VERMONT
DEPARTMENT OF HEALTH

Opioid Settlement Advisory Committee

Date:	12/22/2022
Location and Time:	2-4 p.m. Via Teams
Present:	Caroline Butler, Senator Ruth Hardy, Monica Hutt, Jessica Kirby, Mark Levine, MD, Scott Pavek, Rocket, Representative Dane Whitman, Miro Weinberger, Gwynn Zakov, Cindy Seivwright, David Englander, Traci Sawyers
Absent:	Mayor David Allaire, Chief Shawn Burke, Judge Madeline Motta, Stacey Sigmon, Heather Stein, MD, Deb Wright
Meeting Facilitator and Note Taker:	Mark Levine, and Sarah Gregorek

Meeting Objectives: Third meeting of the Opioid Settlement Advisory Committee		
Agenda Item Welcome and Introductions	**Discussion**	**Next Steps**
Principles for use of funds for opioid litigation from John Hopkins – Mark Levine, MD	https://opioidprinciples.jhsph.edu/wp-content/uploads/2022/02/Opioid-Principles-Doc.pdf The group voted to use these principles to guide the committee and to broaden the title of principle # 4 from Racial Equity to Health Equity.	**Apply these in our decision-making process.**
Mechanics of settlement funding – David Englander	The complexity now is the statute and Vermont did not have an opportunity to comment or amend. Essentially it was model settlement fund language handed down by the administrator of the Fund. While this works fine for creating a long-term funding stream for prevention, going through the annual budget process does not allow for spending a portion of the money sooner or on more urgent matters, like harm reduction, so what we're doing is working with the Office of the Governor as well as the Attorney General's office to see what legal options are available	**As outlined.**

	to us. As well, potentially seeking statutory amendment to the statute so that we can be a little bit more flexible. The current statute requires a stepwise approach in which we would seek recommendations and advice, create a plan that would then go through the budget process and then we could request money from the Administrator. We have gotten signals from the Administrator that they no longer believe that's necessary, so we will seek to expedite that process. No state or territory has sought funds yet. We don't know what the turnaround time is going to be. We hope it is going to be quick.	
Recovery housing – Cynthia Seivwright	Refer to PowerPoint Presentation	
School-based prevention, screening and treatment programs – Traci Sawyers	Refer to PowerPoint Presentation	
Expanding access to and funding for Naloxone and Harm Reduction Packs – David Englander and Mark Levine, MD	It is important that we spend a few moments on naloxone because it is such a primary harm reduction strategy, and it is one that is increasingly more expensive and requiring more support financially. There are a lot of ways to get naloxone out to those who need it, whether it be people who are actually using drugs or people who are associated with them, family members, community members, et cetera.	**Consider as an urgent potentially life preserving harm reduction investment of funds, to be balanced with strategic long-term investments.**

	At the very basic level, if you're actually on a prescription opioid and you meet certain levels of requirement in terms of MME's, there's a Prescriber Rule that sets thresholds for prescribing naloxone at certain dose or if a benzodiazepine is also prescribed. There are also opportunities, of course, to go into a pharmacy and get it, but that's an expensive option for many people, it might require reimbursement through their insurance. Certainly, a lot of work that goes on at the level of the health department and all of the people that we partner within the treatment community and the recovery community to ensure access. And in the EMS community, who are often first responders to nonfatal overdoses, many of whom may not want to be transported anywhere once they've been resuscitated. There's a whole host of novel ways to try to have this in the environment that Vermont is probably at an early adopter phase in, but not yet that prevalent. One is through vending machines. These are machines that a person has to have an access code to obtain what usually isn't just naloxone, it's often in the form of a harm reduction pack. Rhode Island has been, a leader in this. And through our meetings in the Northeast region, we are getting more and more interested, but we only have perhaps 1 machine in the whole state. That is a possible pathway for increasing Naloxone. Oher opportunities are home delivery, mail order, or the Naloxbox present in a place where people gather, you could imagine potentially in a library. Libraries have actually been in	

	the news at times as places people with opioid use disorder frequent. So, there's abundant, current and innovative and probably even more creative ways to have naloxone as available as possible. We can use settlement monies to start to work our way towards a more optimal naloxone situation. Some time-honored, effective strategies still need to be financed on even larger levels. By way of background, in 2013, the legislature passed a Good Samaritan law that allowed anybody to administer Narcan and provided liability protection for them. In 2015, the legislature passed a law that allowed pharmacists to prescribe Narcan, on their own behalf. It didn't need a doctor's order. At the same time. we raised the manufacturers fees to cover these costs. The fee comes from a fee on all drugs that our Medicaid entity purchases and that goes into a fund that has several allowable uses including the purchase and distribution of the Naloxone. Our financial needs have changed because in the beginning, only community-based organizations we're handing it out to the community. Today VDH also provides Naloxone to law enforcement, EMS and more entities are asking, including schools and libraries. It's important to know that any person can get it from a community organization for free. They can walk into a pharmacy, and it will be paid for by any private entity, as well as Medicaid. All covering entities will pay for 6 doses in any given	

	month without prior authorization. A person without insurance can get it at no cost from a qualified community organization.	
Contingency Management as a treatment for Stimulant use disorder	We've gotten some news from Dr. Rawson and that his Internet connection is unstable. He's going to present at the next meeting. He will talk about contingency management for stimulant use, which is the only real evidence-based management strategy for that but it's especially impactful because we see an increasing percentage of our opioid overdose deaths in people who have stimulants and an opioid, usually stimulant plus fentanyl. And the stimulant is more often cocaine then meth, but both are present. I'm of the belief that there are many people who are not choosing to buy the two together because that is a cocktail that some would endorse as part of their lifestyle. But they're thinking they're buying stimulant medication but getting fentanyl and they don't have the tolerance and the dose of fentanyl is pretty potent and they become a statistic. We are seeing increased simulants involved in opioid overdose fatalities because of the increased amount of fentanyl in all illicit drugs. An alternative explanation is the opioids are not mixed with stimulants, but the stimulants are being taken independently, in an attempt to counter the deleterious effects of fentanyl. Both explanations have significant policy implications.	
Public Input	Ed Baker – Concerned about innovative harm reduction measures not being presented on or discussed at the meetings,	

	and that preventing immediate death does not appear to be a priority. Alex Figueroa – Discussed priorities of recovery housing, rural access to MOUD, overcoming barriers to equitable detox. David Koeninger – Advocated for embedding lawyers into Hubs.	
Closing Comments	Next meeting A. Complete final presentations on: 1. Contingency management as a treatment for stimulant Use Disorder 2. Treatment courts B. Begin to focus on recommendation or initial funds.	
Next Meeting:	February 13, 2023, 3 – 4:30 p.m.	