Governor’s Task Force on Overdose Prevention and Intervention  
Department of Administration – Providence, Rhode Island  
March 8, 2017

Dr. Alexander-Scott, Director of the Rhode Island Department of Health (RIDOH), welcomed the Governor’s Task Force members and members of the general public. She thanked the Rhode Island National Guard for funding state-of-the-art equipment to allow comprehensive and early testing for post-mortem examinations at RIDOH’s Medical Laboratory. She expressed her gratitude to the Rhode Island National Guard so that funding for this important medical testing equipment could be made possible. The Director expressed that this kind of collaboration is needed to tackle the overdose epidemic in Rhode Island. She introduced Jennifer Koziol, Rhode Island Department of Health Prescription Drug Overdose Prevention Program Manager.

Ms. Koziol discussed the drug overdose prevention mini-grants offered by RIDOH. The deadline to apply for a mini-grant will be March 17, 2017. These grants will be offered quarterly, with funding up to $5,000. Ms. Koziol stated that the mini-grant projects must be data-driven, and she encouraged those interested to view RIDOH’s website for more information. A member of the Governor’s Task Force asked if grant funding can be used to purchase naloxone. Ms. Koziol answered that grant funding is not eligible for the purchase of naloxone.

Dr. Alexander-Scott introduced Rachael Elmaleh, Communications Specialist at RIDOH, as the communication point of contact for the Overdose Prevention and Intervention Task Force. Dr. Alexander-Scott also welcomed Sharon Morello, as the Medication Assisted Treatment (MAT) Coordinator at BHDDH.

Dr. Alexander-Scott acknowledged the hard work of specific individuals contributing to the Levels of Care for emergency departments in Rhode Island. She acknowledged that Rhode Island is the first state in the nation that will release standardized levels of care; optimal procedures for working with patients who have opioid use disorder.

Dr. Alexander-Scott introduced Dr. Traci Green who presented Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose Opioid Use Disorder. Dr. Green mentioned that the development of Levels of Care has been a collaborative effort of professionals, hospitals, senators, and other dedicated individuals. Dr. Green shared that healthcare institutions already treat patients with chronic pain, so it is known that a great burden falls on those institutions. She also mentioned that Levels of Care offers an excellent opportunity to connect people to treatment for recovery with the Rhode Island Centers of Excellence.

Historically, the focus has been on primary care providers offering the resources necessary to resolve the drug overdose problem. With Levels of Care, hospitals and emergency departments can get involved and offer solutions. The goal of implementing the Levels of Care is to standardize evidence-based care of patients with opioid use disorder in Rhode Island’s emergency departments.

In a previous Governor’s Task Force Meeting, members of the Task Force and members of the public were asked about the essential attributes for the Levels of Care; these suggestions were
incorporated into the final document. The development of the Levels of Care began by collaborating with work groups, task forces, and leaders of various institutions. Project leaders also performed literature reviews and connected with subject-matter experts and members of the public. The core features of the Levels of Care include the 2016 Perry and Goldner Discharge Planning Law, MAT at the Rhode Island Centers of Excellence, AnchorED emergency care for opioid use, the Safer Opioid Prescribing Protocol study, and addiction consultation services.

Levels of Care is a voluntary designation; each emergency department will conduct a self-assessment of its services and resources. The self-assessment form provides insight into these standards of care. The voluntary designation allows hospitals to disclose the resources and services available to patients with substance use disorder. In its transparency, it allows for the people of Rhode Island to see the standards of care that they are likely to receive at different hospitals across the state.

All components of the Levels are evidence-based. Level 3 is the base foundation, and includes: Following procedures related to the 2016 Perry and Goldner Discharge Planning Law; administering substance use disorder screening for all patients; educating all patients who are prescribed opioids on safe storage and disposal; dispensing of naloxone to all patients who are at risk according to clear protocol; offering peer recovery support services in the emergency department; providing active referral to appropriate community provider(s); complying with requirement to report overdoses within 48 hours to RIDOH; and, performing laboratory drug screening including fentanyl on patients who overdose.

Dr. Green emphasized that the Levels build off of each other. Level 2 provides all the services that Level 3 provides in addition to conducting comprehensive, standardized substance use assessments and maintaining capacity for evaluation and treatment of opioid use disorder using support from addiction specialty services.

Level 1 is the highest level of attainment by meeting all the requirements of Levels 2 and 3. A Level 1 designation maintains a Rhode Island Center of Excellence, evaluates and manages MAT, and ensures transitions to and from community care to facilitate recovery.

Levels of Care designation will be supported by RIDOH and Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH), including clarifications, technical assistance, and open communication with state-level employees. Support also includes feedback, timely review, and sample documentation.

Dr. Green offered members of the Task Force and members of the public the opportunity to ask questions. Senator Joshua Miller asked if there had been any consideration in delegating Levels based on geography or the number of people entering a particular hospital, instead of Levels being a voluntary assessment. Dr. Alexander-Scott stated that this concern was previously mentioned and that such a suggestion might happen in the future. Dr. Alexander-Scott thanked the Task Force and other contributing members for support in developing Levels of Care.

A member of the audience asked how information will be released regarding Levels of Care assessments at emergency departments. Dr. Alexander-Scott responded that this information will be sent to hospital Chief Executive Officers and assessments can be shared with individuals, if desired. A member of the public inquired about the protocol for Emergency Medical
Technicians (EMT) to call recovery coaches en route to the hospital if a suspected overdose occurs. Dr. Alexander-Scott confirmed that EMTs still call peer recovery coaches en route to the hospital if a suspected overdose takes place. A member of the audience who disclosed that he was affiliated with a hospital inquired if there was a time-frame for site visits to assess these standards of care at emergency departments. Dr. Alexander-Scott responded by mentioning that as hospitals begin the process of certification, they can reach out to Rhode Island Quality Institute (RIQI). A.T. Wall of the Rhode Island Department of Corrections (RIDOC) asked if RIDOC would be required to comply with the 48-hour reporting plan, or if the hospitals would do so in the case of a suspected drug overdose. Dr. Alexander-Scott welcomed RIDOC to report suspected overdoses, however, it is ultimately a requirement of all Rhode Island hospitals. A member of the public asked if MAT information will be disseminated upon emergency department discharge. Dr. Alexander-Scott confirmed that educational materials- including MAT information - would be available for patients upon discharge from emergency departments.

Dr. Alexander-Scott welcomed Dr. Brandon Marshall of Brown University’s School of Public Health to present Update on Drug Overdose Dashboard – PreventoverdoseRI.org. PreventOverdoseRI.org is Rhode Island’s online public surveillance system that tracks metrics within the Overdose Prevention Action Plan set by Governor Raimondo’s Overdose Prevention and Intervention Task Force. The public dashboard showed that in 2016, there had been an increase in drug overdose mortality. At least 329 Rhode Islanders died of drug overdose; this is a 13% increase from 2015. The dashboard also shows the location of each overdose, revealing that drug overdose affects every community in Rhode Island.

Dr. Marshall reported that 1 in 4 fatalities occur within the city of Providence. Fentanyl is a key driver in the increase in these numbers. In 2016, 58% of overdose deaths were related to fentanyl.

The goal is to reduce overdose deaths by 1/3, or to reach 160 deaths or less by 2018. The Overdose Prevention Action Plan includes four major components: Prevention; rescue; treatment; and, recovery. Treatment strategies include a monthly average of people receiving buprenorphine. Data shows that 6,000 Rhode Islanders are on methadone. This is very close to a 2018 goal. Prevention strategies focus on reducing prescriptions of benzodiazepines and opioids. Recovery strategies include increasing the number of newly trained peer recovery specialists. Rescue strategies show a broad scale naloxone kit distribution in communities across Rhode Island each year. This goal has been met, which was 5,000 kits by 2018.

Dr. Marshall and his team are currently developing private, password-protected pages for each of these strategies to help focus intervention efforts. If a Task Force member would like access to the naloxone private pages, he or she can contact Ms. Koziol. The naloxone private page contains police department participation in naloxone and a naloxone distribution tool, including sources of naloxone.

Dr. Marshall mentioned that the website is getting a substantial amount of traffic. In December 2016, there were 2,838 visitors. Dr. Marshall and his team have provided support to at least 12 states that want to develop a similar dashboard. Dr. Marshall shared that Rhode Island is a national leader in data surveillance on the drug overdose epidemic.
A member of the public asked: “Of the 329 deaths, how many could be opioid-related?” Dr. Marshall did not have the exact number for this population, however, he stated that it was the majority of overdoses. The same individual asked how the number of naloxone kits per region is determined. Dr. Marshall stated that the literature recommended 20 naloxone kits per death. The individual mentioned that metric goals need to increase naloxone kits based on new death data. Dr. Alexander-Scott thanked the efforts of Preventing Overdose and Naloxone Intervention (PONI) for naloxone distribution in Rhode Island.

A member of the public commented that the Prescription Drug Monitoring Program (PDMP) had been very helpful for prescribers, however, there is no way of tracking methadone prescriptions on the PDMP. Dr. Alexander-Scott responded that there are efforts taking place to track methadone and naloxone on the PDMP.

A Task Force member shared a story about two of her students who used the PreventOverdoseRI website to search resources and data. She commented on the value of the information within the website, especially for those with substance use disorder.

Dr. Alexander-Scott mentioned that 2017 will be about the implementation of our strategies and interventions. She introduced Dr. Tara Bogs and Dr. Michael C. Coburn from AdCare of Warwick, RI and Worcester, MA. Dr. Bogs shared that all patients receive education about substance use disorder and naloxone distribution sites while at AdCare. During intake, all individuals are informed about MAT. Prior authorization from insurance companies can take 24-48 hours and does not necessarily mean that it will be accepted initially. AdCare has to refer patients to other clinics to receive MAT depending upon space availability.

Dr. Bogs offered her colleague, Dr. Michael Coburn, to present more information about AdCare. Dr. Coburn manages AdCare’s methadone clinic and a private addiction medicine practice. AdCare treats addiction like a chronic relapsing disease like Type 2 diabetes. Similar to other diseases, addiction has both a behavioral component and a medical treatment. The best time to intervene with patients is while they are in treatment like detoxification. Medications dispensed at AdCare include: Naltrexone (opioid reception antagonist which blocks opioid receptors) and buprenorphine (suboxone; agonist that binds receptor).

He explained that the advantages of buprenorphine include that it is less labor intensive, multi-formulaic, well-tolerated by patients, and safe during pregnancy. The drug can also be used for pain and has less stigma “attached” to it than methadone. Disadvantages include: prolonged course of medical treatment, high potential for withdrawal, prior authorization problems, high-cost, potential for drug interaction with benzodiazepines, and high diversion risk.

He informed the audience about methadone maintenance, which includes a long half life, excellent absorption, sufficient doses block, and less euphoric effects. Studies show that counseling and methadone are effective recovery treatments when treated in tandem. The advantages of methadone include that it is less expensive, well-researched, produces the best outcomes, safe during pregnancy, and safe for patients with other medical illnesses. Disadvantages of methadone is that it can be abused and causes withdrawal, if stopped. It is also dangerous if mixed with alcohol and benzodiazepines and it is labor-intensive.
Dr. Coburn shared that there are four treatments at AdCare: Recovery-based treatment, methadone and recovery-based treatment, naltrexone and recovery-based treatment, and buprenorphine and recovery-based treatment. Finding a prescriber to treat the patient has also been a problem for AdCare. Dr. Coburn admits that this is important because methadone maintenance requires that there be no breaks in treatment.

AdCare program obstacles include: short time in detoxification limits use of utility of naltrexone; prior authorization; difficulty in identifying medical clinics; and, lack of available staff to follow-up with patients/conduct prior authorization. Dr. Coburn has delegated tasks to an AdCare coordinator to gain prior authorization from insurance companies, identify outpatient clinics, arrange recovery center treatment, and collect organized data.

Dr. Coburn offered members of the audience to ask questions. A member of the public inquired about the number of individuals evaluated by AdCare providers. Dr. Coburn responded that there are 10 beds at AdCare, and every day five patients are discharged and five more patients are admitted. He stated that about 80% of patients are interested in MAT.

During the public comment period, a member of the public mentioned that (401) 942-STOP (7867) provides resources to link people with MAT services.

Senator Miller mentioned that there will be a hearing for Rhode Island Senate Bill 329 tomorrow night, March 9; Senate Bill 329 will help alleviate the prior authorization process. The Bill stipulates that if an individual enters the emergency department for healthcare services and is expected to be recommended for MAT, then the individual will be automatically eligible for MAT. With the passing of such a Bill, prior authorization process will no longer be needed for these cases. Senator Miller encouraged members of the audience to attend the hearing.

A Task Force member commented that legislation is important, especially for matters involving emergency department procedures.

Dr. Alexander-Scott stated that “medication assisted recovery” is what we are trying to achieve – this includes treatment. She acknowledged primary-care provider leadership for helping shift the culture of prescribing. She admitted that buprenorphine prior authorization has been an ongoing challenge and this legislation is important.

Dr. Alexander-Scott thanked everyone for their attendance and concluded the meeting.