

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
National Advisory Council

March 26, 2020

Open Session Minutes

5600 Fishers Lane
Rockville, Maryland 20857

Open Session Minutes

Opening Remarks and Introductions

The Center for Substance Abuse Treatment (CSAT) National Advisory Council (NAC) Designated Federal Officer (DFO), Tracy Goss, called the 82nd meeting of the CSAT NAC to order at 1:00 p.m., EDT, on March 26, 2020. Ms. Goss conducted a roll call to establish the quorum. Ms. Daryl Kade, Acting Chair, who presided over the meeting, welcomed attendees and thanked staff and guests who agreed to participate. The meeting was conducted virtually.

Ms. Kade began her remarks by acknowledging the 2019 novel coronavirus (COVID-19) public health emergency and thanking attendees for their concern and efforts to deal with the pandemic. She referred listeners to SAMHSA's homepage for COVID-19 guidance. Ms. Kade is currently serving as the Acting Deputy Director of CSAT. Before this position, she served in various leadership positions within SAMHSA, the Director of the Office of Communications (OC), and the Director of the Center for Behavioral Health Statistics and Quality (CBHSQ), the Acting Director of CSAT, and the Director of SAMHSA's Office of Financial Resources (OFR).

Member Introductions and Updates

Council Members in attendance were: Trenette Clark Goings, PhD, LCSW; Jason Howell, MBA, PRS; Sharon LeGore; Judith Martin, MD; Lawrence Medina, MBA; Eva Petoskey, MS; A. Kenison Roy III, MD, DFASAM, DLFAPA; and Kenneth Stoller, MD.

Also in attendance were: Humberto Carvalho, MPH; Neeraj Gandotra, MD; Shelly Hara; Anne Herron; C. Danielle Johnson Byrd, MPH; and Tracy Weymouth.

Ms. Kade asked the Council Members to introduce themselves and provide some background information.

Dr. Trenette Clark Goings introduced herself first. Dr. Goings is an associate professor and behavioral scientist at the University of North Carolina at Chapel Hill. Her work focuses primarily on health disparities with a special focus on substance use prevention, particularly among adolescents and emerging adults of color.

Mr. Jason Howell introduced himself as a person in long-term recovery from mental health conditions and substance use issues. He is Executive Director of RecoveryPeople, a Texas-based nonprofit organization focusing on empowering peers and families in recovery. RecoveryPeople offers training and technical assistance (TTA) programs on leadership development, recovery workforce, and helps build the capacity of services such as recovery housing and recovery high schools. Mr. Howell also serves on the board of the National Alliance for Recovery Residences (NARR) and helps develop recovery housing standards and codes of ethics.

Dr. Judith Martin is an addiction medicine physician and the Medical Director for Substance Use Services for the city and county of San Francisco. The area experienced an increase in methamphetamine- and fentanyl-related overdoses in 2018 and 2019. The city and county instituted a methamphetamine task force with many stakeholders, consumers, and treatment providers to advise the Mayor. The Mayor's top priority was a drug sobering center where people who are experiencing homelessness and use methamphetamine could have professional care during intoxication. This project has been put on hold since the COVID-19 pandemic hit the area. San Francisco is also working on expanding low-threshold buprenorphine in harm reduction settings, including using telehealth. This initiative is also on hold. Dr. Martin said that she appreciates CSAT's support for opioid treatment programs (OTPs) and substance use programs in general regarding the use of the Part 2 exception during emergency and advice about verbal consent when using telehealth. Her agency is working on increasing the telehealth skills of substance use programs.

Ms. Eva Petoskey is the Behavioral Health Division Manager of the Intertribal Council of Michigan, which works with the 12 federally recognized Michigan tribes. Currently, her organization is providing only essential services due to Michigan's shelter-in-place order and adapting to the use of telehealth. Generally, the Behavioral Health Division provides services for people with substance use disorder and mental health services in coordination with the Indian Health Service, Medicaid, other insurance services, and local tribal resources. The division is working on expanding medication assisted treatment (MAT) into tribal areas, particularly rural and remote areas. The division has also been implementing a large naloxone training and distribution initiative.

Mr. Lawrence Medina is with the Rio Grande Alcoholism Treatment Program, which has provided inpatient and outpatient services in rural and frontier areas for more than 40 years. He is also the co-founder of a recovery community organization called Recovery Friendly Taos County. He sits on the Independent Peer Review Committee for the Substance Abuse Block Grant with the New Mexico Behavioral Health Services Division. Mr. Medina described the challenges of dealing with stigma while attempting to open a detox center in a rural area. Some officials have blocked the attempt. He hopes to continue to be an advocate for those suffering from addiction in rural and frontier areas.

Dr. A. Kenison Roy is an associate professor at Tulane University in the Department of Psychiatry in the Division of Addiction Medicine and serves as the training director for the addiction medicine fellowship, which qualifies people to become board certified in the field. He noted that he is new to this position, having previously worked in the private sector, developing treatment programs, and providing direct patient care. Dr. Roy observed that the COVID-19 pandemic had thrown the training program into some disarray, and they are providing direct patient care via videoconference.

Dr. Kenneth Stoller is an addiction psychiatrist and associate professor at Johns Hopkins University School of Medicine. He serves as Director and Medical Director of the Outpatient Addiction Treatment Service at Johns Hopkins Hospital and the Medical Director at another campus. Dr. Stoller's research involves integrated care models, and he created a hub-and-spoke model for buprenorphine treatment in 2009 that brought together substance use disorder programs and primary care sites. He represents Maryland on the Board of Directors of the American Association for the Treatment of Opioid Dependence; also he is a member of the Joint Commission's Behavioral Health Advisory Council and is a member of the practitioner board of NIH's JCOIN initiative, which focuses on opioid use disorder in criminal justice settings. Dr. Stoller discussed the challenges that COVID-19 has brought to his programs—two of the programs' four nurses have tested positive for the disease.

Consideration of the August 21, 2019 Minutes

Ms. Kade called for a motion for approval of the August 21, 2019, minutes for the 81st meeting of the CSAT NAC. A motion was made and seconded and passed without objections or abstentions. The Council then approved the August 21, 2019, minutes.

CSAT Division/Office Director's Update

Ms. Kade turned to a discussion of activities at SAMHSA and CSAT. SAMHSA received \$425 million in additional funding through the COVID-19 stimulus package, with \$250 million for Certified Community Behavioral Health Clinics (CCBHCs), \$50 million for suicide prevention, \$15 million for tribes, and \$100 million for surge (emergency) grants. Few specifics are known as of yet.

Ms. Kade then introduced Shelly Hara, the Acting Director of the Office of Program Analysis and Coordination (OPAC), who provided an update on SAMHSA's budget for FY 2020. SAMHSA received an overall budget of about \$5.9 billion, of which the substance abuse treatment appropriation was \$3.8 billion, or 65 percent of SAMHSA's entire budget and an increase of around \$21 million over the previous year.

Ms. Hara stated that funding was level for the largest programs—the Substance Abuse Prevention and Treatment block grant was level-funded at around \$1.86 billion, and the State Opioid Response Grant Program received \$1.5 billion. CSAT's discretionary grant portfolio with programs of regional and national significance received \$480 million, with some current programs receiving small increases.

CSAT received funding for several new programs authorized in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), including:

- Comprehensive Opioid Recovery Centers Program—This program, funded at \$2 million, is designed to serve individuals with opioid use disorder for whom there is an increasing need for access to coordinated, comprehensive care services, including long-term care and support services utilizing the full range of the Food and Drug Administration (FDA)-approved medications and evidence-based treatments. Applications for this funding opportunity closed on March 17.
- Emergency Department Alternatives to Opioids Demonstration Program—this \$5 million program will provide funding to hospitals and emergency departments (EDs), including freestanding EDs, to develop, implement, enhance, or study alternative pain management protocols and treatments that limit the use and prescribing of opioids. Funds will also be used to train providers and other hospital personnel to provide alternatives to opioids for patients with painful conditions. Applications for this funding opportunity were also due on March 17.

Next, Ms. Kade introduced Danielle Johnson Byrd, Director of the State Opioid Response Program (SOR). The SOR program aims to address the opioid crisis by increasing access to MAT using the three FDA-approved medications, reducing unmet treatment needs, and reducing opioid overdose deaths through the provision of prevention, treatment, and recovery support activities for opioid use disorder. Currently, 57 states and territories are funded for a total of \$1.5 billion, with a 15 percent set-aside for the ten states with the highest overdose mortality rate. The first cohort is 18 months into a 2-year project period.

Initial data collected in the first year of the grant indicates increases in abstinence from alcohol or illegal drugs at six months when compared to the rate at intake; a decrease in criminal justice involvement and arrests; decreases in health, behavioral, and social consequences related to substance use; and increase in social connectedness and housing stability, and increases in the number of individuals employed or in school.

Ms. Byrd shared several success stories resulting from SOR grants:

- Oregon has implemented a Recovery Gym model in which clients in inpatient treatment are taken to the gym to help them develop healthy habits through exercise. Clients can continue to use the gym free of charge once they leave treatment.
- California has developed the TeleWell behavioral program, which provides psychiatric and addiction medicine services using telehealth technology. This program aims to offer high-quality specialty services in rural and other underserved communities.
- The Brien Center Bridge Program in Massachusetts is being expanded to serve individuals experiencing homelessness, those transitioning from the criminal justice system, and overdose patients in EDs.
- In Connecticut, all hospital EDs now have naloxone available for distribution to patients and loved ones upon discharge following overdose or those at risk for an overdose.

Applications for the next round of SOR grants are due on May 19, and \$1.42 billion is available. In addition to treating opioid use disorder, funds may be used to treat stimulant use disorder.

Council Discussion

Following the presentations, Ms. Kade opened the floor to questions and discussion. The following points and questions were raised:

- Dr. Martin commented that she appreciated SAMHSA's emphasis on naloxone. San Francisco has been providing community naloxone since 2003 and, since 2018, there have been more than 1,700 bystander overdose reversals. She continued that there is still a huge racial disparity in overdoses—while African Americans comprise six percent of San Francisco's population, they comprise 35 percent of the population experiencing homelessness and substance use. As well, overdose rates are four times higher among African Americans. Any advice or success stories on dealing with this disparity would be welcomed. Ms. Byrd replied that she would talk to prevention government project officers to gather information about what is working with minority populations.
- Dr. Roy asked about the second round of SOR grants and whether they would be for different applicants. He was also concerned about how telehealth could be used in the treatment of stimulant use. Ms. Byrd stated that there would be no overlap in funding with the second round of SOR grants—the first cohort of grants ends in September, and the next round begins in October. With regard to the use of telehealth in the treatment of stimulant use, there will be technical assistance provided on contingency management, including telehealth issues.
- Dr. Stoller asked where the public can see grantees' activities and innovative practices, along with outcomes data. It would be useful for future applicants and for states and communities looking for how to address substance use disorder. He also inquired whether SAMHSA is pulling together data from different grants to develop guidance on approaches that have been shown to be effective. Ms. Byrd responded that SAMHSA requires all grantees to collect data, which is used to inform grantees of what works and what does not work. Because the SOR grant program is only 18 months old, SAMHSA is currently collecting and analyzing data and will report out on the results when they are complete. She also referred attendees to the Evidence-Based Practices Resource Center. Ms. Kade added that the TTC are also a source for best practices.
- Mr. Howell expressed that he completely supports telehealth. For rural and frontier areas, telehealth is often described as being a major solution. However, many rural areas do not have the broadband infrastructure necessary to be able to use telehealth. Any way SAMHSA can relay to policymakers the need for additional broadband in rural areas would be appreciated. Ms. Kade noted that Mr. Howell's comment would be shared with leadership, and Ms. Byrd added that grantees could use SOR funds to develop infrastructure.

- Dr. Stoller asked to what extent is SAMHSA working with the Department of Agriculture, which is working on building broadband infrastructure in rural areas. Ms. Kade will get the information to Dr. Stoller.

Treatment Improvement Protocol (TIP) 63

Following the council discussion, Ms. Kade introduced Dr. Neeraj Gandotra, the Chief Medical Officer for SAMHSA, who briefed the council members on *TIP 63: Medications for Opioid Use Disorder*, which is currently being updated to incorporate some necessary changes.

SAMHSA wished to ensure the content of the TIP was up to date and as useful to readers as possible. The update, begun in January 2020, will help provide readers with the latest information needed to understand medications for opioid use disorder. Revisions include:

- Updating statistics from SAMHSA, the Centers for Disease Control and Prevention (CDC), and other health authorities on opioid-related deaths, overdoses, accidents, and hospitalizations.
- Updating the expanded list of qualifying practitioners who are eligible to apply for the waiver to prescribe buprenorphine, including clinical nurse specialists, certified registered nurse anesthetists, and certified nurse-midwives.
- Clarifying the different formulations of buprenorphine available, including an extended-release injection formulation, and adding information about subdermal formulations.
- Adding information about clinical interactions between different formulations of buprenorphine and naloxone with other medications and products, including those for treatment of human immunodeficiency virus (HIV) and hepatitis C.
- Incorporating US Preventive Services Task Force (USPSTF) guidance on performing drug and alcohol screening in primary care settings.
- Checking and rechecking the hyperlinks to online resources.

The revised TIP 63 will include data from the 2018 National Survey on Drug Use and Health (NSDUH), which found that almost 2 million people aged 12 and older had opioid use disorder, and that opioid-related inpatient hospital stays increased by almost 117 percent from 2005 to 2016. Opioids killed more than 47,000 people in 2017, more than in any prior year. Of those deaths, more than one-third involved prescription opioids. These numbers may be trending downward, as they decreased in 2019.

The TIP will also include information on comorbidities, particularly comorbidity with alcohol use disorder. The USPSTF recommends screening adults for alcohol misuse, including risky drinking and alcohol use disorder, and recommends brief counseling for patients with risky drinking. Providers should warn patients who use opioids that alcohol may increase opioid overdose risk.

As noted, the TIP will include the expanded list of health care professionals who are eligible for buprenorphine waiver training and who are eligible after one year to go to the limit of 275 patients. The TIP will also emphasize the importance of testing patients entering buprenorphine or methadone treatment for hepatitis and HIV. Hepatitis B and C are common among patients entering buprenorphine treatment. CDC recommends hepatitis B vaccinations for individuals seeking substance use treatment.

Ms. Kade then introduced Tracy Weymouth, Director of the Division of Pharmacologic Therapies, who provided an update on the OTPs/ Drug Addiction Treatment Act (DATA) Waiver program. Ms. Weymouth began by sharing information on addressing COVID-19 in OTPs. SAMHSA guidance in response to COVID-19 allows the states to assess and develop a plan based on their needs, regulations, and other factors that will help them determine the most appropriate response to meeting patient needs. Resources for states and MAT providers have been posted on the SAMHSA website, including information about telehealth, disaster planning, and Drug Enforcement Agency (DEA) guidance.

Ms. Weymouth next turned to the buprenorphine DATA waiver process. Since the inception of the project, the DATA waiver has gone through five legislative acts. The 2016 Comprehensive Addiction and Recovery Act allowed physicians to increase to the 275 patient waiver limit, providing the physician had their 100-patient waiver limit for one year and allowed nurse practitioners and physician assistants to apply for the initial waiver level of 30 patients.

The 2019 SUPPORT Act expanded the ability of certain practitioners (medical doctors and other qualifying specialists) to treat up to 100 patients in the first year of waiver receipt provided they held a board certification in addiction medicine or addiction psychiatry or provided MAT in a qualified practice setting. The SUPPORT Act also added three new nurse specialties.

As of March 7, there were 45,826 DATA waived physicians at the 30-patient limit; 10,930 at the 100-patient limit; and 5,376 at the 275-patient limit. For certified mid-level practitioners, the figures are 15,079; 4,316; and 564, respectively. Barriers that exist for the DATA waivers include the fact that not all 50 states have prescriptive authority for the three new nurse specialties. In addition, some states require collaborative agreements for non-MD's and DOs. Tennessee is the only state that currently does not allow physician assistants to be a prescriber through the DATA waiver.

Council Discussion

Ms. Kade opened the floor to questions and discussion for Ms. Weymouth and Dr. Gandotra. Council members raised the following questions and discussion points:

- Dr. Martin thanked SAMHSA for revising TIP 63 and commented that some people do not perceive the need for treatment or are not willing to undertake it. One reason seems to be the structure of opioid treatment. People experiencing homelessness might not be

able to keep appointments or have been traumatized in some way by the system. San Francisco has been working on a very low threshold buprenorphine and working to be more flexible to reach more people. She asked if this has been discussed by the TIP 63 authors. Dr. Gandotra said that this topic was not within the scope of the TIP 63 revision. He said that barriers to treatment are an issue that the field has become more aware of, but identifying the right solution to those barriers has been difficult. SAMHSA is working with the Health Resources and Services Administration, DEA, and the Office of National Drug Control Policy to identify barriers and devise a plan to address them.

- Dr. Martin asked Ms. Weymouth about clinical pharmacists and whether their ability to provide buprenorphine could be developed. Ms. Weymouth replied that there had been a good deal of interest in expanding the program to that group.
- Dr. Stoller commented that he hoped that attempts to limit the need for training to provide buprenorphine treatment do not advance in Congress. As a member of the Providers Clinical Support System Steering Committee, he has observed that the majority of training completers acknowledge wanting even more training. He also asked when the process and outcomes data from providers at the 275-patient limit will be made available to the public. This data would be likely to ensure that patients receive high-quality care and help drive future policy related to practice limits. Ms. Weymouth responded that SAMHSA does indeed support training. Ms. Weymouth also noted that she would research the availability of data. Dr. Gandotra stated that SAMHSA's position is that substance use disorder is a complicated condition complex enough to require substantial training. Until substance use disorder is better integrated into medical school and professional school curricula, SAMHSA would not support reductions in the amount of training that would be required for a practitioner to dispense buprenorphine.
- Ms. LeGore asked Dr. Gandotra if increases in deaths have accompanied decreases in opioid deaths due to other drugs. Dr. Gandotra acknowledged that there had been an increase in methamphetamine overdoses as well as increases in the overdose of opioids in combination with other medications and illicit substances. He remarked that the block grant funding can be used to treat any substance use disorder and that some of the SOR funding can be utilized in the form of contingency management for stimulant use disorder. Ms. LeGore commented that focusing on one particular drug may lead to a decline in the use of that substance, but there may be increases in the use of other drugs. Ms. LeGore inquired whether it would be possible for SAMHSA to consider developing educational fact sheets on this topic. Dr. Gandotra replied that SAMHSA has a host of fact sheets available at the website and within the Evidence-Based Practices Resource Center.
- Dr. Martin noted that the state of California does not allow people in Drug Medi-Cal treatment to participate in contingency management. The programs that are using this

evidence-based practice are being cited for kickbacks since the kickback rule. This is one of the policy issues California needs to work on.

CSAT Training and Technical Assistance Programs for Providers

Ms. Kade moved to the next presentation, introducing Humberto Carvalho, Public Health Advisor at the Office of Management, Analysis, and Coordination within OFR. He is responsible for several grants and programs focusing on workforce development. Mr. Carvalho provided an overview of SAMHSA's TTC and outlined some of the new resources available during the COVID-19 public health emergency.

Mr. Carvalho began his presentation by noting that SAMHSA has changed its approach toward providing TTA assistance to providers. Formerly, most TTA was provided to grantees via contracts associated with specific grant programs or cohorts. More recently, SAMHSA has changed its approach to be more open such that any provider or entity can access TTA through the SAMHSA website and grantee websites.

Mr. Carvalho turned to the TTC Program, which aims to develop and strengthen the specialized behavioral healthcare and primary healthcare workforce that provides prevention, treatment, and recovery support services for substance use disorder and mental illness. Currently, there are three TTC networks—the Addiction Technology Transfer Centers (ATTC), Mental Health Technology Transfer Centers (MHTTC), and Prevention Technology Transfer Centers (PTTC). Each region has one ATTC, one MHTTC, and one PTTC, as well as a network coordinating office, an American Indian/Alaska Native center, and a Hispanic and Latino center, for a total of 39 centers throughout the country.

TTCs provide TTA through information dissemination, learning events, virtual learning communities, intensive TA, product development, consultation, and TA, and focus pages. The TTC websites are all organized similarly, with tabs across the top of the page to assist with navigation. The ATTC website, for example, includes opioid-specific resources on one specific page titled "Taking Actions to Address Opioid Misuse." It links to educational packages, training curricula and slides, online courses, recorded webinars, and various toolkits, articles, and other materials. There is another page called "Focus on Stimulant Misuse." All trainings are free of charge and provide a certificate after completion.

The TTCs are addressing COVID-19 by making resources available for providers and healthcare workers to support them and developing additional training materials. Each network has a page devoted to COVID-19 that connects with resources from SAMHSA, CDC, and the TTCs. Currently under development is "Telehealth in Drug Courts," a product focused on the application of telehealth in drug courts for increasing access to substance use treatment services. Other resources cover topics such as responding to public health emergencies, psychosocial impacts of disasters, and behavioral health crisis response systems.

The TTC programs run on a 5-year cycle, and there is now outcomes data available for years 1 and 2 of the ATTC program. As of September 30, the end of year 2, the ATTC program had completed more than 2,300 events and served more than 50,800 participants. The three most common training topics were evidence-based practices, reducing stigma, and addressing cultural competence, and reducing health disparities. Participant satisfaction rates have been consistently high.

Additional initiatives include the Rural Opioid Technical Assistance (ROTA) program in collaboration with the Department of Agriculture; the Center of Excellence for Protected Health Information, which develops and disseminates resources, training, and TA for states, healthcare providers, school administrators, and individuals to improve understanding of federal privacy laws including FERPA, HIPAA, and 42 CFR Part 2; expansion of practitioner education by integrating substance use disorder education into standard curriculum of relevant education programs; and the 2020 National Peer-run Training and TA Center for Addiction Recovery Peer Support, which is a new grant program that will begin in August 2020. Recipients will provide TTA for recovery community organizations and peer support networks.

Report from the Regional Administrators Regarding COVID-19

Ms. Kade next introduced Anne Herron, Director of the Office of Intergovernmental and External Affairs, who gave an update from the SAMHSA regional administrators on what they hear on the ground during the COVID-19 crisis. Along with COVID-19, communities are continuing to deal with the opioid crisis and serious mental illness issues. This combination of crises is raising unique challenges for state authorities who are establishing policies and looking to implement flexibilities and regulatory relief for providers. Also, it is a challenge to keep track of the information being released by the federal government and how it affects behavioral health providers.

Regional administrators can hold calls across their state authorities to let states talk to each other about how they are addressing the crisis and the resources they are bringing to bear. There is an increased demand for access to and use of telehealth. SAMHSA sees support from reimbursors, licensing boards, and scope of practice to allow providers to engage in telehealth, which has been a boon for providers and individuals with substance use disorder. SAMHSA also sees increased use of social supports such as Facebook and texting. The SAMHSA website has a tip sheet for virtual recovery supports.

Residential providers are concerned about their current ability to continue their services during the COVID-19 crisis and the future viability of residential programs. Many are experiencing a severe reduction or complete stoppage of individuals appearing for admission. Some residential programs have responded by changing the level of care they offer and turning to an intensive outpatient program model and using telehealth. Some residential programs have considered continuing residential services and requiring COVID testing or adding a quarantine option.

There is great concern about homeless populations. With closures of public spaces such as libraries and community centers, it is difficult to get information to homeless populations about COVID-19. Some communities have implemented mobile sanitizing stations, phone charging stations, and mobile showers to make contact with the populations who are without a place to stay.

Regarding tribal populations, Ms. Herron stated that SAMHSA is hearing from some tribal elders and tribal programs that the virus is bringing up some historical trauma issues, particularly around misinformation, conspiracy theories, or conflicting guidance they may have heard.

Council Discussion

Ms. Kade opened the floor to questions and discussion about the presentations and other issues of concern. The following questions and discussion points were raised:

- Mr. Howell thanked Ms. Herron for her report and commented on feelings of isolation and concern over food security people are experiencing. While many are food insecure, farmers and wholesalers are unable to get their products to market.
- Dr. Martin commented on the challenges surrounding residential treatment, COVID-19, and shelter-in-place orders. Programs are authorizing extensions to residential treatment because of COVID-19 because some clients would otherwise have nowhere to go. Another challenge is the dispensing of medication in case someone is quarantined. There might be instances when there is no authorized person available to dispense medication.
- Ms. LeGore asked about the peer program models that are coming out in 2020 and whether they were just for peer-to-peer recovery supports or if family peer-to-peer support would also be included. Mr. Carvalho replied that the funding announcement was fairly open for the applicants and explained that the program does not fund peer support; rather, it will fund the training of peers and providers who are working with peers to expand their role. He also mentioned another new program that will be funded, a TTA center for the incorporation of family support systems during substance use disorder treatment and mental health treatment.
- Mr. Medina described the difficulties fee-for-service programs are having with regard to cash flow in rural and frontier areas as a result of COVID-19. Has SAMHSA considered this issue and projected the impact? Ms. Herron responded that SAMHSA needs to examine more closely the business model that is being affected.
- Ms. LeGore asked if telehealth services instituted as a result of COVID-19 will be available for use on other issues after the social distancing measures are lifted. Ms. Herron believes that telehealth is going to continue and is moving into the mainstream. It will get more effective over time. Ms. Kade added that there is information on telehealth on the SAMHSA website.
- Dr. Stoller had several comments. First, personnel working in OTPs need personal protective equipment, and he appreciates SAMHSA's efforts to make that happen. Next,

there should be funding for future systems to assist with medication delivery for when patients cannot get to the clinic. Third, Dr. Stoller hopes that the continued loosening of take-home medication and face-to-face restrictions will continue until CDC says the emergency no longer exists. Also, there needs to be a focus on housing for the neediest and vulnerable OTP patients. Last, there is currently a disallowance for conducting an exam via telehealth for people who are to be inducted onto methadone due to safety issues. However, the mandate for the physical exam for methadone induction does not meaningfully increase safety, and OTP personnel must remain safe and minimize their need to see patients in person during the COVID-19 crisis.

- Ms. Petoskey gave a brief update on the current situation in the tribal community in Michigan. Although providers have transitioned to telehealth, there is limited capacity in some instances. Most of the telehealth in her organization is by telephone contact with clients. The limitations on who is eligible to be tested for COVID-19 in Michigan are creating challenges for residential treatment programs, which are unable to test people and, therefore, are closing. The availability of residential care for substance use disorders is diminishing rapidly. Ms. Kade remarked that she would share Ms. Petoskey's comments with the Office of Tribal Affairs and Policy and will try to get more detail on the \$15 million in the stimulus package for tribes.
- Dr. Martin followed up on Dr. Stoller's comments about the in-person requirement for methadone induction. Although there are some situations where an in-person exam would not be necessary, in other cases, it is necessary to ensure safety. However, there are ways to reduce the amount of actual physical contact, even if the person is in the clinic.
- Dr. Roy asked if there was a desire for guidelines for maintaining the ability for people to enter residential treatment and intensive outpatient treatment programs during public health emergencies. Ms. Kade will share his question with leadership and noted that Dr. McCance-Katz has been encouraging the use of intensive outpatient treatment during the COVID-19 crisis.

Public Comment

Ms. Kade opened the floor for public comments. No written submissions for public comments were received. Mr. Medina asked if he could comment.

Mr. Medina stated that eligibility for the FY2020 Recovery Community Service Program grant had been a point of contention for small communities trying to apply. He spoke to the lead for the grant with SAMHSA and expressed his concern that recovery community organizations could play a big part in helping advocate for policy change and support in the area of addiction. He wishes that SAMHSA would look at the Recovery Community Service Program and the network and work on how to get resources to rural and frontier areas. Another eligibility concern is that the boards of directors of recovery community organizations have to have been

running for two years, and the organizations must be nonprofits. It would be more equitable to include funding for capacity building and to look at the eligibility criterion of two years with a board of directors.

There was also a comment from Dr. H. Westley Clark. He encouraged SAMHSA to consider reviving the African American ATTC that was discontinued. SAMHSA has an obligation to deal with populations that struggle with addiction and behavioral health issues from a unique perspective.

Ms. Kade said that she would make SAMHSA leadership aware of both comments.

Recap: Putting It All Together

Ms. Kade thanked the NAC members, CSAT staff, and guests for a productive meeting. She will be sharing highlights and messages with SAMHSA leadership.

Adjournment

There being no further comments or questions, Ms. Kade asked for a motion to adjourn. Mr. Medina moved to adjourn the meeting, and Dr. Roy seconded the motion. Ms. Kade adjourned the meeting at 3:45 p.m.

I certify that to the best of my knowledge, the foregoing minutes are accurate and complete.

Date

Daryl Kade
Acting Deputy Director, Center for Substance Abuse Treatment