VERMONT
DEPARTMENT OF HEALTH

Opioid Settlement Advisory Committee

Date:	2/24/2025
Location and Time:	10 - noon
Present:	Mark Levine, MD, Shawn Burke, Caroline Butler, Ruth Hardy, Monica Hutt, Liz McLoughlin, Jess Kirby, Deb Wright, Joe Magee, Stacey Sigmon
Absent:	Kristin Atwood, Michael Doenges, Madeline Motta, Scott Pavek, Heather Stein, MD
Meeting Facilitator and Note Taker:	Mark Levine, MD, Sarah Gregorek

Meeting Objectives:		
Agenda Item	**Discussion**	**Next Steps**
Advisory Committee members terms Lauren Layman	Every member of the committee except Monica Hutt and Mark Levine has a term limit of three or four years and the statute says that of the first appointed members, eight shall be appointed for terms of three years and eight shall be appointed for terms of four years. But it doesn't say how that's determined. The three-year term will end August 2025 and the four year term will end August, 2026. So, the question before the committee is how you want to determine which eight will be members for three years and which eight shall be members for four years? After we determine who has a three- or four-year term, in the future, everyone will have a four-year term, and the statute doesn't prohibit reappointment; it says all members shall hold office for the term of their appointments and until a successor has been appointed. You can discuss this now and decide or take this information back to your appointing authority and have them help you with determining the best approach.	OSAC Bill Sarah will send the committee the bill language and ask them to discuss it with the appointing authority and we will revisit this at a future meeting.
Sackler Settlement update Dr. Levine	Vermont will receive a onetime payment of $22 million as part of the Sackler settlement as opposed to what was previously thought to be the settlement before it reached the Supreme Court, which was going to be a monetary amount over 18 years. that was going to be $3,000,000 per year or $54 million.	

	Our Financial Division watches this money closely and there's certainly nothing that's yet been deposited into the treasury that we can spend, so this is all the money that will eventually show up and will be included in the deliberations for the next go around. So there'll be a large pot for the next go around and a lot of important decision making will need to occur regarding strategies for how that will work.	
Opioid Settlement Funding Bill Dr. Levine	The funding recommendation letters from both the committee and from the Department of Health have been sent to the relevant legislative committees which include both Appropriations Committees, Senate Health and Welfare, and House Human Services. The Governor has seen them as well. Jess Kirby and I testified on 2/18/25 in the House Human Services committee and it was mostly a process checking session making sure that the operations of the committee were going well and that we had a process outlined. The committee was quite satisfied and pleased with what we had to say. We outlined what the committee had done over the course of the year, which was we had, as you recall, several process related meetings and during those meetings, we really hammered down exactly what we would do with regard to things like recusal, how we would as a committee make decisions on the various proposals that came in and eventually how we would send the two sets of letters that I mentioned. The Governor suggested the recommendations be packaged as a separate bill and not simply added to the budget bill as line items, to allow for more comprehensive discussion of them. This bill now has legislative sponsors. The first testimony is this week.	Draft Opioid Settlement Funding Bills: S.77 S-0077 As Introduced.pdf H.218 Bill Status H.218
Osher Collaborative Comprehensive Pain Program Dr. Levine	There are two attachments posted on our web site for today's meeting for your review, they are publications related to the Comprehensive Pain Clinic, that is a potential future presentation. This is a program that I'm a big supporter of, called the Comprehensive Pain Program at the University of Vermont. For those who know the history with the opioid crisis, stage one was due to prescription pain medication leading to people becoming addicted to narcotics, followed by going down the heroin pathway as that proved to	

	be less expensive and less challenging to obtain than prescription opioids. Now in current times individuals often go directly to fentanyl and now the polypharmacy stimulant arena. The prescription pathway, though originally the initial pathway, now accounts for a much smaller percentage of those with SUD The perception and indeed the evidence has been that pharmaceutical companies as well as distributors were cultivating this atmosphere of prescriptions and prescription narcotics are good for you; we don't use them enough; physicians aren't treating pain rigorously enough; so while we still see people coming through that pathway, clearly it is not the leading pathway anymore. And this is why we now have opioid settlement monies to work with. The reason for the Comprehensive Pain Clinic is to address this very important issue of chronic pain, which is addressed very poorly by chronic narcotic use. It's a multi-modality approach to treatment of pain using a whole host of complementary-alternative- integrative medicine modalities. Some of which are more physical, like acupuncture, chiropractic, Reiki, massage and the list goes on. And it's a very vast enterprise, a large menu of options for individuals going into this program. At the very earliest inception, the program was led by people with insurance (BCBS) who could afford to have insurance, which agreed to put them through the program. More recently, there's been a Medicaid pilot which is in process. The hope is to convert to just more standard care with the Medicaid program to allow people who didn't have regular third-party insurance or employer support. It is important for insurers to participate as well, and the literature that was provided to you gives an early glimpse at some of the results. There's a fair amount of literature out there now supporting this and it's a large-scale operation which requires a lot of coordination and a large multidisciplinary team which has been going on in Vermont for six years, starting with Blue Cross Blue Shield and moving on to Medicaid. This program is part of the Osher Center at the University of Vermont and the Osher Centers around the country. There are ten of them that are partnered together in the US, along with Sweden and now want to replicate this through other Osher Centers.	

	They're starting to explore how to support this approach in other states that have Osher Centers besides Vermont and the ten others, and they're trying to build and expand on this approach and get more into these communities. They have interested partners including University of Wisconsin, Harvard, Vanderbilt, University of Washington and they hope there'll be University of Miami, Northwestern, and UCSF. The goal is pursuing a multi-site evaluation and hopefully funded research as part of the partnership. Drs. Josh Plavin and Jon Porter have asked to present to our committee an outline of the approach and the research they have done to date and educate us; they're not really wanting to make a specific proposal at this time, but this would be a potential path depending upon how it's received by our committee regarding further expansion of their activity. The goal here is to decide if we want to hear this as a proposal or at least hear this as an educational program for us to benefit from. That could potentially become a proposal. Is this something the committee would like to learn more about? The committee agreed that they would be willing to hear about this program at a future meeting.	
Brainstorming regarding future innovation areas to fuel the RFP process Dr. Levine	What topics of interest and proposals do we want to hear about for the next round of funding? The part of our treatment program that doesn't get a lot of airtime, is the residential treatment. Knowing that such a huge proportion of people go into the hub and spoke at whatever level of care they need but that's an outpatient directed program. There's still 1/4 of the people in the state who are going into treatment, who do go into an inpatient setting like a residential treatment facility and so we analyzed gaps in in the Vermont landscape and especially looked at our justice involved population.	

	It really was evident that we could probably shore up and enhance parts of the residential treatment experience. The second bucket that I identified is harm reduction and this is something I think Senator Hardy brought up along with Scott Pavak 18 months – two years ago. There are programs where you can call in while you're going to be actively injecting a drug and just make sure that someone's there on the other end of the line checking on you so that if something untoward happens but you're alone and there's no one to rescue you, there's a mechanism in place to get help. That mechanism also can double as sort of a resource for you if you're interested in other things like connecting to treatment, but it's mainly meant to be a lifesaving intervention when it needs to be used. We didn't receive any proposals in that arena this time around. I would say that having an overdose prevention center is not the answer to that, there are still plenty of people who use and unfortunately die because they were alone at the time often at home or in a setting where no one knew where they were. There are things happening in that arena that the Department of Health is interested in and working with other firms that do these kinds of things, but we have nothing really to augment the activities and harm reduction that we do today, so this is an area to me that's still open for further creativity and innovation and use of settlement monies. Now I just named one thing a phone related kind of service, but that that's not to exclude from the umbrella anything in harm reduction that is practical, creative, innovative and really will work for people because harm reduction I regard as an area that's always ripe for innovation and trying to help people as much as we can in a user friendly way that's acceptable to them and that they would embrace. Senator Hardy I'm personally interested in expanding two proposals: 1. The domestic violence prevention program in the Northeast Kingdom was really interesting and I would love to see that statewide. 2. Youth center programs in every region of the state Using our past funded programs as incubators and then can we branch out and do it more holistically?	

	Use of the municipal opioid settlement funds. The larger municipalities in Vermont that get funds directly from the settlement and don't come through the state and some of those municipalities are using those funds. A lot of them are giving them to the organizations in their communities that are working on these issues but some of them are not using the funds, in part because I think they don't know how to use the funds, and they're sort of banking them and waiting to figure it out. And some of these are very small amounts of money, but some are adding up to being enough money to actually do something with and I think it would be really helpful if we coordinated a little better with these local municipalities that are getting the money so that if we're funding something in their community or we don't have enough money to fund something in their community, but we've heard a really good idea that we help the municipalities use, help them with the knowledge that we've gained through this process. Liz McLoughlin Brattleboro is very eager to have increased length of stay, especially increased residential treatment. They see that as a very significant impediment to the treatment of people in our community and regarding the transition, there's a real need for sober living in our community. She'd like to see proposals that meet that need. Deb Wright mentioned that she sees many people in her community rotating in and out of residential treatment. There needs to be another level of care after being at a very high level of clinically supervised withdrawal management which include individual counseling, group counseling and life skills.	
Public Comment	None	
Next Meeting	TBD There does not appear to be reason to hold a meeting in March.	