

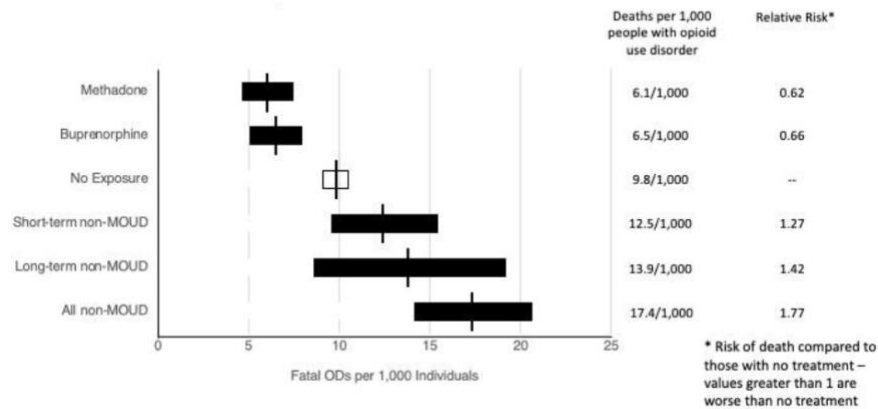


Funding Priority 1: Increase Access to the Most Effective Medications (Methadone and Buprenorphine) for Opioid Use Disorder Across Diverse Settings

Rationale

Medications for opioid use disorder (MOUD), particularly methadone and buprenorphine, are the most effective form of treatment for opioid use disorder (OUD). MOUD is endorsed by entities ranging from the World Health Organization, the White House Office of National Drug Control Policy, the National Institutes of Health, the National Academies of Science, Engineering and Medicine, and numerous other bodies because of its ability to decrease rates of substance use, overdose deaths, transmission of viral infections, and criminal behavior.^{1,2} There is strong evidence that OUD treatments that do not use methadone or buprenorphine are inferior to those that do and result in more deaths.^{1,3,4} In data from Connecticut (Figure 1), individuals receiving OUD treatment with either methadone or buprenorphine reduced their risk of fatal overdose compared to those not receiving any addiction treatment (39% reduction with methadone, 34% reduction with buprenorphine).⁵ These results are consistent with analyses in other states^{3,6}, other countries, and within high-risk subpopulations.⁷⁻⁹ Treatment with MOUD is also cost-effective.^{10,11} Thus, Opioid Settlement Funds should be used to fund initiatives that increase the proportion of people with OUD who initiate treatment with methadone or buprenorphine and are retained on these medications.

Figure 1. Opioid Overdose Death Rate, Connecticut, 2017



Data source: Heimer R, Black A, Lin H, Grau LE, Fiellin DA, Howell BA, Hawk K, D’Onofrio G, Becker WC. Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016–17. Drug Alcohol Depend. 2024; 254 (111040).

Consistent access to MOUD for people with OUD is a crucial tool for reducing overdoses in the state, but people confront several barriers when attempting to initiate or maintain treatment with MOUD, including:

- Limited access to clinicians and treatment programs offering same-day provision of MOUD

- Inadequate numbers of clinicians who accept certain insurances, including Medicaid
- Lack of routine initiation of patients with untreated OUD on MOUD by clinicians in ambulatory (outpatient) care sites, including emergency departments (EDs) and primary care
- Inadequate number of clinicians and treatment programs offering MOUD to adolescents
- Challenges with transportation to treatment settings
- Pharmacies that opt to not dispense buprenorphine (as initiated by prescription) or have limits on dispensing¹²⁻¹⁴

Funding should be directed to decreasing all potential barriers to accessing MOUD and improving retention in MOUD treatment.

Evidence

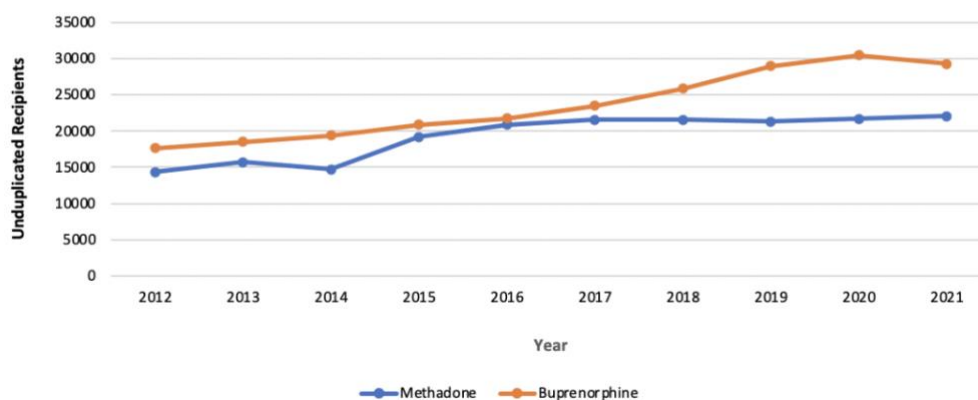
Evidence regarding the efficacy of methadone⁴ and buprenorphine¹ to improve outcomes for people with OUD is overwhelming, particularly with respect to reduction in risk of overdose. Both medications have been demonstrated to reduce the risk of overdose by as much as 50% in clinical trials and in real world clinical practice.

Methadone and buprenorphine use in Connecticut since 2016

Since 2016, several state agencies, including DMHAS, DCP, the Department of Children and Families (DCF), Department of Social Services (DSS), and DOC, have made efforts to increase the number of individuals initiating and engaging in methadone or buprenorphine treatment, including efforts to lower barriers to accessing methadone, increase capacity to prescribe buprenorphine and methadone, and increase access to methadone and buprenorphine for incarcerated people with OUD.¹⁵

The number of individuals receiving methadone increased in the state substantially between 2012 (14,000) and 2017 (21,000), but there have been minimal increases since that time. (Figure 2) Similarly, the estimated number of individuals receiving buprenorphine increased in the state substantially between 2015 (21,000) and 2020 (30,000), with only modest increases since that time. There is less data on the proportion of people who are retained on either methadone or buprenorphine long-term. There are no reliable estimates of the number of people in the state at risk for overdose who would benefit from treatment with MOUD. Nonetheless, the rising number of opioid overdoses indicates there is an unmet need for these treatments in the state. This unmet need includes individuals who use opioids or have OUD and are at risk of overdose but have not initiated MOUD as well as individuals who have initiated MOUD but were not retained in treatment.

Figure 2. Unduplicated Recipients of Medications for Opioid Use Disorder (Methadone or Buprenorphine) in the State of Connecticut, 2012-2021



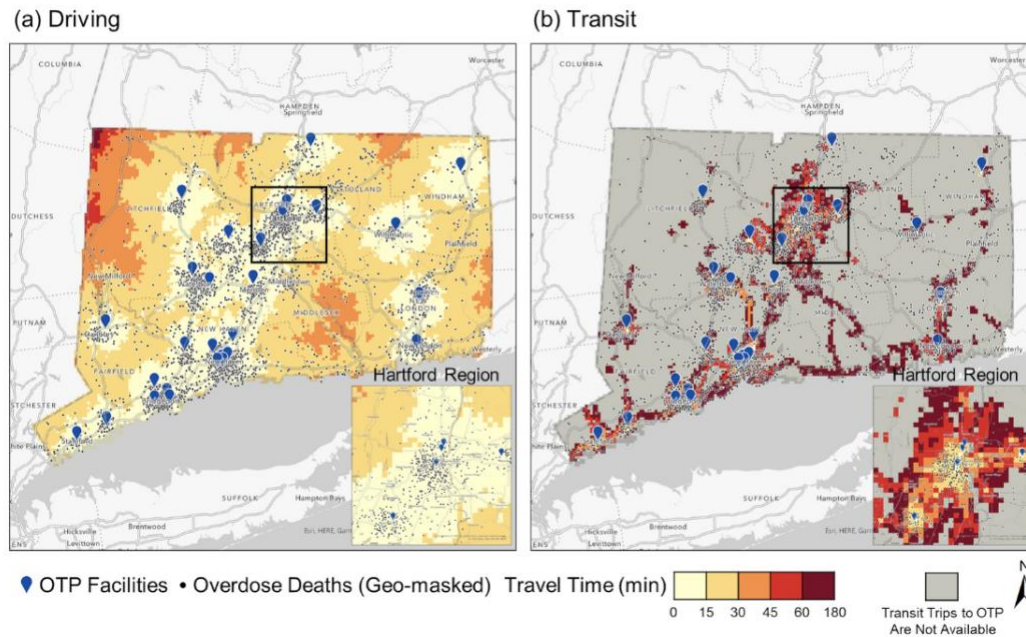
Data Sources: Methadone treatment data displayed in this figure is sourced from the ADPC 2022 Substance Use Triennial Report and Hsiu-Ju Lin, PhD (DMHAS, University of Connecticut School of Social Work). Buprenorphine treatment data reflects an estimate based on DEA Automated Reports and Consolidated Orders (ARCOS) reporting of buprenorphine shipments to the state. Some percentage of unduplicated recipients of buprenorphine may reflect diagnoses or applications other than OUD (e.g., pain management).

Methadone and buprenorphine access in Connecticut since 2016

There are geographic, socioeconomic, and racial disparities in access to methadone and buprenorphine within the state. Methadone access is limited to federally certified opioid treatment programs (OTPs) that are largely concentrated in our state’s urban centers. Given the number and location of these facilities, there is inequitable access to methadone treatment. The location of OTPs in Connecticut, their limited service hours, the fact that many individuals with OUD are reliant on mass-transit for their transportation needs, and policies governing methadone administration pose in combination a significant logistical burden for individuals to engage in methadone treatment. This logistical burden makes it harder for individuals in methadone treatment to achieve other important goals, such as gainful employment. Of note, this is an area of evolving federal regulation. Historically, regulations required 6 day a week, in-person dosing of methadone for the first 90 days of treatment, but during the COVID-19 pandemic, and only recently extended, SAMHSA loosened these regulations¹⁶ increasing the ability OTPs to provide take-home doses to stable patients, as determined by clinical judgement of the OTP even within the first 14 days of treatment.¹⁶

In preparing this report, we conducted an analysis of transportation access to OTPs in the state. In this analysis we estimated both the average weekday morning car-based and the mass transit (bus or train) travel time to at least one OTP from all points in the state. The results of this analysis are presented in Figure 3. In these maps, the gradations in color (yellow-to-red) represent cut-offs for travel time (i.e., 0-15 mins, 15-30 mins, etc.). In the map representing mass transit travel times, the bulk of the state is represented in gray, which reflects locations in the state that do not have ready access to mass transit. There are markers for each OTP in the state (blue mark) and overdose deaths (black dots) in the state. The overdose deaths have been geo-masked to obscure the actual location of the fatality.

Figure 3. Access as Measured by Travel Time, Driving (a) or Mass Transit (b), to At Least One Opioid Treatment Program in the State of Connecticut



Data Source: Maps generated in ArcGIS™ by Junghwan Kim, PhD (Virginia Tech). Data on average weekday morning travel time via driving and mass transit to OTP locations generated from Google Distance Matrix Applied Programming Interface (API) and General Transit Feed Specification (GFTS) datasets, respectively.

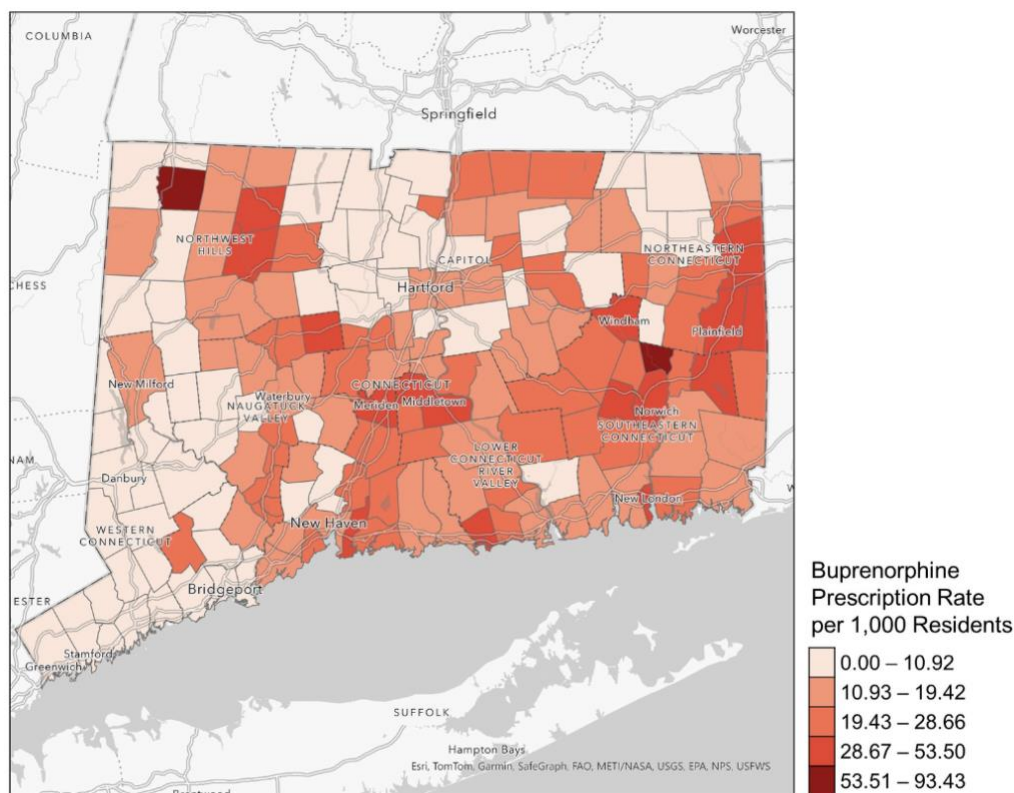
To account for density of unmet need for methadone treatment, we also estimated the average car-based and mass-transit based travel time from the location of all 1,018 opioid-involved overdose fatalities that occurred in 2019 to at least one OTP. This analysis demonstrated relatively good car-based access to OTPs, with the average travel time from the location of an overdose fatality to at least one OTP being 9 minutes and the vast majority of overdose locations (83%) being less than 15 minutes from an OTP. Mass-transit based access was much worse. The average mass-transit travel time to at least one OTP was 75 minutes and OTPs were inaccessible by mass-transit (no mass transit options at all) from one quarter of locations. Among locations with any mass-transit access, the majority (71%) were over 30 minutes of travel time by mass transit away from at least one OTP.

Due to differing federal regulations, access to buprenorphine is fundamentally different than access to methadone. Whereas methadone dispensing is limited to OTPs, any pharmacy can dispense buprenorphine. Given the distribution of pharmacies in the state, buprenorphine is therefore (theoretically) accessible throughout the state if an individual can locate a provider to prescribe buprenorphine. Following passage of the MAT Act by U.S. Congress in 2022, federal law changed allowing for buprenorphine to be prescribed by any DEA-licensed prescriber in the state. Although all prescribers can prescribe buprenorphine, not all prescribes do prescribe¹⁷, and there are no publicly available means to identify prescribers who are actively prescribing buprenorphine in the state.

The best estimates of geographic variation in buprenorphine prescribing in Connecticut come from yearly data from the Drug Enforcement Agency (DEA) reporting system on shipments of buprenorphine¹⁸ and

publicly reported data from the DCP from the Connecticut Prescription Monitoring and Reporting System (CPMRS), otherwise known as the Connecticut Prescription Drug Monitoring Program (PDMP).¹⁹ In our analysis of the DEA data, we found that shipments of buprenorphine to the state increased throughout the state from 2016 to 2022, but increases were unevenly distributed. Zip codes in the greater New Haven area and those in the eastern part of the state around New London and Norwich receive more buprenorphine per capita than other regions of the state. There have also been larger year-over-year increases in shipments of buprenorphine to the New London/Norwich area than in any other part of the state. This variation is reflected in publicly reported PDMP data from the DCP (Figure 3). These data demonstrate higher per capita buprenorphine prescription rates in the eastern part of the state, but also highlight towns in Litchfield County with similarly high per capita buprenorphine prescription rates. Data from the DEA and DCP should be interpreted with the understanding that buprenorphine can also be prescribed for the treatment of pain. We cannot distinguish in these datasets between receipt of buprenorphine for the treatment of OUD versus pain.

Figure 4. Partial Opioid Agonist Rate Per 1,000 Connecticut Residents, Quarter 3, 2023



Data Source: Map generated by Junghwan Kim, PhD (Virginia Tech), from data generated by [the DCP PDMP](#) for buprenorphine dispensed in Quarter 3, 2023.

There are long-standing variations in the demographics of who can access methadone or buprenorphine. Nationally, there are racial and ethnic disparities in buprenorphine prescribing, with prescribing concentrated in areas that are predominately non-Hispanic White, and less prescribing in areas that are predominately non-Hispanic Black.²⁰ In contrast, methadone access is concentrated in areas with higher percentages of Black and Hispanic residents.²¹ Other populations with population-specific risk factors for

overdose, for whom barriers to methadone and buprenorphine access have been documented, include adolescents and the elderly, pregnant and post-partum individuals, those with co-occurring psychiatric, developmental, or medical conditions, and those engaged in high-risk professions such as sex work. Heightened risk for overdose among the unhoused and recently incarcerated is discussed in prior sections and will be revisited in sections to follow. MOUD access is further mediated by the influence of intersecting identities including race, ethnicity, gender, and sexual orientation.

Building on substantial data supporting the efficacy of MOUD for a range of outcomes, there is evidence that programs can improve engagement in MOUD treatment by providing:

- MOUD in a range of care settings, including EDs^{22,23}, hospitals, telehealth, and via mobile delivery services.
- Specialty addiction consult services in general medical hospitals.
- Time-limited or “bridge” treatment between clinical settings.²⁴
- Broad access to low threshold MOUD treatment initiation and retention, including,
 - providing MOUD on the same day as presentation to treatment
 - reducing logistical and financial hurdles to receiving MOUD, and
 - avoiding discharging patients from care for ongoing substance use.^{23,25}
- Provision of dedicated technical support for Connecticut clinicians with state-focused initiatives such as Providers Clinical Support System, Project ECHO, California Bridge, the Maryland Addiction Consultation Service, and Project ASSERT (see Appendix A for further details).
- “Medication first” models and interim MOUD (i.e., models providing MOUD without required counseling).^{26,27}
- Tailored interventional strategies for underserved and marginalized populations listed above.

Potential Impact

The potential impact of increased use of MOUD would be immediate, and retention of individuals in treatment is possible with near- and long-term continuing investment.²⁸ Overall, the risk of overdose, death, and other significant medical and mental health complications can be substantially reduced with the increased use of MOUD.

Strategies

Strategy #1: Strategically expand access to and improve retention on methadone and buprenorphine via federally certified OTPs.

Goal: Ensure geographically strategic, equitable, and timely access to methadone and buprenorphine in OTPs; lower barriers to MOUD initiation and continuation provided through OTPs.

- **Tactic #1:** Fund increased access at existing OTPs including expanded OTP service hours, same-day medication initiation, expanded use of take-home doses, and provision of supportive behavioral health services (such as Cognitive Behavioral Therapy (CBT) and Contingency Management²⁹).
- **Tactic #2:** Fund initiatives that provide linkage to wraparound support services (emphasizing transportation, housing, insurance enrollment, vocational training, employment support, and childcare) for individuals engaged in MOUD via OTPs to support initiation and retention in treatment.
- **Tactic #3:** Fund initiatives that expand and support existing efforts to provide direct integration of behavioral health and psychiatric comorbidity treatment into existing OTPs and otherwise facilitate access to methadone for individuals with co-occurring psychiatric disorders.
- **Tactic #4:** Fund initiatives to develop, implement, and sustain substance use navigator services embedded in OTPs and general medical settings, who are trained to support MOUD initiation, specifically of methadone or buprenorphine, apply harm reduction principles, and collaborate with clinician oversight and quality review.
- **Tactic #5:** Fund initiatives that advance mobile provision of methadone and buprenorphine. Funding should focus on start-up costs (i.e., costs of purchasing and outfitting needed vehicles) and incentivizing the provision of mobile services.
- **Tactic #6:** Fund initiatives to standardize provision of and access to methadone via OTPs in Connecticut, including efforts that facilitate sharing of knowledge and best practices among OTPs within the state and from other states.
- **Tactic #7:** Fund recovery support services that foster the use of MOUD through OTPs.
- **Tactic #8:** Fund initiatives that provide office-based methadone in line with current federal regulations and pilot programs under exemptions from current regulations.³⁰⁻³²

Strategy #2: Increase provision of MOUD for people with OUD who are interacting with emergency departments (EDs) and hospitals, and improve transitions for ongoing care.

Goal: Equip all Connecticut EDs and hospitals to initiate MOUD, provide harm reduction strategies, and develop pathways for ongoing care. Increase access to such services via first responders.

- **Tactic #1:** Fund initiatives that support ED and hospital initiation and continuation of MOUD, inclusive of clinician training and development of clinical pathways, to ensure widespread adoption of screening/identification, brief intervention and referral to treatment (SBIRT), overdose prevention and provision of naloxone upon discharge, and development of collaborations between community addiction providers and hospital-based providers.^{33,34} This may include efforts to disseminate protocols, knowledge, and best practices across all Connecticut EDs and hospitals on MOUD initiation or continuation, treatment of psychiatric comorbidity, pain with acute and chronic illnesses or injuries, and plans for OUD treatment during the perioperative period for elective and emergent surgeries.

- **Tactic #2:** Fund initiatives that support first responders' linkage of patients to evidence-based treatment and harm reduction for persons with OUD.
- **Tactic #3:** Fund initiatives to develop and sustain hospital-based addiction specialist consult services to address hospital-based care of individuals with opioid use and OUD across the lifespan (i.e., including hospitalized infants, children, adolescents, pregnant/birthing people and the elderly).³⁵
- **Tactic #4:** Fund initiatives to expand, where existing, and implement, where currently not existing, recovery support and substance use navigator services in EDs and hospitals who work in collaboration with clinicians, highlight the benefits of MOUD, and collaborate with community partners such as in the Project ASSERT model (see Appendix A for further details).³⁶
- **Tactic #5:** Fund initiatives to develop and implement recovery support and substance use navigator services in pediatric EDs and hospitals focused on engaging with adolescents and youth at risk for opioid overdose, including the development of family-focused treatment plans.
- **Tactic #6:** Fund initiatives to ensure provision of MOUD in skilled nursing facilities by addressing barriers and coordination of treatment across transitions of care.
- **Tactic #7:** Fund initiatives to monitor and develop statewide reporting (e.g., dashboards) for Emergency Medical Services (EMS), ED, and hospital-based responses to the opioid overdose crisis, including universal adoption of standardized policies and practices focused on screening/identification, initiation of MOUD, referral to continuing treatment, overdose education, and provision of naloxone.

Strategy #3: Increase availability of buprenorphine in office-based settings of primary care and behavioral health, federally qualified health centers, hospital-based clinics, recovery support services, and harm reduction services.

Goal: Timely, convenient access to buprenorphine in all parts of the state, especially for underserved and marginalized populations, regardless of insurance status. Lower barriers to buprenorphine treatment initiation and continuation.

- **Tactic #1:** Fund initiatives that train clinicians throughout the state to effectively screen for OUD, address and lower barriers to prescribing buprenorphine, support retention of patients on buprenorphine, and connect patients to wraparound support services (see Appendix A for a description of Maryland Addiction Consult Service (MACS), CA Bridge, PCSS, and ECHO models).
- **Tactic #2:** Fund initiatives to expand access to buprenorphine in office-based settings that are tailored to engage patients with co-occurring psychiatric disorders, pregnant and parenting people, adolescents, and other populations with inequitable access to buprenorphine. Initiatives targeting pregnant and parenting people or adolescents should include support for training and implementation of family care plans.

- **Tactic #3:** Fund initiatives that integrate recovery support and substance use navigators and other wraparound support services into MOUD treatment across office-based and general medical settings.
- **Tactic #5:** Fund expanded access to select, evidence-based behavioral health interventions such as Motivational Enhancement Therapy, drug counseling, Contingency Management or CBT for patients receiving buprenorphine in office-based settings.²⁹

Strategy #4: Ensure access to all FDA-approved medications for OUD for people incarcerated in and transitioning out of DOC.

Goal: All individuals incarcerated in DOC should be screened for OUD and have access to all three FDA-approved MOUD options at time of entry to and exit from DOC.

- **Tactic #1:** Fund efforts to expand access to all FDA-approved MOUD in all DOC facilities. Funding can be allocated for clinical or security staffing, facilities, or medication costs otherwise not currently funded by the DOC budget to support the MOUD program.
- **Tactic #2:** Fund initiatives to ensure timely connection to and retention on MOUD following release from DOC, including support for comprehensive discharge planning and expansion of guest-dosing of methadone at all OTPs in state for people released from DOC.
- **Tactic #3:** Fund initiatives to increase referral to, use of, and retention on evidence-based opioid use prevention and treatment services for youth involved in the criminal legal system.^{37,38} Currently, there is limited evidence on best practices for treatment and prevention of opioid use in youth involved in the criminal legal system and funded initiatives should be directly tied to evaluation of effectiveness to inform future funding and best practices.

Strategy #5: Ensure access to methadone or buprenorphine for people engaging in inpatient or residential addiction treatment services.

Receipt of inpatient or residential addiction treatment services should not preclude treatment with MOUD. Historically, there was significant variation in whether individuals seeking treatment for OUD in inpatient and residential addiction treatment facilities would be offered MOUD or, if already initiated, could be continued while receiving treatment in those facilities. The recently implemented DSS Section 1115 Demonstration Waiver for Substance Use Disorder (SUD) Treatment³⁹, which greatly expanded the ability of Medicaid to pay for inpatient and residential SUD treatment services, included provisions that required treatment providers of inpatient and residential addiction treatment services to offer MOUD, either via initiation or continuation, to all individuals accessing treatment in those facilities.

Goal: All individuals accessing inpatient or residential addiction treatment services should be offered MOUD initiation, be able to continue MOUD while engaging in services, and be supported to continue MOUD at discharge from these facilities.

- **Tactic #1:** Fund initiatives that provide technical support to clinicians in inpatient or residential addiction treatment settings and facilitate development of best practices for the provision of

MOUD in these settings. MOUD, as standard of care, should be offered by OSAC-funded inpatient and residential treatment initiatives and the use (or non-use) of medications should be driven by informed choice on the part of the patient, not by policies, protocols, or systems barriers that exclude MOUD as an option. Funded initiatives can provide technical support for transitions in care models prompted by the above mentioned 1115 demonstration waiver.

Strategy #6: Provide services to improve access to MOUD (methadone or buprenorphine) and retention in MOUD across all settings via provision of community-tailored, culturally responsive, and trauma informed models, especially for populations with unique needs (e.g., psychiatric comorbidity) and those at high risk for overdose but not currently engaging in MOUD treatment, and particularly where evidence demonstrates that tailored services improve outcomes such as retention and mortality.

Goal: Ensure that all individuals accessing MOUD treatment, especially those with unique needs or those at high risk for overdose, are able to access community-tailored, culturally responsive, and trauma-informed models of care.

- **Tactic #1:** Fund initiatives that provide community-tailored, culturally responsive and racially concordant initiatives to increase methadone and buprenorphine initiation and retention among racialized minorities.
- **Tactic #2:** Fund initiatives that support increased methadone and buprenorphine initiation and retention for youth with OUD, including provision of wraparound support services, recovery support, behavioral treatments, and family-involved models such as the Adolescent Community Reinforcement Approach (A-CRA).
- **Tactic #3:** Fund initiatives that provide community-tailored, culturally responsive interventions to educate, correct misconceptions, and improve community perceptions around the use of MOUD (methadone or buprenorphine) for the treatment of OUD.
- **Tactic #4:** Fund initiatives to advance technology-based solutions with strong evidence of improving MOUD (methadone or buprenorphine) treatment engagement, retention, and substance use outcomes that provide 24/7 recovery support, including telehealth and digital delivery of CBT such as CBT4CBT.
- **Tactic #5:** Fund efforts to identify and characterize locations and populations currently with unmet need for MOUD and novel tailored methods to meet the needs of these populations.

Strategy #7: Improve analysis, linkage and timely reporting of existing data pertinent to provision of MOUD in the state.

Goal: Create timely reported metrics on MOUD provision in the state via merging and linking relevant existing data from treatment providers, state agencies, and other entities in the state. Metrics can be used by stakeholders and policymakers to guide funding, policy, and agency efforts to improve MOUD provision.

- **Tactic #1:** Fund the generation of reports on access to methadone and buprenorphine via federally certified OTPs, office-based practices, hospitals, EDs, and other treatment settings with focus on geographic, socio-economic, and racial disparities in MOUD access.
- **Tactic #2:** Fund efforts to generate and support the timely reporting of metrics on the number of overdose survivors in the state who access methadone or buprenorphine within one month of a non-fatal overdose.
- **Tactic #3:** Fund initiatives to track the percentage of people incarcerated in DOC screened for OUD, the percentage with OUD receiving MOUD, and the percentage successfully linked to MOUD following release into the community.

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