



**A. Call to Order**

**B. Welcome, Introductions and Group Norms**

**C. Approval of the Meeting Minutes**

Motion by Dr. Sloan, 2<sup>nd</sup> by Haley Coles

**D. Volunteer to Report at the Next Task Force Meeting**

Haley Coles volunteered to report at the next task force meeting on August 24, 2016.

**E. Discussion: Presentations-What Stood Out?**

-Dr. Salek-for me what stood out was the power of the parent voice, and the importance of peer support within our substance abuse treatment system (which we are covering in Medicaid). It's critical that we have parent voices to advocate for their child, and in some cases it will be a peer voice. It was also interesting for me to hear a different perspective from the pain management community, especially individuals that are board certified and trained in pain medicine that are approaching chronic pain management in a different fashion than what is currently looked at as the standard of care. My take home message was:

- We need to support the parents voice including reimbursement of services on the Medicaid side, and
  - We need to continue to encourage and explore around alternative pain management modalities for chronic pain and think towards centers of excellence
- Debie Moak- the one that kept resonating with me was the failure of the system when parents reach out for help. And understanding how we can do a better job within the medical community of understanding what resources are available, and making sure that families get connected like the navigator system that AZ military family and coalitions have adopted of no wrong door-so that everyone is a resource.
- Q: Sharon Flanagan-Hyde; Clarifying question in terms of recommendation-if we put into place a navigator system are there enough resources to meet today's needs?
- A: Dr Salek- No, not from what we are hearing –it's not only coordinated concerted effort –but also resources are needed to treat.
  - A: Debie- And that leads to why I'm anxious to hear this presentation as AZ looks for solutions, I hopeful this could be one of many.
- Haley Coles- I really appreciated the presentation on pain management. I learned a lot. It's amazing what they were able to do to help so many people get off of opioids that were inappropriately prescribed. One concern was folks who come in with the dependency who aren't ready to get off- even if that that may be appropriate and how we can engage with them. The role of the pain management specialist is not to help them with drug abuse treatment, but it could be incorporated in there. I saw that as an important need. I'm not sure what that would look like, but I saw a great opportunity to help people.
- Dr. Salek- I totally agree with that statement. In the field of medicine we do a good job of siloing- example-I do pain management but, I don't do addiction treatment. The reality is you are doing both. We need to look at a more integrated training related to pain management and addiction because you are treating whole person- integrated health is the future of healthcare

delivery. And as far as the concern of the individuals that are not in a treatment entity-how do you connect the dots with the systems. Unfortunately, right now what we are seeing is that they will find another pain management doctor to go to. Until the stand of care changes it will be hard to address it.

## **F. Medication Assisted Treatment Support System**

- Katherine Cates-Wessel:
  - o I am the executive director for the American Academy of Addiction Psychiatry-a subset specialty of general psychiatry. I am the PI and the project director for two national initiatives funded by SAMHSA— Providers Clinical Support System for Medication Assisted Treatment (PCSSMAT) and Providers Clinical Support System for Opioid Therapies.
  - o Many states are not familiar with them. Both are similar models with evidence based treatment and education resources primary on the internet. Both programs have free mentoring-you can be match up with an expert in pain, addictions, MAT, etc. No one pays anything for any of the course work and training.
  - o PCSSMAT focus is providing waiver training for AAAP (my organization). Our focus is looking at all residency training programs.
  - o Both of these projects are not creating specialist. We are not trying to encourage people to become specialists. We are here to focus on primary care-how can we bring resources to primary care? –physicians, nurses, dentists, pharmacist, etc. We have a broad multi-disciplinary/inter-disciplinary team.
  - o The American Osteopath Academy of Addiction Medicine they are one of our partner organizations. They focus on providing waiver training to rural communities that have hard time finding resources and experts.
  - o Anyone who wants to do the waiver training can do it free of charge at home. We want make sure that everybody knows that these resources are out there.
  - o The American Psychiatric Association does hot topic webinars each month. Anybody can participate. Webinar topics range from how to prepare for DEA inspection to how to del with pregnant women on suboxone.
  - o Other partner is ASAM they provide training in collaboration with American College of Obstetrician and Gynecology (ACOG)-focus on pregnant women
  - o AMERSA- a multi-disciplinary group-we brought them in to help with training because we feel very strongly about multi-disciplinary teams.
  - o PCSSMAT is made up of coalition. The essence of this project is integrated health and interdisciplinary collaboration.
  - o The partner groups get X amount of dollars to create trainings directed towards the various constituencies.
  - o We also have a steering committee that includes the recovery community, drug courts, national association of community health centers, and other groups that can help direct us to what is important.
  - o We wanted to bring in more of the primary care and pain community b/c pain and addiction people do not talk to each other. So we brought in the American Academy of Pain Medicine, American Academy of Neurology, American College of Physicians, American Academy of Pediatrics, American Dental Association (they prescribe about 17% of all opioids. This was an important community that we needed to bring into our

coalition), the American Medical Association, the International Society of Nurses on Addiction, the American Society of Pain Management Nurses, family medicine group, the National Addiction Technology Transfer Center (this group does same thing as PCCSMAT but does not do waiver training. They are looking at what are the important things that we need to know about chronic pain, what are the things that PCPs should look at in screening for mental health and substance abuse disorders).

- Dr. Roger Chow is the co-chair. He is an internist and a specialist in pain management.
  - We trained about 40,000 health professionals collectively. We present over a million health professionals. And our mentor program is free.
  - More recently we were contacted by ONDCP and notified SAMHSA about their interest to train 14 states to focus on getting waiver training. AZ happens to be one of the states.
  - We were asked to come in and provide the waiver training for the state with our existing funds in our grant.
  - I felt strongly if we come in-we should do it in collaboration with what is already going on as a state. We ask questions like -What are the barriers? What do you need? How can we help you in addition to the free waiver training to get more doctors away about MAT? Can we also collect people with mentors and other resources on an ongoing basis and in a sustainable way.
  - HRSA and SAMHSA put together a list of key players to send the letter to- in order to make them aware of our initiative. We added some more people including the medical society, the Governor, the universities. We extended the list out to everybody to give an opportunity to those who want to be involved.
  - We are asking the local stakeholders to identify a location for training, and to do the outreach to the providers that should participate in the training.
  - We bring in the experts and provide the training. We are also developing a website for the 14 states. The website is a centralized location for information and resources for the state.
  - We have also done this before in Indiana-we can put together a local resource guide on MAT.
- Q: Debie-I actually first learned of this initiative and your work when I was at the national council meeting in DC. Who have you reached out to in AZ? And who have you heard from?
- A: Katherine-I can tell you exactly b/c I don't have the chart in front of me. SAMHSA identified the key stakeholders, and we added additional organizations to the list including the department of health services, SAMHSA regional directors, medical schools, the medical societies, etc. I can forward you the list of all the stakeholders invited.
  - A: Debie- That would be helpful. Thanks
- Q: Dr. Sloan- I was just curious on the waiver part, I've been hearing rumors for a long time that they are going to increase the numbers from 100 to 200. Is that in the works?
- A: Katherine- prescribing limits I have not heard. We are hearing that 250 is what HHS is proposing. 3 out of 4 data agency believe that this is a reasonable number.
- Q: Len- Do you know the timeline for when the legislation will get to the president's desk?
- A: Katherine-I heard it will be July, but I don't know that definitively.
- Q: Debie- Are you able to share the outcomes from other states who have mobilized this training?
- A: Katherine-From this effort from ONDCP-no state has completed the training. First training will be in August.

- Q: Haley-the training that you come out to do is specifically to train doctor's to be able to prescribe buprenorphine?
  - o A: Katherine- That correct. That is what ONDCP has asked us to do.
- Q: Haley-How is that different from what is currently available?
  - o A: Katherine- You would typically have to pay money to have someone come out and do the training. In this case, the grant pays for it.
- Q: Dr. Salek- Is there any discussion around making a free training available online?
  - o A: Katherine- we have not made available the eight hour online course on the website.
- Q: Len - Currently, I am sure you have discussed and are aware of the statics that 15-20% of all providers that have a waiver are actively prescribing Buprenorphine. If you expand the pool even wider, do you think that the 15-20% figure will grow too?
  - o A:Katherine- I think you bring up a critical point. There is a fundamental problem. They don't feel comfortable basic substance abuse disorders-addiction-that are much less complicated than heroin or opioid addictions. It's a complicated process and to say just b/c you have completed an eight hour waiver training- now all of sudden you know how to do this (unlikely). If we can give them more opportunities to learn more about how to do motivational interviewing? How do you engage somebody? How do deal with basics of addictions in additions to learning about co-occurring mental health? Many people have co-occurring mental health which makes even more complicated. The concept behind the clinical support system is to provide them other resources and mentors to help providers.
- Dr. Salek- from my perspective what was critical around my development of understanding how to treat addiction was having other colleagues (as you mentioned earlier). That is a critical part of the course of feeling comfortable treating addiction and co-occurring conditions both medical and psychiatric

## **H. What recommendation should be in the task force report in October?**

- Len-One of the on-going issues effecting any discussion about expansion of AHCCCS and MAT is the different movement and shifts around block grants moving from RBHAs.
- Len-Timeline for licensures—not many new MAT programs are coming online currently. The investment in the upfront cost are very difficult to strategize for when not knowing the future of funding—i.e. fee-for-service vs. block grants related to the RBHAs, carve-outs, who in the new merged DBHS-AHCCCS structure is shepherding licensing, etc.
- Len- Having support from the state level, let's look at systematically-all of the players involved.
- Q: Debie- If we move more towards naltrexone that eliminated the DEA correct?
  - o A:Yes
- Q: Debie-Does AHCCCS pay for naltrexone?
  - o A: Dr. Salek-Yes. We always covered the oral naltrexone, injectable form vivitrol. There issue about the community re prior authorization for this medicine. Pharmaceutical therapeutics committee recommended to remove PA b/c it was a perceived barrier to accessing vivitrol. AHCCCS has removed PA for this medication (effective 7/1)

- Dr. Sloan- We got our first patient on vivitrol just last week. I was happy about that. Our numbers are a lot better than most places.
- Len- I have two patients on the meds. They are doing good. But, the upfront side is a lot harder.
- Q: Deb- are there anyways to shorten the 10 day period?
  - o A: Dr. Sloan- Not for vivitrol.
- Dr. Sloan- my recommendation is that AHCCCS would expand letting PCPs see patients in this field.
- Dr. Sloan-I had six AHCCCS patients come into my clinic. We can't treat them b/c I'm not a behavioral health specialist. My staff was on the phone 4-6 hours trying to get placements. Everywhere was full. I had to treat a patient one time for free. It's hard to tell people I can't help them.
- Len- In Tucson for the first time in 15 years I shut the door. The capacity issue is a major concern. Phoenix and Tucson have more facilities compared to a lot of other communities in the state.
- Dr. Salek- to clarify-there is nothing within AHCCCS rules and regs. that would prohibit RBHAs from contracting with any type of physician as long as they go through our regulations related to credentialing to ensure that the individual has the appropriate training background.
- Dr. Sloan-I'm an AHCCCS provider but I can't see suboxone patients.
- Dr. Salek- it's related to the carve-out that we have right now. And part of administrative simplification—AHCCCS merging with the DBHS—is to actually expand integration and expand access to care across the board—b/c historically the RBHA networks have been primarily behavioral health providers. We integrated services for CRS, GMSA, and duals (Medicaid-Medicare), individuals with co-occurring SMI that is all fully integrated. It takes time to develop capacity, infrastructure within the system. The traditional acute plans to understand how to treat people with behavioral health and establishing a network for behavioral health. Likewise on the RBHAs have to establish capacity for physical health conditions.
- Dr. Salek-I think there is perceived barriers in regards to who has traditionally been in the RBHA network. But, there is nothing that prevents the RBHA from contracting and credentialing with non-psychiatrist.
- Len- Timeline for credentialing with the health plan can take 3-6 months.
- Dr. Salek-our policies have been updated with regards to timeline for credentialing. If timeline goes beyond 3 months we definitely need to know. We have centralized credentialing entity for the health plans and RBHAs. With the new managed care regs coming from the federal government there will be even more requirements related to credentialing. We are following the federal rules related to managed care organizations and credentialing standards.
- Len- to ask the newly merged Department of health to frequently and periodically review their process of credentialing and licensure for MAT providers throughout the state.
- Dr. Salek- It will be ADHS for licensure and managed care organizations for credentialing. AHCCCS oversees the MCOs.
- Q: Haley- When AHCCCS pays for Buprenorphine patients, do they require that patients do out-patient therapy?

- A: Dr. Salek-the only way we can require it is by doing prior authorization. That will be very hard to validate. Again we can say absolutely that is the standard of care, but as far as systematically enacting it would be a challenge.
- Haley- The issue I see with AHCCCS patients that have difficulty finding a doctor who contracts with AHCCCS who will provide Buprenorphine. And if they do find a doctor—the doc does not help them get counseling—not an effective form of treatment.
- Haley-I think the best model would be if in the doctor’s office there is counseling so that they don’t have to go somewhere else to receive that necessary part of treatment.
- Dr. Salek- A lot of our behavioral health providers have both medication management as well as the counseling. I wonder if this is around understanding what the network is.
- Dr. Salek-As far as recommendation it’s more integrated care and care coordination to connect the dots between the individuals prescribing the medication as well as those providing the counseling and other support services.
- Dorey-my request is twofold in terms of recommendation for MAT treatment for naltrexone:
  - First request in regards to exposure-educating services providers that does not exist for opioid addicts. As alternative to naltrexone and how it works.
  - Second having it mandatory so that it would at least be offered as a viable option for opioid addicts after detoxing.
- Q: Sharon-clarification-when you say to have a form of naltrexone be mandatory-how do you see that implemented?
  - A: Dorey- I don’t know. That part is not my field. I think provider should have conversation with the patient about the various forms of MAT. Most of them do not know about naltrexone.
- Debie- I liked everything that you said expect one word “mandatory”
- Q: Dorey-How do we change that word?
  - A: Debie-Encourage
- Debie- for me one of the outstanding recommendations has been training for doctors. We need training in a number of settings, but certainly one of the biggest is training for docs on MAT, use of naloxone, addiction meds, co-occurring disorders, screening, motivational interviewing, etc.
- Q: Dr. Sloan- How much does it cost for the insurance companies to an inpatient facility?
  - A: 21 days and approx. \$30,000
- Dr. Sloan- recommend that we look at the effectiveness of outpatient detox vs. inpatient detox
- Len- I think one of the issues about that is tied to the crisis point of entry that people go to when they need help. We are exploring collaboration with the CRC and UPC. It’s not clear for a person in crises that they can and should seek outpatient detoxification. The crisis centers could become an extension of MAT. Capacity needs to grow exponentially and integration for point-of-entry is needed.
- Haley- concern about certain counties not having a single MAT program like Mohave County. And how can we in our recommendation address that. I wonder if one thing we can recommend is that DHS work with existing medical centers in these counties to help them setup MAT programs.
- Q: Dr. Salek- How do individuals in Mohave County currently access methadone treatment?

- A: Haley- They don't
- Q: Dr. Salek- Are they accessing telemedicine services with naltrexone, suboxone, etc.
  - A: Haley- I don't know
  - Dr. Salek-that is usually how we bridge the gap in those areas. Typically what would happen (in AHCCCS) we would cover transportation to the nearest methadone clinic. If the clinic is outside of the network distance requirement than contractors need to take action.
- Debie-What you are saying to me (referring to Haley) is a great case for naltrexone. Whether it is a 30 day injection or a six month implant in those cases. Although it would limit the availability of other choices.
- Haley-That is a good point. And we need to have methadone and suboxone available for people who think that option will work for them.
- Q: Does AHCCCS cover the naltrexone implant?
  - A: Dr Salek- on the drug list we have the oral naltrexone and injection.
- Dr. Salek- soboxone film is available without prior authorization (and is a preferred drug) and vivitrol is now available without prior authorization.
- Dr. Salek-all new drugs are systematically review before PMT. The folks that sit on the PMT are multi-disciplinary—pain management physicians, pediatricians, psychiatrists, etc.
- Haley-refining my recommendation- encouraging counties that have little to no MAT treatment to work with their existing health and behavioral health clinics to setup MAT programs.
- Dr. Len- transitioning GMSA portfolios for dual eligibles from the RBHAs to AHCCCS plans
- Dr. Salek- to clarify-the transition of GMSA is for duals meaning members w/ Medicare and Medicaid.

### **I. What Additional Information Do You Need?**

- Dr. Len- I personally sent a request to Alexandra if she could send be the data and information for the work comp presentation from last meeting.

### **J. Call to the Public**

- Joe Demana- the idea that certain in-patient treatment programs would be turning away people based on having buprenorphine in their system already. And whether or not those organizations have state funding, and if they should continue to receive funding based on that.

### **K. Adjourn**

Dr. Sloan motion to adjourn, 2<sup>nd</sup> Dr. Len

June 30, 2016  
Arizona Access to Treatment Work Group  
Respectfully Submitted By:  
[Insert Your Name and Position Here]

DRAFT