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Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Combatting an Epidemic: Legislation to Help Patients with Substance Use Disorders"
March 3, 2020

Michael Botticelli, Executive Director
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The Honorable Frank Pallone, Jr. (D-NJ)

1. **You mentioned in your testimony that individuals recently released from prison are 120 times more likely to overdose than the general public. Why are newly-released individuals at such high risk for relapse?**

   Numerous studies show that there is a high prevalence of substance use disorder among incarcerated individuals and that many who are incarcerated do not have access to evidenced-based treatment, particularly medications for addiction treatment, while incarcerated.[1] Additionally, seamlessly accessing treatment upon release can be especially challenging for this population since their access to Medicaid benefits is typically terminated or suspended. Risk of an overdose is particularly acute after a period of abstinence from drug use if someone is not on a medication. Overdose rates among this population is exceedingly high; often in the first few weeks following release.[2]

2. **You mentioned H.R. 1329 and H.R. 4141 in your testimony. While they differ in scope, at a high level, both bills would both provide Medicaid coverage to incarcerated individuals. Can you talk about why it's important to ensure continuity of coverage from incarceration to release?**

   As cited above, relapse and overdose rates among those recently released from incarceration is exponentially higher than the general population. One major factor driving these high rates is the lack of access to one of the three FDA-approved medications for opioid use disorder and continuity of that treatment upon release. A

[1] Bronson J, Stroop J, Zimmer S, Berzofsky M. "Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009." U.S. Department of Justice, Bureau of Justice Statistics. June 2017. bjs.gov/content/pub/pdf/dudaspji0709.pdf

[2] MA Department of Public Health. "An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015)." August 2017. mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf

recent study conducted at the Rhode Island Department of Correction showed significant reduction in overdose deaths when initiated on medication treatment while still incarcerated and then transitioned to community-based care.[3] Since cost to correctional facilities can be prohibitive, providing Medicaid coverage that covers addiction treatment can be crucial to providing this evidenced-based care as well as streamlining access to care upon release via a community-based provider.

3. **Your organization was one of the first in the nation to train residents in addiction medicine and addiction psychiatry. Are there any best practices that Boston Medical Center has observed after years of training residents in these programs?**

   One of the factors that had contributed to the opioid epidemic is the lack of an adequately trained workforce on addiction. While improving somewhat, academic training on substance use disorders is often not part of routine medical education. Boston Medical Center (BMC), as New England's largest safety-net hospital, recognized that in order to provide exceptional care for our patient population and our community, treating addiction among our patients needed to be a high priority.

   There are a number of lessons that have come out of our work at BMC. One main lesson is that addiction treatment could be successfully integrated into various care settings including primary care, emergency medicine, pediatrics, psychiatry and prenatal care services. These innovations of care have been widely replicated across the country and should be standards of care for any institution.

   Another lesson from our experience at BMC is that our addiction fellows have gone on to become leaders and champions at other institutions across the country thereby exponentially expanding expertise in other hospitals and care settings. Despite these efforts, there is still a demonstrated lack of medical capacity to meet the demands of the current epidemic and we need to expand the number of fellowship opportunities across the country.

[3] Green TC, Clarke J, Brinkley-Rubinstein L, Marshall BDL, Alexander-Scott N, Boss R, Rich JD. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. *JAMA Psychiatry*. 2018;75(4):405-407. doi:10.1001/jamapsychiatry.2017.4614

The Honorable Lisa Blunt Rochester (D-DE)

1. **Mr. Botticelli, your testimony mentions the transformational difference family support can make for an individual receiving treatment for SUD. How often do you encounter families that don't know the best way to be supportive of their loved one in treatment?**

   Throughout the course of my thirty-year career in the addiction field, this is one of the most consistent issues I have encountered. Families are often confused by the avalanche of information given via the internet, other well-intended parents, and even by treatment providers. Much of this information is not grounded in science and evidence and can be unhelpful at best and further exacerbate the problem at worst. Parents need immediate access to high quality information and support not only for their own well-being but to provide the most effective support for their loved one.

2. **Mr. Botticelli, there's evidence that when a family is involved with their loved one's care, there are better outcomes. In your experience, is this true?**

   This is quite true and my experience at the local, state and federal levels have proven this over and over again. Providing families access to these evidenced-based programs and services is an area that is woefully underfunded and should be expanded.

3. **Addiction is a chronic disease that public health experts agree can be treated with evidence-based therapies, and in some cases, medication. There's often a stigma for individuals with SUD and their families, which can put another barrier in between them and the support services they need. Mr. Botticelli, what effect does stigma have on the families seeking care at the Grayken Center? What types of educational resources help families change their perceptions about SUD?**

   Stigma is perhaps the most pernicious of issues that we face in effectively dealing with the opioid epidemic and substance use disorders more generally. The manifestations of stigma are profound and one of the most damaging is that stigma often results in those affected to either avoid seeking care or to delay seeking care until the disease is much more acute. Since its inception, the Grayken Center at Boston Medical Center has employed a number of efforts to reduce stigma and to provide evidenced-based information to patients and families affected by substance use disorders. From simple things like promoting the use of non-stigmatizing clinically appropriate language to providing both online educational materials and in-person support groups for family members - all are effective means of supporting families.

4. **In 2017, an estimated 46% of Delaware's incarcerated population had substance use issues. Studies show that when the justice-involved population reenters the community, they're at higher risk for relapsing, overdoses, and overdose fatalities. The Delaware Division of Public Health found that 1 in 4 individuals who died from a drug overdose were released from incarceration one year before their death. So, starting this year, Delaware will no longer terminate Medicaid eligibility for incarcerated individuals. Mr. Botticelli, can you elaborate on the risks to incarcerated individuals with SUD who aren't connected or transitioned onto support services before their release? How can an upstream investment in transitioning justice-involved individuals help reduce health care costs over time?**

   Numerous studies show that there is a high prevalence of substance use disorder among incarcerated individuals and that many who are incarcerated do not have access to evidenced-based treatment, particularly medications for addiction treatment, while incarcerated. Additionally, seamlessly accessing treatment upon release can be especially challenging for this population since their access to Medicaid benefits is typically terminated or suspended. Risk of an overdose is particularly acute after a period of abstinence from drug use if someone is not on a medication. Overdose rates among this population is exceedingly high; often in the first few weeks following release.

   Other studies and our own experience at Boston Medical Center and in the Massachusetts Medicaid program show significant reduction in overall health care costs when recipients are on medications for opioid use disorder, particularly methadone and buprenorphine.[4] Additionally, research conducted through the Grayken Center have also shown that those on these medications had significantly lower rates of overdose death.[5] In short, providing access to these medications not only reduce overall health care costs but save lives as well.

[4] Murphy, SM, Polsky, D. Economic Evaluations of Opioid Use Disorder Interventions. PharmacoEconomics 34, 863–887 (2016). https://doi.org/10.1007/s40273-016-0400-5

[5] LaRochelle MR. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality. *Annals of Internal Medicine*. 2018. doi:10.7326/M17-3107