



## STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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Written Testimony of  
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Before the  
House Subcommittee on Oversight and Investigations  
The Energy and Commerce Committee  
2123 Rayburn House Office Building  
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Chairman Murphy, Vice Chairman Griffith, Ranking Member DeGette and Distinguished Subcommittee Members, my name is Rebecca Boss. I am the Director of the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) and oversee Rhode Island's substance use disorder division.

It is a privilege to serve my home state of Rhode Island under the leadership of Governor Gina Raimondo and Secretary of Health and Human Services Eric Beane.

With more than 25 year's experience in both state government and the provider community in substance use disorders, and as a long-standing member of the National Association of State Alcohol and Drug Abuse Directors, also known as NASADAD, I feel that I am uniquely positioned to testify on this crucial matter.

Thank you for the invitation to appear before you to allow me to describe how our state is addressing the critical issue of the opioid overdose epidemic. First and foremost, I wish to thank Congress for the federal funding that is essential to state agencies like BHDDH that comes to us through the Substance Abuse and Mental Health Services Administration (SAMHSA), CDC and HRSA.

Furthermore, we are very appreciative of the action Congress took last year through CURES with \$1 billion to help support prevention, treatment and recovery throughout the country. We are grateful for the funds, which enabled us to carry out our much-needed work with Congressional support.

Addiction and overdose are claiming lives, destroying families, and undermining the quality of life across Rhode Island. For over a decade, opioid dependence and accidental drug overdose have been growing problems across the United States, and Rhode Island has been one of the hardest hit. In 2013, Rhode Island had the highest rates of illicit drug use in the nation, as well as the highest rate of drug overdose in New England, and in 2015 had the fifth highest rate of overdose deaths in the nation.

As the numbers indicate, this problem is not going away. Soon after her election in 2015, RI Governor Gina Raimondo recognized the state did not have a comprehensive statewide strategy to evaluate, prevent, and successfully intervene to reverse the overdose trends. She knew that it was not enough to treat a single overdose; recovery support services needed to expand to embrace the full scope and depth of treatment. Clearly a new strategy had to be implemented.

In August 2015, Governor Raimondo signed an Executive Order establishing the Governor's Overdose Prevention and Intervention Task Force naming the Directors of BHDDH and the Department of Health (DOH) as Co-Chairs. The Task Force included stakeholders and experts in fields ranging from public health and law enforcement to healthcare, community-based support services, insurance, academia, business, government and more. Also included were family members of those who lost loved ones, and have added an invaluable perspective that we in government and the private sector sometimes miss.

The Task Force created a Strategic Plan for Addiction and Overdose and recommended numerous strategies within four areas: prevention, rescue, treatment and recovery. The data-driven plan was created and soon after, with the help of Brown University a website was created ([www.preventoverdoseri.org](http://www.preventoverdoseri.org)) where all efforts are tracked in a public and transparent fashion.

The distinguishing factor of the multi-disciplinary Task Force was that the members brought the Plan back to the sectors they represented. For instance, the Medicaid Director worked with her team to cut red tape that was identified and work with the insurers. The community providers, with their boots on the ground, were nimble enough to put plans in action after our meetings.

Each of the four areas has moved forward with numerous initiatives:

## Prevention

**Safer Prescribing:** To achieve safer opioid prescribing, it is important to weigh the benefits of medication access for patients living with acute and chronic pain with those of the risks of diversion, addiction, overdose, and premature death. Unsafe combinations of prescribed medications are linked to addiction and many overdoses are preventable. *To support these efforts, the Rhode Island Legislature passed the following bills: (2016-H8224A, S2823Aaa): Sets out limits for most initial opioid prescriptions. Requires pharmacies to upload dispensing data within 24 hours. (S2822A): Allows patients to synchronize certain drug refills for chronic conditions by requesting a limited supply (less than 30 days), with pro-rata cost sharing applied by the insurer*

The key strategy to reduce dangerous prescribing is to use the Prescription Drug Monitoring Program (PDMP) and system-level efforts to reduce co-prescription of benzodiazepines with opioids (for pain or opioid use disorder). Before DOH launched its Prescription Drug Monitoring Program Enrollment Enforcement Plan in 2016, more than 30 percent of Rhode Island prescribers had failed to enroll in the PDMP, and fewer than 40 percent were using it. As of July 2016, legislation had passed that all such practitioners shall be automatically registered with the Prescription Drug Monitoring Program maintained by the Department of Health. As of today, 100 percent of practitioners are enrolled. *To support these efforts, the Rhode Island Legislature passed the following bills: (2016-H7847, S2897): Allows the Prescription Drug Monitoring Program to be electronically connected to electronic medical records systems. (H7849, S2874): Adds Schedule V prescriptions to the Prescription Drug Monitoring Program. (H8326, S2946A): Requires DOH to look for federal funding opportunities to improve the PDMP, such as by adding additional analytical functions and incorporating data from similar programs in other states.*

Additionally, DOH Director, Dr. Alexander-Scott co-led a successful national petition drive calling on the FDA to require “black box” labels on opioids and benzodiazepines warning that concurrent use of these medications increases the risk of fatal overdose.

**Reducing the Supply of Prescribed Opiates (Rx):** Rhode Island has developed regulations that limit most opioid dosing for acute pain management to a contained period of time (with exceptions for specifically-determined patients) and supports existing hospital policy to restrict opioid prescriptions from emergency rooms to three days or less.

The promotion of non-opioid therapies for chronic pain, such as chiropractic services, massage therapy, physical therapy, and acupuncture as important alternatives to opioid pain relief is another successful effort in Rhode Island. Access to comprehensive health care coverage, including Medicaid, is a crucial component of these non-opioid alternatives.

**Reducing Demand (Illicit):** We cannot arrest our way out of this crisis, but we must build on partnerships with community organizations and law enforcement to reduce demand for heroin and other illicit drugs. Deaths associated with illicit drug use and fentanyl have increased exponentially in recent years. To address the illicit drug crisis, the Rhode Island Department of Health is working with the Rhode Island State Fusion Center and participating in the New England High Intensity Drug Trafficking Area (NEHIDTA) multi-state Heroin Response Strategy. This program, funded through the Office of National Drug Control Policy, currently maintains a 20-state partnership to address heroin and opioid abuse and trafficking. In fact, Rhode Island has designated a Heroin Response Strategy Drug Intelligence Officer and Public Health Analyst who are positioned at the Rhode Island State Fusion Center.

There is no current data on all fentanyl drug seizures from RI law enforcement since many investigations are ongoing. However, the NFLIS data has shown steady fentanyl seizures in powder form with sporadic counterfeit pill seizures (most recently pills containing furanyl fentanyl). Heroin seizures have declined.

The supply chain enters RI via sources in NY and MA as well as from China via US mail and common carrier services (UPS) etc. Cartels are not prominent in RI but their use of secondary drug trafficking organizations to ship the product is the most common source of transport. We remain concerned about the strong potential for the production of counterfeit A-215, M-30 and V-48/12 pills in our area.

**Hospital Testing for Fentanyl:** Some hospital systems are testing for fentanyl, but we do not yet know the frequency of testing or how many tests are returning positive for fentanyl. DOH is hoping to develop a data feed to include fentanyl test results.

With regards to fentanyl testing in the Emergency Departments, there is some preliminary data from one of the largest hospital systems. Between March 1st and May 31st, just under 3,600

toxicology screens were conducted, of which 11.6% were positive for fentanyl. About 40% of discharges coded as overdose (and which a toxicology screen was conducted) were positive for fentanyl.

In February, Rhode Island started testing all inductees in the Opiate Treatment Program (OTP) system (13 locations throughout RI) and have met regularly with the OTP MD's to analyze findings. Initial results indicate that a large percentage of individuals being admitted to treatment are testing positive for either heroin or fentanyl, or fentanyl alone.

**MODE Team:** Rhode Island has implemented a Multidisciplinary Review of Drug Overdose Death Evaluation (MODE) Team which combines strategies of “rapid response” with “community intervention.” The Team is modeled after the multidisciplinary review processes for child deaths. The purpose of the MODE Team is to gain insight into emerging overdose trends, identify gaps in or opportunities for policy development and prevention programming and inform the distribution of mini-grants to Rhode Island communities for prevention efforts. The MODE Team is comprised of individuals from varying agencies and organizations, including the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH); Rhode Island Department of Health (RIDOH); Boston Medical Center’s Injury Prevention Center; Rhode Island Department of Corrections (RIDOC); and Brown University. Data sources come from RIDOH (Medical Examiner reports, Prescription Drug Monitoring Program (PDMP)), BHDDH (substance abuse and mental health treatment episodes), and RIDOC (incarceration history and medical records from incarceration). The MODE Team has met three times quarterly to review this data on 11 cases. Twenty-five MODE Team recommendations have been developed, with nine community-based drug overdose prevention mini-grants distributed.

**Surveillance, Response, and Interventions (SRI):** This workgroup made up of staff from DOH and BHDDH review overdose information on a weekly basis. When overdoses exceed a certain threshold, alerts are issued to the community, law enforcement, and health providers.

## **Rescue**

**Naloxone as Standard of Care:** Naloxone saves lives by reversing the severe respiratory depression caused by opioids. Its use by laypeople trained to identify and respond to overdose has been linked

to reductions in overdose death rates. People who use opioids are at greatest risk of overdose, and are motivated to protect themselves and others around them to save a life with naloxone. Law enforcement being equipped with naloxone is critical in the fight against opioid overdoses. In fact, in Rhode Island two police departments (East Providence and North Providence) have offered to purchase naloxone for those departments who may not have the funds to purchase it themselves. Further, Rhode Island has promulgated regulations requiring all inpatient substance use disorder providers to offer naloxone to at-risk clients, Emergency Departments are dispensing naloxone to individuals who have overdosed, peers distribute on the street, and inmates with substance use disorders are given naloxone upon release. Fortunately, Medicaid funds pay for Naloxone and allows BHDDH to use other federal funds for additional prevention and intervention activities.

Rhode Island's DOH Director, Dr. Alexander-Scott sent a letter to Rhode Island prescribers encouraging the co-prescription of naloxone and a letter to Rhode Island pharmacists encouraging them to stock naloxone. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H7710A, S2460Aaa): Requires all insurers to cover naloxone and related devices, including in cases where the medication is intended for patients other than the insured.*

**Naloxone in the Community:** Rhode Island State Police invested \$40,000 in Google settlement funds in February 2016 to distribute more than 1,000 naloxone kits to law enforcement agencies. BHDDH has secured \$40,000 from the Substance Abuse Prevention and Treatment block grant to purchase 1,000 units of naloxone in 2016. Kits were distributed at the Department of Corrections and through targeted street outreach by peer recovery coaches. This effort will be sustainable for three additional years.

**Good Samaritan Law:** "The Good Samaritan Overdose Prevention Act of 2016" was strongly advocated by the Task Force, after the previous Good Samaritan law had expired. The new law also expanded immunity to people at risk of violating probation or parole and protects from liability those who use life-saving medical treatments such as naloxone that can prevent an overdose. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H7003)(S-2002) No liability to any person who administers an opioid antagonist to another person to prevent a drug overdose and provides immunity for violations of probation and/or parole for those persons who in good faith, seek medical assistance for a person experiencing a drug overdose.*

## Treatment

**Medication Assisted Treatment:** Evidence indicates that medication-assisted treatment (methadone, buprenorphine or depotnaltrexone\* injection) has profound effects on people with an opioid use disorder. It reduces their risk of death, relapse, chance of going to prison, and greatly improves their quality of life.

Rhode Island supports a model of shared decision making between the individual and their provider. We support the use of FDA-approved medications for the treatment of opioid use disorder including methadone, buprenorphine products, and injectable naltrexone, always in the context of recovery support services. These supports vary based on patient need, but include drug and alcohol counseling, screening and treatment of co-occurring mental and physical health issues, checking of the state prescription drug monitoring database, toxicology screening, individual and group therapies, peer support services, vocational and educational assistance. These supports must include the development of a treatment agreement with every person receiving care. Governor Raimondo, RIDOH, and BHDDH, along with expert advisors to the Task Force began working with primary care practice leaders across the state to overcome barriers to expanding buprenorphine prescribing among primary care providers.

Rhode Island has developed the Centers of Excellence for the Treatment of Opioid Use Disorder which are being established throughout the state. This model provides a means of rapid access to treatment for opioid use disorder, provides all of the above-mentioned services and works collaboratively with community providers of ongoing treatment for the opioid use disorder once stabilized in the Center of Excellence. This model also provides additional support to community providers—be they physicians or other allied providers, or community treatment programs that may not be equipped to assist a person who experiences relapse to opioid use by re-admitting the person to the Center for any additional stabilization needed. These Centers also serve to assist with the workforce development needs of our state in that these centers provide practical educational experiences in opioid use disorder treatment to community providers and trainees alike. Centers of Excellence are funded through private third party insurers as well as Medicaid. With Medicaid expansion, many more people are able to access Medication Assisted Treatment for opioid addiction.

Rhode Island offers medication-assisted treatment through the Department of Corrections. The

Governor proposed \$2.5 million in the FY17 budget for medication-assisted treatment in the state prisons and the General Assembly approved \$2 million in the final budget. The Governor requested repeat-funding in her FY18 budget. Individuals who are awaiting trial are no longer withdrawn from MAT, and those who are opioid dependent and not in treatment are able to be inducted on medication as appropriate. Incarcerated individuals with histories of opioid use disorder are at a significantly increased risk of overdose upon release, so these individuals are also being offered induction on MAT. The Department of Corrections has worked closely with the Rhode Island Medicaid Office to ensure that these individuals are connected to coverage so that there is not treatment disruption upon release.

**Centers of Excellence:** As described above, the Centers of Excellence for the Treatment of Opioid Use Disorders was created and provides comprehensive evaluation, including mental health evaluation and treatment or referral, induction and stabilization services, as well as support to providers in the community. It is envisioned that such Centers would refer stabilized patients to other providers and receive back patients if they destabilize and require more intensive services.

Rhode Island's first Center of Excellence opened in November 2016 at CODAC Behavioral Healthcare. CODAC has six sites with a COE at each site; a seventh will open soon in the state hospital known as the Eleanor Slater Hospital System. Additionally, two community providers are opening new COEs this month.

**Waiver Training:** Rhode Island has sought to address the issues of access to care and workforce development by building a program of physician and practitioner Drug Abuse Treatment Act of 2000 (DATA 2000) trainings which are necessary to obtain the waiver to prescribe buprenorphine to individuals with opioid use disorder from office-based practice. These trainings also offer education on the epidemiology of opioid use disorder in the United States, appropriate assessment and treatment of opioid use disorder, an overview of all FDA-approved medication assisted treatment and evidence-based psychosocial interventions, confidentiality issues related to 42 CFR Part 2, and an overview of special populations that may be affected by opioid use disorder. As such, the course is an excellent overview of current approaches to management of substance use disorders. We have trained over 300 practitioners since January of 2016 and we have established a system where institutions can request trainings as needed. This dovetails well with our practical experience available in Centers of Excellence and which we hope will encourage prescribers to engage in office-based treatment of opioid use disorder.



Rhode Island is leading the way with the training of medical students, the first of its kind in the country. The 2018 Class of the Warren Alpert Medical School of Brown University, which will graduate next May, will be the first class to participate in a new program to complete the training necessary to qualify for a Drug Abuse Treatment Act of 2000 (DATA 2000) waiver prior to graduation. The waiver is necessary to prescribe FDA-approved medications for the treatment of opioid use disorders. Once the new graduates receive their full medical license and DEA registration, they can apply for the DATA 2000 waiver.

**Emergency Department Standards:** Leadership from hospitals and emergency departments throughout Rhode Island joined Governor Raimondo's Overdose Prevention and Intervention Task Force. They will release a first-in-the-nation set of statewide guidelines to save lives by ensuring consistent, comprehensive care for opioid-use disorder in emergency and hospital settings. Released in March 2017, it established a common foundation for treating opioid-use disorder and overdose in Rhode Island hospitals and emergency departments, the standards establish a three-level system of categorization that defines each hospital and emergency department's current capacity to treat opioid-use disorder. All emergency departments and hospitals in Rhode Island will be required to meet the criteria for Level 3 facilities. As a facility's capacity to treat opioid-use disorder develops, that facility can apply for a higher designation.

## **Recovery:**

**Expand Recovery Supports:** The growing need and capacity for peer recovery services mirrors the pace of the epidemic. Successful recovery nurtures the individual's health, home, community and purpose. New opportunities are envisioned that support peer recovery services and medication-assisted recovery. Medicaid coverage for treatment of substance use disorders and parity has allowed Rhode Island to maximize block grant fund and state general revenues to fund these important supports as well as prevention activities.

**Recovery Coaches:** It is important to cultivate a recovery coach pipeline, with a plan to double the number of recovery coaches for statewide and extended coverage, supporting in-prison recovery

coaching and certification, and ensuring proper support and supervision of recovery coaches at this scale. Every effort is being made to expand and create consistency in reimbursement for delivery of certified peer recovery coach services. Since RI developed a certification process in 2014, 98 peer recovery coaches have been certified in RI, nearly double in 2016 than in 2015. A related aspect of this strategy is to standardize help-seeking and recovery supports through standardization of employee assistance programs (EAP) for the workforce and by mandating that all drug treatment programs develop recovery planning (including training programs and referrals, establish certification for recovery housing, and support case management to help people access resources) or coordinate such supports with an outside entity.

DOH has a contract with Anchor Recovery through 2019 to provide peer recovery coaches to inmates upon release from the Department of Corrections and through targeted street outreach to state hotspots.

**Recovery Coaches in Emergency Departments (AnchorED):** In May of 2014, Rhode Island started a pilot program using recovery coaches to respond to overdose survivors while they were receiving treatment in hospital Emergency Departments. On-call coaches respond to overdose survivors and offer support, referrals, resources, family support and training on naloxone. This success of this pilot project supported its expansion to be offered statewide twenty-four hours per day, seven days per week. These coaches have had great success at engaging clients with an 85% follow up rate with treatment and/or recovery support services. This service has provided the state with a wealth of information on the experience of individuals with the healthcare system as well as the addiction treatment system. While engaging with recovery coaches at a crucial point in their addiction, many individuals make the decision that they are ready for treatment – seeing the hope of recovery through shared experience and recognizing their desperate state makes people ready for change.

The number of contacts that the Peers have made in the ED has been steadily increasing from around 85 contacts in the first month to 165 contacts in the most recent month. The majority of patients seen in this program (67%) are not currently receiving treatment for substance use disorders (SUD), but more than 85% of them agree to get a referral to SUD treatment.

**Anchor MORE:** The success of AnchorED spurred the development of AnchorMORE, recognizing that successful consumer engagement does not have to wait for an individual to show up at an ED with an overdose. The Anchor MORE is a community outreach program, placing recovery coaches

on the streets to connect with and engage individuals. Anchor MORE currently dispatches these teams of recovery coaches to areas in which individuals are using substances in public places. Anchor MORE teams are also proactively dispatched to certain areas in the state by looking at overdose data and emergency services pick-up data. Both programs connect individuals with recovery coaches - trained peers with lived experience of addiction. Recovery coaches stay actively engaged with individuals after an encounter and connect them to treatment and recovery support services, including integrated health home teams, homeless assistance programs, employment assistance programs, primary care, and case management services, once the individual is comfortable.

**Recovery Houses:** Safe, drug-free living environments are crucial to support recovery. Rhode Island has identified a funding source to begin the certification process for a network of recovery houses across the state. Legislation passed that requires recovery houses to meet a set of standards to receive state certification. The National Alliance for Recovery Residences (NARR) will be tasked with certifying recovery houses and will receive verified training to become a certifying entity. Recovery housing will include on-site staff and resources in addition to housing. Rhode Island Communities for Addiction Recovery Efforts (RICARES) will be tasked with stakeholder oversight. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H8056A, S2579B): Authorizes BHDDH to develop a process to certify recovery housing facilities for residential substance abuse treatment.*

**Discharge and Recovery Plan:** Through the work done by the Task Force, state health agencies developed a model discharge and recovery plan to promote recovery services for patients with substance use disorder. Known as the Perry and Goldner Bill, the legislation is designed to improve emergency room treatment for those with substance use disorders and ensures patients receive a discharge and recovery plan. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H7616A, S2356Aaa: The Alexander Perry & Brandon Goldner Act): Requires comprehensive discharge planning for patients with substance use disorders and requires insurers to cover expanded medication-assisted treatment.*

**Rhode Island's Future Plans:** Today, Governor Gina Raimondo is issuing an Executive Order declaring that the alarming rate of deaths caused by opioid overdose constitutes a public health crisis. The Executive Order outlines new initiatives in the four areas recommended in the Task Force's Strategic Plan: Prevention, Rescue, Treatment and Recovery. Included in the Order are

educational components, the promotion of existing systems, and the expansion of partnerships. The Governor also incorporated a coordinated public outreach campaign into the Order to engage parents and youth to prevent opioid abuse through the establishment of a Parental Task Force. This Task Force will collaborate with schools to expand access to prevention programming for high-risk youth and the expansion of family support groups throughout the state. The Executive Order asserts that all state agencies, with coordination and support from the Task Force, shall take all necessary actions to reduce opioid overdose deaths. The Departments of Health and Behavioral Healthcare, Developmental Disabilities, and Hospitals will ensure implementation of the Executive Order initiatives and report back to the Governor on a semi-annual basis. *Executive Order 17-07 issued on July 12, 2017.*

**Recommendations:** I humbly submit a few recommendations –

- Any federal initiatives include the involvement of the state agencies. Between the expertise and authority our staffs have within the substance use disorder system, our agencies can help to chart the right course.
- The importance of the Substance Abuse Prevention and Treatment Block Grant cannot be understated. It is a critical component in our efforts to engage our communities in primary prevention. We hope the strong support you have shown continues. As Medicaid has laid the foundation for treatment coverage, the block grant has been critical in providing coverage for recovery support services and prevention efforts.
- Targeted funds to address the many issues I have discussed today would be helpful. Congress has shown generous support to substance use disorder agencies and we certainly hope there is consideration for continued support.
- Treatment for substance use disorders leads to recovery. Access to the treatment has been advanced by Medicaid expansion. Continuing to support funding for Medicaid expansion to single adults with low incomes is essential to helping more people recover from substance use disorders.
- Many individuals living with substance use disorders do not have access to transportation. Permitting mobile methadone or buprenorphine provisions would eliminate that barrier and make treatment more accessible.
- Workforce development in the field of substance use disorders is crucial with a standardized certification program to license workers across all states. If this were coupled with a loan forgiveness program, the workforce could grow to the numbers needed.

- With elder opioid addiction on the rise, parity for Medicare clients would be welcomed by all.
- Repealing the Institution for Mental Disease (IMD) exclusion would allow for meaningful behavioral health care to those who present with a substance use disorder, truly allowing every door to be the right door.

**Conclusion:** I appreciate the opportunity to present testimony before the Subcommittee. Over the last 5 years we have lost more than 1,200 people to drug overdoses, coming from every community in the state. Our work is focused on saving lives. I encourage the Subcommittee and Congress to work with the NGA, NASADAD and ASTHO as well as other partners to leverage the collective knowledge and expertise of State alcohol and drug agency directors and public health departments across the country to help end this epidemic.