Addiction + Overdose Evidence Update

Summary of Study and Work to Date

February 24, 2021

RHODE ISLAND

Governor's Task Force on Overdose, Prevention & Intervention Priorities

Prevention

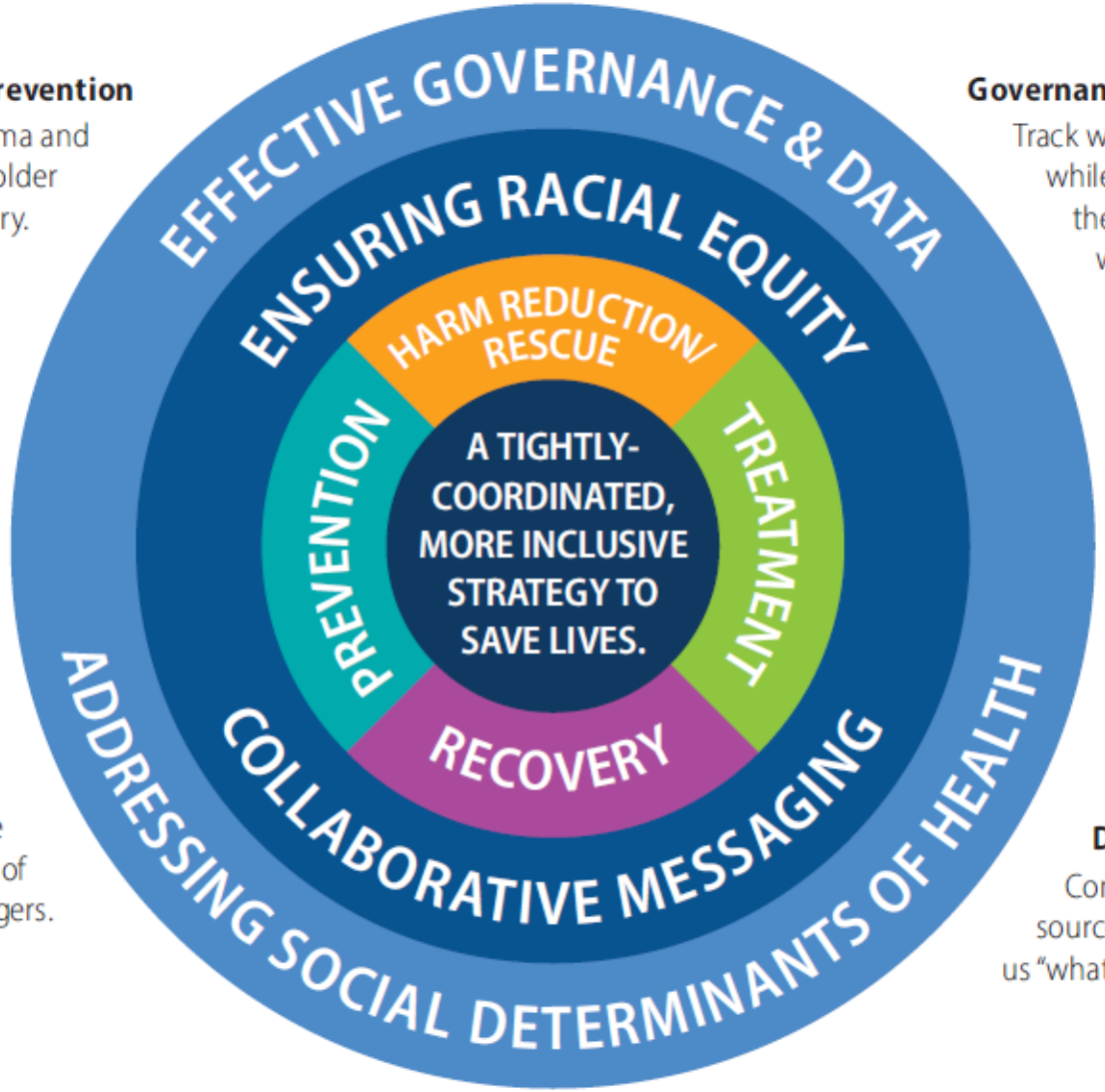
Focus on proven strategies to address trauma and disparities across the lifespan, especially for older Rhode Islanders and people in recovery.

Treatment

Create low-barrier treatment for all substances to maximize access, drive more effective data sharing between the treatment community and clients, and innovate ways to promote and engage people in treatment and recovery support services.

Messaging

Craft linguistically and culturally-appropriate language by collaborating with community partners to ensure the most effective, real-time communications - recognizing the mistrust of state and medical messengers.



Governance

Track what we do and create lines of accountability while strengthening the community's voice in the Task Force, especially the voices of people who use drugs.

Harm Reduction

Create and share innovative services for safer drug use practices while supporting community outreach services and rebuilding trust of law enforcement.

Recovery

Support recovery capital while developing a more diverse certified peer recovery support specialist workforce.

Data

Consolidate analysis across all reporting data sources and build a state profile that clearly tells us "what the data say" as we measure outcomes.

Core Recommendation from Evidence Update

Accelerate a

tightly-coordinated, more inclusive strategy

centered on

harm reduction and recovery resiliency

for people at high risk of fatal overdose right now

to save lives.

Executive Summary

Context | Approach | Findings | Recommendations | Next

RHODE ISLAND

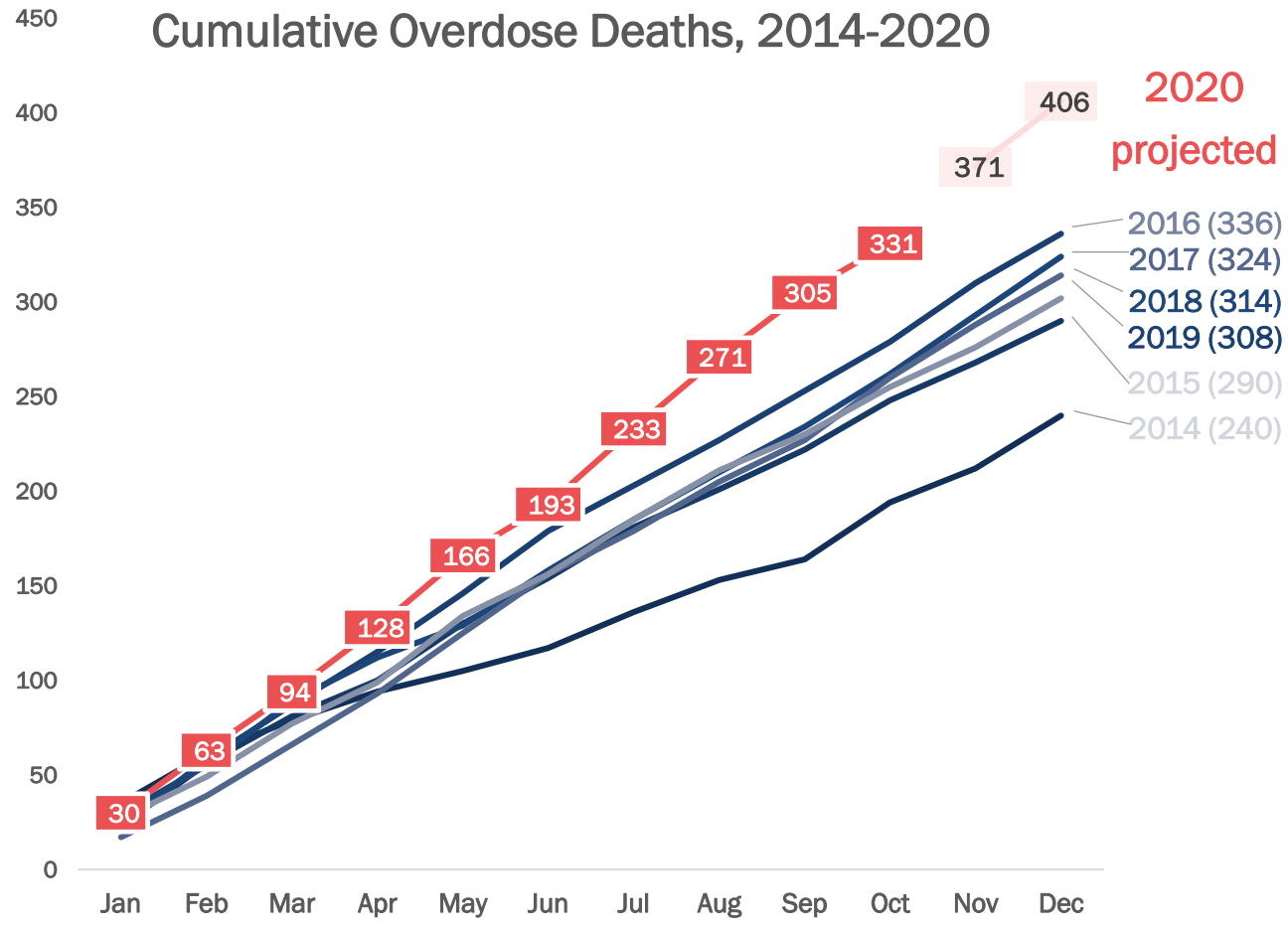
Rhode Island may exceed 400 overdose fatalities this year, 25% higher than our highest year, despite:

- ✓ Three years of falling death rates,
- ✓ Heroic efforts to continue services during COVID, and
- ✓ Stable, strong performance metrics across all pillars.

What changed?
How do we know?
How do we respond?

Performance trends are generally strong or stable, but deaths are historically high.

Pillar	Metric	Trend, 2019-2020
Prev	New opioid prescriptions	Downward
Prev	Benzo + Opioid Combo Rx	Downward
Prev	Opioid Rx to <18-year olds	Downward
Prev	Project SUCCESS classes	Upward
Resc	Naloxone distributed	Upward
Resc	Naloxone to high-risk groups	Upward
Resc	Naloxone covered by insurance	Stable
Resc	Overdoses - layperson gave naloxone	Stable
Tx	People in sustained medication assisted treatment	Stable*
Tx	People in medication assisted treatment	Stable*
Tx	People in medication assisted treatment, % BIPOC	Stable*
Tx	ED visits for those with MAT record	Downward
Tx	Treatment within 6 months of first OUD Dx or OD	Downward
Rec	Recovery Center enrollment, current and new	Upward
Rec	Licensed Peer Recovery Coaches	Upward
Rec	Wages > FPL for those with a prior OUD diagnosis	Downward
Rec	Recovery – self-reported well-being	Upward



* Treatment enrollment is plateauing across all groups in 2020 after several years of steady climbing

First Step: Addiction + Overdose Evidence Update

The Task Force Co-Chairs charged EOHHS with learning as much as possible about the shape, drivers, and trajectory of the current crisis – and recommending strategic actions.

Qualitative Analysis (Key informant interviews)

The team spoke to over 100 people in 44 Key Informant Interviews or Focus Groups - a diverse group of community agency and state agency staff, and providers, as well as people who use drugs and family members of people who use drugs. Topics included:

1. What works well in Rhode Island (strengths of our response)
2. Changes that may have led to rising deaths – both before and because of COVID
3. The impact of structural racism on deaths
4. Strengths and weaknesses of the statewide response structure
5. What "magic wand" changes would make the biggest difference?

Quantitative Analysis

Analyzed demographic, medical, and economic differences in two cohorts of people:

(1) **2020 cohort**: those who died between Dec. 2019 and June 2020 and

(2) **2019 cohort**: those who died between Dec. 2018 and June 2019

We also looked at **environmental factors** – corrections census, Roger Williams Medical Center outpatient addiction program closure - that may have affected outcomes

Findings: Data Ecosystem / Brown University Analysis

STUDY PERIOD: Jan-Aug 2019 vs. Jan-Aug 2020

POPULATION

- Nearly all increase among men (among 58 excess deaths, 55 are men)
- Significant increases among men with depression + men with anxiety
- Significant increases among people age 50-59 with anxiety

ENVIRONMENT

- The majority of overdose decedents in 2020 died at home (45% vs 53%)
- Modest proportional increase across all contributing causes of death except heroin

What we learned – Qualitative Research

Here are some of the most compelling lessons from the qualitative research:

Harm Reduction:

- Deadly Fentanyl, found in substances beyond just opioids, demands an urgent focus on broad, in-depth, and culturally competent Harm Reduction services, including face to face services and more help to people leaving prison
- Messaging should be direct and specific and should also educate people on what an overdose looks and feels like
- Rhode Island should find ways to separate services for people who use drugs from the criminal justice system

Recovery:

- Rhode Island should continue to prioritize investments in Peer Recovery Specialists - and ensure that we recruit more Peer Recovery Specialists of color, to create more culturally competent services
- We must also do better to address the social determinants of health that help shore up people's recovery systems – affordable housing, stable employment, etc. - to help keep people in recovery and address racial disparities in care
- We should consider new ways of measuring recovery, to reflect more than just participation in MAT

Governance:

- There are gaps in the ways that we track the work that we do, carry out project management, and create lines of accountability, and include true community voice, especially from community members of color and people who use drugs
- Creating a stronger governance structure would allow the state as a whole to address the rising number of deaths

What we learned – Qualitative Research

Here are some of the most compelling lessons from the qualitative research:

Treatment:

- Rhode Island gets a lot right with our treatment services, including MAT, especially for people with insurance
- However, there are still barriers to treatment for all substances, including alcohol, that we must address
- It is always critical to raise the quality of treatment, through a more responsive continuous quality improvement and feedback system – and by increasing the number of providers of color for more culturally competent care

Prevention:

- We must look far upstream for true prevention, addressing social determinants, violence and trauma, and disparities and discrimination
- We need proven prevention strategies for people who do not use drugs or alcohol, those in recovery, and across the lifespan – including strategies for older users.
- The key to prevention is similar to what it takes to build recovery capital, including social determinants of health

Messaging:

- There are challenges in our current message – content, messengers, and audience
- We need an ongoing in-depth discussion about the most effective messaging and messengers throughout the pillars, with a focus on culturally and linguistically appropriate language and support for real-time critical communication needs

Findings: Response Challenges + Drivers of Fatal Overdoses

Drivers of Fatal Overdoses Identified in Evidence Update

The 2020 group showed more **evidence of being in a fragile state of recovery** before death and were more likely to die at home before rescue arrived. They may have overdosed due to:

A. Sustained presence of **fentanyl and analogues** in the drug supply , including nearly 75% of all overdose deaths in 2020. Fentanyl is now present in many types of drugs (not limited to opioids), and potentially growing in potency.

B. **COVID-driven social isolation**, fear of disease to the point of not calling paramedics for help, and economic insecurity
   - All of which may exacerbate, or be exacerbated by, underlying anxiety and depression, which were significantly more common in the 2020 cohort.
   - Middle age men – those 40-59, especially those with underlying mental health conditions – were especially hard hit in 2020.

C. These factors are more acute for communities of color, for whom **historical inequities and ongoing structural racism** have deprived them of equitable capital (recovery, financial, social), trust in institutions, and access to equitable services.

Response Challenge Identified in Qualitative Study

D. An insufficient governance and **project management structure** limits our ability to guide a consistent, focused, strategic response that weaves emerging information into action.

Suggested Priority Recommendations

(A) Fentanyl | (B) COVID | (C) Struc. Racism | (D) Governance

(A) Fight Fentanyl Overdoses with Expanded Harm Reduction

1. **Address the challenges of the Good Samaritan Law:** Formally evaluate the Good Samaritan law to determine its implementation, and support proposed changes that arise from that evaluation
2. Review the feasibility (including impacts of federal law and potential need for legislative action) of a **pilot overdose prevention site** that would provide a broad range of drug user health services
3. Establish a workplan to ensure every strategy and implementation plan has **actions steps to reduce structural racism,** and that these actions are measured and reviewed routinely
4. Add **"Harm Reduction"** specifically to the Rescue Pillar title

(B, C) Address COVID Impact: Recovery Resiliency/Capital/ Connections

1. Prioritize and fund a **medication-first treatment** approach that reduces barriers to continued engagement with treatment, including residential treatment
2. Include and fund **trauma-informed mental health services** in SUD or alcohol treatment
3. Recruit and support peers who **reflect the diversity** of those they serve
4. Elevate focused **employment and re-employment** efforts (including Real Pathways & Recovery Friendly Workplaces), with work that is more conducive to recovery
5. Safely prioritize **in-person recovery services** wherever possible

(D) Create a Focused, Staffed Governance Structure

1. Elevate the community's voice, including appointing **community co-chairs** to co-lead each workgroup
2. Create a full time, dedicated **Director of Overdose Prevention + Response,** who leads an **interagency team** with project management capacity, to address the full recommendations
3. Create a **standing legislative/policy team** with membership from each of the Workgroups, advisory to the Task Force
4. **Overhaul state messaging:** fact-based; nationally researched, locally tailored for variety of audiences: people who use drugs, their families and supporters, and people not using drugs.
5. Align and braid dollars and pursue new funding, to **ensure sustainable support for key efforts to prevent overdose deaths**

Critical additional recommendations for each pillar, tied to quantitative and qualitative findings, are in the following slides.

Short-Term Recommendations

Here are a set of short-term recommendations from the research, with longer-term proposals below:

Activity	Pillar
Secure Project Management and functional lead staff from existing state staff. Carry out an audit of all existing meetings/stakeholder engagements to coordinate current work.	Governance
Continue more effective messaging development for harm reduction, especially focused on men 50-59 years old, using SOR dollars	Harm Reduction
Seek dollars for basic needs for people who use drugs, as existing funding cannot purchase many harm reduction items (needles, fentanyl strips, etc.)	Harm Reduction
Work with the Department of Labor & Training to create messaging promoting harm reduction, treatment, and recovery support	Harm Reduction/all
Fully implement the 10,000 Chances Program, and get naloxone into public housing	Harm Reduction
Designate a facilitator for an ongoing conversation with community and law enforcement leaders to enable harm reduction practices and by building champions for harm reduction in law enforcement.	Harm Reduction
Recruit and train more Peer Recovery Specialists who speak languages other than English, who are people of color, and who are recently in recovery	Recovery
Ensure more face-to-face recovery services that take into account COVID restrictions	Recovery
Strategize on hand-offs from treatment, especially for those with anxiety and prior behavioral diagnoses, and those in the demographics most affected by fatal overdoses	Treatment
Implement more effective data sharing between Peer Recovery Specialists and people in treatment, with better sharing of consent	Treatment
Maximize access to treatment: Allow health homes to serve the same people without co-payment challenges, stop tox screens before treatment access	Treatment
Engaging the judicary system to promote treatment and recovery	Treatment/Recovery

Major Next Steps to Implement the Evidence Update

- Workgroup-led implementation process:
  - Regular convening of workgroup chairs and ensure each group has a state and community co-chair
  - Build out workplans for focus areas by April
  - Project management support for chairs
- Task Force Co-Chairs identify and resource focus areas that need active state leadership to succeed
- With Overdose Data Council, update current overdose performance metrics to better reflect evidence update findings (see slide 23)
- Sustainability & Funding Decisions
  - Co-Chairs and other decision-makers continue to make funding decisions in line with the Task Force Strategic Plan and this Evidence Update.
  - The Opioid Stewardship Fund, State Overdose Response (SOR) grant, RIDOH mini-grants, and SAMHSA block grants currently use the Evidence Update recommendations framework

Acknowledgements

Thank you!

The Task Force co-chairs – Director Kathryn Power and Dr. Nicole Alexander-Scott, plus Assistant Secretary Ana Novais and Dr. Jim McDonald

Our research team – Sarah St. Laurent, Deb Florio, Charlotte Kreger, and Cathie Cool Rumsey for the daily work and organization

Plus the **interagency team** that contributed greatly: Linda Mahoney, James Rajotte, Annice Correia Gabel

Our **data and analytics advisory team**

And the 150+ people who gave hours of their time to speak with us and teach us about their experience. It was a gift.

- Please share your feedback and reactions with us, the co-chairs, or workgroup leads:

Marti.Rosenberg@ohhs.ri.gov

Kimberly.Paull@ohhs.ri.gov

Implementation of Evidence Update

Ongoing Work

CY21 Focus Areas

Stewardship Funding

RHODE ISLAND

What We're Doing Now

1. Harm Reduction + Rescue

10,000 Chances Project: Naloxone to overdose hot spots (funded through CARES)

Funded Aids Care Ocean State (ACOS) van

Expanding Peer Outreach (and harm reduction supplies) in overdose hot spots

2. Race Equity

Ensuring that the Race Equity conversation is being woven into all workgroups, starting with Harm Reduction

Focus on new recruitment for the Work Group

3. Treatment

- 24-hour buprenorphine induction hotline
- BH Link connections for immediate buprenorphine or methadone inductions
- Strengthened peer recovery support & coordination between DCYF and social workers at birthing hospitals to support pregnant moms.
- Telemedicine started quickly when COVID began, through work of providers, insurers, and the state

What We're Doing Now

1. Governance

   Adding community co-chairs to some workgroups

   Regular workgroup leaders meeting to align major actions

2. Funding Decisions Based on Evidence Update Recommendations:

   SOR Grant

   RIDOH mini grants

   RIDOH Overdose Data to Action CDC grant

   Opioid Stewardship Fund

   SAMHSA Block grant + Supplements

3. Recovery
   - More Peer Recovery Specialists positions, services reimbursed by insurance
   - Continued growth in Recovery Friendly Workplace program
   - CARES and SOR dollars to support Recovery Housing

4. Messaging / Communications
   - New campaign incorporates findings from Evidence Update (concrete new information; earned media featuring those with lived experience; reduce explicit state imprint)
   - Statewide BH Community Conversation incorporates findings into broader BH communications
   - Working with Department of Labor & Training on outreach to unemployed Rhode Islanders

Next: Priority Focus Areas, by Workgroup

What efforts, over the next 6-12 months, have the most potential to improve outcomes and needs TF engagement?

Harm Reduction / Rescue	1. Use data to expand outreach by peer recovery coaches, to provide harm reduction resources and linkage to care to areas of highest risk 2. Expand home delivered services and increase community/provider referral to all harm reduction and peer recovery support agencies 3. Continue implementing and evaluate 10,000 Chances 4. With the policy workgroup: Coordinate information and process for Good Samaritan Law amendments and implementation (if passed) 5. Begin structured engagement with Law Enforcement, with an initial focus on Good Samaritan education/training 6. With the policy workgroup: Explore the feasibility of overdose prevention sites 7. Partner on Race Equity work
Race Equity	1. Strengthen state support for the Race Equity Work Group by identifying supportive state staff or a state staff co-chair 2. Seeking funding and planning to begin implementation of Recommendation A3: Creating a workplan to ensure every strategy and implementation plan has strategic actions steps to reduce structural racism, and that these actions are measured and reviewed routinely

Next: Priority Focus Areas, by Workgroup

What efforts, over the next 6-12 months, have the most potential to improve outcomes and needs TF engagement?

Treatment	1. Review rates for Substance Use Disorder facilities to enable program sustainability and facility improvements - and to address immediate potential of facility closures - because the best way to reduce fear/anxiety about entering a residential treatment facility is to make physical improvements to the environment and have the appropriate number of focused staff 2. Improvements at Opioid Treatment Programs (OTP) treatment facilities will also allow us to address stigma, including supporting expanded staffing to expand MAT dosing schedules and improve dosing lines to mirror any other medical dispensing facility 3. Increase education on harm reduction tools (such as fentanyl test strips) and provide on-site materials to facilities, particularly to high-risk populations, including those with or at risk for HIV 4. Secure sustainable funding to embed peers into detox, opioid treatment programs, and residential treatment programs to ensure data sharing and improve provider communications, with the scope of work to include job description for focused peer recovery work
Communications/ BH Statewide Conversations	1. Overhaul state messaging efforts, by looking toward nationally researched and locally tailored messaging that is proven to reach a variety of audiences: people who use drugs, their families and supporters, and people not using drugs, including a focus on poisoned drug supply 2. Continue to engage a diverse group of community members in the development, design, and distribution of communications campaign, through focus groups and ongoing input strategies – and use this process to bring in new voices to the Task Force 3. Emphasize anti-stigma messaging, with a race equity lens. Recovery messaging must include the shift from addiction as a vice to addiction as a disease; the hope of a full life; and the reinforcement that true recovery is personal, self-directed, and doesn't look the same – but always needs a welcoming community

Next: Priority Focus Areas, by Workgroup

What efforts, over the next 6-12 months, have the most potential to improve outcomes and needs TF engagement?

Prevention	Invest in prevention education and communications that address overdose, addiction, and strategies for increasing resiliency Increase trauma-informed services, focusing on toxic stress, adverse experiences, and community/family/sexual violence. Implement policies that promote positive social experiences and safeguards against social isolation that aim to reduce the desire to turn to drug use. Integrate prevention programs and audience-specific communications across the lifespan and across physical health programs (falls, injury, etc.) Target prevention, communications, and education activities that engage diverse populations (race, ethnicity, sexual orientation, gender, identify, age, ability, etc.)

Next: Priority Focus Areas, to be completed

What efforts, over the next 6-12 months, have the most potential to improve outcomes and needs TF engagement?

Recovery	❑ Map out RI's resources to support long term recovery by developing a recovery tool based on SAMHSA's evidence-based practice: the "Eight Dimensions of Wellness" ❑ Increase Peer Recovery Specialist re-certification rates
Overdose Fatality Review	❑ Staff governance structure to receive and implement recommendations
Substance Exposed Newborns	❑ Support a reimbursable standard-of-care to screen all women of child-bearing age for mental health and substance use ❑ Better care coordination between mental health, substance use, and primary care providers.
Family Task Force	❑ Identify sustainable funding for family prevention / education and the Crisis Toolkit
First Responders	❑ Distribute information to support public health approach to prevention more effectively and widely ❑ Participate in the review and update of the Good Samaritan law ❑ Participate in conversations on rebuilding community trust with law enforcement and on race equity action plans with other workgroups
Governance	❑ Pursue support for a full time, Director of Overdose Prevention + Response, who leads an interagency team with project management capacity, to address the full recommendations ❑ Continue alignment of Work Groups and track progress toward goals

FY22 Stewardship Fund – Tier 1

List reflects available funding $ ~ $6,152,034

Agency	Program	Amount
BHDDH	Recovery Friendly Workplace - Initiative empowers workplaces to provide support for employees in recovery	$200,000
BHDDH	MAT for Uninsured/ Undocumented Populations	$500,000
DOC	Medication Assisted Treatment (MAT) Expansion	$846,628
RIDOH	Forensic Toxicology Lab	$810,547
RIDOH	Drug Chemistry Lab	$647,250
DOC	Individualized Treatment/Recovery Services - treatment and recovery services tailored to the unique needs of justice-involved populations.	$1,427,909
RIDOH	OSF Acct Supervisor, Lab support, TF project manager	$400,000
RIDOH	Needle Exchange/Harm Reduction Program to OSF	$54,700
RIDOH	Expansion: PDMP Integration Work	$135,000
BHDDH	Expansion: BHOLD 3.0 – enhance ability to conduct evaluations & analytics	$350,000
BHDDH	Housing: Supportive Recovery Housing & programming for people with Alcohol Use Disorder	$780,000

FY22 Stewardship Fund – Tier 2

Potential FY22 Initiatives budget. These initiatives can be considered if the OSF increases.

Agency	Program	Amount
EOHHS	Director of Overdose Prevention and Response FTE	$180,000
DBR	Senior Policy Analyst in OHIC	$165,230
RIDE	Increase Mental Health Professional Categorical for LEAs	$400,000
DOC	Substance Use Assessments, Counseling, and Discharge Planning	$1,784,804

Implementation of Evidence Update: Metric Updates

Potential metric revisions to better track evidence update findings

- CPRS **actual activity** via claims or other administrative data
- Volume of **home delivery** service through ACOS
- Volume of **in person** services at OTPs, RCCs, CPRSs
- # of suspected overdoses with **refusal to transport**
- Treatment enrollment + sustained engagement for **high-risk populations**
- Treatment engagement rate per 100k, split by **race and ethnicity**
- Individuals engaged in **both** mental health and substance use treatment
- More **targeted employment** stats:
  - Real jobs, pathways, skills engagement
  - Rates of Unemployment Insurance, PUA, TDI received and length of time on benefits

Implementation of Evidence Update: Metric updates

Potential metric revisions to better track evidence update findings

- Number of people engaged with the 8 Dimensions of Wellness software
- Process metrics on creation of the Race Equity Plan – and then measuring the action steps created in that plan
- With Communications team: penetration rates, numbers of click-throughs and then movement in the general public survey
- With SEN team: SEN care coordination measurement, number of clients served

Findings Detail

Qualitative | Quantitative

RHODE ISLAND

What we learned – Harm Reduction & Rescue

Harm reduction means putting health and wellbeing first, working with people to mitigate the negative health impacts of drug use, further reducing the chance that drug use will lead to death and other adverse health outcomes

Main Observations from Focus Groups & Interviews

- **Drug Supply:** The rise of fentanyl potency, volume, and variety (including analogues, and fentanyl found in many non-opioids) is key to understanding Harm Reduction & Rescue. We must educate people about the risk – especially those who use do not use opioids (or use casually).
- **Data:** Inability for more real-time data sharing between the state and community organizations creates barriers for fully effective harm reduction outreach and community engagement.
- **Harm Reduction Strategies:**
    - Rhode Island has focused significantly on distributing naloxone. This is a critical strategy and must continue – but we must go beyond naloxone to prioritize additional harm reduction activities.
    - Stakeholders throughout the state support planning for a pilot in-person overdose prevention site, that could also distribute naloxone, clean needles, treatment and recovery information.
    - There are significant challenges in the relationships between law enforcement and people who use drugs – and sometimes, with the organizations that serve them. This affects all people who use drugs but is exacerbated for people of color.
    - For example, the Good Samaritan Law is not working as it should to encourage people to call for help. The research team heard examples of law enforcement members not understanding the law – and other times when people at an overdose scene are arrested for bench warrants despite the existence of the law. Stakeholders noted that this prevents people from feeling safe to call 911 for an overdose.
- **Messaging:** Stakeholders identified that the state is not the correct messenger about harm reduction, and they also want an ongoing in-depth discussion about the most effective messaging and messengers for the range of rescue efforts.

What we learned – Recovery

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Certified Peer Recovery Specialists are a main focus of the state's recovery strategy

Main Observations from Focus Groups & Interviews

Our major recovery strategy has been to promote and support peer recovery specialists, and we have not had an adequate back-up system for the impact of fentanyl and COVID. Also, this strategy did not always work for people of color who did not have peers who reflected their background. We must shore up the scaffolding for recovery capital beyond just peers.

- **Defining Recovery:** Stakeholders have identified new ways of defining and measuring Recovery (success) rather than just avoidance of drug use, including for people who are not opioid users but who are seeking recovery and people who are opioid users but who are choosing not to use MAR/MAT, many times because they have tried it and don't like it. For example, success might people who engage with a harm reduction organization and begin to try and use less, or use more safely,
- **Recovery Capital:** The rise of COVID uncovered the weaknesses of recovery capital for people in Rhode Island at most risk: people in shorter-term recovery, people of color, and people who were most isolated.
- **Peer Recovery Specialists:** While peers are a critical resource, there are holes in the peer network, in terms of diversity and cultural competency of existing peers and funding options for them.

What we learned – Governance

A well-structured statewide response allows us to respond thoughtfully and quickly to new ground information, and in coordinated motion with clear signals from state and community leadership.

Main Observations from Focus Groups & Interviews

- **Silos:** Avoidable silos in state agencies and community organizations keep us from being as coordinated as we need to be in addressing the opioid epidemic
- **Stakeholder Engagement:**
    - Stakeholders appreciate being involved in discussions about the crisis, but are concerned that the discussions do not routinely lead to firm action
    - Decision-makers do not routinely include community members or people affected by the issue – and appear mostly white, middle-class
- **Coordinated Management:** We lack central project management, finance, and evaluation functions, especially for grant-funded projects. For example, some Task Force Workgroups are not staffed and do not have a recognized escalation path

What we learned – Treatment

Medication Assisted Treatment (MAT) is where our focus lies,
but residential treatment and detox serve critical roles as well.

Main Observations from Focus Groups & Interviews

Rhode Island does get a lot right with our treatment services. For people with insurance, there is good access for MAT, and we see people making the strides they want to make. (Access is not possible for those without insurance, however – which includes many people who are undocumented.)

The key to examining Treatment is to focus on Access, Content, and Quality, and to recognize that we must target treatment for poly-substances, not just opioids.

- **Low barrier access to sustained treatment on demand is critical**: There are no waiting lists for MAT, but stakeholders noted that procedural barriers – not capacity – prevent initial and continuous access, in contrast to other states (MA, VT). We also heard that residential treatment lasts 14-30 days at most, which is routinely acknowledged as too short – and people must often get reapproved every 3 days, which can disturb treatment. Access is worse for women, especially women with children who need residential treatment. And after residential treatment, there are often not enough beds in step-down facilities, like Recovery Housing. There are data-sharing barriers in place that do not allow community organizations to communicate with patients in treatment facilities. And overall, COVID has made access to all in-person services more difficult.
- **Treatment Focus**: Substance Use Disorder (SUD) treatment rarely includes integrated mental health services, although stakeholders affirmed that SUD is almost always co-occurring with mental health needs, which have been exacerbated during COVID. MAT in the primary care and medical setting must be in addition to the behavioral health therapies required for treatment success.
- **Quality**: There are different levels of quality through the system. Stakeholders identified a lack of an effective, responsive feedback function to discuss treatment that doesn't line up to expectations and needs. And we must make our workforce more diverse and culturally competent.

What we learned - Prevention

Prevention: Reduce the number of people who develop addiction, including but not limited to opioids, or encounter problematic use of substances.

Main Observations from Focus Groups & Interviews

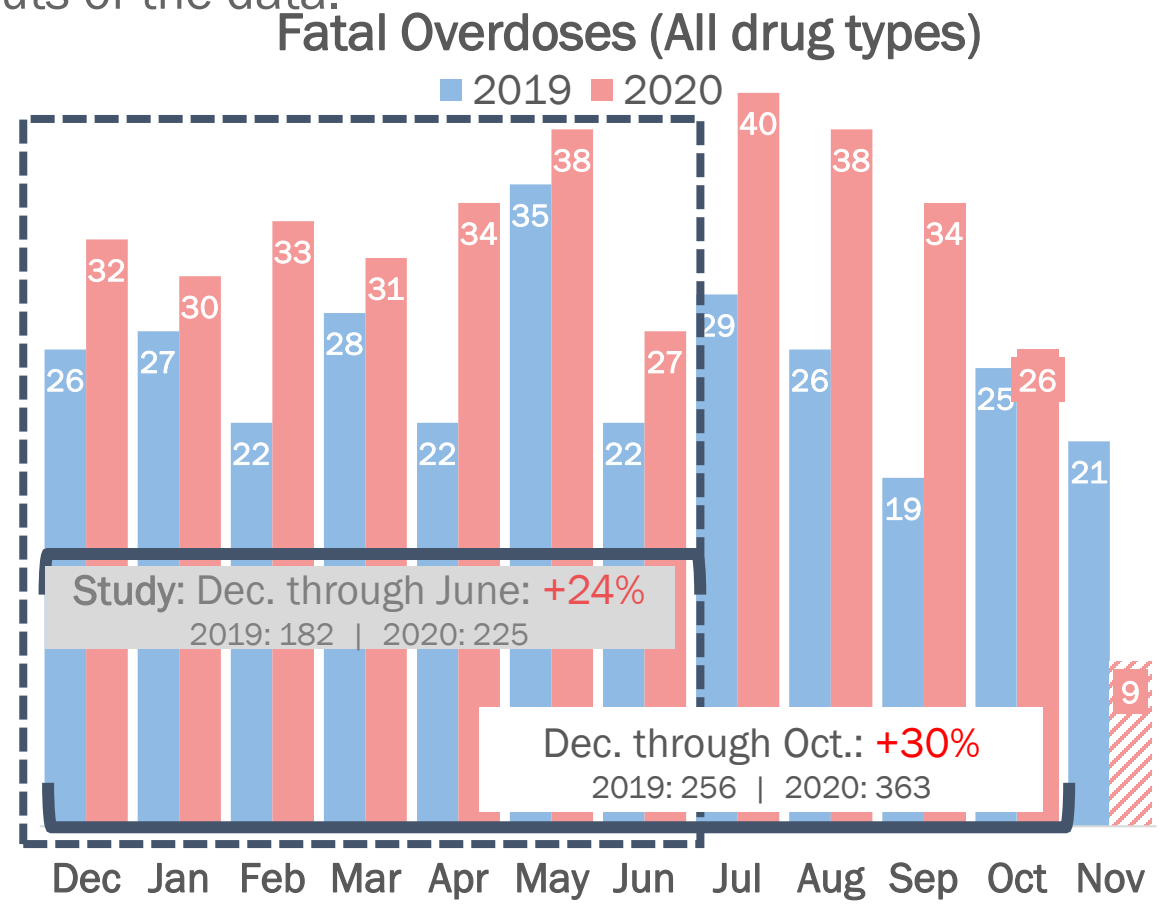
Stakeholders agree that we must look far upstream for true prevention: stopping and treating trauma and violence, ensuring social determinants of health (especially housing), and ending discrimination and disparities. We need to use and systematically advocate for prevention strategies that have been proven to work and invest heavily in them – for both people who do not use drugs and for those in recovery.

- **Expand Determinants of Prevention:** The key to prevention is similar to what it takes to build recovery capital: social determinants of health, including purpose (such as a job with adequate income), place (safe housing), addressing structural racism, and trauma-informed physical and behavioral healthcare treatment
- **Prevent Initial *and* Recurring Symptoms of Disease:** Recovery is another form of prevention, and vice versa. Align select Recovery and Prevention strategies to ensure messages, funding, and investments reinforce the continuum. Rhode Island needs more investment in addiction prevention in general.
- **Target messaging:** As with Harm Reduction, stakeholders are concerned that our current messaging does not share critical facts, may not have the right messengers, and misses people across populations who use or may use drugs – and those who do not identify as people who use drugs. They want an ongoing in-depth discussion about the most effective messaging and messengers for prevention, with a focus on culturally and linguistically sensitive language.

Overdoses grew by 23% in the study period, and +30% through October, but the groups were demographically similar

There were few difference between the two groups – but as we'll see in coming slides, those differences were critical and often visible only in more refined cuts of the data.

Factor	% of total 2019	% of total 2020	% of total, Diff.
Medicaid	60%	58%	-2%
Female	30%	27%	-3%
Veteran	6%	8%	+2%
Race: White	78.5%	79.0%	+0.5%
Race: African American	8.3%	6.3%	-2.0%
Race: Asian, Native American, Mixed, Other, Unk	13.2%	14.7%	+1.5%
Ethnicity: Hispanic	5.5%	9.0%	+4.5%
Ages: 20-29	14.4%	13.8%	-0.6%
Ages: 30-39	24.9%	26.8%	+1.9%
Ages: 40-49	26.0%	24.0%	-2.0%
Ages: 50-59	23.2%	25.5%	+2.3%
Ages: 60-69	9.9%	8.9%	-1.0%
Ages: 70+	1.1%	0.9%	-0.2%
UI, TDI, PUA in 3 months prior to death			



November data are not finalized

In summary, our data show evidence of various states of recovery, pre-existing BH diagnoses, and continued fentanyl contamination.

Text in tan relate to Medicaid-specific findings

The 2020 cohort has more evidence of recovery, though possibly fragile…	…more likely to have a BH diagnosis	… and more likely to die from fentanyl, methadone or other substances
• More likely to have **died before rescue arrived** (+36%, +51% for men) • **More people had wages, but median wages were lower** in six months prior to death (+25ppl w/ wages > $0; -$1,200 in median wages) • More likely to have **recent unemployment insurance** (4x growth in # with UI/PUA in 3 mos. prior to death; 60 fewer days between payment and death) • **Methadone treatment within 3 months prior to death** (+12 ppl, +20% of all people with methadone at time of death) • **Longer time since last overdose** (+ 80 days)	BH diagnoses of note include: • **Anxiety** (+20,+8.27%; +15, +10.1% of 50-59yo) • **Depression** (+14, +3.3%; +12, +7.6% of 50-59yo) • **Alcohol Use Disorder for 50-59 population** (+12, +8% of 50-59yo)	• **Fentanyl** (+39, +4.5%) • **Methadone** that contributes to death (+23, +4.%) ◦ *75%, up from 68% in 2019, have methadone in "Cause Line A" – the primary cause of death, but almost always with other substances. Methadone alone as a cause of death is rare and has not significantly varied since 2014.* • **"Combined"** (+23, +4.5%) • **Tobacco** that contributes to death (+16, +5.7%)

Analytics: Comparing those who died in 2020 to 2019

Population	2019	2020
Full Population	181	223
Also in Medicaid	*108*	*129*
Medicaid % of Total	60%	58%

Also during this period:

Take home methadone started March 2020

The Department of Corrections census fell by almost 30%

- **425 more releases than admissions in March and April to allow for extra capacity**
- **Fewer arrests as proactive policing and criminal activity fell**
- **Number of people in Medication Assisted Treatment (MAT) fell proportionally**

Roger Williams Medical Center closed for MAT – but did not affect death rates

No reported decrease in drug supply or market activity due to travel restrictions

The significant differences – though few – when combined contributed to a substantial rise in overdoses

Prior anxiety and methadone (treatment and as a contributing cause of death) – especially for 50-59 year olds

Total population	2019	2020
Vitals	181	223
Medicaid	108	129
Medicaid % of Total	60%	58%

50-59 year olds	2019	2020
Vitals	42	57
Medicaid	27	41
Medicaid % of Total	64%	72%

Location of Death	2019	2020
Died Elsewhere	101	114
Medicaid	*58*	*74*
Died at Home	80	109
Medicaid	*50*	*55*
Medicaid % of Home	62.5%	50.5%

51% (+28) more men died at home than in 2019, but the difference was not significant

Factor	% of pop 2019	% of pop 2020	% of pop, Diff.	Change in ppl, 2019 to 2020	P-value
Full Population: Fentanyl-involved death	69.6%	74.0%	+4.4%	+29	0.17
Medicaid (MCD) population: Prior Anxiety diagnosis	*44.4%*	*52.7%*	*+8.3%*	*+20*	*0.10*
Methadone listed as cause of death + methadone treatment within 3 mo of death and in MCD	*50% (6 of 12)*	*69% (18 of 26)*	*+19%*	*+12*	
50-59 years: Methadone contributed to death	0.9%	5.4%	+4.5%	+6	0.00
50-59 years (MCD): Prior Anxiety	*9.3%*	*19.4%*	*+10.1%*	*+15*	*0.00*
50-59 years (MCD): Methadone tx within 3 mo of death	*0.9%*	*7.8%*	*+6.9%*	*+9*	*0.00*
50-59 years (MCD): Prior Alcohol Use Disorder	*7.4%*	*15.5%*	*+8.1%*	*+12*	*0.02*
50-59 years (MCD): Prior SUD (excluding OUD) Dx	*16.7%*	*24.8%*	*+8.1%*	*+13*	*0.40*
Died at home: Married	7.5%	21.1%	+13.6%	+17	0.00
Died at home: Any Medicaid claim	62.5%	50.5%	-12.0%	+5	0.05
Died at home: Tobacco listed as a contr. cause of death	58.8%	46.8%	-12.0%	+4	0.05
Died elsewhere (MCD): Prior OUD diagnosis	*48.3%*	*62.2%*	*+13.9%*	*+18*	*0.05*
Died elsewhere (MCD): Prior AUD diagnosis	*55.2%*	*40.5%*	*-14.6%*	*-2*	*0.05*

Also, heroin dropped to nearly zero

Note that methadone is rarely the *only* drug that contributed to death

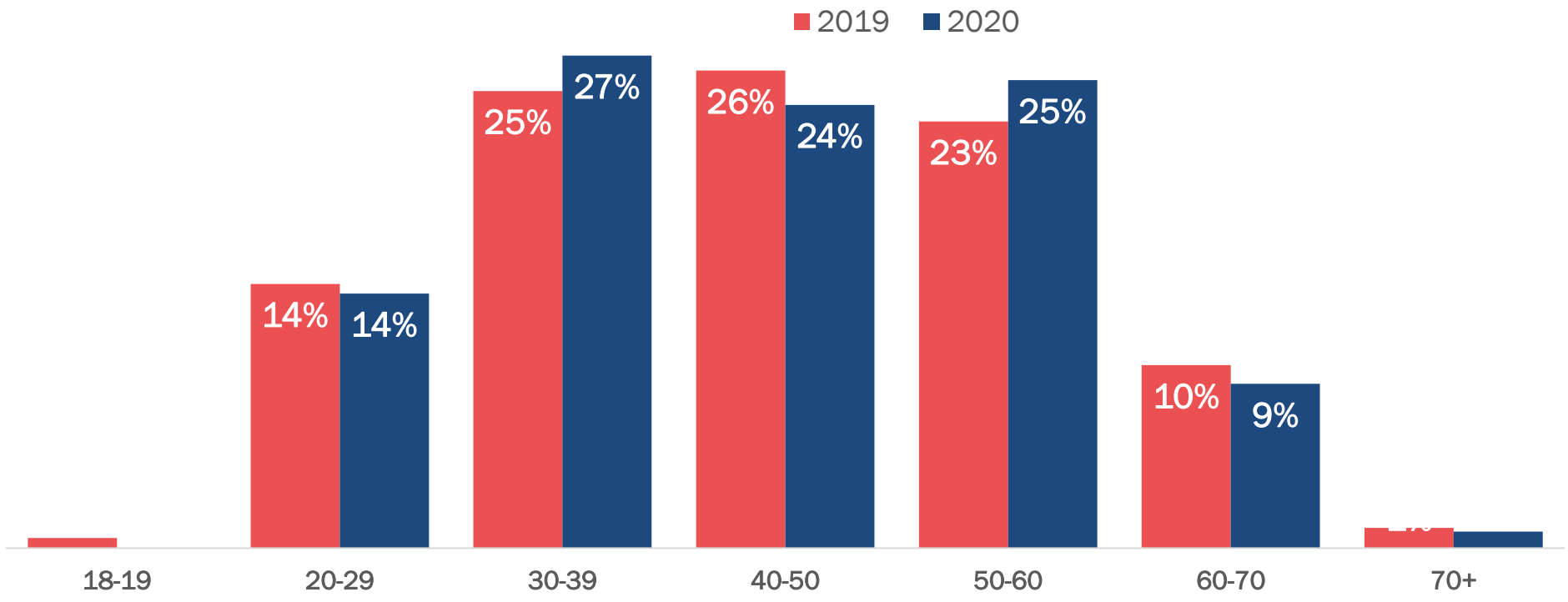
Both methadone factors are also significant for 30-39 year olds

In 2020, those who died elsewhere were also 3x more likely to have a prior overdose (23% vs. 7%)

Quantitative Analysis: Age groups

"2020": Fatal Overdose between Dec. 2019 – June 2020

"2019": Fatal Overdose between Dec. 2018 – June 2019



RHODE ISLAND

Died at residence vs elsewhere

Total population	2019	2020
Full Population (Vitals)	181	223
Also in Medicaid	*108*	*129*
Medicaid % of Total	60%	58%

We analyzed the differences between 2019 and 2020 cohorts on those who died at their residence vs who died elsewhere.

People who died in their residence in were less likely to be on Medicaid, more likely to be married, less likely to have tobacco contribute to death.

Those who died in other places were more likely to have tobacco contribute to death and have a previous OUD diagnosis (and less likely to have an AUD diagnosis).

	2019	2020	% change 2019 to 2020
All Overdoses	**181**	**223**	**23%**
All Overdoses - Male	127	164	29%
All Overdoses – Female	54	59	9%
Died at Residence – Total	**80**	**109**	**36%**
Died at Residence – Male	55	83	51%
Died at Residence – Female	25	26	4%
Died Elsewhere	101	114	**13%**

Died at Residence

Factor	2019	2020	2019 - %	2020 - %	Difference %	Source	Standard Error	Upper CI	Lower CI	Z	p
Marital Status : Married	6	23	7.50%	21.10%	13.60%	Vitals_Deaths	0.05	23.19%	4.01%	2.78	0.00
Tobacco as a cause : No	47	51	58.75%	46.79%	-11.96%	Vitals_Deaths	0.07	2.33%	-26.25%	-1.64	0.05
Any Medicaid Claim	50	55	62.50%	50.46%	-12.04%	Medicaid Claims	0.07	2.12%	-26.21%	-1.67	0.05

Died Elsewhere

Factor	2019	2020	2019 - %	2020 - %	Difference %	Source	Standard Error	Upper CI	Lower CI	Z	p
Tobacco as a cause : Yes	8	20	7.92%	17.54%	9.62%	Vitals_Deaths	0.04	18.37%	0.88%	2.16	0.02
Prior Alcohol Use Disorder	32	30	55.17%	40.54%	-14.63%	Medicaid Claims	0.09	2.37%	-31.63%	-1.69	0.05
Prior Opioid Use Disorder	28	46	48.28%	62.16%	13.89%	Medicaid Claims	0.09	30.84%	-3.07%	1.61	0.05

2020 Cohort Comparison: Died at residence vs elsewhere

Total population	2019	2020
Full Population (Vitals)	181	223
Also in Medicaid	108	129
Medicaid % of Total	60%	58%

In 2020, those who died in residence were less likely to have prior Medicaid claims, more likely to be aged 40-49, and less likely to have prior OUD dx

Comparison of 2020 cohort between those who died at other places vs those who died at residence

Factor	2020 Other places	2020 Residence	2020 Other places %	2020 Residence %	Difference %	Source	Standard Error	Upper CI	Lower CI	Z	p
Age 20-29	21	9	18.4%	8.3%	-10.2%	Vitals_Deaths	0.045	-1.4%	-19.0%	-2.265	0.012
Age 40-49	20	34	17.5%	31.2%	13.6%	Vitals_Deaths	0.057	24.8%	2.5%	2.399	0.008
Age 50-59	34	23	29.8%	21.1%	-8.7%	Vitals_Deaths	0.058	2.6%	-20.1%	-1.504	0.066
Marital Status : Married	15	23	13.2%	21.1%	7.9%	Vitals_Deaths	0.050	17.8%	-1.9%	1.579	0.057
Tobacco as a cause : Yes	20	10	17.5%	9.2%	-8.4%	Vitals_Deaths	0.045	0.5%	-17.2%	-1.856	0.032
Any Medicaid Claim	74	55	64.9%	50.5%	-14.5%	Medicaid Claims	0.066	-1.6%	-27.3%	-2.206	0.014
Prior Claim of Substance Use Disorder other than AUD	56	34	75.7%	61.8%	-13.9%	Medicaid Claims	0.082	2.3%	-30.0%	-1.683	0.046
Prior claim of Substance Use Disorder other than OUD	58	37	78.4%	67.3%	-11.1%	Medicaid Claims	0.079	4.4%	-26.7%	-1.400	0.081
Prior Opioid Use Disorder	46	22	62.16%	40.00%	-22.16%	Medicaid Claims	0.086845	-5.14%	-39.18%	-2.55	0.01
Prior Overdose	17	4	22.97%	7.27%	-15.70%	Medicaid Claims	0.060145	-3.91%	-27.49%	-2.61	0.00

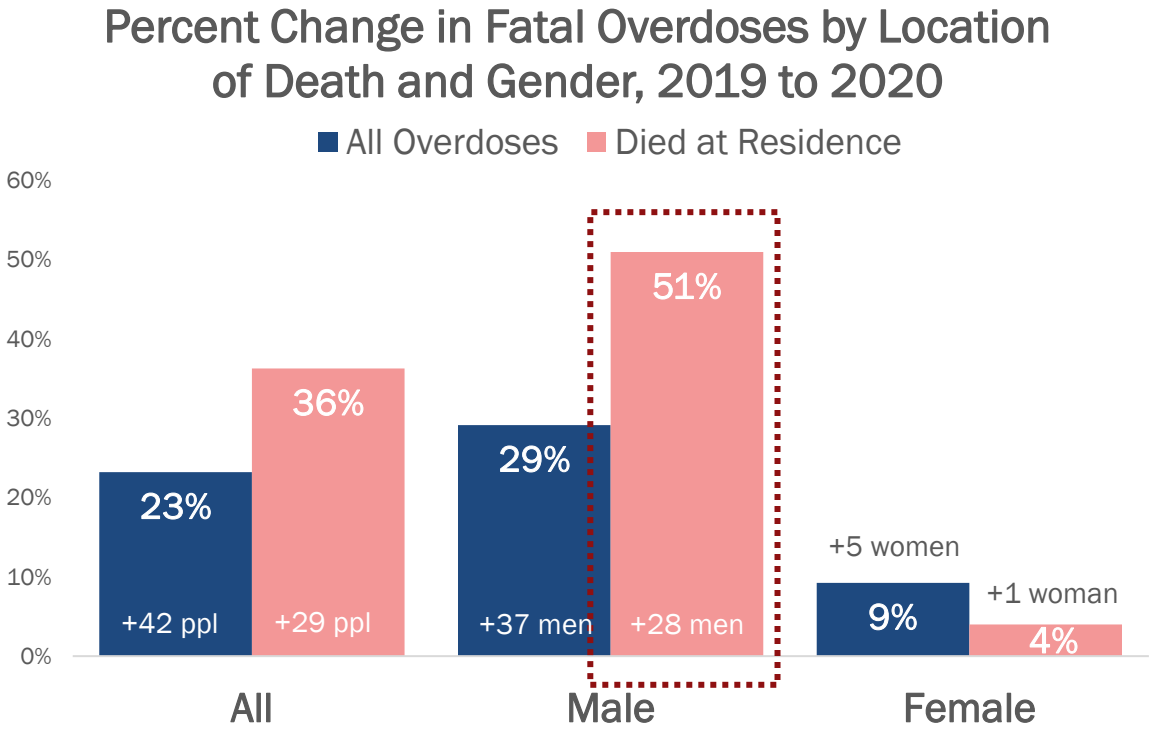
Fentanyl, isolation, and institutional mistrust means many more people in 2020 died in residence – especially men.

Population	2019	2020	% change
Died in Residence	80	109	36%
All deaths	181	223	24%
% of Total	44%	49%	

There were 51% more men – versus 4% more women – who died in their residence in the 2020 cohort. This compares to a 23% increase in all overdoses – 29% for men, 9% for women – in the two cohorts.

Note that the 51% increase, though large, was not statistically significant (p = 0.13)

Statistically significant (P < 0.05) differences from 2019 to 2020



Those who **died in their residence in 2020** were more likely to:

- ✓ Be married (21% of total, up from 7.5% in 2019)
- ✓ Not use tobacco (47% of total, down from 59%)
- ✓ Not be in Medicaid (50% of total, down from 63% in 2019)

Those who died elsewhere in 2020 were more likely to:

- ✓ Have a prior OUD claim (62% of total, up from 48% of total
- ✓ Not have a prior Alcohol Use Disorder claims (40% of total, down from 55%)

Methadone Deaths and Enrollment in Treatment

- We analyzed the deaths dataset and Medicaid claims dataset to determine the enrollment percentage in MAT within 3 months of death date.
- There were 51 people, in total, who died of Methadone as one of the causes. Of these 51 people, 38 (74.5%) of them were in Medicaid . Of those, 24 people were in Treatment within 3 months of death.

	2019	2020	Grand Total
Number of People	**19**	**32**	**51**

	2019	2020	Total	2019%	2020%
Enrolled in MAT within 3 months of Death	6	18	24	50.0%	69.2%
NOT Enrolled in MAT within 3 months of Death	6	8	14	50.0%	30.8%
Grand Total	**12**	**26**	**38**		

Month Of Death	2019	2020	Total
Jan	2	4	6
Feb	3	4	7
Mar	2	5	7
Apr	2	6	8
May	5	8	13
Jun	1	3	4
Dec	4	2	6
Grand Total	**19**	**32**	**51**

The table shows the frequency count of co-occurrence of Methadone with other codes as causes of Death

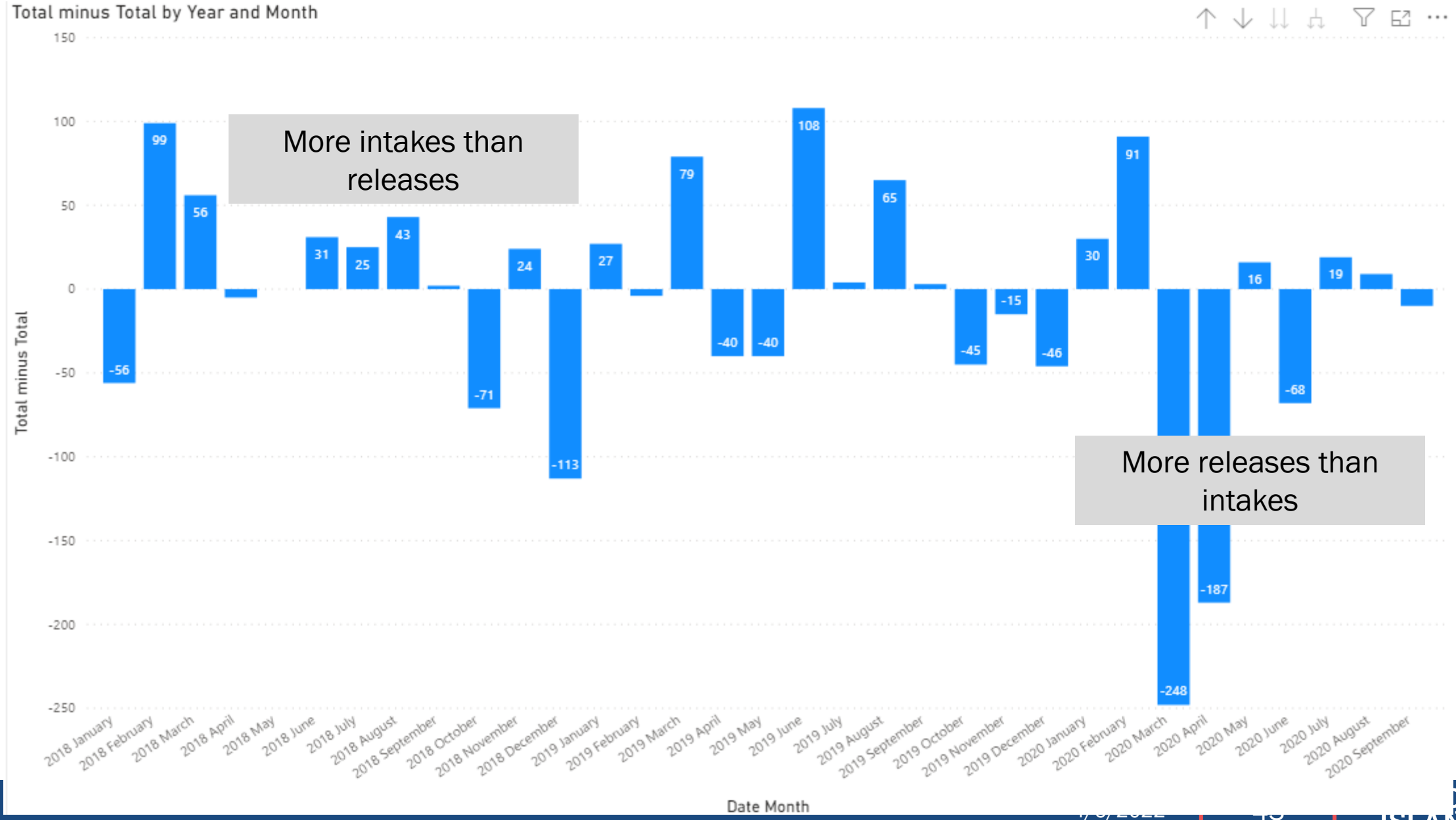
Code	Description	Frequency
T404	Synthetic Opioids Other than Methadone (Fentanyl etc)	27
X44	Drug Poisoning	7
T402	Opioid Overdose	5
X42	Drug Poisoning	5
T424	BENZODIAZEPINE	5
F191	Pyschoactive Substance Abuse	4
T509	Unspecified drugs, medicaments and biological substances	4
F109	Alcohol	3
I517	Cardiomegaly	3
K746	Biliary cirrhosis unspecified	3
T405	Cocaine	3
F179	Nicotine	2
I119	Hypertensive heart disease without heart failure	2
J449	Chronic obstructive pulmonary disease unspecified	2
J459	Severe persistent asthma with status asthmaticus	2
T401	Heroin	2

Roger Williams: Impact of MAT Facility Closure

- For comparison, we identified individuals who received MAT at other (non-Roger Williams) facilities for the same time period as the RW-MAT Cohort, 4/1/19 to 5/31/19 (NRW-MAT Cohort)
- Higher mortality among RW-MAT Cohort 12-months post-closure, but 0 deaths 6-months post closure
  - **Urge caution in interpretation due to relatively low numbers for RW-MAT Cohort**

Mortality Rate for RW-MAT Cohort vs NRW-MAT Cohort		
	RW-MAT Cohort	NRW-MAT Cohort
Count	96	1,519
6-month deaths (%)	0 (0%)	7 (0.46%)
12-month deaths (%)	3 (3.13%)	21 (1.38%)

Department of Corrections: Intakes Minus Releases, by Year / Month



Recommendations Detail

By Overdose Task Force Strategic Plan Pillar

RHODE ISLAND

Proposed Recommendations – Harm Reduction & Rescue

1. Harm Reduction: Naloxone has been our main focus of rescue. We must move beyond naloxone, to include harm reduction

F SR

A. **Rename** the Task Force's Rescue Pillar to Harm Reduction & Rescue to recognize the importance of Harm Reduction in the Task Force's work

F SR 4A

B. Maximize access to recognized **harm reduction materials.** Includes culturally competent distribution of, awareness of and ability to test for fentanyl in illicit drugs through messaging and distribution of fentanyl test strips, plus resources for needle exchange and other materials.

F C 2,4

C. Facilitate the planning for a pilot **overdose prevention site**

F SR

D. Rebuild community trust of law enforcement by **designating a facilitator for a conversation with community and law enforcement leaders** to enable harm reduction practices and by building champions for harm reduction in law enforcement

F C SR 1C

E. Establish a workplan to ensure every strategy and implementation plan has **actions steps to reduce structural racism,** and that these actions are measured and reviewed routinely.

SR

2. Address the challenges of the Good Samaritan Law: Carry out a formal evaluation of the Good Samaritan law to determine how it is implemented and support effective implementation; initiate trainings and the law and its reach; pursue legislation as needed.

F C

3. Pursue additional data-sharing between RIDOH and community organizations, to allow for more effective community outreach

Full Recommendations – Recovery

F C SR All

1. Expand Recovery beyond "absence of drug use" - include reduced use and other Harm Reduction activities, and a focus on ending social isolation, especially during COVID.

2. Recovery Capital: Focus on purpose, place, and people as anchors, especially countering the impact of COVID:

F C SR 2C

A. Purpose: Expand and promote Recovery-Friendly Workplaces and employment and career ladder support for those with SUD and COVID job displacement. Support educational pathways as well for people in recovery.

F C SR 1,2

B, Place: As noted in Prevention, make significant investments in housing resources, such as Recovery Housing and other step-down facilities, especially for people shown to be at highest risk (people 50-59 years of age, people of color, veterans)

F C SR 3

C. People: Promote safe in-person support to counter social isolation and deepen recovery community networks, which COVID has eroded

F C SR

3. Certified Peer Recovery Specialists: Broaden support and investment in the peer recovery network, with increased payment for, and recruitment and training of a more diverse pool of peer recovery specialists to better represent people in new recovery. Turn Peer Recovery Specialists into a career ladder position.

Full Recommendations – Governance (Cross-Pillar)

The following governance recommendations are meant to enable our collective response to achieve the previous recommendations with speed, agility, and equity.

1. To achieve a more formally **coordinated and effective statewide structure** to prevent overdoses and pursue a healthier Rhode Island

A. Appoint **community co-chairs** to co-lead the task force workgroups

B, Create a full time, dedicated **Director of Overdose Prevention + Response** to lead the administration's Task Force activities and to be responsible for aligning the public/private shared work

C. The Director of Overdose Response leads an **interagency team** that breaks down silos between individual state agencies, builds connections with community partners as it implements the Task Force Strategic Plan, and highlights the needs for better data about the overdose response

D. Interagency team will include a **robust project management structure**, to support the Task Force Workgroups and track and report on Strategic Plan action items in a public dashboard. Ensure that adequate data are collected, and that data and evaluations are shared.

2. The Task Force Co-Chairs should pursue more **adequate and diverse community representation**, with community voices encouraged to participate in Workgroups, and more BIPOC members added to the Task Force itself

3. To add shared policy work to Rhode Island's addiction response, create a **standing legislative/policy team** with membership from each of the Workgroups, to create an annual legislative agenda - for example, in FY21 to support the upcoming Governor's Housing Bonds

Full Recommendations – Messaging (Cross-Pillar)

F C SR D

Prevention: Overhaul state messaging efforts, by looking toward nationally researched and locally tailored messaging that is proven to reach a variety of audiences: people who use drugs, their families and supporters, and people not using drugs.

F C SR 3

Harm Reduction: Emphasize anti-stigma messaging, by looking toward nationally researched and locally tailored messaging that is proven to reach a variety of audiences: people who use drugs, their families and supporters, and people not using drugs.

F C SR 3

Recovery messaging must include the shift from addiction as a vice to addiction as a disease; the hope of a full life; and the reinforcement that true recovery is personal, self-directed, and doesn't look the same – but always needs a welcoming community.

Full Recommendations – Treatment

1. Access to medically adequate sustained treatment by lowering barriers and opening doors:

C SR 2 — A. Medication First MAT access – a low-threshold MAT system - including no prior authorizations, no need for tox screen if not medically required, allowances for missed appointments. Explore uptake of non-opioid MAT options for alcohol-use disorder and for stimulants where possible.

C SR 2 — B Ensure access to adequate, quality, residential treatment: pursue mandate of minimum 30-day residential treatment, when medically-necessary, with no reauthorizations necessary until Day 31; implement sufficient family SUD residential treatment facility; no concurrent review.

C SR — C. Carry out rate review activities, to support rates that allow (a) behavioral health workforce to become more diverse and culturally competent.(b) adequately compensate for existing services, and for (c) medication first and reduced administrative barriers

2. Enhance Content of Substance Use Treatment to Reinforce Connection to Harm Reduction, Prevention, Recovery

F SR 2 — A. Strengths-based treatment that nudges people towards trusting their providers and encouraging return [i.e. providing clean needles, fentanyl strips etc.]

C SR 3 — B. Ensure that SUD treatment includes integrated mental health services - and working with OHIC, does so without additional co-pays

C SR — C. Primary Care Providers should partner with SUD providers just as any other specialty – eReferrals, CCD integration, expectation of provider coordination for each shared patient.

Full Recommendations – Treatment

3. Ensure Consistent, High Quality Services among a range of delivery models

C

A. **Facilitate patient consent to data sharing and support provider workflow changes** to ensure person-focused, successful care and allow communication between treatment facilities and community case navigators.

C | SR | 2

B. Evaluate the Centers of Excellence model, to determine their effectiveness and ensure quality, and compare to a Nurse Care Manager model

C | SR

C. Promote safe and accessible patient complaint functions and clarify the state's actions to respond to complaints

Full Recommendations - Prevention

1. Promote Prevention Efforts That Build Personal and Community Resilience, Alternatives to Substance Use, Targeted Messaging

F C SR 3

A. Invest in mental-health and community resiliency: **Trauma-informed behavioral health services** across the lifespan, with a focus on addressing ACEs, toxic stress, family and community violence-reduction programs

F C SR 3

B. Pursue policies around social determinants or social experiences that help **reduce desires to turn to drug use**. Also, pursue prevention policies that safeguard against social isolation (I.e. against cyber bullying, or to promote grief supports)

F C 4A

C. Invest in proven **prevention educational programs**, including updated facts about the crisis i.e. significant rise of fentanyl), the existence of harm reduction strategies (Narcan and fentanyl test strips), and strategies for mental health resilience

F 1D

D. Prevention programs should be **across the lifespan,** with focus on youth (high school and middle school) as well as older adults, including seniors who may be at risk of casual opioid, benzodiazepine, or alcohol misuse

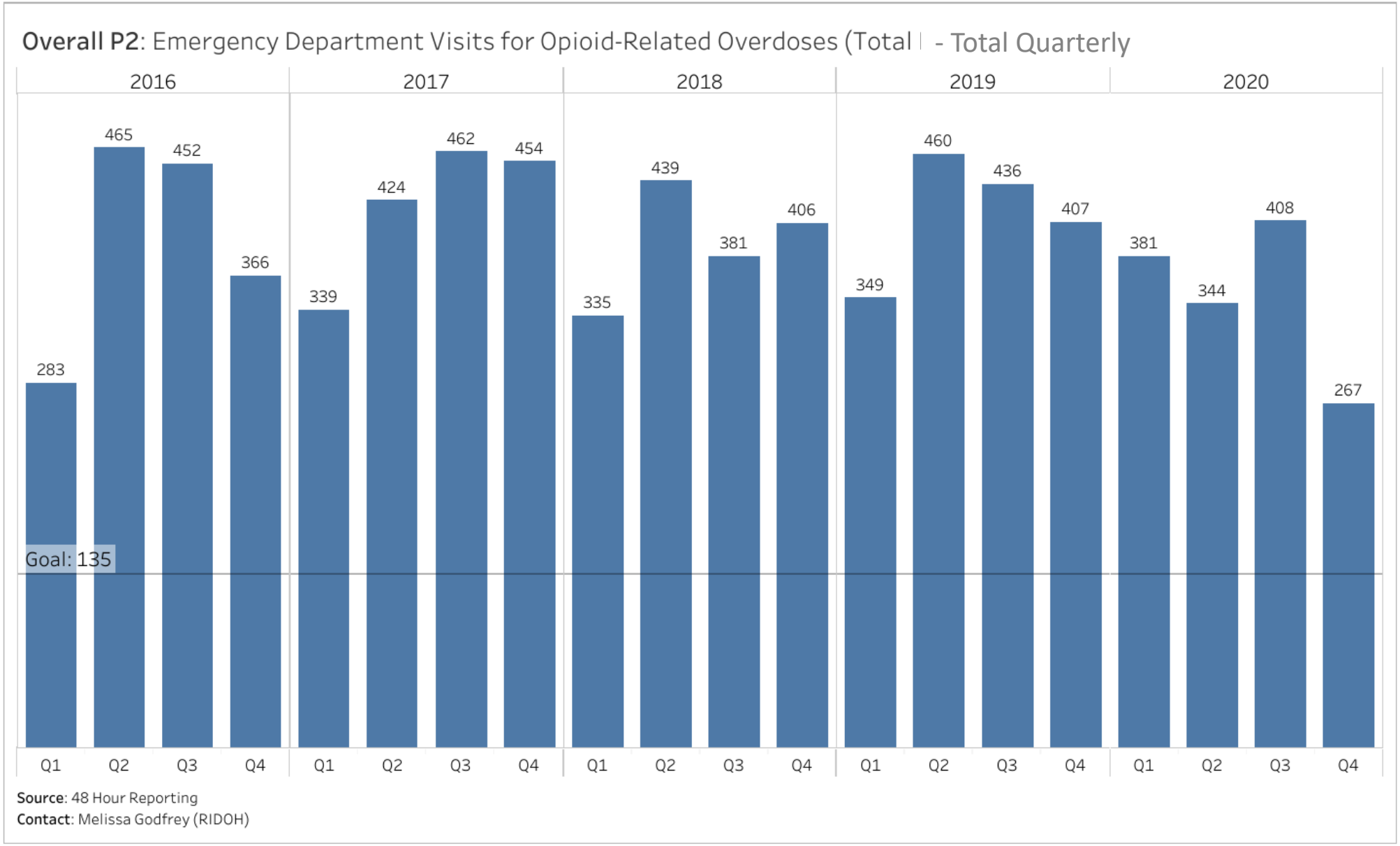
F C SR 1

E. Prioritize prevention strategies that **recognize race equity, eliminate structural racism and disparities** based on race, ethnicity, sexual orientation, gender, gender identity, age, and ability

Key Overdose Metrics

Overarching Goals

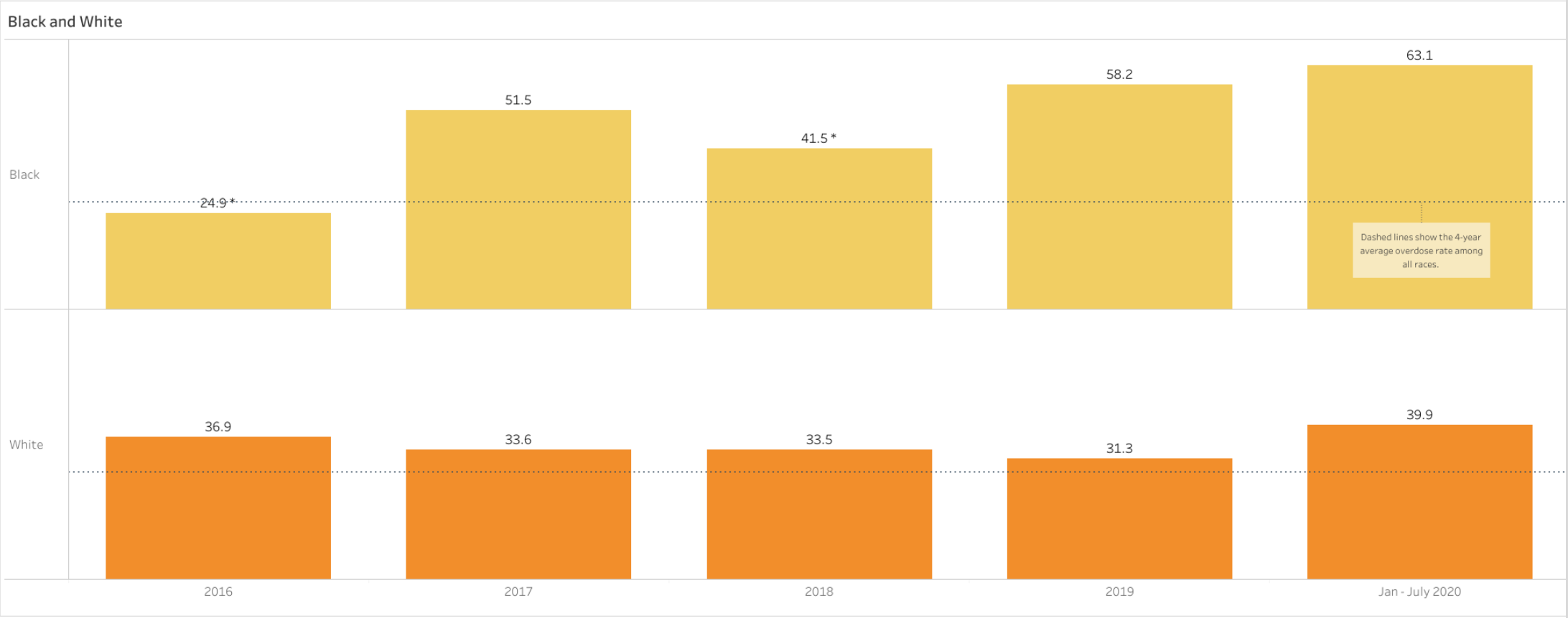
Primary 1 | **Primary 2**



We see a mostly consistent downward trend in quarterly non-fatal overdoses that present, starting in Q2 2019.

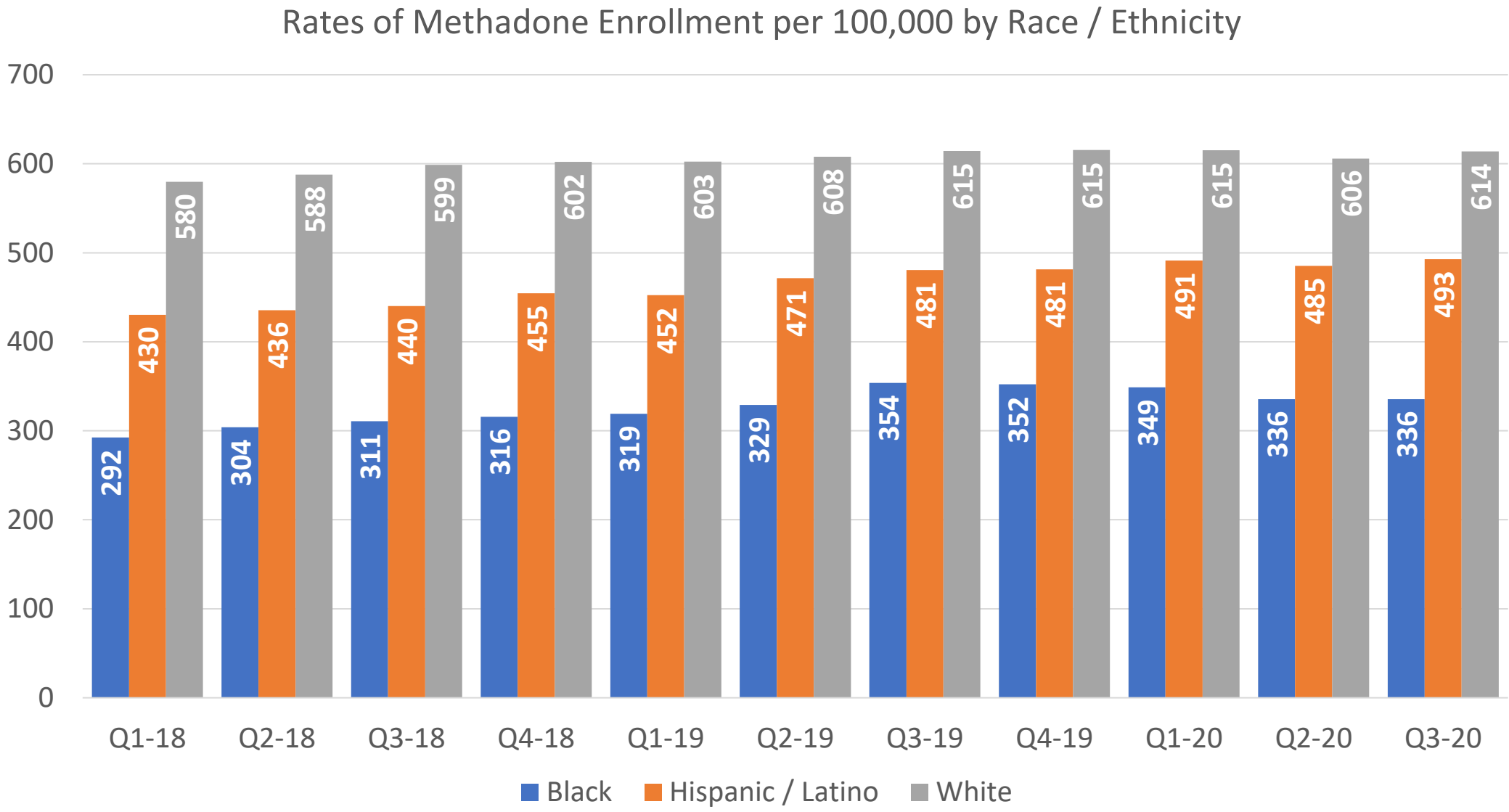
However, this trend could be explained by more fatal overdoses, people who refuse medical transportation, or overdoses where paramedics are never called.

Overdose Death Rate per 100,000 person-years by **Race**, 2016- July 2020



Note: Dashed lines represent annual overdose rates among all races.
Note: The rate is the number of deaths, divided by the total population for each race according to the 2010 Census, multiplied by 100,000
Note: Counts for other races, including 'Asian' and 'Native Hawaiian/Other Pacific Islander', are less than 5 each year and have been supressed. Data does not include cases where the race was "Unknown"
Note: Please use caution when interpreting rates marked by an asterisk.

Though the number of deaths among those identified as Black were small, they represent a 50% higher death rate per 100,000 person-years than those identified as White for the first six months of 2020.



Though rates of enrollment have grown across major race and ethnicity groups, in Q3 2020, those who identify as Black are 42% less likely to have a methadone enrollment record than whites

614 people per 100k person years for those who identify as white, versus 336 for those who identify as Black.

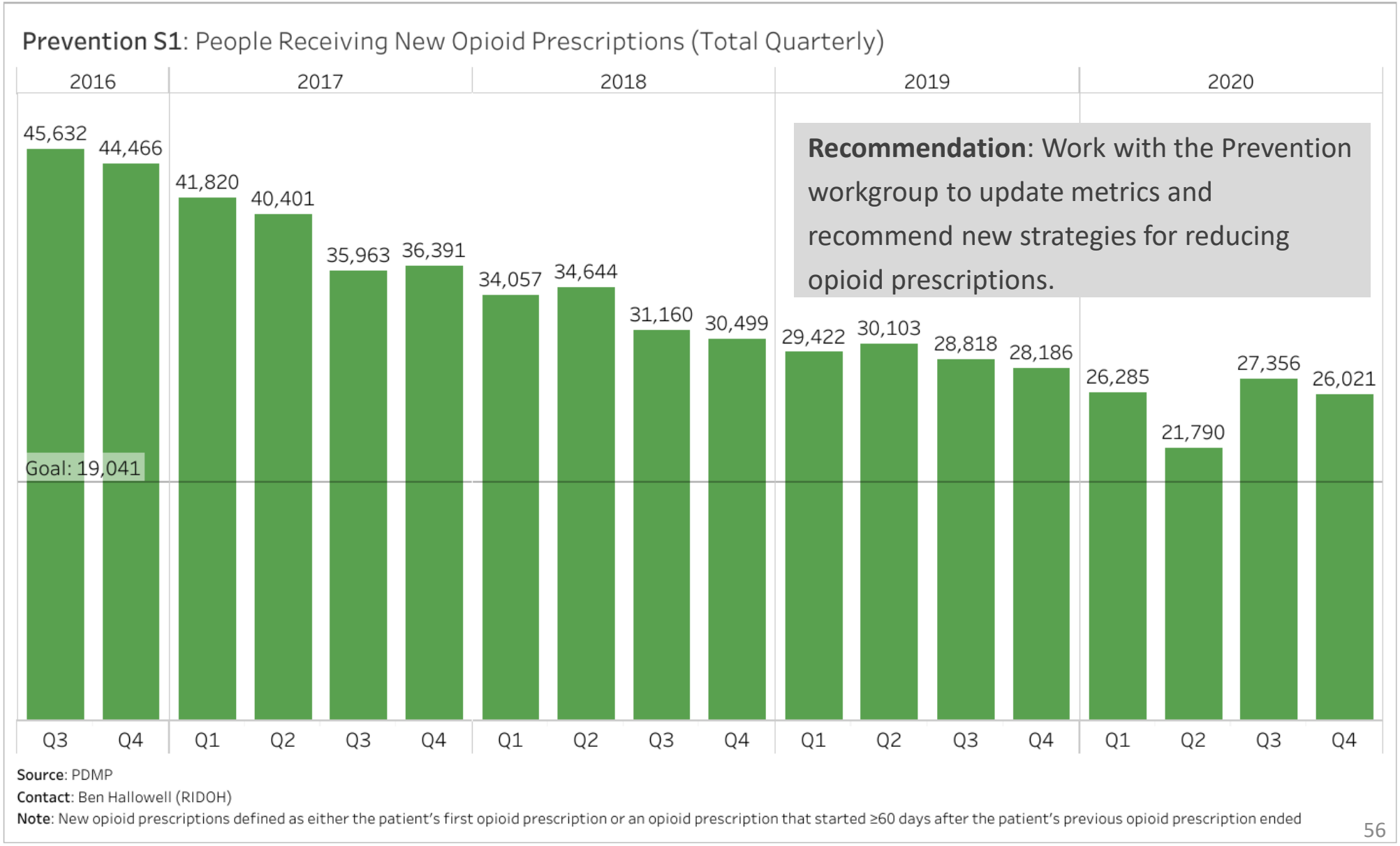
Prevention Pillar

Primary 1 | Primary 2 | **Secondary 1** | Secondary 2 | Secondary 3

For these three secondary prevention – opioid prescribing – slides, we are likely witnessing continuation of the pre-pandemic plateau, requiring new strategies to break through to a lower floor.

From Dr. Matt Collins at the February TF meeting:

[In December edition of Annals of Surgery,](#) there is an article with startling findings. 91% of US surgical discharges got opioid. 5% of non-US surgical discharges got opioid. We may be lowering the morphine equivalents but are we reducing the total amount of meds dispensed?



For these three secondary prevention – opioid prescribing – slides, we are likely witnessing continuation of the pre-pandemic plateau, requiring new strategies to break through to a lower floor.

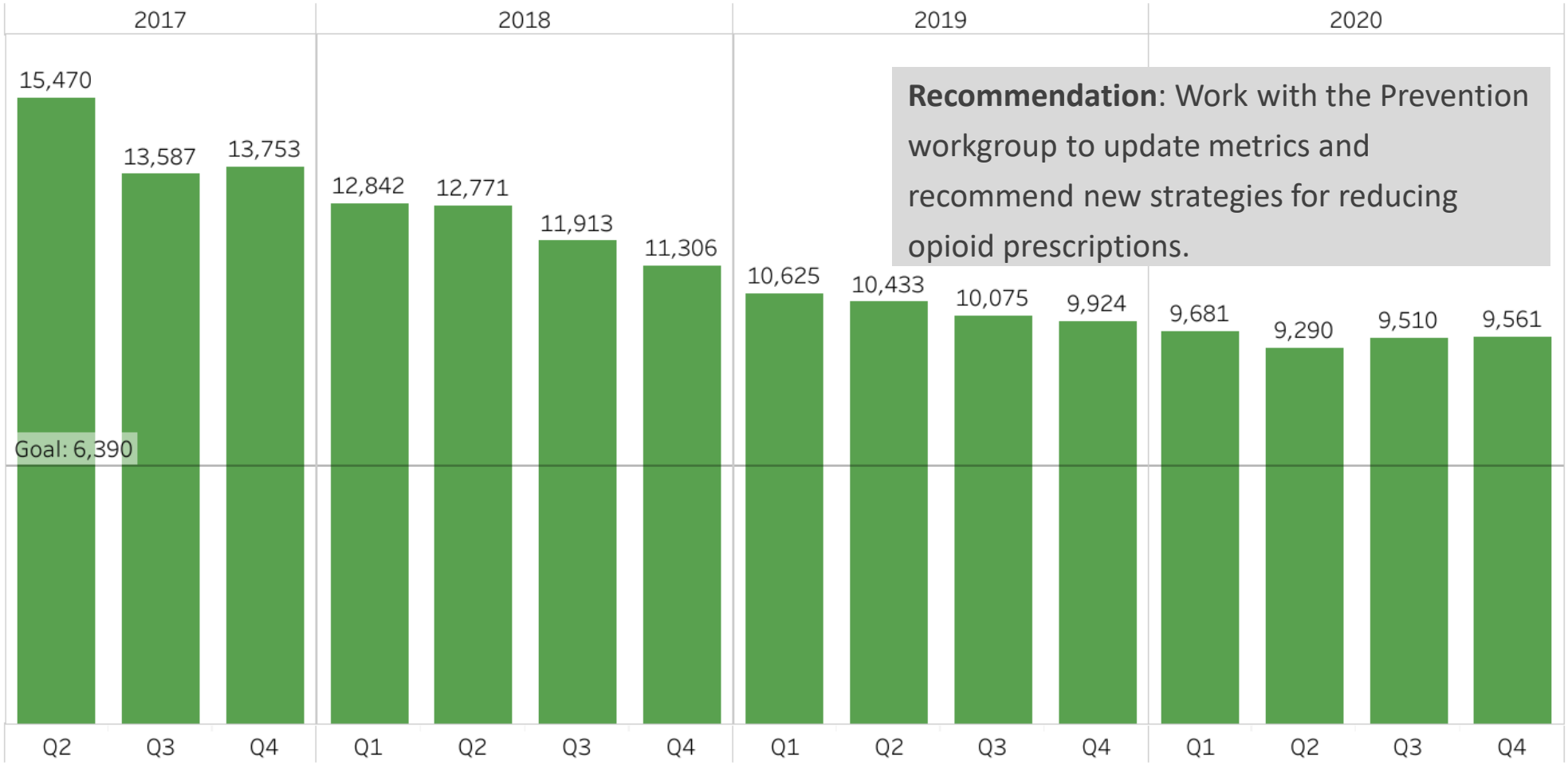
From Dr. Matt Collins at the February TF meeting:

In December edition of Annals of Surgery, there is an article with startling findings. 91% of US surgical discharges got opioid. 5% of non-US surgical discharges got opioid. We may be lowering the morphine equivalents but are we reducing the total amount of meds dispensed?

Prevention Pillar

Primary 1 | Primary 2 | Secondary 1 | **Secondary 2** | Secondary 3

Prevention S2: People Receiving Overlapping Opioid and Benzodiazepine Prescription (Total Quarterly)



Recommendation: Work with the Prevention workgroup to update metrics and recommend new strategies for reducing opioid prescriptions.

Source: PDMP
Contact: Ben Hallowell (RIDOH)
Note 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.

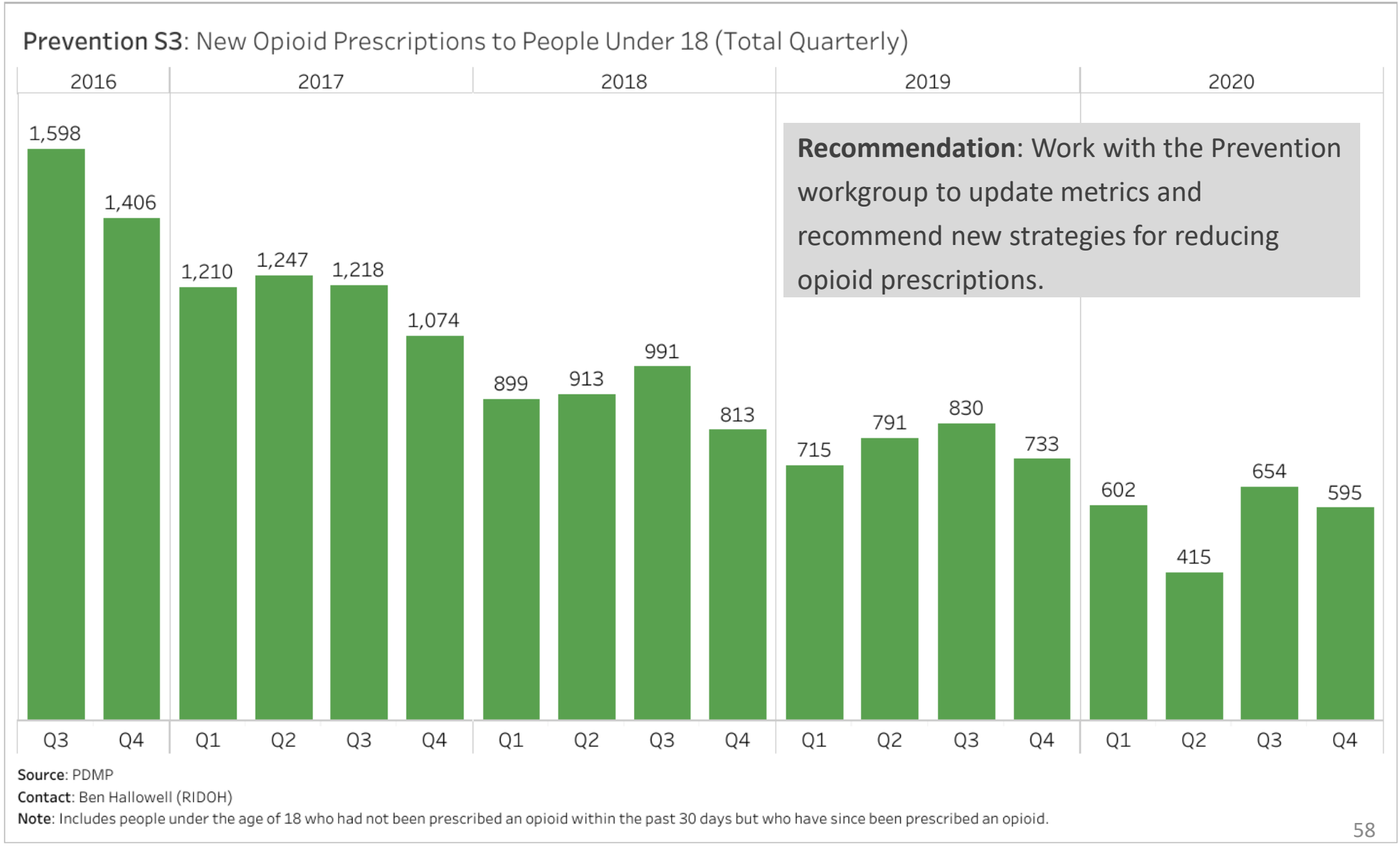
For these three secondary prevention – opioid prescribing – slides, we are likely witnessing continuation of the pre-pandemic plateau, requiring new strategies to break through to a lower floor.

From Dr. Matt Collins at the February TF meeting:

In December edition of Annals of Surgery, there is an article with startling findings. 91% of US surgical discharges got opioid. 5% of non-US surgical discharges got opioid. We may be lowering the morphine equivalents but are we reducing the total amount of meds dispensed?

Prevention Pillar

Primary 1 | Primary 2 | Secondary 1 | Secondary 2 | **Secondary 3**



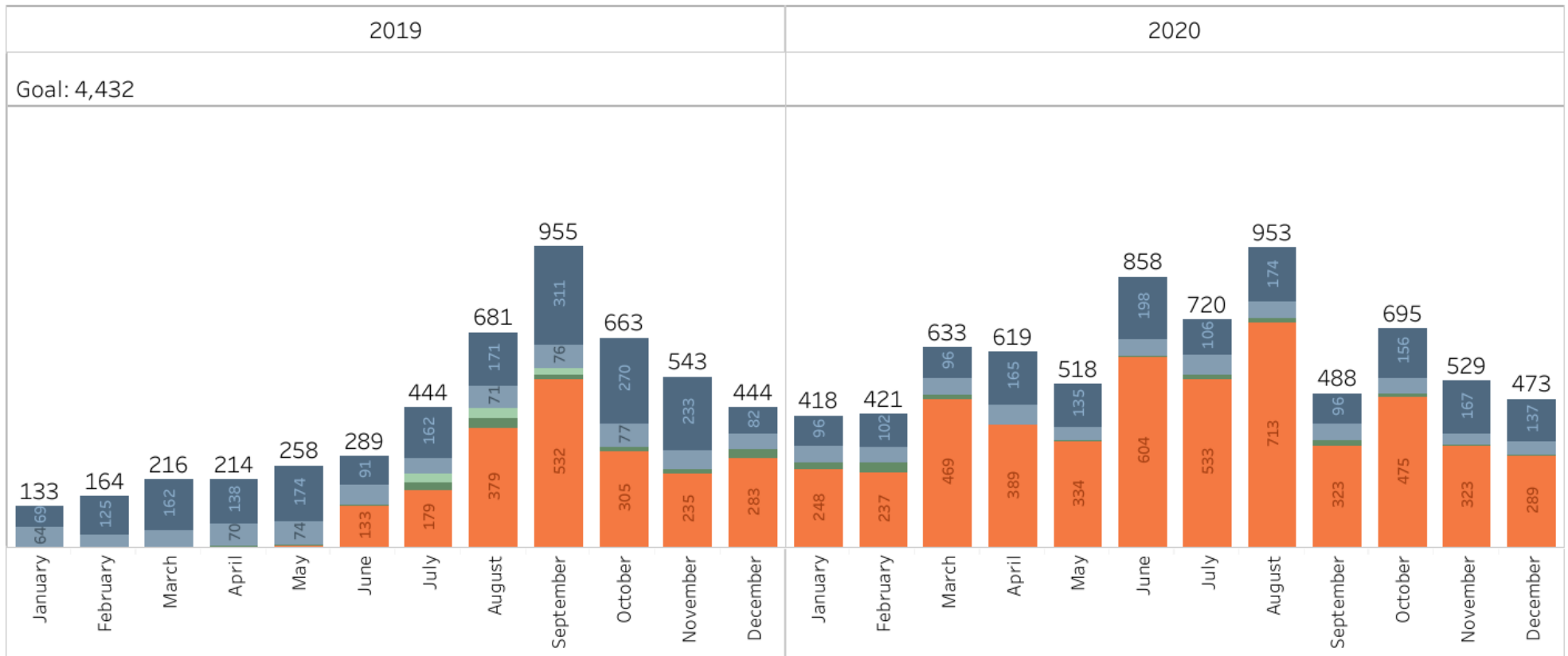
Source: PDMP
Contact: Ben Hallowell (RIDOH)
Note: Includes people under the age of 18 who had not been prescribed an opioid within the past 30 days but who have since been prescribed an opioid.

Rescue Pillar

Primary 1 | Primary 2 | Primary 3 | Secondary 1 | Secondary 2

People Receiving SUD Treatment
Emergency Department
ACI
HOPE Initiative
Other High Risk Populations

Rescue P1: High-Risk Populations Who Have Received a Kit of Naloxone Within the Past 12 Months (Total Monthly)



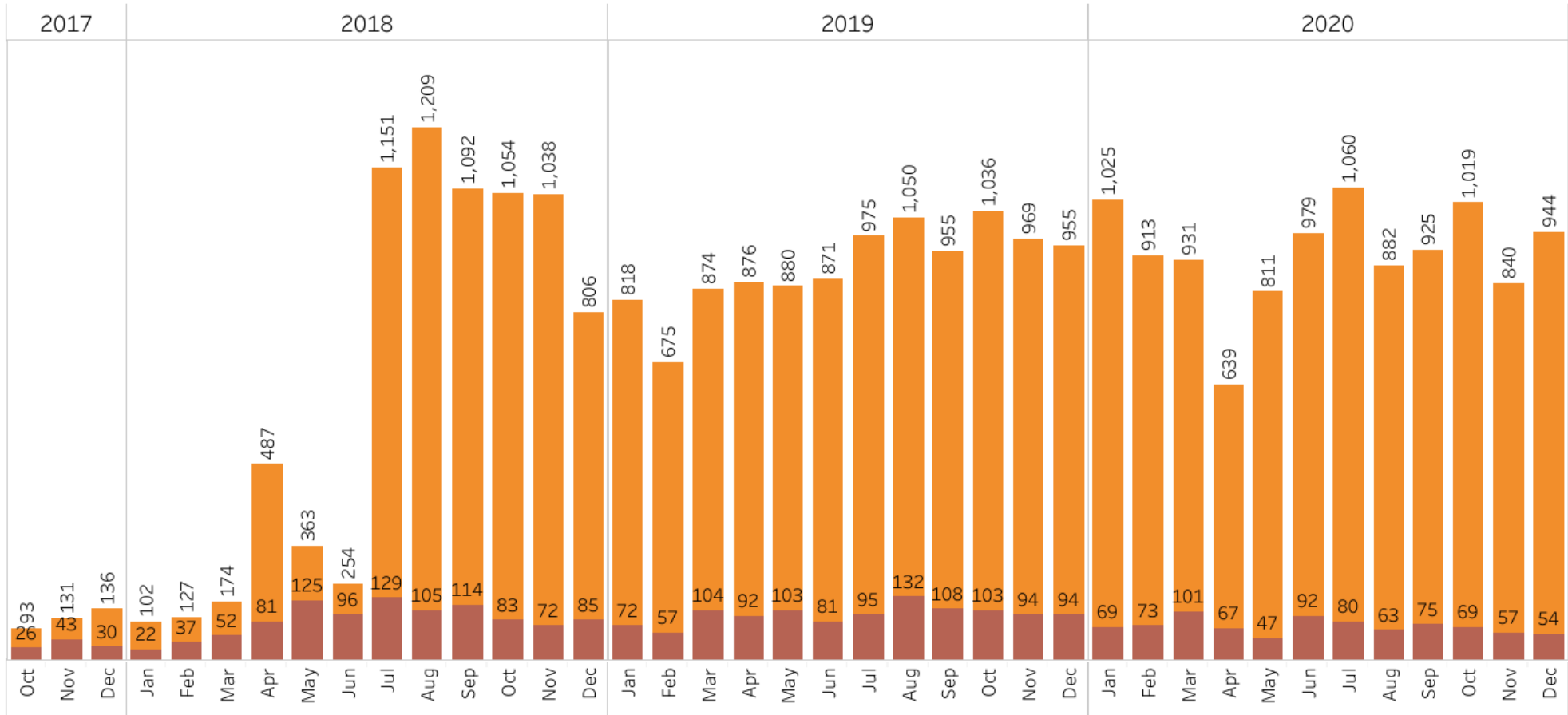
Source: RIBHOLD, 48 hour Reporting, DOC: INFACTS, Wufoo
Contact: Jamie Goulet (BHDDH), Melissa Godfrey (RIDOH), Rosemarie Martin (DOC), Matthew Moynihan (RISP)
Note: "High Risk" is defined as any or all of the following categories: **1**. People receiving SUD treatment for an OUD diagnosis at BHDDH-licensed facilities, **2**. People visiting the ED for a suspected overdose, including those who leave against medical advice, **3**. People leaving ACI and who have been screened positive for OUD, **4**. HOPE clients and their families **5**. Other Misc. High Risk Populations **5.a**. Clients Engaged via Street Outreach or harm reduction services **5.b**. EMS Leave Behind (beginning 10/15/19)

Rescue Pillar

Primary 1 | **Primary 2** | Primary 3 | Secondary 1 | Secondary 2

Non-Standing Order (Insurance)
Standing Order (Insurance)

Rescue P2: Prescription Naloxone Kits Received via Insurance (Total Monthly)



Source: PDMP
Contact: Ben Hallowell (RIDOH)
Note: Includes new prescriptions and standing order prescriptions, but grouped separately so we can see the count of new, standing order, and total combined.

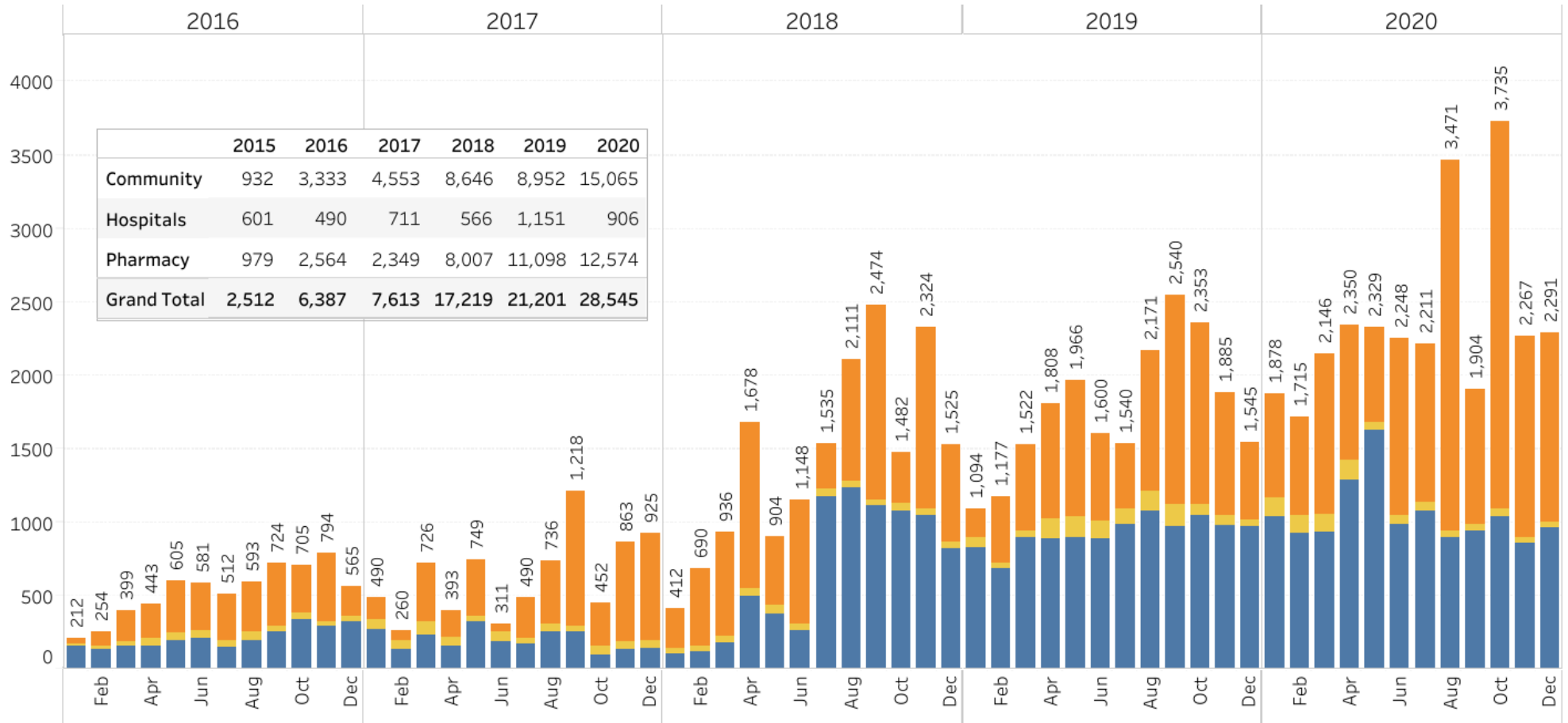
Rescue Pillar

Primary 1 | Primary 2 | **Primary 3** | Secondary 1 | Secondary 2

Community Hospitals Pharmacy

Rescue P3: Naloxone Kits Distributed (Total Monthly)

	2015	2016	2017	2018	2019	2020
Community	932	3,333	4,553	8,646	8,952	15,065
Hospitals	601	490	711	566	1,151	906
Pharmacy	979	2,564	2,349	8,007	11,098	12,574
Grand Total	2,512	6,387	7,613	17,219	21,201	28,545

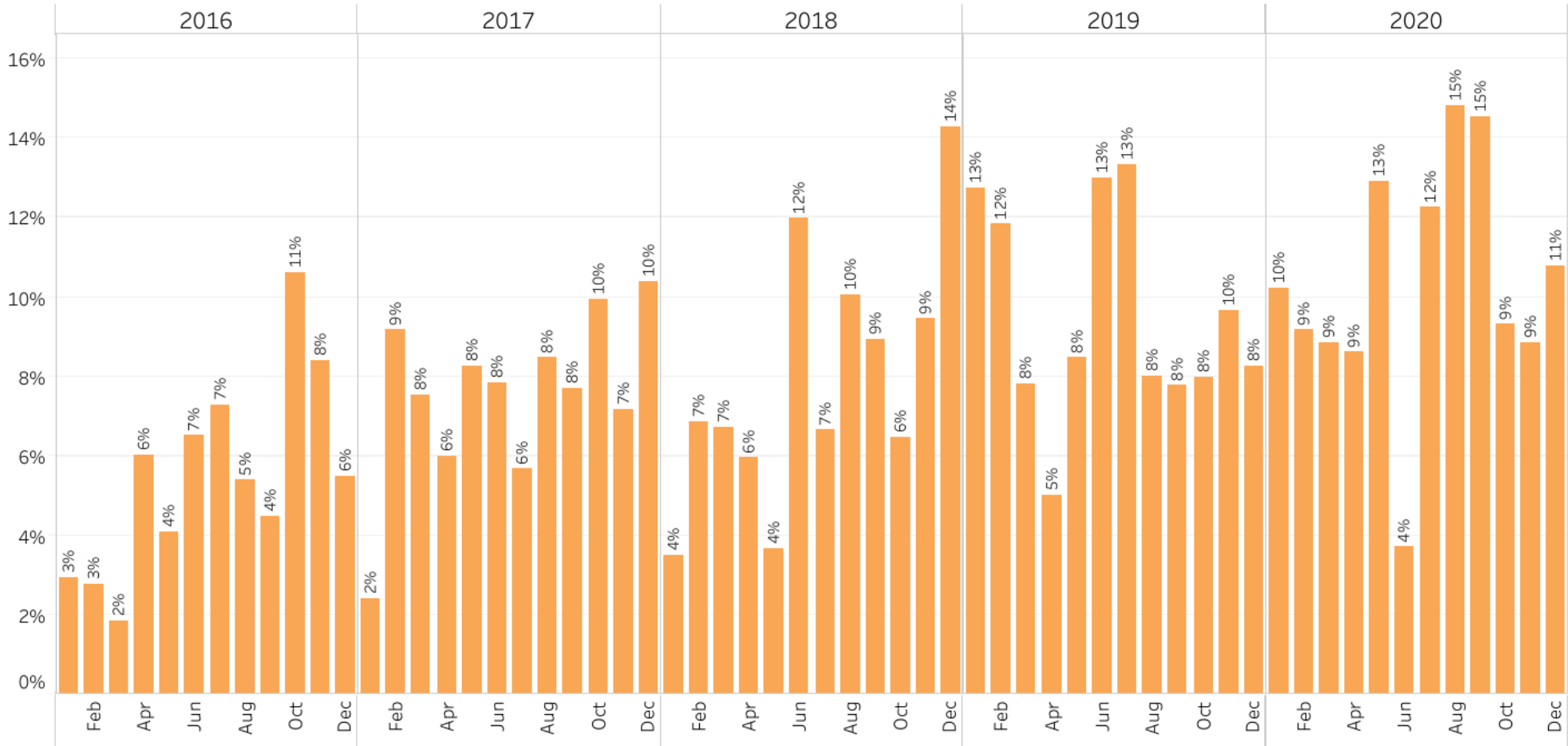


Source: 48 Hour Reporting (Hospital), PDMP (Pharmacy), Wufoo (Non-Pharmacy), PONI (Non-Pharmacy, Community via PONI)
Contact: Melissa Godfrey (RIDOH), Ben Hallowell (RIDOH), Ravenn Hackney (RIDMAT), Michele McKenzie (PONI)
Note: A kit is two doses of naloxone

Rescue Pillar

Primary 1 | Primary 2 | Primary 3 | **Secondary 1** | Secondary 2

Rescue S1: Suspected Opioid Overdoses Reported to Have Received Naloxone Administered by Laypersons Before Arriving at the Emergency Department (Total Monthly)



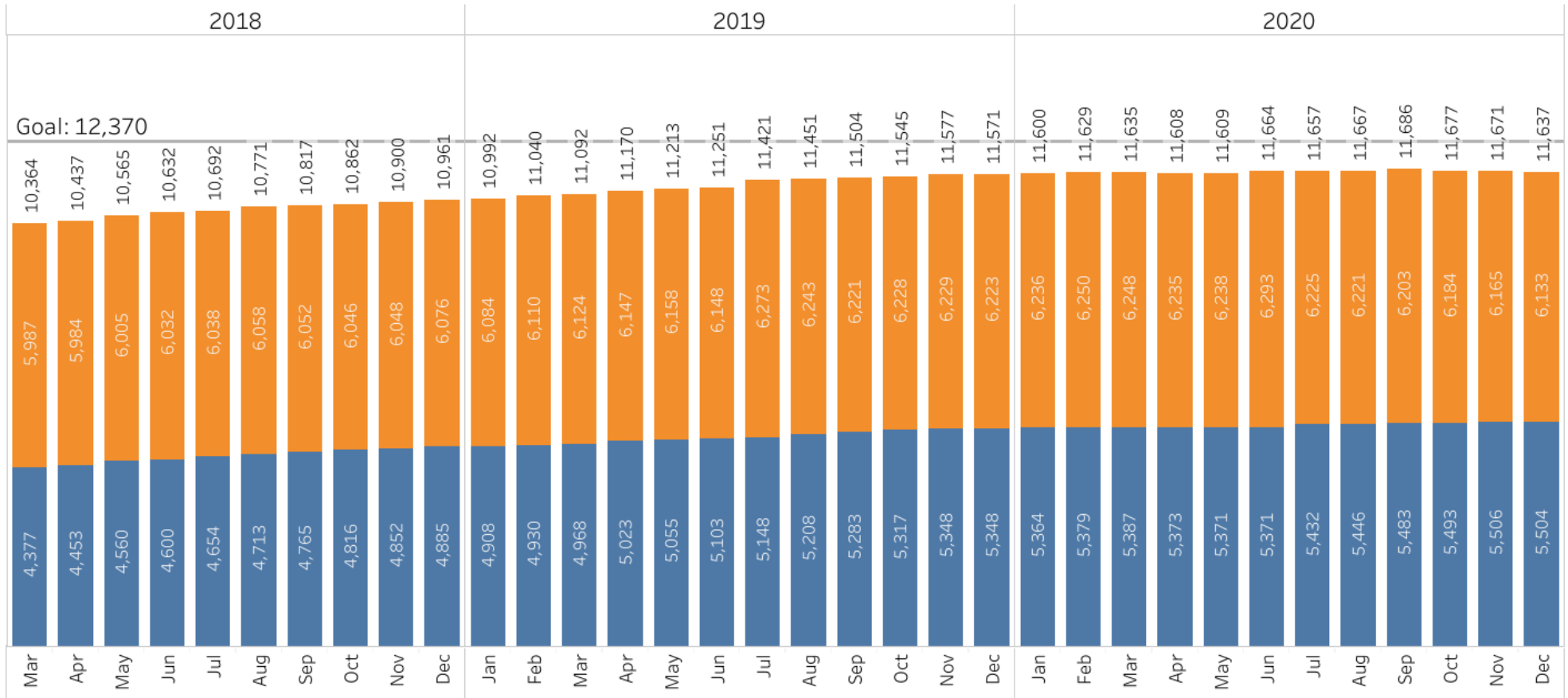
Source: 48 Hour Reporting
Contact: Melissa Godfrey (RIDOH)
Note: Layperson includes people other than EMS and police, such as family members, friends, bystanders, and unknown sources

Treatment Pillar

Primary 1	Primary 2	Primary 3	Waiting List	Secondary 1	Secondary 2	Secondary 3a	Secondary 3b

Methadone Buprenorphine

Treatment P1: People in Sustained Engagement with Medication Assisted Treatment (MAT) (Total Monthly)

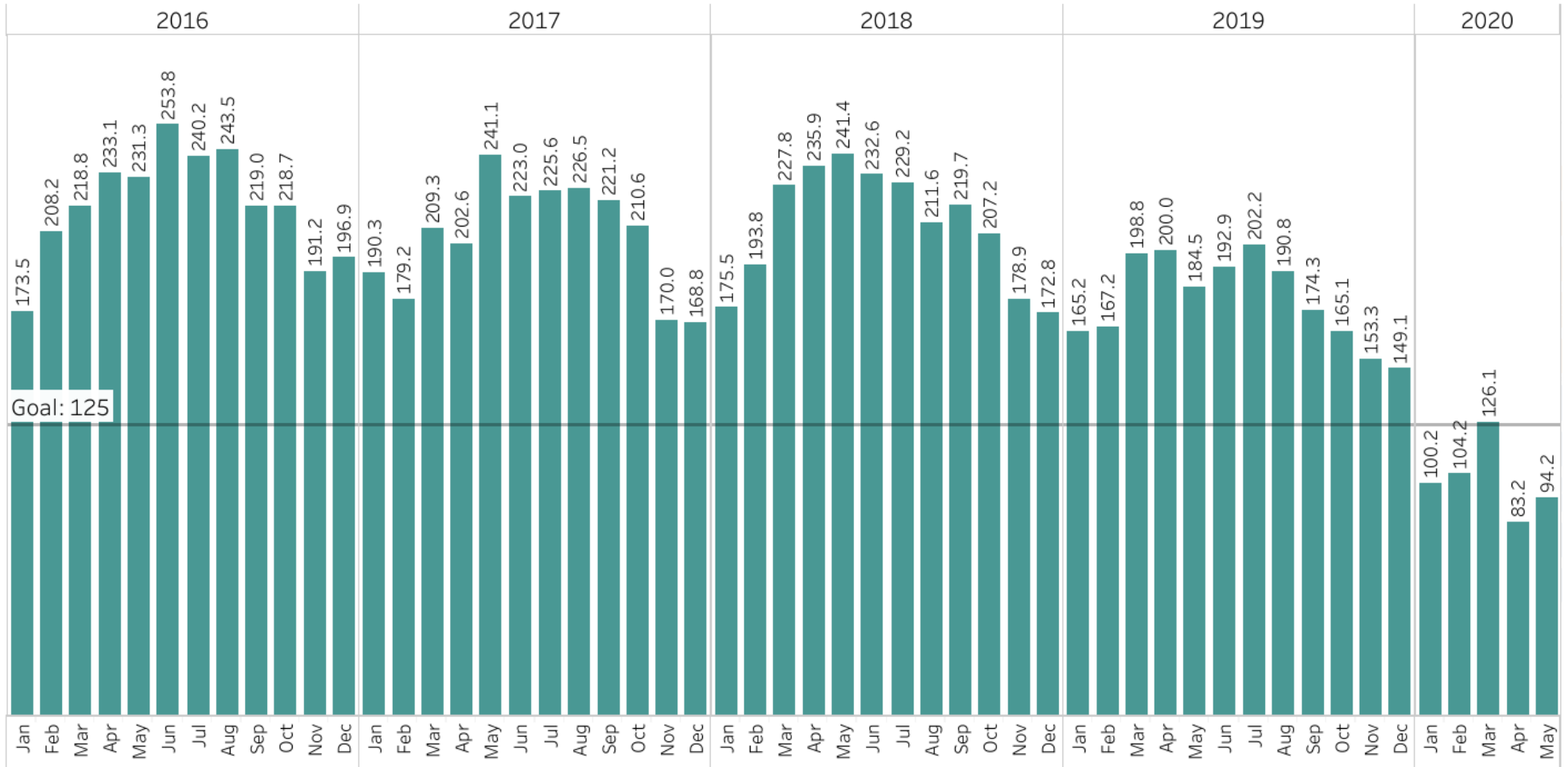


Source: RIBHOLD, PDMP
Contact: Jamie Goulet (BHDDH), Ben Hallowell (RIDOH)
Definition: People continuously enrolled in MAT for at least 180 days with no gap in treatment greater than 7 days within a rolling 2 year period.
Note: Includes anyone with a claim for treatment. Excludes those who transferred to a different level of care.

Treatment Pillar

Primary 1 | **Primary 2** | Primary 3 | Waiting List | Secondary 1 | Secondary 2 | Secondary 3a | Secondary 3b

Treatment P2: Emergency Department Visits with a Substance Abuse-Related Primary Diagnosis for Those Receiving Medication Assisted Treatment (MAT) (ED visits per 1,000 member months)



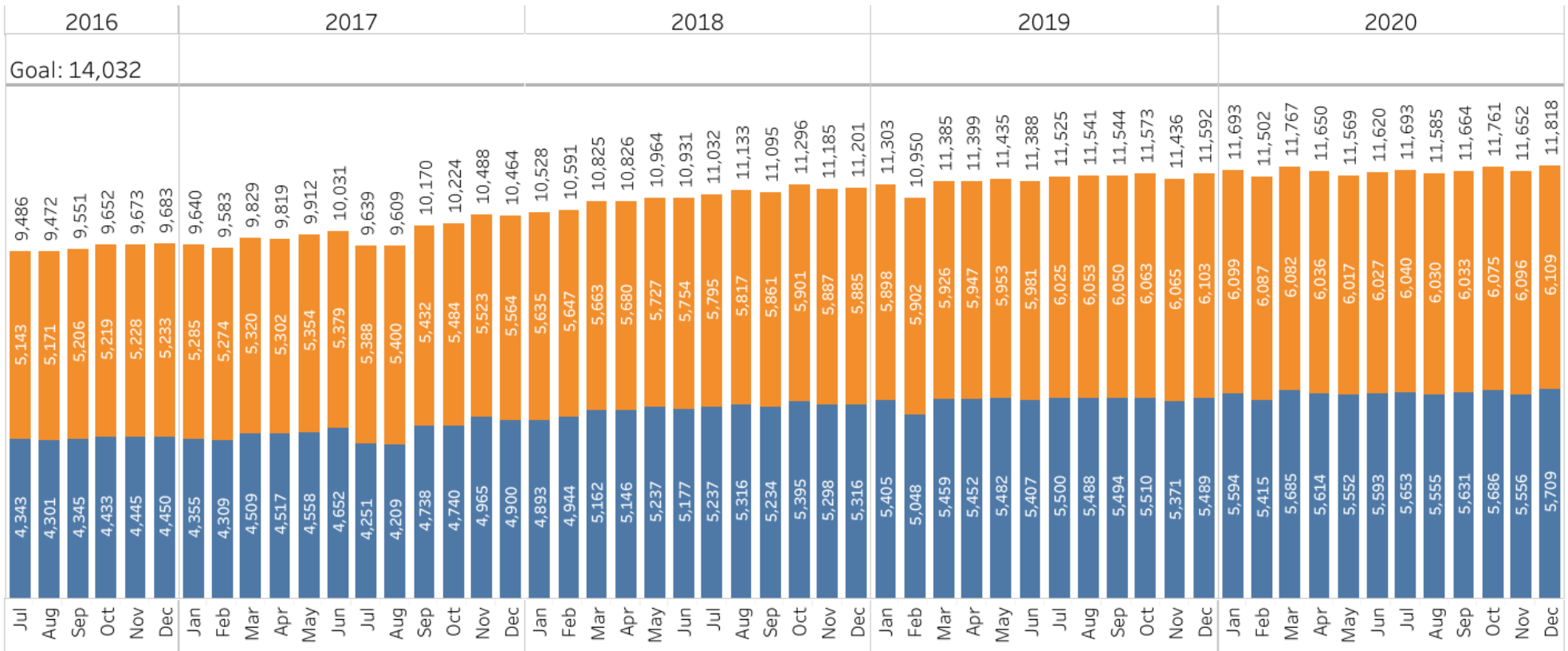
Source: APCD
Contact: Sivakumar Batthala (EOHHS)

Treatment Pillar

Primary 1 | Primary 2 | **Primary 3** | Waiting List | Secondary 1 | Secondary 2 | Secondary 3

Unique monthly number of people receiving Methadone
Unique number of people prescribed buprenorphine

Treatment P3: People Receiving Medication Assisted Treatment (MAT) (Total Unique Monthly)

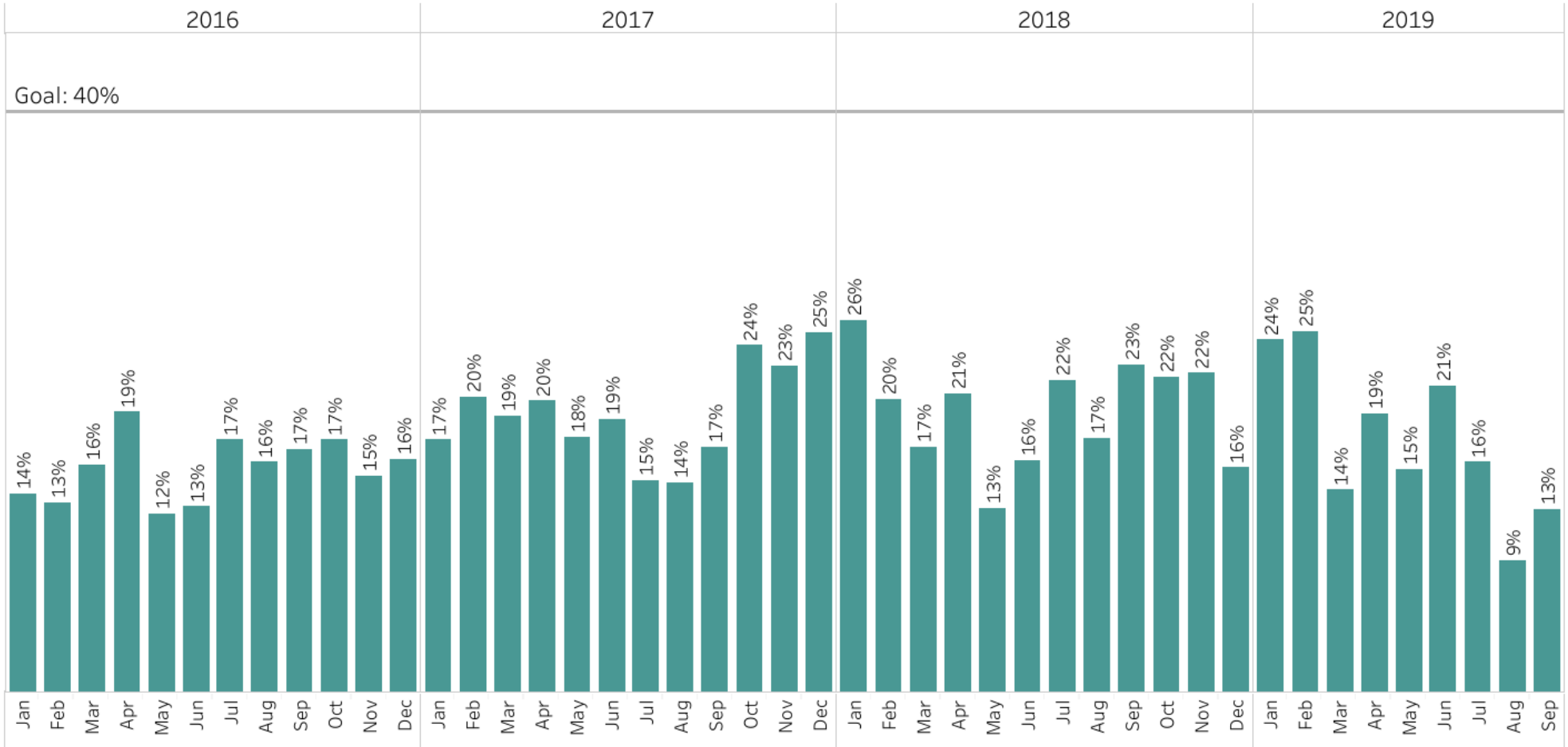


Source: RIBHOLD, PDMP
Contact: Jamie Goulet (BHDDH), Ben Hallowell (RIDOH)
Note: Anyone receiving methadone or buprenorphine that month. Some patients receiving buprenorphine at Centers of Excellence do so via prescription; thus, a small number of patients (<300) may be double-counted in RIBHOLD (BHDDH) and PDMP (RIDOH) data.

Treatment Pillar

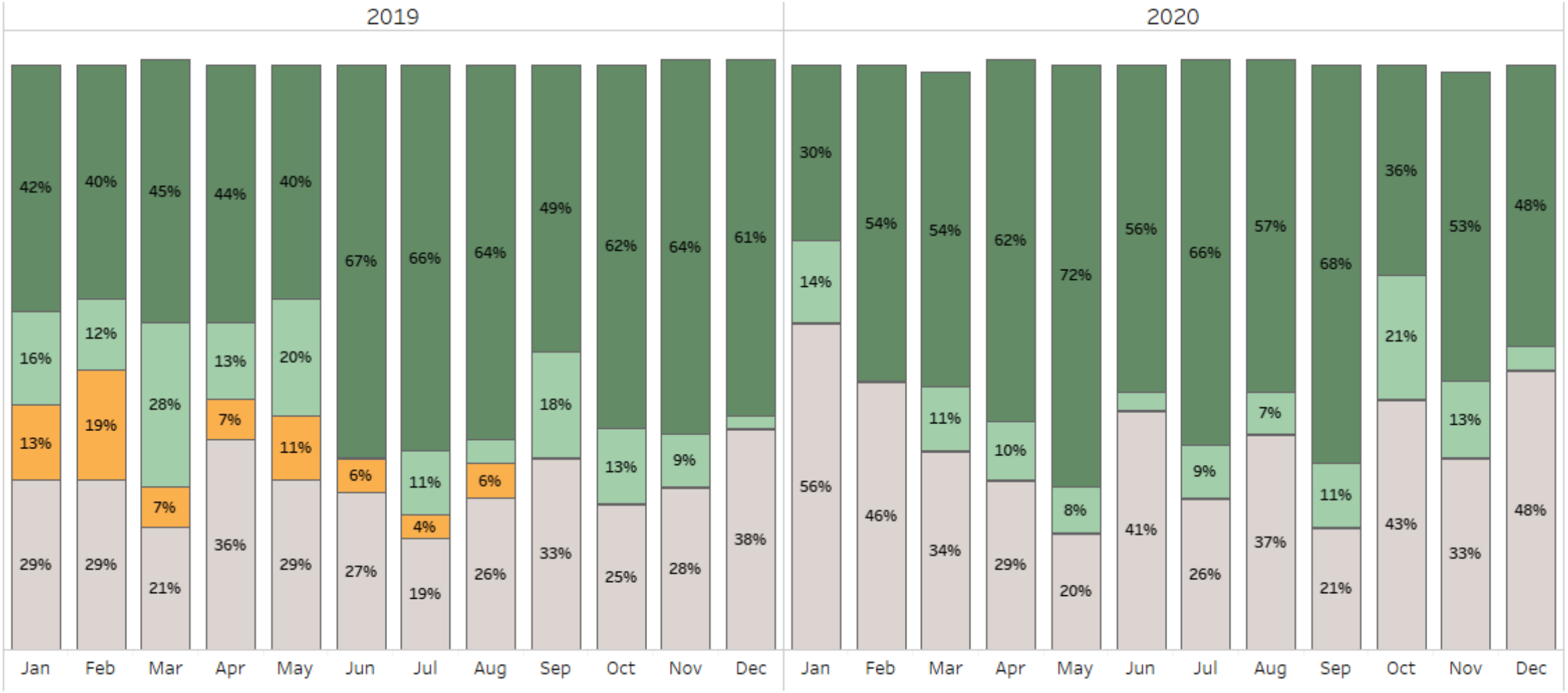
Primary 1 | Primary 2 | Primary 3 | Waiting List | **Secondary 1** | Secondary 2 | Secondary 3

Treatment S1: People Connected to Treatment or Recovery Services Within 6 Months of Being Diagnosed with OUD (Total Monthly)



Source: APCD
Contact: Sivakumar Batthala (EOHHS)
Definition: Includes people diagnosed with MAT and connected to MAT services in less than or equal to 6 months, Total Monthly, 12 Month Look Back

Treatment S2: People with OUD or SUD Successfully Connected to Treatment via BH Link or the HOPE Initiative (Total Monthly)



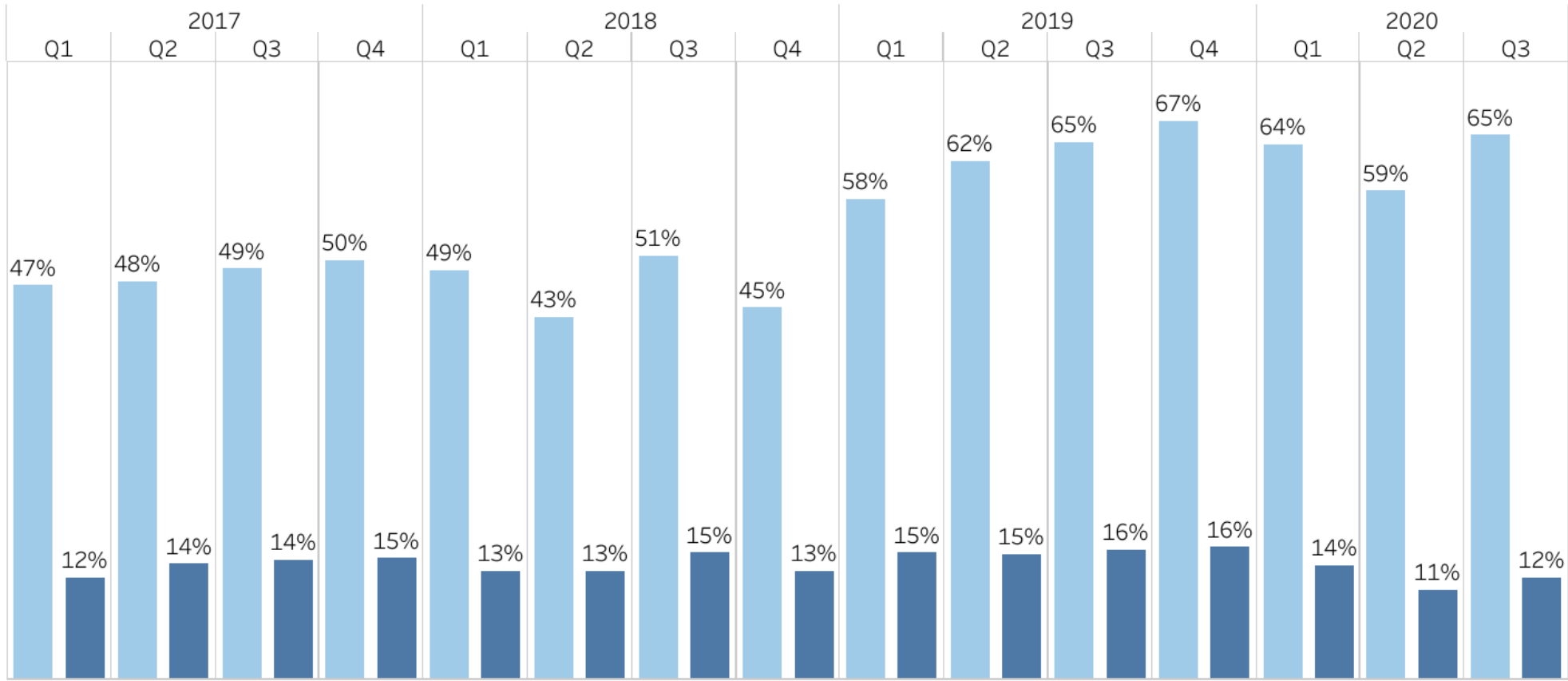
Source: BH Link, HOPE
Contact: Jamie Goulet (BHDDH), Matthew Moynihan (RISP)
Definition: Number of people with a treatment encounter (any kind) within 30 days of a BH Link or HOPE encounter

Recovery Pillar

Primary 1 & 2	Secondary 1	**Secondary 2**	Secondary 3	Secondary 4

Avg. Percent with wages above FPL ($3,035) if working1
Avg. Percent with wages above FPL, including $0 wages

Recovery S2: People in Recovery from Opioid Use Disorder Earning Wages Above the Federal Poverty Line (Total Quarterly)

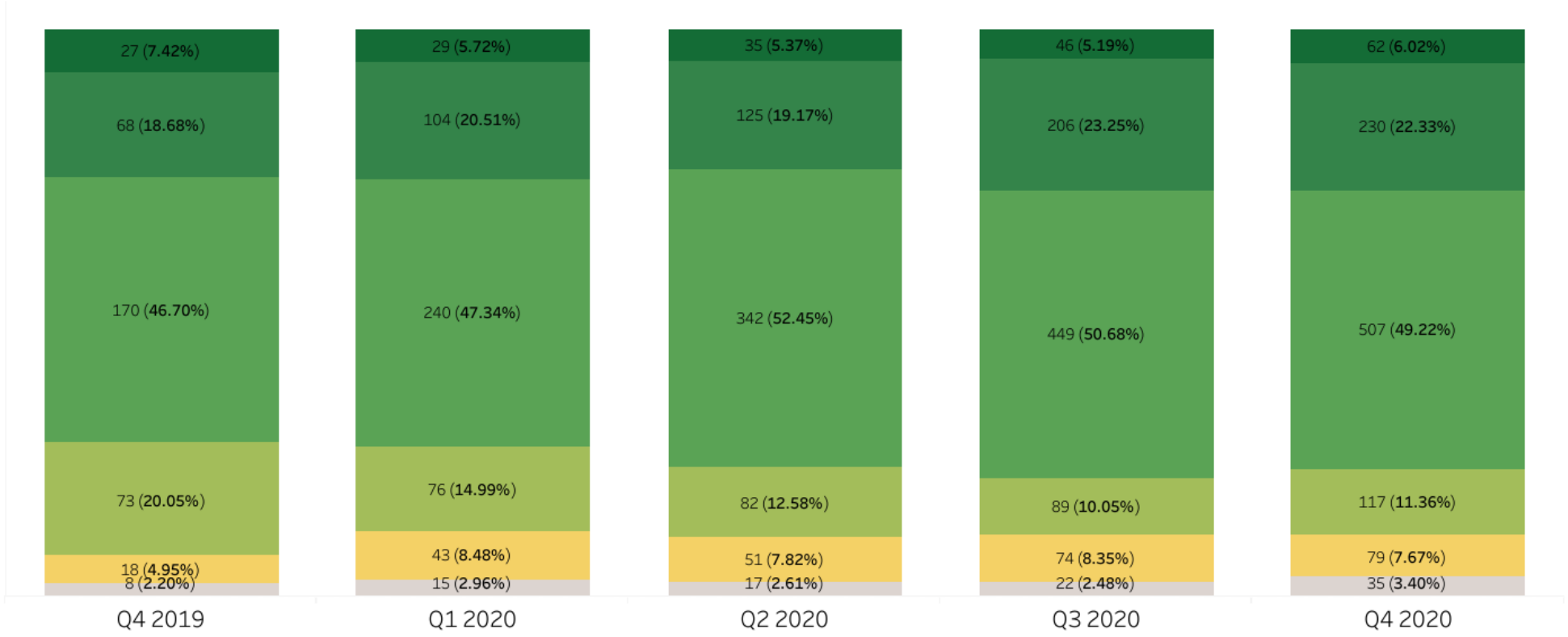


Source: Medicaid + Wage Data
Contact: Sivakumar Batthala (EOHHS)
Definition: Number of people with a Medicaid Claim for OUD claim in the past 2 years who earn wages above $3,035K (100% FPL) in the most recent quarter

Recovery Pillar

Primary 1 & 2 | Secondary 1 | Secondary 2 | Secondary 3 | **Secondary 4**

Recovery S4: Self-Reported Perception of Improved Global Wellness for Those Affected by Opioid Use Disorder



Source: ROMS, Anchor Member Survey
Contact: Mackenzie Daly (BHDDH)
Definition: Number and Percent of people who rated their overall health as "poor", "fair", "good", "very good", or "excellent" per the ROMS at day 1 compared to day 90*.
Note: *Currently shown is the cumulative number of respondents at different points in time.
Note: Question on the ROMS: "Rate your overall health on a scale from 1-5." 1 = "poor", 2 = "fair", 3 = "good", 4 = "very good", and 5 = "excellent". ROMS (October 2019 - August 2020) and Anchor Member Survey (January 2019 - August 2020).

Excellent | Very Good | Good | Fair | Poor | Choose Not to Answer

Note: The metric is all ROMS and Anchor Member Survey responses which are not solely people with OUD. These surveys are completed by anyone seeing a PRS for SUD, MH, or both. We cannot parse out only those with OUD. The Note says ROMS is from Oct 2019-Aug2020 and Anchor Member Survey is from Jan 2019 - Aug 2020, but that was for Q3