

**Vermont Governor's Opioid Coordination Council**  
**June 12, 2017**  
**1:00 – 4:00 p.m.**  
**Center for Achievement in Public Service, VCFA, Montpelier**

**Minutes**

**Present:**

Tri Chairs: A. Gobeille, T. Anderson. Members: D. Allaire, L. Augustyniak, B. Bick, J. Bowen, M. Bucossi, A. Bunting, S. Byers, E. Cowles, T. Donovan, B. Grearson, C. Houde, M. Levine, P. Mallary, R. Marcoux, S. Thompson.

**Designees:** M. Maksym, B. Villella.

**Staff:** J. LaClair, Director; R. Gowdey, Community Engagement Liaison

**Absent:** L. Genge, J. Leddy, D. Ricker, B. Cimaglio, C. Herrick

**Presenters:** Sanchit Maruti, MD (UVMHC); Beth Tanzman (Blueprint for Health); Tony Folland (Dept. Health/ ADAP); Sarah Munro (VT Recovery Network); Ken Sigsbury (Turning Point, Bennington); Stefani Capizzi, (North Central VT Recovery Center, Morrisville)

**Guests:** Diane Derby (Sen. Leahy); Kevin Veller (Rep. Welch), MaryKate Mohlman (Healthcare Reform), Chris Bell (VDH), Jessa Barnard (VT Med. Society), Christine Werneke, (Archetype); Yashira Pepin (Alkermes); Devon Green (VAHHS); Jane Helmstetter (AHS Field); Mairead O'Reilly (VT Legal Aid)

**A. Introductions and Opening Remarks**

- AHS Secretary Al Gobeille called meeting to order 1:05
- Secretary Al Gobeille provided an update for AHS; DEA Inspection for emergency Hub at Northwest Medical Center done this week. Operational by week of June 25. Thank you to Jill Berry Bowen for use of facility.
- Commissioner Tom Anderson, provided an update from the Dept. of Public Safety perspective.
  - Recent Springfield Forum very successful discussion about Opioid crisis, 16 arrests for Heroin trafficking followed the forum.
  - Trends noted by HIDTA; 28 cases of carfentanil (10,000 times more potent than morphine). VT overdoses as of June 3 include 25 fatal and 134 non-fatal.
- Roundtable introductions conducted.

**B. Minutes from May 8 meeting:** First and seconded. Approved without amendment.

**C. Update: Director of Drug Prevention Policy (Jolinda LaClair):**

Tremendous activity since first meeting on May 8:

- Today's panel will focus on VT system of treatment and the recovery network.
- Council committees: The Council Committees, Prevention/ Enforcement and Treatment/ Recovery, have met once.
- Workforce Summit Working Groups: The April 17 Summit, with 160 participants, resulted in two working groups involving 60+ of those participants: Licensure/Higher Education and Affordability/Professional Development. Colin Benjamin, Director of the Office of Professional Regulation, co-leads Licensure with Annamarie Cioffari of Southern New Hampshire University. They are working with input from participants from the Summit to streamline licensure practices

toward improving retention of the workforce. In both committees, other issues include expansion of supervision, use of tele–health for supervision, and loan repayment will be addressed as well as best practices of other States.

- Community Outreach:
  - Meetings/visits will be planned in different regions of the State; members are encouraged to join.
  - Chittenden County Opioid Alliance held a planning session in Burlington three weeks ago. Approx. 100 people are invested in this county-wide initiative. Importance placed on leadership.
  - St. Johnsbury: Jolinda and Rose will visit on June 13: Hub visit, Restorative Justice, and local coalition, “D.A.R.T.” (Drug Abuse Resistance Team), which is the rural, community-based initiative.
  - Hyde Park: Opioid Forum June 27. Information will be sent out.
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- Next OCC meeting: July 10, Burlington area. Agenda will include Director of the Office of National Drug Control Policy (ONDCP) Richard Baum. Location to be determined.
- Timeline next four months: October 1, recommendations completed.

**D. Presentation: Vermont System of Treatment:** Beth Tanzman, Director VT Blueprint; Tony Folland, VT Department of Health Alcohol and Drug Abuse Program.

1. Mr. Folland spoke of the idyllic Vermont that we all know and would like to portray everywhere.
  - Focus on “Hub and Spoke” but also overlaying the responsibility of publicly funded treatment systems throughout the State.
  - What are the services needed to support the Hub and Spoke?
  - Noted a need to be anchored to a medical system.
  - American Society of Addiction Medicine (ASAM) Levels of Care: System is divided into levels of care; Outpatient, Intensive Outpatient, and Residential Treatment Services.
  - Addressed the idea that Vermont is late to the treatment – we were one of the last states to offer methadone for opioid addiction.
  - The key planning timeframe for Hub and Spoke was 2012-2013.
  - The need for partnerships, and the reason for the Council, can be summed up in a Rolling Stone magazine cover portrayal of the iconic “State of Vermont Pure Maple” tin with woodsman resting on a stump, transformed to read, “State of Vermont Pure Heroin” portraying the same woodsman injecting himself.
2. Ms. Tanzman spoke of concepts of Hubs and Spokes reflecting two different treatment settings set up by Federal regulatory structure. These are different in what they can provide and who is offering them.
  - Specialty Addictions treatment programs (Opioid Treatment Programs (OTP) or “Hubs”) where methadone is dispensed, people are seen daily for dosing, and counseling and other services are included. Beginning in early 2000’s federal legislation allowed any MD in a general medical office setting to prescribe buprenorphine for opiate addiction. These are called “Office Based Opioid Treatment (OBOT). Methadone, outside of an OTP, can only be prescribed for pain and not for addictions treatment.
  - The settings (OTPs and OBOTs) are each governed by different regulations so essentially two different settings emerged; one dispensed Methadone (Hub) and one prescribed buprenorphine. Financing was also not coordinated, funding for general medical settings came from Medicaid or funding for specialty opioid treatment settings came from ADAP, two different management teams.

- Many MD's in Vermont began offering medication assisted treatment (MAT) with buprenorphine for addiction in their offices in the early 2000's.
  - The Blueprint for Health works with all primary care practices to encourage them to meet national quality standards. In turn, payers (Medicaid, Medicaid, and Commercial insurers) make additional payments to primary care practices that meet these national standards and they also support the shared utility of a community health team of multidisciplinary people. The Blueprint got involved because Primary Care providers who were "OBOTs" reported that they could provide better MAT if nursing and counseling were embedded in their practices like the community health team.
  - How to bridge the gap between primary care, community health teams and Hubs.
  - Built on the concept of existing Primary Care augmented by Community Health Team which is multidisciplinary and assisted in bridging the gap with Specialty Providers.
  - Having multidisciplinary care in place alleviates the person with the addiction having to organize their own treatment and communicate back to their MD.
  - Health Home created under the Affordable Care Act changed Vermont's Medicaid plan to include Hub and Spoke services and designed an interactive system between specialty opioid addiction treatment programs and primary care offices with augmented staff which puts them all together in a single framework.
3. Mr. Folland continued: services received were based on services available. Purpose of Hub, how to triage more effectively and provide the appropriate services.
- Hubs designed for assessments for people that need a higher level of structure and referrals for care. Medications obtained thru Hubs not available to physicians. Primary function to increase care and reduce silo effect.
  - Assessments aren't just about substance use; medical problems, psychiatric needs, environment needs are also important because no one provider can address all needs.
4. Ms. Tanzman: Spoke state plan amendment and a set of core services that treatment programs and general medical settings were responsible for providing care management, health promotion, transitions of care as well as basic nursing and counseling services for patients in both settings.
- Positions were added throughout the Hubs such as consulting psychiatrists to address the large number of people who have both substance abuse conditions and mental health needs.
  - Positions added in the general medical offices where buprenorphine is prescribed such as full time RN and a full time licensed Masters level mental health addiction counselor for every 100 active patients. This allowed these medical settings to provide not only medication but psycho-social supports as well.
  - Key in Hub and Spoke is what helps promote recovery, not just the medication alone.
  - Hubs also began dispensing buprenorphine. This alleviated the setting driving the medication available.
  - Currently there are 57 full time nurses and counselors working in 77 different Spoke general medical settings.
  - Success - created much more access to treatment, services expanded greatly. Success also gained by stressing that addiction be looked at like any other disease i.e. diabetes, cancer, etc.
  - Question: Request for clarity in numbers of patients being seen in Dr.'s offices vs Hubs. Mr. Folland agreed that approx. 3,300 patients in Hubs statewide and just under 3,000 active Medicaid recipients in 77 Spoke settings.
5. Mr. Folland explained statewide data provided; 3,500 patients in treatment yields more than one million visits per year to offices. This is part of why it is hard for primary care doctors to

offer MAT in their practices – the literally don't have the necessary time in the schedule to cover all these visits.

- Physicians actively treating have increased.
- Vermont leading the U.S. in treatment/care.
- Peter Mallary explains they lead the Treatment and Recovery team. More information to come. Turns discussions to Dr. Maruti UVM

**E. Presentation: Addiction: The Science of the Brain:** Dr. Sanchit Maruti UVM Medical Center

- Dr. Maruti opened by explaining the importance of the information provided by Ms. Tanzman and Mr. Folland and how the timing of care can have a big impact on the person and person's family.
- 21 million Americans have substances abuse disorders which is comparable to those with diabetes and more than those with all cancers combined.
- Only 1 in 10 receives treatment.
- Heroin usage has increased while prescription opioids have remained much the same.
- Dr. Maruti spoke to the increase in overdose deaths.
- Diagnostic criteria: loss of control, physiologic dependence, and what are consequences.
- Emphasizes opioid addiction is a brain condition; common assumptions are that addiction is a matter of choice and morality, but at the center of addiction is the cell or neuron.
- The anatomy of the brain (three parts) and how opioids affect the brain, therefore influence addiction and further decision-making.
- We seek to magnify positive reinforcements and avoid negative reinforcement.
- Exposure to heroin and opioids in teenage years and young adult years result in altering the function of the brain. Certain areas of the brain become disproportionate. Treatment can help restore normal brain function.
- Question: Is damage permanent? Dr. Maruti advised that function can be brought back but there are changes that may not be completely returned to normal.
- This is chronic but not unlike diabetes, high blood pressure, asthma etc.
- This is a brain condition – Genetics account for 50% of how receptors are set, how secretion of chemicals is set, how other transmitters (e.g. dopamine and serotonin) are set.
- Biochemical components contribute also.
- Those with genetic attributes also often experience environmental challenges, poor social influence, adversity, psychiatric conditions or stressors and increased availability.
- "Choice" becomes much less when you look at decision-making with added substances.
- Combining other recovery practices, including counseling and social supports, with abstinence, is more successful than abstinence alone.
- Duration and continuity of this combined treatment gives the best result.
- Data on death rates: no treatment results in very high death rates. Detox is better, continued medication assisted treatment is best and more like regular population.
- UVM Addiction Treatment Program (ATP) includes services from meds to counseling to case management. Development of partnerships very important.

**F. Panel: Treatment and Recovery Services:** Moderators: Bob Bick, Peter Mallary

Peter Mallary introduced the panel: Sarah Munro, Executive Director, VT Recovery Network. Ken Sigsbury, Director, Turning Point Center, Bennington. Stefani Capizzi, Director, North Central VT Recovery Center, Morrisville.

1. Ms. Munro describes the Recovery Center Network:

- Twelve recovery centers throughout VT.
- Centers are funded through global commitment funding. All are underfunded.
- Peer recovery support services are offered, including meetings, and pathway guides support people through Hub, Spokes and hospitals.
- Recovery centers need staff.
- A telephone recovery program is being developed.
- Our State could benefit from the ability for peer recovery support services to bill Medicaid.
- Need recovery coaches and the ability to keep them working.

2. Mr. Sigsbury describes Turning Point, Bennington:

- The rural make-up of VT is difficult for recovery centers.
- Recovery centers are unique in that they are staffed by peers who have been in the same situation.
- Also, unique in that people in need can come in any time door is open.
- Centers facilitate transitional housing, employment, basic needs like food, etc.

3. Ms. Capizzi described North Central VT Recovery Center

- What is working: good relationships with partners. Support for young people.
- Gaps are funding for peer-based recovery and recovery centers. 64% of funding comes from the State, the rest is raised.
- Other challenges are transportation to recovery centers, housing and paid recovery coaches to assist with transition from recovery into “life”.

Bob Bick provided a recap and ideas to keep in mind:

- 6,000 people and 6,000 stories about how they got to where they are.
- Roll-out of physicians into the community.
- Work Force Summit: raised workforce issues.
- Uninsured rate for treatment system: 13%.
- Expansion of Spoke services very positive.
- Rate of overdoses.
- Methadone cannot be given by physicians for addiction.
- VT continues to lead the nation in approach to treatment.

4. Short session of questions and answers followed Mr. Mallary’s recap. Some highlights were:

- a. Discussion on Medicaid and Medicare enrollment.
- b. Budget preparedness to support prevention and recovery efforts.
- c. Additional questions directed to Dr. Maruti to further explain opioid effects on the brain, opiates potency compared to other things like nicotine or alcohol, chronic nature of addiction, as well as how our social environment may contribute.

**G. Committee Reports** Comm. Anderson turned discussions over to Jolinda for Committee updates.

Prevention/Enforcement: Stephanie Thompson, Sheriff Roger Marcoux

1. Ms. Thompson spoke to prevention and the need for consistent, broad messaging, requiring education in schools, best practices, equitable resource sharing, and assistance professional in all schools.
2. Sheriff Marcoux spoke to the enforcement angle looking at mandatory Naloxone/Narcan program with law enforcement.
  - Also, coordination/completion of drug cases started by smaller agencies to State or Federal agencies.

- Scientific roadside drug testing.
- 35 school resource officers; plan to gather these officers together.
- DEA 360 program Youth Summit very successful – students are the best in communicating to other students or other young people. We need to create opportunity, the best way to do that is a Youth Leadership Council. Planning is occurring and more information will be brought back to the Committee.
- Comm. Anderson advises the Sec. of Education will attend next meeting June 27<sup>th</sup>.
- Jolinda supported the idea of putting together a Youth Summit for next year.
- Next OCC meeting scheduled for July 27 will focus on Prevention and Enforcement.

**H. Goals and Recommendations Exercise:** led by Jolinda and Rose

**Notes as transcribed from discussion charts**

The Question: What would you say to the two committees (Treatment and Recovery; and Prevention and Enforcement) as guidance for bring recommendations forward?

Consider the pathways:

- Policy
- Programs
- Infrastructure
- Investment

**General**

- What strategies are low-hanging fruit toward addressing one or more of our overall outcomes, and why this one over that one?
  - How do the data inform the strategies being brought forward?

**Recovery/Resources**

- More staff – Specifically to support those coming out of Corrections, and more generally
- More and better peer supervision
- Family supports
- VABIR/Department of Labor – involve them in recovery work, as has been done in the past to address employment needs and job training for those in recovery
- What is the universe of resources? And how are we deploying them?
- How should we deploy those resources going forward?
- Will recovery get us more bang for the buck – i.e. -- results toward prevention and demand reduction?
- Policy review. Regular review of Spoke services (manage “Dr. Shopping”)
- Recovery centers work with other services/organizations, who are the ones that receive the money (e.g. Corrections, Hubs/Spokes, etc.) Recovery centers get their dollars mostly from ADAP. Is there a more effective and beneficial way to connect dollars to recovery centers?
- Reducing barriers: Transportation, jobs, childcare
  - Applies to both treatment and recovery – need a holistic and comprehensive approach

## **Planning**

- Where do we want to be in 3 years?
- Question: Regarding “Outcome B” (Success in Recovery) – How often is someone’s overdose is a moment of opportunity that makes recovery more likely? Is that a significant entry point? If it is, then it may be a strategic priority to funnel resources toward capturing that moment and ensure treatment and recovery services are immediately available. Use overdose as a “sentinel” event – an opportunity to tie law enforcement with recovery services.
- We are still in a phase of educating the public – and there are good examples of high level of awareness of brain and addiction as disease in the 1950’s-70’s (see “Junkie Priest” 1964 re. 1950’s NYC, describing the need for a place to go after prison, addiction as a medical condition, calling to stop putting people in jail, etc.)
  - So, for example, sharps boxes at every park and ride – it takes coordination. Which doesn’t currently exist.
    - Update: There is now a working group across agencies that is making progress addressing the policy, cost and disposal issues that are a part of sharps disposal
- Prevention plus demand reduction – demand is not going down. If demand continues as prescription rates go down with new law, does it mean more heroin is on the streets?

## **Suggested Goals/Outcomes**

1. Decrease opioid overdoses
2. Treatment on demand (address lack of transportation in both treatment and recovery)
3. No new heroin/opioid users
4. Change prescribing practices (continue to monitor as new law goes into effect)
5. Opioid education for every Vermont student
6. Public education
7. Inventory conflicts between courts, corrections, DCF and law enforcement as individuals move between and among them.
8. Work with root causes – pain; trauma
9. All treatment is payer neutral – Medicaid, Medicare, private. Individuals/groups
10. Diversity, equity, inclusion
11. Recovery is the destination
12. Appreciative inquiry – positive statements of where we’re going
13. Primary care is involved in treatment AND recovery/Physicians part of the solution
14. Work on prevention, and you will change demand (or, “Change the Market”)
15. Zero overdose deaths
16. Sharps disposal statewide
17. Changing prescription practices

## **Public Comment**

- Keep in mind the question/framework: How can physicians be a part of the solutions? Involve them in the discussions/strategy development.
- Goal – Zero overdose deaths

- I. Motion and second to adjourn. Commissioner Anderson adjourned this meeting at 4:07pm.