State Innovations and Interventions in America’s Opioid Crisis

8:00 am- 4:00pm
Monday, October 23, 2017

Portland Marriott Downtown Waterfront
Oregon Ballroom Salon I
1401 SW Naito Parkway
Portland, OR

Being Held in Conjunction with NASHP’s 30th Annual State Health Policy Conference
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- Remarks provided by Cheryl Roberts

Supported in part by the Health Resources and Services Administration of the U.S. Department of Health and Human Services under the National Organizations for State and Local Officials Cooperative Agreement and the Collaborative Improvement and Innovation Network to Reduce Infant Mortality
**State Innovations and Interventions in America’s Opioid Crisis Preconference Agenda**

**Goal of Meeting:** To provide a forum for state policymakers to learn about emerging issues and other states’ experience in opioid use disorder prevention and treatment.

**Learning Objectives:** As a result of attending this meeting, participants will understand how states can:
- Use measurement and data collection, reporting, and sharing strategies to track and address opioid and substance use;
- Meet the unique needs of affected pregnant or postpartum women and infants; and
- Implement transformative and evidence-based prevention strategies and treatment models.

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**Monday, October 23, 2017**

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<td>9:45 am – 11:00 am</td>
<td>The Role of Data in Tackling Opioid Use Disorders</td>
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<td>This session will showcase how states are leveraging data to address and combat issues of opioid and substance use disorders. Participating states will describe innovative data collection, reporting, and sharing strategies, as well as use of measures to inform policy and improvement.</td>
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### 11:15 am – 12:30 pm

**The Opioid Crisis and Maternal and Infant Health**
This session will highlight how states are addressing opioid use during pregnancy and the effects on infant health, including neonatal abstinence syndrome (NAS). Speakers will discuss their states’ efforts related to screening, prevention, treatment, and recovery for pregnant and postpartum women and NAS diagnosis and treatment.

**Moderator:** Cheryl Roberts, Deputy of Programs and Operations, Virginia Department of Medical Assistance Services

- Lisa Ramirez, Project Director, Texas Targeted Opioid Response, Texas Health and Human Services Commission
- Christina Mullins, Director, Office of Maternal, Child and Family Health, West Virginia Department of Health and Human Resources

### 12:30 pm – 12:45 pm

**Lunch is Served**

### 1:00 pm - 2:00 pm

**Luncheon Keynote: Massachusetts’ Experience Addressing the Opioid Crisis**

**Speaker:** Marylou Sudders, Secretary of Health and Human Services, Massachusetts Executive Office of Health and Human Services

**Moderator:** Ana Novais, Executive Director, Rhode Island Department of Health

### 2:00 pm – 2:15 pm

**Break**

### 2:15 pm – 3:30 pm

**Reframing Prevention and Treatment toward Person-Centered Care**
This session will explore how states advance evidence-based substance abuse prevention and treatment models to promote person-centered care, with a focus on alternative pain management and treatment, and recovery-oriented systems of care.

**Moderator:** MaryAnne Lindeblad, Medicaid Director, Washington State Health Care Authority

**Speakers:**
- Julienne Giard, Director of Evidence-Based Practices and Grants, Connecticut Department of Mental Health and Addiction Services
- Nora Stern, MSPT, Program Manager, Providence Health and Services Persistent Pain Project Manager; and Member, Oregon Pain Management Commission, Oregon Health Authority

### 3:30 pm – 4:00 pm

**Key Themes and Takeaways for Continued State Innovation and Intervention**
Participants will identify key themes, takeaways and next steps based on the day’s discussions.

**Emcee:** Cheryl Roberts, Deputy of Programs and Operations, Virginia Department of Medical Assistance Services

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Julienne Giard  
Director of Evidence-Based Practices and Grants  
Connecticut Department of Mental Health and Addiction Services  

Julienne Giard, LCSW is Director of Evidence-Based Practices in the Office of the Commissioner at the Connecticut Department of Mental Health and Addiction Services (DMHAS). Ms. Giard leads or oversees several EBP initiatives (e.g., MAT, Trauma, ACT, CSP, Supported Employment) and consults to other staff across DMHAS who are implementing evidence-based and best practices. She is currently Project Director for a 5-year SAMHSA grant to expand Supported Employment and was previously the Project Director on two other SAMHSA grants on co-occurring disorders and trauma. Ms. Giard has authored several articles and national presentations, and is a clinician in private practice.

Dr. Kimberly Johnson  
Center for Substance Abuse Treatment Director  
Substance Abuse and Mental Health Services Administration  

Kimberly A. Johnson, Ph. D., began her tenure as Director of the Center for Substance Abuse Treatment in February 2016 and leads the center’s activities to improve access to, and promote high quality, effective substance use disorder treatment and recovery services.

Prior to coming to CSAT, Dr. Johnson worked as a scientist at the University of Wisconsin, Madison where her projects included studies on mobile apps for behavior change, quality improvement in care development and acting as the co-director of the national coordinating office of the Addiction Technology Transfer Centers, and as co-deputy director of NIATx. She has also served as the state of Maine single state authority for substance abuse, and as the executive director of a substance abuse treatment agency. In her early career, Dr. Johnson was a child and family therapist and managed treatment and prevention programs.

Dr. Johnson’s dedication and contributions to the behavioral health field earned her numerous awards and she is a highly-regarded thought leader. She has authored a variety of publications on topics important to addiction and recovery.

MaryAnne Lindeblad  
Medicaid Director  
Washington State Health Care Authority  

MaryAnne Lindeblad brings a broad health care and administrative background to the Washington Medicaid program. She has been an active health care professional and leader
spanning most aspects of health care including acute care, long-term care, behavioral health care, eldercare and services for people with disabilities. MaryAnne served for two years as Assistant Secretary for Aging and Disability Services Administration with the Department of Social and Health Services, and Director of the Health Care Services Division with the Health Care Authority. Lindeblad has held a variety of leadership positions, including Assistant Administrator of the Public Employees Benefits Board, and Director of Operations for Unified Physicians of Washington. In 2010, she was selected for the inaugural class of the Medicaid Leadership Institute. MaryAnne currently chairs the executive committee for the National Academy for State Health Policy, serves on the boards of the National Association of Medicaid Directors and Olympia Free Clinic. Lindeblad holds a bachelor of science in nursing from Eastern Washington University, and master’s in public health from the University of Washington.

Dr. Mary McIntyre  
Chief Medical Officer  
Alabama Department of Public Health

Mary G. McIntyre, M.D., M.P.H., SSBB is Chief Medical Officer for the Alabama Department of Public Health (ADPH). Dr. McIntyre received her B.S. in Biology from Winston Salem University in Winston Salem, NC. She earned her medical degree from Meharry Medical College in Nashville and served as resident physician in Internal Medicine at the George Hubbard Hospital in Nashville, TN. She obtained a master’s of public health in Health Care Organization and Policy from the University of Alabama at Birmingham. She studied Lean and Six Sigma at Villanova University from 2010-2011. She is board certified in Public Health and General Preventive Medicine through the American Board of Preventive Medicine. She joined ADPH in January 2011, and served as Assistant State Health Officer for Disease Control and Prevention and State Epidemiologist before taking her current position. Prior to beginning her public health career she served in various roles at the Alabama Medicaid Agency for fourteen years. She provided primary care for eleven years before joining the State. She is a member of the Council of State and Territorial Epidemiologists (CSTE), the American Public Health Association

She is a member of the Council of State and Territorial Epidemiologists (CSTE), the American Public Health Association

Greg Moody  
Director  
Ohio Governor’s Office of Health Transformation

Governor John R. Kasich appointed Greg Moody in January 2011 to lead the Office of Health Transformation. OHT is responsible for advancing Governor Kasich’s Medicaid modernization and cost-containment priorities, engaging private sector partners to improve overall health system performance, and recommending a permanent health and human services structure for Ohio.
Greg began his public service career as a budget associate for the U.S. House Budget Committee in Washington D.C. The Budget Chairman at the time, Rep. John Kasich, asked Greg to study the impact of Medicaid on federal spending – an assignment that set the course for his public policy career. Prior to joining the Kasich Administration, Greg was a senior consultant at Health Management Associates, a national research and consulting firm that specializes in complex health care program and policy issues. He worked with clients to improve Medicaid system performance, and wrote extensively about state health system innovations for the Commonwealth Fund, National Governor’s Association, and other foundations. Greg’s Ohio experience includes serving as Interim Director of the Ohio Department of Job and Family Services (2001).

**Ana Novais**  
Executive Director  
Rhode Island Department of Health

Ana P. Novais, holds a master degree in Clinical Psychology, UCLN, Belgium, and is a graduate from the Northeastern Public Health Leadership Institute, University of Albany, NY and Leadership RI. Ana has worked in Public Health for 30 years including 5 years in Africa (Cape Verde), 5 years in Portugal and for the past 20 years in the USA. Ana has worked for the RI Department of Health since 1998, first as an Education and Outreach Coordinator and as the Chief for the Office of Minority Health assuring the Department addresses the health needs of the racial and ethnic minority communities of RI. Since March 2006 as the Executive Director of Health for the Division of Community, Family Health and Equity, Ana has lead the department efforts to achieve the goal of health equity by focusing in the areas of Health Disparities and Access to Care, Chronic Care and Disease Management, Maternal and Child Health, Environmental Health, Health Promotion and Wellness; and by developing and implementing the “Rhode Island Health Equity Framework” a plan of action for achieving health equity at the state and at local level through the “Health Equity Zones” initiative.

**Lisa Ramirez**  
Project Director  
Texas Targeted Opioid Response  
Texas Health and Human Services Commission

Lisa Ramirez currently serves as the Texas Targeted Opioid Response Interim Project Director while performing duties as the Lead Program Specialist in the Substance Use Disorders Program Services Unit for the Texas Health and Human Services Commission. She leads a team of subject matter experts committed to providing timely access to a full continuum of high-quality integrated substance use and co-occurring psychiatric disorders services for low-income Texas residents. Lisa identifies, plans, develops and implements substance use disorder policy and initiatives. One accomplishment towards this endeavor includes the appropriation of funds during the 84th legislative session for a multi-million-dollar project aimed at improving outcomes associated with prenatal opioid exposure and neonatal abstinence syndrome.

She a graduate of the Women’s Addiction Services Leadership Institute and served as the Women’s Services Network representative for Texas, a component of National Association of
State Alcohol/Drug Abuse Directors. In addition, she served as primary subject matter expert on treatment and intervention services for pregnant and parenting women.

**Cheryl Roberts**  
Deputy of Programs and Operations  
Virginia Department of Medical Assistance Services

Cheryl J. Roberts is Deputy Director of Programs for the Department of Medical Assistance Services in the Commonwealth of Virginia which provides Medicaid and SCHIP services for over 1,000,000 clients in the Commonwealth expending $9 billion a year. In her current position, she is responsible for the program development and executive oversight of non LTSS Medicaid managed care delivery system which covers 700,000 members, dental services, quality management, service, claims and provider operations, and program integrity operations for the agency. Previous responsibilities included oversight long term care, pharmacy services and behavioral health. Prior to working with the Department, Ms. Roberts served as the Chief Operations Officer of a Virginia based Medicaid health plan and was the Assistant Vice President of Operations for a large health insurance company in New York City. Ms. Roberts received her Juris Doctorate from Rutgers’s State University of New Jersey Law School. She serves as an executive committee chair for NASHP and also works on various national health care projects, collaborative and committees.

**Nora Stern, MSPT**  
Providence Health and Services Persistent Pain Project Manager  
Oregon Health Authority Oregon Pain Management Commission Member

Nora Stern is program manager for the Persistent Pain Project at Providence Health and Services and runs the Persistent Pain Program within Providence Rehabilitation Services state-wide. The primary focus of her work involves training health care professional in contemporary concepts regarding the neurophysiology of pain, facilitating the development of new treatment models to support a biopsychosocial approach to treatment, and development of pain education material for patients. The Persistent Pain Project has developed written material, pain education classes, and videos on pain for Providence patients which are used extensively throughout Providence, as well as learning modules for providers. In 2014, the pain project has trained all of the primary care physicians in Oregon in Providence Medical Group. As a physical therapist, she approaches persistent pain treatment by evaluating the aspects of the nervous system that have become too sensitized and addresses the sensitization through pain education, physiological quieting, sensory cortical retraining including kinesthetic awareness and graded motor imagery, and graded exposure and pacing.
Marylou Sudders leads the largest executive agency in Massachusetts, overseeing a $22 billion state budget, twelve agencies and 22,000 public servants. EOHHS services directly touch the lives of slightly more than 1 in 4 residents of the Commonwealth. Sudders’ responsibilities include the state’s MassHealth (Medicaid) program that provides health coverage to 1.9 million low income or disabled residents, chairing the board of the state’s health care marketplace (The Connector), the Autism Commission and, the Center for Health Information and Analysis (CHIA) Oversight Council; and, co-chairs the Governor’s Interagency Council on Homelessness and the state’s first Governor’s Council to Address Aging in Massachusetts. Sudders is leading the Commonwealth’s efforts to address the opioid epidemic, strengthen the Department of Children and Families, and to ensure a sustainable MassHealth program. Professionally trained as a social worker, Sudders has been a public official, private non-profit executive, advocate and college professor. She served as the Massachusetts Commissioner of Mental Health and has also served as a behavioral health expert with the Department of Justice.
State Innovations and Interventions in America’s Opioid Crisis
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Welcome and Opening Remarks

8:30am-8:45am

Emcee
Cheryl Roberts
Deputy of Programs and Operations
Virginia Department of Medical Assistance Services
Opening Keynote

Turning the Tide on the Opioid Crisis: Challenges and Opportunities

8:45am-9:45am

Moderator
Cheryl Roberts
Deputy of Programs and Operations
Virginia Department of Medical Assistance Services

Speaker
Dr. Kimberly Johnson
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services and Administration (SAMHSA)
Dr. Johnson's slides will be presented at the preconference.
The Role of Data in Tackling Opioid Use Disorders

9:45am -11:00am

Moderator
Dr. Mary McIntyre
Chief Medical Officer
Alabama Department of Public Health

Speaker
Ana Novais
Executive Director
Rhode Island Department of Health

Speaker
Greg Moody
Director
Ohio Governor’s Office of Health Transformation
Rhode Island’s Data Initiatives Aimed at Overdose Prevention

Ana Novais, MA
Executive Director
Rhode Island Department of Health

Rhode Island Overdose Epidemic

- From 2011 to 2016, overdose deaths increased by more than 90 percent.
- Fentanyl, a highly potent opioid, poses a great threat and worsens our overdose crisis. The number of overdose deaths related to fentanyl has increased by almost 20-fold since 2011.

Source: Office of the State Medical Examiners
Note: 2017 data is preliminary. Most overdose deaths are confirmed within three months; however, sometimes toxicology test results take longer to confirm.
Governor Raimondo’s Overdose Prevention Action Plan

In August 2015, Governor Raimondo recognized the opioid overdose crisis in Rhode Island and established a comprehensive task force. The Task Force has four evidence-based strategies:
• Prevention
• Rescue
• Treatment
• Recovery

Data Collection is an over-arching strategy used to track progress and success.

Rhode Island Overdose Data Initiatives

Several Rhode Island drug overdose data initiatives have become national models, including:

• Rhode Island’s Drug Overdose Dashboard
• 48-Hour Opioid Overdose Reporting System
• Multi-Disciplinary Drug Overdose Death Review Team
• Prescription Drug Monitoring Program (PDMP) access to Law Enforcement
Rhode Island’s Drug Overdose Dashboard Goals

- Provide comprehensive public-facing data resource
- Facilitate data sharing to promote timely public health action
- Communicate emerging issues (e.g., fentanyl)
- Track the Governor’s Overdose Action Plan — Accountability
- Emphasis on clear visuals, plain language and accessibility, data-focused messaging

Rhode Island’s Drug Overdose Dashboard Home Page

We all have a role to play in ending Rhode Island’s overdose crisis. What’s yours?

[Image of the dashboard home page with options for Family & Friends, First Responders, Providers, and Get Help]
Metrics State Strategic Plan

- **Prevention**: Help doctors protect their patients by using safe prescribing practices.
  - **Fact**: It's time to change how we treat pain — opioids don't need to be the first line of defense.

- **Rescue**: Make sure everyone has access to naloxone.
  - **Fact**: Nearly every opioid overdose death is preventable with naloxone.

- **Treatment**: Make sure everyone who needs it can get medication-assisted treatment (MAT), like methadone or buprenorphine.
  - **Fact**: MAT lowers the risk of both relapse and death.

- **Recovery**: Expand peer recovery services and treatment options that help people start recovery.
  - **Fact**: We're making sure that all patients treated for addiction have a long-term recovery plan.

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Example of Mapping Feature

**Overdose Deaths by City/Town (2014 to 2016)**

- **Bristol**: 54 overdose deaths (12.2 deaths per 100,000 persons)
Example of Treatment Locator

Rhode Island’s Drug Overdose Dashboard Resources

• Content Expertise
  • Stakeholders, Community Partnerships, Data Work Group

• Analysis & Data Visualization
  • RIDOH and Brown

• Data Management & Software
  • Tableau, ArcGIS, Google Maps, Wordpress, MySQL, Bluehost, Stronghold

• Funding: RIDOH CDC grant (RFA-CE15-1501); contract to Brown University
Rhode Island’s 48-Hour Opioid Overdose Reporting System

- Under regulation R23-1-OPIOID, the Rhode Island Department of Health requires every health professional and hospital in Rhode Island to report all opioid overdoses or suspected overdoses within 48 hours.
- Online Data collection began October 2015
- System collects non-identifiable information on patient demographics, naloxone administration, and follow-up services offered
- Reporting completeness, accuracy, and timeliness varies by hospital

Regional Overdose Action Area Response (ROAAR) divides Rhode Island into regions based on pre-determined overdose thresholds.
- Multi-disciplinary team looks at data on weekly basis to alert stakeholders of increased overdose activity within a region.
- When threshold is crossed RIDOH sends “Public Health Advisory” to local stakeholders (i.e. city/town leadership, Fire, EMS, law enforcement, hospitals, treatment providers).
- When a region has three consecutive weeks of increased activity, they are invited to a Community Overdose Engagement (CODE) meeting to develop response plan.
Rhode Island’s Regional Overdose Action Areas

Sample Public Health Advisory

FOR OFFICIAL USE ONLY
Inquiries can be made by replying to this communication.

Public Health Advisory: Regional Overdose Action Area Response
Woonsocket
The Rhode Island Department of Health (RIDOH) is issuing a public health advisory due to increased drug overdose activity in Woonsocket.

From Monday, June 26 to Thursday, June 29, RIDOH received 5 reports of suspected drug overdoses from hospital emergency departments. Increased drug overdose activity in this area is considered more than four non-fatal/fatal overdoses within a seven-day period.

Emergency responders, Emergency Department (ED) providers, and overdose treatment providers should be aware that in 2016, over 50% of Rhode Island’s overdose deaths involved fentanyl. Fentanyl is 100 times more potent than morphine and 50 times more potent than heroin. Most cases of fentanyl-related overdoses have been linked to illicitly-manufactured fentanyl.
Rhode Island’s Multidisciplinary Overdose Death Evaluation Team (MODE)

- Modeled after multidisciplinary review processes for child deaths
- Purpose of MODE
  - Gain timely insight into emerging trends
  - Identify gaps in or opportunities for policy development and prevention programming
  - Inform the distribution of mini-grants to RI communities for prevention efforts
- Membership includes:
  - Medical Examiner
  - PDMP
  - Treatment and behavioral health specialists
  - Department of Corrections
  - Law enforcement
  - Toxicologist
  - EMS
  - Board Medical Licensure
  - ED physician

MODE Meeting Structure

- Details of the decedents files are confidential; participants sign waiver
- Recent epidemiologic data on RI overdose deaths shared to provide context (i.e. trends, demographics, agents)
- In-depth discussion of selected cases by team members
- Recommendations for rapid response ‘mini-grant’ projects for community-based agencies
- Recommendations for policy change
- Findings are shared with the Governor’s Task Force on Overdose Prevention and Intervention
**PDMP Access to Law Enforcement**

**H5469 A / S656 Aaa**

Allows information contained in the PDMP to be disclosed to a certified law enforcement drug diversion investigator of a qualified law enforcement agency certified by the Rhode Island Department of Health.

*As initially introduced:*

- First introduced in 2016 at the request of the RI Attorney General in order to more proactively investigate instances of prescription drug diversion.
- Removed the search warrant requirement, and gave unfettered access to the PDMP to all law enforcement agencies.

---

**Additional protections added to amended version:**

*Set up a process allowing for RIDOH oversight*

- Requires verification that inquiry is part of a diversion investigation (as evidenced by case number).
- LEAs must submit quarterly reports of the data accessed.
- Failure to adhere can result in immediate suspension.

Narrowed agencies qualified to request access

- FDA, DEA, FBI, HHS, RI Attorney General

**Inclusion of Evergreen Clause**

- Annual review by RIDOH, Director can discontinue providing information

**Expiration date 2023**

- General Assembly must reintroduce legislation to continue the program
A data brief is published and disseminated after each meeting.

Community-based organizations can apply to the RIDOH for mini-grants of less than $5,000.

Mini-grant opportunities are available each quarter, projects must be aligned with findings and completed within three months.

Application process is competitive; up to five grants funded each quarter.

Goal is to fund innovative projects, targeting high-risk, hard-to-reach populations to address overdose crisis at the community level.

---

Ana Novais, MA
Executive Director
Rhode Island Department of Health
Ana.Novais@health.ri.gov
Ohio’s State Innovation Model: Using Episodes of Care to Impact the Opioid Crisis (and Other Public Health Priorities)

Greg Moody, Director
Ohio Governor’s Office of Health Transformation

NASHP Preconference:
State Innovations and Interventions in America’s Opioid Crisis
October 23, 2017

Providing Greater Transparency on Opioid Prescribing

The opioid crisis has impacted Ohio as hard as any other state in the nation:
• Most opioid overdose deaths – 3,459 in 2016 including prescription opioids, fentanyl and heroin
• 1 in 9 heroin overdoses nationwide occurs in Ohio
• Opioid overdose deaths increased 25 percent annually on average from 2011 to 2016

Within our broader opioid strategy, one way Ohio is addressing the crisis is through payment innovation – specifically by providing transparency on opioid prescribing to providers within clinically relevant episodes of care. For example:
• Orthopedics (minor injuries like sprains, and major surgeries like spinal fusion)
• Primary care (e.g., low back pain)
• Dentistry

Ohio’s episode-based payment model rewards cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)

- **Negative incentive**: No incentive payment
- **No change**: No incentive payment
- **No Change**: Eligible for positive incentive payment based on cost, but did not pass quality metrics
- **Positive incentive**: Eligible for positive incentive payment based on quality metrics

### Definition of the episode:

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>1. Episode triggers</td>
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<tr>
<td>2. Principal accountable provider (PAP)</td>
</tr>
<tr>
<td>3. Episode duration and spend</td>
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<tr>
<td>4. Potential risk factors</td>
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<tr>
<td>5. Exclusions</td>
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<tr>
<td>6. Quality Metrics</td>
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<tr>
<td>Moody</td>
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</tbody>
</table>
**Definition of the episode: tooth extraction**

<table>
<thead>
<tr>
<th>Category</th>
<th>Episode definition</th>
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</thead>
<tbody>
<tr>
<td>Episode triggers</td>
<td>• A simple or surgical tooth extraction dental code</td>
</tr>
<tr>
<td>Principal accountable provider (PAP)</td>
<td>• Provider or provider group performing the tooth extraction</td>
</tr>
<tr>
<td>Episode duration and spend</td>
<td>• Pre-trigger window 2 (31-60 days prior to extraction): Specific dental evaluation and management (E&amp;M) services, and relevant dental imaging</td>
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<td></td>
<td>• Pre-trigger window 1 (1-30 days prior to extraction): Pre-trigger window 2 inclusions plus medical E&amp;M services, imaging, and medications</td>
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<tr>
<td></td>
<td>• Trigger window: All services and specific medications</td>
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<tr>
<td></td>
<td>• Post-trigger window 1 (1-15 days after extraction): Care after extraction (including complications, relevant imaging, testing, procedures, and medications)</td>
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<td></td>
<td>• Post-trigger window 2 (16-30 days after extraction): Opioids</td>
</tr>
<tr>
<td>Potential risk factors</td>
<td>• Demographic factors (e.g., age, gender)</td>
</tr>
<tr>
<td></td>
<td>• Medical factors (e.g., diabetes, tobacco use disorder, immunocompromised patients)</td>
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<tr>
<td></td>
<td>• Dental factors (e.g., number of teeth extracted, location of teeth extracted, previous root canal)</td>
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<tr>
<td>Exclusions</td>
<td>• Business exclusions (e.g., dual eligibility, third party payer)</td>
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<td></td>
<td>• Clinical exclusions (e.g., HIV)</td>
</tr>
<tr>
<td></td>
<td>• High outlier exclusions (calculated after risk adjustment)</td>
</tr>
<tr>
<td>Quality Metrics</td>
<td>• Potential gain sharing metrics</td>
</tr>
<tr>
<td></td>
<td>— Average difference in morphine equivalent does (MED)/day filled between post-trigger and pre-trigger windows</td>
</tr>
<tr>
<td></td>
<td>— Post-trigger ED visits</td>
</tr>
<tr>
<td></td>
<td>• Potential informational quality metrics</td>
</tr>
<tr>
<td></td>
<td>— Pre- and post-trigger average MED/day filled</td>
</tr>
<tr>
<td></td>
<td>— New opioid prescriptions</td>
</tr>
<tr>
<td></td>
<td>— Timely tooth extraction</td>
</tr>
<tr>
<td></td>
<td>— Preventive services</td>
</tr>
<tr>
<td></td>
<td>— General anesthesia rate (patients under 5 years)</td>
</tr>
<tr>
<td></td>
<td>— Pre-trigger ED visits for known patients</td>
</tr>
</tbody>
</table>

**Tooth Extraction Episode**

Average non-risk adjusted episode spend in dollars

- **Average episode spend by Principal Accountable Provider**: $725 per episode on average at the 90th percentile
- **$159 per episode on average at the 10th percentile**

Count of episodes per Principal Accountable Provider

- **152,925 valid episodes** (after exclusions)

**KEY TAKAWAYS**

- Wide variation in spend distribution among Principal Accountable Providers
- No correlation between average episode spend and count of episodes per PAP

**SOURCE:** Analysis of Ohio claims data for episodes ending between October 1, 2014 and September 30, 2015.
Dentists can play a critical role in addressing the opioid crisis

- Dentists make up 4 percent of unique opioid prescribers in Ohio, but write 8 percent of total opioid prescriptions statewide.
- The majority of dental opioid prescriptions are written for tooth extraction procedures, which informed its selection as the initial dental episode.

Tooth extraction is one of the largest episodes by volume and opioids are prescribed in a majority of these episodes

- 150K Tooth extraction episodes
- 144K Unique Medicaid members
- 1,661 Principal Accountable Providers
- $60M Total episode spend
- 59% Episodes with opioid Rx
- 73% Opioid “naïve” episodes

More than a third of patients who may be at risk for opioid use disorder received an opioid prescription for tooth extraction

Potential risk factors

Share of patients prescribed opioids with risk factor(s)

- Presence of 2+ behavioral health diagnoses, excluding Substance Use Disorders: 21%
- Presence of non-opioid Substance Use Disorder diagnosis: 16%
- Visiting 4 or more opioid prescribers within episode window: 13%
- Medication-Assisted Treatment of Substance Use Disorders (buprenorphine, naltrexone or methadone): 3%

Share of total patients prescribed opioids with 1 or more risk factors for developing opioid use disorder: 36%

SOURCE: Analysis of Ohio claims data for episodes ending between 10/1/2014 and 9/30/2015.

Path Forward: We created opioid quality measures that provide transparency to enable provider behavior change

Quality metrics

Principal Accountable Provider variation

- Average MED\(^1\)/day filled in pre-trigger window\(^2\)
- Average MED/day filled in post-trigger window\(^3\)
- Average difference in MED/day filled\(^4\) (pre- and post-trigger)
- New opioid prescriptions\(^5\)

We will track all opioid prescriptions within 60 days\(^6\) of the tooth extraction procedure and provide insight to providers regarding where they stand relative to their peers, and potentially tie select metrics to payment.

The same metrics will be provided in 8 episodes across Orthopedics, Primary Care, and Dentistry.

SOURCE: Analysis of OH claims data for episodes ending between 10/1/2016 and 9/30/2015.

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\(^1\) Morphine equivalent dose

\(^2\) Average MED/day in 30 days prior to the trigger

\(^3\) Average MED/day in trigger and 30 days after

\(^4\) Average difference in MED/day is calculated as (Average MED in post-trigger window – Average MED in pre-trigger window)

\(^5\) New opioid prescription metric looks for presence of opioid prescriptions for patients without an opioid script in the 90 days before the triggering procedure

\(^6\) 30 days prior to and 30 days after tooth extraction
Make Health Care Price and Quality Transparent

Ohio’s reporting and performance years by episode wave

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<tbody>
<tr>
<td>Wave 1</td>
<td>Acute PCI, Asthma exacerbation, COPD exacerbation, Non-acute PCI, Perinatal, Total joint replacement</td>
<td>Reporting only</td>
<td>Performance Year 1</td>
<td>Performance Year 2</td>
<td>Performance Year 3</td>
<td>Performance Year 4</td>
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</tr>
<tr>
<td>Wave 2</td>
<td>Appendectomy, Cholecystectomy, Colonoscopy, EGD, GI bleed, URI, UTI</td>
<td>Reporting only</td>
<td>Performance Year 1</td>
<td>Performance Year 2</td>
<td>Performance Year 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wave 3</td>
<td>Ankle sprain/strain, ADHD, Breast biopsy, Breast cancer surgery, Breast medical oncology, CABG, Cardiac valve, CHF exacerbation, Dental: tooth extraction, Diabetic ketoacidosis (DKA) / hyperosmolar hyperglycemic state, Headache, Hip/pelvic fracture procedure, HIV, Hepatitis, Knee arthroscopy, Knee sprain/strain, Low back pain, Neonatal (high-risk), Neonatal (low-risk), Neonatal (moderate-risk), ODD, Otitis media, Pancreatitis, Pediatric acute lower respiratory infection, Tonsillectomy, Shoulder sprain/strain, Skin and soft tissue infection, Spinal decompression (without fusion), Spinal fusion, Wrist sprain/strain</td>
<td>Reporting only</td>
<td>Performance Year 1</td>
<td></td>
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</tr>
</tbody>
</table>

Highlighted episodes have opioid clinical and quality measures built into the episode design and definitions.
Ohio’s State Innovation Model (SIM) Partners

Anthem

Medical Mutual

Aetna

UnitedHealthcare

CareSource

Molina Healthcare

 Paramount Advantage

Buckeye Health Plan
The Opioid Crisis and Maternal and Infant Health

11:15am-12:30pm

Moderator
Cheryl Roberts
Deputy of Programs and Operations
Virginia Department of Medical Assistance Services

Speaker
Lisa Ramirez
Project Director
Texas Targeted Opioid Response
Texas Health and Human Services Commission

Speaker
Christina Mullins
Office of Maternal, Child and Family Health
West Virginia Department of Health and Human Resources

Supported in part by the Health Resources and Services Administration of the U.S. Department of Health and Human Services under the Collaborative Improvement and Innovation Network to Reduce Infant Mortality
Lisa Ramirez’s slides will be presented at the preconference.
Opiate Abuse and the Growing Impact on Maternal and Child Health in West Virginia

Christina Mullins, Director
Office of Maternal, Child and Family Health
Bureau for Public Health
October 23, 2017

Overview

• Describe the epidemic in West Virginia.
• Discuss the collaborative relationships used to develop the Drug Free Moms and Babies Project.
• Provide an overview of key strategies and results.
• Discuss lessons learned.
Drug Overdose Rates by State

US Resident Overdose Deaths by State, 2015

West Virginia # 1
41.5 deaths per 100,000
US Rate – 16.3

West Virginia vs. United States

2001-2015 Resident Drug Overdose Mortality Rate
West Virginia and United States

Data Source: WV Health Statistics Center, Vital Surveillance System and CDC Wonder
Rates are adjusted by age to the 2000 US Standard Million.

Mullins
Maternal and Child Health Impact

- Neonatal ICUs at Capacity
- Increasing Numbers of Children in Foster Care
- Increased Enrollment in Early Intervention
- Increased Substance Abuse Identified in Infant Deaths
- Lack of Available Treatment Centers

Infant Mortality Innovation and Improvement Network (CoIIN)
- SIDS/SUID/Safe Sleep
  - Improve safe sleep practices.
- Smoking Cessation
  - Reduce smoking before, during and/or after pregnancy.
- Prevention of preterm and early term births
  - Increase appropriate utilization of 17-P OH progesterone and/or reduce early elective deliveries.
In September 2014, West Virginia neonatologists and pediatricians met with coders and members of the Perinatal Partnership to develop a standardized definition for neonatal withdrawal and guidance on documenting exposure and withdrawal in newborns.

- Neonatal Abstinence Syndrome (NAS) includes neonatal withdrawal from many substances, not just opiates;
- It is exposure with clinical symptoms; and
- It is *not* limited to those cases that require pharmacological treatment.
Intrauterine Substance Exposure

October 2016 - August 2017

- No Exposure: 86%
- Exposure: 14%
- Exposure without NAS: 9%
- NAS: 5%

Initial Challenges

- Data
- Infrastructure
- Expertise
- Treatment Options
Critical Partnerships

- Perinatal Partnership
- Medicaid
- Social Services
- Behavioral Health
- Public Health

Perinatal Partnership

- Founded in 2006 to bring together individuals and organizations involved in all aspects of perinatal care.
- The Partnership formed the Substance Use in Pregnancy Committee to:
  - Make policy recommendations;
  - Identify best practices; and
  - Develop a collaborative and coordinated approach to best meet the needs of this high risk population.
Funders

• Claude Worthington Benedum Foundation
• West Virginia Department of Health and Human Resources
  o Bureau for Behavioral Health and Health Facilities
  o Bureau for Public Health, Maternal Child and Family Health

Drug Free Moms and Babies

Prevention

Early Intervention

Integrated and Comprehensive Care

Addiction Treatment

Recovery Support Services
Key Aspects

• Uniform Screening
• Integrated and Comprehensive Care
• Long-Term Follow-Up
• Program Evaluation
• Provider Outreach
**Results**

- Improved Identification
- Increased Collaboration
- Availability of Case Management
- 429 Participants
- Increase in Self-Referrals

72-95% Negative for Illicit Substance at Delivery

---

**Lessons Learned**

- Requires investments in time, flexibility, and patience.
- Trust takes time and affects early enrollment.
- Transportation and childcare are significant barriers.
- Co-morbidities are common and complicate treatment.
- Coordinating care with physicians in private practice is difficult.
- Following women past the postpartum period is challenging.
- Recovery coaching services are often hard to locate and may be difficult to manage.
- Sustainability plans should be incorporated early.
Contact Information

Christina Mullins, Director
West Virginia Department of Health and Human Resources
Bureau for Public Health
Office of Maternal, Child and Family Health
350 Capitol Street, Room 427
Charleston, WV 25301
Email: Christina.R.Mullins@wv.gov
Phone: 304-356-4392
Luncheon Keynote

Massachusetts’ Experience Addressing the Opioid Crisis

1:00pm-2:00pm

Moderator
Ana Novais
Executive Director
Rhode Island Department of Health

Speaker
Marylou Sudders
Secretary of Health & Human Services
Massachusetts Executive Office of Health and Human Services
If slides are available, Secretary Sudders’s presentation will be available for download after the preconference.
Reframing Prevention and Treatment toward Person-Centered Care

2:15pm -3:30pm

Moderator
MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority

Speaker
Julienne Giard
Director of Evidence-Based Practices
Connecticut Department of Mental Health and Addiction Services

Speaker
Nora Stern
Persistent Pain Project Program Manager
Oregon Health Authority Oregon Pain Management Commission

Supported in part by the Health Resources and Services Administration of the U.S. Department of Health and Human Services under the National Organizations for State and Local Officials Cooperative Agreement
The Department of Mental Health and Addiction Services (DMHAS)

Our Scope

Prevention services available to all CT citizens, treatment services to adults (18+) with psychiatric and/or substance use disorders who lack the financial means to obtain such services on their own. Collaborative programs for special populations (e.g. persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, substance using pregnant women, and persons with TBI or hearing impairment).
The Department of Mental Health and Addiction Services (DMHAS)

Our System Design

Recovery-Oriented System of Care (ROSC) that the State has been developing since a Commissioner’s Policy first established this framework in 2002. A ROSC as one that identifies and builds on each individual’s assets, strengths, and areas of health and competence to support each person in achieving a sense of mastery over mental illness and/or substance use while regaining his or her life and a meaningful, constructive sense of membership in the broader community (DMHAS Commissioner’s Policy #83 and #33).

Connecticut Department of Mental Health and Addiction Services
Drivers of Policy and Practice

- **Data** - Every Funded (and SA unfunded) Agency Provides Data
  *Focus on Opioids*: Driven by Nationals and Statewide trends e.g. treatment utilization, overdose deaths, demographic composition, access to treatment and infectious disease rates

- **Purposeful Connection to Stakeholder Groups** - Stay Relevant
  *Statewide, Regionally, Locally*: Alcohol and Drug Policy Council (ADPC) Commissioner Forums, Site Visits, Persons with Lived Experience, Advocacy Groups, Faith-Based Organizations, Sister State Agencies (DOC, CSSD, DCF, DCP, DPH)

- **Research, Evidenced-Based and Promising Practices** - Use Science
  *Academic Affiliations*: Yale University, UCONN
  *Collective Professional Resources*: Multi-disciplinary staff and associates with personal, clinical, academic and public health perspectives

---

Principles of Recovery in Connecticut

**There are Multiple Pathways to Recovery- Choice**

Traditional Levels of Care-Detox (detox ≠ tx), residential, PHP, IOP, outpatient

Medication Assisted Treatment (MAT)

MI, CBT, Trauma Services

12-Step, Recovery Supports

Alternative Therapies
Principles of Recovery in Connecticut

From an Acute Care Model (Episodic, Illness-Based) to a Chronic Care Model (Longitudinal, Recovery Management)

“Enhance early pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery” (White, 2008).

• Focused attention at several levels (prevention-treatment-recovery continuum)
• Public education and prevention
• Continuity of contact over a sustained period of time
• Individual/family education and empowerment to promote self-management
• Access to the latest advances in medication-assisted treatment
• Access to peer-based recovery support groups and advocacy organizations
• Sustained monitoring (checkups), recovery coaching, and when needed, early re-intervention (White and Kelley, 2010).

GOAL: NO Silos
Recovery Is Not Linear

What Matters Most?

Research has consistently demonstrated that a trusting relationship with a practitioner is one of the most important predictors of a positive outcome resulting from care for a mental health and/or substance use condition; more so than and particular approach or evidenced–based technique (Tondora, et al 2008).

Hope, Compassion and Humanity are Antidotes
In Connecticut

- **DMHAS Treatment**
  - Admission for heroin has been steadily increasing since 2011 after a five-year decline
  - Heroin has replaced alcohol as the primary drug reported at admission to SA programs
  - In FY16, heroin and other opiates accounted for more than half (42%) of all substance abuse treatment admissions

(connecticut department of mental health and addiction services)

Alcohol and Drug Policy Council (ADPC)

- Tasked by Governor Malloy to coordinate state substance abuse prevention and treatment efforts and developed recommendations on how to address the state’s opioid crisis
- Subcommittees working to implement recommendations
  - Prevention, screening and early intervention
  - Treatment and recovery supports
  - Recovery and health management

(connecticut department of mental health and addiction services)
Connecticut Opioid Response (CORe) Initiative

- Governor Malloy engaged the Connecticut Opioid Response (CORe) team to supplement and support the work of the ADPC by creating a focused set of tactics and methods for immediate deployment
- **Tactics include:**
  - Increase MAT use among incarcerated
  - Increase access to buprenorphine
  - Increase accessibility to naloxone
  - Educational efforts with media, agencies, health care and public health personnel
  - Diverting individuals from the legal system to the health care and treatment system

DMHAS Prevention Activities

- Statewide 800 number for people seeking treatment (1-800-563-4086)
- Public messaging (social media, PSAs, website)
- Help promote drop boxes and drug take back days
- Participation in a number of community task forces, workgroups and advisory boards across the state to coordinate efforts
- Federal funding for communities to prevent prescription drug abuse in teens and young adults
Treatment Innovations

• SAMHSA STR, MAT-PDOA grants
• Access
  – Statewide Access Line with transportation
  – Detox, residential treatment, recovery house bed tracking website
• Treatment
  – Recovery coaches in ERs, methadone clinics, OP MAT programs
  – Buprenorphine induction in ERs
  – Criminal Justice initiatives

Lessons Learned

• Use of federal funds
• Creating a MAT treatment provider map
• Medical Examiner’s office
• Education on need for MAT vs “beds”
• Stigma, language
• The story of Kay
Oregon Innovations in Pain Management

Nora Stern, PT
October 23, 2017
Portland, OR

Oregon Pain Management Commission:


- 17 voting members, 2 legislative members

- MDs
- Physician Assistant
- Nurses
- Nurse Practitioner
- Naturopathic Physician
- Chiropractic Physician
- Acupuncturist
- Pharmacist
- Psychologist
- Dentist

- Addiction Counseling
- Physical Therapist
- Occupational Therapist
- Health Care Consumers
- Patient Advocates
- Public Representative
- Legislative Members
  - Senate
  - House
Oregon Pain Management Commission:

The Oregon Pain Management (OPMC) Role:

- Develop a pain management educational program for required completion by health care professionals.
- Recommend curriculum to health care educational institutions.
- Represent patient concerns to the Governor and Legislature.
- Improve pain management in Oregon through research, policy analysis and model projects.

OPMC Partnerships to improve pain care:

- Health Evidence Review Commission
- Integrative Medicine Advisory Group
- Prescription Drug Monitoring Program
- Oregon Opioid Guidelines Work Group
- Oregon Coalition for the Responsible use of Medicine - Regional Summits
- Portland Tri-County Prescription Opioid Safety Coalition
- Oregon Pain Guidance Annual Pain Conference
- Oregon Collaborative for Integrative Medicine
- Oregon’s Healthcare Professional Licensing Boards
- Oregon’s Healthcare Professional Associations
Oregon Opioid Initiative Partnerships

Substance Abuse & Mental Health Services Administration
Centers for Disease Control & Prevention
Department of Justice

Coordinated Care Organizations
Opioid Use Disorder Treatment Programs
Health systems
Emergency Departments
Pain management clinics
Pharmacies

State policy makers and statutes
Oregon Health Leadership Council
Local public health departments
Health Systems

Public safety/ Law Enforcement
Needle exchange programs
OR Coalition for the Responsible Use of Meds
OHSU & NW Addictions Technology Transfer Center

The Oregon Opioid Initiative:

Aim:
Reduce deaths, non-fatal overdoses, and harms to Oregonians from prescription opioids, while expanding use of non-opioid pain care
Oregon Opioid Initiative: Strategies

Pain treatment
- Non-opioid therapies for chronic pain
- Best practices for acute, cancer, end of life pain.

Reduce harms
- Ensure availability of treatment for opioid use disorder
- Increase access to naloxone and MAT

Reduce pills
- Decrease the amount of opioids prescribed

Data
- Use data to target and evaluate interventions

Required Pain Management Education:
- Physicians
- Physician Assistants
- Nursing
- Acupuncture
- Psychologists
- Physical Therapist
- Occupational Therapist
- Chiropractic Physicians
- Naturopathic Physicians
- Pharmacists
- Dentists
Prioritizing Care: Key Domains

- Knowledge of pain
- Sleep
- Nutrition
- Mood
- Activity

Policy Changes: The New Back Care Paradigm

**Increased Coverage:**
- Cognitive Behavior Therapy
- Spinal Manipulation
- Acupuncture
- PT/OT
- Non-opioid medications
- Yoga *
- Interdisciplinary Rehab *
- Supervised exercise *
- Massage Therapy *

* If available

**Decreased Coverage:**
- Surgeries
- Opioids
- Epidural Steroid Injections
Policy Changes: The New Back Care Paradigm

• Focus on biopsychosocial model
• Added evidence-based effective treatments
• Restricting or eliminated ineffective or harmful treatments

Anticipated Outcomes

• Reduced opioid use for back conditions
• Improved outcomes for patients
• Better educated medical workforce
• Reduced costs; paying only for effective care
Lessons Learned and Next Steps:

Opioid management is **not** pain management.

Making progress:
- Educating providers – improve pain treatment
- Educating public – improve understanding of pain
- Integration of behavioral health & primary care

Next steps:
- Beyond back pain… review coverage of pain associated with other conditions.
- Improve integration of best-practice pain care into primary care
- OPG Annual Conference: Thoughtful Approach to Pain

For more information:

Oregon Pain Management Commission (OPMC)
[PMC.Info@state.or.us](mailto:PMC.Info@state.or.us)

Denise Taray – OPMC Coordinator
[Denise.taray@state.or.us](mailto:Denise.taray@state.or.us)

Health Evidence Review Commission
[HERC.Info@state.or.us](mailto:HERC.Info@state.or.us)
Key Themes and Takeaways for Continued State Innovation and Intervention

3:30pm-4:00pm

Emcee
Cheryl Roberts
Deputy of Programs and Operations
Virginia Department of Medical Assistance Services