

HEROIN AND OPIOID EMERGENCY TASK FORCE MEETING
MAY 6, 2015, 1-3PM, WINELAND BUILDING

Chair: Lieutenant Governor Boyd K. Rutherford

Members Attending: Judge Julie Solt, Senator Katherine Klausmeier, Delegate Brett Wilson, Dr. Michael Finegan, Elizabeth Embry, Tracey Myers-Preston, Linda Williams, Nancy Dudley

The **Lieutenant Governor** opened the meeting by highlighting the importance of the Task Force meeting outside of the heroin summits. He commented that the recent events in Baltimore have been at least tangentially related to heroin; the pattern of violence seen targeted CVS and drug stores. There was a focus on pharmaceuticals and opiates that went out, increasing supply on the street at lower prices. The LG further asked for the Task Force's approval of the Upper Shore Summit and Central Maryland Summit Minutes.

Lisa Hadley introduced Barry Page and stated that the Behavioral Health Administration (BHA) and the Office of Health Care Quality (OHCQ) work together to regulate programs.

Barry Page gave a presentation on the BHA.

- Types of programs by funding source
 - Publicly funded providers: Medicaid, grant funds
 - Programs receiving no public funds: private
- BHA and/or OHCQ license and regulate all programs; investigate complaints on all programs
- BHA monitors quality for all publicly funded programs

Regulation/oversight of substance-related disorders treatment programs

- OHCQ
 - Licensing agent for DHMH
 - Responsible for initial and renewal certification to programs that meet required state and federal regulations
 - Investigates complaints; initiates and monitors compliance with sanctioning actions with BHA and Local Addictions Authority
 - Primary responsibility for oversight of SUD programs other than Opioid Treatment Programs

Questions/Comments

- **Certification**
 - A task force member asked what entities were being certified to do. BHA replied that they were being certified to provide one particular level of care.
 - To the question of whether geographical placement was part of the certification process and whether BHA determined need, BHA responded that they did not consider treatment, as they had no say on where treatment programs set up; they only set up compliance with state and federal standards.
- **Wraparound services**
 - BHA was asked, based on their experience with these programs, whether they would support requiring Methadone and Suboxone clinics to have wraparound services. BHA replied that regulations do require counseling and other services (assessment services).

- **Mandated reinforcement**
 - BHA was asked whether a patient who does not participate in the program (maybe only receiving the medication, like Suboxone) should be subject to mandated reinforcement; whether there should be consequences for non-participation. BHA replied that treatment is individualized, and that sometimes a person can be discharged; other times given more intensive treatment. Handing out legal sanctions if someone doesn't comply, however, is out of BHA's area.

BHA

- Establishes state regulations
- Participates in complaint investigations and sanctions with OHCQ and Local Addictions Authority
- Primary responsibility for ensuring compliance of Opioid Treatment Programs (OTPs) with federal and state regulations
- Evaluates effectiveness of network of services funded through public dollars
- Plans for system enhancements, expansion, regulatory actions, legislative initiatives

Questions/Comments

- **Effectiveness of network of services funded through public dollars**
 - A task force member asked how BHA evaluated the effectiveness of the network of services funded through public dollars. BHA responded that the effectiveness was measured by outcomes (decrease in substance use, etc.), looking at the individual and the program.
- **Low-performing programs**
 - In response to a question regarding what is done when a program is doing worse than average, BHA replied that programs are compared and given technical assistance, training, and any other measures that would get them up to par. Lower-than-average performing programs are paired with a program that is meeting the standards to help improve the program.

Certification of New Program

- Application to OHCQ
- Site visit by OHCQ (and BHA for OTPs)
- Review of compliance with regulations
- Initial 6-month certification for a specific level of treatment
- Program revisited by OHCQ after 6 months
- General 2-year certification issued if all requirements met
- Recertification every 2 years

Program Monitoring

- Treatment Program Compliance Reviews
 - Compliance with regulations and conditions of grant award
 - Announced or unannounced
- Jurisdiction Program Audits – when we give funding to a local jurisdiction, they do audits themselves and report to us as part of a condition to us.
- ValueOptions
 - Peer Review (grant-funded programs)
 - Data Mining and audits – look for irregularities within billing by doctors.

- Corrective action plans and followup as needed

Quality of Care

- Outcomes measured through data entered into ValueOptions systems on multiple domains, i.e. substance use, employment, living situation, arrests.
- A task force member asked if individual treatment facilities tracked this by person/client, and BHA responded that yes; additionally, treatment facilities provided the data to BHA. Another task force member explained that private providers aren't tracked because it resulted in extreme inconsistency. There was a move to ASO (Administrative Services Organization) to capture all the public dollars to get a good data set rather than having incomplete and sporadic data.
- Performance data supplied to treatment providers and LAAs
- Promotion of best practices
- Technical assistance and trainings to treatment providers

Authority for Monitoring

- Regulations: COMAR Title 10, Sub 47, 42 CFR Part 8
- Conditions of grant award

Next steps

- Proposed Regulations: Accreditation
 - Proposed regulations will require programs to be accredited in order to be licensed by DHMH
 - Accreditation is "gold standard" in healthcare
 - Accreditation standards are comprehensive, research-based, and updated annually
 - Programs must be accredited by Fall 2016 under the proposed regs

Questions/Comments

- **Accreditation**
 - BHA stated that DHMH let programs know of deficiencies so they can meet accreditation; accreditation is a private process that programs go through and pay for. When asked whether BHA certified all programs, including 12-steps, BHA responded no.
 - Another task force member commented that Maryland reimburses much lower than other states, so it's tough to recruit quality behavioral health providers. There is significant cost for accreditation + labor cost to get a program to pass. Just to find a licensed provider in Garrett is hard. One thing influences another. Certifying programs sounds easy but it's a lot more complex than that. There is 50% more reimbursement (from Medicaid) in DC than in MD – so that makes it very difficult to recruit in MD and difficult for people to make programs in MD. Another task force member commented that psychiatric services on the Eastern Shore have difficulties too.
- **Reimbursement**
 - The state verifies the reimbursement amount.
- **Accreditation**
 - Programs are accredited for 3 years. This is usually provisional. If there are problems, they'll come back and check.
- **Abstinence**
 - Abstinence is verified by drug testing.
- **Post-discharge follow-up**

- The length of time patients are followed up with post-discharge varies by program.
- **Length of treatment/funding**
 - To a question asking how length of treatment is maximized, BHA responded that there are no set times for length of treatment; it's case by case. The length is evaluated against national criteria.
 - A task force member commented that the state has invested in recovery services, so that treatment can be elongated via supportive services.
 - Another member stated that people in Cecil County were being discharged in brief periods of time; the average treatment stay in the early 2000s was in the 28-day+ range; now it's at 14 days – it's simply a funding issue for them.
 - A task force member said that attention is focused on what a person needs clinically and on whether they are at the right level of care to get what they need. It's appropriate to move people on as long as they're moved to a level of care that can take care of them next. It's medically intensive, so it would be a misuse of funds if a certain person is kept at a super high level. This is a way to maximize resources.
 - A member commented that there has been a marked decrease of amount of stays in programs. People were discharged when they still needed to be there due to lack of funds.
 - Another member said that 28 days isn't enough.
 - A member said that there aren't enough of the next levels down (jobs, housing, etc.). Some people don't have to go to go the highest level/rehab. They do fine at lower levels, i.e. 12-step programs.

Local Addiction Authority (LAA)

- Expanding role of LAA (formerly Treatment Coordinator)
- Assist BHA in:
 - Expansion of prevention, treatment, recovery issues
 - System management, including access and quality issues
 - Complaint investigation
 - Overdose prevention activities, including Naloxone.

Questions/Comments

- **Effectiveness of programs**
 - A task force member asked whether instead of relying on providers, could data sets be matched up to see what types of programs were effective over a period of time? The response was that there is data on mental health, but substance abuse data is not available.
- **Naloxone**
 - A member asked whether BHA encouraged medically assisted providers to prescribe Naloxone; BHA replied that they were working on this.
- **Resource availability**
 - A member asked whether BHA had enough resources to do inspections and certifications. BHA responded that they had an increase of applications and will need more help as more applications come in.
- **In between programs**
 - A member asked how to find out what has happened to a particular person in the time between being in a program and coming back into that program; it's not necessarily medical to ask public safety and corrections, so is there a way to find out where that

person was before they come back? BHA replied that some of that information could be found via ValueOptions, where there is information on the services a particular person has paid for and where BHA can also see if people have disappeared from one level of care and didn't go to another.

- **Data from private providers**
 - A member commented that since only publicly funded programs are captured, to get a better idea of what's going on in the state, can the governor do anything with DHMH to encourage all providers to give data? Another member replied that if programs have to be certified, information can be gained through the regulatory process: "to be certified, you have to provide this information, or you may lose certification."
 - Another member commented that the problem with private providers is if the state updated the system and the private providers have to pay out of pocket to update, they don't want to. The member suggested that they do monthly report – # of clients, gender, # using heroin – instead, like a summary. The response was that when regulations are proposed, they will be opened up for comment. Private providers can suggest that if they like, and this can be talked about going forward.
- **Scope of BHA**
 - A member said that the department only addresses issues with existing programs. BHA responded that they needed a way to encourage providers to go where they are needed, and that they were hoping that local addiction authorities would help them do that.
- **Secretary Moyer** commented from his 32 years of experience, he doesn't want people coming to jail in the first place. Taking mental health and drug treatment into the streets should be considered. A different model should be looked at; consider taking a case management system to the streets and delivering medication there; it will help crime. This is being looked at nationwide. The Secretary said his department didn't do reentry very well. Sarasota Memorial/FL has the same issues as Baltimore does. Going to the streets is also much more cost-effective. Salvation Army has a medical triage program. To determine benefits, the question should not be: 'were you a veteran?' It has to be more specific: mention army, navy, etc.
- A member brought up **several consistent trends noted throughout the summits**, with several other members contributing:
 - Treatment on demand vs. treatment when ready – a person has to be high enough to be ready
 - Levels of treatment: don't debate which is better; everyone is different
 - Diversion vs. locking up the user
 - Workforce and how to address it; facilities
 - Insurance: you may be better off without it
 - **MIA** stated that they were policing mental health parity laws on a variety of fronts; everything has to be preauthorized, whether somatic or mental. Carriers have different levels of stringency. MIA looks at providers' criteria. Have to go through hoops. This explains a little of the delay. For an emergency admission, it can get done within 24 hours.
 - Education
 - Narcotics don't start being covered till 7th/8th grade
 - 25% are introduced to drugs in school.
 - Early leaders (Loyola) – help younger students to go on the right path (high school and middle school)

- On the education front, think of using YouTube, videos, etc. to bring more awareness.
 - Prescription drugs – pharmacists and doctors can give more information on these. “If you think you need more, contact me; it may be a sign you’re getting dependent.”
 - Stigma
 - A member stated that stigma is perpetuated by language – there should be a tool to use more positive language and take out the shame.
 - Another member responded that the concept wasn’t too appealing, because it was a public health and not a moral problem.
 - The first member replied that, for example, those who recover are called “clean,” so are addicts “dirty”? This language needs to be changed.
- **Money**
 - A member said that there must be a look to see where money can be shifted – from premature babies born from mothers on heroin and the costs incurred from incarceration. Money is going to start driving this issue. Look at the percentage of the population affected by opiates and what that’s done to judgment, ethics – behavior motivated by possibility of being caught. These issues must be dealt with strategically to make practical plans and not just have high ideas.
- **Motivational interviewing**
 - A member stated that motivational interviewing is important.
- **Other states**
 - A member said that other states and their efforts should be looked at – i.e. VT, GA.
- **GOCCP**
 - A member said that Governor Hogan signed the Justice Reinvestment Coordinating Council in the GOCCP. GOCCP will get federal funding to get data – data from local jails, will hand it over.
- **Rewards**
 - An audience member suggested that there should be rewards for young people for their efforts to help against this fight – those that can do so should be 18 and above.
- **Moving forward**
 - A member explained that workgroups are going to be set up moving forward with the Task Force’s efforts. They will be open, so that no one is limited to only one workgroup. Their meeting times and places will be coordinated so everyone will be on the same page. Other people outside the Task Force can be brought in to contribute. By June 1 have structure of workgroup down and have thoughts (outline) of areas of focus.