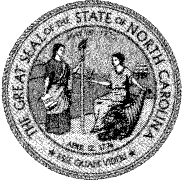

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

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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.

Misunderstanding 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 Centers, and others, there is common misunderstanding around 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 our 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 funding for treatment are regularly one of the top requests 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 clinical 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 different 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, and 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 spent 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 catchment 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.

<u>The Honorable Bob Latta (R-OH)</u>

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.