Benchmarks of Success for Maryland's Workforce System
WIOA Policy Work Group
1:45 – 3:45 PM, May 22, 2018
Video Hubs: DLLR and Columbia AJC
1100 N. Eutaw Street, Baltimore, MD 21201
7161 Columbia Gateway Drive, Columbia, MD 21046

Attendees: Erin Roth, Francine Trout, Sarah Hoyt, Christine Gentry, Bruce England, Charles Hunt, Jacqueline (Tina) Turner, Lauren Gilwee, Lloyd Day, Mary Sloat, Matthew Bernardy, Sara Muempfer, Sarah Sheppard, Shamekka Kuykendall, Wesley Wilson, and Natalie Clements

Handouts:

- Agenda;
- BHA-Funded & Operational Recovery Community Centers;
- 2018 Opioid Operational Command Center Executive Brief;
- Brief Primer on Methadone, Buprenorphine, and Naltrexone in the Treatment of Opioid Use Disorder;
- Medication-Assisted Treatment for Opioid Addiction;
- Public Policy Statement: Definition of Addiction (Long Version); and
- "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health" Executive Summary

Minutes

I. Housekeeping

A. Debrief on Chair/Co-Chair meeting with the WIOA Alignment Group

- As of last month, the committee Chairs, Co-Chairs, and Coordinators had their first monthly meeting with the WIOA Alignment Group.
- The meeting allows for committees to share opportunities for collaboration (e.g. the WIOA Policy Work Group will talk about Measurable Skill Grains and credentials; the Data and Dashboard Committee is interested in defining these terms for the system, and the Professional Development and Technical Assistance Committee can conduct training on how these items are captured and measured).
- The Chair and Co-Chair of this work group will regularly share updates from their meetings with the other committees and WIOA Alignment Group.
- The Communications Committee will create a newsletter for the *Benchmarks of Success* using information from the committees' meetings with the WIOA Alignment Group.

B. Local and Regional Planning Guidance

- DLLR submitted the WIOA State Plan to the federal partners and is now hearing back about follow-up questions and revisions. The plan will be approved by June 30, 2018 at the latest.
- Once the State Plan is approved, then DLLR will release the updated Local and Regional Planning Guidance, with prompts for Local Workforce Development Areas and WIOA Regions to answer in their workforce plans.

- The WIOA Policy Work Group will lead the coordinated effort to update the Local and Regional Planning Guidance (e.g. Local Areas and Regions should answer prompts specific to implementing the *Benchmarks of Success*).
- Work group members are asked to start thinking about what should be added, removed, changed, etc. in the planning guidance and to stay tuned for more information on this front.
- The plan is to issue the guidance this summer.

C. Policy Recommendations Report

- The Policy Recommendations Report is this work group's main deliverable for the year. It will go to the WIOA Alignment Group and the Executive Steering Committee.
- The report will outline what topics the work group explored and how the *Benchmarks of Success* can be implemented.
- A big piece of implementing the *Benchmarks of Success* is strategic partnering with entities that we might not typically think of as immediate "workforce partners." Today, the work group is joined by representatives of the Maryland Department of Health (MDH) and the Opioid Operational Command Center (OOCC).

D. Surveys on Policy Recommendations

- The WIOA Policy Work Group's first meeting served as an introduction to the *Benchmarks of Success*; the second meeting was a brainstorming session for members to think about all of the topics that they would like to focus on. The third meeting was the work group's first deep dive into a topic, customer voice and Jobseeker Advisory Groups, and the group was joined by Annie E. Casey Foundation consultants to speak on the topic.
- As a follow-up to the third meeting, Natalie Clements shared a survey for policy recommendations (which will serve as a template for future surveys), and members were asked to vote on which recommendations they would like to include in the Policy Recommendations Report.
- The survey template will be altered to include a ranking system for policy recommendations moving forward.

II. Debrief on Jobseeker Advisory Groups Survey

- On the survey, and based on the previous meeting discussion, we provided the group with the option to select up to 7 policy recommendations related to Jobseeker Advisory Groups (along with one write-in option). Based off of the results, the work group will lift about half of them into the Policy Recommendations Report.
- Based on the survey results, it seems that the work group should move to recommend the following in the end of year report:
    - Include customers in decision making by establishing local Job Seeker Advisory Groups or focus group(s).
    - Recognize that community advisory groups must have a real impact or source of power. Their contribution must go towards change, or there is no benefit/incentive for participation and no enhancement of the system. If there is no decision-making power, than these forums can do unintentional harm.
    - Jobseeker advisory focus groups require intentional recruiting to get the right people to the table, not just the people that the system is already comfortable with. This requires going to the community.
    - Hold jobseeker advisory meetings at times that are convenient to participants.

III. The Opioid Crisis in Maryland

A. How does this connect to the *Benchmarks of Success*?

- The *Benchmarks of Success* initiative hinges on a vision, shared by the WIOA system partners, to work together to increase the earning capacity of Marylanders by working towards five strategic goals, including increasing access to employment, skills and credentialing, life management skills, and supportive services.
- The fourth strategic goal is about eliminating barriers to employment. The direct connection to this presentation is the Benchmark where we focus on supporting customers in getting support with substance use disorders.

However, it is not uncommon for individuals that need substance use services to also have co-existing barriers. For example, an individual that suffers from substance use disorder may also need mental health services, physical health services, housing services, child care services, transportation services, custodial parent child support services, criminal background services, domestic violence services, or food and energy services.

- Additionally, the last strategic goal under our *Benchmarks of Success* initiative is to strengthen and enhance the effectiveness and efficiency of Maryland's workforce system. This goal requires the breaking down of silos, and for agencies that have not traditionally worked in the same sector to collaborate, to efficiently use resources and serve Marylanders.

B. Presentation and Discussion by Sarah Hoyt (*Opioid Response Program Manager, Maryland Department of Health*) and Christine Gentry (*Chief of Planning, Opioid Operational Command Center*)

- Background on the opioid epidemic in Maryland:
  - In 2016, 115 people died every day from opioid-overdose related deaths in Maryland. Six people will die today from an opioid overdose today in Maryland.
  - "Opioids" refer to a range of drugs, some legally prescribed and others illegal. Many people do not realize that their prescriptions are opioids. Examples of prescribed opioids include: codeine, hydrocodone, oxycodone, hydromorphone, morphine, propoxyphene, fentanyl, and methadone. There are legal and illegal paths to opioid substance abuse. All of these paths can lead to overdose.
  - The rise of opioid use can be contributed to three waves:
    - In the 1990s, there was an increase in doctors prescribing legal opioids for pain management.
    - In the early 2000s, there was easy access to heroin on the streets.
    - In 2013, there was a flood of fentanyl in this country; much of it coming from oversees. Fentanyl is more potent than morphine with a greater number of agonists.
  - From a workforce perspective, the opioid epidemic leads to decreased productivity. This is a health epidemic that requires collaboration and increased resources to combat. This epidemic impacts every sector, both public and private, and is ongoing with increasing indicators.
- Background on the Opioid Operational Command Center (OOCC):
  - In 2015, Governor Hogan stood up the Inter-Agency Heroin and Opioid Coordinating Council and the Heroin and Opioid Emergency Task Force to explore how the state can combat the opioid overdose epidemic. The Task Force wrote 33 recommendations, ranging from increased access to treatment to greater enforcement measures. These recommendations are the foundation of Maryland's statewide response.
  - In 2017, the Task Force recommended creating the Opioid Operational Command Center (OOCC) to coordinate statewide response. The OOCC is made up of state agencies and local level Opioid Intervention Teams (OITs).
  - There is an OIT in every jurisdiction of the state. They are led by the local Health Officer and the Emergency Manager. Other than those two partners, the OIT structure differs by jurisdiction.
  - The OOCC has four goals, based on Maryland Department of Health's (MDH's) priorities, modeled after the public health tertiary prevention models. In this model, prevention is key. The goals center around preventing individuals from becoming addicted, early intervention for those that are addicted, treatment (connect to resources), and data collection (evidence-based practices). These goals share similarities with those of the *Benchmarks of Success*.
  - The OOCC is the management body that identifies and addresses gaps, working closely with subject matter experts.
  - ***Possible policy recommendation: Connect the OITs (and Recovery Community Centers) to the Local Workforce Development Area Directors in an intentional manner.***
  - When the OOCC partnership was first built-out, it focused on the 14 agencies that were essential from the perspective of emergency footing. Now, the OOCC is building out the definition of "state of emergency" for its second phase, to include long-term management. Now, DLLR is involved and has participated in two OOCC meetings to date.

- How does one make recovery an option? This theme of how to support active recovery is magnified by MDH, providers, and partner agencies. Recovery requires an individual to make huge life changes, to recognize unhealthy choices in their life and to actively choose to modify behaviors.
- Maryland has various levels of treatment in place, including federal grant dollars coming in to build out support and to create structures and high standards of treatment. However, there is a workforce shortage of clinical staff to work in these centers. How can Maryland attract younger workers to these careers? Are there Registered Apprenticeship programs or pathways programs that can be put in place? ***Possible policy recommendation: Collaborate with OOCC and MDH to identify occupational hiring needs (i.e., occupation and requisite skill sets, educational levels, certifications, and potential barriers) related to addressing the opioid epidemic***
- There are currently 21 MDH's Behavior Health Administration (BHA) funds Recovery Community Centers. BHA would like to increase this number to at least one Recovery Community Centers in every county. Recovery Community Centers provide behavior health services and have certified Peer Recovery Specialists on staff. The BHA oversees the training and licensing process for the certified Peer Recovery Specialists.
    - These peers have been found to be helpful in supporting individuals in maintaining sobriety. However, many peers have a history of substance use themselves (helps with relatability), and working in an environment and with a population that are not as stable in recovery sometimes leads to a high burnout and relapse rate for peers. How can the peers be better supported in these fields?
    - MDH is currently undergoing a study to see if certified Peer Recovery Specialists can have billable hours for insurance, for now they are not billable by individual. Now, peers are paid at an entry level income. This income can be a barrier to attracting new workers to this field. Making those hours billable to insurance may help, if Maryland could get an extension on its existing Medicaid waiver.
    - If an individual were to come into an American Job Center that would be a good fit for training to be a certified Peer Recovery Specialist, how would that connection be made? MDH and DLLR are planning a pilot program to apply for a USDOL grant to cement this connection (DLLR is now collecting letters of commitment from interested parties. Contact DLLR to learn more if interested in supporting the effort). MDH wants to build out systems of recovery support for those who may face chronic under/unemployment and act as the soft-touch, leading the jobseeker through the training and licensing process.
    - The Maryland Workforce Exchange, if not already being used, should be leveraged to post the certified Peer Recovery Specialist jobs. To be effective, the workforce system should determine what other titles an individual with that license may work under in the public and private sector. Then, the labor market information can be pulled together to determine the depth of need for offering training in this profession.
    - A challenge with career progression from the certified Peer Recovery Specialist may be the criminal background barrier.
    - ***Possible policy recommendation: Collaborate with OOCC and MDH to identify a career pathway that might begin with a peer recovery specialist as an entry-point, but would lead to growth opportunities.***
    - ***Possible policy recommendation: Identify existing, in-demand occupations, that the WIOA network already trains individuals for, and consider creating a stackable credential option for those individuals to also gain the Peer Recovery Specialist certification in order to meet demand identified by the OOCC and MDH.***
- Through the OOCC and response to this epidemic, Maryland has built a continuum of care for public health needs. The State recognizes that any public health epidemic cannot be solved in a silo. This creates a comprehensive spectrum of care, where each agency plays a role (e.g. individuals affected in health epidemics may also have workforce needs, housing needs, education needs, etc.).
- ***Possible policy recommendation: Connect the Recovery Community Centers to the American Job Centers. Foster information sharing between the health and workforce agencies at the State and local levels.***
- ***Possible policy recommendation: Leverage existing workforce resources (e.g. EARN, Maryland Business Works, community colleges, and intermediary health-focused organizations like Baltimore Alliance for Careers in Healthcare) to support MDH and OOCC in addressing the opioid epidemic.***
- The healthcare and workforce system need to also focus on prevention, not just recovery. Prevention is heightened when an individual feels stable in their life (e.g. housing, employment, food, support systems). How can Maryland affect those more social aspects of change?
- Medical-Assisted Treatment (MAT) is surrounded by myths and stereotypes. Some employers assume that MAT replaces one addiction with another, leaving workers "nodding off" at work. However, MAT works to treat

withdrawal and curb cravings. If dosed correctly, and if the individual does not continue opioid use, then MAT leads to normal functionality. If an individual is still "nodding off", then they are likely still using opioids.

- MDH strategic planning emphasizes that there are many paths to recovery, not just abstinence.
- MAT medications include methadone, buprenorphine, and naltrexone.
- MDH wondered how can employers be educated about MAT?
- Note: MAT is an accommodation covered under the Americans with Disabilities Act. Termination due to participation in MAT is discrimination.
- Use of MAT is an individual's choice. Drug courts (or alternative forms of judicial diversion programs) do not mandate MAT. MAT is individualized, determined with the physician for the individual's treatment plan. Opioid use disorder is similar to diabetes in the sense that treatment is individualized and fine-tuned in medication and dosage to meet the individual.
- ***Possible policy recommendation: Start a conversation on stigma and break the taboo on the opioid epidemic and MAT. Opioid use disorder affects many Marylanders and, thus, it is common for recovering individuals to support their recovery with MAT. Educate the workforce system on the epidemic and solutions in a way that is digestible. This effort could potentially leverage the support of our colleagues in the Communications Committee and the Professional Development and Technical Assistance Committee.***

- The Department of Social Services have seen TANF recipients showing signs of opioid use disorder who are deemed "work ready" by health providers and are, thus, referred to workforce training. It seems that sometimes individuals have been prematurely signed off as ready to work by a treatment specialist. One possible cause to this problem may be that there is a timeframe limit on how long treatment may exempt an individual from workforce training.
  - For compliance purposes, TANF agencies focus on the Work Participation Rate (WPR), which only allows for medical exemptions to be "countable" for 12 weeks (JBT code = treatment code).
  - ***Possible policy recommendation: In order to stop the cycle of requiring individuals to participate in work activities when they're not ready due to substance use, consider extending the timeframe where a medical exemption is "countable" towards WPR. When a TANF recipient has a substance use disorder, provide a medical exemption to their work activities and require the individual to see an addiction specialist and/or treatment provider in an effort to support their "work readiness."***
  - ***Possible policy recommendation: Foster collaboration between the AJCs, WIOA partners, and health-focused agencies to deepen the workforce system's understanding of MAT, how it supports the recovery process, and how it relates to work readiness.***
- Treatment for opioid use disorder is one aspect of treating the individual, but there are often other underlying conditions, e.g. it is not uncommon for veterans with opioid use disorder to also suffer from Post-Traumatic Stress Disorder.
  - MDH shared that Baltimore City is piloting a "Hub and Spoke model" for treating co-occurring disorders, where customers visit a main hub of trained workers to diagnose mental illnesses; then they go to spokes for specialized treatments.
  - ***Possible policy recommendation: Building on the "hub and spoke model," hold an employment-centric WIOA convening to take the opportunity to link workforce network partners with tangential or periphery 'spoke' organizations, such as agencies focused on health, transportation, etc.***
- If a member of the workforce network wishes to check to see if a treatment and/or education provider is certified, they can check with their local health department, their local OIT, MDH, BHA, or with Sarah Hoyt directly.
- Educational resources include OOCC periodic webinars. The OITs meet with each other and MDH periodically to share best practices.
- ***Possible policy recommendation: Collaborate with OOCC to hold a webinar(s) on the intersection of the opioid epidemic and workforce solutions.***

IV. Next Steps

- Sarah Hoyt and Christine Gentry will share follow-up information on:
  - Information on certified Peer Recovery Specialists, including educational and training requirements, licensing information, wages, MDH's website link/resources, potential barriers (e.g. criminal background?) etc.;

    - Information on the Recovery Community Centers signage (common branding? How do people know to go to these centers for treatment?);
    - Information on where certified Peer Recovery Support programs are necessary geographically across the state and what the workforce needs are for those programs;
    - One-page on MAT that can be used in employer and partner outreach;
    - MDH website link to map of opioid treatment providers; and
    - List of local health department points of contact.
- Natalie Clements will pull the policy recommendations discussed in today's meeting and send out a ranking survey to the work group members. The work group will review the survey results at the next meeting.
- Work Group members should feel free to reach out to Natalie with ideas for future meetings and/or feedback on the video hub meeting set-up.
- The next meeting will take place from 10:00 AM to 12:00 PM, Friday, June 8, 2018 at the DLLR and Columbia AJC video hubs. In this meeting, the work group will be joined by Dr. Lynne Gillie, Assistant State Superintendent for the Maryland State Department of Education's Division of Career and College Readiness and Chris MacLarion, Director of Apprenticeship and Training at DLLR, to share learnings from the state's youth apprenticeship pilots. These presentations on workforce training for high school age students are a starting place for workforce and K-12 connection.