ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, August 21, 2018
Legislative Office Building, Meeting Room 1D
Hartford, CT
10:00 a.m.

ATTENDANCE

Members/Designees: Craig Allen, Rushford; Charles Atkins, CMHA; Miriam Delphin-Rittmon, DMHAS; Maureen Dinnan, Representative for Rose Rebimbas; John Frassinelli, DOE; Ingrid Gillespie, CT Prevention Network; David Guttchen, OPM; William Halsey, DSS; Joette Katz, DCF; Barbara Lanza, Judicial; Susan Logan, DPH; Kathleen Mauer, DOC; Nancy Navarretta, DMHAS; Monika Nugent, DESPP; Gerard O'Sullivan, DOI; Sandrine Pirard, Beacon; Gary Roberge, Judicial; Greg Shangold, Windham Hospital; Xaviel Soto, DCP; Kristina Stevens, DCF; Judith Stonger, Wheeler Clinic;

Visitors/Presenters: Loel Meckel, DMHAS; Jennifer Chadukiewicz, CCAR; Mark Jenkins, GHHRC; Ramona Anderson, DPH; Yanike Whittingham, DOC; Suzanne Doyon, CT Poison Control; Ana Gopoian, TriCircle, Inc.; Donna Kopf, Parent; Bob Freeman, APT Foundation

Recorder: Karen Urciuoli

The August 21, 2018 meeting of the Alcohol & Drug Policy Council (ADPC) was called to order at 10:00 a.m. by Commissioner Delphin-Rittmon, DMHAS. The meeting was co-chaired by Commissioner Katz, DCF.

Topic	Discussion	Action
Welcome and Introductions	Members of the Council introduced themselves and Commissioner Delphin-Rittmon welcomed all in attendance.	Noted
Review and Approval of Minutes	Minutes were reviewed and approved as written.	Noted
Follow up: Recovery Subcommittee Recommendations for June	Approved by council unanimously.	Noted
State Opioid Response Grant Submission	Commissioner Delphin-Rittmon reported that the grant was submitted, and thanked everyone involved in the information sessions and submission process. The charge for this grant was to think about interventions and identify gaps in terms of prevention, treatment and recovery as well continuing to support initiatives supported by STR and also thing about and identify gaps. The following initiatives will be continued through support from this grant. • Expand recovery coaches from 4 emergency departments to 12, • Continue to support the DOC Living Free initiative • Continued support for methadone maintenance and methadone induction within the DOC facilities • Continue treatment pathways program with SCADD and MCCA • Continue the LEAD programs • Expand recovery coaches in methadone clinics • Change the script campaign continue with targeted social media campaigns • Develop education awareness campaigns through web based training • A series of RFPs will be put forth • Continue to purchase and disseminate Narcan Deputy Commissioner Stevens reported that the SOR dollars will be used as building blocks to programs that have already been developed such as: • Expand supports offered to youth and care givers • Develop a partnership with Beacon to provide substance use treatment and recovery training • Work with recovery coaches and new moms around plans of safe care	Informational

Topic	Discussion	Action
DPH Surveillance System	Kristin Soto provided an overview of what syndromic surveillance is. At the State Health Department they collect data to understand different conditions and illnesses of public health interest. Reportable disease surveillance is when DPH asks different physicians or laboratories to report on individuals that have a specific illness or condition. Syndromic surveillance is a little different; with this type of surveillance they collect all of the emergency department and hospital urgent care center data in the state. It's a little less specific but can be characterized into different syndromes of interest. Reportable disease surveillance occurs from either providers or laboratories within the state and is used for conditions that are often reported such as Lyme Disease, measles, lead or carbon monoxide poisoning. The system gives very detailed information about individuals, however there can be some delays in timeliness; also, it is a very specific type of data so they only get data on information that is on their list of reportable diseases and is not very flexible in responding to emerging needs. This type of surveillance system requires an individuals to have some type of exposure, become ill, seek medical care, have an appropriate diagnosis made, have that result be determined to be significant and get reported to the Department of Public Health. Between an exposure of interest and DPH hearing about the report and being able to respond, it can be anywhere from instantaneously to several weeks. In contrast with traditional syndromic surveillance, this is a very timely system with near real time information. As soon as an individual becomes sick and seeks care in an emergency department or hospital urgent care center DPH receives the entire visit for that patient regardless of what their presentation was. With this type of syndromic surveillance as its historically been conducted they would not get any type of diagnosis or follow-up information, so although the information was very timely and complete it may not always be accurate at it's based on how a patient is presenting and not ultimately how they are diagnosed. In the past few years they have been able to modernize their syndromic surveillance system in CT which gives them the best of both worlds. Just like with traditional syndromic surveillance, they are getting real time notification as soon as a patient seeks care in an emergency department or urgent care center in the state with their initial presentation data. As they move through the healthcare system and get a diagnosis DPH will get update messages from the facility in an automated fashion. The updates might contain information such as their date and time of diagnosis, date and time of discharge, any appropriate diagnosis codes, their discharge dispositions, as well as triage notes. Overall, they get about 1.6 million emergency department records a year and to make sense of them they are characterized into different syndromes of interest. The syndromes can be based on their chief complaint or reason for visit, their discharge diagnosis code specifically ICD 9 or 10 and key words from their triage or other medical notes. Sydromic surveillance was established in 2004. At that time it was a voluntary system that was prompted by the 9/11 attacks, and was initially used to look for bioterrorism events but was quickly adapted to be used instead for situational awareness to get a look at what was going on in the community in addition to getting real time event or outbreak detection. In the Fall of 2015 DPH received funding from the CDC to modernize their syndromic surveillance system and in 2017, additional funding was received the CDC ESOOS grant which specifically aimed to use existing syndromic surveillance systems for opioid overdose morbidity surveillance. Based on the funding they have been able to procure and develop the EpiCenter system which is a product of Health Monitoring Systems. It is a web based application that is fully vendor hosted and supported, and is managed by a small team of syndromic surveillance at DPH and is used by different program area within the department, by local health departments and in the near future possibly hospitals so they can access their own data. Currently they have 100% participation from hospitals and hospital systems within the state. The required reporting of emergency illnesses and health conditions by healthcare providers, which include healthcare facility managers, is done in accordance with the DPH's annual List of Reportable Diseases, Emergency Illnesses and Health Conditions. In 2017 EpiCenter was the Commissioner's new approved format for the reporting of Emergency Illnesses and Conditions. Effective 2018, reportable conditions to the list of Emergency Illnesses and Health Conditions have been modified. This modification does not require any changes to reporting, but clarifies that SyS data may be used to monitor the following syndromes:	Informational – The full presentation can be found on the DMHAS ADPC webpage.

Topic	Discussion	Action
	1. Influenza-like illness 2. Gastrointestinal illness 3. Drug and alcohol, including drug/opioid/heroin overdoses 4. Sexually transmitted diseases 5. Chronic health conditions 6. Extreme weather events 7. Zoonotic and vector borne diseases 8. Toxic hazards 9. Indicators of bioterrorism 10. Other syndromes of public health importance The most recent use of the system was looking at the K2 overdoses on the New Haven green. They were able to quickly pull together an ad-hoc syndrome looking specifically for terms such as K2 and mentions of the New Haven Green, and were able to identify as patients were receiving care in the hospital in near real time. They were also able to identify patients who had repeat encounters based on a recurrence of their encrypted medical record number It was pointed out that the system does not contain some identifiers that are traditionally associated with surveillance data that they collect at the department. They do not collect identifiers such as name, social security number, street address or phone number. All data collected is protected under 19a-25 which is their states confidentiality statute, and can only be used for disease prevention and control. Susan Logan reported on the use of EpiCenter for drug and opioid overdose surveillance, and reported that the work they've been doing does satisfy some of the requirements of Public Act 18-166, which requires DPH to receive overdose reports from hospitals by January 2019, and by January 2020 DPH will report to the local jurisdictions. The work being done using enhanced surveillance grant funding and working with Kristin Soto has enabled them to satisfy both requirements by the end of the 2018 summer. Suspected Overdoses: During April 2018, DPH released a press release which included new data on the number of suspected overdoses seen in CT Emergency Departments during January-April 2018. Key findings included: ▪ 3,090 total ED visits in CT during January-April 2018 ▪ Average of 180 ED visits/week ▪ Hartford County saw 1,021 suspected drug overdose visits, ▪ Followed by New Haven County (907), Fairfield County (416), ▪ New London County (178), Middlesex County (176), ▪ Tolland County (150), Litchfield County (129) and ▪ Windham County (113). Use Case: Overdose Surveillance - Coming Attractions ▪ Improve syndrome definitions for suspected overdoses • August 2018 and ongoing ▪ Automated alerts • Fall 2018-Spring 2019 OD Cluster Detection – Automated Alerts Turn on "surveillance" tools for automated overdose cluster detection:	

Topic	Discussion	Action
	▪ Plan and Implement in Fall 2018 - Spring 2019 ▪ Thresholds for each geographic region (town/city, LH District, or DEMHS region) will be calculated based on OD frequencies over a period of months ▪ Auto alert generated when number of overdoses surges past the threshold ▪ E-mails sent to local health agency staff and potentially other local stakeholders	
Tracking Opioid Overdoses		Postponed to October 16, 2018 meeting.
Sub-Committee Reports		
• Prevention, Screening and Early Intervention	Ingrid Gillespie provided the following update. • Work continues on the integration of PDMP with the electronic medical record. There are currently two major systems that have integrated them; they are Yale New Haven Health Network and the CT Children's Medical Center. The DrFirst software has integrated the CPMRS and is being used by Stamford Hospital and Bristol Hospital. In addition, Walmart/Sam's Club, with 34 stores, has become the first retail pharmacy to integrate the CPMRS. • Evidence Based Opioid curricula in schools – The committee has researched how other states have addressed the opioid use disorder in the health curricula. The SDE will revise their Health and Balances Living Curriculum Framework in Fall 2019 to include opioid education standards and indicators. • Provide guidance and encourage stocking of naloxone in schools – A naloxone survey to assess whether school districts should stock naloxone was developed, the SDE has reviewed and approved the survey and will inform superintendents that it will be distributed to school nurses to complete. • Expand naloxone education for high risk populations – The RBHAOs are determining priority populations in each region and will work with some health districts I naloxone education and distribution. HB-7052 Recommendation for Safe Disposal of Controlled Substances – the vote on this recommendation was tabled for further review/discussion.	Informational
• Treatment	Dr. Charles Atkins provided the following update: • The bed availability portal has been updated to include more recovery houses and halfway homes. CT does not have a certification process for sober living homes and is one of the areas that will be looked at. • Identify and address regulatory barriers that limit access to care – Have explored multiple topics and invited speakers to discuss this issue. • The DMHAS Prevention-Treatment Recovery Conference was held July 17th, at which time another 8 hour DATA training was provided for physicians, APRN's and PA's. • On September 21, 2018 there will be a day long opioid convention with two national keynote speakers	Informational
• Recovery and Health Management	Jennifer Chadukiewicz provided the following update: • Met with the Western CT Opioid Workgroup on August 2nd, this is an existing group that was eager to pilot the recovery friendly rubric. Danbury is now a Recovery Friendly Community. Several other towns are in the process of becoming Recovery Friendly Communities. Region 1 will hold their annual picnic on September 20th at which time the rubric will be completed. Southington and Meriden/Wallingford will also be completing the rubric. • At the September 21st event, there will be two panels that day one will be about recovery friendly communities and the other about recovery coaches. • As a reminder, September is Recovery Awareness Month	Informational
• Criminal Justice	Katie Farrell provided the following update: The next committee meeting is scheduled for September 17th, at which time they will be focusing on three projects • To look at police programs to refer people with addictions to services	Informational

Topic	Discussion	Action
	• Will review the resource list of justice based resource programs within the state, they will be looking to expand it and eliminate any duplication of services as well as any gaps • Will be talking about possible use of naloxone for re-entry and probationers.	
Other Business	Commissioner Delphin-Rittmon provided an update on the recent heath crisis in New Haven, which involved approximately 100 incidents or overdoses on the New Haven Green from a substance identified as K2. The incident went on for over a day and a half and prompted a visit from ONDCP. At that visit ONDCP was briefed and provided next step plans. HIDDA provided a briefing; they discussed what they are seeing and currently investigating. DMHAS has committed funding to provide a street psychiatrist who will be present on the Green to help engage people who are struggling, the psychiatrist may be able to prescribe MAT as well. PRCH, in conjunction with Columbus House, is interested in doing outreach and engagement work on the Green also. In addition, there is interest in having recovery coaches present on the Green to help connect people with treatment. There was discussion around forming a task force that will meet on a regular basis; it will be co-chaired by the mayor of New Haven and Commissioner Delphin-Rittmon.	

NEXT MEETING – Tuesday, October 16, 2018, 10:00 – 12:00, Legislative Office Building

ADJOURNMENT - The August 21, 2018 meeting of the Alcohol and Drug Policy Council adjourned at 12:00 p.m.