A RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS, SARPY COUNTY, NEBRASKA (“COUNTY”) AUTHORIZING, APPROVING AND DIRECTING THE ENGAGEMENT OF CERTAIN LAW FIRMS TO REPRESENT THE COUNTY IN POTENTIAL LITIGATION AGAINST CONTRIBUTORS OF OPIOID ADDICTION CRISIS

WHEREAS, the County is experiencing serious Opioid use as a result of the ready availability of the drug and its abuse; and,

WHEREAS, the County desires to retain the Law Firms identified herein to advise and represent the County regarding litigation and the award of damages from the contributors of opioids within the County.

NOW, THEREFORE, BE IT RESOLVED BY THE SARPY COUNTY BOARD OF COMMISSIONERS, AS FOLLOWS:

Section 1. The County Board of Commissioners, as the governing body of the County, hereby authorizes and approves the engagement of the law firms identified in the Legal Services Agreement, attached hereto and incorporated herein as Exhibit “A” (herein referred to as the “Law Firms”) to represent the County in potential litigation against contributors of the Opioid addiction crises.

Section 2. The County Board of Commissioners hereby authorizes and approves, or confirms authorization and approval, of the Legal Services Agreement, substantially in the form attached hereto and incorporated herein by reference thereto as Exhibit “A”, and directs the Chair of the County Board of Commissioners to execute and enter into the Legal Services Agreement with the Law Firms, setting forth the scope of the work to be performed by the Law Firms, including litigation against contributors to the Opioid addiction crises within the County and the terms and conditions of the employment of the Law Firms. The Legal Services Agreement may be amended, after approval of this Resolution, without further action of the County Board of Commissioners, with the approval of the Board Chair, whose signature on the Legal Services Agreement shall be evidence of such approval.

Section 3. If any section, paragraph or provision of this Resolution shall be held to be invalid or unenforceable for any reason, the invalidity or unenforceability of such section, paragraph or provision shall not affect any of the remaining provisions of this Resolution.

Section 4. This Resolution shall be in full force and effect from and after its adoption as provided by law.

[Signatures for Resolution appear on the following page S-1]
This Resolution was introduced, seconded and adopted at a duly convened meeting of the Sarpy County Board of Commissioners, held on February 13, 2018.

ATTEST:

Sarpy County Board Chairman

CERTIFICATE

I, the undersigned, do hereby certify that I am the duly qualified and acting County Clerk of Sarpy County; that the foregoing is a true and complete copy of a certain Resolution duly adopted by the Sarpy County Board of Commissioners, at a duly convened meeting properly held on February 13, 2018; that said Resolution appears as a matter of public record in the official records of the County Board of Commissioners; that said meeting was duly held in accordance with all applicable requirements of Nebraska law; that said Resolution has not been amended, modified, revoked or repealed; and that same is now in full force and effect.

IN TESTIMONY WHEREOF, witness my signature this February 13, 2018.

County Clerk
EXHIBIT “A”

Legal Services Agreement
ENGAGEMENT TO REPRESENT

RE: Sarpy County, Nebraska civil suit against those legally responsible for the wrongful distribution of prescription opiates and damages caused thereby.

Sarpy County, Nebraska (hereinafter “CLIENT”), by and through its Board of County Commissioners, hereby retains the law firm LEVIN, PAPANTONIO, THOMAS, MITCHELL, RAFFERTY & PROCTOR, PA (“Firm”) pursuant to the Nebraska Rules of Professional Conduct and Neb. Rev. St. §23-1203, on a contingent fee basis, to pursue all civil remedies, as outlined in the Firm’s attached proposal publication, against those in the chain of distribution of prescription opiates responsible for the opioid epidemic which is plaguing Sarpy County, Nebraska including, but not limited to, filing a claim for public nuisance to abate, enjoin, recover and prevent the damages caused thereby. Peter J. Mougey of the law firm LEVIN, PAPANTONIO, THOMAS, MITCHELL, RAFFERTY & PROCTOR, PA shall serve as LEAD COUNSEL. CLIENT authorizes lead counsel to employ and/or associate additional counsel, with consent of CLIENT, to assist LEAD COUNSEL in the just prosecution of the case. CLIENT consents to the participation of the following firms (collectively referred to, herein, as “Attorneys”), if no conflicts exist, including but not limited to conflicts pursuant to Neb. Rev. St. § 49-14,103.01, the Nebraska Ethics laws and the Nebraska Rules of Professional Conduct:

LEVIN, PAPANTONIO, THOMAS, MITCHELL, RAFFERTY & PROCTOR, PA
316 South Baylen Street
Pensacola, Florida

GREENE, KETCHUM, FARRELL, BAILEY & TWEEL, LLP
419 11th Street
Huntington, West Virginia

BARON & BUDD, PC
3102 Oak Lawn Avenue #1100
Dallas, Texas

HILL PETERSON CARPER BEE & DEITZLER PLLC
500 Tracy Way
Charleston, West Virginia

MCHUGH FULLER LAW GROUP
97 Elias Whiddon Road
Hattiesburg, Mississippi

POWELL & MAJESTRO
405 Capitol Street, Suite P-1200
Charleston, West Virginia 25301

ABBoud LAW FIRM
6530 S 84th St,
Omaha, Nebraska 68127
In consideration, CLIENT agrees to pay thirty percent (30%) of the total recovery (gross) in favor of the CLIENT as an attorney fee whether the claim is resolved by compromise, settlement, or trial and verdict (and appeal). The gross recovery shall be calculated on the amount obtained before the deduction of costs and expenses. Total fees and expenses shall not exceed fifty percent (50%) of the gross recovery. CLIENT grants the Firm an interest in a fee based on the gross recovery. If a court awards attorneys’ fees, the Firm shall receive the “greater of” the gross recovery-based contingent fee or the attorneys’ fees awarded. There is no fee if there is no recovery.

LEVIN, PAPANTONIO, THOMAS, MITCHELL, RAFFERTY & PROCTOR, PA and/or the other law firms, hereinafter referred to as the “Attorneys,” shall advance all necessary litigation expenses necessary to prosecute these claims. All such litigation expenses, including the reasonable internal costs of electronically stored information (ESI) and electronic discovery generally or the direct costs incurred from any outside contractor for those services, will be deducted from any recovery after the contingent fee is calculated. There is no reimbursement of litigation expenses if there is no recovery.

The CLIENT acknowledges this fee is reasonable given the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly, the likelihood this employment will preclude other employment by the Firm, the fee customarily charged in the locality for similar legal services, the anticipated (contingent) litigation expenses and the anticipated results obtained, the experience, reputation, and ability of the lawyer or lawyers performing the services and the fact that the fee is contingent upon a successful recovery.

This litigation is intended to address a significant problem in the community. The litigation focuses on the wholesale distributors and manufacturers and their role in the diversion of millions of prescription opiates into the illicit market which has resulted in opioid addiction, abuse, morbidity, and mortality. There is no easy solution and no precedent for such an action against this sector of the industry. Many of the facts of the case are locked behind closed doors. The billion-dollar industry denies liability. The litigation will be very expensive, and the litigation expenses will be advanced by the Firm with reimbursement contingent upon a successful recovery. The outcome is uncertain, as is all civil litigation, with compensation contingent upon a successful recovery. Consequently, there must be a clear understanding between the CLIENT and the Firm regarding the definition of a “successful recovery.”

The Firm intends to present a damage model designed to abate the public health and safety crisis. This damage model may take the form of money damages and/or equitable remedies (e.g., an abatement fund). The purpose of the lawsuit is to seek reimbursement of the costs incurred in the past fighting the opioid epidemic and/or recover the funds necessary to abate the health and safety crisis caused by the unlawful conduct of the wholesale distributors. The CLIENT agrees to compensate the Firm, contingent upon prevailing, by paying 30% of any settlement/resolution/judgment, in favor of the CLIENT, whether it takes the form of monetary damages or equitable relief. For instance, if the remedy is in the form of monetary damages, CLIENT agrees to pay 30% of the gross amount to Firm as compensation and then reimburse the reasonable litigation expenses. If the remedy is in the form of equitable relief (e.g., abatement
fund), CLIENT agrees to pay 30% of the gross value of the equitable relief to the Firm as compensation and then reimburse the reasonable litigation expenses. To be clear, the Firm shall not be paid nor receive reimbursement from public funds unless required by law. However, any judgment arising from successful prosecution of the case, or any consideration arising from a settlement of the matter, whether monetary or equitable, shall not be considered public funds for purposes of calculating the contingent fee unless required by law. Under no circumstances shall the CLIENT be obligated to pay any attorneys fee or any litigation expenses except from moneys expended by defendant(s) pursuant to the resolution of the CLIENT’s claims. If the defendant(s) expend their own resources to abate the public health and safety crisis in exchange for a release of liability, then the Firm will be paid the designated contingent fee from the resources expended by the defendant(s). CLIENT acknowledges this is a necessary condition required by the Firm to dedicate their time and invest their resources on a contingent basis to this enormous project. If the defendant(s) negotiate a release of liability, then the Firm should be compensated based upon the consideration offered to induce the dismissal of the lawsuit.

Local Counsel, Abboud Law Firm, will receive 10% of the fees, the division of the remaining 90% of fees, expenses and labor between the Attorneys will be decided by private agreement between the law firms and subject to approval by the Client. Any division of fees will be will be governed by the Nebraska Rules of Professional Conduct including: (1) the division of fees is in proportion to the services performed by each lawyer or each lawyer assumes joint responsibility for the representation and agrees to be available for consultation with the CLIENT; (2) the CLIENT has given written consent after full disclosure of the identity of each lawyer, that the fees will be divided, and that the division of fees will be in proportion to the services to be performed by each lawyer or that each lawyer will assume joint responsibility for the representation; (3) except where court approval of the fee division is obtained, the written closing statement in a case involving a contingent fee shall be signed by the CLIENT and each lawyer and shall comply with the terms of the Nebraska Rules of Professional Conduct; and (4) the total fee is not clearly excessive. The remaining fees will be divided

LEAD COUNSEL shall appoint a contact person to keep the CLIENT reasonably informed about the status of the matter in a manner deemed appropriate by the CLIENT. The CLIENT at all times shall retain the authority to decide the disposition of the case and personally oversee and maintain absolute control of the litigation.

Upon conclusion of this matter, LEAD COUNSEL shall provide the CLIENT with a written statement stating the outcome of the matter and, if there is a recovery, showing the remittance to the client and the method of its determination. The closing statement shall specify the manner in which the compensation was determined under the agreement, any costs and expenses deducted by the lawyer from the judgment or settlement involved, and, if applicable, the actual division of the lawyers’ fees with a lawyer not in the same firm, as required by the Nebraska Rules of Professional Conduct. The closing statement shall be signed by the CLIENT and each attorney among whom the fee is being divided.

Nothing in this Agreement and nothing in the Attorneys’ statement to the CLIENT may be construed as a promise or guarantee about the outcome of this matter. The Attorneys make no such promises or guarantees. Attorneys’ comments about the outcome of this matter are
expressions of opinion only and the Attorneys make no guarantee as to the outcome of any litigation, settlement or trial proceedings.

SIGNED, this 13th day of February, 2018.

Sarpy County, Nebraska

[Signature]

Sarpy County Board Chairman

Accepted:

LEVIN, PAPANTONIO, THOMAS, MITCHELL, RAFFERTY & PROCTOR, PA
316 South Baylen Street
Pensacola, Florida

By ________________________________ __________________________
Peter J. Mougay
Lead Counsel

[Signature] 4/17/18

Date

Approved as to form:

[Signature]

Chief Deputy County Attorney
Addressing the Opioid Crisis in Lorain County, Ohio

February 12, 2018

How can communities implement solutions that help support treatment, recovery, and prevention services?

Background

According to the 2016 National Survey on Drug Use and Health, prescription opioid misuse or abuse in Lorain County was 2.5 times the national average, while heroin use was more than double the U.S. average. Lorain County, a suburb west of Cleveland with a population of 300,000, was hit particularly hard with more than 130 deaths from fatal opioid overdoses in 2016—more than double the number in 2015. Community leaders knew they had to take swift action to stop the deaths and deliver treatment and recovery services to those in need. They turned to Altarum for help tackling the growing crisis in their community.

To help Lorain County, Altarum implemented its three-phase approach to analyze current resources and determine where additional resources and services are needed. Here's how it unfolded:

Phase One: Research

After identifying all existing resources and services in the county, we determined the challenges and gaps that were hindering the community's ability to respond at full capacity. We completed an environmental scan and identified geographic gaps in the distribution of current treatment and recovery services. A quantitative impact analysis of the downstream economic burden of the crisis—nearly $200 million in 2016 alone—revealed that comparatively little was being spent on treatment and prevention. This research served as a foundation to help determine where and what type of interventions would be most effective.

Addressing the Opioid Crisis in Lorain County, Ohio

Phase Two: Implementation
Altarum conducted interviews and focus groups with dozens of local stakeholders, including those in recovery services, social services, law enforcement, health care, criminal justice, workforce development, higher education, faith-based service, and government. By engaging with organizations on the frontlines of the crisis, Altarum uncovered a strong willingness to collaborate across the community that could be leveraged. We then delivered an outline of concrete strategies and tasks for local implementation. A community task force was formed and the recommendations from the plan were executed.

Phase Three: Evaluation
Altarum evaluated best practices currently in place in other states and localities across the United States to reduce opioid related deaths. We then provided an assessment of Lorain County’s community-based efforts, including both the process and outcomes.

Recommendations
Through these observations and analysis, Altarum provided a comprehensive report and roadmap for behavioral health system transformation in Lorain County. Through their partnership with Altarum, Lorain County, Ohio, has been able to stem the tide of overdose deaths and get more people into recovery through better support service coordination. Their work is held up as a model for other counties and states seeking to do more with their current resources through stronger coordination and targeting services where they are needed most.

Lorain-County-Community-Assessment_Executive-Summary.pdf

Subject Matter Experts

Diana Williams

Emily Ehrlich

Eric Gelman

Areas of Expertise

Behavioral Health

Service Offerings

Addressing the Opioid Crisis in Lorain County, Ohio

- Health Program Management, Technical Assistance, and Evaluation
- Health Research, Policy and Analysis
- Health Policy Analysis
- Health Systems and Services Research

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COMMUNITY ASSESSMENT OF THE OPIOID CRISIS IN LORAIN COUNTY, OHIO

EXECUTIVE SUMMARY

Prepared for The Nord Family Foundation
December 20, 2017
Background

The impact of the opioid crisis in Lorain County, Ohio is far-reaching and substantial, affecting an increasing number of individuals, families, and local communities. According to the 2016 National Survey on Drug Use and Health, prescription opioid misuse or abuse in Lorain County was 2.5 times the national average. Heroin use was more than double the U.S. average. The misuse of these drugs has clear, negative implications for community health, productivity, wealth, well-being, and happiness.

The Nord Family Foundation (NFF) in Lorain County sought to fully understand the nature of the local opioid crisis and identify currently available resources, existing needs, and strategies that could be implemented to address the crisis and lessen its negative impact. NFF engaged Altarum, a health research and consulting firm headquartered in Ann Arbor, Michigan, to conduct a community assessment and offer recommendations for addressing opioid misuse and related problems in Lorain County. The community assessment had four main objectives:

1. Define the extent of the opioid crisis and associated burdens on the county.
2. Identify county strengths and currently available resources for addressing opioid misuse and related problems.
3. Determine needs and potential barriers related to addressing the opioid crisis.
4. Identify potential strategies for mitigating the opioid crisis and its impact.

Four key activities were conducted to achieve the assessment objectives:

1. A quantitative impact assessment of the magnitude of the opioid crisis and its negative economic effects.
2. An environmental scan of treatment and recovery services currently available in Lorain County.
3. Interviews and focus groups with key stakeholders, including individuals and families affected by opioid misuse, substance use treatment and recovery service providers, social service organizations, medical providers, law enforcement, criminal justice, workforce development, higher education, faith-based organizations, and other local government agencies.
4. A web-based search for emerging, promising, and best practices currently being implemented by other States and localities across the United States to address the opioid crisis.
Quantitative Impact Assessment Findings

Magnitude of the Opioid Crisis

- 11.5% of Lorain County residents reported prescription opioid misuse or abuse in the past year, 2.5 times the national average and similar to the rate for the state of Ohio.
- 0.5% reported heroin use in the past year, double the national average.
- Opioid use contributed to 2,691 emergency department visits in Lorain County in 2016.
- Opioid overdose caused 132 deaths in Lorain County in 2016. This number is expected to increase in 2017.

Economic Burden

The annual economic burden of the opioid crisis in Lorain County reached nearly $200 million in 2016. The most significant economic impacts are lost wages, productivity, and tax revenues due to opioid-related fatalities and opioid use disorders; increased healthcare costs resulting from overdoses and indirect health complications; and additional criminal justice (police, judicial, and corrections) expenditures (see table).

2016 Economic Burden of Lorain County Opioid Crisis

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost Earnings/Productivity</td>
<td>$139.8</td>
</tr>
<tr>
<td>Healthcare</td>
<td>$42.9</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>$7.2</td>
</tr>
<tr>
<td>Child and Family Assistance</td>
<td>$4.5</td>
</tr>
<tr>
<td>Treatment and Prevention</td>
<td>$5.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$199.8</td>
</tr>
</tbody>
</table>

Individuals, the Federal Government, and the private sector bear the greatest burden of the opioid crisis primarily through lost individual wages and Federal tax revenues, Medicaid and Medicare expenditures, and decreased workforce. Fewer economic costs fall to State and local governments in the form of lost tax revenues and State expenditures for Medicaid and Medicare, criminal justice, and child and family assistance. Despite the significant costs of preventable and untreated opioid use disorders, comparatively little was spent on treatment and prevention efforts in 2016.
Environmental Scan Findings

- 18 organizations provide substance use treatment or recovery services in at least one location in Lorain County.
- Nearly all services are located in the northern half of the county near Elyria and Lorain. Very few services are available in the more rural area south of I-480.
- No subacute or inpatient detox facility exists in Lorain County.
- No medically managed inpatient services are available for individuals with a primary diagnosis of a substance use disorder.
- Only one residential treatment facility is available for women, and no residential facilities exist for men.
- Availability of medication assisted treatment and recovery housing services is limited.
- More availability exists for intensive outpatient, outpatient, and some recovery support services.
- More services are available for individuals with a primary mental health diagnosis and a co-occurring substance use disorder.

Stakeholder Interview and Focus Group Findings

- The opioid crisis directly or indirectly touches every member of the Lorain County community.
- The number of strong community-based organizations in Lorain County and the willingness of stakeholders to collaborate are two key strengths that will be helpful in addressing the opioid crisis.
- Community problems exacerbated by the opioid crisis include increased crime, economic impacts, and the breakdown of the family unit.
- The opioid crisis creates increased burden on agencies serving the community, including law enforcement, emergency responders, criminal justice, corrections, coroner's office, children's services, treatment providers, hospitals, the faith community, and social service organizations.
- Barriers to accessing services exist, such as delays in receiving services, gaps in the types of services available, and lack of public transportation.
- Current service providers are professional, knowledgeable, caring, passionate, and resilient, creating a strong base to build upon.
- County-level challenges related to addressing the opioid crisis include a lack of awareness about opioid use disorders across the community, insufficient funding, separation of services and agencies for mental health and substance use, competition among providers, and lack of a comprehensive, up-to-date list of available resources.
Best and Promising Practices Findings

▲ To date, most research regarding strategies to address the opioid crisis has concerned interventions implemented within healthcare settings, which have demonstrated positive effects.
▲ Development of community coalitions has been instrumental in creating the community buy-in necessary to implement effective opioid-related interventions and strategies.
▲ Harm reduction strategies such as safe injection sites and nonprescription syringe availability have been associated with increased referrals to addiction treatment and general healthcare, reduced overdose mortality, and reduced injection-related bacterial infections.
▲ Peer certification models, including Ohio's approach, recognize the importance of peer influence and clearly validate the use of peers as valuable stakeholders and partners to many interventions.
▲ Lorain County is currently implementing a number of interventions that have shown promise at curtailing the negative impacts of the opioid crisis. These interventions include peer recovery coach integration in emergency departments, expansion of naloxone/Narcan access, integration of quick response teams, and treatment/recovery drug courts.

Recommendations

After the brief but intensive observation of the landscape and culture surrounding the opioid crisis in Lorain County, Altarum recommends that Lorain County embark on recovery-focused behavioral health system transformation. We offer six strategies that, when effectively implemented, can be expected to reap rapid and long-term success in the county's effort to address the opioid crisis.

1. Further develop efforts to encourage multiple stakeholder involvement and collaborative decision-making.
   ▲ Identify an impartial coordinating entity to facilitate collaboration.
   ▲ Develop inclusive collaborations that will foster sharing and leveraging of resources.
   ▲ Increase collaboration between the Alcohol and Drug Addiction Services Board and the Mental Health Board.

2. Develop a full continuum of culturally appropriate and accessible care and related services.
   ▲ Prevention.
   ▲ Detox.
   ▲ Treatment.
   ▲ Recovery supports.
   ▲ Harm reduction.
3. Institute an education component.
   ▲ Public anti-stigma campaign.
   ▲ Dissemination of information about existing resources.
   ▲ Prevention education, including limiting the prescription of legal opioids.

4. Review current state policies.
   ▲ Assess whether policy changes are necessary to better address the opioid crisis.
   ▲ Develop an advocacy strategy that aligns with the county’s priorities.

5. Develop a system of data collection and coordination.
   ▲ Collect, track, and report individual and systems-level outcome data to improve the system of care.
   ▲ Ensure data are collected regarding specific strategies to address the opioid crisis in order to assess effectiveness.
   ▲ Establish real-time data alert procedures to identify potential spikes in overdose cases.

6. Develop a plan to disseminate information related to addressing the opioid crisis.
   ▲ Results and recommendations from the community assessment.
   ▲ Implementation plan.
   ▲ Updates on current and planned efforts to address the opioid crisis.
The amount of opioids prescribed per person was three times higher in 2015 than in 1999.

MME, morphine milligram Equivalents, is a way to calculate the total amount of opioids, accounting for differences in opioid drug type and strength.

180 MME  
1999 | US

640 MME  
2015 | US

### Opioid Prescribing Practices

National total number and rate of opioid prescriptions (Rx) dispensed per 100 persons annually — United States, 2016

<table>
<thead>
<tr>
<th>Prescribing Opioids</th>
<th>2016 Rx Number</th>
<th>Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>U. S. Census population</td>
<td>323,127,513</td>
<td></td>
</tr>
<tr>
<td>Total patients who had opioid Rx filled</td>
<td>61,862,364</td>
<td>19.1</td>
</tr>
<tr>
<td>Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All opioids</td>
<td>214,881,622</td>
<td>66.5</td>
</tr>
<tr>
<td>LA/ER opioids*</td>
<td>20,394,389</td>
<td>6.3</td>
</tr>
<tr>
<td>Days of supply per Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 30 days</td>
<td>126,546,618</td>
<td>39.2</td>
</tr>
<tr>
<td>≥ 30 days</td>
<td>88,335,004</td>
<td>27.3</td>
</tr>
<tr>
<td>Average opioid Rx per patient</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Average days of supply per Rx</td>
<td>18.1</td>
<td></td>
</tr>
</tbody>
</table>

*Rate per 100 persons adjusted to the U.S. census population

** LA/ER represents opioids that are long acting (LA) or extended release (ER).

Source: QuotientMed™ Translational Data Warehouse

Abbreviation: Rx, prescription
Opioid Prescribing Practices

Trends in annual opioid prescribing rates by days of supply per prescription, United States — 2006-2016

Source: QuintilesIMS * Transactional Data Warehouse. Rate per 100 persons adjusted to the U.S. census population.
4 out of 5 heroin users initiated use with NMPR

<table>
<thead>
<tr>
<th>Incidence</th>
<th>Prior use and past year dependence/abuse of NMPR</th>
<th>Prior use but no past year dependence/abuse of NMPR</th>
<th>No prior use of NMPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin Incidence Rate</td>
<td>31.3%</td>
<td>48.2%</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

Note: Past year NMPR users are those who had initiated NMPR use prior to initiation of heroin use in the past 12 months. Past year NMPR users who initiated NMPR subsequent to initiation of heroin use in the past 12 months are not included. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 
Rx dealers, go from state to state, obtaining pills

- Buying pain pills was the most common method of acquisition in the past 6 months and was reported by about 54% of the sample. Qualitative interviews suggest that for the majority of participants buying did not involve dealing with strangers in anonymous street-based transactions. Pain pill availability was so pervasive that many did not have to venture outside of their immediate social networks to find people who sold pain pills.

- Participants reported buying pain pills from a broad range of sources, such as regular dealers who may travel to other states to obtain pills, more sporadic sellers who attempt to get rid of their prescriptions to make a “quick buck,” and other users who occasionally play a role of a middle man in order to make some extra money and/or cover the cost of their own use. Regardless of their role in pain pill diversion, in many cases these individuals were also friends, co-workers, cousins, or other relatives.

- Interacting with friends as opposed to “strangers” was advantageous for the purpose of trust and safety. Further, some emphasized that dealing with people from their immediate social networks allowed them to maintain privacy and avoid being labeled as drug users.
45% of people who used heroin were also addicted to prescription opioid painkillers.
Drug Overdose Mortality

Age-adjusted rates of drug overdose deaths, by drug or drug class and year — United States, 1999–2015

Source: National Vital Statistics System, Mortality File. Source: National Vital Statistics System, Mortality File, CDC WONDER. Rate per 100,000 population age-adjusted to the 2000 U.S. standard population using the vintage year population of the data year. Because deaths might involve more than one drug, some deaths are included in more than one category. Specification on death certificates of drugs involved with deaths varies over time. In 2015, approximately 17% of drug overdose deaths did not include information on the specific type of drug(s) involved. Some of these deaths may have involved opioids or stimulants. Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD-10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).

Natural and semi-synthetic opioids: Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2). Heroin: Drug overdose deaths, as defined, that involve heroin (T40.1). Synthetic opioids other than methadone: Drug overdose deaths, as defined, that involve synthetic opioids other than methadone (T40.4). Cocaine: Drug overdose deaths, as defined, that involve cocaine (T40.5). Psychostimulants with abuse potential: Drug overdose deaths, as defined, that involve psychostimulants with abuse potential (T43.6). Methadone: Drug overdose deaths, as defined, that involve methadone (T40.3).
PROVISIONAL COUNTS OF DRUG OVERDOSE DEATHS, as of 8/6/2017

Provisional counts for 2016-2017 are based on data available for analysis as of the date specified. Counts for 2015 are based on final annual data. Provisional counts may be incomplete and causes of death may be pending investigation (see Notes on Data Quality). Line segments shown as --- represent likely underreporting due to incomplete data. Provisional counts for 12 months-ending (presented in the table) are the number of deaths received and processed for the 12 months that ended with the specified month. These counts include all seasons of the year and are insensitive to reporting variations by seasonality. Deaths are reported by the jurisdiction in which the death occurred.

<table>
<thead>
<tr>
<th>Selected Jurisdictions</th>
<th>Drug overdose deaths 12 month-ending Jan-2016</th>
<th>Number of deaths for 12 month-ending Jan-2017</th>
<th>% Change</th>
<th>12 month-ending Jan-2017</th>
<th>% Complete</th>
<th>% Pending investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Total</td>
<td>52,809</td>
<td>64,070</td>
<td>21%</td>
<td>99+</td>
<td>0.25</td>
<td>0.07</td>
</tr>
<tr>
<td>22 Reporting Jurisdictions</td>
<td>21,061</td>
<td>26,841</td>
<td>27%</td>
<td>100</td>
<td>0.09</td>
<td>0.07</td>
</tr>
<tr>
<td>Alaska</td>
<td>126</td>
<td>126</td>
<td>0%</td>
<td>100</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Arkansas</td>
<td>378</td>
<td>382</td>
<td>1%</td>
<td>100</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Arizona</td>
<td>181</td>
<td>209</td>
<td>6%</td>
<td>100</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>California</td>
<td>3,324</td>
<td>5,167</td>
<td>55%</td>
<td>100</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Colorado</td>
<td>913</td>
<td>970</td>
<td>6%</td>
<td>100</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Delaware</td>
<td>181</td>
<td>309</td>
<td>71%</td>
<td>100</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Florida</td>
<td>5,167</td>
<td>5,167</td>
<td>0%</td>
<td>100</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Georgia</td>
<td>1,299</td>
<td>1,366</td>
<td>5%</td>
<td>100</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Georgia</td>
<td>1,299</td>
<td>1,366</td>
<td>5%</td>
<td>100</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,893</td>
<td>2,518</td>
<td>33%</td>
<td>100</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Indiana</td>
<td>1,228</td>
<td>1,566</td>
<td>28%</td>
<td>100</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Iowa</td>
<td>303</td>
<td>324</td>
<td>7%</td>
<td>99+</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1,253</td>
<td>1,480</td>
<td>18%</td>
<td>100</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Louisiana</td>
<td>890</td>
<td>1,015</td>
<td>14%</td>
<td>100</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>Maine</td>
<td>270</td>
<td>359</td>
<td>33%</td>
<td>100</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Maryland</td>
<td>1,309</td>
<td>2,171</td>
<td>67%</td>
<td>100</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Minnesota</td>
<td>607</td>
<td>663</td>
<td>8%</td>
<td>100</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Missouri</td>
<td>1,096</td>
<td>1,384</td>
<td>26%</td>
<td>100</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Nebraska</td>
<td>122</td>
<td>112</td>
<td>0%</td>
<td>100</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>New York City</td>
<td>987</td>
<td>1,478</td>
<td>49%</td>
<td>100</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>North Dakota</td>
<td>62</td>
<td>80</td>
<td>29%</td>
<td>99+</td>
<td>0.28</td>
<td>0.28</td>
</tr>
<tr>
<td>Texas</td>
<td>2,599</td>
<td>2,799</td>
<td>7%</td>
<td>100</td>
<td>0.18</td>
<td>0.18</td>
</tr>
<tr>
<td>Virginia</td>
<td>1,005</td>
<td>1,387</td>
<td>38%</td>
<td>100</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Washington</td>
<td>1,134</td>
<td>1,102</td>
<td>3%</td>
<td>100</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Wyoming</td>
<td>34</td>
<td>37</td>
<td>9%</td>
<td>100</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

NOTES ON DATA QUALITY: Provisional counts should be interpreted with caution and in the context of the data quality. Percent complete indicates the percentage of death records available for analysis. Percent pending investigation refers to the percentage of available records that are pending investigation and do not have a final cause of death. Drug overdose deaths are often initially reported with no cause of death pending investigation as they require lengthy investigation, including toxicology. Drug overdose deaths are identified using ICD-10 underlying cause-of-death codes X40-X44, X60-X64, X85, and Y10-Y14. Reporting jurisdictions were selected for inclusion based on two measures of data quality: 1) overall completeness of reporting (≥ 90%), and 2) percentage of records pending investigation (<1.2%).

CDC • National Center for Health Statistics • National Vital Statistics System
EX-DEA AGENT: OPIOID CRISIS FUELED BY DRUG INDUSTRY AND CONGRESS

Whistleblower Joe Rannazzisi says drug distributors pumped opioids into U.S. communities -- knowing that people were dying -- and says industry lobbyists and Congress derailed the DEA’s efforts to stop it
"This is an industry that allowed millions and millions of drugs to go into bad pharmacies and doctors' offices, that distributed them out to people who had no legitimate need for those drugs."

Too big to prosecute, An American Terrorist, Airlift

Whistleblowers: DEA attorneys went easy on McKesson, the country's largest drug distributor; then, rejecting hate, after spending nearly a decade spreading it; and, saving rhino with helicopters
Based on 2015 sales, the top five opioid products were made by Purdue Pharma, Johnson & Johnson, Insys Therapeutics, Mylan and Depomed.

Approximately 80 percent of the global opioid supply is consumed in the United States. The United States, which represents only 5 percent of the global population.

The 300 million pain prescriptions equal a $24 billion market.
Cost Of U.S. Opioid Epidemic Since 2001 Is $1 Trillion And Climbing

February 13, 2016 - 8:00 AM ET

A young woman made under a bridge in the stereotype sector of Philadelphia, a neighborhood that has become a hub for heroin use. The economic costs of the epidemic are mounting, researchers say. In the U.S., opioid abuse and overdose deaths have topped those of breast and cervical cancers.

Image: The Atlantic