

**A Public Health Emergency:  
West Virginia's Efforts to Curb the Opioid Crisis**

Testimony to:

The House of Representatives Committee on Energy and Commerce  
Subcommittee on Oversight and Investigations

The Honorable Frank Pallone, Jr., Chairman  
The Honorable Greg Walden, Ranking Member  
The Honorable Brett Guthrie, Ranking Member  
The Honorable Diana DeGette, Subcommittee Chair

2125 Rayburn House Office Building

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Chairman Pallone, Ranking Member Walden, Ranking Member Guthrie, Subcommittee Chair DeGette and members of the Committee on Energy and Commerce, I am Christina Mullins, the Commissioner of the Bureau for Behavioral Health within the West Virginia Department of Health and Human Resources (DHHR). First, I want to thank the Committee for your commitment to address this crisis. Without the resources provided by this Committee, West Virginia might be in a considerably worse position. I also want to thank you for the opportunity to discuss the importance of the initiatives in West Virginia to address the opioid crisis and the impact of the funding made available through this committee in the effort to promote prevention, treatment and recovery of substance use disorder. The resources provided by both the state and federal governments have allowed West Virginia to transform the state's response to the opioid crisis. This work is saving lives through expanded opportunities for prevention, treatment, and recovery.

While overdose rates in West Virginia have increased since the early 2000s, staff within West Virginia's DHHR began to receive increasing numbers of calls from providers of all kinds in the mid-2000s. Overdose deaths were going up, clients were presenting with substance use disorders, and neonatologists were complaining that the neonatal intensive care units were full of infants withdrawing from drugs. We had no idea that this was only the beginning of what would happen to our state.

Further compounding our challenges during this time was that Medicaid did not pay for residential treatment, and the utilization of medication assisted treatment (MAT) in any setting was very low. Residential treatment services were either privately sponsored or funded by DHHR using the Substance Abuse Prevention and Treatment Block Grant (SAPT) or state revenue. As a result, there were only 197 treatment beds to serve the entire state of West Virginia. Put simply, West Virginia had nowhere near the resources it needed to respond to the worsening crisis.

It is no secret that West Virginia is ground zero of the opioid crisis. There are award winning documentaries and Pulitzer Prize winning stories that describe what happened to our state, and I am sure that these efforts played a significant role in bringing much needed resources to West Virginia. But today, I would like to tell a different story. With your help, West Virginia has reduced overdose deaths for the first time in over 10 years. Opioid prescriptions have decreased by 48%, opioid doses have decreased by 50%, and naloxone prescribing has increased by 208%. Additionally, we have distributed over 10,000 doses of naloxone to local health departments. Treatment capacity has also shifted. The number of Data Addiction Treatment Act (DATA) waived providers has increased 208% since 2017, and the number of residential treatment beds has increased from 197 to 740. Our records indicate that 85% of these beds are always in use. Additionally, nearly all birthing facilities have access to integrated substance use disorder treatment in their community. This fundamental shift in infrastructure and capacity is the result of the significant financial investment of federal, state and drug settlement funds.

West Virginia leveraged federal investments to increase outpatient treatment capacity (including MAT), increase the number and quality of its workforce, distribute life-saving naloxone, conduct

rigorous provider education on opioid prescribing, and stand up Quick Response Teams to follow-up on individuals experiencing non-fatal overdoses. The state used settlement funds and its general revenue to undertake the development of bricks and mortar projects that expanded the availability of residential treatment, including facilities that specialize in pregnant and post-partum women. The scope of this problem required a significant financial investment to adequately respond to this crisis. Braiding available funding sources allowed West Virginia to balance the need for immediate interventions and services with the long-term need to address the systemic issues that serve as an ongoing challenge to the state's opioid response. This testimony will describe how West Virginia transformed its substance use system of care using available federal dollars as a critical cornerstone.

### **Impact of Crisis**

West Virginia is one of the states most impacted by the current opioid crisis. In 1999, West Virginia had a lower rate of overdose deaths than the national average at 4.1 per 100,000 population versus a national rate of 6.0. In 2001, West Virginia surpassed the national rate and in 2010 became the state with the highest rate of overdose deaths in the nation. West Virginia continues to lead the nation in overdose deaths, with its highest rate of 57.8 recorded in 2017.

Loss of life is not the only impact of this crisis. Substance use disorder has had a profound impact on children and their families. West Virginia leads the nation in Neonatal Abstinence Syndrome (NAS), a withdrawal syndrome associated with prenatal exposure to both illicit and legally prescribed drugs. In 2018, 4.9% of infants born in West Virginia were diagnosed with NAS. Of continued concern is that an additional 9.4% of infants were determined to have intrauterine substance exposure (illicit and legally prescribed). Overall, 14.3% of the infants born in West Virginia may have long-term consequences due to exposure to drugs during pregnancy.

Substance use has also directly impacted the state's foster care system. Foster care placement in West Virginia has risen from 4,129 children in care in September 2011 to 6,895 in September 2019, an increase of 67%. Of those currently in foster care placement, the most common reasons are drug use by the parent (51.3%) followed by neglect (34.6%). It is important to note that drug use alone is not sufficient cause for removal. Furthermore, infants in foster care were 420% more likely to have been diagnosed with NAS.

In addition to loss of life and impact to families, the state has also experienced increases in infectious diseases including an outbreak of hepatitis A in March 2018. Nearly 70% of infected individuals reported illicit drug use, and 9% reported experiencing homelessness. Additionally, in 2018 and 2019, the state had 114 new HIV cases associated with injection drug use compared to only 25 cases in 2016 and 2017. This has increased the stigma associated with substance use disorder in certain communities.

There are many contributing factors to the high rate of overdose deaths in West Virginia, including high rates of opioid prescribing, poor economic status and lack of capacity to provide evidence-based treatment. Prior to 2016, there were 197 residential substance use treatment beds available. Additionally, the state has a mental health and substance use

disorder professional workforce shortage making retention of qualified providers very difficult. The Health Resources and Service Administration (HRSA) estimates that only 16.9% of West Virginia's mental health professional need is being met (the workforce with the primary responsibility of delivering substance use disorder treatment), which further strains the state's ability to expand prevention, treatment and recovery programs.

Data is crucial to describe and inform the response to the opioid crisis. Since the start of the opioid crisis, West Virginia has implemented multiple initiatives, each adding lessons learned and informing future strategies. In 2001, the state expanded the capacity to track fatal overdoses in more detail. This was pivotal and helped government officials understand what was happening within the state. In 2011, this information caused the Governor's Office to establish the Governor's Advisory Council on Substance Abuse (GACSA) to help define and guide the response to the opioid crisis. GACSA was the beginning of the stakeholder collaboration that defines West Virginia's approach by working to maximize resources to address the opioid crisis.

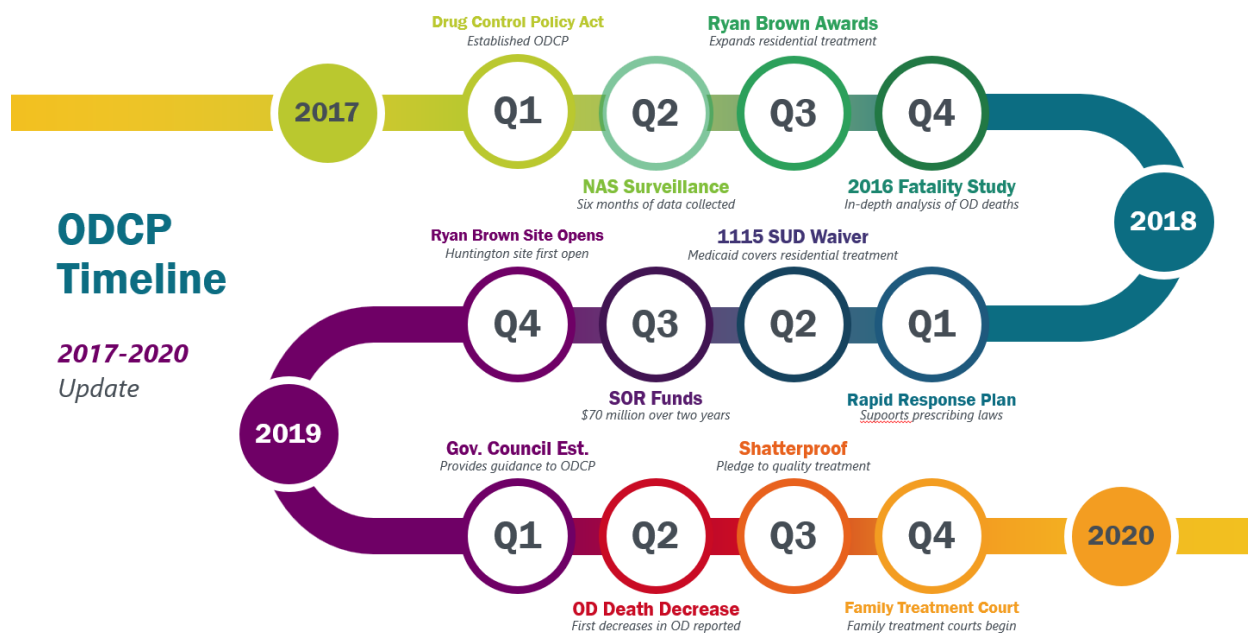
Recommendations from GACSA led to state appropriations for expanding prevention, treatment and recovery programs. Despite these efforts, overdose and NAS rates continued to climb. From 2000 to 2016, there were multiple initiatives and laws passed to address the opioid crisis in the state. However, the resources available at the time could not even begin to meet the demand of the response needed. Various agencies were applying and receiving federal grants, and while this allowed the state to leverage federal resources and expertise, the state still struggled to meet the demands of the response.

In 2017, several significant events converged allowing the state to expand and solidify its response to the opioid crisis. First, at the direction of this committee, West Virginia began to receive an increase in federal support and funding. At about the same time, the West Virginia Legislature passed the West Virginia Drug Control Policy Act, which created the Office of Drug Control Policy (ODCP) to coordinate, support and improve the state's response to substance use. West Virginia also created an appropriations fund to receive state opioid settlements, known as the Ryan Brown Fund. This fund allows for settlements with drug companies to be utilized for the creation of new treatment and recovery infrastructure. Another significant event was the approval of West Virginia for a Centers for Medicare and Medicaid Services (CMS) 1115 Substance Use Disorder Demonstration project. This expansion of Medicaid significantly increased access to residential treatment, medication assisted treatment (including methadone) and peer recovery support services.

In addition to policy and funding changes, the state completed the first of its kind 2016 Overdose Fatality Analysis, funded by the Prescription Drug Overdose: Prevention for States Cooperative Agreement, that helped inform initiatives and led to the near simultaneous development of a Rapid Response Plan (supported by state revenue, the State Targeted Response (STR) grant, and the Prescription Drug Overdose: Prevention for States Cooperative Agreement) with a primary goal to decrease fatal overdoses. The Rapid Response Plan informed both the deployment of financial resources and the passage of the Opioid Reduction Act that required the development of voluntary nonopioid advanced directives and limited the initial supply of opioid prescriptions.

In 2018, Governor Jim Justice convened a new advisory council to advise ODCP and develop a long-term strategic plan (encompassing all available funding mechanisms) with broader goals for continuing to expand prevention, treatment and recovery programs with an emphasis on reducing the impact to children and families. This plan will help to coordinate the implementation of all programs, regardless of funding sources. Over the past year, the ODCP strategic planning process has facilitated streamlined coordination within and across agencies. These combined components will help West Virginia continue to expand the service array for those most in need. Figure 1 illustrates the convergence of key steps taken by West Virginia since 2017.

Figure 1



In West Virginia, DHHR is the primary recipient of the federal funds allocated through this committee. DHHR is comprised of multiple offices and bureaus including the Bureau for Behavioral Health, the federally designated Single State Agency (SSA) which manages the Substance Abuse Prevention and Treatment Block Grant (SAPT) and the State Opioid Response Grant (SOR); the Bureau for Public Health which manages funds from the Centers for Disease Control and Prevention (CDC); the Office of Drug Control Policy (ODCP) which coordinates funding across agencies; the Bureau for Medical Services, the state Medicaid agency; and the Bureau for Children and Families, the agency responsible for child and family services. One important outcome of the federal funding received by West Virginia is that state agencies have been working together across funding streams and breaking down the silos of traditional areas of focus. Through weekly collaborative meetings organized by the ODCP and DHHR’s Cabinet Secretary, this structure allows the bureaus to maximize and leverage financial and human resources across bureaus.

To be successful, coordination of programming must go beyond DHHR’s internal agencies. As a result, the ODCP facilitates regular meetings with the West Virginia Department of Military

Affairs and Public Safety, the agency responsible for law enforcement and corrections in the state, the West Virginia judicial system, members of the higher education system in the state, Workforce West Virginia, the state agency that oversees the unemployment insurance program among other activities, the West Virginia Department of Education, and the West Virginia Board of Pharmacy to facilitate a common vision. Each of these agencies are responsible for implementing key elements of the state's strategic response. In addition to coordination with other state agencies, regional community meetings are typically conducted once per year to get input from community members throughout the state. The most recent rounds of regional meetings were held in the both the fall of 2018 and again in the fall of 2019. Key stakeholders and collaborators are highlighted below:

### **State Departments and Boards**

- West Virginia Department of Health and Human Resources
- West Virginia Department of Education
- West Virginia Department of Military Affairs and Public Safety
- West Virginia Board of Medicine
- West Virginia Board of Pharmacy
- West Virginia Judiciary
- West Virginia State Police
- WorkForce West Virginia

### **Professional Organizations, Associations, and Coalitions**

- West Virginia Association of Recovery Housing
- West Virginia Behavioral Health Planning Council
- West Virginia Behavioral Health Providers Association
- West Virginia Primary Care Association
- West Virginia Healthcare Information Network
- West Virginia Hospital Association
- Various Local Coalitions and Community Groups

### **Local Governments**

- City and County Courts and Day Report Programs
- City and County Health Departments
- City and County Sheriff's Departments
- City and County Emergency Medical Services

### **Hospitals, Healthcare Systems, Provider Networks**

- Comprehensive Community Behavioral Health Centers
- Federally Qualified Health Centers
- An Array of Licensed Behavioral Health Centers
- Managed Care Organizations
- Marshall Health
- West Virginia University Medicine

### **Social Service Institutions and Agencies**

- Prevention Lead Organizations
- West Virginia Perinatal Partnership
- Homeless Service Agencies Including Continuums of Care
- Various Faith and Community Based Nonprofit Organizations

### **Universities and Academic Institutions**

- Marshall University
- University of Charleston
- West Virginia School of Osteopathic Medicine
- West Virginia University

As of December 20, 2019, West Virginia has received \$147,356,427 in federal funds to address the opioid crisis. An additional \$58,908,723 in state funds have also been allocated since July 2016 to support the state's response to this crisis. This total does not include the state share of expenses billed under the 1115 Substance Use Disorder Medicaid Waiver. The total amount of funding allocated/encumbered is constantly changing as new programs are initiated. While West Virginia has not fully expended the total amount of federal funding at the time of this testimony, I cannot stress enough that these funds have been critical in the state's substance use disorder response. West Virginia is constantly working to balance the need to deploy financial resources as quickly as possible while assuring that the funds are effectively and efficiently managed to ensure that we are accountable for these critical resources.

Surveillance reports supported by CDC grants (including Prescription Drug Overdose: Prevention for States (PDO:PFS), Enhanced State Opioid Overdose Surveillance (ESOOS), and the Crisis Notice of Funding Opportunity Announcement) allowed DHHR to identify "hot spots" and high burden areas. Of note is that every county and community in West Virginia has been impacted by the opioid crisis, with all able to document some level of need. West Virginia used this data to develop a clear picture of where the gaps in service were, where the greatest need existed, and where there was sufficient capacity so funds could be used in the most impactful manner. The significant federal investments have allowed West Virginia the flexibility to focus on the hardest hit regions and localities while also allowing us to address statewide needs that benefit all West Virginians. In other words, we did not have to choose between much needed critical projects. For perhaps the first time, West Virginia had the resources to fund what it needed.

DHHR awards grants to outside entities to perform an assortment of programmatic functions and activities funded with federal and state resources. DHHR uses both a purchasing process and a competitive Announcement of Funding Availability (AFA) process to determine which local governments and/or entities receive federal funding, with prioritization given to specific areas of need/personnel in agencies to develop programs. While there are slight variations within and between agencies, all agencies follow the same overall guidelines. The process for DHHR's Bureau for Behavioral Health is provided as one example. The Bureau for Behavioral Health releases an AFA through an established public announcement process, which includes both group e-mails and website postings. AFAs note the services to be provided, the geographic location for those services, the budget limits, grant expectations/requirements, and requests a proposal for the delivery of the specified services. After a public application period, all

grant applications are reviewed using an independent proposal review team. Proposals are scored on the content of the proposal. Based upon the results of the review, funding recommendations are provided to DHHR leadership for consideration and final decision.

In consideration of programmatic awards, West Virginia looks at past performance of programmatic applicants, ability to provide required activities, ability to provide services in the needed geographic location(s) and ability to manage federal funds per required guidance. In some instances, DHHR may direct award agencies for specific programs. In these cases, the agencies selected are the only providers eligible for this service. These awards may be in the form of a grant award or a purchase contract. An example of this type of process would be a contract with a data platform provider that is the sole source provider of an eligible software solution.

In order to effectively and efficiently respond to the opioid crisis, additional workforce was also needed by key state agencies to manage programs and provide the vision for services, as well as at the local level for direct service provision. The addition of qualified personnel takes time; however, this growth has been realized in large part and is already making a difference in the oversight, provision and delivery of the necessary programs. West Virginia has improved its infrastructure and ability to monitor this crisis by hiring additional personnel, acquiring new data systems, and improving the use of existing systems. Enhancements in this area have led to a greater understanding of the opioid crisis and its impact on individuals, families, counties and the state. For example, the PDO:PFS grant supports the Board of Pharmacy (BOP) data analytical team, which includes the first two epidemiologists ever hired by the BOP in order to increase the use of Prescription Drug Monitoring Program (PDMP) data. A research specialist was hired with federal funds from the CDC's ESOOS funding and sends a monthly internal fatal overdose report to key decision makers. Additionally, State Opioid Response (SOR) funding has allowed DHHR to employ additional Bureau for Behavioral Health personnel to ensure coordination across prevention and treatment activities, effectively doubling the workforce of the SSA that focuses on substance use disorder. Challenges often exist in staffing new initiatives in a timely manner. Due to the urgent nature of addressing opioid use and its outcomes, direct assistance from federal partners, such as the CDC, was extremely beneficial to quickly staff initiatives while allowing the state to work on internal hiring.

West Virginia faced several challenges in the deployment of federal resources to its local communities. Some of the issues involved a lack of infrastructure at the local community level to administer federal funding appropriately and/or a lack of a qualified workforce at the local level. To help address these issues, DHHR used technical assistance funds from SAMHSA to provide technical assistance to several entities on the state processes and federal grant requirements. These training opportunities will continue in the future as West Virginia works to strengthen and expand the capabilities of local and regional agencies providing services to those most in need.

Another way the state ensures that every county and every community impacted by this issue has some ability to respond to this crisis is by providing funding to agencies that are the backbone of the behavioral health system. As such, some level of funding has been provided to every county in the state. DHHR uses the SAPT, STR, and SOR to support the statewide behavioral health



infrastructure for prevention via six Prevention Lead Organizations to provide and build prevention infrastructure and activities, including the funding of county coalitions. Treatment is tasked to 13 regional Comprehensive Behavioral Health Centers (CBHC), which serve as the public behavioral health centers in the state. Funding has been awarded to all PLOs and CBHCs to increase capacity and enhance infrastructure to respond to the drug crisis.

The challenges associated with workforce cannot be overemphasized. Overall, West Virginia has one of the lowest participation rates in the workforce of any state in the nation at 53.9% in 2018. It is well known that engagement in the workforce is a factor that contributes to long-term recovery. To overcome the workforce shortages in the state and to promote recovery, West Virginia is actively working to address this issue with a jobs program. Governor Jim Justice's administration has created Jobs and Hope West Virginia (<https://jobsandhope.wv.gov/>), to help those in recovery locate employment and higher education. Transition agents are located throughout the state to help connect employed individuals with a substance use disorder to recovery and treatment options and unemployed individuals in recovery with jobs and education.

### ***Prevention Works***

West Virginia has a well-established Prevention First Network that includes state, regional and local leaders who contribute to prevention planning and coordination activities in the state, including the information and resources shared on Help and Hope West Virginia (<https://helpandhopewv.org>) and Stigma Free West Virginia (<https://stigmafreewv.org>). DHHR funds six Regional Prevention Lead Organizations and community coalitions via multiple federal SAMHSA grants. Several of these agencies also receive funds directly from SAMHSA's Drug Free Community program, HRSA, and other private and government grant programs. With support from DHHR, Prevention Lead Organizations collaborate with 51 county coalitions to implement evidence-based interventions in all 55 counties.

Media campaigns are also being used to provide anti-stigma messaging and inform the audience of available services and programs. A statewide media campaign is currently being tested using SOR funds to increase the awareness that addiction is a disease and reduce the stigma around MAT. All media campaigns direct residents to a 24/7/365 statewide call line, 1-844-HELP4WV, to help people seeking assistance access all levels of treatment and recovery. This state funded call line has fielded more than 41,000 calls since September 2015, with over 14,000 receiving a warm hand-off to a service provider.

West Virginia has also used funds from SAMHSA's SAPT, and STR to increase access to Naloxone, creating a statewide deployment strategy that addresses the highest risk counties in the state while also targeting high contact agencies and providers in other areas/counties. Through these efforts, DHHR has distributed over 10,000 doses of Naloxone to local health departments and Naloxone prescribing has increased 208% from 2017 to 2019. These funds are allowing services to literally save lives and build pathways to recovery.

Funding from SAMHSA's SPF Rx and SAPT sponsor drug take back activities to decrease potential diversion. Two drug take back days occurred in the past year with thirteen counties participating. A total of 269.7 pounds (lbs.) of medication were collected during these events. An additional 539.2 lbs. of medications were collected at permanent drop boxes. Additionally,

over 5,000 Drug Deactivation Kits have been distributed as part of this activity. It is important to note not all medications counted in these totals were controlled substances.

### ***Treatment is Effective***

West Virginia is making use of its federal and state funds to improve access to evidence-based treatment by increasing both providers and residential treatment capacity. West Virginia, a Medicaid expansion state, received a CMS 1115 Substance Use Disorder Demonstration Waiver, which has increased access for Medicaid covered individuals to treatment. Services under the waiver include Peer Recovery Support Specialist (PRSS) funding for stronger participant engagement and navigation of needed services; expansion of access to non-emergency medical transportation to and from treatment; and coverage of residential treatment services. West Virginia further leveraged this investment by using SOR funds to sponsor treatment for those individuals with no insurance or insurance that does not cover substance use disorder treatment.

As required by SAMHSA's STR, West Virginia completed both a strategic plan and a needs assessment. Due to a state moratorium on Opioid Treatment Programs (OTP), the only programs allowed to prescribe Methadone in West Virginia, the plan focused on other evidence-based strategies to increase access to buprenorphine and naltrexone. These activities included promoting and expanding the Comprehensive Opioid Addiction Treatment (COAT) model (a Hub and Spoke model for MAT), increasing the number of DATA-Waivered practitioners and use of the ECHO model for MAT (linking expert specialist teams at an academic 'hub' with primary care clinicians in local communities) to access treatment experts. Overall, federal funding (STR and SOR) has allowed West Virginia to expand access to clinically appropriate, evidence-based practices for out-patient treatment. In 2017, West Virginia had 243 DATA-Waivered providers but as of October 2019, the total has risen to 584. This is a 140% increase in the number of providers that can prescribe buprenorphine. A DATA Waiver is not required to prescribe naltrexone. West Virginia is closely monitoring the expansion of MAT, and there are residents in all 55 counties receiving MAT treatment. From January 2019 to October 2019, over 21,400 Medicaid members were prescribed MAT with approximately 30,000 Medicaid members with an opioid use diagnosis. Buprenorphine was most common MAT prescription (74%), followed by naltrexone (18%) and methadone (8%).

West Virginia has also been able to synchronize other sources of funding to complement its federally funded activities, specifically its drug settlement funding. West Virginia created an appropriations fund to receive state opioid settlements, known as the Ryan Brown Fund. These funds have been utilized to expand treatment capacity through the construction and renovation of new residential treatment and recovery support services. Through use of the Ryan Brown Fund, West Virginia has added 282 new treatment beds, with an additional 110 still under development. In response to the substance use disorder Waiver, another 133 beds have been made available for residential treatment. Treatment expansion has targeted all American Society of Addiction Medicine (ASAM) levels of care and has been designed to allow for increased accessibility no matter what region of the state someone may reside. When completed, this expansion will more than double the number of residential treatment beds available in 2016, allowing for greater access to clinically appropriate treatment models, specifically, MAT.

Some of the more innovative and exciting projects have involved cooperation across state agencies with differing funding streams. With the creation of the ODCP, we have seen increased cooperation and sharing of data and resources in pursuit of common goals. Using both SOR and state funds, West Virginia has begun to expand the use of MAT, including methadone, buprenorphine and naltrexone, to all ten of West Virginia's regional jails through a collaboration between different state agencies, allowing for fewer interruptions in treatment for those who become incarcerated. In addition, a 20-bed correctional unit has been established as an alternative to a court ordered prison term for individuals with substance use disorder who choose to participate in a long-term MAT program. Further cooperation is highlighted by the development of Law Enforcement Assisted Diversion (LEAD) programs in 15 counties, which aim to divert adults with substance use disorder from the criminal justice system to community-based treatment and recovery supports.

As West Virginia leads the nation in NAS, need for increased treatment for pregnant women was also identified as an area of high need in the STR strategic plan. The West Virginia Perinatal Partnership, using funding from DHHR and the Claude Worthington Benedum Foundation, started a wraparound, comprehensive treatment program in 2012 for pregnant women called the Drug Free Moms and Babies Program. Initial evaluation results were promising, and the program has since expanded from the original 4 sites to 11 additional sites for a current total of 15, with STR funding leading the expansion efforts. This expansion is also a prime example of collaborations across multiple funding streams to include multiple federal grants (Maternal and Child Health Title V Block Grant, SAMHSA's SAPT, and STR), state dollars, and private sector funding to address the need for treatment for pregnant women. It is important to note this expansion has allowed for a program in the catchment area of 63% of the 24 available birthing facilities in the state. As an example of the work being done in these programs, please note the video located on the Perinatal Partnership website: <https://wvperinatal.org/initiatives/substance-use-during-pregnancy/drug-free-moms-and-babies-project/>.

Using both the STR and SOR grants, DHHR provided funding to train over 1,000 professionals and peer recovery coaches on effective MAT practices, with a focus on pregnant and postpartum women, opioid overdose survivors, and hospital emergency departments. With SOR funding, West Virginia has worked with the three medical schools in the state to broaden their curriculum and professional development to expand the clinical workforce across West Virginia. In order to compliment the work of the medical schools, West Virginia created the state funded Statewide Therapist Loan Repayment (STLR) program. STLR will repay a portion of eligible student loan expenses in exchange for a 2-year substance use disorder service obligation at a qualified facility in West Virginia. Over 100 people applied demonstrating that, given the opportunity, people want to stay in West Virginia to address the drug crisis. To date, 22 clinicians or future clinicians have been approved for the STLR program and this number is expected to double in the next six months.

Quick Response Teams (QRT) have been established in 20 high risk communities using the SOR grant and state funds. These teams identify and engage individuals who have experienced an opioid-related overdose. Typically, teams are composed of emergency response personnel, law

enforcement officers or health department personnel and a substance use treatment or recovery provider. The purpose of a QRT is to identify individuals who have overdosed and engage them in treatment. Once a person has an opioid overdose and is revived by first responders, the Quick Response Team will contact and engage survivors within 24-72 hours to discuss treatment options. The team will contact victims through repeated house visits, phone calls, text messages, and other communication routes. The goal of QRTs is to reduce the incidence of repeat overdoses and overdose fatalities and to increase the number of people who participate in treatment for opioid use disorder.

Transportation, a long-term issue for rural states such as West Virginia, is being addressed in ways that allow for greater access to treatment and recovery services. As West Virginia is one of the most rural states in the nation, with a lack of mass transit options for many residents, transportation has long been a significant barrier in access to treatment and recovery services. Several strategies have been employed to address this barrier. The 1115 Substance Use Disorder Waiver allows Medicaid funded transportation to treatment via the non-emergency medical transportation provider. Additionally, with SOR funding, West Virginia has partnered with the West Virginia Public Transit Authority to offer after hours transportation and expanded route access to cover more rural areas specifically to assist individuals in accessing treatment and recovery services.

### ***Recovery is Possible***

Since 2016, West Virginia has also increased recovery options for those experiencing a substance use disorder. As noted above, PRSS have been added to the Medicaid funded system of care to increase engagement in recovery. PRSSs, individuals in recovery themselves, are critical to those in recovery. These positions serve as engagers and navigators to and through every level of care. To support recovery efforts, PRSSs have the knowledge and lived experience to not only connect persons in need of recovery to an appropriate program, but to also show the benefits of utilizing these ongoing supports.

Engagement activities as a pathway to treatment have also been expanded. STR and SOR funds have allowed PRSS to be located in regional jails, emergency departments, harm reduction programs, college campuses, and non-profit agencies. There are currently 347 PRSSs certified by Medicaid located throughout the state. As an example of the impact of PRSSs, approximately 3,340 individuals received peer support services through this initiative between May 2018 and April 2019. To strengthen peer services, the Bureau for Behavioral Health used STR funds to sponsor its first peer conference in April 2019 with 265 individuals attending. The two-day training session increased peer workers' intervention skills by practicing methods such as motivational interviewing and developing skills necessary to support others. Peer workers also learned about ethical guidelines and how to respond to overdose survivors.

West Virginia has funded recovery housing for many years utilizing SAMHSA's SAPT and state funds. Currently, there are over 1,200 recovery beds across West Virginia. The majority of the current recovery beds operate under an abstinence-based philosophy, creating a gap for individuals who choose MAT. With the growth in treatment access, West Virginia is utilizing state funds to expand recovery housing, with two current AFAs in process that are targeted to include all pathways of recovery, increasing the availability of MAT friendly recovery housing.

In 2019, West Virginia passed legislation, House Bill 2530, to allow DHHR to contract with an entity to serve as the certifying agency for a voluntary certification program for substance free recovery. The West Virginia Association of Recovery Residences (WVARR), a statewide chapter of the National Alliance of Recovery Residences (NARR), will expand the availability of well-operated, ethical, and supportive recovery housing. WVARR certification is open to any residence or provider willing and able to meet national best-practice standards. Additionally, the legislation requires that only certified agencies may receive referrals or funding from state agencies. WVARR will maintain a directory of recovery residences and serve as an oversight of recovery residence standards.

West Virginia recognizes family engagement is a crucial component of recovery and is expanding programs to support families remaining together by funding residential treatment centers that accommodate mothers and their children. Additionally, DHHR is seeking to identify childcare options for parents to utilize while seeking treatment. We currently have family residential treatment programs in five of the seven Ryan Brown regions with two additional programs in the planning phases for the two remaining regions (northern and eastern panhandles).

As noted earlier, Governor Justice has established a program, Jobs and Hope West Virginia, to help those in recovery locate employment and higher education. This program offers support through a statewide collaboration of agencies that provide West Virginians in recovery the opportunity to obtain career training and to ultimately secure meaningful employment. Transition agents are located throughout the state to help connect employed individuals with a substance use disorder to recovery and treatment options and unemployed individuals in recovery with jobs and education. In the first few months of operation, the 12 transition agents have already coordinated over 1,235 referrals. This program is being expanded to utilize PRSSs in conjunction with the transition agents to better serve the needs of those in the program.

### **Moving Forward**

While significant progress has been made, certain barriers and challenges remain. West Virginia continues to experience workforce shortages, gaps in training related to psychostimulants and polysubstance use, and a lack of evidence-based practices for children impacted by this crisis. It is essential that West Virginia continue to utilize a multi-pronged approach to address workforce shortages. The state is seeking to increase workforce participation rates, especially by those individuals in recovery, retain our young people, and continue to support those individuals already in the workforce. It is challenging to identify flexible resources to fund the scholarships and loan repayment programs that will help keep recent graduates in West Virginia to provide substance use disorder treatment.

We know that our children have experienced multiple adverse childhood experiences which places them at a significantly higher risk for future problems. Continued research, monitoring, and support will also be needed for the children impacted by substance use disorder as some of the consequences of the drug crisis are not solved with treatment options, and some consequences are not yet known. The ability to use funding to address downstream effects and unintended consequences such as potential long-term effects of prenatal exposure to drugs is

crucial for the state to continue to address all facets of this crisis.

West Virginia is experiencing increased utilization of psychostimulants and polysubstance use. Federal funding allows appropriate flexibility to address opioid use disorder; however, the restriction to opioid use disorder only strategies limits the ability to be flexible in responding to emerging polysubstance use issues. Currently, these activities are being funded via other mechanisms, but additional flexibility would allow for streamlining processes. Overall, overdose deaths with opioid prescription involvement have been declining, and in 2018 will be the first year since 2014 there has not been an increase in overdose deaths involving fentanyl. However, the same cannot be said for overdose deaths involving psychostimulants. For example, in 2014, 3% of overdose deaths involved methamphetamine. In 2018, 36% of overdose deaths involved methamphetamine.

A key concern when utilizing time-limited grant dollars is sustainability of efforts in thinking about a bigger, longer-term investment if these endeavors are to have a significant impact and make death rates go down. With the two-year availability of funds some agencies are reluctant to risk expanding programs because of worries associated with sustainability. This concern also affects recruitment of highly qualified staff. The predictable and sustained provision of resources is key to allow States and providers to plan and rely on future year commitments. It can be difficult if not impossible to successfully plan and operate programs if providers are not confident resources will be available beyond a one-year commitment. While this remains a challenge, it has been helped substantially through the approval of carryover requests. From an administrative perspective, I would like to express appreciation for allowing both carryover requests and no-cost extensions. This has allowed West Virginia to implement projects that took additional time to complete but has also facilitated the state's ability to initiate additional projects beyond originally proposed work plans. This flexibility has also allowed the state to respond to unexpected changes in funding and infrastructure.

It would be difficult to believe that West Virginia could have accomplished so much without the support of this committee. These funds have allowed West Virginia to have the resources that it needed to respond to this crisis and resulted in a decrease in overdose deaths and transformed our system of care. The financial resources are crucial to our continuing success and maintaining momentum. While barriers remain, West Virginia is better poised to address future challenges and continue its forward progress. In summary, West Virginia wishes to say thank you to this Committee. Thank you for the support, thank you for the resources, and thank you for allowing us to share what is happening and what is working in West Virginia.