# Commonwealth of Massachusetts

**Executive Office of Health and Human Services**

## Health Policy Commission

**Leslie Darcy**

**Director of Policy and Strategic Initiatives**

**July 8, 2015**

**Governor's Working Group:** An 18 member expert panel, chaired by Marylou Sudders, Secretary of the Executive Office of Health and Human Services (EOHHS)

**Goals:** Reduce the magnitude and severity of harm related to opioid misuse and addiction and decrease opioid overdose deaths in the Commonwealth

**Objective:** Produce actionable recommendations to address the opioid epidemic in the Commonwealth

**Activities:**

- Hosted 4 listening sessions in Boston, Worcester, Greenfield, and Plymouth
- Held 11 in person meetings
- Examined documents and recommendations from more than 150 organizations
- Heard from more than 1,100 individuals from across the Commonwealth
- Reviewed academic research, government reports, and reports of previous task forces and commissions
- Submitted more than 65 actionable recommendations to Governor Baker on June 12, 2015

# The Working Group's KEY STRATEGIES:

## 1. Create new pathways to treatment

Too many individuals seeking treatment utilize acute treatment services (ATS) as their entry point, even when a less acute level of treatment may be appropriate. By creating new entry points to treatment and directing individuals to the appropriate level of care, capacity will be managed more efficiently and the Commonwealth will be better able to meet the demand for treatment.

## 2. Increase access to medication-assisted treatment

Medication-assisted treatment for opioid use disorder (e.g. methadone, buprenorphine, naltrexone) has been shown to reduce illicit opioid use, criminal activity, and opioid overdose death. Increasing capacity for long-term outpatient treatment using medications as well as incorporating their use into the correctional health system, can be a life-saving intervention.

## 3. Utilize data to identify hot spots and deploy appropriate resources

By the time DPH receives overdose death data from the medical examiner, the data is stale. The Commonwealth should partner with law enforcement and emergency medical services to obtain up-to-date overdose data, which can be used to identify hot spots in a timely manner and allocate resources accordingly.

## 4. Acknowledge addiction as a chronic medical condition

Primary care practitioners must screen for and treat addiction in the same way they screen for and treat diabetes or high blood pressure. This will expedite the process for timely interventions and referrals to treatment.

## 5. Reduce the stigma of substance use disorders

The stigma associated with a substance use disorder (SUD) is a barrier to individuals seeking help and contributes to: the poor mental and physical health of individuals with a SUD; non-completion of substance use treatment; higher rates of recidivism; delayed recovery and reintegration processes; and increased involvement in risky behavior.

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## 6. Support substance use prevention education in schools

Early use of drugs increases a youth's chances of developing addiction. Investing in the prevention of youth's first use is critical to reducing opioid overdose deaths and rates of addiction.

## 7. Require all practitioners to receive training about addiction and safe prescribing practices

Opioids are medications with significant risks; however, safer opioid prescribing practices can be accomplished through education.

## 8. Improve the prescription monitoring program

The Commonwealth's prescription monitoring program (PMP) is an essential tool to identify sources of prescription drug diversion. By improving the ease of use of the PMP and enhancing its capabilities, it will no longer be an underutilized resource.

## 9. Require manufacturers and pharmacies to dispose of unused prescription medication

Reducing access to opioids that are no longer needed for a medical purpose will reduce opportunities for misuse.

## 10. Acknowledge that punishment is not the appropriate response to a substance use disorder

Arrest and incarceration is not the solution to a substance use disorder. When substance use is an underlying factor for criminal behavior, the use of specialty drug courts are effective in reducing crime, saving money, and promoting retention in drug treatment. It is important that treatment occur in a clinical environment, not a correctional setting, especially for patients committed civilly under section 35 of chapter 123 of the General Laws.

## 11. Increase distribution of Naloxone to prevent overdose deaths

Naloxone saves lives. It should be widely distributed to individuals who use opioids as well as individuals who are likely to witness an overdose.

## 12. Eliminate insurance barriers to treatment

Removing fail first requirements and certain prior authorization practices will improve access to treatment. By enforcing parity laws, the Commonwealth can ensure individuals have access to behavioral health services.

COMMONWEALTH OF MASSACHUSETTS

# Summary of Short-Term Action Items (6 months to 1 year)

## Prevention

- Increase educational offerings for prescribers and patients to promote safe prescriber practices
- Develop targeted educational materials for schools
- Appoint members to the drug formulary commission
- Integrate information about the risks of opioid use and misuse into school athletic programs
- Conduct a public awareness campaign

## Intervention

- Improve the PMP
- Outreach to prenatal and postpartum providers to increase screening for women with a substance use disorder
- Improve reporting of overdose death data
- Enhance data transparency, including EMS data
- Encourage naloxone to be co-prescribed with opioids
- Amend civil commitment process
- Identify hot spots for targeted intervention, using EMS, hospital, and police data
- Promote the Good Samaritan law
- Consider mandating testing for in utero exposure to alcohol and drugs at every birth
- Encourage and support alternatives to arrest
- Expand availability of Naloxone

## Treatment

- Develop a central statewide database of available treatment services
- Transfer section 35 civil commitment responsibility from DOC to EOHHS
- Increase the number of office based opioid treatment programs
- Require DOI to issue bulletins on chapter 258 of the Acts of 2014 prior to Oct. 2015
- Pilot recovery coaches in emergency rooms and hot spots
- Bulk purchase opioid agonist and naltrexone therapies for correctional facilities
- Add 100 new ATS/CSS beds
- Open Recovery High School in Worcester
- Review capacity in the treatment system for women/families
- Analyze treatment spending in correctional facilities
- Increase the number of stepdown beds and services

## Recovery

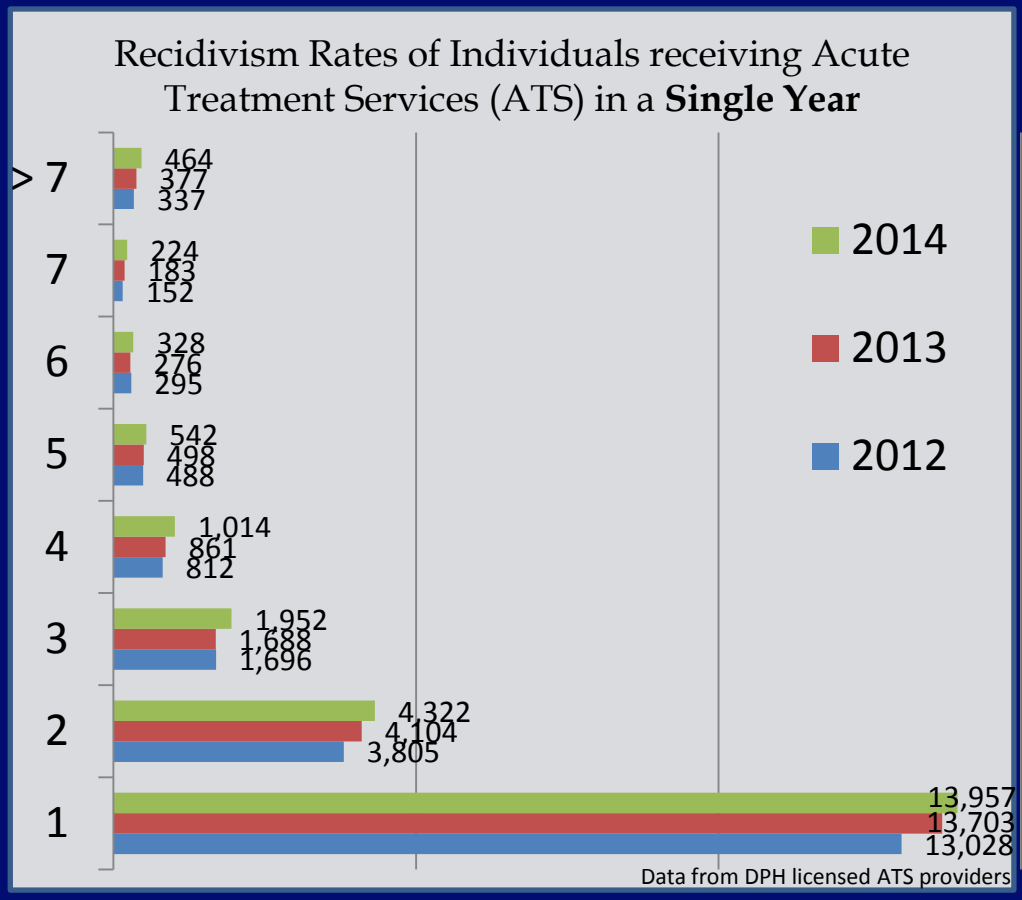
- Promulgate chapter 257 rates for recovery homes effective July 2015
- Establish a single point of accountability for addiction and recovery policy at EOHHS
- Suspend rather than terminate MassHealth coverage during incarceration
- Certify alcohol and drug free housing
- Enforce the requirement that BSAS treatment programs accept patients on an opioid agonist therapy
- Strengthen connections between law enforcement and community providers for individuals upon release
- Explore issuing certificates of recovery
- Review and revise discharge/court notification policies for section 35

Focusing on patient care can increase access without having to add beds

In 2014, **4,524 individuals** utilized ATS 3 or more times

Two individuals utilized ATS **23 times**

In 2014, if these individuals had received ongoing treatment, at least **16,000 additional** individuals could have received ATS



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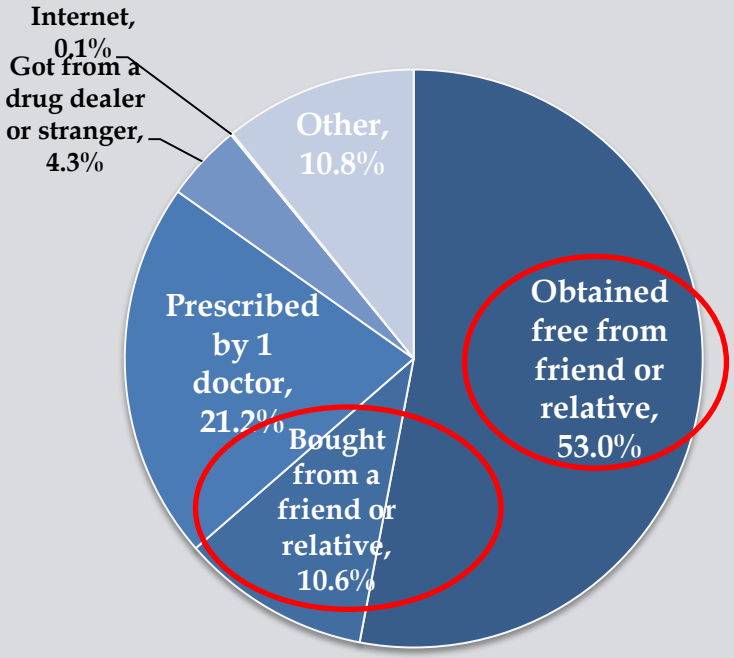
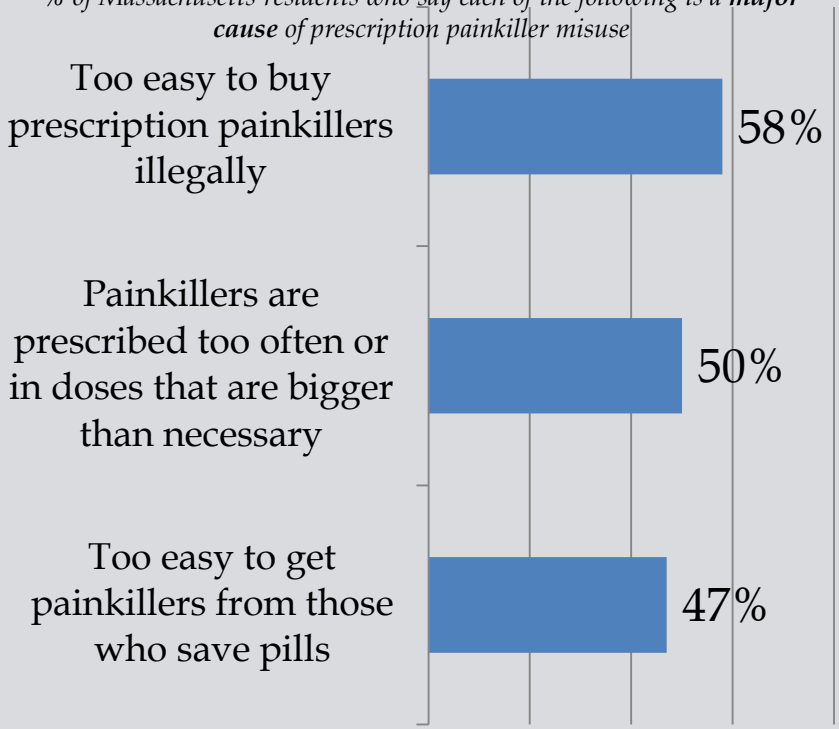
## SOURCE, AMONG THOSE AGED 12 OR OLDER, WHO USED PAIN RELIEVERS NONMEDICALLY (2012-2013)




Source: Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality

## SURVEY: REASON FOR PRESCRIPTION PAINKILLER MISUSE

*% of Massachusetts residents who say each of the following is a **major cause** of prescription painkiller misuse*



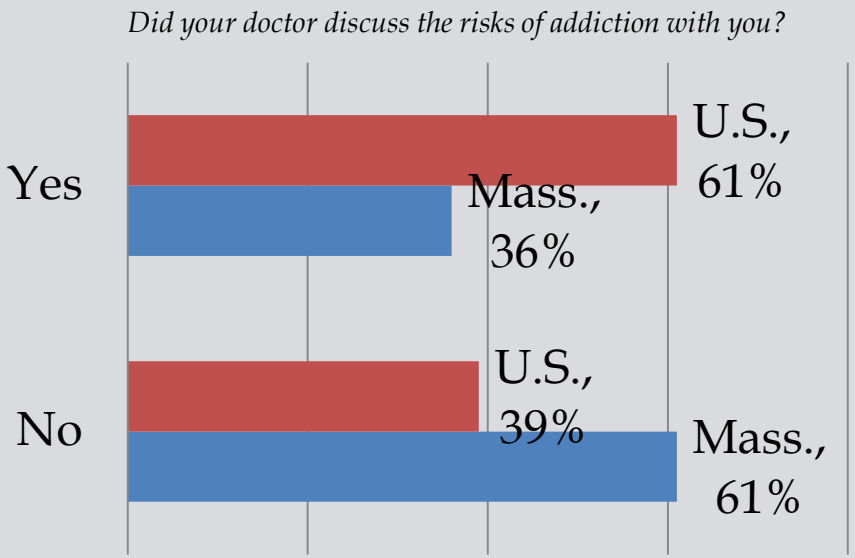

Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States

# MASSACHUSETTS DOCTORS DISCUSS THE RISKS OF PRESCRIPTION PAINKILLERS WITH PATIENTS LESS THAN DOCTORS IN OTHER PARTS OF THE COUNTRY

In a 2015 survey, individuals who, in the past 2 years, **HAD** taken a strong prescription painkiller, such as Percocet, OxyContin, or Vicodin that was prescribed by a doctor for more than a few days, were asked the following question:

"Before or while you were taking these strong prescription painkillers, did you and your doctor talk about the risk of prescription painkiller addiction, or haven't you talked about that?"

Only 36% of Massachusetts residents said "yes", compared to 61% nationally




Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States

# Summary of Mid-Term Action Items (1 year to 3 years)

## Prevention

- **Support substance use prevention curricula in schools**
- **Mandate pain management, safe prescribing and addiction training for all prescribers**
- **Partner with federal government regarding graduate medical education**
- Require manufacturers and pharmacies to dispose of unused prescription medication
- Require prescribers to discuss opioid side effects at point of prescription
- Allow partial refills across all payers
- Eliminate prescription refills by mail for schedule II medications
- Amend the curriculum for teachers as state universities to include training on screening and intervention techniques
- Have state universities develop substance use prevention curricula for schools

## Intervention

- **Improve the PMP to ensure data compatibility with other states**
- **Develop training on neonatal abstinence syndrome and addiction for DCF staff**
- **Improve affordability of Naloxone**
- **Increase access to beds for section 35 patients**
- Implement electronic prescribing for opioids
- Increase screening for substance use at all points of contact in the medical system
- Increase the use of screenings in schools to identify at-risk youth for behavioral health issues

## Treatment

- **Create a consistent public behavioral health policy through licensing reforms**
- **Pilot providing patients with access to an emergent/urgent addiction assessment by a trained clinician and direct referral to the appropriate level of care**
- **Increase points of entry to treatment**
- **Ensure section 35 patients receive a continuum of care**
- Enhance provider accountability by requiring treatment programs to report on outcomes
- Reform purchasing of substance use disorder treatment services
- Require DPH to advance standards of care by establishing industry benchmarks
- Add new non-ATS/CSS treatment beds

## Recovery

- **Fund patient navigators and case managers**
- **Leverage community coalitions to address opioids**
- Ensure all infants with NAS are referred to early intervention by time of hospital discharge
- Increase drug and specialty court capacity
- Expand peer/family support
- Partner with businesses to remove employment barriers that recovering individuals experience

# Summary of Long-Term Action Items (3+ years)

## Prevention

- Support alternate pain therapies through commercial and public insurers & prepare a public report on what non-pharmacological treatments for pain are covered by all private and public insurers

## Intervention

- Improve the PMP by interfacing the PMP with electronic health records

## Treatment

- Establish and promote a longitudinally based system of addiction care
- Integrate primary care into substance use treatment programs

## Recovery

- Reduce stigma among medical and treatment professionals