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CHRISTOPHER NELSON

HIF160140

ADDRESSING THE OPIOID CRISIS: EXAMINING THE SUPPORT ACT FIVE YEARS LATER

FRIDAY, JUNE 9, 2023

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 9:30 a.m., at the Gettysburg National Park Visitor's Center, 1195 Baltimore Pike, Gettysburg, Pennsylvania, Hon. Brett Guthrie, chairman of the subcommittee, presiding.

Present: Representatives Guthrie, Bucshon, Griffith, Joyce, Obernolte, and Tonko.

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Mr. Guthrie. Good morning. The Committee will come to order.

Hey, thanks, everybody, for being here. It is such a great opportunity for us to be together. And I will recognize myself for 5 minutes for an opening statement.

And I just want to say how important it is we are here today, and I know a lot of times it is nice for us to get out of Washington to come to a place such as this. And a lot of people see, on television, there is a lot of, sometimes, fighting back and forth between the two different parties. But I will tell you, as we looked at what is going on in recovery, addiction, and overdoses, we have worked together, and in 2015 we did the SUPPORT Act together. And so Representative Tonko here, all of us are here to work together to move forward. And now we are up for reauthorization of the SUPPORT Act.

A lot of us got here last night and had the chance for a very sobering walk around this battlefield, and standing where Pickett's Charge was. And John Hoptak, I think was his name, was our interpreter, who said 51,000 people over the course of 3 days were wounded, injured, or killed. You know, over 100,000 people every year die of overdoses. And you sit there and try to absorb those numbers as you are watching and trying to imagine what happened here. I mean, the numbers are staggering in this area, to a horrible degree, as well. And we all work together to try to move forward.

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And I have a formal opening statement, and I am actually not going to give it. I will submit it for the record. And I want to recognize my good friend, Dr. John Joyce, who represents this area, for the remainder of my time. I yield to Dr. John Joyce

Mr. Joyce. Thank you for yielding, Chairman Guthrie. And I would also like to thank like to also thank Chair Rodgers, Ranking Member Tonko for coming to Pennsylvania's 13th Congressional District. The poignancy of being at Gettysburg is not lost on the Members of Congress. The battles that we face when we deal with addiction and the battles that families face is an important message to bring home with the great panels that we have assembled here today.

As we approach the 160th anniversary of the Battle of Gettysburg, we do recognize the over 7,000 Americans who lost their lives at this site and remember that sacrifice as we meet on another incredibly devastating issue, and that is the issue of addiction.

That is the scourge upon America, and drug overdoses, which in recent years, as Chair Guthrie just pointed out, have taken over 100,000 American lives annually, leaving behind the devastation to families, to friends, to coworkers.

As we look as a Committee and as a Congress to address these matters, we have to look to the communities, and that is what we are here today to do. We want to hear what recommendations, what

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impact, how the SUPPORT Act can be enhanced, how it can be extended.

So far this year we have made progress by passing the Halt Fentanyl Act, which will permanently schedule fentanyl analogues that have been flooding our communities with a deadly substance leaving death and tragedy in its wake.

In 2022 alone, DEA seized almost 379 million deadly doses of fentanyl, which is enough to kill every man, woman and child in the United States. And that was just what was seized. That is what we were able to capture. That is not what came through and ended up on the streets throughout the United States.

And I am hopefully this bill will pass the Senate and be signed into law, but there is a lot more work that needs to be done in supporting local law enforcement, health care providers, and patients who are facing these issues every day, with those in the throes of addiction.

In 2018, President Trump signed the SUPPORT Act into law, which is a comprehensive measure aimed at combating addiction and helping treatment for those facing the disease. Yet despite these efforts, and the exacerbated response by COVID-19, we are still seeing those increased deaths, and we must examine how the SUPPORT Act can be enhanced, improved, and address the issues that you bring for us today.

We must also be examining what policies need to be addressed to

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ensure that all patients have access to crisis and recovery services and the ability to receive the treatment that they so desperately need. Some of these barriers include looking at the impact of the IMD Exclusion which has restricted access to residential and inpatient care, and whether this can be modernized to ensure the availability for the treatment of patients.

The SUPPORT Act also recognizes that to ultimately be successful in combating the opioid misuse crisis, we must do a better job helping the 50 million Americans who suffer from chronic pain. Pain is a serious and growing disease which is more prevalent in older adults, women, veterans, blue-collar workers and people living right here in Pennsylvania's rural 13th Congressional District.

The SUPPORT Act contains numerous pain-related provisions directing the Federal Government to promote patient awareness and access to non-opioid therapies. I would like to request that the statement from the U.S. Pain Foundation be entered into the record.

[The information follows:]

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Mr. Joyce. Thank you, Mr. Chairman. I yield back.

Mr. Guthrie. The gentleman yields back. And I know we are a couple of minutes over, 50 seconds over. I just want to say what I should have said, how much we appreciate the National Park Service for hosting us. You see the men and women and law enforcement here making sure we are safe and secure. I know you do not deal with these kinds of things every day, I know, but every day you deal with what we are here to talk about, and we appreciate what you guys do.

I will now recognize my good friend from New York, Representative Tonko, for 5 minutes, for an opening.

Mr. Tonko. Thank you, Chair, and good morning, everyone, and thank you to everyone for joining here for this very important topic in this special way, and welcome to our panelists.

This is a vital hearing, and I thank Chair Guthrie and my colleagues for hosting it. As a co-chair of the bipartisan Addiction, Treatment, and Recovery Caucus I am all too familiar with the devastating impact of the disease of addiction. This is a loss many of us know all too well -- the loss of a daughter, a son, father, mother, a sister, or a brother, a neighbor dying much too young and leaving behind a grieving family. Communities are being ripped apart by poisons seemingly beyond our control.

Last year in our nation there was an estimated 109,680 overdose deaths. That is 109,680 lives lost that impact far greater numbers

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than we can imagine. Think of how many people that is, every single day needlessly dying and having their lives cut short. Think of the magnitude of all of those impacted by those 109,680 loved ones. For each of those individuals there is a whole universe of friends, of families, of communities impacted.

I recognize that many of our brave witnesses today were brought here by tragedy and by terrible pain. I hope that as a committee and as colleagues and friends we can learn from their pain and act together with a sense of urgency.

This year, with the reauthorization of the SUPPORT Act we have an opportunity to address the devastating disease of addiction. I think we can all agree there is a crisis at hand. Sadly, in 2021, 94 percent of people aged 12 or older with a substance use disorder did not receive any treatment. It is a startling statistic, but one that makes it clear there is a massive gap in access to treatment.

Over the last decade I have recognized this gap and have made a focus of advocacy in Congress. I am knocking out every single barrier to addiction treatment so that when an individual struggling with the disease of addiction reaches out for help, we have a medical system ready to welcome them with open arms. As a committee, I ask that we work together to make access to affordable and quality addiction treatment our highest priority. I am heartened that as I look across at the members here I see a

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coalition that understands the importance of that goal. In this moment I feel hopeful that together we can find common ground and take that immediate action.

During my time in Congress, we have worked together to pass CARA, the SUPPORT Act, and most recently our bipartisan mental health package. These policies have provided billions of dollars to support the American people and combat that overdose crisis. In particular, we have had a lot of bipartisan success when we worked to pass the SUPPORT Act into law back in 2018. Together we made progress forward in access to, and coverage for, medications for opioid use disorder. We expanded the providers who can prescribe MAT, and we also created an innovative new demonstration program for reentry that has now been put into action.

But we still have more work to do to protect the most vulnerable. Five years later, it is clear that there is widespread support for good reentry policy. I humbly ask, let's come together and pass the bipartisan Reentry Act, which would be game-changer for reducing overdose deaths and suicides by allowing all states to provide pre-release care to Medicaid-eligible individuals up to 30 days prior to release from incarceration. Sheriffs across the country are calling for passage of the Reentry Act. Medical providers and addiction advocates are calling for passage. Beth Macy, the author of "Dopesick," who has seen this disease firsthand, has called for passage of this legislation. Let's heed

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their call.

I also hope we can have a comprehensive discussion on how to expand access to treatment, including medications for opioid use disorder such as buprenorphine and methadone. We also should expand access to naloxone, testing strips, and syringe services so that lives can be saved. I also hope that we will take a look at a bill is called Due Process.

I look forward to discussions over the coming months on how we can support policies to save lives. Addressing the disease of addiction must include a compassionate response, bolstered by the pillars of prevention, of treatment, and of recovery.

I also want to thank everyone for being willing to discuss addiction. For far too long, the disease of addiction has carried an awful stigma. Together, by gathering here to openly discuss this we help share that addiction is not a moral failure but a disease, and if we treat it as such we will be victorious. We can share how recovery is not easy and often not a linear path, but that a light in recovery can be filled with so much hope and serve as inspiration to each and every one of us.

We also make it clear that we will not turn our backs on those who are suffering from addiction. We recognize their pain and the barriers that make treatment and recovery difficult. However, when someone has that moment of clarity and seeks treatment we should have systems in place that move heaven and earth to get people the

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very best treatment available.

So I look forward to learning more from our witnesses here today, and I promise you that I will continue my fight, in a bipartisan manner, to ensure treatment on demand so that all of those who are suffering from this disease of despair have access to treatment, and most importantly, hope.

Thank you. With that I yield back.

Mr. Guthrie. The gentleman yields back. And now we are going to go to the witnesses' opening statements. And for those of you who have not testified before Congress before, you have opening statements of 5 minutes. You will see a green light, yellow light, red light. So I guess -- 1 minute out green, or yellow, or 30 seconds? -- 1 minute out yellow. And so when you see red start wrapping up.

Now this is important, so I am not going to have a heavy gavel. If you have a thought you want to get out and it turns red on you just feel free not to stop mid-thought, mid-sentence. But begin to start summarizing if you get to that point. But we are here to learn so I am not going to have a heavy gavel on you, because we know we have some stories that we need to hear and ideas we need to share.

So with doing that, to introduce our witnesses today I am going to yield to Dr. Joyce, who will introduce you all, and then I will call on you each time.

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Mr. Joyce. Thank you, Chair.

Our first witness is Mr. Mike Straley, founder of Leah's Legacy Foundation. Mike and his wife Robin tragically lost their daughter, Leah, to opioid overdose after a long battle with substance use disorder. He is the author of the "The CALLing" and started, in his daughter's memory, Leah's Legacy Foundation, in an effort to help others who are struggling with substance use disorder.

Our next witness will be Dr. Mitchell Crawford, who is the Medical Director for Specialized Treatment and Recovery, WellSpan Health, and Director of Addiction Services at WellSpan Health Facilities. Dr. Crawford is a clinical specialist in treating substance use disorders, such as opioids, alcohol, and nicotine, and behavioral addictions as well. Dr. Crawford completed his residency at Harvard South Shore Psychiatric Residency Training Program.

Next will be Chief Bill Ceravola of the Reading Township Police Department. Chief Ceravola has been in law enforcement since 1995, and began his career as a crime scene investigator for the Kenner City Police Department in Louisiana. Prior to his time as Chief of Police for Reading Township he was Chief and Officer in Charge for Adams County Police Department.

Our fourth witness is Ms. Emily Keller. Ms. Keller is the former mayor of Hagerstown, Maryland, and prior to her time as

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mayor she served on the Hagerstown City Council. Currently, she is the Special Secretary of Opioid Response, Opioid Operational Command Center in the Office of the Maryland Governor Wes Moore.

Mr. Chairman, I yield.

Mr. Guthrie. Thank you. That concludes witnesses' introductions. Ms. Keller, we are going to go my left to right, so I will call on you first for your 5 minutes for an opening statement.

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STATEMENT OF EMILY KELLER, SPECIAL SECRETARY OF OPIOID RESPONSE, OPIOID OPERATIONAL COMMAND CENTER, OFFICE OF GOVERNOR WES MOORE; MIKE STRALEY, FOUNDER, LEAH'S LEGACY FOUNDATION; MITCHELL CRAWFORD, D.O., MEDICAL DIRECTOR, SPECIALIZED TREATMENT AND RECOVERY, WELLSPAN HEALTH, DIRECTOR, ADDICTION SERVICES, WELLSPAN HEALTH; AND CHIEF WILLIAM CERAVOLA, READING TOWNSHIP POLICE DEPARTMENT

STATEMENT OF EMILY KELLER

Ms. Keller. Thank you. Chairman Guthrie and honorable members of the Subcommittee, thank you for the opportunity to participate in today's hearing. My name is Emily Keller, and I am Maryland's Special Secretary of Opioid Response. In this role, I oversee the Opioid Operational Command Center.

I come before you today as someone who has been directly affected by the overdose crisis. My life in public service began after seeing my best friend, Ashley, struggle with a substance use disorder for many years as she failed to access the care that she needed. After she lost her battle with her disease, I dedicated my life's work to doing everything that I could do to promote access to care for others like her. I made a promise to her that I would be loud for her, and that is exactly what I intend to do.

My story, tragically, is not unique. So many Americans have experienced this same loss as overdose rates skyrocket in our

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country. About seven people a day lose their lives to overdose in Maryland alone. Efforts such as the SUPPORT Act of 2018 have increased our ability in Maryland to respond to this crisis by expanding support for treatment and recovery services, by increasing access to medically assisted treatment, telehealth opportunities, and advancing public health screening and prevention.

In 2021, more than 107,000 people lost their lives due to fatal drug overdose in the United States, an increase of nearly 15 percent from the prior year. In 2020, Maryland ranked sixth-highest in the nation for drug overdose death rates.

For those living in rural communities, access to care can be particularly challenging. For those without a car, that are living in communities that lack public transportation, this barrier can be insurmountable. The ability to utilize telehealth to prescribe MOUD is critical to help reduce overdose deaths, especially in communities like my own.

One in five incarcerated individuals are currently serving a sentence related to a drug offense. Also, the leading cause of death for people leaving prison is overdose. Maryland has taken steps to try to lessen the risk of overdose for people who are incarcerated by passing the Opioid Use Disorder Examination and Treatment Act in 2019, which requires an array of substance use disorder services be available in jails. While medical services

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are available in carceral settings, SUD services are rare. Substance use disorder is a medical condition and deserves to be treated as such. We would not deny someone antibiotics if they were sick, so how is this any different?

In April of this year, the U.S. Department of Health and Human Services issued guidance encouraging states to apply for Medicaid Section 1115 waiver, which allows states to use Medicaid for medical services, including SUD services for people otherwise eligible 90 days pre-release. We applaud Congress and HHS for making this opportunity available to states. I am excited to share that Maryland is using this guidance to prepare an 1115 waiver application. Governor Moore is embracing evidence-based solutions such as harm reduction, which can be used as a model nationally.

Harm reduction is a set of practices that aims to reduce the severe health impacts associated with substance use. Meeting people where they are at is especially important because all people, despite their circumstances, deserve to be treated with dignity and respect. Ensuring that every person, school, and business has naloxone available is an effective way to fight the overdose crisis. The only thing naloxone enables is breathing, and having this lifesaving medication available is key.

Individuals who participate in harm reduction programs are five times more likely to enter treatment, which is significantly higher than the 1 in 10 individuals who enter treatment outside of a harm

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reduction program.

In addition to providing support services and connections to treatment, harm reduction also includes syringe service programs, which greatly reduces the spread of infectious diseases such as HIV and hepatitis.

As we continue to have these conversations and enact policies to help combat the overdose crisis, including people who use drugs in conversation is essential. Taking a "nothing is about us, without us" approach will do so much good. We want to make sure that people who use drugs have a real voice when it comes to the creation of policies and programs that are created to help or affect them.

Governor Moore has vowed to lead with love, and that starts by saving lives. Our priorities include addressing the needs of the individuals that are most at risk for overdose, taking a public health approach to substance use solutions, and leading on evidence-based practices. It also means removing as many barriers to care as possible so that individuals can access treatment and recovery services at the critical times when they decide they are ready to seek help. No one will be left behind.

Thankfully, the SUPPORT Act was groundbreaking in that it was the first piece of Federal legislation to truly address the overdose crisis foremost as a public health issue. This approach is critical to addressing the actual and immediate needs of people

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who use drugs and people with substance use disorder.

As the overdose crisis continues to evolve and the number of stimulant-related overdoses increases, or new drug trends emerge, such as xylazine, we need to remain nimble in our response efforts and ensure policy meets the actual needs of individuals with substance use disorder.

Thank you again for the opportunity to address the Subcommittee today, for your dedication to this issue, and for the hard work you do on behalf of the American people.

[The prepared statement of Ms. Keller follows:]

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Mr. Guthrie. Thank you for being here and thank you for sharing. Hagerstown is a beautiful town.

Ms. Keller. Thank you.

Mr. Guthrie. I get to drive through sometimes when I drive from Kentucky.

Mr. Straley, you are now recognized for 5 minutes.

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STATEMENT OF MIKE STRALEY

Mr. Straley. Thank you, Chairman Guthrie and fellow Committee members. My name is Mike Straley.

My wife Robin and I were scheduled to have dinner with our daughter, Leah Renee Straley, on Thursday, March 1, 2018, at a Delray Beach, Florida, restaurant. Instead, we had her memorial service in Hagerstown, Maryland. Leah Renee Straley passed on Valentine's Day 2018. Her cause of death, fentanyl poisoning. She is forever 26.

Every day there is grief.

Leah's addiction started when she was 14 years old, much of it attributed to peer pressure. It started with marijuana, in her case the drug of choice, and the gateway drug that led to more potent drugs -- cocaine, heroin, painkillers, and ultimately fentanyl.

We are a middle-class family. She was raised in church and had a loving family and friends whose parents were business and shop owners. Addiction does not discriminate.

As parents, we were naive to her addiction at first because she concealed it well. Then the physical signs became apparent. As parents, we wanted to fix the problem, but we quickly learned those who are going through addiction can only help themselves. In Leah's case, she sought that help.

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She entered her first detox center, a local treatment facility in Franklin County, Pennsylvania. Our insurance did not cover the cost. We had to self-pay -- $14,000 for 2 weeks. We tapped into our savings and got help my parents.

We may as well burned that money because in less than a week after her discharge, Leah was back into the addiction cycle.

She graduated high school with honors and received a college stipend to attend a local two-year school. Her major: Drug Counseling. She never completed that degree. At the time of her passing, she was a first-semester junior after starting and stopping her college studies.

She would enter 12 detox centers from age 16 to 26. She lived in at least eight different sober-living homes from California to North Carolina to back here in Pennsylvania. Her best treatment was in California where she had 9 months sobriety.

I changed jobs and my insurance covered the detox treatments and sober-living home stints. Our home was not the answer for her to return to live permanently. As a father, it was difficult at first to tell her that, but she knew it as well. When she was in a sober-living environment that emphasized community, she thrived. Otherwise, she struggled.

When she turned 26, she was no longer on my insurance. She had to turn to state insurance. She sought out a sober-living facility in western Pennsylvania. In her words, it was a dump -- bed bugs,

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unsanitary conditions all throughout the house, including the kitchen.

She decided she was going to take up an offer to visit a "friend" in Delray Beach, Florida. Leah told us her "friend" was "clean." They were roommates at the sober-living home in California. My dad and I drove her to the airport on February 10, 2018. I hugged and kissed her before her flight and told her that her biggest fans were at home and that we believed in her, like I had so many times before. She said she knew she was loved. It would be my last hug and kiss from my daughter.

Fast forward to the morning of February 14, 2018. I received a call at work. I work at Fulton County Medical Center as the Executive Director of the Foundation. At 9:02 a.m. I received a call from the front desk that two Pennsylvania State Police officers were in the lobby, and they wanted to talk with me. We entered a private room, and it was there they informed me that my beloved Leah was found dead earlier that morning in Delray Beach, Florida.

I do not remember much about that conversation, but drove myself to Hagerstown, Maryland, to break the news to my wife. I ran out of paper napkins in my truck about halfway through the 60-minute drive. We then informed our son, Chris, and then my parents. My mom, for over a month, kept a dish towel on her shoulder. It was constantly soaked with tears.

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Grief is not the absence of love. It is proof that love is still there, and it will be always there.

My wife and I started Leah's Legacy Foundation in 2019, a nonprofit committed to helping women in recovery. We provide Leah Legacy purple bags filled with over 40 essentials to women in sober living. We share Leah's journey and ours as grieving parents. I am a speaker and author with a focus on schools, civic groups, conferences, and seminar.

To date we have gifted 523 Leah Legacy bags to women in recovery. We also have Leah's Gathering Place, a small house that was part of our family's property. We have a houseguest there that has over 6 years of sobriety. We also have life skill classes in that house, such as basic banking, Hygiene 101, cooking and banking for women in recovery.

We have turned misery in a mission, calamity into a cause. We want to live our life with a purpose and to honor our beloved Leah Renee Straley.

Thank you.

[The prepared statement of Mr. Straley follows:]

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Mr. Guthrie. Thank you for that powerful testimony.

Dr. Crawford, you are recognized for 5 minutes.

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STATEMENT OF MITCHELL CRAWFORD

Dr. Crawford. America's addiction crisis touches nearly every American in some way, including those of us in this room, including me. I lost my sister, who was a great person and whom I loved dearly, to an overdose in 2015. In the grief for my sister's loss, much like you have heard, I vowed to focus my work on addiction treatment. Fortunately, I have been given an opportunity to do that work. Unfortunately, I still experience the loss of friends, colleagues, patients to fatal overdoses.

It is important to note that sadly my story is not unique. However, I have also witnessed countless patients find long-term recovery, and this continues to provide me with renewed hope. We have treatment, and treatment works.

My name is Dr. Mitchell Crawford, and I am the Director of Addiction Services for WellSpan Health. Subcommittee Chairman Guthrie and members of the House Energy and Commerce Subcommittee on Health, thank you very much for the opportunity to testify this morning.

I would also like to particularly thank Dr. John Joyce, our Congressman here in Adams County, for his all-hands-on-deck approach to combat this addiction crisis.

For background, WellSpan Health is an integrated delivery system of more than 20,000 team members serving the communities of

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central Pennsylvania, including WellSpan Gettysburg Hospital. Our behavioral health network, WellSpan Philhaven, is one of the 20th largest such providers in the nation.

The 115th Congress and the Trump administration deserve credit for the passage of the SUPPORT Act, which enabled hospitals to better coordinate care, expand access to substance use disorder (SUD) treatment and offer alternative pain management treatments. The law reauthorized funding from the Cures Act which put $500 million a year toward the opioid crisis and gave states more flexibility in using the funding. It expanded access to treatment addiction and increased penalties from drug manufacturers and distributors related to the overprescribing of opioids.

The SUPPORT Act was an excellent start, but we have much more work to do.

The number of adults in central Pennsylvania with behavioral health and substance use disorders is increasing and surpassing the capacity of behavioral health and primary care providers to treat them. Given the urgency of this addiction crisis, we cannot overstate the need to increase the number of health care providers who can treat individuals with addiction. Instead of driving people away from doing this work we need to encourage them.

We have already taken big steps. The DEA used to require clinicians who wanted to prescribe buprenorphine for the treatment of opioid use disorder to undergo an extensive training and

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registration process for the so-called "X-waiver." Although this was a revolutionary step in the right direction many years ago, in our current era the extra training and waiver process likely discouraged additional doctors from prescribing buprenorphine for the treatment of opioid use disorder.

Last December, Congress eliminated that provision, which we hope will increase access to treatment and literally prevent thousands of Americans from dying from opioid overdoses.

Looking forward, as mentioned previously, one important barrier to eliminate would be the Institutions for Mental Diseases exclusion, or IMD, which has prohibited Federal payments to states for services for adult Medicaid beneficiaries between the ages of 21 and 64, who are treated in facilities that have more than 16 beds and that provide inpatient or residential behavioral health treatment.

WellSpan appreciated the recent decision from the Drug Enforcement Agency and SAMHSA to release a temporary rule extending COVID-19 telehealth prescribing flexibilities for buprenorphine and other controlled substances through November 11, 2024.

As part of the SUPPORT for Patients and Communities Act, Congress directed the DEA to create a special registration program for telehealth providers. To date, no program has been established, and Congress should push the agency to meet its statutory mandate.

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On a related topic, Congress should make permanent Medicare telehealth flexibilities granted during the COVID-19 public health emergency and extended through 2024 by the Consolidated Appropriations Act.

Keeping with the theme of flexibility, there is bipartisan legislation before this Committee, Modernizing Opioid Treatment Access Act, that would increase access to lifesaving care for people experiencing opioid use disorder by reforming the outdated regulations governing the prescription and dispensing of methadone, largely two crucial changes being that it would allow for prescription of methadone by physicians who are board certified in addiction medicine or addiction psychiatry as well as pharmacies to dispense methadone under Federal oversight. We appreciate the Subcommittee's review and consideration of this proposal.

Finally, Congress should also double down on the commitment to fund the Certified Community Behavioral Health Clinic model. WellSpan's CCBHC, called the START Program, is an innovative, one-stop behavioral health treatment program for patients with a focus on rapid access and stabilization, in collaboration with numerous county agencies and community partners.

I would like to close by bringing us back to what is most important. We know our friends and neighbors are struggling with addiction, and importantly, we know that treatment works.

Thank you again to the members of the Subcommittee on Health

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for focusing your efforts on this critically important topic and for the opportunity to be here today. WellSpan looks forward working with the Committee and the entire Congress to ensure that all Americans have access to high-quality, lifesaving addiction health care services. Thank you, as well, for your service to the citizens of your districts, and I look forward to your questions.

[The prepared statement of Dr. Crawford follows:]

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Mr. Guthrie. Thank you. That is very powerful testimony as well.

Chief Ceravola, you are recognized for 5 minutes for your opening statement.

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STATEMENT OF CHIEF WILLIAM CERAVOLA

Mr. Ceravola. Thank you for the opportunity to be here today, Dr. Joyce.

My name is William Ceravola. I was born and raised in New Orleans, Louisiana. I believe I had a normal childhood. Early on in life I knew I wanted to get into law enforcement. I started working at a pizza shop when I was around 15 years old. Around that time, I started to associate with some coworkers that would help sneak me into a local bar and get me drinks and would also introduce me to marijuana.

I had a relative that was a high-ranking trooper with the Louisiana State Police. I asked him what I needed to do to be a police officer, and he told me the best thing I could do at my age would be to join the military. So I did. In 1986, I went in the U.S. Army, and I loved every minute of serving until 1992, and probably would have made a career out of that but my mission was to be a police officer.

In 1995 I was hired by the Kenner Louisiana Police Department in Louisiana. Of course, I started out as a patrolman and eventually worked to become a crime scene investigator. I remember when I graduated the police academy I thought I could change the world -- I might change some people's worlds; not all of them.

But anyway, as a crime scene investigator I would investigate

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all types of crimes between vehicle break-in to investigating a triple homicide/kidnapping. But it was my job to collect evidence at death scenes, and I would regularly attend autopsies at the morgue. I had to collect evidence that the pathologist would discover, along with photographing and fingerprinting bodies.

One day I went to the morgue, and I noticed that there was a pregnant female there. Little did I know at that time they also performed an autopsy on the fetus. I will never forget that little boy that never had a chance at life. It turns out that his mother passed of an overdose.

I know there is a stigma with overdose deaths that it is their own fault, and it happens to other people, or they have had a poor upbringing. It cannot happen to smart, well-educated, wealthy people, can it? Well, the female that day was a nurse, and she passed in a supply room in a hospital that she worked at. Think about that for a second. How can that be?

Well, I have also seen police officers that get addicted to drugs. I personally had to dismiss an officer because he got addicted to pain killers from an off-duty injury. I wonder why did he not just come to me and say he had a problem. Well, I believe it is because he did not want to be labeled. I have also heard of police officers that are exposed at crime scenes, and someone has had to administer Narcan to save his or her life. I have been told that it could take only one time using some highly addictive drugs

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to get addicted. I worry that those officers became addicted that day.

My police career in Louisiana was a very busy one. Sometimes I wonder how I can sleep at night. In December of 2000, I decided that it would be best to move to East Berlin, Pennsylvania, and raise children. Reading Township is a farming community that is just outside of East Berlin here in Adams County. We have around 6,000 residents. When I started with the Reading Township Police Department, I was a police officer and when the police chief left they selected me to be the officer in charge.

When I first started here, I remember hearing about drug overdoses on a weekly event. Back then we did not have the computers in the cars so we cannot see all the calls. So I was just hearing what was over the radio when I was at work.

At that time we did not have Narcan in the cars. The best we could do was get to the scene and perform CPR, and it usually is in a hectic environment.

In April 2004, my family had a life-altering event. My youngest brother Byron took his life. This weighed heavily on my mother, who already had a drinking problem and a failing marriage. Sadly, one of my other brothers turned to illegally taking pills to cope with our brother's passing. Later he started using shooting up and eventually started using heroin. I knew my mother would never survive losing another son. I saw my mother struggle to

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assist him, and I was so mad she would give him money and provide him a place to be able to use drugs. He would steal from her, but she said, "I cannot stand to think of my son dying underneath a bridge in New Orleans from a drug overdose." He has been in rehab three times, and I can say that he is doing excellent. He has a very good job now, take-home car, health benefits. He, of course, is on medication to help deal with his addiction, but what I worry about is what is going to happen when my mother passes. Is that going to be a triggering event for him?

Over the last 10 years, since I have been carrying Narcan in the car, I can honestly say that overdose deaths in my area have gone down. I do not see it on a weekly basis anymore, and I think being in a rural community, that has helped us a lot. I do not even know how many overdoses we do not know about, that the families are saving.

So I pray that we can build on this success and save more lives. I can attest that we are not just saving the user. We are saving their family, because I have seen families crushed by overdose deaths.

So I will wrap it up with I still wonder about that little boy. What would he be today, 24 years later? What would he be doing today if he had a chance?

[The prepared statement of Mr. Ceravola follows:]

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Mr. Guthrie. Thank you for that powerful testimony as well. And now we have concluded with witness statements, and we will begin questioning from members of the panel, and I will begin by recognizing myself for 5 minutes.

And my first question will be to Chief Ceravola. I actually had jury duty a few years back. I got called by my local county and I was home in August, so I got to serve on jury duty. And I did grand jury, and we would hear 15 to 20 cases a day. And I just expected going in it was going to be all drugs. And there was certainly a good number of that, but what really shocked me is how much was alcohol. I mean, 0.3 with kids in the car, I mean, those kinds of things, domestic abuse, things of that nature. It just kind of shocked me how much is moving forward.

Can you comment on the excessive alcohol use and alcoholism? I know you talked about your mother a little bit. In your enforcement, is alcohol as prevalent? Because the issues we get with the SUPPORT Act, you know, we absolutely have to deal with opioids, but there are other addictions people have as well, and I am thinking about how we need to deal with alcohol. Could you just kind of comment on how alcohol plays into this?

Mr. Ceravola. Yes. I believe that alcohol is definitely a part of this. Like I said, I started out drinking some alcohol and it progressed into marijuana, and I am sure it could have kept going if I did not have that mission in life.

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More importantly, I think a lot of the problem is also mental health. Mental health, I think a lot of people who are on drugs, you have some mental health issues. Not everyone, of course. I can tell you that I have zero tolerance when it comes to alcohol. As a matter of fact, I guess 9, 10 years ago I got a phone call in the middle of the night and it was a sheriff's deputy in Louisiana who said, "We just arrested your mom for a DUI. What should we do?" I said, "Do your job."

My mom still gives me a hard time. "You told them to arrest me?" I said, "No, you were already under arrest. I told them to do their job, because it was not sense in him losing his job because you made a mistake."

I am proud to say that I think that changed my mom's outlook, when I did not come to her rescue. She does not drink. Well, I think she will drink a wine here and there. She has found God again, and she is in a good place now. It took her a long time to get here.

Mr. Guthrie. Good to hear the successes. And I think all of you, if we can keep our microphones kind of close. I think this is kind of a tough room in terms of echoes so please speak into your microphones. I know we can hear, but people behind you can hear better.

Mr. Straley, you said your daughter lived in, I think, 14 different -- we are trying to figure out what works, and when we

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spend taxpayers' dollars how do we do it in the best way that it works and can help people.

So is there any insight you can share on what your daughter went through? She had some months of sobriety and some things, and wraparound services at the end. What do you think worked, and when you said, "Boy, this really was not a good option for my daughter," through her different treatments. What kind of treatment worked and what kind did not?

Mr. Straley. When she was in California she actually received the best treatment, but I understand that was years ago. They were sort of ahead of the curve as far as medically assisted treatment. And, you know, she was out there in sober living in a group setting. When she was in sober-living homes where you were basically on your own she struggled. She struggled to get to meetings. She struggled to interact. But it seemed like when they went together in groups, you know, the peers, the cohorts, that seemed to work.

As far as other treatment, the Suboxone strips certainly worked for her. Other medically assisted, the shot, and things like that, I know that Ms. Keller talked about, those were things that did work for her.

The biggest thing was getting back into the old surroundings, and, you know, breaking that vicious chain. And once she found new friends in a sober living environment, she thrived. But when she

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was out by herself, I know the Chief talked about the mental health problem, that was an issue. There were struggles, and it seemed like she felt as though she was up against the world by herself.

Mr. Guthrie. Dr. Crawford, I only have a few seconds, but Dr. Crawford and Ms. Keller, what do you see as a couple of things that are successful and what we can improve?

Dr. Crawford. Yeah, I will be quick so you have an opportunity to speak as well.

Opportunities, I think, are increasing low-barrier access to treatment, just making it as easy as possible for folks to engage in treatment, and to kind of change culture. We have heard comments about stigma, which I greatly appreciated and agree with. So making an opportunity for folks to kind of normalize that conversation, to feel comfortable to have it, and then being ready to act when they ask for help.

Mr. Guthrie. Ms. Keller?

Ms. Keller. I agree with low-barrier access to treatment, medically assisted treatment, and also wraparound services. So we are not putting someone in a 28-day program and saying, "Okay, here you go. Go about your day." We need to wrap around services, make sure they have financial literacy training, they have access to MOUD when they get out, they have Medicaid or primary care benefits, just an ability to thrive and we are not just expecting someone to be cured in 28 days.

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Mr. Guthrie. Thank you. Thank you for testifying. I will yield back, and I will now recognize Mr. Tonko for 5 minutes for questions.

Mr. Tonko. Thank you, Chair, and thank you again to all of our witnesses. We have seen this in many of our family members and friends and neighbors. Our justice system is a revolving door for those struggling with addiction and mental health issues. Over one-half of people in state prisons and two-thirds of individuals in jails have substance use disorder. The need for uninterrupted and comprehensive coverage for individuals prior to release from incarceration has never been more critical, and the inability of Medicaid to cover otherwise eligible individuals has unintentionally stood in the way, creating burdens for law enforcement and obstacles for individuals who need care. And again, so many of our loved ones end up in an incarcerated setting.

Currently Federal statute prohibits any form of Federal health coverage for incarcerated individuals, except under very limited circumstances. In most cases, Medicaid coverage is immediately terminated when someone is sent to a correctional setting. This creates a serious coverage gap when individuals are released, as they often have no access to health care or addiction treatment during a stressful and dangerous time.

Ms. Keller, thank you for your commitment to promoting access to care in honor of your friend, Ashley, and the many loved ones we

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have lost to this disease. You mentioned that in particular you have seen incarcerated individuals struggle with a lack of access to care coordination upon their release. Can you speak more to why the period post-incarceration is such a critical time to receive treatment and coordination of care?

Ms. Keller. Absolutely. We are actually seeing that people being released from jail are up to 128 times more likely to die from an overdose in the 2 weeks following their release. My friend, Ashley, died from an overdose 6 weeks after her release. It is a very real thing.

If returning citizens were able to have access to health care immediately it could be a game changer. Think about this. You go into jail. You have a substance use disorder. You are not treated in jail. When you get out you still have that substance use disorder. So if you are able to immediately access health care benefits it could really change recidivism rates and what we are seeing. Overdose deaths are actually the fastest-growing cause of deaths that are occurring in U.S. jails as well.

So we need to treat the person. Yes, if they committed a crime and they are serving a sentence they are still a human being and they still have a disease that needs to be treated.

Mr. Tonko. So to clarify, currently can most incarcerated individuals access medications for opioid use disorder while they are incarcerated?

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Ms. Keller. No, they cannot.

Mr. Tonko. Okay. Thanks to the bipartisan work this Committee did together 5 years ago in the SUPPORT Act, states can now apply for a demonstration program to use Medicaid for eligible services for justice-involved individuals returning to their communities, 90 days pre-release. While this demonstration program is wonderful, it is just that, a demo. It can be ripped away at any moment and will require both applications from the state and approval by CMS. I have made the case to my colleagues that we should protect and codify this demonstration program through my Reentry Act. Some are worried about the Federal costs, but I strongly believe that this is one of the most effective ways we can save lives through a relatively small change in policy.

Let me reiterate. I measure success in lives saved and families kept whole. By allowing inmates to receive addiction treatment and other services before returning home, my Reentry Act will bring targeted treatment to those at the highest risk of overdose.

Ms. Keller, again, do you believe that reentry policy such as access to pre-release services, including SUD services, for otherwise eligible individuals is a good use of Federal funding?

Ms. Keller. Yes, Representative. I do not think you can put a price tag on a human life, and if our tax dollars are going to save to allow that person to thrive, then I think that it is absolutely

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worth it.

Mr. Tonko. Some of the most vocal advocates for the Reentry Act that I have authored, and the need for pre-release addiction services and coordination of care, are law enforcement because they see firsthand how this disease of addiction impacts their community. I would like to enter, for the record, a joint letter in support of my Reentry Act from the National Sheriff's Association, the Major County Sheriffs of America, the Major Cities Chiefs Association, and the National Association of Counties.

Mr. Guthrie. Without objection, so ordered.

[The information follows:]

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Mr. Tonko. Thank you. And Chief Ceravola, some people believe that justice-involved individuals are not worthy of treatment or saving or have the mindset that perhaps they do not deserve treatment or at least a lost cause. Further, they think of those with addiction as less. I want to personally thank you for reducing stigma but most of all for seeking humanity in others.

What would you say to other law enforcement members who may be considering carrying Narcan?

Mr. Ceravola. I have actually had some law enforcement officers tell me they are not going to bother. That person did it to themselves. And I explain to them, "You need to do that because, one, it could be your coworker that was affected, but more importantly, you are saving that person's family, not the user. You are giving the user another chance, but you are saving the family."

Mr. Tonko. Thank you. With that I yield back, Mr. Chair.

Mr. Guthrie. Thank you. The gentleman yields back. The Chair will recognize Mr. Griffith for 5 minutes, for the purpose of asking questions.

Mr. Griffith. Thank you very much. I appreciate that.

Mr. Straley, you said that your daughter benefitted from some Suboxone programs, which is buprenorphine. When she was not in the program was she able to access Suboxone on the street, do you know?

Mr. Straley. I do not know. I want to say no.

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Mr. Griffith. And I am going to shift. I just wanted that as a fact point, because in part of my district -- I have a large rural district in Appalachia, and in part of my district there is a number of Suboxone clinics, and what they have found is that it has become a street drug that some of the patients who are there will take some of their dosage and they will sell some of their dosage.

So Dr. Crawford, have you seen any signs of that with your patients, where some of them may not be taking the full dosage, and what do you do to monitor if people are actually taking what you have prescribed them? I assume you prescribe Suboxone because you mentioned buprenorphine.

Dr. Crawford. Correct, yes, I do prescribe medications for the treatment of addiction. And so to more directly answer your question, yes, I have had patients who I suspected of diverting the medications that I prescribed. To be very clear, you know, we take a harm reduction approach and a low-barrier access to care, but we are also not drug dealers, right, so we have to keep people safe, and we have to reduce their risk of harm. So in those circumstances it is very clear from folks like the Drug Enforcement Agency that we could not continue that relationship. That was a clear mark that either this treatment is not effective for them, perhaps they may need a higher level of care, more support wrapped around them, and so we would not continue to go just as --

Mr. Griffith. If you picked it up. And I am going to come

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back to that in a second.

Chief, have you seen any -- and I will use the doctor's term -- "diversion" of Suboxone or buprenorphine in your community?

Mr. Ceravola. I personally have not. I do know that my brother is on Suboxone and that he has to go through a clinic to get his dosage. I do not know if they get it all before you leave or if it -- is it a pill you take a day? I do not know how it really works.

Mr. Griffith. All right. So let's go back to the patients that are doing what they are supposed to do on this, and one of the worries that I have, and why I worry about not having some limitation on how many patients that somebody has on buprenorphine, is that they may not be paying as close attention as you are to whether or not there is a diversion.

But let's go to the ones who are not diverting. Do you ever get them off of the Suboxone? I mean, I know of one case, in Maryland, where a friend of mine's son had this issue, and went to them and said, "Start weaning me off." It took years, but he eventually got off and is doing great. But do you see that in your practice, or do we get them to just where they are stable and they continue to take the substitute opioid, Suboxone, or buprenorphine?

Dr. Crawford. Yeah. Thank you for the question. And just to clarify, you know, nothing we do in medicine is perfect, unfortunately.

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Mr. Griffith. Oh definitely, yeah.

Dr. Crawford. And so --

Mr. Griffith. And clearly nothing we do in Congress is perfect, but you have got a better batting average than we do. But I do appreciate that, but yeah.

Dr. Crawford. Sure. And so, you know, we accept that there is some risk, and we are always balancing the risk and the benefit analysis. And so you heard the majority of folks, 90, 95 percent of people aged 12 and older, depending on which dataset you are looking at, do not have access to treatment or are not engaged. And so that is a risk that we take, that perhaps some folks, a small minority may be diverting. We do not want that to happen, and we act accordingly.

We also know from the literature that the medication that is diverted is actually going, the majority of the time, to folks who do not have access. So it should not happen that way, and we do not want it to happen that way, but that is where we think the majority of that medication is actually going.

And to more directly answer your question, you know, we are talking about a chronic medical disease, similar to other chronic medical diseases like type 2 diabetes or hypertension or high blood pressure. And these are things that folks have that they may take medications for, for the rest of their life, or these are things that they may have changes in their life or changes in their bodies

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that they may not need to take medication anymore.

So I always counsel folks and treat my patients accordingly with we are going to do with what works right now. If that means we are going to take medication for the rest of our lives because that is what works and that is what keeps you alive and healthy, then that is great. If you feel like you want to taper we can do so, but very slowly and for the right reasons.

Mr. Griffith. And that is why I said it took years. You cannot just do it overnight or you get into worse trouble. And I do appreciate that. So you have had some patients who have tapered and gotten off of Suboxone or buprenorphine?

Dr. Crawford. Yes. Yes.

Mr. Griffith. Okay, good.

Ms. Keller, I am going to switch to you and slightly change subjects. Part of the SUPPORT Act had a section in it on drug monitoring. Those were sections that I advocate because like the arm of Maryland, my district stretches out and goes from the Lynchburg/Roanoke area down to an area that is so far west, it is further west than Detroit, Michigan, and we touch a number of different states, and you can actually get prescriptions in five different states. Maryland has a similar situation with its arm, and I am just curious if you all have had success with a drug monitoring program. Does that seem to have stopped the illegal use of getting multiple prescriptions from different doctors in

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different states, or even in Maryland? Have you seen some success with that?

Ms. Keller. We have seen success with the prescription drug monitoring program, and where I am, on the map where Maryland gets very small, we had the same issue. So yes, it has been successful.

Mr. Griffith. And so while everything we do does not work perfectly, every now and then Congress gets one right, and I think that SUPPORT Act was one of those.

I yield back. Thank you.

Mr. Guthrie. The gentleman yields back. The Chair now recognizes Dr. Bucshon for 5 minutes for questions.

Mr. Bucshon. Thank you all for your testimony. I was a surgeon before I was in Congress and a health care provider. I do not have any direct experience with substance abuse, but I have family and friends who have had mental health issues. It is a different but similar problem, chronic, life-long problem.

Dr. Crawford, I mean, if there was one thing that we could do, what would it be?

Dr. Crawford. A great question.

Mr. Bucshon. I mean, you are the professional in this. I mean, you do this every day. And is there one thing that every day you go, "Boy, if we could just do this, that would make a difference"? Is there such a thing?

Dr. Crawford. It is hard to pin down one thing because the

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disease of addiction is multifactorial. I mean, there are so many causes and there are so many diverse kind of treatment pathways for folks. But I think continuing to have these conversations and continuing to have an open mind to what the experts are sharing with you and where the evidence is leading you to help make decisions about grant opportunities and funding pathways and recommendations for alternative payment methods to encourage us to just be a healthier community rather than focusing on efforts that are more reactive once harm has happened.

Mr. Bucshon. Yeah. I am interested in the subject about law enforcement because obviously my county jail in Evansville, Indiana, Vanderburgh County, has a high incidence of both mental health and substance abuse people who are imprisoned there. And I talk to my county sheriffs about that, and I am empathetic to the situation as it relates to the Medicaid program and figuring out ways to address that so that we do not have gaps in care.

There is a huge cost to it. We are trying to figure that out. But I do think -- and I will just speak for myself -- that we have to sort that out, particular people, if they were on Medicaid before, and then they lose it while they are imprisoned, and then they come out, you know, and I think we have addressed some of that, the reapplication process and all that. We are going to sort that out.

Chief, in your area, in this area it is rural America -- I

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represent rural America -- where are the illicit drugs coming from?

Mr. Ceravola. I hate to name just one city but in my area I believe lot of it is coming from Baltimore. I have also been seeing some coming from the York area. But I think most of that is coming through Baltimore.

Mr. Bucshon. Yeah, and one thing, when we are talking about substance abuse, I do not want to overlook, and I will talk to you about this, we are not past the methamphetamine problem, are we?

Mr. Ceravola. No.

Mr. Bucshon. If you were to look at what is the most common thing that you find people have problems within your rural area, what drug would that be?

Mr. Ceravola. Right now I believe it is heroin.

Mr. Bucshon. Heroin.

Mr. Ceravola. Yes.

Mr. Bucshon. So you are closer to an urban area than I am. I am about 3 hours from Indianapolis, but we have a huge meth problem still. You know, we do not make it anymore locally, but now it comes from primarily Mexico. It comes through Chicago, down to Indy, down to us.

And Doctor, I am going to ask you this question because I know with methamphetamine, you know, they have done brain studies on this, and it shows if you are on methamphetamine that your brain may not change, even if you get off of it, for years. I mean,

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there are scientific studies that show this, and that is what makes is so hard for people to quit because their brain still craves this stuff. It is like nicotine. In the medical field we call it upregulation of receptors or something in the tissue, right?

Is that type of thing also -- I mean, I am not aware of that type of chronic brain changes when it comes to things like heroin or cocaine or these other drugs. Do you know if there is any specific reason why long-term treatment like somebody pointed out, you cannot expect people to recover in 90 days, right, and why it is so important to have long-term follow-up and long-term care? There are physiologic changes in people that they cannot overcome just by thinking about it. Is that true?

Dr. Crawford. That is a great question, and it actually kind of connects to the question you first asked me about that kind of silver bullet, which is the recognition that, you know, we have an addiction epidemic and probably behavioral health epidemic. And there is a mosaic of what is actually being used throughout our state and our country. In the west part of our country there is a lot more stimulant misuse. In the northeast there is a lot more opioid misuse. And we have FDA-approved medications to treat opioid use disorder. We do not have FDA-approved medications to treat stimulant use disorder. And so that is one of the big differences.

To more directly answer your question, yes, we do see brain

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changes in folks that are suffering from addiction. A lot of that is reinforcement of pathways, and I will not bore you with all the neurobiology.

Mr. Bucshon. I hated neurobiology, by the way, in medical school. It just was not my thing.

Yeah, I mean, I think that is something -- and I will finish up here, Mr. Chairman -- that we really need to understand, and we have talked about this. The stigma needs to go away as much as possible because there are legitimate medical, physiological changes in people who become addicted that we have to recognize and that we have to find medical ways to get them out of it. And just telling them, "Hey, it is bad to use drugs" just does not help.

I yield.

Mr. Guthrie. The gentleman yields back. The Chair recognizes Dr. Joyce for 5 minutes.

Mr. Joyce. Thank you again, Chair Guthrie.

Mr. Straley, thanks for appearing here and offering such incredibly powerful technology. I offer to you personally, and to your wife Robin, condolences for your loss. Both you and Robin are working in our community, and it has been exemplary work, which allows you to share your experiences in an area that is so critical. What you have messaged to us today is a message that we will return to Washington with.

But I want to ask you to address to us, as far as legislation

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that would inform us to make better Federal policy and face those who are in addiction, specifically you touched on a point that I think is so important for those of us who live in rural areas, that those facing addiction in rural areas, which is why your daughter traveled far from this beautiful community, for those who face those addiction issues here it has to be addressed through a different lens, or perhaps through many different lenses. Do you feel that access to care in rural areas is sufficient?

Mr. Straley. No, I do not.

Mr. Joyce. Do you feel that we should be more attentive to understanding how important that access is, and should that be included in the SUPPORT Act?

Mr. Straley. Absolutely.

Mr. Joyce. Chief Ceravola, opioid overdose reversal medications like naloxone, you and I recognize are critical components to part of the strategy. As you face each and every day as you are called out on each and every call, often you might not know if you are going to have to utilize the ability to reverse an overdose.

According to the Reagan-Udall Foundation, a recent report on naloxone, of the 17 million doses of naloxone that have been distributed in the United States in 2021, more than 84 percent were distributed by local health departments, first responders like you, schools, and other community organizations.

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Can you share how important, once again for us, that law enforcement and first responders are in having that access to naloxone in your cruiser?

Mr. Ceravola. I believe it is very important. I make sure that each one of my police cars has at least one dosage. I think we should have it readily available to anybody who wants it. If somebody walks into my station and says, "I would like a dose," I would be more than happy to give them mine and go get another one.

Another positive thing I have seen lately is in the last couple years we have went through a paid EMS in my area. Prior to that it was all volunteer. So now we are getting ambulances to the scene quicker, so that is another avenue for that Narcan to be administered. Sometimes the ambulance can beat us to the scene now, which used to not be the case.

Actually, one of the things that I did when my brother passed is I put my energy into building a street rod. This past week there was a street rod show in York, and I drove it in the parade through York. And as I am driving along I see a lady sitting with a stable in a corner, and she has a whole bunch of boxes of Narcan sitting on that table. It was an outreach program.

I wanted to pull over and hug her, but I could not stop the parade, and we ended up taking a different route back. But I really wanted to stop and talk to that person, but I did not get a chance to. I think things like that help. And here she is just

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sitting out there on a sunny day with a table full of Narcan, for anybody that wants to come get it.

Mr. Joyce. Thank you, Chief, and thank you, Dr. Crawford. Thank you for bringing your expertise to rural Pennsylvania.

Access to comprehensive treatment for opioid or any drug addiction we have recognized from your testimony is incredibly challenging. And again, I go back to how challenging that is in rural areas here in Pennsylvania 13.

So when we are talking about significant barriers that are driving the lack of access, do you feel that the IMD exclusion is an important barrier that we need to address in our upcoming SUPPORT legislation?

Dr. Crawford. I do, yes.

Mr. Joyce. Within your WellSpan facility, how many inpatients do you treat at different facilities, and locally and comprehensively in all the facilities where your treatment is?

Dr. Crawford. Are you referring to strictly for behavioral health?

Mr. Joyce. Yes, in behavioral health, clearly.

Dr. Crawford. I do not have the exact figures. We have a number of hospitals. We have a standalone behavioral health hospital in Lebanon County. We have an inpatient unit in Lancaster County as well as in Franklin County and others. So at least hundreds, perhaps even low thousands of patients.

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Mr. Joyce. Do you feel that physicians having additional opportunity and not being limited to the number of patients they can prescribe Suboxone, do you find that is an important piece of equipment that a physician is going to have as they are armed appropriately to treat addiction?

Dr. Crawford. I do, yes.

Mr. Joyce. My time has expired, and I yield.

Mr. Guthrie. The gentleman yields back. The Chair recognizes Mr. Obernolte from California for 5 minutes.

Mr. Obernolte. Thank you, Mr. Chairman, and thank you very much to our witnesses. This has been an incredibly poignant hearing for me. I represent an extremely rural section of California. You would not think that my district would be a district that would have a problem with fentanyl, but we do. In the last 18 months, my district has experienced an over 600 percent increase in the number of fentanyl-related deaths, which is incredible. My most difficult day in 19 years of public office was last fall when I had a constituent lose both of her sons in the same afternoon to the same fentanyl poisoning incident. So this is a problem that has its tentacles in every part of our country, and it is something that I am convinced that government, and in particular Congress, needs to play an active role in fixing.

I want to talk about a couple of kind of difficult topics, and one of them is I wish we would stop using the word "overdose." The

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vast majority of these incidences, when someone dies from fentanyl, is not an overdose. It is a poisoning. They did not intend to take fentanyl, not to defend the fact that they thought it was oxy or some other opioid, but this substance was intentionally introduced into a pill that they took, and they did not have the knowledge of what they were taking.

As has been discussed here, Narcan has been a godsend, and it has meaningfully decreased the number of fentanyl-related deaths in my community as we have gotten it into more schools, more law enforcement. Unfortunately, we are seeing a new problem in my district, which is the problem of xylazine. Xylazine does not respond to Narcan, and we do not have a way right now of saving someone who is suffering from xylazine poisoning. That problem is just going to increasingly get worse.

Chief Ceravola, I would like to ask you, with your law enforcement experience, there is a fundamental difference here between preventing opioids like oxycodone from being in our community, because there is a legitimate prescription path for that. So a lot of the oxy that we see diverted is diverted from someone who has a legitimate prescription, or it comes from over-prescription through legitimate channels. But fentanyl and xylazine, that is a completely different thing. You would think that if we could get that off the street, yes, we would still have a problem with substance use and opioid use, but we would not have

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nearly as many people actually dying from it.

So what can we do more to get substances like fentanyl and xylazine off the street?

Mr. Ceravola. I guess the best thing to do is more enforcement and get the courts to work with us, because so many times we see somebody get off on things, and it is like that is something that the person should pay the price for. You know, that is a dealer providing these drugs to the community. That person should not get a light sentence.

Mr. Obernolte. So you are suggesting sentence enhancement for crimes like intentional incorporation of fentanyl into a pill.

Mr. Ceravola. Right. One of the things we always try to do at a death scene is we will try to seize the phone. A lot of times we can go through that phone and see who the provider was, and then we can go after that person. In a most recent case, when I did get to that point, by the time I figured out who it was he had also passed away.

I do notice that there must be some bad batches that come in sometimes, because you will see a spike. Like everybody must have gotten some of this bad batch of heroin. I do not know. That is the only way I can figure out how you can have a spike, like a week, and then it will go right down. It has to be just a bad batch.

Mr. Obernolte. Right. In speaking with my own local law

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enforcement they have found that often the local dealers are unaware that fentanyl has been introduced into what they think they are pressing into oxy pills, and it is actually the higher-up links in that drug supply chain that have that knowledge. But I completely agree with you.

Mr. Ceravola. I can believe that.

Mr. Obernolte. Well, I think we are going to do another round of questioning so I will save my next questions to the going over time. But thank you very much for your testimony.

I yield back, Mr. Chairman.

Mr. Guthrie. Thank you. Mr. Tonko, we have gone pretty efficient with our time, so we will go around and let everybody ask an additional question. Everybody does not have to use their 5 minutes each time, or a closing statement, or just an additional question. So I will recognize myself for 5 minutes.

And I just want to say that we are going to all work together. This is going to be a bipartisan issue going forward. It does not mean we are going to agree on everything, so we are going to work through those disagreements. We are not going to disagree to be disagreeable. And one thing, there are a lot of proposals to expand Medicaid, and we want people in prison to get the help and the coverage and assistant they need because it is cheaper on society as they move forward, as they move out, to not be recidivism. We did pass a bill last year that allows juveniles to

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have access to their Medicaid health care, mental health treatment, because as you said, that is going to be helpful moving forward.

We just want to be careful that -- I used to be in the state legislature. State legislators have to balance their budgets, thank goodness, and nothing they would like more than to send the cost up to Washington, D.C. And there is a responsibility for the states in this. I know that Maryland does a great job with it. Kentucky does a great job with it. There is a responsibility for states and local governments. And as we have to deal with ever-increasing budget deficits, the solution of sending the bill to Washington is not the best.

And like you said, we make decisions that do things like we did with mental health in juveniles, because that worked, and we think it would be effective and save money in the long run. But we just want to be careful as we move forward on the policy we move, and we will work through any differences. I have confidence it will be a strong bill that will be bipartisan and be able to be supported.

I will yield back and recognize my good friend from New York, Mr. Tonko.

Mr. Tonko. Thank you, Mr. Chair. Just a couple of questions.

Ms. Keller, you made reference to evidence-based harm reduction. What does that look like, and what is the benefit of using those approaches?

Ms. Keller. So harm reduction is using evidence-based

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solutions that can aim to reduce the harm that substance use causes. So this provides linkages to care. It also gets people in touch with a peer support specialist. A peer support specialist is someone who has lived experience, who can talk the talk and walk the walk. A lot of times it involves a syringe service program, which provides clean syringes that lower the spread of things like HIV and hepatitis C, which does not just help the person with a substance use disorder, it also helps public health, in general.

The interesting thing is some people, there were theories that harm reduction may enable. But the reality of it is people who are enrolled in a harm reduction program are five times more likely to enter treatment, because they have been treated with dignity and respect, they have a relationship with their peer support specialist, and when that person says, "You know what? I am ready. This is the day that I want to go," they know that they can go to their harm reduction program and be trusted and access the care that they need.

Mr. Tonko. Thank you. I might just ask, Mr. Straley, in regard to Leah, and, you know, Dr. Joyce had asked about the approachability or availability of services in rural areas. Would the addition of those who can prescribe medication-assisted treatment been a helpful thing for Leah --

Mr. Straley. Absolutely.

Mr. Tonko. -- adding more people to those roles?

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Mr. Straley. Yes.

Mr. Tonko. You know, Doctor, you made mention of some of the reforms that we have done with MAT, and I was proud to really push that effort. Some people have said to me, "Well, getting the bill passed is 50 percent of the journey." I think in this case it might be 10 percent, because implementation here requires the entire community, from pharmaceutical companies to pharmacies, doctors, nurses, clinicians to be entering into that equation.

How can we best encourage people you are giving work to enter into that service provider status?

Dr. Crawford. Yeah. You are right, it is an opportunity for us, as health care delivery systems and providers, to meet the communities where they are at is a problem. And I think a lot of it we have talked about in this committee today about stigma and making it something that the health systems and local independent providers and such actually view as a medical disease and something they feel armed and competent to treat.

So as much as we can do to continue to talk about it, raise awareness about it, and continue the great work you all are doing to reduce barriers, to allow people to do it and give them access to training to feel comfortable and confident.

Mr. Tonko. In DEA's own words they indicated that today we have about 135,000 folks that can prescribe under a medication-assisted treatment scenario. With the bill that we passed in

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Congress they said the potential is there for 1.83 million, and it is going to take interacting with the communities that can provide the service. So whatever you can do to advise us, going forward, or whatever encouragement you can provide to your peers, that would be appreciated.

And with that I yield back. Thank you.

Mr. Guthrie. Thank you for yielding, the gentleman yielding. The Chair now recognizes Mr. Griffith for 5 minutes.

Mr. Griffith. Thank you, Mr. Chairman. Let me just say I agree with the Chairman that this problem is so awful with substance abuse, it affects so many people that we are all working together. We do not always agree on what the solution is, but as you can tell from the tenor of our questions today and our comments here this is not a politically divided issue. It is just a question of how can we best do it in the most appropriate way that we can and figure out what we are doing. We will stumble along. And as we talked earlier, Dr. Crawford, we will make mistakes, and the medical community will make mistakes, and hopefully we will figure out how to fix it and do the best that we can moving forward.

With all that being said, Dr. Crawford, I am just wondering, how do you treat differently, or what do you do differently, and have you seen -- I am sure you have -- fentanyl, but also the fentanyl analogs and now xylazine. Have you treated somebody who

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been using the xylazine? It is relatively new. I am just curious.

Dr. Crawford. Yeah, absolutely and unfortunately. And so when you have fentanyl and fentanyl analogs that we see as well now, that are even more potent or stronger, some things that change are that you may need more than one treatment with naloxone, for example. I have had folks where we used all the naloxone we had on hand, and we actually were waiting for the code cart to get to us so that we could push the medication intravenously or intramuscularly. They just were not responding intranasally.

So when you are dealing with these sorts of new classes of potency or strength of these substances, it is a new challenge. We also see a phenomenon like was described previously, where fentanyl is so deadly not only because of the potency but also because it has a profound effect on what we call chest wall rigidity, in that it actually makes your chest tighten and even harder for you to breathe even if you had a little impulse from your body to keep breathing.

So there are new things that we see that come with the new substances. Xylazine we are seeing really profound wounds all over the body -- it does not have to be at the injection site -- that need to be treated in different ways. We have seen folks with amputations from these wounds. And as you are describing, we do not know the best ways to treat these things medically yet. There is not enough time and evidence to support it, so we are doing our

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best to treat it symptomatically and keep folks alive.

Mr. Griffith. All right. You raised all kinds of questions for me. One, what is shocking, the wounds from xylazine. Are they self-inflicted or is it that they do not feel the pain so they get injured accidentally, or is it something that they are doing as a part of the reaction to the drug?

Dr. Crawford. Yeah, it is a reaction to the substance. And we think what is likely happening is that this substance, xylazine, causes essentially clamping of the blood vessels throughout the body, and that is why we can see it in places other than where someone may be injecting. And what happens is that the tissue will die, and it dies from essentially deeper levels and then out. So it is different than a wound you may see that starts as a skin infection and then goes down. So folks need to be trained to look for this all over the body and then comfortable in how they actually treat this different type of wound.

Mr. Griffith. And then the other question that your previous comment raised, we have all seen the studies and reports, but when somebody is taking fentanyl or fentanyl analog and you are trying to do the naloxone or Narcan, which is another common name for the same substance, and you all are pushing it in, what that indicates to me is that when Chief Ceravola finds this happening on the street he has got no way of knowing how much Narcan he should give, or his officers, they have no way of knowing how much Narcan they

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should give without giving them to somebody like you who is an expert. Is that a fair statement?

Dr. Crawford. It is fair to say that, yeah. I think what we always guide folks, and when we talk with our excellent folks on the front lines in the first responder field is do what you can with what you have and try to stabilize folks. What we can do is we can breathe for folks. We can do CPR. We can try to keep them alive and as viable as possible to make it to the next step, which is where we have all the intensive treatment where we can intubate and put tubes in to help them breathe and do all the next-level medical care.

Mr. Griffith. But because these substances are relatively new, not always predictable, particularly with the analogs or with the xylazine, both you and the frontline people in many cases are just having to experiment and hope you get it right. Is that a fair statement as well? Is that true?

Dr. Crawford. We follow the evidence when it is there.

Mr. Griffith. I understand.

Dr. Crawford. And when it is something new, we treat symptomatically, and do our best to keep them alive.

Mr. Griffith. But if it is not working, you are going to go a little bit further in hopes that it does work. Correct?

Dr. Crawford. Yes. We would not give up, for sure.

Mr. Griffith. I yield back.

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Dr. Crawford. Thank you.

Mr. Guthrie. The gentleman yields back. The Chair recognizes Dr. Bucshon.

Mr. Bucshon. Thank you. I just want to get on the record on the fentanyl. It is coming from China, to Mexico, through cartels, to the United States of America, killing our citizens. That is not my opinion; that is what is happening. So I am speaking to the fentanyl itself.

So, you know, all of us at the Federal level not only were looking at preventing people from using it or the demand for drugs by helping people get off of illicit drugs and treat them, but we are also looking on the supply side. I just wanted to put that on the record. You know, the question is how do we address that. We are trying to address the fentanyl analog situation and making the current Administration, scheduling the fentanyl analogs permanent, because believe it or not, the scientist in China, primarily China, chemists will literally change one little molecule on the fentanyl and then it technically may not be illegal in the United States, and they can actually bring it into the United States legally, unless we have fentanyl analogs scheduled as Schedule 1, which means there is no medicinal use. It would be like heroin and other things. I just wanted to put that on the record.

Dr. Crawford, this is a chronic disease, right?

Dr. Crawford. Correct.

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Mr. Bucshon. And would you say in the majority of cases you would not use the term "cured" in these cases, like you would, say, for some other mental health?

Dr. Crawford. Correct. We tend to refer to folks as being in recovery.

Mr. Bucshon. In recovery, yeah. I want to point that out.

So I think also, what are your thoughts on not only medication-assisted treatment, which I am a big supporter of, by the way, and those things, but ongoing so-called wraparound therapy, ongoing engagement with people who are in recovery, and how important that is also. Could you comment on that?

Dr. Crawford. Yeah. So first, I am a psychiatrist who then specialized in the treatment of addictions, so of course I believe in therapy and support of all of the other services that wrap around folks.

I think it is important, and I know you are not suggesting this, but to recognize that the medications themselves, or certain parts of it themselves can be very powerful alone as well.

Mr. Bucshon. Yes.

Dr. Crawford. And so it could be dangerous to suggest that, you know, it has to be this for a certain person and list all the components. We recognize that the gold standard for treatment of opioid use disorder is medication-assisted treatment, and then we offer everything else and share what the benefits are. But we

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should not withhold certain parts of treatment because the person is not interested in other elements.

Mr. Bucshon. Agreed. I mean, as a physician I think, I mean, there is pretty good evidence to show -- and my dad had an alcohol problem for a while, and he ended up kicking it -- that this is a chronic problem and that medication-assisted treatment, if you are talking about weaning people off of it and all of these things, I just personally believe that people have to be, for their lifetime, engaged in some way in the treatment system, whatever that may be. Otherwise, like you pointed out, Chief, where what might happen to your mother and her alcohol problem if her other son died. You know, there can be triggers that people have in their life, and suddenly, even though they are doing well and they are in recovery, something could trigger them, and they could flip back if they do not have someone to reach out to.

I mean, would you agree with that?

Dr. Crawford. I think that is where the low-barrier access comes in. So there is always an open door, and there is no wrong door, is eventually what we would like to get to. So in that moment someone may have been in recovery for 10 years, had not used the substance, and they had a slip, a return to use. Knowing exactly where to go, or at least who to point them in the right direction, and then us welcoming them with open arms, with no judgment, is really what I think would be most beneficial.

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Mr. Bucshon. How do we keep track of those people, so we know? Say they do not come to you for 5 years. I mean, are there programs where we proactively have reach-out programs, where we just touch base with people proactively from a provider perspective?

Dr. Crawford. It is a great idea. I am sure that there are some community organizations that do that. We also know that there are great models, like 12-step programs, for example, that folks stay engaged in for decades, maybe their whole lives. Medically speaking, with a medical model, I do not see that very often, but I think there could be value in that.

Mr. Bucshon. And with your indulgence, Mr. Chairman, I want to ask the Chief one thing. How many people are you seeing that are getting Narcan three, four times, you have been to their same house three, four times?

Mr. Ceravola. Oh, I have seen that multiple times.

Mr. Bucshon. I mean, I am a big supporter of Narcan -- do not get me wrong -- but one of the challenges that we do have is that in some areas people can get complacent and feel like they will just show up and give me Narcan and save me, right? And I have had local law enforcement that have to use so much Narcan they run out, and then they cannot save people. Do you think that attitude prevails amongst the chronic users, that oh well, they will just show up and give me Narcan?

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Mr. Ceravola. I do know that there have been some situations where we saved someone and they actually woke up and fought with us, because here we are trying to save them, and actually we are trying to save ourselves because they are mad that you ruined their high.

Mr. Bucshon. That is a side effect of Narcan. The doctor can probably talk about that too. Narcan, people can have tachycardia, fast heart rates, and this type of reaction. So that is important to understand.

I yield back.

Mr. Guthrie. Thank you. The gentleman yields back, and I now recognize -- Dr. Joyce, I just want to say to all your constituents that are sitting here what a beautiful area of our great country, not only historically important. I have Mammoth Cave National Park, Abraham Lincoln's birthplace. So if you are doing the national park checkoff, please come to Kentucky. But I will tell you this is stunningly beautiful. Everybody here has been wonderful to be around. Saratoga Battlefield. We just got that from my friend from Saratoga.

But the National Park Service, thanks. I am proud of all the people that live in my district that work for the Park Service. They make America's great historic treasures, and even though the history is not always the grandest, greatest of history, it is history, and it is important what you guys do, so thanks a lot.

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And Dr. Joyce.

Mr. Joyce. Well, thank you, Chairman. I think it is important that echo that sentiment. I am a great-grandson of a Civil War veteran, and the battles continue. I think that we all recognize that one of the key battles that we have today is with opioid addiction, with the drug addiction that continues to permeate not just here in rural Pennsylvania but throughout America. I want to thank each and every one of you. I want to thank the National Park Service for providing us the opportunity.

Today's hearing is about the SUPPORT Act, and we are going back to Washington with the great information that you have provided us with today to discuss how that should be reauthorized, how it might be altered, how it could be improved. So for my final question I would like each of you to address, this is your opportunity to tell Washington how should we make the SUPPORT Act better? What Federal component should be improved?

Ms. Keller, I would like to start with you.

Ms. Keller. Thank you very much. I would suggest extending care to loved ones, because like we heard from Mr. Straley, when you lose a loved one you have a hole in your heart, and a lot of people do not know how to handle that moving forward. Or when you love someone with a substance use disorder, a lot of families do not know where to get help. So approaching this from a whole family approach and wrapping our arms around not just the person

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with a substance use disorder but everyone around them that is affected by them, providing more resources for them to go to get help.

And I would also urge you to invest in adolescent care. We are seeing a significant increase in young people with substance use disorder, and with the rise in fentanyl we are seeing a lot of younger people using fentanyl as well. So investing in adolescent resources so they have access to treatment, to mental health providers, and there is a severe lack of that right now.

Mr. Joyce. I think that is a great message to take back. We certainly saw the isolation that occurred with the lockdowns during COVID, that individuals, particularly adolescents, turned to escape, and unfortunately, in some situations, that involved addictions that occurred.

Mr. Straley, Federal legislation that could be better improved or altered as we address the reauthorization of the SUPPORT Act?

Mr. Straley. I would say more funding for treatment centers and also sober living homes, and certainly in our rural area, in Franklin County we have one sober living facility for women and one facility for men, and they are constantly at full capacity. And we need more treatment centers and more sober living facilities to support those that are coming out and want to live a better life.

Mr. Joyce. Dr. Crawford, as a physician I recognize the importance that this is recognized, that addiction is recognized as

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a disease. You made great comparisons talking about the possibility of weaning people from Suboxone over a long term. And you alluded to, and I might just ask you to expound just briefly, you alluded to that someone who suffers from hypertension, I might even postulate that there could be people in this room who are on medicines this morning treating their hypertension. And maybe with alterations to diet and to weight reduction and to exercise you could possibly be weaned from medicines that would treat your hypertension. Similarly for diabetes, type 2 diabetes. If you are treated with medicines for type 2 diabetes, if you alter your lifestyle, if you have weight reduction, you might be able to do that. But in many cases that is not the case, as you and I recognize as physicians.

Can you address two things? I am going to put you on the spot. Can you address two things? I do want to know how to alter, improve, and extend the SUPPORT Act and what recommendations you have at the Federal level. But I also want you to talk about the need for ongoing, long-term therapy as we recognize that addiction is a disease.

Dr. Crawford. Absolutely. Yeah, thank you very much. So I will try to be quite brief with the first part, and I appreciate the opportunity to share this. We touched on this briefly. You know, I believe, frankly, that we are in a behavioral health epidemic. So, you know, if I had a magic wand I would say let's do

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everything we can for behavioral health. But understanding we do not have that, when we think about the SUPPORT Act, I think it would be fantastic to continue to expand, in addition to opioid use disorder, all the other substance use disorders that we see. And we talked about the amount of folks who have died from poisonings, and that is not something we should take lightly, but we lose about three times as many people per year to alcohol. We lose about five times as many people to tobacco, still. So there is a tremendous opportunity for us to do more.

And then to answer your question about the need for ongoing, long-term care, absolutely. So there is a very kind of discussed-about and famous study within academic addiction circles comparing treatment outcomes and adherence to treatment, comparing addiction or substance use disorder to other chronic medical diseases, and there is no statistically significant difference between those.

Mr. Joyce. Thank you. Chief Ceravola, the message that this group, on the Health Subcommittee of Energy and Commerce, if there is an alteration or modification to the SUPPORT Act, from a law enforcement perspective, what should we take back to Washington?

Mr. Ceravola. I think some of the things that we need to improve on is our drug takeback programs. Unfortunately, the last event I was not able to take part in, but I think getting some of the prescription drugs that are not being used anymore out of the medicine cabinets is a big help. I think mental health, with our

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mental health situations, making more beds available to people who need it to recover. And an early outreach and education, because I have a daughter that is going to turn 15 next month, and that is when I took my first drink. And I cannot imagine that she is going to be doing that. Honestly, she has a little bit of mental health issues as it is, and I am afraid she is going to go down that road. But I have to stop that.

Mr. Joyce. Again, thank you Chairman and Ranking Member, and thank you for coming to Gettysburg, Pennsylvania.

Mr. Guthrie. Thanks for hosting us. We appreciate it.

The gentleman yields back. Mr. Obernolte is recognized for 5 minutes.

Mr. Obernolte. Well, thank you, Mr. Chairman. I am delighted I get an opportunity to ask a second round of questions, because Dr. Crawford, I had one for you. I found your testimony very meaningful, and you said something that I found profound, enough so that I made a note of it. You said, "We have treatment, and treatment works." But I think it is important that we are very frank on this issue, because might respectfully push back a little bit on that. I am not sure I agree. I would say we have treatment and sometimes it works.

One recurring theme in people that lose their lives to addiction is that they, quite often, have been in and out of treatment their entire lives. That has certainly been true in my

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own extended family, where I have people that I love that have been in and out of treatment programs and just cannot seem to get the problem solved. Mr. Straley gave some very incredibly emotional testimony about his daughter, who the same thing, in and out of treatment programs until she lost her life.

So it seems to me when someone comes into treatment and says, "I have had enough. I need help. I want this to be over. I will do anything. Let's go," and we put them through treatment, and it does not work. You know, we have missed that opportunity. What can we do to reduce that cycle of in and out of treatment? What can we do to fix that problem that first time?

Dr. Crawford. I wish I knew the full answer to that question. What I could share -- and I appreciate your comment. You are absolutely right. So we have treatment, and treatment works, sometimes. It is probably a good caveat. When I make that comment I speak medically, and so we have no treatment that works 100 percent of the time, really, but it is statistically significantly an improvement over not treating, for example.

But yeah, so what can we do? I think one of the biggest things is taking an approach of harm reduction, as we have talked about, and also personalized care approaches. I think too often we are creating a program that has a structure that we say, okay, this is how you come into it and this is how it works for everyone. And we are all unique individuals with unique life journeys.

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And so I think having more flexibility, really, truly meeting people where they are at. You know, perhaps when they engage with us we should be asking them more what is the most important thing to them instead of assuming we know and trying to prescribe it to them. And so I think there is a lot of opportunity in approaches like that.

Mr. Obernolte. Thank you. That is valuable.

Ms. Keller, you said something in your testimony that really stuck with me also, when you were talking about telehealth and the need to expand access to telehealth. For my district, telehealth has been a complete game-changer, particularly during the pandemic. And I actually wish we would stop calling it telehealth, because I know that is the technical term for it, but when I talk about it I call it virtual health, because telehealth does not encapsulate how comprehensive our virtual treatment options are now. I mean, you are not just talking to a doctor on the telephone. Most of the time you are looking at them through a videoconference. Sometimes you are on remote sensing instruments that there they can use to make diagnoses. It is an amazing, game-changing technology.

And I would say, following onto the discussion we have been having about trying to, when someone goes into treatment, trying to make it so that they get treated, that telehealth can be -- see, I did it -- virtual health could be really, really instrumental in this, particularly because we can use it to treat some of the

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behavioral health options and epidemics that exist in our country.

So my question for you is, because you are an expert in this, how can we, in Congress, expand virtual health and virtual health treatment options for the people that we represent?

Ms. Keller. Thank you for that. I agree that virtual health is going to be --

Mr. Obernolte. I like where you went there.

Ms. Keller. -- yeah, I mean, it is the way of the future, especially when it comes to treatment, because you be in an opioid treatment program, in an inpatient center, and still be receiving mental health treatment or substance use treatment or just primary care treatment, especially in rural areas where you cannot access a program, you cannot drive to one or walk into one.

So I think just making sure that insurance does cover it, that Medicaid covers it, and that every American has access to that. I think it is going to be a game-changer, especially you described you are in a very rural area. So I would venture to guess there are a lot fewer residents who just cannot drive to a treatment center.

Mr. Obernolte. Right. Well, there were some flexibilities granted in Medicare treatment for virtual health options during the pandemic. I know that Congress has been working very hard to extend those flexibilities in areas where they were working, which is the vast majority of them. So we are certainly going to keep up

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that work. But thank you very much.

Thank you very much to all of our witnesses. I really enjoyed the hearing today. I yield back, Mr. Chairman.

Mr. Guthrie. The gentleman yields back, and that concludes two rounds of members' questions. It has been an informative hearing and important work that we have before us to do. So thank you so much for taking your time and hearing your stories. We all have family members that have similar situations.

Now I will ask unanimous consent, we are going to insert into the record, there is a list of documents that have been provided to the staff, both Democrat and Republican staffs have agreed to. I know Mr. Tonko had a list that he submitted for the record. Of course, my written opening statement. So without objection, so ordered. Those are submitted for the record.

[The information follows:]

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Mr. Guthrie. And also you may receive written questions from members. So I will remind members they have 10 days to submit questions for the record and ask the witnesses if you could respond promptly to those questions. I really appreciate that. Members should submit their questions by the close of business on June 23rd.

So thank you so much. Thanks to our law enforcement officers here today. Thank you for your service. And without objection, this Subcommittee is adjourned.

[Whereupon, at 11:10 a.m., the Subcommittee was adjourned.]