ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, December 19, 2017
Legislative Office Building, Meeting Room 1D
Hartford, CT
10:00 a.m.

ATTENDANCE

Members/Designees: Craig Allen, Rushford; Charles Atkins, CMHA; Hope Auerbach, Recovery Health Management Subcommittee; Maureen Dinnan, Representative for Rose Rebimbas; Katie Farrell, Public Defenders Officer; David Fiellin, Yale School of Medicine; Ingrid Gillespie, CT Prevention Network; David Guttchen, OPM; William Halsey, DSS; Shawn Lang, AIDS, CT; Susan Logan, DPH; Nancy Navarretta, DMHAS; Kristina Stevens, DCF; Gerard O'Sullivan, Dept. of Insurance; Sandrine Pirard, Beacon; Ariel Reich, DESPP; Julie Revaz, Judicial; Gary Roberge, Judicial; Jerry Schwab, High Watch Recovery Center; Greg Shangold, Windham Hospital; Xaviel Soto, DCP; Jonathan Steinberg, CT General Assembly; Judith Stonger, Wheeler Clinic; Phil Valentine, CCAR; Melissa Ziobron, CT General Assembly

Visitors/Presenters: Loel Meckel, DMHAS; Julienne Giard, DMHAS; Kathleen Mauer, DOC; Quyen Truong, NCRMHS; Diana Heyman, DMHAS; Joseph Riter, RSL; Lawrence Magras, CHNCT; Yanike Whittingham, DOC; Sondra Violett, DOC; Bert Plan, Beacon; Kim Karanda, DMHAS; Michael Klau-Stevens, DMHAS; Janet Storey, DMHAS; Louise Sorrentino, DMHAS; Shoblis Thanyada, DPH; Heather Clinton, DPH; Ece Tek, Cornell Scott Hill Health; A. Harris, GHHRC; Ana Gopolan, TriCircle Inc.; Janet Lally, Beacon

Recorder: Karen Urciuoli

The December 19, 2017 meeting of the Alcohol & Drug Policy Council (ADPC) was called to order at 10:00 a.m. by DMHAS Deputy Commissioner Nancy Navarretta. The meeting was co-chaired by Deputy Commissioner Kristina Stevens, DCF.

Topic	Discussion	Action
Welcome and Introductions	Members of the Council introduced themselves and Deputy Commissioner Navarretta welcomed all in attendance.	Noted
Review and Approval of Minutes	Minutes were reviewed and approved as written.	Noted
Detoxification/Rehabilitation Bed Census Website Demo	Julienne Giard provided the following update DMHAS became acutely aware of the need for a website like this during the 30+ opioid forums that DMHAS participated in around the state last year and the year before. In every forum the public was asking where are the detox beds, where are the residential treatment beds, when will a bed become available. The planning for the website started at that time. In addition there was legislative interest and a task from HB7052 for the Treatment Committee to create a public information portal. DMHAS partnered with 20 private nonprofit agencies that are DMHAS funded for detox, residential treatment and recovery house programs and partnered with an application developer to develop the site, which covers 57 programs and 1100 beds across the state. An overview of the site was provided. The bed availability website can viewed on various devices and can be accessed at http://www.ctaddictionservices.com/.	Informational
Video of Recovery	Lori Szcygiel presented a recovery video produced for Beacon Health Options. The video can be viewed at https://vimeo.com/243012625/62cf32a6f3 .	Informational
Medicaid Authority Response to the Opioid Crisis	William Halsey provided an overview of the Medicaid program: A Quick Look at CT Medicaid • Total expenditures of approx. $2.5 billion (net/state share) or 15% of the state budget • Estimated federal match for Medicaid is 59% • Serves about 770,000 individuals in Connecticut • Medicaid covers about: • 22% of the Connecticut population • 25% of Connecticut children • 47% of births in Connecticut	Information The full presentation can be found on the DMHAS ADPC webpage.

Topic	Discussion	Action
	• Rebalancing efforts through Money Follows the Person has transitioned almost 4,000 individuals from nursing facilities to the community Medicaid Enrollment and Expenditures • Expenditures have increased proportionate to the increase in enrollment, but per member per month costs have remained remarkably steady. Federal Share of Costs • The federal share of HUSKY Health costs has increased to 59%, up from 50% pre-ACA. This takes into account 100% federal funding for HUSKY D. HUSKY Health Summary • HUSKY Health is improving outcomes while controlling costs. • Health outcomes and care experience are improving. We are enabling independence and choice for people who need long-term services and supports. • Provider participation has increased. • Enrollment is up, but per member per month costs are stable. • The federal share of HUSKY Health costs has increased. CT Medicaid for Substance Use Disorders (SUD) by Levels of Care for CY2016 • Hospital Inpatient Detox • Residential Detox • Partial Hospital Program (PHP) • Intensive Outpatient (IOP) • Hospital Outpatient All – In General • Hospital Outpatient – ED Use • Home Health Agency • FQHCs – Substance Use Disorder • Behavioral Health Clinics • Independent Licensed Practitioners • Methadone Maintenance Pharmacy Initiatives • Prescription Drug Monitoring Program (PDMP) • Prior Authorization on all long acting opioids • Re-fill policy • Morphine Milligram Equivalent (MME) • Pharmacy Lock-in Program • Drug Utilization Review- opioids and benzodiazepines • MAT- Prescription medication available • Provider notification concerning Section 7 of Public Act 16-43 which instructs prescribers to limit opioid RXs to a 7 day supply Pharmacy Prevention Strategies • Primary Prevention Strategies ▪ Section 7 of Public Act 16-43 o Prohibits a prescribing practitioner from issuing a prescription for more than a seven day supply to: ~ An adult for the first time for outpatient use	

Topic	Discussion	Action
	~ A minor at any time ▪ Prior authorization (PA) is required for new long acting opiate therapy (LAO) and is granted when medically appropriate and includes a medical plan of action ▪ Conduct Educational Interventions o Newsletters o Provider education and outreach o Webinars ▪ Patient Safety First – Alerts sent to pharmacy providers at the point of service to prevent duplication of therapy, multiple drugs with the same ingredient, or to alert the pharmacy of medical conditions • Secondary Prevention Strategies ▪ Prescription Drug Monitoring Program (PDMP) Collects prescription data for controlled substance medications into a centralized database, the CT Prescription Monitoring and Reporting System (CPMRS) ▪ The purpose of the CPMRS is to present a complete picture of a patient's controlled substance use, including prescriptions by other providers ▪ CPMRS is used to improve quality of patient care and to reduce prescription abuse, addiction, and overdose ▪ Allows providers the opportunity to properly manage the patient's treatment, including the referral of a patient to services offering treatment for drug abuse or addiction when appropriate ▪ Effective 10/1/2016, early refill edit modified from 85% to require Prior Authorization (PA) when the patient has consumed less than 93% of the original or latest refill prescription ▪ Effective 10/1/2016, early refill edit modified from 85% to require Prior Authorization (PA) when the patient has consumed less than 93% of the original or latest refill prescription • Applies to prescriptions filled for a day supply of 16 days or greater • Prescriptions for a day supply less than or equal to 15 days continue to be subject to the 85% utilization rate • Out of state pharmacy providers are exempt from the new criteria and continue to be subject to the 85% utilization rate-this is to ensure timely delivery of specialty and mail order medications which require shipping • Tertiary Prevention Strategies ▪ DSS and ASOs are now calculating Morphine Equivalent Dosing (MED) which calculates all Calculated amount of morphine being taken by a member based on select drugs which exhibit morphine-like properties as determined by the Centers for Disease Control and Prevention (CDC) ▪ Assists the department and ASOs identifying, monitoring, and addressing potential harmful opioid dosages being taken by their members ▪ According to the CDC, the mortality rate rises rapidly in patients whose prescribed MME dose approaches 200 MME/day ▪ Methadone dispensed at an Opioid Treatment Program is excluded from the MME score Connecticut Medical Assistance Program Opioid Utilization Report • Opioid utilization has been trending downward. Looking at figures from 2016/2017, the number of prescriptions for opiates has been steadily decreasing. • In 2016, legislation was passed to limit opioid prescriptions to a 7 days' supply within the state. The CDC had also released guidelines during 2016 on the use of opiates for non-cancer chronic pain so it is interesting to see that prescribing trends were affected by these changes. • At an educational intervention level through the RDUR program, multiple targeted opiate interventions for CT during 2016/2017 were performed, some of which included:	

Topic	Discussion	Action
	▪ Overutilization of narcotics ▪ Opiate and BZD concurrent use ▪ Medication poisoning ▪ Codeine and Tramadol Utilization ▪ As well as the monthly pharmacy restriction reviews • These RDUR interventions also had an impact on the decline in the number of opioids prescribed to our population Member and Provider Prevention Strategies • In addition to pharmacy initiatives related to the prevention of substance use disorders and overdoses, DSS, along with our Administrative Services Organizations (ASOs), are addressing opioid use in various ways: ▪ Medical ASO: Connecticut Health Network of CT ▪ Dental ASO: Benecare ▪ Behavioral Health ASO: Beacon Health Options (Managed in partnership with DCF and DMHAS) Provider Prevention Strategies • United sense of urgency to collaborate among ASOs • Pain Management PCP and ED physician toolkits (available HUSKY Health website, under pain management) • Pain Management PCP and ED practitioner quick reference guides (website and hard copies) - hard copies delivered to offices and hospitals during 2016 and 2017 • Webinar 2017 – The Practical Aspects of Prescribing Opioids for Chronic Pain (1.25 hour Cat 1 CME opportunity – free of charge to participants) • Develop and disseminate MAT resources for providers • Producing and disseminating a MAT Locator Map • Implement reporting criteria to better identify outliers ▪ Include MME integration into reporting ▪ Educate regarding state law(s) regarding Class II limitations by age ▪ Monitor Class II prescribing volume by provider type and specialty ▪ Compare inappropriate service category to Class II use ▪ Provider-specific reporting with specialty peer group comparisons, normalized for type of service and panel size Secondary Prevention Strategies • Increase the number of primary care and behavioral health providers who offer Medication Assisted Treatment (MAT) • CHN Conference 2016 and 2017 – Essentials of Primary Care Psychiatry ▪ 16 hours Category 1 CME credits ▪ To enhance PCP skills of treating BH conditions in PC setting ▪ Extensive coverage of substance use disorder • Implementation of Project ECHO by Beacon- an evidence based tele-mentoring consultation service ▪ ECHO is an ongoing bi-weekly expert consultation service offered by Beacon free of charge to qualified CT CMAP Providers with six providers and 12 prescribers participating Medication Assisted Treatment (MAT) Initiative • Beacon Medication Assisted Treatment (MAT) Initiative • 4 Primary Goals ▪ Expanding the Medication Assisted Treatment Provider Network ▪ Coordinate and collaborate with multidisciplinary organizations ▪ Analyze and report on quality metrics ▪ Improve access to MAT services	

Topic	Discussion	Action

	• Key Components
	  ▪ Recruitment of MAT BH Prescribers and facilitating Waiver Training
	  ▪ Promoting Web Based Resources for Members and Providers (e.g. MAT Map)
	  ▪ Conducting Project ECHO for Opioid Use Disorders
	Provider Prevention Strategies
	• Outlier prescriber program initiated by all ASOs with various levels of notifications and alerts being used with providers
	• CHN does quarterly mailing to PCPs
	  ▪ Notification letter if one or more patients filling prescriptions for high volume of opioid medications
	  ▪ Considered high volume if member receives greater than 100 MME per day (2017 Q3 – 1,478 members)
	  ▪ 2017 YTD - 1,646 letters mailed
	Member Prevention Strategies – High Dosage Opioids (HDO)
	• CY 2016, 31,537 adults were prescribed two or more opioids
	• High Dosage Scope – In 2016, 2,133 (0.4%) of adult members were high-dosage
	• HDO Age – 45-54 was most common
	• HDO Gender – 52% were Male
	• HDO Race/Ethnicity - 77% White, 9.5% Black, 10% Hispanic, and 3.2% Other
	• HDO Average Dosage Range – 120 to 2,940 MED
	• Various Strategies to impact high dosage members (ICM, care coordination, provider education).
	• Good News – between 2015 and 2016 the rate of high dosage use declined 11%.
	Member Prevention Strategies -
	• Primary Prevention Strategies
	  ▪ Developed High Dosage Opioid Measure and Opioid Poisoning Measure
	  ▪ Quality Management Department nurses conduct quality of care reviews for members receiving greater than 1,100 MME per day (2017 Q3 – 7 members)
	  ▪ Medical record and claims history review performed by CHNCT nurse and referred to physician reviewer for final leveling
	  ▪ Review includes: monthly office notes, imaging, urine toxicology screens, ED encounters for overdoses
	  ▪ Findings shared with CMO and Compliance Department and actions taken as appropriate with possible referral to DSS and/or DPH
	  ▪ 2017 YTD - 10 members reviewed
	  ▪ Development of reports and analytics regarding opioid poisoning
	• Secondary Prevention Strategies
	  ▪ Opioid utilization report developed by all ASOs
	  ▪ CHN: Identifies all members receiving > 100 MME's/day for previous 90 days
	  • All members receiving >550 MME's/day are referred to Intensive Care Management
	  • ICM attempts to contact members to engage
	  • Low success rate in contact and engagement
	  ▪ CHN Care coordination available for care coordination for members with chronic pain
	  ▪ Outreach to all members receiving greater than 550 MME per day (2017 Q3 – 75 members)
	  ▪ Assess member's health status, barriers and strengths
	  ▪ Develop a person centered care plan
	  ▪ Coordinate with specialists and CTBHP
	  ▪ Conduct member visits	

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	▪ YTD 2017 – 208 members filling prescriptions for a high volume of opioids received ICM outreach • Tertiary Prevention Strategies ▪ All ASOs provide Intensive Care Management services to those who have the most acute needs ▪ Opioid poisoning reports are being developed and refined ▪ Methadone and other opioids reports are being developed and refined ▪ Providers/Prescribers who have members with opioid and/or methadone poisoning will be contacted ▪ CHN has escalation process for members with chronic pain and opioid use disorder ▪ Promote ADA guidelines for pain relief ▪ Identify potential fraud cases Dental Treatment and Opioids • Develop metrics for provider comparison to peers including: ▪ Opioid prescription volumes/rates by dental providers relative to dental service delivery ▪ Opioid prescription volumes/rates by dental providers in the absence of dental services delivered +/- "X" days of prescription based on procedure ▪ Follow ED/ER opioid prescribing volumes/rates for dental related ED visits by hospital Next Steps • Continue collaboration among state agencies and ASOs • Continue to improve analytics to identify high risk users • Continue to expand network of primary care and behavioral health providers that can provide MAT • Continue to review authorization practices that are likely to prevent misuse for children and adults • Continue to collaborate with healthcare practices/providers	
Narcan Revivals: State Police Perspectives	Trooper First Class John Martin provided a State Police perspective on using Narcan to treat opioid overdoses: Trooper Martin works in the Troop E in Montville, they cover Southeast CT. Since 2015 they have been issued Naloxone kits, and have had to administer it 35 times. For Trooper Martin, it looks like the overdoses that are requiring police administered Naloxone are tapering off, they are finding that when they arrive at the scene a friend or family member there have often administered their own Naloxone. When a 911 call is received about a possible overdose, troopers will go to scene, assess the situation and if the person's breathing is impaired will administer Naloxone, and first aid CPR if needed. They will also seize any evidence/paraphernalia in hopes of identifying the markings in order to trace them back to the drug dealers. A Naloxone report is then prepared and forwarded to Public Safety. Troop E is working with South Eastern Mental Health Authority (SMHA) and have CIT trained officers and clinicians that are based out of their troop. Following the overdose incident or contact with someone on the street who is living with an addiction, a referral will be made to a clinician; the officer along with a clinician will reach out to that person and offer them a treatment program. Trooper Martin has found that getting a person living with an addiction into a treatment program rapidly reduces the potential for them committing a crime. Ariel Reich reported that since the State Police have started using Naloxone, they have responded to 214 calls, and responded to 216 individuals in medical distress, and have been able to revive 205 people. There seems to be a concentration of cases in the Eastern portion of the state.	Informational
Sub-Committee Reports		
• Prevention, Screening and Early Intervention	Judith Stonger provided the following update: • A recent training was conducted by Dr. Tobin and Dr. Becker in New London. There were approximately 80 people in attendance and positive feedback was received from those in attendance. An additional 5 trainings are being planned for around the state.	

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	• Six health districts have been awarded grants and are working on a variety of activities. • The Drugfreect.org website has been updated. The data and analytics show that there has been increased usage over time. Feedback from users shows that they have found the information within the website helpful. • National Prevention Week, which is a SAMHSA initiative, will be held on May 13-19, 2018. There are a number of activities that are being planned. The first will be a kick-off at the Capitol with a press conference and wellness event/fair. On May 16th there will be a conference for professionals, which is being coordinated by DPH. On May 19th there will be a special event at the Hartford Yard Goats game, it will be held on prevention health promotion night. • The remembrance quilt has been viewed by approximately 1,200 individuals in the past couple of months. The second statewide quilt will be completed before Christmas, there is currently two more local quilts being worked on. • An opioid conference for law enforcement is being planned for April 5, 2018 and is being coordinated by the Governor's Prevention Partnership. They have already identified keynote speakers. • Four health districts around the State are being trained to implement prescriber and community education campaigns including safe storage and disposal information. • A few months ago, CDC approved materials were sent out to providers around the State in advance of the statewide campaign. • On November 21st a press release was issued jointly by DCP and DMHAS which alerted the public and encourage them to secure their meds in advance of holidays and other types of activities where people might be prone to having access to those meds. • DCP has a number of new videos and brochures around the topic of securing meds, safe storage and disposal. • The Change the Script campaign is now complete and will be moving forward. There is a number of print/digital materials that can be modified based on community needs. The plan is to have a statewide kickoff in February 2018. The DCP version of this which is more about the prescription drug monitoring program for prescribers and pharmacies will be kicked off on January 6, 2018. • CCMC and Yale have already implemented the integration of PDMP with EMRs; DCP is currently working with Bristol Hospital and Stamford Hospital. • This group continues to assess the number of schools, colleges and universities that have Naloxone on hand. They are currently talking to the State Department of Education about a way to survey the schools on the availability of Naloxone. • House Bill 7052 – the one page fact sheet that talks about risks, symptoms, services and strategies is done and is on the DMHAS and drugfreect.org website as of October 1st. • The voluntary non opioid directive form is now available on the DPH website. The will begin talking about ways to share that information with the public. • They are looking more closely at policy proposals and considerations for 2018 such as mandating blister packaging for medications, mandating age appropriate evidence based education in schools, requiring the recording of Naloxone use in schools, and expanding the availability of Narcan.	
• Treatment	Dr. Charles Atkins provided the following update: • A website is now up and running which shows the availability of substance abuse beds in CT, anyone can access the site. • A package of MAT documents has been posted on the DMHAS website so that any organization or clinic that wants to offer MAT for opiate use disorders can refer to them. There is a broad array of policies, procedures, signage, benzodiazepine literature, and information about urine testing. • The consensus document on toxicology is now available through the DMHAS website. They would like to do a parallel document looking at adolescents. • A real time real serious issue has been raised around urine toxicology; in 2012 4% of overdose deaths in CT involved	Informational

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	fentanyl, in the first six months of 2017 60% involved fentanyl. There is not a current point of service dip stick that is approved for clinic use; it would be very helpful if they could become available clinics. • SBIRT/Adolescent SBIRT – a lot of trainings are going on, Beacon, UCONN Health, and free trainings at the Women's Consortium. • All LMHA's now have the ability to provide MAT; some are further along than others. This group would like to change this goal to "access" to addiction treatment. • Looking at regulatory barriers some will be addressed in conversations with DPH. There was legislation looking to maybe create a conjoined mental health and substance use clinic license, which would be useful. • Looking at access to mobile MAT and also some cross group work with DOC around helping to broaden access to treatment for those incarcerated.	
• Recovery and Health Management	Phil Valentine provided the following update: • This committee has been working diligently to provide town leadership with a questionnaire, metric, self-assessment to see if they are recovery friendly. Do they know how many recovery meetings are in their town, are there a variety of recovery meetings, is there a recovery community center close by, is there access to other types of recovery services. Once recovery is initiated, how good is the town at maintaining and sustaining recovery and improving the health of the people that live there? They are working to keep it as simple as possible, the conversations are invigorating and they hope to pilot this in three friendly communities that are already willing and eager to look at what the recovery community means by a recovery metric for a recovery friendly town and see what they have to say. They will not be there to provide solutions, they will be there to provide an assessment and let the town treat them like resources and say we can improve this, we can do something here. This is the essence of what they have been working on the last few meetings and will continue to work on this winter and into the spring.	
• Criminal Justice (New)	Julie Farrell and Loel Meckel provided the following update. • The United States Attorney's Office is a new member of the CJ subcommittee and reported on prevention and prosecution activities. Prevention activities include presentations to over 90 high schools since 2016 on opioids and the dangers of their use. Their office serves on a statewide task force that reviews cases of fatal opioid overdoses and many of these cases involve people who started using non-prescribed Xanax in their early teens and moved to using non-prescribed opioids. • PA 17-131/HB 7052 Workgroup Update: The workgroup continues gathering information and developing a report on police referral programs for people with substance use disorders. Existing programs around the nation can be classified as Preventative Deflection or Police Assisted Diversion (PD and PAD) and some programs include both elements. PD programs connect a person to services when there is not a basis for an arrest. PAD programs provide connection to services as an alternative to arrest when there is a basis for arrest. The recommendation in the report will include the need for 1) staff to provide outreach, engagement, and assistance to people referred by police is necessary otherwise most people will not access services and resources, 2) a project director to organize and coordinate planning, implementation, and operation activities among multiple stakeholders, 3) technical assistance from a national organization with experience assisting development of successful police referral programs in order to accelerate the planning and implementation process, and 4) a two phase process of planning and implementation/operation. Planning will require each police department to participate in planning with the prosecutor, public defender, service providers, and community representatives and also to train staff and make significant alterations in police activities, data collection, official policies, and procedures. Planning also requires collaboration and coordination among multiple state and local systems.	
Other Business		

NEXT MEETING – Tuesday, February 20, 2018, 10:00 – 12:00, State Office Building, Old Judiciary Room

ADJOURNMENT - The December 19, 2017 meeting of the Alcohol and Drug Policy Council adjourned at 12:00 p.m.