

## **FINAL REPORT: Heroin and Opioid Emergency Task Force**

The Task Force divided its recommendations into seven areas: 1) Expanding Access to Treatment; 2) Enhancing Quality of Care; 3) Boosting Overdose Prevention Efforts; 4) Escalating Law Enforcement Options; 5) Reentry and Alternatives to Incarceration; 6) Promoting Educational Tools for Youth, Parents and School Officials; and 7) Improving State Support Services. Below are specific recommendations under each topic, highlighting when the recommendation focuses on the need for legislation or an action by a State agency.

It should be noted that prior to the discussion in the report on the recommendations, there is a statement that various stakeholders will be brought together, such as DHMH, local hospitals, skilled nursing facilities and law enforcement to develop a pilot program that establishes a full continuum of substance use disorder services in a target area, including leveraging space in various health care facilities to provide care, resident and treatment for heroin and opioid use disorders.

### **EXPANDING ACCESS TO TREATMENT**

Page 5:

1. Behavioral Health Administration (BHA) should hire a project coordinator and convene a steering committee of internal and external experts, including individuals involved in development of existing model strategies, to advise plan development for the implementation of a Statewide Buprenorphine Access Expansion Program.

Page 6:

1. Department of Health and Mental Hygiene (DHMH) should review the substance abuse reimbursement rates every three years.
2. Legislation to require that the allowed amount a carrier uses to pay benefits to non-contracting providers be not less than 140% of the allowed Medicare amount. Applies only when the provider network is inadequate, not when patient voluntarily goes-out-of-network.
3. Legislation to require carriers to provide prospective enrollees with a list of providers for the enrollee's health benefit plan. List must be accurate upon publication and annually.

Page 7:

1. DHMH should expand access to training for certified peer recovery specialists by facilitating the travel of individuals who have completed the nationally recognized Connecticut Community for Addiction Recovery trainer of trainers (TOT) modules to Maryland to provide recovery coaching TOT modules for trainees to meet Maryland's certified peer recovery credentialing requirements.
2. BHA should develop a pilot to provide recovery support specialists to assist pregnant women with substance use disorders in three targeted jurisdictions (not identified) with the highest rates of prenatal substance abuse.

Page 8:

1. Department of Public Safety and Correctional Services (DPSCS) should create a transition process allowing inmates leaving incarceration with known substance use disorders to be engaged with community resource providers. "All offenders should have made successful application for health insurance and have requisite medical, mental health and addictions appointments scheduled prior to release."
2. Maryland Higher Education Commission (MHEC) should develop strategies to incentivize colleges and universities to create collegiate recovery programs, which is a supportive environment within the campus culture that reinforces the decision to disengage from addictive behavior.

### **ENHANCING QUALITY OF CARE**

Page 9:

1. Legislation to require mandatory registration and query of the Prescription Drug Monitoring Program (PDMP) when prescribing or dispensing controlled substances that contain an opioid or a benzodiazepine.
    - Initially begin with mandatory registration.
    - Goal of implementing a use mandate of the system within 2 years of the legislation's effective date (must conform to DHMH's estimated dates for when the PDMP's information technology and administrative capacity can be enhanced to support it).
    - Consideration should be given to tying the registration mandate to initial receipt or renewal of the CDS permit.
    - Use mandate should apply when prescribing or dispensing a drug to a patient for the first time to treat a specific condition and then at regular intervals after the initial query if treatment includes the use of an opioid and/or benzodiazepine.
    - Legislation should provide for exceptions to the use mandate ---
      - PDMP is unavailable for query due to technical problems;
      - In emergency situations where accessing the PDMP would adversely impact a patient's medical condition;
      - In clinical situations that present a relatively low risk of drug misuse or diversion due to patients seeking drugs from multiple providers, including prescribing and dispensing to patients who are in hospice care, being treated for cancer-related pain or residing in nursing facilities and other facilities often served by a single dispenser.
    - Legislation should also expand the types of clinical support staff that prescribers can delegate to access PDMP on their behalf to include unlicensed staff like medical assistants and emergency room scribes.
- \*\* Report describes the issues between CRISP and EMRs being separate and comments that the creation of a single sign-on connection between CRISP and a provider's EMR would ease the time and IT burden on clinical providers; however, falls short of any recommendation in this area.

Page 11: Legislation authorizing any county in Maryland to establish an Opioid-Associated Disease Prevention and Outreach Program to provide outreach, education and linkage to treatment services, including the exchange of sterile syringes (only authorized in Prince George's and Baltimore City now).

Page 13:

1. DHMH should select accepted performance measures and begin publishing provider-specific, regional and statewide performance data collected from providers and systems.
2. The Boards of Podiatry, Nursing and Pharmacy should require licensees to complete one credit hour of continuing education related to opioid prescribing.
3. Regulations to require some form of medication monitoring for Medicaid enrollees who are being prescribed certain opioids for more than 90 days for chronic pain arising from their conditions that are not terminal. This requirement would exclude cancer patients and others that may include hardship on the patient in certain cases. Report highlights Ameritox, which is a provider of medication monitoring. Ameritox reported that 48% of samples in Maryland contained a drug not prescribed by the doctor who ordered the screen, which is the second worst rate in the country according to Ameritox.

#### **BOOSTING OVERDOSE PREVENTION EFFORTS**

Page 15:

1. BHA should contract with a web developer to create an online overdose response program-compliant training module to increase the number of certified trainees.
  - BHA should also track identifying information about trainees.
  - DHMH should identify a staff physician to issue a statewide order for dispensing to ORP certificate holders by licensed pharmacists (SB 526 of 2015) and then work together to develop a standing protocol requiring the pharmacists provide hands-on instruction to certificate holders on how to assemble and use the specific naloxone delivery device.
2. BHA should also develop a process to track naloxone dispensing through the PDMP.
3. DHMH, in consultation with the Maryland Chapter of the National Council on Alcohol and Drug Dependence and family advocacy organizations, should contract with a PR firm to develop a comprehensive media campaign to raise awareness of the Good Samaritan law in geographic overdose hotspots.

## **ESCALATING LAW ENFORCEMENT OPTIONS**

Page 16:

1. Enactment of a state RICO law to prosecute those who engage in a pattern of wrongdoing as a member of a criminal enterprise.

Page 17:

1. Legislation to create a felony crime for the direct or indirect distribution of heroin or fentanyl, the use of which contributes to the fatal or nonfatal overdose of another. Legislation should establish a complete immunity for a person if evidence of the crime was solely obtained as a result of the person's seeking, assisting or providing medical assistance.

Page 18:

1. Creation of a multi-jurisdictional Maryland State Police Heroin Investigation Unit.
2. Require all Maryland State Police heroin and opioid investigative activities be entered into Case Explorer.

Page 19:

1. Allow the Maryland State Police to negotiate the inclusion of inspectors from various parcel services (US Postal Service) into existing State Police parcel interdiction units as task force members.
2. DPSCS should examine their current Front Entry Search policy and procedures to determine whether they align with national best practices and, if necessary, modify them in order to assist in eliminating the introduction of contraband into all correctional facilities as well as identifying ways to impose gradual disciplinary measures against correctional officers whose improper conduct enables the smuggling of contraband and illegal substances.

## **REENTRY AND ALTERNATIVES TO INCARCERATION**

Page 20:

1. DPSCS and Governor's Office of Crime, Control and Prevention (GOCCP) should collaborate with the Maryland Judiciary to establish a day report center pilot program, which is a non-residential, on-site wrap around services.
2. DPSCS should expand the Segregation Addictions Program, which is housed at the Maryland Correctional Training Center, to try to meet demand. No reference in the report to the exact "need" projections but recommend adding three additional substance use counselors.

Page 21:

1. Legislation to develop a swift and certain sanctions grid for nonviolent offenders released on probation and parole whose offenses relate to their substance use disorder.
2. The GOCCP should incorporate a new goal into Safe Streets that will allow the local Safe Streets coalition to leverage appropriate resources to address the issue of violent crime related to drug trafficking, substance use, and addiction, with a focus on heroin and opioids. At the same time, peer recovery specialists should be incorporated into the Safe Street model. These specialists are those individuals who individuals in recovery or have life experiences from any life-altering events or disruption and are willing to assist others who are in the recovery process .

Page 22:

1. DPSCS should establish a pilot Recovery Unit at Eastern Correctional Institution to house offenders who are engaged in drug programming and are invested in recovery. DPSCS should identify and train offenders with significant incarceration periods to work as peer mentors in this unit.
2. GOCCP should conduct a study of Maryland laws and regulations that establish a “Collateral Consequences” of a criminal conviction. Study should identify those restrictions that appear overbroad and serve as unnecessary barriers to employment of ex-offenders.

### **PROMOTING EDUCATIONAL TOOLS FOR YOUTH, PARENTS AND SCHOOL OFFICIALS**

Page 23:

1. Maryland State Department of Education (MSDE) should assist local school board in the development and promotion of a drug education and information segment on the school websites.

Page 24:

1. MSDE should assist school staff on training on the disease of addiction and signs that a student is abusing heroin and opioids. Information should be given out at school functions, especially pertaining to a sports injury.
2. MSDE should promote “refusal skills” in their curricula to help students resist peer pressure while maintaining self-respect.

Page 25:

1. MSDE should evaluate the success of the Frederick County Student-Based Film Festival and consider replicating it and incorporate a “social norm” theme that not everyone uses drugs.

## **IMPROVING STATE SUPPORT SERVICES**

Page 25:

1. Department of Juvenile Services (DJS) should develop a questionnaire to be used during the Maryland Comprehensive Assessment and Service Planning assessment that will be specifically designed to guide DJS staff in a productive discussion with the youth and parent regarding opiates. Likewise, DHR should implement a comprehensive screening tool to identify clients and families affected by heroin and opioid use. If customers found to be at risk, a more detailed assessment would be given and if determined at risk the customer would be referred to the appropriate resources.

Page 26:

1. A Center of Excellence for Prevention and Treatment should be established under the Behavioral Health Advisory Council but housed in an academic institution to serve as the main body to provide critical oversight or a unifying strategy and accountability for all prevention and treatment programming across the State.

---

### **Following the final recommendations, the report outlines the following:**

Page 28: Provides information on the nine grants awarded through the GOCCP aimed at tackling the opioid and heroin crisis – grants given in Allegany, Carroll, Charles, Howard, St. Mary's, Montgomery, Somerset counties and Baltimore City.

Page 31: Provides information on the \$500,000 grant awarded by GOCCP for Medication Assisted Treatment reentry programs in nine counties, which focuses on the use of Vivitrol and extensive behavioral health counseling. As of November 4, 2015, approximately 304 clients have been evaluated and 61 accepted into the various programs. Twenty-one injections have been given in the detention centers and six injections in the community.

Page 33: Provides a status report on items included in the Task Force's interim report.

- Pages 33-35: Outlines educational efforts by MSDE.
- Page 35: States that all 47 Maryland hospitals have committed to adopting and working with emergency medicine personnel and their staffs to implement the Maryland Emergency Department Opioid Prescribing Guidelines. Periodic updates will be provided by the hospitals to the Maryland Hospital Association on the progress of implementation. MHA is also committed to working with the Maryland College of Emergency Physicians to convene a meeting in the spring to discuss voluntary utilization of Maryland's PDMP and education and training needs for providers and patients.
- Page 35: Maryland State Police have begun facilitating trainings on the Good Samaritan Law and have developed a help card with the number of the newly created crisis hotline in Maryland.

- Page 35: The Governor's Office of Community Initiatives Interfaith Coordinator has identified at least 20 different facilities in Baltimore City and the in the Counties of Anne Arundel, Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Frederick, Harford and Montgomery for inclusion in its database of faith-based organizations that provide addiction treatment services.
- Page 36: Maryland observed its first Overdose Awareness Week between August 30<sup>th</sup> and September 5, 2015.

Pages 38-41: Detail additional monies given for treatment and awareness projects. Monies provided to:

- A.F. Whitsitt Center for expansion.
- 20 jurisdictions to support naloxone training and distribution under the Overdose Response Program.
- Behavioral Health Systems Baltimore to develop and implement specialized training and protocols for peer support specialists to conduct outreach to overdose survivors and linking them with treatment and recovery support services.
- Charles, Calvert and St. Mary's Counties for the implementation of a pilot overdose education and naloxone distribution program for at-risk individuals leaving incarceration.
- Anne Arundel County to expand supportive recovery housing for women with children (Chrysalis House)
- Behavioral Health Systems Baltimore to provide residential detoxification services with childcare services on site in Baltimore City.
- BHA working with the University of Maryland School of Pharmacy on the development of clinical guidelines for primary care practitioners that address, first, when opioid prescribing is, or is not, appropriate, and second, how to mitigate the risks of opioid prescribing should it be initiated. Goal is to begin development process, in consultation with subject matter experts and stakeholders, in December 2015.
- Dorchester County to replace outdated mobile data terminal and overtime for additional investigations.
- Maryland State Police Gain/Heroin Disruption Project.
- Ocean City Police for installation and implementation of license plate reader technology.