Implementation Task Force
NH State Strategy on Prescription Drug Abuse

Healthcare Sector Work Group Meeting
Offices of the NH Hospital Association, Airport Rd, Concord
Thursday, January 22, 2015

Minutes

Present: Tom Barnes, Lisa Muré, Melissa Silvey, Stacy Allard, Julie Hazell-Felch, Lindy Keller, Seddon Savage,

Brief Updates:
To reconfirm this meeting is the 4th Thursday of the month.

- **NH Naloxone**
    1. The governor did have a press release which is a new license for law enforcement personnel, state and local, who want to become licensed to use naloxone.
        - Licensing gives protection from liability in what you do in the course of your licensed work.
        - Areas of concern are there is no requirement for CPR, for first aid or any type of health training for law enforcement in state.
        - Licensing the use of naloxone with law enforcement will mean it is done well.
    2. The press release left a lot of families upset as they were hoping there was going to be a lot more meat on the bones.
        - Some families are upset that this didn't have more substance.
        - Roll-out to care givers was not addressed.
        - This put the governor in a tough spot where she will have defend some of the elements of the press release as it really only emphasized one area of the report.
        - Didn't go into detail about the average citizen that more work is being done and the immediacy of it.
        - It didn't include a strategy on moving forward.
        - Senate wants to create a study committee on the growing opioid problem.
            a) Tym Rourke (Chairman of the Governor's Commission on Alcohol and Drug Abuse, Prevention and Recovery) is not taking a stance on this.
            b) Senator Lou D'Allesandro and Lucy Hodder spoke for the study committee.
                - The Governor's office is in favor of it.
                - Leadership seems to be lacking here as this has been discussed with the larger Opioid Task Force.

        - This is an issue which there is no controversy.
        - Nobody opposes the use of Naloxone.
    - This is not about Naloxone. This is about the opioid problem in general.
    - There are hurdles which need to be cleared with the Board of Pharmacy.
    - There could potentially be a vehicle to move forward any legislation that might be needed to have family access to naloxone.
    - A person can go and ask their own doctor for naloxone.
    - We need to make Lucy Hodder aware that the "Addicts Mom" are upset with the release and have comments on their Facebook page with regards to their opinions.
    - We might want to have the larger Opioid Task Force get a list of the names of who is on the study committee and send the minutes from their meetings to them.
    - Fentanyl is becoming an issue.
        a) First responders have had to call the medical board physician for permission to give a double dose of Narcan because the Fentanyl it is so strong.
        b) The guidelines for the EMT's have been changed to accommodate the need to give double doses if necessary.
        c) The Fentanyl is coming in spray (supposed to be spayed on the tongue) form and it is being sprayed onto the substance which is not evenly distributed.
        d) The Fentanyl on the street is not coming from diverted sources but from manufactured sources.
        e) It supposedly is coming in bulk and is possibly being diverted from the manufacturers or is coming directly from the manufacturers.
    - Law enforcement is being pressured to use Naloxone.
    - To make it available at the Pharmacies is a much more difficult process to go through with the Pharmacy Board.

- **NH PDMP**
    1. People who are using it love it.
    2. Advisory council has an evaluation data reporting committee.
    3. Registration is mandated.
    4. Training portion is going to be critical
        - Providers need to be trained on how to use it, when to use it and what to do when you find it.
        - Other networks might be able to do a Training of Trainers.
        - It is self-evident that the need is to get people using it and comfortable using it.
        - It has been suggested that we try to get state-wide rollout.

- It would be great is the Medical Group Managers Association (MGMA) would be the key people to get every office in the state doing it.
- We should invite someone from MGMA to our next meeting.
- The more providers that use it the more helpful it will be.

- **SBIRT**
  1. Still waiting for contracts to come out.
     - Exhibit A's are almost done. Exhibit A is the scope of work within the contract.
     - There is no projected date on when they will be ready.
     - The end date is June 30, 2015 to spend the money.
     - The RFP did say to those that got these grants that the actual amount would be prorated based on the amount of time to spend the grand and there is the potential for additional funding into the next year to complete the work.
  2. Goodwin has added and adolescent SBIRT.
     - Do three screening questions.
       a) Based off of that they do four screening questions and based off of that do SBIRT.
     - Doing a pre-natal SBIRT.
       a) Screen every trimester.
       b) Screen three months prior to becoming pregnant.
       c) This is a bit more complex.
       d) There is no evidence-based quick screen tool for pregnant women.
       e) We've adapted the NIDA quick screen to add the frequency for pregnancy.

- **METHADONE CONFERENCE**
  1. The Agenda has been written up a couple of weeks ago and is intended to be sent out.
  2. It was a good conference.
  3. Methadone dosing is clearly varied.
  4. There is scatter on patient dosing within clinics and between clinics.
  5. Only pregnant women were looked at for dosing variances and at three different intervals.
  6. The Medicaid Office asked for various data from the Methadone Clinics.
  7. They treat different patient populations to different dosing needs but most likely it is mainly because of cultural differences and medical practices.
  8. There are neo-natal nurses that have stated that some women are falling asleep after dosing.
  9. There are challenges with women being over medicated.

10. There clearly is a desire and a need for communication between methadone clinics and providers.
11. A doctor can provide information on their release to a methadone but they can't even be told if a person is a patient. The federal law on this is much stricter than HIPPA.
12. Across the board the clinics are prescribing much different doses than another.
    - The question is it because that clinic has a population that because of other issues requires the higher dose or is it because that clinic prescribes higher.

- **UPCOMING LEGISLATION**
  1. There is something like 80 bills that have to do with substance issues.
  2. Do not know how many are around opiates.
  3. Many will be combined and some will go away.
  4. Tricia Lucas is retiring and this will make for a difficult season.

- **D-CARE SYMPOSIUM**
  1. Usually for anyone who wants to come.
  2. Opioids will be the topic.
  3. Need ideas for how to make this constructive.
     - Who do we need to be talking to?
     - How can yet another conference be helpful.
     - Not about the what but the who.
     - Get it out to the legislators.

- **NEW HAMPSHIRE HEROIN SUMMIT**
  1. April 10, 2015 Statewide Conference. 7:30 am to 9:00 am Legislative Breakfast; 9:30 am to 4:00 pm for the conference.
  2. It is free and open to the public.
  3. The focus is about the family members of addicts.
  4. Those in the recovery community and how they can become a voice.
  5. About 200 people expected.
  6. The conference has an introduction. Breakouts. Lunch and then secondary breakouts in the afternoon and then a closing speaker.
  7. A recovery panel will also be there.
  8. The conference is being directed to the "average joe".
  9. Only regional legislatures will be invited to be guest speakers.

- **MISCELLEANOUS**

  One of the things that Seddon has been thinking about is improving systems to address opioid related harm. Essentially looking at what is being done and yet the numbers are still rising and highlight what the task forces have been doing. Looking at the various segments of people in the state has been doing. This has been happening, what needs to happen in each of those to make it really effective

whether it is naloxone, SBIRT, best prescribing practices, medication assisted treatment and then what is missing and why is this still going on.

Lisa Murė made a list of the top things we have done or are in the midst of doing and things we still need to do.

What we are doing:

1. Naloxone availability to law enforcement.
2. Drop boxes and "Take Back" events.
3. Subscriber education.
4. Health Protection Program substance use disorder benefit.
5. Seed funding for Community Health Centers for SBIRT.
6. Recruitment efforts for buprenorphine prescribers.
7. Regional Public Health Network strategies.
8. Forums.
9. Collaboration.
10. State plan and the pursuit of funding equally.

Continuing gaps and challenges.

1. Lack of public education and awareness.
2. More prescriber and patient education.
3. Scarcity of recovery support services.
4. Need more education for families and adults for health professional employers.
5. Naloxone availability for families.
6. Lack of special services in care navigation for opioid dependence especially for pregnant women.
7. Adequate insurance coverage for SUDs.
8. Scarcity of medication and treatment.
9. Scarcity of treatment for special populations.
10. Residential treatment and adolescent treatment.
11. Real time access to help.
12. Scarcity of resources.
13. Stigma and lack of knowledge.

One big thing we never talk about is availability. Why is there so much heroin in this state? Interdiction (demand reduction) is really needed. People will use what is there. Law enforcement is taking up the mantra that "we need treatment". We are taking up the mantra "get rid of heroin."

One thing that came up over and over again a lot of this is a continual slashing of budgets over and over again. We used to have good federal and state support for drug trafficking work. What do you think happens when budgets have been slashed for the past twenty years? The problem grows because it isn't being controlled anymore. The same thing on the service side. Think about what the services were twenty years ago. There was more residential.

The other thing New England States got their block grant funding amount, so we did a per capita contribution and it is pathetic when you look at New Hampshire compared to Massachusetts, Vermont, and Maine.

Lindy Keller has one more medical item that needs to attended to and that is "withdrawal management." To get these folks much earlier in the process, where they don't need medication assisted treatment but they do need management of their withdrawal. Right now people do not have anywhere to get that or they don't know where they can get that. HPP is going to include ambulatory withdrawal management. There are lots of other options which will be in the SUD benefit that we don't even have.

It is a complicated message though as we have spent years trying to educate people that withdrawal is not treatment. There are many people who think that clinicians aren't necessarily great, all clinicians, doctors, counselors, other people, of distinguishing between opioid misuse or self-medication symptoms, and opioid addiction. They are really different problems. You can withdraw people who are physiologically dependent or self-medicating for anxiety, but if they have an opioid addiction they need to get into medication assisted treatment. It's not a simple message.

Lindy Keller is talking about the person who wants help and says "I just can't go through withdrawal." If they can access that it is certainly within the scope of service that anybody that is providing withdrawal management to move people toward the longer term treatment. The person with the addiction does not need to decide to make a long term commitment when all they want to do is not get really sick. So the service needs to be provided by a lot of treatment providers who add this on so there is a seamless flow. It's not just for opioids but for withdrawal management period. We did away with detoxes because people went to detoxes for five days and then got out and started using again. We want to say this is the first step of treatment. This is a communication strategy that maybe needs to start with all the contractors as the language is important. We are working on providing language support with definitions.

The priorities are MAT and CHC that we have been talking about. Ben Nordstrom and Mark McGovern are interested in working with New Hampshire and leading that effort. Peter Mason was here and he had some input. BDAS met with Peter separately more in-depth more from the prospective of the community primary care not the clinic based. We are looking at both of those.

Next meeting will be the 4th Thursday of the month, February 26, 2015 at 9:00 am.

FYI-Seddon Savage will not be at the February 26, 2015 meeting. Joe Harding will be the chair for the February 26, 2015 meeting.