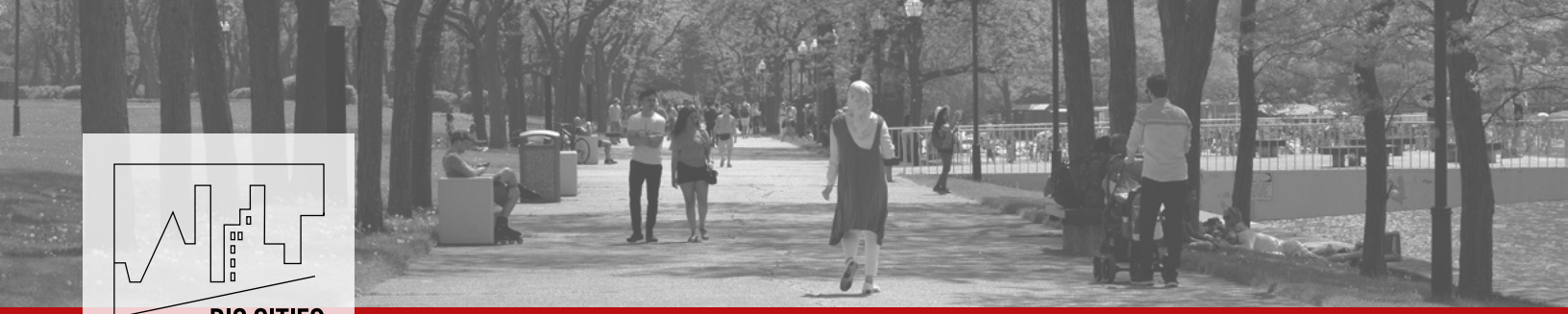

BIG CITIES HEALTH COALITION

POLICY PRIORITIES | Preventing and Mitigating Substance Use Disorder

Public health needs dedicated, sustained federal funding to prevent substance use disorder

Big city health departments are on the front lines of responding to the substance use disorder and overdose epidemic but receive little-to-no dedicated or direct federal funding to support that lifesaving work. Instead, health departments compete for small amounts of grant funds that are not nearly sufficient to address the scale of the problem.

Importantly, the U.S. Centers for Disease Control and Prevention (CDC), at the direction of Congress, took an incredible first step to provide federal funds to local communities with the **Overdose Data to Action (OD2A) project**, a three-year cooperative agreement that began in September 2019 and extended for a fourth year through August 2023.[7] However, from the start there were challenges related to eligibility including questions of burden and geographic definitions.

OD2A also funded states and required them to send only a small portion of funding to communities that were not funded directly. A full accounting of how states did so should be reported to Congress and released publicly. Congress asked that this be addressed in the FY2022 Consolidated Appropriations Act's (P.L. 117-103) Explanatory Statement.

Future efforts should ensure funding not only reaches a wider number of big city health departments, but also that the dollars are predictable and ongoing. CDC is forecasting funding up to 40 local jurisdictions in 2023,[8] and we encourage Congress to provide sufficient dollars for the agency to do so. If we want to turn the tide on opioid-related death and disease, our nation's big cities need dedicated, sustained funding for a host of substance use, overdose prevention, and harm reduction activities.

FUNDING

- Increase funding for CDC's Infectious Diseases and Opioid Epidemic program to:
  - directly fund the nation's largest cities to address and prevent substance misuse and overdose, and reduce the number of fatal and nonfatal overdoses
  - support syringe service programs (SSPs);
  - increase infectious disease testing and linkage to care;
  - increase health department capacity to detect and respond to infectious disease clusters associated with drug use; and
  - conduct outreach and linkage activities in communities that are currently unfunded.
- Enact and fund the Comprehensive Addiction Resources Emergency (CARE) Act (H.R. 6311/S. 3418) to provide $100 billion in federal funding over ten years, which includes $4 billion per year to states, territories, and tribal governments.[9]

Policy Recommendations (continued)

DATA & SURVEILLANCE

- Increase data resources at the local level to expand current overdose surveillance systems, including real-time, nonfatal overdose events and reversal data, to improve information about the full scope of burden of SUDs and associated infectious disease outbreaks, as well as expand use of wastewater surveillance.
- Require states, as part of federal funding agreements, to provide local health departments with real-time access to Prescription Drug Monitoring Program data.

PREVENTION

- Increase availability of naloxone and similar overdose reversal drugs by:
  - allowing CDC funding to be used for the purchase of naloxone;
  - facilitating bulk purchase of naloxone for distribution directly to local health departments;
  - regulating the cost of nasal naloxone and its generic forms; and
  - allowing over-the-counter access and/or expanding use of "standing orders," where a doctor issues a written order that can be dispensed by a pharmacist or other designee(s), without the prescribing doctor being present.
- Consider research exemptions for trials of other types of opioid medicine, such as the Study to Assess Long-term Opioids Maintenance Efforts (SALOME)[11] or innovative policy pilot programs, such as the North American Opiate Medication Initiative (NAOMI).[12]

HARM REDUCTION

- Increase funding for low-threshold services at syringe service providers (SSPs), including case management and outreach, as well as mental health and other medical services.
- Direct CMS to issue a Dear State Director letter, such as the SMD 17-003, to encourage Medicaid programs to apply for a State Plan Amendment (SPA) to cover harm reduction services that include direct services, care coordination, and managing transitions between different service providers.
- Increase availability of drug checking services – i.e., fentanyl testing strips – to the public by exempting such materials from drug paraphernalia laws.
- Remove the federal ban on the purchase of syringes and safe smoking supplies and increase access to Syringe Service Programs (SSPs) through federal dollars and leadership.
- Shield from federal prosecution localities that are exploring implementation of evidence-based and practice-informed harm reduction services, such as "safer" use sites/facilities and overdose prevention centers.[13,14]

REDUCING BARRIERS TO TREATMENT (BUPRENORPHINE)

- Enact the Mainstreaming Addiction and Treatment Act (H.R. 1384/S. 445), eliminating waiver and training requirements for prescribing buprenorphine, which are barriers to treatment.

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For more information, contact Chrissie Juliano at juliano@bigcitieshealth.org

- Make permanent the COVID-19 Public Health Emergency (PHE) flexibility to allow prescribing of buprenorphine via telehealth, including audio-only services, thus enabling 24-hour access to medications for opioid use disorder (MOUD).
- Remove the required initial in-person visit for buprenorphine, as included in the Ryan Haight Act of 2008 (PL 110-425).
- SAMHSA and DEA remove barriers and incentivize pharmacies to stock buprenorphine, as about one in five pharmacies currently refuse to dispense.[10]
- Remove requirement to use HIPAA-compliant platforms to teleprescribe buprenorphine.

REDUCING BARRIERS TO TREATMENT (METHADONE)

- Convene and lead cross-government planning.
- Implement cross-sector policies and interventions (e.g., naloxone distribution in shelters).
- Coordinate and engage with health care systems.
- Train and provide technical assistance to first responders.
- With governmental and non-governmental partners, evaluate the impact of local interventions.

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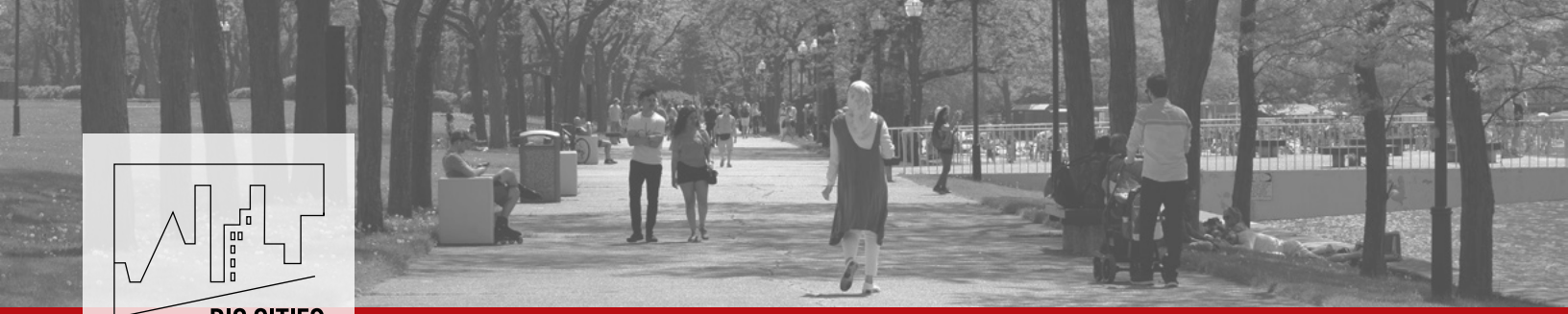

BIG CITIES HEALTH COALITION

PUBLIC HEALTH WORKS | Preventing and Mitigating Substance Use Disorder

PUBLIC HEALTH BRINGS EXPERTISE AND SOLUTIONS

Big city health departments not only prevent, and reduce harm from, overdoses, but also improve outcomes for people who use drugs.

They are among the first to detect trends in emerging drugs, identify inequities in fatal and non-fatal overdoses, recognize hot spots, fund and provide supportive services rooted in reducing harm to individuals using, hold systemwide convenings, and implement quality improvement initiatives.

Big city health departments are also the first to identify and respond to local impacts, working to mitigate the effect of overdose and other harmful effects of substance use, including disease transmission.

They pilot, implement, and test innovative strategies that are often expanded in communities across their respective states and the country.

In 2021, BCHC member Southern Nevada Health District (which serves Las Vegas) launched its CDC-funded Linkage to Action (L2A) mobile outreach unit to prevent drug overdoses through education, surveillance, and assistance with accessing services.

How Big City Health Departments Prevent and Reduce Harm from Substance Use Disorder

PREVENTION

- Invest in policy and programs that prevent substance use and substance use disorders (SUDs) and their co-occurrence with other behavioral health and infectious disease conditions.
- Distribute naloxone and fentanyl test strips; offer drug checking services, and other harm reduction activities.
- Follow up with non-fatal overdose survivors.

DATA

- Collect and disseminate mortality/morbidity and surveillance data, evaluations, local assessment and Overdose Fatality Reviews, and whenever possible, nonfatal overdose surveillance.

COMMUNITY INPUT AND EDUCATION

- Convene stakeholders and establish local task forces.
- Develop and execute community-wide education and stigma reduction campaigns.
- Amplify the voices of those with lived experience.

CROSS-SECTOR PLANNING, IMPLEMENTATION, AND EVALUATION

- Convene and lead cross-government planning.
- Implement cross-sector policies and interventions (e.g., naloxone distribution in shelters).
- Coordinate and engage with health care systems.
- Train and provide technical assistance to first responders.
- With governmental and non-governmental partners, evaluate the impact of local interventions.

POLICY, ADVOCACY, RESEARCH

- Advocate for evidence-informed policy that improves access to prevention, harm reduction, treatment, and recovery support services.
- Invest and participate in research to further understand SUD, risk factors for overdose, and evidence-based interventions to prevent or mitigate the effects of overdose.
- Support arrest deflection programs that promote linkage to treatment and harm reduction services and reduce repeated public safety engagement.

TREATMENT

- Expand health care providers' capacity to offer evidence-based screening, treatment, and recovery services.
- Provide health services to those with SUDs who are incarcerated, experiencing homelessness, and/or pregnant/new to parenting; connect the public at large to safety net and addiction treatment services as needed.
- Establish medication-assisted treatment (MAT) programs across a spectrum of need in populations that are most at risk.

A Philadelphia health department worker explains how to use the overdose reversal drug naloxone contained in a free pack distributed at a public library.

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