



THE CITY OF NASHUA

Division of Public Health and Community Services

Community Services Department

"The Gate City"

July 27, 2018

To NH DHHS re:

Input for NH DHHS Proposal for SAMHSA State Opioid Response Grant Funding

On July 19, 2018, Patty Crooker, the Public Health Network Services Coordinator for the Greater Nashua Public Health Region, from the City of Nashua Division of Public Health and Community Services, presented an overview of the SAMHSA FOA for State Opioid Response (SOR) Grants to the Nashua Mayor's Opioid Task Force (MOTF). Those in attendance provided the following input/feedback to the state for its proposal.

1. *(SOR FOA p.6) "Medical withdrawal (detoxification) is not the standard of care for OUD ... Therefore, if medical withdrawal (detoxification) is performed, it must be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes."*

MOTF Discussion Points:

- This information is contradictory. Individuals must be free of opioids for 5-7 days before injectable ER Naltrexone can be administered.
 - There is a huge need for detox services in NH. To not include detox is a huge barrier.
 - There is no middle place to go between detox and treatment. Treatment centers often won't take patients who are detoxing. However, if someone can maintain short-term sobriety that often prevents them from being eligible for admission into treatment programs because they haven't used in the past X days, which is an admission requirement.
 - There needs to be services other than in-patient and outpatient available.
2. *(SOR FOA p.8) Implement community recovery support services such as peer supports, recovery coaches, and recovery housing.*

MOTF Discussion Points:

- The state needs to establish guidelines and requirements for recovery housing. Many that have popped up have not had appropriate policies/procedures/staffing/models. They need to be monitored.
- Funding for training of CRSWs and Community Health Workers (CHW).
- Funding to provide case management staff to work with individuals in need of services.
- Funding for staffing CRSWs and CHWs (including at Public Health Networks).
- Requirement for hospitals to engage recovery support services/workers when encountering patients with OUD/SUD, particularly in the ED, much like the SANE nurse program for

victims of sexual assault. Currently hospitals are citing HIPAA as a major barrier to entering into this type of collaboration due to ED patients not being in private rooms, patient information not being secured, etc.

3. (SOR FOA p.8) Implement prevention and education services including training of healthcare professionals on the assessment and treatment of OUD, training of peers and first responders on recognition of opioid overdose and appropriate use of the opioid overdose antidote naloxone, develop evidence-based community prevention efforts including evidence-based strategic messaging on the consequence of opioid misuse, and purchase and distribute naloxone and train on its use.

MOTF Discussion Points:

- Include funding to provide education on OUD/SUD science (psychopharmacology) and appropriate language to target groups outside of healthcare (such as: probation/parole staff, public health, police, fire, EMS, “safe stations”, Medicaid/Medicare program staff, court, parks and recreation, DPW staff – people that work within our communities every day) as well as those in healthcare (add priority groups of ED staff, registration, security, case management, environmental and food services staff, medical/nursing/clinical program students, etc.)
- Require municipalities and healthcare to appropriately educate their employees on OUD/SUD science, language, stigma, etc.
- Include funding to provide responder resilience education for first responders, including emergency room, urgent care, and treatment and recovery program staff.
- Include funding for programs to provide 1:1 compassion fatigue/clinical services to public safety personnel, to include emergency department staff.
- Funding for marketing campaigns – some previous statewide campaigns that were developed, some with little/no engagement from local programs, were considered inappropriate/insensitive/ineffective – not sure how this can be improved other than allow for tailored campaigns or agree on existing one (SAMHSA, other EBS for marketing/education).
- Funding for student assistance counselors in all schools.
- Funding/requirement for behavioral health education and programming in all schools, as well as having opportunities available for students’ parents/guardians.

4. (SOR FOA p.9) Provide assistance to patients with treatment costs and develop other strategies to eliminate or reduce treatment costs for uninsured or underinsured patients.

MOTF Discussion Points:

- Need to look at increasing the number of patients a provider can prescribe MAT for. Having accountability is great but it limits the capacity of the treatment facility/provider to have such low limits. This would increase the capacity of our healthcare system to provide medication-assisted treatment to individuals with opioid use disorder.
- The state should establish a fund/grant program for individuals who don't qualify for Medicaid but can't afford insurance or treatment. A similar fund already exists for housing.
- Reduction in what pharmaceutical companies are allowed to charge for prescription medications. Vivitrol is \$12—15K. Suboxone can be \$150/week without insurance.

5. (SOR FOA p.9) Address barriers to receiving MAT by reducing the cost of treatment, developing innovative systems of care to expand access to treatment, engage and retain patients in treatment, address discrimination associated with accessing treatment, including discrimination that limits access to MAT, and support long-term recovery.

MOTF Discussion Points:

- The solution isn't necessarily "reducing the cost of treatment", it is "making treatment more affordable." For some individuals without resources including insurance, any cost for treatment makes it unaffordable.
- Establish a fund/scholarship program for individuals who don't qualify for Medicaid and/or can't afford insurance or treatment. A similar fund already exists for housing. Use funding for that need the care (those who have the most need) creating equity across the board for every person (i.e. limited income individuals) and limit additional financial support for those who don't need it.
- Medicaid reimbursement rates are not realistic. They are not sufficient to sustain organizations serving individuals with OUD/SUD. Low reimbursement rates result in non-competitive pay for clinicians leading to high turnover, decrease in staff experience/training, lower quality of services, and longer wait times for individuals to access services. Is there a way to increase reimbursement rates or provide other assistance/incentives to providers who accept Medicaid?
- Assist organizations in becoming Medicaid providers. The process is difficult and hard to navigate. Provide technical assistance (training on billing, documentation, etc.) as well as assistance with purchasing the IT equipment/systems needed as a Medicaid provider.
- Focus on initiatives that increase health equity to reduce discrimination. Require grantees to demonstrate that their services are inclusive and accessible to all, much like grantees are required to do for CLAS. Monitor implementation and service provision.

- PROGRAM EVALUATION: Require grantees to demonstrate that they are conducting ongoing program evaluation to determine whether activities are being implemented as planned/per guidelines and identify program strengths, weaknesses, and areas for improvement. Require grantees to collect and report standard, valid, unduplicated data to monitor compliance with executed contracts and to measure service delivery/provision across grantees. Evaluation requirements have not always been sufficient in past/current contracts. Require grantees to collect and report patient satisfaction data that is collected anonymously.

6. (SOR FOA p.9) Support innovative telehealth strategies in rural and underserved areas to increase the capacity of communities to support OUD prevention, treatment, and recovery.

MOTF Discussion Points:

- Support development of mobile rehab programs. These can be in collaboration with programs already providing mobile services, including health prevention, screenings, immunizations, treatment. If a program has a mobile component, a treatment or recovery program should be engaged to discuss including SUD/OUD services as well.
 - “ARMOT provides 1.) Case management and recovery support services to individuals with substance use disorders, and 2.) Education and support to rural hospital staff, patients, and their loved ones.” Reference: Addiction Recovery Mobile Outreach Team (ARMOT) <https://www.ruralhealthinfo.org/project-examples/940>

7. (SOR FOA p.9) Grantees are encouraged to collaborate and coordinate with RWHAP grantees for the provision of HIV care and treatment services, including Hepatitis screening, testing, and vaccination for people living with HIV.

MOTF Discussion Points:

- Include funding for provision of HIV/HCV prevention services as IDU is a shared high-risk target population.
- Include collaborations with any organization providing such screening, testing, vaccination services as well as those organizations providing HIV/HCV prevention services, not limited to RWHAP grantees.

8. (SOR FOA p.10) Recipients are also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients.

MOTF Discussion Points:

- Support navigator program (has or is at risk of losing funding federally)
- Increase funding for community health workers! Educate providers and community on the role of CHWs and how they can collaborate – often CHWs say they are not taken seriously by clinicians because they are not medically licensed or certified. The role and expertise of the CHW needs to be explained to the community as they are one of our most useful resources.

Other discussion points of note:

- Transportation to/from treatment, medical, and other related appointments
- Assistance to help defer the cost to low income/homeless, so they can get their prescription at intake into suboxone treatment, without having to wait for their Medicaid to become active
- Assistance to make vivitrol affordable to low income clients
- Sober living programs (including for those with co-occurring diagnoses)
- Syringe Services Programs (SSPs)
- Improving ease, accessibility and application processes the LADC – including reciprocity for licenses from other states.

Respectfully submitted by,

Patty Crooker, MPH, CPH, CHP

Public Health Network Services Coordinator, Greater Nashua Public Health Region
City of Nashua, Division of Public Health & Community Services
603.589.4507

CrookerP@NashuaNH.gov

