DISTRICT OF COLUMBIA
BEFORE THE COMMITTEE ON HEALTH AND
THE COMMITTEE ON THE JUDICIARY & PUBLIC SAFETY

JOINT PUBLIC OVERSIGHT ROUNDTABLE ON THE DISTRICT GOVERNMENT'S STRATEGY AND ACTIONS TO COMBAT THE OPIOID EPIDEMIC
January 28, 2019

TESTIMONY OF WHITMAN-WALKER HEALTH

Pursuant to the Notice of Hearing for this Roundtable, Whitman-Walker Health (WWH or Whitman-Walker) is pleased to submit this testimony on the District Government's response to the opioid epidemic. As noted in the Roundtable Notice, we are addressing the Mayor's Strategic Plan "LIVE.LONG.DC"; implementation of Act 22-617, the Opioid Overdose Treatment and Prevention Omnibus Act of 2018; and Bill 23-0054, the Opioid Overdose Prevention Act of 2019. In light of the broad scope of the January 28 Roundtable and Hearing, we also will address other issues which we believe are critical to an effective response to substance use disorders and the overdose crisis in the District.

Expertise and Interest of Whitman-Walker Health

Whitman-Walker is a community-based, Federally Qualified Health Center offering primary medical care and HIV specialty care, mental health and substance use disorder treatment services, community health services and legal services to residents of the greater Washington, DC metropolitan area. WWH has a special mission to the lesbian, gay, bisexual and transgender members of our community, as well as to all Washington-area residents of every gender and sexual orientation who are living with or otherwise affected by HIV. In calendar year 2018, more than 20,000 individuals received health services from Whitman-Walker. As part of WWH's holistic approach to health, we offer a robust suite of behavioral health programs, including peer support, individual and group psychotherapy, psychiatry and substance use

disorder treatment services to adults and youth. Our behavioral healthcare team includes licensed psychotherapists, psychologists, psychiatrists, and trained peer counselors. In 2017, 1,842 people received mental health services from WWH, and 222 individuals received substance use disorder treatment services from our therapists, psychiatrists and medical providers. Our substance use programs include individual and group psychotherapy, an outpatient group program, and a very successful Medication-Assisted Therapy (MAT) program.

The MAT program uses a low-barrier; patient-centered, team-based approach to treat people with problematic opioid use histories, most of whom have co-occurring mental health disorders. The program has the following aims:

- to help patients replace and extinguish their use of opioids, manage withdrawal through the use of buprenorphine/naloxone, reduce harm and/or establish abstinence from opioids using buprenorphine/naloxone or naltrexone medications, and prevent overdose through the use of naloxone; and
- to help patients examine and change their use of other (non-opioid) drugs and alcohol; and to help patients manage co-occurring mental health disorders and symptoms to improve their quality of life, improve overall functioning, and optimize treatment outcomes, including reducing harm from substance use and improved co-occurring disease management.

Our patients have benefitted greatly from this much-needed low-barrier program. While engaging in treatment, patients are often able to enter or re-enter the workforce in a meaningful way – for what may be the first time in their lives. Employment represents both a significant success and a small program challenge: working full time makes coming to the health center for appointments and groups sometimes challenging, so we have adapted our program to better fit

the needs of these patients, adding more flexibility, and more individual, walk-in check-ins. The addition of a peer recovery support specialist allows WWH to provide additional support in the form of peer support groups and individual peer support check-ins. Patients' co-occurring mental health needs are met via counseling and other medication. Some patients have tapered off buprenorphine completely; others are maintained at a very low level. The MAT program has also acted as a gateway to health care and HCV care and treatment for some. We hear first-hand from patients in groups, how access to MAT has helped them to become more functional, creating a ripple effect into families and community; patients are more present in their families and relationships, more reliable, and can see that change is possible for them. Since it began in 2012, the buprenorphine/naloxone program has become our fastest-growing substance use disorder treatment service.

WWH's approach meets patients where they are – helping them achieve their goal of abstinence from or reduction in opioid use while monitoring their use of other substances. The program combines MAT and counseling and offers referral to a higher level of care for patients when clinically indicated. The availability of multiple treatment groups from which patients may choose means that patients who struggle to find transportation, child care and other services are able to come to the health center at a time that works for them. Similarly, staff from our substance use disorder-MAT program can often see patients on a walk-in or short-wait basis, thus encouraging engagement, retention, and referrals to other care.

Moving From Stigma to Compassion, Harm Reduction and Integrated Treatment

Whitman-Walker's model for substance use disorder treatment and overdose prevention is based on harm reduction principles, integrating primary care providers and other medical professionals into the services that behavioral health professionals and psychiatrists provide. We

believe that a whole-person wellness approach recognizes the intersecting causal networks of addiction and supports patients at all levels of treatment. WWH works to replace stigma and fear with a model that treats everyone as worthy of the best care available. As was noted by many in the January 28 hearing, too often individuals struggling with opioids and other addictive substances have been neglected because of implicit or explicit attitudes that view them as undeserving of treatment. We commend the Administration and Council on their commitment to bring greater care and attention to the opioid epidemic in our community. We also suggest ways to implement and build on the Administration's Strategic Plan and recent legislation, based on the expertise and experience of our behavioral health providers, psychiatrists and primary care providers. We agree that treating individuals struggling with substance use as partners in their own care requires a community-wide education and coordination effort, including not only behavioral health professionals and psychiatrists, but also first responders – including law enforcement officers and emergency medical personnel – and social workers and other social service providers of wrap-around support services. People who misuse substances are members of our community, and our whole community benefits from changing our mentality from a punitive approach that sees people with problematic substance use histories as a public health threat.

Toward an Integrated Community Response to the Addiction Crisis

The opioid crisis calls for a City-wide response that meets patients where they are and is coordinated to help them get to where they want to be. This requires governmental and non-governmental partners to create strong coordinating networks between service providers and community supports. Coordination creates continuity of care, eliminates silos between providers, reduces wasteful and duplicative efforts, and results in patients being linked to the

care and support they need. A patient-centered approach aligns with the Administration's Strategic Plan Goal 5.2, Strategies 6-8, wherein emergency room providers and peer care-coordinators ensure warm handoffs and provide direct links to treatment and social support services. That commitment to integrated services should be expanded to include primary care providers and clinics, first responders, and (as described below) the families and other caregivers of persons who are misusing substances. The District Government also should require coordination and communication between grantees to ensure patients receive continuity in their care and to reap the benefits that emerge from coordination.

The Administration's Strategic Plan Goal 1, Strategy 6 calls for exploring the option of treatment on demand through intake and assessment at multiple points of entry into a system of care for substance use disorder. We support this strategy because it recognizes that timing is critical for patients seeking substance use disorder treatment. Government and community organizations can create a system that is ready to receive patients when they are ready to begin treatment. In accord with Goal 5, Strategy 2, emergency rooms, first responders, acute detox centers, and long-term outpatient or residential treatment facilities should coordinate their policies, resources and actions to lower barriers to continuity of care for patients. The challenge presented by coordinating care between all relevant District agencies and across multiple states creates an opportunity for peer educators to support patients traversing the labyrinthine process to receive adequate care and treatment.

The importance of involving primary care and other medical providers. As already noted, our response to the opioid and overdose crisis needs to include primary care and other medical providers – not just behavioral health professionals and psychiatrists. At Whitman-Walker we have found interdisciplinary consultation critical in order for medical providers to

understand MAT and to assess the importance of behavioral health interventions when needed. In line with the Administration's Strategic Plan Goal 3, Strategy 12, encouraging continuing education for providers, we recommend that the District government commit to education and resources to support all prescribing providers. Increased collaboration between medical and behavioral health providers should also improve an individual's physical health. For many patients, MAT provides a low-barrier entry into the health care system that allows for screening for other chronic illnesses such as diabetes, hypertension, HIV, HCV, and cancer. If more primary care providers become DATA-waivered and can prescribe MAT, then there are more opportunities for communication and collaboration between medical and behavioral health providers and more opportunities for health promotion and screenings.

Establishing a real-time clinical consultation or mentorship program. We also recommend that a program be established to enable providers to consult with other professionals when a clinical question arises. A real-time clinical consultation mechanism like a prescriber hot-line is an opportunity to support training, collaboration and shared resources for prescribers and to provide a link for primary care providers and other medical providers to benefit from the expertise of other providers in the community. For example, a common misconception among medical providers is that a patient has to be completely abstinent from all substances with high misuse potential for a medical provider to prescribe the common MAT: buprenorphine/naloxone. Whitman-Walker's harm reduction approach treats patients as partners in their care and provides MAT if it is safe for the patient, without additional requirements. This approach improves access and adherence while maintaining patient safety.

More Training for Police Officers

We applaud Act 22-617, the Opioid Overdose Treatment and Prevention Omnibus Act of 2018, for eliminating criminal penalties for the possession of drug paraphernalia and testing materials and removing onerous restrictions on needle exchange sites, and Bill 23-54, the Opioid Overdose Prevention Act of 2019, for creating an amnesty clause for voluntary surrender of opioids and narcotic drug paraphernalia. We also applaud Bill 23-54 for mandating that opioid antagonist rescue kits be provided to law enforcement officers and that they be trained in their proper use. These innovations represent a harm reduction approach to policing. We urge the Administration and the Council to ensure the Metropolitan Police Department continue to apply a harm reduction approach to their policing. We understand that officers are frequently entering potentially dangerous environments, and they should be trained in de-escalation and harm reduction techniques.

Ensuring That the Department of Corrections is Fully Integrated With Addiction Treatment Providers

The Administration's Strategic Plan and Act 22-617 both recognize the important role that the carceral system plays in many people's access to addiction treatment. As stated in Strategic Plan Goal 1, Strategy 3 and Goal 6, Strategy 4, the Administration prioritizes ensuring that federal and local government correctional facilities continue the MAT of any person in their custody. Act 22-617 also requires the Department of Corrections (DOC) to coordinate with the Department of Health to ensure appropriate treatment for incarcerated individuals. We respectfully add that community organizations should be empowered to provide additional support to the efforts of the DOC. Community partners can improve on the current program by strengthening the communication between the DOH, other community organizations, and the DOC. Organizational support from local partners provides a mechanism for community input

and cooperation to address to a lack of communication and coordination for transitioning patients between their physician's care into the custody of the DOC and back into the community (Strategic Plan Goal 6, Strategy 5). Failure to follow the prescribed treatment plan and failure to coordinate transition back into the clinical setting increases risk of relapse and puts patients at high risk of overdose upon release. These suggestions align with the Administration's Strategic Plan Goal 6, Strategies 6 and 8, which call for integrating community supports with the criminal justice system and for improving coordination between justice and public health partners.

Increasing Access to Naloxone and Educating the Community on Its Proposer Use

Access to naloxone, known widely by the trade name Narcan, is the primary method of reducing opioid overdose deaths in the District. We applaud that the Administration's Strategic Plan includes increased education and access to naloxone (Goal 4, Strategy 1). We are aware that fentanyl is laced into a diversity of mood altering substances in addition to heroin, including widely used drugs like cocaine and marijuana. We are encouraged that the Council's 2018 Opioid Act includes effectuating a standing order for naloxone at District pharmacies.[1] The standing order can improve access to naloxone for a more diverse population of people. In alignment with many of the strategies of Goal 2 in the Administration's Strategic Plan, access involves community education programming on where to get naloxone, how to administer naloxone, harm reduction approaches to MAT, education about legal provisions when calling 911, and the importance of calling for emergency medical response as soon as possible.

The Administration can take a leadership role with District pharmacies to monitor and coordinate the local naloxone supply. Whitman-Walker providers have been able to effectuate the standing order for naloxone from District pharmacies without a prescription, but they have found that their patients are not aware of the standing order or which pharmacies have a supply.

[1] Act 22-617, Sec. 201 (A).

The District can improve access to naloxone by spreading the news that naloxone is available, without a prescription from a doctor, to not only medical providers, but also emergency responders (police, fire-fighters, EMS), anyone in a substance use disorder program, and – most important – their family and friends. The rules for the standing order need to be clarified and publicized.

We are encouraged that the Council's 2018 Opioid Act protects providers and pharmacists from liability for administering, prescribing or dispensing opioid antagonists.[2] A punitive system for prescribers has been shown to paradoxically increase the number of patients who turn to heroin or purchase opioids from the streets if their prescription is abruptly stopped. A harm reduction approach to substance use disorder treatment engages both patients and providers in determining what care is needed. The prescription drug monitoring program described in Act 22-617 [3] should be used to identify opportunities to increase education and training in proper prescribing of opioid medications and to identify high risk patient populations, not to bring potential criminal and civil liabilities on prescribing physicians.

Naloxone is inherently a community-engaged intervention because the person experiencing the overdose is not conscious at the moment when it needs to be administered. First responders are concerned that they could be held liable for administering naloxone on someone who is unconscious. We believe a coordinated response is needed to address this concern. First, we recommend widespread education that there are no adverse side effects from the administration of naloxone. If you do not need it, it does not hurt you. If you do need it, it can save your life.

[2] Act 22-617, Sec. 301 (B).
[3] Act 22-617, Sec 401.

We also recommend that the Council consider legislation to extend the protections from liability in Act 22-617 to anyone who is involved in the administration of naloxone to individuals in crisis/overdose situations – including first responders, other health professionals, social service providers and friends and family of persons with substance use disorders – provided that they are responding in good faith to someone who appears to be overdosing. As noted above, naloxone has no adverse side effects and can be life-saving if promptly administered; disincentives for its use, including fears of legal liability, should be eliminated when possible.

Police officers have also expressed an unfounded fear that fentanyl poses a threat to their safety in the event of accidental exposure. Thankfully, the 2019 Opioid Bill requires all police officers carry and be trained in the use of naloxone. Training and education should reassure them that they and their partners have both the skills and tools necessary to prevent death from accidental overdose.

Expanding Insurance Coverage of MAT

We are encouraged by the Administration's Strategic Plan Goal 1, Strategy 2 to coordinate with District and federal regulators to lower barriers to effective substance use disorder treatments. Many of the Administration's strategies recognize how insurance companies sometimes implement obstacles to accessing treatment.

Goal 5, Strategy 5 of the Administration's Strategic Plan acknowledges that requirements like prior authorizations for MAT conflict with the harm reduction prescribing standards for our communities. Some public and private insurance plans will not cover naloxone or other MAT in the particular form or dose that is appropriate for a patient's needs. For example, the highly effective extended release naltrexone treatment must be injected when a patient has achieved at least seven consecutive days of complete abstinence from opioids and is therefore most safely

administered immediately after a patient completes an in-patient withdraw management treatment program. In a particularly cruel Catch-22, some insurance plans only cover 3-5 days of in-patient detox treatment. Goal 5, Strategy 4 recognizes that this is too short a stay to ensure that extended release naltrexone can be safely administered. Patients are too often discharged to continue the detox at home, but in most cases this places the patient at high risk of relapse. Cumbersome prior authorization (PA) requirements for effective treatments that require many hours to complete burden our providers and reduce our ability to care for our patients. In particular, insurance plans requiring PA for naloxone when a patient is using the common MAT buprenorphine/naloxone puts them at increased risk of a fatal overdose.

Act 22-617 and the Administration's Strategic Plan Goal 1, Strategy 10 align in requiring insurers to have available opioid use disorder treatments in-network. Both are essential to a comprehensive approach to addressing the opioid crisis in our community. We encourage the Administration to engage with city-wide community partners and insurers to seek solutions to these complex problems. A city-wide response is more efficacious when every insurance plan provides sufficient days of coverage in a detox facility to ensure that patients can successfully transition to MAT.

Increased Funding for Transportation

Another particularly burdensome issue for our patients is transportation to and from treatment. Some of our patients cannot get to their appointments if they cannot afford to take the metro. We request funding for transportation to create continuity of care for patients. Getting between treatment sites and to and from individual or group therapy appointments, is key to creating access to all levels of care. Additionally, the hospitals and EMS that treat overdoses need to be able to transport patients (and information) to the appropriate government and

organization partners. The City's coordination should include adequate transportation to create continuity of care for patients. Providing transportation is a relatively low-cost intervention from the City that provides an incredibly high value for our patients to lift the burden of worrying how they can get to their appointments.

Conclusion

We are encouraged by the Administration and the Council's recent words and actions. Whitman-Walker Health stands ready to contribute to the efforts to combat the effects of the opioid crisis in our community with compassionate and scientifically validated tactics.

Respectfully submitted,

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