**Illinois Opioid Crisis Response Advisory Council Meeting**

**October 16, 2017**

**MEETING MINUTES**

Maria Bruni, Assistant Secretary of Programs, and Nirav Shah, Director of the Illinois Department of Public Health (IDPH), welcomed the group. Assistant Secretary Bruni introduced Stephanie Frank (IDHS/DASA). Ms. Frank is the new project director for the SAMHSA-funded Prevent Drug Overdose (PDO) program. The PDO program is working with six high-need counties to reduce their number of overdose deaths and increase availability of naloxone to first responders.

Lt. Governor Sanguinetti gave an update on her listening tour. The listening tour is taking place across the state, with providers, people with lived experience and their families, law enforcement and other stakeholders giving testimonies on how the opioid crisis has impacted their lives and communities. The Lt. Governor shared that it is evident that Illinois citizens have read the Action Plan and have suggestions for the Implementation Plan. The need is great and differs across the state. Her office welcomes ideas from the Council for discussion topics for upcoming listening tours.

IDPH Assistant Director Don Kauerauf reported that the Task Force held its first meeting and set the framework for how to proceed in establishing the policies and programs listed in the Executive Order. The Task Force also discussed ideas for structuring the Implementation Plan and ensuring communication with the Council. Strategies and recommendations will be generated by the Council and its committees and shared with the Task Force. The Task Force in turn will share its progress with the Council, and anticipates meeting with the Council to discuss recommendations.

Committee Chairs presented their preliminary recommendations (see attached handout, "Committee Preliminary Recommendations for Action Plan Strategies"). Discussion related to each committee's recommendations included the following:

- The Medication-Assisted Treatment (MAT) Committee's preliminary recommendations for addressing Strategy #6 (Increase access to care for individuals with OUD) includes exploring how Vermont's Hub & Spoke model can be effectively implemented in Illinois. This model provides comprehensive MAT, recovery supports and health home services to people with OUD. The Hub & Spoke model has significantly increased Vermont's treatment capacity. Assistant Secretary Bruni will reach out to Barbara Cimaglio, the former Deputy Commissioner of the Vermont Department of Health who helped developed the Hub & Spoke model, and ask her to advise the committee on this.
- Preliminary recommendations for Strategy #3 (Increase accessibility of information and resources) developed by the Public Awareness & Education Committee include a dedicated website that can be easily accessed and navigated, and tailoring messages and messaging to specific target audiences.
    - New Hampshire, North Dakota, Massachusetts and Colorado all have good websites that might serve as a model for Illinois. Assistant Secretary Bruni reported that DASA is talking with other state agencies about the website, website content and capacity issues, and hopes to have an update to share at the next Council meeting.
    - Assistant Secretary Bruni reported that DASA has selected a vendor for the crisis line. It's anticipated that the crisis line will be up and running by the end of November. The crisis line will be in operation 24/7. Operators will have clinical training on ASAM-required levels of care and understand Illinois' Medicaid eligibility

requirements to ensure that people are referred to covered services. An update on the crisis line will be shared at the next Council meeting.
    - Potential messaging to people with OUD could include running television ads at late-night, off-peak hours; posters in gas stations and fast food restaurants; and Family Community Resource Centers (FCRC). It was noted that many people who receive SNAP also receive Medicaid, and FCRC staff could be trained to screen individuals for OUD and help connect them to treatment.
- The Prescribing Practices Committee developed preliminary recommendations for Strategy #1 (Increase PMP use by providers) and Strategy #2 (Reduce high-risk opioid prescribing through provider education and prescribing guidelines).
    - A major barrier to physicians' use of the PMP is interrupted workflow: when seeing patients, physicians have to step away and check the PMP, taking time away from patient treatment. Giving delegates (nurses, physician assistants, etc.) access to the PMP and integrating the PMP with electronic health records are two recommendations that could improve physician workflow and thereby increase PMP use.
    - Council members discussed whether drug courts and law enforcement should have access to the PMP. Concern was expressed that judges could potentially misinterpret clinical information in the PMP, and that information could be used to mandate certain treatment. The Council agreed that the best use of the PMP is in clinical/medical settings, and that we should avoid settings or use that is potentially damaging to patients and/or results in negative consequences.
    - DEA-licensed controlled substance prescribers could have delegates under the scope of their authority check and report to the PMP.
    - Mike Patton (ILPMP – OCAPS Director) reported that the PMP is working with IDHS, the medical community and the state legislature on legislation mandating PMP use as well as capping opioid prescriptions at seven days. Council members expressed concern about mandating use when 50% of physicians do not have access to and/or ability to provide PMP information via integrated PMP-electronic health record systems; the cost and difficulty associated with integrating electronic health records with the PMP; and issues related to monitoring mandated PMP use. Assistant Secretary Bruni suggested that the Prescribing Practices Committee continue their analysis of the barriers to PMP use, and that a more in-depth discussion of the issues related to this pending legislation take place at the next Council meeting.
- The Criminal Justice Populations Committee's preliminary recommendations for Strategy #7 (Increase the capacity of deflection and diversion programs statewide) and Strategy #9 (Decrease the number of overdose deaths after an at-risk individual's immediate release from a correctional or other institutional facility) include prioritizing deflection models, screening for OUD, and ensuring that justice-involved individuals have Medicaid coverage so they can access and receive treatment.
    - Assistant Secretary Bruni noted that the 1115 Waiver addresses Medicaid coverage for this population and includes provisions for streamlining the process to reduce the timeframe when coverage stops due to incarceration.
    - Implementing the new Texas Christian University (TCU) screening tool at all IDOC Reception & Classification Centers can help identify individuals with OUD and direct them to prison sites that offer treatment. Screening people prior to re-entry can help identify their post-release treatment needs. This tool will be distributed to the Council to review.

    - Funding for deflection and diversion programs varies across the state. Council members suggested reaching out to the Illinois Problem Solving Courts Association to explore funding for diversion programs (e.g., drug courts).
- The Children & Families Committee had its initial meeting on October 10th. This diverse group is focusing on cross-system collaboration and integration in developing its recommendations for how action plan strategies #3--#7 can address the needs of children and families. The group also is focusing the role of trauma informed care and plans to use case studies to illustrate the experiences and needs of this target population.

Ron Vlasaty, Executive Vice President of Family Guidance Centers, Inc (FGC)., gave a brief presentation on the FCG's part of the DASA Opioid STR Warm Hand-Off Services project. This project supports OUD screening, recovery coaching and "warm hand-off" services to persons presenting in hospital emergency rooms and medical detox departments. FGC is working with three Chicago hospitals (St. Bernard, Thorek and Methodist). FGC staff are at these hospitals 24/7; they engage patients, screen them for readiness to change and accept treatment, and link those who are willing to accept treatment to appropriate, assessed levels of care (MAT, recovery supports, etc.). FGC staff transport patients to services at hospital discharge, giving them immediate access to care. Recovery support specialists provide case management. Patients who are not willing to accept treatment receive brief intervention services. Since July 1, 2017, FGC has provided 352 warm-hand offs and has an 82% treatment retention rate. To help ensure sustainability, FGC is talking with MCOs about future funding. FGC has offered to provide a shell of their linkage agreement to Council members who are interested in creating similar linkages with hospitals.

Mai Pho (IDPH) gave an overview of the Naloxone Standing Order (for detailed information on the Standing Order go to http://dph.illinois.gov/naloxone). Public Act 99-0480 authorizes trained pharmacists and first responders to dispense naloxone; however, a prescription is needed to dispense naloxone. The Standing Order acts as that prescription and authorizes pharmacies, pharmacists, and opioid overdose education and naloxone distribution (OEND) programs to obtain and/or distribute naloxone. Non-pharmacy OEND programs may include law enforcement agencies, drug treatment programs, local health departments, hospitals or urgent care facilities, or other community-based organizations. Thus, the Standing Order will increase access to naloxone by allowing providers without access to prescribing physician to distribute naloxone to their patients, as long as organizations meet the criteria of enrolled and approved DASA Drug Overdose Prevention Programs (DOPP). A total of 77 entities have registered since the Standing Order was released. IDPH plans to offer informational webinars and will share those dates with the Council.

- Council members discussed physician ambivalence to writing Narcan prescriptions due to cost, and the fact that smaller pharmacies may not carry naloxone. Being able to dispense naloxone to patients at the ER would be a big benefit, but again cost and reimbursement are potential barriers to this. Assistant Secretary Bruni suggested working with HFS on recommendations for MCOs to cover the cost of Narcan dispensed in ERs, and encouraged the Council to develop additional recommendations on providing people with access to Narcan when they leave the ER.

Assistant Secretary Bruni announced Council updates will be shared with at the Task Force's October 20th meeting. Committees should continue to work on their recommendations, and consider adding resources and timeframes to those recommendations. Copies of Council and Committee meeting minutes can be found on the Council's website: http://www.dhs.state.il.us/page.aspx?item=97186.