State Consumer and Family Advisory Committee
MEETING MINUTES

Date: November 14, 2018 **Time**:9:00- 3:00pm **Location**: Ashby Building

MEETING CALLED BY	Benita Purcell, Chairman
TYPE OF MEETING	State CFAC

ATTENDEES

COMMITTEE MEMBERS

NAME	AFFILIATION	PRESENT
Benita Purcell	SCFAC – Chair/Cardinal	x
Mark Fuhrmann	SCFAC -vice chair/Partners	x
Martha Brock	SCFAC / Alliance	x
Kenneth Brown	SCFAC / Alliance	x
Brandon Tankersley	SCFAC/ Alliance	x
Jean Anderson	SCFAC / Cardinal	x
Brandon Wilson	SCFAC / VAYA	x
Susan Stevens	SCFAC	X By Phone
Patty Schaeffer	SCFAC/Partners	A
Lori Richardson	SCFAC/ Sandhills	x
Ron Rau	SCFAC / Sandhills	x
Wayne Petteway	SCFAC/ Trillium	x
Deborah Page	SCFAC / Cardinal	x
Pat McGinnis	SCFAC/ Vaya	P
Angelena Kearney-Dunlap	SCFAC / Cardinal	x
Catreta Flowers	SCFAC/ Trillium	A
Jonathan Ellis	SCFAC / Trillium	x
John Duncan	SCFAC / Cardinal	x
Ben Coggins	SCFAC/ Partners	x

STATE STAFF ATTENDEES

NAME	AFFILIATION	PRESENT
Suzanne Thompson	CE&E Supervisor	x
Stacey Harward	CE&E team	x
CJ Lewis	CE&E Team	
Ken Schuesselin	Associate Director for Consumer Policy	x
Jeff Smith	VA	x
Glenda Stokes	Team Lead, Cust.Svc Comm Rights	x
Karen Burkes	Asst. Director of Operations	x

GUEST

NAME	AFFILIATION
Kristin Britt	
Thomas Dempsey	

1. Agenda topic: Welcome and approval of Agenda and Minutes **Presenter(s): Benita Purcell**

Discussion	Thanked everyone for coming to the meeting and taking time out of their busy day to be at the meeting. • Introductions of committee, guests and staff. • Reviewed agenda and it was approved. • Reviewed the State-to-Local CFAC conference call minutes - approved with no changes • Reviewed SCFAC minutes - approved with no changes. • Benita P. - Cathy H. has resigned from SFCAC. There is an opening. • Catreta F. had total hip replacement surgery.
Conclusions	•

Action Items	Person(s) Responsible	Deadline
• Minutes to be sent out to all Local CFAC members and listserv – Stacey to send to Tammy Baity.		

2. Agenda topic: By-law discussion and approval of by-laws **Presenter(s): Mark Fuhrmann**

Discussion	• Mark F. reviewed by-laws and changes that where suggested and approved. • Martha B. had some questions concerning page 4 of the bylaws – How many meetings per year? Page 3, section 4 states how many meeting. Typo – minimum 11 times a year. • Mark F. – the two major changes: 1) meeting can be attended by phone. If a member reaches 3 absences, the member will be contacted by the chair to discuss situation, the information will be brought back to the committee for a discussion. 2) Voting for election: can be done in person and by absentee votes • Ken B. – section 4 paragraph 3; it should say, *is not in attendance.*
Conclusions	• By -laws passed

Action Items	**Person(s) Responsible**	**Deadline**
Motion: Deb P. made motion to approve the By-laws. Ken B 2nd. By-laws approved. Mark F. will make corrections to bylaws and send to Stacey H. to have in packet for December meeting.	Mark F.	12-18

3. Agenda topic: Division update **Presenter(s): Kody Kinsley**

Discussion	• Introduction of Karen Burkes. She filled the position of *Assistant Director of Operations.* • Medicaid Transformation: Eight companies have sent in their applications and they are being reviewed. • What constitutes mild/moderate vs severe? Possible Dr. Brown or Dr. McCoy can come and speak directly on this. Dr. McCoy is a part-time employee. • SMI is more functional vs. diagnosable when looking at the data. What are the correct qualifications and working with the MCO's to check those lists? There are populations that are set aside. People can have choice between the tailored plan and/or standard plan. Some flexibility in that direction is being worked on at this time. • Tailored plan design work is continuing. The legal plans behind the tailored plans is in conjunction with the MCO. Will they be a private or public corporation? This is in decision and being worked on currently. • Karen B. will be working on the policy that will explain what the division will pay for when it comes to committees and trainings. Karen B. will be leading this in conjunction with Ken and Suzanne. Approximately 60k a year for SCFAC; this is a priority, but Kody wants everyone to see what is being paid for. Clarity should come from the policy. • Benita P – Rep Insko will be at our next SCFAC meeting. There will be a discussion about CFAC having a budget as a line item. Karen B. is invited to the meeting as well as having a document to show. Kody K. wants historical information to have a clear picture especially for the General Assembly. • Martha B. indicated that the SCFAC is in statute, but to say *we will find money from somewhere* minimizes the importance of the committee. Kody K. stated the Division does not give money specifically for SCFAC, but it is funded through the CE&E budget. • Brandon T. – What is the discussion on Medicaid transformation at this time? Where are we? Kody K. – Expansion is up to the General Assembly. Transformation allows the state to use dollars more specifically for the whole person outcomes.

	• Telemedicine and consultation is important and moving forward by another method since Feds/CMS did not approve. Expansion would allow more people to get access to care (males in the SUD area are highest effected). • Martha B - Obama Care (ACA) discussion - What is the percentage that is affected? *I have heard that 3-4% is being reported.* Kody K. will get the number, but believes it is higher. • Martha B. would like to know how many people will be insured post-transformation vs. expansion? Kody K. - *10 million in NC, 2 million with Medicaid. Expansion would add another 500-600k. It would leave approximately 1 million people without insurance.* The way the law would be written would depend on how many people are affected, in addition to an entitlement to care. • Brandon asked, "Is Secretary Cohen making decisions on the assumption that certain things would happen?" Kody K. stated they have not put the cart before the horse, but transformation is moving forward. • Brandon W. – Will DHHS be a center part of the NC Cares model? • Martha B. – There was a discussion at the Triad CFAC. Sarah P. sent an email to Kody K. and the Department. This email voices concerns on taking the consumers voice seriously. • Benita P – This was regarding CAP C, and it appearing that decisions have been made prior to groups input. Kody K. indicated that Dave Richard assured him, no decisions have been made. Kody K. stated he wanted more information/detail as to what makes the committee feel that this occurred. Kody stated they would address anyone within the department about presenting such information. • Martha B. clarified that it is not just CAP C, but the overall input of those at the table. • John D. – There are people under leadership that must get things done off a check list and have to make things work so the structure is there. Kody stated that nothing is going to happen without Dave and others giving it the go-ahead. Kody is okay with voicing the groups concerns with Dave. • Martha B. – Martha participated on the MCAC Subcommittee on Beneficiary Engagement meeting by phone. There were many staff there and on the phone. There is an under representation of consumers and beneficiaries on the board. Martha stated the chair was nice and receptive after she spoke. • Pat M. – Wants to thank Kody K. and the team for being available and present in the VAYA area. • Kody K. – Teams have been working on how we collaborate effectively. • Jean A. – Who dictates the number of seats (20) for MCAC? Kody K. will get the information. STR (15.5 million) and SOAR for SUD/opioid crisis. Going to treatment dollars. Pilots around DSS and those coming out of prison. The vast majority are going into treatment. • Jean A. - Oregon and Wisconsin have limits on pain medication. Is NC following suit? Kody K. is unsure about what is moving forward past the STOP Act. They want to make sure that doctors are making sound decisions when it comes to risk avoidance. Oregon wants to stop by 2020 allowing Medicaid to pay for pain meds. Kody K. stated this is not on NC. • Mark F. and Deb P. - Where is the money for IDD since much money is going into opioids? Kody stated that a better list of the waiver payment should be coming. Kody wants better data and analysis.		
Conclusions	•		
Action Items		**Person(s) Responsible**	**Deadline**

4. Agenda topic: The roles and Responsibilities of the SCFAC **Presenter(s): Suzanne Thompson**

Discussion	**See Attachment** • Martha B.- How many groups do the same role as CFAC? Suzanne T. – None that she is aware of. Martha B.: stated, *"No. That's not what is stated"*. The NC Commission on Mental Health reviews the same plan according to Mark. The statute is 12 years old and things have changed. • Jean A. – Should State CFAC have outreach into the community or table at events? • Mark indicated there are so many groups collecting data, but what is the role (if any) of the coordination of all the data and information? • Brandon W. - Too many silos; everyone needs to be on one platform. • Martha B. indicated that in many years working with DRNC that transportation is a top topic. • John D. indicated how to address social determinates. The ball is in the court of the provider and data is needed. • Martha B. indicated that the group should be advising the General Assembly. Suzanne T. agreed. • New team member Kate Barrow will be assigned to SCFAC after December.
Conclusions	•

Action Items	**Person(s) Responsible**	**Deadline**
•		

5. Agenda topic: DMA update **Presenter(s): Jennifer Bowman**

Discussion	• Five performance measures need to go to Sec. Cohen and she selects up to three; mental health and substance use measures. • Housing longevity through TCLI. • Adherence to medication anti-psychotics. • Diabetic follow up. • Follow-up measure post mobile crisis. • Follow up after discharge for hospital and/or facilities: 1-7 days, 1-30 days post discharge. Measure at the state level so there is consistency across the LME/MCO's. • John D. wants to know if this will bring case management back as this would be vital in tackling social determinates. The statistics will be compared to state-wide averages. Where do the LME/MCO's fall in historical data? The 7 days is in the contract, but the 30 days follow up is not. Early intervention or prevention to go through the other steps? Is that information available? • Jennifer B. stated that there is not a direct claim to early intervention to prevention, and it is difficult to catch such information. Jennifer B. asked that people continue to check the web page/reports page, and they will continue to update the information. • The plan started for the integration began for QM? MANANT group came in with QM and there will be follow up to discuss metric change after the start of the year. • Brandon T. is interested in Peer services and does QM have any movement with PSS? Jennifer B. stated they look at claims numbers and leave PSS to the LME/MCO.

	• Jennifer B. can give data information to the group on all seven LME/MCO's reports. How do they manage quality for DD/TBI? There is a person who is specific to data and quality for DD/TBI. How is TBI/innovations quantified? Jennifer B. stated diagnosis codes are utilized. The TBI population is observed versus separating TBI before age 21 or a TBI diagnoses given after age 21. • Martha B. wants to know how QM section works? Jenifer B. - data request and substance matter experts who want to know more. Different populations. Statistical analysis. Eight people into Quality and two in Behavioral Health Crisis.		
Conclusions	•		
Action Items		**Person(s) Responsible**	**Deadline**
• Jenifer to send report on how date is given from all 7 LME/MCO			

6. Agenda topic: Addictions and Management Operations **Presenter(s): DeDe Serevino**

Discussion	See attachment of Slide presentation •		
Conclusions	•		
Action Items		**Person(s) Responsible**	**Deadline**
•			

7. Agenda topic: Committee reports **Presenter(s): Committee Chairs**

Discussion	• Ron R.: Will draft a new charter. Group will obtain LME/MCO gaps and needs. Brandon W. will get the veterans piece. Group will report to their LME/MCO's and report back together. Come up with an estimate on what it will cost and hand off to another group. What to address as CFAC… • Jean A: LOC meetings at the end of the month. A phone meeting is being planned. They will spend time looking at new legislature members and aides. Background information on legislative members. Pat Porter is a good resource. Louis P. should be invited. • Brandon T. wants to present proposal to Kody about receiving a budget and about sending SCFAC members out into conferences and community. Suggestion was made that Brandon T. present proposal to group and then vote on whether to submit proposal. • Martha B. suggested further conversations on a Legislative Event and what CFAC is to the legislators as well as joining when other events occur (breakfast). The group felt that both the breakfast and ~~Advocacy day~~ the Legislative Event was a good idea and since the breakfast is coming up soon, to move forward with the breakfast. • Mark F. discussed doing a survey with local CFACs on how the SCFAC can help them. Pull off the Statewide Collaborative CFAC meeting next year. Sandhills is working on the collaborative. Suzanne T. will follow up with Ann Kimball and follow up with Mark F. • Jonathan E. requested a standard procedure/form for local CFACs to reach out to SCFAC for assistance. • **Motion**: Lori R. made a motion to adjourn the meeting; Ron R. 2nd motion.		
Conclusions	•		
Action Items		**Person(s) Responsible**	**Deadline**
• Ron R. to draft charter for the new committee • Brandon W. will be working on the Veterans part of the charter		• Ron Rau • Brandon W.	• 12/18 • 12/18

• Brandon T. to present proposal of budget for committee vote • Martha B. and Benita P. to work on the Leg. Breakfast • Mark F. to develop survey concerning LCFAC interaction with SCFAC • Suzanne T. follow up with Sandhills concerning Statewide CFAC collaborative • Develop a standard procedure form for Local CFAC to communicate with SCFAC	• Brandon T. • Martha and Benita • Mark F. • Suzanne T • SCFAC	• 12/18 • 1/19 • 1/19 • 1/19 • 1/19

Meeting Adjourned
Next Meeting: December 12, 2018
Approved 1/9/2019

NC Department of Health and Human Services

SCFAC Roles and Responsibilities

Suzanne Thompson

Community Engagement & Empowerment Team Leader

November 14, 2018

What is the State Consumer and Family Advisory Committee

- In 2006 N.C.G.S. 122C-171 codified the State Consumer and Family Advisory Committee.
- The State Consumer and Family Advisory Committee (SCFAC) is a self-governing and self-directed organization that advises the Department of Health & Human Services and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

SOURCE:

Who is on the State Consumer and Family Advisory Committee

- **The SCFAC is made up of 21 members. The members must be adult consumer of mental health, developmental disabilities and substance abuse services or family members of consumers of mental health, developmental disabilities and substance abuse services**
- **Terms of services are three years**
- **No individual may serve more than two consecutive terms**

How are SCFAC Members Appointed

- The Secretary of Health and Human Services has 9 appointments. These must represent each of the three disability groups.
- The President ProTempore of the Senate has 3 appointments. One from each region of the state.
- The Speaker of the House has 3 appointments. One from each region of the state.

How are SCFAC Members Appointed

- The Council of Community Programs has 3 appointments. One from each region of the state.
- The NC Association of County Commissioners has 3 appointments. One from each region of the state.

Secretary of Health & Human Service

- Vacancies are posted on the DMH/DD/SAS Website for at least 30 days when there is a vacancy
- Applications are submitted to the Community Engagement & Empowerment Team Staff
- Applications are reviewed to ensure meet the requirements of the statute and vacancy announcement.
- Applications then forwarded to the Secretary's office for selection and appointment.

President Pro Tempore of Senate

- Community Engagement & Empowerment Team staff work directly with staff responsible for these appointments to keep them informed of current and future vacancies
- Community Engagement & Empowerment Team staff distribute notice of vacancy and contact information for staff in the President Pro Tempore's office
- President Pro Tempore and his/her staff make appointments and notify the individual selected

Speaker of the House

- Community Engagement & Empowerment Team staff work directly with staff responsible for these appointments to keep them informed of current and future vacancies
- Community Engagement & Empowerment Team staff distribute notice of vacancy and contact information for staff in the Speaker of the House's office
- Speaker of the House and his/her staff make appointments and notify the individual selected

Council of Community Programs

- Community Engagement & Empowerment Team staff work directly with staff responsible for these appointments to keep them informed of current and future vacancies
- Community Engagement & Empowerment Team staff distribute notice of vacancy and contact information for staff in the Council of Community Programs office
- Council of Community Programs staff make appointments and notify the individual selected

NC Association of County Commissioners

- Community Engagement & Empowerment Team staff work directly with staff responsible for these appointments to keep them informed of current and future vacancies
- Community Engagement & Empowerment Team staff distribute notice of vacancy and contact information for staff in the NC Association of County Commissioners office
- NC Association of County Commissioners staff make appointments and notify the individual selected

SCFAC Responsibility

- **Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities an Substance Abuse Services**

SCFAC Responsibility

- **Identify service gaps and underserved populations**

SCFAC Responsibility

- **Make recommendations regarding the service array and monitor the development of additional services**

SCFAC Responsibility

- **Review and comment on the State budget for mental health, developmental disabilities and substance abuse services**

SCFAC Responsibility

- **Participate in all quality improvement measure and performance indicators**

SCFAC Responsibility

- **Receive findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities and substance abuse services**

SCFAC Responsibility

- **Provide technical assistance to local CFACs in implementing their duties**

Secretary Responsibilities

- To provide sufficient staff to assist the SCFAC in implementing its duties
- Assistance shall include
  - data for the identification of service gaps and underserved populations
  - Training to review and comment on the State Plan
  - Training to review and comment on the departmental budget
  - Procedures to allow participation in quality monitoring
  - Technical assistance on rules of procedure and applicable laws

Compensation (NCGS 138-5)

- SCFAC members will receive per diem in the amount of $15 per meeting
- SCFAC members will be reimbursed $.25 per mile to travel to and from the meeting
- Hotel provided for those traveling 100 miles or more
- Dinner reimbursed for those spending the night before the meeting in the hotel
- Lunch provided at the meeting

Accomdations

- **Reasonable accommodations needed for attending meetings will be addressed on an individual basis in accordance with ADA**

Community Engagement & Empowerment Team

- Suzanne Thompson, Team Leader
- Stacey Harward, SCFAC staff support through December 10, 2018
- Kate Barrow, SCFAC staff support effective December 10, 2018
- Wes Rider
- CJ Lewis

NC Department of Health and Human Services

Opioid STR and Other Opioid Initiatives Update

DeDe Severino

Addictions and Management Operations

November 14, 2018

Overview of the Opioid Crisis

How did we get here? Three waves:

- 1991 – increased number of prescriptions for opioids, in part due to marketing as safe and due to increased pressure to more adequately treat pain
    - from 1997 to 2002, Oxycontin prescriptions increased from 670,000 to 6.2 million
    - marketed by Purdue Pharma as safe and non-addicting because of its extended release formulation

SOURCE:

Overview, cont.

- 2010 – rapid increase in deaths due to heroin overdoses, in part due to early efforts to decrease opioid prescribing
  - deaths due to heroin-related overdose increased by 286% from 2002 to 2013
  - approximately 80% of heroin users admitted to misusing prescription opioids first

Overview, cont.

- 2013 - increase in deaths related to synthetic opioids like fentanyl
  - sharpest rise in drug-related deaths occurred in 2016 with over 42,000 opioid overdose deaths, over 20,000 of which were due to fentanyl and fentanyl analogues
  - Declared "public health emergency" in October, 2017

Prevalence

Based on a population estimate for NC of 8,754,236 individuals aged 12 or older, the following totals indicate prevalence of prescription opioid misuse and heroin use, respectively:

	Rx Opioid Use		Heroin Use		
Population Ages 12+	Prevalence	Persons	Prevalence	Persons	Total Persons
8,754,236	4.57%	399,795	0.20%	17,508	417,304

NC Stats

- From 1999 to 2016 more than 12,000 North Carolinians died from opioid-related overdoses
- Nearly 5 people died each day in 2016 from unintentional medication or drug overdoses
- 1683 deaths have been attributed to opioid overdoses in 2017 (to date)
- NC was recently identified as having the 2nd steepest increase in number of deaths in 2017
- 522,933,000 opioid pills were dispensed in 2017 to NC residents

But, the good news is . . .

- Number of ED visits appear to be decreasing slightly
- Although the death rate increased, the rate of increase seems to be slowing
- Opioid prescriptions continue trending downward
  - In the first quarter of 2018, 20% fewer opioid pills were dispensed, just over 110 million, as compared to over 137 million in the first quarter of 2017
  - Some of this can be attributed to the STOP Act, which is legislation that was passed in 2017 that limits the number of opioids that can be prescribed

State Targeted Response to the Opioid Crisis Grant (Opioid STR)

- Section 1003 of the 21st Century Cures Act established an account for a total of $1 billion ($500 million in FY 2017 and $500 million in FY 2018) for prevention, treatment, and other opioid related programming and activities. The activities funded under this grant must supplement the work of the State agency that manages the Substance Abuse Prevention and Treatment Block Grant (SABG).
- NC received $15,586,724 each year for two years, beginning May 1, 2017

Opioid STR, cont.

- Amounts for states were derived from a formula based on unmet need for opioid use disorder treatment and drug poisoning deaths.
- 80% of the funds must be spent for opioid use disorder treatment and recovery support services*
- 5% limit on administrative/infrastructure costs to administer the grant
- Remaining 15% can be used for prevention activities

* This requirement was rescinded for Year 2

Opioid STR, cont.

- These funds are to be used to increase the number of persons served who have an opioid use disorder (cannot supplant)
- Committed to serving approximately 3000 more people over the course of two years

Opioid STR, cont.

- Total number of people served Year 1 = 5744
- Total expenditures = $14,496,107
- Remaining amount carried forward to Year 2
- Analysis of services provided by LME/MCO –
- Spending analysis follows

Opioid STR Year 1 Expenditures - Treatment

Opioid STR/Cures Budgets and Expenditures						
Year 1 as of 07.30. 2018 with ASOUD re-processing						
TREATMENT (no less than 80% of total award)						
	Allocated		Expenditures		% Total Expended	Unexpended
LME/MCO	Non-UCR	UCR	Non-UCR	UCR		
Alliance	$300,000	$1,069,488	$300,000	$1,069,480	100%	$8
Cardinal	$400,000	$3,295,773	$204,759	$3,303,470	95%	$187,544
Eastpointe	$196,531	$400,000	$196,531	$399,994	100%	$6
Partners	$225,000	$1,009,558	$216,743	$1,083,425	105%	-$65,610
Sandhills	$0	$926,042	$0	$926,042	100%	$0
Trillium	$0	$2,462,349	$0	$2,462,349	100%	$0
Vaya	$150,000	$748,867	$146,896	$748,867	100%	$3,104
Contracts*	$1,668,275	$0	$773,149	$0	46%	$895,126
DRUMS - CMS 537170	$0		$160,904	$0		-$160,904
TOTAL	**$2,939,806**	**$9,912,077**	**$1,998,982**	**$9,993,627**	93%	**$859,274**

Opioid STR Year 1 Expenditures - Prevention

PREVENTION						
	Allocated		Expenditures		% Total Expended	Unexpended
LME/MCO	Non-UCR		Non-UCR			
Alliance	$0		$0			$0
Cardinal	$70,000		$70,000		100%	$0
Eastpointe	$865,550		$801,931		93%	$63,619
Partners	$690,744		$665,345		96%	$25,399
Sandhills	$227,264		$223,836		98%	$3,428
Trillium	$330,706		$254,187		77%	$76,519
Vaya	$382,471		$343,533		90%	$38,938
TOTAL	**$2,566,735**		**$2,358,831**		92%	**$207,904**

Opioid STR Year 1 Expenditures – Admin & Totals

ADMINISTRATION (no more than 5% of total award allowed)				
	Allocated	Expenditures	% Total Expended	Unexpended
DMHDDSAS	$158,106	$143,067	90%	$15,039
Evaluator	$10,000	$1,600	16%	$8,400
TOTAL	**$168,106**	**$144,667**	86%	**$23,439**

Summary Totals: Opioid STR

Funds must be expended by 04.30.18

Total Award	**$15,586,724**
Total Allocated	**$15,586,724**
Pending Contracts*	**$0**
Unallocated	**$0**
Total Award	**$15,586,724**
Total Expenditures	**$14,496,107**
Total Unexpended	**$1,090,617**

Opioid STR Year 2 Budgets

Opioid STR/Cures Budgets and Expenditures						
Year 2 as of 10.15.2018						
TREATMENT (no less than 80% of total award)						
	Allocated		Expenditures		% Total Expended	Unexpended
LME/MCO	Non-UCR	UCR	Non-UCR	UCR		
Alliance	$0	$1,525,293	$0	$1,281,690	84%	$243,603
Cardinal	$100,000	$3,128,013	$0	$1,212,711	38%	$2,015,302
Eastpointe	$0	$567,211	$0	$247,933	44%	$319,278
Partners	$100,000	$1,212,066	$0	$624,823	48%	$687,243
Sandhills	$0	$877,718	$0	$436,660	50%	$441,058
Trillium	$0	$2,288,193	$0	$1,212,596	53%	$1,075,597
Vaya	$100,000	$954,669	$0	$597,066	57%	$457,603
Contracts*	$3,268,310	$0	$113,294	$0	3%	$3,155,016
TOTAL	**$3,568,310**	**$10,553,163**	**$113,294**	**$5,613,480**	41%	**$8,394,699**

Opioid STR and State Set-Aside Funds

- Opioid STR Year 2 Services report (through 10.31.18 checkwrite)

State Set-Aside Funds

- $5m appropriation for both SFY 18 and 19 for "substance abuse treatment"
- Allocated from state single stream funds
- Funding provided to LME/MCOs to augment current opioid treatment efforts
- Also awarded 13 community grants of up to $150k each to address strategies in the Opioid Action Plan

State Set-Aside Funds, cont.

Awardees include:

1. Appalachian District Health Dept/Watauga County Sheriff's Dept
2. Appalachian Mountain Community Health Center
3. Bakersville Community Medical Clinic
4. CW Williams Community Health Center
5. Fayetteville Area Health Education Center
6. Haywood Pathways Center
7. Johnston County Health Dept
8. Lumbee Tribe of NC
9. Metropolitan Health Services

10. Public Health Authority of Cabarrus County
11. Scotland County Health Dept
12. Wayne County Health Dept
13. LINC – Leading Into New Communities

- Total award ~ $1.6m
- Initiatives include peer support services and mentoring, rapid response and post-response teams, harm reduction activities, etc.

The Support Act

- STR re-authorized in the Support Act - "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" (P.L. 115-271)
  - bill authorizes $500 million for each of FY 2019 - FY 2021
- Establishes a grant program for emergency rooms to create a protocol to support individuals who have survived an opioid overdose, including having onsite peer recovery coaches.

The Support Act, cont.

- Creates a grant program to establish at least 10 Comprehensive Opioid Recovery Centers (CORCs) throughout the U.S.
- Develop and disseminate best practices for recovery housing
- Student loan repayment for SUD treatment professionals in shortage areas or counties that have been hardest hit by drug overdoses
- Reauthorizes the Office of National Drug Control Policy (ONDCP), as well as the Drug-Free Communities (DFC) and High-Intensity Drug Trafficking Areas (HIDTA) programs

The Support Act, cont.

- Reauthorizes SAMHSA's Residential Treatment for Pregnant and Postpartum Women (PPW) program for FY 2019-FY 2023.
- Temporarily (FY 2019-FY 2023) repeals the IMD exclusion, allowing State Medicaid programs to receive federal reimbursement for up to 30 total days of care in an IMD during a 12-month period for eligible individuals with a substance use disorder
- Adds clinical nurse specialists, certified nurse anesthetists, certified nurse midwifes, and allopathic and osteopathic doctors to the category of qualifying practitioners who can prescribe buprenorphine

State Opioid Response Grant (SOR)

- Authorized under Title II Division H of the Consolidated Appropriations Act of 2018
- Total of one billion dollars each year for 2 years
- Similar to STR grant – allotment based on unmet treatment need and drug poisoning deaths
- NC's allotment for Year 1 is $23,033,316 (over $45m for 2 years)
- Application was submitted 08.13.18, awarded 09.30.18 (will run on FFY)

State Opioid Response Grant (SOR), cont.

- Language is stronger re utilization of MAT; will only allow detox services to be included/covered by these funds IF the individual receives naltrexone (injectable) prior to discharge
- Must address how to improve retention in care
- Requires 2 state level staff – Project Director and a "State Opioid Coordinator" to oversee all federal funding a state receives specific to the opioid crisis

State Opioid Response Grant (SOR), cont.

Required activities include:

- Assess the needs of tribes and include strategies to address such needs
- Implement recovery supports and services
- Implement prevention & education services including training of healthcare professionals
- Cover treatment costs
- Provide treatment transition and coverage for individuals re-entering communities from criminal justice or other rehabilitative settings

State Opioid Response Grant (SOR), cont.

Funding Limitations/Restrictions:

- 5% cap on state level administrative & infrastructure costs
- Up to 2% can be used for data collection & reporting – GPRA required
- Must use FDA approved medications

SOR Budget Year 1

State Opioid Response (SOR) Grant Budget Year 1			
October 1, 2018 - September 30, 2019			
State-Level Administrative & Infrastructure Development Costs - STAFFING			
Position	Salary		Description
Project Director	$	75,000	1 FTE - primary responsibility, designated liaison in & outside the department
State Opioid Coordinator	$	85,000	1 FTE- coordinate all federal funds received to address the opioid crisis
Asst Project Director	$	65,000	1 FTE - oversee specific areas of the grant, primarily special initiatives/pilot projects
Data Analyst	$	65,000	1 FTE assist in claims and data analysis
Data Coordinator	$	120,000	2 FTE - assist providers with GPRA set-up, training, administration, data collection
State-Level Administrative Costs - FRINGES			
FICA	$	31,365	.0765 x 6 FTEs @ $410,000
Retirement	$	77,326	.1886 x 6 FTEs @ $410,000
Insurance	$	36,624	$6104 x 6 FTEs
State-Level Administrative Costs - TRAVEL & OFFICE SUPPLIES			
Grantee Conference	$	1,582	Airfare, hotel, per diem, incidentals x 2 FTEs
Local Travel/Hotel/Per Diem	$	11,674	10,000 miles @.545 per mile, $79.00 x 2 persons x 20 nights, $38.30 x 2 persons x 40 days
General Office Supplies	$	3,600	$50 per month x 12 months x 6 staff
Laptop Computers	$	7,200	$1200 x 6 staff
360 Office Software	$	5,400	$900 x 6 staff
State-Level Infrastructure			
PDMP Module	$	110,000	Narxcare (3 months)
TOTAL STATE-LEVEL ADMIN			**$694,771**
TOTAL ADMINISTRATIVE & INFRASTRUCTURE = $			**(5% allowed = $1,134,974)**
Data Collection, Reporting & Evaluation			
Item	Cost		Description
Evaluator	$	10,000	
FEi-WITS	$	443,990	GPRA
TOTAL DATA COLLECTION, REPORTING & EVALUATION = $			**(2% allowed = $453,990)**
TOTAL CONTRACTUAL COSTS			**$453,990**

SOR Budget Year 1, cont.

Treatment		
Item	Cost	Description
Clinical treatment services	$ 15,000,000	1. Funding to LMEs for MAT; 2000 patients x $625 per month x 12 months
	$ 1,200,000	2. OBOT/OTP Bundled Rate Pilot; 2 OBOT sites @ $225,00 per site, 2 OTP sites @ $375,000 per site (~ 240 participants total)
	$ 400,000	3. DSS-involved Families Pilot; 2 - 3 counties@$400,000 (~75 participants total)
	$ 466,281	4. DPS Initiative
	$ 1,329,994	5. EBCI Proposal
Recovery support services	$ 1,088,280	6. Peer supports and other recovery services
	$ 160,000	7. Oxford House Re-Entry
Provider training	$ 250,000	8. ASAM & MAT training OTP & OBOT staff
TOTAL TREATMENT COSTS		**$ 19,894,555**

SOR Budget Year 1, cont.

Other		
GPRA	$ 500,000	Payments to Providers for GPRA Administration; $200 for all required GPRAs x 2500 participants
TOTAL OTHER		**$500,000**
Prevention		
Item	Cost	Description
Prevention services	$ 1,050,000	Community Naloxone; 14,000 kits
EBCI prevention services	$ 440,000	Components of EBCI proposal; naloxone kits, training, media campaign
TOTAL PREVENTION COSTS		**$ 1,490,000**
TOTAL BUDGET YEAR 1		**$ 23,033,316**

SABG "Mini Plan"

- Updates to the current 2-year plan were due 10.01.18
- Projected allotment for FFY1 is $44,785,489,
- As of 10.01.18, NC can no longer use SABG funds for HIV early intervention services – funds are not "lost"
- 20% prevention requirement is $8,999,329
- Additional questions on SEP services
- Public comment period required