MEETING MINUTES

Alcohol and Drug Policy Council: Treatment and Recovery Support Subcommittee

Meeting Date: May 26, 2016
Present: Charles Atkins, Dave Borzellino, Julienne Giard, Karen Zaorski, Marc Montminy, Marc Bono, Marcia DuFore, Melissa Sienna, Erika Sharillo
Guest: Dr. Feillin, Yale

TOPIC	DISCUSSION	ACTION
CT's Coordinated Response to Opioid Use and Prevention	Opioid Response Initiative: strategic plan working with multiple stakeholders to address opioid use, prevention and overdose. Goal is to develop the plan including ADPC, DMHAS, DCF, DCP, DOC, prevention and treatment providers and others to combat addiction and overdose in CT. CT process fashioned after the Rhode Island strategic planning process that is a partnership between Brown University and the Governor's office. Rhode Island: 90-day plan development period. Public comment throughout the process. Public-facing dashboard to monitor and track progress. 4 key strategies: 1) increase tx access; 2) increase naloxone access; 3) decrease problematic prescribing practices (e.g., Benzos & Methadone); 4) increase access to peer recovery support. Track specific metrics to monitor progress. CT Process: Similar to RI. 90-day lead-in to gather info to develop plan, get feedback and then begin to monitor/track. Led by team of experts at Yale. RI and Brown have offered support. Goals: Strategic expansion of opioid tx programs in underserved communities, increase number of physicians who provide MAT through trainings, linkages between EDs/syringe exchange, etc., into treatment. Address issues of stigma. Expand access to Naloxone through primary care and other prescribers of controlled substances. Data: Use existing data to inform the process. GIS mapping will be available. Subcommittee Recommendations/Reactions: • Manchester hospital to initiate a program to provide care for patients with opioid use problems. Intakes available 24-hours/day. Provide replacement therapy, a bed and comfort measures until ED-initiated MAT can be administered. CRT to partner with MH and provide wrap-around services to patients. Recommendation: Must have opioid tx programs ready to accept these patients after discharge, and within a range of insurances. This is a barrier for some hospital networks that are considering ED-initiated MAT but haven't yet linked to a network for continuing care for patients after discharge. • Integrate counseling with MAT (tremendous variability in the amount of ancillary/ adjunctive services available). Ancillary services needed to address issues related to trauma, psychiatric comorbidity. • Beacon Health Options offering support and trainings to providers to deliver MAT, and initiating dialogue about barriers to prescribing. Goal: expand the MAT network. Trainings are a first step. Local provider support system can provide support to new prescribers.	

	• Would be helpful to compile/distribute sample policies to ensure compliance with accrediting/licensing bodies for practices recommended in the strategic plan.
	• Benzo co-administration with MAT is also variable among MAT programs.
	• Suboxone -Title XIX access very limited. Many/most do not prescribe to Medicaid patients. Issues related to payment/finance are barriers to encouraging physicians/organizations to prescribe. MAT reimbursement rates can make some MATs financially difficult to deliver.
	• 5 FQHC's in CT have received federal funds to expand MAT. Will provide either buprenorphine (standard limits) or naltrexone (no limits).
	• Limited access to Suboxone, and once on Methadone switching MATs is difficult.
	• Make first treatment contact "reality based" and something that is maintained over time. Individualized outreach/contact with person to "walk" him/her into treatment. Models to actively link Pt with Tx (Could scale-up these and other models):
	  • Manchester PD: connection/transportation to care at Manchester hospital, divert when possible from criminal/legal system.
	  • Yale Project ASSERT, Health Promotion Advocates at Yale ED to identify and actively link patients with treatment, with followup after discharge.
	  • Yale ED-initiated MAT with followup in primary care settings. (Journal article circulated)
	  • DMHAS pilot at BACCUS hospital
	  • Beacon ICP model
	• Metrics: include metrics/screening related to comorbidities (trauma, PTSD, depression/mood disorder, etc.). What are/should be the standardized metrics?
	• Host an education event/conference and initiate working toward next steps. Offer 8-hour suboxone course plus a variety of other things. Local implementation, learning collaborative, etc. CT Hospital Association is one logical partner.
	• Concerns about scaleability of the models discussed and access to treatment due to: rural geography, lack of transportation, commercial insurance coverage, etc.
	• ED should not be the critical access point to treatment. Could there be a call-center, other than 211, that could help with access? Possible restructuring of state's crisis response teams to meet this need.
	• Build a "pool" of appointments among providers for rapid access to treatment in the community.	

Preparation for June ADPC meeting	• What will be the process for identifying and prioritizing recommendations for the June ADPC meeting?	