Congressional Hearing on the Opioid Crisis

Testimony Submitted to the House Appropriations Subcommittee on Labor, Health and Human Services (HHS), Education and Related Agencies

The Honorable Tom Cole, Chairman
The Honorable Rosa DeLauro, Ranking Member
2358 Rayburn House Office Building

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Submitted by
Barbara Cimaglio, Deputy Health Commissioner
Department of Health
State of Vermont
Member, Board of Directors, National Association of State Alcohol and Drug Abuse Directors (NASADAD)

Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee, my name is Barbara Cimaglio and I serve as Deputy Health Commissioner within Vermont's Department of Health. In this role, I lead the Department's oversight and development of the State substance use disorder treatment, prevention and recovery service system. I am also a longtime member of the Board of Directors of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Thank you for the opportunity to testify before the Subcommittee today to discuss actions we are taking in Vermont to address the opioid problem and offer considerations related to federal funding for substance use disorders.

States appreciate recent actions taken by Congress to address the opioid crisis: I wish to begin by thanking this Subcommittee in particular and Congress in general, for recent work to address the opioid crisis.

We appreciate passage of the 21st Century Cures Act which included the creation of a $1 billion fund for FY 2017 and FY 2018 to help States enhance treatment, prevention and recovery services. The first installment of these funds, or approximately $500 million, was approved by Congress late last year. Applications for the Cures funding for the States, now known as the *State Targeted Response to the Opioid Crisis (STR) Grants*, were due February 17, 2017. It is my understanding that all fifty States have applied for these dollars – mapping out plans to address their own unique needs and circumstances. In testimony presented to this Subcommittee last week, Secretary Price said awards through this program may be released as soon as April.

The 21st Center Cures Act also included key provisions reauthorizing the Substance Abuse and Mental Health Services Administration (SAMHSA). This included the reauthorization of programs within SAMHSA's Center for Substance Abuse Treatment (CSAT), Center for Substance Abuse Prevention (CSAP), Center for Behavioral Health Statistics and Quality (CBHSQ) and others. NASADAD supports actions to ensure a strong SAMHSA and appreciates the leadership of Ms. Kana Enomoto, SAMHSA's Acting Deputy Assistant Secretary for Mental Health and Substance Use.

Thank you also for your work to pass the Comprehensive Addiction and Recovery Act (CARA) which authorized programs seeking to promote a coordinated and multi-sector approach to addressing the opioid crisis. CARA created several important initiatives, including:

Improving Treatment for Pregnant and Postpartum Women (Section 501): Reauthorizes the Residential Treatment Program for Pregnant and Postpartum Women program to help support family treatment services – where women and their children can receive the help they need together in a residential setting. CARA also created a pilot program to afford States flexibility in providing new and innovative family-centered services in non-residential settings.

State Demonstration Grants for a Comprehensive Opioid Abuse Response (Section 601): For State applications of this grant, there is an emphasis on coordination between an applicant's State alcohol and drug agency and its corresponding State administering authority for criminal justice. This initiative is designed to help promote coordinated planning on issues related to justice-involved individuals with substance use disorders.

Community Coalition Enhancement Grants (Section 103): Authorizes the Office of National Drug Control Policy (ONDCP), in coordination with SAMHSA, to make grants to community anti-drug coalitions to implement community-wide strategies to address their local opioid and methamphetamine problem.

Building Communities of Recovery (Section 302): Authorizes SAMHSA to award grants to recovery community organizations (RCOs) to develop, expand and enhance recovery services. RCO's across the country are doing an excellent job of helping individuals in recovery with the assistance they need to once again contribute to their families, employers and communities.

Financial Burden of substance Use Disorders: The National Institute on Drug Abuse (NIDA) estimates that illegal drugs, alcohol, and tobacco cost society roughly $700 billion every year or $193 billion for illegal drugs, $224 billion for alcohol, and $295 billion for tobacco. According to SAMHSA's 2016 report, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2014*, spending on substance use disorders decreased as a share of all health spending from 2.0 percent in 1986 to 1.1 percent in 2002, and remained stable ever since. Expenditures for substance use disorders represented only 1.2 percent of all health expenditures in 2014.

Benefits of prevention, intervention, treatment, and recovery: A primary message for this Subcommittee is that services to prevent, treat, and maintain recovery from substance use disorders help millions across the country. These services are literally life saving for both individuals and families. In addition, research demonstrates the investments in services save money.

- ***Prevention***: $1 invested in substance abuse prevention saves $10–$18 in costs associated with health care, criminal justice, and lost productivity
- ***Intervention***: Substance abuse screening and brief counseling is as effective as other health prevention screenings
- ***Treatment:*** $1 invested in addiction treatment saves between $4–$7 in costs associated with drug related crime, criminal justice, and theft
- ***Recovery:*** Relapse rates for addiction resemble those of other chronic diseases such as diabetes, hypertension, and asthma

Importance of State-Federal Partnership: NASADAD promotes the work of the National Governors Association (NGA) in its Principles for State-Federal Relations policy position which recommends a strong, cooperative State-federal partnership and maximum State flexibility when managing federal resources.

States recognize the importance of these federal resources and greatly benefit from funds managed by different agencies under this Committee's jurisdiction. In addition to SAMHSA, these agencies include the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS), National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA). We also appreciate the work of agencies outside this Committee's jurisdiction – including the Office of Justice Programs (OJP)/Bureau of Justice Assistance (BJA), the Drug Enforcement Agency (DEA) and others within the Department of Justice (DOJ).

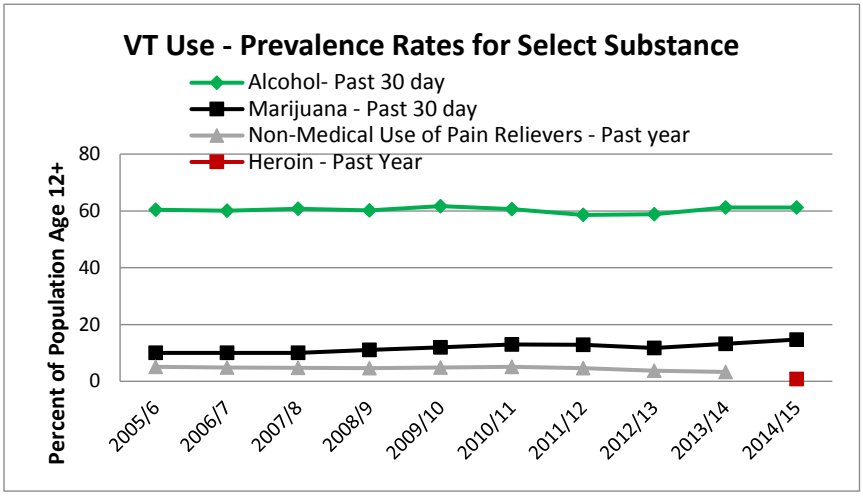
Vermont in particular has leveraged multiple sources of State and federal funding to address opioid use in Vermont. Federal funding opportunities have been fundamental to implementing programming. Examples of these important programs include:

- SAMHSA's Substance Abuse Prevention and Treatment (SAPT) Block Grant,
- SAMHSA's Strategic Prevention Framework (SPF)/Partnerships for Success (PFS) Grants
- ONDCP's/SAMHSA's Drug Free Communities Program
- SAMHSA's Medication-Assisted Treatment (MAT) Prescription Drug and Opioid Addiction Grant
- SAMHSA's Screening, Brief Intervention and Referral to Treatment SBIRT) Grant
- CDC's Prescription Drug Overdose Prevention grant
- DEA's drug takeback program to support state drug takeback initiatives

Vermont is interested in utilizing 21st Century Cures Act funds to better coordinate care between substance use disorder treatment and medical providers; implement programs to improve and expand the substance use disorder workforce; add peer recovery coaches to emergency departments to support individuals who have overdosed on opioids and assist these individuals in seeking treatment for addiction; and providing funding to support community-initiated opioid prevention programs.

Scope of the substance use disorder problem in Vermont: It is worth stepping back for a moment to examine the impact of all substance use disorders in the State first before focusing on the unique issues related to prescription drug abuse and heroin.

Alcohol has consistently been the most frequently used substance in Vermont and an estimated 21,250 Vermonters are alcohol-dependent (NSDUH 2013/14). Marijuana is the next most frequently used substance. Vermont has among the highest rates of alcohol and marijuana use in the United States.



Vermont prevention activities have focused on regional approaches and it is estimated that substance abuse prevention activities reach 65% of Vermont residents at a cost of approximately $9 per person.

Intervention services are provided in schools, medical settings, in other State programs, and at specialty providers. Intervention services were provided in 34% of Vermont supervisory unions in 2016. Intervention activities reached 5.2% of Vermonters at a cost of $151 per person.

The SAPT Block grant funded treatment system served nearly over 11,000 in 2016. Treatment costs in 2016 averaged $3,253 per person. An additional 3,800 people also receive medication assisted treatment in medical settings.

Vermont has a Statewide network of recovery centers that served nearly 6250 Vermonters in 2016 at a cost of $364 per person. These centers provide peer recovery services and other activities to support individual recovery.

Vermont's Strategy for Addressing Opioid Misuse and Dependence

Importance of a comprehensive and aligned approach: Vermont recognized and publicly acknowledged the increasing challenges associated with opioid use when former Governor Shumlin's 2014 State of the State speech was devoted entirely to the topic. Vermont focused on opioids as a public health and medical issue. State and federal resources have been leveraged to address prevention, intervention, treatment, and recovery for opioid use disorders. Such disorders have a far-reaching effect in Vermont families and communities, and increased pressure on Vermont' health care, child protection and criminal justice systems. When Governor Phil Scott took office in January, 2017 he immediately appointed a Drug Prevention Policy Director to bring focus across State agencies on the continuing opioid crisis. The Governor is also convening an Opioid Coordinating Council to develop a multi-disciplinary strategy that will frame his administration's work.

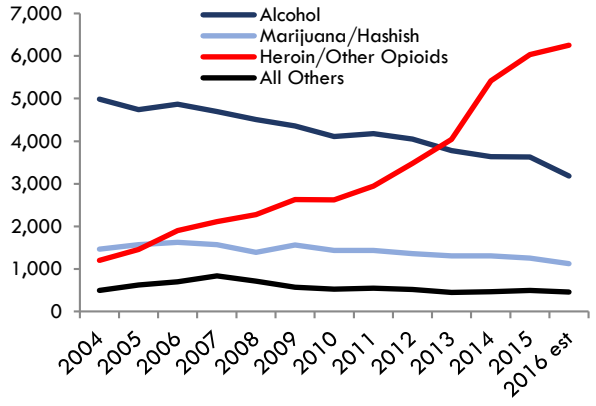
Critical involvement of public health, Medicaid and other insurers, and prescribers: The Division of Alcohol and Drug Abuse Programs (ADAP) within Vermont's Department of Health (VDH) is the designated State substance abuse agency. As such, ADAP is responsible for overseeing the public prevention, intervention, treatment, and recovery service system as well as the prescription drug monitoring program. VDH also coordinates service delivery with the Medicaid division, which oversees physician office-based opioid treatment and pays for most opioid use disorder treatment in Vermont. Vermont has implemented a unique treatment program for opioid use disorders, known as the "Hub and Spoke" model, and has worked with third party payers to assure care is consistent regardless of payer. A more detailed overview of the Hub and Spoke model is offered later.

Vermont has a multifaceted and Statewide approach to addressing opioid addiction that involves multiple community partners. The State alcohol and drug agency director plays a prominent role in guiding this comprehensive strategy. The components of this strategy are:

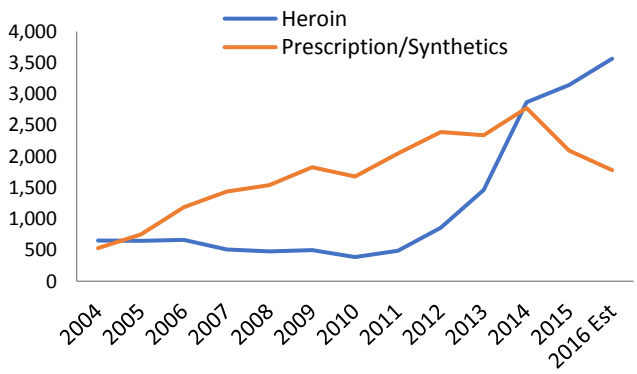
- **Public Information and Messaging** – campaigns targeting the public, prescribers, and those using opioids
- **Pain Management and Prescribing Practices** – training, technical assistance, and tools provided to prescribers, required use of the prescription drug monitoring program
- **Prevention and Community Mobilization** – regional prevention capacity increases to provide assessment and planning, education and outreach, policy change, school-based services, and community-led triage programs
- **Drug Disposal** – implementation of a statewide system
- **Early Intervention** – screening for risky substance use in medical settings and within state programs that directly serve individuals
- **Overdose Prevention and Harm Reduction** – wide distribution naloxone overdose reversal kits, syringe services programs to prevent spread of HIV and hepatitis C, good Samaritan laws to encourage people to seek care in case of an overdose
- **Expanded Access to Treatment and Recovery Services** – rapid increases in medication assisted treatment capacity for opioid use disorders with buprenorphine and methadone through the hub and spoke system of care as well as services for pregnant women with opioid use disorders. Development of peer recovery services
- **Legislation and Rules Enacted** – laws around prescribing opioids for chronic and acute pain, use of the prescription drug monitoring program, good Samaritan protections, drug disposal program funding, pretrial services and alternatives to incarceration

Scope and changes in opioid use in Vermont: Like many States, Vermont saw demand for treatment services for opioid use disorders increase rapidly. In 2014, more people were treated for opioid use disorders than alcohol. Treatment demand was initially driven by prescription drugs. Heroin use, however, began to increase rapidly in 2011. By 2014, heroin overtook prescription opioids as the most commonly used opioid among those in treatment for a substance use disorder.

People treated in the public treatment system by substance (Source: VT Treatment Data System)

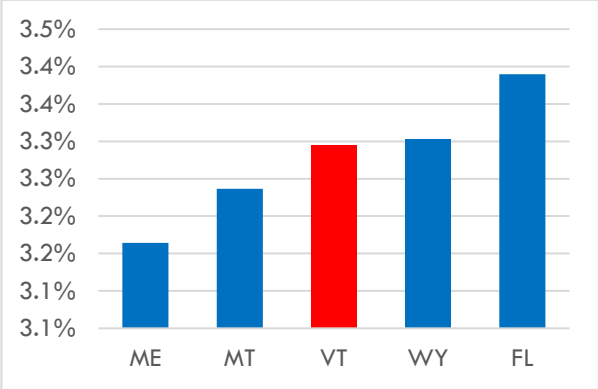


People Treated bt Opioid Type on Admission to the public treatment system (Source VT Treatment Data System)

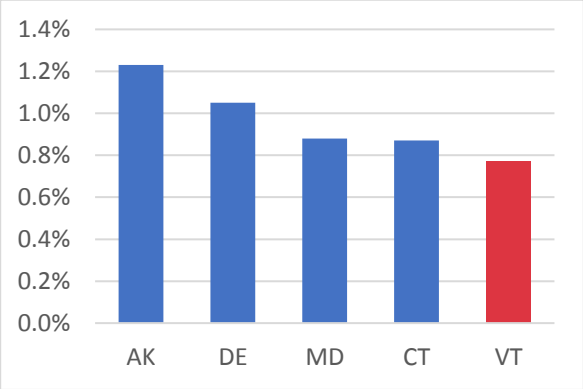


Vermont's data describing the high rate of heroin use is reflected in data collected by SAMHSA's National Survey on Drug Use and Health (NSDUH). In particular NSDUH found that Vermont has one of the lowest rates of past year use of prescription pain relievers and one of the highest for heroin use in the country.

Lowest 5 States for Non Medical Use of Prescription Pain Relievers Age 12+ (NSDUH 2013/2014)



Highest 5 States for Heroin Use Age 12+ (NSDUH 2014/2015)



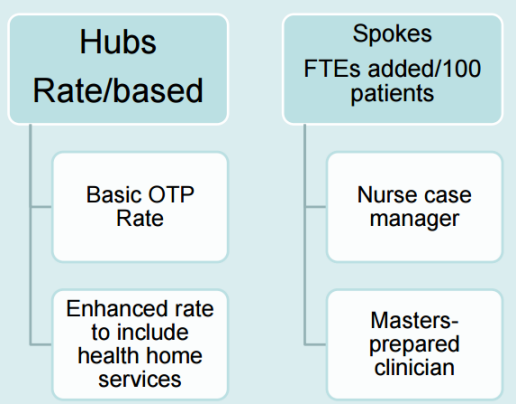
Vermont's Hub and Spoke Treatment System: Vermont's Hub and Spoke system is a Statewide partnership of clinicians and treatment centers designed to provide medication assisted treatment to Vermonters who are addicted to opioids. The Hub and Spoke model ensures that each person's care is effective, coordinated and supported. Depending on need, these services may include mental health and substance abuse treatment, pain management, life skills and family supports, job development and recovery supports. The key goals of the system are to improve access to substance use disorder treatment and integrate substance use disorder treatment with general health care. Services include enhanced health homes for substance use disorder treatment.

A person may enter care by requesting services at a regional opioid treatment center (Hub) or their primary care provider (Spoke).

- Regional Opioid Treatment Centers (Hub) located around the State treat those patients who have especially complex needs with medication assisted treatment.

- Physicians lead a team of nurses and clinicians (Spoke) to treat patients with medication assisted treatment

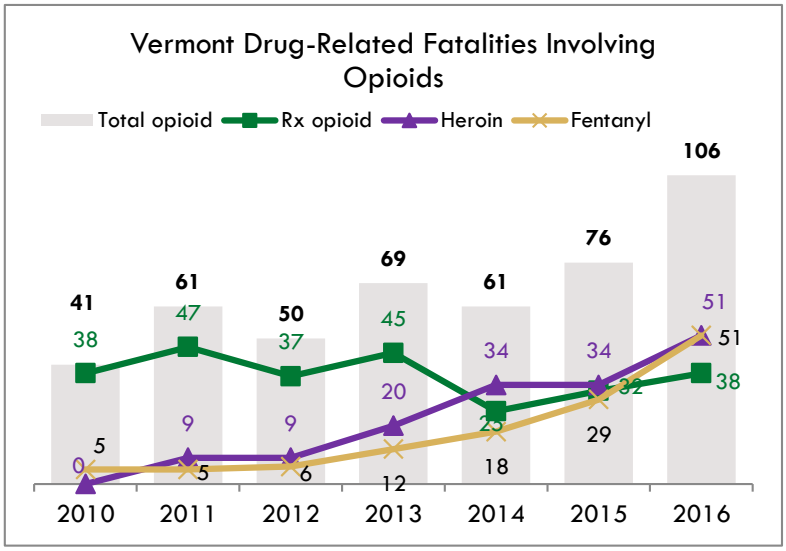
- Each patient's care is supervised by a physician and supported by nurses and counselors who work to connect the patient with community-based support services to ensure care coordination.



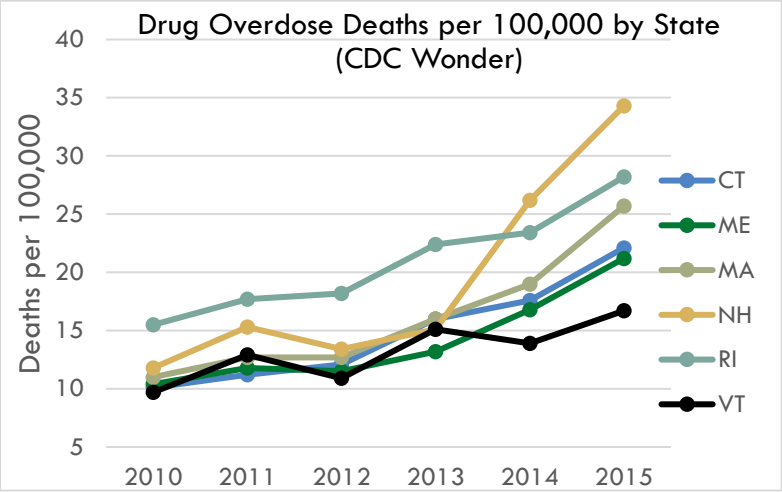
This system has significantly improved access to care – between 2012 and 2016 medication assisted treatment capacity increased by 139%. Approximately 7,150 Vermont adults age 18-64 are currently receiving medication assisted treatment for opioid use disorders and there is still demand for additional services. An initial evaluation of costs suggests that medication-assisted treatment in hubs and spokes is associated with reduced general health care expenditures and utilization, such as inpatient hospital admissions and outpatient emergency department visits, for Medicaid beneficiaries with opioid addiction. A review of 2015 Medicaid claims supports these positive outcomes and indicates that those with opioid use disorders have higher rates of health conditions than the general Medicaid population. It is also important to note that total Medicaid expenditures for those with opioid use disorders on medication assisted treatment are lower than those with opioid use disorders that are not receiving medication assisted treatment. An ongoing evaluation of patients receiving care shall focus on how patients' lives and functioning have been affected by their involvement in the Hub and Spoke system. Initial interviews indicate that those involved typically use heroin for about 10 years before treatment. Finally, more people seem to seek treatment if there are more accessible treatment services available in the community.

Opioid overdose deaths: New England has been particularly impacted by opioid use, resulting in overdose deaths from prescription drugs, heroin, and synthetic opioids such as fentanyl and tramadol. Vermont's overdose death rate is statistically similar to the U.S. rate (CDC, Wonder).

Vermont's accidental and undetermined manner drug-related fatalities involving an opioid (the categories not mutually exclusive – people use multiple substances -- and are from the VDH Vital Statistics System) are due to a combination of heroin, fentanyl and prescription opioids. The number of deaths involving heroin and fentanyl are increasing while those for prescription opioids are trending downward. Preliminary 2015 numbers show those trends have continued.



While deaths are increasing, they are increasing more slowly than other New England States despite high rates of heroin use in Vermont. We attribute this largely to access to medication assisted treatment and widely available naloxone reversal kits.



Naloxone Overdose Reversal Kit Distribution: In 2013, Vermont's Department of Health developed a Statewide naloxone (Narcan®) pilot program for distributing emergency overdose rescue kits to people at risk of an overdose, and to family members and others who may be able to help in the event of an overdose. The project has expanded emergency use kits by providing them free of charge at distribution sites across Vermont, and many town and city police departments are also carrying kits. Naloxone is currently available by prescription and stocked by many pharmacies and is also available over the counter.

In August 2016, the Department of Health issued a standing order for the opioid overdose rescue drug naloxone for all of Vermont. This allows any pharmacy to dispense the life-saving drug to anyone – without a prescription. The standing order is designed to ensure people who are addicted to opioid drugs, as well as their friends and family members, have easy access to naloxone in the event of an overdose. The order also allows insurers and Medicaid to cover the cost of naloxone.

Funding for the naloxone initiative was provided through the State evidence-based education program. The Department of Health and the Attorney General determine the funding sources for the program. This may include lawsuits brought by the Attorney General against pharmaceutical manufacturers.

Three Important Considerations for the Subcommittee: I offer the Subcommittee three key themes to consider as deliberations move forward.

Key nature of sustained and predictable funding through the Substance Abuse Prevention and Treatment (SAPT) Block Grant: We recommend that Congress maintain robust support for the SAPT Block Grant, an effective and efficient program supporting prevention, treatment, and recovery services. The SAPT Block Grant provides treatment services for 1.5 million Americans. At discharge from SAPT Block Grant funded treatment programs, 81.5 percent were abstinent from alcohol and 72.1 percent were abstinent from illicit drugs.

By statute, States must dedicate at least 20 percent of SAPT Block Grant funding for primary substance abuse prevention services. This "prevention set-aside" is by far the largest source of funding for each State agency's prevention budget, representing on average 70 percent of the primary prevention funding that states, U.S. territories, and the District of Columbia coordinate. In 33 states, the prevention set-aside represents at least 50 to 99 percent of the substance abuse agency's budgets.

It is important to continue this work given the positive gains moving forward in a number of areas. For example, according to the Monitoring the Future (MTF) study funded by the National Institute on Drug Abuse (NIDA), from 2000 to 2014, past year alcohol use among high school seniors in America has declined by 18 percent; past year use of cocaine has declined by 48 percent; and since its peak in 2004, the country has seen a 36 percent decline in past year use of prescription opioids.

An important feature of the SAPT Block Grant is flexibility. Specifically, the program is designed to allow States to target resources according to regional and local circumstances instead of predetermined federal mandates. This is particularly important given the diversity of each state's population, geography, trends in terms of drugs of abuse, and financing structure.

We appreciate the difficult decisions Congress must face given the current fiscal climate. We believe it is equally important to note that trends in federal appropriations for the SAPT Block Grant have led to a gradual but marked erosion in the program's reach. Specifically, the SAPT Block Grant has sustained a 29 percent decrease in purchasing power since 2007 due to inflation. In order to restore this important program back to the purchasing power for 2006, Congress would have to provide an increase of $442 million.

Critical role of State alcohol and drug agency directors and National Association of State Alcohol and Drug Abuse Directors: State substance abuse agencies work with stakeholders to craft and implement a statewide system of care for substance use disorder treatment, intervention, prevention, and recovery. In so doing, State agencies employ a number of tools to ensure public dollars are dedicated to effective programming. These tools include performance and outcome data reporting and management, contract monitoring, corrective action planning, onsite reviews, training, and technical assistance. In addition, State substance abuse agencies work to ensure that services are of the highest quality through State established standards of care. Federal policies and resources that promote working through the State substance abuse agency ensure that initiatives are coordinated, effective, and efficient.

NASADAD serves as the voice of State substance alcohol, and drug agency directors from across the country. NASADAD's mission is to promote effective and efficient State substance use disorder treatment, prevention and recovery systems. The Association promotes best practices, shares information about State systems, and collaborates with federal and non-governmental stakeholders from its Washington, D.C. location. NASADAD is led by Robert Morrison, Executive Director, and houses a Research Department and Public Policy Department.

Federal support of, and coordination with, State-based groups focused on the opioid crisis - including the National Governors Association (NGA): Since 2012, NGA's Center for Best Practices has worked with 13 states to help States develop and implement comprehensive plans for reducing prescription drug and heroin abuse. States that participated in NGA's two policy academies have passed legislation, developed public awareness campaigns, launched cross-agency and regional initiatives, and established critical relationships with universities and the private sector. We applaud NGA, led by Scott Pattison, for their leadership on this issue and look forward to our continued collaboration on this and other related efforts.

I also wish to recognize the work of the Association of State and Territorial Health Officials (ASTHO) led by Dr. Michael Fraser. We also wish to recognize ASTHO's current President, Dr. Jay Butler from Alaska, for identifying substance misuse and addiction as his top presidential priority. ASTHO has been working with NGA and NASADAD on these issues, participating in the NGA policy academies, and leading its own set of meetings on the topic. Over the years, the two Executive Directors of ASTHO and NASADAD have joined together to engage in joint presentations at meetings and conferences in order to ensure our efforts are coordinated.

I also recommend coordinating with other State-based groups that are working on this topic. For example, the National Alliance of State and Territorial AIDS Directors have been leaders on issues such as Hepatitis C and other matters related to intravenous drug use. The Safe States Alliance is another important group focused on injury and violence prevention. Close coordination between the federal government and State-based organizations does have an impact on our respective memberships on the ground level.

Conclusion: I sincerely appreciate the opportunity to present testimony before the Subcommittee. I look forward to working with Congress on these important issues. I also encourage the Subcommittee and Congress to work with NGA, NASADAD and ASTHO as well as other partners to leverage the collective knowledge and expertise of State alcohol and drug agency directors and public health departments across the country.