Appendix A: Model Programs for OSAC To Highly Consider Funding to Replicate in Connecticut

(listed in alphabetical order)

CA Bridge Model of low-barrier buprenorphine treatment in emergency departments[1,2] **(Priority 1)**
Emergency department-based interventions that promote initiation of effective, evidence-based treatment for opioid use disorder (OUD), especially buprenorphine, and continuation of MOUD following discharge, have several advantages. First, people with OUD often present to EDs for medical reasons associated with opioid use (overdose, infection). Second, EDs are geographically dispersed through the state and provide twenty-four-hour access to assessment and treatment for OUD. Third, use of ED services for people with OUD is a marker of a high overdose risk and is associated with a high risk of mortality.

Yale researchers developed and refined the initial implementations of ED-initiated buprenorphine.[3-5] This work has led to replication nationally. Despite this, ED-initiated buprenorphine is not the norm in Connecticut-based EDs. In California, the Public Health Institute in collaboration with the California Department of Health implemented the CA Bridge Model supporting low-barrier buprenorphine treatment in 85% of the state's EDs.[2,5] The basic elements of the CA Bridge model include low-barrier buprenorphine treatment, active patient navigation from ED to outpatient treatment, and provision of harm reduction interventions. Early results from this program have been encouraging. Of all the patients with OUD presenting to participating EDs, 60% were provided buprenorphine during their ED or hospital visit, 45% received a buprenorphine prescription, and 40% attended at least one follow-up visit following discharge. Given the need for broad implementation of ED-initiated buprenorphine in Connecticut, the broad reach of the CA Bridge program and its proven effectiveness, we recommend the OSAC highly consider funding an intervention mirroring CA Bridge in Connecticut.

Life skills Training and Project Toward no Drug Abuse (Priority 5)
The Blueprints for Healthy Youth Development lists only one (Lifeskills Training) program that achieves its highest "Model Plus" rating. However, it should be recognized that there is no scientific evidence to date that this intervention decreases initiation of opioids among youth. A second program, Project Toward no Drug Abuse, achieves a "Model" rating and reports a "hard drug use" outcome. We recommend consulting the Blueprint database, or similar databases such as the California Evidence-based Clearinghouse for Child Welfare, for details of these programs or similar prevention programs supported by evidence. We also recommend if funds are used to support programs currently lacking evidence that they require rigorous simultaneous evaluations to assure these interventions are meaningfully in decreasing opioid initiation and producing other anticipated outcomes. These could include primary prevention models with more evidence regarding effectiveness of reducing youth alcohol and other (non-opioid) drug use initiation that should be evaluated for their efficacy related to reducing youth opioid use.

Maryland Addiction Consultation Service/MACS[6,7] **(Priorities 1 & 4)**
Increased access to buprenorphine is contingent on increasing the number of prescribers who are actively prescribing buprenorphine. Historically, prescribing buprenorphine required a special waiver from the DEA (aka "X-waiver") of which, nationally, only 6% of DEA-licensed prescribers pursued with very few among them actively prescribing. Prescribers, especially those practicing in general medical settings (e.g.,

primary care) regularly cite limited training in OUD assessment and treatment, lack of institutional support, insufficient referral options, burdensome regulatory procedures, and prescribing stigma as barriers to increased buprenorphine prescribing. In 2023, Congress passed the MAT Act, which eliminated the need for a special waiver to prescribe buprenorphine, but without addressing these barriers to increase prescribing we are skeptical that, by itself, this change in law will drastically improve the rate of buprenorphine prescribing.

To support increased buprenorphine prescribing in their state, the Maryland Addiction Consultation Service (MACS) model was developed and launched by the University of Maryland School of Medicine in collaboration with the Maryland Department of Health Behavioral Health Administration. The model is tailored to address prescriber-identified barriers to prescribing buprenorphine and included a warmline consultation staffed Monday-Friday/9am-5pm, targeted statewide outreach, diverse prescriber-tailored training offerings, and real-time connection to individualized patient resources and referrals. Early evidence from this model have demonstrated increased geographic penetration of buprenorphine throughout the state of Maryland.

Massachusetts Chapter 55 Public Health Data Warehouse (Priority 3)

Responding to a lack of actionable data in the state to target efforts to address the opioid overdose crisis and the structural barriers to data sharing, in 2015 the Massachusetts Legislature passed a law (aka "Chapter 55") which mandated that the Massachusetts Department of Health analyze and maintain a data set linking individual level data from 10 data sets held by state agencies. The law also obligated DPH to generate a report analyzing seven key questions pertinent to addressing the overdose crisis. This data revealed several insights (e.g., economic costs of OUD, prevalence of OUD, demographic differences of treatment use) that have directly informed the response by policy makers in the state. This process has led to biannual data briefs, legislative reports, and 25 scientific publications. Among these are publications that document the high rate of death among Massachusetts opioid overdose survivors which is 5% within 12 months. Massachusetts data demonstrates that this death rate can be cut in half if overdose survivors receive methadone or buprenorphine. Similar data linkages in Connecticut have been conducted and reveal opportunities to target interventions in the state. We recommend that OSAC fund such efforts.

Multidimensional Family Therapy Helping Youth and Parents Enter Recovery Treatment Model (MDFT-HYPE Recovery)[8-11] (Priority 1)

Early intervention for youth with problems related to opioid use is an important target for secondary prevention. Currently supported by DCF, MDFT-HYPE Recovery is an in-home family-focused substance use treatment program for youth with opioid use problems. The model incorporates the use of MOUD and Multidimensional Family Therapy (MDFT) for a period of intensive treatment followed by recovery monitoring and support for up to 6 months after the focused treatment period ends. This model is supported by evidence to improve substance use and social functioning in youth. Opioid settlement funds could be used to supplement, not replace, those already committed by DCF to expand this youth focused treatment model. Similarly, DCF has significant experience supporting other programs focused on addressing issues of youth substance use or caregiver substance use (e.g., Multisystemic Therapy – Building Stronger Families (MST-BSF)[12], Community Reinforcement Approach[13] models) and we recommend the OSAC rely on their expertise when considering using funds targeting these domains or supporting these efforts. We recommend if funds are used to support these programs that rigorous and simultaneous evaluations be used to assure these interventions decrease adverse opioid-related outcomes.

OnPoint NYC[14] **(Priority 2)**
Building on evidence generated by international models[15], New York City opened the first two sanctioned overdose preventions sites in the United States. This model, which allows for consumption of substances on-site under direct supervision of medically trained professionals, has demonstrated to reduce overdose deaths. In addition to a space for supervised consumption, OnPoint, the model implemented in New York City, also serves as a no-barrier drop-in center providing access to food and showers, harm reduction services, health and wellness services, and case managers that facilitate linkage to mental health services, counseling, and public benefits navigation. These sites also offer screening for HIV and HCV, wound care, and rapid connection to MOUD and other addiction treatment programs for individuals who are interested.[16,17] As Connecticut moves towards its own model of harm reduction centers, as mandated in Public Act No. 23-97, we support the OSAC funding services for these centers in line with lessons learned about provision of a range of services from New York City's models, as feasible within the present scope and interpretation of Connecticut law. If in the future Connecticut or federal statue, or interpretation thereof, were to change to allow provision of safe consumption center services, we also recommend that OSAC fund those efforts.

Physician Clinical Support System – Medications for Opioid use Disorder (PCSS MOUD) (Priorities 1 & 4)
PCSS-MOUD is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) created in response to the opioid overdose epidemic to train primary care providers in the evidence-based prevention and treatment of opioid use disorders (OUD) and treatment of chronic pain. The project is geared toward primary care providers who wish to treat OUD. Through a variety of trainings and a clinical mentoring program, PCSS-MOUD's mission is to increase healthcare providers' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders.[18]

Project ASSERT[19,20] **(Priorities 1 & 6)**
Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is an innovative program which is embedded in EDs to help patients access drug treatment services. First launched and developed in the Yale-New Haven Hospital emergency department in 1999, it uses health promotion advocates, who are integrated into the ED and directly collaborate with healthcare providers, to screen, provide brief interventions, and directly refer patients to specialty substance use treatment. The Project ASSERT model has been effectively deployed on the Yale Addiction Medicine Consult Service at Yale-New Haven Hospital.

Project ECHO (Priorities 1 & 4)
Project ECHO is a model of education in which participants engage in a virtual community with their peers where they share support, guidance and feedback. ECHO models have been successfully implemented in a variety of jurisdictions to improve adherence to opioid prescribing guidelines and the use of MOUD.[21]

Recovery Support Services (Priority 1)
Recovery Support Services refer to a broad range of interventions that aim to establish and maintain environments supportive of recovery; remove personal and environmental obstacles; enhance linkage to and participation in local recovery communities; and increase the hope, motivation, confidence, relationships, and skills needed to initiate and sustain the long-term work of recovery. Two of the most widely implemented such services have been peer recovery support services and recovery community centers. Recovery Support Services are increasingly used in general medical settings such as EDs, hospitals,

and primary care. Recovery Support Services are consistent with MOUD, although historically have discouraged MOUD or not been tailored to those receiving MOUD. Recovery community centers such as the Yale Program for Community Health are entities designed specifically to help provide this growth in recovery capital and enhance remission and quality of life. Additional information is available from SAMHSA and the Recovery Research Institute at Harvard.

U.S. Department of Veterans Affairs (VA) Housing First initiatives (Priority 7)

Housing First is an evidence-based permanent supportive housing approach for vulnerable individuals that emphasizes immediate, rapid access to supportive housing without preconditions such as treatment engagement or abstinence from substance use. Housing First programs often emphasize provision of community-based, client-centered services and have been shown to be able to accommodate and achieve housing stability for many, including individuals with serious mental illness and severe substance use disorders. Since 2011, the VA has implemented Housing First nationally with significant success in housing high risk veterans throughout the country including Connecticut.[22,23] There is strong evidence that Housing First can achieve housing stability, some evidence that it reduces health care utilization costs, especially ED and inpatient hospitalizations[24], but currently no evidence that it improves substance use disorder symptoms.[25] If OSAC funds initiatives to improve housing stability in people at risk of opioid overdose, we recommend they be based on Housing First principles and be tied to rigorous evaluation of their effectiveness in reducing overdose risk.

Vermont Hub and Spoke Model (Priority 1)

Vermont has implemented a system of hubs and spokes for treating OUD and offering MOUD. Nine Regional Hubs offer daily support for patients. At over 75 local Spokes, doctors, nurses, and counselors offer ongoing OUD treatment that is integrated with general healthcare and wellness services. This framework uses MOUD for treatment and efficiently deploys OUD expertise to help expand access to OUD treatment those in the state.

Appendix A References

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