Governor's Commission on AOD
Healthcare Task Force

Offices of the NH Hospital Association, Airport Rd, Concord, NH
Thursday, May 26, 2016

Present:
Gene Harkless, Chair of Department of Nursing University of New Hampshire – Call-in
Mary Bidgood-Wilson, NH Nurse Practitioner Association
Courtney Gray, NH Provider's Association
Julie Hazell-Felch-Manchester Community Health Center
Tom Barnes, PMC Medical Group
Janet Monahan, NH Medical Society
Adrian Thomas, NH Neurospine Institute
Meghan Baston, Elliott Hospital
Seddon Savage, Pain Medicine and Addiction Medicine

Seddon opened the meeting.

Structural Issue

- We tend to send things by email and bring printouts.
- What is our process as a group?
    - Most attendees are bringing in what was sent in email.
    - We will only bring printed items if we plan on spending a lot of time focusing on it.

Healthcare Strategy

- It has the items we have identified over time to be areas in the general healthcare system we would like to see adopted in order to reduce substance related harm.
- The culture and stigmas around addiction should be added to the strategy.
    - Patients feel hated when they go to the ER.
    - Patients feel judged.
    - We hear more and more about security being called because of altercations between staff and clients.
    - People are feeling shamed and blamed in their interactions with healthcare providers.
    - Healthcare providers do not know how to cope with patients that are distressed and are afraid of them.
- The increased use of Recovery workers should help in the future.
- It will be included in the strategy.
- We want to make sure that we are not omitting anything in the strategy.

Meghan Baston, Director of the Elliot Behavioral Health In-Patient Addiction Care for Medical Patients

- I was reached out to with regards what Elliot Hospital is doing with regards to help patients who have substance misuse disorders as well as the barriers we are running into to access treatment for our patients.
    - We have a 12 bed acute in-patient psychiatric unit that is also a designated receiving facility
    - We have a 29 bed geriatric psychiatry unit which is also a designated receiving facility.
    - The Elliot has a Psychiatric Emergency Room where we have psychiatric nurses and techs that care for emergency room patients.
    - We have four beds for patients with behavioral health issues.
    - We have made it clear that we are not going to provide a different standard of care inside the physical plant versus the outside of the physical plant.
    - We have provided extra resource in the form of a psychiatric nurse to also counsel with the patients that are also outside the physical plant.
    - On any given day 20% of our volume in the emergency room is behavioral health patients.
- In house in the general hospital itself we have 6-12 patients that have six weeks that they will be in the hospital.
    - This is an underserved population of patients because part of it is we have a paternalistic school of thought about it because we tell them they can't leave here. The reason we do not want them to leave is we cannot trust them to follow up.
    - The patients are typically in the general in-house population.
    - The clients who come in are not there because of addiction they are there for the issues that their addiction has caused them.
    - Patients were not being cared for properly in the past and feeling stigmatized.
- We created a team of psychiatric nurses and social workers whose job it is solely to provide consultation to the medical staff regarding these patients on the general medical floor.
    - This is available 24 hours a day, 7 days a week.
    - Elliot supports the cost of this and does not bill for the services.
    - In general medicine it is hard to get providers to understand these patients have the same rights as any other patient.
    - The nurse and social workers become an advocate for the patient.
    - We also wanted to change the thinking that the psychiatric nurse and social workers are the only ones to tend to the patient. They are there to advise, guide and assist as necessary the hospital staff concerning the patients they are.
- We have been able to collaborate with organizations and get people in more quickly for medicated assisted treatment.
    - If a patient is in the hospital for six weeks we start them on their subutex and then they get transitioned out in the community and continue their medicated assisted treatment.
- These patients also have legitimate pain.
    - Our pain folk and psychiatrists have created standardized protocols for pain and treatment of these patients.

    - We start tapering them off pain meds after a period of time and transition them on to other medications.
- We now provide education on harm reduction to the patient when they are discharged from the hospital.
    - We've created pamphlets to hand out on hard reduction, etc.
- The only barrier that we have run into is getting people into in-patient rehab.
    - If we keep them for six weeks they are no long eligible.
    - We haven't really treated the substance abuse.
    - We do not have the resources to do that effectively.
- We are tracking things to try and get data such as:
    - AMA.
    - Discharges.
    - Code Greys – we haven't had a Code Grey in three months. We have also implemented a program where we take patients out and have groups if we have multiple patients who are in appropriate stages in their recovery to be able to make sense.
    - We are tracking referrals to the different levels of care.
    - The barrier for Medicated Assisted Treatment is the Medicaid only pays for the suboxone and the patient has to pay $65.00 a week for the therapy. What Medicaid reimburses them is such a mere pittance that if they started taking Medicaid they would have to increase the self-pay rate.
        - Medicaid does not pay for the treatment and requires preauthorization.
        - This is a barrier that the Governor's office should be aware of.
- The Healthcare Taskforce would like to disseminate this information through the Medical Society and Janet will share with Kevin at the Hospital Association.
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UDT Recommendations Status

- The report didn't get out until the last meeting.
- We need more time on this for a discussion.

Clinical Cannabis discussion

- The dispensaries are open.
- Clients are coming in know thinking cannabis is legal and are now admitting to use hoping for a prescription.
- They do not understand that it is not a script but a diagnosis.
- Dispensaries are promoting the idea that it is a treatment for addiction or at the very least it is a step down from opioids.
    - The science isn't there yet.
- We have drafted a Clinical Cannabis – Initial Health Report and Clinical Cannabis – Quarterly Health Report.
    - The Medical Society has them on their web site. https://www.nhms.org/therapeutic-cannabis
    - We have arranged this as a statement of understanding rather than consent.
        - The first part has general things about marijuana and it status in terms of policy.

        - The second is immediate risks and side effects.
        - The third is long term risks and side effects.
        - The fourth is strokes.
    - If you certify somebody it enables them to get cannabis.
    - The statement of understanding states the benefits and risks of using marijuana and is intended to educate patients. It is also intended to educate providers.

Prescribing Rules

- HB 1423 has not made it to the Governor's desk yet. http://www.gencourt.state.nh.us/lsr_search/billText.aspx?id=850&type=4

APNs & PAs authorized to change existing dosing orders for methadone in an Opiate Treatment Program.

- Discussion is requested by the Bureau of Drug and Alcohol Services.
- There is unanimous support that APRN and Pas be allowed to change existing methadone dosing orders in MMT with the understanding that they already can do this in the less supervised context of pain treatment.
    - PAs cannot be exempted from physician's supervision/ultimate responsibility for anything they do.
    - This assumes a physician is ultimately responsible for their actions even though they may determine and write the methadone order.

The next meeting is June 23, 2016
at the NH Hospital Association, 9:00 am to 10:30 am