TREATMENT TASK FORCE

Governor's Commission on Alcohol and other Drugs

Task Force Chair: Stephanie Savard

January 17, 2020 Meeting Minutes		
Welcome & Introductions	**Participants:** Stephanie Savard, Paul Kiernan, Hannah Lessels, Shanna Large, Jessie Daigneault, Monica Edgar, Jaime Powers, Sue Thistle, Emily Robbins, Dave Maura, Steve Kelley, Jan Smith, Amy Daniels, Jake Berry, Alex Casale **On the Phone:** Joee Lindbeck	
Agenda Item	**Discussion**	**Action Steps**
Task Force Business	• Civil Commitment Update o After the Colorado Presentation, Stephanie felt the need to incorporate the perspectives of people with lived experience. Stephanie asked to postpone the April GC presentation and instead to hold a listening session to hear from people outside of the Task Force.	• If you are interested in helping support/plan the listening session, please email Stephanie Savard.
Voting Results	• Narrowed down to 24 strategies. • Transitional living beds was the top strategy. • Integrating SUD services and mental health services was second. • Increase capacity and infrastructure for ASAM level 3 was third. • Twelve strategies received one vote, and the top twelve had more than one vote. • Real-time treatment availability on the Treatment Locator is being built right now. • There is mobile crisis SUD money that is in process. • Review of top 12 with rubric: o Transitional living beds ▪ This is on the list for Recovery Task Force. ▪ By infrastructure, do we mean brick and mortar? GC funds can be used for this. Unless we want to be very specific about it, we leave it up to BDAS to figure out what the need is. "Infrastructure" was meant to be broad so it can encompass brick and mortar if that is what is necessary. ▪ Housing is a crucial element and gap in the system: new stabilization beds in Nashua and Effingham have had issues because they do not take people in withdrawal or on MAT unless they are stable.	

	▪ This is a gap for pre-treatment *and* post-treatment. ▪ BDAS defines transitional living as a lower level of care where an individual receives three hours of clinical services a week, so it does not matter where along the continuum the individual is. ▪ This is only covered by BDAS right now, as it is not an ASAM level of care, so it is not reimbursable. This level of housing will not be able to bill and become self-sustaining. ▪ Do we have data about how many individuals are in need of this level of housing? No, but it has consistently been an issue at the Doorways Community of Practice. ▪ BDAS is doing a lot of work around Recovery Housing, which might reduce the need for this. ▪ This is different from Recovery Housing because it has required clinical services. ▪ Housing remains the main issue, so any investment in this area would be beneficial. ▪ Waitlists for Treatment are so long that many times, people change required level of care by the time a bed is available, so the housing is their main issue. o Integration of SUD with mental health services in general healthcare settings ▪ Some IDNs are working on this (mostly working on billing), but funding runs out after 2020. Could be wait and see, funding later in the year maybe. Our money might be best used in other areas. o Increase capacity for ASAM level 3.0+ including 4.0+ ▪ Major gap for 4.0+ ▪ This would be an effort to eliminate waitlists. Higher levels of care tend to have long waitlists and providing care as soon as possible works best. ▪ This must take Medicaid clients. Medicaid currently pays for 3.1 and 3.5 because when that was written, 3.7 and 4.0 did not exist in the state, so we would need to change the language to cover these. 4.0	

	would not need to bill as 4.0, they could bill for individual services to get it covered. ▪ This money would mostly go to getting hospitals on board: infrastructure $ ▪ CMC discussion ▪ Has there been a count of 3.0+ beds in NH? Yes, but we do not have a count of the waitlists/individuals in need. We get waitlist data monthly from contracted providers. This waitlist data is pre-evaluation sometimes, so it might not all be people who actually need this level. The Doorway data is post-evaluation. There is also still an impression across the state they everyone should go to residential first. ▪ Infrastructure discussion: this money could go to increase infrastructure and then sustainability could come later on. ▪ Bridgestreet Recovery LLC: will be adding detox beds and residential beds. Example that there *are* providers in the state who could apply for the $. o Increase reimbursement rates across all payors ▪ There is an increase happening beginning 1/1/20. Will happen again 1/1/21. ▪ Could revisit depending on if budget cuts occur. ▪ The GC and legislature already acted upon this part of the plan. o Expand access to MAT ▪ IDN is tackling this piece. MAT integration into PCP offices. ▪ SOR funds have been addressing this. DHHS has invested heavily in this area. ▪ MAT is widely available, but methadone remains a gap. o Room and Board reimbursements for Medicaid eligible individuals ▪ Similar to reimbursement strategy. ▪ Right now, room and board is considered a separate funding stream. ▪ Should look at reimbursement as a whole: rate increases sufficient to	

	cover room and board. o Create mobile crisis teams ▪ This is happening across the state. Contracts in process. o Address compassion fatigue ▪ Training? Service support? More than this. Workforce health promotion, peer support, media campaigns, etc. ▪ Need to also increase the workforce so that the existing individuals are unburdened. ▪ NHADACA is doing work in this area to create systems change. Building a sort of outing club to increase peer support. Grant funded compassion fatigue trainings have been free, depends on where the funding comes from. ▪ How can investment help? BDAS funds training and TA, which can include language about compassion fatigue. o Engage payors to support screening, case management, recovery supports best practices ▪ Invest in lobbying through New Futures? ▪ Existing MCO contracts emphasize these elements. ▪ Table this as an investment recommendation. ▪ IDNs have a billing and coding group. o Assess and address insurance barriers ▪ Not a current issue o Real time treatment availability ▪ Already happening. o Technology for treatment in limited resource areas ▪ Helping providers with fees and training for technology. ▪ Legislative barriers. Bills have been proposed in this session around this issue.	
Discussion on Strategies	• As a reminder, voting will be limited to official Task Force members. • The Governor's Commission has funding available: $3.7 million available for SFY20 and about $5 million available for SFY21.	•

	• Patrick Tufts has requested that all Task Forces submit investment recommendations. • About $1.5 will be used as a reserve, so the actual total is ~$6 million. • All other Task Forces are invited to submit recommendations as well, so we can consider recommendations from other Task Forces in order to prioritize and collaborate. • Treatment Task Force has never requested investments since its inception. For this reason, we have been asked to think about recommending around $3-4 million. • We have 39 strategies from the state plan that were under our purview as Treatment. A poll with those strategies was sent to voting members this week and we narrowed it down to 24. • These are only recommendations for investment strategies; BDAS will be responsible for the process of allocating these funds. We cannot recommend specific organizations or types of contracts, only strategies. The amount of funding recommended should be decided based on how much $ we believe would make an impact. • Treatment funds from the GC have been renewed. The Governor's Commission has continuously funded treatment in the state even though this Task Force has not submitted funding requests in the past. • This process for submitting investment recommendations is new. • Once we submit the recommendations, the Chair of the GC (Patrick Tufts) will review and prioritize them, and then they will be considered by the commission. • Two strategies were added that weren't under Treatment in the State Plan: transitional living (was under Recovery) and residential treatment (can be funded via reimbursement, but growing this capacity can be difficult, so additional funds can be helpful)	
Voting via Menti	• Top 4: TLP, Residential 3.0+, Compassion Fatigue, Reimbursement rates	
Investment Recommendation Template • Priorities • Funding	• Reimbursement rates: could this be more of an endorsement without money behind it, and put the money elsewhere. Would our investment be only a drop in the bucket? This will be an advocacy position. • TLP: $1.75 million • Residential 3.0+: $2.0 million • Compassion Fatigue for Workforce Capacity and Retention: $250k	• Stephanie, Amy and Paul will finish filling out the Recommendation Template.

	- Consider that this is a small #, which might get it lowered on the list of priorities when compared with other Task Force recommendations. - Recommendation Template asks us to indicate short term, intermediate or multi-year investment. Realistically, these will take time to fund and will not go into effect until SFY21, but this refers to which pot of funds we are asking from. - Multi-task force recommendations will have more weight in prioritization. Chairs will be communicating with each other around endorsement. - Discussion around incorporating perspectives of people with lived experience: task force members voted based on their professional knowledge of people with lived experience, Doorway anecdotes, NHADACA compassion fatigue training evaluations, etc. - Due to the short timeline, this is less weighted, but in the future, it will be more important. Could be done through focus groups or other mechanisms. - Task Force voted on the above proposed strategies and amounts. Monica Edgar motioned to vote, Shanna Large seconded. No discussion. Eight yes, zero nays. - Dave Maura, Jaime Powers, Danni Leonard abstained from vote.	

Next Meeting: March 20, 2020
Call-In Information: *Join Zoom Meeting:*
https://jsi.zoom.us/j/819262402
Call-in phone #: +1-646-558-8656