May 2024

Concept Report
Expanding Access to a Nurse Care Manager Model of Health Care for People Who Use Drugs

Purpose of the Proposed Request for Proposal (RFP)

In accordance with Section 3-16(j) of the New York City Procurement Policy Board (PPB) Rules, the New York City Department of Health and Mental Hygiene ("DOHMH" or "the agency") is issuing this Concept Report in advance of issuing a Request for Proposals for a capacity building and client services initiative. Specifically, DOHMH is planning to issue an RFP for supporting primary care settings in developing and maintaining their capacity to comprehensively identify and address the holistic health needs of people who use drugs (PWUD) and reduce drug use-related harms. This would be accomplished through the utilization of low-barrier, patient-centered, and harm reduction principles and approaches to engagement in care.

Overview

Overdose deaths and substance use-related harms continue to be a public health crisis in the United States generally and in NYC specifically. In 2022, 3,026 New Yorkers died from an unintentional drug overdose—the highest number since reporting began in 2000. In 2022, overdose death rates in NYC reached unprecedented levels, increasing 12% from 2021 (2,696 deaths). Fentanyl, a highly potent synthetic opioid that has been increasingly found in the unregulated NYC drug supply since 2015, continues to drive overdose mortality. Fentanyl was involved in 81% of overdose deaths in NYC in 2022. Other trends in the types of drugs involved in overdose deaths include the increased presence of xylazine, a non-opioid veterinary tranquilizer that can increase the risk of overdose due to its deeply sedative effect. In 2022, 22% (572) of opioid-involved overdose deaths in NYC also involved xylazine. [1]In 2021, all xylazine-involved overdose deaths also involved fentanyl.[2 *]

Alcohol use and its associated harms result in numerous health and safety consequences. In 2021, alcohol was involved in 39% of overdose deaths.[2] In 2019, there were an estimated 2,066 deaths among New Yorkers attributable to excessive alcohol consumption. Chronic conditions, such as cancers, stroke, and liver disease, caused 49% of these deaths, while acute causes, such as motor vehicle accidents, poisonings, and fall injuries accounted for the remaining 51%.[3]

In the past two decades, the prevalence of smoking has declined significantly among adults in NYC. Due to community and public health efforts, the prevalence of smoking has been halved, from 22% in 2002 to 11% in 2020. However, this progress has not been experienced equally – some New Yorkers continue to smoke at higher rates and receive tobacco treatment at lower rates. During 2019 to 2020, overall smoking prevalence in NYC was similar across different race and ethnicity groups, but there were significant differences when race and ethnicity, gender, and place of birth were considered together. In 2020, among adults who lived in neighborhoods with very high poverty, 14% smoked, compared with 9% of adults who lived in neighborhoods with low poverty.[4]

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[1] Tuazon E, Bauman M, Sun T, Weitz A, DeWalt J, Mantha S, Harocopos A. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2022. New York City Department of Health and Mental Hygiene: Epi Data Brief (137); Sep 2023.
[2] Askari MS, Bauman M, Ko C, Tuazon E, Mantha S, Harocopos A. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2021. New York City Department of Health and Mental Hygiene: Epi Data Brief (133); Jan 2023.
*Note some data included are more recent than others
[3] New York City Municipal Drug Strategy Council. 2022 Report and Recommendations. https://a860-gpp.nyc.gov/concern/parent/3x816q58q/file_sets/pg15bh717 Updated April 23,2023.
[4] Merizier J, Orkin-Prol L, Talati A, Jasek J, Debchoudhury I. Addressing New York City's Smoking Inequities. NYC Vital Signs. 2022;20(1):1-4

Although overdose mortality rates increased from 2021 to 2022 in NYC, these increases were not evenly distributed across the city. Significant disparities remain in drug overdose deaths by race and ethnicity, and neighborhood of residence. In 2022, residents of very high-poverty neighborhoods had the highest rate of overdose death (72.8 per 100,000 residents), compared with residents of high (39.3 per 100,00 residents), and low-poverty neighborhoods (21.8 per 100,000 residents). Black New Yorkers had the highest rate of overdose death (62 per 100,00 residents) compared with Latino/a New Yorkers (53.1 per 100,00 residents) and White New Yorkers (36.5 per 100 residents).[1]

Overdose deaths and substance use-related harms are preventable. Opioid use disorder (OUD) is recognized as a chronic medical condition that can be treated with safe and effective medications. Medications for opioid use disorder (MOUD), specifically buprenorphine and methadone, are the standard of care for the treatment of OUD. Buprenorphine can be prescribed in general practice settings and has been shown to reduce the risk of all-cause mortality, opioid overdose mortality, and illicit opioid use; reduces risk of HIV transmission and diagnosis; reduces risk of HCV infection; improves social functioning; and promotes better quality of life compared to individuals with OUD who are not taking MOUD.[5]

Despite buprenorphine's effectiveness, only 1 in 5 people with OUD in the United States receive buprenorphine treatment for opioid use disorder.[6] Further, disparities in care exist by race and ethnicity, both in initial access to buprenorphine and length of treatment. Treatment data show that buprenorphine is more likely to be offered to White patients and patients with commercial insurance and treatment rates are higher in middle-and-upper-income communities.[7,8] Additionally, longer time spent in treatment is associated with better clinical outcomes; compared to White patients, the duration of buprenorphine treatment is typically shorter for Black and Latino/a patients.[9]

The three (3) FDA-approved medications for the treatment of alcohol use disorder (AUD) are naltrexone, acamprosate, and disulfiram[10]. These medications are effective and, like buprenorphine, can be prescribed in general practice settings. As with medications for OUD, medications for alcohol use disorder (MAUD) are underutilized by both healthcare providers and patients. In 2019, of the estimated 14.5 million Americans with AUD, 1.6% received a medication to manage their AUD.[11]

[5] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder, Mancher M, Leshner AI, eds. *Medications for Opioid Use Disorder Save Lives*. Washington (DC): National Academies Press (US); March 30, 2019.

[6] Jones CM, Han B, Baldwin GT, Einstein EB, Compton WM. Use of medication for opioid use disorder among adults with past-year opioid use disorder in the US, 2021. *JAMA Netw Open*. 2023;6(8):e2327488. doi:10.1001/jamanetworkopen.2023.27488

[7] Lynch S, Katkhuda F, Klepacz L, Towey E, Ferrando SJ. Racial disparities in opioid use disorder and its treatment: A review and commentary on the literature. *J Ment Health Clin Psychol* 2023; 7(1): 13-18. doi: 10.29245/2578-2959/2023/1.1263

[8] Rosen H, Cunningham, CO. Time to end racial disparities in buprenorphine access. *Am Journal of Public Health* 2023; 113(10): 1083-1085. doi: 10.2105/AJPH.2023.307388

[9] Dong H, Stringfellow EJ, Russell WA, Jalali MS. Racial and ethnic disparities in buprenorphine treatment in the US. *JAMA Psychiatry* 2023;80(1): 93-95. doi:10.1001/jamapsychiatry.2022.3673

[10] Naltrexone and acamprosate are first-line medications and disulfiram is a second-line medication for the treatment of alcohol use disorder.

[11] Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration. Sept 2021.

Barriers to care for both OUD and AUD include but are not limited to historically rigid treatment structures and stringent requirements for patients to enter treatment[12]; patient and provider knowledge of evidence-based treatments for OUD and AUD; lack of clinician time to provide OUD/AUD care and the associated follow up[13,14]; and misguided concerns about prescribing MOUD to patients who are not also receiving counseling or prescribing MAUD to patients who are not also participating in a 12-step program.[15]

A critical strategy for addressing the overdose crisis and reducing substance use-related harms is expanding access to evidence-based treatments and increasing the capacity of healthcare providers to provide comprehensive, coordinated care to address the holistic needs of PWUD.

In order to address barriers to buprenorphine treatment, reduce inequities in treatment access, and improve care for people with opioid use disorder, DOHMH implemented the New York City Buprenorphine Nurse Care Manager Initiative in 2016. The initiative was based on a nationally recognized and replicated collaborative care model—known as the "Massachusetts Model"—that utilizes a nurse care manager to ensure delivery of high-quality office-based opioid use disorder treatment while effectively and efficiently utilizing the time of health care providers who provide buprenorphine treatment. This approach increases patient engagement and retention in treatment, supports the management of comorbid medical conditions, and ensures successful connections to additional specialty medical services and behavioral health services.

Recognizing expansion and replication of this initiative as key to increasing access to treatment for substance use disorders (SUDs), DOHMH proposes to expand upon this service delivery model to include additional services, and would contract with 14 organizations to implement or expand this model in primary care safety net settings. In addition to providing buprenorphine treatment, awarded organizations will use this team-based, collaborative care model to provide connections to or direct provision of medication treatment for alcohol use disorder, medications for tobacco use disorder[16], HCV and HIV testing and care, PrEP/PEP, and substance use-related wound care.

Safety-net primary care practices (including federally qualified health centers [FQHCs]) are well-positioned to address substance use disorders. The risk of mortality is greater among people with SUDs generally and OUD specifically[17] as compared to the general population. People who inject drugs are at increased risk for infectious diseases such as HIV and hepatitis C as well as skin and soft tissue infections. The prevalence of cigarette smoking among people receiving methadone or buprenorphine treatment for OUD is high[18]. Additionally, smoking rates and rates of tobacco-related deaths are higher for people who have received SUD treatment

[12] Oliva EM, Maisel NC, Gordon AJ, Harris AH. Barriers to use of pharmacotherapy for addiction disorders and how to overcome them. *Curr Psychiatry Rep.* 2011; 13(5):374-81. doi: 10.1007/s11920-011-0222-2.

[13] Mackey K, Veazie S, Anderson J, Bourne D, Peterson K. Barriers and facilitators to the use of medications for opoid use disorder: A rapid review. *J of Gen Intern Med.* 2020;35(3):954-963. doi: 10.1007/s11606-020-06257-4

[14] Leung JG, Narayanan PP, Markota M, Miller NE, Philbrick KL, Burton MC, Kirchoff RW. Assessing naltrexone prescribing and barriers to initiation for alcohol use disorder: A multidisciplinary, multisite survey. *Front Psychiatry*. 2022; 13:1-7. 13:856938. doi: 10.3389/fpsyt.2022.856938

[15] Williams EC, Achtmeyer CE, Young JP, et al. Barriers to and facilitators of alcohol use disorder pharmacotherapy in primary care: A qualitative study in five VA clinics. *J Gen Intern Med.* 2018;33(3):258-267. doi: 10.1007/s11606-017-4202-z

[16] Currently, there are seven tobacco treatment medications and five types of nicotine replacement therapy (NRT) available for to help individuals reduce or stop use of tobacco or nicotine.

[17] A, Cheng B, Gray S, Stuart H. Mortality Among People With Opioid Use Disorder: A Systematic Review and Meta-analysis. *J Addict Med*. 2020;14(4):e118-e132. doi:10.1097/ADM.0000000000000606

[18] Hall SM, Humfleet GL, Gasper JJ, Delucchi KL, Hersh DF, Guydish JR. Cigarette Smoking Cessation Intervention for Buprenorphine Treatment Patients. *Nicotine Tob Res*. 2018;20(5):628-635. doi:10.1093/ntr/ntx113

services compared with the general population.[19] These increased risk factors for mortality and comorbid conditions highlight the importance of screening and providing care in primary care settings to address the health needs of people who use drugs.[20] Primary care settings are often the first point of entry into the health care system; offering medications for addiction treatment (MAT) gives providers tools to meet a wider range of patient needs and provides a comprehensive approach to treatment that allows providers to identify substance use and SUDs and provide care management alongside and in a similar manner to other chronic medical conditions. In that safety-net primary care practices provide health care to medically underserved populations, they are an ideal point of care for addressing SUDs and the health care needs of people who use drugs.

Purpose of the Proposed RFP

The purpose of the proposed Request for Proposals is to expand on the original NYC Buprenorphine Nurse Care Manager Initiative and further support primary care settings to develop and maintain their capacity to comprehensively identify and address the holistic health needs of people who use drugs (PWUD) and reduce substance use-related harms, utilizing low-barrier, patient-centered, and harm reduction principles and approaches to engagement and care.

As part of the expanded initiative, DOHMH will provide technical assistance and mentoring to enhance the capacity of participating primary care settings to screen for SUDs and related health care needs, ensure participating primary care providers have the knowledge and support needed to prescribe buprenorphine and medications for alcohol use disorder and tobacco use disorder, provide care within a collaborative care model, and facilitate access to additional care and supports as needed. As part of DOHMH's commitment to reducing health inequities and serving medically underserved individuals and communities, we will provide funding to safety net primary care settings. DOHMH anticipates that contractors would need to meet one of the following qualifications in order to be considered for a contract award:

- Federally Qualified Health Center (FQHC)
- FQHC look-alike (i.e., HRSA-designated health centers that meet Health Center Program requirements but do not receive federal award funding). Visit Health Center Program Look-Alikes | Bureau of Primary Health Care (hrsa.gov) for more information about this designation
- Other Safety Net Provider (where at least 35% of the patient volume is comprised of Medicaid beneficiaries or people who are uninsured) demonstrated by a New York State License and Letter from the applicant's Chief Financial Officer stating the Medicaid and/or uninsured patient volume.

DOHMH anticipates that funds would be used to support staffing for the Contractors to successfully participate in the initiative.

The Goals of the RFP

As part of BADUPCT's broader goal of reducing substance use-related harms and reducing the number of opioid-involved deaths in NYC, the goals of the RFP are to:

- Increase buprenorphine and MAUD treatment capacity in safety-net primary care settings

[19] Substance Abuse and Mental Health Services Administration. *Implementing Tobacco Cessation Programs in Substance Use Disorder Treatment Settings: A Quick Guide for Program Directors and Clinicians.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

[20] Visconti AJ, Sell J, Greenblatt AD. Primary care for persons who inject drugs. *Am Fam Physician.* 2019;99(2):109-116. https://www.aafp.org/pubs/afp/issues/2019/0115/p109.html

- Expand access to high quality, evidence-based, low-barrier health care for people who use drugs
- Increase equitable access to buprenorphine and MAUD treatment and comprehensive health care for people who use drugs
- Support primary care providers and nurses in caring for people who use drugs
- Reduce stigma around drug use, people who use drugs, and evidence-based care for people who use drugs

Program Information

All human service programs funded by the NYC Health Department will be expected to describe and implement organizational strategies and approaches to racial equity and social justice through programming and operations, ensuring that services are equitable and responsive to the program participants' needs to address racial health gaps and improve health outcomes for all New York City residents. For more information regarding racial equity and social justice please visit https://www1.nyc.gov/site/doh/health/health-topics/race-to-justice.page."

a. Service Delivery

Selected contractors will be expected to provide services as indicated to all patients who use drugs, ranging from patients who are not experiencing problematic use to patients with opioid use disorder, alcohol use disorder, and/or other substance use disorders.

1. Service delivery model: Contractors will be expected to operate within the framework of the Nurse Care Manager model. This model embodies collaborative care management of substance use disorders with an emphasis on the integration of low-barrier, evidence-based medication treatment for opioid use disorder into primary care. In this model, a dedicated RN-level Nurse Care Manager (NCM) provides structured clinical support to primary care providers. Together, the NCM and PCP will screen and assess patients; provide medication management, motivational counseling, follow-up care, and monitoring; and refer patients to additional health care and supportive services as necessary.
2. Health Care Services: Contractors will be expected to use the NCM model and team-based, collaborative care approach to provide comprehensive health care services to patients who use drugs, including:
    a. Screening and assessing all patients for SUD, including OUD, AUD, and TUD
    b. Harm reduction education including but not limited to education about overdose prevention strategies, training on identifying and responding to an overdose, safer drug use practices; and connections to syringe service programs, Overdose Prevention Centers, and drug-checking services.
    c. Offer and dispense naloxone kits to patients who would like one
    d. Provide information to patients who use drugs about the most current options for care and treatment of SUDs, and, as relevant, provide and discuss information about medication treatment options to patients with OUD, AUD, and TUD.
    e. Provide buprenorphine treatment for OUD, manage all aspects and phases of treatment, including initial visit for buprenorphine treatment, buprenorphine initiation, and ongoing care
    f. Connect to or directly provide medication treatment for AUD and TUD
    g. Provide universal/routine testing for Hep C and HIV, and as relevant connect to or directly provide Hep C treatment and care, PrEP/PEP, and HIV treatment and care

   h. Provide substance-use related wound care including treating skin and soft tissue infections and providing education around wound prevention and basic wound care principles.
3. Care coordination: Contractors will be expected to coordinate care among team members as needed, including health care providers, recovery coaches, behavioral health team members, administrative, and support staff to ensure all patients receive comprehensive care
   a. Collaborate with other members of the care team to address the primary care health needs listed above (Hep C testing, treatment and care; HIV testing, PrEP/PEP, HIV treatment and care; substance use-related wound care)
   b. Address specialty care needs by coordinating internal and external referrals and provide warm handoffs to additional services such as behavioral health care, social supports and/or higher levels of SUD care as needed.

Outreach and Inreach

Contractors will be expected to identify patients by conducting targeted outreach (i.e., inviting people who do not currently utilize any healthcare services at the Contractor's sites) and inreach (i.e., inviting an existing population of patients who currently utilize other health care services at Contractor's sites) to utilize health care services offered as part of this initiative. Initiative staff will conduct outreach and inreach to identify individuals who might be appropriate for SUD treatment, including buprenorphine treatment for OUD and medication treatment for AUD, in venues or neighborhoods where there is an unmet need for primary care services and treatment of substance use disorders.

Participation in Initiative Activities:

Contractors will be expected to participate in the following training, educational activities, and meetings that will be facilitated by DOHMH:

1. Initial Nurse Care Manager Initiative training for participating clinical staff members
2. Quarterly Learning Community meetings
3. Quarterly Nurse Care Manager Continuing Education sessions

Reporting Requirements

DOHMH anticipates that Contractors will provide program utilization and performance data reflecting progress towards the goals of this RFP on a minimum monthly basis using designated DOHMH utilization and performance definitions, survey tools, and reporting systems. Contractors will participate in ongoing data collection and program evaluation as required by DOHMH and other City systems.

Resources provided by DOHMH

In addition to funding, selected Contractors will receive the following resources to support implementation of the SUNCMI model and to promote best practices in providing care to PWUD

1. Training
2. Technical Assistance
3. Clinical Mentorship
4. Public-facing educational materials

Proposed Term of the Contract(s)

The anticipated start date for these contracts is July 1, 2025. DOHMH anticipates that the term of each contract resulting from this RFP will be six years in duration, with renewal options to be determined by DOHMH contingent on the availability of funding.

Proposed Procurement Timeline

The proposed RFP would be issued through the PASSPort system, and proposals will only be accepted through PASSPort. It is anticipated that the RFP issuance date will be in the fall of 2024 with proposals due a minimum of 45 days after the RFP issuance date, anticipated award decisions in winter of 2024/25, and contracts beginning July 1, 2025.

Planned Method of Evaluating Proposals

DOHMH anticipates that proposals will be evaluated based on the extent to which applicants demonstrate relevant organizational experience; the proposed approach to providing the scope of services; the proposed approach to data management, monitoring, and reporting; demonstration of organizational capacity and qualifications, including proposed staffing plan; demonstrate commitment to addressing racial equity and addressing health disparities; demonstrate need in their geographic region; demonstrate commitment to patient-centered, harm-reduction and low-barrier approaches.

Funding Information

DOHMH anticipates awarding up to 14 contracts from the RFP. DOHMH estimates that the annual value of each contract will be $175,000 annually, subject to funding availability.

Use of PASSPort and Prequalification.

To respond to the future RFP and all other Human/Client Services RFPs, organizations must have an account and an approved HHS Accelerator PQL qualification status in PASSPort. Prequalification (PQL) applications and proposals in response to the future RFP will ONLY be accepted through PASSPort. If you do not have a PASSPort account or approved PASSPort HHS Accelerator PQL Application, please visit nyc.gov/passport to get started. If you have any questions about your HHS Accelerator PQL status or for assistance with creating a PASSPort account, please go to nyc.gov/mocshelp.

Provider Conference

DOHMH will hold a virtual meeting for interested providers on May 24, 2024 at 10:00am. The purpose of this meeting is for DOHMH to obtain feedback and input from the provider community relating to the content of this Concept Report.

If you plan to attend this meeting, please email RFP@health.nyc.gov by May 23, 2024 at 2:00pm with the attendee(s) name and email address(es); include **Nurse Care Manager CP RSVP** in the subject line.

Contact Information /Deadline for Questions/Comments

Written comments on this Concept Report are invited by June 29, 2024. Please email RFP@health.nyc.gov and indicate **Nurse Care Manager CP Comments** in the subject line of the email.