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Governor Baker and Secretary Sudders Testify Before Joint Committee on Mental Health and Substance Abuse in Support of the Administration's "CARE Act" Legislation to Combat the Opioid and Heroin Epidemic

BOSTON— Today, Governor Charlie Baker and Secretary of Health and Human Services Marylou Sudders testified at a hearing of the Joint Committee on Mental Health and Substance Abuse in support of the administration's second significant package to fight the opioid and heroin epidemic, including legislation titled "An act relative to Combatting addiction, Accessing treatment, Reducing prescriptions and Enhancing prevention" (CARE Act).

TESTIMONY AS PREPARED FOR DELIVERY BY GOV. CHARLIE BAKER:

Madame Chairs, Mr. Vice Chairs and Members of the Joint Committee on Mental Health, Substance Use and Recovery, thank you for the opportunity to provide testimony regarding "An Act Relative to Combatting Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention." The legislation filed by the Administration will allow the Commonwealth to build upon our efforts to address the opioid epidemic by continuing to expand pathways to treatment and recovery services, holding the medical community accountable for their prescribing habits, and strengthening our education and prevention tools.

Overview

It is not my first time here talking with you all about what we need to do in order to bend the trend in the right direction when it comes to the opioid epidemic. Thanks to your, bipartisan cooperation, we signed a landmark opioid bill last session. But I think that we can all agree there is more work to be done, and I believe this legislation will significantly assist the Commonwealth in our continued fight against the disease.

When I asked Secretary Sudders to chair the Opioid Working Group three years ago, I challenged her and the team to disrupt the status quo and to act with urgency. To develop best practices for combating the crisis, we learned from families who lost loved ones and people struggling with substance misuse about ways we can improve access to treatment and stop addiction before it starts; we listened and engaged in numerous discussions with the health care community, advocates, schools, individuals with addictions in various stages of treatment and recovery, loved ones, and reviewed evidence-based data reports, all of which have helped inform and develop this Administration's comprehensive package of reforms to improve substance misuse prevention, intervention, treatment and recovery strategies.

Our first major first step was the bipartisan enactment of Chapter 52 of the Acts of 2016, an Act Relative to Substance Use, Treatment, Education and Prevention (the STEP Act), which established Massachusetts as the first state in the nation to implement a seven day limit on first-time opioid prescriptions for adults. Today, opioid prescriptions are down by nearly 30% in the Commonwealth.

We completely revamped the prescription monitoring program; and improved education for young people, educators, and medical professionals about the risks of opioid misuse.

We also partnered with the state's colleges and universities and today, nearly every single future prescriber educated in the Commonwealth receives mandatory opioid training.

We brought together our nine schools of social work to adopt core curriculum in addictions for our largest cadre of behavioral health clinicians. More than 56,000 people across the Commonwealth are now trained to use the lifesaving, overdose reversal drug naloxone.

Nearly two years later since the law's enactment and our collective efforts, we are now seeing early signs of progress. Some of our efforts are even being used as a national blue print to help other states. And for the first time, opioid-related deaths in the Commonwealth have decreased by 10%.

The bill before you, the CARE Act, builds upon the foundational work of the STEP Act and offers a more targeted approach to expanding our educational efforts; preventing opioid misuse and addressing barriers to treatment and gaps in care.

Expanding Educational Efforts

In the long run, our ability to meaningfully reduce the problem of opioid addiction will depend on better and wider education about substance misuse in an attempt to stop addiction before it starts.

The STEP Act introduced requirements that every school district in the Commonwealth develop effective substance use prevention education, and adopt an individualized assessment tool to screen students for substance use disorders.

As a result of our Screening, Brief Intervention, and Referral to Treatment program (SBIRT), we have already trained nearly 4,000 school staff in 283 school districts, resulting in 22,000 students screened.

The CARE Act builds on that progress by creating a trust fund to help finance the expansion of educational and intervention programs in schools. This fund will go toward developing information systems that can help identify students at risk and track outcomes. It will also support the implementation of new, school-based models for coordinated support of students in need. My 2019 budget will propose additional funding for school based prevention and intervention so local schools have the resources they need to combat the epidemic.

We will also promote prevention education in public and private higher education intuitions, to be included in freshman orientation programs for students.

Preventing Opioid Misuse

The medical community plays a critical role in both fighting and preventing opioid addiction. Massachusetts is seeing progress thanks to the use of certain tools like MassPAT, our prescription monitoring program.

There is now more accountability for prescribers, and these powerful drugs are tracked more closely than ever before. To date, 95 percent of Massachusetts providers are now registered on MassPAT.

However, there are still vast challenges. Every year in the United States, over 220 million opioid prescriptions are written. Four of five people who become addicted to

heroin start on prescription pain medications.

The CARE Act focuses on six changes that continue to improve the Commonwealth's ability to prevent opioid misuse. First, our legislation mandates that all prescriptions be electronically prescribed by 2020.

This will help cut down on fraud and improve tracking and data collection. States including New York and national pharmacy companies such as CVS are adopting e-prescribing as best practice. Next, to ensure compliance with the state's seven day prescription limit law, we believe that it is important that there is a referral process to report providers who are suspected of violating the law.

Opioid prescriptions issued to treat a work related injury or short term acute pain are putting too many people at risk of developing an addiction.

To address this danger, the bill authorizes the Department of Industrial Accidents, which administers the Commonwealth's workers compensation insurance program, to develop an approved drug formulary to regulate the use of opioids in treating workplace injuries.

It also creates a commission that will develop recommendations on appropriate prescribing practices for the most common oral and advanced dental procedures.

Our legislation will advance the use of "blister packs," standardized, prepackaged doses in order to reduce the likelihood of overprescribing.

More and more we are learning that patients do not need large prescriptions and numerous refills to manage short term acute pain—in fact they may not need opioids at all. Following a change in Federal law, the bill improves on the "partial fill" provision of the STEP Act so that patients will be able to receive a portion of their full opioid prescription without invalidating the remainder of it.

More patients may choose the "partial fill" option if they know they can go back to the same pharmacy within 30 days to fill the rest of the prescription if needed.

And, as one of the most important prevention tools, the bill increases access to naloxone by authorizing a state-wide, standing order that will make it easier for every pharmacy in the Commonwealth to dispense naloxone.

The bill also encourages broader use of naloxone by guaranteeing that practitioners who prescribe and pharmacists who dispense naloxone in good faith will be protected from criminal or civil liability.

Improving Access to Treatment

The CARE Act has a number of provisions to improve access to treatment. First, it creates a commission that will recommend standards to credential recovery coaches, powerful tools to keep individuals in long-term recovery.

The Commonwealth currently has a few recovery coach pilot programs. Last week, the Secretary and I had the opportunity to visit Beverly Hospital which operates one of our piloted recovery coach programs. During that visit, we spoke with a patient who credited his recovery from opioid addiction to the help of his recovery coach.

The recovery coach, who is also in recovery, first sat with the patient for several hours in the emergency room (ER) after being brought in from another overdose. The patient told us that without the recovery coach's intervention, he would have left the hospital and gone right back to using heroin. Instead, with his recovery coach's active support and guidance, he went to treatment and is now living in, and helping to run, a Sober Home all thanks to that intervention in the ER.

Recovery coaches' offer acceptance through shared experiences and we must act to make sure these services are effective and available for more people seeking a path to recovery.

The CARE Act also focuses on two areas where we must improve access to treatment: ensuring that people who are suffering from opioid addiction receive the specialized treatment they need and expanding access to treatment in the emergency room setting.

I'd like to ask Secretary Sudders to address this part of the legislation.

TESTIMONY AS PREPARED FOR DELIVERY BY SEC. MARYLOU SUDDERS:

All of us would agree that voluntary treatment for substance misuse is the best course– but there are times when it may be necessary to involuntarily admit someone. Involuntary treatment is, and should be, used only as a last resort. However, when used clinically appropriately, it can save lives and provide an opportunity to engage someone to accept treatment. Attention has been drawn to a 2016 Department of Public Health study, known as the Chapter 55 report, which

found that people who received involuntary treatment were 2.2 times more likely to die of opioid-related overdoses, as compared to those with a history of voluntary treatment. However, the same study found that, during the 2011 to 2014 reporting period, 98.6% of the individuals who were involuntarily committed survived and were among our sickest and most complex patients, as compared to the individuals who sought voluntary treatment.

Massachusetts law currently allows for involuntary treatment for addiction, referred to as section 35. However, under current law, the courts are the only pathway to involuntary treatment. Courts are open only during normal business hours, Mondays through Fridays. The hospital is not a pathway to involuntary treatment for those at imminent risk of harm as a result of a substance use disorder. If an individual was administered Narcan and transported to an emergency department, they may refuse a substance abuse assessment and walk out of the hospital. Every day, our emergency room physicians make heroic medical decisions with the best information available to them. The bill proposes two important changes to the current section 35 process. One permits medical professionals or police officers to authorize the involuntary transport of a patient to a substance use treatment facility for emergency assessment and treatment when the patient poses an imminent risk of harm to themselves or others. The treatment facility is then required to attempt to engage the patient in voluntary treatment for a period of up to 72 hours. In cases where a patient poses an immediate risk of harm but remains unable to engage in voluntary treatment, medical professionals at the treatment facility would be required to petition a court to commit the patient for involuntary treatment under section 35 of chapter 123 of the General Laws, the existing civil commitment statute. In listening to the concerns expressed previously by some in the medical community, the bill provides civil and criminal protections for the individuals making these assessments and determinations. The second change expands the types of medical professionals who can file a section 35 petition with the court.

Too often we've heard from desperate families who have nowhere else to turn when they are in need of immediate help. Crises of addiction occur 24 hours a day, 7 days a week – not only during the hours when a court is open. Additionally, by not allowing a clinical pathway to involuntary treatment, it contributes to the stigma that addiction is a criminal matter not a medical illness. This provision is effective 2020 to allow for clinical standards to be developed for these involuntary assessments for involuntary treatment and for the expansion of additional treatment capacity.

The 2016 STEP Act introduced a requirement that medical staff in an emergency department conduct a substance use evaluation and provide information on addiction treatment for any patient treated for an opioid overdose. The CARE Act aims to improve the effectiveness of these consultations by expanding the range of

medical professionals authorized to perform the evaluation and by requiring that the emergency departments affirmatively connect the patient with the appropriate level of care, including connecting patients to a recovery coach or an inpatient substance use treatment facility.

The CARE ACT also contains other important provisions. In order to ensure that the appropriate types of treatment facilities are available to serve every patient who needs treatment, the legislation strengthens the oversight authority of the Department of Mental Health (DMH) and the Department of Public Health, the two agencies that license facilities that provide treatment for addiction and/or mental illness.

Before licensing new treatment programs or approving the transfer of license of an existing facility, DMH and DPH will require that a facility demonstrate that it provides the range and quality of services necessary to meet the current, critical treatment needs of the Commonwealth's patients. Prior to receiving a license, providers may be required to demonstrate that they can treat individuals with co-occurring mental health and substance use disorder, and make treatment available to patients with public health insurance.

The CARE Act also establishes a commission to recommend standards that specify how licensed behavioral health clinicians represent their specialty and capability to insurance carriers and patients. These standards will use evidence-based treatments to categorize providers, so in the future; individuals seeking treatment for substance misuse can more easily and effectively find providers that meet their specific needs.

We would like to thank the Committee and Legislature for your continued partnership to address the opioid crisis. Our work to fight this epidemic is never done. While we have made progress, there is still so much more work to do.

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