Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"

January 14, 2020

Dr. Nicole Alexander-Scott, Director, Rhode Island Department of Health

The Honorable Brett Guthrie (R-KY)

Question 1:
As you may be aware, section 7063 of the SUPPORT Act (P.L. 115-271) encourages public-private partnerships to assist with addressing the opioid crisis, specifically for infants with Neonatal Abstinence Syndrome (NAS) and their mothers. While section 7063 is specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) efforts, could you provide information on how your state is using public-private partnerships. In addition, please provide areas of need for where the federal government can work with other entities to better leverage community resources.

Rhode Island (RI) has always taken advantage of its small size by engaging community members within their respective communities to address issues that may arise. RI is divided into 39 municipalities and each municipality has a Regional Prevention Coalition that received federal funding (SOR Grant) to target interventions at their individual community level. Prevention Coalitions are made up of local businesses, law enforcement, community leaders, and often individuals in recovery. Each community conducted a local needs assessment and subsequently offered mini grants to implement targeted responses to the area's identified needs. Many of these grant initiatives included building recovery capital and hosting stigma-reducing events.

Rhode Island has also identified geographic regions where health disparities exist, called Health Equity Zones. We provide 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.

RI's Recovery Friendly Workforce Initiative is another project within which we build public-private partnerships and reduce discrimination and biases in the workplace. This program supports businesses to enact business-wide policies and procedures to create a work environment that is accommodating to those in recovery. This eliminates barriers to employment for those impacted by addiction and creates a mutually beneficial situation for the employer and employee.

The Task Force to Support Pregnant and Parenting Families with Substance Exposed Newborns (SEN Task Force) was re-convened in 2016 at the request of Governor Gina M. Raimondo. The SEN Task Force

is comprised of a diverse array of state agencies and local community-based organizations that share a commitment to improving systems of care for families and children affected by substance use. The SEN Task Force has a long-standing history of building collaboration and consensus among state agencies and community organizations within the recovery/treatment and maternal-child health arenas, and includes the RI Department of Health; RI Department of Children, Youth and Families; RI Department of Behavioral Healthcare, Disabilities and Hospitals; RI Executive Office of Health and Human Services; the Governor's Office; the RI Care Transformation Collaborative; birthing hospitals; medical, behavioral health, and mental health providers; Family Homes Visiting; Early Intervention; WIC; Early Head Start; insurance companies; managed care organizations; colleges and universities; content experts; and, parent support groups. The SEN Task Force is currently developing a three-year strategic plan that will articulate goals and strategies in support of promoting equitable access to a bias-free, coordinated system of care that engenders the health and well-being of families affected by substance use.

Areas of need for where the federal government can work with other entities to better leverage community resources are:

- Federal resources to support resource intensive (but cost effective) care coordination between public and private partners to coordinate and support the work with families. With many players, support up front to establish and maintain coordination that is often not covered through other funding mechanisms would be valuable.

- Federal resources to support continued private public partnerships such as the Task Force to Support Pregnant and Parenting Families with Substance Exposed Newborns (SEN Task Force)

- Identifying new and expectant parents as a priority population, extending through pregnancy into the first year of life, and inclusive of all care givers since the health of the carrying/birth parent and newborn are interconnected with the other family members.

- Community based public and private providers have systems in place to provide residential treatment, recovery housing, etc. However, it often takes additional resources to replicate the existing services to be inclusive of families. Providers may know recovery housing but would need a new building to offer the same supports for recoverees with families.

- Another example would be supporting public private partnerships that are building and supporting a statewide recovery workforce. There is value in having certified peer recovery specialists in diverse and varied environments across the state – however, it will complicate the work and leave a vulnerable workforce if recovery specialists are on teams where they themselves do not have peer support. In order to ensure the vitality and stability of the growing recovery workforce, it needs coordinated centralization, professional support and a backbone learning community. This particularly includes, but is not limited to, perinatal recovery coaches working with new and expectant parents.

Question 2:

Are treatment programs in your state able to share substance use disorder medical records so that they can coordinate care for patients with opioid use disorder?

Under 42 CFR Part 2, it is possible to share substance use disorder medical records from federally funded substance use programs to coordinate care, but this disclosure does require specific consent from the patient involved. This need for consent for care coordination is unique to 42 CFR Part 2 and is not necessary under HIPAA or any other state and federal privacy laws impacting Rhode Island. In practice collecting this consent and operationalizing record sharing is onerous for the providers involved, so our understanding based on feedback from our community is that it rarely happens, even in scenarios where record sharing is very important, such as between the psychiatric hospitals and the community providers who will provide follow-up care.

Further, providers are not always aware that 42 CFR Part 2 only covers substance use disorder treatment information, and as a result, treating providers often also hold back information on mental health treatment that could be very helpful to share for care coordination.

Therefore, the sharing of critical behavioral health (including substance use) patient information by providers to support transitions of care and care coordination occurs inconsistently, which can expose patients to medical errors and system waste. In Rhode Island we have identified the following scenarios which explain how individuals' care coordination is impeded:

• **Patient Location:** Psychiatric inpatient and general care hospitals will sometimes withhold patient location information from the Community Mental Health Centers (CMHSs) or Opioid Treatment Providers (OTPs). The CMHCs or OTPs may be searching for a patient, even checking with hospitals, but may end up filing a missing persons' report for them. They often find out later that the patient had been admitted to a psychiatric facility, but the facility did not think they could disclose that patient was admitted. In addition, the CMHOs and OTPs frequently lack other critical information from the inpatient stay, such as medication changes, to help continue recommended treatment post-discharge.

• **Care Coordination:** Medicaid and Commercial Accountable Care Organizations cannot complete recommended care coordination measures – such as follow-up within seven days of a psychiatric inpatient hospitalization – because treating providers at some hospitals do not believe they can share this information. This means that when patients are discharged from the hospital, community providers that are accountable for the patient's care rarely receive notice of the discharge and cannot ensure the patient receives the follow-up care needed to keep them from being readmitted to the hospital.

• **Dashboards**: Many health care providers, especially Primary Care Providers, are sent alerts or have access to a dashboard operated by our state health information exchange that identifies when one of their patients is admitted to or discharged from any ED or hospital in the state. In several instances, a provider was notified that their patient was at the Emergency Department, but if the patient was then admitted to a psych unit or psychiatric hospital, the provider may not be notified because the hospital does not believe it can share that information with the Health Information Exchange, which will then

share it with the provider. The provider is left not knowing what happened to the patient and may think the technology that notifies them about their patient's admissions and discharges is malfunctioning.

• **Care Integration**: From a study on Enrollment in Medication Assisted Treatment for substance use disorder conducted in Rhode Island, we have found that there is clear lack of coordination for those with co-occurring substance use disorder, mental illness conditions and physical healthcare. Most patients receive care in three places for each of these conditions in part because providers choose to not get waivers to share data, are unable to disentangle mental health from substance use data, or unknowledgeable about data sharing.

Lastly, all of this has a significant impact on developing interoperable solutions for health data sharing across facilities and practices in the state. Because of the difficulty of flagging and segmenting substance use data within an electronic health record, these facilities often choose not to share anything electronically with other providers in the state or with our state Health Information Exchange. Rhode Island's Health Information Exchange participated in a pilot with SAMHSA a few years ago and can handle and segment 42 CFR Part 2 data appropriately with patient consent, but this capability is rarely being used because of the technical infeasibility of operationalizing data segmentation.

To make matters even more complicated, each organization interprets how they are allowed to handle this data a little bit differently. For example, some believe they can send the data to the HIE under the Qualified Service Organization (QSO) agreement and let the HIE segment the data, and others believe they must segment before sending the data to the HIE. There have been major difficulties depending on Electronic Health Records (EHRs) to segment the data, meaning that very little data is shared from these facilities, even on patients with only mental health disorders (and not substance use disorders).

While the protections of 42 CFR Part 2 do help to protect the patient from stigma associated with substance use disorders, the harsh reality is that all of this complexity means that care is rarely being effectively coordinated for patients with substance use disorders. We believe that treating substance use disorder treatment data the same as any other protected health information will help reduce stigma over time. To do this well, there should be protections for patients to help keep them from being discriminated against or criminalized for having a substance use disorder, which is a disease that needs treatment, like any other disease.

2a. Is your state struggling with getting patients to outpatient treatment centers due to the inability of providers to see a patient's full substance use disorder medical record?

The inability of providers to see a patient's full substance use disorder medical record is one obstacle identified by providers. There are other issues as well - when for example, providers occasionally feel "in the dark" about important parts of their patient's health history. However, this does have to be considered in tandem with the actual and potential stigma patients experience, even from health care providers. Patients continue to voice concerns about discrimination and bias in the healthcare field and worry about potential consequences if penalties are relaxed.

2b. Are there policies that Congress can fix to help states with improving outcomes for substance use disorder and lower the costs of increased Medicaid spending in emergency departments?

Adding methadone to the Prescription Drug Monitoring Program would allow emergency department prescribers to have a more complete history of their patients. This would prevent inadvertent/unintended prescriptions of additional opioids and benzodiazepines which could have a lethal outcome. Access to this information would need to be protected with strong enforcement of penalties for any violators, since, as previously mentioned, stigma and discrimination are persistent and serious concerns of the community.

Congress could help improve outcomes in emergency departments by exploring the development of a "opioid response team" within the emergency room. This would minimally increase the ED reimbursement cost, but it would also enable the provision of increased discharge support, thereby avoiding recidivism. The best predictor of an overdose death is a prior overdose. We need to improve our approaches to reach and treat individuals who have had multiple overdoses.

Question 3:

Do you think it makes sense to revise the 42 CFR privacy regulations to allow doctors to communicate about patients with substance use disorder, in other words to treat privacy issues around substance use disorder the same way we treat other mental health disorders or physical medical conditions?

We do strongly agree, as was outlined in the response to question number 2. This is long overdue in many respects and further contributes to the stigma surrounding substance use. Having said that, we need to continue to work with the public and prescribing community about stigma and other negative public attitudes around substance use and co-occurring disorders. Additionally, extant polices can interfere with care in emergency departments, but it is important to ensure coherent and responsible follow up for patients with opioid use disorder.

The prospective of the patients as well as of the physicians is important in this manner. Any potential change must consider who has access to the information, what penalties will be enforced, and the inclusion of a clear grievance procedure. Because all consumer voices matter, Congress should hear from individuals who have had their confidentiality violated in order to understand the potential impact of the citizens that we all serve. If patients know that their medical records related to substance use will be shared without their consent, there will likely be some who will opt to not seek treatment.

Question 4:

In Fiscal Year (FY) 2019 and FY 2020, Congress approved funding for the Centers for Disease Control and Prevention's (CDC) Overdose to Action OD2A grants, which primarily go to states, but has a requirement that 20 percent of the prevention funds go to local health departments. How is your state working with local jurisdictions to ensure that these funds reach local communities?

As Rhode Island does not have local health departments, the statewide Rhode Island Department of Health (RIDOH) will use our established partnerships with local Health Equity Zones, which serve identified 'drug overdose hotspots,' to ensure at least 20 percent of the OD2A funding goes to local communities. The Rhode Island OD2A team analyzed overdose data to determine the geographic areas that are disproportionately impacted by the overdose epidemic. RIDOH issued a competitive request for proposal (RFP) asking local HEZs to develop and implement an overdose action plan in their community. Communities are required to use the funding to implement evidence-based practices (EBPs) and/or innovative interventions in their local communities. Additionally, funded communities will develop and implement a response plan to overdose alerts and use RIDOH data to inform their projects. The OD2A team will provide one-on-one technical assistance for the areas of data, implementation, and evaluation to the funded communities. This project will enhance local capacity to respond to the opioid epidemic.

Additionally, the OD2A project will deploy teams of peer recovery specialists dual-certified as community health workers (PRS/CHWs) to communities experiencing overdose spikes on a weekly basis. RIDOH released a competitive RFP and will contract with two local community-based organizations (CBOs) with experience in street outreach and peer recovery programs. Trained PRS/CHWs with lived experience of substance use disorder (SUD) will provide targeted street outreach in these identified overdose spike areas. This outreach will include referrals to treatment, naloxone trainings, referrals to basic needs, and harm reduction education. They will work with communities to target shelters, public transit, and public areas with heavy foot-traffic. The weekly implementation of this intervention in state 'hot spots' will address the opioid epidemic in near real-time.

Question 5:

How is your state partnering with localities to ensure that they can help inform the state's strategy in addressing opioid misuse?

In addition to the strategies listed in #4, RIDOH has convened a weekly Surveillance Response Intervention (SRI) call since 2017. This call, which includes both behavioral health department staff and first responder partners, reviews the most updated overdose data and implements a rapid response. The SRI team has developed thresholds for overdose spike alerts, and they disseminate public health advisories to impacted communities and partners as necessary. Additionally, program staff provide technical assistance to municipalities that receive alerts to help them implement response plans. This weekly communications system ensures ongoing data sharing and enables the implementation of integrated, data-driven interventions at the local level.

The State Opioid treatment authority at the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) also disseminates the SRI information and collects valuable "Hot Spots" information on a weekly call with various widespread community members, including: High Intensity Drug Trafficking Area (HIDTA), Detox managers, certified outreach peer supports, managers of prevention and health equity zones, etc. This has led to rapid deployment of naloxone, the "Rhode to Health" mobile van clinic, and other supportive tools to meet clients where they are as opposed to waiting for them to proactively pursue treatment.

Additionally, in 2016, RIDOH created www.PreventOverdoseRI.org (PORI). PORI is a comprehensive, user-friendly website that compiles data and resources from across the state. The website uses infographics, interactive maps, charts, and videos to provide timely information about Rhode Island's overdose crisis. The state continues to enhance and promote PORI to localities to ensure they have access to data and resources related to the overdose crisis.

As outlined in the Governor's Overdose Prevention and Intervention Task Force's Strategic Plan, there are also nine cross-cutting Work Groups that meet monthly or bi-monthly. These Work Groups focus on: Prevention, Rescue, Treatment, Recovery, Racial Equity, Harm Reduction, Families, First Responders, and Substance Exposed Newborns.

You may find more details about the Strategic Plan and Work Groups on www.PreventOverdoseRI.org.

Question 6:

How are your state and local health departments working in partnership once the state receives grant dollars to ensure local communities have the resources that they need to address substance misuse and prevent substance use disorders and overdoses?

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) co-shares the State Substance Authority with the Executive Department of Health and Human Services (EOHHS). Rhode Island state agencies such as BHDDH, EOHHS, the Governor's Office, RIDOH, the Department of Labor and Training, RI State Police, the Department of Children, Youth and Families, and others have successfully partnered to coordinate federal funding initiatives to effectively use funding and avoid duplication.

Rhode Island developed a new position in state government cakked the State Opioid Grants Administrator, and her primary function is to ensure the effective administration of cross-agency grant-funded programs related to opioid and other drug overdose prevention and intervention activities, through regular meetings, communication, and data tracking. This role helps to coordinate cross-agency alignment and adherence to state-wide overdose prevention and intervention strategic plan. 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.

In addition, BHDDH coordinates efforts with RIDOH for all our provider networking, 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), which as noted above are focused on a variety of issues related to health promotion, prevention, and social determinants. The Directors of both BHDDH and RIDOH currently Co-Chair Governor Ramonido's Overdose Prevention and Intervention Task Force. Their primary focus and coordinated efforts have been to enforce and build on the Governor's Overdose Strategic Action Plan that addresses Prevention, Treatment, Rescue, and Recovery iniatives for the state. You may also find the action plan on www.preventoverdoseri.org.

Question 7:

We know that many of the interventions needed to address substance use disorder rely on a strong public health workforce, but there is currently a workforce shortage in the behavioral health space. What types of professionals are needed in your state to help address the opioid crisis, and to prevent future crises, as well?

In order to address the opioid crisis, the following types of professionals are in demand:

- DATA-waivered prescribers
- Certified Peer Recovery Specialists
- Certified Community Health Workers
- Licensed Chemical Dependency Professionals
- Psychiatrists
- Individuals willing to work in an Opioid Treatment program
- Qualified prevention workforce
- Psychologists
- Behavioral Health prescribers
- Licensed independent social workers
- Public health professionals with experience in epidemiology, biostatistics, and analytics

In addition to a personnel shortage, there are also financial barriers. For example, we have people who are qualified to be peer recovery specialists and community health workers, yet it is difficult for agencies to allot supportive funding to enable individuals to go through the training and internship process.

Question 8:

The federal government has appropriated millions of dollars to fund Prescription Drug Monitoring Programs (PDMP) through the Hal Rogers program and others. According to the White House Office of the National Drug Control Policy (ONDCP) PDMPs are "a tool that can be used to address prescription drug diversion and abuse." What challenges still exist with PDMPs?

The Federal funding that has been made available to support Rhode Island's PDMP has been critical. The most notably helpful funding to date has been the Medicaid funding made available through Section 5042 of the SUPPORT Act, because it makes the long-term sustainability of the PDMP more feasible as we make enhancements that will increase the ongoing maintenance cost. This Medicaid funding has been especially helpful at the 100% FMAP rate, which ends September 30, 2020, because standard Medicaid funding at 90/10 or 75/25 requires state matching funds which can at times be difficult to identify in the state's limited state budget. It would be helpful if there was more time to use the 100% FMAP rate to provide more time for Rhode Island to make the substantial upfront investments needed to mitigate some of the challenges that still exist with the PDMP.

These challenges include:

- Hiring and sustaining sufficient staff to perform standard administrative functions, improve data timeliness, and improve data quality.
- Hiring and sustaining sufficient staff to develop analyses and evaluation of the PDMP
- Developing the PDMP to be more feature- and data-rich
- Integrating the PDMP into the provider workflow within the EHR to save time and increase PDMP utilization
- Managing interstate data sharing agreements, especially with the complexity that comes with EHR integration of PDMP data from other states

As with many states, the ability to identify what staffing and enhancements are needed, request the approval for federal funding, hire staff, and procure the enhancements takes a significant amount of time. Even though Rhode Island has been one of the first states to take advantage of this funding, we still only have a nine-month period to leverage the 100% FMAP.

8a. How much has your state received and spent on its PDMP to date?

Rhode Island Department of Health (RIDOH) grants and allocations supporting PDMP strategy:

Grant or Allocation	Funding Amount	Funded By	Project Period
Comprehensive Opioid Abuse Site-based Program	$ 2,000,000	DOJ	10/01/2019 – 9/30/2022
Medicaid PDMP Implementation Advanced Planning Document (IAPD) **** This is the 90% federal match for Health Information Technology expenses.***	$ 5,434,238	CMS	9/17/2019 – 9/30/2020
Opioid Overdose Crisis Response Supplement Fund (SURGE) Base	$ 25,000	CDC	9/1/2015 – 8/31/2019
Prescription Drug Overdose Prevention for States (PfS)	$ 2,362,000	CDC	9/1/2015 – 8/31/2019
PDMP-Practitioner & Research Partnerships	$ 113,355	BJA	9/1/2018 – 8/31/2019
Total	**$9,934,593**		

8b. Is there any data or reports that detail the positive outcomes from utilizing a PDMP?

The PDMP is a useful investigative tool for allegations related to diversion. RIDOH has found the PDMP very helpful to illustrate prescribing trends. Please see https://preventoverdoseri.org/prescribing-data/,which illustrates current prescribing trends in Rhode Island regarding opioids as well as other controlled substances. We have recently started using the PDMP to analyze ICD-10 codes in aggregate to determine common diagnoses that resulted in an opioid prescription and subsequent persistent opioid use for greater than 90 days.

Question 9:

Some concerns with PDMPs include a lack of real time data and a lack of interoperability with other states. Do you agree PDMPs face these challenges?

Yes, PDMPs do need more real time data and better interoperability with other states. Rhode Island currently requires data be reported within one business day, but especially with smaller pharmacies, staff are required to monitor reporting timeliness. Ideally, we would prefer the data be real-time, but understand that may pose significant resource and technical challenges to small pharmacies and will need to be phased in over time.

With respect to interoperability with other states, this is more complex. Through the state exchanges, PDMP Interconnect, and RxCheck, Rhode Island is exchanging data with 29 states; however, this is only sharing within a website user interface. Interstate data sharing through EHR integration will need much more attention and work to come to agreements, because states may have different requirements for user types, security protocols, and data storage. With Medicaid PDMP funding, we have added staff to help reach out to states and develop agreements with other states for EHR integrations to ensure that

providers receive the same amount of interstate data whether they use the PDMP website or view PDMP data within their EHR. We anticipate this will be very slow and time intensive work.

9a. If so, are these challenges preventing prescribers and pharmacists from having access to all of the information needed to make an informed decision about whether to prescribe or dispense?

Real-time reporting is a major barrier in Rhode Island. It would be nice to have real-time reporting, yet our current reporting timeframe (less than 24 hours) satisfies our needs. However, we have heard through recent PDMP user stakeholder sessions that some pharmacies' prescribers notice up to a one-week delay on data. This will take considerable work from state staff to improve upon the timeliness of the data. In addition to the issue of not having real-time PDMP data, we also lack the knowledge of whether a controlled substance was picked up at the pharmacy and is in the patient's possession or is still sitting in a "waiting for pick up bin." Some type of Point of Sale (POS) connectivity with the PDMP database will provide more accuracy of the information.

While we are achieving interoperability with other states, it is cumbersome to do this one state at a time and then institution by institution when we achieve integration of the PDMP into an electronic health record. In addition, while we have several very successful EHR integrations of the PDMP with some of our largest provider groups, they do not see all of the data that is available through our PDMP website because of the need to approve these integrations with all of the states. This is a significant challenge and supports the argument for a federal PDMP.

9b. If so, how can we address these problems and improve PDMPs?

The most immediate and simplest step that Congress could take to address these problems is to provide for additional time to receive 100% FMAP funding for Qualified PDMPs under Section 5042 of the Support Act. That would make it easier for Rhode Island and other states to scale the resources needed to make improvements at the state level.

Longer term, we believe it would be beneficial to align state policies on PDMP use, including decisions regarding the type of users who may access data, how data can be accessed and stored through EHR integration, how data can be shared across state lines for other purposes such as analytics, and standards for data transport and security.

If the PDMP were a federally-maintained, standardized database, we could benefit from economies of scale, fewer technical difficulties, and improved functionality. At present, every state must independently scale and grow each individual PDMP.

Question 10:

Does your state's PDMP use HIPAA standards or any named federal standard for data transmission?

Rhode Island's PDMP uses a number of standards for data transmission as outlined below:

- Pharmacy reporting to the PDMP
- Interstate data sharing through PMPi
- Interstate data sharing through RxCheck
- Data sharing with EHR integrations currently or in the future with the following standards:
    - Appriss API (although RI does not want to continue using this standard because it is not in the Interoperability Standards Advisory)
    - NCPDP Script 10.6
    - Smart on FHIR API (future)

In addition, all contracted vendors and RIDOH are required to be HIPAA-compliant and protect data in compliance with all state and federal laws.

Question 11:

Many states are able to share PDMP data across state lines. However, it is my understanding that even if states are connected to an information hub, those states may not have access to state information for all other states connected to that same hub. Is that an issue that your state faces and/or that you are aware is an issue in other states?

Yes, this is an issue here and in other states, since connecting to the interstate hubs does not preclude the requirement to create individual agreements with all other states in order to share data. As described in more detail in the response to question 9, there are also multiple layers to data sharing (through our PDMP website, through EHR Integrations, and for analytic purposes). We have been very successful at obtaining sharing agreements with the PDMP website with 29 other states, but still need to get agreement for the other outlined purposes. We anticipate this will be a slow and resource intensive process, as we must create agreements with each state separately and comply with their respective access laws.

11a. Would states having the ability to access information across all state lines assist in fighting the epidemic?

Yes, especially for a small state like Rhode Island where it takes a short amount of travel time to go to a pharmacy or prescriber in another state. Additionally, there are a fair number of residents who live in other states over the winter and are only in Rhode Island seasonally. Having other states' data will only help in developing a more complete picture of a patient's prescription history.

Additionally, in the event of an emergency in which a methadone clinic in Rhode Island could not dispense according to a normal routine, being able to access information across state lines would be helpful for coordination.

Question 12:
What were the circumstances that you believe led to the opioid crisis in your state?

Historically, Rhode Island has had an above average rate of heroin use, primarily due to access and supply traveling up and down the east coast via Route 95. Illicit prescription misuse began to increase in 2013. In 2014, when over 240 Rhode Islanders lost their lives to overdose, Rhode Island became more aware of the increasing problem, not only with heroin but also with prescribed and illicit OxyContin. Suddenly there were more deaths than the combined deaths caused by car accidents, murders, and suicides. Eighty percent of overdose deaths in 2015 involved **fentanyl** which was a marked 15-fold increase since 2009. On August 4, 2015, Governor Raimondo issued Executive Order 15-14 to establish a broadly representative Task Force to obtain expert input and develop a Strategic Plan to address the opioid crisis. The Strategic Plan was built focusing on four pillars: Prevention, Rescue, Treatment, and Recovery. In order to bridge between the pillars, the Task Force updated the Strategic Plan to include cross-cutting workstreams aimed at addressing the problems that caused the overdose crisis. More detail about the Strategic Plan can be found on https://preventoverdoseri.org.

Question 13:
How does your state ensure that opioid federal grant funds are not diverted for unauthorized purposes?

BHDDH and RIDOH have internal active contract managers and evaluators for every grant. Each have accountability to the Executive Office of Health and Human Services and are required to carry out site visits and review consumers' evaluations for services rendered. Rhode Island is also subject to random external audits on each grant depending on the grantee (SAMSHA, CDC, etc.). The State absolutely depends on our federal partners to be able to address this opioid crisis, we work hard to ensure that the funds are spent effectively and in compliance with the provided federal guidelines.

Each department is required to have an approved active strategic plan and per OHHS regulations, every grant application needs to align with that department's strategic plan. This ensure that the grant activities are furthering the share goals and vision of the department and State as a whole.

Question 14:
How does your state ensure that opioid-related federal grant funds are going directly to the communities most affected by the opioid crisis?

Rhode Island uses diverse overdose datasets to inform the placement of interventions to ensure funding is serving the most vulnerable and hard-to-reach populations. Through requests for proposals, contracting deliverables, and performance measures, we can pinpoint areas with a high concentration of need, as well as provide general education throughout our small state.

Our regional task forces must complete a needs assessment at the start of the contracting period to determine the areas of most need. This helps us to determine the best communities to target for prevention activities.

The Honorable Bob Latta (R-OH)

Question 1:

In addition to the STR and SOR grants, how many other federal grants have your states received related to opioids or substance use disorder prevention and treatment?

Here is the list of grants that Rhode Island has received related to opioids or substance use disorder prevention and treatment:

Grant #	Funding Agency	State Agency	Grant Title	Amount of Award
1	BJA	RIDOH	Bureau of Justice Assistance (BJA) PDMP-Practitioner & Research Partnerships	750,000
2	CDC	RIDOH	Prescription Drug Overdose Prevention for States (PfS)	2,362,000
3	CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Base	3,146,152
4	CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Telehealth Special Project	500,000
5	CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Infectious Disease Vulnerability Assessment	91,100
6	CDC	RIDOH	Enhanced State Opioid Overdose Surveillance (ESOOS)	973,940
7	CDC	RIDOH	Overdose Data to Action *$4.5M per year	13,500,000
8	CMS	Medicaid	Provider Capacity Building Initiative (PCBI)	3,500,000
9	CMS	EOHHS	Support Act - Medicaid Partnership Act	5,434,238
10	DOJ	RISP	Comprehensive Opioid Addiction Program (COAP) (Yr1)	1,800,000
11	DOJ	RIDOH	Comprehensive Opioid Abuse Site-based Program	2,000,000
12	DOL	DLT	National Health Emergency Dislocated Worker Demonstration (NHE)	3,894,875
13	SAMSHA	RIDOH	CARA First Responders Project to Combat RI Overdoses	800,000
14	SAMSHA	BHDDH	State Opioid Response (SOR Yr1 $12.6M, Yr2 $12.6M, Supp. $6.5M)	31,764,809
15	SAMSHA	BHDDH	State Targeted Response to Opioid Crisis (STR)	4,334,014
16	SAMSHA	BHDDH	Medication Assisted Treatment Prescription Drug & Opioid Addiction (MAT-PDOA)	3,000,000
			Total	77,851,128

Question 2:

I understand that the various federal grant programs have different requirements, timelines, applications, etc. How does this administrative burden impact your state?

It is important to be realistic about the difficulties states face while starting the implementation of a grant while simultaneously trying to build the infrastructure and workforce. The first year of the grant took time to build out, and we greatly appreciate the no-cost extensions that we have received. Our current concerns are focused primarily on the financially sustainability of programs if the grants were to quickly reduce their financial support.

It is also difficult to administer the grants with the limited staff, data, and evaluations allowed to us by the current administrative cap. An expanded cap would allow state to have the capacity to properly audit and evaluate programs for effectiveness.

2a. Would it be helpful for the federal opioids and substance use disorder grants to have more standardized application requirements and processes?

Yes, that coordination and standardization would certainly reduce administrative burden. We would also be helped by longer grant periods. For example, OD2A is only a three-year grant. Because it takes so much time to stand up a program, it would be most helpful to have grants of at least five years in duration, so that programs don't lose funding right as they are beginning to fully realize their potential.

Conclusion

Thank you so much for the opportunity to testify and to answer these follow-up questions. If you have any additional questions, you may contact Cathie Cool Rumsey by phone (401) 462-6392 or by email at catherine.coolrumsey@ohhs.ri.gov.