Alcohol and Drug Policy Council

Co-Chairs' Response to Sub-Committee Recommendations Submitted 8/4/16

Excerpted from the "Process for Sub-Committee Recommendations to the ADPC":

Co-Chairs will formally respond in one of the following ways:

(a)* Approve the recommendation and assign an implementation leader;

(b) Approve the recommendation and take time to explore who will be the implementation leader and what human or fiscal resources are needed for implementation as well as the availability of such resources;

(c) Take the recommendation under consideration; or

(d) Not approve the recommendation;

** (a,b,c,d) will be recorded as a response in the last column in the table below*

The Co-Chairs advise the Sub-Committees to proceed with implementation plans which will incorporate the following:

- **Re-visit all proposed Measures of Success (MOS) to ensure they inform the ADPC of successful (or not) amelioration of the opioid health crisis. Measures may refer to individuals or systems of care;**
- **Issues related to health disparities should be incorporated into all implementation plans/MOS;**
- **Detail implementation as it relates to both youth and adult populations (lifespan) as appropriate;**
- **Balance Prevention, Treatment and Recovery components of recommendations;**
- **Resource neutral implementation.**

Recommendations	**Rank**	**Co-Chair's' Response (*refer to a, b, c, d detailed above)**
A. Identify core competencies for Continuing Medical Education around Safe Opioid Prescribing and Pain Management (for both prescribers and non-prescribing medical staff).	12	(b) The Prevention Sub-committee will research and report back to the Council: -Is there a duplication of this effort in the physician/prescriber community? -Explore the roles of UCHC, CT Medical Association and/or other physician/prescriber groups. -Review what other states have done -Revisit recommendation(s) for CT to the ADPC
B. Develop and implement a communication strategy that raises awareness of and provides education on the dangers of opioids and reduces stigma and other barriers for individuals and family members seeking help.	3	(a) The Prevention Sub- committee will: Collapse several related recommendations to create a larger, coordinated statewide prevention and education communication strategy/response Collapse Recommendations B, C, L, and M
C. Provide education and resources regarding dispensing, safe storage and disposal of prescription medications.	8	(a) The Prevention Sub- committee will: Collapse Recommendations B, C, L, and M
D. Expand professional trainings available on adult and adolescent Screening, Brief Intervention and Referral to Treatment (SBIRT) to increase the frequency and number of individual screenings for opioid misuse, brief interventions, and referrals to treatment.	4	(a) The Treatment Sub-committee will: Collapse Recommendations D (accepted as submitted) and F (requesting more detail on scope and scale as well as resources needed) working within existing resources
E. Support the integration of the Prescription Drug Monitoring Program (PDMP) with Electronic Medical	11	(a) The Prevention Sub-committee will:

Records (EMRs) to improve access to patient data and reduce prescription drug misuse and overdose.		Support the work of DCP as the lead (Rod Marriott as a contact person) on their pilot in this area
F. Enhance early identification of substance use problems by requiring children's Enhanced Care Clinics (ECC), for youth age 12-17 inclusive, at intake to services to: i. Conduct urine toxicology screening for common substances of abuse/misuse including opioids. Screening protocols should be trauma-informed and follow best practice standards of care for the populations served. ii. Implement Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT) protocols according to national standards and/or as established by DCF, DMHAS and/or the UConn Health SBIRT Training Institute.	9	(b) The Treatment Sub-committee will: Collapse Recommendations D and F Utilize and incorporate content experts at DSS, DMHAS and DCF related to SBIRT and ECCs Detail scope and scale of recommendation, revisit need for additional resources
G. Establish Rapid Access Centers in each area of the state to engage and facilitate adult and adolescent entry into opioid addiction treatment and recovery support services. The centers would include a core staff comprised of professionals and peers: *1)professional call center staff* who a. identify a caller's eligibility for services (e.g., insurance, entitlements, special population status, etc.); b. confirm the real-time availability of services; c. make initial "warm" connections to a local provider and a peer support staff member, and d. ask permission to conduct a follow-up call within one week, 5 business days, to callers to ensure a connection to care and/or supports occurred; *2)peer support staff* who a. provide recovery coaching/support to callers (person-to-person) by building recovery capital and helping remove barriers to accessing care (sharing community resources to facilitate recovery, advocating for the individual and family, providing transportation, identifying child care, etc.,) b. helping callers navigate multiple service systems, c. Enrolling recoverees in enhanced Telephone Recovery Support) weekly follow-up phone calls to discuss the individual's recovery process.	3	(c) The Treatment Sub-committee, should they pursue re-consideration, will: -Operationalize a project plan with feasible first steps or component parts incorporating adult and youth systems (differences and similarities) -Detail fiscal impact as this recommendation is not cost-neutral as written -If funded, one DMHAS grant submission speaks to expansion of the 1-800 line (which was implemented with no additional dollars). Explore relevance to this recommendation; incorporate action steps
H. Require the 13 DMHAS operated/funded Local Mental Health Authorities (LMHA) to provide Buprenorphine treatment on-site, including psychosocial and recovery support services. Psychosocial services require a comprehensive assessment to determine an individual's recovery plan, including which medication(s), level of care and recovery supports would be most appropriate. The assessment should include the individual's stage of readiness and receptivity to the recommendations.	1	(a) The Treatment Sub-committee will: Work with DMHAS as a lead on implementation plan
I. Reduce disparities in access to medical treatment by expanding the availability and clinical use of MAT to a broader group of incarcerated offenders and offenders re-entering communities using community-based standards of	5	(a) 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)

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.		
J. Establish a workgroup to identify and address regulatory barriers that limit access to care. Some examples include: LADC scope of practice; lack of integrated MH/SA program license; limits on which practitioner licenses can be used in outpatient hospital clinics; hiring regulations and practices regarding persons in recovery; and Medicaid eligibility interruptions given incarceration/ hospitalization.	7	(b) The Treatment Sub-committee will: -Involve DPH in definition of limitations of existing regulation -Explore activities/workgroups in existence to limit duplication of efforts -Provide examples that are specific to ADPC and governor's charge -Involve DSS in discussion of Medicaid rules related to incarcerated individuals; clarify any mis-information regarding benefits
K. The ADPC adopt the "Recovery Language" document developed by the Recovery and Health Management Committee to ensure that all members of the Council and members of the sub-committee are familiar with some alternatives to traditional terminology and can promote the use of such terminology.	10	(a) The Recovery Sub-committee will: Proceed with a communication/dissemination plan. Refine/define MOS
L. The ADPC develop and adopt Fact Sheets for prescribers and supports the dissemination process of such Fact Sheets.	2	(a) The Prevention Sub- committee will: Collapse several related recommendations to create a larger, coordinated statewide prevention and education communication strategy/response Collapse Recommendations B, C, L, and M
M. The ADPC adopt one or more of the Public Service Announcements that have been developed by DMHAS and other currently available educational materials for distribution and assists with the identification of necessary resources to do so.	6	(a) The Prevention Sub- committee will: Collapse several related recommendations to create a larger, coordinated statewide prevention and education communication strategy/response Collapse Recommendations B, C, L, and M
N. 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.	9	(a) The Recovery Sub-committee will: Work in collaboration with SDE and DCP (Stephanie Knudson/John Frasenelli) on implementation plan
O. The appropriate State agencies re-visit the possibility of utilizing the standing order model in CT	13	(d) 8/4/16 ADPC Presentation by DCP addressed CT's approach to prescription of Naloxone.