CITY OF BALTIMORE
STEPHANIE RAWLINGS-BLAKE, Mayor

HEALTH DEPARTMENT
Leana S. Wen, M.D., M.Sc., FAAEM
Commissioner of Health
1001 E. Fayette St.
Baltimore, MD 21202
health.commissioner@baltimorecity.gov
Tel: 410-396-4387

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TO: Members of the House Oversight Committee

FROM: Dr. Leana Wen, Baltimore City Health Commissioner

RE: Testimony: America's Heroin and Opioid Abuse Epidemic

Chairman Chaffetz, Ranking Member Cummings 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 a public health emergency 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. I remember well my patient, a 24-year old mother of two who came to the ER nearly every week requesting addiction treatment. She would be told there was nowhere for her to go that day or the next, and would be offered an appointment in three weeks time. Because she lacked housing and other supportive services, she would relapse. One day, her family found her unresponsive and not breathing. By the time she arrived in the ER, it was too late for us to save her, and she died.

I always think back to my patient now: she had come to us requesting help, not once, not twice, but over and over again, dozens of times. Because we do not have the treatment capacity, people looking to us for help fall through the cracks, overdose, and die. Why has our system failed her, just as it is failing so many others who wish to get help for their addictions?

My colleagues and I frequently felt frustrated by the limitations of clinical practice; by the time patients made their way to us, society had missed significant opportunities to intervene farther upstream in that individual's life. We treat addiction differently than we treat any other illness. Would we ever tell someone who has had a heart attack to wait three weeks to get treatment? Despite scientific studies showing that addiction is a disease and that recovery is possible, many still question why people "choose" a lifestyle of using drugs. Would we impose such stigma on any other disease? These are the experiences that drove me to public health: a desire to tackle the epidemic of addiction at a community level, and, in doing so, save lives while also redefining our societal approach to the treatment of addiction.

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. I am encouraged that the approach to the opioid epidemic is shifting away from the

rhetoric of the "war on drugs" and instead focusing on treating addiction as a disease. But while our rhetoric is changing, funding for treatment lags behind. Of the more than 20 million people who abuse some form of drug, only about 1 in 10 is able to receive treatment. In Baltimore and around the country, our patients come requesting assistance, but are forced to wait weeks, even months, to access needed care.

This struggle is not unique to Baltimore; millions of Americans struggle to find treatment when they are ready to seek it. Ensuring those struggling with addiction can access treatment on-demand requires systems change. We can learn from cities that have taken the lead across the country using innovative approaches to address this national issue; Baltimore is one such city that is at the cutting edge of addiction prevention and treatment.

The Opioid Problem in Baltimore

With over 20,000 active heroin users in Baltimore and far more who misuse and abuse prescription opioid medications, opioid addiction and overdose is a critical health priority in our city. In 2014, 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. (For more information about the state of health of the city, please see Appendix A)

Since my appointment in January 2015, I have made overdose prevention and addiction treatment my top priority. I worked closely with Mayor Stephanie Rawlings-Blake to guide the work of the Mayor's Heroin Treatment and Prevention Task Force that released ten bold and progressive recommendations in July 2015. These ambitious recommendations form the framework and guide the roadmap of our efforts, which are led by the Baltimore City Health Department and 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), in close coordination with our public and private partners across the city.

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 working tirelessly to change the conversation, and our efforts serve as a model nationally and for other local and state jurisdictions. We know what works for combating addiction but we need help to make sure all who seek treatment are able to

get it. 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 as an emergency physician, 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, Baltimore City has been training drug users on using naloxone through our Staying Alive Program. Last year, we successfully advocated for change in State law 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. In 2015, we trained over 8,000 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 federal, state and city legislators so that they can not only save lives, but also serve as ambassadors and champions to their constituents.

b. 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 in 2015, 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. These data led us to target our messaging so that we could save the lives of those who were at immediate risk. We coordinate our data with agencies across the city including the police department, fire department, and hospitals, so as to ensure our information is complete and our efforts are unified.

c. 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" 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.

In order to train even more people in the use of naloxone, we have launched an online platform that now allows residents to get trained online and immediately receive a prescription for naloxone. This online platform, which is the first-of-its-kind around the country and the world, is the next step to reduce barriers to naloxone. In Baltimore, we believe that naloxone should be part of everyone's medicine cabinet and everyone's First Aid kit.

d. 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.

e. We 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.

f. 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.

The evidence is clear: addiction treatment requires a combination of medication-assisted treatment, psychosocial support, and wrap-around services including supportive housing. All of these must be in place for individuals suffering from addiction to recover, and they must be available at the time the individual is seeking these services—the same as for any medical condition.

a. In Baltimore, we have started a 24/7 "crisis, information, and referral" phone hotline 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 hotline 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 approximately 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by family members seeking resources, and police and providers looking to connect their patients to treatment.

b. 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.

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 hotline that will immediately connect people to the level of treatment that they require—on demand, at the time that they need it.

d. 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.

e. We are expanding and promoting medication-assisted treatment, which is evidence-based and a 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.

f. We are expanding our capacity to treat overdose in the community by hiring community-based peer recovery specialists. To build trust, 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.

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 starting to implement a Law Enforcement Assisted Diversion Program (LEAD), 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. Cross agency partnerships will be key in making these programs successful. LEAD implementation in Baltimore involves not only the Health Department and our behavioral health providers but the Police Department, State's Attorney's Office, Public Defender's

Office, and many more entities that together recognize the importance of addiction treatment.

h. We are increasing our capability for case management services for every individual leaving jails and prisons. These individuals are in a highly vulnerable state, and must be linked to appropriate physical and behavioral health care, social and supportive services, employment, mentoring and housing. Our outreach workers already target a subset of this population; we need to expand capacity to every one of these individuals. Additionally, we are deploying community health workers who are individuals in recovery themselves 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 the nature of substance use disorders. 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 are working with restaurants and bar owners to post "Don't Die" posters in their establishments.

b. "DontDie.org" has also become our portal for online trainings and for dispensing of naloxone through the Standing Order mentioned above. Any resident can watch a short (10 minute) video, take a 4-question quiz, and receive a standing order prescription to receive and to use naloxone to save lives.

c. We have also launched a concerted effort to target prevention among our teens and youth. This involves a campaign called "BMore in Control," and we are also incorporating prevention into the public school curriculum.

d. We have established permanent prescription drug drop boxes at all nine of the city's police stations and have conducted educational awareness campaigns around not using prescriptions that were given to anyone else. 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.

e. 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 and Prevention (CDC), there were 259 million prescriptions written for opioids in 2014. That is enough for one opioid bottle 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. 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 have also launched physician "detailing", where we deploy teams of public health outreach workers and people in recovery to visit doctors to talk about best practices for opioid prescribing. We are working on a convening for pharmacists to set pharmacy best practices, and have supported statewide legislation to require the use of Prescription Drug Monitoring Programs by physicians and pharmacists. All of us—as providers, patients, and family members—must play our part to prevent addiction and overdose.

f. As part of our "best practices" recommendations, we are leading efforts to warn patients and prescribers against combining opioids and benzodiazepines. Nationwide, one in three fatal overdoses is due to this combination—a little known but extremely dangerous phenomenon. Physicians routinely prescribe these two medications together, yet because they both result in respiratory depression and sedation, overdoses are common and fatal.

In February, I co-led a group of over 40 City Health Commissioners and State Health Directors across the country urging the U.S. Food and Drug Administration (FDA) to require a "black box warning" on opioids and benzodiazepines that states that concurrent use of the medications increases the risk of fatal overdose. Black box warnings appear on the labels of prescription drugs and call attention to serious or life-threatening risks. We started a public petition and have over 3,000 signatures from people showing their support for this public warning. This is a first-of-its kind petition delivered to the FDA by frontline health officials. (See Appendix B)

While we wait for the FDA to require a "black box warning," we are also calling on prescribers to warn patients about the risks of combined opioid and benzodiazepine use. Patients with chronic pain are often prescribed opioids to treat their pain and benzodiazepines to treat their associated symptoms, such as anxiety and sleep disorders.

Educating patients about this potentially lethal drug interaction is an important step to reduce the toll of addiction and fatal overdose in communities across the country.

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 combating America's heroin and opioid abuse epidemic.

Recently, the Senate passed the Comprehensive Addiction and Recovery Act (CARA) which focuses on prevention and treatment efforts. I urge the House to pass this critical legislation. This is a great first step towards promoting prevention, treatment, and more inclusive communities. Although the bill provides for additional funding, far more resources are needed. We have four specific areas that should be more comprehensively addressed:

1. **Congress can expand funding for and availability of on-demand and wrap-around addiction treatment services**

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, at the time that they need it. The science is unambiguous and unequivocal: addiction treatment requires medication-assisted treatment, psychosocial support, and wrap-around services. The problem is that we are nowhere near capacity to get everyone treatment at the time they need it.

a. Federal funding could expand treatment on-demand. There is often a small window of opportunity to get an individual with substance abuse or mental health issues into treatment. Additional money should be made available to establish 24/7 treatment centers dedicated to substance addiction and mental health. These centers will provide a one stop shop for those in need at the time they need it, and will also alleviate pressure from emergency rooms and jails, both of which are ill-equipped to handle these patients.

b. Congress can push for equitable insurance coverage for evidence-based 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). Services that are not science- and evidence-based—including rapid detoxification or sobriety-only programs—should not be federally funded.

c. Congress can expand funding for wrap-around services. Access to social needs like housing and employment is just as crucial to a person's recovery as medical treatment. These wrap-around services are especially important for those re-entering society after incarceration. Funding for case managers and care coordinators to help those in recovery access services is necessary for those with addiction to have a path to recovery. Housing remains a major challenge. In Baltimore, it is estimated that there are over 18,000 turn-away's each year for individuals seeking recovery housing. Providing stable housing will help to break the cycle of addiction, homelessness, and incarceration, and is critical for supporting those with addiction.

d. Congress can expand funding to diversion programs and ensure that individuals with substance use disorders receive addiction treatment. With the recognition that incarceration is not the solution to addiction, Congress can increase funding to diversion programs such as LEAD and Drug Treatment Courts. Individuals who are incarcerated should also receive evidence-based treatments. Those who enter prison being treated with buprenorphine are often switched to methadone due to its lower cost—a consideration that would not occur for other diseases. Patients should be allowed to continue treatments that work for them upon entering prison, and all who have addictions should be directed to evidence-based treatment options.

2. Congress can directly fund local jurisdictions with highest need

While States have traditionally received block grants from the federal government, local jurisdictions are the closest to the ground in service delivery, and understand the needs of residents the best. We urge Congress to consider direct support for local jurisdictions, particularly those in areas of greatest need, and providing cities and counties with the autonomy to innovate and provide real-time care for our residents. These services include innovative models that are not covered by Medicaid, Medicare, or private insurance, such as:

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 not be 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 jurisdictions 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 change critical federal regulations around addiction and overdose treatment

a. Congress can monitor and regulate the price of naloxone. Naloxone, the opioid overdose antidote, is part of the World Health Organization's (WHO) list of essential medications. Over the last two years, the price of naloxone has dramatically increased. The cost of naloxone skyrocketing means that we can only save a fraction of the lives we were able to before. 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 price increase of naloxone, which would otherwise prohibit us from saving lives at a time that we need to the most.

b. Naloxone should be co-prescribed to every individual receiving opioid medications. This is part of Baltimore's best practices, and we urge this standard to be implemented nationwide. This could be implemented through policy recommendation through the CDC, regulation through the FDA, or through federal legislation. However, we urge federal legislation requiring co-prescribing of naloxone given the escalating rate of opioid overdose deaths.

c. Congress can join local and state health officials to call for a prompt decision by the FDA for "black box warning" labels on opioids and benzodiazepines. This is a rapidly escalating dangerous trend that is fueling the overdose epidemic. (See Appendix B)

d. 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 often becomes 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 eliminate the limits on buprenorphine prescription, and urge further support of broadened access to this proven treatment including for Congress to consider broadening prescription authority of buprenorphine to Nurse Practitioners and other providers.

4. Congress can fund a 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 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. Such national public health campaigns have had dramatic success in the past, including with reducing drunk driving.

Conclusion

While some of the challenges facing Baltimore are unique, we join our counterparts around the country in addressing the epidemic of opioid abuse and addiction. According to the CDC, 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.

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 WHO, treating opioid addiction saves society $12 for every $1 spent on treatment. Treatment also impacts communities by reducing excess healthcare utilization, increasing productivity and employment rates, and decreasing poverty and unnecessary cost to the criminal justice system. Furthermore, treating addiction 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 to address opioid addiction seek to change the face of Baltimore from the "heroin capital" to the center of addiction recovery. Our goal is to make sure all those who suffer from addiction get the services they need to recover.

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, save lives and reclaim people and their families.

I want to thank you for calling this important hearing. I look forward to working with you to stop the epidemic of heroin and opioid addiction in the United States.