ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, December 6, 2016
Legislative Office Building
Hartford, CT
10:00 a.m.

ATTENDANCE

Members/Designees: Charles Atkins, CMHA; Crain Allen, Rushford; Miriam Delphin-Rittmon, DMHAS; Marcia DuFore, NCRMHB; Katie Farrell, Public Defender; Ingrid Gillespie, CT Prevention Network; Stephen Grant, Judicial; Deborah Henault, DOC; Joette Katz, DCF; Shawn Lang, AIDS CT; Susan Logan, DPH; Gregory Shangold, Windham Hospital; Sherrie Sharp, Beacon Health; Kelly Sinko, OPM; Xaviel Soto, DCP; Teresa Spencer, Judith Stonger, Wheeler Clinic; Phil Valentine, CCAR; Katharine Wade, Dept. of Insurance; Melissa Ziobron, CT General Assembly

Visitors/Presenters: Nancy Navarretta, DMHAS; Julienne Giard, DMHAS; Gabriele Krainer, FCA; Charles Dike, DMHAS; Mary Painter, DCF; Bob Freeman, APT Foundation; David Fiellin, Yale; A. Harris, GHHRC; Kelsey Oporda, CSP/BCI/CTIC-NEHIDTA;

Recorder: Karen Urciuoli

The December 6, 2016 meeting of the Alcohol & Drug Policy Council (ADPC) was called to order at 10:00 a.m. by DMHAS Commissioner Miriam Delphin-Rittmon. The meeting was co-chaired by DCF Commissioner Katz.

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
DMHAS Video Clip	DMHAS shared another PSA produced by Tom Gugliotti. Commissioner Delphin-Rittmon thanked all family members and people in recovery who have shared their stories. All PSA's are on the DMHAS website to be viewed and shared.	Informational
Update on Strategic Planning Process	David Fiellin provided an update on the Connecticut Opioid Response Initiative. Since the Governor's announcement on September 24, 2016 the core initiative has been presented at 8 venues around the State. Progress with the tactics and strategies are as follows: Increase access to treatment, consistent with national guidelines, with methadone and buprenorphine • Increase medication use among incarcerated – working with DOC, • DMHAS and UCONN on grant for methadone in correctional facilities. • Access to buprenorphine ▪ Working with DMHAS and UCONN on grant for ED-initiated buprenorphine ▪ DATA 2000 trainings ▪ Targeting DATA 2000 trainings with 6 LHDs (Hartford, New Haven, Bridgeport, Waterbury, Quinnipiac Valley, Ledge Light) ▪ Using DEA buprenorphine shipment and overdose data to target areas of need ▪ Worked with Dr. Sharp, Beacon Health Options, AAAP to increase number of PCSS-MAT mentors from 5 to 10 in state. ▪ Met with Danbury Hospital/AIDS Project Greater Danbury to facilitate treatment initiation and referral ▪ ED-initiated treatment and referral (5 programs) at YNHH ED Reduce overdose risk, especially among those individuals at highest risk. • Accelerate opioid overdose survivors' entry into opioid agonist treatment – ED-based interventions – YNHH ED has made arrangement with 5 local treatment providers/programs to receive patients with ED-initiated buprenorphine Increase adherence to opioid prescribing guidelines, especially among those providing prescription associated with increased risk.	Will continue to update

Topic	Discussion	Action
	• Target education and implementation efforts for practitioners who prescribe more than 90 MME or who co-prescribe opioids and benzodiazepines – working with 6 MHDs regarding provider training. Increase access to and track use of naloxone • Increase naloxone distribution to high-risk individuals • Monitor naloxone use in response to witnessed opioid overdose events • Ensure affordable access to naloxone Progress • Presentations to pharmacists at DPH symposium • Working with 6 LHDs regarding local naloxone data Increase data sharing across relevant agencies and organizations • Create a memorandum of understanding across relevant agencies to allow for data sharing and protection – DPH and DCP working on MOU regarding PDMP data and working with 6 LHDs regarding local data Increase community understanding of opioid use disorder, treatment, decrease stigma • Education efforts with media, agencies, healthcare and public health personnel – providing pharmacy and public health presentations, multiple media conversations and media consultation is in process. Overarching and long-term efforts • Diverting individuals from the legal system to the health care and treatment system – project LEAD discussions in New Haven with mayoral support to couple community policing with case managed referral of individuals with substance use disorders to treatment and other needed services • Creation of supervised or safe injection sites – discussion in New Haven and Hartford are at the contemplative stage by local harm reduction and academic advocates	
Sub-Committee Reports		
• Prevention, Screening and Early Intervention	A. Identify core competencies for Continuing Medical Education around Safe Opioid Prescribing and Pain Management (for both prescribers and non-prescribing medical staff). ➢ Build on existing trainings and practice guidelines through the American Society of Addiction Medicine (SM) and CT State Medical Society's Addiction Medicine • Subgroup formed to address recommendation and co-chairs response • Subgroup considered current training curricula, training providers and efforts from other states • Subgroup drafted a series of new recommendations re: provider education on pain management for review and approval at future subcommittee and council meetings B. Raise awareness of and provide education on the dangers of opioids and reduce stigma and other barriers for individuals and family members seeking help. C. Provide education and resources regarding dispensing, safe storage and disposal of prescription medications. L. Inform prescribers by developing and adopting Fact Sheets; support the dissemination process of such Fact Sheets to prescribers. M. Promote ADPC adoption of one or more of the Public Service Announcements that have been developed by DMHAS and other currently available education materials for distribution. Assist with the identification of necessary resources to do so. ➢ Update the drugfreect.org website to improve user interface and increase ease of access to information • Drugfreect.org was directed to the newly released ct.gov website and modifications to the site will be made from the two ct.gov templates. • Dan Maher from CT Interactive is providing access to authoring tools and utilization data to update and track website. ➢ Support the increased use of evidence-based prevention programs	Informational

Topic	Discussion	Action
	• A list of EBP strategies and interventions has been compiled and will be posted on the website. ➢ Promote safe disposal of prescription drugs through National Take Back Day • The GPP and the Capitol Area Substance Abuse Council were featured on WFSB. • The CPN and DEA sponsored a forum on designer drugs in October. • DMHAS met with the Governor's Office to discuss the distribution of drug deactivation pouches donated by Mallinckrodt Pharmaceuticals. ➢ Develop a comprehensive education strategy to raise awareness on the dangers of opioids and reduces stigma and barriers to treatment • The DPH held a conference on October 27th for health and human service professionals across the state to reveal the CT Opioid Response (CORE) plan and its implication for prevention, treatment and recovery. • The DMHAS is developing a Remembrance Quilt in memory of those who have died from substance use disorders. • The DPH awarded 7 health districts across the state $30k per year for each year to implement community health system interventions aimed at building capacity necessary to prevent prescription drug overdose and abuse. • The Recovery & Health Management subcommittee developed a document on the language of recovery. • The DMHAS is in the process of procuring a consultant to work with the PSEI to develop a comprehensive education strategy. E. Support the integration of the CT Prescription Monitoring and Reporting System (CPMRS) with Electronic Medical Records (EMRs) to improve access to patient data and reduce prescription drug misuse and overdose. ➢ Review requests and provide approvals for healthcare institutions on the (CPMRS) to share data with Appriss (CPMRS vendor) in order to use the product that interfaces the EMRs with the CPMRS • DCP staff met with 4 healthcare providers who are interested in EMR integration and referred them to Appriss. • One of the 4 providers have started to pilot the gateway product that allows the interface between their EMR and the CPMRS. ➢ Handle policy issues that may arise from integration • DCP staff fielded policy related questions from vendor regarding integration up to October 2016. ➢ Provide monetary incentives for seven healthcare institutions to offset the cost of integration • DCP/DMHAS staff identified infrastructure development funds through SPF Rx grant to support the cost of EMR integration for 7 institutions. • DCP scheduled talks with interested healthcare institution to discuss possible integration pilot.	
• Treatment and Recovery Supports	Expand SBIRT offerings, including A-SBIRT • 3 SBIRT resources are available: 1) SBIRT Trainers, 2) Kognito licenses for providers to practice, 3) UConn SBIRT training institute. This subcommittee will work on marketing and disseminating this information statewide. • Train school nurses to do SBIRT • Implement requirement that all school districts have to provide some teacher in-service training on substance abuse, SBIRT Require all 13 Local Mental Health Authorities (LMHAs) to provide MAT for opioid use disorders. • DMHAS identified one-time money for private non-profit LMHAs for MAT start-up. • LMHA MAT Learning Collaborative starting December 16th. • DMHAS awarded SAMHSA MATx Grant – expanding Buprenorphine and Naltrexone at 4 providers. Expand MAT for DOC inmates and re-entry population.	Informational

Topic	Discussion	Action
	• Continue MAT for Bridgeport and New Haven jails (with treatment providers) • Implement MAT at Hartford Correctional Center – JAG grant funding through OPM • Implement MAT at York Correctional Institution – JAG grant funding through OPM • Implement MAT at Willard-Cybulski , Carl Robinson and Corrigan Radgowski – funding TBD Create Regulatory Workgroup to address barriers to efficiency and treatment. • Understand why methadone is not being reported into PMDP and how to correct this. Dr. Atkins to write to Senators Murphy and Blumenthal. • LADC scope of practice does not include mental health assessment and treatment. Expand this scope of practice if warranted. • Addressing the amount of paperwork staff do. Review data reporting requirements across agencies. DMHAS: 1) Can Periodic Assessments be reduced from twice per year per client? 2) Can the CAGE screen requirement be changed to the Audit screen? It is a meaningful use measure for PQRS. 3) Can DMHAS change the GAF to a different functioning measure or delete? • DCF is changing their data system and paperwork may be increasing. • DPH has different MH vs SA requirements for recovery plan intervals, which is problematic. • Allow query of PDMP directly from EHR – push one button – time saver (e.g., Appriss product). Rhode Island, VA and MA have found ways to get this for their providers. Increases efficiency. Follow up with DCP. • Medicaid - Can't bill for two services on same day. Makes it more difficult for clients. • Explore options for Medicaid to pay for teleheath services. Require ECCs to include tox screens upon admission. (Note: The committee's thinking has evolved and the goal is now: As part of the overall evaluation through ECCs, urine toxicology screens, to assist with assessment, diagnosis, and treatment, will be available and obtained at the discretion of the treatment team. • Changing ***requirement*** for tox screens upon all ECC admissions to ***recommended guideline*** to include them as part of treatment process in all addiction treatment settings. • Develop brief document that details purpose of tox screening, benefits, potential pitfalls and ways to meet those challenges. • Disseminate tox screening document.	
	Dr. Mauer provided an update pertaining to the ADPC recommendation regarding Correctional MAT Treatment, and thanked this committee for including DOC in the recommendations. ADPC Recommendation Regarding Corrections Reduce disparities in access to medical treatment by expanding the availability and clinical uses of MAT to a broader group of incarcerated offenders and offenders re-entering communities using community-based standards of care. • This recommendation expands DOC's implementation of MAT in two facilities to the entire corrections system. In doing so, equitable opportunity to access MAT is offered to inmates regardless of facility. • The Treatment Sub-committee will work with DOC as the lead and within available funding. This effort may be limited to a pilot (grant funded). Current Programs in Development • Hartford Correctional Center ~ JAG Grant Funding (OPM) for 9 + months ~ Contracts Development and other Requirements Underway ~ Teams meeting since October 1—Safety and Security, Clinical, Data ~ DPH Licensing Team has toured	The full PowerPoint presentation is available on the DMHAS ADPC webpage.

Topic	Discussion	Action
	~ Dispensing site identified and under construction ~ Warden and others supportive ~ Program Opening Planned for January 2017 • York Correctional Institution ~ JAG Grant Funding (OPM) for 18 months ~ Proposals and contracting underway ~ Will begin to put this program together after January when HCC opens ~ Tentative treatment opening date is May 2017 Longer Term Plans • Pre-Release Center ~ Willard-Cybulski or ~ Carl Robinson Important to induct those who have been incarcerated for extended periods prior to release • Full jail coverage ~ Corrigan Radgowski	
• Recovery and Health Management	Adopt the "Language of Recovery" document presented to the ADPC to ensure that all members are familiar with alternatives to traditional terminology and can promote the use of more "recovery-friendly" terminology. • DMHAS to post document on website • DCF, DOC, CCAR, AIDS-CT to post on their own or link to DMHAS website • Distribute at "New England Symposium on Women & Opioids" - other New England state agencies and other partners now have this document • Encourage use by ADPC Prevention Sub-Committee to include in their anti-stigma activities • Request that Governor's website post – need lead on this (Mary Kate Mason, DMHAS)? • Request that the CT Certification Board and the DARC programs at Gateway and Manchester incorporate into their trainings – Deb Henault • Explore possibility of getting this into the university based medical training programs – need lead on this Insure that school administrators and/or nurses and college public safety personnel have naloxone available to them and that the ADPC assists with obtaining funds, if necessary. • Try to enlist someone from the Department of Ed (DOE) to join this sub-committee – Shawn Lange reached out to DOE • Reach out to school-based health centers – need to assign lead • Reach out to School Nurses Association – need to assign lead • Reach out to Association of Boards of Education – need to assign lead • Reach out to Boards of Regents – Shawn Lang	Informational
Department of Insurance: The Commercial Insurance Industry's Response to the Opioid Crisis	Commissioner Wade reported that Department of Insurance has been working proactively with the industry to survey and understand their practices and programs to combat the opioid epidemic. When the insurance carriers where surveyed, the Department was pleased to find out that they are covering reversal drugs without prior authorization and trying to raise awareness so that people know they are covered. The Departments approach has been to bring the insurance industry into the public conversation to explain the treatment programs they have. The health insurance and property and casualty industry have been working on this for years, particularly in their workers compensation coverage. This is a challenge that the industry is readily facing and trying to work very hard on. On October 12th the Insurance Department held a public forum at the Legislative Office Building; they had 3 health insurers and 2 property and casualty carriers talk about their programs, Dr. Fiellin, along with a drug and alcohol counselor in her 6th year of recovery also participated in the program. The insurance companies that were involved were Aetna, Anthem, Cigna, The Hartford, and Travelers. The forum provided an opportunity for the public to hear directly from	Informational

Topic	Discussion	Action
	the companies so that people would get a sense of the work they are doing. • Aetna reported on their work on super prescribers and how they are using CDC guidelines and claims data to get an understanding of who the super prescribers in their network are. They are getting out information to the providers to understand how they may be prescribing at a higher rate than their peers, and are also sending out additional information from the Medical Director of Aetna. The company does additional outreach to see how they can work with their providers. • The Hartford has a multi-faceted program to educate claim handlers, providers and injured workers. They also use data to reach out to the providers. They use their medical director and other medical professionals to reach out when they see someone is prescribing at a high rate. Additionally, they are working very closely with their injured workers to help move them away from the use of opioids and into other programs including the use of a 10 week telephonic coaching program that they have had some very good success with. It was noted that CT has a low number of super prescribers in the Aetna network. • Anthem talked about its partnership with Aware Recovery, they are doing a pilot in CT on in-home substance abuse treatment. They have approximately 70 people enrolled in the program in CT and have had an incredible success rate. • Travelers is working on predictive modeling which is data driven. They have a patented model to work with injured workers to avoid chronic pain and opioid use. They have an early severity predictor where they have been able to identify 20,000 cases nationwide to help educate people, curb the use of opioids, as well as they have been able to identify 9000 injured workers who are at risk of developing chronic pain. They use a customized sports medicine approach and have been able to avoid people's use of opioids. • Cigna is working with Brandeis University, along with the American Society of Addiction Medicine to help develop evidence based guidelines for treatment, which is one of the challenges in this area. Commissioner Wade indicated that they will continue to have a dialog with the industry and offer them the opportunity to continue to educate the public about their programs. Other Actions: • In May the Department of Insurance issued a bulletin reminding carrier that they need to make sure consumers are aware of coverage for the use of opioid deterrent drugs. • In the Life and Health Unit they've added a full time reviewer for formularies and networks in order to make sure that people are getting access to the types of drugs that they are supposed to, and making sure that the networks are in compliance with the law. • With regard to Special Act 16-4, the Department is surveying companies asking them to provide substance abuse details for cost sharing deductibles and any coverage limitations in a number of categories, the will then issue a report before the end of the year which will provide findings from the survey. They will also look to see if there are issues that need to be addressed either from a regulatory perspective or if there are other public policy measures that need to be taken. • Their Consumer Affairs Division has knowledgeable and professional staff that works with thousands of people every year; they are the front line of the agency that works with the citizens of CT. They were able to participate in the opioid forums with Commissioner Delphin-Rittmon, and were happy to do so in order to let people know about their free services which includes help with navigating the system if they are not being provided with coverage that they are entitled to, they have resources for consumers that address coverage denials and the ability to appeal them, access to a 3rd party review programs, and a behavioral health toolkit that helps people to navigate the claims system. • In order to make people aware of the Department they have been doing public service announcements and are currently working with students at Capital Community College to create Podcasts to help consumers better understand how insurance works, and what the department can do to help them.	

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<tr><td></td><td>Discussion:
Dr. Fiellin clarified that there are a number of evidence based guidelines in the area that relate to the treatment of opiate use disorder, the program that Cigna was describing is the need for established agreed upon evidence based quality metrics that can be used to monitor patients who are receiving medication for the treatment of opioid use disorder, specifically patients in office based settings.
Dr. Shangold noted that in the emergency departments one of the impediments to accessing mental health services in the need to have preauthorization's where there is not 24/7 availability to have things authorized. Many times because people are waiting in the emergency department for 24-48 hours they change their minds about getting help. This is a burden for both the emergency department and their patients. Commissioner Wade indicated that in CT insurance companies are required to have 24/7 coverage for prior authorizations and asked that the Insurance Department be notified of any issues.</td><td></td></tr>
<tr><td>CCAR: Peers in the Emergency Department</td><td>Phil Valentine provided the proposed framework for providing recovery coaches in emergency departments.
<u>Recovery Coach Emergency Department (ED) Program Framework</u>
Purpose:
Through trained recovery coaches, to connect with ED patients and their families to carry a message of hope that recovery from addiction is possible. ED Recovery Coaches will provide ongoing care and assistance as directed by the recoveree.
Staff:
One ED Recovery Coach Manager, three full-time ED Recovery Coaches, per diem recovery coaches as needed.
Where:
Four hospitals (Manchester, Windham, Norwich, New London).
Who:
Overdose patients (priority) and any patients with alcohol/substance use reason for ED visit.
How:
1. Emergency Departments will call ED Recovery Coach Manager who will dispatch coach.
2. Coaches will respond within 2 hours or less.
3. Coach will engage patient and if patient needs detox or inpatient treatment, coach will help find a provider and transport if needed.
4. Coach will help with finding Medication Assisted Treatment (MAT), out-patient, and other types of formal treatment options.
5. Coach will enroll patient in enhanced Telephone Recovery Support (TRS) program (patient will get called daily for the next 10 days) then weekly if desired.
6. Coach will be providing recovery support information to patient and/or friends and family. This can include 12-step, community, on-line and other recovery resources.
7. CCAR will provide ED with "prescription pad" style resource handout that can be attached to discharge paperwork or given to patient, friend/family member.
Proposed Schedule: Coaches available 8 am – 12 midnight, Monday – Sunday
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<tr><th></th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th><th>Saturday</th><th>Sunday</th></tr>
<tr><td>8am-4pm</td><td>RC1</td><td>RC1</td><td>RC1</td><td>RC1</td><td>RC1</td><td>RC2</td><td>RC2</td></tr>
<tr><td>4pm-12am</td><td>RC3</td><td>RC2</td><td>RC2</td><td>RC3</td><td>RC2/RC3*</td><td>RC3</td><td>RC3</td></tr>
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*double coverage (day of week may change depending on ED needs)
Data Collection: Coach will track the following:</td><td>Informational</td></tr>
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Topic	Discussion	Action
	1. Is this first ED contact for overdose/AUD/SUD related health problem? 2. Previous number of ED contacts for these concerns? 3. Has person met with one of our coaches or crisis team before? 4. Was family or friends engaged? 5. Was referral made? Or direct handoff? To where? i.e., treatment, RCC, offsite Recovery Coach, family/friends, faith-based organization, other? 6. Is the person already engaged with treatment provider(s) or recovery support? 7. Recovery Capital survey (to be administered within first 10 days as part of enhanced TRS) and then again 30/60/90 days out.	
Other Business	Recovery High School Update – Teresa Conroy reported that at their first meeting in October workgroups were formed and at the 2nd meeting held on November 30th, the workgroups reported out. This group, which started out with 5 people now has over 100 stakeholders. The group has done a tremendous amount of research and has found that across the nation more schools have closed than opened. NHIDA conducted a study which showed that 88% of the kids were dual diagnosed and the schools did not know how to deal with the mental health issues, and could not fill the budget gap for the treatment of the kids. This prompted the group to look at things differently along with the need to present a budget neutral proposal using existing resources. The group looked into the community for existing resources and found that Rushford is doing the work. Following a meeting with Rushford, the group thought that Rushford would be a good pilot program. Once a constructed proposal is developed, the group would like to see if Rushford is interested in participating. Ingrid Gillespie reported that over the last month she has been talking with a number of treatment providers and local prevention councils who have been doing Narcan trainings and has found that there continues to be a challenge in getting Narcan to people before they leave treatment and also out to the community forums. She would like to know if there is something this council is missing in terms of the consistent accessibility of Narcan for the trainings and for the treatment providers. Commissioner Delphin-Rittmon reported that there are ongoing discussions about the availability of large quantities of Narcan. Integration of Prescription Monitoring Program with EMR's – Xaviel Soto reported that DCP has an interface available that will interface their PMP with EMR's. Also, if anyone or any healthcare institution is interested in sharing data, they can give him a call and he can contact the vendor, he did note that there is a charge for doing so.	Legislative proposal to be shared with this council. Informational Informational

NEXT MEETING – Tuesday, February 21, 2017, 10:00 – 12:00, State Capitol, Room 310
ADJOURNMENT - The December 6, 2016 meeting of the Alcohol and Drug Policy Council adjourned at 12:00 p.m.