Meeting of the OSAC Research and Data Subcommittee
Friday, February 9th, 2024
Microsoft Teams
Virtual meeting

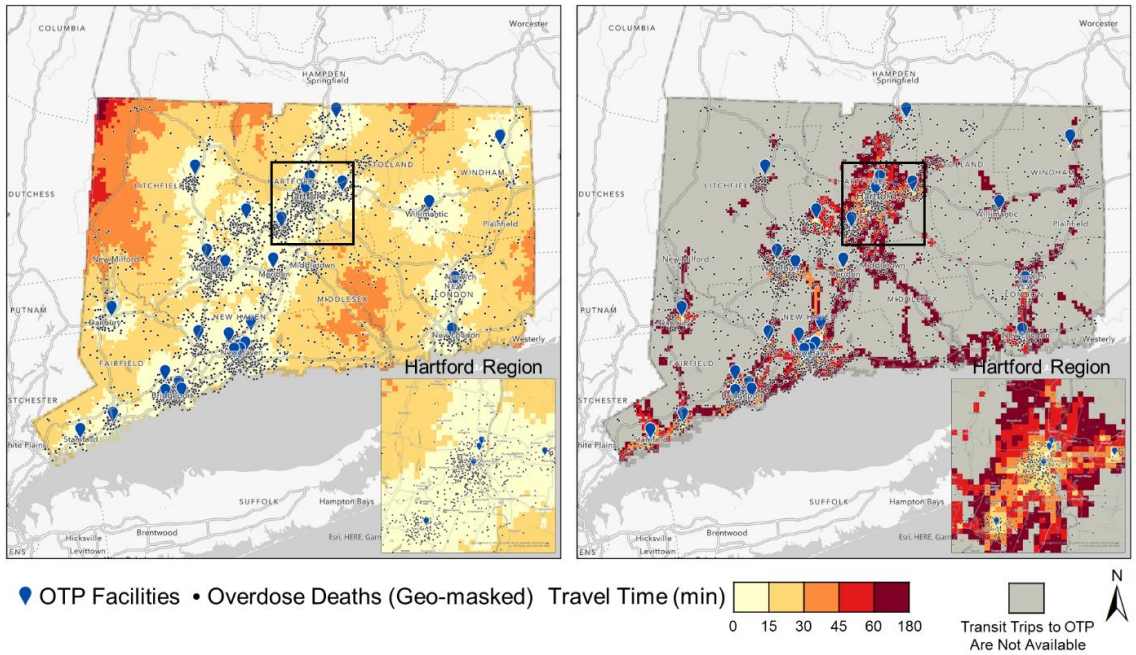
ATTENDANCE

Members present: Srinivas Muvvala, Pareesa Charmchi Goodwin, Ebony Jackson- Shaheed, Paul Januszewski, Lisa Deane, Susan Campion
Members absent: Kennard Ray

Visitors/Presenters: Luiza Barnat

Recorder: Melanie Richard

Topic	Discussion	Action
Welcome	Luiza welcomed all in attendance	Noted
Discussion	The subcommittee reviewed the following recommendation: **Mobile Opioid Treatment Programs (OTP)** Mobile OTPs allow for easier access to medications for Opioid Use Disorder and can be placed in convenient locations across the State. This is a proposal to fund 4 mobile units across the state, utilizing data to assess underserved locations in CT. Based on analysis performed by Yale/Virginia Tech team (Dr. Howell, Dr. Kim et al) on drive time and access to current OTPs, this proposal is to establish units in these geographical areas: Northeast, Northwest, Southeast, and Central CT. These Mobile OTPs will be able to serve individuals in remote locations of the state as well as residential settings such as long term facilities. The anticipated cost for each Mobile OTP project would include start- up and operating costs of $1,000,000 in the first year and ongoing operating cost of $500,000 for subsequent years. The start up cost includes the purchase of a mobile unit. The ongoing operating cost must include a minimum of two staff at all times (nursing and recovery coaching) and ensure all regulatory requirements are met. Figure 1: Map of travel time from all points in Connecticut to nearest Opioid Treatment Program (OTP) providing methadone for the treatment of Opioid Use Disorder (OUD) by (a) drive time (e.g., personal car) and (b) public transit travel time (e.g., bus).	

Topic	Discussion	Action
	(a) Driving (b) Transit  Note. 2019-2021 overdose deaths data. The location of overdose deaths on the map is geo-masked and does not represent the true location to maximize the geoprivacy. CORE Priority _____ Category: ☒treatment ☐harm reduction ☐ prevention ☐ recovery supports Recommended Lead & Partnering Agencies: Department of Mental Health and Addiction Services Vetted by Referral Subcommittee? ☒ yes Vetted by Research and Data Subcommittee? ☒ yes • EBP ☒ or Promising Practice ☐ Program evaluation recommended? ☒yes ☐ no • Pilot ☒ or Established Program ☐ • Local ☐ or Statewide Rollout ☒ Vetted by Finance and Compliance Subcommittee? ☐ , yes • Allowable Strategy ☐ Compliant yes ☐ no ☐ • How much funding/funding amount _$8,000,000.00_____	

Topic	Discussion	Action
	• Proposed project dates __1/1/25-12/31/2027_____ Proposed budget _$8,000,000.00_____ Budget submitted ☐ RFP ☒ Sole Source ☐ Discussion: Committee members asked what the four regions would be and Luiza confirmed that it would be Northeast, Northwest, Southeast, and Central Connecticut. She also confirmed that it would be one vehicle per region, so it would be four vehicles to start off, and then this recommendation can be revisited in the future to see if there is a need for more. This recommendation passed through the Research and Data Subcommittee and will be presented for review to the Finance and Compliance Subcommittee.	
Next steps	Next meeting scheduled for Friday, March 8th, 2025	Noted

NEXT MEETING – Friday, March 8th, 2025, 1:00 – 2:00 p.m.
ADJOURNMENT – Friday, February 9th at 1:36 p.m.

Meeting of the OSAC Research and Data Subcommittee
Friday, April 12th and Friday April 19th, 2024
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Pareesa Charmchi Goodwin, Lisa Deane, Ebony Jackson- Shaheed, Paul Januszewski, Susan Campion
Members absent: Jody Terranova, Susan Logan, Kennard Ray

Visitors/Presenters: Luiza Barnat, Christopher McClure, Michael Hines, Bethany LaPierre, Dr. Stephen Cox, Nita Asani, Eleni Rodis

Recorder: Melanie Richard

Topic	Discussion	Action
Welcome & Introductions	Luiza welcomed all in attendance	Noted
Discussion	The referral subcommittee members reviewed recommendations: The recommendation summary is as follows: **Ensure access to all FDA-approved medications for OUD for people incarcerated in and transitioning out of CT DOC** The goal is to provide individuals screened for an OUD with access to one of the three (3) FDA-approved medications at the time of entry and exit from the CT DOC. Continuity of care and services into and out of the correctional system assists in lessening the chances for illegal use of substances within the facilities as well as decreasing the chances of overdose upon release. The following is requested to expand services for the DOC. Build out Opioid Treatment dosing rooms in two (2) additional facilities, Brooklyn CI and Cheshire CI. Rooms need to built and equipped with all the necessary equipment in order to become fully licensed Opioid Treatment rooms. Equipment includes, dosing machines, cameras, alarms, safe, sink, desks, chairs. Build outs could require construction of walls, doors, countertops, and roll up windows. These requirements are from the DEA, SMASHA, and for National Commission on Correctional Health Care. Provide medications at Manson Youth for up to one year for those who are affected by the opioid crisis. Build out Opioid Treatment dosing treatment rooms in two (2) correctional facilities Garner CI and MacDougall CI. These two facilities are already providing services to the offender population but are operating as a satellite capacity. By building a dosing room for MacDougall CI we will be able to provide more offenders with needed medications. MacDougall will need all the things that Brooklyn and Garner need. Garner will need only a safe, dosing machine and cameras. The room has been created already. These two facilities would become fully licensed treatment programs. Annual Costs for expansion to Brooklyn, Cheshire, and MacDougall, for expansion of vendor services. RFP would be required for	Noted

Topic	Discussion	Action
	Brooklyn and Cheshire would need to take place. MacDougall is existing service that currently has a existing RFP but would need to amend the contract for expanded services. Manson CI would need annual costs for medications and programming services. MacDougall/Walker currently has a contract with CHR to serve 30 inmates with Medicated Assisted Treatment. MacDougall/Walker is two different buildings but considered one correctional institution. DPH, DMHAS and NCCHC have licensed and accredited both buildings. The Walker building is the assessment unit. Originally CHR was contacted for 30 inmates to be served within the Walker building for assessment purposes. An offender who is sentenced to more than two years and a day must go to Walker for a full assessment. (Assessments include, Mental Health, Medical, Vocational, Education, Re-entry, Addiction) Assessments take up to two weeks to complete. Once completed an offender will move to an appropriate sentenced facility. As the DOC moved forward with dosing the assessment unit, it became clear that the Walker building dose on average 15 individual inmates in a two-week period. The remaining contracted 15 available contracted slots were moved to the MacDougall building. The MacDougall building houses high bond and higher-level offenders. If more dollars were allocated and a there was a build out of a room for MacDougall, they could give services to up to 160 offenders. There will be no need to RFP at this time for the MacDougall building. We would need to extend the contact with CHR to accommodate. **The subcommittee voted to pass this with the strong recommendation to evaluate the program going forward, as there is no research in Connecticut that has been done on this yet.** **The Treatment Pathway Program** The Treatment Pathway Program (TPP) is an innovative court-based pretrial diversionary initiative that provides clinical evaluation and referral services. TPP services include substance use disorder treatment, mental health treatment and support services, medication assisted treatment (MAT), housing assistance, enrollment with entitlements, access to medical care, employment services, social supports, basic need items, and peer support by a recovery coach. The target population is justice involved individuals with substance use disorders, mainly opioid/alcohol dependent, charged with nonviolent offenses, who are less likely to be released from custody at time of arraignment. Judicial Branch, Court Support Services Division (JB-CSSD) Pretrial Services staff identifies the clients, who are then evaluated by the court-based Adult Behavioral Health Services (ABHS) JB-CSSD contracted Licensed Clinical Social Worker (LCSW). The LCSW evaluates clients for appropriateness and motivation to participate in TPP. Clients are assessed in lockup prior to their arraignment. During the arraignment, Pretrial Services makes a recommendation to the Court that clients be granted the TPP as a condition of release into the community program in lieu of incarceration. Clients granted TPP are immediately connected with clinical services, a recovery coach, and supportive services in the community. The clients' care is managed during the pendency of their case under the collaborative supervision of Pretrial Services, ABHS clinical provider, recovery coach, and Adult Probation Services. Regions served: Bridgeport, Waterbury, New Haven, New Britain, New London, Torrington, Danielson, Manchester. Current TPP funding expires on June 30, 2024. **Further discussion was needed in order for this subcommittee to approve this recommendation, and it was brought to the next meeting on April 19th, 2024, where it passed through the subcommittee. It will move on to the Finance and Compliance Subcommittee.** Discussion was as follows: Michael Hines, Director of Pretrial Services gave an overview of the history of the Department of Corrections MAT Program. One	

Topic	Discussion	Action
	of the issues that they were having at Bridgeport Corrections was that people were frequent flyers for nonviolent crimes including possession of narcotics. They would use the DOC as part of their recovery, as they would get arrested, go back in, get clean, and then be discharged at the end of a short sentence. It was then that they came to Michael Hines to do an assessment on these clients and repeat offenders. It was successful, and additional funding was received for additional locations in Torrington, New London, and Waterbury, as well as Bridgeport. It was funded for a period until the end of September this past year and then the Judicial Branch picked it up to try to keep the program going, and we had success in 2022 when McKinsey money became available. The program then expanded to four other locations, which has funding until the end of June this year and they are in Manchester, New Britain, Danielson, and New Haven. All of these programs run out of funding in June of this year. Since 2015 through January of 2024, the program has screened 28,171 individuals and of those screened, 16,145 have been placed in the program. If it was decided that an individual was not motivated to go through the program, although they'll be screened, they were not automatically entered into the program. The bail staff do the initial screening, and then a licensed clinical social worker will do an evaluation of those that are recommended for the program in order to determine the level of care they will need. It will then go back in front of a judge to get the court recommendation to approve or deny the individual. Once they leave the program, there is a recovery coach involved, which clients have given credi for their success to that recovery coach as well as their clinician. This warm handoff includes placement into the proper level of care within 24 hours, which includes any appropriate dosing that's based on the clinical recommendation and the medical doctor that they see for dosing. **Prevention and Harm Reduction through Public Access** As part of DMHAS' Prevention and Harm Reduction Strategy, the Prevention and Early Intervention Subcommittee of the ADPC recommends the increase statewide dissemination of both prevention and harm reduction methods including the distribution of medication lock boxes, medication safe disposal pouches, naloxone, fentanyl and xylazine test strips, and prevention and harm reduction educational materials. This recommendation is aligned with the ADPC Prevention Naloxone Recommendations and SAMHSA's Harm Reduction Framework. This will be accomplished through a three-prong approach including: (1) Pilot Harm Reduction Vending Machines in 20 municipalities across Connecticut. (2) Increase access to naloxone aligned with DMHAS Naloxone Distribution Plan. (3) Increase primary prevention through education and stopping opioid diversion. Additional Information: (1) DMHAS in alliance with DPH will operate 20 harm reduction vending machines that offer will offer harm reduction supplies at no cost. The machines will launch as a pilot program and aim to help prevent overdose and provide life-saving supplies. Initially, the machines will contain naloxone, fentanyl/xylazine test kits, and sterile needles and syringes. DMHAS/DPH will change the available products according to usage patterns and community needs (this may include general, first aid and menstrual hygiene kits, and socks and underwear). This will also include an evaluation component where data and learnings will be shared. (2) Recommendation for funding to be allocated for the purchase of naloxone to meet the needs of the state. (Approximately 60,000 kits	

Topic	Discussion	Action
	per year) DMHAS will expand primary prevention efforts through education and stopping opioid diversion. This will include (a) increasing access to naloxone, medication disposal pouches, and opioid rescue kits that can be mounted in public spaces including, but not limited to, college campuses, libraries, and train stations; (b) expansion of the community resource van, and (c) educational materials and information dissemination of this program to a wide variety of audiences. Educational materials will also support reducing the stigma associated with substance use, normalize harm reduction approaches, encourage individuals to engage in substance use treatment and recovery services. Time Frame: July 1, 2024 – June 30, 2029 (5 years) Funding Amount Requested:	

Approach	Annual Cost	5 Year Total	Notes
1	$1,377,392	$5,686,958	Cost and maintenance of 20 Harm Reduction Vending Machines, allocation of products for vending machines, and evaluation of pilot program
2	$2,323,200	$11,616,000	Purchase of Naloxone
3	$709,000	$3,185,000	Cost includes purchases and distribution of medication lock boxes, xylazine test strips, medication safe disposal pouches, opioid rescue kits/naloxboxes, educational materials, staff support, and resource van, gas, maintenance
Total	$4,409,592	$20,487,958	

The subcommittee approved this recommendation, but with program evaluation and careful monitoring of the budget.

Further Discussion:

Mobile OTP

It will be important to focus on the individual program, as we know that it is an evidence-based practice and it's a different modality of delivering the service. Important to look at the numbers and questions like if we provide them a certain amount of money and they only do around 10 inductions a year, then that is not a positive outcome for the program. We want to make sure that whatever the money is invested in with these programs, that they are performing and seeing enough patients. We will want to look at how many clients were referred as well, and what the retention rate is for these clients, or if they are being discharged early. Some other metrics to track and consider would be social economic status, if they are serving an underserved population, rural population, or urban population, any insights on other drugs that may be involved, overdose deaths in these populations, and etc. These metrics will allow us to see how effective the program is, especially if there are four vans and one van is doing better than others.

We have a unique opportunity to track this from the beginning, as well, and we can develop focus groups that will be helpful in asking questions to clients such as why they chose to go to the van as opposed to a brick and mortar. We can develop generic

Topic	Discussion	Action
	evaluation metrics to help us guide the program going forward, especially as we start to see what is working and what is not. **DOC and Naloxone Recommendations:** Naloxone: The naloxone vending machines will be temperature controlled in they are outdoors, otherwise they would have to go through DPH and DCP if they are placed in lobbies, as regulations will have to be followed. We would look at tracking usage of the vending machine, which can be done with information right off of the vending machine, as well as how much is being requested. We would want to look into evaluating whether a vending machine is useful in one community more than another. There is currently a vending machine in New Haven (it's Yale's) and it has a camera on it so that the machine cannot be vandalized and monitored. The plan is for the vending machines to go to 20 different cities that have been included in this recommendation, but ultimately it would be up to DPH and DCP to decide where they would go. DOC: The MOUD program in the DOC system seems to be working, as there are some statistics available that show a decrease in death data from the incarcerated. The people leaving incarceration community that used to account for so many of our fatalities has decreased for accounting for 50% of our fatalities to around 15%. This should require a research study to be published as this is a very important outcome and we do not have any study to point to to show that. We should recommend collecting all data and screening everyone for opioid use disorder, as well as offer medications to figure out a plan moving forward. We would need to connect with DOC to see what data they are collecting. It's also important to know what is happening to clients are they are released. It would be assumed that DOC is tracking from the point of discharge to see if they are connected with a provider in the community before they are released. Luiza will follow up to see what they are tracking.	
Next steps	Next meeting will be scheduled after the full OSAC meeting on 5/11/2024.	Noted

NEXT MEETING – TBD after the full OSAC meeting on 5/11/2024
ADJOURNMENT – Friday, April 12th and Friday, April 19th, 2024

Meeting of the OSAC Research and Data Subcommittee
Thursday, June 6th and Friday, June 14th
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Pareesa Charmchi Goodwin, Ebony Jackson- Shaheed, Paul Januszewski, Jody Terranova
Members absent: Susan Logan, Kennard Ray, Lisa Deane, Susan Campion

Visitors/Presenters: Luiza Barnat, Christopher McClure, Sarah Messier-Smith, Nita Asani

Recorder: Melanie Richard

Topic	Discussion	Action
Welcome	Luiza welcomed all in attendance	Noted
Approval of Minutes	Minutes moved to approval; Paul Januszewski 1st, Ebony Jackson-Shadeed 2nd	
Discussion	The referral subcommittee members reviewed recommendations: The recommendation expansion summary is as follows: **Ensure access to all FDA-approved medications for OUD for people incarcerated in and transitioning out of CT DOC** The goal is to provide individuals screened for an OUD with access to one of the three (3) FDA-approved medications at the time of entry and exit from the CT DOC. Continuity of care and services into and out of the correctional system assists in lessening the chances for illegal use of substances within the facilities as well as decreasing the chances of overdose upon release. The following is requested to expand services for the DOC. Annual costs for two years for expansion to Brooklyn, Cheshire, and MacDougall, for expansion of vendor services. RFP would be required for Brooklyn and Cheshire would need to take place. MacDougall and Garner are existing service that currently have an existing RFP but would need to amend the contract for expanded services. These facilities would become fully licensed treatment programs.	Noted

Topic	Discussion	Action

FY 24 BUDGET
WCCI MOUD Treatment Center

Willard-Cybulski Correctional Institution	100
FACILITY	**CAPACITY**

			Number FTEs	Average Annual Salary	FY24 Budget
I. SALARIES & WAGES					
	Direct Inmate Service Staff				
A	Clinical Program Director		0.50	99,965	49,983
B	Substance Abuse Counselor		1.00	53,830	53,830
C	Nurse Practitioners		0.40	161,117	64,447
D	Therapist		1.00	62,130	62,130
E	Care Coordinator / Re-entry Specialist		1.00	45,698	45,698
F	Nurses		1.10	61,797	67,977
G	Other:	Registered Nurse Coordinator	0.75	88,899	66,674
H	Other:	Medical Assistant	1.00	49,962	49,962
I	Other:	Translation Stipends			990
		Subtotal Direct Service Staff			**$ 461,690**
	Direct Service Support Staff				
J	Other:	Service Director	0.135		

Topic	Discussion							Action
						120,827	16,312	
	K	Other:	Registered Nurse Manager		0.166	102,232	16,971	
	L	Other:	Associate Medical Director		0.05	305,926	15,296	
	M	Other:					-	
	N	Other:	Director of Nursing		0.01	130,563	1,306	
	O	Other:				-		
						Subtotal Direct Service Support Staff	**$ 49,884**	
						TOTAL DIRECT SERVICE SALARIES	**$ 511,574**	
	II. NONSALARY DIRECT SERVICE COSTS							
	A	Temporary Help (non-employee)						
	B	Contract Services						
	C	Telephone					3,500	
	D	Office Supplies & Postage					1,400	
	E	Staff Training & In-service					2,100	
	F	Advertising:						
		1. Recruitement - staff					-	
		2. Program advertising						
	G	Vehicle Expense (gas, oil, repairs)						
	H	Mileage Reimbursement					5,895	
	I	Dues, Fees, Licenses, Subscriptions					1,890	
	J	Inmate Medical Cabinet Supplies					3,312	
	K	Inmate Lab Fees:						

Topic	Discussion			Action
		1. Urines		
		2. Blood		
	L	Inmate Pharmaceuticals	$52,317	
	M	Inmate Training & Supplies	515	
	N	Inmate Recreational Supplies		
	O	Rental/Lease Payments	14,400	
	P	Property and Real Estate Taxes		
	Q	Insurance:		
		1. Umbrella		
		2. Malpractice/Professional Liability	3,500	
		3. Liability		
		4. Property (including liability)		
		5. Vehicle		
		6. Other:		
	R	Dietary		
		1. Food		
		2. Non Food		
	S	Maintenance Supplies/Expenses	3,465	
	T	Utilities (heat, water, electricity)	2,160	
	U	Depreciation	927	
	V	Minor Equipment ($250-$600)	1,000	
	W	Other:		
		TOTAL NON-SALARY DIRECT SERVICE COSTS	**$ 96,381**	
		TOTAL DIRECT SERVICE COSTS	**$ 607,955**	
	III. ALLOCATED EMPLOYEE BENEFITS		133,009	
	IV. ALLOCATED ADMINISTRATIVE EXPENSE		111,144	
	VI. MAJOR EQUIPMENT (breakout in narrative)			
	VII. TOTAL EXPENSES		**$**	

Topic	Discussion	Action
	[redacted] 852,108 Subcommittee members asked for more time to review the recommendation and the supporting documents and agreed to reconvene on Friday, June 14th for further discussion and recommendation vote. Members convened on Friday, June 14th and voted in favor of this recommendation to pass and be presented at the Finance and Compliance Subcommittee meeting.	
Next steps	Next meeting will be scheduled after the full OSAC meeting on 9/10/2024	Noted

NEXT MEETING – TBD after the full OSAC meeting on 9/10/2024
ADJOURNMENT – Thursday, June 6th, 2024 and Friday, June 14th, 2024

OSAC Research and Data Subcommittee
Friday, August 23rd, 2024
9:00 – 10:00 a.m.
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Ebony Jackson-Shaheed, Susan Campion, Gretchen Shugarts, Paul Januszewski, Jody Terranova

Visitors/Presenters: Luiza Barnat, Christopher McClure, Sarah Messier-Smith, Nita Asani

Members Absent: Srinivas Muvvala Kennard Ray

Recorder: Melanie Richard

Topic	Discussion	Action
Introduction	Luiza Barnat introduced Sarah Messier-Smith, Opioid Settlement Program Manager.	Noted
Recommendation Status	The group reviewed the Opioid Settlement Overview and Approved Recommendations and were provided with a copy.	Noted
Recommendations	The group reviewed and approved the following recommendations: Recommendation Title: **LiveLoud Public Awareness and 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. Connecticut recorded measurable positive correlations in access to services following targeted LiveLOUD pilot campaigns:	

Topic	Discussion	Action
	• 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) • 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 Recommendation Title: **Enhancing Medication for Opioid Use Disorder Initiation in 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 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	

Topic	Discussion	Action
	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. 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 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 for incentive management and program administration to support program fidelity.	

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td></td><td>Funding Amount:
<table>
<tr><td></td><td>Annual Cost</td><td>5 Year Cost</td></tr>
<tr><td>Coordinator and back up: 1.5FTE staff salary and fringe $95,000 x 1.5FTE x 7 sites</td><td>$997,500</td><td>$4,987,500</td></tr>
<tr><td>Incentives: $599 per client x 50 annual clients per site x 7 sites</td><td>$209,650</td><td>$1,048,250</td></tr>
<tr><td>UConn School of Medicine Contingency Management Program: Training, Technical Assistance, Pre/Post Assessment, Fidelity Monitoring</td><td>$139,488</td><td>$697,440</td></tr>
<tr><td>Toxicology screening: 27 screens per client at 5.75 per screen x 50 participants x 7 sites</td><td>$54,338</td><td>$271,690</td></tr>
<tr><td>Supplies</td><td>$17,929</td><td>$89,645</td></tr>
<tr><td>Technology-enabled incentives management system: $6300/month</td><td>$75,600</td><td>$378,000</td></tr>
<tr><td>Total</td><td>$1,494,505</td><td>$7,472,525</td></tr>
</table>
CORE Priority: #1 Linkage to Treatment Category: ☒treatment ☐harm reduction ☐ prevention ☐ recovery supports</td><td></td></tr>
<tr><td>Next steps</td><td>Next meeting will be scheduled after the full OSAC meeting on 9/10/2024.</td><td>Noted</td></tr>
</table>

NEXT MEETING – TBD after the full OSAC meeting on 9/10/2024.
ADJOURNMENT – Friday, August 23rd, 2024 at 9:45 a.m.

Meeting of the OSAC Research and Data Subcommittee
Monday, November 4th, 2024
3:00 – 4:00 p.m.
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Paul Januszewski, Ebon Jackson-Shaheed, Gretchen Shugarts, Susan Campion

Visitors/Presenters: Luiza Barnat, Christopher McClure, Sarah Messier-Smith

Members Absent: Kennard Ray

Recorder: Melanie Richard

Topic	Discussion	Action
Minutes	Minutes were motioned to be approved by Gretchen Shugarts, seconded by Paul Januszewski.	
Recommendation Status	The group reviewed the Opioid Settlement Overview and Approved Recommendation and were provided with a copy.	Noted
Recommendations	The group reviewed and approved the following recommendation: Recommendation Title: Promote and Expand Opioid Overdose Education and Prevention in CT's Colleges and Universities This recommendation is for funding for technical assistance, from national leaders in the field of collegiate recovery, to support opioid overdose education and prevention at Connecticut institutions of higher education. National level technical assistance, over the span of two academic years and under the umbrella of the Connecticut Healthy Campus Initiative, would provide an opportunity for campuses to increase their capacity to effectively disseminate opioid overdose education while simultaneously developing and/or enhancing recovery friendly communities at their institutions. Research demonstrates that college-aged adults are more likely than other age groups to misuse opioids generally, including prescription pain relievers, heroin use, and other opioids including fentanyl, have worse opioid use disorder treatment outcomes, including higher rates of 24-week relapse than older adults. Research further indicates that college students have limited knowledge about how to recognize an opioid or an opioid overdose and importance of naloxone administration to reverse an opioid overdose. Further, college aged individuals have a lower perceived risk of opioid overdose death. 1 The Healthy Campus Initiative, a coalition committed to creating and sustaining healthy campus and community environments throughout Connecticut, focuses on implementation of on-campus activities that will positively impact the campus community environment. The Connecticut Healthy Campus Initiative has provided funding to 13 campuses, to be used between June 30, 2023—December 13, 2024, to support the efforts of institutions of higher education in the state of Connecticut to implement opioid and stimulant education and awareness activities. It is requested that OSAC funding be made available to build upon these efforts by providing 2 years year of technical assistance, available to any Connecticut institution of higher education. The Technical Assistance would be available to all accredited colleges and universities in CT, including the Community Colleges, and include: • A Technical Assistance Summit, to establish opioid overdose awareness and overdose prevention education as a collective statewide collegiate priority.	

Topic	Discussion	Action

It is critical that collegiate settings recognize the risks of opioid overdose and their unique ability to educate tens of thousands of people about prevention, treatment, harm reduction, and recovery supports as a workforce development initiative that warrants specific attention, among many competing collegiate priorities. The Summit will include breakout sessions for college faculty/staff, students, and community.

- Following the summit, monthly interactive presentations would be held within a dedicated professional learning cohort provided by national experts, SAFE Project (Stop The Addiction Fatality Epidemic) in collaboration with the Connecticut Healthy Campus Initiative. These monthly opportunities would focus on how to implement evidence-based best practices for disseminating public health messaging about opioids and overdose prevention to the entire campus community including students, family of students, faculty, and staff. Topics would include how to effectively disseminate: opioid overdose response training; information about secure medication storage and disposal; education about the multiple pathways of recovery for opioid use disorder including medications, psychotherapy, peer support communities, and harm reduction; and education about stigma-reducing behaviors.
- Personalized Technical Assistance requested by any participating institution to address individualized capacity building needs around the topic of opioids and overdose prevention. Funding would also be available for campus staff and students create specific events/initiatives on campuses related to the TA topics.

Technical Assistance would be provided by national content experts, SAFE Project (Stop The Addiction Fatality Epidemic). Costs include preparation time by SAFE Project staff for each presentation.

	4/1/25-10/31/25	11/1/25-10/31/26	11/1/26-10/31/27	To
Technical Assistance (TA) with SAFE Project (yearly allocations)**:** • 12 Monthly 60-Minute Training Meetings for **Faculty and Staff** • 12 Monthly 60-Minute Meetings for **Students & Community Engagement** • 240 Hours of **Individualized Technical Assistance** as requested by participating institutions • **Reporting** on impact and progress of the TA (6 month, 12 month, and final report)	---	$38,000	$38,000	$76
Kickoff Summit: Presenter preparation time, travel and speaking fees; summit location and meal expenses; and materials necessary for training	$65,000	---	---	$65
Supplies (Harm Reduction supplies, marketing materials)	$20,391	$85,000	$85,000	$19
Project Coordinator and Indirect Expenses	$38,500	$66,000	$66,000	$17
Student and Community Engagement Incentives	---	$12,000	$12,000	$24
Campus Specific Events and Initiatives	---	$30,000	$30,000	$60
Indirect Expenses	$18,583.65	$34,650	$34,650	$87
Total Cost	$142,475	$231,150	$231,150	$60

1 Shelton RC, Goodwin K, McNeil M, Bernitz M, Alexander SP, Parish C, Brotzman L, Lee M, Li WB, Makam S, Ganek N, Foskett D, Warren C, Metsch LR. Application of The Consolidated Framework for Implementation Research to inform understanding of barriers and facilitators to the implementation of opioid and naloxone training on college campuses. Implement Sci Commun. 2023 May 23;4(1):56. doi: 10.1186/s43058-023-00438-y. PMID: 37221618; PMCID: PMC10204023.

CORE Priority: Priority 6, Strategy 1, Tactics 1&2; Priority 6, Strategy 2, Tactics1&2
Category: ☐ treatment ☒ harm reduction ☒ prevention ☐ recovery supports

Recommended Lead & Partnering Agencies:
Connecticut Healthy Campus Initiative/CT Clearinghouse

Topic	Discussion	Action
	DMHAS Funding Amount: $604,775 Budget submitted ☐ Proposed project dates: 4/1/25-10/31/27 RFP ☐ Sole Source ☒ The OSAC Research and Data Subcommittee approved this recommendation to move forward to the Finance and Compliance Subcommittee for further review. They noted that as we continue to review the budget and evaluation of this recommendation, they would like to know more details on how it's done and how evaluations are conducted. It is being approved with the stipulation of receiving more information on the content.	
Next steps	Next meeting will be scheduled after the full OSAC meeting on 11/19/2024.	Noted

NEXT MEETING – TBD after the full OSAC meeting on 11/19/2024.
ADJOURNMENT – Monday, November 4th, 2024 at 3:47 p.m.

Meeting of the OSAC Research and Data Subcommittee
Monday, December 9th, 2024
3:00 – 4:00 p.m.
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Paul Januszewski, Ebony Jackson-Shaheed, Gretchen Shugarts, Lisa Deane

Visitors/Presenters: Luiza Barnat, Sarah Messier-Smith, Nita Asani

Members Absent:

Recorder: Melanie Richard

Topic	Discussion	Action
Minutes	Minutes were motioned to be approved by Paul Januszewski, seconded by Gretchen Shugarts.	
Recommendations	The group reviewed the Opioid Settlement Overview and Approved Recommendation and were provided with a copy. Recommendation Title: Connecticut Harm Reduction Centers Continuation Harm Reduction Centers provide low-barrier, drop-in support for individuals who use substances, particularly those who are at high risk for opioid overdose. The goals of these centers include but are not limited to (1) Broadly improving the overall health and well-being of individuals who use drugs, through measures including but not limited to reduction of unintentional overdoses and disease transmission; (2) increasing engagement between providers of treatment services, health care and social services and the individuals who access the drop-in center; (3) reducing the number of fatal overdoses in the immediate and surrounding areas of the center. Harm Reduction Centers also reduce disease transmission through education, supplies, and wound care; distribute Naloxone and harm reduction supplies; provide connections to housing, employment, and other needed resources such as obtaining identification; and provided medical and behavioral health treatment options in-house or via referral. Community Engagement is a key component of the Harm Reduction Centers, both doing street level outreach to people who use drugs to welcome them to the Centers and building relationships with local businesses and community partners to increase referrals and build community relationships. Centers regularly hold in person groups and social events to increase a sense of community amongst the participants. Between 10/1/23-10/1/24, the Harm Reduction Centers collectively had 4,284 total visits of 1,395 unique individuals. Of these individuals, there were the following connections to care: • Withdrawal Management (AKA Detox): 59 • Medication for Opioid Use Disorder: 83 • HIV/Hep CT Testing: 128 • Wound Care: 259 • Mental Health Treatment: 63 The Department of Mental Health and Addiction (DMHAS) currently supports three Harm Reduction Centers with federal block grant funding in New Haven, New London, and Waterbury, which are CT's communities with the 2nd-4th highest known fatal overdose rates. Funding for these programs ends on 9/29/25. This proposal requests to continue the operation of the three existing centers beyond the current end date to include an additional three (3) years of operation at each	Noted

Topic	Discussion	Action

site. This request also includes three-year funding for a new site in Bridgeport, the municipality with the next highest known fatal overdose rates. The annual cost of operation per site is $500,000.00.

There is also a Harm Reduction Center located in Hartford, the city with the highest fatal opioid overdose rates, funded by SAMSHA's State Opioid Response Grant at $175,000 per year without opportunity for an increase in the budget. Given Hartford's overdose rate and the growing disparity of Black men dying from overdoses at higher rates than any other demographic, we are proposing a funding match for this program at $325,000 for program expansion.

	Year 1 Cost	Year 2 Cost	Year 3 Cost	Total Co
$500,000 per Harm Reduction Center x 4 Centers	$2,000,000	$2,000,000	$2,000,000	$6,000,0
$325,000 for Hartford Harm Reduction Center	$325,000	$325,000	$325,000	$975,00
Total	$2,325,000	$2,325,000	$2,325,000	$6,975,0

CORE Priority: Priority 2 Strategy 2: Create Harm Reduction Centers that provide ancillary supports services for people using drugs

Category: ☒ treatment ☒ harm reduction ☐ prevention ☒ recovery supports

Recommended Lead & Partnering Agencies:
DMHAS
Partnering Agencies

Vetted by Referral Subcommittee: ☐

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 ☐
- Proposed Funding Amount: $2,325,000 per year; $6,975,000 total for 3 years.
- Approved Funding Amount:
- Budget submitted ☐
- Proposed project dates: 9/30/25-9/29/28
- Approved project dates:

RFP ☒ (New Bridgeport Location) Sole Source ☒ (Existing Locations)

This recommendation passed through with four votes in favor and one vote opposed. It will go through to the Finance and Compliance Subcommittee for review.

Recommendation Title: SafeSpot Overdose Hotline Expansion to Connecticut

Topic	Discussion	Action
	The SafeSpot Overdose Hotline is a 24 hour-7-day a week service that provides immediate, accessible, real-time support to individuals at risk of an overdose. SafeSpot has a proven track record of providing this service for the Massachusetts Department of Public Health. Since January 2023, the team has supervised over 11,500 use events across more than 4,500 calls for service, with 21 overdoses detected and successfully reversed. SafeSpot prevents opioid-related fatalities and improves health outcomes by generating a safety plan with people who use drugs alone and offering real-time phone-monitored supervision of drug use. As part of safety planning, SafeSpot caller-operator interactions typically include guidance on overdose prevention, drug-checking, and developing safer use networks. Interested callers are connected to harm reduction services and supplies, treatment (including medication for opioid use disorder), crisis response, and other supports as needed. SafeSpot supports and facilitates person-centered, evidence-based, harm reduction practice. The hotline team, who all work virtually, is directed and staffed by people with lived experience with substance use and overdose. They are housed at the Boston Medical hospital, a large academic medical hospital that focuses on harm reduction and overdose prevention. SafeSpot collaborates with its public health funders and community partners to ensure the hotline is responsive to the needs of people who use drugs and their care providers. The hotline has a track record of assisting people who might not feel comfortable or who are unable to physically access harm reduction services in physical settings. This high-risk category is primarily made up of women, people of color, sex workers, and LGBTQIA+ people. This recommendation would fund the expansion of the SafeSpot Overdose Hotline to Connecticut. SafeSpot already supports people who use drugs in Connecticut, which is taxing on the call volume without funding for additional operators. More than 648 calls have been taken from callers in Connecticut since May 2024, with over 3,226 use events recorded, reflecting approximately 14.2% of the total call volume. This is made up of several callers in geographically diverse areas of the state. SafeSpot would commit to hiring people who use drugs in Connecticut; having local operators involved encourages a feeling of community ownership and trust in our services and ensures operators are aware of Connecticut resources. **CORE Priority**: Priority 2, Strategy 3, Tactic 1: Fund a safe drug use hotline to reduce solitary opioid use. Category: ☐ treatment ☒ harm reduction ☐ prevention ☒ recovery supports Recommended Lead & Partnering Agencies: DMHAS Boston Medical Center/SafeSpot Hotline Vetted by Referral Subcommittee: ☐ 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? ☐	

	Year 1 Cost	Year 2 Cost	Year 3 Cost	Total Co
Personnel Costs (Including Administration, Program Coordinator, 2 Full Time Operators, Per Diem Operators)	$392,402	$396,793	$408,697	$1,197,8
Other Direct Costs (including training, evaluation, supplies, travel)	$62,140	$57,750	$57,750	$177,64
Indirect Costs	$45,454	$45,454	$46,645	$137,55
Total	$499,996	$499,997	$513,062	$1,513,0

Topic	Discussion	Action
	• Allowable Strategy ☐ Compliant yes ☐ no ☐ • Proposed Funding Amount: 7/1/26-6/30/26: $499,996, 7/1/26-6/30/27: $499,997; 7/1/27-6/30/28: $513,062; Total: $1,513,085 • Approved Funding Amount: • Budget submitted ☐ • Proposed project dates: 7/1/25-6/30/28 • Approved project dates: RFP ☐ Sole Source ☒ **There were some concerns from members about EMS locating the callers in case they do not give an accurate address, so it was recommended that the years of funding were contingent on the statistics and data that could be provided after one year instead of giving a blanket approval for three years. This recommendation passed with three votes in favor, and two votes opposed. It will be reviewed at the Finance and Compliance Subcommittee.** <u>Recommendation Title: Supportive Housing as Recovery</u> This proposal would fund CT Department of Housing (DOH) Rental Assistance Program (RAP) Housing subsidies, client supports (security deposit, furniture, etc.), and trauma-informed case management services that would follow and support an individual from homelessness to being housed and maintaining housing stability. The program would target heads of household (1) with Opioid Use Disorders or at risk for overdose and (2) who are experiencing homelessness or who were homeless prior to entry to Substance Use Disorder (SUD) treatment, inclusive of Sober and Recovery Homes, who do not have a safe and/or viable housing discharge plan. Housing as a Health-Related Social Need (HRSN), previously known as Social Determinant of Health, plays a significant role in influencing substance use, particularly opioid use, and affects both the risk of addiction and recovery outcomes. Individuals experiencing homelessness or unstable housing are more likely to use substances as a means of coping with the trauma, stress and uncertainty of their situation. Opioids and other substances may be used to self-medicate mental health issues that are often exacerbated by housing instability. People who are unsheltered or in unsafe living environments are more frequently exposed to drug use and availability, which increases the risk of starting or relapsing into opioid use. Research has shown that having stable housing significantly improves recovery outcomes for individuals with opioid use disorder. Finally, program models that integrate supportive housing are more effective in reducing opioid use, as the model allows individuals to access housing without first requiring sobriety, thus providing immediate stability and support to initiate recovery. **Strategy to identify potential participants**: The By Name List (BNL) consists of persons experiencing homelessness who have accessed homeless services by calling 211, contacted HUB staff (drop-in centers for referral to housing and homelessness assessment and referrals), and/or have worked with homeless outreach staff. The BNL allows our provider systems to know who is currently homeless and to understand the inflow (the number of people becoming homeless each month) and the outflow (the number of people obtaining permanent housing). Currently there are approximately 4500 people on the BNL, with approximately 30% having a known or self-identified substance use disorder. **Supportive Housing Model Components:** • The **Rental Assistance Program (RAP) certificate** is an ongoing housing subsidy. Individuals experiencing homelessness have very limited options of affordable and deeply affordable apartments, and their potential histories of unestablished credit or eviction often dissuade landlords from renting to them. Having a RAP certificate that affords guaranteed rent payment along with client supports incentivize landlords to rent to this special population. • **Wrap-around, community-based Case Management Services** include landlord/tenant negotiation, referral to substance use/mental health/medical	

Topic	Discussion	Action
	care, budgeting, tenancy rights and responsibilities and tenancy sustaining skill building. The Case Management services would be provided by Private Non-Profit (PNP) agencies with experience providing case management to unhoused and housing insecure individuals with substance use and/or co-occurring mental health disorders. • **Client Support** includes funding for apartment application fees, security deposits for new apartments, furniture, and/or for payments of basic utilities that prohibit persons from renting an apartment.	

	Year 1 Cost	Year 2 Cost	Year 3 Cost	Total Co
Supportive Housing Model Components: RAP Certificate = $14,000 per person Wrap-Around Case Management Services = $9,500 per person Client Support = $5,000 per person Total: $28,500 per person annually x 500 individuals = $14,250,000	$14,250,000	$14,250,000	$14,250,000	$42,750
Program Evaluation	Pending	Pending	Pending	
Total				

CORE Priority: Priority 2: Reduce Overdose Risk and Mortality, Especially Among Individuals at Highest Risk and Highest Need with Linkage to Treatment, Naloxone, and Harm Reduction; Priority 7, Strategy 3: Provide affordable supportive and transitional housing for people with SUD; increase access to "Housing First" models and other models of affordable, supportive, and transitional housing to unhoused people with or at high risk for OUD.
Category: ☐ treatment ☐ harm reduction ☐ prevention ☒ recovery supports

Recommended Lead & Partnering Agencies:
Department of Mental Health and Addiction Services
Department of Housing
PNP provider agencies

Vetted by Referral Subcommittee: ☐
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 ☐
- Proposed Funding Amount:
- Approved Funding Amount:
- Budget submitted ☒
- Proposed project dates: 7/1/25-6/30/28
- Approved project dates:

RFP ☐ Sole Source ☒

Topic	Discussion	Action
	All members of this subcommittee were in favor of this recommendation, so it will pass to the Finance and Compliance Subcommittee for review.	
Next steps	Next meeting will be scheduled after the full OSAC meeting on 1/14/2025.	Noted

NEXT MEETING – TBD after the full OSAC meeting on 1/14/2025.
ADJOURNMENT – Monday, December 9th at 3:59 p.m.