.0 and assess whether adjustments to the program should be made • If the evaluation results are favorable, expand the reach of MOMS • Ensure that MOMS providers are adhering to ASAM dosing guidelines for MAT for pregnant women[35]
Drug courts and specialized dockets	**Strong evidence alignment** / **Moderate implementation reach** OMHAS has launched several programs related to drug courts, covering 46 counties. The programs are described below: **Specialized Docket Subsidy Project** • OMHAS distributes funding to approximately 140 specialized dockets in 42 counties. Funding can be used for administrative costs, treatment services, such as MAT, and recovery supports. **Addiction Treatment Program** • Provides addiction treatment and recovery support services to clients involved with selected specialized dockets. These clients must have an opioid and/or alcohol addiction and be deemed eligible for MAT. **Legacy Drug Courts** • OMHAS funds 23 courts in 17 counties for comprehensive supervision, drug testing, treatment services, sanctions and incentives.	• Create and follow an evidence-based standard of MAT utilization in drug courts and jails/prisons • Adopt diversion programs to encourage low-level, non-violent offenders to seek addiction treatment • Adjust sentencing requirements (i.e., mandatory sentencing) to increase the use of alternative sentencing programs

Table 6. **Treatment services** (cont.)

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Treatment referral for justice-involved clients with substance use disorder, including appropriate use of MAT	**Strong evidence alignment** / **Moderate implementation reach** • The Addiction Treatment Program began providing MAT and recovery support services for clients on a specialized docket in 2014. • In 2016, the DPS Office of Criminal Justice Services provided funds to 5 drug treatment projects through the federal Residential Substance Abuse Treatment (RSAT) Program, which funds addiction treatment in prisons, jails and after-care facilities. • All 27 Ohio prisons offer the Medicaid Pre-Release Enrollment Program and more than 15,000 Ohioans transitioning from prison to the community have been enrolled in a Medicaid managed care plan.	• Increase access to MAT and other substance abuse treatment services while individuals are incarcerated • Increase the number and reach of transitional services to individuals who are reentering into the community (treatment services, recovery supports, healthcare access, job training, etc.)
Tobacco cessation treatment within healthcare setting Included in SHIP	**Moderate evidence alignment** / **Weak implementation reach** **OHT and ODM** • A clinical quality metric for tobacco screening and cessation has been added to Ohio CPC and Medicaid managed care plan contracts. • Performance on this metric for CPC and ODM has not yet been reported. • Ohio Medicaid covers tobacco cessation, including all FDA-approved pharmacotherapy, although use of this coverage is fairly low.[36] • ODM is not currently undertaking any initiatives to increase tobacco cessation among Medicaid enrollees. **ODH** • ODH funds 5 community cessation projects in 12 counties to develop capacity to address adult tobacco dependence, including training on tobacco use screening and referral for healthcare providers. • ODH also funds 3 Disparity Demonstration Projects designed to decrease tobacco use among high-risk groups (people with mental illness, people with disabilities, low-income Ohioans). • ODH does not currently fund any programs to support screening or cessation for youth tobacco use.	Launch a high-intensity effort to increase cessation services by healthcare providers, with particular emphasis on Medicaid enrollees
Tobacco cessation treatment within healthcare setting: Pregnant women Included in SHIP	**Strong evidence alignment** / **Weak implementation reach** • ODH's Maternal and Child Health Program funds 28 Baby and Me Tobacco Free Programs in Ohio which focus on training that includes screening for tobacco use, consistent with USPSTF recommendations. • Ohio Partners for Smokefree Families funds 6 cessation projects in southern Ohio, consistent with USPSTF recommendations.	Increase awareness of cessation services for pregnant women among healthcare providers

Table 6. **Treatment services** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Tobacco quitlines and mobile phone-based cessation programs Included in **SHIP**	**Strong evidence alignment**	**Weak implementation reach**	• Remove all barriers to use of the Quit Line • Expand awareness, use and capacity of the Quit Line
	• The Ohio Tobacco Quit Line, which provides evidence-aligned quit coaching and nicotine replacement therapy, is highly effective for those who can access it, but utilization is much lower than in most other states.[37] • Access to Ohio's Quit Line is not universal. Many privately-insured Ohioans do not have access to the Quit Line. • As of July 1, 2016, all Medicaid and Medicare enrollees are eligible to enroll in the Quit Line.		

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Table 7. **Treatment system access and coverage**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Insurance coverage: Access to coverage, including Medicaid Included in SHIP	**Strong evidence alignment**	**Stong implementation reach**	• Continue policies that have contributed to Ohio's historically low uninsured rate, including maintenance of current Medicaid extension eligibility levels • Ensure that Medicaid managed care plans provide adequate coverage for all forms of evidence-based substance abuse treatment, including MAT coverage consistent with ASAM guidelines • Assess the extent to which Medicaid Managed Care organizations are held accountable for paying for services
	Medicaid eligibility • Ohio extended Medicaid eligibility to all adults with incomes less than 133% FPL in 2014. • According to a SAMHSA survey, 86.2% of outpatient substance abuse treatment facilities in Ohio accept Medicaid, compared to 62% in the U.S. overall.[38] • Ohio's uninsured rate for adults ages 18-64 was 4.7% in 2016, compared to 9.7% in the U.S.[39]		
Insurance coverage: Parity for behavioral health care Included in SHIP	**Moderate evidence alignment**	**Unknown implementation reach**	• Actively promote awareness of federal and state parity laws • Strengthen monitoring and enforcement of federal behavioral health parity law, regulations and guidance • Address problems identified through the consumer hotline
	Parity monitoring and enforcement • ODI has had a complaint process for consumers for several years. However, prior to 2018, stakeholders report that most consumers either did not know about this process or had difficulty navigating it. • The 2018-19 state budget (HB 49) required the superintendent of insurance to develop consumer and payer education on mental health and addiction services insurance parity and establish a consumer hotline to collect information and help consumers understand and access their insurance benefits. • In order to meet this requirement, ODI has released an **online toolkit** that includes a 2018 mental health parity report, a comparison chart of Ohio mental health benefits and an FAQ page for consumers.		

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Table 8. **Treatment system capacity and workforce**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Treatment system capacity	**Unknown evidence alignment** (implementation in progress) / **Unknown implementation reach** **Behavioral Health Redesign** • OHT, OMHAS and ODM are leading Behavioral Health Redesign, an initiative to improve community behavioral health system capacity. Key components of the initiative include recoding all Medicaid behavioral health services, a Specialized Recovery Services (SRS) program for adults with severe and persistent mental illness and carving Medicaid behavioral health benefits into managed care. • Behavioral Health Redesign began in June 2015 as a result of the FY 2016-2017 budget. • While pilots of the new billing codes took place in 2017, full implementation was delayed until 2018. It is too early to assess the effectiveness of this significant systems change. **System capacity data** • Other than the MAT provider information described above, there is limited data available to assess the capacity of Ohio's addiction treatment system relative to need. • OMHAS and ODM have data on behavioral health utilization for the publicly-funded system, but comprehensive statewide data from the privately-funded system (commercial insurance and cash only) is not available. • Beginning July 1, 2017, ORC 5119.362 requires all community addiction services providers to report "waiting list" data to OMHAS on a monthly basis (posted on the **OMHAS website**). However, stakeholders report that this data has significant limitations and does not provide useful information to describe unmet need or system capacity.	• Improve data collection and reporting on need for and utilization of addiction treatment services in order to be able to better assess treatment system capacity and current and future workforce needs
Behavioral health workforce (including workforce development programs such as higher education financial incentives, health career recruitment for minority students and career pathways programs) Included in **SHIP**	**Moderate evidence alignment** / **Unknown implementation reach** • OMHAS is implementing initiatives to increase the behavioral health workforce for specific services, including the DATA 2000 waiver MAT trainings mentioned above, the Ohio Women's Network of providers, enhanced training on the ASAM criteria, ECHO model support and other continuing education. • The FY 2018-19 state budget included $6 million to assist OMHAS-certified community behavioral health providers with hiring/developing new entry-level behavioral health professionals and to incentivize existing behavioral health professionals in attaining a higher level of professional recognition (credential), including loan repayment or tuition reimbursement. • The number of Ohioans participating in evidence-based behavioral health workforce development programs, including efforts to increase workforce diversity, is unknown.	• Strengthen the behavioral health workforce through increased reimbursement rates, enhancing the Behavioral Health Workforce Initiative and continuing to build integration with physical health care • Develop behavioral health workforce pipeline programs, including outreach to increase the diversity and cultural competence of addiction treatment workforce

Table 8. **Treatment system capacity and workforce** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Behavioral health integration (Integration between general health system and specialty substance-use related services) Included in **SHIP**	**Strong evidence alignment**	**Unknown implementation reach**	• Continue to implement Behavioral Health Redesign • Identify baseline data and evaluation steps to assess overall impact of Behavioral Health Redesign on addiction treatment capacity, quality and integration with physical health care
	Behavioral Health Redesign • Behavioral health primary care integration, an evidence-based approach, is a key component of Behavioral Health Redesign. • It is too early to assess the effectiveness of this significant systems change or the extent to which care is now integrated throughout the state.		

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Recovery

Table 9. **Recovery services**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Recovery housing	**Moderate evidence alignment** / **Weak implementation reach** • Ohio Recovery Housing-certified recovery housing is available in 32 counties with a total of 110 recovery houses. • The 2018-2019 Budget (HB 49) included $21 million to expand treatment facilities through a capital appropriation for recovery housing. It also created the All Roads Lead to Home Program. • ADAMH continuum of care requirements include recovery housing. • 2014 MBR adjusted the recovery housing protocols (such as, family can stay; no arbitrary limits on length of stay; MAT is allowed; connections to community addiction services).	Increase the number of Ohio Recovery Housing-certified recovery houses throughout the state
Peer support (also referred to as recovery coaching)	**Moderate evidence alignment** / **Weak implementation reach** • Peer support is included in ADAMH board continuum of care requirements. • In 2016, OMHAS began formally certifying Peer Recovery Supporters and Medicaid began covering peer support for people with serious and persistent mental illness as part of Specialized Recovery Services. People in recovery from substance use disorder are only eligible if they also have serious and persistent mental illness. • 66 counties have at least 1 certified Peer Recovery Supporter[40], although some focus on mental health rather than alcohol or other drug use. • Several ADAMH boards are using Cures STR grant funding for Recovery Coaches/Peer Supporters for people in recovery from substance use disorder.	Extend Medicaid coverage of peer support to include people in recovery from substance use disorder
12-step mutual aid groups focused on alcohol (such as AA)	**Strong evidence alignment** / **Strong implementation reach** • ADAMH board continuum of care requirements include "multiple paths to recovery such as 12-step approaches." • According to OAC 4729:4-1-04, individuals on probation are required to participate in "alcoholics anonymous, narcotics anonymous, or a similar twelve-step program, or its equivalent." • There are Narcotics Anonymous, Alcoholics Anonymous and other 12-step programs available throughout the state.	Maintain 12-step programs as an option for Ohioans in recovery

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Evidence sources

Prevention

Table 10. **Appropriate use of, and access to, prescription opioids: Prescribing and dispensing**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	**Report, guideline or evidence registry**
Opioid prescribing limits for acute pain	Veterans Health Administration, 2017	**Acute Pain Management: Meeting the Challenge**
	Up to Date, 2018	**Prescription of Opioids for Acute Pain in Opioid Naïve Patients**
	Centers for Disease Control and Prevention, 2016	**CDC guideline for prescribing opioids for chronic pain—United States** Note: There are additional prescribing guidelines listed on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery.** However, the National Academies of Sciences, Engineering and Medicine's 2017 consensus study report ("Pain Management and the Opioid Epidemic") describes the 2016 CDC guidelines as the "most recent, comprehensive and influential."
Other opioid prescribing guidelines for acute pain	Veterans Health Administration, 2017	**Acute Pain Management: Meeting the Challenges**
	Up To Date, 2018	**Prescription of Opioids for Acute Pain in Opioid Naïve Patients**
Opioid prescribing guidelines for chronic pain (non-cancer, non-terminal pain)	Centers for Disease Control and Prevention, 2016	**CDC guideline for prescribing opioids for chronic pain—United States, 2016** Note: There are additional prescribing guidelines listed on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery.** However, the National Academies of Sciences, Engineering and Medicine's 2017 consensus study report ("Pain Management and the Opioid Epidemic") describes the 2016 CDC guidelines as the "most recent, comprehensive and influential."
Prescription Drug Monitoring Program (PDMP)	The PEW Charitable Trusts, 2016	**Prescription Drug Monitoring Programs: Evidence-based practices to optimize prescriber use**
	What Works for Health, County Health Rankings and Roadmaps, 2017	**Prescription drug monitoring programs (PDMPs)**
E-prescribing of controlled substances (EPCS)	What Works for Health, County Health Rankings and Roadmaps, 2015	**Computerized provider order entry (CPOE)**

Table 11. **Appropriate use of, and access to, prescription opioids: Non-opioid pain management**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Provider and patient education on non-opioid pain management	Prescription Drug Monitoring Program Training and Technical Assistance Center, 2017	**Prescription Drug Monitoring Program Training and Technical Assistance Center**
	Centers for Disease Control and Prevention, 2016	**Nonopioid Treatments for Chronic Pain**
Insurance coverage for non-opioid pain management-Complementary and integrative therapies (acupuncture, massage, chiropractic/spinal manipulation) **Insurance coverage for non-opioid pain management-Rehabilitative therapies** (physical therapy, occupational therapy, multi-disciplinary) **Insurance coverage for non-opioid pain management-Exercise and movement** (tai chi, yoga and other exercise) **Insurance coverage for non-opioid pain management-Psychological** (cognitive behavioral therapy, progressive relaxation, mindfulness-based stress reduction, operant therapy) **Insurance coverage for other non-pharmacologic, non-opioid pain management** (e.g. biofeedback, laser therapy) **Insurance coverage for non-opioid pain management-Pharmacologic** (NSAIDs, muscle relaxants, topicals)	American College of Physicians, 2017	**Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the American College of Physicians** These guidelines are specific to low back pain. More general guidelines were not identified.
	Veterans Health Administration, 2017	**Acute Pain Management: Meeting the Challenge**
Prescription drug disposal and take-back programs	National Academies of Science, Engineering and Medicine, 2017	**Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use** See recommendation 5-1 (allow individuals to return drugs to any pharmacy on any day of the year, rather than relying on occasional take-back events).

Table 12. **Child and family-focused prevention**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	**Report, guideline or evidence registry**
Early childhood interventions (ages 0-5): Nurse-Family Partnership home visiting program	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)**
	National Institute on Drug Abuse, 2016	**Principles of Substance Abuse Prevention for Early Childhood: Research-Based Early Intervention Substance Abuse Prevention Programs (Chapter 4)** Note: Nurse-Family Partnership is highlighted here because it is identified by both the Surgeon General's report and the NIDA report, has been evaluated and found to be effective in reducing substance use and is being implemented in Ohio.
	See also: home visiting programs reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery**, and **Home Visiting Evidence of Effectiveness.**	
Early childhood interventions (ages 0-5): Other evidence-based home visiting programs	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)**
	National Institute on Drug Abuse, 2016	**Principles of Substance Abuse Prevention for Early Childhood: Research-Based Early Intervention Substance Abuse Prevention Programs (Chapter 4)**
	See also: home visiting programs reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery**, and **Home Visiting Evidence of Effectiveness.**	
Early childhood interventions (ages 0-5): Parenting education (such as Incredible Years and similar programs with substance use reduction outcomes)	National Institute on Drug Abuse, 2016	**Principles of Substance Abuse Prevention for Early Childhood: Research-Based Early Intervention Substance Abuse Prevention Programs (Chapter 4)** Note: Incredible Years is highlighted here because it is included in the NIDA report and is being implemented in Ohio.
	See also: other parenting education programs reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery**.	

Table 12. **Child and family-focused prevention** (cont.)

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	**Report, guideline or evidence registry**
School-based universal prevention programs: PAX Good Behavior Game and Botvin Life Skills	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)** Note: PAX Good Behavior Game and Botvin Life Skills are highlighted here because they are included in the Surgeon General's report and are being implemented in Ohio.
	See also: other school-based programs reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery**.	
School-based universal prevention programs: DARE Keepin' it REAL	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)**
	Washington State Institute for Public Policy, 2017	**Benefit Cost Analysis: Public Health and Prevention**
Other school-based prevention programs for children ages 5-17 (universal or selective prevention)	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)**
	See also: specific programs reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery.**	
Mentoring programs for youth (youth peer mentoring, mentoring programs to prevent delinquency, Big Brothers Big Sisters)	What Works for Health, County Health Rankings and Roadmaps, 2016	**Youth peer mentoring** **Mentoring programs: Delinquency** **Big Brothers Big Sisters**
Community or family-based prevention programs for children ages 5-17 (universal or selective prevention)	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)**
	See also: specific programs reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery.**	

Table 12. **Child and family-focused prevention** (cont.)

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Community mobilization to reduce youth access to tobacco	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)
	See also: specific programs reviewed by the evidence registries on the HPIO Evidence Resource Page: Prevention, Treatment and Recovery.	
Enhanced enforcement of laws prohibiting sales of alcohol to minors	The Community Guide, Centers for Disease Control and Prevention, 2006	Alcohol – Excessive Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors
	What Works for Health, County Health Rankings and Roadmaps, 2014	Enhanced enforcement of laws prohibiting alcohol sales to minors

Table 13. **Other community-based prevention**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Prevention programs for ages 18+ (including college and workplace programs)	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Appendix B)**
	See also: specific programs reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery**.	
Local community prevention coalitions using evidence-based models, such as Communities that Care (CTC) and PROSPER	U.S. Department of Health and Human Services, Office of the Surgeon General, 2016	**Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health** Note: CTC and PROSPER are highlighted here because they are included in the Surgeon General's report and are being implemented in Ohio.
	See also: coalition models and community-wide approaches reviewed by the evidence registries on the **HPIO Evidence Resource Page: Prevention, Treatment and Recovery**.	
Smoke-free policies	The Community Guide, Centers for Disease Control and Prevention, 2012	**Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies**
	Centers for Disease Control and Prevention, 2014	**Best Practices for Comprehensive Tobacco Control Programs**
	What Works for Health, County Health Rankings and Roadmaps, 2017	Smoke-free policies for **indoor areas** and **outdoor areas**
Increase unit price for tobacco products	The Community Guide, Centers for Disease Control and Prevention, 2012	**Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products**
	Centers for Disease Control and Prevention, 2014	**Best Practices for Comprehensive Tobacco Control Programs**
	What Works for Health, County Health Rankings and Roadmaps, 2017	**Tobacco taxes**

Table 13. **Other community-based prevention** (cont.)

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Media campaigns for tobacco prevention	The Community Guide, Centers for Disease Control and Prevention, 2010	**Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution**
	Centers for Disease Control and Prevention, 2014	**Best Practices for Comprehensive Tobacco Control Programs**
	What Works for Health, County Health Rankings and Roadmaps, 2014	**Mass media campaigns against tobacco use**
State funding for tobacco prevention and control	Centers for Disease Control and Prevention, 2014	**Best Practices for Comprehensive Tobacco Control Programs**
Increase alcohol taxes	The Community Guide, Centers for Disease Control and Prevention, 2007	**Alcohol – Excessive Consumption: Increasing Alcohol Taxes**
	What Works for Health, County Health Rankings and Roadmaps, 2017	**Alcohol taxes**
Regulate alcohol outlet density	The Community Guide, Centers for Disease Control and Prevention, 2007	**Alcohol – Excessive Consumption: Regulation of Alcohol Outlet Density**
	What Works for Health, County Health Rankings and Roadmaps, 2014	**Alcohol outlet density restrictions**
Dram shop (commercial host) liability and other alcohol sales restrictions	The Community Guide, Centers for Disease Control and Prevention, 2010	**Alcohol – Excessive Consumption: Dram Shop Liability** See also: systematic reviews for maintaining limits on **days of sale** and **hours of sale**
	What Works for Health, County Health Rankings and Roadmaps, 2014	**Dram shop liability laws** See also: systematic reviews for **alcohol days of sale restrictions** and **drink special restrictions**

Treatment

Table 14. **Screening and early intervention**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Screening, Brief Intervention and Referral to Treatment (SBIRT) for adults and screening practices consistent with the USPSTF screening recommendation for primary care providers (adult alcohol misuse)	Substance Abuse and Mental Health Services Administration, 2013	Systems-Level Implementation of Screening, Brief Intervention and Referral to Treatment: Technical Assistance Publication Series—TAP 33
	U.S. Preventive Services Taskforce, 2013	Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care Note: B-grade recommendation for adults aged 18 and older.
SBIRT for adolescents and screening consistent with American Academy of Pediatrics Policy statement on alcohol use by youth	U.S. Preventive Services Taskforce, 2013	Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care Note: I-grade recommendation for adolescents (under 18 years of age)
	American Academy of Pediatrics, 2010	Policy Statement - Alcohol Use by Youth and Adolescents: A Pediatric Concern
Tobacco use screening	U.S. Preventive Services Task Force, 2015	Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions Note: A-grade recommendation for adults and pregnant women

Table 15. **Treatment services**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Medication-Assisted Treatment for opioid use disorder	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health
	U.S. Department of Veterans Affairs and Department of Defense, 2015	VA/DoD Clinical Practice Guidelines for the Management of Substance Abuse Disorders
	The American Society of Addiction Medicine, 2015	ASAM National Practice Guideline for the use of Medications in the Treatment of Addiction Involving Opioid Use
Medication-Assisted Treatment for alcohol use disorder	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health
	U.S. Department of Veterans Affairs and Department of Defense, 2015	VA/DoD Clinical Practice Guidelines for the Management of Substance Abuse Disorders
	The American Psychiatric Association, 2018	Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder
Behavioral therapies/Psychosocial treatment for substance use disorder	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health
	U.S. Department of Veterans Affairs and Department of Defense, 2015	VA/DoD Clinical Practice Guidelines for the Management of Substance Abuse Disorders
Treatment for infants with Neonatal Abstinence Syndrome (NAS)	Substance Abuse and Mental Health Services Administration, 2018	Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants
Treatment for pregnant women with substance use disorder, including appropriate use of MAT	The American Society of Addiction Medicine, 2015	ASAM National Practice Guideline for the use of Medications in the Treatment of Addiction Involving Opioid Use
	U.S. Department of Veterans Affairs and Department of Defense, 2015	VA/DoD Clinical Practice Guidelines for the Management of Substance Abuse Disorders

Table 15. **Treatment services** (cont.)

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Treatment for justice-involved clients with substance use disorder, including appropriate use of MAT	The American Society of Addiction Medicine, 2015	ASAM National Practice Guideline for the use of Medications in the Treatment of Addiction Involving Opioid Use
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
Drug courts and specialized dockets	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
	What Works for Health, County Health Rankings and Roadmaps, 2016	Drug courts
Treatment for justice-involved clients with substance use disorder, including appropriate use of MAT	The American Society of Addiction Medicine, 2015	ASAM National Practice Guideline for the use of Medications in the Treatment of Addiction Involving Opioid Use
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers

Table 15. **Treatment services** (cont.)

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Tobacco cessation treatment within healthcare setting	U.S. Preventive Services Task Force, 2015	Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and pharmacotherapy interventions
	The Community Guide, Centers for Disease Control and Prevention, 2012	Tobacco Use and Secondhand Smoke Exposure: Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments
	What Works for Health, County Health Rankings and Roadmaps, 2017	Tobacco cessation therapy affordability
Tobacco cessation treatment within healthcare setting: Pregnant women	U.S. Preventive Services Task Force, 2015	Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and pharmacotherapy interventions Note: A-grade recommendation for adults and pregnant women
	The Community Guide, Centers for Disease Control and Prevention, 2012	Tobacco Use and Secondhand Smoke Exposure: Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments
	What Works for Health, County Health Rankings and Roadmaps, 2017	Tobacco cessation therapy affordability
Tobacco quitlines and mobile phone-based cessation programs	The Community Guide, Centers for Disease Control and Prevention, 2012	Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions
	What Works for Health, County Health Rankings and Roadmaps, 2017	Tobacco quitlines
	The Community Guide, Centers for Disease Control and Prevention, 2011	Tobacco Use and Secondhand Smoke Exposure: Mobile Phone-Based Cessation Interventions
	What Works for Health, County Health Rankings and Roadmaps, 2016	Cell phone-based tobacco cessation interventions

Table 16. **Treatment system, workforce capacity, access and coverage**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Insurance coverage: Access to coverage, including Medicaid	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
Insurance coverage: Parity for behavioral health care	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
	What Works for Health, County Health Rankings and Roadmaps, 2015	Mental health benefits legislation
Treatment system capacity	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
Behavioral health workforce	What Works for Health, County Health Rankings and Roadmaps, 2017	Higher education financial incentives for health professionals serving underserved areas
	What Works for Health, County Health Rankings and Roadmaps, 2015	Health career recruitment for minority students
	What Works for Health, County Health Rankings and Roadmaps, 2017	Career pathways and sector-focused employment
Behavioral health integration (Integration between general health system and specialty substance-use related services)	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers

Recovery

Table 17. **Recovery Services**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Recovery housing	National Alliance for Recovery Residences (NARR), 2017	NARR Standards Version 2.0
	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Chapter 5)
Peer support (also referred to as recovery coaching)	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2009	What are Peer Recovery Support Services?
	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Chapter 5)
12-step mutual aid groups focused on alcohol (such as AA)	U.S. Department of Health and Human Services, 2016	Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health (Chapter 5)

Notes

1. Ohio Administrative Code (OAC) § 4731-11-13
2. "When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed." CDC guidelines.
3. *Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments*. The Governor's Cabinet Opiate Action Team, 2016. http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf
4. *Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain 80 mg of a Morphine Equivalent Daily Dose (MED) "Trigger Point"*. The Governor's Cabinet Opiate Action Team, 2013. http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Chronic-Pain.pdf
5. "Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risk when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day." CDC guidelines.
6. Information provided directly by the Ohio Board of Pharmacy, 3/27/18.
7. American Medical Association. "Fact sheet: Physicians' and Other Health Care Professionals' Use of State Prescription Drug Monitoring Programs." (2017).
8. The Pew Charitable Trusts. "Prescription Drug Monitoring Programs: Evidence-based Practices to Optimize Prescriber Use." (2016)
9. Centers for Disease Control and Prevention. Prevention Status Reports. (2015).
10. Prescription Drug Monitoring Program Training and Technical Assistance Center http://www.pdmpassist.org/
11. Research indicates that EPCS reduces medication errors and adverse drug events, improves patient safety and increases adherence to clinical guidelines. EPCS is not specific to opioids, but can be used for opioid prescriptions.
12. *OH EPCS Prescriber and Pharmacy Enablement Status – October 2017*. SureScripts, 2018.
13. OAC § 4731-29-01
14. OAC § 4729-8-02
15. OAC § 4729-8
16. Information provided directly by the Ohio Department of Health to HPIO, January 2018.
17. Health Policy Institute of Ohio, "Connections Between Education and Health: The Importance of Early Learning." (2017)
18. Office of Juvenile Justice and Delinquency Prevention, Model Programs Guide, Review of Drug Abuse Resistance Education (DARE) (1983-2009)
19. ibid
20. Ohio Attorney General Mike DeWine, "Ohio Joint Study Committee on Drug Use Prevention Education." (2017)
21. Attorney General DeWine Awards #2.7 Million in Grants for Drug Use Prevention Education, 8/2/17 press release: http://www.ohioattorneygeneral.gov/Media/News-Releases/August-2017/Attorney-General-DeWine-Awards-$2-7-Million-in-Gra
22. "Safe Schools and Health Students: Program Overview," Ohio Mental Health and Addiction Services, accessed April 2, 2018. http://mha.ohio.gov/Default.aspx?tabid=908
23. CDC Prevention Status Reports rate Ohio's cigarette tax as "yellow," indicating moderate implementation of recommended policies, based on comparison of cigarette tax rates in other states.
24. CDC Prevention Status Reports rate Ohio's state funding for tobacco control as "red," indicating weak implementation of recommended policies.
25. CDC Prevention Status Reports rate Ohio's beer and wine taxes as "red," indicating weak implementation of recommended policies, based on comparison of alcohol tax rates in other states.
26. CDC Prevention Status Reports rate Ohio's commercial host (dram shop) liability as "yellow," indicating moderate implementation of recommended policies.
27. National Quality Forum (NQF) metric 28: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco use.
28. OAC § 4731-33 (proposed)
29. Ohio Department of Mental Health and Addiction Services, "Regional Judicial Opioid Initiative Ohio Team: Providers of Medication Assisted Treatment and Status of Specialized Dockets as of January 2018." (2018)
30. ibid
31. ibid
32. Substance Abuse and Mental Health Services Administration, "National Survey of Substance Abuse Treatment Facilities (N-SSATS): 2016." (2017).
33. C. William Swank Program on Rural-Urban Policy at The Ohio State University, "Taking Measure of Ohio's Opioid Crisis." (2017).
34. Avalere analysis of SAMHSA Opioid Treatment Program Directory and CDC WONDER data. http://avalere.com/expertise/life-sciences/insights/midwest-and-mid-atlantic-states-face-provider-shortage-
35. The American Society of Addiction Medicine (ASAM), "ASAM National Practice Guideline for the use of Medications in the Treatment of Addiction Involving Opioid Use." (2015)
36. Data provided by ODM to HPIO show that in FY 2016, five percent of Medicaid managed care enrollees age 18+ received cessation medication and two percent received cessation counseling. According to the 2015 Ohio Medicaid Assessment Survey, 42 percent of Medicaid enrollees age 19-64 smoke.
37. HPIO, "State Policy Options to Reduce Tobacco Use and Secondhand Smoke Exposure." (2017)
38. Substance Abuse and Mental Health Services Administration, "National Survey of Substance Abuse Treatment Facilities (N-SSATS): 2016." (2017)
39. HPIO analysis of U.S. Census Bureau data. 2016 American Community Survey 1-year estimates, accessed through the American FactFinder. "Table B27001 - Health Insurance Coverage status by sex by age." U.S. Census Bureau. Accessed Feb 14, 2018. https://factfinder.census.gov/bkmk/table/1.0/en/ACS/16_1YR/B27001/0400000US39
40. Ohio Department of Mental Health and Addiction Services, OhioMHAS Public Database, accessed 2/26/18: http://workforce.mha.ohio.gov/Workforce-Development/Job-Seekers/Peer-SupporterCertification#44810-