CORPORATE OFFICE
P.O. Box 967
Duncansville, PA 16635
P: 814-940-0407
F: 888-218-8253
pyramidhc.com

October 31, 2022

DELIVERED VIA ONLINE PORTAL: https://www.nj.gov/opioidfunds/

Opioid Recovery and Remediation Advisory Council
New Jersey Department of Human Services
PO Box 001
Trenton, NJ 08625

RE: Opioid Settlement Fund Feedback Regarding Increased Medicaid Reimbursement Rates for Substance Use Disorder Treatment Services for Adults in Residential and Outpatient Settings

Dear Members of the Opioid Recovery and Remediation Advisory Council:

The Pyramid Healthcare, Inc. ("Pyramid Healthcare") family of companies is providing information and feedback below regarding the State of New Jersey's request for recommendations[1] as to how to distribute over $300 million in Opioid Settlement Funds over the course of the next 18 years through the Opioid Recovery and Remediation Advisory Council pursuant to Executive Order 305.[2]

We urge the Council dedicate a significant portion of the State's Opioid Settlement Fund allocation toward invest in a robust behavioral health provider infrastructure through increased reimbursement rates to be distributed by the Department of Human Services ("DHS"). In order to properly address the effects of the opioid epidemic and to get those affected by substance use disorders, more aggressive action needs to be taken to ensure a provider network that is able to administer the full continuum of care across the behavioral healthcare spectrum. The Council should address years of chronic underfunding in the mental health and substance use system and take meaningful, impactful steps toward building a provider network sufficient to address the opioid epidemic in New Jersey through increased Medicaid reimbursement rates for residential and outpatient treatment services.

In New Jersey, Pyramid Healthcare operates seven commercial outpatient treatment facilities as High Focus Centers in addition to our Medicaid residential treatment facility in Hammonton. In 2021 we served 7,500 New Jersey residents across 140,000 behavioral health treatment visits. Our Hammonton location has been serving New Jerseyans since 2018 and has a total 194 residential treatment beds (including inpatient withdrawal management, short-term residential, and long-term residential beds), which served over 1,750 unique clients in 2021.

---

[1] https://www.nj.gov/opioidfunds/.
[2] Executive Order 305, Governor Philip D. Murphy (Aug. 31, 2022), *available at* https://nj.gov/infobank/eo/056murphy/pdf/EO-305.pdf.

We admit approximately 240 clients per month at this facility, but are forced to turn away approximately 650 clients per month because of insufficient staffing levels and thus having no beds available. Having to turn away clients in need of services because we cannot hire appropriate staff is a direct result of the current Medicaid reimbursement rates being insufficient to compensate our clinical and administrative staff at levels commensurate with their expectations.

Only a serious and sustained investment in funding for substance use services will allow a more comprehensive continuum of care across outpatient and residential treatment services.

There is a tremendous demand for high quality detox/rehabilitation services and not enough available bed capacity in the system. Securing adequate nursing staff has always been a challenge in the behavioral health field, particularly in programs that primarily serve Medicaid clients, but this challenge has become insurmountable due to the COVID-19 pandemic, increase inflation raising the cost of goods and services for mental health and substance use providers, and the unprecedented changes in the labor market over the past several years that is leading healthcare professionals to go to the highest paid opportunities or even leaving the healthcare field entirely due to higher compensation or general burnout and fatigue. State Medicaid fee-for-service (FFS) schedule reimbursement rates should be increased to allow providers to pay more competitive wages to our staff in order to be able to provide the capacity the state so desperately needs. Providers need to remain competitive in order to assure adequate, qualified staffing and to administer high-quality care.

Currently, New Jersey Medicaid reimbursement rates for 3.7 (short-term residential) and 3.5 (long-term residential) are well below market comparisons. Pyramid Healthcare operates residential detox/rehabilitation programs with Medicaid contracts in five (5) states. The current rates for these services in New Jersey are approximately 35% lower than these other markets. In addition, New Jersey costs for major expense categories such as professional staff and insurance coverage is approximately 10% higher than surrounding states and markets. New Jersey Medicaid reimbursement rates for residential services have remained essentially unchanged for years while surrounding states are enacting substantive increases. For example, Pennsylvania over the past year has raised their overall rates approximately 15% and Maryland is in the process of adopting approximately 7.25% rate increases. Uncompetitive reimbursement rates do not empower providers to recruit, retain, and engage appropriate staffing to serve our patients and force us to turn away patients in need of care.

These services are not sustainable at the current reimbursement rates. This problem is getting worse as the cost to attract and retain staff, such as registered nurses, continues to rise without any commensurate increases in payment rates. These factors, combined with inflation, effectually result in annual rate decreases to providers. This is particularly important for the 3.5 (long-term) level of care where there is an extreme shortage of beds due to the extremely low existing reimbursement rate of approximately $162 per day. Continued high readmission rates to detox services, inpatient psychiatric hospitalizations, and high rates of emergency room utilization will occur without the proper access to long-term residential services for those in need of substance use disorder treatment.

Specifically, we propose the following actions:

- The adoption of immediate 35% reimbursement rate increases for residential and outpatient substance use treatment services.
- Passage of Annual COLAs for residential and outpatient substance use treatment provider reimbursement rates.
- Mandating DHS to conduct a rate study for residential and outpatient treatment providers.

Immediate 35% Reimbursement Rate Increase

See attached for Pyramid Healthcare's recommendations for Medicaid reimbursement rate increases for residential and outpatient substance use treatment services for adults. Specifically, we recommend the following immediate reimbursement rate changes to reflect a 35% rate increase:

Service Name	Bill Code	Current Rate (SFY2023)	SFY2024 Rate (35% increase)
Intensive Outpatient	H0015 HF	$103.46	$139.67
Partial Care	H2036 HF	$74.00	$99.90
Halfway House	H2034 HF	$94.05	$126.97
Long Term Residential – Base Rate	H0026 HF	$130.00	$175.50
Short Term Residential	H0018 HF	$231.53	$312.57
Inpatient Withdrawal Management	H0010 HF	$449.69	$607.08

Establish Annual Cost-of-Living Adjustment based on the Consumer Price Index for Programs Providing Mental Health, Substance Use Treatment, or Services to Persons with Developmental Disabilities. [3]

We furthermore urge the adoption of language mandating annual cost-of-living (COLA) adjustments for residential and outpatient substance use treatment services. Specifically, we propose the adoption of the following language through an appropriate legislative vehicle:

> 1. a. Notwithstanding any other provision of law to the contrary, the terms of a contract entered into between the Divisions of Mental Health and Addiction Services and Developmental Disabilities in the Department of Human Services and a program providing mental health services, substance use treatment services, or services to persons with developmental disabilities on or after the effective date of this act shall include an annual increase in the cost of living adjustment received by the organization. The cost of living adjustment shall be based on the Consumer Price Index for the previous 12-month period beginning October 1 and ending September 30, as published by the United States Department of Labor.
>
> b. On October 1 of each year, the department shall announce the rate of the increase in the cost of living adjustment received by a program providing mental health services, substance use treatment services, or services to persons with developmental disabilities pursuant to subsection a. of this section.
>
> c. As used in this section, a program providing mental health services, substance use treatment services, or services to persons with developmental disabilities shall include State programs

[3] A508, "Establishes annual cost of living adjustment based on Consumer Price Index for programs providing mental health, substance use treatment, or services to persons with developmental disabilities", 220th New Jersey Legislature (2022), *available at* https://pub.njleg.state.nj.us/Bills/2022/A1000/508_I1.PDF.

partially funded or fully funded by Medicaid and licensed or approved by the Commissioner of Human Services or other appropriate State licensing entities.

2. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

3. This act shall take effect immediately.

Require DHS to Conduct a Study of Residential and Outpatient Substance Use Disorder Treatment Availability Provided Under Medicaid

For the state to better understand the competitive market for various caregiving positions across the behavioral healthcare spectrum as well as where New Jersey falls in relation to other states with regard to its substance use treatment provider network, the State should require DHS to conduct a rate study for residential and outpatient treatment providers:[4]

1. a. Within six months of the effective date of this act, the Commissioner of Human Services shall contract with a third party entity to conduct a study of the impact of State Medicaid policies on the adequacy of the number and type of residential and outpatient substance use disorder treatment resources, unmet treatment demand, and the quality of patient outcomes at such treatment facilities. For the purposes of this section, “residential and outpatient substance use disorder treatment” includes the following services: residential detoxification, short-term residential substance use disorder treatment; long-term residential substance use disorder treatment; partial hospitalization substance use disorder treatment programs; and intensive outpatient substance use disorder treatment.

b. The study, at a minimum, shall:

(1) compare national averages and federal recommendations for patient length of stay at residential and outpatient substance use disorder treatment facilities with State data;

(2) assess whether existing State Medicaid policies regarding patient length of stay at residential and outpatient substance use disorder treatment facilities sufficiently allows for: providers to implement treatment plans; patients to make sufficient and measureable progress toward treatment goals; and the achievement of measurably successful treatment outcomes. This analysis shall include but not be limited to a study of the impact of the suspension of prior and continuing authorization requirements, pursuant to Medicaid Alert 2020-04, as a result of the coronavirus disease 2019 (COVID-19) public health emergency, on substance use disorder treatment services and patient outcomes;

(3) establish a means to receive input from providers that deliver residential and outpatient treatment to recipients of Medicaid, in addition to other stakeholders including people in recovery; and (4) estimate the annual costs, disaggregated by level of care, of permanently eliminating the

---

[4] A5159, “Requires DHS to conduct study of residential and outpatient substance use disorder treatment availability provided under Medicaid, and to temporarily suspend Medicaid prior and continuing authorization requirements for short-term residential substance use disorder treatment”, 219th New Jersey Legislature (2020), *available at* https://pub.njleg.state.nj.us/Bills/2020/A9999/5159_I1.PDF.

prior and continuing stay authorization requirements for all levels of residential and outpatient substance use disorder treatment. The annual cost estimate for each level of care shall indicate the amount attributed to those patients who voluntarily enter treatment and to those patients who are court ordered to enter treatment.

c. The contracted third party entity shall have the authority to require providers to submit cost reports, provider surveys, and other materials and data in order to complete the study pursuant to this section.

d. The Commissioner of Human Services shall report the findings and conclusions of the study, as submitted to the commissioner by the contracted third party entity, as well as any recommendations for legislation to improve the quality of care and patient outcomes provided at, and the number and type of, residential and outpatient substance use disorder treatment providers in the State, to the Legislature within six months of contracting with a third party entity to conduct the study. The report shall also include any policy changes the commissioner intends to implement, without the need for legislative action, subsequent to the findings of the study.

e. As used in this section: “Medicaid" means the program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

2. This act shall take effect immediately. Section 1 shall expire upon the submission of the study’s finding to the Legislature pursuant to subsection d. of that section.

Please make significant investments in Medicaid residential and outpatient treatment rates to ensure a robust network of providers across the full continuum of care for Medicaid substance use treatment and recovery services. Thank you for your support of mental health, behavioral health, and substance use providers in New Jersey and for considering my requests on behalf of Pyramid Healthcare. If we can provide any additional information or materials, please contact me at crosier@pyramidhc.com or 667-270-1582. In addition, we invite you to reach out and schedule a visit to our Hammonton facility or one of our High Focus Center (HFC) locations sometime soon.

Sincerely,

Collan B. Rosier
Vice President of Government Relations

Dominic J. Barone, LSW, LCADC, CCS, CPRS
Vice President of Operations (NJ/MD Residential)

Dear Governor Murphy and Esteemed Members of the Opioid Recovery and Remediation Advisory Council,

Thank you for opening this portal for the crucial public input needed for the best ways to utilize the money NJ receives from opioid settlements. I have been meeting for several weeks with a group of citizens with lived experience of addiction and recovery, comprised of family members, allies, and people that identify as in recovery, as well as people who use drugs. We all work closely with people that use substances, people in recovery, and the families affected by it, and we are the experts in identifying gaps in the current NJ system because we live it, and assist others with it, every day.

We agreed on many points. Transportation for those seeking assistance is practically non-existent. Safe, inclusive, affordable recovery housing, especially for marginalized populations (minorities, non-English speaking, LGBTQIA+, etc,), needs to be implemented and expanded in all areas across the state. Medications for Opioid Use Disorder need to be easily accessible, affordable, and normalized. However, we decided that all issues and gaps that we discussed could not be adequately addressed without an official oversight and accountability entity that could look at the whole continuum of Substance Use Services in NJ. Therefore, we propose a New Jersey Office of Recovery that could examine, advise, and coordinate the many sectors involved in addressing substance use in our state.

Because addiction is multifaceted, the approach must be as well. NJ has programs that address SUD in many different agencies: DHS (DMHAS), DOH, OAG, DCPP, DCF, DCA, DOJ, DCJ, etc. These agencies are often unaware of each other's programming and efforts, leading to duplicate services or to "reinventing the wheel." Collaboration among the divisions is rare, frequently leads to ineffective services and gaps, and sometimes to losing the very people that they are intended to serve. The bureaucracy within and among agencies often leads to a stalemate for front line workers, who are looking to assist people in an incredibly time sensitive manner.

The Office of Recovery should be led by an individual that has personal lived experience with addiction (self or family) as well as experience working in the professional field. They should not be required to have higher degrees and only clinical experience; instead, this person should have a thorough knowledge of how the different systems that address SUD in NJ work and an understanding of the importance of grassroots input in reimagining the continuum of care. This office should accept and investigate complaints regarding SUD care, and have the ability to impose restrictions on entities that are non-compliant with best practice directives and rules. The Director of this office should report directly to the Governor, independent of any other government office, in order to have standing among all divisions. There should be enough staff

members (minimum 4) to assist this Director with the momentous task of surveying, evaluating, and re-creating a recovery oriented system of care in New Jersey that treats addiction as the public health crisis that it is, instead of approaching people with SUD as criminals in need of punishment. The budget for this program should be $1.25 million per year for 10 years.

As NJ implements more harm reduction services, it must also look at how harm reduction hostile its current programs and systems are. An office dedicated to overseeing and transforming the continuum of substance use services and care could make this happen in all programs, in all divisions, and assist NJ in its efforts to become a leader for compassionate and effective care in the SUD field. With all of the innovations NJ has begun and will continue to imagine over the years of settlement funding, it is imperative that the oversight and structure be put in place to guarantee that the monies will be put to best use throughout the divisions. Accountability and transparency are paramount in implementing a more effective system of care to save the lives of more NJ citizens.

9 New Jerseyans die each day from drug related deaths. That's 9 families devastated and left to pick up the pieces EVERY DAY. It's time to do something different.

Thank you,

Heather Ell

Member of "Advocate to Allocate"

Dear Governor Murphy and Esteemed Members of the Opioid Recovery and Remediation Advisory Council,

Thank you for opening this portal for the crucial public input needed for the best ways to utilize the money NJ receives from opioid settlements. I have been meeting for several weeks with a group of citizens with lived experience of addiction and recovery, comprised of family members, allies, and people that identify as in recovery, as well as people who use drugs. We all work closely with people that use substances, people in recovery, and the families affected by it, and we are the experts in identifying gaps in the current NJ system because we live it, and assist others with it, every day.

We agreed on many points. Transportation for those seeking assistance is practically non-existent. Safe, inclusive, affordable recovery housing, especially for marginalized populations (minorities, non-English speaking, LGBTQIA+, etc,), needs to be implemented and expanded in all areas across the state. Medications for Opioid Use Disorder need to be easily accessible, affordable, and normalized. However, we decided that all issues and gaps that we discussed could not be adequately addressed without an official oversight and accountability entity that could look at the whole continuum of Substance Use Services in NJ. Therefore, we propose a New Jersey Office of Recovery that could examine, advise, and coordinate the many sectors involved in addressing substance use in our state.

Because addiction is multifaceted, the approach must be as well. NJ has programs that address SUD in many different agencies: DHS (DMHAS), DOH, OAG, DCPP, DCF, DCA, DOJ, DCJ, etc. These agencies are often unaware of each other's programming and efforts, leading to duplicate services or to "reinventing the wheel." Collaboration among the divisions is rare, frequently leads to ineffective services and gaps, and sometimes to losing the very people that they are intended to serve. The bureaucracy within and among agencies often leads to a stalemate for front line workers, who are looking to assist people in an incredibly time sensitive manner.

The Office of Recovery should be led by an individual that has personal lived experience with addiction (self or family) as well as experience working in the professional field. They should not be required to have higher degrees and only clinical experience; instead, this person should have a thorough knowledge of how the different systems that address SUD in NJ work and an understanding of the importance of grassroots input in reimagining the continuum of care. This office should accept and investigate complaints regarding SUD care, and have the ability to impose restrictions on entities that are non-compliant with best practice directives and rules. The Director of this office should report directly to the Governor, independent of any other government office, in order to have standing among all divisions. There should be enough staff

members (minimum 4) to assist this Director with the momentous task of surveying, evaluating, and re-creating a recovery oriented system of care in New Jersey that treats addiction as the public health crisis that it is, instead of approaching people with SUD as criminals in need of punishment. The budget for this program should be $1.25 million per year for 10 years.

As NJ implements more harm reduction services, it must also look at how harm reduction hostile its current programs and systems are. An office dedicated to overseeing and transforming the continuum of substance use services and care could make this happen in all programs, in all divisions, and assist NJ in its efforts to become a leader for compassionate and effective care in the SUD field. With all of the innovations NJ has begun and will continue to imagine over the years of settlement funding, it is imperative that the oversight and structure be put in place to guarantee that the monies will be put to best use throughout the divisions. Accountability and transparency are paramount in implementing a more effective system of care to save the lives of more NJ citizens.

9 New Jerseyans die each day from drug related deaths. That's 9 families devastated and left to pick up the pieces EVERY DAY. It's time to do something different.

Thank you,

Rich Alexander

Member of "Advocate to Allocate"

Dear Governor Murphy and Esteemed Members of the Opioid Recovery and Remediation Advisory Council,

Thank you for opening this portal for the crucial public input needed for the best ways to utilize the money NJ receives from opioid settlements. I have been meeting for several weeks with a group of citizens with lived experience of addiction and recovery, comprised of family members, allies, and people that identify as in recovery, as well as people who use drugs. We all work closely with people that use substances, people in recovery, and the families affected by it, and we are the experts in identifying gaps in the current NJ system because we live it, and assist others with it, every day.

We agreed on many points. Transportation for those seeking assistance is practically non-existent. Safe, inclusive, affordable recovery housing, especially for marginalized populations (minorities, non-English speaking, LGBTQIA+, etc,), needs to be implemented and expanded in all areas across the state. Medications for Opioid Use Disorder need to be easily accessible, affordable, and normalized. However, we decided that all issues and gaps that we discussed could not be adequately addressed without an official oversight and accountability entity that could look at the whole continuum of Substance Use Services in NJ. Therefore, we propose a New Jersey Office of Recovery that could examine, advise, and coordinate the many sectors involved in addressing substance use in our state.

Because addiction is multifaceted, the approach must be as well. NJ has programs that address SUD in many different agencies: DHS (DMHAS), DOH, OAG, DCPP, DCF, DCA, DOJ, DCJ, etc. These agencies are often unaware of each other's programming and efforts, leading to duplicate services or to "reinventing the wheel." Collaboration among the divisions is rare, frequently leads to ineffective services and gaps, and sometimes to losing the very people that they are intended to serve. The bureaucracy within and among agencies often leads to a stalemate for front line workers, who are looking to assist people in an incredibly time sensitive manner.

The Office of Recovery should be led by an individual that has personal lived experience with addiction (self or family) as well as experience working in the professional field. They should not be required to have higher degrees and only clinical experience; instead, this person should have a thorough knowledge of how the different systems that address SUD in NJ work and an understanding of the importance of grassroots input in reimagining the continuum of care. This office should accept and investigate complaints regarding SUD care, and have the ability to impose restrictions on entities that are non-compliant with best practice directives and rules. The Director of this office should report directly to the Governor, independent of any other government office, in order to have standing among all divisions. There should be enough staff

members (minimum 4) to assist this Director with the momentous task of surveying, evaluating, and re-creating a recovery oriented system of care in New Jersey that treats addiction as the public health crisis that it is, instead of approaching people with SUD as criminals in need of punishment. The budget for this program should be $1.25 million per year for 10 years.

As NJ implements more harm reduction services, it must also look at how harm reduction hostile its current programs and systems are. An office dedicated to overseeing and transforming the continuum of substance use services and care could make this happen in all programs, in all divisions, and assist NJ in its efforts to become a leader for compassionate and effective care in the SUD field. With all of the innovations NJ has begun and will continue to imagine over the years of settlement funding, it is imperative that the oversight and structure be put in place to guarantee that the monies will be put to best use throughout the divisions. Accountability and transparency are paramount in implementing a more effective system of care to save the lives of more NJ citizens.

9 New Jerseyans die each day from drug related deaths. That's 9 families devastated and left to pick up the pieces EVERY DAY. It's time to do something different.

Thank you,

Andora Hightower

Member of "Advocate to Allocate"

2023, 2024 - 2027 EVIDENCE-BASED PROGRAMS

Answer the following questions for each evidence-based program you would like to be considered for funding with the County's state funding allocation for substance use prevention, early intervention, treatment and recovery support services.

Agency Name: Alumni in Recovery, a NJ Nonprofit Corporation 501c(3)

Program Name: Expansion of Bergen County Programs

Description: Alumni in Recovery ("AinR™") provides a safe and reliable program to heighten local communities' awareness, hope, and resources. We aim to end the stigma of addiction and Substance Use Disorder by sharing our stories with middle and high school students, parents, and communities. We assist people in identifying and finding language skills to talk in open forums by listening to our members, who are local to the areas they volunteer, share their personal experiences with addiction, start a conversation, and connect within their communities through shared experiences.

SCHOOL PROGRAMS: AinR™ offers free speaking presentations in schools. AinR™ members speak about relatable emotional developmental challenges they had experienced and make them highly relational. The parental feedback we have received is that their children talk after AinR™ presentations, which helps open up family communications. By having these presentations in schools through local people, we begin to remove barriers and destigmatize perceptions about addiction.

OUR COMMUNITY PROGRAMS: AinR™ Community-Based Events bring people in communities together connecting in solution-based informative discussions, beginning with our members' stories. Establishing community engagements both live and virtual, for people everywhere to attend and get into action is crucial to turning the tide on the epidemic and addressing addiction. Relationship and community building are key and require all of us to be well-informed and connected. We have opportunities for people to have a way of being involved in our mission through volunteerism.

Bringing Unity to the Community: Our town and school-based events help all people of all socioeconomic backgrounds navigate the addiction landscape and find ways to help the community work together to overcome the throes of addiction and help each other in the process. To have both the recovery community and the grieving community working together with the community they serve is imperative to create connections and remove barriers. We held our second successful *WALK TO REMEMBER: Addiction Awareness and Recovery* event in Westwood in April of 2022. The Walk encourages community collaboration and the opportunity to engage in solutions. The disease of addiction does not discriminate, and we can help our friends and neighbors on a local all-inclusive level by engaging people everywhere. The *Walk* event included many elaborate and educational elaborate displays including our partner organization, The Black Poster Project. Over 700 people from all over the County attended this event.

Community-Building Partnerships: Within Bergen County, Alumni in Recovery has established working relationships with law enforcement agencies, county and town leaders, alliances and stigma-free committees, and multiple treatment and prevention resources such as Bergen New Bridge Medical Center. AinR™ CEO Nancy Labov received a Meritorious Service Award from the Bergen County Prosecutor's Office for Community Partnership, for 2021.

Pizza Positivity Project: An opportunity schools and police departments to work together. Police buy pizza and students write notes of inspiration (the "positivity" factor) for the addiction service inpatients at Bergen New Bridge Medical Center in Paramus. It is highly healing for the patients, destigmatizes, and aids in awareness. A bridge for many.

Social Media & Virtual Platform: AinR™ has informative discussion series through social media and virtual engagements for Bergen County. Whether it be our members having topic discussions to view, many are geared toward teens, or use of our "Video Library" of our members sharing as they do, in professional quality videos.

"Heart At Work": A virtual law enforcement series on a bimonthly basis in partnership with the Bergen County Prosecutor's Office to feature the ongoing efforts of police departments regarding the opioid epidemic. This is an innovative, collaborative forum to engage the public. The primary purpose of these informative talks is to connect, destigmatize and humanize our local law enforcement officers. It also provides the bonus of raising awareness, promoting educational opportunities about the dangers of substance misuse, AND community resources for good mental health promotion.

We Bridge the Gap by connecting and empowering local people. The recovery community and the grieving community have a platform to speak of their personal experiences to help their communities become informed about addiction locally, as well as many programs to engage all walks of life, which helps to educate and build community.

Objectives: Our Objective is to expand AinR's ™ reach into more schools and communities in Bergen County/ To do this, the organization needs supportive funding to ensure delivery through coordinating and scheduling, as well as marketing. We need to expand our programs in both geography *and* frequency; produce more and higher quality educational materials (such as our Video Library); increase our usage of social media to both educate our constituents and enlarge our reach; continuously expand our presence to become a well-known, accessible and reliable addiction resource; and, increase our volunteer pool on both the "(school alumni)Recovery Member" and "(bereaved parent)Parent Member", as well as our "Community Member" involvement. levels to be able to expand our reach.

Location or Setting for its Delivery: Schools and communities in Bergen County, including, but not limited to, middle schools, high schools; town events; special purpose events; community forums, etc. Plus, virtual events via Zoom for specific related topics (e.g., addiction awareness, first-responder recognition for assistance with overdose issues, etc.)

Expected Number of People to Be Served (annually): presently around 8000 yearly, not including our walk or Recovery Day events; Foreseeably, can reach indefinite numbers. Our goal is to engage all walks of life in Bergen County.

Cost of Program (annually): We are not looking for more than $15k/ yr. as per this proposal. The $15,000 would ensure coordination management costs for Bergen County school and community presentations. The complete annual projection for Alumni In Recovery organization is $100,000.00/year to have ongoing success and growth within Bergen County

Evaluation Plan: AinR™ will monitor metrics for all new venues, schools, community events, and special events held and compare year-over-year figures for :

- Number of events held
- Number of attendees/audience reached
- Amount of new resource material produced (e.g. video programs)
- Other metrics as appropriate

Check:

☒Prevention	☐Treatment
☐Early Intervention	☒Recovery support

Check:

☐Evidence-based ☐Promising Practice

☐Evidence Informed ☒Other_______________

Contact Name: Nancy Labov

Contact Email: Nancy@Alumniinrecovery.org

77 Brant Avenue, Suite 210 · Clark, New Jersey · 07066
www.anjc.info · www.njchiropractors.com

October 28, 2022

Opioid Funds Proposal
PO Box 001
Trenton, NJ 08625

RE: Opioid Settlement Fund Spending Plan Public Feedback
ATTN: DHS Commissioner Sarah Adelman

Dear Commissioner Adelman:

The Association of New Jersey Chiropractors("ANJC") representing nearly 2000 Doctors of Chiropractic and caring for hundreds of thousands of patients throughout the State of New Jersey applaud Governor Murphy, your department and other stakeholders in the ongoing efforts to help battle the opioid crisis.

For over one hundred years, the Chiropractic profession has been at the forefront of drug-free healthcare to those that suffer from a wide variety of physical maladies. Our profession, for over one hundred years, continually has worked with patients throughout the entire state, day in and day out, to reduce the need of medications from over the counter to highly addictive medications like opioids and others.

Doctors of Chiropractic can be found in hospitals, Veteran's facilities, Olympic and professional sports teams with an education federally overseen and licensed in every state in the country.

Being a large part of the solution against the overuse and abuse of medications for decades, has been a task that the chiropractic profession and we have been huge, but quiet part of the solution to the opioid epidemic. With lower back pain being one of the most common reasons why opioids were prescribed to patients, research shows there is no evidence that opioids provide clinically significant relief to chronic low back pain. As many as one in four people who receive prescription opioids long term for non-cancer pain in primary care settings, struggle with addiction.

The International Association for the Study of Pain stated lower back pain "…in 2017 was estimated to be about 7.5% of the global population, or around 577.0 million people. Many of those individuals seek medical attention including opioids for relief of their pain.

Meanwhile, a growing body of research shows that early intervention with chiropractic services can have a significant impact on the long-term use of prescription opioid pain medications for some patients.

The American Chiropractic Association has put together a four (4) page informational document titled A Common Sense Strategy to Fight Opioid Abuse , that concisely spells out the alarming statistics involved with opioid abuse and the various organizations that are promoting non-pharmacological treatment for patients in pain. It can be found at: https://www.acatoday.org/wp-content/uploads/2022/02/Opioid_Crisis_CommonSenseStrategy_2022.pdf

The ANJC respectfully requests consideration to be included at the table in any/all discussions relating to the opioid epidemic as well as the discussions of how to battle abuse and provide non- pharmacologic healthcare therapies for those suffering in pain.

In addition, we request that a significant amount of funds be allocated toward developing an ongoing program of conservative care options which must include chiropractic care and other non-pharmacologic modalities.

The ANJC requests allocation of $725,000 which would be utilized as follows:

- Quarterly continuing education programs for doctors of chiropractic to be able to identify opioid abuse in their patients
- Multilingual public outreach educating population on pitfalls of opioid addiction and evidenced based benefits of non-pharmacological care as proven pain management options.
- Develop ongoing training for doctors for Naxolone indications and usage
- Create and expand community awareness of non-pharmacologic treatment options to include behavior modifications and conservative therapies directed at pain reduction
- Nutritional programs directed at pain reduction and anti-inflammatory strategies
- Initiate grade school education and awareness of opioid pitfalls and importance of exercise, good healthy habits, etc.
- Develop “Back School” care programs for grade school students educating on specific exercises, stretches and flexibility regimens geared toward low back injury prevention
- Multi-disciplinary education on benefits of non-pharmacologic care such as chiropractic, exercise and other evidenced based conservative therapies etc.

We believe implementing the above suggestions will go a long way to educating and reducing opioid abuse, addiction and financial costs

Again, congratulations on the settlements and the foresight to put together this great initiative for the citizens of New Jersey.

Respectfully submitted on behalf of the members of the ANJC Association of NJ Chiropractors,

Dr. Jordan Kovacs, DC
ANJC President

Dr. Victor Rossi, DC
ANJC Vice President

Dr. Andreas Skounakis, DC
ANJC President Elect

October 31, 2022

To Whom It May Concern:

I am writing as a concerned citizen of New Jersey and employee of the Paterson Police Department who oversees the Department's Alternative Approaches to Public Safety. With over 1,700 overdoses per year, our jurisdiction very much sees the opioid epidemic—and experience of fentanyl—in our work and our community daily. We see compassion fatigue from all who experience and respond to overdose. On the day-to-day level, I work to develop and educate a team of community partners, social workers, and first responders to start combatting stigma of (and fatigue from) addiction in our community; this outreach is executed via our City's DPLS-sponsored Opioid Response Team. Moreover, I oversee Paterson's Coalition for Opioid Assessment and Response (COAR), which includes policy makers from the City HHS, City Public Safety, County Prosecutor's Office, County HHS, local Emergency Department, and local Regional Health Hub. COAR hosts quarterly stakeholder meetings where we bring similar messaging to de-stigmatize MAT/MOUD and addiction science among the community.

I'D LIKE TO SHARE SOME MAIN/RECURRING CONCERNS, AS SEEN ON THE GROUND IN PATERSON:

1. Even if we educate people about what evidence-based MAT/MOUD they should seek out to increase their chances of success (i.e. mortality) and work to de-stigmatize these concepts, there are far too few providers (and nearly none that have inpatient options) in our area. Then, the negative work/failed practices by treatment providers in the area re-stigmatizes MAT or re-enforces old stigma that essentially promotes the idea that "MAT doesn't work" when, in reality, if treated with best practice and given proper support/wrap-around services, MAT/MOUD more than likely would have been sufficient.
2. Even if we educate providers about what evidence-based MAT/MOUD they should provide, there is little incentive for them to do so. As primarily religious non-profits, I believe that their motivation is to maximize ROI per client (not nefariously, just out of necessity). For for-profit or hospital settings, their motivation is to get patients out and cleared to their next-step quickly…
   (1) Medicaid reimbursement rates are not as plentiful for non-OBAT/OBAT-navigator-having programs, which is many of those in our City. Getting an OBAT Navigator takes too much expense/time for many resource-short nonprofit programs to achieve.
   (2) Medicaid is fee-for-service rather than reimbursement based on patient's success/longitude in program. How this manifests:
      a. They get more money when people "fail out" and ultimately cycle back into their program in the future.
      b. They get more money when people "fail-out" of their 30-day program early; they can still bill for a 30-day program and can take a new patient in the original person's spot, essentially maximizing profit received per-day, rather than per-patient.

(3) There are also perverse practices by wrap-around providers (such as shelters) such as discriminating against individuals on MAT/MOUD or enforcing arbitrary caps on MAT/MOUD dosage in order to access their services. This is illegal according to NJSB2964 and the federal ADA legislation. In many cases, even best-practice treatment providers are forced to taper clients before dismissal just so that they can get into a shelter bed post-release. While this is not nefarious, it is medically inappropriate, because people will likely not be physically sustained on the low dose that they are now forced to take. While we appreciate DMHAS' attempt to RFP for this type of improvement, the truth remains that enabling/supporting enforcement could also be a quick/low-cost answer, compared to providing some shelters with enough support to follow law as written.

HERE ARE SOME RECOMMENDATIONS FOR REMEDIES THAT CAN LIKELY BEGIN TO CLOSE THE EQUITY GAP IN THE OUD TREATMENT INDUSTRY:

We must make medications for drug treatment – particularly the well-studied methadone & buprenorphine – more available to those who are not local to, aware of, or likely to access an OBAT. Low/Middle Income communities who are more used to accessing pharmacies, urgent care, clinics, and the ER must be better prioritized for (1) information about how to access evidence-based care, and (2) information about evidence-based treatment options (even the nitty-gritty) so that they can advocate for themselves when attending one of the various local treatment providers who often work contrary to best practices.

1. **MAKE CONTINUING EDUCATION REQUIRED (via COEs)**: Specifically important for anyone who gets public contracts to Rx or treat people with MAT/MOUD (uninsured, drug court, etc.). Even better would be to make continuing education via COE required for anyone who is licensed by DMHAS or DOH to serve addicted individuals. This is standard practice for MANY other public services/offices and I believe that serving individuals as vulnerable and in high-medical need as addicted persons should be prioritized for a similar requirement.
2. **TIE "MAT/MOUD BEST PRACTICES" TO PUBLIC CONTRACTS**: If there is decision to not enforce best practices via licensure or punitive measure, perhaps such standards of care can be baked into requirements related to public contracts to specifically support uninsured individuals or drug court clients. This seems like a simple/easy way to address ongoing issues with treatment equity. Perhaps the guidance for grantees of certain contracts could look something like: "if you believe that you should dose a specific patient contrary to these terms, you will be required to reach out to your MAT COE's 24/7 bupe hotline for approval, which must be documented in the patient's record."
3. **HOLD PROVIDERS/SHELTERS ACCOUNTABLE**: Support regionally-designated institutions (such as the Northern/Southern MAT Centers of Excellence, or the upcoming Northern NJ Harm Reduction Research Center @ Montclair State) to perform enforcement of best practice/legal policies as appropriate (if this is too wide of an infrastructure for the state to develop or take on directly). It could be proactive, or upon request from local municipalities/social workers suspecting foul play among their residents. Empower watch-dog partnerships in local municipalities that are hosting large volumes of individuals who are homeless, low-income, uninsured, congregate shelter, and/or potentially high risk for overdose. One way to consider this enhancement would be to provide each COE with funds to host one liaison per county who can act as said watchdog and filter through various complaints at the local level/have

jurisdiction to enforce. I think we all recognize that stigma of MOUD/MAT is reinforced when arbitrary policies at treatment providers/wrap-arounds are developed (such as no MAT patients allowed, or no use of MAT over 2 mg/day).

4. **SUPPORT LOW-BARRIER ACCESS TO SUBOXONE/SUBLOCADE/THEIR GENERICS:** I am incredibly grateful for what the State is doing on naloxone distribution; what would be great is any guidance/support to suboxone distribution as it is being done in places like Camden and Philadelphia (on the street, via first responders and/or easy to access addiction clinics). This means extending/securing teledoc (video or audio) as potential ways to secure a medical appointment with an OBAT. *(PLEASE SEE ATTACHED LETTER TO GOVERNOR REGARDING TELEDOC POLICY, AS SENT EARLIER THIS FALL).* This also means supporting programs like RealFix, which plan to bridge gaps seen in the OBAT model and (effectively) compete with the drug dealers who prey on those who are stuck in the cycle between homelessness and finding effective/lasting treatment. *(PLEASE SEE ATTACHED POLICY RECOMMENDATIONS FROM REALFIX and POWERPOINT EXPLAINING THE REALFIX MODEL).*
5. **INCREASE HARM REDUCTION/EVIDENCE-BASED TREATMENT (MOUD) CAMPAIGNS/ MESSAGES IN URBAN AREAS/TO URBAN OUTLETS**: Expansion of Harm Reduction and Evidence-based Treatment (MOUD/MAT) marketing in all communities, though specifically focused on culturally appropriate messaging in suburban/urban communities that often alienate, stigmatize, and generally disparage the work of SSPs. It is vital that we combat the NIMBY mindset and recognize that when well-resourced and well-supported, programs that follow evidence (including SSPs) are vital to supporting a healthy community; we need to show data to combat NIMBY stigma. I do believe that there has been a certain level of advocacy on this topic in Newark, but I don't believe that the campaign has made its way to Paterson; if helpful, I am happy to act as conduit of getting any existing messages/materials out in Paterson.
6. **SUPPORT COMMUNITY-LED MODELS THAT ARE ALREADY TRUSTED AND OPERATING ON THE GROUND**: I am in favor of continuing the DPLS approaches to Opioid Response Teams (ORT) and allowing their ground operations/dynamics to be locally determinable. This branding has been very successful to date in Paterson and has garnered positive attention from those from in multiple silos/levels seeking to do good/share good information and science with their respective audiences. Moreover, it may be beneficial to incentivize/support data-sharing collaborations at the local levels, such as what Paterson COAR was created to achieve. I would be happy to elaborate on our work further/if helpful to can assist others interested in driving similar change in their communities.

Thank you for your consideration of these suggestions. I wish the state all the best in determining how to best utilize/allocate funds from the Opioid Settlement Fund.

Sincerely,

Andrea M. Ramalho

Andrea M. Ramalho
Sr. Program Manager for Alternative Public Safety Strategies
Paterson Police Department

André Sayegh
Mayor

City Hall
155 Market Street
Paterson, New Jersey 07505
Phone: (973) 321-1600
Fax: (973) 321-1555

Governor Phil Murphy
Office of the Governor
225 W State St.
Trenton, NJ 08625

September 26, 2022

RE: Tele-medicine to Support those with Substance Use Disorders beyond COVID-19

Dear Governor Murphy,

The City of Paterson was recently named an awardee of the Bloomberg Mayor's Challenge, a competitive grant program to which 631 cities from around the world applied; only 15 were awarded, three of which are located in the United States. One critical factor of our awarded idea is to leverage use of tele-medicine to better-reach individuals in need of treatment for Opioid Use Disorder (OUD). Specifically, RealFix plans to link callers to tele-medicine appointments wherein they can be prescribed and receive Suboxone (buprenorphine/naloxone combination) within 90 minutes. This is a game changer because for the first time, RealFix makes it easier to obtain medication to counter withdrawal and cravings than illicit opioids.

Our idea benefited from a *potentially* temporary allowance during COVID-19, to use video and/or audio tele-medicine appointments when onboarding OUD patients into MAT. Addiction treatment providers have attested that utilizing tele-medicine has in itself been a "game changer," making services more accessible to low-income individuals who often have transportation barriers. Allowing audio-only tele-medicine has also been instrumental in that many low-income patients lack the broadband access or devices necessary for video tele-medicine appointments. Both factors are essential to make this evidence-based treatment more equitably available to all Patersonians and New Jersians as a whole.

The US Department of Justice recently recommended the restriction of the capacity of DEA Qualifying Practitioners to prescribe controlled substances via tele-medicine as of October 13, 2022, citing the end of the COVID-19 pandemic. However, it is possible for the State of New Jersey to extend these important, equity-building practices long-term. If we are to follow the lead of the New York Department of Health, we too can create a "Guidance for Accessing

Buprenorphine through Telemedicine" that does not have to expire nor be contingent upon the status of any state of emergency. To remain in-step with our neighbors, the State of New Jersey would ideally extend the permission to onboard patients via video and audio tele-medicine appointments, while providing practitioners with clear, state-specific guidelines to follow.

If one good thing came out of the COVID-19 pandemic it is that it forced us to try new things, which saved lives and improved delivery of traditional services. It would be a shame to discontinue what we saw working and what we know can be leveraged to help make further improvements, such as bridging service gaps and enhancing equity of treatment via RealFix. We now ask that our state follow the lead of New York Department of Health by permanently permitting the use of video and/or telemedicine to onboarding patients into Medication Assisted Treatment.

Sincerely,

Mayor Andre Sayegh
City of Paterson

While RealFix seeks to make Medication Assisted Treatment available on demand, several policy changes would also be instrumental in changing the addiction treatment industry.

Recommended Opioid Use Disorder Addiction Treatment Policy Changes

As discussed in the Paterson/Rutgers/Vital Strategies Meeting 6/15/2022

Edward Boze

Preface

Thanks to Vital Strategies for meeting with the City of Paterson/Rutgers NJ Medical School RealFix team regarding policy changes to dramatically improve the Opioid Use Disorder (OUD) treatment industry.

While the City of Paterson's RealFix program seeks to make Medication Assisted Treatment (MAT) for OUD available on demand, several policy changes would also be instrumental in changing the addiction treatment industry.

OUD persists not because we lack an effective treatment. MAT has been shown to be extremely effective particularly compared to Abstinence Based Treatment which has twice as many deaths and an estimated 10X as many relapses. The primary issue is access to MAT and the policies in place which limit access by not putting the patient at the center.

Below, are nine policy issues as agreed upon by the RealFix team and their corresponding policy solutions. We welcome your collaboration and a follow up meeting to discuss our proposals.

Noting this is a working document, we have also added four other policy issues that need further research on our part.

Recommended Policy Changes to Be Discussed

1. Increase the Reimbursement Rate for Treatment Using Buprenorphine

The underlying problem is a perverse set of incentives which reward practitioners of the least effective methods of treatment while providing a rate for the most effective treatment which is barely financially sustainable.

Suboxone/Buprenorphine is the often the most appropriate form of MAT because it does not require an in person visit for a daily dose which is the case for Methadone. However, currently physicians providing MAT using Suboxone/Buprenorphine are compensated at only $178/patient/mo. and that includes the services of a Navigator. At this rate, physicians can barely cover their costs. This also creates an inequity.

High and medium income clients more often have a primary care physician (PCP). The PCP does not rely upon providing MAT as an income producer for their practice. They make their money on other services making their practice financially sustainable. Therefore, the more convenient Buprenorphine, for which a 7-30 day script can be provided, is available to high and medium income patients.

Low income clients often do not have a PCP for a variety of reasons such as convenience, cost and availability. Therefore, when they seek addiction treatment, they seek it from an addiction treatment center. At $178/patient/mo., treatment centers cannot afford to provide MAT via Buprenorphine because it might involve only a single visit per month. For this reason, in low income communities, methadone clinics are the dominant form of MAT because they are financially sustainable. Methadone MAT centers receive $1,380/patient/mo., because the physician is being compensated for each day's visit during which a dose is administered. Of the sample Medicaid treatment centers studied, only 3% of patients received a medication other than Methadone despite Methadone being very inconvenient for

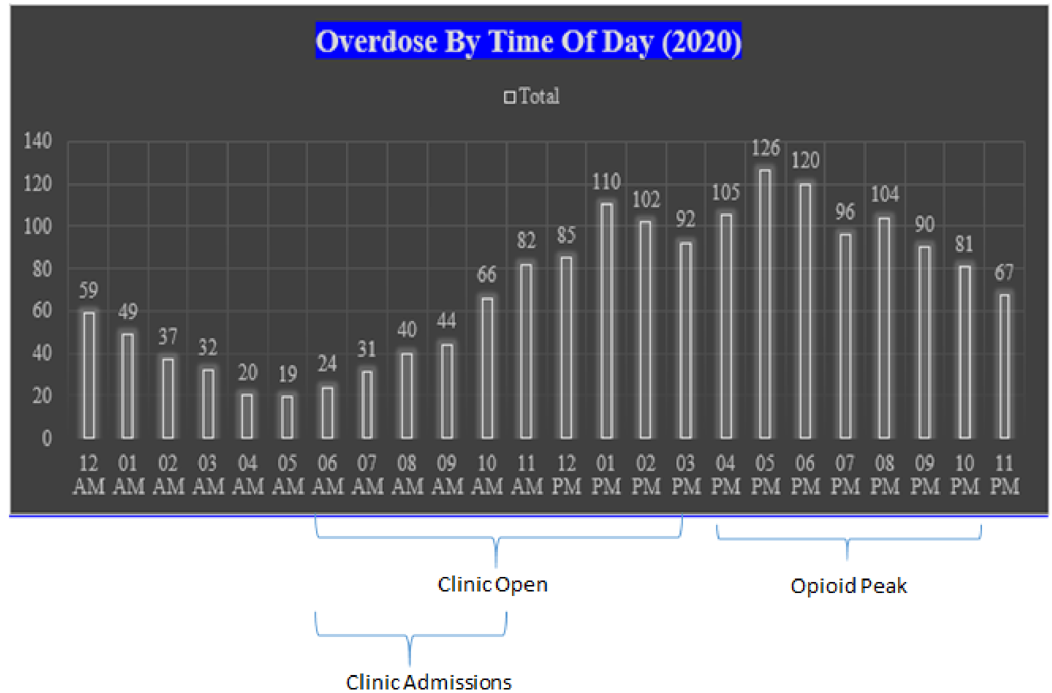
low income clients who often have transportation barriers preventing their daily attendance at a treatment center.

A converse effect of these reimbursement rates is that a center may provide Buprenorphine, but perversely require that the patient come daily/almost daily (as if they were on Methadone) even though it is not medically necessary to do so. The daily dosage of Methadone is why it has yielded the nickname “liquid handcuffs”. It is oppressive and resource-cumbersome to require this method of treatment and, frankly, it would not be acceptable to high and middle income clients.

Therefore, we recommend the Medicaid re-imbursement rate for treatment using Buprenorphine be increased.

2. Provide Supplemental Reimbursement for Admissions Times Which Reflect the Needs of the Patient

Treatment center opening hours do not match the peak daily periods of opioid abuse. Treatment center hours are setup for the convenience of providers, usually during the day (6 AM to 3 PM). Moreover, the admission times are even more limited (6 AM to 11 AM). However, most patients overdose in the evening (4 PM to 10 PM). This means, that at the time when most patients need assistance they have nowhere to go. Therefore, we recommend a supplemental re-imbursement for admission times which reflect the needs of patients.



3. Change Re-Imbursement for Abstinence Based In-Patient Treatment to be Based Upon the Number of Days of Treatment Completed

Abstinence based treatment has twice as many deaths as Medication Assisted Treatment (MAT) and studies suggest a relapse rate 10 times that of MAT. Despite this, in 2019, over 70% of those admitted to treatment in Passaic County did not have MAT in their plan (i.e. the plan was for Abstinence).

Regrettably, there is no middle option between abstinence-based treatment and MAT. Patients are offered one or the other. Those in abstinence programs often leave against medical advice in order to seek illicit opioids to counter overwhelming withdrawal symptoms and cravings. Patients are not given the safety-net option of quickly receiving an appropriate dose of medication, such as buprenorphine, to counteract withdrawal.

Furthermore, we understand that Medicaid re-imbursement is the same for the treatment provider whether the client completes a course of treatment or not. The provider is compensated for the days of treatment in the plan (ex. a 7-day detox) as opposed to the days of treatment actually completed. This provides a perverse financial incentive to have the client fail out of treatment early. Failure is cheaper for the provider and relapses create repeat business.

Therefore, we recommend that re-imbursement be related to the number of days the client remains in treatment with some level of enforcement or oversight to ensure honesty in reporting. This would remove the perverse incentive and encourage providers to offer medication as a safety-net alternative to illicit opioids as it would result in greater treatment retention.

4. Speed the Processing of Claims for Office Based Addiction Treatment

As we understand it, in New Jersey, Managed Care Organizations (MCOs) which administer Medicaid, were provided with a sum of money to support Opioid Use Disorder Treatment.

The Office Based Addiction Treatment (OBAT) model was launched in January 2019 to increase the number of addiction treatment providers available by enlisting and enabling physicians to treat addiction within their own practice.

However, unlike large treatment centers which can bill the state directly for services rendered, the OBATs must bill the MCOs. The MCO's performance in paying claims has been very poor. Claims often take 6 months or more, the OBATs must employ claims managers for repeated follow-up on claims submitted and the same type of claim accepted one time is often rejected another time. This makes it impossible for some OBATs to continue to provide Medication Assisted Treatment.

There seems to be no oversight provided by the state regarding the efficient processing of claims. In addition, there is a perverse incentive for the MCO to deny the claims because they have already been provided funding to support addiction treatment and therefore any claims rejected are funds they get to retain as profit.

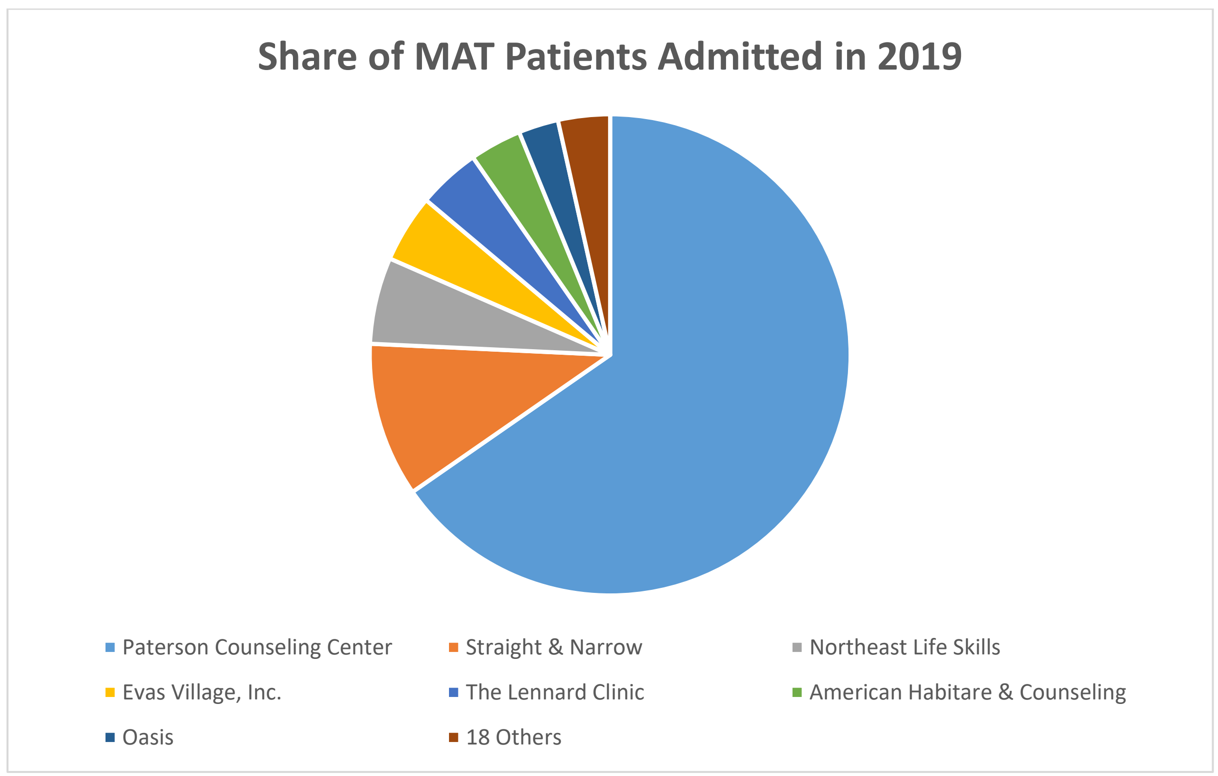
Therefore, we recommend speeding the processing of claims to OBATs by:

- Providing oversight of claims processing. MCOs found to process their claims in-efficiently or inaccurately will be penalized in the form of funding for the following year thereby reducing the incentive to deny claims.
- Allowing OBATs to bill State Medicaid directly at all times, not just during the Medicaid Presumptive Eligibility wait period. This is the best option.

For additional insight, please contact OBAT, Dr. Tony Juneja at 212-925-2222.

5. Require Treatment Center Transparency Regarding MAT Admissions and Practices Thereby Facilitating the Choice of Quality Treatment Providers

In 2019, of the 25 treatment centers in our area claiming to provide Medication Assisted Treatment, 18 of them (i.e. 72%) in total provide only 3% of the MAT in the area. Some had only a single admission with MAT in their plan that year. (See figure below.)



When calling some of these treatment centers, they stated that while they would allow admittance for someone with a prescription for medication for treatment, they could not connect the patient with a physician who could provide a prescription.

We do not consider these treatment centers to be true supporters (or even “understanders”) of MAT. Any patient prudent enough to seek MAT would be very ill served in seeking treatment at one of these providers.

Therefore, we recommend requiring treatment centers disclose to patients the percentage of their admissions with MAT in their plan. This one statistic will help patients choose true MAT providers.

To this end, we also recommend that the State DMHAS put out a clear set of best practice or a standard of care as it relates to MAT and dosing and furthermore require treatment providers disclose whether they comply with these best practices. For example, we are witness to a well-known, local program that has created arbitrary rules that patients only receive 8 mg/day or less of Buprenorphine when evidence based medicine indicates the correct dose to be 16 mg because that dosage not only counters withdrawal but reduces cravings and better prevents relapses.

Side Note: As the RealFix program will be developing MAT best practices, we would welcome collaborating with State DMHAS on this endeavor.

If for any reason the State DMHAS is not comfortable requiring or promulgating best practices, we do recommend that State DMHAS create (at minimum) a mechanism by which to require continuing education among MAT treatment providers by way of the MAT Center of Excellence. The goal of requiring continuing education to keep MAT Licensure would be to ensure that all programs are guided by medical professionals who are as aware of and up to date about the fields of MAT and addiction sciences as they continue to evolve. Failing to take even this minimal action means that MAT providers can continue to practice outdated science and fail patients due to their own outdated knowledge or understanding of MAT and addiction sciences.

6. Make the MAT via Teledoc Permanent

During the Covid19 state of emergency, the Substance Abuse and Mental Health Services Administration (SAMHSA) pre-emptively exercised its authority to exempt Opioid Treatment Programs from the requirement to perform an in-person physical evaluation (under 42 C.F.R. § 8.12(f)(2)) for new patients being treated with buprenorphine. I believe this same exemption applied to Office Based Addiction Treament (OBAT) as well.

It is imperative that this exemption be continued indefinitely.

7. Ease Pharmacy Restrictions and Prohibit Arrangements between Pharmacies and Insurance Providers which limit the availability of Sublocade

Buprenorphine has a "street value" and is therefore easily diverted (i.e. illicitly sold) particularly by the poor and especially the homeless for whom it is prescribed.

Conversely, Sublocade is an injectable form of buprenorphine which lasts 30 days. As such, it is impossible to divert and is therefore a very useful tool in treating the homeless who suffer from OUD.

Unfortunately, Sublocade is very difficult for Medicaid insured patients to receive. In 2018, extended-release buprenorphine comprised only 0.06 percent of all Medicaid buprenorphine prescriptions for OUD. This compared to .21 percent of prescriptions for patients with employer sponsored healthcare. Two reasons may be responsible.

Specialty Pharmacy Requirements: Sublocade can only be distributed by a "Specialty Pharmacy". We are unsure of the reasons for this requirement but we recommend it be investigated in hopes the

restrictions can be eased. Still, this does not explain the difference between the Medicaid and non-Medicaid insured.

Exclusive Arrangements Between Pharmacies and Insurance Providers: While the Medicaid Managed Care Organizations in the area allow for Sublocade, the MCO dominant in the region is Horizon. However, Horizon will allow Sublocade only through an exclusive arrangement with Accredo. Since they are not local, it creates an issue for practitioners who need a local Specialty Pharmacy which can deliver the medication within minutes of the patient entering their office for their scheduled visit. Because of the cost of Sublocade (over $1500 per dose), practitioners prefer this approach over ordering the medication in advance because of the possibility that the patient will miss their appointment.

Therefore, we recommend that these exclusive arrangements be prohibited.

8. Address Exclusionary Zoning and Licensing Practices that Restrict Treatment Centers that Accept Medicaid

We believe the majority of treatment providers statewide don't accept Medicaid. Furthermore, municipalities deliberately resist the zoning and licensing of treatment centers. We suspect this to especially be the case if the treatment center accepts Medicaid.

Therefore, we suggest additional research as follows.

1. Verify the percent of treatment centers which do not accept Medicaid
2. Verify the percent of those that accept Medicaid that are predominantly Methadone.
3. Determine why treatment centers who accept Medicaid are so rare
    a. Is it the financial compensation model (as we have stated in Section 1)?
    b. Is it zoning (i.e. towns discriminating against treatment centers that accept Medicaid)?

We also suggest Googling "NIMBY Syndrome/Property Values/Substance abuse treatment" for an abundance of articles.

While we anticipate this to be among the most difficult policy issues to address, there is precedent. We recommend looking at the 2017 New Jersey Supreme Court ruling requiring municipalities to allow the development of affordable housing for poor and middle-class families.

9. Changing the X Waiver System for Physicians and Buprenorphine vs. Suboxone

We applaud the Drug Addiction Treatment Act (DATA 2000) waiver legislation which allowed clinicians to prescribe buprenorphine within limits. The limits pertain to the number of patients being treated at any one time, 30, 100, and in emergency situations 275 for 6 months.

Furthermore, we applaud allowing buprenorphine to be provided in the form of a buprenorphine/naloxone combination such as Suboxone.

However, while making this policy change may be an uphill struggle, we recommend lesser restrictions on the buprenorphine/naloxone combination.

Restrictions on buprenorphine (bup) make sense. Bup can be abused and might become a narcotic of choice in areas even among recipients that never abused opioids. Therefore, we would not want to facilitate bup “pill mills” as happened with prescription opioids.

The buprenorphine/naloxone combination however is much different. It cannot be abused which is the purpose of the formulation. When taken as prescribed the buprenorphine is active and the naloxone is inactive. If, however, the recipient tries to abuse the medication by snorting or injecting it, the naloxone rather than the bup becomes the active ingredient preventing euphoria and actually replacing opioids on receptors. Studies show that even illicitly obtained Suboxone is used for its intended purpose.

Therefore, as stated, we recommend a distinction between buprenorphine and the buprenorphine/naloxone combination and instituting lesser restrictions on the buprenorphine/naloxone combination.

Opioid Use Disorder (OUD) Treatment

A Problem of
Poor Customer Service

All cities globally were invited to enter this competition. 631 entered from 99 countries.

Paterson was one of only 15 cities to win $1M for their proposal of “RealFix”.

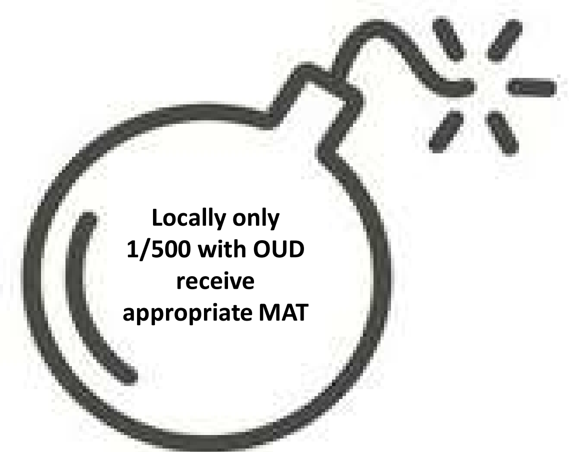
Current State of OUD Treatment

If OUD treatment were a burger joint…

We would be serving
- A terrible hamburger
- At 6 AM
- After a one week wait
- With no delivery available
- For $200
- With no Yelp Review

Current State of OUD Treatment

As a result…



- In 2017, percentage of people who needed treatment for OUD who received it: 30%
- In 2019, rates of MAT planned in treatment at admission in Passaic County, only 27%
- Percent of Medicaid insured receiving Buprenorphine when receiving MAT: Estimated 3%

Current State of OUD Treatment
Breaking it down… Worst vs. Best

Worst Burger vs. Best Burger

Abstinence Based Treatment

Medication Assisted Treatment (MAT)

Abstinence Based Treatment has twice as many deaths compared to MAT and an estimated 10 times as many relapses.

If Abstinence Based Treatment required FDA approval, it would not be granted.

Yet abstinence remains the dominant form of treatment. It is what we are marketing.

A year ago, the strongest message supporting MAT was found on Findtreatment.gov

Medications used in treatment

Although no single recovery pathway is right for everyone, people who are addicted to opioids are usually more successful with **medication-assisted treatment (MAT)**. This treatment uses FDA-approved medication together with counseling and behavioral therapies.

What if I used the same kind of language regarding ice cream?

Although no single flavor of ice cream is right for everyone, people who like ice cream usually prefer vanilla ice cream.

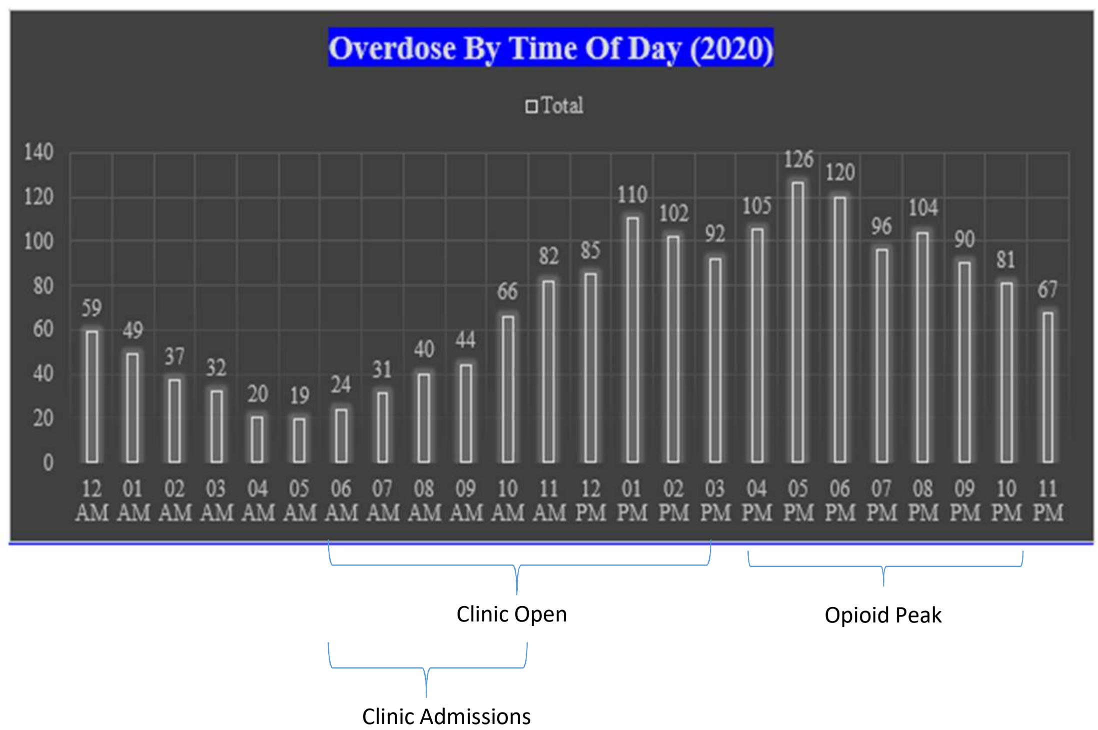
We should not be framing this decision as a matter of preference. People need facts, data and testimonials.

Current State of OUD Treatment

Breaking it down… Time of Day

Treatment Availability Currently vs. Opioid Peak

Treatment Centers typically close at 3 PM and admissions are only from
6 AM to 11 AM.



Current State of OUD Treatment
Breaking it down… Wait Time

Treatment Currently	vs.	Opioid Dealers
You often need to wait a week to be admitted.		Dealers will get you opioids anytime.

In short, in the evening when you are facing withdrawal,
which sufferers “fear more than death”,
illicit opioids are the only fix available.

Current State of OUD Treatment

Breaking it down… Transportation

Opioid Dealers	vs.	MAT via Methadone*
Dealers will get you opioids anywhere.		Arrive every morning for your dose, despite the transportations cost faced by low income clients.

* Methadone is sometimes referred to as liquid handcuffs because you can’t live your life.

If you were a diabetic, would you find it acceptable to have to go to a clinic every morning to receive your insulin?

Current State of OUD Treatment

Breaking it down… Cost

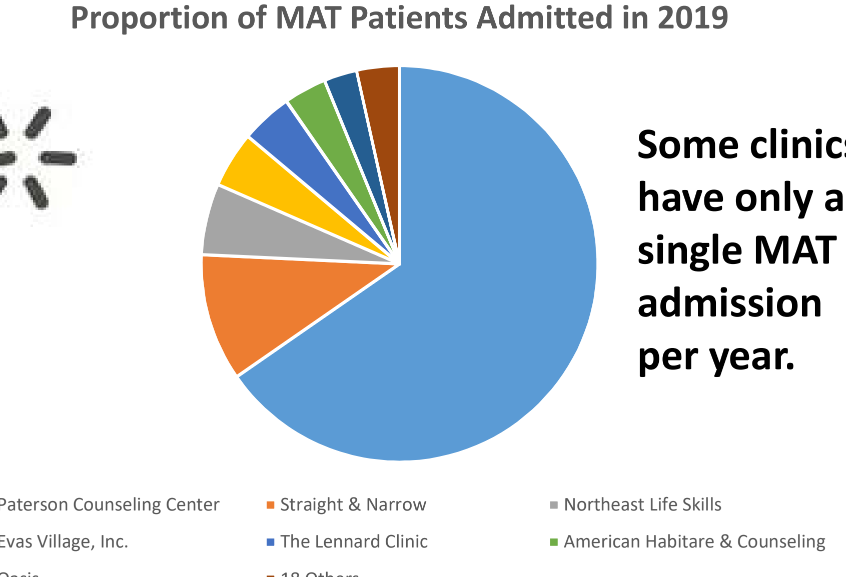
Abstinence Inpatient	vs.	MAT via Methadone	vs.	MAT via Suboxone
$3,270/month with anecdotally 13-17 readmissions per patient.		$1,380/month		$179/month. which includes Navigator services.

Current State of OUD Treatment

Breaking it down… Lack of Transparency

While all treatment centers that support MAT are listed, the government site does not provide information to debunk false claims and identify the true and quality MAT providers.

72% of MAT providers in practice do not provide MAT.



Without this information all options and providers look equal which is hardly the case. Choosing the right one is a matter of luck.

Proposed Solution:

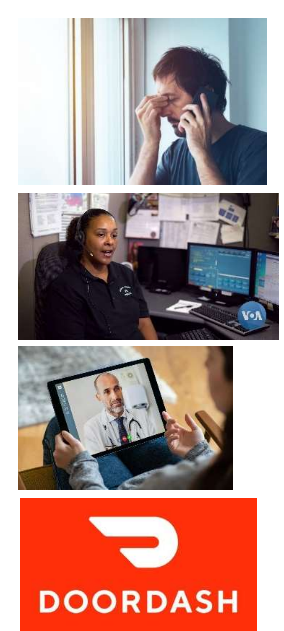
Appropriate MAT Anytime, Anywhere, (AMATAA) in 90 minutes or less

Branded as “RealFix”, it is a Four Part Solution

Part 1: MAT via Teledoc

for those with shelter

- In the evening, you, the OUD patient, calls the 1-833-RealFix call center for treatment.
- You are evaluated for Medicaid eligibility and then directed to a teledoc for MAT onboarding.
- The teledoc conducts the onboarding and wires your prescription to the 24/7 pharmacy.
- A private delivery company picks up and delivers your prescription within 90 minutes of the referral.
  - Where a private solution is unavailable, EMTs fill in the service gaps.
- Later, you are contacted and referred to a validated local brick and mortar MAT provider for ongoing treatment.



Part 2: MAT for the unsheltered

via St. Joe's OORP

- The unsheltered OUD patient, calls the 1-833-RealFix call center or 911 for treatment.

- Private provider, transports the patient to St. Joe's OORP.
  - Where private provider is unavailable, EMTs will fill in the service gaps.

- St. Joe's OORP conducts MAT onboarding, begins medication and provides a supply of the appropriate medication.

- An Eva's peer recovery counselor brings the patient back to a bed at Eva's.

- Eva's refers the patient to a local inpatient MAT provider.

Part 3: MAT Referrals via RealFix.org

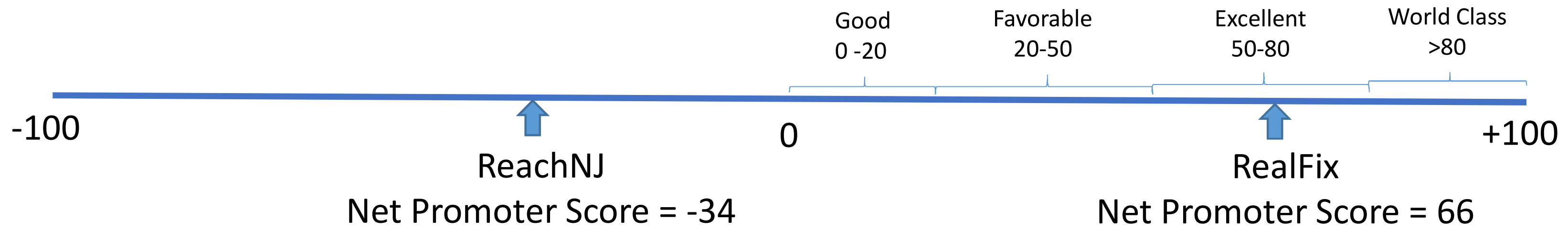
- We will create a new website, Realfix.org, and a 1-833-RealFix virtual call center backed up by our 911 call center.
- Rutgers New Jersey Medical School will vet MAT providers based upon data and a review of their MAT practices. Patient reviews will also be solicited.
- The website will provide referrals to vetted providers enabling informed decisions.
- The call center will also provide data driven referrals.
- Transparency will force providers to adopt proven appropriate treatment modalities.
- Rutgers New Jersey Medical School, preferably in collaboration with the Rutgers Behavioral Health unit, will in the long term oversee operations.

Part 4: Treatment Center Engagement

- Rutgers New Jersey Medical School and Dr. LaPietra of St. Joseph's will document MAT best practices and limitations.
- Treatment centers will be engaged to adopt best practices and thereby be promoted on RealFix.org resulting in more referrals.

Pilot Results

- **Part 1: MAT via Teledoc:** Medications were delivered in hand in an average of 76 minutes, fastest 55 minutes, slowest 87 minutes. This proved, for the first time, that a sufferer could receive relief through treatment easier than through illicit opioids.
- **Part 2: MAT for the unsheltered:** Outreach workers began offering the service to the addicted homeless who were successfully treated within the 90 minute window.
- **Part 3: MAT Referrals via RealFix.org:** A mocked up website was created and reviewed by panelists who dramatically preferred it over the ReachNJ website.



Pilot Results

- **Part 1: MAT via Teledoc:** Medication was delivered in hand in an average of 76 minutes, fasted 55 minutes, slowest 87 minutes. This proved that a sufferer could receive relief through treatment easier than through illicit opioids.
- **Part 2: MAT for the unsheltered:** Outreach workers began offering the service to the addicted homeless who were successfully treated within the 90 minute window.
- **Part 3: MAT Referrals via RealFix.org:** The a mock website was designed and reviewed by panelists who dramatically preferred it over the ReachNJ website.
- **Part 4: Treatment Center Engagement:** We began engaging treatment providers and practices have already started to change.

RealFix Requests

1. **Teledocs and Nurses:** If you have or know any doctors or nurse practitioners who might be interested in taking MAT teledoc onboarding appointments, please tell me who they are by emailing me at eboze@Patersonnj.gov.

   This could be a full time addiction treatment provider or someone who just wants to dip their toe in this field. Compensation rates are good and we can address medical liability insurance and billing concerns. We can also make a Navigator available.

2. **Engage with Dr. Weiss of Rutgers NJ Medical School:** Please email Dr. Weiss at weiss@njms.rutgers.edu so that we can begin formulating best practices and start providing referrals to you.

3. **Best Practice Presentation by Dr. Weiss:** Let's schedule this ASAP.

Questions?

New Jersey Boys & Girls Clubs Prevention Initiative Proposal

About the New Jersey Alliance of Boys & Girls Clubs: The New Jersey Alliance of Boys & Girls Clubs (Alliance) is a statewide network of 22 local Clubs that provide close to 40,000 youth age 6 to 18 years old with a safe "home away from home" where they develop relationships with caring adults, and engage in enriching programs during the critical hours after school, weekends and during the summer when they are most likely to engage in risky behaviors or become victims of crime.

For more than 150 years, Boys & Girls Clubs across New Jersey have been in the forefront of youth development, working with young people from disadvantaged economic and social circumstances. Clubs work to enable all youth, especially those who need us most, to reach their full potential as productive, caring, and responsible citizens. New Jersey Clubs work to wrap learning and personal growth in fun ways to engage youth in the areas of healthy habits, academic enhancement, and character and leadership development. Through one-on-one and small group interactions, Club staff strive to instill in each youth a sense of competence, influence and belonging.

New Jersey Clubs are well matched to support efforts to discourage and prevent the misuse of opioids for youth and their families in twelve New Jersey counties. As NJ distributes opioid settlement funds to ensure the strongest positive impact on communities, the Alliance proposes the launch of a new three year *New Jersey Boys & Girls Club Prevention Initiative*. Sixteen Clubs across New Jersey will expand prevention programming to 2,075 youth, and create a Community Health Forum model to provide substance use prevention, along with intervention resources and support to Club families and other community members. Clubs will implement 32 forums impacting approximately 2,130 adults in Atlantic, Bergen, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Monmouth, Morris, Passaic and Union Counties.

Youth Prevention Programming Strategy: Much attention has been placed on addressing Adverse Childhood Experiences (ACEs) and the effects of trauma on children and youth, their overall mental health, and the link to opioid and other addictions. Boys & Girls Clubs nationwide are leading the way in integrating a trauma-informed approach throughout communities to reduce the harmful effects of trauma and violence on individuals, families, and communities. To that end, Clubs use innovative strategies to reduce the risk of young people with trauma and mental health issues from entering the criminal and juvenile justice systems. Afterschool programs serve as a primary point of entry into a well-coordinated set of community based services for children and youth who are exhibiting challenging behaviors as a result of known or previously unknown trauma. This coordinated care approach, inclusive of afterschool professionals, is critical in identifying and effectively addressing children's trauma and mental health challenges via a team approach that utilizes multiple community-based professional and lay resources. The New Jersey Alliance of Boys & Girls Clubs (Alliance) proposes that sixteen New Jersey Boys & Girls Clubs will provide two programs, SMART Moves and Positive Action to discourage approximately 2,075 youth members living in twelve New Jersey counties from using opioids.

SMART Moves is a health promotion program focusing on building social-emotional skills such as effective communication, decision-making, and refusal skills. As such, the program addresses many of the risk and protective factors that may determine whether young people engage in risky health behaviors, including opioid use. This It 11-session program focuses on building the attitudes and skills necessary for healthy decision-making and is comprised of five sequential units: Positive View of the future, Effective Communication, Decision Making, Resistance and Refusal Skills, and Media Literacy.

Positive Action is a systematic educational program that promotes an intrinsic interest in learning and encourages cooperation among students. Positive Action works by teaching and reinforcing the intuitive philosophy that you feel good about yourself when you engage in positive actions. The Positive Action curriculum teaches youth that positive physical, intellectual, and social/emotional thoughts lead to positive actions and feelings. The program is delivered in age appropriate modules for elementary, middle, and high school aged youth, and includes a family

component. Specific units and lessons include avoiding harmful substances, refusing to engage in unhealthy and risky behaviors, mental health, goal setting, and how to responsibly manage your individual actions. Positive Action is well-suited to an afterschool setting, because it combines classroom-style instruction with engaging hands-on activities that get kids moving, interacting, and learning through role-play, action, and other participatory activities.

To ensure that staff is well-versed in implementing these two programs, Club Directors and Youth Development Specialists (YDS) at each Club site will undergo specialized training through the Positive Action. The training is a six-hour in-person seminar conducted annually.

Youth Prevention Evidence-Based Curriculum: Positive Action is widely recognized as an evidence-based model by agencies that include the U.S. Department of Education's What Works Clearinghouse, SAMHSA's National Registry of Evidence Based Programs and Practices (NREPP), and the Office of Juvenile Justice and Delinquency Prevention (OJJDP). A series of validated studies have shown Positive Action to reduce drug, alcohol, and tobacco use by 71%. The program's holistic approach has also been proven to reduce behaviors such as bullying, disciplinary referrals, and suspensions while improving test scores, pro-social behavior, and employability. In partnership with Boys & Girls Clubs of America, Positive Action has been implemented at Clubs across the country with great success.

In 2018, Boys & Girls Clubs of America (BGCA) developed an Opioid & Substance Use Prevention guide (OSUP) in collaboration with the Partnership for Drug Free Kids. The guide was developed in response to increasing needs faced by local Clubs across the country, including the need to effectively support youth dealing with grief and trauma from opioid-related losses, and the need to increase efforts in substance abuse prevention, both at Clubs and in the larger community. OSUP provides educational materials and 29 evidence-informed substance abuse prevention strategies with focus across five audiences (staff, youth, family, school, community). OSUP strategies are integrated into mentor-mentee activities and mentor training, and are utilized in efforts to engage families and implement community prevention activities. We know that a young person's social-emotional skills are linked to healthier outcomes, including substance use

prevention, mental health, and smoking. This social-emotional skill building starts early – stronger social-emotional skills, noticed as early as kindergarten, are correlated with improved measures of overall health into adulthood. To address this, many of the evidence-based risk-taking behavior prevention curricula focus much of their content on social-emotional skill-building opportunities given the link between higher social-emotional skills and reduced health risk-taking, especially for substance use. Additionally, health behavior research shows that health promotion education programs can be effective at reducing young people's engagement in risky behaviors such as substance use, sexual health, or violence. Although it is common to assume that a focus on teaching health facts contributes to health behavior change, health programs should include specific elements to be considered effective. Some of these elements include:

- Building self-efficacy through skills practice
- Addressing individual and group norms that support healthy behaviors
- Addressing social pressures and influences, including the media
- Using strategies to personalize information to engage youth

BGCA has used this research to guide the development of the SMART Moves health promotion program. SMART Moves is BGCA's foundational program focused on universal health promotion through skill building for youth in Grades K-8.

Community Health Forums: An additional program component extends beyond the Club walls to educate the parents and family members of the young people we serve through a series of community health forums. Through these forums, the Boys & Girls Club will serve as a central gathering point to connect community members with a host of health-related agencies to learn about the risks of opioids. Participants will obtain concrete lessons, resources and supports to encourage at-risk children and teens, along with their families, to live a healthy and drug free lifestyle.

Boys & Girls Clubs are uniquely qualified to host these Community Health forums, as Clubs are

established pillars in the communities we serve with strong relationships with local service providers and community members. Throughout the state, Clubs have partnerships with entities such as drug prevention and intervention agencies, food banks, hospitals and healthcare professionals, nutrition and fitness experts, universities and community colleges and others. Among the population we serve, Clubs hold a distinctive place of trust in our individual communities that enable us to impact populations that other agencies may struggle to reach. These health forums will leverage this trust by providing parents and families with critical health-related information from a wide range of community partners. Each of the sixteen participating Clubs will host two forums per year, for a total of 32 forums to engage a total of approximately 2,130 community members annually.

Outcome Measures

Outcomes for Positive Action	Outcomes for SMART Moves Core	Outcomes for Community Health Forums
• Reduce substance use and misuse • Improve social-emotional health • Reduce problem behaviors • Improve academic achievement	• Youth report positive views of their future • Youth report confidence in being able to make decisions about health • Youth report knowing how to say no to peer pressure to engage in unhealthy behaviors • Youth report feeling confident in accessing health resources, in person and online	• Community members increase knowledge of how youth are impacted by opioids and other substance use within families, communities, and peer groups • Community members will gain information about local health related and prevention resources. • Community members understand that youth decision-making and risk-taking behaviors are often deeply influenced by experiences of trauma

Target Population: Sixteen Boys & Girls Club sites in twelve counties: Atlantic, Bergen, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Monmouth, Morris, Passaic and Union will engage 2,075 youth members in prevention programming. Additionally, Clubs will create 32 Community Health Forums in those twelve counties to broaden the reach of the program, and educate families and community members. Clubs are generally located in a communities most under-resourced areas. More than two-thirds of Club members are age 12 and under, 30% live in single parent households, and 52% qualify for the free or reduced-price lunch program. Fifty two percent of Clubs serve over 70% low income families and 69% are youth of color.

Evaluation Plan: Formative evaluation will take place on an ongoing basis throughout each program to ensure that participants are engaged and responding to the lessons. Boys & Girls Clubs has developed a suite of evaluation resources to measure the impact of the programs. Summative Evaluation will be conducted utilizing survey tools to measure attitudes and skills that can lead to the intended outcomes of the program, and track the progress of youth towards building skills that support healthy decision-making. The resources include a pre-/post-test, a follow-up survey, and retrospective post-test survey. Additionally, Clubs will participate in the BGCA National Youth Outcomes Initiative (NYOI). Through a member-reported survey, the impact of our substance abuse strategies will be evaluated utilizing questions from the CDC's Youth Risk Behavior Surveillance System (YRBS) that monitor health risk behaviors among young adults, including abstention from alcohol and drug use.

Budget: The Alliance is requesting $1,550,000 in funding to support the three-year implementation of the New Jersey Boys & Girls Club Prevention initiative. These funds will provide the above outlined programming and community outreach to help our communities recover from the opioid epidemic and its affects. The funds would be broken out to $550,000 in year one, $500,000 each for year two and three. The allocation would support a portion of the time for a Social Worker and/or Prevention Specialist at each of the sixteen implementation sites; Youth Development Staff time; an annual full day Positive Action training for a minimum of two

staff per site including travel costs; the purchase of the Positive Action curriculum and materials; Community Health Forum costs; administration and evaluation costs.

Summary: The three year New Jersey Boys & Girls Club Prevention initiative targets Club youth in twelve New Jersey counties, as well as, those in the community at-large to reach the following goals:

- Provide positive, outcome-oriented strategies to directly address drug abuse prevention among children and teens
- Strengthen youth resistance to drug use
- Build youth leaders and celebrate their personal achievements and impact on communities
- Educate community members about the impact and dangers of opioid use and increase knowledge of local community resources.

If this prevention program is funded, NJ Boys & Girls Clubs will provide critical programs to address the mental health needs of young people who may be at risk of misusing opioids or other drugs. This expansion of services will also provide important information to the youth and families we serve in communities that struggle the most.

PROPOSED USE OF NJ STATE SETTLEMENT FUNDS TO COMBAT THE OPIOID EPIDEMIC:

ASSESSMENT, INTERVENTION, AND REFERRAL (AIR) FOR OPIATE USE AND MISUSE AMONG JUSTICE-INVOLVED ADOLESCENTS AND ADULTS

Dr. Paul Boxer, Professor, Department of Psychology, Rutgers University, Newark, *Project Co-Director*

Dr. Pamela Valera, Assistant Professor, School of Public Health, Rutgers University Biomedical and Health Sciences, *Project Co-Director*

Dr. Stephanie Marcello, Chief Psychologist, University Behavioral Healthcare, Rutgers University Biomedical and Health Sciences, *Project Clinical Consultant*

Dr. Jamey Lister, Assistant Professor, School of Social Work, Rutgers University, New Brunswick, *Project Outreach and Service Consultant*

Project contact: Dr. Paul Boxer, pboxer@rutgers.edu; Department of Psychology, Rutgers University, 101 Warren Street, Newark NJ 07102; 973-353-3943

Goal of this proposed project:

The broad goal of the proposed activities is to **reduce and prevent opioid use among youth and adults who are involved in the New Jersey juvenile or criminal justice system**. We will achieve this goal by increasing the availability and accessibility of effective, evidence-based services targeting the reduction and prevention of opioid use in this critically under-served population in the State of New Jersey.

Total amount of funding requested:

We have estimated a cost of approximately $940,000 for this proposed project, which is inclusive of personnel, webinar development and related training materials production, equipment, in-state travel, and supplies.

Timeline of expenditures:

From the date of funding onward, we anticipate a timeline of 36 months (3 years) for completing this project.

Target population served:

Our target population for this project is adolescents and adults involved in the New Jersey juvenile or criminal justice system. They may be involved in any sector of the system, including probation supervision, diversionary services, secure custody, or parole. We will focus specifically on justice-involved adolescents and adults who have had some engagement with opioid use or abuse.

Summary of proposed project:

Opioid use disorders (OUD) include the misuse of prescription opioids (OxyContin and Vicodin), heroin, and synthetic opioids such as fentanyl. OUD is widespread among adults involved in the criminal justice system, particularly those in the U.S. jail system. In 2016, over 2.1 million people in the U.S were impacted by OUD, with more than 200,000 individuals (24 to 36%) who suffered from heroin use, and at least 19% passed through the criminal justice system. Justice-involved individuals released to the community are likely to die of an opioid overdose, especially within the first few weeks after reentering society. Inmates are particularly at a high risk of opioid-related overdose upon post-release because of a lapse in medical coverage, lack of financial resources, relapse, disruptions in drug treatment, and inadequate access to medication-assisted treatment (MAT) as evidence-based psychological treatments. Drug overdose is the leading cause of death among formerly incarcerated individuals. Beyond these relatively severe conditions and outcomes, opioid involvement can be linked to justice involvement more broadly for adolescents as well as young adults. According to trends monitored by the U.S. Bureau of Justice Statistics, about 15-18% of offenses bear some connection to drug use – juveniles and adults charged with possession or sale or engaged in unlawful behavior to obtain drugs. Along with other substances, opioids have played a significant role in leading young people and adults into the justice system.

Of the nation's 3,163 local jails, fewer than 200 across 30 states provide MAT. The protocol for jail-based MAT programs is primarily limited to the provision of injected naltrexone immediately before release, and only the Rhode Island Department of Corrections offered all three modes of MAT medications. Meanwhile, many inmates go an extended time without treatment, increasing the likelihood of experiencing opioid-related withdrawal, overdose, or even death. With respect to the justice system more broadly, we have known for quite some time that only a small percentage of youth and adults in custody or under court supervision are given access to evidence-based treatments that can reduce the likelihood of recidivism generally. It is likely that fewer still receive effective treatments targeted towards substance use specifically, whether MAT for individuals dependent on substances or psychological/psychosocial approaches such as cognitive-behavioral therapy (CBT) for other forms substance use and abuse.

We propose to advance the quality and expand the availability of opioid use treatment and prevention services throughout the State of New Jersey for justice-involved adolescents and adults. We will do this through an expansive new community treatment and action-oriented research program. Leveraging the multidisciplinary expertise of our team, the broad and deep resources of Rutgers University, and our multi-sector engagements with local and state

community partners, we will implement a multi-phase project beginning with focus groups with key stakeholders in Essex County and ending with the delivery of best-practice treatment and prevention services in every county in the state. Our proposed project will proceed through the following phases:

PHASE 1: LOCAL KNOWLEDGE ASSESSMENT

We will convene **multiple focus groups in Essex County comprised of key stakeholders representing the sectors of juvenile and criminal justice (e.g., prosecutors, defenders, jail officials, judges, police officers), substance use treatment, and behavioral health (e.g., counselors, clinical administrators, psychiatrists), and social services (e.g., referral agents, case managers, agency directors).** We will solicit information from stakeholders regarding their views on the current availability of help and support for justice-involved adolescents and adults who are dealing with opioid abuse or dependence. We also will identify optimal points of access for engaging patients/clients in services, avenues for connectivity among the relevant sectors, and training needs for providers and any other professionals involved or potentially involved in service referral or delivery. Finally, we will utilize our focus groups to solicit membership for a local community advisory panel that will be tasked throughout our project with providing advice and feedback through ongoing, regular meetings. (~3 months)

PHASE 2: PROOF-OF-CONCEPT IMPLEMENTATION

The results of our focus groups will be collated and analyzed to develop a **preliminary "proof of concept" assessment, intervention, and referral (AIR) process that we will pilot-test in Essex County with a cohort of about 5 justice-involved individuals dealing with opioid abuse or dependence.** Although the details will emanate from the focus groups, we envision a brief assessment tool (such as Clinical Opiate Withdrawal Scale) and intervention (Motivational Interviewing) to be delivered on-site in police stations, jails, or courthouses. We expect that patients/clients would be adolescents or adults in diversion, probation, re-entry, or parole services – i.e., under supervision but not in secure custody. Essex County offers several different venues where this population is managed. Our AIR process would entail an evaluation of patients'/clients' level of risk/addiction and readiness to engage in treatment along with a single session of motivational interviewing, a validated model for initiating substance abuse treatment. At the close of the process, patients/clients would be provided with referral information to connect them as quickly and effectively as possible to providers offering appropriate care. We will assess the effectiveness of the proof-of-concept program via brief interviews with patients/clients, referral sources, and justice officials involved in the provision of services. (~4-5 months)

PHASE 3: COUNTY-WIDE SERVICE IMPLEMENTATION

Pending a successful "proof of concept" trial, we will **implement our assessment-intervention-referral (AIR) program at a larger scale – throughout Essex County**. Although eastern Essex is heavily urbanized, western Essex includes a mix of suburban and more rural municipalities – affording an excellent test of the portability of our AIR model across different types of communities. In this phase, we will implement a more extensive evaluation design while

delivering services to up to 40 justice-involved adolescents or adults county-wide at locations around the county identified in collaboration with our stakeholder panel. Our evaluation design will focus on examining patient/client and family satisfaction with the accessibility, quality, and referral/follow-up aspects of the AIR service for opioid abuse or dependence. This phase also will incorporate modular training for stakeholders across all sectors in Essex County engaged in substance use services, focusing on the research evidence base for our AIR service along with an overview of our techniques and specific interventions. This training will be prepared and made available as a webinar through Rutgers University's Behavioral Research and Training Institute. (~6 months)

PHASE 4: PARTIAL STATE-WIDE SCALE-UP IMPLEMENTATION

Pending successful county-wide implementation of our AIR program, **we will work in partnership with the Rutgers University County Extension Service to identify five additional counties for scaling up our approach – one additional county in the northern region of NJ, and two each in the central and southern regions.** We will then adapt AIR for delivery and portability through Rutgers extension offices in those six counties – county "hubs" where the AIR program can be accessed and administered directly and from which the AIR program can be delivered to other sites around the county via trained staff. This phase of our project will utilize a similar evaluation design as the preceding phase. It will also include the delivery of our training module to appropriate stakeholders across the participating counties. (~9 months)

PHASE 5: FULL STATEWIDE IMPLEMENTATION

Finally, pending a successful six-county implementation of AIR, **we will launch a statewide delivery of the AIR program through all 21 counties of the state** via the Rutgers Extension, which maintains field offices in every county. In some counties, Rutgers Extension programming is integrated into county administrative infrastructure, setting the stage for smooth synergy between Rutgers services and county needs. (~13-14 months)

Project leadership:

Paul Boxer, PhD, Project Co-Director. Boxer is Professor of Psychology at Rutgers University-Newark and has been conducting applied community-based research in greater Newark since 2006. He holds affiliate appointments in the Rutgers School of Criminal Justice and the Rutgers School of Social Work and has partnered with multiple local and state agencies in his work including the City of Newark and Newark Police Department, the Hudson County Prosecutor, the NJ Juvenile Justice Commission, the NJ Department of Law and Public Safety, the NJ Department of Education, the NJ State Parole Board, and the NJ State Police. Boxer's projects have been funded by multiple federal (National Institutes of Health, Centers for Disease Control, National Science Foundation, Department of Justice), state (State of NJ), and private (American Psychological Foundation) agencies, and he has published extensively on issues related to juvenile and criminal justice as well as mental health and intervention.

Pamela Valera, PhD, MSW, Project Co-Director. Valera is an Assistant Professor of Public Health at the Rutgers University Biomedical and Health Sciences campus. She holds an affiliate appointment at the Rutgers School of Social Work and the Rutgers New Jersey Medical School. Dr. Valera is a public health social worker who implements evidence-based interventions for substance use and mental health (e.g., Mental Health First Aid Training with Correctional Officers, Group-based tobacco treatment with Justice-involved populations) in the New Jersey and Pennsylvania State Departments of Corrections. Most recently, she is working with the Northern New Jersey Medication Assistant Treatment Center of Excellence.

Stephanie Marcello, PhD, Project Clinical Consultant. Marcello is Chief Psychologist in the Rutgers University Behavioral Health Care (UBHC) service, and assistant vice president for academics, integration, and innovation in the Rutgers Behavioral Research and Training Institute. Marcello directs numerous professional psychology training programs within UBHC and is a leading expert in the application of motivation interviewing. She supervises clinical staff at multiple levels and has worked extensively to broaden the reach of evidence-based intervention services across the State of New Jersey.

Jamey Lister, PhD, Project Outreach and Service Consultant. Lister is an Assistant Professor of Social Work in the Rutgers School of Social Work. His program of applied research focuses on identifying strategies to remove barriers to evidence-based treatments for addiction, with a focus on ensuring health equity for marginalized groups. Lister is also nationally recognized expert on the treatment of opioid use disorders; he has led projects funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration and received awards for his work from the National Institute on Drug Abuse and the College on Problems of Drug Dependence.

Since 1999,

the Family & Community Health Sciences Department has been providing educational and social support to grandparents residing in Cape May County who are the primary caregivers for their grandchildren.

Support Group Goals:

- Strengthen family relationships
- Provide educational programs
- Identify community resources
- Improve the quality of life for families

Cooperating Agencies: Rutgers, The State University of New Jersey, U.S. Department of Agriculture, and County Boards of Chosen Freeholders. Rutgers Cooperative Extension, a unit of the Rutgers New Jersey Agricultural Experiment Station, is an equal opportunity program provider and employer.

Rutgers partners with Cape Assist, Cape May County Board of Chosen Freeholders, CMC Dept. of Aging & Disability Services, the CMC Prosecutor's Office, Cape Regional Medical Center and many others who provide services for the community.

Rutgers Cooperative Extension

Family & Community Health Sciences Department
Christine Zellers, MPP
FCHS Educator

Mailing Address:

4 Moore Road
Cape May Court House, NJ 08210

Location:

355 Court House-S. Dennis Rd.
Cape May Court House, NJ

(609) 465-5115 Ext. 3609

Family & Community Health Sciences

Grandparents Raising Grandchildren

Support Group

Why we began and why we continue

In 1998, Marilou Rochford, former FCHS Educator for RCE of Cape May County was teaching a parenting education seminar. Three members of the group approached her after the class. They were grateful for the information shared since parenting was different for them "the second time around". They explained that they were each raising their grandchildren and needed information, guidance, and support. They shared their stories and the unique challenges they faced. The need for a support group took shape as a vibrant and successful program for Grandparents Raising their grandchildren.

Since it's creation in the late 1990s the Grandparents Raising Grandchildren program at Rutgers Cooperative Extension of Cape May County has continued to provided support services for caregivers and their families by offering monthly programming.

As the need for kinship care continues so does the need for services to keep caregivers healthy and well. Moving into 2020 and beyond the program continues to welcome new families and expand outreach to encourage a healthy family dynamic for grandparents throughout Cape May County.

If you are a grandparent raising your grandchild please feel free to attend a meeting or reach out to our staff to get more information.

Did you know...

2.7 million grandparents in the U.S. are raising their grandchildren. 49,177 Grandparents in New Jersey are raising their grandchildren without the parent present in the home and have sole responsibility for the child.

Program Topics

- Health, Nutrition and Wellness
- Coping with Stress
- How to navigate school systems
- Caring for yourself as a caregiver
- Wellness practices for overall health
- Strengthening Family Communications

Monthly programs are available to Cape May County residents at no cost. Every season, different topics are offered based on the current needs and interests expressed by our grandparent community. A light supper is served and childcare is available.

Your kindness empathy and selflessness are making our journey a little lighter and has such an impact on our family" - anonymous grandparent

Receive our newsletter...

"GRANDparents Connection" is published twice a year & addresses current issues facing you and your grandchildren. To request the newsletter, please email:
marian.courtney@co.cape-may.nj.us

Call: 609-465-5115 Ext. 3609

FCHS
Family & Community Health Sciences

Partial funding for our *Grandparent Raising Grandchildren* Support Group is provided through a grant from the Cape May County Division of Aging & Disability Services

Budget for proposal

PI Holly Lister, PhD, Psychologist, Behavioral Research and Training Institute
Coordinator of Center for Integrated Care
Program Director RU Integrated Substance Use Disorder Training Program
Program Director RU Integrated Substance Use Disorder Internship Program
10% FTE / fringe
$9000 / $5130 (Total $14130)

CO-I Stephanie Marcello, PhD, Assistant VP of Academics, Integration and Innovation
Chief Psychologist, Rutgers University Behavioral Health Care
5% FTE / fringe
$7000 / $3990 (Total $10990)

CO-I Anna Marie Toto, EdM
Program Manager, Center for Integrated Care
5% FTE / fringe
$5250 / $2993 (Total $8243)

Naloxone kits ($140/kit in bulk order for 250 kits): $35,000
Trainers for physician education: $10,000
Trainers for SBIRT: $10,000
Local travel to sites: $5000

Total: $93363
Overhead 8%: $7470

Total, Annual: $100,833
5-year total: $504,165

Digitizing the NJ Substance Use Disorder Prevention and Support Systems

Proposed Partnership with NJ to Expand Prevention, Referral to Treatment and Recovery Support for Substance Use Disorder

Prepared for: Office of New Jersey Governor Phil Murphy

Prepared by: Brenda Berry, Regional Director
CHESS Health

October 31, 2022

Table of Contents

Table of Contents 2
Executive Briefing 3
Our Understanding of NJ Opioid Settlement Funding Priorities 4
NJ Desired Outcomes 4
Example Partnership Approach for NJ 5
CHESS Health Key Functionality—An Overview 8
Why should NJ partner with CHESS? 10
Return on Investment & Outcomes 12
CHESS Health Overview 12
CHESS Customers 14
CHESS Statewide Installations 14
Next Steps 17

Executive Briefing

Thank you, Governor Murphy, and your team, for providing this opportunity for stakeholders to participate in providing ideas, insights, and information about how the upcoming Opioid Settlement Funding should best be spent in New Jersey. We are confident that we can support cross-agency, statewide and regional efforts toward harm reduction, streamlining linkages to care and supporting all NJ citizens suffering from substance use disorder in their treatment and recovery journeys.

As the following pages will detail, CHESS Health (CHESS) is a digital health company with peer support specialists focused on addressing the substance use disorder crisis (SUD). We have a platform for the entire addiction lifecycle, from prevention to intervention to treatment and recovery. We're best known for our evidence-based Connections App, which has been proven in clinical trials and customer implementations to improve the recovery outcomes of individuals in treatment for SUD.

We also hear every day from the individuals that use Connections about how it is helping them achieve their recovery goals. Before reading our proposal, we encourage you to watch this video in which individuals from diverse communities nationwide talk about how the Connections App and the peer community within it have helped them.

Link: https://vimeo.com/749168456#t=14

In this executive Briefing, we outline how our solution can address NJ's stated requirements for the Opioid Settlement Fund Spending Plan Public Feedback project and deliver on your desired outcomes. In this document, we will provide a high-level overview of CHESS' recommended solution, after which we will provide justification as to why CHESS is the right choice for supporting the NJ SUD landscape.

Our goal for submitting this Briefing is to generate interest among the Settlement Funding Committee to have an opportunity to present our solutions either in person or remotely for their consideration.

Our Understanding of NJ Opioid Settlement Funding Priorities

Developed to support State and Local responses to combating the opioid epidemic, Governor Murphy signed several bills to combat the state's opioid crisis and expand harm reduction efforts.

These bills will bring services to residents of NJ to expand harm reduction and prevention efforts, connect individuals to treatment and expand treatment and recovery supports. These services will build on investments included in the Governor's budget from recent years.

New Jersey has a robust substance use prevention, treatment and recovery infrastructure in place and seeks to expand and bolster these services through funding recently made available through the Opioid Settlement funding.

In the Governor's Opioid Settlement Fund Spending Plan Public Feedback Project, the following categories were provided toward which any funding must go.

NJ Settlement Funding Requirement
Supporting people in treatment and recovery
Providing connections to care
Addressing the needs of justice-involved persons
Addressing the needs of pregnant or parenting people who use drugs and their families
Preventing over-prescribing and ensuring the appropriate prescription of opioids by medical professionals
Preventing problematic use of opioids
Preventing overdose deaths and harms through harm reduction strategies
Other goals such as supporting first responders, training, and cross-system collaborative efforts, and/or research

NJ Desired Outcomes

By leveraging the CHESS digital platform designed for states, counties, payers and providers, NJ can significantly enhance the lives of their SUD populations, their families, and the communities in which they live in addition to addressing the challenges above in the following ways:

1. Get more individuals into treatment earlier by automating and digitizing the Screening/Brief Intervention/Referral to Treatment (SBIRT) process
2. Optimize referrals to treatment capabilities without adding additional physical staff
3. Maximize 24/7 peer recovery support and crisis intervention services to all NJ citizens, resulting in fewer hospitalizations, ED visits and relapses to higher levels of care

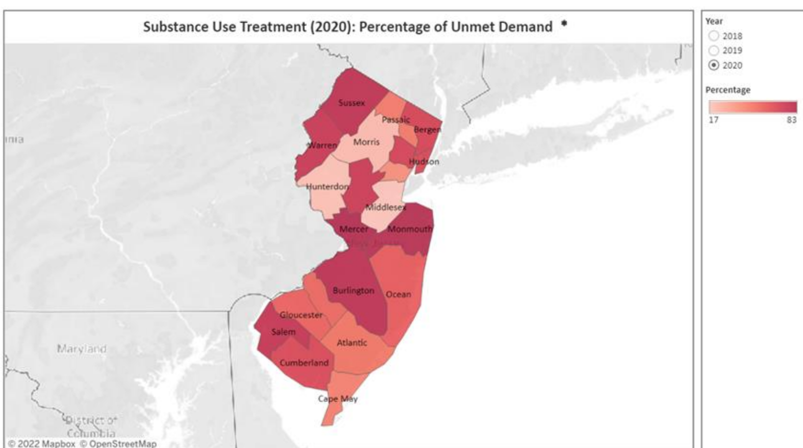
Example Partnership Approach for NJ

Having had the opportunity to meet with substance use disorder/opioid abatement stakeholders in the state through our membership in the ***NJAMHAA Technology Council***, CHESS is presenting the following combination of platforms and services that can be delivered through existing NJ programs. Our recommendations are based on our understanding of the current SUD/Opioid landscape in New Jersey and our years of experience with other states in their fight against substance use-related overdoses and deaths.

With our suite of solutions, NJ can screen more individuals for SUD and Mental Health, improve the process of referring individuals to SUD, MH or SDOH services, and provide 24/7/365 recovery support and crisis intervention services to all NJ citizens.

Additionally, with the high rate of staffing shortages and unmet demand for treatment across the state, NJ now has the opportunity to streamline the referral process by eliminating endless phone/fax/email referral requests and can leverage eRecovery to provide 24/7 recovery support and crisis intervention services to it's citizens in treatment and recovery from SUD without adding additional staff.

Unmet Demand: Average Proportion of NJ Household Surveys (2003, 2009 & 2016) estimated adult population who did not receive treatment in the 12 months prior to the interview but who felt they needed and wanted treatment times the adult resident population for the selected year.



New Jersey is fortunate to have a comprehensive county-based system in the Governor's Council on Alcohol and Drug Abuse (GCADA) which provides prevention planning, public awareness and education and administers the Alliance to Prevent Alcoholism and Drug Abuse Program.

"The Council is an active and collaborative participant in the planning and coordination of New Jersey's addiction prevention, treatment, and recovery services, both through the development of a Comprehensive State Alcoholism and Drug Abuse Master Plan, and its Alliance to Prevent Alcoholism and Drug Abuse Program, the largest network of community-based anti-drug coalitions in the nation."

The GCADA's overarching strategic vision is a future characterized by safe and healthy families and communities.

As an example of how CHESS solutions could be deployed in NJ, the GCADA, with funding from the state, could be considered HUBS for any of the CHESS initiatives described below. These are high-level Pro-forma examples of how other states are leveraging CHESS solutions and are designed to elicit further discussion.

ePrevention

PREVENTION

Project Objectives	Project Fundamentals	Deployment Approach
• Expand SUD & MH secondary prevention efforts by leveraging Digital MH and SUD screenings/SBIRT • Increase community outreach opportunities by casting a wider net into the communities to reach individuals not currently in treatment	• Unique automation of screening and interventions to offer an alternative to traditional screenings/SBIRT • Self-screening/anonymous screenings ✓ more screenings completed ✓ more honest answers ✓ better feedback • Support for any screener (e.g., CAGE, CRAFFT, AUDIT) • Rules engine prompts feedback and interventions, including help lines and/or self-referral to treatment	• Links to self-screeners can be published statewide through websites & social media: ○ State, County & City platforms ○ Healthcare providers ○ Hospitals ○ Schools ○ Other media • State & County have access to dashboards/data ○ Which organization published the screening link ○ Screening results for both anonymous and identified screenings ○ What actions or interventions did the individual select

INTERVENTION/LINKAGES TO CARE

eIntervention

Project Objectives	Project Fundamentals	Deployment Approach
• When the opportunity for intervention exists, too often, there's no one available or capable of delivering the intervention and/or making the referral (i.e., EDs, EMS/First Responders) • Virtual Peer Intervention for Linkages to Care • Provide efficient access to treatment among SUD & MH Stakeholders	• Have CHESS peers engage individuals who need help, wherever they are, through technology ○ EDs, Deflection, Re-entry, QRT • Start with easy text messages; once engaged, move to calls • More than one-time effort; up to 30 days of attempts to outreach • Closed-loop referral platform tracks referral outcomes • CHESS has a platform and peers; and can also partner with local peers	• CHESS works w NJ to identify Participating organizations (EDs, EMS, QRT, First Responders, etc.) • CHESS works w local project coordinators to develop referral networks • CHESS trains all participating stakeholders on obtaining verbal consent for a text from CHESS peers • CHESS peers engage with individuals with the goal of creating a referral to treatment

eRecovery

SUPPORTING INDIVIDUALS IN TREATMENT & RECOVERY

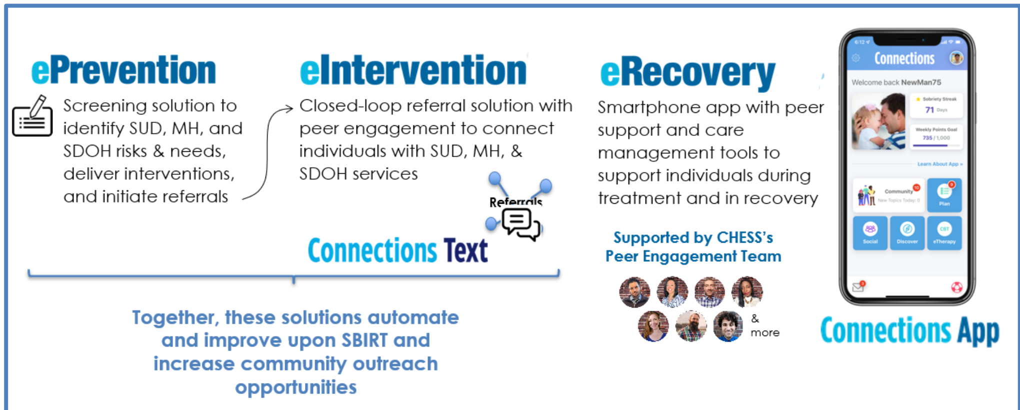
Project Objective	Project Fundamentals	Deployment Approach

• Provide 24/7 peer recovery support and crisis intervention services to help individuals stay in treatment and recovery	• Value for the individual, the provider, and the community
	• CHESS model is to collaborate with providers & peers to reach thousands in recovery
	• Available in Spanish, supported by bi-lingual peers
	• Contingency management option available January 2023
	• Does not take the place of local peer support, but provides a compliment to those services
	• No treatment is provided through the app, patients are encouraged to stay in outpatient treatment with their current provider
		• GCADA and CHESS partner to introduce eRecovery to local providers
		• CHESS trains local provider staff on eRecovery/Connections App
		• CHESS offers a "Near-Zero" effort program for provider staff
		  ○ Introduce the concept of Connections to patients
		  ○ Provide patient with "Quick Enrollment" link
		  ○ Patient downloads Connections
		  ○ CHESS Onboarding team welcomes patients

About CHESS Health

Based in Rochester, NY, CHESS provides a suite of solutions that address the addiction lifecycle from prevention to intervention to treatment and recovery. Our customers span all types of organizations, including health plans, state and local governments, treatment providers, and more. Through these organizations, thousands of individuals depend on our recovery every day, and thousands more are referred to treatment each month and our screening/early intervention functionality will reach thousands more.

The CHESS suite of solutions are the only digital solutions commercially available to address the **entire addiction management life cycle** from Prevention to Intervention to Recovery Support, as depicted in the image below.



CHESS Health Key Functionality—An Overview

eRecovery, including the Connections App

CHESS is best known for eRecovery, which includes three components: the Connections App, CHESS' 24/7 Peer Engagement team, and CHESS Dashboard (care management functionality for the care team (e.g., counselors, case managers, peer recovery coaches)).

The purpose of the Connections App is essential and simple, especially for state agencies. Individuals seeking to achieve recovery from SUD typically need 12 months of outpatient therapy, most of which will be weekly (some individuals start with intensive outpatient therapy and then move to weekly treatment). When individuals are in therapy, there is a gap of days or a week (167 hours), and sometimes, even more, between therapy sessions. During this treatment gap, individuals will inevitably face risk moments, such as triggers, cravings, anxiety, negative thinking, etc., which, when severe or compounding, can lead the individual to lapse (return to drug/alcohol use) and if this substance use becomes recurrent, lead to relapse and drop-out from treatment.

The simple purpose of the Connections App, backed by the CHESS 24/7 Peer Engagement Team[1], is to support individuals during this treatment gap (between visits), all day and night long, in order for the individual to stay in recovery and be more likely to attend their next therapy session. After their next session, Connections and the CHESS Team will be there again for the next 167 hours (or however long).

This simple purpose is vitally important because individuals do not relapse at their provider's office for their weekly therapy session – they relapse and drop out of treatment between sessions. With the App and our peer support between sessions, relapses are less likely, individuals stay in treatment longer, and their long-term treatment outcomes are better.

The Connections App does not deliver treatment. We don't replace providers or local peers. We complement the work of providers and peers by supporting individuals between treatment sessions so they stay in treatment longer.

The key functionality of the Connections App that helps individuals to stay in treatment and recovery (and to support the work of their care team) includes:

- Anonymous discussion forums connecting individuals with others in recovery (peers) to discuss recovery, mental wellness, and fun/social topics (these forums are safe and supportive because they are actively moderated 24/7 by the CHESS Peer Engagement Team)
- Video support group meetings (termed "Alongside" meetings)
- Digital CBT programs for learning and practicing recovery skills
- Appointment and medication reminders
- Daily and weekly surveys for tracking recovery progress and identifying relapse risks
- Sobriety tracking
- Gamification (points, level, badges)
- Content library (articles, videos, etc.)
- 1:1 and group messaging
- 1:1 and group video calls
- Crisis help button

Connections is routinely given by providers to their patients for the same purpose – to support patients between treatment visits so they stay in treatment longer—better outcomes without additional clinician work.

CHESS recently released a Spanish version of the Connections App: ***Conexiones.*** This version has all the robust functionality of Connections and is backed by our team of bi-lingual peers.

eIntervention

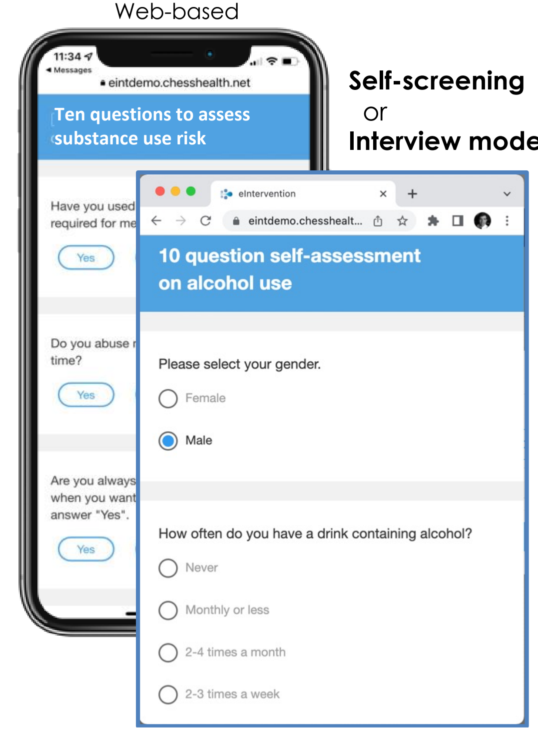
For states to reduce the consequences and costs of substance use disorder, connecting more individuals to treatment is vital. By some estimates, only 10% of Americans with SUD are in treatment.

[1] The CHESS Peer Engagement Team is made up of a diverse set of certified peer recovery support specialists – all of whom have lived experience and are CHESS Health employees.

eIntervention is a web-based, closed-loop referral solution that connects healthcare providers, government agencies, and community programs–optimized for behavioral health and substance use disorder. States can use eIntervention, and our accompanying Connections Text service, to help connect patients to treatment providers and wraparound services (housing, employment, health, etc.).

Connections Text is CHESS' virtual intervention service where a dedicated team of peer recovery support specialists engages individuals via text or phone, such as when they are in an Emergency Room or have just left one, to encourage and support them to get treatment and start their recovery journey.

ePrevention



ePrevention is CHESS' newest solution. As the name implies, the purpose is to prevent the onset of SUD. ePrevention encompasses screening capabilities, both interview style and, more importantly, self-screening, to identify at-risk individuals. ePrevention supports standardized screeners such as the AUDIT, CRAFFT, CAGE, etc., as well as customized screeners.

The power of ePrevention is in the feedback it provides based on the screening answers. In the self-screening mode, individuals are presented with their risk score/summary feedback and then a set of interventions encompassing motivating content, resources, prevention tools, self-moderation tips, and, for those individuals whose risk indicates need for treatment, the ability to request appointments from local providers.

Data Security:

CHESS Health has over six years of experience delivering its technology solutions for behavioral health and utilizes industry best practices concerning data security and operational controls. Across our suite of solutions, all customer/patient data is encrypted in transit and at rest. Complex passwords, auto-logouts, role-based security, and segregated databases control access to patient data. Intrusion detection, vulnerability scanning, virus protection, and penetration testing protect the networks and devices used by CHESS employees and the solution databases hosted at Amazon Web Services (AWS), which has the industry's most advanced physical controls protecting its data centers. Organizationally, CHESS strictly limits access to production systems, limits access to patient and customer data, ensures all devices are encrypted, and the company has strong methodologies and written policies spanning all aspects of its hiring, training, engineering, and customer support processes relevant to data and system controls. CHESS has also achieved HITRUST Certification for the past two years.

Why should NJ partner with CHESS?

We understand that NJ may not have a project like the one we are proposing as part of their current planning process. However, given the recent Governor's Opioid Settlement Fund Spending Plan Public Feedback Project,

which focuses on opioid abatement strategies statewide, it is essential to know that several states have deployed the CHESS platform as presented in this proposal with great success. Outlined later in the document is a summary of these critical projects.

Focusing directly on the requirements of the NJ Opioid Settlement Feedback project, the expanded table below provides highlights of how the CHESS solutions address each of the stated requirements.
As indicated in the table below, CHESS offers solutions to support 7 of the 8 categories listed.

NJ Settlement Funding Requirement	CHESS Health Solution
Supporting people in treatment and recovery	✓ eRecovery
Providing connections to care	✓ eIntervention
Addressing the needs of justice-involved persons	✓ eRecovery, eIntervention
Addressing the needs of pregnant or parenting people who use drugs and their families	✓ eRecovery
Preventing over-prescribing and ensuring the appropriate prescription of opioids by medical professionals	✓ N/A
Preventing problematic use of opioids	✓ eRecovery, ePrevention
Preventing overdose deaths and harms through harm reduction strategies	✓ eRecovery, ePrevention
Other goals such as supporting first responders, training, and cross-system collaborative efforts, and/or research	✓ eRecovery, eIntervention, Connections Text

Supporting NJ Citizens

- Patients love our Connections App and have access to support and engagement 24/7/365
- Using the App correlates with a 40-50% reduction in key relapse risk factors
- Strengthening coping skills and improving recovery capital helps improve overall recovery outcomes for individuals

Supporting NJ Providers

- Patients stay in treatment longer with the support they get from the Connections App and peer team
- Staff have fewer patient-related crises to manage (with little/zero staff effort), which helps to address staff burnout
- For IP/OP treatment alumni, App keeps them engaged with the recovery community
- Clinical trials by both Drs. Gustafson & Carroll, with 6–12-month follow-ups, found 30-50% greater abstinence compared to the control group

Supporting the State of New Jersey

- Quality data analysis by payer (Medicaid, Commercial, etc.) and provider; the eRecovery/Connections app will help the state measure outcome success
- Using the App correlates with patients staying in treatment 20%+ longer, including 30-45% reductions in early drop-out from Intensive Outpatient programs
- Experience: Multiple states and departments – DOH, DHS, DOC, BH, CYFD & more can use CHESS tools

Return on Investment & Outcomes

Previously, we described the primary purpose of the Connections app – to support patients between therapy sessions, typically weekly therapy sessions, to help them stay in recovery, avoid relapse, and to stay in treatment. By some measures, the relapse rate for individuals is as high as 60%. Some studies have measured it takes individuals five attempts at recovery before they achieve long-term recovery.
The eRecovery/Connections App ROI for state entities is clear – by supporting citizens to relapse less, and to stay in treatment and recovery longer, these individuals incur fewer total costs (behavioral health and physical health costs) than individuals who do not have this additional support.

A Medicaid health plan measured cost of care savings of $278 per member/per month because their members with the Connections App returned to higher levels of care (residential, detox, inpatient) at a substantially lower rate than similar members without the App.

The State of Oklahoma did a similar claims analysis and measured the difference in return to higher levels of care at 27%. They also measured how long individuals with the App stayed in outpatient treatment; they found, on average, an additional 37 days compared to a similar cohort without the App.

CHESS does not yet have ROI data from its ePrevention solution – the goal here is to reduce the onset of addiction and, for those identified at high-risk, get them to treatment sooner. In either case, the use of ePrevention helps states avoid costs associated with the consequences of substance use disorder among its populations.

CHESS Health Overview

Treatment and recovery from Substance Use Disorder (SUD) is a lifelong journey.

It requires a multi-level support system, including individualized healthcare, self-care, and social support. Treatment is most successful when it is comprehensive, individualized, and integrated into the person's life, and recovery is a process of continuous growth that is not necessarily linear. Current approaches that support prevention, treatment, and recovery help only a small portion of people with SUD to receive adequate, sustainable care.

There are several reasons for this, but one of the most significant is the lack of treatment and recovery support access. In particular, people with SUDs often face substantial barriers to care, such as cost, lack of insurance, and lack of qualified providers. Additionally, the social stigma surrounding SUDs can discourage people from seeking help, and even when they do, the treatment they receive is less than what is needed.

With a steadfast commitment to a human-centered approach, CHESS is the leading provider of evidence-based digital health solutions that are geared toward addressing the crisis of substance use disorder. Our thought-leading solutions are designed to empower more people to access treatment and make meaningful connections that support lifelong recovery and reduce the impact of SUD on communities and individuals.

The CHESS team is composed of passionate and experienced individuals who are committed to making a difference in the lives of those affected by Substance Use Disorder and their communities. Our team includes clinicians, technologists, designers, and business professionals who share a common belief that technology can be leveraged to improve access to quality care and support for those affected by SUD.

At CHESS, we leverage our expertise, depth of insight into SUD, and incomparable level of experience to improve outcomes, reduce medical costs, and mitigate the personal and secondary effects of SUD. To date, we have seen exceptional results with over 85% of individuals who have used our solutions reporting that our platform has improved their treatment and reliable data showing that our programs correlate with individuals staying in treatment 20%+ longer.

Real Evidence. Real Recovery.

Our tagline is "Real Evidence, Real Recovery."

Our "Real Evidence" starts with our academic/research roots. The Connections App, known initially as "ACHESS," was the work of University of Wisconsin professor David H. Gustafson, Ph.D., who developed the original smartphone app and validated its effectiveness in multiple studies. Subsequently, CHESS partnered with Yale School of Medicine professor Kathleen M. Carroll, Ph.D., to integrate her CBT4CBT programs -- innovative, clinically validated online programs for teaching and practicing recovery skills.
The following are links to peer-reviewed articles about ACHESS and CBT4CBT (the research names for the Connections App):

- **Using Smartphones to Improve Treatment Retention Among Impoverished Substance-Using Appalachian Women: A Naturalistic Study**
- **Youth in Intensive Outpatient Treatment at New Directions, Inc.**
- **An E-Health Solution For People With Alcohol Problems**
- **The Journal of Substance Abuse Treatment: Treatment seeking as a mechanism of change in a randomized controlled trial of a mobile health intervention to support recovery from alcohol use disorders**
- **A Pilot Test of a Mobile App for Drug Court Participants**
- **The effect of bundling medication-assisted treatment for opioid addiction with mHealth: study protocol for a randomized clinical trial**
- **JAMA Psychiatry: A smartphone application for alcoholism recovery: A randomized controlled trial**
- **Journal of Dual Diagnosis: How Patients Recovering From Alcoholism Use a Smartphone Intervention**

In addition, CHESS has numerous case studies and white papers detailing customer implementations, which can be found at https://www.chess.health/category/case-studies/

CHESS Customers

CHESS currently has over 200 customer partners, including states, counties, health plans, and providers. Notable customers include Anthem, Hazelden Betty Ford (the nation's preeminent addiction treatment provider), and the states of West Virginia, Oklahoma, and New Mexico. In one of our newer projects, The Harris County, TX, Department of Health is providing eRecovery/Connections App to all incarcerated individuals with a diagnosis of SUD upon re-entry.

CHESS Statewide Installations

State of Oklahoma

Oklahoma Understands the SUD Problem all too Well.

Substance Use Disorder (SUD) is a public health crisis in Oklahoma, one that's been steadily growing for more than a decade. Nearly 1,000 Oklahomans die each year from a drug-related overdose. According to an article published by the Oklahoma Policy Institute, 300,000 people in the state struggle with substance abuse but only one in three get the care they need. Teresa Stephenson, Director of Opioid and Women Specific Treatment Services/State Opioid Treatment Authority at the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), says "One of the problems plaguing Oklahoma has been a lack of connectivity, coordination, and SUD recovery resources across our state." Stephenson added, "We've had multiple entities trying to tackle the issue on their own, but with the rural nature of our state, many lacked the resources with which to expand access and get people the care they need in a timely manner." That, however, is changing.

The State of Oklahoma has been sponsoring the use of the Connections App in the state since 2016 when it first subsidized the use of the App by the nationally-recognized Women in Recovery program at Oklahoma Family & Children Services – a prison diversion program for women with SUD (and a remarkable recidivism rate of just 4%).

In late 2020, Oklahoma expanded its use of the CHESS platform statewide, making it available to all state-contracted SUD providers, federally qualified health centers (FQHCs), recovery coaching organizations, the 211 line, hospital emergency departments, correctional facilities, department of human service caseworkers, and more. Every month, thousands of Oklahomans get recovery support and/or connected with treatment through the CHESS platform.

The Connections App is used widely across both the urban and rural areas of the state – one individual shared the following:

> hi I'm █████ I live in slick, Oklahoma and I've been sober now for 96 days I am glad that I have you guys support and I hope we can enjoy some good times and conversation here thanks for the awesome support in such little time

Slick, Oklahoma is a community of just 148 individuals. There are no health or behavioral health providers of any kind, no counselors, and no AA meetings – for individuals like this one, the Connections App offers them vital recovery support not available locally.

The outcomes data measured in Oklahoma also indicate individuals are benefitting from the Connections App and relapsing less. From recovery progress data captured through the App on a weekly basis, individuals using the App reduced key relapse risk factors by 26.8%, including a 34.3% reduction in their urges/cravings for substances and a 28.5% reduction in difficulty sleeping and 24.8% reduction in feeling depressed.

> **26.8%**
> Reduction in key relapse risk factors

Currently, CHESS is working with the State of Oklahoma's Department of Mental Health and Substance Abuse Services (ODMHSAS) on a claims analysis/total cost of care analysis similar to what was done in West Virginia.

State of West Virginia

A Rapid Statewide Roll-Out of eRecovery to Combat COVID-19 for Immediate Impact

The COVID-19 crisis resulted in the shutdown of SUD providers and community support resources. This resulted in patients not getting to treatment, missing meetings, and disengaging from therapy—all of which have exacerbated the negative impact of social isolation. Combined, these risk factors are driving patient relapse and, sadly, high levels of overdose. The state of West Virginia was determined to address the issue by leveraging technology to scale their SUD treatment efforts. By partnering with CHESS Health, the state was able to rapidly implement CHESS Health's evidence-based patient engagement platform to connect treatment providers with people in need.

In April 2020, the State of West Virginia used federal funds to make CHESS Health's **Connections App** available to support the recovery of its citizens with substance use disorder (SUD).

The Connections App is available through 45 participating SUD treatment providers, sober living homes, college recovery programs, quick response teams, crisis support lines, and through www.hope4wv.com, the state's social services website. In 18 months, thousands of West Virginians have used the App – 3.5 months of recovery support per person, on average.

The following exemplifies the feedback of many using the Connections App:

> JoshD$
>
> You guys are all amazing this has been my greatest tool in my recovery thank you everyone

27.7%

Reduction in key relapse risk factors

The outcomes data measured in West Virginia support this anecdotal feedback. From recovery progress data captured through the App on a weekly basis, individuals using the App reduced key relapse risk factors by 27.7%, including a 34.6% reduction in their urges/cravings for substances and a 40.6% reduction in encountering risky situations.

The largest Medicaid managed care organization in the state analyzed medical and behavioral health claims from its members with SUD, comparing those who used the Connections app to those that didn't (both followed similar treatment journeys) and measured a 92% difference in the rate of readmission to a higher level of care/hospital readmission within six months. Members who used the Connections App had very few returns to detox/residential treatment, whereas members without the App had substantially more – the cost savings spread across all members of each cohort was $282 per member per month ($3384 annualized).

$282 pm/pm

Total cost of care savings from fewer readmissions

High-Level Timeline

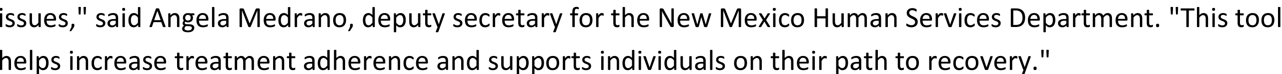
Task	Duration
Planning and contracting	4 weeks
Creation of provider website for orientation and enrollment	1 week
Governor's press release announcing project	1 day
Media campaign	1 week
First provider education sessions	3 days after announcement
First provider go-live	3 days after first education session
Direct-to-consumer webpages built and live	2 weeks

State of New Mexico

As our newest state partner, New Mexico Human Services Department (HSD) announced in June of 2022 that they are partnering with CHESS Health to provide peer support via the eRecovery Connections app for community members in treatment and recovery for substance use disorder.

The App is part of the *Connections for Recovery Initiative*, which equips New Mexico's behavioral health providers with an additional tool to support people battling opioid, alcohol, or other substance use disorder.

"The Connections app is a support tool to be used in conjunction with treatment for people with substance use disorder or people experiencing behavioral health issues," said Angela Medrano, deputy secretary for the New Mexico Human Services Department. "This tool helps increase treatment adherence and supports individuals on their path to recovery."



"We need to do everything we can to keep helping people achieve sustained recovery from substance use disorder," said Neal Bowen, PhD., Director of HSD's Behavioral Health Services. "That's exactly why the time is right for us to support individuals day and night, no matter where they are —We can do that with the Connections app."

Next Steps

As previously stated at the beginning of this document, our goal is to have an opportunity to present our solutions, use cases and other supporting information to the NJ Opioid Settlement Committee either in person or remotely for consideration. Please contact Brenda Berry, Regional Director at bberry@chess.health for more information or to arrange a presentation of the CHESS solutions.

In conclusion, everyone at CHESS is excited at the prospect of working with New Jersey in this capacity, and we are eagerly anticipating welcoming you to the fast-growing list of CHESS customers. We will work extremely hard to build a strong, long-term partnership focused on providing your communities with the support they deserve, reflecting the many challenges and roadblocks of the addiction life cycle.

Collaborators on Daniel M. Rosenblum's Opioid Settlement Fund Proposal

The following all collaborated on developing Opioid Settlement Fund proposal submitted by Daniel M. Rosenblum:

- Stanley H. Weiss, MD, Professor, Department of Medicine, Rutgers New Jersey Medical School, and Department of Biostatistics and Epidemiology, Rutgers School of Public Health

  Dr. Weiss is the founder of the Essex-Passaic Wellness Coalition (the regional chronic disease coalition for Essex & Passaic Counties). He is also the principal investigator for Rutgers' subcontract with the City of Paterson for evaluation and assessment of the RealFix program, as well as for a NJDOH-funded project engaging women of color about COVID-19 vaccination.

- Daniel M. Rosenblum, PhD, Principal Research Associate and Assistant Professor, Rutgers New Jersey Medical School, and Department of Biostatistics and Epidemiology, Rutgers School of Public Health

  Dr. Rosenblum is the project director for the Essex-Passaic Wellness Coalition, and also collaborates with Dr. Weiss in his work with the City of Paterson (as well as in many other endeavors, including Dr. Weiss's cohort studies of drug users) and the aforementioned project engaging women of color about COVID-19 vaccination. He is also the project director for a separate NJDOH grant supporting regional chronic disease coalitions to engage in further outreach and education about COVID-19 vaccination.

- Alexander I.G. Hoffman, PhD, Public Health Representative II, Department of Medicine, Rutgers New Jersey Medical School

  Dr. Hoffman is the coordinator of the Essex-Passaic Wellness Coalition, as well as of the separate NJDOH grant supporting regional chronic disease coalitions to engage in further outreach and education about COVID-19 vaccination.

- Claire E. Burns-Lynch, MPH, Research & Teaching Specialist III, Department of Medicine, Rutgers New Jersey Medical School.

  Ms. Burns-Lynch is a research associate of Drs. Weiss and Rosenblum focusing on Dr. Weiss's cohort studies of drug users.

Collaborators on Dr. Stanley H. Weiss's Opioid Settlement Fund Proposal

The following all collaborated on developing the Opioid Settlement Fund proposal submitted by Stanley H. Weiss, MD:

- Stanley H. Weiss, MD, Professor, Department of Medicine, Rutgers New Jersey Medical School, and Department of Biostatistics and Epidemiology, Rutgers School of Public Health;
- Daniel M. Rosenblum, PhD, Principal Research Associate and Assistant Professor, Rutgers New Jersey Medical School, and Department of Biostatistics and Epidemiology, Rutgers School of Public Health;
- Claire E. Burns-Lynch, MPH, Research & Teaching Specialist III, Department of Medicine, Rutgers New Jersey Medical School.
- Over 40 collaborators and staff assisting with this project, all of whom are part of our Rutgers Health Sciences IRB-approved research protocol.

Our study and data are protected by a Certificate of Confidentiality from the National Institute on Drug Abuse (NIDA).

A SHIFT LEFT:
Revised Regulations for Opioid Prescribing in New Jersey

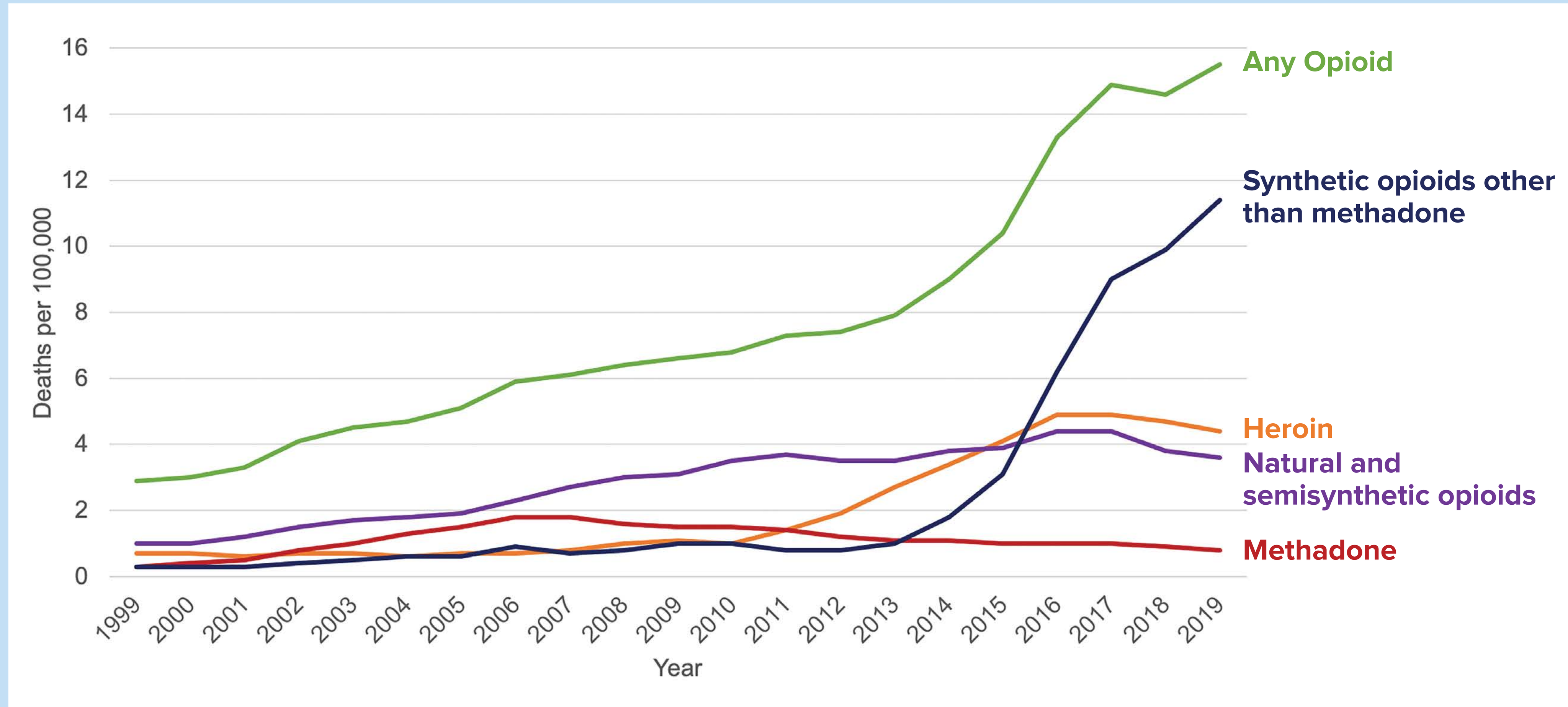
Scott Metzger, MD[1], Olivia Metzger[2]

[1]Immediate Past President, New Jersey State Board of Medical Examiners, Trenton, New Jersey
[2]Student, University of Wisconsin–Madison, Madison, Wisconsin

BACKGROUND

- In the United States, 9.3 million people, or 3.4% of the population, have misused prescription opioid pain relievers since 2020[1]
- The risk of opioid misuse increases when patients have a combination of ≥2 substance-use disorders or mental disorders (eg, anxiety and mood disorders, schizophrenia, bipolar disorder, major depressive disorder, conduct disorders, posttraumatic stress disorder, attention deficit hyperactivity disorder)[2]
- Even a 3-day supply of opioids may cause addiction in high-risk patients; as a result, long-term success can only be achieved by preventing unnecessary initiation of opioids[3]

FIGURE: Age-Adjusted Rates of Drug Overdose Deaths Involving Opioids, by Type of Opioid: United States, 1999–2019[4]



GOAL

- To highlight key initiatives in New Jersey aimed at reducing rates of prescription opioid abuse with potential to serve as a model for nationwide adoption

METHODS

- In February 2021, changes to opioid-prescribing regulations were introduced and unanimously approved by the New Jersey medical board[5,6]
- The public comment period on novel prescribing regulations ends April 23, 2022[5,6]

TABLE 1: Key Updates to Opioid-Prescribing Regulations in New Jersey[5,6]

Preexisting	Changes
Physical examination and assessment of psychological function	• Screening for behavioral health conditions, including anxiety and depression, is a key element of the new regulations • Acknowledgment of direct correlation between higher dose of opioids and greater incidence of behavioral health conditions
Existing medical records requirements were limited to the following: • Medical history • Examination findings • PMP data • Complete name, dosage strength, and instructions for frequency of use of controlled substance	• Updated regulations require development of a treatment plan with a defined objective for pain relief, improvement in physical and psychological function, and further planned evaluations. When treating chronic pain, terms of the pain-management agreement must also be specified • Patients must be informed of possible treatment alternatives to ensure their active engagement in the care process • A chief complaint that is not based on a specific treatment plan (eg, documenting a chief complaint of "medication refill") is no longer sufficient for documentation of clinical improvement
Existing regulations noted the importance of documenting patient understanding of a pain-management plan, but had no defined strategy for modifying the plan of therapy if treatment goals were not met	• Because long-term opioid use is associated with increased risk of opioid-use disorder, updated regulations mandate that HCPs inform patients about best practices for treatment discontinuation, plans for modification of the treatment plan, and evaluation of risks versus benefits of therapy • Updated regulations mandate discontinuation of medication if patients have not achieved documented meaningful improvement
Prior regulations ensured that patients had access to opioid therapy	• To ensure that patients can continue taking medication with proven benefit, new regulations reaffirm the importance of legitimate opioid use, including patients with cancer, patients in hospice care and long-term care facilities, and patients receiving medication-assisted treatment for substance abuse or opioid dependence

RESULTS

- Screening for both opioid-use disorder and behavioral health disorders, and measurement of decreases in new cases of opioid-use disorder and overdose deaths throughout New Jersey
- Future nationwide replication of New Jersey's success in changing opioid-prescribing regulation

CONCLUSIONS

- **Updated prescribing regulations in New Jersey focus on ensuring that opioids are prescribed for chronic pain, with assurance of a treatment plan, assessment of risks, and monitoring for benefits of therapy**
- **New regulations define the treatment plan and require specific documentation for healthcare providers (HCPs) treating patients with chronic pain**
- **These new regulations provide HCPs with the tools to prescribe more safely**

REFERENCES

1. Substance Abuse and Mental Health Services Administration (SAMHSA). Key substance use and mental health indicators in the United States: results from the 2020 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2020. HHS Publication No. PEP21-07-01-003, NSDUH Series H-56. https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf. Published October 2021. Accessed April 13, 2022.
2. Substance Abuse and Mental Health Services Administration (SAMHSA). Co-occurring disorders and other health conditions. https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/co-occurring-disorders. Updated November 4, 2021; last updated April 13, 2022. Accessed April 13, 2022.
3. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use - United States, 2006-2015. MMWR Morb Mortal Wkly Rep. 2017;66(10):265-269. doi:10.15585/mmwr.mm6610a1
4. Hedegaard H, Miniño AM, Warner M. Drug Overdose Deaths in the United States, 1999-2019. NCHS Data Brief. 2020;(394):1-8.
5. New Jersey Division of Consumer Affairs. Rule Proposal 54 N.J.R. 333(a). https://www.njconsumeraffairs.gov/Proposals/Pages/bme-02022022-proposal.aspx. Published February 22, 2022. Accessed April 13, 2022.
6. New Jersey Division of Consumer Affairs. New Jersey Administrative Code Title 13 Law and Public Safety: Chapter 35 Board of Medical Examiners. https://www.njconsumeraffairs.gov/regulations/Chapter-35-State-Board-of-Medical-Examiners.pdf. Published December 6, 2021. Accessed April 13, 2022.

Federation of State Medical Boards Annual Meeting; New Orleans, Louisiana; April 28–30, 2022.

I plan on using the money given by the federal government and the state to enhance programs already in place as well as create a new one that may transform the state of NJ's addiction and mental health program.

I See You NJ

I would like to create a new program that focused on outreach in low-income communities. I would like this program to be called "I See You NJ". This program is needed because the main problem I see in NJ's efforts to help those with substance abuse and mental health problems is the lack of outreach to the individuals themselves. Most of the programs offered have to be found by the person needing help. However, there are many individuals who don't seek the help needed or may not have access to technology like phones or computers that connect them to these resources. Most of the programs also need to be applied for rather than just giving the support that is clearly needed.

The new program I want to implement would have two crucial elements. First, it would work with those in nearby communities in the area to set up a neighborhood watch system. NJ has one of the worst drug problems, even surpassing NYC, as most of the crime was pushed out of the city and into places such as Newark, Trenton, and Elizabeth. The drug problem has been on the rise due to the many modes of transportation through highly traveled airports, highways, and public transportation systems making it easy to smuggle and distribute drugs. Another reason we have a huge drug problem is the fact that we have several gangs that cause drug distribution and drug-related violence throughout the area. Through working with people in the community, a neighborhood watch, and an increase in camera surveillance in the area, drug distribution could be cracked down on and easily reported preventing the spread. People are also less likely to try and sell drugs in an area they feel is highly watched. The community watch can also be given a stock of Narcan to distribute within the community on a weekly basis.

The second crucial part of this program would focus on setting up more syringe access programs and counseling programs in these underdeveloped areas. In all of NJ, there are only 7 centers, which is low compared to other states like Kentucky with over 20 centers. This would help prevent the spread of disease through dirty needles and start to connect these individuals with other support services allowing them to consider getting help in a way more targeted toward rehabilitation. The counseling services offered would also pay professionals to help offer behavioral therapy in group sessions and provide a safe space to host AA meetings. The counselors could also be provided with medical devices to help deal with withdrawal symptoms.

I would like the state to allocate a total of 30 million dollars to implement this new program. 5 million dollars would directly go to setting up cameras and surveillance technologies throughout the state's counties with the highest rates of opioid use and addiction like Camden and Newark. Another 5 million would go into creating the neighborhood watch program by providing individuals with training, gear, and uniforms. This would also be used to set up a website and a communications medium so that individuals can apply and share information they might have. 5 million dollars would go to rent for buildings spaces to host offices for counselors and support groups for those with addiction and mental health disorders with an additional 5 million to hire counselors, purchase withdrawal devices or medications, and raise money and spread awareness. 10 million dollars would be given to help set up more syringe access programs. The funding for this would go towards purchasing syringes, purchasing materials to set up the location, and creating flyers with resources on them for those without access to

technology. This would also go towards stocking up on a Narcan supply to be distributed within the communities on a weekly basis by counselors and the neighborhood watch.

Talk. They Hear You

I would also like to expand upon the Talk. They Hear You Program. Talk. They Hear You. is SAMSHA's underage drinking campaign, which helps parents and caregivers start talking to their children early about the dangers of alcohol. This program is important because it reveals a key part of prevention. Talking to the youth and making them aware of addiction and its importance. This mobile application is a great way to seek help, support, and education right from an individual's fingertips making this information more easily accessible than ever before. It reveals information about being informed on mental health and drug addiction, being prepared and understanding what it looks like when someone is having an overdose, and taking action in regards to how to stop an overdose or prevent it. This will help those without access to support gain it in an easy way.

To expand this program I would like 25 million dollars to be allocated towards Talk. They Hear You. 10 million dollars would go towards marketing the app on all main forms of social media such as Facebook, Instagram, Twitter, and TikTok. The goal would be to take this app made in NJ to new levels making it known nationwide as it is a such great tool. Another 10 million dollars would go towards refining the app and making sure it is easy to use, has a nice setup, and has no bugs or glitches. This money would also go towards creating new content for the app and creating a youtube podcast representing the app. The last 5 million dollars would go towards services that can be provided through the app such as counseling and devices such as Narcan allowing them to be shipped freely.

NJ 211

I would like the state to consider the expansion of the NJ 211 Partnership program. This program focuses on helping individuals find solutions to personal needs by informing them of resources in their community, like daycare facilities, shelters, affordable housing units, social services, employment training programs, senior services, medical insurance, and more. Their statewide service is free, confidential, multilingual and always open. They have various systems to help with substance abuse such as counseling, intake, education, prevention, detoxification, treatment, housing, and support services. With regard to mental health services, they provide hotlines, intake, counseling, psychiatric services, and support groups. This program is important because it is a one-stop shop for anything someone with these problems may be looking to gain access to. They are open for donations and they have helped over 1,000,000 people in the state gain support and help in moments of despair.

I want the state to allocate 35 million dollars to expand this program and support the resources they already have in place. I would like 10 million dollars to go directly toward mental health and 10 million to go toward substance abuse resources so that each department can use the money in its specific respects. Then 5 million dollars would work to spread awareness and knowledge of NJ 211. 5 million would be dedicated to having people go into schools and other community settings to talk about the program and provide fliers. 2 million would go towards social media marketing. The remaining 3 million would go towards providing housing and beds for those with these issues that might be homeless.

NJ Family Care

I would like to expand the NJ Family Care Program. This program is New Jersey's publicly funded health insurance program, which includes CHIP, Medicaid, and Medicaid expansion populations. That means qualified New Jersey residents of any age may be eligible for free or low-cost health insurance that covers doctor visits, prescriptions, vision, dental care, mental health and substance use services, and even hospitalization. This program is crucial because it provides the necessary and proper professional care aside from counseling or support groups that individuals may need. It helps expand health insurance to those who may not have it and help to expand the way healthcare is provided in NJ. However, I would like to see an expansion on who may be eligible for the program because the income on paper is never a true statement of how some individuals may actually be struggling. I would like them to expand eligibility to households who bring in 7,000 a month instead of the maximum of 4,000 dollars a month. This would help reach thousands more individuals who may be struggling with mental health disorders, substance abuse, and hospitalization.

I would like the state to allocate 25 million dollars to provide funding for the program so that they could change the terms of eligibility based on household income and family size. The total funding amount would be used to pay the difference between the new eligibility requirement. This would ensure the same services and quality of service will be provided while reaching so many more individuals. This would also ensure that the individuals already using the service won't be affected by the new changes.

NJ Division of Mental Health and Addiction Services

Lastly, I would like to create a new division within the NJ Division of Mental Health and Addiction services program. The New Jersey Division of Mental Health and Addiction Services (NJDMHAS) serves individuals with mental illness and/or substance abuse problems and assists their family members. I would like to create a division that allocated money to assist these individuals by providing free counseling for mental illness as well as a rehab program that was set up in an outpatient format. We would work with rehabilitation centers such as Brookdale or Seacrest rehab center to pay for services that individuals can seek more serious help from without the burden of paying if they do not have insurance or cannot afford it. This would be a charity program apart of the NJDMHAS that helps give support to those in need.

I would like 30 million dollars to be donated by the state to help support the money needed to both start this program and provide the help being given. 10 Million dollars of the money would pay for the programs and medication themselves. 10 million would provide the initial implementation of the program including marketing strategies to inform people about the new program. The remaining 10 million dollars would go towards fundraising events in efforts to keep the program running after the initial funding runs. This would rely on volunteers and donations by individuals and other rehab centers who might consider offering discounts or free care themselves.

Dear Governor Murphy and Esteemed Members of the Opioid Recovery and Remediation Advisory Council,

Thank you for opening this portal for the crucial public input needed for the best ways to utilize the money NJ receives from opioid settlements. I have been meeting for several weeks with a group of citizens with lived experience of addiction and recovery, comprised of family members, allies, and people that identify as in recovery, as well as people who use drugs. We all work closely with people that use substances and those in recovery, and the families affected by it, and we are the experts in identifying gaps in the current NJ system because we live it, and assist others with it, every day.

We agreed on many points. Transportation for those seeking assistance is practically non-existent. Safe, inclusive, affordable recovery housing, especially for marginalized populations (minorities, non-English speaking, LGBTQIA+, etc,), needs to be implemented and expanded in all areas across the state. Medications for Opioid Use Disorder need to be easily accessible, affordable, and normalized. However, we decided that all issues and gaps that we discussed could not be adequately addressed without an official oversight and accountability entity that could look at the whole continuum of Substance Use Services in NJ. Therefore, we propose a New Jersey Office of Recovery that could examine, advise, and coordinate the many sectors involved in addressing substance use in our state.

Because addiction is multifaceted, the approach must be as well. NJ has programs that address SUD in many different agencies: DHS (DMHAS), DOH, OAG, DCPP, DCF, DCA, DOJ, DCJ, etc. These agencies are often unaware of each other's programming and efforts, leading to duplicate services or to "reinventing the wheel." Collaboration among the divisions is rare, frequently leads to ineffective services and gaps, and sometimes to losing the very people that they are intended to serve. The bureaucracy within and among agencies often leads to a stalemate for front line workers, who are looking to assist people in an incredibly time sensitive manner.

The Office of Recovery should be led by an individual that has personal lived experience with addiction (self or family) as well as experience working in the professional field. They should not be required to have higher degrees and only clinical experience; instead, this person should have a thorough knowledge of

how the different systems that address SUD in NJ work, and an understanding of the importance of grassroots input in reimagining the continuum of care. This office should accept and investigate complaints regarding SUD care, and have the ability to impose restrictions on entities that are non-compliant with best practice directives and rules. The Director of this office should report directly to the Governor, independent of any other government office, in order to have standing among all divisions. There should be enough staff members (minimum 4) to assist this Director with the momentous task of surveying, evaluating, and re-creating a recovery oriented system of care in New Jersey that treats addiction as the public health crisis that it is, instead of approaching people with SUD as criminals in need of punishment. The budget for this program should be $1.25 million per year for 10 years.

As NJ implements more harm reduction services, it must also look at how harm reduction hostile its current programs and systems are. An office dedicated to overseeing and transforming the continuum of substance use services and care could make this happen in all programs, in all divisions, and assist NJ in its efforts to become a leader for compassionate and effective care in the SUD field. With all of the innovations NJ has begun and will continue to imagine over the years of settlement funding, it is imperative that the oversight and structure be put in place to guarantee that the monies will be put to best use throughout the divisions. Accountability and transparency are paramount in implementing a more effective system of care to save the lives of more NJ citizens.

9 New Jerseyans die each day from drug related deaths. That's 9 families devastated and left to pick up the pieces EVERY DAY. It's time to do something different.

Thank you,

Member of Advocate to Allocate

Received: 2 January 2022 | Revised: 22 February 2022 | Accepted: 3 March 2022

DOI: 10.1002/oby.23428

ORIGINAL ARTICLE

Obesity Biology and Integrated Physiology

Higher protein intake during caloric restriction improves diet quality and attenuates loss of lean body mass

Anna R. Ogilvie[1] | Yvette Schlussel[1] | Deeptha Sukumar[2] | Lingqiong Meng[1] | Sue A. Shapses[1,3]

[1]Department of Nutritional Sciences, Institute of Food, Nutrition, and Health, Rutgers University, New Brunswick, New Jersey, USA

[2]Department of Nutrition Sciences, Drexel University, Philadelphia, Pennsylvania, USA

[3]Department of Medicine, Rutgers-Robert Wood Johnson Medical School, New Brunswick, New Jersey, USA

Correspondence
Sue A. Shapses, Department of Nutritional Sciences, Institute of Food, Nutrition, and Health, Rutgers University, 59 Dudley Rd., New Brunswick, NJ 08901, USA.
Email: shapses@rutgers.edu

Funding information
This data collection and analysis were funded by the Institute for the Advancements of Food and Nutrition Sciences and by the NIH, grant number AG-12161.

Abstract

Objective: Higher protein intake during weight loss is associated with better health outcomes, but whether this is because of improved diet quality is not known. The purpose of this study was to examine how the change in self-selected protein intake during caloric restriction (CR) alters diet quality and lean body mass (LBM).

Methods: In this analysis of pooled data from multiple weight loss trials, 207 adults with overweight or obesity were examined before and during 6 months of CR (approximately 10 food records/person). Body composition was measured by dual-energy x-ray absorptiometry. Diet quality was assessed using the Healthy Eating Index in 2 groups: lower (LP) and higher (HP) protein intake.

Results: Participants (mean [SD], 54 [11] years; 29 [4] kg/m^2) lost 5.0% (5.4%) of weight. Protein intake was 79 (9) g/d (1.0 [0.2] g/kg/d) and 58 (6) g/d (0.8 [0.1] g/kg/d) in the HP and LP groups, respectively ($p < 0.05$), and there was an attenuated LBM (kilograms) loss in the HP (−0.6% [1.5%]) compared with the LP (−1.2% [1.4%]) group ($p < 0.01$). The increased Healthy Eating Index score in the HP compared with the LP group was attributed to greater total protein and green vegetable intake and reduced refined grain and added-sugar intake ($p < 0.05$).

Conclusions: Increasing dietary protein during CR improves diet quality and may be another reason for reduced LBM, but it requires further study.

INTRODUCTION

Individuals with overweight or obesity often have poor-quality diets that lack fruits and vegetables, whole grains, and legumes and contain excessive amounts of added sugar and saturated, compared with unsaturated, fatty acids (1), which can lead to higher risk of greater weight gain and chronic disease (2,3). Weight loss (WL) of 5% to 10% may prevent chronic disease (4); however, WL diets that restrict energy also reduce healthy food and micronutrient intake (5). The effect of higher protein intake during WL on health outcomes has been reported extensively, and there is evidence that it can promote a healthy body weight, attenuate loss of muscle mass (6,7), and reduce chronic disease (8-10). In addition, it was shown that dietary protein contributes to nutrient adequacy in the general population (11). However, the impact of self-selected dietary protein on diet quality has not been examined, to our knowledge, in a longitudinal study (11), such as during caloric restriction (CR). The link between protein intake and diet quality is important because diet quality is suboptimal in the US, and higher-protein WL diets are popular. In addition, the nutrient adequacy in populations consuming lower

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.
© 2022 The Authors. Obesity published by Wiley Periodicals LLC on behalf of The Obesity Society (TOS).

energy intake, such as in young children and older individuals, or during calorie-restricted diets requires more research. It is possible that, if dietary protein affects intake of other foods and diet quality, this can provide further insight into outcomes associated with low-calorie higher-protein diets.

Epidemiological studies have indicated that use of diet quality indices, rather than single nutrients or food intake in isolation, provides a comprehensive analysis of dietary intake (12). The Healthy Eating Index (HEI) aligns with key recommendations of the Dietary Guidelines for Americans, with a goal to achieve recommended nutrient intakes within the recommended energy intakes (13). The proportional scoring structure of HEI (14) is an appropriate metric to examine longitudinal change such as in a WL trial. Evidence has indicated that a better diet quality has health benefits and that it is associated with reduced weight gain (2) or greater WL (15,16); however, little is known about how HEI is influenced by protein content of the diet.

To address the knowledge gaps, a pooled analysis of completed trials was performed to maximize the number of participants undergoing a similar protocol for moderate WL. Lifestyle modification (i.e., diet and behavior therapy) using group counseling was delivered in 16 sessions over 6 months (17,18), similar to that recommended by the Guidelines (2013) for Managing Overweight and Obesity in Adults (18). The primary goal in this study was to determine how changes in self-selected protein intake during CR affect intake of other foods (with low or zero protein), diet quality using HEI-2015, and nutrient adequacy during 6 months of WL in adults with overweight and obesity. Whether changes in protein intake and other foods in the diet are associated with lean body mass (LBM) after WL in this population was also examined. It was hypothesized that higher protein intake during WL would improve diet quality and attenuate LBM loss compared with lower protein intake.

Study Importance

What is already known?

- Obesity is a heterogeneous disease often associated with a poor-quality diet.
- Intensive nutrition counseling for weight loss (WL) can increase diet quality; however, the role of higher protein intake on diet quality during caloric restriction (CR) is not known.
- Understanding the link between diet quality and protein intake during WL is important because higher dietary protein during weight-stable conditions is associated with attenuated loss of lean body mass (LBM) and other reported health benefits.

What are the new findings?

- Individuals with overweight and obesity improved the quality of their diet more with a higher (79 g/d) compared with a lower (58 g/d) protein intake.
- Individuals who self-select a diet with higher protein intake during CR, compared with lower intake, also reduced intake of low- or zero-protein foods, including refined grains and added sugar, and increased intake of green vegetables.
- Greater protein intake and better diet quality during CR attenuate loss of LBM.

How might these results change the focus of clinical practice?

- Moderately higher protein intake (1.0 g/kg/d) at 20% of energy intake with WL counseling can be encouraged for successful weight loss, to improve diet quality, and to attenuate loss of LBM.
- Counseling for weight management that recognizes that there is a wide potential range of protein intake that is interconnected to other food choices may improve the quality of advice to patients.

METHODS

Trial designs

This analysis included pooled data of multiple trials from the same laboratory at Rutgers University (19-23) in which participants followed a 6- to 12-month WL intervention, with weekly counseling sessions during the first 8 weeks and at least twice monthly sessions thereafter with a registered dietitian nutritionist (RD/RDN). Because all participants completed 6 months of WL, this time point was used for the current analysis.

This group of WL trials in our laboratory that were funded by the NIH (AG-12161) are included in the Osteoporosis, Weight Loss, and Endocrine database (OWLE). Trial registration of the original studies is at ClinicalTrials.gov NCT01631292, NCT00473031, NCT00472745, and NCT00472680 (Supporting Information Table S1). These clinical trials were selected because participants had BMI > 25 kg/m^2 and participated in at least 6 months of nutrition education and behavior modification using similar protocols. Additionally, there was consistency among these trials, with study staff adhering to evidence-based practices (i.e., RDN) and standard operating procedures to enhance validity.

The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Institutional Review Board of Rutgers University, the State University of New Jersey (protocol code 94-011 and 11/20/2020). Informed consent was obtained from all participants involved in the study.

In the original trials, participants received calcium and vitamin D supplementation or assignment to high or normal protein groups. All participants were encouraged to lose weight following

a 500-calorie-deficit diet and to consume healthier foods using the Academy of Nutrition and Dietetics/American Diabetes Association's Food Lists for Weight Management. Participants included in these studies were advised to consume protein intake (18% of the calories) from less-processed sources (i.e., poultry, red meat, fish, legumes, and dairy). The subset (n = 24) included in this study who were encouraged to consume higher protein intake (23) reported intake ranging from 13% to 29%, which was similar to the other 183 participants who were asked to consume 18% protein (10%-28%).

Participants were informed on procedures for reporting accurate food records during initial phases of screening and intervention. Baseline 24-hour recall and monthly food records were documented. Physical activity level was based on the reported time spent walking for exercise or other walking and scored from 0 to 3 (24). All participants were advised to maintain their usual physical activity during the intervention. Height at baseline and monthly weight were measured on a stadiometer and digital balance scale, respectively. Body composition (fat mass and LBM) was assessed using dual-energy x-ray absorptiometry (Lunar Prodigy Advance, GE Healthcare) at baseline and 6 months.

Participants

In the original WL trials, adult women and men with overweight and obesity were screened between 2000 and 2012 for eligibility in the primary WL studies (19-23). Participants were recruited from the New York-New Jersey-Pennsylvania metropolitan area in the US. Participants between the ages of 24 and 75 years with BMI of 25 to 40 (≥23 if Asian) were recruited for these studies. A brief physical examination, for screening purposes, confirmed that all participants met inclusion criteria, as described previously (19-23). Participants randomized to weight maintenance in these trials were excluded from this analysis. Participants were also excluded from this analysis if they did not report a 24-hour recall at baseline or did not report food records during the intervention. Participants completed an informed consent before enrollment in the original clinical trials, approved by the Rutgers University Institutional Review Board.

In a previous study (25), with a 16% difference in HEI between groups (WL with a 2.3% greater protein intake than weight maintenance control individuals), a sample size of at least 21 per group would provide 90% power to detect a difference in HEI due to WL. In another study examining HEI among individuals who eat animal-protein products, an estimated group of at least 63 persons was needed to detect a 4.8-score difference between groups (β of 0.90 and α of 0.05) (26). Based on these 2 studies, and allowing for some missing data, we estimated that, with 1 covariate, 100 persons per group would be needed.

Dietary assessment and calculations

Food records that were collected from the original trials were never previously analyzed or reported. Baseline 24-hour recall and food records were collected monthly using forms provided by the laboratory and validated by an RD. Over the WL duration, 3-day food records (2 weekdays, 1 weekend day per week) were entered at 1 month, 3 months, and 6 months. These food records were entered by the RD or staff (verified by the RD) into Automated Self-Administered 24-hour Dietary Assessment Tool (ASA24, US version; National Cancer Institute [NCI]-NIH). Diet quality, nutrient intake, and sources of dietary protein (red meat, processed meat, poultry, organ meat, seafood, eggs, soy, nuts, seeds, and legumes) were examined.

The HEI encourages intake of fruits, vegetables, whole grains, and protein foods high in fiber and unsaturated fats. Additionally, HEI discourages intake of saturated fatty acids (SFAs), refined grains, added sugar, and sodium. The HEI (calculated with SAS version 9.4 code, SAS Institute, Inc.; NCI and US Department of Agriculture [USDA]) has 13 food components (scored as 0-5 or 0-10) with a maximum score of 100 (14). The food components include the following: whole grains; total fruit (includes fruit juice); whole fruit (excludes fruit juice); total vegetables; greens and beans (dark green vegetables and all types of legumes); total protein foods (meat, poultry, eggs, and legumes); seafood and plant proteins (fish, shellfish, nuts, seeds, legumes, and soy foods [not beverages]); dairy (milk, yogurt, cheese, and fortified soy beverages); and fatty acids ratio (polyunsaturated and monounsaturated fatty acids to SFAs). Foods that are unfavorable to HEI include the following: refined grains, sodium, added sugar, and SFAs (13). The HEI incorporates energy intake into the score, making it applicable for CR diets that vary in calories. Unlike other indices that use population means or a dichotomous scoring structure for comparing populations, HEI uses proportional scoring, making it better suited to track change over time. It also includes a greater range of protein sources to address questions related to dietary protein in this study.

Statistical analysis

Descriptive statistics were used to define baseline characteristics. Data were assessed for skewness and normality, and Levene's test for equal variances analyzed homoscedasticity. To examine change in dietary protein from baseline to CR, the sample population was divided by the median (lower protein [LP] and higher protein [HP]). Mixed models ANCOVA was used to assess how longitudinal change in dietary protein affected change in other foods in the LP or HP groups (controlled for baseline protein intake). One-way ANCOVA assessed change in body composition between protein groups, controlling for age and sex. A sensitivity analysis was also performed using mixed model ANCOVA with dietary protein examined as a continuous rather than categorical variable. Multiple imputation was used to handle partial missing body composition data (n = 8). A sensitivity analysis was completed to compare findings with and without multiple imputation for body composition. Multiple linear regression was used to determine the extent that protein sources contributed to change in protein intake and LBM in the total sample. In addition, multiple linear regression was used to determine how change in protein intake contributed to change in micronutrient intake (adjusted for age, sex, and BMI) and to determine which food components

predicted improvement in HEI during CR. SPSS Statistics version 27 (IBM Corp.) was used for the analyses.

RESULTS

Participant characteristics

There were 314 individuals who participated in the trials, and 272 were assigned to WL and measured for body composition at baseline and 6 months (Supporting Information Figure S1). Participants ($n = 209$) who recorded intake at baseline and during the intervention were eligible for this study. Two participants were removed for lack of feasibility of reported dietary intake: one because of very low protein and energy intake during WL and one as an outlier for high protein intake (>3 SD). Analysis included 24-hour recalls at baseline ($n = 207$) and 1,870 food records during CR (~10 days of intake/person). This sample is predominantly female (88%) and White (85%), and most have overweight (BMI: 29.1 [4.1]; Table 1). Baseline body weight did not differ significantly between the LP (77.3 [14.1] kg) and HP groups (81.1 [14.7] kg). Fat mass and LBM also did not differ between groups (LP [LBM: 42.6 (8.3) kg, fat mass: 32.3 (7.7) kg] and HP [LBM: 44.9 (8.6) kg, fat mass: 34.8 (9.0) kg]).

CR

Participants lost 5.0% (5.4%; $p < 0.001$) of their baseline body weight (79.7 [14.6] kg). During CR, the LP group consumed less protein, at 58.3 [6.6] g/d, compared with the HP group, at 78.6 [9.4] g/d (Table 2). In addition, the percentage protein intake during CR was lower in the LP (17.8% [2.9%]) compared with the HP group (19.9 [2.8%]; $p < 0.001$). During CR, carbohydrates (LP: 51% [5.3%] vs. HP: 47.4% [5.8%]) differed between groups ($p < 0.001$). Dietary fat intake averaged 32.8% [4.8%], and it did not differ between groups. The physical activity level score was 1.0 (0.7), and physical activity did not differ significantly between the LP and HP groups or change over time. Both protein groups lost a similar amount of weight and fat mass during CR, but there was a greater decrease in LBM in the LP compared with the HP group ($p < 0.01$), whether calculated as percentage (not shown) or kilogram loss (Figure 1).

TABLE 1 Baseline characteristics

Age (y)	54.4 ± 10.7
Female	183 (88%)
Race/ethnicity	
White	176 (85%)
Black	24 (12%)
Other	7 (3%)
Weight (kg)	79.7 ± 14.6
Lean mass	33.5 ± 8.4
Fat mass	43.8 ± 8.5
BMI (kg/m^2)	29.1 ± 4.1
Overweight (BMI 25-29.9)	138 (67%)
Obesity (BMI ≥30)	69 (33%)
Dietary intake	
Energy (kcal/d)	1,829 ± 626
Protein (% kcal)	17.5 ± 5.3
Carbohydrate (% kcal)	48.9 ± 9.9
Fat (% kcal)	33.7 ± 8.5

Note: Data given as means ± SD or *n* (%). $n = 207$.

Diet quality

The HEI score improved in the entire sample from baseline to CR over 6 months ($p < 0.05$). Multiple linear regression models were constructed to determine foods that contributed to the improved HEI with CR, indicating that total fruit, whole grains, refined grains, dairy, and seafood/plant protein sources all contributed to the rise in HEI in the unadjusted and adjusted models ($p < 0.05$; Supporting Information Table S3). In the HP group, compared with the LP group, HEI component scores that improved during CR include dairy, added sugar ($p < 0.05$), total protein, seafood/plant protein, refined grains, and vegetable greens and beans ($p < 0.01$; Table 2). Diet quality (HEI) improved over time in both groups, with a greater increase in the HP compared with the LP group ($p < 0.05$; Table 2). Intake of SFAs (23.3 [14.5] g), added sugar (46.8 [38.1] g), refined grains (171 [83] g), and sodium (31.8 [11.8] g) decreased during CR ($p < 0.05$), but they did not differ between groups. In the sensitivity analysis, using protein as a continuous variable, protein intake also contributed significantly to the increase in HEI and the same dietary components. The change in protein intake by group was also analyzed (mixed models ANCOVA) and this indicated that HP improved scores for HEI and certain food components (Supporting Information Figure S2).

Total protein intake was 68.4 (3.0) g/d in the entire sample during CR and was largely from animal protein (46.8 [16.3] g/d). Protein sources that accounted for 70% of variance for the change in protein intake from baseline to CR were poultry, unprocessed red meat, seafood, cured meat, cheese, milk, eggs, and nuts/seeds ($F = 50.6$; $p < 0.001$; Supporting Information Table S2). Protein sources that were not consumed in significant quantity and that did not contribute to the change in protein intake were organ meats, legumes, yogurt, and soy products. In addition, of all protein sources, only poultry accounted for the variance in LBM change, with $\beta = 0.433$ (95% CI: 0.042-0.824; $p < 0.05$; not shown). Furthermore, when examining whether food categories (fruits, vegetables, grains, protein, dairy, and oils/fat) could explain the variance for LBM change, only total protein could ($\beta = 1.919$; 95% CI: 1.384-2.455; $p < 0.001$).

Micronutrients

Baseline nutrient intake was below the recommended daily allowance for calcium, magnesium, potassium, choline, fiber, and vitamins

TABLE 2 Mixed models assessment of diet quality food scores before and during caloric restriction by protein intake

	Baseline	Caloric restriction		*p* value, interaction
	(n = 207)	LP	HP	
Dietary protein				
Intake (g/d)	77.8 ± 29.2	58.29 ± 6.6	78.56 ± 9.4	<0.001
Intake (g/kg/d)	0.99 ± 0.38	0.84 ± 0.14	1.01 ± 0.21	<0.001
HEI components (total score)				
Total protein (5)	4.4 ± 1.2	4.1 ± 0.7	4.5 ± 0.5	<0.001
Seafood/plant protein (5)	2.9 ± 2.3	2.5 ± 1.2	3.2 ± 1.1	<0.001
Total dairy (10)	5.3 ± 3.4	6.1 ± 1.8	6.1 ± 1.8	0.028
Total vegetables (5)	3.5 ± 1.6	3.9 ± 0.8	3.8 ± 0.7	0.821
Greens and beans (5)	2.4 ± 2.3	2.4 ± 1.2	2.6 ± 1.1	0.004
Total fruit (5)	2.9 ± 2.0	3.5 ± 1.1	3.1 ± 1.2	0.431
Whole fruit (5)	3.1 ± 2.2	3.6 ± 1.2	3.5 ± 1.1	0.822
Whole grains (10)	3.4 ± 3.6	3.7 ± 2.1	4.1 ± 2.2	0.533
Refined grains[a] (10)	5.8 ± 3.8	6.4 ± 1.9	6.7 ± 2.1	<0.001
MUFA+PUFA/SFA (10)	5.0 ± 3.9	5.7 ± 1.8	5.5 ± 1.6	0.642
SFA[a] (10)	6.0 ± 3.6	7.0 ± 1.5	6.4 ± 1.9	0.205
Added sugar[a] (10)	8.0 ± 2.3	7.8 ± 1.5	8.3 ± 1.2	0.039
Sodium[a] (10)	3.6 ± 3.3	3.7 ± 1.9	3.2 ± 1.6	0.873
HEI (100)	56.5 ± 18.5	60.4 ± 8.0	60.9 ± 7.6	0.010

Note: Values are reported as means ± SD. The LP (n = 104) and HP (n = 103) groups are shown using linear mixed models ANCOVA (controlling for baseline protein intake). Baseline diet quality and HEI component scores did not differ significantly between groups, and dietary protein (percentage of energy intake) was 17.8% ± 2.9% and 19.9% ± 2.8% in the LP and HP groups, respectively ($p < 0.001$).

Abbreviations: HEI, Healthy Eating Index-2015; HP, higher protein; LP, lower protein; MUFA, monounsaturated fatty acid; PUFA, polyunsaturated fatty acid; SFA, saturated fatty acid.

[a]HEI moderation component (higher score indicates lower intake and healthier diet).

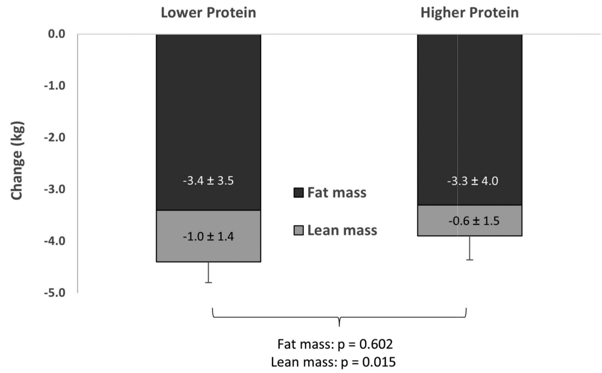


FIGURE 1 Body composition change due to 6 months of weight loss. Values are means ± SD for change in fat, lean mass, and total weight (kilograms), and they compare the lower protein (n = 104) and higher protein (n = 103) groups using ANCOVA (adjusted for age and sex)

D and E. Micronutrient intake further decreased ($p < 0.05$) for all micronutrients during CR, except for vitamins K, D, C, B_{12}, and A. In addition, a greater intake of protein during CR was associated with most vitamins and minerals (excluding vitamin B_1, folate, vitamin E, copper, and iron; Table 3).

DISCUSSION

A higher quality diet is associated with WL, largely attributed to higher fiber, fruit, and vegetable intake and controlled portion sizes (15,16). Consistent with this, individuals in the current study showed an improvement in diet quality during CR compared with baseline. In addition, higher protein intake during CR has been shown to contribute to certain health outcomes (10). These benefits may be attributed to a higher protein intake alone and/or alterations in dietary patterns caused by change in protein intake. To our knowledge, no previous study has examined how the amount of protein intake during CR affects diet quality. In this study, we used multiple food records during 6 months of WL to examine whether change in self-selected dietary protein affects diet quality and food component scores. We found that individuals with higher protein intake (79 g/d), compared with lower protein (58 g/d) intake, during CR had a greater improvement in diet quality. In addition, change in protein intake in the HP compared with the LP group resulted not only in greater total protein and dairy scores (as expected) but also greater intake of dark green vegetables and reduced intake of refined grains and added sugar. Overall, WL in individuals consuming higher compared with lower protein intake attenuated loss of LBM, which was somewhat expected, but also altered low- or zero-protein foods, which improved diet quality.

TABLE 3 Regression coefficients and 95% CIs examining the contribution of protein intake on change in micronutrient intake from baseline to caloric restriction

Vitamin	*β* (95% CI)	*p* value	Minerals	*β* (95% CI)	*p* value
Vitamin B3	0.267 (0.224 to 0.310)	<0.001	Selenium	1.087 (0.894 to 1.281)	<0.001
Choline	3.706 (3.142 to 4.271)	<0.001	Phosphorus	9.670 (8.277 to 11.062)	<0.001
Vitamin B6	0.023 (0.017 to 0.029)	<0.001	Potassium	15.320 (11.086 to 19.553)	<0.001
Vitamin D	0.090 (0.059 to 0.121)	<0.001	Sodium	12.884 (7.374 to 18.395)	<0.001
Vitamin B2	0.010 (0.006 to 0.013)	<0.001	Zinc	0.053 (0.030 to 0.077)	<0.001
Vitamin K	1.935 (0.819 to 3.051)	<0.001	Magnesium	1.075 (0.502 to 1.649)	<0.001
Vitamin B12	0.077 (0.027 to 0.127)	0.003	Calcium	2.519 (0.266 to 4.772)	0.029
Vitamin A	8.393 (2.948 to 13.838)	0.003	Copper	0.007 (−0.001 to 0.016)	0.088
Vitamin C	0.518 (0.032 to 1.004)	0.037	Iron	−0.022 (−0.057 to 0.012)	0.205
Vitamin B1	0.004 (−0.002 to 0.009)	0.165			
Folate	0.138 (−1.029 to 1.305)	0.816			
Vitamin E	0.005 (−0.028 to 0.037)	0.767			

Note: n = 207; controlled for energy, age, sex, and BMI.

In this study, individuals who self-selected higher protein intake during CR lost less LBM than those who consumed lower protein intake. An increased protein intake of 1.0 g/kg/d is not especially high, and adherence to this should be achievable with nutrition counseling, even in individuals who typically consume low protein intakes. The benefits of more LBM and greater insulin sensitivity with increased protein intake have been studied extensively (7,27-30); however, there is still lack of clarity regarding whether the health benefits are entirely due to protein intake alone when individuals are self-selecting sources of protein during WL (31). The Preventing Obesity Using Novel Dietary Strategies (POUNDS) Lost trial examined 2 levels of protein intake (18% and 20% of calories), indicating only a trend for greater LBM loss in the LP group (32). This protein intake is comparable to the LP and HP groups in our current study, which indicated a significantly greater loss of LBM due to LP intake. The POUNDS Lost study (57% women) showed that there was a greater LBM loss in women than in men (33), and this may one reason for greater LBM differences between groups in the current study, which also had a greater proportion of women (88%).

In the Health, Aging and Body Composition study (Health ABC), self-selected protein intake was examined over 3 years in 2,066 older individuals who were not undergoing WL (30). In this study (30), the lower and upper 2 quintiles of protein consumed were 55 g/d compared with 79 g/d, and change in LBM was −0.9 kg and −0.5 kg in the 2 groups, respectively. In the current WL study, the LP and HP groups consumed 58 and 79 g/d of protein, with LBM change of −1.0 and −0.6 kg, respectively. Together, these findings suggest that a higher dietary protein of about 80 g/d (or 1 g/kg/d) preserves LBM compared with a normal protein intake (of ~60 g/d or 0.8 g/kg/d) and that this may be especially important to consider in women and elderly populations who are more susceptible to consuming inadequate dietary protein. The current study indicated that, during reduced energy intake, lean protein sources (largely poultry) accounted for a significant proportion of variance in LBM change during WL. Other factors such as the reported physical activity were low in this population and they did not differ between groups or over time; therefore, they do not explain the attenuated LBM loss in the HP group. In individuals who are not losing weight, diet quality is associated with higher LBM, with or without physical activity (34). Understanding how to preserve LBM during CR continues to be a concern in the field, and future studies might explore further whether protein sources in combination with other foods affect LBM.

Identifying high-quality proteins and the amount required for sufficient intake, which are influenced by several variables, remains controversial. Most measures of protein quality by amino acid composition and digestibility (protein digestibility-corrected amino acid score and digestible indispensable amino acid score) suggest that proteins from animal sources are more complete to varying degrees than plant sources (35). However, other nutrients often consumed in excess in the Western diet that tend to accompany animal-protein intake may reduce the benefit of including "complete" proteins in the diet. For example, observational studies have shown that, in individuals who are not dieting, protein consumption from animal sources is associated with a dietary pattern that has a greater intake of saturated fat, cholesterol, sodium, and added sugar and less fiber, all of which lower diet quality (36,37). However, unlike reported high intakes of added sugar and sodium, SFA intake in the US (although still high) has been shown to be closer to recommended levels (≤10% of total energy intake, or ≤22 g/d) (38). This is consistent with findings in this study, showing that SFA intake was 23 g/d at baseline and decreased to 17 g/d in both protein groups during CR. In this study, a greater intake of total protein during CR was largely from lean meats such as poultry and unprocessed red meat, as well as seafood, dairy, and nuts and seeds. Consequently, HEI components such as sodium and SFAs that may have worsened with increased total protein intake were at healthier levels during CR and they did not differ between protein groups. Multiple other studies have shown that individuals consuming plant-based diets meet protein needs and have a higher quality diet than omnivores (36,39), but this tends to be driven by fruit and vegetable intake, not necessarily higher quality protein intake (35). One study concluded that diets with protein sources that are predominantly from lean meat or plant sources have similar diet quality (40). In this study,

we showed that higher protein intake (from lean animal and plant sources), with dietary counseling to support WL, can contribute to a healthier dietary pattern, as indicated by a lower consumption of refined grains and added sugar and a higher consumption of green vegetables.

In addition to a high-quality diet, micronutrient intake contributes to nutrient adequacy during CR, and high-protein foods have been shown to be good sources of minerals (11). Our data indicated that many of the same nutrients that are below recommended intakes in the general population (41) were also low in participants in this study. Not surprisingly, these micronutrients became further compromised during modest WL. However, greater protein density was positively associated with multiple B vitamins, choline, and vitamins A, C, D, and K, as well as multiple minerals. Others have found that protein from animal sources increases consumption of zinc, potassium, vitamin B_{12}, riboflavin, and folate (11,40). Protein from plant sources contributes to higher intakes of calcium, copper, folate, potassium, magnesium, and thiamin (11,42). Our data during CR indicated that protein intake, as well as change in dietary pattern associated with altered protein intake, was an important contributor to increased micronutrient intake.

A strength of this work is that, to our knowledge, no previous study has examined how protein intake during an energy-restricted diet alters diet quality and patterns of food intake. This sample included pre- and postmenopausal women as well as men, increasing generalizability to the American population, but it was largely limited to a White population. Additionally, all participants were counseled by dietitians using the same nutrition-education behavior-modification intervention, increasing the consistency of nutrition counseling. This diet prescription and the counseling would be expected to and did improve diet quality. However, because the studies were conducted within one primary location, this could limit generalizability of the findings. Although the lower protein intake may reflect general lower adherence to the provided advice, both groups lost a similar amount of weight, suggesting that adherence to reduced calorie intake was similar between groups. Because methods used in this study to measure LBM do not discern between organ and muscle mass, the greater loss in the LP group during WL cannot be attributed only to muscle mass and its associated health benefits. However, muscle mass (but not organ mass) correlates with WL (43). Another limitation is that individuals with overweight and obesity typically underestimate intake (44). However, because we analyzed 10 food records to estimate dietary intake, and a dietitian educated participants to accurately report food intake and reviewed this with participants to reinforce validity of intake, it is expected that the quality of the nutrient analysis was enhanced (45).

CONCLUSION

These findings indicate that a moderately higher protein intake during CR improves diet quality and attenuates loss of LBM. The self-selected higher protein intake during WL improves diet quality, largely owing to consumption of low-fat protein sources, greater intake of green vegetables, and reduced intake of refined grains and added sugar, to better align with the Dietary Guidelines for Americans. Although the findings in this pooled analysis indicate that only dietary protein explained the variability in LBM changes during CR, the link to other food choices should be explored as a possibility in future studies. Accordingly, it would be interesting to determine whether higher self-selected protein intake that improves diet quality, compared with a protein supplement alone, differentially affects LBM or other health outcomes. Also, future WL studies are needed to determine whether the dietary shifts in relation to self-selected protein intake are consistent in individuals consuming different ethnic food patterns or in vulnerable populations at risk for meeting nutrient adequacy, such as in children or the elderly.O

ACKNOWLEDGMENTS

We are grateful to the RDs (R Zurfluh, N von Thun) who counseled individuals in this study and to M Watford, DPhil, for reviewing the manuscript.

CONFLICT OF INTEREST

The authors declared no conflict of interest.

AUTHOR CONTRIBUTIONS

ARO, DS, and SAS collected the data. ARO, YS, and SAS analyzed the data. ARO and SAS wrote the first draft, with contributions from LM and YS. All authors reviewed and commented on subsequent drafts of the manuscript.

CLINICAL TRIAL REGISTRATION

The original trials: ClinicalTrials.gov identifiers: NCT01631292, NCT00473031, NCT00472745, and NCT00472680, and the registration of this study is at: osf.io/67y3n.

DATA AVAILABILITY STATEMENT

Not applicable owing to Institutional Review Board regulations on open data access for these studies. The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Anna R. Ogilvie https://orcid.org/0000-0002-0970-9177
Sue A. Shapses https://orcid.org/0000-0002-3128-2325

REFERENCES

1. US Department of Health and Human Services and US Department of Agriculture. *2015-2020 Dietary Guidelines for Americans*. 8th ed. Published December 2015. https://health.gov/our-work/nutrition-physical-activity/dietary-guidelines/previous-dietary-guidelines/2015
2. Fung TT, Pan AN, Hou T, et al. Long-term change in diet quality is associated with body weight change in men and women. *J Nutr.* 2015;145:1850-1856.
3. Quatromoni PA, Pencina M, Cobain MR, Jacques PF, D'Agostino RB. Dietary quality predicts adult weight gain: findings from the

Framingham Offspring Study. *Obesity (Silver Spring)*. 2006;14:1383-1391.

4. Ryan DH, Yockey SR. Weight loss and improvement in comorbidity: differences at 5%, 10%, 15%, and over. *Curr Obes Rep*. 2017;6:187-194.
5. Engel MG, Kern HJ, Brenna JT, Mitmesser SH. Micronutrient gaps in three commercial weight-loss diet plans. *Nutrients*. 2018;10:108. doi:10.3390/nu10010108
6. Pasiakos SM, Cao JJ, Margolis LM, et al. Effects of high-protein diets on fat-free mass and muscle protein synthesis following weight loss: a randomized controlled trial. *FASEB J*. 2013;27:3837-3847.
7. Devkota S, Layman DK. Protein metabolic roles in treatment of obesity. *Curr Opin Clin Nutr Metab Care*. 2010;13:403-407.
8. Leidy HJ, Clifton PM, Astrup A, et al. The role of protein in weight loss and maintenance. *Am J Clin Nutr*. 2015;101:1320S-1329S.
9. Virtanen HEK, Voutilainen S, Koskinen TT, et al. Dietary proteins and protein sources and risk of death: the Kuopio Ischaemic Heart Disease Risk Factor Study. *Am J Clin Nutr*. 2019;109:1462-1471.
10. Drummen M, Tischmann L, Gatta-Cherifi B, Adam T, Westerterp-Plantenga M. Dietary protein and energy balance in relation to obesity and co-morbidities. *Front Endocrinol (Lausanne)*. 2018;9:443. doi:10.3389/fendo.2018.00443
11. Phillips SM, Fulgoni VL 3rd, Heaney RP, Nicklas TA, Slavin JL, Weaver CM. Commonly consumed protein foods contribute to nutrient intake, diet quality, and nutrient adequacy. *Am J Clin Nutr*. 2015;101:1346S-1352S.
12. Liese AD, Krebs-Smith SM, Subar AF, et al. The Dietary Patterns Methods Project: synthesis of findings across cohorts and relevance to dietary guidance. *J Nutr*. 2015;145:393-402.
13. Krebs-Smith SM, Pannucci TE, Subar AF, et al. Update of the Healthy Eating Index: HEI-2015. *J Acad Nutr Diet*. 2018;118:1591-1602.
14. US Department of Agriculture. *Healthy Eating Index*. Accessed February 1, 2022. Updated April 27, 2022. https://www.fns.usda.gov/healthy-eating-index-hei
15. Christifano DN, Fazzino TL, Sullivan DK, Befort CA. Diet quality of breast cancer survivors after a six-month weight management intervention: improvements and association with weight loss. *Nutr Cancer*. 2016;68:1301-1308.
16. Ptomey LT, Willis EA, Goetz JR, et al. Portion-controlled meals provide increases in diet quality during weight loss and maintenance. *J Hum Nutr Diet*. 2016;29:209-216.
17. Heymsfield SB, Wadden TA. Mechanisms, pathophysiology, and management of obesity. *N Engl J Med*. 2017;376:1492.
18. Jensen MD, Ryan DH, Apovian CM, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Obesity Society. *J Am Coll Cardiol*. 2014;63:2985-3023.
19. Pop LC, Sukumar D, Schneider SH, et al. Three doses of vitamin D, bone mineral density, and geometry in older women during modest weight control in a 1-year randomized controlled trial. *Osteoporos Int*. 2017;28:377-388.
20. Pop LC, Sukumar D, Tomaino K, et al. Moderate weight loss in obese and overweight men preserves bone quality. *Am J Clin Nutr*. 2015;101:659-667.
21. Riedt CS, Cifuentes M, Stahl T, Chowdhury HA, Schlussel Y, Shapses SA. Overweight postmenopausal women lose bone with moderate weight reduction and 1 g/day calcium intake. *J Bone Miner Res*. 2005;20:455-463.
22. Riedt CS, Schlussel Y, von Thun N, et al. Premenopausal overweight women do not lose bone during moderate weight loss with adequate or higher calcium intake. *Am J Clin Nutr*. 2007;85:972-980.
23. Sukumar D, Ambia-Sobhan H, Zurfluh R, et al. Areal and volumetric bone mineral density and geometry at two levels of protein intake during caloric restriction: a randomized, controlled trial. *J Bone Miner Res*. 2011;26:1339-1348.
24. Haskell WL, Lee I-M, Pate RR, et al. Physical activity and public health: updated recommendation for adults from the American College of Sports Medicine and the American Heart Association. *Med Sci Sports Exerc*. 2007;39:1423-1434.
25. Pascual RW, Phelan S, La Frano MR, Pilolla KD, Griffiths Z, Foster GD. Diet quality and micronutrient intake among long-term weight loss maintainers. *Nutrients*. 2019;11:3046. doi:10.3390/nu11123046
26. Clarys P, Deliens T, Huybrechts I, et al. Comparison of nutritional quality of the vegan, vegetarian, semi-vegetarian, pesco-vegetarian and omnivorous diet. *Nutrients*. 2014;6:1318-1332.
27. Kim JE, O'Connor LE, Sands LP, Slebodnik MB, Campbell WW. Effects of dietary protein intake on body composition changes after weight loss in older adults: a systematic review and meta-analysis. *Nutr Rev*. 2016;74:210-224.
28. Smith JD, Hou T, Ludwig DS, et al. Changes in intake of protein foods, carbohydrate amount and quality, and long-term weight change: results from 3 prospective cohorts. *Am J Clin Nutr*. 2015;101:1216-1224.
29. Wycherley TP, Moran LJ, Clifton PM, Noakes M, Brinkworth GD. Effects of energy-restricted high-protein, low-fat compared with standard-protein, low-fat diets: a meta-analysis of randomized controlled trials. *Am J Clin Nutr*. 2012;96:1281-1298.
30. Houston DK, Nicklas BJ, Ding J, et al. Dietary protein intake is associated with lean mass change in older, community-dwelling adults: the Health, Aging, and Body Composition (Health ABC) Study. *Am J Clin Nutr*. 2008;87:150-155.
31. Cava E, Yeat NC, Mittendorfer B. Preserving healthy muscle during weight loss. *Adv Nutr*. 2017;8:511-519.
32. Sacks FM, Bray GA, Carey VJ, et al. Comparison of weight-loss diets with different compositions of fat, protein, and carbohydrates. *N Engl J Med*. 2009;360:859-873.
33. Tirosh A, de Souza RJ, Sacks F, Bray GA, Smith SR, LeBoff MS. Sex differences in the effects of weight loss diets on bone mineral density and body composition: POUNDS LOST Trial. *J Clin Endocrinol Metab*. 2015;100:2463-2471.
34. Xu F, Greene GW, Earp JE, et al. Relationships of physical activity and diet quality with body composition and fat distribution in US adults. *Obesity (Silver Spring)*. 2020;28:2431-2440.
35. Food and Agriculture Association of the United Nations. Dietary Protein Quality Evaluation in Human Nutrition. FAO Food and Nutrition Paper 92. *FAO*. 2013.
36. Aggarwal A, Drewnowski A. Plant- and animal-protein diets in relation to sociodemographic drivers, quality, and cost: findings from the Seattle Obesity Study. *Am J Clin Nutr*. 2019;110:451-460.
37. Richter CK, Skulas-Ray AC, Champagne CM, Kris-Etherton PM. Plant protein and animal proteins: do they differentially affect cardiovascular disease risk? *Adv Nutr*. 2015;6:712-728.
38. Shan Z, Rehm CD, Rogers G, et al. Trends in dietary carbohydrate, protein, and fat intake and diet quality among US Adults, 1999–2016. *JAMA*. 2019;322:1178-1187.
39. Parker HW, Vadiveloo MK. Diet quality of vegetarian diets compared with nonvegetarian diets: a systematic review. *Nutr Rev*. 2019;77:144-160.
40. Nicklas TA, O'Neil CE, Zanovec M, Keast DR, Fulgoni VL 3rd. Contribution of beef consumption to nutrient intake, diet quality, and food patterns in the diets of the US population. *Meat Sci*. 2012;90:152-158.
41. Webber KH, Lee E. The diet quality of adult women participating in a behavioural weight-loss programme. *J Hum Nutr Diet*. 2011;24:360-369.

42. Dikariyanto V, Berry SE, Pot GK, Francis L, Smith L, Hall WL. Tree nut snack consumption is associated with better diet quality and CVD risk in the UK adult population: National Diet and Nutrition Survey (NDNS) 2008–2014. *Public Health Nutr*. 2020;23:3160-3169.
43. Bosy-Westphal A, Kossel E, Goele K, et al. Contribution of individual organ mass loss to weight loss-associated decline in resting energy expenditure. *Am J Clin Nutr*. 2009;90:993-1001.
44. Lichtman SW, Pisarska K, Berman ER, et al. Discrepancy between self-reported and actual caloric intake and exercise in obese subjects. *N Engl J Med*. 1992;327:1893-1898.
45. Kos J, Bättig K. Comparison of an electronic food diary with a nonquantitative food frequency questionnaire in male and female smokers and nonsmokers. *J Am Diet Assoc*. 1996;96:283-285.

SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

How to cite this article: Ogilvie AR, Schlussel Y, Sukumar D, Meng L, Shapses SA. Higher protein intake during caloric restriction improves diet quality and attenuates loss of lean body mass. *Obesity (Silver Spring)*. 2022;00:1–9. doi:10.1002/oby.23428

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Create Buprenorphine Bridge Clinics: Expanding on the Opioid Reduction Options (ORO) model, this opportunity would provide emergency departments (EDs) with funding to establish a bridge clinic. The Bridge model (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7673896/pdf/wjem-21-257.pdf) is a clinical model in which ED practitioners screen patients for opioid use disorder (OUD), provide short-term prescriptions for buprenorphine (https://reports.addictionpolicy.org/evidence-based-strategies/patient-services), and then provide patients with warm handoff directly to a co-located, outpatient bridge clinic that provides medications for opioid use disorder (https://reports.addictionpolicy.org/evidence-based-strategies/systems-improvements*)*. The Bridge model may be modified to establish a virtual bridge clinic utilizing telehealth. The Center for Opioid Recovery and Engagement (CORE) ED Buprenorphine Program's Bridge model (https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep21-pl-guide-5.pdf) in Philadelphia increased the number of individuals with OUD receiving ED-initiated buprenorphine from 20% to 68% and increased treatment retention from 5% to 68% after implementation. The CORE ED Buprenorphine Program included certified Recovery Specialists on the multidisciplinary OUD team, which aided retention efforts. The estimated cost is $600,000 per hospital per year including 3 FTE recovery specialists, 1 FTE supervisor, 1 FTE patient navigator, and 0.5 FTE physician.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Expand EMS Buprenorphine Utilization and Recovery Support Services: This opportunity would aim to improve outcomes of individuals who are administered naloxone by EMS to reverse an opioid overdose. Funding would build the capacity of EMS paramedic units to provide high-dose buprenorphine to treat withdrawal symptoms with a bridge to long-term care. The intervention would also provide the patient with a naloxone kit and access to a Recovery Specialist immediately through telehealth and/or through follow-up based on contact information gathered by EMS. Bupe FIRST EMS (https://www.tandfonline.com/doi/abs/10.1080/10903127.2020.1747579) in Camden enrolled 18 patients who all had improved symptoms and no signs of precipitated withdrawal. The estimated cost is $850,000 per county per year including 7 FTE recovery specialists (4 day, 3 night), 0.5 FTE supervisor, 0.25 FTE patient navigator, and 0.5 FTE physician.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Expand Street Crisis Response Teams: Modeled on San Francisco's Street Crisis Response Team (https://abc7news.com/sf-first-street-crisis-response-team-mental-health-addiction-911-calls/8390976/) and building on work in New Jersey by Salvation and Social Justice (https://www.nj.com/opinion/2021/05/our-next-battle-reducing-police-interaction-in-drug-and-mental-health-issues-opinion.html) and the Newark Community Street Team, this opportunity would fund teams including a behavioral health clinician, peer specialist, and medical professional. The teams would respond to non-violent mental health and addiction-related 911 calls and connect individuals with behavioral health support, on-scene counseling, and/or ambulance transport. The program would be designed to reduce law enforcement involvement in non-violent activity. "Research shows that co-responder models decrease arrests and hospitalizations; increase connection to SUD treatment and resources; reduce costs and the demand on the justice system; and reduce feelings of threat and stigma among individuals who interact with co-response teams compared to law enforcement alone. Between July 2020 and July 2021, co-responder teams in Colorado fielded over 25,900 calls, 98% of which avoided arrest and 86% of which involved co-responders providing health assessments and referrals to community resources" (https://reports.addictionpolicy.org/evidence-based-strategies/systems-improvements). The estimated cost is $600,000 per county per year including 5 FTE recovery specialists, 1 FTE supervisor, and 2 FTE case managers.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Create Overdose Prevention Centers: This funding would support the creation of overdose prevention centers where people can safely use pre-obtained drugs with staff available to intervene in the event of an overdose. Two such sites have opened in New York City. Overdose prevention centers have been shown to reduce disease transmission, mortality, crime, and litter while increasing treatment engagement (https://westminstercollege.edu/student-life/the-myriad/the-impact-of-safe-consumption-sites-physical-and-social-harm-reduction-and-economic-efficacy.html). Overdose prevention centers, which could be co-located with existing Harm Reduction Centers, "serve as nexus points for naloxone distribution, syringe exchange, wraparound support services, and referrals to health care, housing, and treatment" (https://www.bostonglobe.com/2022/09/05/opinion/what-do-with-opioid-settlement-funds-open-overdose-prevention-centers/). Based on a study of the estimated costs and benefits of a hypothetical supervised consumption site in Providence, Rhode Island, each overdose prevention center could serve 400 individuals per month with a net cost of $783,899 per year (https://linkinghub.elsevier.com/retrieve/pii/S0955-3959(22)00236-5). The estimated cost is $1,500,000 per center in year 1 including securing space and center buildout and $850,000 per year thereafter including supplies, 10 FTE recovery specialists, 2 FTE supervisors, 4 FTE case managers, and 2 FTE nurses.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Expand Recovery Support Services: Building on the initial pilot of cross-training recovery specialists as community health workers in partnership with the NJ Department of Health, there is an opportunity to expand resources and supports available to hospital- and community-based recovery specialists throughout their interventions and follow-up. This should include the ability to provide resources for housing, food, and other environmental factors that are barriers to their recovery. Funding should support a dedicated team of cross-trained recovery specialists/community health workers to assist and connect patients to services that address health justice and overall wellness. The estimated cost is $600,000 per county per year including 5 FTE recovery specialists, 1 FTE supervisor, and 2 FTE case managers.

Institute for
Prevention
and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor’s request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR’s proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Expand Social Supports for Families in Schools: Using a multi-tiered approach, offer young families parental supports as well as opportunities to bond with their children utilizing the Social Development Strategy (https://reports.addictionpolicy.org/evidence-based-strategies/children-and-families). Implement social-emotional and prevention curricula in all schools. Implement School Based Youth Services in all middle and high schools. Develop and implement a school-based educational prevention program utilizing certified recovery specialists who will share personal stories of their struggles and identify when they began using substances and how their substance use disorder escalated. The estimated cost is $250,000 per school per year including 1 FTE school-based prevention specialist and 1 FTE family advocate.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Expand SUD Services for Pregnant and Postpartum Individuals: Create more programs that include treatment, aftercare, and case management services for pregnant and postpartum individuals (https://reports.addictionpolicy.org/evidence-based-strategies/children-and-families). From 2008 to 2016, the number of neonatal abstinence syndrome cases, which is a withdrawal syndrome that can occur when newborns are exposed to substances including opioids during pregnancy, doubled to 685 babies diagnosed in New Jersey (https://www.nj.gov/health/news/2018/approved/20180409a.shtml). The Nurture New Jersey 2021 Strategic Plan reported that women who experienced negative health during pregnancy describe disjointed and siloed program-based care that lack connections to and navigation between services and lack access to helpful information on available resources, especially in low-income neighborhoods (https://nurturenj.nj.gov/wpcontent/uploads/2021/01/20210120-Nurture-NJ-Strategic-Plan.pdf). This is especially true for pregnant and postpartum individuals who experience substance use disorder. The program would increase the capacity of clinical providers and community-based organizations to support and serve this population. This would include developing and implementing trainings and education programs for clinical providers and community partners, extending partnerships and collaboration between supports and resources, and increasing access to medication for opioid use disorder. The estimated cost is $600,000 per hospital per year including 3 FTE recovery specialists, 1 FTE supervisor, 1 FTE patient navigator, and 1 FTE case manager.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Create a Digital Health Platform for Interdisciplinary Pain Rehabilitation Programs: Develop a digital health platform that provides the benefits associated with interdisciplinary pain rehabilitation programs (IPRPs) for patients with chronic pain to decrease opioid medication prescribing in New Jersey. We are proposing the creation of a digital health platform to provide the benefits of IPRPs to the state of NJ. This platform will provide training resources to providers, standardized digital health content for patients, a registry to track outcomes and prospective analytics to identify and treat high risk patients before they become victims of the opioid epidemic. The platform will be available in multiple languages to facilitate access by our underserved communities. Although the initial pilot will be done in collaboration with RWJBarnabas Health, the platform will be made available to every hospital system in the state, integrating these systems and providing a true population health intervention. Because 20-40% of patients suffering from substance use disorder also suffer from chronic pain, the platform would be immediately applicable to this population. The estimated cost is $10 million to cover the buildout of the digital health platform, curriculum, and registry as well as the creation of a pilot program and subsequent outcome monitoring. Once successfully piloted, the platform would be offered across the state free of charge.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Increase Funding for Community Coalitions: "Community coalitions are an effective approach that brings together the key sectors within a community to collaborate, develop, and implement comprehensive strategies that reduce risk factors for substance use and addiction, such as high rates of poverty, social norms, and drug availability, and counterbalance them with protective factors, such as community engagement and healthy activities. Community coalitions serve to establish and strengthen communities while improving health outcomes and promoting attachment and engagement amongst its members and reducing the likelihood of substance use and that young people will live lives free of addiction. Coalitions utilize the Strategic Prevention Framework, a community-based, public health approach to reduce alcohol, tobacco and other drug use that includes providing information, enhancing skills, providing support, enhancing access and reducing barriers, changing consequences, changing physical design, and modifying or changing policies. A national evaluation of community coalitions conducted in 2019 found that substance use/misuse declined for youth living in communities with a coalition and community coalitions significantly increased the number of youth who reported not using substances in the past 30 days. Research shows that every dollar invested in prevention programs, it can save more than $64.20" The estimated cost is $300,000 per community served per year including 1 FTE prevention manager, 1 FTE prevention specialist, and various meeting and event costs. (https://reports.addictionpolicy.org/evidence-based-strategies/children-and-families).

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Screening for Substance Use Disorders and Adverse Childhood Experiences (ACEs) in Pediatric and Primary Care: "Programs that provide interventions that are culturally responsive and resilience-focused to children impacted by addiction and that have ACEs are a key strategy in disrupting intergenerational SUDs and providing targeted services to arguably one of the most at-risk populations of children. Preventing ACEs can lead to a significant reduction in chronic health conditions and socioeconomic challenges, including obesity (by 2%), depressive disorder (by 44%), substance use (by 33%), medically uninsured people (by 4%), and unemployment (by 15%). Research shows that for each one-point increase in the ACE scale, the odds of children developing a SUD in adulthood rises by 34-41%. Studies have shown that screening early can increase the identification of ACEs and can improve child outcomes and parent-child relationships when professionals utilize interventions to address ACEs, such as parenting education, referrals to services, counseling, and social supports, in primary care settings. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice for identifying, reducing, and preventing risky substance use and misuse, as well as dependence on alcohol and drugs. Findings from a 2019 study suggest that adolescents who received SBIRT in primary care settings reported few psychiatry visits and were less likely to have mental health diagnoses or chronic conditions after a 1-year follow-up compared to the control group. At year 3 of the study, those in the SBIRT group reported less outpatient visits, fewer SUD diagnoses, and more visits to substance use treatment" (https://reports.addictionpolicy.org/evidence-based-strategies/children-and-families). The estimated cost is $700,000 per county served per year including 1 FTE project director, 4 FTE screening coordinators, 4 FTE community health workers, and training costs.

Institute for Prevention and Recovery

Background

The RWJBarnabas Health Institute for Prevention and Recovery (IFPR) – as a leading public health organization in New Jersey – fosters innovative partnerships within communities, transforms care delivery, and pursues health justice to address both the clinical and social determinants of health. For over 30 years, IFPR has provided substance use disorder prevention programs, nicotine and tobacco treatment, and innovative recovery support and social care services. Serving over 20,000 individuals with substance use disorder per year, IFPR is the largest provider of recovery support services in New Jersey and the largest provider of hospital-based recovery support services in the United States.

Approach

IFPR submits the following proposed programs, initiatives, and service enhancements for consideration in response to the Governor's request for the public and relevant stakeholders to provide input on the best use of the opioid settlement funds that New Jersey is receiving. IFPR's proposals are evidence-based and shaped by direct input from staff who tirelessly serve New Jersey residents every day. We thank you for the opportunity to provide input and are available to provide additional details upon request.

Proposal

Ensure Support Group Access: "Recovery support groups are free, peer-led services that create opportunities for people in recovery to share experiences, connect with others with lived experience, and learn skills in a safe and supportive environment. Support groups help individuals navigate the early stages of recovery, learn how to manage their chronic illness, and create positive social connections to sober peers. It is important to ensure that there is a wide range of support groups and programs available that provide a structured, supportive, and culturally competent environment for people in recovery from a SUD. Engaging in 12-step facilitation (TSF) or mutual support groups (MSG), has been shown to be as effective as certain behavioral therapies in decreasing substance use but shows slightly higher rates of continuous abstinence. A study that compared the effectiveness of TSF/MSGs to other established treatments, such as cognitive-behavioral therapy (CBT) and motivational enhancement therapy (MET), found that 24% of the TSF/MSGs participants were continuously abstinent for the first year post-treatment compared to 15% of CBT and 14% MET participants. After three years, 36% of the TSF/MSG group reported abstinence and 24% of the CBT group and 27% of MET group reported abstinence. Research shows that individuals who attend MSGs within the first three months after treatment and who attend 90 meetings in 90 days have significantly better outcomes compared to those who attend less frequently" (https://reports.addictionpolicy.org/evidence-based-strategies/patient-services). The estimated cost is $600,000 per year including 3 FTE recovery specialists, 1 FTE supervisor, 1 FTE patient navigator, and 1 FTE case manager.

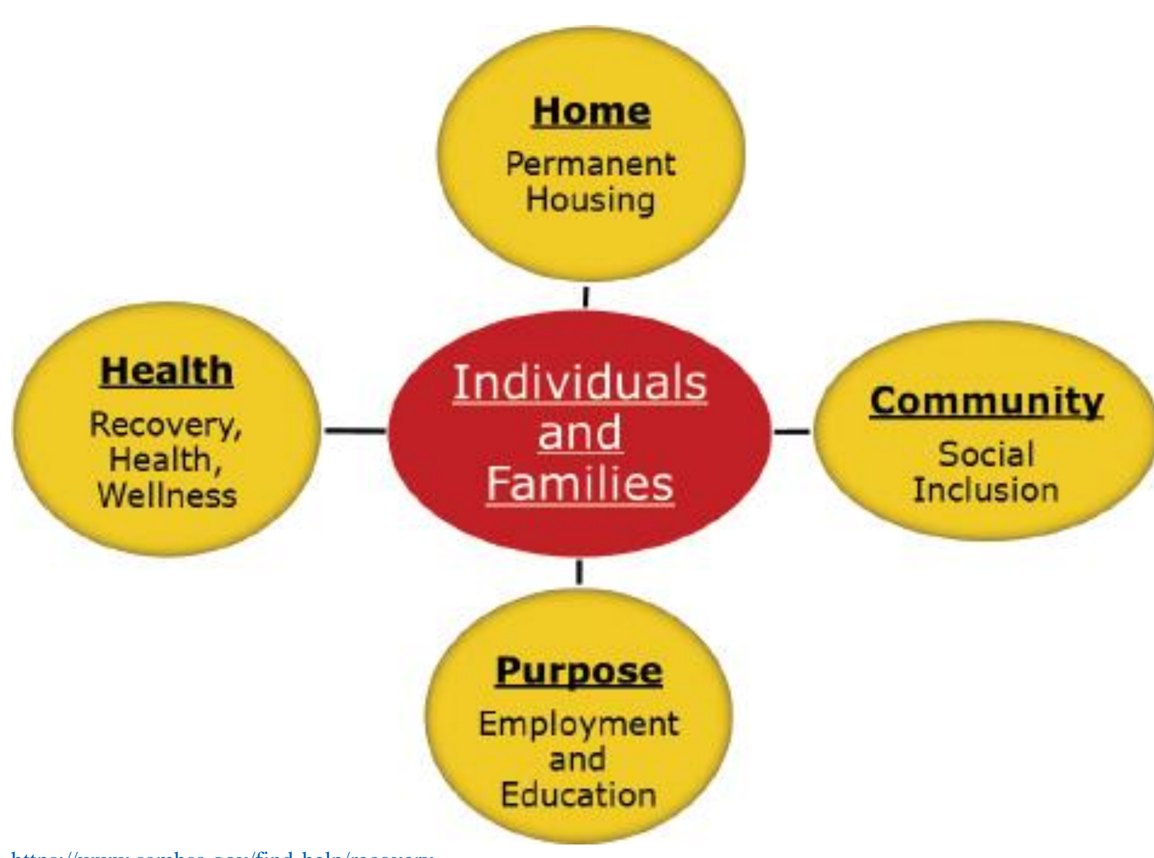
NEW JERSEY OFFICE OF RECOVERY

SAMHSA'S DEFINITION OF RECOVERY
FROM MENTAL HEALTH DISORDERS OR SUBSTANCE USE DISORDERS:

"Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."

This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. Recovery can have many pathways that may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. There are four major dimensions that support a life in recovery:

- **Health**: Learning to overcome, manage, or more successfully live with symptoms and making healthy choices that support one's physical and emotional wellbeing
- **Home**: A stable and safe place to live
- **Purpose**: Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; increased ability to lead a self-directed life; and meaningful engagement in society
- **Community**: Relationships and social networks that provide support, friendship, love, and hope



https://www.samhsa.gov/find-help/recovery

We must never forget how the opioid settlement funds flowing into our state were, and are, prepaid through lives lost, families destroyed and our collective future compromised. In honor of those suffering and no longer with us, New Jersey must use the settlement funds efficiently and effectively.

We owe our loved ones change: more of the same "business as usual" is failing our people. And a significant part of that change needs to be the establishment of a New Jersey Office of Recovery.

Recovery is a process, not a destination. Recovery, via a variety of paths, is happening in our communities. If we are to abate the growing addiction carnage, we must organize, develop and fund successful long term recovery strategies. Successful programs need to be studied, duplicated and scaled up if appropriate.

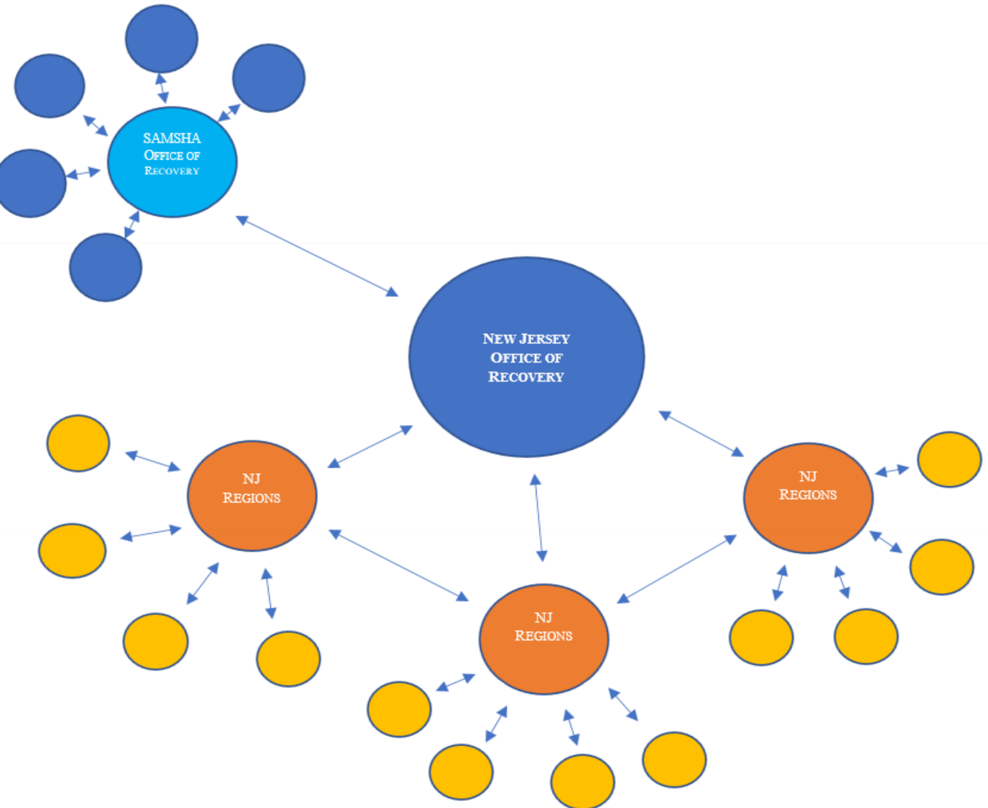
The list of Opioid Remediation Uses, Core Strategies and Approved Uses (Exhibit E of the March 25, 2022 Final Agreement of the Distributor Settlement) contains more than 30 strategies and initiatives which are foundational to servicing an individual's recovery. And there are many more successful programs in our communities, saving and changing lives, which have not yet caught the attention of those charged with providing supportive resources. Currently there is little to no mechanism, and thus, little attention in our state to what is actually working (and not working) real time. By the time statistics are gathered, compiled, released and reviewed, issues have intensified and opportunities are lost.

New Jersey was on the right track in marshalling the power of the community over a decade ago when it created a single, part time position of Addiction Services Consumer Advocate. After a series of unfortunate decisions, that role was eliminated. The Citizen's Advisory Council for Addiction, although still showing on New Jersey's website, has not been active since 2013. New Jersey has not been harnessing the solutions to this epidemic.

How do we improve outcomes? How do we move our loved ones from the tenuous state of "sober" onto a path of recovery? How do we stop the revolving door of detox/treatment/sobriety? The answers lie in our communities. We must establish a communication channel between the state and the community.

SAMHSA has created a national Office of Recovery (https://www.samhsa.gov/about-us/who-we-are/offices-centers/or). New Jersey needs to continue the nexus between national efforts and our communities. The New Jersey Office of Recovery is the essential communication hub between

community solutions and the state resources. The Office of Recovery will ensure New Jersey resources are applied efficiently and effectively to the most promising and proven solutions.



To achieve meaningful results, it is paramount the staff of the Office of Recovery are authentically grounded in their personal wellness, loyal to the mission, have significant lived experience and hold no conflicts of interest in serving those seeking, or in recovery. The staff are servant-leaders: collaborators that authenticate, report and share. Integrity and purpose must be key qualities for those associated with this office as they are ambassadors for New Jersey recovery.

"Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." New Jersey and its collective communities need an Office of Recovery to restore its full potential.

For more information:

Lisa E. Gladwell, Esq.
Recovery Advocate
41 Wayne Avenue
River Edge, New Jersey 07661
LisaGladwell@aol.com
201-599-9514

56547156

Jill S. Slattery
55 O'Connor Circle
West Orange, New Jersey 07052
Jillsslattery43@gmail.com

September 3, 2022

Opioid Funds Proposal
PO Box 001
Trenton, New Jersey 08625

Re: Suggestion for opioid payout funds

Dear Sir or Madam,

I think it has now been well established that opioid blockers such as suboxone not only save lives but also allow people with an opioid addiction to live a life free of that illness. The problem, as I understand it, is while any physician can prescribe an opiate, only very few "specialized" physicians can prescribe suboxone and the like. Does that make any sense? Not to me. So let's use some of those funds to train doctors - family physicians, internists, psychiatrists, and all other interested physicians- to enable them to prescribe suboxone and other opioid blockers. This is really a no brainer.

Sincerely,

Jill S Slattery

Jill S. Slattery

Tips for updating QuickBooks Desktop rep

You can export a report, change certain formatting or add new f

QuickBooks will update and keep these changes:

1. **Renamed report titles**
2. **Font, Fill, and Number formatting**
   (in row & column headers only)
3. **Resized columns**
4. **Renamed column & row headers**
5. **Inserted rows & columns**
   You must enter text or a formula in the row to preserve it.
6. **New Excel formulas**
   The updated report must contain the row associated with your formula
7. **Inserted text**
   Make your new text always appear next to a particular row by entering the text as a formula (e.g. ="inserted text")

QuickBooks will NOT support these changes:

- Font formatting in non-header cells*
- Inserted rows that are left empty
- Moved data cells

ort in Excel

ormulas, and then update it with new QuickBooks data.

F	G	H	I	J
My Company P&L				
Profit & Loss				
July through August 2012				
	07/16/12	Aug 16	TOTAL	
Ordinary Income/Expense				
MONEY IN (aka Income)				
40100 · Construction Income				
40110 · Design Income	3,054.02	3,900.00	6,954.02	
40199 · Less Discounts given	0.00	-48.35	-48.35	*
Total 40100 · Construction Income	3,054.02	3,751.65	6,905.67	
40500 · Reimbursement Income				
40520 · Permit Reimbursement Income	0.00	487.00	487.00	
Total 40500 · Reimbursement Income	0.00	487.00	487.00	
Total Income	3,054.02	29,197.65	46,343.45	
* Labor Income less Design Income	3,054.02	13,227.00	21,596.71	Labor Diff
Cost of Goods Sold				

Renamed date columns
Deleted columns
Sorted columns

- Inserted columns in between QuickBooks row headers

- User-defined formulas may not b supported in collapsed reports w updated to the same excel sheet

	Jan - Dec 21	Jan - Dec 20	Jan - Dec 19
Ordinary Income/Expense			
Income			
40010 · Donations	73,681.53	62,283.81	54,780.46
	0.00	0.00	
Total Income	73,681.53	62,283.81	54,780.46
Gross Profit	73,681.53	62,283.81	54,780.46
Expense			
50100 · Bank Charges	1,159.81	1,226.63	845.38
50200 · Communication/Marketing			
54600 · Web Site Hosting	315.96	399.03	774.88
Total 50200 · Communication/Marketing	315.96	399.03	774.88
50401 · Professional Fees	0.00	878.00	1,303.00
50450 · LICENSES	0.00	278.00	386.00
50604 · DETOX TRANSIT EXPENSES	25,141.05	16,527.74	16,175.67
50608 · MOVE IN FEES FOR TREATMENT	37,447.77	18,228.70	15,528.16
51000 · Insurance	358.55	220.10	588.17
51400 · Travel			
68320 · Travel	0.00	1,696.30	1,050.24
51400 · Travel - Other	0.00	163.95	32.00
Total 51400 · Travel	0.00	1,860.25	1,082.24
51500 · ADVERTISING	7,893.10	2,872.00	5,262.79
51800 · Postage, Courier, Shipping	1,225.66	583.42	664.79
52700 · Stipends	3,000.00	2,200.00	4,024.98
53601 · Program supplies			
53600 · OFFICE EXPENSES	1,216.96	1,521.03	4,212.86
Total 53601 · Program supplies	1,216.96	1,521.03	4,212.86
54100 · Telephone	0.00	936.04	416.47
62800 · Facilities and Equipment			
62805 · SHOW EVENT RENT	0	0	524.85
Total 62800 · Facilities and Equipment			524.85
65000 · Operations			
65040 · Supplies	3,155.75	1,581.17	1,756.36
Total 65000 · Operations	3,155.75	1,581.17	1,756.36
65046 · EXPO SHOW SUPPLIES			0.00
65047 · EXPO SHOW FEES			0.00
Total Expense	80,914.61	49,312.11	53,546.60
Net Ordinary Income	-7,233.08	12,971.70	1,233.86
Net Income	**-7,233.08**	**12,971.70**	**1,233.86**

Jan - Dec 18
65,765.87
65,765.87
65,765.87
563.01
2,726.69
2,726.69
0.00
175.00
9,947.17
31,248.96
385.92
1,623.00
0.00
1,623.00
3,940.89
152.01
4,200.00
723.75
723.75
309.55
727.50
727.50
4,332.84
4,332.84
450.37
3,476.73
64,983.39
782.48
782.48

5000 Sagemore Drive, Suite 203, Marlton, NJ 08053 | P: 609-261-0001 | F: 609-261-5854 | www.prevplus.org | info@prevplus.org
Executive Director: Elizabeth Majewski

Prevention Plus of Burlington County
5000 Sagemore Drive, Suite 203
Marlton, NJ 08053

October 31, 2022

New Jersey Department of Human Services
222 South Warren Street
P.O. Box 700
Trenton, NJ 08625

RE: Opioid Settlement Fund Spending Plan Public Feedback

To Whom It May Concern:

Prevention Plus of Burlington County supports the use of promising and evidence-based prevention programs for all age populations as a crucial component to solving the ongoing opioid crisis in New Jersey. Our agency recommends sustainable funding for the recently established NJ county-based Prevention Hubs to increase awareness and access to prevention resources and programs to all NJ youth, families, schools, and organizations. The work of the NJ Prevention Hubs is rooted in science and provides evidence-based programming to groups of all ages as well as warm handoffs to ready professionals and services to those in need of further assistance.

Prevention Plus has been educating the local community, for over 30 years, that addiction is a disease that is both preventable and treatable. Our highly trained staff members provide programs designed to equip children, youth, and adults with the skills and knowledge necessary to make healthy lifestyle choices. We also offer staff development and training to community agencies in order to enhance the ability of the Burlington County community to address the full range of needs of our diverse population. We are committed to prevention as well as replacing the denial and lack of understanding about substance abuse with accurate information concerning the symptoms, effects and treatment of addiction.

Prevention Plus is in support of the New Jersey Prevention Network's request of $150,000 annually per county prevention agency plus support for NJPN through the life of the settlement funds to ensure the maximum effectiveness of the state's current investments. $3.3 million per year for 18 years amounts to less than 10% of New Jersey's allocation of the settlement funds. Yet, it will produce a savings of an estimated $1.06 billion in costs to healthcare, criminal justice, and other individual and societal costs.

5000 Sagemore Drive, Suite 203, Marlton, NJ 08053 | P: 609-261-0001 | F: 609-261-5854 | www.prevplus.org | info@prevplus.org
Executive Director: Elizabeth Majewski

Sincerely,

Elizabeth Majewski

Elizabeth Majewski
Executive Director

EVIDENCE-BASED PREVENTION:
A KEY COMPONENT TO OUR OPIOID RESPONSE

PROPOSAL SUBMISSION:

The New Jersey Prevention Network (NJPN) **supports prevention** as an essential part of the solution to address the opioid crisis in NJ and recommends sustainable funding for the NJ county-based **Prevention Hubs** to maximize the state's investment in spreading and scaling up evidence-based programs and interventions that prevent opioid use disorder and improve quality of life for all New Jersey residents.

SUBMITTED BY:

Diane Litterer, MPA, CPS
CEO and Executive Director
New Jersey Prevention Network
dianelitterer@njpn.org

I. Evidence-Based Primary Prevention is a Critical Component of the Response to the Opioid Crisis.

Prevention Parable (Story by: Irving Zola)

Imagine a high waterfall that plunges into a large river. At the bottom of this waterfall, hundreds of people work along the shores of the river trying to save those who have fallen down the waterfall and are drowning in the river. As the people along the shore work frantically to rescue as many as possible, one person looks up at the seemingly never-ending stream of people falling down the waterfall and begins to run upstream. Another rescuer hollers, 'Where are you going? There are so many people that need help here.' To which the person replies, 'I'm going upstream to find out why so many people are falling into the river.'

Prevention professionals are those who go upstream utilizing evidence-based strategies to strengthen policies, build resiliency, and develop systems to support youth, families and communities. The New Jersey Prevention Network (NJPN) and prevention partners across New Jersey are providing quality prevention services that work to prevent youth drug use and its negative effects across the lifespan.

To effectively address the opioid crisis, we need to continue to strengthen this critical prevention infrastructure that addresses the core, underlying issues that drive substance misuse and which has the expertise and can adapt to the evolving drug use landscape. It would be short-sighted to neglect using the Opioid Settlement funds to strengthen these infrastructures that target core risks, enhance protective factors and build resiliency in NJ communities to buffer against future crises.

People use drugs for reasons. Typically, those who become addicted struggle with hopelessness, trauma or mental illness — often all three. This economic and social pain is the commonality across drug crises. Until policymakers prioritize healing the distress that makes particular people and communities facing economic loss and trauma especially vulnerable to addiction, this vicious cycle will only continue.

There's a phenomenon known as generational forgetting, originally identified by Lloyd Johnston, who led the largest national survey on drug use among youths for the past 43 years. The idea is that young people often avoid the drug that is currently the most feared. But since they have little experience with those that were popular earlier, they are less aware of their potential dangers. This results in a broadly defined cycle in which, roughly every 10 to 15 years, a different drug epidemic appears. Heroin, for example, was the demon drug of the 1970s, crack in the 1980s, heroin again in the 1990s, methamphetamine in the 2000s, prescription opioids in the 2010s and now fentanyl and other opioids that are being sold as heroin. By seeing and covering each crisis as being caused by a particular substance — without understanding why addiction persists — we miss the opportunity to use policy to reduce related harm.

Maia Szalavitz
"The Most Important Question about Addiction."
The New York Times, September 29, 2022.

Supporting treatment and recovery is important, and to effectively manage current and future crises, adopting a strategy of prevention is essential. Our colleagues in treatment, recovery support and harm reduction are working downstream to save one life at a time. Prevention works upstream to stop folks from falling in the "river" of addiction to begin with and completes the continuum of care.

Primary prevention is a comprehensive public health approach that works upstream to address individual and community risk factors – working to improve them before more serious problems occur. This upstream work addresses risk factors, social determinants of health (SDOH) and other contexts such as adverse childhood experiences (ACEs) that may lead to substance use and its negative consequences. ACEs are strongly related to the development and prevalence of a wide range of health problems, including substance use, throughout the lifespan. It is

estimated 40% of children in New Jersey have experienced at least one ACE, with 33% of them being children under the age of 5.

A multi-pronged, primary prevention approach works at the individual, family and community levels to improve knowledge, attitudes and behaviors, and enact policies that positively impact the environment in which we live, learn, and play. This approach reaches the entire community, provides benefits to those at particular risk of substance misuse, and can also produce positive effects in other areas such as educational and economic attainment, reduction of violence, and improved mental health. In essence, because it addresses root causes of addiction, primary prevention *is* an opioid prevention strategy.

INDIVIDUAL BASED
RISK FACTORS

- Parental drug/alcohol use
- Depression
- Anxiety
- Early substance use
- Emotional problems in childhood
- Sexual abuse
- Early aggressive behavior

FAMILY BASED
RISK FACTORS

- Parental drug/alcohol use
- Substance use among parents or siblings
- Inadequate supervision and monitoring
- Child abuse/maltreatment
- Parental favorable attitudes towards alcohol and/or drugs
- Marital conflicts
- Parental depression

SCHOOL/COMMUNITY
RISK FACTORS

- Peer rejection
- Substance using peers
- Loss of close relationship or friends
- Poor academic achievement
- School violence
- Societal/community norms about alcohol and drug use

The National Opioid Settlement Agreement provides a unique opportunity to address the addiction crisis in a lasting and sustained way. The settlement agreement lists Prevention Programs as a core abatement strategy to be given priority, yet they have not been explicitly

listed as a funding priority for the NJ opioid settlement funds. Every dollar spent on prevention can save an estimated $18 in direct, healthcare, criminal justice and other societal costs.[i]

There is an urgent need to take increased action to prevent issues in the first place — and focus on the root causes that can increase risk for substance misuse, mental health issues and/or suicide. These approaches have a broader effect and can also support positive outcomes for a range of other related issues like poor academic and career attainment, bullying, depression, violence, unsafe sexual practices and job and economic attainment.

"Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy."
Trust for America's Health Issue Report. November 2017

II. NJ's Strategic Investment in Local Coalitions and Prevention Hubs in a Statewide Network

Having a prevention infrastructure in place is critical. NJ has made a strategic investment in its prevention infrastructure by supporting multi-sector Regional Prevention Coalitions (RCs) that serve every county in the state whose priorities include addressing alcohol, marijuana/cannabis and a strong focus on opioid misuse prevention by reducing prescription medication misuse across the lifespan and the use of opioids. National research highlighted in "Pain in the Nation" recognized the importance of these community partnerships in identifying local challenges and

local solutions to address the opioid crisis.

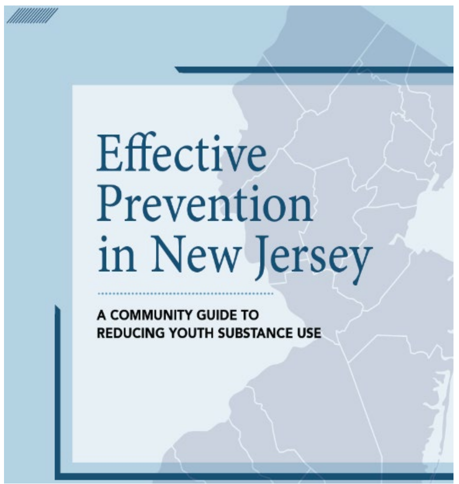
One of the biggest challenges communities face in countering the opioid crisis is the lack of a standing mechanism that bring all of the needed partners and resources together to address major epidemics within a community...Experts have identified the most effective way to tackle major health and well-being issues is to develop local partnerships — that bring together the different expertise, capabilities and resources across an entire community. Local leaders, institutions and citizens have both a greater understanding of their community's most pressing challenges and shared interest in addressing them.

"Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy."
Trust for America's Health Issue Report. November 2017

The Regional Coalitions have deep local knowledge and reach. They assess community needs and drug use trends and respond by providing tailored, evidence-based prevention policies, strategies and interventions that support youth, individuals, families and communities. RCs collaborate with local partners such as municipal alliances, law enforcement, faith-based organizations, schools, treatment agencies, local legislators, healthcare providers, health departments, and other local level community agencies to ensure a coordinated response and leverage existing resources.

Recently, through the Prevention Block Grant Supplemental Funds, the state has built on this critical investment by funding the establishment of a state system of **Prevention Hubs** (https://www.njpreventionhub.org/) in each county to amplify the coalition's environmental strategies and activities and strengthen this statewide network. The Prevention Hubs catalyze cross-learning, build capacity through training and technical assistance, and promote supportive services such as a "warmline" to direct residents to a wide array of resources, including navigating local, regional and state services. The Prevention Hubs engage all sectors of the community including youth, parents, schools, law enforcement, faith-based organizations and more. The county Hub activities are rooted in science and provide evidence-based programming and resources to reduce the risk factors that lead to drug and alcohol use/misuse. They are experts who provide community-wide education and outreach – including to specific disparate communities and populations. NJPN serves as the coordinating agency to guide strategic implementation of the statewide Prevention Hub system, build capacity, and support and promote Hub activities.

III. Evidence-Based Prevention Programs Support NJ Communities and Residents Across the Lifespan



Primary prevention programs are designed to reach communities and individuals at crucial points of life, so that the right information and support is provided in the right way at the right time. Our work is driven by years of research that has guided prevention to ensure effective interventions. NJPN compiled and highlighted these evidenced based strategies and a compendium of evidence-based programs in the "Effective Prevention in NJ: A Community Guide to Reducing Youth Substance Use" Toolkit. While NJ's Prevention Hub agencies currently implement these programs, current funding does not allow for sufficient spread, scale, nor sustainability of the programs in the years to come. These include programs that target populations across the lifespan, including young children, youth and teens, parents, and older adults. Here are some examples of the evidence-based programs being implemented through the prevention agencies and their Regional Coalition and Prevention Hubs initiatives.

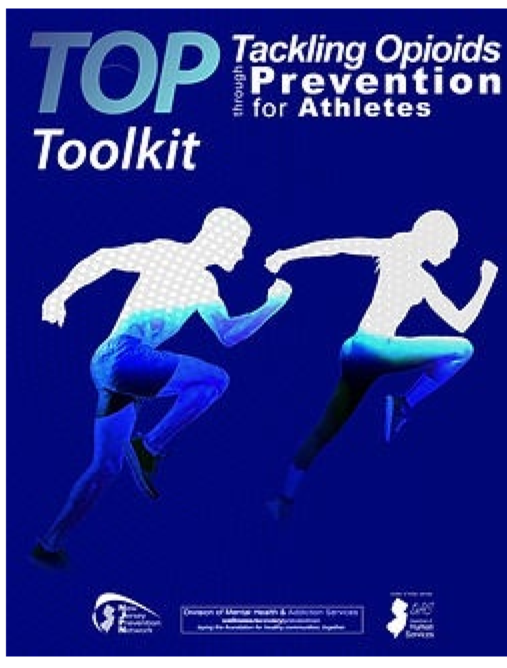
For Young Children:

- Footprints for Life™ program: a comprehensive, research-based substance use prevention intervention created by WellSpring Center for Prevention. This program is for early elementary school-aged children and by using puppets and stories that feature "real life" situations," designed to "build assets and teach life skills.

For Youth and Teens:

- LifeSkills Training: The LifeSkills Prescription Drug Abuse Prevention Module specifically gives adolescents the skills and knowledge necessary to help them avoid misuse of opioids and other prescription drugs.

- Tackling Opioids through Prevention (TOP) for Athletes Toolkit, which raises awareness of opioid use and abuse among young student athletes and provides evidence-based recommendations and information to encourage and promote policy and practice changes that will strengthen schools, athletic departments and community based athletic programs. This toolkit was developed in response to community need to protect NJ's 300,000 high-school student athletes as "young adults who participate in athletics may be at a greater risk to engage in non-medical prescription opioid use because of their greater risk of injury or because of a greater opportunity to receive diverted opioid medications from teammates." Rooted in science, this toolkit provides examples of best practices community messaging, and evidence-based policy and program examples that are effective in evoking positive behavioral change. In addition to the toolkit, RCs provide technical assistance and training in its effective use.



- Preventure: "an evidence-based prevention program that uses brief, personality-focused interventions to promote mental health and delay substance use among youth. The program aims to equip young people with self-efficacy and cognitive behavioral skills to help them cope with the numerous developmental challenges that many adolescents face, such as academic stress, peer pressure, interpersonal conflict, and identity development."

- Screening, Brief Intervention and Referral to Treatment (SBIRT): a "comprehensive, integrated evidence-based public health approach and model for identifying substance misuse that delivers early intervention and treatment services for persons at risk of developing substance use disorders." We provide training on SBIRT implementation to build capacity among school administrators and counselors and other community members on this effective prevention and early intervention strategy.

For Parents and Children:

- Strengthening Families: "an evidence-based family skills training program for high-risk and general population families. Parents and youth attend weekly skills classes together, learning parenting skills and youth life and refusal skills. They have separate class training for parents and youth, followed by a joint family practice session." Prevention Hubs are currently providing these services to families with criminal-justice involvement, pregnant and mothering women, and other community families.

For Older Adults:

- Wellness Intervention for Senior Education (WISE): a wellness and prevention program targeting older adults, designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. WISE provides valuable educational services to older adults on topics including medication misuse and management, stress

management, depression, and substance misuse. Created by NJPN and implemented locally by prevention agencies, the program has reached over 40,000 individuals and has been included on SAMHSA's National Registry of Evidence-based Programs and Practices.

In addition to these primary prevention activities, NJ's Prevention Hub agencies provide and support secondary prevention by providing early intervention programs for youth who are experimenting with alcohol and drug use by promoting screenings such as SBIRT for identification and referral of those most at risk for use and providing a warmline to connect individuals to local and statewide resources for treatment and recovery, including peer recovery support. We also provide tertiary prevention by promoting harm reduction strategies for those with a substance use disorder. Comprehensive, multi-pronged prevention approaches that seek to impact environmental strategies and policy, as well as provide evidence-based programming for individuals, families and communities can and do reduce harm. Harm reduction strategies are infused across all the work we do; in particular, we work to reduce stigma, provide education on Narcan use, promote the importance of medication for opioid use disorder (MOUD), and make connections to recovery support services.

IV. Maximizing NJ's Strategic Investment in Prevention: A Call to Action

Sustaining and building upon NJ's prevention infrastructure is critical to be able to continue to effectively respond to the opioid crisis, as well as to be able to pivot and evolve to meet the changing drug landscape and continue to attack the root causes that put youth, families and communities at increased risk for substance use. Addressing these upstream causes – often related to social determinants of health including adverse childhood events – helps to create resilient individuals, families and communities to protect against the onset of substance use/misuse.

The New Jersey Prevention Network on behalf of the NJ's system of Prevention Hubs is requesting a relatively modest investment of $150,000 annually per county prevention agency plus support for NJPN through the life of the settlement funds to ensure the maximum effectiveness of the state's current investments. $3.3 million per year for 18 years amounts to less than 10% of New Jersey's allocation of the settlement funds. Yet, it will produce a savings of an estimated $1.06 billion in costs to healthcare, criminal justice and other individual and societal costs.

---

[i] Miller, T. R., & Hendrie, D. (2008). Substance abuse prevention dollars and cents: A cost-benefit analysis. DHHS. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

October 31, 2022

New Jersey Drug Take-Back Program

Kirk Herweck
Sr. Director
Consumer Drug Take-Back

THE PROBLEM FOR NEW JERSEY

01/01/2022 through 10/24/2022

Office of the New Jersey Chief State Medical Examiner

# of Suspected Drug Deaths

2,354 Drug deaths so far in 2022

BEST PRACTICES FOR EFFECTIVENESS

Inmar is the NATIONWIDE LEADER

-Commercial Consumer Drug Take-Back programs - located nationwide in pharmacies, the preferred choice of residents for unwanted drug returns

-Program Operator providing comprehensive Drug Stewardship programs in all six states where mandated

Drug Responsibility Services

-Every controlled substance prescription receives a safe home storage packet

-Sufficient number of pharmacy-hosted geographically-located take-back receptacles within 15 miles of every citizen

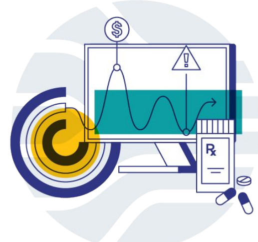
-Purposeful location of mail-back supplies in typically underserved areas

-Twice a year drug take-back events as needed to increase resident convenience

Program promotion and consumer education

-Combining innovative educational and marketing strategies targeting the opioid crisis and proper drug disposal

-Coordinating effective and consistent messaging with drug safety advocate groups to amplify message throughout the state



Measuring for results & reporting

Consistent measuring and adapting of household marketing programs producing steady growth of awareness and overall utilization with year over year proof of effectiveness

*Inmar can implement any or all of these services leveraging in-house resources

CONSUMERS ARE AWARE THAT PRESCRIPTION DRUG ABUSE IS AN ISSUE AND UNDERSTAND THE IMPORTANCE OF PROPER DRUG DISPOSAL

In a recent survey of 1,000 people across the US, we learned:

88% consider prescription drug abuse in the US a serious problem

74% believe prescription drug abuse in the US needs more attention than it's currently receiving

57% are aware of the environmental impact of disposing of Rx medications in the trash or flushing them down the toilet

Inmar confidential – do not copy, distribute or use without Inmar written permission, 2022

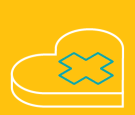
WHY IS THERE CONCERN ABOUT IMPROPER DRUG DISPOSAL?

ENVIRONMENTAL CONTAMINATION

83 of 117 water samples taken from the Hudson river in recent years contained levels of drug contamination

DIVERSION / MISUSE

NJ overdose deaths **increased by nearly 30%** in 2020 and have just returned to pre-pandemic numbers still
2,354 lives



CHILD POISONINGS

In U.S. one child every ten minutes treated in emergency room for medication poisoning

60,000
under age of 5

Sources: Insider NJ
Office of the New Jersey Chief State Medical Examiner
CDC National Center for Health Statistics; Vice; Science Direct; Safe Kids Worldwide

Inmar confidential – do not copy, distribute or use without Inmar written permission, 2022

TOO MANY DRUGS IN HOMES!
YET, CONSUMERS ARE NOT AWARE OF LOCAL Rx DISPOSAL PROGRAMS

57%

have disposed of Rx drugs in the trash or flushed them down the toilet

76%

would like access to a local kiosk or mail-in program.

Only 31%

have used a collection kiosk

The situation demands more opportunities for consumers to conveniently dispose of these medications

WHAT IS THE GOAL FOR NEW JERSEY?

01

An Effective Remediation Program

Safe in-home storage and safe disposal in pharmacies, law enforcement and mailback, that will serve all NJ residents, including rural areas and typically underserved populations

02

Educate Consumers Where They Are

An effective program that will educate NJ residents **where they are**, which is increasingly on various online platforms

03

Successful Education Campaign

An effective education campaign & reporting to track success in all areas and demographics

04

Efficient Collection & Reporting

An effective program to efficiently collect and report data on the amount of drugs collected & destroyed

The Inmar program is customizable to best meet the needs of New Jersey and its residents

Inmar confidential – do not copy, distribute or use without Inmar written permission, 2022

EXISTING INMAR INFRASTRUCTURE PROVIDES STANDARDIZATION, EFFICIENCY & RELIABILITY

INMAR'S BUSINESS PRACTICES DAY-IN AND DAY-OUT CREATE THE PERFECT BLEND FOR A ROBUST DRUG STEWARDSHIP PROGRAM

Rx LOGISTICS
85% of all supply chain returned Rx products

REGULATORY EXPERTISE
20 experts with 150 years combined experience

CDTB SUCCESS
Over 5,900 collection locations

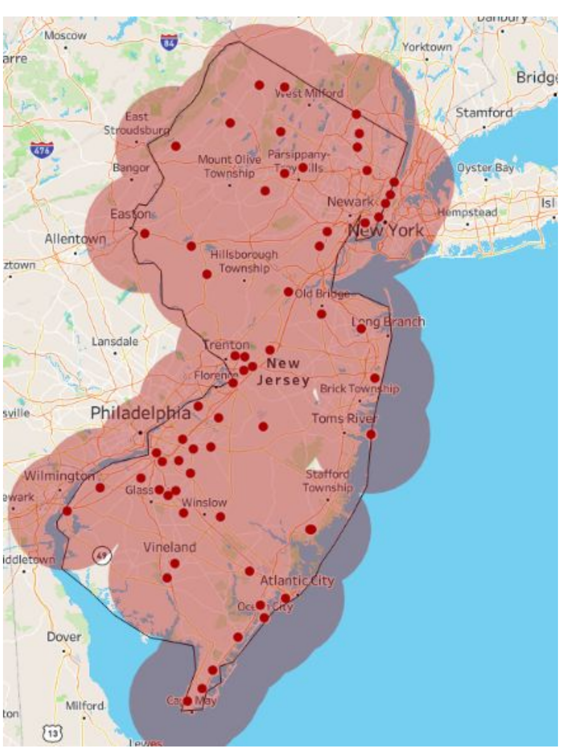
CONSUMER ENGAGEMENT
Over 41 years of experience

DRUG STEWARDSHIP
All 6 mandated states

INMAR intelligence

Inmar confidential – do not copy, distribute or use without Inmar written permission, 2022

THE NEW JERSEY MODEL



STEPS TO SUCCESS

Analysis:

- Identify location of current kiosks
- Map for 15-mile radius coverage
- Gap analysis to a 5-mile radius
- Determine “underserved areas”
- Local charitable groups across the state

Financial commitment for:

- Gap coverage with additional collectors
- Promotion & education across the state
- Polling to indicate need by area and success
- Reporting to prove the final result

- Each red dot represents Inmar’s current collection receptacle locations with a 15 mile radius from its center
- Goal for New Jersey should be to cover state with a five-mile radius of accessibility

Inmar confidential – do not copy, distribute or use without Inmar written permission, 2022

THANK YOU!

KIRK HERWECK

Sr. Director, Consumer Drug Take-Back
kirk.herweck@inmar.com
P: 636-734-3559

Scan this code to save my information

Inmar confidential – do not copy, distribute or use without Inmar written permission, 2022

Title of the proposal

<u>Evidence-based Family Support and Wellness</u>

Description of the proposed project

Program need and description

Data from the Centers for Disease Control (CDC) and Prevention show that American's are at risk for a multitude of behaviors that are harmful to their health and well-being. These include alcohol, tobacco, e-cigarettes, marijuana, prescription opioid misuse and other illicit drug use, physical inactivity, unhealthy eating, lack of sleep and uncontrolled stress. Their family members suffer along with them as the struggle with addiction.

Research also indicates that the majority of US, including NJ, residents experience two or more co-existing risk behaviors, and over a third three or more risk behaviors. Together, multiple risk habits interact to compound the pain, suffering and sadness youth and their families experience by increasing the likelihood of injury, illness, and personal and social problems, while hindering positive development of the person.

Solving the national epidemic of multiple substance use and other health risks among youth requires using evidence-based programs that integrate alcohol and drug use prevention with wellness promotion. The Community Connections program provide the only evidence-based interventions that address substance use and chronic disease risk behaviors in a single intervention and setting, to cost-effectively improve the "whole health" of those participating.

Community Connections is designed to enhance the positive development of individual by teaching them to connect avoiding substance use with increasing wellness behaviors and desired future images. These include participating in sports and physical activities, eating healthy, getting plenty of sleep and controlling stress.

Community Connections is a practical, single-session evidence-based screening and brief intervention designed to save organizations' time and money. It has been shown to prevent and reduce alcohol, tobacco and marijuana use, while increasing healthy habits such as physical activity which are necessary for promoting and protecting the overall health and well-being of people. It provides tailored feedback and positive image messaging to increase motivation for increasing wellness habits and avoiding substance use. It assists people in setting and monitoring multiple health behavior goals to initiate behavior change and increase self-regulation skills

Everything needed to successfully implement family support is conveyed to attendees and weekly meetings The program comes with free face-to-face, online and telephone support by the developer. The one-time purchase pricing eliminates future materials costs and ensures program sustainability. In addition, practical online or onsite training is offered to become certified as a Support Program Implementer.

Program benefits

The Community Connections program fills a key gap in achieving the life and coping skills needs of contemporary population affected by substance abuse. Specifically, Community Connections is the one of the few programs that teaches individuals how alcohol and other drug use interferes with health behaviors and positive image achievement necessary for experiencing mental and physical well-being.

Community Connections also teaches youth critical self-management skills to set and monitor multiple health behavior goals to reach and maintain a healthy lifestyle and combat multiple health risks common among Americans.

Community Connections is designed to increase child, parent and provider interest and participation by emphasizing positive images of youth engaged in wellness promoting habits. In addition, Community Connections is customized to each youth's individual needs by providing messages tailored to their current health behaviors and desired self-images as realized values.

Community Connections dovetails well with and will enhance other life skill activities and programs we offer at our organization. These activities and programs include…

Community Connections is quick and easy to implement, it provides a very practical solution to offering an evidence-based program within a busy organizational setting like ours. As such, it will increase the reach of our prevention and recovery program to a greater number of individuals.

Since Community Connections teaches youth how substance use risk behaviors and wellness behaviors are connected and influence each other, it offers a unique educational and motivational strategy for improving the whole health and well-being of people in our NJ region.

Implementation plan

In the proposed project, we will implement Community Connections to reach several hundred people suffering with addiction or in recovery and family members to enroll in our organization during a 12-month period. Last year, 20 individuals were seen at our organization.

Our target of several hundred participants will receive online/onsite training from Community Connections to learn how to implement help and support to our organization's members, as well as train others to use it in the future.

Community Connections will provide to parents/caregivers of participating members to reinforce and strengthen positive outcomes in multiple behavior improvements. Parent training teaches parents/caregivers more about each of the targeted health behaviors. These include promoting physical activities, healthy eating, getting adequate sleep, controlling stress, goal setting, and avoiding alcohol and other drugs.

We also plan to use the online (or paper) pre and posttest surveys to monitor program fidelity and assess critical immediate pre-post-program factors predicting both wellness and substance use behaviors of individuals. These data will be used to promote and sustain our program and make improvements over time.

Population served

All individuals 18 years and up enrolled at our organization will be offered support through Community Connections.

Requested amount of Opioid Settlement - $9,700 per year

Financial breakdown of how money will be used

- **$1,000 amount of funding will be requested to purchase Community Connections program materials and training.**
- **$700 amount of the budget will be dedicated to the analysis and reporting of evaluation data to assess the quality of program implementation and behavioral outcomes resulting from the support program.**
- **$8,000 funding will be used for staff support, purchasing equipment, and providing copies of program materials to implement and evaluate the program. This will allow individuals to achieve goals set while participating in Community Connections and increase their wellness behaviors and positive self-image.**

How will we track project success?

The proposed project's success will be assessed and tracked at two levels. First, program quality and immediate program effects will be evaluated using two strategies.

The pre and post-program surveys include three measures predictive of the targeted behaviors, including fiver wellness-promoting habits and five substance use behaviors. These measures include behavioral intentions, social norms and perceived harmfulness of using each substance, as well as two qualitative measures of program benefits and limitations.

Healthy behaviors assessed will included self-care, physical activity, healthy eating, getting adequate sleep, controlling daily stress and setting goals to improve health/fitness, while substance use measures will include alcohol, tobacco, e-cigarette, marijuana and opioid use.

In addition, an Instructor's Survey will assess quality of program implementation on seven key indicators of implementation success.

Measures will be collected immediately before and after implementation of each program. These two instruments will be monitored on a continual basis to ensure program implementation quality.

All program evaluation tools are included with the Community Connections program. The program developer will be available by phone and email to address all program implementation and evaluation issues, and provide support as needed throughout the project.

1. **Expand capacity and reach of the MAT Centers of Excellence through education, mentoring, academics, innovation:**
    a. Build interactive webpage to house online training program and central listing for in-person addiction education
    b. Expand training within academic medicine for students and Continuing Education
        i. Executive Clinical Training Program
            1. for LPN, RN, APP, MD
            2. Immersive clinical training program for interdisciplinary clinicians who have not had formal addiction training
        ii. Pilot the integration of SUD ASAM levels of care within academic medicine
            1. Provide state funding for state-run medical schools in New Jersey with a faculty practice plan to construct state-of-the-art Level III.7-D medically monitored inpatient detoxification units and Level III.7 residential treatment units which can serve as Centers for Addiction Research, Education and Treatment (CARE Treatment Hubs). The CARE Treatment Hubs would include both academic leaders and medical students in the treatment of persons living with opiate use conditions.
    c. Create statewide MAT Prescribing Hotline (for patients), in addition to existing MAT Provider Hotline
    d. Partner with pharmacies to build extended release and sublingual buprenorphine stockpile program
    e. Fund addiction medicine services in hospitals across New Jersey

2. **Expand access to harm reduction and low barrier co-located evidence-based care:**
    a. Expansion of harm reduction centers
        i. Incorporation of treatment at harm reduction centers
    b. 24/7 community-based access centers for urgent access to MAT and behavioral healthcare
        i. licensing must include MAT and harm reduction;
        ii. Recommend pilot with COEs, 3-4 pilot sites in most highly affected counties; 5 year project funding minimum; cover 24/7 staffing and supplies
        iii. Chemical Health Urgent Care- located in high-risk communities similar to Urgent Care System used in primary care, but specializing in treatment of chemical addictions
    c. Community paramedicine programs incorporating MAT
    d. Mobile units for existing and expanded low-barrier programs
        i. Expand outreach to faith-based communities
    e. State-wide gap funding effort to cover medication and transportation for patients in need of SUD treatment
        i. Consider model after New York Matters Network
        ii. Cover medication and transportation for patients in need of SUD treatment
        iii. Gap coverage to include copays and other barriers patients with insurance face (i.e. Medicare and private insurance holders)

f. Expand Naloxone Distribution Program- to additional service providers
g. Integrating licensing for health, behavioral health, and substance use disorder care
h. Expand Patient Navigator programs to provide home-visiting services

3. **Funding for Social Determinants of Health support for people with SUD and in recovery**
    a. Expand Housing First model: low barrier, harm reduction focused
        i. Expand housing first with housing vouchers for individuals and families in recovery
        ii. Build new single-home units using the Oxford House Model
        iii. Partner housing units with CARE Treatment Hubs (noted above)
        iv. Rental assistance for recovery housing
    b. Transportation expansion: door-to-door services (individual and family) for treatment access and early recovery
        i. Contract with roundtrip or other alternative for door-to-door individual or family transportation
        ii. Services for people in recovery to travel from recovery homes to work (note: many have DUIs that prevent them from driving, need employment to maintain rent during transition)
    c. Employment assistance: social enterprise system who hire persons in recovery with criminal backgrounds
        i. Partner with community-based programs to develop social enterprises which hire persons in early recovery with criminal backgrounds
        ii. Smartphone coverage- approve smartphones as durable medical equipment, ensure coverage plan

FY 2023 Board Members

Chair
Jacques Hryshko, LPC, ACS

Vice Chair
Anthony Comerford, PhD

Treasurer
Theresa C. Wilson, MSW, LCSW

Secretary
Mary Jo Buchanan, MPA, LCSW

Immediate Past Chair
Susan Loughery, MBA

At-Large Members
Mary Gay Abbott-Young, LCADC
Mary Pat Angelini, MPA, CPS
Robert J. Budsock, MS, LCADC
Alan DeStefano, MSW
Anthony DiFabio, PsyD
Frank A. Ghinassi, PhD, ABPP
Derry Holland, LCSW
Erika Kerber, Esq.
Deborah Megaro, MBA
Kristine Pendy, LCSW
Louis A. Schwarcz, MA
Kathy White-Thomas, MS

President and CEO
Debra L. Wentz, PhD

October 31, 2022

The Honorable Phil Murphy
Office of the Governor
PO Box 001
Trenton, NJ 08625

Dear Governor Murphy:

On behalf of the New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA), thank you for this opportunity to provide input on how the opioid settlement funds New Jersey is receiving may be best utilized.

There are widely published principles to be followed for this undertaking, some of which I will highlight below. There is also New Jersey's list on the portal page for this submission on how funds must be spent. These are both critical and necessary to shaping any recommendations; however, I wish to emphasize up front that all approaches to prevention and treatment will require significant ongoing investment in the workforce. It is well documented that the behavioral health workforce was experiencing shortages prior to COVID due to both recruitment and retention challenges. The workforce shortage is now a workforce crisis, and it must be addressed as such, with funds from the opioid settlements invested substantially in each year of its disbursement to build and sustain a stable, qualified workforce.

Principles for the Use of Funds

The following principles are an amalgamation of those that have been espoused by many stakeholders at the local, state and national levels. Their importance is such that I felt them worthy of being included prior to discussion of specific uses of settlement funds.

1. All opioid settlement funds must supplement, and not supplant, current resources.
2. The process and disbursements must be fully transparent.
3. Funds must go to programs and approaches utilizing evidence-based practices.
4. Funds should be distributed based on state data with a focus on racial equity.
5. While immediate needs are a priority, so too should long-term prevention strategies, particularly for children and youth, be a primary investment.

Use of Funds

The list of uses the funds may be utilized for allows for comprehensive, innovative approaches. For instance, "supporting people in treatment and recovery" opens the door to spending on housing and other social determinants of health. "Addressing

3635 Quakerbridge Road, Suite 35, Mercerville, NJ 08619 Phone: 609.838.5488 Fax: 609.838.5489 www.njamhaa.org

the needs of justice involved persons" supports further expansion of various diversion programs. New Jersey has made great strides in recent years in expanding medication assisted treatment, fighting stigma, and toward decriminalizing addiction in treating opioid use disorder (OUD) and other substance use disorders (SUDs), among other advances. We now have the opportunity to exponentially increase all of these efforts and new ones as we strive to save lives and provide greater opportunities to those in recovery. Below are NJAMHAA's priority recommendations, in brief. I and our members, the organizations that are on the front lines of daily service to New Jerseyans with SUDs, look forward to ongoing opportunities to provide more detailed input on how to best utilize the settlement funds to serve this population in the years ahead.

Education

Investment is needed for both educating the public and the healthcare workforce. A public awareness campaign should have several goals: educating parents on how to protect their children; informing the public on their rights under state and federal parity laws; and providing information on how to find and access treatment. For youth, Teen Mental Health First Aid (tMHFA) is an evidence-based program that teaches teens "how to identify, understand and respond to signs of mental health and substance use challenges and crises among friends and peers" (MHFA.org). Under a grant funded program, the National Council for Mental Wellbeing selected dozen of New Jersey schools and youth-serving organizations to receive this training for free in 2022. New Jersey must provide ongoing funding to bring this program to all of its communities. The state must also work with all colleges and universities to increase addiction education and training, and mandate such education for all state-funded medical, nursing and pharmacy schools. The training for prescribers must include safe prescribing of opioids for chronic pain.

Prevention and Early Intervention

Prevention needs to be integrated across all possible settings – at schools, community organizations (such as libraries and community centers) and in primary care – and funding provided to sustain these efforts.

School-based services provide the greatest avenue to "meeting youth where they are" and much greater investment for in-school services is needed. The first step to expanding school-based services must be an audit of all existing services. While only 90 schools currently operate School Based Youth Services Programs funded by the Department of Children and Families, a large percentage of other schools have similar models that are funded in other ways. To best target its resources, New Jersey must first know the current landscape and where the true gaps and needs are. Screening programs such as SBIRT – Screening, Brief Intervention, and Referral to Treatment – is another evidence-based programs that should be expanded in schools and primary care offices.

Treatment

It is widely know that there is a high prevalence of mental illnesses among individuals with OUD and other SUDs as well as physical comorbidities, such as heart disease and diabetes. It is also clear that opioid misuse and abuse do not occur in isolation and are more often than not used along with other substances. For these, and other reasons, such as transportation issues, the best approach to successful engagement and treatment is an integrated one.

New Jersey is fortunate to be one of the federal demonstration states for Certified Community Behavioral Health Clinics (CCBHCs). Among other things, the model requires a full continuum of SUD services and medication assisted treatment to address OUD and other SUDs, along with mental healthcare, primary care and case management. The Substance Abuse and Mental Health Services Administration will soon be releasing guidance on how existing demonstration states can add organizations to the demonstration. New Jersey currently has only seven CCBHCs in the demonstration, but there are twelve other New Jersey CCBHCs funded by federal expansion grants. New Jersey must take the opportunity to bring as many organizations as can meet the high standards of the CCBHC model into the demonstration for the benefit of both its citizens and the state's bottom line, as demonstration CCBHCs receive a very high enhanced federal match.

Demonstration CCBHCs offer other advantages for individuals with OUD and other SUDs. They all offer crisis services and are integrating with New Jersey's 988 crisis response system. They have sophisticated tracking and reporting systems and are currently expanding their relationships with and services to criminal justice involved entities and individuals. Perhaps most importantly, CCBHCs have been shown to improve access to timely, appropriate care. New Jersey must increase its OUD and other SUD treatment system capacity and expanding the CCBHC model is one approach to doing so.

Another priority must be to examine the time limits set for various modalities of care. There is no evidence showing that treatment limited to 30 days or 24 visits is effective. OUD and other SUDs are chronic illnesses and need to be treated the same as other chronic health conditions like diabetes and heart disease — with no limits on initial access or additional treatment that may be needed further in the future. Arbitrary time limits on treatment and recovery supports contribute to relapses, exacerbating capacity issues.

A third priority approach to improving access to treatment is to ensure justice involved individuals are connected to care. The Administration must work with the Legislature to see that a bill requiring Medicaid enrollment 60 days pre-release becomes law. More broadly, Senator Vitale has introduced a bill that would also require Medicaid eligibility determinations for those waiting pre-trial release. Studies continue to show the disparate number of overdose deaths in the months following release from incarceration. Ensuring health insurance coverage and linkages to providers pre-release can go far to reduce those numbers.

New Jersey Association of Mental Health and Addiction Agencies, Inc.
Champions for Transforming Lives and Health Systems

Harm Reduction

On behalf of those in need, NJAMHAA and its members are extremely grateful to the Administration for its increased investment in harm reduction services in the FY2023 budget. This was possible because harm reduction services have proven effective in preventing overdose from opioids, poly-use and other substances. More lives can be saved by expanding access to these services, that ultimately lead many to engage with OUD and other SUD treatment and start on their path to recovery.

Recovery Supports

Individuals with OUD and other SUDs need access to recovery support services, which have also been proven to be extremely effective. These services include sober living residences and self-help and mutual support groups. Through these programs, individuals encourage each other to persevere through treatment and overcome challenging situations that could lead to relapse.

Case management is another critical recovery support as it connects individuals to all types of needed services, addressing the whole person. Case management should be funded as a component of all levels of service, not just recovery support service. It must be supported in pre-release, re-entry and harm reduction programs and all levels of the treatment continuum for individuals with OUD and other SUDs.

Social Services and other Supports to Address the Social Determinants of Health for Individuals with OUD and other SUDs

Case managers are able to assist in addressing stable and safe housing, food and other social determinants of health (SDoH) including education and employment opportunities. Addressing SDoH has been shown to have a tremendous positive impact on all aspects of individuals' health. Providing support to address SDoH, along with SUDs, mental illnesses and other health conditions may be best coordinated, tracked and funded via the CCBHC model, bringing us back to our first treatment recommendation.

Case management services, wherever they are found, can only achieve the potential they have to improve lives if the resources they seek to link individuals to are available. We are pleased that New Jersey's 1115 waiver renewal is looking at innovative housing supports, but much more is needed. New Jersey must increase temporary, transitional, and permanent housing stock as well as education, employment training and other opportunities. Increased investment to expand reentry programs is also recommended as it would bring case management, SUD services and all other supports to a population hit hard by overdose deaths.

www.njamhaa.org Phone: 609.838.5488 Fax: 609.838.5489 3635 Quakerbridge Road, Suite 35, Mercerville, NJ 08619

In Conclusion

We have touched only briefly on education, prevention, treatment, harm reduction, and recovery supports. Each area could have been further elaborated on and more added. However, the real work lies ahead and NJAMHAA and its members look forward to continued opportunities to explore each area further with your Administration and other stakeholders. On a final note, I will repeat my opening comment on the workforce crisis. None of the recommendations here or from others are possible without a stable, qualified workforce. The opioid settlement funds offer the opportunity to make significant investments to build the necessary workforce and must be a top priority.

Thank you in advance for your thoughtful consideration of our recommendations.

With warmest regards,

Debra L. Wentz

Debra L. Wentz, PhD
President and Chief Executive Officer

I. Evidence-Based Primary Prevention is a Critical Component of the Response to the Opioid Crisis.

Prevention Parable (Story by: Irving Zola)

Imagine a high waterfall that plunges into a large river. At the bottom of this waterfall, hundreds of people work along the shores of the river trying to save those who have fallen down the waterfall and are drowning in the river. As the people along the shore work frantically to rescue as many as possible, one person looks up at the seemingly never-ending stream of people falling down the waterfall and begins to run upstream. Another rescuer hollers, 'Where are you going? There are so many people that need help here.' To which the person replies, 'I'm going upstream to find out why so many people are falling into the river.'

Prevention professionals are those who go upstream utilizing evidence-based strategies to strengthen policies, build resiliency, and develop systems to support youth, families and communities. The New Jersey Prevention Network (NJPN) and prevention partners across New Jersey are providing quality prevention services that work to prevent youth drug use and its negative effects across the lifespan.

To effectively address the opioid crisis, we need to continue to strengthen this critical prevention infrastructure that addresses the core, underlying issues that drive substance misuse and which has the expertise and can adapt to the evolving drug use landscape. It would be short-sighted to neglect using the Opioid Settlement funds to strengthen these infrastructures that target core risks, enhance protective factors and build resiliency in NJ communities to buffer against future crises.

People use drugs for reasons. Typically, those who become addicted struggle with hopelessness, trauma or mental illness — often all three. This economic and social pain is the commonality across drug crises. Until policymakers prioritize healing the distress that makes particular people and communities facing economic loss and trauma especially vulnerable to addiction, this vicious cycle will only continue.

There's a phenomenon known as generational forgetting, originally identified by Lloyd Johnston, who led the largest national survey on drug use among youths for the past 43 years. The idea is that young people often avoid the drug that is currently the most feared. But since they have little experience with those that were popular earlier, they are less aware of their potential dangers. This results in a broadly defined cycle in which, roughly every 10 to 15 years, a different drug epidemic appears. Heroin, for example, was the demon drug of the 1970s, crack in the 1980s, heroin again in the 1990s, methamphetamine in the 2000s, prescription opioids in the 2010s and now fentanyl and other opioids that are being sold as heroin. By seeing and covering each crisis as being caused by a particular substance — without understanding why addiction persists — we miss the opportunity to use policy to reduce related harm.

Maia Szalavitz
"The Most Important Question about Addiction."
The New York Times, September 29, 2022.

Supporting treatment and recovery is important, and to effectively manage current and future crises, adopting a strategy of prevention is essential. Our colleagues in treatment, recovery support and harm reduction are working downstream to save one life at a time. Prevention works upstream to stop folks from falling in the “river” of addiction to begin with and completes the continuum of care.

Primary prevention is a comprehensive public health approach that works upstream to address individual and community risk factors – working to improve them before more serious problems occur. This upstream work addresses risk factors, social determinants of health (SDOH) and other contexts such as adverse childhood experiences (ACEs) that may lead to substance use and its negative consequences. ACEs are strongly related to the development and prevalence of a wide range of health problems, including substance use, throughout the lifespan. It is estimated 40% of children in New Jersey have experienced at least one ACE, with 33% of them being children under the age of 5.

A multi-pronged, primary prevention approach works at the individual, family and community levels to improve knowledge, attitudes and behaviors, and enact policies that positively impact the environment in which we live, learn, and play. This approach reaches the entire community, provides benefits to those at particular risk of substance misuse, and can also produce positive effects in other areas such as educational and economic attainment, reduction of violence, and improved mental health. In essence, because it addresses root causes of addiction, primary prevention *is* an opioid prevention strategy.

INDIVIDUAL BASED
RISK FACTORS

- Parental drug/alcohol use
- Depression
- Anxiety
- Early substance use
- Emotional problems in childhood
- Sexual abuse
- Early aggressive behavior

FAMILY BASED
RISK FACTORS

- Parental drug/alcohol use
- Substance use among parents or siblings
- Inadequate supervision and monitoring
- Child abuse/maltreatment
- Parental favorable attitudes towards alcohol and/or drugs
- Marital conflicts
- Parental depression

SCHOOL/COMMUNITY
RISK FACTORS

- Peer rejection
- Substance using peers
- Loss of close relationship or friends
- Poor academic achievement
- School violence
- Societal/community norms about alcohol and drug use

The National Opioid Settlement Agreement provides a unique opportunity to address the addiction crisis in a lasting and sustained way. The settlement agreement lists Prevention Programs as a core abatement strategy to be given priority, yet they have not been explicitly listed as a funding priority for the NJ opioid settlement funds. Every dollar spent on prevention can save an estimated $18 in direct, healthcare, criminal justice and other societal costs.[i]

There is an urgent need to take increased action to prevent issues in the first place — and focus on the root causes that can increase risk for substance misuse, mental health issues and/or suicide. These approaches have a broader effect and can also support positive outcomes for a range of other related issues like poor academic and career attainment, bullying, depression, violence, unsafe sexual practices and job and economic attainment.

"Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy."
Trust for America's Health Issue Report. November 2017

II. NJ's Strategic Investment in Local Coalitions and Prevention Hubs in a Statewide Network

Having a prevention infrastructure in place is critical. NJ has made a strategic investment in its prevention infrastructure by supporting multi-sector Regional Prevention Coalitions (RCs) that serve every county in the state whose priorities include addressing alcohol, marijuana/cannabis and a strong focus on opioid misuse prevention by reducing prescription medication misuse across the lifespan and the use of opioids. National research highlighted in "Pain in the Nation" recognized the importance of these community partnerships in identifying local challenges and local solutions to address the opioid crisis.

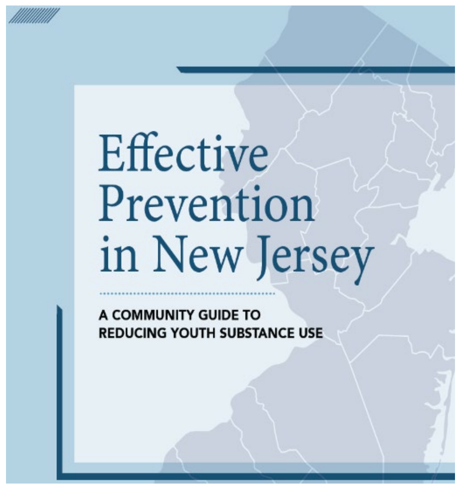
One of the biggest challenges communities face in countering the opioid crisis is the lack of a standing mechanism that bring all of the needed partners and resources together to address major epidemics within a community...Experts have identified the most effective way to tackle major health and well-being issues is to develop local partnerships — that bring together the different expertise, capabilities and resources across an entire community. Local leaders, institutions and citizens have both a greater understanding of their community's most pressing challenges and shared interest in addressing them.

"Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy."
Trust for America's Health Issue Report. November 2017

The Regional Coalitions have deep local knowledge and reach. They assess community needs and drug use trends and respond by providing tailored, evidence-based prevention policies, strategies and interventions that support youth, individuals, families and communities. RCs collaborate with local partners such as municipal alliances, law enforcement, faith-based organizations, schools, treatment agencies, local legislators, healthcare providers, health departments, and other local level community agencies to ensure a coordinated response and leverage existing resources.

Recently, through the Prevention Block Grant Supplemental Funds, the state has built on this critical investment by funding the establishment of a state system of **Prevention Hubs** (https://www.njpreventionhub.org/) in each county to amplify the coalition's environmental strategies and activities and strengthen this statewide network. The Prevention Hubs catalyze cross-learning, build capacity through training and technical assistance, and promote supportive services such as a "warmline" to direct residents to a wide array of resources, including navigating local, regional and state services. The Prevention Hubs engage all sectors of the community including youth, parents, schools, law enforcement, faith-based organizations and more. The county Hub activities are rooted in science and provide evidence-based programming and resources to reduce the risk factors that lead to drug and alcohol use/misuse. They are experts who provide community-wide education and outreach – including to specific disparate communities and populations. NJPN serves as the coordinating agency to guide strategic implementation of the statewide Prevention Hub system, build capacity, and support and promote Hub activities.

III. Evidence-Based Prevention Programs Support NJ Communities and Residents Across the Lifespan



Primary prevention programs are designed to reach communities and individuals at crucial points of life, so that the right information and support is provided in the right way at the right time. Our work is driven by years of research that has guided prevention to ensure effective interventions. NJPN compiled and highlighted these evidenced based strategies and a compendium of evidence-based programs in the "Effective Prevention in NJ: A Community Guide to Reducing Youth Substance Use" Toolkit. While NJ's Prevention Hub agencies currently implement these programs, current funding does not allow for sufficient spread, scale, nor sustainability of the programs in the years to come. These include programs that target populations across the lifespan, including young children, youth and teens, parents, and older adults. Here are some examples of the evidence-based programs being implemented through the prevention agencies and their Regional Coalition and Prevention Hubs initiatives.

For Young Children:

- Footprints for Life™ program: a comprehensive, research-based substance use prevention intervention created by WellSpring Center for Prevention. This program is for early elementary school-aged children and by using puppets and stories that feature "real life" situations," designed to "build assets and teach life skills.

For Youth and Teens:

- LifeSkills Training: The LifeSkills Prescription Drug Abuse Prevention Module specifically gives adolescents the skills and knowledge necessary to help them avoid misuse of opioids and other prescription drugs.

- Tackling Opioids through Prevention (TOP) for Athletes Toolkit, which raises awareness of opioid use and abuse among young student athletes and provides evidence-based recommendations and information to encourage and promote policy and practice changes that will strengthen schools, athletic departments and community based athletic programs. This toolkit was developed in response to community need to protect NJ's 300,000 high-school student athletes as "young adults who participate in athletics may be at a greater risk to engage in non-medical prescription opioid use because of their greater risk of injury or because of a greater opportunity to receive diverted opioid medications from teammates." Rooted in science, this toolkit provides examples of best practices community messaging, and evidence-based policy and program examples that are effective in evoking positive behavioral change. In addition to the toolkit, RCs provide technical assistance and training in its effective use.

- Preventure: “an evidence-based prevention program that uses brief, personality-focused interventions to promote mental health and delay substance use among youth. The program aims to equip young people with self-efficacy and cognitive behavioral skills to help them cope with the numerous developmental challenges that many adolescents face, such as academic stress, peer pressure, interpersonal conflict, and identity development.”

- Screening, Brief Intervention and Referral to Treatment (SBIRT): a “comprehensive, integrated evidence-based public health approach and model for identifying substance misuse that delivers early intervention and treatment services for persons at risk of developing substance use disorders.” We provide training on SBIRT implementation to build capacity among school administrators and counselors and other community members on this effective prevention and early intervention strategy.

For Parents and Children:

- Strengthening Families: “an evidence-based family skills training program for high-risk and general population families. Parents and youth attend weekly skills classes together, learning parenting skills and youth life and refusal skills. They have separate class training for parents and youth, followed by a joint family practice session.” Prevention Hubs are currently providing these services to families with criminal-justice involvement, pregnant and mothering women, and other community families.

For Older Adults:

- Wellness Intervention for Senior Education (WISE): a wellness and prevention program targeting older adults, designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. WISE provides valuable educational services to older adults on topics including medication misuse and management, stress management, depression, and substance misuse. Created by NJPN and implemented locally by prevention agencies, the program has reached over 40,000 individuals and has been included on SAMHSA’s National Registry of Evidence-based Programs and Practices.

In addition to these primary prevention activities, NJ’s Prevention Hub agencies provide and support secondary prevention by providing early intervention programs for youth who are experimenting with alcohol and drug use by promoting screenings such as SBIRT for identification and referral of those most at risk for use and providing a warmline to connect individuals to local and statewide resources for treatment and recovery, including peer recovery support. We also provide tertiary prevention by promoting harm reduction strategies for those with a substance use disorder. Comprehensive, multi-pronged prevention approaches that seek to impact environmental strategies and policy, as well as provide evidence-based programming for individuals, families and communities can and do reduce harm. Harm reduction strategies are infused across all the work we do; in particular, we work to reduce stigma, provide education

on Narcan use, promote the importance of medication for opioid use disorder (MOUD), and make connections to recovery support services.

IV. Maximizing NJ's Strategic Investment in Prevention: A Call to Action

Sustaining and building upon NJ's prevention infrastructure is critical to be able to continue to effectively respond to the opioid crisis, as well as to be able to pivot and evolve to meet the changing drug landscape and continue to attack the root causes that put youth, families and communities at increased risk for substance use. Addressing these upstream causes – often related to social determinants of health including adverse childhood events – helps to create resilient individuals, families, and communities to protect against the onset of substance use/misuse.

The New Jersey Prevention Network on behalf of the NJ's system of Prevention Hubs is requesting a relatively modest investment of $150,000 annually per county prevention agency plus support for NJPN through the life of the settlement funds to ensure the maximum effectiveness of the state's current investments. $3.3 million per year for 18 years amounts to less than 10% of New Jersey's allocation of the settlement funds. Yet, it will produce a savings of an estimated $1.06 billion in costs to healthcare, criminal justice, and other individual and societal costs.

---

[i] Miller, T. R., & Hendrie, D. (2008). Substance abuse prevention dollars and cents: A cost-benefit analysis. DHHS. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

Using NJ's Opioid Settlement Funds: Harm Reduction through Narcan Vending Machines

Lisa Campanella, Senior Policy Analyst
lisa@newjerseyop.org
New Jersey Resource Project

While the state of New Jersey has made more of an effort through regulation and legislation to expand access to the life-saving overdose-reversing drug, naloxone, access can be even expanded further through the use of naloxone vending machines. A number of cities have instituted this program, including New York and Philadelphia, as well as Las Vegas, San Diego, and Detroit. We recommend a portion of the opioid settlement funds be used to implement such a program in New Jersey.

Cities have adopted a number of different implementation methodologies. For example, in New York which is partnering with a nonprofit, the Fund for Public Health in New York, the organization offered grants to harm reduction organizations to install vending machines.

NY is also spending $730,000 to fund ten machines spread over all five boroughs to six contractors, all of whom are registered with the state of New York as an "opioid overdose prevention program" and who provide services directly to people who are drug users. (NY is also going a step beyond just naloxone supplies in the machines, free of charge. Five of the machines will also carry sterile syringes. Contractors may also use their own funds to add on other items such as safer smoking kits, condoms, and pregnancy tests.)[1]

Philadelphia established the Narcan Near Me program in February 2022, in conjunction with a Canadian company, Dispension Industries. (The Canadian company is piloting a program in Vancouver to dispense hydromorphone from the kiosks. The goal in Canada is to manage patients' opioid dependence and protect them from fentanyl which is in so much of the drugs. Whether there is the political will to create such a program in the United States remains to be seen.)

In Philadelphia, anyone can access naloxone for free with a touch of a button. There is an option to fill out a brief survey or skip it. There is also an emergency option in case someone is in the process of overdosing at that moment.

The two doses of naloxone are accompanied by gloves, a mask/face shield (in case rescue

---

[1] https://filtermag.org/naloxone-vending-machines-new-york/

breaths are required), and instructions. The kiosks are available 24 hours and are monitored remotely by the Department of Health to keep them stocked. Unlike programs in Las Vegas (and some in Kentucky), there is no requirement to pre-register to ensure access. NJ should follow Philadelphia's lead.[2]

Has the program been successful so far? Charlie Nolan, a harm reduction specialist with the City of Philadelphia's Department of Public Health indicated, "I would say it's pretty effective. It's been accessed nearly 400 times since it's been installed. I'm probably out restocking… twice a week."

Wayne State University in Michigan installed 15 machines across the state. It included placing one machine on its campus in Detroit. Unlike the tower machines in Philadelphia, these look like typical vending machines, but there's no payment required. So far over 19,000 individual doses of naloxone have been distributed. The University wants to expand the program even more and applied for a grant from the state. If chosen, the University could place 20 more vending machines throughout the state in October 2022.[3]

One small study concluded that using these vending machines to dispense naloxone and increase access to the drug will particularly benefit young adults (ages 18-30) opioid users in high risk underserved populations.

Why is this the case? Apparently typical naloxone distribution efforts (pharmacies?) do not reach young adults. The convenience and the privacy of accessing the naloxone added to more naloxone use. Apparently young adults felt comfortable accessing it at these kiosks. The young people "identified safety, lack of police presence, and low costs as important vending machine features."[4]

The goal with any harm reduction method is to save lives. Only if people's lives are saved is there any possibility for treatment and recovery. Naloxone vending machines are an additional tool in the arsenal to potentially save more lives and an appropriate use of the opioid settlement funds, whether it's three quarters of a million dollars such as in New York, or even more. We

---

[2] https://whyy.org/articles/philly-unveils-first-of-its-kind-narcan-vending-machine-at-west-philly-free-library/

[3] https://usamdt.com/drug-news/u-s-cities-installing-narcan-vending-machines/https://usamdt.com/drug-news/u-s-cities-installing-narcan-vending-machines/

[4] https://www.sciencedirect.com/science/article/pii/S2772724622000695

leave it to the experts to determine where these machines should be deployed and in what numbers.

Using NJ's Opioid Settlement Funds: Mobile MAT

Lisa Campanella, Senior Policy Analyst
lisa@newjerseyop.org
New Jersey Resource Project

PROPOSAL

To expand mobile Medication Assisted Treatment (MAT) units throughout NJ, particularly in rural areas of South Jersey, utilizing funds in the amount of up to $2 million, from the opioid settlements to facilitate expansion of treatment for those with Opioid Use Disorder (OUD). The mobile MAT vans would include those which dispensed MAT and not simply prescriptions.

BACKGROUND

In June 2021, the DEA lifted a moratorium on mobile MAT units which had been in place since 2007. This allows the use of new licensed mobile units so long as they operate in connection with a licensed Narcotics Treatment Program (NTP) which already dispenses MAT.[1]

NJ already operates some mobile units, including one at the Atlantic County Correctional Facility and one recently approved by the NJ Department of Human Services to dispense prescriptions for MAT.

What is a mobile MAT unit, as defined by the DEA's regulations? "A mobile NTP is an NTP operating from a motor vehicle that serves as a mobile component of the NTP and engages in maintenance and/or detoxification treatment with narcotic drugs in schedules II-V at a location or locations remote from but within the same State as a registered NTP and operates under the registration of the NTP."[2]

The DEA rules place no limits on how far the vans travel, how frequently they stop, so long as they return to either the brick and mortar location or another DEA approved, secure, and fenced facility, at the end of each operational day. However, the vans must operate in the same state as the brick and mortar.[3] The DEA relies on the state of NJ's rules and regulations as to which NTP's are qualified to dispense medication. The DEA also indicated that after a year,

---

[1] See DEA rule change published in Federal Register: deadiversion.usdoj.gov/fed_regs/rules/2021/fr0628.3.pdf.
[2] See page 6 of the DEA's Federal Register publication referred to above.
[3] Note comment on page 3 of the Federal Register.

they would review the "return to base-same day requirement," in coordination with the Dept. of HHS and the Office of National Drug Control Policy (ONDCP), page 7 of the FR.
Why are these mobile MAT vans so vital to so many communities throughout NJ? In 2021 alone, 3,081 New Jerseyans succumbed to overdose through the use of opioid and opioid-related pharmaceuticals.[4] Although treatments exist which have proven to be effective in treating OUD, only a fraction of the population has access to it, namely Medication Assisted Treatment (MAT).

According to SAMHSA, as of 2019, only 19.7% of Americans with OUD received MAT even though research as far back as 2014 demonstrated its efficacy.[5, 6]

There are numerous barriers to people who need and could greatly benefit from this treatment, including a lack of transportation, a lack of insurance, and homelessness. A vehicle which comes to individuals to dispense MAT would be a boon to rural as well as underserved individuals suffering from OUD.[7]

The authors concluded 'the New Jersey Medication Assisted Treatment Initiative (NJ-MATI) sought to reduce barriers to treatment by providing free, opioid agonist treatment (OAT, methadone or buprenorphine) via mobile medication units (MMUs). To evaluate barriers to OAT, logistic regression was used to compare opioid-dependent patients enrolled in NJ-MATI to those entering treatment at fixed-site methadone clinics or non-medication assisted treatment (non-MAT). Client demographic and clinical data were taken from an administrative database for licensed treatment providers. The MMUs enrolled a greater proportion of African-American, homeless, and uninsured individuals than the fixed-site methadone clinics. Compared to non-MAT and traditional methadone clients, NJ-MATI patients were more likely to be injection drug users and daily users but less likely to have a recent history of treatment. These observations suggest that the patient-centered policies associated with NJ-MATI increased treatment participation by high severity, socially disenfranchised patients who were not likely to receive OAT."

---

[4] https://www.nj.gov January 18, 2022
[5] Thomas CP, Fullerton CA, Kim M, et al. Medication Assisted Treatment with Buprenorphine: Assessing the Evidence. Psychiatry Serv.2014; 65(2): 158-170. doi: 10:1176/appi.ps.201300256
[6] Key substance use and mental health indicators in the United States: Results from the 2018 National Survey in Drug Use and Health (HHS Publication No. PEP 19-5068, USDOH series 16-54.). Rockville, MD: Center for Behavioral Health Statistics and quality, Substance Abuse and Mental Health Services Administration.
[7] "Mobile opioid agonist treatment and public funding expands treatment for disenfranchised opioid-dependent individuals," Gerod Hall Ph.D., M.P.H., et al
https://doi.org/10.1016/j.jsat.2013.11.002.

These findings clearly suggest a preference for mobile MAT units over brick and mortar facilities to serve those who need the medication the most. Moreover, as of 2016, over 90% of those brick and mortar NTP's were located in more urban areas.[8] This often forces rural patients to travel long distances to receive doses of MAT or forgo treatment as inaccessible. For those in rural NJ that may mean hours of travel, if transportation is even available.

NJ has one operating mobile MAT unit, Project ROW, which facilitates treatment and dispenses MAT to incarcerated individuals at the Atlantic County Corrections Facility.[9] Recently the New Jersey Department of Human Services, issued an RFP for a mobile van. However, it only dispenses prescriptions. While this is a promising beginning, it clearly does not go far enough. As we saw with narcan pharmacy deserts, not all patients will have access to a pharmacy, much less one that can fill the prescription. Thus, the patient who resides in rural NJ again has to rely on finding transportation. Moreover, a van that dispenses no medications will not necessarily reach populations like the unhoused.

Valerie Mielke, the Assistant Commissioner for the New Jersey Division of Mental Health and Addiction Services (D-MAS) in the Department of Human Services acknowledged as much in a November 22, 2021, interview.[10] She bears responsibility for the oversight of NJ's community public mental health system as well as all substance use prevention, treatment, and recovery support services.

She stated that: "States should think about how the mobile units can help fill treatment gaps. In some states, particularly in rural areas, there may not be an opioid treatment program, or OTP, that's easily accessible for residents. Here in New Jersey, for example, we didn't have an OTP in each of our counties until just a few months ago." She went on to say that "...states should look at where underserved populations [those without ready access to treatment] are, and locations where high degrees of overdose and opioid misuse exist [and bring medications to those patients]."

As Ms. Mielke acknowledged, a mobile unit offers "flexibility," because staff can reach out to

---

[8] Leonardson J. Gale JA. distribution of Substance Abuse Treatment Facilities Across the Rural-Urban continuum.2016.https://muskie.usm.maine.edu/Publications/rural/pb35bSubstanceAbuseTreatmentFacilities.pdf.

[9] https://www.aatod.org/opioid-education/elearning/how-to-webinar-expanding-the-use-of-mobile-vans/

[10] "Mobile Medication Units Help Fill Gaps in Opioid Use Disorder Treatment."

patients throughout the day, especially those who have difficulty reaching the brick and mortar facility because of location or hours.

In particular, according to the Assistant Commissioner, “Mobile units can also go where people diagnosed with OUD may congregate—such as homeless shelters, tent cities, and correctional facilities.[11] Mobile units are a great way to engage people in these settings with treatment services. Imagine someone who’s homeless and can’t easily access a pharmacy; providing them with buprenorphine via a mobile unit eliminates that problem.” However, while Assistant Commissioner Mielke touts low-barrier buprenorphine treatment from a mobile unit, “where individuals receive a prescription and immediately start treatment,” this clearly is not the definition of “immediately start treatment” if there is no access to a pharmacy or the individual has no insurance to pay for the medication.

As the Assistant Commissioner stated in the interview, “we hope to allow new mobile units to both prescribe and dispense medication, which we couldn’t do under the moratorium. And thanks to new funding from the Substance Abuse and Mental Health Services Administration, we can move forward with purchasing new vehicles.” With that funding, as well as funding from the opioid settlements, it should be a priority for the Department to put vans on the road to directly dispense medication and not simply prescriptions. Moreover, these vans can also offer harm reduction services. Ms. Mielke points to that as well stating: “I would point to our work combining treatment services with harm reduction services, as well as our work bringing medications to correctional facilities: Jails don’t have to worry about obtaining OTP certification when a mobile unit can bring methadone, buprenorphine, and naltrexone directly to the facility. We take these medications to one jail [the Atlantic County corrections facility] now and hope to expand to other locations.”

As Ms. Mielke indicated, “mobile units are a great way to meet individuals where they are and break down barriers to treatment and recovery. States may not realize this, but Medicaid can help support the treatment provided in mobile units. Many of the people served by mobile units are Medicaid enrollees, and states can bill for services provided. These dollars have been critical in sustaining mobile medication unit services in New Jersey.[12]

THE COSTS

---

[11] DEA added a modification to its regulation, 21 CFR 1301.13(e)(4), that makes clear NTP’s may operate at correctional facilities where provided by the state.

[12] Read the full interview at ”https://www.pewtrusts.org/en/research-and-analysis/articles/2021/11/22/mobile-medication-units-help-fill-gaps-in-opioid-use-disorder-treatment)

The costs to set up a mobile MAT unit are flexible and depend on how big the van is and how many staff are needed on board. Will it be a large RV with a separate examining area, office, and dispensing spaces, as well as a bathroom or a small truck with a separate cab? Will it be a new vehicle or a refurbished one? The costs could be as high as $250,0000-$300,000 per van plus the cost of staff.[13]

The DEA, in its explanations in the Federal Register above, compared service costs between brick and mortar operations versus mobile units. They concluded the cost might be as low as $100,00 to set up a mobile van. They compared rental costs, the cost of installing a security safe to hold the medication, and labor costs only. I think The estimates are clearly underestimated (as they attribute only $40,000 for vehicle costs and $48,000 for labor costs, which would include a nurse and doctor but didn't seem to include a driver or security).

Utilizing both opioid settlement and SAMHSA funds, it seems possible to create a fleet of these vans throughout NJ, having at least a dozen vans should be the minimum, to cover rural Monmouth, Ocean, Atlantic, Cape May, Burlington, Cumberland, Gloucester, Salem Counties, and rural area in the northern part of the state, for example, Passaic, Somerset, Warren and Sussex Counties. This proposal suggests a $2 million minimum for this project.

---

13 https://www.aatod.org/opioid-education/elearning/how-to-webinar-expanding-the-use-of-mobile-vans/

Public Proposal to the New Jersey Opioid Recovery and Remediation Advisory Council

October 31, 2022

Joe Hinderstein
joseph.hinderstein@uniteus.com
217 Broadway Floor 8
New York, NY 10007
www.UniteUs.com

Commissioner Sarah Adelman, Chair
Opioid Recovery and Remediation Advisory Council
PO Box 001
Trenton, NJ 08625

Dear Commissioner Adelman and Members of the Advisory Council,

Thank you for the opportunity to present the New Jersey Opioid Recovery and Remediation Advisory Council (Advisory Council) with a solution that promotes the long-term resiliency of individuals, families, and communities in New Jersey who are affected by the opioid crisis. Unite Us offers an innovative solution to aid the State's ongoing efforts to address the opioid epidemic through a collaborative, inter-departmental, and data-driven strategy.

At Unite Us, we recognize that individuals with substance use disorders (SUD), including opioid use disorder (OUD), often face barriers and stigma when seeking services. These barriers compound the negative impacts of SUD/OUD on their health and quality of life. Unite Us understands that many individuals with SUD/OUD have unmet needs, including housing, transportation, employment, and food insecurity that intersect with their substance use and make it more difficult to access treatment. We also know that an effective recovery support system cannot exist without a robust network of community partners and the infrastructure in place to support personalized, coordinated care. To fully address the State's opioid crisis, the State should measure and commit to addressing disparities, including differences in access to treatment and fatal overdose rates across racial, ethnic, and other groups.

Our proposal offers an array of products and services to increase access to evidence-based prevention, treatment, and recovery programs, while maintaining client privacy and compliance with 42 CFR Part 2. Our solution will support individuals on their path to and maintenance of recovery, reduce harm to people who use drugs and their loved ones, and support data-driven work to strengthen the statewide SUD/OUD system of care—ultimately creating a more resilient state.

Thank you for the opportunity to provide feedback and suggestions about how to support this important work in New Jersey.

Best Regards,

Dan Brillman

Dan Brillman
Chief Executive Officer
Unite Us

Executive Summary

Opioids have caused deaths and hospitalizations across New Jersey, devastating many families and communities. Unite Us' solution advances New Jersey's goals of ending the opioid epidemic through a collaborative, inter-departmental, and data-driven approach. Our products and services will aid the State's departments to work cross functionally and **promote the long-term resiliency of individuals, families, and communities affected by the opioid crisis**. At its core, our solution seeks to:

1. Support a **"no wrong door" approach** to prevention, treatment, and recovery services by creating an accountable, coordinated ecosystem of health and social services providers that can be leveraged by the SUD/OUD care continuums in New Jersey, including state departments and agencies.
2. Provide New Jersey with **unmatched data and analytics** solutions that enable monitoring of service utilization, outcomes, and gaps in care to facilitate resource allocation and investment decisions, while protecting client privacy.
3. Enable **real-time tracking of settlement funds distribution** to improve transparency and accountability, ensuring the funding is going to those in-need and preventing waste, fraud, and abuse.

Unite Us' coordinated care networks demonstrate that a **robust, collaborative, and holistic community-wide approach to identifying and addressing unmet needs improves individual quality of life, advances community health, and promotes health equity**. Our solution will enable clinicians, therapists, care coordinators, and human service providers across New Jersey to work together to:

- Securely connect residents to mental and behavioral health services, including crisis response teams and other triage services.
- Maintain dignity and privacy by utilizing a care coordination platform that ensures 42 CFR Part 2 compliance regardless of care setting.
- Collaboratively develop individualized treatment plans that reflect a resident's personal journey and incorporate clinical care and wraparound services, such as vocational training, housing, counseling, and education.
- Promote access to evidence-based and evidence-informed programs like Medication-Assisted Treatment (MAT) and peer recovery support services.
- Increase access to support resources using closed-loop referrals, so that any organization where community members have trusted relationships—whether that is barber shops, churches, or community centers—can send referrals to care on behalf of those in need.
- Expand service capacity using de-identified service-level data.
- Meet the mandate for transparency and accountability without burdening community-based organizations through detailed, real-time data reporting that provides visibility into how funding is driving outcomes across the state.

Unite Us can partner with New Jersey to deliver **real results that promote the long-term resiliency of individuals, families, and communities in New Jersey** who are affected by the opioid crisis, through a collaborative, inter-departmental, and data-driven approach.

About Unite Us

Unite Us was established in 2013 by Dan Brillman, an Air Force Reserve Pilot, and Taylor Justice, an Army Veteran. As Dan and Taylor navigated their personal transitions from the military and back to civilian life, they each faced a profound gap in services while trying to navigate a complex service delivery system. They realized their experiences were not unique, and Veterans and their families were suffering every day because they couldn't sufficiently access the care they needed. Unite Us was founded to address the fragmented health and social care delivery system and its negative impact on Veteran health. Since then, we have since expanded our mission to ensure every individual, no matter who they are or where they live, can access the critical services they need to thrive.

To address our nation's fragmented care systems and communication silos, Unite Us has developed a healthcare infrastructure that enables a paradigm shift in health and social care. **With Unite Us, communities can empower health and social care providers to deliver accountable care through a network approach**. Our model shifts the responsibility for successful transitions between care settings to Unite Us and our network of providers, rather than the individuals or families in crisis, as is commonplace today.

The Impact of Our Work

Our coordinated care networks are composed of cross-sector providers connected through Unite Us' HIPAA- and 42 CFR Part 2-compliant technology platform working together in real-time to support the complex needs of individuals and families they jointly serve. Our networks include partners who provide a broad range of services, such as housing, employment, food assistance, behavioral health, and utilities assistance, as well as healthcare entities, educational institutions, United Ways, and other organizations representing a range of sectors.

Unite Us pairs our technology with on-the-ground community experts who work directly with local partners to strengthen and optimize the network to meet community needs. This combined approach changes the traditional care delivery model to one that goes beyond just making a referral to ensuring needs are met through coordinated health and social care. Our team is changing the status quo because we know from experience that the old system has failed those who need care the most and leads to staff burnout and fatigue.

Healthier communities are created by helping individuals become healthier. **Our networks have measurably impacted the lives of millions of people by better connecting them to housing, employment, food, behavioral health, and other services they need**. Impact can be measured and analyzed across all partners in the network to generate data sets that can be used to better understand the needs of community members and identify gaps in available services, such as where there are unmet mental health needs. These data sets can be configured to cover a variety of geographies including the entire state, specific counties, or communities, and even zip codes.

Today, **our Platform serves >18 million clients with 10.4 million connections to care and 720,000+ services onboarded to the network**. Unite Us has fully operational networks in 44 states, 21 statewide networks, and thousands of social service and healthcare providers using our Platform. Our partnerships include North Carolina's Department of Health and Human Services,

Virginia's Department of Health, Rhode Island's Executive Office of Health and Human Services, Louisiana's Department of Children and Family Services, and many other government agencies.

Our Action Plan

1. Onboard the SUD/OUD Care Continuum onto the Unite Us Platform, including County Health Departments, Evidence-Based Prevention, Treatment and Recovery Providers, and Community-Based Organizations

To increase access to evidence-based prevention, treatment, and recovery providers, reduce harm to people in New Jersey who use drugs and their loved ones, support data-driven work, strengthen system-wide infrastructure, and divert or deflect individuals from the criminal justice system to public health services, we recommend onboarding organizations to the Unite Us Platform. The Unite Us Platform is a care coordination and case management tool that facilitates secure care coordination in a common platform from across participating organizations serving people with SUD/OUD in New Jersey.

We recommend that New Jersey make the Unite Us Platform available to:

- **County health departments.**
- **Government-funded and private sector evidence-based prevention, treatment, and recovery providers.**
- **Community-based social service organizations, including those that offer reentry and diversion services to individuals involved with the criminal justice system.**

The Unite Us Platform enables cross-sector organizations to seamlessly communicate and coordinate care for each New Jersey resident. It helps providers to easily screen New Jersey residents and identify co-occurring physical, behavioral, and social needs in a centralized Platform shared with all partners across the community. Once a referral is made, each subsequent interaction is captured in the Unite Us Platform in real-time, giving all partners visibility to an individual's entire social care journey with detailed outcomes data.

The Unite Us Platform includes:

- A **multi-tenant, single instance, software as a service (SaaS) Platform**. This means there is only one instance of the solution, hosted in the cloud, rather than individually installed versions of the software at resident sites. All users, regardless of their organization or location, can collaborate on a person's care without concerns about data currency or software version.
- An **Enterprise Master Person Index (EMPI)** to reduce record duplication and to effectively track each person's total care journey across all health, human, and social services.
    - As part of the intake process, the Unite Us Platform empowers care professionals to capture a wide range of demographic questions. The Unite Us Platform's no wrong door approach enables one single view of a person and prevents New Jersey residents from needing to repeatedly share their story, which can erode trust.

- **Robust, informed consent** that requires a one-time consent to be documented for every referral and allows individuals to revoke their consent at any time, giving them full control over how their information is shared. The consent form links to our publicly available privacy policy and outlines how information may be shared within the network to connect individuals with the services they need.
- **Secure, HIPAA-compliant communication** between the individual, referral source, and referred organization as part of the referral process and feedback loop.

Given the Advisory Council's focus on connecting New Jersey residents to services that are inherently sensitive, Unite Us has a robust set of certifications and complies with regulations to meet those needs. The Unite Us Platform is HITRUST-, SOC 2 Type 2-, and NIST-certified, and in alignment with all federal privacy regulations, such as 42 CFR Part 2 and FERPA. Access to the Unite Us Platform is role- and permission-based. Our Platform runs on a strict permissions engine that controls every user's access to information (with specific controls around 42 CFR Part 2) based on their role in the network. This structure is the backbone of our HIPAA-compliant architecture; users can only view information they are legally allowed to view, in service categories that are permitted under HIPAA, 42 CFR Part 2, etc., and only for residents to whom they are directly providing services.

There are heightened data privacy standards deployed to protect inherently sensitive information, such as mental/behavioral health services, SUD treatment, HIV/AIDS support services, legal services, and services offered to survivors of domestic or sexual violence. **These enhanced protections ensure when an individual receives a sensitive service, that information is visible only to the organization providing the service. In accordance with 42 CFR Part 2, other organizations on the platform see no indication that such services have been provided.**

Unite Us has successfully implemented and socialized the Unite Us Platform across the nation, including in New Jersey. Our hands-on approach to implementation and network building includes one-on-one workflow planning with organizations to ensure a seamless referral experience that solves real-life inefficiencies, high touch support through the registration process, and re-training as needed post-launch for any users. This model of support is unique to Unite Us and reflective of our community-focused approach to networks. Accountability is at the core of Unite Us' approach to community engagement, which promotes efficient service delivery and real-time data integrity.

Any organization that joins the Unite New Jersey Network agrees to Unite Us' Network Standards. Those standards include:

- Responding to all referrals, even if it is just to note that the need has been resolved or cannot be addressed.
- Indicating the specific outcome (from a structured data set of 700+ options).
- Keeping capacity up to date in real time.
- Listing eligibility criteria to ensure accountability and responsiveness.

This level of accountability within the network ensures that all organizations keep data around needs, referrals, and outcomes accurate, while also making sure individuals are quickly and successfully connected to services.

The Unite Us Network in New Jersey launched in 2022, and includes more than 240 programs available to receive referrals. We have a team of New Jersey based Community Engagement Managers whose sole focus is to rapidly expand the depth and breadth of the network across the state. Our intention is to have a statewide coordinated care network of community-based organizations by the end of 2023.

In addition to working with many healthcare providers in the state, Unite Us recently began a partnership with the New Jersey Department of Health and its Division of Family Health Services. Unite Us' team and Platform will be supporting the Colette Lamothe-Galette Community Health Worker program, focused on the Healthy Women and Healthy Families program. The existing infrastructure of healthcare, social, and human service agencies on **the Unite Us network will strengthen New Jersey as you look to support recovery, reduce harm, and enable data-driven work to end the opioid epidemic**.

2. Leverage Advanced Analytics to Better Understand the SUD/OUD Population in New Jersey & Monitor System Activity in Real-Time

As part of the Advisory Council's plans to **support data-driven interventions and strengthen system-wide infrastructure**, we recommend that New Jersey leverage the Unite Us Social Connector product. Social Connector will enable New Jersey to better understand key health and social needs among the SUD/OUD population, deliver the most relevant services to patients and families, and measure the corresponding impact on health outcomes. Data from Social Connector are provided via interactive visualizations, empowering our customers to take action on the insights.

Social Connector Product Features

Social Connector includes advanced models, visualizations, and scored output that enable New Jersey to:

1. **Understand Needs in the Population:** Identify the greatest unmet needs and opportunities in the population. What is the opportunity, who represents the opportunity, where is the opportunity, and how can New Jersey address the opportunity?
2. **Proactively Engage Individuals with Services:** Prioritize highest opportunity individuals for proactive social care outreach and enrollment.
3. **Develop Tailored Action Plans:** Leveraging referral capabilities and available services in the Unite Us network, New Jersey can identify the most relevant and impactful "next best action" individuals can take to address their needs most efficiently and effectively.
4. **Continuously Monitor and Measure Network Activity:** Understand who is engaging in services, what services they are engaging in, and the outcomes of those services.
5. **Measure ROI, Savings, and Impact:** Evaluate the effectiveness and impact of the programs and services. Enrollment rates, health system utilization, and more.

Unite Us Insights Center

The Unite Us Insights Center is our data platform that provides access to robust, real-time social care analytics that equip cross-sector network partners to match, prove, and improve performance standards. In the Unite Us Insights Center, New Jersey can:

- Identify areas of need in your state to strategize a scalable path towards action, and proactively inform individual case management to drive positive outcomes.
- Track the impact of your investments at the resident and services level.

In the Insights Center, New Jersey can understand the impact you are having on the community and across your residents with data, including the Network Activity, Health Equity, and Workforce Management data reporting. **With these three modules, New Jersey has access to more than 45 visualizations that are filterable to display the information you need.**

By providing access to the Network Activity and Health Equity data reporting to key stakeholders, state agencies, county health departments, and community-based organizations can see a full picture of what is happening in local communities related to these programs.

Network Activity Data Reporting

The Network Activity data reporting provides New Jersey with detailed metrics on the volume of activities and interactions within a network. We provide you with the **tools to understand performance in specified geographies, timeframes, organizations, and by resident demographic profiles**.

With this data reporting, New Jersey can:

- Evaluate network coverage, as well as network trends.
- Understand who your residents are, what services they seek, whether they have received their requested services, and how organizations within your network can serve residents' needs.
- Deep dive into network service events (service episodes, cases, and referrals).
- Understand rejection reasons and why services are not received. This empowers New Jersey to track services that are needed but unavailable within the network to design initiatives for improvement.
- Assess performance in specified geographies, timeframes, organizations and by resident demographic profiles.

Health Equity Data Reporting

The Health Equity data reporting gives New Jersey insight into the residents being served in Unite Us networks through a health equity lens. The goal of the Health Equity data is to **provide our partners with a deeper understanding of the residents they serve and what differences might exist between demographic groups on the network impact level**. In addition, the data includes metrics to better assess how and why residents within different demographic groups are or are not getting connected to the services they need with an aim to identify those requiring targeted interventions.

With the Health Equity data reporting, New Jersey can:

- Establish a baseline understanding of your residents served and their care journeys.
- Deep dive into demographic factors (e.g., race, ethnicity, age group, gender) impacting health disparities.
- Analyze areas for further improvement, such as organizational workflow optimization, community service gaps, or opportunities for additional navigation support to ensure equitable access to services.
- Explore methods to bridge health and social care in locations where gaps persist.
- Drive positive outcomes for the community by testing and deploying new interventions.

Workforce Management Data Reporting

As networks grow in services and resident volumes, we recognize New Jersey's desire to track usage of the system. The **Workforce Management data reporting helps you track usage metrics to manage team activity and performance**.

With Workforce Management data reporting, New Jersey can:

- Assess capacity, adoption, and engagement of your workforce by monitoring user login, referral, and case activity.
- Compare workforce performance at the organization and program levels to identify any capacity or engagement gaps.
- Track growth trends in workforce user performance over time as well as their catalysts (e.g., long-term dynamics or unique boosts).
- Understand volume, trends, outcome conversion success, and efficiency by users. Monitor data entry, quality, logins, and performance.

SFTP Data Delivery Option

Our data delivery option can provide New Jersey with access to the line-level data attributed to your organization within the Platform (i.e., data for residents served by or referred to your organization) on a set cadence, usually monthly. The data can be provided in identifiable or de-identified format.

The Unite Us Data Governance Committee reviews both identifiable and de-identified data requests to ensure we are adhering to the strictest data privacy parameters outlined in HIPAA and 42 CFR Part 2. The data is delivered in .csv format in a folder via SFTP. These files are created periodically and placed in a dedicated SFTP folder that is accessible only to authorized state users designated by the state.

Unite Us has multiple data delivery options to meet your needs. We are happy to work with you to determine the best data solution.

3. Leverage Common Infrastructure to Track the Opioid Settlement Funds through Unite Us

In Executive Order No. 305, Governor Murphy cites the need to make collaborative, inter-departmental, and data-driven efforts to end the opioid epidemic. The **Unite Us Payments solution supports data-driven work and strengthening system-wide infrastructure, while also**

addressing public demand for transparency and accountability about how opioid settlement funds are used. The State can show how opioid settlement funding is disbursed and how it is serving people and populations most impacted by the opioid epidemic.

As opioid settlement funds are awarded to community service providers, the State can use Unite Us Payments to monitor service delivery and spend-down in real time. Unite Us will onboard organizations funded through opioid settlements and train them to document the services they deliver using opioid settlement funding. The streamlined, workflow-embedded documentation automatically generates standardized data and gives New Jersey visibility to the work performed by these programs through intuitive, interactive visualizations. Importantly, this will enable the state of New Jersey to track funding against any health equity goals by ensuring that the populations impacted the most by the opioid epidemic receive equitable and efficient access to funded programs. This **data is updated daily, which enables the state of New Jersey to adjust its funding strategy in real-time rather than relying on non-standardized, manual reports at the end of the quarter or year to assess if the opioid settlement funding had the intended impact**.

Unite Us has a proven track record of implementing our Payments solution with state and local government agencies, providing comprehensive guidance and support from implementation through impact evaluation. Relevant examples include:

- Unite Us provides the technology for the Department of Health and Human Services (NC) to reimburse community-based organizations for more than $500 million in social services provided to Medicaid recipients through its 1115 waiver.
- We helped Metro United Way of Louisville (KY) track the distribution of a $1 million co-investment for community-based organization capacity building, long-term housing, and wraparound services.
- With Unite Us' assistance, the United Way of Greater St. Louis, St. Louis County, and the City of St. Louis (MO) tracked the distribution of more than $7.1 million in CARES Act funding for rental and mortgage assistance.
- Unite Us enables ChristianaCare (DE) to track the amount of services provided to community members through their Community Investment program and tie it back to patient outcomes.
- Our solution enables Santa Fe County and the City of Santa Fe (NM) to track four total funding streams, both federal and local, across community-based organizations.

Next Steps

We are confident that our proposed proven, flexible, innovative, and scalable solution will help New Jersey address the opioid epidemic. The Unite Us team would be happy to discuss scoping, pricing, and timelines with the Advisory Council. Please reach out to Joe Hinderstein (joseph.hinderstein@uniteus.com).

10 Industrial Way East, Suite 108, Eatontown, NJ 07724

Opioid Funds Proposal
PO Box 001
Trenton, NJ 08625

RE: Recommendations for Use of Opioid Settlement Funds

Dear Governor Murphy,

As President and CEO of CPC Behavioral Healthcare, I am writing to provide recommendations for the use of the Opioid Settlement Funds. Established in 1960, CPC is a long time provider of substance use and mental health services in Monmouth County and neighboring communities. Known as a "safety net" agency, CPC seeks to improve the lives of the most vulnerable residents in the community suffering from complex, chronic disorders through innovative and evidence-based practices. CPC is one of NJ's original 7 Certified Community Behavioral Health Clinics (CCBHC) designated through the SAMHSA demonstration grant in 2017. Our CCBHC provides a variety of substance use programming including traditional and intensive outpatient services, ambulatory withdrawal management, long term Medication Assisted Treatment (MAT), 24/7 crisis response/stabilization and care management. We at CPC commend the State's vision to invest the settlement funds to establish and enhance opioid use prevention, treatment and support services.

Through our decades of delivering outpatient substance use services at CPC, we have significant experience with the positive impact of Medication Assisted Treatment (MAT). CPC embraces a harm reduction philosophy, which is a cornerstone of the MAT model. Clinicians practicing harm reduction recognize that there is more than one path to recovery. MAT medications are an evidence based treatment for opioid addiction. They are prescribed at CPC and across the country to help individuals end their use of opioids and maintain recovery. I propose a substantial investment of the settlement funds to enhance the existing NJ licensed providers' capacity to deliver MAT as well as provide opportunities for new providers to implement MAT programs in underserved communities. I believe this can be accomplished through initiatives that include increasing the number of prescribers who obtain and maintain a buprenorphine waiver, as well as fund additional clinical positions to assure sufficient licensed provider capacity to deliver individual and group substance use therapy.

Of equal importance is assuring individuals recovering from a substance use disorder have access to the social determinants of health (SDOH). The World Health Organization identifies SDOH as the conditions in which people are born, grow, live, work and age. Examples of SDOH are an individual's access to safe housing, food, income and other resources to meet daily needs. Our experience at CPC has been that access to the SDOH can be a predictive factor in an individual attaining and maintaining substance use

recovery goals on a long term basis. I propose a substantial investment of the settlement funds to improve access to the SDOH for individuals with substance use disorders. In recent years, CPC was awarded a contract through the NJ Division of Mental Health and Addiction Services (DMHAS) to provide care management services to individuals with an opioid use disorder. Our care managers working in the program assist enrolled clients in accessing SDOH through State and local resources. Enrolled clients also have access to a State funded housing subsidy that pays up to 70% of the individual's rent in apartments inspected and approved by DMHAS through their contracted Supportive Housing Connection. A total of 200 slots were awarded statewide under this initiative. I recommend that settlement funds be used to increase current provider capacity and fund additional programs to deliver care management, access to State funded housing subsidies and similar services to individuals with opioid use disorders.

Of note is the fact that there does not exist a current regulatory structure that permits the billing of care/case management for individuals with a substance use disorder under NJ Medicaid. NJ's Targeted Case Management (TCM) regulation (N.J.A.C. 10:73) exclusively funds case management services through NJ Medicaid for individuals diagnosed with a serious mental illness. I propose that the TCM regulation be expanded to include service eligibility to individuals with a substance use disorder. Alternatively, I propose that a new regulatory structure be enacted to provide case/care management services to individuals with a substance use disorder. In either instance, the regulations should at the minimum cover individuals with an opioid use disorder. I recommend an investment of the settlement funds to cover the cost of the proposed case/care management services to NJ Medicaid.

Thank you for your time and consideration in this matter. Please feel free to contact me at 732-935-2220 or vsansone@cpcbhc.org with any questions.

Sincerely,

Vera Sansone

Vera Sansone
President & CEO

Contact: Ryan Palmer | rpalmer@pipnj.org

Population(s) of Focus and Statement of Need

The proposed geographic catchment area where services will be delivered is the County of Hudson located in Northern New Jersey. Hudson County comprises 12 municipalities: Bayonne, Jersey City, Weehawken, Kearny, East Newark, North Bergen, West New York, Hoboken, Harrison, Guttenberg, Union City and Secaucus. New Jersey itself has 21 counties and is the most densely populated state in the country. Hudson County is the smallest in size, yet one of the most densely populated counties in the State of New Jersey. It is also the sixth most densely populated county in the United States [Black Ink Technology, 2022].

Hudson County is located in the heart of the New York metropolitan area. Ellis Island and Liberty Island lie entirely within Hudson County's waters. Most of the county falls between the Hackensack and Hudson Rivers on a geographically long, narrow peninsula. In this contiguous urban area, it is often difficult to know when one has crossed a civic boundary. Jersey City, the Hudson County seat, ranks 75th among the 100 most populous cities in the United States. Of municipalities with over 50,000 people, Guttenberg, also in Hudson County, is the most densely populated in the United States. The area of Hudson County known as North Hudson (Union City, West New York, North Bergen, Harrison and Guttenberg) has the largest Cuban American population in the United States after Miami. Hudson County is a densely populated, urban community that is diverse in its ethnic makeup and in its culture.
Hudson County has a total population of 724,854. Due to limitations of data regarding those who identify as LGBTQ+, we do not have clear data on Hudson County's LGBTQ+ or nonbinary/gender non-conforming population. According to survey data collected by UCLA's Williams Institute, 4.1% of New Jersey's population identifies as LGBTQ+. Based on qualitative data from Hudson Pride Center, we believe this estimate is low for our population. Applying 4.1% to our population, we conservatively estimate that Hudson County has at least 30,000 LGBTQ+ identifying individuals.

Approximately seventy-eight percent (77.9% - around 564,600 residents) of Hudson County's residents are racial/ethnic minorities [US census, 2020]. Hudson County has four communities on the list of the 100 cities (population over 5,000) with the highest percentage of foreign-born residents: West New York (62%), Union City (59%), Guttenberg (55%) East Newark (57%). Fifty-nine percent (59%) of the population speaks a language other than English in the home, with Spanish being the top language [city-data.com]. While the county is economically diverse, over 13% of the population lives below the poverty threshold and lacks health insurance [US Census, 2020]. Additionally, 58% of the population does not live in a home that they own, with a high number of renters [US Census, 2020]. Alarmingly, Hudson County ranks second in NJ for children living below the federal poverty level; second in NJ for children eligible for free/reduced price school meals; second in NJ for families receiving TANF (welfare); and second in NJ with cases of child abuse/neglect [Annie E. Casey Kids Count Data Center].

Need for Harm Reduction Services

While Hudson County is a vibrant urban community with many strengths, it also faces a variety of unique challenges. Hudson County drug-related, STI-related and social determinants

Contact: Ryan Palmer | rpalmer@pipnj.org

of health data show a clear ***need for harm reduction services in our selected populations of focus.*** The Robert Wood Johnson Foundation (RWJF) County Health Rankings for 2021 identified Hudson County (HC) as having one of the lowest rankings for access to clinical care in the state of New Jersey (17th out of 21 counties). Hudson County ranks 4th highest in the state for residents reporting to be in poor or fair health versus considering themselves to be in good health [RWJBarnabas, 2018]. Research suggests that the extent of the problem in Hudson County can be attributed to overstretched local resources that are unable to adequately meet the complex needs of this vast and diverse population that resides in a relatively small geographic area. The primary factors for reaching this conclusion were the high levels of uninsured residents (HC 13% vs. NJ 9%) [RWJF County Health Rankings, 2021], low ratio of primary care physicians per resident (HC 1,890:1 vs. NJ 1,180:1) [RWJBarnabas, 2021], and a high number of preventable hospital stays (HC 5,687 vs. NJ 4,333) [RWJB, 2021]. Also, as of 2019, there were an estimated 75,000 undocumented immigrants living in Hudson County [Migrant Policy Institute, 2019]. This creates limitations and barriers to available community services and access to care. The RWJF rankings also point to social and economic stressors as a result of elevated exposure to violent crimes (HC 342 per year vs. NJ 253) [RWJB, 2021], high rates of children living in poverty (HC 20% vs NJ 12%) [RWJB, 2021], income inequality (HC 6.1 ratio of household income at the 80th percentile to income at the 20th percentile vs. US 3.7) [RWJB, 2021].

Hudson County's geographical location in the New York City metropolitan area makes the community vulnerable to high rates of drug trafficking due to its many types of access points and close proximity to major airports. The Office of National Drug Policy has identified Hudson County as a designated high intensity drug trafficking area. The Drug Environment Report notes that Hudson County accounted for the 7th highest rate of drug related arrests in 2021 with 367 arrests [Drug Monitoring Initiative, 2021]. The largest city in our county, Jersey City, accounted for the 4th highest drug related arrest rate in the state with 246 arrests [Drug Monitoring Initiative, 2021]. Substance use treatment records show that most of the admissions in Hudson County were due to heroin and opiates, totaling 1,407 in the past year [NJ Substance Abuse Monitoring System, 2021]. There were 186 opioid-related drug deaths in Hudson County in 2021, based on available data from January to October [NJ CARES, 2021]. Hudson County had the 5th highest opioid related death rate in the state. This is a 3.9% increase from the 2020 total of 179 [NJ CARES, 2021]. In 2020, there were 798 administrations of the opioid overdose reversing medication naloxone throughout Hudson County [NJ CARES, 2021]. In 2021, there were 982 naloxone administrations by law enforcement or emergency medical services in Hudson County [NJ Dept. of Health, 2021]. Hudson County was one of the five counties in the state that cumulatively accounted for 51% of naloxone administrations in NJ during the past year [Drug Monitoring Initiative, 2021]. Out of pocket costs for naloxone average about $100, making it inaccessible for many in Hudson County [CVS Pharmacy, 2018]. In 2019, there were 174 confirmed drug related deaths in Hudson County. Fentanyl was involved in 125 of those 174 deaths [Office of the NJ Chief State Medical Examiner, 2019]. Recent data reports that 96% of suspected heroin submissions to forensic labs in New Jersey contained fentanyl or fentanyl compounds [Drug Monitoring Initiative, 2019].

Intravenous drug users are at greater risk of HIV and other infectious diseases. Many people who have a substance use disorder or who are chronic drug users have co-occurring health conditions, including HIV/AIDS, hepatitis B, hepatitis C, tuberculosis, syphilis,

Contact: Ryan Palmer | rpalmer@pipnj.org

chlamydia, trichomoniasis, gonorrhea, and genital herpes [drugabuse.gov, 2022], and we see challenges relating to sexually transmitted infections (STIs) in Hudson County. In 2019, there were 4,331 STI cases in the county (922 gonorrhea cases, 3,409 chlamydia cases) [CDC Atlas Plus, 2019]. Hudson County ranked 3rd highest in the state in 2019 for these types of infections. The racial makeup of these cases were mostly Black/African American and Hispanic/Latinx individuals [CDC, 2019]. Hudson County also ranks 2nd highest in the state for new HIV diagnoses (117 cases in 2020) [CDC Atlas Plus, 2020]. Most of the new HIV diagnoses in the state were among Black/African American and Hispanic/Latinx individuals. In 2020, Hudson County ranked highest in the state for persons being prescribed the HIV prevention medication PrEP (1,042) [CDC Atlas Plus, 2020]. As of 2018, there were 2,248 (43.9%) Hispanic/Latinx, 1,572 (30.7%) Black/African American, 930 (18.2%) White, 262 (5.1%) multiple races, and 106 (2.1%) other/unknown race persons with a diagnosis of HIV in Hudson County. There were 15.2% more Hispanics/Latinx individuals with an HIV diagnosis in Hudson County compared to the number of cases in the state [Hudson County HIV Profile, 2020]. Also, in Hudson County, 51.9% of individuals who were newly diagnosed reported transmission through male to male (based on biological sex, not gender identity) sexual contact [Hudson County HIV Profile, 2020]. As of December 2020, there are 5,211 people living with HIV/AIDS in Hudson County [Hudson Pride Center, 2020]. In December 2019, there were 5,190 people living with HIV/AIDS in Hudson County [Hudson Pride Center]. According to a recent report, out of 2,769 Hudson County residents surveyed who are living with HIV/AIDS, 696 report not having insurance [Hudson County HIV/AIDS Services Planning Council, 2021]. Of these 2,769 residents, 2,402 identified as a racial/ethnic minority and 35 as transgender [Hudson County HIV/AIDS Services Planning Council, 2021].

This data leads us to identity the following ***existing service gaps, health disparities and incidence of poor health indicators influenced by social determinants of health:*** 1) Availability and accessibility of health care for Hudson County residents/lack of economic stability and access to quality clinical care; 2) Need for greater access to naloxone and related harm reduction resources due to a large percentage of uninsured individuals who are economically disadvantaged; 3) Need for substance test strips in Hudson County due to high rates of fentanyl overdoses; 4) Need for harm reduction supplies to reduce the spread of sexually transmitted infections primarily in the LGBTQ+ population and racial/ethnic minorities in Hudson County.

All of ***this relevant socioeconomic, psychosocial, and public health data further demonstrates the need for harm reduction services in the population(s) of focus***. In order for ***the project to reach our population(s) of focus***, we will 1) coordinate a Harm Reduction Task Force comprised of key partners who directly serve our populations of focus; 2) coordinate Narcan/naloxone trainings to high risk individuals and families with outreach in our populations of focus, and distribute Narcan kits in order to provide an accessible way for community members to obtain opioid overdose reversal medication; 3) provide free access to fentanyl substance test strips in order to help curb overdose deaths; 4) outreach to our identified populations in need through peers and partners with previously established relationships (e.g. Hudson Pride Center for members of the LGBTQ+ community, RWJBarnabas for racial/ethnic minorities with SUD); 5) provide free harm reduction services/supplies and access to PrEP/PrEP counseling, sexual safety education, and free safe sex kits; and 6) create and promote information

110B Meadowlands Parkway, Suite 302
Secaucus, New Jersey, 07094

www.pipnj.org
info@pipnj.org

Social Media
@pipofhudson

p (201) 552-2264
f (201) 552-2269

campaigns regarding the harm reduction supplies distributed through social media/demographic targets that are most utilized by our populations of focus (Instagram, Snapchat, Grindr, etc.).

Proposed Implementation Approach

The following table shows ***our goals and measurable objectives for the proposed project***:

Goal 1: Enhance community-based overdose prevention programs, the availability of harm reduction supplies, and other harm reduction services to help control the spread of infectious diseases and the consequences of such diseases for individuals with, or at risk of developing, substance use disorders and HIV and other STIs.				
Objective 1A: By May 29, 2025, increase the access to harm reduction equipment and supplies by distributing a total of 31,296 supplies (10,432 per year) to populations of focus. This includes 600 doses of Narcan with training on how to use it for a total of 275 people trained.. **Objective 1B:** By May 29, 2025, increase the capacity of partner organizations to engage in harm reduction strategies by training, providing harm reduction supplies for, assisting with updating policies for, and/or coordinating harm reduction services with a minimum of 12 partner organizations and 480 individuals.				
Projected Number of Harm Reduction Supplies Distributed by Grant Funds				
	Year 1	Year 2	Year 3	Total
SUD Harm Reduction supply units: 200 doses of Narcan (100 packs) + 1,400 test strips + 600 Deterra drug deactivation pouches + 200 lockboxes =2,300 STI/Safe sex Harm Reduction supply units: 4,432 condoms (4,000 condoms & 432 finger condoms) + 3,000 lubricant + 500 dental dams + 200 at-home HIV tests = 8,132	10432	10432	10432	31,296
Individuals trained to administer Narcan	75	100	100	275
Individuals trained to implement or enhance their organization's harm reduction strategies	160	160	160	480
Goal 2: Reduce negative personal and public health impacts as a result of substance use and misuse.				
Objective 2A: By May 29, 2025, reach at least 7,000 people with, or at risk of, SUD and/or STIs through our harm reduction efforts. **Objective 2B:** By May 29, 2025, increase access to education, treatment, and support services for individuals at risk for or with a SUD and/or STIs by providing 14,000 referrals to support services and at least 1,500 linkages to support services.				
Projected Number of Unduplicated Individuals to be Reached with Grant Funds				
	Year 1	Year 2	Year 3	Total
Number of unduplicated individual service encounters.	1,500	2,750	2,750	7,000
Projected Number of Referrals and Linkages to be Supported by Grant Funds				

Number of referrals to support services.	3,000	5,500	5,500	14,000
Number of linkages to support services.	300	600	600	1,500

Our statement of need specifically identified a variety of service gaps and data-indicated problems. Our goals and objectives ***align with the statement of need*** by addressing them through specific actions related to both the objective and the identified need. The following table identifies the need, measurable objective, and action that we will implement to address it.

Need Identified in A-2	Corresponding Goal and Measurable Objective
1) Lack of insurance, lower socioeconomic status, and related inequities. This grant provides free and preventative services to populations facing social, economic, and health inequities. and helps reduce barriers in accessing care.	Goal 1; Objective 1A Goal 1; Objective 1B Goal 2; Objective 2A
2) People are overdosing and suffering from addiction. This grant provides narcan, fentanyl test strips, and other safe drug use supplies to prevent overdose/death, and reduce the harms of addiction. It also increases opportunities to connect those in need with education, treatment, harm reduction materials, and recovery services.	Goal 1; Objective 1A Goal 2; Objective 2A Goal 2; Objective 2B
3) There is widespread transmission of HIV and STIs, especially among populations of focus. This grant offers harm reduction supplies to prevent additional infections and connects people to services who need it.	Goal 1; Objective 1A Goal 1; Objective 1B Goal 2; Objective 2A

Partners in Prevention, in collaboration with our key partners, utilizes SAMHSA's Strategic Prevention Framework that includes: 1) assessing needs; 2) building community capacity (often through coalition building) among numerous sectors; 3) planning through the creation of action plans specific to each activity and aligning them with our measurable objectives and assigning clear roles and responsibilities to all staff and partners; 4) monitoring implementation progress via identified benchmarks, identifying challenges, and adjusting our action plan accordingly; and 5) evaluating the effectiveness of our efforts. This is done with both sustainability of interventions and cultural competency always at the forefront throughout each stage of the process. The following table clearly defines what ***action steps will be implemented to meet objectives*** and ***how our project will utilize culturally informed strategies*** and ***evidence-based interventions***:

Required Activity **(Evidence-Based Interventions = bolded)**	Culturally Informed Strategies
Assess organizational readiness and create a strategic action plan based upon identified strengths, gaps (including those related to social determinants of health), and opportunities for capacity development required to impl. an **evidence-based harm reduction program (naloxone/PreP distribution, etc.)** at the service delivery and organizational levels through **coalition building (Harm Reduction Task Force)**.	Identify linguistic and other cultural barriers and target culturally competent outreach, such as use of language at a 6th grade reading level; translation of outreach into Spanish and other languages where a barrier is present; provide translation services and outreach in Spanish and other languages as needed.
Develop a sustainability plan to ensure that harm reduction	Through direct engagement of population of

program elements are continued after the grant ends (**modify policies/practices/ physical design** supporting sustainability).	focus, ensure needs of hard to reach individuals and groups are at the forefront of sustainability.
Develop **policies and procedures** to implement **evidence-based trauma informed practices** (e.g. trauma informed staff training, SUD/HIV peer referrals without stigma, harm reduction strategies and implementation) throughout each level of the organizational structure.	Ensure that policies and procedures meet the needs of all and are communicated in a linguistically appropriate manner (e.g. 6th grade reading level, in Spanish/other languages as needed) and address potential biases.
Distribute **opioid overdose reversal medication** and **deliver overdose prevention education to focus populations** regarding the consumption of substances including but not limited to opioids and their synthetic analogs.	Conduct outreach/prevention education in Spanish and other languages; ensure overdose reversal medication distribution is culturally sensitive and reaches populations of focus.
Establish **processes, protocols, and mechanisms for referral to treatment and recovery support services** and **referral to treatment for infectious diseases** such as HIV, STIs, and viral hepatitis.	Conduct outreach by Spanish/other language speaking staff; engage the LGBTQ+ community and people with SUD through those with established relationships (Hudson PRIDE).
Assemble a **harm reduction advisory council (Task Force) that meets regularly to guide program activities and project implementation** [including people who use drugs (PWUD), individuals in recovery, harm reduction service providers, and other key community members such as public safety officers, mental health providers, treatment providers].	Through recruitment of populations of focus, ensure that the Harm Reduction Task Force is representative of the diversity of our community including: individuals from a variety of racial/ethnic backgrounds; the LGBTQ+ community; and PWUD.
Designate staff to provide **program design, implementation, and evaluation** to meet grant program and reporting requirements.	Evaluation will collect demographic data to track outreach to racial/ethnic minority populations and the LGBTQ+ community.
Purchase **equipment and supplies to enhance harm reduction efforts** (e.g. safer sex kits, Naloxone, lock boxes, fentanyl test strips, medication deactivation pouches) and distribute to community members and partners.	Through targeted outreach, ensure distribution efforts reach populations of focus and include linguistically appropriate information (6th grade reading level, Spanish/other languages).

Our ***organizational harm reduction service delivery model*** views substance use disorders and the spread of infectious disease as both a medical challenge for the individual and public health challenge for the community, and relies on the 7 Strategies of Community Change (endorsed by SAMHSA) to focus harm reduction efforts where personally needed (individual prevention) and at the community level (targeted environmental change) for broader, upstream impact. These strategies inform our harm reduction delivery by:

1. Providing Information - conduct community outreach to make sure everyone is aware of available resources; work to reduce stigma around SUDs, HIV/other infectious diseases, and harm reduction interventions.
2. Building Skills - increase the capacity of individuals and systems to better identify and support those in need of harm reduction, as well as increase effective outreach;
3. Providing Support - increase referrals to needed services; use funds to provide needed harm reduction materials where there are gaps;
4. Enhancing Access/Reducing Barriers - provide harm reduction kits (naloxone, PreP);

improve systems and processes to increase the ease and opportunity to utilize systems and services (ensure childcare, transportation, safety, special needs and cultural and language sensitivity); and create barriers to dangerous use, such as lock boxes for prescription opioids.
5. Changing Consequences - incentivize treatment in non-punitive ways and advocate for medical rather than punitive interventions;
6. Changing Physical Design - make it easier for those in need to access harm reduction kits/materials, and easier to dispose of hazardous materials (such as used needles);
7. Modifying Policies - reduce stigma and criminal intervention and change systems to better address the needs of those with SUDs and/or HIV/other infectious diseases.

Staff and Organizational Experience

Partners in Prevention (PIP), formerly the National Council on Alcoholism and Drug Dependence of Hudson County (NCADD Hudson), was established in 1988 as a 501(c) 3 non-profit organization. Our mission ***(purpose)*** is to improve wellness and prevent substance use disorders and related health challenges in Hudson County and New Jersey. In order to fulfill our mission, PIP works toward a number of ***goals***, including**:** increasing collaboration and capacity to reduce the impact of substance use disorders; reduce youth substance use and access; reduce misuse of substances and increase wellness; support individuals and families in health choices; and reduce the harm, stigma, and impact of substance use and related public health issues. The agency was founded (***organizational background***) after the Hudson County Commissioners identified the need for a non-governmental, county-wide organization to serve as a substance abuse prevention resource center and to refer those in need to substance use treatment. Seed money to help launch the new agency was provided through grants from Hudson County and the New Jersey Department of Health. In 2002, NCADD Hudson adopted "Partners in Prevention" as a legal alias to identify its key focus of preventing substance abuse in individuals, families, schools and the broader community. We serve thousands of individuals across Hudson County each year with a variety of prevention and referral services. We maintain cooperative relationships with numerous organizations, advocates, and key stakeholders in all sectors of the community based on shared interests in preventing substance abuse-related problems, and the shared goal of finding productive avenues for working together to serve our community.

Partners in Prevention's current ***organizational budget is*** $1,931,800 for 2021-22. We currently ***employ 22 staff members***, and ***provide a number of services***, including coalition coordination and training to ensure we work collaboratively with numerous partners and stakeholders in all sectors of the community (Hudson County Coalition for a Drug-Free Community -HCCDFC- and other coalitions); evidence-based prevention education and training for individuals, families, and systems (Prevention Education Department); social-emotional learning and culturally competent training (Lindsey Meyer Teen Institute/Training Department); public policy advocacy around substance use/related public health norms, laws, and stigma (HCCDFC/LMTI); and harm reduction efforts (HCCDFC/other coalitions and task forces).

Community & Organizational Partnerships
Although our agency and coalition have dozens of partners who assist in our work, the chart below identifies ***other organization(s) that will partner on this proposed project*** and include ***their experience providing harm reduction services to the population(s) of focus, and their specific roles and responsibilities for this project***.

Partner & Experience	Related Activity/ies	Roles/Responsibilities
RWJBarnabas Hospital System - coordinates overdose prevention efforts/recovery support in Hudson County such as peer outreach/ hospital recovery support and narcan training through the Opioid Overdose Recover Program.	Distribute opioid overdose reversal meds; deliver overdose prevention education; serve on the Harm Reduction TF; distribute harm reduction kits (narcan, fentanyl test strips, etc.); refer those with SUDs to medically assisted treatment.	Oversee the Peer Specialist; coordinate substance use-specific overdose prevention and harm reduction material distribution. Collect and provide harm reduction and SUD treatment referral data.
Hudson Pride Center (HPC)- coordinates the Ryan White initiative for Hudson County; is the primary PreP outreach coordinator. HPC is the lead support service agency to the LGBTQ+ community and the majority of their clients are part of our focus population.	Distribute HIV prevention kits (safe sex/safe needle/etc.) and conduct prevention outreach to target populations; serve on the Harm Reduction Task Force; refer to treatment for infectious diseases such as HIV, STIs, and viral hepatitis.	Oversee LGBTQ+ outreach and PreP education/infectious disease prevention and referral; coordinate harm reduction material distribution; provide harm reduction and infectious disease referral data.
County of Hudson - Department of Health and Human Services - coordinates all NJ Dept. of Health and Human Services funded treatment providers and coordinates mobile SUD/overdose prevention outreach program.	Develop the Harm Reduction Task Force; develop policies and procedures to implement evidence-based trauma informed practices; distribute harm reduction materials; provide treatment referrals.	Serve on the Harm Reduction Task Force; assist with harm reduction material distribution through mobile outreach; serve as the primary SUD treatment referral partner (monitor DMHAS-funded treatment available).

Data Collection and Performance Measurement

Staff will collect and track all required performance measures, as detailed in the table below. All information will be collected by PIP or their partner organizations and reported in the required SPARS system. Data will also be entered bi-monthly into Reach Collaboration and Reach Program, the evaluator's online, client-centric documentation and tracking tools. Project goals and objectives will be translated to a logic model and activities will be documented in alignment with the logic model. This alignment will track process and behavioral/conditional outcomes. Process outcomes are those items related to required activities and focus on the dose of intervention, e.g. the numbers of referrals, linkages to services, and harm reduction items purchased. Behavioral/conditional outcomes focus on what has changed because of the implementation of the project, e.g. organizational policy/practice changes. Other community level outcomes will be tracked and monitored that may change as a result of the implemented interventions, including but not limited to drug-related infections, overdoses, rates of disposal, and overall drug use in the population of focus. Descriptive and comparative analyses will be conducted. Alignment and outcomes will be reviewed on a monthly basis by the project

evaluator/project staff to track progress toward expected outcomes. Recommendations for improvements will be identified and implemented on an ongoing basis. This is bolstered by evaluation support from an evaluator with extensive experience with SAMHSA/related grants.

Performance Measures	**Data Source**	**Collection Frequency**	**Responsible Staff for Data Collection**	**Method of Data Analysis**
Objective 1A				
List and quantity of harm reduction materials purchased with grant funds	Purchasing logs	Quarterly	Evaluator and Project Director (PD)	Descriptive statistics
Number of harm reduction supplies distributed (i.e., received by client)	Service logs	Quarterly	Partner org., evaluator and PD	Descriptive statistics
Number of people trained to use Narcan/naloxone	Training logs	Quarterly	Evaluator and PD	Descriptive statistics
Objective 1B				
Number of people and organizations engaged in the harm reduction task force	Meeting logs	Monthly	Evaluator and PD	Descriptive statistics
Number of trainings for partner orgs. to enhance their harm reduction efforts	Training logs	Quarterly	Evaluator and PD	Descriptive statistics
Number and types of changes orgs. make because of their engagement in this grant	Partner survey	Annually	Evaluator and PD	Descriptive statistics, content summary
Objective 2A				
Number of unduplicated individual service encounters	Service logs	Quarterly	Partner orgs., evaluator and PD	Descriptive and comparative statistics
Objective 2B				
Number of referrals to support services	Service logs	Quarterly	Partner orgs., evaluator and PD	Descriptive and comparative statistics
Number of linkages to support services	Service logs	Quarterly	Partner orgs., evaluator and PD	Descriptive and comparative statistics
Number of policies and procedures related to harm reduction, trauma-informed practices, e.g., developed and/or implemented because of this grant.	Partner survey	Annually	Evaluator and PD	Descriptive statistics, content summary

The Use of an Emergency Department Peer Navigator Program (EDPN) to Provide Linkage to Medication for Opioid Use Disorder (MOUD) and Harm Reduction Services to Ultimately Improve Clinical Outcomes and Quality of Life Measures

*This proposal will also be submitted as a component of a larger proposal by the Rutgers Addiction Research Center (RARC). However, we would like to highlight our program separately because of our urgent needs to provide continued harm reduction and social support services to our patients. We believe we are especially suited to obtain support because of our already established impact on clinical outcomes and quality of life for the patients we have served.

Summary: Our Emergency Department Peer Navigator Program (EDPN) is a collaborative effort between the Departments of Emergency Medicine, Psychiatry, Internal Medicine, and Infectious Disease in order to provide robust addiction care and recovery support services for patients from Essex County by providing linkage to clinics providing medication for opioid use disorder (MOUD), harm reduction, and social support services. The population we serve are overwhelmingly resource limited, with high rates of illicit drug use, poverty, homelessness, financial instability, and uninsured status. There is a high rate of co-occurring psychiatric disorders and infectious disease complications. Our EDPN are from the Newark, NJ area and have lived experience of the issues impacting our population. They provide a "warm hand-off" to ED patients with OUD and within 72 hours from discharge perform outreach to encourage MOUD clinic attendance, retention, provide ongoing peer support, assistance with social support services, as well as provide referrals to local rehabilitation programs, medical and specialty care services. The primary aim when we first created our EDPN program in 2019 was to increase MOUD initiation in the ED and improve linkage to outpatient clinics providing MOUD. Our patients were able to receive medication vouchers, naloxone kits, and social needs assistance (housing, shelter, food, identification, phones, etc.) through our EDPN who engaged with patients in the ED and periodically thereafter. Our current aim is to identify at least 1,000 ED patients with OUD annually, screen for complications of drug use, and increase referral and linkage to appropriate follow-up services that include MOUD. Patients with high-risk features will be given special emphasis by the EDPN and will receive a naloxone kit and education on naloxone administration as well as access to MOUD vouchers, harm reduction equipment and supplies (e.g., substance testing kits, safe use kits, wound care supplies) as supplied by the grant. We aim to provide at least 80% of our service encounters with at least 3 referrals; e.g. outpatient MOUD clinic, harm reduction services, and social support services. We hope that at least 50% of the referrals will eventually become engaged with harm reduction support services including our longitudinal EDPN program. On an annual basis we aim to enroll 300 patients into our longitudinal EDPN program for OUD where patients receive harm reduction peer services for at least 6 months in order to facilitate ongoing engagement in addiction care. For patients with both OUD and co-occurring infectious diseases (e.g. HIV, hepatitis B/C, STI) we will assess outcomes via both an addiction and ID care continuum by also improving linkage to ID treatment (e.g. PrEP, antiretroviral therapy, hepatitis vaccination, chronic hepatitis treatment). We will strengthen our telehealth services and develop novel communication methods, especially during the COVID crises, between patients, peer navigators, and providers by creating an interactive online platform that provides educational, screening, social services, and therapy tools

and distribute prepaid phones to facilitate attendance at virtual clinic appointments. Finally we will expand our Opioid Overdose Education and Naloxone Distribution (OEND) Training Sessions to include more shelters and community rehabilitation programs in the Newark area. In recent studies of our program's impact we have shown that engagement with our EDPN program improves clinical outcomes (for both overall health as well as from opioid-related causes) and improves quality of life measures. We hope to receive funding to sponsor our program for at least the next 3 -5 years. We hope to eventually offer this program indefinitely until our population with OUD needs for harm reduction and social support services have been adequately addressed.

A-1 Population of Focus and Geographical Catchment Area

• Our population of focus will be patients from the University Hospital (UH) Emergency Department (ED) with opioid use disorder (OUD). We expect our population to be overwhelmingly resource limited, with high rates of intravenous drug use (IVDU), poverty, homelessness, financial instability, and uninsured status at the time of intake. Based on local patterns of drug use, the population served will primarily be patients who use heroin and illicit fentanyl. Essex County accounted for the highest number of overdose deaths in the state of New Jersey (NJ) and reported 343 opioid-related fatalities and 2,685 drug overdose deaths from January 1st to October 31st 2021.[1,2] 2020 NJ-SAMS data suggest that heroin abuse is the single largest category of substance abuse requiring treatment in Essex County, with the number of heroin admissions being more than double any other category of substances. Heroin accounted for 46% of all substance use disorder admissions in 2020. In 2020 New Jersey lost 3,046 lives to suspected drug-related deaths, primarily from heroin and fentanyl. [3,4,5] In 2020, New Jersey had the highest amount of fentanyl and adulterants in the drug environment than ever reported. 93% of suspected heroin cases to forensic labs contained fentanyl or fentanyl class compounds in the fourth quarter of 2020.[6] Only 6% of patients treated for substance use disorder in Essex County received buprenorphine, compared to 10% statewide.[2]. Among patients treated for substance abuse, 17% are uninsured, and therefore often unable to access treatment.[3]
• Our catchment area will be Essex County, NJ, including the city of Newark. Our population of focus are people with OUD who live in Newark NJ or the surrounding communities hence it is an urban, predominantly African-American population.

A-2 Statement of Need: Addressing Service Gaps and Barriers Related to Obtaining Linkage to Medications for Opioid Use Disorder (MOUD) through the Creation of an ED Peer Navigator (EDPN) Program

• The opioid epidemic has a major impact on emergency departments (EDs) across the country, resulting in patients presenting daily with opioid related complications including intoxication, withdrawal, infections, and injury. The ED is therefore an ideal location for implementing targeted interventions for patients with OUD, such as treatment linkage to outpatient care. Consequently, in recent years many ED,[7-14] including our own, have adopted ED-based peer recovery support programs to assist patients with linkage to MOUD treatment. Studies have shown that these types of interventions by themselves, or in combination with other services have been effective in linking patients to MOUD.[12-14]
• In 2018 we received a grant from SAMHSA that allowed us to create our ED Peer Navigator (EDPN) Program as well fund the distribution of buprenorphine vouchers and naloxone

distribution kits. Our primary aim when we created the EDPN program was to increase the degree to which patients that visit the ED with complications of opioid use initiate MOUD and obtain follow-up care to aid their recovery process. Our patients were also able to receive buprenorphine vouchers, naloxone kits, and social needs assistance through our EDPN who engaged with them in the ED and periodically thereafter.

• Our EDPN program is similar to most models of peer programs that have emerged in recent years by assisting patients with linkage to care by scheduling the initial appointment for recovery services for patients, a so-called "warm handoff".[8] We also support continued engagement in recovery services by periodically checking-in with patients and conducting quality of life and health/addiction needs assessments, using SAMHSA Government Performance and Results Act (GPRA) surveys, via navigator-patient tele-visits immediately after ED discharge, at 3-months, and at 6-months post initial ED visit encounter. Our EDPN also offer case management and assist patients with a variety of social needs such as obtaining identification, medication vouchers, transportation services, food programs, government phones, housing/shelter referral, and applying for medical insurance.

• **Status of Funding**: In 2018, UH received a grant from SAMHSA for $1.5 million to create our ED bridge clinic for our patients with OUD; this grant supported our EDPN program through 2021 however we are now in need of continued funding to support our continued EDPN harm reduction patient services. We are now in need for financial support to help support the salaries of our EDPN so that they may continue to perform the activities that are vital to our program such as engaging with patients with OUD in the ED, providing clinic referrals and linkages to MOUD treatment, social assistance (food, housing, obtaining ID), check-in calls (quality of life surveys), community education (shelter and rehab naloxone training programs), and ongoing support and motivation to individuals with OUD in order to facilitate their continued recovery from their drug addiction. In 2021 we were awarded a SAMHSA grant for "Expanding Buprenorphine training to providers" in the amount of $147,222 to support our educational services to health care providers; however this grant does not cover the patient-orientated and social support services aspects of our program; the aim of this grant was to support the clinical education and training of various healthcare trainees (medical student, nurse practitioner, residents, etc.) on MOUD. **Currently we are in need of financial support for the patient harm reduction orientated and social support services aspects of our program** which includes providing patient access to harm reduction equipment and services, assistance with social support services (e.g. housing, food, phone, insurance, obtaining ID through the EDPN), linkage to MOUD by the EDPN (through our addiction, primary and specialty care clinics), and the collection of performance measures for our enrolled patients on quality of life, clinical outcomes, healthcare engagement, addiction recovery, as well as psychosocial needs.

• Extent of the Problem: HIV and IVDA in Essex County

According to a 2018 survey of 523 persons who inject drugs (PWID) in Newark NJ, 1 out of 4 PWID have overdosed in the past 12 months and 31% have tried but were unable to obtain MOUD. Only 32% of PWID obtained a syringe from syringe service programs and only 24% obtained sterile syringes from pharmacies. In 2018 the prevalence of persons living with HIV/AIDS in Essex County was nearly three times higher than the state's rate, 1194.9 vs. 419.7 per 100,000 persons, respectively.[15] Moving forward, using grant funds we hope to mitigate the spread of HIV and related infectious disease complications in our population of patients with OUD through the distribution of harm reduction equipment and supplies (infectious disease testing kits, sterile syringes, wound care supplies, etc.) through our EDPN program.

• Extent of the Problem: Socioeconomic Barriers Preventing Linkage to MOUD

Our EDPN program is identifying and attempting to mitigate the social determinants of health factors that can negatively impact addiction recovery and overall health. In a retrospective study of a population of 149 patients who were engaged with our navigator program for at least one year we sought to determine if status of employment, phone, housing, or insurance was associated with incidence of repeat ED visits and/or hospitalizations for both all-causes as well as for opioid-related causes. Status of employment had minimal impact; only the average incidence of repeat ED visits for all causes was higher in patients who were unemployed (3.26) as compared to employed (3.04). However, we did find that patients who lacked phone, housing, and insurance had consistently increased ED visits and/or hospitalizations for both all-causes and for opioid-related complications. We found that patients who had no phone had higher average incidence of repeat ED visits for both all-causes (3.24) and for opioid-related complications (1.12) the year after enrollment into our program as compared to those individuals who have a phone (2.07 for all-cause, 0.67 for opioid-related cause). Patients who had no phone also had a higher average incidence of repeat hospitalizations for all causes (0.82) and for opioid-related causes (0.35) as compared to those individuals who had a phone (0.57 for all-cause, 0.06 for opioid-related causes). Patients who were homeless had a higher average incidence of repeat ED visits for both all-causes (2.79) and for opioid-related complications (0.88) the year after enrollment into our program as compared to those individuals who have housing (2.03 for all cause, 0.68 for opioid-related cause). Homeless patients also had a higher incidence of repeat hospitalizations for all causes (0.74) as compared to those individuals who had housing (0.56). Patients who were uninsured had a higher average incidence of repeat hospitalizations for both all-causes (0.70) and for opioid-related complications (0.20) the year after enrollment into our program as compared to those individuals who have insurance (0.59 for all-cause, 0.09 for opioid-related causes). By identifying the impact that these social determinants have on overall health and healthcare utilization we realize that moving forward we need to strengthen the support services for our socioeconomics disadvantaged patients.

• Extent of the Problem: COVID-19 Affecting Access to MOUD

In the face of COVID-19, we recognized that many of our patients were unable to receive any addiction treatment services without a telephone or access to internet services; all addiction treatment services were operating via telemedicine during peak COVID-19 surges. Therefore, we began to distribute harm-reduction packages that included phones with pre-paid minutes and helped patients apply for government phones. Telemedicine, even post-pandemic, may help patients stay better engaged in care since many patients face issues with accessing transportation. Additionally, our EDPN program has adapted to COVID-19 by transitioning to virtual contact. We will expand our virtual communications by creating an interactive website that patients can use to assess our educational materials and community resources. On this website patients can also access social, mental health, and addiction surveys which can aid the patient, provider and EDPN recognize when additional interventions may be needed.

SECTION B: Providing Services to Priority Populations More than 50% of our population of focus will serve urban racial and/or ethnic minorities. The majority of our population of focus (patients enrolled in our EDPN program) were African-American (67.8%), while only 9.5% were Caucasian, and 20.9% were other (Latinx, Asian, etc). The majority of our patients engaged in our EDPN program had opioid use disorder (83.8%), 37.8% had alcohol use disorder, 35.8% used cocaine, and 14.9% had benzodiazepine dependence. 22.8% were homeless, 89.3% had no phone, 85.9% were unemployed, 19.8% had no health insurance, and 55.0% had a history of

incarceration, prison or jail. According to the most recent ACS,[16] the racial composition of Newark was: black or African American: 50.13%; white: 28.58%; other race: 16.64%; two or more races: 2.42%; Asian: 1.88%; Native American: 0.33%; Native Hawaiian or Pacific Islander: 0.03%. The percentage of people in the Newark-NYC area who are LGTBQ+ is estimated to be 4.5%.[17]

SECTION C: Proposed Implementation Approach

C-1 Goals and Measurable Objectives

Projected Number of Individuals to be Reached with Grant Funds

	Year 1	Year 2	Year 3	Total
Number of service encounters*	1,000	1,000	1,000	3,000
Number of referrals to support services⁑	2,400	2,400	2,400	7,200
Number of linkages to support services†	1,200	1,200	1,200	3,600
Number of linkages to longitudinal EDPN program‡	300	300	300	900

* Number of patients approached in the ED by EDPN per year

⁑ Number of individual referrals to support services through EDPN program per year. Aim of 80% of service encounters receiving at least 3 referrals; e.g. MOUD clinic, longitudinal EDPN program, and social services.

† Number of individual linkages (engagements) with support services. Aim of at least 50% of the referrals eventually becoming engaged with support services. Support services includes harm reduction programs (e.g. EDPN longitudinal program, community needle exchange programs), social work, mental health, and MOUD treatment through addiction medicine, primary care, or other specialty clinics (e.g. psychiatry, obstetrics, infectious disease)

‡ Number of patients who were engaged with the longitudinal EDPN program per year

Goal 1. Patients that present to the ED with high-risk complications from opioid use will receive higher quality care that will enhance access to MOUD and harm-reduction modalities. Our EDPN and/or ED physicians will review harm reduction materials with patients and provide referrals to MOUD through primary care, addiction medicine, and specialty care clinics. We aim to identify at least 1,000 ED patients with OUD annually, screen for complications of drug use, and increase referral and linkage to MOUD clinics. Objectives include:
1. Harm reduction educational materials [18] will be given to each patient and discussed with the EDPN at the initial ED presentation. Our harm reduction includes general information about the health effects of opioid use, reducing risk with MOUD, reducing risk with naloxone, how to respond to an overdose, and reducing risk with safer using strategies (e.g. fentanyl test strips, syringe exchange programs).
2. Patients will also be encouraged to initiate buprenorphine and will be provided a prescription for buprenorphine as well as instructions for home induction if not already started in the ED. All our ED providers at UH have their DATA waiver and are familiar with buprenorphine induction using standard dosing. Some ED providers are also familiar with alternative buprenorphine dosing strategies such as microdosing and macrodosing. We aim to create an ED guideline to educate ED providers on alternative buprenorphine dosing strategies by the end of the 1st year in order to increase eligibility for buprenorphine induction in the ED.
3. Patients will be referred to providers who can provide both addiction and primary or specialty medical care within 72 hours after ED discharge. Ongoing MOUD treatment is available across our clinic network through the departments of Psychiatry (Psych), Internal Medicine (IM), Infectious Disease (ID), Obstetrics & Gynecology (Ob/Gyn), and Anesthesiology (Anes). Since COVID-19 we offer telehealth appointments as well.
4. Patients with high-risk features will be given special emphasis by the EDPN and will receive a naloxone kit and education on naloxone administration as well as access to harm reduction equipment and supplies as supplied by the grant. High-risk features include following: ED visits for opioid overdose, ED visits for opioid withdrawal, frequent ED visits, and untreated infectious complications of drug use including HIV and hepatitis C. We will gather data on OUD and complications of OUD among ED patients to describe rates of heroin and other opioid use, rates of IVDU, and rates of HIV and hepatitis C.

5. For patients with OUD, we will provide information about HIV prevention with PrEP, and referral to IM or ID clinics for those who are interest in initiating PrEP. We will offer testing for HIV and hepatitis C at least annually, and referral to ID clinic for those who test positive. For patients with a new HIV diagnosis, or those with a pre-existing diagnosis not in treatment, a EDPN will meet with the patient in the ED and orient them to treatment and follow-up, in order to facilitate a warm hand-off to ID clinic, where they will receive comprehensive addiction care including MOUD and specialized ID services.

Goal 2. On an annual basis we aim to enroll 300 patients into our longitudinal EDPN program for OUD in order to facilitate ongoing engagement in MOUD, improve clinical outcomes, and provide social support services. Objectives include:
1. Each patient will receive an initial face-to-face conversation with our EDPN when they present at the initial ED visit. Our EDPN themselves are from the Newark community and have experience and training in social work, addiction support, and utilize culturally informed and evidence based strategies. The EDPN will serve as advocates, peers, and navigators to support the recovery from OUD. Our EDPN have personal experience with OUD and recovery, are culturally competent and themselves are from minority backgrounds, and can easily connect with our patient population. Our EDPN are well familiarized and connected with the various rehabilitation and addiction programs within Newark and the surrounding areas.[19]
2. Buprenorphine/naloxone will be offered as initial therapy for patients starting MOUD at our Addiction Clinic, IM Clinic, ID Clinic, Psych Clinic, Pain Clinic and via telemedicine services.
3. For patients believed to illicitly diverting buprenorphine the EDPN may recommend transition to monthly injections of extended-release naltrexone or buprenorphine and/or in-person buprenorphine administrations.
4. The EDPN will help the MOUD clinics identify patients who would especially benefit from telehealth services for example those with disability, transportation difficulties, or quarantine restrictions due to COVID-19 in order to facilitate continued engagement in care.
5. The EDPN will perform interviews to collect key baseline and performance measures data at intake, three months, six months post-intake, then once per year, and at discharge from program if applicable. The EDPN will call individuals with OUD within 72 hours from ED discharge to reinforce the value of participation in harm-reduction activities and confirm receipt of referral to a MOUD clinic. During these interviews the EDPN will collect responses to the SAMHSA GPRA surveys to obtain data on quality of life, healthcare engagement, addiction recovery, as well as psychosocial needs.[20]
6. The EDPN will assist patients with their social service needs such as applying for identification, food programs, government phone programs, housing programs, and applying for insurance. The EDPN will prioritize obtaining insurance coverage for uninsured patients to improve MOUD access.
7. Annually we will record the number of referrals to the addiction clinics offering MOUD, and the number of linkages to MOUD treatment after referral. We will compare the outcomes of individuals that receive opioid harm-reduction navigation with those that present to the ED at times when the EDPN are not available in order to establish the impact of the EDPN program at the end of each year.
8. For patients without HIV on MOUD, we will measure outcomes along an addiction care continuum, with the goal of at least 50% linkage to care, 80% retention in care, 70% remission from illicit opioid use, 100% screening for eligibility for PrEP, and initiation of PrEP for 50% of eligible patients by year three of grant funding.
9. For patients with HIV, we will measure outcomes along the HIV care continuum with the goal of achieving at least 80% linkage to care, 90% retention in care, 100% antiretroviral treatment, and 80% HIV viral load suppression rates.
10. For patients screening positive for chronic viral hepatitis C, we will refer them to ID clinic for hepatitis C treatment, with the goal of achieving 25% initiating treatment for chronic hepatitis C and of those, 90% will achieve sustained virologic response.

Goal 3. Expand access to buprenorphine to our patients without medical insurance by using vouchers and assisting patients to apply for insurance. Objectives include:
1. We will use grant funds to purchase buprenorphine vouchers for our 20% of patients who are not insured. Our EDPN will identify those uninsured patients who would actually be eligible for Medicare or Medicaid and assist patients in the insurance application process or refer patients to case management. For patients without

insurance, and therefore without a ready way to obtain MOUD, vouchers will be provided for 30 tabs of buprenorphine/naloxone, and the EDPN will promptly initiate support in the process of application for insurance.
2. Those uninsured patients who do not qualify for insurance will be referred to the CARE center at UH to obtain medication vouchers through a State Opioid Response (SOR) grant through the Division of Mental Health and Addiction Services (DMHAS).

Goal 4. By the end of the first year we will develop and implement novel communication methods, especially during the COVID crises, between patients, EDPN, and providers by creating an interactive online platform that provides educational, screening, social services, and therapy tools. We will strengthen our telemedicine addiction services to expand the capacity of the UH clinics offering MOUD, lower the barriers for providers to participate in MOUD services, and increase accessibility for patients with limited mobility due to disability or due to quarantine reasons from COVID infection. Objectives include:
1. We will create an interactive website to promote communication between our physicians, EDPN, and patients. Our online platform will provide educational materials, community resources, as well as screening tools and surveys (GPRA surveys) in order to follow a patient's addiction recovery progress, social service and mental health needs. The interactive website will also have access to computer-based cognitive behavioral therapy and audio records to expand access to therapy to our patient population.[21-24]
2. We will promote continued engagement with the virtual aspects of our navigator program and telehealth medicine services by helping patients apply for long-term phones. Currently telehealth visits are available for a number of our medical services at UH including emergency medicine, primary care, mental health, addiction medicine, infectious disease, obstetrics, etc.

Goal 5. Expand our Opioid Overdose Education and Naloxone Distribution (OEND) Training Sessions to Include More Shelters and Community Rehabilitation Programs in the Newark Area. Objectives include:
1. By the end of each year we hope to deliver at least 10 community outreach events with at least 12 attendees at each event. We have been able to deliver 5-7 sessions over the past 2 years. We will educate audience members on the mechanism of opioid overdose, overdose prevention, signs of an overdose, overdose response, and legal protections for both responders and people experiencing overdose. We will evaluate our OEND curriculum using already validated pre- and post-workshop tests assessing changes in knowledge and attitudes.[25]
2. At each OEND training session we will distribute naloxone kits using grant funds and provide a hands-on demonstration on how to use and deliver naloxone to reverse an opioid overdose.

C-2 Required Activities to Fulfill the Desired Outcomes

Harm Reduction Service Delivery Model

• SAMHSA describes four dimensions that support a life in recovery: health, home, purpose and community.[26] Extra emphasis will be given to high-risk patients with OUD complications such as overdose and HIV. By focusing on the ED population, this project will identify many individuals who would otherwise not access medical care and addiction services. We will provide the following recovery support services in order to support a life in recovery:

Support in finding housing, applying for insurance, food, and government phone programs through our EDPN
Access to harm reduction equipment and supplies at the initial ED encounter for high risk patients
Testing for HIV and hepatitis C in the ED and treatment through the ID Clinic
HIV prevention with PrEP offered at the addiction, ID and IM clinics
Comprehensive medical and addiction care with availability for MOUD treatment across our network (e.g. addiction medicine, psych, IM, ID, Ob/Gyn, and pain clinics)

Outreach and peer support from EDPN who are from the community and who are culturally sensitive to the issues faced by our population
Screening, brief intervention, referral to treatment with EDPN; addiction counseling and cognitive behavioral therapy with a licensed social worker and/or mental health provider
MOUD offered via telemedicine to expand access to MOUD, lower the barriers for providers to participate in MOUD services, and increase accessibility for patients with limited mobility due to physical disability, lack of transportation, or due to quarantine restrictions because of COVID-19
Access to an interactive online platform that provides educational, screening, social services, and therapy tools to foster communication between patients, providers and EDPN
Collaboration with community partners to expand our Opioid Overdose Education and Naloxone Distribution (OEND) training sessions and assemble an ED-focused harm reduction advisory council

Required Activities at the Initial ED Encounter

Patients who present to the ED with complications from opioid use will be offered MOUD with buprenorphine/naloxone products, harm reduction education,[17,18] testing for co-occurring infections, and referral to continued outpatient addiction, primary care, and specialty care services. Patients will be referred to providers who can provide both addiction and primary or specialty medical care (e,g. psych, ID, ob/gyn, pain) within 72 hours.
Patients without medical insurance who are interested in MOUD after discharge from the ED will be given buprenorphine vouchers using grant funds and will be given assistance in applying for insurance.
High risk patients will be provided with harm reduction equipment and supplies using grant funds; including sharps disposal and medication disposal kits; substance test kits, including test strips for fentanyl and other synthetic drugs; syringes to prevent and control the spread of infectious diseases; safe smoking kits/supplies; naloxone kits; safe sex kits, including PrEP resources and condoms; and wound care management supplies. Vaccinations services for hepatitis A hepatitis B vaccination as well as treatment for HIV and hepatitis C is already available through our IM and ID clinics.
EDPN with lived experience of the issues impacting our population will meet with patients face-to-face in the ED and within 72 hours perform outreach via phone to encourage clinic attendance, clinic retention, and provide ongoing peer and access to social support services as well as referrals to local rehabilitation programs, as well as medical and specialty care services.[19]

Required Activities during Enrollment in the EDPN Program

At intake to MOUD therapy, clinicians or EDPN will assess patients for OUD using DSM 5 criteria, and collect other baseline characteristics using the GPRA surveys.[20]
The EDPN will interview patients and collect performance measures data at intake (<72 hours from initial ED visit), three months, six months post intake, then once per year, and at discharge from program if applicable. Performance measures include data on quality of life, healthcare engagement, addiction recovery, as well as psychosocial needs.
Patients will be screened for co-existing substance use disorders (SUD) and mental disorders, and referred for comprehensive care and specialized services as needed through our network
To mitigate risk of diversion abuse deterrent formulations of buprenorphine that include naloxone will be used; at the MOUD clinic patients will have random urine drug screens to establish buprenorphine compliance, and for patients believed to be diverting buprenorphine, transition to monthly injection of extended release naltrexone or extended release buprenorphine may be recommended by the EDPN to the MOUD providers.
The EDPN will encourage patients to engage with our telehealth services and our interactive online platform especially during COVID19 surges.

Required Activities with Our Community Collaborators

We will expand our Opioid Overdose Education and Naloxone Distribution (OEND) Training Sessions to include more shelters and community rehabilitation programs in the Newark area by engaging with medical students to educate community members on the mechanism of opioid overdose, overdose prevention, signs of an overdose, overdose response, and legal protections for both responders and people experiencing overdose.

We will assemble a harm reduction advisory council that will serve as our quality improvement (QI) committee who will meet regularly to guide program activities and project implementation. Group members will include EDPN program staff, research associate, medical student volunteers, patients with OUD from our EDPN program, MOUD providers (our addiction medicine trained physicians across the departments of psych, EM, IM, ID, and OB), and other key community members (from our existing connections with community shelter and rehabilitation organizations).[19]
We will encourage our community collaborators to participate in the Northern NJ MAT Center of Excellence webinar series to foster continued education, networking, and peer support.[27]

D: Staff and Organizational Experience

D-1 Institutional Services Related to OUD and MOUD at Rutgers NJMS and University Hospital

• **Centers of Excellence:** Rutgers has received a grant from the state to become a Center of Excellence in Medication-Assisted Treatment (COE) for northern NJ in 2018. This has led to a significant expansion of our addiction services. We serve as a hub for MOUD providers across northern NJ by staffing a "provider hotline" for MOUD-related questions and hosting twice-weekly tele-consultation "drop-in" office hours.
• **Addiction Medicine:** Our Addiction Medicine program at UH has an especially diverse and collaborative faculty, with attendings in the departments of Psych, EM, IM, ID, Ob/Gyn, and Anes.[28] Since COVID-19 many of our outpatient clinics offer telehealth appointments as well. Our addiction medicine fellows provide consultation services on admitted patients with OUD with residents, medical students, and community coordinators. The majority of the addiction medicine consults at UH are for patients who are socioeconomically disadvantaged and have significant psychosocial stressors. There is a high rate of co-occurring psychiatric disorders and many patients suffer from multiple SUD (although opioids are the most predominant substance).
• **ED Bridge Clinic:** Our ED Bridge Clinic utilizes EDPN to improve retention in addiction care and ongoing outpatient medical stabilization. The EDPN work with EM physicians to identify patients with OUD who are candidates to initiate MOUD. The EDPN provide patients brief counseling, collect demographic information, and provide resources that patients can use to manage their addiction through outpatient clinics and community resources. The EDPN escort patients who are discharged from the ED to the Comprehensive Addiction Resources + Education (CARE) Center at the Behavioral Health Sciences Building where they begin their first step in managing their opioid addiction. The EDPN assist patients in obtaining linkage to ongoing outpatient addiction treatment, provide referral to other clinical specialty services as well as assist patients with their social needs in order to optimize a safe hospital discharge.

D-2 Historical and Current Capacity of the Applicant Organization to Implement Harm Reduction Services

Our EDPN program increases linkage to outpatient services for MOUD and improves quality of life measures. Since the creation of our EDPN Program in November 2019, from all the ED patients who had service encounters with our EDPN (approximately 4,280 ED patients who were approached by an EDPN) approximately 28.81% (1,233 patients) were eventually linked to MOUD care. Approximately 180 total patients have engaged longitudinally with our EDPN program for at least 6 months. Patients who were followed by the EDPN longitudinally had a higher linkage rate; ultimately 83% of the patients who enrolled into our EDPN program eventually attended a clinic appointment offering MOUD. Prior to our EDPN program our linkage rate was only 27%. After 3 months of being in the EDPN program 51.3%

patients had increased quality of life measures as measured by the SAMHSA GPRA surveys, while 16.7% were neutral, and 29.2% were dissatisfied. Similarly after 3 months, 58.3% of patients reported satisfaction in their health, 13.9% were neutral, and 26.4% were dissatisfied.

After the creation of our EDPN program there was an increase in the prescribing of buprenorphine and take-home naloxone in our population of ED patients with OUD. After implementation of the EDPN program, the rate of naloxone distribution rose to 19.6 kits per month from 2.9 kits per month. This represents a 575.86% increase in the rate of distribution of naloxone kits. A similar improvement was also seen with buprenorphine prescribing after implementation of our ED navigator program. Prior to implementation of our navigator program the rate of buprenorphine administrations was only 36.7 per month while after the creation of our EDPN program it rose to 69.6 per month representing a 89.65% increase in buprenorphine prescribing.[13]

Our EDPN were able to assist patients in overcoming barriers to accessing evidence-based addiction services by providing assistance with social service needs. The EDPN assisted 23 patients to apply for federal phones, 173 patients to apply for housing, 121 patients to apply for medication insurance, and 9 patients to apply for food programs. We were also able to help 108 patients obtain bus tickets from the hospital, provide 121 patients who did not have medical insurance with buprenorphine vouchers, and 121 patients with vouchers for buprenorphine.

Our EDPN program has also supported the creation of a harm reduction community outreach program. We trained 7 medical students to assist our EDPN and directly engage with community members who interact with patients who are high risk for OUD by delivering Opioid Overdose Education and Naloxone Distribution (OEND) community training workshops in the Newark area. The audience were community members at risk of witnessing an opioid overdose (e.g. residents and/or workers of shelters and rehabilitation programs). Topics included the mechanism of opioid overdose, overdose prevention, signs of an overdose, overdose response, safer use strategies, and legal protections for both responders and people experiencing overdose. We have delivered 7 OEND workshops with approximately 12 individuals attending each session. We have collected approximately 30 pretest and posttest surveys from the audience members. The recipients had both an improvement in knowledge and attitude after the training.

Our EDPN program improves overall health as reflected by the decrease in ED visits and hospitalizations from both all-causes as well as from opioid-related complications. Overall we did find that our program was effective in improving overall health and healthcare utilization as reflected by the decrease in ED visits and hospitalizations from both all-causes as well as from opioid-related complications. The average number of ED visits 1 year pre vs post enrollment, respectively, for all-causes was 3.09 vs 2.20 ($t < 0.05$); for opioid related complications 1.80 vs 0.72 ($t < 0.05$). The average number of hospitalizations 1 year pre and post enrollment, respectively, for all-causes was 0.83 vs 0.60 ($t = 0.05$); for opioid related complications 0.39 vs 0.09 ($t <0.05$). ED visits from all-causes decreased in 60.40% patients, had no change in 18.79%, and increased in 20.81%. ED visits from opioid-related complications decreased in 61.74% patients, had no change in 26.85%, and increased in 11.41%. Hospitalizations from all causes decreased in 30.20% patients, had no change in 50.34%, and increased in 19.46%. Lastly, hospitalizations from opioid-related complications decreased in 20.81% patients, had no change in 75.84%, and increased in 3.36%. Only two patients (0.01%) died within 1 year after they enrolled in our patient navigator program.

D-3 Key Staff Positions

Project Director (PD)/Principal Investigator (PI): Cynthia Santos M.D.
Dr. Santos has extensive specialized experience related to the required activities of this grant. She is triple board-certified in Emergency Medicine, Medical Toxicology, and Addiction Medicine and has the education, training, and background to develop the training, assessments, and program-related material on harm reduction. She is currently the Medical Student Toxicology Elective Course Director, Director for the Clinical Implications of Human Poisonings Course, Director of the Medical Toxicology Residency Scholarly Tract, Medical Toxicology Consultant on-call for the New Jersey Poison Information & Education System (NJPIES), and Addiction Medicine Consultant for Rutgers NJMS. She has experience of being the Principal Investigator (PI) for grants awarded from SAEM/MTF, SAMHSA, and HFNJ. These grants funded the creation of our ED bridge clinic and EDPN program, the creation of a harm reduction curriculum, the creation of an educational module to provide healthcare trainees on harm reduction, and funded research on buprenorphine genomics. Her background is Dominican and she was raised in Queens, NY. The base salary for the PD/PI is budgeted at $190,000. The PD/PI will devote 21% of their level of effort to the grant, equating to $39,982 paid through the grant annually.
Peer Support Worker (PSW)/EDPN Manager: Leonardo Torres
The PSW/EDPN Manager will oversee all grant-related activities and services. He will also train and supervise the EDPN. He has been the project director for our ED bridge clinic since 2018 and has been the Program Director for our previous awarded grants from SAMHSA and HFNJ. The salary for the Peer Support Worker is budgeted at $67,774. He will devote 10% of his level of effort to the grant, equating to $6,774 annually paid through the grant.
Research Associate (RA): Christine Ramdin, PhD
Christine Ramdin, PhD is a research associate with the department of emergency medicine at Rutgers New Jersey Medical School. She holds a PhD in Biomedical Informatics from Rutgers University, and has research interests in addiction and pain medicine. She has been the Research Associate for our ED bridge program since 2018 and has served as co-PI for our previous awarded grant from HFNJ and was the Grant Evaluator for a previously awarded SAMHSA grant which funded the creation of our ED bridge clinic to link patients with OUD to treatment and social support services. The salary for the research associate is budgeted at $65,994. She will devote 10% of her time to this grant's activities, equating to $6,599 paid through the grant.
ED Peer Navigators (EDPN): Donna Jenkins and Able Jeffries
Donna Jenkins and Able Jeffries are our EDPN for our MOUD ED bridge program. Ms. Jenkins and Mr. Jeffries are both African American and are from the Newark area. Donna Jenkins has been a EDPN at our institution since the creation of our ED bridge program in 2018 and Able Jeffries recently joined the program in October 2021. The EDPN assist patients in obtaining linkage to ongoing outpatient Addiction Medicine and other clinical specialty services as well as assist patients with their social needs (linkage to housing, phones, identification, insurance, etc.) in order to optimize a safe discharge from the emergency department. They are both dedicated to continuing their peer navigator services should we obtain future funding. The salary for each EDPN is budgeted at $45,784.00. Each EDPN will devote 100% of their level of effort to the grant, equating to $91,568 per year.

Section E: Data Collection and Performance Measurement

In recent years, EDPN programs have been shown to increase the prescribing of MOUD and improve linkage to addiction care. However what is not known is whether it can improve overall clinical outcomes and healthcare utilization in patients with OUD. We will assess the impact of our EDPN Program by collecting data on clinical outcomes (from EMR) and quality of life measures (from GPRA responses, ref 20) in order to apply for larger NIH research grants. Please see **Attachment 1** for the specific primary and secondary variables we will collect on clinical outcomes and quality of life. On an annual basis, we will compare MOUD clinic follow-up rates, clinical outcomes (repeat ED visits and hospitalizations for both opioid-related and all causes, subsequent urine drug screens, mortality), and quality of life measures (e.g. housing

satisfaction, financial/employment status, community engagement, social connectedness, mental health, physical health, substance use) between those who utilize our EDPN program and those who do not. We will also look specifically at patients with high risk features to assess whether they have received appropriate harm reduction equipment and supplies, and linkage to care for both MOUD and follow-up ID treatment (including vaccination and/or prophylaxis) for HIV, hepatitis, and other STI as appropriate. Finally, we will also look at social determinants of health factors (race, status of medical insurance, lack of housing, access to phone and/or internet, employment, etc.), and other predictors such as comorbidities (e.g. co-occurring substance use, psychiatric condition, infectious disease history) that may impact clinical outcomes.

The Peer Support Worker/EDPN Manager, RA, and PI/PD will oversee the collection, analysis and sharing of data related to grant activities. Our organization is well experienced with evaluating public health programs. Our organization has close ties with the NJ Poison Information and Education System (NJPIES) which is located within the UH campus. Many of the addiction consultations are received through NJPIES and several of the addiction faculty, including the PD, Cynthia Santos, provides consultation for NJPIES. Cynthia Santos trained at the medical toxicology fellowship program at the Centers for Disease Control (CDC) where she was involved in several National Poison Database Service (NPDS) studies evaluating the data collected by individual state poison centers.

The PD, EDPN Manager, RA, medical students, and fellows will conduct clinical outcomes and quality of life research using data from the EMR and completed SAMHSA surveys. We will prospectively collect patient data on quality of life at intake, 3 months, and 6 months and compare changes over time. At the end of the year, we will also retrospectively review data from the EMR on clinical outcomes on patients who were referred to our program regardless of whether they were linked to MOUD treatment to compare clinical outcomes in patients who were enrolled in our program to those patients who were approached by our EDPN but did not enroll in our program. We will also compare clinical outcomes for each patient the year before and after enrollment into our program to assess whether patients had improved clinical outcomes after enrolling into our program.

Data will be analyzed monthly and will be used to design iterative QA/QI cycles in attempt to improve the quality of care provided frequently. Every month, the investigators will analyze the data to determine how well the program is meeting its objectives. On a quarterly basis, the EDPN program data will be presented to the EDPN Advisory Board for involvement in the QI process. Annually and at the end of the grant period all data will be analyzed by the PI/PD, EDPN Manager (Peer Support Worker), RA, investigators, and EDPN advisory board to evaluate overall program performance.

Overall Budget Justification: Our budget for this grant primarily consists primarily of staff salaries and harm reduction equipment and supplies. The PI, Cynthia Santos, MD will dedicate approximately 30% of her academic time towards this grant, which equates to $39,982 in salary per year. As PI, Dr. Santos will oversee program implementation, data collection/analysis, QI efforts, and new applications for grant funding. She will continue to provide acute care for patients with substance use disorder in the ED, and continue to provide addiction consultation for medical toxicology and addiction medicine for inpatients. She will oversee the expansion of the EDPN program, the analysis of quality of life data from the SAMHSA GPRA surveys, and analysis of clinical outcome data from the electronic medical record and death registry. She will

oversee the development and implementation of the telemedicine and telecommunication efforts. She will also oversee the community outreach projects related to harm reduction education and oversee the development of the community advisory board. Leonardo Torres, Project director will be dedicating approximately 10% of his time to this grant per year, which equates to $6,774 in salary per year. His function will be primarily to oversee and manage the activities of the Emergency Department Peer Navigators (EDPN), as well any medical students helping the EDPN with data collection/input/analysis. He will meet frequently with the entire team to ensure all targets are met. Two of our EDPNs will each dedicate 100% of their time to this grant per year, a total of $91,568 per year. Their primary function will be to provide screening brief intervention and referral to treatment (SBIRT) to patients with SUD in the ED, provide social support services (assistance with applying for medical insurance, housing, food programs, accessing phone/internet services, etc.), provide ongoing support to patients enrolled in the longitudinal EDPN program to ensure linkage and retention with outpatient addiction treatment, and administer the SAMHSA GPRA survey interviews to enrolled patients to collect data on quality of life. Christine Ramdin, PhD, the research associate will dedicate approximately 10% of her time per year to the grant, which equates to a total of $6,599 per year. The research associate will assist the PI in analyzing data from SAMHSA GPRA surveys, electronic medical record, and death registry. She will also analyze the pretests/posttests of the attendees who received the community harm reduction education. She will help Dr. Santos and Leonardo Torres with steering program activities, organizing program meetings, and performing QI/QA to ensure the project deliverables are being met. Our program costs will include support to provide telecommunication services (e.g., website, prepaid phones), buprenorphine vouchers, and harm reduction equipment and supplies. We are requesting $1,500 per year to pay IST to assist with website creation, hosting, and ongoing maintenance for the interactive website that we will create to facilitate communication between patients, EDPN, and providers. We would like to provide prepaid phones with 3-month plans, equating to $2,480 per year, to patients without phones to facilitate virtual clinic appointments. We would like to provide per year $7,500 for buprenorphine vouchers, $26,250 for naloxone kits, $800 for wound care management supplies, $300 for condoms, $1,800 for dental dams, $1,000 safe smoking kits/supplies, $180 for sharps disposal and medication disposal kits, $2,400 for substance test kits per year, and $2,500 for medication lock boxes. We would also like to purchase a harm reduction vending machine to provide patients with these supplies at either or ED or clinic sites for $1,677. We also wish to provide patients with gift cards (with emphasis for paying for MOUD vouchers, prepaid phones, food, transportation) as incentive to continue our program, equating to $8,000 per year. Our emergency department already routinely screens all patients for HIV and Hep C and we will provide these ID test services for our enrolled patients as well. Our total requested budget per year equates to $201,311 in direct costs (without including indirect or fringe costs).

We hope to receive funding to sponsor our program for at least the next 3 -5 years. We hope to eventually offer this program indefinitely until our population with OUD needs for harm reduction and social support services have been adequately addressed.

Salaries (List)	Annual Costs
Cynthia Santos M.D, PI	39,982
Leo Torres, PD	6,774.20
Christine Ramdin, RA	6,599.40
Navigators	91,568
Total Personnel	**144,924**
Program Costs (List)	**Annual Cost**
Phones with 3-month plans	$2,480
Website	$1,500
Buprenorphine vouchers	7,500
Naloxone kits	26,250
Wound care management supplies	800
Condoms (male and female)	300
Dental dams	1,800
Safe smoking kit/supplies	1,000
Sharps disposal and medication disposal kits	180
Substance test kits	2,400
Harm reduction vending machine	1,677
Medication lock boxes	2,500
Patient Gift Cards	8,000
Total Program Costs	**56,387**
Total Direct Costs Annually	**201,311**

<u>Attachment 1: Data Collection Instruments/Interview Protocols</u>

Instrument 1. Quality of Life

Quality of Life data will be derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) Government Performance and Results Act (GPRA) Client Outcome Measures Survey. The EDPN will perform interviews using the GPRA survey tools to collect key baseline and performance measures data at intake, three months, six months post-intake, then once per year, and at discharge from program if applicable. To view the full survey please go to the following link below, which is reference #20: CSAT GPRA Client Outcome Measures Tool (samhsa.gov)

Form Approved
OMB No. 0930-0208
Expiration Date: 02/28/2022

Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Substance Abuse Treatment (CSAT)

Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs

SAMHSA's Performance Accountability and Reporting System (SPARS)
March 2019

Public reporting burden for this collection of information is estimated to average 36 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information, if all items are asked of a client/participant; to the extent that providers already obtain much of this information as part of their ongoing client/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate, or any other aspect of this collection of information, to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-0208.

Instrument 2. Variables

• **Independent Variables:** Demographics such as age, race, gender, status of housing, phones access, internet access, employment status, medical insurance status, incarceration history; documented history of substance use disorder(s), history of previous MOUD use; diagnosis of HIV, hepatitis B and/or C, and/or sexually transmitted infections; presence of high risk features which will include the following: ED visits for overdose, withdrawal, frequent ED visits, and untreated infectious complications of drug use including HIV and hepatitis C.

• **Primary Variable:** The primary intervention/predictor variable will be linkage to care (attendance at MOUD clinic) within 3 weeks from the initial ED visit with the MOUD clinics within our network including the CARE Program, and the other clinics within our hospital network that offer MOUD such as the Early Intervention Support Services (EISS), Behavioral Health Sciences, as well as clinics within the IM, ID, Ob/Gyn, Anes departments.

• **Secondary Variables (for all patients approached by EDPN):** Number of service encounters (patients approached by the EDPN in the ED); number of referrals (within 72 hours from ED visit) to clinic providing MOUD; number of attempts to contact patients to provide referrals, number of support service referrals including harm reduction programs (e.g., needle exchange programs), social work, mental health, addiction care, primary care and other specialty care services; administration of MOUD in the ED (e.g., buprenorphine, methadone, naltrexone); receipt of a naloxone kit at discharge from the ED; screening for eligibility and initiation if eligible for PrEP, HAART, hepatitis vaccination and treatment; prescription for MOUD given at ED visit; voucher for MOUD treatment if patient uninsured.

• **Additional Secondary Variables (for patients enrolled in our longitudinal EDPN program):** Number of ED visits 1 year before and after the index case; cause of ED visit(s) 1 year before and after; number of hospitalizations 1 year before and after; cause of repeat hospitalizations 1 year before and after; type of hospitalizations (e.g., observation, general floor, ICU); number of repeat hospitalizations within 30 days after the index ED visit; disposition of hospitalization (e.g., home, rehab, hospice); record of death in (death registry and in EMR); engagement and retention with the addiction treatment clinics (appointment attendance, number of addiction prescriptions received, compliance with treatment regimen (as assessed by urine drug screens); changes in quality of life scores as determined from GPRA survey responses over time (at intake, 3 months, 6 months, and annually), see quality of life outcomes for individual domains; substance relapse (from UDS and BAL) after index case (from follow-up ED or clinic visits); patient satisfaction with program.

• **Clinical Outcomes - Repeat ED visits, hospitalizations, mortality, subsequent urine drug screens:** We will compare rate of linkage to addiction treatment and clinical outcomes (e.g., repeat ED visits and hospitalizations for both substance-related and all causes, mortality) between patients enrolled in our EDPN longitudinal program and those who did not enroll to assess EDPN program effectiveness. To assess patient improvement in outcomes we will look at linkage/adherence to treatment, subsequent urine drug screens, number of repeat ED visit and hospitalizations, type of hospitalization (observation, inpatient, ICU) for both substance-related and all-causes one year before and after enrollment into the EDPN program. ED provider and

admission notes will be reviewed to determine causes of ED visits and hospitalizations. For example, opioid-related visits will be defined as visits for MOUD refills, opioid overdoses, current opioid use leading to medical complications, opioid withdrawal, trauma in the setting of opioid use, and infectious complications secondary to drug abuse.

•**Telecommunication Outcomes:** Engagement with our interactive website and telemedicine services will be determined by the submission of surveys electronically, virtual chat/contact with EDPN and/or provider, receipt of MOUD and other addiction treatment prescriptions, and the attendance of telemedicine appointments. Clinical outcomes (e.g., repeat ED visits and hospitalizations for substance related and all causes, linkage/retention in outpatient addiction treatment, treatment adherence, and relapse) will be compared between those EDPN patients who are engaged with the interactive website and those who do not to assess the impact of virtual engagement with our program.

• **Quality of Life Outcomes:** Patients enrolled in our longitudinal EDPN program will complete GPRA interviews on quality of life (see Instrument 1) which will be used to prospectively collect data on drug and alcohol use, housing conditions, education, employment, source of income, community engagement, social connectedness, changes in crime and criminal justice status, and perception of mental and physical health. When assessing patient perception of their mental and physical health we will ask patients to rate their current health, whether they received treatment for mental or physical health issues in the last 30 days, satisfaction with health, quality of life, and whether they are currently experiencing any issues such as depression and anxiety. Finally, we will evaluate changes in their social connectedness, such as interaction with family members, participation in faith/religious groups or sober groups, and satisfaction with personal relationships.

• **Community Outreach Outcomes:** Number of community service organizations (e.g., Helping the Homeless, Newly Destined, Elev8, The Warming Center, Respite Center Better Life, Rutger's Jordan and Harris Community Health Center, Newark Community Street Team/EMS Overdose Response Team, Leonard Clinic, Essex County Jail, Fairmont, Newark Transitional, and Circle of Life Shelter) who we establish a Memorandum of Understanding (MOUD) with, number of patients with SUD who are referred by each community organization, number of patients who obtain referrals to MOUD and other addiction treatment services including harm reduction services, number of patients who obtain linkages to addiction treatment services, number of patients who engage with telemedicine services for linkage to MOUD and other addiction treatment services, number of patients who receive harm reduction education including harm reduction guides, number of patients who receive naloxone kit and education on naloxone use. For EMS additional variables will include number of patients with SUD who are approached by EDPN, EMS and Newark Community Outreach Street Team, number of patients who are treated with buprenorphine on the scene by EMS, and change in COWS score (https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf) if treated with buprenorphine by EMS. Community members from local shelter and rehabilitation programs who attend the OEND session will complete a prevalidated performance tool (https://doi.org/10.2105/AJPH.2016.303141) to assess changes in knowledge and attitudes on responding to an opioid overdose and effective strategies on supporting individuals with substance use disorders.

References

1. New Jersey Coordinator for Addiction Responses and Enforcement Strategies (CARES). Suspected Drug Related Deaths. Available at: https://www.njoag.gov/programs/nj-cares/nj-cares-suspected-overdose-deaths/ Accessed on January 27th 2022
2. Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. MMWR Morb Mortal Wkly Rep. 2018;67(5152):1419-1427. doi:10.15585/mmwr.mm675152e1
3. Department of Human Services, Division of Mental Health and Addiction Services Office of Planning, Research, Evaluation and Prevention. New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview 2020; Essex County. Available at: https://www.nj.gov/humanservices/dmhas/publications/statistical/Substance%20Abuse%20Overview/2020/Ess.pdf Accessed on January 27th 2022
4. Department of Human Services, Division of Mental Health and Addiction Services Office of Planning, Research, Evaluation and Prevention. New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview 2020; StateWide. https://www.nj.gov/humanservices/dmhas/publications/statistical/Substance%20Abuse%20Overview/2020/Statewide.pdf Accessed on January 27th 2022
5. Department of Human Services, Division of Mental Health and Addiction Services Office of Planning, Research, Evaluation and Prevention. Governor Murphy Releases Report on New Jersey's Response to the Opioid Overdose Epidemic During COVID-19 Public Health Emergency in 2020. Available at: https://www.nj.gov/humanservices/news/pressreleases/2021/approved/20210527.html Accessed on January 27th 2022
6. New Jersey's Response to the Opioid Overdose Epidemic: A Year in Review, 2020. Supported by the Centers for Disease Control (CDC), Overdose Data to Action Grant (NU17CE924966) from the CDC. Available at: https://d31hzlhk6di2h5.cloudfront.net/20210527/22/2f/f6/c6/860e131630d897a70b5235e0/Final_Opiod_Response_Report_2020.pdf Accessed on January 27th 2022
7. Waye KM, Goyer J, Dettor D, et al. Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. Addict Behav. Feb 2019;89:85-91. doi:10.1016/j.addbeh.2018.09.027
8. Liebling EJ, Perez JJS, Litterer MM, Greene C. Implementing hospital-based peer recovery support services for substance use disorder. Am J Drug Alcohol Abuse. Mar 4 2021;47(2):229-237. doi:10.1080/00952990.2020.1841218
9. Bogan C, Jennings L, Haynes L, et al. Implementation of emergency department-initiated buprenorphine for opioid use disorder in a rural southern state. J Subst Abuse Treat. Mar 2020;112s:73-78. doi:10.1016/j.jsat.2020.02.007
10. Bassuk EL, Hanson J, Greene RN, Richard M, Laudet A. Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review. J Subst Abuse Treat. Apr 2016;63:1-9. doi:10.1016/j.jsat.2016.01.003
11. Bohnert AS, Bonar EE, Cunningham R, et al. A pilot randomized clinical trial of an intervention to reduce overdose risk behaviors among emergency department patients at risk for prescription opioid overdose. Drug Alcohol Depend. Jun 1 2016;163:40-7. doi:10.1016/j.drugalcdep.2016.03.018

12. Walter LA, Li L, Rodgers JB, et al. Development of an Emergency Department-Based Intervention to Expand Access to Medications for Opioid Use Disorder in a Medicaid Nonexpansion Setting: Protocol for Engagement and Community Collaboration. JMIR Res Protoc. Apr 29 2021;10(4):e18734. doi:10.2196/18734
13. Ramdin C, Guo M, Fabricant S, Santos C, Nelson L. The Impact of a Peer-Navigator Program on Naloxone Distribution and Buprenorphine Utilization in the Emergency Department. Subst Use Misuse. Dec 31 2021:1-7. doi:10.1080/10826084.2021.2023187
14. Dahlem CHG, Scalera M, Anderson G, et al. Recovery opioid overdose team (ROOT) pilot program evaluation: A community-wide post-overdose response strategy. Subst Abus. 2021;42(4):423-427. doi:10.1080/08897077.2020.1847239
15. State of New Jersey Department of Health, County and Municipal HIV Statistics, 2018. Available at: https://www.state.nj.us/health/hivstdtb/hiv-aids/statmap.shtml Accessed on January 27th 2022
16. World Population Review. Newark New Jersey Population 2021. Available at: https://worldpopulationreview.com/us-cities/newark-nj-population. Accessed on January 27th 2022
17. Conron, K.J., Luhur, W., & Goldberg, S.K. Estimated number of US LGBT adults in Large Metropolitan Statistical Areas (MSA). (December 2020). The Williams Institute, UCLA, Los Angeles, CA. Available at: https://williamsinstitute.law.ucla.edu/wp-content/uploads/MSA-LGBT-Ranking-Mar-2021.pdf
18. University Hospital CARE Navigator Team, Harm Reduction Guide. We Keep Us Safe: How to Prevent and Respond to an Overdose. Available at: https://sites.rutgers.edu/mat-coe/wp-content/uploads/sites/473/2021/09/Copy-of-Guide-FINAL-2.pdf Accessed on January 27th 2022
19. University Hospital ED Peer Navigator Discharge Resources. Available at: https://rutgersconnect-my.sharepoint.com/:w:/g/personal/leonator_njms_rutgers_edu/ET0OFe10tJBIq241tHK9uA0B9QYMYfeshjPWHm9y_onGaA?e=XQcpHh Accessed on January 27th 2022
20. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs. Available at: https://spars.samhsa.gov/sites/default/files/CSATGPRATool1.pdf Accessed on January 27th 2022
21. Choosing Therapy, 15 Best Addiction Podcasts for 2021. Available at: https://www.choosingtherapy.com/addiction-podcasts/ Accessed on January 27th 2022
22. Ourselves Black Podcast. Available at: https://ourselvesblack.com/ob-podcast Accessed on January 27th 2022
23. BLCKNLIT, Addiction Recovery for the Black Woman: Inside the Mind of Shayla Martin. Available at: https://podcasts.apple.com/us/podcast/addiction-recovery-for-the-black-woman-inside-the/id1478936584?i=1000463401809 Accessed on January 27th 2022
24. Addiction Technology Transfer Center Network, Funded by SAMHSA. Recovery Month Podcast Series: Recovery in African American Communities. Available at: https://attcnetwork.org/centers/great-lakes-attc/product/recovery-month-podcast-series-recovery-african-american Accessed on January 27th 2022

25. Lewis DA, Park JN, Vail L, Sine M, Welsh C, and Sherman SG, 2016: Evaluation of the Overdose Education and Naloxone Distribution Program of the Baltimore Student Harm Reduction Coalition American Journal of Public Health 106, 1243_1246, https://doi.org/10.2105/AJPH.2016.303141
26. Substance Abuse and Mental Health Services Administration. Recovery and Recovery Support.; 2017. Available at: https://www.samhsa.gov/recovery Accessed on January 27th 2022
27. Webinar Archive – Northern New Jersey MAT Center of Excellence (rutgers.edu). Available at: https://sites.rutgers.edu/mat-coe/webinar-archive/
28. Addiction Medicine Faculty, Rutgers New Jersey Medical School. Available at: https://njms.rutgers.edu/departments/psychiatry/amf_faculty.php Accessed on January 27th 2022
29. Agency for Healthcare Research and Quality (ahrq.gov), Plan-Do-Study-Act (PDSA) Directions and Examples. Available at: https://www.ahrq.gov/health-literacy/improve/precautions/tool2b.html Accessed on January 27th 2022

Name: Radhika Shah
Contact Information: 201-936-4213
radhikas0930@gmail.com
My name is Radhika Shah, and I am currently a junior at Rutgers University - New Brunswick. I am majoring in Cellular Biology and Neuroscience and minoring in Health Administration. Currently, I work at Robert Wood Johnson University Hospital in the Post Intensive Care Unit. Throughout my time at the hospital, I have seen many patients who struggle with their recovery with substance abuse because there are not enough things to help them come out of it. I do believe that there are many things that the state can do to provide a little more support to these people who need someone rooting for them and are on their side.

Proposals

1. **Expansion of Syringe Services Programs**
    a. When Governor Phil Murphy signed into law in January of 2022, allowing needle exchange programs through the Department of Health rather than municipalities having to approve each one, he invested into harm reduction. However, since January, the state has only seen seven syringe service centers. All of these needle exchange sites are private-run programs. If the state was able to expand and create many more centers that were even more accessible to all, it would allow for more users to make use of the services with ease. With more centers open across the state, the community would realize that there are drug users that need help. The more people that realize there is an addiction issue, the less stigma and shame there would be around drug users and the topic overall. As residents of New Jersey, it is disheartening to hear that over 3,000 residents lost their lives to drug addiction in the past year. The allocation of money would go to the resources needed to keep the syringe site a safe place along with making sure there is a good amount of health professionals who could provide their services. According to the CDC, people who participate in these syringe services programs, are 5 times more likely to enroll in a drug treatment plan to overcome their addiction. In the long run, allocating more money into these centers would allow people to prevent serious diseases and illnesses that come with drug usage and addiction. It would be more expensive for the state to pay for the treatments of drug users for serious conditions such as endocarditis, skin infections, and deep tissue abscesses, all very common and costly illnesses associated with drug addiction.
2. **More state-run rehabilitation centers**
    a. While there are many rehabilitation centers in New Jersey, most of them are private and very expensive for many people to afford. This is the section of funding that would apply towards supporting people in treatment and recovery. If

people have a better chance at recovery, there is less chance of them relapsing and going back to where they started. Just like patients in a hospital, we follow up with them through many years after their illness to make sure they are recovering mentally and physically. The same should apply to users without shaming or stigmatizing them. Upon further research, I was only able to discover 8 free or low-cost rehabilitation centers in New Jersey. These centers would be for people with no insurance that would receive money from grants. With the amount of people within the population of drug users without insurance, these 8 centers would not have enough space for a large number of people to receive the care that they need to overcome this disease. While it depends on insurance, the length of the program, and the facility, an outpatient rehabilitation center in New Jersey can cost $5,000 or more for a 3 month-long program. When hearing this number, many users can be discouraged from spending this much money on getting rid of their addiction. If there was more of the funding allocated to more state-run rehabilitation centers that would be able to provide services at free or very low costs, more users would be able to get treatment.

3. **Make over-the-counter sales of needles and syringes required**
    a. The current law of New Jersey makes it so that it is allowed for needles and syringes to be sold over-the-counter. However, it is not required for places to sell needles and syringes over-the-counter. I can only imagine the judgment people would receive walking into a pharmacy or any other store that would provide over-the-counter medication, only to be denied a needle or syringe. Drug users are aware that they have an addiction and most of the time try to be as safe as they can. With needles being readily accessible to purchase, it eliminates the chances of transmitting bloodborne diseases. Doing this would just be another thing that would give users the chance to be as safe as they can. Pairing this with the bill that Governor Murphy signed in January of 2022, decriminalizing the possession of syringes in New Jersey, will allow people to realize that they can ask professionals for help. If it takes having access to needles and syringes over-the-counter for drug users to inject safely, then I believe that the government would allocate money to this rather than the hefty healthcare fees that come with the serious illnesses related to drug use.
4. **Education and keeping people informed**
    a. It was surprising to me that I was only able to hear about some of this information after conducting detailed research online myself. If drug addiction is a large issue in the community, there should be more information about it out in the open. Due to the fact that there is such a large stigma around drug usage, there is a sense that information regarding drug usage does not want to make its way to the mainstream. For users that do not have access to the internet, it becomes very difficult for them to find places to go to receive the care that they need or go to

one of the seven needle exchange programs in the state of New Jersey. I am also sure that many drug users do not know that some places may sell needles and syringes without a prescription. There should be open information about where users can safely inject and discard their needles. Doing so would ensure public safety as well as the safety of the users. Providing information about the sites and prevention methods, act as a large prevention method on its own. The more people know about the effects of drug usage, the more they can develop the desire to overcome it and access different types of treatments, as long as they know about said treatments through public information. With more information about drug addiction making its way to the public, there is hope that many people will drop the shaming and stigmatizing drug users.

5. **Have specific centers for pregnant and parenting people**
    a. Within the population of drug users, it is very common for pregnant women to be struggling with substance abuse. There are very few centers and facilities that cater to the proper care that they need to ensure the safety of both the mother and the child. This allocation of the funding would fall under the category of addressing the needs of pregnant or parenting people who use drugs and their families. With specific centers, there would be more access to information and more access to the risks that come with substance abuse during pregnancy. At these centers with extra funding, health services could be offered along with any medications and prenatals that would help support. More importantly, people suffering with substance abuse and are pregnant simultaneously have a larger chance of developing serious, life-threatening diseases such as heart defects, Hepatitis infections, HIV, Neonatal Abstinence Syndrome, and Fetal Alcohol Spectrum Disorders. Neonatal Abstinence Syndrome is when a newborn experiences withdrawal symptoms after birth. With the proper staffing and medical care provided at these centers and clinics, it could encourage many expecting parents to seek help and provide them with that strong will to overcome their addiction.

Works Cited

"8 Free New Jersey Rehab Centers - Addiction Resource." *Addiction Resource*, https://www.facebook.com/AddictionResourceNet/, 18 Oct. 2022, https://www.addictionresource.net/free-rehab-centers/new-jersey/.

admin. "How Much Does Outpatient Drug Rehab Cost in New Jersey? - Seacrest Recovery Center New Jersey." *Seacrest Recovery Center New Jersey*, 18 Oct. 2022, https://seacrestrecoverycenternj.com/new-jersey/much-outpatient-drug-rehab-cost-new-jersey/.

"Drug & Alcohol Rehab Centers for Pregnant Women." *American Addiction Centers*, 18 Oct. 2022, https://americanaddictioncenters.org/rehab-guide/pregnant-women.

"Federal Funds Coming to Fight NJ's Opioid Crisis." *NJ Spotlight News* , 18 Oct. 2022, https://www.njspotlightnews.org/2022/09/nj-gets-almost-67-million-federal-funds-to-fight-opioid-epidemic/.

"Opioid Settlement Funds." *The Official Web Site for The State of New Jersey*, 18 Oct. 2022, https://www.nj.gov/opioidfunds/.

"ReachNJ." *The Official Web Site for The State of New Jersey*, 18 Oct. 2022, https://nj.gov/humanservices/reachnj/.

"Syringe Access Expansion Laws Passed by New Jersey Senate and Assembly." *National AIDS Treatment Advocacy Project - NATAP - HIV - AIDS Treatment Information*, 18 Oct. 2022, https://www.natap.org/2022/HCV/012522_01.htm.

"Syringe Services Programs (SSPs) FAQs | CDC." *Centers for Disease Control and Prevention*, 18 Oct. 2022, https://www.cdc.gov/ssp/syringe-services-programs-faq.html.

The Pew Charitable Trusts. "Syringe Distribution Programs Can Improve Public Health During the Opioid Overdose Crisis | The Pew Charitable Trusts." *The Pew Charitable Trusts | The Pew Charitable Trusts*, The Pew Charitable Trusts, 18 Oct. 2022, https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/03/syringe-distribution-programs-can-improve-public-health-during-the-opioid-overdose-crisis.

zbarby. "Department of Health | News | Governor Murphy Signs Legislative Package to Expand Harm Reduction Efforts, Further Commitment to End New Jersey's Opioid Epidemic." *The Official Web Site for The State of New Jersey*, 18 Oct. 2022, https://www.nj.gov/health/news/2022/approved/20220118a.shtml.

I think more needs to be done to identify why people choose to abuse substances and why we are not doing enough to address mental health and the root causes of addiction. One of the sources of addiction that should be looked at is the State of New Jersey itself. While the Department of Human Services is fighting opioid and Fentanyl addiction other branches of the State are promoting addictive behaviors by promoting gambling. The Diagnostic and Statistical Manual of Mental Disorders, DSM-5 includes Gambling Disorder as a recognized mental disorder, yet some State agencies are aggressively marketing all forms or gambling as a glamorous lifestyle, including casinos, sports betting, lotteries, scratch-off and online gambling. It is not glamorous, it is an addiction and a mental disorder. What is the State of New Jersey doing to reduce the other known deadly addictions like smoking and alcohol, except extracting sin taxes? Why isn't more money being spent to help people save their own lives from those addictions and not encourage this destructive behavior? Is it ethical for a governmental agency to only care about raising tax revenues when it is also promoting harm to its own residents? Why is the part of the State of New Jersey promoting other addictions that may become the gateway to opioids? One branch of the State encouraging addictive behaviors, while the other tries to stop the opioid epidemic is not a great strategy for helping all people in this State and solving problems that are destroying some people's lives.

On the opioid recommendations, I have one and that is Naloxone or Narcan. It works to save lives, but it is not easy to get or it is expensive to purchase from a pharmacy. I asked two different pharmacies and it was over $100. Yet, pharmacies are excellent and logical locations for people to obtain Naloxone. New Jersey had one three-day free give away in 2020. That is a sad commentary on making this antidote readily available. In July of this year, the Murphy Administration expanded distribution to a limited number of "eligible agencies." That action was helpful, but this program should now be expanded more broadly. Settlement money should be used to provide free and easy access to anyone who seeks Naloxone without a prescription. The State of New Jersey should establish a fully free distribution program for Naloxone at all pharmacies, every day of the year without a prescription. Free literature on proper use and identification of possible overdose indicators should also be included with the Naloxone.

The State of New Jersey should also provide free distribution of Naloxone to all public schools and to all colleges and universities in New Jersey. Efforts should be made to provide it not just to central locations, but also to all residential student housing through training and assigning to residential advisors and at all fraternities and sororities at all schools in the State. The program should also include any interested community-based organization whether or not they are specifically involved in substance abuse issues. The idea is to save lives and that means getting Naloxone everywhere that substance abuse with opioids is occurring. Get this critical antidote to all of the places where it can save lives, since there is limited time to reverse the effects of these drugs. Time is of the essence when it comes to making this life-saving antidote readily available everywhere.

With Fentanyl becoming so widespread, the State should also consider more widespread distribution of Fentanyl test kits.

The second part of the broader distribution should be to spend money from this settlement providing greater advertising for the availability of Naloxone to all people in the State. That should include, print, radio, TV, telephone, text, social media and billboards.

This enhanced Naloxone distribution program will save more lives and money spent from the settlement will be money well spent.

Thank you for your interest and consideration.

10/31/22

As the President and CEO of the Mental Health Association in New Jersey, I would like to make recommendations regarding the Opioid Settlement Funds based on our perspective as a statewide advocacy organization. We identify barriers in the behavioral healthcare system, raise awareness about them and help to remove them. Our focus is often on systems of care -and the stated needs of individuals and families suffering from substance use disorder.

Many struggling with addiction site lack of transportation as a major barrier in accessing treatment. Stable funding of vouchers for transportation would be a significant way to address this need.

Safe housing is a critical component for recovery in the community. Our housing sources for those dealing with SUD are inadequate, disjointed, and not well regulated. A statewide commitment to housing could be a dedicated trust that made housing and consistent regulations available to those with SUD.

More than 50% of those being treated for SUD are also suffering from mental illness, and yet there is inadequate training, education, and resources to support treatment of co-occurring disorders. We recommend an investment of funds to inform and support – education, training of clinicians, integration of treatment programs.

Families are an important part of a recovery system, yet they are left out of the recovery plan. Services for family members are often developed on a voluntary basis, leaving families uninformed, frightened and frequently not knowing where to turn for help. Financial reimbursement for family services would generate many more resources for families of SUD members.

One of the ways to include/assist families in distress will be delivered through the new 988 statewide program. It will be responding to both SUD and mental health crises.. A crucial part of it will be mobile outreach and will frequently be relating to families in crisis. Funding this part of the 988 initiative would be significant recognition of families in the lives and recovery of those suffering from behavioral health problems.

On behalf of MHANJ, thank you for considering our recommendations.

PARENT SUPPORT GROUP OF NEW JERSEY

Target population:

Parents Support Group of New Jersey is a non-profit program, one of the very few groups available that is *strictly* for parents of addicted children. Established over 30 years ago, Parent Support Group of New Jersey helps mothers and fathers to understand and cope with their child's disease of addiction. We believe that addiction is an illness and that changed attitudes and responses by the parents can greatly help their child's recovery.

The volunteer facilitators who lead the groups, have all struggled with addiction with their own children, and now give back and lead the groups. The groups meet weekly either in person or on Zoom. Referrals to counselors are also available at no charge.

Our groups focus on coping methods needed by parents while their children drink to excess, abuse drugs, lose jobs and housing, and refuse rehabs and medical care. Absolute confidentiality is practiced and required by all parents. The parents in the groups continue to support each other, learn ways to respond to the addict, and hope for the miracle that their child will find a new life in recovery.

Our groups provide support and guidance in free weekly meetings at six locations across the state to talk about their current situation, learn about addiction, be provided tools for coping, receive resource materials, and much, much more. We can understand the pain these parents are going through and how difficult it is, but we can help them to cope as we have been there.

Goal:

In order to sustain and expand our services, we need finances that support our structural costs for communication, marketing, and physical presence in the community. Funds have now dwindled in the wake of Zoom meetings during the pandemic, while the need to support parents has grown with documented increased drug and alcohol abuse. We have all lived with the fear of losing our child to overdose. Through supporting each other, we sustain hope for the miracle that our child will find a new life in recovery

PARENT SUPPORT GROUP OF NEW JERSEY

Total funding amount requested:

Item	Amount per year
Meeting room rental	$2,000
Answering service	$1,600
Phone	$600
Website (Domain & internet)	$2024
Zoom	$149
Part time secretary	$28,186
Counselors	$650
Accountant	$3,500
Bookkeeper	$1,200
Honorarium for educational speakers	$2,000
Marketing flyers to therapists, ERs	$200
Bank fee	$523
Post Office Box	$148
TOTAL	$42,780

Summary of Initiative:

With this grant request, we plan to search out parents in need of support via outreach into the community through contact with therapists, churches, and hospital emergency rooms to provide contact information about our group. We will offer Introductory Sessions at NJ rehab facilities for parents and invite them to a group. We will maintain a strong organizational base responsive to all calls through maintaining a 24 hour communication system.

We appreciate your consideration of our request,

Cheryl Sherry

President

My goal is to train incarcerated individuals who are preparing for release from prison to become Certified Recovery Support Practitioners (CRSP), also known as Peer Specialists. I can attest that the class is inspiring and can be provided by the Mental Health Association in New Jersey Consumer Connections program. The aim would be for Catholic Charities to help me administer the program, Consumer Connections to provide the training, while the New Jersey Prevention Network (NJPN) pays for the certification and insurance. Peer supported recovery has been expanding in recent years due to recognition of the importance of lived experience in supporting individuals in substance use disorder recovery[4]

I currently work for Catholic Charities Diocese of Trenton which provides numerous services to the community including counseling, supported employment, and, most critically for these individuals, case management. The depth of experience and involvement that Catholic Charities has in this community will make them an ideal partner in standing up and administering my proposed program.

Many of the issues and benefits that this program will address and offer are longstanding and well defined in the research. My aim is to utilize existing infrastructure (Catholic Charities, MHANJ, NJPN), clinical and economic research and my own expertise to implement a much-needed program. I believe that with the combination of evidence-based practice, instructional and personal experience, we can address this educational challenge and benefit the incarcerated and formerly incarcerated as well as the community and state.

Respectfully yours,

Robert Brooks

A.A.S., A.D.D., WRAP Co-Facilitator, Peer Health Coach

---

[4] https://www.mhanj.org/consumer-connections

October 27, 2022

Opioid Funds Proposal
c/o PO Box 001
Trenton, NJ 08635

Re: Opioid Settlements

To Whom It May Concern:

Thank you for the opportunity to comment on how the opioid settlement funds should be used by the state of New Jersey.

Partnership to End Addiction is a New York-based non-profit organization with more than 25 years of research and policy experience aimed at transforming how our nation addresses addiction. We turn the knowledge and insights gained from research, and the experience of families impacted by addiction, into actionable policy recommendations.

Decades of research, by our organization and others, show that we can effectively end our nation's addiction crisis by adopting a public health approach. We continually monitor and evaluate state and federal responses to the opioid crisis, tracking policy solutions and legislation to identify best practices and initiatives that align with a public health approach. In order to have the greatest impact, New Jersey must ensure that it invests its opioid settlement funds in evidence-based, public-health approaches that comprehensively address prevention, treatment and recovery.

We have developed a number of tools and resources to help guide states in determining how to spend the opioid settlement funds. We encourage you to review the reports and publications listed below:

- We developed a guide for state policymakers with recommendations to implement a public health approach to address the opioid crisis (Ending the Opioid Crisis: A Practical Guide for State Policymakers). The guide includes examples of data-informed, treatment-focused initiatives on the state and local levels that can serve as models for others.
- Together with a group of the nation's leading experts in addiction research, treatment and policy, we co-authored a comprehensive report outlining recommendations for addressing the opioid crisis. Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic provides clear guidance on abatement strategies based on decades of research evidence and is intended to help guide state and local policymakers in how to effectively spend the opioid litigation funds.
- The Johns Hopkins Bloomberg School of Public Health developed Principles for the Use of Funds from the Opioid Litigation, which were then endorsed by a coalition of organizations, including Partnership to End Addiction. We were asked to lead the work on developing indicators for state and local governments to assess their readiness to receive opioid settlement funds and adhere to the principle of investing in youth prevention.
- We leveraged that work into a blog, published by *Health Affairs*, where we shared practical, sustainable, and research-based recommendations for states on how they should invest opioid settlement funds and other federal funding to prevent substance use and promote youth mental health.
- We recently coauthored an opinion, published by STAT, on the importance of directing opioid settlement funds towards prevention strategies.

- We served as a peer reviewer for a model state law for opioid litigation proceeds developed by the Legislative Analysis and Public Policy Association and supported by the Office of National Drug Control Policy.

With respect to the allowable uses of the funds, we would encourage the state to focus prevention efforts on preventing the use of all harmful substances, not just opioids. Prevention efforts targeted to a specific substance are often ineffective. Broad strategies aimed at promoting positive youth development are far more effective in preventing substance use and other negative outcomes. We also encourage using funds to provides services, resources and supports to family members who are supporting a loved one struggling with substance use. When families are involved, informed and supported, the outcomes for those with addiction are better. Yet, families impacted by addiction receive little to no government support.

Thank you for the opportunity to provide comments. We respectfully offer our time and expertise to help the State as it determines how to spend the settlement funds.

Sincerely,

Lindsey C. Vuolo

Lindsey Vuolo
Vice President of Health Law & Policy

Morris County Hope One Project

Population served: Morris County, New Jersey (494,228)

The Morris County Sheriff's Office Hope One Project 2023 funding budget is $158,186. This project serves individuals who suffer from substance use and mental health disorders. The Morris County Sheriff's Office has coordinated the HOPE ONE Mobile Outreach vehicle, a law enforcement diversion program. Since April 3, 2017, the vehicle has been strategically deployed to areas experiencing a high volume of opiate overdoses or substance usage and is continuously staffed with a multi-disciplinary team consisting of a Morris County Sheriff's Officer, a Mental Health Professional and a Peer Recovery Specialist. This project provides approximately 1,000 life-saving Naloxone training and kits each year to prevent overdose deaths. The mission of this project is to continue and expand outreach for individuals interested in accessing community-based substance use and mental health services. In addition, develop continued partnerships by collaborating with law enforcement and service providers to increase contacts through the Police Assisted Addiction & Recovery Initiative (PAARI), Hope One mobile outreach and the Hope Hub. The Hope Hub team is made up of a Sheriff's Officer and a Social Case Worker. Once an individual or family consents to participate in the Hope Hub, the team will connect the family or individual to necessary providers to ensure a continuum of care. The Hope One Project allows client progress to be tracked and analyzed using REACH software provided by our research partner which determine success, or the need for necessary program adjustments. The Hope One team also works with Community Connections, a model to assist court involved individuals access services which will lead to a more successful reintegration into the community. The implementation of these strategies will identify and provide treatment, harm reduction, recovery support and mental health services to individuals or families that are at an elevated risk. The Hope One Project has been successfully replicated in eight (8) other counties across the State of New Jersey.

This project includes partnerships between:

1. Acenda Health ($30,400)
    a) Assist PAARI contacts from Police Departments
    b) Train new Police Departments to implement PAARI

2. Mental Health Association of Essex and Morris County ($36,888)
    a) Full time team member for Hope One Project

3. PIK-Prevention is Key/CARES (Center for Addiction, Recovery, Education and Success)
    a) Full time Peer Recovery Specialist ($40,898)
    b) Naloxone Kits 1,000 kits X $42= ($42,000)

4. Epiphany Community Services ($8,000)
    a) Research partner to collect, monitor and analyze project results

5. Morris County Department of Human Services

6. Family Promise of Morris

7. Morris County Chiefs of Police Association

The total operating budget per year for Morris County Hope One is $158,186. This project was funded by the State of New Jersey in 2021. This year (2022), we were able to continue to operate Hope One with a one-time donation and county Chapter 51 funding. There is currently no 2023 funding for the Hope One Project.

Opioid Settlement Funds - Proposal for Disbursement
Syringe Services Program
October 2022

The opioid crisis in the United States of America has persisted and worsened since the start of the Covid-19 pandemic, with overdose rates rising through 2021 across the population of the USA (CDC, 2022) and in select demographics such as race (CDC, 2022) and for teenagers (Friedman et al., 2022). New substances other than opioids (synthetic or otherwise) are resulting in increased overdoses, including methamphetamine (Han et al., 2021). Intravenous substance use also presents additional health risks, such as transmission of HIV, hepatitis C virus (HCV), and more (Rapoport et al., 2017).

Syringe services programs (SSPs) are one harm reduction measure that can address multiple barriers to individual and community recovery. Governor Murphy's administration and New Jersey's legislature passed Bill S3009 ScaSca (2R) on January 18th, 2022 (A4847, 2022) and joined the National Institute on Drug Abuse (NIDA, 2022), Substance Abuse and Mental Health Services Administration (SAMHSA) (Department of Health and Human Services, 2016), and the Centers for Disease Control and Prevention (CDC, 2019) in acknowledging the efficacy of hygienic syringe distribution programs and syringe service programs. SSPs are associated with a reduction in HIV transmission among people who inject substances (Aspinall et al., 2014), including with combined prevention approaches (Des Jarlais et al., 2016); decrease in improper disposal of syringes (Levine et al., 2019); and reduction in HCV transmission (Platt et al., 2017) (CDC, 2018). Stigma-infused perspectives on crime increases associated with SSPs are not supported by research (Carico et al., 2020) (Galea et al., 2001) (Marx et al., 2000).

With this research base, as well as US federal offices' guidelines for both funding access as well as program implementation on the state level, New Jersey's opioid settlement funds would be well-invested in syringe services programs (SSPs) in the state. For equity of access, SSPs can be constructed in each county in the state of New Jersey, along with cities with a population that exceeds 75,000 people, with one SSP for each factor of 75,000 residents, with a ceiling of three SSPs per city. Estimates for yearly operating costs can range from $400,000 for a small rural SSP (serving 250 clients) to $1.9 million for a large urban SSP (serving 2,500 clients) (Teshale et al., 2019) and approximately $407,000 per year for an academic medical center-based SSP (Bartholomew et al., 2021). To counter issues related to 'not in my backyard' (NIMBY), offerings for a given county or city can include mobile SSPs, which have estimated operating costs of approximately $311,000 per year (Bartholomew et al., 2021). A community advisory board would also be necessary for each step of the implementation process, involving key stakeholders such as people in recovery and community members and leaders.

Research and budgetary concerns are both extremely important when developing harm reduction strategies for intervention in the opioid crisis. Additional aspects of importance include historical context as well as the mechanics of needle syringe exchange programs (NSEPs). The biologic function of NSEP is to minimize the likelihood of contracting HIV (and other viruses) by decreasing the time that needles and syringes spend in active circulation (Drucker et al., 1998). There are two ways that NSEP lessen the time a syringe is spent in use and circulation - first, by increasing "the total number of syringes and needles available in a given time . . ." and second

by reducing “the average circulation time of each syringe and needle by physically removing used syringes from circulation” (Drucker et al., 1998). However, they provide IV drug users with much more than sterile injecting equipment, including but not limited to sex education, drug treatment, and referrals to medical, legal, and social resources (Drucker et al., 1998).

Sites can incorporate other benefits for participants. Peer health navigators can offer peer support services (SAMHSA, 2022); case managers present on-site can discuss wellness domain needs such as linkages to Social Services benefits including as SNAP, GA, and housing in tandem with resources such as local food pantries; fentanyl test strip and Narcan provision; and medical staff can provide testing for infectious diseases and address additional medical concerns participants may have, making referrals as needed, e.g. for wound care. Transportation can also be addressed through the provision of bus tickets, train tickets, and other means to increase accessibility to sites.

Location is another aspect that is important to consider when creating NSEPs. A successful needle exchange program, implemented in Liverpool, U.K., in 1986, was located next to the city’s Methadone clinic. The area was known by drug users, making the site easily accessible to those who needed it. The location was also frequented by sex workers, which was essential to preventing the spread of AIDS (Szalavitz, 2021). It is ideal for sites to be placed in cities with high populations of IV drug users and in areas where IDU frequent in order to reach the demographic that these programs serve. The presence of law enforcement or other government agencies can also decrease the likelihood that IDU will feel safe utilizing a NSEP, especially given that IDUs often have a history of negative police interactions (Szalavitz 2021). Therefore, it is ideal to avoid placing NSEP in areas with heavy police presence.

In conclusion, short of the evidence-based practice of statewide and nationwide decriminalization of all substances (Csete et al., 2016) (Hughes and Stevens, 2010), NSEP/SSPs are a practical, viable harm reduction solution to intervene on behalf of individuals and communities severely affected by the opioid epidemic.

References

A4847, Bill S3009 ScaSca (2R), Session 2020-2021. (New Jersey, 2022). njleg.state.nj.us/bill-search/2020/S3009

Aspinall, E. J., Nambiar, D., Goldberg, D. J., Hickman, M., Weir, A., Van Velzen, E., Palmateer, N., Doyle, J. S., Hellard, M. E., & Hutchinson, S. J. (2014). Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *International journal of epidemiology*, *43*(1), 235–248. https://doi.org/10.1093/ije/dyt243

Bartholomew, T. S., Patel, H., McCollister, K., Feaster, D. J., & Tookes, H. E. (2021). Implementation and first-year operating costs of an academic medical center-based syringe services program. *Harm reduction journal*, *18*(1), 116. https://doi.org/10.1186/s12954-021-00563-8

Hughes, C. E., Stevens, A. (2010). What can we learn from the Portuguese decriminalization of illicit drugs?, *The British Journal of Criminology, 50*(6), 999–1022. https://doi.org/10.1093/bjc/azq038

Carico, R. R., Jr, Hussain, N., Sheppard, J., Thomas, C. B., & Fenerty, J. (2020). Syringe services programs and real-world research: An overview for pharmacists. *Journal of the American Pharmacists Association : JAPhA*, *60*(5), e29–e33. https://doi.org/10.1016/j.japh.2020.02.029

Centers for Disease Control. (2022). Overdose death rates increased significantly for Black, American Indian/Alaska Native people in 2020. CDC Newsroom. Accessed via https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html

Centers for Disease Control and Prevention. (2019). Summary of information on the safety and effectiveness of syringe services programs (SSPs). Centers for Disease Control and Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention. Accessed via: https://www.cdc.gov/ssp/syringe-services-programs-summary.html

Centers for Disease Control and Prevention. (2018). Managing HIV and Hepatitis C outbreaks among people who inject drugs: a guide for state and local health departments. Centers for Disease Control and Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention. Accessed via: https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-guide.pdf

Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., Cepeda, J., Comfort, M., Goosby, E., Goulão, J., Hart, C., Kerr, T., Lajous, A. M., Lewis, S., Martin, N., Mejía, D., Camacho, A., Mathieson, D., Obot, I., Ogunrombi, A., … Beyrer, C. (2016).

Public health and international drug policy. *Lancet (London, England)*, *387*(10026), 1427–1480. https://doi.org/10.1016/S0140-6736(16)00619-X

Department of Health and Human Services. (2016). Implementation guidance for syringe services programs: SAMHSA-specific guidance for states requesting use of substance abuse prevention and treatment block grant funds to implement SSPs. Accessed via: www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf

Des Jarlais, D. C., Kerr, T., Carrieri, P., Feelemyer, J., & Arasteh, K. (2016). HIV infection among persons who inject drugs: ending old epidemics and addressing new outbreaks. *AIDS (London, England)*, *30*(6), 815–826. https://doi.org/10.1097/QAD.0000000000001039

Drucker, E., Lurie, P., Wodak, A., & Alcabes, P. (1998). Measuring harm reduction: the effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV. *AIDS (London, England)*, *12 Suppl A*, S217–S230.

Friedman, J., Godvin, M., Shover, C.L., Gone, J.P., Hansen, H., Schriger, D.L. (2022). Trends in drug overdose deaths among US adolescents, January 2010 to June 2021. JAMA, *327(14)*:1398–1400. doi:10.1001/jama.2022.2847

Galea, S., Ahern, J., Fuller, C., Freudenberg, N., & Vlahov, D. (2001). Needle exchange programs and experience of violence in an inner city neighborhood. *Journal of Acquired Immune Deficiency Syndromes,* (28), 282-288.

Greenwald, Glenn (2009). Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies http://dx.doi.org/10.2139/ssrn.1543991

Han, B., Compton, W. M., Jones, C. M., Einstein, E. B., & Volkow, N. D. (2021). Methamphetamine Use, Methamphetamine Use Disorder, and Associated Overdose Deaths Among US Adults. *JAMA psychiatry*, *78*(12), 1329–1342. https://doi.org/10.1001/jamapsychiatry.2021.2588

Levine, H., Bartholomew, T. S., Rea-Wilson, V., Onugha, J., Arriola, D. J., Cardenas, G., Forrest, D. W., Kral, A. H., Metsch, L. R., Spencer, E., & Tookes, H. (2019). Syringe disposal among people who inject drugs before and after the implementation of a syringe services program. *Drug and alcohol dependence*, *202*, 13–17. https://doi.org/10.1016/j.drugalcdep.2019.04.025

Marx, M. A., Crape, B., Brookmeyer, R. S., Junge, B., Latkin, C., Vlahov, D., & Strathdee, S. A. (2000). Trends in crime and the introduction of a needle exchange program. *American Journal of Public Health, 90*(12), 1933–1936.

National Institute on Drug Abuse. (Accessed 2022). Syringe services programs. National Institute on Drug Abuse, Research Topics. Accessed via: https://nida.nih.gov/research-topics/syringe-services-programs

Platt, L., Minozzi, S., Reed, J., Vickerman, P., Hagan, H., French, C., Jordan, A., Degenhardt, L., Hope, V., Hutchinson, S., Maher, L., Palmateer, N., Taylor, A., Bruneau, J., & Hickman, M. (2017). Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *The Cochrane database of systematic reviews*, *9*(9), CD012021. https://doi.org/10.1002/14651858.CD012021.pub2

Rapoport, A. B., Beekmann, S. E., Polgreen, P. M., & Rowley, C. F. (2017). Injection Drug Use and Infectious Disease Practice: A National Provider Survey. *Open Forum Infectious Diseases*, *4*(Suppl 1), S340. https://doi.org/10.1093/ofid/ofx163.810

Substance Abuse and Mental Health Services Administration. (2022). Peer support workers for those in recovery. Substance Abuse and Mental Health Services Administration, Recovery Support Tools and Resources. Accessed via: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

Szalavitz, M. (2021). *Undoing drugs : the untold story of harm reduction and the future of addiction*. Hachette Go.

Teshale, E. H., Asher, A., Aslam, M. V., Augustine, R., Duncan, E., Rose-Wood, A., Ward, J., Mermin, J., Owusu-Edusei, K., & Dietz, P. M. (2019). Estimated cost of comprehensive syringe service program in the United States. *PloS one*, *14*(4), e0216205. https://doi.org/10.1371/journal.pone.0216205

The New Jersey Reentry Corporation

Proposal for Opioid Use Disorder, MAT/Mental Health/Hepatitis Treatment Pilot Initiative

The New Jersey Reentry Corporation (NJRC) is a nonprofit organization that provides critically needed services for court-involved individuals, post-release. This organization focuses on seven main components: (1) addiction treatment, (2) sober transitional housing, (3) training and employment, (4) Medicaid registration and healthcare access, (5) Motor Vehicle Commission identification, (6) legal services, and (7) mentoring. As a result, clients have an **average recidivism rate of 19.7 percent**, a **re-incarceration rate of less than 10 percent**, and **an average employment rate of 60 percent** (adjusted seasonally).[1]

The NJRC model is based on the principle of "Integrated Reintegration": integrated services foster community reintegration of returning citizens. The program seeks to assist other counties in implementing the innovative pilot program model established by the United States Department of Justice, Bureau of Justice Assistance, Hudson County, and Jersey City. NJRC seeks to reduce the prevalence of factors correlated with incarceration, including homelessness, unemployment, substance dependence, a lack of social support, and a rupture in sense of connectivity to place and community. NJRC seeks to benefit the State of New Jersey by creating opportunities for an increase in partnerships between stakeholders, improving the socioeconomic status of participants, and reducing the cost burden of mass incarceration. Participants are provided with the essential tools for rebuilding their lives and the opportunity to view themselves as healing agents within their own communities.

NJRC presently serves over 14,000 clients across eight reentry sites, the Community Resource Center, and the Training Center.[2] NJRC provides for an effective integrated service delivery model, which is driven by licensed social workers, a biopsychosocial evaluation, and ongoing case management services through our case management system. In addition to being designated a New Jersey State Supreme Court pro-bono activity with 73 volunteer lawyers assisting to address outstanding warrants, NJRC partners with Federally Qualified Health Centers (FQHC) at every site to provide for basic medical and mental health needs. Moreover, NJRC partners with state certified (Division of Mental Health and Addiction Services) treatment providers to provide for addiction treatment in accordance with clinical "best practices." NJRC partners with NJDOC, NJSPB, county jails, county probation, county Drug Courts, and the Federal District Courts.

NJRC proposes an Opioid Use Disorder, MAT/Mental Health/Hepatitis Treatment Pilot Initiative to concurrently treat those affected by and address the complex relationship between the opioid addiction epidemic, the mental health crisis, and the significant increase in hepatitis transmission. To fund this program, NJRC requests a funding allocation of $4.021 million.

The Opioid/Fentanyl Crisis

I. Burgeoning Crisis

Addiction to opioids, particularly fentanyl, has significantly increased in recent years in the State of New Jersey. Over the course of six years, from 2015 to 2020, over 15,314 individuals died

---

[1] NJRC, *Program Data*.
[2] Ibid.

due to drug overdoses. Of these 15,314 deaths, 9,491 of them were due to fentanyl, a synthetic opioid that is approximately 50 to 100 times more potent than morphine. Even worse and more significant, fentanyl as a cause of death has played an increasingly higher proportion among drug overdoses. In 2015, 26.28% of drug deaths were due to fentanyl, yet, in 2020, that percentage was 81.99%.[3]

New Jersey suffered 2,849 total overdose deaths in 2022[4] – an increase of 80 percent from 2015.[5] In 2019, opioid overdose death comprised 3.97 percent of total opioid related deaths nationally, and opioid overdose death rate per 100,000 in NJ was 1.46 times higher than the national rate.[6] Not only has this epidemic caused significant death throughout the United States but it has been particularly pronounced in our state. Provisional data from the **CDC reports that New Jersey had the highest annual percentage increase in overdose deaths in the nation** as of November 2017,[7] and from January 2017 to January 2018, annual counts of overdose deaths increased by a projected 21.1 percent, compared to an overall national increase of only 6.6 percent.[8]

Particularly impacted by the opioid/fentanyl crisis is the incarcerated population of which approximately **75 percent** is addicted[9] and upwards of **25 percent** are addicted to fentanyl/heroin.[10] Upon release, the risk of overdose death for the previously incarcerated is approximately **130 times greater** than that of the general population. Many reentry clients die within weeks of re-joining the community.[11] As highly-potent synthetic opioids such as fentanyl increasingly penetrate the heroin supply, the risk will likely climb further.

II. Surging Growth and Opioid Overdose Deaths in Communities of Color

According to the New York Times,[12] the heroin/fentanyl epidemic made striking inroads among African-Americans and Latinos last year— particularly in urban counties where fentanyl has become widespread.

According to the Department of Law & Public Safety of New Jersey, Blacks and Hispanics together accounted for about 22 percent of drug overdose deaths in the state. By 2021, this percentage rose to approximately 40 percent.[13] Not only has the total number of overdose deaths risen steeply in recent years, but this opioid epidemic has increasingly affected communities of color. While the overall

---

[3] Office of the Chief Medical Examiner of New Jersey, accessed September 2022, https://ocsme.nj.gov/Dashboard?_gl=1*14kpfj0*_ga*MjI1OTU1MDQ1LjE2NjI0NzUxMjg.*_ga_5PWJJG6642*MTY2MjQ3NTEyOC4xLjAuMTY2MjQ3NTEyOC4wLjAuMA.
[4] Ibid.
[5] Ibid.
[6] amfAR, "Opioid and Health Indicators Database." amfAR. 2022.
[7] Serrano, 2018.
[8] CDC, 2018.
[9] GCADA, 2014.
[10] Rich, J. & Satel, S. "Access to Maintenance Medications for Opioid Addiction is Expanding." Slate. 8 May 2018.
[11] World Health Organization, "Preventing overdose deaths in the criminal-justice system." WHO. 2014.
[12] Goodnough, Abby and Katz, Josh. The Opioid Crisis is Getting Worse, Particularly for Black Americans. The New York Times. 2017. Accessed November 13, 2018. https://www.nytimes.com/interactive/2017/12/22/upshot/opioid-deaths-are-spreading-rapidly-into-blackamerica.html.
[13] "The Opioid Epidemic's Impact on Communities of Color," https://www.nj.gov/oag/njcares/databyrace/Drug-Related%20Death%20Data.pdf.

death toll is higher for whites, the death rate is increasing faster for Latinos and African-Americans, according to data from the Centers for Disease Control and Prevention. **Latino fatalities increased 52.5 percent between 2014 and 2016** as compared to 45.8 percent for whites.[14] (Statisticians say counts for Hispanics are typically underestimated by 3 to 5 percent.).[14] **The most substantial increase of opioid addition deaths was among African-Americans — 83.9 percent**,[15] with statistics revealing that the drug death rate is rising most steeply among African-Americans between the ages of 45 and 64.[16]

According to a 2018 landmark study sponsored by Howard University Hospital and College of Medicine, entitled *The Effects of Opioid Addiction on the Black Community*,[17] the opioid epidemic has severely impacted local communities of color. National and state data demonstrates the opioid/fentanyl epidemic has irreparably harmed African-American youth.[18] Indeed, the opioid/fentanyl crisis is the leading cause of death among minority races of the American population, surpassing heart disease.[19]

Across all demographic groups, fentanyl has caused a huge spike in overdose deaths in New Jersey in just the last year. Evidently, addiction to opioids has not abated and the rate of opioid death continues to increase.

III. Inability to Access Medication Assisted Treatment by Indigent Communities of Color

State and national health experts contend the worsening nature of the crisis[20] suggests that progress against it will be slow. Access to medication-assisted treatment and naloxone, which can save people who have overdosed, is crucial. With New Jersey having the highest racial disparity in the nation, more than twice the national average at 12.2 to 1,[21] persons being released from incarceration are disproportionately African-American and Latino. As overdose deaths keep climbing, there is a good chance that life expectancy will be found to have declined again this year, said Robert Anderson, chief of the mortality statistics branch of the National Center for Health Statistics.[22]

An important distinction is that while 62 percent of persons benefitting from addiction treatment programs administered by the New Jersey Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) are Caucasian, in sharp contrast 62 percent of persons entering the jurisdiction of the New Jersey Department of Corrections are persons of color. While DMHAS and Drug Court provide for disproportionate treatment opportunities to the majority

---

[14] Bebinger, Martha. What Explains The Rising Overdose Rate Among Latinos? National Public Radio. 2018. Accessed November 13, 2018. https://www.npr.org/sections/health-shots/2018/05/16/609814648/what-explains-the-rising-overdose-rate-among-latinos.
[15] Ibid.
[16] Goodnough and Katz.
[17] Griffith, Clairmont, La France, Bernice, Bacchus, Clayton, and Ortega, Gezzer. The Effects of Opioid Addiction in the Black Community. Howard University Hospital and Howard University College of Medicine, Washington, US. International Journal of Collaborative Research on Internal Medicine & Public Health. Vol. 10 No. 2. 2018. Accessed November 13, 2018. http://internalmedicine.imedpub.com/The-effects-ofopioid-addiction-on-the-black-community.pdf
[18] Ibid.
[19] Ibid.
[20] Katz, Josh. Short Answers To Hard Questions About The Opioid Crisis. The New York Times. 2017. Accessed November 13, 2018. https://www.nytimes.com/interactive/2017/08/03/upshot/opioid-drug-overdose-epidemic.html.
[21] Nellis, A. The Color of Justice: Racial and Ethnic Disparity in State Prisons. The Sentencing Project. 2016.
[22] Goodnough and Katz.

population, the New Jersey Department of Corrections only provides for treatment for a mere five (5) percent of their addicted population. The inequities of treatment access are exacerbated because indigent African-Americans and Latinos, particularly the formally incarcerated population, cannot access Medication Assisted Treatment (MAT) for three reasons: (1) more **than eight out of ten (8/10) men and nine out of ten (9/10) women of New Jersey's formerly incarcerated have chronic medical conditions**,[23] which are not treated, thereby complicating treatment protocols; (2) 67 percent of the formerly incarcerated have no health insurance eight (8) months after release and are therefore **ineligible for any Medicaid addiction treatment** access;[24] and (3) only 56 of the 244 fee for service (FFS) treatment providers offer any form of MAT.[25]

IV. Hepatitis B and C

Currently, 13,000 individuals are incarcerated in New Jersey state prisons. Studies suggest that as many as four of every five incarcerated individuals have been diagnosed with Substance Use Disorder (SUD), putting them at higher risk of hepatitis B (HBV) and C (HCV) than the general population. HBV and HCV are chronic viral infections which can lead to cirrhosis and liver cancer and can be easily prevented and treated. HCV is now curable in 8-12 weeks and thus it is imperative to diagnose and cure those infected to stop the ongoing spread amongst high risk individuals. The opioid epidemic has been responsible for ongoing acute HBV and HCV cases in the US and focused approaches to these syndemics are important.

In the United States, between 12 and 35 percent of inmates tested positive for Hepatitis C, as compared to only 1.3 percent among non-incarcerated individuals.[26] As hepatitis B and C are transmitted through blood, drug users are at significantly higher risk of contraction due to the sharing of needles and other drug preparation equipment. A study found that each individual that injects a substance with infected equipment is likely to transmit Hepatitis C to approximately 20 others.[27] In another study within Rhode Island prisons, for example, 20 percent of incoming inmates tested positive for Hepatitis B, signifying the disparity in transmission when compared to the general population, with only five percent of the general public testing positive.[28]

The elevated risk of contraction in prisons furthers the need for Hepatitis B and C screening as a routine aspect of entrance into the New Jersey Department of Corrections (NJDOC). The Center for Disease Control and Prevention (CDC) reports that about 2 in 3 people with Hepatitis B and 50 percent of those with Hepatitis C are unaware that they are infected. Failing to screen inmates results in a serious and costly public health problem, as untreated hepatitis may advance to cirrhosis and liver cancer which can necessitate frequent hospitalizations, procedures, and liver transplant. The CDC's best practices are to test all current and former drug users.

---

[23] Mallik-Kane, K. & Visher, C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. The Urban Institute. 2008.
[24] Ibid.
[25] Curtis, Kaya, Forkey, Katie, Reynolds, Will. 3 Waves of the Rise in Opioid Overdose Deaths. New Jersey Opioid Addiction Report: A Modern Plague. 2018; 9. Accessed November 13, 2018. http://njreentry.org/wp-content/uploads/2018/09/Published_9_24.pdf.
[26] Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings. 2003. *Morbidity and Mortality Weekly Report*. The Center for Disease Control and Prevention.
[27] Viral Hepatitis—A Very Real Consequence of Substance Use. National Institute on Drug Abuse.
[28] Hepatitis B Transmission in Prisons: sharing needles, sex, mother-to-child, vaccine for prevention. 2004. *National AIDS Treatment Advocacy Project*.

The CDC has documented a link between the contraction of the Hepatitis B virus (HBV) and human immunodeficiency virus (HIV). As both viruses share modes of transmission, individuals at high risk of contracting HBV are also at a high risk of contracting HIV. Additionally, individuals with HIV that also become infected with HBV are more likely to have HBV advance to a chronic infection.[29] Serious complications are common among those with a coinfection of HIV and HBV, including elevated risks of liver-related morbidity and mortality.[30] A link also exists between HIV and Hepatitis C (HCV). Between 62 and 80 percent of drug users who are HIV-positive also tested positive for HCV.[31]

The New Jersey Department of Corrections does not routinely test individuals for Hepatitis B or C as a part of its intake process. However, the **CDC recommends testing for hepatitis B and C upon entry for all individuals upon entry into correctional and detention facilities and vaccinating all for hepatitis B**.[32][33] The Federal Bureau of Prisons in 2018 has recommended opt-out testing upon entrance into the Department of Corrections.[34] Early prevention and treatment has shown to be cost-effective and reduces transmission and incident of advanced liver disease.[35] New York[36] and Pennsylvania[37] have implemented routine opt-out testing measures in its correctional facilities. The U.S. Preventive Services Task Force, the leading group in setting health policies in the United States, recommends people in jail or prisons be tested as well.

V. Addiction and Mental Health

Many people who are addicted to opioids also have mental illness. According to the National Survey on Drug Use and Health, from 2015-2016, approximately 62 percent of the more than two million individuals who had an OUD also had a co-occurring mental illness and about 24 percent had a

[29] Gatanaga H, Yasuoka A, Kilkuchi Y, et al. Influence of prior HIV-1 infection on the development of chronic Hepatitis B infection. Eur J Clin Microbiol Infect Dis. 2000 Mar;19(3):237-9.
[30] Thio CL, Seaberg EC, Skolasky R, et al. Multicenter AIDS Cohort Study. HIV-1, hepatitis B virus, and risk of liver-related mortality in the Multicenter Cohort Study (MACS). Lancet. 2002 Dec;360(9349):1921-6.
[31] Yehia BR, Herati RS, Fleishman JA, Gallant JE, Agwu AL, Berry SA, et al. (2014) Hepatitis C Virus Testing in Adults Living with HIV: A Need for Improved Screening Efforts. PloS ONE 9(7):e102766. https://doi.org/10.1371/journal.pone.0102766
[32] Center for Disease Control and Prevention. “Testing, Vaccination, and Treatment for HIV, Viral Hepatitis, TB, and STIs.” Accessed 9/28/2022.
[33] Center for Disease Control and Prevention. “Sexually Transmitted Infections Treatment Guidelines, 2021, Persons in Correctional Facilities.” https://www.cdc.gov/std/treatment-guidelines/correctional.htm#:~:text=All%20persons%20housed%20in%20juvenile,specific%2Fhepb.html.
[34] Federal Bureau of Prisons. *Preventive Health Care Screening*. June 2018. Federal Bureau of Prisons, Clinical Guidance.
[35] He T, Li K, Roberts MS, Spaulding AC, Ayer T, Grefenstette JJ, et al. Prevention of Hepatitis C by Screening and Treatment in U.S. Prisons. Ann Intern Med. 2016;164(2):84-92.
[36] Akiyama, M. J., Kaba, F., Rosner, Z., Alper, H., Holzman, R. S., & MacDonald, R. (2016). Hepatitis C Screening of the “Birth Cohort” (Born 1945-1965) and Young Inmates of New York City Jails. *American Journal of Public Health*, 106(7), 1276-1277. doi:10.2105/AJPH.2016.303163
[37] Larney, S. Mahowald, M.K., Scharff, N. Flanigan, T. P., Beckwith, C. G., & Zaller, N. D. (2014). Epidemiology of hepatitis C virus in Pennsylvania state prisons, 2004-2012: limitations of 1945-1965 birth cohort screening in correctional settings. *American Journal of Public Health*, 104(6), e69-e74. doi: 10.2105/AJPH.2014.301943

serious mental illness.[38] Yet, despite such high figures, only between 24 and 29.6 percent received treatment.[39]

Mental illness, especially when not diagnosed, can exacerbate the detrimental effects of opioid addiction. It is thus an imperative that those who have OUD receive mental health treatment when needed.

VI. The New Jersey Reentry Corporation for Opioid Use Disorder, MAT/Mental Health/Hepatitis Treatment Pilot Initiative

In order to address the opioid epidemic, which has become the defining public health crisis of our time, the New Jersey Reentry Corporation (NJRC) is proposing a pilot initiative, based in the eight reentry sites, to provide access to Opioid Use Disorder (OUD) treatment and Medication Assisted Treatment (MAT) to clients and local populations.

NJRC currently serves **14,613** clients, of which **78 percent** are addicted.[40] New Jersey Reentry Corporation is requesting $1,340,640 for each of three years, totaling $4,021,920, from the State opioid funds to provide for MAT induction and maintenance, mental health screening, intensive outpatient treatment, and the screening and treatment of Hepatitis B and C. The funds would be used to staff an OUD Healthcare Administrator, three Licensed Physician's Assistants—which is necessary to monitor the compliance with MAT "best practices"—and nine Licensed RN navigators for each of our nine sites, who will work in cooperation with local Federally Qualified Health Centers (FQHC) and in conjunction with NJRC case managers and participants.

VII. MAT-Based Treatment Model

Through partnership with local hospitals across the state, the program will provide addiction screening and personalized treatment plans including high-intensity MAT. Upon entrance into the program, patients will receive a needs-based screening and the development of a personalized treatment plan. All forms of MAT will be offered and provided according to the needs of each individual. Where needed, patients will be enrolled in a residential program lasting at least fourteen days. Upon release from residential treatment, program participants will be assigned an NJRC navigator based at the proximate NJRC reentry site, and MAT will be maintained on an outpatient basis.

VIII. NJRC Navigators

Integral to the program will be NJRC navigators. NJRC Navigators will work with participants on an individual basis to design, modify, and implement a treatment plan for co-occurring illnesses and to maintain continuity of care. In addition to connecting participants to service providers, NJRC navigators will make home visits and accompany participants to doctor's appointments as needed, in order to facilitate long-term self-sufficiency and to prevent costly emergency room visits and hospitalizations.

---

[38] Jones, C. M., McCance-Katz, E. F. "Co-occurring substance use and mental disorders among adults with opioid use disorder." Drug Alcohol Depend. 2019 Ap 1;197:78-82. doi: 10.1016/j.drugalcdep.2018.12.030.Epub 2019 Feb 14.

[39] Ibid.

[40] NJ Reentry Program Data.

IX. New Jersey Reentry Corporation Medical/Mental Health/Behavioral Pilot Initiative Budget

Expenses:

Program Staffing/Support

OUD Healthcare Administrator* @ 40 hours per week ($40.86 per hour) plus fringe (28% on average or $23,000 per year) for support of proposed initiative only	$108,000
Three (3) Licensed Physician's Assistants* @ 40 hours per week ($50.48 per hour) plus fringe (28% on average or $29,400 per year) for support of proposed initiative only	$403,200
Nine (9) Licensed RN Navigators* @ 40 hours per week ($34.61 per hour) plus fringe (28% on average or $20,160 per year) for support of proposed program only	$829,440
Budget per year	**$1,340,640**
Total Budget	**$4,021,920**

* The OUD Healthcare Administrator will track and evaluate the program, maintain and expand NJRC partnerships with Federally Qualified Health Centers (FQHC) as well as in and out patient addiction treatment facilities to ensure clients receive addiction treatment and a continuum of care based on individual needs, provide recommendations for improvement, create final report, and document the impact of the pilot program.
* The Licensed Physician's Assistant (LPA) will evaluate and monitor clinical needs of patients, monitor the compliance with medication assisted treatment (MAT) "best practices," and work closely with the MD and LRNN to track and evaluate the pilot program and provide recommendations for improvement.

* The Licensed RN Navigator (LRNN) will work with patients individually to coordinate and implement a personalized treatment plan and to ensure continuum of care standards are met and maintained, develop a relationship with patients and their support system, monitor patient progress made during the period of intensive treatment through collaboration with the health care providers in the program, and work closely with the MD and LPA to track and evaluate the pilot program and provide recommendations for improvement.

Corvino Foundation Inc. Proposal

Our Foundation was founding for the sole purpose to help individuals leaving treatment with a bridge into Recovery Housing and to help build a stable foundation through the first 6 months of recovery.

Originally, we started the Foundation because we lost my brother to liver failure due to his excessive addiction to drugs and alcohol. I myself have 18 years in recovery and wanted to give back to those in a similar situation to what my brother was facing. We established the Foundation in March of 2020, during the pandemic and took the time to find the holes in the recovery community that were being under represented. After meeting with a number of treatment centers, halfway houses and recovery houses we realized that the recovery house system was a mess. They received no support from the state, a class F license had just been established, but that only focused on the condition of the recovery house itself and some of the houses were fleecing the tenants trying to build back their life.

Our first step was to partner with a larger non-profit to help us facilitate and administer the scholarship so we didn't have to spend a lot of time and money on structure. We partnered with a non-profit outside of the state of NJ, the Herren Project, so we didn't have any bias toward the scholarship program. We then met with different treatment centers and halfway houses to build a partnership so we could receive candidates that were in need of the scholarship and those individuals would be vetted by the partner. The next step was to put together a network of recovery houses that met our rental assistance budget and met our structural requirements. They needed to have drug testing, a 12-step minded recovery, a step-up program and waive any intake fee for new residents. We currently have 18 recovery houses in our network to place individuals on scholarship.

Once the structure was put together, we started looking for "Peer Certified Recovery Specialists" in the state that were licensed to become our Recovery Coaches. Currently we have 4 recovery coaches, 2 men and 2 women, who are 1099's through the Herren Project and we pay $20 hr. to provide support to the individuals on scholarship. They will work with their assigned scholars for 14 hrs. over 6 months.

The rental assistance is paid directly to the Recovery House through the Herren Project and each house receives $200 per week no matter what they charge the residence per week. The extra money left over from our payment can be used by the Recovery House however they see fit. In order to fall within our network, we have to vet the recovery house and they need to supply us with a w-9 for tax purposes.

Scholarship Structure

We receive an application, signed recovery coach agreement and a personal statement from the candidate stating why the need the scholarship and how it can help them with their recovery. We work with a case manager at the partner facility bringing forward the candidate for scholarship consideration.

- Rental assistance is for 7-weeks
- The Corvino Foundation pays the first month in full. ($800)
- Week-5 the Corvino Foundation pays 75% ($150) and scholar pays 25% ($50)
- Week-6 the Corvino Foundation pays 50% ($100) and scholar pays 50% ($100)
- Week-7 the Corvino Foundation pays 25% ($50) and scholar pays 75% ($150)

- The idea is that the scholar gradually gets use to paying their own rent and budgeting properly until they pay the entire cost of the rent in week-8.

This gives the scholar a bridge out of treatment, a safe house free of temptation and an opportunity to find a job that will help them to pay their rent and starting building back their life. The commitment made by the Recovery Houses to waive the intake fee allows the scholar to be whole at the end of 7-weeks with no debt hanging over their head moving forward.

The most important part of the scholarship is our group of Recovery Coaches. We pay what we pay because we need a solid group of coaches, with professional experience, but more important an experience in their own recovery from addiction. They also benefit from coaching by receiving some extra money to help themselves and families, but they also get the opportunity to remember the pain and fear associated with early recovery. Which helps them to stay sober and continue to achieve their goals.

Over the past 3 years our footprint has grown. 2021 we awarded 20 scholarships, with 17 of those scholars completing the 7-weeks of rental assistance and moving toward changing their lives. In 2022 we added the additional phases to extend recovery coaching over 6 months and have awarded 35 scholarships. Our results were similar to 2021 with 5 individuals not completing the 7-weeks and a few scholarships having to be halted due to not meeting our requirement or the recovery house requirements.

Budget

Each scholarship costs us a total of approx. $1716

- That pays for rental assistance
- Pays the Recovery Coaches $20 hr. over 14 hrs.
- 20% goes to the Herren Project for administration fees
- $50 is added to a client fund for misalliance items (phone card, bike, etc.)

2020/2021 Scholarship Budget

Corvino Family Donated: $66,671

Smaller Donors: $6,000.59

Grant to Herren Project: $51,480

- We awarded 20 scholarships for 2020/2021 from December 2020 through December 2021

2022 Scholarship Budget

Budget Carry Over: $12,510

Corvino Family Donation: $51,058

Total Grant available w/ Herren Project: $63,568

- We awarded 35 scholarships till October 2nd, 2022, having to pause the program till January 2023 due to lack of funding.

Our Foundation has successfully been able to assist 55 individuals over the last 2 years with a scholarship and 80% of the scholars have completed the 7-weeks of rental assistance, including the requirements in place for recovery coaching. We not only assist the scholars, but are also an advocate for the recovery house community and a support system for our recovery coaches. We will continue to make an impact for years to come, but we are fighting to build revenue for the Foundation so a pause in our program doesn't need to happen again. Because we are primarily a family funded Foundation, we have decided to not run typical fundraising events, since we don't want to take funds away from another recovery non-profit who needs them in order to survive. The Corvino Family has made strategic investment in small business as a way to generate revenue to continue our mission, including targeting donors with the resources to help us grow and hopefully become sustainable.

We would like some of the money awarded to the State of NJ to be used in a grant that could help us and other non-profits in the recovery community to be sustainable and allow us to really focus on improving our mission of helping addicts recovery and prosper in their new life.

Recommendations for the Allocation of Opioid Settlement Dollars

An influx of new funding resulting from several large settlements related to the opioid epidemic presents a unique opportunity for investments that will have a substantive impact in turning the tide of the addiction epidemic here in New Jersey. Settlement dollars are not subject to the same restrictions that federal and state grant dollars must comply with and can, therefore, be used to address previously unmet needs. Equally important to how these dollars are expended is the inclusion of those most impacted by the opioid epidemic in the decision-making process. People who use drugs, individuals in recovery, and families who have lost loved ones to overdose death must be adequately represented and empowered in determining funding allocations.

The New Jersey Coalition for Addiction Recovery Support (NJ-CARS), New Jersey's statewide recovery community organization, urges key decision makers overseeing the allocation of opioid settlement dollars to ensure that these funds address dire needs in the addiction recovery service structure, specifically:

Harm Reduction:

Bold investment in evidence-based harm reduction services, training, and infrastructure development. This includes the expansion of the Department of Health's Harm Reduction Center (also known as syringe access program) program to 21 counties; pilot programs to introduce overdose prevention sites (also known as safe use sites) to New Jersey, following the model of New York City; and expanded availability of naloxone and fentanyl testing strips to people who use drugs, their friends and family, and community providers.

Funding Equity:

Enhancing existing funding and creating new funding mechanisms that ensure communities most impacted by the overdose epidemic and war on drugs are adequately funded. Additionally, because small recovery community organizations and community leaders often do not have the ability to compete for grant funding, microgrant programs that allow organizations with adequate capacity to administer smaller grants to organizations lacking such capacity should be established for community based recovery support, engagement, and harm reduction services.

Recovery Infrastructure Development:

Infrastructure development and improvement initiatives that increase recovery capital in the built environment. Major funding streams like the Substance Abuse Prevention and Treatment (SAPT) block grant preclude brick and mortar investments, e.g., facility improvements for substance use disorder treatment and community recovery service settings, investments in new construction for recovery residences, community peer recovery centers, and other facilities that will free up block grant and other existing funding streams for programmatic expenses. At the same time, funding should also support existing recovery residence programs and community peer recovery organizations and centers to operate more efficiently and equitably. Ultimately, using funds to support community building initiatives to support infrastructure improvement, stabilization, and rehabilitation of proactive recovery groundwork substructures would help make communities decimated by the opioid overdose crisis whole again.

https://nj-cars.org @NJrecovery Cindymarie Dix (she/her) | cdix@preventionlinks.org

The Community Hub
9 Church Street
Bernardsville, NJ 07924

28-OCT-2022

Opioid Funds Proposal c/o
PO Box 001
Trenton, NJ 08625

Dear Governor Murphy, and Esteemed Members of the Opioid Recovery and Remediation Advisory Council,

Thank you for initiating this portal for soliciting crucial public input and proposals that are needed to identify effective mechanisms to utilize the State funding that NJ receives from opioid settlements. Community in Crisis is a NJ non-profit organization engaged in the recovery support, prevention, and education of individuals with or affected by substance use and co-occurring mental health disorders.

Community is the grateful recipient of the DMHAS grant to establish the Community Peer Recovery Center (CPRC) for Somerset County that places our peers on the front-line working closely with people that use substances, people in recovery, and the families affected by it. This extraordinary peer-based mission provides us with a unique perspective in identifying gaps in the current NJ system because we live it, and assist others with it, every day.

Our Community Peer Recovery Center focuses on the four dimensions of recovery; health, home, purpose, and community, for which individuals will improve their well-being, live self-directed lives and reach their full potential. The proposed Recovery Friendly Workplace initiative is aligned with this effort that directly benefits persons in recovery maintaining or reentering employment, businesses adding or retaining employees, and delivering multiple dividends to the greater community of Somerset County.

Thank you for your kind consideration.

For additional information, please contact:

David Martinak, Advocate Email: dmartinak@communityincrisis.org / Tel: 908.801.1060
Ken Musgrove, Director Email: kmusgrove@communityincrisis.org / Tel: 908.801.4243

RECOVERY FRIENDLY WORKPLACE FOR SOMERSET COUNTY

Proposal Goal:
Initiate and execute a Recovery Friendly Workplace (*RFW*) initiative throughout Somerset County. Recovery friendly workplaces are businesses of any type or size committed to making foundational change in the way they hire, treat, retain, and support employees living in or seeking recovery from substance use and mental health disorders. Another objective of the RFW initiative is to foster entrepreneurialism within the recovery community through collaboration with stakeholders, resources, and community partners. The Community Peer Recovery Center of Somerset County will develop *RFW* training, evaluation, and implementation roadmap for businesses to introduce *RFW* practices into their respective workplaces that benefit both employee and employer.

Total Funding Amount & Timeline of Expenditure:
A total budget of $560,125 is anticipated over a five-year period (see attached budget) with the possibility of extension based on the success of the initiative. The first-year expenditures ($104,705) will be weighted towards the *RFW* program development, and the subsequent years ($113,855) weighted more heavily with the *RWF* implementation throughout the county businesses.

Target Population Served:
This *RFW* program is intended to serve the estimated 30,000 Somerset County residents that currently have a substance use and co-occurring mental health disorder and thousands more that have been affected or are already living in long-term recovery. Also, this *RFW* program will serve the 10,000 county businesses with a labor force of 200,000 engaged in widely diverse industries. Initially, the *RFW* will target the sectors with the highest incidence of substance use and sectors of likely workforce re-entry.

Summary of Initiative:
The Recovery Friendly Workplace (*RFW*) is an evidence-based initiative, of the Somerset County Community Peer Recovery Center, that challenges stigma, empowers employees, and designs workplaces to provide support for employees in recovery and all those impacted by substance use and co-occurring mental health disorders. A *RFW* strengthens the employer and employee by addressing workplace factors that support recovery maintenance and educating leadership about the link between recovery, well-being, and performance. The *RFW* staff will be entirely comprised of Peer Recovery professionals with lived experience in multiple pathways of recovery.

Employer Benefits include:

- Employee retention & employee satisfaction
- Improved attendance & punctuality
- Increased productivity and creativity
- Reduced health care cost through improved safety, health & wellness
- Enhanced workplace culture, policies, practices, EAPs & stigma reduction
- Improved community connection & public relations
- Net positive return-on-investment

The Community Hub
9 Church Street
Bernardsville, NJ 07924

Program Review:
RFW primary data such as number of participating organizations, total employees, training, new hires, company *RFW* designations, evaluation data, will be collected and monitored. For individuals who choose to participate, data will be collected on a voluntary basis in the areas of client substance use, family living conditions, employment status, social connectedness, access to treatment, retention in treatment, criminal justice status, and effectiveness of activities related to diversity, inclusion, equity and cultural/linguistic competence.

BUDGET	YEAR 1			YEAR over YEAR (for 4 years)		
Recovery Friendly Workplace- Somerset County						
	RFW Personnel	**Labor**	**Materials**	**Personnel**	**Labor**	**Materials**
Progaram Development:						
Conduct Industry Research & Create RFW						
Roadmap; Create RFW Toolkit; Develop RFW	Prgm Mgr/Sr Traine	$25,500	$5,000	Prgm Mgr/Sr Traine	$8,500	$2,000
Training Materials; Develop Marketing Materials,						
Social Media Content & Press releases; Identify	CPRS /Jr Trainer	$7,875		CPRS /Jr Trainer	$5,625	
National, State, County resources & connections to						
Social Services; Advocate for RFW Programs,						
RFW Execution - Participanting Orgs						
Conduct outreach, target industires/orgs with	Prgm Mgr/Sr Traine	$21,250	$2,000	Prgm Mgr/Sr Traine	$34,000	$5,000
highest RFW utility; Conduct initial on-site internal						
interviews, evaluations; lock-in key internal	CPRS /Jr Trainer	$17,100		CPRS /Jr Trainer	$27,000	
stakeholders; Conduct RFW trainings on-site (or						
CPRC); Conduct annual assessment to sustain RFW						
Marketing Costs						
e-materials, Social Media content, advertising	Marketing Staff	$5,100	$10,000	Marketing Staff	$5,100	$8,000
Printed materials, advertising, press content,						
Travel Expenses & Supplies			$10,880			$18,630
TOTALS		**$76,825**	**$27,880**		**$80,225**	**$33,630**

Center for Health Services Research
Institute for Health
Rutgers, the State University of New Jersey
Submitted by: Stephen Crystal, Ph.D., Board of Governors Professor of Health Services Research

Recommendations for NJ Opioid Settlement

The epidemic of opioid overdoses in New Jersey is a complex phenomenon that calls for a new and increased level of effort and collaboration across the state to develop more-effective solutions, track the evolving forms of the epidemic and the effectiveness of current and new initiatives to reduce overdoses, and create improved information systems to target interventions, including those funded through settlement funds. The Center for Health Services Research at Rutgers, which I lead, has been intensely involved over recent years in studying the overdose problem in New Jersey and nationally, and assessing the effectiveness of alternative strategies for reducing the unacceptable levels of overdose. Based on this research, we would like to make the following broad recommendation for use of settlement funds:

The State of New Jersey should devote a small fraction of its new investments from Settlement Funds to health services research that will more effectively utilize data to better inform intervention, evaluate the effectiveness of Settlement-funded programs on an ongoing basis, and support quality and outcome measurement for measurement-driven quality improvement and development of more-effective interventions. A partnership between state health agencies and health services researchers at Rutgers has the potential to assure more-effective use of resources through settlement funds as well as existing programs such as Medicaid. The Rutgers Center for Health Services Research is eager to extend existing partnerships in order to support more effective use of data and an improved system of metrics that can better inform strategies to reduce overdoses and provide performance benchmarking.

State agencies have made important strides in gradually improving the use of data and supporting one-off program evaluations, but further improvement in the use of data would greatly benefit from a sustained, stably supported partnership between researchers at Rutgers, the State University, and our home state. As we have learned in multiple studies supported by the National Institute of Drug Abuse, the FORE Foundation, Pew Trusts, and other research funders, assessing which interventions are most effective is a complex, methodologically challenging task that requires considerable analytic expertise, sustained researcher-policymaker partnership, addressing difficult statistical and measurement issues, linkage across multiple datasets held by different state and federal agencies, and the skills of highly expert data analysts.

Data currently held by various state and federal agencies, including Medicaid claims, state death and birth data, universal billing data for hospital and ED services, provider data on the location of services, state police data on drug seizures, Medicare data for elderly and disabled individuals, insurance data on the privately-insured, and many other existing data sources, when linked together, have the potential to inform opioid response efforts in a much more effective manner. However, these data are currently scattered in multiple data “silos” and we lack, in New Jersey, a sustained, integrated system to support linkage and analysis of these data on an ongoing basis, and their integration into a coherent system of metrics and outcome measures.

We provide below some examples of the type of work that should be supported through Settlement funds as a sustained resource to better target opioid response efforts and overdose prevention across the state. These are, however, only illustrative. We would be happy to provide more-specific proposals for the scope, scale, and design of the proposed partnership and component studies. We can be reached at scrystal@rutgers.edu.

Some examples of the type of work that could help to transform NJ opioid response efforts, if supported on a sustained basis, include the following.

--development of a system of metrics for hospital and Medicaid health plan performance in engaging individuals with opioid use disorder, and those surviving overdoses, in life-saving treatment with medications for opioid use disorder; identification and spread of best practices in emergency treatment of overdoses, such as buprenorphine initiation in the ED setting.

--continuously updated chartbooks of overdose patterns, including both fatal and non-fatal overdoses.

----cost-effectiveness analyses that identify costs of acute treatment for overdoses, neonatal abstinence syndrome, infections (e.g. endocarditis) and other opioid-related acute events, and potential cost offsets for initiatives to expand access to MOUD.

--rigorous outcome evaluations of new services funded by Settlement funds.

--sustained support for technical assistance to NJ health agencies in more-effective utilization of data for quality and outcome measurement.

--development of accountability metrics for Medicaid health plans to assure accountability for network adequacy of opioid use disorder treatment capacity and treatment engagement of at-risk populations.

--a study of access to OUD treatment during the perinatal period, and outcomes for children who are prenatally exposed to opioids, with recommendations for improving outcomes.

--analyses of opportunities for improving access and outcomes through optimal use of tele-health strategies.

--assessment of existing practices in methadone maintenance treatment (e.g., policies on take-homes), impact of the methadone maintenance take-home policy changes during the public health emergency, and impact of tele-health flexibilities during this period for MOUD access and outcomes.

--analysis of adequacy and quality of supply of providers for office-based addiction treatment, and strategies for improving navigation services

--analysis of effective practices in integration of OUD treatment with primary health care in other states with recommendations for care integration in NJ through Medicaid and other programs.

--assessment of health plan barriers to access to OUD treatment.

--assessment of access to medications for opioid use disorder in residential care for opioid use disorder.

--linkage of treatment, overdose and mortality data for individuals released from prison, to identify overdose risk and effectiveness of interventions, including pre-release medications for opioid use disorder and peer navigation, to reduce risk.

We look forward to the opportunity to discuss the potential for a sustained health services research partnership between Rutgers and state university opioid use disorder health services researchers, as part of a renewed collaboration to reduce opioid overdoses in the state through data-informed strategies. We welcome the opportunity to share further information on partnership opportunities for improved use of data in New Jersey to fight the epidemic of opioid overdoses. We would be happy to work with state personnel on specific resource requirements, deliverables and timetables. Optimally, an investment of $500,000 per year would support a robust and sustained data integration support initiative.

I am writing as a resident of NJ and Director of Policy at Salvation and Social Justice (SandSJ) where for years we have worked with directly impacted communities to address the War on Drugs and the destructive effects of its punitive policies on Black communities. SandSJ's advocacy in this space is largely connected with the issue of reparative justice, which involves significant community investments to repair the harms committed. We at SandSJ encourage NJ to invest opioid settlement monies towards the following:

- *violence interruption, harm reduction and restorative justice hubs as an effective and preventative mechanism to keep residents safe and interrupt the racial disparities within the carceral system. Specifically, an $80 million investment in restorative justice hub pilot programs and violence interruption work over the next three years. These investments would offer wrap around services for at risk youth in target cities and reduce initial and repeat contact with the youth justice system, programs should have consistent funding, and should not have to reapply for funding each year. Investments should continue to support the establishment of critical harm reductions centers.*
- *$20 million investment in community led first response pilot programs throughout ten pilot cities. These community led first response teams would serve as an alternative to law enforcement response for nonviolent, substance use, behavioral and mental health calls. In previous years, the state's police budget has far exceeded that of the Dept of Health, informing the state's approach to substance use calls and further criminalizing what is a public health issue. Investment in these pilots would be an investment in healthier and safer NJ communities.*
- *$75 million towards neighborhood maternal health centers in cities experiencing a birthing desert. Funding supports preventative, perinatal and postpartum care; addresses needs of pregnant women with opioid or substance use disorder; and advances the quality of services provided to improve health outcomes and reduce maternal morbidity. The decades long war on drugs have adversely affected Black families, and in a state where Black women are 7 times more likely than white women to die before or after giving birth due to racism and bias at hospitals and clinics it is critical that significant investments be made to ensure that Black mothers are receiving quality, necessary and lifesaving medical services.*

Thank you .

Sea Change

Recovery Community Organization

Mission: Envisioning and operationalizing the intersection of community-based recovery services and advocacy/organizing for systems change.

Proposal created by Elizabeth Burke Beaty, CPRS, CPLC

"When We Fight, We Win"

-Greg Jobin-Leeds

WHAT:

In New Jersey we are creating a power model to normalize harm reduction. This model has been established by Sea Change Recovery Community Organization. We are finding a unique intersection between successful boots on the ground services and advocacy to build power to move the needle on normalizing harm reduction.

WHY:

Imagine a world where we have what we need to overcome our challenges, where we can get and stay well. Life is hard. We all struggle with something and for many this includes substance use disorder. Too many people are dying because they are not getting the compassion they deserve or the proper care in keeping them alive. We believe that all people who use substances deserve to live productive, happy lives.

Too many wonderful, brave, strong people are keeping their stories a secret due to the stigma and shame. And too many are dying because of stigma and lack of education and care. These people must be seen and heard, not judged or "othered." They deserve to be empowered. This is a moment when we must overcome our squeamishness with difficult topics, come together, and move forward in a new way. Too often there is no room for these conversations in our wider public discourse, so we must rise up. We must take action. We must move the needle to normalize harm reduction.

HOW + WHEN

Through our core values we harness the power of grassroots organization to mainstream harm reduction and crush the stigma of substance use disorder.

CORE VALUES

1. True Harm Reduction
2. Co-Active Leadership
3. Activism
4. Openness
5. Collaboration
6. Dignity/Respect
7. Nurturing Environments
8. Power Sharing
9. Centering Affected Community Voices

10. Health
11. Human Rights
12. Access for All / Distributive Justice
13. Racial Justice

NEXT STEPS

STEP ONE:

Timeline > Sept 2022 - Sept 2023

- Free 1:1 support 24/7
- 8-10 support group meetings weekly (supporting all pathways of recovery and harm reduction)
- Regular recovery special events and physical activities (new healthy lifestyle support)
- New members monthly meeting
- Regular meetings with legislators
- Caucuses - The People's Action, Salvation and Social Justice - Rev. Boyer, Latino Action Network
- Continue to grow working relationships with affinity groups and community collaborations.

What's needed:

- Support existing services at SeaChangeRCO.org (website shows all services provided free of charge) - Crucial financial need (see budget) in order to maintain and build capacity (currently under-funded and growing)*
- As we build, track what works and what doesn't work - tracking via reg assessments to build out training programs for other RCO/ORG collabs.
- Build more infrastructure through 1;1s and research and build database

What's needed:

- Staffing
- General Operational Funding

* Sea Change RCO Financial Report and proposed buget

2021 (First “official” year)	Amount	
Income	10840.81	Fundraisers & donations
Expenses	1449.09	
Finished Year with:	**9391.72**	

2022 (Second year First Quarter)	Amount	
Income	10000.00	
Expenses	2803.53	
Current balance:	**16588.19**	

2022/2023 Budget

Expenses	**Amount**	
Salary CEO / Project Chair	$80,000	
COO	$50,000	
Fellowship stipend	$6,000	
Internship stipend	$2,000	
Rent	$15,000	
Contractor Fees	$4,800	
General Operating Expenses	$40,000	
Total Expenses	**$197,800**	
INCOME		
Carry over from 2021	$9,391	
NJRP Grant	$10,000	
Jetty Rock Foundation	$5,000	
Ocean County Cultural & Heritage Commission	$1,000	
Total Income	**$25,391**	
TOTAL ASK	**$200,000**	**To support all existing services and projected 2022 growth**

Angels in the air. Boots on the ground.

Angels in Motion (AIM) is a registered 501(c)(3) non-profit, volunteer organization that participates in street outreach and provides recovery support services to individuals that are experiencing homelessness and struggling with substance use disorders (SUD). AIM chooses to show love, compassion, and hope in our local communities. We believe in harm reduction and meeting individuals with SUD exactly where they are: in the community. One of our goals is to guide them into recovery, when they are ready. We offer clean supplies and Narcan, as well as first aid for wound care and infection control. AIM provides direct linkages to treatment facilities and offers recovery support services upon discharge. AIM operates without any paid staff or costs associated with a physical location. As a result, 100% of the funding we receive, which is all donation based, is provided directly to those we serve, allowing us to meet the challenges faced by those we help. Many of our volunteers also spend their own funds to provide whatever else is needed by the population we serve. Funding would aid in relieving the burden on the volunteers who give so much of their time and financial resources. Our goal is to increase the number of individuals we serve in the community. Assisting more people into treatment and recovery will lessen the number of overdoses in the community and decrease the number of individuals experiencing homelessness.

During our outreach efforts, we gain the trust of those with SUD and are there to listen to them, without judgement. We get to know many by name. However, there are always new faces and more people to serve. The lack of food and resources, as well as those with SUD not seeking medical assistance, is what makes our outreach important and valuable. Our staple outreach engagement tool is a blessing bag. Blessings bags are a perfect way to make that first contact and start building trust on the streets. Each bag contains snacks, drinks, handmade note of encouragement, and an AIM resource pamphlet with our phone numbers and resource information for shelter, social services, medical assistance, mental health treatment, crisis hotlines, and more. In 2021, AIM was able to create and distribute 15,000 blessing bags throughout South Jersey.

Our goal is to guide each person struggling into recovery when they are ready. In 2021, we provided sober living funding to 125 individuals to continue their journey of recovery in sober living housing. We get calls daily for sober living funding and continue to assist those seeking help with housing assistance, when funds are available. Living in a healthy recovery environment after treatment severely decreases risk for relapse and provides a better opportunity for ongoing success in sobriety. We also provided expedited transportation for 185 clients for admission appointments at rehab facilities through ride share services. Transportation continues to be a huge barrier for individuals with SUD, especially for those with Medicare and uninsured individuals. Hospital-based detoxication facilities that accept Medicare include Summit Oaks, Carrier Clinic, and New Bridge Medical Center. These facilities are in North Jersey and as gas prices continue to increase, we are facing extreme challenges: namely funds to continue providing transportation. The funding will allow AIM to continue its mission to serve the needs of our most vulnerable populations throughout our community.

AIM is requesting $1 million dollars in funds [to cover a period of three years] to continue our efforts decreasing the number of unnecessary overdose deaths in our communities and making a difference in the lives of those ready to begin their recovery journey. These funds would allow us to offer full time employment to our current volunteer team leaders, which includes a dually licensed clinician: Licensed Clinical Alcohol and Drug Counselor and Licensed Social Worker, Outreach Coordinator, and Certified Peer Recovery Specialist. Descriptions of the positions and salaries are found in the budget below, along with other expenses required for program efficiency.

Staffing Costs	License	Salary	Role
Program Director	Licensed Clinical Alcohol and Drug Counselor, Licensed Social Worker, Certified Trauma Professional	$85,000 per year	• Provide diagnosis and assessment for individuals seeking treatment to ensure they are linked to appropriate level of care • Provide supervision to staff • Provide outreach to individuals who are having difficulties in accepting services • Will be aware of the complex impact of trauma on a person's suffering and how it shapes a person's efforts to cope. • Utilize trauma informed approach to provide support, counseling and encouragement to individuals with co-occurring issues.
Certified Peer Recovery Specialist	Completion of peer recovery specialist certification	$50,000	• Walk side by side with individuals seeking recovery from substance use disorders, and meet them where they are to engage, build rapport and promote recovery • Assist with recovery plans and provide other supports based on individual's strengths, needs and goals • Will provide short term case management and connections to case once discharged from treatment facilities based on SAMHSA's eight dimensions of wellness: emotional, spiritual, intellectual, physical, environmental, financial, occupational, and social.
Outreach Coordinator	Six years of structured street outreach experience providing compassionate supportive services to individuals with SUD	$70,000	• Coordinate & facilitate scheduled outreach in a safe/structured manner • Coordinate community events • Liaison with community partners • Plan & coordinate fundraising events • Assist local agencies and police departments with coordination to care
Part time secretary		$20,000	• Handle incoming organizational calls • Record sober living funding requests and relays information to director in timely manner. • Complete follow up calls
Part time payroll/bookkeeping		$20,000	• Organize, collect, and store the financial records • Facilitates payroll process
Ongoing staff training		$10,000	• Provide ongoing training with the most up to date evidenced based trauma informed care for individuals with SUD

			• Required CEU trainings for licensure and certificate renewals

Program Costs	Funding Amount	Rationale for funding
Narcan	$25,000	Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose. Having the community trained and carrying Narcan is the most effective way to reduce the number of deaths from overdose. AIM provides Narcan to individuals SUD on the streets and encourages them to never use alone. AIM goes into the community to events to provide education and resources to families, communities, and other agencies regarding substance use and how to identify an overdose.
Fentanyl strips for outreach distribution	$5,000	Many individuals consume fentanyl without knowledge. Overdose deaths involving fentanyl have quadrupled in recent years. This makes evidence-based harm reduction strategies such as fentanyl test strips, safety planning, and access to safe supply more vital than ever. Fentanyl test strips can identify the presence of fentanyl in unregulated drugs.
Outreach supplies, client assistance	$50,000	Blessing bag supplies, care packages for clients entering treatment, wound care supplies, identification fees, bus passes for clients in sober living
Sober living funding & emergency hotel costs	$85,000	Sober living will provide clients a safe place to live when beginning their recovery journey. Rent typically ranges from $150-$200 per week. By providing rental assistance, clients can focus on their recovery, and address other important needs such as their mental health and physical health. Nearly all of our clients are coming directly from homelessness and do not have a stable environment to wait for a sober living vacancy or a treatment bed. This funding is to provide shelter for individuals who are entering into treatment/recovery and will provide a safe and secure housing plan until beds become available, making them readily accessible to staff.
Transportation expenses	$70,000	Rides for expedited transportation for treatment via ride share, gas for staff members
Technology, office supplies, misc.	$20,000	

Angels in Motion thanks you for your time, support and consideration as we all work together to fight the opioid epidemic and save lives. If you need additional information, please contact the New Jersey Chapter Director, Susan Long, at the contact information below.

Sincerely,

Susan Long, LSW, LCADC, CTP, DRCC
Angels in Motion New Jersey Chapter Director
Aim.angelsinmotionnj@gmail.com
609-214-7090

Opioid Settlement Fund Spending Plan

Community in Crisis, Bernardsville NJ

Community Peer Recovery Pop Up

October 2022

Proposal Goal: Implement Peer Recovery Pop Up (PRPU) locations throughout Somerset County bringing recovery services directly to underserved communities. Peer Recovery Pop Ups are a temporary resource site without walls, offered monthly at predetermined locations. The PRPUs will serve to supplement Somerset County's Community Peer Recovery Center. They will be set up and implemented within a highly visible, well-trafficked location, thereby removing barriers, such as transportation, lack of insurance, and stigma, and enhancing community access. Local representation helps to build community trust and nurture a willingness to access recovery services. The goal in the first twelve months will be to continue the pilot PRPU already implemented in North Plainfield and increase outreach to one or two more PRPUs dependent on funding.

Total Funding Amount: $300,000 ($100,000 annually for 3 years)

Timeline of Expenditure: 12-month period starting immediately upon award of grant funding.

Target Population Served: Initially provide resources to those towns in Somerset County with the highest incidence of fatal overdoses in 2021, as reported by the Drug Monitoring Initiative (DMI): Bound Brook/South Bound Brook (7) Somerset (6), Hillsborough (3) and Manville (3), as well as the least underserved areas by recovery support services. These communities have greater BIPOC populations, lower socioeconomic demographics, and greater health disparities than the County average. The eventual goal would be to bring a PRPU to all 21 municipalities in Somerset County.

Summary of Initiative: The Peer Recovery Pop Up is a supportive, substance-free, safe, and non-judgmental community-based environment where individuals can access peer support, information on substance use treatment, recovery support services and connections to other community resources. The key ingredient to the PRPUs is bringing support and services to the individual in their own familiar environment, meeting them exactly where they are. The activities are led by a Certified Peer Recovery Specialist (CPRS) and volunteers with lived experience of substance-use disorders, co-occurring mental health conditions and multiple pathways to recovery.

The Peer Recovery Pop Up will be open to all individuals at all stages of recovery, from those making the initial steps to those sustaining recovery. Family members and friends directly and indirectly affected will also find resources and support at the PRPU. The Peer Recovery Pop Up offers a space for social connection and a place of belonging where participants can experience the process of recovery by fostering a sense of empowerment and independence.

- One-on-One Peer CPRS Support
- Recovery Coaching
- Education Regarding Telephone Recovery Support
- Mental Health Peer Support (when available)

- Bilingual peer support (when available)
- Community Resource Navigation / Connection
- All Recovery Meetings / Multiple recovery pathways discovery
- Educational Workshops / Trainings
- Free Narcan kits
- Free Fentanyl Test strips
- Free Wellness items

Primary data such as those served, duplicated and unduplicated participants, and services provided will be collected. For those who choose to participate in additional services post PRPU, data will be collected on a voluntary basis in the areas of client substance use, family living conditions, employment status, social connectedness, access to treatment, retention in treatment, criminal justice status, and effectiveness of activities related to diversity, inclusion, equity, and cultural/linguistic competence.

Peer Recovery Pop Up Budget

(Draft Proposal)

Certified Peer Recovery Specialist (FT)	$90,000	$65K + Fringe
Roundtrip mileage to PRPU	$1,000	
Wellness Kits*	$ 600.00	40 x $15
Recovery Kits*	$ 400.00	40 x $10
Supplies and equipment*	$ 5,000.00	
Advertising/Marketing/Promotion	$ 3,000.00	
TOTAL Annual Funding	$100,000.00	

* Wellness kits include toiletries, comfort items, snack, drawstring bag, and related items.
* Recovery kits include state provided Narcan, fentanyl test strips, water and related items.
* Office supplies, equipment, phone/laptop

View History Report

Audit Trail

Show detailed result
Init Request Opioid Proposal Submitted by Nancy@alumniinrecovery.org <Nancy@alumniinrecovery.org>

Preferred Language	English
First Name	Nancy
Last Name	Labov
Email Address	nancy@alumniinrecovery.org
County of Residence	BERGEN
Municipality of Residence	Old Tappan Borough
Organization (if applicable)	Alumni In Recovery
Do you identify as a (select all that apply)	Member of a recovery organization,Prevention outreach/educator
Overdose prevention	Checked
Promote long-term resiliency of individuals and families	Checked
Prevention, education, and eliminating stigma	Checked
Recovery and social support services	Checked
Proposal (When thinking about your proposal, please consider details such as the proposal goal, total funding amount and timeline of expenditure, target population served, and a summary of the initiative).	4 An organization of local people speaking in schools on a peer to peer approach about the pathway of addiction and substance misuse. Both volunteer groups within Alumni In Recovery 501c3, young people in recovery, and parents that have lost children to overdoses. Present in schools and for community events alongside The Black Poster Project (a powerful display of hundreds of posters/images of lives lost to addiction primarily overdoses). Bridging schools with this valuable resource in a unified consistent format-through speaker guidelines, we have the ability to connect to community and empower local people to hear each other's stories, and provide solutions through the topic of addiction awareness. This is an innovative approach, and hundreds of people have already gotten involved to be of service and can grow. Please see the file upload for complete details
File Upload (optional)	2024-2027 FORM Evidence Based Programs-AlumniinRecovery.docx
File Uploaded	YES
Anonymous Email Address	nancy@alumniinrecovery.org

Completed Stages:

Init Request: ✔ 10/31/2022 08:15:55 PM - Nancy@alumniinrecovery.org <Nancy@alumniinrecovery.org>

Uploaded Files

Name	Uploaded by	Version	Source
2024-2027 FORM Evidence Based Programs-AlumniinRecovery.docx	SYSTEM	1	File Upload (optional)

0 Comments 0 Emails

Comments

Comments(0)

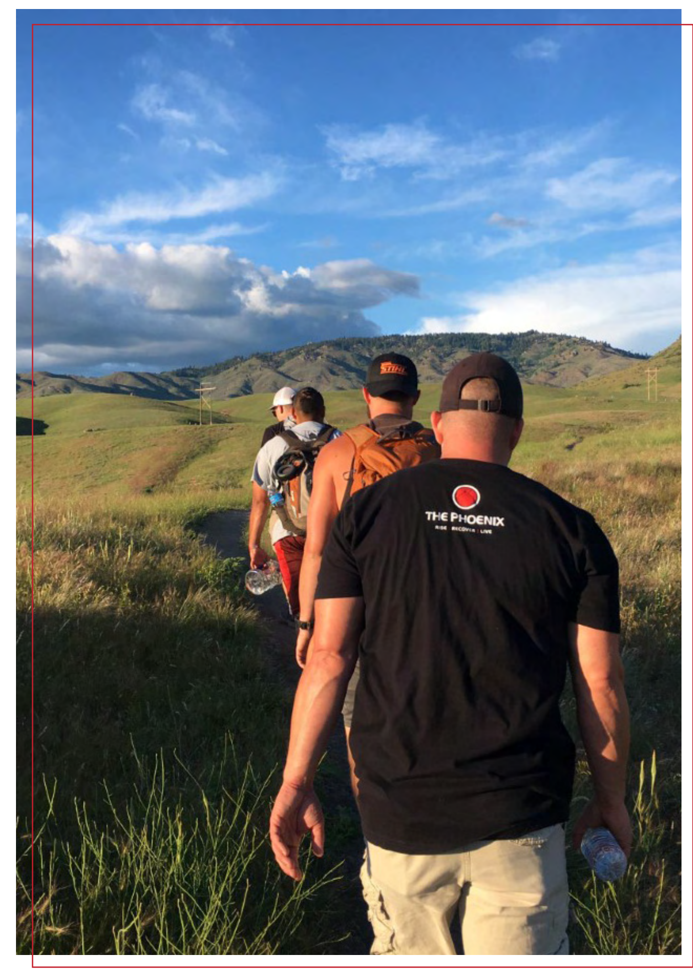
To link emails to this workflow - send or CC them to this workflow using the following workflow specific address: wf-e3584b5f13ff437fa77cfc1c01cbcbc8.prod@simpligov.com . All emails sent into the workflow will display in the list below.

UNBROKEN.
UNBROKEN.
UNBROKEN.
UNBROKEN.
UNBROKEN.
THE PHOENIX
2021 ANNUAL REPORT
THEPHOENIX.ORG

THE NEED

We are currently facing a public health crisis that is claiming the lives of over 150,000 people per year in the US.[1] With over 40 million people currently living with substance use disorder, it is critical that we work to find support for those individuals.[2] While professional treatment is helping many start their recovery journey, supportive social networks also play a critical role in addressing their needs in seeking and maintaining sobriety. No matter the means of getting and staying sober, one critical component for success is finding a support network through which individuals encourage one another.[3]

Unfortunately, societal stigmatization makes makes it challenging for some to easily find this community, meaning that they may either return to the original groups they previously associated with during their substance use or remain socially isolated, both options increasing the risk of relapse. This is where The Phoenix comes in, where we work to meet that need by creating a safe, inclusive, and supportive community where our members can flourish.



1. Esser, M.B., et. al, (2020). Deaths and years of potential life lost from excessive alcohol use—United States, 2011–2015. Morbidity and Mortality Weekly Report, 69(30), 981.

2. SAMHSA, 2021.

3. Best, D. (2012). Addiction recovery: a movement for social change and personal growth in the UK. Brighton: Pavilion Publishing.

WE ARE THE PHOENIX

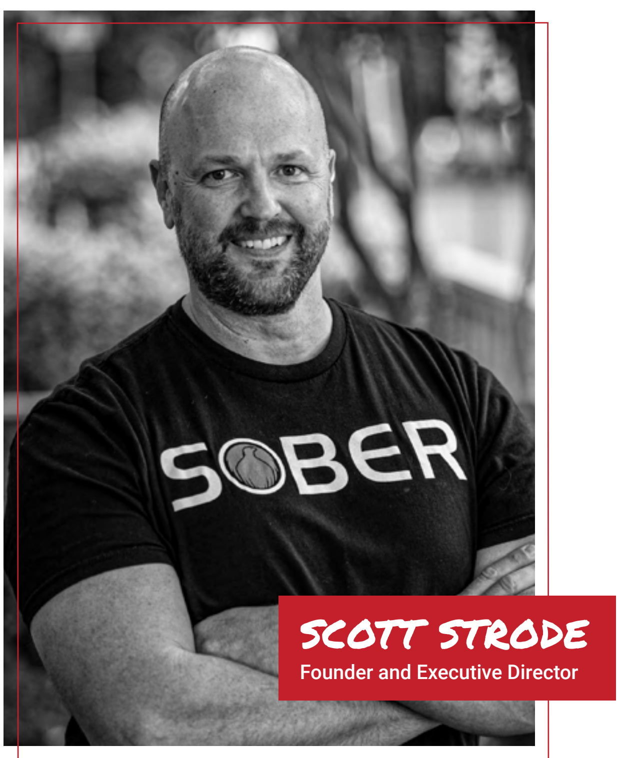
OUR MISSION **To build a sober active community that fuels resilience and harnesses the transformational power of connection so that together we rise, recover, and live.**

The Phoenix is an innovative nonprofit organization that helps anyone impacted by substance use heal by leveraging the intrinsic transformative power of social connection and activity.

Through group fitness, meditation, running, climbing, hiking, music, book club, and other meaningful activities, The Phoenix combats the isolation, shame, and hopelessness that often surrounds substance use and perpetuates relapse.

Events at The Phoenix are FREE to anyone with at least 48 hours of continuous sobriety. By meeting each person where they are and believing in them until they can believe in themselves, we create an environment where healing happens and recovery flourishes. We help thousands of individuals rise every day from the ashes of addiction and find the hope and support they need to thrive.

Over the past 15 years, The Phoenix has grown from a small community serving a few dozen people in Boulder, to a growing national movement.



SCOTT STRODE

Founder and Executive Director

Our Board

Don Fertman
Gregory Sheindlin
Scott Strode
Dave Gann
Lorna Donatone
Alan Vorwald
Lauren McCann

A LETTER FROM OUR EXECUTIVE DIRECTOR AND FOUNDER

While 2021 was a yet another trying year for our community and for our world, I am both honored and proud to say that The Phoenix organization as a whole and as and as individuals embodied one of my favorite quotes:

Between stimulus and response, there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.
Viktor E. Frankl

Despite the incredible challenges faced through the various surges of COVID-19, we find ourselves on the precipice of rapid, hockey-stick growth. The Phoenix served 27,668 new members in 2021—our most impactful year yet from a new member perspective.

In 2021 alone, we served more new members than we did in the first 10 years of The Phoenix.

This is happening, it's happening fast, and we are ready.

The lasting effects of the pandemic – isolation, disconnection, loss – have undoubtedly and horrifically accelerated the substance use epidemic in our country and abroad, and it is all our responsibility to fight it, together. As this urgent need for recovery support in today's environment builds, we too are growing in size and impact, braced to take on this challenge, not alone, but with our community, allies, supporters, and partners.

Volunteers are core to our mission and the path we are taking to drive this rapid yet sustainable growth. We intentionally launched our volunteer engagement strategy this year, hiring dedicated staff and building out a thoughtful process for intake, onboarding, and supporting Phoenix volunteers. Our volunteers now have the tools and support necessary to seamlessly bring their talents and passions to their communities—not only to drive impact for The Phoenix, but perhaps more importantly, to provide a supportive space for them to self-actualize. Through this strategy, 532 new volunteers were activated and trained in 2021, impacting 7,471 community members and leading 6,320 Phoenix events around the country. With an acute focus on training, support, and instilling our core values, we continue to drive confidently towards our 2022 goal of 2,000 volunteers activated.

We also launched our mobile app this October—a technological and community-driving advancement that we are extremely proud of and that is rapidly driving impact, with 6,272 downloads in 2021, ~50% being net new members to our community. The Phoenix app brings to life in a meaningful way our core value propositions: connection, meaningful activities, and community, to members anywhere, at any time. We launched with a core set of functionalities: a class finder, a sobriety tracker, groups based on location and shared interests, and CONNECT, which allows community members to connect 1-1 to provide mutual support. We will be expanding this functionality in 2022 as well as partnering with other apps in our space, with the vision of becoming a leader in recovery technology.

2021 has been a year of hardship, but in that hardship, we have been further empowered to drive deeper toward our mission of impacting one million people in recovery. We have made tremendous strides and we have big goals for 2022.

We could not and cannot do this alone. From the bottom of my heart, thank you for being a part of this movement – we are stronger together.

Scott Strode
Founder and Executive Director

BASED ON 2021 SURVEYING ONLY.

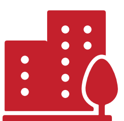
WHO WE SERVE

A movement where together, we're stronger.

We serve individuals at all stages of recovery. Our national community includes individuals from all backgrounds and lived experiences, including high-risk populations such as:

U.S. Veterans

Incarcerated Individuals


Treatment Centers

Individuals Experiencing Homelessness

And Many More

Justice system involvement

Living in poverty

Women

Identity as a member of the LGBTQ+ community

Active military or veterans

Our community primarily faces substance use associated with: Alcohol, street and prescription opioids, and methamphetamine.

"Pride in my recovery was the most important muscle that I strengthened in those first classes, and connection with the Phoenix community is how I grew stronger"

Liz
Tampa, FL

OUR IMPACT

We find strength in numbers.

77,669

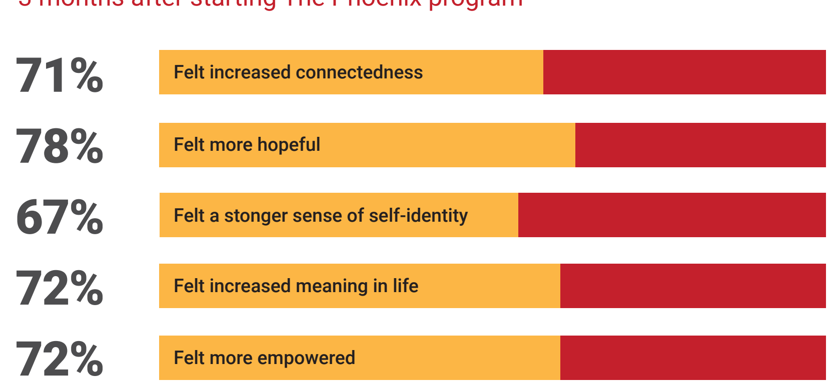
Total people served since 2006

27,668

New members in 2021

For those new to recovery*

3 months after starting The Phoenix program



After three months of participation in The Phoenix, members are asked to report retrospectively on their sense of CHIME (when joining The Phoenix versus now). The figures reported here are the percentage of individuals new to recovery, who report positive change across CHIME.

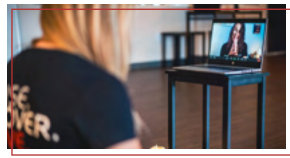
As The Phoenix membership base has diversified, the CHIME analysis is now categorized into four subgroups, depending on how members self-identify upon joining The Phoenix. It is likely that due to this change in data collection procedures, the analysis of data is affected.

*To see more of our 2021 Member Outcomes report, **click here.**

OUR PROGRAMS

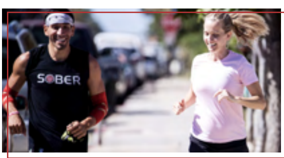
In-person Local Programming

Local classes held in communities around the US and Canada



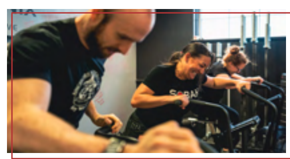
Live Stream

Virtual classes held daily with over 60 events held each week



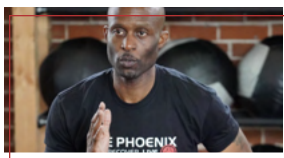
Community Challenges

Online community events that allow individuals to complete activities separately but together with The Phoenix community, such as virtual 5Ks or photography challenges



NEW CrossFit Community Centers

We've partnered with CrossFit to inspire hope and strength through safe, accessible, and inclusive communities focused on fitness and other meaningful activities. Started in July 2021



On-demand

The Phoenix programming accessible anywhere, anytime

Edovo Partnership

Our on-demand content used in prison and jail systems on tablets, expanding the reach of The Phoenix

We lift more than barbells.

324

Classes per week

Yoga

Group Fitness

CrossFit

Biking

Boxing

Running

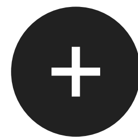
Music

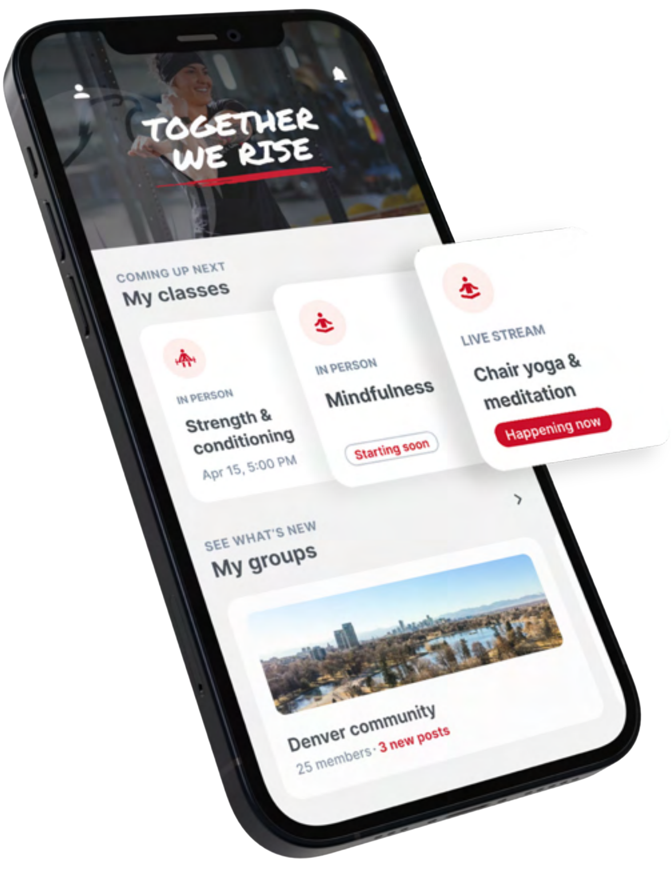
Meditation

Dancing

Rock Climbing

Hiking


And more

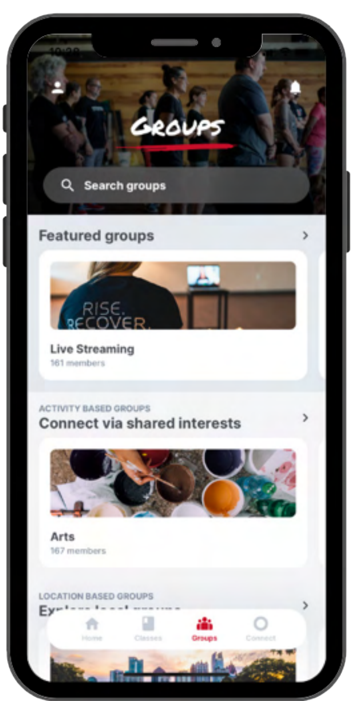


THE PHOENIX APP

Our sober active community, reimagined.

The Phoenix App distills the most essential aspects of our movement—community, shared activities, multiple pathways, and stigma reduction, and delivers them in new and exciting ways to anyone, anywhere.

Sense of community is what makes the Phoenix special. The Phoenix App fosters an ecosystem for members to connect, support, and inspire one-another.



Since the launch of The Phoenix App in **October 2021**, we've seen:

Downloads in 2021

New members from the app

Avg. review rating 4.9

Groups

Scan this code to download our app today!

VOLUNTEER. IMPACT. GROW.

Volunteers are central to our mission and movement.

We're building a vibrant community of people in recovery with support, hope, and resilience.

In 2021, we launched our **volunteer engagement strategy** .

532

Volunteers Trained and Activated

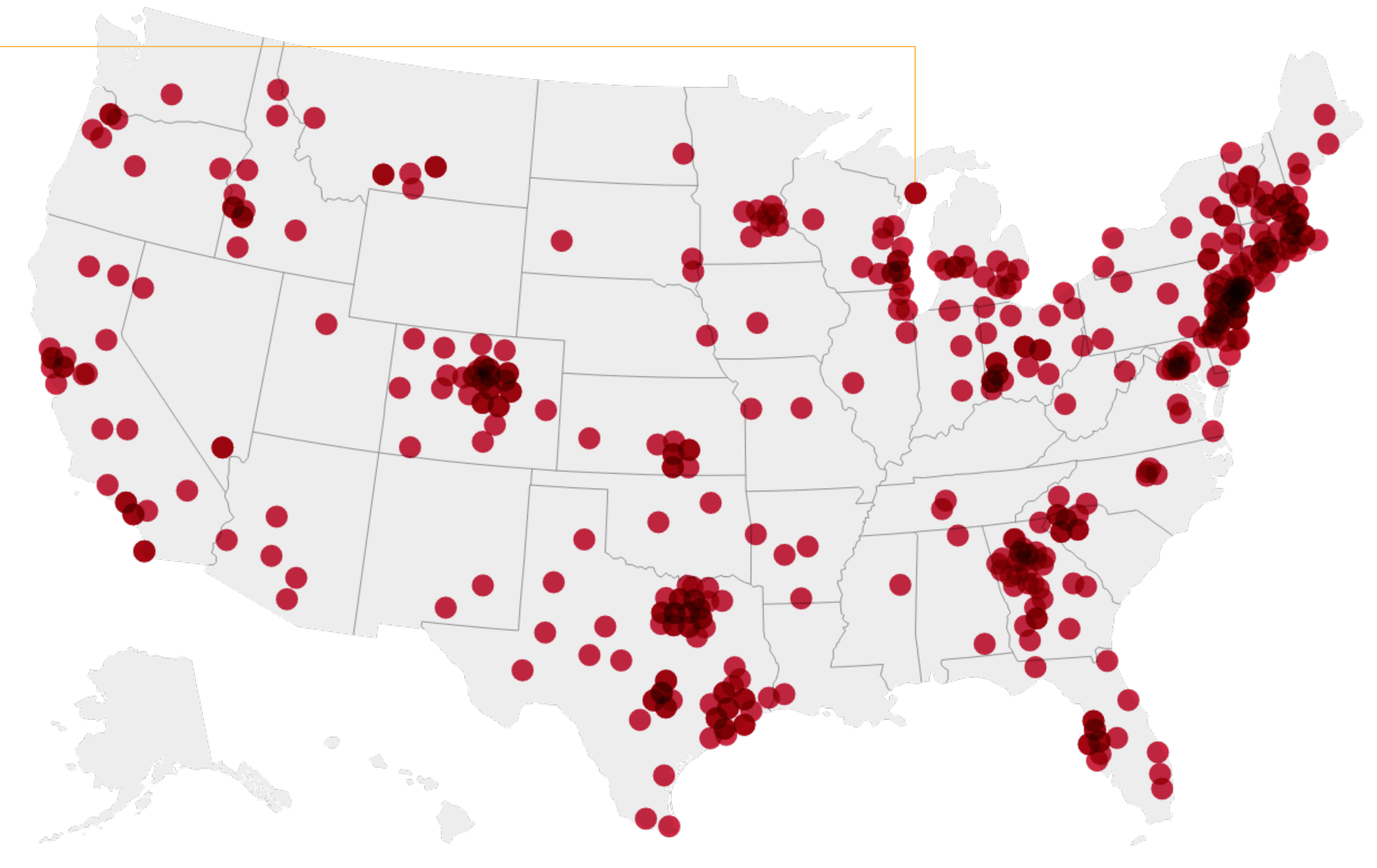
7,471

People Impacted by Phoenix Volunteers

To see more of the amazing impact by our volunteers in 2021, scan the QR code or click here.

WHERE WE ARE LOCALLY

Connected by more than a zip code.



Our 1st Canadian Volunteer Location began programming in October 2021.

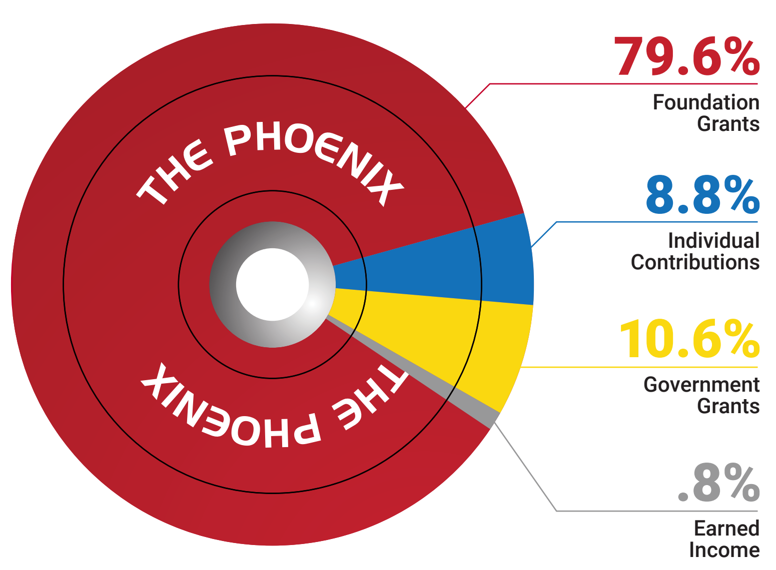
36
States

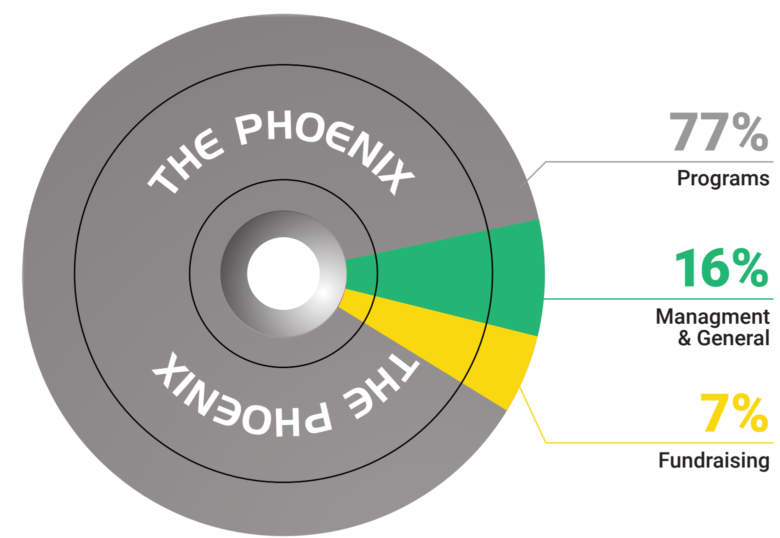
108
Counties

Our virtual programs served members in all 50 states and abroad.

FINANCIAL SNAPSHOT

In 2021, our generous supporters contributed $15.6 million. After spending $13 million to create impact in the lives of our members, we are moving into 2022 with a budget surplus.





$15.6 Million
Revenue

$13 Million
Expenses

THANK YOU

The Phoenix community could not have survived and thrived in the way we did without our amazing partners. Thank you to all those that have contributed to positively impacting the lives of so many individuals. Together, we will shatter the stigma around recovery.

Timmy’s Wings of Hope

Summary

Timmy's Wings of Hope was started in memory of my fiancé, Timothy Poskay. Timothy was a Retired Linden Fire Fighter/EMT that dedicated over 14 years of his life helping others. Timmy was awarded the Lifesaving Valor Award for his involvement in an incident that required assisting with two gunshot victims. Timothy injured his back working as a firefighter while lifting a person that needed to be taken to the hospital. While lifting this person, he injured his back and was sent to a doctor. The doctor immediately prescribed Oxycontin which was the start of Timothy's addiction. Like so many people in New Jersey, Timothy passed away on February 14, 2022 after he overdosed on Fentanyl. Tim enjoyed fishing, hunting, snowboarding, working on his quad and sitting around his homemade fire pit in his backyard with his three children. A proud graduate from Rutgers University with a degree in Labor Relations and he also held a bachelor's degree in Fire Science from New Jersey City University. Tim had an unbelievable drive and so many dreams he wanted to fulfill. We hope that we are able to We here at Timmy's Wings of Hope are happy to share that we have been approved to serve the community under a 501 (c)(3) as a Non-Profit Organization. Our mission is to provide support services and compassionate care to those with a Substance Abuse Disorder. Timmy's Wings of Hope outreaches individuals in the community to provide recovery tools and resources such as recovery education, sober house scholarships and referral services. Timmy's Wings of Hope is Timmy's Wings of Hope will coordinate clean and sober events in the community, provide education regarding the proper use of naloxone and fentanyl test strips, encourage overall wellness and relapse prevention skills and provide a sober

house scholarship to any individual that qualifies. In addition, Timmy's Wings of Hope provides sober house scholarships, recovery retreat scholarships and clothes for interviewing purposes to any individual that qualifies for such. This nonprofit will also set a goal to open sober houses throughout New Jersey. At this time, Timmy's Wings of Hope is requesting $40,000 which comes out to about $3,333 per month. This will allow us to have rental space where we can meet with members, secure our supplies, and have a computer for members to use for interviewing purposes. Any left-over money will be for community events, for clothing, or for additional supplies.

Description

Timmy's Wings of Hope is an outreach and intervention services that provides individuals with substance abuse disorder, their family, and other community members assistance and resources to maintain and clean and sober lifestyle.

Persons eligible for these services include:

- Persons with SUDs
- Family members of loved ones with SUDs.

Mission: Timmy's Wings of Hope mission is to provide support services and compassionate care to those with a Substance Abuse Disorder.

Timmy's Wings of Hope will partner with people in recovery, their families and the community to foster wellness and provide essential recovery resources. Each and every participant and family member will be provided the resources to succeed with our supportive services for recovery.

The team members and volunteers of Timmy's Wings of Hope, meet every three months for community-based meetings for persons with SUD's and/or family members of persons with SUDs. Until obtaining funding for rental space or have secured donated space, these meetings take place in a public area such as a park or library in a location that is accessibly for the participant(s) and virtually.

Timmy's Wings of Hope will provide information, resources, and linkage for the following:

- Outpatient levels of Care,
- Inpatient/Medical detoxification programs,
- Resources for family support,

Goals

Timmy's Wings of Hope Substance Abuse Outreach and Intervention program has numerous goals including:

1. Our short-term goal is to provide referrals for treatment and rehabilitation options to those with SUDs and/or family members of SUDs, in a manner that encourages community involvement.
2. Provide education regarding the proper use of naloxone and fentanyl test strips.
3. Open sober living homes throughout New Jersey for both male and female

4. Provide a safe space for individuals to apply for jobs and meet with Timmy's Wings of Hope team

Healing Theatre

Since 1991 the “Visions” theatre play on addiction and recovery based in New Jersey, has silently reached more than 40,000 people in the hearts of treatment centers, shelters, institutions, correction centers and communities with the message of hope and recovery from substance abuse.

The Visions cast which numbers over twenty members per performance has grown to more than 500 volunteers. The majority of the cast (few actors here) have never been on stage before. Their powerful scenes on stage of active addiction with all its talons is leaving audiences weeping. More importantly, the cast serve as examples of the hope and recovery that comes from drug and alcohol addiction. In 2001 the Visions cast and crew was awarded a Points of Light Award from President Bush for their community service and volunteerism.

The play which started out as a twenty five minute one act has grown to well over an hour performance with a musical score. Behind every performance is lighting, sound and staging, turning rehabs and shelters into theatrical arenas.

The play has made its way to nine states and as far west as Texas and as far north as Michigan. If the Visions troupe is able to acquire a large stage for a performance, hundreds are bused in from various treatment centers for a free night of theatre, coffee and cake.

The Visions play has also gone off Broadway for three separate runs. Where sixty percent of all ticket sales were donated to area treatment centers, shelters, women in need and youth groups. The play has been presented in the House of Representatives in Washington D.C. in an effort to impact addiction funding. Visions

has been performed on the large stages of the Trump Marina in Atlantic City and multiple times at the Philadelphia Convention Center. Yet, most of the play's intimate performances are free in the hearts of rehabs, shelters and institutions and communities where our wonderful audiences are.

Theatre is such a powerful medium. It can bring hope to those who feel hopeless. A healing for both audiences and cast.

www.visionsrecoveryplay.com