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CRAFTING PUBLIC POLICY TO ADDRESS THE NATION'S OPIOID EPIDEMIC

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P R O C E E D I N G S

MS. ZEZIMA: All right, well, welcome, everyone. Thanks for coming out on this rainy day, really appreciate it. I'm Katie Zezima, a national correspondent for The Washington Post. I cover drugs and other issues around the country, so with me, we have Admiral Brett Giroir, the assistant secretary for health at the Department of Health and Human Services, Regina LaBelle, the principal at LaBelle Strategies, as the visiting policy fellow at the Margolis Center for Health Policy at Duke University, and John Hudak, a senior fellow and deputy director for the Center for Effective Public Management and Governance Studies here at Brookings.

So I'm going to ask some questions. We're going to hopefully get a really, you know, robust conversation going and then look forward to opening it up to questions from all of you since I'm sure you have many, so let's kick it off; going to ask everyone on the panel to respond to this question: You know there's been quite a lot of public policy implemented around the opioid crisis, but the number of overdose deaths is continuing to rise, particularly if it's from fentanyl, so is what is being done in the, you know, local, state, and federal level sufficient given that people are continuing to die at alarming rates, and what must be done to stem this tide of overdose deaths, so, Admiral, go ahead.

ADMIRAL GIROIR: Okay, well, good morning, and thank you very much for inviting me to be on the panel and I really look forward to some open discussion. I always have trouble sitting down and speaking, but I'm going to do my best (Laughter) now that I'm tethered on the microphone.

So as I've said many times and will continue to say, the substance use crisis, particularly opioid misuse crisis, is the most important public health challenge of our time. There is no question about that. And that although we are doing as many

things as we think that we can, there's always room to do more. Our five-point strategy has been
well-documented about improving pain control, improving data, improving access to treatment, improving research, and improving the availability of opioid reversal agents, and within those five pillars there are just many, many, many
sub-strategies that I'm sure we'll get into and talk about today.

What I do want to say, though, in response to this question is, the number of deaths and overdoses are far too many and no one can declare victory, but you need to look at the most recent data, certainly from 2016 to 2017, the number of overdose deaths have increased. However when you look at the data more recently in other looks at the data, it does look like we are making an impact on the overall crisis.

Some of the things you would like to see happen that are happening, since January 2017, the amount of morphine milligram equivalence for prescriptions have gone down by 19 percent, the number of individuals receiving buprenorphine for MAT is up 21 percent, the number of prescriptions for naltrexone up 47 percent, the number of prescriptions for naloxone up 368 percent. The last NSDUH data, which is the National Survey on Drug Use and Health, shows that pain reliever misuse and pain reliever use disorder have both statistically significantly decreased between 25 in 2016 and 2017.

The number of overdoses, going to the emergency rooms between the 3rd and 4th quarter of 2017 have declined for opioids almost 14 percent, and if you look at the mortality curves, looking at the rolling 12 months, not just 2016 to 2017, but the most recent 12-month periods, we are starting to hit a plateau and actually start to going down. So, again, what I'm not doing here is declaring victory.

We have to redouble our efforts, and you saw just three weeks ago we had a major opioid push across HHS with 1.5 billion dollars in grants with new strategy

documents, with the new surgeon general's documents, with new CDC money, HERSA money, all going out, but what I don't want us to believe is that everything we're doing is not making an impact because we're starting to see signs that your efforts, your efforts, our efforts, together, are starting to impact that, and I look forward to answering specific questions and elaborating on what our next steps are.

MS. ZEZIMA: Here, for you.

MS. LABELLE: Okay. So thank you very much for having us here today to talk about this important issue. I previously served in the Obama Administration in the White House of National Drug Control Policy for the entirety of the two terms, and in answer to the question of, have we done enough, I think that I'm really pleased that this is one of the few areas in this area and in Congress where we have bipartisan agreement on what to do, and many of the things that we began in the Obama Administration have continued and actually been increased and expanded upon in this current HHS under the leadership of Admiral Giroir and others at HHS, Secretary Azar. So that's a wonderful thing.

But I think we can all agree that we still haven't done enough to address the issue in light of the fact that we're still seeing increased rates of overdose deaths, but also we need to make sure that we're looking at the issue of opioid use disorders not just in the -- not just about opioids themselves, but about addiction, and if you look at the addiction epidemic and all of the drugs that are involved in driving rates of substance use disorders in this country that's really -- I see the opioid epidemic as kind of the on-ramp to the broader discussion about the totality of substance use disorders.

So in that respect, we have a long way to go, and we really need to change our healthcare system, our treatment system, and our criminal justice system to recognize the disease of addiction, and recognize that it is a disease that can be

prevented, treated, and from which people can recover. So I think that if we -- certainly we haven't done enough yet on the opioid epidemic, but we certainly haven't gone far enough to address the entirety of the diseases of addiction in this country.

And I think, also, you know, H.R.6 which I think we're going to talk about today which is a legislation that Congress just passed in a bipartisan manner to address the opioid epidemic that has a lot of good pieces of legislation in it. The other piece that I think are [sic] important is to look at the barrier, so not necessarily at passing new laws, but looking at existing laws that stand in the way of treating the addiction as a public health issue, what are the legal barriers, what are the policy barriers, what are the regulatory barriers. So those are some things that I actually plan to be looking at in the future in the next couple of years to explore how we can remove those barriers to address addiction as the disease that it is.

MR. HUDAK: So I think one of the challenges with an issue like this is that it is so dynamic, and one of the benefits that we've seen from this administration, and as Regina said continuing on the work of the previous administration is a recognition that there needs to be coordination of strategy, coordination of data, coordination of a varity of means of communication, because ultimately while federal policymakers are setting agendas and federal policymakers are making recommendations, this is a local level issue.

This is not just an issue that individuals in counties and municipalities are facing on the frontlines, but they're facing it in different ways; what is creating problems, what is motivating opioid use disorders or overdose deaths in one state may be very different than the underlying forces that are causing it in another state, or in another area of another state. And so one of the, I would say, biggest challenges is this idea that there can be

one-size-fits-all strategies, that you can design something at the federal level that will help Ohio and will help Alaska and will help Arizona.

The reality is that the key to success, the pathway to success here, like in a lot of areas of policy, is to make sure that federal policymakers assist local leaders and assist local policymakers in addressing the opioid crisis, but also that they get out of the way when they're causing too many problems, and we have a lot of policy at the federal level that is creating those types of complications. H.R.6 tries to deal with a couple of them, and, hopefully, it ultimately will once the legislation is signed, but there are a variety of ways that I think local leaders can continue to communicate with state officials and with federal officials to say, "This is where we need help," and, of course, help in some cases means money, and in a lot of cases it means money, but in other cases, they can say, "Here is what we need help with," and it is the freedom to do what we know will work, what we have seen has worked elsewhere, or what we think might work, and whether that's working with a Pilot Grant Program from HHS, or whether it is just expanding what they have seen in other areas is helpful on their own with their own money so long as federal officials and federal law allows them to do it.

That creates this, as I said, dynamic area of policy that is extraordinarily difficult to tackle. One of the reasons why overdose rates are as high as they are is because this is so complicated, because throwing money at it might help a little bit, but it's not going to solve the problem. Because, again, what is helping in one state isn't necessarily going to help in another state. That creates a complexity that local level officials just are not prepared for. They don't have the capacity to deal with in necessarily a strategic way, and so it's that broader conversation, that inclusive conversation among policymakers that's going to solve this.

One of, I think, the benefits of the opioid crisis, as it is right now, is that it

is so widespread that individuals are naturally involved in it. This is not something that is localized to one or two or three states, but because this is an issue that affects every public health official in the United States, every member of Congress, every state legislator, everyone has some stake in this. And while that's unfortunate because it means tens of thousands of Americans are dying of overdose deaths, hundreds of thousands of Americans have opioid use or other substance use disorders, it does mean that you could sure-up that kind of political support, as Regina said, to create an area of policy which is rare in our politics right now, and that is where bipartisan support can be applied to tackle what is a massive national level issue.

MS. ZEZIMA: And since we're talking about the congressional bill now, I'll ask you this, John: What in it will make real change, do you think? You know there's been some criticism that a lot of it is kind of tinkering around the edges, some have also said it's come a little more -- you know, it's a political document rather than a policy document; what in it concrete do you see that you think will make real change on the ground in these states and in these places that are really suffering from this?

MR. HUDAK: You know, I agree with the criticism. This is a small bill relative to the size of the problem. This is an issue that I think a lot of members of Congress can pat themselves on the back over and go home to their constituents especially in an election year and say, "Hey, we're working to tackle the opioid crisis, but there are a couple of -- there are a handful of real palpable benefits from this legislation. One is an expansion of funding opportunities of pilot programs within states."

Now, whether the appropriations process ultimately funds these programs to the levels that necessary, that remains to be seen. I think we have an experience this year with an appropriations process that has worked better than it has in quite some time, so I think there's some optimism around that, but if those programs are

funded, that's going to mean money in the hands of local governments to do what they need to do to begin doing the research in data collection and having those types of coordination efforts that can be meaningful.

Second, there are several provisions in the legislation that as I said in my opening remarks gets the federal government out of the way, or at least lessens their impact, and so the caps on the number of patients that a doctor can treat using buprenorphine is a real positive, lifting that cap from a hundred patients to 275 patients. That is a real benefit. That means that people will be able to engage in this. We'll be able to use this in a way that they were somewhat restricted from before. Now, that said, that's one part of a problem. There are a lot of doctors who are not prescribing this medicine to their full capacity, and so part of this is physician education as well, making physicians better aware of these opportunities, and for the benefits that we know come from medication-assisted treatment.

And third is the removal of -- I say, third, not that this is exclusive. Third is the removal of limitations in terms of Medicaid reimbursement for inpatient treatment for individuals with substance use disorders. This is something that was restrictive for inpatient facilities, was creating the types of incentives that pushed individuals into other avenues of treatment when inpatient treatment might have been best for them. It's not universally best for everyone but for sets of patients it can be.

Again, that is government getting out of the way. That is government listening to local public health officials and to physicians in saying, "This is something that can help, so let's do what we can to make sure that outdated federal policy is not restricting our ability to serve those people most in need."

MS. ZEZIMA: And what I wanted to ask you, you know, you talked a bit about the additional money that you all have allocated recently, so was any of that money

reallocated because of the public health emergency, and has any money been reallocated because of that? So we're hoping you can talk about that and then also what you all have done in the past couple of weeks with that money you spoke of.

MR. HUDAK: So the additional funding that has been supplied, again in a bipartisan fashion, is not a result of the public health emergency --

MS. ZESIMA: Mm-hmm.

MR. HUDAK: -- declaration, per se, but it's a result of the fact that this is a public health emergency, and I want to stress and build on some of the comments earlier that one of the philosophies of the funding cycle, at least currently, is that we want to promote local activity. So if you look at the state or opioid response grants through SAMHSA, the recent 930 million and 500 million before that, it allows great flexibility for the states and localities to use that money as is seen fit in the localities, and we have really stood fast upon that with the one caveat that it has to be evidence based.

So we need to support evidence-based practices, and, again, to build on some of the discussion, addiction is a disease. It needs to be treated holistically, and the best evidence shows that medication-assisted treatment usually with agonists but sometimes with antagonists, depending on the person, combined with psycho-behavioral support and recovery services are really key. So we do insist that MAT is offered in order to get reimbursed by the programs.

Similarly, the technical assistance has been dramatically changed from sort of a D.C. centric technical assistance program to what SAMHSA has done, Dr. Elinore McCance-Katz to decentralize that so in every state, all 50 states, there is a program and contractors working at the very local level to supply technical assistance as is needed. So I fully do agree that this type of local empowerment is very important. The HERSA money that's gone out is to empower the community health centers, and the

community health centers are very, very responsive to the local needs.

Dr. Sigounas has now, I believe, about 70 percent of the health centers now have MAT and behavioral support along with their typical physical types of typical physical services that they've already done. So we have really tried to push that down to the local level to the degree that we can. I would say the CDC, as well. CDC is providing grants to localities to empower their data collection systems and very importantly to link the electronic health records with PDMPs, a Prescription Drug Monitoring Program so we can create a uniform workflow.

So I just want to again build on the comments that we absolutely believe this is and assess this as a public health emergency, addiction as a disease. Opioid use is only one aspect of that disease; if you look, methamphetamines on the rise 35-percent, cocaine on the rise 35-percent. The underlying psychosocial issues among the 18-to-35-year-olds, suicidal thoughts, suicidal ideations, suicide, suicidal attempts all on the rise, so this is a more generalized problem within our society of which we do believe addiction is an important symptom of that, but one that we're tackling, you know, head on right now because of the deaths and the overwhelming disruption to families and society.

MS. ZEZIMA: Has any additional money been allocated through HHS because of the public health emergency that was declared, or --

ADMIRAL GIROIR: Again, the declaration, itself --

MS. ZEZIMA: Yeah.

ADMIRAL GIROIR: -- hasn't caused the money to be allocated or the programs.

MS. ZEZIMA: Mm-hmm.

ADMIRAL GIROIR: The fact that there's an underlying need that led to the public health declaration really is what's driving the funding, I think both by Congress

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MS. ZEZIMA: Mm-hmm.

ADMIRAL GIROIR: -- and our allocation or efforts within HHS.

MS. ZEZIMA: Mm-hmm. You made a very important point that I want to talk about, too, which is, you know, meth use is up, cocaine use is up; if you go out and you talk to people, you know, local law enforcement in the field, they say they're having really big issues with that fentanyl is being mixed with them often, you know. Is the public policy response to the opioid epidemic kind of helped, building an infrastructure in place to respond to these other emerging drug threats that are happening right now, I guess, Regina, if you want to talk about that?

MS. LABELLE: So the bulk of funding for states to deal with all substances comes through a block grant that's provided by SAMHSA through HHS, and that has been level funded for a number of years. So that money would be -- you know, could be used for everything. The opioid monies can also build the treatment system that can help with this, but they're not specifically -- you know, they're specifically tied in many cases to the opioid issue. However I think one thing in terms of the meth use is, I was speaking with someone from Kentucky the other day and many states are seeing increasing meth use rates, and because of the supply right now of meth is mostly liquid meth.

It's not what we used to think about with trailer parks, people making the meth in their trailer, that's not what we're seeing. We're seeing liquid meth coming through Mexico, in many cases, and the meth is being injected. So to the extent that the syringe exchange programs are being established in areas of the country that have never had them before, such as Kentucky, they will be able to do outreach to individuals who are injecting meth that they would not have been able to do during the last time we really

faced an increase in meth use and cocaine, and so the challenge is -- so the great thing -- first of all, I want to commend HHS for the recent SOR grants in 900 million.

They require that they be used for evidence-based treatment, and I really want to underscore that. That's very important. Because basically you're saying you may not like medications to treat opioid use disorders, but the science leads us to the use of medications that's effective. So if you want to use federal funds, you need to provide evidence-based treatment, and that's really critically important and hopefully that will make a difference.

But in terms of cocaine, we don't have that same type of treatment for meth or for cocaine, so we need to -- again, we need to focus on prevention, but the treatment will be a little bit different, but the recovery supports will remain the same in terms of making sure that people have stable housing, that they have employment opportunities. So the continuum of care is the same, but we don't have the same types of treatment available for the new, what we're seeing as, emerging drugs.

MS. ZEZIMA: Think (inaudible).

ADMIRAL GIROIR: No, I absolutely agree, but I just want to say that the absolute intent of all the funding is to not just solve, "solve opioids," but to create the philosophical, scientific, the infrastructure to look at addiction and issues such as mental illness all across the board, and that really includes, for example, enabling our community health centers to have the type of providers to shift the workforce so that we have more behavioral health providers, that we understand models of care that include not just an addiction psychiatrist which is very, very important, but when you are talking about two-million people with opioid use disorder, you will never have enough addiction psychiatrists.

We need to train primary care physicians, nurse practitioners, midwives,

everyone, to understand how to treat addiction as part of a team with MAT, and all the very important components to that, including peer counselors, including social workers, including behavioral health people who can work holistically on a team, and it is certainly our intent that what we're building right now will have brought applications across the spectrum of use disorders because this is not going away.

In fact, if you look at a recent publication by Dr. Burke that just came out in *Science*, it basically shows that if you look at our overall addiction problem since 1980s, we're on an exponential curve and that really hasn't changed. The substances that are the subject of any given five or ten-year period changes, but that is on an exponential curve that we have to fundamentally engage as a government and as a whole of society.

MS. ZEZIMA: You know, people often say that in order to have an effective response, you need what is basically a three-legged stool, so a prevention treatment and enforcement. You know, there are very different policy initiatives that kind of work in concert together; you know, how do you craft policy where kind of each leg is equally balanced and you're able to really, you know, deal with those three issues that have -- you know, are so important for the drug issue?

MR. HUDAK: Yes.

MS. LABELLE: So I just want to really briefly -- and I'll turn it over to you in a second, but I think that -- so just to -- the White House Office of National Drug Control Policy is supposed to do that.

MS. ZEZIMA: Mm-hmm.

MS. LABELLE: And H.R.6 did reauthorize that office, and, you know, what our role was, in the seven-and-a-half years I was there, was to bring law enforcement together with public health, and the first individual we had, Gil Kerlikowske

was a former police chief, but he also really embraced public health approaches so he could go to law enforcement and say, "This is why carrying naloxone is a important part of community policing." And also he could speak to public health about what was important to law enforcement, so they were -- it was communicating across many spectrums of opinions about law enforcement.

And then the second person we had in the office was in Recovery, Michael Botticelli, who came from a public health perspective, so it kind of lent itself to that change, that reform that we saw, but that office, which was just reauthorized, can allow for that dialog, and by establishing a strategy with goals for the entirety of drug policy across the federal government, and also to set an example for states. That's really the goal of that office.

MR. HUDAK: Yeah, I think this is a really important issue, particularly around opioids, is not just striking that balance in terms of the design of policy, but striking that balance in terms of rhetoric around that policy, right, so enforcement is going to be a critical part of this fight against the types of substances are creating use disorders. Particularly with opioids, I think the fight against synthetics is something that is challenging, not just in terms of their source, which in many cases is China, but their roots of entry into the United States which are not, despite some rhetoric out there, being smuggled across the U.S./Mexican border in the dark of night but are actually coming through the mail system and through other shipping routes as well.

And so being able to combat that, having a more powerful conversation with China, not about steel, not about soybeans, but about the production of synthetics, I think is a really important part of American foreign policy which is so often left out of this conversation, or in decades past, so terribly mismanaged in the fight against the inflow of drugs into the United States. But having that strong enforcement side, particularly foreign

enforcement or border enforcement rather than domestic enforcement, is an important signal to individuals who are dealing with the struggle of addiction.

I mean, for too long in this country, addiction was treated as a public safety issue and not a public health issue, and because of that it disincentivizes individuals from getting help. The Admiral, I think, very eloquently explained the purpose of new grant funding and continued grant funding in this area, and it is to do -- to reverse those prior trends, those prior sorts of perceptions of what addiction was, and that's important, and that starts at the local level, being able to convey to individuals that you are not a criminal, you are ill, you are dealing with a medical condition, and that is a very easy, or -- I shouldn't say

easy -- that is a very important first step towards finding prevention and treatment strategies for those individuals. And I think layering on top of that, for a lot of people in this country, they see addiction as someone else's issue, a disease that affects other people. I think in many ways the pervasiveness of opioid use disorders and the overdose crisis around opioids in this country has pulled that curtain back to show people that it can happen in anyone's living room, in any family, and most family members know, or probably don't know, that someone in their family has an opioid use disorder, and part of that conversation, part of that broader rhetoric around treatment and prevention, is talking to groups who are sort of nontraditionally thought of as individuals who are susceptible to use disorders.

That includes, increasingly, senior citizens, veterans, retired athletes, and enormous numbers of Americans who are often forgotten in the conversation around substance use disorders who policy and efforts in this area have to begin to address and have to begin to embrace to say, "You are patients, too. We are here to help you." Your service in Iraq entitles you to healthcare, but it also entitles you to be treated when it

comes to substance use disorders in the same way that we treat anyone, with compassion and with care and with extended care beyond that moment where you're having a crisis with an overdose or the moment where you are making a certain decision about using a substance or not, but to have that continuing conversation whether it's through VA, whether it's through, you know, private physicians or whatever platform you are getting medical care from, but to make sure that those groups are being included as well.

ADMIRAL GIROIR: I just want to make the comment, as well, as the senior advisor for opioids policy at HHS, part of my job is to build bridges to other agencies, and I can say that the interaction between DOJ, particularly DEA, but DOJ, ONDCP, and our office has grown tremendously even in the past few months. Everybody understands we cannot arrest our way out of addiction. Addiction is a disease and needs to be treated as such. That being said, I can't have 120 pounds of fentanyl coming into our country on regular basis that is enough to kill 30-million people.

Our job will be a whole lot easier if we could eliminate those supplies. On the second day of Mr. Uttam Dhillon being appointed as acting Director of DEA, I was in his office facilitated by Jim Carroll who's the current acting director of ONDCP, and just last week I think it's sort of emblematic of what we're trying to do. We organized a panel at HHS. There may have been panels similar to this before, but certainly not within the current administration where Jim Carroll, the acting director of ONDCP, John Martin who runs DEA Diversion Control, Dr. Ellie McCance-Katz, the surgeon general and myself, and Dr. Vanila Singh on the pain management inner agency task force, who leads that, met with the American Society of Addiction Medicine, the family practice people, the nurse midwives, the nurses, about 20 different organizations of healthcare providers to have an open discussion about how we need to work better as an entire community,

integrating DOJ with HHS and public health, and it was a tremendous dialog that we had because we do need to bridge some divides. I mean, there are differences in culture.

My parents were both police officers. My mom's a retired police officer, okay, everybody in my family is police officers, so I understand kind of that point of view, and also the public health point of view, and we can work together and I think we are getting there very productively, but it's going to take continued work and dialog and that just can't happen in D.C. Those kinds of things have to happen at the local level as well.

Bad prescribers, that's a law enforcement issue. People smuggling, people -- I mean, really bad prescribers, intentionally bad prescribers, not just on the tails of a normal distribution. Those are law enforcement issues, as is the smuggling of all these drugs, or the mail, of all these drugs primarily from China, fentanyl, car (?) fentanyl into the country.

MS. ZEZIMA: Mm-hmm. So I'm sure you all have some questions, so would love to open it up to you to see who

the --

ADMIRAL GIROIR: (inaudible) people aren't shy. That's great.

MS. ZEZIMA: Yeah, I know. It's fantastic. So people (inaudible) microphones for you, so just hold tight and we'll get all your questions in.

MS. CARTY: Thank you. Good morning, distinguished panelist as well as good morning to this amazing dynamic and diverse audience I have the pleasure of sharing one hour with. My name is Dawn Lee Carty, founder of Speak Life. I don't profess to be a policy writer, but I am a activist. I am a [sic] advocate and I am a lobbyist for medicinal cannabis therapy.

I stand before you today -- oh, and I am a mom of a 11-year-old child who also medicates with medicinal cannabis. I stand before you today with a suggestion,

98 seconds of a suggestion. The money that we invest into these politicians as far as going into their candidacy and the support given to these politicians, why don't we make big pharma great again? Why don't we make big pharma great again by cherry-picking the best growers, the best farmers, the best doctors who have been documenting medicinal cannabis treatment for over 25 years and develop a thinktank?

The monies that you give these politicians, create a think tank, and from there create an exit drug from albeit -- create an exit drug from this opioid crisis. Every time you will gain respect from the community, from the world, and also you'll stand and also let yourself feel like this -- you're taking accountability for creating this opioid crisis. By doing that, I just really feel that it'll be a positive movement moving forward, something that you may want to consider. I know that cannabis is not that most safe thing or happiest thing that this room wants to hear right now, but I have a 11-year-old daughter who at one time had 60 seizures a day.

Imagine a six-month-old child having 60 seizures a day and medicating on valium, lorazepam, diazepam. She's been a medicinal cannabis therapy patient for three years now, and my daughter is now 90-percent seizure free. So although my words might be a little muffled today because I know I'm the big elephant in the room, I'm speaking life that there is advocacy in cannabis. There is advocacy and people are really wanting it and they are being penalized by it, and I feel like the politicians such as Andy Harris are being paid to stop this progression.

MS. ZEZIMA: Do you have a specific question about how it can help opioids or --

MS. CARTY: Well, it was just a suggestion that this --

MS. ZEZIMA: Mm-hmm.

MS. CARTY: -- might be something that you may want to consider. I think that it will be an alternative to crafting your public policy. It will be something that I know a lot of Americans do wish for.

MS. ZEZIMA: Okay. Thank you.

MS. CARTY: Thank you.

MS. ZEZIMA: Thank you very much. Yes? You (inaudible).

SPEAKER: Thank you. Usually the best way to get someone to not do something is to offer them a preferable alternative. Now, humans developed in a situation where they have to struggle really hard to survive just to collect food, avoid predators and stuff like that. Today it's not a struggle. There's no problem at all surviving and that leads to a lot of boredom, and boredom is a major driver towards drugs and other addictions, screen time, video games and such, and it seems like you're treating the symptoms of basically boredom, and the question is: Is anybody looking at alternatives, productive useful things that people can be doing, you know, actually creating alternatives for people so they don't get bored and get into drugs and stuff like that?

MS. ZEZIMA: (inaudible).

MS. LABELLE: I mean, there are social determinants that go into why individuals develop a substances disorder. It's a combination of the environment as well as hereditary, you know, heredity, so it's really -- there's not one thing. We're not one factor, there is a combination of factors, but I'm a lawyer and not a doctor, so I'll let the doctor speak.

ADMIRAL GIROIR: Oh, thanks. (Laughter) Again, I agree what was just said. I will say scientifically by NSDUH data that the number one reason why people misuse opioids is because of pain; 62.4 percent of the people misuse opioids because of

pain. So in order for us to solve the opioid crisis, or at least one aspect of the overall substance abuse crisis, we have to deal with pain, and pain needs to be dealt with not just as a pill, but as a holistic multimodal kinds of a therapeutic option that includes physical fitness, physical therapy, psycho-emotional support, non-opioid pain medications, other types of behavioral therapy, so again, why that -- you know, I don't think we have the magic answer about why 18-to-35-year-olds, despite our youth making tremendously positive choices almost across the spectrum, have an increased issue with substance abuse.

Part of it is our fault for overprescribing opioids to begin with, having them so available that if you're bored or you're having trouble sleeping or you're stressed, you pull them out of the cabinet; two weeks later if you're on a high enough dose, you have the disease of addiction and telling that person to stop is like telling you to stop breathing for 15 minutes. So, again, very complex, many social determinants, but I do want to highlight pain as an issue that we need to deal with. We can't just say, "Stop doing opioids." We have to provide an alternative, a solution. Again, the pain management interagency best practices task force which is run out of our office, it was legislated. It also has DOD and VA. The draft gaps and recommendations are posted on the Web, and there will be a report posted for all of your input, and your input as well, within the next month.

MS. ZEZIMA: And I know that there has been one piece of this is trying to create a, you know, abuse-deterrent pain medication. I know that was something so many people are working on. Can you talk a little bit about that and how that is, you know, coming from the government as well?

ADMIRAL GIROIR: Anybody want --

MR. HUDAK: No, please.

MS. LABELLE: I mean, that, you know, so abuse deterrent formulations have been in existence for a little while, and I know that there is $500 million, I believe, that went to NIH to identify -- some of which --

MS. ZEZIMA: Mm-hmm.

MS. LABELLE: -- was to identify alternatives. One of the issues however is coverage, insurance coverage of alternatives for a pain treatment, so that's a big part of the challenge.

ADMIRAL GIROIR: I will be talking to 700 insurance companies today and it certainly is on my (Laughter) --

MS. ZEZIMA: Great. What will you be saying to them? (Laughter)

ADMIRAL GIROIR: -- list. That in addition to assuring that we limit the inappropriate prescribing of opioids, we need to guarantee the appropriate prescribing of opioids for particularly pain patients who have chronic
un-relapsing in pain such as cancer patients, patients with sickle cell disease which is one of my personal causes who have discrimination even before this much less after the opioid issues to treat addiction as a disease in a comprehensive holistic way and to cover alternative therapies.

MS. ZEZIMA: Mm-hmm.

ADMIRAL GIROIR: You know, the data show that for many chronic pain syndromes, physical therapy, physical fitness, overall health, is much better than chronic opioids, so these alternatives need to be covered.

In terms of the NIH, I just want to mention that there is an exciting, new initiative that feeds in to what we were talking about before that's one of the cross HHS, crosscutting initiatives. It's called the Healing Communities Initiative, and this is going to supply in the neighborhood of a hundred-million dollars a year for five years to

communities that are very hard hit to really bring the federal government, all of our agencies together, DOJ, HUD, Department of Labor in complete conjunction with local and state authorities to try to reduce the overdose disorders, overdose deaths by 40 percent within three years, and it's, again, trying to empower community models in urban, suburban, and rural communities to really understand what the best practices are.

So a lot of the NIH money does go to basic type of research, can we have non-addictive opioids, how do we treat with MAT better because MAT is good. It's better than the alternative, but none of us are satisfied with the current results; we have a long way to go. But a lot of the money is also going to sort of community models of how to provide holistic care across the spectrum and bring everyone together and then spend that out community to community to community.

MS. ZEZIMA: You know, and obviously each community is kind of dealing with something different, but, you know, we're at this point now where we have this prescription issue that we've had for a very, very long time. We have the heroin issue we've had for a while, and now we have this, you know, fentanyl crisis that's happening right now. I mean, are we kind of fighting the current crisis, or are we still fighting the one from 10 years ago; how do you kind of do all of these together since they are very specific things, you know, that are contributing?

MR. HUDAK: Well, I think one of the important parts of that was mentioned before. We have this struggle with addiction in this country, but in any five-to-ten-year period, the substances that are of most importance cycle in and out. Ideally they would just cycle out and go away, but that's not what the experience is. What, I think, the crisis with opioids has shown us, or shined a stronger light on, is just how vulnerable the mental health and addiction medical infrastructure is in this country and how ill-prepared we are because we have not built that up in a sufficient way in a variety of areas, and I

talked earlier about different groups of individuals who are nontraditional or at risk, including veterans and all, but of the biggest struggles in this country, particularly around this infrastructure, is in rural communities.

You know, if you're 75 minutes from a local treatment center, what do you think the likelihood of going to that treatment center for help is, if you live in a city and it's seven blocks away and you're unlikely to go to that treatment center, and so what is going to work in Washington, D.C., is not necessarily the same type of infrastructure problem that exists in rural Idaho. Even though the problem might be the same in both places, it might be worse in rural Idaho, and that's not just an opioid issue, it's a meth issue, it's for a variety of substances. And so designing and strengthening that infrastructure in ways that makes up for a lot of lost time and is able to be designed in the right ways for what that population faces, whether it's the substances that that population faces, the infrastructure that population faces, or the socioeconomic forces that can affect choices over substance use as well.

Designing those, and the grant programs do a very good job, as the Admiral said, giving local level flexibility, recognizing that there is a need for that, but like I said, making up for what is really an embarrassing mental health and addiction service infrastructure in this country that can't keep up.

MS. ZEZIMA: And, Admiral, I know you have been on, well, telemedicine as well for this, so talk a little bit about that.

ADMIRAL GIROIR: I think telemedicine is very important across the board, I think, in many aspects of the healthcare system and not just in tele mental health or tele MAT, but, again, we provided a clarification based on some of DEA's interpretation that you can deliver MAT by telemedicine now, and that's, I think, very, very important. As long as you have a DEA registered provider, they don't need to be waivered, so, you

know, we're very hopeful of that. I think part of the legislation also said that for Medicare reimbursement, you don't need to "Be in a rural area. You can be in an underserved area and be reimbursed for that."

So, I do -- coming from Texas, you know, there's still a dozen or so counties that don't have a physician or any healthcare provider. I think it's like 20 or 25.

MS. ZEZIMA: Mm-hmm.

ADMIRAL GIROIR: And it's a very big country, and we're going to need to use technology to our advantage, and, again, not only have the providers but build the model systems, the hub-and-spoke systems, the ancillary providers in to make sure that care is distributed and we focus on behavioral health. And, again, behavioral health critically important for addiction, but smoking, alcohol use, obesity. You know, there are huge behavioral health components to all of these, so what we're building now has very long-lasting benefits, but we need to build it and we need to build it fast and we need to build it in a resilient fashion with the appropriate reimbursement because a billion dollars here or there or SAMHSA grants won't go very far --

MR. HUDAK: No.

ADMIRAL GIROIR: -- unless the entire reimbursement system is geared to building and incentivizing the system we need.

MS. ZEZIMA: Mm-hmm.

MS. LABELLE: Katie, I wanted to add one thing --

MS. ZEZIMA: Yeah, please.

MS. LABELLE: -- that both said -- most of my colleagues said. So substances go in and out of vogue, but the one constant is alcohol.

MS. ZEZIMA: Mm-hmm.

MS. LABELLE: And I think that we can't forget the number of people in

this country with alcohol use disorders, the number of people with untreated alcohol use disorders and that has to be something that we focus on when we're talking about treatment and addiction.

MS. ZEZIMA: Mm-hmm. So do we have time for a question, and you -- sure.

SPEAKER: Thank you. Hi, good morning, everyone. Thank you so much for being here with us today. I was wondering if you could talk a little bit about what you would say is at the root of the double standard in terms of how our country responded to the crack cocaine crisis in the eighties and nineties and the sort of crisis that we're facing today. You know, as you know today's mostly white opioid addicts are considered part of a public health issue whereas, you know, crack cocaine addicts who happen to be African American in underserved communities were faced with an all full-blown, you know, war on drugs. So I was wondering if you could talk about what you would say is at the root of, you know, that double standard and how it changes and clears our own perceptions of drug addiction.

MR. HUDAK: Well, I mean, I think the answer is fairly obvious in your question. The roots of the manner in which racism affects public policy in the United States, and frankly elsewhere in the world, as well, is profound, and it is hard to defend the differences in enforcement and even in laws around punishment between powder and crack cocaine, particularly in the 1980s, other than a racialized basis for it.

Now, there are also positives growing out of the opioid crisis in that if it is affecting groups of people who raise awareness, then it means the awareness around that struggle is going to be more than if it was in underserved or communities of color. Now, that's unfair, but there are a lot of individuals in this country who are people of color who face opioid use disorders or other substance use disorders, and I would hope, at

least, if sort of the bleaching of substance use disorders in this country means that it raises awareness, it build a better substance use infrastructure, it helps with treatment and prevention; that that will be spread around, and hopefully that is the case, but I think you're right.

There are a lot of areas of public policy that have very dark histories in this country, and mental health and addiction services are absolutely toward the top of that list. I think there are a lot of really competent professionals. There are a lot of well-intentioned individuals in our government and in our Congress now who are not only thinking seriously about racial divisions and the way that individuals can access treatment and prevention programs, but also how we can learn from our past mistakes. And so hopefully the future of mental health and addiction treatment in this country is brighter than like I said what is a pretty dark past in this country.

MS. ZEZIMA: Got time for one more. You right there with the mock-turtleneck-on woman, you. (Laughter)

SPEAKER: Okay, thank you. So thank you for your leadership and sharing your perspectives this morning. So I'm from the Alliance of Community Health Plans and our clinical leaders are very much invested in addressing the opioid epidemic, and in recent meetings together there has been a concern about some of the challenges in sharing health information on substance use disorder. So from their perspectives, trying to coordinate care, you want to have as much information as possible including understanding the history of addiction and some of these challenges or if someone's actively under treatment, and there is a standard; I believe it's 42 CFR Part 2, which is a bar higher than HIPPA, itself, that which makes it very difficult to essentially have that information be coordinated.

So just curious about your perspectives on that discussion and if you see

in the future at all some of that relaxing given the, you know, state of emergency we have with the opioid crisis and, well, you know, what can groups do to try and help, you know, and frankly just sort of share that information more freely?

MS. LABELLE: I mean, 42 CFR was a [sic] aspect of a lot of congressional intention this year. SAMHSA has done for the last several years put out clarifying information because there is a lot of misinformation. So, you know, Congress, I'm sure, will take it up again. They did not remove it entirely this year in this legislative session. But it will come up because there are a lot of people who want to share that information.

I think the most important thing is to listen to those who -- I mean, to both sides on this issue. Those who are opposed are very opposed because if we think that stigma is gone on this and that it's just another disease, we are kidding ourselves. This is not just another disease. There is a lot of stigma attached to substance use disorders. There are a lot of doctors who don't want to treat those patients. So to that is something that if a change is made in the next year, we need to have the realization that stigma is alive and well. And that removing that in its entirety, I actually -- and so removing it in its entirety will/could have an impact on individuals who have the disease of addiction, but they'll discuss it a lot. I'm sure it's going to come up again because there's a lot of healthcare providers that want that information.

I don't know if you have anything else.

MS. ZEZIMA: Okay. All right, so it is 11:00, so I think we are unfortunately done with this, so thank you all for coming. I really appreciate it. (Applause) And I'll say thank you to all of our -- everyone on the panel for sharing their thoughts and taking the time, so good discussion.

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