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Chair Blunt, Ranking Member Murray, Members of the Committee: I am honored to be here today. My name is Charissa Fotinos, and I am the deputy chief medical officer and director of behavioral health integration for the Washington State Health Care Authority; the agency that administers the state Medicaid program. I am a board certified Family Medicine and Addiction Medicine physician and have spent a large part of my career practicing medicine serving people with behavioral health conditions. In my current position I have spent much of the last 4 years working with my colleagues across the state to address the opioid crisis. I appear before you today to review our progress, describe some of our efforts, present some of our ongoing challenges and to ask for your continued support in responding to this public health emergency.

Washington State continues to struggle with the opioid epidemic. There were 739 opioid overdose deaths in 2017, up from 694 in 2016. This increase was primarily due to an increase in deaths involving fentanyl. As is true with many health conditions, huge disparities among communities exist, Native Americans in Washington experience opioid overdose death rates that are 3 times higher than non-Hispanic whites.

Despite these challenges we are making some progress. My colleague Dr. Gary Franklin first discovered the problem with overdose deaths related to prescription drug overdoses, and since that discovery we have implemented collaborative practice guidelines that have contributed to a sustained 44% decline in the rate of prescription opioid related deaths.

Our efforts to increase the number of waived prescribers and increase access to medications has seen an increase in the number of persons covered by Medicaid receiving medication assisted treatment for opioid use disorder or OUD, from about 5,000 in 2013 to over 21,000 in 2017, a 4 fold

increase. Through the 2nd quarter of 2018 about a third of people on Medicaid with a diagnosis of OUD were receiving treatment. Across the state 90 day retention rates for medication are about 72%. Initiating and retaining people with opioid use disorder on medications is essential since medications reduce a person's risk of death by more than 50%.

In 2018 37,900 naloxone kits were distributed across Washington, exclusive of any provided by a pharmacy. Over 3,000 overdose reversals were reported from syringe service programs alone.

Several metrics also suggest our prevention efforts are headed in the right direction. Our last Healthy Youth Survey reported the proportion of 10th graders using prescription pain pills to get high was 4.4%, a steady 50% decline since 2006. The number of 10–24 year olds receiving an opioid prescription decreased almost 40% during 2015 to 2017. And, in 2018, our Prescription Monitoring Program database was queried over 20 million times, far exceeding the total number of controlled substances dispensed.

We believe part of this success has been due to the fact that in 2015 multiple state agencies along with our tribal nations and external stakeholders collaborated to develop a state opioid response plan. Governor Inslee's executive order issued in 2016 called attention to the epidemic and directed state agencies to implement the response plan which focuses on 4 goals: prevention, treatment, overdose response, and measurement. The plan has provided a blueprint for action, reduced duplication of effort and helped identify ongoing gaps as strategies are developed and activities implemented. In addition, the states' nine accountable communities of health, created through a Medicaid transformation project, are required to implement and will be measured on improvements made from their own regional opioid response plans. The transformation project also allows Medicaid funds to be used for housing and employment supports; critical elements of many people's recovery.

There are 17 strategies and 105 activities in the state opioid response plan. Included is a copy of our state plan, an example of a routine report and some of our metrics.

Scientific studies show that opioid replacement medications like methadone and buprenorphine are highly effective in reducing opioid related overdose risk and in improving outcomes. In order to better support people on these medications, we recognized the need to work towards integration

of our currently distinct physical health, mental health and substance use disorder systems of care. Each system has different funding streams and different conceptual frameworks. This has highlighted the need to develop a coordinated infrastructure of care for persons struggling with opioid and other substance use disorders. By leveraging $21.3 million of the $33.4 million dollars awarded the state with the State Targeted Response, STR, and State Opioid Response, SOR, grants and funds allocated by the state, we are working to create this infrastructure.

Loosely modeled after Vermont's hub and spoke and Massachusetts' nurse care manager models, federal and state funds have been used to develop regional networks of care for persons with opioid use disorder across the state. By providing funds to hire nurses, care coordinators and provide additional administrative support to practices, we have expanded capacity and started to build what we hope will be more integrated systems of care. The networks are responsible for getting new patients stabilized on opioid treatment medications and for providing and coordinating their medical, mental health and substance use disorder treatment needs. Monies from the SOR grant are being used to develop linkages to jails, emergency departments and syringe service programs. Funding technical support to assist in the development of these networks has been a critical part of this work.

We are focusing our efforts on two particularly vulnerable populations, persons who are pregnant and parenting and those who are justice involved. The Governor has requested additional funds to expand programs focused on persons who are pregnant and parenting and their newborns. Federal funds allocated to the Child Abuse Prevention and Treatment Act and the Kinship Navigator programs will further support efforts at achieving positive health outcomes for parents struggling with OUD and their children. The Governor has also advanced a funding proposal to support a Law Enforcement Assisted Diversion program. We are also pursuing a Medicaid waiver that would allow persons eligible for Medicaid to start or continue medications for opioid use disorder while in jail.

Despite all of this work, challenges remain. Stigma and the shame of persons experiencing opioid use disorder and that of their families remains a barrier to care and delays recovery. Maintaining the pre-existing conditions protections of and essential benefits of the Affordable Care Act is critical. In 2013, 22,250 people covered by Medicaid in Washington had a diagnosis of OUD. A year

after implementation in 2015 that number was 48,688. It is likely that many of these persons would have experienced an overdose without Medicaid expansion.

It's important to note that while Washington's overall rate of opioid overdose deaths remains below the national average, the rate of methamphetamine related deaths in Washington has doubled since 2013 and is higher than the national average. This highlights the need for us to develop systems capable of addressing multiple substance use disorders in responding to the epidemic.

While we are moving in the right direction, our efforts should be considered crisis triage and just the start of a long term response effort. As is true of many chronic conditions there are periods of stability and episodes of relapse. We need to rethink how we fund treatment in the context of chronic disease management to include funding peers and recovery supports. We also need to work closely with our other government partners to make available supported housing and employment.

Continued funding of the substance abuse block grant, continued leadership at the Federal level to promote evidence based care, continued work to reduce barriers to information exchange across provider types, and the elimination of barriers that prohibit states from combining money across funding streams to support what will be an ongoing response to this crisis will be paramount.

Through my experience as a family physician, I have witnessed the effects substance use disorders have on individuals and their families. In my previous role as the Medical director of a county health department and now in my current role at the state, I have gained a broader perspective. Families, communities and a generation of children are being impacted. Developing a long term coordinated response that recognizes and helps address the breadth of these impacts will be necessary to help restore fractured communities and reduce the risk of future generations experiencing the same. Thank you for the opportunity to testify, I look forward to answering your questions.