Substance Abuse Task Force
Medication Assisted Treatment Work Group
April 7, 2016
3:00 p.m.
GOYFF Conference Room B
1700 West Washington Street, PHOENIX, ARIZONA 85007

A general meeting of the Medication Assisted Treatment Work Group of the Substance Abuse Task Force was convened on April 7, 2016 at the Governor's Office of Youth, Faith and Family, Suite 230, 1700 West Washington Street, Phoenix, Arizona 85007, notice having been duly given.

Members Present (8)	
Debbie Moak, Governor's Office of Youth, Faith and Family	
Sara Salek, Arizona Health Care Cost Containment System	
Len Ditmanson, COPE Community Services	
Peggy Chase, Terros	
Doray Elkins, Community Member	
Reuben Howard, Pascua Yaqui Tribe	
Gagan Singh, Banner Health	
Michael White, Community Medical Services	
Staff/Guests Present (3)	**Members Absent (0)**
Samuel Burba, Governor's Office of Youth, Faith and Family	
Sharon Flanagan-Hyde, Flanagan-Hyde Associates	
Christina Corieri, Governor's Administration	

Call to Order

- **Debbie Moak, Co-Chair,** called the Medication Assisted Treatment (MAT) Work Group of the Substance Abuse Task Force to order at 3:06 pm with six (6) members and two (2) staff and guests present.

Welcome/Introductions

- **Debbie Moak, Co-Chair,** welcomed everyone and reminded the Work Group that it will be functioning under Arizona Open Meeting Law. As such, there will be a call to the public at the end of each meeting. Public members that wish to address the Work Group may complete a "request to speak" form and place it in the basket at the sign-in table. During the call to the public, the public member will be given two (2) minutes to address the Work Group.
- **Sharon Flanagan-Hyde, Facilitator,** thanked Debbie for her comments and asked the Work Group members to introduce themselves.
- **Sharon Flanagan-Hyde** informed the Work Group of the following items:

- Task Force members who are unable to attend in person may teleconference in;
- Task Force members are not allowed to send or assign a designee to attend in their place;
- And Task Force members may suggest experts for issue-specific presentations to the Work Group. Suggestions are to be given to Sharon and she will then consult with the Co-chairs, Debbie and Sara, who will determine invitations.

- **Sharon Flanagan-Hyde** requested that a member of the Work Group give a report-out to the Substance Abuse Task Force on April 13th. Sharon assured the members that she would be available to coach them and would provide the meeting minutes in advance of the meeting. **Peggy Chase** volunteered to give the report out at the next Substance Abuse Task Force meeting on April 13th.

Evidence-Based Practices, Sharon Flanagan-Hyde, Group Facilitator

- **Sharon Flanagan-Hyde** introduced the agenda item and informed the Work Group that the purpose of the agenda item was to ensure that all four Work Groups use a common definition of Evidence-Based Practices (EBPs).
- **Sharon Flanagan-Hyde** introduced a document that included the Report of the Autism Spectrum Disorder Advisory Committee, a statement from the Substance Abuse and Mental Health Services Administration (SAMHSA), and web links and definitions provided by Task Force member Claire Scheuren. The document gives examples of how the Work Group may choose to define terms such as Evidence-Based Practice and Evidence-Based Programs while acknowledging "emerging" and "promising" practices.
    - **Len Ditmanson** stated that the reality is that there is not much published literature in this field yet. As the program moves forward it will be important to better understand how we can best collect data and inform future practice.
    - **Peggy Chase** stated if we are working on a definition, Evidence Based Practice (EBP) is the definition of the practice. We are more concerned that we are including EBP, emerging trends and promising practices in how practitioners employ Medication Assisted Treatment (MAT).
    - **Reuben Howard** stated that it is his understanding that this Task Force is to address AZ diversity. When we discuss Evidence-Based Programs we are talking about data. Data collection and sharing on tribal lands has traditionally been difficult. Collecting and sharing tribal-collected data is not an easy task.
    - **Peggy Chase** stated that many times while we discuss EBP, none of us are funded to employ models to 100% fidelity. For example, in some cases the fidelity requires video, and this is not funded.
    - **Sara Salek** stated that when we are looking for outcomes we must consider fidelity.
    - **Len Ditmanson** stated that an emerging trend in MAT is integrating behavioral health into the medical health field. One of the things that we still need to work on is ensuring that addiction is seen as a chronic medical disease.
- **Sharon Flanagan-Hyde** asked each Work Group member to inform the group of one or two things that they believe need to be represented in the final report from the Task Force in regards to MAT.
    - **Michael White** – Education on MAT and cultural change in the community
    - **Len Ditmanson** – Access to care
    - **Peggy Chase** – Educating medical providers how and why to adopt MAT. Addressing the shortage of behavioral health medical providers
    - **Reuben Howard** – Coordination of care
        - Providing medication, treating illness, prevention, case management and caring for families
    - **Gagan Singh** – Access (defined – limited workforce and how do we magnify to reach the greatest possible population including tribal high risk)
    - **Doray Elkins** – Greater use of non-opiate opiate blocker in MAT (specifically Naltrexone). Utilizing evidence-based models.
    - **Sara Salek** – MAT for pregnant women and Naloxone (preventing death due to overdose)

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- **Debbie Moak** – The workforce and scaling it. Come up with a wide range of solutions and scale those opportunities for the state
- **Christina Corieri** – MAT in prison (Vivitrol to mitigate relapse) and address the growing need for providers. How can we expand programs to include loan repayment for medical students? There are certain programs in AZ such that if the area that you serve in is lower income or underserved, then physicians may be able to get loan repayment in rural areas. The idea would be to expand the program to include urban areas.
- **Len Ditmanson** – Lifting the cap on the number of patients that a provider can treat on specific MAT drugs such as Buprenorphine.
- **Gagan Singh** – substance specific and population specific – adolescence, co-occurring with serious SMI, LGBT, etc.
- **Christina Corieri** – data coming in from the CSPMP – 4 and 4 report – how can we intervene with those to get them on a treatment regimen?
- **Gagan Singh** – I do not receive that report
- **Christina Corieri** – I receive the report on a monthly basis and it is publicly available

- **Sharon Flanagan-Hyde** began to organize the Work Group's content onto a flipchart. The items listed on the chart are as follows:
  - Access to MAT
    - Increasing the number of providers/training
    - Scope of practice
    - Increased impact per provider
    - List MAT drugs – authorization requirements
  - Education to system partners
  - Targeted strategies for special populations
    - MAT and pregnant women
    - DOC populations
  - Coordination of care
  - Detox
  - Awareness of MAT and decrease in stigma
- Conversation arose about each category leading to expansive dialogue on each category.
  - **Peggy Chase** stated that doctors were concerned about risk to their license. When I train, I think of it as how do the medical providers become more comfortable with MAT. It is important that providers are able to choose if they participate in MAT programs.
  - **Debbie Moak** stated that she is aware of online training programs for MAT.
  - **Len Ditmanson** stated that trainings like this are a concern, speaking for my agency. Eight hours is low when educating someone on substance abuse. I would like to see MAT in conjunction with cognitive therapy.
  - **Sara Salek** stated that MAT is only one component of a biopsychosocial issue
  - **Len Ditmanson** stated that in mental health we have a lot of barriers. If it is too difficult to get to care, people are just not going to do it.
  - **Gagan Singh** stated that New Mexico has a program, Project ECHO, which has someone that knows how to prescribe that can help medical providers.
  - **Sara Salek** Many providers are risk averse; these are people that are at high risk from morbidity so what is the incentive for our providers besides wanting to serve this population? Treating pregnant women is an important consideration and risk versus benefit.
- **Sharon Flanagan-Hyde** reviewed the categories for the Work Group to consider. When you think about those, I would like to go around the room and have you think ahead to October. What are the topics that you would like to see in that report?
  - **Debbie Moak** stated shame and stigma reduction. MAT becomes a healthy approach to many when MAT is professionally done and the shame and stigma are eliminated
  - **Sara Salek** stated pregnant women

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- **Doray Elkins** stated prevention of relapse and Department of Corrections (DOC) populations
- **Gagan Singh** stated educating and supporting additional providers
- **Reuben Howard** stated prevention and early intervention strategies.
  - **Sharon Flanagan-Hyde** stated that the Task Force has a Prevention and Early Intervention Work Group now
- **Reuben Howard** stated that part of the evaluation of prevention and early intervention programs for the tribes is that tribes have been working to get access to the block grants that come to AZ. However, the overall percentage of block grant funding that tribes get per population is low. Would like to evaluate the amount of dollars that are distributed to the tribes for prevention programs.
  - **Sharon** stated that these are some of the issues the prevention and early intervention workgroup discussed yesterday. In terms of this Work Group, what would you like to see?
- **Reuben Howard** stated that he would like to see a good model for MAT. Coming from a reservation, we are all related on the reservation. We can all personally relate to substance abuse addiction because we all have one or two family members that are addicted. We want something that is practical.
- **Peggy Chase** stated that it is important that we address access to MAT programs
- **Len Ditmanson** stated that it is important that we educate and re-culture the profession for ICD-10. Unless doctors begin coding appropriately we miss a great deal of specificity of the aliment. For example F1117 is an opiate dependent person. When an opiate dependent person comes to the ER, practitioners need to be trained to diagnose and refer appropriately.
- **Doray Elkins** stated that New Jersey has stopped prescribing opiates in the ER. A lot of drug seeking is done through ERs.
- **Christina Corieri** stated that we expect a bill that will mandate the use of the CSPMP and only allow Emergency Room doctors to prescribe a maximum of a five-day dose.
- **Len Ditmanson** stated that it is important to provide MAT in a timely and appropriate way similar to a person that is diagnosed with chronic heart failure.
- **Christina Corieri** stated that she would like to see an increase in the number of providers so people in need do not need to wait.
- **Michael White** stated coordination of care and improving urine analysis.
- **Debbie Moak** stated that this Work Group discussed access to care (MAT) as a sub-point but inquired if it was given the prominence that it needs.
- **Sharon Flanagan-Hyde** stated that access to care has been added to the list as a primary point.
- **Len Ditmanson** stated that in terms of lack of coordination to care, we need to strengthen early identification and intervention strategies. Substance abusing patients often have years of abuse and mental health agencies continued to wait until they come in to get care. This is a significant culture that needs to change. Today, “hitting bottom” is often death. Coordination of care is in the best interest of the client.
- **Peggy Chase** stated that everything has really occurred in the adult arena in silos. We have been developing a model at Terros so that there is coordination back when a person is in a MAT program. It has been a difficult arena with all the changes in Washington for 42-CFR. There are things occurring from that. The key is having all the appropriate documentation to do everything we want to do. The addictions field is just one part of the larger puzzle.
- **Michael White** stated that value would be added by adding a MAT training to RELAS
- **Gagan Singh** stated that MAT as a mandated training for practitioners would be good.
- **Christina Corieri** stated that opiate prescribing training is also a potential mandated training
- **Debbie Moak** stated that there are so many trainings for standard practice that should be considered for treatment and prescribing. The target population is not just doctors but the greater population as well.

- **Sharon Flanagan-Hyde** asked the Work Group if there were any further related topics or practices that they would like to discuss before moving on to the next agenda item.

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- **Len Ditmanson** stated that there are several medical colleges and state funding that could/should be linked to mandated training in the medical institutions
- **Christina Corieri** stated that the State can tie state dollars to training; however, there are a lot of requirements on medical institutions so understandably we might get push back.
- **Len Ditmanson** stated that rather than making a top down mandate, it may make more sense for training requirements to come from medical agencies and boards.
- **Gagan Singh** stated that there is significant benefit in trainings such as these. For example, when I got SBIRT training I became a better practitioner. When we show providers that they will become better providers, I believe we will have more headway.
- **Len Ditmanson** stated that in addressing access to care, telemedicine is a resource that would be an effective platform for MAT.
- **Sara Salek** stated yes, but there are unique barriers in addiction medicine and telemedicine.
- **Len Ditmanson** stated that telemedicine is a viable option
- **Michael White** asked how do you then get the medicine to the individual.
- Significant discussion took place on how to potentially break the barrier of access to medication once it is prescribed through telemedicine. The topic then shifted slightly to how to provide behavioral health to the rural areas. Telemedicine was again raised as a potential option.
- **Sara Salek** stated that there is not a one size fits all model for MAT treatment and there are limitations – it is not a cure. When I hear that we just need to use this drug over that drug, I feel the need to remind everyone that no patient is the same as others.
- **Len Ditmanson** stated that for pregnant women this is a huge issue. There is no approved Vivitrol medication
- **Sara Salek** stated that the standard of care has been methadone but understand that Vivitrol has been discussed
- **Doray Elkins** – raising awareness around MAT thought process.

- **Sharon Flanagan-Hyde** observed that many members mentioned a divide in the treatment community concerning MAT. She then asked the following two questions: "What is the magnitude of the divide?" and "What is needed to shift that?"
  - **Peggy Chase** stated that re-education is necessary. Many providers were trained many years ago. When you are brought up in different disciplines it can be difficult to accept new and innovative practices. Additionally, stigmas within and outside the treatment arena tend to make it difficult to accept MAT.
  - **Gagan Singh** stated that it is important to remember that MAT is not necessarily the "magic bullet" and is not the only treatment for substance abuse.
  - **Doray Elkins** stated that for some people MAT is a pathway to recovery. We all agree that MAT must be attached to therapy.
- **Sharon Flanagan-Hyde** asked for any additional comments before moving on to the next agenda item. None were made.

Data Collection and Presentation, Sharon Flanagan-Hyde, Group Facilitator

- **Sharon Flanagan-Hyde** asked the group what articles, information and data should be brought to this table for group consideration.
  - **Len Ditmanson** stated that outcomes and data are slowly coming in. We should be able to tap into the research institutions and the State agencies. I have a contact that I would be willing to reach out to.
  - **Christina Corieri** stated that she knew of research students that would be willing to work on this for the group or state agency.
  - **Doray Elkins** stated that she had a contact for re-entry data. However, the data is currently raw numbers and in a very large data set.

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- **Sharon Flanagan-Hyde** clarified that the data suggested by Doray will need evaluation by an analyst, perhaps a graduate student. Doray replied that she was unsure but would be willing to share the contact for further investigation as to the state of the data.
- **Christina Corieri** stated that comparative data with other states should be considered. Where are the higher MAT numbers and how are they obtaining those numbers? What are the outcomes of having those higher MAT numbers?
- **Debbie Moak** asked for a current and comprehensive inventory of MAT programs in Arizona.
- **Len Ditmanson** stated that the Work Group needs data on how many people need MAT. One way might be to look at the number of people utilizing the clean needle exchange program.
- **Gagan Singh** suggested a literature review on recent MAT, especially on special populations. Some information from SAMHSA on what they see the most promising options.
- **Sara Salek** stated that she has many resources on MAT and other treatments that she will be more than happy to share with the group.
- **Gagan Singh** volunteered to do the literature review. He also suggested reaching out to the American Society of Addiction Medicine.
- **Reuben Howard** asked a question of Sara Salek concerning AHCCCS. In the recent RFPs for the RHBAs, did it include the establishment for MAT centers?
  - **Sara Salek** stated that she will need to pull the parameters for each of the RBHAs to see if MAT clinics are specifically called out.
- **Reuben Howard** asked Sara Salek if she thought strengthening the language in the contracts and deliverables would solve access to care.
- **Sara Salek** stated that simply strengthening the language would not solve the access to care problem for the state because there are many other contributing factors. She additionally stated that we can do a better job overall on increasing access to care than just strengthening language.
- **Len Ditmanson** asked Reuben Howard if Indian Health Services (IHS) would want to help with access to care
- **Reuben Howard** stated that IHS is not involved in this
- **Peggy Chase** stated that cultural competency, when thinking and planning about access to care, is critical for our work. We have to think about how and why people access care as well as other ethnic factors. Look at the number of Latinos that are accessing care and the number of Latinos that need care and the numbers simply do not line up.

- **Sharon Flanagan-Hyde** asked for any further comments before moving on to the next agenda item. No comments were made. She then expressed gratitude for the work completed during this meeting and informed the group that their work would be shared at the next Task Force meeting.

Call to the Public

- **Debbie Moak** made a call to the public. No public were present.

Adjourn

- **Debbie Moak** called for a motion to adjourn.
  - **Doray Elkins** moved for the adjournment.
  - **Gagan Singh** seconded the motion.
  - The motion passed with no dissenting votes and the meeting adjourned at 4:54pm.

Dated the 8th day of April
Medication Assisted Treatment Work Group of
the Substance Abuse Task Force
Respectfully Submitted By:
Samuel Burba
Program Administrator, GOYFF

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