NCMS Opioid Task Force
Minutes
May 7, 2018
NCMS Headquarters, 222 North Person St., Raleigh, NC

Members Attending In Person	Members Attending By Phone	Staff Attending
John Reynolds, MD, Chair	Chris Griggs, MD	Bob Seligson
Palmer Edwards, MD	Michelle Jones, MD	Steve Keene
Larry Greenblatt, MD	Venkata Jonnalagadda, MD	Melanie Phelps
David Henderson, JD	Gandhari Loomis, MD	Conor Brockett
Joe Jordan, PhD	Josh Miller, MD	Kristen Spaduzzi
Dan McKerney, PA-C		Franklin Walker
Charlie Monteiro, MD		
Bryant Murphy, MD		
Robert Rich, MD		
Dave Tayloe, MD		
John Woodyear, MD		

I Dr. Reynolds called the meeting to order, reviewed the charge and led introductions of Task Force members.

II Conor Brockett provided an overview of activities occurring in North Carolina:

- Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC) and its 7 key areas of focus
- Opioid resources on the NCDOJ website
- STOP Act related efforts
- Health plan coverage policy changes
- NC Industrial Commission (workers comp) rules (handout provided)
- Syringe Exchange Programs
- Lock up Meds and Operation Med Drop
- Training and CME/CEUs by NCMS, NCMB, NCHA, NC AHEC, Project Echo and others
- Naloxone Standing Order passed in 2016 (according to the NC Harm Reduction Council there have been approximately 10,000 reversals).
- NCMB's Safe Opioid Rx 2016—proposing refinements to rule; considering how to address situations where PA or NP are MAT trained but their supervising or collaborating physician is not.
- Pending Heroin & Opioid Prevention & Enforcement (HOPE) Act (handout provided)—area of concern: expanded law enforcement access to NC CSRS. Will need the task force to help staff evaluate the various iterations of the bill.

III Franklin Walker provided an update on the NCMS Foundation's Project OBOT

- Funding through gifts and grants, with over $500,000 currently pledged
- Physician training and compliance (MAT)
- Create sustainability

- Enhanced quality of care, access to care, privacy, and compliance (through use of Recovery Platform, which integrates with EHRs, CSRS, telehealth)
- Improved reimbursement via payment reform
- Highlighted the difference between the cost of incarceration vs the cost of treatment (the latter being significant less costly by a ratio of 4:1)
- Current Partners: NCMS Foundation; local health departments, UNC Gilling's School of Public Health, Project Echo (provides training in opioid addition treatment at no cost), MAHEC (MAT and waiver training), LabCorp (cost-effective, purpose-built buprenorphine panel for MAT patients), Recovery Platform (technology solution)
- Pilot sites: Madison County, Granville/Vance, and Brunswick County Local Health Departments for MAT; Pender County, for Virtual Drug Court
- MAHEC MAT enhancement with using technology

IV The Task Force discussed the following issues:

- RX opioid vs rise of heroin and fentanyl usage—Rx opioid deaths are decreasing; while heroine and fentanyl deaths are increasing
- Which are accidental, and which are intentional?
- Rescue vs recovery.
- Access and reimbursement issues need to be addressed (in VA, pilot program pays $250 per member per month (PMPM) to manage patients under care)
- Majority of MAT is provided on cash basis rather than through Medicaid
- Need more waivered providers (MAT trained) who actually provide the service (it was noted that a large percentage of MAT trained/waivers providers do not offer the service; OBs were mentioned specifically because of the number of addicted pregnant woman
- Can we identify areas in addition to incarceration where money can be saved?
- Discussed need for culture change--better to use alternative therapies first before opioids are prescribed
- Does Medicaid managed care provide a potential solution on payment and access
- Individuals are at increased risk if they smoke, use alcohol, are bipolar or have depression, have a family history of addiction
- Can the CAGE questionnaire/assessment tool help identify folks at risk for addiction vs those who need pain management?
- How do we address the stigma of addiction? Recognize it as a chronic disease?

V Areas for potential action:

- Recruit and train more physicians, PAs and NPs on MAT (Note--can this be baked in to Project OBOT?
- Develop toolkit for implementing MAT in practice to assist MAT-trained providers to provide the service, perhaps a mini-course to really provide hands on training (Note—Project OBOT?)

- Identify and disseminate a screening tool (perhaps CAGE?) to help determine risk of addition development vs the need for pain management (Note--can this be promoted through Project OBOT?)
- Create a support network and mentoring for MAT providers (Project OBOT?)
- Develop directory of support systems/resources (Project OBOT?)
- Look for opportunities to advocate for fair reimbursement for MAT
- Develop metrics such as increasing the number of providers trained on MAT and providing the service (Project OBOT?)
- Explore a charitable deduction for providers who see uninsured MAT patients
- Work with payers to expand treatment options
- Should we bring in folks from other states to see what in being done elsewhere?

VI Follow-up items

- NCMJ link to Issue on the Opioid Crisis
- Link to NEJM article re: suicide rates contributing to opioid deaths.
- Staff to review notes and get together with Dr. Reynolds to determine next steps before scheduling another meeting.

VII There being no further business, the meeting was adjourned.

Respectfully Submitted,

Melanie G. Phelps, JD
SVP, Health System Innovation,
Deputy General Counsel