Open Session Minutes

5600 Fishers Lane

Rockville, Maryland 20857
OPEN SESSION MINUTES

Call Meeting to Order

The Center for Substance Abuse Treatment (CSAT) National Advisory Council (NAC) Designated Federal Officer (DFO), Tracy Goss, called the 86th Meeting of the CSAT National Advisory Council to order at 1:00 p.m. EDT on April 27, 2022. The DFO thanked the attendees for joining the meeting and conducted a roll call to ensure the quorum. After noting that the quorum was met, the DFO indicated that CSAT’s Center Director, Yngvild K. Olsen, M.D., M.P.H. would preside over the meeting. The DFO then confirmed that the meeting was being held virtually for all participants, and she reminded participants of the proper protocol to follow when speaking. The DFO then turned the meeting over to Dr. Olsen, the CSAT NAC Chair.

Welcome, Opening Remarks

Dr. Olsen thanked the NAC members for their service and introduced herself briefly. She spoke about a time during her medical school attendance that she spent on the Pine Ridge and Eagle Butte reservations, where her interest was first piqued about healthcare issues. She also shared her appreciation of the opportunity she now has due to being named the Director of CSAT. Before inviting members to introduce themselves, she extended a welcome to the new members and thanked the current members, noting that many current members allowed their terms to be extended.

Member Introductions and Updates

The following council members were in attendance: Dianne L. Clarke, Ph.D.; Wesley L. Geminn, PharmD, BCPP; Jason Howell, MBA, PRS; Charisse Evonne Peoples, Ph.D.; Eva Petoskey, MS; and Kenneth Stoller, M.D.

Other attendees included: Miriam E. Delphin-Rittmon, Ph.D.; Tom Coderre; Robert Baillieu, M.D.; C. Danielle Johnson Byrd, M.P.H.; Spencer Clark, M.S.W., LMSW, ACSW; Darrick Cunningham, LCSW, BCD; Kirk E. James, M.D.; Patti Juliana, Ph.D.; and Talisha Searcy, MPA, MA.

Dr. Olsen invited the council members to introduce themselves. Dr. Clarke, a new NAC member, began the introductions. Dr. Clarke greeted everyone and expressed her excitement as a new member for the potential to impact the field at a national level. Dr. Clarke serves as the Chief Executive Officer of Operation PAR, Inc., a comprehensive substance use treatment program operating in seven counties in Florida. She shared that Operation Par is in its 52nd year of operation; its first methadone program (Opioid Treatment Program) was in 1970. She stated that she had been in the field since 1980, gaining her start with Operation PAR by working the midnight shift, where she fell in love with the people, the science, and the mission. After leaving for about five years to do child welfare work, she returned to the addiction field.

Dr. Geminn, also a new NAC member, shared that he is with the State Opioid Treatment Authority (SOTA) for the Tennessee Department of Mental Health and Substance Abuse Services, where he serves as the Chief Pharmacy Officer and Director of a residency program. Dr. Geminn also
expressed his appreciation for the warm welcome and his excitement to be on board.

Jason Howell shared that he is a person in long-term recovery from mental health and substance use issues. He currently serves as the Executive Director of RecoveryPeople, a statewide peer and family-led organization based in Texas that focuses on infrastructure development and the three major areas of advocacy, peer to career workforce development, and the enhancement and expansion of recovery services. He expressed particular excitement around helping recovery houses modify their programming policies and procedures to support persons taking medications for their substance use disorder and helping develop the recovery house manager curriculum, potentially leading to a credential in the future.

Dr. Peoples, also a new member, shared that she is a staff psychologist at Court Services and Offender Supervision Agency in Washington, DC. She has been with the agency since 2009. She conducts psychological assessments for new admissions to the agency’s Reentry and Sanctions Program, which is a program of assessment and treatment readiness. She explained that interdisciplinary teams conduct assessments and depending on the program through which the individual enters, recommendations are made to further treatment, e.g., inpatient, outpatient, long-term, co-occurring, residential treatment, or substance use focused groups. Dr. Peoples studied at Case Western Reserve University in pediatric psychology. Before her current position, she worked in quality improvement. Noting that many individuals she works with have substance use disorders (SUDs), Dr. Peoples expressed interest in hearing about what is going on in the field.

Before introducing herself, Eva Petoskey extended congratulations to Dr. Olsen on her recent status change from Acting Director to Director of CSAT. Ms. Petoskey shared that she is a person in long-term recovery and recently celebrated 45 years of sobriety. Ms. Petoskey, a member of the Grand Traverse Band of Ottawa and Chippewa Indians, works with the Inter-Tribal Council of Michigan (ITCM) as the Behavioral Health Manager. ITCM is a consortium of the 12 federally recognized tribes in Michigan and has various prevention, treatment, and recovery support initiatives. She said the organization takes measures to integrate cultural teachings, such as the seven grandfather teachings, into its initiatives. She shared that she will soon be retiring from her position at the end of May, but not from the field. She will be working with tribal women elders on initiatives involving supporting recovery and healing within the tribal community.

Dr. Stoller stated that he is an Addiction Psychiatrist at Johns Hopkins Medicine in Baltimore. Dr. Stoller shared that one area under his responsibility is the Outpatient Addiction Treatment Program, which includes an Opioid Treatment Program (OTP). Dr. Stoller stated that in his role as Medical Director for Behavioral Health for Johns Hopkins Healthcare, he oversees the administration of four different health insurance arms, providing him an opportunity to view the field from different perspectives. He shared that his interests are in systems of care, co-occurring mental health and SUDs, and cost issues. He also serves on the American Association for the Treatment of Opioid Dependence (AATOD) board and will be the Conference Chair of its conference in October; he encouraged those interested in opioid use disorder (OUD) and its treatment to attend the conference.
Consideration of the August 12, 2021, Minutes

The DFO entertained a motion to adopt the minutes from the CSAT NAC meeting held on August 12, 2021, noting that they had been certified according to the Federal Advisory Committee Act (FACA) regulations and reflected council members' edits. Ms. Petoskey moved to adopt the minutes. Mr. Howell seconded the motion. Hearing no response to her call for discussion, the DFO called for a vote. A unanimous vote adopted the minutes.

SAMHSA Leadership Discussion with CSAT Council Members

Dr. Olsen introduced Acting Deputy Assistant Secretary, Tom Coderre and opened the floor for him to speak to the NAC members. Mr. Coderre stated that it was a pleasure to be with the group, thanked everyone for their service, and noted that he was excited to listen to what the Assistant Secretary had to share. Dr. Olsen then introduced the Assistant Secretary for Mental Health and Substance Use and Administrator for SAMHSA, Miriam E. Delphin-Rittmon, Ph.D. Dr. Olsen shared that Dr. Delphin-Rittmon served as the Commissioner of the Connecticut Department of Mental Health and Addiction Services for six years; before that, she served as their Deputy Commissioner, Senior Policy Advisor, and Director of the Office of Multicultural Healthcare Equity. Throughout her career, Dr. Delphin-Rittmon has been committed to promoting recovery-oriented, integrated, and culturally responsive services and systems that foster dignity, respect, and meaningful community inclusion. Before her current appointment, Dr. Delphin-Rittmon was an Adjunct Associate Professor at Yale University. She had been on faculty for more than 20 years and was the Director of Cultural Competence and Research Consultation with the Yale University Program for Recovery and Community Health. She’s had experience in the White House as Senior Advisor to the Administrator of SAMHSA via a two-year White House appointment.

Dr. Delphin-Rittmon began her remarks by thanking Dr. Olsen for her work and leadership in the interim role as CSAT’s Acting Director and now as its Director. Dr. Delphin-Rittmon then discussed four questions that NAC members had previously submitted. She began by addressing the first question, “How we can address some of the discriminatory and counterproductive state legislation that appears to be written related to the methadone maintenance that makes it counterproductive and perhaps not aligned with some of SAMHSA’s thinking?” Dr. Delphin-Rittmon read a portion of the legislation in question regarding methadone flexibilities. She noted that language seems to align with SAMHSA’s current language. She suggested that new language is scheduled to be released at the state level, which may offer even greater alignment.

Dr. Delphin-Rittmon asked if that clarification of language addressed the question sufficiently. Dr. Stoller responded, stating that he was the person who submitted the question and thanked Dr. Delphin-Rittmon for her response. He said that he would need to go back and review the link he submitted, as it may not have included the entirety of the legislation. He recalled other language that included having pharmacists involved in the care and addressing issues regarding stopping methadone and other items less aligned with SAMHSA’s language. He expressed continued concern about states where legislation has been introduced that is not in alignment with high quality and easy access to treatment. Dr. Stoller asked if SAMHSA had an overall approach to address this issue.
Dr. Delphin-Rittmon responded that SAMHSA would still try to address such issues. While there are limitations in terms of ways SAMHSA can impact what happens at the state level, there are also opportunities to share guidance, for example, if there is an OTP.

Dr. Delphin-Rittmon read aloud the second question previously raised regarding federal efforts to reform methadone treatment. “The Office of National Drug Control Policy published a letter shortly after the new administration took office that discussed their legislative priorities. One of those priorities mentioned the effect of modernizing methadone treatment, but no further information has been offered other than that. There have been more recent comments about making the COVID-related waivers permanent. Is more being considered there?”

Dr. Delphin-Rittmon responded that SAMHSA was again working on regulations; she said those would appear in the upcoming Notice of Proposed Rulemaking later this year. She stated that while being limited in the level of detail that she could share, she offered some high-level detail of what SAMHSA is considering, including: 1) language about making some of the COVID flexibilities permanent and ultimately eliminating barriers; 2) additional information related to split dosing or patient-centered care plans as it relates to dosing, as well as harm reduction activities, peer support services, recovery support services, and telehealth; and 3) discussions related to standards of treatment.

Dr. Geminn responded, stating that he had submitted that question before the impact of COVID and was appreciative of the extra flexibilities mentioned by Dr. Delphin-Rittmon that were not necessarily COVID-related, like harm reduction, and addressing some of the other barriers that can affect enrollment and retention. Dr. Geminn stated that he understood SAMHSA could not provide additional details until the rulemaking was published, but what was shared was helpful.

Dr. Delphin-Rittmon stated that the third question asked about any new data on overdose trends. She noted that overdose data from the Centers for Disease Control and Prevention (CDC) from April 2021 looked at some of the patterns and trends; they showed for the 12-month period, there were 100,000 overdose deaths as compared to the September 2021 data that showed 104,000 deaths during the previous 12-month period, indicating that the overdose numbers were unfortunately increasing. She further stated that in looking at the period from May 2020 to April 2021, there had been a 28 percent increase in drug overdose deaths. In terms of opioid-involved overdoses, there’s been a 40 percent increase from about 56,000 to 75,000. The data also showed a 49 percent increase in the involvement of fentanyl and other fentanyl-related analogs, and synthetic opioids were involved in about 85 percent of all overdoses. Dr. Delphin-Rittmon offered to make the CDC data available for anyone wanting a more in-depth review.

Dr. Stoller responded that he had submitted the question on data because he was alarmed that in Baltimore City, 92 percent of the illicit drugs have fentanyl. He argued that the statistic speaks to the importance of comprehensive treatment addressing not only OUD but also other drugs.

Dr. Delphin-Rittmon agreed that the numbers were striking, confirming that additional work needs to be done on fentanyl, blanketing the country with naloxone, addressing stigma, and getting people connected to MOUD, psychosocial interventions, and other wraparound services and supports. She said all these things could make a difference in recovery services and support.
Dr. Delphin-Rittmon said the last question focused on the continuing disparities and access for addiction treatment, specifically whether differences in disparities were being seen. She shared that the data show definite differences as it relates to age and people accessing services. She shared an example that among people 12 or older, about 14.9 percent needed treatment within the past year, compared to 1.6 percent of adults 26 or older and 1.3 percent of young adults reporting having received substance use treatment in 2020. Dr. Delphin-Rittmon then turned the discussion back to Dr. Olsen, who opened the floor for questions.

Mr. Howell commented that the Building Communities of Recovery (BCOR) funding opportunity just came out, and it included recovery housing as an allowable expense; he thanked SAMHSA for continuing to support recovery services. He further shared that he was very excited to hear the President talk about peer specialists and the creation of a national certification program. Still, he said that it also raises concerns about whether national credentialing will shift focus away from what is being done at the state level. He asked Dr. Delphin-Rittmon if it was known what approach SAMHSA would take to reach out and engage the different states that have already been doing this work?

Dr. Delphin-Rittmon responded with excitement to see the level of support for behavioral health at the highest level, citing many items on the President's agenda as central to SAMHSA’s work. She agreed that a lot of work was being done at the state level and stated that it was certainly a goal to use a participatory approach in the work moving forward to have national and state competencies align in a set of standard core competencies.

Ms. Petoskey commented that it had been a privilege to be a director for an Access to Recovery (ATR) initiative for about 12 years and that the goals of that initiative were genuinely responsive to community needs in trying to expand access to treatment and recovery as well as to the array of services offered. She stated that earlier work laid the foundation for the current recovery movement and normalized the idea that people needed more than clinical services in their recovery. Sadly, she said, tribes in Michigan still grieve the loss of that flexibility and the responsiveness of the initiative. She expressed her hope that in moving forward under Dr. Delphin-Rittmon’s leadership, SAMHSA might consider some of the successes of previous initiatives and integrate those components of responsiveness and flexibility into its vision for the future of treatment plans.

Dr. Delphin-Rittmon thanked Ms. Petoskey for her comment and agreed that SAMHSA should draw from lessons learned from previous grants. She went on to say, remembering her work as a commissioner, that ATR did bring real value, and some of what SAMHSA is considering now includes opportunities to put in place some of the services and supports and wraparounds that Ms. Petoskey mentioned.
CSAT Updates

Topic: Physician Update

Robert Baillieu, M.D., Physician, Office of the Director, provided the first division update from CSAT staff. Dr. Baillieu began by introducing himself and sharing information on his role as Senior Advisor within CSAT. He shared that CSAT priorities are to promote evidence-based practice across CSAT, SAMHSA, and the Department of Health and Human Services (HHS); ensure a cohesive and integrated practice environment; promote CSAT projects of national importance, and work with SAMHSA centers and HHS divisions to promote CSAT goals. Since the last meeting, he shared that his focus has included helping to produce evidence-based guides; work on 42 CFR Part 2 and Part 8; interagency collaboration to establish evidence-based practices; and ongoing work to promote patient-centered, comprehensive treatment. Looking ahead, his plans include continued work on promulgating CSAT's initiatives through evidence-based guides and practice implementation work, data considerations, promoting patient-centered practice, and continued work with SAMHSA centers and HHS divisions to promote CSAT goals.

Topic: Division of Pharmacologic Therapies (DPT)

Patti Juliana, Ph.D., Director, DPT, provided the second update. Dr. Juliana began her presentation with an overview of the functions of DPT. She noted that key activities include OTP certification and support, accreditation bodies' oversight and monitoring, Drug Addiction Treatment Act of 2000 (DATA) waiver activities, provider support, and grant programs. She commented that DATA Waiver activities had kept their group particularly busy, as have activities around provider support because of work with Providers Clinical Support System (PCSS)-MAT and the PCSS-Universities. In terms of their work with grants, she stated that DPT has been working with some of the initial comprehensive opioid recovery centers to be sure to have available medications for opioid use disorder treatment within those centers. She noted DPT has also recently assimilated practitioner education grants. Dr. Juliana continued her grant discussion, explaining that Emergency Department Alternatives to Opioids Demonstration Program involves alternatives to medication in the emergency rooms and is a demo project of 12 grantees. She said DTP's scope has widened and is now focused on provider support, whether OTPs or office-based buprenorphine services.

Moving from the recap to new items since the August 2021 meeting, Dr. Juliana shared that there has been an increase of 81 new OTPs as of April 12, 2022. Guidance was issued in November related to the Mobile Medication Units, with one unit approved and operational since the rule change and seven units awaiting state visits and the Drug Enforcement Administration (DEA) approvals. She stated that efforts related to Regulatory Relief included take-home and telehealth flexibilities being extended, and a review is being conducted of 42 CFR Part 8. New activities under the DATA Waiver Program for Buprenorphine Certification included revisions to the guidelines and training exception (30E), effective April 28, 2021. By the beginning of June, DPT was able to waive anyone who had applied since April 28 and has now approved or certified over 12,000 providers as of the end of March of 2022, bringing the total DATA Waived providers to over 121,000—an increase of over 22,000 since March 2021. Dr. Juliana shared a map overview of current programs noting that there is still one state, Wyoming, that does not have an OTP; she said she anticipates that will change; she highlighted overall increases in Alaska and Hawaii. She
also shared a breakdown of the providers who received waivers during the last year. The bulk of the 30E waivers was for many emergency room physicians who saw the benefit of overdose reversals and being able to prescribe medication for three days.

In summary, Dr. Juliana shared that some of the things DPT will be working on for next year include: 1) identifying and addressing gaps in access to Medication for Opioid Use Disorder (MOUD) across the country; 2) identifying OUD treatment needs by locale (with SAMHSA Regional Administrators and SOTAs); 3) facilitate MOUD providers access to CSAT-funded technical assistance and training resources; 4) improving the capacity of state criminal justice systems to provide MOUD; 5) enhance DPT's intra-division monitoring and evaluation functions; and 6) improving consistency of state-based approaches and federal guidance, e.g., increasing the number of meetings and reestablishing ongoing meetings with the SOTAs, increasing communications, taking a more regional approach, and arranging for training at the AATOD conference for the SOTAs.

**Topic: State Opioid Response (SOR) Program Update**

C. Danielle Johnson Byrd, Director, SOR Team, gave the update on the SOR program. Since its inception, accomplishments of the SOR program include 971,372 clients receiving treatment services, 692,069 clients receiving recovery support services, and 307,956 overdose reversals being reported. In addition, 4,265,396 naloxone kits have been distributed as of April 8, 2022. The SOR/ Tribal Opioid Response Program Instrument has also been revised to collect comprehensive data on the full range of required education and prevention activities to inform congressionally mandated reports on the SOR program. Ms. Johnson Byrd shared that current priorities include enhancing efforts to increase data collection and timely reporting by connecting grantees to SAMHSA’s wide range of training and technical assistance (TA) resources, disseminating SAMHSA resources and toolkits, and engaging in ongoing training and education activities for grantees that help facilitate successful implementation of the grant programs. In looking ahead, the FY2022 SOR grant announcement is in its final stage of development and review; she said its publication was expected in the next few weeks. Additionally, Ms. Johnson Byrd said the Opioid Response Network (ORN) grant would be transferred to and managed by the SOR Team, and an in-depth evaluation of the SOR program performance is in the planning stage.

**Topic: Division of State and Community Assistance (DSCA) Substance Abuse Prevention and Treatment Block Grant (SABG)**

Spencer Clark, MSW, LMSW, ACSW, Acting Branch Chief, Performance Partnership Grant Branch, provided the next update. Mr. Clark began his presentation by explaining that the SABG serves as the primary safety net for 60 grantees (50 states, territories, one tribe in Minnesota (the Red Lake Band of Chippewa Indians), and the District of Columbia), covering the expanse of prevention, intervention, harm reduction, treatment, and recovery support. Of those elements, Mr. Clark shared that prevention and treatment are the most experienced; they are moving into the harm reduction area, and recovery support services have been the primary focus area for expansion in the coming years. He also noted that supporting crisis services has been important this year. Other areas of priority include improving suicide prevention, assessment, and response systems across the SUD continuum of care, especially with persons with co-occurring conditions;
expanding SUD recovery support services; addressing issues of health equity, and supporting activities that enhance the strength, diversity, and expertise of the SUD workforce; and using SABG performance measures, data, and evaluation to improve services accessibility, quality, and effectiveness. In terms of accomplishments, the SABG was appropriated $1,778,879,000 for FY 22 and approved 60 SABG plans and SABG reports; treated 1,758,392 persons across the SUD treatment continuum (July 1, 2019 through June 30, 2020); supported targeted housing, recovery support services, SUD infrastructure, and crisis services through COVID-19 and American Rescue Plan (ARP) Supplemental Funding; provided much needed COVID-19 Testing & Mitigation Supplemental Funding; and adapted services to address health and safety concerns related to COVID-19, including extensive adoption of telehealth services and increased support of mobile SUD services, including OUD mobile medication services. Mr. Clark concluded by sharing SABG’s focus for future activities, among which included: a continued focus on overdose prevention, harm reduction, and response activities such as naloxone overdose kit distribution and the use of fentanyl test strips to reduce overdose deaths; a 10 percent set-aside for non-clinical recovery support services which is proposed to be in the next budget as well as a change in the way HIV case rates are measured for the set-aside for HIV (which is part of the block grant); and continued attention to grantee issues related to compliance with the SABG MOE (maintenance of effort) to make sure that states are continuing to support the services with the primary focus on women’s services, prevention set-aside, and injection drug use.

*Topic: Performance Measurement Branch (PMB)*

Talisha Searcy MPA, MA, Branch Chief, Performance Measurement Branch, continued by introducing herself as new to SAMHSA and explaining how her team, is a bit of a cross-cutting group that CSAT newly formed to ensure that CSAT collects, shares, and uses program data to advance its mission. The team's key priority is to establish CSAT’s learning agenda to identify ways to improve data collection and then leverage those lessons learned to inform program improvement and future work and how efforts may need to be prioritized going forward. Ms. Searcy shared that the team uses three avenues to achieve its priority: compliance, performance measurement and analysis, and program evaluation. The key accomplishment of the branch thus far has been its obtainment of the Office of Management and Budget approval for CSAT programs’ data collection tools (i.e., Government Performance and Results Act, SABG application guidance). Ms. Searcy said that she is looking forward, and the focus will be on rolling out newly approved data collection tools (i.e., grantees and staff training, policy development), developing a strategy to evaluate CSAT priority programs, and completing SABG program data quality assessments.

*Topic: Division of Services Improvement (DSI) Update*

Darrick Cunningham, LCSW, BCD, Director, DSI, began the final update by thanking the NAC members for joining the meeting. Mr. Cunningham then shared that DSI has served nearly half a million clients and highlighted that one of DSI’s most important roles is to ensure that the numbers served are congruent with SAMHSA’s intake and follow-up standard, with the goal of always moving that number forward. Next, Mr. Cunningham shared DSI’s work with disparity impact statements (DIS), noting that diversity, equity, and inclusion are important to the division. He stated that DIS are, in part, how DSI operationalizes their desire to ensure they are being as diverse, equitable, and inclusive. He further highlighted recent work on a trauma inventory and commented that trauma-informed care is now mandated in the agency’s notices of funding opportunities.
Moving into a discussion of the budget, Mr. Cunningham noted that with the generous budget of $431 million, DSI would be able to continue to fund existing programs and some new efforts. With programs now in the pre-award phase, he commented that the Residential Treatment for Pregnant and Post-Partum Women and the Targeted Capacity Expansion (TCE)-Special Projects programs just received comments from the public. Mr. Cunningham concluded his presentation by highlighting changes made to some of DSI’s more recently launched NOFO announcements. Namely, he said exciting things are happening with BCOR related to housing. Such as allowing contingency management as an allowable activity and human immunodeficiency virus (HIV) testing services and recovery housing. Annual BCOR funding has also increased from $200,000 to $300,000 to accommodate the additional allowable activities and increase organizations’ capacity to provide required services.

Additionally, Mr. Cunningham said that with all NOFOs, they had increased annual qualitative or progress reporting to semi-annual to improve grant oversight and ensure program integrity. In the Adult/Family Treatment Drug Court program, he said that they significantly expanded the aperture of who can apply for those grants. For Recovery Housing, they added additional language that emphasizes the important option for recipients to clarify what recovery housing entails; the additional language outlines that applicants have the option of providing peer recovery support services. For the TCE-HIV NOFO, five percent of annual funds may be spent on hepatitis and/or HIV/AIDS testing and services if an outbreak occurs in the recipient's geographic area; and linkages were provided to HIV prevention services. Regarding the Medication Assisted Treatment – Prescription Drug and Opioid Addiction program, funding for grants has increased to $750,000; priorities for the grant include harm reduction, mobile and non-mobile medical units, recovery housing, and contingency management.

**Council Discussion**

Dr. Olsen opened the floor for the NAC to engage in the discussion following the CSAT updates. Dr. Geminn asked if there was any preliminary information from the DEA about the three-day exception, noting that there was excitement in his state about the potential to dispense three days’ worth of supplies and medications from the emergency room with this exception and that they were trying to educate providers. Still, they did not yet have definitive guidance to share.

Dr. Olsen responded by saying that CSAT had received several questions from the field on that topic and that those questions have been forwarded to the DEA. She explained that the DEA was in the process of gathering questions and that she would forward that response to the group once received. Dr. Olsen stated that it was her understanding that practitioners would need to send one request and ask that the exception apply to operate under the exception. She said that it would only need to be a one-time email to cover operating under the exception and that practitioners would not have to send a new email each time. Dr. Olsen stated that it was also her understanding that the DEA is compiling a FAQ document that would be shared.

Dr. Stoller then commented on the required data from buprenorphine practices treating 275 or more patients, stating that he has often asked for an update, but SAMHSA doesn’t yet have data to summarize. He shared that he hears more and more about the increasing pressures of well-meaning advocates to allow methadone prescribing by primary care practices, which he considers alarming. To this end, he said they must get data from these and other buprenorphine practices, especially
those technically required to submit ongoing data. He added that existing data on buprenorphine should consider future regulatory changes for methadone. In closing, he inquired if there had been any progress.

Dr. Juliana responded that they were working with the programmers to enable them to pull and utilize that data more efficiently. She stated that not everybody is good at filling out reports, and some of the data are very mishmashed, so not all data will be good data. Dr. Juliana asked Dr. Stoller to clarify from his perspective how that data would inform any decisions made about methadone prescribing in private practice.

Dr. Stoller responded, stating that he comes from the perspective of having prescribed methadone but in a much more controlled scope in terms of an OTP physician prescribing to patients. Now, however, he said there's advocacy around giving a prescription pad to primary care providers and making MOUD more medicalized. He went on to say, "If we knew more about what services were provided by practices that are providing buprenorphine now, well, there is a lot of research that shows the quality of that treatment isn’t very high, that there is not a lot of monitoring, and that people aren’t referred to ongoing treatment. What are the outcomes in those practices?” He said such concerns call for additional data before taking the following steps. He added that he would also like to know how many people are treated. Also, with the decrease in the necessary training for people with up to 30 patients, he said he'd be interested in knowing whether those providers are providing treatment and how many patients they are providing treatment to. As a DATA waiver trainer, Dr. Stoller said the providers that he trains are interested in and willing to provide more treatment the more they learn, so he has concerns about gradually reducing the required training.

In response to Dr. Stoller, Dr. Olsen reflected on Dr. Delphine-Rittmon’s comments about having an opportunity to do things differently and rethinking how they do things, and using lessons learned. To this end, she said that might mean looking at mobile medication units, various telehealth options, and other pieces and being thoughtful about how they are put together.

Mr. Howell thanked Mr. Cunningham and his team for getting the recovery housing language in the funding opportunities. While SAMHSA has conceptually supported recovery housing over the years, it wasn’t until SAMHSA included that language in the funding opportunities that grantees could operationalize the support. He reminded the group that recovery housing is a form of recovery support services.

Mr. Cunningham responded by stating that in his earlier remarks, he failed to mention Dona Dmitrovic, who is in their newer Office of Recovery, which is a cross-cutting area. He said the Office of Recovery’s role was established to evaluate and initiate policy, programs and services with a recovery focus and ensure the voices of individuals in recovery are represented. The Office will support the growth and expansion of recovery support services across the country.

Dr. Olsen thanked Mr. Howell and Mr. Cunningham for their remarks and stated that one of the things she has been struck by since starting last fall under Dr. Delphin-Rittmon’s leadership is just how much cross-collaboration there is now within SAMHSA, recognizing that it is going to take all of the departments and agencies together to be able to address these issues.

Dr. Stoller expressed concern about what he’s currently seeing in the field. He said on one side,
there is pressure to provide more medication as treatment and minimize the importance of other treatments such as counseling and promoting low threshold and harm reduction insights with essentially no oversight (which he said is okay as long as there are other treatments). This side, he called the simplification of medication as treatment. He said, on the other side is an accredited system where there is an ever-increasing number of accreditation standards being required to ensure comprehensive care. He advocated for SAMHSA to continue being an agency of reason, recognizing that medications are important and save lives. Still, they can only get patients so far. They promote additional helpful treatments and assist people with substance use disorder to get the meaningful recovery they deserve. He also argued that having an accreditation system bound by many requirements (for example, Centers for Medicare & Medicaid Services, DEA, and SAMHSA) limits treatment access. For instance, he said it is too difficult to open a small OTP in a rural area that might really need it because half of the budget would need to be used to support the regulatory people. He concluded his remarks by thanking SAMHSA for its leadership and for taking a thoughtful approach.

Dr. Geminn stated that they try to make sure they’re in lockstep with other regulatory agencies in Tennessee, so they maintain frequent contact with their division of Medicaid and local DEA offices to resolve or avoid conflicts in regulation hopefully.

Dr. Olsen responded in agreement noting the need to provide wraparound services in ways that engage individuals.

Ms. Petoskey commented that they have really struggled with access to methadone in rural parts of the region they serve, stating as an example that until just a couple of months ago, there were no Opioid Treatment Programs at all in the upper peninsula of Michigan. She said there is now a program scheduled to open, but it’s located on the far eastern side of the upper peninsula, and there is almost a 600-mile distance across that part of the state from one end to the other with no programs in between. Ms. Petoskey asked for input from the group if others had found viable solutions in similar cases. She also mentioned that they have progressed with buprenorphine but stated that that was not even accessible for quite a while. In tribal and rural clinics, she said they have found that many physicians and other potential prescribers are unwilling to do it.

Dr. Olsen responded that she thinks that, unfortunately, the stigma of addiction and even the medications used to treat substance use disorder have a stigma associated with them that extends to the healthcare profession and healthcare professionals. She mentioned the PCSS mentioned early by Dr. Juliana as one possible resource in combatting the issue.

Dr. Clarke commented on the workforce problem the field faces, i.e., attracting people to the field. With a need so great, she emphasized that being able to go upstream into schools, colleges, and maybe even into magnet high schools to get people interested in this part of behavioral health is very important. She continued to share that during her work as Chair of the Opioid Task Force in her county, a project was conducted with all the physicians prescribing buprenorphine to determine how many were still prescribing buprenorphine. She said more than half of them were no longer doing so, citing that they weren’t making enough from the program and didn’t have the specialty to know what to do with the clients. She stated that the experiment serves as a reminder that as these initiatives are being moved forward, we mustn’t forget the workforce that has to work within the initiatives and what we must do to prepare those people for the challenges they will face.
Dr. Clarke said that from her experience, extending back to when the field was primarily comprised of paraprofessionals (as they were called then), people looked down on the field of addiction because it was “people helping people.” She cautioned that as the work has been professionalized over the years, the pendulum is swinging back. She said she fears that peer recovery supports are seen as cheap labor. She said, “that should never happen as they’re too important.” She said she fears that they will have to depend on peer recovery folks to carry the brunt of the work when everyone is needed on the team.

Mr. Clark noted that the workforce theme was very important last spring when the department thought about COVID-19 and ARP funding. Several states were trying to improve workforce retention and recruitment. He said it is an area they continue to explore with the block grant funds.

Mr. Howell commented more about workforce development and determining the appropriate role for the peer workforce. He shared concerns about preparing recovery-ready workplaces as peer specialists, and other peer roles are being acknowledged. He stated that with the move towards integration and incorporating peers, those peers are being put in work settings that may not understand what they do. He said, because of this, they see a lot of turnovers, boundaries crossed, and a lack of fidelity.

Dr. Olsen thanked the group for the rich discussion, stating that clear roles and expectations and having ways to support the peer recovery specialists are key. She said it might be good to have Dona Dmitrovic come to the next NAC meeting and talk more about some of the Office of Recovery's work as an agenda item. Moving to the next segment, Dr. Olsen stated that Dr. Kirk James would be presenting on oral health and its link to SUD and SAMHSA’s actions to address oral health within this context.

**Topic: Substance Use Disorder and Oral Health**

Kirk E. James, M.D., Health Systems Branch Program Coordinator, DSI, began his presentation by thanking the NAC members for their service and feedback and providing a brief overview of his background, including his service on the HHS Oral Health Committee. He said that during his over two decades of service, his work has mainly involved the intersection of HIV and SUD and, most recently, overseeing grants dealing with medication for OUD. Dr. James then gave an outline of the topics he would cover.

During the first segment of his presentation, Dr. James stated that good oral health can be defined as "free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissue lesions, congenital disabilities such as cleft lip and palate, and scores of other diseases and disorders that affect the oral, dental, and craniofacial tissues, collectively known as the craniofacial complex."

Next, Dr. James referenced the eight significant findings from the Surgeon General's 2000 Report on Oral Health. He also referenced the HHS Oral Health Strategic Framework (2014–2017) that was authored by HHS Oral Health Coordinating Committee to provide the context for leveraging current and planned oral health priorities and actions across HHS and partner agencies, noting that the framework is currently being updated. He continued to discuss three guiding principles, those
being: 1) oral disease is a health and healthcare problem and not solely a dental problem; 2) long-term visibility of oral health in program and policy planning requires a comprehensive, deliberate, and innovative approach; and 3) HHS is a critical part of a larger oral health enterprise poised to implement the Framework’s goals through collaborative efforts to create collective impact.

Following the principles, Dr. James addressed the following five goals: 1) integrate oral health and primary health care, 2) prevent disease and promote oral health, 3) increase access to oral health care and eliminate disparities, 4) advance oral health in public policy and research, and 5) increase the dissemination of oral health information and improve health literacy. Concluding this segment of his presentation, Dr. James shared critical areas for improving oral health in America, those being: 1) collaboration between dental and other health care professionals to provide integrated oral, medical, and behavioral health care in schools, community health centers, nursing homes, medical care settings, as well as dental clinics; 2) diversifying the nation’s oral health professionals; addressing the costs of educating and training the next generation, and ensuring a strong research enterprise dedicated to improving oral health; and 3) reduce or eliminate social, economic, and other systemic inequities that affect oral health and access to care—policy changes also are needed.

In his third point, Dr. James discussed the links between SUD and oral health. Focusing on tobacco, he stated that smoking is a major cause of gum disease and that people who use methamphetamine are four times as likely to have cavities and two times as likely to have untreated cavities compared with people who do not use drugs and have double the risk of decayed, missing, or filled teeth. Dr. James pointed out that one of the publications that SAMHSA puts out is the Treatment Improvement Protocol (TIPs) and that TIP #33 was recently updated to talk about the treatment for stimulant use disorders. He further pointed to an FDA warning released in January of this year regarding buprenorphine and oral health. Still, he was sure to highlight findings that showed that the benefits of using buprenorphine outweighed the associated risks.

In speaking about SAMHSA’s actions to address SUDs and oral health, Dr. James made a note of the following: 1) participating in HHS Oral Health Coordinating Committee and assisting with the revision of the HHS Oral Health Strategic Prevention Framework; 2) supporting Tobacco Cessation programs as part of SAMHSA discretionary grants; 3) educating the public about oral health (e.g., TIP #33 -Treatment for Stimulant Use Disorders, Response to FDA drug warning about buprenorphine); and 4) garnering insight from experts in the field and other key stakeholders on how to address this important topic.

In conclusion, Dr. James stated that he hoped to engage in discussion with NAC members about their experience in this area to garner more insight from experts in the field of SUD.

**Council Discussion**

Mr. Howell shared that as a person in long-term recovery, he was excited that the topic of oral health was being covered, as it is one of relevance to almost everyone in the recovery community. Mr. Howell stated that he felt the presentation was rich and appreciated the slant toward prevention but would like more focus on how persons in recovery who have missing teeth or need an extraction can be connected to affordable dental services, so they do not have to choose between living with the pain or “using” to deaden the pain. Mr. Howell continued with a second comment.
pointing out that once people in recovery are connected to a dental provider, it provides an opportunity for dental providers to learn about trauma-informed care, knowing that people in recovery are coming in with a lot of shame and a lot of trauma and often must move through a lot of different dental hygienists, repeatedly triggering their trauma.

Dr. Clarke commented that trauma-informed care was important as many clients have severe reactions triggered by the “closeness” of dental visits and everything that goes along with receiving dental care. Regarding the financial aspect of the issue, Dr. Clarke shared that from her experience, it’s rare to find a dentist who will take Medicaid because the rates are extremely low, and there is very poor insurance coverage. She stated that Medicare also does not cover dental for individuals over 65 years old, the same population who need assistance the most after long years of substance use. Dr. Clarke concluded by commenting on the prescribing practices of dentists, stating that dentists were notorious for prescribing opiates very freely and that there is a great need for them to be better educated about prescribing to the recovery community.

Dr. James reminded the group that SAMHSA’s perspective speaks to treating the whole person. Beyond that, he agreed that SAMHSA does need to address the practical matters of cost, including issues with Medicaid and Medicare. To that end, the question becomes how SAMHSA can best help. Perhaps part of the answer lies in introducing something feasible and practical into noticing funding opportunities that encourage substance use disorder treatment programs to incorporate oral health into their overall delivery of services.

Dr. Clarke added that the federally qualified health centers (FQHCs) have been expanding dental care through some of the grants that have come out, and it has been a godsend for many people. Notwithstanding, she expressed concern because of practitioner shortages at FQHCs. She concluded by emphasizing the importance of partnering between behavioral health and the medical communities.

Mr. Howell asked Dr. James if he knew those organizations’ funding mechanisms to provide dental services to persons with HIV, understanding that Dr. James had previously worked with HIV programs and that some AIDS service organizations partner with dental clinics or have dental clinics,

Dr. James responded that he could not say offhand. His experience was related to monitoring grantees serving individuals with SUD at high risk for contracting HIV or AIDS, but those grantee programs could probably provide insight.

Dr. Olsen mentioned that the Ryan White program has some applicability potentially for the population of people living with HIV. She summarized that this is probably a very untapped area in terms of figuring out how to better partner with and connect the different pieces of the healthcare system; specifically, how to include an understanding of behavioral health conditions and how to incorporate trauma-informed care into the dental perspective.

Ms. Petoskey referred to the conversation about ATR, stating that they were able to expand the array of services to include emergency dental care under that initiative. However, she noted that today, so many people are living outside of a health care system that even if there was potential for them to get Medicaid, they don’t have it. Further, even if they did, Medicaid doesn’t provide
anything for dental care in many states other than a significant medical emergency, leaving preventive care or interventions uncovered. As mentioned by Dr. James, a potential solution moving forward would be for SAMHSA in its notices of funding opportunities to incorporate some language on required activities and optional activities, under which grantees could include providing dental care.

Dr. James commented in agreement, stating that required and allowable activities are included in the template but that they need to be able to tie those activities to funding. He concluded that it was something deserving more investigation. He acknowledged that many individuals don’t truly understand the importance and impact of good oral health until after dental work has been done. They see how it can change a person’s entire outlook. Dr. James also pointed out that dental phobia was a genuine issue that needed to be addressed.

Dr. Olsen commented that funding considerations/allowable expenses are considerations when creating the NOFOs. She also shared that she was struck by the conversation regarding transportation challenges to dental visits and whether other similar pieces of the broader oral health set of activities need to be better addressed through the case management component. She acknowledged that there were, in fact, lessons that could be learned from the ATR experience and how Medicaid allowances function in certain states to cover areas like transportation to medical visits. She also questioned how SAMHSA could improve the education of the public regarding behavioral health providers and the substance use disorder system, noting that not everyone recognizes the importance of oral health and how oral health fits in the bigger picture.

Dr. James agreed that he would be interested in hearing others’ thoughts on that matter.

Dr. Clarke said that too often, the issue is finding the resources to resolve the dental issue once it has been identified, noting many screening tools include items related to dental care.

Mr. Howell echoed Dr. Clarke’s sentiment and stressed the importance of understanding that if you start an oral health awareness campaign, you need to first have a solution and resources in place.

Dr. James acknowledged Mr. Howell’s point and the importance of being ready to act after making people aware of the issue.

Dr. Olsen commented that one of the things being explored is more of a stakeholder engagement discussion with all relevant stakeholders, not just NAC members.

In response, Mr. Howell stated that high-level conversations and strategic conversations to start moving toward solutions would be a step in the right direction but cautioned that it would not be a one-size solution given the vast diversity between the states.

To clarify her previous comments, Ms. Petoskey added that the use of recovery resources was reserved as a last resort after exhausting an individual’s other resources under ATR. She commented that “When SAMHSA sets a policy, SAMHSA can’t be expected to be the answer to everything, as the needs are very complex. However, at the same time, SAMHSA should have processes in place to prevent having to watch people perish because they couldn’t see a dentist. Believing that there's a solution to everything, the approach should be that we just have to keep
trying, which involves consultation with various people at all levels.”

In summary, Dr. James stated that SAMHSA could look to some programs or special initiatives that have been successful in the past, with the recognition that SAMHSA will probably be forced to be a little more innovative in its approach to addressing current concerns.

Looking at comments in the chat, Dr. Olsen noted references to the American Dental Association, the dental health industry, the FQHCs, the PCSS Steering Committee, and other partners to engage in the discussion. In closing, Dr. Olsen thanked Dr. James for his work and engagement and the participants’ discussion.

**Public Comment**
The DFO notified the NAC that public members submitted no written comments. She proceeded to ask for any real-time comments/questions from the public; there were none.

Dr. Olsen thanked members of the NAC for the day’s rich discussion. She emphasized how invaluable their experiences and insights are to resolving the challenges.

**Adjourn Open Meeting**
The DFO asked for a motion to adjourn. Dr. Stoller motioned to adjourn; Mr. Howell seconded his motion. With all NAC members in favor of the motion, the DFO adjourned the meeting at 4:24 p.m. EDT.