



# The Fight to End the Nation's Overdose Epidemic and Restore Compassionate Care: Profiles in Leadership

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Research collaboration led by

**manatt**

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# Introduction

In 2021, drug-related overdose deaths topped 107,000.<sup>1</sup> Despite a nearly 50% decrease in opioid prescribing over the past decade, drug overdose mortality continues to trend in the wrong direction.<sup>2</sup> Of particular concern is that the increase in drug-related deaths is occurring disproportionately among youth and among people who are Black, American Indian and/or Native Alaskan.<sup>3</sup> Patients with pain continue to suffer from restrictions on access to legitimate pain care options, including opioid analgesics as well as non-opioid modalities. And while naloxone has

saved tens of thousands of lives, it is clear that greater access to harm reduction initiatives must include more than only naloxone.

In the face of these devastating data, the nation needs to redouble its efforts to reduce the death and destruction arising from these issues and offer evidence-based treatment and action to all who need them. As part of charting a path forward, the American Medical Association (AMA) and Manatt Health released a [national policy roadmap](#) in December 2020 with detailed recommendations for policymakers. In 2022, the

AMA and Manatt released a more comprehensive [state toolkit](#) that expanded on the initial recommendations by describing specific tools and strategies for making progress across six major areas:

1. Increase access to evidence-based treatments to help patients with a substance use disorder (SUD).
2. Ensure access to addiction medicine, psychiatry and other trained physicians.
3. Enforce mental health and SUD parity laws.

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<sup>1</sup> Ahmad, F.B., Cisewski, J.A., Rossen, L.M., Sutton, P. "Provisional drug overdose death counts." National Center for Health Statistics. 2022. Available at: [www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm](http://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm).

<sup>2</sup> IQVIA Xponent limited to retail pharmacy-dispensed prescriptions. State-by-state comparison available at [www.igvia.com/locations/united-states/solutions/life-sciences/information-solutions/essential-information/prescription-information](http://www.igvia.com/locations/united-states/solutions/life-sciences/information-solutions/essential-information/prescription-information). Definition: USC 78312 Opioid Reversal Agents (naloxone) and USC 78340 Drug Dependence (buprenorphine and buprenorphine/naloxone), excludes buprenorphine indicated for pain management (USC 02200).

<sup>3</sup> Kariisa, M., Davis, N.L., Kumar, S., et al. "Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics—25 States and the District of Columbia, 2019–2020." Morbidity and Mortality Weekly Report (MMWR). Centers for Disease Control and Prevention. July 22, 2022. Available at: [www.cdc.gov/mmwr/volumes/71/wr/mm7129e2.htm](http://www.cdc.gov/mmwr/volumes/71/wr/mm7129e2.htm).

4. Improve access to multidisciplinary, multimodal care for patients with pain.
5. Expand harm reduction efforts to reduce death and disease.
6. Improve public health data surveillance, monitoring and evaluation.

In this year's report, ***The fight to end the nation's overdose epidemic and restore compassionate care: Profiles in leadership***, we highlight the work of more than 25 practicing physicians, policymakers, dedicated researchers and advocates who illustrate how the strategies across these six domains can be turned into reality. Readers will

undoubtedly see that just because a feature story is presented under one domain, the actions taken by these leaders cut across multiple domains. We also are acutely aware that these leaders represent a much larger group of physicians and others taking action. Most of them work daily in their practices, behind the scenes in state agencies, universities, jails and prisons, hospitals, clinics, and on the streets; some strategically use their clinical expertise, academic leadership and public advocacy to address the stigma and myths that still complicate our nation's response to the epidemic. Fueled

by a fierce determination to upend the status quo and stem the tide of drug-related overdose deaths and destruction, all of them are making a dramatic difference in the lives of Americans. All are extraordinary leaders. Our fondest hope is that their stories will inspire others to join the fight to advance proven policies, illuminate the path forward and help heal the scars in communities across the nation.

# **AMA substance use and pain care task force**

# AMA substance use and pain care task force: Changing the narrative from punishment to compassionate care

## Profile of Patrice A. Harris, MD, MA, and Bobby Mukkamala, MD

In 2014, the American Medical Association (AMA) established organized medicine's first task force to identify and promote the specific actions all physicians could take to reduce opioid-related harms and improve health outcomes. Originally called the AMA Opioid Task Force, it was led by Patrice A. Harris, MD, MA, a child psychiatrist and member of the AMA Board of Trustees. Now called the AMA Substance Use and Pain Care Task Force, it is comprised of more than 25 national, specialty and state medical societies, which have developed a series of consensus-driven recommendations that Dr. Harris says "are essential to raise physician awareness for the need for us to take collective responsibility and take action to help our patients." The [original recommendations](#) focused

on the following actions physicians could take:

- Support physicians' use of effective prescription drug monitoring programs (PDMP).
- Enhance education on effective, evidence-based prescribing and treatment for patients with pain and those with a substance use disorder (SUD).
- Support access to comprehensive, affordable, compassionate treatment for patients with pain and those with an SUD.
- Put an end to stigma.
- Expand access to naloxone in the community and physician prescribing.
- Encourage safe storage and disposal of prescription medication.

"In 2014-15, we looked at the programs and policies that others were saying would address the opioid epidemic," said Dr. Harris. "What we saw were programs and policies that were not really based on the patient, what was best for the patient, but rather something more from law enforcement and punitive actions. That's where the Task Force saw our unique role—and while these recommendations seem commonplace today, it took hard work to make that happen."

Dr. Harris highlighted that since the recommendations were first issued, physicians and other health care professionals have reduced opioid prescribing by nearly 50% and increased PDMP use from less than 100,000 queries in 2014 nationwide to more than 1.1 billion queries in 2021.<sup>4</sup> And while physicians have

<sup>4</sup> American Medical Association. "2022 Overdose Epidemic Report." 2022. Available at: [https://end-overdose-epidemic.org/wp-content/uploads/2022/09/AMA-Advocacy-2022-Overdose-Epidemic-Report\\_090622.pdf](https://end-overdose-epidemic.org/wp-content/uploads/2022/09/AMA-Advocacy-2022-Overdose-Epidemic-Report_090622.pdf).

increased access to naloxone and treatment for SUDs, drug-related overdose mortality has increased each year—now spiking to more than 107,000 yearly deaths, according to the U.S. Centers for Disease Control and Prevention (CDC).<sup>5</sup>

“Policymakers also have a clear role to play in removing barriers to care,” said Dr. Harris. “The Task Force knew that restricting physicians and creating barriers to care for patients was not going to have the desired effect of improving care and saving lives. We must inspect what we expect because a lot of regulations, policies, and laws get passed. We need to ensure that the right metrics are used, see if the policies are meeting those metrics, and if not, it’s essential to reevaluate and revise those programs and policies.”

To help medical societies better advocate and provide policymakers with guideposts on effective policies in support of patients, the Task Force released the following [2019 recommendations](#) focused on actions policymakers could take:

- Remove inappropriate administrative burdens or barriers that delay or deny care for Food and Drug Administration (FDA)-approved medications used to help treat opioid use disorder (MOUD).
- Support assessment, referral and treatment for co-occurring mental disorders, as well as enforce meaningful oversight and enforcement of state and federal mental health and SUD parity laws.
- Remove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs.
- Support maternal and child health by increasing access to evidence-based treatment, preserving families and ensuring that policies are nonpunitive.
- Support reforms in the civil and criminal justice system that help ensure access to high-quality, evidence-based care for opioid use disorder (OUD), including MOUD.

“Physicians can’t do it alone,” said Bobby Mukkamala, MD, a surgeon, former chair of the AMA Board of Trustees, and current chair of the Task Force. “The epidemic actually demonstrates de-volution. I know

some people say that the epidemic has evolved, but that would suggest positive change. I think it’s clear the opposite has occurred, and we need to push harder to stop further decline.”

Dr. Mukkamala echoed Dr. Harris’ call for evidence-based policies, but emphasized that policy is just a starting point.

“In early 2022, we published a new report with Manatt Health that specifically identified more than 400 laws, regulations and other policies across the nation that have the potential to truly help patients,” said Dr. Mukkamala. “Our recommendations emphasize removing barriers to care for patients with pain whether it’s prior authorization, step therapy or a nonopioid alternative option for their pain as well as arbitrary right dosage caps and arbitrary numbers on what can be prescribed.

Patients need the federal x-waiver removed to allow more patients to get buprenorphine for opioid use disorder. We need to make it easier to get people trained to take care of their patients with pain. We also need to address barriers to mental illness and care for people who are incarcerated so whether it’s a jail or prison, they don’t deny medications to people with a substance use

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<sup>5</sup> *Id.*



disorder who are incarcerated. We can't leave people behind and break up families when a person has a substance use disorder or somebody who is about to be a new parent has a substance use disorder."

Dr. Harris said that the Task Force also must continue to emphasize how policy actions must be combined with a commitment to confront racial, gender and other inequities. She said that Black and Brown individuals continue to receive less and different treatment for pain, mental health and SUD than white individuals. "We can't shy away from truth-telling," said Dr. Harris. "I'm glad the focus on the epidemic has been elevated, but we have to realize the elevation occurred when middle-class and upper-middle-class white families began to be impacted by the epidemic. So while we must urge policymakers to take these actions, we must ensure that the solutions are equitably provided."

Debunking stigma and "truth-telling" also continue to play a huge role in helping patients, said Dr. Harris.

"There's nothing helpful about Black people being undertreated for pain," said Dr. Harris. "These are myths that also exist among medical professionals. Black people don't have thicker skin. Black people don't have a higher tolerance for pain, and when a Black male or female comes into the emergency department and needs opioids for pain care, the default should not be that this person is simply drug-seeking. This is why when we talk about equity, we need the data, and we need to disaggregate the data by sex, by race, by age, by ethnicity. We have to make sure that we have attuned toward these special populations—young people, people who are Black and Brown, differences by community, and the issues surrounding past and present approaches to the epidemic."

**AMA-MANATT HEALTH STATE TOOLKIT TO END THE NATION'S DRUG OVERDOSE EPIDEMIC: LEADING-EDGE ACTIONS AND STRATEGIES TO REMOVE BARRIERS TO EVIDENCE-BASED PATIENT CARE**

- Increase access to evidence-based treatments to help patients with a substance use disorder (SUD).
- Ensure access to addiction medicine, psychiatry and other trained physicians.
- Enforce mental health and SUD parity laws.
- Improve access to multidisciplinary, multimodal care for patients with pain.
- Expand harm reduction efforts to reduce death and disease.
- Improve public health data surveillance, monitoring and evaluation.

## LOOKING TO THE FUTURE

Both Dr. Mukkamala and Dr. Harris said that there are reasons to be hopeful, but recognized the challenges are significant.

“We need to make sure we have our eyes on all aspects of this epidemic,” said Dr. Mukkamala. “Our communities have suffered. Young people are dying at the highest rates, and that is tragic. It’s up to us to take the policies that work and ensure they are funded, that they are implemented, and that they are working as intended.”

“Physicians have continued to run toward the emergency,” said Dr. Harris. “Physicians have stepped up in their practices, and we have helped raise the level of conversation. Changing policy continues to be necessary, but those policies must be evidence-based, which requires ongoing vigilance and commitment.”


Please also watch a recent discussion of these issues with Dr. Harris, Dr. Mukkamala and Manatt Health Managing Director Joel Ario [here](#).



**Patrice A. Harris, MD, MA;**  
**former AMA President;**  
**former Chair, AMA**  
**Substance Use and Pain**  
**Care Task Force**



**Bobby Mukkamala, MD;**  
**former Chair, AMA Board**  
**of Trustees; Chair, AMA**  
**Substance Use and Pain**  
**Care Task Force**



**Increase access to  
evidence-based  
treatments to help  
patients with a  
substance use  
disorder (SUD)**

# Delivering compassionate care for pregnant people with an SUD

## Profile of Ruchi Fitzgerald, MD

Ruchi Fitzgerald, MD, is a family physician and addiction medicine specialist who cares for women affected by substance use disorder or mental health conditions while pregnant. In the decade since she completed a family residency in Montana, she has championed compassionate care in a world that can be quite hostile, even punitive.

“Everyone deserves humane care,” says Dr. Fitzgerald, who currently is an assistant professor in the Departments of Family Medicine and Psychiatry/Behavioral Sciences at Rush University in Chicago and the associate program director for the Rush Addiction Medicine Fellowship at the Rush University Medical Center in Chicago. “I have a hard time with judgmental providers, judgmental social service agencies and a judgmental system that winds up causing my patients

incredible pain and suffering. My job is to protect my patients, and because they often are people who are pregnant and use drugs, it’s hard enough to convince them we are compassionate when so many are calling for punishment.”

One of the challenges that Dr. Fitzgerald faces on a daily basis is the tremendous difference in consequences between a “notification” of substance use and a “report” of abuse and neglect. In her world, a notification is a way to get supportive services for a birthing parent, while a report brings punishment and detours families from seeking services. Legally, a “notification” may be required under federal and state law when a newborn experiences clinical signs of withdrawal from a controlled substance or alcohol. A notification, however, is legally distinct from a

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Implement Plans of Safe Care for pregnant, peripartum and parenting individuals: [New Mexico Statutes § 32A-4-3.](#)
- Remove criminal and other penalties for pregnant, postpartum and parenting women: proposed [Illinois House Bill 5835.](#)

“report” of alleged child abuse or neglect.

“This distinction was not taught in medical school, and it is incredibly difficult to understand—let alone properly implement—in hospitals or with child welfare agencies,” said Dr. Fitzgerald. “What winds up

happening, unfortunately, is that someone decides that a pregnant person who is in treatment or who uses drugs is a terrible person and sends a report to the child welfare agency without taking a minute to understand whether the individual is in treatment or identify what needs treatment and what resources are necessary to create a healthy, healing environment for the whole family.”

Dr. Fitzgerald tries to build trust with her patients by assuring them that she will not send a report to the child welfare agency if the individual is in treatment and receiving care, though she cannot always be sure that a patient won't be transferred or that the child will end up in the child welfare system.

“It shouldn't be this hard to have humane treatment in the community,” she says, bemoaning the many barriers to accessing medication for opioid use disorder (MOUD) as well as the “dramatic under-use” of contingency management strategies that reward healthy behavior.

“I've had far too many patients tell me that they don't see prenatal care because they are truly afraid of losing their baby,” she said. “And I've had many patients who receive

MOUD and other supportive services stay in recovery who are wonderful parents. By changing the law to stop unwarranted investigations, we would help so many pregnant people and families.”

Fitzgerald is particularly critical of policies that end up separating mothers from their children or cut off MOUD for postpartum patients.

“It's hard to explain to a pregnant person that MOUD is best for her and her fetus when the child welfare agency might tell the person that MOUD may be grounds to remove the child. I'm eager to help advance legislation that would remove a person receiving MOUD from automatically being defined as an alleged child abuser.”

Despite all the challenges, Dr. Fitzgerald is an optimist who believes we will make progress in treating addiction as a public health issue, noting that “my patients deserve my absolute best” and “addiction is a family disease.”

Beyond practicing compassionate care, Fitzgerald is committed to training programs and other efforts to build a workforce of physicians committed to treating addiction. “I have benefited from my mentors,” she observes, “and I hope to give back.”

“Recovery is possible with the right supports, even in the most challenging of situations—I have not seen that punishment or threats are productive for my patients and families. I am truly hopeful that we will see much positive change for families in the next few years as we all work together, raise awareness, and listen to the voices of our patients.”



**Ruchi Fitzgerald, MD,  
family physician and  
addiction medicine  
physician**

# Building bridges, reducing stigma, copying best practices

## Profile of former California policy maker Kelly Pfeifer, MD

Combining her experiences as a physician with strategic leadership skills and a fierce determination to save lives, Kelly Pfeifer, MD, has led numerous breakthrough policy initiatives to combat the SUD epidemic in California. Under Dr. Pfeifer's leadership as the director of the California Health Care Foundation's (CHCF) High-Value Care team, CHCF launched several [pilot programs](#) to test strategies to reduce opioid overprescribing, promote evidence-based addiction treatment and expand access to naloxone. The pilots were remarkably successful. As hoped and planned, they sparked a decision by the state of California to adopt key elements of the pilots on a statewide basis. They also led to Dr. Pfeifer being hired as the Deputy Director of Mental Health and Substance Use Disorder Services at the California

Department of Health Care Services (DHCS). In this role, she oversaw statewide implementation of the policy changes that were first tried out in the CHCF pilots. She also launched new efforts, including a first-in-the-country initiative that uses Medicaid dollars to treat stimulant use disorders through contingency management.

Even though Pfeifer left DHCS in mid-2022 to work on abortion care access, her impact is still felt in the policies that were adopted and in her foundational reframing of how to approach the epidemic. Throughout her tenure at DHCS and CHCF, Dr. Pfeifer shared her own lived experience as a physician who inadvertently contributed to opioid deaths through her prescribing. Instead of reinforcing a "not my fault" orientation, this approach welcomed state leaders and providers into a nuanced discussion of what role each person could play in helping. She paired this with a strong focus on using data to make decisions and determine what really works to save lives.

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Ensure Medicaid encompasses the continuum of substance use disorder (SUD) treatment: [California's Contingency Management Program](#) as outlined in the [CalAIM 1115 Demonstration](#).
- Expand community-based naloxone distribution efforts: California Department of Health Care Services' [Naloxone Distribution Project](#) amplifies the landmark study by Gail D'Onofrio, MD, about interventions for opioid use disorder; [read here](#).

In reflecting on how she led CHCF's initial work, Dr. Pfeifer humbly shares that she "stole shamelessly," claiming that there was "not a single idea that started with me."

She specifically referenced Dr. Gail D’Onofrio’s landmark [study](#) on strategies to combat the opioid epidemic that formed the basis of the [CA Bridge](#) program (also known as [ED Bridge](#)), which has now scaled nationally, saying, “We

wanted to prove it worked outside an academic study.” From there, she aimed to translate “the scientific language of [medication-assisted treatment] to shape the narrative toward harm reduction” and sought to leverage unlikely partnerships.

## “The opioid epidemic is a national crisis that is hyper local. To save lives, we must get past the stigma of ‘not in my backyard.’”

In her work, Dr. Pfeifer maintained a sharp focus on three primary goals—reducing overprescribing of opioids; increasing access to medication for opioid use disorder (MOUD); and promoting harm reduction, including broad access to naloxone. As for the means, Dr. Pfeifer is a pragmatist; she recognized that the approach to reaching these goals sometimes needs to vary based on the politics and culture of any given community. For example, harm reduction in a conservative California county may need to mean something a bit different from harm reduction in a progressive community. So long as leaders see people with SUDs as worthy of saving, they are welcome in Dr. Pfeifer’s big-tent approach to combatting the epidemic. As she says, “understanding these differences, and accepting the

gray areas in between, has ensured that coalition members are effective in their leadership of their communities and beyond.”

Perhaps most notably, Dr. Pfeifer focuses on making on-the-ground improvements in the lives of people with SUDs. It is exceptionally hard to adopt and implement new ways of doing things anywhere but especially in a state as large and complex as California. Dr. Pfeifer used her persistence, passion, communication skills and strategic leadership ability to do so, ensuring that the promising ideas embedded in policy papers or discussed in workshops became a reality on the ground for many Californians.



**Kelly Pfeifer, MD**

*“Like so many providers, I thought I was a part of the solution to pain. When I got a call from a coroner, sharing that one of my patients had died of an overdose while clutching a bottle with my name as the prescriber, I realized I was actually part of the problem. As a physician leader, I’m not here to point the finger of blame but instead to find true solutions that address every aspect of this devastating crisis, and we need everyone’s help to do that.”*

# Supporting evidence-based treatment for pregnant people

## Profile of Carolyn Sufrin, MD, PhD

[Carolyn Sufrin](#), MD, PhD, does not mince words in her advocacy for pregnant, postpartum and parenting individuals with a substance use disorder (SUD), saying it is “cruel and inhuman practice” to force someone to stop medication to treat opioid use disorder (MOUD). “Clinical practice and research make clear that MOUD helps maintain recovery and supports health and wellness,” said Dr. Sufrin. “There is no valid reason to prevent a pregnant person or an individual who just gave birth from continuing buprenorphine or methadone.”

As a board-certified obstetrician and gynecologist whose research focuses on reproductive health care for incarcerated women with an SUD, Dr. Sufrin knows that providing high-quality SUD care for people in jail or prison may require extra steps for leaders and workers.

“Much of my work falls under ‘implementation science,’” said Dr. Sufrin. “The clinical evidence is clear, but not everyone understands how to implement that in a carceral setting. Whether the issue is intake screening, dispensing methadone or buprenorphine, or ensuring that pregnant individuals continue to receive MOUD postpartum, these all are operationally possible, and there are great examples throughout the country of it being done. But there are also unique factors specific to pregnant and post-partum people in this setting, such as the stigma and judgment they experience because they use substances during pregnancy.”

Dr. Sufrin pointed to major policy changes such as Maryland [requiring](#) all jails and prisons to offer MOUD by 2023; a small-town jail in [Franklin, Massachusetts](#); and larger-scale efforts such as a recent [announcement](#) from the Milwaukee sheriff.

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Provide evidence-based medical care, including medications to treat opioid use disorder (MOUD), to justice-involved populations: [Availability of Medications for the Treatment of Opioid Use Disorder Among Pregnant and Postpartum Individuals in US Jails](#).
- Implement plans of safe care for pregnant, peripartum and parenting individuals: [Pregnancy Prevalence and Outcomes in U.S. Jails](#).



Dr. Sufrin noted, however, that despite some progress in some areas of the country, [45% of prison systems do not provide MOUD at all](#). Among systems that do provide MOUD, half do so only for pregnant women. Even worse, a [survey](#) of policies at more than 800 jails across the country found that “few” continued MOUD postpartum; in fact, among the 504 jails that provided MOUD during pregnancy, more than half (274 jails or 54.4%) discontinued MOUD after pregnancy, with practices ranging from “abrupt cessation” to tapering of medication (see table). According to the same [survey](#), only 152 jails (30.2% of MOUD-available jails in this study)—less than one-third—provided access to initiation and continuation of MOUD with both medications. Perhaps most alarming, according to Dr. Sufrin, is the forced withdrawal from MOUD following childbirth for pregnant individuals who are incarcerated. In addition to the trauma of being separated from their newborn baby—and despite clinical best practice guidelines to continue MOUD indefinitely—her team’s [research](#) has found that even at jails that provide MOUD in pregnancy, the majority abruptly halt MOUD after delivery, implying, as the January 2022 study states, “that the benefit of MOUD is solely for the fetus . . . and does not reflect standard practices for chronic disease management of OUD.”

Dr. Sufrin said, “A postpartum individual already is experiencing hormonal fluctuations and bleeding that follows childbirth. An incarcerated postpartum individual also has to cope with the removal of her newborn, forced inability to breastfeed, and when MOUD is forcibly withdrawn, it adds symptoms, including sweats, diarrhea, cravings, shakes, nausea, and vomiting. Forced withdrawal causes an inhuman level of suffering.”

**TABLE 2. AVAILABILITY OF MEDICATION FOR THE TREATMENT OF OPIOID USE DISORDER AMONG PREGNANT INDIVIDUALS IN US JAILS**

MOUD availability	Jails, No./total No. (%)
<b>During pregnancy</b>	
MOUD available <sup>a</sup>	504/836 (60.3)
Continuation only	237/504 (47.0)
Initiation and continuation	267/504 (53.0)
Methadone available	385/504 (76.4)
Continuation only	247/385 (64.2)
Initiation and continuation	137/385 (35.6)
Buprenorphine available	381/504 (75.6)
Continuation only	171/381 (44.9)
Initiation and continuation	210/381 (55.1)
Methadone only available	123/504 (24.4)
Continuation only	84/123 (68.3)
Initiation and continuation	39/123 (31.7)
Buprenorphine only available	119/504 (23.6)
Continuation only	46/119 (38.7)
Initiation and continuation	73/119 (61.3)
Both methadone and buprenorphine available	262/504 (52.0)
Continuation only	107/262 (40.8)
Initiation and continuation	152/262 (58.0)
Withdrawal only (no MOUD available) <sup>b</sup>	190/577 (32.9)
Withdrawal and MOUD available <sup>c</sup>	387/577 (67.1)
<b>During postpartum period</b>	
MOUD available for continuation <sup>d</sup>	120/504 (23.8)
No MOUD continuation	274/504 (54.4)
Discontinuation with tapering	165/274 (60.2)
Abrupt discontinuation	61/274 (22.3)
Conditional discontinuation <sup>e</sup>	47/274 (17.2)
Did not report	110/504 (21.8)

Abbreviation: MOUD, medication for opioid use disorder.

<sup>a</sup> Data do not include jails for which the provision of MOUD was uncertain.

<sup>b</sup> There was a higher likelihood of doing withdrawal only among paper responses than among online responses (126 vs. 64;  $P = .01$ ).

<sup>c</sup> There was a higher likelihood of doing withdrawal and MOUD among paper responses than among online responses (267 vs. 120;  $P = .03$ ).

<sup>d</sup> Among jails providing MOUD during pregnancy.

<sup>e</sup> Some respondents stated that they did not routinely continue providing MOUD after pregnancy but would consider allowing it depending on the remaining time in an individual’s jail sentence or whether an individual was expressing breast milk.

Source: Sufrin C, Kramer CT, Terplan M, et al. JAMA Network Open. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788243>.

# “It is our duty to recognize and respond to the harm and suffering connected to jails and prisons, especially for pregnant persons with a substance use disorder.”

When asked what an evidence-based approach looks like, Dr. Sufrin recommended the following:

- **Ensuring comprehensive intake screenings for all arrestees.** Dr. Sufrin sees this as “low-hanging fruit” that all jails and prisons can implement. Appropriate intake screenings will identify inmates with SUD and those that have been treated for SUD in the past.
- **Continuing MOUD for established SUD patients.** During intake, nurses or other health care workers should confirm whether someone is receiving treatment for SUD and verify the dose and duration of the MOUD regimen. They should then ensure that patients continue to have access to these therapies.
- **Initiating MOUD for those identified as having SUD.** Jails and prisons can play a more central role in addressing the SUD epidemic by initiating treatment for incarcerated individuals who are not yet in

treatment and want to begin.

“And when we build care systems for those who are incarcerated and returning from incarceration, we have to follow that up with protective policies upon release,” said Dr. Sufrin. “Without linkages to care, death from overdose is highly likely.”

While acknowledging the challenges, Dr. Sufrin said that the goal should be to help justice-involved individuals receive counseling and be connected to housing and food supports pre-release, as well as ongoing medical care for their SUD disorders. At release, individuals should receive naloxone to prevent fatal overdose. Jails and prisons should avoid releasing individuals in the middle of the night, a time when supports and shelters are less available, and individuals may be more vulnerable to a wide variety of influences.

“I know that pregnant people make some very nervous, and a pregnant person with a substance use disorder can elicit a lot of different

emotions,” said Dr. Sufrin. “But I see and treat individuals who benefit from treatment for themselves and their babies. As a physician, I follow the science and listen to patients for what is best for their care, to ensure positive outcomes in the short and long term for them and their pregnancies.”



**Carolyn Sufrin, MD, PhD**

*“People in jails are forced to withdraw from medication-assisted treatment after they give birth and are returned to custody. Forced withdrawal during this critical post-partum period is a cruel and unusual practice common in the U.S. justice system.”*

# Mobilizing to help children, adolescents and young adults

Profile of Sharon Levy, MD, MPH, Deepa Camenga, MD, MHS, FAAP, and Christine Rodriguez, MPH

Young people using substances such as cannabis, illicitly manufactured fentanyl and others are not a science experiment, said Sharon Levy, MD,<sup>6</sup> a pediatric addiction medicine specialist who started one of the nation's first outpatient substance use disorder (SUD) treatment programs for young people in Massachusetts, on a recent webinar sponsored by the American Medical Association (AMA) and Manatt Health.<sup>7</sup> Dr. Levy was joined by Deepa Camenga, MD,<sup>8</sup> a pediatric addiction medicine specialist from Connecticut, and Christine Rodriguez,<sup>9</sup> a harm reduction advocate from AIDS United.

"When young people use addictive, psychoactive substances, they 'hijack' the reward centers in young people's brains, fulfilling a developmental drive for risk-taking and excitement," said Dr. Levy. "It's not a surprise that

<sup>6</sup> Dr. Sharon Levy, MD, MPH, is the Director of Adolescent Substance Use and Addiction Program at Boston Children's Hospital and Associate Professor Pediatrics at Harvard Medical School.

<sup>7</sup> "The Substance Use Disorder Epidemic Among Youth: Responding to a Growing Crisis," Manatt Health and AMA webinar, July 27, 2022, recording and webinar documents are available [here](#).

<sup>8</sup> Dr. Deepa Camenga, MD, MHS, FAAP, is an Associate Professor of Emergency Medicine, Pediatrics & Public Health and the Associate Director for Pediatric Programs at the Yale Program in Addiction Medicine in the Yale Schools of Medicine & Public Health.

<sup>9</sup> Christine Rodriguez, MPH, is a Senior Program Manager at AIDS United. Through its harm reduction portfolio, AIDS United engages in grant-making, technical assistance and advocacy to reduce the health, psychosocial and socioeconomic disparities experienced by people who use drugs.

## **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- **Take legal action to enforce parity rights:** [Massachusetts Attorney General's Office Behavioral Health Parity Agreements](#) with payers will provide nearly \$1 million to promote initiatives designed to prevent or treat substance use disorders and help increase access to behavioral health care services.
- **Administration of naloxone in schools:** Albuquerque Public Schools [established guidelines and procedures governing the utilization of naloxone](#) in its schools to prevent opioid-related overdose deaths.
- **Naloxone distribution on college campuses:** The University of North Carolina at Chapel Hill established a [Naloxone Distribution Program](#) that enables students' access to naloxone free of charge, without a prescription, and anonymously at on-campus pharmacies.
- **Decriminalize syringe services programs supplies:** The National Institute on Drug Abuse offers [resources](#) to learn the facts on syringe services programs.

young people are drawn to these experiences, and we can't ignore the data showing that the situation is getting more dangerous as the drug supply gets more potent.<sup>10</sup> Indeed, the number of adolescents dying from overdoses is rising more quickly than any other age group—it nearly doubled in 2020 and increased another 20% in 2021.<sup>11</sup>

One family, the Hausmans, agreed to allow the story of their son's death to be shared on the webinar to raise awareness about the unthinkably high stakes underlying these data. Their son, Landen, a high-school sophomore and basketball player with two brothers, died earlier this year of an accidental overdose. While he had struggled with anxiety and depression since eighth grade, he had been doing great; just back from a ski trip and looking forward to a basketball game when he died suddenly and unexpectedly on the floor of his bathroom in Bethesda, Maryland, after ingesting a counterfeit Percocet pill laced with fentanyl. As his dad said:



Story shared with permission from the Hausman family. Pictured here: Landen and Marc Hausman.

“When someone dies through a drug overdose or suicide, or something else society deems to be unseemly, the natural tendency is to kind of just hide it away, because it's some sort of reflection on the person or on the family, and it's something that's perceived as a weakness . . . But when Landen died, we decided to go the other way because the reality is the depression and alcohol and drug abuse is not unique to Landen, and I

want people, especially young people, to understand that . . . more often than not, you make a poor choice, and you're going to get a second chance, but sometimes you don't.”<sup>12</sup>

Even with deaths increasing, however, few young people receive any treatment. Dr. Levy highlighted the following:

- Only one in 10 teens struggling with a SUD receive any treatment.
- Less than one out of 10 teens with opioid use disorder (OUD) receive lifesaving medications, such as buprenorphine or methadone.<sup>13</sup>
- Only one in 20 youth receive any counseling around vaping.<sup>14</sup>

Making matters even more complicated is the broader mental health crisis among youth. Dr. Levy noted that as many as one in five children aged 3 to 17 have a reported mental, emotional, developmental or behavioral disorder. In 2020, mental health-related emergency department visits by youth aged 12 to 17 were a third higher than in 2019.

<sup>10</sup> Also, see Levy, S., and Sundaram, S., “Adolescence: A high-risk time for substance use disorders,” Harvard Health Blog, August 7, 2018, [link](#).

<sup>11</sup> Friedman, J., et al., Research Letter: “Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021,” April 12, 2022, JAMA, [link](#).

<sup>12</sup> Story shared with permission from the Hausman family. Hausman, M., “My Son's Death,” LinkedIn, January 24, 2022, [link](#). Video of Marc's remarks at Landen's memorial service available [here](#). Peetz, C., “After Whitman student's fentanyl overdose, family hopes awareness will prevent similar tragedy,” Bethesda Magazine, April 23, 2022, [link](#).

<sup>13</sup> Hadland S.E., et al. Trends in Receipt of Buprenorphine and Naltrexone for Opioid Use Disorder Among Adolescents and Young Adults, 2001–2014. JAMA Pediatr. 2017 Aug 1;171(8):747–755.

<sup>14</sup> Chadi N., et al. Treatment for Nicotine Use Disorder Among Medicaid-Enrolled Adolescents and Young Adults [published online ahead of print, 2019 Sep 23]. JAMA Pediatr. 2019;173(11):1103–1105.

## IT MAY BE 2022, BUT THE TREATMENT SYSTEM FOR YOUNG PEOPLE AND SUD IS STUCK IN 1985

Dr. Camenga echoed Dr. Levy's call for change, highlighting multiple clinical, workforce and policy-specific areas where more can be done. "By supporting increased access to SUD treatment in primary care, providing meaningful incentives to build outpatient adolescent substance use treatment programs, and enforcing mental health and substance use disorder parity laws, we can save a lot of young lives," said Dr. Camenga.

She also highlighted the need to train more pediatric addiction medicine experts to address the treatment gap. "There are not, and will never be, enough pediatric addiction medicine specialists to close this gap," said Dr. Camenga. She explained that of the 750,000 physicians that can prescribe opioid analgesics in the United States, only about 100,000 are trained to prescribe addiction treatment. Of that 100,000, only a fraction actually prescribe medications to treat opioid use disorder, and less than 1% of those are pediatricians.

Dr. Camenga also described how the current treatment system is antiquated in that it is not easily accessible to the community or referring providers. In other areas of health care, technology within the electronic medical record has greatly accelerated the ability to identify available treatments and providers. However, the substance use treatment system often

relies on the phone and fax. She described a list of issues that arise when she works with families to try to secure substance use treatment for their child:

- The list of treatment providers in the area may or may not take the family's insurance; even if it does, it may not have an opening for weeks or more. As a result, health providers may end up making a long series of phone calls, searching for a spot that can take the child during the precarious period right after an overdose when the risk of death remains high.
  - Even if there is an opening, the facility may not be willing to accept an adolescent who requires MOUD. Plus, the search
- can take even longer if the adolescent has a history of aggressive behavior or requires support for additional conditions such as autism or an intellectual or developmental disability.
  - Once a child can secure treatment, the insurance company may only allow the young person to stay for a short period of time, falling short of their physician's recommended course of treatment.
  - If outpatient care is appropriate, there still might not be an opening in a practice for weeks to months, or insurance-related barriers such as limited "in-network" providers may make it extraordinarily challenging to find someone who can treat the adolescent.

**A deadly, illicit drug market—readily accessible to any young person with a phone—is combining with a lack of treatment options and harm reduction initiatives to drive up deadly overdoses among young people.**



“These all are common, preventable, and deadly problems,” said Dr. Camenga. “Without updating policies [to help with treatment access], we should not be surprised when more young people die.”

## **PREVENTION IS THE NAME OF THE GAME FOR HARM REDUCTION**

Young people have always sought new experiences and taken risks, said Rodriguez, who provided multiple ways in which harm reduction can help save lives from overdose.

“The nation’s drug supply is contaminated with illicit fentanyl, and more people than ever are dying of preventable overdose,” said Rodriguez. “We have a great opportunity to get young people the tools they need to stay safe and alive so that the choice to use drugs isn’t the last thing they do.”



**Sharon Levy,  
MD, MPH**

Rodriguez said that she understands that some of the elements of harm reduction can make people uncomfortable, especially when it comes to young people, which is why greater support for community-based programs can help the most.

“We get naloxone, for example, directly into the hands of young people who use drugs. We teach them how to save a life from overdose. We provide sterile needles and syringes in the community because we want to stop the spread of hepatitis C and HIV. We understand that we can’t force anyone into treatment, so we’re going to give people all the tools they need to stay as safe as possible.”



**Deepa Camenga,  
MD, MHS, FAAP**

At the policy level, Rodriguez said that having age-appropriate, evidence-based drug education and naloxone for youth in high schools, colleges and public spaces is a good start. Removing barriers to distributing sterile needles and syringes broadly would be another important policy initiative.

“We also support overdose prevention centers and other evidence-informed but not-yet mainstream policies because they are providing lifesaving services in a non-punitive, non-judgmental way,” said Rodriguez. “We can’t wish or punish ourselves out of this epidemic, so we must put our energies into everything that will save a life.”



**Christine Rodriguez,  
MPH**

**Ensure access to  
addiction medicine,  
psychiatry, and  
other trained  
physicians**

# Ending the epidemic means more than just one policy

## Profile of Charles Reznikoff, MD, and Stephen Taylor, MD, MPH

Profile of Stephen M. Taylor, MD, psychiatrist and ASAM board member, and Charles Reznikoff, MD, MPH, internist and addiction medicine specialist at Minneapolis' Hennepin Healthcare

The more complicated and comprehensive a piece of state legislation becomes, the more difficult it becomes to move forward, according to Stephen M. Taylor, MD, MPH, who serves on the board of directors for the American Society of Addiction Medicine (ASAM), and Charles Reznikoff, MD, who works in addiction medicine and internal medicine at Hennepin Healthcare and is an associate professor of medicine at the University of Minnesota Medical School in Minneapolis.

"The nation's overdose epidemic, however, is complicated, and there are many areas of state—and federal—policy that need to be addressed," said Dr. Taylor. "Many people confuse the fact that the issue isn't so much an opioid epidemic as really an epidemic of the disease of addiction, which is not a drug-specific disease. This includes fentanyl, methamphetamine, cocaine and other substances."

Dr. Taylor, who currently practices in Alabama, explained that the overdose deaths he sees commonly occur with people who've been using methamphetamine and then have had their drug laced with fentanyl. Rather than focus on just "opioids," Dr. Taylor says the right question to ask is: "How do we get people treatment for addiction, for the disease of addiction in an ongoing way, to treat this chronic potentially recurrent disease according to the model that is necessary for providing adequate treatment for people who have that disease?"

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Protect provider discretion to develop individualized treatment plans: ASAM's [Speaking the Same Language: A Toolkit for Strengthening Patient-Centered Addiction Care in the United States](#) and *AMA Journal of Ethics* article, "[Addressing Obstacles to Evidence-Informed Pain Care.](#)"
- Address disparities by ensuring data by race and ethnicity is widely available: ASAM's [Public Policy State Advancing Racial Justice in Addiction Medicine](#) (February 2021).

Dr. Reznikoff agreed that states need to have a long-term commitment to treating SUDs.

"There are at least 2.5 million Americans living with an opioid use disorder, and that's just opioid use disorder, and 80-90 percent receive



no treatment,” said Dr. Reznikoff. “We really need to mobilize to give best care to these people while they are still alive. We have a lot of work to do.”

As an example of the multifaceted solutions needed, Dr. Taylor highlighted the interplay among substance use treatment, social supports, physician education and financial reality.

“Having an addiction is clearly a medical disease but it’s impacted by so many factors in society that are contributing to this condition, including unfair access to housing and inadequate access to quality education and to jobs,” said Dr. Taylor. “We have to increase the physician workforce to treat substance use disorders, but we also have to understand, accept and confront the fact that race comes into play here as well. The very same factors that contribute to people of any color or any ethnicity developing a substance use disorder are also the factors that we see that disproportionately affect people in the African American community.”

Dr. Reznikoff also highlighted the need to address systemic issues.

“We debate in this country whether it is a human right to receive treatment for a medical condition, and we take the debate even further if someone is in jail or prison,” said Dr. Reznikoff. “The debate should not be about whether to provide care, but how can we build off proven models of care to treat individuals in all settings.”

Dr. Reznikoff said that the COVID-19 pandemic laid bare some of the financial vulnerabilities of health care institutions, including that the financial stresses of the COVID-19 pandemic put addiction medicine programs in jeopardy of being cut from that financial stress.

“We don’t make much money,” said Dr. Reznikoff, referring to pain and addiction clinicians’ revenue. “Payment reform was not necessarily on policymakers’ top priority lists during the height of the COVID pandemic, particularly when it comes to treating individuals with substance use disorders. I’m from Minnesota, so I’ll use an analogy: it felt like the country was taking its snow tires off as winter approaches. I’m really worried about addiction services being cut and what that will mean for those who

already have difficulty finding treatment.”

Both Dr. Taylor and Dr. Reznikoff pointed to naloxone as another example of the need to look beyond a single policy intervention.

“It’s great that there are millions of doses of naloxone being prescribed by physicians, dispensed by pharmacists and distributed by harm reduction organizations,” said Dr. Reznikoff. “It’s excellent by medical standards to have an intervention that saves lives, but we have to do more than just get more naloxone in people’s hands. We need to build programs to help people bridge to treatment when they’re ready. There are good examples of bridge programs in the country, but they have to be financially supported.”

“We also have to think about more than just naloxone distribution in the community,” said Dr. Taylor. “People who leave jail or prison are at very high risk from overdose—meaning we need to ensure that when people leave jail or prison, they have naloxone.”

On the front end of treatment, Dr. Taylor emphasized the role of policymakers in enforcing mental health and SUD parity laws.

"I'm dismayed that far too few state policymakers enforce the law—or require evidence-based treatment guidelines to be used by third-party payers," said Dr. Taylor.

One positive, recent example, however, occurred in Illinois, where the Department of Insurance levied a [\\$1.25 million penalty](#) against Celtic Insurance Company, a subsidiary of Centene Corporation, for extensive violations of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Illinois Network Adequacy and Transparency Act. Some of the major violations found that Celtic:

- Created a barrier to treatment by imposing prior authorization for all SUD claims
- Failed to utilize ASAM medical necessity criteria for SUD benefit determinations
- Failed to sufficiently complete Non-Quantitative Treatment Limitation comparative analysis to prove adherence to Illinois and federal laws

Dr. Reznikoff agreed with the need for greater enforcement of parity laws, but also said that there is a great need to help patients with pain access all treatments recommended by their physicians.

"Advocating for multidisciplinary pain teams, which really is the standard of care of treating pain, is going to require additional funding from public payers as well as requirements for private payers to cover more treatments," said Dr. Reznikoff. "I worry that with the financial stress that the health care system is under, the

questions being asked are: 'Whom do we furlough, the cardiologist or the acupuncturist?' and that's a false choice. As we are establishing our multidisciplinary pain teams, medical societies need to be active in supporting comprehensive pain care. It's all connected—difficult to do everything at once, but we can't lose our focus on the need for comprehensive policies to help our patients."



**Charles Reznikoff, MD,  
internist and addiction  
medicine specialist at  
Minneapolis' Hennepin  
Healthcare**



**Stephen Taylor, MD, MPH,  
psychiatrist and ASAM  
board member**

# Training future addiction medicine leaders

## Profile of Cara Poland, MD, MEd, FACP, DFASAM

Board-certified Addiction Medicine Physician Cara Poland, MD, MEd, FACP, DFASAM, wanted the state of Michigan to train a future generation of physicians to treat SUDs, but first, she realized that Michigan's medical schools needed core faculty. Like nearly every state in the United States, Michigan is seeing staggering increases in overdose deaths due to illicitly manufactured fentanyl, fentanyl analogs, methamphetamine and cocaine. Methamphetamine and alcohol use disorders also remain top issues in Michigan.

"In 2018, during a statewide meeting of the seven medical schools, I asked how many schools had core faculty to teach addiction. Only one did," Dr. Poland said. "Now, all do. It sounds obvious, but you can't train medical students in addiction if you don't have trained faculty."

Dr. Poland, Associate Professor of obstetrics and gynecology (OB/GYN) and reproductive health at Michigan State University, said that the 2018 meeting was eye-opening for everyone. The state had been working through multiple efforts to increase access to evidence-based treatment for substance

use disorders (SUDs), but it hadn't considered the role of medical schools and residency programs.

"We had a blind spot, but we all had that ah-ha moment when we realized we could do better for our communities if we just built it into the curricula," she said. "But we didn't stop there—we also have built a program to assist physicians through the practice pathway for addiction medicine board certification." There are also dedicated pathways for residency programs and social work programs.

The four education pathways are available through the [Michigan Collaborative Addiction Resources & Education System](#) (MI CARES).

The MI CARES modules—which are available [free of charge](#) to medical schools and students—are incorporated into classroom electives, asynchronous electives and clinical electives across the four years of medical school.

Michigan State initially offered the year-one elective to 32 medical students, but ended up increasing the cap to 36. Last year, it offered the course to 48 students and again upped its cap, this time to 52 students.

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

Promote programs that help ensure a full continuum of care: [Michigan Collaborative Addiction Resources & Education System](#) (MI CARES), which guides and supports providers through the practice pathway program for the Addiction Medicine subspecialty.

"We still have a wait list for this elective of 50 students of a class of 200. That's over one-quarter of the students saying: We want this education," said Dr. Poland, who pointed to multiple policy actions that could further help Michigan and other states:

- Use the state opioid litigation settlement funds to hire core addiction medicine or addiction psychiatry core faculty.
- Urge the National Board of Medical Examiners to make SUDs a core competency—if they don't test it, medical schools won't include it.

- Teaching institutions should build clinical addiction teams treating SUDs across the American Society of Addiction Medicine (ASAM) Criteria Levels of Care to cement the institution as a leader in ending the overdose and death epidemic.

In addition to the successful implementation for medical students, [MI CARES](#) has enrolled more than 600 physicians in almost every state who can now move forward to become board-certified in addiction medicine.

## “You can’t train medical students in addiction if you don’t have trained faculty.”

Dr. Poland emphasized that the training being done in Michigan builds on a foundation of medical evidence, non-stigmatizing practice and the recognition that a patient with an SUD is like any other patient with a chronic disease. Follow-up surveys given to students are also helping Dr. Poland and other faculty evaluate the coursework and the students’ perceptions of patients with an SUD, the role of treatment and addiction medicine overall.

Among the students’ responses:

- *Amazing intersession! Completely changed my mindset and understanding of patients with SUDs. The PCSS training we completed should be mandatory for all ECE students. Extremely valuable.*

“We didn’t figure it out overnight, but we’re on a great path. I also realize that not all of our students and residents will choose addiction medicine as their career,” said Dr. Poland. “But all of them—whether they become surgeons, OBGYNs, family physicians, general internists or any other specialty—will be able to better serve their patients. And for the physicians using MI CARES to become board-certified, it’s gratifying to know that we’re helping fill gaps in training across the nation.”

“I’m grateful for my co-faculty and the students who challenge themselves and are open to learning a field of medicine that is incredibly rewarding,” said Dr. Poland. “And as faculty, I need to learn how to continue to be better for my students. What we’re building at Michigan State University will resonate throughout the nation, so we must always strive to improve.”

To learn more about MI CARES, please visit [micaresed.org](http://micaresed.org).



**Cara Poland,  
MD, MEd, FACP, DFASAM**

*Dr. Poland’s brother Max died of an SUD, and she dedicates her life’s work to him.*

- *Dr. Alan and Dr. Poland are both extremely passionate about the topic, and it came through and made the class interesting and enjoyable.*
- *This was fantastic!! I absolutely loved this intersession, and Dr. Poland & Dr. Alan are amazing! They made the zoom time together not only informative and engaging but truly fun.*
- *This was probably my favorite intersession and I can’t say enough positive things about it. Just keep it up! I appreciate the work that everyone put in to make this intersession possible.*
- *This was the best intersession I have taken. The combination of patient care, board cases, and training was great. Also, I wish Dr. Poland and Dr. Alan could teach all of my classes!*



# Expanding access to treatment through telehealth

## Profile of Lewei Allison Lin, MD, MS

Addiction psychiatrist Lewei Allison Lin, MD, MS, will do whatever she can to reach and keep her patients with a substance use disorder (SUD) engaged in care—whether that means telehealth visits (i.e., video or audio-only visits) or in person.

“Barely 10 percent of individuals with a substance use disorder receive any type of care in this country,” said Dr. Lin. “We should make sure there are no closed doors for getting help, and we should also research and learn from policy changes to ensure we are best meeting our patients’ needs.”

Dr. Lin highlighted how telehealth visits have been helpful for many of her patients, but that was the case even before the COVID-19 pandemic.

“I would love to see every patient in person,” said Dr. Lin. “But not everyone can get to my office. For some patients, it meant having to take three buses to come for a visit and sometimes they were coming weekly for counseling. No wonder they were struggling to stay in care.

If it’s audio-only or audio with video, I’m thrilled to stay in contact and keep my patients engaged.”

Keeping patients engaged could mean counseling, medications to treat opioid use disorder (MOUDs), connections to primary care or addressing any other needs a patient might have.

Dr. Lin’s most recent research [findings](#) focused on the impact of policy changes for MOUDs in the Veterans Health Administration (VA) during COVID-19. In a national, retrospective study, she found that:

- The number of patients receiving buprenorphine for opioid use disorder (OUD) increased from 13,415 in March 2019 to 15,339 in February 2021.
- By February 2021, audio-only visits were used by the most patients (50.2%; 4,456 visits), followed by video visits (32.4%; 2,870 visits) and in-person visits (17.4%; 1,544 visits).

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Adopt federal flexibilities to initiate buprenorphine for SUD via audio-only and video telehealth: [Dr. Lin’s Toolkit for Opioid Use Disorder Treatment With the Provider Clinical Support Team](#).
- Conduct evaluations at set intervals using state and federal data: [Impact of COVID-19 Telehealth Policy Changes on Buprenorphine Treatment for Opioid Use Disorder](#), evaluating Veterans Health Administration (VA) use of telehealth during pandemic.

Dr. Lin and her colleagues found COVID-19 policy changes were associated with significant ongoing increases in the number of patients receiving buprenorphine, but the delivery of care shifted to telehealth visits, suggesting that any reversal of COVID-19 policies must be carefully considered.

“I think those of us in the addiction field knew that telehealth could help with access, which is a huge

challenge in the field, but the research helps provide evidence and helps to advocate for continued flexibility in how care is delivered—and what care should be supported.”

Those “continued flexibilities” include decreased barriers to starting and continuing care for an individual on buprenorphine for opioid use disorder via audio-only and video telehealth.

## “Patients and clinicians need options and those options should also include telehealth.”

She acknowledges some tension in the medical community about what is lost when a patient and doctor do not occupy shared space in a clinic. “Every patient is different. Understandably, some patients and some clinicians prefer in-person visits, but this has to be balanced with what is feasible to help patients stay engaged in care.” She said she understands that some practices—such as verifying toxicology screens—may be more difficult in a telehealth visit, and we need to help clinicians think about how to assess patients virtually.

As the pandemic continues to evolve, Dr. Lin fears that there may be a push to return to the way we delivered care pre-pandemic.

“We all want human connection,” said Dr. Lin. “But we also have to listen to the data that tell us patients respond differently and access care differently. Telehealth is not for everyone, but it’s clear that it is providing connection and helping many. Moving forward, patients and clinicians should have options, and determining what approaches will help patients stay engaged in care should be a big factor.”



**Lewei Allison Lin, MD, MS**

*“My approach to addiction care is built on a foundation that good care is not measured by whether the patient is using substances one day or another. It is instead a shared goal and building an ongoing relationship with the patient to help them regain their lives and functioning. One of the biggest challenges is that the symptoms of addiction and stigma surrounding it makes it really hard for people to get help. The most important thing is how do we help patients feel like they can reach out and come to treatment especially when they’re struggling? That’s the disease of addiction – and my goal is to find ways to keep people engaged when they need us the most.”*



**Enforce mental  
health and  
substance use  
disorder (SUD)  
parity laws**

# Enforcing mental health and SUD parity laws: Tenacious Trio transforming the parity landscape

## Profile of Jane Beyer, JD, Kathryn Dzurec, JD, and Erica Weyhenmeyer

Even the regulators were surprised that their informal hallway conversations became a national effort to help ensure people with a mental illness or substance use disorder (SUD) get the care that the law requires.

“We’re a pretty tenacious trio,” said Katie Dzurec, a former top regulator with the Pennsylvania Insurance Department (PID). “Our jobs require us to enforce the law, and our efforts hopefully will lead to saving lives.”

Dzurec was joined by Jane Beyer from Washington and Erica Weyhenmeyer from Illinois. Together, they helped form the Mental Health Parity Working Group of the National Association of Insurance Commissioners (NAIC) to make parity enforcement a front-burner issue for insurance

regulators nationwide. What started in the hallway became a collaborative environment among several hundred state and federal regulators, provider groups and consumer advocates. Their shared goal was to break down the historical barriers to enforcement and ensure parity between mental health and SUDs compared to medical and surgical services. The overall goal of the group has always been to develop tools to ensure parity is relentlessly analyzed and redressed by state regulators who often have limited resources.

Each regulator brought her own unique background to the team. Dzurec inherited a set of Pennsylvania market conduct exams that showed SUDs and other mental health claims were covered differently from other medical claims by insurers, but

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Participate in the [NAIC Mental Health Parity Working Group](#).
- Require insurers to attest to compliance: Leverage parity templates prepared by the [Pennsylvania Insurance Department](#).

it took a colossal effort to gain access to documents showing that carriers had completed the analyses required under the Mental Health Parity and Addiction Equity Act (MHPAEA). As a result, the team created templates capable of documenting those efforts and the existing disparities that continued



to persist. Beyer knew from her 20-year career in state government, including a stint as Washington's behavioral health commissioner, that concerns had been raised about commercial insurers' coverage of mental health and SUD treatment services, especially crisis services, and began designing targeted data calls and research projects to better understand the problems. Weyhenmeyer, who has a background in compliance, says parity enforcement is a key component of her role as Chief

Market Conduct Examiner for the Illinois Department of Insurance (IDOI), and she has experienced "personal discomfort" with the way some insurers tried to blame their parity violations on third parties.

The Working Group recognizes the importance of treating coverage of and access to mental and physical health services comparably for patients. It remains challenging, however, for the Working Group to define parity in specific contexts such as provider reimbursement, where insurers pay some medical

specialists, such as neurosurgeons and cardiologists, substantially more than mental health specialists. The Working Group also is considering how and when insurers impose utilization barriers, such as prior authorization, in different ways for different services.

What is unique, according to the regulators, is that the Parity Working Group follows the "collaboration not competition" approach to take complicated issues and try to make them workable across the board.

## POLICIES IN ACTION

- The U.S. Departments of Labor, Health and Human Services, and Treasury issued the [2022 Mental Health Parity and Addiction Equity Act Report to Congress](#), which highlights the National Association of Insurance Commissioners (NAIC) Working Group's meetings to "engage state regulators on MHPAEA implementation and enforcement efforts."
- **Pennsylvania:** The Pennsylvania Insurance Department (PID) has an extensive market conduct program, with nonquantitative treatment limitation (NQTL) templates available [here](#) and exam results posted [here](#). In 2019, the PID [fined](#) UnitedHealthcare \$1 million for parity violations and UnitedHealthcare agreed to conduct an \$800,000 public outreach campaign to educate consumers about mental health and substance use disorder (SUD) benefit. As Dzurec said, "If we don't enforce and follow through with corrective actions, nothing happens."
- **Washington:** In 2019, Beyer and the Office of the Insurance Commissioner (OIC) teamed up with the University of Washington to conduct data calls on parity, and a resulting [report](#) identified both best practices and areas of concern with insurer practices.
- **Illinois:** The Illinois Department of Insurance (IDOI) posts the [results](#) of its market conduct exams on its website. In 2020, IDOI announced it was [issuing](#) more than \$2 million in fines for parity violations by five insurers. Violations in 2022 included those focused on denials of medication for mental health and SUD. Link = [www.illinois.gov/news/press-release.25578.html](http://www.illinois.gov/news/press-release.25578.html).

“We’re able to do this because our working group can harness an incredible diversity of skills, from market analysts and examiners to experts in evaluating nonquantitative treatment limitations (NQTLs),” said Dzurec, whose Pennsylvania NQTL templates have raised the bar on how parity should be measured. “Regulators are engaged in the process and bring both problems and solutions to the table.”

“Federal regulators add another critical dimension,” said Beyer, currently the senior health policy advisor for the Washington State Office of the Insurance Commissioner (OIC) and vice chair of the NAIC Parity Working Group. “Regulators from the Centers for Medicare and Medicaid Services (CMS) and the Department of Labor (DOL) participate in every meeting, which helps add to the analytic depth of the issues for everyone.”



**Jane Beyer, JD (WA)**

Recognizing the various concerns that plans and providers have about parity, Weyhenmeyer, who currently chairs the Working Group, said the group seeks to collaborate to find solutions that work across state lines.

“The group has heard very consistent themes from providers about the challenges they have contracting with commercial insurers—how NQTLs like prior authorization and reimbursement rates do not appear to be at parity,” said Weyhenmeyer. “By sharing transparently how states have responded to these concerns, and the specific NQTLs leveraged, the working group has helped states boost the efficiency of their parity work.”



**Kathryn Dzurec, JD (DC)**

“Members of this group genuinely want to help each other by sharing what they’ve learned in their pursuit of parity,” said Beyer. “We aim to ensure that states have access to systemized approaches to achieving mental health parity, and are driving toward a future where insurance carriers are asked many of the same questions and states are focused on some common NQTLs. This kind of collective action across the states would act like a rising tide, raising the standards for mental health parity across states in America.”



**Erica Weyhenmeyer (IL)**

# Enforcing parity, expanding treatment networks

## Profile of Colorado Insurance Commissioner Mike Conway, JD, and Colorado Chief Deputy Commissioner Kate Harris

Mike Conway and Kate Harris continue to push for answers and innovative solutions because too many Coloradoans are dying by suicide or drug-related overdose and suffer from a lack of access to behavioral health and addiction medicine care.

“Some people say certain things are too hard to figure out,” said Conway, the Insurance Commissioner at the Colorado Division of Insurance. “We have the difficult discussions with the insurance industry, medical providers and the legislature to figure it out.”

One area that has separated Colorado from most other states is the work to identify how to meaningfully address chronically inadequate networks for mental health and substance use disorder. This also has included efforts to analyze compliance with state and federal mental health and substance use disorder (SUD) parity laws.

Conway and Harris, the DOI’s Deputy Commissioner, pointed to [H.B. 1269](#), a 2019 law that gave the Division of Insurance (DOI) resources to hire dedicated staff for parity enforcement and behavioral health reform. For the first time, the

DOI had the resources to “dig into data” and, as Conway put it, start “peeling back layers” about “what we know and don’t know” to “find solutions to hard problems.”

In 2021, Colorado unveiled [Regulation 4-2-75](#), which set new standards for evaluating behavioral health and SUD treatment networks by collecting an array of new information from insurers on both their network capacity and, equally important, the volume of services actually delivered. Collecting the needed data has required “hard conversations” with insurers and is still a work in progress, but Harris is confident the data will help direct resources to the most intractable problems, such as expanding access to medications to treat opioid use disorder (MOUD), which are the gold standard for treating SUDs.

“Knowing that there are access issues and being able to pinpoint where those issues are across the full continuum of care for substance use disorder are two distinct things,” said Harris. She is eager to dig into the data and to understand responses from insurers on not just current access issues, but also on emerging strategies to recruit and retain behavioral health providers in

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

Require insurer reporting on network capacity and the number of patients being treated: [Colorado Insurance Regulation 4-2-75](#).

their networks. For her, the chance to build new policy to help more people access the care they need is the most exciting part of the job.

Change also requires persistence and making tough decisions, as Conway demonstrated when he rejected an earlier set of market conduct parity exam reports because he found them “flawed and inadequate.” Conway then ordered a full new round of examinations that are ongoing. The Commissioner’s bold move captured the attention of market conduct examiners nationwide and has led to a new accreditation program aimed at enhancing the expertise of examiners.

Both Harris and Conway underscored the importance of relationship-building—with both

insurance carriers and government officials. While Harris said that a lot of the struggle with issuers is “overcoming a resistance to change,” and Conway admitted that conversations with insurers are not always “candy and roses,” establishing trust and building relationships with insurance

## “People are dying from overdose at higher and higher rates, so—from a regulator’s standpoint—we can’t be satisfied.”

Conway and Harris also pointed to the fact that they have also built staff expertise to do the hard work of parity analysis and regulatory enforcement.

“Market conduct exams are hard to interpret,” said Conway. “My staff, however, is not satisfied with the easy answers or surface-level explanations from insurers that tend to hide real problems facing consumers.”

“It’s a lot of work to develop regulations and forms to capture the data that can be used to bring meaningful change to a state with diverse population, geographic and economic needs as ours,” said Harris. “But we’re getting there with networks, formularies, and many other areas that will pay future dividends.”

Conway and Harris acknowledge that much remains to be done. Conway is passionate about insurance affordability issues, and Harris noted that many of the policies they are tackling are only useful to someone if they

companies is key to their work. Similarly, Conway noted that his success with legislators is largely attributed to consistency, saying, “By building relationships and credibility with leadership, it gives us the ability to improve access to behavioral health care and addiction medicine services.”

have insurance coverage in the first place, and that those who are underinsured or uninsured are largely left behind.

“As insurance regulators, it’s our job to tie everything together,” said Conway. “And at the end of the day, we’re going to do everything necessary to implement the laws and policies that will help consumers most.”



**Colorado Chief Deputy  
Commissioner of  
Health and Life Policy  
Kate Harris**



**Colorado Insurance  
Commissioner  
Michael Conway, JD**

*“When we came into the division in 2019, the suicide rate in teens was the number one cause of death for adolescents in Colorado. It’s still in the top two or three. There is that drive to find solutions to a very glaring problem. I love problems. I love finding solutions to problems that are hard to figure out, especially when people say that it’s too hard or impossible to figure out. Candidly, that’s never the case. It may be an uphill battle and it may take a lot of time, but it’s never too hard to figure it out.”*



**Improve access to  
multidisciplinary,  
multimodal care  
for patients with  
pain**

# Providing individualized pain care

## Profile of Chad Kollas, MD, and Steven Stanos, DO

You really have to dig deep into the things a patient does on a daily basis to understand how to treat their pain, according to Steven Stanos, DO, Executive Medical Director of Rehabilitation and Performance Medicine at Swedish Pain Services in Seattle, Washington. “Of the many patients I’ve been fortunate to meet and work with who struggle with chronic pain, I can’t help but appreciate the individual stories that really define what is happening with a patient presenting with a complaint of pain. Their unique stories help me to better understand and develop an individualized treatment plan our team can provide and the patient can benefit from.”

Dr. Stanos recalled an older patient who had intense pain in his knees—not an uncommon scenario. After talking with the patient, Dr. Stanos was able to appreciate there was more to the patient’s complaint than the severe osteoarthritis in his knees. There

were additional underlying medical and psychosocial issues that were contributing equally to the patient’s presenting complaint. Many times, a treatment plan needs to assess the biological, psychological and social needs of the patient, a biopsychosocial approach.

As part of his treatment, said Dr. Stanos, we incorporated physical therapy to strengthen his legs and to better support his knee joints, occupational therapy to assess pacing and body mechanics, and psychological counseling to help him learn strategies to better manage stress related to the patient’s caregiver role helping his wife who was also struggling with medical problems.

“He didn’t appreciate how ongoing stress contributed to his perception of pain and worry. Adding simple stretching exercises for his hip and daily sit-to-stand leg-strengthening exercises helped him to strengthen his legs and decrease pain. Adding

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Promote access to evidence-based interdisciplinary pain management delivery models: The Swedish Hospital System’s [Structured Functional Restoration Program](#) provides a “pain boot camp” involving intensive coordination of care by a number of pain specialists and providers.
- Protect provider discretion to develop individualized treatment plans: [New Hampshire House Bill 1639](#).

5 minutes of tai chi exercises to his morning routine taught him he could calm his nervous system while improving his balance.”

Dr. Stanos and his colleagues say that their practice focuses on “functional restoration” with a goal of not only helping patients decrease their baseline pain but also learn to adjust their activity during flare-ups in pain, and apply techniques that help them to improve psychosocial function, including relaxation techniques like deep breathing and meditation.

“We don’t assume any patient needs any particular treatment until we fully assess and develop a comprehensive biopsychosocially

based plan,” said Dr. Stanos. “Some patients might benefit from opioid therapy, while others may benefit from different non-opioid pharmacologic agents and injections. Another patient might benefit from active therapy, like physical therapy and aerobic exercise, or a combination of a number of pharmacologic and non-pharmacologic approaches. We don’t know until we complete a comprehensive assessment and truly understand the patient’s unique story.”

## “Supporting patients with pain one patient at a time.”

—Steven Stanos, DO

### **MAINTAINING COMPASSION AND DIGNITY IN PAIN CARE**

Comprehensive treatment for patients receiving hospice and palliative care also begins with understanding their unique needs, said Chad Kollas, MD, who is the medical director of Palliative and Supportive Care at Orlando Health Cancer Institute in Florida.

“I see extremely vulnerable patients. Many experience considerable pain, and I can’t afford to lose access to any evidence-based tools to help effectively treat that pain.”

Dr. Kollas said that he’s encouraged by [proposed revisions](#) to the 2016 opioid-prescribing guideline from the U.S. Centers for Disease Control and Prevention (CDC). The [2016 guideline](#), which was supposed to be a series of voluntary recommendations, included specific, numeric thresholds for maximum daily dosage and quantity for an opioid prescription. The AMA and many medical associations have consistently advocated for CDC to rescind those guidelines because of the predictable, unintended consequences to patients and physicians.

Following the interview with Drs. Stanos and Kollas, the CDC released its “CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022.” In addition to removing the numeric thresholds from its recommendations, the CDC said “This clinical practice guideline provides voluntary clinical practice recommendations for clinicians that should not be used as inflexible standards of care. The recommendations are not intended to be implemented as absolute limits for policy or practice across populations by organizations, health care systems, or government entities.” Link: [www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s\\_cid=rr7103a1\\_w](http://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w)

“Those consequences have included patients of mine with Stage IV cancer and in hospice being denied opioid therapy at the pharmacy counter,” said Dr. Kollas. “I’ve had to spend hours on the phone with pharmacists, pleading with them to not make my patients suffer.”

Dr. Kollas also pointed to state legislative efforts that are needed to help protect physicians who prescribe opioid therapy that might go beyond the CDC 2016 guideline. This includes legislation

in Oklahoma, New Hampshire and, most recently, Minnesota that provides protections for physicians who prescribe opioid therapy in good faith to patients with pain.

“The 2016 guideline was supposed to exempt patients with chronic pain, in hospice or who have cancer,” said Dr. Kollas. “But the effect of putting arbitrary, specific numbers in statute effectively created a one-size-fits-all approach to pain care that has been extremely difficult to apply with any sensitivity or compassion.”

Dr. Kollas said that he’s encouraged by recent efforts, but it will take a long time to restore balance for patients with pain—and the long-term implications will take even longer to resolve.

“The 2016 CDC guideline has not only affected patients. It has caused many physicians—from primary care to surgery to pain medicine—to no longer prescribe opioid therapy at all,” said Dr. Kollas. “I am hopeful the revisions to the 2016 guideline will help, but that will take many others to take action.”



**Chad Kollas, MD, Medical Director of Palliative and Supportive Care at Orlando Health Cancer Institute**



**Steven Stanos, DO, Executive Medical Director, Rehabilitation and Performance Medicine, and Medical Director, Swedish Pain Services, Providence Swedish**



# Removing stigma from pain treatment

Profile of Rita Agarwal, MD, Edwin C. Chapman, MD, and Cara Sedney, MD, MA

“When children have pain, it needs to be treated,” said Rita Agarwal, MD, clinical professor of anesthesiology at the Stanford University School of Medicine and past president of the Society for Pediatric Pain Medicine. “The stigma that many patients with pain experience unfortunately extends to our youngest patients, but they are often not able to advocate for what they need.”

Dr. Agarwal highlighted that untreated pain is akin to preventable suffering. She pointed to data from the [National Survey on Drug Use and Health](#) (NSDUH) that many people who say that they misuse opioid analgesics do so to self-treat pain. These are often children and adolescents who have had an acutely painful injury or operation, that transitions into persistent or chronic pain. And while the NSDUH data may not fully reflect the situation for her youngest patients, Dr. Agarwal said that she is increasingly concerned by physicians and other health care professionals who avoid the appropriate use of opioids as part of a comprehensive pain management

plan, because of fear of substance misuse or illicit substance use.

Edwin C. Chapman, MD, founding member and secretary of the board of directors of the Leadership Council for Healthy Communities, also raised concerns about the consequences of untreated pain, the relationship between pain management and health equity, and physician fears when prescribing opioids.

Dr. Chapman described the dangers of inaccessible pain medications, saying that “the patients who cannot get access to legal pain medications have no choice and initially move toward street drugs.” With so many of these drugs now being laced with fentanyl, there has been a dramatic rise in overdose deaths related to illicit substances. In fact, according to recent [reports](#), 96% of overdose deaths in Washington, D.C., have been attributed to fentanyl.

While Dr. Chapman’s practice now primarily focuses on addiction medicine in Washington, D.C., he stressed the need to address both

## **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

Promote access to evidence-based pain management delivery models: AMA’s [“What does a sufficient pain care formulary look like?”](#)

physical and psychological pain, especially in Black communities.

“We want to take a village approach, said Dr. Chapman. “And that village approach of course involves medical treatment and reconciliation at the core, but we also need advocacy and legal surveillance,” said Dr. Chapman. He specifically advocated for a better relationship between the criminal justice system and outpatient treatment as a more equitable step toward managing the overdose epidemic.

“The people in my community face stigma from every angle. It’s not a surprise that people turn to other

sources of pain relief if they are told that ‘it’s in your head,’ and in the Black community, there remains deep mistrust of health care. This is true for young people, working people, those who are homeless, and my older patients.”

“The data show that we have a lot of work to do to help our patients with pain,” said Cara Sedney, MD, MA, associate professor and residency program director of the West Virginia University Department of Neurosurgery.

Dr. Sedney explained how common policy approaches to overdose and the 2016 U.S. Centers for Disease Control and Prevention (CDC) opioid prescribing guideline focused almost exclusively on how to restrict prescription opioids, increasing the stigma on patients

with pain and not addressing the rise in overdose deaths caused by illicit fentanyl, methamphetamine and cocaine. Dr. Sedney said that while CDC’s revised 2022 guideline removes many of the most problematic features of the 2016 version, states will have to remove the 2016 version from current policy.

In a recent [study](#), Dr. Sedney focused on the impact of restrictive opioid prescribing laws on patients. Physicians interviewed as part of the research revealed that fear of disciplinary action led to refusal to prescribe opioids, leaving patients with no choice but to turn to illicit substances.

“Nearly all of the patients we interviewed who used illicit substances had started with

chronic pain, and many of our participants noted that the sort of care gap where they were unable to continue their medication,” said Dr. Sedney, going on to explain the need for fail-safes to prevent patient abandonment and the detrimental impacts of opioid restriction policies on patients with chronic pain.

“Untreated pain has tremendous consequences,” said Dr. Agarwal. Although there are a number of multimodal, non-opioids, and non-pharmacologic, approaches to pain treatment that we should continue to explore, she explained, there are insurance barriers that often make these alternatives less accessible. “This is why individualized care is so important,” she said.



**Rita Agarwal, MD**



**Edwin C. Chapman, MD**



**Cara Sedney, MD, MA**

**Expand harm  
reduction efforts  
to reduce death  
and disease**

# Saving lives with naloxone

## Profile of Nabarun Dasgupta, MPH, PhD

"I almost got kicked out of school 20 years ago for distributing naloxone," said Nabarun Dasgupta, MPH, PhD, who today is a senior scientist and Innovation Fellow at the University of North Carolina (UNC) Gillings School of Public Health Injury Prevention Research Center. "Then and now, thankfully, there are harm reduction methods to keep people who take drugs alive."

Dasgupta was part of the innovative [Project Lazarus](#), the first program in the world to do pharmacy-based naloxone distribution to reverse overdose and had a focus on community-based responses and referrals for pain care, substance use disorders (SUDs) and other needs. The Project Lazarus model has been widely emulated due to its long history of saving lives.

The need for community-based interventions hasn't changed. The Campus Health program at UNC, for example, has a campus-wide naloxone distribution program.

"It's important to normalize naloxone in all settings—whether college campuses, high schools, or medical settings and places of employment," said Dr. Dasgupta. "And it's critical

that we get affordable naloxone into the community given the numbers of people dying."

Dasgupta said that while naloxone has made great strides in being accepted as an overdose intervention, it is also true that "the formalized, pharmaceutical-centric approach to distribution is much more expensive and far less effective." Injectable vials of naloxone distributed by harm reduction teams cost less than \$4, whereas nasal spray conventionally used by police officers and public officials and prescribed by physicians costs between \$50 and \$150 for a two-dose prescription.

"Having the nasal spray available is excellent for those who prefer that—and have insurance to pay for it," said Dr. Dasgupta. "But naloxone handed out through a community-based harm reduction program is three times as likely to be utilized compared to when it is distributed by police or other public programs. And while I'm encouraged that physicians and pharmacists are helping increase access to naloxone, an insurance-based system is not sufficient to meet today's needs."

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Reduce pricing and increase access for local entities to purchase naloxone: [Remedy Alliance for the People](#).
- Eliminate prior authorization for naloxone and reduce other barriers to naloxone access: University of North Carolina at Chapel Hill Campus Health [Naloxone Distribution Program](#).
- Authorize harm reduction centers: [Project Lazarus](#).

### **INNOVATION MEANS CUTTING OUT THE MIDDLEMAN**

In addition to the high cost of naloxone continuing to be a barrier, Dasgupta also advocates for removing the prescription status of naloxone that keeps it behind the pharmacy counter. In 2022, Dasgupta and other leading community-based harm reduction experts launched the [Remedy Alliance](#), which serves as a "buyers' club" to directly negotiate with pharmaceutical companies for affordable, injectable naloxone. The Remedy Alliance has

organized 150 community-based programs and expects to distribute 1–2 million doses in its first year alone. Recently, the Food and Drug Administration (FDA) and the White House [announced support](#) for the Remedy Alliance distribution model. One goal is to increase access to marginalized populations that have been left out of accessing naloxone.

*“The AMA encourages action to remove the prescription status of naloxone to make it more available over the counter (OTC) and for purchase and distribution by harm reduction organizations.”*

**—Letter from AMA Executive Vice President and CEO, James Madara, to Rahul Gupta, MD, Director of the White House Office of National Drug Control Policy. February 15, 2022.**

<https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-2-15-Letter-to-Gupta-re-ONDCP-Naloxone.pdf>

“The innovation is really in bringing the right people together to meet the need of communities,” said Dr. Dasgupta. “In the last two months, we have activated all sorts of new civic groups, from Buddhist

collectives to Native American tribal organizations, to mental health facilitators serving rural Black communities in the South.”

Dr. Dasgupta said that he hoped continued pressure on manufacturers would lead to positive action, but he also highlighted other innovations and partnerships that would help, including the following:

- Universities and high schools holding overdose awareness and prevention activities, including how to recognize signs of overdose and the role of naloxone in saving lives
- Community health fair partnerships with harm reduction organizations to include overdose awareness and prevention “booths”

“It keeps me up at night that in the last year alone, there have been over 150,000 research papers published about SUD and public health interventions to the epidemic. Each paper has a handful of researchers committing 100-150 hours of work to their publication because they are dedicated to mitigating this deadly crisis. While this is important work, we just don’t need any more research demonstrating that we need hundreds of thousands of additional doses of naloxone in the community.”

To prove his point, Dr. Dasgupta highlighted research in *The Lancet*

estimating how much naloxone states would need to reduce the incidence of fatal overdose.<sup>15</sup> Unfortunately, the research team found that there aren’t any states that are distributing nearly enough naloxone to meet the demand.

“We’ve made some good strides,” said Dr. Dasgupta. “The harm reduction community is small but mighty. We will continue to do the work, but we could really use more help.”



**Nabarun Dasgupta,  
MPH, PhD**

*“Our job increasingly should be to get the money, get the naloxone, and get out of the way. By bringing the cost of naloxone down, we can reduce the opportunity cost and innovate to try new ways to get the drugs into the right hands through community-based outreach programs.”*

<sup>15</sup> Irvine, Michael A., et al. “Estimating Naloxone Need in the USA across Fentanyl, Heroin, and Prescription Opioid Epidemics: A Modelling Study.” *The Lancet Public Health*, no. 3, Elsevier BV, Mar. 2022, pp. e210–18. Crossref, doi:10.1016/s2468-2667(21)00304-2.

# Streamlining access to naloxone in the ED

## Profile of Don Stader, MD

“The number one rule of treatment is that you have to be alive,” said Don Stader, MD, an emergency physician and the architect of Colorado’s efforts to have naloxone distribution efforts in every ED in the state.

Through the [Colorado Naloxone Project](#)—and with a healthy dose of state legislative advocacy—more than 100 hospitals in the state have established naloxone education and distribution programs.

Dr. Stader explained that “it’s a no-brainer” to start in the ED because that’s where patients who overdose receive care, and it is those patients—and their families and friends—who need naloxone most. The American College of Emergency Physicians (ACEP) and American Medical Association (AMA) are among dozens of medical societies supporting increased efforts to distribute naloxone from the ED. ACEP’s [“Emergency Department](#)

[Naloxone Distribution: Key Considerations and Implementation Strategies](#)” details many of the issues that EDs should consider when starting a program.

“Too few people who survive an overdose receive take home naloxone,” said Dr. Stader. “We have to recognize that barriers and stigma play a huge role in the treatment of patients with opioid use disorder (OUD). Often, because of previous treatment experiences, people who use drugs mistrust the medical profession. But by offering compassion and naloxone, we start to change that narrative and re-establish a therapeutic bond. When we place naloxone in their hands and provide them with overdose education, we demonstrate that we care about them. Treatment starts with compassion, and that’s at the heart of the Colorado Naloxone Project.”

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

Coordinate efforts with emergency departments (EDs) to connect nonfatal overdose patients to treatment options: [University of Colorado Health System](#)’s model permits initiation of buprenorphine in the ED and connects patients to social workers to conduct an in-depth screening and, where appropriate, coordinate referrals for treatment.

*“A hospital or emergency department shall receive reimbursement under the medical assistance program for the cost of an opiate antagonist if, in accordance with section 12-30-110, a prescriber, as defined in section 12-30-110 (7)(H), dispenses an opiate antagonist upon discharge to a medical assistance recipient who is at risk of experiencing an opiate-related drug overdose event or to a family member, friend, or other person in a position to assist a medical assistance recipient who is at risk of experiencing an opiate-related drug overdose event.”*

—[Colorado House Bill 22-1326](#)

What’s also essential in Colorado is that recent [legislation](#) requires private payers and the state Medicaid program to reimburse hospitals for the cost of take-home naloxone provided to patients. That has helped Colorado EDs provide more than 5,000 naloxone kits. The legislation also removes administrative requirements for record keeping and labeling, which Dr. Stader said is another small step toward removing all barriers to distributing the lifesaving medication.

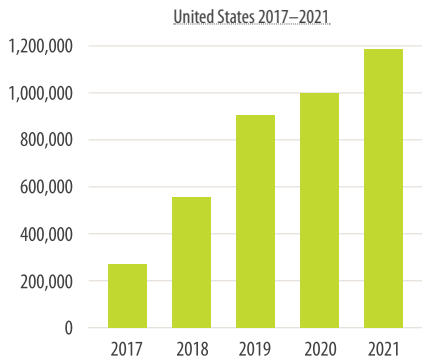
“These are just two of many barriers we addressed in the legislature,” said Dr. Stader. “Confronting stigma and ensuring emergency physicians and other health care professionals have conversations about naloxone is much larger lift.”

**“A person who, in good faith and in a timely manner, seeks medical assistance for someone who is experiencing a drug overdose shall not be cited, arrested, or prosecuted for a violation.”<sup>16</sup>**

—<https://legislature.vermont.gov/statutes/section/18/084/04254>

<sup>16</sup> In this statute, “[S]eeks medical assistance’ shall include providing care to someone who is experiencing a drug overdose while awaiting the arrival of medical assistance to aid the overdose victim.”

### Naloxone prescriptions dispensed from retail pharmacies<sup>1</sup>



The AMA urges physicians to prescribe naloxone to patients at risk of overdose, and also advocates for naloxone to be available over-the-counter to make it readily accessible to everyone as an essential step to save lives from opioid-related overdose.

Harm reduction and other community-based organizations **distributed more than 3.7 million doses of naloxone between 2017–2020.**<sup>5</sup>

During the COVID-19 pandemic, the number of **individuals filling a naloxone prescription from retail pharmacies decreased more than 26%.**<sup>6</sup>

To make his point, Dr. Stader highlighted how most individuals still receive naloxone from harm reduction organizations that provide services to people who use drugs. Over the past few years, those organizations have distributed greater amounts of naloxone than what has been prescribed by physicians and other health care professionals.

“This is a ‘both-and’ situation,” said Dr. Stader. “When I use naloxone in my ED to save a person’s life, I need to do everything I can to keep that person alive after they leave—and that means talking with them, understanding what they need, and hopefully reaching a place where they will accept take-home naloxone and OUD treatment. EDs and medical establishments offer

a distinct advantage over harm reduction agencies, in that patients can return to us and actually receive treatment for OUD, with medications such as buprenorphine and methadone.”

While proud of Colorado’s success so far in establishing ED naloxone distribution programs, the organization looks to grow. The Colorado Naloxone Project has incorporated a 501(c3) nonprofit called The Naloxone Project. Within Colorado, they have launched an initiative called Colorado MOMs (Maternal Overdose Matters) and are in the process of implementing naloxone-dispensing for labor and delivery units and neonatal intensive care units (NICUs). Outside of Colorado, The Naloxone Project is looking to expand to ten additional states in 2023.



**Don Stader, MD,**  
emergency department  
physician in Denver,  
Colorado

*“Offering naloxone means showing physicians care.”*





**Improve public  
health data  
surveillance,  
monitoring and  
evaluation**

# Documenting effective interventions spurs equitable care

## Profile of Professor Ricky Bluthenthal, PhD

Ricky Bluthenthal, PhD, has built a career proving that there is “great opportunity in providing quality care to low-resourced people.” As the Associate Dean for Social Justice and a Professor in the Department of Population and Public Health Sciences and the Institute for Prevention Research at the Keck School of Medicine at the University of Southern California, Bluthenthal has documented the effectiveness of public health interventions for vulnerable populations of drug users, taking social drivers of health into special account.

Bluthenthal pointed to three “big areas” of progress that policymakers and researchers should continue to address:

1. Building an infrastructure to deliver biopharmaceutical solutions to those in greatest need
2. Addressing chronically under-resourced populations
3. Advancing clinical best practices for this high-need population

When Bluthenthal began his career as a researcher, HIV was a fatal diagnosis, hepatitis C had not yet been identified, and there were no medications available to treat opioid use disorder (OUD). Today the landscape is very different. Scientific progress has led to therapeutics that ensure HIV is preventable, hepatitis C is curable, and OUD is treatable with not only one but three different medications.

“We have made extraordinary advances in biomedical science. But what we haven’t done in the last 30 years is to create an infrastructure for biomedical distribution that reaches the population most in need,” says Bluthenthal. “That is the next frontier.”

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

Decriminalize safe syringe program supplies: [“Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program clients,”](#) as [presented](#) at “Needle Exchange Programs: Benefits and Challenges” in January 2020.

What continues to prevent the country from realizing that frontier, however, are key structural and social barriers that will be difficult to remove, said Bluthenthal. This includes growing economic inequality coupled with decreasing resources available to fully support adequate social welfare systems for underserved populations. In turn, he said, this creates systemic barriers to wellness, especially for people lacking shelter or living in urban and ethnic neighborhoods.

Bluthenthal says it boils down to several key policy opportunities:

- Make buprenorphine and methadone available across all forms of insurance—and provide transportation to get people to care whenever necessary.
- Make sterile needle and syringe exchange programs more ubiquitous by funding them to a far greater degree.
- Don't think of overdose prevention as just naloxone—contingency management solutions can help people who use stimulants, for example, but these solutions need to be funded to reach more people

“The combination of a lack of assistance, staggering social inequality, and a punitive criminal justice system for justice-involved individuals creates desperate conditions, especially for those struggling with substance use disorder,” says Bluthenthal. He points to hunger, homelessness and chronic health struggles as symptoms of a health system that does not adequately serve those in greatest need.

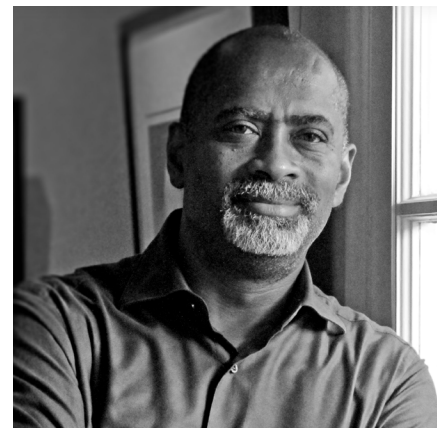
“For too long, we have been operating under the misunderstanding that giving resources to people with a drug problem just perpetuates their drug problem. But our research indicates this is false,” observes Bluthenthal. “The data shows that funding evidence-based solutions reduces the spread of infectious disease, keeps people stable in treatment,

and stops them from dying. These are the outcomes everyone wants, but too often stigma against people who use drugs undermines efforts to fund programs.”

## CHANGING THE SYSTEM

When asked what motivates him to continue his work as a researcher, he remarks that he believes in generational progress and remains committed to helping mentor young professionals and encouraging them to dedicate their research to this area. He shared his own story—the son of a teenage mother, in a household where his stepfather worked two jobs to invest in Bluthenthal's education—commenting that “my stepfather was never going to directly benefit from the sacrifice he made in my education, but he knew it would make a tremendous difference for my future.”

Bluthenthal wants to make a similar generational impact on the researchers working to combat the OUD epidemic today. He said, “While I may only be around for ten more years as a researcher, my students will be around for 50 plus years to come. They will be the leaders ushering in new advances that combat this crisis. I invest in them, as my stepdad did in me.”



**Ricky Bluthenthal, PhD**

*“If you grind on it, there is a chance things get better. It doesn't always happen at the pace I would like, but there is progress being made. We must keep grinding.”*

# Maine's all-of-the-above efforts

## Profile of Gordon Smith, JD

Maine's Director of Opioid Response, Gordon Smith, knows it is a tall order "to do everything right to help people survive" the drug overdose epidemic that continues to grip his state, but he finds inspiration in the thousands who are alive because of naloxone, and the hundreds more who are in long-term recovery. There were more than 9,500 overdoses in Maine in 2021—with 6.6% being fatal.

"It's the continuum of care that's essential," said Smith. "We have to keep people alive for as long as possible, get people to stop using alone, get them into treatment when they're ready, help them find housing and a job, and then stay engaged with them for the long term."

Implementing programs to address elements across the continuum is part of the [statewide response](#) put into place in 2019. There is no single point of emphasis in the multimodal, policy-rich

state action plan, said Smith, since all elements—primary prevention, harm reduction, access to treatment, recovery supports, community support—may be needed throughout an individual's path to long-term care. Smith also knows, however, that the statewide strategy must be supported by statewide policy, including leaders on the ground to implement that policy. For example, Maine increased access to naloxone and broadened the state's Good Samaritan protections, which helped result in more than 250,000 doses of naloxone in the community, [leading](#) to more than 2,000 documented community-based, opioid-related overdose reversals in 2021 alone, and more than 2,500 anticipated in 2022.

Following a successful 2019 pilot program showing the efficacy of implementing medication-assisted treatment in corrections settings, Maine also took action to help ensure medications to

### **POLICIES FROM THE JANUARY 2022 STATE TOOLKIT:**

- Expand harm reduction efforts: [Maine's OPTIONS Initiative](#).
- Evidence-based care for justice-involved populations: [Maine Department of Corrections](#) facilities.

treat opioid use disorder (MOUD) were available and offered across carceral settings in the state, which has led to more than 2,000 individuals receiving MOUD while incarcerated in state and county facilities. The Maine [OPTIONS \(Overdose Prevention Through Intensive Outreach Naloxone and Safety\) Initiative](#), an effort of the Governor's Office, Maine Office of Behavioral Health, and other state agencies, embedded a behavioral health liaison in each of Maine's 16 counties—

which, in turn, has reached more than 2,500 individuals, including helping hundreds arrive to a first appointment for SUD treatment.

The state's opioid response action plan will work only as much as the key stakeholders work together, said Smith, who pointed to positive relationships between government, health systems, physicians, community leaders and many others. Smith, who served for two

decades as the executive director of the Maine Medical Association, said that he's heartened by how many people are working together but also acknowledges that it often feels like an uphill climb.

"We have to be honest that we're losing people faster than we're saving them," said Smith, who pointed to [data](#) showing that nearly 80% of fatal overdoses involve fentanyl."

## "We have to do everything right to help people survive."

Smith highlighted several of the ongoing challenges Maine faces:

- We're saturating communities with naloxone, but we're losing people who die in isolation.
- We've passed laws and policies to remove prior authorization for MOUD, but we still are fighting barriers to residential treatment.
- We've built out community liaisons through OPTIONS and other programs, and there is more we can do around supports for housing and employment.
- We've increased primary prevention efforts in schools, but fentanyl is so deadly that too many young people don't appreciate or understand the risks.

- We've drastically increased funding for MOUD and behavioral health, and we're investing more to support a trained workforce to provide care.

Smith said he understood that the challenges are considerable, but he remains inspired by those in recovery. "I've met and heard hundreds of people who are alive today because of the efforts we've taken," said Smith. "That gets me going every day, and it's why I'll never stop working to save more lives."



**Gordon Smith, JD**

*"We have the most power to address the epidemic when we focus on social drivers of health that contribute to demand for drugs."*

