A PUBLIC HEALTH EMERGENCY: STATE EFFORTS TO CURB THE OPIOID CRISIS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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[1]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD011.pdf.

[2]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD013.pdf.

[3]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD015.pdf.

[4]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD016.pdf.

[5]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD017.pdf.

[6]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD018.pdf.

[7]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD019.pdf.

[8]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD020.pdf.

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[9]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD021.pdf.

[10]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD022.pdf.

[11]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD023.pdf.

[12]The information has been retained in committee files and also is available at https://docs.house.gov/meetings/IF/IF02/20200114/110367/HHRG-116-IF02-20200114-SD025.pdf.

A PUBLIC HEALTH EMERGENCY: STATE EFFORTS TO CURB THE OPIOID CRISIS

TUESDAY, JANUARY 14, 2020

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:09 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, Hon. Diana DeGette (chair of the subcommittee) presiding.

Members present: Representatives DeGette, Schakowsky, Kennedy, Ruiz, Kuster, Castor, Sarbanes, Tonko, Clarke, Pallone (ex officio), Guthrie (subcommittee ranking member), Burgess, McKinley, Griffith, Brooks, Mullin, and Walden (ex officio).

Also Present: Representative Latta.

Staff present: Mohammad Aslami, Counsel; Joe Banez, Professional Staff Member; Kevin Barstow, Chief Oversight Counsel; Jeffrey C. Carroll, Staff Director; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Chris Knauer, Oversight Staff Director; Kevin McAloon, Professional Staff Member; Lino Pena-Martinez, Staff Assistant; Emily Ryan, GAO Detailee; Benjamin Tabor, Policy Analyst; Rebecca Tomilchik, Staff Assistant; C. J. Young, Press Secretary; Jennifer Barblan, Minority Chief Counsel, Oversight and Investigations; Mike Bloomquist, Minority Staff Director; Tyler Greenberg, Minority Staff Assistant; Peter Kielty, Minority General Counsel; and Alan Slobodin, Minority Chief Investigative Counsel, Oversight and Investigations.

Ms. DEGETTE. The Subcommittee on Oversight and Investigations hearing will now come to order.

The Chair now recognizes herself for purposes of an opening statement.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Today, the subcommittee on Oversight and Investigations is holding a hearing entitled "A Public Health Emergency: State Efforts to Curb the Opioid Crisis." The purpose of today's hearing is to examine states' efforts and successes in addressing the opioid epidemic, as well as opportunities for future federal support.

And just to let everybody know, Dr. Alexander Scott, the reason why we are getting started a little late, the plane was delayed. But now the doctor is on her way. And so, we will swear in the wit-

nesses when we get to that point. And if we have to do that one later, we will.

The Chair will now recognize herself for an opening statement.

As I said, today, the Committee continues its bipartisan efforts to combat the opioid crisis.

As we know, the country is in the midst of an epidemic unlike any in recent history. According to the Centers for Disease Control and Prevention, from 1999 to 2017, nearly 400,000 people died from opioid overdoses. In 2017, more than two-thirds of drug overdose deaths involved opioids.

The crisis has continued to evolve, and the challenges that we face have continued to evolve along with it. The first wave of this crisis began in the 1990s with the over-prescribing of pain medication. The second wave began in 2010, with increased deaths due to heroin overdoses.

Like the first two waves, the third wave—marked by the rise of synthetic opioids like fentanyl—has shattered lives, traumatized families, and devastated communities.

Now, unfortunately, it looks like a fourth wave of the crisis may have already arrived. The opioid epidemic has fueled a huge increase in methamphetamine use. In 2018, there were more than twice as many deaths involving meth as in 2015, and meth is increasingly turning up in overdose deaths and drug busts across the country.

Given the complexity of the epidemic and its ability to evolve, states, federal government agencies, and Congress must remain vigilant.

To that end, this Committee has taken numerous steps to investigate the origins and drivers of the crisis so we can learn from it as we try to get ahead of the next wave. Through committee hearings, we have heard from states, federal agencies, and drug distributors about their roles and responses.

The groundbreaking work by the Committee uncovered some of the failures that led to where we are today. And looking forward, we're focused on identifying ways to stem this crisis and bring relief to the millions of Americans who are suffering.

As part of that effort, our committee has worked across the aisle to pass bipartisan legislation designed to give states the tools and resources needed to help those impacted by substance use disorder.

These legislative packages provided states with billions of dollars in federal funding to assist in the opioid response, treatment, and recovery efforts.

And we have made some progress. CDC provisional data indicates that drug overdose deaths have fallen for the first time in decades. While this downward shift is welcome news, the crisis is far from over, and we must continue to look for ways to bring relief to struggling cities and towns throughout the country.

Today's hearing continues those bipartisan efforts. Day in and day out, states are on the front lines of this epidemic that kills more than 130 Americans every day. As the epidemic now enters a new decade, states face the challenge of keeping pace with an evolving crisis.

In keeping with this Committee's bipartisan commitment to finding solutions to this national emergency, last September, the Com-

mittee sent letters to 16 states requesting information about on-the-ground efforts to curb the epidemic.

The Committee has sought to understand whether federal funds actually reached the hardest hit communities, how states used the funds provided by Congress, and what strategies have proven to be successful.

Today, we have five key states that have each received a letter from this Committee. These states represent the first line of defense against the crisis, and they each play pivotal roles in treatment, recovery, and prevention efforts.

I want to thank all of you for coming today.

The states compose a large swath of the country. While their demographics, geography, and challenges vary, each has felt the effect of this epidemic, and they all rank among the states with some of the highest overdose death rates. As such, each of them has taken a number of steps to curb the epidemic.

For example, Pennsylvania was able to distribute nearly 13,000 naloxone kits free of charge in 2018 and again in 2019, thanks to a combination of state and federal funding.

North Carolina provided treatment to 12,000 uninsured persons, thanks again to federal funding.

And Rhode Island has been able to expand medication-assisted treatment in the prison system, resulting in a 62 percent reduction in overdose deaths.

These are just a few examples of how the states are fighting this epidemic and helping communities.

As Congress considers future action to address this crisis, all of our witnesses today provide important insights on how federal funds are being used to combat the epidemic, what efforts are proving successful, and what we need to do for further improvement.

I thank the witnesses for their service, for being here to testify on behalf of their states. And I look forward to hearing how we can all continue to work together to find the desperately needed solutions.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

Today, the Committee continues its bipartisan efforts to combat the opioid crisis.

The country is in the midst of an epidemic unlike any in recent history. According to the Centers for Disease Control and Prevention, from 1999 to 2017, nearly 400,000 people died from opioid overdoses. In 2017, more than two-thirds of drug overdose deaths involved opioids.

This crisis has continued to evolve, and the challenges we face have evolved along with it. The "first wave" of this crisis began in the 1990s with the over-prescribing of pain medication. The "second wave" began in 2010 with increased deaths due to heroin overdoses.

Like the first two waves, the "third wave"—marked by the rise of synthetic opioids such as fentanyl—has shattered lives, traumatized families, and devastated communities.

Now a "fourth wave" of the crisis may have already arrived. The opioid epidemic has fueled a huge spike in methamphetamine use. In 2018, there were more than twice as many deaths involving meth as in 2015, and meth is increasingly turning up in overdose deaths and drug busts across the country.

Given the complexity of the epidemic and its ability to evolve, states, federal government agencies, and Congress must remain vigilant.

To that end, this Committee has taken numerous steps to investigate the origins and drivers of the crisis so we can learn from it as we try to get ahead of the next

wave. Through Committee hearings, we have heard from states, federal agencies, and drug distributors about their roles and responses.

That groundbreaking work by the Committee uncovered some of the failures that led to where we are today. Looking forward, the Committee is focused on identifying ways to stem this crisis and bring relief to the millions of Americans who are suffering.

As part of that effort, our Committee has worked across the aisle to pass bipartisan legislation designed to give states the tools and resources needed to help those impacted by substance use disorder.

These legislative packages provided states billions of dollars in federal funding to assist in opioid response, treatment, and recovery efforts.

And we have made some progress. CDC provisional data indicates drug overdose deaths have fallen for the first time in decades. While this downward shift is welcome news, this crisis is far from over—and we must continue to look for ways to bring relief to struggling cities and towns throughout the country.

Today's hearing continues those bipartisan efforts. Day in and day out, states are on the front lines of this epidemic that kills more than 130 Americans every day. As the epidemic now enters a new decade, states face the challenge of keeping pace with an evolving crisis.

In keeping with this Committee's bipartisan commitment to finding solutions to this national emergency, last September, our Committee sent letters to 16 states requesting information about on-the-ground efforts to curb the epidemic.

The Committee has sought to understand whether federal funds reached the hardest hit communities, how states used funds provided by Congress, and what strategies have proven successful.

Today, we have before us five key states that each received a letter from this Committee. These states represent the first line of defense against the crisis and each play pivotal roles in treatment, recovery, and prevention efforts.

These states compose a large swath of the country. While their demographics, geography, and challenges vary, each has felt the impact of the epidemic, and they all rank among the states with some of the highest overdose death rates.

As such, each of these states has taken a number of steps to curb the epidemic.

For example, Pennsylvania was able to distribute nearly 13,000 naloxone kits free of charge in 2018 and again in 2019, thanks to a combination of federal and state funding.

North Carolina has provided treatment to 12,000 uninsured persons, thanks again to federal funding.

And Rhode Island has been able to expand medication-assisted treatment in the prison system, resulting in a 62 percent reduction in overdose deaths.

These are just a few examples of how states are fighting this epidemic and helping communities.

As Congress considers future action to address this crisis, the witnesses today provide important insights on how federal funds are being used to combat the epidemic, what efforts are proving successful, and what areas need additional improvement.

I thank the witnesses for their service, and for being here today to testify on behalf of their states. I look forward to discussing how we can all work together to find solutions to resolving this public health emergency.

And with that, I am pleased to yield for purposes of an opening statement, Mr. Guthrie, 5 minutes.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEATH OF KENTUCKY

Mr. GUTHRIE. Thank you. Thank you, Chair DeGette, for holding this important hearing on state responses to the opioid crisis.

Our local communities are suffering. On average, 130 Americans die every day from an opioid overdose. And opioids were involved in 47,600 overdose deaths in 2017, which accounted for 67.8 percent of all drug overdose deaths.

In Kentucky, there were 1,160 reported opioid-involved deaths in 2017.

The Energy and Commerce Committee has been steadfast in its efforts to help combat the opioid epidemic, with both investigations

and legislation. Whether it was the Committee's investigations into the prescription drug and heroin epidemic, opioid distributors, patient brokering, or the major opioid manufacturers, we have continued to ask questions and get answers for the American public.

When it comes to legislation, this Committee led the way on the passage of the 21st Century Cures Act, the Comprehensive Addiction Recovery Act, and the SUPPORT for Patients and Communities Act. I was proud to work on all three of these comprehensive laws, which are designed to combat the opioid crisis through prevention, advancing treatment and recovery initiatives, protecting communities, and bolstering our efforts to fight synthetic drugs like fentanyl.

This hearing is a critical opportunity for us to check in with the states, those that are on the front lines battling the nation's opioid epidemic, to see how the federal money Congress provided has been allocated and spent, what successes they are having in combating the epidemic, but also what challenges they are still facing, and what additional authorities and resources could be helpful.

The good news is that each state testifying before us today has seen a decrease in their overdose death rates. Federal assistance is making a difference. In addition, states are creating and implementing innovative approaches to combating the epidemic.

Examples include expanding efforts to connect people to treatment through EMS and emergency departments, expanding and increasing the availability of naloxone and medication-assisted treatment, increasing non-emergency transportation options to treatment for those in rural areas, and expanding neonatal abstinence syndrome treatment programs for pregnant and parenting mothers, and efforts to address workforce issues through the initiatives such as a loan repayment program, and broadening the curriculum in training in medical schools.

This hearing is a great platform for the states to share how the federal funding has made a difference in what programs are working. Not only is it helpful for us in Congress as we continue to conduct oversight and legislate, but also to the states as they learn from each other about new ideas or innovative approaches that can be implemented.

While progress is being made and some of the overdose death rates are declining, the Director of National Institute of Drug Abuse, Dr. Nora Volkow, declared this week that this country still has not controlled its addiction problems. Some states are continuing to see a high number of first responder emergency department encounters due to an overdose.

In addition, states are still facing many challenges, including a lack of qualified workforce and infrastructure, varying requirements and time length in different federal funding streams, and restrictions on funding, including that some funds have been restricted to opioids, impeding flexibility to address emerging challenges.

In addition to the continuing threat of opioids, states are starting to see more instances of polysubstance abuse and polysubstance overdose deaths, with states specifically citing stimulants such as methamphetamine and cocaine as a growing concern.

Nationally, since last year methamphetamine, has been detected in more deaths than opioids such as oxycodone and hydrocodone. In 14 of the 35 states that report overdose deaths to the Federal Government on a monthly basis, methamphetamine is involved in more deaths than fentanyl.

The threats are evolving and the fight is not over. We want to continue partnering with state and local entities to combat the opioid epidemic as well as emerging threats, which is why it is important not to let our foot off the gas. Congress needs to continue supporting the states, and this Committee needs to continue conducting oversight of these critical issues.

I want to thank all the witnesses for being here today. I look forward to hearing from you about all your successes we have had in combating our nation's opioid epidemic, but also how the threat has changed, what challenges remain, and what more we in Congress can do with our partners, you, in this fight.

And I yield back.

[The prepared statement of Mr. Guthrie follows:]

PREPARED STATEMENT OF HON. BRETT GUTHRIE

Thank you, Chair DeGette, for holding this important hearing on state responses to the opioid crisis.

Our local communities are suffering. On average, 130 Americans die every day from an opioid overdose and opioids were involved in 47,600 overdose deaths in 2017, which accounted for 67.8 percent of all drug overdose deaths. In Kentucky, there were 1,160 reported opioid-involved deaths in 2017.

The Energy and Commerce Committee has been steadfast in its efforts to help combat the opioid epidemic, with both investigations and legislation. Whether it was the Committee's investigations into the prescription drug and heroin epidemic, opioid distributors, patient brokering, or the major opioid manufacturers—we have continued to ask questions and get answers for the American public.

When it comes to legislation, this Committee led the way on passage of the 21st Century Cures Act, the Comprehensive Addiction and Recovery Act, and the SUPPORT for Patients and Communities Act. I was proud to work on all three of these comprehensive laws, which are designed to combat the opioid crisis through prevention, advancing treatment and recovery initiatives, protecting communities, and bolstering our efforts to fight synthetic drugs, like fentanyl.

This hearing is a critical opportunity for us to check in with states-those that are on the front lines battling the nation's opioid epidemic-to see how the federal money Congress provided is being allocated and spent, what successes they are having in combatting the epidemic, but also what challenges they are still facing, and what additional authorities and resources could be helpful.

The good news is that each state testifying before us today has seen a decrease in their overdose death rates. Federal assistance is making a difference. In addition, states are creating and implementing innovative approaches to combatting the epidemic. Examples include: expanding efforts to connect people to treatment through EMS and emergency departments; expanding and increasing the availability of naloxone and medication-assisted treatment; increasing nonemergency transportation options to treatment for those in rural areas; expanding neonatal abstinence syndrome treatment programs for pregnant and parenting mothers; and efforts to address workforce issues through initiatives such as loan repayment programs and broadening the curriculum and training in medical schools.

This hearing is a great platform for the states to share how the federal funding has made a difference and what programs are working. Not only is it helpful for us in Congress as we continue to conduct oversight and legislate, but also, to the states as they learn from each other about new ideas or innovative approaches that can be implemented.

While progress is being made and some of the overdose death rates are declining, the Director of the National Institute of Drug Abuse, Dr. Nora Volkow, declared this week that this country still has not controlled its addiction problems. Some states are continuing to see a high number of first responders and emergency department encounters due to an overdose. In addition, states are still facing many challenges,

including a lack of a qualified workforce and infrastructure, varying requirements and timelines in different federal funding streams, and restrictions on funding, including that some funds have been restricted to opioids, impeding flexibility to address emerging challenges.

In addition to the continued threat of opioids, states are starting to see more instances of polysubstance use and polysubstance overdose deaths, with some states specifically citing stimulants such as methamphetamine and cocaine as a growing concern. Nationally, since late last year, methamphetamine has been detected in more deaths than opioids such as oxycodone and hydrocodone. In 14 of the 35 states that report overdose deaths to the Federal Government on a monthly basis, methamphetamine is involved in more deaths than fentanyl.

The threats are evolving, and this fight is not over. We want to continue partnering with state and local entities to combat the opioid epidemic, as well as other emerging threats, which is why it's important to not let our foot off the gas. Congress needs to continue supporting the states and this Committee needs to continue conducting oversight of these critical issues.

I want to thank all of the witnesses for being here today. I look forward to hearing from all of you about successes we have had in combatting our nation's opioid epidemic, but also how the threat has changed, what challenges remain, and what more we, in Congress, can do to be partners in this fight.

Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes the chairman of the full committee Mr. Pallone for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairwoman DeGette.

Today's hearing continues the Committee's ongoing, bipartisan efforts to combat the opioid epidemic. Whether fueled by prescription drugs or illicit synthetic opioids, this epidemic is a constantly evolving threat, putting people, families, and communities at grave risk.

This is not a crisis that we can solve overnight; and it requires ongoing federal and state attention.

And states are on the front lines of this national emergency, providing much of the support for those in need. They are our eyes and ears on what is occurring on the ground. And that is why this hearing is so important.

It is the latest in a series of hearings we have held on the opioid crisis. In the past, we have heard from several states, including Rhode Island, about on-the-ground efforts to curb the epidemic. Last year, we also heard from federal agencies about the urgent threat posed by fentanyl.

The Committee also conducted a 2-year bipartisan investigation into opioid distribution practices.

The Energy and Commerce Committee has also been at the forefront of passing critical legislation that gives our federal, state, and local partners the tools and resources required to succeed in this fight, including three pieces of legislation—all bipartisan—that were designed to give states funding and support.

In 2016, the Committee passed, and President Obama signed into law, the Comprehensive Addiction and Recovery Act, "CARA," and the 21st Century Cures Act; of course I have to mention Chairwoman DeGette's major role in that. These two laws authorized over $1 billion in state-specific grants and helped states bolster evidence-based treatment, prevention, and recovery efforts.

In 2018, the SUPPORT Act was passed and signed into law reauthorizing, opioid-specific funding, increasing opioid abuse and overdose prevention training, and improving coordination and quality of care.

And then, in December, the House passed H.R. 3, the Lower Drug Costs Now Act, which included $10 billion in additional opioid funding.

This Committee is committed to making sure communities are receiving the support they need to get relief from this crisis. And that is why we sent letters to 16 states last year requesting information on how federal funds have assisted states in this fight, and what additional help Congress can provide as we consider future action.

We wanted to know how states are using federal opioid funds, what is being done to ensure those funds reach the hardest-hit regions, and how funds have helped transform state treatment systems. Based on the responses, we heard that the federal money has allowed states to take important and innovative approaches to addressing opioid addiction.

One of the most effective tools that are available to the states is Medicaid. Several states elaborated on the important role of Medicaid in stemming this crisis in their responses to the Committee. A study released last week found that about 8,000 lives have been saved from an opioid overdose thanks to the expansion of Medicaid under the Affordable Care Act.

We also want to hear about any emerging trends in substance abuse that they are seeing. For example, several states informed the Committee that while they continue to fight the opioid epidemic, they are also seeing an increase in methamphetamine and polysubstance use. And this, of course, is an alarming trend that threatens to become the next epidemic. And I want to hear how Congress can help states confront this unfolding danger.

So, again, I thank the witnesses. I look forward to hearing about their efforts.

Thank you, Madam Chair, for continuing your efforts on this. I don't think anybody wants my time. If not, I am going to yield back. Thank you.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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This is an alarming trend that threatens to become the next epidemic, and I want to hear how Congress can help states confront this unfolding danger.

I thank the witnesses for being here today, and look forward to hearing about their states' efforts in combating this crisis.

I yield back.

Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes the ranking member of the full committee Mr. Walden for 5 minutes.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Good morning, Madam Chair. And thanks for holding this critically important hearing.

As I was preparing for this, I noticed that in my biggest country in my district, they have a yellow alert up for opioids. They have two overdoses on average per week in Jackson Country, Oregon. They had seven last week—fortunately no deaths.

The first responders administered naloxone injections in the county five times last week, and they believe that it is probably heroin with a pretty heavy dose of fentanyl in it. So, the deadly scourge continues.

For many years, as you have heard, the Energy and Commerce Committee, and this subcommittee, in particular, has been at the forefront of congressional efforts to address the opioid crisis and substance use disorder issue. And we have done a lot of work on prevention. We know we have a lot more work to do.

This Committee has held hearings, and conducted investigations on opioids and the opioid epidemic for nearly two decades, bringing in Purdue Pharma to testify in 2001 about the abuse of OxyContin, through our bipartisan investigations last Congress into the rise of

fentanyl, opioid manufacturing, opioid distribution, and the substance use disorder treatment industry.

These early hearings helped inform our legislative work, including the Comprehensive Addiction Recovery Act, or "CARA," the 21st Century Cures Act which authorized the state-targeted response to the opioid crisis grants, and billions more in federal appropriations to produce programs that fight, treat, and stop substance abuse and support access to mental health services. These efforts culminated in the signing into law of the SUPPORT Act in the last Congress.

In my home state of Oregon, we have seen the results, a 3.1 percent reduction in opioid deaths based on the most recent statistics from the CDC.

I am pleased we have continued to work together in this space. It is important, including by continuing our work on fentanyl and, with this important hearing today, examining how the states are utilizing the funding and the authorities provided by Congress.

But there is so much more we could do together. Earlier this year Energy and Commerce Republicans published a Request for Information about the substance use disorder treatment industry. The RFI was built off the patient brokering investigation that we conducted in the last Congress. And this investigation brought us to the question of what is good treatment and, conversely, what is bad treatment, which is the central question posed by our RFI.

With the billions of dollars we are sending into the states for prevention and treatment, we need answers. Just yesterday, Energy and Commerce Republicans sent a letter to the three opioid manufacturers we began investigating together last Congress, asking them to complete production to our request. It is critical we fully understand the causes of the opioid epidemic in order to ensure that our solutions are the right ones. And it is important that they answer our questions.

We should also hold a comprehensive series of hearings to conduct oversight and implementation of the SUPPORT Act. For example, relevant to today's hearing, the SUPPORT Act included the INFO Act, sponsored by Mr. Latta, which calls for the creation of a public and easily acceptable electronic dashboard linking to all the nationwide efforts and strategies to combat the opioid crisis. The INFO Act was designed to meet a specific need of local stakeholders who were telling us that despite Congress having devoted record numbers of federal dollars to combat the opioid crisis, they had trouble finding what resources were available and where they were—certainly an issue we heard a lot about from Mr. McKinley and others.

This provision is absolutely critical in helping those on the front lines of the opioid crisis. And I am really concerned about its slow implementation.

In addition to oversight of the SUPPORT Act, we also need to begin working on the next wave of legislation to address not only the opioid crisis but also substance use disorders more broadly. Most urgently, we need to reauthorize the fentanyl ban, which is set to expire in a matter of weeks. Reauthorizing the prohibitions on various forms of fentanyl has broad bipartisan support. We should do that expeditiously.

And today's hearing is an important step, though, to understand the impact that federal grant dollars are having on states. I want to thank all of our witnesses for being here and being part of this equation. And I look forward to hearing from you.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Madam Chair, thank you for holding this critically important hearing

For many years, the Energy and Commerce Committee—and this Subcommittee in particular—has been at the forefront of the Congressional effort to address the opioid crisis, as well as substance use disorder prevention and treatment more broadly.

This Committee has held hearings and conducted investigations on opioids and the opioid epidemic for nearly two decades—from bringing in Purdue Pharma to testify in 2001 about the abuse of OxyContin, to our bipartisan investigations last Congress into the rise of fentanyl, opioid manufacturing, opioid distribution, and the substance use disorder treatment industry.

These early hearings helped inform our legislative work including the Comprehensive Addiction and Recovery Act, or CARA, the 21st Century Cures Act, which authorized the State Targeted Response to the Opioid Crisis grants, and billions more in federal appropriations to boost programs that fight, treat, and stop substance abuse, and support access to mental health services. These efforts culminated in the signing into law of the SUPPORT Act last Congress. In my home state of Oregon, we've seen the results, with a 3.1% reduction in opioid deaths based on the most recent statistics from the CDC.

I am pleased that we have continued to work together in this space, including by continuing our work on fentanyl, and with this important hearing today examining how the states are utilizing the funding and authorities provided by the Congress.

But there is so much more that we could do together. Earlier this year, Energy and Commerce Republicans published a Request for Information about the substance use disorder treatment industry. This RFI built off of the patient brokering investigation we conducted together last Congress. This investigation brought us to the question of what is good treatment—and conversely, what is bad treatment—which is the central question posed by the RFI. With the billions of dollars we are sending into the states for prevention and treatment, we need answers.

Just yesterday, Energy and Commerce Republicans sent a letter to the three opioid manufacturers we began investigating together last Congress, asking them to complete production to our requests. It is critical that we fully understand the causes of the opioid epidemic in order to ensure that our solutions are the right ones.

We should also hold a comprehensive series of hearings to conduct oversight of the implementation of the SUPPORT Act. For example, relevant to today's hearing, the SUPPORT Act included the INFO Act, sponsored by Mr. Latta, which calls for the creation of a public and easily accessible electronic dashboard linking to all of the nationwide efforts and strategies to combat the opioid crisis. The INFO Act was designed to meet a specific need of local stakeholders who were telling us that despite Congress having devoted record numbers of federal dollars to combat the opioid crisis, they had trouble finding what resources were available and where they were. This provision is absolutely critical in helping those on the front lines of the opioid crisis and I am concerned about its slow implementation.

In addition to oversight of the SUPPORT Act, we also need to begin working on the next wave of legislation to address not only the opioid crisis, but substance use disorders more broadly. Most urgently, we need to reauthorize the fentanyl ban, which is set to expire in a matter of weeks. Reauthorizing the prohibitions on various forms of fentanyl has broad bipartisan support and we should be able to do this expeditiously.

Today's hearing is an important step to understanding the impact that the federal grant dollars are having in the states, and I thank all of our witnesses for being a part of this conversation. I look forward to hearing not only about the successes in each of your states—and there are many—but also understanding the barriers that still exist, either in federal law or in the conditions of the federal dollars, and the ideas you have for how the Congress can continue to assist as you and your communities fight this battle on the front lines.

Mr. WALDEN.With that, I would yield the balance of my time to the ranking member on the Subcommittee on Health, Mr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding. And, of course, it was under your leadership of the full committee that last year we worked in a bipartisan manner to produce legislation that ultimately was signed into law by President Trump in October of 2018. And it really began in this subcommittee with a member day that we did. And we heard from over 50 members, of not just the Committee but throughout the Congress, the problems they had in their districts and the ideas that they were bringing to the table that we could, we could work on.

The SUPPORT Act was written to help advance treatment and recovery initiatives for those affected by opiate habituation.

I, too, want to thank our witnesses for being here today. You will be helpful in understanding the challenges that we face continuing this fight against opioid addiction and death, while ensuring that patients can manage their pain. It is important for Congress to have hearings like this where we can ensure the effectiveness of legislative efforts and identify gaps where they exist.

Thank you, Mr. Chairman. I yield back.

Mr. WALDEN. And, Madam Chair, I would yield back with the notation that some of us have the other subcommittee upstairs, so we will be coming and going between hearings.

So, thank you, and I yield back.

Ms. DEGETTE. Thank you. Thank you.

I ask for unanimous consent that the Members' written opening statements to be made part of the record.

Without objection, so ordered.

I now want to introduce the witnesses for today's hearing.

Ms. Jennifer Smith, who is the Secretary of the Department of Drug and Alcohol Programs, Commonwealth of Pennsylvania. Welcome.

Dr. Monica Bharel. Dr. Bharel is the Commissioner, Department of Public Health, Commonwealth of Massachusetts.

Dr. Nicole Alexander-Scott. I think they beamed you here from the airport, so congratulations. She is the Director of the Department of Health, the State of Rhode Island.

Ms. Christina Mullins, Commissioner, Bureau of Behavioral Health, Department of Health and Human Services, State of West Virginia. Welcome.

And Mr. Kody Kinsley, Deputy Secretary, Behavioral Health and Intellectual and Developmental Disabilities, Department of Health and Human Services, State of North Carolina. Welcome to you.

Thanks to all of you for appearing in front of the subcommittee today. As you are aware, the Committee is holding an investigative hearing. And when we do so, we have the practice of taking all of our testimony under oath.

Do any of you have an objection to testifying under oath today?

Let the record reflect the witnesses responded no.

The Chair then advises you that under the rules of the House and the rules of the Committee, you are entitled to be accompanied by counsel. Does any of you wish to be accompanied by counsel?

Let the record reflect the witnesses have responded no.

So, if you would, would you please rise and raise your right hand so that you may be sworn in.

[Witnesses sworn.]

Ms. DEGETTE. You may be seated.

Let the record reflect that the witnesses responded affirmatively. And all of you are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the U.S. Code.

The Chair now recognizes our witnesses for 5-minute summaries of their written statements. In front of each of you, there is a microphone, a timer, and a series of lights. The timer counts down your time, and the red light turns on at the end when your 5 minutes have come to an end.

And so now, Ms. Smith, I am pleased to recognize you for 5 minutes.

TESTIMONY OF JENNIFER SMITH, SECRETARY, DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS, COMMONWEALTH OF PENNSYLVANIA; MONICA BHAREL, M.D., COMMISSIONER, DEPARTMENT OF PUBLIC HEALTH, COMMONWEALTH OF MASSACHUSETTS; CHRISTINA MULLINS, COMMISSIONER, BUREAU OF BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH AND HUMAN RESOURCES, STATE OF WEST VIRGINIA; AND KODY KINSLEY, DEPUTY SECRETARY, BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE OF NORTH CAROLINA; AND NICOLE ALEXANDER–SCOTT, M.D., DIRECTOR OF THE DEPARTMENT OF HEALTH, STATE OF RHODE ISLAND

TESTIMONY OF JENNIFER SMITH

Ms. SMITH. Thank you, Chairman, Ranking Member, and members of the subcommittee. My name is Jennifer Smith, and I am Secretary for Pennsylvania's Department of Drug and Alcohol Programs, as well as a member of the National Association of State Alcohol and Drug Abuse Directors.

Thanks for your interest in how Pennsylvania is using the state opioid response funding to promote prevention, treatment and recovery efforts.

Acting as the state's single authority for substance use disorder services, my department coordinates efforts with federal and local entities, as well as across state departments. Our ability to orchestrate resources and direct policy during the opioid crisis has been a crucial component in effecting long-term changes and maximizing resources available to our communities.

We are grateful for these federal grant opportunities at a time of hopelessness and despair for families and communities. I can say with certainty that this funding has saved lives.

With a population of 12.8 million, Pennsylvania is the fifth most populous state, consisting of 67 counties that range from large urban centers to rural counties. Our state is among those hardest hit by the nation's prescription opioid and heroin epidemic. In 2014, we lost more than 2,700 Pennsylvanians to drug-related overdoses, which equates to seven deaths per day.

By 2017, that number had tragically doubled to more than 5,400 lives lost, or 13 deaths per day. As statistics rose year over year, our primary focus became simple: keep Pennsylvanians alive.

That meant infusing naloxone into communities, implementing warm hand-off protocols to transition overdose survivors from emergency departments into treatment, expanding access to evidence-based practices such as medication-assisted treatment, and launching a 24/7 Get Help Now Hotline.

I am proud to say that in 2018, Pennsylvania reported an 18 percent decrease in overdose deaths.

While it's not clear whether this promising trend will continue in 2019, it is clear that the more than $230 million in federal funding that the state has received is making a tremendous impact. We have used these resources and the momentum of the crisis to collaborate, modernize, and innovate, using dollars across the full continuum.

In prevention, we reduced opioid prescribing by 25 percent, developed prescribing guidelines, incorporated addiction content into medical school curriculums, and established over 800 prescription drug take-back boxes across the state.

In treatment, we established a naloxone standing order, and distributed over 55,000 free kits, developed a warm hand-off model that's been used over 6,400 times, expanded treatment capacity through 45 Centers of Excellence and eight hub-and-spoke programs, increased our DEA X waiver physicians to over 4,000, offered loan repayment, awarded 3. million to expand supports for pregnant women and women with children, and expanded MAT into our state correctional institutions.

In terms of recovery support, we awarded 2.1 million to expand community recovery services, developed a Web site to share recovery stories and spread hope, and awarded grant funds to build recovery housing support.

In the coming months, Pennsylvania will be focused on integrating quality into our four major goals of reducing stigma, intensifying primary prevention, strengthening the treatment system, and empowering sustained recovery. Without sustainable federal funding, the collaboration necessary to accomplish these goals will be greatly diminished.

Although we've made significant strides, our work is not done, and we need your help. In terms of funding, we need flexibility to address the system, not a substance.

We need consistency with funding vehicles and reporting mechanisms where possible, such as utilizing the block grants, as well as continued use of the single state authority as the central coordinating entity; sustainability to allow for the continued relationship fostering, stigma reduction, and integration of services.

Moving an entire system of care is a monumental task. We are working diligently and we've made staggering progress. But please don't give up. The long-term success of our programs and communities depends on sustained funding and support.

Just two other quick considerations would be to address stigma in a more uniform way across the nation through language and action, and to seek ways to address the dire workforce shortage challenges experienced by every state.

Thank you again for allowing me to share what Pennsylvania is doing and our suggestions for moving the system forward. I look forward to answering any questions you may have.

[The prepared statement of Ms. Smith follows:]

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

HOUSE ENERGY AND COMMERCE OVERSIGHT & INVESTIGATIONS SUBCOMMITTEE HEARING
JANUARY 14, 2020

Testimony of
JENNIFER SMITH, SECRETARY

Chairman DeGette, Ranking Member Guthrie, and members of the Subcommittee, my name is Jennifer Smith and I have the pleasure of serving as Secretary for Pennsylvania's Department of Drug and Alcohol Programs (DDAP) as well as a board member of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Thank you for inviting me today and for your interest in how Pennsylvania is addressing the opioid crisis – in particular, how the commonwealth is using the State Opioid Response (SOR) funding to promote prevention, treatment and recovery efforts.

Pennsylvania is only one of three states with a dedicated cabinet-level department to solely oversee drug and alcohol (or addiction) programming. Acting as the Single State Authority (SSA) for substance use disorder services, DDAP is responsible for the administration of control, prevention, intervention, treatment, rehabilitation, research, education, and training activities within the department as well as across state agencies. We serve a critical role in coordinating efforts with the federal and local levels, as well as across state departments. Our ability to orchestrate resources and direct policy during the opioid crisis has been immeasurably beneficial. A central planning and coordinating entity, the SSAs in this case, is a crucial component in affecting long-term change in the addiction field and maximizing the resources available at all levels of government and across all sectors.

Our commonwealth is very grateful for grant opportunities from the federal government at a time of hopelessness and despair for many families and communities. The receipt of the State Targeted Response (STR) and now the SOR funds was pivotal for taking action on the strategies that SSAs across the nation had developed as part of their comprehensive strategic goals to address the crisis. I can say with certainty that for Pennsylvania, which has one of the highest overdose death rates in the country, this funding has saved lives. Thank you and we appreciate the opportunity to share how we've put the dollars into action.

Pennsylvania Landscape

With a population of 12.81 million, the Commonwealth of Pennsylvania is the fifth most populous state according to the 2010 census. The state consists of 67 counties that range from large urban centers, such as Philadelphia and Pittsburgh, to rural counties where populations don't exceed 5,000. While this diversity is welcome and celebrated in the Keystone state, it can also bring about challenges in addressing socioeconomic factors and, more specifically, health care. In a state whose motto is "Pursue your happiness," the reality is that Pennsylvania is among the states hardest hit by the nation's prescription opioid and heroin epidemic. Like many other states across the nation, we didn't get here overnight. The opioid crisis in the commonwealth was fueled by the combination of many factors including the overprescribing of opioids, cheaper and more pure heroin, geographic positioning along drug trafficking routes, and finally a relatively stagnant drug and alcohol system that was providing inadequate levels of care and evidence-based treatment options for individuals with opioid use disorder. As overdose deaths statistics were rising year over year, our primary focus became simple - keep Pennsylvanians alive. This meant infusing easily accessible naloxone into communities across the state, implementing warm hand-off protocols to catch overdose survivors in the emergency departments and smoothly transition them to treatment providers, expanding access to evidence-based practices like Medication Assisted Treatment (MAT) through major health care systems,

and launching a 24/7 Get Help Now hotline that provides callers with direct connections to treatment providers.

I am proud to say that in 2018 Pennsylvania saw its first decline in overdose death rate in over 15 years. Coroners and medical examiners reported an 18% decrease in overdose deaths from 2017 to 2018. While it is not clear whether this promising trend will continue in 2019 due to the increased potency of fentanyl and a spike in polysubstance use combining stimulants with opioids, what is clear is that the more than $230 million in federal funding the state has received is making a tremendous impact on our drug and alcohol system. The funding has been used for both statewide efforts and local initiatives that otherwise would not have been possible. As a commonwealth, we believe in the importance of these dollars being directed to communities where they can make the biggest difference. As such, we have ensured that a significant portion of the dollars are funneled directly to those entities. Later in my testimony you will find a chart detailing the funding allocations as well as a brief narrative explaining some of the ways in which Pennsylvania has infused this federal funding into our drug and alcohol system.

Keys to Success Supported by Federal Funding

Collaboration. Pennsylvania's Governor Tom Wolf has made our response to this crisis a priority and has received praise by the American Medical Association (AMA) calling our response "a model for the nation." In January 2018, Governor Wolf took an unprecedented step to establish a disaster declaration and Opioid Command Center in Pennsylvania combining 17 state agencies to break silos and collectively combat the crisis, as well as allowing for the voice of local government and private entities to share best practices and innovative solutions. As a result, DDAP has partnered with sister agencies and other local and community organizations to implement critical drug and alcohol prevention, treatment, and recovery programs. This innovative thinking across state government has greatly contributed to the overdose reduction we saw in 2018. The specific initiatives listed below were made possible through a combination of SOR funding, specialty grants through the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

1. *Increased naloxone awareness, access, and distribution.* Through a combination of state and federal funding, the commonwealth distributed nearly 13,000 naloxone kits free of charge directly to Pennsylvanians across three days in December 2018 and September 2019. Funding used toward public messaging and awareness of naloxone availability in Pennsylvania communities – throughout our standing order prescription, as well as naloxone availability through Centralized Coordinating Entities for first responders – likely also contributed significantly to this reduction in deaths.

2. *Warm hand-off implementation.* While overdose deaths have decreased, first responder and emergency room overdose encounters have not. Federal funding that is funneled to the local entities has helped establish local warm hand-off protocols between emergency departments, county drug and alcohol authorities, and supportive services. Federal funds also helped support regional Warm Hand-off Summits throughout the state in 2018 and 2019 to bring together local partners for education and planning. Through our efforts, we

have identified that a key component to a successful warm hand-off implementation are integrating Certified Recovery Specialists (CRS) into hospitals. When an individual experiencing an overdose presents in the emergency room, the CRS become a critical lifeline. As individuals with lived addiction experience, they can relate to the individual in crisis and provide necessary support in coordinating their treatment. At this time, every county has established warm hand-off protocols and are at differing levels of implementation. To date, more than 5,000 individuals have directly entered treatment through a warm hand-off from an emergency room. Some counties are seeing 9 out of every 10 overdose survivors using the warm hand-off process.

3. *Building the system for the long-term, including expanding MAT.* As mentioned above, Pennsylvania has been creative in using these funds to build the treatment and social support system for the long-term, in particular for those who are 1) un- or underinsured and/or 2) specialized populations like pregnant women, women with children, veterans, and re-entrants.

   Furthermore, MAT has been expanded through the creation of 45 Centers of Excellence to treat opioid use disorder patients, eight unique hub-and-spoke model providers as part of the Pennsylvania-Coordinated Medication Assisted Treatment program (including one funded by SAMHSA's Medication-Assisted Treatment Prescription Drug and Opioid Addiction [MAT-PDOA] grant), and through the establishment or expansion of rural providers as part of the Agency for Healthcare Research and Quality (AHRQ) grant. The Pennsylvania-Coordinated Medication Assisted Treatment program alone has served more than 4,500 individuals and provided training to nearly 400 waived physicians.

   Lastly, a key component to Pennsylvania's expansion of MAT is having more waivered health care professionals to provide an access point into treatment through primary care physicians. The Wolf Administration has hosted eight MAT Summits supported by federal funding throughout the commonwealth, providing training to nearly 100 additional doctors and mid-level providers to become DATA-waived to prescribe buprenorphine.

4. *Get Help Now Hotline.* Since November 2016, Pennsylvania has hosted, with the support of federal funding, a Get Help Now hotline. Individuals and their loved ones can call the toll-free number 24 hours-a-day, 7 days-a-week, 365 days-a-year to connect directly to treatment or learn more about local resources. The hotline is staffed partially by CRSs, trained in crisis management, who can connect individuals directly to treatment providers by a warm-line connection regardless of a person's insurance. For individuals who do not feel comfortable on the phone, there is also a chat feature available on our website. To date, the hotline has fielded more than 52,000 calls and provided nearly 21,500 warm-line connections to treatment and supportive services.

Modernization. In 2018, DDAP made the important decision to transition to the nationally recognized American Society of Addiction Medicine (ASAM) Criteria as a tool for determining clinical placement within the treatment system. This transition marks the shift away from a 20-year old state specific tool where the use of medication to treat substance use disorder was only

included in an appendix. A multidisciplinary workgroup was used to plan the transition, roll-out training to over 8,000 clinicians, and develop a guidance document for use by clinicians transitioning from the outdated tool. DDAP also updated its contractual arrangements to mandate that every contracted treatment provider in the commonwealth offer MAT at all levels of care. Additionally, the transition to the ASAM Criteria allows Pennsylvania to maximize Medicaid dollars to support the under/un-insured by meeting federal requirements.

Innovation. Governor Wolf often refers to Pennsylvania as a 'commonwealth on a comeback' and that could not be truer for the drug and alcohol treatment system. As stated, the influx of federal funding has allowed Pennsylvania to meet the needs of our drug and alcohol system more creatively and produced numerous projects coined as a model for the nation. I'd like to provide two examples below.

> First, a partnership between DDAP and the Department of Corrections. Using federal funding, the Department of Corrections has expanded its MAT program to all state facilities, giving individuals the best chance to succeed upon re-entering society. We have implemented additional forms of MAT beyond the more commonly accepted non-narcotic form (i.e. Vivitrol or Naltrexone) to include Methadone and Suboxone. During the first year of the project, more than 1,000 inmates have received MAT services. Additionally, DDAP has recently contracted with several county jails to expand the use of MAT within their system.
>
> Second, a collaboration between DDAP and the Department of Health launching the state's first loan repayment program for health care professionals serving individuals with opioid use disorder. The program supports the supply and distribution of health care practitioners where there is high use of opioids and a shortage of providers exists. Applicants must be a practitioner in an eligible discipline with two years of employment and must agree to practice in the field for an additional two years. Federal grant funding has allowed us to creatively address a rural workforce shortage by awarding more than 90 individuals from 23 different counties.

Community Impacts

To better understand how the funding has made an impact on a local level, it is important to detail how Pennsylvania's drug and alcohol system is structured. Local government entities are critical partners in the provision of prevention, intervention, treatment and treatment-related services in Pennsylvania. DDAP has contractual agreements with forty-seven (47) Single County Authorities (SCAs). These county or county affiliated agencies plan, administer, and evaluate services at the local level. To date, SCAs have received more than $57 million for treatment services and more than $13 million for prevention programming. The statewide needs assessment, overdose death data, and treatment data indicate that all areas of the state have been affected by the opioid crisis therefore all 47 SCAs have received funding to address their local needs for both treatment and prevention services. SCAs are responsible for contracting with and funding services to non-governmental agencies such as treatment and prevention providers at the local level. Each SCA determines what licensed treatment providers or prevention and recovery support services will meet their identified local needs.

In addition to funding provided directly to our sister state agencies and SCAs, Pennsylvania also uses various competitive processes to obtain contracted services for identified agency needs at the local level. As mentioned previously, Pennsylvania is a very diverse state and many challenges we face are related to socioeconomic factors. During his first term, Governor Wolf signed an executive order strengthening protections for vulnerable populations. As such, he has challenged his administration to actively review regulations and services to these populations. This has resulted in the Administration administering contracts with new recovery support programs like 16 local programs focused on assisting individuals with stable housing while engaged in MAT, nine programs supporting pregnant women and women with children, programs to support employment efforts for those in recovery and local initiatives that work with police, and first responders to support individuals' connections to treatment after arrest or overdose all with the support of our federal funding.

Challenges with Federal Opioid Fnnding

While Pennsylvania has made great strides with the federal funding, the focus on collaboration, stakeholder input, and information sharing has allowed us to look at challenges and opportunities associated with the unprecedented funding. I would be remiss if I did not take the opportunity to share some challenges, although not insurmountable, the commonwealth has experienced with the limitations of funding. Those challenges include:

1. *Broad issues of Addiction & Polysubstance Use.* To date, Federal funding is targeted at opioids. Pennsylvania, like many other states, continues to grapple with broader issues of addiction. Pennsylvania is currently monitoring an increase in stimulant use (e.g. methamphetamine, cocaine) related to the crisis. Federal funding opportunities should recognize that this crisis has shifted over time – and will continue to shift – affording states with greater flexibility to address substances in addition to opioids. In September, Pennsylvania had the pleasure of hosting the nation's first Psychostimulant Symposium bringing together more than 300 attendees including national thought leaders, health care providers, law enforcement, first responders, and community partners to discuss the rising trends and appropriate treatment options for individuals presenting with psychostimulant-usage. The Symposium was met with great response and we are continuing to work with our co-host the Liberty Mid-Atlantic High Intensity Drug Trafficking Area (HIDTA) program to host an annual event. With that, we were pleased to see the 2020 Appropriations Package currently includes stimulant abuse as an allowable use of funds for the SOR grant. Over time, we hope that Congress would gradually transition from investments in drug specific grants to SAMHSA's SAPTBG in order to afford states more flexibility to address their own unique needs and circumstances.

2. *Acute Funding for a Chronic Condition.* Addiction treatment stakeholders across the commonwealth express a desire for consistent, long-term funding, as addiction is a chronic, relapsing disease. Providers understand that long-term programs that offer a range of treatment and recovery supports are needed. Planning for these programs is difficult when funding mechanisms favor larger, short-term infusions of dollars. Said

another way, short-term funding promotes short-term solutions. Funders should consider mechanisms that support a longer horizon. A long-term focus would reduce uncertainty, thus promoting greater flexibility.

3. *Federal Coordination of Effort.* Pennsylvania receives grant funding to address the opioid crisis from a list of federal partners (e.g. DOJ, DOL, SAMHSA, CDC) with incongruent funding requirements, data collection mechanisms, and timelines for use. These disparate requirements make it difficult to integrate grant dollars into a cohesive, commonwealth-wide strategy. Pennsylvania spends considerable administrative energy ensuring that the *right* dollars are being used for the *right* projects. This creates an opportunity cost of missed benefits were those resources better allocated. Better coordination for funding at the federal level, coupled with a concerted effort to reduce administrative burdens across grants, would support greater flexibility in grant use at the state level. With this in mind, we appreciate the benefits of a strong Office of National Drug Control Policy (ONDCP) and continued funding for the HIDTA program. In addition, we appreciate the SUPPORT Act's creation of the Interdepartmental Substance Use Disorders Coordinating Committee (ISUDCC). We are pleased that SAMHSA will be leading the committee and that state alcohol and drug agencies are required to serve on the committee.

Opportunities for Growth

While Pennsylvania's communities have felt significant impacts in terms of overall community health, loss of life, and economic hardships, we have been able to use these challenges to identify potential opportunities for growth where resources could aid communities devastated by the disease of addiction. These opportunities include:

1. *Persist in dedicating resources to address the crisis.* This is an ongoing, long-term crisis that will require long-term planning and funding. We request that the federal government continue its financial and policy support of evidence-based treatment and seek to reduce barriers where possible. For example, Pennsylvania is strongly supportive of the proposed federal legislation eliminating the X waiver. As proposed, H.R. 2482 would allow physicians to prescribe buprenorphine for opioid use disorder without the current DEA waiver requirement. This change would modernize treatment practices for primary care physicians. They would have the ability to provide MAT to their patients as they would prescribe any other medication, eliminating a barrier to treatment and help decrease stigma surrounding the disease of addiction.

   From a funding perspective, as noted above, we respectfully request the SAPTBG administered by SAMHSA be considered as the funding vehicle for future allocations as it provides greater flexibility, sustainability, and a more streamlined approach to reporting. Differing reporting requirements for each funding vehicle presents a burden for Pennsylvania and our partners. From a policy perspective, we'd like to stress the value of SAMHSA's leadership and guidance. Their role in assisting states and communities by establishing best practices, as well as monitoring and allocating dollars should not be underestimated. We hope that leadership and guidance will continue and opportunities to expand their efforts should be considered.

Unfortunately, far too few individuals who need treatment seek treatment. In 2017, the US Surgeon General estimated that only 19% of those who needed treatment received it. To this end, more resources and effort are needed to not only foster public awareness, but specifically to combat the stigma of addiction. Stigma plays a key role in an individual's willingness to participate in treatment and access health care. We know that untreated addiction and mental health issues generate significant societal costs in health care, criminal justice, and the economy. Governor Wolf has recently announced a focused all-agency effort, 'Reach Out PA: Your Mental Health Matters,' aimed at expanding resources and state's comprehensive support of mental health and related health care priorities. On a parallel track, DDAP has partnered with two nationally recognized non-profit organizations and a Pennsylvania higher education institution to address this issue in the nation's first social behavioral change campaign geared toward substance use disorder. The three-year campaign innovatively pairs state and local resources with social media to provide real-time outcomes in combatting stigma. A similar campaign was recently completed in another state geared toward mental health. The project proved to move the public perception needle an unprecedented amount of 8 percentage points.

Another key factor in the nation's ability to adequately address the crisis and provide appropriate healthcare depends on the viability of the addiction treatment workforce. Workforce shortages are already present across Pennsylvania due to factors such as low wages, emotional burnout, and costly education and training requirements. Demands on the addiction treatment workforce will increase as more people move toward treatment and recovery. We suggest the federal government consider strategies to expand workforce capacity and proficiency. Policies that promote entry into this workforce can also serve the dual purpose of employing individuals in recovery. Pennsylvania has taken a small step in this direction by using grant dollars to institute the loan repayment program that was mentioned previously.

2. *Rebuild Local Economies.* Next, government can speed up disaster recovery through investments that support communities experiencing high rates of poverty, unemployment, and substance use. The US Department of Health and Human Services has found "on average, counties with worse economic prospects are more likely to have higher rates of opioid prescriptions, opioid-related hospitalizations, and drug overdose deaths." Families, peers, workplaces, and communities all play a crucial role in achieving and sustaining recovery – and advancing toward positive outcomes in impoverished communities has been difficult.

3. *Build Resilience to Future Crises.* Finally, the most efficient way to help communities cope with and recover from a disaster is to build resilience in disaster-prone areas before a crisis strikes. Pennsylvania recommends increased investments in evidence-based prevention activities that seek to mobilize communities and strengthen families. Specifically, the commonwealth is focusing its strategic efforts on expanding evidence-based curricula and resources to school-aged children, encouraging awareness of education and support groups, and strengthening family-based prevention and intervention services. The SAPTBG represents a valuable investment in prevention given

that 20 percent of the program must be allocated to primary prevention activities. We are thankful for that funding stream and appreciate SAMHSA's Strategic Prevention Framework (SPF)/Partnership for Success (PFS) Grants that are managed by state alcohol and drug agencies given the program's systemic and state-specific approach to support prevention.

Future Goals for Pennsylvania

As previously stated, our initial federally funded efforts were centered around keeping people alive. We have begun to switch our initial focus toward enhancing the quality of the drug and alcohol continuum. During the Wolf Administration's second term, we will be focused on four major goals: reducing stigma associated with substance use disorder; intensifying primary prevention efforts; strengthening treatment systems; and empowering sustained recovery. We intend to accomplish these goals through the strategies below. Without continued and sustained federal funding, the modernization and collaboration of these efforts will be widely diminished. Although we have made significant strides in Pennsylvania, our work is not done.

Reduce Stigma

- Educate policymakers about treating addiction as a medical disease.
- Advocate harm-reduction strategies with proven outcomes.
- Celebrate recovery stories to empower those still struggling.

Intensify Primary Prevention

- Expand evidence-based resources to school-aged children.
- Encourage awareness of education and support groups for our communities.
- Strengthen family-based prevention and intervention services.

Strengthen Treatment Systems

- Increase treatment providers trained in evidence-based practices.
- Capitalize on recent system updates designed to improve patient placement and data collection methods.
- Incorporate best practices into standardized policies and procedures.
- Eliminate barriers that prevent MAT from being integrated into all levels of care.
- Modernize the rate setting process and payment model to ensure sustainability and quality.
- Expand workforce capacity and proficiency.
- Integrate quality measures.

Empower Sustained Recovery

- Established sustainable funding and support for grassroots recovery organizations.
- Create a recovery friendly business network.
- Support the careers of certified professionals in the field of recovery.
- Aid in establishing additional recovery schools for youth.
- Promote a family-centered approach to recovery.
- Promote the pardon process.

On behalf of Governor Wolf and Pennsylvania, thank you again for the opportunity to offer testimony on the important topic of how states are using federal funding to promote opioid treatment and recovery. I hope that you've found the narrative to be helpful and as stated previously, enclosed are tables further detailing funding allocations to our sister agencies and local entities. Pennsylvania is committed to continuing work with each of you and members of the assembly to combat the opioid crisis and to provide high-quality services and supports to individuals across the commonwealth and nationwide.

ENCLOSURE

Table 1

The below table details the amount of federal funding Pennsylvania has received for prevention, treatment and recovery for opioid use disorder, including the following specific grant funding.

Funding Source	**Amount**
Opioid State Targeted Response (STR)	$53,015,158
State Opioid Response (SOR) & Supplement	$141,052,265
Medication Assisted Treatment – Prescription Drug and Opioid Addiction	$5,700,000
CDC Crisis Response	$5,185,486
CDC Enhanced State Opioid Overdose Surveillance (ESOOS)	$1,666,000
CDC Overdose to Action (OD2A)	$8,448,267
CDC Prevention for States	$6,560,000
U.S. Department of Labor	$4,997,287
BJA Cat. 5	$750,000
BJA Cat. 6 (Prescription Drug Monitoring Program)	$1,000,000
BJA Cat. 6 (Department of Corrections)	$996,408
Coverdell Forensic	$230,386
RSAT	$587,463
Comprehensive Opioid Abuse Program	$1,200,000
TOTAL	**$231,388,720**

Table 2

The below table details Pennsylvania's federal funding recipients, allocation, and purpose of the allocation (e.g. prevention, treatment, etc.).

Recipient	**Purpose**	**Allocation**
Single County Authorities (SCAs)	Prevention	$13,255,000
Department of Health	Prevention	$1,100,000
Pennsylvania Commission on Crime and Delinquency	Prevention	$5,025,000
Department of Aging	Prevention	$1,310,000
Pennsylvania State Police	Prevention	$2,500,000
Department of Military and Veterans Affairs	Prevention	$1,000,000
UPMC Children's Hospital of Pittsburgh	Prevention	$800,000
First Choice Services, Inc.	Prevention	$2,447,027
Harmelin and Associates, Inc.	Prevention	$2,498,077
Red House Communications	Prevention	$4,559,545
Pennsylvania County/Municipal Health Departments	Prevention	$1,495,528
Philadelphia Department of Public Health	Prevention/Surveillance	$759,012
Allegheny County Health Department	Prevention/Surveillance	$685,679
University of Pittsburgh	Prevention/Evaluation	$800,000
Single County Authorities (SCAs)	Treatment	$57,690,925

Department of Health	Treatment	$27,348,000
Pennsylvania Commission on Crime and Delinquency	Treatment	$7,000,000
Department of Corrections	Treatment	$8,900,000
Department of Military and Veterans Affairs	Treatment	$1,000,000
Department of Insurance	Treatment	$400,000
University of Pittsburgh Medical Center	Treatment	$5,607,231
COAP re-entry - naloxone	Treatment	$996,408
University of Pittsburgh	First Responder	$200,000
Department of Human Services	Recovery Support	$30,000,000
Penn State University	Outreach/Education	$100,000
University of Pennsylvania	Outreach/Education	$120,000
University of Pittsburgh	Outreach/Education	$120,000
Temple University (2nd of 2 contracts)	Outreach/Education	$100,000
Villanova University	Outreach/Education	$75,000
East Stroudsburg University	Outreach/Education	$85,000
Drexel University	Outreach/Education	$100,000
Quality Insights, Inc.	Outreach/Education	$928,786
Department of Drug and Alcohol Programs	Administration	$5,736,140
InGenesis, Inc.	Abstractor Staff	$78,387
Appriss, Inc.	Integration	$1,986,515
Public Health Management Corporation	Good Samaritan	$55,500
Fei.com, Inc.	Data Collection	$2,625,000
Adams County Coroner	Surveillance	$10,000
Public Health Management Corporation	Program Evaluation	$711,858
Adams County Coroner	Surveillance	$10,000
Allegheny County Coroner	Surveillance	$10,000
Armstrong County Coroner	Surveillance	$10,000
Berks County Coroner	Surveillance	$10,000
Blair County Coroner	Surveillance	$10,000
Bradford County Coroner	Surveillance	$10,000
Cambria County Coroner	Surveillance	$10,000
Carbon County Coroner	Surveillance	$10,000
Chester County Coroner	Surveillance	$10,000
Delaware County Coroner	Surveillance	$10,000
Fayette County Coroner	Surveillance	$7,163
Forest County Coroner	Surveillance	$10,000
Franklin County Coroner	Surveillance	$10,000
Greene County Coroner	Surveillance	$10,000
Indiana County Coroner	Surveillance	$7,613
Lancaster County Coroner	Surveillance	$10,000
Lawrence County Coroner	Surveillance	$5,000
Lehigh County Coroner	Surveillance	$10,000
Montgomery County Coroner	Surveillance	$10,000
Philadelphia County Coroner	Surveillance	$10,000

Westmoreland County Coroner	Surveillance	$10,000
York County Coroner	Surveillance	$10,000
County Coroner/Medical Examiners	Surveillance	$1,278,685
Health Monitoring Systems, Inc.	Surveillance	$98,000
Workforce development – central PA	Workforce development	$1,183,845
Workforce development	Workforce development	2,000,789
Workforce development	Workforce development	$411,438
Workforce development	Workforce development	$532,595
Labor and Industry - administrative	Workforce development	$228,620

Ms. DEGETTE. Thank you so much. And don't worry, we don't intend to give up.

Dr. Bharel, you are recognized now for 5 minutes.

TESTIMONY OF MONICA BHAREL, M.D.

Dr. BHAREL. Chair DeGette, Ranking Member Guthrie, and members of the subcommittee, thank you for the opportunity to speak with you today.

In my role as Commissioner of Public Health and as the state's chief physician, I am dedicated to addressing the opioid epidemic in Massachusetts. I commend Congress and our federal agencies for funding those working tirelessly on the front lines every day.

Our data indicates that in Massachusetts our public health-centered approach to the opioid epidemic is working. I'm heartened to let you know that from 2016 to 2018, our opioid overdose deaths have declined by four percent. We continue to focus on prevention and education, naloxone availability, medication treatment, behavioral health counseling, and sustained recovery support.

We have made progress, but it's still unacceptable that nearly 2,000 individuals in Massachusetts die from this preventable disease each year.

In my clinical practice, I cared for people with this disease. And I will never forget that behind these numbers, which we will talk about today, are real people, their families, and their communities.

Since 2016, we have been awarded approximately $159 million in federal funding specific to opioid use disorder prevention, treatment, and recovery. And we've allocated approximately $111 million of those funds.

We've used federal funding to support expansion and enhancement of our treatment system through a data-driven approach that targets high-risk, high-need priority populations and disparities, with a goal of reducing opiate overdoses and deaths.

In 2015, Governor Baker appointed a working group who developed an action plan emphasizing data to identify hotspots and deploy appropriate resources. Additionally, a law referred to as the Public Health Data Warehouse enabled us to link 28 different data sets across state government and establish a public-private partnership to maximize the use of data to study this major public health crisis. This is unprecedented in Massachusetts.

So, our approach started with data analytics and research, allowing us to gain a deep understanding of who is dying, where and why, so that new investments could be strategic and impactful. Our data led us to quickly focus our efforts on five key populations that we saw were still suffering from overdoses and overdose deaths:

Persons released from incarceration, communities of color, persons with co-occurring mental health and substance use disorders, people with a history of homelessness, and mothers with opioid use disorder.

Our data showed, in fact, that the rate of opioid overdose death for mothers with opioid use disorder was more than 300 times higher for mothers without it. In response, one of the programs we set up was Moms Do Care, which is currently 100 percent federally funded. This innovative approach built a seamless, integrated con-

tinuum of care for pregnant and parenting women with substance use disorder.

It provides access to medication, prenatal and postnatal care, maternity and pediatric care, behavioral health counseling, and peer-to-peer recovery supports, and so much more.

With federal funds, we are also supporting and expanding our prescription drug monitoring program, allowing all Massachusetts prescribers enhanced access to this vital system.

While we have had many successes, we do see opportunities for federal assistance so we can continue to make progress. This includes funding that is flexible. When funding requirements restrict us to addressing only opiates, states are limited in our flexibility to address the changing landscape of substance use disorder. Flexibility would enable us to address other substances connected to this epidemic, such as cocaine and methamphetamine.

Additionally, there are currently federal barriers to medication-assisted treatment such as methadone and buprenorphine, and these barriers should be removed. This would allow medication-assisted treatment to be regulated more similarly to other chronic disease treatments, and available in traditional healthcare settings to increase access and reduce stigma.

In conclusion, we are grateful to Congress for the commitment to address this opioid epidemic. Much of our progress can be attributed to federal funding we receive. And I encourage Congress to continue these critical funding efforts. This crisis did not build overnight; and it will take time to reverse.

Addiction is not a choice; it is a disease. And with the continued support of our federal partners, we will build a solution to tackle this epidemic in Massachusetts and this country.

Thank you.

[The prepared statement of Dr. Bharel follows:]

The Commonwealth of Massachusetts
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000

United States House Energy and Commerce
Oversight and Investigations Subcommittee

"A PUBLIC HEALTH EMERGENCY:
STATE EFFORTS TO CURB THE OPIOID CRISIS"

January 14, 2020

Testimony of
Commissioner Monica Bharel, MD, MPH
Massachusetts Department of Public Health

Chair DeGette, Ranking Member Guthrie, and members of the committee, thank you for the opportunity to provide testimony on this important issue today. The Massachusetts Department of Public (DPH) is one of the nation's oldest public health departments, just celebrating our 150th anniversary, and one that has been at the forefront of public health across the country. The mission of DPH is to keep people healthy and communities strong as we work to prevent illness and injury, ensure access to high quality public health and health care, and promote wellness and health equity for all residents.

In 2015, one of Governor Charlie Baker's first actions upon taking office was to appoint an 18-member working group tasked with developing an action plan in response to the opioid crisis. The group, chaired by our Secretary of Health & Human Services, conducted its work by holding public meetings, assessing the resources devoted to the problem, and submitting specific recommendations. The goals were and continue to be to reduce opioid related deaths and to improve access to treatment.

In my role as the Commissioner of Public Health and as the state's chief physician, I have worked to keep efforts focused on addressing the opioid epidemic in our state. I commend Congress and the federal agencies for providing additional funding and support to the state and local agencies working tirelessly on the front lines every day. I am pleased to be here today to tell you about what the Commonwealth is doing to prevent people from becoming addicted to opioids and other substances in the first place, improving access to treatment, and providing appropriate recovery services for our state's residents.

Background

This latest data indicates that the Commonwealth's public health-centered approach to the opioid epidemic is working and I am heartened to let you know that from 2016 to 2018, our opioid overdose

deaths have declined by four percent. We continue to focus on the widespread availability of naloxone, medication and behavioral health treatment, and sustained recovery services. We have made progress but there is still much work to do; nearly 2,000 individuals in Massachusetts die from opioid use disorder every year, all real people who leave behind families and communities grappling with loss.

Since 2016, the Department, which encompasses the Single State Authority and the State Opioid Treatment Authority, has been awarded $159,131,562 in federal grant funding specific to opioid use disorder prevention, treatment, and recovery. Massachusetts has used federal funding to support expansion and enhancement of our treatment system through a data-driven approach that targets high-risk, high need priority populations and disparities with the goal of reducing opioid overdose and deaths.

Action Plan and Focus on Data

We are proud of our efforts to deploy these federal funds to local communities in an expedited manner, through our streamlined procurement process and according to the Action Plan set out in 2015 by Governor Charlie Baker.

A key strategy outlined by Governor Baker's opioid working group was to utilize data to identify hot spots and deploy appropriate resources. In 2015, Governor Baker signed legislation authorizing DPH to access data across multiple independent data sets that existed in multiple public agencies. The project, referred to as Public Health Data Warehouse (PHD), enabled us to link 28 data sets and establish an unprecedented public-private partnership to maximize the use of data to study a major public health crisis. This was unprecedented in Massachusetts and is now used as a model by other states.

We use a precision public health approach to inform policy and improve practice. Our data analysis and research allowed us to gain a deep understanding of who was dying, where and why, so that new investments could be strategic.

Combining individual-level data across multiple data sources generated insight not available from one source alone. The data contains patient-specific information such as prescriptions, treatment visits, hospital and emergency room visits, ambulance runs, insurance claims, and opioid-related deaths. Individual names are not used in the data warehouse, but each person has a unique number, so it's possible to tell, for example, that someone rescued by first responders from an overdose was the same person later admitted to a hospital. Being able to provide locally-relevant data insights was a powerful tool in creating a fact-based approach to this crisis.

Our Findings and Response

This precision public health approach led us to focus intently on several key populations:

- Persons released from incarceration
- Mothers with opioid use disorder
- Persons with co-occurring disorders
- People with a history of homelessness
- Communities of color

One new finding, enabled by our cross-referencing of data, showed that for persons released from Massachusetts prisons and jails, the opioid-related overdose death rate is 120 times higher than for the

general population. This fact galvanized action and investment in drug treatment in corrections along with distribution of naloxone to those returning to the community after incarceration.

For example, since 2017, criminal justice-involved individuals with an opioid use disorder have been served by the 100 percent federally-funded Medication-Assisted Treatment Re-Entry Initiative (MAT-RI). The goals of this program in 9 county Houses of Correction are to provide people reentering the community after incarceration with case management, recovery support, linkage to medication and behavioral health treatment, other addiction treatment services and supports, and to prevent opioid overdose and recidivism.

Other data-driven policies have helped stem the tide of overdoses here in the Commonwealth in response to data findings, including a finding that mothers with opioid use disorder had a 321 times higher rate of overdose death than mothers without it.

As a result, we established the "Moms Do Care" program, currently a 100 percent federally funded program. The program operates in 10 distinct health care settings and uses an innovative approach to building and sustaining a seamlessly integrated, trauma informed continuum of care for pregnant and parenting women with a history of opioid use disorders. Since 2016, it has enrolled 522 women, each receiving access to medication and behavioral health treatment and other forms of treatment for addiction; prenatal and postnatal care; specialized labor, delivery, maternity and pediatric care; and peer-to-peer recovery and parenting support. To date, 368 of those in the program were prescribed medication at the time of enrollment. Moms Do Care has received dozens of personal testimonials from women who have received help for their substance use disorder and are now in recovery.

In Massachusetts, the Baker-Polito Administration continues to prioritize our response to the opioid crisis. In collaboration with our Legislature, our state has doubled spending to address the opioid crisis and improve access to treatment for addictions, mental illness and co-occurring disorders. Our Administration is investing nearly $220 million over five years from the federally approved 1115 Medicaid waiver, which began in fiscal year 2018, to meet the needs of individuals with addictions and/or co-occurring disorders. In September 2018, the Commonwealth was awarded $35.8 million in federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the State Opioid Response (SOR) grant. This funding is being directed towards the expansion and creation of a number of initiatives that I have discussed.

DPH has been consistently refining the methodologies used to identify high-burden communities and expediting the release of opioid-related overdose data to inform and target prevention, intervention and treatment responses in a timely manner. Federal funds to address the opioid crisis have provided Massachusetts with the ability to fund a variety of opioid-related prevention, intervention, treatment and recovery support service initiatives, as well as addictions workforce development programming, and communication/media campaigns to inform and educate the general public and specific target audiences impacted by the epidemic, in rural and urban regions across the state.

Use of Federal Dollars

Allow me to summarize how Massachusetts has used our federal dollars to combat the opioid epidemic.

As outlined in Governor Baker's Action Plan, the Commonwealth continues to partner with subject matter experts and organizations that specialize in training to engage in capacity building and workforce development across the state to: a) increase the number of prescribers who receive a DEA-X waiver, enabling them to practice opioid dependency treatment with approved buprenorphine; b) increase the amount of certified addictions counselors and recovery coaches; c) improve the knowledge base on evidence-based addiction prevention and treatment practices; d) reduce the stigma associated with addiction disorders. In 2015, Massachusetts was the first state in the Nation to introduce core competencies into its medical school curriculums. That has grown to include professionals ranging from nurses and doctors, to social workers and physical therapists. We strive to enhance existing capabilities and workforce skill sets in identified areas of need, including partnering with sister state agencies to address opioid overdose prevention training needs in their workforce.

With federal funds we are also supporting improvements to the Massachusetts Prescription Drug Monitoring Program, known as PDMP, to ensure universal prescriber usage, including making PDMP information available in electronic health records so physicians and pharmacists can quickly check a patient's PDMP report before prescribing or dispensing medications. Massachusetts is also part of a national network of PDMPs that are linked, which allows for more extensive tracking and monitoring of prescribing practices and patterns. In addition, we are expanding the development of the state's Population Health Information Tool, an online platform that provides information individuals and communities can leverage to inform best practice interventions to better identify and address addiction and other health risks.

Addiction treatment and service providers in geographic settings that were identified as being of highest need and which were addressed through the application of federal funds include:

a) expanding Office Based Opioid Treatment and behavioral health treatment to high-risk priority populations including individuals experiencing homelessness, individuals with co-occurring SUD and mental health diagnoses, pregnant women, people of color, and people who identify as LGBTQ;
b) increasing the number of community-based Overdose Education and Naloxone Distribution (OEND) Programs;
c) expanding community-based first-responder post-overdose follow-up programs in high-priority locations using a model of in-person, home-based outreach and support after a 911 call for an overdose, aiding individuals and families who may not be accessing other available services;
d) increasing capacity at Recovery Support Centers;
e) engaging individuals re-entering the community from a correctional setting receiving medication for opioid use disorder (MOUD) to access continued treatment, including behavioral health counseling, and recovery supports, and retention in the recovery process;
f) expanding programming that targets pregnant and parenting women with OUD and their dependent children and families;
g) improving capacity to identify and serve individuals with opioid use disorder and facilitate their access to treatment by implementing opioid treatment programs, including buprenorphine induction, in hospital emergency departments and community health centers;
h) expanding recovery programming that supports individuals who are stabilizing in their recovery to develop and maintain social connectedness, receive case management, gain access to housing support, and participate in job readiness programs.

Federal Assistance to Address Current Challenges

The availability of federal funding that is flexible is critically important. Providing flexibility to address substance use disorders through prevention, intervention, treatment and recovery, coupled with funding for workforce development and capacity building, as well as supporting surveillance and research activities comprehensively over time, will provide states with necessary resources to strategically plan and execute initiatives.

However, when the requirements of a funding opportunity are restricted to addressing only opioids, states like Massachusetts are limited in flexibility to address the changing landscape of substance misuse, addiction, and co-occurring mental health conditions. Addictions rarely exist without a concomitant behavioral health condition, such as depression, anxiety, post-traumatic stress disorder or other conditions. **It is important that federal funding permit flexibility to support services and programming that are inclusive of treatment for mental health conditions, opioids, and other substances such as alcohol, cocaine, and methamphetamine**.

We strongly encourage future legislative efforts to refrain from a narrow focus on "opioids" when referencing prevention, treatment, and recovery activities in statute and instead encourage broadening the legislative language to include, "substance misuse disorders." While the opioid epidemic is a crisis today in many states, other drugs such as methamphetamine, cocaine, and benzodiazepines, often in combination with opioids, are emerging as predominant causes of substance misuse among some populations. This is in addition to the long-standing challenge of alcohol misuse and addiction.

Additional flexibilities and broadening of applicability of the funding would allow Massachusetts and other states to study those initiatives in a manner that will allow mitigation of the risks and harms associated with substance misuse, develop and strengthen the evidence base of best practices for preventing and treating addiction disorders, and lead to healthier individuals, families, and communities.

Another challenge where we can use federal assistance is in expanding the use of Naloxone. As we see every single day, Naloxone is a lifesaving antidote that, if available and administered quickly, can reverse an opioid overdose while it is occurring. Outreach workers and first responders should have the ability to provide naloxone to individuals who are using opioids as a harm reduction strategy.

The United State Secretary of Health and Human Services (HHS) has the regulatory authority to exempt drugs from the requirement of a prescription to be dispensed, if doing so would not pose a risk to public health. [See 21 USC c. 9 §353(b)(3)]. Allowing states the flexibility to choose whether to make naloxone available over-the-counter by exempting it from this requirement would pose no risk to public health, since naloxone has little to no side effects at the dose necessary to reverse an opioid overdose. On the contrary, eliminating a prescription requirement would significantly benefit public health by increasing the availability of this lifesaving antidote, thereby providing individuals with a second chance at life and recovery.

HHS could adopt emergency regulations that exempt naloxone from requiring a prescription if the state has authorized over-the-counter use. Making naloxone accessible and affordable to everyone would save lives in my state and across the country. I urge you to support expanding access to this lifesaving drug.

Federal support to improve access to fentanyl testing would be helpful. Fentanyl, a synthetic opioid that is 50 to 100 times more potent than morphine, is being detected in an increasing proportion of postmortem toxicology screens for opioid-related overdose deaths. Among the 445 opioid-related overdose deaths in Massachusetts in 2019, where a toxicology screen was also available, 410 of them (93%) had a positive screen result for fentanyl. While these data indicate fentanyl availability and use is on the rise, most treatment providers cannot readily access rapid urine fentanyl tests due to the federal classification of the tests. The federal government can fix this by designating rapid urine fentanyl tests as waived under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Massachusetts is partnering with police departments to coordinate Drug Checking pilots using drug checking portable machines to check material that is in police possession for fentanyl for public health purposes. With no current CLIA-waived fentanyl tests, health care and substance use disorder treatment providers that currently use similar tests to screen for other drugs at the point of care must send samples to offsite CLIA-certified laboratories for fentanyl testing potentially delaying treatment.

Immediate intervention and treatment are of paramount importance in this epidemic, and giving providers the ability to test for fentanyl use in real time provides another opportunity to save lives.

Medication-assisted treatment (MAT) in conjunction with behavioral health treatment is a proven method of treating opioid use disorder by reducing overdose deaths, improving treatment outcomes, and preventing the spread of infectious disease. Medications utilized for treatment include methadone, buprenorphine, and naltrexone, which are prescribed and dispensed to patients through opioid treatment programs or clinical offices, in accordance with federal law and regulations.

The Drug Enforcement Administration (DEA) allows for DATA waiver permits for qualified physicians, nurse practitioners (NP), and physician assistants (PA) to obtain a waiver from the separate registration requirements of the Drug Addiction Treatment Act of 2000 (DATA 2000) to treat opioid addiction with buprenorphine. Physicians applying for the DATA waiver must complete no less than eight (8) hours of additional training with respect to the treatment and management of opioid-addicted patients, while NPs and PAs must complete twenty-four (24) hours of specialized trainings. This compels medical practices to redirect their providers from attending to their patients in order to complete these trainings, which creates another barrier to increasing the number of providers able to prescribe buprenorphine. Coupled with the difficult registration process providers are required to undertake, many providers who have completed the requisite training do not ultimately obtain their DATA waiver.

Additionally, physicians, NPs, and PAs must attest that they have the capacity to refer addiction treatment patients for appropriate counseling and other non-pharmacologic therapies to continue to prescribe. Physicians may not have more than thirty (30) patients on such addiction treatment for the first year, and are then only able to prescribe to two hundred and fifty (250) active patients in subsequent years. NPs and PAs are limited to a cap of one hundred (100) active patients after their first year. There are no such exclusionary waivers for any other types of medications, including opioids. The patient cap also limits providers' ability to provide access to treatment, as those who specialize in addiction medicine and focus on care for patients seeking addiction treatment are limited to a smaller panel, despite their expertise and potential ability to serve more patients than the cap currently allows.

Federal barriers for methadone and buprenorphine should be removed, allowing MAT to be regulated more similarly to other chronic disease treatments and available within traditional health care settings to increase access and reduce stigma. Massachusetts continues to request that the requirement

for medical providers to obtain a waiver from the Drug Enforcement Administration (DEA) to treat opioid use disorder with buprenorphine be eliminated. Federal law should also be amended to support the integration of methadone in the primary care setting.

Finally, we are grateful to Congress for the commitment to address the opioid epidemic. The progress made in Massachusetts is attributable in part to the significant infusion of federal funding we receive, and I encourage Congress to continue these critical funding efforts. We must ensure that the infrastructure, capacity, and support for the population continue to be bolstered and enhanced in the coming years because this crisis did not build overnight, and it will take time to reverse.

Thank you for your dedication to this issue and your work on behalf of so many individuals and families who continue to struggle with opioid addiction, something which is not a choice. Addiction is a disease, and with the continued support of our federal partners, we will build a solution to tackle this epidemic – in my state of Massachusetts and across this country.

Ms. DEGETTE. Thank you so much.

Ms. Mullins, you are recognized now for 5 minutes.

TESTIMONY OF CHRISTINA MULLINS

Ms. MULLINS. Thank you. Chairwoman DeGette, Ranking Members, and members of the subcommittee, my name is Christina Mullins, and I am the Commissioner for the Bureau for Behavioral Health within the West Virginia Department of Health and Human Resources. And I also serve as a member of the National Association of State Alcohol and Drug Abuse Directors.

First, I want to thank you for your commitment to address this crisis. Without the resources provided by this Committee, West Virginia would be in a considerably worse position.

I also want to thank you for the opportunity to discuss the importance of the initiatives in West Virginia to address the opioid crisis and the impact of the funding made available through this Committee to promote prevention, treatment, and recovery for substance use disorder.

It is no secret that West Virginia has been Ground Zero of the opioid crisis, with the highest overdose rate in the nation. There are award-winning documentaries and Pulitzer-Prize winning stories that describe what happened to our state. And I am sure these efforts have played a significant role in bringing much-needed resources to West Virginia. But today, I would like to tell you a different story.

With your help, West Virginia has reduced overdose deaths for the first time in over ten years. Both opioid prescriptions and opioid doses have decreased by about 50 percent, while naloxone prescribing has increased by 208 percent. Additionally, we have distributed over 10,000 doses of naloxone to local health departments.

Treatment capacity has been transformed. The number of people that can prescribe buprenorphine has more than doubled, from 243 to 584 since 2017. We have increased the number of residential treatment beds from 197 to 740. And our records indicate that those beds are about 85 percent full at about all times.

Additionally, nearly all birthing facilities have access to integrated substance use disorder treatment in their community. This extraordinary increase in infrastructure and capacity is the result of a significant financial investment of federal, state, and drug settlement funds.

West Virginia leveraged federal investment to increase outpatient treatment capacity, increase the number and quality of its workforce, distribute lifesaving naloxone, conduct rigorous provider education on opioid prescribing, increase evidence-based prevention programs and stood up quickly response teams to follow up on individuals who experience non-fatal overdoses.

In addition to these efforts, the state also increased its infrastructure for surveillance and data analysis. And this work drives all of our programmatic decision-making.

The state complemented the work of its federal projects by using settlement funds and general revenue to undertake the development of construction projects that expanded the availability of residential treatment, including facilities that specialize in pregnant

and postpartum women. The scope of this problem required a historic financial investment to adequately respond to this crisis.

Rating funding sources allowed West Virginia to balance the need for immediate intervention and services with the long-term need to address the systemic issues that serve as an ongoing challenge to the state's opioid response.

While significant progress has been made, certain barriers and challenges remain. West Virginia continues to experience substantial workforce shortages. Gaps in training related to psychostimulants and polysubstance use, and a lack of capacity to serve children impacted by this crisis.

In addition, a key concern when utilizing time-limited grant dollars is sustainability of effort in thinking about a bigger longer-term investment of these endeavors or to have a continuing impact in increasing treatment availability and reducing overdose deaths. The predictable and sustained provision of resources is key to allow states and providers to plan and rely on future year commitments. It can be tough to successfully plan and operate programs if providers are not confident resources will be available beyond a 1-year commitment.

It would be difficult to believe that West Virginia could have accomplished so much without the support of this Committee. These funds have allowed West Virginia to have the resources that it needed to respond to this crisis, and resulted in a decrease in overdose deaths, and transformed our system of care. Our overdose deaths are down at this point, our records say, by ten percent.

The financial resources are crucial to our continuing success and maintaining momentum. Ongoing funding for state alcohol and drug agencies to coordinate substance use prevention, treatment, and recovery services at the state level will ensure continued progress.

While barriers remain, West Virginia is better poised to address future challenges and continue its forward progress.

In summary, West Virginia wishes to say thank you to this Committee, SAMHSA, and CDC. Thank you for your support. Thank you for the resources. And thank you for allowing us to share what is happening and what is working in West Virginia.

[The prepared statement of Ms. Mullins follows:]

A Public Health Emergency:
West Virginia's Efforts to Curb the Opioid Crisis

Testimony to:

The House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

The Honorable Frank Pallone, Jr., Chairman
The Honorable Greg Walden, Ranking Member
The Honorable Brett Guthrie, Ranking Member
The Honorable Diana DeGette, Subcommittee Chair

2125 Rayburn House Office Building

Submitted By:

Christina Mullins, Commissioner
Bureau for Behavioral Health
West Virginia Department of Health and Human Resources

350 Capitol Street, Room 350
Charleston, West Virginia 25301

Email: Christina.R.Mullins@wv.gov

Tuesday, January 14, 2020
2123 Rayburn House Office Building

Chairman Pallone, Ranking Member Walden, Ranking Member Guthrie, Subcommittee Chair DeGette and members of the Committee on Energy and Commerce, I am Christina Mullins, the Commissioner of the Bureau for Behavioral Health within the West Virginia Department of Health and Human Resources (DHHR). First, I want to thank the Committee for your commitment to address this crisis. Without the resources provided by this Committee, West Virginia might be in a considerably worse position. I also want to thank you for the opportunity to discuss the importance of the initiatives in West Virginia to address the opioid crisis and the impact of the funding made available through this committee in the effort to promote prevention, treatment and recovery of substance use disorder. The resources provided by both the state and federal governments have allowed West Virginia to transform the state's response to the opioid crisis. This work is saving lives through expanded opportunities for prevention, treatment, and recovery.

While overdose rates in West Virginia have increased since the early 2000s, staff within West Virginia's DHHR began to receive increasing numbers of calls from providers of all kinds in the mid-2000s. Overdose deaths were going up, clients were presenting with substance use disorders, and neonatologists were complaining that the neonatal intensive care units were full of infants withdrawing from drugs. We had no idea that this was only the beginning of what would happen to our state.

Further compounding our challenges during this time was that Medicaid did not pay for residential treatment, and the utilization of medication assisted treatment (MAT) in any setting was very low. Residential treatment services were either privately sponsored or funded by DHHR using the Substance Abuse Prevention and Treatment Block Grant (SAPT) or state revenue. As a result, there were only 197 treatment beds to serve the entire state of West Virginia. Put simply, West Virginia had nowhere near the resources it needed to respond to the worsening crisis.

It is no secret that West Virginia is ground zero of the opioid crisis. There are award winning documentaries and Pulitzer Prize winning stories that describe what happened to our state, and I am sure that these efforts played a significant role in bringing much needed resources to West Virginia. But today, I would like to tell a different story. With your help, West Virginia has reduced overdose deaths for the first time in over 10 years. Opioid prescriptions have decreased by 48%, opioid doses have decreased by 50%, and naloxone prescribing has increased by 208%. Additionally, we have distributed over 10,000 doses of naloxone to local health departments. Treatment capacity has also shifted. The number of Data Addiction Treatment Act (DATA) waivered providers has increased 208% since 2017, and the number of residential treatment beds has increased from 197 to 740. Our records indicate that 85% of these beds are always in use. Additionally, nearly all birthing facilities have access to integrated substance use disorder treatment in their community. This fundamental shift in infrastructure and capacity is the result of the significant financial investment of federal, state and drug settlement funds.

West Virginia leveraged federal investments to increase outpatient treatment capacity (including MAT), increase the number and quality of its workforce, distribute life-saving naloxone, conduct

rigorous provider education on opioid prescribing, and stand up Quick Response Teams to follow-up on individuals experiencing non-fatal overdoses. The state used settlement funds and its general revenue to undertake the development of bricks and mortar projects that expanded the availability of residential treatment, including facilities that specialize in pregnant and post-partum women. The scope of this problem required a significant financial investment to adequately respond to this crisis. Braiding available funding sources allowed West Virginia to balance the need for immediate interventions and services with the long-term need to address the systemic issues that serve as an ongoing challenge to the state's opioid response. This testimony will describe how West Virginia transformed its substance use system of care using available federal dollars as a critical cornerstone.

Impact of Crisis

West Virginia is one of the states most impacted by the current opioid crisis. In 1999, West Virginia had a lower rate of overdose deaths than the national average at 4.1 per 100,000 population versus a national rate of 6.0. In 2001, West Virginia surpassed the national rate and in 2010 became the state with the highest rate of overdose deaths in the nation. West Virginia continues to lead the nation in overdose deaths, with its highest rate of 57.8 recorded in 2017.

Loss of life is not the only impact of this crisis. Substance use disorder has had a profound impact on children and their families. West Virginia leads the nation in Neonatal Abstinence Syndrome (NAS), a withdrawal syndrome associated with prenatal exposure to both illicit and legally prescribed drugs. In 2018, 4.9% of infants born in West Virginia were diagnosed with NAS. Of continued concern is that an additional 9.4% of infants were determined to have intrauterine substance exposure (illicit and legally prescribed). Overall, 14.3% of the infants born in West Virginia may have long-term consequences due to exposure to drugs during pregnancy.

Substance use has also directly impacted the state's foster care system. Foster care placement in West Virginia has risen from 4,129 children in care in September 2011 to 6,895 in September 2019, an increase of 67%. Of those currently in foster care placement, the most common reasons are drug use by the parent (51.3%) followed by neglect (34.6%). It is important to note that drug use alone is not sufficient cause for removal. Furthermore, infants in foster care were 420% more likely to have been diagnosed with NAS.

In addition to loss of life and impact to families, the state has also experienced increases in infectious diseases including an outbreak of hepatitis A in March 2018. Nearly 70% of infected individuals reported illicit drug use, and 9% reported experiencing homelessness. Additionally, in 2018 and 2019, the state had 114 new HIV cases associated with injection drug use compared to only 25 cases in 2016 and 2017. This has increased the stigma associated with substance use disorder in certain communities.

There are many contributing factors to the high rate of overdose deaths in West Virginia, including high rates of opioid prescribing, poor economic status and lack of capacity to provide evidence-based treatment. Prior to 2016, there were 197 residential substance use treatment beds available. Additionally, the state has a mental health and substance use

disorder professional workforce shortage making retention of qualified providers very difficult. The Health Resources and Service Administration (HRSA) estimates that only 16.9% of West Virginia's mental health professional need is being met (the workforce with the primary responsibility of delivering substance use disorder treatment), which further strains the state's ability to expand prevention, treatment and recovery programs.

Data is crucial to describe and inform the response to the opioid crisis. Since the start of the opioid crisis, West Virginia has implemented multiple initiatives, each adding lessons learned and informing future strategies. In 2001, the state expanded the capacity to track fatal overdoses in more detail. This was pivotal and helped government officials understand what was happening within the state. In 2011, this information caused the Governor's Office to establish the Governor's Advisory Council on Substance Abuse (GACSA) to help define and guide the response to the opioid crisis. GACSA was the beginning of the stakeholder collaboration that defines West Virginia's approach by working to maximize resources to address the opioid crisis.

Recommendations from GACSA led to state appropriations for expanding prevention, treatment and recovery programs. Despite these efforts, overdose and NAS rates continued to climb. From 2000 to 2016, there were multiple initiatives and laws passed to address the opioid crisis in the state. However, the resources available at the time could not even begin to meet the demand of the response needed. Various agencies were applying and receiving federal grants, and while this allowed the state to leverage federal resources and expertise, the state still struggled to meet the demands of the response.

In 2017, several significant events converged allowing the state to expand and solidify its response to the opioid crisis. First, at the direction of this committee, West Virginia began to receive an increase in federal support and funding. At about the same time, the West Virginia Legislature passed the West Virginia Drug Control Policy Act, which created the Office of Drug Control Policy (ODCP) to coordinate, support and improve the state's response to substance use. West Virginia also created an appropriations fund to receive state opioid settlements, known as the Ryan Brown Fund. This fund allows for settlements with drug companies to be utilized for the creation of new treatment and recovery infrastructure. Another significant event was the approval of West Virginia for a Centers for Medicare and Medicaid Services (CMS) 1115 Substance Use Disorder Demonstration project. This expansion of Medicaid significantly increased access to residential treatment, medication assisted treatment (including methadone) and peer recovery support services.

In addition to policy and funding changes, the state completed the first of its kind 2016 Overdose Fatality Analysis, funded by the Prescription Drug Overdose: Prevention for States Cooperative Agreement, that helped inform initiatives and led to the near simultaneous development of a Rapid Response Plan (supported by state revenue, the State Targeted Response (STR) grant, and the Prescription Drug Overdose: Prevention for States Cooperative Agreement) with a primary goal to decrease fatal overdoses. The Rapid Response Plan informed both the deployment of financial resources and the passage of the Opioid Reduction Act that required the development of voluntary nonopioid advanced directives and limited the initial supply of opioid prescriptions.

In 2018, Governor Jim Justice convened a new advisory council to advise ODCP and develop a long-term strategic plan (encompassing all available funding mechanisms) with broader goals for continuing to expand prevention, treatment and recovery programs with an emphasis on reducing the impact to children and families. This plan will help to coordinate the implementation of all programs, regardless of funding sources. Over the past year, the ODCP strategic planning process has facilitated streamlined coordination within and across agencies. These combined components will help West Virginia continue to expand the service array for those most in need. Figure 1 illustrates the convergence of key steps taken by West Virginia since 2017.

Figure 1

In West Virginia, DHHR is the primary recipient of the federal funds allocated through this committee. DHHR is comprised of multiple offices and bureaus including the Bureau for Behavioral Health, the federally designated Single State Agency (SSA) which manages the Substance Abuse Prevention and Treatment Block Grant (SAPT) and the State Opioid Response Grant (SOR); the Bureau for Public Health which manages funds from the Centers for Disease Control and Prevention (CDC); the Office of Drug Control Policy (ODCP) which coordinates funding across agencies; the Bureau for Medical Services, the state Medicaid agency; and the Bureau for Children and Families, the agency responsible for child and family services. One important outcome of the federal funding received by West Virginia is that state agencies have been working together across funding streams and breaking down the silos of traditional areas of focus. Through weekly collaborative meetings organized by the ODCP and DHHR's Cabinet Secretary, this structure allows the bureaus to maximize and leverage financial and human resources across bureaus.

To be successful, coordination of programming must go beyond DHHR's internal agencies. As a result, the ODCP facilitates regular meetings with the West Virginia Department of Military

Affairs and Public Safety, the agency responsible for law enforcement and corrections in the state, the West Virginia judicial system, members of the higher education system in the state, Workforce West Virginia, the state agency that oversees the unemployment insurance program among other activities, the West Virginia Department of Education, and the West Virginia Board of Pharmacy to facilitate a common vision. Each of these agencies are responsible for implementing key elements of the state's strategic response. In addition to coordination with other state agencies, regional community meetings are typically conducted once per year to get input from community members throughout the state. The most recent rounds of regional meetings were held in the both the fall of 2018 and again in the fall of 2019. Key stakeholders and collaborators are highlighted below:

State Departments and Boards

- West Virginia Department of Health and Human Resources
- West Virginia Department of Education
- West Virginia Department of Military Affairs and Public Safety
- West Virginia Board of Medicine
- West Virginia Board of Pharmacy
- West Virginia Judiciary
- West Virginia State Police
- WorkForce West Virginia

Professional Organizations, Associations, and Coalitions

- West Virginia Association of Recovery Housing
- West Virginia Behavioral Health Planning Council
- West Virginia Behavioral Health Providers Association
- West Virginia Primary Care Association
- West Virginia Healthcare Information Network
- West Virginia Hospital Association
- Various Local Coalitions and Community Groups

Local Governments

- City and County Courts and Day Report Programs
- City and County Health Departments
- City and County Sheriff's Departments
- City and County Emergency Medical Services

Hospitals, Healthcare Systems, Provider Networks

- Comprehensive Community Behavioral Health Centers
- Federally Qualified Health Centers
- An Array of Licensed Behavioral Health Centers
- Managed Care Organizations
- Marshall Health
- West Virginia University Medicine

Social Service Institntions and Agencies

- Prevention Lead Organizations
- West Virginia Perinatal Partnership
- Homeless Service Agencies Including Continuums of Care
- Various Faith and Community Based Nonprofit Organizations

Universities and Academic Institutions

- Marshall University
- University of Charleston
- West Virginia School of Osteopathic Medicine
- West Virginia University

As of December 20, 2019, West Virginia has received $147,356,427 in federal funds to address the opioid crisis. An additional $58,908,723 in state funds have also been allocated since July 2016 to support the state's response to this crisis. This total does not include the state share of expenses billed under the 1115 Substance Use Disorder Medicaid Waiver. The total amount of funding allocated/encumbered is constantly changing as new programs are initiated. While West Virginia has not fully expended the total amount of federal funding at the time of this testimony, I cannot stress enough that these funds have been critical in the state's substance use disorder response. West Virginia is constantly working to balance the need to deploy financial resources as quickly as possible while assuring that the funds are effectively and efficiently managed to ensure that we are accountable for these critical resources.

Surveillance reports supported by CDC grants (including Prescription Drug Overdose: Prevention for States (PDO:PFS), Enhanced State Opioid Overdose Surveillance (ESOOS), and the Crisis Notice of Funding Opportunity Announcement) allowed DHHR to identify "hot spots" and high burden areas. Of note is that every county and community in West Virginia has been impacted by the opioid crisis, with all able to document some level of need. West Virginia used this data to develop a clear picture of where the gaps in service were, where the greatest need existed, and where there was sufficient capacity so funds could be used in the most impactful manner. The significant federal investments have allowed West Virginia the flexibility to focus on the hardest hit regions and localities while also allowing us to address statewide needs that benefit all West Virginians. In other words, we did not have to choose between much needed critical projects. For perhaps the first time, West Virginia had the resources to fund what it needed.

DHHR awards grants to outside entities to perform an assortment of programmatic functions and activities funded with federal and state resources. DHHR uses both a purchasing process and a competitive Announcement of Funding Availability (AFA) process to determine which local governments and/or entities receive federal funding, with prioritization given to specific areas of need/personnel in agencies to develop programs. While there are slight variations within and between agencies, all agencies follow the same overall guidelines. The process for DHHR's Bureau for Behavioral Health is provided as one example. The Bureau for Behavioral Health releases an AFA through an established public announcement process, which includes both group e-mails and website postings. AFAs note the services to be provided, the geographic location for those services, the budget limits, grant expectations/requirements, and requests a proposal for the delivery of the specified services. After a public application period, all

grant applications are reviewed using an independent proposal review team. Proposals are scored on the content of the proposal. Based upon the results of the review, funding recommendations are provided to DHHR leadership for consideration and final decision.

In consideration of programmatic awards, West Virginia looks at past performance of programmatic applicants, ability to provide required activities, ability to provide services in the needed geographic location(s) and ability to manage federal funds per required guidance. In some instances, DHHR may direct award agencies for specific programs. In these cases, the agencies selected are the only providers eligible for this service. These awards may be in the form of a grant award or a purchase contract. An example of this type of process would be a contract with a data platform provider that is the sole source provider of an eligible software solution.

In order to effectively and efficiently respond to the opioid crisis, additional workforce was also needed by key state agencies to manage programs and provide the vision for services, as well as at the local level for direct service provision. The addition of qualified personnel takes time; however, this growth has been realized in large part and is already making a difference in the oversight, provision and delivery of the necessary programs. West Virginia has improved its infrastructure and ability to monitor this crisis by hiring additional personnel, acquiring new data systems, and improving the use of existing systems. Enhancements in this area have led to a greater understanding of the opioid crisis and its impact on individuals, families, counties and the state. For example, the PDO:PFS grant supports the Board of Pharmacy (BOP) data analytical team, which includes the first two epidemiologists ever hired by the BOP in order to increase the use of Prescription Drug Monitoring Program (PDMP) data. A research specialist was hired with federal funds from the CDC's ESOOS funding and sends a monthly internal fatal overdose report to key decision makers. Additionally, State Opioid Response (SOR) funding has allowed DHHR to employ additional Bureau for Behavioral Health personnel to ensure coordination across prevention and treatment activities, effectively doubling the workforce of the SSA that focuses on substance use disorder. Challenges often exist in staffing new initiatives in a timely manner. Due to the urgent nature of addressing opioid use and its outcomes, direct assistance from federal partners, such as the CDC, was extremely beneficial to quickly staff initiatives while allowing the state to work on internal hiring.

West Virginia faced several challenges in the deployment of federal resources to its local communities. Some of the issues involved a lack of infrastructure at the local community level to administer federal funding appropriately and/or a lack of a qualified workforce at the local level. To help address these issues, DHHR used technical assistance funds from SAMHSA to provide technical assistance to several entities on the state processes and federal grant requirements. These training opportunities will continue in the future as West Virginia works to strengthen and expand the capabilities of local and regional agencies providing services to those most in need.

Another way the state ensures that every county and every community impacted by this issue has some ability to respond to this crisis is by providing funding to agencies that are the backbone of the behavioral health system. As such, some level of funding has been provided to every county in the state. DHHR uses the SAPT, STR, and SOR to support the statewide behavioral health

infrastructure for prevention via six Prevention Lead Organizations to provide and build prevention infrastructure and activities, including the funding of county coalitions. Treatment is tasked to 13 regional Comprehensive Behavioral Health Centers (CBHC), which serve as the public behavioral health centers in the state. Funding has been awarded to all PLOs and CBHCs to increase capacity and enhance infrastructure to respond to the drug crisis.

The challenges associated with workforce cannot be overemphasized. Overall, West Virginia has one of the lowest participation rates in the workforce of any state in the nation at 53.9% in 2018. It is well known that engagement in the workforce is a factor that contributes to long-term recovery. To overcome the workforce shortages in the state and to promote recovery, West Virginia is actively working to address this issue with a jobs program. Governor Jim Justice's administration has created Jobs and Hope West Virginia (https://jobsandhope.wv.gov/), to help those in recovery locate employment and higher education. Transition agents are located throughout the state to help connect employed individuals with a substance use disorder to recovery and treatment options and unemployed individuals in recovery with jobs and education.

Prevention Works

West Virginia has a well-established Prevention First Network that includes state, regional and local leaders who contribute to prevention planning and coordination activities in the state, including the information and resources shared on Help and Hope West Virginia (https://helpandhopewv.org) and Stigma Free West Virginia (https://stigmafreewv.org). DHHR funds six Regional Prevention Lead Organizations and community coalitions via multiple federal SAMHSA grants. Several of these agencies also receive funds directly from SAMHSA's Drug Free Community program, HRSA, and other private and government grant programs. With support from DHHR, Prevention Lead Organizations collaborate with 51 county coalitions to implement evidence-based interventions in all 55 counties.

Media campaigns are also being used to provide anti-stigma messaging and inform the audience of available services and programs. A statewide media campaign is currently being tested using SOR funds to increase the awareness that addiction is a disease and reduce the stigma around MAT. All media campaigns direct residents to a 24/7/365 statewide call line, 1-844-HELP4WV, to help people seeking assistance access all levels of treatment and recovery. This state funded call line has fielded more than 41,000 calls since September 2015, with over 14,000 receiving a warm hand-off to a service provider.

West Virginia has also used funds from SAMHSA's SAPT, and STR to increase access to Naloxone, creating a statewide deployment strategy that addresses the highest risk counties in the state while also targeting high contact agencies and providers in other areas/counties. Through these efforts, DHHR has distributed over 10,000 doses of Naloxone to local health departments and Naloxone prescribing has increased 208% from 2017 to 2019. These funds are allowing services to literally save lives and build pathways to recovery.

Funding from SAMHSA's SPF Rx and SAPT sponsor drug take back activities to decrease potential diversion. Two drug take back days occurred in the past year with thirteen counties participating. A total of 269.7 pounds (lbs.) of medication were collected during these events. An additional 539.2 lbs. of medications were collected at permanent drop boxes. Additionally,

over 5,000 Drug Deactivation Kits have been distributed as part of this activity. It is important to note not all medications counted in these totals were controlled substances.

Treatment is Effective

West Virginia is making use of its federal and state funds to improve access to evidence-based treatment by increasing both providers and residential treatment capacity. West Virginia, a Medicaid expansion state, received a CMS 1115 Substance Use Disorder Demonstration Waiver, which has increased access for Medicaid covered individuals to treatment. Services under the waiver include Peer Recovery Support Specialist (PRSS) funding for stronger participant engagement and navigation of needed services; expansion of access to non-emergency medical transportation to and from treatment; and coverage of residential treatment services. West Virginia further leveraged this investment by using SOR funds to sponsor treatment for those individuals with no insurance or insurance that does not cover substance use disorder treatment.

As required by SAMHSA's STR, West Virginia completed both a strategic plan and a needs assessment. Due to a state mortarium on Opioid Treatment Programs (OTP), the only programs allowed to prescribe Methadone in West Virginia, the plan focused on other evidence-based strategies to increase access to buprenorphine and naltrexone. These activities included promoting and expanding the Comprehensive Opioid Addiction Treatment (COAT) model (a Hub and Spoke model for MAT), increasing the number of DATA-Waivered practitioners and use of the ECHO model for MAT (linking expert specialist teams at an academic 'hub' with primary care clinicians in local communities) to access treatment experts. Overall, federal funding (STR and SOR) has allowed West Virginia to expand access to clinically appropriate, evidence-based practices for out-patient treatment. In 2017, West Virginia had 243 DATA-Waivered providers but as of October 2019, the total has risen to 584. This is a 140% increase in the number of providers that can prescribe buprenorphine. A DATA Waiver is not required to prescribe naltrexone. West Virginia is closely monitoring the expansion of MAT, and there are residents in all 55 counties receiving MAT treatment. From January 2019 to October 2019, over 21,400 Medicaid members were prescribed MAT with approximately 30,000 Medicaid members with an opioid use diagnosis. Buprenorphine was most common MAT prescription (74%), followed by naltrexone (18%) and methadone (8%).

West Virginia has also been able to synchronize other sources of funding to complement its federally funded activities, specifically its drug settlement funding. West Virginia created an appropriations fund to receive state opioid settlements, known as the Ryan Brown Fund. These funds have been utilized to expand treatment capacity through the construction and renovation of new residential treatment and recovery support services. Through use of the Ryan Brown Fund, West Virginia has added 282 new treatment beds, with an additional 110 still under development. In response to the substance use disorder Waiver, another 133 beds have been made available for residential treatment. Treatment expansion has targeted all American Society of Addiction Medicine (ASAM) levels of care and has been designed to allow for increased accessibility no matter what region of the state someone may reside. When completed, this expansion will more than double the number of residential treatment beds available in 2016, allowing for greater access to clinically appropriate treatment models, specifically, MAT.

Some of the more innovative and exciting projects have involved cooperation across state agencies with differing funding streams. With the creation of the ODCP, we have seen increased cooperation and sharing of data and resources in pursuit of common goals. Using both SOR and state funds, West Virginia has begun to expand the use of MAT, including methadone, buprenorphine and naltrexone, to all ten of West Virginia's regional jails through a collaboration between different state agencies, allowing for fewer interruptions in treatment for those who become incarcerated. In addition, a 20-bed correctional unit has been established as an alternative to a court ordered prison term for individuals with substance use disorder who choose to participate in a long-term MAT program. Further cooperation is highlighted by the development of Law Enforcement Assisted Diversion (LEAD) programs in 15 counties, which aim to divert adults with substance use disorder from the criminal justice system to community-based treatment and recovery supports.

As West Virginia leads the nation in NAS, need for increased treatment for pregnant women was also identified as an area of high need in the STR strategic plan. The West Virginia Perinatal Partnership, using funding from DHHR and the Claude Worthington Benedum Foundation, started a wraparound, comprehensive treatment program in 2012 for pregnant women called the Drug Free Moms and Babies Program. Initial evaluation results were promising, and the program has since expanded from the original 4 sites to 11 additional sites for a current total of 15, with STR funding leading the expansion efforts. This expansion is also a prime example of collaborations across multiple funding streams to include multiple federal grants (Maternal and Child Health Title V Block Grant, SAMHSA's SAPT, and STR), state dollars, and private sector funding to address the need for treatment for pregnant women. It is important to note this expansion has allowed for a program in the catchment area of 63% of the 24 available birthing facilities in the state. As an example of the work being done in these programs, please note the video located on the Perinatal Partnership website: https://wvperinatal.org/initiatives/substance-use-during-pregnancy/drug-free-moms-and-babies-project/.

Using both the STR and SOR grants, DHHR provided funding to train over 1,000 professionals and peer recovery coaches on effective MAT practices, with a focus on pregnant and postpartum women, opioid overdose survivors, and hospital emergency departments. With SOR funding, West Virginia has worked with the three medical schools in the state to broaden their curriculum and professional development to expand the clinical workforce across West Virginia. In order to compliment the work of the medical schools, West Virginia created the state funded Statewide Therapist Loan Repayment (STLR) program. STLR will repay a portion of eligible student loan expenses in exchange for a 2-year substance use disorder service obligation at a qualified facility in West Virginia. Over 100 people applied demonstrating that, given the opportunity, people want to stay in West Virginia to address the drug crisis. To date, 22 clinicians or future clinicians have been approved for the STLR program and this number is expected to double in the next six months.

Quick Response Teams (QRT) have been established in 20 high risk communities using the SOR grant and state funds. These teams identify and engage individuals who have experienced an opioid-related overdose. Typically, teams are composed of emergency response personnel, law

enforcement officers or health department personnel and a substance use treatment or recovery provider. The purpose of a QRT is to identify individuals who have overdosed and engage them in treatment. Once a person has an opioid overdose and is revived by first responders, the Quick Response Team will contact and engage survivors within 24-72 hours to discuss treatment options. The team will contact victims through repeated house visits, phone calls, text messages, and other communication routes. The goal of QRTs is to reduce the incidence of repeat overdoses and overdose fatalities and to increase the number of people who participate in treatment for opioid use disorder.

Transportation, a long-term issue for rural states such as West Virginia, is being addressed in ways that allow for greater access to treatment and recovery services. As West Virginia is one of the most rural states in the nation, with a lack of mass transit options for many residents, transportation has long been a significant barrier in access to treatment and recovery services. Several strategies have been employed to address this barrier. The 1115 Substance Use Disorder Waiver allows Medicaid funded transportation to treatment via the non-emergency medical transportation provider. Additionally, with SOR funding, West Virginia has partnered with the West Virginia Public Transit Authority to offer after hours transportation and expanded route access to cover more rural areas specifically to assist individuals in accessing treatment and recovery services.

Recovery is Possible

Since 2016, West Virginia has also increased recovery options for those experiencing a substance use disorder. As noted above, PRSS have been added to the Medicaid funded system of care to increase engagement in recovery. PRSSs, individuals in recovery themselves, are critical to those in recovery. These positions serve as engagers and navigators to and through every level of care. To support recovery efforts, PRSSs have the knowledge and lived experience to not only connect persons in need of recovery to an appropriate program, but to also show the benefits of utilizing these ongoing supports.

Engagement activities as a pathway to treatment have also been expanded. STR and SOR funds have allowed PRSS to be located in regional jails, emergency departments, harm reduction programs, college campuses, and non-profit agencies. There are currently 347 PRSSs certified by Medicaid located throughout the state. As an example of the impact of PRSSs, approximately 3,340 individuals received peer support services through this initiative between May 2018 and April 2019. To strengthen peer services, the Bureau for Behavioral Health used STR funds to sponsor its first peer conference in April 2019 with 265 individuals attending. The two-day training session increased peer workers' intervention skills by practicing methods such as motivational interviewing and developing skills necessary to support others. Peer workers also learned about ethical guidelines and how to respond to overdose survivors.

West Virginia has funded recovery housing for many years utilizing SAMHSA's SAPT and state funds. Currently, there are over 1,200 recovery beds across West Virginia. The majority of the current recovery beds operate under an abstinence-based philosophy, creating a gap for individuals who choose MAT. With the growth in treatment access, West Virginia is utilizing state funds to expand recovery housing, with two current AFAs in process that are targeted to include all pathways of recovery, increasing the availability of MAT friendly recovery housing.

In 2019, West Virginia passed legislation, House Bill 2530, to allow DHHR to contract with an entity to serve as the certifying agency for a voluntary certification program for substance free recovery. The West Virginia Association of Recovery Residences (WVARR), a statewide chapter of the National Alliance of Recovery Residences (NARR), will expand the availability of well-operated, ethical, and supportive recovery housing. WVARR certification is open to any residence or provider willing and able to meet national best-practice standards. Additionally, the legislation requires that only certified agencies may receive referrals or funding from state agencies. WVARR will maintain a directory of recovery residences and serve as an oversight of recovery residence standards.

West Virginia recognizes family engagement is a crucial component of recovery and is expanding programs to support families remaining together by funding residential treatment centers that accommodate mothers and their children. Additionally, DHHR is seeking to identify childcare options for parents to utilize while seeking treatment. We currently have family residential treatment programs in five of the seven Ryan Brown regions with two additional programs in the planning phases for the two remaining regions (northern and eastern panhandles).

As noted earlier, Governor Justice has established a program, Jobs and Hope West Virginia, to help those in recovery locate employment and higher education. This program offers support through a statewide collaboration of agencies that provide West Virginians in recovery the opportunity to obtain career training and to ultimately secure meaningful employment. Transition agents are located throughout the state to help connect employed individuals with a substance use disorder to recovery and treatment options and unemployed individuals in recovery with jobs and education. In the first few months of operation, the 12 transition agents have already coordinated over 1,235 referrals. This program is being expanded to utilize PRSSs in conjunction with the transition agents to better serve the needs of those in the program.

Moving Forward

While significant progress has been made, certain barriers and challenges remain. West Virginia continues to experience workforce shortages, gaps in training related to psychostimulants and polysubstance use, and a lack of evidence-based practices for children impacted by this crisis. It is essential that West Virginia continue to utilize a multi-pronged approach to address workforce shortages. The state is seeking to increase workforce participation rates, especially by those individuals in recovery, retain our young people, and continue to support those individuals already in the workforce. It is challenging to identify flexible resources to fund the scholarships and loan repayment programs that will help keep recent graduates in West Virginia to provide substance use disorder treatment.

We know that our children have experienced multiple adverse childhood experiences which places them at a significantly higher risk for future problems. Continued research, monitoring, and support will also be needed for the children impacted by substance use disorder as some of the consequences of the drug crisis are not solved with treatment options, and some consequences are not yet known. The ability to use funding to address downstream effects and unintended consequences such as potential long-term effects of prenatal exposure to drugs is

crucial for the state to continue to address all facets of this crisis.

West Virginia is experiencing increased utilization of psychostimulants and polysubstance use. Federal funding allows appropriate flexibility to address opioid use disorder; however, the restriction to opioid use disorder only strategies limits the ability to be flexible in responding to emerging polysubstance use issues. Currently, these activities are being funded via other mechanisms, but additional flexibility would allow for streamlining processes. Overall, overdose deaths with opioid prescription involvement have been declining, and in 2018 will be the first year since 2014 there has not been an increase in overdose deaths involving fentanyl. However, the same cannot be said for overdose deaths involving psychostimulants. For example, in 2014, 3% of overdose deaths involved methamphetamine. In 2018, 36% of overdose deaths involved methamphetamine.

A key concern when utilizing time-limited grant dollars is sustainability of efforts in thinking about a bigger, longer-term investment if these endeavors are to have a significant impact and make death rates go down. With the two-year availability of funds some agencies are reluctant to risk expanding programs because of worries associated with sustainability. This concern also affects recruitment of highly qualified staff. The predictable and sustained provision of resources is key to allow States and providers to plan and rely on future year commitments. It can be difficult if not impossible to successfully plan and operate programs if providers are not confident resources will be available beyond a one-year commitment. While this remains a challenge, it has been helped substantially through the approval of carryover requests. From an administrative perspective, I would like to express appreciation for allowing both carryover requests and no-cost extensions. This has allowed West Virginia to implement projects that took additional time to complete but has also facilitated the state's ability to initiate additional projects beyond originally proposed work plans. This flexibility has also allowed the state to respond to unexpected changes in funding and infrastructure.

It would be difficult to believe that West Virginia could have accomplished so much without the support of this committee. These funds have allowed West Virginia to have the resources that it needed to respond to this crisis and resulted in a decrease in overdose deaths and transformed our system of care. The financial resources are crucial to our continuing success and maintaining momentum. While barriers remain, West Virginia is better poised to address future challenges and continue its forward progress. In summary, West Virginia wishes to say thank you to this Committee. Thank you for the support, thank you for the resources, and thank you for allowing us to share what is happening and what is working in West Virginia.

Ms. DEGETTE. Thank you.

Now, Mr. Kinsley, I would like to recognize you for 5 minutes.

TESTIMONY OF KODY KINSLEY

Mr. KINSLEY. Good morning. Thank you, Chair DeGette, Ranking member Guthrie, and the honorable members of the subcommittee for this opportunity to testify on North Carolina's response to the opioid epidemic.

On behalf of the 10.4 million North Carolinians, approximately 426,000 of whom misuse prescription or illicit opioids; I want to express my deepest gratitude, for your support of funding that has helped us turn the tide on the epidemic. This investment has saved lives, transformed communities, and has made the downpayment on breaking the cycle of addiction, trauma, and poverty in our state.

I'm also grateful to the committed staff of numerous federal agencies that have worked quickly to support a concerted strategy, working across interconnected systems of healthcare, housing, employment, and justice.

North Carolina was hit hard by the crisis. In 2016, 1,407 North Carolinians died of an unintended opioid overdose. For each death, there were six overdose hospitalizations. And we were one of the top eight states for fentanyl overdose deaths.

Since the start of the epidemic, nearly 100,000 workers have been kept out of the workforce because of the opioid misuse alone. Today, close to half of the children in North Carolina's foster care system have parental substance use as a factor in their out-of-home placement. And, of course, the human cost, the loss to communities and families, is immeasurable.

The scale of the problem underpins our magnitude of accomplishment. Our state's comprehensive response, the North Carolina Opioid Action Plan, is organized into three pillars: prevention, harm reduction, and connections to care.

These pillars encompass numerous strategies; all made possible because of federal funding: cutting the supply of inappropriate opioid prescriptions; making access to lifesaving naloxone ubiquitous; supporting syringe exchange programs; making addiction medicine a core of medical education; partnering with county and local communities; launching interventions at the starts of treatment that start treatment at the time of overdose reversal; and blending together broader efforts to support recovery in the housing, employment; and address the root causes of substance use disorder.

With these efforts, North Carolina saw the first decline in deaths in five years, decreasing nine percent between 2017 and 2018. We have also seen a 24 percent decline in opioid prescribing, and a 20 percent increase in the number of uninsured individuals receiving treatment.

One million North Carolinians do not have health insurance. And half of the opioid overdose visits to the emergency room are uninsured. Therefore, our highest priority has been expanding evidence-based treatments to those without insurance.

We have focused on medication-assisted treatment as the gold standard of care, providing treatment to an additional 12,000 people.

Our success is clear, but with your help, there is much we can do. We could stretch grant fathers—grant dollars further if doctors were no longer required to obtain a separate DEA waiver to prescribe buprenorphine for addiction. There is no additional waiver requirement to prescribe the exact same medication that is being prescribed for other conditions.

We should strengthen our focus on justice-involved populations. A recent study found that exiting North Carolina prisons were—prisoners leaving North Carolina prisons were 40 times more likely to die of an opioid overdose than the general population. We are grateful to have recently received a $6.5 million grant from the Department of Justice to create pre-arrest diversion programs and expand jail-based treatment in our state. But, with 56 prisons and 96 jails, we have a long way to go.

But most significant of all would be giving us more time. Sustaining funding over longer windows of time, or permanently, would allow states to ready systems for the next waive of the epidemic. That waive is already cresting, as we are starting to see rising rates of overdose deaths from methamphetamine and benzodiazepine.

Before major federal funding for this epidemic became available, 12,000 people in North Carolina had already died. Meanwhile, North Carolina's share of the substance abuse, prevention, and treatment block grant has not changed in recent years, while North Carolina was one of the fastest-growing populations in the country, growing nine percent between 2010 and 2018.

Growing the block grant at pace with population and inflationary costs, and an updated allocation formula would allow states to make better use of short-term funding, prevent the next epidemic, and save lives.

Most of all, safeguarding Medicaid expansion and the Affordable Care Act is critical to our long-term success in fighting the opioid epidemic. States with higher rates of insurance coverage have a more sustainable way of providing treatment, and are able to prioritize their precious federal block grant dollars and opioid response grants on system investments. This is why we are working hard every day to expand Medicaid in North Carolina.

In closing, I want to applaud the flexibility of much of the federal funding we have received, which has allowed each state to respond to its own pressing needs. Our strategies are working, but our eyes are on the horizon. We appreciate your leadership. And I welcome your questions.

[The prepared statement of Mr. Kinsley follows:]

STATEMENT OF

KODY KINSLEY

DEPUTY SECRETARY FOR BEHAVIORAL HEALTH AND IDD

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

A PUBLIC HEALTH EMERGENCY: STATE EFFORTS TO CURB THE OPIOID CRISIS

BEFORE THE

U.S. HOUSE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

JANUARY 14, 2020

Testimony

Good morning, I want to thank Chair DeGette, Ranking Member Guthrie, and the honorable members of the Subcommittee for the opportunity to testify on North Carolina's use of federal funds to combat the opioid epidemic in our state.

I am pleased to say that the story of these funds is a success story. And I want to applaud the members of this committee, and the many federal agencies who have worked hard to ensure that these vital funds are distributed quickly and efficiently.

These federal funds have directly enabled North Carolina to turn the tide on the opioid epidemic in our state. I'm excited to share with you the successes that we have been able to achieve directly because of these funds, and our ongoing efforts to build upon this progress.

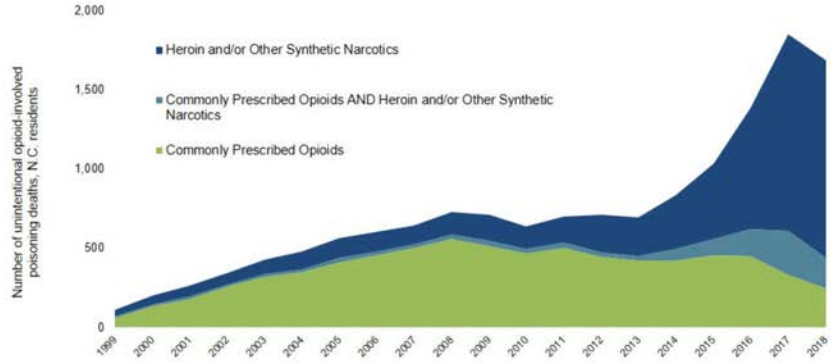
We are committed to fully abating the opioid epidemic in North Carolina and building a more resilient infrastructure that prevents future waves of drug use from reaching these same epidemic proportions.

The Scope of the North Carolina's Opioid Crisis

As you know, North Carolina was hard hit by the opioid crisis. The consequences have been large, and far reaching. Over the past two decades, we have lost more than 12,000 citizens to an opioid overdose. In 2016, North Carolina was in the top eight states for fentanyl overdose deaths alone.[1] Our data estimates that there are 426,000 North Carolinians that misuse prescription or illicit opioids.

[1] The Fentanyl Epidemic: State Initiatives to Reduce Overdose Deaths. (2019) Drug Strategies and Shatterproof. Available: https://www.shatterproof.org/download-fentanyl-report

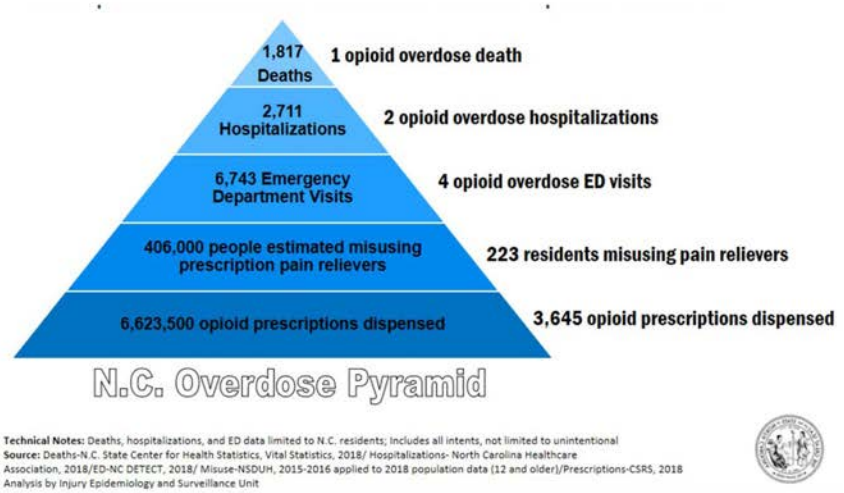
Figure: Unintentional Opioid Overdose Deaths in North Carolina, 1999-2018.



*Heroin and/or Other Synthetic Narcotics (mainly illicitly manufactured fentanyl and fentanyl analogues)

Technical Notes: Cases with only an Opium (T40.0) or only Other and Unspecified Narcotics (T40.6) code are excluded; Unintentional medication and drug poisoning: X40-X44 and any mention of T40.2 (Other Opioids), T40.3 (Methadone),T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics); Limited to N.C. residents
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 1999-2018
Analysis by Injury Epidemiology and Surveillance Unit

There is not a system in the state that hasn't been impacted by this crisis. For each opioid overdose death, there were approximately six overdose hospitalizations and ED visits.



Close to half of the children in the North Carolina foster care system have parental substance use as a contributing factor to their out of home placement. From the start of the epidemic in 1999, 99,700 workers have been kept out of the workforce in North Carolina because of the opioid crises alone - an almost three percent decline in the state's prime-age labor force participation.[2] [3]

And ultimately, the human cost- the loss to communities, to families- is immeasurable.

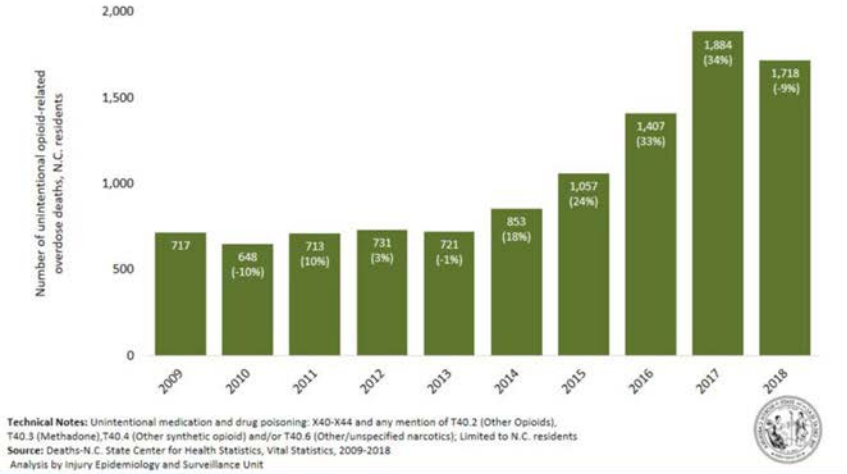
[2] American Action Forum. State-by-state: The labor force and economic effects of the opioid crisis. (2018) Available: https://www.americanactionforum.org/project/opioid-state-summary/#back-to-map

[3] Krueger. (2017). Where have all the Workers Gone? An inquiry into the decline of the U.S. Labor Force Participation Rate. Brookings Papers on Economic Activities. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6364990/#!po=0.862069

North Carolina has leveraged federal opioid funding to turn the tide on the crisis

The scale of the problem underpins the magnitude of the successes achieved, in large part enabled by the federal opioid dollars. Since 2016, when the first of the major federal opioid grants was received, North Carolina saw its first decline in opioid overdose deaths in five years, decreasing nine percent from 2017 to 2018.

Figure: Number of unintentional opioid overdose deaths in North Carolina, 2009-2018



We have also seen a 10% decline in opioid overdose emergency department visits, and a 20% increase in the number of people without health insurance and Medicaid beneficiaries receiving treatment for opioid use disorder.

We have achieved this by leveraging the federal opioid funds to execute a coordinated statewide strategic plan - The North Carolina Opioid Action Plan. The plan lays out specific high impact strategies to reduce overdose deaths and support the counties and communities on the front lines.

The Opioid Action Plan organizes our strategies into three core pillars of response. We want to 1) Prevent people from struggling in the first place 2) Reduce Harm to prevent overdose deaths and 3) Connect people to the care they need through both linkages to care and building treatment capacity.

Figure: North Carolina Opioid Action Plan Overview

Our success in leveraging federal funds to achieve many of our strategies in each of these three areas underpins the results we've seen.

Since 2016, North Carolina has received the following major federal awards to respond to the opioid epidemic through prevention, treatment, and recovery. The below grants total to $112.48M over three years, or $37.5 million per year. By the end of 2020, $104 million of the total $112M will be completed. A list of federal opioid grants received by DHHS is listed below.

Grant Name	Total Amount Awarded	Start date	End Date
SAMSHA State Targeted Response (STR) Grant	$31,173,448	05.01.17	01.31.20
SAMSHA State Opioid Response Grant	$46,066,632	09.30.18	09.29.20
SAMSHAM State Opioid Response Grant Supplement	$12,023,391	09.30.18	09.29.20
SAMSHA State Prevention Framework for Prescription Drugs (SPF-Rx)	$1,858,080	9/1/2016	8/31/2021
SAMSHA Medication Assisted Treatment-Prescription Drug and Opioid Abuse Program (MAT PDOA)	$2,873,291	09.01.16	08.31.20
CDC Public Health Crisis Response Funding for Opioid Overdose Preparedness and Response	$4,058,976	9/1/2018	11/30/2019
CDC Overdose Data to Action (OD2A) Gran	$7,003,731	9/1/2019	8/31/2022
CDC Prevention for States (PfS) Grant	$6,263,984	9/1/2015	8/31/2019
CDC Enhanced Surveillance of Opioid-Involved Morbidity and Mortality (ESOOS)	$1,166,004	9/1/2017	8/31/2019

In line with the great need, North Carolina has quickly deployed and utilized its federal funding. For example, North Carolina spent down 93% of its State Targeted Response Grant in year one and 90% in year two, one of the highest spend down rates in the nation for that grant. All

carryforward from the first year of the grant was spent down in year two. North Carolina is currently in a no-cost extension for the remainder of the year two funds and will fully spend down those funds by the end of that period in April 2020. NC DHHS also spent down over 90% of its CDC grant Public Health Crisis Grant in the first 12 months. This is a clear indication of our effectiveness in getting funds distributed, and that the funds are very much needed.

Connecting people to high quality, evidence-based treatment

Recognizing the criticality of treatment and responding to the high rates of uninsured in North Carolina, the single largest way North Carolina has leveraged its funds is in expanding evidence-based treatment, with a focus on medication assisted treatment as the gold standard of care. Through the SAMSHA State Targeted Response Grant and State Opioid Response grants, we have directly funded claims-based opioid use disorder treatment for more than 12,000 unique people through our public behavioral health safety net system. In accordance with General Statute, funding for direct services including treatment is provided through the local management entities-managed care organizations (LME-MCOs) that are responsible for the provision of publicly funded behavioral health services. These LME-MCOs then contract with direct service providers. There are seven LME-MCOs that provide services across all 100 counties. Due to the high need for treatment and recovery supports for people without health insurance, 100% of funds allocated to the LME-MCOs in year one of the State Opioid Response Grant have been spent down. Reflecting the scale of the demand in North Carolina, through the State Targeted Response Grant, LME-MCOs regularly spent down the entirety of their treatment funds before the end of the grant years.

Over the course of the grants, the number of opioid treatment programs - comprehensive programs that provide all three forms of MAT as well as psychosocial supports, care management, and other services - in the state has grown to over 80 programs.

North Carolina is also building the pipeline for the next generation of doctors to provide addiction treatment. Through these federal funds, we implemented a residency training program to incorporate addiction training and the DATA 2000 waiver training into the curriculum of medical resident, nurse practitioner, and physician assistant programs. The DATA 2000 waiver, named for federal Drug Addiction Treatment Act of 2000,[4] is the federally required DEA waiver to prescribe buprenorphine, one of the most commonly used forms of MAT. In the programs first year, over 900 current and future providers have received their waiver to prescribe, and more than 30 residencies will include this training in their curriculum ongoing.

In addition, four out of the five medical schools in North Carolina will now provide addiction training as part of their standard curriculum. We are working to establish that just like any other chronic disease - such as hypertension and like diabetes - addiction training should be part of the standard of medical education.

This program alone will mean that North Carolina has doubled its number of waivered providers in just one year. However, this enormous undertaking also demonstrates that the requirement to obtain a separate DEA waiver to prescribe buprenorphine for addiction is a barrier to expanding access to care. It is worth noting that there is no additional waiver requirement to prescribe the exact same medication, when its being prescribed for other conditions like pain. There are no additional waiver requirements for medicines with much higher risk profiles, like insulin and

[4]DEA Requirements for DATA Waived Physicians (DWPs)
https://www.deadiversion.usdoj.gov/pubs/docs/dwp_buprenorphine.htm

even fentanyl.[5] With this in mind, we applaud HHS's recent efforts to improve privacy regulations in 42CFR that have limited care coordination around addiction. These requirements reflect outdated approaches; there are modern solutions to ensure patient privacy while enabling us to move toward more integrated care.

We have also leveraged funds to build innovative linkage to care programs in a wide variety of settings. If we are going to invest heavily in building our treatment capacity, we must also make sure that the people who need it most are connected to that care. North Carolina's vision is that no door is the wrong door to getting high quality, evidence-based treatment, and that getting treatment should never be a matter of chance or luck.

Through the SAMHSA and CDC funds, North Carolina has piloted linkage to care programs by locating peer support specialists - state-certified individuals with lived experience - in emergency departments and with local EMS agencies to connect people who have recently experienced an overdose to care. We also implemented a novel pilot which uses EMS agencies to induct people on MAT and bridge them to community treatment providers.

This is most evident our work to connect people involved in the criminal justice system to care. North Carolina's justice system includes a state prison system with 127,000 people incarcerated, on probation or under post release/parole supervision in addition to our 100 counties, each with their own sheriff, local law enforcement, jails and courts.[6]

[5] Berk. (2019). To Help Providers Fight The Opioid Epidemic, "X The X Waiver". Health Affairs Blog. Available https://www.healthaffairs.org/do/10.1377/hblog20190301.79453/full/

[6] North Carolina Department of Public Safety. (2020). Department of Public Safety Statistics. Available: https://www.ncdps.gov/about-dps/department-public-safety-statistics

A recent study found that people exiting North Carolina prisons were 40 times more likely to die of an opioid overdose.[7] We directed federal funding to implement programs that connected people at various points in the justice system. This includes implementing four jail-based medication assisted treatment, including North Carolina's first jail to offer all three MAT medications, as well piloting connections to MAT through pre-arrest diversion, recovery courts, prison re-entry MAT programs, and community correction and supervision-based treatment programs.

A recent evaluation of a pilot program in Wilkes and Iredell counties, which connects people under community corrections supervision to medication assisted treatment found strong reductions in substance use, as well as a reduction in recidivism.

[7] Ranapurwala, Shanahan, Alexandridis, Proescholdbell, Naumann, Edwards, and Marshall. (2018). Opioid Overdose Mortality Among Former North Carolina Inmates: 2000–2015. American Journal of Public Health. Available: https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304514

Table: Wilkes-Iredell Community Correction pilot. Changes in Substance Use between Intake and Six Months

General Alcohol and Drug Use			
Substance	**Intake**	**Six Months**	**Percent Change**
Any alcohol	23.3	9.5	-66.31
Binge drinking (4/5+ drinks)	7.8	0.00	-100.0
All Misused Drugs*	92.2	37.9	-56.89
Prescription drugs only+	56.3	10.3	-81.71
Specific Drug Use			
Substance	**Intake**	**Six Months**	**Percent Change**
Marijuana	38.8	24.1	-37.89
Oxycontin/Oxycodone	33.3	2.6	-92.63
Benzodiazepines	22.4	10.3	-54.02
Cocaine	18.1	9.5	-47.91
Methamphetamine	21.6	9.5	-56.02
Heroin	16.4	2.6	-84.15
Percocet	12.9	0.0	-100.0
Morphine	8.6	0.9	-89.53
Codeine	4.3	.9	-79.07
Other misused drugs	64.7	8.6	-86.71

*All Misused Drugs includes unprescribed prescription drugs & misuse of prescribed drugs
+Subset of All Misused Drugs

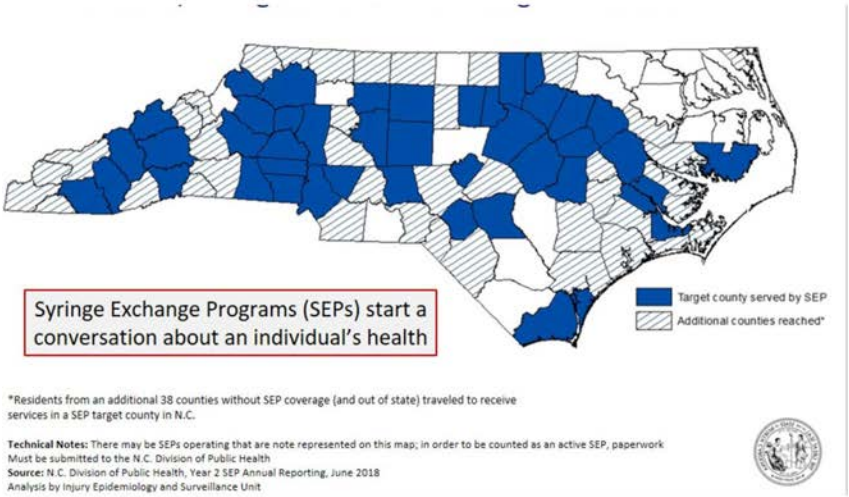
Changes in Involvement with the Justice System

Justice Involvement	Intake	Six Months	Percent Change
Confined in justice facility	15.4	1.9	-87.66
Committed crime	94.2	38.5	-59.13

And we were able to leverage these pilots to gain additional funding, having just received a $6.5 million grant from the Department of Justice's Bureau of Administration to expand these types of strategies to additional sites.

Preventing Overdose Deaths through harm reduction

North Carolina has also leveraged these funds to rapidly expand its harm reduction efforts. Harm reduction encompasses practical strategies that aim to immediately prevent overdose deaths. Although North Carolina only legalized syringe exchange programs in 2016, we now have 30 operating programs serving 42 of our 100 counties. The programs went from serving 5,000 people to serving 9,000 people in the last year, and made over 1,000 referrals to treatment, distributed over 19,000 naloxone kits, and provided thousands of tests for HIV and Hepatitis C.



Building the capacity of counties and communities on the front lines of the epidemic.

North Carolina has also worked closely with its counties and communities to implement key strategies from the NC Opioid Action Plan and give them the resources they need to respond where the state has been hit hardest. North Carolina has deployed its federal opioid funding to more than 50 county and community partners, including units of local government, including health departments; jails and county EMS; the Eastern Band of the Cherokee Indian, North Carolina's only federally recognized tribe; community-based organizations; local hospital systems; and community coalitions across the hardest hit areas in the state.

In the recent CDC Public Health Crisis Response Funding for Opioid Overdose Preparedness and Response, NC DHHS competitively awarded 22 local health departments to implement key strategies from the opioid action plan. The Local Health Department Request for Applications (LHD RFA) was open for all local health departments and districts in North Carolina. Applicants were scored on four content areas which included: (1) organizational readiness and assessment of need (includes burden of overdose deaths); (2) project description and sustainability; (3) evidence of collaborations/partnerships and letters of commitment; (4) and an evaluation plan. The Organizational Readiness and Assessment of Need portion required applicants to include epidemiological data to show how much their jurisdiction has been impacted by the opioid epidemic.

A list of partners who have received North Carolina federal opioid dollars is included at the end of this testimony for reference. This list may continue to evolve, including as new grants are awarded and as older grants come to a close.

We have also formed a strong coordinated infrastructure for response. Many counties have adopted the NC Opioid Action Plan to create their own county strategic response plan. The North Carolina Department of Health and Human Services (NCDHHS) convenes over 150 stakeholders from across the state through its Opioid and Prescription Drug Abuse Advisory Council every quarter. Its most recent meeting, which focused on jail-based MAT programs, drew over 350 people. This demonstrates both the relationship NCDHHS has built with the state's stakeholders, and the hunger and energy for these topics.

North Carolina has used additionally its SPF-Rx grant to adopt evidence - and practice-based strategies to address the two priorities of underage drinking and prescription drug misuse/abuse. The project has built the capacity and supported the development of partnerships with local communities. It has also strengthened the state's current prevention infrastructure at the local level by developing a systematic, ongoing monitoring system for substance abuse related consumption patterns and consequences; and track progress on prevention performance measures. It has also used prevention dollars on public education campaigns to increase knowledge about opioid disposal, safe storage, and the harms of sharing or misusing medications.

Tracking our progress and measuring our impact

North Carolina has additionally invested in improving its surveillance capacity to both rapidly monitor the state of the epidemic, but also improve our ability to deploy resources to the areas where it is most needed. North Carolina broadly evaluates its response to the epidemic and the implementation of the Opioid Action Plan using 13 metrics. These are regularly updated and

publicly available down to the county level at the NC Opioid Data Dashboard.[8] These metrics are tracked at the county level.

The impact of federal funds directed toward substance use disorder treatment are monitored in a number of ways. The NC Treatment Outcomes and Program Performance System (NC-TOPPS) is used to gather outcomes and performance data on behalf of all mental health and substance use disorder consumers in North Carolina's public system of services. For people receiving substance use disorder treatment, a wide range of metrics are monitored, including retention in treatment, engagement in recovery supports, Emergency Department visits, arrests and involvement of the justice system, family participation in treatment, employment, housing status and more. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' Quality Management section further annually conducts a gaps and needs assessment of the LME-MCO network, including examining patients served, number of providers accepting new patients, and number of LME-MCO members with choice of providers within 30 miles or 30 minutes for urban areas, or 45 miles or 45 minutes of their residency.

These are all examples of one undeniable conclusion: These federal funds saved lives.

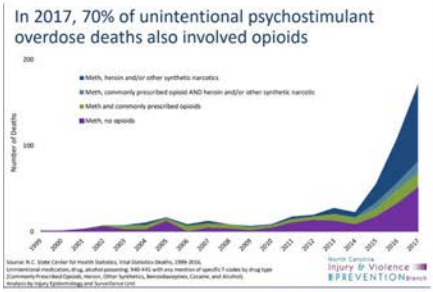
And we are very proud of what we have achieved. But the reality is we have much more work to do if we're going to truly abate this crisis.

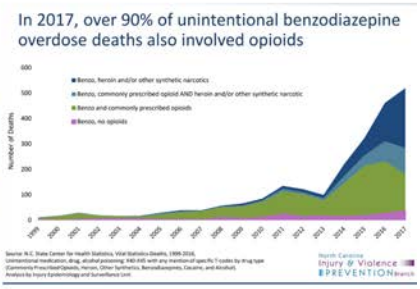
[8] https://injuryfreenc.shinyapps.io/OpioidActionPlan/

Rising overdose deaths from new emerging substance are driven by fentanyl contamination

Already, North Carolina is starting to see rising rates of overdose deaths from methamphetamine and benzodiazepines. More than 70% of these overdose deaths involved fentanyl contamination, which suggests that the epidemic is shifting once more.

Figures: Percent of benzodiazepine and psychostimulant deaths involving opioids in North Carolina





I started my professional career at a substance use disorder and behavioral health treatment center in Western North Carolina. Those of us who have been in this field long enough know that these epidemics come in waves. Today it is opioids, in the coming years it will be something new: methamphetamine, benzodiazepines, cocaine. Just like there were the waves of crack and cocaine in the decades before this one.

Sustainable and flexible funding is critical for both maintain the progress made, and more permanently abating the epidemic.

This is because all of these are just symptoms of the broader disease of addiction. We must build a robust infrastructure that can move further upstream to prevent and treat the root causes of addiction. Otherwise, we will just be squeezing the balloon, reactively responding to each new wave of emerging substances.

Our experiences are a clear example of why flexible and sustainable funding is both critical to maintaining the success of these funds and unlocking the tools we need to ensure we are building a proactive response.

We are very proud of the 12,000 uninsured persons we were able to treat through our federal funding. But this is only a start to meeting the full need in our state. In North Carolina, for every single person who is brought to the emergency department, nearly **half** has no health insurance at all.

Governor Cooper has made expanding Medicaid under the ACA one of his top priorities and remains committed to that goal. It is the most important tool in a sustainable response to the opioid epidemic and would bring an additional $4 billion into North Carolina for healthcare.

But until that goal is realized, these federal funds are often the only way people without insurance can afford the lifesaving treatment they need. The current reality in North Carolina is that those 12,000 people could lose their support for addiction treatment if these funds are not continued.

Sustainable funding also unlocks new activities to further our response. One of the biggest needs from our counties, communities, and treatment providers is to build capacity. However, it is

difficult to hire the staff when funding is just a one- or two-year cycle, and there isn't certainty about the future of the funding.

Treatment providers in rural and underserved areas need to know that there is sustainable and long-term funding for them to build and expand in the areas that need them the most. I often make the analogy that you wouldn't build a hardware store if there was only two years of funding for nails.

We are very appreciative of the funding models set forward by the Substance Abuse Prevention and Treatment Block Grant and recommend a transition over time from opioid specific resources to investing in the Substance Abuse Prevention and Treatment Block Grant to ensure long term sustainability of these funds. Simply giving us more time would be incredibly impactful. Sustaining funding streams over longer windows of time - or permanently - would allow states to ready systems for the next wave of the epidemic.

Finally, I want to applaud the flexibility of much of the federal opioid funding provided, which has allowed each state to respond to its own pressing needs. To advance our response, there is a need for increased access to funding that can be spent on capital projects and infrastructure. In many of the NC communities hardest hit by the opioid epidemic, it is difficult to implement programs and build treatment and recovery access because the community lacks basic infrastructure, including broadband and cell phone services. In many places, facilities need to be constructed to provide adequate services.

I want to thank you again for the opportunity to share North Carolina's experience deploying federal opioid funding, and I welcome your questions.

Appendix- Funding Recipients, Amount Allocated, and Purpose

Recipient	Federal Grant	Purpose	Amount Allocated	Type of entity
Buncombe County Local Health Department	CDC Public Health Crisis Response Funding for Opioid Overdose Preparedness and Response	Recruit and fund local health departments/districts in North Carolina to implement strategies to prevent fatal and non-fatal opioid overdoses, increase access and linkages to care services for the most vulnerable populations, and build local capacity to respond to the opioid epidemic in North Carolina.	$98,024.61	Local Governmental Organization
Stanly County Local Health Department	Same as above	Same as above	$99,808.97	Local Governmental Organization
Cleveland County Local Health Department	Same as above	Same as above	$68,925.00	Local Governmental Organization
Cabarrus County Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Iredell County Local Health Department	Same as above	Same as above	$85,972.73	Local Governmental Organization
Mecklenburg County Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Macon County Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Durham County Local Health Department	Same as above	Same as above	$98,530	Local Governmental Organization
Wake County Local Health Department	Same as above	Same as above	$99,935.33	Local Governmental Organization

Dare County Local Health Department	Same as above	Same as above	$93,193	Local Governmental Organization
Beaufort County Local Health Department	Same as above	Same as above	$26,943	Local Governmental Organization
Guilford County Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Haywood County Local Health Department	Same as above	Same as above	$66,383.47	Local Governmental Organization
Pitt County Local Health Department	Same as above	Same as above	$59,484.20	Local Governmental Organization
Appalachian District Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Alamance County Local Health Department	Same as above	Same as above	$67,769	Local Governmental Organization
Granville-Vance County Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Nash County Local Health Department	Same as above	Same as above	$20,000	Local Governmental Organization
Forsyth County Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Davie County Local Health Department	Same as above	Same as above	$67,613.39	Local Governmental Organization
Onslow County Local Health Department	Same as above	Same as above	$95,700	Local Governmental Organization

Hoke County Local Health Department	Same as above	Same as above	$100,000	Local Governmental Organization
Alexander County EMS	CDC Public Health Crisis Response Funding for Opioid Overdose Preparedness and Response	Distribute funds to local EMS agencies to develop or enhance post-overdose response teams to prevent overdose and connect those who have had a non-fatal overdose to harm reduction, care, treatment, and recovery support.	$6,000	Local Governmental Organization
Guilford County EMS	Same as above	Same as above	$20,000	Local Governmental Organization
Macon County EMS	Same as above	Same as above	$20,000	Local Governmental Organization
McDowell County EMS	Same as above	Same as above	$20,000	Local Governmental Organization
Onslow County EMS	Same as above	Same as above	$20,000	Local Governmental Organization
Pasquotank Camden & Perquimans County EMS	Same as above	Same as above	$30,000	Local Governmental Organization
Stanly County EMS	Same as above	Same as above	$20,000	Local Governmental Organization
DHHS/Division of Mental Health/Developmental Disabilities and Substance Abuse Services	PfS and OD2A	Improve NC's PDMP (Controlled Substances Reporting System, CSRS) functionality, timeliness of data, interstate/intrastate operability, use for public health/tracking high risk prescribing behaviors, and active management to inform provider reporting. Funds will also support integration of PDMP with other health systems data and ensure that the PDMP is easy to use and access by all providers in NC.	$315,000	State agency
University of North Carolina Injury	PfS, OD2A, Crisis and ESSOS	Provide additional epidemiologic expertise to our program. Provide technical assistance that is not available in the Division of Public Health.	$2,256,397	Public University

Prevention Research Center (UNC IPRC)		Work closely with NC DETECT (state Emergency Department data system) to develop local dashboards and training local health departments to track and monitor drug-related events. Support statewide academies to train DPH staff and partners in evidence-based strategies in medication and overdose prevention and evaluate and improve the method of conducting the community partner training. Provide epidemiologic and data support to support the NC-Enhanced Project coordination and expand nonfatal drug overdose and dissemination of this data. Partner with NC DETECT (ED data) to hire and supervise Graduate Research Assistants (GRAs) to complete outlined activities around nonfatal surveillance and development of dashboards and portal. Support a multi-state peer-to-peer overdose prevention initiative to convene partners to identify promising practices and effective strategies from the field in other states, including but not limited to NC. Include multiple process evaluations to ensure that key components can be replicated in other areas and for future scaling up.		
Department of Insurance	Crisis and OD2A	In collaboration with the Office of Chief Fire Marshall, NCDOI provides state-wide communication on safe prescription drug use, storage and disposal through Operation Medicine Drop.	$200,000	State Agency
DHHS/Division of Health Service Regulation	PfS/OD2A	Enhance the Office of Emergency Medical Systems (OEMS) training and tracking efforts among EMS agencies, systems, and other partners in response to the opioid epidemic	$277,800	State Agency
The National Foundation for the Centers of Disease Control and Prevention, Inc. (CDC Foundation)	OD2A	Provide surge staffing needs for the opioid crisis and response to NC.	$199,500	Federal Partner
Governor's Institute, Robeson Health Care Corporation (RHCC), Insight Human Services, RHA Health Services, Dare County Health Department, Community Impact	State Prevention Framework for Prescription Drugs (SPF-Rx)	North Carolina has used its SPF-Rx grant to adopt evidence- and practice-based strategies to address the two priorities of underage drinking and prescription drug misuse/abuse. The project will build state-wide capacity and support the development of partnerships with local communities. It will also strengthen the state's current prevention infrastructure at the local	$1,858,080	Local Government, community-based organization

NC (CINC), Wake Forest University Health Sciences (WFUHS), Pacific Institute for Research and Evaluation (PIRE), North Carolina Training and Technical Assistance Center (NCTTA)		level by developing a systematic, ongoing monitoring system for substance abuse related consumption patterns and consequences; and track progress on prevention performance measures.		
Governor's Institute, Robeson Health Care Corporation, Burke Recovery, Cleveland County Health Department, Insight Human Services, Coastal Horizons Center, Project Lazarus, RHA Health Services, Port Health, Dare County Health Department Community Impact NC, North Carolina Training and Technical Assistance Center (NCTTA)	State Targeted Response Grant	Substance use prevention education media campaign, and implementation of substance use prevention efforts including evidence-based practices and curricula training, prevention, and recovery policy summit, Provision of technical assistance to high need counties, and direct funding to twelve counties to implement prevention strategies	$2,230,771	Local Government, community-based organization
Lighthouse Software Systems	State Targeted Response Grant	Funds the license for the Central Registry, the software used by all Opioid Treatment Programs (OTPs) in the state for data collection and oversight.	$121,200	For Profit
Recovery Communities of NC	State Targeted Response Grant	Post overdose rapid response team and evaluator for recovery supports and connections to care after an overdose.	$37,500	Community based organization
LocalLocal Management Entity-Management Care Organizations (LME-MCOs): Alliance Health Cardinal Innovations Eastpointe LME/MCO Partners Behavioral Health Management Sandhills Center Trillium Healthcare Vaya Health	State Opioid Response Grant	ASAM Levels of Care: • ASAM Level 1 (individual, group, family therapies, medication administration, medication management, etc.) • ASAM Levels 2.1 (SAIOP) and 2.5 (SACOT) Medication Assisted Treatment Recovery Supported Housing	$27,375,950	Quasi-Governmental Organization

DSS-Involved Families Pilot	State Opioid Response Grant	Pender, Onslow and Haywood identified through RFP process as 3 counties with the highest rates of DSS-involved families due to SUD, implemented strategies and services to reduce out-of-home placements. Approximately 75 participants	$400,000	Local Government
Department of Public Safety	State Opioid Response Grant	In partnership with the Department of Public Safety, provide funding to 2 reentry centers where incarcerated individuals, readying for exit, receive naltrexone and work with dedicated staff to connect to SUD services in the community and other needed supports.	$466,281	State Agency
Eastern Band of the Cherokee IndiansIndian	State Opioid Response Grant	Based on the needs assessment submitted, provide funding to NC's only federally recognized tribe for services, supports and trainings to augment current MAT services. Activities include development of a community rapid response team, extensive training in culturally-appropriate trauma-informed care (Beauty for Ashes), training in and purchase of a biofeedback machine (to focus on pain management), implementation of a tobacco cessation curriculum for individuals receiving OUD treatment.	$1,329,994	Federally Recognized Tribe
Eastern Band of the Cherokee Indian Hospital Authority	State Opioid Response Grant	Naloxone kits Training in naloxone administration Implementation of a media campaign	$1,001,394.00	Federally Recognized Tribe
Oxford House	State Opioid Response Grant	Oxford House Reentry Coordinators x 2, to collaborate with the Reentry Initiative described above, as well as work with other re-entering individuals with an OUD in need of recovery supported housing	$1,114,443	Community based organization
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	State Opioid Response Grant	Salary of staff to implement grant, including grant required positions - .05FTE Principle Investigator, State Opioid Coordinator, Project Director, Assistance Project Director, Data Analyst, Data Coordinator, Fringe, Travel, and office supplies	$584,771	State Agency
External contractors for evaluation, PDMP services, and GPRA implementation	State Opioid Response Grant	1. Evaluator- Analysis of NC TOPPS, GPRA & other desired data 2. PDMP software module (NarxCare) 3. GPRA- Analytic tools to assist with GPRA entry, uploads, and analysis	$563,990	External organization

Local Management Entity- Management Care Organizations (LME-MCOs): Alliance Health Cardinal Innovations Eastpointe LME/MCO Partners Behavioral Health Management Sandhills Center Trillium Healthcare Vaya Health	State Targeted Response Grant	ASAM Levels of Care: • ASAM Level 1 (individual, group, family therapies, medication administration, medication management, etc.) • ASAM Levels 2.1 (SAIOP) and 2.5 (SACOT) Lab services FDA Approved Medications (Methadone, buprenorphine, naltrexone, probuphine) Peer mentoring, peer coaching, recovery partners. Transportation, childcare and other services	$10,843,163	Quasi-governmental organizations
Oxford House	State Targeted Response Grant	Oxford house re-entry coordinator, data and reporting specialist, direct costs	$231,666	Community based organization
UNC Chapel Hill Project ECHO	State Targeted Response Grant	Enhancement of current ECHO for MAT project based out of the University of North Carolina-Chapel Hill	$1,012,739	Local University
North Carolina Healthcare Association	State Targeted Response Grant	Emergency Department Peer Support Specialist Pilot which placed peer support specialists in 6 emergency departments to connect people to care after an overdose.	$1,373,653	Community Based Organization
NC DHHS Information Technology Division	State Targeted Response Grant	Modify current Drug Regulatory management system (DRUMS) to enable the NC SOTA application, registration, inspection and surveillance paper-based processes to be integrated into the NC Controlled substances reporting Acts DRUMS a state of the art MS SQL database. Developer, Staff, and Supplies	$442,257	State Agency
Buncombe County Jail Durham County Jail Haywood County Jail New Hanover County Jail Watauga County Sheriff's Office	State Opioid Response Grant Supplement	Jail based Medication Assisted Treatment Program in four counties to continue and induct inmates on medication assisted treatment. Watauga county pre-arrest diversion program	$1,256,425	Local Governmental Organizations
WakeMed, Duke, and Duke Regional Hospitals	State Opioid Response Grant Supplement	Expansion of Medication Assisted Treatment in the Emergency Department	$1,349,000	Local hospital systems
Licensed Management Entity-Management Care Organizations (LME-MCOs):	State Opioid Response Grant Supplement	ASAM Levels of Care: • ASAM Level 1 (individual, group, family therapies, medication administration, medication management, etc.) • ASAM Levels 2.1 (SAIOP) and 2.5 (SACOT)	$8,927,063	Non-governmental organizations

Alliance Health Cardinal Innovations Eastpointe LME/MCO Partners Behavioral Health Management Sandhills Center Trillium Healthcare Vaya Health		• Opioid Treatment/Medication Assisted Treatment Medications – FDA-approved medications = Labs/Toxicology Estimated 842 patients at an average cost of $633 per month x 12 months		

Ms. DEGETTE. Thank you.

Dr. Alexander-Scott, you are now recognized for 5 minutes for your opening statement.

TESTIMONY OF NICOLE ALEXANDER–SCOTT, M.D.

Dr. ALEXANDER-SCOTT. Thank you. Chairwoman DeGette, Ranking Member Guthrie, and distinguished members of the Committee, thank you for inviting me to join you today to discuss Rhode Island's efforts to address the opioid overdose epidemic.

Collaboration between states, federal agencies, and federal leaders such as yourselves is critical to our shared goals of preventing overdoses and saving lives.

This issue has taken a staggering toll on my state. Since I became the Director of the Rhode Island Department of Health in 2015, an overdose death has occurred in every city and town in Rhode Island. During this time, more Rhode Islanders have lost their lives to drug overdoses than to car crashes, firearms, and fires combined.

Almost immediately after coming into office in 2015, Governor Gina Raimondo formed an Overdose Prevention and Intervention Task Force to develop a centralized, strategic, data-driven comprehensive plan to prevent overdoses. The task force includes stakeholders and experts in various fields, including public health, law enforcement, behavioral health, community-based support services, education, veterans' affairs, and recovery.

As a co-chair of this task force, I have helped steer our efforts into our four focused areas: prevention, treatment, recovery, and rescue or reversal. We have changed the culture of prescribing in Rhode Island and have dramatically reduced our prescribing numbers.

We now have a vast statewide treatment network in place.

We have cultivated a group of certified peer recovery specialists who work side-by-side with people in recovery.

We have put thousands of naloxone kits onto the streets.

And, most importantly, we have started to give people hope. And we're focusing at the community level.

We have learned that regardless of your race or ethnicity, regardless of your ZIP Code, income, or insurance status, every door for every person should make treatment and recovery services available. We believe that addiction is a disease, and recovery is possible.

One prime example is the story of Jonathan Goyer from East Providence, Rhode Island. Jonathan became dependent on opioids at 15 years of age. At 25, after more than 30 tries, and after reaching depths that many of us could not fathom, he was finally able to find, sustain, and maintain a life in long-term recovery.

He is now thriving as an expert advisor to Governor Raimondo's task force, and he leads our state's recovery-friendly workplace program.

When you talk to Jonathan about his journey, he says, "The opposite of addiction is not sobriety. The opposite of addiction is connection." This is true for every community.

We are trying to make the connection and the sense of community that brought Jonathan and so many others back from the

brink a part of every overdose prevention effort we put in place in Rhode Island. We have had some success.

After the number of drug overdose deaths increased each year in Rhode Island for the better part of a decade, that number decreased by 6.5 percent between 2016 and 2018. However, significant challenges remain. Fentanyl-related overdose deaths continue to increase. And the opioid conversation must be considered within the larger context of an addiction epidemic that has alcoholism, tobacco use, cocaine use, and other substances involved.

We can broaden the scope even further to talk about the health implications of social and emotional isolation, and the need to address the root causes of these challenges in our community. All of this requires us to look beyond what many believe to be our traditional focus areas in public health.

We need to look at the socioeconomic and environmental determinants of health which determine roughly 80 percent of what makes you healthy and what makes me healthy. These are factors like access to quality education, access to fresh fruits and vegetables, and reliable transportation.

We need to ensure that all children grow up in homes and go to schools where they feel safe, supported, and loved; to ensure that people have the houses that are healthy, safe, and affordable; and to ensure that people have jobs that offer fair pay. This is a part of our response.

The efforts and the progress that I've outlined today would not have been possible without the tremendous contributions of Congress and the federal agencies you fund. I thank you for that sincerely. I look forward to partnering with you to address what lies ahead on behalf of Rhode Island and on behalf of the Association of State and Territorial Health Officials, where I served as immediate past president.

Thank you.

[The prepared statement of Dr. Alexander-Scott follows:]

Written Testimony of
Nicole Alexander-Scott, MD, MPH
Rhode Island Department of Health
Before the
House Energy and Commerce Oversight and Investigations Subcommittee Hearing
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"
January 14, 2020

Chairwoman DeGette, Ranking Member Guthrie, and distinguished members of the committee, I am pleased to testify before you today to discuss Rhode Island's efforts to curb the opioid crisis.

As the Director of the Rhode Island Department of Health (RIDOH), I have the privilege of serving under the leadership of Governor Gina M. Raimondo, and with Womazetta Jones, the Secretary of Rhode Island's Executive Office of Health and Human Services. I am also the Immediate Past President of the Association of State and Territorial Health Officials (ASTHO), the national organization representing public health agencies in the United States, the U.S. Territories, and the District of Columbia. The members of ASTHO, who are the chief health officials of these jurisdictions, formulate and influence public health policy and ensure excellence in state-based public health practice.

In my capacity as the Director of RIDOH and through my work with ASTHO, I have seen firsthand the tremendous contributions that Congress and federal agencies have made to our nation's response to the opioid overdose crisis. In particular, Congressman Jim Langevin and Congressman David Cicilline have been tireless advocates for the health and safety of the individuals and families impacted by opioid-use disorder. I also want to commend the tremendous vision and leadership of U.S. Surgeon General Jerome Adams who has personally come to Rhode Island to engage in dialogue about the innovative steps that can be taken at different levels of government to helps us prevent overdoses and saves lives. Health officials throughout the country firmly believe that preventing individuals from misusing opioids and other substances in the first place is the best way to end our nation's epidemic. I stand ready to partner with you in this effort.

Like every state in the nation, Rhode Island has been profoundly affected by the opioid overdose epidemic. Since I became the Director of RIDOH in 2015, an overdose death has occurred in every city and town in Rhode Island. During this time, more than 1,500 Rhode Islanders have lost their lives to accidental drug overdoses, more than have died from car crashes, firearms, and fires combined. As we parse various policy proposals and discuss different data trends, it is important for us to pause and remember that behind every one of those fatalities there is a story, there is a family, and there is the tremendous pain associated with loss. These people are our brothers and sisters, our co-workers, neighbors, and friends. They are the people we have known for years through church, synagogue, or mosque, or from little league, or the PTA. We can't

bring these people back. But we can honor them and love them as a community by doing everything we can to prevent any additional drug overdose deaths.

This is a sentiment shared wholeheartedly by Governor Raimondo. Overdose prevention was an absolute priority for her when she came into office in 2015. For this reason, she acted quickly to address the fact that Rhode Island did not have a centralized, strategic, comprehensive plan to address our state's drug overdose crisis. She knew that it was not enough to treat individual overdoses; recovery support services needed to be expanded to embrace the full scope and depth of treatment, and impactful prevention strategies needed to be put in place. In response, she formed an Overdose Prevention and Intervention Task Force. This Task Force is led by me and Kathryn Power, the Director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The Task Force includes stakeholders and experts in various fields including public health, law enforcement, healthcare, community-based support services, education, veterans' affairs, insurance, academia and research, and government. Also included are family members of those who have lost loved ones and people in active recovery. Their perspectives have been invaluable.

The Task Force created, and has been building upon, a data-driven, community-informed Strategic Plan to prevent overdoses and save lives. The four focus areas of the plan are prevention, treatment, recovery, and rescue. One of the greatest strengths of Rhode Island's response has been our utilization of data and our dissemination of data. Rhode Island's progress toward the goals of the Task Force, and a wealth of additional data on opioid-use disorder, are available in a user-friendly format in seven different languages at www.preventoverdoseri.org. People who are looking for help for substance-use disorder can also go to this website to find resources and support. This website was developed and is maintained in partnership with the Brown University School of Public Health.

A second strength of our overdose response efforts in Rhode Island has been our ability to braid funding and build synergy between efforts supported by various federal funding sources. Over the past four years, and extending through at least 2022, overdose response efforts in Rhode Island have been (and will be) supported by $76,751,128 from a range of federal agencies funded by Congress: the U.S. Department of Justice (DOJ), the Bureau of Justice Assistance (BOJ), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Labor (DOL), and the Substance Abuse and Mental Health Services Administration (SAMSHA). Our ability to align our various efforts in Rhode Island with all of the different requirements of these varied funders is a testament to the culture of collaboration that has been nurtured in our state. By braiding these funds, we have coordinated multiple funding sources while maintaining meticulous accounting of each to address the prevention, treatment, and recovery needs impacting every part of the state. However, none of this would be possible without your support of the grantmaking work of these agencies.

An enormous amount of work is still before us. For example, fentanyl-related overdose deaths continue to increase in Rhode Island, and overdoses involving multiple substances is a growing concern. However, the targeted efforts of the Task Force have helped Rhode Island make some progress. After the number of drug overdose deaths increased each year in Rhode Island for the better part of a decade, that number decreased by 6.5% between 2016 and 2018. (Rhode Island's

2019 data are not yet finalized.) Additionally, Rhode Island has made tremendous progress in shifting public perceptions surrounding opioid-use disorder. We have started to lessen the stigma driven by fear, discrimination, and bias, that for too long has kept people from coming forward and saying that they need help. Opioid-use disorder is a chronic illness, in the same way that diabetes, asthma, and heart disease are chronic illnesses. We are still learning about the complex interplay of developmental, biological, neuropsychological, and social factors that result in the development of opioid-use disorder. However, we know unequivocally that it can be treated. Public health agencies must make it a priority to address the stigma that gets between people and the care that they need.

Prevention

It is impossible to consider the opioid-use disorder crisis in America without confronting the socioeconomic and environmental determinants of health. Research has demonstrated that socioeconomic and environmental determinants of health, such as housing, community environments, employment, and education, determine roughly 80% of health outcomes at the individual and community level. Rhode Island's Health Equity Zones (HEZs) are a significant component of our response to the current crisis in that they are helping to build community level frameworks for resiliency and healthy living. In the ten HEZs throughout Rhode Island, residents and community partners are coming together to address the root causes of health disparities at the local level and to build healthier, more resilient communities. Again, with braided funding from a variety of federal sources, HEZs have, for example, helped get naloxone in the community, set up drop-in centers to strengthen support and social connections among members of the recovery community, implemented programs to address the impact of trauma, and helped expand job opportunities in specific communities. More information about HEZ is available online at: www.health.ri.gov/HEZ.

Prevention work in Rhode Island has also included changing the way our healthcare providers approach the treatment of acute and chronic pain. In 2017, RIDOH enacted regulations that limited the initial prescription of an opioid to no more than 20 doses and no more than 30 morphine milligram equivalents, or MMEs (this is a measure of potency), for individuals new to opioids. These regulations also prohibited long-acting or extended-release opioids for initial prescriptions for acute pain (like methadone) for people new to opioids. Subsequent regulations in 2018 required healthcare providers to have conversations with their patients on the risks of taking an opioid prescription. These conversations need to cover the risks of dependence, and alternative treatment options, among other topics.

RIDOH's Prescription Drug Monitoring Program (PDMP) has also been central to Rhode Island's work to prevent overprescribing. The PDMP is a centralized data repository related to controlled substance prescribing. Data in the PDMP can be used by prescribers and pharmacists to understand what controlled substance prescriptions are being written for their patients. Prescribers are required to check the PDMP prior to writing a controlled substance prescription for the first time and every three months thereafter for patients on long-term opioid therapy. In 2016, RIDOH launched a campaign to increase utilization of the PDMP. At the time, only 70% of Rhode Island prescribers were enrolled in the system, and only 40% were using it. Today, 100% of prescribers are enrolled. (The PDMP is supported by the CDC's Prescription Drug

Overdose Prevention for States grant and the DOJ's Comprehensive Opioid Abuse Site-Based Program grant.) We continue to make the PDMP more user friendly (for example, by integrating the PDMP into electronic health records). And we are working toward the goal of making Rhode Island's PDMP meet specific CMS quality standards by 2022 (making it a "qualified PDMP," in CMS terms).

Together, these efforts have had a significant effect. Between 2017 and 2019, Rhode Island saw a:

- 25% decrease in number of opioid prescriptions
- 38% decrease in number of people co-prescribed opioids and benzodiazepines (benzodiazepines are a class of drugs primarily used for treating anxiety; patients who are co-prescribed opioids and benzodiazepines are at elevated risk for overdose)
- 31% decrease in the number of people receiving new opioid prescriptions
- 41% decrease in the number of prescriptions for high-dose opioids
- 4% decrease in the median MME per prescription

A form of innovative, secondary prevention that the Rhode Island State Police have put in place is our Heroin-Opioid Prevention Effort (HOPE). HOPE brings law enforcement officers and substance abuse professionals together to make sure those who are struggling with substance-use disorder receive the help they need. Service teams that include a counselor, a Certified Peer Recovery Specialist, and a plain-clothes State Police officer do personal follow-up with people who have recently overdosed, regardless of involvement with the criminal justice system. HOPE also provides a ride home or to a treatment facility for individuals who have been in custody and are being released. The program offers human connection, support, and care. This program is supported by the DOJ's Comprehensive Opioid Addiction Program.

Treatment

Treatment saves lives. Expanding access to FDA-approved medications for the treatment of opioid-use disorder, including methadone, buprenorphine products, and injectable naltrexone, is critical to addressing the overdose epidemic. It is also critical that treatment be provided in the context of recovery support services. These supports vary based on patient need, but include drug and alcohol counseling, screening and treatment of co-occurring mental and physical health issues, consulting the PDMP, toxicology screening, individual and group therapies, and peer support services. Task Force leadership has worked closely with the leaders of large primary care practices throughout Rhode Island to address barriers to providing treatment.

Strategically leveraging federal funding, Rhode Island has also made a significant investment in the establishment of Centers of Excellence for the Treatment of Opioid Use Disorder. BHDDH oversees 13 Centers of Excellence throughout Rhode Island that provide comprehensive evaluation, including mental health evaluation and treatment or referral, induction and stabilization services, as well as the additional services listed above. Employing a "circulatory system" model, which builds on the "hub and spoke" model, Centers of Excellence work collaboratively with community treatment providers, where patients can go once stabilized. This

"circulatory system" model supports community providers (be they physicians or other allied providers) who may not be equipped to assist a person who experiences a relapse and who needs to be treated again at a Center of Excellence. These Centers of Excellence also assist with the workforce development needs of our state. They provide practical educational experiences in opioid-use disorder treatment to community providers and trainees alike.

These Centers of Excellence work closely with BH Link. Under the leadership of former BHDDH Director Rebecca Boss, BH Link opened in 2018 and is a 24/7 community-based walk-in/drop-off triage facility. It serves Rhode Islanders who are experiencing behavioral health (mental health or substance-use disorder) crises. People can get immediate assistance and can get seamlessly transferred to ongoing outpatient care. Additionally, BH Link operates a 24/7 call-in center to help connect people to resources and care, and it manages our Rhode Island suicide hotline. BH Link is funded with State Opioid Response dollars from SAMHSA.

The efforts with these partners and with these facilities have paid dividends.

- Since January 2016, Rhode Island has seen a 19% increase in the number of patients who are regularly receiving methadone.
- Since November 2016, Rhode Island has seen a 30% increase in the number of individuals receiving buprenorphine.
- Since January 2016, Rhode Island has seen a 327% increase in the number of individuals receiving naltrexone.

Another significant effort has been the development of a program to offer treatment through the Rhode Island Department of Corrections. The program, launched in 2016, screens all Rhode Island inmates for opioid-use disorder and provides treatment for those who need it. Upon release, former inmates can continue their treatment without interruption at a Center of Excellence or through a primary care provider. Patients are also assisted with enrolling or re-enrolling in health insurance to make sure they are covered when they return to the community. Individuals who are living with opioid-use disorder and who do not have it treated while incarcerated are at extremely high risk for overdose after leaving the correctional system because of their diminished tolerance and because of a range of social factors that confront all individuals post incarceration. This program has resulted in sizable decreases in overdose deaths among individuals who were recently incarcerated. While a handful of programs elsewhere in the nation provide one treatment medication or another to certain segments of incarcerated populations, Rhode Island was the first state to make the full suite of medications available to every individual coming in or leaving the correctional system.

Additionally, Rhode Island has partnered with hospitals and emergency departments on treatment. In 2017 Rhode Island developed its *Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder*. This set of statewide guidelines ensures consistent, comprehensive care for opioid-use disorder in emergency departments and hospitals. In addition to establishing a common foundation for treating opioid-use disorder and overdose in Rhode Island hospitals and emergency departments, the standards establish a three-level system that defines each hospital and emergency department's capacity to treat opioid-use disorder. Hospitals and emergency departments in the

highest tier offer treatment as Centers of Excellence. However, all emergency departments and hospitals in Rhode Island are required to meet the base level of criteria, which includes dispensing naloxone to all patients at risk, providing comprehensive discharge planning to people who overdose, offering peer recovery support services, and reporting all overdoses within 48 hours to RIDOH.

This last requirement for hospitals and emergency departments to report overdoses within 48 hours to RIDOH has allowed RIDOH to help cities and towns throughout the state develop localized overdose response plans. This effort has also allowed RIDOH to send almost real-time alerts to communities about overdose hotspots, and to do statewide overdose "heat mapping" to identify vulnerable areas with remarkable specificity.

Recovery

Rhode Island has seen significant increases in the need for peer recovery services. Certified Peer Recovery Specialists are central to peer recovery services in Rhode Island. Certified Peer Recovery Specialists walk side-by-side with individuals in recovery. They help people create their own recovery plans and develop their own recovery pathways. Rhode Island has worked to create a Peer Recovery Specialist pipeline to expand the number of Peer Recovery Specialists, supporting in-prison Peer Recovery Specialist certification, and ensuring proper support and supervision of Peer Recovery Specialists at a scale commensurate to Rhode Island's need. BHDDH works to maintain consistency in reimbursement for delivery of Certified Peer Recovery Specialist services. Since Rhode Island developed a certification process in 2014, nearly 700 Peer Recovery Specialists have been certified.

These coaches have had great success at engaging clients. Approximately 85% of clients follow up with treatment and/or recovery support services. Certified Peer Recovery Specialists stay actively engaged with individuals after an encounter and connect them to treatment and recovery support services, including integrated health home teams, homeless assistance programs, employment assistance programs, primary care, and case management services, once the individual is comfortable.

RIDOH has an effort underway to target community overdose hotspots in the near future with Certified Peer Recovery Specialists who are dually certified as Community Health Workers. These public health professionals will connect the most vulnerable, high-risk individuals to resources for basic needs, treatment and recovery, and harm reduction services.

This aligns with past and existing efforts to get Certified Peer Recovery Specialists into places where they can connect with the most vulnerable individuals. For example, Certified Peer Recovery Specialists meet with overdose survivors while they are receiving treatment in Rhode Island emergency departments.

Work with Certified Peer Recovery Specialists complements the Task Force's efforts on recovery housing. In 2016, legislation was passed in Rhode Island that authorized BHDDH to develop a process to certify recovery housing facilities for residential substance abuse treatment

and to ensure that these facilities meet quality standards. Recovery housing includes on-site staff and resources, and the Rhode Island Communities for Addiction Recovery Efforts (RICARES) provides stakeholder oversight. There are currently 43 certified recovery houses across the state that have the capacity to serve 438 individuals. Many of the recovery houses offer sliding-fee scales for the weekly fees. (SAMHSA's State Targeted Response to Opioid Crisis grant supports recovery housing in Rhode Island.)

Rescue

Rhode Island data clearly demonstrate that a significant number of overdoses occur in public spaces, such as streets, parking lots, restaurants, stores, and beaches. One third of the opioid overdose calls to which EMS responded in Rhode Island in 2018 occurred in public places. The percentage of opioid overdoses that EMS responded to that occurred in public places increased from 29.6% in 2016 to 34.2% in 2018. We also know that naloxone saves lives. Naloxone is a medication that reverses the severe respiratory depression caused by opioid overdose. No clinical expertise is needed to administer this medication. For this reason, Rhode Island has made great efforts to get naloxone into the hands of people in the community.

The Task Force's Naloxone Work Group worked with all city and town police departments in Rhode Island to train officers on the use of naloxone and to equip these departments with naloxone. (SAMHSA's CARA First Responders Project to Combat Overdoses grant supports Rhode Island's work to get naloxone to law enforcement.) Rhode Island has regulations requiring all inpatient substance-use disorder providers to offer naloxone to at-risk clients, emergency departments are dispensing naloxone to individuals who have overdosed, peers distribute it on the street, and correctional facility inmates who are living with substance-use disorders are given naloxone upon release. In addition, naloxone has been distributed to public libraries, mall security officers, Rhode Island Department of Children, Youth and Family field staff, community-based organizations (such as Project Weber/RENEW and Preventing Overdose and Naloxone Intervention, or PONI), and Rhode Island's needle exchange program, ENCORE. Overall, the Task Force nearly doubled its distribution of naloxone kits from 7,798 in 2017 to 16,771 in 2018, surpassing its goal of distributing 10,000 kits.

Work has also been done at the policy level. In July 2018, RIDOH made regulatory changes that now require prescribers to co-prescribe naloxone to patients who are at a higher risk for opioid overdose. (Patients at higher risk include those with a history of opioid-use disorder, and those also being prescribed a benzodiazepine.) In 2019, legislation was passed in Rhode Island that prevents life insurance companies from discriminating against anyone who has had a prescription for naloxone or has purchased naloxone.

Looking forward

Fentanyl remains a huge challenge for Rhode Island, as it is for many states throughout the country. The percentage of overdose deaths in Rhode Island that involved fentanyl rose from 5% in 2009 to 72% in 2018. Cocaine is also a concern. In 2009, roughly 25% of fatal overdoses in Rhode Island involved cocaine. That figure is now closer to 50%, and the majority of cocaine-

involved deaths in 2019 involved cocaine and at least one other substance. We are also monitoring local trends related to methamphetamine use, which has been on the rise across the nation.

Trends related to cocaine and methamphetamine, along with the persistent challenges of alcoholism, tobacco use, and chronic marijuana use, underscore how important it is for us to consider opioid-use disorder within the larger context of substance use. And the scope needs to be broadened still so that our public health interventions are responding to issues such as social and emotional isolation. This requires us to look beyond what many believe to be our traditional focus areas in public health. We need to work to ensure that all children grow up in homes where they feel safe, supported, and loved; to ensure that people have houses that are healthy, safe, and affordable; and to ensure that people have jobs that offer fair compensation. The Task Force is starting to do some of this work of getting upstream and putting prevention efforts in place to get at the root causes of the health issues in our communities. We recently updated our Strategic Plan and have added Working Groups that focus on issues such as harm reduction, diversity, the family-level impacts of opioid-use disorder, and substance exposed newborns (with support from CDC's Opioid Overdose Crisis Response Supplement Fund.)

Congress and federal agencies can further support states by ensuring that funding to address this crisis is sustained and predictable. The addiction epidemic is touching all facets of our society and the federal funding that Rhode Island and all states have received is critical in our work to prevent individuals from becoming dependent in the first place, working to get them the treatment they need, and ensuring recovery services are available. Our state has worked so hard over the past several years and we are undoubtedly making progress, but that all hinges on a sustained commitment from Congress. States do the most successful public health work with consistent, predictable, and sustainable federal funding. Predictable resources help providers plan effectively. This can sometimes be challenging with one- or two-year grant cycles.

Moreover, more flexibility in grants would be tremendously helpful. This would allow states to use funds more effectively to address health issues such as opioid misuse, the use of non-opioid illicit drugs, mental health, and suicide. (One possibility is transitioning opioid-specific funds into the Substance Abuse Prevention and Treatment Block Grant.)

This flexibility could be coupled with increased coordination between funders before grant opportunities are announced. This would allow different state agencies to more effectively collaborate and utilize the infrastructures already developed through separate, previous funding opportunities. (For example, ensuring that all funding for maternal and child health efforts builds upon the maternal and child health infrastructure that has been developed through years of CDC of funding.)

I greatly appreciate the opportunity to present testimony before the Subcommittee. We have lost too many lives to the drug overdose epidemic in Rhode Island and across the country. However, your dedication and support have undoubtedly helped us save lives as well. I thank you for that, and I look forward to all the progress we can continue to make together.

Ms. DEGETTE. Thank you so much, Doctor.

It is now time for members to ask questions. And the Chair will recognize herself for 5 minutes.

As I mentioned in my opening statement, and as many of you mentioned—and thank you—the Committee has really been focusing on the opioid epidemic for quite some number of years. And this subcommittee, in particular in the last few Congresses, I was the ranking Democrat, now I am the chair, but it has been a real bipartisan effort over the years to help address this crisis.

And, ultimately, under, of course, a number of pieces of legislation and the 21st Century Cures Act which Congressman Upton and I sponsored, we provided the states with a considerable amount of funds to address substance abuse. And so, we are happy to see that some of those funds have been used as part of your efforts.

But several of you mentioned that we need to give more flexibility to the states to address; I believe, Ms. Smith, you said to address the system, not the substance. And I'm wondering if some of you can talk about what we need to do to give that flexibility as some of the substances shift.

Ms. Smith, do you want to expand on that a little bit?

Ms. SMITH. Yes, I'd be happy to. Thanks for asking that question.

And this goes to in many of your opening remarks you mentioned about the polysubstance use and the increase in particularly methamphetamine and cocaine that many states across the nation are seeing. And I think one of the challenges has been for us, with the funding being so focused on opioids, it's been a little bit challenging depending on the types of programs that we wanted to establish in making sure that we were appropriately tying it to opioids, while at the same time recognizing that some folks who benefit from the program may not identify opioids as their primary substance, or even identify them at all as a substance that they're utilizing.

Ms. DEGETTE. Do you think that that is getting more, more noticeable, that people are moving from opioids?

Ms. SMITH. Absolutely.

Ms. DEGETTE. Mr. Kinsley, you are shaking your head yes. Are you seeing that as well?

Mr. KINSLEY. Absolutely we're seeing that in North Carolina. And I think that in North Carolina, the substance abuse prevention and treatment block grant is the only real, sustainable tool we have to build the workforce and build the treatment sources for those individuals to go to to get ahead of the problem.

Ms. DEGETTE. Dr. Alexander-Scott, you talked a lot about what Rhode Island is trying to do. What about this crisis are you dealing with now that you weren't able to see a couple of years ago? Are there some new things that you're seeing now?

Dr. ALEXANDER-SCOTT. Certainly, the increase in the percent of fentanyl with overdose deaths that are occurring.

We are seeing, also, an increase in polysubstances, and multiple substances involved with overdose deaths. And we recognize the importance of going upstream more, to really get at the root causes of what is driving many of the challenges associated with both mental health and substance use.

Ms. DEGETTE. And do you think that the federal, the language with some of the federal funds you are getting is too restrictive for trying to address some of those issues?

Dr. ALEXANDER-SCOTT. There is opportunity to be more deliberate in allowing for the flexibility so that we can look more upstream and engage more at the community level.

Ms. DEGETTE. Ms. Mullins, what would you say the key challenge you are facing, your state is facing right now with addiction?

Ms. MULLINS. Right now, my key challenge is a workforce. I do not have enough people to deliver the treatment that is needed for the state. We could open more days for prescribers, but we do not have the therapists to be able to support that prescribing.

Ms. DEGETTE. And Dr. Bharel, I wanted to ask you, in your written testimony, you said that Massachusetts utilized federal funding to support expansion and enhancement of our treatment system. Can you tell me specifically about how the federal funds enabled you to do that?

And what could be done more if you had more flexibility?

Dr. BHAREL. Absolutely. Thank you for your leadership in this area. What we have been doing in our public health approach to this opioid epidemic is focusing on, of course, prevention and intervention, but really enhancing our treatment system.

And as has been said before, what we're dealing with now, many of us, is trying to build a system in a place that where for behavioral issues in general, for many, many decades have been underfunded. So, we're really trying to build up systems of care so that these individuals can get the treatment that they need.

We have used some of our federal funding to enhance treatment opportunities, including increasing our treatment beds within our system to over 1,200, including increasing training and availability of office-based opioid treatments, and enhancing the availability of methadone through opioid treatment programs.

Ms. DEGETTE. Thank you. So, I just want to, again; I want to thank all of you for your efforts and let you know this Committee and the full Energy and Commerce Committee is committed to helping make the maximum flexibility.

I will remind you that in the recent federal 2020 government funding bill, Congress continues to invest $1.5 billion in SAMHSA's state opioid response grants. And so, in response to the changing drug abuse landscape, we allow grantees to use this funding to address stimulant use. But if there is more we can do, please let us know, because you, we want you to consider ourselves to be your partners with that.

I will recognize Mr. Guthrie for 5 minutes of questioning.

Mr. GUTHRIE. Thank you very much. I appreciate it. And appreciate you all being here and telling your stories. And talking about bipartisan, you asked a lot of the questions that I had originally. So, moving forward, and you all have answered them well.

And I guess one thing I want to get at, flexibility. And I remember when we did the markup on I guess it was the SUPPORT Act, or it might have been the Comprehensive Recovery Act, but our colleague on the Committee Bobby Rush, I don't know if he had an amendment or he just made a point, that different communities

have different, different issues. And opioids are in every community. He was speaking specifically on his.

I remember the discussion being on there are X amount of resources we are going to—we are focusing on here. And I guess my hope is as you bring more workers, using the money you can—you can't always use the opioid money, for somebody on another substance, but it helps you build the infrastructure that has the same kind of moving forward. And we do need to open up and look at that. That is something I think we absolutely need to look at.

Something that was interesting to me is that as we were having our hearing, it was a hearing or a roundtable; we had a couple, we had some that had passed away. We had some members who experienced that. And they talked about the patient brokering. And I just walked away with this appalling that there seem to be, not any states that you represent, but he was in a state and was just being sent from one broker to the other.

And I know a couple of you guys, a couple of states have looked at that. And I think Dr. Alexander-Scott, Rhode Island, has looked at patient brokering. So, it is my understanding that Rhode Island certifies recovering housing and started this certification two years ago.

Can you talk about the certification process, why Rhode Island started it, and about how many recovery homes you have certified?

Dr. ALEXANDER-SCOTT. Yes, thank you.

Well, I will be happy to provide additional information to support this. Our sister agency, the Department of Behavioral Health Care, Developmental Disabilities, and Hospitals, recognized the importance of having social determinants of health addressed, such as housing. And recovery housing is a critical tool for supporting those living the lives of recovery, like Jonathan that I mentioned earlier.

We wanted to make sure that there was a level of quality and standards across all of the recovery houses that were available. And this sister agency in Rhode Island oversees the certifications to help establish those standards.

I can get back to you on the official number that we have of recovery houses that are available. But this has been a quality and data-driven program that we have felt to be critical to supporting this opioid epidemic.

Mr. GUTHRIE. OK, thank you.

Also, I think, Pennsylvania, it is my understanding that in the last year, Pennsylvania passed legislation that enables the Department of Drug and Alcohol Programs to regular and license recovery housing that receives federal funding. Can you talk about why you needed to do this, and the effect of it, and when it goes into effect?

Ms. SMITH. Yes, absolutely. I mean, I think it was passed by the legislature and our governor for the same reasons that it was in other states like Rhode Island. We were definitely identifying issues both through parents, through advocacy groups, through individuals who were attending recovery housing events and noticing that there seemed to be some inconsistencies with practices. And so, we felt it was really critical to pass some kind of legislation that enables us to have some oversight of these entities.

What's interesting is in Pennsylvania, we don't really know the exact number of current recovery houses operating. We know that

it's in the thousands. And so, what this legislation will enable us to do is create regulations so that any house that receives referrals or funding from state or federal entities will have to be licensed by our department.

So, it won't require that every recovery house in Pennsylvania be licensed, but the hope is that folks are utilizing the Web site that contains the licensing information to utilize those licensed entities that they know have some level of quality services. And maybe it will reduce business at some of the more scrupulous entities.

Mr. GUTHRIE. OK, thank you.

I have a cousin who is a neonatologist. And he never talks about any individual patient but just the issue in general when we talk a lot about this. And so, I know that for the opioid mother, the neonatal abstinence syndrome, so I—and I only have a few seconds—so maybe one of you, have any of you used federal dollars for neonatal abstinence syndrome? And has that reduced it in your state?

And whoever wants to go first. Probably one of you has time to answer. Is anybody working with that specifically?

Ms. MULLINS. West Virginia is working very specifically to provide treatment to women affected by a substance use disorder. It doesn't—the treatment itself sometimes can increase neonatal abstinence syndrome with the use of medication-assisted treatment. But our babies are being born healthier. Their birth outcomes are better.

So, we're really optimistic that with continued effort there, we can make more progress.

Mr. GUTHRIE. Thank you. I yield back.

Ms. DEGETTE. The Chair now recognizes Mr. Pallone for 5 minutes.

Mr. PALLONE. Thank you, Madam Chair.

As Congress and the Committee consider further action on the opioid crisis, I would like to hear more about how federal funds have been used to make a difference. And based on the states' submissions to the Committee, which I mentioned in my opening, it appears several states have successfully used federal funds to respond to the crisis.

So, let me see how many I can get through here.

Mr. Kinsley, in your testimony, you noted that federal funding had enabled North Carolina to provide opioid use disorder treatment for 12,000 uninsured people. In the same testimony, you mentioned that, and I quote, "Since 2016, when the first of the major federal bureau grants were received, North Carolina saw its first decline in opioid overdose deaths in five years, decreasing nine percent from 2017 to 2018."

So, what factors do you attribute to North Carolina's success in reducing overdose deaths and providing treatment to people who really need it?

Mr. KINSLEY. Thank you. Our focus has been 100 percent on medication-assisted treatment and naloxone distribution in communities. I believe the naloxone distribution has been directly tied to the halt in deaths and the reduction in deaths that we have seen.

And after that, important programs that have linked individuals into care have been able to sustain that treatment and move individuals in recovery. Programs like Peer Support Specialists, indi-

viduals who are in recovery themselves, we place them in emergency departments.

We've worked with our local EMS providers to actually induct people into treatment, so that if an individual who has an opioid reversal through an EMS visit does not want to go to the hospital, they can actually begin their treatment then. And there's a follow-up group of folks that come out and see those individuals after the fact.

There's been a lot of very scaled, very strategic focused interventions like that that have moved people into recovery and into the treatment pipeline that have been really important for us in North Carolina.

Mr. PALLONE. Thanks.

Let me go to Ms. Smith. I was encouraged to hear from your testimony that Pennsylvania has witnessed an 18 percent decrease in overdose deaths from 2017 to 2018. So, what factors do you attribute the reduction to?

And what are the few key areas that Pennsylvania should focus on to continue that trend, if possible?

Ms. SMITH. Yes. I think the keys for us are not all that different, actually. A big focus on getting naloxone into communities. Big focus on what we call a warm hand-off process, which is getting overdose survivors from the hospital into treatment.

We had a major issue in our hospitals and health systems with individuals overdosing and then being quickly released back out onto the street to overdose again repeated times.

So, I think those two things have been key for us. I think moving forward, what we'd like to do is spend a little bit more time and energy in the prevention space trying to prevent before we get to worrying about needing naloxone and needing to activate the warm hand-off process.

But our primary focus was really keeping people alive. Now that we've started to get a handle on that through naloxone, and warm hand=off, and expanding treatment, now I think we can spend some time and energy really thinking about looking upstream and how do we improve our prevention efforts.

Mr. PALLONE. OK, thank you.

Let me go to Dr. Alexander-Scott with regard to Rhode Island's response to the Committee. You noted that federal funds had enabled the state to improve data, and surveillance, and treatment capacity, and support innovations in delivery and treatment.

Can you give us some specific examples of how federal funds have helped Rhode Island in those areas?

Dr. ALEXANDER-SCOTT. There are multiple examples, similar to what has been mentioned.

Since you asked about data specifically, we use data in as real-time as possible. We obtain 48-hour reporting from our emergency departments for any suspected or actual overdose that has occurred. And on a weekly basis we have a cross-agency team that assesses where overdoses are, GIS-mapped across the state. And we release advisories to municipalities, key stakeholders, and providers to focus their areas when the overdose deaths have increased beyond a certain threshold.

That allows us to drive out the resources and services that we have based on data in real-time at the local level, which is one example.

We continue to expand treatments and recovery services with the intention of meeting people where they are. So, going out to reach folks through a mobile recovery and treatment vehicle is another example.

Mr. PALLONE. Thank you.

I don't know if I can get West Virginia in. Ms. Mullins noted that the state treatment system has been completely overhauled in response to the opioid crisis, and much of the positive work to date has occurred with and was made possible as a direct result of the federal funds awarded since 2016.

Do you want to give us briefly some examples of how federal funds have let West Virginia provide treatment and recovery services, particularly in rural and financially-disadvantaged parts of the state, if you could?

Ms. MULLINS. Specifically really, it has given us the ability to expand our clinical providers who could provide MAT.

We now have people in all of our 55 counties able to receive MAT. And then we have prescribed in, located physically in most counties. That's been the number one success we really experienced with the federal funds.

Mr. PALLONE. Thank you.

Thank you, Madam Chair.

Ms. DEGETTE. Thank you.

The Chair now recognizes the gentleman from Oregon for 5 minutes.

Mr. WALDEN. Thank you, Madam Chair. And thanks again for the hearing. And to our witnesses, thanks for your participation as well.

I want to start with a question about transportation issues. It is a big problem in districts like mine. Just to put it in perspective, mine would stretch from the Atlantic to Ohio, bigger than almost any state east of the Mississippi. At my roundtables for the 2nd District of Oregon, 2017, I heard from a witness in Hermiston. She had to travel five hours to another state, Washington State, just to find a provider who would help her with treatment and get her off of her addiction.

For each of the witnesses, what is your state doing to address access to treatment faced by rural patients where there is no local help? If you could be kind of brief on that, because I have another one on 42 CFR Part 2 I want to get to as well.

So, if anybody wants to weigh in on how to help in the rural areas. Yes, sir.

Mr. KINSLEY. Thank you for the question. North Carolina has 100 counties. We have, we are dosing currently about 20,000 people a day at our opioid treatment programs. I think our largest two strategies to address rural access has been first and foremost moving as much care into office-based outpatient treatment programs as possible. That's why we'd love to see the DEA X waiver requirement removed to try to make that easier.

We've doubled the number of physicians in North Carolina. We have a long way to go. We're not going to get large-scale OTP providers there.

The second, we've been heavily investing in Project ECHO, which is leverage our ability to try to train providers to give them the support they need to take on these patients.

Mr. WALDEN. Yes, we, as you know, in the SUPPORT Act expanded who could administer Suboxone and other treatments.

Anybody else want to weigh in on this?

Ms. SMITH. Yes, I'd be happy to very quickly.

So, Pennsylvania is really fortunate in that we have a large number of opioid treatment providers already in the state. So that's an advantage for us. But beyond that, to assist rural communities, we have a particular RAMP grant we call it, Rural Access to Medication, where we are expanding access to medication-assisted treatment in rural areas thanks to the grant from the Federal Government.

As well as we've offered a loan repayment program for practitioners in areas that are hard hit by the opioid epidemic but also have workforce shortages, which you can imagine is mostly rural areas. And the commitment for that loan repayment program is that you have to have two years of experience treating SUD patients, and you have to commit to an additional two years of treating in that area.

Mr. WALDEN. Ah, an incentive to stay. OK.

I want to move on to this 42 CFR Part 2 issue, the confidentiality of alcohol and drug abuse patient records.

I heard a lot from providers about how this impacts negatively the effective exchange of information regarding individual substance use disorder treatment and there are other health issues. We passed legislation in the House overwhelmingly to try and address this, protect patient privacy but allow the right flow of information to other medical providers. Tragically, it went up on the rocks in the Senate. And I would like to see us renew our efforts here.

Can you all tell me briefly just are you seeing patients impacted by this? I sure heard it from providers in my district.

Yes, Doctor?

Dr. BHAREL. In Massachusetts, we provided comments related to a 42 CFR and some of the obstacles that that produces. As we have started to think about what is the next step or what needs to happen to fight this opioid epidemic, one of the issues is around appropriate behavioral health integration, both with mental health issues and substance use issues, as well as how to connect that to the medical care that an individual needs. And there are many aspects of 42 CFR that are an obstacle there.

Mr. WALDEN. Did others run into this? Yes, Doctor?

Dr. ALEXANDER-SCOTT. The other place to be aware of where it may be considered is within the school system, making sure that school nurses and psychologists are able to exchange the information needed to care for children who have mental health or even substance use challenges.

Mr. WALDEN. OK. Do others want to comment on this?

Mr. Kinsley.

Mr. KINSLEY. North Carolina is fully supportive of modernizing 42 CFR in an attempt to both maintain privacy but also move us to integrated care. I think what's important is that we have to also systematically address stigma to help reduce——

Mr. WALDEN. Right.

Mr. KINSLEY [continuing]. The systematic exclusion of individuals from employment, housing, and everything else that they experience as well.

Mr. WALDEN. Exactly. Anyone else? Ms. Smith?

Ms. SMITH. He said exactly what I was going to say, that really addressing stigma——

Mr. WALDEN. He was looking at your notes, I think.

Ms. SMITH [continuing]. Has to be, has to be the primary concern here, you know.

Mr. WALDEN. Yes.

Ms. SMITH. I think it's important to protect those individuals——

Mr. WALDEN. Absolutely.

Ms. SMITH [continuing]. Who suffers from this disease. But at the same time, I don't know how we move to a truly integrated system of care when we treat their record differently.

Mr. WALDEN. Right.

Ms. SMITH. We keep talking about treating them the same as everyone else. Treat them the same as someone who has heart disease or diabetes, but access their medical record.

Mr. WALDEN. Right.

Ms. SMITH. I think we need to change that conversation.

Mr. WALDEN. This has led to death. So, we need to fix this.

I hope we can, Madam Chair, renew this effort to pass reform here. I know the Administration's done some things they could within the existing law, but I don't think that gets far enough. And you have been generous with the time.

Ms. DEGETTE. This is an issue we have been working on for a long, long time in this Committee. And we do need; we do need to find a resolution.

Mr. WALDEN. Thank you, Madam Chair.

Thank you to all of you.

Ms. DEGETTE. The Chair now recognizes the gentle lady from Illinois Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Madam Chair.

In 2018, the overall rate of opioid overdose deaths in Illinois fell for the first time in five years. The decrease was likely impacted by the efforts of this Committee and Congress to combat the opioid epidemic. But, this trend was primarily driven by the decline in deaths among white residents.

Today, in Illinois, opioid overdose deaths among blacks and Latinos continue to rise. In fact, my hometown of Chicago experienced more opioid overdose deaths than homicides in 2017. Of the 796 people who died from opioid overdose—opioid deaths that year, 400 were African American.

And a recent study from the American Journal of Public Health found that black and Hispanic residents of Cook County, Illinois, were more likely to experience a fentanyl-involved overdose than whites. That doesn't square with the sort of public perception of the opioid crisis as a white suburban and rural issue.

So, I wanted to ask you, Dr. Alexander-Scott, I know you have experience not only in your state but, as the president, former president of the Association of State and Territorial Health Officials, can you tell us how the Congress, how we can help states to address the overlooked racial disparity in the opioid epidemic?

Dr. ALEXANDER-SCOTT. Thank you so much for this question. It's such a critical issue for us.

We in Rhode Island are also starting to take a more deliberate approach to addressing this by really making sure that we have the health equity lens in terms of how we are implementing our overdose prevention and intervention efforts. We have to make sure that every community that is impacted by this has the opportunity to have access to the treatment services, as well as continue to look upstream to address the root causes that exist.

We cannot overlook the socioeconomic and environmental determinants that are occurring in various communities——

Ms. SCHAKOWSKY. And I appreciate that. Congressman Guthrie raised this question to some extent as well. So, go ahead.

Dr. ALEXANDER-SCOTT [continuing].To be able to tackle this.

The start is with what you have done, which is really expose the fact that different races and ethnicities are impacted by this epidemic in different ways. And we have to make sure that we are taking into account the cultural and socioeconomic and environmental influences that are contributing to why we have different outcomes, and really focus on addressing the root causes and making sure that the funding that you appropriate is able to take place at the community level and be driven by what the community needs to make the difference.

Ms. SCHAKOWSKY. Thank you very much.

Dr. Bharel, is that right? Your testimony mentioned, in your testimony, you mentioned that you are focusing on communities of color in your state responses. And so, what does that look like?

Dr. BHAREL. Yes, thanks for bringing up this important issue. One of our five areas where we found an increase in overdoses and overdose deaths is in our communities of color. So we have been using federal funds to assist us in those efforts. To give you an example, as we have all noted as, our opiate overdose deaths thankfully have begun to decline; from 2016 to 2017, when we broke down our death data by race and ethnicity, we found that the only group still with an increasing rate of opiate overdose deaths was black men. So we have rerouted some of our efforts to be able to focus on communities of color. Just to give you a few examples, we redid some of our campaigns, including prevention campaigns to address different communities and provide them in different languages.

Additionally, another example is we have a licensed addiction counselor program that we have now focused on Latino and African American members of our community so that more individuals can be trained and then go back to their communities to provide services.

Ms. SCHAKOWSKY. Thank you. I think the statistics are just completely unacceptable in Chicago and a lot of metropolitan areas and especially among communities of color. And it would be a terrible mistake to go with just this overall data and not look at the par-

ticular communities. Thank you for responding to this question. I yield back.

Ms. DEGETTE. I thank the gentle lady. I now recognized the gentlemen——

Ms. SCHAKOWSKY. Oh, I wondered if I could offer something, something for the record as well, I forgot.

Ms. DEGETTE. Well, what is it?

Ms. SCHAKOWSKY. If I could put in the study that I mentioned. The geographic distribution of fentanyl involved overdose deaths in Cook County, in Cook County, Illinois. And U.S. News & World Report article titled "Separate, Unequal, and Overlooked."

Ms. DEGETTE. Without objection, both items will be entered into the record.

The Chair now recognizes the gentleman from Texas.

Mr. BURGESS. I thank the Chair for the recognition. Dr. Bharel, just briefly, Mr. Guthrie had talked a little bit about patient brokering. I will share with you some of the most troubling testimony we have had in this subcommittee on this issue was from your Assistant Attorney General, I think his name was Eric Gold, who came and testified to one of our oversight investigation subcommittees about sober homes that were located in other states. So his Massachusetts residents would be lured to other locations to have their treatment and, of course, all covered by my insurance with no real, identifiable metrics as to whether or not anyone was getting better. And in fact, I think he shared with us data that not only did they not get better, but he had had a number of deaths of Massachusetts residents that had happened as a result of being farmed out to a sober home.

So, as a kind of follow-up to his testimony, is there anything that the—you is the state's sort of Chief Medical Officer, is there anything else that you can share with us about what he told us that day?

Dr. BHAREL. Absolutely, so the quality of care that our patients receive in this system is absolutely critical that we all make sure it reaches the highest standards for a very vulnerable population.

There are several things we do at the state level. We take very seriously our responsibility to license and contract with all of the substance addiction services that we provide through the Department of Public Health. And through that licensing and contracting authority, which has recently been enhanced actually through Massachusetts law, we are able to set the criteria and have a feedback loop. We also respond to complaints, do re-licensing every two years, and can at any time go in to inspect a site.

Specifically, in terms of sober homes, we now in Massachusetts have a voluntary, sober home certification program which must meet certain criteria and standards, and we have seen improvement and have over 2,000 beds in that system as well.

Mr. BURGESS. Very good about that and just to be clear, when Mr. Gold came and testified to us, he wasn't talking about sober homes within the state or within the Commonwealth of Massachusetts. He was talking about sober homes that might be in the more agreeable Southern climate, not that there is any more agreeable climate than Massachusetts in January, I am sure, but I have never experienced that. But that was the deal, that people would

be—get lured, say OK, you can come to spend your winter in a sunny location and you all sort of lose control of the situation when that happens.

So I guess what I am asking, are we doing any better as far as being able to communicate between states about when this type of activity happens when you lose a resident to addiction in another state? Is there some type of follow-up that is done on that?

Dr. BHAREL. So, I don't have any specific examples of patient brokering to give you, and I can have the Attorney General's Office follow up to see what they can provide.

Mr. BURGESS. Sure.

Dr. BHAREL. But I will say one of the things we need to do in our state if people are leaving is making sure that we have the facilities and the appropriate access to care in the state. And we have been working really hard on that.

One really important success that many of us have in terms of cross-state communication is the prescription monitoring programs.

Mr. BURGESS. Sure.

Dr. BHAREL. And ours in Massachusetts, which now providers are required to use before prescribing opioids and benzodiazepines, is connected to 37 other states and Washington, DC. And that really helps understand care that individuals may have received in other states as well.

Mr. BURGESS. And of course, the whole NASPER program was a product of this Committee many, many years ago. I remember us working on it, as did we work on Project Echo when Orrin Hatch was over in the Senate Finance Committee. So thank you for mentioning Project Echo.

And Mr. Kinsley, let me just ask you if I could, and Mr. Walden already addressed the 41 CFR Part 2 issue, but do you feel that within your state that your programs are able to share the appropriate addiction medical records so that they can coordinate care with people undergoing treatment for opiate use disorder, substance use disorder?

Mr. KINSLEY. The simple answer is no. We have invested a lot of resources through peer support and other tools to try to support that coordination of care, care management, et cetera, but there is still a huge limitation. And even doctors within the same systems can't easily talk to one another to coordinate care around their patients.

Mr. BURGESS. Again, I would just in agreement with Mr. Walden; I think we should redouble our efforts. We got 42 CFR Part 2 reform done on the House floor in 2018. We were not able—it didn't survive the Senate. So when President Trump signed the big bill into law, that part was removed. We need to continue to work on that because it is critically important.

Thank you, Madam Chair; I yield back.

Ms. DEGETTE. The Chair recognizes the gentleman from Massachusetts for five minutes.

Mr. KENNEDY. Thank you, Madam Chair. I want to thank the witnesses for being here today, your testimony. I want to thank our colleagues as well on this Committee for their attention.

Dr. Burgess, you are welcome to Boston any time in winter. The weather might not be the warmest. The Super Bowl rings tend to

warm you up, though, so we have had our share of those. Hopefully, it might be something you guys can experience some time soon. But we will move right along, Dr. Bharel.

You sit on the Massachusetts Harm Reduction Commission, which in March 2019 recommended exploring the use of evidence-based safe injection facilities or safe consumption sites. These sites are shown to reduce the risk of infection, improve public health outcomes, and increase outreach to treatment services. Safe injection facilities are supported by the Massachusetts Medical Society and the implementation of these sites is currently being explored by the Massachusetts State Legislature.

So Dr. Bharel, can you elaborate a little bit about how the Harm Reduction Commission came to recommend highlighting evidence-based safe injection facilities. And additionally, as addressed briefly in the report, could you explain why the state-operated facilities do not violate federal law?

Dr. BHAREL. So thank you, Congressman, and thank you for your support of the work happening in Massachusetts and around the country.

Talking broadly about the Harm Reduction Commission, first to address the safe injection facilities, these were reviewed and the evidence was reviewed, and a recommendation was to look at this further through our legislative process, and I understand there to be legal barriers both at the states and federal level.

Talking about harm reduction broadly and what we currently have the capacity to do in public health, we have really been focusing our effort on the high-risk populations I have mentioned, and one of the important harm-reduction pieces including syringe service programs, we have expanded those in Massachusetts several years ago to less than 10 to over 30 now and have had markedly good response rates of not only collecting syringes, but also providing harm-reduction services, decreasing infections, and connecting people to care.

One statistic that has been very helpful for individuals is that for every 100 syringes that are handed out, 120 are returned, so we are also cleaning our neighborhoods and communities as well, so we have a focused effort in that, as well as outreach to communities at highest risk.

Mr. KENNEDY. Are there evidence-based treatment strategies such as FDA-approved drugs like buprenorphine, methadone, and naltrexone that are considered the gold standard for treating those who suffer from opioid use disorder?

Doctor, our Commonwealth's response to the Committee indicated that the state had increased access to medication-assisted treatment to those who have been incarcerated and are reentering the community. Can you describe the types of treatments Massachusetts is providing to the incarcerated population in the state and if there is any disconnect seeing as individuals who are incarcerated lose Medicaid once they are incarcerated to any roadblocks that come from that bureaucratic disconnect?

Dr. BHAREL. Absolutely. I am proud to say that one of the areas where we have had a lot of improvement is in training individuals with incarceration. As I mentioned in my testimony that one of our five high-risk groups, in fact, we see from our data that when indi-

viduals are released from incarceration, the risk of opioid overdose death is 120 times higher than other individuals, especially in the two to four weeks after release. That data and information really helped us open up dialogue in new ways with our criminal justice colleagues. And now, the Department of Corrections is offering FDA-approved medication for opioid use disorder, as well as a pilot happening in seven of our jail systems.

We also are expanding our program of post-release assistance because as has been mentioned earlier, individuals not only need to be connected to medications when they leave, but also employment and housing opportunities.

Mr. KENNEDY. Thank you, Doctor. Mr. Kinsley, a study published just recently found that states that expanded Medicaid had a six percent overall lower rate of opioid use or opioid overdose deaths than states that did not choose to expand Medicaid. For specific opioids, this rate was as high as 11 percent lower mortality. Unlike the other four states represented here, obviously, North Carolina decided not to expand Medicaid.

Sir, has that diminished the state's ability to provide long-term-evidence-based treatment options to uninsured citizens?

Mr. KINSLEY. Absolutely, and thank you for the question, Congressman. We estimate 426,000 people have an opioid or prescription misuse. We have been able to provide treatment to 12,000 uninsured folks. Half of everybody coming into an ED room with an opioid overdose are uninsured. We are digging out of this hole with a teaspoon. We are proud of our progress. We have so much further to go. Based off the recent JAMA report that came out, we estimate 415 North Carolinians would be alive today had we expanded Medicaid in 2014.

Mr. KENNEDY. Thank you. I yield back.

Ms. DEGETTE. The gentleman from West Virginia is now recognized for five minutes.

Mr. MCKINLEY. Thank you, Madam Chairman. I would like to enter into the record this letter from the Voices for Non-Opioid Choices. It deals with the non-opioid options to treat in acute pain. I ask unanimous consent we enter that.

Ms. DEGETTE. Without objection.

Mr. MCKINLEY. Thank you. I guess maybe to focus back on Ms. Mullins on some of your testimony and first, I want to congratulate you for West Virginia the work you have done. Like you said, we have been the epicenter of this problem. We have grown from 52 to 57 deaths per 100,000. It is just incredible to see what is happening.

My concern has been from the day one on this that we never really understood the contributing factors that have led to abuse. We have had people in here from NIH, and CDC. They will talk about the socio-economic issues. And we have been able to quibble back and forth about it, but there are states like New Hampshire that have an absolute opposite socio-economic contributing factor as compared to West Virginia, and for years, they were the number two in the country.

So I would like to understand more about what we are doing about prevention rather than the treatment. From my engineering perspective, that is how we—when we have a building collapse or

a building failure, we go back and find out what caused it. And then we can fix it, but let's so it doesn't happen again.

So my question back to you, what do you think the contributing factors are? Because I look at, for example, and I agree with Dr. Scott, who said it is connectivity. I want to see how that goes together because Texas, Texas has a rate of only 10.5 to our 57. What are they doing right in Texas that we, in West Virginia or maybe around the country, can learn about what are they doing there? Because we know the drugs are coming across. It is not like we don't have access to these illegal drugs. We know where they are coming from. What can we learn from that to prevent people from abusing drugs?

Ms. MULLINS. So, I think in terms of contributing factors West Virginia experienced a perfect storm when we had prescribers trying to treat pain. We have individuals in high-injury occupations, coal mining. And some of the other industries that we have in West Virginia are prone to accidents. So we had influxes of pills coming into the state. We had easy availability. And those things were how the perfect storm, if you will, got started with low incomes and people—the recession and the different things that were happening, people becoming frustrated.

But in my opinion, we have to go further backstream. We have to start with our kids. We have kids in absolute crisis. They are not living with their parents. Many of them are living in foster care.

Mr. MCKINLEY. Let me interrupt. I would like to have more of a dialogue with you about this. So rather than take all the time, there are a couple more things because I am concerned if we don't stop the prevention, if we don't get into the prevention, we are going to see even more neonatal abstinence problems with our children. We are going to see the impact it is going to have on foster families, and foster children in our foster homes as a result of this. So I am really curious about how we stop it in the first place or how we mitigate the problem into the future.

So let me go to the last comment. I would like to hear from any of you on the panel is that we know when the tobacco settlement occurred years ago, 97 percent, 97 percent of the money that came in for tobacco settlement payments went for non-tobacco use. They were used for fixing potholes. They were balancing state budgets. Should we do the same thing? Because I would imagine that we are going to see quite a bit of litigation over this opioid. And there are going to be some federal settlements on this.

Is there a role for us for the Federal Government to try to step in to make sure that that money doesn't go for fixing potholes and balancing budgets? Is there some way that we can assure it will go for things like prevention, or foster care, or neonatal to assure long-term funding for people that are making investments in treatment?

How would you react to a federal involvement in these settlements? Any of you.

Dr. ALEXANDER-SCOTT. Thank you for the question, Congressman. We would welcome the opportunity to have sustainable funding that allows us to really focus on this epidemic comprehensively and over the long term.

Many of us have referenced the importance of stability with the funding, particularly when you look at making sure that the funding can be implemented at the community level. The community entities that we are engaged with need to know that the funding that is available to them to address determinants of health and to address the comprehensive system will be in place for a long enough time for there to be an impact and the improvement that we want to see. So the assistance that is welcome to help us do that across the board is certainly to be well received.

Ms. DEGETTE. The gentleman from California is recognized for five minutes.

Mr. RUIZ. Thank you very much and thank you all for being here for the incredible work that you are doing in your states.

This Committee has worked in the bipartisan manner over the last several years to pass legislation to help states implement programs to help curb the opioid crisis sweeping our nation. But more can and more must be done.

While members on both sides of the aisle are committed to addressing this issue, at the same time, there are continued efforts not to expand Medicaid in some states and even to make access to Medicaid more difficult overall, despite the fact that increased access to care means increased access to life-saving treatment.

In fact, just last week, a new study was published in the Journal of the American Medical Association, JAMA, found that expanding Medicaid under the Affordable Care Act may have saved as many as 8,000 people from a fatal opioid overdose. I would like to ask unanimous to insert this for the record.

Ms. DEGETTE. Without objection.

Mr. RUIZ. And according to the Kaiser Family Foundation, another study, in 2017, Medicaid covered 54 percent of people who received treatment for opioid use disorders. So despite the words about wanting to increase access to mental health and addiction treatment, there are also efforts to roll back the Affordable Care Act, which would eliminate coverage of the essential health benefits like mental health services and addiction treatment. And we feel the Medicaid expansion, if we truly want to address this crisis in a meaningful way, we need to work to increase coverage, and expand Medicaid, not take it away.

Time after time, I have cared for a patient who is overdosing in the emergency department. They usually come unresponsive and blue. And in the emergency department, we treat everybody with a life-threatening illness regardless of their ability to pay. But once they are stabilized and leave the emergency department, leave the hospital, they need to find treatment to help them beat their addiction. They need to go to the facilities that offer the programs that receive the grant money and those facilities often benefit if they have Medicaid. And if they don't have Medicaid, they won't go because the opioid epidemic is an unprecedented crisis. States have needed to make fundamental changes to their treatment systems to combat opioid addiction and substance abuse disorder.

So I would like to hear how federal funding has played a role in supporting these treatment systems.

Ms. Mullins, West Virginia's response to the Committee, notes that the state's treatment infrastructure was initially not capable

of meeting rising demands for opioid treatment services. How have the federal funds helped West Virginia enhance the treatment infrastructure system, including the role that Medicaid has played?

Ms. MULLINS. So Medicaid has been a key component. We have used Medicaid—we were approved for an 1115 SUD waiver. So we have used that as part of our backbone to pay for treatment services. But the 1115 waiver doesn't enable us to train our providers. It doesn't enable us to build our infrastructure. So we use the grant funds to wrap around that waiver and build infrastructure, as well as cover people with no insurance or who are under insured. That has been our strategy, to braid those funds together. And I don't think that we could have done one without the other.

Mr. RUIZ. And according to a recent study, opioid treatment is much more widely accessed in states that expanded Medicaid. Rhode Island and West Virginia, two Medicaid-expanded states, both noted in their responses to the Committee the importance of federal Medicaid dollars and their ability to address the opioid crisis.

Mr. Kinsley, from North Carolina, correct, you raised in your written statement that Medicaid is "the most important tool in a sustainable response to the opioid epidemic. It would bring an additional $4 billion into North Carolina for healthcare."

How would expanding Medicaid help the state further develop its treatment infrastructure to address the opioid crisis?

Mr. KINSLEY. Thank you for the question. The interconnection with substance use disorder and employment and the fact that the vast majority of individuals get their health insurance through employment cannot be overlooked. I remind my team every day that they are potentially one drug test away from losing their health insurance and ending up in a place where they have no way to pay for the treatment that they need to recover and get back into the employment workforce.

In North Carolina, we estimate that 500,000 additional people would have insurance with Medicaid expansion. This would be our ability to then ship those individuals to get treatment through Medicaid, through the 1115 waiver and then use our resources to invest in building the system capacity with scale and leverage our results.

Mr. RUIZ. Thank you. You see, we have done some good work here that we took a step forward in combating the opioid epidemic, but if we make it harder for people to enroll in Medicaid, such as repealing the Medicaid expansion from the Affordable Care Act, repealing the essential health benefits that mandate mental health coverage, by making it difficult for people to enroll like work requirements and actually block granting Medicaid as well, then we are going to take five steps back. And so it is very important to keep that big picture perspective in our efforts. I yield back.

Ms. DEGETTE. I thank the gentleman. We turn now to the gentleman from Virginia for five minutes.

Mr. GRIFFITH. Thank you very much, Madam Chair. Let me first answer a question that Mr. McKinley asked of you all and that was how do we treat this money? And we had the tobacco settlement and a lot of—many states went for naught.

In Virginia, they created a separate commission that handled the Tobacco Commission Money for economic development purposes. Whatever purpose your individual states might want, I recommend that model because then you can take that lump sum of money and have it stretch out to assist. In this case, it would be with whatever issues you all have with substance abuse, but that Virginia model has worked well for economic development in the former tobacco producing areas of the Commonwealth.

My district is the area stretched between West Virginia and North Carolina, down to Kentucky and Tennessee. And while Virginia's numbers look better than West Virginia, my district does not. I have both Martinsville in the North Carolina side that is heavily impacted and then all the areas in coal country in Virginia that look very much like West Virginia when it comes to the opioid crisis. And so I am very concerned about a lot of these issues.

And we all are moved by testimony from time to time, and earlier, you all had a discussion related to privacy versus integrated medical care. The testimony I remember is the man who came in to testify for his brother, who could not testify because he had died. He had licked the opioid problem and then was in a major car accident, and because the doctors had no idea that he had an opioid problem and because he was unconscious and could not tell anybody don't give him the opioids, they gave him the opioids. He survived the injuries from the accident. He did not survive the reintroduction of opioids to his system. So we have to work on that problem and I appreciate all of your testimony in that regard.

Foster care. Mr. Kinsley, you said half of the children in foster care, their parents had some form and it was one of the factors, some form of drug addiction, but I didn't see in your written testimony how many young people that were.

Mr. KINSLEY. I can get you the exact number. We have about 12,000 individuals in North Carolina in the foster care system.

Mr. GRIFFITH. So roughly 6,000?

Mr. KINSLEY. Yes, sir.

Mr. GRIFFITH. And I thought it was interesting that Dr. Alexander-Scott, in your answer to another question, mentioned the school systems and making sure that there was money there.

I know several families that have first gone through foster care and then adopted children who came out of households where the parents were addicted to various drugs, but particularly opioids. And they have significant behavior problems, and it is taking a lot of effort.

What can we do to help our school systems deal with the next generation? They may not have drug problems themselves, but there are lots of behavior problems.

Dr. ALEXANDER-SCOTT. In Rhode Island, we have introduced a student assistance services program that allows for counseling, peer recovery, and support for both the students and their families. And the ability to have that be integrated with physical health services are for students in school really will allow for a comprehensive approach to addressing the needs to our youth and that is——

Mr. GRIFFITH. Including behavior problems that are a result of being around folks who were using drugs at the time of those first couple of years. Would that also be included?

Dr. ALEXANDER-SCOTT. It does address the mental health, as well as behavioral challenges that youth often face.

Mr. GRIFFITH. I appreciate that. Thank you very much. And Ms. Smith, I really want to learn more about what Pennsylvania is doing with its drug—excuse me, its doctor loan repayment program.

Ms. SMITH. Yes.

Mr. GRIFFITH. Because representing an area that has both significant, as Pennsylvania and West Virginia do, we are all right there in the Appalachian Mountains together. We need more healthcare providers out in our most affected areas, the rural areas, particularly the coal counties that have been affected by this. Tell me about that program some more.

Ms. SMITH. Sure. So this was an innovative program that we decided to use some of our federal funding for. So we are a Medicaid expansion state which means for treatment dollar purposes, a lot of our patients are Medicaid patients, which means the federal grant dollars we are getting, we can really use to be innovative and think of creative ideas. So we have done some housing things.

In this case, we decide how do we address the workforce issue because it really is an issue all across the nation. So, we decided that you had to be practicing in an area with high opioid use. You had to have at least two years of experience treating patients with substance use disorder. And you had to commit to an additional two years in order to make good on that loan repayment.

Mr. GRIFFITH. Have you had the program long enough to know if the doctors, or healthcare providers, stay after their two years or their additional two years?

Ms. SMITH. So two years have elapsed. It is the first.

Mr. GRIFFITH. I look forward to getting that information in the future, and my time is up.

Ms. SMITH. I am happy to share some additional information about how many we have granted, et cetera.

Mr. GRIFFITH. I appreciate that and I yield back.

Ms. DEGETTE. I thank the gentleman. I turn now to the gentle lady from New Hampshire for five minutes.

Ms. KUSTER. Thank you, Madam Chair, and I just want to say thank you to you for your leadership. In my seven years in Congress, this is one of the best, most productive hearings I have been at, and it is an honor to be on this Committee.

I am the founder and co-chair of the bipartisan Opioid Task Force that has close to a hundred members. Just to give you a sense of the scope, New Hampshire, as my colleague, Mr. McKinley, suggested, was hit very hard, along with West Virginia. A perfect storm situation. But what I am proud of is that New Hampshire has some very innovative models coming out of the opioid epidemic. Yes, indeed, we need to include methamphetamines and cocaine and the rest.

And I want to focus in on a particularly vulnerable population and a particularly expensive population, for the taxpayers, for our communities, and for individuals' personal lives. And that is the in-

carcerated population where we know that at least 65 percent, in some of our counties as high as 85 percent, of our incarcerated population have co-occurring mental health and substance use issues.

And one of my big a-ha moments in the last seven years was to discover that something that passed Congress many, many years ago at the inception of Medicaid, called the Medicaid Inmate Exclusion, caused people to lose coverage and lose the funding for healthcare, namely mental health treatment, substance use treatment during that period of incarceration. New Hampshire is a Medicaid expansion state, thank God, given the discussion today. But literally, the day you go in, you lose your coverage. And to me, if we were to design a system that would fail American taxpayers, families, and communities, it would be this system because what happens is people live with very, very high recidivism rates. And we all do. We are the taxpayers. And we have people incarcerated for drug-related crimes, getting no treatment for their mental health or substance use disorder, and when they come out, we all act shocked that they go back to their addiction. We are not shocked that they go back to their diabetes. And we shouldn't be shocked that they go back to their addiction.

So I have introduced legislation that we call the Humane Correctional Health Care Act and what this would do is continue Medicaid coverage during incarceration so that we can ensure treatment for substance use disorder and mental illness. And what happens that we have already demonstrated in New Hampshire is a dramatic drop in the recidivism rate, from the upwards of 50 to 60 percent down to 18 percent. And I don't care if you are a Republican or a Democrat, left, right, or center, that is saving lives and saving taxpayer dollars and I am very pleased that Mr. McKinley agreed to join today, as did Dr. Ruiz.

So quickly moving on to questions, Dr. Scott, in 2016, I know Rhode Island implemented a state-wide treatment program for opioid addiction within your Department of Corrections. I would love to get the JAMA studies for the record and to share them with my colleagues. But can you just explain the overall decrease in overdose deaths and what the outcomes so far of that program have been?

Dr. ALEXANDER-SCOTT. Thank you for that question. The key to the program has been making sure that we have all three FDA-approved medications for medication-assisted treatment available to those who are incarcerated. We also allow for screening of all incarcerated inmates or substance use disorder, so that if they weren't previously on an MAT option that was made available to them. And the final key is making sure that prior to release from incarceration, they are connected to one of our community-based behavioral health agencies. They become a client in advance and make sure that once they are released, they are able to have a warm handoff directly to continue to receive recovery and treatment services at the community level.

Ms. KUSTER. And that is one of the key components for our programs as well, so as I continue to build bipartisan support for this legislation, I would love to work with you and others. I know, Ms. Smith, you mentioned housing or maybe the doctor, but I would like to work on what those supports are to eliminate the barriers

to recovery so that people can be successful in their lives, get back to raising their children, get back to work, get back to paying taxes. So thank you. I yield back and I appreciate this hearing.

Ms. DEGETTE. I thank the gentle lady. The gentle lady from Indiana is recognized for five minutes.

Mrs. BROOKS. Thank you, Madam Chairwoman, and thank you so much to you and ranking member for holding this really important hearing. I am really pleased that we are focusing once again on opioids. It is some of the most important work that I have done in my time here in Congress and I want to thank each of you and particularly all the states that responded to the Committee's questions. It really is wonderful to see all of the progress and all of the efforts that each of your states are making.

I think while it is not getting much media attention any more, I mean there was a period of time in the last few years where opioid issues were on the front pages and on TV all the time. And it is not anymore. It has fallen off of the radar, sadly, of the American people except for those families and those professionals and people who are dealing with this day in and day out. So I really want to thank you for your work.

I want to focus, go back to the workforce issues because all of this, whether it is prevention, whether it is treatment, whether it is the work that you all are doing, if we don't have the workforce, I say the workforce even beyond physicians in addiction; we need to stay focused. My friend across the aisle, Brad Schneider, from Illinois and I introduced the Opioid Workforce Act and it is meant to try to raise the cap on graduate medical education residency slots by a thousand more residencies across the country in addiction medicine. I know that I have spoken to IU Med School in Indiana. I represent Indiana and you know, IU has, with its grand challenge, tried to put a lot more emphasis on addiction medicine in all levels, whether it is in nursing, whether it is in prescribing practices, whether it is in addiction medicine.

I want to go back just briefly to start on your loan repayment program and to learn if any other states are doing that.

Ms. Smith, building on what my colleague said, you wanted to say a little bit more about your loan repayment and then I just want to do like lightning rounds to find out if your states are doing it, and if not, why not?

Ms. SMITH. Yes. So very quickly to add, I was able to find the data here in my notes. We made 91 awards to individuals from 23 different counties that totaled $4.7 million for that program. And it was a combination of both mental and behavioral health practitioners, so more of the clinician level. And then $1.8 million of it was for actual medical professionals, which include CRNPs, physician assistants, and physicians. So we tried to really capture the full range of professionals as part of that program. And the second round of awards is currently out, so applications are being submitted to us for a second round of awarding for that program.

Mrs. BROOKS. And do you believe if we increased the number of residency slots in addiction medicine would that be helpful?

Ms. SMITH. I do believe it would be helpful.

Mrs. BROOKS. Thank you. Dr. Bharel?

Dr. BHAREL. Thank you for this important attention to the professional training. In Massachusetts, we were the first state to develop voluntarily with all four of our medical schools' core competencies that were standardized for all medical students. That was quickly then taken up by all of our three dental schools, as well as our advanced practice nursing programs, physician assistant programs, and training over 8,000 individuals in a standardized way so that they could balance the needs of pain management with the potential for opioid misuse.

Additionally, our social work schools have taken up that training as well as physical therapists. So it is enhancing the capacity for individuals to treat this medical illness.

Mrs. BROOKS. I know one of the challenges with med schools is in the past, they have given very little time to addiction medicine and pain issues. Are they starting with the first year now in your med schools?

Dr. BHAREL. So the trick with our core competencies is we allow each individual medical school to create the curriculum the way that they needed to based on what their curriculum is, so they imposed it in multiple different ways, but that allowed—usually curriculum changes take two to three years. This we were able to do in a matter of weeks because the core competencies were broad enough for them to incorporate. And we know from graduating medical students, they are saying that they are seeing the difference and they feel more prepared.

Mrs. BROOKS. Thank you. Ms. Mullins?

Ms. MULLINS. Sure. We are very excited. We just did a loan repayment program this year. We had over a hundred applicants; I think 102. We funded 22 of those applications in the first round with a 2-year requirement to practice within the state. That was focused on therapists because some of West Virginia's existing loan repayment programs focus on the medical, the physician end, so we really wanted something to focus on the therapy level. But in addition to that, we also provided about 154 scholarships which with the same types of requirements that eliminated the front-end investment and some of the student loan debt as well.

Mrs. BROOKS. Thank you. Mr. Kinsley, very briefly.

Mr. KINSLEY. We have a loan repayment program for both doctors and mid-levels; we have worked to train over 900 residents in North Carolina and currently four of our five medical schools have built the training into their core curriculum.

Mrs. BROOKS. Thank you, and with the chair's indulgence, if we could get Rhode Island to answer.

Ms. DEGETTE. Absolutely. I am not leaving Rhode Island out.

Mrs. BROOKS. Thank you. Dr. Alexander-Scott.

Dr. ALEXANDER-SCOTT. Thank you. Our loan repayment program has also expanded to include behavioral health providers and our medical school does now incorporate the data waiver training into our medical school curriculum so that as students graduate, they automatically have the data waiver to be able to prescribe buprenorphine.

Mrs. BROOKS. Thank you all for working so hard with your higher ed institutions. It is critically important. It will make a difference. I yield back.

Ms. DEGETTE. The gentle lady from Florida is recognized for five minutes.

Ms. CASTOR. Well, thank you, Chair DeGette. I want to thank you as well for calling this hearing on the public health epidemic that is the opioid crisis and thanks to all of you, all of our expert witnesses for everything that you are doing to help families deal with the dire consequences.

In Florida, in the past few years, we have lost well over 5,000 of our neighbors per year; and while I am really proud of the work of this Committee passing 21st Century Cures and the Comprehensive Addiction and Recovery Act and the SUPPORT Act; there is one glaring problem that has been highlighted by a few of my colleagues here today, and that is the lack of continuity of care and resources in the minority states that have not expanded Medicaid. And unfortunately, the State of Florida is one of those.

Mr. Kinsley, North Carolina has not expanded Medicaid. I believe all of the other states have here today, Pennsylvania, Massachusetts, West Virginia, and Rhode Island. In your written testimony, you noted that "for every single person who is brought to the emergency department, nearly half has no health insurance at all." Further, you stated that expanding Medicaid "would bring an additional $4 billion into North Carolina for healthcare."

All of the Democratic members of the Florida congressional delegation yesterday sent a letter back home to the opening day of the Florida legislature. And our message to the governor and to our members back in Florida was that you are not doing right by our citizens.

One recent study said if Florida expanded Medicaid, we would draw down almost $14 billion for our state over the next five years alone. It would improve people's health. It would improve people's access to healthcare, and it would do so much for families who suffer the consequences of substance use disorder.

Mr. Kinsley, talk to us again about how expanding Medicaid in North Carolina would allow the state to better target the use of federal grant dollars to address the opioid epidemic.

Mr. KINSLEY. Thank you for the question, Congresswoman. At present, more than two-thirds of the Federal state opioid response and state targeted response grants that North Carolina received are just going for treatment or expanding care for the individuals that are uninsured. And that is a laudable and notable purpose for those dollars, but we do not have those dollars available to building our workforce, to training our individuals, to increasing the way that our system works together and coordinates care. Instead, we are expanding treatment because we do not have Medicaid expansion in North Carolina.

The North Carolina state legislature reopened and reconvened today around a budget that has not been able to be passed primarily in the debate on Medicaid expansion in North Carolina. And I, too, hope that we are able to expand and increase access in North Carolina.

Ms. CASTOR. Other recent studies have shown that now 37 states plus the District of Columbia have expanded. The other states that haven't, we are sending our dollars to and subsidizing the budgets

in healthcare of some of these other states. Congresswoman Kuster wants to take me to lunch for something.

Ms. Smith, how many lives have you saved in Pennsylvania because Pennsylvania expanded Medicaid?

Ms. SMITH. So, in Pennsylvania, as a result of Medicaid expansion, we have been able to treat about 125,000 additional patients. So for us, that is huge. I can tell you with the large amount of funding, over $230 million coming to the state, if we did not have Medicaid expansion, you would not be hearing me talking about a loan repayment program, about how things—about expanding MAT and corrections, about any of those things because the reality is we would be spending all of those dollars just on I will call it plain old treatment.

So, as a result of Medicaid expansion, we have been able to repurpose those dollars in ways that allow us to modernize the system, to integrate with physical health, mental health, and behavioral health, all together in one system moving forward. So I really can't stress enough the importance of having participated in Medicaid expansion and certainly, hope that it continues for years to come.

Ms. CASTOR. Dr. Bharel, how about you in Massachusetts?

Dr. BHAREL. In Massachusetts, the foundation of our treatment is having access to the medical treatment that is proven and evidence based. Because we have that, we have been able to tackle the very challenging and complex issues related to getting individuals to that care, preventing disease in the first place, and making sure that individuals who are at the highest risk not only obtain that care but stay in with recovery coaching which is, by the way covered by our Medicaid 1115 waiver now.

Ms. CASTOR. Thank you. And Ms. Mullins, West Virginia, I believe, has the highest share of population served through Medicaid. And you talked about the importance of predictability. How important has Medicaid expansion been to opioid and substance use, treatment. You talked about the predictability of care and the predictability of those resources.

Ms. MULLINS. It is very important in terms of sustaining. I talked about the infrastructure that we have been building without Medicaid paying for residential treatment. There is no way to sustain those valuable services. And according to my notes, we have over 21,000 West Virginians receiving medication-assisted treatment in our state.

Ms. CASTOR. Thank you very much. I yield back.

Ms. DEGETTE. Thank you so much. The gentleman from Maryland, Mr. Sarbanes, is recognized for five minutes.

Mr. SARBANES. Thank you, Madam Chair. Thanks to the panel of witnesses, very compelling testimony today, and I thank you all for coming.

We have learned, of course, that one of the root causes is inappropriate prescribing practices and a number of you have spoken to that today and we know that many states such as Virginia and Maine and Rhode Island have set prescribing limits for opioids.

Dr. Alexander-Scott, you highlighted that as part of the response to addiction crisis, your state enacted regulations in 2017 that limited the initial prescription of an opioid for a new patient to no

more than 30, what are called morphine milligram equivalents, or MMEs, per day.

Could you describe a little bit more for us the danger to some patients of exceeding that limit? And do you think that the policy has been successful in steering providers to make better prescribing decisions for their patients?

Dr. ALEXANDER-SCOTT. Thank you, Congressman. We had data that said the higher the morphine milligram equivalence a patient is on for, the longer period of time, the higher their risk is of becoming addicted to opioids over time, and thus their risk of an overdose.

We wanted to make sure that there was flexibility for the provider in determining what was needed for the patient; we also thought it critical to distinguish between acute pain and chronic pain in limiting the opioids prescribed.

So by cutting off the MME at 30 for an acute reason for pain, we have seen a substantial decrease in the number of opioids prescribed for an initial use of pain, particularly for acute pain scenarios.

We have chosen to handle chronic pain needs separately because oftentimes, people already have an addiction or a tolerance to opioids that require a more multi-disciplinary approach to addressing that.

Mr. SARBANES. Let me drill down on that a little bit more. Because I know the CDC, in their recommendations, has indicated that providers should avoid prescribing over 90 MMEs a day and many states have put that kind of recommendation into code. I think Nevada and South Carolina have limited opioid prescriptions to 90 MMEs or under in most patient cases. There are a lot of products on the market, especially extended release and long-acting opioid products, that do exceed that even 90 MME a day limit. And some of them even double or triple that limit.

So I understand that the products are intended for patients who have become opioid resistant, as you mentioned to these lower dose-products, but do these high dosage opioids pose enough of an overdose risk that we should at least begin to explore methods to limit their market availability in your judgment?

Dr. ALEXANDER-SCOTT. We have certainly considered that in our regulation's approach for acute pain management in addition to the 30 morphine milligram equivalents limitation. We have also required that long-acting opioids are not used for acute pain in those scenarios as well because of the challenge that can occur, and again, distinguishing from those patients that already are dealing with chronic pain and would need to be handled separately.

Mr. SARBANES. Well, thank you. I know FDA has taken previous action to limit the use of these high-dose products and they have imposed something called a REMS, a risk evaluation and mitigation strategy program on providers who prescribe these products. I also know that there was a recently released JAMA study on this topic that failed to find any evidence that the REMS program was actually successful at achieving those goals of reducing inappropriate prescribing.

Given the CDC recommendations, state precedent on prescribing limits, and the lack of existing action, it may be time for FDA or

Congress, or both of us, to explore options for limiting the market availability of high-dose opioid products that are currently on the market and limiting these new high-dose products, restraining them from entering the market in the future. So I think that is something we want to look at, and I look forward to exploring a wide array of solutions to combating the opioid crisis and making sure states have the funding and flexibility to support these affected communities. And thank you again for your testimony. I yield back.

Ms. DEGETTE. The gentleman from New York, Mr. Tonko, is recognized for five minutes.

Mr. TONKO. Thank you, Madam Chair. Thank you to our panel for an interesting and very helpful conversation. In your testimony, many of you hit on a topic that is near and dear to my heart and that is eliminating bureaucratic and unnecessary barriers to substance use treatment. Research has shown that individuals who are being actively treated with buprenorphine lower their risk of opioid overdose by up to 50 percent, even when provided without corresponding comprehensive psychosocial supports or services. With any other medication that lowered mortality by 50 percent, we would be rightfully hailing this as a miracle drug and doing everything in our power to get it out to anyone who could possibly need it. Unfortunately, here in the United States, we continue to make it harder to obtain these medications than the powerful opioids that got us into the problem in the first place.

So Secretary Smith, I was pleased to see that in your testimony, you called for the elimination of the requirement for providers to obtain a waiver from the DEA in order to prescribe buprenorphine for treating opioid dependence. I have introduced the bipartisan Mainstreaming Addiction Treatment Act with over 100 co-sponsors to do exactly that.

Can you describe for the Committee why this is such an important step to take in expanding access to addiction treatment?

Ms. SMITH. Absolutely, and thank you so much for sponsoring that legislation that we are fully supportive of. So I mentioned earlier in my opening that we have expanded our DEA X waivered physicians to over 4,000. And we are near the top of the list when you look at states in terms of number of X waivered physicians. But looks can be deceiving. So when you actually take a look at those 4,000 waivered doctors, and you look at what are their prescribing capacities, and then whether or not they are actually prescribing up to their capacity or not, it is pretty staggering. So we have got a very large percentage who are still at that 30 patient capacity level and most of them are not even prescribing up to 30 patients. And so we have worked with an organization called Vital Strategies to design a survey that is going to go out to all 4,000 of our X waivered physicians in the state to ask some very specific questions about why they aren't treating more patients. Would they be willing to treat more patients? Is it an education issue? Is it a barrier because of additional oversight?

And so anecdotally, we definitely heard that efforts to over-regulate are what they often say. Doctors who were trained to administer any and all kinds of medications but to specifically call out this kind of medication and say you need a special waiver to ad-

minister this; they just don't want to be bothered with that. And so Pennsylvania believes that any steps we can take to eliminate those barriers, to change the conversation around the idea that treating addiction is a clinical necessity and we rely on trained physicians to be able to provide that treatment.

Mr. TONKO. If I could have the rest of the panel respond yes or no. Do you agree with the assessment just made by Secretary Smith?

Dr. BHAREL. Yes, hello. Thank you for that question. The access to MAT and decreasing the barriers are critical and we often spoke about it in our testimony.

Mr. TONKO. Do you agree with the waiver?

Dr. BHAREL. Yes.

Mr. TONKO. I want to use my time here wisely. So thank you. Yes.

Ms. Mullins?

Ms. MULLINS. Yes, but we don't have a therapist to really support those physicians once they are—can prescribe. For us, the workforce shortage is way more impacted on the therapy and the counseling side.

Mr. TONKO. Mr. Kinsley, please.

Mr. KINSLEY. Yes, we are supportive.

Mr. TONKO. And Doctor?

Dr. ALEXANDER-SCOTT. Yes, we support and also look to expand the services available as well.

Mr. TONKO. OK, and many of you also mentioned individuals released from incarceration as a population particularly vulnerable to opioid overdose, with Commissioner Bharel noting that the justice-involved population has death rates of 420 times higher than the general population. I heard your exchange with my colleague from New Hampshire.

So, while federal grant opportunities such as the Medication and Assistive Treatment Reentry Initiative are helping to fill in some of the gaps, I believe a more comprehensive and sustainable strategy is required, therefore; I have championed the Medicaid Reentry Act which would allow states to restart Medicaid benefits for incarcerated individuals 30 days prior to release providing a sustainable funding stream for medication-assisted treatment, case management, and recovery support services, and creating a more seamless transition back into community care.

Commissioner Bharel, would be allowing states the flexibility to restart Medicaid benefits for eligible incarcerated individuals 30 days prior to release help to reduce overdose deaths for that population?

Dr. BHAREL. Making sure there is a continuity of care is critical both to medical and the other support mechanisms that you stated.

Mr. TONKO. Thank you. I have exhausted my time. I have several other questions which I will submit to the subcommittee, and with that I yield.

Ms. DEGETTE. I thank the gentleman. The gentle lady from New York is recognized now for five minutes.

Ms. CLARKE. Thank you very much, Madam Chair, and I thank our ranking member. We have heard a lot of encouraging stories from the states today about how they would be able to put federal

funds to use and make progress. But it is also clear that there are still unmet needs and unresolved challenges that states face as they work to address the ongoing crisis.

I would like to explore some of the remaining challenges as we consider further support.

Ms. Mullins, in your testimony, you noted unresolved challenges around building a robust addiction treatment workforce, including attracting and retaining people to work in rural areas throughout the state. Can you describe what steps the state is undertaking to address this challenge and what additional hurdles remain?

Ms. MULLINS. So there are multiple challenges for this. It is a pervasive workforce shortage in all areas of employment in West Virginia. We do not have enough people to fill our vacancies. But it also is about parity in terms of what we pay our mental health and addictions workforce. It is not the same, so when students graduate with debt, they are graduating with levels of debt that cannot really expect to earn salaries that are commensurate with their levels of education. So to me, that is a fundamental thing that we must address and end the student loan debt to go with it. So we have really been focusing on those loan repayment programs, scholarship programs, anything that we can to really increase A, our pipeline, but then also to provide the ongoing education that we can. And we are finding that our individuals that are entering recovery have a really strong interest in providing services, so we are paying particular attention in our loan repayment programs, even to persons who might be in recovery and wishing to take those next steps to enter the workforce.

Ms. CLARKE. So is that at the state level? Is it something at the federal level that you think can be helpful in sort of undergirding and helping to unearth individuals who would move into that line of work?

Ms. MULLINS. I think the flexibility to use the funds in those creative ways would really be very beneficial.

Ms. CLARKE. Very well. Secretary Smith, in your written testimony submitted to the Committee, you also referenced a lack of additional treatment, excuse me, addiction treatment workforce, and noted that "Demand on addiction treatment workforce will increase as more people move toward treatment and recovery."

So can you describe how the lack of addiction treatment workforce has inhibited Pennsylvania's ability to provide services to vulnerable populations? And what steps has your state taken to address this problem given, that more people are moving toward treatment and recovery?

Ms. SMITH. Yes, certainly. Our workforce challenges, particularly in urban centers like Philadelphia and Pittsburgh, have really inhibited the ability for some of those more vulnerable populations to access treatment. To give you an example, we have an advisory council that advises my department and one of the members of that council is a practicing addiction medicine physician who happens to also treat adolescents. But he is part of the Latino community and his practice is so overwhelmed with patients that he is working well into the night beyond his office closure hours because those individuals have nowhere else to go.

And so part of the challenges that we hear in building a workforce where you don't have communication barriers, so where you have got doctors who are treating patients that really understand them and communicate with them, a lot of the challenges come down to the education and training requirements and some of those language barriers that exist in being able to meet those requirements.

Ms. CLARKE. So you have ID'd a cultural competence essentially.

Ms. SMITH. Yes.

Ms. CLARKE. Very well. Mr. Kinsley, in North Carolina's response letter to the Committee, the state notes that "in many of North Carolina's communities hardest hit by the opioid epidemic it is difficult to implement programs and build treatment and recovery access because the community lacks basic infrastructure including broadband and cell phone service."

So can you describe how broadband and cell phone services are important to helping North Carolina address the opioid epidemic in these communities; what more could Congress do to overcome this challenge?

Mr. KINSLEY. Thank you for the question. Telehealth access in our rural communities is the key strategy for our efforts to expand access to treatment, yet there are many parts of North Carolina that can't sustain more than a 4G signal digitally or have access to broadband. And so, without those, we are not able to sustain those services. That, of course, is built on the fact that it is a sustainable approach for education, for all these providers, for parity. I agree with what all of my colleagues have said.

Ms. CLARKE. Very well. I have run out of time and Dr. Scott, I did have a question for you, but I will submit it for your response at a later time.

But Madam Chair, I would like to ask for this letter from the New York State Office of Addiction Services and Support to be added to the record.

Ms. DEGETTE. Without objection, it is entered.

Ms. CLARKE. OK, thank you. I yield back, Madam Chair.

Ms. DEGETTE. The Chair now recognizes the very patient, Mr. Latta for five minutes and welcome to the subcommittee.

Mr. LATTA. Well, thank you, Madam Chair, and first, I want to thank you very much for letting me to waive on today. I really appreciate it because this is a really important and very relevant topic.

Just in one of the major newspapers in the State of Ohio yesterday had an article that just came out and something we have heard coming. But we know that in 2009 we had 1,423 people die of an overdose in the State of Ohio. That number went up in 2017 to 4,854. And the trend right now, thank heavens, it is going down. It was 3,764 last year, but these are all deaths that we don't want to see at all, these overdose deaths.

I know when I have gone around my district, it is very important when I am talking to my healthcare providers and other folks out there. One of the things they were telling me for several years is we can't find help. And it is everything from finding the dollars to finding where they can get services. So in the last Congress, I introduced what we call the INFO Act, which established a dash-

board through HHS so that states and communities could go out there and find help.

What I would like to ask you all today are just some questions as to what is going on in your states, if I may, and if I could ask everyone, I don't have a lot of time, but maybe be brief on your answers, but some of your states have developed public-facing dashboards. When were these dashboards created and what information do you have in them? If we could just go right down the line.

Ms. SMITH. Sure. I will be as brief as possible. Pennsylvania does have an interactive opioid data dashboard. If you go to pa.gov/opioids, you are able to access that. It contains information like prescription drug monitoring information, overdose deaths, naloxone distributions, NAS, EMS leave-behinds, treatment statistics, and the number goes on and on and on. So happy for you to check that out and if you have questions, let me know.

And was there a second part to your question?

Mr. LATTA. It was mainly about what information do you have contained in them.

Ms. SMITH. Yes, and it was established about two years ago.

Mr. LATTA. Thank you.

Ms. SMITH. You are welcome.

Dr. BHAREL. Thank you for the question. Since 2015, Massachusetts has put out a quarterly dashboard that contains much of the same information related to a number of deaths, both reported and predicable using a predictive model, as well as by town and city, so all 351 towns and cities get a report on the number of deaths in their communities so they can do local-based planning as well, as well as EMS and healthcare data.

We also, since 2015, have put together for the first time data across state government, so we are looking for the first time at house data as it relates to public health, but also criminal justice, schools, et cetera.

Mr. LATTA. Thank you.

Ms. MULLINS. So for West Virginia, over the last couple of years, we have been using reports uploaded quarterly that highlight things like overdose deaths, prescription drug monitoring, and different data points that we have been focusing on through our grants with the Centers for Disease Control and surveillance. We do that quarterly. But this week, actually, we expect to upload and make public a dashboard that tracks nonfatal deaths, nonfatal overdoses, and stay tuned. We are really looking forward to releasing that this week.

Mr. LATTA. Thank you.

Mr. KINSLEY. North Carolina launched its opioid action plan dashboard in 2017. This dashboard not only has key data points and is updated consistently around the opioid epidemic, but it also broadens into other aspects of substance use disorder. It allows counties and local communities to drill down into the information in their community which we have seen as being incredibly powerful at aligning all of us to the same strategies and also getting foundations, nongovernmental entities, and private/public partnerships onboard with focusing their dollars in the same way that we need to focus.

And the other thing is that all of these indicators relate back to our strategy, those key performance indicators that help us measure our success in this effort.

Dr. ALEXANDER-SCOTT. Similar to what has been heard, in Rhode Island, when the governor activated the Overdose Prevention and Intervention Task Force, we understood that having a dashboard would be critical to that. And that was activated in the 2015 time frame.

Our dashboard does serve as a metric for each of our strategic initiatives on prevention, recovery, reversal, and treatment, and also allows for the public to be able to access where treatment services are. And naloxone is available, as well as access to other recovery services that are needed.

Mr. LATTA. Thank you. In my last 15 seconds, if I could do this real quick, if I could just real quick, maybe it is a yes or no. Have your communities had problems finding those federal dollars out there to get that help? Yes or no, down the line.

Ms. SMITH. Yes and no.

Mr. LATTA. OK.

Ms. MULLINS. Mostly no because of the way our procurement system has worked and the capacity to put data out into the communities so they know what problems they are seeing and they can then ask us for the appropriate funding targeted.

Ms. MULLINS. I would go with Secretary Smith's answer yes and no. Many people have no trouble, but there are still some folks out there struggling to find that information.

Mr. LATTA. Thank you.

Mr. KINSLEY. We have been able to deploy funds to more than 50 local communities. Our issue is primarily that we don't have enough funds because they are all going to augment treatment.

Dr. ALEXANDER-SCOTT. We use a data-driven process to target which communities need it most and are really looking, given that it is Rhode Island, to make sure that every town and city has access to the services needed.

Mr. LATTA. Thank you very much. Madam Chair, again, I would like to thank you very much for allowing me to waive on today.

Ms. DEGETTE. I thank the gentleman. But I want to thank all of our witnesses. One of the members said this was one of the best hearings we have had this session and I agree. It is really excellent and very good information as we move forward to see what our next steps are.

In response to the Committee's September 18th letter, the Committee received responses from 16 states regarding how the states address the opioid crisis with the support of federal funding. And I move to enter all of those responses into the record. And in addition, let us see, we are going to enter them all from Florida, Indiana, Kentucky, Maine, Maryland, Massachusetts, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, West Virginia, and Wisconsin. Without objection, those will be ordered.

And in addition, in continuation of our bipartisan work looking at addiction and treatment issues today, the Committee is sending a bipartisan letter signed by the ranking member, myself, and others, letters to the DEA, DHS, and HHS about the emergence of

what this panel was talking about methamphetamine and polysubstance use and what the administration is doing about this. I would ask for unanimous consent to enter those three letters into the record. Without objection, that will be ordered as well.

The Chair would like to remind Members that pursuant to the Committee rules; they have ten business days to submit additional questions for the record to be answered by the witnesses. Several of the members did ask the witnesses to answer additional questions and I would ask all of you to respond promptly if you receive any of those questions. And with that, this subcommittee is adjourned.

[Whereupon, at 12:31 p.m., the subcommittee was adjourned.]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you, Madam Chair. Last Congress, the Energy and Commerce Committee worked in a bipartisan manner to produce legislation that was signed into law by President Trump. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, or SUPPORT Act, was written to help advance treatment and recovery initiatives for those affected by opioid addiction.

I thank our witnesses for being here today. Your testimony will be helpful in understanding the challenges we face in continuing this fight against opioid addiction and death, while ensuring that patients can manage their pain. It is important to Congress to have hearings like this one, where we can ensure the effectiveness of our legislative efforts and identify gaps in which we can improve the health of Americans.

I yield back.

ANDREW M. CUOMO
Governor
ARLENE GONZÁLEZ-SÁNCHEZ, M.S., L.M.S.W.
Commissioner

January 10, 2020

Honorable Diana DeGette
Chair
Subcommittee on Oversight and Investigations,
Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Honorable Brett Guthrie
Ranking Member
Subcommittee on Oversight and Investigations,
Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chair DeGette and Ranking Member Guthrie:

Thank you for the opportunity to share with the Committee on Energy and Commerce a description of some of the initiatives that New York State has launched to address the opioid epidemic under Governor Andrew M. Cuomo's leadership and to comment on how we are using federal funds to combat this crisis.
The issue of addiction, and in particular the prevalence of opioid addiction, has grown to be and continues to be a major public health crisis across the country. New York State has not been insulated from the epidemic. Consistent with the national trend, New York has seen a rise in fatal overdoses with opioid overdose deaths increasing by 573% between 2004 and 2017.

Fortunately, there is some good news to report in New York. Through the implementation of various programs, we have increased access to treatment, improved support for those in recovery, expanded awareness of heroin and opioid addiction, and enhanced statewide prevention efforts. These efforts have led to the first decrease in 10 years in opioid overdose deaths among New York State residents, both inside and outside of New York City.

Many successful initiatives in New York have been accomplished with the assistance of federal funding, most notably through the Opioid State Targeted Response Grant (STR) and the State Opioid Response Grant (SOR). Funding through these grants has enabled us to focus on establishing and enhancing services in the areas with the highest needs, determined by the rate of opioid-related overdose deaths, the rate of opioid-related emergency department visits, and the percentage of residents with opioid use disorder (OUD) leaving their counties to access services elsewhere.

We have used a substantial amount of this funding to establish Centers of Treatment Innovation, or COTIs, which deliver critical services including mobile treatment and transportation, telepractice, peer support, and

rapid linkage to medication-assisted treatment (MAT). These COTIs have helped to bring about a positive transformation within the OASAS system of care and have engaged nearly 14,000 people who may not have otherwise come into contact with an OASAS-certified treatment program. More than 8,800 of these individuals have been admitted to an OASAS-certified treatment program and 8,200 have received MAT.

Between 2016 and 2018, counties targeted under the first year of the STR Grant saw a 25% decrease in opioid-related overdose deaths, compared to only a 5% decrease for non-STR Grant counties. In addition, during the same time period, opioid-related emergency department visits decreased by 48% in the first STR Grant counties while decreasing by 19% in counties not targeted. Currently, there are 20 COTI providers serving 35 counties, and in the coming year with SOR funding, we plan to expand these services to every county in New York State.

In addition to the COTIs, STR/SOR funding has also been used to increase services for incarcerated individuals who are transitioning out of the criminal justice system. Using a combination of federal, state, and local funding, 42 county correctional systems plus Rikers Island, which serves the five boroughs of New York City, and seven state facilities now offer Substance Use Disorder (SUD) counseling, MAT education and services, and, upon release, a discharge plan for individuals to continue MAT with linkages to treatment.

New York has also used federal funds to address shortages of qualified medical practitioners, mainly in underserved rural areas of the state. We have implemented a program to train medical practitioners in the provision of MAT using buprenorphine for individuals with an OUD in high-need counties of the state. Participants who completed this training have received guidance on strategies to manage patients in an office setting, including best practice guidelines and procedures, and case-based learning.

OUD services were also expanded at four pre-existing New York State Department of Health AIDS Institute 'Health Hubs' and eight new Health Hubs were created. This initiative is making unique addiction and other critical health services available in places where they did not previously exist, were available in a limited capacity, or were only available to individuals after a long waiting list. This effort expanded hours of service, increased staffing, established peer navigators, increased rapid access to MAT, and facilitated linkages to community-based care.

New York State also used STR and SOR funds to train first responders and other likely witnesses to recognize and respond to opioid overdoses in the targeted high need counties. This initiative included providing naloxone kits or information on how to get kits at local pharmacies using the state's Naloxone Copayment Assistance Program (N-CAP). As a result of these efforts, more than 11,700 individuals have been trained on Narcan administration using STR and SOR funds.

To increase services focused on youth and young adults, OASAS has developed a statewide youth and young adult driven infrastructure to support local communities of young people in recovery from substance use disorders. STR and SOR funds were used to establish five Collegiate Recovery Programs across the state where colleges provide supportive environments that reinforce the decision to engage in a lifestyle of recovery from substance use disorder.

Through the use of this federal funding, we have also opened new recovery centers and youth clubhouses throughout the state. These are non-clinical facilities which offer support to promote long-term wellness and

recovery through skill building, recreation, wellness education, employment readiness, and other social activities. New York State now has 32 recovery centers and 24 youth clubhouse locations. Additionally, a Recovery Center/Youth Clubhouse has been opened at the Saint Regis Mohawk Tribe that is serving youth mostly under age 18. In 2018, recovery centers in New York State, recorded over 72,000 visits and young people made nearly 41,000 visits to youth clubhouses in 2018. In addition, the results of a survey conducted between August and October 2019, 762 people who attended one of 25 participating recovery centers indicated that, over 80% of respondents reported that they were less likely to use substances as a result of the services received, and 85% of respondents reported that the services had helped them "cope when things go wrong". Recovery centers provide essential supports for adults, families and young people who need to find safe spaces to connect with others without using substances. The large numbers of people who have accessed these new services in communities all over New York State illustrates the demand for these services. Every visit represents a step toward healthier living for that individual.

On the prevention side, OASAS providers have partnered with more than 90 community organizations across the state to deliver evidence-based prevention services to underserved, hard-to-reach youth. Results from these programs indicated increases in peer pressure resistance skills, positive shifts in attitudes and perceptions of substance use, and general increases in knowledge of SUD in all age groups from kindergarten through 12th grade. Adults participating in parenting programs also showed positive results in post-intervention assessments.

An additional evidence-based practice, the Strengthening Families Program, is being delivered with STR and SOR funding to families in New York City shelters and permanent supportive housing. This program is focused on establishing effective communication between parents and children, positive family management practices, and a supportive family environment, all of which have been shown to lead to reduced substance use among youth.

Youth in foster care is another area of focus for New York State. Historically, youth in foster care are among the highest-risk populations for developing problems with substance use. While many foster care agencies have been able to incorporate and/or develop relationships to provide prevention and treatment services into their continuum, this had been limited due to the multiple needs of the population. By working with our state partners at OCFS and using part of this federal funding, we implemented a brief screening tool, " CRAFT", and the evidenced based practice 'Teen Intervene', to further assist in meeting the needs of high risk youth ages 12 to 19 and to establish a protocol for Screening, Brief Intervention and Referral to Treatment in a voluntary foster setting.

We have also increased targeted services for pregnant women in areas of the state with high rates of pregnant women entering treatment, and babies born with neonatal abstinence syndrome, through the Maternal Wraparound program. Four providers received funding to implement this program, which involves intensive care management and recovery support services for women who are pregnant, including services for up to six months after they give birth.

Through federal grant funding, we have also launched numerous bilingual (i.e., English and Spanish) public awareness campaigns across New York State, including several focused on targeted populations such as Native American communities, Latino communities, and pregnant women. These campaigns include outreach

through radio and television, billboards, ads on public transportation, displays in medical offices and content in medical journals.

As we look forward, it is critical for states that funding provided through the STR and SOR grants is made permanent by incorporating the full amount of the SOR funding into the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG). Rather than providing time-limited grants with restrictions on use, a permanent increase in the SAPT-BG would allow states more flexibility to address their individual needs through existing infrastructure and help them to better address emerging drug use trends, as well as sustain ongoing efforts to develop prevention, treatment, and recovery services. In order to prevent the next crisis, stable and sufficient funding must be allocated to support states in a way that allows them to best meet their unique needs in addressing substance abuse as it arises.

To better address the treatment needs of the diverse communities and populations of New York State, we also recommend the suspension of the DEA rules limiting the establishment of new mobile methadone clinics in states that do not already have an existing program. Like many states, New York has a large number of rural communities with limited access to specialized medical and behavioral health care. Allowing the development of carefully-regulated mobile methadone programs would reduce, or even eliminate in some cases, the travel time associated with participation in an Opioid Treatment Program, and will increase access to this type of treatment in regions where these resources are currently very limited.

Additionally, to further expand access to MAT, we recommend that the following actions be taken to facilitate access to buprenorphine:

- Removing the cap of thirty (30) patients the first year a practitioner can prescribe buprenorphine.
- Reducing the number of training hours for Nurse Practitioners (NPs) and Physician Assistants (PAs) to obtain a prescribing waiver for buprenorphine from 24 to eight training hours, consistent with physicians.
- Reform regulatory requirements that prevent initiation of buprenorphine via telehealth to increase access to MAT.

It is imperative that action be taken to increase access to all forms of MAT for those in need of treatment. Failure to do so will put more lives at risk.

We also recommend steps to increase the availability of services for people in criminal justice settings. According to the National Institutes of Health, one in 70 people who are released from prison or jail are hospitalized within a week of their release. This is 2.5 times higher than the rate of hospitalizations for people who were never incarcerated. Because these individuals use Medicaid services such as inpatient hospital stays, psychiatric admissions, and emergency department visits for drug overdoses at a far higher rate in the months immediately following their release, we recommend that incarcerated individuals be allowed to receive transitional services 30 days prior to their release from custody. Allowing them to receive Medicaid reimbursed services will improve health outcomes and decrease overall costs due to reduced emergency services and reincarceration.

Additionally, there is a workforce shortage of qualified addiction professionals. Currently, the Health Resources Services Administration's National Health Service Corp Substance Use Disorder Loan Repayment Program's (NHSC SUD LRP) eligibility criteria are based on Health Program Shortage Areas (HPSAs) for primary care and/or mental health shortage areas, not areas with high opioid-and other drug-related overdose and use rates. This means high opioid-and-other-substance-overdose-and-use-rate areas in NYS do not qualify for these vital workforce recruitment and retention programs. A system to document areas with high opioid-and-other-drug-related overdose and use rates must be developed and used as the criteria to qualify for the NHSC SUD LRP to ensure areas most in need of these workforce funds may qualify for them.

Finally, New York State has made substantial advancements in establishing equivalence between behavioral and primary health care, enacting significant parity-related insurance law changes beginning in 2017. However, in many cases, the monitoring and enforcement of such laws, particularly the Mental Health Parity Addiction Equity Act, are insufficient. Stronger enforcement of this law on a federal level will further support our efforts to increase parity, particularly among individuals who are covered by non-New York State regulated plans and will decrease the use of New York State funding that is used to pay for those who are underinsured. Parity enforcement is critical to ensuring timely access to behavioral health care, especially in cases where individuals are not covered by insurance policies that fall under New York State's existing protections.

Although we are making progress in fighting the opioid epidemic, we know that this crisis is not over, and we must remain vigilant in our efforts to address it. The most recent quarterly report on overdose deaths from New York State's Department of Health showed opioid overdose deaths among New York State residents outside of New York City decreased 16% between 2017 and 2018. This is a significant milestone in our efforts to address this crisis. Similarly, preliminary data from the New York City Department of Health and Mental Hygiene showed that drug-related overdose deaths decreased between 2017 and 2018.

With the ongoing support of the federal government, we will be able to continue our progress, and bring lifesaving assistance and resources to those who have been affected.

I look forward to working with you on these important efforts.

Sincerely,

Arlene González-Sánchez

Arlene González-Sánchez

Commissioner

501 7th Avenue I New York, New York 10018-5903 I oasas.ny.gov I 646-728-4760

1450 Western Avenue I Albany, New York 12203-3526 I oasas.ny.gov I 518-473-3460

FRANK PALLONE, JR., NEW JERSEY
CHAIRMAN

GREG WALDEN, OREGON
RANKING MEMBER

ONE HUNDRED SIXTEENTH CONGRESS

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COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

January 14, 2020

The Honorable Uttam Dhillon
Acting Administrator
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

Dear Acting Administrator Dhillon:

We write today regarding our concerns over increasing use of stimulants, such as cocaine and methamphetamine, in the United States.

We have conducted extensive oversight and legislative work related to opioids and fentanyl, both of which remain threats to Americans and therefore remain top priorities. However, the use of stimulants by Americans has been increasing and is extremely concerning. As noted by the 2018 National Drug Threat Assessment, "as the ongoing opioid crisis justly receives national attention, the methamphetamine threat remains prevalent" and "the cocaine threat has rebounded."[1]

We are concerned that while the nation, rightly so, is devoting much of its attention and resources to the opioid epidemic, another epidemic—this one involving cocaine and methamphetamine—is on the rise.

Cocaine is a Schedule II drug under the Controlled Substances Act and is a white, crystalline powder derived from coca leaves grown in Bolivia, Peru, and Colombia. Cocaine base, or crack, looks like small irregularly shaped chunks or rocks that are whiteish and solid. The drug is an intense, euphoria producing stimulant drug with strong addictive potential that can be snorted, injected, or smoked.[2]

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According to the Centers for Disease Control and Prevention (CDC), "[a]lmost 5 million Americans reported current cocaine use in 2016, which is almost 2 percent of the population."[3] While cocaine-involved overdose death rates in the United States decreased from 2006 to 2012, they began increasing again in 2012.[4] CDC further reports that cocaine "was involved in nearly 1 in 5 overdose deaths during 2017."[5] According to a recently released National Vital Statistics report, in 2017, there were 14,948 drug overdose deaths in the United States involving cocaine, which accounted for 21.3 percent of drug overdose deaths in the United States that year.[6]

According to the 2018 National Drug Threat Assessment, cocaine availability and use in the United States have reemerged, with cocaine initiates and cocaine-involved overdose deaths exceeding the 2007 benchmark levels.[7] According to the Assessment, this increase is largely due to the significant increases in coca cultivation and cocaine production in Colombia as well as the increasing presence of fentanyl in the cocaine supply.[8] In addition, the Assessment notes that the "[a]verage retail price per pure gram of cocaine decreased while average gram purity increased between January 2012 and March 2017."[9] According to U.S. Customs and Border Protection (CBP) data, in fiscal year (FY) 2019, there were 89,207 pounds of cocaine seized nationwide, compared to 51,592 pounds in FY 2018.[10]

Methamphetamine is a Schedule II drug under the Controlled Substances Act and is a pill or powder; however, crystal meth can resemble glass fragments or shiny blue-white rocks. Methamphetamine is a highly addictive drug with potent central nervous system stimulant

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properties and can be swallowed, snorted, injected, or smoked.[11] The 2018 National Drug Threat Assessment notes that an "[a]nalysis of domestic methamphetamine purchases from January 2012 through March 2017 indicates that the price per pure gram of methamphetamine decreased 13.6 percent—from $81 to $70—while the purity increased six percent—from 87.9 percent to 93.2 percent."[12]

Methamphetamine remains prevalent and widely available in the United States.[13] According to CBP data, in FY 2019, there were 68,585 pounds of methamphetamine seized nationwide, compared to 57,440 pounds in FY 2018.[14] Most of the methamphetamine in the United States is produced in Mexico and smuggled across the Southwest Border. While cartels continue trafficking fentanyl, they are also continuing to traffic cheaper and more potent supplies of methamphetamine.[15]

Compared to the methamphetamine being produced in Mexico, there is more limited production in the United States, and seizures of domestic methamphetamine laboratories have steadily declined for years.[16] This shift is largely a result of the Combat Methamphetamine Epidemic Act of 2005, which "requires retailers of non-prescription products containing pseudoephedrine, ephedrine, or phenylpropanolamine to place these products behind the counter or in a locked cabinet. Consumers must show identification and sign a logbook for each purchase."[17] Since ephedrine and pseudoephedrine are precursor chemicals that are used to make methamphetamine, production shifted to Mexico where the precursor chemicals were more accessible.

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Rates of overdose deaths from all psychostimulants, including methamphetamine, have been increasing since 2010.[18] In 2017, more than 10,000 Americans died from an overdose involving psychostimulants with abuse potential, which was a 37 percent increase from 2016.[19] According to the aforementioned National Vital Statistics report, in 2017, there were 9,356 drug overdose deaths in the United States involving methamphetamine, which accounted for 13.3 percent of drug overdose deaths in the United States that year.[20]

The National Vital Statistics Report breaks down the drugs most frequently involved in drug overdose deaths in 2017 by the U.S. Department of Health and Human Services' (HHS) ten regions, and found that, "[i]n the majority of states west of the Mississippi River, methamphetamine was the most common drug implicated in drug overdose deaths" in 2017.[21] Further, while cocaine was not ranked number one for any of the regions, it was ranked in the top six for all of the regions, and in the top three for six of the ten regions.[22]

Unlike medication assisted treatment available for the treatment of substance-use disorders involving opioids, there is currently no U.S. Food and Drug Administration (FDA)-approved medication for the treatment of a substance-use disorder involving cocaine or methamphetamine.[23, 24] Rather, a substance use disorder involving cocaine or methamphetamine is best prevented and treated with behavioral therapies.[25] Because a cocaine overdose often leads

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to a heart attack, stroke, or seizure,[26] and a methamphetamine overdose often leads to a stroke, heart attack, or organ problems, first responders and emergency room doctors treat the overdose by treating those conditions.[27, 28]

According to a former chief of operations for the DEA, "[a]ny time in our history, when we have had a period of high opioid abuse, like we have been experiencing over the past few years, ultimately, it's followed by an increased level of abuse and addiction of powerful central nervous system stimulants like methamphetamine."[29]

We remain committed to advance treatment, improve prevention, protect communities, and bolster efforts to fight deadly illicit drugs like opioids and fentanyl. However, our country's fight against illicit substances must be multi-faceted and we want to ensure that the appropriate attention and resources are devoted to combat these other substances as well. Accordingly, we seek to better understand how the relevant agencies are monitoring and combating this growing threat.

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To assist us in our efforts, we ask that you please make arrangements to provide a briefing to Committee staff by February 4, 2020. We appreciate your prompt attention to this request. Should you have any questions about this request, and to schedule the requested briefing, please contact Kevin McAloon of the Majority Staff at (202) 225-2927 or Brittany Havens or Jen Barblan with the Minority Staff at (202) 225-3641.

Sincerely,

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Chairman

Greg Walden
Ranking Member

Anna G. Eshoo
Chairwoman
Subcommittee on Health

Michael C. Burgess, M.D.
Ranking Member
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Diana DeGette
Chair
Subcommittee on Oversight
and Investigations

Brett Guthrie
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COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

January 14, 2020

The Honorable Chad Wolf
Acting Secretary
Department of Homeland Security
Washington, DC 20528

Dear Acting Secretary Wolf:

We write today regarding our concerns over increasing use of stimulants, such as cocaine and methamphetamine, in the United States.

We have conducted extensive oversight and legislative work related to opioids and fentanyl, both of which remain threats to Americans and therefore remain top priorities. However, the use of stimulants by Americans has been increasing and is extremely concerning. As noted by the 2018 National Drug Threat Assessment, "as the ongoing opioid crisis justly receives national attention, the methamphetamine threat remains prevalent" and "the cocaine threat has rebounded."[1]

We are concerned that while the nation, rightly so, is devoting much of its attention and resources to the opioid epidemic, another epidemic—this one involving cocaine and methamphetamine—is on the rise.

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Sincerely,

Frank Pallone, Jr.
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Greg Walden
Ranking Member

Anna G. Eshoo
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January 14, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar:

We write today regarding our concerns over increasing use of stimulants, such as cocaine and methamphetamine, in the United States.

We have conducted extensive oversight and legislative work related to opioids and fentanyl, both of which remain threats to Americans and therefore remain top priorities. However, the use of stimulants by Americans has been increasing and is extremely concerning. As noted by the 2018 National Drug Threat Assessment, "as the ongoing opioid crisis justly receives national attention, the methamphetamine threat remains prevalent" and "the cocaine threat has rebounded."[1]

We are concerned that while the nation, rightly so, is devoting much of its attention and resources to the opioid epidemic, another epidemic—this one involving cocaine and methamphetamine—is on the rise.

Cocaine is a Schedule II drug under the Controlled Substances Act and is a white, crystalline powder derived from coca leaves grown in Bolivia, Peru, and Colombia. Cocaine base, or crack, looks like small irregularly shaped chunks or rocks that are whiteish and solid. The drug is an intense, euphoria producing stimulant drug with strong addictive potential that can be snorted, injected, or smoked.[2]

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[1] U.S. Drug Enforcement Administration, *2018 National Drug Threat Assessment* (Oct. 2018) (www.dea.gov/sites/default/files/2018-11/DIR-032-18%202018%20NDTA%20final%20low%20resolution.pdf).

[2] U.S. Dept. of Justice, Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide, 2017 Edition* (2017)

According to the Centers for Disease Control and Prevention (CDC), "[a]lmost 5 million Americans reported current cocaine use in 2016, which is almost 2 percent of the population."[3] While cocaine-involved overdose death rates in the United States decreased from 2006 to 2012, they began increasing again in 2012.[4] CDC further reports that cocaine "was involved in nearly 1 in 5 overdose deaths during 2017."[5] According to a recently released National Vital Statistics report, in 2017, there were 14,948 drug overdose deaths in the United States involving cocaine, which accounted for 21.3 percent of drug overdose deaths in the United States that year.[6]

According to the 2018 National Drug Threat Assessment, cocaine availability and use in the United States have reemerged, with cocaine initiates and cocaine-involved overdose deaths exceeding the 2007 benchmark levels.[7] According to the Assessment, this increase is largely due to the significant increases in coca cultivation and cocaine production in Colombia as well as the increasing presence of fentanyl in the cocaine supply.[8] In addition, the Assessment notes that the "[a]verage retail price per pure gram of cocaine decreased while average gram purity increased between January 2012 and March 2017."[9] According to U.S. Customs and Border Protection (CBP) data, in fiscal year (FY) 2019, there were 89,207 pounds of cocaine seized nationwide, compared to 51,592 pounds in FY 2018.[10]

Methamphetamine is a Schedule II drug under the Controlled Substances Act and is a pill or powder; however, crystal meth can resemble glass fragments or shiny blue-white rocks. Methamphetamine is a highly addictive drug with potent central nervous system stimulant

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(www.dea.gov/sites/default/files/sites/getsmartaboutdrugs.com/files/publications/DoA_2017Ed_Updated_6.16.17.pdf#page=51).

[3] Centers for Disease Control and Prevention, *Opioid Overdose, Data, Other Drugs* (https://www.cdc.gov/drugoverdose/data/otherdrugs.html) (accessed Nov. 14, 2019).

[4] *Id.*

[5] *Id.*

[6] Holly Hedegaard, M.D., M.S.P.H., et al, *Regional Differences in the Drugs Most Frequently Involved in Drug Overdose Deaths: United States, 2017,* U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, National Vital Statistics Reports, Volume 68, Number 12 (Oct. 25, 2019) (www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_12-508.pdf).

[7] U.S. Drug Enforcement Administration, *2018 National Drug Threat Assessment* (Oct. 2018) (www.dea.gov/sites/default/files/2018-11/DIR-032-18%202018%20NDTA%20final%20low%20resolution.pdf).

[8] *Id.*

[9] *Id.*

[10] U.S. Customs and Border Protection, *CBP Enforcement Statistics Fiscal Year 2020* (www.cbp.gov/newsroom/stats/cbp-enforcement-statistics) (accessed Nov. 15, 2019).

properties and can be swallowed, snorted, injected, or smoked.[11] The 2018 National Drug Threat Assessment notes that an "[a]nalysis of domestic methamphetamine purchases from January 2012 through March 2017 indicates that the price per pure gram of methamphetamine decreased 13.6 percent—from $81 to $70—while the purity increased six percent—from 87.9 percent to 93.2 percent."[12]

Methamphetamine remains prevalent and widely available in the United States.[13] According to CBP data, in FY 2019, there were 68,585 pounds of methamphetamine seized nationwide, compared to 57,440 pounds in FY 2018.[14] Most of the methamphetamine in the United States is produced in Mexico and smuggled across the Southwest Border. While cartels continue trafficking fentanyl, they are also continuing to traffic cheaper and more potent supplies of methamphetamine.[15]

Compared to the methamphetamine being produced in Mexico, there is more limited production in the United States, and seizures of domestic methamphetamine laboratories have steadily declined for years.[16] This shift is largely a result of the Combat Methamphetamine Epidemic Act of 2005, which "requires retailers of non-prescription products containing pseudoephedrine, ephedrine, or phenylpropanolamine to place these products behind the counter or in a locked cabinet. Consumers must show identification and sign a logbook for each purchase."[17] Since ephedrine and pseudoephedrine are precursor chemicals that are used to make methamphetamine, production shifted to Mexico where the precursor chemicals were more accessible.

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[11] U.S. Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide, 2017 Edition* (2017) (www.dea.gov/sites/default/files/sites/getsmartaboutdrugs.com/files/publications/DoA_2017Ed_Updated_6.16.17.pdf#page=54).

[12] U.S. Dept. of Justice, Drug Enforcement Administration, *2018 National Drug Threat Assessment* (Oct. 2018) (www.dea.gov/sites/default/files/2018-11/DIR-032-18%202018%20NDTA%20final%20low%20resolution.pdf)..

[13] *Id.*

[14] U.S. Customs and Border Protection, *CBP Enforcement Statistics Fiscal Year 2020* (www.cbp.gov/newsroom/stats/cbp-enforcement-statistics) (accessed Nov. 15, 2019).

[15] Josh Meyer, *What are Mexican drug cartels fighting over? The chance to sell fentanyl here,* THE WASHINGTON POST (Nov. 7, 2019).

[16] U.S. Dept. of Justice, Drug Enforcement Administration, *2018 National Drug Threat Assessment* (Oct. 2018) (https://www.dea.gov/sites/default/files/2018-11/DIR-032-18%202018%20NDTA%20final%20low%20resolution.pdf).

[17] U.S. Drug Enforcement Administration, *Drugs of Abuse, A DEA Resource Guide, 2017 Edition* (2017) (www.dea.gov/sites/default/files/sites/getsmartaboutdrugs.com/files/publications/DoA_2017Ed_Updated_6.16.17.pdf#page=54).

Rates of overdose deaths from all psychostimulants, including methamphetamine, have been increasing since 2010.[18] In 2017, more than 10,000 Americans died from an overdose involving psychostimulants with abuse potential, which was a 37 percent increase from 2016.[19] According to the aforementioned National Vital Statistics report, in 2017, there were 9,356 drug overdose deaths in the United States involving methamphetamine, which accounted for 13.3 percent of drug overdose deaths in the United States that year.[20]

The National Vital Statistics Report breaks down the drugs most frequently involved in drug overdose deaths in 2017 by the U.S. Department of Health and Human Services' (HHS) ten regions, and found that, "[i]n the majority of states west of the Mississippi River, methamphetamine was the most common drug implicated in drug overdose deaths" in 2017.[21] Further, while cocaine was not ranked number one for any of the regions, it was ranked in the top six for all of the regions, and in the top three for six of the ten regions.[22]

Unlike medication assisted treatment available for the treatment of substance-use disorders involving opioids, there is currently no U.S. Food and Drug Administration (FDA)-approved medication for the treatment of a substance-use disorder involving cocaine or methamphetamine.[23, 24] Rather, a substance use disorder involving cocaine or methamphetamine is best prevented and treated with behavioral therapies.[25] Because a cocaine overdose often leads

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[18] Centers for Disease Control and Prevention, *Opioid Overdose, Data, Other Drugs* (www.cdc.gov/drugoverdose/data/otherdrugs.html) (accessed Nov. 14, 2019).

[19] *Id.*

[20] Holly Hedegaard, M.D., M.S.P.H., et al, *Regional Differences in the Drugs Most Frequently Involved in Drug Overdose Deaths: United States, 2017,* U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, National Vital Statistics Reports, Volume 68, Number 12 (Oct. 25, 2019) (www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_12-508.pdf).

[21] Erin Schumaker, *Meth, not fentanyl, driving overdose deaths in western US,* ABC NEWS (Oct. 25, 2019).

[22] Holly Hedegaard, M.D., M.S.P.H., et al, *Regional Differences in the Drugs Most Frequently Involved in Drug Overdose Deaths: United States, 2017,* U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, National Vital Statistics Reports, Volume 68, Number 12 (Oct. 25, 2019) (www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_12-508.pdf).

[23] National Institute on Drug Abuse, *Cocaine* (July 2018) (www.drugabuse.gov/publications/drugfacts/cocaine).

[24] National Institute on Drug Abuse, *Methamphetamine* (May 2019) (www.drugabuse.gov/publications/drugfacts/methamphetamine).

[25] *Id.*

to a heart attack, stroke, or seizure,[26] and a methamphetamine overdose often leads to a stroke, heart attack, or organ problems, first responders and emergency room doctors treat the overdose by treating those conditions.[27, 28]

According to a former chief of operations for the DEA, "[a]ny time in our history, when we have had a period of high opioid abuse, like we have been experiencing over the past few years, ultimately, it's followed by an increased level of abuse and addiction of powerful central nervous system stimulants like methamphetamine."[29]

We remain committed to advance treatment, improve prevention, protect communities, and bolster efforts to fight deadly illicit drugs like opioids and fentanyl. However, our country's fight against illicit substances must be multi-faceted and we want to ensure that the appropriate attention and resources are devoted to combat these other substances as well. Accordingly, we seek to better understand how the relevant agencies are monitoring and combating this growing threat.

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[26] National Institute on Drug Abuse, *Cocaine* (July 2018) (www.drugabuse.gov/publications/drugfacts/cocaine).

[27] National Institute on Drug Abuse, Drug Facts, Cocaine (last revised July 2018), *available at* www.drugabuse.gov/publications/drugfacts/cocaine; Methamphetamine (last revised May 2019), *available at* www.drugabuse.gov/publications/drugfacts/methamphetamine.

[28] National Institute on Drug Abuse, *Methamphetamine* (May 2019) (www.drugabuse.gov/publications/drugfacts/methamphetamine).

[29] Josh Meyer, *Meth Is Cheaper, More Potent, and More Common than Ever, Meth's big comeback has been driven by large-scale production, and it's riding the long tail of the opioid crisis,* VICE (Nov. 13, 2019).

To assist us in our efforts, we ask that you please make arrangements to provide a briefing to Committee staff by February 4, 2020. We appreciate your prompt attention to this request. Should you have any questions about this request, and to schedule the requested briefing, please contact Kevin McAloon of the Majority Staff at (202) 225-2927 or Brittany Havens or Jen Barblan with the Minority Staff at (202) 225-3641.

Sincerely,

Frank Pallone, Jr.
Chairman

Greg Walden
Ranking Member

Anna G. Eshoo
Chairwoman
Subcommittee on Health

Michael C. Burgess, M.D.
Ranking Member
Subcommittee on Health

Diana DeGette
Chair
Subcommittee on Oversight
and Investigations

Brett Guthrie
Ranking Member
Subcommittee on Oversight
and Investigations

VOICES FOR NON-OPIOID CHOICES

January 14, 2020

Representative Diana DeGette, Chair
Representative Brett Guthrie, Ranking Member
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chair DeGette and Ranking Member Guthrie,

On behalf of Voices for Non-Opioid Choices ("Voices"), we are pleased to submit this statement for the record of the hearing entitled ***"A Public Health Emergency: State Efforts to Curb the Opioid Crisis."*** We applaud the Subcommittee for continuing to address the epidemic of substance use in the United States. To that end, we believe no discussion of substance use, and the commensurate Congressional response, is sufficient without considering how to prioritize prevention. Congress, along with the Trump Administration, must tackle the problem of substance abuse on multiple fronts – supporting states to offer treatment options to their citizens, as well as amplifying preventive efforts to avoid the development of substance use disorder.

Voices is a nonpartisan coalition dedicated to one proven method of preventing substance misuse -- ensuring patient and provider access to safe and effective non-opioid pain management therapies. Our 31 members include groups representing licensed healthcare professionals, such as physicians, nurses, dentists, therapists, as well as patient advocacy groups, students, individuals in recovery and retirees. We are united in our belief that it is crucial to prevent addiction before it starts by increasing the availability and utilization of non-opioid approaches through responsible policy changes.

The over-prescription of opioids following an acute pain incident is a significant contributing factor to the current U.S. opioid epidemic. On average, patients receive 80 opioid pills to manage pain following a surgical procedure, which is typically well above what is necessary to help these patients adequately control their symptoms.[1] Every year in our country, three million Americans become persistent opioid users following surgery.[2] Unfortunately, some of these users will go on to develop substance use disorder and never recover.

Leading practitioners, researchers and health care experts know how to reverse this trend without sacrificing quality pain management. Increased use of non-opioids has been proven in peer-reviewed

[1] Bicket M, et al. Prescription opioid oversupply following surgery. Journal of American Pain Society 2017.
[2] Brummett CM, Waljee JF, Goesling J, et al. New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults. JAMA Surg. Published online June 01, 2017152(6):e170504. doi:10.1001/jamasurg.2017.0504

studies to reduce unnecessary opioid use after surgery,[3] and research on the benefits of multimodal approaches to pain management, which prioritize non-opioid use and minimize opioids, shows that such approaches provide better patient outcomes than patients receiving opioids following surgery.[4]

We have made progress on many fronts combatting the opioid epidemic, including slight decreases in overdose deaths and some modest reductions in opioid prescribing rates in certain populations. Without additional action to prevent substance misuse, however, we are at risk of stalling this progress. Medicare policy continues to prioritize less expensive opioids over the life-saving potential of non-opioids in the surgical setting.

We look to Congress and the Administration to act to prevent opioid misuse by promoting broad use of non-opioid treatments as a first-line therapy for acute pain across all treatment settings.

Last year, the Centers for Medicare and Medicaid Services (CMS) wisely adopted a policy change that would provide separate reimbursement for non-opioid pain management approaches provided during surgery to patients treated in an Ambulatory Surgery Center (ASC). This was a welcomed change that appropriately incentivizes the utilization of non-opioid therapies. Unfortunately, because most surgeries performed in the United States every year occur in a hospital outpatient department (HOPD) setting, CMS has not yet taken sufficient action to ensure that these patients can access available pharmacologic and non-pharmacologic non-opioid approaches to alleviate their acute pain. For example, many common orthopedic procedures take place in the HOPD setting and are not eligible to be performed in the ASC. The estimated 8 million Medicare patients who undergo these procedures every year are therefore unable to reasonably access non-opioid pain management approaches.

Given that most of these procedures – and associated opioid prescribing – take place in the HOPD setting, we urge Congress to work with the Administration to adopt reimbursement policies that better incentivize the utilization of non-opioid approaches for pain management. This is why we are pleased to support H.R. 5172, the "***Non-Opioids Prevent Addiction In the Nation Act***" or the "***NOPAIN Act***" introduced by Representatives Terri Sewell (D-AL) and David McKinley, P.E. (R-WV). The NOPAIN Act would change this policy by directing CMS to provide separate Medicare reimbursement for non-opioid treatments used to manage post-surgical pain in both the hospital outpatient department (HOPD) and the ambulatory surgery center (ASC) settings.

Congress and the Administration must continue to work hand-in-hand to solve the substance abuse emergency currently taking place in the United States, and specifically the issues around opioids. We hope that commonsense solutions and changes to outdated policies can help increase access to non-opioid approaches to pain management and therefore prevent opioid addiction or dependence from ever occurring after an acute pain incident such as a surgical intervention.

We look forward to your continued work on solving the crisis and stand available to answer any questions.

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[3] Mont MA, Beaver WB, Dysart SH, Barrington JW, Del Gaizo DJ. Local infiltration analgesia with liposomal bupivacaine improves pain scores and reduces opioid use after total knee arthroplasty: results of a randomized controlled trial. *J Arthroplasty*. 2018;33(1):90-96.

[4] Wang MY, Chang HK, Grossman J. Reduced Acute Care Costs With the ERAS® Minimally Invasive Transforaminal Lumbar Interbody Fusion Compared With Conventional Minimally Invasive Transforaminal Lumber Interbody Fusion. *Neurosurgery*. 2017. [epub ahead of print]

Sincerely,

Chris Fox
Executive Director

JAMA Network Open.

Original Investigation | Health Policy

Association of Medicaid Expansion With Opioid Overdose Mortality in the United States

Nicole Kravitz-Wirtz, PhD, MPH; Corey S. Davis, JD, MSPH; William R. Ponicki, MA; Ariadne Rivera-Aguirre, MPP; Brandon D. L. Marshall, PhD; Silvia S. Martins, MD, PhD; Magdalena Cerdá, DrPH, MPH

Abstract

IMPORTANCE The Patient Protection and Affordable Care Act (ACA) permits states to expand Medicaid coverage for most low-income adults to 138% of the federal poverty level and requires the provision of mental health and substance use disorder services on parity with other medical and surgical services. Uptake of substance use disorder services with medications for opioid use disorder has increased more in Medicaid expansion states than in nonexpansion states, but whether ACA-related Medicaid expansion is associated with county-level opioid overdose mortality has not been examined.

OBJECTIVE To examine whether Medicaid expansion is associated with county × year counts of opioid overdose deaths overall and by class of opioid.

DESIGN, SETTING, AND PARTICIPANTS This serial cross-sectional study used data from 3109 counties within 49 states and the District of Columbia from January 1, 2001, to December 31, 2017 (N = 3109 counties × 17 years = 52 853 county-years). Overdose deaths were modeled using hierarchical Bayesian Poisson models. Analyses were performed from April 1, 2018, to July 31, 2019.

EXPOSURES The primary exposure was state adoption of Medicaid expansion under the ACA, measured as the proportion of each calendar year during which a given state had Medicaid expansion in effect. By the end of study observation in 2017, a total of 32 states and the District of Columbia had expanded Medicaid eligibility.

MAIN OUTCOMES AND MEASURES The outcomes of interest were annual county-level mortality from overdoses involving any opioid, natural and semisynthetic opioids, methadone, heroin, and synthetic opioids other than methadone, derived from the National Vital Statistics System multiple-cause-of-death files. A secondary analysis examined fatal overdoses involving all drugs.

RESULTS There were 383 091 opioid overdose fatalities across observed US counties during the study period, with a mean (SD) of 7.25 (27.45) deaths per county (range, 0-1145 deaths per county). Adoption of Medicaid expansion was associated with a 6% lower rate of total opioid overdose deaths compared with the rate in nonexpansion states (relative rate [RR], 0.94; 95% credible interval [CrI], 0.91-0.98). Counties in expansion states had an 11% lower rate of death involving heroin (RR, 0.89; 95% CrI, 0.84-0.94) and a 10% lower rate of death involving synthetic opioids other than methadone (RR, 0.90; 95% CrI, 0.84-0.96) compared with counties in nonexpansion states. An 11% increase was observed in methadone-related overdose mortality in expansion states (RR, 1.11; 95% CrI, 1.04-1.19). An association between Medicaid expansion and deaths involving natural and semisynthetic opioids was not well supported (RR, 1.03; 95% CrI, 0.98-1.08).

(continued)

Key Points

Question Is state Medicaid expansion associated with county-level opioid-involved overdose deaths in the United States?

Findings In this serial cross-sectional study of 3109 counties within 49 states and the District of Columbia from 2001 to 2017, Medicaid expansion was associated with reductions in total opioid overdose deaths and deaths involving heroin and synthetic opioids other than methadone. Expansion was associated with increased mortality involving methadone.

Meaning The findings suggest that expanding eligibility for Medicaid may help to mitigate the opioid overdose epidemic.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Abstract (continued)

CONCLUSIONS AND RELEVANCE Medicaid expansion was associated with reductions in total opioid overdose deaths, particularly deaths involving heroin and synthetic opioids other than methadone, but increases in methadone-related mortality. As states invest more resources in addressing the opioid overdose epidemic, attention should be paid to the role that Medicaid expansion may play in reducing opioid overdose mortality, in part through greater access to medications for opioid use disorder.

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Introduction

Drug overdose is a leading cause of injury-related death in the United States, responsible for more than 70 000 fatalities, or approximately 200 deaths per day, in 2017. Fatal drug overdoses have increased markedly during the past 2 decades in large part because of overdoses involving opioids, including prescription opioids and illegal opioids, such as heroin and illicitly manufactured fentanyl. Between 2001 and 2017, the age-adjusted mortality rate for opioid-related overdoses more than quadrupled, from 3.3 to 14.9 per 100 000 standard population. In 2017, more than two-thirds of all drug overdose fatalities (47 600 deaths) involved an opioid.[1] Although overdose mortality may have stabilized in the past year, rates remain inordinately high.

The 2010 Patient Protection and Affordable Care Act (ACA) was signed into law during the rise in overdose deaths. Designed to increase access to and improve the quality of health insurance coverage, the ACA permits states to expand Medicaid coverage to essentially all non–Medicare-eligible people younger than 65 years with incomes at or below 138% of the federal poverty level ($16 643 for an individual in 2017).[2] The law also requires that individuals who receive coverage through the expansion be provided with mental health and substance use disorder (SUD) services on parity with other medical and surgical services.[3] From the beginning of Medicaid expansion in 2014 to the end of study observation in 2017, a total of 32 states and the District of Columbia opted to expand Medicaid eligibility.[4]

Medicaid provides essential health care access to millions of low-income people and, by extension, greater access to low-cost prescription medications, including opioid pain relievers (OPRs). Such increased access to OPRs, particularly among a patient population with higher rates of chronic disease and disability compared with non-Medicaid recipients,[5] has led some observers to question whether Medicaid expansion will contribute to additional opioid-related harms. To the contrary, recent studies[6-8] have found that although Medicaid expansion was associated with an increased rate of overall Medicaid-reimbursed prescriptions, changes in prescriptions for OPRs before vs after the expansion were not significantly different in expansion vs nonexpansion states.

Furthermore, Medicaid expansion has been an important source of coverage for SUD treatment, including for people with opioid use disorder (OUD). Previous research suggests that uptake of medications for opioid use disorder (MOUDs), including methadone, buprenorphine, and extended-release naltrexone, has increased more in expansion states compared with nonexpansion states.[6-11] These medications (often in combination with counseling and behavioral therapies) have been linked to improvements in treatment retention and OUD remission as well as reductions, in some cases as high as 50%, in all-cause and overdose-related mortality.[12,13] Medicaid-reimbursed prescriptions for the opioid overdose reversal medication naloxone have also increased significantly more in expansion states compared with nonexpansion states.[14] Early Medicaid expansions in Arizona, Maine, and New York in 2001 and 2002,[15] along with more recent expansions in state Medicaid-eligibility thresholds for parents,[16] have been associated with fewer drug overdose deaths. However, to our knowledge, with only 1 recent exception,[17] no study has examined the association of ACA-related Medicaid expansion with opioid-related overdose mortality more specifically.

Previous studies[12,16,17] of the association of Medicaid expansion with fatal overdoses have been conducted at the state level. Although the most appropriate spatial scale for this association remains unclear, state-level analyses may not adequately reflect local (within-state) variation in the level and rate of growth of overdose deaths or differences in policy implementation, such as local disparities in the capacity for or accessibility of SUD treatment. Using overdose mortality and related covariates measured at the county rather than the state level, this study aimed to provide improved estimates of the association between Medicaid expansion under the ACA and fatal opioid-involved overdoses from 2001 to 2017. We examined this association for county × year counts of total opioid overdose deaths and separately by class of opioid (ie, natural and semisynthetic opioids, methadone, heroin, and synthetic opioids other than methadone). For comparison with prior research, we also examined all drug overdose deaths as a secondary outcome.

Methods

This serial, cross-sectional study used data from 3109 counties in 49 states and the District of Columbia from January 1, 2001, to December 31, 2017. We organized this information into a series of space-time observations, with each observation referring to 1 year of data per county for a total of 52 853 county-years (3109 counties × 17 years). Analyses excluded Alaska because of substantial changes in the size and shape of counties within the state during the study period. Individual data were aggregated to the county level. This study and was approved by the institutional review board of the University of California, Davis. No informed consent was required because this was a retrospective review of existing mortality data. The study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Outcome

We determined annual, county-level counts of opioid overdose deaths from the restricted-use version of the National Vital Statistics System multiple-cause-of-death files.[18] Overdose deaths were identified based on the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)* external cause of injury codes X40 to 44 (unintentional), X60 to 64 (suicide), X85 (homicide), and Y10 to 14 (undetermined). Among deaths with drug overdose as the underlying cause, we used the following *ICD-10* specific drug codes to identify our outcomes: all opioids, T40.0-T40.4 and T40.6; natural and semisynthetic opioids, T40.2; methadone, T40.3; heroin, T40.1; and synthetic opioids other than methadone, T40.4. Deaths involving more than 1 class of opioid were included in the counts for each opioid subcategory; thus, opioid subcategories are not mutually exclusive.

Exposure

Data on state Medicaid expansion status were obtained from the Kaiser Family Foundation.[4] We created an indicator of the proportion of each calendar year during which a given state had Medicaid expansion in effect; states that expanded Medicaid were assigned a value of 0 in years before Medicaid expansion, a value between 0 and 1 in the year in which Medicaid expansion went into effect (according to the policy effective month), and a value of 1 in all subsequent years, whereas states that did not expand Medicaid by the end of the study period were assigned a value of 0 in all years. Of the 32 states (including the District of Columbia) in our study population that opted to expand Medicaid eligibility, 26 did so on January 1, 2014, then 2 additional states did so later that same year, followed by 2 states in 2015 and 2 states in 2016 (**Table 1**).

Covariates

Annual, county-level estimates for a range of sociodemographic characteristics were obtained from GeoLytics Inc to be used as covariates, including age (percentage aged 0-19, 20-24, 25-44, and 45-64 years); percentage male; percentages non-Hispanic white, non-Hispanic Black, and Hispanic;

Table 1. Status and Effective Date of Medicaid Expansion by State[a]

State	Status	Effective Date
Alabama	Not adopted	NA
Alaska[b]	Adopted	September 1, 2015
Arizona	Adopted	January 1, 2014
Arkansas	Adopted	January 1, 2014
California	Adopted	January 1, 2014
Colorado	Adopted	January 1, 2014
Connecticut	Adopted	January 1, 2014
Delaware	Adopted	January 1, 2014
District of Columbia	Adopted	January 1, 2014
Florida	Not adopted	NA
Georgia	Not adopted	NA
Hawaii	Adopted	January 1, 2014
Idaho	Not adopted	NA
Illinois	Adopted	January 1, 2014
Indiana	Adopted	February 1, 2015
Iowa	Adopted	January 1, 2014
Kansas	Not adopted	NA
Kentucky	Adopted	January 1, 2014
Louisiana	Adopted	July 1, 2016
Maine	Adopted	January 1, 2014
Maryland	Adopted	January 1, 2014
Massachusetts	Adopted	January 1, 2014
Michigan	Adopted	April 1, 2014
Minnesota	Adopted	January 1, 2014
Mississippi	Not adopted	NA
Missouri	Not adopted	NA
Montana	Adopted	January 1, 2016
Nebraska	Not adopted	NA
Nevada	Adopted	January 1, 2014
New Hampshire	Adopted	August 15, 2014
New Jersey	Adopted	January 1, 2014
New Mexico	Adopted	January 1, 2014
New York	Adopted	January 1, 2014
North Carolina	Not adopted	NA
North Dakota	Adopted	January 1, 2014
Ohio	Adopted	January 1, 2014
Oklahoma	Not adopted	NA
Oregon	Adopted	January 1, 2014
Pennsylvania	Adopted	January 1, 2015
Rhode Island	Adopted	January 1, 2014
South Carolina	Not adopted	NA
South Dakota	Not adopted	NA
Tennessee	Not adopted	NA
Texas	Not adopted	NA
Utah	Not adopted	NA
Vermont	Adopted	January 1, 2014
Virginia	Not adopted	NA
Washington	Adopted	January 1, 2014
West Virginia	Adopted	January 1, 2014
Wisconsin	Not adopted	NA
Wyoming	Not adopted	NA

Abbreviation: NA, not applicable.

[a] States' decisions about adopting the Medicaid expansion are as of December 31, 2017.

[b] Alaska is excluded from analyses because of substantial changes in the size and shape of counties during the study period.

percentage of families living in poverty; median household income (per $10 000); percentage unemployed; population density (1000 residents per square mile); and overall mortality rate (per 1000 people). We also considered the presence of co-occurring state policies, which have been associated in prior research[19-21] with changes in opioid-related harm, including prescription drug monitoring programs, overdose Good Samaritan laws, naloxone access laws, and medical marijuana laws. Information on these policies was derived from the Prescription Drug Abuse Policy System[22] and from McClellan and colleagues[19] and updated by us.

Statistical Analysis

We examined the association between state Medicaid expansion status and county-level risk of fatal opioid overdoses overall and by class of opioid using Bayesian hierarchical Poisson models, with overdose deaths assumed to be distributed proportionally to the population of each county (aged ≥12 years). We introduced a 1-year lag between overdose rates and Medicaid expansion to address the possibility of temporal bias and to allow time for changes in Medicaid coverage, services, and related behaviors to materialize. Analyses with Medicaid expansion instead measured concurrently with overdose rates produced similar results (eTable 2 in the Supplement). Furthermore, because drug-specific overdose rates may be variously underestimated or overestimated among states[23] and for comparison with prior research, we conducted a secondary analysis with all drug overdose deaths as the outcome.

In practice, our models compared overdose trends in counties within states that expanded Medicaid before vs after the expansion with trends in counties within nonexpansion states. Unlike conventional difference-in-difference methods, the Bayesian approach does not assume that trends in overdose deaths before Medicaid expansion were the same among counties within expansion and nonexpansion states. Instead, by incorporating county-level random intercepts and trends, along with state-level fixed effects, growth mixtures among counties within states that occurred during the study period and could bias effect estimates were explicitly modeled. We also included conditional autoregressive spatial random effects, which account for the lack of independence in spatially contiguous counties (ie, spatial autocorrelation) and minimize the influence of large outlying rates in low-population counties by allowing each area to borrow strength from neighboring areas. All models also included fixed and random effects by county for Medicaid expansion to account for local variation in policy implementation across counties within states. We modeled secular trends in overdose using fixed linear and quadratic time trends and included annual, county-level sociodemographic covariates measured concurrently with overdose and co-occurring state policies with 1-year time lags.

Analyses were implemented using the Integrated Nested Laplace Approximation method in R software, version 3.4.3 (R Project for Statistical Computing)[24] from April 1, 2018, to July 31, 2019. Integrated nested Laplace approximation is an alternative to standard Markov chain Monte Carlo methods for estimating the integral of a posterior (probability) distribution. Whereas Markov chain Monte Carlo samples from the posterior distribution of model parameters, integrated nested Laplace approximation returns comparable approximations to the posterior marginals in considerably less time.[25,26] Results are reported as median relative rates (RRs) from the posterior marginal distribution and 95% credible intervals (CrIs) indicating a range of values that is expected to contain the true RR with 95% probability (a Bayesian analogue of a standard CI).

Results

There was a total of 383 091 opioid overdose fatalities across observed US counties for the study period of January 1, 2001, through December 31, 2017, with a mean (SD) of 7.25 (27.45) deaths per county (range, 0-1145 deaths per county) (**Table 2**). The overall opioid mortality rate increased over time, from 2.49 deaths per 100 000 people in 2001 to 11.41 deaths per 100 000 in 2017 (**Figure 1**). Rates were generally higher in expansion states than in nonexpansion states (eFigure in the

Supplement). Overdoses involving natural and semisynthetic opioids accounted for the largest share of all county-year opioid overdose deaths (40.9%), followed by those involving heroin (25.3%), synthetic opioids other than methadone (24.0%), and methadone (17.1%). By 2017, most opioid overdose deaths (59.9%) involved synthetic opioids other than methadone (eg, illicitly manufactured fentanyl).

The estimated associations of 1-year lagged Medicaid expansion with RRs of opioid overdose deaths, overall and by class of opioid, are presented in **Figure 2** (results for all model variables are in eTable 1 in the Supplement). Medicaid expansion was associated with lower risk of overdose mortality involving all opioids. Specifically, counties within states that expanded Medicaid had a 6% decreased rate of opioid overdose deaths after expansion compared with counties within states that did not expand Medicaid eligibility (RR, 0.94; 95% CrI, 0.91-0.98). In drug-specific analyses, counties within states that expanded Medicaid had an 11% decreased rate of fatal heroin overdoses (RR, 0.89; 95% CrI, 0.84-0.94) and a 10% decreased rate of overdose deaths involving synthetic opioids other than methadone (RR, 0.90; 95% CrI, 0.84-0.96) after the expansion compared with counties in nonexpansion states. In contrast, the expansion was associated with an 11% increased rate of methadone-involved overdose deaths (RR, 1.11; 95% CrI, 1.04-1.19). An association between Medicaid

Table 2. County-Level Fatal Opioid Overdoses and Sociodemographic Characteristics, United States, 2001-2017[a]

Characteristic	Mean (SD) [Range]	Mean Change for 2017 vs 2001
Opioid-related deaths		
No.	7.25 (27.45) [0-1145.00]	12.31
Rate, No./100 000 population	6.69 (13.80) [0-2083.33]	8.92
Natural or semisynthetic opioid-related deaths		
No.[b]	2.96 (10.71) [0-278.00]	3.55
Rate, No./100 000 population	3.36 (11.27) [0-2083.33]	3.49
Methadone-related deaths		
No.[b]	1.24 (4.27) [0-98.00]	0.56
Rate, No./100 000 population	1.42 (9.75) [0-2083.33]	0.20
Heroin-related deaths		
No.[b]	1.84 (11.08) [0-758.00]	4.43
Rate, No./100 000 population	0.91 (3.05) [0-75.30]	2.47
Synthetic opioid-related deaths		
No.[b]	1.74 (12.44) [0-687.00]	8.90
Rate, No./100 000 population	1.61 (4.80) [0-195.49]	5.61
Population aged ≥12 y, No.	82 415.89 (263 708.70) [34.00-8 649 898.00]	11 427.32
Age, %		
0-19 y	26.80 (4.34) [0-134.09]	−0.94
20-24 y	6.91 (1.20) [0-32.53]	0.59
25-44 y	25.06 (3.46) [0-124.04]	−2.27
45-64 y	25.05 (3.02) [0-127.15]	−0.23
Male, %	49.56 (2.18) [35.23-249.61]	−0.31
Race/ethnicity, %		
White	76.31 (20.35) [0-355.51]	−8.52
Black	8.89 (14.81) [0-91.74]	−0.36
Latinx	7.39 (12.99) [0-105.52]	1.93
Living in poverty, %	12.60 (6.59) [0-61.63]	3.37
Median household income per $10 000, $	4.54 (1.24) [1.27-34.90]	−0.18
Unemployed, %	6.96 (4.17) [0-67.28]	0.09
Population density, 1000 per square mile[c]	0.22 (1.25) [0-50.92]	0.02
Overall mortality rate, No./1000 residents	8.58 (3.69) [0-125.00]	0.62

[a] Sample size was 3109 counties from 2001 to 2017 (52 853 county-years).

[b] Deaths involving more than 1 class of opioid were included in the counts for each opioid subcategory.

[c] The mean population density was 0.22 × 1000 or 220 per square mile.

expansion and deaths involving natural and semisynthetic opioids was not well supported (RR, 1.03; 95% CrI, 0.98-1.08).

Consistent with previous research, our secondary analysis of overdose fatalities involving all drugs found that counties within states that expanded Medicaid had a 2% decreased rate of all drug overdose deaths after the expansion compared with those in nonexpansion states (RR, 0.98; 95% CrI, 0.96-1.00). Additional sensitivity analyses excluding 4 states with high levels of underreporting of specific drugs (ie, Alabama, Indiana, Louisiana, and Pennsylvania)[23] produced substantively similar results as those in the primary analyses (eTable 2 in the Supplement).

Discussion

In this nationwide, population-based study of the association of Medicaid expansion under the ACA with county-level rates of opioid overdose mortality, we found empirical support for adopting and sustaining health coverage expansions as a potential tool for reducing opioid overdose deaths in the United States. Consistent with prior analyses[16,27] examining Medicaid expansion and mortality from other causes, we found decreased rates of opioid overdose deaths associated with the adoption of Medicaid expansion. In particular, given 82 228 opioid-related deaths from 2015 to 2017 in the 32 states that expanded Medicaid between 2014 and 2016, our findings suggest that these states would have had between 83 906 and 90 360 deaths in the absence of the expansion, implying that Medicaid expansion may have prevented between 1678 and 8132 deaths in these states during those years.

Figure 1. Opioid Deaths per 100 000 Persons

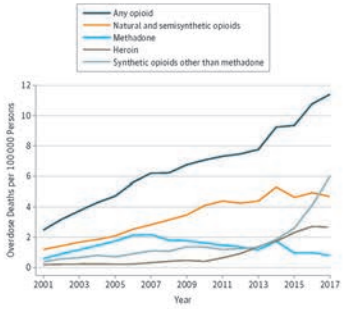
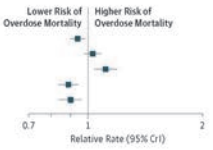


Figure 2. Estimated Associations of 1-Year Lagged Medicaid Expansion With Relative Rates of Opioid Overdose Deaths Overall and by Class of Opioid

Opioid	Relative Rate (95% CrI)
Any	0.94 (0.91-0.98)
Natural and semisynthetic opioids	1.03 (0.98-1.08)
Methadone	1.11 (1.04-1.19)
Heroin	0.89 (0.84-0.94)
Synthetic opioids other than methadone	0.90 (0.84-0.96)



CrI indicates credible interval.

In analyses differentiated by class of opioid, we found a more substantial decreased risk associated with overdose deaths involving heroin and synthetic opioids other than methadone, which have been associated with continued increases in opioid-related deaths in recent years. These findings align with previous research that indicates that implementation of the ACA was associated with 40% decreased odds of being uninsured among persons with heroin use disorders, primarily because of Medicaid expansion, whereas no changes in insurance coverage were detected among persons with prescription OUDs.[28] We also did not find support for an association between ACA-related Medicaid expansion and natural and semisynthetic opioid overdose mortality.

The observed association between Medicaid expansion and decreased total opioid overdose deaths and deaths involving heroin and synthetic opioids other than methadone is likely in part attributable to the ACA's inclusion of mental health and SUD services as essential health benefits. Expanded Medicaid eligibility has substantially increased access to these services among the low-income population.[10,29] Recent evidence demonstrates that compared with nonexpansion states, Medicaid expansion states experienced increases in overall prescriptions for, Medicaid-covered prescriptions for, and Medicaid spending on both MOUDs, particularly buprenorphine and naltrexone, and the opioid overdose reversal medication naloxone.[6-8,11,14,30,31,35]

Two prior studies[12,16] have found associations between income eligibility expansions for Medicaid and reductions in SUD-related deaths, and a recent study[17] assessed changes in opioid-related deaths in Medicaid expansion vs nonexpansion states. Whereas the last study[17] found that Medicaid expansion was associated with larger increases in opioid overdose mortality, particularly in 2015 and 2016, analyses were conducted only at the state level. This approach may have masked within-state variation in the level and rate of growth of opioid overdoses, as well as differences in local policy implementation. To our knowledge, ours is the first study to quantify the association between ACA-related Medicaid expansion and opioid-related deaths at the county level.

Although the rate of methadone-related mortality is relatively low compared with other opioid classes, our finding that Medicaid expansion was associated with increased methadone overdose deaths deserves further investigation. At the individual level, treatment of OUD with methadone has been rigorously studied and found to be equally and, in some cases, more effective than other MOUDs in suppressing illicit opioid use, particularly heroin use, and retaining persons in treatment.[31,32] On the basis of this evidence, in combination with our findings for heroin and synthetic opioids other than methadone, increased access to MOUDs likely not did not contribute to the observed increase in methadone mortality associated with Medicaid expansion. In contrast, past research has found high rates of methadone use to treat pain (rather than to treat OUD) among Medicaid beneficiaries and that the drug is disproportionately associated with overdose deaths among individuals in this population,[33,34] underscoring the importance of ongoing local, state, and federal actions to address safety concerns associated with methadone for pain in tandem with Medicaid expansion.[7,8]

Limitations

This study has limitations. First, we relied on *ICD-10* coding of death certificate data, which may not reliably identify the specific drugs involved in fatal overdoses and may lead to an underestimation or misclassification of opioid overdose mortality.[23] However, a secondary analysis that examined overdose deaths involving all drugs and sensitivity analyses excluding states with high levels of underreporting of specific drugs produced similar results as those in our primary models. Second, we included deaths from opioid overdoses across the entire population, not just among Medicaid enrollees, which may understate the estimated outcomes of Medicaid expansion for those individuals most directly affected. Third, although we controlled for various county-level sociodemographic characteristics and state-level co-occurring policies, unmeasured confounding is still a possibility. Fourth, we did not examine the specific provisions of Medicaid expansion that may be associated with changes in opioid-related deaths (eg, state-level difference in Medicaid's preferred drug lists). In addition, this study focused on the association of Medicaid expansion with

fatal overdoses only. Future studies should consider the association of expansion with the spectrum of opioid-related harms, including prevention of SUD and nonfatal overdoses. Also, future studies should explicitly examine possible mediators and moderators of the association between Medicaid expansion and opioid overdose risk, including access to and use of OPRs, MOUDs, and naloxone; local SUD treatment capacity; and the extent to which the association of Medicaid expansion with overdoses varies by individual sociodemographic characteristics and contextual conditions.

Conclusions

This study found that Medicaid expansion was associated with reductions in opioid overdose deaths, particularly deaths involving heroin and synthetic opioids other than methadone, but with increases in methadone-related mortality. These findings add to the emerging body of evidence that Medicaid expansion under the ACA may be a critical component of state efforts to address the continuing opioid overdose epidemic in the United States. As states invest more resources in such efforts, attention should be paid to the role that health coverage expansions can play in reducing opioid overdose mortality, potentially through greater access to MOUDs.

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Corresponding Author: Nicole Kravitz-Wirtz, PhD, MPH, Violence Prevention Research Program, Department of Emergency Medicine, University of California Davis School of Medicine, 2315 Stockton Blvd, Sacramento, CA 95817 (nkravitzwirtz@ucdavis.edu).

Author Affiliations: Violence Prevention Research Program, Department of Emergency Medicine, University of California Davis School of Medicine, Sacramento (Kravitz-Wirtz); Network for Public Health Law, Los Angeles, California (Davis); Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, California (Ponicki); Center for Opioid Epidemiology and Policy, Department of Population Health, New York University School of Medicine, New York (Rivera-Aguirre, Cerdá); Department of Epidemiology, Brown University School of Public Health, Providence, Rhode Island (Marshall); Mailman School of Public Health, Department of Epidemiology, Columbia University, New York, New York (Martins).

Author Contributions: Dr Kravitz-Wirtz had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Kravitz-Wirtz, Marshall, Martins, Cerdá.

Acquisition, analysis, or interpretation of data: Kravitz-Wirtz, Davis, Ponicki, Rivera-Aguirre, Marshall, Cerdá.

Drafting of the manuscript: Kravitz-Wirtz, Cerdá.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Kravitz-Wirtz, Ponicki, Rivera-Aguirre.

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SUPPLEMENT.

eFigure. Opioid-Related Overdose Deaths per 100,000 People in United States Counties, by State Medicaid Expansion Status, 2001-17

eTable 1. Relative Rates Associated With Medicaid Expansion and County Characteristics, Total Opioid-Related Overdose Deaths and by Class of Opioid

eTable 2. Relative Rates Associated With Medicaid Expansion and County Characteristics, Total Opioid-Related Overdose Deaths, by Primary and Alternative Model Specifications

The Geographic Distribution of Fentanyl-Involved Overdose Deaths in Cook County, Illinois

Elizabeth D. Nesoff, PhD, Charles C. Branas, PhD, and Silvia S. Martins, MD, PhD

Objectives. To contrast the geographic distribution of fentanyl-involved and nonfentanyl-involved fatal overdoses between 2014 and 2018 in Cook County, Illinois.

Methods. We conducted a spatial analysis using locations of fentanyl-involved fatal overdoses (n = 1433) compared with nonfentanyl opioid and polydrug fatal overdoses (n = 1838) collected through the Cook County Medical Examiner's Office from 2014 to 2018. We also used logistic regression to test significant individual- and neighborhood-level covariates.

Results. Fentanyl overdoses geographically clustered more than nonfentanyl overdoses, and this difference was statistically significant. One area in particular showed significantly elevated risk for fentanyl overdoses ($P<.05$) located in 2 specific neighborhoods of Chicago. The odds of a fentanyl-involved overdose were significantly increased for men, Blacks, Latinos/as, and younger individuals. Neighborhood deprivation score was the only significant neighborhood-level predictor (odds ratio = 1.11; 95% confidence interval = 1.07, 1.17).

Conclusions. Fentanyl-involved fatal overdoses follow a distinct geographic distribution associated with resource deprivation in neighborhoods where they occur. This suggests an evolving bifurcated drug market, with drug markets in resource-deprived neighborhoods disproportionately likely to include fentanyl. (*Am J Public Health.* Published online ahead of print November 21, 2019: e1–e8. doi:10.2105/AJPH.2019.305368)

Illicitly manufactured fentanyl and fentanyl analogs have become increasingly prevalent in the US drug market. The Drug Enforcement Administration's National Forensic Laboratory Information System reported that the number of seized drug samples testing positive for fentanyl more than doubled from 2015 to 2016, rising from 14 440 to 34 119; this increase continued into 2017, with an estimated 25 460 reports in the first 6 months of 2017 alone.[1,2] Potency of fentanyl and fentanyl analogs has also increased.[3] Much of this illicit fentanyl has been mixed with heroin as fentanyl powder is similar in appearance to white powder heroin.[4] Fentanyl has also been combined increasingly with illicit drugs other than heroin, including cocaine; Drug Enforcement Administration laboratories in Pennsylvania detected a 112% increase in fentanyl-adulterated cocaine samples from 2016 to 2017.[4,5] Fentanyl is increasingly found in counterfeit medications: fentanyl was present in 89% of seized counterfeit OxyContin tablets in Canada, and fentanyl has been found in counterfeit Xanax (alprazolam), Norco (acetaminophen–hydrocodone), and other medications in the United States.[4,6]

This influx of illicitly produced fentanyl in the US drug market has contributed to a significant increase in the number of overdose deaths attributable to synthetic opioids since 2013.[7,8] Synthetic opioid-involved deaths in 2016 accounted for 30.5% of all drug overdose deaths and 45.9% of all opioid-involved deaths, with a 100% increase in the rate of these deaths from 2015.[9] More than 55% of opioid overdose deaths occurring nationally in 2017 involved synthetic opioids, accounting for more than 27 000 overdose deaths and exceeding the total number of all opioid overdose deaths in 2013, when deaths involving synthetic opioids first began to rise.[4]

While some people who use drugs seek out fentanyl and fentanyl-adulterated drugs, there is evidence that many people who consume fentanyl may be unaware they are consuming fentanyl or may prefer not to use fentanyl but find it unavoidable.[10,11] There is a lack of consensus as to why fentanyl is being incorporated into illicit street drugs at such high rates, especially considering that fentanyl is lethal at much lower doses than other opioids and is significantly more potent by weight compared with heroin.[12] One theory is that fentanyl is significantly cheaper to produce than heroin as heroin costs approximately $65 000 per kilogram wholesale whereas illicit fentanyl is available at roughly $3500 per kilogram.[6] As a consequence, drug dealers may be incentivized to incorporate fentanyl into their products to reduce costs and increase profits despite the public health risks. Fentanyl also increases the addictiveness of the drugs with which it is combined, including nonopioids such as cocaine, resulting in increasing drug usage frequency.[13] There is some speculation that these market forces could result in 2 drug markets analogous to the crack and cocaine drug markets of the 1980s,[14] with poorer people who use drugs priced out of access to pure heroin or cocaine.

Examining trends in the geographic distribution of fentanyl-involved overdoses may shed light on any patterns in fentanyl

ABOUT THE AUTHORS

The authors are with the Department of Epidemiology, Columbia University Mailman School of Public Health, New York, NY.

Correspondence should be sent to Elizabeth D. Nesoff, Columbia University Mailman School of Public Health, Department of Epidemiology, 722 W 168th St, 5th floor, New York, NY 10032 (e-mail: en2408@columbia.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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availability and the evolving bifurcation of different opioid markets. If fentanyl and fentanyl-adulterated drugs are targeted to areas where people who use drugs are unable to afford higher drug prices or larger drug quantities of unadulterated drugs, then we would expect to see more fentanyl in poorer or more resource-deprived neighborhoods. There has been little discussion on the pattern of fentanyl distribution—whether it follows a similar distribution to other drugs, particularly drugs it is mixed with, or if a unique set of geographic and social factors influence fentanyl use and related overdoses. Identifying areas with more fentanyl may also target areas for lay naloxone administration[15] and fentanyl test strip availability,[12] as well as identify new harm-reduction strategies. The purpose of this study was to examine geographic trends in the distribution of fentanyl-involved overdose deaths and discern if fentanyl-involved overdoses follow a bifurcated geographic distribution independent of other overdose deaths.

METHODS

The Columbia University Medical Center institutional review board waived review of this study.

Data Sources

The Cook County Medical Examiner's Office provides information on all deaths that fall under the jurisdiction of the medical examiner or are reported to the medical examiner in Cook County, Illinois, and qualify for further investigation. Cook County is the second most populous county in the United States (population: 5 180 493) and includes Chicago and the surrounding suburbs.[16] These data include full toxicology reports and Global Positioning System (GPS) coordinates for where the overdose occurred (the location of injury). Data are publicly available for download and updated regularly.[17] Data included in this analysis were from August 1, 2014, to August 15, 2018.

We grouped all records indicating a derivative of fentanyl or fentanyl metabolite (e.g., fentanyl, carfentanil, 4-ANPP,[3] U-47700[8]) as the primary cause of death (n = 1433; Table 1) using text-based identification of drug involvement.[18] Records that listed an illicit or prescription opioid (e.g., heroin, oxycodone, codeine, morphine) or a substance that was listed as part of a fentanyl-involved overdose (e.g., cocaine, LSD, methamphetamine, MDMA) but that did not include fentanyl as part of a polydrug overdose served as a comparison group (n = 1838; see Figure A for overdose categorization available as a supplement to the online version of this article at http://www.ajph.org).

TABLE 1—Description of Fentanyl-Involved Fatal Overdoses and Nonfentanyl Opioid and Polydrug Fatal Overdose Comparisons: Cook County, Illinois, August 1, 2014, to August 15, 2018

	Fentanyl-Involved[a] Fatal Overdoses (n = 1433)	Nonfentanyl Opioid and Polydrug[b] Fatal Overdoses (n = 1838)
Individual-level covariates		
Age, y, mean ±SD	43.1 ±12.5	44.2 ±12.6
Race/ethnicity, no. (%)		
Non-Latino/a Black	619 (43.2)	666 (36.2)
Non-Latino/a White	616 (43.0)	966 (52.6)
Latino/a	185 (12.9)	170 (9.2)
Other	13 (0.9)	36 (2.0)
Gender, no. (%)		
Male	1114 (77.7)	1343 (73.1)
Female	319 (22.3)	495 (26.9)
Neighborhood-level covariates		
Household income in $10 000s, median ±SD	4.79 ±2.76	5.08 ±2.82
Neighborhood deprivation score		
Mean ±SD	−0.04 ±1.84	−0.45 ±1.81
Low (range = −5.00–0.00), no. (%)	715 (49.9)	1123 (61.1)
Moderate (range = 0.01–1.00), no. (%)	252 (17.6)	266 (14.5)
High (range = 1.01–5.00), no. (%)	466 (32.5)	449 (24.4)
Index of Concentration at the Extremes, range = −1 to +1, mean ±SD	−0.11 ±0.74	0.07 ±0.73
Population density per square mile in 1000s, mean ±SD	16.4 ±23.0	15.3 ±13.1

[a]Substances used, identified in medical examiner toxicity screen as primary cause of death, were fentanyl and fentanyl metabolites, carfentanil, 4-ANPP, and U-47700, alone or in combination with drugs listed in footnote b.

[b]Substances used, identified in medical examiner toxicity screen as primary cause of death, were opioids (heroin, codeine, methadone, morphine, hydrocodone, tramadol, oxycodone, oxymorphone, buprenorphine, mitragynine, opioid, opiate) and nonopioids (cocaine, amphetamine, methamphetamine, lysergic acid diethylamide [LSD], 3-fluorophenmetrazine [3-FPM], methylenedioxyamphetamine [MDA], methylenedioxymethamphetamine [MDMA], 7-aminoclonazepam, clonazepam [Klonopin], delorazepam, diazepam [Valium], diclazepam, etizolam, lorazepam [Ativan], midazolam [Versed], nordiazepam, and temazepam [Restoril]).

We excluded suicides and homicides from this analysis, as well as deaths in which opioid use was a secondary contributing factor (e.g., a person who died of chronic obstructive pulmonary disease but also had opioids in his or her system would be excluded because the primary cause of death was not accidental drug overdose). Demographic information included age, gender, and 2 racial/ethnic categories with a separate designation for Latino/a. We recoded race/ethnicity into 1 racial/ethnic category with non-Latino/a White, non-Latino/a Black, Latino/a, and other (combining Asian, American Indian, "other," and "unknown").

We took neighborhood demographic variables for each census block group in Cook County, including population totals and median household income, from 5-year American Community Survey (ACS) estimates for each year of overdose data (e.g., we paired 2014 ACS estimates with 2014 fatal overdoses).[16] Because 2018 ACS estimates were not yet available at the time of data analysis, we assigned overdoses 2017 ACS values. We calculated population density by taking the total population of each census block group and dividing by the area of the census block group in square miles.

Measures

Previous research has demonstrated the importance of neighborhood context in risk for drug use[19] and drug overdose.[20] To provide a window into the broader neighborhood context not fully explained by demographics, we calculated the neighborhood disadvantage score by using census block group–level items from ACS as described previously. The items used to create the index included the percentages of (1) adults aged 25 years or older with a college degree, (2) owner-occupied housing, (3) households with incomes below the federal poverty threshold, and (4) female-headed households with children. We used Ross and Mirowsky's[21] formula to generate the index: {[(c/10+d/10)−(a/10+b/10)]/4} (percentages are entered as whole numbers, not decimals). Each 1-unit increase in the neighborhood disadvantage score is equivalent to an increase of 10 percentage points for each component item of the index.[21] The total score has a possible range from −5 to +5, where −5 is very low or little disadvantage, and +5 is very severe disadvantage. This metric has been used in previous investigations examining the relationships between neighborhoods, mental health, and risk factors for heavy drinking and violent crime.[22,23]

We assessed the level of Black–White segregation in Cook County census block groups by using the Index of Concentration at the Extremes (ICE).[24] We subtracted the number of Blacks from the number of Whites in a block group, and then divided by the entire population of the block group. The values range from −1 to +1, where −1 is 100% Black, 0 is 50% Black and 50% White, and +1 is 100% White. Whereas other measures of community-level racial segregation only give information about whether segregation exists, the ICE measure quantifies the polarization by group and considers majority-White and majority-Black communities to be qualitatively different.[24]

Data Analyses

We imported all overdoses with GPS coordinates (n = 3271) into ArcGIS 10.6 (ESRI, Redlands, CA) and mapped them. We used the spatial join tool in ArcGIS to identify the census block group where each overdose took place and assigned the corresponding census block group measures (e.g., neighborhood disadvantage score, population density) to the overdose.

To evaluate the global property of clustering in the data, we compared the K functions for the 2 groups in R 3.4.1 (R Foundation for Statistical Computing, Vienna, Austria; see Appendix A for sample R code). Clustering occurs when event locations tend to be near other event locations. If there was no difference in where fatal fentanyl overdoses occurred compared with fatal opioid overdoses in general, we would expect to see no significant difference when we compared the K functions for the 2 groups.[25] If the difference is within the banded region (similar to a confidence interval, designated by dashed lines in Figure 1), we would fail to reject the null hypothesis of no significant difference between where fentanyl and nonfentanyl fatal overdoses occur. When the difference function is above the upper limit, fentanyl overdoses exhibit more clustering than nonfentanyl overdoses, and if the function is under the lower limit, the nonfentanyl overdoses are more clustered than fentanyl overdoses. We calculated the difference in K functions for all study years combined (2014–2018) and each year individually to assess temporal shifts in clustering related to the recent introduction of fentanyl into the drug marketplace.

We mapped kernel intensity estimates to assess geographic variability in fentanyl overdoses and nonfentanyl opioid overdoses and then mapped the kernel ratio function to assess the spatial variation in risk—the property that the risk or "odds" of an event occurring varies geographically.[25] This is a nonparametric tool that maps the ratio of intensity of fentanyl overdoses to intensity of nonfentanyl overdoses and may identify areas of elevated risk for fentanyl overdose.[25] We then calculated a log ratio of kernel intensity functions for fentanyl and nonfentanyl overdoses to get a log relative risk surface and used Monte Carlo randomization of the fentanyl group labels (i.e., we randomized which location was designated a fentanyl overdose vs a nonfentanyl overdose) to detect significant local differences in fentanyl and nonfentanyl overdose intensities. This method maps the significant areas of log relative risk at a P level of less than .05.[25] We mapped all years combined and each year individually to assess temporal changes in relative risk for fentanyl-involved overdoses.

Finally, we used logistic regression to assess possible individual- and neighborhood-level correlates of fentanyl-involved overdose. We first assessed the univariable relationship between odds of a fentanyl-involved overdose and each covariate of interest separately. We then assessed covariates that were significant in univariable analysis (at $P < .05$) in the multivariable model. As this method does not account for spatial variation in fentanyl and nonfentanyl overdoses, we calculated spatial semivariograms to detect residual spatial variation not accounted for by the covariates for each model.[25] To select the best fitting and most parsimonious model, we calculated Akaike's information criterion and checked for multicollinearity by using variance inflation factors.[25] The final multivariable model presented here represents the most parsimonious model according to these criteria.

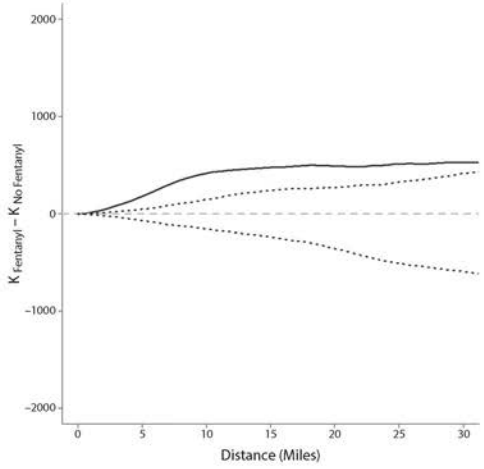


FIGURE 1—Difference in Fentanyl and Nonfentanyl Overdoses K Functions With Confidence Bands (Dashed) and Distance in Miles: Cook County, Illinois, 2014–2018

We then used geographically weighted regression (GWR) to further investigate the spatial variation of covariates at overdose locations. Unlike logistic regression, GWR does not assume that the relationship between covariates and the outcome of interest is consistent—or stationary—across the study area. Rather, GWR assesses whether the relationships between a set of covariates and an outcome vary by geographic location as the fitted coefficient values of a global logistic regression model may not represent detailed local variations in the data sufficiently.[26] GWR constructs a separate logistic regression equation for every location in the data set, which incorporates the dependent and independent variables of locations falling within the bandwidth of each overdose location. While GWR has some limitations, such as multicollinearity[27] and approaches to calculating goodness-of-fit statistics,[28] it is a useful tool for investigating spatial nonstationarity and is used here as a sensitivity analysis to determine if further inquiry into spatial variation of fentanyl overdose deaths is warranted.

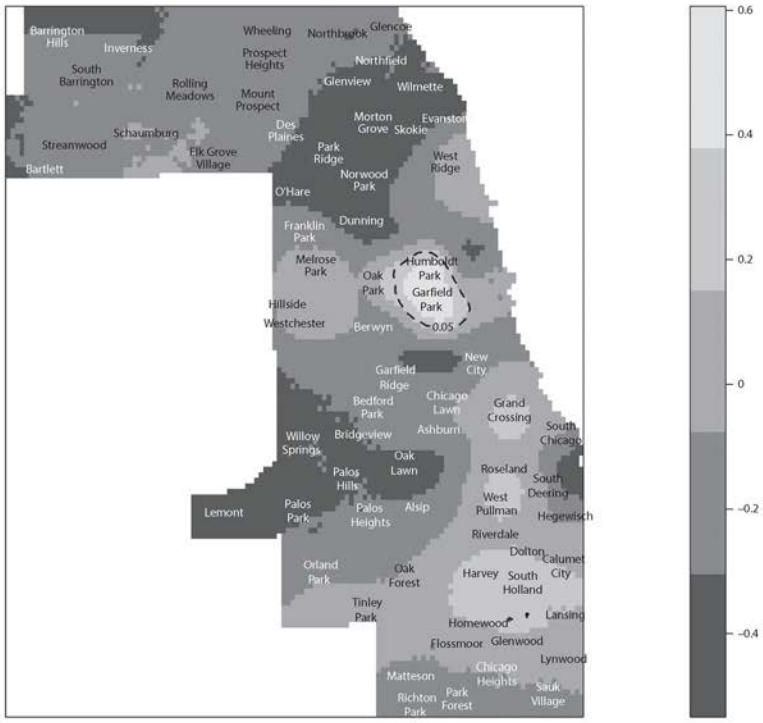
RESULTS

Table 1 presents a description of fentanyl-involved fatal overdoses and nonfentanyl opioid fatal overdoses, including substances used by both groups. A larger proportion of nonfentanyl overdoses were White (nonfentanyl: n = 966; 52.6% vs fentanyl: n = 616; 43.0%) while a larger proportion of fentanyl overdoses were men (fentanyl: n = 1114; 77.7% vs nonfentanyl: n = 1343; 73.1%). Age distribution was similar for both groups. A larger proportion of nonfentanyl overdoses occurred in neighborhoods with low neighborhood deprivation (nonfentanyl: n = 1123; 61.1% vs fentanyl: n = 715; 49.9%; see Table A, available as a supplement to the online version of this article at http://www.ajph.org, for substances commonly reported in polydrug overdoses).

The difference in the K functions for fentanyl and nonfentanyl overdoses for all years combined show that fentanyl overdoses cluster more than nonfentanyl overdoses, and this difference is significant (Figure 1). When we examined the K functions by year, much of this difference occurred starting in 2016 and may be related to the influx of fentanyl in the drug market at that time (Figure B, available as a supplement to the online version of this article at http://www.ajph.org). In 2014 and 2015, fentanyl overdoses clustered more than nonfentanyl overdoses, but this difference was not significant. Starting in 2016, the clustering of fentanyl overdoses was significantly greater than clustering among nonfentanyl overdoses.

The overall kernel intensity ratio maps identified several areas of elevated fentanyl overdoses compared with nonfentanyl overdoses (designated in yellow in Figure C, available as a supplement to the online version of this article at http://www.ajph.org), but one area in particular showed significantly elevated risk for fentanyl overdoses ($P < .05$; Figure 2). This area was located in the western neighborhoods of Chicago around Humboldt Park and Garfield Park (Figure D, available as a supplement to the online version of this article at http://www.ajph.org). Kernel intensity maps by year showed temporal variation in fentanyl risk. The 2014 map showed multiple areas of significantly elevated risk (Figure E, available as a supplement to the online version of this article at http://www.ajph.org). After 2015, maps were similar to the map for all years combined and showed 1 area of significantly elevated risk; this area changed in size but centered around the Humboldt Park and Garfield Park neighborhoods. In 2017, there were 2 additional areas of significantly elevated risk southwest of Chicago near Tinley Park and Harvey, but these regions were not significant for any other year.

Results from univariable logistic regression showed that several individual- and neighborhood-level risk factors were significantly associated with fentanyl overdoses (Table 2). In univariable analysis, the odds of a fentanyl-involved overdose were significantly increased for men, Blacks, Latinos/as, and younger individuals, and these covariates were assessed in multivariable analysis. Median household income (odds ratio



Note. Lighter grays indicate areas of elevated fentanyl overdoses compared with nonfentanyl overdoses. Dashed line represents the significant areas of log relative risk at $P < .05$. See Figure D, available as a supplement to the online version of this article at http://www.ajph.org, for color version.

FIGURE 2—Map of Kernel Intensity Ratio Estimates Showing Significant Local Differences in Fentanyl and Nonfentanyl Overdose Intensities: Cook County, Illinois, 2014–2018

[OR] = 0.963; 95% confidence interval [CI] = 0.938, 0.987; $P = .003$), neighborhood deprivation score (OR = 1.128; 95% CI = 1.086, 1.172; $P < .001$), and ICE (OR = 0.720; 95% CI = 0.661, 0.794; $P < .001$) were also significant and assessed in multivariable analysis. Population density was not significant (OR = 1.004; 95% CI = 0.999, 1.008; $P = .092$) and was not included in multivariable analysis.

In the multivariable logistic regression, median household income was not significant when we controlled for individual age, gender, and race/ethnicity (OR = 0.98; 95% CI = 0.95, 1.01; $P = .128$) and was significantly correlated with neighborhood deprivation index ($r = -0.639$; $P < .001$). ICE showed multicollinearity (variance inflation factor > 3) with race/ethnicity of individual overdose cases and with neighborhood deprivation score. ICE was also significantly correlated with individual race/ethnicity ($r = -0.490$; $P < .001$) and neighborhood deprivation score ($r = -0.500$; $P < .001$). The

TABLE 2—Univariable and Multivariable Logistic Regression Results for Odds of Fentanyl Overdose: Cook County, Illinois, August 1, 2014, to August 15, 2018

Variable	Univariable OR (95% CI)	Multivariable OR (95% CI)[a]
Age	0.993 (0.988, 0.999)	0.984 (0.977, 0.990)
Race/ethnicity		
Non-Latino/a White (Ref)	1.458 (1.256, 1.692)	1.448 (1.205, 1.742)
Non-Latino/a Black	1.707 (1.354, 2.152)	1.570 (1.239, 1.989)
Latino/a	0.566 (0.287, 1.049)	0.511 (0.258, 0.954)
Other		
Sex (Ref: female)	1.287 (1.096, 1.514)	1.327 (1.126, 1.565)
Neighborhood deprivation score (−5 to +5)[b]	1.128 (1.086, 1.172)	1.114 (1.066, 1.165)
Index of Concentration at the Extremes (−1 to +1)	0.720 (0.661, 0.794)	
Median household income (in $10 000s)	0.952 (0.928, 0.977)	
Population density (in 1000s)	1.004 (0.999, 1.008)	

Note. CI = confidence interval; OR = odds ratio. Sample size n = 3271. For adjusted model, Akaike's information criterion = 4400.

[a]Adjusted for other covariates in the column.

[b]OR denotes a 1.00-unit change in the score over the −5 to +5 scale.

model containing age, gender, and ICE showed poorer fit compared with the model containing age, gender, race/ethnicity, and neighborhood deprivation score (Akaike's information criterion = 4410 vs 4400; Table B, available as a supplement to the online version of this article at http://www.ajph.org).

The odds of a fentanyl-involved overdose increased 11.4% with each unit increase in neighborhood deprivation (95% CI = 1.066, 1.165; $P < .001$) when we controlled for age, race/ethnicity, and gender. Residual semivariograms for models with neighborhood deprivation score indicated no unexplained spatial variation. GWR models supported this finding (Figure F and Table C, available as supplements to the online version of this article at http://www.ajph.org); there was no variation in the relationship between neighborhood deprivation score and the odds of a fentanyl overdose across the study region.

DISCUSSION

This study describes the geographic distribution of fatal fentanyl-involved overdoses compared with other fatal opioid and polydrug overdoses and examines neighborhood-level correlates of overdose fatality. Few studies have examined the local geographic distribution of drug overdoses and associated neighborhood-level risk factors. Much of this work has been ecological, using large geographic units such as zip codes or counties on a national scale.[29] This study provides a unique perspective on the geographic distribution of overdose locations by using point-level data, allowing for a more localized investigation of overdose risk factors, and supports the hypothesis that fentanyl may be targeted to more resource-deprived neighborhoods.

We employed a variety of parametric and nonparametric tests to assess if fentanyl-involved overdoses follow a bifurcated geographic distribution independent of other overdose deaths. The difference in K functions showed that fentanyl overdoses clustered more than other overdoses, suggesting that fentanyl does not follow the same geographic distribution as that of the general drug-using population. This finding was supported by the lack of significance of population density in logistic regression. Kernel intensity ratio maps identified several areas of elevated risk for fentanyl-involved overdose, indicating that the odds of a fentanyl-involved overdose occurring varies geographically. We also assessed temporal variations in these trends by looking at all study years combined (2014–2018) and each year individually to make sure that overall trends could not be attributed to the sudden influx of fentanyl into the drug market after 2014. All analyses conducted after 2014 found significant sustained spatial variation in fentanyl-involved overdoses compared with opioid and polydrug overdoses.

Our findings suggest that fentanyl-involved overdoses are concentrated in resource-deprived neighborhoods over and above what we see for opioid and polydrug overdoses. This supports the hypothesis of an evolving bifurcated drug market, with people who use drugs in resource-deprived neighborhoods potentially unable to access drugs free of fentanyl. In addition, the odds of a fentanyl-involved overdose were significantly increased for men, Blacks, Latinos/as, and younger individuals. These findings echo previous studies of risk for crack cocaine use, which identified socioeconomic disadvantage as a fundamental cause of racial disparities in crack use.[14]

The physical and social characteristics of disadvantaged neighborhoods can undermine residents' mental health, increasing risk for drug use.[19,20,23] Neighborhood risk factors for drug use may be modifiable through targeted infrastructure improvements or other community development strategies, such as park-making or building renovation,[30–32] but this research has not been extended to overdose prevention to date. For example, vacant lot remediation has been shown to significantly reduce gun violence[31] and improve residents' mental health in cities[30]; this presents a possible strategy for reducing drug use in resource-deprived neighborhoods. Further inquiry into specific, modifiable aspects of neighborhood deprivation that can be used to create actionable policy and interventions for harm reduction and overdose prevention is warranted.

Limitations

This study was limited to fatal overdoses only and does not account for possible geographic variability in nonfatal overdoses. We could not explore geographic factors that might reduce risk for fatal overdose, such as access to health services or naloxone distribution. It is possible that nonfatal fentanyl-involved overdoses differ from fatal overdoses in significant and meaningful ways; future research should

include nonfatal overdoses in place-based inquiry.

The Cook County Medical Examiner's Office began routinely testing for fentanyl in June 2015[33]; there is potential for misclassification bias for overdoses before this date. Generalizability of findings may be limited to urban areas where fentanyl is readily combined with opioids such as white powder heroin. For example, black tar heroin is more difficult to mix with fentanyl and is primarily sold in areas west of the Mississippi River—areas that have not experienced the same influx of fentanyl into the drug supply.[4]

GPS coordinates indicated where an overdose occurred (location of injury); we do not have data on locations where drugs were purchased or consumed. It is possible that people who use drugs may travel to certain neighborhoods to purchase and consume drugs,[34] but mobility among people who use drugs and variation in activity centers has not been widely studied. As we did not have access to home addresses, interpretation of findings is limited to where the overdose occurred and cannot be expanded to include neighborhoods where people who use drugs lived or purchased drugs. However, previous research has shown that more than 70% of people who use drugs purchase drugs in their neighborhood of residence,[35] and a San Francisco, California, study found that opioid users traveled on average 1.5 miles between locations where they lived, hung out, and used drugs.[34] Although our data do not directly record the location where drugs were purchased, these data provide a proxy location to explore the characteristics of neighborhoods where drugs were purchased and consumed.

Conclusions

Fentanyl-involved fatal overdoses follow a unique geographic distribution compared with fatal nonfentanyl opioid and polydrug overdoses associated with resource deprivation in neighborhoods where they occur. This suggests an evolving bifurcated drug market, with drug markets in resource-deprived neighborhoods disproportionately likely to include fentanyl. Future research should explore modifiable aspects of neighborhood deprivation that can be used to create actionable policy and interventions for prevention of fentanyl-involved overdoses. AJPH

CONTRIBUTORS

E. D. Nesoff conceptualized the study, obtained the data, conducted the analyses, and wrote the first draft. C. C. Branas and S. S. Martins contributed to the analyses, assisted with writing and editing the article, and contributed to the interpretation of the results. All authors read and approved the final article.

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CONFLICTS OF INTEREST

All authors have no possible conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

This research used publicly available data disseminated such that participants cannot be identified and was deemed non–human participant research by the Columbia University Medical Center institutional review board.

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SEPARATE, UNEQUAL AND OVERLOOKED

AMID AN OPIOID EPIDEMIC OFTEN SEEN AS RURAL AND WHITE, BLACK AMERICANS IN CITIES LIKE CHICAGO HAVE BEEN STRUGGLING AND DYING FOR DECADES.

BY JOSEPH P. WILLIAMS SENIOR EDITOR, U.S. NEWS AND WORLD REPORT

JAN. 28, 2019, AT 6:00 A.M.

CHICAGO – As best as he can recall, the first time Daniel James used heroin was in 2009 or 2010, when he was in his late 30s. It was shortly after he'd been released from prison for the second or third time, resettling not far from West Garfield Park, the hardscrabble neighborhood where he grew up.

A high school dropout scraping by as a part-time forklift operator, James was partial to smoking pot or sniffing cocaine in his free time, hoping to numb a lifetime of pain. He'd been sexually abused by his father, who later killed himself, and his unstable mother soothed her demons with crack cocaine. There was rejection, depression and almost as many years spent incarcerated as on the outside.

In West Garfield Park, a once vibrant African-American community crippled in the violence and destruction unleashed after Martin Luther King Jr. was assassinated in 1968, opportunities to get a quality education, a decent-paying job or away for good are rarer than hen's teeth. Mind-altering substances, however – from booze to the harder, illegal stuff that can instantly replace misery with euphoria – are as common as the boarded-up businesses along nearby West Chicago Avenue.

Though he'd come to buy marijuana that day, James' weed dealer handed him three small packets of white powder, on the house. Check out the heroin, he said; if you like it, come back.

"I snorted it thinking it would be like cocaine," says James, now in his late 40s, a compact, heavyset African-American man with a neatly trimmed mustache, modest horn-rimmed glasses and wide, gap-toothed smile. "And then just this warmness came over my whole body. I was in my house just chilling for two or three days. I thought, 'Hey, man, this is really cool.'"

"I went back and I bought some."

When he inhaled those first grams of powder, a choice that eventually brought him to the brink of death, James became part of a separate and unequal epidemic, one rooted in decades of communal decay, neglect and suffering – the bitter residue of the nation's ugly racial history.

Daniel James grew up in West Garfield Park and first tried heroin a decade ago. Today, he works as an unpaid manager for a recovery home where he lives, and picks up construction jobs for cash. While he's been clean for about a year, he says staying that way is tough.

For the past several years, American attention has been fixated on fighting opioid overdoses in largely white towns, where reports of climbing fatality rates have struck like a thunderbolt, revealing communities in economic and social distress. Opioid abuse there, the narrative goes, stems from economic instability and an explosion in prescriptions for pills like OxyContin – a powerful analgesic that morphed from pain reliever to addictive street drug, a gateway to hardcore heroin use.

Yet population health analysts, academics and on-the-ground specialists say heroin and its related plagues of crime and death have stalked African-American neighborhoods for decades, garnering little to no attention. And when the government has bothered to address it in cities like Chicago, critics say, it's usually through police crackdowns on users and dealers rather than increased access to intervention, drug treatment or badly needed economic aid.

The disparities in attention, resources and long-term strategies have led to a tale of two opioid crises. One is white, a malady of medical and mental health, and worthy of a White House-level task force. The other is black, criminal and largely ignored, even as statistics show black opioid users are dying at a skyrocketing pace.

An Overlooked Epidemic

As the country has sounded the alarm and searched for solutions in places like Parkersburg, West Virginia; Chillicothe, Ohio; and Burlington, Vermont, the opioid epidemic went relatively unnoticed in poor communities with large minority populations like West Garfield Park, East Baltimore and the Southeast quadrant of Washington, D.C.

"The opioid epidemic has largely been portrayed as a problem affecting young whites in suburban and rural areas," says the Chicago Urban League report "Whitewashed: The African American Opioid Epidemic," released in late 2017. "In Illinois, the Midwest, and indeed much of the United States, this is a wholly inaccurate depiction."

Numbers tell part of the story: A U.S. News analysis using Centers for Disease Control and Prevention data found the age-adjusted rate of fatal opioid-related overdoses among blacks in America averaged 3.7 deaths per 100,000 population between 2005 and 2013, far below the 7.6 average rate for whites during that time. Yet between 2014 and 2017, the fatal overdose rate among blacks rose by 130 percent, more than twice the 61.5 percent surge for whites over that period.

Moreover, the number of black overdose victims in urban areas soared in recent years – from roughly 5 deaths per 100,000 in 2012 to about 17 in 2017, according to a similar analysis of federal statistics.

A cross rests against a mural in West Garfield Park. In 2017, Chicago saw 670 homicides, while 796 people died from an opioid-related overdose – about 400 of them were black, and about 290 were white.

Meanwhile, fentanyl – a synthetic drug used medically to aid people in pain, like cancer patients – has raised the stakes for black and white heroin users alike. The potent substance, cheaper than heroin and often added by dealers or distributors to cut the drug, has transformed opioid addiction and drug abuse in general into a game of Russian roulette. Users often won't know if the smack they purchased has a lethal fentanyl-to-heroin ratio until they ingest it, and by then it could be too late. It's also showing up in drugs like cocaine and methamphetamine.

James, from West Garfield Park, has "died" himself at least once: He says he snorted fentanyl-laced heroin, blacked out on the street and came to life inside an ambulance after a paramedic gave him a dose of a rescue drug, probably naloxone.

Two hours later, James says, he bolted from the emergency room against his doctor's advice.

"I had to go get more heroin," he says.

Roots

To Kathie Kane-Willis, co-author of the Urban League report, the opioid crisis in black America is a pestilence hidden in plain sight, mostly because the country ignores places like the West Side of Chicago.

Driving her red Honda Fit around the epicenters of Chicago's opioid crisis, the petite, silver-haired researcher – friendly and open, a former heroin user who still lives on the West Side – ticks off the obvious signs.

Block after block of abandoned houses marked by the city with a big red X, likely shelters for drug-using squatters. Empty heroin baggies littering a pond in the heart of Garfield Park, an urban green space honoring the nation's 20th president. Unusual traffic on otherwise quiet city streets, with cars coming and going at all hours. Young drug dealers – "corner boys" – loitering in battered areas like the intersection of South Albany Avenue and West Madison Street, the adjacent edge of a vacant lot strewn with garbage.

A day before on the same block, a pair of young men in black parkas – one sipping a tall can of beer at 2 p.m., his hood pulled low – stood idly on the sidewalk in bitingly cold weather. Amid snow flurries and a stiff breeze, a series of cars drove up, stopped for a few minutes in front of the pair, then pulled away.

Kathie Kane-Willis, director of policy and advocacy for the Chicago Urban League, says the roots of the opioid crisis in urban black America are complex, and stretch back decades.

President Donald Trump has used Chicago as shorthand for a scourge of urban gun violence, but data show the drugs peddled on Windy City streets proved far deadlier in 2017. Chicago that year saw 670 homicides, while 796 people died from an opioid-related overdose – about 400 of them were black, and about 290 were white. The overdose death rate increased by 18 percent for whites and 11 percent for blacks, city statistics show, yet remained highest among blacks in the city.

Experts say the death figures are out of proportion, given that blacks and whites make up roughly equal percentages of Chicago's population. Yet "the federal government's response to the opioid epidemic has lacked much, if any, focus on how African Americans are impacted," according to the Chicago Urban League report.

In its final report, the President's Commission on Combating Drug Addiction and the Opioid Crisis briefly noted demographic statistics that may point to reasons for the disparity, while also citing a study showing a lower prevalence of opioid use disorder among blacks in past years. As summarized by the Chicago Urban League analysis: "The majority of black Americans with opioid use disorders fall in the lowest income bracket, rarely receive treatment, utilize public insurance programs like Medicare and Medicaid, and primarily live in metropolitan areas."

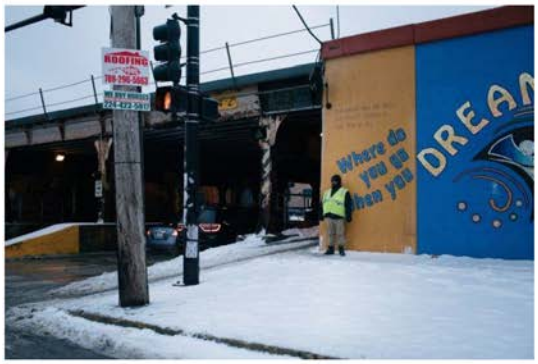
While heroin laced with fentanyl is the chief suspect in the latest phase of America's opioid crisis, Kane-Willis says the roots of the problem in urban black America stretch back decades and are far more complex.

In Chicago, it mostly begins and ends with the city's turbulent history, she says – a past featuring decades of bigoted white civic leaders openly hostile to African-Americans who'd fled the Jim Crow South in the early 20th century. The Windy City's famed political machine, Kane-Willis says, balked at improving substandard housing and schools in black neighborhoods. It also ignored blatant real estate discrimination and did nothing when whites fled to the suburbs after neighborhoods like West Garfield Park began to integrate.

When violent unrest swept through American cities after King's assassination in 1968, Chicago was among the hardest hit. Once the smoke cleared, demolition and disinvestment trumped reinvestment and reconstruction. West Side factories relocated to Dixie, burned-out homes were razed and never rebuilt, and drugs – including heroin – flowed in along with crime and decay. As long as the users were black, Kane-Willis says, the city preferred punishment to rehabilitation.

"When you're talking about the drug market, you're talking about the intersection of all of those things," says Kane-Willis, steering the Honda past gaping, empty lots – open wounds from the chaos of 1968 that lie like missing teeth between tidy row homes and apartment buildings.

"There used to be tons of jobs here," she says. "That's something that you hear now: 'Oh, the opioid epidemic is because of loss of jobs to China.' But in Chicago, manufacturing jobs moved to the South first."



A Safe Passage representative – part of a program designed to give students safe routes to and from school – stands near Green Line tracks for the L train on Chicago's West Side.

And where neglect and despair exist, Kane-Willis says, drugs almost always fill the vacuum, triggering a vicious cycle in the 'hood: Dealers peddle heroin to earn a living. Destitute users turn to crime to finance their habit. Police lock up everyone they can catch. And the revolving door of the criminal justice system sends dealers – unemployable because of a prison record – and users who weren't treated for addiction back to the streets.

"You've got the perfect combination," says Kane-Willis, pulling to the curb on Lake Street, concluding the tour. "An area that nobody cares about and a population that's willing to (commit crime) because they want to earn the money or there are no other opportunities available to them, and society views them as disposable and expendable."

Help Wanted

At Haymarket Center, a rehabilitation and treatment center in downtown Chicago, an impromptu roundtable discussion convenes in Heartland Alliance Health's James West Clinic, tucked inside the facility. A half-dozen addiction and recovery experts gather to discuss the disparities between the black and white opioid epidemics.

Holding the floor, addiction counselor Tony Strong says in his view, there isn't much difference between the epidemic gripping Appalachia and the one hammering his city's West Side. Both black and white users are in pain, he says, and in his line of work, "help is help."

In West Garfield Park, he says, the crises intersect.

"I live there, and there is also a large number of homeless Caucasians" from outside the area who are addicted to heroin, says Strong, a tall man with a piercing, no-nonsense demeanor and dreadlocks woven into thick twin braids down to his neck. They came to the 'hood to buy drugs, he says, but addiction's inevitable price – job loss, disavowal by loved ones, vagrancy, poverty – forced them to stay.

"It's not a black or white thing," he says. "It's a poor thing at that point."

Dr. Elizabeth Salisbury-Afshar, a physician, researcher and addiction specialist, adds an important caveat: The path to rehab for black opioid victims almost always goes through prison.

"We deal with a lot of people who are in incarceration" says Salisbury-Afshar. She sees patients part time in a rented office at Haymarket, but is also director of the Center for Multi-System Solutions to the Opioid Epidemic at the Washington-based American Institutes for Research. "And I honestly feel it's super lucky if they even can make it here" to treatment.

A youthful clinician passionate about her work, Salisbury-Afshar says opioid victims face long odds in getting treatment, mostly because medical care and rehab programs are lacking in places like West Garfield Park. Meanwhile, she says, police and city leaders see drug users as moral failures, not victims of a problem that has plagued their community for generations.

Dr. Elizabeth Salisbury-Afshar says drug users too often are seen as moral failures, not victims of a problem that has plagued a community for generations.

Indeed, as fentanyl has increasingly appeared in heroin supplies, blacks and adults 65 and over saw the largest percent-change increases in opioid-involved overdose death rates from 2016 to 2017, according to a December report from the CDC. The rate for blacks jumped by 25.2 percent, while the rate for older Americans surged by 17.2 percent.

Salisbury-Afshar points out other hurdles: Medicaid or private insurance doesn't always cover the full scope of expensive inpatient drug rehabilitation and treatment; patients who have criminal records struggle to find jobs and supportive family; and recovery from addiction can sometimes take years. Strong says he went through treatment 13 times over several decades before he truly kicked his addiction.

Salisbury-Afshar says the situation – helping a patient get into a program, navigate insurance bureaucracies and commit to rehab – can be so tenuous she often sends up a silent prayer.

"I say, 'Oh, please, can we at least make sure they have a couple months of time here?'" she says. "Because I know if they end up back out on the streets after the first month, it's a setup for failure" – meaning relapse and probably another trip back to prison.

"We say a lot of times that addiction is a medical condition, addiction is a disease," says Salisbury-Afshar. But in places like West Garfield Park, "we continue to incarcerate people for it."

Dr. Evan Lyon, a physician and the chief integrated health officer at Heartland Alliance, a Chicago-based nonprofit that aids the poor, says politicians aren't seeing the big picture. Drug addiction in general, he says, is "a symptom of a much larger root cause," specifically people and communities grappling with decades of unaddressed trauma.

When authorities use data-generated, shaded maps of the city to track hot spots of crime and poor public health, he says, the problems always overlap. The maps, Lyon says, "are dark on the (black and poor) South Side, and they're dark on the West Side – education levels, premature births, low birth weights, early pregnancy, violence."

For the opioid crisis, he says, "you could take the same maps and just put different labels on."

Pedestrians pass under tracks for the L train in West Garfield Park.

Ultimately, the group at Haymarket Center concludes, an ideal plan to break heroin's grip on the West Side of Chicago would involve a broad combination of initiatives, ranging from harm reduction to sustained investments in schools, housing and quality job-training programs, addressing the factors that cause drug use to proliferate. None of them expect that kind of help to arrive any time soon.

Until then, they'll do what they can, distributing lifesaving drugs like naloxone and working the system to get care to users who want to stop – like Daniel James.

After several years of addiction, prison and at least one round of rehabilitation and relapse, James' rock-bottom moment came a little over a year ago, not long after his near-fatal overdose. Homeless and hungry during the brutal Chicago winter, he stumbled past a shelter where a stranger staying there offered him something to eat.

The simple favor, he says, led to an epiphany: Kick heroin – now – or die.

While he's been clean for about a year, James says, staying that way is tough. A steady job has been elusive, temptation is perpetual and optimism can feel like a chore – much like daily life can be in West Garfield Park.

"The way this shit is so set up, it makes us look like we're at fault for these circumstances," he says, his rumbling baritone voice breaking, a tear spilling down his cheek. "I have a community that's already suffering."

Insisting that community just say no to an illegal drug that can ease the suffering, James says, "is like telling a chicken, 'Well, just fly.'"

STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Eric J. Holcomb
Governor

October 8, 2019

Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pallone, Ranking Member Walden and the members of the House of Representatives Committee on Energy and Commerce:

Thank you for the opportunity to update you regarding Indiana's progress in addressing the opioid crisis. From the first day of my administration, we have made attacking the drug crisis and helping Hoosiers recover from substance use disorder a top priority.

In 2017, I signed an executive order appointing the State of Indiana's first executive director for drug prevention, treatment and enforcement and called for an "all hands on deck" approach to addressing this public health crisis. Shortly afterward, the Indiana Commission to Combat Drug Abuse developed a strategic plan, focused on our key priorities of reducing the incidence of substance use disorder, keeping people alive, expanding timely access to quality treatment, and taking steps to help prevent others from becoming dependent on substances.

Working with Indiana's federal partners, local governments and private organizations, our state agencies have coalesced to tackle this mission. Our efforts have been bolstered with federal grants which we have effectively leveraged to combat the drug crisis, working collaboratively to engage stakeholders. We have increased timely access to treatment and recovery housing, expanded access to and the availability of naloxone, implemented guidelines for opioid prescribing and launched a medication-assisted treatment pilot program for jail inmates.

State Targeted Response grants and State Opioid Response grants appropriated by Congress have helped Indiana launch mobile crisis teams across 14 counties, create Mobile Integrated Response Systems in 24 counties, place peer recovery coaches in emergency departments in 19 hospitals and expand school-based prevention initiatives. We're building treatment infrastructure that can meet people where they are, and help them get their lives back through evidence-based care. Inpatient and residential capacity has increased 65% and we now have more treatment available than ever before.

Additionally, Indiana's Medicaid waiver expanded access to substance use treatment to 1.6 million people. Under the waiver, since February 2018, more than 63,000 Hoosiers have received treatment for substance use. Over 40,000 people received outpatient treatment and more than 10,000 people have received inpatient services. More than

11,000 Medicaid patients have received Medication Assisted Treatment at our Opioid Treatment Programs.

In response to the committee's questions:

1. ***Since 2016, how much federal funding for opioid use disorder prevention, treatment, and recovery has Indiana received?***

	SAMHSA	CDC	BJA
2016	$ 948,352	$1,924,513	$0
2017	$12,675,992	$2,863,135	$0
2018	$29,873,215	$6,345,334	$4,063,050
2019	$27,620,073*	$7,153,983	$0
Total	*$71,117,632*	*$18,286,965*	*$4,063,050*
Grand Total	**$93,467,647**		

**Funding amount has been awarded but not yet received by the state.*

   a. ***What challenges, if any, exist in deploying federal funds to local communities in an expedited manner?***

      In anticipation of the receipt of federal funding, the Division of Mental Health and Addiction (DMHA) met with Indiana Department of Administration (IDOA) to discuss the state procurement process, anticipate challenges and work to expedite solutions. This partnership has helped to ensure that state procurement rules and processes do not unnecessarily cause delays in the awards of contracts and disbursement of funds.

      Local infrastructure to utilize these funds among community partners at times has been problematic as some providers have had difficulty in building community partners or struggle with the volume of activity due to their other priorities in addiction treatment and prevention. We have been creative in utilizing other state agencies or branches of state government to help build capacity and provide technical assistance to partners to help build the infrastructure and capacity needed to utilize the federal funding.

      The specificity of these funds going solely to opioid use disorder has caused some local communities to not utilize money because other substances (methamphetamines) are more problematic in their area.

   b. ***To date, how much of this federal funding has your state used or allocated? Please provide a list of each funding recipient; the purpose for allocating money to them (e.g. prevention, treatment, etc.), and the amount that has been allocated to them.***

      Indiana has allocated all of the federal funding that has been awarded. See attachment #1 for further details.

c. ***If your state has not used the entirety of federally allocated funding, please explain why.***

Indiana has allocated all of the federal funding that has been awarded.

2. ***Please describe how your state determines which local government entities (i.e. counties, cities and towns) receive federal grant funding to address the opioid crisis. Specifically, please identify localities impacted most by the opioid epidemic in your state, and include the total amount allocated to each locality, as well as the factors your state considers in distributing these funds.***

As part of the strategic planning process, heads of the relevant state agencies convened to share data and identify areas most in need, assess the resources available to the communities and identify gaps at the community, regional and statewide level. Based on this assessment and amount of funding DMHA would issue a request for proposal, listing the goal of the project and relevant requirements of the respondent.

Unlike other states that have a fragmented county by county approach, Indiana has a centralized agency that oversees mental health and addiction services for the state.

The primary factor Indiana considers when distributing funds is if the vendor meets the specific requirements listed in the scope of work that is sent out for bidding. Our specific requirements are decided upon by taking our goals for the funding into consideration including organizational capacity, statement of need and ability to execute the request. We have the same requirements for private sector vendors and governmental agencies.

In situations where a lack of infrastructure, resources and cooperation has led to a lack of response to the funding proposals, the state has helped identify organizations, provide additional resources and foster cooperation among entities working in this area to ensure project success.

For further details, please see attachment #1.

3. ***Please describe how your state determines which non-governmental organizations (i.e. non-profits, treatment centers, or other entities) receive federal grant funding to address the opioid crisis. Specifically, please identify the non-governmental organizations that have received funds in your state, and include the total amount allocated to each entity, as well as the factors your state considers in distributing these funds.***

Indiana uses the same approach regardless of the type of organization, local governmental agency or city or town.

For details, please see attachment #1.

4. ***Do federally appropriated funds to address the opioid crisis provide your state with the flexibility to focus on the hardest hit regions or localities? Please describe how, if at all, this flexibility has helped Indiana in using funds to target vulnerable populations or at-risk areas. If no, please explain what additional flexibility should be considered in helping your state address the hardest hit regions or localities.***

   Federal funding has not been restricted to specific demographic or geographic entity or to a population in the state, allowing for the funds to be focused on areas of high need. However, some of Indiana's areas of highest need due to drug abuse are not opioids but rather other substances (methamphetamines). Indiana needs flexibility to focus on all substances, not just opioids.

5. ***In what ways, specifically, have federal funds extended to Indiana helped change your state's treatment system and/or led to a reduction in opioid overdoses?***

   Federal funds have supported systemic change within Indiana's addiction treatment system through infrastructure development and greater access to needed services. Specific examples of this include:

   1. Indiana forged a partnership between a statewide call center (IN211) and a software platform (OpenBeds) to allow for 24-hour access and streamline the process of finding addiction treatment. This partnership resulted in over 700 referrals for an addiction treatment bed and over 4300 referrals for outpatient treatment for 2018.
   2. Indiana increased the number of residential addiction treatment beds by 250 since receiving the State Targeted Response Grant with almost 200 of these beds being added with support from federal funds. This increase in bed capacity allowed Indiana to better prepare for the SUD Medicaid Waiver approval in February 2018 that allows for reimbursement of residential addiction treatment.
   3. Indiana utilized federal funds for reimbursement of addiction residential treatment for 320 individuals who did not have access to a third party payer, totaling 3,345 bed days
   4. Indiana's State Opioid Treatment Authority, the Division of Mental Health and Addiction and Office of Medicaid Policy and Planning, partnered to develop a bundled rate for individuals in treatment at a certified Opioid Treatment Program (OTP), effective September 1, 2017. Supported by just under $40 million in federal funds, over 11,000 individuals received treatment in an OTP funded by Medicaid since the program's inception.
   5. Indiana utilized federal funds to support two mobile addiction treatment teams in fourteen counties. These teams were able to engage over 330 individuals in

rural communities to ensure access to needed mental health and addiction treatment.

6. Indiana utilized over $1 million in federal funds to purchase Naloxone to ensure local health departments and first responders across the state sufficient access to the life-saving medication.

6. ***What performance measures is· Indiana using to monitor the impact of federal funds for opioid use disorder and other substance use disorder treatment?***

As outlined in our strategic plan, Indiana utilizes the following metrics to monitor the state's activity related to substance use disorder:

1. Number of persons with overdoses admitted to hospitals or emergency departments
2. Deaths from overdoses
3. Opioid prescription rates
4. Number of babies born with Neonatal Abstinence Syndrome
5. Program level data regarding people seeking treatment. (An increase in the number of people engaged in treatment reveals the increased accessibility to treatment in Indiana. The state is also working on a data project to help estimate the number of person entering and continuing in recovery.)

7. ***According to the Substance Abuse and Mental Health Services Administration, State Targeted Response to the Opioid Crisis (STR) Grants provide funding to states to: (1) conduct needs assessments and strategic plans; (2) identify gaps and resources to build on existing substance use disorder prevention and treatment activities; (3) implement and expand access to clinically appropriate, evidence-based practices for treatment – particularly for the use of medication-assisted treatment (MAT) and recovery support services; and (4) advance coordination with other federal efforts for substance misuse prevention.***

   a. ***Has your state conducted a needs assessment and strategic plan? If yes, please describe that plan.***

"A strategic Approach to Addressing Substance Abuse in Indiana" was adopted by the Indiana Commission to Combat Drug Abuse in May of 2017 (See Attachment #2, also available online at https://www.in.gov/recovery/1063.htm.)

> *"With an initial focus on opioids, we will develop and implement a data-driven system focused on substance abuse prevention, early intervention, treatment, recovery, and enforcement that substantially reduces the prevalence of substance use disorder (SUD) in Indiana and helps those with SUD achieve recovery and become or return to being productive, contributing members of their communities.*

We will coordinate, align, and focus the resources of Indiana state government and leverage the resources of other public sector entities and other sectors—including businesses, higher education institutions, health care systems, philanthropies, and not-for-profit organizations—to respond to the current opioid crisis and enhance the potential for timely responses to future crises resulting from substance abuse and addictions.

Toward that end, we will develop and implement complementary public health and public safety strategies that: Recognize substance use disorder as a chronic disease and incorporate prevention, treatment, and recovery systems accordingly, and are designed to reduce the supply of and demand for illicit substances.

Key Components:

1. *Data Driven: Data will inform all systems and programs created for government, individuals, families and providers—evolving as learning increases and as Indiana's drug crisis changes.*
2. *Comprehensive and Holistic: Indiana's approach will be multi-faceted and focused on substance abuse prevention, early intervention, treatment, recovery and enforcement.*
3. *Collaborative: The state will align and focus the efforts of multiple state agencies that currently provide substance abuse services and resources. Further, Indiana's approach makes clear that local communities, state officials, and the federal government must all have a stake in helping overcoming the drug crisis."*

b. Has your state identified gaps and resources to build on existing substance use disorder prevention and treatment activities? If yes, please describe those findings.

One of the biggest gaps identified in the State of Indiana is lack of a qualified workforce to address the needs of individuals with an addiction and specifically an opioid use disorder. Some of our strategic approaches to increasing our addiction workforce and reducing limitations across the state include but are not limited to: increasing the number of certified recovery coaches, allowing for Medicaid reimbursement of recovery coaches, increasing the number of Certified Addiction and Drug Abuse Consultants (CADAC), increasing knowledge and skills of our current workforce around OUD by using telehealth and telecommunications, increasing integration of programs such as drug courts, diversion programs and supporting expansion of improvement as it relates to SUD treatment.

Specific examples of these initiatives include:

1. Indiana utilized federal funds to add recovery coaches to local hospital emergency departments with the goal of connecting individuals to treatment prior to leaving the hospital. This initiative added recovery coaches to our workforce in 24 hospitals around our state with over 1,000 patients being seen and over 400 patients engaging in treatment. As of July 1, 2019, all peer support services in Indiana are reimbursed through Medicaid which allows for sustainability of the peers in the ED initiative.
2. Indiana added two new CADAC credentials for bachelors- and masters-level licensed social workers with required supervision hours and course work but need to take the certification exam. This has resulted in adding over 30 new CADACs.
3. Indiana used federal funds to start a Project ECHO Extension for Community Healthcare Outcomes. This initiative, which launched March 2018, is a partnership between local healthcare providers and a team from Indiana University to utilize technology to improve knowledge around treatment for opioid use disorders in rural areas. Topics have included: an overview of opioid use disorder, review of SBIRT techniques, medication assisted treatment, related morbidities, overdose prevention, pain management and treating opioid use disorder in special populations. Some of our targeted tracks include: physicians (focused on buprenorphine prescribers), community health workers, licensed social workers, Recovery Coaches in ED, women who are pregnant and First Steps providers.

c. ***Has your state implemented and expanded access to clinically appropriate, evidence-based practices for treatment-particularly for the use of MAT and recovery support services? If yes, please describe how you have done so.***

Through the STR grant, Indiana was able to contract with 9 hospitals and behavioral health providers to employ peer recovery coaches in the emergency departments of 24 hospitals in Indiana. In this project, completely funded by STR, at least 18 peer recovery coaches encountered 1,032 patients from February 2018 to March 2019. Nearly 2 of every 3 patients admitted to these hospitals for an OUD related illness were successfully engaged by a peer recovery coach. 415 patients received some type of SUD treatment with 51% of those being connected to MAT services. Nearly 9 in 10 of those who received MAT as a result of the peer recovery coach encounter chose a methadone/OTP provider.

Through the STR grant, Indiana was able to make treatment more accessible to rural communities through Mobile Response Teams. These teams operated in 14 Southeast Indiana counties, encountering 334 people between March 2018 and March 2019. These teams were comprised of both peer recovery coaches and clinicians. As these counties are very rural with sparse resources for addiction care, the teams traveled to where the patient was to offer assistance. 97 patients were encountered in their home and 36 were encountered while in jail. The teams

were able to make 72 successful referrals to treatment during the first encounter and 83 people walked away with at least a naloxone kit for overdose reversal.

Through STR funding alone, Indiana was able to add 197 residential treatment beds to the state. Each provider who received STR dollars to expand their residential capacity offered at least one type of MAT to their patients. Indiana was also able to get the Open Beds platform running to utilize real-time information to connect people to a treatment bed anywhere in the state.

Two neonatal abstinence units were opened in Indiana using STR dollars, in Saint Joseph and Clark counties, as well as a facility in Indianapolis that focuses treatment on pregnant mothers and mothers with dependent children. These locations offer on-site and community based services, peer recovery coaching walk-in intervention services, assessments, community center and telephone recovery coaching.

Lastly, STR dollars are currently being used to incentivize more prescribers to obtain their waiver. The prescribers were offered a stipend of $600 to take the waiver training and another $600 stipend upon seeing their first waiver patient. Providers primarily treating pregnant women were offered a premium bonus as well as those who practiced in communities of color. As of this report, we can confirm that STR funds were used to add at least 42 new prescribers in Indiana; 12 of these primarily treat pregnant women.

d. ***Has your state advanced coordination with other federal efforts for substance use disorder prevention? If yes, please describe how.***

The Division of Mental Health and Addiction Treatment works collaboratively with Mental Health Promotion and Addiction Prevention Team receiving federal block grant funds through the Substance Abuse Prevention Treatment Block Grant. Funds are currently awarded to 14 communities. The Prevention Team has targeted efforts to address underage drinking at four Indiana colleges.

Prevention efforts are based on the Strategic Prevention Framework endorsed through SAMSHA. The state dedicated $7 million towards this effort, slightly more than the mandated minimum 20% of the total Block Grant award. The state is looking to increase the funding to continue efforts to address Alcohol, Tobacco and Other Drug prevention initiatives.

Indiana was also awarded a five year SAMHSA grant for $1.8 million each year to support efforts in 10 counties. The SPF Partnership for Success program is designed to address two of the nation's top substance abuse prevention priorities: (1) underage drinking among persons aged 12 to 20; and (2) prescription drug misuse among persons aged 12 to 25.

Indiana also received a three year grant award for $1 million from the Office of Juvenile Justice Delinquency Program. DMHA is the pass-through for a Mentoring Program for Youth Who Are at High Risk for Opioid Use. We are in year two of the grant.

8. ***What additional resources would be most helpful to provide to communities struggling with opioid and other substance use disorders, including prevention and/or treatment options?***

   Indiana needs the flexibility to fight substance use disorder no matter the individual's substance of misuse.

In closing, thank you again for the opportunity to provide an update on our state's efforts, in partnership with local and federal partners, to combat the drug crisis and help people live full and productive lives in recovery.

While one life lost from a drug overdose is too many, we are seeing encouraging signs that demonstrate our Next Level Recovery efforts are having a positive impact and saving lives. CDC data shows that Indiana's drug overdose death count declined 12.9% in 2018, faster than the national average. The number of opioid pills dispensed last year declined 23% and opioid prescriptions were down 12%, falling faster than the national average. Of course, there is much more to do.

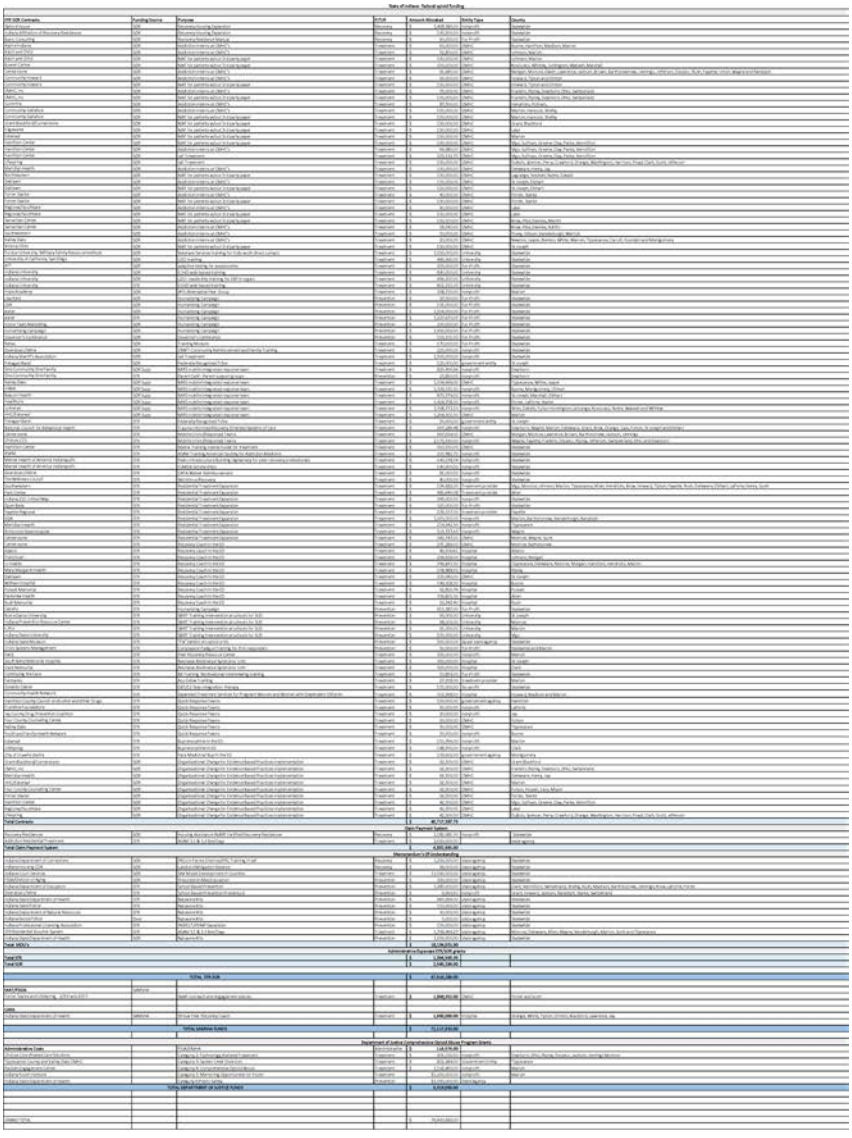
Thank you for your continued support of our efforts to fight the drug epidemic facing our state and the nation. We must be nimble as we continue to combat the opioid crisis while simultaneously working to address and prevent future crises involving substance use. To that end, we ask that you provide additional flexibility for states to utilize federal funds to address substance use more broadly. To ensure that federal funding reaches states most impacted by the drug crisis, we urge you to revise your funding metrics and allocate future funds to states based on the most current data available.

We appreciate your continued support of our efforts to help more Hoosiers recover from or avoid substance use disorder. If you need any further information, please contact Douglas Huntsinger at (317) 232-1080 or DHuntsinger@gov.in.gov.

Sincerely,

Eric Holcomb

Eric J. Holcomb
Governor of Indiana



Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Substance Abuse and Mental Health Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel.: (207) 287-2595; Fax: (207) 287-9152
TTY: Dial 711 (Maine Relay)

October 18, 2019

One Hundred Sixteenth Congress
Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

RE: Congressional Response Letter due 10.18.19 from the State of Maine

Dear Chairman Pallone and Members of the Subcommittee:

Please find Maine's response below to your letter of inquiry dated September 18, 2019.

1) **Since 2016, how much federal funding for opioid use disorder prevention, treatment, and recovery has Maine received?**

Please refer to Attachment A

a. What challenges, if any, exist in deploying federal funds to local communities in an expedited manner?

Maine has consistently worked to efficiently and effectively target and distribute federal funding for substance use-related work as quickly as possible. However, there are internal and external factors that can delay the process of getting funding to its destinations.

Some of these factors include: the rural nature of many significantly impacted communities and the associated barriers to accessing services, such as reliable transportation, a lack of local Medication Assisted Treatment (MAT) or other service providers, stigma among tight-knit communities, local public safety compassion fatigue, and access to consistent childcare in order to attend treatment as scheduled. These barriers have led to an underutilization of grant-funded treatment slots.

Additional challenges include lack of real-time data and ability to share data across agencies, ability to coordinate response efforts, siloed programming, complex financial

processes that can cause delays in contract encumbrance and timely reimbursement to providers, have historically delayed expedited disbursement of federal funds.

In January 2019, Maine experienced a change in administration and many activities are underway to address several of the barriers outlined above. This includes Governor Mills' Executive Order 1, which called for the expeditious implementation of Medicaid Expansion in January 2019. Through July, one in ten expansion enrollees experienced an opioid use disorder, proving it an effective part of opioid response. Executive Order Number 2 established innovative strategies for immediately combatting the opioid crisis in Maine and mandates that efforts must focus on overdose and death prevention, treatment and recovery, prevention, and improving access to support services. Efforts focused on these strategies are championed at the Executive level through the experienced leadership of Maine's first Opioid Response Director. In a major step forward, the Opioid Response Director has convened the Prevention and Recovery Cabinet to help coordinate Maine's efforts as they relate to substance use. Many other actions have stemmed from the Executive Order Number 2 including but not limited to; the establishment of intra-departmental coordinating councils, implementation of real-time data tools, and increased investment in harm reduction and anti-stigma campaigns.

b. To date, how much of this federal funding has your state used or allocated? Please provide a list of each funding recipient, the purpose for allocating money to them (e.g. prevention, treatment, etc.), and the amount that has been allocated to them.

Please refer to Attachment A

c. If your state has not used the entirety of federally allocated funding, please explain why.

Maine is working diligently to ensure that we spend all awarded funding in ways valuable to the communities we serve. The process to track all federal funding awards and spend is being restructured in a coordinated effort by grants and contract teams across multiple State of Maine Departments including; Department of Health and Human Services, Department of Public Safety, Department of Corrections, and Department of Education.

At final reconciliation, there have been very limited unspent federal funds, and reasons for underspending include, but are not limited to, unanticipated levels of Medicaid reimbursement, individuals not being able to access services in the contracted provider's area, implementation delays in contract activities, or billing not being corrected quickly across State fiscal cycles. State program and fiscal teams maintain regular checkpoints to identify trouble areas and red flags, as well as to create corrective and redirection plans for unspent funds.

2. Please describe how your state determines which local government entities (i.e. counties, cities, and towns) receive federal grant funding to address the opioid crisis. Specifically, please identify localities impacted most by the opioid epidemic in your state, and include the total amount allocated to each locality, as well as the factors your state considers in distributing these funds.

Historically, and as stated in 1)a., lack of access to real-time data has presented a challenge when trying to determine how to distribute funding in the most effective and productive way. Historically, Maine waited for the release of the medical examiner overdose death reports and also uses data sources such as Syndromic Surveillance to help identify communities most negatively impacted by the opioid epidemic. However, with the implementation of the High Intensity Drug Trafficking Areas' (HIDTA) Overdose Detection Mapping Application Program (ODMAP) and efforts to connect EMS data to Maine' Syndromic Surveillance, the State is starting to receive the benefit of real-time data. This enables the State to better track non-fatal overdoses and grasp how substance use is affecting all counties in the State, so that it may utilize this information to better determine which communities most need assistance and resources. In 2017, Maine was recognized as the first State in the nation by SAMHSA to use geo-mapping and hot-spotting analysis to strategically steer resources.

Additionally, there is a limited amount of community/primary prevention organizations in Maine and the funding is allocated in a prescribed structure to all nine public health districts across the State. Structure for this implementation is described below. Referrals are often received from schools, Juvenile Justice Community Corrections Officers, law enforcement and health care providers. AdCare Educational Institute provides technical assistance and administration of prevention training for health care and prevention providers, as well as social service agencies and others interested in substance use prevention with funds allocated from multiple SAMHSA and Federal CDC awarded grants.

3. Please describe how your state determines which non-governmental organizations (i.e. non-profits, treatment centers, or other entities) receive federal grant funding to address the opioid crisis. Specifically, please identify the non-governmental organizations that have received funds in your state, and include the total amount allocated to each entity, as well as the factors your state considers in distributing these funds.

The State has many different levers available to determine which NGOs to partner with. These levers include the competitive procurement process, provider capacity analyses, Waiver of Competitive Bid mechanisms leveraged in emergency circumstances, and organizational exceptionalism evaluations.

As part of an existing business process, when SAMHS applies for federal funding for the uninsured and most vulnerable individuals, we confirm and submit the following language in every justification to the Substance Use Treatment and Recovery service funder: ME SAMHS agrees to subcontract/subgrant to Providers upon a strategic a/o competitive process as federal and state regulations require. ME SAMHS submits that there are existing community Provider support and resources to enable contracts to be in place within 3 months of award receipt, per Funding Opportunity Announcement (FOA) grantee requirements.

Maine administers primary prevention services through the University of New England (UNE), which secured the role of vendor for substance use prevention through a competitive bid process. The award was just over $3.1 million, and UNE administers these funds to community prevention providers who then provide prevention services within all nine public health districts across the State. Community providers complete the Strategic Prevention Framework to do assessments of their community to determine needs and select strategies based on the Center for Substance Abuse Prevention (CSAP) 6 core strategies (Education, Environmental, Information Dissemination, Problem Identification and Referral, Alternatives, and Community Based Processes).
Finally, Maine's competitive procurement process is guided by Maine's Administrative Procurement Code, Title 5: Chapter 155, and Request for Proposals are reviewed by a team of subject matter experts and are scored on the following criteria: organization qualifications and experience, specification of work to be performed and proposed cost. Maine's justification to sole source or not competitively procure services is typically made on the basis of whether the contracted organization – or the services it provides – is unique, such as a State association that is statutorily obligated to perform a particular service. However, there are circumstances such as a state of emergency or cost to the State when competitive procurement might prove to be more costly to the taxpayer than sole source.

4. Do federally appropriated funds to address the opioid crisis provide your state with the flexibility to focus on the hardest hit regions or localities? Please describe how, if at all, this flexibility has helped Maine in using funds to target vulnerable populations or at-risk areas, If no, please explain what additional flexibility; should be considered in helping your state address the hardest hit regions or localities.

Maine has found that recent federal funding opportunities have been exceptionally flexible when it comes to utilization of funds and giving Maine the flexibility to best determine what our communities need. Community prevention providers can make decisions about strategies they will implement based on their community-level data and utilizing the Strategic Prevention Framework process outcomes.

There is an opportunity to improve the flexibility of funds for support services like transportation. Consumers covered by Medicaid have access to Non-Emergency Transportation which is a great help in accessing their medical appointments, but for the vulnerable un/under-insured populations, transportation remains a barrier. For a large and rural State like Maine, it would very helpful to have more funding opportunities that would address the transportation barrier for non-covered individuals.

There are some limitations with using federal primary prevention dollars for Screening Brief Intervention and Referral to Treatment, which could be beneficial for early identification of treatment needs to prevent long- term substance use disorder in our State's youth and young adults. Another limitation is that because funding goes to Statewide prevention providers, funding going to each community is not substantial enough to be able to implement some of the more robust and costly evidenced based programs.

Other areas of flexibility that Maine continually seeks to address are: funding flexibility for addiction disorders vs. substance-specific disorders, effective co-occurring programming, as well as underwriting the uncovered healthcare costs of the underinsured vs. the uninsured, e.g. co-pays, deductibles.

There are several circumstances and populations Maine considers when making assessments for how to best distribute resources for at-risk and vulnerable populations: the homeless, persons who inject drugs, pregnant/parenting women, veterans, as well as measures such as overdose death rates, substance exposed infants, and Morphine Milligram Equivalent (MME) dispensations from the Prescription Drug Monitoring Program. As noted in 1.) A., the lack of access to real-time data has presented a challenge in best determining how to most effectively and positively distribute funding in a quickly reactive or proactive way to best impact to the vulnerable populations in those regions.

5. In what ways, specifically, have federal funds extended to Maine helped change your state's treatment system and/or led to a reduction in opioid overdoses?

The State would like to specifically highlight the ability to utilize recently awarded federal funding for the purchase of Naloxone, and the administrative oversight of a Statewide Naloxone distribution network, which will have a large impact on reversing potentially fatal overdoses. Evaluation and research efforts are underway through partnerships with the University of Maine System to determine what is working, and what isn't, so that course corrections can occur quickly. Maine is also focused on implementing rapid induction programs in Emergency Departments. A great deal of effort and staff are now devoted to focusing on the opioid epidemic, and substance use in

general, from micro-level efforts (family impact and supports) to macro-level initiatives (widespread systems change).

The original 2016 budget for Maine's MAT program, the evidence-based practice with the greatest effectiveness, was $250,000 per year, and is now $4.4M going into FY20 thanks to the support of our federal funders.

Federal funds have also supported activities, technology enhancements, and policy development that helped shape Maine's Chapter 488, or "PMP law," which is partially credited with effecting the greatest reduction of per capita opioid prescribing in 2017.[1]

Maine is also utilizing federal funding to implement MAT in correction facilities and addressing treatment barriers for the re-entry population. Work is underway to bridge programming between the Departments of Public Safety and Health and Human Services for both pre- and post- diversion.

6. **What performance measures is Maine using to monitor the impact of federal funds for opioid use disorder and other substance use disorder treatment?**

Some of the treatment measures that Maine is tracking include:

- Reduction in fatalities
- Increase in MAT providers in rural areas
- Increase in community-level implementation of State-supported new initiatives
- Reductions in Substance Exposed Infants
- Increase in providers trained in new Evidence Based Practices (EBPs)
- Numbers/demographics served in EBPs such as MAT, relapse prevention
- Specific outcomes of the numbers /demographics served in EBPs such as MAT, relapse prevention
- Improved prescribing behaviors
- Number of data sets/systems linked to improved quality/timeliness of opioid data
- Youth and young adults past 30 days of use of prescription drugs, marijuana, and alcohol
- Youth perception of harm, perception of getting caught, adverse childhood experiences, protective factors, and risk factors
- Number of people reached with prevention activities
- Number of prevention interventions

[1] https://bangordailynews.com/2018/06/19/health/maine-leads-nation-in-decline-of-prescription-opioid-sales-report-finds/

7. According to the Substance Abuse and Mental Health Services Administration, State Targeted Response to the Opioid Crisis (STR) Grants provide funding to states to: (1) conduct needs assessments and strategic plans; (2) identify gaps and resources to build on existing substance use disorder prevention and treatment activities; (3) implement and expand access to clinically appropriate, evidence-based practices for treatment particularly for the use of medication-assisted treatment (MAT) and recovery support services; and (4) advance coordination with other federal efforts for substance misuse prevention.
a. Has your state conducted a needs assessment and strategic plan? If yes, please describe that plan.

Yes. In 2017, Maine completed a joint Prevention-Treatment Strategic Plan and Needs Assessment as required by SAMHSA's Opioid State Targeted Response funding. Other substance use funders also require needs assessments and strategic plans at the grantee and/or subrecipient level, as well.

Additional details on Maine's STR Strategic Plan and Needs Assessment are referenced in 7.A and 7.B below.

b. Has your state identified gaps and resources to build on existing substance use disorder prevention and treatment activities? If yes, please describe those findings.

Yes, in the Needs Assessment, the State identified gaps and resources to build on existing SUD prevention and treatment activities. For example, in the Needs Assessment, Maine's PMP identified benzodiazepine (co)prescribing as an area of concern; under Maine's Overdose Data to Action funding, the State was awarded support to implement a Statewide Controlled Substance Stewardship Activity, which will closely focus on co-prescribing of opioids and benzodiazepines. The MeCDC Prevention team has built upon existing prevention interventions to include work with corrections, schools, and health care providers based on data analysis and has recently began work with developing prevention programming for the 18-25 year-old population based on data showing that population with the higher rates of use and overdose.

Additionally, Maine noted a need for additional trauma-informed resources within the existing training relationship of the SA Prevention workforce development team, child protection staff and law enforcement allies. In Maine's pending Bureau of Justice Assistance application (?) policy (?), the State has proposed to utilize the existing relationships identified above to develop a specific protocol/policy for law enforcement, Emergency Medical Services (EMS) personnel, and child welfare staff to utilize when responding to families impacted by overdose. This protocol/policy will enhance the support for families that will ultimately work toward a goal of getting people into treatment, reducing the likelihood of generational substance use, and increase the education about addiction and substance use across professions.

The State looks forward to the potential positive outcome for Maine under that funding opportunity.

c. Has your state implemented and expanded access to clinically appropriate, evidence-based practices for treatment—particularly for the use of MAT and recovery support services? If yes, please describe how you have done so.

Yes, the State has been able to expand access to clinically appropriate and evidence-based services; under the State Targeted Response grant, Maine cautiously proposed the original ability to only serve up to 270 individuals per year in MAT services, but at the close of the last reporting period was proudly able to report that over 700 individuals were served to SAMHSA and NASADAD. Other services surpassed similar expectations.

Following Camden, New Jersey's hot-spotting model, the State has been able to accomplish this expansion through the targeting of treatment and recovery resources to areas reflecting the highest needs, e.g. Substance Exposed Infants and overdose deaths.

d. Has your state advanced coordination with other federal efforts for substance use disorder prevention? If yes, please describe how.

Yes, the State has advanced coordination with other federal efforts for SUD prevention. The State Prevention Team regularly partners with law enforcement and corrections, Child Protection Services, data surveillance, Medicaid, Department of Education, Drug Free Community grantees, and all their implied funders.

Since the beginning of 2019, under the leadership of the Mills' Administration, the State offices have met on an almost weekly basis, drafted and executed strategic plans, and implemented new programming – many being joint ventures between first responders and public health as seen in Naloxone distribution - and enhanced existing programming, such as MAT to effect a more outcomes-focused approach.

8. What additional resources would be most helpful to provide to communities struggling with opioid and other substance use disorders, including prevention and/or treatment options?

As highlighted in answer 4, the State would benefit from resources that effect a greater ability in addressing current transportation infrastructure needs from a macro-level. Additionally, more ability to provide support to impacted family members, increased ability to utilize funds for mental health treatment, and a larger focus on the social determinants of health such as housing, food, poverty reduction, and child care while in

treatment, would allow the State to more holistically approach this significant problem that our State is facing.

Continued support for services such as workforce development, implementation of the SUD 1115 waiver, funding flexibility for addiction disorders vs. substance-specific disorders, and effective co-occurring programming would all realize an impact at the community level as well.

Overall, stable and secure funding opportunities for both prevention and treatment, with aligned reporting requirements for the State and providers, would create less pain points, promote continuity of programming, and ensure efficacy of administration and outcomes.

In closing, I would like to thank you for the opportunity to highlight the incredible work being done in the State of Maine and invite you to visit to see it for yourself firsthand.

Please reach out to me directly if I can be of further assistance or answer any additional questions.

Sincerely,

Jessica M. Pollard, PhD
Director, Maine Office of Substance Abuse and Mental Health Services

Grant	NOA	Allocated/Encumbered	Recipient	Purpose
MPS	$ 8,240,940.00	$ 7,593,331.91	See Attached Spreadsheet	Prevention of prescription drugs, marijuana and alcohol misuse
MSOR	11,154,294	6,704,587	See Attached Spreadsheet	Prevention, Treatment and Recovery Activities related to Opioid Use Disorder
OD2A	4,625,213	298,610	See Attached Spreadsheet	Prevention of drug overdose
OPCE	3,644,354	3,228,810	See Attached Spreadsheet	Prevention of opioid overdose
OPPS	91,900	63,740	See Attached Spreadsheet	Prevention of opioid overdose (HIV, Hepatitis)
PDOP	2,976,102	1,893,406	See Attached Spreadsheet	Prevention of prescription drug use
SAPTBG	28,466,897	36,681,355	See Attached Spreadsheet	Prevention, Treatment and Recovery Activities related to Substance Use Disorder
STR/MOSTR	4,078,058	4,191,402	See Attached Spreadsheet	Prevention, Treatment and Recovery Activities related to Opioid Use Disorder
SPF-RX	1,486,464	1,378,924	See Attached Spreadsheet	Prevention of prescription drug and opiate use
	$ 64,764,222.00	$ 62,034,165.08		

***Please note that abovelisted federal funding is reflective of the Single State Authority (SSA), which primarily focuses resources on uninsured treatment services and SSA Primary Prevention activities. Additional opioid funds as administered by other state departments are not reflected in this accounting.*

Legal Name	MPS	MSOR	OD2A	OPCE	OPPS	PDOP	SAPTBG	SPFRX	SPFRX2	MOSTR	STR	Grand Total
2 1 1 MAINE INC							80,000.00					80,000.00
ABILIS SOLUTIONS CORP				91,350.00								91,350.00
ACADIA HEALTHCARE INC							971,850.76			-	440,399.39	1,412,250.15
Adam Graphic Corporation							610.00					610.00
ADCARE EDUC INST OF MAINE INC	152,897.00	165,000.00		88,616.00			949,808.65	41,250.00	334,923.00		150,000.00	1,882,494.65
ALISON JONES WEBB						-						-
ALLIANCE FOR ADDICTION & MENTAL HLTH SERV	18.31						1,061,386.82					1,061,405.13
ANDROSCOGGIN CTY OF							5,000.00					5,000.00
APPRISS INC						618,526.70						618,526.70
AROOSTOOK CTY ACTION PROG INC	193,676.09						128,295.06					321,971.15
AROOSTOOK MENTAL HLTH SERV INC		251,161.00					1,435,396.53					1,686,557.53
BANGOR AREA RECOVERY NETWORK INC		187,500.00										187,500.00
BANGOR CITY OF	177,877.75	27,500.00		2,500.00			119,614.91					327,492.66
CAPQUALITY CARE INC							231,635.00					231,635.00
CARIBOU CITY OF							2,177.08					2,177.08
CARY MEDICAL CENTER							5,000.00					5,000.00
CATHOLIC CHARITIES MAINE		101,000.00					1,888,300.50				401,000.00	2,390,300.50
CENTRAL MAINE COMMUNITY HLTH							18,688.68					18,688.68
CENTRAL MAINE COUNSELING SERV											-	-
CENTRAL ME FAMILY COUNSELING		326,146.00					384,315.06					710,461.06
Coastal Business Center							1,433.00					1,433.00
Colonial Management Group, LP							155,880.00					155,880.00
COMMITTEE FOR CHILDREN		149,815.10										149,815.10
COMMITTEE FOR CHILDREN		3,000.00										3,000.00
COMMUNITY CARE							47,706.57					47,706.57
COMMUNITY CONCEPTS INC							92,164.29					92,164.29
CONNECTICUT PEER REVIEW ORGANIZATION INC		-	18,729.25	493,834.50								512,563.75
CORRECT CARE SOLUTIONS LLC		457,446.00										457,446.00
CRISIS & COUNSELING CTR INC							525,038.94					525,038.94
CROOKED RIVER COUNSELING PA		283,646.00								11,739.64	476,131.36	771,517.00
CROSSROADS FOR WOMEN INC							1,636,578.58					1,636,578.58
DAY ONE							3,605,475.03					3,605,475.03
DIRIGO SAFETY LLC	20,000.00											20,000.00
DISCOVERY HOUSE BR INC		1,258,731.74					757,279.01				339,922.00	2,355,932.75
DISCOVERY HOUSE WC INC							424,400.00				139,924.00	564,324.00
Education Development Center	21,570.00								21,570.00			43,140.00
ENSO LLC		637,465.48					212,500.00				214,966.04	1,064,931.52
EVERGREEN BEHAVIORAL SERVICE											37,812.60	37,812.60
FELcom, Inc.				619,416.68			587,372.74					1,206,789.42
GT PORTLAND COUNCIL OF GOVT				34,500.00								34,500.00
GuideSoft Inc.		3,041.74	48,689.76	426,941.65								478,673.15
HANCOCK CTY OF							5,000.00					5,000.00
HEALTHY ACADIA	180,168.77	744,556.75					125,000.00				111,892.00	1,161,617.52
Healthy Communities of the Capital Area							20,997.00					20,997.00
HEALTHY COMMUNITY COALITION							20,000.00					20,000.00
HONEYWELL INTERNATIONAL INC							484.50					484.50
HORNBY ZELLER ASSOC INC	566,712.08					391,029.00		88,454.50	85,868.50			1,132,064.08
INDIAN TOWNSHIP							15,000.00					15,000.00
INFORMATION SYSTEMS & NETWORKS CORP							328,567.93					328,567.93

Legal Name	MPS	MSOR	OD2A	OPCE	OPPS	PDOP	SAPTBG	SPFRX	SPFRX2	MOSTR	STR	Grand Total
Katahdin Shared Services Inc							21,250.00					21,250.00
KENNEBEC BEHAVIORAL HEALTH							469,115.81					469,115.81
KENNEBEC CTY OF							14,500.00					14,500.00
KENNEBUNK TOWN OF							5,000.00					5,000.00
KEY 3 WEST, INC										55,522.50	455,488.00	511,010.50
MAINE ACCESS IMMIGRANT NETWORK		13,080.00										13,080.00
MAINE ACCESS POINTS		80,000.00										80,000.00
MAINE BEHAVIORAL HEALTHCARE							1,153,184.00				-	1,153,184.00
MAINE MEDICAL ASSOCIATION				50,000.00		250,000.00						300,000.00
MAINE PRETRIAL SERVICES INC							540,283.50					540,283.50
MAINEGENERAL COMMUNITY CARE							1,004,863.38					1,004,863.38
MAINEGENERAL MEDICAL CTR		27,500.00		2,500.00			620,634.90					650,634.90
MAINEHEALTH		542,400.00					596,400.00				302,400.00	1,441,200.00
MAYO REG HOSPITAL							150,903.59				8,195.65	159,099.24
MEDICAL CARE DEVELOPMENT							29,936.00					29,936.00
MERCY HOSPITAL							346,083.34					346,083.34
MERRIMACK RIVER MED SERV INC							492,415.00					492,415.00
MID COAST HOSP	115,638.00											115,638.00
MID COAST HOSPITAL	60,141.00	53,500.00					1,401,502.99				83,500.00	1,598,643.99
MILESTONE RECOVERY							2,279,775.00					2,279,775.00
NAMI MAINE INC		45,000.00										45,000.00
OAKLAND TOWN OF							14,540.00					14,540.00
OPEN DOOR RECOVERY CTR							162,096.07					162,096.07
ORONO TOWN OF							4,856.75					4,856.75
PAN ATLANTIC RESEARCH INC							253,657.26					253,657.26
PENOBSCOT BAY YMCA							20,000.00					20,000.00
PENOBSCOT COMMUNITY HEALTH CENTER							1,401,877.79					1,401,877.79
PENOBSCOT COMMUNITY HEALTH CTR							111,930.96					111,930.96
PENOBSCOT INDIAN NATION	207,322.34						116,848.46					324,170.80
POINTS NORTH INSTITUTE				40,000.00								40,000.00
PORTLAND CITY OF	183,822.27	27,500.00		2,500.00			349,809.96					563,632.23
PORTLAND COMMUNITY HEALTH CENTER		366,590.80									331,509.00	698,099.80
PORTLAND RECOVERY COMMUNITY CENTER		580,220.12					628,238.00					1,208,458.12
PREMIER MARKETING GROUP INC							450.00					450.00
PUBLIC CONSULTING GROUP INC	277,499.00	175,000.00			63,740.00	168,865.29			129,672.00			814,776.29
RECOVERY CONNECTIONS OF MAINE LLC		70,000.00										70,000.00
REDINGTON-FAIRVIEW GEN HOSP	175,779.00						118,869.77					294,648.77
RESULTS MARKETING & DESIGN LLC	140,008.00		23,466.66	504,315.24		464,984.76	414,263.44					1,547,038.10
RINCK ADVERTISING INC	653,000.00			600,000.00	-		898,776.00	1,721.31	270,464.69	-	100,000.00	2,523,962.00
RIVER VALLEY HEALTHY	175,779.00						96,669.40					272,448.40
SABLE Inc							218.00					218.00
SAGADAHOC CTY OF							10,000.00					10,000.00
SEBASTICOOK VALLEY HOSPITAL							5,000.00					5,000.00
SEQUEL CARE OF MAINE, LLC							62,200.00					62,200.00
SHEENA BUNNELL							15,000.00					15,000.00
SHI INTERNATIONAL CORP							1,979.00					1,979.00
SMART CHILD & FAMILY SERVICES		112,000.00									135,000.00	247,000.00
SOUTHERN MAINE HEALTH CARE							20,000.00					20,000.00
THE OPPORTUNITY ALLIANCE							562,750.00					562,750.00

Legal Name	MPS	MSOR	OD2A	OPCE	OPPS	PDOP	SAPTBG	SPFRX	SPFRX2	MOSTR	STR	Grand Total
THIRD STAGE SYSTEMS, LLC							10,000.00					10,000.00
Thomas Arthur Vallee							1,180.00					1,180.00
TOWNSQUARE MEDIA AUGUSTA/WATERVILLE LLC							120,976.00					120,976.00
TRI-CTY MENTAL HLTH SERV							1,571,639.89					1,571,639.89
UNIV OF MAINE SYS			207,723.95	267,073.55								474,797.50
UNIV OF ME SYS	8,000.00											8,000.00
UNIV OF NEW ENGLAND	4,283,423.30	15,785.97		5,261.98			2,988,733.48	56,207.31	348,792.69	-	396,000.00	8,094,204.73
VEAZIE TOWN OF							5,000.00					5,000.00
WALDO COUNTY GENERAL HOSPITAL							20,000.00					20,000.00
WASHINGTON COUNTY; ONE COMMUNITY							6,712.00					6,712.00
WASHINGTON CTY OF							8,009.75					8,009.75
WELLSPRING INC							1,002,472.58					1,002,472.58
WESTBROOK CITY OF							5,000.00					5,000.00
WESTERN MAINE HEALTH CARE CORP							22,183.39					22,183.39
YORK CNTY SHELTER PROGRAMS INC							613,144.78					613,144.78
YORK HOSPITAL							67,468.44					67,468.44
Total	$ 7,593,331.91	$ 6,704,586.70	$ 298,609.62	$ 3,228,809.60	$ 63,740.00	$ 1,893,405.75	$ 36,681,355.32	$ 187,633.12	$ 1,191,290.88	$ 67,262.14	$ 4,124,140.04	$ 62,034,165.08

BILL LEE
GOVERNOR
STATE OF TENNESSEE

October 30, 2019

Honorable Frank Pallone, Jr., Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-0001

Honorable Greg Walden, Ranking Member
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-0001

Honorable Anna G. Eshoo, Chairwoman
Subcommittee on Health

Honorable Michael C. Burgess, M.D., Ranking Member
Subcommittee on Health

Honorable Diana DeGette, Chairwoman
Subcommittee on Oversight and Investigations

Honorable Brett Guthrie, Ranking Member
Subcommittee on Oversight and Investigations

Dear Chairman Pallone, Ranking Member Walden, Chairwoman Eshoo, Ranking Member Burgess, Chairwoman DeGette, and Ranking Member Guthrie:

Tennessee has received numerous federal grants in recent years that have aided our state's efforts to address the opioid epidemic. These grants help support our Department of Health (TDH) and Department of Mental Health and Substance Abuse Services (TDMHSAS) across a continuum of services, including prevention, early intervention, treatment, and recovery support. These grants also support the continued surveillance and prevention of opioid misuse within the state.

Our TDH and TDMHSAS have been the recipients of ten federal grants (both discretionary and non-discretionary) from the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC), and the U.S. Department of Health & Human Services. These grants have greatly enhanced Tennessee's efforts to combat the opioid crisis within our state.

The funding from the BJA is used to support numerous projects, including: a multi-agency taskforce regarding Tennessee overdose data and rapid response intervention efforts; implementation of the Tennessee Bureau of Investigation's access to the Controlled Substance Monitoring Database; predictive modeling; integration of Emergency Medical Services' data into TDH's surveillance activities; and expansion of analytical work for new drugs of concern. The funding from the BJA has been extremely valuable in supporting and expanding TDH's overdose prevention and surveillance efforts.

The CDC grant funding primarily supports prescription monitoring and overdose prevention and surveillance activities, including: data improvements and linkage; training; and the establishment of a drug overdose reporting system. For each of the next three years, $3,000,000 will be deployed to local jurisdictions for overdose prevention and response activities, with priority given to those local communities most highly impacted by the opioid epidemic.

The SAMHSA State Targeted Response (STR) grant, now in its no-cost extension year, has made significant impact on our efforts to curtail Tennessee's challenges related to opioid misuse, abuse, diversion, and

overdose. The STR grant has allowed our TDHMSA to address overdose related deaths through naloxone distribution, has supported the training of professionals and key stakeholders on opioid overdose disorders, has supported the implementation of an Opioid Overdose Rapid Response System, and has improved access and availability of clinical treatment and recovery services. Moreover, STR funding was critical in expanding access to medication assisted treatment, implementing new strategies for pregnant women, and supplementing existing resources.

The Department of Health and Human Services State Opioid Response (SOR) grant has reinforced prevention, treatment, and recovery activities in response to the opioid epidemic. Tennessee's SOR grant strategy aims to: (1) increase awareness of the dangers of opioids; (2) educate key stakeholders on preventing overdose; (3) reduce the number of overdose related deaths through naloxone distribution; (4) train health professionals to assess and treat individuals with opioid use disorder; and (5) expand access to medication assisted treatment, clinical treatment, and recovery services through a hub-and-spoke model. The SOR grant has further expanded many of the evidence-based interventions set forth by the STR grant.

The federal grants have augmented our collective efforts related to the opioid epidemic. Tennessee has distributed over 70,000 units of naloxone and saved over 7,500 lives. Tennessee has established over 330 prescription drug take-back boxes. Approximately 10,000 uninsured adults received clinical treatment for opioid use disorders and approximately 3,000 uninsured adults received medication assisted treatment in state fiscal year 2019.

In addition to grants specific to the opioid response, TDH also applies funding to public health priorities from core public health funding sources within funding allowance and grant directives. For example, the Maternal and Child Health block grant has been used to support Tennessee's Neonatal Abstinence Syndrome surveillance system, which provides weekly updates to providers and public health stakeholders across the state. Because data from this system is available in real time, Tennessee was the first state to document a year-to-year decline in neonatal abstinence syndrome in 2018 after nearly a decade of increase.

With state and federal investment, we are working to further ensure that Tennesseans living with opioid use disorder find recovery and live independent and fulfilling lives. Tennessee appreciates the work of this Administration and Congress, and we look forward to future opportunities and partnerships. Thank you for your ongoing commitment to resolving the opioid crisis now and in the future.

Sincerely,

Bill Lee
Governor

Cc: Members of the Tennessee Congressional Delegation

Tony Evers

Office of the Governor | State of Wisconsin

October 16, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce

The Honorable Anna G. Eshoo
Chairwoman
Subcommittee on Health

The Honorable Michael C. Burgess, M.D.
Ranking Member
Subcommittee on Health

The Honorable Diana DeGette
Chair
Subcommittee on Oversight and Investigations

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Oversight and Investigations

Dear Honorable Members of the House Energy and Commerce Committee:

Thank you for your work helping states like Wisconsin combat the opioid crisis. Partnership with the federal government is critical to our efforts to decrease substance abuse, lower preventable deaths, and work to end the epidemic. As you look forward to future appropriation bills and legislation, I urge you to prioritize opioid-related funds and programs so that we can continue to expand our work helping Wisconsinites.

Below, please find responses to your questions. If you require any further information, please reach out to Kate Bukowski, State Federal Director, at 202-624-5997 or kate.bukowski@wisconsin.gov.

Sincerely,

Tony Evers

Tony Evers
Governor, State of Wisconsin

1. **Since 2016, how much federal funding for opioid use disorder prevention, treatment, and recovery has Wisconsin received?**

   From 2016 to present, the Wisconsin Department of Health Services (DHS) has been awarded and administered ten federal discretionary grants for opioid use disorder prevention, treatment, and recovery to address the opioid crisis in Wisconsin. Three of these grants began in 2015. As of October 1, 2019, DHS has been awarded $90,817,655 in federal funding from these ten grants. Please see table one of the appendix for grant details, including the amount awarded by each grant.

   a. **What challenges, if any, exist in deploying federal funds to local communities in an expedited manner?**

      Given the large amount of funding received, DHS has been very successful in spending down and deploying funds to partners and stakeholders in communities statewide. However, there are challenges in doing so. The primary challenges center around the short time periods and large funding amounts of some awards (specifically the State Targeted Response grant (STR) and State Opioid Response grant (SOR)) and the state procurement process for awarding funding. In most cases, DHS encounters the biggest hurdles during the first year of a grant. Examples of the primary challenges include receiving all necessary approvals from the federal agencies (e.g. workplan, budget, etc.); in some cases, hiring staff; writing and receiving internal approval on grant funding opportunities/request for proposals; and processing contracts with grant awardees. By the time all requirements are met and the necessary processes take place, six to eight months of the first grant year has passed. Recipients, then, face implementation-related challenges wherein they are required to wait until they have funding in-hand to hire staff, purchase any necessary equipment, etc., to get up and running. This process has led to underspending by many recipients, which has been difficult, or impossible if the life of the grant is one year, to catch up on in the following years of the grant. Specifically, with the STR and SOR awards from SAMHSA, short time frames, large funding amounts, and being setup as year-to-year funding is a challenge. Congress also allocated SOR funds prior to STR ending, as there was a seven month overlap from the time SOR was awarded, until STR ended. In order to not supplant funding, DHS could not obligate SOR funds to recipients until STR had ended, leaving only five months for recipients to spend the funds. States also did not know that an SOR supplement would be awarded. In Wisconsin, this added more than six million in additional funding to be moved. The Opioid Crisis Cooperative Agreement through the CDC is another example of this. This one-year grant left recipients with six to seven months to spend the funds by the time it was received.

      Wisconsin is grateful for the plethora of federal support to address the opioid crisis in our state. It has led to many positive outcomes throughout the continuum of care. It is possible more could have been accomplished with more fluidity and flexibility of funds had it been allocated differently from Congress.

   b. **To date, how much of this federal funding has your state used or allocated? Please provide a list of each funding recipient, the purpose for allocating money to them (e.g. prevention, treatment, etc.), and the amount that has been allocated to them.**

      Please see tables 2-11 in the appendix for detailed information of each grant. Each grant is represented by a table and lists each funding recipient; the amount of funding allocated to them; and categorizes the grant activity as a prevention, intervention, treatment, recovery, or evaluation effort.

c. **If your state has not used the entirety of federally allocated funding, please explain why.**

As is mentioned in the previous response, there are challenges in deploying funds. The majority of the underspending Wisconsin has experienced is due to grant awardees not spending the entirety of the funding. Overall, Wisconsin has been able to spend the vast majority of the funding received and DHS expects that to continue among the agency's ongoing grant awards. Please see table one in the appendix, which details the amount of underspending for each grant.

2. **Please describe how your state determines which local government entities (i.e. counties, cities, and towns) receive federal grant funding to address the opioid crisis. Specifically, please identify localities impacted most by the opioid epidemic in your state, and include the total amount allocated to each locality, as well as the factors yonr state considers in distributing these funds.**

Data driven decision-making is a focus of DHS. With each grant application for federal funding, DHS conducts an updated needs assessment to identify high need areas of the state; high need areas are prioritized for funding opportunities. The DHS needs assessment looks at many indicators including opioid related death data; opioid related overdoses; PDMP prescribing data; hospital admissions; emergency room visits; MAT prescribers; Medicaid data related to OUD diagnosis and MAT claims data; naloxone Emergency Medical Services runs; as well as protective factors such as an active substance use prevention coalition; an engaged local public health department; and drug courts. The needs assessment generates a list of priority counties. This list provides guidance in awarding funds. In addition, all funding deployed goes through the state procurement process, which requires local government entities to respond to a grant funding opportunity/request for proposal. Applications received are a critical part in determining how funds are awarded. The applicant provides a local scope of the problem, how they plan to address the issue, and a budget.

Please see tables 2-11 in the appendix for detailed information of each grant, which provides the total amount awarded to each local government entity.

3. **Please describe how your state determines which non-governmental organizations (i.e. non-profits, treatment centers, or other entities) receive federal grant funding to address the opioid crisis. Specifically, please identify the non-governmental organizations that have received funds in your state, and include the total amount allocated to each entity, as well as the factors your state considers in distributing these funds.**

As mentioned in the response above, DHS conducts an updated assessment to identify high need areas of the state, which are prioritized for funding. Just as with local government entities, DHS uses this needs assessment to help determine which non-governmental organizations are awarded funding. Although an assessment assists the department in prioritizing needs, the state procurement process requires all organizations, including non-governmental organizations, to respond to funding opportunities via a grant funding opportunity/request for proposal. Applications received are a critical part in determining how funds are awarded. The applicant's description of the local scope of the problem, their project plan, and budget also help to guide the selection.

Please see tables 2-11 in the appendix for detailed information of each grant which provides the total amount awarded to each local government entity.

4. **Do federally appropriated funds to address the opioid crisis provide your state with the flexibility to focus on the hardest hit regions or localities? Please describe how, if at all, this flexibility has helped Wisconsin in using funds to target vulnerable populations or at- risk areas. If no, please explain what additional flexibility should be considered in helping your state address the hardest hit regions or localities.**

The federally appropriated funds to address the opioid crisis have provided Wisconsin with the flexibility to focus on the hardest hit regions or localities. As previously stated, DHS prioritizes its funding based on a statewide needs assessment. Such assessment analyzes the needs of vulnerable populations, including IV drug users, pregnant women, and individuals in the criminal justice system. Since DHS has been very successful in writing for, receiving, and appropriately allocating multiple federal grants, the department has been able to expand the programming focus from the most impacted communities and, in fact, award funding statewide. While there are areas of high need, DHS knows that the opioid crisis is pervasive; it breeches all geographic, population, race, socio-economic divides. As such, in addition to focusing on high need areas, DHS provides as much funding as possible to increase statewide efforts in prevention, treatment, and recovery.

5. **In what ways, specifically, have federal funds extended to Wisconsin helped change your state's treatment system and/or led to a reduction in opioid overdoses?**

DHS has used funds from several different grants to improve Wisconsin's treatment system and reduce opioid overdoses. Funding from MAT-PDOA, STR, SOR and the Opioid Crisis Cooperative Agreement grants have all contributed to increasing access to treatment statewide. Funding has supported the opening of new opioid treatment centers in high need areas of the state; grants to organizations and agencies statewide targeting MAT expansion; and assisted counties in developing and building an increase in MAT services locally. In Wisconsin, counties are the first line of defense when it comes to treatment for substance use disorder. In accordance, DHS has prioritized substantial funding to counties whom address waitlists for opioid use disorder treatment and necessary recovery support services. DHS has also supported efforts to build workforce capacity by increasing the number of MAT providers, which improves access to care. Along with statewide partners, x-waiver trainings have been provided statewide to build the workforce. Moreover, DHS supports innovative projects such as the ED2 Recovery program; a partnership between DHS, community recovery organizations and hospitals wherein trained recovery coaches and peer support specialists are stationed in emergency departments and meet with individuals following a suspected opioid overdose to provide peer support, treatment referrals, and other recovery support services.

6. **What performance measures is Wisconsin using to monitor the impact of federal funds for opioid use disorder and other substance use disorder treatment?**

DHS is using many measures to determine the impact of federal funds. Every strategy, initiative or program has an evaluation component built into it. DHS reviews each one independently to determine its impact and value. On the statewide level, the department monitors many different measures to help determine if the collective efforts are leading to positive outcomes as a state. As of August 2019, the department has collected data, which indicates positive change. Wisconsin is hopeful for the following reasons:

- Opioid-related deaths declined 10% in 2018 from an all-time high in 2017 - the first significant decrease since 1999.
- Inpatient hospitalizations for opioids have decreased in two consecutive years.
- Emergency room hospitalizations for opioids decreased for the first time in 2018 since 2013 (20% decrease from 2017 to 2018).
- More Medicaid members with an OUD diagnosis are receiving MAT medication. In 2017 46% of Medicaid members with an OUD were receiving MAT.
- Individuals receiving services from OTPs have increased every year since 2013, with over 10,500 individuals served in 2017.

- Counties and Tribes have increased treatment capacity and decreased waiting lists for individuals needing OUD services, with over 2,000 individuals receiving services the last two years.
- There has been a 30% decrease in opioid prescriptions from 2014 to 2018.
- There has been a 16% decrease in babies born with neonatal abstinence syndrome (NAS) from 2017 to 2018.

7. **According to the Substance Abuse and Mental Health Services Administration, State Targeted Response to the Opioid Crisis (STR) Grants provide funding to states to: (1) conduct needs assessments and strategic plans; (2) identify gaps and resources to build on existing substance use disorder prevention and treatment activities; (3) implement and expand access to clinically appropriate, evidence-based practices for treatment- particularly for the use of medication-assisted treatment (MAT) and recovery support services; and (4) advance coordination with other federal efforts for substance misuse prevention.**

   a. **Has your state conducted a needs assessment and strategic plan? If yes, please describe that plan.**

      Data driven decision-making is a focus of DHS. As discussed above, DHS has conducted and regularly updates a statewide needs assessment on the opioid issue. The DHS needs assessment looks at many indicators including opioid related death data; opioid related overdoses; PDMP prescribing data; hospital admissions; emergency room visits; MAT prescribers; Medicaid data related to OUD diagnosis and MAT claims data; naloxone Emergency Medical Services runs; as well as protective factors such as an active substance use prevention coalition, an engaged local public health department, and drug courts.

      In addition, DHS has developed a strategic plan with the overall goal of reducing the number of opioid-related deaths in Wisconsin. DHS is working to achieve this goal by fulfilling the following objectives:

      - Advance prevention strategies;
      - Increase access and availability of naloxone;
      - Expand access to treatment and recovery support services; and
      - Increase retention in treatment services.

      Internally, DHS has six teams that work collaboratively to coordinate all efforts related to these objectives. The teams are Prevention, Medication-Assisted Treatment, Workforce Development, Data, Emergency Response, and Communications.

   b. **Has your state identified gaps and resources to build on existing substance use disorder prevention and treatment activities? If yes, please describe those findings.**

      Specifically related to treatment, DHS has identified gaps in services, as well as resources to expand. Every state confronts a treatment services gap. Wisconsin conducts a statewide needs assessment, which assists the department in identifying geographic locations lacking treatment facilities, in addition to providers. DHS used GIS mapping to plot treatment providers around the state and then calculate and illustrate a 30-minute drive time radius from all providers. A 30-minute drive time was selected as a reasonable amount of time to travel for care. This map clearly identified the many different areas of the state lacking access to treatment. In an attempt to remedy these gaps, the department, for example, partnered with Federally Qualified Health Centers to provide MAT for opioid use disorder. This partnership has been particularly beneficial in rural areas where there is less access to treatment in Wisconsin.

Regarding prevention, the primary tool to remedy gaps was capitalizing on and enhancing strengths that already existed. Wisconsin has a robust infrastructure of substance use prevention coalitions supported by regional prevention centers funded by DHS. With over 100 coalitions statewide, DHS made the strategic decision to filter funding for prevention efforts down to coalitions at the local level to generate the greatest impact. Coalitions typically function on limited resources; any additional funding allows them to expand the reach of their efforts locally.

c. **Has your state implemented and expanded access to clinically appropriate, evidence-based practices for treatment-particularly for the use of MAT and recovery support services? If yes, please describe how you have done so.**

Expanding access to treatment, specifically MAT, and recovery support services are a priority for DHS. As is mentioned in previous responses, funding from multiple grants have all contributed to increasing access to treatment statewide. Examples include the opening of new opioid treatment centers in high need areas of the state; grants to organizations and agencies statewide targeting MAT expansion; assisting counties in developing and building increase MAT services locally; providing substantial funding to counties addressing waitlists for opioid use disorder treatment and recovery support services; distributing grants to organizations to train recovery coaches and peer support specialist in an effort to build workforce capacity; and providing trainings for practitioners to increase the number of MAT providers statewide building the workforce and increasing access to care.

d. **Has your state advanced coordination with other federal efforts for substance use disorder prevention? If yes, please describe how.**

A coordinated response to the opioid crisis in all areas is what DHS strives for. In the area of prevention, DHS works to align all efforts supported by SAMHSA and CDC funding, leveraging these funds to make the greatest impact. DHS has been able to use prevention efforts supported by STR and SOR to enhance the existing infrastructure in Wisconsin to address substance use prevention. One successful strategy continues to be coordinating with other federal prevention grants administered by DHS. For example, prevention funding from STR and SOR was awarded to coalitions at the local level to generate the greatest impact. This funding allowed to DHS to expand the reach of prevention efforts being supported by other federal grants; the PFS 15 grant and SPF Rx grant. Due to limited funds, only coalitions in high need areas were part of PFS 15 and SPF Rx. STR and SOR allowed DHS to support coalitions in implementing prevention strategies targeting opioids statewide.

8. **What additional resources would be most helpfnl to provide to communities struggling with opioid and other substance use disorders, including prevention and/or treatment options?**

Given the role that DHS plays, longer grant periods and increased flexibility would be most helpful. Previous responses have outlined the challenges the department and State currently encounter. Setting up the large grants awards like STR and SOR, similar to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), could improve efficiency. SAPTBG funding is awarded to states yearly, but states have two years to spend the funding. This provides states with more time to spend the funds; added flexibility; removes the need for no cost extensions; and an ongoing yearly allocation allows for better planning and the opportunity to be more strategic. It would also be helpful if at least a portion of the funding were broader than opioids and addressed substance use disorders as a whole. The reasons for this are varied. First, history tells us that this will not be the last drug epidemic we face nationally. There are already signs of increased use and deaths related to stimulants (methamphetamine, cocaine, etc.) across the country. Being as proactive as possible will be best in addressing the next epidemic. Second,

many individuals are poly drug users, meaning they use more than one type of drug either at the same time or at different times. Prevention and treatment efforts need to be broader than just opioids. We must treat the whole patient in order to improve success rates for long-term recovery. Lastly, the current wave of the opioid crisis is illicit fentanyl. The only way we can address this issue is to begin addressing all illicit drugs. Fentanyl is found in not just heroin and illicitly manufactured prescription drugs, but other drugs including methamphetamine, cocaine, and marijuana. We need to tackle the issue as a whole by addressing all substances and treating all substance use disorders.

Appendix

Table 1: Wisconsin Opioid Grant Overview

GRANT	FUNDER	TIME PERIOD	AWARD AMOUNT	AMOUNT EXPENDED	AMOUNT UNDERSPENT
Medication-Assisted Treatment - Prescription Drug and Opioid Addiction (MAT - PDOA)	SAMHSA	August 2015 – July 2018	$2,793,097	$2,610,536	$182,561
Strategic Prevention Framework Partnerships for Success - 2015 (SPF PFS 2015)	SAMHSA	September 2015 - August 2020	$8,240,940	Ongoing	N/A
Prescription Drug Overdose: Prevention for States (PDO:PfS)	CDC	September 2015 - August 2019	$7,891,264	$7,809,264	$82,000
Prescription Drug /Opioid Overdose-Related Deaths Prevention Project (PDO)	SAMHSA	September 2016 - August 2021	$5,000,000	Ongoing	N/A
Strategic Prevention Framework for Prescription Drugs (SPF Rx)	SAMHSA	September 2016 - August 2021	$1,858,080	Ongoing	N/A
Enhanced State Opioid Overdose Surveillance (ESOOS)	CDC	September 2016 - August 2019	$1,247,551	$1,244,563	$2,988
State Targeted Response to the Opioid Crisis (STR)	SAMHSA	May 2017 – April 2019	$15,273,876	$13,323,432	$1,950,444
Opioid Crisis Cooperative Agreement 2018 (CoAg)	CDC	September 2018 - November 2019	$2,715,063	Ongoing	N/A
State Opioid Response (SOR)	SAMHSA	October 2018 - September 2020	$30,211,878	Ongoing	N/A
Overdose Data to Action (OD2A)	CDC	October 2019 - September 2022	$15,585,906	Ongoing	N/A
		TOTAL AMOUNT OF FUNDING AWARDED:	**$90,817,655**		

For Tables 2-10, please refer to the following labels for the "Allocation Purposes" column:

- Prevention (P)
- Treatment (T)
- Recovery (R)
- Intervention (I)
- Evaluation (E)

Table 2: MAT – PDOA

FUNDING RECIPIENT	FUNDING AMOUNT	ALLOCATION PURPOSE
Columbia County	$584,375	T
Sauk County	$1,372,381	T
University of Wisconsin Board of Regents - Population Health Institute	$467,744	E

Table 3: SFP PFS 2015

FUNDING RECIPIENT	FUNDING AMOUNT (Award to date; grant is ongoing)	ALLOCATION PURPOSE
Community Advocates, Inc.	$1,846,590	P
Marshfield Clinic Research Institute (division of Marshfield Clinic, Inc.)	$2,404,775	P
Northeastern Wisconsin Area Education Center, Inc. (NEWAHEC)	$2,194,041	P
University of Wisconsin Board of Regents - Population Health Institute	$900,000	E

Table 4: PDO PfS

FUNDING RECIPIENT	FUNDING AMOUNT	ALLOCATION PURPOSE
About Health	$154,567	P
AIDS Resource Center of Wisconsin	$30,000	P
Blacktooth Inc.	$32,119	P
Bowman Performance Consulting	$66,509	P
City of Wauwatosa	$31,350	P
Columbia County	$5,500	P
Evergreen Evaluation	$7,500	P
Greenfield County	$30,500	P
Iron County	$31,172	P
Kenosha County	$122,800	P
LaCrosse County	$18,103	P
Marquette University	$12,443	P
Medical College of Wisconsin	$574,848	P
Patricia Frazak - consultant	$51,502	P
Pharmacy Society of Wisconsin	$93,561	P
Public Health Madison/Dane County	$474,614	P
Sustaining Natural Circles	$143,674	P
Tanya Hiser - consultant	$47,197	P
The Brigham and Womens Hospital	$29,163	P
Washburn County	$26,498	P
Washington/Ozaukee County	$45,500	P
Waukesha County	$8,250	P
Waupaca County	$33,263	p
Winnebago County	$36,005	P
Wisconsin Association for Perinatal Care	$461,553	P
Wisconsin State Lab of Hygiene	$309,592	P

Table 5: PDO

FUNDING RECIPIENT	FUNDING AMOUNT (Award to date; grant is ongoing)	ALLOCATION PURPOSE
Kenosha County	$902,208	I
Sauk County	$902,208	I
University of Wisconsin Board of Regents - Population Health Institute	$400,000	E
Waukesha County	$902,208	I

Table 6: SPF Rx

FUNDING RECIPIENT	FUNDING AMOUNT (Award to date; grant is ongoing)	ALLOCATION PURPOSE
Northeastern Wisconsin Area Education Center, Inc. (NEWAHEC)	$862,088	P
University of Wisconsin Board of Regents - Population Health Institute	$297,292	E

Table 7: ESOOS

FUNDING RECIPIENT	FUNDING AMOUNT	ALLOCATION PURPOSE
AE Business Solutions	$8,242	P
Image Trend	$60,000	P
Wisconsin State Lab of Hygiene	$129,480	P

Table 8: STR

FUNDING RECIPIENT	FUNDING AMOUNT	ALLOCATION PURPOSE
211 Wisconsin, Inc.	$400,000	T/R
AIDS Resource Center of Wisconsin	$499,774	R
Bad River Tribe	$152,505	T/R
Brown County	$113,253	T/R
Community Advocates, Inc.	$251,307	P
Dane County	$726,819	T/R
Dodge County	$637,297	T/R
Douglas County	$164,818	T/R
Forest County Potawatomi Tribe	$250,000	T/R
Green County	$356,442	T/R
Ho-Chunk Tribe	$157,904	T/R
Jefferson County	$279,468	T/R
Kenosha County	$318,770	T/R
La Clinica Family Health	$726,222	T/R
La Crosse County	$363,364	T/R
Lac Du Flambeau Tribe	$126,113	T/R
Manitowoc County	$127,695	T/R
Marquette County	$165,417	T/R
Marshfield Clinic -Recovery Corps	$120,000	R
Marshfield Clinic Research Institute, a division of Marshfield Clinic, Inc.	$661,846	P
Milwaukee County	$2,978,176	T/R

Monroe County	$75,000	T/R
Northeastern Wisconsin Area Education Center, Inc. (NEWAHEC)	$571,947	P
Portage County	$154,941	T/R
Racine County	$253,272	T/R
Rock County	$276,141	T/R
Sharps Compliance, Inc.	$49,500	P
Sheboygan County	$179,455	T/R
Southwestern CAP, Inc.	$250,000	T/R
St. Croix Tribe	$75,000	T/R
Stockbridge Munsee Tribe	$235,046	T/R
Tellurain, Inc.	$250,000	T/R
University of Wisconsin - Stevens Point	$278,488	T/R/P
University of Wisconsin Board of Regents - School of Medicine and Public Health ED 2 Recovery	$2,297,610	R
University of Wisconsin-Madison Offices of Research and Sponsored Programs -Project ECHO	$151,520	T
University of Wiscosnin Board of Regents - School of Medicine and Public Health ER Toolkit	$41,411	T
Waukesha County	$350,084	T/R
Winnebago County	$357,947	T/R

Table 9: CoAg

FUNDING RECIPIENT	**FUNDING AMOUNT (Award to date; grant is ongoing)**	**ALLOCATION PURPOSE**
Adams County	$17,000	P
Barron County	$4,800	P
Bayfield County	$1,625	P
Buffalo County	$17,216	P
Burnett County	$4,800	P
Central Racine County Health Department	$28,775	P
Chippewa County	$4,800	P
City of Cudahy Health Department	$78,000	P
City of Greendale Health Department	$33,500	P
City of Greenfield Health Department	$18,000	P
City of Menasha Health Department	$30,000	P
City of Milwaukee Health Department	$56,000	P
City of Racine Health Department	$18,000	P
City of West Allis Health Department	$18,500	p
Columbia County	$33,000	P
Crawford County	$23,060	P
Douglas County	$4,800	P
Dunn County	$1,625	P
Eau Claire City-County Health Department	$18,000	p
Florence County	$14,637	P
Green County	$17,139	P
Helping Hands Foundation	$137,249	P

Iowa County	$25,000	P
Iowa County	$87,300	P
Jefferson County	$25,206	P
Juneau County	$7,650	P
KW2 - consultant	$200,000	P
La Crosse County	$29,000	P
La Crosse County	$65,273	P
Lac Courte Oreilles Tribe	$1,625	P
Lafayette County	$6,998	P
Lincoln County	$19,900	P
Milwaukee County	$16,561	P
North Shore Health Department	$17,839	P
Northeast Wisconsin Technical College	$26,115	P
Pepin County	$4,800	P
Pierce County	$4,800	P
Polk County	$134,154	P
Public Health Madison & Dane County	$30,000	P
Richland County	$45,000	P
Rock County	$10,619	P
Rusk County	$4,800	P
Sawyer County	$1,625	P
St. Croix County	$1,625	P
St. Croix Tribe	$4,800	P
TAPFIN Funding Solutions	$99,298	P
Taylor County	$14,000	P
Trempealeau County	$45,554	P
Uuiversity of Wisconsin System	$133,796	P
Walworth County	$17,695	P
Washburn County	$18,000	P
Waukesha County	$20,000	P
Western Technical College	$14,983	P
Wisconsin EMS Association	$140,000	P
Winnebago County	$136,938	P
Wisconsin Society of Addiction Medicine	$80,000	P
Wisconsin State Lab of Hygiene	$127,409	P

Table 10: SOR

FUNDING RECIPIENT	**FUNDING AMOUNT (Award to date; grant is ongoing)**	**ALLOCATION PURPOSE**
211 Wisconsin, INC	$166,666	T/R
Adapt Pharma-NARCAN DIRECT	$102,750	I
ARC Community Services, INC.	$249,896	T/R
Bad River Tribe	$31,250	T/R
Brown County	$47,188	T/R
Columbia County	$58,333	T/R
Community Advocates, Inc.	$131,400	P
Dane County	$151,420	T/R

Dodge County	$277,500	T/R
Douglas County	$31,440	T/R
Dunn County	$53,800	T/R
Forest County Potawatomi Tribe	$104,167	T/R
Green County	$93,940	T/R
Ho-Chunk Tribe	$31,250	T/R
Jefferson County	$73,250	T/R
Kenosha County	$86,490	T/R
La Clinica Family Health	$277,778	T/R
La Crosse County	$103,612	T/R
Lac Courte Oreilliles Tribe	$87,000	T/R
Lac Du Flambeau Tribe	$31,250	T/R
Manitowoc County	$145,138	T/R
Marshfield Clinic Research Institute, a division of Marshfield Clinic, Inc.	$303,950	P
Menominee Tribe	$47,515	T/R
Menominee County	$87,436	T/R
Milwaukee County	$838,612	T/R
Monroe County	$31,440	T/R
North Central Healthcare	$44,630	T/R
Northeastern Wisconsin Area Education Center, Inc. (NEWAHEC)	$294,650	P
Portage County	$31,250	T/R
Racine County	$72,315	T/R
Rock County	$63,000	T/R
Sauk County	$52,614	T/R
Sheboygan County	$41,876	T/R
Sokoagon Chippewa Tribe	$80,135	T/R
Stockbridge Muusee Tribe	$31,250	T/R
Tellurian, INC.	$104,167	T/R
Unified Grant/Iowa County	$235,500	T/R
United Community Center	$250,000	T/R
University of Wisconsiu - Stevens Point	$246,525	P/T/R
University of Wiscousin Board of Regents - Population Health Institute	$293,187	E
University of Wisconsin Board of Regents - School of Medicine and Public Health ED 2 Recovery	$583,314	R
University of Wisconsin Board of Regents - School of Pharmacy	$39,831	T
Washington County	$235,500	T/R
Waukesha County	$63,000	T/R
Winnebago County	$102,675	T/R

Table 11: OD2A

FUNDING RECIPIENT
This grant was just awarded, and funding has yet to be deployed to any partners and stakeholders.

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"

January 14, 2020

Ms. Jennifer Smith, Secretary, Pennsylvania Department of Drug and Alcohol Programs

The Honorable Brett Guthrie (R-KY)

1. As you may be aware, section 7063 of the SUPPORT Act (P.L. 115-271) encourages public-private partnerships to assist with addressing the opioid crisis, specifically for infants with Neonatal Abstinence Syndrome (NAS) and their mothers. While section 7063 is specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) efforts, could you provide information on how your state is using public-private partnerships. In addition, please provide areas of need for where the federal government can work with other entities to better leverage community resources.

   - The Administration is assessing the potential for a public-private partnership related to residential pediatric recovery centers. We are surveying clinicians to determine areas of need for infants diagnosed with NAS and their mothers when discharge from the hospital is possible. Additionally, starting in 2018 the Department of Health (DOH) began collecting data from hospitals of the incidence of NAS in their facility. DOH epidemiologists analyzed this data and published a report in August 2019. You can find this report on the DOH website: https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/2018%20NAS%20REPORT.pdf.
     Starting in January 2020 the Department transitioned this data collection to our Newborn Screening Reporting system to create a system for follow up by our Newborn Screening nursing staff. By using the Newborn Screening reporting system, DOH is better able to track referrals made for follow-up services and identify whether there are outstanding gaps in services or needs for families of babies born with NAS. DOH will continue to monitor data and resources to determine opportunities for future partnerships.
     Pennsylvania is in a second year of a Perinatal Quality Collaborative with three specific aims: Reduce maternal mortality and morbidity, improve identification of and care for pregnant and postpartum women with OUD and improve identification of and care for opioid exposed newborns. The collaborative is working with 60 birth sites and 12 health plans to identify processes that need improvement and quickly adopt best practices to achieve the identified aims.

2. Are treatment programs in your state able to share substance use disorder medical records so that they can coordinate care for patients with opioid use disorder?

- Through state regulation, Pennsylvania places additional confidentiality requirements on substance use disorder (SUD) records above and beyond those requirements imposed by 42 CFR Part 2. The Department of Drug and Alcohol Programs (DDAP) has heard from its stakeholders that these additional requirements create issues in coordinating care for patients with opioid use disorder between specific entities (e.g. insurers and providers). Other stakeholder groups see the requirements as key to protecting individuals with SUD from stigma and discrimination. DDAP is currently undertaking an exhaustive Stakeholder Survey to better understand knowledge, beliefs, practices and barriers related to Pennsylvania's substance use confidentiality policies. It is our hope that this work will lead to a better understanding of issues related to substance use disorder records.

    a. Is your state struggling with getting patients to outpatient treatment centers due to the inability of providers to see a patient's full substance use disorder medical record?

        - In our experience, Pennsylvania not seen difficulty in having clients enroll in outpatient treatment due to concerns of confidentiality of prior treatment. Clients who give consent to enroll in outpatient treatment also give consent to release of records from another provider for purposes of referral and care planning consistent with applicable regulations.

    b. Are there policies that Congress can fix to help states with improving outcomes for substance use disorder and lower the costs of increased Medicaid spending in emergency departments?

        - Current policies around DATA-waived practitioners create roadblocks and impediments to beginning treatment when individuals present at the emergency department (ED). Specifically, the limits that surround a practitioner's ability to provide medication without the patient continuing to present at the ED is inefficient and drives costs. In other settings the need for the DATA-waiver create impediments to treatment which also drive patients to EDs. It is important that treatment can be initiated at a variety of access points, including the ED. Removing requirements for practitioners to obtain the additional waiver will reduce costs and allow for immediate access to SUD treatment. Improved access to services will lead to fewer patients relying on EDs for treatment. This treatment is better provided in a more cost-effective outpatient setting which will have a better understanding of the needs of this population. Making better use of community-based treatment, by eliminating policy burdens, will result in better continuity of care, reduce the likelihood of relapse, and limit ED use.

3. Do you think it makes sense to revise the 42 CFR privacy regulations to allow doctors to communicate about patients with substance use disorder, in other words to treat privacy

issues around substance use disorder the same way we treat other mental health disorders or physical medical conditions?

- According to the Centers for Disease Control and Prevention's National Center for Health Statistics, Pennsylvania ranks #3 in the nation for age-adjusted drug overdose death rates. We recognize that the protections provided in 42 CFR Part 2 have always been designed to encourage individuals to seek treatment for substance use disorder (SUD) without fear that their information will be disclosed unnecessarily without their knowledge. Considering this devastating overdose statistic, however, it is imperative to explore rulemaking that evolves alongside advances in health information technology to remove barriers and address interoperability issues – particularly as Part 2 was promulgated 45 years ago.
  In balancing these two seemingly distinct issues, we ultimately view stigma as being at the heart of both. While protecting a population that still experiences widespread stigma – from their peers, healthcare providers, policymakers, and even toward themselves – the additional releases currently required by Part 2 perpetuate the message, in turn, that SUD is a shameful condition that should still be treated in secret, unlike other medical diseases like diabetes, cancer, and HIV. During a time of unprecedented federal funding that has been funneled to states to improve public awareness, treatment accessibility, and care coordination for patients with SUD, confidentiality regulations must strike the right balance between respecting a patient's desire for privacy, while removing appropriate administrative barriers for all providers to care for their patients.

4. In Fiscal Year (FY) 2019 and FY 2020, Congress approved funding for the Centers for Disease Control and Prevention's (CDC) Overdose to Action OD2A grants, which primarily go to states, but has a requirement that 20 percent of the prevention funds go to local health departments. How is your state working with local jurisdictions to ensure that these funds reach local communities?

   - The Department of Health is in the process of providing grants to 9 local health departments to fund local prevention and response activities related to the opioid epidemic. The Department is utilizing 30 percent (approximately $2.5 million) of the CDC OD2A grant for this purpose. The local health departments proposed activities based on the specific needs of their communities. Examples of funded activities include establishing Overdose Fatality Review Teams, overdose surveillance, Police Assisting in Recovery Program, EMS and law enforcement home visits, and various education targeting prescribers, pharmacists, parents, families, seniors, veterans, colleges and universities, and the general population.

5. How is your state partnering with localities to ensure that they can help inform the state's strategy in addressing opioid misuse?

- To better understand how the funding has made an impact on a local level, it is important to detail how Pennsylvania's drug and alcohol system is structured. Local government entities are critical partners in the provision of prevention, intervention, treatment and treatment-related services in Pennsylvania. DDAP has contractual agreements with forty-seven (47) Single County Authorities (SCAs). These county or county affiliated agencies plan, administer, and evaluate services at the local level. To date, SCAs have received more than $57 million for treatment services and more than $13 million for prevention programming. The statewide needs assessment, overdose death data, and treatment data indicate that all areas of the state have been affected by the opioid crisis; therefore, all 47 SCAs have received funding to address their local needs for both treatment and prevention services. SCAs are responsible for contracting with and funding services to non-governmental agencies such as treatment and prevention providers at the local level. Each SCA determines what licensed treatment providers or prevention and recovery support services will meet their identified local needs.
  In addition to funding provided directly to our sister state agencies and SCAs, Pennsylvania also uses various competitive processes to obtain contracted services for identified agency needs at the local level. Pennsylvania is a very diverse state and many challenges we face are related to socioeconomic factors. During his first term, Governor Wolf signed an executive order strengthening protections for vulnerable populations. As such, he has challenged his administration to actively review regulations and services to these populations. This has resulted in the Administration administering contracts with new recovery support programs like 16 local programs focused on assisting individuals with stable housing while engaged in MAT, nine programs supporting pregnant women and women with children, programs to support employment efforts for those in recovery and local initiatives that work with police, and first responders to support individuals' connections to treatment after arrest or overdose all with the support of our federal funding.
  Finally, in addition to providing grant funding to nine local health departments (from previous question), the Department of Health also provides funding to Coroners and Medical Examiners for their participation in sharing timely and comprehensive data on overdose deaths. To date, the Department has provided over $1 million in funding to Coroners and Medical Examiners and is currently providing a total of $608,000 per year through August 2022. As of today, 54 out of 67 Coroners and Medical Examiners share overdose death data with the Department.

6. How are your state and local health departments working in partnership once the state receives grant dollars to ensure local communities have the resources that they need to address substance misuse and prevent substance use disorders and overdoses?

- Through a combination of state and federal funding, the commonwealth distributed nearly 13,000 naloxone kits free of charge directly to Pennsylvanians through local health departments across three days in December 2018 and September 2019. The commonwealth continues to discuss opportunities with localities on best methods to distribute naloxone.

The Department of Health maintains a syndromic surveillance system for monitoring disease indicators in near real-time. This system is connected to 164/168 (98%) emergency departments around the state. It captures visits related to suspected drug overdoses, including those related to over-the-counter, prescription and illicit drugs. Once a statistically significant number of events are detected, the relevant local communities (e.g. health centers, EMS, police, SCAs) receive an EpiCenter alert on the spike. Localities then use this data to better respond to significant overdose events.

7. We know that many of the interventions needed to address substance use disorder rely on a strong public health workforce, but there is currently a workforce shortage in the behavioral health space. What types of professionals are needed in your state to help address the opioid crisis, and to prevent future crises, as well?

   - Another key factor in the nation's ability to adequately address the crisis and provide appropriate healthcare depends on the viability of the addiction treatment workforce. Workforce shortages are already present across Pennsylvania due to factors such as low wages, emotional burnout, and costly education and training requirements. These shortages include the professionals who provide the direct counseling for individuals with SUD as well as health care professionals such as physicians and nursing staff. Demands on the addiction treatment workforce will increase as more people move toward treatment and recovery. We suggest the federal government consider strategies to expand workforce capacity and proficiency. Policies that promote entry into this workforce can also serve the dual purpose of employing individuals in recovery. Pennsylvania has taken a small step in this direction by using grant dollars to institute the loan repayment program, a collaboration between DDAP and the Department of Health launching the state's first loan repayment program for health care professionals serving individuals with opioid use disorder. The program supports the supply and distribution of health care practitioners where there is high use of opioids and a shortage of providers exists. Applicants must be a practitioner in an eligible discipline with two years of employment and must agree to practice in the field for an additional two years. Federal grant funding has allowed us to creatively address a rural workforce shortage by awarding more than 90 individuals from 23 different counties.

8. The federal government has appropriated millions of dollars to fund Prescription Drug Monitoring Programs (PDMP) through the Hal Rogers program and others. According to the White House Office of the National Drug Control Policy (ONDCP) PDMPs are "a tool that can be used to address prescription drug diversion and abuse." What challenges still exist with PDMPs?

   - Integrating with Electronic Health Records (EHRs) and Pharmacy Management Systems in a cost-effective, sustainable way remains a challenge. Integration helps minimize any workflow disruption by providing near-instant and seamless access to critical prescription history information to prescribers and pharmacists. With the help of federal funding, the Department has made significant progress with integrating the PDMP, and has

successfully integrated with 29 health systems, 25 independent hospitals, 205 private practices, and 1,611 pharmacies.
Additionally, while PDMP data alone has been tremendously useful for understanding the opioid crisis and driving prevention programs, to get the full picture the Department needs data on fatal and non-fatal overdoses that occur in Pennsylvania. The issue is that Coroners and Medical Examiners are not required to submit toxicology and autopsy results on overdose deaths, which are critical for understanding the nature of the death and which drugs were involved. Furthermore, the Department is not able to collect identified information on overdoses that present to emergency departments. The ability to collect identified fatal and non-fatal overdose data and link it to PDMP data would allow the Department to better identify the risk factors associated with overdose, better predict where spikes in overdoses will occur, and ultimately make more informed decisions when allocating resources for opioid-crisis prevention and response.

a. How much has your state received and spent on its PDMP to date?

   - The PDMP Office was formed in 2016. Since then, it has received approximately $12.2 million in state funds and has been awarded $19 million in federal funds and has spent $8.9 million in state funds and $8.4 million in federal funds. A large portion of the federal funds are still being spent down. It is important to note that this funding does not just support the PDMP system, it also supports several statewide prevention programs, including Continuing Medical Education, Academic Detailing, Patient Advocacy Program, First Responder Training, Overdose Surveillance, as well as funding to local health departments, coroners, and medical examiners.

b. Is there any data or reports that detail the positive outcomes from utilizing a PDMP?

   - PDMP Interactive Data Report - https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx
   - PA Opioid Data Dashboard - https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/; on the "Preventing Addiction" page.
   - PDMP Annual Reports
     - 2016-2017 - https://www.health.pa.gov/topics/Documents/Programs/PDMP/2016-17-ABC-MAP-Annual-Report.pdf
     - 2018 - https://www.health.pa.gov/topics/Documents/Programs/PDMP/2018-ABC-MAP-Annual-Report.pdf

9. Some concerns with PDMPs include a lack of real time data and a lack of interoperability with other states. Do you agree PDMPs face these challenges?
   a. If so, are these challenges preventing prescribers and pharmacists from having access to all of the information needed to make an informed decision about whether to prescribe or dispense?
   b. If so, how can we address these problems and improve PDMPs?

- Interstate sharing of data helps prescribers and pharmacists get a more complete picture of their patients' controlled substance prescription histories. The Pennsylvania PDMP is sharing data with 21 other states, D.C., and the military health system. Most importantly, this includes all surrounding states (as well as Florida), where patients are most likely to travel to and from.
  The PDMP also collects information on all controlled substance dispensations by the subsequent business day. The PDMP has reduced doctor shopping by over 92% since the system launched, which indicates that the current data collection frequency is effective. Moving to real-time data collection would be very costly, may contain errors, and would likely not have significant benefit beyond what has already been accomplished. Though real-time data collection can help deter same-day doctor shopping (i.e., an individual seeing multiple prescribers and filling multiple prescriptions in the same day), such drug-seeking behavior would be associated with the individual's PDMP record by the next day, and all associated prescribers would be alerted by the system, making it very difficult for the individual to repeat this activity in the future.

10. Does your state's PDMP use HIPAA standards or any named federal standard for data transmission?

    - Yes, the PDMP system complies with HIPAA and HITECH regulations and utilizes NIST 800-53 Moderate standards to ensure the protection of PHI and PII.

11. Many states are able to share PDMP data across state lines. However, it is my understanding that even if states are connected to an information hub, those states may not have access to state information for all other states connected to that same hub. Is that an issue that your state faces and/or that you are aware is an issue in other states?
    - For any given state that Pennsylvania wishes to exchange PDMP data with, that state must first grant permission. The Pennsylvania PDMP is currently sharing data with 21 other states, D.C., and the military health system. This includes all surrounding states (as well as Florida), where patients are most likely to travel to and from. There is no evidence to suggest that it is beneficial to query all states and doing so would increase the rate of false-positive patient matches dramatically. The vast majority of non-residents receiving dispensations in Pennsylvania are from a bordering state.

    a. Would states having the ability to access information across all state lines assist in fighting the epidemic?
       - There is no evidence to suggest that it is beneficial to query all states and doing so would increase the rate of false-positive patient matches dramatically. The vast majority of non-residents receiving dispensations in Pennsylvania are from a bordering state

12. What were the circumstances that you believe led to the opioid crisis in your state?

- The opioid crisis in the commonwealth was fueled by the combination of many factors including the overprescribing of opioids, cheaper and more pure heroin, geographic positioning along drug trafficking routes, and finally a relatively stagnant drug and alcohol system that was providing inadequate levels of care and evidence-based treatment options for individuals with opioid use disorder.

13. How does your state ensure that opioid federal grant funds are not diverted for unauthorized purposes?

- Local government entities are critical partners in the provision of prevention, intervention, treatment and treatment-related services in Pennsylvania. DDAP has contractual agreements with forty-seven (47) Single County Authorities (SCAs). These county or county affiliated agencies plan, administer, and evaluate services at the local level. To date, SCAs have received more than $57 million for treatment services and more than $13 million for prevention programming. SCAs are responsible for contracting with and funding services to non-governmental agencies such as treatment and prevention providers at the local level. Each SCA determines what licensed treatment providers or prevention and recovery support services will meet their identified local needs. DDAP monitors each SCA to assure that fiscal and program standards are met. DDAP also partners with other state agencies to implement direct services at the community level. To implement these services, Pennsylvania uses various competitive processes to obtain contracted services for identified agency needs at the local level. This has resulted in contracts with new recovery support programs like 16 local programs focused on assisting individuals with stable housing while engaged in MAT, nine programs supporting pregnant women and women with children, programs to support employment efforts for those in recovery and local initiatives that work with police, and first responders to support individuals' connections to treatment after arrest or overdose all with the support of our federal funding. All these procurements result in contracts which identify the fiscal, reporting and program requirements. DDAP and the other state agencies monitor these contracts for compliance.

14. How does your state ensure that opioid-related federal grant funds are going directly to the communities most affected by the opioid crisis?
- The statewide needs assessment, overdose death data, and treatment data indicate that all areas of the state have been affected by the opioid crisis therefore all 47 SCAs have received funding to address their local needs for both treatment and prevention services. SCAs are responsible for contracting with and funding services to non-governmental agencies such as treatment and prevention providers at the local level. Pennsylvania uses various competitive processes to obtain contracted services for identified needs at the local level. The procurement process may include criteria that limits the applicants to certain high-risk areas of the Commonwealth. An example is the procurement for housing support services for individuals with OUD. Applications were open to providers in 15 rural and 15 urban counties identified as having the highest rates

of OUD and overdose deaths. The criteria help to direct the funding to those communities most affected by the opioid crisis.

The Honorable Bob Latta (R-OH)

1. In addition to the STR and SOR grants, how many other federal grants have your states received related to opioids or substance use disorder prevention and treatment?

   - The below table details the amount of federal funding Pennsylvania has received for prevention, treatment and recovery for opioid use disorder, including the following specific grant funding.

Funding Source	**Amount**
Opioid State Targeted Response (STR)	$53,015,158
State Opioid Response (SOR) & Supplement	$141,052,265
Medication Assisted Treatment – Prescription Drug and Opioid Addiction	$5,700,000
CDC Crisis Response	$5,185,486
CDC Enhanced State Opioid Overdose Surveillance (ESOOS)	$1,666,000
CDC Overdose to Action (OD2A)	$8,448,267
CDC Prevention for States	$6,560,000
U.S. Department of Labor	$4,997,287
BJA Cat. 5 (Prescription Drug Monitoring Program)	$750,000
BJA Cat. 6 (Public Health and Public Safety Collaboration - PDMP)	$1,000,000
BJA Cat. 6 (Department of Corrections)	$996,408
Coverdell Forensic	$230,386
RSAT	$587,463
Comprehensive Opioid Abuse Program	$1,200,000
TOTAL	**$231,388,720**

2. I understand that the various federal grant programs have different requirements, timelines, applications, etc. How does this administrative burden impact your state?

   - Pennsylvania receives grant funding to address the opioid crisis from a list of federal partners (e.g. DOJ, DOL, SAMHSA, CDC) with incongruent funding requirements, data collection mechanisms, and timelines for use. These disparate requirements make it difficult to integrate grant dollars into a cohesive, commonwealth-wide strategy. Pennsylvania spends considerable administrative energy ensuring that the *right* dollars are being used for the *right* projects. This creates an opportunity cost of missed benefits were those resources better allocated. Better coordination for funding at the federal level, coupled with a concerted effort to reduce administrative burdens across grants, would

support greater flexibility in grant use at the state level. With this in mind, we appreciate the benefits of a strong Office of National Drug Control Policy (ONDCP) and continued funding for the HIDTA program. In addition, we appreciate the SUPPORT Act's creation of the Interdepartmental Substance Use Disorders Coordinating Committee (ISUDCC). We are pleased that SAMHSA will be leading the committee and that state alcohol and drug agencies are required to serve on the committee.

While Pennsylvania has made great strides with the federal funding, the focus on collaboration, stakeholder input, and information sharing has allowed us to look at challenges and opportunities associated with the unprecedented funding. There are some challenges, although not insurmountable, the commonwealth has experienced with the limitations of funding. Those challenges include:

Broad issues of Addiction & Polysubstance Use. To date, Federal funding is targeted at opioids. Pennsylvania, like many other states, continues to grapple with broader issues of addiction. Pennsylvania is currently monitoring an increase in stimulant use (e.g. methamphetamine, cocaine) related to the crisis. Federal funding opportunities should recognize that this crisis has shifted over time – and will continue to shift – affording states with greater flexibility to address substances in addition to opioids. We were pleased to see the 2020 Appropriations Package currently includes stimulant abuse as an allowable use of funds for the SOR grant. Over time, we hope that Congress would gradually transition from investments in drug specific grants to SAMHSA's SAPTBG in order to afford states more flexibility to address their own unique needs and circumstances.

Acute Funding for a Chronic Condition. Addiction treatment stakeholders across the commonwealth express a desire for consistent, long-term funding, as addiction is a chronic, relapsing disease. Providers understand that long-term programs that offer a range of treatment and recovery supports are needed. Planning for these programs is difficult when funding mechanisms favor larger, short-term infusions of dollars. Said another way, short-term funding promotes short-term solutions. Funders should consider mechanisms that support a longer horizon. A long-term focus would reduce uncertainty, thus promoting greater flexibility.

Federal Coordination of Effort. Pennsylvania receives grant funding to address the opioid crisis from a list of federal partners (e.g. DOJ, DOL, SAMHSA, CDC) with incongruent funding requirements, data collection mechanisms, and timelines for use. These disparate requirements make it difficult to integrate grant dollars into a cohesive, commonwealth-wide strategy. Pennsylvania spends considerable administrative energy ensuring that the *right* dollars are being used for the *right* projects. This creates an opportunity cost of missed benefits were those resources better allocated. Better coordination for funding at the federal level, coupled with a concerted effort to reduce administrative burdens across grants, would support greater flexibility in grant use at the state level.

a. Would it be helpful for the federal opioids and substance use disorder grants to have more standardized application requirements and processes?

- Pennsylvania is extremely grateful for the significant federal funding over the last several years to address the Opioid Crisis. Efforts to provide greater flexibility in grant use and a long-term focus would allow states to plan for sustainable efforts to address the range of SUD treatment needs. Reducing administrative burdens of multiple requirements will allow states to focus more effort on implementation of quality and effective services and less on meeting a broad range of diverse requirements.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER
Governor
KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary
MONICA BHAREL, MD, MPH
Commissioner
Tel: 617-624-6000
www.mass.gov/dph

February 19, 2020

Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone,

Thank you for the opportunity to testify before the Energy and Commerce Committee's Subcommittee on Oversight and Investigations January 14, 2020 hearing on "A Public Health Emergency: State Efforts to Curb the Opioid Crisis". Attached, please find answers to the additional questions from members of the Subcommittee. If you have any additional questions, please do not hesitate to reach out to me. Thank you again for this opportunity.

Sincerely,

Monica Bharel, MD, MPH
Commissioner
Department of Public Health

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"

January 14, 2020

Dr. Monica Bharel, Commissioner, Massachusetts Department of Public Health

The Honorable Brett Guthrie (R-KY)

1. *As you may be aware, section 7063 of the SUPPORT Act (P.L. 115-271) encourages public-private partnerships to assist with addressing the opioid crisis, specifically for infants with Neonatal Abstinence Syndrome (NAS) and their mothers. While section 7063 is specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) efforts, could you provide information on how your state is using public-private partnerships? In addition, please provide areas of need for where the federal government can work with other entities to better leverage community resources.*

   We have a number of examples to share. The Mass. Department of Public Health has worked closely with birth hospitals to implement the MA Perinatal-Neonatal Quality Improvement Network to improve services and treatment outcomes for substance exposed newborns. This initiative has brought together more than 30 Massachusetts hospitals, community groups, and state agencies in structured, collaborative improvement efforts, with over 300 health care providers participating in twice-yearly statewide summits that anchor the project.

   To better engage the obstetric and women's health communities, this network is also participating in the Alliance for Innovation on Maternal Health (AIM). AIM is a national organization focused on eliminating preventable maternal morbidity and mortality, including related to maternal opioid use disorder. By engaging Massachusetts hospitals in AIM, the network strives to align the obstetric community and birth hospitals to implement the AIM Opioid Bundle to improve overall maternal health outcomes and to address associated racial inequities in maternal morbidity and mortality associated with substance misuse.

   In response to Governor Baker's signing An Act Relative to Substance Abuse, Treatment, Education and Prevention (Chapter 52 of the Acts of 2016), the Department established mandatory monthly reporting of maternal drug dependence to opioid and benzodiazepines (F11.20 or F13.20) and newborn exposure (P04.49 or P96.1) requiring birth hospitals to report the number of infants born exposed to controlled substances. The Department has incorporated analysis of this monthly reporting in its quarterly opioid report (https://www.mass.gov/lists/current-opioid-statistics) shared publicly and with stakeholders.

Additionally, we are working to foster and support perinatal provider collaboratives focused on improving dyadic care for families affected by substance use disorders. These coalitions include medical, behavioral health, and other community providers as well as personnel from public state agencies. These partnerships improve coordination of care inter-department communication, and service quality improvement.

One way SAMHSA could partner with private entities to improve services, and service delivery, would be to foster innovative technologies to facilitate access to interventions for perinatal women with substance use disorders. An example of this is the federal Health Resources and Services Administration's Maternal and Child Health Bureau call for proposals to create technological innovations to assist in care and treatment of perinatal women with opioid use disorder. A recipient of the Innovation Prize funding created a mobile-accessible Plan of Safe Care platform. SAMHSA could replicate this style of competitive award to entice research organizations and tech companies to help develop innovative behavioral health products that could be piloted or disseminated in state agency or provider systems.

Additionally, SAMHSA could investigate ways to partner with housing entities – public and private – to develop opportunities for states to provide long-term and recovery oriented housing programs for women with children, and families.

In general whenever the federal government can allow braiding and blending of funds from different federal agencies across public agencies, including mental health and child welfare, this will allow us to enhance our care across the social determinants of health and the various needs of the individuals.

Massachusetts Public Health Data Warehouse (PHD) is a private/public data model that has informed and driven policy working to combat the opioid epidemic, and soon, other emerging public health priorities. We have collaborated with over 50 groups from across local, state, and federal government; academic institutions; healthcare delivery; and Consulting Agencies, Foundations, Private Companies, and Think Tanks. They helped us by providing data, subject matter expertise and analytic capacity which enabled the Department to execute a robust analytic agenda to inform Massachusetts' response to the opioid epidemic.

2. *Are treatment programs in your state able to share substance use disorder medical records so that they can coordinate care for patients with opioid use disorder?*

The short answer is no. Governor Baker has long requested that the impediments and unintentional barriers that have been created as a result of 42 CFR Part 2 be addressed. Treatment programs are able to share very limited information subject to 42 C.F.R. Part 2 (see response to question #3). Providers who want to share information regarding specific

patients with any person or entity must have a signed consent from the patient to release information which complies with 42 C.F.R. Part 2 and HIPAA. The consent form must be specific, include purpose, and include dates, signed and dated by the patient/client. Additionally, if providers want to share information with an external agency they must have a Qualified Service Organization Agreement in place which conforms to 42 C.F.R. Part 2. The limitations make it very difficult to engage in population health management and for Medicaid programs to provide complete data to providers to engage with individuals with complex medical and behavioral health conditions.

a. *Is your state struggling with getting patients to outpatient treatment centers due to the inability of providers to see a patient's full substance use disorder medical record?*

   Please see the response to question #3 regarding potential improvements to 42 C.F.R. Part 2 for care coordination and case management.

b. *Are there policies that Congress can fix to help states with improving outcomes for substance use disorder and lower the costs of increased Medicaid spending in emergency departments?*

   We recommend changing the scheduling of naloxone in order to make it more widely available over-the-counter, without a prescription. We recommend revising the requirements for Medications for Opiate Use Disorder, particularly methadone therapy, to make it more accessible for patients and increase their continued compliance. Current federal methadone regulations have not been substantially changed in more than 30 years creating barriers through daily dosing requirements, limits to take-home medications, arbitrary time-in treatment requirements, and counseling requirements prior to receiving take-home doses. We further recommend that methadone therapy not be restricted primarily to stand alone clinics, but be integrated within primary care and other settings, including mental health and other substance misuse providers. Such barriers make long term compliance very difficult. Patients who have housing instability, lack of transportation, access to child care, or who are actively employed, are often unable to receive this evidence-based gold standard of treatment. By removing these barriers, access and continued compliance with treatment would be increased.

3. *Do you think it makes sense to revise the 42 CFR privacy regulations to allow doctors to communicate about patients with substance use disorder, in other words to treat privacy issues around substance use disorder the same way we treat other mental health disorders or physical medical conditions?*

   Yes. In August 2019, SAMHSA requested comments to proposed amendments to 42 CFR Part 2. The overall aim of the amendments was to facilitate a more coordinated care

approach among providers who treat patients with SUD. As you can see from the attached comments submitted in October 2019, the Department expressed support for SAMHSA's goal of increasing the coordination of care while ensuring that privacy protections for patients seeking treatment for SUD remain in place. In general, although we are largely supportive of the proposed changes in the areas of re-disclosure requirements, consent to entities without a treating provider relationship, disclosures by OTPs to the PDMP, expansion of the medical emergency exception, alignment of the research exception with HIPAA, and clarification of the audit and evaluation exception, they do not go far enough.

There is one specific amendment that we believe hinders the goal of integrated care. Specifically, while the amendment clarifies what qualifies as "payment and health care operations" for purposes of written consent by the patient it does **not** include care coordination or case management under this definition. This is inconsistent with HIPAA which does include case management and care coordination under the umbrella of "health care operations." This inconsistency perpetuates unnecessary confusion among health care providers navigating the requirements of both Part 2 and HIPAA. More substantively, restrictions on disclosure for case coordination and case management services present obstacles for providers to provide the full continuum of care necessary for SUD patients. Ideally, there should only be one privacy law rather than two.

4. *In Fiscal Year (FY) 2019 and FY 2020, Congress approved funding for the Centers for Disease Control and Prevention's (CDC) Overdose to Action OD2A grants, which primarily go to states, but has a requirement that 20 percent of the prevention funds go to local health departments. How is your state working with local jurisdictions to ensure that these funds reach local communities?*

In November 2019 the Massachusetts Department of Public Health announced the availability of funding to build upon the existing work of the Massachusetts Opioid Addiction Prevention Collaborative (MOAPC) and Substance Abuse Prevention Collaborative (SAPC) currently taking place in community clusters across the Commonwealth. These collaboratives were asked to submit proposals to support or expand one existing strategy currently in place in a single community or across a cluster, that addressed needs of at least one of the following DPH priority populations:
People with a history of substance use disorder and-

- who have co-occurring mental health
- who are incarcerated or have a history of incarceration
- who are experiencing (or have a history of) homelessness or housing instability
- Pregnant and post-partum women
- Communities of color
- Occupations at high risk of overdose and death from opioids (i.e. construction industry)
- Individuals who have experienced a non-fatal overdose

- Other high risk groups as locally identified

Twenty out of 28 eligible communities applied for funding available through the 20 percent prevention funds set aside, and all were funded to implement local strategies aimed at reducing fatal and non-fatal overdose in at least one of the high risk populations identified in the application, with a start date of July 1, 2020.

5. *How is your state partnering with localities to ensure that they can help inform the state's strategy in addressing opioid misuse?*

Since its creation in 2013, the Massachusetts Opioid Overdose Prevention Collaborative (MOAPC) enlisted a portion of the prevention funds set aside from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) from SAMHSA to fund grantees across the Commonwealth to implement local policy, practice, systems, and environmental change to: (1) prevent the misuse of opioids and (2) prevent/reduce fatal and non-fatal opioid overdoses.

MOAPC's include mayors/town managers, boards of public health, substance abuse prevention and treatment providers; narcan pilot sites and other BSAS-funded overdose prevention and treatment programs (as available); local/regional hospitals; representatives from the criminal justice system; public safety and first responders; consumers of substance abuse treatment services; community members including youth, parents, and social service agencies.

MOAPC consumption strategies for the prevention of opioid misuse and prevention/reduction of fatal and non-fatal opioid overdoses include: prescriber/dispenser education; community awareness/knowledge/norms; safe storage and disposal; parent information; prescription recipient information; school athlete awareness/knowledge/norms; school-based health curricula; and youth awareness/knowledge/norms. Consequence strategies include: overdose risk, recognition, and response training with at-risk populations; increasing access to naloxone; overdose risk, recognition, and response information; awareness of the Good Samaritan Law; reducing barriers to calling 911; and promoting linkages to treatment.

Additionally, through the SAMHSA grant, we have created Partnership for Success 2015 (PFS 2015), which funds 16 high need communities impacted disproportionately by the opioid crisis to prevent prescription drug misuse and abuse among high school aged youth. Examples include: education to parents about the risks of opioid prescriptions, help for them to engage in conversations with their kids, prescription safe storage and disposal, public education, and local campaigns about the risks of prescription drugs etc. Outcomes for the PFS 2015 include:

- Enhanced community infrastructure to address prescription drug misuse and abuse among high school aged youth (e.g., more diverse partnerships and stakeholders participating in prevention activities).
- Increased knowledge among prescribers of the dangers of over-prescribing opioids (e.g., provider/prescriber training)
- Increased awareness among parents/caregivers, student athletes, and coaches of the need to monitor the use of prescription medications following sports injuries (e.g., opioid misuse prevention student athletes packet).
- Increased community participation in national DEA drug take-back days and associated activities.
- Reductions in home-based access to prescription medications for the purpose of misuse due to safer storage and disposal practices.
- Increased discussions between parents/caregivers and their children about the dangers of misusing/abusing prescription medications.

In addition to the above, we use a data-driven approach to help inform local communities of the changes in the opioid epidemic in all 351 towns and cities in MA. This includes quarterly reports that break down the opioid overdose deaths by town and city and hotspot mapping to show areas of increase and decrease in overdose activity.

6. *How are your state and local health departments working in partnership once the state receives grant dollars to ensure local communities have the resources that they need to address substance misuse and prevent substance use disorders and overdoses?*

   The Department of Public Health Massachusetts Opioid Overdose Prevention Collaborative (MOAPC) grantees are clusters of communities in which a lead municipality applied as the lead applicant in collaboration with 2-4 other neighboring municipalities in their region, (2) counties or public health districts comprised of multiple municipalities, and (3) large individual municipalities with a population over 150,000. An additional requirement is that the applicant needed to have an individual or combined average of 30 or more cases per year of unintentional deaths and non-fatal hospital events associated with opioid poisonings during the three-year period prior to the writing of the application. Priority was given to clusters that strengthened Public Health Districts, built upon existing collaborations, and encouraged new or expanded collaborations in coordination with local municipalities. Currently, there are 19 lead MOAPC grantees and 99 partner municipalities – 116 total municipalities. The lead community has discretion on how to allocate resources among the members of the cluster. This ranges from instances in which all members of the cluster share these resources equally to instances in which resource allocation within the cluster is based on need, capacity, and strategies being implemented.

   We partner with the Police Assisted Addiction and Recovery Initiative (PAARI), a community policing movement focused on creating non-arrest pathways to treatment and

recovery. By creating entry points to treatment, PAARI is working toward a vision where non-arrest diversion programs become a standard community policing practice across the country, reducing overdose deaths, expanding access to treatment, improving public safety, diverting people away from the criminal justice system, and increasing trust between law enforcement and their communities.

MDPH funds Learn to Cope, a non-profit support network that offers education, resources, peer support, and hope for parents and family members coping with loved ones who are addicted to opiates or other drugs. Learn to Cope collaborates with communities across the state to spread messages of prevention, education, awareness, and advocacy. Learn to Cope was the first parent network in the country to provide the nasal Naloxone, and many of its group meeting facilitators are trained and certified to provide overdose education and nasal naloxone kits at each chapter.

Overdose Education and Naloxone Distribution (OEND) is the result of joint public health system and community advocate efforts, including collaboration between MDPH's Office of HIV/AIDS, the Bureau of Substance Addiction Services, community HIV prevention programs, substance use treatment programs, syringe service providers, and hospital emergency departments. Program services include issuance of standing orders for trained nonmedical public health workers to train and distribute nasal naloxone to potential opioid overdose bystanders, providing nasal naloxone, mucosal atomizers, and educational materials to agencies for distribution, and working through community meetings, street outreach, home delivery, and homeless shelters.

Massachusetts' Center for Strategic Prevention Support (CSPS), formerly the MA Technical Assistance Partnership for Prevention (MassTAPP/State TA Center) guides DPH-funded prevention programs across the Commonwealth through an evidence based five-phase Strategic Prevention Framework process. It provides individualized technical assistance; expert consultant services; online learning events (e.g., webinars); in-person events (e.g., regional meetings, quarterly meetings, and an annual statewide conference); peer-to-peer learning; and a website and monthly electronic newsletter.

7. *We know that many of the interventions needed to address substance use disorder rely on a strong public health workforce, but there is currently a workforce shortage in the behavioral health space. What types of professionals are needed in your state to help address the opioid crisis, and to prevent future crises, as well?*

In Massachusetts, we are working to address the workforce development needs for professionals treating substance use disorder. Some examples of our efforts include:

1. Medical student core competencies and DATA waiver training during medical school: during my testimony I mentioned that Massachusetts was the first state to have all of our medical schools agree on a set of core competencies for medical

student training. (published competencies in Academic Medicine) These core competencies were then adopted by all dental schools, advanced practice nursing,, physician assistant, social worker and physical therapy programs across the state. Additionally all medical schools now provide the required DATA waiver training for buprenorphine to graduating medical students. We welcome an opportunity to assist in making this model consistent across training throughout the country.

2. Recovery coaches -we have developed training programs for recovery coaches and recovery coach supervisors. We have successfully piloted recovery coach services being embedded in emergency departments; now a benefit covered by MA Medicaid.
3. Licensed Alcohol and Drug Abuse Counselors-
   Increasing the number of Licensed Alcohol and Drug Abuse Counselors in areas of highest need: we fund the cost of participants for the Black Addiction Counselor Education and Latinx Addiction Counselor Education programs (both currently run through AdCare Educational Institute). BSAS also works with our Healthcare Workforce Center to ensure that Licensed Alcohol and Drug Abuse Counselors and other behavioral health professionals apply for and receive (when eligible) loan repayment opportunities through the federally funded Mass Loan Repayment Program.

Overall increased training and education: Through partnerships with organizations such as AdCare Educational Institute, Praxis, Institute for Health & Recovery, and Health Resources in Action, we provides SUD prevention, intervention, treatment, and recovery related training, which are open to anyone working within the system. These trainings are also available to anyone in other human services sectors, such as Massachusetts' Department of Children and Families, Department of Mental Health, Department of Corrections, and Department of Youth Services.

Loan repayment and other incentives to work with highest risk populations are also needed. As are incentives for non –English services, sign language services and communities with less access to care.

8. *The federal government has appropriated millions of dollars to fund Prescription Drug Monitoring Programs (PDMP) through the Hal Rogers program and others. According to the White House Office of the National Drug Control Policy (ONDCP) PDMPs are "a tool that can be used to address prescription drug diversion and abuse." What challenges still exist with PDMPs?*

   a. How much has your state received and spent on its PDMP to date?

      To date, the PDMP has received $3,628,000 in Federal support, of which $2,526,000 has been spent.

   b. *Is there any data or reports that detail the positive outcomes from utilizing a PDMP?*

The PDMP is used so that a prescribers and pharmacists are able to see a patient's prescription record outside of his/her own limited network. Between CY 2013 and CY 2019, there has been a 61% reduction in the number of individuals who have received a Schedule II opioid prescription from 4 or more prescribers, involving 4 or more pharmacies in a 90 day period. The majority of the individuals who continue to trip this threshold do so because of a complex medical condition.

In 2016, Governor Baker signed legislation that limited the number of days that a physician could write a prescription. We believe this legislation, in conjunction with the mandate that prescribers utilize the PDMP, accounts for Schedule II opioid prescriptions falling by over 40% in MA.

The PDMP is an extremely valuable source of data that can be used to inform individual practitioners and the healthcare community. We provide quarterly reports to prescribers comparing their prescribing patterns to their peers in four drug categories: opioids, sedatives, stimulants, and OUD treatment drugs (e.g., Suboxone). From survey data we know that these reports serve as a basis for reflection and change in prescribing practices.

The publication of county and city and town prescription trend analyses is another source of valuable data for researchers and for the healthcare community.

9. *Some concerns with PDMPs include a lack of real time data and a lack of interoperability with other states. Do you agree PDMPs face these challenges?*

Massachusetts has completely overhauled its PDMP. Massachusetts pharmacies submit prescription records within 24 hours or the next business day, and these records are posted within seconds to the PDMP. Although not real-time, the PDMP provides accurate and timely information to practitioners and pharmacists. MA PDMP users have access to **39** states and U.S. Territories, the District of Columbia, and the Military Health System. One area of concern is the interstate access for providers who have integrated PDMP data into their EHR systems. There are several barriers for these integrated providers. First, integrated providers are treated as individual entities divorced from their state PDMP. Certain states allowed providers to integrate without state audit controls that ensure that end users are registered with their state PDMP, and that each search can be identified and tracked by the state PDMP. Secondly, the security of the API used for integration can be in question. MA requires one of a small number of APIs that have been approved by the Department's IT security team. Finally, there are statutory barriers (e.g. NH), that allow sharing data with only other state PDMPs. These barriers, it is important to note, would not be overcome by the promotion of the BJA sponsored data sharing hub, RxCheck, which has its own set of security and functionality issues to address.

a. *If so, are these challenges preventing prescribers and pharmacists from having access to all of the information needed to make an informed decision about whether to prescribe or dispense?*

Although not ideal, there are workarounds. the prescriber at a MA hospital looking for data on a patient from another state, will not have access to the patient's out of state records through the patient's EHR, but can query that patient from MassPAT, the web-based PDMP.

b. *If so, how can we address these problems and improve PDMPs?*

Additional education and uniform security protocols will help. Already we are seeing EHR vendors code to APIs that are approved by MA.

10. *Does your state's PDMP use HIPAA standards or any named federal standard for data transmission?*

Yes. MA meets or exceeds National Institute of Standards and Technology (NIST) guidelines for the transmission of electronic protected health information (EPHI) as required by the HIPAA security rule.

11. *Many states are able to share PDMP data across state lines. However, it is my understanding that even if states are connected to an information hub, those states may not have access to state information for all other states connected to that same hub. Is that an issue that your state faces and/or that you are aware is an issue in other states?*

Please see the response to #9 above.

a. *Would states having the ability to access information across all state lines assist in fighting the epidemic?*

One national database as the data set for all PDMPs might create more problems but we would need to understand more about the details. For example, the larger the data set, the more likely an individual might have his or her prescription records merged incorrectly in a patient report. Patient matching algorithms have and are continuing to improve, however, short of collecting and transmitting identifiers such as the individual's social security number, these will remain imperfect.

The MA PDMP has a high utilization rate because it is a valuable clinical tool. High utilization promotes safe prescribing and dispensing. The potential of a mismatch,

and therefore inaccurate data, would undermine confidence in the effectiveness of the PDMP to recognize and to prevent SUD.

12. *What were the circumstances that you believe led to the opioid crisis in your state?*

As in other states, Massachusetts experienced very significant increases in prescribing of opioids for acute and chronic pain over a number of years. Soon afterward, we identified the increased availability of heroin in our state. Subsequently, synthetic opioids (such as fentanyl) became far more prevalent in the illicit drug supply, leading to an increase in opioid overdoses and overdose deaths.

13. *How does your state ensure that opioid federal grant funds are not diverted for unauthorized purposes?*

MDPH utilizes a multi-pronged contract oversight and management system that ensures the appropriate and authorized use of funds. First, the state uses a competitive, public, and transparent procurement process to select community-based entities, including non-governmental organizations, non-profits, treatment centers, and others to serve as sub-recipient partners on federal grant awards. MDPH frames the details of procurements based on the requirements of the funding opportunity, including stating special terms and conditions of award around the authorized use of funds. (Detailed information about the procurement process is provided on the "Doing Business with DPH" website: https://www.mass.gov/ info-details/doing-business-with-dph).

Once vendors are selected, they are engaged through a contracting process that again outlines the terms, conditions and requirements of the award from both programmatic and fiscal perspectives. As part of implementation oversight, ongoing regular meetings are held, both by phone and in-person, with all sub-recipients to manage and monitor performance, adherence to requirements, and progress towards achieving goals. With regards to fiscal monitoring, vendors submit monthly invoices detailing expenditures based on standard budget and billing categories. State contract and fiscal managers review all billing and invoicing prior to approving payment, and periodic fiscal reviews or audits are conducted as needed or required. This close monitoring ensures compliance with the requirements of the funding, mitigates risk, and supports successful implementation.

14. *How does your state ensure that opioid-related federal grant funds are going directly to the communities most affected by the opioid crisis?*

In 2015, one of Governor Baker's first actions upon taking office was to appoint a 16-member working group, chaired by his Secretary of Health and Human Services, and tasked

with identifying short and long term strategies to respond to the opioid crisis. By holding public meetings, assessing the resources devoted to the problem, and submitting recommendations, an Action Plan was developed that serves as a blueprint for addressing the opioid crisis in the state (https://www.mass.gov/lists/governors-opioid-addiction-working-group). A key strategy outlined by the working group was to utilize data to identify hot spots and deploy appropriate resources.

The Commonwealth has prioritized linking data sets across government agencies (e.g. medical claims, death records, ambulance trips, post-mortem toxicology, prescription drug monitoring program, the Department of Mental Health, birth records, the Department of Correction, Houses of Correction, and the Department of Veteran's Services) to better understand the opioid epidemic, guide policy development, and help make programmatic decisions (www.chapter55.digital.mass.gov; www.mass.gov/public-health-data-warehouse-phd). Additionally, MDPH produces quarterly reports on opioid overdose related deaths in the Commonwealth overall, by county, city/town, and based on population demographics. Localities most impacted by the opioid crisis in the state can be found on this website: www.mass.gov/lists/current-opioid-statistics. These tools allow tracking of current opioid morbidity and mortality trends, thereby allowing MDPH to identify areas of most concern and inform and guide strategy and resources.

Through these efforts, we have targeted attention to the following priority populations:

- **Persons with history of incarceration**: analysis of statewide data has found that "compared to the rest of the adult population, the opioid-related overdose death rate is 120 times higher for persons released from Massachusetts prisons and jails
- **Persons with co-occurring disorders**: State data indicates that the risk of fatal opioid overdose is six times higher for persons diagnosed with a serious mental illness (SMI) and three times higher for those diagnosed with depression.
- **Veteraus**: The percentage of identified veterans who had a fatal opioid-related overdose was three times the state average.
- **Individuals experiencing homelessness**: The opioid-related overdose death rate is 16 to 30 times higher for homeless individuals compared to the rest of the adult population.
- **Persons who use multiple substances**: The percent of opioid-related overdose deaths involving cocaine and fentanyl but without likely heroin is increasing across all races.
- **Pregnant and parenting women**: Among women of child-bearing age, the number of opioid related deaths in MA increased from 9.6 deaths per 100,000 females in 2012, to 12.8 deaths per 100,000 in 2013. The state's child welfare agency reported a 13.5% increase in allegations of a substance exposed newborn from 2015 to 2016.
- **Persons Who Inject Drugs**: Preliminary data indicates that in 2017 the proportion of HIV infection among PWID increased to approximately 15% of reported cases, up from an average of 4-8% in previous years.

Examples of our data briefs and quarterly reports can be found at mass.gov/opioidresponse and a few examples at below links:

- Legislative Report: Chapter 55 Opioid Overdose Study - August 2017 PDF
- Legislative Report: Chapter 55 Opioid Overdose Study - September 2016 PDF
- Opioid and Stimulant Data Brief March 2019
- Data Brief: Chapter 55 Opioid Overdose Study - August 2017 PDF
- Data Brief: Chapter 55 Opioid Overdose Study - September 2016 PDF

The Honorable Bob Latta (R-OH)

1. *In addition to the STR and SOR grants, how many other federal grants have your states received related to opioids or substance use disorder prevention and treatment?*

Since 2015, the Department has received the following in addition to STR and SOR:

SAMHSA funding:
1. 2015-2018: Medication Assisted Treatment-Prescription Drug and Opioid Addiction
2. 2015-2018: State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Implementation
3. 2015-2020: Strategic Prevention Framework
4. 2018-2021: MAT-PDOA (second round)
5. Ongoing, annual, non-competitive funding: Substance Abuse Prevention and Treatment Block grant

CDC funding:
1. 2016-2019: Prescription Drug Overdose Prevention for States (PDO PfS)
2. 2016-2019: Enhanced State Opioid Overdose Surveillance (ESOOS)
3. 2018-2019: Emergency Response: Public Health Crisis Response-Opioid Overdose Crisis
4. 2019-2022: Overdose Data to Action (OD2A)

2. *I understand that the various federal grant programs have different requirements, timelines, applications, etc. How does this administrative burden impact your state?*

The administrative burden for submitting grant applications with varying timelines and requirements can be substantial. A significant amount of oversight, coordination, and planning is necessary for the successful management of new grant submissions, as well as ongoing oversight and management of funded grants from both the programmatic and fiscal perspectives. When federal grants have differing timelines and requirements, it can create risk and vulnerability for states that have limited administrative capacity to meet multiple competing federal grant deadlines simultaneously, in addition to addressing state level

priorities. Federal grant writing and budgeting is an acquired skill, so when application requirements differ qualified staff are needed to respond yet can be challenging to identify, and new staff must be trained which can take time. This is especially important in an environment where funding is awarded competitively.

a. *Would it be helpful for the federal opioids and substance use disorder grants to have more standardized application requirements and processes?*

Yes, standardizing the submission processes and application requirements would be helpful in reducing the administrative burden and in streamlining the submission process. Specifically, the format for the grant program narrative, budget justification and the required supporting documentation all differ by agency and by grant program within agencies (e.g., SAMHSA, CDC, NIH, HRSA, etc.), and require prior knowledge and acquired skills to successfully complete in a competitive grant environment. If federal grant applications all had the same core standard sections and subsections, less specialized training and skill development would be needed and the administrative burden would be reduced.

With regard to the submission process, currently, new federal grant applications can be submitted through either eRA Commons or through grants.gov. Having two separate submission systems with similar functionality can cause confusion and a duplication of efforts, and can hinder a state's ability to develop standardized operating procedures for submitting federal grants.

Thank you for the opportunity to address these questions.

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"

January 14, 2020

Ms. Christina Mullins, Commissioner, Bureau for Behavioral Health
West Virginia Department of Health and Human Resources

The Honorable Brett Guthrie (R-KY)

1. ***As you may be aware, section 7063 of the SUPPORT Act (P.L. 115-271) encourages public-private partnerships to assist with addressing the opioid crisis, specifically for infants with Neonatal Abstinence Syndrome (NAS) and their mothers. While section 7063 is specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) efforts, could you provide information on how your state is using public-private partnerships. In addition, please provide areas of need for where the federal government can work with other entities to better leverage community resources.***

   One of West Virginia's (WV) most successful public-private partnerships is work involving NAS. In 2009, neonatologists started to express concern about the number of infants exposed to drugs in utero to both the WV Department of Health and Human Resources' (DHHR) Office of Maternal, Child, and Family Health (OMCFH) and the state's perinatal improvement collaborative, the Perinatal Partnership. This led OMCFH to fund a research collaboration between a state university and a local hospital to conduct a cord blood study at eight birthing facilities in the state. The findings were staggering: approximately 20% of cords tested positive for drugs or alcohol.

   These results led to the creation of the Drug Free Moms and Babies Project by the Perinatal Partnership. The pilot project was initially launched with funding from federal resources and from a private foundation, the Claude Worthington Benedum Foundation. This project continues to grow based on the success of the initial pilot sites. State and State Target Response (STR) grant funds were used to expand the program with the Perinatal Partnership actively pursuing options for long-term sustainability. Recently, an opportunity became available through the Centers for Medicare and Medicaid Services (CMS) Innovation Center Maternal Opioid Misuse (MOM) grant. WV is now working with CMS to determine how the program can become a more robust billable service.

   There were two additional outcomes of the results of the cord blood study. One was the realization that the data used for surveillance of NAS, hospital discharge data, was most likely underreporting the prevalence of NAS. OMCFH worked with West Virginia University (WVU) to address underreporting by adding intrauterine substance exposure and NAS to an OMCFH-funded and WVU-implemented risk assessment tool used at all births in

WV. Grand Rounds at WV hospitals occurred for proper documentation to ensure occurrences were being recorded. This helped to assure that hospital discharge data aligns with state-specific surveillance. In addition, DHHR's Cabinet Secretary tasked the Perinatal Partnership to establish a workgroup to address NAS. This workgroup included payors, state offices, and organizations with an interest in addressing NAS. The collaborative also created additional opportunities such as establishing relationships to expand contraceptive options to women at risk of overdose or substance use disorder (SUD).

WV is also currently one of the six pilot sites for ATLAS, a quality improvement initiative spearheaded by the non-profit organization Shatterproof. The goal of ATLAS is to provide consumers of SUD treatment services a public interface with not only the location of services, but the type of services provided and measures of quality that are assessed by patient surveys and claims data. The interface will also help providers of SUD services to benchmark service quality. The project is utilizing resources and knowledge from both state and private partners, and while the first iteration of the public interface may have less information than originally planned, the process has been informative for both the state and ATLAS and has advanced the idea of quality SUD care in WV.

Areas of Need:
WV would benefit from government-private relationships in several areas.

- *Work with communities to build out evidence-based practices specific to stimulants.* WV's drug crisis has experienced many transformations, from prescription opioids, to heroin, to fentanyl and fentanyl analogs. Currently, polysubstance and psychostimulant use, particularly methamphetamine use, is experiencing significant growth. In contrast to opioid use disorder (OUD), there are limited evidence-based treatment options for psychostimulants. In fact, psychostimulants are an area providers highlight as needing additional resources for treatment. Additional research and information, from basic to translational, is needed to ensure clinicians have the knowledge to treat people using evidence-based practices.
- *Explore novel economic and infrastructure solutions to expanding access to treatment.* While WV still has work to do to increase access to treatment, many of the barriers are unrelated to treatment infrastructure such as childcare access and transportation. WV is working to address these barriers with State Opioid Response (SOR) funding, but sustainability and scope of these efforts are limited and of concern.
- *Facilitate evidence-based practices for resolving workforce shortages.* The need for workforce cannot be emphasized enough. The state's low workforce participation rate has wide-reaching effects. This is compounded by low college graduation rates in the state, despite having one of the highest rates of high school graduation. In some areas of WV, it can take months for funded community partners to find the workforce to implement a program, crucially delaying increases in treatment.
- *Leverage expertise to identify future needs as a consequence of the current state of the drug crisis.* WV has been in the midst of the drug crisis for over ten years. There

are far-reaching consequences that are still unknown. For example, long-term outcomes of infants exposed to drugs in utero, as well as the potential consequences to their offspring due to the trauma of the drug crisis are not defined. This leaves the state unable to fully establish systems and programs to address future needs.

- *Work with communities to build out evidence-based practices specific to keeping families unified, addressing cycles of trauma, and prevention.* One of WV's highest need for partnerships is child welfare. Since 2014, the number of children in state care has increased by 63%, with approximately 50% of children in care due to parental drug use. The partnership opportunities are vast, ranging from strategies to keep families together, to addressing trauma in children, to prevention. Evidence-based practices need to be implemented to help children and families overcome the trauma of this epidemic
- *Exploration of mechanisms for reimbursement of support mechanisms.* People with SUD often need additional services beyond medical. These can be time intensive and reliant on specialized funding sources such as grant opportunities, making sustainability a concern. Increasing reimbursement mechanisms for these services may aid in recovery.

2. ***Are treatment programs in your state able to share substance use disorder medical records so that they can coordinate care for patients with opioid use disorder?***

Yes, treatment programs in WV are able to share substance use disorder medical records with the patient's direct permission. However, the extra requirements under 42 CFR occasionally cause confusion for providers.

   a. ***Is your state struggling with getting patients to outpatient treatment centers due to the inability of providers to see a patient's full substance use disorder medical record?***

   Providers in WV have not indicated this to be a primary issue they face with getting patients to outpatient treatment centers. However, some providers have expressed that issues have occurred related to this subject, typically due to provider misunderstanding of 42 CFR Part 2. In these occurrences, the state has worked with providers by offering guidance on 42 CFR Part 2 compliance and the requirements therein.

   b. ***Are there policies that Congress can fix to help states with improving outcomes for substance use disorder and lower the costs of increased Medicaid spending in emergency departments?***

   In 2016, 56% of people that died from an overdose in WV were incarcerated at some point as an adult. This represents an opportunity for referral and engagement to treatment. WV has leveraged STR and SOR funds to expand treatment into correctional settings. However, there is no continuity of care after release. Medicaid

eligibility for incarcerated individuals 30 days prior to release would allow for case management and continuity of care to ensure proper Medication Assisted Treatment (MAT) follow-up and services. Additionally, revisions to 42 CFR Part 2 concerning information sharing, including the ability to be included in health information exchanges (HIE), would enhance the ability of both behavioral health and medical health practitioners to provide comprehensive treatment. While not directly related to policy, early identification of problematic substance use and, thereby, early access to intervention programs are critical to prevent individuals from reaching a crisis emergency state. Another consideration is the differential reimbursement between inpatient and outpatient care. While inpatient is more intensive, the differential pay provides an incentive for residential treatment.

3. ***Do you think it makes sense to revise the 42 CFR privacy regulations to allow doctors to communicate about patients with substance use disorder, in other words to treat privacy issues around substance use disorder the same way we treat other mental health disorders or physical medical conditions?***

Some providers err on the side of interpreting 42 CFR Part 2 conservatively to remain compliant. Treating SUD diagnosis like any other diagnosis would allow providers to be more confident in their ability to share information. Modernizing 42 CFR Part 2 would clarify data sharing between providers. Additionally, care teams for individuals with SUD are increasingly composed of individuals outside of strict clinical roles, such as peer recovery support specialists, and the ability to include these individuals as part of the care team is crucial for comprehensive care. In recent years, progress has been made in addressing SUD stigma. This is making some of the intent behind 42 CFR Part 2 obsolete. However, it is important to be vigilant for possible effects of discrimination and stigma of SUD diagnosis in revisions of 42 CFR Part 2.

4. ***In Fiscal Year (FY) 2019 and FY 2020, Congress approved funding for the Centers for Disease Control and Prevention's (CDC) Overdose to Action OD2A grants, which primarily go to states, but has a requirement that 20 percent of the prevention funds go to local health departments. How is your state working with local jurisdictions to ensure that these funds reach local communities?***

In WV, OD2A funds five local health departments to implement Quick Response Teams (QRTs). Twenty-four to 72 hours after a non-fatal overdose, a team visits the individual with the goal to link them to services and treatment. This model has been successfully implemented in Huntington, WV. The state is expanding these teams through OD2A, SOR grants, and state funds.

5. ***How is your state partnering with localities to ensure that they can help inform the state's strategy in addressing opioid misuse?***

In late 2018 to early 2019, the Bureau for Behavioral Health (BBH) sponsored six regional listening tours across the state to not only to provide information about state priorities and funding opportunities associated with SOR, but to also receive feedback for community needs. Additionally, the WV Office of Drug Control Policy (ODCP) invited community partners to participate in the state's strategic plan process to address SUD. There were six full-day sessions where a draft of the strategic plan was presented; community members then broke into small groups to make recommendations for activities to prioritize. This information was compiled and used to inform the final draft of the plan.

The success of the SOR and ODCP regional meetings influences how WV prioritizes its work. Additionally, DHHR participates in multiple workgroups led by the state's Behavioral Health Association to receive firsthand information from treatment providers, which guides work and priorities. The Bureau for Public Health (BPH) conducts monthly calls with local health departments to disseminate information, listen to local concerns and develop action plans. BBH also elicits feedback from the WV Mental Health Consumers Association concerning priorities and services needed.

6. ***How are your state and local health departments working in partnership once the state receives grant dollars to ensure local communities have the resources that they need to address substance misuse and prevent substance use disorders and overdoses?***

DHHR works closely with local health departments (LHDs) on several key areas including harm reduction programs (HRPs), QRTs, and naloxone distribution. Over the last two years, the agencies have worked hand-in-hand to address community concerns around public safety (syringe litter), stigma, infectious disease and adequacy of community resources. This approach has resulted in the deployment of increased funds and sharing of staff to address identified needs. In addition to the local and state partnerships around policy and programs, the OD2A grant funds a position with BPH to coordinate all QRTs regardless of funding source. DHHR believes it is crucial that LHDs and other community partners have access to an individual that can leverage expertise at the state level and be able to address common barriers through policy and position statements. There are 15 LHDs that have a harm reduction program, and BPH has a coordinator position to serve as a liaison and resource. Through this participation, the coordinators have the knowledge and ability to increase access to naloxone for the respective program's LHDs, thereby streamlining processes, knowledge and resource dissemination.

7. ***We know that many of the interventions needed to address substance use disorder rely on a strong public health workforce, but there is currently a workforce shortage in the behavioral health space. What types of professionals are needed in your state to help address the opioid crisis, and to prevent future crises, as well?***

WV has the lowest workforce participation in the nation. This has a direct impact on the ability of community providers to implement initiatives. As a result, the state is experiencing

extreme workforce shortages at every level of behavioral health from psychiatry and therapists to support staff. Currently, WV's greatest behavioral health workforce need is therapists. Treatment providers and teachers have stated that this is the largest barrier to expansion services from prevention to treatment. Addressing the mental health needs of both individuals with SUD and their families will help to address the problems of today and build future resiliency. WV also has a social worker shortage. These professionals fill multiple roles in the state from prevention to child welfare workers to part of SUD treatment teams. Another area the state needs substantial investment in is behavioral health professionals that work with children and adolescents, both within and outside of the school systems. A large focus is on treatment for those with SUD currently, which is appropriate. However, WV also needs to build a robust children and adolescent mental health system for prevention of SUD, and to increase resiliency and address trauma for children impacted by the drug crisis.

8. ***The federal government has appropriated millions of dollars to fund Prescription Drug Monitoring Programs (PDMP) through the Hal Rogers program and others. According to the White House Office of the National Drug Control Policy (ONDCP) PDMPs are "a tool that can be used to address prescription drug diversion and abuse." What challenges still exist with PDMPs?***

WV is one of only a few states that uses a local vendor, Mahantech, for the PDMP. Because of the local connection and the nature of the contract, the WV Board of Pharmacy has access to all data and can enhance the PDMP as innovation and advances on best practices occur. One of the challenges WV is currently experiencing relates to growing pains from the transition of taking the PDMP from a clinical decision-making tool to a public health surveillance tool and using it as a mechanism to track prescribing patterns. Another challenge the state faces is ensuring the location of the practitioner in all prescribing records, including the PDMP and the Drug Enforcement Administration (DEA) maintained lists, are updated and consistent with each other. While this is not a major concern for clinical decisions, it creates barriers in using PDMP data for surveillance and descriptions of prescribing patterns.

Regulations that govern the use of PDMPs often lag behind the identified potential uses of the data. For example, researchers and law enforcement may not be able to access and use PDMP data. In general, while PDMPs have been around as clinical decision-making tools for over a decade, the enhanced usage of the data is in its infancy. The Prescription Drug Overdose (PDO) grant funded the first PDMP analytical team in WV. In March 2017, the WV Board of Pharmacy hired their first epidemiologist, which was quickly followed by a second epidemiologist and data analyst. This enhanced capacity for data analysis has increased the data usage in guiding state policy and tracking prescribing trends in a timely manner. In other words, decreasing barriers associated with using the PDMP as a clinical decision-making tool have made large strides in past years, but using the PDMP data in other capacities is still growing.

   a. ***How much has your state received and spent on its PDMP to date?***

BPH has allocated approximately $2,000,000 to the WV Board of Pharmacy, the agency that houses the states PDMP, through the CDC grants BOOST and Prescription Drug Overdose: Prevention for States (PDO). The PDMP is also supported by WV Board of Pharmacy mechanisms.

b. Is there any data or reports that detail the positive outcomes from utilizing a PDMP?

While WV believes there are positive outcomes in using the PDMP as a clinical decision-making tool, the state is finding its use as a public health surveillance tool extremely valuable. In 2017, BPH, in collaboration with CDC, the WV Board of Pharmacy, and other stakeholders, conducted an analysis of people that died from an overdose in 2016. Death records were matched to multiple data sources including the PDMP. Results indicated that 40% of people that experienced a fatal overdose had filled a controlled substance prescription within 30 days of death; 66% had filled a prescription within a year of death; and 91% were identified as having at least one controlled substance prescription within their lifetime. By matching data sources, WV also identified that 33% of people that had a fatal overdose had a controlled substance in their system at death but did not have a current prescription.

These results helped to both guide recommendations of the Opioid Rapid Response Plan and inform legislation. During the 2018 WV legislative session, legislation was introduced to limit the days of initial prescriptions, an expansion of prior initiatives to address overprescribing. This action, combined with other initiatives, has resulted in a 50% decrease in opioid doses dispensed from 2014 to 2019. The PDMP data has also been used for targeted messaging for academic detailers. There were a few geographic regions with high co-prescribing rates of benzodiazepines and opioids; academic detailers were able to target messaging to providers in those regions to address co-prescribing. The WV Board of Pharmacy provides a monthly surveillance report to track trends in doses dispensed, number of naloxone prescriptions, and MAT prescriptions, among others. This has allowed the state to monitor effects of initiatives and policies. Currently, PDMP data is being used to assess the scope of SOR activities, as well as identify gaps in MAT providers in the state.

9. Some concerns with PDMPs include a lack of real time data and a lack of interoperability with other states. Do you agree PDMPs face these challenges?

Initially, this was a concern since WV has a local vendor. However, the WV Board of Pharmacy leveraged PDO funding to integrate with the Après Health Gateway to allow for greater interoperability. An additional concern with inter-state sharing is the ability of state systems to support additional queries from other states. This concern is addressed by limiting the number of states that have access to the system to states that border WV. Timeliness of PDMP data in WV is less of a concern. There are potential lags in data based on when data is entered and system updates. However, this lag is approximately 48 hours, which is likely the shortest timeframe that is realistically achievable.

a. ***If so, are these challenges preventing prescribers and pharmacists from having access to all of the information needed to make an informed decision about whether to prescribe or dispense?***

Overall, these concerns could affect decision making, but in general are not large concerns. Prescribers and dispensers in WV can query bordering states where patients are most likely to receive normal care. Additionally, other safeguards related to opioid prescribing have been put in place through insurance mechanisms such as prior authorizations and lock-in protocols for some of the larger payors in the state. WV has learned there is no one solution, but a multi-level approach with checks and balances within and across systems is needed to fully address the crisis.

b. ***If so, how can we address these problems and improve PDMPs?***

In general, many of the concerns with usability of PDMPs have been addressed. The state continues to increase uptake of options made available through PDO, but the infrastructure is in place to allow integration and inter-state queries.

10. ***Does your state's PDMP use HIPAA standards or any named federal standard for data transmission?***

Yes, the state follows HIPAA.

11. ***Many states are able to share PDMP data across state lines. However, it is my understanding that even if states are connected to an information hub, those states may not have access to state information for all other states connected to that same hub. Is that an issue that your state faces and/or that you are aware is an issue in other states?***

As mentioned previously, there are technology infrastructure concerns with allowing all states to have access. As states address overprescribing through legislation, this decreases the number of people that would be able to take advantage of these issues. Furthermore, in WV, Medicaid and PEIA, the public employee health insurance agency, have mechanisms in place related to opioid prescribing, which adds another layer of oversight when insurance is the payor.

a. ***Would states having the ability to access information across all state lines assist in fighting the epidemic?***

Access to border states' information is critical; access to states outside of where residents usually receive care would have less impact. This is also an example of why using PDMP data in multiple ways is critical. By analyzing prescribing patterns, states can identify prescribers that may be overprescribing and investigate

appropriately, and not just rely on patterns of patient use. By treating the PDMP as a comprehensive data resource, states can expand the ability to identify problematic opioid use and prescribing.

12. What were the circumstances that you believe led to the opioid crisis in your state?

From 2006 to 2014, there were over 1.1 billion prescription pain pills supplied to WV. In 2011, the state had the highest prescribing rate at 139.6 per 100 persons. WV also has a high rate of disability with 39.2% of adults reporting a disability compared to the 25.6% national rate. This is not surprising due to WV's large blue-collar workforce, which comes with risk of injury. Additionally, WV had a slower than average recovery from the 2008 financial crisis. The situation was compounded when dependence became addiction as the state began to address overprescribing and pill mills within communities. As these problems grew, it became evident that the state had an inadequate treatment infrastructure, including the workforce, to meet what felt like a sudden demand for treatment resources.

In recent years, WV has been on the forefront of the evolving drug crisis, with fentanyl and fentanyl analogs appearing in toxicology reports before many other states, as well as methamphetamine which makes addressing the current needs more challenging. The state has been required to address the crisis while being in the midst of it. Federal funds allowed the state to drive large, systematic change to address gaps in services and increase treatment and prevention. Current concerns include the ability to sustain present efforts while adapting to the ever-changing needs of the drug crisis. This work must be completed while also responding to the child welfare crisis that is a consequence of this epidemic.

13. How does your state ensure that opioid federal grant funds are not diverted for unauthorized purposes?

The majority of federal grant funds have been awarded and distributed to DHHR. DHHR has rigorous guidelines associated with contracts and sub-awards, and awards grants to outside entities to perform an assortment of programmatic functions or activities funded with federal and state resources. While there are slight variations within and between agencies, they follow the same overall guidelines. BBH's process is provided as an example: The grant soliciting process starts with an Announcement of Funding Availability (AFA). BBH releases an AFA through an established public announcement process. AFAs note the services to be provided, the geographic location for those services, the budget limits, grant expectations/requirements, and request a proposal for the delivery of the specified services.

After a public application period, all grant applications are reviewed using an independent proposal review team. Proposals are scored based upon their content, and the review team provides funding recommendations to DHHR leadership for consideration and final decision. In consideration of programmatic awards, WV looks at past performance of program applicants, ability to provide required activities, ability to provide services in the needed geographic location(s), and ability to manage federal funds per required guidance.

In some instances, DHHR may direct award agencies for specific programs. In these cases, the agencies selected are the only providers eligible for this service. These awards may be in the form of a grant award or a purchase contract. An example of this type of process would be a contract with a data platform provider that is the sole source provider of an eligible software solution.

Two formal mechanisms are used to monitor contractors and grantees after money has been awarded, audits and compliance checks. DHHR maintains policies and procedures to oversee the grant award and monitoring process to ensure services are delivered in accordance with the applicable grant agreement or contract. Processes allow for the review of sub-awardee audits. Additionally, the state requires reporting from grantees on activities and other data points such as the number of persons served.

An additional level of scrutiny to opioid-related funding is provided by DHHR's Office of Drug Control Policy (ODCP). The ODCP, at the direction of the DHHR Cabinet Secretary, facilitates regular meetings involving the Commissioners of each DHHR Bureau and Office that has activity related to SUD services. In this meeting, Commissioner and Director-level staff discuss current funding and initiatives. The purpose of this meeting is to ensure all funding is distributed with both an emphasis on state needs/initiatives while remaining within the guidance of the awarded funds.

14. How does your state ensure that opioid-related federal grant funds are going directly to the communities most affected by the opioid crisis?

Per the STR grant, WV completed both a strategic plan and a needs assessment. These processes, combined with statewide regional meetings and the ODCP strategic plan, have noted regional needs and service gaps while providing a cumulative framework for utilizing federal and state funds to address the identified needs. An additional factor in determining localities that receive funding is a response to the guidance of the specific funder and funding source. This is combined with a need to balance statewide needs and oversight with local needs and service capacity. For example, in response to one federal grant, state-level stakeholders assembled and developed a strategy to expand WV's existing partnership with the U.S. Drug Enforcement Administration (DEA) to address prescription drug control in in the state. This strategy included the formation of an assessment team to determine appropriate responses to enforcement actions. Local health departments (LHDs) have credibility with both local and state-level stakeholders, as well as surveillance and evaluation capacity. DHHR has been working with LHDs to disseminate analyses of prescribing and overdose trends. LHDs are also jurisdictionally positioned throughout the state to perform the contractual services. This allows leverage for implementation of two major strategies, QRTs and harm reduction programs.

Every WV county and every community is impacted by this issue and can justify need; as such, some level of funding has been provided to every county. Because of large population variations in WV's 55 counties, 27% of the county-level federally funded sub-awards were allocated to the top 11 burdened counties. Further, 51% of this funding was allocated to the top 22 burdened counties.

DHHR uses both a purchasing process and a competitive Announcement of Funding Availability (AFA) process to determine which local government entities receive federal funding, with prioritization given to specific areas of need/personnel in agencies to develop programs. As part of the AFA, communities must specify and explain their need. This is incorporated into the application scoring rubric. The state also reviews data regularly: burden, need and service availability in the region. This has led to targeted outreach to organizations and funding opportunities limited to geographic areas that are high in burden and low in services. However, the general lack of workforce has inhibited the ability of at least one project directed at a high need community. The community lacked infrastructure to be able to receive funding and meet compliance in accordance with the state's agreements.

The Honorable Bob Latta (R-OH)

1. ***In addition to the STR and SOR grants, how many other federal grants have your states received related to opioids or substance use disorder prevention and treatment?***

In addition to the STR and SOR grants, West Virginia has received the following federal grants related to opioids or SUD prevention and treatment:

Grant	Year(s)
Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality	FFY16, FFY17, FFY18
Overdose Data to Action	FFY19
Prescription Drug Overdose Prevention for West Virginia	FFY16, FFY17, FFY18
Public Health Emergency Response - Cooperative Agreement to Emergency Response - Public Health Crisis Response	FFY18
Expansion of Naloxone Distribution to EMS Agencies and WV State Police and High Risk Selected Communities Pilot Prevention Programs	FFY18
Comprehensive Abuse Site-Based Program	FFY19
Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes	FFY19
Public Health Emergency Response - Cooperative Agreement to Emergency Response - Public Health Crisis Response (in-kind)	FFY18
WV PDO Grant Contribution	FFY16, FFY17, FFY18, FFY19
Substance Abuse Prevention & Treatment Block Grant	FFY16, FFY17, FFY18, FFY19
WV Strategic Prevention Framework for Prescription Drug	FFY16, FFY17, FFY18, FFY19
Strategic Prevention Framework-Partnerships for Success	FFY16, FFY17, FFY18

2. ***I understand that the various federal grant programs have different requirements, timelines, applications, etc. How does this administrative burden impact your state?***

Each of the federal grant programs received by WV contain distinct requirements for reporting, applications, compliance, etc. The various requirements do add an administrative burden to the state in monitoring the differing requirements to ensure all funding is utilized

and distributed according to the specific guidelines of each grant program. Specific impacts to the state related to the varying requirements of differing grant programs include, but are not limited to, the hiring of additional compliance staff, training time for current staff, training time for sub-awardees of each program, time spent completing applications, maintenance of multiple reporting processes to include purchasing of new software and modification of existing platforms and mechanisms, and revisions of state processes to meet varying requirements. The time, effort, and expense related to addressing varying requirements has direct impacts on the amount of funding that ultimately reaches the individuals in need. However, it is understood that these requirements are maintained to verify the funding is being used by states to meet the intent of each grant program and allow for funding with a narrower focus. Additionally, some of the staggered timelines allow the state the ability to distribute workloads across the year. However, if grants have the same focus and comparable structure this increases administrative and programmatic burden.

a. ***Would it be helpful for the federal opioids and substance use disorder grants to have more standardized application requirements and processes?***

WV agrees that standardizing the application requirements and processes could allow for more streamlined workflow for the agency and personnel and enhance productivity. The differences across applications can pose a challenge in ensuring all requirements are met to ensure a complete and competitive application. However, WV acknowledges that in order to meet some goals of funding standardization may not be appropriate.

NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
KODY H. KINSLEY • Deputy Secretary for Behavioral Health & IDD

The Honorable Frank Pallone, Jr.
Chairman
House and Energy and Commerce Committee
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Pallone,

I want to sincerely thank you for the opportunity to appear before the Subcommittee on Oversight and Investigation at the hearing entitled "A Public Health Emergency: State Efforts to Curb the Opioid Crisis." I appreciate the opportunity to share North Carolina's response to the opioid crisis in our state, and the essential role that the federal opioid funding has played in that response. North Carolina has deployed the federal opioid funds to execute the North Carolina Opioid Action Plan, the statewide strategic plan to turn the tide on this deadly crisis and support counties and communities on the front lines. As I said in my testimony- these federal opioid funds saved lives, and helped North Carolina turn the tide on its opioid crisis. Still, much more work is needed to turn back overdose deaths to pre-epidemic levels and to build the infrastructure needed for a stronger and more resilient North Carolina. Thank you for your and the Committee's leadership on this critically important issue.

Enclosed are the answers to the honorable committee members questions. Please reach out to me with any additional questions.

Sincerely,

Kody H. Kinsley,

Deputy Secretary
Behavioral Health and Intellectual and Developmental Disabilities
North Carolina Department of Health and Human Services

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"

January 14, 2020

Mr. Kody Kinsley, Deputy Secretary, Behavioral Health and Intellectual and Developmental Disabilities, North Carolina Department of Health and Human Services

The Honorable Brett Guthrie (R-KY)

1. As you may be aware, section 7063 of the SUPPORT Act (P.L. 115-271) encourages public-private partnerships to assist with addressing the opioid crisis, specifically for infants with Neonatal Abstinence Syndrome (NAS) and their mothers. While section 7063 is specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) efforts, could you provide information on how your state is using public-private partnerships. In addition, please provide areas of need for where the federal government can work with other entities to better leverage community resources.

North Carolina has leveraged a number of public-private partnerships to advance care for pregnant and parenting women and infants that have been impacted by the opioid crisis. An example list of current programs is detailed below.

To advance the care of infants with NAS and their mothers, North Carolina needs continued movements towards and investment in integrated care that addresses the needs of the mother-child dyad. This includes expanding the number of treatment providers that work with pregnant and parenting women through expanded training opportunities as well as models that incentivize integrated and high quality care. The federal government can also partner with states to expand resources and supports to implement the federal CAPTA requirement that children that are born substance affected receive a plan of safe care that helps connect the mother-child dyad to needed supports.

2. Are treatment programs in your state able to share substance use disorder medical records so that they can coordinate care for patients with opioid use disorder?

   Treatment providers are able to share medical records are governed by the relevant 42CFR and HIPAA regulations.

   a. Is your state struggling with getting patients to outpatient treatment centers due to the inability of providers to see a patient's full substance use disorder medical record?

There are substantial barriers to getting patients into outpatient treatment centers, including affordability and physical access. Currently providers are able to share records with the patients signed consent. However, as detailed in the answer below, confusion about 42 CFR Part 2 on behalf of providers can lead to an overcorrection and limit coordination.

b. Are there policies that Congress can fix to help states with improving outcomes for substance use disorder and lower the costs of increased Medicaid spending in emergency departments?

Policies that support more integrated care, earlier intervention, and accessible treatment in lower cost settings help both improve outcomes and lower the costs of increased spending in emergency departments. This includes increased investment in upstream prevention, including earlier access to mental health supports for adverse childhood experiences, and moving towards a 'no door is the wrong door' policy for access to evidence based, high quality addiction treatment. It also includes investments that help improve care coordination and case management for people with substance use disorders.

3. Do you think it makes sense to revise the 42 CFR privacy regulations to allow doctors to communicate about patients with substance use disorder, in other words to treat privacy issues around substance use disorder the same way we treat other mental health disorders or physical medical conditions?

There are two sets of issues around 42 CFR privacy regulations and care coordination: misunderstanding around 42 CFR Part 2, and then the way that the letter of 42CFR impacts privacy and coordination.

Misunderstauding about 42 CFR is widespread. 42 CFR Part 2 was initially promulgated in 1975. As addiction treatment has modernized, including integrating medication assisted treatment to innovative care settings including hospitals, primary care practices, Federally Qualified Health Ceuters, and others, there is common misunderstanding arouud what records in what settings are Part 2 records, and what types of providers are Part 2 providers. This can lead to providers overcorrecting, which limits care coordination and appropriate record sharing, for example when there is the patients consent. Updated clarification that clearly lays out key points of confusion with 42 CFR Part 2 in the modern treatment landscape can greatly improve care coordination.

Changes to 42 CFR must both consider the real and ongoing stigma of substance use disorders, as well as the modern tools now available to ensure record privacy while allowing for care coordination. Treatment must move towards more integrated and

coordinated care. However, people with substance use disorders continue to face discrimination for their chronic medical condition. Fundamentally, we must address the underpinning stigma around substance use disorders.

4. In Fiscal Year (FY) 2019 and FY 2020, Congress approved funding for the Centers for Disease Control and Prevention's (CDC) Overdose to Action OD2A grants, which primarily go to states, but has a requirement that 20 percent of the prevention funds go to local health departments. How is your state working with local jurisdictions to ensure that these funds reach local communities?

North Carolina has deployed funds to over 32 local governmental entities and has budgeted over 30% of its Overdose Data to Action grant to go directly to local health departments. NC DHHS competitively awarded 22 local health departments to implement key strategies from the opioid action plan: expansion and support for syringe exchange programs, programs that support justice involved persons, and expanding or creating post overdose response teams.

5. How is your state partnering with localities to ensure that they can help inform the state's strategy in addressing opioid misuse?

North Carolina's strategy is guided by the North Carolina Opioid Action Plan. This strategic plan to combat the opioid epidemic in North Carolina was recently updated to respond to the changing epidemic, and Governor Cooper launched the new version of the Opioid Action Plan in June of 2019. The update process of this strategic plan involved widespread stakeholder engagement, including open to the public input and listening sessions, outreach to key stakeholders, counties and communities.

6. How are your state and local health departments working in partnership once the state receives grant dollars to ensure local communities have the resources that they need to address substance misuse and prevent substance use disorders and overdoses?

North Carolina has worked closely with its counties and communities to deploy funds in our hardest hit areas. In the most recent grant, the State Opioid Response Grant, more than two thirds of the grant went to counties, community based-organizations, and tribes, and to provide treatment to people without health insurance out in the communities. North Carolina has deployed its funding to more than 50 local government organizations, including health departments, jails and county EMS, the Eastern Band of the Cherokee Indian, North Carolina's only federally recognized tribe, community-based organizations, local hospital systems, and community coalitions across the hardest hit areas in the state. We have also leveraged onr existing behavioral health system, through the licensed managed entity- managed care organizations (LME-MCOs), to quickly distribute funds to provide treatment to uninsured people out in the counties and communities. Increased fnnding for treatment are regularly one of the top reqnests North Carolina receives from counties and communities.

NC DHHS regularly convenes local health departments, including hosting a regular opioid work group for local health directors so that local health directors can regularly and directly communicate needs, advice, and on the ground feedback. NCDHHS also convenes quarterly a meeting of over 100 statewide stakeholders from counties and communities.

7. We know that many of the interventions needed to address substance use disorder rely on a strong public health workforce, but there is currently a workforce shortage in the behavioral health space. What types of professionals are needed in your state to help address the opioid crisis, and to prevent future crises, as well?

   Where North Carolina sees the greatest shortages in workforce are our large rural areas. This includes physicians and psychiatrists trained in addictions, other prescribers such as PAs and NPs, as well as licensed cliuical addiction specialists and certified peer support specialists. The help address the opioid crisis and future crises, there must be a combination of increased education, incentives for behavioral health care to practice, and investments in technology which in combination build the needed rural behavioral health infrastructure. Continuing education of prescribers, improved funding for alternatives for pain management, a more robust and compensated workforce, treatment on demand and better utilization of the PDMP all factor into prevention of future crises.

8. The federal government has appropriated millions of dollars to fund Prescription Drug Monitoring Programs (PDMP) through the Hal Rogers program and others. According to the White House Office of the National Drug Control Policy (ONDCP) PDMPs are "a tool that can be used to address prescription drug diversion and abuse." What challenges still exist with PDMPs?

   PDMPs are a critical tool to both preventing prescription diversion and misuse and also equipping providers with improved point of care information for clinical decision making. North Carolina is appreciated of the federal investment in PDMPs to increase both the use and usefulness of these important tools.

   There are still some challenges that would further improve PDMPs. This includes enhances support for patient matching to better resolve patient entities. For example, patients may occasionally be duplicates, or have identical names. Similarly, expanding supports to increase registration and utilization of providers is needed. Finally, North Carolina has been investing in tools to increase the ease of use of PDMPs, but has the differeut types of end users grow, there are increasingly different end point needs.

   a. How much has your state received and spent on its PDMP to date?

Between 2009 and 2019, North Carolina received 2.94 million federal dollars for its PDMP. Between 2009 and 2019, the State spent $6 million on its PDMP, with state dollars making up the remainder of the expenditure.

b. Is there any data or reports that detail the positive outcomes from utilizing a PDMP?

Support and increased utilization of the PDMP is a strategy in the North Carolina Opioid Action Plan. The PDMP is also leveraged in North Carolina's Opioid Data Dashboard, accessible here: https://injuryfreenc.shinyapps.io/OpioidActionPlan/ **. This helps counties know their own data, including the burden and availability of treatment in their area.**

9. Some concerns with PDMPs include a lack of real time data and a lack of interoperability with other states. Do you agree PDMPs face these challenges?

The PMP Clearinghouse does provide the option to enable real time reporting. For background, NC G.S. 90-113.73 (a) outlines, "The dispenser shall report the information required under this section no later than the close of the next business day after the prescription is delivered; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered" which is as stringent as the majority of states. NC PDMP is now pushing for entities to integrate the CSRS with their EMR/PMS. Through the web portal, users have access to search 40 other states/territory PDMP to include Military Health System and Puerto Rico. Gateway Integration current allows for NC integrated users to query 3 other states due to other states legislation.

If so, are these challenges preventing prescribers and pharmacists from having access to all of the information needed to make an informed decision about whether to prescribe or dispense? If so, how can we address these problems and improve PDMPs?

It is a concern that when prescribers and pharmacists need to access the PDMP outside their workflow it takes additional time and the efforts that North Carolina is taking to mitigate these concerns are described in the next question. Though users may not be integrated, they still have access to PMP AWARxE web portal to query other states' data.

North Carolina has recently adopted Gateway, a program which connects the PDMP to EHR (Electronic Health Records) enables practitioners and pharmacists to access the PDMP in one click within their workflow. This will allow prescribers and pharmacists to quickly access the PDMP information and North Carolina is working to integrate prescribers and pharmacists throughout the state. As more entities integrate, it will be easier for practitioners and pharmacists to access PDMP in the course of their typical workflow.

There are opportunities to improve PDMPs, including through strengthening pharmacy software systems to enable them to utilize the 'Enable Real-Time Reporting' functionality.

Additionally, increasing tools for education and training on the use of PDMPs, and supports to implement reporting by the end of the business day, as well as improving compliance enforcement for states that have mandatory PDMP checking laws.

10. Does your state's PDMP use HIPAA standards or any named federal standard for data transmission?

All data transmitted within NC is HIPAA compliant.

11. Many states are able to share PDMP data across state lines. However, it is my understanding that even if states are connected to an information hub, those states may not have access to state information for all other states connected to that same hub. Is that an issue that your state faces and/or that you are aware is an issue in other states?

North Carolina PDMP is interoperable with 40 other PDMPs, including all bordering states, as well as, Puerto Rico and the Military Health System through PMPi Hub. North Carolina is also in the process of connecting to RxCheck which will allow for connection with the few additional states that are not on the PMPi Hub. While North Carolina has been working hard to connect with other states and entities, however there are other states whose current legislature do not permit that state PDMP to share data with other state PDMP's or they are restricted to only sharing with neighboring states.

a. Would states having the ability to access information across all state lines assist in fighting the epidemic?

NC currently is sharing data with 40 other states/territories nation-wide via our web portal but only 3 states via Gateway Integration. This interstate sharing feature works differently in the web portal and the Gateway Integration. In the web portal, the user can select which states they would like to query for their patient. With the Gateway Integration product, each entity must be approved separately by each state for access to their data. If approved, every state that approved that entity for interstate sharing is queried automatically for every search. The more state's queried for one search, creates more risk for errors in patient matching.

It appears that this functionality is available for other states to utilize in a similar fashion as North Carolina. While there is still much work to be done, most states have connected with the majority of state PDMPs. Transactions of connections can be seen here.

12. What were the circumstances that you believe led to the opioid crisis in your state?

The opioid epidemic, while unique in scale, shares the roots of previous substance use outbreaks in North Carolina and across the country. A systematically underfunded and

undersupported behavioral healthcare system, stigma and a lack of public understanding about addiction, aud a historically punitive response to substance use disorders met rapidly growing rates of opioid prescribing. Many prescribers were unaware of the dangers of over-prescribing opioids and the risks of addiction were minimized, and were slow to come to light. More than 12,000 North Carolinians had died of opioid overdoses from 1999 to when the first major SAMSHA federal opioid awards arrived in 2016.

13. How does your state ensure that opioid federal grant funds are not diverted for unauthorized purposes?

The Department of Health and Human Services uses programmatic, contract and budget staff to provide strict oversight of its grants to ensure that dollars are speut for the awarded purposes. Divisions also requiring reporting back from subgrantees to ensure appropriate use of funds. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, which is the SSA for SAMSHA's federal opioid grants, provides clinical, programmatic and fiscal oversight and monitoring of managed care organizations (MCOs) and providers to assure appropriate use of funds. NC contracts with seven MCOs that in turn contract with credentialed providers across their catchmeut areas. These MCOs are responsible for monitoring and oversight of their provider network.

14. How does your state ensure that opioid-related federal grant funds are going directly to the communities most affected by the opioid crisis?

North Carolina monitors overdose burden at the county level using 13 metrics, including overdose deaths, overdose emergency department visits, EMS naloxone administrations, and more. NC DHHS makes the data publicly accessible through the North Carolina Opioid Data Dashboard (https://injuryfreenc.shinyapps.io/OpioidActionPlan/) which enables counties to have ready access to their data and for the state to use consistent overdose metrics. In a recently conducted vulnerability assessment, Graham, Swain, Cherokee, Wilkes, and Michell counties were rated as the most vulnerable counties based on overdose and injection drug related infectious disease rates per capita. However, the counties with the greatest total number of opioid overdose deaths include Wake, Durham, Mecklenburg, New Hanover and Buncombe Counties.

The Honorable Bob Latta (R-OH)

1. In addition to the STR and SOR grants, how many other federal grants have your states received related to opioids or substance use disorder prevention and treatment?

Since 2016, North Carolina has received the following major federal awards to respond to the opioid epidemic through prevention, treatment, and recovery. The below grants total to $112.48M

over three years, or $37.5 million per year. By the end of 2020, $104 million of the total $112M will be completed.

Grant Name	Total Amount Awarded	Start date	End Date
SAMSHA State Targeted Response (STR) Grant	$31,173,448	05.01.17	01.31.20
SAMSHA State Opioid Response Grant	$46,066,632	09.30.18	09.29.20
SAMSHAM State Opioid Response Grant Supplement	$12,023,391	09.30.18	09.29.20
SAMSHA State Prevention Framework for Prescription Drugs (SPF-Rx)	$1,858,080	9/1/2016	8/31/2021
SAMSHA Medication Assisted Treatment-Prescription Drug and Opioid Abuse Program (MAT PDOA)	$2,873,291	09.01.16	08.31.20
CDC Public Health Crisis Response Funding for Opioid Overdose Preparedness and Response	$4,058,976	9/1/2018	11/30/2019
CDC Overdose Data to Action (OD2A) Gran	$7,003,731	9/1/2019	8/31/2022
CDC Prevention for States (PfS) Grant	$6,263,984	9/1/2015	8/31/2019
CDC Enhanced Surveillance of Opioid-Involved Morbidity and Mortality (ESOOS)	$1,166,004	9/1/2017	8/31/2019

2. I understand that the various federal grant programs have different requirements, timelines, applications, etc. How does this administrative burden impact your state?

   Some of the federal opioid funds, in particular the SAMSHA State Targeted Response and State Opioid Response grants have prioritized flexibility of dollars. This is critical for allowing states to target strategies most needed in their area.

Two administrative issues which do place a burden on the state which, if mitigated, would greatly increase North Carolina's ability to rapidly deploy federal funds to local communities in need. Short planning periods make it difficult to deploy funds with sufficient time for local communities to effectively plan and complete projects. If the state receives sufficient notice of funding and the intent of the funding, it can work to partner with local communities, provide support to the communities, and complete much of the state subcontracting processes in advance so that funds can be deployed to the communities as soon as the state receives the funding. Short funding cycles are an additional challenge. In addition to the aforementioned issue, one of the greatest needs across local communities is the ability to build their own capacity. When federal funds are only allocated for one- or two-year cycles, and future funding availability is unclear, it makes it difficult for local communities to utilize these funds to recruit and hire the staff that they need. This is true for both behavioral health providers and clinical staff, as well as program managers, project directors, and others needed to build a robust community response. Further, many local communities are reticent to begin programs or hire staff on short term grant funding if there isn't certainty about funding to sustain the program.

a. Would it be helpful for the federal opioids and substance use disorder grants to have more standardized application requirements and processes?

It would be helpful for grants to have a more standardized application process, as well as post award contracting processes. We encourage lower burden applications that allow flexibility for states to craft their responses to their needs on the ground. However, North Carolina recognizes that the federal opioid and substance use disorder grants are often deployed for different purposes, and so the requirements and processes should match the goals of the grant.

Establishing consistency around the allowable costs for federal opioid grants, and emphasizing flexibility in those allowable costs would both reduce administrative burden and allow for more integrated responses. For example, North Carolina's CDC OD2A grant provided awards to local health departments for overdose prevention activities, however, the CDC funds cannot be used on naloxone, even though SAMSHA funds can be used to purchase naloxone. This makes it more administratively difficult for both states and counties to have a more integrated response.

Currently, federal funds are not allowed to be used for the evidence-based strategies to prevent overdose deaths and the associated spread of costly diseases, including syringe exchange program supplies and fentanyl test strips. However, more than 80% of opioid overdose deaths in North Carolina involve heroin and fentanyl, and North Carolina has seen a rapid increase in Hepatitis C rates. Providing resources to deploy these proven methods would greatly help North Carolina's ability to nimbly respond to the epidemic as it continues to evolve.

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"A Public Health Emergency: State Efforts to Curb the Opioid Crisis"

January 14, 2020

Dr. Nicole Alexander-Scott, Director, Rhode Island Department of Health

The Honorable Brett Guthrie (R-KY)

Question 1:
As you may be aware, section 7063 of the SUPPORT Act (P.L. 115-271) encourages public-private partnerships to assist with addressing the opioid crisis, specifically for infants with Neonatal Abstinence Syndrome (NAS) and their mothers. While section 7063 is specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) efforts, could you provide information on how your state is using public-private partnerships. In addition, please provide areas of need for where the federal government can work with other entities to better leverage community resources.

Rhode Island (RI) has always taken advantage of its small size by engaging community members within their respective communities to address issues that may arise. RI is divided into 39 municipalities and each municipality has a Regional Prevention Coalition that received federal funding (SOR Grant) to target interventions at their individual community level. Prevention Coalitions are made up of local businesses, law enforcement, community leaders, and often individuals in recovery. Each community conducted a local needs assessment and subsequently offered mini grants to implement targeted responses to the area's identified needs. Many of these grant initiatives included building recovery capital and hosting stigma-reducing events.

Rhode Island has also identified geographic regions where health disparities exist, called Health Equity Zones. We provide targeted funding to those Health Equity Zones to assess prevention, treatment, and recovery resources in their communities, identify service gaps, and make system changes to address them.

RI's Recovery Friendly Workforce Initiative is another project within which we build public-private partnerships and reduce discrimination and biases in the workplace. This program supports businesses to enact business-wide policies and procedures to create a work environment that is accommodating to those in recovery. This eliminates barriers to employment for those impacted by addiction and creates a mutually beneficial situation for the employer and employee.

The Task Force to Support Pregnant and Parenting Families with Substance Exposed Newborns (SEN Task Force) was re-convened in 2016 at the request of Governor Gina M. Raimondo. The SEN Task Force

is comprised of a diverse array of state agencies and local community-based organizations that share a commitment to improving systems of care for families and children affected by substance use. The SEN Task Force has a long-standing history of building collaboration and consensus among state agencies and community organizations within the recovery/treatment and maternal-child health arenas, and includes the RI Department of Health; RI Department of Children, Youth and Families; RI Department of Behavioral Healthcare, Disabilities and Hospitals; RI Executive Office of Health and Human Services; the Governor's Office; the RI Care Transformation Collaborative; birthing hospitals; medical, behavioral health, and mental health providers; Family Homes Visiting; Early Intervention; WIC; Early Head Start; insurance companies; managed care organizations; colleges and universities; content experts; and, parent support groups. The SEN Task Force is currently developing a three-year strategic plan that will articulate goals and strategies in support of promoting equitable access to a bias-free, coordinated system of care that engenders the health and well-being of families affected by substance use.

Areas of need for where the federal government can work with other entities to better leverage community resources are:

- Federal resources to support resource intensive (but cost effective) care coordination between public and private partners to coordinate and support the work with families. With many players, support up front to establish and maintain coordination that is often not covered through other funding mechanisms would be valuable.

- Federal resources to support continued private public partnerships such as the Task Force to Support Pregnant and Parenting Families with Substance Exposed Newborns (SEN Task Force)

- Identifying new and expectant parents as a priority population, extending through pregnancy into the first year of life, and inclusive of all care givers since the health of the carrying/birth parent and newborn are interconnected with the other family members.

- Community based public and private providers have systems in place to provide residential treatment, recovery housing, etc. However, it often takes additional resources to replicate the existing services to be inclusive of families. Providers may know recovery housing but would need a new building to offer the same supports for recoverees with families.

- Another example would be supporting public private partnerships that are building and supporting a statewide recovery workforce. There is value in having certified peer recovery specialists in diverse and varied environments across the state – however, it will complicate the work and leave a vulnerable workforce if recovery specialists are on teams where they themselves do not have peer support. In order to ensure the vitality and stability of the growing recovery workforce, it needs coordinated centralization, professional support and a backbone learning community. This particularly includes, but is not limited to, perinatal recovery coaches working with new and expectant parents.

Question 2:
Are treatment programs in your state able to share substance use disorder medical records so that they can coordinate care for patients with opioid use disorder?

Under 42 CFR Part 2, it is possible to share substance use disorder medical records from federally funded substance use programs to coordinate care, but this disclosure does require specific consent from the patient involved. This need for consent for care coordination is unique to 42 CFR Part 2 and is not necessary under HIPAA or any other state and federal privacy laws impacting Rhode Island. In practice collecting this consent and operationalizing record sharing is onerous for the providers involved, so our understanding based on feedback from our community is that it rarely happens, even in scenarios where record sharing is very important, such as between the psychiatric hospitals and the community providers who will provide follow-up care.

Further, providers are not always aware that 42 CFR Part 2 only covers substance use disorder treatment information, and as a result, treating providers often also hold back information on mental health treatment that could be very helpful to share for care coordination.

Therefore, the sharing of critical behavioral health (including substance use) patient information by providers to support transitions of care and care coordination occurs inconsistently, which can expose patients to medical errors and system waste. In Rhode Island we have identified the following scenarios which explain how individuals' care coordination is impeded:

• **Patient Location:** Psychiatric inpatient and general care hospitals will sometimes withhold patient location information from the Community Mental Health Centers (CMHSs) or Opioid Treatment Providers (OTPs). The CMHCs or OTPs may be searching for a patient, even checking with hospitals, but may end up filing a missing persons' report for them. They often find out later that the patient had been admitted to a psychiatric facility, but the facility did not think they could disclose that patient was admitted. In addition, the CMHOs and OTPs frequently lack other critical information from the inpatient stay, such as medication changes, to help continue recommended treatment post-discharge.

• **Care Coordination:** Medicaid and Commercial Accountable Care Organizations cannot complete recommended care coordination measures – such as follow-up within seven days of a psychiatric inpatient hospitalization – because treating providers at some hospitals do not believe they can share this information. This means that when patients are discharged from the hospital, community providers that are accountable for the patient's care rarely receive notice of the discharge and cannot ensure the patient receives the follow-up care needed to keep them from being readmitted to the hospital.

• **Dashboards**: Many health care providers, especially Primary Care Providers, are sent alerts or have access to a dashboard operated by our state health information exchange that identifies when one of their patients is admitted to or discharged from any ED or hospital in the state. In several instances, a provider was notified that their patient was at the Emergency Department, but if the patient was then admitted to a psych unit or psychiatric hospital, the provider may not be notified because the hospital does not believe it can share that information with the Health Information Exchange, which will then

share it with the provider. The provider is left not knowing what happened to the patient and may think the technology that notifies them about their patient's admissions and discharges is malfunctioning.

• **Care Integration**: From a study on Enrollment in Medication Assisted Treatment for substance use disorder conducted in Rhode Island, we have found that there is clear lack of coordination for those with co-occurring substance use disorder, mental illness conditions and physical healthcare. Most patients receive care in three places for each of these conditions in part because providers choose to not get waivers to share data, are unable to disentangle mental health from substance use data, or unknowledgeable about data sharing.

Lastly, all of this has a significant impact on developing interoperable solutions for health data sharing across facilities and practices in the state. Because of the difficulty of flagging and segmenting substance use data within an electronic health record, these facilities often choose not to share anything electronically with other providers in the state or with our state Health Information Exchange. Rhode Island's Health Information Exchange participated in a pilot with SAMHSA a few years ago and can handle and segment 42 CFR Part 2 data appropriately with patient consent, but this capability is rarely being used because of the technical infeasibility of operationalizing data segmentation.

To make matters even more complicated, each organization interprets how they are allowed to handle this data a little bit differently. For example, some believe they can send the data to the HIE under the Qualified Service Organization (QSO) agreement and let the HIE segment the data, and others believe they must segment before sending the data to the HIE. There have been major difficulties depending on Electronic Health Records (EHRs) to segment the data, meaning that very little data is shared from these facilities, even on patients with only mental health disorders (and not substance use disorders).

While the protections of 42 CFR Part 2 do help to protect the patient from stigma associated with substance use disorders, the harsh reality is that all of this complexity means that care is rarely being effectively coordinated for patients with substance use disorders. We believe that treating substance use disorder treatment data the same as any other protected health information will help reduce stigma over time. To do this well, there should be protections for patients to help keep them from being discriminated against or criminalized for having a substance use disorder, which is a disease that needs treatment, like any other disease.

2a. Is your state struggling with getting patients to outpatient treatment centers due to the inability of providers to see a patient's full substance use disorder medical record?

The inability of providers to see a patient's full substance use disorder medical record is one obstacle identified by providers. There are other issues as well - when for example, providers occasionally feel "in the dark" about important parts of their patient's health history. However, this does have to be considered in tandem with the actual and potential stigma patients experience, even from health care providers. Patients continue to voice concerns about discrimination and bias in the healthcare field and worry about potential consequences if penalties are relaxed.

2b. Are there policies that Congress can fix to help states with improving outcomes for substance use disorder and lower the costs of increased Medicaid spending in emergency departments?

Adding methadone to the Prescription Drug Monitoring Program would allow emergency department prescribers to have a more complete history of their patients. This would prevent inadvertent/unintended prescriptions of additional opioids and benzodiazepines which could have a lethal outcome. Access to this information would need to be protected with strong enforcement of penalties for any violators, since, as previously mentioned, stigma and discrimination are persistent and serious concerns of the community.

Congress could help improve outcomes in emergency departments by exploring the development of a "opioid response team" within the emergency room. This would minimally increase the ED reimbursement cost, but it would also enable the provision of increased discharge support, thereby avoiding recidivism. The best predictor of an overdose death is a prior overdose. We need to improve our approaches to reach and treat individuals who have had multiple overdoses.

Question 3:
Do you think it makes sense to revise the 42 CFR privacy regulations to allow doctors to communicate about patients with substance use disorder, in other words to treat privacy issues around substance use disorder the same way we treat other mental health disorders or physical medical conditions?

We do strongly agree, as was outlined in the response to question number 2. This is long overdue in many respects and further contributes to the stigma surrounding substance use. Having said that, we need to continue to work with the public and prescribing community about stigma and other negative public attitudes around substance use and co-occurring disorders. Additionally, extant polices can interfere with care in emergency departments, but it is important to ensure coherent and responsible follow up for patients with opioid use disorder.

The prospective of the patients as well as of the physicians is important in this manner. Any potential change must consider who has access to the information, what penalties will be enforced, and the inclusion of a clear grievance procedure. Because all consumer voices matter, Congress should hear from individuals who have had their confidentiality violated in order to understand the potential impact of the citizens that we all serve. If patients know that their medical records related to substance use will be shared without their consent, there will likely be some who will opt to not seek treatment.

Question 4:

In Fiscal Year (FY) 2019 and FY 2020, Congress approved funding for the Centers for Disease Control and Prevention's (CDC) Overdose to Action OD2A grants, which primarily go to states, but has a requirement that 20 percent of the prevention funds go to local health departments. How is your state working with local jurisdictions to ensure that these funds reach local communities?

As Rhode Island does not have local health departments, the statewide Rhode Island Department of Health (RIDOH) will use our established partnerships with local Health Equity Zones, which serve identified 'drug overdose hotspots,' to ensure at least 20 percent of the OD2A funding goes to local communities. The Rhode Island OD2A team analyzed overdose data to determine the geographic areas that are disproportionately impacted by the overdose epidemic. RIDOH issued a competitive request for proposal (RFP) asking local HEZs to develop and implement an overdose action plan in their community. Communities are required to use the funding to implement evidence-based practices (EBPs) and/or innovative interventions in their local communities. Additionally, funded communities will develop and implement a response plan to overdose alerts and use RIDOH data to inform their projects. The OD2A team will provide one-on-one technical assistance for the areas of data, implementation, and evaluation to the funded communities. This project will enhance local capacity to respond to the opioid epidemic.

Additionally, the OD2A project will deploy teams of peer recovery specialists dual-certified as community health workers (PRS/CHWs) to communities experiencing overdose spikes on a weekly basis. RIDOH released a competitive RFP and will contract with two local community-based organizations (CBOs) with experience in street outreach and peer recovery programs. Trained PRS/CHWs with lived experience of substance use disorder (SUD) will provide targeted street outreach in these identified overdose spike areas. This outreach will include referrals to treatment, naloxone trainings, referrals to basic needs, and harm reduction education. They will work with communities to target shelters, public transit, and public areas with heavy foot-traffic. The weekly implementation of this intervention in state 'hot spots' will address the opioid epidemic in near real-time.

Question 5:

How is your state partnering with localities to ensure that they can help inform the state's strategy in addressing opioid misuse?

In addition to the strategies listed in #4, RIDOH has convened a weekly Surveillance Response Intervention (SRI) call since 2017. This call, which includes both behavioral health department staff and first responder partners, reviews the most updated overdose data and implements a rapid response. The SRI team has developed thresholds for overdose spike alerts, and they disseminate public health advisories to impacted communities and partners as necessary. Additionally, program staff provide technical assistance to municipalities that receive alerts to help them implement response plans. This weekly communications system ensures ongoing data sharing and enables the implementation of integrated, data-driven interventions at the local level.

The State Opioid treatment authority at the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) also disseminates the SRI information and collects valuable "Hot Spots" information on a weekly call with various widespread community members, including: High Intensity Drug Trafficking Area (HIDTA), Detox managers, certified outreach peer supports, managers of prevention and health equity zones, etc. This has led to rapid deployment of naloxone, the "Rhode to Health" mobile van clinic, and other supportive tools to meet clients where they are as opposed to waiting for them to proactively pursue treatment.

Additionally, in 2016, RIDOH created www.PreventOverdoseRI.org (PORI). PORI is a comprehensive, user-friendly website that compiles data and resources from across the state. The website uses infographics, interactive maps, charts, and videos to provide timely information about Rhode Island's overdose crisis. The state continues to enhance and promote PORI to localities to ensure they have access to data and resources related to the overdose crisis.

As outlined in the Governor's Overdose Prevention and Intervention Task Force's Strategic Plan, there are also nine cross-cutting Work Groups that meet monthly or bi-monthly. These Work Groups focus on: Prevention, Rescue, Treatment, Recovery, Racial Equity, Harm Reduction, Families, First Responders, and Substance Exposed Newborns.

You may find more details about the Strategic Plan and Work Groups on www.PreventOverdoseRI.org.

Question 6:

How are your state and local health departments working in partnership once the state receives grant dollars to ensure local communities have the resources that they need to address substance misuse and prevent substance use disorders and overdoses?

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) co-shares the State Substance Authority with the Executive Department of Health and Human Services (EOHHS). Rhode Island state agencies such as BHDDH, EOHHS, the Governor's Office, RIDOH, the Department of Labor and Training, RI State Police, the Department of Children, Youth and Families, and others have successfully partnered to coordinate federal funding initiatives to effectively use funding and avoid duplication.

Rhode Island developed a new position in state government cakked the State Opioid Grants Administrator, and her primary function is to ensure the effective administration of cross-agency grant-funded programs related to opioid and other drug overdose prevention and intervention activities, through regular meetings, communication, and data tracking. This role helps to coordinate cross-agency alignment and adherence to state-wide overdose prevention and intervention strategic plan. All of the opioid grant funds are reviewed by the State Opioid Grants Administrator, who is responsible for coordinating and leveraging efforts across state agencies and closely tracking spending and activities toward outcomes.

In addition, BHDDH coordinates efforts with RIDOH for all our provider networking, which includes BHDDH-funded Regional Prevention Task Forces focused on coordinating substance abuse prevention activities within seven regions and RIDOH's network of Health Equity Zones (HEZs), which as noted above are focused on a variety of issues related to health promotion, prevention, and social determinants. The Directors of both BHDDH and RIDOH currently Co-Chair Governor Ramonido's Overdose Prevention and Intervention Task Force. Their primary focus and coordinated efforts have been to enforce and build on the Governor's Overdose Strategic Action Plan that addresses Prevention, Treatment, Rescue, and Recovery iniatives for the state. You may also find the action plan on www.preventoverdoseri.org.

Question 7:

We know that many of the interventions needed to address substance use disorder rely on a strong public health workforce, but there is currently a workforce shortage in the behavioral health space. What types of professionals are needed in your state to help address the opioid crisis, and to prevent future crises, as well?

In order to address the opioid crisis, the following types of professionals are in demand:

- DATA-waivered prescribers
- Certified Peer Recovery Specialists
- Certified Community Health Workers
- Licensed Chemical Dependency Professionals
- Psychiatrists
- Individuals willing to work in an Opioid Treatment program
- Qualified prevention workforce
- Psychologists
- Behavioral Health prescribers
- Licensed independent social workers
- Public health professionals with experience in epidemiology, biostatistics, and analytics

In addition to a personnel shortage, there are also financial barriers. For example, we have people who are qualified to be peer recovery specialists and community health workers, yet it is difficult for agencies to allot supportive funding to enable individuals to go through the training and internship process.

Question 8:

The federal government has appropriated millions of dollars to fund Prescription Drug Monitoring Programs (PDMP) through the Hal Rogers program and others. According to the White House Office of the National Drug Control Policy (ONDCP) PDMPs are "a tool that can be used to address prescription drug diversion and abuse." What challenges still exist with PDMPs?

The Federal funding that has been made available to support Rhode Island's PDMP has been critical. The most notably helpful funding to date has been the Medicaid funding made available through Section 5042 of the SUPPORT Act, because it makes the long-term sustainability of the PDMP more feasible as we make enhancements that will increase the ongoing maintenance cost. This Medicaid funding has been especially helpful at the 100% FMAP rate, which ends September 30, 2020, because standard Medicaid funding at 90/10 or 75/25 requires state matching funds which can at times be difficult to identify in the state's limited state budget. It would be helpful if there was more time to use the 100% FMAP rate to provide more time for Rhode Island to make the substantial upfront investments needed to mitigate some of the challenges that still exist with the PDMP.

These challenges include:

- Hiring and sustaining sufficient staff to perform standard administrative functions, improve data timeliness, and improve data quality.
- Hiring and sustaining sufficient staff to develop analyses and evaluation of the PDMP
- Developing the PDMP to be more feature- and data-rich
- Integrating the PDMP into the provider workflow within the EHR to save time and increase PDMP utilization
- Managing interstate data sharing agreements, especially with the complexity that comes with EHR integration of PDMP data from other states

As with many states, the ability to identify what staffing and enhancements are needed, request the approval for federal funding, hire staff, and procure the enhancements takes a significant amount of time. Even though Rhode Island has been one of the first states to take advantage of this funding, we still only have a nine-month period to leverage the 100% FMAP.

8a. How much has your state received and spent on its PDMP to date?

Rhode Island Department of Health (RIDOH) grants and allocations supporting PDMP strategy:

Grant or Allocation	Funding Amount	Funded By	Project Period
Comprehensive Opioid Abuse Site-based Program	$ 2,000,000	DOJ	10/01/2019 – 9/30/2022
Medicaid PDMP Implementation Advanced Planning Document (IAPD) **** This is the 90% federal match for Health Information Technology expenses.***	$ 5,434,238	CMS	9/17/2019 – 9/30/2020
Opioid Overdose Crisis Response Supplement Fund (SURGE) Base	$ 25,000	CDC	9/1/2015 – 8/31/2019
Prescription Drug Overdose Prevention for States (PfS)	$ 2,362,000	CDC	9/1/2015 – 8/31/2019
PDMP-Practitioner & Research Partnerships	$ 113,355	BJA	9/1/2018 – 8/31/2019
Total	**$9,934,593**		

8b. Is there any data or reports that detail the positive outcomes from utilizing a PDMP?

The PDMP is a useful investigative tool for allegations related to diversion. RIDOH has found the PDMP very helpful to illustrate prescribing trends. Please see https://preventoverdoseri.org/prescribing-data/,which illustrates current prescribing trends in Rhode Island regarding opioids as well as other controlled substances. We have recently started using the PDMP to analyze ICD-10 codes in aggregate to determine common diagnoses that resulted in an opioid prescription and subsequent persistent opioid use for greater than 90 days.

Question 9:

Some concerns with PDMPs include a lack of real time data and a lack of interoperability with other states. Do you agree PDMPs face these challenges?

Yes, PDMPs do need more real time data and better interoperability with other states. Rhode Island currently requires data be reported within one business day, but especially with smaller pharmacies, staff are required to monitor reporting timeliness. Ideally, we would prefer the data be real-time, but understand that may pose significant resource and technical challenges to small pharmacies and will need to be phased in over time.

With respect to interoperability with other states, this is more complex. Through the state exchanges, PDMP Interconnect, and RxCheck, Rhode Island is exchanging data with 29 states; however, this is only sharing within a website user interface. Interstate data sharing through EHR integration will need much more attention and work to come to agreements, because states may have different requirements for user types, security protocols, and data storage. With Medicaid PDMP funding, we have added staff to help reach out to states and develop agreements with other states for EHR integrations to ensure that

providers receive the same amount of interstate data whether they use the PDMP website or view PDMP data within their EHR. We anticipate this will be very slow and time intensive work.

9a. If so, are these challenges preventing prescribers and pharmacists from having access to all of the information needed to make an informed decision about whether to prescribe or dispense?

Real-time reporting is a major barrier in Rhode Island. It would be nice to have real-time reporting, yet our current reporting timeframe (less than 24 hours) satisfies our needs. However, we have heard through recent PDMP user stakeholder sessions that some pharmacies' prescribers notice up to a one-week delay on data. This will take considerable work from state staff to improve upon the timeliness of the data. In addition to the issue of not having real-time PDMP data, we also lack the knowledge of whether a controlled substance was picked up at the pharmacy and is in the patient's possession or is still sitting in a "waiting for pick up bin." Some type of Point of Sale (POS) connectivity with the PDMP database will provide more accuracy of the information.

While we are achieving interoperability with other states, it is cumbersome to do this one state at a time and then institution by institution when we achieve integration of the PDMP into an electronic health record. In addition, while we have several very successful EHR integrations of the PDMP with some of our largest provider groups, they do not see all of the data that is available through our PDMP website because of the need to approve these integrations with all of the states. This is a significant challenge and supports the argument for a federal PDMP.

9b. If so, how can we address these problems and improve PDMPs?

The most immediate and simplest step that Congress could take to address these problems is to provide for additional time to receive 100% FMAP funding for Qualified PDMPs under Section 5042 of the Support Act. That would make it easier for Rhode Island and other states to scale the resources needed to make improvements at the state level.

Longer term, we believe it would be beneficial to align state policies on PDMP use, including decisions regarding the type of users who may access data, how data can be accessed and stored through EHR integration, how data can be shared across state lines for other purposes such as analytics, and standards for data transport and security.

If the PDMP were a federally-maintained, standardized database, we could benefit from economies of scale, fewer technical difficulties, and improved functionality. At present, every state must independently scale and grow each individual PDMP.

Question 10:
Does your state's PDMP use HIPAA standards or any named federal standard for data transmission?

Rhode Island's PDMP uses a number of standards for data transmission as outlined below:

- Pharmacy reporting to the PDMP
- Interstate data sharing through PMPi
- Interstate data sharing through RxCheck
- Data sharing with EHR integrations currently or in the future with the following standards:
    - Appriss API (although RI does not want to continue using this standard because it is not in the Interoperability Standards Advisory)
    - NCPDP Script 10.6
    - Smart on FHIR API (future)

In addition, all contracted vendors and RIDOH are required to be HIPAA-compliant and protect data in compliance with all state and federal laws.

Question 11:
Many states are able to share PDMP data across state lines. However, it is my understanding that even if states are connected to an information hub, those states may not have access to state information for all other states connected to that same hub. Is that an issue that your state faces and/or that you are aware is an issue in other states?

Yes, this is an issue here and in other states, since connecting to the interstate hubs does not preclude the requirement to create individual agreements with all other states in order to share data. As described in more detail in the response to question 9, there are also multiple layers to data sharing (through our PDMP website, through EHR Integrations, and for analytic purposes). We have been very successful at obtaining sharing agreements with the PDMP website with 29 other states, but still need to get agreement for the other outlined purposes. We anticipate this will be a slow and resource intensive process, as we must create agreements with each state separately and comply with their respective access laws.

11a. Would states having the ability to access information across all state lines assist in fighting the epidemic?

Yes, especially for a small state like Rhode Island where it takes a short amount of travel time to go to a pharmacy or prescriber in another state. Additionally, there are a fair number of residents who live in other states over the winter and are only in Rhode Island seasonally. Having other states' data will only help in developing a more complete picture of a patient's prescription history.

Additionally, in the event of an emergency in which a methadone clinic in Rhode Island could not dispense according to a normal routine, being able to access information across state lines would be helpful for coordination.

Question 12:
What were the circumstances that you believe led to the opioid crisis in your state?

Historically, Rhode Island has had an above average rate of heroin use, primarily due to access and supply traveling up and down the east coast via Route 95. Illicit prescription misuse began to increase in 2013. In 2014, when over 240 Rhode Islanders lost their lives to overdose, Rhode Island became more aware of the increasing problem, not only with heroin but also with prescribed and illicit OxyContin. Suddenly there were more deaths than the combined deaths caused by car accidents, murders, and suicides. Eighty percent of overdose deaths in 2015 involved **fentanyl** which was a marked 15-fold increase since 2009. On August 4, 2015, Governor Raimondo issued Executive Order 15-14 to establish a broadly representative Task Force to obtain expert input and develop a Strategic Plan to address the opioid crisis. The Strategic Plan was built focusing on four pillars: Prevention, Rescue, Treatment, and Recovery. In order to bridge between the pillars, the Task Force updated the Strategic Plan to include cross-cutting workstreams aimed at addressing the problems that caused the overdose crisis. More detail about the Strategic Plan can be found on https://preventoverdoseri.org.

Question 13:
How does your state ensure that opioid federal grant funds are not diverted for unauthorized purposes?

BHDDH and RIDOH have internal active contract managers and evaluators for every grant. Each have accountability to the Executive Office of Health and Human Services and are required to carry out site visits and review consumers' evaluations for services rendered. Rhode Island is also subject to random external audits on each grant depending on the grantee (SAMSHA, CDC, etc.). The State absolutely depends on our federal partners to be able to address this opioid crisis, we work hard to ensure that the funds are spent effectively and in compliance with the provided federal guidelines.

Each department is required to have an approved active strategic plan and per OHHS regulations, every grant application needs to align with that department's strategic plan. This ensure that the grant activities are furthering the share goals and vision of the department and State as a whole.

Question 14:
How does your state ensure that opioid-related federal grant funds are going directly to the communities most affected by the opioid crisis?

Rhode Island uses diverse overdose datasets to inform the placement of interventions to ensure funding is serving the most vulnerable and hard-to-reach populations. Through requests for proposals, contracting deliverables, and performance measures, we can pinpoint areas with a high concentration of need, as well as provide general education throughout our small state.

Our regional task forces must complete a needs assessment at the start of the contracting period to determine the areas of most need. This helps us to determine the best communities to target for prevention activities.

The Honorable Bob Latta (R-OH)

Question 1:
In addition to the STR and SOR grants, how many other federal grants have your states received related to opioids or substance use disorder prevention and treatment?

Here is the list of grants that Rhode Island has received related to opioids or substance use disorder prevention and treatment:

Grant #	Funding Agency	State Agency	Grant Title	Amount of Award
1	BJA	RIDOH	Bureau of Justice Assistance (BJA) PDMP-Practitioner & Research Partnerships	750,000
2	CDC	RIDOH	Prescription Drug Overdose Prevention for States (PfS)	2,362,000
3	CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Base	3,146,152
4	CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Telehealth Special Project	500,000
5	CDC	RIDOH	Opioid Overdose Crisis Response Supplement Fund (SURGE) Infectious Disease Vulnerability Assessment	91,100
6	CDC	RIDOH	Enhanced State Opioid Overdose Surveillance (ESOOS)	973,940
7	CDC	RIDOH	Overdose Data to Action *$4.5M per year	13,500,000
8	CMS	Medicaid	Provider Capacity Building Initiative (PCBI)	3,500,000
9	CMS	EOHHS	Support Act - Medicaid Partnership Act	5,434,238
10	DOJ	RISP	Comprehensive Opioid Addiction Program (COAP) (Yr1)	1,800,000
11	DOJ	RIDOH	Comprehensive Opioid Abuse Site-based Program	2,000,000
12	DOL	DLT	National Health Emergency Dislocated Worker Demonstration (NHE)	3,894,875
13	SAMSHA	RIDOH	CARA First Responders Project to Combat RI Overdoses	800,000
14	SAMSHA	BHDDH	State Opioid Response (SOR Yr1 $12.6M, Yr2 $12.6M, Supp. $6.5M)	31,764,809
15	SAMSHA	BHDDH	State Targeted Response to Opioid Crisis (STR)	4,334,014
16	SAMSHA	BHDDH	Medication Assisted Treatment Prescription Drug & Opioid Addiction (MAT-PDOA)	3,000,000
			Total	77,851,128

Question 2:
I understand that the various federal grant programs have different requirements, timelines, applications, etc. How does this administrative burden impact your state?

It is important to be realistic about the difficulties states face while starting the implementation of a grant while simultaneously trying to build the infrastructure and workforce. The first year of the grant took time to build out, and we greatly appreciate the no-cost extensions that we have received. Our current concerns are focused primarily on the financially sustainability of programs if the grants were to quickly reduce their financial support.

It is also difficult to administer the grants with the limited staff, data, and evaluations allowed to us by the current administrative cap. An expanded cap would allow state to have the capacity to properly audit and evaluate programs for effectiveness.

2a. Would it be helpful for the federal opioids and substance use disorder grants to have more standardized application requirements and processes?

Yes, that coordination and standardization would certainly reduce administrative burden. We would also be helped by longer grant periods. For example, OD2A is only a three-year grant. Because it takes so much time to stand up a program, it would be most helpful to have grants of at least five years in duration, so that programs don't lose funding right as they are beginning to fully realize their potential.

Conclusion

Thank you so much for the opportunity to testify and to answer these follow-up questions. If you have any additional questions, you may contact Cathie Cool Rumsey by phone (401) 462-6392 or by email at catherine.coolrumsey@ohhs.ri.gov.