Meeting Minutes
Treatment, Health Systems, and Research Subcommittee of the Governor's Council on Substance Abuse Prevention and Treatment
Wednesday, October 14, 2026, Approved

Attendees:

Subcommittee Members Attending: Dr. Jim Berry, Candace Facemyer, Dr. Deb Koester (chair), Dr. Garrett Moran, Brienne Taylor, Beth Welsh
Invited Subcommittee Members Not Attending: Rebecca Alley, Dr. Thomas Bailey, Shawna Chapman, Dr. Jorge Cortina, Ashli Cottrill, Jennifer Fields, Ken Fitzwater, Heather Jarrett, Constance Harvey, Emalene Heaton, Keith King, Heidi Life, Anita Mallett, Raj Masih, Charles Mullins, Amy Proffitt, Victoria Swain, Josh Titlow, Timothy Watson, Jessica Whitmore, Danielle Woods-Huffman, Lisa Zappia
Office of Drug Control Policy (ODCP) Staff Attending: Jessica Smith
State Opioid Response (SOR) Staff Attending: Mark Lanyon
Marshall University Staff Attending: Bradley McCoy

Opening:

Deb Koester provided welcome and opening remarks of this meeting of the Governor's Council on Substance Abuse Prevention and Treatment – Treatment, Health Systems, and Research Subcommittee. The meeting was called to order on Wednesday, October 14, 2026, and was conducted by Microsoft Teams conference. Deb Koester approved the September 15, 2026 meeting minutes. There was no further discussion. The purpose of the meeting was to discuss the 2027 State Plan draft and priorities.

Agenda:

2027 State Plan Draft

- 2027 State Plan Goals and Strategies are due Monday, November 2, 2026.
- Chairs will present their Goals and Strategies on the November 18, 2026 virtual Governor's Council meeting.
- The final draft of 2027 State Plan with key performance indicators (KPIs) is due Friday, November 20, 2026. A copy of the 2027 State Plan draft is included below before changes were discussed on the meeting.
- Deb Koester shared the thematic analysis from the Town Hall Meeting Summary Report and discussed recommendations and priorities identified for the 2027 State Plan. The Subcommittee discussed the importance of ambulatory services and sober living homes that could dimmish need for rural treatment beds.
- The Subcommittee discussed how to educate providers on comorbidity and continuity in levels of care.
    - The West Virginia University Rockefeller Neuroscience Institute (WVU RNI) is creating an ecosystem of care as a continuity solution. A recovery care coordinator will be the individual who is accountable/responsible for maintaining communication and continuity of care across the PRSS, provider, therapist, case manager, and patient significant other. This position can be filled by a peer or someone who is not a peer. This is under current hiring and implementation.

    - Marshall Health has a similar peer navigator position that partners with Valley Health and the local Coalition for the homeless who follows patients in services across the system of care. They currently follow individuals for six months and after housing placement; however, this time will possibly be extended.
- Deb Koester reviewed the current 2026 State Plan and provided historical context behind it.
- Deb also reviewed a draft 2027 State Plan Draft which will be further revised to incorporate the following discussion:
    - Add a key performance indicators (KPIs) about documenting and sharing existing models for supporting individuals across the system of care. This could include a white paper and/or case studies to document models, a webinar to share the models, and a roundtable to discuss barriers and challenges to developing the models in more communities.
    - Add a KPI about inviting the Youth Subcommittee to provide updates on their work around youth treatment options and transitional youth.
    - Regarding transportation, Dr. Berry shared a new initiative he is developing in collaboration with a faculty member from Eastern Tennessee State University's (ETSU) (Andrea Clements). The program is called "Uplift Appalachia" and focuses on engaging churches and the faith community to address transportation barriers and churches being "addiction ready."
    - Goal 1: Change "Reverse" to "Continue to decrease" the trend of overdose deaths.
    - Goal 1, Strategy 2: Change "investigate" to "explore" and keep the KPI about meeting with Managed Care Organizations (MCOs).
    - In the Plan, integrate and/or emphasize the need for providers trained to provide 'evidence-based' care.
    - Goal 2, Strategy 1: Combined KPIs 5 and 6, and remove KPI 7 because it is covered by others.
    - Goal 2, Strategy 3: Remove.
    - Goal 2, Strategy 5: Update to say 2027

Additional Discussion

- The Subcommittee would like to invite a member of the Primary Care Association (PCA) to be a member of the Subcommittee.
- The Subcommittee discussed how to implement stigma training across the 2027 State Plan and possibly readd the Stigma Subcommittee.

Adjournment:

Deb Koester closed the meeting by thanking all Subcommittee members for their attendance. The Subcommittee will meet again on November 17, 2026 at 1:00 PM.

DRAFT 2027 TREATMENT, HEALTH SYSTEMS, AND RESEARCH

Goal 1: Reverse the trend of overdoses and deaths in West Virginia through early intervention to reduce overdose events, connect people in crisis to care, and assure access to treatment to reduce relapse.

Strategy 1: Strengthen, support, and expand the infrastructure and capacity of Quick Response Teams (QRTs) across the state.

KPI 1: By March 31, 2027, identify elements of fidelity and competency for QRT.
KPI 2: By May 31, 2027, complete development of the white paper on what is needed (above).
KPI 3: By March 31, 2027, develop a 'Community of Practice' (CoP) for all QRTs/PRSSs in the state regardless of their funding source that meets at least quarterly in 2027.
KPI 4: By December 31, 2027, development or modify a QRT toolkit for WV where components include: 1) recommended standardized training/onboarding upon hire; 2) opportunities for experiential learning for new PRSSs to spend time with experienced PRSSs on other QRTs; 3) recommended policies, processes, and procedures for QRT programs including data collection and notification of overdoses in the county/jurisdiction, and 4) billing for PRSS services on QRTs under the 1115 waiver (when possible).

Strategy 2: Continue to investigate the incorporation of digital health tools, such as RPM (remote physiologic monitoring) and RTM (remote therapeutic monitoring), into the available approaches and resources across the state.

KPI 1: By March 31, 2026, document and schedule presentations for updates on existing digital health tools in WV.
KPI 2: By June 30, 2026, if appropriate, meet individually with each managed care organization to identify opportunity for integration/access of digital health tools among their members.
KPI 4: By December 31, 2026, if appropriate, develop strategies to expand availability of digital health tools to at least 500 patients in West Virginia.

Goal 2: Improve access to effective treatment for substance use disorder in outpatient and residential facilities and among all populations.

Strategy 1: Expand technical assistance and support for initial training, ongoing support (programmatic, administrative, and clinical), and sustainability of a statewide Community of Practice on Contingency Management.

KPI 1: By March 31, 2027, define and disseminate elements of fidelity for Contingency Management programs.
KPI 2: By March 31, 2027, develop a Community of Practice for organizations interested in or implementing Contingency Management with the first virtual meeting to be a statewide facilitated panel discussion (i.e., starting new, sustaining, etc.) and virtual meetings held at least quarterly.
KPI 3: Through December 31, 2027, offer periodic virtual meetings (at least quarterly) for administrators to support implementing and sustaining a Contingency Management Program (i.e., regulatory perspectives, incentives, data collection, sustainability, etc.). .
KPI 4: Through December 31, 2027, promote the 'hub and spoke' model for providers using ECHO with a focus on Contingency Management.
KPI 5: By June 30, 2027, explore and document other contingency management models that provide incentive-based and/or value-based payments.
KPI 6: By December 31, 2027, engage payers to explore integration of a incentive-based and/or value-based model in West Virginia.
KPI 7: Through December 31, 2027, explore integration of stimulant use disorders into Contingency Management programs in WV.

Strategy 2: Expand technical assistance and support (programmatic, administrative, and clinical) for organizations operating mobile units to deliver services in rural WV communities.

KPI 1: By January 31, 2027, create an additional map for mobile unit services based on organizational coverage.
KPI 2: By March 31, 2027, develop a Community of Practice for organizations offering mobile unit services that can discuss success and challenges (i.e., connectivity issues) and can share ideas on cost saving strategies.
KPI 3: By December 31, 2027, develop a white paper that seeks to address the return on investment of mobile units and includes, but is not limited to, depreciation and maintenance costs, return on investment based on up front, ongoing, and sustainability costs.

Strategy 3: Increase the number of clinical providers in the state to meet the needs of people needing treatment for substance use disorder.

KPI 1: Through December 31, 2027, continue to educate providers on available loan repayment programs each semester to support clinicians.

Strategy 4: Develop recommendations for health care providers, state agency partners, and leaders around the state to address barriers among individuals who are uninsured, underinsured, and/or homeless.

KPI 1: By June 30, 2027, conduct up to 4 virtual roundtables among healthcare providers/systems, state agency partners, managed care organizations, and other leaders to discuss the current needs and challenges for individuals who are uninsured, underinsured, and/or homeless.
KPI 2: By September 30, 2027, develop a summary report and recommendations from the virtual roundtables.

Strategy 5: Provide education to address stigma related to substance use disorder in healthcare settings (i.e., providers and staff in hospitals, urgent cares, primary care practices, and opioid treatment programs), communities, courts and corrections.

KPI 1: By March 31, 2027, discuss priorities and strategies to address stigma in communities and the healthcare setting in 2026.
KPI 3: By June 30, 2027, develop recommendations and next steps for stigma training and education in healthcare settings, communities, courts, and corrections.