OPIOID SETTLEMENT PRIORITIES

Recommendations from the Addiction Solutions Campaign

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ADDRESSING THE OPIOID CRISIS. INVESTING IN SOLUTIONS.
3 Impact Areas to Change the Trajectory

BACKGROUND

As the opioid epidemic continues to wreak devastation on individuals, families and communities across the country, the need to implement solutions to this public health crisis is urgent.

The good news is that, unlike many other public health crises that have faced our nation, **we already know what to do to stem the opioid epidemic.** The solutions to addressing this crisis exist; we must invest in implementing them.

Investment of settlement funds in support of the science-based recommendations described below would change the trajectory of the opioid crisis, and **should not require continuing funding to sustain.** Instead, the recommended changes should ultimately reduce costs to state and localities and could have the potential for the kind of improvements in family, social and economic conditions that foster optimism, private investment, jobs and new revenue.

ABOUT THIS DOCUMENT

This document outlines three major strategic priorities for addressing the opioid epidemic. Its authors represent four of the longest tenured and well-respected organizations in the addiction sphere. The recommendations included here are not new. They are not merely the opinions of the authors. They are taken from scientific reviews and consensus documents developed by panels of experts.

Importantly, this document is not, nor does it purport to be, a complete list of effective evidence-based strategies. Rather, it is a curated set recommendations that are **1) scientifically sound; 2) rapidly scalable; 3) politically viable and 4) financially sustainable.**

For the sake of clarity and precision, we have divided the recommendations into three impact areas, and outlined specific strategies to achieve the major goals for each with investment of settlement funds.

KEY RECOMMENDATIONS

IMPACT AREA 1 — *Enhance public and professional education; Create informed demand for effective policies and interventions.*

Our longstanding national policies to curb drug misuse and addiction have not worked. The reason we developed the wrong solutions is that we had the wrong ideas about the problem. This mistake continues to negatively impact the way we perceive and manage substance use disorders, and has had been disproportionately harmful for low-income communities, communities of color, and rural communities.

There is critical need for accessible, factual, understandable information about these issues — particularly for those whose social roles bring them closest to youth, such as parents, teachers, healthcare workers and public officials.

Specific Strategies to Enhance Understanding and Create Informed Demand:

1) Implement public awareness campaigns focused on parents that show proven effective steps they can take to help protect their children.
2) Invest in data-driven policies.
3) Invest in a Consumer Guide to Prevention and Treatment
4) Inform the public about their rights to fair and equitable insurance benefits under the Parity Act of 2008
5) Mandate education and training in addiction in all state-funded medical, nursing and pharmacy schools.

IMPACT AREA 2 — *Implement evidence-based prevention and early intervention strategies to reduce substance misuse and related harms.*

The most effective and economical way to avoid the costly consequences of opioid misuse and addiction is to invest in effective prevention and early intervention to reduce its incidence. Addiction is a developmental disorder that starts with substance use during adolescence. Prevention involves: 1) delaying the onset of substance use in youth and 2) screening to identify those at risk to halt the trajectory towards addiction.

Specific Strategies to Improve Prevention and Early Intervention:

1) Create and empower a state prevention office.
2) Use legislative powers to reduce adolescent's access and exposure to legal addictive substances.
3) Create state tax incentives and/or investment grants for family services and for communities to organize.
4) Commission a state-wide review of school-based prevention to assure that schools are properly trained, organized and equipped to deliver evidence-based prevention interventions.
5) Establish a state Screening and Brief Intervention (SBI) program and educate, train, and incentivize health care professionals to understand correct methods for identifying risk factors and promoting positive behavioral change — particularly in pediatric and school healthcare settings.
6) Ensure fair insurance reimbursement for SBI and approved addiction medications in states' Medicaid programs and essential health benefits (EHB) benchmark plans.
7) Invest in data-driven prevention interventions and policies.

IMPACT AREA 3 — *Expand access to evidence-based addiction treatment services, integrated with mainstream healthcare.*

It is critical to note that the development and proliferation of our current system of addiction treatment pre-dates the major scientific advances that have shown addiction to be a preventable and treatable chronic medical disease. **Although there are many good individual treatment providers, they are operating within a fundamentally broken and underresourced system.** Rather than funding a broken system, we should modernize addiction treatment by integrating in into mainstream healthcare.

The best use of the Opioid Settlement funds in the area of addiction treatment would be to promote and financially incentivize true integration of addiction care with the rest of healthcare — including training healthcare professionals.

Specific Strategies to Expand Access to Quality, Integrated Treatment:

1) Increase treatment capacity.
2) Increase the availability of medication-assisted treatment (MAT) for opioid addiction.
3) Use Payment Models to Promote Quality Treatment.
4) Use licensing requirements to drive quality.
5) Ensure that your state medical association adopts best practices for the design and implementation of Prescription Drug Monitoring Programs.
6) Educate and train physicians, nurses and other prescribers in safe prescribing of opioids for chronic pain.
7) Provide funding to support internships and fellowships in addiction treatment to expand the workforce.
8) Provide educational incentives for physicians, nurses and other prescribers to take the 8-hour SAMHSA course in Medication-Assisted Addiction Treatment.
9) Authorize state Medicaid and Block Grant funds to enhance reimbursement for certified evidence-based addiction treatment.
10) Support conversion to electronic health records for addiction treatment providers.
11) Review state Medicaid and Block Grant guidelines to assure there are no undue restrictions of availability of and reimbursement for FDA-approved medications to treat addictions.
12) Invest in ongoing peer and family recovery service development and implementation.

SUMMARY

With appropriate investment in the evidence-based solutions, we can reduce the incidence of addiction through prevention and education, increase the number of people with addiction who receive treatment, reduce overdose deaths, minimize reliance on incarceration, and improve the quality of treatment so that people with addiction recover and lead healthy lives. Doing so will reduce the economic and social burden of addiction and drug overdose, which is now the leading cause of death among people under 50 in our country. The imperative is clear and pressing.

The strategies outlined above and detailed in the full document are backed by decades of scientific research, rapidly scalable, politically viable, and financially sustainable. Investing public or private dollars in these solutions will immediately reduce the devastation of the current opioid epidemic, and will create the framework needed to build a more sensible and durable prevention, treatment and recovery infrastructure in this country for the future.

OPIOID SETTLEMENT PRIORITIES:
Recommendations from the Addiction Solutions Campaign

The **Addiction Solutions Campaign** is a consortium of the leading policy, advocacy, education and technical assistance organizations in the addiction field. We are:
Legal Action Center,
Center on Addiction,
Partnership for Drug-Free Kids and
Treatment Research Institute at Public Health Management Corporation

Together we bring more than 125 years of experience, skills and resources to impact our nation's primary preventable health problem through public and professional education, policy development and advocacy, and translational research in addiction prevention and treatment.

The current opioid epidemic in our country has now claimed more lives than AIDS or breast cancer — even more than the Vietnam, Iraq and Afghanistan wars combined. Add to these tragic losses the estimated $740 billion annual costs of addiction to healthcare, criminal justice and national productivity.[1] Equally devastating, is the incalculable devastation that the epidemic has wrought on communities and families across the country, and the sense of national despair that accompanies an under-addressed, and un-abating public health crisis.

But the addiction epidemic can be abated — and we can bring to bear the needed solutions immediately to stem the devastation and prevent future crises. Unlike other health and social threats to this country, **we already have science-based, scalable, cost-effective methods to substantially, rapidly and sustainably:** reduce the incidence of addiction through prevention and education, increase the number of people with addiction who receive treatment, reduce overdose deaths, minimize reliance on incarceration which has disproportionately harmed people of color, and improve the quality of treatment so that people with addiction recover and lead healthy lives. Doing so will reduce the economic and social burden of addiction and drug overdose, which is now the leading cause of death among people under 50 in our country.

Yes, these are bold claims but they are factual. A 2016 Surgeon General's Report, Facing Addiction,[2] reached these exact conclusions following a review of the past 30 years of research in this field — and those conclusions were ratified by over 1,000 expert reviewers as well as by all five federal agencies responsible for addiction policies. In addition, a separate Commission on Combating Drug Addiction and the Opioid Crisis, convened by President Trump and led by New Jersey Governor Christie[3] reached virtually identical conclusions as those laid out in the 2016 Surgeon General's Report. Implementation of the recommendations outlined in both reports are possible rapidly — especially if there is an infusion of new funding at the state and city levels from the Opioid Settlement combined with corresponding changes in current state legislation, licensing, financing and educational practices. The recommended changes in state policies and practices are described below; they are neither politically divisive nor economically imprudent. Importantly, investment of settlement funds in support of the science-based recommendations described below would change the trajectory of the opioid crisis, and **should not require continuing funding to sustain.** Instead, the recommended changes should ultimately reduce costs to state and localities and could have the potential for the kind of improvements in family, social and economic conditions that foster optimism, private investment, jobs and new revenue.

For the sake of clarity and precision, we have divided the science-based recommendations for state use of Opioid Settlement funds into three impact areas:

IMPACT AREA 1: Enhance public education to correct long-held misconceptions, and to create informed demand for more effective policies and interventions;

IMPACT AREA 2: Implement evidence-based, community-wide prevention and early intervention to reduce the incidence of addiction and overdose;

IMPACT AREA 3: Modernize addiction treatment by integrating it with mainstream healthcare and increase access to evidence-based addiction support and treatment services.

These specific impact recommendations are preceded by a general section on historical and conceptual issues in this field that provide rationale for and set the context for the recommendations that follow.

IMPACT AREA 1

Enhance public and professional education — Create informed demand for effective policies and interventions.

Our longstanding national policies to curb drug misuse and addiction have not worked. The reason we developed the wrong solutions is that we had the wrong ideas about the problem. This mistake continues to negatively impact the way we perceive and manage substance use disorders, and has had been disproportionately harmful for low-income communities, communities of color, and rural communities.

Stigma and misunderstanding perpetuate bad policies and ineffective solutions.

Throughout history, addictions have been conceptualized as a sign of weak character, a personality disorder, or a habitual series of bad personal choices. This characterization of addiction is easy to understand, since cardinal features of addiction include failure to carry out normal adult role functions because of cravings for and uncontrolled use of alcohol or other drugs. For many seriously affected patients, lying, stealing, and negligent, dangerous acts (e.g. drunk driving, overdose) are all too common behavioral effects of the addiction rather than enduring character traits.

WHAT A PUBLIC HEALTH APPROACH LOOKS LIKE:

- Delay and reduce alcohol and drug **use** by our young;
- Recognize and intervene rapidly in cases of substance **misuse** to avert the many, costly cases of drugged and drunk driving, accidents and injuries;
- Avert overdose incidents and deaths from opioids, alcohol and sedatives;
- Treat even very serious cases of addiction with recovery as an expectable outcome.

With this as the guiding concept, it is understandable that addictions have been treated largely as public safety problems to be dealt with through laws, interdiction and punishment —rather than public health problems better addressed through prevention, early intervention, and medical management.

While virtually every American knows that the country is in the midst of an unprecedented opioid crisis, very few understand the fundamental facts about drug use, misuse (also called harmful use) and addiction. Unfortunately, this includes some clinicians who are treating patients with substance use problems, and some policy-makers who are driving funding, regulatory and legislative responses. Without awareness and basic understanding about substance use disorders, we cannot advance effective policies and interventions. **There is critical need for accessible, factual, understandable information about these issues — particularly for those whose social roles bring them closest to youth, such as parents, teachers, healthcare workers and public officials.**

ADDICTION IS NOT THE SAME AS SUBSTANCE MISUSE — Though opioids, cigarettes, alcohol and many other drugs of abuse are different in many ways, they all share three features that inform prevention, treatment and recovery. First, all are commonly used, usually starting in the teenage years and often continuing through middle age.[1, 2] Second, using any of these substances at high doses, in a manner that is not prescribed by a physician, or in certain contexts can immediately cause a health or social problem to the user and sometimes to those surrounding them. This is termed substance misuse. These problems may be of low severity and transient, but they can also have serious, enduring, and costly consequences, such as an arrest for driving under the influence (DUI), an automobile crash, intimate partner and sexual violence, child abuse and neglect, suicide attempts and fatalities, a stroke, or an overdose death. Ongoing use of opioids, marijuana, cigarettes, alcohol or other substances at high doses and/or high frequencies (thresholds vary across substances) can produce an independent illness that impairs health and function and may require special treatment. These are called substance use disorders and they can range from mild and temporary to severe and chronic. The most serious of the substance use disorders are commonly called addictions.

STIGMA AND LACK OF EDUCATION ARE THE LARGEST BARRIERS TO TREATMENT.

Families trying to get help for someone with a substance use disorder face numerous challenges: primary care doctors who have often received no training about the disease; an insurance system that is at best difficult to navigate and at worst hostile to behavioral health; and a treatment system that is outside of the medical mainstream and sometimes doesn't provide evidence-based treatment. As a result, individuals and families often make ill-informed choices about care. Some make extreme personal financial sacrifices rather than fighting the insurance company for the coverage they are entitled to. Others with less privilege have few options as publicly funded addiction care is often limited in availability and quality.

It is in the interests and within the assigned responsibilities of state and local governments to promote and sustain public and professional education efforts and Opioid Settlement funds would be wisely spent on policies and programs that show measurable evidence of greater public awareness and involvement in drug-related issues.

Two sets of educational recommendations follow:

1. City and State Investments in General Public Education should focus on:

- **Implementing public awareness campaigns focused on parents** that show proven effective steps they can take to help protect their children. Key points should include differences among substance use, misuse (also called harmful use) and addiction — and how to reduce risk factors and promote protective factors
- **Investing in data-driven policies.** States and cities differ dramatically in the nature and amount of drug use and drug risks — cities should partner with colleges and universities to analyze available data (e.g. student surveys, arrest reports, ER visits) to identify the most pressing issues and the most "at risk" populations (e.g. high school and college students) to target best-fitting local policies and prevention and treatment strategies.
- **Investing in a Consumer Guide to Prevention and Treatment.** States license and regulate most addiction treatment but they rarely do enough to educate parents, counselors, parole/probation workers and others who refer individuals to addiction treatment on the availability of that care, or how to compare available treatment options for quality and effectiveness. As a result, selecting treatment can be a 'shot in the dark'. Investing in systems that inform consumers about what to look for in good treatment will promote more effective, high-value care.
- **Informing the public about their rights to fair and equitable insurance benefits** under the Parity Act of 2008
  - o Assure your State Insurance Commissioner and Medicaid Director fully enforces Parity in the licensed insurers' and Medicaid plans within your state
  - o The Addiction Solutions Campaign is spearheading a national Campaign to improve consumer understanding of their rights to equitable coverage for substance use and mental disorder services, and to work with policy-makers and regulators to improve insurer compliance with the law.

2. City and State Investments in Professional Education should focus on:

- **Mandating education and training in addiction** in all state-funded medical, nursing and pharmacy schools. At least a one semester course and preferably a full-year course in addiction.
  - o Offer loan forgiveness programs as an incentive to encourage medical professionals to serve as addiction treatment providers in your state for a designated period of time. [1]
    - Require that all physicians and nurses take an 8-hour, online course in addiction as a condition of re-licensure (CE) credits.
    - Provide extra CE credits for physicians, nurses and other healthcare professionals who take the SAMHSA 8-hour course on medication assisted treatment.
    - Increase funding for clinicians to pursue internships and/or fellowships in addiction training.
- **Expanding fellowships, internships and other training opportunities** in addiction medicine and addiction psychiatry.

IMPACT AREA 2

Implement evidence-based prevention and early intervention strategies to reduce substance misuse and related harms.

The most effective and economical way to avoid the costly consequences of opioid misuse and addiction is to invest in effective prevention and early intervention to reduce its incidence. Unfortunately, in most states prevention education is limited to one or two trainings in school settings. Worse, many schools continue to implement prevention programs that are demonstrably ineffective.

Addiction is a developmental disorder that starts with substance use during adolescence.

Research shows that the at-risk years for substance misuse are 12-25 and that over 80% of all addictions occur in this period.[4] Put differently, if a family/community is able to prevent youth from becoming addicted during their high school and college years — there could be 80% less people with addiction. The reason for elevated risk in this period is not only the social risks associated with teen behavior; neurobiology has shown that adolescent brains are not fully developed until about age 25 and are far more susceptible to all drug effects than adult brains.

Prevention involves: 1) delaying the onset of substance use in youth and 2) screening to identify those at risk to halt the trajectory towards addiction.

This new science has informed and improved modern prevention efforts. Given the expanded at-risk period, it follows that prevention interventions (tailored to the age/gender/ethnicity of the children) must occur throughout the entire at-risk period; and prevention effects are multiplied when interventions come not only from schools but also parents, healthcare, and all venues affecting youth, including technology driven interventions. Research shows that not all prevention interventions are equally effective — some don't work at all, and still others have negative side effects. In contrast, many prevention interventions developed for schools, parents, clergy and other groups carry the same level of research evidence as is used by the FDA to approve new medications and devices. These are the proven "evidence-based prevention practices" recommended by all experts. Finally, research shows that effective prevention also requires public policies that reduce the availability and accessibility of opioids and other drugs and ones that promote protective factors.

Considered together, these research findings indicate that the most effective methods of organizing prevention efforts **are at the family and community level** through implementation of proven effective organizational frameworks. In fact, large-scale, real-world studies have shown that when communities organize and deliver community-wide, coordinated prevention policies and practices that consider cultural differences and experiences, they reduce not only alcohol and drug misuse, but also virtually all the major adolescent risk factors (e.g. school drop-out, bullying, suicide, car crashes, fights, unwanted pregnancies, etc.) by 40% — compared with similar communities that simply receive information about effective prevention strategies.[5] When coupled with evidenced based family interventions which involve training caregivers and young people on risk and protective factors, outcomes can be significantly improved. Thus, evidence-based, family and community delivered prevention not only improves the quality of family and community life, it produces cost savings that can sustain and enhance the prevention effort.

Therefore, it is in the interests and within the assigned responsibilities of state and local governments to promote and sustain community-delivered, evidence-based prevention; Opioid Settlement funds would be wisely spent on policies and programs that are able to show measurable evidence of reductions in substance misuse, addiction and related harms among youth.

1. City and State Prevention Investments should focus on:

- **Creating and empowering a state prevention office** — Unlike healthcare interventions that are delivered in traditional care settings (e.g. clinics, hospitals, health centers), most states do not have a well-developed and well organized method to deliver prevention interventions. This has been a mistake. However, prevention efforts at these offices should NOT simply focus on substance use but all relevant risks to youth. Research has shown that most of the personal and environmental risk factors for substance misuse and addiction are also relevant risks for mental health, physical health, most social harms — thus separate drug use, bullying, pregnancy, drop-out, etc. prevention programs are NOT needed and may even reduce the impact of generic prevention messaging.

- **Using legislative powers to reduce adolescent's access and exposure to legal addictive substances,** for example:
  - Raise taxes on alcohol, nicotine and marijuana products;
  - Implement environmental use laws;
  - Restrict advertising and marketing of alcohol, nicotine and marijuana products, particularly near schools and colleges.
- **Creating state tax incentives and/or investment grants for communities** to organize and implement community-wide, evidence-based prevention policies and practices
- **Commissioning a state-wide review of school-based prevention** to assure that schools are properly trained, organized and equipped to deliver evidence-based prevention interventions — Prevention should be a significant part of the school curriculum **every year of middle and high school** and in multiple courses (e,g, health, history, biology, driver education, etc).
  - Ensure that prevention initiatives are sensitive to age, gender, sexual orientation, and racial, ethnic, religious, or cultural group.
  - Ensure that school athletic programs have properly trained coaches to focus on risks of opioid use and misuse among student-athletes.[2]
  - Use school websites to provide drug education and helpful resources to students and parents.[3]
- **Establishing a state Screening and Brief Intervention (SBI) program** and educating, training, and incentivizing health care professionals to understand correct methods for identifying risk factors and promoting positive behavioral change — particularly in pediatric and school healthcare settings.
- **Ensuring fair insurance reimbursement for SBI and approved addiction medications** in states' Medicaid programs and essential health benefits (EHB) benchmark plans. Several states have activated SBIRT Medicaid codes.[4]
- **Investing in data-driven prevention policies.** States and cities differ dramatically in the nature and amount of drug use and drug use risks — cities should partner with colleges and universities to analyze available data (e.g. student surveys, arrest reports, ER visits) to identify the most pressing issues and the most "at risk" populations (e.g. high school and college students) to target best-fitting local policies and prevention and treatment strategies on the group and individual level. Data driven prevention allows for personalized interventions that target individual risk and protective factors rather than universal one-size fits all approaches.
  - Ensure that prevention approaches address the full range of risk factors known to increase substance use (e.g., poor coping skills, trauma, family history of substance use, peer substance use, psychiatric symptoms like depression and anxiety) and the protective factors known to decrease risk (e.g., academic opportunities and achievement, family and peer support, a nurturing school or community environment).
  - Use technology based assessments and interventions to scale tailored prevention programming at the individual and community level based on the unique risk and protective factors.
  - Develop interventions and systems that embed ongoing evaluation and monitoring to assess impact and outcomes in real-time.

IMPACT AREA 3

Expand access to evidence-based addiction treatment services, integrated with mainstream healthcare.

The current addiction treatment system is broken.

Our conception of addiction was strained in the 1960s, when rates of substance misuse increased among college students, and Vietnam War veterans developed serious opioid addictions. It was not politically or socially acceptable to arrest and incarcerate college kids and war veterans. There was a compelling national need for treatment, but the existing health care system was neither trained to care for, nor especially eager to accept, patients with substance use disorders. For these reasons, a new system of substance use disorder treatment programs was created, but with administration, regulation, and financing purposely placed outside mainstream health care. Since the late 1970's virtually all treatments for addiction have been provided by specialty "addiction treatment programs", which are geographically, financially, culturally, and organizationally separate from the rest of mainstream health care. The focus of that form of addiction treatment has been to first "detoxify" the patient, and then to confront, with group counseling, the dishonesty and impulsive character traits that were thought to underlie an "addictive personality." The confrontation phase of treatment was often led by dedicated, earnest peer counselors who were themselves modeling a new "recovery" lifestyle emphasizing personal honesty, social responsibility, and abstinence from all substance use.

Creating this separate system of substance use disorder treatment programs at that time was a critical step forward in addressing the burgeoning substance use disorder problems in our nation, and beginning to acknowledge that people struggling with addiction required care. However, that separation also created unintended and enduring problems. First, the prevailing views of addiction had little provision for physicians, medications, information systems, professional therapies, or most of the prominent features of modern healthcare. The decision to focus treatment only on the severely addicted left few provisions for detecting or intervening clinically with the far more prevalent cases of early-onset, mild, or moderate substance use disorders. By the 1980's we began an ineffective 'war on drugs' that disproportionately harmed people of color and perpetuated ill-informed racial biases about drug use. Because addiction was not accepted as an illness, medications were considered inappropriate or unnecessary by many providers and insurers — thus not profitable to develop by most pharmaceutical companies. Consequently, until the 1990s, few U.S. Food and Drug Administration (FDA) approved medications were available to treat addictions. For these reasons, virtually all major healthcare organizations — even academic centers — eliminated addiction treatment.

Meanwhile, in the rest of mainstream healthcare, pharmaceutical benefits from private insurance fostered development of new medications; and there was a growing consumer movement — epitomized by those affected by HIV/AIDS — demanding more access and better treatments. Because of segregation, these forces were never present in the addiction field — the "condition" was so stigmatized that consumers felt unable to demand their rights. Thus, the remarkable advances in curing and managing other diseases spurred by medical education, pharmaceutical research and the consumer movement simply did not occur in the segregated addiction treatment system. Unfortunately, one thing is certain — adding more funding to perpetuate existing, conceptually antiquated and culturally segregated prevention and treatment policies and practices simply will not work.

It is critical to note that the development and proliferation of our current system of addiction treatment pre-dates the major scientific advances that have shown addiction to be a preventable and treatable chronic medical disease. Research over the past several decades has elucidated our understanding of the biological bases of addiction, as well as the long-term impacts on brain structure and function. Our current understanding of the disease of addiction suggests that treatment follow an integrated chronic disease model of care, rather than the separate acute care model that was the framework for our national treatment system.

Addictions are best treated through continuing outpatient care and monitoring, using individualized treatment regimens comprised of evidence-based medications, behavioral therapies, social supports and clinical monitoring. Yet, misguided policies, regulatory practices and insurance provisions have limited the availability of these evidence-based treatments for substance use disorders and reduced the potential benefits of proper addiction care. These factors have led to the creation and perpetuation of a system of care that is plagued by inconsistent quality standards and inadequate funding for effective clinical care.

Rather than funding a broken system, we should modernize addiction treatment by integrating in into mainstream healthcare.

Most individuals who receive addiction treatment do not receive the kind of evidence-based care needed to promote long-term recovery. Individuals with substance use disorders who receive inadequate care often relapse, which perpetuates the perception that addiction is untreatable. One impulse may be to use Opioid Settlement funds at the state and local levels to simply increase the number of beds and outpatient addiction treatment slots. Although this might seem like a wise approach given the significant need to expand treatment access, replication without modernization would be very much ill-advised and ineffective for two major reasons. First, as described above, from the beginning the existing addiction treatment system was designed around an inaccurate understanding of addiction; and it has been financially, culturally and geographically segregated from the rest of healthcare. Few in the public are satisfied with existing care and most patients do not want it - they drop out rapidly. **More funds spent this way will only produce more of what we have — but not better quality or effectiveness.**

Second, more funds to perpetuate the separate, segregated addiction treatment system will not address the burgeoning costs and consequences of unidentified, unaddressed substance misuse and addiction that occur in mainstream healthcare — especially hospital and emergency care. Currently addiction treatment systems and mainstream health systems are now almost completely independent of one another, and both suffer from this lack of integration. Improving outcomes in both settings requires that they come around to a common care approach, patient management strategy, means of information exchange and outcome expectation. This will better serve our nation in not only reducing the opioid crisis but also improving the quality and efficiency of mainstream healthcare by reducing the costs of unaddressed substance misuse (approximately $120 billion annually). New funds are needed for integrated care and telehealth addiction solutions that advance new data driven sustainable models.

The best use of the Opioid Settlement funds in the area of addiction treatment would be to promote and financially incentivize true integration of addiction care with the rest of healthcare. Some of the rationale supporting this recommendation has been discussed above. In summary, it is now clear that addiction is an illness that erodes the function of the inhibitory, motivational, stress and reward circuitry of the brain; and the resulting impediments remain significant for months to years following drug cessation. For these and other reasons serious addictions are now considered chronic illnesses best treated like other chronic illnesses with predominantly outpatient care that is tailored to the specific needs of the patient; that is proactive in nature; that includes regular clinical monitoring to predict and avert potential relapses; and that involves a well-trained, properly compensated set of professionals who have the skills and ability to provide all evidence-based medications, therapies and social supports necessary to achieve full recovery.

There are practical reasons for this recommendation as well. First, expanding addiction treatment from the current complement of about 15,000 will not be easy — particularly finding sites that communities will agree to and appropriate staff to provide care. Moreover, experience suggests that at least half of the patients who enter the new programs will have co-occurring physical and mental health problems.

Meanwhile, there are over 30,000 patient-centered medical homes and 550,000 primary care practices that already have the professional staff, continuing care approach, information systems, substantial prescriber training and experience with healthcare insurance. To be sure, these care teams would require supplemental training in the screening, diagnosis, management, medication and monitoring of addicted patients. But that training would be relatively rapid and also serve the general interests of managing all the existing mainstream healthcare patients whose substance misuse and addiction are currently being ignored. **Opioid settlement funds could provide the initial investment needed for this training.**

However, even with sufficient training primary care practices will not be able to manage the most severely and chronically affected among the addiction patient population. Thus, true specialty addiction care will certainly continue to play a critical role. To enhance and expand this type of care, **Opioid settlement funds could be used to promote and incentivize expansion of evidence-based specialty treatment and clinically functional organizational linkages between healthcare systems and better addiction treatment programs.**

1. City and State Investments in Expanding and Improving Treatment should focus on:

- **Increasing treatment capacity.**
  - o One major reason for the lack of available treatment is the shortage of physicians trained to address addiction, and the limited number of those who have specialized in addiction medicine. This presents a significant barrier to integrating addiction care into the health care system. Insuring that all physicians have basic training in addiction, and expanding the workforce of addiction medicine physicians and addiction psychiatrists, will help to increase access to care.

- **Increasing the availability of medication-assisted treatment (MAT) for opioid addiction.**
  - o Medication-assisted treatment (MAT) — the combination of psychological/behavioral therapy and FDA-approved medications (i.e., methadone, buprenorphine, naltrexone) — is the most effective means of treating opioid use disorders and preventing opioid overdose. Despite its proven effectiveness, fewer than ten percent of patients with opioid addiction receive MAT.

- **Using Payment Models to Promote Quality Treatment.**
  - o States should use reimbursement contracts to promote evidence-based treatment. As a condition of reimbursement, states should establish benchmarks for providing quality care and develop metrics that can be used for quality reporting and for holding providers accountable.

- **Using licensing requirements to drive quality.**
  - o Impose clinical standards for licensed facilities to ensure that addiction treatment services are evidence-based and integrated into the mainstream health care system.

- **Ensuring your state medical association adopts best practices for the design and implementation of Prescription Drug Monitoring Programs.**

- **Educating and training physicians, nurses and other prescribers in safe prescribing of opioids for chronic pain.**
  - o Ensure that your state health department adopts the Centers for Disease Control and Prevention (CDC)'s *Guideline for Prescribing Opioids for Chronic Pain.* Several states are adopting the CDC's prescribing guideline in their Medicaid program.

- **Providing educational incentives for physicians, nurses and other prescribers to take the 8-hour SAMHSA course in Medication Assisted Addiction Treatment.**
  - o Provide incentives to physicians, nurses and other prescribers who become waivered to prescribe buprenorphine
  - o Develop an up-to-date and easy to use website to enable physicians and other healthcare workers to refer patients to licensed addiction treatment.

- **Authorizing state Medicaid and Block Grant funds to enhance reimbursement for certified evidence-based addiction treatment.**
  - o Reduce existing state Medicaid and Block Grant reimbursements for segmented, discontinuous care that requires patient discharge and readmission from/to different programs within the care continuum— Increase reimbursement for organizations that develop shared patient agreements to provide truly continuous care along the continuum
  - o Use pay-for-performance incentives to increase retention and active participation in outpatient addiction treatment.

- **Supporting conversion to electronic health records for addiction treatment providers** — this will require provision of adequate resources to addiction treatment programs, most of which still lack even basic computer systems due to omission from the federal initiative to support development of those systems by health care providers, and training and technical assistance to allow much-needed collaboration and coordination among specialty mental healthcare, specialty addiction care and mainstream general healthcare.

- **Reviewing state Medicaid and Block Grant guidelines to assure there are no undue restrictions of availability of and reimbursement for FDA-approved medications to treat addictions.**
- **Invest in ongoing peer and family recovery service development and implementation.**
    - Ensure funding includes peer and family recovery services that keep individuals and their concerned significant others engaged in care and recovery networks which provide ongoing support and guidance outside of traditional treatment.

CONCLUSION

At this moment when we are facing an epidemic of overdose with historic impact on American life expectancy, we have a tremendous opportunity to implement a series of programs and policies that can reduce theeconomic and social burden of addiction and drug overdose. We know what works. We have well-researched efforts — the 2016 Surgeon General's Report, Facing Addiction, as well as the report issued by the Commission on Combating Drug Addiction and the Opioid Crisis — to lay out the path forward. And we have the potential of an influx of dollars through the opioid settlement to be able to fund the systemic change necessary to reverse course on this public health crisis. The programs and policies described above would reduce the incidence of addiction through prevention and education, increase the number of people with addiction who receive treatment, reduce overdose deaths, and improve the quality of treatment so that people with addiction recover and lead healthy lives. The Addiction Solutions Campaign stands ready to help in any way so that this critical opportunity to invest settlement dollars wisely yields the best possible results.

ENDNOTES

1 Governor's Task Force on Prescription Drug and Heroin Abuse. (2015, October 20). *Recommendations of the Governor's Task Force on Prescription Drug and Heroin Abuse: Implementation plan: Update, Fall 2015.* Retrieved from Virginia Department of Health Professions website: https://www.dhp.virginia.gov

2 Massachusetts Department of Elementary and Secondary Education. (2016). *Guidance on school policies regarding substance use prevention.* Retrieved from http://www.doe.mass.edu.

3 State of Maryland, Office of Lt. Governor Boyd K. Rutherford. (2015, December 1). *Final report: Heroin and opioid emergency task force.* Retrieved from https://governor.maryland.gov.

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1. Governor's Task Force on Prescription Drug and Heroin Abuse. (2015, October 20). *Recommendations of the Governor's Task Force on Prescription Drug and Heroin Abuse: Implementation plan: Update, Fall 2015.* Retrieved from Virginia Department of Health Professions website: https://www.dhp.virginia.gov
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