



**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 (SUD) and overdose epidemics but receive insufficient dedicated or direct federal funding for that lifesaving work.

Most states and some local health departments [receive funding](#) from the Centers for Disease Control and Prevention (CDC) through the Overdose Data to Action (OD2A) program. OD2A is a critical resource for prevention of opioid and polysubstance use. Prevention efforts include harm reduction and linkage to care initiatives with a focus on health equity and reducing stigma.

Local communities need additional funding to ensure that SUD prevention continues to stem the tide of overdose and death. In 2023, [CDC forecasts funding up to 40 local jurisdictions](#) – and we encourage Congress to provide sufficient funding for the agency to do so.



#### **FUNDING**

- ▶ Increase funding for CDC's Infectious Diseases and Opioid Epidemic program to:
  - 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 the most in need.
- ▶ Publicly report the amount of federal funding states are sub-granting to local communities.
- ▶ Enact and fund the Comprehensive Addiction Resources Emergency (CARE) Act ([H.R. 6311/S. 3418 in the 117th Congress](#)) to provide \$125 billion in federal funding over ten years, of which \$3.3 billion per year to hardest hit counties and cities. [The bill supports](#) local decision-making and federal research and programs to prevent substance use disorder while expanding access to evidence-based treatments and recovery support services.



#### **PREVENTION**

- ▶ Increase availability of naloxone and similar overdose reversal drugs by:
  - permanently allowing CDC (particularly OD2A) funding to be used to purchase 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 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](#)) or innovative policy pilot programs, such as the North American Opiate Medication Initiative ([NAOMI](#)).



## DATA & SURVEILLANCE

- ▶ Increase data resources at the local level to expand 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; 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.



## HARM REDUCTION

- ▶ Increase funding for [low-threshold services](#) at SSPs, including case management/ outreach, and mental health and other medical services.
- ▶ Direct CMS to issue a Dear State Medicaid Director letter, akin to 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 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](#).



## REDUCING BARRIERS TO TREATMENT (BUPRENORPHINE)

- ▶ 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, as included in the [Ryan Haight Act of 2008 \(PL 110-425\)](#).
- ▶ Instruct SAMHSA and DEA to [remove barriers](#) and incentivize pharmacies to stock buprenorphine. About one in five pharmacies currently refuse to dispense.

## REDUCING BARRIERS TO TREATMENT (METHADONE)

- ▶ Finalize SAMHSA OTP proposed rule that:
  - allows for take-home doses of methadone for stable patients in OTPs including upon entry into treatment;
  - allows use of telehealth to provide services including initiation of treatment with methadone;
  - removes requirement for having an opioid use disorder (OUD) for 1 year before receiving methadone;
  - allows for flexibility with initial dosing of methadone to be greater than 30 mg if clinically indicated and documented in the patient's medical record.
- ▶ Instruct SAMHSA and DEA to create a pilot program to allow pharmacies to dispense methadone in partnership with appropriate governmental health authorities.
- ▶ Remove requirement to use HIPAA-compliant platforms to teleprescribe buprenorphine.

*The Big Cities Health Coalition (BCHC) is a forum for the leaders of America's largest metropolitan health departments to exchange strategies and jointly address issues to promote and protect the health and safety of their residents. Collectively, BCHC's 35 member jurisdictions directly impact more than 61 million people, or one in five Americans.*

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