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TO: Members of the Senate Health, Education, Labor, and Pensions Committee

FROM: Dr. Leana Wen, Baltimore City Health Commissioner

RE: Committee Hearing: Opioid Abuse in America: Facing the Epidemic and Examining Solutions.

Chairman Alexander, Ranking Member Murray and Members of the Committee,

Thank you for inviting me to testify on the epidemic of opioid abuse that is sweeping across our country. Opioid abuse is an epidemic and a public health emergency – one that is claiming the lives, the livelihoods, and the souls of our citizens.

As an emergency room (ER) doctor, I have witnessed firsthand the effects of substance addiction on individuals and families, including treating hundreds of patients who have overdosed on opioids. My colleagues and I frequently felt frustrated by the limitations of clinical practice; by the time patients made their way to us, we had missed significant opportunities to intervene further upstream in that individual's life. This experience is what drove me to public health: a desire to tackle the epidemic of opioid abuse at a population level, and, in doing so, save individual lives while also redefining our societal approach to the treatment of addiction. Now, as the Health Commissioner of Baltimore City, I work every day with my dedicated staff at the Health Department and partners across our city, to prevent overdose and stem the tide of addiction.

The Opioid Problem in Baltimore

With approximately 19,000 active heroin users in Baltimore and far more who misuse and abuse prescription opioid medications, our city cannot be healthy without addressing opioid addiction and overdose. Last year in our city, 303 people died from drug and alcohol overdose, which is more than the number of people who died from homicide. Drug addiction impacts our entire community and ties into nearly every issue facing our city including crime, unemployment, poverty, and poor health. It claims lives every day and affects those closest to us – our neighbors, our friends, and our family.

To develop our framework to fight addiction and overdose in Baltimore, Mayor Stephanie Rawlings-Blake convened the Heroin Treatment and Prevention Task Force in October of 2014. Understanding that health is not just about physical health, but also behavioral health, the Mayor made this one of her administrations top priorities. She charged the Task Force with developing bold and progressive recommendations that could be implemented to turn the tide against

addiction in our city. These recommendations serve as our roadmap and call to action, led by the Baltimore City Health Department, in close collaboration with public and private partners across the city, including our major partner, Behavioral Health System Baltimore, a nonprofit that is the designated behavioral health authority of the city (of which I serve as Chair of the Board).

Baltimore's Response to Addiction and Overdose

Our work in Baltimore is built on three pillars:

- First, we have to prevent deaths from overdose and save the lives of people suffering from addiction.
- Second, we must increase access to quality and effective on-demand treatment and provide long-term recovery support.
- Third, we need to increase addiction education and awareness for the public and for providers, in order to reduce stigma and encourage prevention and treatment.

Our work in each of these areas is multifaceted because addressing a disease like addiction requires a comprehensive approach. We are glad to share these pillars with the Committee and appreciate the greater national public health focus on this issue. The opioid epidemic is affecting every part of our country. We are all in this together, and Baltimore is happy to share our innovations and lessons learned.

1. Preventing deaths from overdose

In Baltimore, I have declared opioid overdose a public health emergency and led the charge in one of the most aggressive opioid overdose prevention campaigns across the country.

a. The most critical part of the opioid overdose prevention campaign is expanding access to naloxone – the lifesaving drug that reverses the effect of an opioid drug overdose. Naloxone is safe, easily administered, not addictive, and nearly 100% effective at reversing an overdose. In my clinical practice, I have administered naloxone to hundreds of patients and have seen how someone who is unresponsive and about to die will be walking and talking within seconds. Since 2003, we have been training drug users on using naloxone through our Staying Alive Program. Last year, we successfully advocated for change in State legislation so that we can train not only individuals who use drugs, but also their family and friends, and anyone who wishes to learn how to save a life. This is critical because someone who is overdosing will be unresponsive and friends and family members are most likely to save their life.

   Our naloxone education efforts are extensive. This year, we have trained over 7,000 people to use naloxone: in jails, public housing, bus shelters, street corners, and markets. We were one of the first jurisdictions to require naloxone training as part of court-mandated time in Drug Treatment Court. We have trained state and city legislators so that they can not only save lives, but also serve as ambassadors and champions to their constituents. We use up-to-date epidemiological data to target our training to "hotspots", taking naloxone directly into the most at risk communities and putting it in the hands of those most in need. This was put into effect earlier this year, when we saw that 39 people

died from overdose to the opioid Fentanyl between January and March of 2015. Fentanyl is many times stronger than heroin, and individuals using heroin were not aware that the heroin had been laced with Fentanyl. This data led us to target our messaging so that we could save the lives of those who were at immediate risk.

Already, our naloxone outreach and trainings are changing the way our frontline officials approach addiction treatment, with a focus on assessment and action. In addition to training paramedics, we have also started to train police officers. The initial trainings were met with resistance from the officers who were hesitant to apply medical interventions that some did not see as part of their job description. However, in the first month of carrying naloxone, four police officers used naloxone to save the lives of four citizens. Recently, I attended a training where I asked the officers what they would look for if they were called to the scene for an overdose. In the past, I would have received answers about looking for drug paraphernalia and other evidence. This time, officers answered that their job was to find out what drugs the person might have taken, to call 911 and administer naloxone, because their duty is to save a life. By no means is naloxone training the panacea for repairing police and community relations. However, it is one step in the right direction as we make clear that addiction is a disease and overdose can be deadly. We are changing the conversation so that all of our partners can join in encouraging prevention, education, and treatment.

b. As of October 1, 2015, I have the authority to write blanket prescriptions for naloxone for the roughly 620,000 residents in Baltimore City, under a "Standing Order" which was approved by the Maryland State Legislature. This is one of the single largest efforts in the country to achieve citywide naloxone distribution. A Standing Order means that someone can receive a short training (which can be done in less than five minutes) and immediately receive a prescription for naloxone, in my name, without having seen me personally as their doctor. We also successfully advocated for Good Samaritan legislation, which expanded protections for those who assist in the event of an overdose, and malpractice protection for doctors who prescribe naloxone. Finally, our state Medicaid program has agreed to set the co-pay for naloxone at $1. While we still struggle with the pricing for naloxone (see below), this has allowed us to provide prescriptions to patients and others at a greatly reduced cost. We have to get naloxone into the hands of everyone who can save a life – which we believe is each and every one of us.

   Some people have the misconception that providing naloxone will only encourage a drug user by providing a safety net. This dangerous myth is not based on science but on stigma. Would we ever say to someone whose throat is closing from an allergic reaction, that they shouldn't get epinephrine because it might encourage them to eat peanuts or shellfish? An Epi-Pen saves lives; so does naloxone, and it should be just as readily available. Our mantra is that we must save a life today in order for there to be a better tomorrow.

2. Increasing access to on-demand treatment and long-term recovery support

Stopping overdose is only the first step in addressing addiction. To treat people with substance addiction, we must ensure there is adequate access to on-demand treatment. Nationwide, only 11% of patients with addiction get the treatment they need. There is no physical ailment for which this would be acceptable – imagine if only 11% of cancer patients or 11% of patients with diabetes were being treated. If we do not increase access to quality treatment options we are merely treading water, waiting for the person who has overdosed to use drugs and overdose again.

a. In Baltimore, we have started a 24/7 "crisis, information, and referral" phone line that connects people in need to a variety of services including: immediate consultation with a social worker or addiction counselor; connection with outreach workers who provide emergency services and will visit people in crisis at homes; information about any question relating to mental health and substance addiction; and scheduling of treatment services and information. This line is not just for addiction but for mental health issues, since these issues in behavioral health are so closely related and there is a high degree of co-occurrence. Those who are seeking treatment for behavioral health should be able to easily access the services they need, at any time of day. This 24/7 line has been operational since October 2015; already, there are nearly 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by family members seeking resources and providers looking to connect their patients to treatment.

b. We have secured $3.6 million in capital funds to build a "stabilization center" – also known as a sobering center – for those in need of temporary service related to intoxication. This is the first step in our efforts to start a 24/7 "Urgent Care" for addiction and mental health disorders – a comprehensive, community-based "ER" dedicated to patients presenting with substance abuse and mental health complaints. Just as a patient with a physical complaint can go into an ER any time of the day for treatment, a person suffering from addiction must be able to seek treatment on-demand. This center will enable patients to self-refer or be brought by families, police, or EMS – a "no wrong door" policy ensures that nobody would be turned away. The center would provide full capacity treatment in both intensive inpatient and low-intensity outpatient settings, and connect patients to case management and other necessary services such as housing and job training.

c. We are developing a real-time treatment dashboard to obtain data on the number of people with substance use disorders, near-fatal and fatal overdoses, and capacity for treatment. This will enable us to map the availability of our inpatient and outpatient treatment slots and ensure that treatment availability meets the demand. The dashboard will be connected to our 24/7 line that will immediately connect people to the level of treatment that they require—on demand, at the time that they need it.

d. We are expanding our capacity to treat overdose in the community by hiring community-based peer recovery specialists. These individuals will be recruited from the same neighborhoods as individuals with addiction, and will be trained as overdose interrupters who can administer overdose treatment and connect patients to treatment and other necessary services.

e. We have implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which provides universal screening of patients presenting to ERs and primary care offices. Three of our hospitals are early pioneers in SBIRT; we are looking to expand it to all hospitals and clinics in the city to ensure delivery of early intervention and treatment services for those with or at risk for substance use disorders.

f. We are expanding and promoting medication-assisted treatment, which is evidence-based and highly effective method to help people with opioid addiction recover. This combines behavioral therapy with medication, such as methadone or buprenorphine, along with other support. Taking medication for opioid addiction is like taking medication to control heart disease or diabetes. When prescribed properly, medication does not create a new addiction, but rather manages a patient's addiction so that they can successfully achieve recovery. Baltimore has been at the leading edge of innovation for incorporating medication-assisted treatment, including providing medications in structured clinical settings through the Baltimore Buprenorphine Initiative. This year, we expanded access to buprenorphine treatment by offering services in low-barrier settings, such as recovery centers, emergency shelters, and mental health facilities. Providing access to buprenorphine services in these settings allows us to engage people who are more transient or unstably-housed into much needed treatment.

g. We are working to expand case management and diversion programs across the city so that those who need help get the medical treatment they need. In our city of 620,000, 73,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an affliction. Baltimore already has highly-effective diversion efforts such as Drug Treatment Courts and Mental Health Treatment Courts. We are looking to implement a Law Enforcement Assisted Diversion Program, a pilot model that has been adopted by a select group of cities, which establishes criteria for police officers to identify eligible users and take them to an intake facility that connects them to necessary services such as drug treatment, peer supports, and housing – rather than to central booking for arrest.

   Finally, we are increasing our capability for case management services for every individual leaving jails and prisons. These individuals are at a highly vulnerable state, and must be connected to medical treatment, psychiatric and substance abuse treatments if appropriate, housing and employment support, and more. Our outreach workers already target a subset of this population; we need to expand capacity to every one of these individuals. Additionally, as mentioned above, we are deploying community health workers in order to reach people where they are in the community as well as provide a credible messenger. In deploying this tactic, we are also excited to bring jobs and opportunities to vulnerable individuals and neighborhoods that otherwise have limited employment opportunities.

3. Providing education to reduce stigma and prevent addiction

In addition to treating patients, we must also change the dialogue around substance use disorder. The Baltimore City Health Department is leading a citywide effort to educate the public and providers on the nature of substance addiction: that it is a disease, recovery is possible, and we all must play a role in preventing addiction and saving lives.

a. We have been at the forefront of changing public perception of addiction so those in need are not ashamed to seek treatment. We have launched a public education campaign "DontDie.org" to educate citizens that addiction is a chronic disease and to encourage individuals to seek treatment. This was launched with bus ads, billboard ads, a new website, and a targeted door-to-door outreach campaign in churches and with our neighborhood leaders.

   We have also launched a concerted effort to target prevention among our teens and youth entitled "BMore in Control." We have established permanent prescription drug drop boxes at all nine of the city's police stations. This means that anyone can drop-off their unused, unwanted, or unnecessary prescription drugs—no questions asked. Drugs left in the home can end up in the wrong hands—spouses, elderly family members, or even our children. I have treated 2-year olds who were dying from opioid overdose, again underscoring that all of us can be at risk and must play a role.

b. We are targeting our educational efforts to physicians and other prescribers of opioid medications. Nationwide, over-prescribing and inconsistent monitoring of opioid pain medications is a major contributing factor to the overdose epidemic. According to the Centers for Disease Control, there were 259 million prescriptions written for opioids in 2014. That is enough for one opioid prescription for every adult American. Every day, people overdose or become addicted to their prescription opioids.

   To address this, I have sent "best practice" letters to every doctor in the city and will also do so for all dentists and pharmacists. The letter addressed the importance of the Prescription Drug Monitoring Program and judicious prescribing of opioids, including not using narcotics as the first line medication for acute pain and emphasizing the risk of addiction and overdose with opioids. Importantly, this best practice requires co-prescribing of naloxone for any individual taking opioids or at risk for opioid overdose. Hospitals keep naloxone on hand if patients receive too much intravenous morphine or fentanyl. Patients must also receive a prescription for naloxone if they are to be discharged with opioid medications that can result in overdose.

   These best practices were developed through convening ER doctors, hospital CEOs, and other medical professionals in the city. To reach practicing doctors, we have been presenting at Grand Rounds, medical society conferences, and are also about to launch physician "detailing", where we will employ teams of public health outreach workers and people in recovery to visit doctors to talk about best practices for opioid prescribing. We are working with providers to ensure best

practices will be used when prescribing opioids and that we all play our part—as providers, patients, and family members—to prevent addiction and overdose.

Working with the Federal Government

The Baltimore City Health Department, together with our partners across the city and state, has made significant progress in tackling the opioid epidemic. However, there are some areas where we face continued challenges. Though there is much that can be done on the city and state levels, the federal government plays a critical role in the campaign against addiction and overdose. We appreciate the opportunity mention four specific areas that can be addressed:

1. **Expand funding and availability of on-demand addiction treatment service**

We must treat addiction as a disease and not a crime or a moral failing. In order to successfully treat the disease, we need to ensure there are sufficient high-quality treatment options available to those in need.

a. Federal funding could expand treatment on-demand including 24/7 dedicated centers for substance addiction and mental health and proven intervention models such as LEAD and expand case management services for vulnerable individuals. These programs will help to ensure that those in need have a path to recovery.

b. Congress can push for equitable insurance coverage for addiction services. Medicare pays for pain medications that can lead to addiction, yet many states do not cover medication-assisted treatment and other evidence-based interventions for addiction recovery. Congress can ensure that Medicaid, Medicare, and private payers cover on-demand treatment for acute care (such as sobering, urgent care, and residential services), as well as ongoing treatment and services like medication-assisted treatment and case management. These rates should also be equivalent to mental health and physical health care rates (which they are not currently, leading to a dearth of providers and inadequate care).

c. Congress can remove barriers to prescribing Buprenorphine. Buprenorphine is a medication-assisted treatment option with a much lower chance of overdose than methadone. Importantly, it can be administered by a primary care provider rather than in a designated drug-treatment clinic. This helps to increase the accurate perception that substance use disorder is a medical condition. Unfortunately, at the moment, only medical doctors can prescribe buprenorphine, and a doctor can only provide Buprenorphine to a maximum of 100 patients**.** This barrier does not exist for any other medication, and significantly limits the ability of patients to access a life-saving treatment option and leaves many patients with methadone as their only option for medication-assisted treatment. Methadone requires administration in a designated treatment clinic, which are often a point of contention within the communities in which they operate due to the stigma associated with drug addiction. We strongly support current efforts underway at the Department of Health and Human Services to revise the limits on buprenorphine prescription in a given year, and urge further support of broadened access

to this proven treatment including by requesting Congress to consider broadening prescription authority of Buprenorphine to Nurse Practitioners and other providers.

2. Provide Cities and States with opportunity to innovate around addiction recovery

There are many services not covered by Medicaid, Medicare, or other forms of insurance that are critical to addiction recovery. Congress can provide funding to local jurisdictions and to States that can give grants and incentives to support innovative, evidence-based programs that do not simply focus on the medical component of addiction but the broader psychosocial components. These include:

a. New care delivery models. There is research on new treatment options such as starting buprenorphine from ERs, mobile buprenorphine induction, or telemedicine treatment that would be not eligible for existing reimbursement yet offer much promise. These are examples of delivery models that local and state agencies should have the option of providing grant funding for, with the option of being included in Medicaid formulary after sufficient time and evidence.

b. Peer recovery specialists. In Baltimore, we are aiming to provide a peer recovery specialist for every individual who presents for overdose or addiction-related condition to our ERs and other facilities. However, we are limited by the lack of funding for these individuals. There should be opportunities for expanded funding and reimbursement for services rendered by these trained community health workers; grant funding to local and state agencies can be one way to pursue this.

c. Case management services. Individuals leaving incarceration or inpatient stays are at very high risk; they must receive wrap-around services that connect them immediately to needed medical and psychiatric assistance. These case management services have inconsistent reimbursement; innovative programs including with telemedicine and use of peer recovery specialists should be encouraged.

d. Community resources for recovery. Recovery from addiction involves more than clinical treatment but also support and long-term care. Local and state agencies can also innovate with interventions such as recovery housing and reentry support; federal funding can assist in these necessary steps.

e. Prevention. Grant support for tailored and targeted prevention support including public education and provider education must also be a critical component.

3. Congress can monitor and regulate the price and availability of naloxone.

Naloxone is a generic medication that is part of the World Health Organization's list of essential medications. Over the last two years, the price of naloxone has dramatically increased. In Baltimore, the cost per dose of naloxone has quadrupled—meaning that we can only save a quarter of the lives we could have saved. This is particularly problematic for cities and counties that must purchase naloxone for use by paramedics, police officers, and other front-line workers. Manufacturers have claimed that this price increase is related to increased demand. However, it is unclear why the cost of a generic medication that is

available for much lower costs in other countries will be suddenly so expensive. Congress can join efforts by Senator Sanders and Congressman Cummings to call for investigation into the reason for the price increase, which would otherwise prohibit us from saving lives at a time that we need to the most.

4. **Congress can push for national stigma-reduction and opioid-awareness campaign**
Many local jurisdictions like Baltimore have launched public education campaigns. There is much more education that must be done in order to encourage people with addiction into care and to disband stigmas that are leading many communities to avoid providing treatment altogether. Local jurisdictions are also limited by funding constraints. Congress can push for the launch of a national campaign to reduce stigma and to increase awareness of opioid addiction. This national campaign will provide the spotlight this critical issue requires.

Conclusion

While some of the challenges facing Baltimore may be unique, we join our counterparts around the country in addressing the epidemic of opioid addiction. According to the Centers for Disease Control, the number of people dying from overdose has quadrupled from 15 years ago. In many states, there are more people dying from overdose than from car accidents or suicide. Contrary to popular perception, the fastest growing demographic of people dying from prescription opioid overdose is white and middle-aged women.

There are some who say the opioid problem is too big and too complicated—that it cannot be solved. It is true that treating the opioid epidemic requires many approaches. However, this is an issue that requires our attention. According to the World Health Organization, treating opioid addiction saves society $12 for every $1 spent on treatment. Treatment also has impact in many other ways to communities by reducing excess healthcare utilization, increasing productivity and employment rates, and decreasing poverty and unnecessary cost to the criminal justice system. Not to mention that it is a moral imperative and a matter of life and death.

Baltimore has been fighting the heroin and opioid epidemic for decades and we continue to make progress with bold ideas and innovative strategies. Our efforts around opioid addiction seek to change the face of Baltimore from the "heroin capital" to becoming the center of addiction recovery. We are glad to share our lessons with our counterparts around the country and with our national leaders. With dedicated partners like you in Congress, we can fight the epidemic together, save lives and reclaim people and their families.

On behalf of the Baltimore City Administration, I want to thank you for calling this important hearing. We look forward to working with you to stop the epidemic of opioid addiction in the U.S.