Meeting of the OSAC Research and Data Subcommittee
Monday, January 27, 2025 2:00 p.m. – 3:00 p.m.
&
Monday, February 10, 2025 2:00 p.m. – 3:00 p.m.
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Paul Januszewski, Srinivas Muvvala, Lisa Deane, Gretchen Shugarts, Ebony Jackson-Shaheed, Lisa Deane
Members absent: Susan Campion
Visitors/Presenters: Luiza Barnat, Sarah Messier-Smith
Recorder: Sarah Messier-Smith

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td>Review Minutes and Approve</td><td>To be reviewed in a future meeting</td><td>Noted</td></tr>
<tr><td>Discussion</td><td>The subcommittee members discussed a data collection plan for OSAC recommendations approved thus far. Sarah provided an overview of data collected within the DDaP system that does not need to be separately collected. This discussion continued over two meetings. The data collection plan as identified during the meetings is as follows:
<table>
<tr><th>Recommendation</th><th>Data Points</th><th>Reporting Dates</th></tr>
<tr><td>SSP Supplies</td><td>~Distribution Amounts
~Estimated Individuals Served
~Annual CT SSP Report (available each June/July) includes # served, # visits, # new SSP clients, demographics (gender, age, race/ethnicity), services info (# tested HIV/Hep C, treatment referrals, supply distributions), primary substance reported
* Note: This report cannot be broken down by funder but provides a comprehensive outline of SSP supply distribution.</td><td>Yearly and/or upon utilization of all funds</td></tr>
</table></td><td>Noted</td></tr>
</table>

Topic	Discussion			Action
	Mobile OTP	~DDaP Data ~Connections to Treatment (number and type) ~MOUD inductions on vehicle vs referral ~Engagement Retention in MOUD ~Harm Reduction Supplies dispersement (syringes, Naloxone kits) ~Van location (days, hours) & Individuals Served: Per Day/Location, identify number individuals prescribed MOUD/MOUD type, number individuals dosed, number individuals provided education or resources but not started on MOUD ~# individuals with reduced or eliminated substance use	July 15 January 15	
	TPP	~DDaP Data ~New individuals in reporting period per court ~Number individuals connected to treatment through TPP per court ~Number of planned successful discharges ~Number of clinical assessments completed	July 15 January 15	
	DOC OTP Expansion	Build out completion dates	Upon completion of build out	
	Naloxone Saturation	~Number of Kits purchased and distributed ~Agency/facility type (PNP, Hospitals, School, etc)	Yearly and/or upon utilization of all funds	
	Harm Reduction Vending Machines	~VM locations ~Supplies Provided by count (by VM location) ~# Unique Individuals Served (by VM location) ~Participant Zip Codes Served (by VM location)	Every 6 months upon implementation	

Topic	Discussion			Action
	Primary Prevention	~Naloxbox locations and kits disseminated per box ~Services provided and individuals reached ~Supplies disseminated ~Events (location, type, number engaged) ~Advertising communications for events hosted	Every 6 months upon implementation; presentation to OSAC after 18m of data collection	
	Deactivation Pouch Campaign	~Number pouches disseminated by zip code	Yearly and/or upon utilization of all funds	
	Contingency Management	~DDaP Data (includes substances used) ~# Individuals served ~Incentives Provided (average per person, total incentive dispersed) ~CM Program Treatment Outcomes/Discharge Reasons ~Average number of visits attended per individual engaged ~Substance Use Reduction Outcomes	Every 6 months upon implementation	
	LiveLOUD	~Engagement/Reach Data per tactic (include breakdown by language) ~Communities reached per tactic ~Outline of tactics used	Upon completion of each campaign phase	
	ED Bridge	# trainings provided/attendees # individuals served # individuals inducted on MOUD # individuals connected to community tx % retained in MOUD at 3m, 6m If return admission, reason for re-admission	Every 6 months upon implementation	

Topic	Discussion			Action
	College TA	Outcome Targets: A: Collegiate Recovery Programs/Communities built B: Opioid Overdose Prevention/Response Programs implemented C: Stigma reduction strategies (campaigns, training programs, etc) designed and implemented Example benchmarks of these outcomes include: A, B, C: Percent of involved campuses with action plans drafted A, B, C: Percent of drafted action plans that have been implemented B: Increase in checklist items for each campus (NASPA Checklist) B, C: Faculty, Staff, and Students Impacted by Trainings A, B: Each engaged campus builds a coalition of supportive offices, staff, organizations C: Individual stigma reduction, as quantified by movement between training pre/post surveys A: CRC growth as evidenced by new student engagement	6 months and 12 months post-implementation and upon project completion	
	SafeSpot	~Number of calls ~Use Events (how many times someone uses on the call) ~Zip Code (for understanding how our marketing is working) ~Type of Substance Used ~Route of use ~Hold time ~Call outcome (Mark Safe vs Overdose vs Disconnect) ~Safety Actions Taken ~Linkages to Care/Resources	Every 3 months upon implementation	

Topic	Discussion			Action
	Supportive Housing	~Number served ~Length of time from voucher approval to housed ~Referrals and connection to treatment ~Exit destinations for people leaving the program ~Demographics	Every 6 months upon implementation; comprehensive eval starting at 2.5 months from implementation for report out at year 3	
	Harm Reduction Centers	~Total Visits ~Unique Individuals ~Naloxone Kits Distributed ~Harm Reduction Supplies Dispensed ~Client Demographics ~Connections to Care and Medical Support ~Medical Treatment Received (MAT Induction, Testing/Screening for HIV, Hep C, etc, Wound Care)	April 15th, October 15th	
Next steps	Next meeting scheduled for February 21, 2025 at noon.			Noted

NEXT MEETING – February 21, 2025 at noon
ADJOURNMENT – February 10, 2025 at 3pm.

Meeting of the OSAC Research and Data Subcommittee
Friday, February 21st, 2025
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Gretchen Shugarts, Ebony Jackson- Shaheed, Paul Januszewski, Lisa Deane, Maritza Bond
Members absent: Susan Campion

Visitors/Presenters: Luiza Barnat, Sarah Messier-Smith

Recorder: Melanie Richard

Topic	Discussion	Action
Welcome	Luiza welcomed all in attendance	Noted
Minutes	Minutes approved.	
Discussion	The subcommittee reviewed the following recommendations: **Connecticut Community for Addiction Recovery (CCAR) Emergency Department Recovery Coach (EDRC) Continuation** The purpose of this recommendation is to provide continued funding for Recovery Coaching in the Emergency Departments at 9 acute care hospitals (Bradley Memorial, Bridgeport Hospital, Greenwich Hospital, John Dempsey Hospital, Milford Hospital, Sharon Hospital, Waterbury Hospital and the two Yale New Haven Campuses). Funding for this initiative will expire on 6/30/25. In March 2017, DMHAS partnered with CCAR to pilot an initiative that pairs on-call recovery coaches with Emergency Departments in four hospitals in eastern Connecticut. The recovery coaches, who are individuals with lived addiction recovery experience, assist people who are admitted with opioid overdose and other alcohol or drug-related medical emergencies and connect them to treatment and other recovery support services. CCAR coaches provide Naloxone education bedside and educate individuals on various Harm Reduction resources, including connecting the individual to their chosen resources and services. Coaches are available 16 hours per day (8:00 am – 12:00 midnight), 7 days per week. With information from this successful pilot and support of federal grants, the program expanded to additional hospitals in 2018, serving a total of 22 emergency departments. This portion of the initiative is funded through SAMSHA SOR funding. In 2022, DMHAS partnered with CCAR to expand the initiative into the last 9 acute care hospitals to cover all 31 emergency departments in CT, as well as 5 Satellite 24-Hour Emergency Departments. This made Connecticut the first state to offer this service to every emergency department. The CCAR EDRC expansion was initially funded by the McKinsey Settlement Fund, and funding will expire on 6/30/25. In 2023, CCAR received 5056 referrals from the original 22 SOR-funded Hospitals and 565 referrals from the additional nine, during which time CCAR Recovery coaches aided in the connection to care to over 55 different community-based providers. In 2024, CCAR received 1250 referrals from the nine hospitals included in this recommendation. Based on the individual's identified wants and needs, individuals were connected to a variety of levels of care including Withdrawal Management, Inpatient Treatment, Intensive Outpatient, Medication for Opioid Use Disorder, and Outpatient Treatment. A report compiled in 2021 by individuals with Yale Program for Recovery and Community Health identified that persons treated for an opioid-use disorder or overdose in	

Topic	Discussion	Action
	one of CT's EDs who had a CCAR Recovery Coach had a significantly reduced chance of death or likely death than those without a RC, despite presenting with greater severity of illness (including comorbid serious mental illness, history of suicide attempts, and polysubstance use). Additionally, these individuals were more likely to receive withdrawal management, IOP, MOUD treatment with Suboxone, and other therapeutic services. Funding Amount Requested: $60,000 per hospital annually for 9 hospitals Annual Amount: $540,000 Number of years: 4 Total Amount Requested: $2,160,000 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 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 ☐ • Proposed Funding Amount: • Approved Funding Amount: • Proposed Project Dates: 7/1/25-6/30/29 • Approved Project Dates: • Budget submitted ☐ RFP ☐ Sole Source ☒ **Helping Youths and Parents Enter (HYPE) Recovery: Expanding Access to OUD Treatment and Recovery for Youth and Young Adults Across Connecticut** This request is to expand access to opioid treatment for youth in Connecticut. Under this proposal DCF, the state's authority for children's mental health, will lead statewide expansion of Multidimensional Family Therapy (MDFT) for opioid use disorders, known locally as HYPE Recovery, from six teams currently to a total of 18 teams resulting in statewide access to this critical program. MDFT is an evidence-based youth treatment for substance use and co-occurring mental health disorders. The HYPE Recovery model also includes training MDFT Therapist Assistants to deliver post-treatment recovery supports using the evidence-based Recovery Monitoring and Support (RMS) model. DCF proposed to use OSAC funding to accomplish these goals by doing the following: • train and certify 60 clinical staff in the 12 existing standard MDFT teams in the HYPE Recovery opioid treatment protocols, • provide these staff enhanced MDFT case consultation and supervision consistent with the higher level of clinical acuity these youth present in treatment and to ensure fidelity to the HYPE Recovery protocols,	

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
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train and certify the existing 24 Therapist Assistant staff in the standard MDFT teams to deliver RMS,
provide RMS coaching and case consultation to TA staff in the standard MDFT teams to ensure fidelity to the RMS model, and
modify existing data systems to collect, monitor and report on expansion efforts, implementation progress, model fidelity and client outcomes.

DCF contracts with CT agencies to provide MDFT services. Currently, there are 18 MDFT Teams; six of those teams are MDFT-HYPE Teams (Standard MDFT training/capability plus HYPE Recovery training/capability) and 12 are Standard MDFT Teams. This proposal is to train the staff of the 12 existing Standard MDFT Teams to be MDFT-HYPE teams so that all 18 MDFT Teams in CT will be MDFT-HYPE Teams. This will result in the ability to serve 576 youth and their families throughout Connecticut, as outlined below:
<table>
<tr><th>DCF Region</th><th>Existing HYPE Recovery Team Service Areas</th><th>Existing Standard MDFT Teams for Proposed HYPE Recovery Expansion</th></tr>
<tr><td>Region 1</td><td>1 Team: Bridgeport, Norwalk</td><td>1 Team: Bridgeport, Norwalk</td></tr>
<tr><td>Region 2</td><td>1 Team: Milford, New Haven</td><td>2 Teams: Greater New Haven</td></tr>
<tr><td>Region 3</td><td>1 Team: New London, Norwich</td><td>2 Teams: New London, Norwich, Willimantic</td></tr>
<tr><td>Region 4</td><td>1 Team: Hartford, Manchester</td><td>3 Teams: Hartford, Manchester</td></tr>
<tr><td>Region 5</td><td>1 Team: Waterbury, Danbury, Torrington</td><td>2 Teams: Waterbury</td></tr>
<tr><td>Region 6</td><td>1 Team: Meriden, New Britain</td><td>2 Teams: New Britain, Meriden</td></tr>
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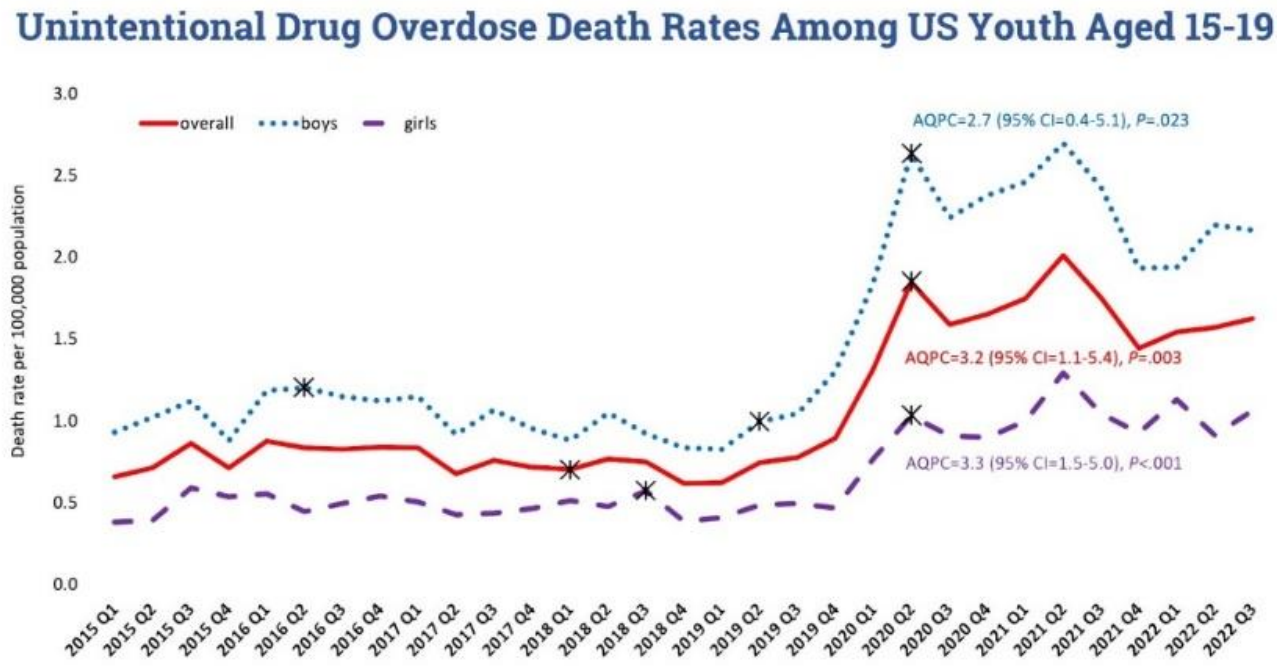
Topic	Discussion	Action
	Statement of Need: Substance use disorder is a pediatric condition. Nationwide an estimated 1 in 5 adolescents report opioid use in the past 12 months. Two out of 3 adults treated for an opioid use disorder report that they first started using opioids when they were younger than 25 (Uchitel et al., 2021). Opioid misuse among youth commonly occurs in combination with alcohol (66.9%), cannabis (49.9%) cocaine (35.5%), hallucinogen (49.4%) and other drug use. Friends and relatives are the most common sources of opioids for adolescents (33.5%) and young adults (41.4%) underscoring the importance of family-based interventions.[1] And while overdose deaths for youth are lower than adults, since 2019 they have been climbing particularly among boys.[2]	



Data sources: National Vital Statistics System's multiple-cause-of-death 2019-2021 final and 2022-2023 provisional data and the U.S. census monthly data. *: Joinpoints identified indicate significant changes in nonlinear trends using Bayesian Information Criterion. AQPC=average quarter percentage change during 2019 Q1-2023 Q1.

Like adults, the picture of youth opioid use in Connecticut is evolving. While opioid overdose deaths among youth remain low, some forms of opioid use are on the rise placing more youth, who are more likely than their adult counterparts to be opioid naïve, at risk of overdose in the future. Between 2017-2023 self-reported misuse of prescription pain medicine among Connecticut high schoolers increased from one in 10 youth to one in eight[3]. During that same period, self-reported lifetime use of heroin among high schoolers declined from 2.2% to 1.1%. Thus, the source of opioids is more likely than ever to be the family's medicine cabinet further underscoring

[1] Hudgins, J.D., Porter, J.J., Monuteaux, M.C., Bourgeois, F.T. Prescription opioid use and misuse among adolescents and young adults in the United States: A national survey study. (2019) PLoS Med 16(11)): e1002922. https://doi.org/10.1371/journal. pmed.1002922

[2] Retrieved on November 12, 2024 from Unintentional Drug Overdose Death Rates Among US Youth Aged 15-19 | National Institute on Drug Abuse (NIDA)

[3] Connecticut Department of Public Health, 2023 Connecticut School Based Health Survey, retrieved from: ttps://portal.ct.gov/-/media/dph/cshs/2023/2023cth-graphs_ctdph-suppression_redacted_for-public-release-clean07022024.pdf?rev=7a2dfa34e806492cb6f4d9eeca000f9f&hash=2DFB41D7369D0862A49C5EA941C61C82

Topic	Discussion	Action

the need for family treatment approaches.

Rationale for HYPE Recovery as the Model to Expand Statewide:

1. *The hub intervention of HYPE Recovery, MDFT, is an evidence-based practice that has demonstrated effectiveness in treating youth substance use and co-occurring conditions*.
    - The results from standard MDFT delivered across the state of Connecticut stand out as exceptional: During the 2021-2022 fiscal year there was a 66% reduction in drug use other than alcohol and cannabis among youth who were using these drugs at intake. At discharge, 94% of youth were abstinent from these drugs.
2. *HYPE Recovery specifically was developed to address youth and young adult opioid use*.
    - HYPE Recovery adds to standard MDFT opioid-specific interventions to reduce overdose risk, like Family Overdose Prevention Planning, Naloxone and opioid family education modules, and opiate withdrawal assessments.
    - HYPE Recovery promotes youth access to MOUD directly or through formal agreements with community MOUD provider(s).
3. *HYPE Recovery directly provides up to six months of evidence-based Recovery Monitoring and Support (RMS).*
    - RMS helps youth and their families build on progress made during treatment, monitor substance use and triggers, facilitate connections to pro-social/pro-recovery groups to help build recovery capital, and when needed rapidly re-engage youth into treatment or other services.
4. RMS is derived from multiple evidence-based practices shown to increase recovery and abstinence among youth. These continuing care approaches have been shown to significantly increase:
    - returns to treatment more often and more quickly when needed, and total days of treatment received (Dennis & Scott, 2012),
    - linkages and retention in continuing care after discharge from residential treatment (Godley et al., 2007, Godley et al., 2014), and
    - participation in substance-free activities with pro-recovery peers, and significantly decrease substance use (Godley et al., 2018).
5. *CT's existing HYPE Recovery teams demonstrate success serving a high severity population*. All youth with OUD at intake meaningfully reduced their opioid use by discharge and had other positive outcomes including reduced substance use, improved mental health, reduced aggression and violence, reduced involvement in delinquent activities, improved school or vocational functioning, and improved family functioning. Additionally:
    - 83% of youth showed a reduction in opioid and other drug use (e.g., benzodiazepines, cocaine, and methamphetamine).
    - 63% of youth with OUD were abstinent from opioids and all other drugs (other than alcohol and marijuana) at discharge.
6. *Connecticut has a ready infrastructure to rapidly expand access to HYPE Recovery.*
    - Staff in the 12 standard MDFT teams already are trained and certified in the MDFT approach.

2-Year Project Budget Summary

Category	Year 1	Year 2	TOTAL OSAC Project Costs
1) MDFT International Personnel and Fringe costs for MDFTI, Inc. (model developers) to personnel to train and certify treatment team staff in the HYPE Recovery opioid use interventions and educational modules	$162,526.55	$113,117.45	$275,644.00
2) Chestnut Health Systems Personnel and Fringe costs for training and certifying the 24 therapist assistants to deliver Recovery Monitoring and Support (RMS) continuing care recovery services by Chestnut Health Systems and subcontract for RMS expert Quality Assurance raters	$61,136.61	$47,206.73	$67,193.34

Topic	Discussion	Action

3) Travel for Trainers	$11,820.00	$7,320.00	$19,140.00
4) Other: Wrap Funds for prosocial recovery activities: $200/youth x 576 youth/year = 115,200/year Awareness Campaign: $300,000/year Quality assurance and program monitoring data system subscription: $3800/year	$419,000.00	$419,000.00	$838,000.00
TOTAL Direct Costs	**$654,483.16**	**$586,644.18**	**$1,241,127.34**
Indirect Costs	$22,567.29	$14,242.07	$36,809.36
TOTAL Costs	**$677,050.45**	**$600,886.25**	**$1,277,936.70**

CORE Priority: Priority 1 (Strategies 3 and 6): Increase Access to MOUD; Priority 2 (Strategy 4): Reduce Overdose Risk and Mortality with Linkage to Treatment; Priority 3 (Strategy 1): Improve collection, analysis, sharing, and use of data; Priority 4 (Strategies 1 and 2): Invest in Training and Support of the Addiction Workforce; and Priority 5 (Strategy 4): Expand access to MOUD treatment for youth and young adults.

Category: ☒treatment ☐harm reduction ☐ prevention ☐ recovery supports
Recommended Lead & Partnering Agencies:
Lead Agency: Department of Children and Families
Training Partners:

- Multidimensional Family Therapy International, Inc. (MDFTI, Inc.) – developer of MDFT, and MDFT for Opioid Use Disorders (HYPE Recovery)

Chestnut Health Systems – developer of Recovery Monitoring and Support (RMS)
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: Year 1: $677,051; Year 2: $600,886; totaling: $1,277,937
- Approved Funding Amount:
- Budget submitted ☒
- Proposed project dates: 7/1/25-6/30/27
- Approved project dates:

RFP ☐ Sole Source ☒

Topic	Discussion	Action
	Connecticut Drug Data Collaborative (CT-DDC) Summary of Request: The Connecticut Drug Data Collaborative (CT-DDC) is a transformative initiative designed to provide comprehensive, near real-time insights into the state's evolving drug landscape, empowering Connecticut's public health and safety stakeholders to make timely, informed decisions in response to the overdose epidemic. As a software-based, centralized data platform, the CT-DDC will integrate data from five community drug testing sites—Connecticut Harm Reduction Alliance (Hartford), New Haven Syringe Services Program, Liberations Program (Bridgeport), Alliance for Living (New London), and McCall Behavioral Health (Torrington)—alongside confirmatory testing results from the Connecticut Department of Public Health's Laboratory and information from other sources, such as the Department of Emergency Services and Public Protection and the Office of Chief Medical Examiner. This initiative is overseen by the Connecticut Overdose Response Strategy (CT-ORS) in partnership with the Connecticut Prevention Network (CPN), who will complete statewide analysis, trend identification, and coordination of resources across regions. The CT-DDC will include an Administrator Dashboard (Phase 1) and Public-Facing Website (Phase 2), both of which are described further below. The primary objective of the CT-DDC is to bridge existing data gaps in Connecticut's drug monitoring systems, which often rely on delayed and fragmented information from drug checking sites, arrests, hospitalizations, and post-mortem reports. By integrating data from diverse sources, the CT-DDC will provide a real-time, comprehensive view of the substances present in the state, enabling harm reduction, treatment, and other public health organizations to engage more effectively with their clients and empowering policymakers to make data-driven decisions on resource allocation and intervention strategies. The CT-DDC will not only facilitate integration of data for multiple stakeholders but will serve to streamline crucial workflows for harm reduction organizations undertaking community drug checking. This Recommendation includes funding for the Database Build, Hosting and Maintenance; a Data Analyst position; and funding for operational costs of the 5 community drug checking sites. Connecticut Prevention Network would serve as the fiduciary for the initiative. The CT-DDC will: 1. Centralize Drug Data and Expand Connectivity in three phases • Phase I: The CT-DDC will focus on enhancing each community drug checking site's ability to enter and analyze data and respond to both site specific and state specific trends. • Phase II: The data inputted by the community drug checking sites will be available to Harm Reduction and Treatment programs for analysis and dissemination via a public facing website. • Phase III: CT-DDC will focus on expanding the platform's capacity to incorporate additional data points that will capture a more comprehensive view of the illicit drug environment in Connecticut. 2. Enable Near Real-Time Data Analysis and Enhance Client Communication and Harm Reduction Efforts 3. Support Evidence-Based Policymaking and Resource Allocation 4. Future-Proof the System for Comprehensive Drug Landscape Analysis In summary, by consolidating diverse data streams, the CT-DDC will serve as a powerful tool for stakeholders across the state, creating a holistic view of Connecticut's drug environment. This unique approach will enable the early detection of dangerous trends, the issuing of rapid alerts, and the implementation of coordinated interventions to safeguard communities. The CT-DDC's emphasis on breaking down silos between public health, law enforcement, and community organizations makes it more than a data system—it has the potential to become Connecticut's centralized hub for understanding and responding to the illicit drug supply, which will enhance public safety and health outcomes. Its ability to adapt to new threats, incorporate evolving data sources, and foster cross-agency collaboration will position Connecticut as a leader in innovative, evidence-based responses to the opioid crisis.	

Topic	Discussion	Action

Category	Year 1	Year 2	Year 3	Total
		Personnel (Employed by CPN)		
Epi/Data Scientist	$106, 250.00	$108,906.25	$111,628.91	**$326,785.16**
Supplies	$600.00	$600.00	$600.00	**$1,800.00**
Equipment (Laptop, Monitor, Printer)	$5000.00			**$5,000.00**
Indirect	$25,285.00	$25,050.63	$25,322.89	$75,658.52
		Contractual		
Amston Health:				
Platform Development	$437,170.00	---	---	**$437,170.00**
Hosting/Maintenance	$16,000.00	$16,000.00	$16,000.00	**$48,000.00**
Drug Checking Sites:				
Drug Checking Services, Maintenance, Supplies, Software updates (5 sites x $25,000 per site)	$125,000.00	$125,000.00	$125,000.00	**$375,000.00**
Total	$715,305.00	$275,556.88	$278,551.80	$1,269,413.68

CORE Priority: Priority 2, Strategy 4, Tactic 3: Fund efforts to collect, report, and disseminate real time data on the drug supply in Connecticut.
Category: ☐ treatment ☒ harm reduction ☐ prevention ☐ recovery supports

Recommended Lead & Partnering Agencies:
DMHAS
Connecticut Overdose Response Strategy (CT-ORS)
Community Drug Checking Sites
Connecticut Prevention Network

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:
- Approved project dates:

Topic	Discussion	Action
	RFP ☐ Sole Source ☒ **CT Prevention Network: Statewide Prevention Workforce Development and Life Skills Training Project** Key Components: • Evidence- Based Youth Prevention • Community-Based learning opportunities for caregivers and other adults • Prevention Workforce Development The proposal for the Connecticut Prevention Network (CPN) to partner with PreventionCorps CT (part of Americorps) and recruit a total of 10 Full-time Servicemembers (2 per DMHAS Region). These Servicemembers would become trainers in evidence-based prevention and participate in community outreach and engagement. CPN is non-profit association comprised of the five Regional Behavioral Health Action Organizations (RBHAOs) which work together to implement statewide initiatives. Together the RBHAOs serve all 169 municipalities in Connecticut. The RBHAOs have a history of success in recruiting full-time staff through the PreventionCorps initiative. There are several former PreventionCorps service members who have continued in the field of Prevention and have been employed by the RBHAOs, CT Clearinghouse and DMHAS. PreventionCorps Servicemembers would be part of the Regional Behavioral Health Action Organizations (RBHAOs) and will receive professional development that enhances the prevention workforce in CT. PreventionCorps Servicemembers will offer statewide Botvin Life Skills Training (LST) to elementary and/or middle school-aged youth. The program consists of eight (8) class sessions of approximately 45 minutes each. Ideally these sessions run consistently across three years and will engage a minimum of 60 young people per region per year. Botvin Life Skills Training is a research-validated substance use prevention program proven to reduce the risks of alcohol, tobacco, drug misuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive and exciting program provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations. CPN will offer learning opportunities for caregivers, parents, and other involved adults while youth are engaged in the LST including Healthy Outcomes from Positive Experiences (H.O.P.E.) training- Tufts Medical, Everyone's An Asset Builder- Search Institute, Talk They Hear You -SAMHSA, and Narcan Education. Additionally, PreventionCorps Servicemembers will become trainers in a variety of primary and secondary prevention skills to provide training and resources across the lifespan including Suicide Prevention and Postvention Training of Trainers, Naloxone Education, Mental Health First Aid, Youth Mental Health First Aid, the Search Institute's Everyone is an Asset Builder, CT Substance Exposed Children, and Adolescent Screening, Brief Intervention and Referral to Treatment (A- SBIRT), and more. This initiative will continue to positively impact the relationships between statewide, regional and local prevention providers, youth serving organizations, parent groups and other important community groups that influence healthy youth development. Additionally, the initiative is intended to be easily and efficiently replicated in all communities across the State of Connecticut and is designed to create community level change by introducing evidence-based opportunities for families to learn skills together, make connections with town services, and receive new resources.	

Topic	Discussion	Action

	Year 1 Cost	Year 2 Cost	Year 3 Cost	Total Cost
10 Prevention Corps Staff (2 per RBHAO): $25,000 per staff x 10	$250,000	$250,000	$250,000	$750,000
Botvin Life Skills Training (LST) 15 LST Training of the Trainers (10 Prevention Corps Staff + 1 RBHAO Coordinator per Region) = $1070pp x 15=$16,050 LST Trainer Materials= $200pp x 15=$3,000 Participant Materials: 300 youth participants x $10 /youth=$3,000 Refreshments: 300 youth x $50pp=$15,000 Incentives for families of youth who complete all LST sessions = $100 x 300 possible completions=$30,000	$67,050	$67,050	$67,050	$201,150
Administration: 5 RBHAO x $10,000 (including supervision, marketing, supplies, mileage, professional development)	$50,000	$50,000	$50,000	$150,000
Annual Program Evaluation (Evaluator Salary, printed reports)	$30,950	$30,950	$30,950	$92,850
Indirect (15%)	$59,700	$59,700	$59,700	$179,100
Total	$457,700	$457,700	$457,700	$1,373,100

CORE Priority: Funding Priority 4: Invest in Training and Support to Increase the Size of the Addiction Workforce; Funding Priority 5: Fund primary prevention of opioid use among youth.

Category: ☐ treatment ☐ harm reduction ☒ prevention ☐ recovery supports
Recommended Lead & Partnering Agencies:

CT Prevention Network, Department of Mental Health and Addiction Services, Prevention Corps, Local Partner Organizations, (ie. Youth Service Agencies, Community Centers, Libraries, Boys and Girls Clubs, Scouts, RESCs, etc.)
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: $488,750 annually for 3 years totaling $1,466,250
- Approved Funding Amount:
- Budget submitted ☐

Topic	Discussion	Action
	• Proposed project dates: September 1, 2025-August 31, 2028 • Approved project dates: RFP ☐ Sole Source ☒ The subcommittee passed the Connecticut Community for Addiction Recovery (CCAR) Emergency Department Recovery Coach (EDRC) Continuation. The group asked for an evaluation model to be included with the second recommendation, Helping Youth and Parents Enter (HYPE) Recovery: Expanding Access to OUD Treatment and Recovery for Youth and Young Adults across Connecticut, and would like some follow up with DCF about what training is included for providers and prescribers to take in these patients and start the medications. Sarah will go back to DCF and make certain that this information is provided to the full OSAC Committee, but this recommendation passed and will be presented to the Finance and Compliance Subcommittee for review. The third recommendation, Connecticut Drug Data Collaborative passed with some continuances, as they would like to see the database centralized so that the data could be shared beyond just the public dashboard and with the community. The fourth recommendation, CT Prevention Network (CPN) Statewide Workforce Development and Life Skills Training Project did not pass through for review from the Finance and Compliance Subcommittee, as this group would like to see this recommendation include some evidence of how they're going to incorporate opioid use disorder treatments into the practice.	
Next steps	Next meeting scheduled for Friday, April 11th, 2025.	Noted

NEXT MEETING – Friday, April 11th from 1:00 – 2:00 p.m.
ADJOURNMENT – Friday, February 21st at 12:54 p.m.

Meeting of the OSAC Research and Data Subcommittee
Monday, April 21st, 2025
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Gretchen Shugarts, Ebony Jackson- Shaheed, Paul Januszewski, Lisa Deane, Maritza Bond, Susan Campion
Members absent:

Visitors/Presenters: Luiza Barnat, Sarah Messier-Smith

Recorder: Melanie Richard

Topic	Discussion	Action
Welcome	Luiza welcomed all in attendance	Noted
Minutes	Minutes approved.	
Discussion	The subcommittee reviewed the following recommendations: **Opioid Treatment Program Access Expansion** This proposal is to fund an increase in access to admission and same-day provision of Medications for Opioid Use Disorder (MOUD) at all eight existing non-profit agencies that have Outpatient Opioid Treatment Programs (OTP) in Connecticut. Currently, program hours and admission availability varies across CT's OTPs. In general, both admission and dosing hours are limited, typically during weekday morning times. As a result, individuals experience long waits for admission and MOUD induction, increasing overdose risk. Additionally, insufficient admissions hours result in individuals ready for discharge at residential programs, long-term care facilities, and hospitals remaining in these settings for additional medically unnecessary days while awaiting transfer of their MOUD to an Outpatient OTP. Extensive data is available indicating MOUD, particularly methadone and buprenorphine, are the most effective Opioid Use Disorder (OUD) Treatments. Methadone and Buprenorphine reduce overdose risk and all-cause mortality when compared to other OUD treatment options. Additionally, evidence shows that MOUD reduces rates of substance use, transmission of viral infections, and criminal behavior and is a cost-effective treatment. When exploring MOUD as a treatment option with an opioid-using individual, the practitioner should educate the individual on all MOUD options available to them and support them in making an informed choice on the best option available to them. OTPs are the only sites where individuals can be prescribed all 3 FDA-approved MOUD (buprenorphine, naltrexone, and methadone). This expansion has the potential to increase access for under-resourced individuals. Despite recent decreases in overdose deaths, drug overdose death rates are higher among the non-Hispanic Black and Hispanic populations compared to the non-Hispanic White population. OTPs are predominately located in urban areas where large populations of BIPOC (Black, Indigenous, and People of Color) individuals reside. OTPs provide access to all 3 FDA approved Medications for Opioid Use Disorder (MOUD); expansion of their treatment hours would help decrease disparities in treatment access and increase access to all 3 medications in urban areas and for BIPOC populations.	

Topic	Discussion	Action
	Per feedback received from the Connecticut Hospital Association (CHA), the allocation of funds to enable the expansion of the hours of operation of methadone clinics around the state beyond normal business hours will improve access to the services patients require in order to manage their life in recovery, and afford hospitals with an opportunity to improve patient throughput in both emergency medicine and behavioral health settings in those instances where a referral to a methadone clinic must be made at a time other than a normal business hour. Providers will be expected to utilize funding to increase operating hours, particularly at locations with limited admission hours, and thus increase admissions by at least 10-15% of existing location census, including ensuring adequate medical staff availability for provision of access to same-day MOUD. Amount of funding provided per agency would vary depending on number of OTPs operated by the agency. Specific operational expansions and changes will vary depending existing practices and area need; OTP leadership will be expected to collaborate with DMHAS staff to identify opportunities and plans for program enhancement as part of the contracting process. Minimally, OTPs will be expected to have admission hours with same-day MOUD prescription at least 5 days a week. In areas where there is a lack of on-site admissions (such as New London county), agencies will be required to utilize funding to ensure on-site admissions and inductions are available at a frequency that matches area need. Funding will be provided for expansion and start-up of the increased admission and same-day MOUD access. Programs are expected to build infrastructure over the course of the funding to sustain expanded hours and access via service billing. References: The Connecticut Opioid REsponse (CORE) Initiative: Report on Funding Priorities for the Opioid Settlement Funds in the State of Connecticut. March 2024 Sordo L, Barrio G, Bravo M J, Indave B I, Degenhardt L, Wiessing L et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies BMJ 2017; 357 :j1550 doi:10.1136/bmj.j1550 Krebs E, Enns B, Evans E, Urada D, Anglin MD, Rawson RA, Hser YI, Nosyk B. Cost-Effectiveness of Publicly Funded Treatment of Opioid Use Disorder in California. Ann Intern Med. 2018 Jan 2;168(1):10-19. doi: 10.7326/M17-0611. Epub 2017 Nov 21. PMID: 29159398.	

	Year 1 Cost	Year 2 Cost	Year 3 Cost	Total Cost
Root Center for Advanced Recovery—10 locations	$1,000,000	$1,000,000	$1,000,000	$3,000,000
Connecticut Counseling Center—5 locations	$500,000	$500,000	$500,000	$1,500,000
APT Foundation—5 locations	$500,000	$500,000	$500,000	$1,500,000
Community Health Resources (CHR)—2 locations	$300,000	$300,000	$300,000	$900,000
Cornel Scott-Hill Health Center—2 locations	$300,000	$300,000	$300,000	$900,000
Liberation Programs—2 locations	$300,000	$300,000	$300,000	$900,000
Recovery Network of Programs (RNP)—2 locations	$300,000	$300,000	$300,000	$900,000
Chemical Abuse Services Agency (CASA)—1 location	$150,000	$150,000	$150,000	$350,000
Total	$3,350,000	$3,350,000	$3,350,000	$10,050,000

CORE Priority: Priority 1, Strategy 1, Tactic 1: Fund increased access at existing OTPs including expanded OTP service hours, same-day medication initiation, expanded use of take-home doses, and provision of supportive behavioral health services

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

Recommended Lead & Partnering Agencies:
DMHAS
CT Opioid Treatment Centers

Vetted by Referral Subcommittee: ☐

Topic	Discussion	Action
	Vetted by Research and Data Subcommittee? ☐ • EBP ☒ or Promising Practice ☐ • Recommended Outcome Review: Data Collection and Output Reporting ☐ Program Evaluation ☐ • Pilot ☐ or Established Program ☒ Local ☐ or Statewide Rollout ☒ Vetted by Finance and Compliance Subcommittee? ☐ • Allowable Strategy ☒ Compliant yes ☒ no ☐ • Proposed Funding Amount: $3,350,000 yearly for 3 years totaling $10,050,000 • Approved Funding Amount: • Budget submitted ☒ • Proposed anticipated project dates: 7/1/25-6/30/28 • Approved anticipated project dates: • RFP ☐ Sole Source ☒ **Connecticut Community for Addiction Recovery (CCAR) Recovery Centers Continuation** This request is to seek funds to keep 3 Recovery Community Centers—Torrington, Danbury, and New London—open, continue offering evening and weekend hours at the busier centers, and provide statewide young people and family support. Initial funding for these initiatives began on 9/29/23 via congressionally directed federal funding and has been exhausted. CCAR offers accessible support without barriers to ensure everyone can seek help. Services are provided at no cost and do not require insurance. CCAR provides a compassionate and non-judgmental environment for everyone seeking recovery. Each person's autonomy is honored, and they are encouraged to define what recovery means to them. Staff support various recovery paths, including Medication for Opioid Use Disorder (MOUD) and harm reduction strategies and offer a variety of activities and groups that support recovery and overall health and wellness. This recommendation is for a 1-year continuation (7/1/25-6/30/26) for CCAR's Recovery Community Centers in Torrington, Danbury, and New London, as well as continuation of the existing Extended Hours and Young People and Services Programming. There will be a competitive bidding process for the continuation of the 3 Recovery Centers for the following 3 years starting 7/1/26. CCAR will need to develop a sustainability plan for their Extended Hours and Young People and Families Services beyond the one year of continuation funding. **<u>Recovery Community Centers (RCCs):</u>** • Recovery-oriented sanctuaries anchored in the heart of communities that serve as hubs offering a variety of recovery support services supporting the 'many pathways of recovery'. Centers attract people in recovery, family members, friends and allies. • Services include: o **Recovery Coaching:** Recovery community centers offer recovery coaching, providing personalized support to individuals at various stages of their recovery journey. o **Recovery Support Services:** A variety of Peer-run support meetings; Recovery and Advocacy trainings; Wellness Activities including Journaling, yoga, gardening, and meditation; opportunities to getting involved with the larger "Recovery Community" including building a support system and	

Topic	Discussion	Action
	connecting to community resources; volunteer opportunities via Telephone Recovery Support; and Young People and Family Services o **Community Resource Navigation:** Individuals are helped to connect with local resources and higher levels of care, including Medication for Opioid Use Disorder (MOUD), withdrawal management, intensive outpatient programs (IOP), and both inpatient and outpatient care. CCAR staff and volunteers are experienced in linking individuals to community and state programs that support housing, employment, food insecurity, and other resources to help build recovery capital. o **Naloxone Training:** Our staff and numerous volunteers are trained to administer naloxone effectively to reverse overdoses. • Utilization Data for Recovery Community Centers included in this recommendation (data from center opening through 2/28/25) o Torrington (opened Feb. 2024) ▪ # of visits= 4,084 ▪ # of unique individuals= 1,136 o Danbury (opened Apr. 2024) ▪ # of visits= 1,211 ▪ # of unique individuals= 381 o New London (opened June 2024) ▪ # of visits= 5,134 ▪ # of unique individuals= 3,178 • The Jail Diversion Recovery Coaching program was recently ended due to premature ending of temporary funding. Jail Diversion clients in need of Recovery Coaching can be referred to their local Recovery Center for recovery supports. • **Extended Hours:** Hours at the busiest Recovery Centers (Hartford, Bridgeport, and New Haven) were extended to Tuesday-Friday 4:30-8pm and Saturday 9am-5pm. Participants who visit the centers during the extended hours are mainly people who work during the day and young people, which generally is a different population from daytime hours. Over 3,000 individuals attended extended-hours programming in 2024. • Number of Extended Hours visits o Bridgeport (12/1/2023 – 2/28/25): 5,642 o Hartford (12/1/2023 – 2/28/25): 5,298 o New Haven (4/1/24 – 2/28/25): 2,845 o Torrington (9/1/24 – 2/28/25): 1,167 o **Young People & Family Services:** CCAR's Young People and Family Services supports young adults aged 18 to 32, as well as families with loved ones who are in recovery or struggling with substance use. The program offers peer-led groups that utilize the All-Recovery meeting format and provide a wide range of support both virtually and in person. There is a focus on engaging the community through outreach to schools, colleges, and other places where young people gather. Additionally, recreational activities are organized that provide direct peer support and make recovery enjoyable. In addition to helping young people and families build support networks, recovery coach training is offered to assist young people in recovery with finding employment and a sense of purpose. • Total participants: Over 1,000 young individuals and families engaged in YPFS programs in 2024 • 106 Young People All Recovery Meetings were held • 36 Parents in Recovery Meetings were held • 66 Family, Friends, and Allies Meetings were held Multiple studies highlight the effectiveness of Recovery Community Centers (RCCs) in supporting individuals with substance use disorders. Studies demonstrate significant benefits RCC participants gain from engagement, such as improved emotional well-being and stronger social support systems. References: Kelly JF, Fallah-Sohy N, Cristello J, Stout RL, Jason LA, Hoeppner BB. Recovery community centers: Characteristics of new attendees and longitudinal investigation of	

Topic	Discussion	Action
	the predictors and effects of participation. J Subst Abuse Treat. 2021;124:108287. doi:10.1016/j.jsat.2021.108287 Kelly JF, Stout RL, Jason LA, Fallah-Sohy N, Hoffman LA, Hoeppner BB. One-Stop Shopping for Recovery: An Investigation of Participant Characteristics and Benefits Derived From U.S. Recovery Community Centers. Alcohol Clin Exp Res. 2020;44(3):711-721. doi:10.1111/acer.14281	

Budget Category	Year 1	Year 2	Year 3	Year 4	Total
CCAR: **Personnel** (Salaries and Fringe): New London: $146,089 Torrington: $ 202,591 Danbury: $148,651 Extended Hours + Young People and Family Program: $190,286 **Other** (Including travel, program expenses and membership, rent/utilities, information technology, phones, office supplies and program pamphlets, insurance, and volunteer support) New London: $109,741 Torrington: $81,805 Danbury: $137,880 Extended Hours + Young People and Family Program: $20,600 **Subtotal:** $1,037,643 **Indirect** (10%): $103,76 **Total:** $1,141,407	$1,141,407				$1,141,407
3 Recovery Community Centers (To be determined via competitive bidding process) x $350,000 per Center		$1,050,000	$1,050,000	$1,050,000	$3,150,000
					Grand Total: $4,291,407

CORE Priority: Priority 1: Increase Access to the Most Effective Medications (Methadone and Buprenorphine) for Opioid Use Disorder Across Diverse Settings, Appendix A, Recovery Support Services

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

Recommended Lead & Partnering Agencies:
Department of Mental Health and Addiction Services (DMHAS)
Connecticut Community for Addiction Recovery (CCAR)

Vetted by Referral Subcommittee: ☒

Vetted by Research and Data Subcommittee? ☐

- EBP ☒ or Promising Practice ☐
- Recommended Outcome Review: Data Collection and Output Reporting ☐ Program Evaluation ☐
- Pilot ☐ or Established Program ☒

Topic	Discussion	Action
	Local □ or Statewide Rollout ☒ Vetted by Finance and Compliance Subcommittee? ☐ • Allowable Strategy ☒ Compliant yes ☒ no ☐ • Proposed Funding Amount: Y1: $1,141,407, Y2: $1,050,000, Y3: $1,050,000, Y4: $1,050,000, Total: $4,291,407 • Approved Funding Amount: • Budget submitted ☒ • Proposed anticipated project dates: 7/1/25-6/30/29 • Approved anticipated project dates: RFP (Years 2-4) ☒ Sole Source (Year 1) ☒ For the first reviewed recommendation, members of this subcommittee approved this for review at the Finance and Compliance Subcommittee, with the understanding that if this recommendation is approved by the entire OSAC Committee, part of the contracting process would be that Gina Florenzano and her team(SODA) would be sitting down with the agency to create a plan on implementing the money. This group highlighted that we owe it to the public to be able to ensure that we are looking at measurable ways that we are tracking the spending of these funds so that we have real, tangible measurable outcomes. It is also important to note that currently many of these projects are just getting started and are in their infancies, so it is difficult to have those measurable outcomes at this stage, but it will be important as the programs grow. This recommendation has been approved with the caveat that there is a sustainment plan, a staffing plan to address shortages, and measurable outcomes. The second proposal passed with the recommendation of extending it to 18 months. Dr. Muvvala wanted to remind this subcommittee that it's purpose is to make sure that the funding recommendations are evidence-based practices and then look at the outcomes data in the future to make sure that the intention of those funds is being used correctly. The other committees are there to go into the granular details regarding funding and implementation.	
Next steps	Next meeting scheduled for Monday, June 2nd, 2025	Noted

NEXT MEETING – Monday, June 2nd, 2025, 2:00 – 3:00 p.m.
ADJOURNMENT – Monday, April 21st, 2025 at 1:57 p.m.

Meeting of the OSAC Research and Data Subcommittee
Monday, June 2, 2025 2:00 p.m. – 3:00 p.m.
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Lisa Deane, Pareesa Charmichi-Goodwin, Ebony Jackson-Shaheed, Lisa Deane, Maritza Bond
Members absent: Susan Campion, Paul Januszewski
Visitors/Presenters: Luiza Barnat, Sarah Messier-Smith, Melanie Richard, Nita Asani
Recorder: Sarah Messier-Smith

Topic	Discussion	Action
Review Minutes and Approve	To be reviewed in a future meeting	Noted
Discussion	**Discussion of standardized information to be included in proposal drafts:** The subcommittee previously requested updates to the recommendation form to ensure OSAC members get a full but succinct picture of the recommendations for review. Feedback shared by the subcommittee includes the following: • Specific evidence that this would work for overdose abatement • Provide language and evidence of how the particular submission would benefit opioid/overdose abatement • Highlighting importance of data driven decision making • Concise project summary • Budget aligned with Exhibit E/National Settlement Agreement • Clearly identified target population—specific communities that will be served vs impacted • Defined performance indicators • Clarity around statewide outcomes that will be reported and monitored long-term Feedback will be applied, and an updated recommendation template will be shared at a future meeting. **Discussion of data points for recently approved initiatives**: The subcommittee members discussed a data collection plan for OSAC recommendations recently approved. The data collection plan as identified during the meetings is as follows:	Noted

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td></td><td>
<table>
<tr><td>Emergency Department Recovery Coaching</td><td>~# admissions per primary drug of choice
~# referrals by type/level of care (including MOUD)
~readmission rate
~demographics (including town of residence)
~time/day trends of admission
~length of time for RC contact post discharge
~# of follow ups post-discharge</td><td>Every 6 months upon implementation</td></tr>
<tr><td>OTP Access Expansion</td><td>~increased same day MOUD induction for unduplicated individuals by MOUD type (to assess caseload growth)
~increase prescribing staff hired (by FTE)
~DDaP Data
~insurance rates (private vs Medicare/Medicaid vs uninsured)</td><td>Every quarter upon implementation</td></tr>
<tr><td>Recovery Centers (Torrington, Danbury, New London)</td><td>~Referrals to services outside the RC (by type)
~Service utilization during visit (includes individual RC, groups, etc)
~# visits
~# unique participants
~# individuals served using opioids/opioid use history/at risk of OD
~Demographics (including town of residence)
~Referral source into RC</td><td>Every 6 months upon implementation</td></tr>
</table>
Data collection grid will be shared with subcommittee members for opportunity for additional feedback.
</td><td></td></tr>
<tr><td>Next steps</td><td>Next meeting scheduled for June 24, 2024 at 2:00 p.m.</td><td>Noted</td></tr>
</table>

NEXT MEETING – June 24, 2024 at 2:00 p.m.
ADJOURNMENT – June 2, 2025 at 2:57 p.m.

Meeting of the OSAC Research and Data Subcommittee
Tuesday, June 24, 2025 2:00 p.m. – 3:00 p.m.
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Lisa Deane, Pareesa Charmichi-Goodwin, Ebony Jackson-Shaheed, Maritza Bond
Members absent: Susan Campion, Paul Januszewski
Visitors/Presenters: Sarah Messier-Smith, Melanie Richard, Nita Asani
Recorder: Sarah Messier-Smith

Topic	Discussion	Action
Review Minutes and Approve	To be reviewed in a future meeting	Noted
Recommendation Review	The Group reviewed the following OSAC proposals: **Project Title: Expansion of Prevention in CT Fatherhood Initiative** Summary of Request: The Connecticut Fatherhood Initiative, collaborative multi-agency effort led by the Connecticut Department of Social Services (DSS) aims to build capacity within its eight (8) DSS-Certified Fatherhood agencies (Madonna Place in Norwich, New Opportunities in Waterbury, GBAPP in Bridgeport, Career Resources in Bridgeport, St. Joseph's Parenting Center in Stamford, Catholic Charities of Hartford, CRT in Hartford, Family Strides in Torrington). Currently, each agency employs a 0.5 FTE Case Manager; this proposal seeks to employ an additional full-time case manager at each agency, resulting in each agency employing 1.5FTE Case Managers and increasing the annual number served from 330 to 1030 individuals. This expansion also allows the opportunity for agencies to expand in new regions dependent on area need. These case managers will integrate into existing agencies, providing an extensive range of social services to fathers in need, thereby expanding their reach and/or establishing new capacities within diverse communities. Research consistently shows that children with involved fathers have higher chances of success including lower rates of alcohol and substance use and improved performance in school. Fathers, although crucial partners in youth substance use prevention, often remain difficult to reach . By equipping fathers with essential tools and knowledge, we can significantly enhance outcomes for children, including reductions in substance use, food insecurity, poverty, and school-related issues. The fathers engaged with these programs often face substantial challenges including financial instability, not living with their children, involvement with the criminal justice system, systemic discrimination, and are generally young and single parents. The demographics of the current clients served are: 48% African American, 23% Hispanic, and 25% Caucasian. Of these, 50% of all clients were under the age of 33, and 81% were single fathers. In Bridgeport, one program specifically supports fathers under 25, and currently serves 48 young fathers – of which 73% were African American, 23% were Hispanic, with 29 participants under the age of 23, and all were single. This highlights the critical need for comprehensive support services tailored to the unique challenges faced by at-risk fathers, fostering their development into more involved and effective parents. Educating CT's most at-risk demographic (black and Hispanic men aged 30-55) about the dangers of fentanyl, xylazine and fake medications is an evidence-based prevention strategy that is integral to this project. Having access to hundreds of fathers that	Noted

Topic	Discussion	Action
	make up the most at risk group for opioid overdose each year, the case managers are uniquely positioned to impart prevention knowledge and facilitate change in opioid using behaviors. For example, case managers are addressing drug and alcohol use in the 24:7 Dad ® Program (an evidence-based curriculum building parental and personal skills) group meetings and are educating fathers on how to communicate about drug and alcohol use with their children. The case managers increase the protective factors for these men (finding housing, training for and location of jobs, financial support, assistance with communication and relationships) which decreases the likelihood of recidivism, return to drug use, and potential opioid overdose. This is a wholistic strategy for prevention of opioid use by fathers, as it addresses all risk factors in their lives and provides them with the support and resources they need. Training and technical assistance will be provided by the DMHAS Prevention Program Manager (in-kind) and Governor's Prevention Partnership Program staff to ensure case managers can offer substance use prevention and mental health promotion services to resource seeking fathers and their families including drug and alcohol education, suicide prevention, mental wellness, youth communication strategies, and positive coping mechanisms. Case managers will also be provided specific training around opioid education for caregivers and youths, age-appropriate resources, safe storage, and naloxone training. The pilot phase has resulted in: •An Enhanced Intake Process: Changes have been made to intake forms to explore the role of substance use or mental illness in the fathers' lives with the goal of improving access to quality services available to fathers and families. •Increased referrals: Case managers have significantly increased referrals to mental health/substance use treatment for fathers, which can have significant impact on the lives of the fathers and children, if followed through. "Paternal substance abuse is associated with a father's guilt and shame about has failure to fulfill his parental societal role. These feelings, coupled with substance abuse and societal norms, may cause fathers to avoid involvement with their children, creating a family with an absent father." •Substance Use Awareness: A forum has been created for teen fathers to discuss their own substance use and the full effects. •Parental Accountability: Fathers of all ages have been given the opportunity to reflect upon their substance use choices, take accountability, and learn how that translates to their children's decisions. •Effective Communication: Participants learn that they plan a crucial role in discussing mental health and substance use with their children. •Family Engagement Events: Events have emphasized the importance of open communication within families. •Suicide and Naloxone Training: Agency staff and fathers have received training on suicide prevention and naloxone administration and free naloxone kits. •Safe Storage Solutions: Lock boxes and lock pouches have been provided for safe storage of substances or medications at home, reducing the risk of children accessing harmful substances. Evaluation will be completed by CPES (Center for Prevention Evaluation and Statistics through UCONN Health). The expected evaluation will focus on the transfer of information from DMHAS/DSS to case managers, from case manager to father, and then from father to child. Surveying and interviewing case managers and fathers helps to understand how knowledge is being put into action to prevent substance use and to prevent overdose fatalities. The number of individuals trained in Naloxone administration will be tracked will include report of use of Naloxone; connection of people who use opioids to treatment/medication will also be tracked. Additionally, the Evaluator will conduct focus groups, surveys and interviews.	

Topic	Discussion	Action

Description	Year 1	Year 2	Year 3	Total
Case Managers x 8 sites (includes salary, fringe, 2.5% increase for Y2 & Y3)	$708,000	$725,700	$743,843	$2,177,543
Training ($3,000 per site) + **Supplies/Marketing** ($3,200 per site) x 8 sites	$49,600	$49,600	$49,600	$148,800
Training + Technical Assistance by Governor's Prevention Partnership (staff salary and fringe)	$30,000	$30,000	$30,000	$90,000
Evaluation (UConn)	$75,000	$75,000	$75,000	$225,000
Total Cost	$862,600	$880,300	$898,443	$2,641,343

CORE Priority: Priority 2, Strategy 1, Tactics 1 (Fund initiatives that directly distribute naloxone to high-risk individuals or people around them including families, friends, and caregivers), 3 (Fund outreach, education, and harm reduction service linkage efforts targeting people who are inadvertently exposed to illicit fentanyl when seeking other substances), & 4 (Fund initiatives that provide community-tailored, culturally responsive, socially and racially concordant initiatives to increase access to and use of harm reduction services in populations at high risk of overdose who are currently accessing harm reduction services at lower rates); Priority 5, Strategy 2 (Expand access to programs that address social determinants of health and community mental health to decrease opioid initiation and progression to OUD

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

Recommendation was reviewed by the Research and Data Subcommittee on 6/24/25 and was not approved to move forward. Primary sited concern is inability to gauge potential impact is unclear given lack of opioid/substance use data regarding participants and participant outcomes is not available.

Additional information requested/concerns:
• Inability to gauge potential impact is unclear given lack of opioid/substance use data regarding participants and participant outcomes is not available
• Gather info on # of individuals with opioid use (past or present) and general substance use or SUD risk factors to help

Topic	Discussion	Action
	assess opioid use/OD risk **• Outcomes of individuals with opioid use/substance use/significant risk factors** **• Want more info on generational impact/generational goals** **• More granular detail on how this will prevent opioid deaths** **• Streamlined list of opioid use related interventions including connections to OUD tx and Harm Reduction** **• Is there data to support the proposed program is relevant to OUD abatement?** **• Recommendation: collect data for 3-6m (or amount of time to determine SU/opioid use trends) and resubmit recommendation** **Project Title: Statewide Opioid Prevention Support to Local Prevention Councils (LPCs) and Prevention Workforce Development** Key components: •Evidence-based Prevention •Community-based learning opportunities •Prevention Workforce Development •Enhanced capacity and relationships among community providers/partners •Replicable model •Project milestones and annual evaluations Summary of Request: This proposal is for funding dedicated to hiring and training five Opioid Prevention Specialists, one each per Regional Behavioral Health Action Organization, to support each of the 121 Local Prevention Councils (LPC) by conducting town level opioid prevention needs analysis, identifying resources and building coalition capacity, leading the development of LPC strategic plan and sustainability plans, increasing outreach to community partners, and coordinating opioid prevention efforts in the specific communities. The three initial outcomes of this initiative will be: 1. Opioid Prevention: An increase in evidence-based prevention programs through community organizations (LPCs) across the state. 2. Capacity Building and Sustainability: Local Prevention Councils that experience stable leadership, continued growth and improved services. 3. Workforce Development: Increase in Certified Prevention Specialists The CT Prevention Network (CPN) is made up of five (5) RBHAOs covering all 169 municipalities across CT. Part of their role with CT DMHAS is to administer contracts for 121 Local Prevention Councils (LPC). LPC funding comes from the federal block grant, and the municipal amounts are determined by CT DMHAS based on population size. Funding amounts range from $2265.16 to $10,356.82 annually. LPC funding is used to support grassroots initiatives determined by assessing local needs and existing resources. LPCs are mostly volunteer led and vary in capacity. A few of the LPCs have hired part-time or full-time staff with financial support from federal or foundation grants, municipal dollars and, less frequently, private donations. The majority of the LPCs subsist entirely on annually allocated LPC funds. Currently, only 15% of LPC funding can be used for	

Topic	Discussion	Action

administrative support, which is insufficient to hire a full or half-time person. Opioid Prevention Specialists at each of the LPCs would improve long-term planning and sustainability, while simultaneously increasing the number of Prevention Professionals in our state. Given the nature of small, volunteer organizations, long-term planning and steady leadership have been persistent challenges for many of the LPCs. Each of the 5 RBHAOs have identified a need for consistent and direct support for the leadership and membership of the 121 LPCs.

The RBHAOs propose that OSAC funds be dedicated to hiring five Opioid Prevention Specialists (OPS), 1 in each RBHAO/DMHAS Region. The OPS will be a resident in the region, adding local lived experience and equity to the process. CPN would train the OPSs in evidence-based prevention practices and coalition capacity building. The RBHAOs will also prepare each OPS for becoming Certified Prevention Specialists through the CT Certification Board (CCB). Their time would be focused entirely on the support, training, and enhancement of the LPCs. OPSs will be responsible for building the capacity of each LPC's by providing primary prevention focused programs and trainings across the lifespan including Life Skills Training, SBIRT and A-SBIRT, Youth Mental Health First Aid, and Teen Mental Health First Aid. The Opioid Prevention Specialists will coordinate regional and statewide prevention learning communities, assist in building relationships with other organizations, and assist in increasing LPC membership and sector representation, among other responsibilities.

This initiative would have statewide impact by reducing risks related to opioid and other substance misuse. By increasing awareness, providing education/skill building, reducing access, peer normative messaging, and changing policies LPCs can have a meaningful impact on opioid abatement when they are high functioning coalitions. LPCs need dedicated staff who will provide guidance and institute the use of proven effective prevention strategies. This proposal is inclusive of the design of an innovative curriculum by the RBHAOs to include consistent skills for the OPS to follow similar steps statewide and a planning guide for the LPCs; this would address local concerns and can be easily replicated.

Baseline information about the LPC's structure and functioning will be collected at the project onset. By the end of year one the OPSs will assist as LPCs draft mission statements, complete internal assessments, and develop comprehensive 3–5-year plans. Markers of progress at each LPC include completion of LPC coalition self- assessment, completion of sector agreements, training in the Strategic Prevention Framework (SPF), and LPC completion of the steps involved in the SPF. Process measures will track LPC progress. Local needs assessments will provide baseline data that will be used to mark trends, behavior change, and consequences of opioid use over the term of the contract. The evaluator will report both process and outcome measures in an annual report.

Markers of progress for the OPS include leading the LPC through all steps of the SPF including: conducting a local needs assessment, coalition capacity building, planning, implementation of evidence-based opioid prevention programs, and evaluation. Progress towards certification with CCB will be monitored by training hours. Additionally, Opioid Prevention Specialists will act as a liaison with town officials by sharing data and identifying areas where municipal opioid settlement funds might be strategically applied.

	Year 1 Cost	Year 2 Cost	Year 3 Cost	Year 4 Cost	Year 5 Cost	Total Cost
5 Prevention Coordinator positions including Fringe	500,000	515,000	530,450	546,363	562,753	2,654,566

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td></td><td>
<table>
<tr><td>Training of Trainers</td><td>25,000</td><td>25,000</td><td>25,000</td><td>10,000</td><td>10,000</td><td>95,000</td></tr>
<tr><td>Annual Program Evaluation: 10hours/month x 12months x $50/ hour</td><td>6,000</td><td>6,000</td><td>6,000</td><td>6,000</td><td>6,000</td><td>30,000</td></tr>
<tr><td>Administrative costs 15%</td><td>79,650</td><td>81,900</td><td>84,218</td><td>84,354</td><td>86,813</td><td>416,935</td></tr>
<tr><td>Total</td><td>610,650</td><td>627,900</td><td>645,668</td><td>646,717</td><td>665,566</td><td>3,196,501</td></tr>
</table>

CORE Priority: CORE Priority #5: Primary Prevention.
Category: ☐ treatment ☐ harm reduction ☒ prevention ☐ recovery supports

Recommendation was reviewed by the Research and Data Subcommittee on 6/24/25 and was not approved to move forward. Primary sited concern is more information is required regarding activities that are likely to impact opioid abatement. Currently, the only EBP for OUD included is Life Skills Training. Additional requested information/concerns include:
• How are these positions different than other prevention staff at RBHAOs (other than these staff would be specifically focused on engaging the LPCs)
• Tying the interventions to CORE report
• Sustainability concerns
• More opioid response centered—more clarification on trainings/tactics/strategies specific to OUD
• SBIRT listed but not evidence based for Opioid Use—what's the supporting evidence for this intervention?
• Seeking more info about the new activities the LPCs will being doing the community
• Include education goals to focus on MOUD, naloxone, Harm Reduction—current trainings listed are not OUD related other than Life Skills
• What's the evidence that coalition building is an effective form of opioid abatement?
</td><td></td></tr>
<tr><td>Additional Discussion</td><td>Discussion of standardized information to be included in proposal drafts: The updated form was shared ahead of the meeting and reviewed for additional feedback. No modifications were offered during the meeting, though members requested to provide additional feedback via email if needed.

Discussion of data points for recently approved initiatives: The subcommittee members discussed a data collection plan for OSAC recommendations recently approved. The data collection plan as identified during the meetings is as follows:
<table>
<tr><td>Emergency Department Recovery Coaching</td><td>~# admissions per primary drug of choice
~# referrals by type/level of care (including MOUD)
~readmission rate
~demographics (including town of residence)
~time/day trends of admission
~length of time for RC contact post discharge
~# of follow ups post-discharge
~previous overdose history (lifetime)</td><td>Every 6 months upon implementation</td></tr>
</table>
</td><td></td></tr>
</table>

Topic	Discussion			Action
	OTP Access Expansion	~increased same day MOUD induction for unduplicated individuals by MOUD type (to assess caseload growth) ~increase prescribing staff hired (by FTE) ~DDaP Data ~insurance rates (private vs Medicare/Medicaid vs uninsured)	Every quarter upon implementation	
	Recovery Centers (Torrington, Danbury, New London)	~Referrals to services outside the RC (by type + outcome of connection) ~Service utilization during visit (includes individual RC, groups, etc) ~# visits ~# unique participants ~# individuals served using opioids/opioid use history/at risk of OD ~Demographics (including town of residence) ~Referral source into RC	Every 6 months upon implementation	
Next steps	Next meeting will be scheduled after the July 7, 2025 full OSAC meeting.			Noted

NEXT MEETING – Next meeting will be scheduled after the July 7, 2025 full OSAC meeting.
ADJOURNMENT – June 24, 2025 at 3:00 p.m.

Meeting of the OSAC Research and Data Subcommittee
Friday, December 5, 2025 1:00 p.m. – 2:00 p.m.
Microsoft Teams
Virtual meeting

ATTENDANCE

Members present: Srinivas Muvvala, Ebony Jackson-Shaheed, Maritza Bond, Susan Campion, Gretchen Shugarts
Members absent: Paul Januszewski, Pareesa Charmichi-Goodwin
Visitors/Presenters: Sarah Messier-Smith, Luiza Barnat
Recorder: Sarah Messier-Smith

Topic	Discussion	Action
Review Minutes and Approve	The following minutes were reviewed and approved: 1/27+2/10/25: first by Maritza Bond, second by Ebony Jackson-Shaheed; Susan Campion abstains. 2/21/25: First by Gretchen Shugarts, second by Ebony Jackson-Shaheed 4/21/25: First by Gretchen Shugarts, second by Susan Campion 6/2/25: First by Ebony Jackson-Shaheed, second by Srinivas Muvvala 6/24/25: First by Srinivas Muvvala, second by Maritza Bond; Susan Campion and Gretchen Shugarts abstain.	Noted
Discussion of Approved Recommendation Data Collection	Subcommittee members discussed a data collection plan for OSAC recommendations that were recently approved. The data collection plan as identified during the meetings is as follows: **CT-DDC:** Anticipated Data Points: • Summary of activities conducted (including number of drug checking results obtained and entered into database) • Updates on progress on steps toward implementing the project implementation plan (including database and dashboard creation, entering/uploading data, community notifications of information availability) • Dashboard Engagement Statistics • Impact of the project in bridging data gaps including communication on project effectiveness Anticipated Reporting Dates: • Every 6 months upon contract execution **MDFT HYPE:** Anticipated Data Points: • Number of individuals served by the MDFT for OUD teams • Substance use disorder(s) for individuals served • Number of individuals discharged o Clients that received OUD protocol o Clients that received MAT o Clients that received RMS	Noted

Topic	Discussion	Action

	• Treatment outcomes at discharge
	  o Discharge type and reason for discharge (completed or did not complete and reason for non-completers)
	• Substance use reduction data
	  o Use GAIN data including substance use severity and intensity
	• Client demographics
	  o Age, race, gender
	• Log of prosocial and incentive recovery activity
	  o Amount per client (average per person, total incentives dispersed)
	  o Funding usage
	Anticipated Reporting Dates:
	• Quarterly upon contract execution	

Review of Opioid Settlement Advisory Committee Project Data Collection And Outcome Report	Sarah provided a brief overview of the report. No concerns or edits were noted during the meeting.	Noted
Next steps	Next meeting will be scheduled after the January 13, 2026 full OSAC meeting.	Noted

NEXT MEETING – Next meeting will be scheduled after the January 13, 2026 full OSAC meeting.
ADJOURNMENT – December 5, 2025 at 2:01pm