Governor Dan McKee's Overdose Task Force
January 8, 2025

Richard Leclerc; Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
Jerome Larkin, MD; Director, Rhode Island Department of Health
Ana Novais, MA; Assistant Secretary, Rhode Island Executive Office of Health and Human Services
Cathy Schultz, MPH; Task Force Director, Rhode Island Executive Office of Health and Human Services

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Welcome and Announcements

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Save the Date

2025 Statewide Community Overdose Engagement (CODE) Summit

February 12, 2025 | 8:30 a.m. - 4 p.m.

Crowne Plaza Hotel, Warwick

Learn and interact with fellow Rhode Islanders invested in ending the overdose crisis, share local resources, and engage with municipalities in the development of local overdose response plans.

Registration information will be available in the week ahead.

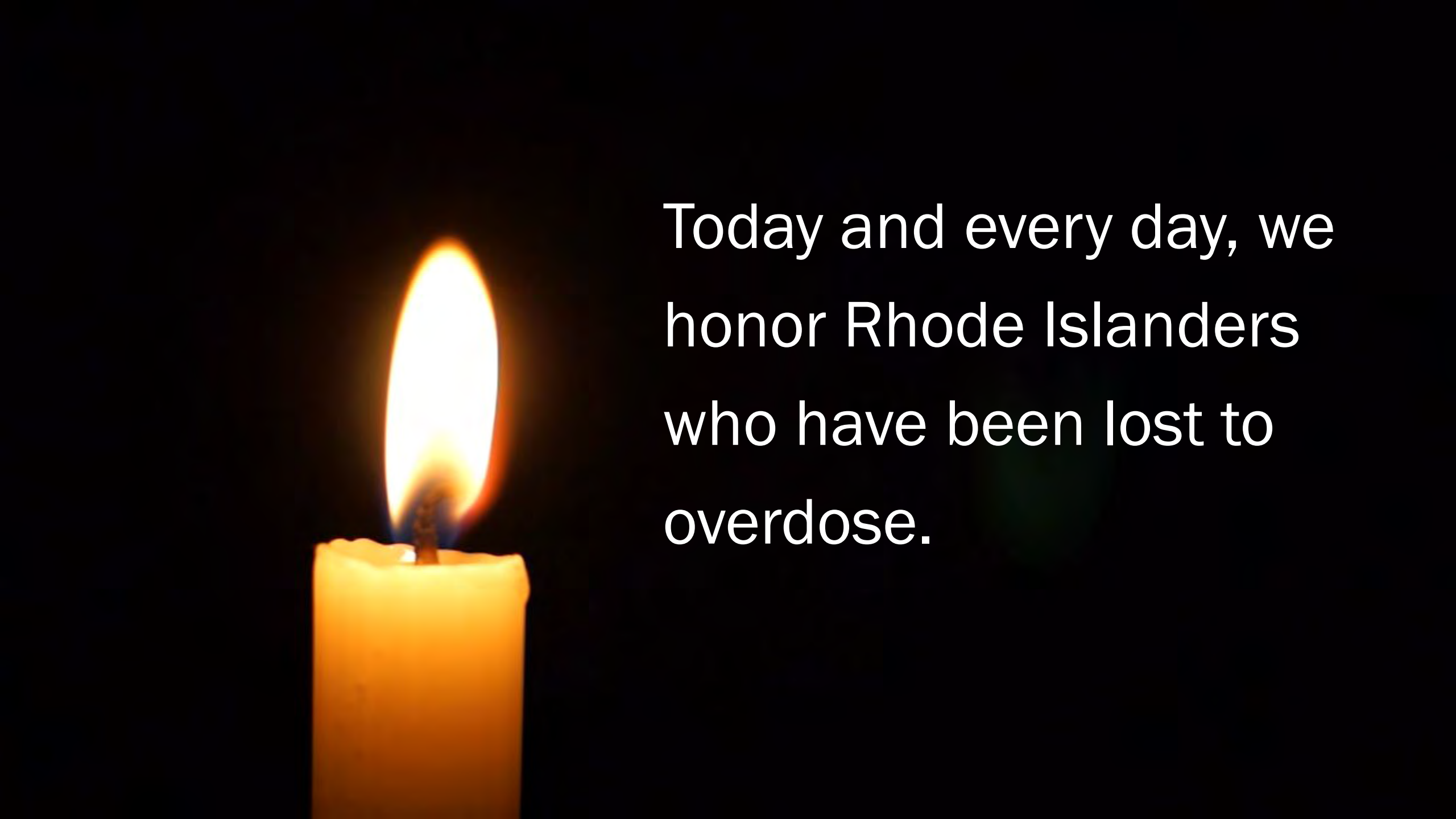
Please note the 2025 CODE Summit will occur in place of the February 2025 Overdose Task Force meeting.

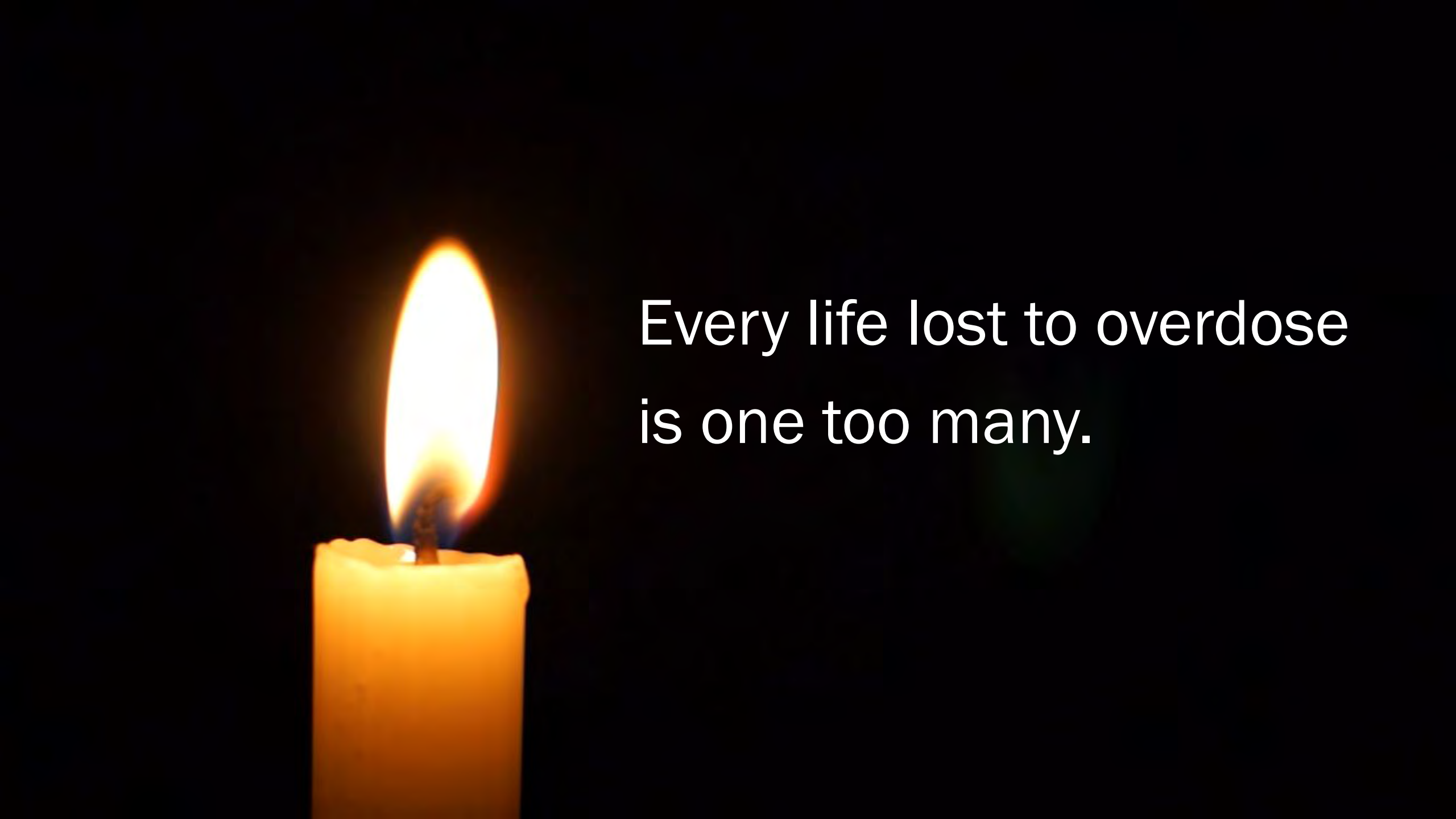
Accidental Drug Overdose Deaths in Rhode Island, January 1, 2024 - June 30, 2024

January 8, 2025

Governor Dan McKee's Overdose Task Force Meeting

RHODE ISLAND DEPARTMENT OF HEALTH


Today and every day, we
honor Rhode Islanders
who have been lost to
overdose.


Every life lost to overdose
is one too many.

Presentation Overview

- Office of State Medical Examiners (OSME) Fatal Overdose Data
- Rhode Island OSME Data Trends
- RIDOH Opioid and Stimulant Use Data Hub
- Additional Resources
- Key Takeaways
- Questions

OSME Fatal Overdose Data
January 1, 2024 - June 30, 2024

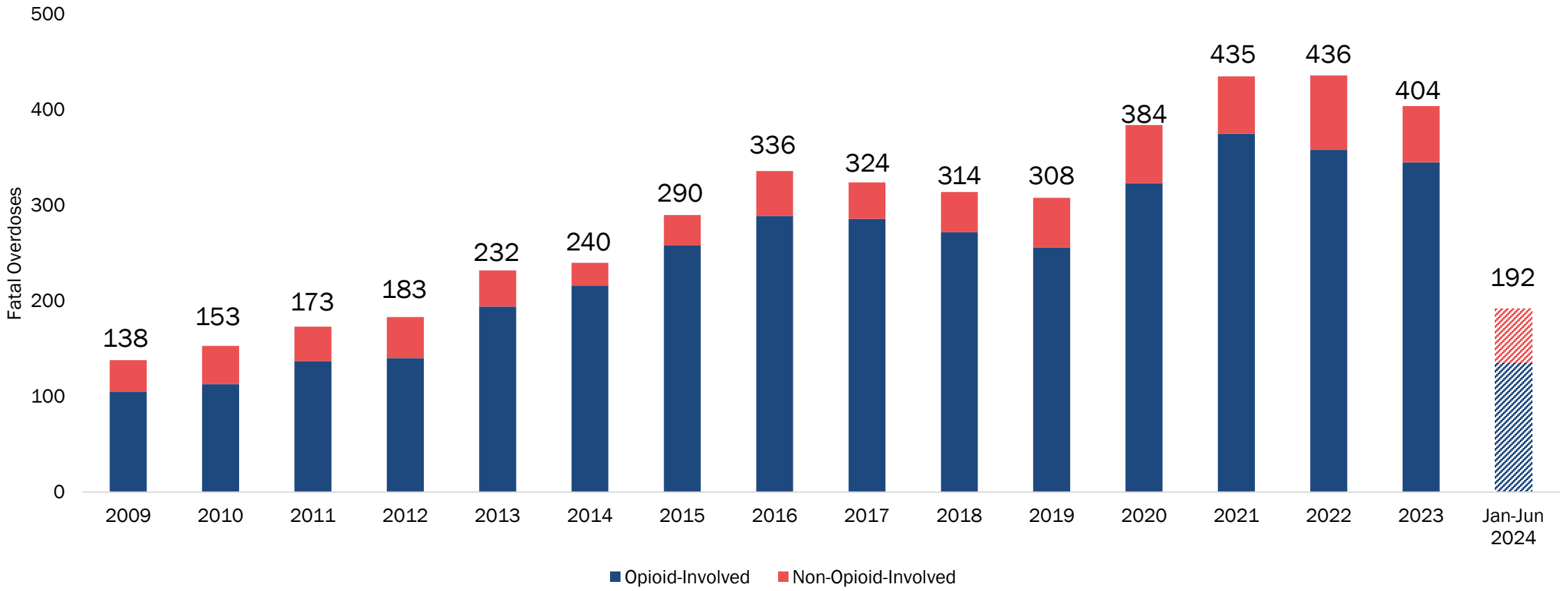
How Does RIDOH Report on Fatal Drug Overdoses?

- The Rhode Island Department of Health (RIDOH) reports on drug overdose deaths using data from the OSME.
- The cause and manner of an individual's death are based on clinical judgment, experience, and consideration of the following:
  - Autopsy results
  - Toxicology testing
  - Scene investigation
  - Medical history
- RIDOH reports on drug overdose deaths whereby the manner of death is recorded as "Accident" and does not include manners such as suicides, homicides, or undetermined deaths.

Race and Ethnicity Groups

Ethnicity	Race	Combined Race and Ethnicity
Hispanic or Latino	Asian	Hispanic or Latino (of any race)
	Black or African American	
	White	
	Unknown	
Non-Hispanic or Unknown	Black or African American	Black, non-Hispanic or unknown ethnicity
	White	White, non-Hispanic or unknown ethnicity
	Additional Race Categories	Asian, non-Hispanic, American Indian or Unknown Race

Fatal Overdoses in Rhode Island by Year January 2009 – June 2024

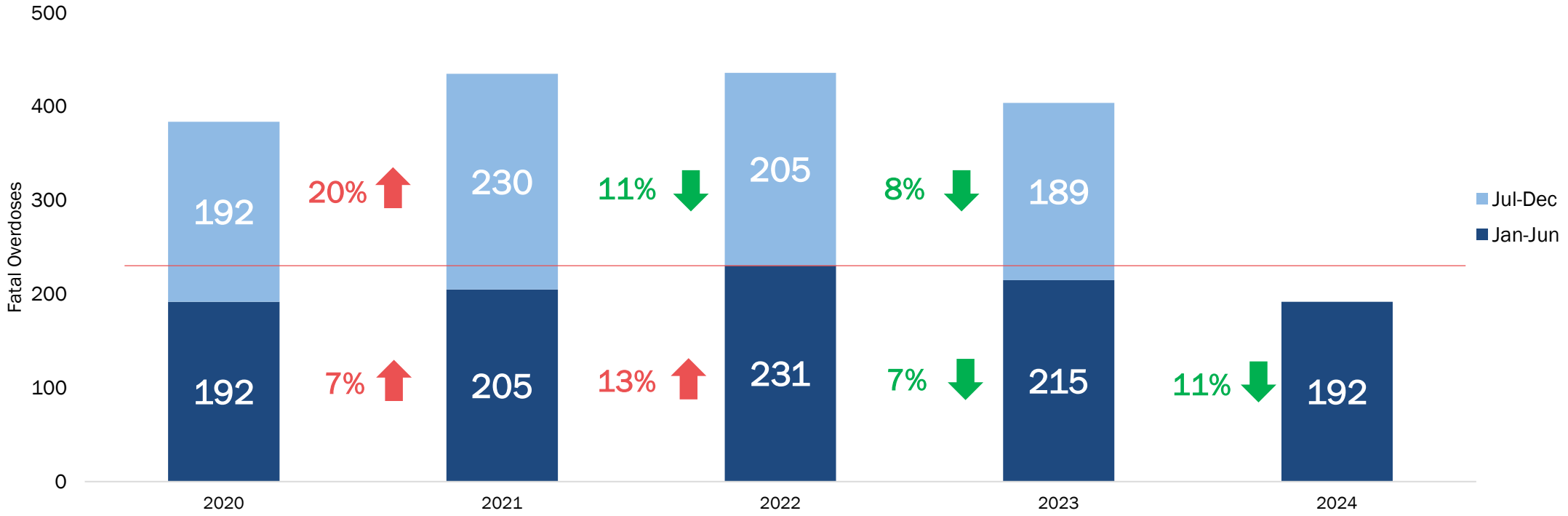


Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths.

Fatal Overdoses in Rhode Island by Year
January 2020 – June 2024

From January 2024 to June 2024, the number of fatal overdoses occurring in Rhode Island decreased by 11% compared to the first six months of 2023.

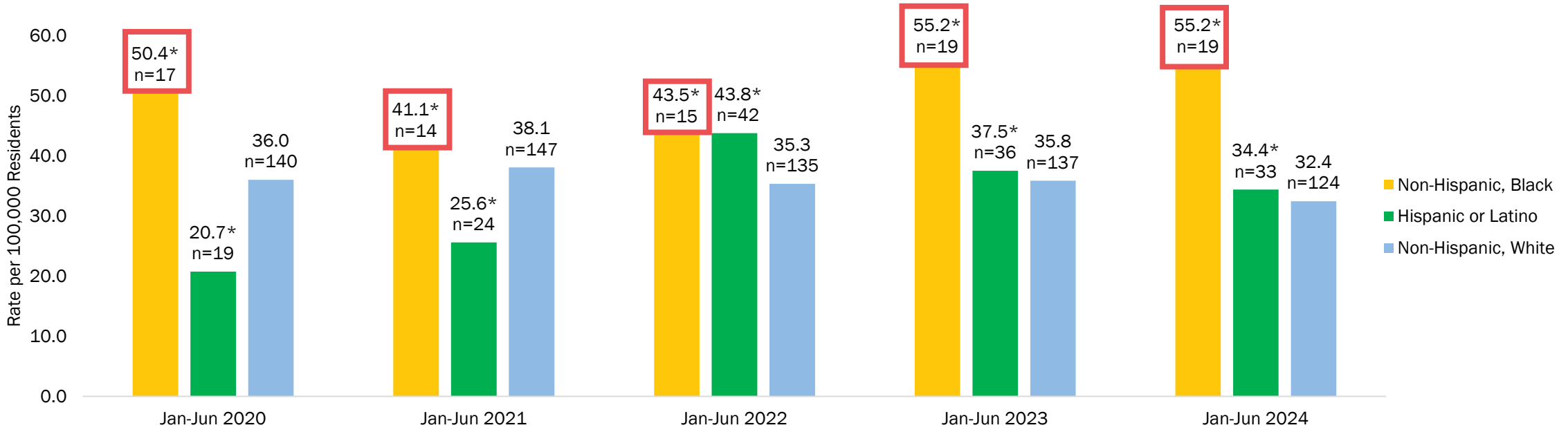


Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths.

Overdose Rate by Race and Ethnicity Among Rhode Island Residents, January 2020 – June 2024

From January to June 2024, non-Hispanic, Black Rhode Islanders continued to have the highest rate of fatal overdose compared to other race and ethnicity groups.



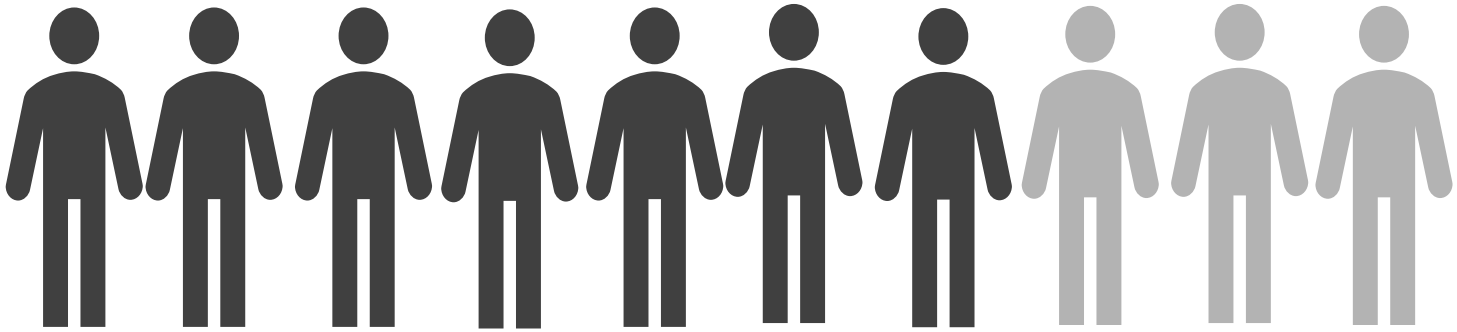
Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

*Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths. Population denominator based on CDC WONDER single-race population estimates for each year accessed April 16, 2024; 2022 estimate applied for 2023 and 2024 rates. Data limited to accidental drug overdose deaths occurring in Rhode Island among Rhode Island residents. Due to RIDOH's Small Numbers Reporting Policy, fatal overdoses among decedents of unknown or additional race and ethnicity are not shown. All other racial and ethnic groups include people who identify as non-Hispanic ethnicity or have unknown ethnicity. Counts less than five are suppressed. *Please use caution when interpreting rates marked by an asterisk.*

Proportion of Fatal Overdoses by Sex January 2024 – June 2024

Most individuals who died from a drug overdose were

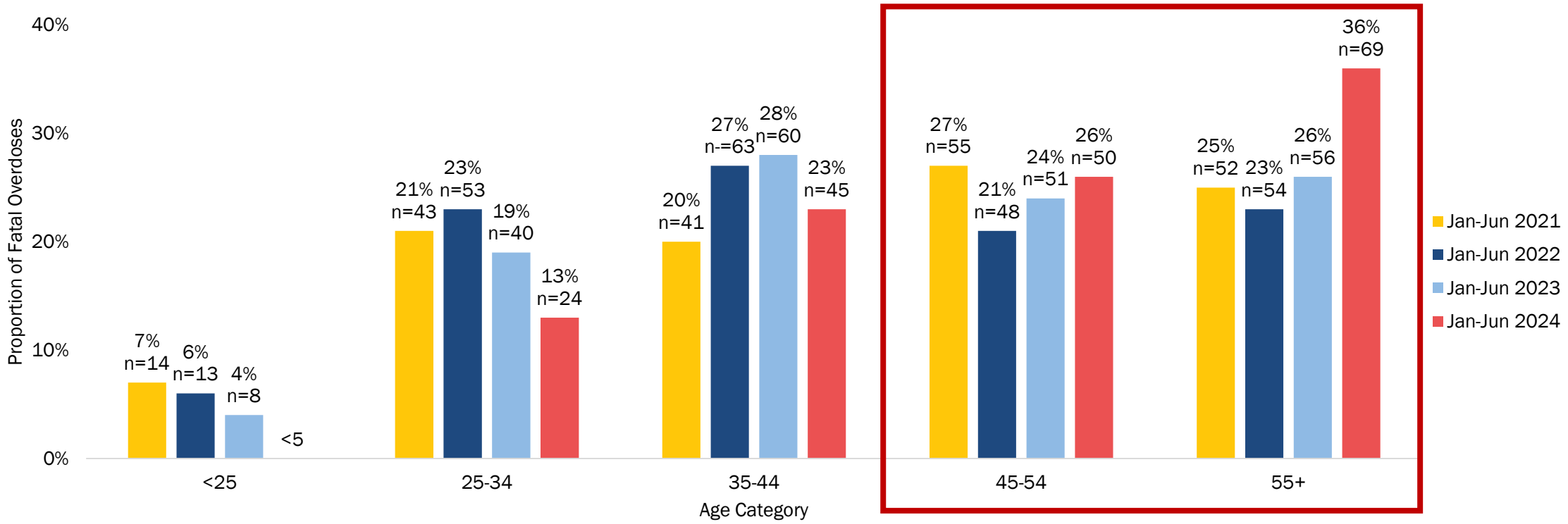
male (74%, n=142), as categorized by the OSME.



Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths.
Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

Proportion of Fatal Overdoses by Age Category January 2021– June 2024

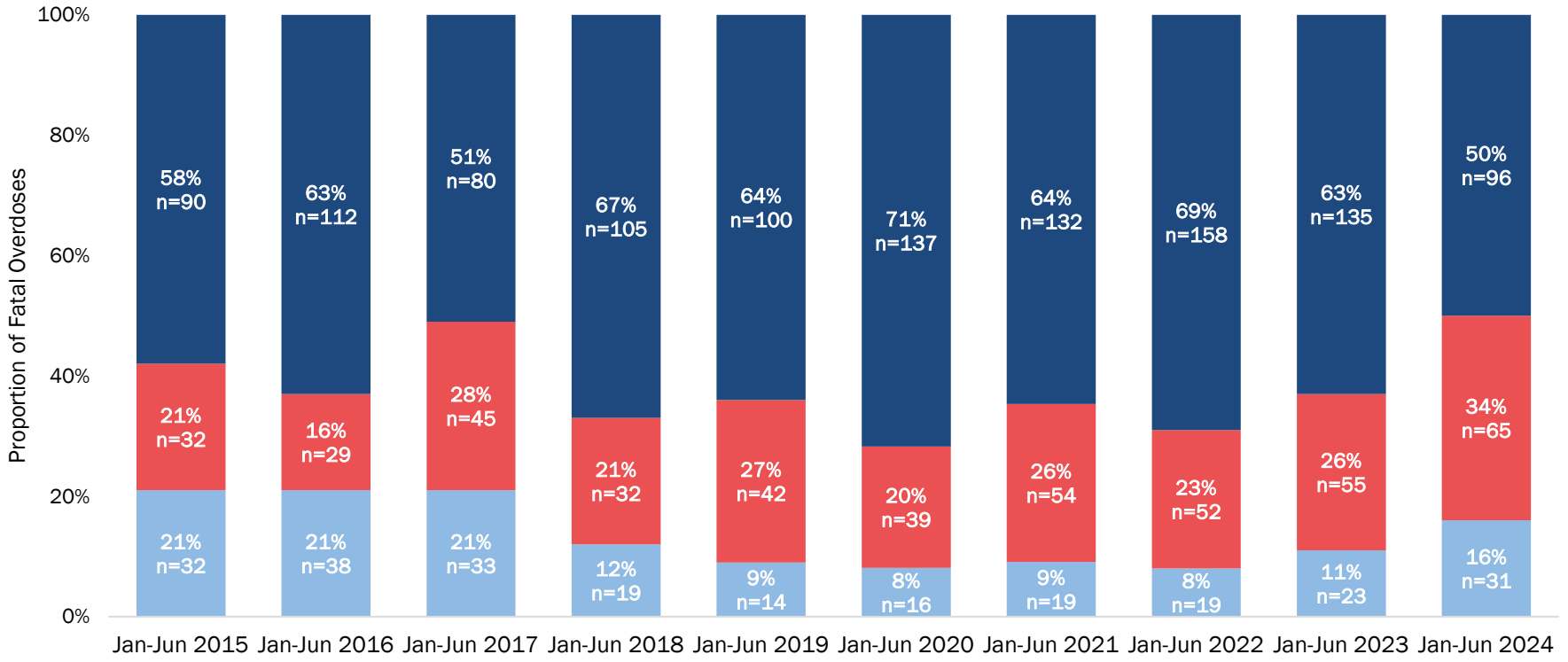
From January to June 2024, **62%** of fatal overdoses occurred among individuals **age 45 and older.**



Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths.
Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

Fatal Overdose by Drug Type January 2015 – June 2024

In the first six months of 2024, the proportion of fatal overdoses involving **illicit drugs alone** has **decreased** from **63% (n=135)** to **50% (n=96)**. **Half** of fatal overdoses continue to involve **prescription drugs alone** or in **combination** with illicit drugs.



Prescription drugs can involve:

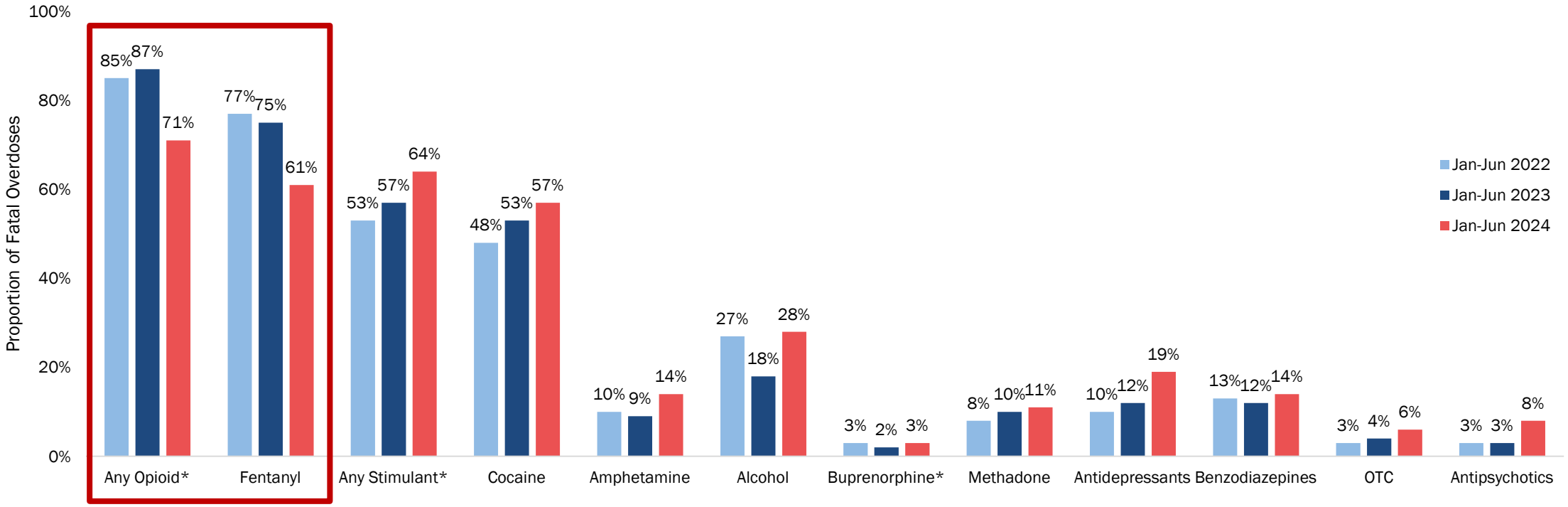
- *Antidepressants*
- *Antipsychotics*
- *Buprenorphine/Methadone*
- *Anticonvulsants*
- *Muscle relaxers*
- *Benzodiazepines*
- *Prescription opioids*
- *Etc.*

Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

*Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths. Excludes overdoses with unknown or missing drug type. Percentages may add to more than 100% due to rounding. *Buprenorphine indicates any buprenorphine product and does not indicate whether it was prescribed to treat pain, substance use, or was obtained without a prescription.*

Substances Contributing to Fatal Overdose January 2022 – June 2024

From January to June 2024, opioid and fentanyl-involved overdoses notably decreased. **Fentanyl** contributed to **61% of overdose deaths.**



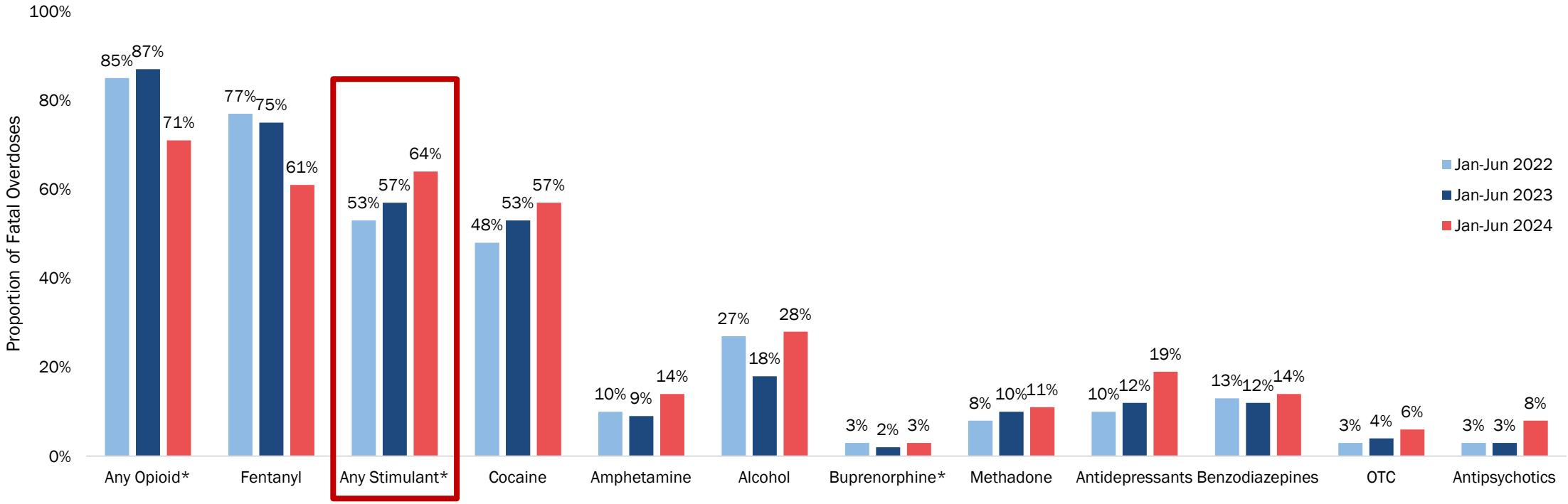
Note: Substance categories are not mutually exclusive. More than one substance can contribute to cause of death.

Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

*Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths. *Any opioid includes fentanyl-involved overdoses as well as other opioids such as oxycodone, morphine, heroin, buprenorphine, and tramadol. Stimulant-involved overdoses include overdoses where cocaine, amphetamine, or methamphetamine contributed to cause of death. Buprenorphine indicates any buprenorphine and does not indicate whether it was prescribed to treat pain, substance use, or was obtained without a prescription.*

Substances Contributing to Fatal Overdose January 2022 – June 2024

Stimulant-involved overdoses continue to increase, with **any stimulant** contributing to **64% of overdose deaths.**



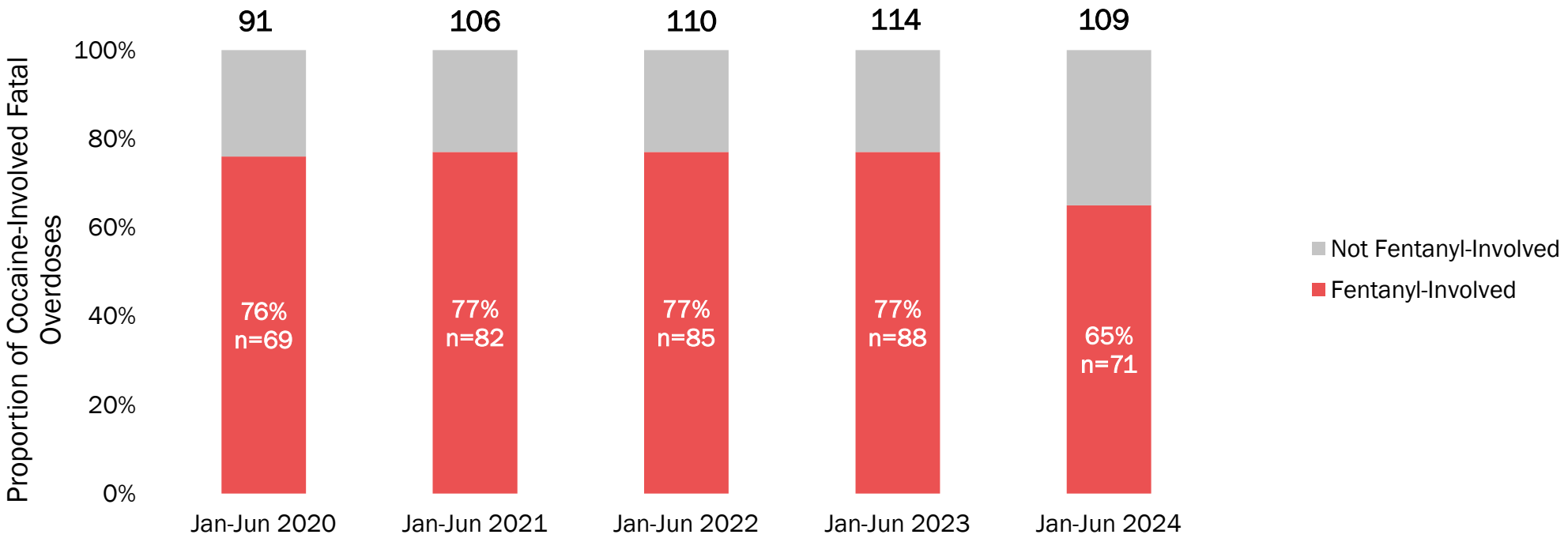
Note: Substance categories are not mutually exclusive. More than one substance can contribute to cause of death.

Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

*Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths. *Any opioid includes fentanyl-involved overdoses. Stimulant-involved overdoses include overdoses where cocaine, amphetamine, or methamphetamine contributed to cause of death. Buprenorphine indicates any buprenorphine and does not indicate whether it was prescribed to treat pain, substance use, or was obtained without a prescription.*

Cocaine-Involved Fatal Overdoses January 2020–June 2024

The proportion of cocaine-involved fatal overdoses that also involved fentanyl **decreased from 77%** in the first six months of 2023 to **65%** in the first six months of 2024.

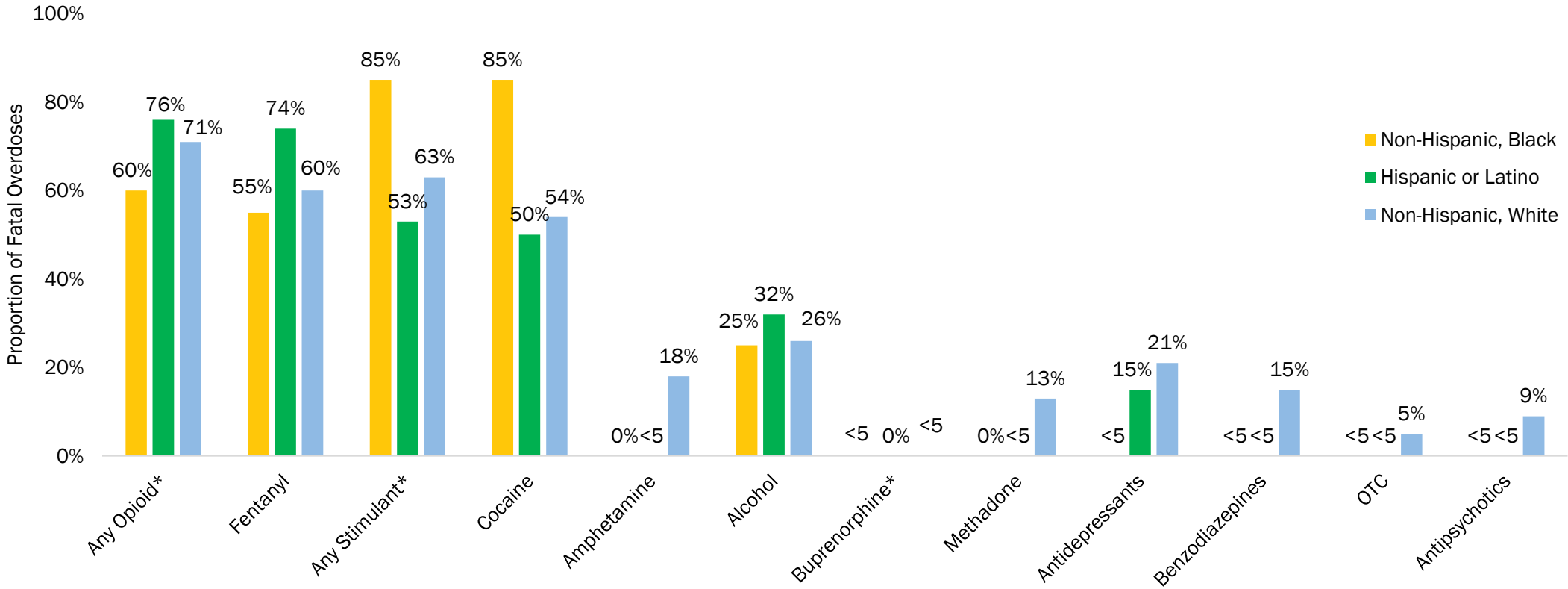


Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths.Toxicology results do not differentiate between a person's intentional polysubstance use or potential fentanyl contamination. Drug categories are not mutually exclusive. More than one substance may have contributed to the cause of death.

Fatal Overdose by Substance and Race and Ethnicity January 2024 – June 2024

In the first six months of 2024, the proportion of fatal overdoses involving any stimulant was vastly greater among non-Hispanic, Black individuals.



Note: Substance categories are not mutually exclusive. More than one substance can contribute to cause of death.

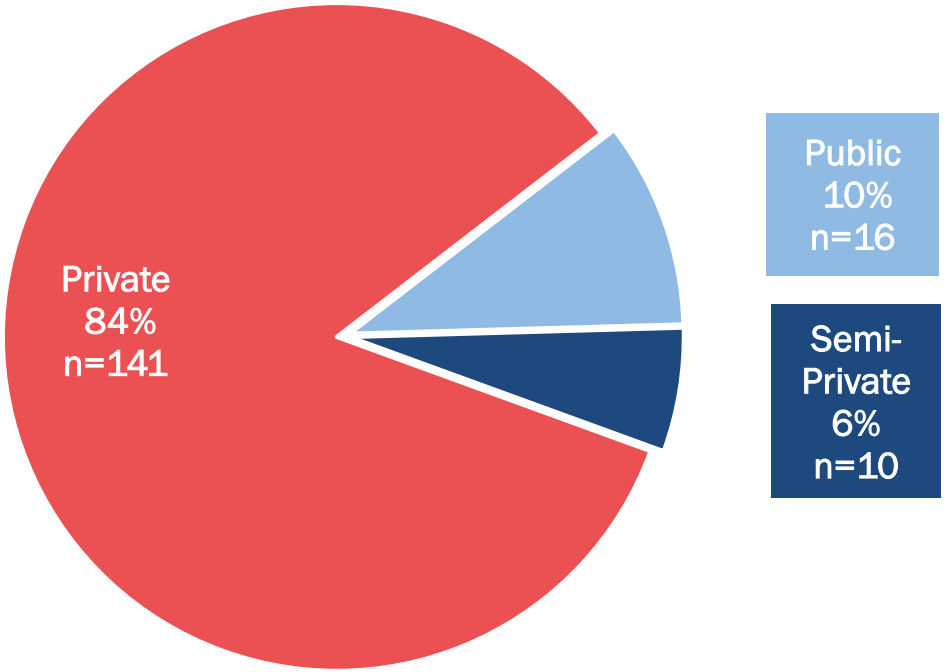
Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele.

*Note: Data reflect accidental drug overdose deaths and do not include suicides, homicides, or undetermined deaths. *Any opioid includes fentanyl- involved overdoses. Stimulant-involved overdoses include overdoses where cocaine, amphetamine, or methamphetamine contributed to cause of death. Buprenorphine indicates any buprenorphine and does not indicate whether it was prescribed to treat pain, substance use, or was obtained without a prescription. Due to RIDOH's Small Numbers Reporting Policy, fatal overdoses among decedents of unknown or additional race and ethnicity are not shown. All other racial and ethnic groups include people who identify as non-Hispanic ethnicity or have unknown ethnicity. Counts less than five are suppressed.*

Types of Overdose Locations
January 2024 – June 2024

The OSME collects information about the locations of fatal overdoses. The locations are classified as **Private**, **Semi-Private**, or **Public.** From January to June 2024, 84% of fatal overdoses occurred in private settings.

Private	Private residence, garage, camper
Semi-Private	Hotel, motel, shelter, assisted living facility, nursing home, hospital, prison, group home, treatment facility, transitional housing
Public	Business, parking lot, bar, sidewalk, wooded area, office, motorways/roads, cemetery, park, abandoned property, railroad tracks



Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024.
Note: Excludes unknown or missing setting. Percentages may not add up to 100% due to rounding .

Fatal Overdoses by Incident Municipality January 2024 – June 2024

- In the first six months of 2024, at least one fatal overdose took place in almost all of Rhode Island's cities and towns.
- Rhode Island municipalities with the highest rates of fatal overdose are:

1. **Woonsocket:** 55.8 per 100,000 residents
2. **Providence:** 53.8 per 100,000 residents
3. **Pawtucket:** 34.6 per 100,000 residents
4. **Cranston:** 34.0 per 100,000 residents
5. **Warwick:** 28.9 per 100,000 residents

Statewide Rate:

29.4 per 100,000 residents

Source: Office of State Medical Examiners (OSME), Rhode Island Department of Health (RIDOH). Data updated as of December 23, 2024. Prepared by Heidi Weidele. Note: Municipal estimates from the American Community Survey, statewide estimates from CDC Wonder, 2022 estimates applied for 2024 rates. Fatal overdoses are restricted to Rhode Island residents.

Key Takeaways: January 2024 – June 2024

- Overdose deaths decreased by 11% compared to the first six months of 2023.
- The rate of overdose remains similar among all race and ethnicity groups, with non-Hispanic, Black Rhode Islanders continuing to experience the highest rate of fatal overdose.
- Although most overdoses occurred among individuals age 25 and older, 62% of overdoses involved those age 45 and older.

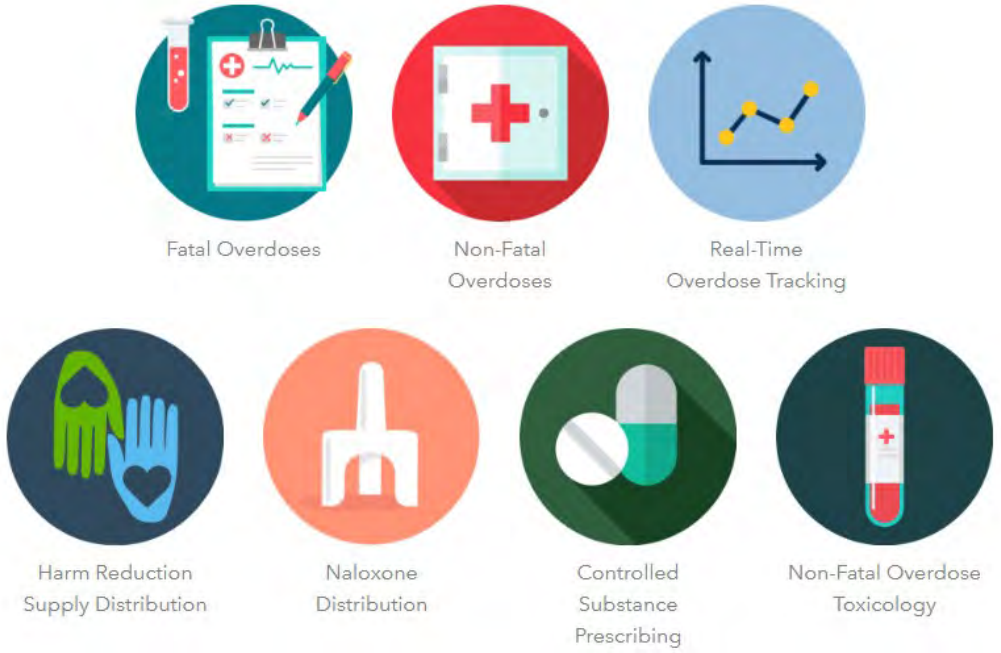
Key Takeaways: January 2024 – June 2024 (continued)

- The proportion of overdoses involving illicit drugs alone decreased, while the proportion involving prescription drugs (alone or in combination with illicit drugs) increased.
- Opioids contributed to 71% of fatal overdoses in the first six months of 2024, while any stimulant contributed to 64% of fatal overdoses.
- Stimulant and cocaine-involved fatal overdoses were more common among non-Hispanic, Black individuals compared to Hispanic or Latino and non-Hispanic, white individuals.

RIDOH Opioid and Stimulant Use Data Hub

For more information, visit RIDOH's Opioid and Stimulant Use Data Hub at health.ri.gov/od-datahub

- Fatal Overdoses
- Non-Fatal Overdoses
- Overdose Heat Maps
- Naloxone Distribution
- Data for Download
- Data Requests



For more data, local resources, and access to free naloxone, visit PreventOverdoseRI.org

PREVENT OVERDOSE RI

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Additional Resources

- Order **free educational brochures, posters, and fact sheets** for community outreach on RIDOH's Addiction and Overdose Publications webpage.
- If you would like to receive **RIDOH Overdose Spike Alert emails**, please use this link to subscribe.
- The **Governor's Overdose Task Force** relies on the support, engagement, and feedback from its various work groups: Prevention, Rescue, Harm Reduction, Treatment, Recovery, First Responder, Racial Equity, Substance-Exposed Newborns (SEN), and Family Task Force. The work groups meet on a monthly or bi-monthly basis and are always welcoming new volunteers.
- To receive the **Governor's Overdose Task Force monthly newsletter**, please use this link to subscribe.
- The **Rhode Island Overdose Fatality Review (OFR) Team** develops recommendations for State and local partners to prevent fatal overdoses throughout the state. Read OFR reports here.
- For more **data**, **local resources**, and access to **free naloxone**, visit PreventOverdoseRI.org.


We’re grateful to those across our state, **especially frontline care providers**, who give so much of themselves **every day**, to address the overdose crisis.

2024-2025 Treatment Work Group Initiatives

Linda Mahoney, CDCS, CS; State Opioid Treatment Authority (SOTA), Associate Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals and Co-Chair, Treatment Work Group

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Governor's Overdose Task Force
Treatment Work Group

Past Year Summary
Current Initiatives
and Future Direction

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Past Year Work: Treatment Work Group

- **Skilled Nursing Facilities - Skilled Nursing Facility Resistance**
  - Avoiding Legal Risks Posed By Nursing Home Admissions of Substance Abuse Disorder Patients - Skilled Nursing News

- **How to Become a "Safe Zones" Provider – Blue Cross & Blue Shield Certification**
  - Safe Zone Application | Blue Cross & Blue Shield of Rhode Island

- **"Project Start" at the Boston Medical Center**
  - www.bu.edu/familymed/about-us/for-our-patients

- **American Society of Addiction Medicine (ASAM) 4th Edition Changes**
  - What's new in The ASAM Criteria 4th Edition

- **Substance Use Disorder (SUD) Reimbursement Rates and Expectations**
  - FY25 Medicaid Reimbursement Rate Updates | Executive Office of Health and Human Services

Previous Work

- Rhode Island Overdose Fatality Review (OFR) recommendations
- Addiction Care Today (ACT), crisis stabilization (CSU), and acute stabilization
- COBRE Point Study Stimulant interventions
- Reducing stigma within the healthcare community
- Expanding women and children services
- PreventOverdoseRI.org - Treatment-related resources
- SUD conference planning
- Expanding buprenorphine access via TEVA Pharmaceuticals and pharmacy options
- Substance-Exposed Newborn (SEN) Program and new peer supports
- Reviewing treatment - metrics and goals
- Opioid treatment provider (OTP) medical directors, RIDOH, and BHDDH - Drug Enforcement Agency (DEA) changes

Current Treatment Work Group Initiatives

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Current Topics and Presenters

72-Hour Rule (21 CFR Part 1306)

- Dr. Rachel Wightman: Emergency department (ED) **inductions** and three-day distribution of methadone
- Single-dose inductions/return daily for additional two days
- Medical Director's meeting for **coordination** issues: VICTA, Addiction Recovery Institute (ARI), CODAC, and the Behavioral Health Group (BHG)
- Importance of **releases**, face sheets with last doses both faxed and given to the individual for follow-up appointments

Imani Project: Year-End Report

- Three cohorts/churches (22 weeks): 12-week Yale curriculum with 10 weeks of coaching, sustainability, and support plan.
- 42% African-American, 25% Caucasian, 13% American Indian, 8% Biracial, 21% Hispanic, and 13% other.

Expanding Contingency Management (CM) in Rhode Island for People of Color

- ✓ Add CM outside of OTP system
- ✓ Seek community input to review CM process, tools, and language
- ✓ Enhance CM process as needed and provide staff/team training
- ✓ Assure CM staff diversity/expertise to meet population needs
- ✓ Ongoing quantitative and qualitative data review by all stakeholders
- ✓ Institute corrective measures as indicated by the review process

Next Steps on Expanding CM in Rhode Island: Options Beyond OTPs

- Discharge planning from the hospital, rehabilitation, and detoxification - American Society of Addiction Medicine (ASAM)
- Referral from the Outpatient (Level 1), Intensive Outpatient Program (Level 2), shelters, and/or prisons
- Follow ups after ED for overdose reversals
- Building referrals for first responders
- CM in street outreach for retention and engagement
- Enhanced referral and engagement support by peer coaches

Treatment Work Group 2024 Planning Session

Goal 1: Increase capacity and reduce barriers to ensure “treatment on demand”
Goal 2: Monitor and improve treatment access and outcomes
Goal 3: Improve partnerships among SUD and other providers
Goal 4: Educate and address changes in Federal policies

Identified Main Objectives - Increase:

- Retention in treatment
- Access to treatment for everyone
- Training in evidence-based practices (EBPs)
- Outreach to underserved populations
- Education re: SUD treatment and new risks

BHDDH and the Treatment Work Group

- **Maximized braided funding** to avoid duplication and to increase resources
- Utilize **data** and program evaluations for sustainability reviews
- Continue to expand racially equitable Brick and Mortar treatment investments
- Build **provider partnerships with in-need communities**.
- Expand distribution of low-threshold Medications for Opioid Use Disorders (MOUD)
- Embed Physical Therapist in our OTPs to support pain management
- Expand "Safe Landings" and other "Gap" programs

- Stimulant use disorder **Treatment conference**
- Increase access to mobile services
- Community led events that educate on the **continuum of care**: prevention, treatment, harm reduction and recovery supports
- Support Opioid Treatment Programs as the gold standard for OUD treatment.
- Embed family counseling supports in all treatment facilities.
- **Adolescent SUD treatment expansion**
- Finally…Invest in treatment by reducing stigma and barriers to ensure On-Demand treatment

Future


SUBSTANCE USE DISORDER TREATMENT MONTH
SAMHSA
HEALTHY NEW YEAR
TALK WITH YOUR PROVIDER.
Find treatment options and resources for substance use disorders.
SUBSTANCE USE DISORDER TREATMENT MONTH
SMALL STEPS FORWARD...
...ARE STILL STEPS.
Find treatment options and resources for substance use disorders.
SAMHSA


2025
NEW YEAR, NEW BEGINNINGS.
Find treatment options and resources for substance use disorders.
FINDTREATMENT.GOV
SUBSTANCE USE DISORDER TREATMENT MONTH
SAMHSA
SUBSTANCE USE DISORDER TREATMENT MONTH
SAMHSA
NEW YEAR, NEW BEGINNINGS.
Find treatment options and resources for substance use disorders.
FINDTREATMENT.GOV

SUD Treatment Month: Substance Use and the Substance Abuse and Mental Health Services Administration

- Week 2 (January 12 – 18): Reducing Stigma
- Week 3 (January 19 – 25): Demystifying Treatment Options
- Week 4 (January 26 – 31): Supporting Treatment-Friendly Communities
- Virtual Backgrounds
- Sample Newsletter Content

Strategic Plan: Supporting Treatment

Core Treatment Strategies

Core Strategy 1: Increase access to various levels of treatment, including but not limited to medications for opioid use disorder (MOUD) and reduce racial and cultural access barriers

Core Strategy 2: Monitor and improve evidence-based practices treatment programs and outcomes

Core Strategy 3: Improve coordination and partnerships among SUD providers with all healthcare providers

Core Strategy 4: Support substance-exposed newborns interventions and infrastructure

Core Strategy 5: Develop and implement treatment policies

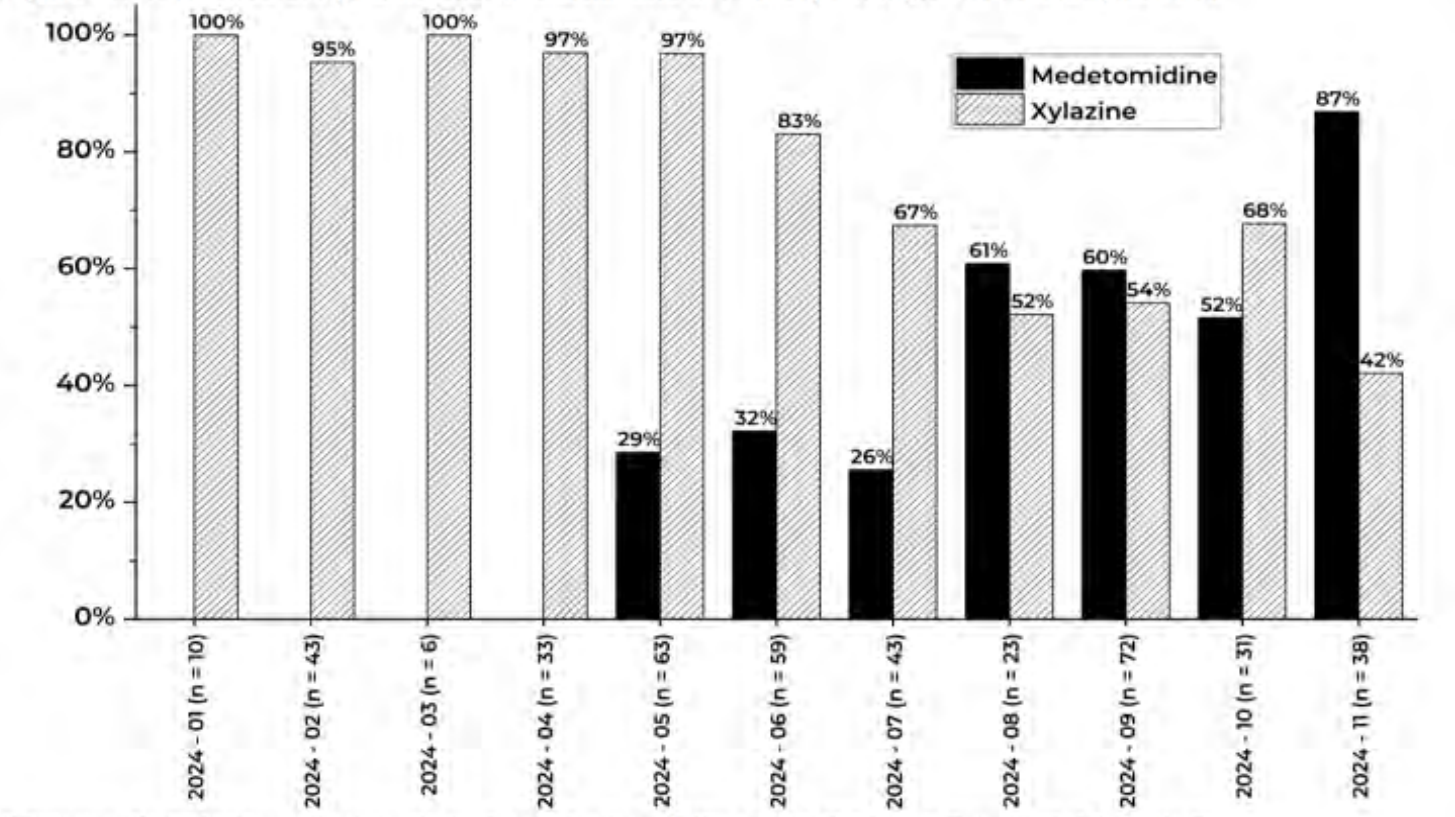
Core Strategy 6: Build a more diversified workforce

Medetomidine: Instruct, Educate, and Respond

Philadelphia Department of Heath

The Philadelphia Medical Examiner's Office (MEO) initiated toxicology testing for medetomidine on May 18, 2024. Since then, medetomidine has been detected in 46 overdose decedents. All decedents who had toxicology testing positive for medetomidine were also positive for fentanyl. Of all overdose deaths since May 18, 2024, with finalized toxicology testing by MEO, 13.5% had medetomidine detected and 18.25% of decedents with finalized toxicology that was positive for fentanyl during this period also had medetomidine detected.

Figure 1: Prevalence of Xylazine and Medetomidine in Fentanyl Samples in Philadelphia, PA



Data source: Center for Forensic Science, Research and Education, PA Groundhogs, Philadelphia Department of Public Health

Promoting MOUD as a treatment for a chronic medical condition

- The final rule makes permanent flexibilities for the provision of unsupervised doses of methadone and the use of telehealth, including audio-only telehealth, in initiating buprenorphine

- Also, revises criteria for unsupervised "take-home" methadone doses by:
  - Reframing from rule-based to clinical judgment-based using benefits and risk framework
  - Emphasizes patient education on safe transportation and storage of medication
  - Allowing patients eligibility for take-home doses upon entry into treatment

Use this QR Code to link to further information

SAMHSA
Substance Abuse and Mental Health Services Administration

If you are interested in joining the Task Force Treatment Work Group, contact Natasha Andrews
Natasha.Andrews@bhddh.ri.gov
First Tuesday of the month at 10 a.m.

For more information, contact
Linda.Mahoney@bhddh.ri.gov
401-462-3056

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Pregnancy Inpatient Hospital Admission

Needed Pathway Option to Start Medications for Opioid Use Disorder in Pregnancy in Rhode Island

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Disclosures

- No financial disclosures to report.

General Background

Overdose mortality rates more than tripled from 2018 to 2021 in pregnant and postpartum women age 35-44 [1] and patients with opioid use disorder (OUD) experience higher rates of pregnancy complications. [2, 3]

- **May 2024:** Presentation at the Governor's Overdose Task Force Substance-Exposed Newborns (SEN) Work Group by Dr. Kelley Saia, FACOG Boston Medical Center Project RESPECT
- **December 2024:** Presentation at Rhode Island's 7th Annual Substance-Exposed Newborns Conference by Arlo Narva, MSS and Katie Gonzalez, BA CHW CPRS
- Inpatient admission for the initiation of medications for opioid use disorder (MOUD) in pregnancy across all stages of pregnancy is currently offered at many hospital centers across the country, including:
  - San Francisco General, University of California San Francisco, Boston Medical Center, Brigham and Women's Hospital, Jefferson Health, University of Pennsylvania, University of Michigan, Parkland Health and Hospital System (Dallas), Banner Health (Phoenix), Emory, Johns Hopkins, University of Pittsburgh, and Swedish (Seattle)

1. B Han, et al. Pregnancy and postpartum drug overdose deaths in the US before and during the COVID-19 Pandemic. JAMA Psychiatry. 2023
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We admit patients for chronic disease management often in pregnancy - and substance use disorder (SUD) should not be an exception.

Evidence for MOUD in Pregnancy

MOUD (buprenorphine or methadone) is standard of care treatment for pregnant patients with opioid use disorder (OUD). [1]

- Treatment of OUD with MOUD is known to reduce mortality by 50%. [2]
- During pregnancy, MOUD treatment outcomes are improved significantly compared to the general population with OUD. [3]
- Benefits of MOUD stabilization during pregnancy far outweigh costs of an inpatient admission for medication stabilization:
  - **Improved birth outcomes** [4]
  - **Improved infant outcomes** [5]
  - **Improved maternal outcomes** [3, 4]

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Why Is an Inpatient Option Needed in Pregnancy?

Fentanyl is different and creates more challenges. [1, 2]

- Fentanyl withdrawal is more severe than withdrawal from other opioids. [3]
- Polysubstance exposure including fentanyl analogues, xylazine, nitazenes, medetomidine. [4]
- Starting MOUD (buprenorphine or methadone) is more challenging in the fentanyl era.
  - Precipitated withdrawal risk [5]
  - Inadequate control of withdrawal using outpatient doses allowed by federal regulations [6]

"Providers should be aware that opioid withdrawal can negatively affect the health of the pregnant person and developing fetus. In the pregnant person and the fetus, withdrawal can cause an irregularly fast heart rate (tachycardia) as well as increased muscle activity and metabolism. High blood pressure and tachycardia can also reduce oxygen supply to the fetus. Severe withdrawal from opioids may also lead to preterm delivery (SAMHSA)."

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Untreated OUD in Pregnancy

- **Costs of Failed Outpatient MOUD Attempts Are Higher in Pregnancy:**
  - Risk for overdose
  - Risk of ongoing substance exposure
  - Risk for pregnancy complications (e.g., preterm labor, C-section, preeclampsia)
  - Higher rates of family separation

- **Benefits of Inpatient MOUD Starts:**
  - Stabilization of high-risk pregnancy, safety, harm reduction, nutritional repletion, hygienic care, immediate obstetrics (OB) assessments, ultrasound, lab work, psychiatry consultation, social work assessment, and housing/residential treatment placements
  - Project RESPECT (BMC) preliminary data

What Do Rhode Island Providers Say?

Providers at CODAC, MOMS PRN/MATTERS, Victa, and Lifespan agree that inpatient hospital options for MOUD initiation for both methadone and buprenorphine in pregnancy are vitally needed.

- Multiple recent reports of pregnant patients with poor medical and psychosocial outcomes trying to navigate MOUD starts as an outpatient.
- Inadequate control of withdrawal leading to the return to use and failed MOUD starts - in some instances resulting in pregnancy complications or loss of treatment engagement.
- Pregnant patients who are Rhode Island residents have gone to Massachusetts and Connecticut to access inpatient care for MOUD starts because the service is not accessible in Rhode Island.

Predicted Demand Is Low

Other hospital systems have been able to implement protocols to meet need.

- In 2023 there were a total of 64 opioid-exposed newborns in Rhode Island.
  - Of those 64, there were nine newborns with illicit opioid exposure, 42 newborns with exposure to MOUD (methadone/buprenorphine), and 13 with prescription opioid exposure.
  - Inpatient treatment would be optional for patients.
- Leading OB/GYN programs have been able to implement protocols which are not overly burdensome on inpatient hospital operations.

Current Status in Rhode Island

- Hospital leadership in Rhode Island have voiced concerns around offering an inpatient pathway for MOUD starts in pregnancy, including:
  - Cost (gap in reimbursement versus cost)
  - Lack of hospital capacity and staffing; not sufficient volume of patients to justify creation of a pathway
  - Inadequate staff training
- However, birthing hospitals must currently take care of these patients and provide this service when patients have medical emergencies (e.g., when they present for other pregnancy and medical complications).

Current Status in Rhode Island (continued)

- Medically-managed, residential treatment/detoxification can't do it all.
  - Limited ability to manage patients with medical complexity (e.g., hypertension, cardiac disease, high risk pregnancy)
  - Challenges of bed availability; a disconnect from when a patient is ready to start MOUD
  - Lack of OB consult availability
  - Not medically equipped to do fetal monitoring
- Pregnant patients with OUD and active use are told they need to get onto medications for opioid use disorder, but inpatient hospital admission is not offered when needed.

Cost Assessment Challenges and Potential Next Steps

- There are gaps in what insurance reimburses versus actual cost to hospitals.
  - It has been challenging to target a dollar value due to lack of billing transparency.
  - Outdated billing system assessments.
- Insurers have and will engage in discussion.
- Received inpatient protocols from Cooper University Hospital (Camden, New Jersey), San Francisco General Hospital, and Boston Medical Center available for implementation.
- Hospital systems and insurers must come together.

Questions?

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Public Comment

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