Lamont-Bysiewicz Transition Policy Committee Reporting Template

Committee Name:

Co-Chairs:

Please address the following questions using this template in a memo not exceed 2 pages. You are welcome to submit appendices or other attachments in addition to the memo.

1. **How do you propose the Lamont Administration should prioritize the policy goals in this area, and on what timeframe?**

Overall: Create a cabinet or commissioner level position charged with coordinating and prioritizing efforts to address opioid safety and addiction, and to increase access to behavioral health across the state. Charge DMHAS/DPH Commissioners with 1) effective immediately, prominent public reporting, weekly, of deaths and ER overdose reports related to opioids with publication of data by town and 2) cataloging and leveraging influx of federal funds into Connecticut for expanding integration of behavioral health, primary care, and SUD treatment.

Workforce development:

Medical/Psychiatric Providers: Offset costs (fees and lost work) of prescribers to attend 8-24 hour DATA 2000 training needed to allow prescribing of buprenorphine for the treatment of opioid use disorder.

Medical/DO/APRN/PA license renewals should require evidence of continuing education in pain management, opioid safety, and addiction; system already in place. timeline over first term of office.

Promote and incentivize providers to practice addiction medicine both as specialty service and as integrated within primary care practice in Connecticut and to support/fund training on medications for treatment of opioid use disorders for all licensed independent providers, both medical (MD, DO, APRN,PA) and behavioral (LCSW, LPC, PsyD, LADC).

Charge Connecticut state community and university colleges with expansion of existing behavioral health workforce training and substance use disorder training at both the provider level (LIPs) and non-provider level to address unmet needs for behavioral health and SUD treatment.

Remove administrative barriers to integration of behavioral health providers into primary care practices.

Treatment of opioid use disorder:

Require all licensed addiction treatment facilities to offer naltrexone, buprenorphine and/or methadone for the treatment of opioid use disorder.

Eliminate prior authorizations and other administrative burdens for medications to treat opioid use disorder.

Establish a Standard of Care for Treatment Centers and institute better oversight on sober home facilities.

Binding arbitration between methadone providers (federally licensened opioid treatment programs) and Department of Social Security regarding reimbursement, patient travel and fees structure (per patient vs. bundled).

DMHAS and the Department of Justice should scale up initiatives to provide treatment preceding and post release of inmates who suffer from addiction disease to prevent an overdose in jail or upon release.

Funding innovations and pilot programs focused on developing evidence based technologies that address the opioid crisis.

Capacity to Treat of behavioral health disorder:

Eliminate prior authorization and treatment plans for short term behavioral health treatment (up to 12 visits).

Incentivize on-site behavioral health services in PCMH recognized primary care practices.

Inventory and promote state's capacity for virtual (tele-health) behavioral and psychiatry services and mandate coverage across all insurance plans. Incentivize private expansion of school based health center behavioral health services to all high schools across state.

Data sharing:

Create Public Health Data Warehouse as achieved in Massachusetts: www.massmed.org/News-and-publications/vital-signs/game-changing-use-of-data-drives-opioid-practice/#.XARVdDIOkwA

Provide DCP with adequate resources to to fully support and improve the PDMP, including funds devoted to integrating with all electronic medical records in the state and for proactive surveillance for high risk prescribing patterns; timeline over next budget cycle.

Risk reduction:

Access to naloxone should be further expanded and/or moved to a virtual "over the counter" access model in all licensed Connecticut pharmacies.

Require veternarians to log all prescriptions and dispersements of opioids onto a central tracking system.

Education:

Institute an evidence-based prevention program in public schools at the middle-school level. A possible program could be Botvin LifeSkills Training which has proven to cut drug use by up to 75%.

2. **Which goals are achievable in the first 100 days of the Administration?**

   All above.

3. **Which goals will require legislation to move forward? Which items can be advanced through the actions of the Administration alone? What is the fiscal impact of these legislative or executive actions?**
   Mandating education and/or training for providers will likely require modification of existing legislation. Fiscal impact minimal.

   Mandating expanded naloxone coverage will likely require legislation**.** Unknown fiscal impact.

   Mandating a Life Skills prevention program in public schools will likely require legislation. Unknown immidate fiscal impact but prevention of addiction will lead to a significant cost savings over time.

   Not clear if the creation of a new cabinet or commissioner level position on opioid safety and addiction would require legislation or if it could be done through the actions of the administration alone**.** Initial fiscal impact may be high, but better data sharing and safety coordination could lead to significant cost saving over time.

4. **Are there specific challenges you can identify with regard to achieving the Lamont Administration's goals, and how would you suggest to address those?**

The major difficulty with assuring proper, evidence-based treatment for opioid use disorder is the stigma directed against this form of treatment. Careful but pervasive social marketing may be needed to overcome this problem. There may be push-back from the CT State Medical Society and the CT Hospital Association with any attempt to expand educational/training requirements; this can be addressed by collaborating with other physician groups. Many of the above suggestions require reallocation of financial resources, which will be difficult. New sources of revenue could include: A) grant funding, B) a line item fee as part of the renewal process for CT Controlled Substance Licenses, C) tax on manufacturers of opioids to market their products in CT, D) leveraging interstate resources, etc.

5. **How will implementation of policy in this area create jobs and spur economic growth?**
   Expanding medication-based treatment for opioid use disorder to parts of the state where it is inadequate will create some jobs. Making the working age workforce healthier is economically beneficial, with fewer work days lost. People receiving effective medication-based treatment for opioid use disorder can be on medication and work; they can't if they are hospitalized, incarcerated, in residential programs or no longer living.

Expanding the capacity of /access to behavioral health services addresses also accomplishes these goals. The economic burden of mental health disorders is severe and quantified: World Health Organization (2017) estimates $1trillion dollars per year in lost productivity to the global economy from depression and anxiety alone (WHO Mental Health Action Plan 2013-2020).

6. **Are there opportunities for cost savings for CT state government in the context of implementing this policy?**

   Medication treatment of opioid use disorder is cost effective: https://ldi.upenn.edu/brief/show-me-money-economic-evaluations-opioid-use-disorder-interventions

   Interventions to address opioid safety and opioid use disorder could be expected to significantly reduce the resource drain on first responders, law enforcement, the judicial and prison systems, emergency departments, and other medical facilities, allowing for cost savings and resource reallocation.

7. **What examples of success from other states, countries, or the private sector in this policy area should the Administration study?**

Massachusetts Public Health Data Warehouse: www.massmed.org/News-and-publications/vital-signs/game-changing-use-of-data-drives-opioid-practice/#.XARVdDIOkwA

Vermont: Hub and spoke model for treatment of opioid use disorder

Rhode Island: (1) Opioid Treatment Centers of Excellence, (2) all medications for treatment of opioid use disorder available throughout the criminal justice system, (3) Levels of care for opioid-related conditions throughout Emergency Departments and Hospitals: http://health.ri.gov/publications/guides/LevelsOfCareForTreatingOverdoseAndOpioidUseDisorder.pdf

Ohio Fentalny Related Bill: https://www.legislature.ohio.gov/download?key=10242&format=pdf

Ohio's successful efforts in mitigating the accidental overdose death toll: https://www.nytimes.com/2018/11/25/health/opioid-overdose-deaths-dayton.html

8. **Are there any other issues/considerations you would like to highlight with regard to this policy area?**
   -Safe injection facilities/mobile vans - research suggests these sites are effective in preventing deaths among society's most vulnerable. A 2014 review of 75 studies concluded such places promote safer injection conditions, reduce overdoses and increase access to health services.

-Enhanced penalties for drug traffickers who knowingly sell illicitly manufactured opioids such as fentanyl – Ohio Gov. John Kasich has signed a bill this year that increases penalties for drug trafficking and some other drug offenses when the drug involved is a fentanyl-related compound. https://www.legislature.ohio.gov/download?key=10242&format=pdf
-Integrated and coordinated efforts by local and federal law enforcement officials to help mitigate dangerous drug trafficking.
-Inadequate numbers of pain and addiction medicine specialists.
-Financial misalignment to favor prescribing over non-opioid/non-pharmacologic treatments for pain.
-Need for interventions to address stigma associated w/chronic pain, mental health and addiction.
-Importance of evidence-based responses, focusing on high impact, well supported interventions.
-Study various drug court models and non-prison that only use evidence-based treatments for low risk individuals. Enhance existing diversion programs.
-Critical public health importance of data sharing.
-The separation of the management of mental health/behavioral health treatment and physical health treatment by the state with regards to licensure, authorization and payment, and credentialing creates barriers to full integration of behavioral health and primary care. Consider replicating the Medicare approach of a common provider enrollment, billing, and rules in light of national policy on mental health parity.

Resources and references:

https://chapter55.digital.mass.gov/

https://www.legislature.ohio.gov/download?key=10242&format=pdf

http://health.ri.gov/publications/guides/LevelsOfCareForTreatingOverdoseAndOpioidUseDisorder.pdf

www.massmed.org/News-and-publications/vital-signs/game-changing-use-of-data-drives-opioid-practice/#.XARVdDIOkwA

https://ldi.upenn.edu/brief/show-me-money-economic-evaluations-opioid-use-disorder-interventions

Draft report of the Opioid Taskforce – this report is undergoing public comment and is available on the Judicial Branch website at - https://www.jud.ct.gov/Committees/Opioid_taskforce/default.htm

http://health.ri.gov/publications/guides/LevelsOfCareForTreatingOverdoseAndOpioidUseDisorder.pdf

Ohio Fentalny Related Bill: https://www.legislature.ohio.gov/download?key=10242&format=pdf

Ohio's successful efforts in mitigating the accidental overdose death toll: https://www.nytimes.com/2018/11/25/health/opioid-overdose-deaths-dayton.html

AJPH Perspectives Report on the challenges and economic determinants of the Opioid Crisis: https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304187