Evaluation of Methods of Combating the Opioid Epidemic in the State of Connecticut

Per Public Act No. 18-166

AN ACT CONCERNING THE PREVENTION AND TREATMENT OF OPIOID DEPENDENCY AND OPIOID OVERDOSES IN THE STATE

For Submission To:
Co-Chairs of the Alcohol and Drug Policy Council and the Joint Standing Committee of the General Assembly Having Cognizance of Matters Relating to Public Health

Prepared by a Workgroup of the Connecticut Alcohol and Drug Policy Council

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I. Executive Summary

Section 4 of Public Act 18-166 requires the Connecticut Alcohol and Drug Policy Council (ADPC) established under section 17a-667 of the Connecticut General Statutes to convene a working group to evaluate methods of combating the opioid epidemic in the state. The workgroup was charged with investigating a list of items posed by the legislation. The workgroup was also charged with advising the co-chairpersons of the Council, the Commissioners of the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), regarding the results of the workgroup's findings. Please see **Appendix A** for PA 18-166.

The working group was established under the direction of the co-chairs of the ADPC. Membership was based on the need for subject matter experts from the following state departments: DMHAS, DCF, Department of Insurance (DOI), Department of Public Health (DPH), and Department of Consumer Protection (DCP). Department of Correction (DOC) was invited to participate related to section 6a and that content will be submitted under separate cover by DOC. Other participants included representatives from Connecticut Poison Control Center, as well as the chiropractic and physical therapy professional provider communities. **Appendix B** provides a list of the work group members. The working group drafted preliminary findings in August and September 2018. Input from members was elicited in verbal and written formats September-November 2018 and the report was finalized December 2018.

Relevant findings will be discussed in greater detail within the discrete sections of the report. However, certain findings are especially noteworthy and are summarized below.

- The state has been successful in making naloxone more widely available. This may be helping slow the increase of overdose deaths. The increased availability of naloxone has been the result of efforts across multiple state agencies, continually evolving legislation that increases access to naloxone, and comprehensive training related to the use of naloxone. DMHAS has trained over 3,500 individuals over the past five years and is now using a statewide network of regional advocacy groups to train and distribute naloxone to constituents within their region. The Department of Public Health, along with other organizations, has also been providing training.
- DMHAS providers have contributed to making naloxone more widely available. A recent survey indicated that over 90% of DMHAS providers maintained emergency supplies of naloxone. Close to 60% of DMHAS providers prescribe naloxone to program participants or their families. However, significantly fewer numbers of providers actually distribute naloxone to program participants. Only 20% of DMHAS addiction service agencies distribute naloxone to program participants or their families. The recently conducted survey identifies areas where improvements can be made.
- The increased access to naloxone may be having an impact on overdose deaths related to opioids. While overdose deaths have grown substantially over the past five years,

recent data from the Office of the Chief Medical Examiner (OCME) seems to indicate that calendar year 2018 deaths may be plateauing. OCME data showed 615 deaths in the first six months of the calendar year. If that data is extrapolated for the entire year it would predict 1,030 overdose deaths, an increase of only 13 deaths from last calendar year.

- In order to address a question regarding the treatment status of individuals who died as a result of an overdose it is important to note, that a small number of individuals who died as a result of an opioid overdose were in active treatment at the time of their death. This may suggest that engaging individuals who are actively using opioids in treatment is challenging. DMHAS has developed an innovative program that utilizes recovery coaches to reach out to individuals in emergency departments who survived an overdose. These peers work to engage these individuals and connect them to follow-up treatment. These efforts are showing promise.
- Opioid-related admissions declined in DMHAS' treatment system in FY 18 after six years of growth. Opioid-related admissions grew slightly between FY 16 and FY 17, but the past fiscal year showed that these admissions have declined by 5%. This may be indicative that the epidemic has reached a peak. A similar trend has been identified with substance use treatment agencies that are not funded by DMHAS.
- Various projects are underway throughout the state, which are designed to strengthen the state's capacity for overdose surveillance and the identification of "hot spots". The Connecticut Poison Control Center has piloted a syndromic surveillance system which requires Emergency Medical Services (EMS) to contact the Connecticut Poison Control Center after they have assessed and treated a person with a suspected overdose. Addresses will be loaded into mapping software in order to better identify hot spots. DPH is involved in two other related projects. One uses the EpiCenter surveillance system to track near real-time heroin overdoses being treated in hospital emergency departments. The second initiative involves piloting an automated alert system to identify local and regional drug and opioid overdoses that exceed established thresholds.
- While research evidence for the use of alternative non-pharmacological interventions is still developing in terms of cost savings and improvements in quality of life, it can be stated that the use of these interventions is low risk/non-invasive, reduces the use of opioid medications for pain, and at the least, maintains or slightly improves function in persons with pain. Furthermore, early access to these interventions which can potentially be achieved through reductions in barriers to access can facilitate these valuable outcomes. Given our review of the research evidence, clinical guidelines, risk factors and cost factors, there is ample indication that physical therapy, acupuncture, massage and chiropractic care should be part of the response to chronic pain.

II. Introduction and Background

The Connecticut Alcohol and Drug Policy Council (ADPC) is a legislatively mandated body comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from addictions, and other stakeholders in a coordinated statewide response to alcohol, tobacco and other drug (ATOD) use and abuse in Connecticut. The Council, co-chaired by the Commissioners of the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), is charged with developing recommendations to address substance-use related priorities from all State agencies on behalf of Connecticut's citizens across the lifespan and from all regions of the state.

Section 4 of Public Act 18-166 requires the CT Alcohol and Drug Policy Council (ADPC) established under section 17a-667 of the general statutes to convene a working group to evaluate methods of combating the opioid epidemic in the state. The workgroup was charged with investigating a list of items posed by the legislation and advising the co-chairpersons of the Council, the Commissioners of the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), regarding the results of the workgroup's findings.

Connecticut, like much of the country, has seen a significant increase in opioid use over the past seven years. This increase has been observed in escalating overdose deaths, increased admissions to treatment programs that are related to opioid use, and significant expansion in services such as methadone maintenance to meet this increased demand. According to data published in 2018 by The Office of the Chief Medical Examiner in Connecticut, a total of 1,038 fatal overdoses were recorded in the state in calendar year 2017, most of which involved one or more opiates (OCME, 2018). By comparison, the number of overdose deaths in 2012 was only 357. Increased prevalence of fentanyl and fentanyl analogs are major contributors to this increase.

Beginning in 2011-2012, based on DMHAS data, admissions for opioid treatment in Connecticut began to rise significantly across the state. Treatment admissions related to opioids increased between 5% and 10% per year until FY 2017 when admissions only increased slightly from the prior fiscal year. Opioid-related admissions in the Connecticut treatment system declined for the first time in FY 18, reversing a period of significant growth in opioid admissions. Admissions to methadone maintenance programs and opioid-related admissions to detoxification programs have also shown a decline in FY 18. This shift is being closely monitored and may be a sign that the epidemic is slowing.

The Connecticut Alcohol and Drug Policy Council (ADPC) was charged by Governor Malloy in 2015 to make necessary recommendations including legislative and policy changes to address the opioid crisis. Governor Malloy also commissioned a comprehensive statewide strategic plan by Yale University resulting in the CT Opioid Response (CORE) report in 2016. The ADPC

has effectively harnessed diverse stakeholder input to propose and implement innovative responses to the opioid crisis with interventions organized around prevention, treatment, recovery support services, and criminal justice.

While a portion of PA 18-166 focuses on the evaluation of methods to combat the opioid epidemic, the legislation also provided expanded opportunities for increasing access to naloxone. The legislation permits prescribing practitioners and pharmacists to develop relationships with community providers for the purpose of distributing naloxone to these groups. This includes health care providers, law enforcement, emergency medical services, and governmental agencies. Public Act 18-166 makes effective use of Connecticut's existing ADPC to further evaluate methods of combatting the opioid epidemic in the state. Findings will be reported to Co-Chairs of the Alcohol and Drug Policy Council and the Joint Standing Committee of the General Assembly Having Cognizance of Matters Relating to Public Health to further Connecticut's response.

III. ADPC Working Group Evaluation of Methods of Combating the Opioid Crisis in the State of Connecticut

The next sections are responsive to PA 18-166 Sec. 4. Numbers that are listed in the sections below refer to the specific legislation and the number of the items that DMHAS was directed to include in the report. The actual legislation can be found in Appendix A.

(1) The number of persons annually who receive services from each methadone treatment program funded by contract with the Department of Mental Health and Addiction Services, the rate at which such persons relapse and the number of such persons who die as the result of a drug overdose while participating in such program;

DMHAS-funded methadone programs served 13,474 individuals in fiscal year 2018 which began on July 1, 2017 and ended on June 30, 2018. There were 4,476 new admissions to funded methadone programs and 4,825 discharges during FY 18. During fiscal year 2017, DMHAS funded methadone programs served 13,539 unduplicated clients. There were 5,598 admissions and 4,955 discharges during fiscal year 2017. The fiscal year 2018 data shows slight reductions in clients served and admissions and discharges. This appears to be consistent with data that shows reduced opioid-related admissions to all substance abuse treatment programs. FY 18 was the first year since 2012 which did not see increased opioid-related admissions.

When one examines data that includes reporting from non-funded methadone maintenance treatment providers, this shows that there were 21,571 individuals who were served in DMHAS funded and non-funded programs. FY 17 data shows that 21,530 individuals were served in funded and non-funded methadone maintenance programs. This shows a slight increase between FY 17 and 18, but the data also seems to indicate that admissions are plateauing. At the same time, DMHAS has observed a growth in admissions to other specialized medication assisted treatment programs such as those offering buprenorphine and Suboxone. These increases are part of a deliberate strategy DMHAS implemented that is focused on expanding alternative to methadone.

PA 18-166 requested information related to the number of persons who relapse after admission into a methadone program. DMHAS collects periodic data that shows whether a client in a methadone program is abstinent or has reduced their substance use. Data compiled for FY 17 shows that approximately 71% of all clients admitted that year achieved abstinence or reduced their substance use. The same data for FY 18 shows that approximately 62% achieved abstinence or reduced their substance use. This data is illustrative of the fact that addictions are a chronic illness and persons with substance use disorders do relapse.

The information listed above looks only at new admissions to methadone maintenance during a given fiscal year. There are a number of clients receiving treatment in the DMHAS system who have been active for a number of years. When one considers every client who was active in methadone maintenance during the year, fewer people relapse. In FY 17, approximately 78% of all active clients remained abstinent or reduced their substance use. In FY 18, approximately 76% remained abstinent or reduced their substance use. DMHAS also uses one other indicator to evaluate the success of methadone programs. Methadone maintenance is one program type where a long length of stay is a desirable outcome. Currently, almost two-thirds of the clients who are active in methadone maintenance programs have been in treatment for over a year.

There have been obvious concerns raised about the high number of opioid-related overdose deaths occurring in the state. One question posed relates to how many of the individuals who have died from an overdose are active in Connecticut's treatment system. The University of Connecticut, in collaboration with Yale, conducted a study to identify how many of the individuals who died as a result of a drug overdose were participating in a methadone program. This study utilized client level data provided by the Office of the Chief Medical Examiner (OCME) and matched that information to client level data contained in DMHAS' data system. Only a small number of individuals who died as a result of an overdose were active in the DMHAS treatment system at the time of their death. The study used DMHAS data that covered the period of January 1, 2017 through June 30, 2017. During that time there were only 16 overdose deaths that involved a client who was active in a methadone maintenance program at the time of their overdose. This amounted to just over 2.4% of all overdose deaths. Interestingly, only a total of 27 individuals who died from an overdose in the first six months of 2017 were open in any DMHAS substance abuse program at the time of their death. This represents about 3% of all opioid-related overdose deaths. The low number of individuals who were involved in treatment at the time of their deaths suggests that more needs to be done to engage individuals who are actively using opioids into treatment.

Conclusion:
Connecticut has wide availability of methadone maintenance services and has begun to expand access to other medications such as buprenorphine and naltrexone. Individuals in these programs who have been in treatment less than a year should be considered high-risk for overdose and must be offered increased access to naloxone while being served in these treatment programs. The overdose and treatment data cited in this section highlight the need for improved engagement methods. Many of the individuals who died from an overdose were not connected to treatment programs. More needs to be done in this area to engage these individuals in treatment. Innovative models using persons in recovery are showing a great deal of promise in this area.

(2) The availability of opioid antagonists, as defined in section 17a-714a of the general statutes, at each such methadone treatment program and each state-funded treatment program for persons with substance use disorder;

In order to answer item number 2 above, DMHAS conducted a survey of all funded substance abuse programs to determine whether these providers were making naloxone available to program participants and their families and significant others. As part of the survey, DMHAS asked a range of questions related to naloxone prescribing and distribution within an agency's programs. The survey also sought to identify which agencies and programs maintained a supply of naloxone for emergencies that might arise during program operations. An example would be a residential program that maintained a supply of naloxone for potential overdoses that may occur while an individual was in residence at the program. The survey attempted to drill down to the program level at each agency since some programs might distribute and prescribe naloxone while other agency programs may not do this.

The survey was conducted over a 3-week period in September 2018. The survey results were broken down into categories as follows:

- **Agencies and Programs Maintaining Naloxone for Program Emergencies**
- **Agencies and Programs Distributing Naloxone to Consumers and their Families/Significant Others**
- **Agencies and Programs Offering Prescriptions for Naloxone to Consumers and their Families/Significant Others**

Each category will be discussed in greater detail below.

Agencies and Programs Maintaining Naloxone for Program Emergencies:

- Forty-four substance abuse treatment agencies responded to the survey questions related to this category. Of those 44 agencies, 40 agencies reported that they maintain a supply at one or more program sites.
- Overall, 91% of DMHAS agencies report maintaining an emergency supply of naloxone.
- DMHAS funds five methadone providers that have 16 programs across the state. All five methadone providers maintain naloxone for program emergencies.

Agencies and Programs Distributing Naloxone to Consumers and their Families/Significant Others:

This category sought to identify which agencies and programs actually were distributing naloxone to consumers and their families or significant others. This implies that agencies are directly providing naloxone to consumers and families.

- Forty-four agencies responded to the survey questions related to this category. Of those 44 agencies, nine agencies reported that they distribute naloxone at one or more program sites.
- Overall, approximately 20% of DMHAS addiction service agencies distribute naloxone to program participants or their families.

- DMHAS funds five methadone providers that have 16 programs across the state. Three out of five methadone providers routinely distribute naloxone to program participants.

Agencies and Programs Prescribing Naloxone to Consumers and their Families/Significant Others:

This category examines prescribing practices as they relate to naloxone and DMHAS funded providers. Some agencies may prescribe naloxone instead of distributing it.

- Forty-four agencies responded to the survey questions related to this category. Of those 44 agencies, 25 providers report prescribing naloxone at one or more program sites.
- Overall, 57% of DMHAS addiction service agencies prescribe naloxone to program participants or their families.
- DMHAS funds five methadone providers that have 16 programs across the state. Three out of five methadone providers are prescribing naloxone to program participants.

The results of our survey indicate that naloxone is most frequently prescribed through outpatient, medication assisted treatment (MAT), and intensive outpatient programs. Ten respondents (25%) indicated that they began stocking naloxone for emergencies before calendar year 2016. Twenty-four providers reported acquiring emergency naloxone between 2016-2017, and six providers indicated that they began stocking it in 2018. The naloxone nasal spray is overwhelmingly popular, with 34 providers reporting that they stock it.

Conclusion:

DMHAS has been successful in ensuring that methadone maintenance providers maintain supplies of naloxone for emergency situations. The survey that was conducted above highlights that greater emphasis must be placed on ensuring that medication assisted programs are routinely distributing naloxone to program participants or their families. Research is clear that these individuals are at high risk for overdose.

(3) The advantages and disadvantages of a licensed mental health professional at each such methadone treatment program and each treatment program for persons with substance use disorder being permitted to dispense an opioid antagonist directly to a person at the time of such person's discharge from such program without the need for such person to obtain the opioid antagonist from a pharmacy under section 20-633c or 20-633d of the general statutes;

Connecticut has taken a number of steps over the past **seven (7**) years to make naloxone more widely available. Legislation was first introduced in 2011 and each successive legislative session has introduced new pieces of legislation that have made naloxone more accessible. A Good Samaritan Law was introduced in 2011 that protected people who call 911 seeking emergency

medical services for an overdose from arrest for possession of drugs/paraphernalia. Legislation enacted in 2012 allowed prescribers (physicians, surgeons, Physicians' Assistants, APRNs, dentists, and podiatrists) to prescribe, dispense or administer naloxone to any person to prevent or treat a drug overdose and the prescriber is protected from civil liability and criminal prosecution. The protection from civil liability and criminal prosecution was extended to the person administering the naloxone in response to an overdose in 2014. Legislation enacted in 2015 allows pharmacists who have been trained/certified to prescribe and dispense naloxone directly to customers requesting it. Most recently, PA 18-166 allowed prescribers to develop agreements with organizations wishing to train and distribute naloxone. All of these changes have supported efforts to make naloxone widely available.

The advantages of making naloxone available to those at risk of opioid overdose, along with their family and friends, are well established. Among non-elderly opioid users, overdose is the most common cause of death[1] and overdose deaths have risen every year in Connecticut since 2012[2]. Since most fatal overdoses involve opioids[3], increasing naloxone availability has been widely viewed as an appropriate response. Naloxone itself, although still available only by prescription, is considered "remarkably safe"[4] and studies have not found an increase in substance use due to its availability[5]. In fact, after overdose education and naloxone prescriptions, some patients report positive behavior changes[6]. Research studies have concluded that bystanders can be trained to identify an opioid overdose and respond with naloxone as well as trained professionals[7]; that bystanders are willing to administer naloxone to others[8]; and that opioid overdose mortality rates decreased with increasing community naloxone distribution[9]. Studies have also determined that community naloxone is a cost-effective strategy for responding to the opioid epidemic[10].

Many well-respected national and international organizations are recommending broad access to naloxone, among them the American Medical Association (AMA)[11] and the World Health Organization (WHO)[12]. The Federal Guidelines for Opiate Treatment Programs (OTPs), which cover methadone maintenance programs, were updated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015, and describe the prescribing /distribution of naloxone as an "essential complement" to overdose prevention along with education, particularly for situations where the patient's tolerance has decreased (e.g., detoxification)[13]. They further recommend that this information be provided as a routine part of relapse prevention education, beginning with orientation. SAMHSA's Treatment Improvement Protocol (TIP) 63 for Medication Assisted Treatment (MAT), which also applies to methadone maintenance programs, concludes that every patient misusing opioids or who has an opioid use disorder (OUD) diagnosis should receive opioid overdose prevention education and a prescription for naloxone[14]. The American Society of Addiction Medicine (ASAM) National Practice Guidelines, released in 2015, recommend that patients being treated for OUD be given prescriptions for naloxone[15].

At this point, naloxone administration is simple with the availability of the newer naloxone nasal spray and the Evzio auto-injector. In terms of target populations for naloxone, many lists of those at high-risk for overdose exist with slight variations, the following one from the 2018

revision for the SAMHSA Opioid Overdose Toolkit is representative and includes persons with the following[16]:

- History of overdose
- History of substance use disorder (SUD)
- Taking both benzodiazepines and opioids
- Decreased tolerance for opioids due to recent release from incarceration, detox, etc.
- Doses of opioids of >50 morphine milligram equivalents (MME)/day

Disadvantages for prescribing/distributing naloxone are few and basically involve cost. The price of naloxone has increased in recent years, although most commercial insurance plans will cover naloxone, aside from co-pays or deductibles (some insurance companies are now waiving such costs). Connecticut Medicaid also covers the cost of naloxone. Cost varies depending on formulation. One consideration is the fact that naloxone, as with all medications, does expire after 18-24 months and should be replaced. Since most SUD treatment programs are shorter than 18-24 months this may not be a concern. Clients being discharged from treatment can be informed of how to acquire replacement naloxone if the doses they are provided expire. An additional resource to consider is the time needed to educate program staff and integrate naloxone curricula into routine relapse prevention education. DMHAS has staff available to provide such training at no cost to programs in need. It would then be the responsibility of the program staff to educate clients and families/significant others about naloxone and either prescribe or distribute it, on an ongoing basis.

Some technical issues related to the language used in the legislation (item 3) are discussed below:

- The term "dispense" from a pharmacy and legislative perspective (section 20-571), does not include the act of delivering or administering a drug/device to a patient, but references the technical aspects of filling a prescription, such as selecting the correct product from stock; counting, measuring, compounding or preparing the drug/device; placing it in the proper container, etc. In fact, it is the pharmacist who will *dispense* the drug/device to a staff person who will deliver/distribute it to the patient.

- Prescribing vs. Dispensing naloxone – per the SAMHSA TIP 63 on Medication Assisted Treatment, "clients are more likely to access naloxone if their program provides it directly to them rather than sending them to another organization to get it". It's likewise clear from the medication adherence literature that a certain percentage of prescriptions are never filled (primary non-adherence).

- The term "licensed mental health professional" is probably better replaced with the term "licensed behavioral health professional" to reflect current terminology. The intent to refer to an array of licensed disciplines (counselors, social workers, etc.) is understood.

- Not mentioned in the legislation, but critical to the effectiveness of naloxone distribution success, is involvement of others, specifically those most likely to witness

and respond to an overdose by administering naloxone. This is made clear in the ASAM Practice Guidelines "…patients, family members and significant others should be trained in use of naloxone." Inviting family members/significant others to participate in education provided by SUD treatment programs, at which they learn when and how to use naloxone, is an important element in saving lives.

- Providing naloxone or prescriptions at the point of discharge – Putting off education on and access to naloxone until the point of discharge unnecessarily increases risk of relapse and overdose, as it is not uncommon for clients to leave treatment prematurely prior to completion, especially if it is their first exposure to treatment. As was stated in the federal guidelines for opioid treatment programs, providing education and access beginning at *orientation* is recommended.

- Methadone treatment program (opioid treatment program – OTP) vs. every substance use disorder (SUD) treatment program – there is no reason to restrict naloxone distribution to only OTPs given the widespread use, availability, prescribing, and diversion of opioids. 2012 Connecticut legislation allows a prescriber (physician, APRN, PA among others), to prescribe naloxone to any person for the purpose of preventing or treating an overdose. Consequently, any SUD treatment program with access to a prescriber can prescribe/dispense or deliver/distribute naloxone to the clients and/or their family members/significant others. However, limited access to a prescriber may serve as a barrier for some SUD treatment programs.

Conclusion:
The literature is clear that access to naloxone is critical regardless of who is actually distributing the medication to program participants. It is less important to designate a specific license or class of individuals than it is to simply ensure that programs who serve high-risk individuals are making naloxone available. It is recommended that all SUD treatment programs, including those providing methadone, incorporate naloxone education and distribution to their clients and/or family/significant others early in their treatment stay (e.g., orientation) on an ongoing basis to reduce the risk of opioid overdose.

(4) Whether a nonfatal drug overdose at a hospital or outpatient surgical facility should qualify as an adverse event under section 19a-127n of the general statutes;

The National Quality Forum (NQF) in 2001 began talking about adverse events which they called never events. These were serious, preventable events related to patient safety that should "never" occur in a hospital setting. These events were viewed as something the hospital was responsible for and the event could have been prevented. The reason for tracking these events was to improve patient care and patient safety. The NQF now is calling these events serious

reportable events (SREs). An overdose related to opioid use does not fall into a category where it has been caused by the hospital. The hospital is fulfilling its duty to treat the patient but is not in a position to prevent the overdose. The exception would be if a hospital's medication error resulted in a non-fatal overdose and in that situation it appears that the hospital would be required to report this since it was a result of the care provided by the hospital. The table below shows one adverse event associated with medication errors.

NQF 4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).	**Excludes reasonable differences in clinical judgment on drug selection and dose. Includes, but is not limited to, death or serious injury associated with: a) over- or under-dosing; b) administration of a medication to which a patient has a known allergy or serious contraindication; c) drug-drug interactions for which there is a known potential for death or serious injury, and d) improper use of single-dose/single-use and multi-dose medication vials and containers leading to death or serious injury as a result of dose adjustment problems**	**This event is intended to capture:• The most serious medication errors including occurrences in which a patient receives a medication for which there is a contraindication, or a patient known to have serious allergies to specific medications/agents, receives those medications/agents, resulting in serious injury or death. These events may occur as a result of failure to collect information about contraindications or allergies, failure to review such information available in information systems, failure of an organization to ensure availability of such information and prominently display such information within information systems, or other system failures that are determined through investigation to be cause of the adverse event;• Occurrences in which a patient dies or suffers serious injury as a result of failure to administer a prescribed medication;• Occurrences in which a patient is administered an over- or under-dose of a medication**

		including insulin, heparin, or any other high alert medication including but not limited to medications listed on the Institute for Safe Medication Practices "High Alert Medication List";• Occurrences in which a patient dies or suffers serious injury as a result of wrong administration technique. This event is not intended to capture: Patient death or serious injury associated with allergies that could not reasonably have been known or discerned in advance of the event.

Conclusion:
Based on information available through the National Quality Forum on adverse events related to medications, a nonfatal drug overdose at a hospital or outpatient surgical facility should not qualify as an adverse event. Adverse events relate to preventable errors caused by the hospital while somebody is under their care. Opioid overdoses, unless they are somehow caused by the hospital, should not qualify as an adverse event.

(5) The role of health carriers, as defined in section 19a-755b of the general statutes, in shortening a person's stay at a treatment program for persons with substance use disorder;

Coverage of "Substance Use Disorder Services" is a Mandated Essential Health Benefit

Coverage for substance abuse disorder is a mandated benefit in Connecticut for fully insured plans and the Department's regulatory scrutiny ensures that these health plans are in compliance with all state and federal laws before they can be marketed in Connecticut. Under current law, substance use disorder treatment programs are required to be covered and subject to medical necessity. CGS 38a-591a et seq. concern the Department's utilization review and external review laws. These parts of the law require that insurers, among other things, use clinical reviewers with certification and background in a similar field as the services being requested, require medical criteria standards for insurers when evaluating requests for behavioral health services, have 24-hour turnaround times for carriers to review urgent requests for behavioral health services and 24-hour expedited determinations for appeals of

insurance company denials of certain behavioral health services through the Department's External Review Program.

In addition, the Connecticut Insurance Department's (CID) Consumer Affairs division investigates and adjudicates policyholder complaints and the Market Conduct division reviews company practices to make certain that consumers receive the benefits to which they are entitled. If a pattern of noncompliance is detected through multiple complaints, the Consumer Affairs division will refer the complaint to the Market Conduct division for further investigation. Additionally, the Market Conduct division regularly reviews carriers' practices to ensure compliance with all Connecticut laws and regulations.

Recent Insurance Department Actions

The Connecticut Insurance Department has been a partner in working with all stakeholders including consumer groups, legislators, other executive branch agencies, insurance carriers, and others to create sound public policy to combat the opioid epidemic and is an active member of the Alcohol and Drug Policy Council.

The Department has collaborated on various laws and participated in many working groups on these topics. Last year, the Department was actively engaged on P.A. 17-131, a comprehensive Governor's initiative to prevent prescription opioid abuse, to ensure that the bill would contain language requiring carriers to cover medically monitored inpatient detoxification services and medically managed intensive inpatient detoxification services, if medically necessary, for insureds diagnosed with a substance abuse disorder per the American Society of Addiction Medicine (ASAM). The bill additionally requires the ASAM criteria to be followed for admission to alcohol and drug treatment facilities. In 2016, the Department contributed to and supported P.A. 16-43 and in 2015, the Department assisted in drafting P.A. 15-198 – two comprehensive Governor's bills to curb the opioid epidemic and break down barriers to getting people the proper treatments. P.A. 16-43 ensures that carriers in Connecticut will continue to cover opioid antagonists and to do so without prior authorization.

In October 2016, the Department held a Symposium on Opioids with major carriers to learn more about their programs and strategies to curb opioid abuse and provide coverage for treatment addiction for their policyholders. Following this symposium, the Department issued a report in 2017 "*Ensuring Access and Coverage in Connecticut for Substance Abuse Treatment*"[17] that was distributed to the Governor, the Insurance & Real Estate and Public Health Committees, and posted publicly on the Department's website. The report reviews a survey that the Department implemented of 16 health insurance companies to determine whether any barriers for substance abuse treatment existed for policyholders in the fully insured individual, small group, and large group plans regulated by the Insurance Department. The report examined the extent to which coverage is provided, the types of treatments covered, requirements that policyholders must meet, and any cost-sharing requirements for such services.

2015 & 2016 Behavioral Health Working Group

CID also convened a Behavioral Health Working Group in 2015[18] and in 2016[19] and submitted these working groups' reports to the General Assembly. The groups' memberships included consumer representatives, behavioral health providers, representatives from the Comptroller's Office, the Office of the Healthcare Advocate, and the Departments of Social Services, Public Health, Mental Health and Addiction Services, Children and Families, and Developmental Services, and the health carriers. The Department successfully achieved passage of P.A. 16-175 on the group's behalf. This Public Act clarified the intent of the adverse determination statute to provide a link to the clinical criteria used on all adverse determinations and also implemented enhanced transparency of clinical guidelines.

The group convened again in 2016, but no participants came forward with any additional data or legislative recommendations. As a result of the 2016 working group, the Department worked with the Department of Public Health to survey Connecticut behavioral health providers licensed as Licensed Clinical Social Workers, Social Workers (MSW), Psychiatrists, and Psychologists to obtain information from the provider community to identify any issues that they and their patients may be experiencing related to insurance coverage. The Department recently closed the survey and is currently in the process of analyzing the results.

Insurance Department Annual Report Card on Health Insurance Carriers in Connecticut

Finally, the Department's annual Consumer Report on Health Insurance Carriers in Connecticut[20], is a comprehensive tool that consumers and public policymakers can use to meaningfully compare health insurers against a number of factors including quality measures. The Department has been publishing the report since 1998 and has greatly enhanced it over the last two years to include quality measures for behavioral health and substance abuse coverage. The 2017 edition was expanded to include data on how insurance companies are doing in providing follow-up treatment for mental health and substance abuse care. The Report Card is distributed each October to the Insurance and Real Estate Committee.

Below is the current data collected and published in the Report Card:

Utilization Review (UR) statistics for Behavioral Health Services broken down by inpatient admissions, outpatient services, procedures and extensions of stay:

- Number of UR request received
- Number of denials (excluding partial denials)
- Number of partial denials
- Percentage of UR request that were denied (including partials)
- Number of appeals of denials
- Percentage of denials that were appealed
- Number of denials reversed on appeal
- Percentage of appealed denials that were reversed

- Number of upheld appeals that went to external appeal
- Percentage of all appeals that went to external appeal
- Percentage of external appeals that were reversed

Inpatient Discharges & Average Length of Stays:

- Total number of inpatient discharges with mental health as the principal diagnosis at either a hospital or treatment facility
- Total discharges/1,000 member months
- Average length of stay

Totals and percentage of members who received:

- Any mental health service
- Inpatient mental health service
- Intensive outpatient or partial hospitalization health services
- Outpatient or emergency department health services

Chemical dependency utilization:

- Total number of inpatient discharge at either hospital or treatment facility
- Average length of stay

Totals and percentage of members who received:

- Any chemical dependency service
- Inpatient chemical dependency services
- Intensive outpatient or partial hospitalization health services
- Outpatient or emergency department health services

Follow-up after hospitalization for mental illness for members 6 years and older:

- Percentage of members who had an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner on the date of discharge up to 30 days after the hospital discharge
- Percentage who had an outpatient visit, intensive outpatient visit or partial hospitalizations with a mental health practitioner on the date of discharge up to seven days after the hospital discharge

Percentage of members 18 years and older treated with antidepressant medication who met at least one of the following criteria during intake period:

- An outpatient, intensive outpatient or partial hospitalization setting with a diagnosis of major depression
- An emergency department visit with any diagnosis of major depression
- At least one inpatient claim/encounter with any diagnosis of major depression
- Those who remained on antidepressant medication for at least an 84-day period (12 weeks)
- Those who remained on antidepressant medication for at least 180 days (six months)

The Department added the following two categories in 2016 as a result of the recommendations of the 2015 Behavioral Health Working Group

Data reflecting denial and appeal rates for children and adults:

- Authorization of Medical Necessity Coverage by Type and Level of Treatment
- Denial of Medical Necessity Coverage by Type and Level of Treatment
- Denials of Medical Necessity Upheld or Overturned by Type and Level of Treatment

Levels and Types of Treatment include the following:

- Acute Inpatient
- Residential
- Partial hospitalization
- Intensive Outpatient
- Routine Outpatient
- Substance Abuse Detox

***Additional Reports** related to this area are available Appendix C*

Conclusion:
Coverage for substance abuse disorder is a mandated benefit in Connecticut for fully insured plans within the state. Carriers are required to cover medically monitored inpatient detoxification services and medically managed intensive inpatient detoxification services and the Department's regulatory scrutiny ensures that these health plans are in compliance with all state and federal laws before they can be marketed in Connecticut. A number of mechanisms are in place to ensure consumer rights are protected. The CDI was involved in recent legislation that was enacted (P.A. 17-131). This comprehensive Governor's initiative to prevent prescription opioid abuse, included language requiring treatment, if medically necessary, for insureds diagnosed with a substance abuse disorder per the American Society of Addiction Medicine (ASAM).

(6) The availability of federal funds to supply emergency medical services personnel in the state with opioid antagonists and provide training to such personnel in the administration of opioid antagonists;

Under the Department of Public Health's (DPH) existing funding from the Centers for Disease Control and Prevention (CDC), the Department is not permitted to purchase naloxone. There is new CDC Public Health Emergency Response to the Public Health Opioid Crisis funding awarded to Connecticut beginning September 1, 2018, but, unfortunately, will not allow for the purchase of naloxone. The federal funding awarded in September may be able to support the proposed CT Poison Control Center (CT PCC) budget in order to move forward with rolling out statewide EMS-administered naloxone reporting through the CT Poison Control Center (see section 7

below). State Departments will continue to monitor federal funding opportunities related to naloxone distribution. DMHAS does offer naloxone training at no cost to interested parties upon request. Approximately 3,500 individuals have been trained by DMHAS in the use of naloxone. Federal State Opioid Response (SOR) funds awarded in October 2018 through a DMHAS grant application, includes an allocation of naloxone to the Department of Public Health. DMHAS will be purchasing additional supplies (12,000 kits) through another recently awarded grant.

Conclusion:
As stated previously, it is essential that naloxone be made widely available along with training for those who are called upon to administer the life-saving medication. Emergency medical services (EMS) personnel are on the front lines in our fight to reduce opioid overdoses. DPH's Office of Emergency Medical Services (OEMS) has been making training available over the past several years. State agencies should evaluate if current or new state or federal initiatives provide funding that would make naloxone available to EMS. If it is determined that additional training may be needed, this may be accommodated through DMHAS' Regional Behavioral Health Action Organizations (RBHAO) and through a DMHAS trainer who has trained almost 3,500 individuals across the state.

(7) The development and implementation of a state-wide uniform prehospital data reporting system to capture the demographics of prehospital administration or use of an opioid antagonist and opioid reversal outcomes as a result of such administration or use;

A pilot was recently concluded in October 2018 which included the Connecticut Poison Control Center, UConn Health, and Hartford American Medical Response (AMR), the company which provides ambulance service to part of Hartford, to report overdoses by emergency medical service (EMS) personnel https://today.uconn.edu/school-stories/tracking-opioid-overdoses-real-time-save-lives/. The project, launched May 1, included a protocol wherein Connecticut Poison Control Center Specialists in Poison Information asked the emergency responders a series of pre-determined questions and record the data. The test program was collaboration between the Connecticut Poison Control Center, the Department of Emergency Medicine at Saint Francis Medical Center, the DPH Office of Emergency Medical Services (OEMS) and American Medical Response (AMR), which provide ambulance services to two-thirds of the city of Hartford.

Emergency medical service personnel are calling-in overdoses to the Connecticut Poison Control Center and providing information which is captured in the poison center's electronic health record. Scaling up of this service is planned for 2019. With support, the Connecticut Poison Control Center will cover the entire state 24/7. The uniqueness of this service include:

real-time data acquisition 24/7; higher quality of information; differentiation between overdose and suicidal attempts; near real-time reporting capabilities; collaboration with DPH, OEMS, and New England High Intensity Drug Trafficking Area (NEHIDTA). The Connecticut Poison Control Center is exploring state and federal resources to further support the statewide initiative.

Conclusion:
A tracking system like that which was used in the pilot described above can provide valuable information related to overdose trends and the success of various initiatives that have been put in place to reduce opioid overdose deaths. Through the use of near real-time reporting, it can also serve to identify hot spots and rapidly identify areas where overdoses are clustering possibly due to "bad batches" of opioids or supplies that are more heavily laced with fentanyl or one of its analogs. The type of system can also be instrumental in identifying the number of people with suspected opioid overdoses who received naloxone and who first administered it. The availability of additional funding sources that can be used to build on this pilot should be further explored. An example of this is a project DPH is involved in where public health and emergency preparedness funding is being used to support a full-time triage nurse at CT Poison Control Center to answer opioid overdose calls from EMS.

(8) *The development of a state-wide strategy to (A) identify potential sources of federal funding for treatment and prevention of opioid use disorders, and (B) maximize federal reimbursement and grant funding for state initiatives in combatting the opioid epidemic in the state; and*

The Governor's Office has generally had a staff person convene an inter-agency grants coordination call on a regular basis. This is an opportunity to hear across agencies about the federal grants that are being applied for and that have been awarded. A spreadsheet of grants by state agency was distributed before the call to facilitate the process. Re-implementing and sustaining this mechanism may be the best way to identify potential sources of federal funding and to coordinate, not duplicate, efforts. DMHAS, and other state agencies, are aggressively pursuing all federal funding being made available for this epidemic. Connecticut has been successful in obtaining many federal grants for this purpose.

The federal grants coming into the state are being used for non-reimbursable services needed for individuals with opioid use disorders (OUD) or at risk of developing OUDs. It is emphasized that federal dollars are not to supplant other funding sources. State resources are therefore able to be maximally used for reimbursable services, drawing down the federal match.

Conclusion:
The state's effort to combat the opioid crisis is currently a multi-agency effort drawing upon multiple mechanisms to address aspects of the crisis. Given the broad nature of the state's response, it is essential that efforts among all parties are coordinated in order to avoid duplication and to ensure that all available strategies are being used. This may be even more

important as the state is undergoing a transition to a new Governor, legislators, and key staff. A solution that has been effective is communication via a regularly scheduled multi-agency call led by the Governor's Office.

(9) ***Whether*** *the* ***use*** *of* ***physical*** *therapy, acupuncture,* ***massage*** *and chiropractic care can reduce* ***the*** *need for opioid* ***drugs,*** *as* ***defined*** *in section* ***20-140*** *of the general statutes, in mitigating a* ***patient's*** *chronic* ***pain***

There are several ways of responding to this topic. The ***research evidence*** base to support the use of physical therapy, acupuncture, massage, and chiropractic care to reduce the need for opioid drugs in mitigating a patient's chronic pain is growing. A key reference document on this topic was published June 2018 by the Agency for Healthcare Research and Quality (AHRQ) titled, "Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review". The authors included 218 publications in this review. The types of pain conditions included chronic low back pain, chronic neck pain, osteoarthritis, fibromyalgia, and chronic tension headaches. The **strength of the evidence**, improved **functioning** and improved **pain** were all evaluated for each condition relative to different interventions. The evidence is specific to the type of pain condition. Improvements in functioning are slight. Not all interventions reduce pain even if they improve functioning. However, for this population of patients with chronic pain, slight improvements or the prevention of further loss of function may be extremely important to their quality of life.

In general, the strength of the evidence using these outcome indicators tends to be low/moderate. Alternatively, if we use the outcome indicator of **need for opioid drugs**, there is literature showing less use of opioid medications when patients have early access to nonpharmacological interventions. In this discussion, it is also important to note that the evidence base for opioid medications reducing non-malignant chronic pain is not clear.

An important factor to consider is ***risk and invasiveness*** of interventions for the patient. These nonpharmacological interventions are not risky or invasive. There is literature showing overall ***costs*** of care are less when patients use these alternative interventions. ***Clinical guidelines*** are moving in this direction. The American College of Physicians in 2018 (JAMA) states nonpharmacological interventions are now first line treatment for low back pain.

Given our review of the research evidence, clinical guidelines, risk factors and cost factors, there is ample indication that physical therapy, acupuncture, massage and chiropractic care should be part of the response to chronic pain. Several factors are important in the delivery of this care: a multidisciplinary approach; early access to these interventions; barriers need to be

reduced (e.g., attention to direct access, deductibles, copays, limits, pre-authorization); and patient and family education is needed.

Conclusion:
This topic involves multiple interventions relative to multiple types of chronic pain conditions. Based on available literature, we recommend, as a first phase, targeting changes in access to these four interventions for two types of chronic pain: low back pain and neck pain. Given experience and results of phase one, additional types of chronic pain could be added.

(b) On or before January 1, 2019, the working group shall report its findings to the co-chairpersons of the Alcohol and Drug Policy Council. The co-chairpersons shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding such findings and any recommendations for legislation.

Findings:

1. Connecticut has a comprehensive methadone maintenance system which is available across most of the state. Over the past three years, DMHAS has been successful at increasing access to other medication assisted treatments like buprenorphine and naltrexone. DMHAS and sister agencies have successfully obtained federal funding that has been made available to address the opioid epidemic.

2. Connecticut has introduced comprehensive legislation which has served to make naloxone widely available within the state. Since 2011, each legislative session has produced new legislation that makes naloxone more accessible to persons with substance use disorders and their families.

3. Almost all of DMHAS' funded addiction treatment providers have emergency supplies of naloxone. This is also available to program participants in methadone programs, which are serving clients who are among the highest risk for overdose. Efforts to expand access to naloxone among substance abuse providers should focus on gaps that have been identified in the DMHAS system.

4. DMHAS, along with its sister agencies, has been successful at securing funds which make naloxone more widely available. DMHAS and DPH have tapped into their provider systems to ensure that naloxone is widely available. DMHAS, through a recent grant award, plans to obtain an additional 12,000 doses of naloxone for distribution to its providers, consumers (including those re-entering communities from incarceration and other high-risk populations), and families.

5. In addition, almost 3,500 individuals have been trained across the state regarding the use of naloxone. In order to augment these efforts, DMHAS has recently charged its Regional Behavioral Health Action Organizations (RBHAOs) with the expansion of local training and distribution of naloxone.

6. DMHAS has introduced innovative engagement models that seek to link persons who have overdosed to treatment through the use of recovery coaches. This program is demonstrating positive outcomes in connecting these individuals to care.

7. Coverage for substance abuse disorders is already a mandated benefit in Connecticut for fully insured plans and the Department's regulatory scrutiny ensures that these health plans are in compliance with all state and federal laws before they can be marketed in Connecticut. A number of mechanisms are in place to ensure consumer rights are protected.

Recommendations:

1. Seek funding or utilize existing discretionary grant funding to support innovative outreach and engagement models that focus on linking those who have survived an overdose and other high-risk individuals to medication-assisted treatment. This might include expanding ongoing efforts to prescribe buprenorphine in hospital EDs to those individuals who have survived an overdose.

2. Continue to increase access to other medication-assisted treatments like buprenorphine and naltrexone.

3. Three of the five methadone providers funded by DMHAS routinely distribute naloxone to program participants. DMHAS should collaborate with the remaining two providers in order to identify and mitigate barriers that may be preventing them from distributing naloxone. This could include identifying funding or working with providers to utilize a client's insurance to obtain a prescription prior to discharge from one of these programs.

4. Require Connecticut substance abuse treatment providers who serve the highest risk opioid users to train program participants and their families about naloxone upon admission to the program. These programs should be encouraged to distribute naloxone to participants and their family members.

5. Nonfatal drug overdoses at a hospital or outpatient surgical facility should not qualify as an adverse event. Adverse events relate to preventable errors caused by the hospital while somebody is under their care. Opioid overdoses, unless they are somehow caused by the hospital, should not qualify as an adverse event.

6. Explore opportunities for state or federal support to build on the syndromic surveillance data collection system that is currently in use by DPH. This could build on a DPH pilot which is using the surveillance data to identify overdose clusters in specific localities based on established thresholds. The pilot is designed to alert local stakeholders of the clusters in near real-time.

7. Physical therapy, acupuncture, massage, and chiropractic care should be part of the response to chronic pain. Based on available literature regarding alternative opioid treatment therapies, we recommend, as a first phase, targeting changes in access to these four interventions for two types of chronic pain: low back pain and neck pain. Given experience and results of phase one, additional types of chronic pain could be added.

8. Reconvene the Governor's Multi-Agency Grant Coordination telephone calls. These calls provided a Governor's Office staff person to provide oversight and coordination to multi-state agency efforts to capture additional funding for the opioid crisis. Reconvening these calls could also serve to identify critical legislation that would assist the state in addressing the opioid crisis.

9. Explore whether recently awarded federal funding or existing state funds can be used to expand emergency medical services (EMS) access to naloxone through the CT Poison Control Center. If gaps in access exist and current funds cannot be utilized, explore whether recent grants awarded to DMHAS can be directed to EMS to purchase naloxone and training in its administration.

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V. Appendix

Appendix A: Legislation

Public ACT No. 18-166
AN ACT CONCERNING THE PREVENTION AND TREATMENT OF OPIOID DEPENDENCY AND OPIOID OVERDOSES IN THE STATE:

Sec. 4. *(Effective from passage)* (a) The Alcohol and Drug Policy Council established under section 17a-667 of the general statutes shall convene a working group to evaluate methods of combating the opioid epidemic in the state. The working group shall investigate and advise the co-chairpersons of the council regarding the following:

(1) The number of persons annually who receive services from each methadone treatment program funded by contract with the Department of Mental Health and Addiction Services, the rate at which such persons relapse and the number of such persons who die as the result of a drug overdose while participating in such program;

(2) The availability of opioid antagonists, as defined in section 17a-714a of the general statutes, at each such methadone treatment program and each state-funded treatment program for persons with substance use disorder;

(3) The advantages and disadvantages of a licensed mental health professional at each such methadone treatment program and each treatment program for persons with substance use disorder being permitted to dispense an opioid antagonist directly to a person at the time of such person's discharge from such program without the need for such person to obtain the opioid antagonist from a pharmacy under section 20-633c or 20-633d of the general statutes;

(4) Whether a nonfatal drug overdose at a hospital or outpatient surgical facility should qualify as an adverse event under section 19a-127n of the general statutes;

(5) The role of health carriers, as defined in section 19a-755b of the general statutes, in shortening a person's stay at a treatment program for persons with substance use disorder;

(6) The availability of federal funds to supply emergency medical services personnel in the state with opioid antagonists and provide training to such personnel in the administration of opioid antagonists;

(7) The development and implantation of a statewide uniform pre-hospital data reporting system to capture the demographics of pre-hospital administration or use of an opioid antagonist and opioid reversal outcomes as a result of such administration or use;

(8) The development of a statewide strategy to (A) identify potential sources of federal funding for treatment and prevention of opioid use disorders, and (B) maximize federal

reimbursement and grant funding for state initiatives in combatting the opioid epidemic in the state; and

(9) Whether the use of physical therapy, acupuncture, massage and chiropractic care can reduce the need for opioid drugs, as defined in section 20-14o of the general statutes, in mitigating a patient's chronic pain

(b) On or before January 1, 2019, the working group shall report its findings to the co-chairpersons of the Alcohol and Drug Policy Council. The co-chairpersons shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding such findings and

Sec. 6. *(Effective from passage)* (a) As used in this section:

(1) Opioid agonist has the same meaning as provided in section 17a-714a of the general statues;

(2) "Long-term injectable opioid antagonist" means naltrexone for extended-release injectable suspension or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of opioid use disorder;

(3) "Opioid drug" has the same meaning as provided in section 20-14o of the general statutes; and

(4) "Partial opioid agonist" means a medication that binds to the opiate receptors and provides relief to individuals in treatment for abuse of or dependency on an opioid drug and that causes less conformational change and receptor activation in the central nervous system than a full opioid agonist.

(b) Not later than January 15, 2019, the Department of Correction, in consultation with the Departments of Mental Health and Addiction Services, Public Health, and Social Services and the Office of Policy and Management, shall review the pilot program established pursuant to section 18-100j of the general statutes, as amended by this act, that provides medication-assisted treatment to inmates with opioid use disorder in correctional facilities and report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and the judiciary regarding the following:

(1) A comprehensive plan for expanding the pilot program to serve all inmates with opioid use disorder state-wide, including estimates of the lives saved by the pilot program, the costs, short-term savings and long-term savings of the pilot program, including, but not limited to, savings to other state departments and agencies, and the availability of federal funds for expansion of the pilot program;

(2) Opportunities to expand the pilot program without incurring additional costs,

(3) including, but not limited to, through the use of existing programs that make long-term injectable opioid antagonists available to the state at a reduced cost or no cost; and

(4) The feasibility of the Department of Correction embedding, within available resources, treatment of opioid use disorder in its health care delivery system.

(c) The Departments of Correction and Mental Health and Addiction Services shall seek, within available resources, all available federal funds for expanding access to medication- assisted treatment for opioid use disorder in correctional facilities. If federal funds are available, the Department of Correction shall expand the pilot program, including, but not limited to, by offering the program in additional correctional ffacilities, increasing the number of inmates with access to the program or providing partial opioid agonists through the program. Not later than January 1, 2020, the Commissioners of Correction and Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary and public health regarding the availability of funds and the plan for expansion of the pilot program.

Sec. 7. Section 18-100j of the general statutes is repealed and the following is substituted in lieu thereof *(Effective from passage):*

Not later than October 1, 2013, the Department of Correction may initiate, with support from the Departments of Mental Health and Addiction Services and Public Health, a pilot treatment program for methadone maintenance and other drug therapies at facilities including, but not limited to, the New Haven Community Correctional Center. The pilot program shall [be for eighteen months and shall] serve sixty to eighty inmates per month. The Department of Public Health may waive public health code regulations that are not applicable to the service model of the pilot program. Not later than [October 1, 2014, and Apri11, 2015] <u>July 1, 2019</u>, the Department of Correction shall report on the results of the program to the joint standing committee of the General Assembly having cognizance of matters relating to human services, the judiciary, <u>public health</u> and appropriations and the budgets of state agencies.

Appendix B: Committee Composition

Marianne Buchelli, CT Department of Public Health

Barbara Cass, CT Department of Public Health

Ralf Coler, CT Department of Public Health

Brie Wolfe, CT Department of Public Health

Susan Logan, CT Department of Public Health

Julienne Giard, CT Department of Mental Health and Addiction Services

Karin Haberlin, CT Department of Mental Health and Addiction Services

Lauren Siembab, CT Department of Mental Health and Addiction Services

Jim Siemianowski, CT Department of Mental Health and Addiction Services

Mary Mason, CT Department of Mental Health and Addiction Services

Nancy Navarretta, CT Department of Mental Health and Addiction Services

Leslie O'Brien, CT Department of Consumer Protection

Rod Marriott, CT Department of Consumer Protection

Mary Painter, CT Department of Children and Families

Kathleen Mauer, CT Department of Correction

Gerard O'Sullivan, CT Department of Insurance

Linda Kowalski, CT Chiropractic Association

Victor Vaughn, CT Physical Therapy Association

Suzanne Doyon, CT Poison Control

Mike Dugan, Capitol Consulting, LLC

Josh Hughes, Capitol Consulting, LLC

Ryan Oakes, Accenture

Appendix C: Additional Reports and Resources

- *Consumer Report Card on Health Insurance Carriers in Connecticut:* Connecticut Insurance Department, October 2017: http://www.ct.gov/cid/lib/cid/2017ConsumerReportCard.pdf.

- *Ensuring Access & Coverage in CT for Substance Abuse Treatment*: Connecticut Insurance Department, January 31, 2017: http://www.ct.gov/cid/lib/cid/2017-SubstanceAbuseTreatment.pdf.

- *Protecting Behavioral Health for Consumers in Connecticut: A Report of the Behavioral Health Working Group*: Connecticut Insurance Department, December 22, 2016: http://www.ct.gov/cid/lib/cid/2016-Dec-Behavioral-Health-Working-Group-Report.pdf.

- *Protecting Behavioral Health for Consumers in Connecticut: A Report of the Behavioral Health Working Group*: Connecticut Insurance Department, February 23, 2016: http://www.ct.gov/cid/lib/cid/2016-Behavioral-Health-Working-Group-Report.pdf.

- *Combating the Opioid Crisis:* Connecticut Association of Health Plans, July 2018.

- *Various additional information from carriers in Connecticut,* Summer 2018.

- *Integrated Chronic Pain Program (ICPP): Summary of Results*

- *Association Between Utilization of Chiropractic Services for Treatment of Low-Back Pain and Use of Prescription Opioids*
  James M. Whedon, DC, MS, Andrew W.J. Toler, MS, Justin M. Goehl, DC, MS, and `
  Louis A. Kazal, MD2

- *Cross Sectional Analysis of Per Capita Supply of Doctors of Chiropractic and Opioid Use in Younger Medicare Beneficiaries*
  William B. Weeks, MD, PhD, MBA, and Christine M. Goertz, DC, PhD

- *Opioid Use Among Veterans of Recent Wars Receiving Veterans Affairs Chiropractic Care*
  Lisi AJ[1,2], Corcoran KL[1,2], DeRycke EC[1], Bastian LA[1,2], Becker WC[1,2], Edmond SN[1,2], Goertz CM[3], Goulet JL[1,2], Haskell SG[1,2], Higgins DM[4,5], Kawecki T[1,2], Kerns RD[1,2], Mattocks K[6,7], Ramsey C[2], Ruser CB[1,2], Brandt CA[1,2]. Pain Med. 2018 Sep 1;19(suppl_1):S54-S60. doi: 10.1093/pm/pny114.

- *FDA Education Blueprint for Health Care Providers Involved with the Management or Support of Patients with Pain. (May 2017).*

- *National Dialogue for Healthcare Innovation's Opioid Crisis Solutions Summit: A Roadmap for Action.*

- *APTA White Paper – Beyond Opioids: How Physical Therapy can Transform Pain Management to Improve Health.*

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