OPIOID SETTLEMENT ADVISORY COMMITTEE (OSAC)
Meeting of Tuesday, September 10th, 2024
Teams Virtual Meeting
10:00 a.m. – 12:00 p.m.

ATTENDANCE

Members/Designees: Nancy Navarretta, Commissioner, DMHAS; Neil O'Leary, Waterbury; Jody Terranova, Deputy Commissioner, DPH; Jennifer Kolakowski, Dr. Srinivas Muvvala; Judy Dowd, OPM; Kimberly Grove; Lisa Deane; Senator Cathy Osten; Representative Toni Walker, Hartford; Bridget Fox; First Selectman Rudy Marconi, Ridgefield; Mayor Lisa Marotta, Rocky Hill; First Selectwoman Maureen Nicholson, Pomfret; Dawn Niles; John Lally; Patrick McCormack, Christian Spencer, Amy Bethge, Erica Teixeira, Martiza Bond, Maggie Young, Robert Miller, Megan Albanese, Attorney Timothy Birch, Elizabeth Rivera-Rodriguez, Susan Campion, Christine Gagnon, Ebony Jackson-Shaheed, Erica Texeira, Russell Melmed, Tracey Hanson, Dr. Marilyn Sanders, Janine Vose, Daniel Farley

Visitors/Presenters: Luiza Barnat; Christopher McClure; CT-N, Nita Asani, Danielle Ebrahimi, Dr. David Fiellin, Michael Hines, Sarah Messier-Smith, Karolina Wytrykowska, Matthew Fitzsimmons, Krystin DeLucia, Gretchen Shugarts, Tempestt Latham, Francis Gregory, Melissa Sienna, Kimberly Karanda, Dr. Sheila Alessi, Craig Safran, Deborah Lake, Robert Heimer, Christy Knowles, Marilyn Sanders, Michelle Masi, Kathy Nguyen, Roland Harmon, Sarju Shah

Recorder: Melanie Richard

The September 10th, 2024 meeting of the Opioid Settlement Advisory Committee (OSAC) was called to order at 10:00 a.m. by Commissioner Nancy Navarretta, DMHAS.

Topic	Discussion	Action
Welcome and Introductions	Commissioner Navarretta welcomed all in attendance and introduced the following new members of the Opioid Settlement Advisory Committee: • Senator Heather Somers, Ranking Member, Public Health • Representative Tammy Nuccio, Ranking Member, Appropriations • Senator Eric Berthel, Ranking Member, Appropriations • Daniel Farley, Public Health Ranking Member Designee • Dr. Marilyn Sanders, Individual with Experience Supporting Infants and Children Affected by the Opioid Crisis • Janine Vose, Municipal Representative, Dayville	Noted
Review and Approval of Minutes	Minutes approval from July 9th, 2024 meeting – moved by Maritza Bond, seconded by Attorney Timothy Birch Minutes approved, no further discussion.	Informational
Public Comment	No requests were received regarding public comments. Senator Cathy Osten addressed the legislation that was passed last year to require temperature controlled, alarmed Narcan boxes. In her district, Uncas Health, is not allowing these boxes to be out anywhere without the temperature-controlled feature which means that the number of sites available for Narcan availability has decreased. She stated that the money we have relative to the opioid settlement dollars may be well spent in making the boxes temperature controlled and should be brought to the Committee for recommendation for funding use. Senator Osten was concerned with the time it may take to pass through the recommendation process.	Informational

Topic	Discussion	Action
	Luiza Barnat explained that the Narcan boxes that are being taken down across the state are not the Narcan boxes that were funded by OSAC that are temperature controlled, but Narcan boxes that towns installed. The boxes that were approved by OSAC are not being affected, as they will follow the legislation. Senator Osten iterated that the boxes that the towns installed are coming down as a result of the legislation, which has now been brought to the attention of this group, and it is important to reach out to the health districts to find out how many boxes are coming down and how much it would cost to fund temperature-controlled boxes in the place of those. Commissioner Navarretta stated that through Mr. Neil O'Leary and through our RBHAO's and contacts with municipalities, we can certainly reach out and see what barriers may exist, as well as see if there are any gaps in coverage, so we will be reaching out immediately.	
Settlement Financials	Chris McClure, DMHAS Chief of Staff, gave a presentation on updates regarding the Opioid Settlement Advisory Committee and the funding disbursements of the settlement dollars thus far. Please see the linked Power Point presentation for key takeaways. Presentation by Chris McClure: Settlement Financials Update | OSAC Updates Last year, we adopted bylaws for the administration of the Committee. Due to membership changes and requests from Committee members, we have presented proposed changes to the bylaws for your consideration. These changes included reflecting the change in committee membership as part of PA 24-150, adjusting quorum rules to exclude unfilled appointments, and requiring voting committee members to appear on camera when casting votes. There were no objections to these changes, so the bylaws have been moved to be amended as presented.	Informational Motion to Vote Chris McClure, DMHAS
Contingency Management Presentation	Nancy Navarretta, Commissioner, DMHAS introduced Dr. Sheila Alessi, Professor at UConn School of Medicine, who will be presenting on Contingency Management. This is an evidence based practice the Committee will be having a vote on as a recommendation. It is a behavioral treatment for stimulant use disorder. Contingency Management Presentation Discussion: Russell Melmed questioned if contingency management has been used effectively for opiate use disorder specifically? Are you aware of other states around the country that have used their settlement funds to either pilot programs or existing established programs for contingency management? Dr. Alessi explained that there are numerous studies on using contingency management to address use in the context of opioid use disorder treatment, specifically medication. This could help target improved adherence to medication for opioid use disorder, and you can also use it to target treatment engagement to encourage people to come back more often than they may otherwise come back. Many states have gotten started before the opioid settlement funding started rolling out because people have been thinking about how we can get something like this into practice for a while. Martiza Bond stated that approaches that work for individuals that have substance use disorder don't necessarily work for all, but with that being said, the contingency management model has proven to be successful in many states. California was a predominant highlight, but it has been shown to be successful in Vermont, New York, and Ohio, to start. In saying that, the focus on this presentation was specifically on stimulants, and the recommendation presented to today is addressing stimulant use disorder. It would be important	Informational Dr. Sheila Alessi Uconn School of Medicine

Topic	Discussion	Action
	to monitor what areas overdoses are happening so they can be included in the service area, so that we can continue mapping out where overdose is happening. Is there a specific service area that is going to be the focus, and will there be further justification on the data to support why you want to use the contingency management model? How will you be tracking long term behavior changes? This model is certainly the gold standard, but it does not tie to reducing fatalities and been linked to that. Dr. Alessi responded that contingency management is the go-to gold standard treatment based on evidence and experience and because it is medically necessary to target stimulant use disorder, as there are no effective treatment currently. In thinking about trying to get things proved as a billable service, we need to think about the health condition and what is appropriate and necessary for that health condition. Commissioner Navarretta explained that since this would be an RFP process, we are not able to confirm which service areas would be included, as this is just the model presentation at this time. Luiza Barnat stated that stimulant use disorder as it relates to cocaine specifically and calls attention to the health disparities in our state. We do know that the black population has the highest rate of death for either suspected or not suspected opiate use, and that is often related to stimulant use disorder, as cocaine is involved in about 40% of the deaths that have occurred in the state. Addressing stimulant use disorder, especially cocaine use disorder is very important in the context of mitigating opioid related deaths because they often happen in poly-substance use versus only using opioids. Commissioner Navarretta noted that people buying cocaine may also not be aware that the substance also contains an opioid, fentanyl, or xylazine, and even though they may not intentionally buy an opioid they are a victim of the opioid crisis. Representative Toni Walker questioned how much data exists that goes along with the use of abstinence affecting the opioid pandemic right now. Dr. Muvvala explained that the contingency management model for cocaine use disorder or stimulant use disorder is an adjunct to the services that are being provided for the treatment of opioid use and to target deaths associated with stimulant use, so it is part of the comprehensive care that is being applied. To clarify, abstinence from stimulant use is the goal in this, so it would specifically reduce stimulant use and cocaine use, thereby preventing accidental overdose by fentanyl or other substances. Representative Toni Walker questioned if Vivitrol could be used and Dr. Muvvala explained that it could be used for opioid use disorder, but we do know that the efficacy of methadone and buprenorphine is much higher, so they would be the first line of treatments. Russell Melmed commented that we need to think carefully about funding treatment for things that are opioid use disorder and how they are deployed. Commissioner Navarretta mentioned that people are dying unintentionally from stimulant use disorder because of opiates found in the stimulants, so a goal would be to get people to not use stimulants, which contingency management would work on addressing. The goal is to have people be adherent to their medication for OUD. Dr. Muvvala wanted to reiterate that if we're only focusing on treating co-occurring disorders, we would miss a lot of people who are only using stimulants that have been dying accidentally with opioid overdose. This is to targe stimulant use disorder and prevent the deaths associated with it in the context of unadulterated fentanyl, which is quite common in the supplies.	
Funding Recommendations for Committee Vote	Nancy Navarretta, Commission, DMHAS presented the following recommendations for Committee review and vote:	Motion to Vote

Topic	Discussion	Action
• **LiveLoud Public Awareness and Education** • **Treatment Bridge Model for Connecticut's Emergency Departments** • **Contingency Management**	**Title:** LiveLoud Public Awareness & Education Odonnell Company is currently contracted with the Connecticut Department of Mental Health & Addiction Services' (DMHAS) for the LiveLOUD campaign which promotes anti-stigma, harm-reduction, prevention, and treatment for individuals with opioid use disorder (OUD), their communities, and others at risk of opioid overdose. An expansion of Live LOUD is recommended to maximize the impact and reach of the public health campaign and meet the Connecticut Opioid Settlement Advisory Committee (OSAC) goals of urgently and efficiently decreasing the adverse impact of opioids. DMHAS' LiveLOUD public awareness and communications campaign responds directly to the CORE Report funding priorities. Strategic goals incorporate efforts to **reduce stigma** among all Connecticut residents and to **raise awareness about treatment** pathways—including highly effective **medications for opioid use disorder**. LiveLOUD shares **prevention and harm reduction** information, not only for those who are struggling with addiction, but for potential first-time users, family and friends, and the community at large. For individuals who are at the highest risk, the LiveLOUD effort is able to identify key audiences and work with **specific high-risk groups** to create messaging, and identify media and outreach channels, for effective reach and engagement. DMHAS's LiveLOUD campaign aligns closely with the CORE guiding framework, looking to data, science, and evidence to guide the work. It **prioritizes education and prevention for young adults** through messaging, channel choices, partnerships, and outreach. It also ensures **racial equity and affirms gender identity** through an inclusive, culturally connected communication and media approach; and provides full transparency with data to share how funding is spent and the direct impacts provided. Materials are available in English and Spanish, and the website is ADA accessible. The LiveLOUD website includes a "Where to Get Treatment" section that links to CT treatment options. Connecticut recorded measurable positive correlations in access to services following targeted LiveLOUD pilot campaigns: • 50% increase in access line calls for information on support and treatment • Increased opioid recovery transportation services • Increased OUD screenings The awareness, education, and anti-stigma messaging in LiveLOUD campaigns also aligned with measurable impacts in the state: • Increased naloxone dispensing rate • Increased 211 calls for support • Reversed trend of opioid overdose deaths Continued funding for LiveLOUD will help maintain the progress Connecticut has made reducing harm, unifying stakeholders, connecting audiences with resources, and saving lives. Funding would allow for the following: • Digital Media: Continuation of 7 proven tactics and adding 5 new tactics for between 10-17 weeks depending on tactic including Google Search, Display Ads, Streaming TV, LGBTA+ Dating App Ads, Amazon Digital Ads, Broadcast Radio, Streaming Audio/Podcasts • Social Media: Continuation of 4 proven tactics and adding 4 new tactics for 8-17 weeks depending on tactic • Print/Online Publications: Addition of English and Spanish Community Newspapers and Digital Publications • Out of Home: Digital Billboards, Bus Ads, and Local Community Signage The Treatment ADPC subcommittee submitted the recommendation for OSAC consideration with the following notations • Ensure there is statewide inclusion of major components (IE: Billboards spread throughout state)	

Topic	Discussion	Action
	• Ensure physical collateral reaches communities/neighborhoods impacted by opioid use; provide to Churches, Community centers, etc. • Ensure resources are available on the LiveLOUD website across the lifespan • Include stakeholder feedback in rollout of content Funding Amount Requested: $1.5 million Number of years: 1 year CORE Priority: #1 Access to Medications, #2 Reduce Overdose Risk and Mortality, #6 Reduce Community Stigma Category: ☒treatment ☒harm reduction ☒ prevention ☐ recovery supports Recommended Lead & Partnering Agencies: Department of Mental Health and Addiction Services Odonnell Company Vetted by Referral Subcommittee? ☒ yes Vetted by Research and Data Subcommittee? ☒ • EBP ☒ or Promising Practice ☐ Program evaluation recommended? ☐yes ☒ no • Pilot ☐ or Established Program ☒ • Local ☐ or Statewide Rollout ☒ Vetted by Finance and Compliance Subcommittee? ☒ • Allowable Strategy ☒ Compliant yes ☒ no ☐ • How much funding/funding amount: $1.5 million • Proposed project dates: January 1, 2025 – December 31, 2025 • Proposed budget: $1,500,000 • Approved budget: $600,000 Budget submitted ☒ • RFP ☐ Sole Source ☒ Results of Committee Vote: ____X__ Proceed with Recommendation _____ Do Not Proceed with Recommendation **Title**: Treatment Bridge Model for Connecticut's Emergency Departments As noted in the CORE report, implementation of ED-initiated buprenorphine was initially developed by Yale and has been replicated nationally with positive impact on increasing buprenorphine initiation and treatment engagement yet is not consistently implemented in Connecticut EDs. Commonly cited barriers to ED buprenorphine initiation including stigma, time and competing priorities, lack of referral sources for continued care, and lack of provider knowledge and training. Various models include the use of training incentivization, training and technical assistance, standardized screening processes, brief psychosocial interventions, referrals and warm hand offs to continued MOUD treatment, Recovery Coaching, provider guidelines and decision trees, and Harm Reduction education and tools, including Naloxone. ED Buprenorphine induction was found to be a relatively brief and cost effective intervention	

Topic	Discussion	Action
	with positive impact including increase of ED initiated MOUD, increase in ED provided or prescribed naloxone, and increased treatment engagement post-ED intervention. CCAR currently provides Emergency Room Recovery Coach services and there are existing pathways for naloxone distribution in EDs. Therefore, this recommendation is intended to RFP to CT hospitals to increase in low-barrier Emergency Department-initiated MOUD in CT and includes funding for the following: • Training and Technical Assistance offered to all front-line staff including Prescribers and Recovery Coaches including but not limited to: Motivational Interviewing, provision of harm reduction education and tools, MOUD initiation and prescription best practices, data collection. Hospitals will be required to contract with a subject matter expert(s) to provide the training and technical assistance as part of the provided funding, if the training and TA can not be provided internally. • Development and incorporation of processes to screen all individuals for OUD and introduce MOUD as a treatment option to decrease disparities • Financial Support for Site Champion • Financial Support to offset costs associated with revenue losses when providers are in training • Development and Dissemination of best practice protocols for various scenarios (Patient in Withdrawal, Pregnant Patient, MOUD indication post overdose, etc) Hospitals will be required to engage with local resources to obtain Harm Reduction tools for dissemination and utilize internal resources or community providers for referrals to ongoing MOUD treatment. Overdose rates and population density will be considered during the Request for Proposal (RFP) hospital selection process. Annual Amount: $125,000 x 5 hospitals (one per DMHAS region) = $625,000 annually Number of years: 5 years Total Request: $3,125,000 CORE Priority: #1 Linkage to Treatment Category: ☒treatment ☒harm reduction ☐ prevention ☒ recovery supports Recommended Lead & Partnering Agencies: Department of Mental Health and Addiction Services Connecticut Community for Addiction Recovery CT Hospitals Vetted by Referral Subcommittee? ☒ yes Vetted by Research and Data Subcommittee? ☒ • EBP ☒ or Promising Practice ☐ Program evaluation recommended? ☐yes ☒ no • Pilot ☐ or Established Program ☒ • Local ☐ or Statewide Rollout ☒ Vetted by Finance and Compliance Subcommittee? ☐ • Allowable Strategy ☒ Compliant yes ☒ no ☐ • How much funding/funding amount: $3,125,000 • Proposed project dates: July 1, 2024-June 30, 2029	

Topic	Discussion	Action
	• Approved project dates: July 1, 2025 – June 30, 2027 • Proposed budget: $625,000 • Approved budget: $625,000 annually; $1,250,000 for two years • Budget submitted ☒ • RFP ☒ Sole Source ☐ Results of Committee Vote: ___X___ Proceed with Recommendation _____ Do Not Proceed with Recommendation **Title:** Contingency Management Contingency Management (CM) is an evidence-based therapeutic intervention in which tangible reinforcers are provided to clients for meeting an objective goal for an incentivized behavior. Continency Management is the most effective treatment available for stimulant use disorders, substances for which there are no FDA-approved medications nor overdose reversal medications, with demonstrated effectiveness in increasing rates of abstinence and treatment retention. Cocaine, a common stimulant in CT, is often found in substance combinations for overdose in CT. Stimulant users are at times unaware of opioids in their drug supply and thus are at risk for opioid overdose. Black individuals are disproportionately impacted by overdose deaths involving cocaine in CT. Contingency management has also been demonstrated to be effective as an adjunct to Medications for Opioid Use Disorder (MOUD); an analysis of 60 clinical trials over 3 decades found that CM improved MOUD adherence. Evidence demonstrates higher incentive amounts are correlated with improved outcomes; $599 is the highest amount that can be provided to a client per year without tax implications. HHS/SAMSHA grants do not allow incentives above $75 per client annually, necessitating other revenue resources for program implementation. This recommendation is to fund 7 providers in CT: 5 programs serving adults (one per DMHAS region), and 2 programs serving youth (DCF MOU required) to implement Contingency Management to complement their existing continuum of substance use disorder treatment. Providers will be required to utilize Evidence Based Contingency Management protocols to target stimulant use in the context of co-involvement with opioids and overdose risk, Medications for Opioid Use Disorder (MOUD) adherence, or both. Funding will be provided to the 7 identified providers to staff a Contingency Management Coordinator and back up Coordinator positions (responsible for implementation, oversight, and fidelity monitoring), provide incentives, and purchase toxicology screening to track protocol adherence. Programs will be expected to serve at least 50 clients annually for with a maximum caseload of 25 clients at a time. UConn School of Medicine's Contingency Management team will provide pre and post assessments, fidelity monitoring, and staffing training and technical assistance prior to and for the duration of the Continency Management implementation. A digital platform will be utilized to manage the calculation and immediate delivery of incentives, with proactive security features to control and eliminate user errors, fraud, waste, and abuse. The platform ensures fidelity across all sites and provides real-time client-level and project-level reporting.	

Topic	Discussion	Action
	Funding Amount:	

	Annual Cost	2 Year Cost	5 Year Cost
Coordinator and case manager: 1.5FTE staff salary and fringe $95,000 x 1.5FTE x 7 sites	$997,500	$1,995,000	$4,987,500
Incentives: $599 per client x 50 annual clients per site x 7 sites	$209,650	$419,300	$1,048,250
UConn School of Medicine Contingency Management Program: Training, Technical Assistance, Pre/Post Assessment, Fidelity Monitoring	$139,488	$278,976	$697,440
Toxicology screening: 27 screens per client at 5.75 per oral saliva screen x 50 participants x 7 sites	$54,338	$108,676	$271,690
Supplies	$17,929	$35,858	$89,645
Technology-enabled incentives management system: $6300/month	$75,600	$151,200	$378,000
Total	$1,494,505	$2,989,010	$7,472,525

CORE Priority: #1 Linkage to Treatment Category: ☒treatment ☐harm reduction ☐ prevention ☐ recovery supports

Recommended Lead & Partnering Agencies:
Department of Mental Health and Addiction Services
UConn School of Medicine

Vetted by Referral Subcommittee? ☒ yes

Vetted by Research and Data Subcommittee? ☒

- EBP ☒ or Promising Practice ☐ Program evaluation recommended? ☐yes ☒ no
- Pilot ☒ or Established Program ☐
- Local ☐ or Statewide Rollout ☒

Vetted by Finance and Compliance Subcommittee? ☒

- Allowable Strategy ☒ Compliant yes ☒ no ☐
- How much funding/funding amount: $7,472,525
- Proposed project dates: 7/1/25-6/30/30
- Approved project dates: 7/1/25 – 6/30/27
- Proposed budget $7,472,525
- Approved budget: $2,989,010 Budget submitted ☒

Topic	Discussion	Action
	• RFP (participating agencies) ☒ Sole Source (UConn for TA) ☒ Results of Committee Vote: ___X___ Proceed with Recommendation _____ Do Not Proceed with Recommendation The Opioid Settlement Advisory Committee members voted to pass these three recommendations with an established quorum of members.	
Subcommittee Updates	**Referral: First Selectman Rudy Marconi** This subcommittee continues to meet and review proposed recommendations. The Referral Subcommittee will be meeting before the next scheduled Opioid Settlement Advisory Committee meeting to review additional proposed recommendations. **Research and Data: Dr. Srinivas Muvvala** This subcommittee has continued to meet monthly and review the recommendations received from the referral and other subcommittees and will be meeting before the next scheduled Opioid Settlement Advisory Committee meeting. They also met separately with folks at UConn about contingency management as well as a a meeting for the California Bridge Model to learn about their programs, and to bring that information back to the subcommittee. We will continue to meet and further focus on expanding buprenorphine and other MAT treatments across the state. **Finance and Compliance: Representative Toni Walker** This subcommittee continues to meet and review proposed recommendations. Representative Toni Walker wanted to note that they did reduce the time frame for recommendations from 5 years to 2 years because they want to make sure that as the funding is allocated, that as a committee we are looking at the areas that we need and making sure that the recommendations have the impact that we are expecting.	Informational
Next Steps	The next OSAC meeting is scheduled for Tuesday, November 19th, 2024, from 10:00 a.m. – 12:00 p.m. The subcommittees will continue meeting to review the recommendation submissions.	Informational

NEXT MEETING – Tuesday, November 19th, 2024 - Video Conference Call through Teams
ADJOURNMENT – September 10th, 2024 meeting of the Opioid Settlement Advisory Committee adjourned at 11:49 a.m.