State of Rhode Island and Providence Plantations
State House
Providence, Rhode Island 02903-1196
401-222-2080

Gina M. Raimondo
Governor

October 18, 2019

The Honorable Frank Pallone, Jr.
Chairman
The United States House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

The Honorable Greg Walden
Ranking Member
The United States House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Mr. Pallone and Mr. Walden:

My office received the letter issued from the United States House Committee on Energy and Commerce on September 18, 2019. Enclosed, please find the State of Rhode Island's comprehensive response to the Committee's questions, which includes data detailing Rhode Island's use of federal funds to combat the opioid crisis.

Should you have any additional questions, please contact the State Opioid Grants Coordinator, Catherine Cool Rumsey, or Ryan Erickson, Policy Advisor in the Governor's Office. Ms. Cool Rumsey can be reached by phone at (401) 462-6392 and by email at Catherine.CoolRumsey@ohhs.ri.gov; Mr. Erickson can be reached by phone at (401) 222-8135 and by email at Ryan.Erickson@governor.ri.gov.

Sincerely,

Gina M. Raimondo
Governor

CC: The Honorable James Langevin, Member, U.S. House of Representatives
The Honorable David Cicilline, Member, U.S. House of Representatives

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

1. **Since 2016, how much federal funding for opioid use disorder prevention, treatment, and recovery has Rhode Island received?**

Rhode Island state agencies have received various federal funding awards that have helped in addressing the opioid use disorder crisis. Please see Appendix A1 for our List of Federal Grants; Appendix A2 for a list by our Strategic Pillars (1) Prevention/Preparedness 2) Rescue 3) Treatment, and 4) Recovery); and Appendix A3, which outlines the grants in more detail. In addition to federal awards, Rhode Island allocates a portion of our Substance Abuse Block Grant toward treatment for uninsured and underinsured to treat clients with opioid disorders.

We would also like to note that although your questions are geared towards federal grants, we do want to emphasis the importance the federal Medicaid match dollars have had on our ability to address the opioid crisis. Medicaid match dollars fund the majority of treatment for opioid dependence in RI and without the ACA we would not be where we are today in combating this crisis.

   a.) **What challenges, if any, exist in deploying federal funds to local communities in an expedited manner?**

Rhode Island faces a number of challenges in deploying federal funds to local communities in an expedited manner, but we have developed ways to overcome the challenges and to distribute funds to our community partners.

Our primary challenge is that state rules for hiring and vendor procurements often cause these activities to take more time than is optimal for short-term federal funding opportunities. The entire state procurement process ensures strong vendor selection but requires substantial time. Procurement can have many steps, with time needed for staff to be hired to facilitate procurement activities, for internal agency approval processes, and to conduct the process to procure with the Department of Administration (DOA) Division of Purchases. Other factors, such as legal reviews, can sometimes also add to delays. State agencies work hard to prepare for procurement, but the process can often take months. We are working closely with the state Division of Purchases to find ways to exedite the procurement process.

We also recognize the challenges facing smaller community organizations who are a key part of Rhode Island's response to the addiction epidemic. For example, state contract payment works on a cost reimbursement model, which can be a challenge to community organizations with limited capital, who struggle to incur the up-front costs. We have also been focused on helping safety net providers whose capacity is strained by this crisis.

In addition, Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) has been able to provide MAT services to those who are uninsured or underinsured with a focus on those who are incarcerated, which was a population that we had not been able to reach previously. Rhode Island was one of the first states to offer all three FDA approved medications within our prison system to individuals with an opioid use disorder, and the state's Corrections to Community program reaches those who are leaving prison or already on probation or parole. Governor Raimondo and the Rhode Island General Assembly allocated dollars to implement the program and then federal funds support the Confidential: Preliminary Work Product Under RIGL 38-2-2(4)(k)

transition post release. This process has reduced the overdoses deaths of individuals release from our Adult Correctional facilities by 62 % in the first year. It would be helpful if this type of intervention is supported by federal funds.

There are workforce challenges for community-based organizations that simply don't have enough adequately trained employees to handle this volume of work. Developing the specialized workforce takes time and is often not immediately available when crises arise.

Finally, there are some grant guidelines that organizations find challenging, such as the Government Performance and Results Act (GPRA) measurement tools data gathering requirements, and the prohibitions on funds being used for critical infrastructure needs. Rhode Island's aging buildings need updating and it is difficult to find the resources to pay for those repairs.

b.) o date, how much of this federal funding ha your state used or allocated? Please provide a list of each funding recipient, the purpose for allocating money to them (e.g. prevention, treatment, etc.), and the amount that has been allocated to them.

All of Rhode Island's current federal funds awarded have been allocated. Please see Appendix B for summary of allocations.

c.) If your state has not used the entirety of federally allocated funding, please explain why.

Rhode Island has not spent the entirety of the funding for some federal grants, although the balance of this unspent funding has been allocated and will be requested for approval in a carry forward or no cost extension request to our federal funder.
As mentioned earlier, in addition to the time it can take to procure a vendor to conduct the work, there have been agreements, policies or processes that needed to be reviewed by legal counsel and worked out with the vendor that have caused additional delays in obligating and spending down the funds within the allotted time frame.

For example:

- For our CARA grant, we had delays in hiring staff and in pursuing a data management system and did not spend all of the funds in the time allotted. A request for a Carry Forward will be submitted in January 2020.
- The Rhode Island State Police Hope Initiative is awaiting final budget approval from the Bureau of Justice Assistance to begin spending for their project.
- We have not expended all Year One dollars from our State Opioid Response funds due to some delayed start-ups, mainly due to procurement requirements, as explained above.
- Finally, we are working to spend all of the SUPPORT Act Section 5042 dollars available for developing a Qualified Prescription Drug Monitoring Program (PDMP) before the end of FFY20.

At this time we may struggle to identify the 10% state match needed to continue our work. We are currently going through the required process to commence spending, including CMS approval of our funding request and the above-mentioned staffing and procurement processes. These processes delay our ability to start spending within a limited timeline.

In each of these situations, we have plans to begin spending as quickly as possible to meet our strategic goals and serve Rhode Islanders in need. Leniency on funding spend-down timelines to account for the delays would further help us accomplish these goals.

2.) Please describe how your state determines which local government entities (i.e. counties, cities, and towns) receive federal grant funding to address the opioid crisis. Specifically, please identify locatities impacted most by the opioid epidemic in your state, and include the total amount allocated to each locality, as well as the factors your state considers in distributing these funds.

The entire state of Rhode Island has been affected by the opioid crisis, as noted by Governor Raimondo when she declared the overdose epidemic a public health crisis in 2015 and called for the formation of the Overdose Prevention and Intervention Task Force, the coordinating body for the State's overdose response activities. Because Rhode Island does not have county or municipal health departments, our statewide Department of Health carries out activities that may happen at the local level in other states. We fund the prevention activities for cities and towns using a regionalized process that is determined by census.

However, we recognize that the crisis impacts some communities more significantly than others, which is why the state has also identified and, as appropriate, prioritized interventions in the municipalities with the highest burden of overdose based on datasets that collect fatal and non-fatal overdoses.

For example, the SURGE base grant included funding that went to all municipalities to prepare for and/or implement a local Community Overdose Response Plan. The intention of the funds was to enhance the state's ability to respond to the crisis, so it was a priority to increase community capacity by providing a means for them to adopt and implement local policies and strategies in order to address the crisis on a local level.

Rhode Island has also identified geographic regions where health disparities exist, called Health Equity Zones. We provided targeted funding to those Health Equity Zones to assess prevention, treatment, and recovery resources in their communities, identify service gaps, and make system changes to address them. These communities are Bristol, West Warwick, Pawtucket/Central Falls, Newport, Washington County, Woonsocket, and the Olneyville neighborhood in Providence.

Finally, we provided funds to New Shoreham, a rural island community with a high-risk population and barriers to treatment, to provide a rapid response crisis telehealth system that links them to evidence-based MAT at a Center of Excellence. We fund the cities and towns for prevention using a

regionalization process which is determined by census. Federal funds addressed prevention, naloxone distribution (our rescue workgroup), treatment and recovery throughout the state.

For the BJA grant, the Project DOVE goal was to improve maternal and neonatal outcomes related to opioids in pregnancy in Rhode Island. The project created a continuing education course for medical providers and targeted academic detailing to pre-natal providers in Charlestown, Middletown, Warren, West Warwick, and Woonsocket and its surrounding areas. These communities were selected based on data from the Prescription Drug Monitoring Program (PDMP). Please see Appendix E.

However, grants directly to municipalities represent only a limited portion of our use of federal funds for community-based efforts. The majority of federal grant funding, particularly through the State Opioid Response grant, has been dispersed to communities through community organizations, including local behavioral health providers and other community initiatives. (Of note: As mentioned earlier, Rhode Island does not have county governments).

3.) Please describe how your state determines which non-governmental organizations (i.e. non-profits, treatment centers, or other entities) receive federal grant funding to address the opioid crisis. Specifically, please identify the non-governmental organizations that have received funds in your state, and include the total amount allocated to each entity, as well as the factors your state considers in distributing these funds.

The State has developed and refined a series of strategies for ensuring that federal grant funds go to high-need projects that we believe will provide the greatest benefit to people with substance use disorder, their families, and their communities.

Rhode Island's rigorous procurement process helps to ensure that contracts are awarded to the highest quality proposals by both programmatic delivery and cost, but which can be time consuming. Many of the contracts described in our Appendices were awarded through full Request for Proposal processes, with specific guidelines, a technical review team, and official scoring of proposals. When there is only one appropriate vendor for the desired service, we use a single or sole source contracting process. Rhode Island also has a Master Price Agreement list with selected, state-approved entities who can submit bids and proposals for a scope of work or service. This rigorous process ensures quality, but ultimately leads to barriers in expediency, as outlined above. When addressing the opioid crisis, we worked with our state partners in the Purchasing office to respond appropriately in a timely manner

Additionally, we have developed governance structures between state agencies to ensure that federal grant funds support projects that work in tandem with each other and make the most efficient use of federal grant resources. The state agencies receiving opioid- and addiction-related Federal grants gather at monthly strategic Interagency grant meetings to avoid duplication of effort and to coordinate programs. These meetings align common goals associated with the Governor's Overdose Task Force strategic plan to address the opioid crisis. Please see this page on our Prevent Overdose RI website for further information on the strategic planning process and data collection efforts.

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

We utilized our Strategic plan needs assessment to identify the need for increased recovery support centers. A Request For Proposal was written with specific delieverables to address vulnerable populations and posted to the state's website for the required 30 days. Qualified content experts reviewed the submitted applications. The awards for start-up funds were granted to allow for increased recovery capital capacity throughout the state. Once the winning agency received their award letter they then began working towards completion of the project.

Please see Appendix B for a list of all of our awards to community agencies for the range of prevention, treatment, rescue, and recovery work that has been carried out with support from the federal funds we have received.

4.) Do federally appropriated funds to address the opioid crisis provide your state with the flexibility to focus on the hardest hit regions or localities? Please describe how, it at all, this flexibility has helped Rhode Island in using funds to target vulnerable populations or at-risk areas. If no, please explain what additional flexibility should be considered in helping your state address the hardest hit regions or localities.

The structure of federally appropriated funds to address the opioid crisis does permit the flexibility to focus on hardest hit regions or localities and vulnerable populations, but limits on the uses of federal funds do pose some challenges in allowing the state to address some of the crisis's most intractable challenges. Data available from the PreventOverdoseRI.org website includes municipal level geo heat maps that describe overdose death hot spots as well as emergency department admissions (by patient town of residence). These data are used by multiple state departments in Rhode Island, including our Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) to prioritize grant funding and delivery of services to areas of high need at the municipal or regional level.

Rhode Island Overdose Action Area Reports (ROAAR) are real time advisories that are issued by the Rhode Island Department of Health (RIDOH) and shared with public safety, BHDDH, and other key stakeholders in fighting the opioid overdose epidemic. ROAARS are issued when there is an increase in overdose activities within Rhode Island cities and towns to alert first responders, the public health community and other stakeholders who can then take action to mitigate impact.

For example, BHDDH funds mobile outreach peer recovery specialists who can be deployed to the cities and towns where the ROAAR is issued in order to outreach to individuals at risk of overdose, attempt to engage in treatment and distribute naloxone. RIDOH also collects hospital overdose data within 48 hours of hospitalization. That information is then reviewed by the Surveillance Response Team (SRT), which consists of several state and federal team members. The SRT team reviews this information each week and determines hotspot areas of the state, and where to initiate more intense responses, such as visits from the funded Outreach Mobile Van and distribute information on latest trends and patterns of the addiction crisis (including for example the existence of counterfeit pills or an increase in cocaine and fentanyl, etc.).

Another example of how funds are used to target vulnerable populations is through a BHDDH weekly call with all detoxification centers' SUD residential providers, BHLink our 24-hour ED diversion center for behavioral health crises, Peer recovery specialists, Anchor ED hospital peers, and recovery center directors. The goal of this call is to share the "Hotspot "location of the week. The intent is that Naloxone and risk information would then be flooded to the "Hotspot" area, along with information on latest trends and patterns of the addiction crisis. Federal funds also support an outreach mobile van which can also be deployed to the "hotspot" cities and towns where the ROAAR was issued.

While the federal funds provide flexibility to focus on the hardest hit areas of the state, we would greatly appreciate some additional flexibility in the types of interventions or strategies we are allowed to fund. For example, not all grants allow us to fund naloxone provision, an important aspect of our rescue strategic aim. Additional naloxone provision would allow us to better address the need in the hardest hit communities. Restricting funds for only opioids limits the state's ability to be responsive to an overall addiction crisis-linked to our overdose rates. Using formula block grants, like Substance Abuse Prevention and Treatment Block Grant (SAPTBG) instead of discretionary grants would allow states the flexibility to address the needs across all regions as well as reduce spend down delays.

And as noted above, we are prohibited from funding infrastructure – literal bricks and mortar – that our treatment providers so desperately need. One critical gap in the allowed uses of available funding is housing. Very often, our treatment programs and even our unified jail/prison system provide excellent care to people with substance use disorder whose journeys to recovery stall when exiting treatment or incarceration because they do not have access to safe, stable housing. Additionally, treatment providers who would be willing to expand their services, and serve an unmet need, cannot expend the capital required to build a new facility.

5.) In what ways, specifically, have federal funds extended to Rhode Island helped change your state's treatment system and/or led to a reduction in opioid overdoses?

Rhode Island's main goal is always to reduce the number of overdose deaths. In 2016, prior to the distribution of most federal grants, Rhode Island was ranked fourth in the nation for overdose deaths per capita. With a population of just over 1 million people, we lost 336 people in 2016. Rhode Island has always been a target for heroin use because of the access afforded from the Route 95 corridor that reaches all the way up the east coast. Fentanyl related overdoses increased by 71% from 2016-2018.Between 2017 and 2018 there was a 6% reduction in deaths, and the state improved its ranking to tenth in the nation. However, since even one death is too many, we still have a long way to go.

At a high-level here are ten ways the federal funds extended to Rhode Island have helped to change our state's treatment system and/or led to a reduction in opioid overdoses:

- **Improved Data and Surveillance:**
    - Promotion of interoperability of the PDMP and electronic health records (EHRs)
    - Improved surveillance systems to identify overdose hotspots

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

- **Expanded Treatment Capacity:**
  - Increased community capacity to respond to the overdose crisis at local level by improving access, including new treatment options (discussed in more detail below)
  - Decreased barriers to medication-assisted treatment (MAT)
  - Provision of MAT services to those who are uninsured or underinsured
  - Provision of funds for the Corrections to Community program
- **Supported Innovations in the Delivery of Treatment:**
  - Implementation of telehealth systems linking individuals to MAT
  - Development of community and family-based prevention and early intervention care models, including efforts to reduce child maltreatment, which has been found to be associated with parents diagnosed with SUD
  - Creation of new partnerships between the community and law enforcement, such as the Hope Initiative
  - Implementation of a centralized triage center for behavioral health crises (BHLink)

Rhode Island's strategic plan (described more fully below) has four components: Prevention, Treatment, Recovery and Rescue – and we strategically attack on all four fronts. Here is some more detail on the ten ways that federal funds have changed our treatment system:

Treatment efforts have resulted in the increase in and acceptance of individuals receiving medications to assist with their opioid treatment. MAT is required in all areas, including in recovery housing, in Substance Use Disorder (SUD) residential facilities and other treatment agencies. Due to these requirements, Rhode Island's cumulative number of people prescribed buprenorphine or methadone has reached an all-time high.

Another key strategy that we have developed through federal funding is a new mix of treatment opportunities – including an increase in community-based services - intended to improve care to people with substance use disorder and to reduce the stigma accompany seeking treatment:

- One key investment made for Rhode Islanders through the grants was our centralized triage center called BH Link. BH Link offers 24/7 behavioral health access to treatment via walk in services or the opportunity to call into a 24/7 bilingual treatment referral line. Access is now available for individuals or their families through self-referral, or transport by emergency management systems, which can now divert non-medical cases from emergency departments. (if clients are in need of Emergency Department (ED) medical services for issues such as a non-fatal overdose, there are peer recovery coaches in all Rhode Island EDs to assist with treatment options.)
- BHDDH also has contracted to utilize a 37-foot mobile "Rhode to Health" treatment unit that travels throughout the state to assist people in rural areas who normally don't have access to care. The van offers a stigma-reducing opportunity for buprenorphine inductions, peer recovery supports or treatment referrals with a warm handoff.

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

- Rhode Island has expanded recovery community centers from two to seven. Access to treatment and recovery in RI begins in the community through braided dollars from all opioid grants coming into the state from a variety of departments (HRSA, CDC, MAT-PDOA, CMS, etc.)
- Funding has also supported the expansion of Community Health Teams focused on providing whole-family, bi-generational supports and resources to families affected by maternal substance use disorder and neonatal abstinence syndrome. These teams are now aligning with our existing Family Home Visiting teams, for streamlined referrals. This work has stemmed from our identification of gaps in our service array and has allowed us to support new pathways for engaging and serving families and initiating systems and policy changes.

We have also used funding to maximize data supports to address the crisis:

- Federal funds have supported our ability to promote interoperability of the PDMP with electronic health records (EHRs) of our two major hospital systems. This has dramatically reduced the time it takes a healthcare provider to check the PDMP before prescribing an opioid and thereby reduced provider burden.
- We have also been able to embed a risk algorithm in one hospital system's emergency departments which will prompt an ED provider to check the PDMP if a patient has a high risk for opioid use disorder or opioid overdose. While we are still evaluating outcomes, we anticipate that this will help to engage patients at high risk before overdose occurs.
- Federal funding has helped us improve surveillance systems to identify overdose hotspots and provide subawards to increase community capacity to response to the overdose crisis at the local level. These grants have also enabled us to create systems that more easily refer people into treatment. Some examples include: The Levels of Care certification which decreases barriers to MAT and provides naloxone at discharge, providing support from Certified Peer Recovery Specialists in emergency rooms, and setting up a telehealth system that links individuals to evidence-based MAT at a Center of Excellence.

Finally, Federal funding has allowed us to build new and exciting partnerships between community organizations and law enforcement:

- The HOPE Initiative is the nation's first statewide law enforcement-led opioid overdose prevention outreach and engagement program. It is a program designed to align with and enhance current efforts by utilizing law enforcement skills and resources to execute tasks that support the Task Force's five action areas: Prevention, Rescue, Treatment, Recovery, Public education.
- This program supports comprehensive cross-system planning and collaboration among officials who work in law enforcement, pretrial services, the courts, probation and parole, child welfare, reentry, PDMP's ad emergency medical services, as well as health care providers, public health partners, and agencies that provide substance use treatment and recovery support services.

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

6.) What performance measures is Rhode Island using to monitor the impact of federal funds for opioid use disorder and other substance use disorder treatment?

Rhode Island is committed to strong evaluation and data-driven review of our response to the addiction crisis and has put data the center of every proposed and implemented intervention to the maximum extent possible.

The Governor's Task Force has implemented strategic metrics across all agencies addressing the opioid use disorder. Please see Appendix C1. Along with the Governor's Task Force metrics, BHDDH uses GPRA and includes consistent performance measures around recidivism, step down to less restrictive services based upon clinical assessment as well as many others in each contract depending upon the scope of work. State agencies have also set metrics for interventions they monitor through contracts with providers.

There are also specific grant measurements to track our work to improve our PDMP and our naloxone distribution, which you can find in Appendices C2.

7.) According to the Substance Abuse and Mental Health Services Administration, State Targeted Response to the Opioid Crisis (STR) Grants provide funding to states to: (1) conduct needs assessments and strategic plans; (2) identify gaps and resources to build on existing substance use disorder prevention and treatment activities; (3) implement and expand access to clinically appropriate, evidence-based practices for treatment – particularly for the use of medication-assisted treatment (MAT) and recovery support services; and (4) advance coordination with other federal efforts for substance misuse prevention.

a. Has your state conducted a needs assessment and strategic plan? If yes, please describe that plan.

Yes, Rhode Island has conducted needs assessment and ongoing strategic planning to allow us to most effectively address this addiction crisis. These planning activities are reflected throughout our Governor's Overdose Task Force website:

Original Task Force Strategic Action Plan

Updated Task Force Strategic Plan, through December 2021 (Also attached as Appendix D)

Data to Track our Action Plan

Strategic Planning:

The Overdose Task Force has just completed the second round of Overdose Prevention & Intervention strategic planning. The first plan was developed with RIDOH, BHDDH, the Governor's Office, Brown University, and stakeholders and advocates for recovery. Their efforts were to engage the most up to date treatment and research, along with interviews of individuals in various focus groups in order to be

able to provide and complete a through needs assessment. The needs assessment later led to the original strategic plan, linked to above

The Task Force updated the Strategic Plan in 2019 to address new developments and to continue the efforts and achievement of the original plan. The goal is always to save lives, but the 2019-2021 plan also addresses the need to expand prevention and recovery work with the intention to reduce the onset of new use and to sustain those in recovery by providing them with resources to thrive and maintain their recovery capital. The "refreshed" strategic plan was designed with all state partners, including individuals in recovery and treatment, for optimum implementation capability. Because Rhode Island is a small state, we are able to gather for weekly meetings to discuss new grants and new research that could move us in new directions in a timely way to address trends and patterns. Importantly, both plans commit the state to concrete actions linked to strategic goals that, we hope, will drive significant progress.

In order to address this ever-changing and evolving addiction crisis, members of the Governor's Overdose Task force team have created eight sub-working groups. The first four workgroups meet monthly to review the strategic plan performance metrics that address the four pillars; Treatment, Prevention Rescue (Naloxone distribution) and Recovery. The other four workgroups address specific issues such as: Substance Exposed Newborns, Harm Reduction Efforts, Family Needs, and the First Responders.

Needs Assessments:

Because Rhode Island uses a strong interagency approach to our Task Force work, we are able to combine the needs assessments carried out by multiple agencies to support Task Force strategic planning.

For example, the Rhode Island Task Force to Support Pregnant and Parenting Families with Substance Exposed Newborns (SEN Task Force) is conducting a needs assessment to inform their strategic planning process. Their goal is to identify current and existing substance use disorder prevention and treatment activities that impact families affected by maternal substance use disorder and substance exposed newborns, identify gaps and resources, and, develop and implement a statewide system of care to support families affected by substance use disorder. The SEN Task Force convened four focus groups, with pediatricians, families, foster families, and community-based providers. They presented the results of these focus groups at a half-day retreat made up of key interdisciplinary stakeholders. The stakeholders identified four overarching strategic planning pillars: (1) Ongoing education and workforce development; (2) Improved interdisciplinary, family-centered care coordination; (3) Expansion of, and access to longitudinal, integrated treatment and recovery resources; and (4) Development and alignment of public and private policies, protocols, and regulations. Using the pillars as a framework, the Task Force is researching local and national best practices and developing an implementation plan. All of this work will be communicated to the broader Overdose Task Force for alignment with the statewide plan.

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

BHDDH convenes the State Epidemiology and Outcomes Workgroup (SEOW), which conducted a state level behavioral health needs assessment in 2017 and a regional needs assessment in 2018. The department uses the findings from the SEOW assessments to inform all BHDDH planning processes and Task Force planning. They have also developed a 2019-2024 Departmental Strategic Plan that focuses on several objectives designed to address BHDDH's system needs or gaps associated with the opioid epidemic. In addition, the SAMHSA Substance Abuse Prevention and Treatment Block Grant (SAPTBG) requires a Prevention Strategic Plan, which BHDDH has completed, with a focus on prevention of opioid overdose. Each of these plans and needs assessments are coordinated, although in some cases foci are dictated by funding stream or source.

b.) Has your state identified gaps and resources to build on existing substance use disorder prevention and treatment activities? If yes, please describe those findings.

As identified elsewhere in this document, here are some of the gaps in services and resources to build in the future:

- To address gaps in care and treatment services, expand person-centered addiction approaches including those that emphasize increasing access to treatment on demand, implement universal screening for maternal SUD, implement a systematic approach to support intentional pregnancies in women with substance use disorder, and increase the number of SBIRT-trained prenatal providers;
- To address the gap in OUD/SUD residential treatment and address wait times, expand bed capacity, including piloting a family residential program;
- To address the gap in availability of MAT, expand access to MAT by increasing the number of Data-waivered prescribers;
- To address the gap in available recovery supports, increase the number of certified peer recovery specialists and increase the footprint of recovery community centers accredited by a national accreditation body;
- To address the gap in diversion programs for prescription opioids in homes, ensure that each community in RI is implementing strategies for safer storage and disposal of opioids and other medications;
- To support the SUD workforce adequately. We are working on identifying supports for this challenge.

RI state agencies such as the Executive Office of Health and Human Services (EOHHS), Governor's Office, RIDOH, BHDDH, Department of Labor and Training, RI State Police, Department of Children, Youth and Families, and others are partnering to coordinate federal funding initiatives in order to utilize funding effectively. We hold a monthly grants coordination meeting conducted to help facilitate these efforts.

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

c.) Has your state implemented and expanded access to clinically appropriate, evidence-based practices for treatment—particularly for the use of MAT and recovery support services? If yes, please describe how you have done so.

The State's overdose response strategies have focused extensively on the proliferation of evidence-based strategies, including medication assisted treatment, in appropriate settings. Here are several examples of evidence-based treatment practices we are implementing:

Rhode Island Centers of Excellence's (COE) are specialty centers that use evidence-based practices and provide treatment and coordination of care to individuals with moderate -to severe opioid use disorder. The goal is to ensure timely access to appropriate Medication-Assisted Treatment (MAT) services and assist 2,000 DATA-waivered prescribers dealing with complex cases that need wrap around services that they cannot provide. RI now has five agencies with 14 locations throughout the state. Our Centers of Excellence have liaisons, funded by the MAT-PDA grant, that go to primary care offices and work with prescribers that have a need for MAT referrals or need clinical support while they build up their practices to meet the capacity.

Recovery Support services have grown through our ability to expand our local recovery community centers from two sites to eight. Peers now have a local "Hub" to be trained and be supervised as well as a center to connect individuals to community events and various resources such as SNAP, Employment, Housing, and additional recovery supports such as 12 step meetings and other ways to lead a healthy lifestyle. We know, for example, that many individuals want to find recovery, but it is very hard to maintain recovery without a roof over your head.

The various opioid support grants have allowed our recovery houses to become certified and meet the National Association of Recovery Residences (NARR) standards. Since the certification and payment for safe recovery houses has been federally funded, over 850 people have been placed in safe and, -sober living environments. Through federal dollars and the various grant implementations, individuals are remaining drug free, and have been placed in stable housing, and are receiving valuable assistance through employment and vocational opportunities.

RIDOH has funded navigators in Emergency Rooms to link individuals to care and have worked with hospitals around the state to adopt standards that provide for the initiation of MAT in the emergency room. Additionally, they used SURGE funding to create a rapid response crisis telehealth system that links high risk individuals who live on a rural island (the town of New Shoreham on Block Island) with a lack of resources to evidence-based MAT at a Center of Excellence. RIDOH funding was also used to provide linkages to care such as peer navigators in the Department of Corrections, through Street Outreach, at emergency departments, and in recovery clinics.

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

d.) Has your state advanced coordination with other federal efforts for substance use disorder prevention? If yes, please describe how.

Rhode Island has significantly advanced coordination with other federal efforts for substance use disorder prevention over the past few years in an interagency manner through our Culture of Collaboration. Here are several examples:

Rhode Island developed a new position in state government: Opioid Grants Administrator. Their primary function is to ensure effective administration of cross-agency grant-funded programs related to opioid and other drug overdose prevention and intervention activities. This role helps to coordinate cross-agency alignment and adherence to state-wide overdose prevention and intervention strategic plan when administering grants. All of the opioid grant funds are reviewed by the State Opioid Grants Administrator, who is responsible for coordinating and leveraging efforts across state agencies and closely tracking spending and activities toward outcomes. As noted earlier, regularly scheduled opioid grants status meetings are held with all appropriate agencies, including BHDDH, RIDOH, Medicaid, the Department of Labor and Training, and the Rhode Island State Police. As we begin to look for ways to seek shared funding toward future strategic priorities, the Opioid Grants Administrator will facilitate the collaboration and coordination between state agencies.

BHDDH (funded by SAMHSA for enforcement activity) coordinates efforts with RIDOH (funded by the CDC for prevention work) for all of our tobacco education and cessation services, as well as the enforcement of state and federal laws. We spark coordination at the sub-state level among our provider network, which includes BHDDH funded Regional Prevention Task Forces focused on coordinating substance abuse prevention activities within seven regions and RIDOH's network of Health Equity Zones (HEZs) focused on a variety of issues related to health promotion, prevention and social determinants.

Internally, BHDDH coordinates opioid funding with existing SAMHSA Substance Abuse Prevention and Treatmetn Blcok Grant (SAPTBG) funding to ensure sustainability. For example, SAMHSA SAPTBG funding support the network of seven regional prevention task forces and delivery of Project SUCCESS (Student Assistance Services) within 32 of Rhode Islands (35) school districts and between those two initiatives, all of the six required prevention strategies are delivered to citizens of these regions. Additional opioid funds have supported the implementation of opioid awareness activities (information dissemination), opioid specific education in schools (the addition of an opioid specific module to the Prevention Education Series offered as part of Project SUCCESS to 7th and 9th grade), and environmental change strategies to increase use of safer storage and disposal practices for prescription medications (especially opioids). In Rhode Island, the SAPTBG funds core activities, while discretionary grants scale up, enhance, and expand strategies that are substance or population group specific.

8.) What additional resources would be most helpful to provide to communities struggling with opioid and other substance use disorderss, including prevention and/or treatment options?

Rhode Island has identified our additional resources that would be most helpful to provide to communities struggles with our additional crisis:
Confidential: Preliminary Work Product Under RIGL 38-2-2(4)(k)

Response to House of Representatives Committee on Energy and Commerce's request for information regarding how Rhode Island is addressing the opioid crisis and its use of federal funding to promote treatment and recovery efforts.

1) Additional funding to support:
    a) Social determinants of health, including affordable housing, transportation (especially to/from treatment and recovery supports), and recovery friendly employment
    b) Residential treatment beds for pregnant and parenting people and their families
    c) Additional recovery housing
    d) Improved transitions from residential to outpatient services
    e) Adequate supports for our behavioral health workforce
    f) Sustainability for the projects listed throughout this document, including BH Link, the Hope Initiative, etc.

2) More funding flexibility, to allow use for bricks and mortar expenses, including repairs to state-owned treatment facilities and the creation of new facilities; and the ability to use Department of Agriculture funding not just in rural areas. (Rhode Island's small size makes this rural requirement difficult for us to implement.) If stigma is truly to be addressed, then it would start by upgrading treatment facilities in order to attract a sustainable workforce and foster a sense of safe professional treatment living.

3) There is a strong need to weave in the need for sustainability support through Medicaid or other federal tools.

4) Additional time to leverage 100% Federal Financial Participation under the SUPPORT Act, Section 5042 PARTNERSHIP Act to promote the expedient development of Rhode Island's Qualified PDMP.

5) Routing federal funds through the State Substance Authority (SSA) would help ensure coordination and collaboration between state departments.

Finally, the major assurance that we need is that there will be a gradual transition from funding such as the State Opioid Response grant to the SAPT Block Grant, in order to afford states the flexibility needed to address our unique needs. As much as this has been an opioid crisis response, it truly is more. Prevention, Treatment, and Recovery funding needs to address alcohol and other drugs as well. Allocating funds to target one drug and not those at risk or addicted to other drugs, including alcohol limits our ultimate success in not repeating this crisis with a new analogue or drug problem in the future.

Rhode Island has greatly appreciated the federal funding that we have received and is committed to continuing to use it in the most effective ways possible to address our serious addiction crisis. We are happy to provide any additional information that you need and to answer any questions you might have.

RI State Federal Grants

Funding Agency	State Agency	Grant Title	Amount of Award
BJA	RIDOH	Bureau of Justice Assistance (BJA) PDMP-Practitioner & Research Partnerships	750,000
CDC	RIDOH	Prescription Drug Overdose Prevention for States (PfS)	2,362,000
CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Base	3,146,152
CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Telehealth Special Project	500,000
CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Infectious Disease Vulnera	91,100
CDC	RIDOH	Enhanced State Opioid Overdose Surveillance (ESOOS)	973,940
CDC	RIDOH	Overdose Data to Action *$4.3M per year	12,900,000
CMS	Medicaid	Provider Capacity Building Initiative (PCBI)	3,000,000
CMS	EOHHS	Support Act - Medicaid Partnership Act	5,434,238
DOJ	RISP	Comprehensive Opioid Addiction Program (COAP) (Yr1)	1,800,000
DOJ	RIDOH	Comprehensive Opioid Abuse Site-based Program	2,000,000
DOL	DLT	National Health Emergency Dislocated Worker Demonstration (NHE)	3,894,875
SAMSHA	RIDOH	CARA First Responders Project to Combat RI Overdoses	800,000
SAMSHA	BHDDH	State Opioid Response (SOR Yr1 $12.6M, Yr2 $12.6M, Supp. $6.5M)	31,764,809
SAMSHA	BHDDH	State Targeted Response to Opioid Crisis (STR)	4,334,014
SAMSHA	BHDDH	Medication Assisted Treatment Prescription Drug & Opioid Addiction (MAT-PDOA)	3,000,000
		Total	76,751,128

Funding Source	Grant Title	Primary State Agency	Funded Amount	Start Date	End Date	# of Years	Data / Evaluation	Strategic Pillar 1: Preventio/ Preparedness	Strategic Pillar 2: Rescue	Strategic Pillar 3: Treatment	Strategic Pillar 4: Recovery
BJA	**Bureau of Justice Assistance (BJA) PDMP-Practitioner & Research Partnerships**	RIDOH	750,000	30-Sep-18	29-Sep-19	1 year	Project Dove: PDMP Use to Improve Pregnancy and Neonatal Outcomes in 5 RI Communities BMC Injury Prevention Dr. Traci Green Conduct a study of the impact of opioid prescribing during pregnancy and addiction response CME program and academic detailing, from annual provider surveys and quantitative analysis of PDMP, maternal, and neonatal outcomes				
CDC	**CDC Prescription Drug Overdose Prevention for States (PfS)**	RIDOH	2,362,000	01-Sep-15	31-Aug-19	4 years	Maintain and enhance PORI 48 Hour Reporting System, Weekly SRI meetings and ROARS, Quarterly MODE meetings, Report on Gov. TF Metrics	Rapid response mini-grants in response to MODE findings Academic detailing to prescribers Manage PDMP Fund SEN Coordinator and SEN workgroup	Fund community-based naloxone trainings Fund MRC to maintain statewide naloxone data collection Convene naloxone workgroup	Fund MAT liaisons in PCPs Fund MAT liaisons in DOC Embed social worker in WWPD to connection to treatment in lieu of arrest	Fund recovery coaches in DOC, through targeted street outreach, and specializing in pregnant/parenting population
CDC	**CDC Opioid Overdose Crisis Response Supplement Fund (SURGE) Base**	RIDOH	3,146,152	01-Sep-18	31-Aug-19	1 year	Obtain high quality and timely data STATUS NOTES: Improve use of PDMP	Surge evidence-based response strategies at state and local levels		Improve surge support of medical providers and health systems	Support new and expectant parents of SEN
CDC	**CDC Opioid Overdose Crisis Response Supplement Fund (SURGE) Telehealth Special Project**	RIDOH	500,000	01-Sep-18	31-Aug-19	1 year				Rapid crisis response telehealth system linking high risk pops with evidence-based MAT, at a COE (CODAC) to treat SUD	
CDC	**CDC Opioid Overdose Crisis Response Supplement Fund (SURGE) Infectious Disease Vulnerability Assessment**	RIDOH	91,100	01-Sep-18	31-Aug-19	1 year	Census-tract level assessment measuring vulnerability to overdose and HIV/ HCV, due to unsterile injection drug use				
CDC	**CDC Enhanced State Opioid Overdose Surveillance (ESOOS)**	RIDOH	973,940	01-Sep-16	31-Aug-19	3 years	Comprehensive Toxicology Testing: Linking PDMP Data to Mortality Data: Improving Scope and Data Quality of Emergency Department (ED) Admission Discharge Treatment (ADT) Data: Improving EMS data Timeliness and Reporting Improving scope/ reporting of fatal OD data through SUDORS				
CDC	**Overdose Data to Action *$4.3M per year**	DOH	12,900,000	01-Oct-19	31-Sep-22	3 years	Address the need for an interdisciplinary, comprehensive, and cohesive public health approach. Focused on: increasing comprehensiveness and timeliness of surveillance data; building state and local capacity for public health programs, making Prescription Drug Monitoring Programs (PDMPs) easier to use and access.				
CMS	**Provider Capacity Building Initiative (PCBI)**	Medicaid	3,000,000	01-Oct-19	01-Apr-21	18 mos.	Explore alternative payment methodologies that support implementation of effective treatment approaches, and implementing innovative approaches to recruit and retain a diverse workforce.			Ensure the highest quality care for Rhode Islanders on Medicaid, improve access to timely treatment and rapid recovery, address the needs of our providers	
CMS	**Support Act - Medicaid Partnership Act**	EOHHS	5,434,238	19-Sep-19	30-Sep-20	1 year	Planning PDMP Improvements Develop a Qualified PDMP per the Support Act, Section 5042, Medicaid Partnership Act				
DOJ	**US DOJ BJA – Comprehensive Opioid Addiction Program (COAP)**	RISP	1,800,000	01-Oct-18	30-Sep-21	3 years	Collaborate and analyze statewide law enforcement/ criminal justice data to identify individuals at the highest risk for overdose Provide support to the State Drug Chemistry lab for upgrades to existing testing protocols	Provide appropriate training to law enforcement personnel conducting mobile outreach assignments Develop appropriate awareness campaign for middle school and high school students on substance use		Outreach teams to encourage appropriate treatment resources to those at risk for overdose	Develop mobile outreach teams, of SU professionals and law enforcement throughout the state to conduct residential visits of identified at-risk individuals Provide support to families of those at risk and encourage appropriate involvement with available recovery resources
DOJ	**Comprehensive Opioid Abuse Site-based Program**	DOH	2,000,000	01-Oct-19	31-Sep-22	3 years	Strengthen the nation's PDMP system and support enhancements to PDMPs that improve clinical decision making and prevent the abuse and diversion of controlled substances.				

Funding Source	Grant Title	Primary State Agency	Funded Amount	Start Date	End Date	# of Years	Data / Evaluation	Strategic Pillar 1: Preventio/ Preparedness	Strategic Pillar 2: Rescue	Strategic Pillar 3: Treatment	Strategic Pillar 4: Recovery
DOL	**US DOL National Health Emergency Dislocated Worker Demonstration (NHE)**	DLT	3,894,875	7/1/18	30-Jun-20	2 years		Develop the skilled healthcare professionals needed to address the opioid crisis Provide addiction/opioid education and services for workers/workforce Provide career and training services for residents impacted by the opioid crisis including screening training for CBOs and public housing agencies			
SAMHSA	**SAMHSA CARA First Responders Project to Combat RI Overdoses**	RIDOH	800,000	30-Sep-18	29-Sep-22	4 years			Make naloxone available to law enforcement for emergency treatment of known or suspected opioid overdose Train and provide resources to first responders at two specialized levels of training - approximately 1,900 municipal police officers, 5,000 EMS providers, and more than 4,500 firefighters	Establish processes, protocols, and mechanisms for first responders to refer consumers to appropriate treatment and recovery services to reduce recurrence of overdose and divert arrest	
SAMHSA	**SAMHSA State Opioid Response (SOR)**	BHDDH	31,764,809	01-Oct-18	30-Sep-20	2 years	Awaiting SAMHSA response regarding GPRA Working on methods to administer and collect GPRA while keeping within 2% data cap	Increase the capacity of the community to assess,	Reduce number of opioid overdose-related deaths and adverse events	Increase access to MAT STATUS NOTES: Increase access to treatment services in the community	Increase access to recovery support services in the community
SAMHSA	**SAMHSA State Targeted Response to Opioid Crisis (STR)**	BHDDH	4,334,014	01-May-17	30-Apr-19	2 years		Support comprehensive response using strategic p	Reduce number of opioid overdose-related deaths and adverse events Increase rescue activities re prescription and illicit drugs	Increase access to treatment for prescription and illicit drugs	Increase access to recovery services re prescription and illicit drugs
SAMHSA	**SAMHSA Medication Assisted Treatment Prescription Drug & Opioid Addiction (MAT-PDOA)**	BHDDH	3,000,000	01-Sep-16	31-Aug-19	3 years	Data being conducted by Rhode Island College through GPRA	Decrease illicit opioid use and decrease use of prescription opioids in a non-prescribed manner Focus on populations coming out of incarceration	Focus on victims of opioid overdose seen in emergency settings	Provide rapid initiation and ongoing treatment for Opioid use disorder in high risk areas Make all FDA approved medications for treatment of OUD available Increase number of admissions into MAT and number of individuals receiving integrated care and treatment	Provide other necessary psychosocial interventions including peer recovery

Appendix A3

Rhode Island Opioid Grants

Below in alphabetical order by funding grant agency.

Active Grants (Funds Awarded)

Grant #1

Grant Name: Bureau of Justice Assistance (BJA) PDMP-Practitioner & Research Partnerships **Funded by:** BJA **Funded Amount:** $ 750,000.00
Department: DOH (*Department of Health*)
POC: Kristine Campagna Kristine.Campagna@health.ri.gov
Project Period: 9/1/2018 – 8/31/2019 1yr No Cost Extension to start 11/30/2019
Project Goals: Using PDMP (*Prescription Drug Monitoring Program*) • Improve pregnancy and neonatal outcomes in (5) RI Communities. • Conduct a study of the impact of opioid prescribing during pregnancy and addiction response CME program and academic detailing from annual provider surveys and quantitative analysis of PDMP, maternal and neonatal outcomes.

Grant #2

Grant Name: Prescription Drug Overdose Prevention for States (PfS) **Funded by:** CDC **Funded Amount:** $ 2,362,000.00
Department: DOH (*Department of Health*)
POC: Jen Koziol Jennifer.Koziol@health.ri.gov
Project Period: 9/1/2015 – 8/31/2019 4yrs
Project Goals: • Manage PDMP (Prescription Drug Monitoring Program) • Fund SEN (*Substance Exposed Newborns*) Coordinator and SEN workgroup • Fund community-based naloxone trainings • Maintain statewide naloxone data collection • Fund MAT (*Medicated Assisted Treatment*) liaisons in PCPs (*Primary Care Providers*) • Fund MAT liaison in DOC • Embed social worker in WWPO to connect to treatment in lieu of arrest • Fund Recovery Coaches in DOC (*Department of Corrections*) through street outreach and specializing in pregnant/parenting population

Grant #3

Grant Name: Opioid Overdose Crisis Response Supplement Fund (SURGE) Base **Funded by:** CDC **Funded Amount:** $3,146,152.00
Department: DOH (*Department of Health*)
POC: Lauren Conkey Lauren.Conkey@health.ri.gov
Project Period: 9/1/2015 – 8/31/2019 1yr Plans to apply for 90 day extension
Project Goals: • Develop evidence-based response strategies at state and local levels. • Improve use of PDMP. Improve SURGE support of medical providers and health systems. • Support new and expectant parents of SEN.

Grant #4

Grant Name: Opioid Overdose Crisis Response Supplement Fund (SURGE) Telehealth Special Project **Funded by:** CDC **Funded Amount:** $ 500,000.00
Department: DOH (*Department of Health*)
POC: Gina DeLuca Gina.DeLuca@health.ri.gov
Project Period: 9/1/2018 – 8/31/2019 1yr Plans to apply for 90 day extension
Project Goals: • Work with Medicaid to expedite payment method for telemedicine • Enable rapid crisis response telehealth system linking high risk populations with evidence-based MAT, at a COE (*Center of Excellence*)/(CODAC) to treat SUD.

Grant #5

Grant Name: Opioid Overdose Crisis Response Supplement Fund (SURGE) Infectious Disease Vulnerability Assessment **Funded by:** CDC **Funded Amount:** $91,100.00
Department: DOH (*Department of Health*)
POC: Thomas Bertrand Thomas.Bertrand@health.ri.gov
Project Period: 9/1/2018 – 8/31/2019 Plans to apply for 90 day extension
Project Goals: In conjunction with the Brown School of Public Health, RIDOH sought to determine whether existing data could predict specific neighborhoods at high risk for an opioid-related outbreak in Rhode Island, a state with a high burden of injection opioid use. • A predictive model was developed using machine learning methods. • Interactive maps were created which ranked neighborhoods predicted to be at high risk for outbreaks of HIV, HCV, and opioid overdoses.

Grant #6

Grant Name: Enhanced State Opioid Overdose Surveillance (ESOOS) **Funded by:** CDC **Funded Amount:** $ 973,940.00
Department: DOH (*Department of Health*)
POC: Leanne Lasher Leanne.Lasher@health.ri.gov
Project Period: 9/1/2016 – 8/31/2019 3yrs
Project Goals: • Implement Emergency Medical Services overdose surveillance system • Implement Emergency Department Admission, Discharge, Transfer OD surveillance system • Implement State Unintentional Drug Overdose Reporting System (SUDORS)

Grant #7

Grant Name: Overdose Data to Action **Funded by:** CDC **Funded Amount Approved** $ 4,300,000.00 (per yr)
Department: DOH (*Department of Health*)
POC: Jen Koziol Jennifer.Koziol@health.ri.gov
Project Period: 10/1/2019 – 9/31/2022 3yrs
Project Overview: Address the need for an interdisciplinary, comprehensive, and cohesive public health approach. Focused on: increasing comprehensiveness and timeliness of surveillance data; building state and local capacity for public health programs, making Prescription Drug Monitoring Programs (PDMPs) easier to use and access.

Grant #8

Grant Name: Provider Capacity Building Initiative (PCBI) **Funded by:** CMS **Funded Amount:** $3,000,000
Department: Medicaid
POC: Chantele Rotolo Chantele.Rotolo@ohhs.ri.gov
Project Period: 18-month planning project - future opportunity for add
Project Overview: To increase provider capacity to address SUD. Ensure the highest quality care for Rhode Islanders on Medicaid, improve access to timely treatment and rapid recovery, address the needs of our providers by: supporting ongoing learning, exploring alternative payment methodologies that support implementation of effective treatment approaches, and implementing innovative approaches to recruit and retain a vibrant and diverse workforce.

Grant #9

Grant Name: SUPPORT Act – Medicaid PARTNERSHIP Act **Funded by:** CMS - Medicaid IAPD **Funded Amount:** $ 5,434,238
Department: EOHHS (Executive Office of Health and Human Services
POC: Melissa Lauer Melissa.lauer@ohhs.ri.gov
Project Period: 9/19/19 – 9/30/2020 – Update/Extension anticipated for future years
Project Goals: • Planning for PDMP improvements • Develop a Qualified PDMP per the SUPPORT Act, Section 5042, Medicaid PARTNERSHIP ACT • Workflow integration of PDMP for healthcare providers through interoperability projects • Enhance PDMP and related reporting capabilities

Grant #10

Grant Name: Comprehensive Opioid Addiction Program (COAP) **Funded by:** US DOJ BJA **Funded Amount:** $ 1,800,000.00
Department: RISP (*Rhode Island State Police*)
POC: Captain Matt Moynihan Matthew.Moynihan@risp.gov
Project Period: 10/1/2018 – 9/31/2021 3yrs
Project Goals: • Build system network to collaborate with and analyze statewide law enforcement/criminal justice data to identify individuals at the highest risk for overdose • Provide support to State Drug lab for upgrades to existing testing protocols • Provide support to families of those at risk, encourage available recovery resources • Develop mobile outreach teams & train law enforcement personnel to conduct outreach

Grant #11

Grant Name: Comprehensive Opioid Abuse Site-based Program **Funded by:** US DOJ **Funded Amount:** $ 2,000,000.00
Department: DOH (*Department of Health*)
POC: Peter Ragosta Peter.Ragosta@health.ri.gov
Project Period: 10/1/2019 – 9/31/2022
Project Overview: Category 3: Harold Rogers PDMP Implementation and Enhancement Projects The objective of Category 3 is to strengthen the nation's PDMP system and support enhancements to PDMPs that improve clinical decision making and prevent the abuse and diversion of controlled substances.

Grant #12

Grant Name: National Health Emergency Dislocated Worker Demonstration (NHE) **Funded by:** US DOL **Funded Amount:** $ 3,894,875.00
Department: DLT (*Dept. Labor & Training*)
POC: Chris Tanguay Christopher.Tanguay@dlt.ri.gov
Project Period: 7/1/2018 – 6/30/2020 2yrs
Project Goals: • Develop the skilled healthcare professionals needed to address the opioid crisis. • Provide addiction/opioid education and services for workers/workforce. Provide career and training services for residents impacted by the opioid crisis including screening training for CBOs (*Community Based Organizations*) and public housing agencies.

Grant #13

Grant Name: CARA First Responders Project to Combat RI Overdoses **Funded by:** SAMHSA **Funded Amount:** $ 800,000.00
Department: DOH (*Department of Health*)
POC: Carolina Roberts Santana c.robertssantana@health.ri.gov
Project Period: 9/1/2018 – 8/31/2022
Project Goals: • Make naloxone available to law enforcement for emergency treatment of known or suspected opioid overdose. • Train and provide resources to first responders at two specialized levels of training – approximately 1900 municipal police officers, 5000 EMS providers, and more than 4500 firefighters. • Establish processes, protocols, and mechanisms for first responders to refer consumers to appropriate treatment and recovery services to reduce recurrence of overdose and divert arrest. Establish processes, protocols and mechanisms for first appropriate treatment and recovery services to reduce recurrence of overdose and divert arrest.

Grant #14

Grant Name: State Opioid Response (SOR) **Funded by:** SAMHSA **Funded Amount:** $ 31,764,809.00
Department: BHDDH (*Behavioral Healthcare, Developmental Disabilities, and Hospitals*)
POC: Adam Nitenson adam.nitenson@bhddh.ri.gov
Project Period: 9/1/2018 – 8/31/2020 2yr SAMHSA expected to approve No Cost Extension
Project Goals: • Increase the capacity of the community to assess, plan and implement strategies to prevent substance / opioid misuse. • Reduce the number of opioid overdose and related deaths and adverse events. Increase access to MAT (*Medicated Assisted Treatment)*. • Increase access to treatment services in the community. Increase access to recovery support services in the community. • The SOR grant funding is distributed over a 2-year timeframe. Year 1 distribution was $12.6M. A "SOR Supplement" was awarded in April 2019 which provided an additional $6.5M to the life of the grant. A Year 2 distribution of $12.6M is expected in Sept. 2019. Under the SOR grant BHDDH has funded and is managing (45+) Service Provider contracts.

Grant #15

Grant Name: State Targeted Response to Opioid Crisis (STR) **Funded by:** SAMHSA **Funded Amount:** $ 4,334,014.00
Department: BHDDH (*Behavioral Healthcare, Developmental Disabilities, and Hospitals*)
POC: Pearson Potts pearson.potts@bhddh.ri.gov
Project Period: 5/1/2017 – 4/30/2019 2yr No Cost Extension approved
Project Goals: Expand Recovery Housing, original target of 700 beds. Individuals were admitted to Recovery Housing under the grant for 365 days after which time they can self-pay or move onto homes of their own. • Support comprehensive response using strategic planning and needs/ capacity assessments • Increase prevention activities re prescription and illicit drugs • Reduce number of opioid overdose-related deaths and adverse events • Increase rescue activities re prescription and illicit drugs • Increase access to treatment for prescription and illicit drugs • Increase access to recovery services re prescription and illicit drugs

Grant #16

Grant Name: Medication Assisted Treatment Prescription Drug & Opioid Addiction (MAT-PDOA) **Funded by:** SAMHSA **Funded Amount:** $ 3,000,000.00
Department: BHDDH (*Behavioral Healthcare, Developmental Disabilities, and Hospitals*)
POC: Pearson Potts jaime.bernard@bhddh.ri.gov
Project Period: 9/1/2016 – 8/31/2019 3yrs Expecting to apply for 90 day extension
Project Goals: • Decrease illicit opioid use and decrease use of prescription opioids in a non-prescribed manner. Focus on populations coming out of incarceration. • Focus on victims of opioid overdose seen in emergency settings. Provide rapid initiations and on-going treatment for Opioid use disorder in high risk areas. • Make all FDA approved medications for treatment of OUD available. Increase number of admissions into MAT and number of individuals receiving integrated care and treatment. • Provide other necessary psychosocial interventions including peer recovery.

Note: Funds allocated reflect are for each year of the grant period
Please note that administrative costs and indirect costs are not included in this report.

AGENCY/PROVIDER	SERVICE	Amount Funded	Procurement Method	Determination of Value	Prevention Treatment Rescue Recovery
ARI	MAT - un/underinsured	fee for service	Delegated Authority	Client Choice	Treatment
Community Care Alliance	Recovery Community Center	300,000.00	Competitive Bid Process	Negotiation with vendor	Recovery
City of Barrington	Regional Prevention Task Force 5	333,286.00	Delegated Authority	Census	Prevention
City of Providence	Regional Prevention Task Force 3	333,286.00	Delegated Authority	Census	Prevention
City of Woonsocket	Regional Prevention Task Force 2	333,286.00	Delegated Authority	Census	Prevention
Coastline	Project Success	525,000.00	Delegated Authority	Negotiation with vendor	Prevention
Coastline	Regional Prevention Task Force 4	333,286.00	Delegated Authority	Census	Prevention
Coastline	Regional Prevention Task Force 7	333,286.00	Delegated Authority	Census	Prevention
CODAC	MAT - un/underinsured	fee for service	Delegated Authority	Client Choice	Treatment
CODAC	OTP Liaison	130,381.30	Delegated Authority	Negotiation with vendor	Treatment
CODAC	Integrated Mobile Unit	333,957.70	Single Source	Negotiation with vendor	Treatment
Community Care Alliance	Mobile Treatment & Comm Liaison	306,486.44	Delegated Authority	Negotiation with vendor	Treatment
Center for Treatment and Recovery	MAT - un/underinsured	fee for service	Delegated Authority	Client Choice	Treatment
Center for Treatment and Recovery	OTP Liaison	85,030.00	Delegated Authority	Negotiation with vendor	Treatment
Discovery House	MAT - un/underinsured	fee for service	Delegated Authority	Client Choice	Treatment
Discovery House	OTP Liaison	130,381.30	Delegated Authority	Negotiation with vendor	Treatment
RI Dept of Labor and Training	Access for Workforce Recovery - MOU	$187,500.00	MOU with State Agency	Negotiation with agency	Recovery
Community Care Alliance (East Bay Region)	Mobile Treatment & Comm Liaison	306,486.44	Delegated Authority	Negotiation with vendor	Treatment
East Bay Community Action Program	Recovery Community Center	299,552.00	Competitive Bid Process	Negotiation with vendor	Recovery
Gateway	Corrections to Community	85,800.00	Delegated Authority	Negotiation with vendor	Treatment
Gateway	Mobile Treatment & Comm Liaison	1,377,420.00	Delegated Authority	Negotiation with vendor	Treatment
Horizon Healthcare Partners	BH LINK	1,320,000.00	Competitive Bid Process	Negotiation with vendor	Treatment
Journey to Health, Hope and Healing	MAT - un/underinsured	fee for service	Delegated Authority	Client Choice	Treatment
Journey to Health, Hope and Healing	OTP Liaison	84,629.51	Delegated Authority	Negotiation with vendor	Treatment
John Snow Inc.	Prevention Resources Center	37,500.00	Single Source	Negotiation with vendor	Prevention
Newport County Community Mental Health Center	Mobile Treatment & Comm Liaison	306,085.00	Delegated Authority	Negotiation with vendor	Treatment
Parent Support Network	Family Task Force	56,250.00	Single Source	Negotiation with vendor	Recovery
Parent Support Network	Recovery Community Center	300,000.00	Competitive Bid Process	Negotiation with vendor	Recovery
Phoenix Houses of NE	Enhanced Detox	250,000.00	Competitive Bid Process	Negotiation with vendor	Treatment
Providence Center	Corrections to Community	85,799.00	Delegated Authority	Negotiation with vendor	Treatment
Providence Center	Mobile Treatment & Comm Liaison	172,720.00	Delegated Authority	Negotiation with vendor	Treatment
Providence Housing Authority	Housing Retention	300,000.00	Single Source	Negotiation with vendor	Recovery
Recovery Housing	Recovery Housing	500,000.00	Delegated Authority	Client Choice	Recovery
Rhode Island College	Primary Care Integration	110,982.00	Single Source	Negotiation with vendor	Treatment
RI Dept of Corrections	Corrections to Community - MOU	114,000.00	MOU with State Agency	Negotiation with agency	Treatment
RI State Police	Hope Initiative - MOU	450,000.00	MOU with State Agency	Negotiation with agency	Encompasses all categories
RI Department of Health	NAS Coordination/Enhancement - MOU	200,700.00	MOU with State Agency	Negotiation with agency	Treatment
RI Department of Health	Behavior Risk Factor Survey	19,000.00	MOU with State Agency	Negotiation with agency	Prevention
Salve Regina University	Supported Employment Svcs	79,750.00	Single Source	Negotiation with vendor	Recovery
Thrive	Mobile Treatment & Comm Liaison	307,000.00	Delegated Authority	Negotiation with vendor	Treatment
Town of Tiverton	Regional Prevention Task Force 6	333,286.00	Delegated Authority	Census	Prevention
TriCounty Community Action	Regional Prevention Task Force 1	333,286.00	Delegated Authority	Census	Prevention
VICTA	MAT - un/underinsured	fee for service	Delegated Authority	Client Choice	Treatment
Care Transformation Collaborative	CHT/NCM	600,000.00	Single Source	Negotiation with vendor	Treatment
City of Barrington	Regional Prevention Task Force 5	98,385.00	Delegated Authority	Census	Prevention
City of Providence	Regional Prevention Task Force 3	94,105.00	Delegated Authority	Census	Prevention
City of Woonsocket	Regional Prevention Task Force 2	98,166.00	Delegated Authority	Census	Prevention
Coastline	Regional Prevention Task Force 4	158,900.00	Delegated Authority	Census	Prevention
	Regional Prevention Task Force 7				
Town of Tiverton	Regional Prevention Task Force 6	93,654.00	Delegated Authority	Census	Prevention
TriCounty Community Action	Regional Prevention Task Force 1	34,295.00	Delegated Authority	Census	Prevention
Recovery Housing	Recovery Housing	2,895,000.00	Delegated Authority	Client Choice	Recovery
Care Transformation Collaborative	CHT/NCM	2,741,250.00	Single Source	Negotiation with vendor	Treatment
Dr. Freidman	Psychiatrist	130,000.00	Single Source	Negotiation with vendor	Treatment
The Providence Center	Safe Stations	150,000.00	Single Source	Negotiation with vendor	Treatment
JL Media	Media Campaigns	177,000.00	State MPA - bid process	provided a budget	Encompasses all categories
Rhode Island College	Evaluation	366,474.00	Purchasing Exemption	Negotiation with vendor	Treatment
CODAC	MAT Services	578,800.00	Delegated Authority	Negotiation with vendor	Treatment
Care New England Health Systems	MAT Services	137,000.00	Delegated Authority	Negotiation with vendor	Treatment

Duffy & Shanley	Media Campaigns	375,000.00	State MPA - bid process	provided a budget	Encompasses all categories
Journey to Health, Hope and Healing	MAT Services	224,600.00	Delegated Authority	Negotiation with vendor	Treatment
Community Care Alliance	MAT Services	153,400.00	Delegated Authority	Negotiation with vendor	Treatment

Note: Funds allocated reflect each year of the grant period
Please note that consultants not contracted for the program services were not included in this report.

AGENCY/PROVIDER	SERVICE	Amount Funded	Procurement Method	Determination of Value	Prevention Treatment Rescue Recovery
The Providence Center	Drug Overdose Prevention for Law Enforcement	304,786	Single Source	Worked with vendor to negotiate staffing and program costs to pilot pre-arrest diversion program	Prevention
Rhode Island Hospital	Drug Overdose Prevention Program	80,944	Single Source	Worked with vendor to negotiate staffing and program costs to enhance ED Levels of Care	50% Treatment 50% Prevention
Rhode Island Hospital	Medication Assisted Treatment Pilot Project for Medical Residents	154,938	Single Source	Worked with vendor to negotiate staffing and program costs to pilot nurse care managers in primarcy care to link to MAT	50% Treatment 50% Recovery
Parent Support Network of RI, Inc.	Peer Support to Parents with Young Children	116,150	Single Source	Worked with vendor to negotiate staffing and program costs for peer support services	Recovery
RI Disaster Medical Assistance Team	Statewide Naloxone Management System	323,934	Single Source	Worked with vendor to negotiate staffing and program costs to provide and track naloxone training and develop enhanced publicly available naloxone	Rescue
The Providence Center	Community Health Navigator Program	374,332	Single Source	Worked with vendor to negotiate staffing and program costs for community health navigator program	25% of each
RI Disaster Medical Assistance Team	First Responders Naloxone Adminisratin Training and Supply	250,000	Sole Source	Worked with vendor to negotiate staffing and program costs to provide naloxone and training to RI law enforcement.	Rescue
Town of Bristol	Health Equity Zone	59,995	Internal RFP	Worked with vendor to negotiate staffing and program costs for SURGE assessment	25% of each
Local Initiatives Support Corporation	Health Equity Zone	60,000	Internal RFP	or to negotiate staffing and program costs for SURGE assessment	25% of each
RI Disaster Medical Assistance Team	Municipal Overdose Response Plan Project	234,000	Single Source	Worked with vendor to negotiate staffing and program costs to develop and implement local overdose response plans statewide.	25% of each
Thundermist Health Center - Woonsocket	Health Equity Zone	60,000	Internal RFP	or to negotiate staffing and program costs for SURGE assessment	25% of each
Thundermist Health Center - West Warwick	Health Equity Zone	60,000	Internal RFP	Worked with vendor to negotiate staffing and program costs for SURGE assessment	25% of each
Olneyville Housing Corporation	Health Equity Zone	60,000	Internal RFP	or to negotiate staffing and program costs for SURGE assessment	25% of each
Boston Medical Center Corporation	Prescription Drug Overdose Prevention Research	739,958	Single Source	Worked with vendor to negotiate staffing and program costs for overodose-related policy evaluation and to conduct interveiws with drug users to identify drug use patterns to information interventions	25% of each
RMC Research Corporation	Prescription Drug Overdose Prevention Research	206,579	Single Source		50% Treatment 50% Prevention
South County Hospital Healthcare System	Health Equity Zone	60,000	Internal RFP	Worked with vendor to negotiate staffing and program costs for SURGE assessment	25% of each
Women's Resource Center of Newport & Bristol Counties	Health Equity Zone	60,000	Internal RFP	Worked with vendor to negotiate staffing and program costs for SURGE assessment	25 % of each
RI Disaster Medical Assistance Team	CODE Phase 2	358,400	Single Source	Worked with vendor to negotiate staffing and program costs to develop and implement local overdose response plans statewide.	25% of each
CODAC, Inc.	Telehealth Opioid Treatment Project	372,597	Single Source	Worked with vendor to negotiate staffing and program costs to develop and implement telehealth project to connect rural populations to MAT.	treatment

AGENCY/PROVIDER	SERVICE	Amount Funded	Procurement Method	Determination of Value	Prevention Treatment Rescue Recovery
	personnel	1,011,239			
	software vendor expenses	322,000			
	provider workflow integration, clinical decision support, and other interoperability projects	3,250,000			
	stakeholder engagement and planning activities, including multi-state collaboration planning	400,000			
	analytics capability development	400,000			
Total		5,383,239			

State of Rhode Island: Opioid Data Council Metrics by Pillar

Pillar	Level	Metric	Definition	Baseline	Target	Data source
Overall						
	P1	Drug Overdose-Related Accidental Deaths (Cumulative Unique Total Year to Date)	(blank)	314	265 (15% decrease over 3 years)	1. RIDOH Website (for summary), 2. SUDORS (for details)
	P2	Emergency Department Visits for Opioid-Related Overdoses (Average Monthly)	(blank)	128	135	48 Hour Reporting
Prevention						
	P1	Evidence-Based Activities Focused on Substance Use Completed by Prevention Coalitions and Health Equity Zones (Total Quarterly)	1. Prevention Coalition Activities: Count it, Lock it, Drop it and Take Back, 2. Any Health Equity Zone (HEZ) activities focused on substance use	83 (Takeback: 15, CLD: 50, & HEZ: 18)	Increase	1. Prevention Coalitions 2. RIDOH HEZ Data
	P2	Students Who Have Received the Project Success Prevention Education Series (Total Year to Date)	Students who received all 4 topics of the education series plus the opioid-specific module	3,529 (2017 - 2018)	3,700 (2018-2019)	RISAS
	S1	People Receiving New Opioid Prescriptions (Total Monthly)	People who had not been prescribed an opioid within the past 30 days but who have since been prescribed an opioid	33,476 (Q3 2018)	5% annual reduction, QoQ	PDMP
	S2	People Receiving Both an Opioid and Benzodiazepine Prescription in a 30-Day Period (Total 30-Day Period)	People who had not been prescribed both an opioid and a benzodiazepine within the past 30 days but who have since been prescribed both. This could include people with two new prescriptions or one existing benzodiazepine prescription who are newly prescribed an opioid, or vice versa.	11,235 (Q3 2018)	5% annual reduction, QoQ	PDMP
	S3	New Opioid Prescriptions to People Under 18 (Total Monthly)	People under the age of 18 who had not been prescribed an opioid within the past 30 days but who have since been prescribed an opioid.	876 (Q3 2018)	Reduction	PDMP
Recovery						

State of Rhode Island: Opioid Data Council Metrics by Pillar

Recovery	P1	New Enrollments in Recovery Community Centers (Total Monthly)	Total Number of people newly enrolled in BHDDH-funded recovery community centers in the month. Includes only those enrolled in services who were not previously enrolled for the past 30 days. Currently includes Anchor Pawtucket, Anchor Warwick, and PSN. Will soon include: The Serenity Center, East Bay Community Recovery Project, and South County Facility (soon to be named).	TBD	TBD	BHDDH-Funded Recovery Centers: PSN, Anchor Warwick, & Anchor Pawtucket Will soon include: The Serenity Center, East Bay Community Recovery Project, and South County Facility (soon to be named)
	P2	Enrollments in Recovery Community Centers (Total Monthly)	Total Number of people enrolled in BHDDH-funded recovery community centers in the month. Includes both those newly enrolled and those continuing enrollment. Currently includes Anchor Pawtucket, Anchor Warwick, and PSN. Will soon include: The Serenity Center, East Bay Community Recovery Project, and South County Facility (soon to be named).	TBD	TBD	BHDDH-Funded Recovery Centers: PSN, Anchor Warwick, & Anchor Pawtucket Will soon include: The Serenity Center, East Bay Community Recovery Project, and South County Facility (soon to be named)
	S1	Licensed Certified Peer Recovery Specialists (CPRS) (Total Monthly)	Includes all Certified Peer Recovery Specialists (CPRS) with licenses that are either "active" or "lapsed" because CPRS can continue to work with a "lapsed" license for up to one year.	90	Increase, pending Gabby's input on contract targets if applicable	Rhode Island Board of Certification
	S2	People in Recovery from Opioid Use Disorder Earning Wages Above the Federal Poverty Line (Total Quarterly)	Number of people with a Medicaid Claim for OUD claim in the past 2 years who earn wages above $3,035K (100% FPL) in the most recent quarter	TBD	Increase, specific target TBD. Dependent on baseline that is still pending.	Medicaid + Wage Data

State of Rhode Island: Opioid Data Council Metrics by Pillar

Recovery	S3	People Leaving a Certified Recovery House For Stable Housing (Total Monthly)	Denom: Cumulative unique number of people in recovery housing through current month from beginning of year; Num: same, but for who left for "stable" housing “Stable” housing definition pending BHDDH, will be provided per SAMHSA’s Treatment Episode Data Set (TEDS). Includes both "independent" and "dependent" housing.	TBD, data collection scheduled to begin in August 2019, expecting first round of data in September or October 2019. Will revisit then.	Increase, specific target TBD. Dependent on baseline that is still pending.	Recovery housing providers
	S4	Self-Reported Perception of Improved Global Wellness for Those Affected by Opioid Use Disorder (Total Monthly)	Per the ROMS, those who rated their overall health as “Rate your overall health on a scale from 1-5": Percent at 90 days choosing 3 (good), 4 (very good), 5 (excellent)	-159 (because survey is not be administered at 90 days)	Increase	ROMS
Rescue						
	P1	High-Risk Populations Who Have Received a Kit of Naloxone Within the Past 12 Months (Total Monthly)	1. People receiving SUD treatment for an OUD diagnosis at BHDDH-licensed facilities, 2. People with an ED visit for overdose (includes AMA), 3. People leaving ACI and who have been screened positive for OUD, 4. HOPE clients and their families	TBD	TBD (80%?)	1. Wufoo 2. 48 hour Reporting 3. DOC: INFACTS 4. HOPE
	P2	Naloxone Kits Received via Insurance (Total Monthly)	Includes new prescriptions and standing order prescriptions, but grouped separately so we can see the count of new, standing order, and total combined	5,245	9,063 (20% annual growth rate)	PDMP
	P3	Naloxone Kits Distributed (Total Monthly)	A kit is two doses of naloxone	16,771	10,000 per our December 2018 meeting, but this looks wrong. Let's revisit.	1. 48 Hour Reporting (Hospital) 2. PDMP (Pharmacy) 3. Wufoo (Non-Pharmacy, 4. PONI Non-Pharmacy, Community via PONI)

State of Rhode Island: Opioid Data Council Metrics by Pillar

Rescue	S1	Overdoses Reported to Have Received Naloxone Before Arriving at the Emergency Department (Total Monthly)	Naloxone administered to patient experiencing an overdose before arrival at ED. Could be administered by EMS, police, family / friend, unknown, other. Data should also include the total number of ED visits for overdoses as the denominator. Those who received naloxone before arriving at the hospital is the numerator. The resulting percentage is the number we want to report here.	77%	95%	48 Hour Reporting
	S2	Substance Use Disorder Treatment Provider Sites Using the Pharmacy Delivery Model for Naloxone Distribution (Total Monthly)	Includes BHDDH-licensed MAT, residential, & detox SUD treatment providers that dispense prescribed naloxone kits on site	6, 27%	22, 100% Confirm with Jamie that 22 is the true total.	BHDDH-licensed facilities via survey
Treatment						
	P1	People in Sustained Engagement with Medication Assisted Treatment (MAT) (Total Monthly)	People continuously enrolled in MAT for at least 180 days with no gap in treatment greater than 7 days. Includes anyone with a claim for treatment. Excludes those who transferred to a different level of care. 1. Methadone, 2. Buprenorphine	TBD	TBD	1. RIBHOLD 2. PDMP
	P2	Emergency Department Visits with a Substance Abuse-Related Primary Diagnosis for Those Receiving Medication Assisted Treatment (MAT) (Total Monthly)	For all people who received MAT of any length of time in past 12 months, rate per 1,000 people of ED visits for substance-related (primary diagnosis) treatment Rate of substance-related (primary diagnosis) ED visits per 1,000 people, for those on MAT for any length of time in past 3 years	133	125 (5% annual decrease)	APCD
	P3	People Receiving Medication Assisted Treatment (MAT) (Total Unique Monthly)	Anyone receiving 1. Methadone, 2. Buprenorphine, or 3. Vivitrol in the current month	11,139	14,032 (8% Annual Increase)	1. RIBHOLD 2. PDMP 3. Alkermes

State of Rhode Island: Opioid Data Council Metrics by Pillar

Treatment	PWL	People on the High Priority Wait List for Residential Treatment Services (Total Monthly)	People exceeding their maximum allowable number of days on the residential treatment waiting list, based on their priority assessment. There 6 priority levels defined here with the maximum allowable days each priority level can wait before being automatically elevated to the "High Priority Wait List". Priority 1: Pregnant injecting women (Two days), Priority 2: Pregnant substance abusers (Two days), Priority 3: Injecting drug users (Two weeks), Priority 4: Persons with HIV (Two days), Priority 5: Persons with TB (Two weeks), Priority 6: All others (100 days) As reported to BHDDH and deduplicated; For short-term, mixed and long-term residential treatment services (3.1, 3.3, 3.5)	11	0	RIBHOLD
	S1	People with a new OUD diagnosis connected to treatment or recovery services within 6 months (Total Monthly, 12 Month Look Back)	Includes people diagnosed with MAT and connected to MAT services in less than or equal to 6 months, Total Monthly, 12 Month Look Back	0.27	TBD, Kim has, year by year analysis for target – talk to Jesse and Brown about best practices Kim & Susan Jacobson at Thundermist	APCD
	S2	People with OUD or SUD Successfully Connected to Treatment via BH Link or the HOPE Initiative (Total Monthly)	Number of people with a treatment encounter (any kind) within 30 days of a BH Link or HOPE encounter	12%	30%	Temporary Data Source: Medicaid Claims only 2/14/19 1. BH Link: RIBHOLD + Claims, 2. HOPE: HOPE +Database
	S3	Vulnerable Populations Receiving Medication Assisted Treatment (MAT) Services (Total Quarterly)	Includes: Not Caucasian (race), Hispanic (ethnicity)	TBD	TBD	Temporary Data Source: Medicaid Claims only 2/14/19 RIBHOLD

Appendix C2

Additional Performance Metrics

PDMP Metrics: To continue supporting RI's Qualified PDMP in the future, RI will be required to report on a variety of measures per the PARTNERSHIP Act:

"(A) The percentage of covered providers (as determined pursuant to a process established by the State) who checked the prescription drug history of a covered individual through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance.

"(B) Aggregate trends with respect to prescribing controlled substances such as—

"(i) the quantity of daily morphine milligram equivalents prescribed for controlled substances;

"(ii) the number and quantity of daily morphine milligram equivalents prescribed for controlled substances per covered individual; and

"(iii) the types of controlled substances prescribed, including the dates of such prescriptions, the supplies authorized (including the duration of such supplies), and the period of validity of such prescriptions, in different populations (such as individuals who are elderly, individuals with disabilities, and individuals who are enrolled under both this title and title XVIII).

Additionally, RI will report several quality measures to CMS based on what is determined most valuable to help measure positive outcomes of the investment in the PDMP. This will be a component of the PDMP planning project.

RIDOH BJA SEN: Response: 100% of families referred to First Connections; 100% of families referred to Early Intervention; 100% of families receive follow-up calls at 3, 6, 9, and 12 months after delivery.

# of recovery coaches trained to support new and expectant parents

SAMSHA CARA metric goals:

GOALS OF THE EVALUATION

Goal 1. Increase Naloxone availability for law enforcement officers (LEO).

Objective 1. 1. By January 1, 2019, establish contracts and memorandum of agreements that define the purchasing, tracking, storage and distribution of Naloxone to law enforcement agencies.

Objective 1. 2. By March 2019, collaborate with MRC NOPE-RI program and RISP HOPE-RI program to establish processes for naloxone use reporting, naloxone training compliance and naloxone re-ordering after administration by law enforcement agencies.

Objective 1. 3. By June 2019, implement the data collection system to monitor naloxone administration by first responders.

Objective 1. 4. By September 2022, 100% of participating law enforcement agencies will have established policies and procedures for naloxone administration documentation, resupply and sustainability.

Goal 2. Train first responders on Naloxone administration, mental health, and substance use recognition and other related opioid related professional training.

Objective 2.1. By June 2019, coordinate all training curriculum for EMS, Fire and Law Enforcement Officers.

Objective 2.2 By March 2020, 30% of first responders will participate in NOPE-RI training, overdose medical response and mental health and self-care training.

Objective 2.3 By March 2021, 60% of first responders will participate in NOPE-RI training, overdose medical response and mental health and self-care training.

Objective 2.4. By September 2022, 100% of Rhode Island first responders will participate in annual continuing education opportunities on naloxone training, overdose medical response and opportunities on mental health and self-care training.

Goal 3. Increase patient referral by first responders to treatment and recovery services.

Objective 3.1 By January 2019, delineate variables and identify all reporting pathways for non-fatal/fatal drug overdose, and patient referral pathways to treatment and recovery services for first responders.

Objective 3.2 By March 2019, create opportunities to train all first responders about BH link and the HOPE Statewide Pre-Arrest Diversion Outreach.

Objective 3.3 By December 2020, 30% of non-fatal overdose victims will be referred to the HOPE Statewide Pre-Arrest Diversion Outreach Team by first responders.

Objective 3.4 By December 2021, 60% of non-fatal overdose victims will be referred to the HOPE Statewide Pre-Arrest Diversion Outreach Team by first responders.

Objective 3.5 By December 2022, 90% of non-fatal overdose victims will be referred to the HOPE Statewide Pre-Arrest Diversion Outreach Team by first responders.

Goal 4. Collaborate with mental health providers to increase the number of overdose patients who receive treatment.

Objective 4.1 By September 2020, 40% of overdose survivors referred to treatment by first responders will be admitted treatment recovery services.

Objective 4.2 By September 2021, 60% of overdose survivors referred to treatment by first responders will be admitted treatment recovery services.

Objective 4.3 By September 2022, 80% of overdose survivors referred to treatment by first responders will be admitted treatment recovery services.

Goal 5. Integrate data management, evaluation metrics, and quality improvement efforts to enhance statewide opioid overdose surveillance.

Objective 5.1. By August 2019, develop an evaluation plan to measure all data points related to the program.

Objective 5.2. By December 2019, expand and improve RIEMSIS to track and report program activities, including documentation of naloxone administration prior to EMS unit's arrival.

Objective 5.3. By September 2020, conduct training to improve field reporting sources in 50% of EMS agencies.

Goal 6. Implement a Naloxone leave-behind program for persons at high-risk for overdose who refuse EMS transport.

Objective 6.1 By December 2019, develop protocols and reporting procedures to instate and monitor an EMS Naloxone-leave behind program for persons refusing EMS transport following an overdose reversal.

Objective 6.2 By March 2020, engage 5 EMS agencies providing service to communities with highest rates of overdose to participate in Naloxone-leave behind program.

Objective 6.3 For EMS agencies participating in the pilot program, by June 2022, 90% of persons refusing EMS transport following overdose reversal will receive a Naloxone kit for their household.

BHDDH Metrics: In addition, per SAMSHA grant requirements BHDDH uses GPRA and includes consistent performance measures around recidivism, step down to less restrictive services based upon clinical assessment as well as many others in each contract depending upon the scope of work.

Governor Gina M. Raimondo's Overdose Prevention and Intervention Task Force

Strategic Plan Update

Outlining Strategies and Actions through December 2021

Strategic Plan Update: Overview

Keep focus on saving lives *and* go upstream to prevent overdose deaths.

This plan:

- **Keeps our strategic pillars** of prevention, rescue, treatment, and recovery.
- **Adds new core principles to act as bridges between each of the pillars—**or important, cross-cutting workstreams aimed at addressing the problems that caused the overdose crisis.
- **Puts new emphasis on prevention and recovery—**or going upstream and downstream while maintaining our focus on saving lives through robust rescue and treatment resources.
- **Aligns with new funding sources,** specifically the State Opioid Response grant from SAMHSA, the CDC-SURGE grant, the Dislocated Worker Grant from the Department of Labor, and grants from the Department of Justice to support the HOPE Initiative.

Strategic Plan Update: Building on Past Progress

Building on the infrastructure developed under the last three years, this plan proposes significant new investments in critical areas of overdose response.

Accomplishments under Last Strategic Plan:

- Creation of 14 Centers of Excellence
- Extensive opioid competence at RI hospitals through Levels of Care; 48-hr ED reporting
- Robust Medication Assisted Treatment (MAT) at the Department of Corrections
- Community Overdose Engagement Summits and state/local partnerships

Strategic Plan Update: Core Principles

While we cannot let up on our focus of saving lives, the Task Force needs to do more to change the social conditions that cause substance use disorder and that keep people with substance use disorder from getting effective support.

- Task Force Expert Advisors and Co-Chairs all expressed that the strategic pillars are a good way to outline the Task Force's day-to-day actions and goals, but **there are important, cross-cutting principles that ought to be informing our work**.
- To **keep the bigger picture in mind**, and to **keep a focus on some of the overdose crisis's most intractable problems**, this plan proposes creating five new **core principles** to guide the work of the Task Force:
  - **Integrating Data to Inform Crisis Response**
  - **Meeting, Engaging and Serving Diverse Communities**
  - **Changing Negative Public Attitudes on Addiction and Recovery**
  - **Universal Incorporation of Harm-Reduction**
  - **Confronting the Social Determinants of Health**

Strategic Plan Update: Explaining Core Principles

Integrating Data to Inform Crisis Response

Making sure we're faithful to data as a way of understanding what's working and what isn't.

- While the State has always considered data its most important resource for determining the effectiveness of its response to the overdose crisis, reflected through regular, data-focused check-ins with the Executive Office of Health and Human Services, this plan will take that focus on data one step further.
- "Integrating Data to Inform Crisis Response" calls on the State and Task Force members to ensure that all of our actions are measurable.

Core Principle	Prevention	Rescue	Treatment	Recovery
Integrating Data to Inform Crisis Response	Track primary prevention effectiveness, building on work to curb unnecessary opioid prescription and promote safe opioid storage	Leverage data tracking for advanced understanding about where rescue resources can be deployed most effectively	Set and pursue client outcome metrics for state-sponsored treatment programs, directing people to evidence-based care	Build recovery-focused metrics that track what helps someone with SUD enter—and stay in—recovery

Strategic Plan Update: Explaining Core Principles

Meeting, Engaging, and Serving Diverse Communities

Understanding and addressing structural disparities and discrimination, working to eliminate barriers to care in diverse communities.

- Nationally, women, people of color, people with less economic security, and specialized populations like veterans do not have access to substance use disorder care that would help them get well.
- Even as Rhode Island experienced a slight drop in overdose deaths last year, some data suggest that the overdose crisis is getting worse—not better—among women and communities of color.
- Going forward, consideration of how our actions impact, and improve, SUD care for diverse communities will be integrated into our work through this core principal.

Core Principle	Prevention	Rescue	Treatment	Recovery
Meeting, Engaging, and Serving Diverse Communities	Ensure that prevention resources are attentive to differences across communities and are deployed equitably	Work with first responders to understand how service needs vary across communities and ensure robust assistance to first responders in communities of the highest need	Make sure treatment resources are accessible to and meet the needs of all Rhode Islanders, appreciating the diversity of our communities' needs	Reduce—or eliminate—discrimination and structural barriers that prevent people with SUD from attaining meaningful, lasting recovery

Strategic Plan Update: Explaining Core Principles

Changing Negative Public Attitudes on Addiction and Recovery

Taking meaningful steps to eliminate stigma and to change the conversation on addiction and recovery in Rhode Island.

- A society dominated by negative attitudes on addiction and recovery remains one of the biggest, most intractable barriers to seeking substance use disorder treatment, or for delivering effective substance use disorder care.
- In particular, negative attitudes about Medication Assisted Treatment prevent people from accessing life-saving care.
- Establishing a core principle of changing negative public attitudes about substance use disorder will help the State put stigma reduction front and center.
- A partnership between the State and the Boston Federal Reserve will help to provide a research basis for changing negative public attitudes

Core Principle	Prevention	Rescue	Treatment	Recovery
Changing Negative Public Attitudes on Addiction & Recovery	Develop prevention resources that also cultivate better understanding of substance use disorder's challenges; build on work to educate medical professionals in the position to refer to treatment resources	Continue to provide training and resources that adequately reflect the challenges of living with substance use disorder to law enforcement, first responders, and medical personnel	Broaden public attitudes about seeking treatment for SUD through public awareness and sharing the stories of people who get well; continuing to demonstrate to the community about the availability and effectiveness of treatment	Create more recovery-friendly environments and broaden understanding of the possibility of recovery for anyone with the right supports in place

Strategic Plan Update: Explaining Core Principles

Universal Incorporation of Harm Reduction

Putting health and wellbeing first, further reducing the chance that SUD will lead to death and other adverse health outcomes.

- In the most basic sense, "harm reduction" means taking a big picture perspective on the health of people with substance use disorder, and meeting them "where they are" when delivering substance use disorder care, working with them to mitigate the negative health impacts of substance use disorder.
- This principle asks that the State continue to be dynamic in meeting the needs of people with substance use disorder, and to design programs that offer people with substance use disorder a "low threshold" of entry into care.

Core Principle	Prevention	Rescue	Treatment	Recovery
Universal Incorporation of Harm Reduction	Increase awareness of harm reduction services and tactics among more lay responders to overdoses	Deploy more harm-reducing SUD/overdose resources, making them more immediately accessible	Create more linkages between treatment and harm reduction resources across the system; adding "fast access" or other very low threshold buprenorphine as HR strategy	Ensure that harm reduction resources are present in recovery-focused settings and ensure that recovery resources account for total personal health, not just SUD

Strategic Plan Update: Explaining Core Principles

Confronting the Social Determinants of Health

Seeing the overdose crisis in the context of the environments, policies, and society that caused it.

- To solve the overdose crisis, we need to account for the social determinants of health, like housing, community environment, employment, and education—the things that, in addition to medical intervention, account for a person's health outcomes.
- We cannot fix the social determinants of health immediately, but it is important to start taking the big picture view on the overdose crisis, and to see people with substance use disorder in the context of the society that drives SUD in the first place.
- To start, we can start to evaluate how existing substance use disorder programs either fit with or work against the social determinants of substance use disorder.

Core Principle	Prevention	Rescue	Treatment	Recovery
Confronting the Social Determinants of Health	Incorporate of social determinants into prevention planning—building social capital that helps prevent addiction; give communities power to design & implement prevention plans	Make rescue resources more accessible to high-risk populations, through the lens of social determinants	Add social capital, and factor in the social determinants of health, in developing treatment plans	Factor social capital in to the development of recovery plans; build a society where all Rhode Islanders have access to the social and community supports needed to sustain recovery

Strategic Plan Update: Major Actions in New Plan

While we propose many new projects, the actions below are the key initiatives of the new plan.

- **PREVENTION:** Scaling up evidence-based primary prevention programs in schools and communities
- **RESCUE:** Leveraging community-focused infrastructure, like increased mobile outreach capacity, to serve diverse communities, incorporate harm reduction approaches, and confront social determinants of health
- **TREATMENT:** Opening BH Link/other resources to create "treatment on demand"
- **TREATMENT:** Launching the HOPE Initiative for statewide pre-arrest diversion and enhancing treatment capacity
- **RECOVERY:** Designing a "recovery success" metric that helps us understand and reinforce pathways to successful recovery
- **RECOVERY:** Creating new pathways for people in recovery to get good careers

Strategic Plan Update: Metric Development

- As the initial drafting of the strategic plan came to a close, EOHHS convened a process of establishing metrics to track the progress of the plan outlined here.
- Metrics are nearly finalized, pending some final decisions about which metrics will ensure the success of the strategic plan.

Final metrics will be presented to the Task Force on 03/13.

APPENDIX

Updates to Strategic Plan: Outlining Actions through December 2021

Detailed Action Items

Strategic Plan Update: Prevention – Goals

Prevention may be the hardest area to get right: there are a lot of conflicting opinions about what works, and it's often difficult to quantify the benefits of prevention programs because the payoff can be years in the future.

This plan suggests pursuing a prevention strategy that focuses on applying and faithfully sticking to data-driven approaches to make this challenging area more concrete, and building on our successes in secondary prevention to do more in the area of primary prevention.

- Effective, evidence-based, statewide primary prevention—in schools, professional settings, and anywhere we can get peoples' attention
- Harnessing the predictive power of big data
- Focusing on the subtle changes—or "nudges"—that can drive bigger actions
- Prevention resources for families of people who are at risk

Strategic Plan Update: Prevention – Detailed Goals

We will build on our successes in the area of *secondary prevention* and do more in the area of *primary prevention*.

- **Goal 1 – Primary Prevention:** Building on our partnership with Truth Imitative, the Task Force will make recommendations on and see through to completion the creation of community-driven prevention resources. These activities, intended to focus first on communities at highest risk, will include:
  - Goal 1A: Evaluate current school-based prevention initiatives for effectiveness and observance of best practices to then inform recommendations for school-based prevention initiatives.
  - Goal 1B: Strengthen the role of afterschool programs and creating better linkages to afterschool prevention activities.
  - Goal 1C: Develop of education resources that meaningfully address self- and social-stigma leveraging the best available research and Expert Advisor guidance.
  - Goal 1D: Develop specialized primary prevention activities for communities at highest risk.
- **Goal 2 – Tailored Education on Benzodiazepine Prescribing:** Similar to the activities undertaken by RIDOH to curb excess opioid prescribing--education materials, academic detailing, tailored electronic alerts—the Task Force will sponsor and promote activities that will curb excess benzo prescribing.
  - Goal 2A: Create a provider curriculum offering guidance on benzodiazepine prescription.
  - Goal 2B: Create patient education materials on benzodiazepine abuse and overdose risks.
- **Goal 3 – Enhanced PDMP/Secondary Prevention Data Integration:** Integrate PDMP and ROARR systems to alert health professionals about spikes in overdose activities.
- **Goal 4 – Data Partnerships to Identify Risk Factors:** Link disparate sources of healthcare and SUD data to develop better predictive models for who is likely to develop substance use disorder and work on prevention activities responsive to these findings. Could be developed in tandem with a partner recruited to manage this analysis.

Strategic Plan Update: Prevention – Detailed Goals

- **Goal 5 – Behavioral Economics as a Lens for Prevention Activities:** Recruit partners to propose and evaluate prevention-focused "nudges," or subtle changes in operations that can drive big changes in behavior.
  - Goal 5A: Develop and pilot new pharmacy-based "nudges" to incentivize co-prescribed naloxone pickup and safe opioid disposal.
  - Goal 5B: Develop and pilot new mobile outreach nudges that incentivize seeking of treatment resources.
  - Goal 5C: Create new incentives for the proliferation of non-opioid pain management procedures
- **Goal 6 – Creating a Family-Focused Recovery Specialist Model:** Use the success of the Peer Recovery Specialist to create a Family-Focused Peer Recovery navigator for families at high risk. These Family-Focused Recovery specialists would work with families who have identified a loved one at risk of developing Substance Use Disorder.
  - Goal 6A: Evaluate the feasibility of intensive family intervention services by layering on this peer model clinical support services.
- **Goal 7 – Drug Manufacturer-Funded Takebacks:** Propose financial incentives or other binding agreements that incentivize pharmaceutical companies and insurers to ensure opioids and other dangerous prescriptions are disposed of. Or alternately: propose formal partnerships with pharmaceutical companies and insurers that effectively incentivize people to dispose of excess prescription medications.
- **Goal 8 – Workforce Sector-Targeted Outreach:** Build on the Governor's Recovery-Friendly Workplaces Initiative to provide primary prevention materials for any workers taking disability leave.
  - Goal 8A: Create a worker education curriculum for people preparing for disability leave, targeting high-risk industries.

Strategic Plan Update: Rescue – Goals

The impact of the Task Force's "Rescue" focus to date are an excellent example of harm reduction strategy in action, but there is much more we can do.

This plan offers a few essential guidelines for guaranteeing that rescue resources are universally available for as long as they're needed.

- Developing a plan for funding rescue resources, including naloxone, as long as needed
- Setting a state standard for universal naloxone accessibility by guaranteeing its distribution in varied settings, even in unexpected ones
- Integrate a new statewide crisis resource, BH Link, with first responders, which will help first responders and improve care

Strategic Plan Update: Rescue – Detailed Goals

The impact of the Task Force's "Rescue" focus to date are an excellent example of harm reduction strategy in action, but there is much more we can do.

- **Goal 9 – Find and Ensure Sustainable Funding for Naloxone:** Work with State agencies, federal authorities, and private partners to ensure that there is a continuous source for funding bulk naloxone purchases.
  - Goal 9A: Propose a dedicated funding stream for Naloxone purchases.
  - Goal 9B: Ensure that Rhode Island meets the obligations of S 2930/H 8313, and propose ways for insurers to more readily support distribution of naloxone.
- **Goal 10 – New Standard of Public Naloxone:** Have naloxone available and to train staff working in any setting where there is an AED, or establish a similar standard to have naloxone available in any building of a certain size.
  - Goal 10A: Create statewide guidelines for public naloxone availability, and consider enforcing these guidelines through regulation or partnership with property insurers.
  - Goal 10B: Set and meet individual targets for naloxone distribution and use by setting.
- **Goal 11 – Make Naloxone Easier to Obtain in Priority Settings:** Develop a list of "naloxone critical" settings like OTPs, doctors' offices, and recovery centers, where naloxone should be instantly accessible without obtaining and filling a separate prescription.
  - Goal 11A: Ensure naloxone is given to people exiting the ACI.
  - Goal 11B: consider mandatory naloxone distribution through state-contracted services.
- **Goal 12 – Creation of More Rescue Dyads:** Take models established by opioid treatment providers and pharmacies to create more pharmacy partnership dyads in key settings.

Strategic Plan Update: Rescue – Detailed Goals

- **Goal 13 – Integrate BH Link with the Rescue/First Responder Network:** Work with emergency services providers to direct appropriate referrals to BH Link before or after someone overdoses.
  - Goal 13A: Refine and drive continuous improvements in transportation protocols that will get people to BH Link.
  - Goal 13B: Facilitate new partnerships between BH Link and community first responder groups.
  - Goal 13C: Facilitate new partnerships between BH Link and healthcare providers across the system, including hospitals, primary care offices, and community health centers.
- **Goal 14 – Better Care After Naloxone Administration:** Develop or improve standards of care for first responders personnel following the administration of naloxone.
  - Goal 14A: Use discharge planning mandates and Levels of Care to require a best practice for managing withdrawal.
- **Goal 15 – Evaluate Levels of Care:** Evaluate the impact of Levels of Care designation at hospitals, understanding if current levels are resulting in more saved lives.
  - Goal 15A: Incentivize more hospitals to achieve Level One.
  - Goal 15B: Evaluate current hospital discharge planning procedures to develop an understanding of what prevents people who have overdosed from transitioning to treatment and identify new ED-initiated linkages to treatment in ongoing care.
- **Goal 16 – Use Expanded Syringe Services as Opportunity for Outreach:** Build on the work of syringe service programs, targeting them for significantly enhanced naloxone distribution.

Strategic Plan Update: Treatment – Goals

We need to make treatment more available to people in all settings, and make treatment resources more focused on catching people who fall through gaps in the continuum of care.

This plan suggests that we set a goal of universal "treatment on demand" by bringing together planned and existing treatment resources, and asking our providers to work with us in catching people who fall out of treatment when they encounter all-too-frequent.

- Integrating BH Link into the statewide overdose response and overdose treatment systems to ensure that treatment "sticks"
- Integrate the HOPE Initiative as a treatment and recovery pathway
- Creating new incentives for treatment providers to observe best practices to keep them focused on treatments that get people well
- See beyond opioids to ensure people with non-opioid SUD challenges are getting the services they need
- Developing strategies for broader proliferation of buprenorphine use

Strategic Plan Update: Treatment – Detailed Goals

We need to make treatment more available to people in all settings, and understand how it fits in the continuum of care as a component of our healthcare system.

- **Goal 17 – Work Toward a "Treatment on Demand" Model:** Implement aspects of a "Treatment on Demand" system in Rhode Island. "Treatment on Demand" would make treatment resources available to people with SUD the moment they decide they want it, creating frictionless access to treatment. Components include:
  - Goal 17A: Stand up and support statewide mobile outreach/mobile crisis services.
  - Goal 17B: Stand up mobile/home induction of Medication Assisted Treatment, or other ways to ensure fast access to MAT in varied settings (pharmacies or other lite-clinical settings).
  - Goal 17C: Create a "waiting list response system" so that anyone presented with the necessity of waiting for a treatment service can be seamlessly referred to another treatment source (can be integrated with BH Link).
  - Goal 17D: Create better process for referring people to COEs and ensuring their deeper integration into the treatment system.
- **Goal 18 – Integrating BH Link into the Overdose Response System and Post-Overdose Treatment Settings:** Fully connect BH Link to all pieces of the state's overdose response system.
  - Goal 18A: Integrate BH Link as a priority resource for all other state treatment systems, including: emergency departments, the HOPE Initiative, Centers of Excellence, Community Mental Health Centers, Community Health Centers, and other, to-be-identified care resources.

Strategic Plan Update: Treatment – Detailed Goals

- **Goal 19 – Support the HOPE Initiative:** Provide support to the HOPE Initiative and help to integrate it with SUD treatment resources as a way to enhance access to treatment.
- **Goal 20 – Better Data Assessment of Treatment Program Outcomes:** Create useful and meaningful evaluation prtocols for treatment programs (could occur through partnership with program like Shatterproof).
  - Goal 20A: Continue to evaluate the impacts of Medication Assisted Treatment-driven programs to determine which have the best outcomes and most robust wrap-around services.
  - Goal 20B: Continue work to determine the settings that help us to understand which Medication Assisted Treatment modality is best in a given treatment plan.
- **Goal 21 – Improving Post-Overdose Treatment Engagement:** Incentivize treatment providers to think more extensively about post-overdose care. Despite strides in handoffs to recovery and sustained treatment resources, more improvements are needed.
  - Goal 21A: Require treatment providers to provide “warmer” handoffs, and support them through a referral clearinghouse like BH Link.
  - Goal 21B: Support expanded capacity at recovery centers to close gaps in the continuum of care by making recovery resources even more accessible through treatment settings.
- **Goal 22 – Map Out and Expand Non-Opioid Substance Use and Other Treatment Programs:** Create more treatment services unrelated or unspecific to opioid, which could include non-opioid chronic pain treatment centers, cocaine treatment services, alcohol addiction, and other substance use treatment disorders.
  - Goal 22A: Assess availability of all opioid and non-opioid treatment services available to different populations in the state, focusing on traditionally marginalized populations.
  - Goal 22B: Undertake an assessment of need for non-opioid treatment services and develop a plan for sustainable non-opioid treatment resources in the future.

Strategic Plan Update: Recovery – Goals

Simply put: more attention needs to be paid to what is helping people enter and sustain recovery. Robust recovery supports are critical to preventing overdose.

This plan suggests getting a better understanding of the recovery supports that work and making sure everyone starting in recovery gets seamless access to these supports for as long as they need them.

- Getting data on "what works" in recovery—to help people with SUD and providers helping them get a clear idea of what will give them their best shot to stay in recovery in the long term
- Support the recovery supports in high demand, like programs with waiting lists that we already know are helping people to build new lives
- Build career and job opportunities for people in recovery—building economic security and a sense of purpose
- Get more communities across Rhode Island to build a recovery-friendly society through visibility and through concrete action

Strategic Plan Update: Recovery – Detailed Goals

More attention needs to be paid to what is helping people enter and sustain recovery.

- **Goal 23 – Develop Recovery-Focused Data Protocols:** Create a new "recovery success" metric that follows individuals' histories of care over defined periods of time.
  - Goal 23A: Create recovery metrics that allow us to see how well treatment and recovery programs are working by tracking 3-, 6-, and 12-month outcomes for enrollees in OUD treatment programs.
  - Goal 23B: Use this data to assess which treatment and recovery interventions work best for keeping someone in recovery and to support broader proliferation of these services.
  - Goal 23C: Consider an established partnership through the Brown Policy Center.
- **Goal 24 – Expand Peer Recovery Resources in High Demand:** Use federal grant funding sources to expand recovery sources in high demand.
  - Goal 24A: Increase funding for recovery housing programs, for which there is a waiting list.
  - Goal 24B: Increase funding for recovery community centers, which are limited both in hours and geographic coverage.
  - Goal 24C: Improve career development programs SUD-related health worker services like Peer Recovery Specialists to incentivize more stable workforces and less turnover in these programs.

Strategic Plan Update: Recovery – Detailed Goals

- **Goal 25 – Support Workforce-Driven Efforts to Keep People in Recovery**: Support and improve the Governor's Recovery-Friendly Workplace Initiative.
  - Goal 25A: Stand up and guide the creation of the Recovery Jobs Program in partnership with the Department of Labor and Training.
  - Goal 25B: Build on the work of the Recovery-Friendly Workplace Initiative to create a more positive, recovery-friendly workforce culture statewide.
  - Goal 25C: Leverage the Recovery-Friendly Workplace Initiative to change public attitudes about addiction through Rhode Island workplaces.
- **Goal 26 – Support Development of MAT-Focused Peer Recovery Specialists:** Support the development of MAT-focused Peer Recovery Specialists and the creation of MAT-Peers through the U.S. Department of Labor Dislocated Worker Grant through strategic guidance and integration of MAT-Peers across the SUD care delivery system.
- **Goal 27 – Establish More Community and Faith-Based Recovery Support Services:** Incentivize the development of more bottom-up, grassroots, community-driven recovery support services, to provide people in recovery more local connections.
  - Goal 27A: Incentivize the development of community-based recovery programming through CODE activities, Local Prevention Coalitions, and Health Equity Zones.
  - Goal 27B: Ensure CODE activities, Local Prevention Coalitions, and Health Equity Zones are working in unison.
  - Goal 27C: Incentivize the creation of more faith community programming, borrowing on successful models and mobilizing faith communities' willingness to start recovery initiatives.
  - Goal 27D: Provide guidance or programs for fighting stigma on the community level through standing and to-be-developed programs.

Appendix E

Project Dove

IMPROVING MATERNAL AND NEONATAL OUTCOMES THROUGH SAFER PRESCRIBING

Rhode Island BJA Harold Rogers PDMP Grant Final Progress Report

Project Dove represents a researcher-practitioner partnership to 1) develop a Continuing Medical Education (CME) course for prescribers in identifying and responding to prescription opioid misuse and opioid use disorder among pregnant women patients, 2) implement academic detailing of prescribers treating pregnant women in high-burden communities, and 3) evaluate outcomes associated with these interventions. The project used PDMP data to identify intervention communities with high rates of prescribing to women of childbearing age for delivery of intensified outreach and academic detailing; and aimed to promote implementation of evidence-based medical practice in the intervention communities and statewide.

Project Accomplishments

Collaboration

The project included collaboration with an existing taskforce facilitated by RIDOH. The Rhode Island Task Force to Support Pregnant and Parenting Families with Substance-Exposed Newborns (SEN Task Force) convened in 2016 with a mission to build a comprehensive system of supports for women, newborns, and families by providing prevention and intervention opportunities to avoid or ameliorate the outcome of prenatal substance exposure along the continuum of care. The Education Workgroup of the SEN Task Force provided feedback on course content, and the project team collaborated on development of referral resource documents for providers and patient handouts, including a brochure for patients providing information on NAS hospital procedures, plans of safe care, and involvement of Department of Children, Youth, and Families (DCYF). The brochure was vetted and approved by RIDOH and DCYF.

Intervention Community Selection

The team used data from Rhode Island's prescription drug monitoring program to examine opioid prescriptions (excluding buprenorphine) by city/town of residence filled during the first six months of 2016 to women of childbearing age (15-44 years). We compared rates per 1,000 women by city/town of residence, ranked rates by county, and selected the highest-ranking community in each of the five Rhode Island counties. All five of the selected communities were rural or exurban.

Course Development

The intervention included creation and deployment of a course for medical providers, including physicians, midwives, nurses and advanced practitioners who care for pregnant women. The course was developed by a team of public health researchers and medical providers with specialties in obstetrics, neonatology, addiction psychiatry, and emergency medicine; and expertise in substance use disorders treatment, pregnancy, neonatal abstinence syndrome and trauma-informed care. The team received iterative feedback from national and local experts in opioid prescribing best practices, opioid use disorder and medication treatment in pregnancy, and neonatology.

Course content aimed to provide clinicians with information and tools to help patients on opioid therapy understand its implications for pregnancy, identify and respond to prescription opioid misuse among pregnant patients, and provide

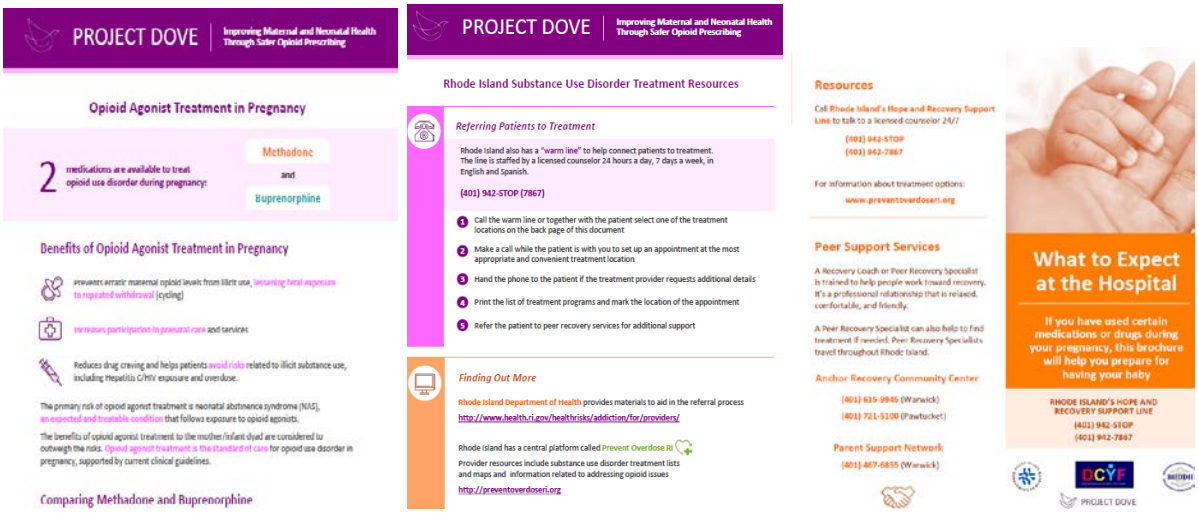
care for pregnant women with opioid use disorder. The course included didactic content, case scenarios, and scripted patient-provider interaction videos. The course consisted of three modules that qualified for 3.5 CME/CEU and met the Rhode Island opioid prescribing CME licensure requirements. Sample video thumbnails:

Live CME Events

In fall/winter 2017, faculty from Brown University and Boston University Medical Center delivered three live CME events in locations convenient to the intervention communities, reaching 130 providers. The Chief Administrative Officer of the RI Board of Licensure and the RI Medical Director sent email and print letters encouraging attendance at the events to providers in the intervention communities.

Enduring Course Website

In January 2018, the team launched an online version (www.projectdove.org) housing the CME modules and downloadable resource documents. Resource documents included screening and monitoring tools, clinical support tools and checklists, information on Rhode Island referral resources, and patient educational handouts. Sample document thumbnails:



Academic Detailing

Academic detailers with subject matter training visited medical providers in five targeted Rhode Island communities and immediate surrounding areas. The academic detailers requested individual meetings with providers with a controlled substance license, prioritizing clinicians specializing in family medicine, obstetrics/gynecology, and internal medicine. In some cases, provider offices requested a group presentation for clinicians and staff in the office. Detailers provided informational materials and discussion of evidence-based best practice recommendations for prenatal and immediate postpartum care. Informational packets included materials on screening and response to opioid issues, chronic opioid therapy in pregnancy, medications for OUD in pregnancy, Rhode Island treatment and recovery resources, managing childbirth pain for women with OUD, and patient educational handouts. All providers were encouraged to attend the online continuing education course.

Three academic detailers met with providers or staff one-on-one (N=154) or in 8 group presentations to providers and their staff (N=99). A personalized letter and Project Dove informational packets were hand-delivered or mailed to providers who did not respond to email or telephone contact attempts. A total of 423 informational packets were distributed to healthcare providers in the five intervention communities.

Project Outcomes

Methods

Prescriber survey: Evaluation included a survey administered in 2017 (baseline; N=576) and 2018 (follow-up; N=504) to assess RI prescribers' practices related to opioids and self-efficacy in addressing opioid use disorder among pregnant women. The survey was administered online to all prescribers in the intervention communities and a random sample of prescribers in the remaining communities. Participant responses were compared between time points and between groups using t-tests and chi-square tests. Generalized linear mixed models were used to evaluate trends within and between groups over time.

Controlled substance dispensing: Prescription Drug Monitoring Program (PDMP) data included both buprenorphine and buprenorphine-naloxone (henceforth referred to as buprenorphine) prescriptions for the treatment of opioid use disorder as well as nd other opioid analgesic prescriptions to women of childbearing age (15-44). We calculated monthly prescription rates per 100,000 residents. We used interrupted time series (ITS) with segmented regression analyses to evaluate the effect of the academic detailing on prescription measures pre- (April 2016-August 2017, 17 time periods) and post- (September 2017-December 2018, 16 time periods) intervention. ITS allows extrapolation of the level and

trend in prescriptions before the academic detailing intervention to predict trend and level change after the intervention compared to the counterfactual effect (absence of intervention) while controlling for secular trends and control group change. We examined autocorrelation of residuals with the Durbin-Watson test using a lag of 12 time periods. We plotted the autocorrelation function (ACF) and partial autocorrelation function (PACF) to detect autoregressive terms. Significant autoregressive (AR) terms were added to the segmented regression model (AR(8) for buprenorphine and AR(12) for all other opioids). We visually inspected the random distribution of residuals which confirmed normal distribution. We did not consider delays in the effects of the intervention; therefore, we did not use a lag period. We observed seasonality in the month of July which was added to the models using dummy variables. We produced plots of the observed and the counterfactual segments of the interrupted time series for both the intervention and control group. The model coefficients were estimated by generalized least squared regression fitted by maximum likelihood.

Methadone treatment for OUD: We used data collected by the RI Dept of Behavioral Healthcare, Developmental Disabilities, and Hospitals of recipients of methadone treatment for OUD from all publicly funded opioid use disorder treatment facilities. Monthly rate of women age 15-44 receiving methadone for OUD per 100,000 were calculated for intervention and control groups as above. Analyses were identical to those used for controlled substance dispensing.

Neonatal abstinence rates: Using diagnostic data for hospital discharges from 2015 to 2018, we identified infants with NAS based on the presence of ICD-9 code 779.5 or ICD-10 code P96.1 in any of the diagnostic fields. We calculated NAS rates per 10,000 live births for intervention and control communities. NAS rate differences between the intervention and the control communities and interaction between group and time were assessed with the generalized linear regression model using ANOVA F statistic for the model effects and the t statistic for the coefficient estimates. P values were considered significant at $p<0.05$.

Clinical outcomes: As an assessment of possible intervention effects on related clinical outcomes, we tested for changes in the NAS rates per 10,000 live births over the course of the study period for babies born to women residing in intervention versus control communities. Depending on the findings of the other outcomes, an increase in NAS rates could signify possible intervention-related impacts of MOUD access, failure of the intervention to alter continued exposure and risk through opioid analgesic prescribing or further illicit opioid use, or untreated or undertreated OUD in pregnant women with OUD.

Results

Prescriber survey

Prescribers in intervention communities were significantly more likely than prescribers in the control communities to improve on pregnancy-specific outcomes, including comfort with methadone or buprenorphine treatment in pregnant women, preparedness to discuss pregnancy implications of chronic opioid therapy, and preparedness to refer pregnant women to resources for OUD. Prescribers in the intervention communities were also significantly more likely to be familiar with the warm line, which was a key component of the professional education provided to the intervention communities. Across items, effect sizes for the intervention communities were medium to high, with Cohen's d ranging from 0.4 to 0.7. Effect sizes for the control communities were small to medium, with Cohen's d ranging from 0.2 to 0.4. See Table 1 for significant intervention results by survey item.

Table 1: Significant intervention results in prescriber survey

Item	Scale	Treatment Group *M (SD)*		Control Group *M (SD)*		Group*Time		
		Baseline	Follow-up	Baseline	Follow-up	*F*	*df*	*p*
Which ranking most closely describes your **comfort level with regard to the use of methadone or buprenorphine for opioid use disorder in pregnant women**?	1 (Not comfortable at all) to 5 (Extremely comfortable)	1.78 (1.3)[a]	2.39 (1.5)[a]	1.55 (1.0)	1.60 (1.1)	7.52	883	<0.01*

Item	Scale	Treatment Group *M (SD)*		Control Group *M (SD)*		Group*Time		
		Baseline	Follow-up	Baseline	Follow-up	*F*	*df*	*p*
As a clinician, how prepared do you feel in the following areas: **Helping patients on chronic opioid therapy understand implications of use in pregnancy**	1 (Not prepared) to 4 (Very prepared)	1.99 (1.1)[a]	2.44 (1.0)[a]	1.98 (1.0)	2.03 (1.0)	4.90	891	<0.05*
As a clinician, how prepared do you feel in the following areas: **Referring pregnant women and their families to resources for prescription opioid use, misuse, and opioid addiction**	1 (Not prepared) to 4 (Very prepared)	2.45 (1.1)[a]	2.89 (1.0)[a]	2.20 (1.1)	2.18 (1.1)	5.26	886	<0.05*
I am familiar with the state's warm line for connection to Tx services	1 (Strongly disagree) to 4 (Strongly agree)	2.23 (0.9)[a]	2.80 (0.9)[a]	2.10 (0.9)[b]	2.26 (0.9)[b]	7.17	934	<0.01*

Note: Means that share a letter are significantly different. Treatment Baseline *N* = 46 – 91; Control Baseline *N* = 231 – 392; Treatment Follow-up *N* = 39 – 64; Control Follow-up *N* = 232 – 393.

Items expected to be influenced by the statewide efforts were examined across the overall prescriber survey sample. Statewide analyses showed significant improvements on all of the expected outcomes, including accessing the PDMP, integrating the information obtained in the PDMP into clinical decision making, naloxone prescribing, and patient counseling about opioid risks.

Table 2: Significant statewide results in prescriber survey

Item	Scale	Baseline *M (SD)*	Follow-up *M (SD)*	Change
Rank how well you feel you currently perform the following:				
Accessing the PDMP within my clinical practice	1 (Not well at all) to 7 (Extremely well)	5.28 (2.1)	5.73 (1.9)	+0.45
Prescribing naloxone to my patients at risk and/or their caregivers		4.10 (2.2)	4.53 (2.2)	+0.43
Providing advice to patients/caregivers on opioid medication disposal techniques		4.25 (2.0)	4.66 (2.0)	+0.41
Integrating the information obtained in the PDMP into clinical decision making and care		5.49 (1.9)	5.82 (1.7)	+0.33
Estimate average frequency (in past year):				
that you prescribed or **recommended giving naloxone** to patients or caregivers of patients who are at risk for overdose	0 (Never) to 4 (Once or more a day)	0.76 (1.0)	1.18 (1.2)	+0.42
that you and your delegates in **total used the RI PDMP**	0 (Never) to 4 (Daily or almost daily)	2.15 (1.5)	2.55 (1.5)	+0.40
Estimate the frequency in which you counsel your patients (or caregivers of patients) who receive an opioid Rx about:				
Risk of relapse, if treating OUD with an opioid agonist	1 (Never) to 4 (Always)	2.78 (1.1)	2.98 (1.0)	+0.20
Risk of opioid addiction		3.26 (0.8)	3.40 (0.8)	+0.14

Baseline *N* = 289 – 455; Follow-up *N* = 303 – 431

Controlled substance dispensing

After adjusting for prescription level and trend in the control communities, the academic detailing intervention was associated with a significant differential change in both the level (i.e., the impact of the intervention) and trend (i.e., gradual effect) in the buprenorphine prescription rate (per 100,000). The rate of buprenorphine prescriptions in the intervention communities was lower compared with the control group by 89.1 (p= 0.0061), however the intervention communities sustained a significant increase over time compared with the control group, by 10.02 prescriptions per month (p=0.0002) (Table 3). We also observed a significant decrease in trend in the intervention communities in the rate of all other opioids dispensed by 11.5 per month compared with the control communities (p=0.0008) and a decrease in level by 9.7 prescriptions dispensed per month in the intervention communities compared with the control communities; the difference did not reach significance, however (Table 3). Figures 1 and 2 show the interrupted time series graphs for buprenorphine and all other opioid prescriptions.

Table 3: Segmented regression results for buprenorphine and all other opioids

Measure/Parameter	Coefficient[a]	95% CI	*p* value
Buprenorphine			
Intercept	589.5	561.9 to 617.1	<0.001
Differential change in **level** (intercept) per month between the intervention and the control group	-89.1	-150.4 to -27.8	0.0061
Differential change in **trend** (slope) per month between the intervention and the control group	10.2	5.1 to 15.3	0.0002
All other opioids[b]			
Intercept	3289.1	3243.1 to 3335.1	<0.001
Differential change in **level** (intercept) per month between the intervention and the control group	-9.7	-118.8 to 99.5	0.863
Differential change in **trend** (slope) per month between the intervention and the control group	-11.5	-17.8 to -5.1	0.0008

CI: confidence interval

[a]Generalized least square coefficient estimates. All models adjusted for the secular trend, the control group, the seasonal month and the autoregressive term.

[b]All opioids excluding buprenorphine and buprenorphine + naloxone

Figure 1: Trends in buprenorphine prescriptions before and after academic detailing starting August 2017.

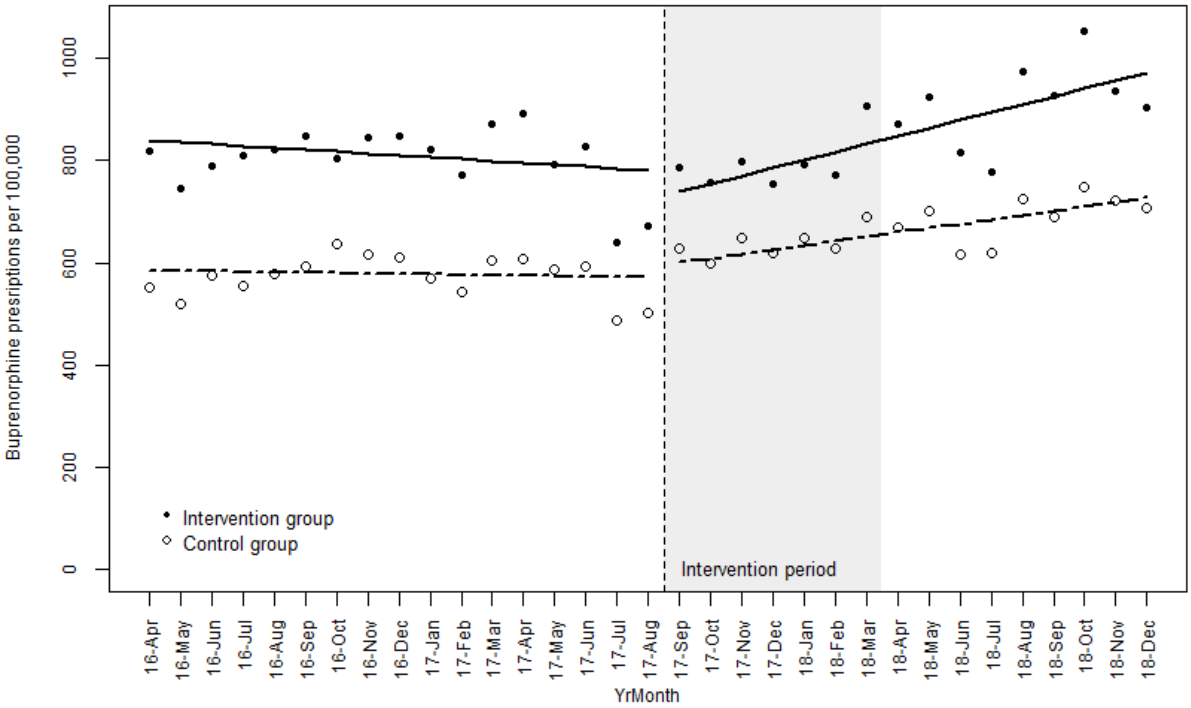
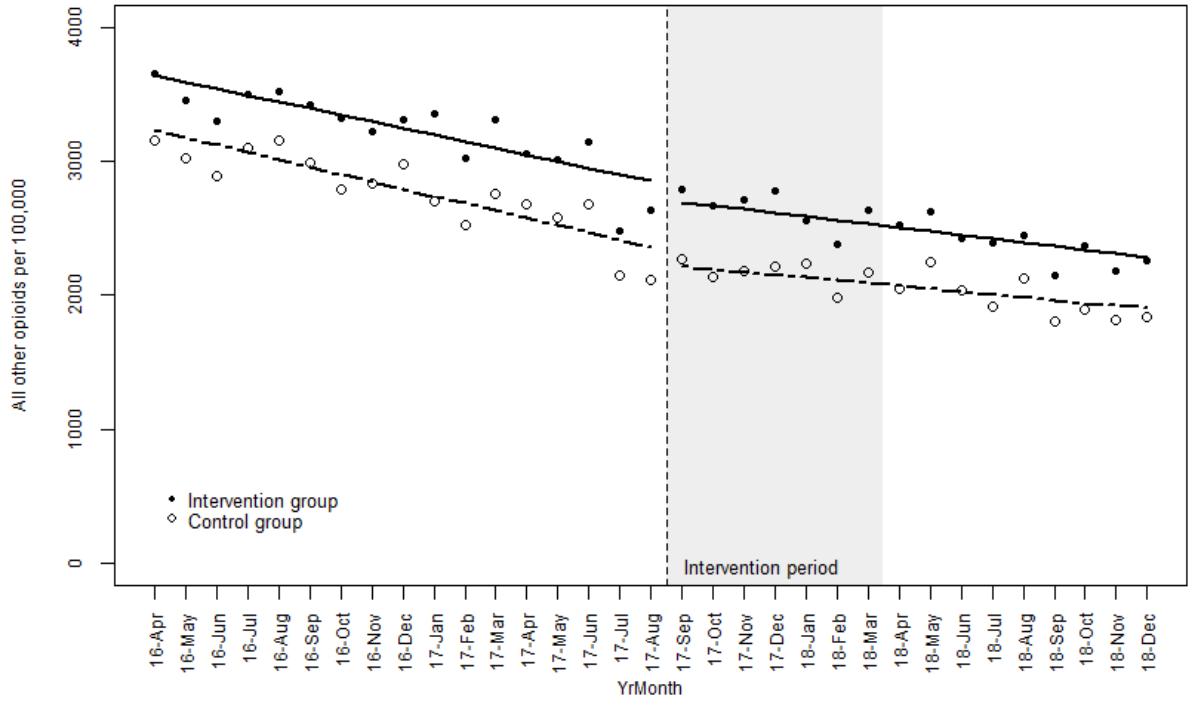


Figure 2: Trends in all other opioid prescriptions (excluding buprenorphine) before and after academic detailing starting August 2017.



In statewide outcomes, PDMP queries increased steadily over the project period, from 72,737 during the second quarter of 2016 to 120,667 in the last quarter of 2018.

Opioid treatment program recipients

Within intervention communities, the average monthly rate of women age 15-44 receiving methadone for OUD per 100,000 increased by 2% from 625.4 pre-intervention to 637.5 post-intervention. Within control communities, the average monthly methadone recipient rate increased from 485.8 to 540.4. After adjusting for methadone recipient level and trend in the control communities, we found that the academic detailing intervention was associated with a significant differential change in both the level (i.e., the impact of the intervention) and trend (i.e., gradual effect) in the methadone recipient rates (per 100,000). The intervention communities sustained a greater increase in trend per month in women of childbearing age receiving methadone for OUD by 2.8 per 100,000 patients as well as a higher level increase by 27.8 per 100,000 patients compared with the control communities (p<0.0001).

Table 4: Segmented regression results for methadone recipients

Measure/Parameter	Coefficient[a]	95% CI	*p* value
Intercept	455.8	452.7 to 458.9	<0.001
Differential change in **level** (intercept) between the intervention and the control group	27.8	20.6 to 34.9	<0.001
Differential change in **trend** (slope) per month between the intervention and the control group	2.8	2.3 to 3.2	<0.001

Neonatal abstinence syndrome outcomes

The NAS rate per 10,000 live births showed no significant change over time in the intervention and control communities. The ANOVA analysis of the NAS rate by group controlling for time period showed that the overall model was not significant ($F(3,4) = 0.11$, $p = 0.95$) and the effect size was small (adjustedR2 = 0.07). The rate of NAS increased faster in the control group (2.23 per 10,000 births per year, $p=0.8548$) compared to the intervention group (0.25 per 10,000 births per year, $p=0.9734$), but the difference between groups and the interaction between group and time period did not reach statistical significance.

Dissemination

Project results will be presented at two upcoming national conferences:

Using Academic Detailing to Improve Maternal and Neonatal Health Through Safer Opioid Prescribing (oral presentation). November 2019. International Conference on Academic Detailing. Boston, MA.

A State, Community, and Research Partnership to Address Opioid Use Disorder in Pregnant and Parenting Women (oral presentation). November 2019. American Public Health Association Annual Meeting. Philadelphia, PA.

Three manuscripts have been drafted and are near ready for submission:

Project DOVE: Improving maternal and neonatal health through safer opioid prescribing- a CME activity for medical providers. Authors: Judith A. Linden, Gillian Leichtling, Tirah Samura, Adam Czynski, Traci C. Green. Target journal: MedEdPortal

Outcomes of an academic detailing intervention to improve care for pregnant women with opioid use and use disorder. Authors: Traci C. Green, Gillian Leichtling, Erin E. Stack, Sanae El Ibrahimi, Judith A. Linden, Erica L. Oliveira, Sarah E. Bowman, Kristine Campagna. Target journal: Preventive Medicine

A comprehensive statewide partnership to expand systems of care to address opioid use disorder among pregnant and parenting women. Sarah E. Bowman, Gillian Leichtling, Erin E. Stack, Carlie L. Alfaro, Kristine Campagna, Judith A. Linden, Traci C. Green. Journal of Public Health Management and Practice