LETTER OF INTENT

To: Indiana Department of Administration
Procurement Division Room W468, IGCS

From: FSSA/Division of Mental Health and Addiction
402 W. Washington St, W353
Indianapolis, IN 46204
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Date: June 14, 2017

Are federal funds\(^1\) going to be used for this procurement? \(\square\) Yes \(\square\) No

If yes, have all requirements/restrictions associated with the federal funding been incorporated into this solicitation and the specifications? \(\square\) Yes \(\square\) No

Description of Services:
Indiana received $10.9M in funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the 21st Century Cures Act to support initiatives that address our states opioid epidemic. One of the required goals for the SAMHSA application includes a need for integrated treatment and recovery services. SAMHSA approved Indiana's plan to address this goal through the Indiana Peer Recovery and Support Initiative (IPRSI). This goal is based on the need for integrated treatment and recovery services, especially for patients who have overdosed on an opioid, and is expected to increase the number of people who receive opioid use disorder (OUD) treatment, increase the number of people who receive OUD recovery services and increase the number of providers implementing medication assisted treatment (MAT).

Scope of Work:
Systematic reviews of peer-delivered recovery support across the spectrum of substance addictions in the United States – the gold standard of evidence-gathering – have produced generally positive findings for such services (e.g., Bassuk et al., 2016), including substance-specific outcomes, such as reductions in use, and distal outcomes, such as increased housing stability. A core goal for Indiana's overall response to the OUD crisis is the formation of an initiative – the Indiana Recovery and Peer Support Initiative, or IRPSI, that utilizes recovery coaching and peer support linked to emergency rooms (ERs) in the state. The use of multiple non-physician roles within the ER, sometimes called Social Emergency Medicine, increasingly is recommended as a best practice, including in a recent

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\(^1\) If available, please attach a copy of the agreement that memorializes the source of these federal funds.
commentary in the Annals of Emergency Medicine, the journal of the American College of Emergency Physicians (Anderson et al., 2016).

While formal design of recovery and support initiatives within the ER setting is an ongoing topic of research, the SAMHSA-sponsored program AnchorED in Rhode Island issued general replication guidance in a SAMHSA webinar (Joyce & Bailey, 2014), and the Department of Emergency Medicine at Yale University recently published favorable results from a randomized trial of a similar program (D’Onofrio et al., 2015). The IRPSI’s strategic design is based on the preliminary work completed by these entities and recommendations from Project POINT, a partial replication of D’Onofrio’s work in Marion County, Indiana within the Eskenazi Health system (Personal Correspondence, Dr. Krista Brucker, Project POINT Administrator, 2017).

The IRPSI will focus specifically on individuals who arrive in an ER setting after having overdosed on any opioid (including prescription drugs, regardless of the source, heroin, fentanyl, and others). Special emphasis will be placed on those revived using Naloxone subsequent to an overdose. Any interested ER within the state of Indiana will be eligible to participate. To do so, that entity will sign a memorandum of understanding with a community mental health center or DMHA-certified addictions entity and register with IRPSI. This MOU will link the ER with appropriate non-physician health professionals, including those with LMHC, LCSW, and LMFT certifications who have addictions certification (e.g., CAPCII, Indiana’s internationally-recognized Certified Addiction Peer Recovery Coach credential; https://www.icaada.org/credentials-navigation), and those with an LCAC certification, LAC certification, or any other Indiana recognized certification. Bachelors-prepared individuals and those with a GED or high school diploma who also have CAPCII certification will be allowed to offer services, though with additional supervision (see below). These individuals, for the purposes of this project universally labeled Recovery Coaches (RCs) will be on-call 24 hours a day, 7 days a week, and be able to arrive at the ER within 30 minutes of receiving a call – protocols recommended by AnchorED (Joyce & Bailey, 2014). ERs additionally will be required to implement twice-monthly supervisory meetings between physician and nursing staff and IRPSI recovery partner staff (Joyce & Bailey, 2014). ERs utilizing bachelors-prepared or GED/high school diploma-level staff also will be required to offer additional individual supervision, and all participating agencies will be encouraged to monitor interaction fidelity (Personal Correspondence, Dr. Krista Brucker, Project POINT Administrator, 2017).

Both Project POINT and the Yale randomized trial that serve as models for IRPSI utilize basic principles in structuring the recovery and support process. Thus, RCs and patients will complete the following sequential steps:

**Screening and Assessment:** Patients will work with the RC to complete an assessment of substance use, especially (but not exclusively) prescription opioids or heroin, within the past 30 days, including administration of a diagnostic tool to ascertain whether the patient is dependent on opioids, such as the Mini-International Neuropsychiatric Interview, or MINI (D’Onofrio et al., 2015). RCs would be free to collect additional pertinent information as needed to facilitate the process, such as family substance use history and preferred route of use. Patients who are critically ill or unable to communicate due to psychosis or schizophrenia, as well as those who need immediate mitigation of suicidal ideology, will not enter this process (D’Onofrio et al., 2015).
Immediate Counseling and Intervention: D’Onofrio and colleagues modified a traditional alcohol brief intervention (D’Onofrio et al., 2005) to specifically meet the needs of patients who have overdosed on opiates. This modified protocol also includes a 27-item fidelity checklist (D’Onofrio et al., 2015). RCs will complete an intervention with patients in approximately 10 to 15 minutes, prior to the referral process.

Referral to Treatment and/or Buprenorphine Administration: RCs will “discuss a variety of treatment options...based on patient insurance, residence, and preferences. The RC directly will link the patient with the referral. This will include reviewing the patient’s eligibility for services, insurance clearance, and arranging transportation... Patients exhibiting moderate to severe opioid withdrawal will be provided with sufficient doses of buprenorphine until a scheduled appointment in the hospital’s primary care center [or referral target]. [If treatment is available in the hospital], office-based buprenorphine treatment will be provided for 13 weeks by physicians and nurses using established procedures. After 10 weeks, patients will be transferred for ongoing opioid agonist maintenance treatment to either a community program or a clinician, or will be offered detoxification over a 2-week period, based on stability, insurance, and preference” (D’Onofrio et al., 2015, p. 1639). In cases where a participating ER does not have any physicians or care providers with a buprenorphine wavier, at least one physician will be expected to complete training and receive a waiver within 4 months of receiving support for participation in IRPSI.

Post-Treatment Care Coordination: IRPSI includes modalities that support up to 12 weeks of continued care and treatment with physician and nursing staff. However, little rigorous research has examined individualized concomitant psychosocial care with peer support, case managers, or other behavioral health providers (e.g., those defined by Medicaid regulations). There is little extant research about models of OUD extended care involving provision of psychosocial support. The closest research analogue is for patients with alcohol use disorders, as research on alcohol tends to precede similar work on other substances. Even so, a meta-analysis of 15,235 trials related to alcohol use disorders found only six rigorous studies focusing on individualized continued care more than seven days after detoxification (Lenaerts et al., 2014). Effects of these types of approaches, including home visits and telephonic support, were generally positive where measured. The IRPSI model will utilize evidence-based approaches as part of a continued care model. These include community support/life skills training, contingency management training, and therapeutic educational support, along with other appropriate assistance (as supported by reviews such as Marsch & Dallery, 2012). The utilization of evidence-based approaches as well as the inductive generalization of long-term alcohol use disorder paradigms to OUDs suggests that this addendum to work like Project POINT is supported by the literature, though continuous evaluation, facilitated through data collection in the state’s data-system (DARMHA), will be especially important for this project.

Estimated Annual Contract Cost: $100,000

Estimated Initial Contract Length: Eight Months
Contract Effective Date: 09/01/17

Previous RFP (or BAA) number: N/A

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Agency Head Approver: Kevin Moore, Director

Agency Head Approval: ____________________________
   (This signature required)

Agency Head Signature Date: ____________________________
   (MM/DD/YYYY)