New York State Senate Task Force on
Opioid Addiction
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Presentation by:
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Introduction:

Thank you for the opportunity to present this written testimony on the Opioid epidemic. My name is Alan Wilmarth and I serve as the Administrative Director, Behavioral Health for the UHS system. I have worked in the behavioral health field for over 38 years and have witnessed the primary drug of choice change over the years. While Nicotine and Alcohol are always the top two drugs of abuse in our society, we experience a cyclical pattern between Opioids, other sedative or depressant drugs such as Valium, Xanax, Librium, etc. and stimulants such as cocaine and methamphetamine. In more recent years we have also experienced a new addition to the field which are the synthetic drugs such as "spice" and "K-2." These drugs are part of a larger group known as synthetic cannabinoids. While the current focus is on Opioids, and rightfully so, it is very important to remember that alcohol, other depressants, cocaine, methamphetamine and synthetic drugs continue to pose a significant risk to the residents of our region, state and nation. I hope this document will serve to inform you of some things that are going well in the efforts to curb the Opioid crisis, changes we are seeing in the primary drugs of choice currently and some specific legislative actions that I believe can serve to improve the effectiveness of our prevention and treatment efforts across the state.

What is working well in our battle against Opioid Use Disorder:

By way of introduction to this section, I believe it very important to state that the vast majority of OASAS licensed providers across New York State work in a collaborative manner to ensure needed treatment services are provided to all who seek them in a safe, effective and efficient manner. Many things are going well and I believe we should take time to recognize and celebrate them.

Examples of what is going well:

1. **Opioid Overdose Prevention:** There are numerous Opioid Overdose Prevention programs across the state and they are working tirelessly to educate and prepare as many drug users and their families. While this effort may not have reduced the actual number of overdoses, it has certainly contributed to the reduction in fatalities resulting from overdoses.
2. **Access to Services:** Many OASAS licensed providers now provide open access to assessment and treatment services. In many cases this includes same day admission to either inpatient our outpatient treatment programs based on patient need.

3. **Payment for Inpatient Rehabilitation:** The action by the legislature to require Medicaid Managed Care payers to cover the first 14 days of inpatient rehabilitation last year and expanding to up to 28 days this year has been a tremendous step forward in the treatment of addiction. This has allowed treatment programs to focus on access and engagement / retention of patients in treatment rather than on spending valuable human resources trying to obtain prior authorization for admission.
4. **Offering Medication Assisted Treatment (MAT) in jails and prisons:** While this initiative is in its infancy across the state, OASAS has been actively engaged in supporting pilot programs offering MAT to individuals who may become incarcerated and are already on MAT or are in need of it. I believe over time this will reduce the fatal overdose rates among inmates with OUD who are released from incarceration. I also believe it has the potential to reduce recidivism in the criminal justice system if we are successful in retaining patients in treatment after their release from incarceration.
5. **Opioid Treatment Courts:** This new addition is a welcome mandate in my opinion. Many of the drug treatment courts currently operating have been resistant to accepting MAT and some actually prohibit it. I believe that having an Opioid Treatment Court will address this gap in services and offer individuals with OUD the opportunity to experience a better outcome in their drug treatment court experience.
6. **Acute inpatient hospital patients:** Patients admitted to acute inpatient hospital beds with medical conditions related to their drug use are being offered the opportunity to begin MAT while in the hospital. Then upon release from the hospital, the patient is already admitted to the OTP and can continue treatment with no delay or interruption in their care. During their hospital stay, staff from the OTP round on the patient to provide counseling services throughout their stay. While not a wide spread practice, we have found this to be very effective at improving the health of our patients and in improving their engagement in treatment.

Changes in the Landscape:

As mentioned in the introduction, our nation has had an ongoing problem with addiction. Substance Use Disorders are nothing new and the Opioid epidemic simply highlighted the growing nature of this national public health crisis. While arguments can certainly be made on the role big pharma played in this most recent epidemic, the

reality exists that we have seen the primary illicit drugs of choice vacillate between stimulants, sedatives and narcotics for many generations. In line with that history, we are seeing changes in the presenting drug of abuse currently.

1. **Fentanyl:** One of the first major changes we saw as the market for prescription Opioids began dry up is that Heroin was starting to be laced with Fentanyl. Today, it is very rare for us to actually find Heroin in urine drugs screens. The vast majority of our positive drug screens containing Opioids are positive for Fentanyl. This trend may well be a contributing factor to the decline in Opioids as primary drug of choice that we are seeing in our region. To a person, every patient we have interviewed over the past year states they do not like the "high" that comes from Fentanyl. They are also expressing an understanding that the number of analogs for the drug and the high mortality associated with the drug as a result of those analogs, is prompting many to move to other substances.
2. **Methamphetamine:** We are seeing a significant increase in methamphetamine as the drug of choice among our patients presenting for treatment. As mentioned above, at least some of this migration is related to the intentional choice to avoid Fentanyl. Methamphetamine use presents its own set of challenges which include, extreme paranoia, psychosis, violence and self harm. Patients suffering from methamphetamine use disorder are often either injured themselves or inflict injury on others when in overdose situations or when they have been on a several day binge with the drug. There are no medications to serve as antidotes for methamphetamines like there are for Opioids so patients are often treated with antipsychotic medications to try and reduce the severity of symptoms. There are also no identified MAT agents that have proven effective for amphetamine use disorder.
3. **Poly substance use:** We have been seeing a significant increase in the number of individuals presenting with poly substance dependence. Of specific concern are the combinations of Opioids (including MAT agents) and stimulants or benzodiazepines. In addition, we are seeing cannabis in combination with multiple other drugs of abuse. This creates significant concern in the MAT clinics as the combination of other active agents with Methadone has significantly increased the likelihood of fatal overdose.
4. **Synthetic Cannabinoids:** This class of drug is not a high volume presentation at this time, but when a patient under the influence presents, they create significant impact on the treatment system. In most cases the patient requires general

anesthesia and placement on a ventilator until the drug clears their system. This creates medical risk and is an extremely expensive intervention as it requires intensive care unit placement for several days and places patients at risk for respirator associated illnesses and also withdrawal once they are weaned from the respirator.

5. **Alcohol:** We are seeing a significant increase in the number of individuals presenting for treatment of an alcohol use disorder. It is unclear what is driving this increase as there is no specific data that reflects a growing use rate of alcohol in the general public, but the data are clear that we are seeing more people presenting for treatment of this disorder.
6. **Vaping:** While the data on long term impact and risks associated with vaping are limited and unclear at this time, it is clear that we are seeing an increase in use and it is also clear that we are seeing a significant increase in individuals using multiple substances in their vaping devices. The mixtures of substances and frequency of use are a growing concern and should receive ongoing attention, research and education.

Legislative Actions that can help:

While we are seeing the landscape of addiction in our society change, one thing that appears clear is that the impact of this disease is not lessening. The ongoing demand for treatment services and the growing reluctance to stop using all mood altering substances in lieu of only stopping selected substances are combining to place new and difficult challenges on treatment providers. The following are some legislative actions that I believe would make a positive impact on the field of addictions treatment.

1. **Prevention Programs need to be given consistent and long term funding:** It is my belief that if we want to have long term measurable impact on the disease of addiction in our society, it is essential that we focus on sustained prevention in schools and communities across the life span. Prevention has shown meaningful results in stemming the flow of addiction. Historically, we have funded prevention for periods of time and then cut funding when we seemed to be making progress. I believe it is essential to maintain a commitment to prevention and to fund that commitment adequately. Legislative action that focuses on providing meaningful prevention funding will produce sustainable results in the fight against addiction.

2. **Maintenance of insurance coverage, including Medicaid for persons who are incarcerated:** One of the critical risks for fatal overdoses with opioids has been persons released from incarceration. Given the rapid decrease in tolerance to the drug, persons who have been incarcerated for even a few weeks who leave and relapse face very high risk for fatal overdose. Protection of healthcare benefits might lessen this risk by increasing the ability to receive care while incarcerated. Community agencies licensed by OASAS could provide the treatment services rather than relying on contracted providers who do not specialize in addictions treatment. Legislation that would keep healthcare benefits in place could reduce stigma, overdose risk and improve treatment retention post release from incarceration.
3. **Incentives to use treatment options other than Opioids for management of chronic pain:** Providers who have large contingents of patients receiving chronic opioids for the management of chronic pain have limited options funded by insurance payers to assist their patients. For example, alternative treatments such as acupuncture, meditation, physical therapy, mindfulness and other similar treatments have been shown to be effective, but for many patients, their insurance does not cover such treatments but they will continue to pay for opioids. If providers could refer patients to these alternative treatment options and have confidence that they would be covered by insurance, I believe the reliance on opioids could be reduced. Another possibility in this arena would be to work with payers to set up special payment structures like those used in the management of diabetes, hypertension and heart disease. Such payment structures have proven effective in incentivizing providers to focus extra time and effort on reaching specific agreed upon goals with their patients. Legislation that requires for reimbursement of alternative treatment options for chronic pain or that sets standardized goals for the treatment of chronic pain and incentivizes providers to reach those goals with their patients would both reduce the reliance on opioids and improve levels of functioning in patients with chronic pain.
4. **Revision of payment structure for OTP programs:** Under the current reimbursement structure for OTP programs, payment can only be received for the days a patient actually attends the clinic to receive their medication. As a person progresses in their recovery, we encourage employment, furthering education and other activities that reflect a higher level of functioning.

Historically, we would offer patients a take home does of medication as they stabilized and they could continue earn additional take out doses as their condition improved. The issue is that providers spend the same amount of time to draw up, bottle, seal and label a take home dose as they do a dose being given directly to the patient to take in the clinic. Each time a patient is given a take home dose, the clinic spends money on the medication, the label, the bottle and the nursing time to prepare that dose yet the provider cannot generate any revenue from that take home dose. This means that if patients are doing well and coming to the clinic less frequently, the clinic progressively loses more and more money. Some clinics address this by adopting the policy that all patients must attend a certain number days per week in order to remain in the program. I would propose that legislative action that allowed OTP programs to bill for take home doses of medication would incentivize the clinics to offer more take home doses to patients who are doing well in their recovery and would incentivize patients to pursue additional opportunities if they knew they could attend the clinic less frequently.

5. **Revise Data requirements:** OASAS used to publish a document referred to at the IPMES report. This report took data from providers, that was required at admission and discharge of every patient, and assembled it into a report for the program to review. This afforded programs to evaluate how they were performing compared to their colleagues and to identify areas for performance improvement activities. OASAS no longer publishes the IPMES report but providers are still required to submit the PAS 44 and PAS 45 forms for every admission and discharge. These forms are long and take considerable time to complete. If the data is not being utilized to advise the field, then the data collection and submission should not be required any longer. Legislative action to work with OASAS to determine the need for continuing to require such lengthy data submissions would be appreciated as it would afford programs more time to focus directly on patient care.
6. **Review Work Place injury requirements:** Up until a few years ago, New York State ranked second in the nation for the highest rate of persons diagnosed with a workplace injury listed as a back strain or injury to be started on an opioid at their first visit and to still be on that opioid two years later. We need to address this with our occupational health providers across the state. Legislative action to review current protocols and set standards for the review of symptoms, level of

physical functioning and need for continued opioid prescriptions may well reduce opioid use disorder development and save lives.

7. **Reduce licensing barriers:** While considerable progress has been made in the area of providing integrated care, the reality exists that DOH, OMH and OASAS remain three distinct state agencies each with their own sets of rules and regulations and each with their own interpretation of what integrated licensure looks like. We need a clear legislative intervention to establish one set of rules for providing integrated treatment services. Primary care providers within our medical group are asking for assistance in working with patients thought to have an opioid use disorder, but getting those services into the primary care center and being able to generate revenue from said services remains a challenge. Conversations with each state entity result in a different set of processes to establish integrated services. We truly need one clearly defined process that all state agencies will follow. I believe this will only occur with some form of legislative intervention.

Please accept my sincere thanks to the committee for your time and attention in the review of this document. I appreciate your focus on this issue and your expressed desire to take actions that can assist treatment providers across the continuum of medical and behavioral health services in combating addiction in our communities and across the State of New York. Please feel free to reach out to me in the event you need any further clarification on any points I have raised.